NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board

Public Board Meeting

Tuesday, 26th March 2024
at 9.30 am

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

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

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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 26th March 2024
Time: 9.30 am
Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Dr Gerry McSorley, Acting ICB Chair

AGENDA

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Dr Gerry McSorley	9.30
ii)	Declarations of Interest		Verbal	Dr Gerry McSorley	
iii)	Minutes of the previous meeting held the 30th January 2024	Approve	Enclosure	Dr Gerry McSorley	
iv)	Matters Arising, including Action Log	Note	Enclosure	Dr Gerry McSorley	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair • Update and Overview	Note	Verbal	Dr Gerry McSorley	9.35
ii)	Chief Executive • Update and Overview	Note	Verbal	Mr John Turner	9.45
3. KEY UPDATES					
i)	Public Health	Note	Verbal	Professor Derek Ward	10.00
ii)	Healthwatch	Note	Enclosure	Mr Dean Odell	10.05
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	Legal Duties – Information on Health Inequalities	Consider	Enclosure	Mrs Sandra Williamson	10.15
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	Integrated Quality and Performance Report	Receive	Enclosure	Mrs Clair Raybould/ Mr Martin Fahy	10.25
6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report – Month Eleven	Receive	Enclosure	Mr Matt Gaunt	10.40
BREAK AT 10.50 AM (10 MINUTES)					
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	Social Finance	Note	Enclosure	Mr Matt Gaunt	11.00

8. GOVERNANCE					
i)	Lincolnshire NHS Joint Forward Plan 2023-28	Approve	Enclosure	Mr Pete Burnett	11.10
ii)	Delegation of Specialised Commissioning and the joint commissioning arrangements	Approve	Enclosure	Mrs Sandra Williamson	11.20
iii)	ICB Emergency Preparedness, Response and Resilience (EPPR) Annual Report 2023/24	Receive	Enclosure	Mrs Clair Raybould	11.30
iv)	Report from the System Quality and Patient Experience Committee (QPEC) Development Session held on the 4th March 2024	Receive	Enclosure	Mrs Sharon Robson	11.40
v)	Report from the Service Delivery and Performance Committee meetings held in January and February 2024	Receive	Enclosure	Mrs Dawn Kenson	11.45
vi)	Report from the Audit and Risk Committee meeting held on the 19th March 2024, including approval of revised Terms of Reference	Receive	Enclosure	Mrs Margaret Pratt	11.50
9. INFORMATION /CLOSING ITEMS					
i)	Report on the ICB Annual Report for 2023/24	Note	Enclosure	Mrs Jules Ellis-Fenwick	11.55
ii)	Risks identified during the course of the meeting	Consider	Verbal	Dr Gerry McSorley	12.00
10. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 28th May 2024 at 9.30 am at Bridge House, Sleaford	Note	Verbal	Dr Gerry McSorley	Close

Please send apologies to: Jules Ellis-Fenwick, ICB Board Secretary via email at: julieellis1@nhs.net

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

Special Resolution - The Board will be asked to consider the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest' - (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)
Items in the private part of the meeting are either commercial in confidence or relate to individual staff and patients.

NHS
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MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY, 30th JANUARY 2024 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	Acting ICB Chair and Chair of the Primary Care Commissioning and Delegated Functions Committee
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	Mr Matt Gaunt	Director of Finance
	Mr Martin Fahy	Director of Nursing
	Dr Sunil Hindocha	Interim Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Margaret Pratt	Non-Executive Director and Chair of the Audit and Risk Committee
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Director
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS	Mr Nick Blake	Programme Director, Primary Care (item 5 (iii) only
	Ms Charley Blyth	Director of Communications and Engagement
	Mrs Sara Brine	Head of Mental Health Transformation, ICB (item 4 only)
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Jules Ellis-Fenwick	ICB Board Secretary and Head of Corporate Governance
	Mrs Kirsten Guy	ICS Research Lead (item 5 (ii) only)
	Mrs Louise Jeanes	Cancer Programme Director (item 5 (ii) only)
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Steph King	Strategic Communications and Engagement Lead Manager (item 7 only)
	Mr Dean Odell	Healthwatch Representative
	Mrs Victoria Sleight	Head of Community Mental Health Transformation, LPFT (Item 4 only)
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
APOLOGIES:	Ms Anita Day	Non-Executive Director
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mr Andrew Morgan	Group Chief Executive, Partner Member, NHS and Foundation Trusts

24/173 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire Integrated Care Board and emphasised that whilst the meeting was being held in public it was not a public meeting. The meeting was being held both on a face to face basis and via Microsoft Teams as a Live Event.

This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams. Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma which was published on the website.

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

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

24/174 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

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

Declaration of Interest from Committees:
No items declared.

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

The Board agreed to:

- **Note the interest as declared.**

24/175 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 28th November 2023 and agreed to:

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

24/176 MATTERS ARISING

Dr McSorley presented the Action Log as included in the pack of papers. There were five actions, all of which were identified as complete.

The Board agreed to:

- **Note the action log.**

Dr McSorley proposed, and it was agreed, to bring forward Item four on the agenda as Mrs Brine and Mrs Sleight had joined the meeting to co-present this item, but did need to leave by 10.30 am.

CORE PURPOSE 1: HEALTH INEQUALITIES

24/177 REDUCING INEQUALITIES FOR PEOPLE WITH SEVERE MENTAL ILLNESS (SMI)

Mrs Williamson introduced the paper included in the pack and advised that the focus for today's briefing was on reducing inequalities for people with SMI. The Board will be aware based on previous briefings on health inequalities and the Director of Public Health report that people with SMI generally live 15-20 years less the general population.

The report and supporting presentation had been produced to outline the work being undertaken to reduce health inequalities in SMI, which is a complex issue that requires a multi-faceted approach.

Mrs Williamson handed over to Mrs Sara Brine Head of Mental Health Transformation at the ICB and Mrs Victoria Sleight, Head of Community Mental Health Transformation at LPFT at this point to run through the presentation.

Both individuals thanked the Board for the opportunity to present the details of the work being undertaken and went through the presentation. There were a number of areas highlighted, the first of which referred to the vision of the Lincolnshire Mental Health, Dementia, Learning Disabilities and Autism Alliance (MHDLDA) *"Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities".*

Other areas highlighted:

- Lincolnshire Prevention Concordat (for better mental health) including understanding local needs and assets, action being taken on prevention and promotion of mental health and wellbeing and tackling inequalities, defining success and measuring outcomes, leadership and accountability.
- Overview of the Mental Health Population Profiles of people in Lincolnshire with a mental health condition and integrated approach to this being undertaken with Public Health colleagues.
- Work being undertaken with Community Connectors along with examples of the community engagement and activity being delivered.

The next steps were also outlined, including some of the challenges and key for focus and action going forward.

The final slide of the presentation set out the details of a case study taken from one of the integrated case based teams which provided insight into the personal case of a patient named Carl and what action was taken by that team, and the situation 12 months on. This had been included to bring to life the work taking place.

Dr McSorley thanked both individuals for an informative and thorough presentation and opened up the discussion for questions.

Mrs Robson referred to the SMI Physical Health Checks and advised that she understood that one of the side effects of anti-psychotic medications is weight gain, increased sugar levels and blood pressure, which in turn can lead to the risk of diabetes and cardiovascular disease and asked whether in terms of the comprehensive assessment if medicines management is engaged in that piece of work. Mrs Robson also asked for clarification on what outcome measures were being considered beyond the number of completed checks.

Mrs Brine advised that in terms of the anti-psychotic medication and any medicines management input, this was likely to be through the pharmacy team in primary care. If a patient had figures which were being flagged as a concern then the right individuals and professionals would be brought in to address that. Some individuals are also supported by LPFT, and their care will involve multi-disciplinary teams.

Dr Thomas advised that normally patients should be subject to a yearly medication review and any concerns should be picked up by the GP at that stage.

Dr Hindocha added that anti-psychotic medication should be picked up as part of the full health check but there are always risks in terms of the balance between physical and mental health.

In terms of outcomes, as a GP he would be looking at whether this had made a difference in terms of the patients reduced cardiovascular events and mortality rate expectancy and whether their pre-life expectancy has increased as a result of intervention. The biggest challenge facing general practice is having a case manager for every single person with severe mental health illness. This would assist in the on-going care and treatment of these individuals by ensuring they receive the necessary services they require and access to support they need.

Professor Ward commented that the case study demonstrated very well there is wrap around support in place for these individuals. Keeping people fit healthy is fundamental for secondary care prevention and helping people manage their own conditions better will in the long term save the system money and produce better outcomes for patients.

Councillor Bowkett emphasised the importance of keeping people fit and well and provided some personal insight into this for the Board's information and commended the suggestion by Dr Hindocha to have a case manager assigned to every single person with SMI.

Mrs Kenson asked whether other professionals can carry out health checks besides a GP and could they be carried out in people's homes or do they have to take place in the practice. Mrs Brine advised that the target is for primary care to address, and they will have a multi-disciplinary team in place carrying out some elements of the health check such as blood tests, blood pressure review by way of examples. Ultimately it would be up to the GP to review to determine the on-going support required. Those people who are supported by LPFT would also have health checks carried out by professionals in their teams. The key is picking up those individuals who are not currently engaged but also recognising those patients who have been diagnosed and are supported through the appropriate pathway.

Mrs Connery referred back to Mrs Robson's comments on outcomes and advised that LPFT have arranged a Development Session where there will be Experts by Experience present to discuss what those might be. Some people are not registered with a GP and the challenge is accessing those individuals.

Mrs Jolly queried how the Voluntary and Care Sector (VSCS) can tap into the resource and support that has been outlined to instigate that wrap around service, specifically where they are coming across individuals who may not have been identified by other sectors. Mrs Sleight acknowledged that engagement with the voluntary sector needed to improve and provided some examples of where the VSCS could help such as accessing hard to reach groups, adding that she was happy to pick up the conversation outside of the meeting.

Mrs Pratt referred to the recently published PCN's Annual Report which celebrated the integration of both public health and mental health into the work of general practice networks, and asked whether this is consistent across all of the PCNs and what are the opportunities to expand this. Mrs Sleight advised that when the Community Mental Health Transformation programme launched it was implemented in phases. The case study provided had been taken from a well-developed Vanguard site in Lincoln City. Where there are some wave two sites, particularly in the East Coast, there are gaps, but the ambition is to have a consistent approach in place across the whole of Lincolnshire with everyone having access to the same set of outcomes.

The conversation moved on to PCNs and their population health profiles, along with comments about outcome growth and streamlining of data as currently there is a considerable amount of duplication and also the better use of resources through the PCN Alliance.

Mr Turner advised that firstly he wished to express his appreciation for the attendance by Mrs Brine and Mrs Sleight. It was a great presentation followed by a good discussion and thanked 'Carl' for allowing the Board to hear his story. Secondly, thought needs to be given in terms of the outcomes that could be demonstrated this time next year for both SMI and patients with

learning disabilities, building on the superb work as demonstrated today, which was agreed and noted.

Dr McSorley drew the discussion to a close at this point.

24/178 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that he had some specific points to highlight for the Board's information.

Since the last Board meeting, Mrs Elaine Baylis had been formally appointed as the United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) Group Chair from the 1st April 2024. This was congratulated and welcomed by the Board.

Mr Kevin Lockyer had recently been re-appointed as the Lincolnshire Partnership NHS Foundation Trust (LPFT) Chair for a further three years. This was also welcomed by the Board.

Dr McSorley had met regularly with the Trust Chairs, Lincolnshire Leaders Group (LLG) and hosted the System NEDs Strategic discussion on the 29th January 2024 looking at what the strategic plans should be for the incoming period. It was a positive event with meaningful contributions by those who attended.

Dr McSorley referenced the recent visit to the county's NHS services by Professor Claire Fuller, NHSE Medical Director of Primary Care, and reported that she was enormously impressed with the work being carried out collectively in the Lincolnshire system and in partnership with a variety of other organisations, such as, but not exclusively, the University of Lincoln which hosted the event.

Mr Turner and Dr McSorley had recently met with new colleagues from Healthwatch, namely Mrs Michelle Duggan, Chair of the Board of Trustees and Mr Navaz Sutton, Chief Executive Officer, HWLincs in the spirit of growing relationships between the two organisations.

The Board's next Development Session is scheduled to take place on the 27th February 2024 and would include an hour session on Equality, Diversity and Inclusion (EDI) work, which the Board needs to be involved and engaged with. A number of colleagues present in the room had engaged with Audit Yorkshire regarding the development of the ICB going forward and on the subject of EDI, there is an upcoming NHSE EDI event planned to take place on the 8th March which ICB and Lincolnshire system colleagues would be attending. Dr McSorley would also be attending and had agreed to sit on one of the four panels.

Mrs Debbie Barnes had joined a system-wide meeting of Board Members on the 8th January to provide a briefing on Lincolnshire's devolution proposal. It was confirmed that the ICB and system colleagues had written a collective letter to Lincolnshire County Council (LCC) to formally offer its support of Lincolnshire's devolution proposal.

On a final note, there had been some questions received from two members of the public. Mr Turner would cover these as part of his Chief Executive update.

Dr McSorley handed over to Mr Turner at this point.

Chief Executive update

Mr Turner advised that he had some specific points to highlight to the Board but firstly it was important to recognise that since the Board last met on the 26th November, the NHS had been through an exceptionally intense time and remained in the midst of the winter period.

There had been significant issues with industrial action in relation to the junior doctors strike, Christmas and New Year and the associated pressures that brings, and seasonal illness such as flu, COVID and Norovirus. Having said that, the overall performance of the NHS in Lincolnshire continued to compare well to many other parts in the rest of the country. The position in terms of electives was strong with clear plans in place to reach the requirement to achieve zero patients waiting 78 weeks by the end of March 2024, alongside with the work to address performance in respect of cancer, mental health and primary care.

Mr Turner updated the Board with the positive news that the Lincolnshire system is now out of the Tier 1 support measures for both cancer and elective care, which was welcomed, and the efforts of all colleagues contributing to this achievement was recognised.

Other points to highlight:

- Professor Derek Ward had commenced in his role as System Lead for the Community and Primary Partnerships and a number of events were planned to take place over the coming months to pull together the approach to be taken forward.
- The advert was out for the ULHT and LCHS Group Chief Executive, which was scheduled to close at the end of that week.
- The final planning guidance for 2024/25 was still awaited from NHSE but in the interim work continued with all the planning requirements already communicated, and Mr Turner expressed his appreciation to Mr Burnett and colleagues involved in this work.
- The next Quarterly System Review Meeting (QRSM) with NHSE regional team is scheduled to take place on the 31st January 2024 and the Board Members will be appraised of the outcome.
- Arrangements with the University of Lincoln continue to go from strength to strength and the appointment of its first Dean of the Medical School, namely Dr Jamie Read was welcomed, as was the news that the University has secured an £11million research deal, which will benefit the health and care of the county in time.
- Joint work continued on the development of the People and Digital functions and the Board will be updated in due course.
- The work on the delegation of 59 specialised commissioning services on an East Midlands footprint continued and was shaping up positively. There was a separate paper on this included in the pack of papers for consideration later in the meeting.
- Mr Turner continued to liaise with partner colleagues outside of Lincolnshire, such as the new CEO for North West Anglia NHS Foundation Trust (NWAFT), new CEO for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG), Hull and North Yorkshire and Norfolk and Waveney ICBs.

Mr Turner referred to two questions received from members of the public at this point, which were read out for information along with an indication of the proposed response. It was noted that the response would be sent directly to the members of the public after the meeting. The full question and response would also be attached to the minutes of the meeting and published on the ICB website as per usual practice.

The Board considered the update, and a brief discussion took place on patient and public involvement and the Accessible Information Standard (AIS) which related to one of the questions received by the member of the public. It was noted that the ICB Board Assurance Framework included a risk in relation to failing to engage effectively with the population of Lincolnshire and a report was included in the pack of papers on the People and Communities Strategy by way of assurance, which would be discussed later in the meeting.

The Board agreed to:

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

24/179 KEY UPDATES

Public Health

Professor Ward provided a verbal update in relation to Public Health and outlined the department's current efforts to support the population of the county with regard to the increase in use of vapes, as well as the national rise in measles amongst younger children, though was able to confirm that there were no cases in the Lincolnshire population at the present time. A proactive approach was being taken to ensure as much uptake of the MMR vaccination as possible, with this work happening through the Health Protection Board who reports to the Health and Wellbeing Board. An Annual Report will also be produced.

Professor Ward referred to the presentation earlier in the meeting on health inequalities and advised that an Executive Inequalities Group has been established which he Co-Chairs jointly with Mrs Williamson. A key focus of that group is to embed health inequalities into the day to day delivery of services and this sits within the approach set out in the Integrated Care Strategy which has five key enablers, which were summarised for information. The ICS Strategy will be refreshed over the coming months.

The forthcoming launch of the Community Primary Partnership development work was also introduced to the Board and a summary of the profiling and stakeholder engagement completed to date was shared.

The Board considered the update. Dr Thomas referred to the number of measles cases and commented that there needs to be an increased level of testing and thought needs to be given to a process to raise awareness.

Mrs Pratt referred to the refresh of the ICS Strategy and asked whether this would include the importance of data sharing in a rational way. Professor Ward advised that one of the five key enablers is population health management and intelligence, for which Mr Gaunt is the ICB Executive Lead and system SIRO. A significant amount of work has been carried out at population level to connect up a lot of different intelligence and there is now an understanding of groups experiences through health and care pathways. That information is all pseudonymised or anonymised. Data is available at an individual level and there is a different workstream in place to connect that information together with a view to providing this for individuals to front line clinicians to enable them to provide the right care and support to patients.

Mr Gaunt endorsed Professor Wards comments, adding that population health is from a system perspective and the impact is being able to make it personalised so that clinicians understand the patient cohort being referred to. The insights should also give a complete picture where as currently, and as discussed earlier in the meeting, there is a gap in hard to reach groups. In short, and by way of assurance, as much that can be done at a local level was being actioned. Dr Hindocha added that the Lincolnshire system is the only one in the country that has Data Sharing Agreements in place across all PCNs, which is a really good platform to build on.

As a final point of note, Mr Burnett outlined the information included in the digital element of the ICB Strategy, specifically pertaining to the Shared Care Record which can be accessed by members of the public along with clinicians and care professionals across the health and adult social care sector. There is also an additional section which sets out how data is joined up.

The Board agreed to:

- **Note the Public Health verbal report.**

Dr McSorley advised that the next item to be considered would be the update on the Clinical Directorate and the Research and Innovation Hub and welcomed Mrs Louise Jeanes and Mrs Kirsten Guy to the meeting.

CORE PURPOSE 2: HEALTH OUTCOMES

24/180 CLINICAL DIRECTORATE AND RESEARCH AND INNOVATION HUB

Dr Hindocha introduced the next item and the report which outlined the development of Lincolnshire's research and development hub and the key principle of the Clinical and Care Directorate, which is to be the best evidence based, data driven, clinically-led system. The research bid as referred to earlier by Mr Turner in the meeting is part of this work. Dr Hindocha handed over to Mrs Jeanes and Mrs Guy to run through the detail as part of a presentation included in the pack of papers.

Mrs Jeanes thanked the Board for the opportunity to attend the Board meeting and advised that she currently has a leadership role in the Care and Clinical Directorate, and is supported by Mrs Guy, who is leading on the establishment of LIfE.

The presentation highlighted to the Board the importance and benefits of an active health and care research programme in any system and updated on the progression already made in formalising and developing Lincolnshire's, drawing upon the many pockets of activity already occurring. This also incorporated the work that is being supported by partners across the system in readiness for a launch event in April 2024 which will be supported by an information portal for public and staff to encourage awareness, engagement and involvement.

Mrs Robson commended the work to date and firstly commented that the information provided in the report and as part of the presentation appeared to indicate the basis of the development of a Clinical Strategy and was interested to ascertain whether that was correct. Secondly, the information indicated that the Clinical and Care Directorate will be the collective of all health care professionals in Lincolnshire and has something been agreed and where has that been considered. Dr Hindocha advised that the next step is socialisation of this work and provided examples of how this will take place, including the first step being the briefing provided to the Board today.

Mrs Blyth added that she had been working very closely with Mrs Guy on the Research Hub which had been through a huge engagement and involvement process in the development of this, and work is taking place on the establishment of some co-production workshops to shape to ensure the public voice is heard in terms of how they want to access this information.

Following a discussion on engagement, demonstrating evidence of how the initiatives are embedded and demonstrable outcomes for patients. In summary, the Board confirmed they were unanimously supportive of this work, and the need for commitment to it to realise the benefits to health and care outcomes in Lincolnshire.

The Board agreed to:

- **Note the report and update on the development and progress of Lincolnshire Academy of Clinical Excellence (LACE) and the Research and Innovation programme.**

Mrs Jeanes and Mrs Guy left the meeting at this stage.

Dr McSorley directed the Board back to item 3.2 on the agenda – Healthwatch update.

KEY UPDATES CONTINUED

Healthwatch

Mr Odell advised that the report included in the pack of papers summarised patient experience feedback received by Healthwatch during December, and he would take the document as read, but wished to highlight the following points:

- The majority of the experiences shared related to Mental Health. These experiences came in via the Healthwatch Community Mental Health Survey which received 91

responses. 67% of those respondents found it difficult to access adult services. Both service users, parents/carers, and professionals highlighted consistent concerns, with long waiting times being the most significant issue.

Mr Odell referred to previous comments made by Mrs Connery where she indicated that Lincolnshire Partnership NHS Foundation Trust (LPFT) have some of the lowest numbers of community waiting times when benchmarked against other mental health Trusts, but this did still remain a concern based on the recent feedback received from service users.

Over the past six months professionals working in mental health service had noticed an increase in more complex cases and a rise in the number of young people needing support for their mental health.

Mrs Connery advised that she had made comments previously about the work being carried out in response to the survey, which was referenced in the Healthwatch report, but added that LPFT are also conducting a full demand and capacity review of all its services as part of their Operational Plan for 2024/25. It is about having the right services in the right place at the right time and this feeds into the discussion at the recent system NED meeting which had taken place in respect of access and what is a suitable length of waiting time. Waiting times for Talking Therapies was included in the Integrated Performance and Quality report and indicated they were currently longer than they should be. Additional training places were coming on line in 2024/25 to improve that position.

In respect of Children and Young People's Services (CYP), the performance data is scrutinised by the Service Delivery and Performance Committee, and the membership includes a Non-Executive Director representative from LPFT and Lincolnshire County Council who are co-leading on that piece of work.

Building on Mrs Connery's point about Children and Young People, Mrs Raybould advised that the Service and Delivery Committee have recently carried out deep dives into mental health and CYP and when the detail was last reviewed it did demonstrate some quite lengthy waiting times. However, since that time waiting times have reduced considerably and Lincolnshire is performing well in comparison to other organisations when looking at the level of demand into those services, but there is more work to be done as outlined by Mrs Connery.

Mr Odell referred to the comments in the report in relation to NHS dentistry, where access continued to be a top concern.

Mrs Williamson advised that she is due to meet with Healthwatch representatives in the coming weeks in relation to dentistry. The ICB has established its Dental Strategy and as part of that there is a workstream on improving access, and Healthwatch have been invited to support the ICB in terms of looking at the local solutions being put in place to improve access. Work is due to complete on the Oral Health Needs Assessment which will determine what the plan looks like for the next three years in terms of local areas where access is particularly poor, based on population need and also including prevention. Information on the plans would be brought back to the Board in due course.

Councillor Bowkett referred to the unacceptable behaviours being exhibited by some of the local NHS dentists who also provide private care, which had been detailed on social media. Dr McSorley asked Mrs Williamson for clarification on the contractual position in respect of NHS dentists. Mrs Williamson advised that some dentists do provide both NHS and private dental services and the ICB's contract and responsibility is on the NHS offer only and there are not the same assurances and mechanisms in place regarding private care. The dental contract does allow for some flexibility in terms of commissioning arrangements, and this is being looked at for next year in terms of specific targeted groups as part of the Oral Health Needs Assessment

Dr Thomas advised that he had recently met with Dr Kenny Hume, the lead for the Local Dental Committee who had indicated that dentists are contracted for a certain number of episodes of care, for which they are remunerated; they will not provide dental care outside of what they are contracted to do.

Mrs Raybould advised that the way in which dental commissioning works is very different. The majority of dental providers now are predominantly private with only a small amount of NHS provision; hence the work to improve NHS dental provision through the Dental Strategy.

There were some further comments in relation to provision for emergency dental treatment where NHS access is not available. Mrs Williamson advised that a new interim offer in respect of emergency access is being trialled and a considerable amount of communication has been carried out to raise awareness.

Dr McSorley asked whether there was an update on the position in relation to fluoridisation. Professor Ward advised that currently half of the county (the West) receives water which contains fluoride; the other half do not (the East). This is demonstrated in terms of prevention with the number of dental issues experienced by members of the public being significantly higher in the East. There are numerous discussions taking place in regard to the ambition to fluoridate the whole water supply and this is now at the stage where this needs to be picked up via the ICB directly into NHSE and the Department of Health and Social Care. Ultimately, it is the decision of the Secretary of State for Health and Social Care.

Some final points of note were highlighted by Mr Odell:

- Healthwatch Lincolnshire has been selected by Healthwatch England to carry out two Enter and View Visits in the new year. These visits will be to Grantham Community Diagnostic Centre (CDC) and Skegness Urgent Treatment Centre. The purpose of this activity is to understand the experiences of people attending CDCs for diagnostic tests and the experiences of staff working in CDCs.
- Healthwatch will continue to undertake Enter and View visits in Lincolnshire Care Homes in 2024 and will publish the reports from the last three visits in January.
- Campaigns Healthwatch Lincolnshire has strategically chosen to prioritise in 2024/25 - menstrual health, respiratory conditions, neurological conditions, and mental health.

The Board agreed to:

- **Note the Healthwatch report.**

CORE PURPOSE 2: HEALTH OUTCOMES CONTINUED

24/181 INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the performance section of the Integrated Quality and Performance Report and advised that she would take the report as read but wished to highlight some specific points for the Board's attention.

As the Board was aware, the Service Delivery and Performance Committee reviews reports on performance and delivery and detailed scrutiny occurs by service area alongside quality. This report contains the key constitutional targets and information will be provided verbally in the meeting where more recent data is available on key operational targets.

As a first point of note, and as touched upon by Mr Turner earlier in the meeting, the ICB had been successful in exiting the Tier 1 support measures for both cancer and elective care. This was really positive news in light of a really challenging period in the NHS in terms of winter, industrial action and storms Babet and Henk which have caused severe flooding in a number of areas in Lincolnshire.

Despite those challenges, overall performance had improved over winter and the Winter Plan was delivered well although it was recognised there was further work to be done around patient experience.

Mrs Raybould highlighted some specific areas of performance for the Board's information:

- 4 hour A&E performance in January to date was at 73.5% which was really positive in the context of the challenges shared.
- There had been significant reduction in long ambulance handover delays. This is as a result of working in partnership with system partners to manage the risks, including acute and ambulance services, community services (both physical and mental health), adult social care and the voluntary sector.
- Category two performance data was included in the pack, and the 30 minute target in Lincolnshire had been achieved at some points in the month. The Lincolnshire system remains in Tier Two, but positive improvement has been noted. Other systems have contacted the ICB in the last few weeks to understand the measures put in place to improve performance.
- Cancer – as referred to by Mr Turner the system had been stood down from Tier One. One of the areas to highlight from the reports relates to colorectal which links to the presentation by the Clinical and Care Directorate earlier in the meeting, where performance had previously been high at 65% of backlog. This was now down to 25% and earlier diagnosis as referred to by Dr Hindocha which was reflective of the great work of the ICB Cancer Team and joint work with ULHT and primary care colleagues.
- A further area is the lung pathway which went live on the 4th December 2023 whereby there had been 399 less scans undertaken than the previous month.
- Planned care – the December 78 week outturn position was 45, which is much better than planned. The expected outturn position for January was 20 but there had been a critical incident that day with ULHT in relation to water and this may have an impact on the theatre availability. Patient choice is the main reason for the 20 individuals waiting.
- ULHT in particular, but all of the Lincolnshire Trusts have done an excellent job of protecting elective and cancer during the two periods of industrial action, which was to be commended.
- Since the Board last met some CDC activity had commenced in Lincoln and Mablethorpe.
- Talking Therapies – in November performance was above plan. The latest rolling rate is 25.7% against the target of 33%, which represents good recovery but as discussed earlier in the meeting, there is more work to be done.
- First episode of psychosis – performance was 75%, having previously been at 67% but at the last Board meeting had been 38% so there had been significant improvement, which is positive news for patients.

The Board considered the performance update. Mrs Pratt asked for further information in relation to the percentage of patients not treated within 28 days of last minute elective cancellations ULHT where performance appeared to be considerably lower than the target. Mrs Raybould advised that this remained one of the constitutional targets, but due to elective recovery that is not currently an area of focus, but she would look at the specific detail.

Action: Mrs Raybould

Dr Hindocha added that one of the Clinical Directors at ULHT is looking at a piece of work focusing on optimising patients before they get cancelled.

Mrs Raybould handed over to Mr Fahy at this point to present the Quality Section of the report.

Quality Section

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

- There had been some challenges occurring in the delivery of young people's Speech and Language Therapy services, and Mr Fahy described the support being provided across the system to mitigate this and ensure Lincolnshire's young people receive the best support possible.
- There had also been some challenges in respect of the lymphoedema services. Mr Fahy assured the Board that a number of actions had been taken to stabilise the situation, and a wider piece of work will be undertaken to consider how best to meet the needs of patients with lymphoedema to ensure appropriate pathways of care are in place with sufficient capacity and capability to meet identified need. A 'Lower Limb Summit' is being planned for early in 2024.
- The Bourne Galletly practice's recent CQC inspection report had come back as Outstanding overall, which was really positive news and to be commended.
- To date EMAS, ULHT and NWAFT have transitioned to Patient Safety Incident Report Framework (PSIRF). As a result, these organisations no longer report serious incidents so thematics rather than actual numbers will be provided in the future. The rest of the wider partner organisations will transition to PSIRF over the coming months.
- In respect of quality improvement, an assurance piece of work had been carried out in respect of Freedom to Speak Up Arrangements. The ICB and all of its system partners have formal arrangements in place.
- Working Together to Safeguard Children 2023 statutory guidance was published in December Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk).
- NHSE Midlands have developed professional and minimal standards of care relating to patients awaiting handover on the back of ambulances outside acute hospital trusts. Mr Fahy as the Director of Nursing and Dr Hindocha as Interim Medical Director were asked to confirm that they accepted the document and that it will be adhered to within acute trusts for their respective systems by 29 December 2023, which was actioned.
- In 2021 safe and wellbeing reviews (SWRs) were set up by NHS England as part of the response to a safeguarding adults review (SAR) and subsequent report concerning the deaths of three inpatients at Cawston Park after long in-patient stays published on 9 September 2021.
- The Autumn booster vaccination programme was extended to the 31st January 2024. The ICB is the second highest performer across the East Midland region.

The Board considered the update. Mr Turner asked whether the Board would support a letter being written to the Bourne Galletly practice commending the outcome of their CQC inspection, which is an outstanding achievement, which was agreed.

The ICB Board agreed to:

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

Mr Blake joined the meeting at this stage to present the next item.

24/182 UPDATE ON THE PRIMARY CARE SYSTEM LEVEL ACCESS IMPROVEMENT PLAN

Mr Blake presented a report which provided an update on the Primary Care System Level Access Improvement Plan which was presented to the Board in November 2023 and highlighted performance over the last two months.

Mr Blake highlighted the areas where there had been some challenges but overall good progress was being made to resolve these. These included:

- GP Referrals into community pharmacies for a range of minor ailments and conditions, the idea being to reduce the demand on GP practices and also inconsistency of delivery of the service. In Lincolnshire, the referral rates are relatively low with 26% of practices making a referral in December 2023. Rurality, access to community pharmacies, use of locum pharmacists and the high level of dispensing practices (GP

practices who dispense prescriptions to their patients) in Lincolnshire make performance improvement challenging – work is underway to promote the service to practices and to support pharmacies train up staff, so they are able to offer the service consistently.

The Pharmacy First service is due to launch on 31 January 2024 – this combines the GP community pharmacy referral scheme with an extended range of conditions that pharmacies can treat with prescription only medicines without the need for the patient to see a GP. This is a real opportunity to promote this service to patients and practices. Lincolnshire is very close to 100% of its pharmacies signing up to the Pharmacy First initiative, which will support local communities to access appropriate care quickly and locally for seven common conditions which ordinarily demand waiting for a GP appointment or result in people visiting Urgent and Emergency Care (UEC) clinics. Improvements in referral rates are expected to be seen and a fortnightly Task and Finish Group has been established to oversee that piece of work.

Another area for improvement is patient access to records, around 50% of practices in Lincolnshire are fully compliant with the contractual requirement. GP practices have raised concerns about data protection risks with making records available and with regards to the amount of time for clinical staff to review records before making them available to patients. This is a national issue and the ICB is working with regional ICB colleagues to take a consistent approach to improving the position – a key immediate action is to support practices who are close to compliance to become fully compliant.

There has been good progress on supporting GP practices move to digital telephone systems, the national deadline for all practices currently using analogue systems to sign a contract with a digital system provider by 15 December 2023 was met. Work is ongoing to support practices moving to digital systems by April 2024.

On a final note, engagement has taken place with the Patient and Participation Groups (PPGs) around co-production with an initial meeting with representatives having taken place the previous week.

Dr McSorley thanked Mr Blake for his update and asked whether there were any questions.

Councillor Woolley advised that she wished to raise a point of note, although this was not directly linked to the report presented, in that she had recently shared information with Dr McSorley and Mr Turner on the number of missed GP appointments in November, which she had recently posted on social media – 17,000 in total in Lincolnshire, which is a significant number. The response was quite illuminating in that this demonstrated a huge amount of time wasted by GPs and also patients who are unable to access appointments.

Referring to the communication around the rollout of Pharmacy First, Councillor Woolley requested that consideration is given to handling this in a measured way. Mrs Blythe advised that she Chairs a weekly meeting with all of the Lincolnshire Communications and Engagement Leads which is used to provide a briefing on what is happening at that time, what is coming up, current challenges and opportunities and so on. The push to encourage the change in behaviors across the system will be shared in that forum and by way of an example the ICB Comms Lead for Pharmacy First had that week briefed everyone on this initiative and the communication to raise awareness of that service. Referring to Councillor Woolley's point about missed appointments, that meeting could also be used to raise awareness through the various communications platforms.

Dr McSorley added that the final deals on Pharmacy First had only been reached in the last couple of days so he was slightly hesitant in terms of mass public communication of a service at this stage because of concerns about this being launched on the date indicated, certainly he was aware of some IT issues wrapping around this, which had been discussed in detail by the Primary Care Commissioning and Delegated Functions Committee.

Dr Thomas commented that this is a complete step change for community pharmacy and the first experience the patient has is the important one. If they attend the community pharmacy service and their experience is not positive, then they will potentially not use it again in the future.

Mrs Kenson asked whether it is up to the public or the practice to push on-line access, and if it is the responsibility of the ICB what action is being taken. Mr Blake advised that the patient would need to request GP access and there is variation across the practices in terms of how many actively promote this. Work is taking place with the PCNs in terms of the practices Improvement Plans in terms of on-line access.

The Board agreed to:

- **Note the update on the Primary Care System Level Access Improvement Plan.**

Mr Blake left the meeting at this point.

CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

24/183 MONTH NINE – FINANCE REPORT

Mr Gaunt presented the finance report of the Lincolnshire Integrated Care System (ICS) and the ICB for month nine (up to 31st December 2023) and advised that the position since the last Board meeting had changed in terms of expectations in terms of the full year.

As the Board was aware, a Financial Plan had originally been set with a system deficit of £15.4m. The plan was designed to address three issues which sit at the heart of driving sustainability – making in-roads into the deficit and progressing towards achievement of current balance, reducing agency spend by 3.7% and improving productivity and finally securing NOF 4 exit.

At the point the Financial Plan was agreed there were some unmitigated risks identified which amounted to around £20m at that planning stage. Over the first seven months of the year, the ICB and its NHS system partners delivered the Cost Improvement Programme (CIP), exercised positive employment cost controls in reducing agency spend, maintaining acute headcount at the opening position (by way of examples) and absorbed several inflationary pressures, demonstrated a good track record of financial improvement and secured NOF 4 exit.

Nationally there were concerns around industrial action and the impact it was having across services and organisations financial positions. In late October, the Lincolnshire system, along with every other system in the country was requested to look at the forecast position for the full year. This was completed and in light of the work undertaken a revised full year position had been agreed with NHS England which essentially is a worsened financial deficit by £12m across the Lincolnshire system.

Referring to the report and outturn financial position, the ICS' H2 financial reset plan is to deliver a £27.4m deficit for the full financial year. The outturn position is to achieve plan. This represents a £12.0m adverse variance against the £15.4m planned deficit at the outset of the year. This is reflected of all the risks previously reported to the Board, but also a series of mitigations.

There are three strands of areas where improvement had to be made in order to meet the revised deficit and these are in the realms of productivity, and the response to the elective backlog. The second area is workforce and continuing with the positive actions to date and the third area is in respect of expenditure run rates.

Heading towards the end of month ten, the planned deficit was on track to be delivered, and as referred to by Mrs Raybould earlier in the meeting, despite industrial action it has been possible to sustain and protect elective services, which is very positive for patients, but equally, because of the way in which financial arrangements work, it enables the system to earn additional income which is supporting the mitigation strategy. The system also remained on track to deliver the workforce and expenditure run rate controls.

There were two further points for the Board's information; the capital expenditure is reported as being slightly off trajectory but Mr Gaunt was confident the allocation would be spent by year end and also to note the investment into the Mental Health Investment Standard had been maintained.

In summary, the ICB expects to deliver the revised Lincolnshire system deficit at 31st March 2024 in line with the H2 financial reset plan.

The Board considered the report. Mrs Pratt asked whether the ICB and its system partners remained on track to deliver its previously stated ambition of securing NOF 3 exit by November 2024. Mr Turner advised that exit from NOF 3 remained an ambition rather than a specific target.

The Board considered the report and agreed to:

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

Mrs Stephanie King joined the meeting at this point for the presentation and discussion on the next item.

CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

24/184 PEOPLE AND COMMUNITIES STRATEGY

Mr Burnett advised that the ICB Constitution sets out the legal duties (section 14Z45 of the Health and Social Care Act) and principles it will adhere to when developing and maintaining arrangements for public involvement. This is also recognised in the Board Assurance Framework as BAF Risk 0002 which is focused on the ICB ability to meet this legal duty.

The People and Communities Strategy presented demonstrates how the ICB will meet its legal duties, through understanding and empowering local communities, ensuring the patient and public voice is at the heart of service design and decision making.

The strategy was presented to System Quality and Patient Experience Committee (SQPEC) for a detailed review and evaluation on 9th January 2024 alongside details of the involvement and engagement activities and feedback which are reported into the Operational Quality Assurance Group (OQAG) on a quarterly basis.

In reviewing the strategy SQPEC also agreed to:

- An annual delivery plan of involvement and engagement to be presented and agreed by SQPEC as part of the operational planning process.
- Confirmation of reporting of feedback and outcomes into the Operational Quality Assurance Group (OQAG) and SQPEC

SQPEC were overwhelmingly supportive of the strategy and requested for the document to be presented to the Lincolnshire ICB Board seeking its formal approval and adoption. The committee agreed that the strategy would benefit from having a forward by either the ICB Chair or CEO which, if supported, could be drafted once the strategy was approved.

Mrs Robson, as Chair of SQPEC confirmed the strategy was considered in detail at its meeting in January, with a specific focus on how the risks will be managed. The Committee endorsed the strategy for approval by the Board.

Dr McSorley acknowledged the Board had not had the opportunity to go through the strategy due to time constraints in the meeting, but asked whether based on the scrutiny and assurance by SQPEC if the Board was happy to approve the document.

Mr Burnett added that a People and Communities Annual Report 2023/24 will be produced in the coming months which will demonstrate and evidence the ICB's commitment to involving people and communities.

Mrs Ellis-Fenwick advised that the ICB Annual Report 2023/24 also has to include information on how the ICB has met its statutory duties in relation to public involvement and she would be working with Mrs King to ensure the detail was incorporated to meet that requirement.

On that basis and the assurance provided from SQPEC, the Board agreed to:

- **Approve the ICB People and Communities Strategy.**
- **Agree to receive the Annual People and Communities Involvement Report at the Board ahead of its publication.**

Mrs King left the meeting at this point.

GOVERNANCE

24/185 UPDATE ON THE EAST MIDLANDS ICB COLLABORATIVE ARRANGEMENTS AND SPECIALISED COMMISSIONING

Mrs Williamson presented a report which firstly provided an update on the work being carried out on the East Midlands ICB Collaborative Arrangements for Pharmacy, Optometry and Dentistry, including the associated governance arrangements and the Distributed Leadership Model, which as alluded to by Mr Turner earlier in the meeting, the arrangements were working really well.

The second part of the report provided a briefing on Specialised Commissioning, which as reported to the Board in September the ICB had made an application for delegation of 59 specialised services, which had been approved by NHS England in December 2023. The paper provided an update on progress of the work to support the delegation arrangements to the ICB from the 1st April 2024.

The Board noted that a report would be presented to the Board at its March meeting seeking approval of sign-off of the associated governance documents to support the delegation arrangements, which would also require amendments to the ICB's key governance documents, such as the Scheme of Reservation and Delegation.

The Board agreed to:

- **Note the briefing report.**

24/186 PRIMARY CARE COMMISSIONING AND DELEGATED FUNCTIONS COMMITTEE

Dr McSorley presented the report from the Primary Care Commissioning and Delegated Functions Committee meeting held on the 20th December 2023 and advised that he would take the report as read. On this occasion, there was nothing specific to escalate to the Board.

The Board agreed to:

- **Note the report.**

24/187 SYSTEM QUALITY AND PATIENT EXPERIENCE COMMITTEE

Mrs Robson presented the reports from the System Quality and Patient Experience Committee meetings held on the 1st December 2023 and 9th January 2024. The majority of items from the January report had been covered off as part of the main agenda, but there were a few points to highlight to the Board.

- A deep dive presentation took place in relation to the Infection Prevention and Control work stream within the integrated Health Protection functions of both LCC and the ICB. This followed the NHSE regional meeting in October where the ICB was identified as an outlier in terms of C difficile. Discussions took place regarding the C difficile and E coli targets and the trajectories identified that Lincolnshire is not an outlier in these areas and that the trend mirrors the national performance which has seen uptake in infections rates across the UK.
- The Quality Impact Assessments (QIA) methodology that relate to the H2 reset will come to the next QPEC meeting.
- The Committee will be holding a Development Session in early March to review the current work programme, Quality Strategy and confirm deep dive topics going forward, key priorities and the interface between the other Board Committees.

The Board agreed to:

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

24/188 SERVICE DELIVERY AND PERFORMANCE COMMITTEE

Mrs Kenson presented a report from the Service Delivery and Performance Committee meetings held on 15th November 2023 and 13th December 2023 and advised that she would take this as read but there were some points to highlight for the Board's information:

- Good progress across winter to date and positive impact with the various interventions put in place, and which the Committee receives monthly updates on.
- There had also been very good progress in relation to Children and Young People (CYP), including Mental Health Services.

There were no items for escalation to the ICB Board by the Committee in November and December.

The Board considered the report and agreed to:

- **Note the report.**

24/189 AUDIT AND RISK COMMITTEE

Mrs Pratt provided a verbal briefing from the Audit and Risk Committee meeting held on the 26th January 2024 and provided a brief summary of the key items discussed. The following was highlighted for the Board's information:

- Draft External Audit Planning for the 2023/24 audit was considered and noted be on track.
- Update report on progress against actions from the previous year's audit was considered and planning for 2024/25 noted.
- The draft Head of Internal Audit Opinion was scheduled to be considered by the Committee at its next meeting in March along with the External Audit Plan for approval.
- Work had commenced on the Annual Governance Statement by the ICB Board Secretary, and the Committee would be receiving the first draft at its meeting in March.
- The process for tightening up recommendations from internal audit reports where the timescales had slipped needed to be strengthened and this had been escalated to the Chief Executive.
- Committee Terms of Reference had been reviewed and some slight amendments made in terms of the membership which now included reference to attendance by all the Board Committee Non-Executive Directors, which would be brought to the Board for approval at the March meeting.

The Board considered the report and agreed to:

- **Note the report.**

24/190 ANY RISKS IDENTIFIED

The Board considered whether any new risks had been identified during the meeting and agreed nothing specific had been highlighted.

24/191 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 26th March 2024 at 9.30 am at Bridge House, Sleaford.

Chair Signature

Date

Questions from the Board meeting held on 30th January 2024

Question One

Who does the wheelchair service (AJM healthcare) report to? As I have been waiting over 15 months to take delivery of a powered wheelchair and have encountered many problems along the way.

I have submitted a complaint on the 17th November 2023 to AJM healthcare following a catalogue of errors and incompetence over 15 months, which I have still not had a formal response to. The service manager did say she was going to look into the compliant and get back to me in December 2023 but never did, then when I chased this up at the beginning of January she would not take my call.
It is clear that this is a organisation wide problem as many people have complained about the same or similar problems not just within Lincoln but at branches across the country.
I would like to know what you intend to do to improve this service and to hold them accountable for the disgusting way in which they treat their service users?

My other query is regarding the treatment and support with Functional Neurological Disorder (FND). I was diagnosed with FND in April 2019 and have been given very little in the way of support and treatment. How do you intend to improve this going forward.

Response:

Thank you for your questions.

The service is commissioned by the ICB and there is a contract that AJM hold with the ICB for this service. The wheelchair service will change to a new provider on 1 April 2024. The new provider is NRS and the contract was awarded following a joint procurement with Lincolnshire County Council. NRS currently provide the community equipment service to the ICB and the Council.

Without details of the individual circumstances of the complaint it is not possible to provide a full answer to the question raised but if you would care to contact Mr Tim Fowler, Associate Director of Contracting and Procurement (t.fowler@nhs.net) or the ICB complaints team (licb.feedbacklincolnshireicb@nhs.net) we can look into the query.

Again, without specific details of your individual circumstances, it is difficult for the ICB to comment on. If you could provide further information, we can provide a detailed response.

Question Two

As RNIB's Regional Campaigns Officer for the East Midlands, I'm enquiring into any work that is currently being done to improve Accessible Information Standard (AIS) compliance within Lincolnshire ICB.

Providing accessible health information improves patient safety, experience and outcomes as well as enhancing patient dignity and independence. Also, by ensuring appointment letters are accessible the cost of 'did not attends' is reduced, and people's treatment is not delayed. Despite this, RNIB have found that only 11% of patients covered by the NHS Accessible Information Standard (AIS) have equitable access to the NHS since the Standard's launch in 2016.

Thank you for your question to the Board. You will hopefully have heard the discussion in the meeting at which the Board agreed with your comments regarding the importance of improving AIS standards across the county's NHS.

It is important to clarify that the ICB is not directly responsible for issuing clinician to patient communications (such as appointment letters, clinical updates etc). These are sent from NHS provider organisations, such as our acute hospitals trust, general practice surgeries etc. However, we do understand our responsibility regarding encouraging all providers to ensure AIS compliance, as well as ensuring when we do issue communications to our communities we also comply.

Currently our communications and engagement teams, alongside our 'health inequalities' team undertake work to ensure that our outreach to communities is as accessible as possible. This is done through such measures as working alongside community, voluntary and partner organisations who specialise in advising us how to reach all parts of our communities as well as undertaking that on our behalf (which is often more appropriate and successful). We also undertake translation of written materials, and ensure that wherever possible, we meet AIS standards, for example our website is fully to standard. We are also working on some guidance for staff which will be launched on our new intranet area.

The ICB has a statement on its website in respect of AIS - Accessibility statement - Lincolnshire ICB. There is also an information sheet on the website linked from our Equalities Page.

- Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB
- Accessible Information Standard v1_updated Mar 22 (1).docx (live.com)

Please see links below to our main provider organisations and their information on the Accessible Information Standard.

Accessible information standard – meeting your communication needs - United Lincolnshire Hospitals (ulh.nhs.uk)
Equality and Diversity :: Lincolnshire Community Health Services NHS Trust
The Accessible Information Standard - Leicestershire Partnership NHS Trust (leicspart.nhs.uk)

In August 2022, Healthwatch Lincolnshire published its AIS Report outlining patient experience and its recommendations to improve accessible information. Healthwatch recommended that ICB boards appoint a board member to be responsible for ensuring services meet communication needs; appoint an Accessible Information Champion in each health care service; establish a panel representing people with accessible information needs; and establish mandatory accessible information training for all staff. Have any of these recommendations been adopted by the ICB?

ICB Board has noted the recommendations in the Healthwatch report, and that new guidance is due to be published on AIS. The ICB will continue to ensure that it complies with its statutory duties and the Board has agreed that oversight of compliance with AIS will be monitored through our System Quality and Patient Experience Committee (SQPEC), which is one of the Board Committees.

I**n addition to this, does the ICB run any groups focused on improving the experience of patients with visual impairments?** The ICB does not currently run any focused groups. However, we are running a rolling programme of Health Inclusion workshops for system staff - each one focuses on the needs of a different population group who experience health inequalities . We are also part way through an 18-month programme, we intend covering sensory impairment in Quarter One 2025/26.

On a final note, we accept there is always more to be done and appreciate your suggestions regarding potential improvements.

Not Delivered
In Progress
On Track to Deliver
Complete

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

Date of Meeting:	**Tuesday, 28th February 2024**
Agenda Item:	**1 (iv)**
Reporting Officer:	**Dr Gerry McSorley, Acting ICB Chair**

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
30/01/24	24/177	ICB Chair and Chief Executive Update	To publish the questions and responses received on the ICB website, attach the details to the minutes of the meeting and issue to the individual who submitted the details.	Mrs Ellis-Fenwick	February 2024	Questions and responses published on the website. Details attached to the minutes. Response emailed to the members of the public who submitted the details.	Complete.
30/01/24	24/180	Integrated Performance Report	To look into the detail behind the performance in respect of the % of patients not treated within 28 days of last minute elective cancellation.	Mrs Raybould	February 2024	The figure stated did not factor in the post COVID position with significant with significant backlogs and Industrial action.	Complete.

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
30/01/24	24/180	Integrated Performance Report	To send a letter of congratulations to the Bourne Galletly Practice on the outcome of their recent CQC inspection – overall rating of Outstanding.	Dr Gerry McSorley and Mr John Turner	February 2024	Letter sent to the practice dated 6th February 2024.	Complete.

healthwatch Lincolnshire

Monthly Report
February 2024

Contents

Location of comments:

Location data is mapped using postcodes of services. The map points are coloured according to the sentiment of the comment:

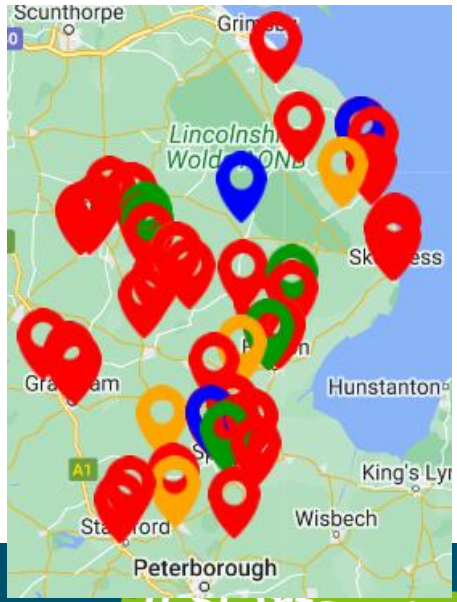
Positive - green

Negative - red

Mixed - orange

Neutral - blue

Unclear - grey



Call us on **01205 820892**
info@healthwatchlincolnshire.co.uk
www.healthwatchlincolnshire.co.uk
HealthwatchLincolnshire HealthwatchLinc

Overview

Monthly Report

During January 2024 Healthwatch Lincolnshire received **76** patient experiences directly to our Information Signposting Team. This is a summary of the key themes raised by patients, carers and service users during January 2024 about services in Lincolnshire.

For more details you can call us on 01205 820892
Email: info@healthwatchlincolnshire.co.uk

Overall Sentiment

7% of all comments were **positive**
78% of all comments were **negative**
4% of all comments were **neutral**
11% of all comments were **mixed**

January 2024 – Feedback Service Themes Sentiment

36%

Hospital Services (All services)

46%

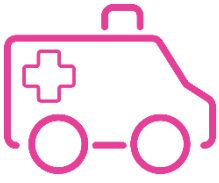
GP Services

8%

Community Health Services

3%

Accident & Emergency



3%

Patient Transport

12%

Dentistry

13%

Mental Health & Learning Disabilities

11%

Social Care

%s total greater than 100% as many comments we receive relate to multiple services

Pharmacy

These experiences highlight various issues within the pharmacy services, particularly regarding medication access and communication. In the first instance, a patient tested positive for COVID-19 and encountered challenges in obtaining antiviral medication due to pharmacy unavailability, despite prompt action from healthcare providers. Another individual, acting as a full-time carer for an elderly parent with Parkinson's disease, expressed frustration over ongoing medication errors and missing prescriptions, despite efforts to address concerns with both the medical practice and pharmacy. Additionally, a patient faced difficulties with the pharmacy's text notification system for prescription pick-ups, experiencing unreliable service and adding pressure to pharmacy staff. These stories underscore the importance of efficient medication management, reliable communication channels, and responsive healthcare support to ensure patient safety and well-being.

"Informed 111 that had tested positive for COVID and I am registered to get antiviral meds. Few hours later a doctor called after a lengthy discussion he sent a prescription to Boots Skegness. I called Boots the chemist, to be told they haven't got the meds I needed and I'd have to wait until Monday, by this time the window for taking the meds would be too late to be of any use. I then called 111 again and explained what had happened and they would arrange another doctor to call me. I had a call at 9.35pm and was told if I felt the illness was getting worse to contact the emergency service. Luckily, here we are on Monday, still showing positive on my recent test. But now feeling better than I have for a few days."

Full time carer for elderly parent has ongoing concerns with Hawthorn Medical Practice and Chemist , Whitworth Chemist , Lumley Road, Skegness. This concerns medication for parents Parkinsons Disease being prescribed at the wrong dose for many years, this was clarified by the Parkinsons Nurse Specialist. Over the Christmas period there have been missing medication for Parkinsons Disease , Madopar, and previously missing warfarin. Carer has contacted both Hawthorn Medical Practice and Chemist but has got no where and feels like they are going round in circles with complaints and nothing has been resolved. Carer did contact Integrated Care Board yesterday to escalate their concern and try and get a resolution. Carer feels that missing medication is unsafe situation and could be harmful to their parent. Has made complaints before and told to move GP Practice. On advice from Carers first carer has raised a Safeguarding concern in relation to missing medication. Does not want parent to go into care home as had previous very bad experience with father and does not want the same thing to happen. Carer feels that NHS and the Care system is failing and care and sorting medication should not be left to unpaid carers.

Patient has negative experience with repeat prescriptions. The pharmacy notify that medication is ready to collect by text service. However this is very hit and miss as to whether it works properly. Often the text service is down. Frustrating for both patients and the Pharmacy staff. Ordering medication online is good and very easy. But the text service needs overhauling as the poor staff in the Pharmacy don't need the extra pressure of the text service continually breaking down.

Community Pharmacy Lincolnshire acknowledges the widespread issue of medication shortages, attributing them to global manufacturing challenges, increased demand, and various external factors such as Brexit and the COVID-19 pandemic. They highlight the strain on pharmacy staff, who spend significant time sourcing medications and dealing with patient frustration. Community Pharmacy England advocates for reforms in Serious Shortage Protocols, generic substitution policies, concessions systems, and a strategic review of medicine supply and pricing. Despite efforts, patients may need to consult their general practitioner for potential medication alternatives. Regarding emergency pharmacy access, recent regulatory changes have allowed some pharmacies to reduce their hours due to funding reductions and minimal patient demand during certain times, without a requirement for 24-hour services.

Response from Community Pharmacy Lincolnshire

"We know that there are many medications in short supply but there is no definitive list available; this is worldwide issue related to the manufacturing of drugs, and in some cases due to a dramatic rise in demand (for example with certain drugs used to manage type 2 diabetes) across the globe. Stock availabilities also change frequently, and different pharmacies may have difficulty obtaining different medications due to factors such as wholesaler access. In most cases, when a medication is not available the pharmacy will do its utmost to obtain supplies, but in some instances the patient will need to contact their GP to ask if an alternative medication can be prescribed.

The Community Pharmacy England (CPE)2023 Pharmacy Pressures Survey found that:

- **92% of pharmacy teams are dealing with medicine supply issues daily, an increase from 67% in the 2022 pressures survey.**
- **Almost all pharmacy owners (97%) reported significant increases in wholesaler and medicine supply issues.**
- **And 71% of pharmacy owners reported significant increases in delays in prescriptions being issued.**

Pharmacists and their teams are spending disproportionate amounts of time sourcing medicines: in the CPE Pressures Survey 93% of pharmacy owners told us their staff were spending longer than ever before on medicines procurement. Pharmacies sometimes have to deal with deliveries that do not arrive or to manage minimum order surcharges or quotas. These difficult circumstances, which are outside of the pharmacies control, often result in pharmacy staff being on the receiving end of patient frustration, with 84% of pharmacy owners saying they had experienced aggression from patients due to

medicine supply issues. When there are supply issues pharmacies also have to spend time explaining the issues and reassuring patients, liaising with prescribers, and in some case putting Serious Shortage Protocols (SPPs) into operation. SSPs can be activated by the Secretary of State as a way of helping to mitigate specific shortages by allowing pharmacies to dispense specific alternatives for patients, and while this is helpful, operationalising them can be complex and time-consuming for pharmacies. Furthermore these SSPs are not in place for all medicines; recent supply issues with medicines used to manage attention deficit hyperactivity disorder (ADHD) could not be subject to an SSP, as most of the affected medicines are controlled drugs.

What is causing medicine supply issues? - Medicines shortages and supply issues can be caused by a variety of factors from manufacturing issues, regulatory problems or distribution issues, to drug recalls, stockpiling or simply increased demand. Multiple drug groups and conditions are affected by supply and pricing issues these include drugs used in diabetes, epilepsy, HRT, and antibiotics used to treat Strep A which experienced a surge in cases at the end of 2022 beginning of 2023. Community Pharmacy England believe wider medicines market problems are being caused by a combination of factors such as Brexit, COVID, war and inflationary pressures. It also seems to be the case that the very low prices of medicines (as driven by effective procurement by pharmacies) in the UK leave our market more susceptible to global market shocks. The Nuffield Trust considered this in their December 2022 report, noting in particular five causes of issues as: the COVID pandemic, rapidly rising commodity prices, a surge in prescriptions for HRT products, Brexit, and some of the UK's price-setting mechanisms. They conclude: "Unpicking which of these factors may be behind any individual shortage, or any wider spike, is very difficult."

Community Pharmacy England are working with government asking them to take in four key areas:

1. **Reform of Serious Shortage Protocols (SSPs).**
2. **Generic Substitution: Pharmacists should be allowed to supply any equivalent generic medicine against a prescription requesting a brand which may be in short supply.**
3. **Overhaul the concessions system.**
4. **Undertake a strategic review of medicine supply and pricing.**

We hope the above can help clarify the reasons why your local community pharmacy may have issues obtaining prescription medications, despite significant efforts, and patients may need to go back to your general practitioner to discuss potential changes.

In relation to emergency pharmacy access. The Pharmaceutical Needs Assessment (PNA) considers access requirements for patients to pharmacy services both in and outside of normal working hours, taking into account travel times within a rural county such as Lincolnshire. Based on access and patient demand, the latest PNA did not identify any gaps in the pharmacy provision in the county to require an out of hours service to be commissioned. Recently due to regulatory

changes some previously 100 hour pharmacies have been able to reduce their opening hours to a minimum of 76 hours per week (excluding bank holidays), but there is no requirement for the commissioning of 24-hour pharmacy services. The reduction is due to significant reduction of pharmacy funding over recent years, as well as contractors analysing the patterns for their business; where contractors have reduced hours it's usually because there is very little, if any patient demand at these times and they want to focus their resources in such a way as to support more patients." – **Community Pharmacy Lincolnshire**

Community Health Services

Comments shared with us this month about community health services related to diabetes and incontinence care.

One carer raised their concerns for their dependent who had been fitted with a diabetic sensor without the purpose of it or how to use it being explained to them. The dependent is also partially sighted, has dementia and other health needs which means they are unable to read the measurements taken by the sensor. Concerns were raised about the potential harm this could cause. With the consent of the parties involved Healthwatch has raised this issue to the relevant individuals in the system is in the process of being resolved.

Family member of elderly parent who is in a care home, bedbound, has previously been in hospital, discharged in November, now incontinent and registered with the Incontinence Team. Family member has been informed by the home that the incontinence pads provided are not suitable and that the family member needs to purchase correct ones, which they have done since November. Has been informed by the care home that it could take 3 months to get the correct ones via the Incontinence Team and would need re-assessing.

Access to suitable incontinence pads was also flagged as a concern. The pads provided by community health services were not suitable and would have to pay for their own as it would take months for the correct ones to be provided if not.

Patients carer contacted Healthwatch about raising a concern about the care given by the Community Nurses fitting a diabetic sensor to your elderly relatives arm without explaining to them and carer what it is and how to use it. Putting the sensor in a place on relatives arm where they cannot scan it. Not taken into account that relative is partially sighted, has dementia, Charles Bonnet Syndrome, restricted mobility and unable to see the device given to read the sensor, or the units of insulin on the syringe. They were unable to see the figures on the device or work the device to read their blood sugar. The device also beeped all night kept them awake and worried them. Also issues that with a normal blood sugar machine elderly parent finds this difficult to use. Also issues that elderly parent cannot see the figures on their insulin syringes. Carer worried that may not give themself the correct dose and cause harm. Issues with other medication about getting tops off medication and seeing packets and confusion about what day it is which may cause them to have too much or too little medication. Carer has contacted Community Nurses Office but nothing has been resolved.

NHS Dentistry

Access to NHS dental services continues to be a top concern for many. We continue to hear from patients who have been trying to access NHS dental services in the county for years. The only option available currently appears to be to pay for private treatment. One individual shared the treatment they need will cost them £7000. The majority cannot afford private treatment and this is likely to worsen existing health inequalities.

A carer whose dependent has complex mental health needs shared their struggle of getting a referral to the community dental service. The carer has been passed from service to service, unable to get their dependent referred for the care they need. This issue is in the process of being resolved.

Overall, these experiences shed light on the challenges individuals face in accessing NHS dental services in Lincolnshire, particularly in areas like Spalding and Skegness. Patients and carers expressed frustration over the lack of available NHS dentists, long waiting times, and financial barriers to private treatment. Issues such as closures of dental practices, difficulties in finding alternative dentists, and cancellations of appointments have left many feeling neglected and anxious about their oral health. The stories also highlight concerns regarding affordability, especially for vulnerable groups like pensioners and families with young children. Areas that require improvement include increasing NHS dental provision, ensuring affordability and accessibility of services, and addressing communication gaps between patients, dental practices, and healthcare authorities.

"My dentist was closed down (they closed the doors and never opened them again) we were not referred to another dentist and as such were not able to access NHS dental. I have looked on the NHS website and rang every dentist on the list in a 50 mile radius and none are taking NHS! I can't afford private treatment, I don't get any benefits and I need a filling, as a filling I had done a few months ago with my old dentist has fallen out. This situation with dentists is awful as many are now only private."

"I am a NHS patient with Mydentist, Algitha Road, Skegness, and have had the last 5 appointments cancelled over the last 3 years. I have an ICD fitted and a large AAA and require regular treatment to stop infection witch could be fatal. Yesterday 19th Jan Mydentist phoned and informed me that my Feb appointment is cancelled and no more appointments will be made unless I go private. As a pensioner with my health problems."

Carer made contact because their spouse, who has Emotionally Unstable Personality Disorder,self harms in numerous ways, one being they pull their teeth out if they hurt or are loose.To the extent that they now only have 2 full teeth and 2 broken teeth. They have trouble eating anything that is not soft. Because of this problem their mental health is suffering badly.They suffer with anxiety badly and most of the time they won't go out of the house because they feel embarrassed. They want dentures, but unfortunately they have a severe phobia of dentists and pass out as soon as they go in the door of a dentist. Spouse is 6 foot 4 and is a large individual to pass out anywhere. They have spoken to several dentists who say they cannot help but one gave me the number of the community dental service. Carer telephoned them and they said we need to be referred by a dentist or doctor. Obviously getting them to the dentist is a problem, and the doctor said they cannot refer as they don't deal with mouths or teeth, even though their spouses mental health is getting worse. They have also been in touch with Single Point of Access who gave them the number for Community Health Service Trust. They advised to ring 111 who only advised getting them into a dentist. The psychiatrist discharged spouse 2 years ago saying that pulling their teeth out was a problem and they couldn't do any more for them .The carer spoke to their carers first contact and they suggested getting in touch with Healthwatch about helping them to try and get them referred to the community dental services.Carer is extremely concerned for their spouses mental health and wellbeing as they are losing weight (even though that is not a bad thing), but it is the consequences on their overall health not just mental health. All they want is a set of dentures and they are not in a position to go private, although that wouldn't help with the anxiety side of things. Sorry if this email is a rant, but carer at the end of their tether as to what to do. They have no support and they feel that they are going round in circles all the time.

Patient contacted Healthwatch on behalf of 5 year old close relative. The family are NHS patients registered at Mydentist at Skegness. The 5 year old was taken to the dentist last week for a check up and their carer was charged £25 . Patient saying that this cannot be right , what if they need further treatment they would be not be able to pay. Surely all childrens teeth are teeth are precious and check ups should be free to make sure they do not need further treatment and that they have healthy teeth.

"Can't find an NHS dentist in Spalding, and yet another private one has issued letters to their NHS patients saying they're stopping NHS and that if people want to stay with that dentist they will have to pay as private patients. So that adds even more would-be NHS patients to the area, trying to get on an NHS list and finding none. We don't understand why there are none in our area or even in our county! What happens to all the new dentists passing their degree each year. Where do we have to go to get our teeth seen to, fixed. Do we have to wait, will it get better, will that definitely happen? What do we do in the meantime? My spouse has had a private dentist do a scan and x-rays and produced a report saying many teeth must be removed or infection will eat into the bone, quoting £7000. They said the work of previous dentist had this that and the other thing wrong, but we cannot return to that dentist or complain as they stopped working after virtually being closed down by the CQC due to below-standard inspections.

I haven't mistyped that, it was £7000, and that doesn't include anything to replace the teeth so that they can actually eat something for the rest of their life. Adding that in, the total bill is likely to approach one-and-a-half times spouses entire annual state pension. Ludicrous money, out of this world money. Only has the state pension for income and not enough in savings for that. So they would have to use all of our life savings, and borrow as well. This cannot be! Spouse has paid 50 years of national insurance and should be able to have NHS. I don't know where we are expected by the authorities to go; we have no car so would have to use public transport, and we cannot travel very far in both directions out and back home in the same day due to connections available and last buses or last train times. The NHS website lists the nearest dentist as Nottingham, but we cannot get there in time to even get home again on the same day, let alone have the dental appointment, it's stupid. We don't in any case want to travel on transport due to new COVID infections expanding, we normally shield ourselves by not going out in public, as little as possible. Nobody is listening; there are no dentists here (Spalding, Lincolnshire)."

Positive Stories

Here are some of the positive experiences shared with us this month.

These three experiences reflect positive encounters with healthcare services. In the first instance, quick access to an initial x-ray was noted, despite a subsequent wait to be seen. However, the nurse practitioner was commended for their kindness, compassion, and knowledge. The second account involves the admission of an elderly relative to A&E at Pilgrim Hospital, where they received attentive care, prompt treatments, and appreciated gestures like tea and food during their stay. Lastly, a medication review at Stickney Surgery showcased effective communication about appointment delays, followed by a thorough and reassuring consultation with the practice nurse, who addressed the patient's concerns with positivity and clarity. Overall, these experiences highlight instances of compassionate care, effective communication, and patient-centeredness within the healthcare system.

"Quick access to initial x-ray. There was a long wait to be seen after, but we were told this on booking in. The nurse practitioner we saw was kind, compassionate and knowledgeable. Really pleased with the service."

"Elderly relative admitted to A&E at Pilgrim Hospital by GP with pneumonia and raised erratic heart rate in December 23. Relative was very frightened and anxious about being admitted to hospital as their spouse was an inpatient 6 months later and had a bad experience. They are also very deaf even with hearing aids and still very independent even though very ill. Their elderly spouse accompanied them.They were kept in A&E for nearly 2 days in a rhesus bay as needing to be continually monitored on a heart machine and scoring high for sepsis. A&E was very busy and waiting room and department full. They were treated with kindness and respect, treatments and investigations carried out promptly and acted upon. They were surprised at how good the care and treatment was on A&E, Integrated Assessment Unit, and 7B. They were particularly pleased with the cups of tea, food, and a favourite was the porridge."

Patient attended the Stickney Surgery for a medication review with Practice Nurse. The Nurse was running late with their clinic but the Receptionist informed the patient when they checked in that the clinic was running approximately 10 mins late. Once patient was called in to see the Nurse, they apologised for the delay. The appointment was not rushed and the patient was made to feel at ease. Any questions that the patient asked were responded to in a very positive manner and advice was given that was appropriate for the patient to address their concerns. All follow up procedures were explained.

Healthwatch Lincolnshire Update

NHS Dental Recovery Plan – Our Response

The NHS and the Government have published a plan to recover NHS dentistry setting out a major new focus on prevention and good oral health in young children, and an expansion of dental workforce.

What we think

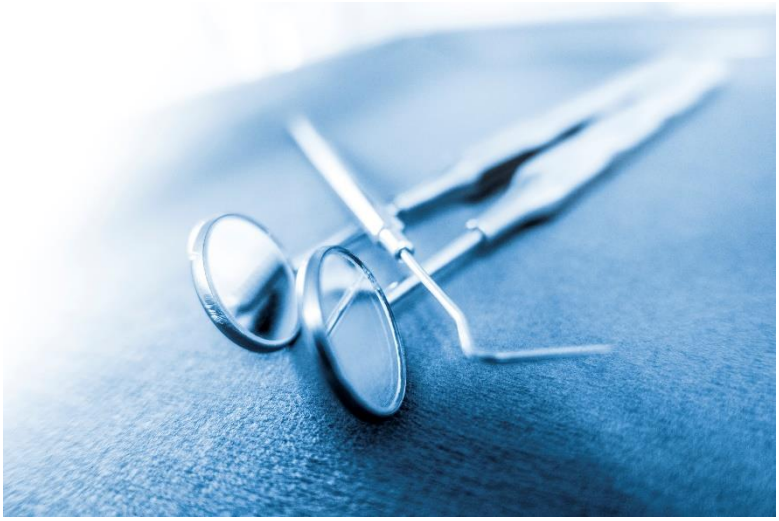
Over the last few years Healthwatch Lincolnshire have continued to raise concerns on behalf of Lincolnshire people, about NHS dentistry, including providing evidence at the government health select committee which has resulted in the publication of the dental recovery plan.

The proposed dentistry recovery plan is a positive step forward in addressing critical issues in dental care. However, it's essential for dentists to fully embrace the new premium payment system, actively promote appointment availability for new patients, and prioritise those with urgent dental needs to ensure fair and equitable access to NHS dental services.

The increasing cost of living has made dental care less affordable for many, leading to a concerning trend where one in five* individuals are now avoiding dental visits due to financial constraints. This marks a significant increase from one in ten just a year ago, highlighting the urgent need for solutions to make dental care more accessible and affordable for all.

Initiatives aimed at incentivising dentists to work in underserved areas, often referred to as 'dental deserts', and the use of mobile dental vans to reach remote communities are commendable efforts. Additionally, expanding prevention programs for children is crucial for promoting good oral health from a young age.

While these measures are commendable, more transformative strategies are needed to ensure the long-term sustainability of NHS dentistry. One crucial aspect is to make it easier for people to register with a local NHS dentist and receive regular check-ups and preventive care, fostering trust and enabling proactive management of oral health issues.



Ultimately, the goal is for individuals to have easy access to comprehensive dental care, similar to how they would with a local general practitioner (GP), ensuring timely treatment and preventative measures are in place for optimal oral health outcomes."

*Data from a poll of 2008 adults living in England, January, 2024

Menstrual Health Survey

Our focus for the first quarter of 2024 is menstrual health covering topics such as Endometriosis, Polycystic Ovary Syndrome (PCOS) and Menopause. So far, we've had over 360 responses! A huge thank you to everyone who has taken the time to share their experiences.

If you would like to share your experience as a patient/service user, **please do so here**.

If you are a professional working in services which support those navigating these conditions and would like to share your thoughts, **please do so here**.

Both surveys close at the end of March.

Respiratory Health – Our focus from April – June 2024

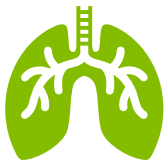
As Healthwatch Lincolnshire, we are dedicated to improving the quality of healthcare experiences for individuals. Between April to June, we will be focused on hearing the experiences of those living with respiratory conditions such as asthma and COPD.

We understand the significance of involving those directly affected by these conditions in shaping the services and support available to them. Therefore, we are initiating a collaborative effort to gather insights and perspectives through patient experience surveys.

Are you working with those affected by respiratory conditions? We would like to hear from you! Together, we can work towards creating a more supportive and responsive environment for those managing respiratory conditions in our community.

Additionally, we are keen on learning about any existing work or initiatives already carried out in the community. By understanding past efforts, we can build upon existing knowledge and experiences to further enhance our collective impact.

Contact info@healthwatchlincolnshire.co.uk or call 01205 820 892



Enter and View Activity

The Enter and View visits to Grantham Community Diagnostic Centre (CDC) and Skegness Urgent Treatment Centre have been completed. Thank you to the team of authorized volunteers, the NHS teams and those who shared their views for their support.

The work was part of a project carried out by Healthwatch England and the findings have been shared with them.

Our Enter and View visits to some care homes in Lincolnshire will recommence in February.

Engagement Activity

Our Involvement Officer has been out and about speaking to many different communities and representing the patient voice in different system meetings. This includes:

- Working with the Lincolnshire Traveller Initiative whose support has been invaluable to our project with the Care Quality Commission (CQC),
- Engaging with the Lincolnshire Veteran and Families Network and Family Hubs,
- Attending Quality Review Meetings and the United Lincolnshire Hospital Trust (ULHT) patient panel,
- Workshops on Health Inequalities focusing on Neurodiversity and Autism.

Volunteering

In January our volunteers clocked up 50 hours vounteering – amazing!

- Several Warm Hubs in the county were visited, reaching out to many vulnerable as to the work of HWL and how signposting from HW could assist them with appropriate personal or family issues.
- The Enter and View team were busy visiting Skegness Hospital and Grantham Community Diagnostic Centre. Much positive feedback was obtained, and the NHS staff were very please to see the team in action.

- Horncastle Community Centre, in the heart of the town, was visited 3 times as part of the NHS/University of Lincoln REN Project. Again, much information for the survey was obtained from numerous community groups.

A huge thanks to our brilliant volunteers for their invaluable support!

Demographics

In addition to location data, for those who consent, we are collect demographic data from the individuals who contact our Information Signposting Officer to ensure we are hearing from a people across all the communities in Lincolnshire.

Demographic	Number of people	Demographic	Number of people
Age		**Ethnicity**	
0 to 12	**1**	**White: British/English/Northern**	**18**
18 to 24	**2**	**Irish/Scottish/Welsh**	
25 to 49	**8**	**White: Irish**	**1**
50 to 64	**8**	**White: Gypsy, Traveller or Irish**	**1**
65 to 79	**17**	**Traveller**	
80+	**4**		
Gender		**Carer**	**7**
Male	**11**	**Long term condition**	**14**
Female	**30**		

Healthwatch Lincolnshire
Rooms 33-35, The Len Medlock Centre
St Georges Road
Boston
Lincs
PE21 8YB

www.healthwatchlincolnshire.co.uk
t: 01205 820892
e: info@healthwatchlincolnshire.co.uk
@HealthwatchLinc
Facebook.com/healthwatchlincolnshire

Item 4 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED BOARD

Agenda Number:	4 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Legal Duties – Information on Health Inequalities
Report Author:	Sandra Williamson Director for Health Inequalities, Prevention and Regional Collaboration
Presenter:	Sandra Williamson Director for Health Inequalities, Prevention and Regional Collaboration
Appendices:	Appendix 1 - Health Inequalities Legal Duty - Summary of Information on Health Inequalities to be Collected, Analysed and Published

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

Recommendations

The ICB Board is asked to note and consider all the information in this report and the actions being undertaken.

Summary

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

NHS commissioners (NHS England and ICBs) are under specific legal duties to take account of health inequalities issues in the exercise of their functions. Under duty s. 13SA of the National Health Service (NHS) Act 2006 NHS England is required to publish a Statement on Information on Health Inequalities (Statement) setting out:

- a description of the powers available to relevant NHS bodies to collect, analyse and publish information; and
- the views of NHS England about how those powers should be exercised in connection with such information.

The current Statement, which was published on the 27 November 2023, provides information on how powers should be exercised by ICBs and Trusts in connection with health inequalities information for the periods 2023/24 and 2024/25.

The information published sets out requirements for ICBs (and NHS Trusts) to collect, analyse and publish information relating to a small number of health inequalities for the periods 2023/24 and 2024/25 disaggregated by age, sex, ethnicity and deprivation.

NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed.

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

NHS England has a statutory duty to conduct an annual assessment of ICBs to include the extent to which they have fulfilled their statutory obligations around Health Inequalities

Progress to date:

- Work is underway within the ICB to produce the 2023/24 performance report to meet the requirements.
- A draft report will be presented to Service Delivery and Performance Committee in March 2024, once this work is concluded.

Next steps

- Sharing draft report / insight with relevant Programme Boards/ NHS Trust and inform and alignment with 2024/25 planning in addressing identified health care inequalities and priorities for action
- The report will then be presented to the ICB Board and published as an additional report to the ICBs 2023/24 Annual Report
- The report will be expanded during 2024/25 to cover other local health inequalities data e.g. other protected characteristics.
- Work with Providers in sharing insight to ensure their Board reports meet the requirements of the Statement and system direction.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Adopt a population health management approach, underpinned by working with people and communities in understanding health care needs and addressing healthcare inequalities – with the aim of improving outcomes in population health.
Aim 2: Tackle inequalities in outcomes, experience and access.	The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency and support ICBs and Trusts to use the data to shape and monitor improvement activity and drive improvement in the provision of good quality services and reducing healthcare inequalities.
Aim 3: Enhance productivity and value for money.	Through the utilisation of a PHM approach, we anticipate that we will be able to target the need where it is greatest for those population groups identified.

	Use data to inform service improvements, e.g. through changes to resource allocation
Aim 4: Help the NHS support broader social and economic development.	Through defining and implementing social value with reference to the social determinants of health will help to reduce local inequalities and improve health.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	Not applicable

Risk and Assurance

Scoping has confirmed that the data is available to meet the national requirements laid out in the Statement on Information on Health Inequalities. No risks have been noted in relation to the completion of the Health Inequalities report at this stage.

Risks are managed within the Health Inequalities Programme governance arrangements.

There is a risk that if inequalities identified in terms of variation in outcomes associated with age, sex, IMD and ethnicity are not addressed, that the healthy life expectancy gap and associated quality of life, will widen further in Lincolnshire.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	The report highlights – how information about health care inequalities should be used to inform service improvements, e.g. through changes to resource allocation and targeted intervention
Does the report highlight any quality and patient safety implications?	Not applicable at this stage.
Does the report highlight any health inequalities implications?	The report highlights the approach that is being taken to tackle health inequalities for Domains covered by the Statement – Indicators related: • to Core20PLUS for adults or children and young people • to inclusive recovery of services
Does the report demonstrate patient and public involvement?	The Statement on Information on Health Inequalities includes a duty to publish information on health inequalities within or alongside annual reports in an accessible format.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable at this stage.

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

Report previously presented at:

Not applicable.

Is the report confidential or not?

Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

Appendix 1: Report to ICB Board March 2024

Legal Duties – Information on Health Inequalities

What is the NHSE Statement on Information on Health Inequalities?

NHS England (NHSE) published its first **Statement on Information on Health Inequalities** on Monday 27 November 2023. It relates to requirements for the periods 2023/24 and 2024/25.

The Statement sets out the powers available to Integrated Care Boards (ICBs), NHS trusts and NHS foundation trusts to collect, analyse and publish information relating to health inequalities, and the views of NHS England about how those powers should be exercised.

It focuses on a small number of data indicators along with a limited number of expectations on how the information should be used. The indicators are aligned to the NHS five Strategic Priorities for addressing healthcare inequalities and the Core20PLUS5 approach.

What are the requirements for ICBs and Trusts

While NHSE recognises the value of collecting, analysing and publishing information on health inequalities, to manage the burden on ICBs and trusts, they are taking a proportionate and phased approach to helping organisations gather and make use of available information on health inequalities

For the period 2023/24 and 2024/25, NHSE's views on how ICBs and Trusts should exercise their powers to collect, analyse and publish information on health inequalities include the need to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing and publishing information on health inequalities set out in the Statement and summarised below.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action including as outlined in the Statement.

ICBs and trusts are required, in their annual reports, to review the extent to which they have exercised their functions consistently with NHSE's views set out in the Statement and explain whether the information has been published, summarise the

inequalities it reveals, and state how the information has been used in the relevant period to guide action.

Why is this important?

Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which people are born, grow, live, work and age. These conditions influence how people think, feel and act and can affect both physical and mental health and wellbeing.

Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs.

NHSE's Healthcare Inequalities Improvement Programme vision is for the NHS to deliver "**exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes**".

Lincolnshire's Health Inequalities Programme Vision is "t**o increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county".**

Good quality, robust data enables the ICB to understand more about the populations it serves. Identifying groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and delivering targeted action to reduce healthcare inequalities.

The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency and support ICBs and Trusts to use the data to shape and monitor improvement activity and drive improvement in the provision of good quality services and reducing healthcare inequalities

What information on health inequalities must be collected, analysed and published by the ICB?

The table below provides a high-level summary of the information on health inequalities that should be collected, analysed and published in relation to the Statement on Information on Health Inequalities. The Statement includes one or more indicators for each domain and, where data is available, disaggregation by age, sex, ethnicity and deprivation.

Domain	Level data available	
	ICB	Trust/Foundation Trust
Elective recovery	Y	Y
Urgent and emergency care	Y	Y
Respiratory (Covid 19/Flu Vaccination)	Y	
Mental health	Y	Y
Cancer	Y	
CVD	Y	
Diabetes	Y	
Smoking cessation		Y
Oral health (Children and young people)	Y	Y
People with a learning disability and autistic people	Y	
Maternity and neonatal care	Y	

Progress to date and next steps

- Scoping has been completed to determine availability of data against each of the indicators – this has confirmed that Lincolnshire data is available and reportable for each of the domains. The majority of data is available directly from national sources, the gaps can be filled by local data sources, such as Lincolnshire's joined data set.
- Work is currently underway to develop the ICB's first performance report in relation to the Statement. This will be presented to the Service Delivery and Performance Committee in March 2024.
- The report will then be presented to the ICB Board and published in the ICBs 2023-24 Annual Report.
- The report will be expanded during 2024/25 to cover other local health inequalities data e.g. other protected characteristics
- Work with providers to ensure their board reports meet the requirements of the Statement and system direction.

Ann Johnson-Brown
Assistant Director Health Inequalities
13/02/24

Item 5 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Integrated Quality & Performance Report – March 2024
Report Author:	James Singleton, Performance Manager
Presenter:	Clair Raybould- Director for System Delivery Martin Fahy- Director of Nursing
Appendices:	Performance & Quality Report

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

Recommendations

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

Summary

- This report is underpinned by the reporting that is received at the Board Committee for Quality and the monthly Service Delivery and Performance Committee.

- This report shows the latest analysis of key system operational performance and quality indicators covering normal variation, trends and shifts in performance over time for key metrics and measures across a number of areas of ICB delivery.

- The report is designed to provide assurance to the Board that there full understanding of the drivers for performance and the high level actions in place to address off track performance and quality in areas that are likely to have the most significant impact for patients.

Industrial Action

- Industrial action has continued to impact upon the delivery of services throughout January and February 2024 with Junior Doctors taking 6 days of action during January and a further 5-days of action during February 2024.

Urgent & Emergency Care

- All Types (T1 & T3) 4 hour performance for February was 65.7% against a plan of 76%.
- Category 1 mean response times for EMAS Trust was 09:14 minutes against a standard of 07:00 minutes during Feb 24. Category 2 mean response time was 49:45 minutes against an expectation of 30 mins by the end of March 2024
- The Lincolnshire Division Category 2 mean response time 47:40 minutes during Feb 24 which was better than the overall Trust Category 2 mean response time.

Cancer

- At the end of February, 200 patients were waiting over 62 days, this is an improvement from January where we finished with 249 in the backlog.
- The percentage of patients being told their cancer diagnosis outcome within 28 days decreased to 68.7% in January from 71.8% in December. A drop in performance was anticipated due to the loss of activity over the Christmas period.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals continues to improve and decreased by 935 on prior month to 115,858 in January
- The number of patients waiting more than 78 weeks across all Providers decreased by 56 on prior month to 114 in January and is forecasted to be virtually eliminated by end of March except for patient choice or complexity.
- The number of patients waiting over 65 weeks continues to decrease but is above plan. This has been impacted by the focus on eliminating 78 week waits and Industrial Action. NHSE have revised the national target for elimination of this cohort to Sept 24. The number of patients waiting has decreased by 416 on prior month to 1,201.

Mental Health

- The NHS Talking Therapies (previously IAPT) access rate was 19.5% in January (cumulative position)- the standard is 33% by March 2024. This was slightly below plan for the month of January (2.25% against 2.30% plan) and below the cumulative plan (20.6%)
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 77% in January (rolling 12 months)- above the 60% standard

Primary Care

- Richmond Medical Practice had a CQC inspection report published in February and have been rated 'requires improvement' from previously being 'inadequate'

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

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

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

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

Report previously presented at:
Not applicable

Is the report confidential or not?
Yes ☐ No ☒

Integrated Performance & Quality Report

NHS
Lincolnshire
Integrated Care Board

March 2024

21/03/2024

NHS
Lincolnshire
Integrated Care Board

Contents

Executive Summary

NHS Lincolnshire Integrated Care Board

Overview

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

Industrial Action has continued to impact upon the delivery of services throughout January and February 2024 with Junior Doctors taking 6 days of action during January and a further 5-days of action during February 2024.

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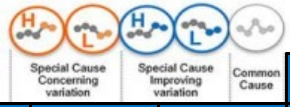
Lincolnshire ICB Performance Dashboard

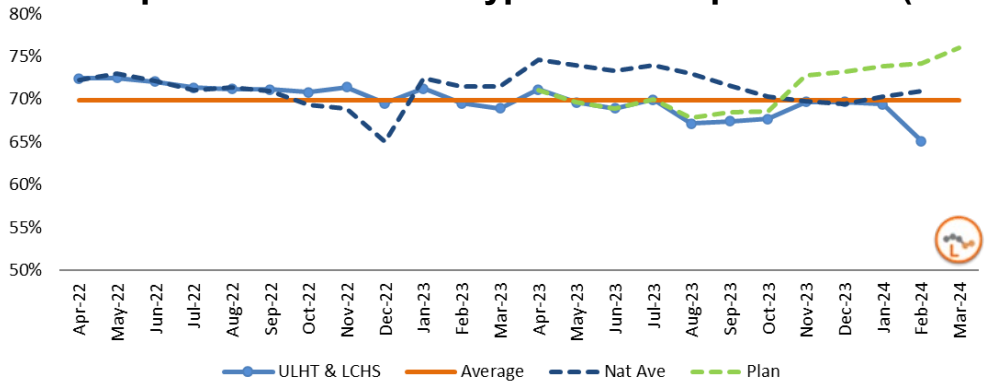
NHS Lincolnshire Integrated Care Board



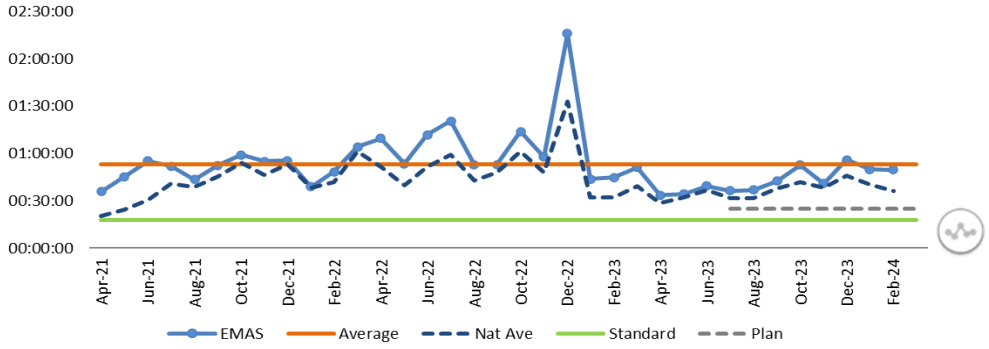
Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend	
								Sparkline	Variation
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ULHT+LCHS)	●	74.2%	Feb-24	65.1%	69.5%	70.9%		
	A&E admission, transfer, discharge within 4 hours (ULHT+LCHS+SMG)	●	76%	Feb-24	65.7%	69.5%	70.9%		
	Ambulance response times - Mean response time- Category 1 (EMAS)	●	00:07:00	Feb-24	00:09:14	00:08:38	00:08:25		
	Ambulance response times - Mean response time- Category 2 (EMAS)	●	00:18:00	Feb-24	00:49:45	00:42:38	00:36:20		
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	●	96%	Jan-24	81.6%	89.1%	87.5%		
	Patients receiving treatment for cancer within 62 days of an urgent GP referral	●	85%	Jan-24	55.5%	57.0%	62.3%		
	% of patients told cancer diagnosis outcome within 28 days (ICB)	●	75%	Jan-24	68.7%	77.2%	70.9%		
Planned Care	RTT: % of incomplete pathways within 18 weeks	●	92%	Jan-24	51.8%	54.8%	57.0%		
	Percentage waiting six weeks or less for a diagnostic test	●	99%	Jan-24	69.0%	69.8%	73.8%		
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)		-	Jan-24	1.04%	1.02%	1.22%		
	Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size)		-	Jan-24	0.10%	0.08%	0.18%		
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	●	0.8%	Q3 23/24	32.91%	24.1%	28.3%		
Mental Health	NHS Talking Therapies access - people that enter treatment (ICB)	●	2.30%	Jan-24	2.25%	N/A	1.94%		
	NHS Talking Therapies- recovery rate (ICB)		50%	Jan-24	49.3%	N/A	49.8%		
	People experiencing first episode psychosis waiting to start a package of care (ICB)	●	60%	Jan-24	77.0%	N/A	70.8%		
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	●	95%	23/24 Q3	77.0%	N/A	N/A		
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	●	95%	23/24 Q3	57.0%	N/A	N/A		

Urgent Care

4 hour performance at all types A&E departments (ULHT & LCHS)



Ambulance response times – Cat 2 mean response time (EMAS)



NHS Lincolnshire Integrated Care Board

Current system pressures

- All Types (T1 & T3) 4 hour performance for February was 65.7% against a plan of 76%.
- CAT2 30 mean performance for Lincolnshire ICB remains over 30mins. The February position was 47:40 minutes which was a deterioration on the January position however Lincolnshire resource has been supporting bordering areas which has impacted performance and is better than the EMAT Trust average Category 2 mean of 49:45 mins.
- Pressures within the system have included 2 episodes of industrial action during Jan and Feb 24 increased staff sickness, the impact of bed availability of Infection, Prevention and Control measures, as well as the typical increase in demand seen during the winter months.
- Overall ambulance handover times has decreased in February (58:00) compared to December (58:53). Handovers exceeding 1 hour have improved in February compared to December.
- There were 2367 patients waiting more than 12 hours in Emergency Departments in February. This is an improvement against the January position which was 2444 (a 3.15% decrease)

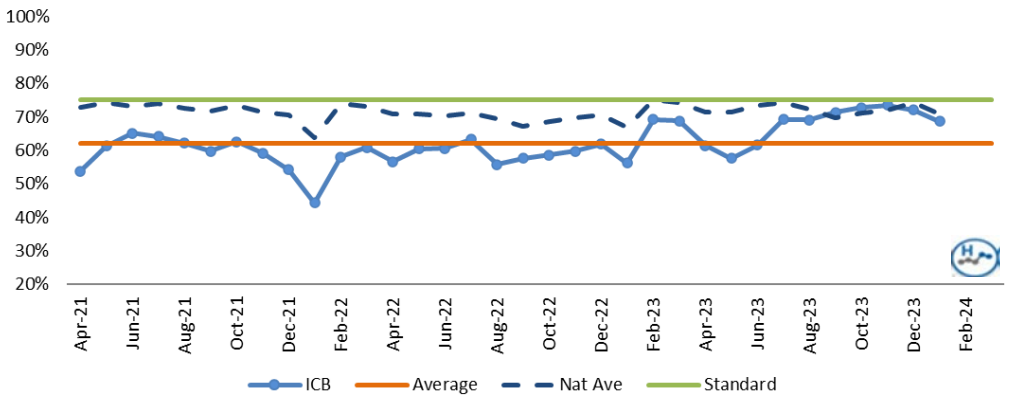
UEC Recovery Plan actions

The system focus includes:

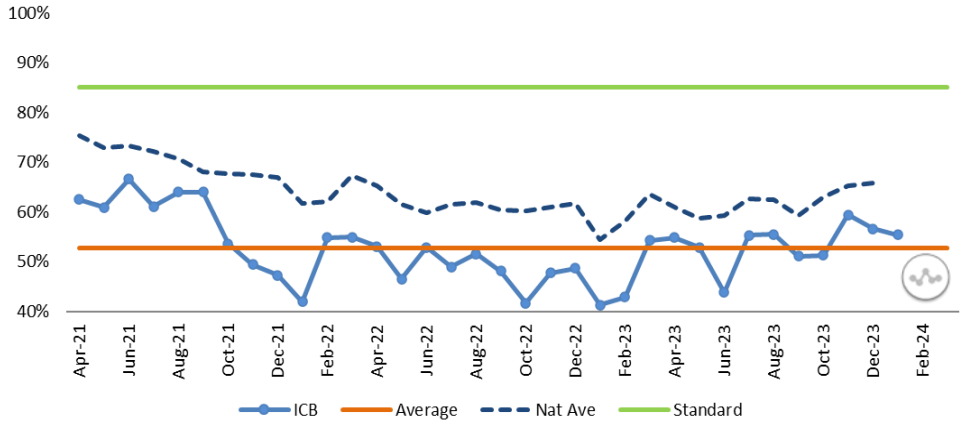
- Recovery from the impact of two spells of Industrial Action
- Focussed system attention, including twice daily meetings, to achieve all types 4 hour 76% performance
- Maximising the additional Active Recovery Beds, acute and community escalation bed capacity opened for Q4
- Ongoing use of cohorting in line with revised SOP and with risk assessments ongoing for increased cohorting capabilities
- Operationalising substantive OOHs Clinical Site Manager capacity across acute sites
- Trusted Assessor role in ED supporting with earlier intervention and signposting to more appropriate areas such as SDEC
- Continuation of Clinically led Multi Agency Discharge Events (MADEs)
- Monitoring Cat 2 mean ambulance performance and focussing on efficiencies through the whole call cycle including post and pre-handover times
- EMAS Trust go-live with ITK links to CAS for CAT3 validations to avoid an ambulance dispatch that can be dealt with in a more appropriate way
- Group UEC programme board to continue to deliver the ED recovery plan and elements of the UEC GIRFT visit recommendations that sit within the group with system GIRFT visit recommendations being developed
- Continued roll out of criteria led discharge and SAFER processes, including Medically Optimised v Discharge Ready dashboard and daily oversight and review of delayed discharges of care
- Focus on maximising system capacity to 95% occupancy

Cancer

% of patients told cancer diagnosis outcome within 28 days (ICB)



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

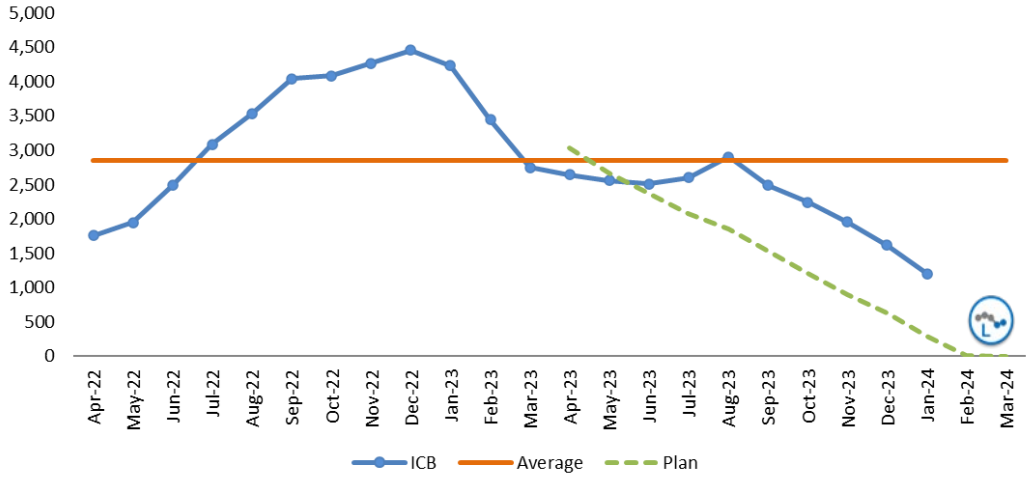


Current system pressures	Actions to recover
• The backlog position has improved and currently stands at 200, we remain below our projected trajectory with the ask from NHSE to get to 217 by the end of March 2024. • All of the major tumour sites have seen a reduction in backlog apart from Head & Neck, colorectal continues to account for the largest percentage of the backlog at 29%, second largest being urology accounting for 17% of the backlog. • Some tumour sites struggled to meet 28 day Faster Diagnosis Standard (FDS) in February – Head & Neck & Haematology being the most notable. However the majority of tumour sites performed well in February against FDS. • All tumour sites are experiencing pathology delays, however across the board the position appears to be improving although further improvement is needed in line with the Best Practice Timed Pathways. • A number of teams have staffing issues both clinical and managerial. As management team members are promoted into new posts this is having a domino effect with a considerable amount of movement within teams. • The Cancer Centre Manager at ULHT has left their position, this is placing pressure on an already stretched team.	• ULHT / ICB continue to lead an intensive support programme for cancer focussing on 28-day Faster Diagnosis Standard and patients waiting over 62 day backlog. Focus is on 8 specialities Colorectal, Urology, Head & Neck, Lung, Upper GI, Skin, Gynae and Breast. • Work is ongoing with individual tumour sites to look at reasons why patients predominantly with a cancer diagnosis are delayed in meeting their 28 day FDS. • 7 day working has commenced in Pathology and this appears to be having a positive impact, more time is needed to embed to confidently measure any impact. • The lung cancer pathway continues to provide results, the ongoing review highlights that significantly less patients (less than half) are now having to undergo CT scans due to the new triage system that is in place. • Daily PTL meetings are in place with colorectal and urology teams to ensure patients are moving through their pathways in a timely manner. • A Recovery Action Plan is being developed collaboratively with all tumour sites to ensure actions to meet performance targets and reduce backlogs are measurable, timely and visible.

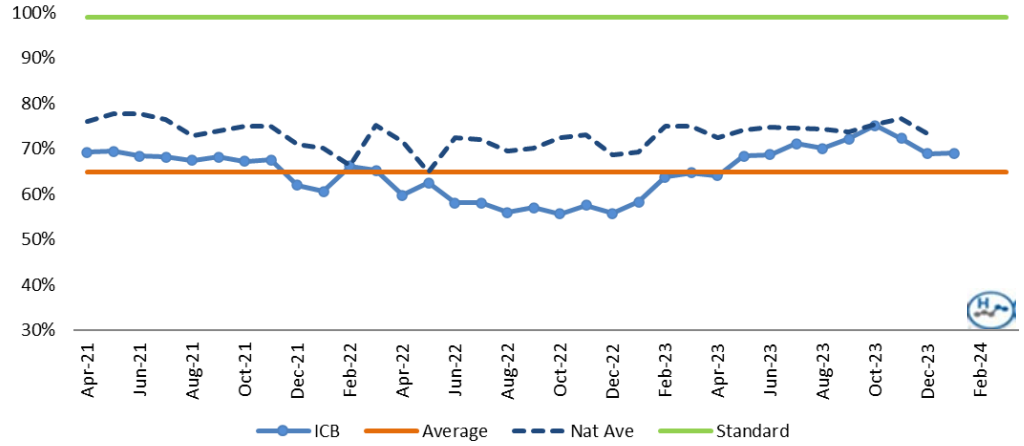
Planned Care

NHS Lincolnshire Integrated Care Board

Patients waiting over 65 weeks for treatment (ICB)



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



Current system pressures

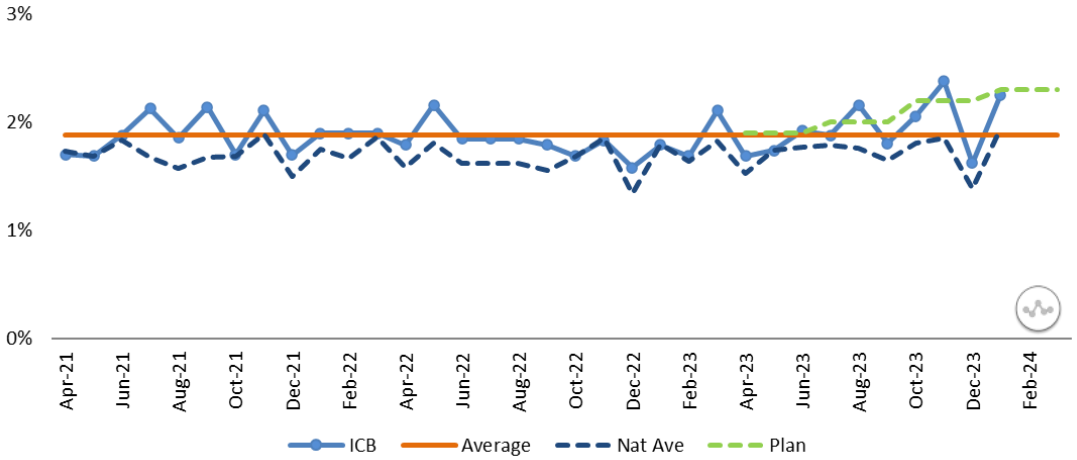
- Main priority continues to be the elimination of 78 week waits. This continues to be challenging but is a much-improved position across all Providers and on trajectory to be virtually eliminated by March 24.
- The actual number of patients waiting over 65 weeks is above plan but continues to decrease. This has been impacted by the focus on eliminating 78 week waits and Industrial Action.
- Patients were offered the opportunity to move Provider where they had been waiting over 40 weeks and met certain criteria as part of a national programme. However, uptake was low due to geography and limitation on distance patients were willing to travel. Only 0.3% of eligible patients transferred locally which also reflected national outcome. Patients continue to exercise their right to choose even if this may mean waiting longer for an appointment.
- The national ambition for diagnostic recovery is for 95% of patients to be seen within 6 weeks by March 2025. Within Lincolnshire we were also working to a regional ambition of 85% of patients to be seen within 6 weeks by March 2024 but this has slipped to May due to impact of Industrial Action.

Actions to recover

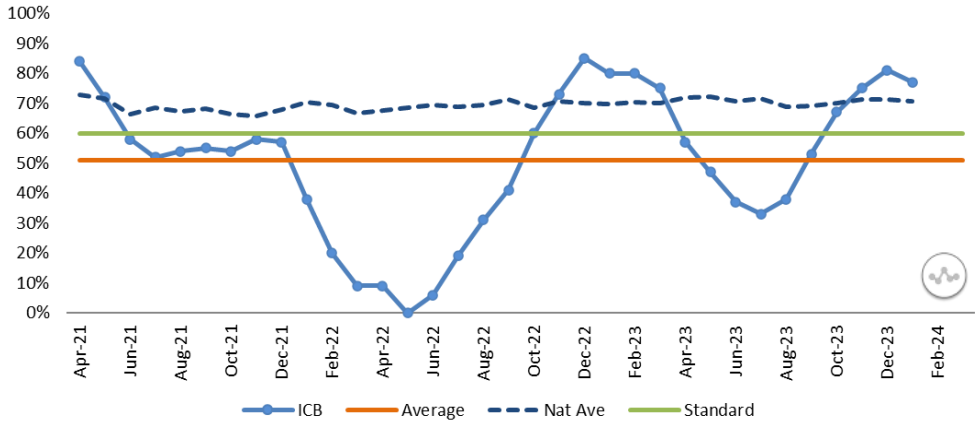
- All Providers continue to focus on outpatient recovery as this continues to be the biggest area of challenge nationally and is still where most patients are currently waiting.
- An outpatient sprint is currently underway at ULHT with a focus on increasing clinic slot utilisation, reducing missed appointments, increasing patient initiated follow up (PIFU) rates and reintroducing directly bookable new appointments.
- The System is performing well on providing specialist advice to GPs and is consistently above the national target of 16% of new outpatient attendances.
- Additional capacity is being provided both internally and via mutual aid from alternative providers for most challenged specialties at ULHT including ENT, Gastroenterology and Dermatology.
- Mutual aid is being sought by NWAFT for their challenged specialties (Ophthalmology and Dermatology) and is being supported by the Elective Activity Coordination Hub.
- NLaG have virtually eliminated 65 week waits and have a local target to eliminate 52 week waits by March 24 ahead of the national ambition although this has been impacted by recent industrial action.
- Percentage of patients seen with 6 weeks for a diagnostic test has increased marginally on previous month with Echo, CT and MRI continuing to be the current areas of challenge, however remedial actions are in place and improvement in outcomes are being seen.

Mental Health

NHS Talking Therapies- Access (ICB)



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



NHS Lincolnshire Integrated Care Board

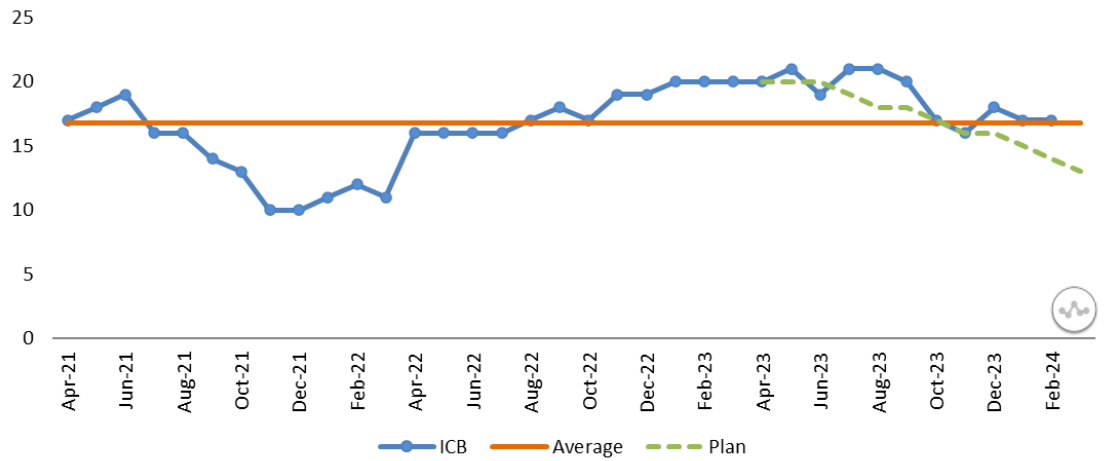
Current position	Actions to recover
NHS Talking Therapies • December saw a reductions in access, which is a typical trend for December due to the Christmas and New Year period. • The service has now recruited to all but one vacancy against the funded establishment. • According to modelling, the service remains short of 30 staff, even when all vacancies are filled, to ensure the service meets the national target and 16 staff to meet the local target. • Waiting times are longer than we would like for treatment, the balance is to ensure this is addressed and not only increasing the numbers to meet the access rate. • We continue to challenge the access rate with NHSE with a system view they are currently overly ambitious, and benchmarking would suggest very few services in the Midlands are likely to achieve.	**NHS Talking Therapies** • Recent relaunch event and promotional activity (Oct 2023) • To appoint to a new role to ensure promotion and comms and working closely with primary care to ensure all people suitable for the service are referred or signposted to the service. (Feb 2024). • Ensuring enough staff are trained in long-term conditions, this is now a requirement for all new staff into the service when they have gained relevant experience. (March 2024). • Service to complete demand and capacity exercise to fully understand required capacity to increase access and ensure waiting times are minimised. (May 2024). • Work across the system to secure further expansion to meet the suggested staffing numbers from NHSE, currently 30 staff short. (May 2024). • Training places allocated to reduce vacancies. • Work has commenced on modelling the new Talking Therapies standards for 24/25, i.e. improved attrition, reliable recovery and improvement. • The service is outsourcing treatments to an external provider and will continue to do so to reduce waits over 90 days.

Lincolnshire ICB Quality Dashboard

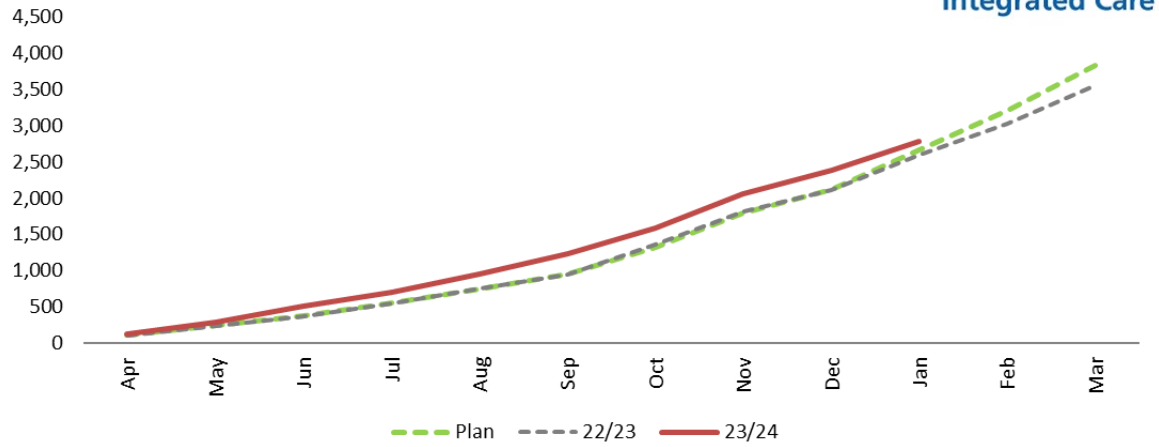
Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend	
								Sparkline	Variation
Incidents	Never events (ULHT)		0	Feb-24	0	N/A	N/A		
	Never events (NLAG)		0	Feb-24	0	N/A	N/A		
	Never events (NWAFT)		0	Feb-24	0	N/A	N/A		
	Serious Incidents (ICB)		-	Feb-24	18	N/A	N/A		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)		-	Oct-23	1.0319	1.0516	1.0021		
	Hospital Standardised Mortality Ratio (HSMR) (ULHT)		100	Jan-24	93.22	N/A	N/A		
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)		-	Oct-23	1.0028	1.0516	1.0021		
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)		-	Oct-23	1.0275	1.0516	1.0021		
Infection, Prevention, Control	MRSA Cases (ICB 12 month rate per 100,000)		-	Jan-24	0.29	0.68	0.94		
	C-Diff Cases (ICB 12 month rate per 100,000)		-	Jan-24	25.89	29.44	28.31		
	E-Coli Cases (ICB 12 month rate per 100,000)		-	Jan-24	27.95	37.16	38.88		
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)		14	Feb-24	17	N/A	N/A		
	Cumulative Learning Disability Healthchecks (ICB)		2657	Jan-24	2774	N/A	N/A		
Patient Experience	Patient experience of GP services (ICB)		-	2023	70.9%	N/A	71.3%		
	Friends & Family Test: A&E Recommended (ULHT)		-	Jan-24	76.0%	N/A	78.0%		
	Friends & Family Test: Inpatient Recommended (ULHT)		-	Jan-24	91.0%	N/A	94.0%		
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)		-	Jan-24	98.0%	N/A	93.0%		
	Friends & Family Test: Community Recommended (LCHS)		-	Jan-24	90.0%	N/A	94.0%		
	Friends & Family Test: Mental Health Recommended (LPFT)		-	Jan-24	94.0%	N/A	85.0%		
Primary Care	Primary Care CQC- number of practices rated as 'Inadequate' by CQC		0	Feb-24	1	N/A	N/A		
	Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC		-	Feb-24	6	N/A	N/A		
	GP Appointments- percentage seen by a GP		35.9%	Jan-24	34.7%	N/A	N/A		
	GP Appointments Mode- percentage seen face to face		66.1%	Jan-24	68.1%	N/A	N/A		
	GP Appointments- time from booking to appointment same day		23.1%	Jan-24	45.0%	N/A	N/A		
	GP Appointments- time from booking to appointment < 2 Weeks		84.4%	Jan-24	79.9%	N/A	N/A		
	Enhanced access provision per 1000 of the PCN adjusted population (ICB)		60	Jan-24	57.9	N/A	N/A		
	The percentage of available GP enhanced access appointments utilised (ICB)		80%	Jan-24	71.8%	N/A	N/A		

Learning Disability & Autism

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



Learning Disability Annual Health Checks (ICB)



NHS Lincolnshire Integrated Care Board

Current system pressures	Actions to recover

LD Inpatients

- There are currently 17 LDA ICB Inpatients, 2 above the planned trajectory of 15.
- There are currently 17 LDA IMPACT inpatients, 4 above the planned trajectory of 13.
- There are currently 0 LDA children & young people (CYP), with a planned trajectory of 2.
- Work continues with NHSE Provider Collaborative on improving process and better collaborative ways of working to ensure that data is accurate and timely.
- Lincolnshire ICB continue to work with the provider market to source the most appropriate accommodation for citizens within the LDA cohort with discharge plans in place [RAG-rated GREEN].
- Learning from Safe and Well Reviews and Care (Education) and Treatment Reviews amongst others drive the strategic and operational planning for the Lincolnshire LDA cohort of patients.

LD Annual Health Checks

- Delivery YTD (up to the end of January) is 2,774 Health Checks, ahead of the YTD plan (+117).

LD Inpatients

- Transforming care Liaison service recruitment ongoing.
- DSR and Community CTR process working well with significant impact on admission rates (98% avoidance with Community CTR).
- Ongoing work to support and provide legal framework for discharges.
- System market development work with current and new providers for appropriate community accommodation that suits the needs of the LDA cohort.
- Future provision work ongoing to feed market requirements.
- Long Term Section 17 Leave pilot has been approved by EO Investment Board and will commence in April 24.
- Ashley House being considered as therapeutic respite for 16-25 year olds.

LD Annual Health Checks

- Regional data has flagged a relatively low level of health actions plans recorded for Lincolnshire patients – this will be picked this year to understand whether this is a coding issue, to review the quality of HAPs and support practices to improve where required.

Insight and Signals – Quality and Patient Experience

LCHS:

Quality and contract oversight has highlighted a number of areas of challenged service provision within the Trust, including CYP speech and language therapy (SLT); lymphoedema and skin integrity; initial health assessments for Looked After Children (LAC); and more recently palliative and end of life care. It is recognised these services sit a part of system pathways of care and therefore improvement needs to be considered within the context of wider contributing factors. A number of task and finish groups have already been established to address the immediate quality concerns, which include representation of partner organisations relevant to the particular pathway of care. ICB and LCHS Executive agreement has been reached in relation to the approach required to scope the challenges and establish the work programme to address the broader issues.

LIVES:

Action has been taken by LIVES following escalation of concerns regarding the organisation's controlled drug (CD) license. Whilst this issue has now been addressed further work has been undertaken to understand any quality concerns, including the indemnity arrangements in place between LIVES and EMAS, and confirm any implications from a service delivery perspective. A CQC visit took place in November and the report published 22 January 2024 rates LIVES as Requires Improvement overall and for safety, effectiveness, and well led; and Good for caring and responsiveness. A subsequent ICB quality visit was undertaken 16 February 2024, no significant quality concerns were highlighted through the visit.

Magna House:

In April 2023 CQC inspection report rated Magna House, a 29-bed independent mental health hospital in Lincolnshire, as Inadequate due to a number of factors including recording and reporting incidents; patients experiences of care; building maintenance issues causing risks to patients; practice in relation to rapid tranquilisation; and staffing concerns, particularly in relation to registered mental health nurses. Significant work has been undertaken to support improvement and following further CQC inspection in October 2023 Magna House is now rated as Good overall and across all 5 CQC domains of safe; effective; caring; responsive; and well-led.

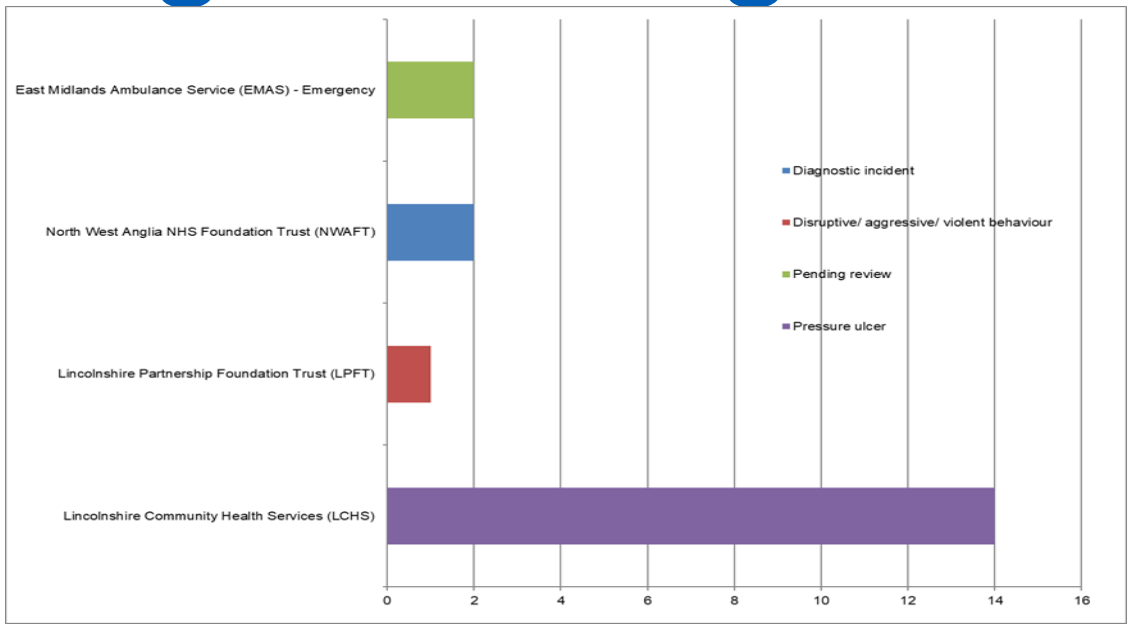
Right Care Right Person (RCRP)

RCRP is a framework for assisting police with decision-making about when they should be involved in responding to reported incidents involving people with mental health needs National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk). Within Lincolnshire there is a commitment to a phased approach to implementation of RCRP. Multiagency strategic and tactical Boards are in place to oversee and agree application of the framework. Information and assurances are being requested through a number of routes, including local safeguarding partnerships. The System Quality and Patient Experience Committee will be seeking assurance regarding assessment of impact and actions being taken to mitigate any identified risks.

Insight and Signals – Primary Care

Practice	CQC Rating	Information to note
Caskgate	Inadequate	CQC published report 2nd August 2023 following inspection of the Practice 24th May 2023. The report rated the practice as Inadequate and the CQC issued section 29 warning notices 7th June 2023. Areas of concern relate to safeguarding; medicines management; oversight of prescribing practice; Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts; patient records; secure storage of patient notes and other confidential documentation; and premises safety. The Practice have responded appropriately to CQC level of concern and extensive support plan now in place with ICB and LMC. The support plan has included regular meetings with the Practice senior team to help support the improvement plan. Specialist support from Medicines Optimisation, Safeguarding and Infection, Prevention and Control. Additional funding agreed through Section 96 funding to support resilience and delivery of the CQC action plan, including locum funding; coding and workflow; Advance Nurse Practitioner capacity; and note summarisation. Long term estate strategy is being developed for the practice with the ICB engaging with local partners to identify possible solutions.
Richmond Practice	Requires Improvement	The Practice had an inspection May 2023 and the CQC report published 13 October 2023 rated the Practice as Inadequate overall, with Inadequate in Safe and Well Led; Requires Improvement for Effective and Responsive; and Good for Caring. The CQC placed the Practice into Special Measures; Warning Notices were issued 27 June 2023 relating to Safe Care and to Governance. Concern areas identified related to infection prevention and control, emergency response, resuscitation (DNACPR) documentation and outstanding patient reviews. A support plan was put in place which the Practice responded to positively. However, CQC undertook a further inspection early December 2023, and the report was published 2 February 2024 rating the Practice as Requires Improvement overall and for Effective, Responsive, and Well Led; Good for Caring; and Inadequate for Safe. The CQC report noted that whilst progress had been made in relation to the Warning Notices, insufficient improvements had been made to comply with all aspects. The Warning Notices remain in place and the Practice remains in Special Measures. The ICB will continue to engage with the Practice to review support required to make the necessary improvements.

Insight and Signals- Serious Incidents



There has been a total of (n=18) patient safety incidents reported on STEIS between 6 February 2024 and 5 March 2024. This figure represents a slight increase when compared to the previous report (n=15). The increase in reporting this month is attributed to a) ULHT reporting (n=2) Health Services Safety Investigations Body (HSSIB) cases on STEIS and b) delayed receipt of a couple of patient safety incidents reported in relation to NWAFT. As referenced in previous reports, the overall decrease in reporting of serious incidents is attributed to organisations transitioning to the Patient Safety Incident Response Framework (PSIRF).

- Pressure ulcers continue to account for most of the patient safety incidents recorded on STEIS, relating to care provided by Lincolnshire patients. As illustrated in the graph (n=9) pressure ulcers have been reported this month, of which all had been received from LCHS. This figure represents a continued decrease when compared to the last report (n=12).
- In addition, LCHS reported a single slip/trip/fall incident within the timeframe referenced.
- ULHT have recorded (n=2) patient safety incidents on STEIS. The reporting has been undertaken in accordance with PSRIF requirements. PSIRF requires that all incidents reported through for Health Services Safety Investigations Body (HSSIB) investigation require recording on STEIS. The (n=2) incidents reported relate to provision of maternity services.
- LPFT have reported a single patient safety incident on STEIS this month. The single incident related to an apparent/actual/suspected self-inflicted harm.
- In addition, it is noted that there were (n=5) serious incidents reported, in relation to Lincolnshire patients, by other healthcare providers:
    - NWAFT – A total of (n=4) patient safety incidents have been reported on STEIS by NWAFT. The incidents focus on diagnostics (n=2) and treatment delays (n=2)
    - Pharmacy – A single pharmacy patient safety incident has been reported, relating to a practitioner performance concern

Quality Improvement

- CQC is moving to its new single assessment framework https://www.cqc.org.uk/guidance-regulation/providers/assessment. As part of the transition CQC are aligning themselves to ICBs rather than the historical arrangements of teams being aligned to individual providers. Locally the ICB and providers are considering how the changes impact established ways of working with the CQC, to ensure there continues to be positive working relationships.
- Better Lives Lincolnshire Leadership Team have endorsed the development of a cohesive, collaborative and inclusive approach to improvement, learning and innovation for the ICS under the banner of LIfE: Lincolnshire Improvement for Everyone. The purpose is to improve the health and wellbeing of people in Lincolnshire, by facilitating stronger collaboration across organisations and more effective scaling of innovation; making the most of all the resources and the expertise that exists in Lincolnshire. The intention is to shift the focus from assurance to improvement. A working group will be responsible for developing a framework that will create the conditions for change and enable delivery of changes across the system. Engagement in this work will incorporate representation across the breadth of organisations within the ICS including NHS; Local Authority; Primary Care; Voluntary and 3rd Sector; and the University.
- Lincolnshire has been part of the Midlands Nursing & Midwifery Excellence Network since its inception in Q1 of 2023/24. The concept of 'Excellence' is based on a number of elements that are considered to support achievement of positive staff experiences and the positive impact this has on patient safety and quality of care. Examples of this include ward/team accreditation processes; shared decision-making councils; staff recognition awards; professional development; staff wellbeing; and quality governance arrangements. Submissions of information from the respective trust/system nursing and midwifery leaders to the network is co-ordinated by the ICB and increasingly the quarterly submissions reflect the achievements of the nursing and midwifery partners across the ICS, including Primary Care. It is recognised the current development of a Lincolnshire Social Care Nursing Advisory Council (SCNAC) will further strengthen the opportunity to contribute to the Nursing & Midwifery Excellence agenda as an ICS.
- Recent publication of an RCN article 'Helping general practice nursing staff find their voice in Lincolnshire' https://www.rcn.org.uk/news-and-events/Blogs/helping-general-practice-nursing-staff-find-their-voice-in-lincolnshire-070324 highlights the significant work that has been undertaken over a number of years, including the launch of a Career Start programme for nurses who are newly qualified or new to general practice; establishment of a Trainee Nurse Associate programme in general practice which has achieved comparable numbers to our local NHS Trusts; development of a successful Return to Practice Programme for general practice; establishment of an annual GPN conference and GPN awards; establishment of a process for allocating workforce development funding across practices based on a training needs analysis and commissioning well-evaluated training programmes; and promotion of general practice as a place to work at universities, colleges and schools.

Quality and Patient Experience Thematic Update- Medicines Optimisation

- Over the past 12 months, the Lincolnshire Medicines Optimisation (MO) team has achieved significant milestones and a much-improved position in respect of Ghost Generic prescribing in Lincolnshire (the ICB were an outlier in this respect), the launch of an Opioid toolkit aimed at patients and professionals called 'Pain Star', facilitated a forecast £5.6m reduction in what the prescribing spend in Lincolnshire may have been in 2023/24 and answered 285 clinical queries from GP practice staff and associated organisations between Jan 23 and Dec 23.
- The MO team also had a significant amount of collaborative work across the year including working with the acute trust to publish various shared care agreements & guidelines, linking with Community Pharmacy to roll out Pharmacy First Service across Lincolnshire with 100% of pharmacies providing face-to-face services signed up to provide the service. In addition, the Community Pharmacy Clinical lead worked with primary care team and relevant stakeholders such as Local Pharmaceutical Committee and Local Medical Committee to promote the service with the aim of improving access and capacity in general practice. The MO team worked collaboratively to deliver the successful implementation of the Lincolnshire Care Home policy and procedures, and facilitated the first system-wide Medication Safety Network meeting with great attendance.
- Collaboratively working with national NHSE Team enabled the successful delivery of Antimicrobial TARGET training, with over 60 healthcare professionals from a range of care settings benefiting from this teaching, and the prescribing of shorter, 5-day course antibiotics over 7-day courses has increased since the vent, particularly in the East of the region. Furthermore, our commitment to antimicrobial stewardship was demonstrated through the World Antibiotic Awareness campaign, which encompassed expert presentations, appearances on Team Talk, and widespread dissemination of educational materials across primary care settings.

What's next for MO team in 24/25?

- The Lincolnshire MO team has planned a work plan for 2024/25 that should deliver similar cost efficiencies to 2023/24 as well as improving prescribing in priority areas such as antimicrobial stewardship, diabetes and reducing the carbon impact of inhaler use in Lincolnshire, along with work transitioning Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) into an Area Prescribing Committee (APC). The team also plans to work with external stakeholders to promote 2025/2026 placements in Lincolnshire for Foundation Trainee Pharmacist Cohorts who will have the additional training needed to facilitate Independent Prescribing designation.

Item 6 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	System Financial Management Report February 2024 (Month 11)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Presenter:	Matt Gaunt, Director of Finance
Appendices:	Appendix 1: Lincolnshire Integrated Care Financial Position Appendix 2: Lincolnshire Integrated Care System Income & Expenditure Summary Appendix 3: Lincolnshire Integrated Care Board Income & Expenditure Analysis

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

Recommendations

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

Summary

Summary Financial Position

The report presents the year-to-date and outturn position of both the ICB and the ICS for the financial year 1st April 2023 to 31st March 2024.

Through the Month 9 reporting cycle, the ICS moved the forecast position to that agreed with NHS England as part of the 2023/24 half 2 (H2) financial reset process to a £27.4m deficit. The ICS is delivering actions to enable delivery of this reset outturn. The ICS has improved this position by £15.4m in Month 11 due to the ICS receiving funding from NHS England for the initial planned deficit in month. The ICS is reporting a £11.9m deficit for the year.

Year To Date Financial Position

The H2 financial reset plan was for the ICS to deliver a deficit at month 11 of £44.3m which represented a £14.6m adverse variance to the initial 2023/24 plan. The ICS reported a £14.1m improvement to this by delivering a deficit of £30.2m against this plan at month 11. The £14.1m improvement is due to the year-to-date impact of receiving the £15.4m funding in month for the ICS' initial planned deficit.

The H2 financial reset plan was for the ICB to deliver a deficit of £31.8m at month 11 which represented a £17.3m adverse variance to the initial plan for 2023/24. The ICB reported a deficit of £17.6m at month 11 which represents a £14.1m improvement on the H2 financial reset plan. The £14.1m improvement is due to the year-to-date impact of receiving the £15.4m funding in month 11 for the ICS' planned deficit at the outset of the year.

Outturn Financial Position

The ICS' H2 financial reset plan is to deliver a £27.4m deficit for the full financial year. The outturn position is to deliver a £11.9m deficit which represents a £15.4m favourable variance to this plan. This represents a £3.4m favorable variance against the £15.4m planned deficit at the outset of the year.

The ICB expects to deliver a £1.4m deficit by 31st March 2024. The initial plan at the beginning of the year was for the ICB to deliver a £2.4m surplus for the full year so the position reported at month 11 is a £3.8m adverse variance against this plan. This is in line with the H2 financial reset plan having adjusted for the funding received in month for the planned deficit at the beginning of the year.

Risks and mitigations

The ICS has identified £13.9m of risks within its reported outturn position. After mitigations this provides a net risk position of zero. The ICS is assuming that it will receive allocations from NHS England, in Month 12, that were anticipated within the H2 financial reset plan. Discussions are ongoing with NHS England, and it is expected that there will be conclusion from very soon.

Efficiencies

At Month 11 the ICS delivered £72.8m in efficiencies which equates to a £4.0m favourable variance against the £68.7m plan. The full year plan is to deliver efficiencies of £78.9m and the outturn at Month 11 was to deliver £4.8m more than this plan with a forecast of £83.3m. The ICS Financial Recovery Plan constituted £55.0m of the total efficiency requirement.

Capital

The ICS is reporting a £4.4m underspend against its year-to-date plan of £26.1m due to slippage on some projects. At Month 11 the ICS is planning to overspend by £20.9m against its £32.6m full year Capital Allocation. This is due to the impact of the intra-NHS Right of Use asset liability reassessments in-year relating to NHS Property Services. It is expected that these will be excluded from the ICS' Capital Departmental Expenditure Limit.

It is expected that any year-to-date slippage on capital projects will be mitigated in full by the financial year end.

Mental Health Investment Standard (MHIS)

At the 29th of February 2024, the ICS is expecting to achieve its MHIS target for 2023/24. The target spend for the year is £154.2m and the ICS is committed to meeting this target.

Prior year under-delivery of £6.2m is to be delivered in 2024/25 and 2025/26 and plans have been agreed with NHS England.

Better Payment Practice Code

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

ICB Financial Duties

The ICB, as a statutory organisation, must fulfil certain financial duties. Although the ICB is expecting to meet its H2 financial reset plan, expenditure would be greater than allocations and income received and so is a breach of statutory financial performance targets. The ICB has a statutory obligation to achieve its statutory targets which includes expenditure not being greater than allocations and revenue. The current financial position therefore means that the ICB is in breach of this statutory requirement.

This is, however, in line with the plan set and agreed with NHS England.

The table below demonstrates delivery against the key financial duties as at month 11.

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

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

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**
No conflict identified	Not applicable

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

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes
Does the report highlight any quality and patient safety implications?	Not Applicable
Does the report highlight any health inequalities implications?	Not Applicable
Does the report demonstrate patient and public involvement?	Not Applicable
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not Applicable

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

Report previously presented at:
The month seven and full year financial position was discussed in detail at the ICB Finance and Resource Committee.
Is the report confidential or not?
Yes ☐ No ☒

Appendix 1 – Lincolnshire Integrated Care Financial Position

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Year To Date				Full Year			
	Plan	Actual	Variance		Plan	Outturn	Variance	
	£m	£m	£m	%	£m	£m	£m	%
United Lincolnshire Hospitals NHS Trust	(18.2)	(18.2)	0.0	0.0%	(20.8)	(20.8)	-	0.0%
Lincolnshire Partnership NHS Foundation Trust	3.0	4.9	1.9	1.3%	3.0	8.8	5.8	3.6%
Lincolnshire Community Health Services NHS Trust	-	0.7	0.7	0.6%	-	1.4	1.4	1.0%
Lincolnshire ICB	(0.4)	(17.6)	(17.3)	(1.0%)	17.8	(1.4)	(19.2)	(1.1%)
ICS Total Surplus/(Deficit)	(15.5)	(30.2)	(14.7)	(0.9%)	(0.0)	(11.9)	(11.9)	(0.7%)

Appendix 2 – Lincolnshire Integrated Care System Income & Expenditure Summary

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Forecast Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	(1,646.9)				(1,797.7)			
ICB Net Expenditure								
Acute Services	841.6	845.3	(3.8)	(0.5%)	923.6	925.3	(1.7)	(0.2%)
Mental Health Services	190.4	189.7	0.6	0.3%	204.4	209.2	(4.7)	(2.3%)
Community Health Services	162.3	167.3	(5.0)	(3.1%)	172.5	179.6	(7.1)	(4.1%)
Continuing Care Services	54.7	58.9	(4.2)	(7.7%)	60.1	64.9	(4.8)	(8.0%)
Primary Care Services	167.6	182.4	(14.8)	(8.8%)	182.1	199.1	(16.9)	(9.3%)
Memo: Prescribing	145.8	158.1	(12.3)	(8.4%)	157.5	171.2	(13.7)	(8.7%)
Other Commissioned Services	6.8	6.3	0.4	6.6%	7.4	7.0	0.5	6.3%
Other Programme Services	4.7	4.4	0.3	6.7%	5.5	5.0	0.5	9.2%
Reserves / Contingencies	(1.8)	0.4	(2.2)	123.1%	(18.9)	(19.8)	0.9	(4.6%)
Delegated Primary Care Commissioning	205.7	196.1	9.6	4.7%	226.4	213.3	13.2	5.8%
ICB Running Costs	15.4	13.7	1.7	10.9%	16.7	15.6	1.1	6.6%
Total ICB Net Expenditure	**1,647.3**	**1,664.6**	**(17.3)**	**(1.0%)**	**1,780.0**	**1,799.1**	**(19.2)**	**(1.1%)**
ICS Providers I&E - Adjusted Financial Performance								
Income	(966.4)	(989.4)	22.9	(2.4%)	(1,057.7)	(1,084.9)	27.1	(2.6%)
Pay	674.2	684.8	(10.6)	(1.6%)	736.0	746.6	(10.6)	(1.4%)
Non-Pay	301.2	311.7	(10.4)	(3.5%)	332.7	343.3	(10.6)	(3.2%)
Non Operating Items	6.2	5.5	0.7	11.6%	6.8	5.5	1.4	20.1%
TOTAL Provider Surplus/(Deficit)	**(15.2)**	**(12.5)**	**2.6**	**(0.3%)**	**(17.8)**	**(10.5)**	**7.2**	**(0.7%)**
TOTAL ICS Surplus/(Deficit)	**(15.5)**	**(30.2)**	**(14.7)**	**0.9%**	**(0.0)**	**(11.9)**	**(11.9)**	**0.7%**

Appendix 3 – Lincolnshire Integrated Care Board Income & Expenditure Analysis

System I&E Analysis	Year to Date				Full Year			
	Net Expenditure Plan £m	Net Expenditure Actual £m	Net Expenditure Variance £m	Net Expenditure Variance %	Net Expenditure Plan £m	Net Expenditure Outturn £m	Net Expenditure Variance £m	Net Expenditure Variance %
System Revenue Resource Limit	**1,646.9**				**1,797.7**			
ICB Net Expenditure								
Acute Services	**841.6**	**845.3**	**(3.8)**	**(0.5%)**	**923.6**	**925.3**	**(1.7)**	**(0.2%)**
Acute services - NHS	802.5	798.7	3.8	0.5%	880.5	874.4	6.1	0.7%
Acute services - Independent/commercial sector	30.4	36.4	(6.0)	(19.8%)	33.5	39.1	(5.6)	(16.9%)
Acute services - Other non-NHS	1.9	4.1	(2.2)	(112.9%)	2.1	4.9	(2.8)	(135.8%)
Acute Services - Other Net Expenditure	6.8	6.2	0.6	9.2%	7.5	6.8	0.7	9.2%
Mental Health Services	**190.4**	**189.7**	**0.6**	**0.3%**	**204.4**	**209.2**	**(4.7)**	**(2.3%)**
MH Services - NHS	111.7	110.9	0.8	0.7%	118.7	122.4	(3.8)	(3.2%)
MH Services - Independent / Commercial Sector	35.4	32.4	3.0	8.6%	38.6	36.7	1.8	4.8%
MH Services - Other non-NHS	41.7	45.3	(3.6)	(8.6%)	45.6	47.9	(2.4)	(5.2%)
MH Services - Other net expenditure	1.5	1.1	0.4	24.6%	1.7	2.1	(0.4)	(26.8%)
Community Health Services	**162.3**	**167.3**	**(5.0)**	**(3.1%)**	**172.5**	**179.6**	**(7.1)**	**(4.1%)**
Continuing Care Services	**54.7**	**58.9**	**(4.2)**	**(7.7%)**	**60.1**	**64.9**	**(4.8)**	**(8.0%)**
Primary Care Services	**167.6**	**182.4**	**(14.8)**	**(8.8%)**	**182.1**	**199.1**	**(16.9)**	**(9.3%)**
Prescribing	145.8	158.1	(12.3)	(8.4%)	157.5	171.2	(13.7)	(8.7%)
Other Primary Care Services	21.8	24.3	(2.5)	(11.4%)	24.6	27.8	(3.2)	(11.4%)
Other Commissioned Services	**6.8**	**6.3**	**0.4**	**6.6%**	**7.4**	**7.0**	**0.5**	**6.3%**
Other Programme Services	**4.7**	**4.4**	**0.3**	**6.7%**	**5.5**	**5.0**	**0.5**	**9.2%**
Reserves / Contingencies	**(1.8)**	**0.4**	**(2.2)**	**123.1%**	**(18.9)**	**(19.8)**	**0.9**	**(4.6%)**
Delegated Primary Care Commissioning	**205.7**	**196.1**	**9.6**	**4.7%**	**226.4**	**213.3**	**13.2**	**5.8%**
Primary Medical Services	148.9	146.3	2.6	1.8%	162.2	159.7	2.4	1.5%
Delegated Dental, Ophthalmic and Pharmacy Services	56.8	49.8	7.0	12.3%	64.2	53.5	10.7	16.7%
Dental Services	33.4	26.5	6.9	20.7%	38.8	28.1	10.7	27.7%
Ophthalmic Services	6.7	6.9	(0.2)	(2.9%)	7.4	7.4	-	0.0%
Pharmacy Services	16.7	16.4	0.3	1.6%	18.0	18.0	-	0.0%
ICB Running Costs	**15.4**	**13.7**	**1.7**	**10.9%**	**16.7**	**15.6**	**1.1**	**6.6%**
Total ICB Net Expenditure	**1,647.3**	**1,664.6**	**(17.3)**	**(1.0%)**	**1,772.1**	**1,799.1**	**(19.2)**	**(1.1%)**
TOTAL ICB Surplus/(Deficit)	**(0.4)**	**(17.6)**	**(17.3)**	**(1.0%)**	**17.8**	**(1.4)**	**(19.2)**	**(1.1%)**

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Social Finance and Service Transformation
Report Author:	Mr Matt Gaunt, Director of Finance
Presenter:	Mr Matt Gaunt, Director of Finance
Appendices:	Draft model for a transformation fund

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

Recommendations

The Board is asked to note the content of this report.

Summary

Social Finance or Investment is an approach to mobilising private capital that delivers a social dividend and an economic return to achieve social and environmental goals through innovative service transformation and is used increasingly within health and social care.

It aims to leverage private capital to address challenges in areas of social and environmental need; brokered through Social Finance companies who match investors with suitable opportunities. It is used when traditional funding sources are constrained or not available.

Lincolnshire ICB has entered into discussions with two social investment companies to explore the possibility of working in collaboration with them to develop a Transformation Fund to support delivery of service transformation in Lincolnshire.

The ICB Director of Finance to lead work with the social investment companies to develop the concept with a view to developing a business case that has clear aims, objectives, outcome measures and repayment metrics.
The aim is to develop and agree a business case and implementation plan ready for mobilisation by autumn.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Increase capability to develop services that deliver improved outcomes.
Aim 2: Tackle inequalities in outcomes, experience and access.	Will support service change initiatives that improve equity of access. .
Aim 3: Enhance productivity and value for money.	Supplement traditional funding routes by providing new income streams.
Aim 4: Help the NHS support broader social and economic development.	Expand breadth of resources available for community and charitable organisations
Conflicts of Interest	**Summary of conflicts**
No conflict identified	N/A

Risk and Assurance
No direct implications to this paper.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes, potential additional resources to support service transformation.
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Not applicable.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

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

Report previously presented at:
Previously discussed at ICB Executive

Is the report confidential or not?
Yes ☐ No ☒

Social Finance and Service Transformation

Introduction

1. Lincolnshire ICB has entered into discussions with two social investment companies to explore the possibility of working in collaboration with them to develop a Transformation Fund to support delivery of service transformation in Lincolnshire.

2. Social finance is an approach to mobilising private capital that delivers a social dividend and an economic return to achieve social and environmental goals. Social finance aims to leverage private capital to address challenges in areas of social and environmental need, this is brokered through Social Finance companies who match investors with suitable opportunities.

3. Social Finance or Investment is a way of funding longer term, more innovative and risky service transformation within health and social care. It is used when traditional funding sources are not available:

    - It enables investment in one part of the system, and benefits realization elsewhere in the system.

    - Some financial risk sits partly with the social investors. This supports the NHS to invest in more innovative projects. The ICB would need to agree how any failure to meet the outcomes would be funded with the investor.

    - It enables Social Care and NHS to work together with a joint funded scheme, removing traditional organizational constraints, operating alongside statutory sector governance structures.

    - It enables the charitable sector to develop their services and create sustainable impact for local people.

How does social finance work?

4. The diagram at **Appendix A** sets out broadly how the funding model would work, creating a model for a Lincolnshire Transformation Fund.

5. Both social investment companies have had previous success working with social care and NHS Commissioners.

6. Some models use a Community Interest Company as a vehicle for the funding and some do not. It will be important to work with the social investment companies to agree the detail of the structure to deliver the agreed financial model. If a company is used, it would be important to ensure the membership of the company reflects the ongoing needs of the partnership and protects the interests of all stakeholders.

7. One of the key advantages the model is expected to realise is the recycling of the investment funding to ensure it is leveraged throughout the cycle.

8. Repayments of the original investment will be made based on an agreed outcomes framework. Some social investment may be provided by way of grants directly to charitable organisations and some will be an investment that is to be repaid only if the

agreed outcomes are reached. The final agreement for the social investment will set out what these outcomes are.

9. The key difference between the 2 social investment companies is that one provides project management and support (at cost) and is willing to work to broader strategic aims, flexing the operational element of the work to meet the overarching aims. The other, is an 'arms length' approach whereby it is for the ICB and its partners to work to deliver agreed, measured outcomes.

10. Both social investment companies will work with the ICB to develop the business case (including benchmarking outcomes) and delivery program plan.

11. The ICB would act as broker to introduce the social investment companies to the charitable organisations who will help to deliver the service transformation. The process is very much a collaborative partnership across health, social care and the charitable sector and as such, involving the right people and organisations will be key to the success of the project.

Next Steps

12. The ICB Director of Finance to lead work with the social investment companies to develop the concept to create business plans that have clear aims, objectives, baseline outcome measures and repayment metrics.

    Key considerations will be:
    - Governance and Leadership of the fund
    - How the fund will operate to distribute its funds over time
    - The size, skill-set and organizational culture of the people
    - Stakeholder engagement and relationships / partnerships
    - Impact and evaluation

Timeline

13. Both social investment companies would be able to develop and agree a business case and implementation plan ready for mobilization by October / November 2024, one believed the lead time could be as little as 3 months. Both require agreement at their own Board as part of the process.

Draft model for a Transformation Fund in Lincolnshire

Social Investment is a way of funding longer term, more innovative and risky service transformation within health and social care. It is used when traditional funding sources are not available: Enables investment in one part of the system, and benefits realization elsewhere in the system.

1. The financial risk sits partly with the social investor. This supports the NHS to invest in more innovative projects. The ICB would need to agree how any failure to meet the outcomes would be funded with the investor.
2. Enables Social Care, charitable sector and NHS to work together with a joint funded scheme, removing traditional organizational constraints, operating alongside statutory sector governance structures.
3. The return on investment is expected to be more than 12 months and investors will commit to an initial funding period of at least 5 years.
5. Social Finance Ltd is funded by social investors and provides expertise in social investment and operational management support to the Fund.
6. The Community Partnership Fund aims to be self-replenishing as value generated by outcomes is paid back into the Fund and therefore it can then be re-invested into new schemes.

Item 08 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Lincolnshire NHS Joint Forward Plan 2023-28
Report Author:	Feargus Mack – ICB Associate Director – Planning & Transformation
Presenter:	Pete Burnett, Director of Strategic Planning, Integration and Partnerships
Appendices:	- Joint Forward Plan Priority 1: A new relationship with the public [Refreshed content] - Allocation of duties and responsibilities [Updated document] - JFP Delivery Plan 2023-28

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

Recommendations

The Board is asked to approve the following:

- The updated Joint Forward Plan, which has amended content for Priority 1: A new relationship with the public, is re-published on the ICB website.
- The updated Allocation of Duties and Responsibilities document is re-published on the ICB website.
- The JFP Delivery Plan is published on the ICB website.
- A summary of the system's 2024/25 operational plan is published once completed in May 2024 which will set out how the NHS are planning to meet the 2024/25 priorities and planning guidance.

Summary

The national requirement

- The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to prepare their Joint Forward Plan (JFP) before the start of each financial year.

- Systems have significant flexibility to determine their scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.

The Lincolnshire approach

Rather than cover all the national requirements in as single document, the Lincolnshire NHS agreed to develop separate documents, which are tailored to the target audiences:

- *NHS Lincolnshire Joint Forward Plan 2023 – 2028* [published June 2023]
  - a relatively concise public-facing document, which is easy to read and understand articulating our new strategy for the NHS in Lincolnshire, co-produced with people and communities.

This is underpinned by a number of more technical documents which are primarily targeting health and care staff but will still be publicly available:

- *Allocation of Duties and Responsibilities* [first published June 2023]
  - outlining how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised. This will be updated annually.
- *JFP Delivery Plan 2023-28* [first version attached]
  - collating the delivery plans for the system service transformation and enabler programmes; the development of these will also be informed by further engagement with people and communities.
  - Providing further details on how the five JFP priorities will be delivered.

Developing and testing the JFP Delivery Plan

- Once the Joint Forward Plan was published, work started on developing the JFP Delivery Plan 2023-28
- There have been three review sessions with the Lincolnshire Leaders Group (LLG), the last of which was on 24/01/24. Discussions mainly focussed on the headline ambitions, testing whether programmes had the right balance in terms of ambition and deliverability. These ambitions have since been reviewed and refined.
- The JFP Delivery Plan 2023-28 has since been reviewed by: the Health and Wellbeing Board, the ULHT and LCHS Board in Common, LPFT's Sustainability Committee and the Primary Care Advisory Group.
- There has also been a third round of citizen engagement to inform the ongoing development and delivery of the Joint Forward Plan. This feedback has been fully considered – the table below summarizes the changes that have consequently been made.

	Joint Forward Plan	JFP Delivery Plan
A new relationship with the public	Content amended to reflect latest citizen feedback, as well as recent progress in developing Our Shared Agreement and associated common language	The detailed programme delivery plans include specific information on how the five Joint Forward Plan priorities will be delivered. These plans have been informed by the citizen feedback in terms where further clarification/ assurance has been sought and desired outcomes.
Living well and staying well	No changes – the key points in the citizen feedback regarding the importance of the priorities reiterated the existing rationale and objectives	
Improving access		
Integrated community care		
A happy and valued workforce		

Recommendations for immediate next steps

It is proposed that the following documents are published on the ICB website on 28/03/24:

- The updated Joint Forward Plan, which incorporates the updated content for Priority 1: A new relationship with the public (attached)
- The updated Allocation of Duties and Responsibilities document (attached)
- The JFP Delivery Plan (attached)

Recommendations for following next steps

At the time of writing, the national 2024/25 priorities and operational planning guidance had not been published. Amended guidance for publishing the Joint Forward Plan and Joint Capital Resource Use Plan was issued on 22/03/24.

The key amendments are set out below:

Joint Forward Plan Guidance
Clarified dates for preparing and publishing 2024/25 Joint Forward Plans:

- ICBs and their partner trusts are required to prepare a JFP before the start of each financial year, setting out how they intend to exercise their functions in the next five years.
- To provide the opportunity to reflect the 2024/25 priorities and operational planning guidance, once published, NHS England is setting Sunday 30 June 2024 as the date for ICBs to publish and share their JFPs with us, their integrated care partnerships and health and wellbeing boards.

Joint Capital Resource Use Plan Guidance
Clarified dates for preparing and publishing 2024/25 Joint Capital Resource Use Plans:

- NHSE request the published capital plans are shared by Sunday 30 June 2024.

As the significant work had already gone into the development of the documents attached in line with the expectation they are published by the 31st March 2024 it is proposed that:

- The documents attached are published as planned.
- It is anticipated that the finalised national planning guidance will be line with interim guidance published in December 2023 and February 2024. Should there be anything materially different or additional, the relevant section(s) of the JFP Delivery Plan will be updated accordingly and the document republished.
- A summary of the system's 2024/25 operational plan is published once completed in May 2024 which will set out how the NHS are planning to meet the 2024/25 priorities and planning guidance.
- The Joint Capital Resource Use Plan is developed and published by 30/06/24, as per the amended guidance.

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

Risk and Assurance
As per the paper.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report highlight any quality and patient safety implications?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report highlight any health inequalities implications/	If yes, include the details otherwise state 'No or Not Applicable'
Does the report demonstrate patient and public involvement?	If yes, include the details otherwise state 'No or Not Applicable'
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	If yes, include the details otherwise state 'No or Not Applicable'

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

Report previously presented at:
A previous version of the JFP was presented to the Board in 2023.
Is the report confidential or not?
Yes ☐ No ☒

Our strategy

At the heart of our strategy is the recognition that we need to evolve our relationship with the public. Together with the people of Lincolnshire, we are building a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

At its core the 'Our Shared Agreement' describes the foundations of an evolving relationship between health, care, communities, and the people of Lincolnshire that is rooted in partnership, education, personalised care and making decisions together.

An initial description of these foundations, that have been developed by working with people from Lincolnshire, is set out below.

Priority 1: A new relationship with the public

Why is this important?

Health and care services in Lincolnshire are under increasing pressure and people don't always receive quality care. Conversely staff can't always deliver the level of care they want to and as a result morale can be low. We need to tackle this together and evolve a new relationship and ways of working between the local NHS, its partners and the people of Lincolnshire.

The care we provide must have the needs of people at its heart, and it must be provided with kindness and compassion. We want to shift the conversation between healthcare professionals and people receiving care to one which focuses on people's strengths and what matters to them. This will give people more choice and control and enable them to live their best and healthiest life.

We want to value and respect people's knowledge and expertise and enable families and carers to better understand how they can support and contribute in a culture of openness and honesty, humility and understanding.

This is what we're doing to evolve this new relationship:

1. **Creating the 'Our Shared Agreement.** Together we are:
    - Building a shared view and agreement with the public about what the best wellbeing, care and health for Lincolnshire looks like – including sharing the impact of not adopting

new ways of doing things so people are able to take educated and informed decisions in their daily lives.

- Learning how staff across the NHS and its partners can successfully adopt new ways of working and supporting them to feel confident in being able to work in different way through learning and development and tailoring services, process and procedures .
- Demonstrating the impact this new relationship is having on staff and people by highlighting where it IS working well so we can build on strengths.

2. Making decisions together

Together we will:

- Help people to make meaningful and informed decisions about the care or treatment they receive.
- Deliver care with the focus on what matters most to the person, and their family and carers, at the centre of it.
- Ask 'what matters to you?' on a routine basis and learn from work already being done in some services and communities.
- Help Lincolnshire people to feel confident about personalised care and shared decision-making which focuses on people's needs and make shared decision making a priority across the NHS, Lincolnshire County Council and voluntary, community and social enterprise organisations in Lincolnshire.

3. Develop and design services together

Together we will:

- Build stronger relationships with the public, volunteers, support groups and community groups and work alongside them to improve health and care services.
- Include all sectors of society including groups that can be overlooked and create safe and inclusive spaces to give everyone the confidence to contribute to discussions.
- Use our new relationship and way of working with the public as a framework for developing and designing services together, throughout our engagement and co-production approaches.
- Equip staff with the skills needed to enable collaborative working, and use our shared agreement to give people the freedom to **coproduce something fundamentally different**.
-

4. Work with people and their families to manage their own health and wellbeing

Together we will:

- Better understand how well people can manage their own health and support them to be more independent and make positive changes to their lifestyle.
- Introduce health and well-being coaches who can work with individuals to better manage their own care and achieve their health and wellbeing goals.
- Use care coordinators who will work with people and their carers to identify what is important to them and develop a single personalised care and support plan.
- Create groups of people with similar needs who can support each other and understand their recovery or look after themselves better.

How will this benefit people and the community?

People will have a say on healthcare in Lincolnshire and how it is delivered giving them greater control over their own health and wellbeing. They will be better supported to understand the options available and make informed decisions about their treatment and lifestyle choices. People will be connected to others with similar experiences as part of vibrant and thriving local communities. They will receive more personalised care from staff who have the time to really listen to them, their families and their carers.

How will this benefit clinicians and professionals working in the NHS in Lincolnshire?

Clinicians and professionals will have time to really understand and listen to what matters to people and their families or carers, and they will be able to adopt a person-centred, collaborative approach with people. They will develop new networks, discover different community resources, and embrace learning and development opportunities that support new ways of working to put the person first. They will feel safe, valued, supported and empowered by their organisation. The result will be less duplication of tasks, fewer health inequalities and unnecessary contacts with health and care services for people.

How will this benefit staff working in the NHS in Lincolnshire?

Staff will have time to really understand and listen to what matters to people and their families or carers, and they will feel that their workplace is committed to making personalised care a reality. New networks and new partnerships will enable staff to adopt a flexible whole-person approach that works across traditional boundaries. They will feel motivated, valued and understood in their job.

Lincolnshire NHS

Joint Forward Plan

Allocation of duties and responsibilities

2024 update

V23/02/24

Contents

Introduction

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts to prepare a Joint Forward Plan (JFP) before the start of each financial year.

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

In developing the JFP, the Lincolnshire NHS agreed to develop two separate documents rather than cover all the National requirements in as single document. The two documents that have been developed are as follows:

1. The new strategy for the county titled 'Lincolnshire NHS Joint Forward Plan 2023-28'
2. The allocation of duties and responsibilities (this document) titled 'Lincolnshire NHS Joint Forward Plan Allocation of duties and responsibilities'

The purpose of the strategy is to set out the priorities the Lincolnshire NHS and its partners will jointly focus on over the next five years to meet the local population's physical and mental health needs.

These priorities have been identified through engagement with clinical leaders, staff, patient representatives and public from the start, holding conversations in our communities and working with our local Healthwatch to run a survey and webinars. The strategy can be found on the NHS Lincolnshire Integrated Care Board (ICB) website on the 'Strategy and Planning' page under the 'About us' section.

Purpose of This Document

The purpose of this document is to outline how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised.

The document outlines how each of the duties identified in the NHSE England document 'Guidance on Development of the Joint Forward Plan' December 2022 are delivered. This document should be seen as a 'reference document' which allows the public and our stakeholders to look at each duty and understand how this are implemented in Lincolnshire.

The duties outlined in the document are not delivered in isolation and therefore there is duplication in some of the content covered across the different duties. However, this approach allows each duty to be reviewed in ion its own rather than requiring the reader to review the full document to understand how they are delivered.

This document will be reviewed and updated annually and will be republished in March each year.

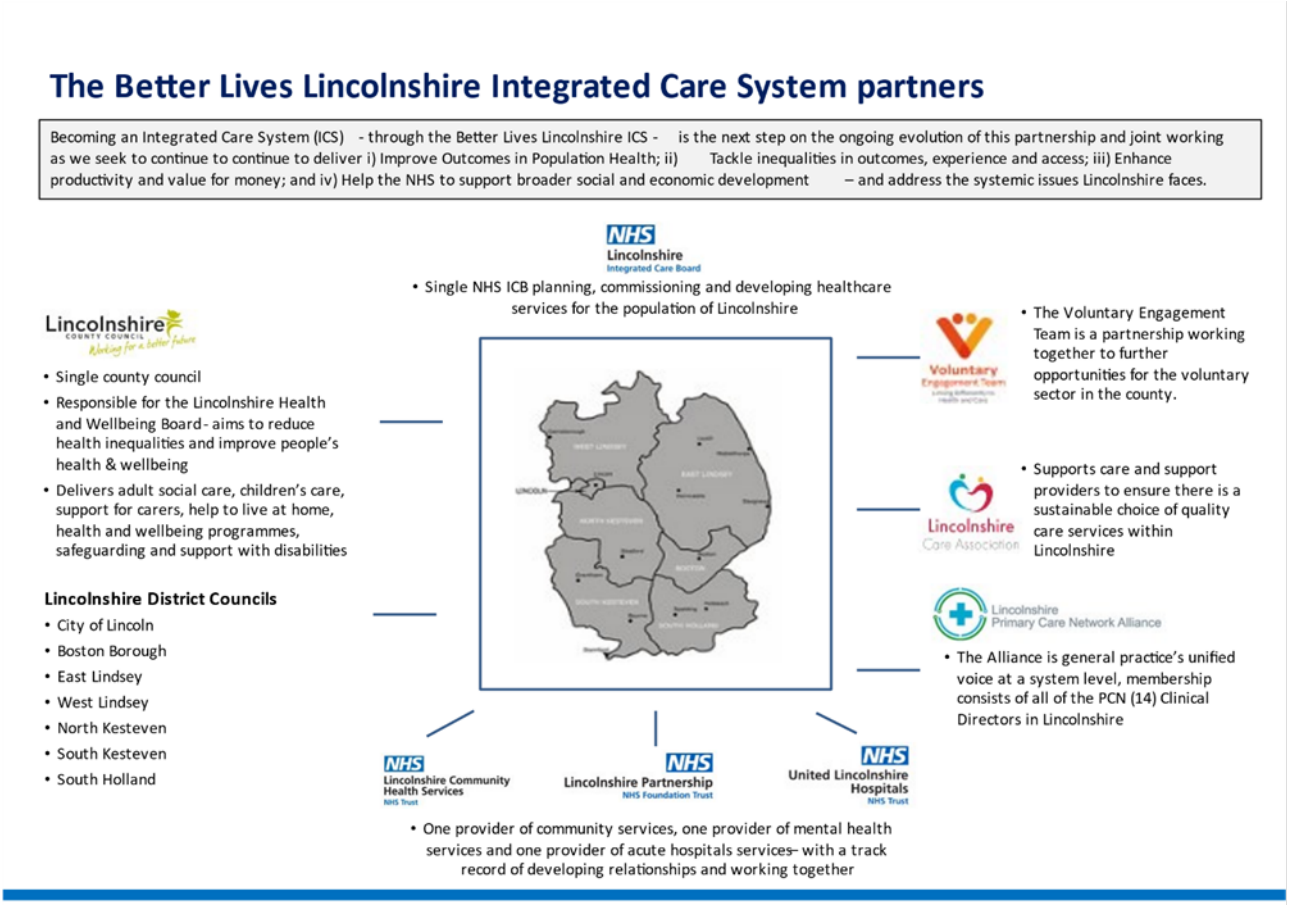
Duty to promote integration

Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would a) improve quality of those services b) reduce inequalities in access and outcomes

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

They exist to achieve four aims:

- Improve outcomes in population in 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



Integrated Care Board

NHS Lincolnshire Integrated Care Board (ICB) was established on the 1st July 2022 following enactment of the 2022 Health and Care Act. The ICB takes the lead on

- Setting system level strategy and plans, including the joint 5 year forward and capital plans.
- Working with partners to ensure effective arrangements in place and across the system to deliver performance, transformation and outcomes.

- Commissioning and managing contracts, delegation and partnership agreements with providers and primary care.
- First line oversight of health providers across the ICS – coordinating any support for providers and providing assurance input to regulator assessments.

The NHS Lincolnshire ICB is composed of the following members:

- Chair
- Chief Executive
- One Partner Member NHS and Foundation Trusts
- One Partner Member Primary Medical Services
- One Partner Member Local Authority
- Five Non-Executive Members
- Director of Finance
- Medical Director
- Director of Nursing
- Director of System Delivery
- Executive Board Mental Health Member

Lincolnshire ICB Board			
Non-Executive Members	**Executives**	**Partner Members**	**Other Members**
① Chair	① Chief Executive Officer	① Local Authority	① Executive Board Mental Health Member
⑥ Non-Executive Members	① Director of Finance	① Provider of Primary Medical Services	
	① Director of Nursing	① NHS Trust	
	① Medical Director		
	①Director of System Delivery		

The NHS Lincolnshire Integrated Care Board is the NHS organisation responsible for overseeing plans for meeting the health needs of the Lincolnshire population, managing the NHS budget and arranging for the provision of physical and mental health services across the county. These services include planned care, cancer care, emergency care, mental health, learning disability and Autism, maternity services and community and GP services for the 808,267 registered patients across 82 GP practices.

The NHS Lincolnshire ICB arranges for the provision of NHS services from a wide range of partners in and outside of Lincolnshire including:

- All GP practices in Lincolnshire
- United Lincolnshire Hospitals NHS Trust (ULHT)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG)
- North West Anglia NHS Foundation Trust (NWAFT)
- East Midlands Ambulance Services NHS Trust (EMAS)
- The Voluntary, Community and Social Enterprise (VCSE) sector
- Pharmaceutical, Optometry and Dental services (PODs)in the county

The ICB uses its resources and powers to achieve demonstrable progress on the four key aims of an ICS, collaborating to tackle complex challenges, including:

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

We involve local patients, carers, the public and organisations such as Healthwatch Lincolnshire to help us better understand local need and commission high-quality care that is safe, effective and focused on the patient experience – as set out in the NHS Constitution and the ICB Constitution.

General Practice (GP) services are commissioned by the ICB under delegated agreement from NHS England. From 1st April 2023, all ICBs will assume delegated responsibility for primary care services, including Pharmacy, Optometry and Dentistry, and ICBs will also enter into joint working arrangements with NHS England to jointly commission some specialised services. It is intended that NHS England will delegate further direct commissioning functions to ICBs from April 2024.

Integrated Care Partnership

Each ICS is required to have a Partnership at system level established by the NHS and local government as equal partners. The ICP is a Joint Committee of the ICB with the local authority, rather than a statutory body.

Lincolnshire only has one upper tier local authority, namely Lincolnshire County Council, and as such only has one ICP called the Lincolnshire Integrated Care Partnership.

The ICP operates as a forum to bring partners – local government, NHS and others together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The ICP has specific responsibility to develop an 'integrated care strategy' for its whole population (covering all ages) using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.

The strategy set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. This will be complemented by the Joint Health and Wellbeing Strategy prepared by each Health and Wellbeing Board in the geographical area of the ICS.

The Lincolnshire Integrated Care Partnership is composed of the following members:

- The Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners (Chair)
- ICB Chief Executive (Vice Chair)
- The Executive Councillor for Children's Services, Community Safety, Procurement and migration
- The Executive Councillor for Adult Care and Public Health
- Three further County Councillors

- The Director of Public Health
- The Executive Director of Children's Services
- The Executive Director of Adult Care and Community Wellbeing
- ICB Chair
- ICB Chief Executive
- The Executive Councillor for Children's Services, Community Safety, Procurement and migration
- The Executive Councillor for Adult Care and Public Health
- Three further County Councillors
- The Director of Public Health
- The Executive Director of Children's Services
- The Executive Director of Adult Care and Community Wellbeing
- Designated representative from NHS England
- Chief Constable / representative Lincolnshire Police
- Designated representative for Voluntary and Community Sector

The following roles will attend both the Integrated Care Board and the Integrated Care Partnership meetings:

- ICB Chair
- ICB Chief Executive
- Local Authority Partner
- NHS Trust Partner
- Chair of the Health and Wellbeing Board and Integrated Care Partnership
- Public Health Representative

Health and Wellbeing Board

The Lincolnshire ICS contermiousity with Lincolsnhire County Council also means that there is only one Health and Welbeing Board in the county. It aims to reduce health inequalities and improve people's health and wellbeing. It is also the forum for agreeing the Better Care Fund.

The Board is responsible for:

- Producing the Joint Strategic Needs Assessment (JSNA)
- Informing the priorities in the Joint Health and Wellbeing Strategy (JHWS)
- Agreeing the Pharmaceutical Needs Assessment (PNA)
- Ensuring the local NHS five-year plan takes account of the JSNA and JHWS

The Health and Wellbeing Board and ICP membership is the same to ensure consistency in approach and delivery across the two committees.

Provider Collaboratives

To support the delivery of Integrated Care there are a number of provider collaboratives which are as follows:

Lincolnshire Health and Care Collaborative

Lincolnshire Health and Care Collaborative (LHCC) is the system-wide collaboration of provider organisations delivering joined up health and care for the county of Lincolnshire. The collaboration is composed of United Lincolnshire Hospitals NHS Foundation Trust; Lincolnshire Partnership NHS Foundation Trust; Lincolnshire Community Health Services NHS Trust; the Lincolnshire Primary Care Network Alliance; the Lincolnshire Care Association; the Lincolnshire Voluntary Engagement Team (VET); and Lincolnshire County Council.

LHCC has a shared ambition to deliver integrated, affordable and sustainable health and care services to the population of Lincolnshire now and in the future. It aims to ensure engagement, alignment and shared decision making of all the partner organisations in the implementation and benefits realisation through designing integrated services that ensure delivery of local health and care services for agreed population groups which are integrated around the needs of the patients.

Towards the end of 2022 a review of provider arrangements in Lincolnshire was conducted. One of the recommendations of the review was to improve shared strategic and operational decision making to further integrate health and care delivery. This will be achieved through establishing a formal provider group to include ULHT and LCHS as a start but also to engage and involve LPFT, Primary Care Network Alliance.

The work of LHCC will now be taken forward through the development of the group model and a greater focus on integrated care teams based around localities, and a review of back-office functions.

The Group model will become formally established on the 1st April 2024 and the Chair has been appointed by NHS England. The recruitment to the Chief Executive is taking place in early 2024 and it is anticipated that the remaining board positions will be appointed by the end of 2024.

East Midlands Mental Health and Learning Disability Alliance

The NHS-led East Midlands Mental Health and Learning Disability Alliance Provider Collaborative model integrates provider and commissioning skills to drive transformation at scale through clinical and expert by experience leadership around several specialised services such as Forensic Services, Children and Young People inpatient services, Gambling addiction, Veterans Mental health and Adult Eating Disorders.

Lincolnshire Mental Health, Dementia, Learning Disabilities and Autism Alliance (MHDLDA Alliance)

The MHDLDA Alliance is a local partnership between LPFT, the ICB, Public Health, LCC, district councils, Lincolnshire Police, substance misuse services, Primary Care Networks and the VCSE sectors. The Alliance works on behalf of the ICS to deliver transformation at scale and provides a vehicle to promote mental wellbeing, to drive up quality of services, to reduce health inequalities and to ensure better utilisation of resources for the whole population of Lincolnshire.

Duty to have regard to wider effect of decisions

In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.

The NHS in Lincolnshire and the wider ICS Partnership have a long history of joint working and governance arrangements going back over a decade. This includes a range of joint governance arrangements in the Lincolnshire NHS to ensure all statutory organisations fulfil the Duty to have regard to wider effect of decisions taken in the provision and delivery of health and care services.

The Integrated Care Board and Integrated Care Partnership membership includes partners from across the Integrated Care System. Underpinning the work of the Integrated Care Board are joint assurance committees with the NHS Providers which are as follows:

- Finance and Resource Committee
- Quality and Patient Experience Committee
- Service Delivery and Performance Committee
- System Workforce Committee

These Committees are ICB Joint Committees with the three provider partner organisations in Lincolnshire. They are Chaired by an ICB Non-Executive Member and include Non-Executive Director representation from each of the three provider partner organisations, Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust. They provide a system approach to oversight and assurance to ensure a joined-up approach across Lincolnshire.

The NHS and ICS has governance arrangements outside of the Statutory Arrangements to ensure the wider effects of decisions are considered, these are:

<u>Better Lives Lincolnshire Leadership Team (BLLLT)</u>

The BLLLT provides executive leadership to the Lincolnshire Integrated Health and Care system, "Better Lives Lincolnshire". BLLLT is co-chaired by the Chief Executive Officers (CEO) of Lincolnshire County Council and the NHS Lincolnshire ICB. Its membership includes the CEOs from LPFT, LCHS and ULHT, two district council CEOs, Director of Adult Social Care, Director of Public Health, CEO of Lincolnshire Care Association, representatives from the Lincolnshire Voluntary Engagement Team, the Primary Care Network Alliance Clinical Director.

BLLLT's role is to provide leadership to:

- An integrated approach to tackling Health, Wellbeing and Health Inequalities challenges
- in Lincolnshire and improving health in our county
- An integrated approach to the design and delivery of local integrated Health and Care in
- Lincolnshire (this will be led and driven by the Lincolnshire Health and Care Collaboration)
- An integrated approach to management of key resources and disciplines, e.g.:
    - Population Health Management
    - Better Care Fund
    - Business Intelligence
    - Community Development
    - Health and Care Employment/Labour Market
    - Evidence Based Care
    - 'Anchor Institutions'/Social & Economic Value
    - Joint 'Commissioning'
    - Workforce

Lincolnshire NHS Leaders Group

The Lincolnshire NHS Leaders Group (LLG) provides high level governance oversight of key shared priorities and concerns within the NHS in Lincolnshire and provides direction when agreed. The membership of LLG consists of the Chairs and CEOs of the Lincolnshire ICB and NHS Trusts, Chair/Vice Chair of the Lincolnshire PCN Alliance, EMAS Chair and CEO and the ICB Medical Director.

The work of the LLG will be based on the principles of joint working and partnership, transparency, support, challenge, and good governance. It meets once a month and the LLG Chair role is shared on a rotational basis by the Chairs of the NHS Organisations.

The work of LLG is primarily concerned with key matters within and across the NHS in Lincolnshire. Partners in the Lincolnshire Integrated Care System will be informed and engaged as appropriate (e.g., through H&WB/ICP, BLLLT). Where appropriate LLG agrees key system matters decisions.

Triple Aim

Underpinning both the statutory and system governance arrangements are numerous joint working arrangements that focus on delivery of care that support the delivery of the '*Duty to have regard to wider effect of decisions'* and the implementation of the triple aim. Further details of this are outlined in the following relevant sections of this document:

- Financial duties
- Duty to improve quality of services
- Duty to reduce inequalities

Financial duties

The plan must explain how the ICB intends to discharge its financial duties

The Lincolnshire NHS has a record of delivery built on a strong foundation of positive relationships, engagement in a clear set of objectives and flexible and collaborative ways of working, which we have developed to support financial delivery. The Lincolnshire Directors of Finance have devised a financial framework to support partnership working, and this has been jointly agreed by the NHS organisations based in Lincolnshire: Lincolnshire Community Health Services NHS Trust (LCHS), United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Integrated Care Board (LICB).

The framework has key components:

1. Lincolnshire NHS Financial Recovery Plan (FRP) is designed to bring financial sustainability to the system by achieving recurrent financial balance by March 2025.
2. Lincolnshire NHS risk and gain share arrangements which set out how the ICB manages risk across the system.
3. Lincolnshire NHS Investment protocol which introduced tighter controls on investment decisions with a double lock in operation overseen by the ICB Finance and Resource Committee (ICB F&RC). The double lock protocol was approved by system partners in June 2022.

The framework also includes an approach for system financial reporting which has been in place since the creation of ICBs, and our approach to assessing and developing productivity reporting.

The system has operated with bi-weekly meetings of the Financial Leadership Group (FLG) since 2020 this group has expanded to include regular meetings with deputy director level and has acted as a forum to establish new joint arrangements, develop the entire finance function, conduct reviews into and strengthen financial governance arrangements, and manage in year financial delivery. Most recently the FLG has commissioned the procurement of a single professional advisor for Internal Audit Services.

Finally, the system has agreed arrangements for capital planning and prioritisation.

<u>Lincolnshire NHS Financial Recovery Plan (FRP)</u>

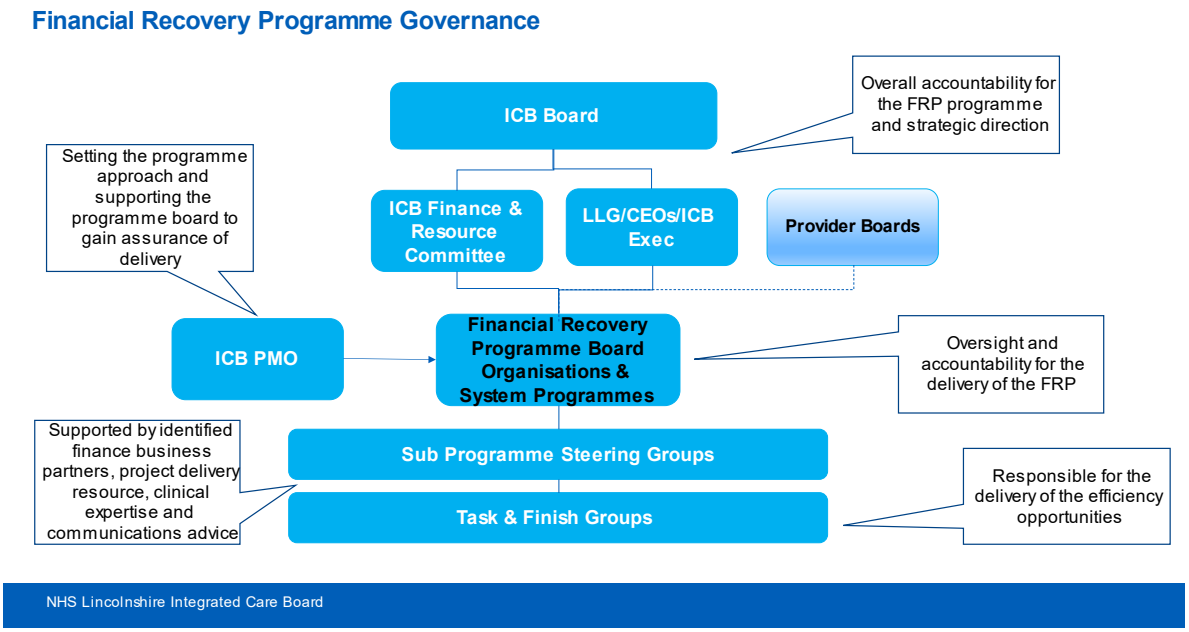
The FRP sets out the steps required to deliver system recurrent financial balance over a two-year period, focusing on recurrent delivery in 2023/24 and a pipeline that delivers system financial sustainability in 2024/25 and beyond. The FRP programme will aim to drive productivity and efficiency across the system. As it stands the FRP details the delivery plan for the 2023/24 financial year with the objective of supporting exit from the National Oversight Framework Level 4.

The plan summarised:

	2023/24	2024/25
FRP	£55m	FRP in 2024/25 to be confirmed through medium term planning cycle
Underlying plan deficit at start of year	£67m	Underlying deficit to be confirmed through medium term planning cycle
Programme pipeline	Emerging	Established
In year deficit	£19m	£break even

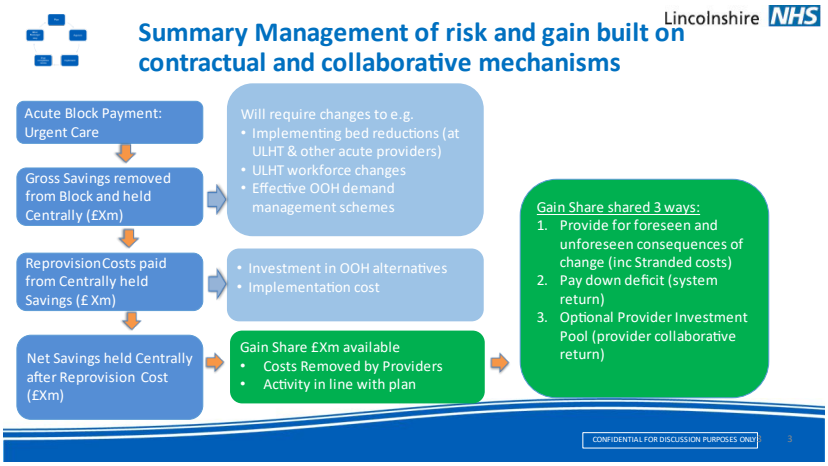
The Lincolnshire NHS FRP will require some level of non-recurrent delivery in the 2023/24 financial year; however, the Lincolnshire NHS business rule will be to operate an efficiency pipeline that ensures prior to each planning cycle that recurrent savings have been identified which match every £1 of non-recurrent benefit.

The assurance mechanisms for the Lincolnshire NHS FRP will be through weekly review of delivery actions and lead indicators at the FRP Programme Board with reports monthly to CEOs who will act as point of escalation for the system SRO for the FRP. The SRO and Programme Director will report monthly to the ICB Finance and Resource Committee for oversight and assurance and at the ICB Board. The ICB Director of Finance acts as the overall SRO for the delivery of the FRP, and the LLG has implemented a governance framework to monitor delivery. Each SRO has been asked to set out the outline of their programme works by drafting a 'plan on a page' which outlines the deliverables, milestones and resources required. From May 2023 a monthly reporting cycle has been agreed updating the ICB Finance & Resource Committee, Lincolnshire Leaders Group (NHS organisations Chairs and CEOs), Provider CEOs and Provider Boards (as required).



Lincolnshire NHS risk and gain share

The Lincolnshire NHS risk and gain arrangements that have been in place throughout 2022/23 to manage the consequences of system change, will continue, and are strengthened by the creation of the Lincolnshire NHS risk and opportunity pool. The risk and gain arrangements apply a break glass which necessitates all partners coming together to agree remedial actions should the FRP go off track. On a practical level that will happen through the FRP Board, however, the formality of invoking the risk and gain arrangements will continue. The risk and opportunity pool is a source of funds to facilitate swift remedial action.



Accountability for Planned Care delivery and Urgent and Emergency Care delivery rests with the Planned Care Board and Urgent and Emergency Care Board, respectively. The Lincolnshire NHS partner Boards would expect these groups to identify risks or opportunities which could be managed through deployment of the risk and opportunity pool.

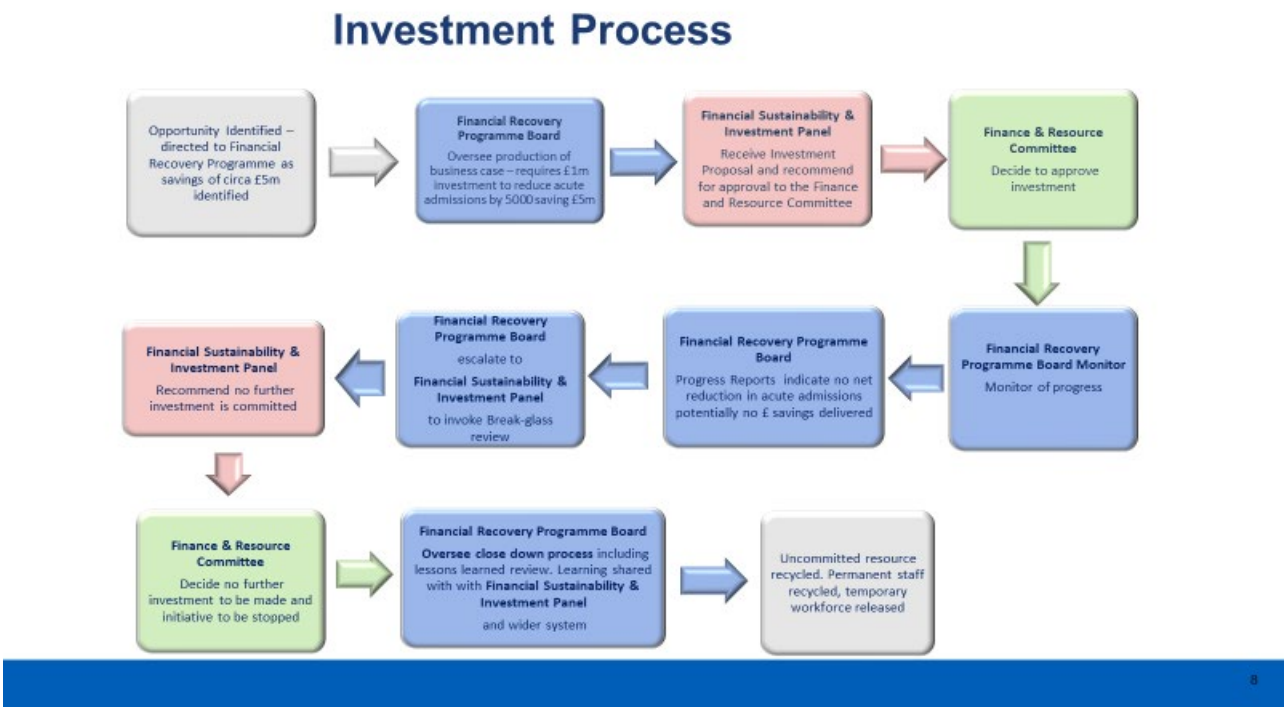
The Finance Leaders Group will be expected to provide scrutiny of any requests to deploy the Lincolnshire NHS risk and opportunity pool, and the ICB Finance and Resource Committee will receive and approve utilisation of the risk and opportunity pool. The ICB Finance and Resource Committee will receive reports on the use of the risk and opportunity pool quarterly.

Lincolnshire NHS Investment Protocol

Tighter controls on investment decisions with triple lock in operation overseen by the ICB Finance and Resource Committee (ICB F&RC). The double lock protocol was approved by system partners in June 2022, and this will continue.

This control will be managed through the Financial Sustainability and Investment Panel (FSIP) and reported into the ICB F&RC regularly. The FSIP is an executive group chaired by the ICB Medical Director and its members include Lincolnshire NHS Directors of Finance, Executives representing Nursing and Operations and colleagues from NHSE national and regional teams.

The operation of the investment protocol is illustrated below:



The partners agree to commit to sustainable investment in line with the published annual operating plan, and to maintain expenditure within system and organisational budgets. The investments within the plan will be approved on the basis they meet Lincolnshire NHS objectives and are financially sustainable in the long term. This will establish expenditure baselines at system and organisation level, that are clearly aligned to objectives that the entire system prioritises.

Where a partner organisation is seeking to prioritise any new spending within that organisation that is outside of system agreed purpose, timing or value then that organisation's Board will be asked to provide a formal update to the ICB Finance and Resource Committee of why that investment is required. Recognising that such action builds an unanticipated financial pressure for the whole system, the update will set out what other spending to the same quantum would plan to be discontinued and over what timeframe the investment becomes sustainably funded.

Implementing any Joint Local Health Wellbeing Strategies

The plan must set out the steps that the ICB proposes to take to implement any Joint Local Health and Wellbeing Strategy's (JLHWSs) to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

The Lincolnshire Health and Wellbeing Board is the forum where councillors, commissioners (NHS Lincolnshire ICB and Local Authority) and communities work together with other partners to improve the health and wellbeing of our local population and reduce health inequalities. Among its key responsibilities is the production of the local JSNA.

The Joint Strategic Needs Assessment, or JSNA, provides a picture of current and future health and wellbeing needs of the local population, by collating a range of evidence in one place. It tells us about lifestyle behaviours, health conditions, the needs of vulnerable groups and the wider factors that impact on health and wellbeing, like transport, housing and employment. Information comes from a range of sources including national data sets, registrations of births and deaths, NHS and council services, and local surveys or consultation events. The JSNA highlights who Lincolnshire's priority groups are in relation to health and social care need. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and social care.

The Integrated Care Board (ICB) and Integrated Care Partnership (ICP) are also required to take account of the JSNA in the planning of local health services and in the development of the Integrated Care Partnership Strategy. The JSNA has been used to inform the Lincolnshire Interim ICP Strategy, which sets out the plans across four aims that set our strategic direction up to 2025.

These aims are:

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

The refreshed ICP Strategy published in March 2024 shows the overall profile of the health and wellbeing of the Lincolnshire population, identifying those conditions that are causing the greatest ill health and mortality, for example, cardiovascular disease and musculoskeletal conditions. Deprivation and high disease prevalence, for example Chronic Respiratory disease and Cardiovascular disease are recognised as key challenges affecting some of the ICB population.

Joint Local Health and Wellbeing Strategy (JHWS)

This section provides details on how the ICB in 2022/23 contributed to the delivery of the Lincolnshire Health and Wellbeing Strategy as required under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

For many years, the NHS and Local Authority have worked in close partnership with partners to tackle health inequalities. All organisations have an important role to play, whilst the ICB have a legal duty to respond to inequalities in the health of their populations, both in terms of access to services and outcomes on life expectancy. No one organisation can do this in isolation. The Health Inequalities programme will require involvement of all NHS organisations, Local Authority and wider partners to work together if we are to achieve real and lasting improvements for people living within Lincolnshire.

The JHWS for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing.

The Local Authority Director of Public Health attends the ICB Board meeting and provides an update at each meeting. Through our work with the local authority public health team and active engagement at the Health and Wellbeing Boards, we have confirmed the ICB's contribution to the delivery of the joint health and wellbeing strategies.

Duty to improve quality of services

Each ICB must exercise its functions with a view to securing continuous improvement in a) the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness b) outcomes including safety and patient experience

The Lincolnshire System Quality and Patient Experience Committee (System QPEC) was established with the transition to an ICB in July 2022 and is the Quality Committee of the Board, providing assurance to the Board regarding quality of care as defined by the National Quality Board (NQB) Shared Commitment to Quality, which includes recognition of the need to acknowledge and address health inequalities within the local community as part of improving quality. The meeting is chaired by the ICB Non-Executive Member (NEM) who leads on quality and there is representation from provider Trust NEMs who Chair the Quality Committees in their respective organisations, alongside Lincolnshire's Director of Public Health and Healthwatch. Attendance includes nursing and medical directors from the ICB and provider Trusts. Nationally available data and local intelligence is currently used to inform assurance processes through System QPEC, however, further work from 2023/24 onwards is required to move to reporting that reflects outcome measures relevant to improved quality and considers impact in addressing known health inequalities.

Lincolnshire has a well-established System Quality Group (SQG) that has been in place since 2019/20 and has evolved as ICS quality governance arrangements have developed. The meeting is chaired by the ICB Director of Nursing as the designated executive lead for quality and includes executive membership or nominated deputies across a range of partners including the ICB, Lincolnshire provider Trusts, East Midlands Ambulance Trust, Local Authority, Primary Care, NHSE, Health Education England, CQC and Healthwatch. SQG provides a forum for information and intelligence sharing with commissioners, providers and ALBs (arm's length bodies) reporting on those areas of escalated concern, areas for improvement and sharing of good practice. Themes from the reporting are used to inform priorities for system-wide improvement work, either through the respective programme boards e.g. UEC, planned care etc or quality specific improvement work. The SQG hosts a schedule of deep dives, informed through the information and intelligence sharing processes, whereby individual programme boards present the work happening and provides opportunity to engage additional clinical and/or quality support, if not already in place, to progress necessary improvements.

During 2022/23 two areas for quality specific system improvement work were identified through SQG:

- Tissue viability, in particular pressure damage
- Communication with patients

Programmes of work under the SQG have been established to progress this work. For tissue viability this has led to the establishment of an ICS Pressure Damage quality improvement steering group which will oversee a 3 year programme of working, including development of KPIs and outcome measures. For communication with patients, each of the represented organisations are undertaking work and this is shared through SQG to ensure learning and themes are considered across the ICS.

Quality assurance of commissioned services is reported through ICB quality governance arrangements, for primary care to the Primary Care Quality & Performance Oversight Group meeting and for all other commissioned services the Operation Quality Assurance Group. Escalation of quality concerns is through to SQG or System QPEC depending on the nature of the concern.

Locally the Primary Care Quality & Performance Oversight Group, which historically focused on GPs, has developed to incorporate the four pillars of primary care to include Pharmacy, Optometry and Dental, within the context of the collaborative quality oversight arrangements being established for the East Midlands. With the delegation of Pharmacy, Optometry and Dentistry quality assurance and improvement becoming the responsibility of Lincolnshire ICB from the 1st April 2023 there has been a full transition programme of work in liaison with NHSE and Midlands ICBs to facilitate the arrangements for this. Lincolnshire ICB continue to work collaboratively with the other East Midlands ICBs and Nottingham & Nottinghamshire ICB who have hosted the transferred staff from NHS England since 1st July 2023. The staff who transferred include contracting and clinical advisor staff who undertake the main operational quality assurance and improvement activity with Pharmacy, Optometry and Dental providers. A Lincolnshire ICB

Quality Team member links into this operational function and ensures information and intelligence feeds through into the existing Lincolnshire Primary Care Quality oversight function and committees. Committee membership will be amended to include representatives for Pharmacy, Dental and Optometry as appropriate.

Processes in place align to the National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, including the approach to quality risk response and escalation, that are underpinned by learning and improvement.

Well established processes are in place with providers and the ICB for development and review of organisation specific Quality Accounts, however, Lincolnshire has registered an interest in piloting the NHSE proposed System Level Quality Accounts. This is reflective of the positive system approach in Lincolnshire to new ways of working to improve quality of care and services.

Lincolnshire health organisations are working together through a collaborative forum to share learning, approach and collaborate on relevant areas regarding the Patient Safety Incident Response Framework (PSIRF). All main health organisations are due to transition to PSIRF by April 2024.

Never Events remain an area of focus for the health system and examples of good practice, such as the Surgical Never Event Summit hosted by the acute Trust in December 2022, will be used to identify and promote learning from within Lincolnshire and through links with other systems.

Medication Safety is recognised as being a key part of Patient Safety. The National Medicines Safety Improvement Programme (MedSIP) key ambitions are '*to reduce medicine administration errors in care homes by 50% by March 2024; and to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024*'. Lincolnshire are working towards this by:

- Improving the quality of prescribing by way of establishingthe Area Prescribing Committee and the Lincolnshire Medication Safety and Device Network, both are system wide groups that will bring together each area to work collaboratively on Prescribing Quality and Medication Safety issues.
- Building on the work done by the opioids for non-cancer pain and polypharmacy clinical reference groups to effectively reduce high dose opiate prescribing and by reducing the amount of medications each person takes which in turn reduces the number of errors and risk of side effects/overdose.
- Reducing inequalities in prescribing by way of utilising the Medication Optimisation Team, who are subject matter experts, to look at prescribing in Lincolnshire and make recommendations to the GPs to ensure all residents of Lincolnshire receive person-centred quality prescribing, that is clinically safe and effective regardless of the area they reside in.
- Medicines Safety Officer and Medical Devices Officer fulfilling duties to implement and monitor standards for medication safety and safe prescribing; leading on developing a system wide workplan in conjunction with the system that focuses on reducing medication related harm, to share learning from incidents to ensure they are less likely to happen again and to provide GP practices with support when needed. Taking action to improve medical device safety, supporting incident reporting and sharing learning.

There is a well-established System Infection Prevention and Control (IPC) group that includes representation from the ICB, the NHS trusts and the Local Authority. This will continue to be a vital route in establishing agreed practice across the system partners and facilitate ongoing co-ordination of routine IPC matters and response to escalated IPC concerns. Lincolnshire also has a collaborative approach to health protection across the county and work is being undertaken to further strengthen the arrangements between the ICB and Lincolnshire County Council through the development of an Integrated Health Protection Framework.

Through the SQG and System QPEC there are a number of shared priorities that have implications for quality, however, improvement work is being driven through the respective programme boards, which include quality representation, or organisation specific processes. These priorities include:

Urgent & Emergency Care (UEC) – quality specific element is in relation to harm reduction, harm review processes and outcomes. This includes ongoing work to establish processes that treat delayed discharge as a potential harm event

Cancer - quality specific element is in relation to effective clinical prioritisation, harm review processes and outcomes

Elective backlog - quality specific element is in relation to effective clinical prioritisation, harm review processes and outcomes

Maternity – continued engagement in the Ockenden Insight Visits, led by the Local Maternity and Neonatal System (LMNS) with regional support and guidance where necessary and will be conducted in line with recommendations from the national and regional teams, which support the outcome of Ockenden. With the publication of the three year delivery plan for maternity and neonatal services action has been taken to benchmark the Lincolnshire position and inform areas of focus within the local plans.

Mortality – managed through organisation specific processes but there is review and learning through the Lincolnshire Systemwide Mortality Group. Roll out of Medical Examiner to primary care will further improve opportunities for learning.

Workforce – is a common theme through UEC; cancer; planned care; mental health learning disability and autism; and community services. Whilst the People Board hold responsibility for developing the workforce capacity and capability and the individual programmes of work organisations feed into this, SQG and System QPEC are sighted on the quality impact of workforce challenges, in relation to safe staffing and also the impact on service developments intended to improve quality of care for the local population.

Healthwatch feedback has identified three key areas of concern that have been incorporated into the SQG and System QPEC priorities:

Dental – work is taking place with the transition of commissioning responsibility of dental services from NHSE to the ICB to establish a Lincolnshire dental strategy that is informed by feedback from patients and the public

GP Access – areas for improvement are managed through primary care governance arrangements which include quality representatives to ensure impacts are fully understood and actioned appropriately

Communication – themes from this have informed the need for SQG quality improvement work in relation to communication with patients

System QPEC has endorsed the ICB Continuous Listening Model, which reflects elements also undertaken by provider trusts, to understand the experiences of people using commissioned and provided services in Lincolnshire, through to opportunities for co-production, particularly when establishing programmes of work to review or redesign patient pathways of care.

As a system there is recognition that strong and cohesive clinical leadership is integral to improving quality of services. The Lincolnshire Clinical and Care Directorate has been established, which aligns to the five principles set out in the guidance *'Building strong integrated care systems everywhere'* (NHSE/I September 2021):

1. Integrating clinical and care professionals in decision-making at every level of the ICS
2. Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities
3. Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s)
4. Providing dedicated leadership development for all clinical and care professional leaders
5. Identifying, recruiting and creating a pipeline of clinical and care professional leaders

The Clinical and Care Directorate incorporates three key elements:

- Strategic Board, chaired by the ICB Medical Director with clinical and professional executive representation across the health and care system
- Clinical and Care Academy, a face to face and virtual network supporting health and care practitioners to adopt, share and evaluate innovation, research and best practice
- Lincolnshire Learning Network, a patient centred, system-based resource, led by clinicians and care professionals, to achieve the best outcomes for our citizens

The Clinical and Care Directorate will provide advice, support and resource to the quality improvement priorities highlighted through the system programme boards and quality governance arrangements.

Duty to reduce inequalities

Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities.

The duty to promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved.

The Lincolnshire Integrated Care Board (ICB) has a legal duty under the Health and Care Act (2022) to reduce inequalities between persons with respect to their ability to access health services; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The Act also places duties on the ICB to:

- have regard to the wider effects of decisions on inequalities.
- promote integration requires consideration of securing integrated provision across health, health-related and social services where this would reduce inequalities in access to services or outcomes achieved.

The ICB is also required to collect, analyse and publish information relating to health inequalities in line with NHS England's Statement on Information on Health Inequalities .

To do this effectively, the ICB works with its partner organisations to reduce health inequalities and embeds this requirement into its commissioning strategies and policies. Lincolnshire is deeply engaged in addressing health inequalities, through the local authority, NHS trusts and wider sector partners already being represented on both the Integrated Care Board (ICB) Board and the Integrated Care Partnership (ICP), with inequalities prominently identified as one of the key challenges for the health and care system and the population.

We have a shared Joint Health and Wellbeing Strategy in place informed by Lincolnshire Joint Strategic Needs assessment (JSNA) and Global Burden of Disease.

Our ambition for the Better Lives Lincolnshire, by 2030 is- 'for the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well'.

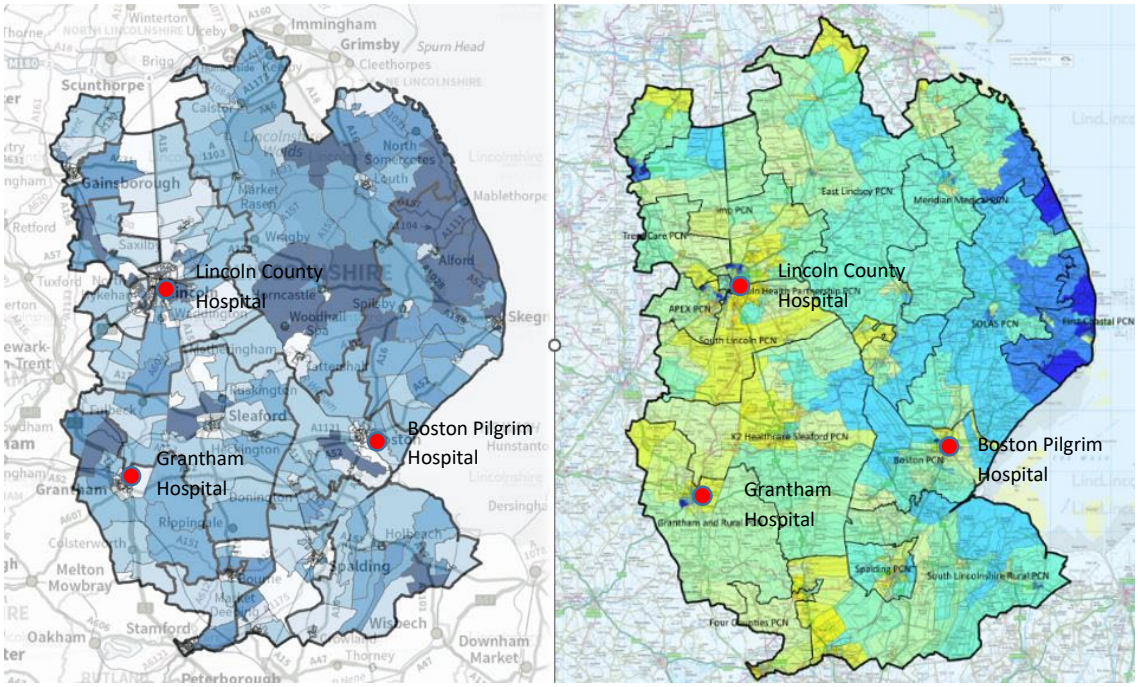
Lincolnshire has a challenging combination of rurality, coastal and urban deprivation, an ageing population, and a low-wage economy; this combination defines the difficulty of the mission to improve its population health.

While most of our population enjoys good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

There is a stark 20-year difference in healthy life expectancy between the highest and lowest socio-economic deciles of the population – based on Index of Multiple Deprivation (IMD) quintiles.

- The Chief Medical Officer's annual report 2021: Health in Coastal Communities, elucidates these challenges and specifically references the east coast, for example, communities in Skegness and Mablethorpe. According to 'The Centre for Towns' measures these conurbations rank: 1st (Mablethorpe) & 4th (Skegness) in the 20 most deprived places in England and Wales (combines economic and social isolation). Mablethorpe is 5th in the top 20 places for social isolation. It is already known that residents of such communities find access to healthcare problematic, face a declining bus network and experience poor broadband relative to the major cities/ urban areas.

The maps below show (left) the concentration of older adults in the Eastern parts of the county along with the large areas of socio-economic deprivation in the urban areas, in rural Eastern areas and along the coastal strip (right). This is a specific problem in Lincolnshire as two of its three major secondary care facilities (marked in red on the map) are located well away from the coast.



We have many areas in Lincolnshire that have different pockets of social deprivation due to its demographics:

- We have areas with significant above average disease prevalence – resulting in premature mortality.
- An ageing population - It is predicted that the elderly population in Lincolnshire will increase by 3.4% in the next ten years, and the rate of increase in people aged over 85 is particularly pronounced with an expected increase of 52.4%.
- High levels of lifestyle factors such as smoking and obesity.

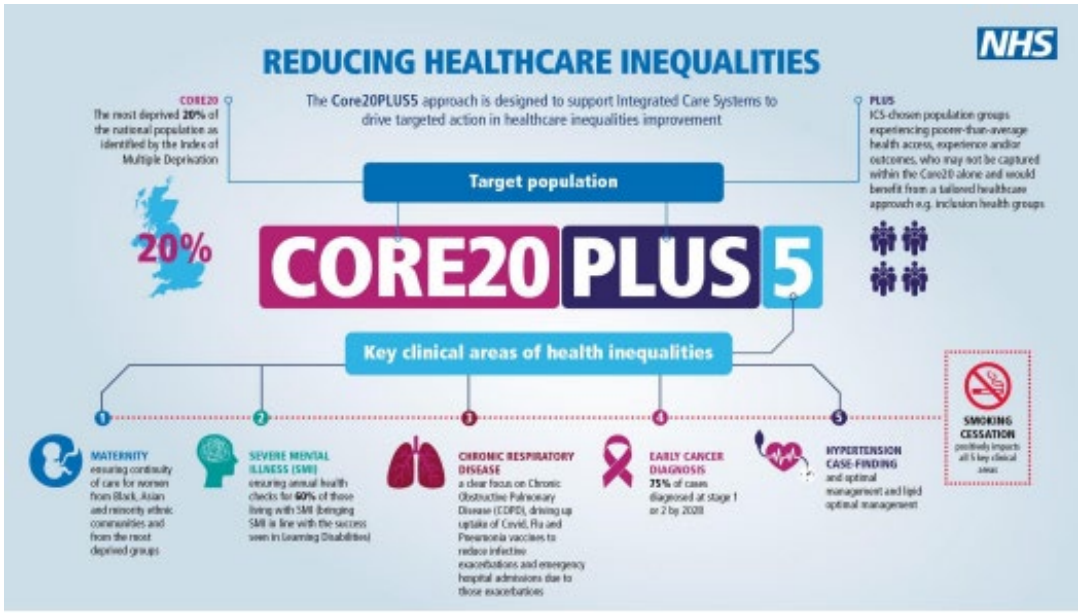
The Lincolnshire Joint Strategic Needs Assessment (JSNA) provides additional intelligence on health inequalities across many of the diseases causing the greatest burden for example, Diabetes, Cardiovascular Disease (CVD) and COPD, as well as on the main risk factors, for example, smoking and physical inactivity.

Smoking remains the greatest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities.

National

Nationally, NHS England has outlined an approach to support the reduction of health inequalities at both national and system level. Providing exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes.

The approach described below – 'Core20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement for Adults and Children and Young People. This approach has been embedded within our Health Inequalities and Prevention Programme



Within Lincolnshire our Core 20Plus population are:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 121k patients (14.8% of Lincolnshire patients)
- Plus – People from ethnic minority backgrounds (151k patients, 15.6% of Lincolnshire patients), with the largest ethnic minority group being “any other white background” (8.5%) - a significant proportion of this group is people from an Eastern European background.
- ICS locally determined population groups (evidence and insight based) experiencing poorer-than-average health access, experience, and/ or outcomes who may not be captured within the CORE20 alone and would be benefit from a tailored health care approach – known as ‘Inclusion Health groups’
    - Adult key groups identified for Lincolnshire include Gypsy, Roma and Traveller groups, people who are homeless, rural and coastal communities, farming and military families, carers.

- For children and young people this also includes children in care, care leavers, those in the justice system, those not in education, children with special educational needs and disabilities. Adults and children and young people with mental health conditions, learning disabilities and autism are also more likely to experience health inequalities.

The Five National Strategic Priorities for Health Inequalities Improvement are embedded with the Health Inequalities framework for action as defined below:

- Priority 1: Restore NHS services inclusively.
    - By understanding waiting lists, Did Not Attends (DNAs) and cancellations (all broken down by ethnicity and IMD quintiles)
- Priority 2: Mitigate against digital exclusion
    - Ensuring providers offer face to face care to patients who cannot use remote services and assessment of the impact of digital consultation channels on patient access
- Priority 3: Ensure datasets are complete and timely
    - by prioritising improved recording and collection of ethnicity data across all settings of clinical data
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
    - through increased uptake of COVID and flu vaccinations, ongoing management of long-term conditions and annual health checks for people with learning disabilities
- Priority 5: Strengthen leadership and accountability
    - Systems and Providers should have a named executive for tackling health inequalities

The effectiveness of our response depends on a system approach, recognising the need for action by all partners across the whole range of factors that influence and determine inequalities. It will also depend on our ability to become increasingly sophisticated and systematic in the way that we use data and insight to build our understanding of our population's health and wellbeing needs – with a view to understanding how need varies between groups and at different levels of our system, as well as which groups and communities are impacted most by inequalities. With this in mind, we have in place a system-wide Health Inequalities and Prevention Programme Board between Lincolnshire's NHS and Local Authority with wider partners to reduce the avoidable inequity in people's health across the county.

Actions to address Health Inequalities

Our Health Inequalities approach promotes primary and secondary preventative services and addresses the inequalities in access and uptake, alongside work led through the ICP which targets the wider determinants of health. Core20PLUS5 is embedded in our work.

Reducing health inequalities and improving health equity is everyone's business and will be a "golden thread" through all our work and at all levels from all partners. Changing the way we think about health inequalities and shifting to equality of outcomes for all by connecting the dots between the wider determinants of health and the population's health outcomes e.g. impact of jobs or housing on people's health.

Vision:

- To increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

Approach:

- Tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire.

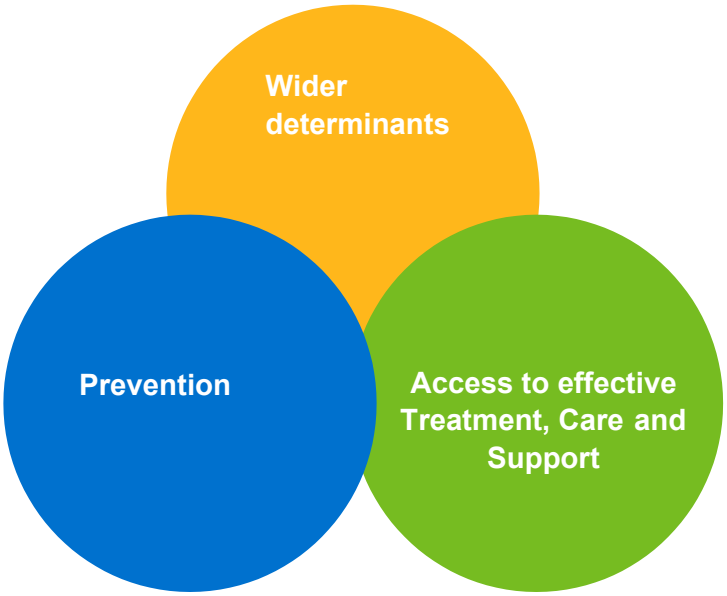
Ambition:

- A year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

Tackling health inequalities and preventing ill health continues to be one of our key system priorities. Our Health Inequalities Framework for Action, developed in partnership with stakeholders, sets out the principles which underpin this work and how we will use our resources to take practical action to reduce health inequalities and provide exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes to:

- Implement the Core20PLUS5 programme and improve access, experience, and outcomes for our key vulnerable groups identified as being at risk of inequity in access and outcomes such as ethnic minority groups, those living in highest deprivation and ICS locally determined population groups.
- Understand our local population and local health needs, through using the joint strategic needs assessments (JSNAs) and the collation of additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.
- Work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve, to improve health and healthcare for the local population.
- Seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch.
- Enable co-production with people with lived experience to inform decision making.
- Improve health outcomes through embedding Population Health Management insights and intelligent evaluation.

This is achieved through action to address at three levels to have an influence on health outcomes:



- Wider determinants: Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives
- Prevention: Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity
- Access to effective Treatment, Care and Support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all – for example ensuring there are health inequalities impact assessments for all commissioned services.

System Approach to Prevention

Working with system partners, Lincolnshire ICBs' 'life-style approach' to prevention continues to move forward at pace. Prioritising prevention in Lincolnshire is important as it supports people to live longer, healthier lives. Through helping individuals to make healthier lifestyle choices, we not only save lives by reducing premature mortality, but also contribute to the sustainability of the healthcare system by reducing avoidable illness and admissions.

The NHS Long Term Plan (LTP) provides funding for evidence-based NHS prevention programmes that include reducing smoking, obesity, and alcohol intake. In collaboration with the Local Authority commissioned integrated lifestyle service, 'One You Lincolnshire,', behavioural support is available across Lincolnshire to address the root causes of poor health, rather than to merely treat symptoms.

These services which are designed to help people stop smoking, maintain a healthy weight and make sure their alcohol intake is within a healthy limit; continue to grow and ensure equity of access for both NHS inpatients and the general population.

With support from system partners, Lincolnshire has expert programmes available including;

I. Tobacco Dependency Services

Since January 2023, Mental Health patients at Lincolnshire Partnership NHS Foundation Trust (LPFT) and pregnant patients under United Lincolnshire Hospitals NHS Trust (ULHT) have been able to access 'in-house' Tobacco Dependency Services.

- Maternity: Implementing the NHS Long Term Plan, alongside the Saving Babies' Lives care bundle element, the Maternity Team have developed and implemented a new model of enhanced support for all expectant mothers, to become smokefree. From a variety of locations across Lincolnshire, patients identified as a smoker receive both behavioural support and Nicotine Replacement Therapy (NRT) from the STAAR (Stop Smoking Team – Act Advise Refer) Team for the duration of their pregnancy.
- Mental Health: Originally rolled-out in Rehabilitation Units, the QUIT Team now provide behavioural support and NRT to all Mental Health Inpatient smokers across Lincoln, Boston and Sleaford.
- Acute and Community Inpatients: Both services are due to commence in March, with the Acute service to initially be provided at Lincoln County Hospital before being rolled out further. The Community Inpatient services will begin within John Coupland Hospital (Gainsborough) with additional locations added upon successful recruitment of additional Tobacco Dependency Advisors.

As part of the full patient pathway, onward referral to One You Lincolnshire are provided for any patient that requests this upon discharge from NHS services. Therefore, ensuring ongoing support to aid long term quit success**.**

II. Weight Management Services

Nationally there are 4 tiers of weight management for both Adult and Children each covering a different activity which plays a crucial role in providing a comprehensive approach to preventing and treating obesity.

Specifically for the population of Lincolnshire, Tiers 1 and 2 are provided within the county (NHS and County Council commissioned services), whilst Tier 3 and 4 services are currently provided in Derbyshire by University Hospital of Derby and Burton (UHDB).

The programme is establishing an NHS Weight Management Steering Group to provide oversight and assurance of this NHS Long Term Plan prevention priority. The first meeting of the group will be held in Q1 2024.

Alongside this we are working closely with all GP Practices to raise awareness of and increase eligible referrals to the (Tier 2) NHS Digital Weight Management Programme (DWMP) which supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

III. Diabetes Prevention Programme

Referenced within weight management services, diabetes is another fundamental programme within prevention, as type 2 diabetes is largely preventable through lifestyle changes. The 'Healthier You' NHS Diabetes Prevention Programme (NDPP), also known as the Healthier You programme, is provided across Lincolnshire by Xyla Health and Wellbeing, and identifies people at risk of developing type 2 diabetes.

Whilst continuing to increase referrals to Tier 2 weight management services to help achieve remission in diabetes, we are working closely with Xyla Health and Wellbeing to ensure all GP Practices are routinely referring eligible patients to the NDPP, and where necessary we are collaboratively liaising with practices to understand any barriers to referrals and/or uptake.

In utilising the approach of Making Every Contact Count (MECC); plans are underway to enlist the support of the specialist vaccination service team to also increase uptake in the Diabetes Prevention Programme.

This targeted focus on prevention will see the team undertake a dual role of providing both covid-19 vaccinations during the booster programmes with the addition of a 'reach out service' around health promotion initiatives and holistic support. This work will be in conjunction with the 2 identified PCNs to target individuals on the diabetes register.

Working together with a specific population group, the aim will be to understand the barriers, challenges/ reasons leading to low referrals and uptake. Work will then commence to co-produce solutions with people with lived experience and key stakeholders to encourage, support and increase uptake.

Working with partners to tackle Health Inequalities

We have made some good progress on our approaches to addressing health inequalities, but recognise we have a great deal more work to do. We have deepened our understanding of the current challenges and adopted more systematic ways to use data.

Insight from engagement with people and communities was a key influencer in the way we delivered the vaccination programme and supporting campaign. It also influenced many of the programmes and projects implemented across the Lincolnshire system aimed at reducing health inequalities. Example below:

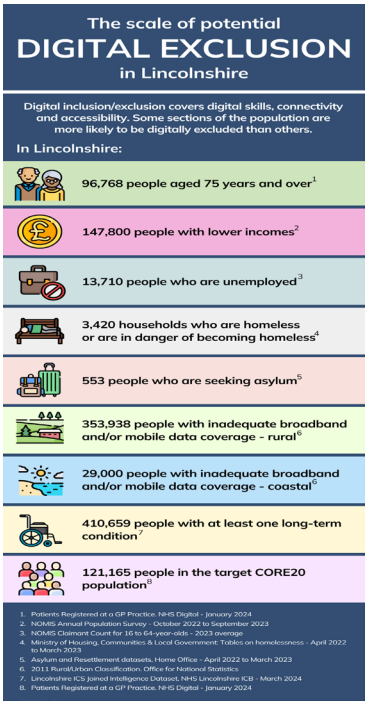
- Lincolnshire ICB has been successful and selected to form part of the Core20PLUS Connectors Programme in 2023/24. Voluntary Centre Services (VCS) is the delivery partner, and the focus is on Children and Young People with Diabetes. This project will help understand what is driving the inequity of access identified and how to break down barriers across the county for access, experiences, and outcomes.

We are working with partners to implement the NHS Digital Inclusion and Health Inclusion Frameworks – developing local plans through multi agency strategic groups.

- Health Inclusion Groups

In 2023/24 we developed an 18-month series of Health Inclusion Workshops which aim to educate the Lincolnshire workforce on the health inequalities they face and provide an insight into how the experience, access and outcomes may differ to the rest of the population. The workshops have all been co-produced and are co-facilitated with people with lived experience and subject matter experts. A total of 176 staff from across the system have attended the workshops.

What has become apparent from developing the workshops is the absence of data we have for some Health Inclusion groups which hides the health inequalities experienced by them. Utilising the NHSE Health Inclusion Framework we will develop a Health Inclusion Strategy for Lincolnshire in 2024/25. The need for accurate coding will be form part of this and help us to understand the Health Inequalities experienced by our Health Inclusion groups.



•Digital Inclusion

In 2023/24, we established a Digital Inclusion Strategy Group made up of system partners. We have established who is most at risk from digital exclusion in Lincolnshire and are working through the Digital Inclusion Framework which will support the development of a Digital Inclusion Strategy for Lincolnshire in 2024/25.

Demonstrating due regard in decision making

An Equality Impact Analysis (EIA) and Health Impact Assessment (HIA) is completed on all ICB commissioning decisions and policies to ensure access and inclusion for protected and marginalised groups and communities.

All service re-designs, business cases and transformation projects, new services and procurement exercises undergo a process of EIA. The use of Health Equity Assessment Template (HEAT) has been embedded within the Integrated Care System (ICS) planning processes, investment decisions, system Quality Improvement process and clinical pathway improvement process (Lincolnshire Academy for Clinical Excellence) and ICS governance arrangements.

Lincolnshire's Health Inequalities Programme Vision is "to increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county".

The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency and support ICBs and Trusts to use the data to shape and monitor improvement activity and drive improvement in the provision of good quality services and reducing healthcare inequalities. The report will share insight for the relevant Programme Boards/ NHS Trusts and alignment with 2024/25 planning in addressing identified health care inequalities and priorities for action.

Joint Strategic Needs Assessment

- This section explains how the ICB in 2022/23 discharged its duty under Section 14Z36 of the Health and Care Act 2022 to have regard to the need to reduce inequalities.

The Lincolnshire Health and Wellbeing Board is the forum where councillors, commissioners (NHS Lincolnshire ICB and Local Authority) and communities work together with other partners to improve the health and wellbeing of our local population and reduce health inequalities. Among its key responsibilities is the production of the local JSNA. The Joint Strategic Needs Assessment, or JSNA, provides a picture of current and future health and wellbeing needs of the local population, by collating a range of evidence in one place. It tells us about lifestyle behaviours, health conditions, the needs of vulnerable groups and the wider factors that impact on health and wellbeing, like transport, housing and employment. Information comes from a range of sources including national data sets, registrations of births and deaths, NHS and council services, and local surveys or consultation events

The JSNA highlights who Lincolnshire's priority groups are in relation to health and social care need. The JSNA aims to establish a shared, evidence-based consensus on the key local priorities across health and social care.

The Integrated Care Board (ICB) and Integrated Care Partnership (ICP) are also required to take account of the JSNA in the planning of local health services and in the development of the Integrated Care Partnership Strategy. The JSNA has been used to inform the Lincolnshire interim ICP Strategy, which sets out the plans across four aims that set our strategic direction up to 2025. These aims are:

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

The Interim ICP strategy shows the overall profile of the health and wellbeing of the Lincolnshire population, identifying those conditions that are causing the greatest ill health and mortality, for example, cardiovascular disease and musculoskeletal conditions. Deprivation and high disease prevalence, for example Chronic Respiratory disease and Cardiovascular disease are recognised as key challenges affecting some of the ICB population.

In response to the NHS Long Term Plan, the ICB, along with system partners, set out plans last year to take a systematic population health approach to reducing health inequalities and addressing unwarranted variation in care.

Joint Local Health and Wellbeing Strategy (JHWS)

- This section provides details on how the ICB in 2022/23 contributed to the delivery of the Lincolnshire Health and Wellbeing Strategy as required under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

For many years, the NHS and Local Authority have worked in close partnership with partners to tackle health inequalities. All organisations have an important role to play, whilst the ICB have a legal duty to respond to inequalities in the health of their populations, both in terms of access to services and outcomes on life

expectancy. No one organisation can do this in isolation. The Health Inequalities programme will require involvement of all NHS organisations, Local Authority and wider partners to work together if we are to achieve real and lasting improvements for people living within Lincolnshire.

The JHWS for Lincolnshire aims to inform and influence decisions about the commissioning and delivery of health and care services in Lincolnshire so that they are focused on the needs of the people who use them and tackle the factors that affect everyone's health and wellbeing.

The Local Authority Director of Public Health attends the ICB Board meeting and provides an update at each meeting. Through our work with them, and active engagement at the health and wellbeing boards, we have confirmed the ICB's contribution to the delivery of the joint health and wellbeing strategies.

Duty to involve the public

ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided

Lincolnshire ICB's 'People and Communities Strategy' and 'People and Communities Involvement Report 2022-23' describes our commitment to involvement and explains how we are fulfilling our statutory duties.

The Health and Care Act 2022 mobilises partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes.

These partnerships between the NHS, social care, local authorities and other organisations will only build better and more sustainable approaches if they are informed by the needs, experiences and aspirations of the people and communities they serve. The ICB is fully committed to involving patients, the public, partners and key stakeholders in the development of services and ensuring they are at the heart of everything we do.

We understand that partnership working is key to empowering patients to have more choice and control over their own health. Through these partnerships, we can better understand the health needs of our population, resulting in improved health outcomes.

Lincolnshire ICB recognises the importance of working with our partners, to enable a collaborative approach to involving our communities and benefiting from the trusted and established relationships they have with the people of Lincolnshire. By working together, we reach different people in different ways and have the conversations with them that are important to them with trusted individuals.

Our strong relationships with Voluntary, Community, and Social Enterprise organisations enables us to commission them to undertake some work on behalf of, and in partnership with, the ICB. The ICB is committed to delivering engagement at all levels from working with community leaders at a neighbourhood level or through partnership working such as Lincolnshire's Integrated Care Partnership - Better Lives Lincolnshire. We regularly work in partnership with Healthwatch Lincolnshire to deliver engagement activities and Every-One, a local charity organisation who involve people with lived experience, in our involvement and co-production. We work closely with the Lincolnshire Voluntary Engagement Team (LVET), a collective of VCSE organisations working together with a specific focus on developing and delivering health, care, and wellbeing services in Lincolnshire working with partner agencies.

Our day-to-day processes and systems have been established to work across engagement teams within the ICB and NHS Provider Trusts across Lincolnshire. Joint working enables us to collaborate and reduce duplication, leveraging the links we all have with their patient groups and memberships while supporting each other:

- Our ICB and NHS Provider Trusts' engagement teams in Lincolnshire have a shared leadership, meeting fortnightly to share good practice, coordinate activities and offer support to each other in addition to overall leadership of the Communications and Engagement Teams
- We share survey and analysis software across all NHS organisations
- We reduce consultation and engagement fatigue in our communities by awareness of engagement activities being undertaken across Lincolnshire and often 'go out once' to local groups and communities and share all the opportunities to get involved with our partner organisations.
- Through collaboration we have created and introduced an Insight Database, storing multiple examples of activities and feedback. This is available to all NHS and partner organisations to search for feedback on specific services or geographical areas, from which we can better understand our communities and use this as a basis for future engagement.

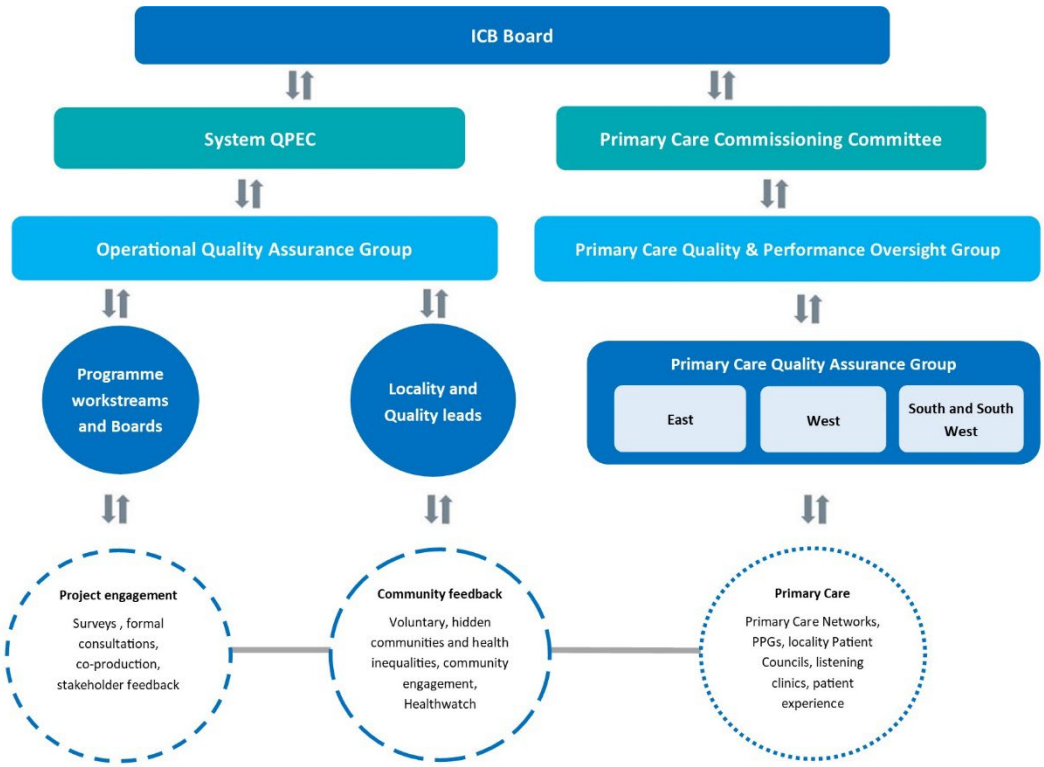
Timely and meaningful engagement is a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

Reports on the outcomes of our engagement activities are reported to the ICB Operational Quality Assurance Group Meeting and the System Quality and Patient Experience Committee (QPEC). Updates are provided to the ICB Quarterly through the QPEC Report and a formal report is presented at the board annually. Identified issues are escalated to our Primary Care Commissioning Committee (PCCC) if it is regarding a GP surgery. Feedback from programme specific engagement is also shared with our project leads to help shape and steer their programmes of work. See diagram below.

Our engagement and involvement function is part of the ICB's Strategic Planning, Integration and Partnerships team, ensuring patients and our communities are at the heart of service development, improvement, and transformation. Strong links are maintained with the ICB Nursing and Quality Team to align patient experience and engagement with quality and safety.

We also have a dedicated communications and engagement team to focus solely on primary care, recognising the vast array of specific feedback we receive from patients and the public and enabling us to ensure this reaches the teams developing primary care and its services in a timely manner for them to respond to.

How we report and listen to the feedback we have heard:



Lincolnshire ICB has adopted the **ten principles of engagement** set out by NHS England in the ICS design framework – these have been developed from work with systems across the country and, when embedded effectively, will create a golden thread running throughout the ICS, whether involvement takes place within neighbourhoods, in places or across the whole of Lincolnshire.

The strategy is dynamic in nature, flexing in accordance with the needs and feedback of our communities. Therefore, some of the content is well established and progressed work, and some references to intended developments and collaborations. This document was developed during the transition period between CCGs and the ICB and our first People and Communities Involvement Report 2022-23, and subsequent annal involvement reports will demonstrate how we continue to work towards this and deliver the principles of engagement. We will engage with Lincolnshire People and Communities to review our progress against the strategy, identify gaps and areas of improvement as well as successes we can build on.

Lincolnshire is the fourth largest county in England with an area of 5,921 sq. km and a predominantly rural geography, an ageing population and areas of high socio-economic deprivation. We recognise and strive to overcome the barriers this creates when engaging with all of our different communities.

We recognise the differences in our communities from their health needs, ability to access services (both digitally and in person), and the ways they want to get involved.

All of our commissioning and involvement activities are built on a solid understanding of our population, service users, their experiences and the people that support them. We will utilise the knowledge, relationships, networks and strong links our partner organisations already have with our communities to ensure a fully holistic, system approach to involvement. We will use existing and tested opportunities to engage and communicate and seek to identify the best partner with the best relationship to lead the conversation. Working as partners will strengthen our collective messages and involvement activities. As well as joining up care, we will join up our engagement and experience work to capture and improve the patient journey and use this to empower joined up system working.

We continue to build strong relationships with our community groups and support organisations to help us reach more individuals and communities. We work closely with groups and venues providing warm spaces, foodbanks, as well as individuals such as Islamic leaders and social prescribers to draw on their wealth of experience and links to communities.

The engagement team supports programmes within the ICB to ensure that sufficient involvement activities have been undertaken to inform the following assessments:

- Equality Impact Assessments
- Quality Impact Assessments
- Health Inequality Impact Assessments (HEAT)

The involvement activities support the programme teams to fully understand the impacts for people and communities of any proposed changes. The insights and diverse thinking of people and communities are essential to enabling Lincolnshire ICB to tackle health inequalities and the other challenges faced by health and care systems.

Our engagement within projects to tackle health inequalities is informed and driven by the latest demographic and Census data and Joint Strategic needs assessment via the Lincolnshire Research Observatory. Our People and Communities Involvement Report 2022-23 provides further details of our programmes of work undertaken to address inequalities. This work has strengthened relationships within our communities and often seldom heard groups.

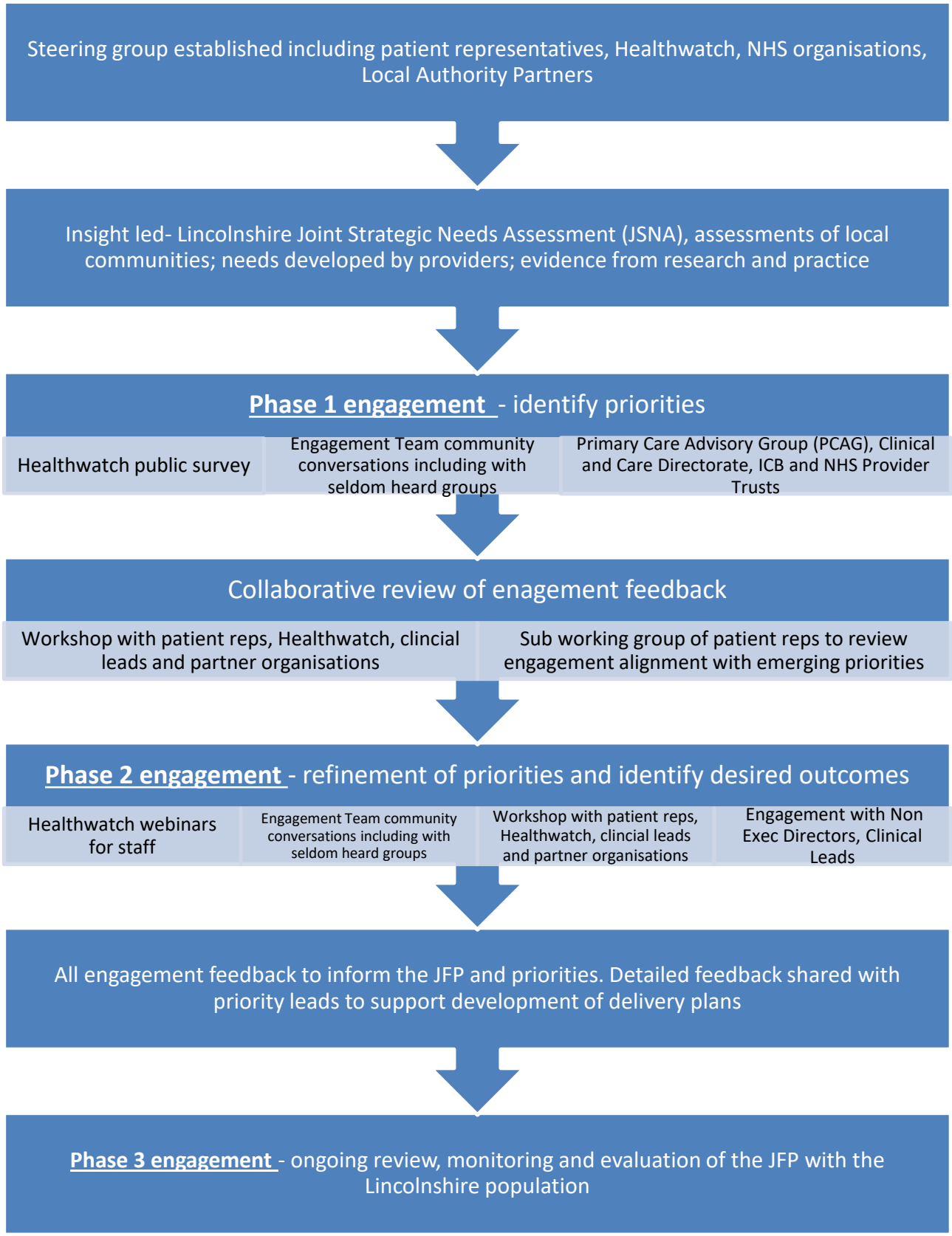
This commitment to involvement is woven throughout all of our programmes of work including the development of Lincolnshire's Joint Forward Plan. We are co-producing our JFP with patient representatives, stakeholders, clinicians, and staff, and is based on a strong foundation of insight and intelligence. We have also commissioned Healthwatch Lincolnshire to undertake some engagement to maximise the opportunities for involvement. Our approach to engagement so far has been robust and will continue after publication of the document.

Engagement was undertaken in three phases to allow consideration of feedback at each stage of development and review. It takes into account Lincolnshire's unique landscape and demographics, reaching out into various communities, groups as well as areas of deprivation and health inequalities.

- We have embedded the patient voice in the development and decision-making process with patient representatives as key members of our Joint Forward Plan Steering Group, working alongside Healthwatch, Local Authority representation and leads from our provider trusts and primary care teams.
- Our patient representatives attended clinical / organisational workshops and reviewed outputs to ensure alignment of public engagement feedback with the emerging priorities.

- Working in partnership, Healthwatch Lincolnshire have supported the engagement, undertaking a public survey in the first phase of engagement to identify priorities and staff webinars to test these during the last phase.
- The ICB engagement team carried out extensive community engagement in the first phase of engagement to understand what was important to the population of Lincolnshire and this was considered by staff, partner organisations and patient representatives at the workshop to identify emerging priorities.
- Further community engagement was undertaken during the second phase of engagement to test these priorities with the public and gain an understanding of what outcomes could be achieved for our communities.

Following the publication of the document we will built on this approach with a third phase of continual engagement with our population. This third phase of engagement enabled us to involve the wider Lincolnshire population on the document as a whole, the priorities and ongoing monitoring and evaluation of our work undertaken to achieve these. this has demonstrated our approach to ensure regular and transparent communications to everyone involved in the engagement and development of the Joint Forward Plan.


Steering group established including patient representatives, Healthwatch, NHS organisations, Local Authority Partners
Insight led- Lincolnshire Joint Strategic Needs Assessment (JSNA), assessments of local communities; needs developed by providers; evidence from research and practice
Phase 1 engagement - identify priorities
Healthwatch public survey
Engagement Team community conversations including with seldom heard groups
Primary Care Advisory Group (PCAG), Clinical and Care Directorate, ICB and NHS Provider Trusts
Collaborative review of enagement feedback
Workshop with patient reps, Healthwatch, clincial leads and partner organisations
Sub working group of patient reps to review engagement alignment with emerging priorities
Phase 2 engagement - refinement of priorities and identify desired outcomes
Healthwatch webinars for staff
Engagement Team community conversations including with seldom heard groups
Workshop with patient reps, Healthwatch, clincial leads and partner organisations
Engagement with Non Exec Directors, Clinical Leads
All engagement feedback to inform the JFP and priorities. Detailed feedback shared with priority leads to support development of delivery plans
Phase 3 engagement - ongoing review, monitoring and evaluation of the JFP with the Lincolnshire population

Phase one public engagement activities:

A robust plan for engagement has been produced to support the development of the Joint Forward Plan and its joint NHS Priorities for the next five years. Alongside the consideration of existing insight and intelligence, engagement was undertaken to understand the views of patients and the public.

The ICB commissioned Healthwatch Lincolnshire to undertake a public survey to gather feedback on what was important to them, what they felt the NHS priorities should be over the next five years as well as their own experiences of services.

The Healthwatch online survey was available in different formats on request and hosted on Healthwatch Lincolnshire's website as well as NHS Lincolnshire ICB and NHS provider websites. The link was also shared with over 9000 contacts on the ICB engagement stakeholder database.

The online survey was regularly promoted through various channels including:

- Social media (Twitter, Facebook and Instagram) across the ICB and Trusts accounts as well as requests regularly being sent to Lincolnshire partners to share and extend the reach
- Healthwatch channels (Website, social media, mailing lists)
- Sent to Lincolnshire Resilience Forum partners (Local Authority, East Midlands Ambulance Service, Public Health, Police, University of Lincoln and other partners)
- NHS Lincolnshire Engagement Bulletin
- Press releases
- Next-door online forum
- Provider's member databases and staff networks
- Via leaflets with QR codes handed out during face to face engagement activities

Healthwatch also ran two virtual webinars via Zoom that members of the public were able to register to attend via the Healthwatch Lincolnshire website.

Community conversations

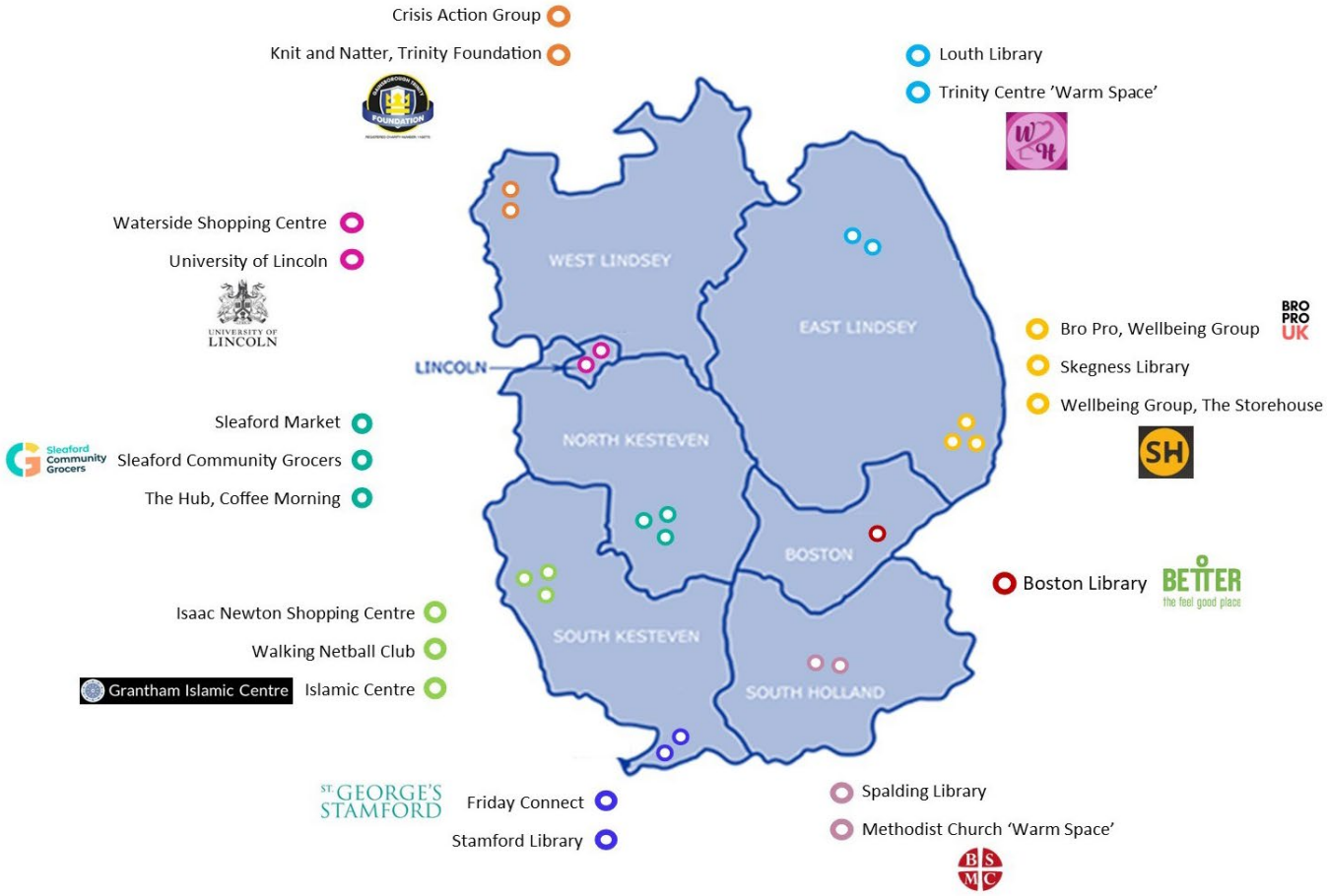
The NHS Lincolnshire ICB engagement team undertook discussions with the public and community groups between 10th February and 21st February 2023, attending 20 community group meetings across eight localities in Lincolnshire including meeting with communities from deprived areas, students, people with mental health issues and minority ethnic groups.

Throughout the engagement period the team incorporated a number of different activities to speak to members of the public such as attending existing community group meetings, display stands in public places, 1-1 and virtual meetings. Each location and event was chosen to enable us to reach as wide and varied population as possible to ensure that all voices in our community were given an opportunity to be heard.

NHS Lincolnshire ICB have also been gathering experiences of care through a survey which has been open since June 2022, the results of which will also be fed into the programme.

- Patient representatives embedded within the programme - members of the Steering Group to shape the work; attending the engagement workshop alongside partner organisations; members of the Task and Finish Groups to review feedback and develop draft priorities
- 1028 responses to the Healthwatch online survey
- Attended 20 engagement events across Lincolnshire, talking to 254 people
- Engagement sent to over 9000 people on our stakeholder database

- Engagement sent to over 13,000 staff through organisation communications
- 388 responses to our Experiences of Care survey
- Shared via other partner organisations
- Attended community events across Lincolnshire at no cost and was able to target people who do not usually engage with the NHS
- Focussed on areas with high levels of deprivation and health inequalities
- Supported patients to get involved who would not be able to access the survey online

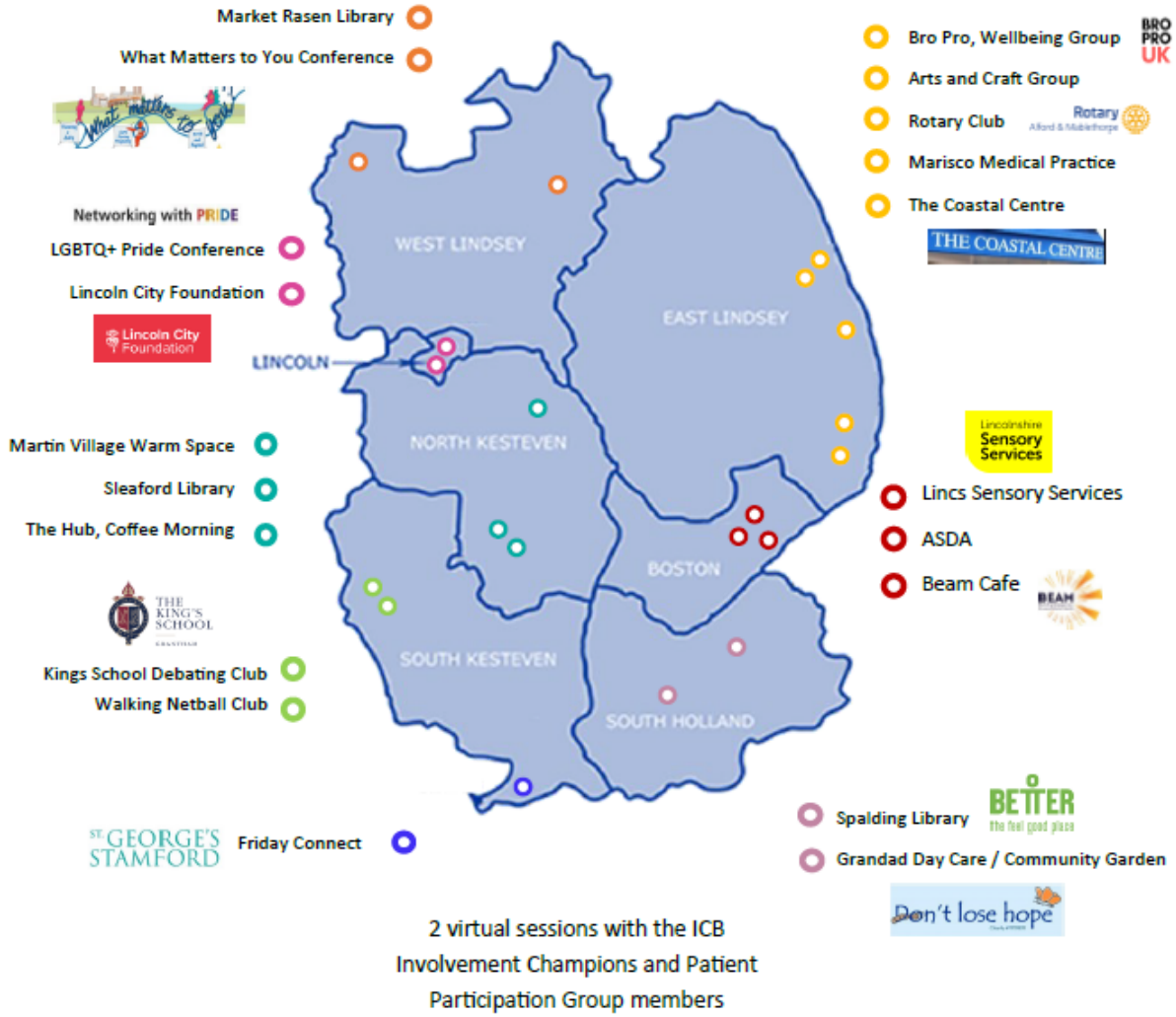


Phase two public engagement activities:

During the second phase of engagement the NHS Lincolnshire ICB engagement team undertook discussions with the public and community groups between 5th and 16th June, attending 22 community group meetings across 13 localities in Lincolnshire, talking to 252 people including engaging with seldom heard groups such as those from deprived areas, younger people, people with mental health issues and those from LGBTQ+ community and other protected characteristics.

To ensure we could reach as wide and varied population as possible and to ensure that all voices in our communities were given a fair opportunity to be heard we incorporated a number of different activities to speak to members of the public such as attending existing group meetings and display stands in public places. Two virtual events were also held with our ICB Involvement Champions and PPG representatives.

The map below shows the breadth and reach of activity undertaken by the NHS Lincolnshire ICB Engagement Team.



Healthwatch Lincolnshire also undertook 2 webinars to gather views from members of staff.

The feedback from phase 2 engagement will be considered by the team working on the development of the Joint Forward Plan to help shape the document before publication and also the Steering Group who have oversight of the process and ensure the engagement has been duly considered. Along with further detailed feedback, this report will also be shared with priority leads to inform the development of their delivery plans to incorporate the feedback heard, identify any gaps identified, areas of focus within priorities or where we need to strive to make this priority 'go further'.

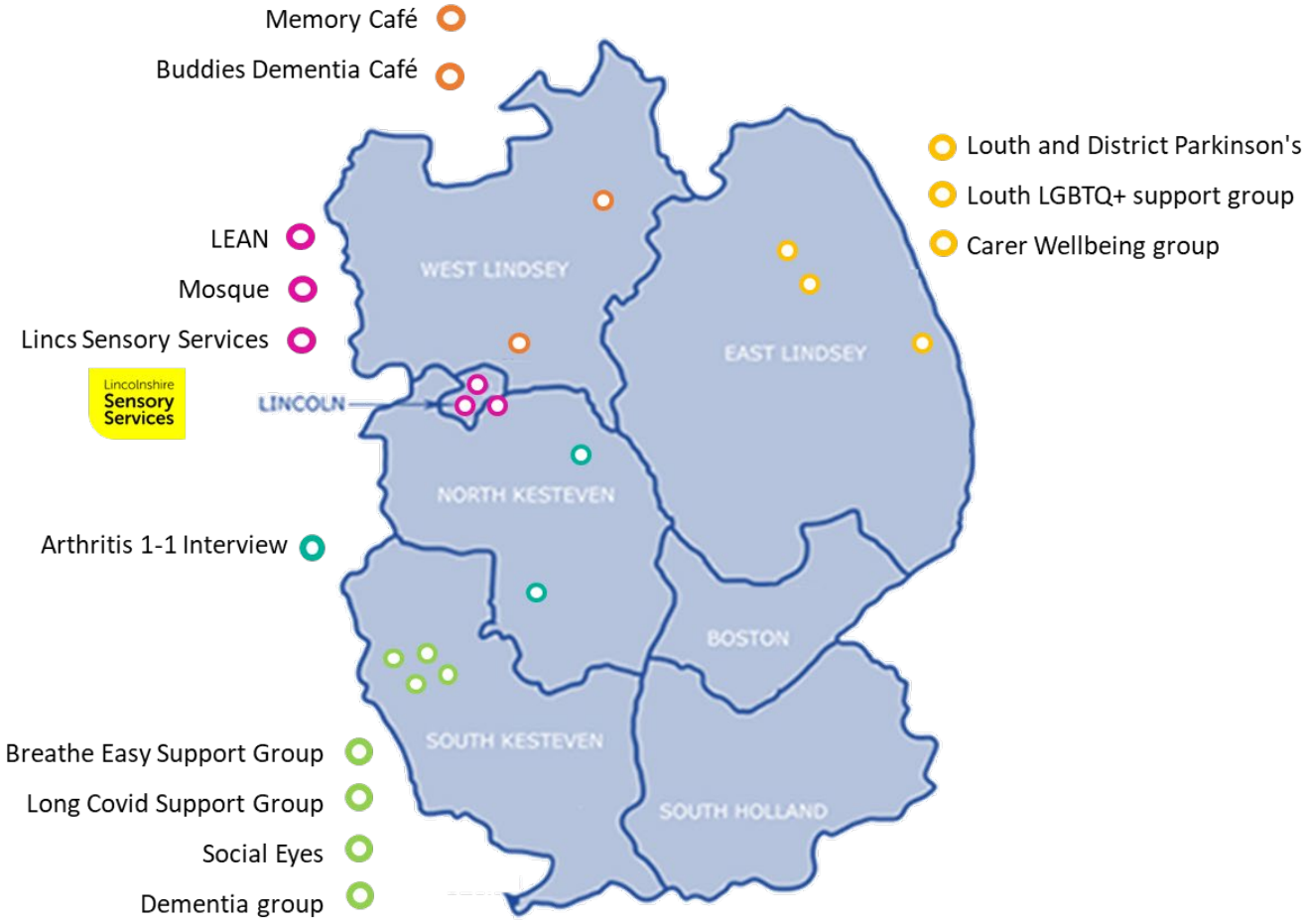
<u>Phase three public engagement activities:</u>

Throughout a 5-week period in November and December 2023 we engaged with 13 different groups across Lincolnshire.

In the previous two phases of engagement, we incorporated several different activities to speak to members of the public such as attending existing group meetings, display stands in public places and holding virtual meetings.

However, during this third phase of engagement, to ensure all communities have been given a fair opportunity to have their say, we concentrated our activities on those groups that we had not heard from as much during phases one and two.

The map below shows the breadth and reach of activity undertaken by the NHS Lincolnshire ICB Engagement Team.



The feedback provided will support a review and refresh of the Joint Forward Plan to ensure the needs and views of our communities are reflected in the document and help shape the main priorities.

Duty to patient choice

Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them

Lincolnshire ICB recognises its legal duty described in the NHS Constitution (January 2021) as an individual's right to receive care and treatment that is appropriate to meet their needs and reflects their preferences; and the responsibilities set out in the NHS Choices Framework (2020) in relation to choices about healthcare; where to get more information to help individuals choose; and how to complain if they are not offered a choice.

Lincolnshire understands these responsibilities in relation to patient choice and have established a range of mechanisms to support individuals in considering their options and making informed choices regarding access to the care and services they require. The ICB will continue to support and develop choice where services are available and meet the needs of the population of Lincolnshire. This will be captured in commissioning plans as well as in the detail of contracting arrangements with services in and outside of Lincolnshire.

The Elective Activity Coordination Hub (EACH) is a service provided within Lincolnshire to assist with patient referrals to Community Services and Hospitals (including Private) for NHS treatment. Working on behalf of GP practices EACH liaises with patients to offer choice of provider, discuss the current position around waiting times and identify with the patient the best place for their care. The EACH also liaises proactively with patients who have been on hospital waiting lists for a prolonged period of time to see if there are any clinically suitable alternative providers that can be offered.

In addition to EACH Lincolnshire ICB has an established 'My Planned Care – Waiting Well' page on its website that provides a range of information including indicative wait times for procedures at NHS hospitals across Lincolnshire and neighbouring counties and what to do if there is a change in a person's condition whilst awaiting a planned procedure.

The NHS across Lincolnshire has also introduced a smartphone app called WaitLess, which is designed to help people choose the least pressured urgent and emergency care services and to understand waiting times better. The number of Systems currently using the WaitLess app are limited and therefore at present it only displays waiting times for facilities inside Lincolnshire, however, as neighbouring systems develop mechanisms for informing the public of waits for urgent and emergency care the ICB will look to promote these through existing communications routes, to ensure those people resident on the borders of the county are appropriately informed.

Following admission to hospital it is important there is early consideration of discharge arrangements that need to be in place and that can be implemented as soon as a patient no longer needs to be in acute hospital care. Significant work is taking place in Lincolnshire to ensure appropriate pathways of care are in place and where needed, alternative out of hospital support is available. The processes being developed recognise individuals and families need to be engaged at the earliest opportunity to facilitate good care planning, that involves the individual in decisions regarding their care. To support these processes work is taking place to establish a system Choice Policy that will provide a framework for informed decision making in relation to expectations regarding discharge arrangements.

Personalisation is fundamental to enabling individuals and their families to have greater choice and control over the way their assessed needs can be met. Within Lincolnshire there is a Personal Health Budget (PHB) Implementation Strategy for 2022-2024 which includes an emphasis on ensuring PHBs are accessible to all people who are eligible for one, exploring new opportunities to proactively launch the programme into a range of new cohorts and services. This includes consideration of both established funding streams such as Continuing Health Care and Childrens Continuing Care through to non-established funding streams such as Child and Adolescent Mental Health Services (CAMHS); joint funded packages for high intensity users and long-term conditions; and social prescribing. Whilst Lincolnshire ICB has consistently achieved the year-end target as mandated by NHSE the aspirations set out in the Personal Health Budget (PHB) Implementation Strategy for 2022-2024 highlights the continued focus on personalisation within the county.

Lincolnshire ICB as a robust complaints policy and process in place and information for the public on how to raise a complaint, which would include issues relating to patient choice, is included in the ICB website Your feedback matters - Lincolnshire ICB. Learning from complaints is used to inform a range of functions within the ICB, including where appropriate, gaps in commissioning or processes that support access and patient choice which require improvement.

Duty to obtain appropriate advice

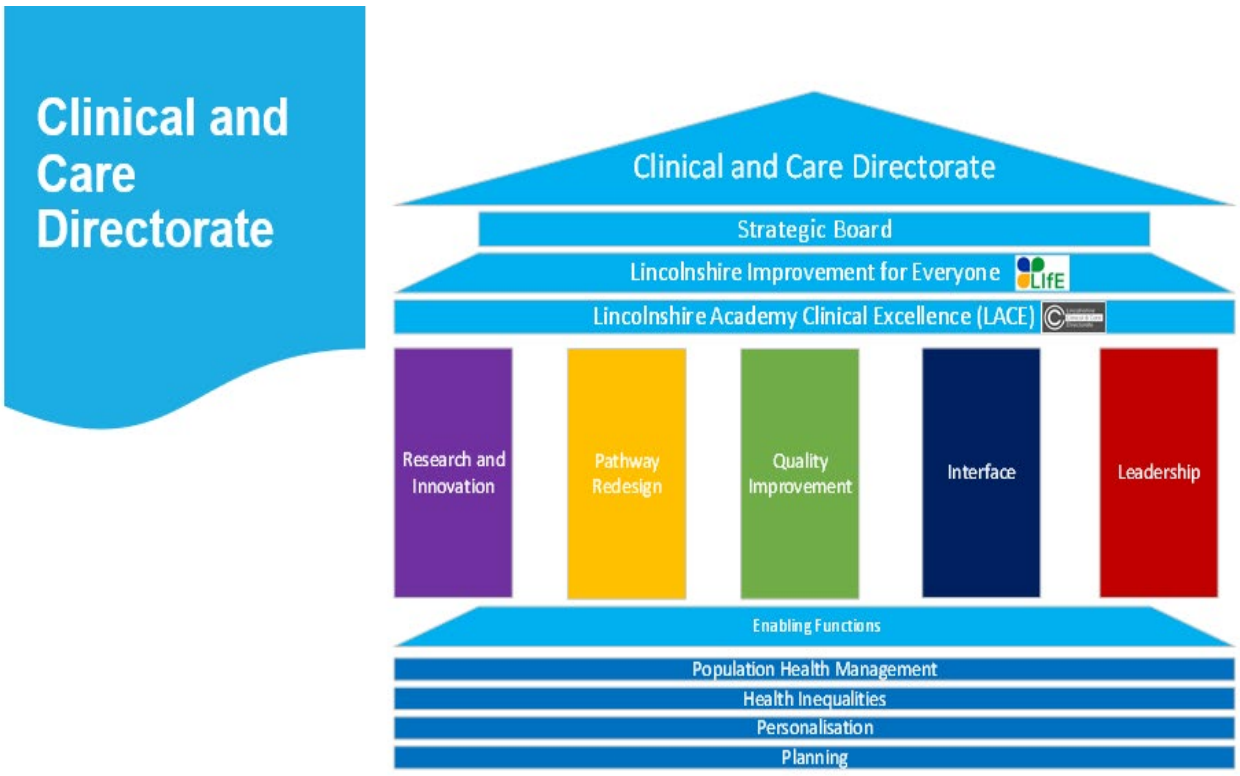
Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.

The Lincolnshire ICB has established the Care and Clinical Professional Directorate. This includes senior clinicians and care sector leaders from medicine, nursing, allied health professional's adult and children's care services supported by a management team. Senior colleagues from the ICB are also part of the core membership. We invite other clinicians' dependant on the pathway redesign topic who are not part of the core membership but have the relevant expertise. The outputs are shared widely, including through the Primary Care Advisory Group which includes all of primary care not just general practice.

The CCD aligns with the five principles set out in the NHSE guidance: 'Building strong integrated care systems everywhere' (Sep 2022)

- Integrating clinical and care professionals in decision-making at every level of the ICS
- Creating a culture of shared learning, collaboration, and innovation, working alongside patients and local communities
- Ensuring clinical and care professional leaders have appropriate resources to carry out their system role/s
- Providing dedicated leadership development for all clinicians and care professional leaders.
- Identifying, recruiting, and creating a pipeline of clinical and care professional leaders.

The Clinical and Care Directorate (CCD) will be the collective voice of all health and care professionals in Lincolnshire. It will provide evidence-based decision-making by well-led clinical professional groups. The infographic depicts the structure and alignment of the elements included within the CCD.



The Strategic Board is a leadership committee of the CCD and sets Lincolnshire's clincal direction and acts as an advisory group and a source of clincal expertise to the ICS, ICB, LHCC and MLHDAA. Members of the Strategic Board are senior clinicians who are invited to represent components from the ICS.

The ambition is the development of a cohesive approach to improvement, learning, research, and innovation at a Lincolnshire ICS system level under the banner of LIfE: Lincolnshire Improvement for Everyone.

The CCD has been structured with the five key component parts, these parts include;

- Research and Innovation
- Pathway redesign
- Quality Improvement
- Interface
- Leadership

The first three parts make up the fundamentals of the LACE these elements work closely together to ensure research, innovation, pathway redesign and quality improvement are at the heart of transforming clincal excellence and improving patient outcomes. Interface is a forum for primary and secondary care clinicians to improve patient flow and care with the aim of reducing duplication, following best practice, and therefore improving patient care. The leadership program will enable senior medical colleagues to develop together to lead clinical change in our system. We hope to create a pipeline for this development to secure succession planning.

The purpose is improving the health and wellbeing of people in Lincolnshire, by supporting the delivery of our long-term population health improvement goals as well as care delivery. The added value of working as a system facilitating stronger collaboration across organisations and more effective scaling of innovation; using existing assets and the expertise that exists in Lincolnshire. Shifting the focus from assurance to improvement, which is everyone's business, adopting learning health and care system concept, understanding the relationship between investment and outcomes. The end-product will be a Lincolnshire framework which drives more effective improvement, agreeing common language and principles.

The proposed framework will focus on two main elements:

- Creating the conditions for change: identifying goals, priorities and resources; building relationships and trust; seeing diverse expertise as an asset; developing shared system leadership
- Enabling the planning and delivery of changes across the system

The Better Lives Lincolnshire Leadership Team endorsed the approach.

We have established Links with Q, The Health Foundation and NHS Confederation to provide peer learning support programme and opportunity to test Q framework in Lincolnshire. Establishing an ICS working group, links to national support offers. Draw up the framework, building on our work to date finally test and refine.

Lincolnshire Academy for Clinical Excellence (LACE) is the facilitator of clinical care pathway reviews for the ICS, bringing together clinical and operational experts with people with lived experience, to review and redesign care pathways, using a variety of methods and techniques such as evidence synthesis and quality improvement tools.

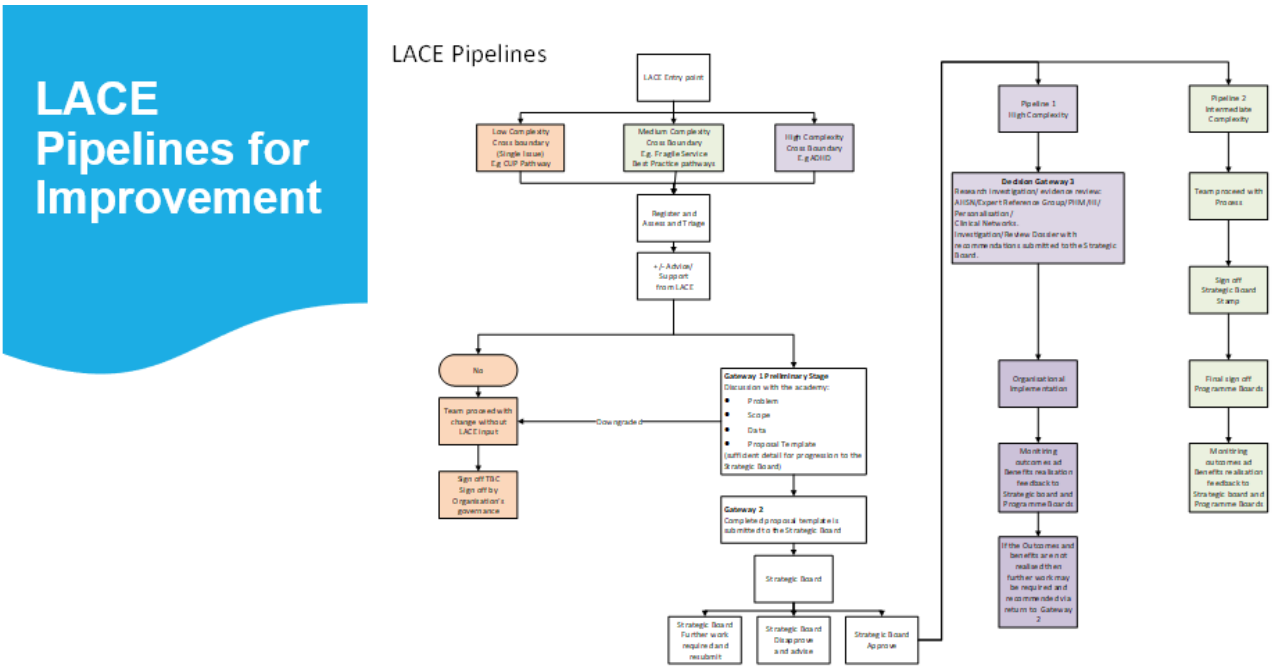
We look in detail at the data, including population health analysis, health inequalities and personalisation. Alongside this, we collate clinical evidence by searching the clinical database and clinical papers. We also seek advice from national, regional, and local experts in the area of interest.

We are developing strong links with the University of Lincoln and the Health Innovation East Midlands (HIEM) to formulate the process of evidence synthesis. This will be a fundamental part of service redesign, starting with gathering current clinical evidence, best practice and inviting leading clinical experts to inform pathways.

We draw all elements together and provide guidance to teams regards Improvement options these include Low, Medium, and High complex pipelines. There are 5 stages to the pipeline for the high complex these contain the following.

- Seeking approval from the Strategic Board
- Establishing stakeholder and expert engagement
- Detailing the current position and areas for improvement
- Mapping the future state and building a high-level strategy and plan
- System sign-off and ownership of the strategy and plan

The following infographic depicts this.



Colorectal

As an example, we have recently completed the redesign of the colorectal pathway. We had an uptake of FIT testing below 30% for new Two Week Wait referrals for suspected colorectal cancers. With the methodology described, and with the help of the Chair of the British Gastroenterology Society, we have redesigned that pathway. The result has seen an increase in the adoption of FIT testing to well above 80% and often nearing 100%.

ADHD

LACE is currently undertaking a detailed review of ADHD services for adults in Lincolnshire at the request of the ICB's Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team.

Working with the Chief Commissioning Manager and his team, LACE are partway through the five stages of its most complex review pipeline, facilitating a series of workshops involving local clinical, operational and commissioning experts as well as people with lived experience, all coming together to form The Expert Reference Group (Stage 2). The Strategic Board, having approved the review (Stage 1), has received verbal updates on its progress and will receive a copy of the final strategy and dossier for sign-off prior to its implementation (Stage 5).

Workshops 1 and 2 of the review (Stage 3) have focused upon exploring the current position using detailed local data analysis, best practice guidance via evidence synthesis carried out by Health Innovation East Midlands, and clinical standards' and personalisation gap analyses, carried out by the current, independent providers. A survey of people with lived experience of ADHD and using local healthcare services, was also carried out. All of this intelligence, which was presented and reviewed at the workshops, was then supplemented by the experts during

a series of activities to deepen the understanding of the issues and causes that would benefit most from a quality improvement approach.

Workshop 3 (+ Workshop 4 = Stage 4) began focusing upon the desired future state or vision for services by agreeing an aim statement underpinned by three objectives. The major elements of the current and desired future pathway were agreed and mapped in relation to each other. Workshop 4, not yet delivered, will focus upon agreeing outcomes and outcome measures for each of the elements of the care pathway. The outputs from workshops 3 and 4 will form the basis of a high-level strategy which the commissioning team will use to inform their commissioning intentions going forward once approval has been granted by the Strategic Board.

The three workshops already undertaken, have been well attended with good representation from independent service providers, NHS staff from across the system, university, and public health staff. Attendees were very engaged in the workshops and the post-workshop feedback via anonymous surveys, has been extremely positive.

This has been our first example to test the complex pipeline it was commissioned by the Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team. It has been a testbed for the LACE method and pipeline of activities for detailed reviews. There have been 4 workshops (1,2&3 completed) including clinical and operational experts as well as people with lived experienced, together comprise the Expert Reference Group. 3/4 private providers engaged and in attendance. Detailed exploration of the issues, data, evidence base, solution generation resulting in a high-level strategy by March 2024.

There are many pipelines now commencing some led by the LACE team some led by other improvement teams/ individuals across the system. The oversight and progress of these programmes of work are aligned with the Strategic Board. The approach the CCD is taking is integral to the success of integration to improve patient outcomes locally.

Duty to promote innovation

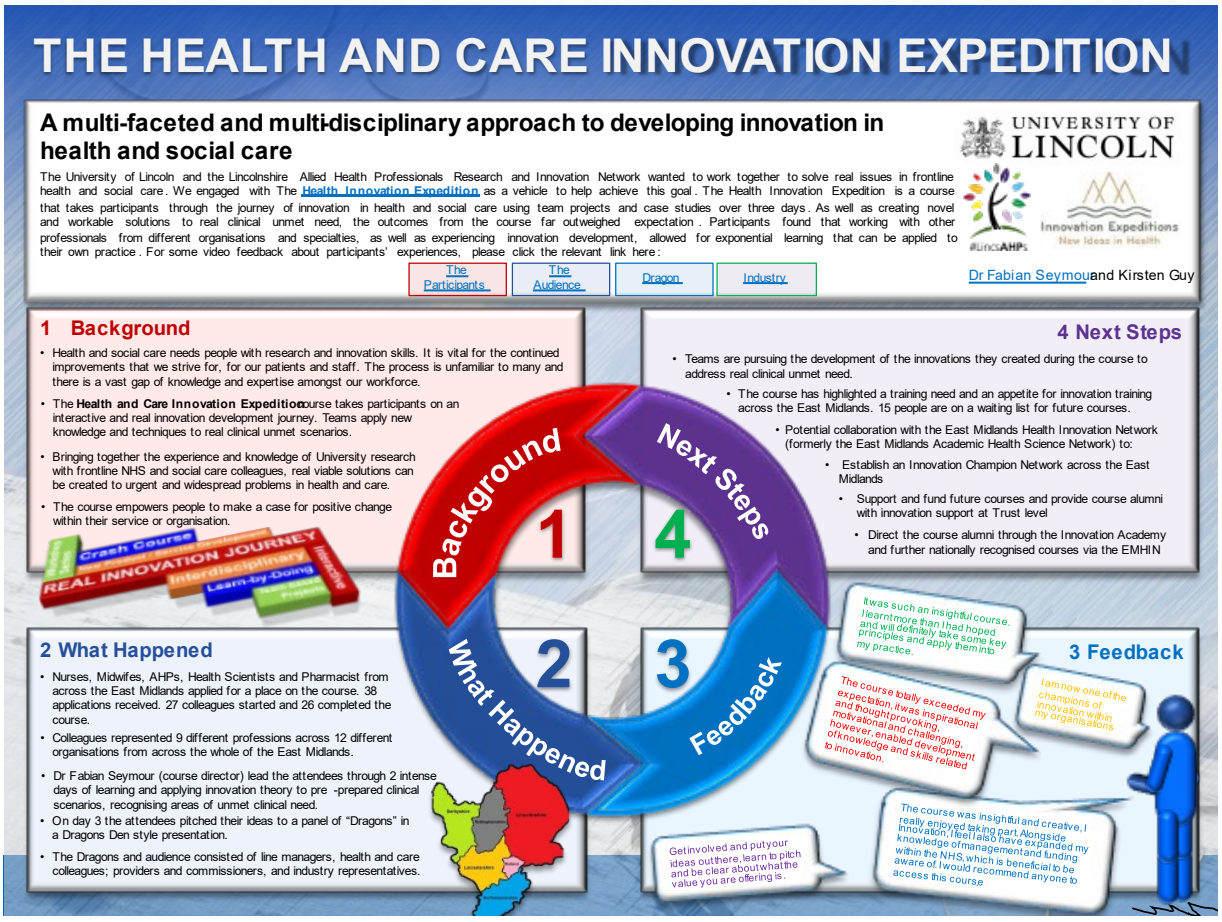
Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).

Our ICS has close links with the Health Innovation East Midlands (HIEM). In May 2024, a 2 year fixed term ICS Innovation Lead post, in partnership with HIEM, will support innovation across our system and link with ICS counterparts within the East Midlands. Health Innovation East Midlands was established by NHS England in 2013, as one of 15 organisations across England acting together as the innovation arm of the NHS. Bringing together partners from across all sectors involved in health and care including the NHS, social care and public health, patients, research, third sector and industry – to identify, test and spread new technologies and better ways of working.

The work of all the Health Innovation Networks is broadly split between three different, but complementary commissions:

- NHS England (covering our core work around innovation)
- NHS Improvement (supporting safer care through our Patient Safety Collaboratives)
- Office for Life Sciences (helping innovators to spread their great ideas and technologies, and in doing so support economic growth).

We are looking forward to exploring a support package and working ever more closely with HIEM who continue to support our health and care organisations to adopt and spread innovative ways of working that will mean our services can treat more patients more quickly and achieve better outcomes. This would enable sharing best practice from national and regional teams, to evaluate at a local clinical level and into front line practice.



Feedback poster from the 2023 Health and Care Innovation Course

In June 2024, we will be delivering our 2nd Health and Care Innovation Course in partnership with the University of Lincoln and newly for this year, Health Innovation East Midlands (HIEM). This four-day course is open to nurses, midwives, AHPs, pharmacists and health scientists from across the East Midlands. Using Health Innovation Expedition: New ideas in Health & Social Care as the innovation vehicle, attendees are empowered to innovate more effectively and are given the tools to navigate the complexities of getting ideas developed, adopted, and spread throughout the NHS and social care settings. Attendees work on innovative solutions to current clinical challenges in 4 workshops. Day 4 is the final workshop and will consist of a Dragons Den showcase where group ideas will be pitched to relevant national, regional and local partners. Please see the feedback poster above and the links to videos from the Dragons Den Day last year.

We are delighted to be developing an ICS Research and Innovation Strategy, which will be published in April 2024. Including Innovation demonstrates our collective commitment to innovation in addition to research. Although different specialities, there are many benefits to dovetailing our strategy. Please see further details in the research section below.

HIEM Blood Pressure Optimisation programme

The Blood Pressure Optimisation programme aims to support local systems in identifying patients with hypertension, providing the right care to reduce the incidence of heart attacks, strokes, and dementia.

HIEM are supporting primary care staff within East Midlands Primary Care Networks (PCNs) to implement the Proactive Care Framework for hypertension to optimise clinical care and self-management for people with high blood pressure and other CVD risk factors.

The Framework offers:

- Risk stratification to prioritise which patients to see first.
- Use of the wider workforce to support remote care and self-care.
- Supporting patients to maximise the benefits of remote monitoring and virtual consultations where appropriate.

In addition, we are working collaboratively with Integrated Care Systems to improve existing case finding initiatives to increase the detection of people with hypertension.

Improving care for patients with lower limb wounds

Project summary

EMAHSN locally supported the AHSN Network Transforming wound care national adoption and spread programme. The programmes aim is to ensure that all patients with lower limb wounds receive evidence based care which leads to:

- faster healing of wounds
- improved quality of life for patients
- reduced likelihood of wound recurrence
- uses health and care resources more effectively.

The programme uses the evidence, learning and recommendations from the National Wound Care Strategy Programme (NWCSP).

EMAHSN took part in Phase 1 of the programme and supported Lincolnshire Community Health Services NHS Trust to establish a dedicated Lower Limb Wound Clinic Test and Evaluation Site.

The challenge

Most wounds to lower limbs heal within a few weeks. Chronic lower limb wounds are those below the knee that are slow or fail to heal. Chronic lower limb wounds account for at least 42% of all wounds in the UK, with leg

ulcers being the most common type (34% of the total wound population, compared to 7% pressure ulcers and 8% diabetic foot ulcers).

A large proportion of the total wound care spend is for these chronic lower limb wounds because of their slower healing rates. In 2019, there were an estimated 739,000 leg ulcers in England with estimated associated healthcare costs of £3.1 billion per annum year.

Based on evidence from the National Wound Care Strategy Programme, the prevalence of total leg ulcers is expected to increase by around 4% annually, to over 1 million by 2036 if there is no intervention. This is driven by an increase in leg ulcers that either recurs after healing or do not heal.

The solution

The three key elements of the programme are:

- People: the delivery of training to all staff supporting patients with wounds
- Processes: implementing a new evidence-based model based on the recommendations of the NWCSP
- Technology & design: supporting data collection and provision of care through a new digital wound management system

Atrial Fibrillation

The Atrial Fibrillation (AF) programme focused on improving the detection and treatment of AF in primary care. It was active in the East Midlands from 2016 and was selected as a national programme to implement across the 15 AHSNs between 2018 and 2020.

It facilitated collaboration between GPs and other clinical support groups, such as pharmacists, to deliver more timely treatment and evaluation of these approaches.

Impacts

Between April 2016 and March 2020, the programme achieved the following in the East Midlands:

- Deployed 925 devices to participating GP practices and support services to increase detection.
- Supported the treatment of an additional 25,127 people diagnosed with AF.
- Supported our East Midlands health system to achieve a 90% anticoagulated rate of people diagnosed with AF by March 2020 (against a national target of 90% by 2029).
- Contributed to the avoidance of 1,005 AF-related strokes.
- Contributed to the avoidance of 254 AF-related deaths.
- Saved the East Midlands health and care system £22.8M.

The examples outline successful innovations that are being tested across the East Midlands, HIEM have funded a System role to support Innovation, this role will support the learning and upscaling of these innovations across Lincolnshire to improve outcomes for patients.

The Director of Public Health is a core member of the Clinical Directorate and is the key link to the JSNA, as well as the conduit of the clinical voice in the JHWS. Through that mechanism, we installed WHZAN technology into our care homes that enable much greater support to care home staff for remote monitoring. This improves the standard of care we can offer to care home residents.

Duty in respect of research

Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.

We have the ambition to be the leading county for rural and coastal research.

Lincolnshire's history in research to date has been focused on individual Trust level and general practice-based work. We have pockets of research delivery excellence in cardiology, haematology, mental health, pre-hospital, gambling, and addiction, and we have ambitions to ensure equity and increased opportunities to be involved in research from a public and workforce perspective. The Clinical Research Network (CRN) East Midlands is 1st for recruitment to Primary Care studies, out of the other 15 Local Clinical Research Networks (CRNs) and Lincolnshire is 3rd in the East Midlands with over 8,000 recruited within 2023/24.

Research and Innovation forms an integral part of LiFE (Lincolnshire Improvement for Everyone) and moving forwards this will be integral to the synthesis of the evidence required to make positive, impactful change. In terms of evidence synthesis informing pathway redesign, please see the examples in the section above on the **Duty to obtain appropriate advice.**

Facilitated by our ICB we have established an ICS Research Leaders Group which builds on established research partnerships within our ICS. The Group meets monthly with representation from research leaders across the NHS, Lincolnshire County Council, Universities (University of Lincoln and Bishop Grosseteste University), voluntary sector and wider partners. Its purpose is to provide strong and effective leadership and partnership working across the health and care system, with a commitment to maximising shared research opportunities to deliver better health and wellbeing outcomes to the people of Lincolnshire. We are developing an ICS dashboard that will allow the group to demonstrate impact and monitor research and innovation activity across the ICS to ensure a co-ordinated approach that will maximise opportunities for Research and Innovation. This group will have strategic and operational functions and will oversee the development of the ICS Research and Innovation Strategy.

In April we are launching our Research and Innovation Hub.

Research and Innovation Hub

LIfE

Lincolnshire Improvement for Everyone

Improving the Health and Wellbeing of people in Lincolnshire

Our Research and Innovation Hub will be a virtual place that brings together the Lincolnshire Public, our Workforce and our colleagues at our universities to drive research and innovation in our county for benefit of our rural and coastal community. A Hub website is in development and will initially be public facing. It will be a resource where the Public can find out about health and care research, why it is important, what is happening nationally, regionally and in Lincolnshire, and how to get involved. Sitting within the Lincolnshire ICB website, it will be a 'one stop shop' for Research and Innovation in the county. The public content has been co-produced with the public during 2 workshops which were very well attended. The website will continue to evolve to include sections for our workforce, researchers, and our research leaders. The hub launch will be a celebration of Research and Innovation in Lincolnshire, with attendees from all our ICS, local and regional partners, national speakers and the Lincolnshire public. It will be a launch pad for our collective ambition for Research and Innovation to drive excellence in rural and coastal health and wellbeing.

At the Hub launch we will also be publishing our first ICS Research and Innovation Strategy. Our strategy has been co-produced during a series of collaborative workshops with senior leaders in our system, partners and our public. Our 5 year strategy is ambitious and reflects our commitment to ensuring that research and innovation are embedded in our core business rather than being an add-on.

Our 4 strategy principals align with national and local priorities and goals:

1. Reflects the needs of our rural and coastal community

2. Collaborative, co-ordinated and trusted partnerships

3. Research, Innovation and Evidence embedded in everything we do.

4. Delivered by a sustainable, capable and confident workforce

The Implementation plan will follow later in 2024 and will set out the road map for achieving our collective goals and vision.

Lincolnshire has a novice but emerging research and innovation workforce and therefore building capacity, capability and confidence is vital. Since November 2023 we have secured nearly £50,000 from our local and regional partners to support our innovative capacity and capability initiatives for our workforce and public. As an example, the ICB, Lincolnshire County Council and the University of Lincolnshire have developed a foundation research training programme which will be offered to all colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations. The programme has been created following survey feedback from our Allied Health Professionals (AHPs) and Lincolnshire County Council (LCC) workforce. The programme has been joint funded by the CRN, Lincolnshire County Council and United Lincolnshire Hospitals NHS Trust.

- Starting at the end of March, the training will be 8 online sessions over 5 months culminating in an in-person celebration marketplace event to explore the 'what next'.
- No prior knowledge of research required.
- For all staff (registered and unregistered).

The programme aims to demystify research and ignite passion and interest, to grow research skills and knowledge across Lincolnshire, for the benefit of the Lincolnshire population and our workforce.

Our Allied Health professional (AHP) council are very much part of our research cultural shift and want to increase their participation in delivering and developing research. We have a trailblazing paramedic colleague working in our local ambulance service already doing primary research. He is the first paramedic in the country to be awarded a prestigious Advanced Clinical and Practitioner Academic Fellowship (ACAF). We have recently launched our Council for Allied Health Professionals in Research (CAHPR) hub and have growing community of research aware, active and engaged non-medical clinicians creating a diverse, multi-professional research workforce within the county.

We now have a medical school and are working closely with the University of Lincoln to coordinate the research activity in our ICS. We have a national exemplar site, the Institute of Rural and Coastal health, which directly addresses one of the key challenges we face which is health inequalities in those areas of our county.

We have a formal MOU with the University and supported the successful E3 bid for the University of Lincoln to establish England's first integrated/transdisciplinary research centre for Coastal and Rural Health Research. This centre will tackle serious and urgent geographical inequities impacting on physical, mental, social, and economic health and wellbeing. A national powerhouse will be created to generate critical intelligence and tested solutions for implementation. The centre will build on the excellence and demonstrated success of the Lincoln International Institute for Rural Health (LIIRH) through synergised and scaled up connections with Lincoln's Community and Health Research Unit (CaHRU), and the Development, Inequality, Resilience and Environments (DIRE) group from the Department of Geography. This is part of the strategy to significantly increase our research capacity.

Additional initiatives are for another bid for Health Determinants Research Collaborations led by our Director of Public Health.

Please see this poster below as an example of our symbiotic relationship with the University of Lincoln and the commitment in Lincolnshire to provide a platform to exchange ideas on sustainable development challenges that brings national recognition and speakers to share impactful policy ideas beyond academia.

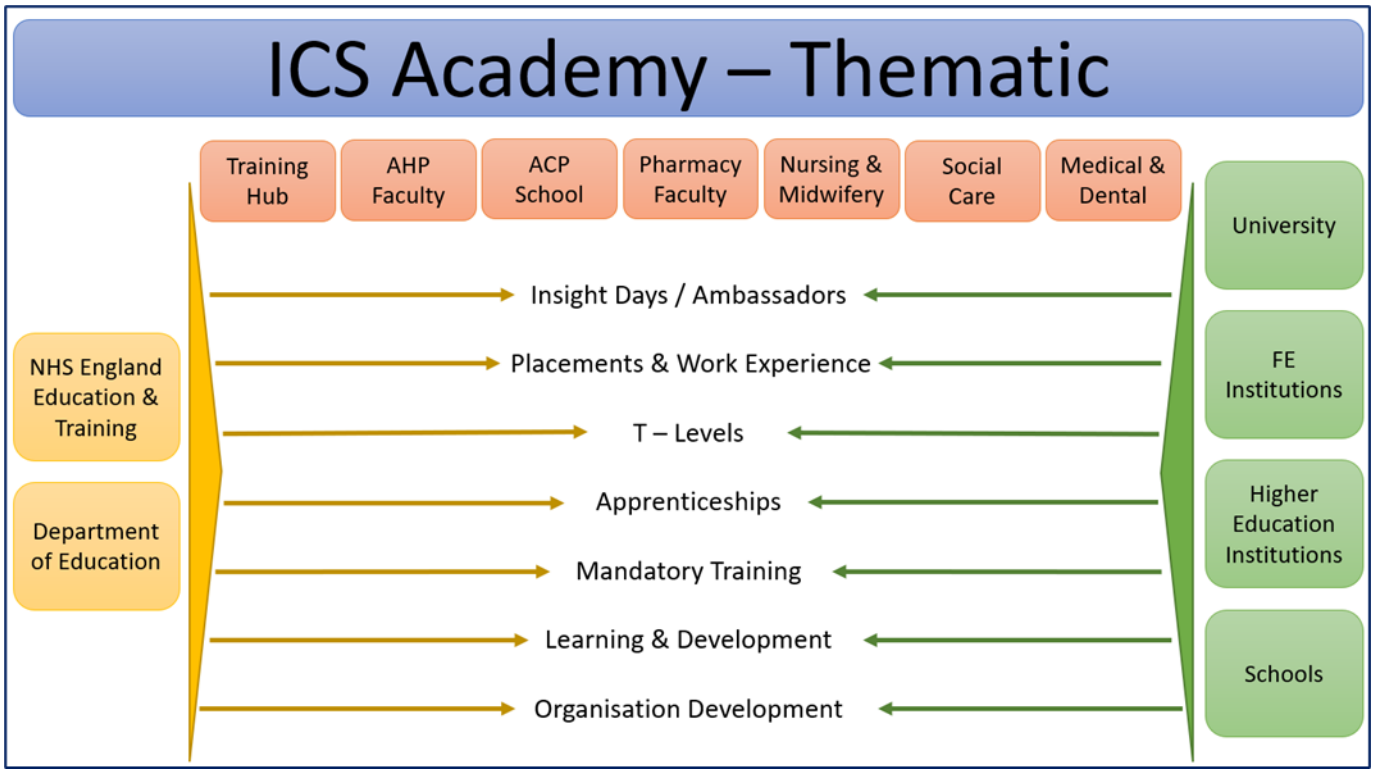
Duty to promote education and training

Each ICB must have regard to the need to promote education and training so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.

The Duty to promote education and training is delivered jointly with partners across the NHS in Lincolnshire through the People Board which has an ambition to create and embed an ICS Academy. The Academy will be a key enabler to support our Health & Wellbeing work at 'System', 'Place' and 'Local' level so that we can attract, develop and retain the best people through education, learning & development that meets our system strategic objectives for a 'One Workforce'

The creation of an Academy will enable us to work beyond individual organisational boundaries to maximise our workforce talent, build greater capacity and capability and help improve outcomes in health and social care.

We will also partner with other enabling functions which will link into the Academy such as Quality Improvement, Digital Innovation and Research.



Developing our people is a theme in the Lincolnshire People Plan and this theme not only includes how we aim to invest in identifying the talents and skills of our existing staff, but also those in our pipelines for the future. Our ambition is that our ICS Academy will provide a 'one-stop' place for us to make multi-professional decisions in the investment of our people development activities. This includes a set of Faculties and enabling functions. We are on the journey to describe and establish this.

Duty as to climate change

Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, and all Trusts, Foundation Trusts, and Integrated Care Boards to contribute towards statutory emissions and environmental targets. The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

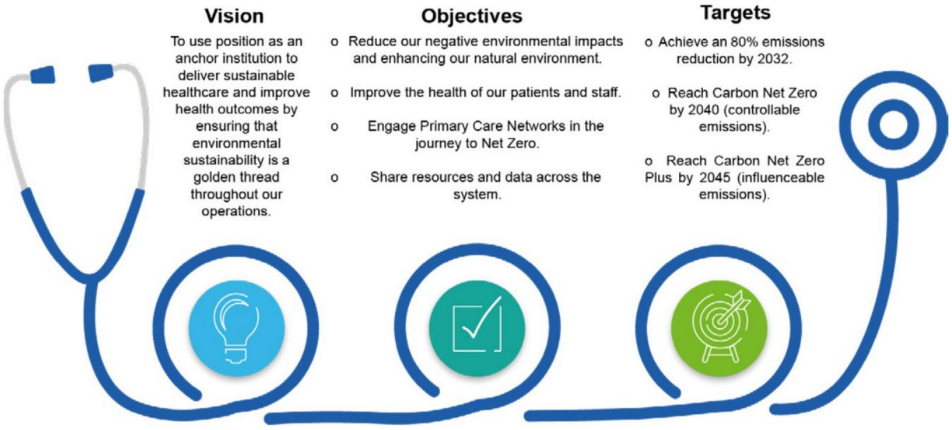
Climate change and its effects on the environment, and the health and wellbeing of the population is now recognised on a global scale. Lincolnshire is not immune to the health harms and impacts of climate change. As a coastal county, some areas of our region are under serious threat of flooding from future rising sea levels, making this issue even closer to home. Responsibility for tackling climate change and reducing carbon emissions cannot be achieved by government or governing bodies alone; everyone needs to play their part and contribute, no matter how small the contribution. Across the NHS in Lincolnshire and with our County and District Council partners, we are steadfast in our resolve to really make a difference and achieve our collective net zero carbon targets and ambitions. We are working together and recognise the benefits and opportunities that a Greener NHS can have on health inequalities, improving social value and our roles as anchor partners. We have adopted the Lincolnshire County Council three guiding principles:

- Do not waste anything
- Consider wider opportunities
- Take responsibility and pride

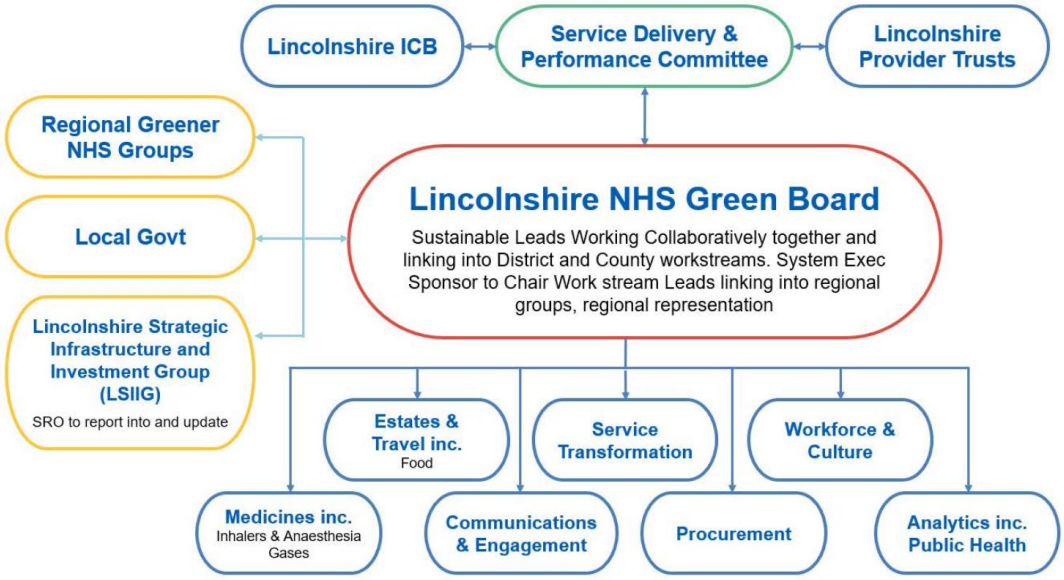
Each Trust and the ICB are meeting this new duty through the delivery of localised Green Plans- approved by Boards and overseen by a Senior Responsible Officer.

Our ICB Green Plan supports our net zero ambition, it sets out the aims, objectives, and delivery plans for carbon reduction. The link to our Plan is Slide 1 (icb.nhs.uk). The ICB 'net zero lead' is Sarah Connery the CEO of LPFT responsible for overseeing its delivery.

Our Vision and ambitions are as follows:



We have a System Lincolnshire NHS Green Board – the structure is set out below:



We recognise that sustainability impacts on all that we do in terms of changes to services and capital projects. We have agreed to use a single Sustainability Impact Assessment.

NHS Lincolnshire is working meaningfully towards the United Nations (UN) Sustainable Development Goals (SDGs) through our Green Plan, which we have aligned to relevant SDG targets. The SDGs underpin a global action framework to 2030, adopted by every UN member country to address the biggest challenges facing humanity. Each goal has targets and indicators to help nations and organisations prioritise and manage responses to key social, economic and environmental issues. We have considered how the System can contribute to the SDGs, as well as how sustainability objectives contribute towards the delivery of this strategy.

The NHS and its people contribute to multiple SDGs through the delivery of its core functions

Issues relating to our Estate – The NHS Net Zero Building Standard, published on 22nd February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet

the needs of patients now and in the future. There is an NHS Net Zero Travel and Transport Strategy NHS England » Net Zero travel and transport strategy published in October 2023 The NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040.

This strategy describes the interventions and modelling underpinning these commitments, walking through each of the major components of the NHS fleet and outlining the benefits to patients and staff. A forthcoming net zero travel and transport implementation toolkit and technical support document will also be provided to trusts and systems to aid local and regional delivery.

Addressing the particular needs of children and young persons

The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25

Lincolnshire recognises the importance of engagement with a range of partners across the system if the health and care needs of children, young people (CYP) and their families are to be appropriately met. Whilst a CYP Health Strategy for Lincolnshire 2019-2025 has been in place for a number of years and progress against priorities in this document has been made, it was recognised by Lincolnshire system partners that the landscape had changed during COVID. This led to a review and refresh in 2022/23 of the priorities being supported and led by the CYP Integrated Transformation Board.

The CYP Integrated Transformation Board is in place to provide strategic oversight of CYP services in Lincolnshire, with the aim of transforming pathways across health and care, incorporating education and facilitates everyone working together to maximise the health and wellbeing of all children and young people, ensuring the voice of CYP and families is heard throughout the work. The Board brings together representatives from a range of partners including Lincolnshire's Integrated Care Board (ICB), Lincolnshire County Council (LCC) Children's Services and Public Health, Lincolnshire's NHS Providers and the Community and Voluntary Sector, including representation from individuals who have lived experience from a patient or carer perspective. Representation at the Board includes the ICB Director of Nursing, who is the health Executive Lead for CYP and Lincolnshire County Council Director of Childrens' Services.

The Board is aligned to Lincolnshire's Integrated Care System and Long-term Plan with the aim of maximising the health and wellbeing of, and reducing health inequalities among, children and young people in Lincolnshire, including supporting a seamless transition into adulthood. Within this context the CYP Integrated Transformation Board agreed through its work in 2022/23 the following overarching objectives:

- Prioritise prevention and early intervention to reduce the need for health care and improve outcomes for CYP and their families and carers.
- Collaborate and co-produce to ensure health care is integrated, respectful and responsive to the needs of CYP and their families and carers.
- Ensure services are accessible, seamless, sustainable, and financially viable for the future whilst continuing to meet best possible quality and safety standards.

CYP Integrated Transformation Board has a number of priorities that were agreed through the Board development work that took place in 2022/23 and through emerging themes in 2023/24, which align to the predominant health needs of our local CYP population in Lincolnshire and correlate with the national priorities identified by NHSE and monitored through the Midlands regional CYP Transformation Board. These CYP priorities are:

- Epilepsy
- Asthma
- Diabetes
- Urgent & Emergency Care
- Transition

Programmes of work for these priorities are being established to ensure there is engagement of appropriate system partners and professionals with the relevant expert knowledge, alongside the opportunity for co-production with CYP and their families.

Palliative and End of Life (PEOL) has some specific elements that focus on the needs of CYP, and it has been agreed these will form an additional priority overseen by the CYP Integrated Transformation Board, with reporting linked through to the Lincolnshire PEOL programme to ensure there are appropriate connections with the wider care pathways, particularly in relation to transition of CYP into adult services.

Over a third of Lincolnshire children are overweight or obese, which is above both the regional and national average. Childhood obesity has both immediate and long-term negative effects on a child's wellbeing. Obese children are more likely to be obese in adulthood, with an increased risk of adult health problems such as type 2 diabetes, heart disease, stroke and cancer. The NHS Long Term Plan (2019) advocates increasing treatment services for extremely overweight children. The multiplicity of and inter-relationship between the causes of unhealthy weights make this a difficult are to address and requires a joined up, long-term approach. The Board will support local and national initiatives to tackle childhood obesity.

Deteriorating mental health in CYP across the UK was present before the pandemic and has worsened during it, with mental health problems disproportionately affecting children suffering financial hardship. There is a need to ensure CYP have timely access to appropriate crisis and mental health services, with resources directed into early intervention and prevention, building resilience and ensuring that professionals are trained to spot the signs of mental ill health, such that they are equipped to support children and refer appropriately.

Within Lincolnshire our emotional wellbeing services have a positive impact on reducing referral rates to Children's and Adolescent Mental Health Services (CAMHS) locally, although in line with the national picture there have been sustained higher referral rates across all services following the pandemic. Whilst locally there has been increased investment in early, low to moderate intervention and more preventive and community support for CYP, there is ongoing work to look at how Lincolnshire can best meet the increased mental health needs of CYP.

Responsibility for delivery of the Lincolnshire CYP Mental Health Local Transformation Plan sits with the 'all age' Mental Health Learning Disability and Autism (MHLDA) Programme Board, however, the CYP Integrated Transformation Board has committed to ensuring there is appropriate CYP representation and support to the programme. Key priorities of the MHLDA Programme Board relevant to CYP include the:

- Lincolnshire CYP Emotional Wellbeing and Mental Health Review and Transformation Programme
- Further roll out of Mental Health Support Teams (MHST)
- Development of an Autism all age pathway

Integral to all the CYP work within Lincolnshire is an understanding of the need to address health inequalities. Publication of NHSE CYP Core20PLUS5 has provided opportunity to consider the profile of this within the context of the agreed Lincolnshire priorities. It has been agreed the CYP Core20PLUS5 clinical areas of health inequalities and their associated deliverables will be developed within the respective workstreams (asthma; diabetes; epilepsy; oral health; and mental health) whilst governance and oversight of the whole CYP Core20PLUS5 will sit with the CYP Integrated Transformation Board. Further work will take place during 2023/24 to establish PLUS population groups relevant to Lincolnshire programmes of CYP work.

Lincolnshire has well established arrangements in place for Special Educational Needs and Disabilities (SEND), which ensure the local system partners are sighted on the needs of CYP, within the context of their respective statutory duties, supported by leadership and governance arrangements that facilitate collaborative working to meet the needs of CYP. The governance for the Health SEND Committee and the Lincolnshire County Council Steering Group both report into the CYP Integrated Transformation Board and inform the strategic priorities of the Board.

Lincolnshire ICB and Lincolnshire County Council have well established integrated commissioning arrangements for CYP that support delivery of the priorities agreed through the CYP Integrated Transformation Board and (MHLDA) Programme Board.

It is recognised within Lincolnshire that safeguarding is a collective responsibility, whilst individuals and organisations have distinct roles, the system cannot operate effectively unless individuals and organisations work together. Due to the continued co-terminosity of boundaries for police, local authority and health, Lincolnshire has retained its local partnership safeguarding arrangements through transition into an Integrated Care System (ICS). Oversight is provided by the Lincolnshire Safeguarding Children Partnership (LSCP) and within the ICS there are connections with the other safeguarding partnerships, including Safer Lincolnshire Partnership and

Lincolnshire Domestic Abuse Partnership, to ensure the needs of CYP are appropriately considered within the context of the wider safeguarding partnership priorities.

The LSCP Business plan for 2022-2025 identifies the partnership strategic priorities as:

- Tackling Child Exploitation
- Enhancing the Emotional Wellbeing of Children and Young People
- Promoting Healthy and Respectful Relationships
- To identify and reduce the impact of neglect on children and young people
- To identify and reduce the impact of sexual and physical harm
- To identify and reduce the impact of Domestic Abuse on children, young people and their families

All partners, including health, will continue to engage in the work required to progress these priorities, undertake review of achievement and participate in future priority setting.

Over half of Looked After Children (LAC) have entered care due to suffering abuse or maltreatment, with care-experienced children having poorer health, developmental and quality of life outcomes compared to children who are not in care. The local health system supports well-coordinated, targeted health services for LAC which address the variety of health problems of these vulnerable children and young people. Care leavers are particularly vulnerable when transitioning into adulthood and out of care and the local health system works with partners in facilitating the provision of transitional support and resources to this group.

The Safeguarding Accountability and Assurance Framework (SAAF) identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations. The NHS organisations within Lincolnshire will continue to use this framework to demonstrate compliance with their statutory safeguarding responsibilities.

Addressing the particular needs of victims of abuse

The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions

The draft Victims Bill published May 2022 will mean, if passed, that outreach and support services will be statutory. This Bill places a new duty on Local Authorities, Police and Crime Commissioners (PCC) and Integrated Care Boards (ICB) to collaborate when commissioning support services for victims of domestic abuse, sexual abuse and serious violence, to facilitate more holistic and coordinated support services.

The Domestic Abuse Act 2021 requires Tier One Local Authorities to appoint a multi-agency Domestic Abuse Local Partnership Board, which assesses the need, and commissions support for all victims and survivors of domestic abuse, including children. The makeup of Local Partnership Boards can vary across areas, but as a minimum, the Boards include members from across the system, representing Local Authorities, victims and survivors and their children, domestic abuse charities or voluntary organisations, health care providers, and the police or other criminal justice agencies. Within Lincolnshire the Domestic Abuse Partnership includes representation from the ICB and the three NHS / Foundation Trusts.

During 2022/23 the ICB participated in work undertaken within Lincolnshire to develop and commission an outreach service model to support the victims of domestic abuse that includes:

- A Universal digital based support offer to all victims of domestic abuse in Lincolnshire
- A Support Hub, including helpline, effective triage function and strength-based assessment provision
- Partnership, Outreach and Engagement Team
- Community based Adult Support Interventions including complex needs pathway
- Community based Children and Young People support interventions
- Recovery Support
- An IDVA (Independent Domestic Violence Advisers) Service

Following a successful procurement process, which included victim and survivor representation, a contract for the new outreach service was awarded from April 2023. Processes are in place to monitor the uptake and impact of the new model as the service develops. Through the Lincolnshire Domestic Abuse Partnership arrangements health partners will continue to engage in the focus on victim support and consider how referral and sign posting to the outreach service can be strengthened by increasing knowledge and awareness of health professionals and practitioners. Through the partnership the ICB will also continue to engage in the work being undertaken by the Perpetrator Project Group and will liaise with health partners as required by the work programme.

Lincolnshire's proposed perpetrator response consists of a multiagency perpetrator management approach, a behaviour change programme, victim support response and an education and training programme for children, young people, professionals and the wider community. The ICB will participate within this multiagency forum and will support its rollout.

Work undertaken as part of the outreach service model development highlighted the importance of tackling domestic abuse through the lens of violence against women and girls. Many forms of these crimes take place within the context of domestic abuse, including stalking and harassment cases and sexual offences. Within Lincolnshire there is work taking place to tackle violence against women and girls (VAWG) led by the police. The work being undertaken is helping to build victim profiles and factors associated with VAWG. Through its representation on the Lincolnshire Domestic Abuse Partnership; Safer Lincolnshire Partnership; and the Serious Violence Core Priority Group (CPG) the ICB is sighted on the work happening as part of VAWG and any themes that may be highlighted relevant to the local health partners.

The Serious Violence CPG was established in 2022/23 under the governance arrangements for the Safer Lincolnshire Partnership, in response to the Serious Violence Duty under the Police, Crime, Sentencing and Courts Act 2022, which includes responsibilities for appropriate commissioning (and co-commissioning) within the local health system to prevent, treat and manage serious violence as set out in its strategy and where possible, (co-) commission support services for those at risk of or involved in serious violence. The ICB has been represented on the Serious Violence CPG since its inaugural meeting in 2022/23 and will continue to represent health in this forum. During 2022/23 a Serious Violence strategic needs assessment was undertaken, using a public health approach and is referred to as the Lincolnshire Violence Reduction Needs Assessment (VRNA). From this assessment work has taken place to develop a Serious Violence Prevention Strategy and priorities for this were informed by outcomes of data analysis, a review of evidence of best practice, and stakeholder interviews in the VRNA.

All of the safeguarding partnerships hold responsibilities relevant to the support of victims, in particular the Lincolnshire Safeguarding Children Partnership (LSCP) Business plan for 2022-2025 identifies its partnership strategic priorities include:

- Tackling Child Exploitation
- Identifying and reducing the impact of neglect on children and young people
- Identify and reducing the impact of sexual and physical harm
- Identify and reducing the impact of Domestic Abuse on children, young people and their families

From a health perspective there are a range of support and care pathways that have been commissioned and provide assessment and support to victims. Whilst some specialist elements are commissioned by NHSE, such as the Sexual Assault Referral Centre (SARC) delivered by Spring Lodge in partnership with Lincolnshire Partnership NHS Foundation Trust, there are also services commissioned locally through health, either as specific services to support victims, or that incorporate meeting the health needs of victims through wider service scopes. An area of particular focus is Child Protection Medicals and the ICB agreed, through the LSCP, to establish a task and finish group to review current arrangements within Lincolnshire and the outcome of the work has been the development of a documented local process for child protection medicals.

Workforce

Evidence-based, integrated, inclusive workforce plan that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans

Over the last three years the Lincolnshire ICS has been developing its People Plan in line with the National NHS People Plan and more recently on the ten People Functions set out in the 'Building strong integrated care systems everywhere: guidance on the ICS people function' guidance. The diagram below shows the iteration of the plan over the first three years:

Towards 'One Workforce' – timeline for the People Board

2020/21

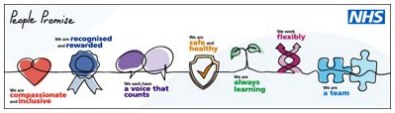
- *COVID-19 presented opportunities to really develop **relationships** across health and care – particularly as we responded to the pandemic in Lincolnshire*
- ***Partnership working**, collaboration and shared endeavours certainly moved forward*
- ***The first People Plan 20/21** came from this collaboration and set the scene for future working*

2021/22

- *The workforce cell progressed into the **'People Team'** as a strategic leaders group reporting to the People Board.*
- *Senior people leaders within the People Team provided strategic oversight for the **four pillars of the 21/22 People Plan** in addition to their roles in provider organisations.*
- *Further engagement with wider **system partners** e.g., Lincolnshire Care Association (LinCa), Primary Care and the Voluntary sector has progressed well*

2022/23

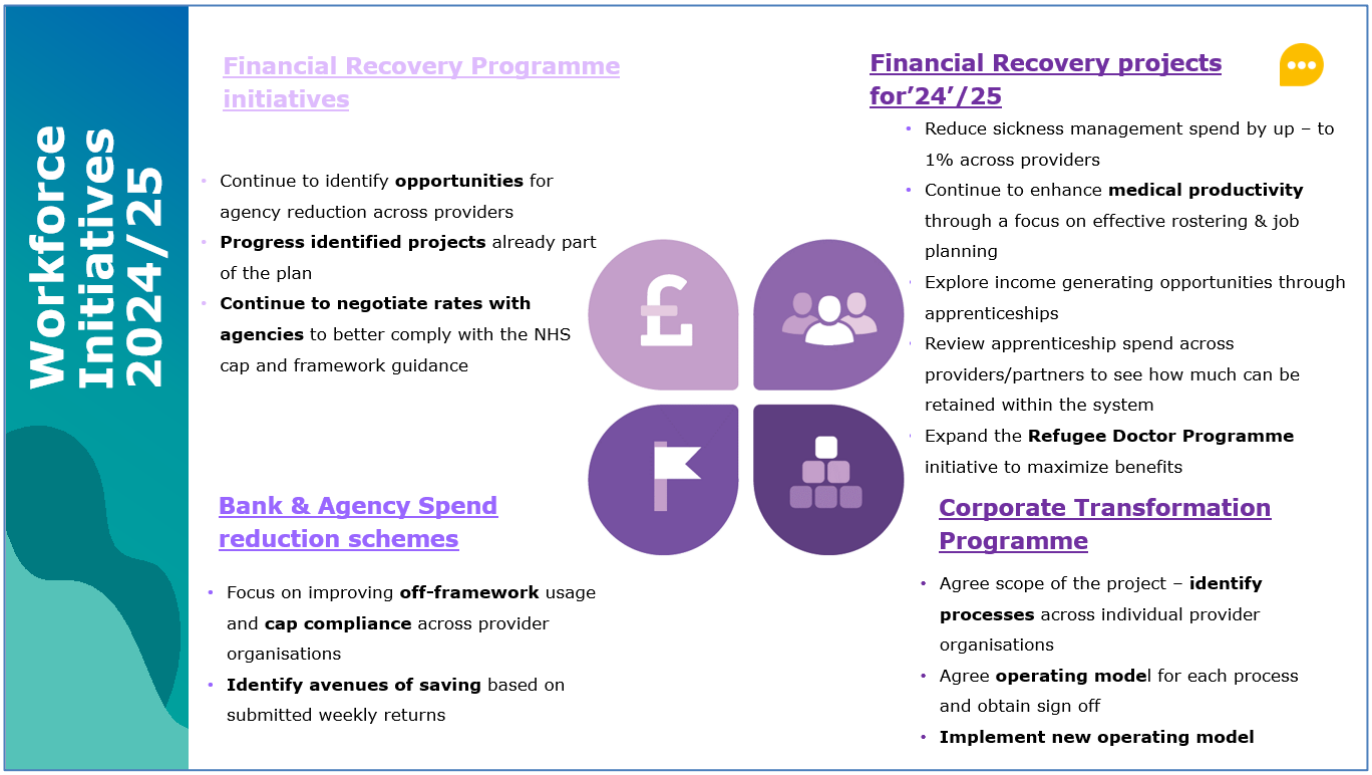
- ***There is now the requirement and foundation on which to deliver key people priorities,***
- ***Lincolnshire is looking to build on the strengths of collaboration in delivering the 2022/23 People plan, now incorporating the People Hub – Centre of Innovation.***



For 23/24, the System People Plan is continuing to look to progress an ambitious programme of innovations that will be offered System wide and will concentrate on the integration of all sectors within the ICS.

The highlights of the People Plan 23/24 are shown in the diagram below:

Alongside this plan the System is also looking to address a number of specific workforce issues that are outlined in the diagram below:



For 23/24 the ICB have invested in the Lincolnshire People Hub, to take forward a number of the projects outlined in the People Plan and the Workforce Plan. This is the engine room for our People Innovation:

As an example of some of the specific areas we are looking to address the ICS has invested in a workforce planning tool to ensure the integrated and evidence-based workforce plan that will ensure the right people in the right place at the right time. The tool allows for scenario development to understand the impact of operational

decisions (such as care closer to home) on the size and shape and skillset of the workforce across the Providers, primary care and in the future social care.

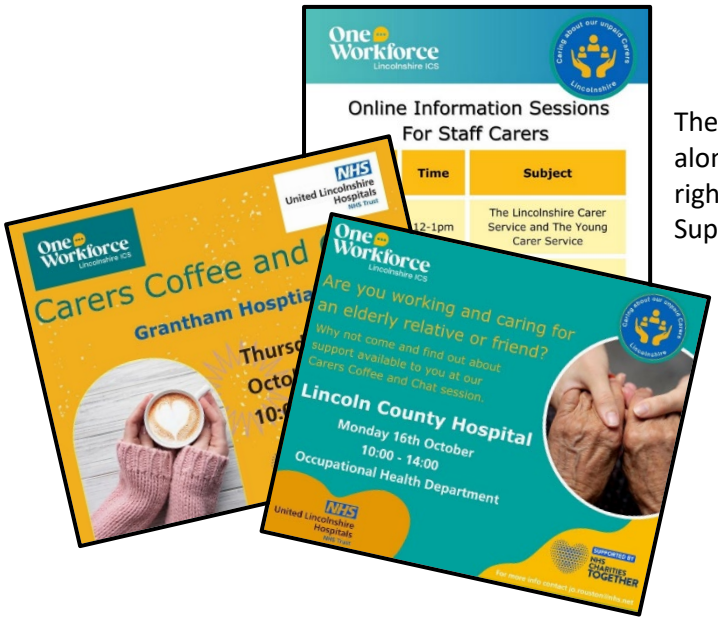
Through the 'Developing our People' Theme we will be developing an understanding of Leadership across the whole of the ICS and working with all sectors to enable an integrated approach to our Leadership offer. This will build on the excellent work that we are already doing through programmes like Mary Seacole, where all sectors of Health and Social Care come together.

As part of our Attraction campaign, we have the Be Lincolnshire website where we showcase living and working in Lincolnshire. With contributions from across Health and Social care it is a showcase for the work that we do and will be further developed to be the front door for our recruitment. Moreover, this year we are working to enhance our System wide offers for all aspects of Health and Wellbeing – knowing that if our people look after themselves, they will be there for our patients.

How well has the ICB looked after its people?

As part of our People Plan we have been looking at all the ways we can look after our People, whether that is about how their health and wellbeing, their feeling of belonging or even the things we can offer to develop and retain them. The following paragraphs outline a few of the projects that we have working on to make sure that our staff want to stay with us.

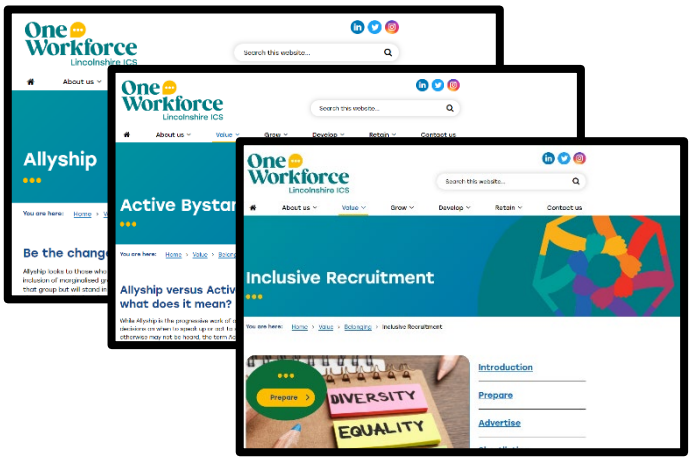
As part of a System wide project to enhance the support to our staff who are also unpaid carers, we have partnered with EveryOne to conduct a project funded by NHS Charities. The Engagement with the Carer's project continues to grow with the online community showing a steady increase. The combination of specific Carer's events and promoting the offer at other events has allowed the team to engage with a wider audience. Engagement this quarter has included the 'I care too' campaign; this has been launched to coincide with Care's Rights Day.



The project promoted their online information events alongside our partnership organisations, to outline carer's rights. And there has been an agreement to conduct Peer Support training in partnership with SHINE.

The Carer's Passport has also been in development and this will be going to partner organisations in Q4 to start looking at plan for adoption.

The work within Value our People hasn't stopped there. Following the success of the Allyship Tool kit, it has now found a new accessible home on the One Workforce website; allowing people to adapt the formatting to their individual needs.



This is now sitting alongside The Active Bystander, Psychological Safety, System Networks and Inclusive Recruitment Toolkits in the Belonging section of the One Workforce site.

[Belonging :: Lincolnshire One Workforce (oneworkforcelincs.co.uk)]

Within the Wellbeing projects, work has continued on the Women's and Men's Health and Wellbeing areas. Including some great progress working in collaboration with the ULHT Women's Group to create a full System Women's Health offer. Moreover, the inclusion of the Oasis Project and the extensive training offers available from the Staff Wellbeing Hub has made the One Workforce Wellbeing page the one stop shop for all staff.

Check out all the Wellbeing offers here:
[Health and Wellbeing :: Lincolnshire One Workforce (oneworkforcelincs.co.uk)]

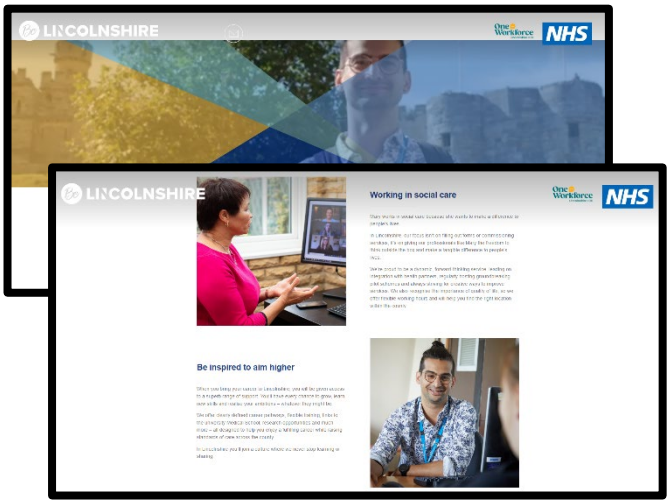
How has the ICB promoted new ways of working and delivering care?/ How has the ICB contributed to growing the NHS workforce?

The System has been developing a number of new ways of working and has concentrated on our whole system working. By looking at ways that we can recruit and retain together we are ensuring that people will stay within the Health and Social Care family ensuring the best care for our population.

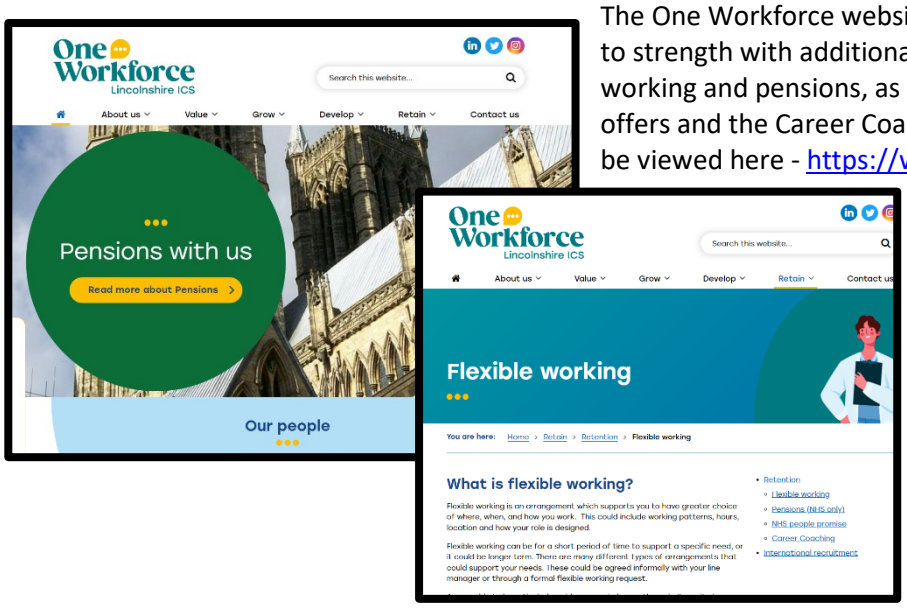
This approach covers our Attraction into the System as well as Retaining the staff that we have. Moreover, we have been developing a collaborative group to grow our people – developing new career pathways and apprenticeship opportunities that will help people reach their full potential.

The Be In Lincolnshire web presence continues to grow and develop. This is a coordinated site where people can look for careers in all areas of Health and Social Care. And where they can read about other's experiences of living and working in the county. Moreover, conversations are ongoing with organisation including Primary Care to develop a targeted recruitment campaign for hard to recruit roles and locations.

The website can be accessed here - https://www.beinlincolnshire.com/



The system has developed the One Workforce brand that has continued to be embedded in partner organisations across the System. A significant amount of work has gone on to include the Pharmacy and AHP faculties in the branding and they have been using it extensively. The story of the People Team work and the One Workforce Brand was also featured in the Public Sector Focus magazine. You can read the article here - https://flickread.com/edition/html/index.php?pdf=6538e23f7270c#26 (pages 26-27).



The One Workforce website has continued to go from strength to strength with additional information added on flexible working and pensions, as well as details of the System Benefit offers and the Career Coaching opportunities. The website can be viewed here - https://www.oneworkforcelincs.co.uk/

The work that the system has been undertaking to Retain our People has continued to show positive results on the Retention statistics for the 3 Provider organisations. But not resting on our laurels, the People Hub have continued the focus on retention with the publication of a benefits booklet that is applicable to members of staff across heath and care.

All 3 providers in the system has achieved Timewise accreditation for flexible working and are continuing to share their experiences with other organisations.

The system has introduced a Career Coaching offer has gone from strength to strength with over 60 personnel currently within the coaching cohort; with participants from all 3 providers, the ICB and Social Care. This will continue to grow and has seen the majority of the attendees either staying in their current role with a clearer vision of where they are going, or moving on to other roles within the system.

Performance

Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate.

As an Integrated Care System, we continue to develop our approach with partner organisations for self-assurance and regulation against national performance standards. Our Health and Wellbeing Board plays a role in holding the ICS to account for delivery of our jointly agreed plans and our ability to positively impact outcomes for our population. The Health Overview and Scrutiny Committee continues to play an important statutory role in scrutinising major service change.

The Lincolnshire system has established governance for programmes through partnership boards which are inclusive of our border providers. The delivery of both plans and performance is monitored monthly by the ICB System joint committee for Service Delivery and Performance, membership includes Executive Directors from across the system and Non-Executive Directors from both the ICB and our main NHS providers. Underpinning the Committee there are various oversight and delivery groups, a clinical reference group along with specific task and finish groups to support delivery and performance at programme as required. We continue to expand on our principles of a one system approach, role modelled throughout the pandemic to secure continuous improvements in system performance and reduce unwarranted variation.

A publicly available ICB Integrated Performance Report is tabled at the ICB Public Board meeting. This monthly report is available to the public on the NHS Lincolnshire ICB website.

In addition to formal Board reporting system performance is also routinely considered at:

- Monthly Service Delivery & Performance Committee meetings: reporting progress against national priorities and system strategy captured in the annual operational plan and JFP Delivery Plan 2023-2028 (available on the ICB website)
- Quality Patient Experience Committee (escalations from Operational Quality Groups)
- Weekly updates to the ICB Executive
- Fortnightly Financial Leadership Group
- Monthly People Team meeting
- Weekly system CEO meeting

Digital/data

Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.

The combined vision for digital in the ICS is 'Digitally enabled staff, digitally empowered population.' To achieve this ambition there are five agreed objectives:

- Ensure strong foundations for technology enabled care
- Drive digital readiness and digital inclusion
- Use information to empower decision making and improve outcomes
- Enable improved health and care delivery and outcomes
- Provide public facing digital services

These objectives support the goals of reform in "A plan for digital and social care."

As we start to deliver this strategy in Lincolnshire we will be *equipping the system digitally for better care* through improving our technical infrastructure, converging and sharing the provision of our digital services. We will continue to improve our digital maturity through initiatives such as:

- Completing the implementation of our Electronic Prescribing and Medicines Administration systems,
- Implementing an Electronic Patient Record at the acute hospital,
- Continuing to develop our already extensively used Shared Care Record including sharing this with the East Midlands Ambulance Service, and
- Increasing digital health solutions that enable sharing and interoperability of electronic systems, for example implementing a Customer Relationship Management System within voluntary services to improve the ability to use social prescribing, voluntary and community groups and volunteers.

These activities will enable sharing of information to those clinicians and professionals involved in health and care delivery so that they have the information they need, where and when they need it to provide timely and appropriate services.

We will *support independent healthy lives* through improving the digital systems that support social prescribing, which will result in this information becoming part of the digital eco-system available to all those who provide services. We will continue to scale our work on digital care plans that are co-produced, visible and accessible to all involved in a person's health and care. We will allow all those involved in health and care including those across voluntary services and care homes to access relevant information through the Shared Care Record that supports them in making better and more timely decisions.

We have established a group specifically focused on digital inclusion, to ensure that we support all those for whom digital solutions are an appropriate option. We acknowledge that for some digital health solutions they will not always be the way that they interact with services. However, we recognise that digital health solutions are key to transformation and an ability to cope with rising demand. Digital health solutions can bring efficiencies and support process change, that will then allow us to provide a range of appropriate access and interactions that see the majority using digital health channels.

We will *accelerate adoption of proven technology* building on our existing remote monitoring and wearable technology initiatives, schemes and research. We will share our data through secure data environments at a regional level to support research. Supported by national funding we will further develop the functionality of our patient facing digital solutions that enable patient engagement in relation to booking management, pre-operative assessments and visibility to the individual of health and care information in records held. We will use the NHS App and national services such as NHS Login in combination with digital health solutions designed for our local population.

We will *support the workforce* building the skills of our digital teams as we start to use new technologies and methods such as cloud-based services, robotic process automation and improve our cyber security. But, of course, the success of digital health solutions depends on the entirety of our workforce having the digital literacy and confidence to use new technology and use it safely, so we will be aiming to educate, build confidence and support staff in digital solutions through process change support, clinical engagement, communication, digital champions and online 'how to' resources.

Estates

Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.

Lincolnshire ICS have reviewed the system-wide estates and infrastructure challenges and acknowledges that a "do nothing/do minimum" approach is not sustainable. We have significant issues with our current estate and are developing our infrastructure plans to modernise our NHS infrastructure across our whole system for the next 15 years; providing the right care in the right place to meet demand, creating supply chain and job opportunities. We recognise the need to deliver change and to attract significant capital investment across the system.

Lincolnshire ICS has, with external support, developed a strategic health framework/strategy and evidence base to provide a strong case for health infrastructure investment in the county.

To develop a future healthcare system that is financially sustainable and able to deliver the growing needs of the population, Lincolnshire ICS constituent partners who provide Acute, Community, Primary and Mental Health services along with Local Authority and Voluntary Sector partners are working together to develop a systemwide service that is joined up and aligned:

This strategy acknowledges the following key issues and challenges currently affecting the delivery of healthcare across the system;

- **Geographical disparity** - Clinical services are not currently in the right place to meet patient demands. Geographical challenges with the rural nature of the region, with a lack of infrastructure; compounding issues with accessibility to services
- **Current health inequalities** and health deprivation- One of the gravest inequalities faced by our most disadvantaged communities is poor health. Eastern coastal towns, such as Mablethorpe and Skegness, and urban areas, including Lincoln and Gainsborough, tend to have higher levels of deprivation and poorer healthcare outcomes across the lifecycle. For instance, in East Lindsey, over one in four people have a long-term limiting illness and 73% of adults are obese or overweight. In Lincoln, deaths in people aged under 75 are due to preventable causes which is 35% above the national average.
- There is **low healthy life expectancy** of under 60 years in coastal areas, including the towns of Mablethorpe and Skegness.
- **Significant backlog maintenance** across the system, with costs in the order of **£382m** projected.
- **An aging estate and poor digital infrastructure** - We have significant issues with our current estate and are developing our infrastructure plans to modernise our NHS infrastructure across our whole system for the next 15 years. Limited significant investment across the system in recent years has resulted in compromised patient outcomes.
- **Workforce allocation efficiencies** – With the existing resources often addressing reactive needs rather than preventative aspects of care.
- **Ageing population** - The population aged above 65 is anticipated to increase by approximately 37% over the next 20 years with the proportion of this age group anticipated to increase also from circa 23% in 2021 to 31.5% in 2041. (Other age groups remain at a similar level). This will compound the pressures on the healthcare system.
- Lincolnshire ICS is a **financially challenged system** and estate utilisation efficiency savings in clinical and non-clinical space needs to be part of our financial recovery.
- There are opportunities for **innovation and technology upgrades** to support the delivery of services to a dispersed and rural population.
- There are risks that are current poor estate inhibits our ability to deliver the Greener NHS **Net Carbon Zero** targets

We acknowledge our system partners have been successful in securing investment for key investments such as improvements to Urgent & Emergency Care facilities at Boston and Lincoln, provision of new acute inpatient mental healthcare facilities in support of the eradication of dormitory accommodation and our plans for community diagnostic centres, building on our first one in Grantham. The planned Integrated Health and Care Centres in Sleaford and Boston are further examples of how our partners propose to integrate services, prioritise proactive care closer to home, support the reduction of health inequalities, and generate social value for the community. However, this will not make the transformational step change that is needed.

As agreed with our system partners, Lincolnshire ICS has developed a strategic infrastructure framework, underpinned by clinical strategies. This work reflects a strategic health narrative and evidence base to provide a strong case for health infrastructure investment across the system. This work has been undertaken to:

- Set the framework to enable each Trust and Primary Care within the system to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs across Lincolnshire.
- Support the production of capital investment plans for Trusts within Lincolnshire and places and help ICSs to aggregate and prioritise requirements against other system demands for capital.
- Comply with the requirements of the Fundamental NHSE Business Case and Estates Criteria to have a system wide Estate strategy, to set the strategic context to which all Organisational level business cases will sit.
- Application of Net Zero Carbon Building Standards (February 2023) and Digital First principles to comply with national policy and ambitious infrastructure agendas.
- Comply with advice as set out in 'Planning, assuring, and delivering service change for patients' (2018) paper.
- Enable ICS support for future Business Case submissions where they align with the system wide strategy

This framework supports the *Levelling Up* agenda - as a system it is critical that we improve productivity, boost economic growth, encourage innovation, create good jobs, enhance educational attainment, and renovate the social and cultural fabric of those parts of the UK that have stalled and not – so far – shared equally in our nation's success.

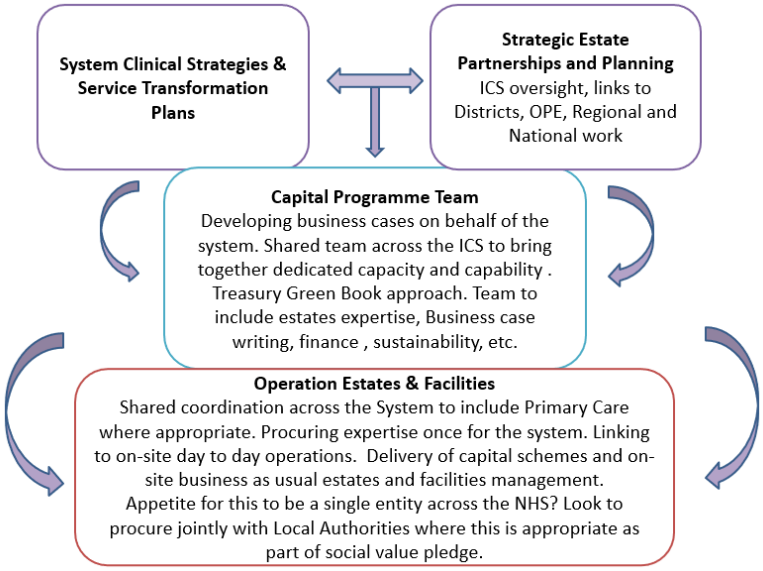
The framework will support the Clinical Strategy developments across the ICS. It is designed to support these discussions with the aim of highlighting the quantum of capital that is needed to transform the estate to meet clinical and population needs.

As part of us developing future estate and facilities we are actively working with system partners on integration opportunities. These include Levelling Up opportunities- such as the South Holland Castle Sports Centre development that will include space for social prescribing and other community services and the "PE21" and Sleaford integrated health and care facilities.

We recognise the part we, as the NHS, can play in support of economic sustainability. As an active member of the Greater Lincolnshire One Public Estate Board we work closely with partners to maximise opportunities that presents. The roll out of Community Diagnostic Centres supports our plans for expanding community-based services. Through our partnership working we are looking to develop a hub and spoke model on the east coast on regeneration and brownfield sites that offer the appropriate access and parking.

Rationalising our corporate estate across the ICS is a systemwide agreed approach and work is underway to support this. There is a room and desk booking system that partners have agreed to use that is compatible with that being used by Lincolnshire County Council.

The provider estates and facilities teams have been working in a more collaborative and integrated way. There is a Lincolnshire Operational Estates Group that reports into the Lincolnshire Strategic Infrastructure and Investment Group. LCHS and LPFT already have a shared service and have been supporting the ICB and Primary Care providing expertise on estates and lease issues. The vision is to further develop these opportunities in line with the following model:



We recognise that collaboration across all system partners will improve and maximise opportunities for investment to the county. It also supports the utilisation and efficient use of our existing estate. This is an overarching strategy which underpins further work across the system over the next 10-15 years.

Supply chain

Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.

Our overall approach to healthcare provider selection and goods and services procurement is designed to deliver best value for money. The ICB will retain oversight and accountability for selection and procurement spend with the allocation of totality of system funding discussed and prioritised through joint working structures with key providers and spend of limited resources geared to areas that are best able to maximise value using best value principles.

Selection and procurement activity in the ICB operates through two linked programmes: selection for healthcare services and procurement for goods, works and other services.

The ICB operates its provider selection and procurement approach in line with the ICB's Procurement Policy and the ICB Standing Financial Instructions. The Procurement Policy is currently being updated. The Procurement Policy is geared to ensure that the goods, services, works and healthcare services are acquired legally, responsibly, fairly, in keeping with the ICB's values and with the ICB securing value for money, consistency and quality, whilst managing the risks associated with such purchases. The Procurement Policy sets out the roles and responsibilities of the ICB Executive Officers, Department Heads and Employees in undertaking procurement activities, including the requirement to operate provider selection and procurement activity in accordance with The Health Care Services (Provider Selection Regime) Regulations 2023, and The Public Contracts Regulations 2015 (PCR2015).

The Health Care Services (Provider Selection Regime) Regulations 2023 came into force on 1 January 2024. The Regulations set out of changes to way the ICB secures healthcare services for our population and the ICB will develop its approach to selection having due regard to the Regulations, good practice and case law as this emerges.

The Procurement Bill, which will also reform the existing Procurement Rules, received Royal Assent in October 2023. In early 2024 secondary legislation (regulations) will be laid to bring some elements of the Bill and the wider regime into effect. The 'go live' date is expected to be October 2024 and the ICB will change its policy and operations to comply with the Regulations. Existing legislation will apply until the new regime goes live, and will also continue to apply to procurements started under the old rules.

Selection and procurement activities reflect Social Value principles, the Armed Forces Covenant and NHS-wide policies for the Greener NHS and eliminating modern slavery. We will continue to expand and embed innovation in our selection and procurement activities so that we consistently meet our objectives and deliver value for money and improved quality and outcomes.

Our partner Trusts in the Lincolnshire system already have strong collaboration in procurement for goods, and we continue to build on these collaborative arrangements during 2024 including extending the use of supporting technology such as the Atamis system to support improved productivity and increased efficiency throughout the supply chain and strategic sourcing cycle.

Population health management

The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.

Strategic Overview

The Lincolnshire ICS is committed to positioning PHM methodology and approaches at the heart of our transformation and improvement initiatives, utilising the novel insights this provides to shape our system to meet the needs of our local people, ensure best use of our collective resources and to achieve better outcomes for the local population. PHM is recognised as best practice to enable gold standard decision making across the local system. Our ICS has a mature Population Health Management Programme which has been in operation since early 2020.

The programme is well resourced and supported with the following:

- A single ICS Senior Responsible Officer (ICB Executive Board member)
- ICS PHM Steering Group
- Programme Director
- Programme Management Office

Partnership

Our local PHM Programme seeks to create a *Coalition of Interest & Intent* with advocates of the methodology in all partner organisations across the system. Our approach to transformation aligns three ICS programmes which describe how we design and deliver effect change – PHM, Reducing Health Inequalities and Personalisation. The local PHM Steering Group is diverse and includes membership from transformation delivery programmes and organisational boards across the system, including partner Trusts, local authority, and the voluntary sector.

To support local adoption of PHM, Lincolnshire has commissioned a three-year Strategic Partnership with Optum UK, ensuring the local capacity and capability is developed robustly and sustainably. The partnership has enabled the programme to rapidly build the required local infrastructure and support organisations, teams, and individuals to upskill and upscale PHM application.

System PHM Infrastructure

Data Infrastructure

Enabled by a collaborative approach to Information Governance, the Lincolnshire Joined Intelligence Dataset (LJID) has been created and is available for use by colleagues across all statutory organisations & general practice. This dataset includes linked data from primary care, secondary care (acute and mental health), community services and adult social care for 100% of the Lincolnshire population. This dataset is considered to be one of the most comprehensive in the country.

Discrete senior leadership capacity is identified within the system (ICB Director of Intelligence and Analytics) to lead the development and expansion of the LJID to include data from additional sources such 111, ambulance services and the voluntary sector. A robust workstream has been developed of Data Infrastructure and IG professionals to support and deliver on the ambitions for the linked dataset.

Analysts from across the ICB, Commissioning Support Unit, provider Trusts, Local Authority & General Practice have access to the linked dataset via the PHM Reporting Suite with robust sub-licencing process in place.

Workforce Training and Development

The Lincolnshire system has a well-established Analyst Network which includes over 100 colleagues from across partner organisations. This network provides a forum for training, peer support and open discussion about intelligence generation and use of the linked dataset.

The PHM programme will continue to deliver training, mentoring and buddying opportunities to non-analyst colleagues across Lincolnshire to build capability and capacity to utilise PHM methods at all levels of the system. This work focusses on three key outcomes:

- Collaborative working with analysts to effectively interpret available intelligence and generate insight
- Effective utilisation of intelligence in high quality decision-making, planning and intervention design
- Application of the full PHM cycle to drive transformation and improvement

Intelligence and Insight

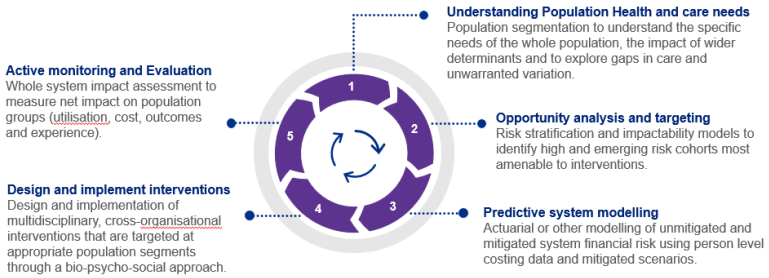
The Lincolnshire PHM Reporting Suite (PHMRS) has been created to utilise and interpret the comprehensive person-level linked dataset in partnership with Optum UK. The PHMRS enables analysts to interrogate the dataset and create new intelligence products and population insights for stakeholders across the system and provide a single platform for advanced data and analytical techniques, such as population segmentation, risk stratification and financial risk modelling.

The PHM programme has led the design of the Strategic Segmentation Model for the local population. This defines a segmentation framework which allows the ICS to understand the population at the highest level, define the strategic outcomes for each segment of the population and agree how to measure our impact on the people within each segment. This will provide a keystone to the understanding of population need in the county and serve as a common language around which the system can shape itself to better meet the needs of our people. A wide range of intelligence products are now being utilised across the system to inform a breadth of system activity.

Innovation, Intervention and Implementation

Our local approach to PHM centres around creating space for collaboration, learning, and understanding our population, with diverse teams drawn from a variety of partners to enable effective working across organisational boundaries.

The PHM Cycle — making things stick through continuous learning and doing



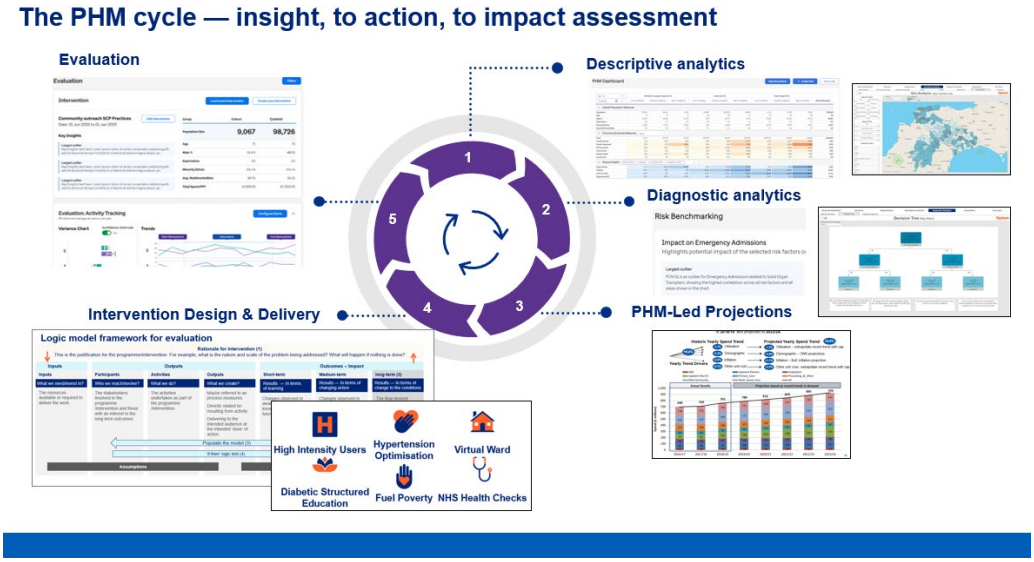
Following the PHM Cycle (above), multi-disciplinary teams are supported to understand a cohort of people, the challenges they face and the things we can improve to deliver better outcomes and health gain.

The PHM cycle embeds evaluation in any new intervention designed and ensures evidence-based decisions can be made about refining, upscaling or stopping new interventions or service with confidence.

Incentives (Financial Modelling and PHM Projections)

The Lincolnshire Joined Intelligence Dataset provides a novel opportunity for the ICS to better understand and model the potential future view of our population and their health needs. A PHM Projections Model has been built which creates a platform upon which we can model the impact of potential transformation and improvement initiatives and clearly identify expected finance, activity & resource implications. This work is the first of its kind in the country and will be used to inform investment decision making, prioritisation and allocative efficiency initiatives.

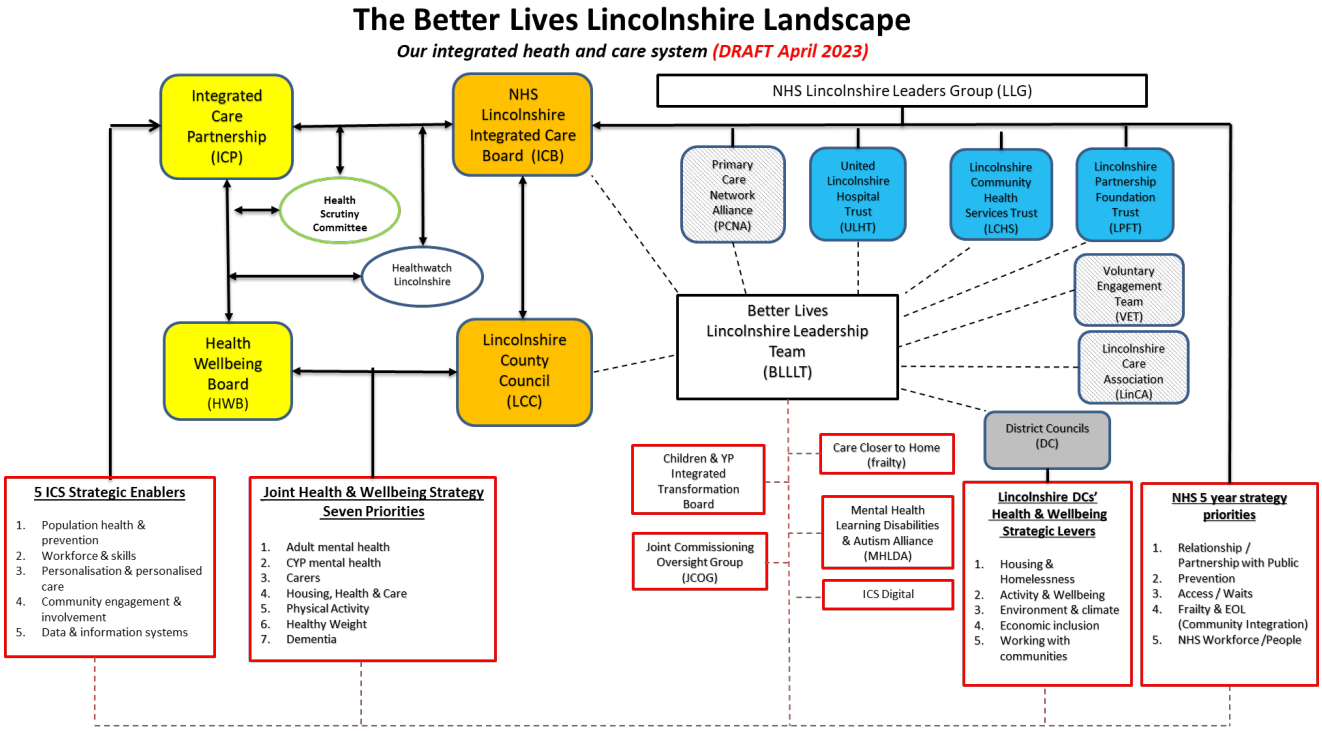
With the PHM now complete is 2024 we are in a strong position to embed PHM and business as usual across Lincolnshire and apply this methodology consistently and at scale.



System development

How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.

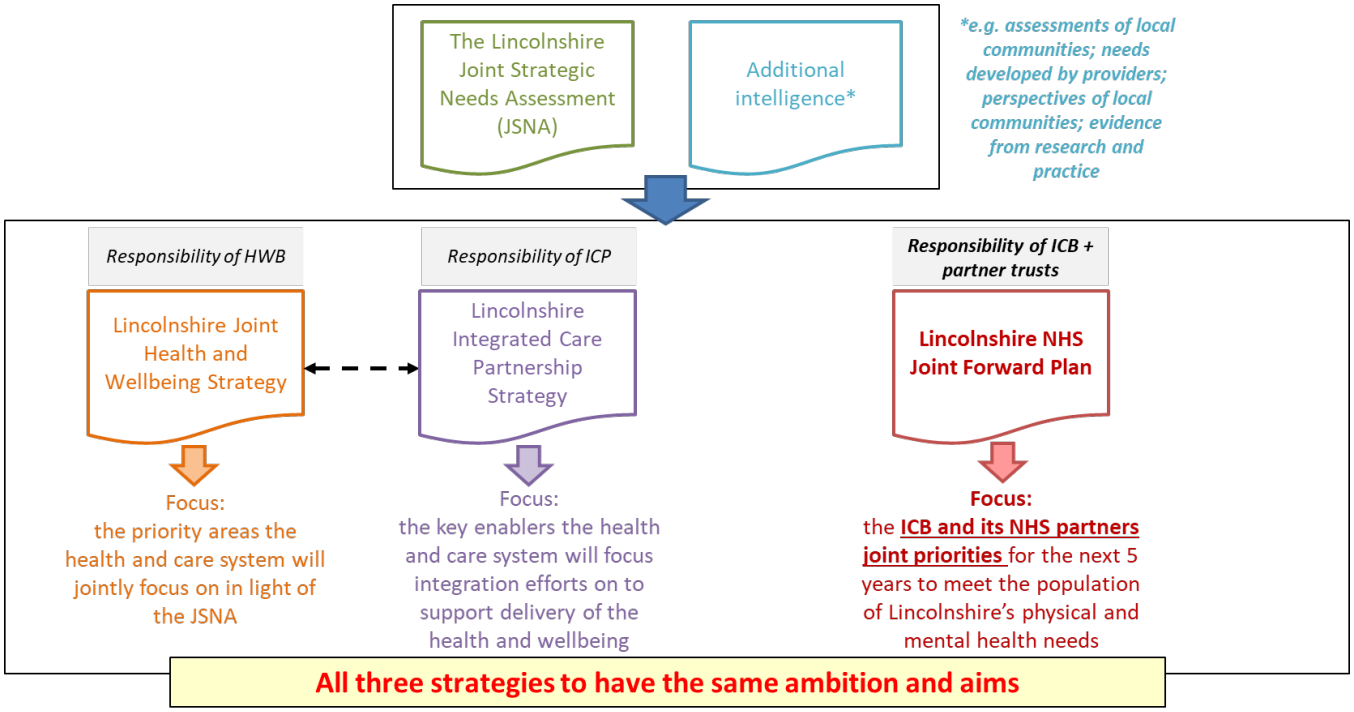
The architecture of the Integrated Care System aims to ensure an integrated approach to commissioning, delivery and transformation in the Health and Care System in Lincolnshire. An illustration of the architecture is outlined below:



Already detailed in this document are the roles and purpose of the following arrangements detailed above:

- NHS Lincolnshire ICB Board
- Lincolnshire Integrated Care Partnership
- Better Lives Lincolnshire Leadership Team
- Lincolnshire Leaders Group
- Lincolnshire Health and Care Collaborative
- Mental Health, Learning Disability and Autism Alliance

Through these joint arrangements the ICS will continue the ongoing development for health care provision though continued strengthening of relationships, development of strategies and plans to meet the health needs of the Lincolnshire population. The work programme that underpins these arrangements to date comes from The Lincolnshire Joint Strategic Needs Assessment, the Lincolnshire Joint Health and Wellbeing Strategy, the Lincolnshire Integrated Care Strategy, and the NHS Lincolnshire Joint Forward Plan. The relationship between these documents is illustrated below:



Underpinning the high-level governance structures outlined above are a significant number of joint working arrangements across the ICS. Membership is taken from organisation across the ICS and there is a joint Senior Responsible Officer who leads the development and implementation of the detailed work programmes. The work programmes are pertaining to the NHS Mandate are identified in the NHS Lincolnshire Operational Plan System Narrative document which is published on the NHS Lincolnshire ICB website.

The joint working arrangements are outlined below but are not limited to the following:

- Clinical and Care Directorate
- Urgent and Emergency Care Board
- Elective Care, Cancer and Diagnostic Board
- Financial Leadership Group
- Financial Recovery Programme Board
- Children and Young Peoples Transformation Board
- Local Maternity and Neo-natal Services
- ICS Digital and Information Executive Group
- Lincolnshire Strategic Infrastructure and Investment Group
- Lincolnshire Investment Committee
- Population Health Management Board
- Personalisation Board
- Health Inequalities Board
- Lincolnshire Safeguarding Board
- Joint Commissioning Operations Group

System Development

In late 2022 the ICB, working with NHS provider colleagues in the county, and in close liaison with NHSE Midlands Region, agreed to commission an external and impartial review of the NHS provider landscape in the county.

The current phase of this piece of work came to a conclusion in March 2023. The report included 10 recommendations which were approved by all organisations. It was agreed that the work of implementing the recommendations is progressed through four workstreams, these being:

- Workstream 1 - CPP (Community and Primary Partnership)
- Workstream 2 - Provider Group (ULHT and LCHS)
- Workstream 3 – Corporate Service Transformation
- Workstream 4 - Cultural Change

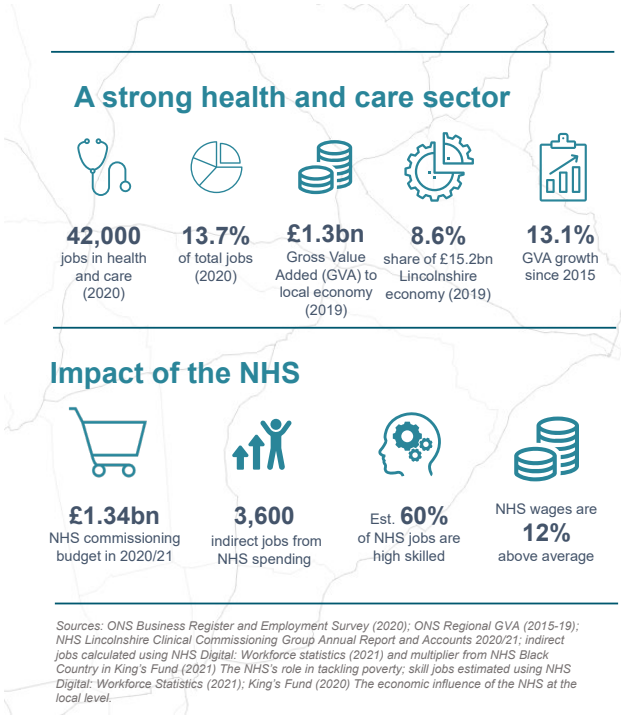
The review, recommendations and future plans were, and continue to be, informed by the Fuller Review and Hewitt Review.

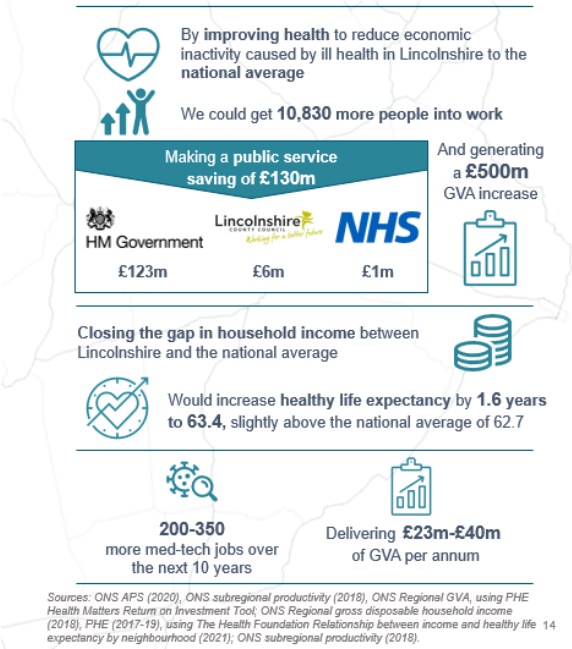
Supporting wider social and economic development

How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as 'anchor institutions' within their communities.

The NHS, and wider health and care sector, is a crucial part of the Lincolnshire economy. We see ourselves as an anchor partner and work closely with our partners in industry, the public and voluntary sectors.

Lincolnshire has recognised the importance of the role that the NHS plays to support the wider determinants of health and wellbeing including the supporting the Levelling Up agenda and the local economy. Our £1.3bn health and care sector has 42,000 jobs, and our NHS is a major anchor institution, employing 11,250 people directly and supporting a further 3,600 jobs across the rest of the local economy. We have a new medical school at the University of Lincoln and leading health research assets, including the National Centre for Rural Health and Care, and Lincoln International Institute for Rural Health.





There are four Towns Funds in Lincolnshire – Skegness, Mablethorpe, Boston and Lincoln. Skegness and Mablethorpe are working together as the Connected Coast. In 2019 each of the four towns were invited to bid for up to £25m. The NHS has been represented and an active member of each of these Boards, which have private, public and voluntary sector partners. The Investment Plans were submitted in 2020 and were well received and a total of £89.3m funding was announced in 2021. The individual projects were developed and were subsequently approved in 2022. Several schemes have been completed and others are now under construction. These include the Campus for Future Living in Mablethorpe.

This innovative Towns Fund project brings together partners including University of Lincoln, Nottingham Trent University, Health Education England, ULHT, LPFT and LCHS as well as the local GP Practice and PCN.. This is a flagship project for Mablethorpe and one that will position the area as an exemplar in medi-tech and care.

The Campus will provide a base for the development and testing of Medi-tech applications. It will also support the continued professional development of clinicians, with both clinical and non-clinical medical placements, strongly aligned to the new medical school at the University of Lincoln. There will also be the opportunity for training and

development of people working in care, and the campus will oversee a self-employed 'Care Network' of carers. A social enterprise coffee hub will be based at the campus too.

The NHS is part of a coalition of local, regional, and national partners involved in the development of the Campus for Future Living which will put Mablethorpe at the heart of the provision health and care related jobs and businesses.

Building on these partnerships there have been several successful Levelling Up 2 bids which the NHS has been actively involved in. These include the £20m redevelopment Castle Sports Centre in Spalding and the £14.2m PE21/Rosegarth Square regeneration project in Boston. Most of the UK Shared Prosperity Funding has been devolved to District Councils. The NHS has senior representation at five of the District Levelling Up Partnership Boards that have been established to manage the process and bids.

For the Lincolnshire ICS, key responsibilities are improving the outcomes in relation to the health of the population and tackling inequalities, thus ensuring that patient experiences are the best possible and that the productivity of the system is optimised and maximises value for money. Through delivering this the ICS will support the broader social and economic development within their area.

The ethos of population-based health and social care is the premise that underpins the service vision. The overall vision is of a need-based, proactive, preventative approach. Primary care is at the heart of the service vision alongside a new generation of ICS-controlled, community-based assets including a hub and spoke model of Community Diagnostic Centres and integrated health and care hubs/ Cavell Centres. The Grantham CDC is in operation and in 2024 there will be two further ones opening in Lincoln and Skegness. We recognise the challenges that there are in terms of health and access to services, public transport etc. These community facilities will be enablers and a key focus point for the work required across the Lincolnshire PCNs as the drivers for population-based care. They need to be uplifting and empathetic, providing flexible spaces that can adapt over time to continue to meet the needs of the population.

Understanding the needs of our populations underpins all the work we do, and our approach is described in other chapters of this Joint Forward View. Our engagement work, especially regarding our proposals regarding a hub and spoke model Community Diagnostic Centres along the east coast, supports this direction of travel.

Feedback below has been received from Skegness cancer support group, wellbeing group, economically deprived residents attending for a free meal and general members of the public:

Key challenges when accessing services:

- **Transport issues** – many people in the area do not own a vehicle leaving them reliant on friends and family, feel like a burden asking for lifts, hard to organise if they friends/family suddenly cancel or already have plans, current road infrastructure is poor, elderly do not like traveling rural roads, especially when dark – adding to the stress of the appointment
- **Cost/distance** – petrol is expensive, sometimes too ill to travel on public transport for such long distances to Boston and Lincoln. Taxi to Lincoln around £100 return and £40 return to Boston. People have had to cancel appointments/treatment because they cannot afford to get to them. People would rather wait for an appointment to be seen more locally than travel and be seen quicker.
- **Inconvenient for childcare/those who work** due to such a long distance to nearest hospitals – have to organise childcare/take time off work for appointments as takes half/a full day – meaning reduced pay/increased outlay for childcare.

Impacts:

- Residents are suffering in pain/self medicating and waiting for appointments closer to home or for when they can afford/organise travel
- Women are not attending routine mammogram appointments due to distance/time needed off work – not convenient
- Residents are attending A&E and calling for ambulances to get help/diagnosis when pain has got unbearable

Perceived benefits of having a CDC along the East Coast:

- Easier access for residents in rural communities who cannot travel far – more people likely to attend if offered locally
- Less stress than going to a hospital
- People being diagnosed quicker and receiving better treatment and outcomes – potentially less people attending A&E

Case Study

The Boston Integrated Care Centre proposal builds on the work that has been undertaken regarding the Sleaford Cavell Centre which is the agreed approach that will be rolled out across the ICS. The vision is to create a focal place in the community that starts to help people see health in a different way - moving away from reactive treatment of illness to proactive health improvement and illness prevention. The Centres will provide a tangible space with a focus on supporting local populations, enabling access to information and signposting patients to the most appropriate health, social or third sector services to empower them to manage their physical and mental health, and maintain their wellbeing. This health management starts at birth and continues through a patient's life to a point of supporting with end-of-life care.

This new operating model is predicated on putting the patient/customer at the centre, with previously disparate services coming together to deal with the 'whole person' in as seamless a way as possible. That means collaboration not just co-location, sharing facilities, handing over not handing off, getting to the root causes of issues, focusing on prevention as well as cure, opening doors instead of perpetuating traditional barriers.

Since 2015, the Borough Council and the NHS have driven forward a passionate partnership vision for health/wellbeing regeneration. Starting life as "West Street, Boston" (2015), to 'PE21' (2018-now) and "Rosegarth Square" (2022). Outputs have included: Concept master-planning for Future High Streets and One Public Estate (OPE) funding; part of the Boston Town Deal Investment Plan (2019); 2xLevelling Up Fund (LUF) bids (2021/22) and Opportunity Development Fund work (2022). . For the NHS this includes the integration of the Liquorpond Surgery, the services provided within the existing Boston Health Centre located on the site that is no longer fit for purpose and a Community Diagnostic Centre. There is a community hub – the Len Medlock Centre and the PCN is working collaboratively with the Centre regarding future integration opportunities.

This leadership 'banging the drum' has - brought more partners to the table; encouraged engagement; and shaped the vision. It has driven awareness of the project, its interventions and its potential outcomes from all sectors (private / public / voluntary), and all levels (local groups, to Government departments). Despite funding setbacks, and the Pandemic, the resilient partnership work has strengthened. It now includes the Primary Care Network (PCN) and links the South East Lincolnshire Councils health partnership and wellbeing strategies, other Towns Fund Projects and the Sleaford Cavell Project. Funding for the OBC was secure at the end of 2022/23 and was vied to Boston Borough Council who led the procurement of the team to support the delivery of the outline business case. Boston has been identified as a Levelling Up Partnership area and the local NHS is actively engaged with the DLUHC national team.

The approach seeks to combine 'Pride in Place,' with the principles of the Dahlgren-Whitehead model, to deliver a place and facilities that people are proud of and want to visit. We are committed to using the Social Value Engine as a methodology to establish the full extent of impact and outcomes. There is a joint vision for social, environmental and economical regeneration of 'PE21'

Boston has a higher prevalence than the England average for cancer, atrial fibrillation, coronary heart disease, cardiovascular disease, heart failure, hypertension, peripheral artery disease, stroke, asthma, COPD, obesity, chronic kidney disease, diabetes, rheumatoid arthritis, epilepsy, palliative care, and dementia. GP referrals to outpatients, elective admissions and A&E attendances are all above England average. Overall deprivation in this PCN is higher than the Lincolnshire average with 22.9% of the population in the most deprived quintile. From 2019 to 2041 Boston population is predicted to increase from 73,836 to 80,048, an increase of 8.4%. Boston older people population (65+) will increase from 13,715 to 20,085 by 2041, an increase of 46.4%. Over 85s will increase from 1,904 to 4,106 by 2041, an increase of 115.7%

As described in the above case study the NHS is committed to inclusive economic development. Our joint procurement team is leading on ensuring that all contracts have a minimum of 10% social value weighting.

The system has also agreed to use the Social Value Engine as a way of measuring this in capital and service models and business cases: Home - Social Value Engine A number of staff across the system are trained to use the model and are developing a community of Practice. Examples of its use already includes the eradication of mental health dormitory accommodation in Boston on the Norton Lea site, the Primary Care Carlton Centre project, the Personalisation programme and K2 PCN Community Mental Health project. From April 2022 all NHS procurements include a minimum 10% net zero and social value weighting. The Net zero and social value guidance for NHS procurement teams helps to unlock health-specific outcomes (building on the Governments Procurement Policy Note PPN 06/20). Net Zero and Social Value is applied via the Evergreen assessment for NHS England Medicines tenders.

Another example of partnership work to meet the needs of some of our most vulnerable members of society are our Night Light Cafés. These are safe spaces that offer an out-of-hours Mental Health, non-clinical support service and are staffed by teams of trained volunteers who are available to listen. They are in community spaces across the county. They can provide signposting advice and information on other organisations that may be able to help with specific needs, such as debt advice or emergency food parcels. On average, almost 29 guests a week visited a Night Light Café in 2021 and over 1,000 phone calls were made to people who needed support or a friendly ear to listen to them. 339 referrals were made from other agencies into the service. Night Light Cafés allow people to have better access to face-to-face help when they are struggling in an evening, when practices and community mental health teams are less readily available. The service is open from 4pm Monday to Friday, and from 8pm Saturday and 6pm on Sunday.

Led by the YMCA the Nomad Centre in Lincoln is another example of social value from partnership working. Nomad provides 22 comfortable ensuite bedrooms for people who are homeless or threatened with homelessness. It also has a professional kitchen which provides three meals a day, every day of the year. The Nomad Day Centre brings together a range of professionals to provide essential support to people experiencing homelessness, including mental health and physical wellbeing services.

We are supporting wider economic developments in Lincolnshire through several workstreams. We are members of Team Lincolnshire Team Lincolnshire Homepage – Team Lincolnshire. This is an independent partnership of ambitious, forward-thinking private and public sector organisations, united by the common goal of championing a stronger local economy. One example has been LPFT supply chain event for the Norton Lea development – seeking local suppliers – both Team Lincolnshire and the Chamber of Commerce promoted the event.

We play an active partnership role with the Greater Lincolnshire Local Enterprise Partnership and have Board members on the Health and Care Programme Board. We have also been engaged in the Circular Economy development discussions being led by Lincolnshire County Council and the Local Enterprise Partnerships (LEP).

Our Anchor Partnership work is developing, and we are working with partners across the Providers, the County Council and the University of Lincoln. Our focus is on the UN Sustainability Goals and how these resonate with us in Lincolnshire. It links to our Greener NHS, Health Inequalities, Workforce, Procurement and Place based strategies. Our partnership working includes all the members of the Integrated Care Partnership, the University of Lincoln and the Towns Funds.

NHS Lincolnshire Joint Forward Plan 2023 - 2028

Delivery Plans

Contents

ⓘ For further information on the content of this document, individual project delivery plans and associated modelling, please contact Feargus Mack - f.mack@nhs.net

Executive summary

- NHS Lincolnshire Joint Forward Plan 2023-28 and where it fits within our strategic vision for health and care
- JFP Delivery Plan 2023-28 | Headline ambitions
- Summaries of the system transformation programme plans
- Delivering on the Joint Forward Plan priorities

NHS Lincolnshire Joint Forward Plan 2023-28

The national requirement

- The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to prepare their Joint Forward Plan (JFP) before the start of each financial year.
- Systems have significant flexibility to determine their scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements

The Lincolnshire approach

Rather than cover all the national requirements in as single document, the Lincolnshire NHS agreed to develop separate documents, which are tailored to the target audiences:

- **NHS Lincolnshire Joint Forward Plan 2023 – 2028** [published June 2023]
  - a relatively concise public-facing document, which is easy to read and understand
  - articulating our new strategy for the NHS in Lincolnshire, co-produced with people and communities

This is underpinned by a number of more technical documents which are primarily targeting health and care staff but will still be publicly available:

- **Allocation of Duties and Responsibilities** [first published June 2023]
  - outlining how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised. This will be updated annually.

- **JFP Delivery Plan [this document]**
  - collating the delivery plans for the system service transformation and enabler programmes; the development of these will also be informed by further engagement with people and communities
  - Providing further details on how the five JFP priorities will be delivered

- **Activity, Workforce and Finance Plans** [currently in development]
  - Rolling, five-year projections (detail for Years 1 & 2; estimates for Years 3-5) that reflect the programme delivery plans as far as possible

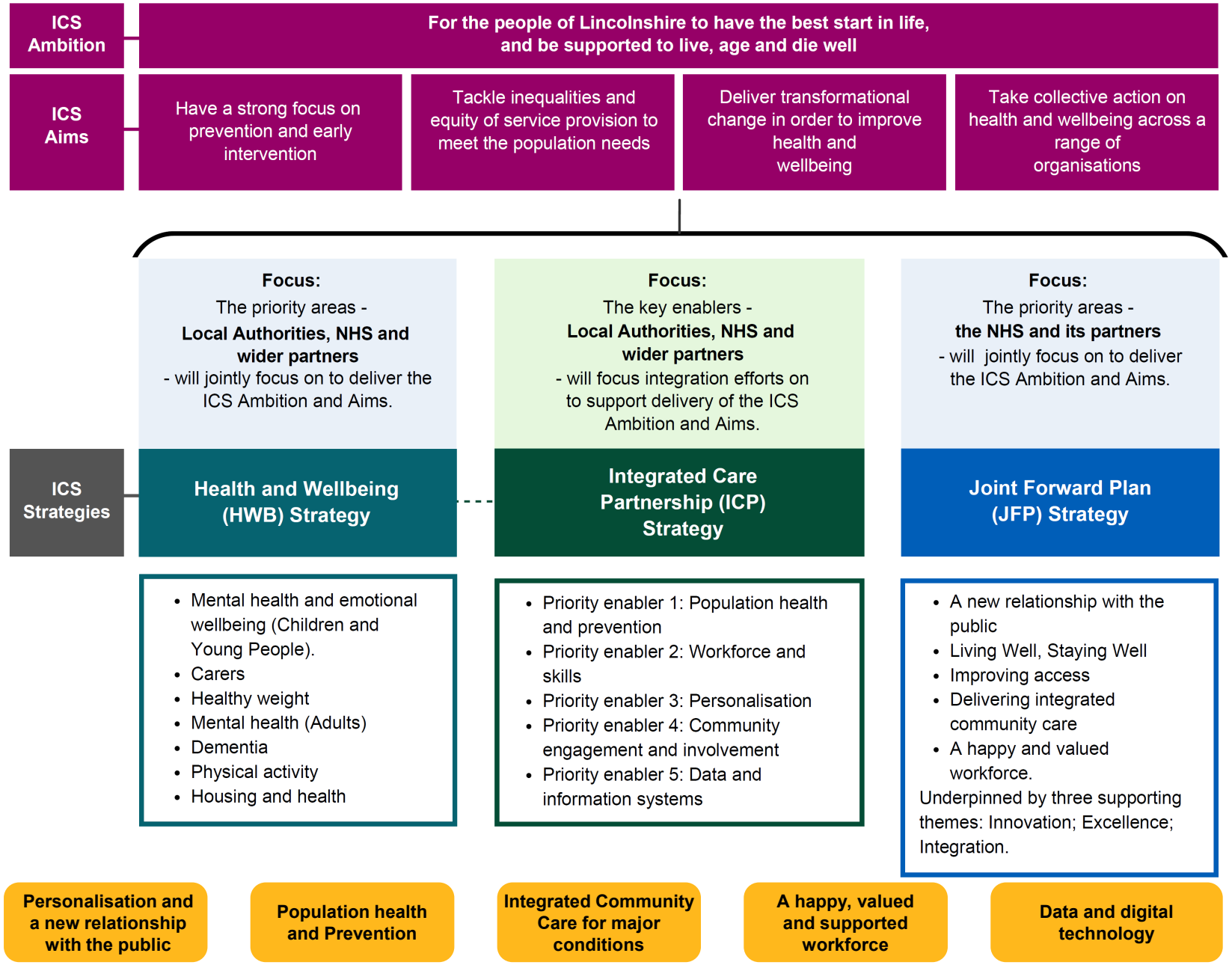
Key drivers

The key drivers informing the development of this plan have been

- Population insight: understanding the needs, causes, outcomes and disparities of our populations through analysis of population and public health data, along with patient and citizen feedback
- Current status of local services: service sustainability, efficacy and efficiency, including analysis of performance and benchmarking data
- System strategy: Health & Wellbeing Strategy, Integrated Care Strategy and the NHS Lincolnshire strategy
- National priorities, objectives & targets e.g. urgent and emergency care, primary care access, and elective and cancer care recovery plans

These programme delivery plans will continue to be evolved in response to national policy (e.g. Major Conditions Strategy) and local developments (e.g. development of Community Primary Partnerships).

Where the JFP fits within our strategic vision for health and care



Our five cross-cutting strategic themes

Personalisation and a new relationship with the public

At the heart of the Better Lives Lincolnshire strategy is the recognition that we need to establish a new relationship with the public.

Together with the people of Lincolnshire, we want to build a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

This strategic theme has five key elements:

- Creating a shared agreement.
- Supporting shared decision making
- Developing and designing services together
- Working with people and their families to manage their own health and wellbeing
- Supporting people to feel connected and engaged in their local communities

Population health and Prevention

Population health and prevention is the 'golden thread' that runs through our strategies and underpins its focus on improving health and wellbeing and tackling inequity.

Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work. Addressing these determinants throughout the life course allows us to consider the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

People have different needs at different points in their lives and we have specific ambitions relating to each life stage: Preconception, infancy and early years (0-5); Childhood and adolescence (5-19); Working age (16-64); Ageing well

Integrating community care for major conditions

Integrating primary care: delivering timely access to primary care – general practice, pharmacy, dental, optometry – today, while designing a sustainable future.

Integrating Specialist Care: delivering improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new models of care, via a one team approach, transcending organisational boundaries; adopting a more proactive and holistic approach informed by individual wishes and need; Focussing on prevention, early identification and diagnosis; Delivering both timely, urgent care & long-term ongoing care

Integrating community partnerships, developed around PCN footprints; supporting their ongoing evolution to provide person-centred care, delivered by multi-disciplinary & multi -agency teams, for local communities, reflecting population need

A happy, valued and supported workforce

We truly appreciate our people and everything they do. We also appreciate the link between an engaged, happy workforce who feel valued and the quality and efficiency of the care they are able to deliver.

Having the right workforce in the right place at the right time allows our services to meet the healthcare needs of people locally.

To continue to do this we need a constant flow of talented people from our communities into the organisations. We also need to provide good opportunities for training and development to encourage them to stay in Lincolnshire rather than move elsewhere.

To develop our workforce in Lincolnshire we will:

- Value our people
- Grow our people
- Develop our people
- Retain our people.

Maximising data and digital technology

As health and social care services face unprecedented challenges, data, digital technology will be at the heart of how we transform health services for the benefit of citizens, patients and staff.

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

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

JFP Delivery Plan 2023-28 | Headline ambitions

All Age

- By April 24 over 40,000 people will have had a *what matters to me* conversation
- By April 25, co-production is embedded in service redesign in 5 programmes
- By April 25, more of the workforce are aware of the personalisation agenda
- By April 2024 6080 people will have accessed a new group/service after social prescribing
- 85% of patients, who need a primary care appointment, to receive one within 2 weeks by 2025
- Reduce the prevalence of smoking across all social groups to meet the national smokefree 2030 ambition
- Healthy life expectancy a five year rise by 2035, with a narrower gap between local areas where hit is highest and lowest

Start Well

- Decrease smoking at time of delivery from 11.4% to 7.9%
- Increase breast milk at first feed from 67.3% to 70%
- Childhood vaccinations above 95%, with equitable uptake by all areas & groups
- 95% of accepted CYP MH referrals assessed ≤ 4 weeks; no CYP waiting >12 weeks for treatment by March 2025
- 90% of children with Type 1 diabetes receive all 6 of the care process for diabetes
- 10% reduction in ED attendances due to asthma in 2024/25
- 10% reduction in unplanned admissions due to epilepsy in 2024/25

Live Well

- Increase % of adults on obesity register accessing healthy lifestyle offer from 5% to 10% by 2028
- 80% of the expected number of people with hypertension are diagnosed by 2029
- 500 patients over 24/25 and 25/26 achieve remission from Type 2 Diabetes
- 65% of patients 25-85 with a CVD risk score >20% on lipid lowering therapies by 2026
- Reduction in smoking among people with a severe mental illness from 40% to 35%
- 5% more COPD patients accessing pulmonary rehabilitation by 2025
- Increase diagnosis at stage 1 & 2 for lung & colorectal cancer to 75% by 2028

Age Well

- Covid, flu & pneumonia vaccs increased among people with respiratory condition by 10% by 2028 in areas of greatest deprivation & ethnic groups
- Antibiotics in primary care: Broad-spectrum antimicrobials <10%; 75%+ of amoxicillin prescriptions are 5-day courses
- Increase the dementia diagnosis rate in people 65+ to 66.7% by 2025
- Frailty: reduce progression from mild-moderate and moderate-severe by 5% by 2028
- 70% of high-risk fallers have a proactive care plan in place by 2025
- 70% of people in the last year of life have a care plan by 2025, 80% by 2026
- 10% less people in their last year of life have an unplanned admission by 2026

Personalisation

KEY AREAS OF WORK

Culture and behaviour change

- Our Shared Agreement; Co-Production; Working with partners and people with lived experience to bring to life what a new personalised & proactive relationship between people and the health & care system could be

Workforce and People

- Focussing on people's strengths and assets, and 'what matters' to them, enabling shared decision making that encourages people to have more choice and control and to live their best and healthiest life.

Training Teams

- Training in new tools and techniques, coaching and motivational interviewing, strength-based approaches and analysing impact.

Toolkit/Resource Development:

- Ease and simplify ways of embedding strength based and personalised approaches into new pathways and service redesign.

Social Prescribing:

- Growing Lincolnshire's social prescribing model

Social Movement:

- Developing a network of champions, advocates & voices of personalised care

Areas of focus

- Working with stakeholders to understand the programme interdependencies around service redesign work and agreeing the implementation and delivery timescales. The areas of focus are: Frailty; Serious Mental Illness – Physical Health Checks; Musculo Skeletal pathways – Hip and knee (embedding personalised approaches); High Intensity Users of secondary care; Discharge Hubs and Intermediate Care; Reduction in people on MSK waiting lists

TARGET OUTCOMES

Experts by experience are an integral part of the health and care system:

- By April 25, co-production is embedded in service redesign in 5 programmes

There is increased awareness and understanding of Our Shared Agreement and Personalisation among both citizens and staff

- By April 24 over 3000 health & care staff will have completed a foundation in personalised strength-based approaches
- By April 25, all operational staff involved in service redesign will have completed the SDM & PCSP via the train the trainer programme; there is an increase in attendance & awareness of personalisation huddles and the person-centred learning network; champions of personalisation are present in all stakeholders

People feel valued whether that is as a carer, person accessing services or family member, and is considered an expert in themselves/their own care

- By April 24, 40,000+ people will have had a *what matters to me* conversation

People understand their own wellbeing needs and how to support themselves:

- By April 2024, 75% of people who complete a PAM and have their treatment/support tailored will see an improvement in their knowledge, skills and confidence to manage their own health and wellbeing;
- By March 2024 there is a reduction of people on waiting lists and outpatient follow ups following attendance at the Aches and Pains hub in Grantham
- By April 2028, people report that they are able to access the support that matters to them at the right time, including community-based support, peer support, self-help resources, advocacy or other specialist support

People feel more actively involved and in control of their health and wellbeing

People recognise & understand the value of connecting into their local communities

- By April 24: over 16,000 people will have been referred to social prescribing since 2019; 6080 people will have accessed a new group/service after social prescribing;

People feel able to take responsibility for their own care/health, and are able to self-serve/self-assess where appropriate

- By April 2028 ?% increase in the number of people using technology enabled care to stay independent and/or improve quality of life

Personalisation and a new relationship with the public | Population health and Prevention | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | Data and digital technology

Health Inequalities & Prevention

KEY AREAS OF WORK

Embedding a system approach to health inequalities (HI)
- Implementing HI tools and embedding HI approaches within governance; providing a programme of HI Training & Development; developing HI leads/champions within NHS Trusts and PCNs; embedding within financial & contract arrangements

HI performance and intelligence
- Developing intelligence and insights to support understanding of health inequalities and prevention priorities; developing system HI metrics, KPIs & dashboards; improving data collection; utilise PHM approaches to address HI and work with system BI colleagues to develop HI elements of the joined data set reporting suite

HI in clinical areas and cross cutting themes
- Work with programmes to deliver against 5 national HI priorities and 5 clinical priority areas within Core20plus5 for Adults and Children & Young People. Ensuring people on the margins are able to access services and that any digital arrangements are inclusive and do not exacerbate Health Inequalities

Communication and engagement
- Collecting and using insights from Core20plus groups to reduce the gap in access, experience & outcomes; Co-production and engagement is a golden thread

Prevention
- Improving the population's health and preventing illness & disease; catching the causes of ill health as early as possible to prevent or reduce the chances of them leading to more serious conditions; supporting people to live well and stay well

Digital Inclusion
- Addressing digital exclusion and ensuring alternatives are available for those within our population who need them; adopting and implementing national guidance on digital inclusion through development of a system Digital Inclusion Strategy

Inclusion Health
- Improving access, experience, and outcomes for people in inclusion health groups by understanding their needs and delivering integrated and accessible services

TARGET OUTCOMES

Increased equity of access, experience and outcomes
- for people from: 20% most deprived areas; Black, Asian and ethnic minority backgrounds; health inclusion groups; other Lincolnshire population segments experiencing worse access, experience and outcomes - measured through service/clinical data on service access, experience and outcomes
- e.g. Reduction in waiting times of people living in 20% most deprived to align with overall population rates in specialities where there is a variance; Increase in uptake of faecal immunochemical tests by 3% for 4 selected G.P Practices

Prevention of ill health:
- Equitable vaccination take up for childhood immunisations plus Covid, flu & pneumonia vaccination in areas of greatest deprivation and ethnic groups
- Reduce the prevalence of smoking across all social groups to meet the national smokefree 2030 ambition
- Reduction in smoking among people with a severe mental illness from 40% to 35%
- Increase achievement of all 6 Health checks for people with SMI in areas of greatest deprivation from 47% to 60%; increase access by ethnic groups by 2028
- Increase achievement of recovery outcome for Talking Therapies in areas of greatest deprivation from 42% to 57% (to the level experienced in the least deprived) and increase access to NHS Talking Therapies for ethnic groups by 2028
- 74% of the expected number of people with hypertension are diagnosed by 2025.
- Reducing the difference in the premature death rate (under-75) between the 20% most deprived to the 20% least deprived (from cardiovascular disease mortality.
- Increase % of adults on obesity register accessing healthy lifestyle offer(s) from 5% to 10% by 2028; 5% increase in uptake to the Digital Weight Management offer and Diabetes Prevention Programme in areas of greatest deprivation and targeted population groups by 2025
- 10% Increase of people with Type 1 and Type 2 diabetes receiving all 8 care processes in areas of greatest deprivation and targeted population groups by 2028

Reduction in the gap for healthy life and life expectancy and disability:
- A five year rise in healthy life expectancy by 2035, with a narrower gap between local areas where hit is highest and lowest

Personalisation and a new relationship with the public | **Population health and Prevention** | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology

Primary Care, Communities & Social Value

KEY AREAS OF WORK

Integrating primary care

Integrating primary care and delivering access

- Maintain and develop BAU elements of primary care commissioning: general practice, dental, pharmacy and optometry
- Foster and develop Leadership across and communication between the LMC, LPC, LDC and LOC
- Improve access to community pharmacy services in line with Pharmacy First
- Empower patients to manage their own health by providing them with technology and information
- Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions.
- Improve productivity and reduce time wasting activities across primary care
- Improve collection, accuracy and utilisation of primary care data

Developing Partnerships to Support Primary Care Integration

- Design and implement new sustainable model/s of integrated primary care
- Deliver the Primary Care People Plan
- Develop a Lincolnshire framework for enhanced services
- Enhance our primary care estate and develop our digital capabilities
- Transform the conversation between primary care and the public by through a comprehensive programme of comms, engagement and co-production

Vaccinations

- Develop & implement a Lincolnshire-wide Vaccine Strategy to deliver the ambitions detailed within of the newly published National Strategy
- Enable the ICB to assume delegated commissioning responsibility
- Support providers to develop an integrated staffing model

TARGET OUTCOMES

Integrating primary care

Access

- 85% of patients, with an identified clinical need for an appointment, to receive one within 2 weeks of their contacting their practice by March 2025
- All patients will be able to communicate with someone within their practice, either virtually or via telephone, on the day they contact them and know how their enquiry has been dealt with by March 2025
- 100% of practices have enabled online patient appointment booking and cancelling, repeat prescriptions and access to care records by March 2025
- 100% of GP practices using CBT or system with the same functionality by April 2024
- 100% of practices using high quality online consultation tools by April 2025

Transformation Integrating primary care

- Completed 'big conversation' with the public and key stakeholders including national teams and horizon scanning 'think tanks' with a view to creating a shared vision for the future model of integrated primary care for Lincolnshire by March 2025
- Integrated Primary Care Strategy completed by June 2025
- Early adopters appointed and evaluation indicators agreed by March 2026

Vaccinations

- Resilience: requisite central workforce in place March 2024
- Access: new delivery model in place & co-administration of vaccines the default model by April 2025.
- Uptake: Agree system-wide uptake targets for all vaccination programmes by March 2024; Meet all vaccination uptake targets by March 2027; Identify variation in uptake between PCNs and develop and implement mechanisms to close the uptake gap, focusing on continuous improvement and learning by March 2027

Personalisation and a new relationship with the public

Population health and Prevention

Integrated Community Care for major conditions

A happy, valued and supported workforce

Data and digital technology

Primary Care, Communities & Social Value

KEY AREAS OF WORK

Integrating community partnerships

PCN Development

- Develop different ways of working at PCN level to enable demand to be managed and/or capacity to be released and support improved access
- Fully implement the PCN DES with a view to supporting improvements to population health via proactive identification, care coordination and case load management of patients with longer-term health and social care needs,
- Further enhance leadership capability and capacity across the PCNs
- Continue to implement ARRS roles
- Develop and implement integrated pathways of care across primary and community care for therapy and nursing services to meet the specific needs of PCN populations
- Implement delivery plans for High Intensity Users and Social prescribing
- Build, implement and evaluate a Lincolnshire wide Quality Framework

Integrating Care

- Implement case management and care co-ordination model to support delivery of PCN integrated primary and community teams
- Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients
- Deliver Integrated community teams (community nursing & community therapy)
- Develop and implement the Integrated Communities Strategy
- Codesign and implement a framework for working in partnership with the voluntary sector

TARGET OUTCOMES

Integrating community partnerships

Additional Roles Reimbursement Schemes (ARRS)

- Lincolnshire will have 392.50 WTE ARRS roles in place (this is Lincolnshire share of the 26,000 WTE manifesto commitment) by March 2024. At Month 8 Lincolnshire has 496.64 WTE, well above the end of year target.

High intensity Users

- 3 PCNs will be offering a High Intensity User Service by April 2024
- By June 2024 we will have reviewed other HIU provision to ensure it is in line with the national HIU framework

Social Prescribing

- A refreshed Social Prescribing model to be developed and commissioned from 1st April 2025

Primary Care Networks

- All PCN will have in place agreed objectives, aligned to system objectives by December 2024
- All PCN managers will have undergone a Leadership Programme delivered through an independent specialising in PCN Manager development by March 2024

Partnerships

- Strategic partnership model between ULHT/Primary Care/ICB agreed by June 2024
- Strategic partnership model with VCSE (LVET) agreed by June 2024
- Model of MDT working in place in every PCN by June 2026
- Integrated delivery models in place for community therapy and nursing in every PCN by June 2026
- Implement quality framework across all PCNs by June 2026

Personalisation and a new relationship with the public | **Population health and Prevention** | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | **Data and digital technology**

Primary Care, Communities & Social Value

KEY AREAS OF WORK

Integrating Specialist Care

Ageing well – Older age

- Implement the Lincolnshire Frailty Strategy and associated delivery plans
- Fully delivery the local Lincolnshire and national aspirations for the Enhanced Health in Care Homes (EHCH) programme
- Fully implement the Lincolnshire-wide Palliative and End of Life integrated care model rooted in primary care facilitating 24-hour access to planned and responsive community-based care via a single point of access in line with agreed care plans supported by a strategic commissioning framework.
- Deliver the recommendations outlined by GIRFT and the proactive/primary care elements of the Lincolnshire Dementia strategy including the recovery of the dementia diagnosis rates. This work is led by LPFT
- Implement the Lincolnshire Falls pathway: people with the potential of falling are proactively identified and are proactive managed by timely and effective multi-disciplinary interventions including an effective falls response.

Long Term Conditions – Working age

- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework with a view to supporting: Prevention and management of risk factors; Early and accurate complete diagnosis; Proactive care; Clinical Pathway Review; Integrated pathways of care;
- Deliver Transformation, Targeted and Transactional programmes of change in line with national "must do's" & guidance, best practice and local clinical priorities
  - Major conditions identified in the NHS LTP – cardiovascular disease including Stroke, Diabetes and Respiratory
  - Other long-term conditions where opportunities are identified

TARGET OUTCOMES

Integrating Specialist Care

Frailty

- Reduce progression by 5% by 2028
- Reduce the growth in numbers of beds by 70 beds by 2028

Enhanced health in care homes

- Reduce unplanned admissions of people living in a care home by 5% by 2026
- 90% of people living in a care home to have a PSCP in place by 2026

Palliative & end of life care

- 70% of people in the last year of life to have a care plan by 2025, 80% by 2026
- 10% less people in their last year of life have an unplanned admission by 2026

Falls

- 70% of high-risk fallers will have received a holistic falls assessment by 2025
- 10% more patients stay at home post fall response by 2025

CVD

- 85% of the expected number of people with AF are diagnosed by 2029
- 80% of expected number of people with hypertension are diagnosed by 2029
- 80% of t people diagnosed with hypertension are treated to target as per NICE guidelines by 2029

Diabetes

- NDPP – No. of patients referred to service and No. of patient who achieve at least the first milestone on the programme (contract ends Nov 25):
- Remission - 250 patients per year/ 500 24/25 and 25/26

Respiratory

- Increase the number of patients with a diagnosis of COPD accessing pulmonary rehabilitation by 5% by 2025
- % COPD patients where diagnosis confirmed by spirometry (% and delivery date TBC)

Personalisation and a new relationship with the public | **Population health and Prevention** | **Integrated Community Care for major conditions** | **A happy, valued and supported workforce** | **Data and digital technology**

Urgent & Emergency Care

KEY AREAS OF WORK

10 High Impact Interventions:

- Same Day Emergency Care (SDEC); acute frailty service provision; Inpatient flow & length of stay; Community bed productivity & flow; Care Transfer Hubs; Intermediate care demand & capacity; Standardising and improving care across all virtual ward services; Increasing usage of Urgent Community Response services; Single point of access - facilitating whole system management; Acute Respiratory Infection Hubs

Ensuring achievement of key performance standards:

- Programme of work with executive oversight to deliver the 4-hour standard & improve the 12 hour wait in ED position; Focus on reducing conveyance & increased support to patients in community (review of community pathways of care to ensure integration of services that support people in their own homes & increasing availability of alternatives to ED). Improving the efficacy of Virtual Wards - ensuring that the requisite specialist community provision and digital infrastructure is in place. Maximising the use of SDEC

Mental health: Working with the Adult & CYP Mental Health programmes

- e.g. MH UEC pathways review; 111 option 2; Boston liaison; MHUAC all-age

Frailty: Working with the PCCSV programme on supporting the frail cohort, nursing and care homes and end of life care

- UEC-focussed frailty initiatives include Frailty SDECs & Frailty Assessment Units, increasing capacity & geographical coverage of both in line with population need.

Lincolnshire system approach to Intermediate care:

- **E**xploring joint commissioning opportunities & making best use of available resources (including BCF discharge funding). Moving towards a system-wide and outcome-based model which prevents unnecessary acute hospital admission, supports timely discharge and maximises independent living through reablement & rehabilitation.

2026-28

- Continued delivery of national performance standards relating to UEC; increasing care closer to home, reducing the requirement for patients to attend EDs to access acute & community services; Evolution of simplified access for both patients & professionals; Increased integration of services across pathways of care; Move towards commissioning of pathways of care rather than individual services

TARGET OUTCOMES

Improved patient experience

- Reduction in complaints from patients and professionals, reduction in long waits in EDs and in community for ambulance attendance. Reduction in the number of patients accessing acute services via Eds

Improved patient outcomes

- Increase in the number of patients returning to their own home, reduction in long term care requirements, reduction in incidents reported within the UEC pathways

Reduction in waiting times

- In both UTCs and EDs with delivery of the 4-hour performance target and the wider time to first assessment and triage metrics

Reduction in readmissions

- Fewer patients requiring re-admission following discharge from hospital

Supporting care closer to home

- **I**ncrease in the number of patients supported at home avoiding attendance at ED or hospital admission

Reduction in acute length of stay and acute bed occupancy

- Ambitions to be developed as part of the planning round

Workforce and financial impact

- Reduction in agency/bank and locum spend

Personalisation and a new relationship with the public | Population health and Prevention | **Integrated Community Care for major conditions** | A happy, valued and supported workforce | Data and digital technology

Planned Care

KEY AREAS OF WORK

Waiting List Reduction:

- *Eliminate 65 week waits by March 2024 and 52 week waits by March 2025*; Mutual aid will continue to be delivered predominantly from independent sector providers for challenged specialties, particularly for Gastroenterology and Dermatology; A new ENT weekend working proposal is to be implemented at ULHT - this will be evaluated and rolled-out to other specialties.
- *Increase patient choice*: Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice. Promote the Patient Initiated Digital Mutual Aid System which allows us to offer patients the ability to more easily and proactively 'opt-in' to move provider when they have been waiting over 40 weeks for care and meet the criteria. This will be extended to all patients waiting over 18 weeks by Sept 2024. Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients both at point of referral and via PIDMAS.
- *Increase Activity*. ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies; Expand implementation of Getting It Right First Time (GIRFT) programme to other specialties; Expand the range of services and procedures to be delivered in the community and moved away from secondary care; Work with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers; Expand the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times; Maximise capacity at the recently accredited Grantham Surgical Hub using HVLC principles as well as the planned increase to 2.5 session days.
- *Demand Management*: .Review to determine the future priorities of the EACH for 2024-28 to maximise on opportunities to re-direct to more appropriate services; promoting self-care and increasing activity within community services

TARGET OUTCOMES

Waiting List Reduction:

- Eliminate 65 week waits by March 2024 and 52 week waits by March 2025;
- All patients in the 65-week 'cohort' will be given a first outpatient appointment before 31/10/23 in most specialties to ensure their treatment pathway is completed by March 2024. Those more challenged specialties will be working towards a deadline of 31/12/24 to ensure all patients have had their first outpatient appointment
- Decreased waiting list – measured weekly via WLMDS submission.
- Decreased waiting times in line with, or better than, national trajectory - measured monthly via the national My Planned Care platform and the national electronic Referral Service.
- Reduction in harm caused by long-waits (measured through evaluation of harm reviews by Quality team)
- Increase in choice of Provider where appropriate – measured though the EACH and e-Referral Service (e-RS) reports.
- Care closer to home where community services can be increased.
- Increasing the utilisation of the EACH gives patients a single point of access for all appointment queries – measured through EACH Practice utilisation reports and Practice visits.
- Impact on system partners is being worked through as part of the current planning round and will be discussed when the annual planning guidance is released

Personalisation and a new relationship with the public | Population health and Prevention | Integrated Community Care for major conditions | A happy, valued and supported workforce | Data and digital technology | Recovery/Access

Planned Care

KEY AREAS OF WORK

Outpatients:

- *Virtual Consultations:* Monitoring on a specialty level to ensure those specialties who are not meeting the target increase their virtual consultation usage
- *Patient Initiated Follow Ups (PIFU)*: maximising utilisation where PIFU is already live; explore where it can be rolled out to the smaller specialties; explore opportunities to utilise available system funding for Remote Patient Monitoring
- *Specialist Advice:* Reviewing response times by specialty for A&G through e-RS for all providers – address where this is outside of the 48-hour response period.; review the conversion rates of A&G to referral; development of an A&G tracking tool by ULHT to support specialities not hitting the 16%.
- *Increasing Clinic Utilisation*: Implement the 6-4-2 process for booking patient slots; Expand directly bookable functionality to all major specialties and use full digital functionalities to reduce Missed Appointments

High Volume Low Complexity & Day Case Rates

- ULHT theatre productivity programme: increasing day case rates, increasing theatre utilisation and improving pre-operative assessment.
- Gateway reviews and action planning for all six HVLC specialties, working with the GIRFT team
- Grantham surgical hub : the intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery. Weekend working and 2.5 session days will become BAU to maximise efficiency; Increase day case surgery rates to ensure compliant with British Association of Day Case Surgery (BADS).
- Ophthalmology: Scoping the potential to use Louth Hospital as an ophthalmology hub.

TARGET OUTCOMES

Outpatients:

- Continue to perform better than the national target of 16% of new outpatient attendances; and work towards increasing the provider level usage. Where specialties are meeting the 16%, stretch targets will be agreed.
- Improved patient experience – reduction in complaints from patients and General Practice queries
- Reduction in waiting times – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Improved RTT performance – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Reduction in DNAs - this has been part of the national 'Action on Outpatients' programme and is embedded as a key enabler in ULHT's Integration and Improvement Plan
- Reduction in agency / bank and locum spend.

High Volume Low Complexity & Day Case Rates

- Patients will have a reduced wait for an outpatient appointment.
- Patients will have a reduced wait for a surgical procedure.
- Improvement in quality outcomes
- Increased productivity in day case procedures – completing more activity than before in the same time.
- Reduce the number of bed nights by utilising day case.
- Reduce LOS following elective surgery by implementing discharge plans on admission e.g., for hip replacement – physio and OT in place to mobilise patient on return from surgery, ensure appropriate adjustments had been made at home.
- If GIRFT principles are followed - it will ensure a positive impact on system partners in terms of increased activity, engaged workforce, reduce financial pressures improved patient satisfaction.

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Diagnostics

KEY AREAS OF WORK

Community Diagnostics Centres (CDCs)

- Ongoing development and implementation of the CDC facilities across the county, with ULHT being identified as a lead provider.
- Continued engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This will contribute to the ambition to address health inequalities, as well as being aligned to the Lincolnshire Joint Forward Plan ambition to improve access and support the public in understanding how best to access services.
- Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites.
- Continued consultation and collaboration with existing and new system partners, including those from the independent sector, to ensure services are delivered effectively, efficiently and as productively as possible.

Endoscopy

- Work with the system main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.

Electronic booking

- Implementation of a 6-month trial of the SwiftQ booking process; support ULHT and EMRAD to progress an electronic booking process across the Trust as required.
- Implementation of the Rad Cockpit software
- Progress the bids for AI funding to trial AI software in radiology.

TARGET OUTCOMES

- Meet the aim to provide diagnostic tests to 85% of patients within 6 weeks by March 2024 and to 95% of patients by March 2025.
- Planned CDC activity for 2023/24 is likely to be in excess of 32,000 tests across 6 of the main modalities, with significant increases planned for 2024/25 and 2025/26 as the two new CDC facilities become fully operational, where it is anticipated that activity will be in excess of 150,000 tests in total for all three sites.
- Improving population health outcomes and address health inequalities by increasing the availability and accessibility of services through expansion of the Grantham CDC and development of additional facilities in Lincoln, Skegness and potentially Boston.
- Increasing diagnostic capacity to reduce waiting times, address unmet need and improve performance metrics. This will be for planned and unplanned care, as well as cancer pathways. By moving outpatient diagnostics off the main acute sites, capacity will be created to improve UEC pathways and for more complex patients include cancer and cardiac tests.
- Improve productivity and efficiency through the transformation of clinical pathways, with the provision of co-ordinated diagnostic testing and inclusion of new technology.
- Increase in digital interoperability and connectivity across the system to provide greater information sharing between system partners and enable improved management of complex cases, in addition to providing patients with more choice when booking their appointments through an electronic system and at CDC sites which are closer to home and easy to access

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Cancer

KEY AREAS OF WORK

Backlog reduction and performance improvement

- Return the number of people waiting for longer than 62 days to 217 by March 2024
- Improve performance for diagnosis and treatment standards

Service improvement/pathway redesign

- Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways
- Implement new (Cancer of unknown primary) CUP pathway
- Finalise Galleri Trial 2024
- Roll out of the targeted lung health check programme – this will contribute to the national ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.
- Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.
- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028..
- Scope, develop and commence transition of PFUP protocols and models of working to support other long term condition specialities aligning with PIFU
- Scope and commence transition of personalised care models of working to support people living with other long term conditions in Lincolnshire
- Colorectal HI Programme will focus on improving uptake of Faecal Immunochemical Testing in the seven most deprived practices
- Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening

TARGET OUTCOMES

Backlog reduction and performance improvement

- Reduce number of patients waiting over 62 days to 217 by March 2024
- Return performance back to pre-covid levels (and beyond) by March 2026
- Ensure 28FDS performance reaches 75% by the end of March 2024
- Return focus back to 62-day performance and meeting 62-day targets as laid out in new constitutional standards

Service improvement/pathway redesign

- PFUP and remote monitoring: saved outpatient appointments reused at front end of pathways to reduce backlog and waits, improving patient experience
- New streamlined pathway for CUP patients to ensure they are not delayed in getting a diagnosis.
- Galleri Trial: Lincolnshire patients will undergo final blood test to look for cancer markers aiding earlier diagnosis.
- Targeted lung health check programme will lead to earlier diagnosis of lung cancer patients.
- Personalised care model: improving patient experience

Lincolnshire Maternity & Neonatal System

KEY AREAS OF WORK

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans
- By 2024, specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- Publish equity and equality plans in 2023/24 and take action to reduce inequalities in experience and outcomes.

Supporting our workforce to develop their skills & capacity to provide high-quality care

- Meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting & improving standards & structures that underpin our national ambition

- Implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- By 2024, enable women to access their records and interact with their digital plans.

TARGET OUTCOMES

Headline ambitions

- reduction in smoking in pregnancy from 11.4% to 7.9%
- Increased breastfeeding rates: Increase breastmilk at first feed from 67.3% to 70%

Listening to women and families with compassion which promotes safer care

- Perinatal pelvic health services and perinatal mental health services are in place.
- The number of women accessing specialist perinatal mental health services increases
- Maternity and neonatal services achieve UNICEF BFI accreditation.

Supporting our workforce to develop their skills and capacity to provide high-quality care

- Achieve target establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses

Developing and sustaining a culture of safety to benefit everyone

- Improved scores in the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey for midwifery, obstetrics and gynaecology

Meeting and improving standards and structures that underpin our national ambition

- Improved metrics for maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births.
- Minimising for the gap on these metrics for people from: 20% most deprived areas; Black, Asian and ethnic minority backgrounds; health inclusion groups; other Lincolnshire population segments experiencing worse access, experience and outcomes

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Children & Young People

KEY AREAS OF WORK

Co-ordination of health information sharing into safeguarding children's front door Strat discussions
- Improve processes for the sharing of health information at multi-agency strategy discussions to ensure robust local arrangements are in place

Diabetes
- Reduce variation of care; Increase CYP utilising technology; access to psychological support services

CYP Child Protection Medicals
- Review and revise health model so it has the capacity and capability required to consistently deliver timely Child Protection medicals to required standards

Clinical Intervention in Schools Review
- Provide a robust health offer to meet the needs of CYP with SEND in Lincolnshire's 'All Needs' special schools.

Asthma
- Implementation of NHSE National Asthma Bundle; Access to diagnostic hubs, community spirometry & FeNO testing; Increased access to training for staff; Increased access to resources for CYP & families to support self-management

Epilepsy
- Improved access to: Epilepsy Specialist Nurse; appropriate mental health and psychological support services; tertiary neurology as required

CYP Therapy Review
- Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs

Children's Community Nursing (CCN) Review.
- Develop new service model that meets best practice and offers an on-call service; direct nursing care and PEOL care to all children on the CCNS caseload

Palliative End of Life Care for Babies, Children & Young People
- 24/7 out of hours specialist clinical support/advice rota for professionals

Integration of assessment processes and support for CYP with SEND.
- Integrating EHC SEND, Independent Placements & Continuing Care processes

TARGET OUTCOMES

Co-ordination of health information sharing into safeguarding children's front door Strat discussions
- Improved risk assessment and subsequent decision-making regarding children at risk of harm

Diabetes
- CYP have equal access to all care processes (December 2024.)
- CYP have improved management and control of their Diabetes (March 2025)

CYP Child Protection Medicals.
- Improved support for CYP who are potential victims of abuse and neglect

Clinical Intervention in Schools Review
- CYP getting the right health, care and education, in the right place, at the right time, as close as possible to where they live

Asthma.
- 10% reduction in ED attendances due to asthma in 2024/25

Epilepsy.
- 10% reduction in unplanned admissions due to epilepsy in 2024/25

CYP Therapy Review.
- Improved access to universal and targeted therapy services in the community reducing demand and pressure on the specialist therapy service.

Children's Community Nursing (CCN) Review.
- Reduce unnecessary recurrent ED attendance for CYP with long-term conditions and complex health needs and disabilities.
- Reduce the number of admissions to the inpatient wards

Palliative End of Life Care for Babies, Children & Young People
- Improved care provision, access, and choice of venue of death

Integration of assessment processes and support for CYP with SEND.
- Better fulfilment of the SEND and Alternative Provision mission: Fulfil children's potential; improve parent/carer experience; support financial sustainability

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Children & Young People's mental health

KEY AREAS OF WORK

Prevention and Community Assets
- Night Light Café pilot

Early Intervention:
- Online MH support service recommissioning
- Primary care CYP MH Practitioner pilot roll-out
- CYP counselling offer pilot
- On-going delivery and expansion of Mental Health Support Teams (MHSTs)

Community Specialist Mental Health:
- Increase staffing and reduce waiting times in community specialist mental health support
- Introduce Avoidant/Restrictive Food Intake Disorder (ARFID) pathway/ CAMHS Eating Disorders
- Complex Needs Service review

Urgent and Emergency Care:
- CYP MH liaison in Lincoln and Boston
- Mental Health Urgent Assessment Centre all-age pathway
- Kooth digital online pilot
- Crisis respite

Transitions pathways:
- Ensuring transitions are seamless between CYP & adult MH services

TARGET OUTCOMES

Early Intervention:
- CYP counselling offer pilot: Increased access to early intervention support
- On-going delivery and expansion of MHSTs: Increased access to low-moderate MH support in schools/colleges; More Lincolnshire CYP have good emotional wellbeing and MH, teaching them self-care skills to develop and strengthen their own emotional resilience; More CYP with early indicators of emotional wellbeing and/or MH needs are supported in their education settings and prevented from needs escalating; Reduced health & wellbeing gap to prevent further widening of inequalities

Community Specialist Mental Health:
- Investment to reduce waiting times in community CAMHS: Reduced waiting times for specialist mental health support
- Introduce ARFID pathway/CAMHS Eating Disorders: Increased access to specialist mental health assessment and treatment for CYP presenting with ARFID
- Complex Needs Service review: Reduced risk of CYP with complex needs or behaviours escalating and negatively impacting on their life chances

Urgent and Emergency Care:
- CYP mental health liaison in Lincoln and Boston: Increased access to 24/7 mental health crisis support and assessment for CYP and families
- MHUAC all-age pathway: Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA; Increased access to 24/7 mental health crisis support and assessment
- Kooth digital online pilot: Increased access for CYP to support during MH crisis
- Crisis respite: Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA

Transitions pathways:
- Seamless CYP and Adult MH transitions pathways: Improved patient journey and experience for 18-25-year-olds from CYP to Adult mental health services

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Adult mental health

KEY AREAS OF WORK

Prevention and Early Intervention:

- Roll out of the Mental Health Prevention Concordat Plan
- Continued development of alternative MH crisis provision. and Holistic health for the homeless expansion

Transformation of Community Services:

- Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing; development of a MH VCFSE strategy – to build resilience and generate volunteering opportunities; continued investment into primary care roles and supporting locality mental health team provision; increase workforce and improve pathways for IPS/EIP services; continued growth of CRT and PACT services countywide; further development of the adult eating disorder pathways; developing local model for SMI Health checks

Mental Health Urgent and Emergency care:

- MH UEC Pathways review and CRV provision; 111 option 2 service Provision; Boston Liaison service
- Options appraisal/business case for East Coast provision
- Right Care Right Person (RCRP) Programme

Inpatient services:

- Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available

Access

- Increasing the capacity/productivity of these services: NHS Talking therapies; Perinatal Services; Neuropsychology: Remote assessment pathway; Psycho-oncology; ME/CFS Pathway

TARGET OUTCOMES

Prevention and Early Intervention:

- Concordat: Inequalities are reduced; people are more responsible for their own care; disease burden is reduced. Reduction in variation of patient outcomes
- Crisis alternatives: Reduction in suicide rate. People better supported in communities. Improved self-efficacy.

Transformation of Community Services:

- Target to deliver 4507 SMI Physical health Checks by 31/03/24
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services

Mental Health Urgent and Emergency care:

- Reducing number of people with Mental ill health needing to attend A&E, primary care and secondary MH services

Inpatient services:

- More people supported within Lincolnshire
- Reduced inappropriate adult acute bed days out of area.

Access

- Increase the number of adults and older adults accessing NHS Talking Therapies treatment
- More people supported through these services

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Dementia

KEY AREAS OF WORK

Dementia Strategy development-
- This will have a key focus on prevention of avoidable cases of dementia; improving experience of people being diagnosed and living with dementia; championing participation, innovation and research

Prevention agenda
- Focused prevention programme aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Utilising health inequalities data to support delivery

Primary care
- Improve the dementia diagnosis rate – supporting PCNS with case finding
- Promoting use of the Diagnosis Advanced Dementia Mandate Tool as part of the primary care dementia pathway for patients with advanced/severe presentation of dementia in care homes
- Reduction of inappropriate Antipsychotic prescribing for people with dement

Memory Assessment Service
- Move towards a stand-alone MAS model in order to improve the dementia diagnosis rate for Lincolnshire and reduce memory assessments waits

Complex Dementia – managing challenging behaviour (all settings)
- Implement the role of Dementia ambassadors in care homes
- Ensure the appropriate use of antipsychotic medication
- Review & develop education and training programmes for supporting people with dementia and improve access for carers and care professionals

Palliative and End of life Care (PEOLC)
- Explore how we can adopt elements of the Derbyshire toolkit to strengthen the PEOLC offer for people with dementia.
- Enhanced Health in Care Homes is dedicated to improving PEOLC for people in care homes of which dementia patients are covered.

Young Onset Dementia
- New specialist pathway to be developed and implemented for Lincolnshire

TARGET OUTCOMES

Prevention agenda
- Increase in Health Check 5 year (50-65)
- Reduction in people with MCI and Memory and Cognitive Problems

Primary care
- Increase in DDR for Lincolnshire
- Reduction in Anti-Psychotic Prescribing
- Increase in people with an advanced Care Plan and Respect form.
- Increase in the number of Medication Review and Dementia Care Plans

Memory Assessment Service
- Decrease of average time to assessment
- Decrease in the average time to diagnosis.
- Reduction in waiting list
- Improve the outcomes, access and experience for people accessing the service

Learning Disability and Autism

KEY AREAS OF WORK

Service improvement

- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD
- Develop and mobile a new ADHD pathway
- Develop and mobile the CYP Autism Diagnostic pathway
- Mobilise the Lincolnshire Virtual Autism Hub
- Service transformation review focussing on urgent care & community support
- Neurodivergent Pathways: Review Tics Tourette's and Functional Neurological Disorder and Acquired Brain Injury pathways. These are currently OATs with services commissioned on a spot purchase basis – evaluate both the CYP and Adult OATs panels in 2024/25 to determine whether this meets the needs of Lincolnshire citizens or whether cases for change are required

Accommodation Strategy:

- Develop a short-term plan and accommodation strategy to inform accommodation requirements for the LDA programme. This includes wider creative market engagement which will lead to several procurements with the market for 2024/25

Dynamic Support Register:

- Continual review of the Dynamic Support Register which informs all age admission avoidance where clinically appropriate

LDA Roadmap:

- Move to BAU: Purple light Epilepsy toolkit benchmarking; Lincolnshire LeDeR programme (Learning from Lives and Deaths - people with a learning disability and autistic people); Section 17 pilot as part of the accommodation strategy; Development of all age community support for Lincolnshire Autistic Community and family/carers; Sensory Environment work within the wards; CYP key workers.

TARGET OUTCOMES

For these two service improvement initiatives:

Physical Health Liaison Pathway

- Reduction in health inequalities for LDA citizens.
- Improved quality of annual health checks.
- Reduced (Inappropriate) demand on emergency departments and acute hospital admissions

Virtual Autism Hub

- Reduce health and societal inequalities experienced by autistic people and their families/carers
- Represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented.
- Providing employment opportunities within the hub, which can have positive impact on individuals' mental health.

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Medicines Optimisation

KEY AREAS OF WORK

Primary care cost efficiencies
Identifying and addressing unwarranted variation in primary care prescribing

Community Pharmacy Integration
Including: Discharge Medicine Service; oral contraception; Blood Pressure Check Service; Smoking Cessation Advanced service; Palliative care drug stockist scheme

MO integration across the system
Engagement with practices; primary/secondary care interface

Secondary Care Procurement
Targeted list of drugs

Biosimilars
Implementation of biosimilar switch policy/protocol; addressing unwarranted variation

Antimicrobial Stewardship
Continued analysis of prescribing data; engagement of prescribers across the system

Quality and Safety
Establish Medicines Safety Network; strengthen Local Intelligence Network around the management and use of controlled drugs; Promote safe prescribing & deprescribing of opioid medication; Ensure the safe prescribing of valproates

Aseptic production
Develop a pharmacy aseptic hub to supply aseptic medicines beyond ULHT into the wider ICS and region

Antidepressant reduction
Upskilling prescribers; Identifying patients in primary care for reduction; Ensure new prescriptions in line with good practice standards and system guidelines

Pharmacy Workforce:
Focus on: marketing and attraction; recruitment; training and placements; career mapping

TARGET OUTCOMES

- **Better use of NHS resources**
- **Reduction in prescribing of targeted self-care products.**
- **More services provided to patients at their local community pharmacy**
- **Supporting patients with their medicines following discharge from hospital**
- **Improved compliance with formulary and local prescribing guidelines**
- **Reduce multi-drug resistant infections, reduction in number and length of hospital stays**
- **Reduce medicines-related harm to patients**
- **Improved patient clinical outcomes through improved availability and distribution of aseptic products**
- **More equitable access to pharmacy professionals for advice and drug supply**

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People & Workforce

KEY AREAS OF WORK

Value our People

- Work together across the system to deliver against the six high impact actions set out in the equality, diversity and inclusion improvement plan for the NHS
- Embed a compassionate culture built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system level networks
- Develop and launch system-wide occupational health & wellbeing services

Grow our People

- Widen access of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships.
- Engage with higher education institutions to support students, placement capacity and maximise accreditation of recognition of prior learning (RPL)
- Adopt new recruitment practices and systems in line with the national overhaul
- Embed strategic workforce planning through enhanced systems & processes

Develop our People

- Increase placement capacity & experience to support increased training places
- Develop multi-professional, system-based rotational clinical placement models
- Agree the system level Leadership Development & Talent framework
- Fully embed digital technology in training pathways

Retain our People

- Continue to embed the People Promise elements to enhance staff experience
- Agree and publish a consistent system-wide benefits offer
- Continue to focus on flexible working as a means of retaining our staff
- Work with specific staff groups/network through pilot projects
- Continue to strengthen our pastoral care for international recruits

TARGET OUTCOMES

Financial Recovery projects for 24/25

- Overall general sickness management: reduce sickness management spend by 1% across provides
- Medical productivity increased through effective job planning
- LCHS Apprenticeship Centre embedded as a revenue generating unit

Bank & Agency Spend reduction schemes

- Reduce agency spend at all providers to ≤3.7% of pay bill: focussing on improving off-framework usage and cap compliance across provider organisations

Corporate Transformation Programme

- Design and implementation of new operating model

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Digital

KEY AREAS OF WORK

- Digital Social Care Records
- Development of the Lincolnshire Care Record
- Scope an online go-to resource for the population to navigate health, care and wellbeing
- Improve cybersecurity
- Improve technical infrastructure
- Integration of digital systems
- Improve technical capabilities for collaboration
- Develop framework to assess and address digital skills readiness (staff or population)
- Technology enabled care (remote monitoring, virtual wards, etc)
- Robotic Process Automation
- Support areas with digital solutions that enable business change (such as People and Workforce)
- Introduce shared system intranet
- Use operational data to provide intelligence at a system level
- Handover of maintenance and support of the reporting platform from external arrangements
- Replacement of the reporting platform
- Determine requirements for social prescribing digital solution
- Access for clinicians to LACE evidence base
- Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services

TARGET OUTCOMES

- improved decision making across pathways of care, improving patient outcomes and use of resources
- The population will be supported in keeping well, avoiding admissions, accessing health and care services only when needed making best use of resources and supporting choice and access and reducing health inequalities.
- Avoiding breaches of information including patient information, recovery costs and reputational damage.
- Provide the infrastructure that enables a modern, mobile workforce and patients to access online services.
- Reducing the need for travel and making more efficient use of resource and expertise across geographical areas in the context of rising demand
- Improve processes through speed and efficiency, freeing up staff to deal with more complexity
- Ensuring that at the end of the Optum contract, access and ongoing development of the joined intelligence dataset does not cease
- Informs a system level decision on where information needs to be captured, how it is shared to support PHM, health and care delivery, and reporting
- Putting research and evidence into practice to achieve best outcomes for patients
- Ability to manage information that supports third sector support into health and care and social prescribing

Personalisation and a new relationship with the public

Population health and Prevention

Integrated Community Care for major conditions

A happy, valued and supported workforce

Data and digital technology

Delivering on the Joint Forward Plan priorities

Priority 1: A new relationship with the public

Programme	Initiative	More information
Personalisation	**Our Shared Agreement** Working with partners and people with lived experience to 'bring to life' and demonstrate what a new personalised and proactive relationship between people and the health and care system could look like and the impact It could have. Embedding the five foundations of Our Shared Agreement' that help to describe how we should/could work together. - Being prepared to do things differently - Understanding what matters to ourselves and each other - Working together for the wellbeing of everyone - Conversations with and not about the people - Making the most of what we have available to us	65
Maternity and neonatal services	- All women will be offered personalised care and support plans.	171
Cancer	- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028: Roll out Personalised Follow up Pathways across pathways and long-term conditions	157
Mental health: Adult	- Mental Health Prevention Concordat - Community MH transformation: whole person care – being mindful of physical, mental and social needs, assets, wishes and goals; Co-production – involving experts by experience as equal partners in the design, development and delivery of services	203
Learning Disabilities & Autism	- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD, who will subsequently receive more personalised care - The Lincolnshire Virtual Autism Hub, which will represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented, as well as providing employment opportunities	222

Delivering on the Joint Forward Plan priorities

Priority 1: A new relationship with the public

Programme	Initiative	More information
PCCSV	- Transforming the conversation between primary care and the public through a comprehensive programme of comms, engagement and co-production - Developing and commissioning a refreshed social prescribing model - Strategic partnership model with VCSE (LVET) agreed by June 2024 - 3 PCNs will be offering a High Intensity User Service by April 2024 - Implementing a case management and care co-ordination model to support delivery of PCN integrated primary and community teams - Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients - Implementing the Lincolnshire Frailty Strategy and associated delivery plans - Enhanced health in care homes: ensuring 90% of people living in a care home to have a personalised care and support plan in place by 2026 - Palliative & end of life care: ensuring 70% of people in the last year of life to have a care plan by 2025, 80% by 2026 - Falls: 70% of high-risk fallers will have received a holistic falls assessment by 2025	103
UEC	- Strength-based approach to supporting flow and transfer of care	119
Dementia	- Personalised care and support planning for people with dementia	212

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Health Inequalities & Prevention	**Preconception, infancy and early years** - High-quality midwifery and children's services that support mums, babies and little ones to get the best start in life - Increase the number of babies and infants vaccinated and immunised against diseases - Encourage more people planning a pregnancy to take folic acid supplements before, during and after pregnancy. - Reduce smoking during pregnancy and increase the number of smoke-free homes - Help parents and young families to stay active, eat well and look after their health. - Support more mums to breastfeed and increase breastfeeding rates at six to eight weeks - Increase the number of people accessing mental health services and support good relationships between parents and infants. **Childhood and adolescence** - Support young people with the services they need to keep them healthy and promote physical, mental and emotional wellbeing. - Develop mental health support teams to support young people's mental health and emotional wellbeing. - Give children and young people with disabilities or long-term conditions the support they need to reach their potential and lead a full and independent life, including psychological support. - Work with schools and colleges to encourage healthy habits, identify health needs early and provide access to support. - Improve oral health especially in deprived groups.	82

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Health Inequalities & Prevention	**Working age** - Work with people to understand their skills and knowledge and give them the confidence to look after their own health and wellbeing. - Identify people who could benefit from NHS health check and screening programmes and increase take-up - Ensure regular physical health checks for people with severe mental illnesses and people with a learning disability. - Increase access to NHS talking therapies for anxiety and depression and provide additional support by expanding local services such as peer support, mental health social prescribers and community connectors. - Support more people to stop smoking and offer people in hospital who smoke, including pregnant women & high-risk mental health outpatients - Support more people who need help achieving a healthy weight by increasing uptake of our integrated lifestyle service and the NHS Digital Weight Management programme. - Improve support for people suffering from and at risk of Type 2 Diabetes to help reverse and stop the progression of the disease, - Reduce cardiovascular disease through early detection, better management of those known to be at high risk and encouraging people to manage their own health better. - Better support people waiting for treatment for musculoskeletal conditions such as back pain. Explore opportunities to improve their physical and mental health prior to any planned operations. - Improve oral health, especially in deprived groups. **Ageing well** - Find out what matters to patients and their carers for better future care planning. - Encourage more people to get vaccinated and immunised against disease, especially those in deprived groups - Improve oral health. - Provide care focused on the individual for patients and carers living with cancer. - Improve early diagnosis and detection rates for cardiovascular disease and cancer, particularly colorectal cancer. - Improve brain health and prevent people from developing dementia by understanding risk factors e.g. smoking, high alcohol intake & hearing loss - Develop a Strength and Balance programme to prevent falls	82

Delivering on the Joint Forward Plan priorities

Priority 2: Living well and staying well

Programme	Initiative	More information
Primary Care, Communities & Social Value	- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework, which will include supporting prevention and management of risk factors;	103
Mental health: Adult	- Mental Health Prevention Concordat - Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing - Further development of the adult eating disorder pathways including prevention and early intervention - Developing a local model for SMI Health checks delivery including interventions to support aiming to reduce premature mortality and reduce co-occurring conditions - Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place	203
Dementia	- Focused prevention programme aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Utilising health inequalities data to support delivery	212

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Urgent & Emergency Care	- A focus on increasing care closer to home and reducing the requirement for patients to attend EDs in order to access services - Evolution of simplified access for both patients and professionals (including HCP SPAs and NHS 111)	119
Planned Care	**Waiting List Reduction** - Eliminate 65 week waits by March 2024 and 52 week waits by March 2025 - Increase patient choice: promoting the Patient Initiated Digital Mutual Aid System which allows us to offer patients the ability to more easily and proactively opt-in to move provider when they have been waiting over 40 weeks for care and meet the criteria; Promoting the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients and increase number of specialties clinically triaged to optimise referral management; Expanding patient validation support by the EACH to out-of-area Providers with Lincolnshire patients - Increase Activity. Expanding the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times; Maximising capacity at the recently accredited Grantham Surgical Hub using HVLC; Increase self-referral for a range of conditions to meet local and national strategies; Expanding the range of services and procedures to be delivered in the community and moved away from secondary care; Working with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers; Expanding AQP Community Optometrist Triage Assessment and Treatment Service (COTATS) to include Independent Prescribers to support patients accessing medication at time of ophthalmology appointment rather than via a GP appointment. Incremental increase planned over next 3 years across the county - Scoping methodology for producing non-chronological waiting lists to ensure patients access services according to need - Scoping model for Women's Health Hub for Lincolnshire to meet national strategy **Outpatients** - Making the most of Virtual Consultations and Patient Initiated Follow Ups - Increasing Clinic Utilisation: Implement the 6-4-2 process for booking patient slots; Expand directly bookable functionality to all major specialties and use full digital functionalities to reduce Missed Appointments **High Volume Low Complexity & Day Case Rates** - ULHT theatre productivity programme: increasing day case rates, increasing theatre utilisation and improving pre-operative assessment. - Grantham surgical hub : the intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery; Increase day case surgery rates to ensure compliance with BADS	131

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Diagnostics	- Community Diagnostics Centres: Ongoing development and implementation of the CDC facilities across the county; Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities and identify locations for future CDC sites. - Endoscopy: development of new endoscopy and PET CT facilities - Electronic booking: trial of the SwiftQ booking process; implementation of the Rad Cockpit software	152
Cancer	- Improving access to Targeted Lung Health checks by end of 2026 we will have provided CT scans to 100% of the total population eligible for Lung screening, Q4 24/25 rollout to First Coastal and First Coastal Rural - Breast Pain clinics are held weekly, one at Lincoln- North Hykeham Health Centre and one at Boston - Boston health clinic. Plan for further clinic at Skegness pending demand. The referral numbers are steadily increasing and 84.7% of GP practises have now made at least one referral to the pathway. - Planning to provide four Chemotherapy Chairs at the Skegness CDC - Chemotherapy Treatment Bus – providing non-complex treatment to patients across Lincs - Gynae community clinics in around Spring/Summer 2026, once the workforce is trained - 81% of endometrial patients (patients with a thickness of 10mm or below) can be seen in a community clinic which in turn would free up consultant to see first appointment 2WW patients and reduce the waiting time along with many other benefits. A new community-based clinic will be delivered to support patients that don't need consultant intervention in the hospital. Locations are yet to be confirmed, but it could potentially mirror the breast pain clinics and be located in health centres in the community. The aim of the project is very clear – to reduce unnecessary referrals into the hospital by still supporting the patients and assessing their needs. This will support earlier and faster diagnosis of cancer by reducing waiting times and ensuring that consultant time is more appropriately prioritised - Supporting 14 community cancer support groups, 7 financial support groups and 19 other cancer wellbeing groups across the county	157

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Children & Young People	- Diabetes: Reduce variation of care; Increase CYP utilising technology; access to psychological support services - Clinical Intervention in Schools Review: Providing a health offer to meet the needs of CYP with SEND in Lincolnshire's 'All Needs' special schools. - Asthma: Implementation of NHSE National Asthma Bundle; Access to diagnostic hubs, community spirometry & FeNO testing; Increased access to training for staff; Increased access to resources for CYP & families to support self-management - Epilepsy: Improved access to: Epilepsy Specialist Nurse; appropriate mental health and psychological support services; tertiary neurology - CYP Therapy Review: Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs - Children's Community Nursing (CCN) Review: Develop new service model that meets best practice and offers an on-call service; direct nursing care and PEOL care to all children on the CCNS caseload - Palliative End of Life Care for Babies, Children & Young People: 24/7 out of hours specialist clinical support/advice rota for professionals - Integration of assessment processes and support for CYP with SEND: Integrating EHC SEND, Independent Placements & Continuing Care processes	177
Mental health: Children & Young People	- Investment in Community Specialist Mental Health to reduce waiting times in community CAMHS - Increased access to specialist mental health assessment and treatment for CYP presenting with Avoidant/Restrictive Food Intake Disorder - CYP mental health liaison in Lincoln and Boston: Increased access to 24/7 mental health crisis support and assessment - MHUAC all-age pathway: increased access to 24/7 mental health crisis support and assessment - Kooth digital online and crisis respite: Increased access for CYP to support during MH crisis	195

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Mental health: Adult	- Continued development of alternative MH crisis provision - Holistic health for the homeless expansion - Continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision - Increase workforce and improve pathways for IPS/EIP services - Continued growth of CRT and PACT services countywide - Further development of the adult eating disorder pathways including prevention and early intervention - Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place - NHS111 to be the first point of contact for anyone in a mental health crisis - Implement a Single Virtual Contact Centre for calls to 111 and 999 and a mandated Interactive Voice Response option (SPA) - Expanding the MH urgent assessment provision to the east of the county - Introduce Cloud contact centre - Working with Lincolnshire Police and wider stakeholders to implement the national Right Care Right Person programme - Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available - Increasing workforce within NHS Talking therapies services, including supervision and long-term condition pathways, to reduce waits for first and follow up appointments, looking at digital options. - Improving waiting times for perinatal services and ensuring provision meets need - Increase capacity to meet local population demand, reduce waiting times and improve patient experience in neuropsychology, psycho-oncology, ME/Chronic Fatigue service design and development. - Ensuring model for dual diagnosis meets the needs of the Lincolnshire population.	203

Delivering on the Joint Forward Plan priorities

Priority 3: Improving access

Programme	Initiative	More information
Learning Disabilities & Autism	- Physical Health Liaison pathway: provide hospital and community staff with training on the support needs of patients with LD - The Lincolnshire Virtual Autism Hub, which will provide easily accessible community support, signposting and a level of advocacy - Development of a Children & Young People's Autism Diagnostic Pathway	228
Primary Care, Communities & Social Value	- Improve access to community pharmacy services in line with Pharmacy First - Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions	103

Delivering on the Joint Forward Plan priorities

Priority 4: Delivering integrated community care

Programme	Initiative	More information
Primary Care, Communities & Social Value	Entire portfolio which is comprised of these three programmes: - Integrating primary care: Integrating primary care and delivering access; Developing Partnerships to Support Primary Care Integration; Vaccinations - Integrating community partnerships: PCN Development; Integrating Care - Integrating Specialist Care: Ageing well – Older age; Long Term Conditions – Working age	103
Children & Young People	- An integrated care pathway for CYP Asthma - Develop suitable clinical intervention within schools for CYP with complex health needs in an education setting closest to a CYP's home. - Develop an integrated CYP Therapy Service that provides specialist physio, SALT & OT for CYP with complex physical or speech, language & communication needs - Integration of assessment processes and support for CYP with SEND: Integrating EHC SEND, Independent Placements & Continuing Care processes	177
Mental health: Children & Young People	- Complex Needs Service review: Better integrated care available in the community for Lincolnshire CYP with complex presentations, who may be engaging in risk taking behaviours	195
Mental health: Adult	- Continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision	203
Dementia	- Move towards a stand-alone MAS model in order to improve the dementia diagnosis rate for Lincolnshire and reduce memory assessments waits	212
Medicines optimisation	- Community Pharmacy Integration including: Discharge Medicine Service; oral contraception; Blood Pressure Check Service; Smoking Cessation Advanced service; Palliative care drug stockist scheme - MO integration across the system : Engagement with practices; primary/secondary care interface	239

Delivering on the Joint Forward Plan priorities

Priority 5: A happy and valued workforce

Programme	Initiative	More information
People & Workforce	• Work together across the system to deliver against the six high impact actions set out in the equality, diversity and inclusion improvement plan for the NHS • Embed a compassionate culture built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system level networks • Develop and launch system-wide occupational health & wellbeing services • Widen access of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships • Engage with higher education institutions to support students, placement capacity and maximise accreditation of recognition of prior learning (RPL) • Adopt new recruitment practices and systems in line with the national overhaul • Embed strategic workforce planning through enhanced systems & processes • Increase placement capacity & experience to support increased training places • Develop multi-professional, system-based rotational clinical placement models • Agree the system level Leadership Development & Talent framework • Fully embed digital technology in training pathways • Continue to embed the People Promise elements to enhance staff experience • Agree and publish a consistent system-wide benefits offer • Continue to focus on flexible working as a means of retaining our staff • Work with specific staff groups/network through pilot projects • Continue to strengthen our pastoral care for international recruits	270

Delivering on the Joint Forward Plan priorities

Priority 5: A happy and valued workforce

Programme	Initiative	More information
Personalisation	• By April 2026, All relevant staff working on the agreed pathway development have completed appropriate personalisation training as part of their induction/mandatory training • By April 2028 Personalisation is included in the values-based recruitment policy for all statutory organisations and is a key part of the selection process as well as appraisal process/supervision processes • By April 2028 there is a clear strategy in place to embed personalisation in workforce development at every level (training, degree, post grad, CPD etc) • By April 2028 all local policies and procedures reflect how personalisation and strength-based approaches are embedded in service delivery and the organisations core values.	65
Primary Care Communities & Social Value	• Deliver the Primary Care People Plan	103
Maternity	• Supporting our workforce to develop their skills & capacity to provide high-quality care	171
Medicines Optimisation	• Pharmacy workforce development – focus on: marketing and attraction; recruitment; training and placements; career mapping	239

Section 1: Introduction

- The national requirement and the Lincolnshire approach
- How it was developed – key drivers
- Where it fits with our strategic vision for health and care

NHS Lincolnshire Joint Forward Plan 2023-28

The national requirement

- The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to prepare their Joint Forward Plan (JFP) before the start of each financial year.
- Systems have significant flexibility to determine their scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements

The Lincolnshire approach

Rather than cover all the national requirements in as single document, the Lincolnshire NHS agreed to develop separate documents, which are tailored to the target audiences:

- **NHS Lincolnshire Joint Forward Plan 2023 – 2028** [published June 2023]
  - a relatively concise public-facing document, which is easy to read and understand
  - articulating our new strategy for the NHS in Lincolnshire, co-produced with people and communities

This is underpinned by a number of more technical documents which are primarily targeting health and care staff but will still be publicly available:

- **Allocation of Duties and Responsibilities** [first published June 2023]
  - outlining how the legal duties and responsibilities of the ICB and NHS partner Trusts in Lincolnshire are exercised. This will be updated annually.

- **JFP Delivery Plan [this document]**
  - collating the delivery plans for the system service transformation and enabler programmes; the development of these will also be informed by further engagement with people and communities
  - Providing further details on how the five JFP priorities will be delivered

- **Activity, Workforce and Finance Plans**
  - Rolling, five-year projections (detail for Years 1 & 2; estimates for Years 3-5) that reflect the programme delivery plans as far as possible

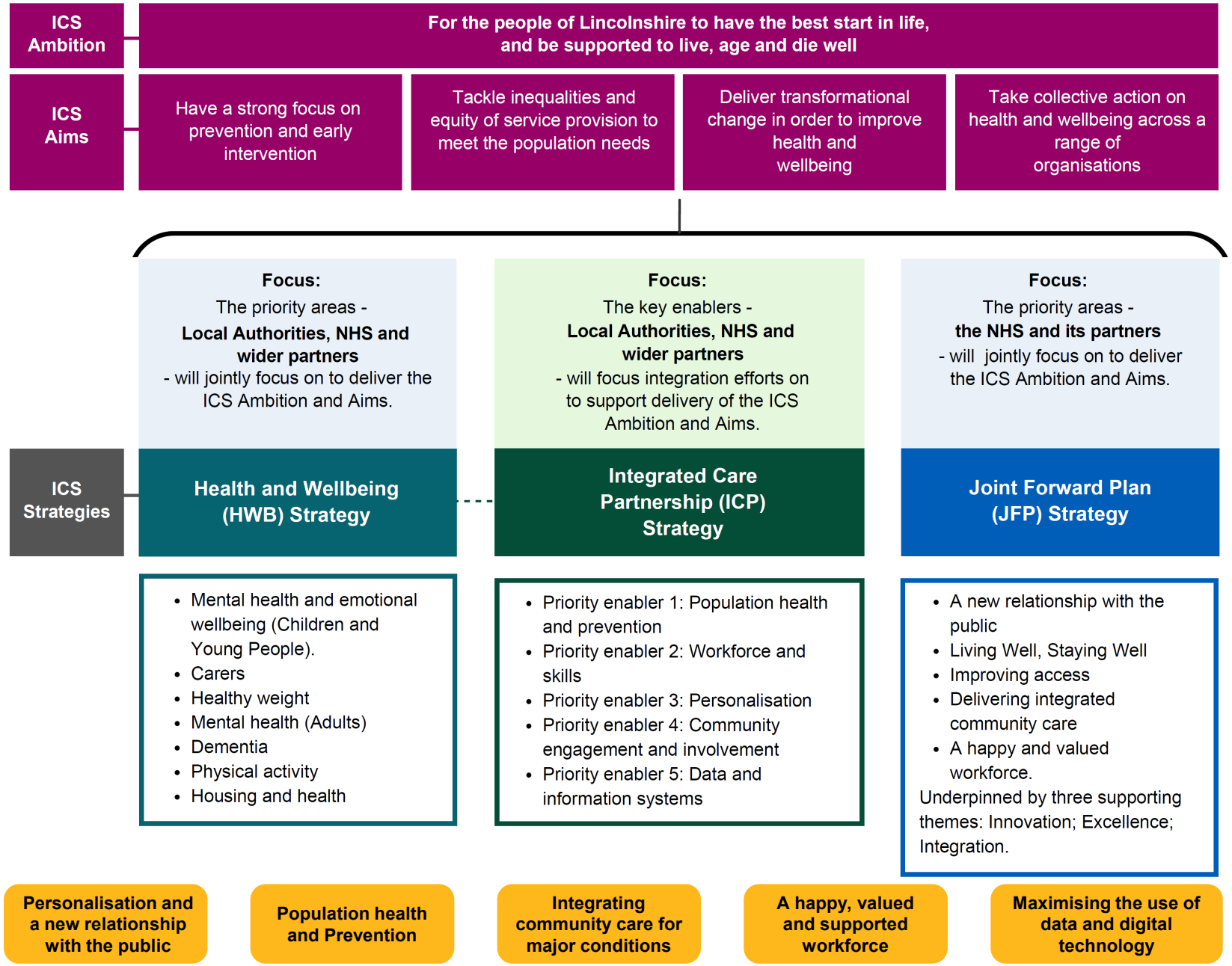
Key drivers

The key drivers informing the development of this plan have been

- Population insight: understanding the needs, causes, outcomes and disparities of our populations through analysis of population and public health data, along with patient and citizen feedback
- Current status of local services: service sustainability, efficacy and efficiency, including analysis of performance and benchmarking data
- System strategy: Health & Wellbeing Strategy, Integrated Care Strategy and the NHS Lincolnshire strategy
- National priorities, objectives & targets e.g. urgent and emergency care, primary care access, and elective and cancer care recovery plans

These programme delivery plans will continue to be evolved in response to national policy (e.g. Major Conditions Strategy) and local developments (e.g. development of Community Primary Partnerships).

Where the JFP fits with our strategic vision for health and care



Our five cross-cutting strategic themes

Personalisation and a new relationship with the public

At the heart of the Better Lives Lincolnshire strategy is the recognition that we need to establish a new relationship with the public.

Together with the people of Lincolnshire, we want to build a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

This strategic theme has five key elements:

- Creating a shared agreement.
- Supporting shared decision making
- Developing and designing services together
- Working with people and their families to manage their own health and wellbeing
- Supporting people to feel connected and engaged in their local communities

Population health and Prevention

Population health and prevention is the 'golden thread' that runs through our strategies and underpins its focus on improving health and wellbeing and tackling inequity.

Addressing the wider determinants of health will help improve overall health by helping to improve the conditions into which people are born, live and work. Addressing these determinants throughout the life course allows us to consider the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

People have different needs at different points in their lives and we have specific ambitions relating to each life stage: Preconception, infancy and early years (0-5); Childhood and adolescence (5-19); Working age (16-64); Ageing well

Integrating community care for major conditions

Integrating primary care: delivering timely access to primary care – general practice, pharmacy, dental, optometry – today, while designing a sustainable future.

Integrating Specialist Care: delivering improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new models of care, via a one team approach, transcending organisational boundaries; adopting a more proactive and holistic approach informed by individual wishes and need; Focussing on prevention, early identification and diagnosis; Delivering both timely, urgent care & long-term ongoing care

Integrating community partnerships, developed around PCN footprints; supporting their ongoing evolution to provide person-centred care, delivered by multi-disciplinary & multi -agency teams, for local communities, reflecting population need

A happy, valued and supported workforce

We truly appreciate our people and everything they do. We also appreciate the link between an engaged, happy workforce who feel valued and the quality and efficiency of the care they are able to deliver.

Having the right workforce in the right place at the right time allows our services to meet the healthcare needs of people locally.

To continue to do this we need a constant flow of talented people from our communities into the organisations. We also need to provide good opportunities for training and development to encourage them to stay in Lincolnshire rather than move elsewhere.

To develop our workforce in Lincolnshire we will:

- Value our people
- Grow our people
- Develop our people
- Retain our people.

Maximising data and digital technology

As health and social care services face unprecedented challenges, data, digital technology will be at the heart of how we transform health services for the benefit of citizens, patients and staff.

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

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

Our planning aims, approach, principles & priorities

Our Planning Aims

Maximising the use of our collective resources

Better Care
Improving patient outcomes: patient experience; patient safety; clinical effectiveness

Better Health
Improving the health of the Lincolnshire population – tackling the burden of disease & health inequalities

Better Value
Reducing the per capita cost of healthcare: reducing avoidable activity; eliminating waste

Our Planning Approach

Expert-led; intelligence-driven; year-round

Diagnosing & Prioritising
Analysing citizen feedback, public health, PHM & performance data

Defining & designing
Exploring and testing desirability, viability & feasibility

Planning the change
Developing the blueprint for implementation

Managing implementation
Executing plans to move to future state

Evaluating & Refining
Change is refined/embedded/ spread/stopped

Our Improvement Priorities

Integration; Excellence; Innovation

Stop
avoidable illness & intervene early

Shift
to digital and community

Share
the best

Strengthen
the hands of the people we serve

Support
our partners

Section 2: Our population

a) An overview of the health and wellbeing of Lincolnshire's population: headlines from the Joint Strategic Needs Assessment (March 2023)
b) Our target populations from a health inequalities perspective
c) Getting a deeper understanding of: the population's differing health needs, preferences and risks; the inequalities that exist within the county

POPULATION

Size

Lincolnshire's population is

768, 364

(Census 2021)

129
people per km²
(Census, 2021)

9.5%
Population projection by 2040
(ONS, 2018)

6,559
Births recorded
(ONS, 2021)

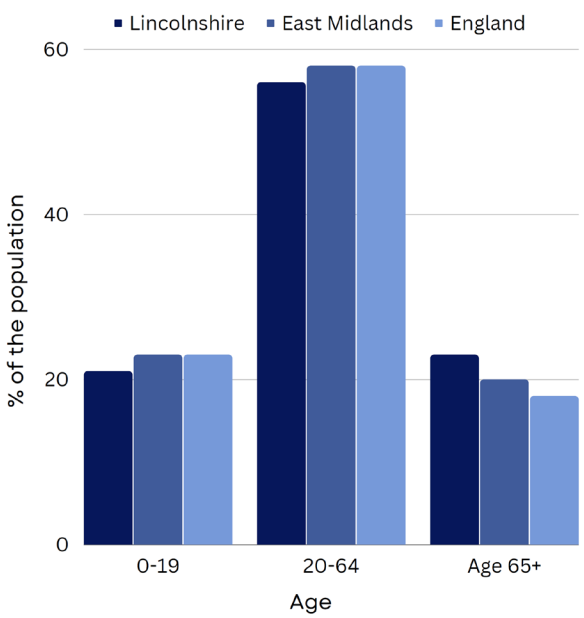
9,128
Deaths recorded
(ONS, 2021)

813, 119
Patients are registered with a GP practice in Lincolnshire
(NHS England, Feb 2023)

Demographics

Age

(Census 2021)

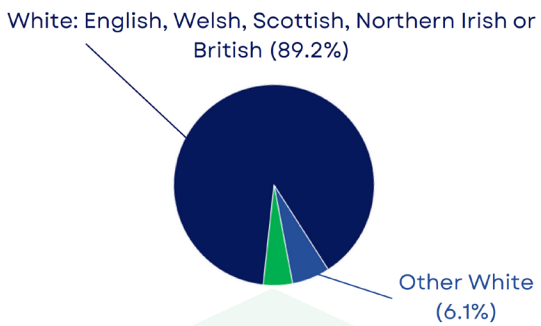


Sex

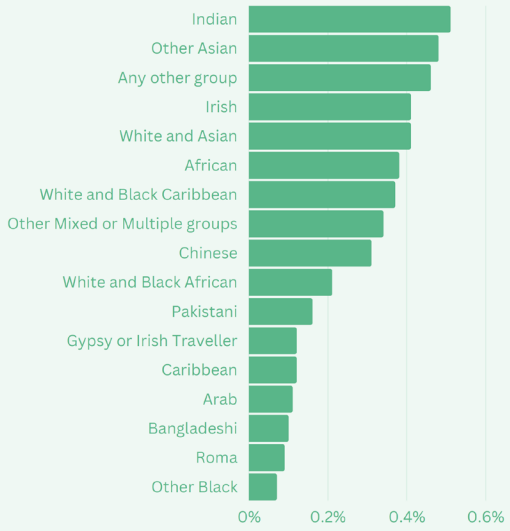
(Census 2021)

Ethnicity

(Census 2021)



Other Ethnic Groups (4.7%)



Characteristics

19.1% have a disability (26.8% of households)

304, 863 people are married or in a civil partnership

2.7% identify as lesbian, gay, bisexual, pansexual or queer

14, 921 (1.9%) follow a religion other than Christianity

8.71% use a main language which is not English

(Census 2021)

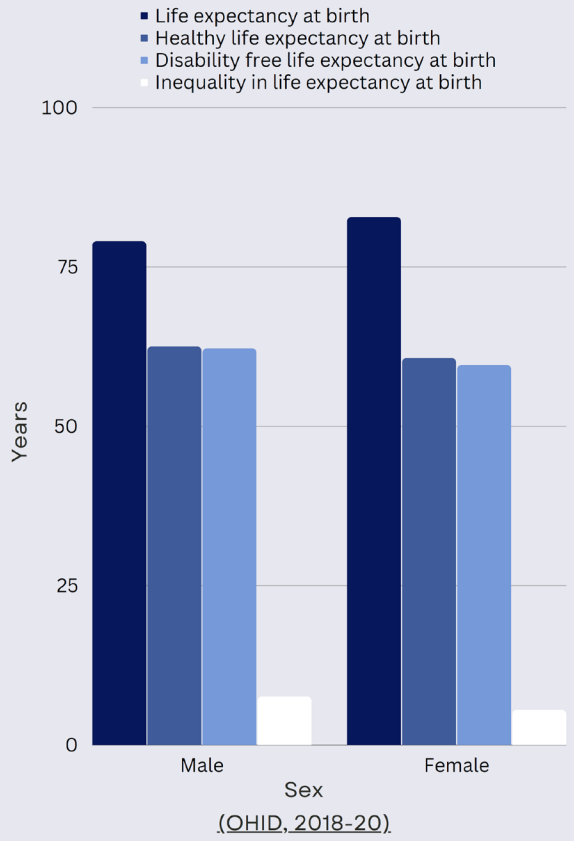
Last updated March 2023

HEALTH & WELLBEING

Life Expectancy

Females live
4.5 years
longer than males (ONS, 2021)

Males live
2.6 more years
disability free than females (ONS, 2018-20)



(OHID, 2018-20)

Health Outcomes

79.3%
of residents report being in good or very good health


(Census, 2021)

The top 5 conditions amongst patients registered with GP practices in Lincolnshire are:


Hypertension | Depression | Obesity | Diabetes | Asthma

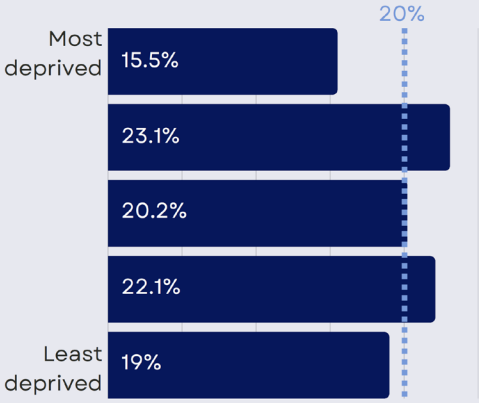
(QOF, 2021-22)

Of 9,128 deaths in Lincolnshire in 2021;

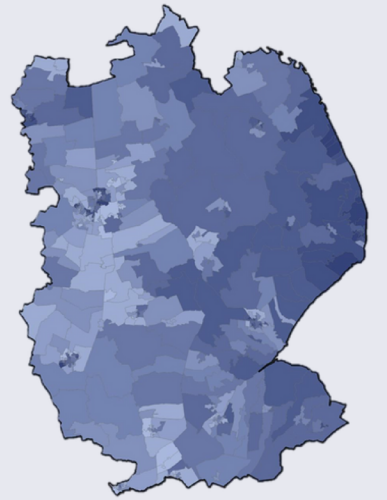
31.3%	10.7%	25.2%	3.8%	25.9%
were before their 75th birthday	involved Covid-19	had underlying cancer	had underlying COPD	had underlying cardiovascular disease

(OHID, 2021)

Deprivation



(IMD, 2019)



Last updated March 2023

START WELL

Population

21%
of Lincolnshire's population are aged 0-19 years (161,200 people) (Census 2021)

2%
Population projection by 2040 (ONS, 2018)

6,559
Births recorded (ONS, 2021)

18.1%
of mothers smoke in early pregnancy (MSDA, 2018-19)

66.4%
of babies' first feed was breastmilk (MSDS, 2020-21)

3.2 per 1,000
rate of deaths in infants aged under 1 year (ONS, 2019-21)

15.4%
of children live in income deprived families (OHID, 2020-21)

0-5 years

3.1%
of school pupils have a social, emotional or mental health need (DfE, 2021-22)

38.3%
of year 6 pupils are overweight or obese (NCMP, 2021-22)

64.1%
of children achieve a good level of development at the end of reception (DfE, 2021-22)

5-11 years

23.9%
of reception aged pupils are overweight or obese (NCMP, 2021-22)

25.5%
of 5 year olds have visible dental decay (OHID, 2018-19)

11-18 years

78.5 per 10,000
hospital admissions for unintentional and deliberate injury amongst 0-14 year olds (OHID, 2021-22)

47
is the average achievement across 8 qualifications (Attainment 8 score) (DfE, 2021-22)

5.4%
of 16-17 year olds are not in education, employment or training (DfE, 2021)

14.1 per 1,000
young women under 18 became pregnant (ONS, 2020)

Disease burden

The top causes of years lived with disability for children & young people in Lincolnshire are:

1. Dermatitis
2. Headache disorder
3. Anxiety
4. Asthma
5. Depressive disorders

(GBD, 2019)

JSNA

Last updated March 2023

LIVE WELL

Population

56%
of Lincolnshire's population are aged 20-64 years (426, 800 people) (Census 2021)

-0.67%
Population projection by 2040
(ONS, 2018)

Health behaviours

15.4%
of adults currently smoke
(GPPS, 2020-21)

67.6%
of adults are overweight or obese
(OHID, 2020-21)

62.9%
of adults are physically active
(OHID, 2020-21)

20.4%
of adults drink over 14 units of alcohol a week
(Health Survey for Eng, 2015-18)

Health outcomes

179.1 per 100,000
mortality rate from causes considered preventable amongst under 75s
(ONS, 2021)

15.8%
of adults have a common mental health disorder
(APMS, 2017)

Wider determinants

23.9%
of 16-64 year olds are economically inactive
(ONS, 2021-22)

25.6%
have a level 4 qualification or above
(Census, 2021)

14.2%
of households are experiencing fuel poverty
(BEIS, 2020)

13.3%
of residents live in social rented properties
(Census, 2021)

Disease burden

The top causes of years lived with disability for adults in Lincolnshire are:

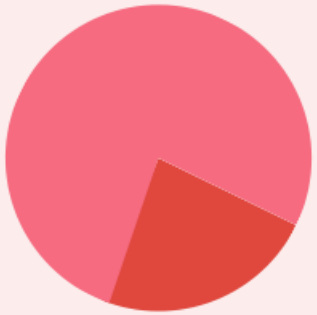
1. Low back pain
2. Depressive disorders
3. Headache disorders
4. Diabetes
5. Neck pain

(GBD, 2019)

JSNA
Last updated March 2023

AGE WELL

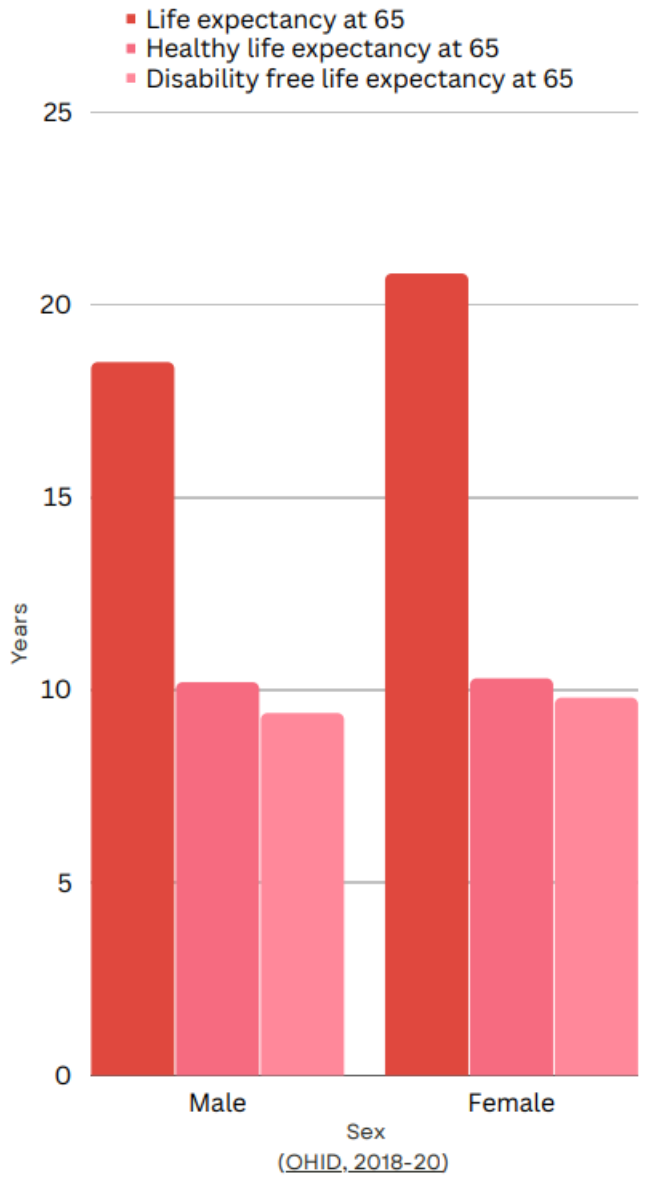
Population



23%
of Lincolnshire's population are aged 65 years or over (179, 805 people) (Census 2021)

40%
Population projection by 2040
(ONS, 2018)

Life expectancy



(OHID, 2018-20)

19.1%
of people are disabled under the Equality Act 2010
(Census, 2021)

14.4%
of those aged 66+ live alone
(Census, 2021)

3.2%
of people provide 50+ hours of unpaid care
(Census, 2021)

15.5%
extra deaths from all causes occur in the winter
(ONS, Aug 2019-Jul 2020)

1,712 per 100,000
hospital admissions due to falls in people aged 65+
(HES, 2021-22)

3.95%
of patients aged 65+ have dementia
(NHS Digital, 2020)

46.2%
of social care users, aged 65+, have as much social contact as they would like
(ASCOF, 2021-22)

526 per 100,000
adults aged 65+ are permanently admitted to residential and nursing homes
(ASCOF, 2021-22)

Disease burden

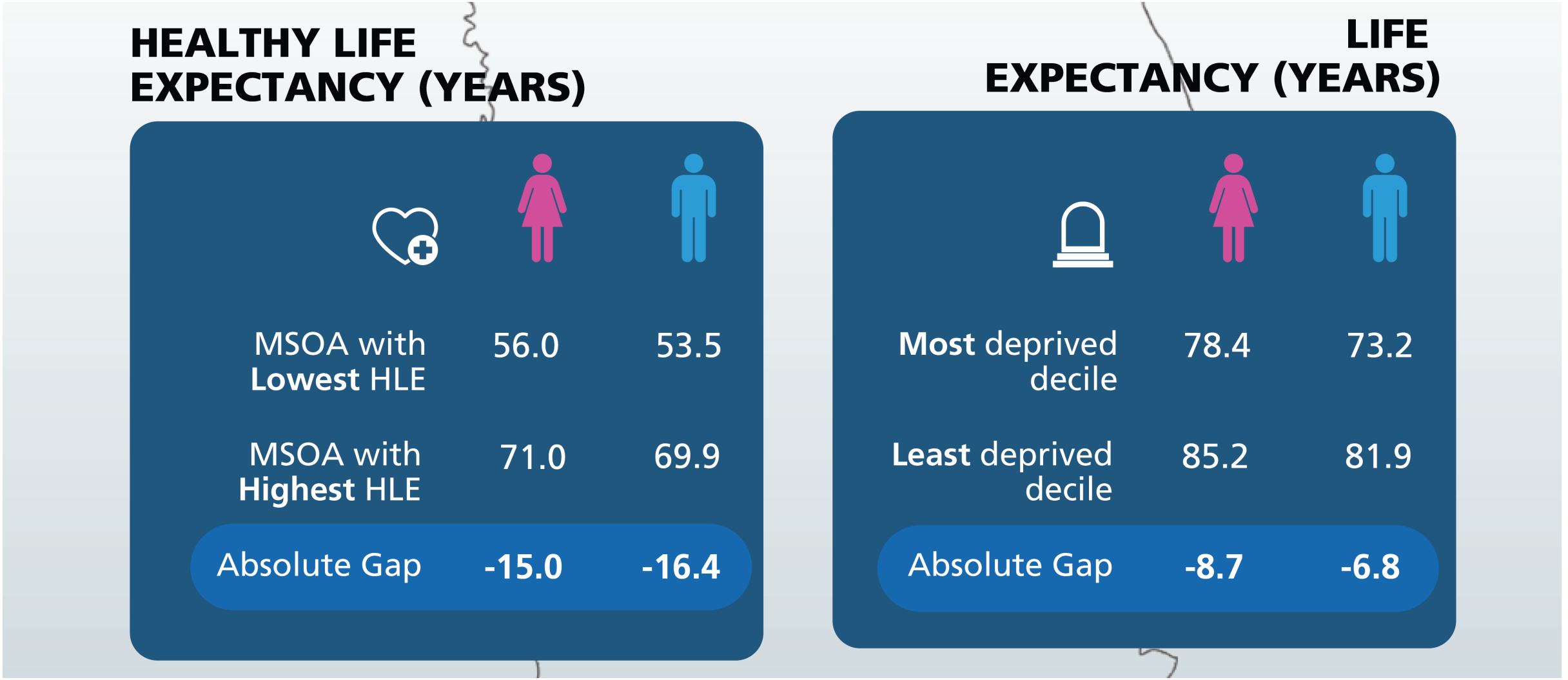
The top causes of years lived with disability for older adults in Lincolnshire are:

1. Low back pain
2. Diabetes
3. Age related hearing loss
4. COPD
5. Osteoarthritis

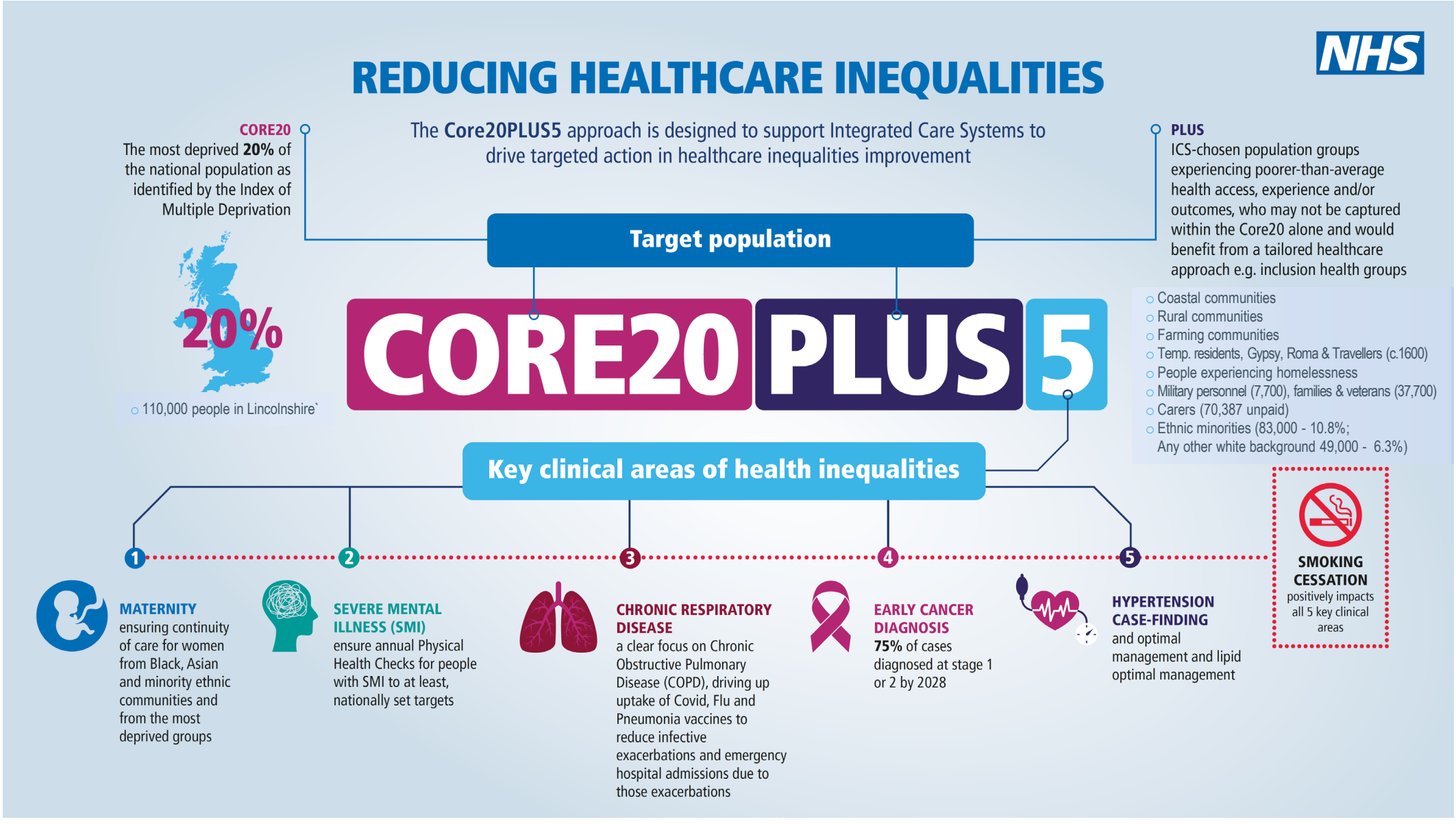
(GBD, 2019)

JSNA
Last updated March 2023

Health Inequalities: Life & healthy life expectancy gaps in Lincolnshire



Health Inequalities: Target Populations - Adults



Health Inequalities: Target Populations - Children & Young People

Lincolnshire Population Segmentation Model | Introduction

In population health management, a population segmentation model is used to categorise a large population into distinct groups or segments based on specific shared characteristics or health-related factors. The purpose of using a population segmentation model is to gain a deeper understanding of the population's health needs, preferences, and risks, and to tailor interventions and strategies accordingly. Critical purposes of using a population segmentation model in population health management include:

1. **Targeted Interventions**: Population segmentation helps identify subgroups within the population that have similar health characteristics or needs. By understanding the unique characteristics of each segment, organizations can design targeted interventions and programs to address specific health issues faced by each group. This approach increases the effectiveness of interventions by focusing on the needs of each segment.
2. **Resource Allocation:** With limited resources available, population segmentation helps prioritise resource allocation based on the identified health needs of different segments. By understanding the prevalence and severity of health conditions within each segment, healthcare systems can allocate resources strategically to provide optimal care and support where it is most needed.
3. **Risk Stratification:** Population segmentation enables risk stratification, which involves identifying individuals or subgroups at higher risk of developing certain health conditions or experiencing poor health outcomes. By categorising the population into risk tiers, healthcare organizations can proactively intervene and provide preventive care to individuals at higher risk, potentially reducing future healthcare costs and improving overall health outcomes**.**
4. **Health and Care Planning:** Population segmentation models inform healthcare planning by providing valuable insights into the health status, utilisation patterns, and needs of different population segments. This information helps in forecasting future healthcare demands, designing appropriate healthcare delivery models, and developing targeted health promotion campaigns
5. **Evaluation and Monitoring:** Population segmentation allows for better evaluation and monitoring of improvement initiatives. By comparing outcomes and health indicators across different segments, the system can assess the effectiveness of interventions and make data-driven decisions to refine and improve their population health management strategies.

Overall, the purpose of using a population segmentation model is to identify and understand the diverse needs of different population segments, enabling healthcare organisations to deliver targeted, efficient, and effective interventions and ultimately improving health outcomes for the entire population.

Design of The Lincolnshire SSM

The Lincolnshire SSM has been co-designed by a cross-system group of subject matter experts over a number of months, working to a directive and ambition from a system-wide Executive Leadership group.

The Lincolnshire SSM is an MECE model, this is a Mutually Exclusive Collectively Exhaustive model used to group data into categories that follow two specific rules: Mutually Exclusive – An item (or individual) can only be in one category at a time; and Collectively Exhaustive – All items (or individuals) must be included in one category. The MECE method is an analytics standard and makes it easier to analyse and derive useful conclusions, in this case on the focus of attention and resources across population need in relation to health and care.

Lincolnshire Population Segmentation Model | Application

The Lincolnshire Strategic Segmentation Model & the Joint Forward Plan

Currently in Lincolnshire we predominantly arrange ourselves around those parts of the system that are under pressure, and which require specific attention, such as UEC, or planned care, with a few notable exceptions such as the recent Frailty initiative. A system focus can be incredibly useful for making short term or rapid change to efficiency, productivity or quality of processes or pathways.

However, it is very difficult for direct care or clinical pathway stakeholders to make meaningful upstream change outside of their area of accountability or remit. Without upstream impact - prevention, early intervention, system transformation across organisations, workforces, contracts and resources – we cannot make any longer-term improvement to the cause of our pressures. Taking this traditional approach, we cannot switch from an organisation, system or disease pathway focus to a population health outcomes focus; or from a system designed to treat ill-health to one also designed to proactively prevent ill-health and intervene in the wider determinants of health.

Together the system planning approach and SSM present a huge opportunity for the Lincolnshire ICS to think differently about how we meet the challenges within our system whilst, and by, concentrating on the outcomes for our population.

We need to consider whether the current governance structures that we have in place meet the needs of each of our population segments and whether accountability for the outcomes for those segments is sitting with the right groups or individuals (or in some cases, with anyone at all). It is likely that we will need to rearrange some of our governance structures across the ICS to be able to respond effectively and make longer term improvements which focus proactively on population outcomes and the causes of ill health and system pressures, rather than reactively on the implications of that ill-health.

Adoption and Use

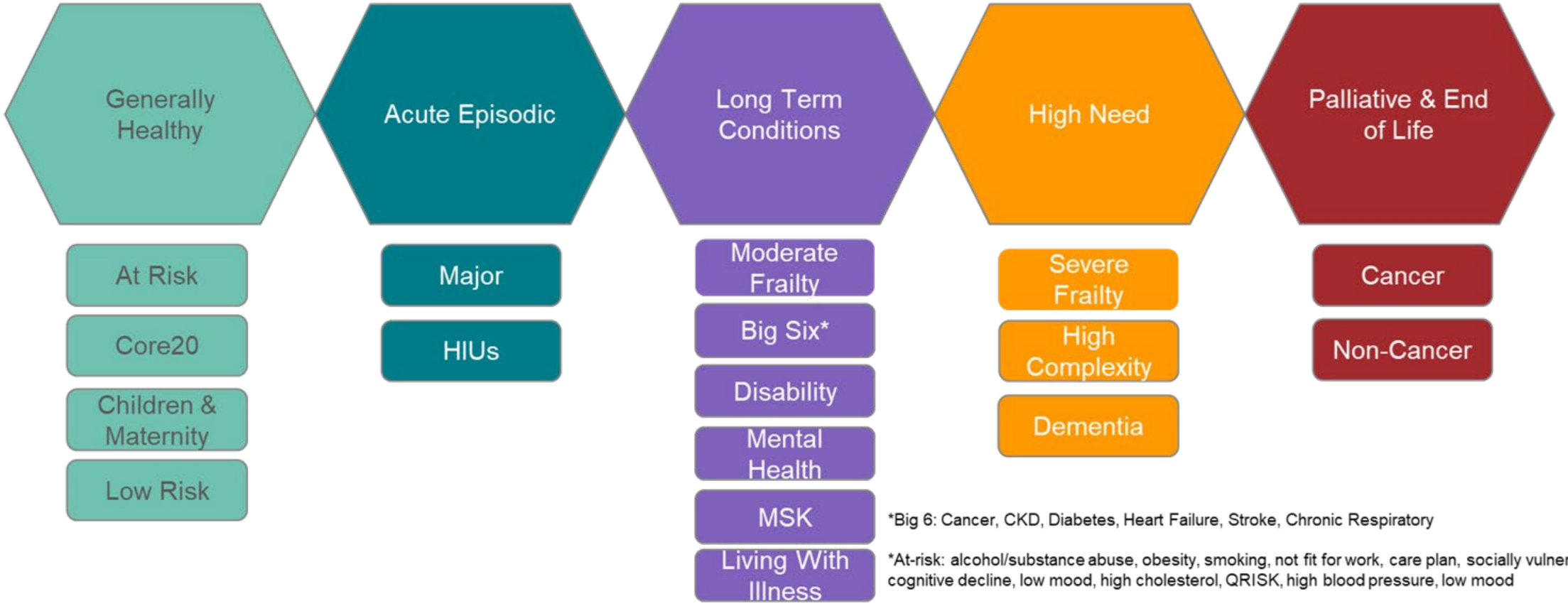
To gain maximum benefit for our local people from taking a consistent PHM approach in Lincolnshire and utilising a segmentation model to identify opportunity for improvement and monitor impact, it is recognised that an incremental approach to adoption will be required.

This model will not be able to be successful in isolation and therefore requires recognition and adoption by all partner organisations and to form part of the core infrastructure of the ICS. The plan for this will need to be codesigned throughout 23/24 with key partners such as the Clinical & Care Directorate, Strategy & Planning Directorates and other system stakeholders.

Approval of the *concept* of this segmentation model has been sought and received from all organisational boards and the ICS Clinical & Care Directorate. Detailed planning for implementation and adoption will continue into 2024/25, This is complex and needs to take account of: NHS England's operating model, regulatory factors/requirements and evolving system discussions regarding functions, roles and accountability.

In the meantime, we will continue to signal our system intent to use this approach, with specific areas of work e.g. framing the stocktake of population healthcare needs with the five segments; mapping service lines and system transformation programmes to the segmentation model; starting to analyse and report against these segments.

Lincolnshire Segmentation Model | Summary View



*Big 6: Cancer, CKD, Diabetes, Heart Failure, Stroke, Chronic Respiratory

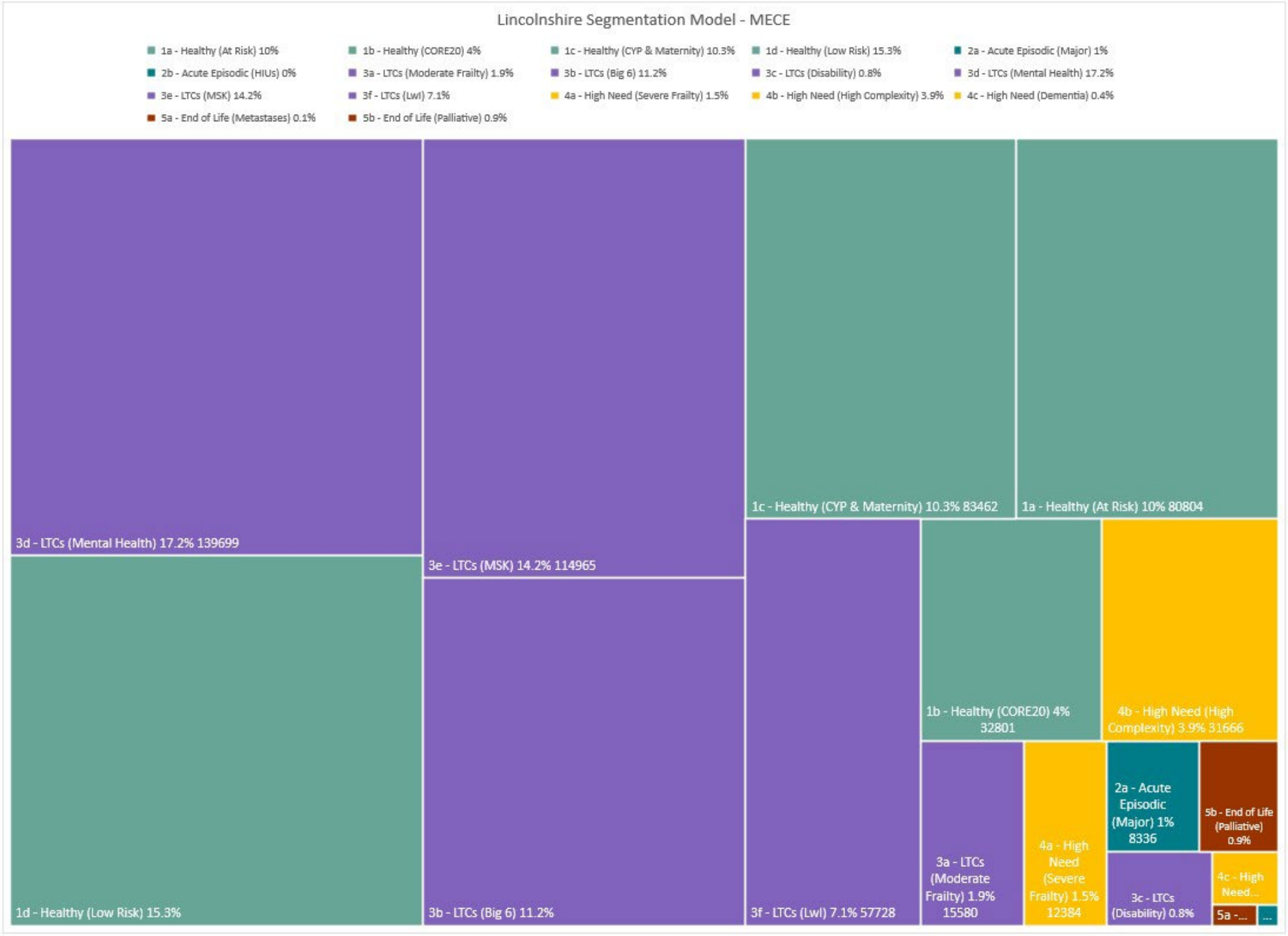
*At-risk: alcohol/substance abuse, obesity, smoking, not fit for work, care plan, socially vulnerable, cognitive decline, low mood, high cholesterol, QRISK, high blood pressure, low mood

*MSK: admission, outpatient attendance, or is on a waiting list, for one of the following specialties - Trauma and Orthopaedics, Rheumatology, Physiotherapy Service. We have also looked in the primary care dataset to look for any complaints of musculoskeletal pain, history of MSK issues or and referrals to a MSK Service.

*Mental Health: depression, anxiety, serious mental illness (e.g. bipolar & schizophrenia)

*Frailty: as defined by Electronic Frailty Index (eFI), these segments are defined by a high number of frailty deficits

Lincolnshire Segmentation Model – Cohort sizes

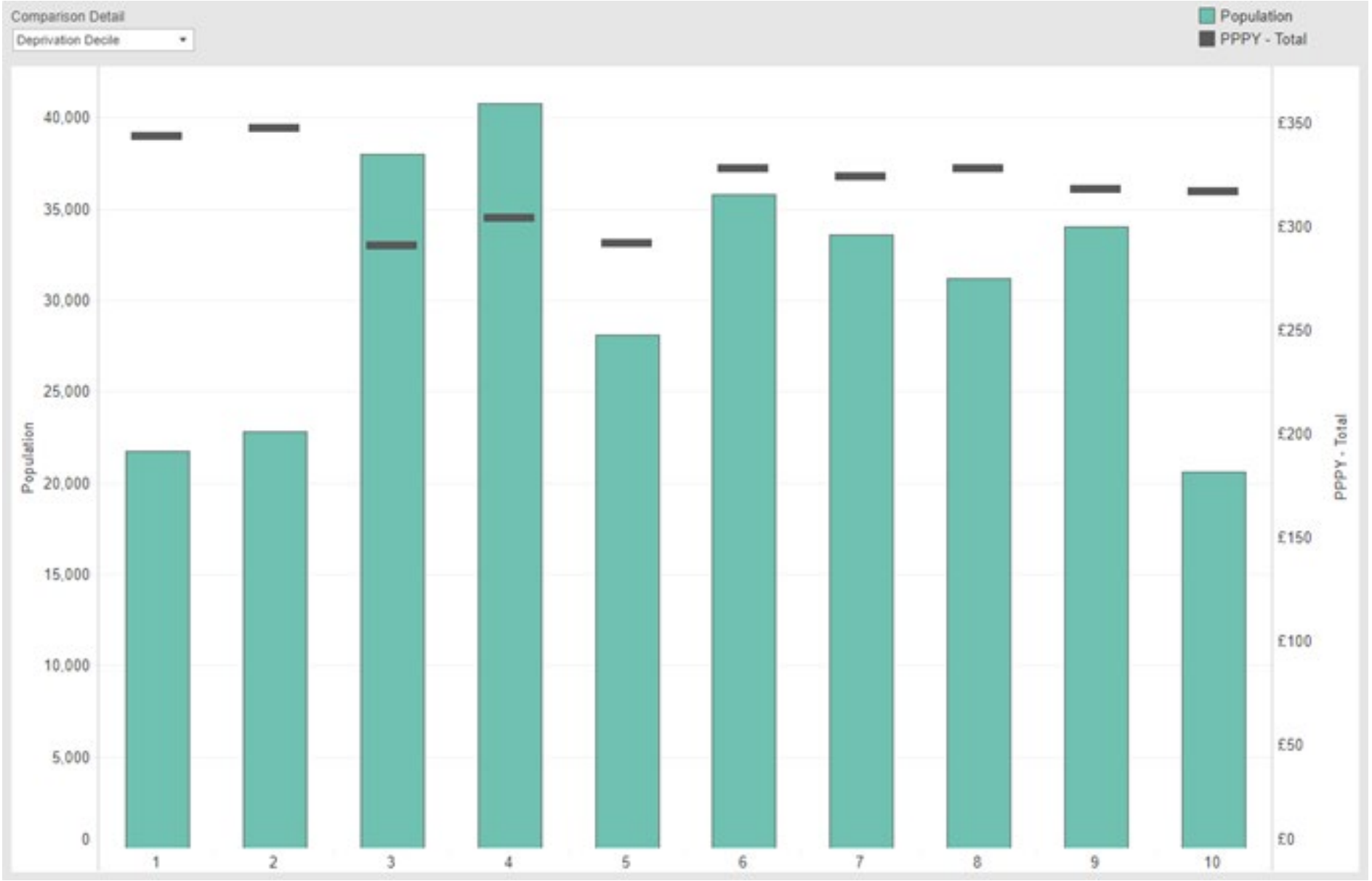


Segments by Spend and decile of multiple deprivation

Bringing together the population segmentation model and health inequalities

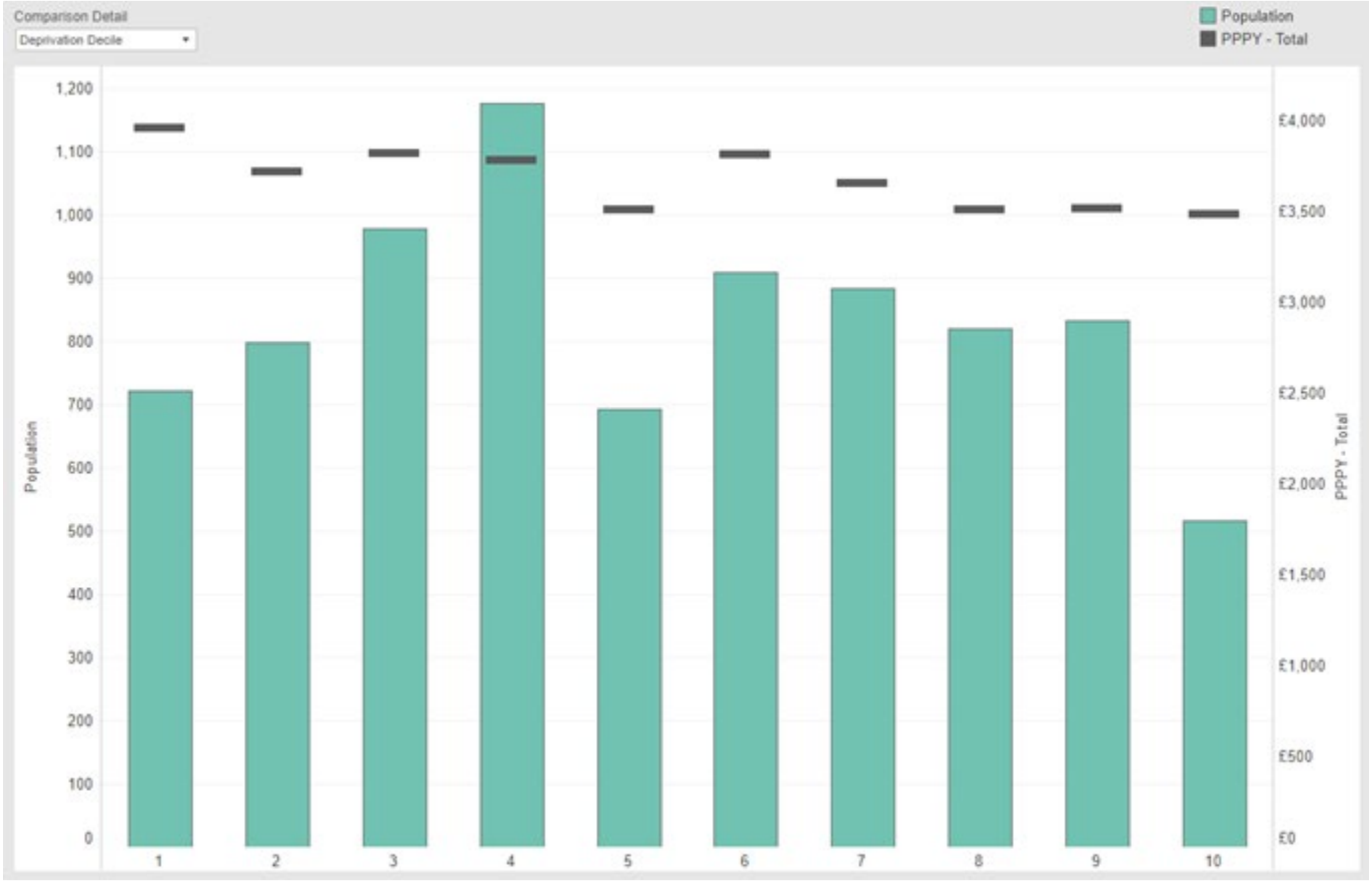
- The charts over the next five pages focus on each headline population segment and show the total population in the segment, and the Spend Per Person Per Year, split by the national decile of multiple deprivation within which those people live.
- IMD Deciles are national ones, reflecting where Lincolnshire's communities feature in the national scale of deprivation. This means that the number of people in each IMD decile in Lincolnshire is different depending on how relatively deprived they are.
- Therefore, population numbers are incredibly useful for understanding the *scale* of need.
- Spend Per Person Per Year (PPPY) is comparative and useful for understanding differences in the indicative cost of care for individuals in any given decile of a segment.
- This is why Lincolnshire has higher numbers of people in the middle deciles of any segment, as we have higher populations generally in the moderate range of deprivation deciles. However, there are clear gradients in the individual indicative cost of care for people in almost any segment when you look from the most deprived deciles (1 and 2) to the least deprived (9 and 10).

Segments by Spend PPPY and IMD Decile: 1. Generally Healthy



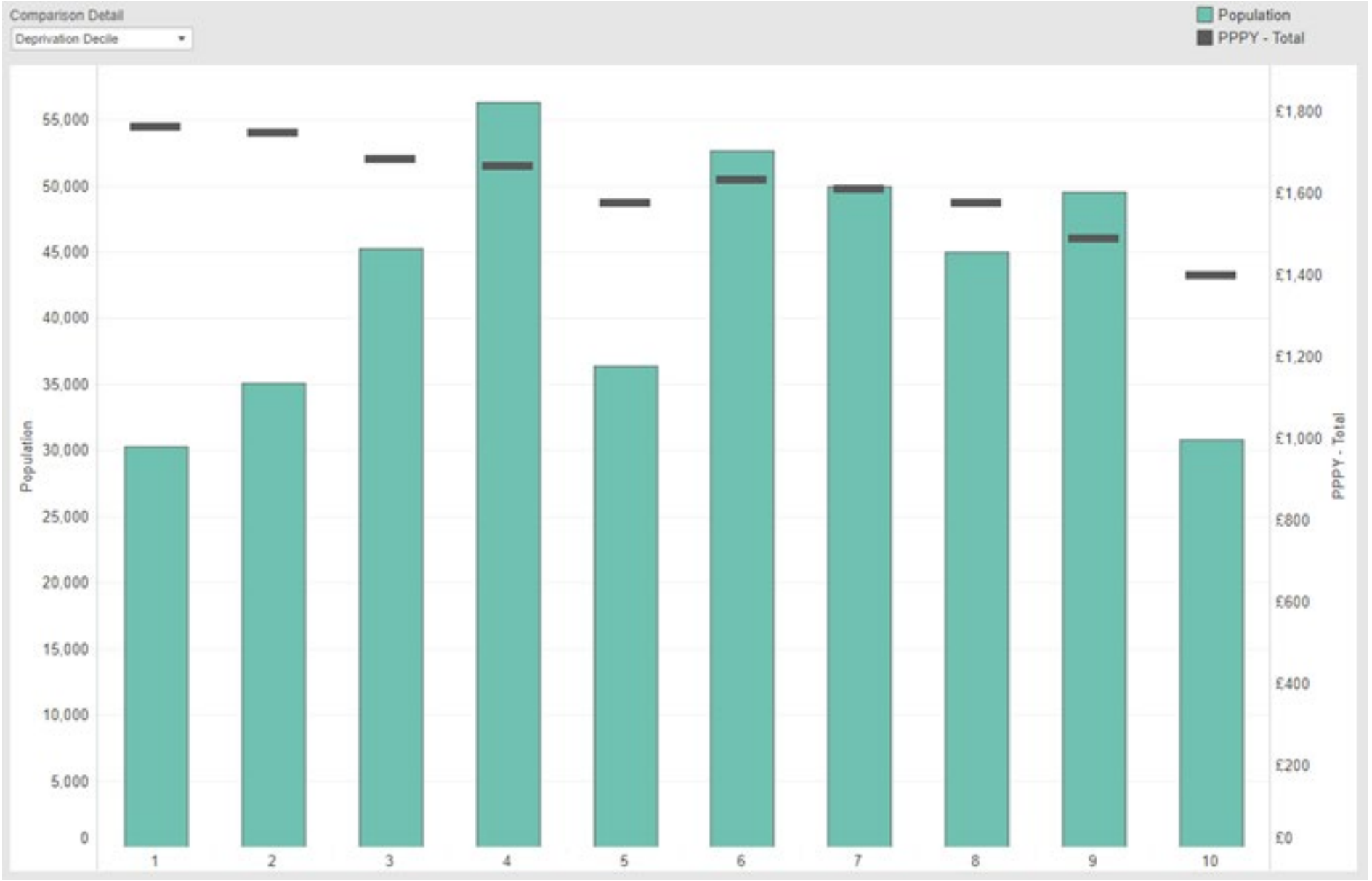
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 2. Acute Episodic



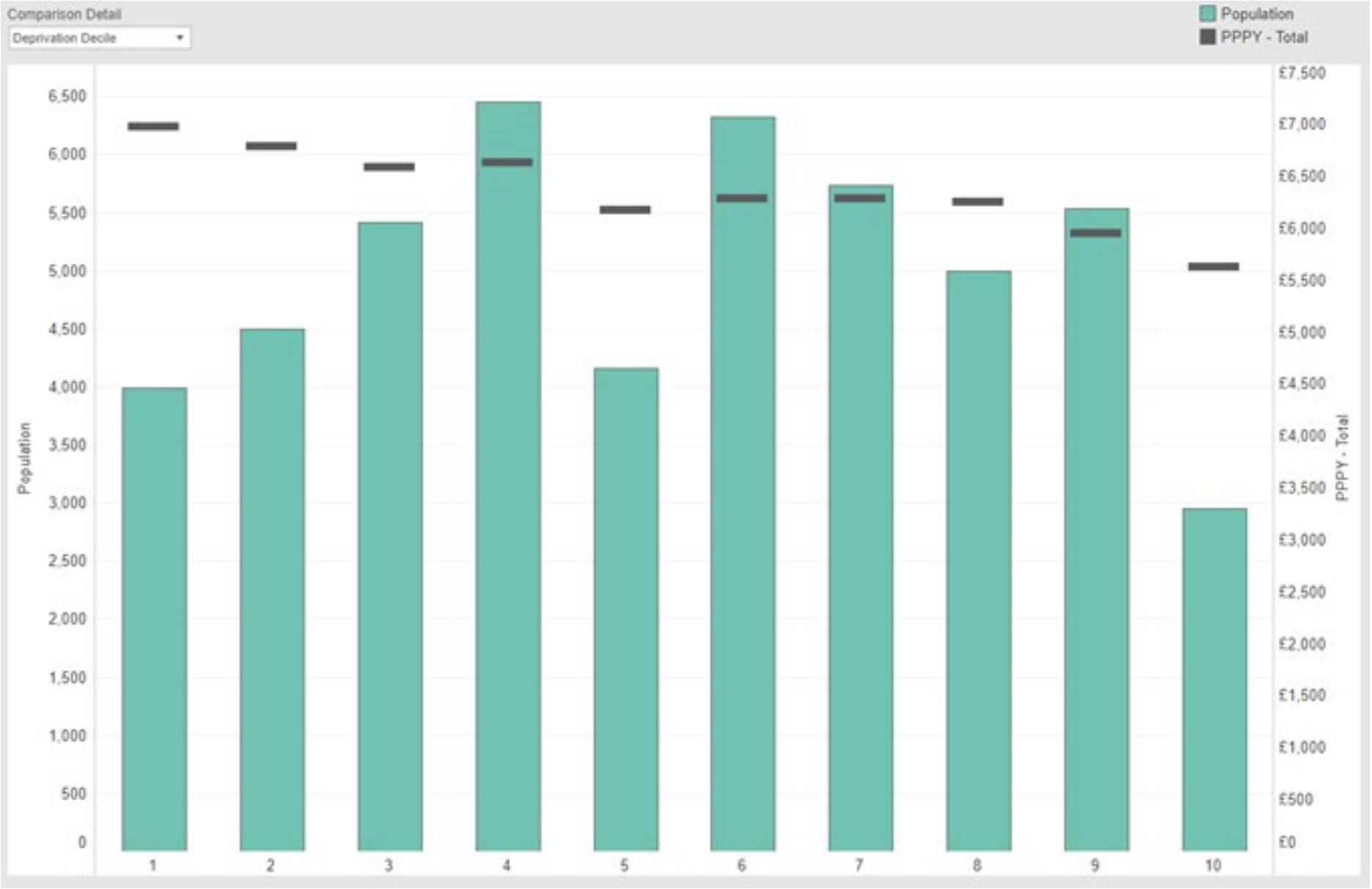
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY & IMD Decile: 3. Long Term Conditions



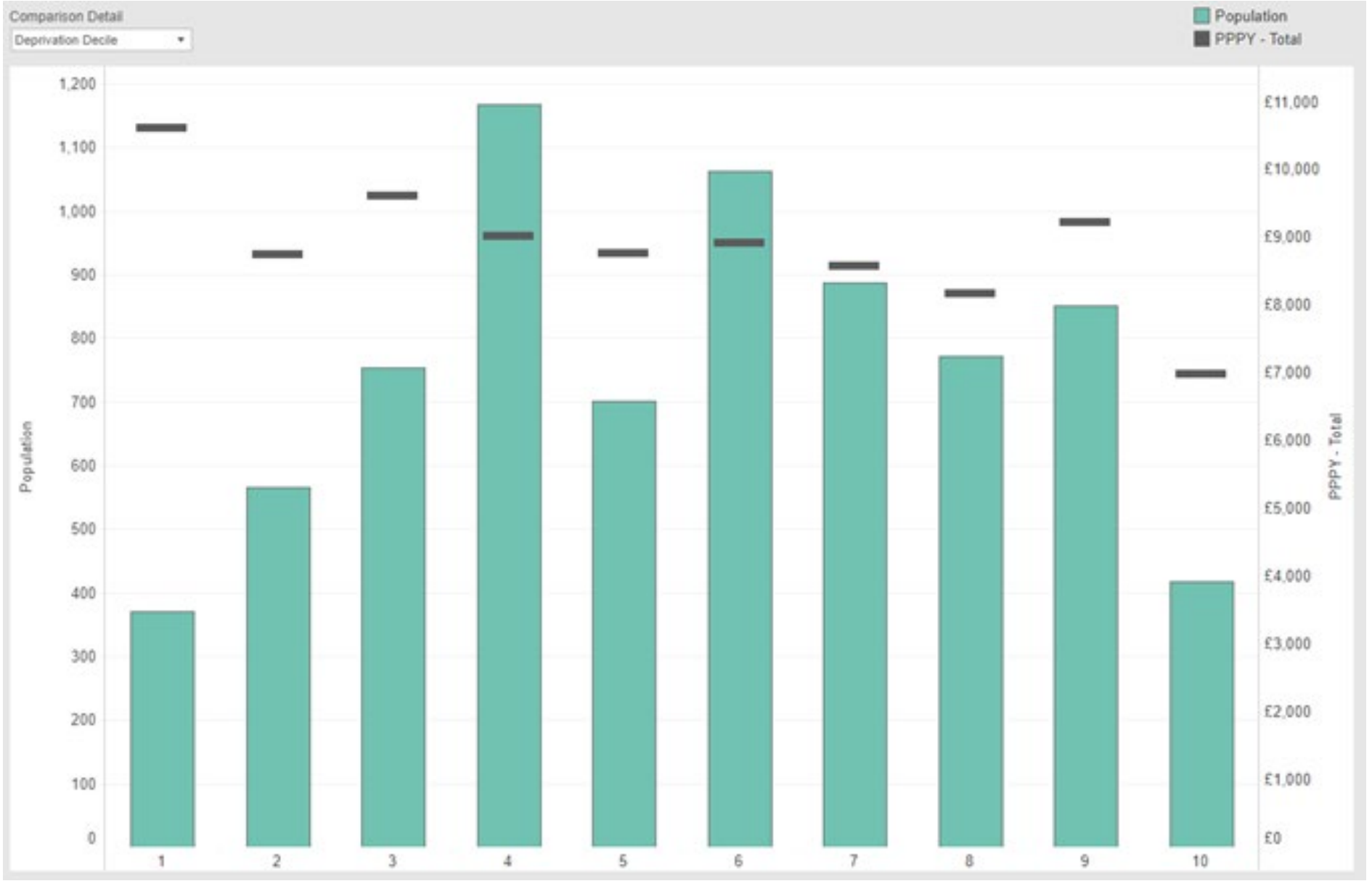
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 4. High Need



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Segments by Spend PPPY and IMD Decile: 5. Palliative & End of Life



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2023. Optum Reporting Suite

Section 3: Our 2023-28 priorities

a) Cross-cutting methodologies
   - Personalisation | Health inequalities

b) Service transformation & improvement programmes
   - Primary Care, Communities & Social Value | Urgent & Emergency Care | Planned care, cancer & diagnostics | Local Maternity & Neonates System | Children & Young People | Mental health & Dementia | Learning Disabilities & Autism | Medicines optimisation

c) Enabler programmes
   - People & Workforce | Digital, Date & technology | Estates | A Greener NHS

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

1. Future state

- Personalisation is rooted in the belief that individuals want to have a life, not a service. It's a way of working that changes the conversation from 'what's the matter with you?' to 'what matters to you?' and should be seen as a significant cultural and behavioural transformation for Lincolnshire's health and care system and population.
- Collectively our aim is to shape the relationship and conversations between people, professionals and the health and care system to one which focuses on people's strengths and assets and 'what matters to them' - providing a positive shift in power and decision making that enables people and those who are important to them to have more choice and control to be able to live their best life.
- Personalisation is a critical enabler and a generational behaviour change, that will help to transform the way we work with and improve outcomes for people and carers of all ages in Lincolnshire.
- Working with people with lived experience colleagues from across the health and care system are coming together to help describe what that new relationship should and could feel like. The work is being developed under the term 'Our Shared Agreement' and through co production we have developed a set of 5 foundations that help to describe how we will and shall work together, recognising that this will change and evolve over time.
- Working together with people with lived experience to co-produce and co-design services is a fundamental and core part of the personalisation programme but is also central to the Our Shared Agreement and the new relationship.

Our Shared Agreement: and the five foundations

Being Prepared to do things differently

Together we will:
- Be open to change and acknowledge it will take time
- Have patience and learn by doing
- Have and give permission to do things differently

Understanding what matters to ourselves and each other

Together we will:
- Offer a safe non-judgemental environment for you to be open and honest and to be ourselves
- Embrace and value differences and implement this in a person-centred way
- Make no decisions about you without you

Working together for the wellbeing of everyone

Together we will:
- Walk alongside you instead of leading you by asking the service users, carers and all involved in their care, what their goals are and how we will achieve them together
- See the wellbeing of staff as equally important

Conversations with and not about people

Together we will:
- Recognise the importance of active listening and having time to make choices
- Do what we say we will do, in an environment of openness and honesty
- Offer information, knowledge and skills

Making the most of what we have available to us

Together we will:
- Be honest about what is and isn't available
- Recognise our own strengths and opportunities
- Recognise support starts with the individual, family and community
- Actively support communities to best manage their health and wellbeing

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Collaboration with **Population Health Management intelligence** will enable us to identify where we can have the biggest impact on improving **Health Inequalities** for our population using personalised and strength-based approaches. Embedding proactive personalised ways of working together with people and carers should be considered an integral way to how we deliver services, such as:

- Including people in any service redesign through Co - Production.
- Through exploring and understanding what's important to people and their carers through 'what Matters to You' conversations
- Proactively planning for now and into the future through personalised care and support and advanced care planning which are owned by the person and shareable to all relevant parties.
- Ensuring that people and carers have meaningful information that enables them to make a shared decision with health & care professionals about their treatment, care, health & wellbeing
- Working together to understand people's knowledge and skills and confidence to look after their own health and wellbeing, through coaching and strength-based conversations and tailoring the intervention accordingly.
- Supporting people to feel connected and engaged in their local communities.

National Guidance/Requirements

- NHS Long term Plan and NHS Universal Personalised Care
- NHSE Guidance Proactive care: providing care and support for people living at home with moderate or severe frailty (published Dec 23); Support for 2023/24 system planning for Community Health Services (CHS) including Personalised Care LTP commitments.
- Fuller Stocktake (Primary Care); NHSE Major Conditions Strategy (out for consultation)
- People at the Heart of Care: Adult Social Care Reform White Paper
- Think Local Act Personal (TLAP) Making it real, how to do personalised care and support.

Local Strategies

- Integrated Care Partnership Strategy (ICP) – Key Enabler 3 Personalisation
- Joint Forward Plan (JFP) – Priority 1 – A new relationship
- VCSE Alliance Community Strategy

The Long-Term Plan mandates that **personalised care** will become business as usual across the health and care system and **Personalisation** will contribute to national priorities (reducing occupancy rates, unnecessary appointments, AARS roles delivery, proactive support and enhanced community response).

Personalisation is explicit in the Fuller stocktake recommendations and implicit in the recent Hewitt report. Personalisation contributes to delivery of Network Contract Directed Enhanced Services and Quality and Outcomes Framework and will be a key element of the anticipated NHSE 'Proactive Care' framework.

The Adult social Care white paper, People at the Heart of Care, sets out an ambitious 10-year vision for how support and care will be transformed in England. The vision puts people at its heart and revolves around 3 objectives:

- People have choice, control, and support to live independent lives.
- People can access outstanding quality and tailored care and support.
- People find adult social care fair and accessible.

Emerging evidence base is demonstrating the impact personalised approaches can have on reducing demand

1. What Matters to you conversations, supported Self-Care and Self-Management

If people and carers are **more informed, better activated, and have a clear plan** they are likely to have;

- 18% fewer GP contacts
- 38% fewer emergency admissions
- 32% fewer attendances to A&E

People **most able to manage a** mental health condition, as well as any physical health conditions, experienced 49% fewer emergency admissions than those who were least able

Providing **better personalised support to those least able to manage**, can reduce A&E attendances by 6% & emergency admissions by 7% (Health Foundation, 2018)

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

2. Shared Decision Making / Strength Based Approaches
People have long been saying that they want to be **more involved** than they currently are in making decisions about their own health and health care (Care Quality Commission Inpatient Survey 2020; GP Patient Survey 2022; Community Mental Health Survey 2021).

In all three surveys on average 50% of people state they are not as involved in the decision making about their care and treatment as they would like to be.

Cochrane Review 2017 states; optimal shared decision-making improved communication, information sharing and risk assessment, thereby helping patients feel more satisfied with their choices, knowledge base, and decisions. Optimal shared decision making also helps to reduce repeat appointments, therefore, saving time in the long run.

3. non-medical interventions
- 20% GP consultations are for non-medical interventions such as psycho, social, and economic issues.
- 4% of GP appointments could be dealt with by Social Prescribing link worker

NHS Alliance & Primary Care Foundation (2015)

- *What is in and out of scope?*

In Scope:
- Adults, all organisations,
- PHB's – cultural and behaviour change

Out of scope:
- Children and Young people – until more resource and capacity is made available.

PHB's operational delivery – sits with the CHC & PHB team

2. What's being done to get there | Overview

The approach: Continuing to co–produce and develop the building blocks around personalised and strength-based approaches

Culture and behaviour change - Our Shared Agreement - Co-production	Working with partners and people with lived experience to 'bring to life' and demonstrate what a new personalised and proactive relationship between people and the health and care system could look like and the impact It could have. Exploring the use of language across the health and care system to support a shift from deficit based – what wrong with you, the team, organisation, system to strengths based – what's strong in you, team, organisation, system. Feeling comfortable having open and honest conversations as part of the evolving relationship between people and the system. Working with people and professionals to develop and improve services
Workforce and People	Focus on people's strengths and assets, and 'what matters' to them, enabling shared decision making that encourages people to have more choice and control and to live their best and healthiest life.
Training Teams	Training teams in new tools and techniques, coaching and motivational interviewing, strength-based approaches and analysing impact.
Toolkit / Resource Development	Ease and simplify ways of embedding strength based and personalised approaches into new pathways and service redesign.
Social Prescribing	Growing Lincolnshire's social prescribing model
Social Movement	Developing a network of champions, advocates, and voices of personalised care in Lincolnshire

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Area of work	Programme Lead	Stage	Proposed Implementation dates
1. Frailty	ICB	Scoping	Jan 24 - 27
2. Serious Mental Illness – Physical Health Checks	ICB	Scoping	Jan 24 – 27
3. Muscle Skeletal pathways – Hip and knee -Embedding personalised approaches	Personalisation	Consultation/ Implementation	Jan 24 - 25
4. Roll out of High Intensity Use of secondary care	ICB – Health Inequalities	Delivery	Spring 24 onwards
5. Social Prescribing Development	Personalisation	Planning	Current
6. Discharge Hubs and Intermediate Care	Home First Partnership / UEC	Scoping	TBC
7. Direct Payments/Personal Budgets	LCC	Scoping	TBC

Response to potential improvement opportunities

- Reduction in people on MSK waiting lists

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

3. What's being done to get there | Detail

Initiative	Deliverables	23/24		24/25			
		Q3	Q4	Q1	Q2	Q3	Q4
Culture and Behaviour Our Shared Agreement (OSA) and Co-production	1. Co-producing with people with lived experience and staff a way of describing, illustrating and demonstrating the shift in relationships between people, staff and the Health and Care System.		*				
	2. Produce a paper with Sub-Group to go to relevant Boards and groups which will set out the required wider system support – complete		*				
	3. Funding agreed for the ongoing evolution of the Our Shared Agreement by BLLLT - Complete		*				
	4. Funded 12-month implementation plan to be completed		*	*			
	5. Develop a 'day in the life' of people and healthcare staff to show new relationship in actions.	*		*	*	*	*
	6. Wider engagement / consultation on the '5 foundations'		*	*	*	*	*
	7. Call out for personal stories/experience that illustrate one or more of the foundations (Story Matrix)			*			
	8. Embed the OSA agreement in areas of service redesign (LACE, Hospital Discharge, MSK hip and knee pathway)						
	9. OSA and the 5 foundations are embedded in the Personalisation evaluation and impact framework. - complete		*				
	10. Personalisation evaluation and impact framework is launched			*			
	11. Developing a new relationship through the OSA and Co – Production is included in the ICP and JFP strategy review. – complete		*				
	12. Launch of the Our Shared Agreement					*	
	13. Launch of the Co- Production Strategy					*	
	14. Encouraging ways of working that are based on collaboration, information sharing and a holistic approach to health and wellbeing.						*
	15. Embedding a workforce culture of feeling comfortable and confident having strength-based person-centred conversations with people						
	16. Advocating Personalised strength-based approaches e.g. Self-care and prevention						*
Training Teams	1. Co – production of a strength-based personalisation learning and development Curriculum for delivery from April 25						*
	2. Roll out of the train the trainer programme for Shared Decision Making and Personalised Care and Support planning		*	*	*	*	*
	3. Working with partners to commission a L&D programme for Strength based personalised approaches for 23/24	*	*				
	4. Map trusted assessor models and share best practice		*				
	5. Baselining and TNA for target groups of staff (frailty / hospital discharge)		*				
	6. Roll out of Strength based approaches programme for targeted cohorts of staff (frailty / hospital discharge)		*	*			
Communication and marketing campaign – creating a social movement	1. Recruit to a comms and marketing lead for the IAAP programme		*				
	2. Develop, deliver and promote a range of personalisation comms assets and events. (Podcasts, newsletters, blogs, social media activity)	*	*				
	3. Review and redesign of the IAAP website to be the home of the 'how' to embed strength based and personalised approaches.		*				
	4. IAAP Conference 24 – Personalisation and Co - Production			*			
	5. Preparing People to have confidence to ask questions about their treatment, their health and wellbeing. (MSK Pathway)		*				
	6. Developing Social Prescribing assets that educate and promote the value and importance of Social Prescribing		*				
	7. Recruit to Personalisation Champions		*				

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

Initiative	Deliverables	23/24		24/25			
		Q3	Q4	Q1	Q2	Q3	Q4
Toolkit / Resource Development / Including Impact and Evaluation framework	1. Co - creation of an interactive 'how to' guide and options to embedding personalised and strength-based approaches (web based), which will include a range of tools, techniques and evaluation options, including the co – production framework.		*				
	2. Implementing decision support tools across the MSK pathway	*	*				
	3. Information Standard for PCSP and Social Prescribing to be implemented (Mandated for NHS providers)		*				*
	4. Standard operating procedure for Personalised Care and Support planning		*				
	5. Testing the patient activation measure (PAM) in service redesign as a way of understanding people's skills, knowledge and confidence to be able to look after their own health and wellbeing, thus tailoring the response or intervention required.	*	*				
	6. Developing an option appraisal for Flourish the online PAM tool re: ongoing funding.				*		
	7. Use of digital technology to support the embedding of Strength based and personalised approaches with staff and people.		*				
	8. Completion of the co-produced Personalisation evaluation and impact framework that will identify an agreed set of short-, medium- and long-term outcomes.						
	9. Working with the LWC team to develop evaluated and quantifiable case studies and people's stories ready for use from April 24		*	*			
	10. Building Personalisation and strength-based approaches into the LACE processes for deep reviews.						
Service redesign	1. MSK wellbeing hub: Protype a community offer to people with an MSK condition registered with K2 PCN and or on a waiting list with ULHT – test and learn (Grantham Joint Aches and Pains Hub)		*				
	2. Scoping and baseline setting the personalisation / strength-based offer with 4 early adopter PCN's with a focus on frailty		*				
	3. Impact and evaluation framework to be tested out through the frailty work		*				
	4. Recruiting to Co - production groups		*	*			
	5. PDSA methodology : embedding strength-based personalisation approaches (frailty)			*	*	*	*
	6. Scoping and baseline setting for personalised approaches in 2 service redesign areas SMI physical health checks and hospital discharge/ intermediate care. (case for change, TNA, outcomes)			*			
	7. Identifying opportunities and mapping out touchpoints for personalised and strength-based approaches		*	*	*	*	*
	8. PDSA methodology : embedding strength-based personalisation approaches (Hospital discharge & SMI Physical health checks)		*	*	*	*	*
	9. Exploring new ways to contract and commission Personalised Care through outcomes measures				*	*	
	10. Processes and procedures are reviewed and amended to support working in a Personalised and strength-based way.		*	*	*	*	*
Social Prescribing	1. Working with partners to develop a shared vision and plan of social prescribing that takes into account the two procurement exercises that are underway – ICB Social Prescribing and LCC Wellbeing Lincs.			*			
	2. Paper to SMODG re: Options appraisal for Social RX		*				
	3. Launch of Health Coaching module on Social RX	*					
	4. Publish the recommendations from the Health Inequalities project		*				
	5. Contributing to the development of the VCSE Alliance strategy		*	*	*	*	*

Personalisation

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	L,S A	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Culture and Behaviour **Our Shared Agreement**	Working with partners and people with lived experience to 'bring to life' and demonstrate what a new personalised and proactive relationship between people and the health and care system could look like and the impact It could have	L	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro
Partnerships	Working with partners and people with lived experience to develop, implement and deliver and evaluate a Co-production framework for ICS	S		Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro								
Creating the right environment	Exploring new ways to contract and commission Personalised Care through outcomes measures with an agreed pathway	L																				
Social Prescribing	Influencing and supporting the strategic development of social prescribing in Lincolnshire	S			Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro								
Service redesign	Embedding strength based personalised approaches in service redesign programmes (phased over next 5 years)	S		Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro		Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro
	MSK Health and Wellbeing Hub – prototype	L	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro															
Workforce	Developing a personalisation and strength-based curriculum for Lincolnshire which focuses on local development and delivery.	L					Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro	Co-Pro								
	Module based delivery in SDM, SBA, PCSP, MI.	L																				
	Commissioning / bespoke learning and development programmes for specific workstreams eg: Hospital Discharge & frailty	L																				

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	L,S, A	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Communication, Marketing, and engagement	Bringing Personalisation to life: Collation and publication of people and workforce stories	L		Co – Pro	Co – Pro	Co – Pro		Co – Pro	Co – Pro													
	Holding Personalisation conference & roadshows which can be specifically tailored depending on audience i.e.: PCN's / Maternity	L			Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro				Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro				Co – Pro	Co – Pro
	'Co - producing, running, and evaluating a 'Just ask campaign ' for MSK Initially. Roll out learning	L		Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro													
Tools and Resources	Co - creation of a web based interactive guide and options to embedding personalised and strength-based approaches	L			Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro							
	Reutilisation of the IAAP website	L																				
	Toolkit for services / practitioners to use to support the embedding of Strength based personalised approaches inc evaluation tools into service redesign	L			Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro							
	Use of technology and digital solutions to improve communication for staff / people (Digital PCSP)	L																				
Evaluation Framework **Using the 5 Foundations of Our Shared Agreement as the guiding principles for the programme**	Development of a Personalisation impact and evaluation framework based on the PHM Logic Model that can be used in service redesign and PDSA work	L		Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro	Co – Pro												

Personalisation

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4. Projected impact on patients and system partners

Please click on the link below to the It's all about people impact and evaluation framework. This is a developing piece of work that has been co – produced with people with lived experience and partners.

IAAP Impact and Evaluation Framework v2

The framework has been developed around the 5 foundations of the Our Shared Agreement and has several longer-term outcomes identified plus more detailed KPI's and measures against each foundation. It also includes the benefits that can be attributed to people, workforce, and the system.
The sections highlighted in yellow are specifically relevant to the work the personalisation programme are leading on, the rest are system KPI's / measures that are relevant to all or some partners across the ICS.
The KPI's for 23/24 will be captured through the following methods;

- Peoples' stories and case studies
- Use of PHM data such as theographs
- ICB engagement surveys with the public
- Personalisation Awareness Survey (Workforce)
- IAAP Maturity Assessment
- Personalised Care Institute Dashboard and the IAAP dataset– Workforce training data
- NHSE personalisation dashboard – PHB, Social Prescribing, PCSP and Shared Decision Making data
- Clinical Systems and Social RX– to corroborate NHSE data
- Flourish – Online Patient Activation Measure dashboard
- External research support for the MSK work which will support the wider programme

Extending the reach of the programme through

- Videos hits
- Attendance at the conference
- Podcast hits
- Website activity
- Attendance at Personalisation Huddles, webinars and the Person-centred learning network

Work is underway to develop a dashboard for the programme for April 2024 onwards which will bring together all the information, intelligence and data into one place

Outcomes and outputs are summarised in the following pages.

Personalisation

Programme: Personalisation	SRO: Chris Wheway	Programme lead: Kirsteen Redmile	Clinical/Technical Lead: Dr Sadie Aubrey / Dr Kavel Patel

OSA Foundation	Outputs	Outcomes (in bold are referenced as 23/24 outcomes)	
		Patients & Population	System Partners
Foundation 1 **Being prepared to do things differently**	Personalisation and Our Shared Agreement are included in the NHS Joint Forward Plan and the Integrated Care Partnership strategies OSA social change campaign Co – Production Strategy for ICS Co – Production groups are recruited to for all service redesign work Personalisation Leadership programme Shared Plan for Social Prescribing and community-based support NHS Contracts and schedules include Personalisation outcomes Learning and development curriculum for Personalisation & Strength based approaches	**Experts by experience are an integral part of the health and care system** **There is strong evidence the public have an awareness and understanding of Our Shared Agreement** People are starting to report that there is an improved relationship between themselves and the health and care system	**System leadership recognise the importance of a personalised approach and consistently supports its adoption** **Primary Care Networks have a dedicated workforce who have time to be able to work with people to focus on the behaviour changes they need to make to improve their health and wellbeing.** A shared vision for the future of social prescribing and community-based support Personalisation and strength-based approaches are seen as best practice across all parts of the health and care system, including non-patient facing Lincolnshire ICS can evidence it works to build and nurture relationships and infrastructure for partnership with the VCSE sector inc. grassroots orgs in diverse communities Contracting, commissioning and procurement policies / processes considers / includes co – production and Personalisation as a core requirement The workforce are clear on what we are trying to achieve through the Personalisation programme and Our Shared Agreement, and what is expected of them

Personalisation

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OSA Foundation	Outputs	Outcomes (in bold are referenced as 23/24 outcomes)	
		Patients & Population	System Partners
Foundation 2 Understanding what matters to ourselves and each other	Evaluated and quantifiable case studies and people's stories . Standardised operating procedure for PCSP. Agreed digital solution for PCSP. Patient portal – access to PCSP Staff access the local PCSP offer. Patient Activation Measures Extensive learning and development offer Review of HR processes to include personalisation and strength-based approaches. Use of podcasts and other communication techniques to demonstrate the uniqueness of people	**People in Lincolnshire feel valued whether that is as a carer, person accessing services or family member, and is considered an expert in themselves/their own care and experience.** We see people as individuals with unique strengths, abilities, aspirations and requirements and value people's unique backgrounds and cultures People are as involved as possible in writing their personalised care and support plans and provide help from people who understand the importance of person-centred planning People feel more knowledgeable and confident about looking after their health and wellbeing.	**We have 'what matters to me' conversations with people, find out their strengths and what they want to achieve and build these into their Personalised Care and Support Plans** All relevant staff working on the agreed pathway development have completed appropriate personalisation and strength based approaches learning and development. Personalisation is included in the values-based recruitment policy and is a key part of the selection process as well as appraisal process/supervision processes We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them

Personalisation

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OSA Foundation	Outputs	Outcomes (in bold are referenced as 23/24 outcomes)	
		Patients & Population	System Partners
Foundation 3 Working together for the wellbeing of everyone	Engagement plan for OSA which uses a range of techniques and methodologies to connect with people we don't normally connect with. Business case for additional resource to extend the remit of the programme to include children and young people. Personalisation and strength-based approaches is unincluded in induction and mandatory training. Collaboration with Lincoln Uni and other higher education providers to ensure personalisation is included in the local curriculums. Personalisation and strength-based approaches are included in • Organisational operational plans. • LACE deep dive processes • Service redesign process mapping. Partnership and collaborative working with other transformation programmes.	**We are creative in how we engage with people including workforce . It is built on going to people and not expecting them to come to us.**	Personalised care and strengths-based approaches are expanded to services for children and young people by 2027/8 Workstreams are aligned and shared priorities identified (including across Health Inequalities, Population Health Management, Personalisation, Public Health, Social Care, PHBs etc) People get what they need, when they needs it, as organisations work seamlessly together for person centred outcomes. Staff report feeling their work environment enables them to work effectively with colleagues across the system There is a clear strategy in place to embed personalisation in workforce development at every level (training, degree, post grad, CPD etc) Staff training in care and health includes personalisation and the work of the personalisation programme is part of induction for all new staff

Personalisation

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OSA Foundation	Outputs	Outcomes (in bold are referenced as 23/24 outcomes)	
		Patients & Population	System Partners
Foundation 4 Conversations with and not about people	Use of decision support tools across a range of pathways Staff access the local SDM training. People Reported Outcome measures Citizen surveys Public information and leaflets are reviewed and co – produced (where possible) Public 'just ask' campaign Shared Decision Making is included in clinical pathway reviews. Reflective Practice opportunities - Personalisation Huddles (6 weekly) & Person Centred learning network (4 weekly)	**People understand their own wellbeing needs and how to support themselves where possible** **People tell us they feel more actively involved and in control of their health and wellbeing** People feel listened to and heard, and do not need to repeat their story unnecessarily. People tell us they have access to the information they need and understand to manage their condition/circumstances and know who to turn to for support	**Shared Decision-Making conversations are recognised and endorsed as best practice across the ICS, enabling more people to understand the benefits, harms and possible options available to them.** Honest conversations and active dialogue between people and professionals are at the heart of everything we do Shared decision making is embedded in agreed pathways, processes and Standard Operating Procedures and learning is shared

Personalisation

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OSA Foundation	Outputs	Outcomes (in bold are referenced as 23/24 outcomes)	
		Patients & Population	System Partners
Foundation 5 Making the most of what we have available to us	VCSE Alliance community Strategy. Protype MSK wellbeing hub Collation and publication of People's and workforce stories Bespoke and commissioned learning and development offers Toolkit for services / practitioners to use to support the embedding of Strength based personalised approaches inc evaluation and impact framework in service redesign work Contract and commissioning guidance for outcome based, personalised and strength based ways of working. Personalisation maturity assessment to be completed as part of service redesign baselining.	**People including workforce recognise and understand the value of connecting into their local communities** **People feel able to take responsibility for their own care/health as much as they can, and are able to self-serve/self-assess where appropriate** **People feel more involved in their treatment plan and are more knowledgeable about their options** More people use technology to stay independent or improve quality of life	**People including workforce recognise and understand the value of connecting into their local communities** **The workforce tell us they are equipped with tools to be able to implement personalised approaches** **A personalised approach is recognised as best practice and is the norm across Lincolnshire** Contracting and finance teams take a holistic approach which considers Social Value and personalised ways of working and enables recognition/adoption of personalised/strengths-based approaches. Recognition of the importance of the voluntary, community, faith and social enterprise sector (VCFSE) and engaging them in discussions about system change and transformation from the beginning. We keep up to date with local activities, events, groups and learning opportunities and share this knowledge so that people have the chance to be part of the local community

Personalisation

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5. What's needed to make this happen

Input from providers

- On 13/03/24, the Better Lives Lincolnshire Leadership Team (BLLLT) fully endorsed and committed to the Our Shared Agreement and the new relationship, this included personal, organisational and system commitments. The Personalisation team will work with identified leads across the ICS to agree and develop a costed implementation plan and will help to lead, facilitate, influence, and deliver against the agreed plan.
- This will require leadership and commitment from our workforce to transform the way they work through;
  - Co - production and co design
  - Embedding our shared agreement and the 5 foundations
  - Learning and development opportunities
  - Use of behavioural science
  - Changing HR processes
  - Operational procedures and processes
  - Commissioning and contracting arrangements.

Requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities)

- Digital: Use of technology to promote people's independence, commitment to the development of the patient portal to enable people to be able to access their PCSP, use of digital system that interface with each other to improve how information is communicated and shared.
- Currently working with PHM and HI to confirm how the 3 key enablers support one another.
- Workforce: To work together to consider how strength based and personalised approaches is built into all appropriate HR processes, including induction and mandatory training. Exploring opportunities to build the approaches into local curriculums within higher education.

Other support requirements

- Communication, engagement, and marketing – this is a key part of the programme of work, with both professionals and the public. The programme is hoping to bring in some additional capacity to support this piece of work, however there is a requirement for all organisations and partners to understand what the programme's ambition is and how they can support some of the messaging, marketing and engagement that will be required.
- Business intelligence: important to have BI expertise aligned to the programme to supported with being able to demonstrate impact and outcomes and how we might be able to do those through less traditional methods.

Resource requirements: investment and non-financial

- Substantive investment in the personalisation programme beyond March 25 – see risks and mitigation below

Personalisation

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6. What could make or break progress

Interdependencies with other programmes/organisations

- Specific interdependency with HI and PHM
- All transformation programmes and in particular Primary Care, Community and Social Value (frailty & HIU), Community Mental Health (SMI Physical Health Checks), Maternity, Living with Cancer, Adult Social care, Personal Health Budgets

Challenges & Risks

	Risks / Challenges	Mitigation
1	System executive and leadership teams have identified and agreed that personalisation is one of the key enablers to transform the health and care system in Lincolnshire, with it featuring in two strategies, however the risk is that this is just rhetoric and managing expectations and reality means this becomes too hard to do.	Managing expectations will be key to transforming the way we work. This is generational change and will therefore take courage, time, commitment and dedication that it is the right thing to do.
2	Contracting and commissioning needs to focus on person centred outcomes	Working with commissioners to enhance the Schedule 2 to include more specific personalised care outcomes.
3	Processes/ procedures / systems need to change to enable staff to work in a person-centred way – we need to move away from transactional ways of working.	Learning from LCC Adult Care who have fundamentally changed their processes to support staff to work in a strength-based way.
4	Our workforce has change fatigue and personalised care can be seen as ‘a nice’ to have, takes more time and has little impact on the wider system challenges.	Using the network of champions, advocates, and voices of personalised care in Lincolnshire to demonstrate the impact personalised care can have on people / workforce
5	Recognising the value and importance of the community and VCSE sector by certain parts of the health and care system is still challenging, with a lack of understanding and awareness.	Part of the LCC Community Strategy which is focusing on addressing the opportunities and barriers to working with the VCSE sector in and ICS.
6	There is a lack of system commitment and engagement with some of the key enablers such as a digital solution for personalised care and support planning, creating a scatter gun approach and a lack of consistency for people and staff.	Working with colleagues to agree the escalation route for the Personalisation programme board for system decision making
7	The Personalisation team is only funded until March 2025. There is a risk that all the progress that has been made will be lost if there isn’t a dedicated resource of expertise, knowledge, and skills from April 2025 to be able to continue to drive forward this key enabler across the Lincolnshire ICS.	A business plan will be co – produced with people with lived experience and key partners for ICS consideration and approval by July 2024.

Personalisation

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7. Stakeholders

Stakeholders

- People with lived experience
- Lincolnshire County Council – Public Health and Adult Care
- Lincolnshire Voluntary Engagement team
- District Councils
- Lincolnshire Partnership Foundation Trust
- Lincolnshire Community Health Services
- United Lincolnshire Hospital
- Primary Care Network Alliance
- Primary Care Networks
- Integrated Care Board
- NHS England
- VCSE (St Barnabas, Age UK Lincoln and south Lincolnshire, Active Lincolnshire, Voluntary Centre services, Lincolnshire community and voluntary service)
- Lincolnshire Care Association

Project team (Fixed term contracts funded through the joint funding for the programme)

- People with Lived Experience
- Kirsteen Redmile (NHS) – Lead Change Manager (NHS)
- Chris Erskine (LCC) Principal social worker (LCC)
- Matt Evans – Project Manager (NHS)
- Caty Collier – Social Prescribing development lead (VCSE)
- Alison Smith- Workforce development lead (LCC)
- Shibina Mathews – project support officer (NHS)
- Jenny Brereton – Lead for Personalisation (LCC)
- Mary Nel – Lead Professional (LCC)
- Vicky Thomson – Co – Production Partner (VCSE)
- People with Lived experience

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: Simon Lowe (Clinical Lead – PCN HI)John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

1. Future state

Vision: To increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county.

We will tackle health inequalities and wider causes of ill-health through an embedded, integrated system approach tailored to meeting varying needs within Lincolnshire in order to achieve our ambition - a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

We will use our resources to take practical action to reduce health inequalities and provide **exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes**. We will shift more of our resources to **focus on prevention**, making it easier for people to be able to make healthier choices and reduce the risk of developing ill health, disease and premature death.

We will achieve our ambitions via action to address:

- **Wider determinants**: Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.
- **Prevention:**. *Primary* - working with partners to prevent disease or injury before it occurs, making it easier for people to make healthier choices and reduce the risk of ill health and disease; *Secondary* - detecting the early stages of disease and intervening before full symptoms develop , providing treatment to support changes in lifestyle and behaviours to improve a person's healthy life expectancy; *Tertiary* - helping people manage long-term conditions and injuries to improve their quality of life and life expectancy.
- **Access to effective treatment, care and support:** Actions to improve the provision of and access to healthcare and the types of interventions planned for all

The plan supports delivery of the following national requirements:

- Five strategic priorities for Health Inequalities
- Core20plus5 (Adults) and Core20plus5 (Children and Young People)
- LTP priorities and High Impact Interventions for Prevention (Modifiable Risk Factors, CVD, Respiratory, Diabetes)

The programme also leads on Lincolnshire NHS **Joint Forward Plan Priority 2: Living well, staying well.**

In scope:

- Health Inequalities and Prevention initiatives directly led/delivered by the Health Inequalities Programme
- Joint Forward Plan Priority 2: Living well, staying well oversight.

Out of scope:

- Health Inequalities and Prevention improvement initiatives directly led/delivered by other transformation programmes – these are not detailed within this section of the plan, as they are included within the relevant transformation programmes' section.

System level assurance for these initiatives in respect of Health Inequalities & Prevention requirements (including reporting to NHS Midlands HI & Prevention Teams) will be provided by the Health Inequalities Programme.

Health Inequalities & Prevention

Programme: Health Inequalities & Prevention	SRO: Sandra Williamson	Programme lead: Ann Johnson-Brown	Clinical/Technical Lead: Simon Lowe (Clinical Lead – PCN HI)John Parkin (Prevention – Smoking Dependency) Andy Fox (Public Health Lead)

2. What's being done to get there | Overview

Health Inequalities and Prevention Programme workstreams:

Embedding a system approach to health inequalities (HI)
Implementing HI tools and embedding HI approaches within governance arrangements; providing a regular programme of HI Training & Development; developing awareness and workforce leads /champions within NHS Trusts and PCNs, developing supporting strategies and embedding within financial and resource strategies and contract arrangements.

HI performance and intelligence
Developing intelligence and insights to support understanding of Health Inequalities and Prevention priorities, supporting programmes with access to and understanding of HI data, research and intelligence; developing system HI metrics, KPIs & dashboards; improving data collection to support understanding and performance; develop and collate insights on core20plus population groups such as inclusion health groups , use of HI metrics within internal and public performance reports; utilise PHM approaches to address HI and work with system Intelligence colleagues to develop HI elements of the joined data set reporting suite

HI in clinical areas and cross cutting themes:
Work with programmes to deliver against 5 national HI priorities and 5 clinical priority areas within Core20plus5 for Adults and CYP. Lead on local cross cutting HI themes, ensuring people on the margins are able to access services and that any digital arrangements are inclusive and do not exacerbate Health Inequalities; work with LACE and Quality team to integrate Health inequalities within improvement approaches.

Communication and engagement
Collecting and using insights from Core20plus groups to reduce the gap in access, experience and outcomes service access; improve understanding of barriers for core20plus groups; co-production and engagement as golden thread through HI programme workstreams and initiatives and JFP priority2

Prevention
Improving the population's health and preventing illness and disease, catching the causes of ill health as early as possible to prevent or reduce the chances of them leading to more serious conditions, accelerating preventative programmes and supporting people to live well and stay well

Digital Inclusion
System lead. Addressing digital exclusion and ensuring alternatives are available for those within our population who are unable to utilise digital access channels and service delivery; adopting and implementing national guidance on digital inclusion through development of system Digital Inclusion Strategy and plan in partnership with digital programme colleagues

Inclusion Health
System lead. Improving access, experience, and outcomes for people in inclusion health groups by understanding the characteristics and needs of people in inclusion health groups; developing the workforce for inclusion health; delivering integrated and accessible services for inclusion health; demonstrating impact and improvement through action on inclusion health. Developing Strategy and plan as per new National Health Inclusion Framework .

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery
Preconception, infancy and early years	
Provide high-quality midwifery and children's services that support mums, babies and little ones to get the best start in life possible.	Maternity and Neonatal Programme – Transformation Plan and Quality Plan, Assurance Dashboard.
Increase the number of babies and infants vaccinated and immunised against diseases, especially those from deprived groups or ethnic minority communities.	Midlands Antenatal and Newborn Screening Programme Board plan
Encourage more people planning a pregnancy to take folic acid supplements and stay fit and well before and after pregnancy.	Maternity and Neonatal Programme – Transformation Plan, including staying fit and well project in partnership with Active Lincolnshire
Reduce smoking during pregnancy and increase the number of smoke-free homes	Tobacco Dependency Service (Maternity Pathway)
Help parents and young families to stay active, eat well and look after their health.	Family Hub project (partnership approach, LCC lead organisation) LCC Public Health - Glojii Project
Support more mums to breastfeed and increase breastfeeding rates at six to eight weeks	Breast Feeding Strategy and plan (completed by March 2024 Family Hub Project (partnership approach, LCC lead organisation) Relaunch Latch on Lincs campaign (LCC funded)
Increase the number of people accessing mental health services, and support good relationships between parents and infants.	Expansion of LPFT Perinatal MH Team (completed) Establishment of Trauma and Loss Service within Perinatal MH Team (completed) Family and Baby Support (Fab) Project Family Hub project (LCC lead organisation)

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery
Childhood and adolescence	
Support young people with the services they need to keep them healthy and promote physical, mental and emotional wellbeing.	CYP Transformation Programme MHLDA - CYP MH Transformation Programme
Encourage more parents and guardians to vaccinate and immunise their children against disease – especially those in deprived groups or ethnic minority communities.	Lincolnshire Immunisation Board and CYP Immunisation Group
Develop mental health support teams to support young people's mental health and emotional wellbeing.	CYP Transformation Programme MHLDA - CYP MH Transformation Programme
Give children and young people with disabilities or long-term conditions the support they need to reach their potential and lead a full and independent life, including psychological support.	CYP Transformation programme (includes Core 20 plus5 CYP) MHLDA - CYP MH Transformation Programme
Work with schools and colleges to encourage healthy habits, identify health needs early and provide access to support.	CYP Transformation Programme Healthy Weight Partnership LCC Public Health
Improve oral health especially in deprived groups.	PCCSV – Dental Strategy LCC Public Health

Health Inequalities & Prevention

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery
Working age	
Work with people to understand their skills and knowledge and give them the confidence to look after their own health and wellbeing.	Personalisation Programme – embedding use of patient Activation Measure (PAM) Work Well Partnership Programme
Identify people who could benefit from NHS health check and screening programmes and encourage more people to take up the opportunity	NHS Health Checks programme (LCC Public Health) Making Every Contact Count (MECC (delivery by C19 Vaccination team)
Ensure regular physical health checks for people with severe mental illnesses and people with a learning disability.	MHLDA Programme - SMI Health Checks Plan MHLDA Programme – LD Physical Health Checks
Increase access to NHS talking therapies for anxiety and depression and provide additional support by expanding local services such as peer support, mental health social prescribers and community connectors.	MHLDA - Community Mental Health Transformation Programme
Support more people to stop smoking and offer people in hospital who smoke, including pregnant women and high-risk mental health outpatients, NHS-funded tobacco dependency services.	Maternity and Neonatal Transformation Programme – Tobacco Dependency Service
Support more people who need help achieving a healthy weight by increasing uptake of our integrated lifestyle service and the NHS Digital Weight Management programme.	PCCSV - PCN DES delivery
Improve support for people suffering from and at risk of Type 2 Diabetes to help reverse and stop the progression of the disease, for example through our NHS Diabetes Prevention programme.	PCCSV LTCs Programme - Diabetes review & improvement plan; Diabetes: primary & secondary prevention
Reduce cardiovascular disease through early detection, better management of those known to be at high risk and encouraging people to manage their own health better.	PCCSV LTCs Programme - CVD - primary & secondary prevention plan
Better support people waiting for treatment for musculoskeletal (MSK) conditions such as back pain. Explore opportunities to improve their physical and mental health prior to any planned operations.	Personalisation Programme – MSK waiting list – Different conversations; decision support tools; prototype one stop shop model for waiting well; strength based language
Improve oral health, especially in deprived groups.	PCCSV – Dental Strategy

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JFP Priority 2: Living well, staying well:

Ambitions	Delivery
Ageing well	
Find out what matters to patients and their carers for better future care planning.	Personalisation Programme – embedding 'what matters to you' and strength based conversations approaches across system
Encourage more people to get vaccinated and immunised against disease, especially those in deprived groups	Lincolnshire Immunisation Programme Board
Improve oral health.	PCCSV – Dental Strategy
Provide care focused on the individual for patients and carers living with cancer.	Cancer: Living with Cancer programme
Improve early diagnosis and detection rates for cardiovascular disease and cancer, particularly colorectal cancer.	Health Inequalities Programme – HI within Colorectal screening project Cancer Programme – early Diagnosis and Screening PCCSV LTCs Programme - CVD - primary & secondary prevention plan PCCSV Frailty Programme
Improve brain health and prevent people from developing dementia by understanding risk factors such as smoking, high alcohol intake and hearing loss.	MHLDA Programme – Lincolnshire Dementia Strategy; Dementia Prevention
Develop a Strength and Balance programme to prevent falls.	PCCSV Ageing Well – Falls review & improvement plan; Improved community-based falls response

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3. What's being done to get there | Detail

Health Inequalities & Prevention Programme Deliverables & Milestones:

Embedding a system approach to health inequalities:

- HI Strategy - Q4 22/23 draft; Q1 24/25 sign off by ICB Board
- Annual HI Training Plan – developed Q4 each year; delivery Q1-Q4 annually
- Develop network of Health Inequalities Champions - Scoping Q1 24/25; implementation Q2 24/25; live Q3 24/25
- Roll out HEAT to provider trusts – Q1 - Q4 24/25
- Embedding HI within provider trusts – scoping Q1 & Q2 24/25
- Scoping next steps to support HI lens to resource allocation – scoping Q4 24/25 - Q1 25/26

Prevention:

- Scope and complete needs assessment for provision of Tier 3 Weight Management Services within Lincolnshire – Scope/needs assessment Q2 - 2024/25
- LTP Tobacco Dependency Services:
  - move to BAU (MH and Maternity) following evaluation - Q1 24/25
  - Implement workforce service – Timescales TBC (awaiting NHSE guidance/funding information)
- HI Grant fund for VCSE - renewal/expansion following evaluation - 24/25 & 25/6
- Wider determinants project with District Council - Scoping & proposal/ brief developed – Q4 23/24
- Inclusion Health project with LCC/ District Council– Scoping & proposal/ brief developed – Q4 23/24
- Scope project/s to support HI lens within LTCs Primary & Secondary prevention – Scoping Q4 24/25
- Explore further opportunities for MECC – scoping Q1 24/25

HI performance and intelligence:

- Virtual HI hub - evaluation of initial phase - Q4 24/5
- Develop phase 2 of Lincolnshire Core20plus5 HI Dashboard (Adults) – Live Q1 24/25
- Develop Lincolnshire Core20plus5 HI Dashboard (CYP) – live Q1 24/25
- Collect / improve insights on inclusion health groups – Q4 24/25
- Continue to improve data quality and collection rates – ethnicity, protected characteristics – Q1-4 24/25
- Extend data collection to encompass health inclusion groups - Q4 24/25
- Further develop PHM RS HI elements and HI reporting suite – Q4 24/25

HI in clinical areas and cross cutting themes:

- HI within Elective Care outpatient waiting list project - solutions co-produced - Q1 24/25; Solutions implemented - Q3 24/25
- HI within Bowel cancer pathway project - solutions co-produced - Q2 24/25; Solutions implemented – Q4 24/25
- HI & Transport (cross cutting theme) - Scoping Q1 24/25
- Investigate whether specific HI issue within Diabetes prevention and LTC support (access/experience/outcomes) – Q2 25/6
- Investigate whether specific HI issue within uptake and outcomes for LD Health checks – Q3 24/25
- Investigate whether specific HI issue within uptake and outcomes of SMI Health checks – Q1 24/25
- Investigate whether specific HI issue within uptake of vaccinations to support respiratory/COPD – Q2 24/25

Communication and Engagement:

- HI Community Connectors – Role out to further core20plus 5 clinical areas - scoping Q1 24/25

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3. What's being done to get there | Detail

Health Inequalities & Prevention Programme Deliverables & Milestones (cont.):

Digital Inclusion:

- Develop and implement Digital Inclusion Strategy and Action Plan – development by Q1 24/25; implementation Q1 - Q4 24/25

Inclusion Health:

- Develop and deliver Inclusion Health Strategy and Plan – scoping & development of draft strategy and plan - Q1 24/25, Consultation - Q2 24/25, Implementation Q3 24/25 onwards
- Inclusion Health workshops (part of annual HI training plan) – delivery Q3 23/24 to Q3 24/25
- Inclusion health guides - Q4 23/24 to Q3 24/25
- Implement Safe Surgeries scheme within General Practice - Scoping and implementation plan Q3/Q4 23/24,

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Embedding a system approach to health inequalities	HI Strategy																					
Embedding a system approach to health inequalities	Annual HI Training Plan																					
Embedding a system approach to health inequalities	Develop network of Health Inequalities Champions																					
Embedding a system approach to health inequalities	Roll out HEAT to provider Trusts																					
Embedding a system approach to health inequalities	Embedding HI within Provider Trusts																					
Embedding a system approach to health inequalities	Scoping next steps to support HI lens to resource allocation																					
Prevention	Scope and complete needs assessment for provision of Tier 3 Weight Management Services within Lincolnshire																					
Prevention	Tobacco Dependency Services (Maternity/ Acute/ MH/Community																					
Prevention	Tobacco Dependency Services (Workforce)						Timescales TBC by NHSE															
Prevention	HI VCSE Grant fund																					
Prevention	Wider determinants project with District Council																					
Prevention	Inclusion Health project with LCC/ District Council																					
Prevention	Scope project/s to support HI lens within LTCs Primary & Secondary prevention																					
Prevention	Explore further opportunities for MECC																					

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
HI performance and intelligence:	Improve data & insights on inclusion health groups																						
HI performance and intelligence:	Virtual HI hub																						
HI performance and intelligence:	Develop phase 2 of Lincolnshire Core20plus5 HI Dashboard (Adults)																						
HI performance and intelligence:	Develop Lincolnshire Core20plus5 HI Dashboard (CYP)																						
HI performance and intelligence:	Continue to improve data quality and collection rates – ethnicity, protected characteristics																						
HI performance and intelligence:	Extend data collection to encompass health inclusion groups																						
HI performance and intelligence:	Further develop PHM RS HI elements and HI reporting suite																						
HI in clinical areas & cross cutting themes	HI within Elective Care outpatient waiting list project																						
HI in clinical areas & cross cutting themes	HI within Bowel cancer pathway project																						
HI in clinical areas & cross cutting themes	HI & Transport – Cross Cutting Theme																						
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within Diabetes prevention and LTC support (access/experience/outcomes)																						
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within uptake and outcomes for LD Health checks																						
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within uptake and outcomes of SMI Health checks																						
HI in clinical areas & cross cutting themes	Investigate whether specific HI issue within uptake of vaccs to support respiratory/COPD																						

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Communication and Engagement	HI Community Connectors – Role out to further core20plus 5 clinical areas																						
Digital Inclusion	Digital inclusion strategy & plan																						
Inclusion Health	Develop and deliver Inclusion Health Strategy and Plan																						
Inclusion Health	Inclusion Health workshops																						
Inclusion Health	Inclusion Health guides																						
Inclusion Health	Implement Safe Surgeries scheme within General Practice																						

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4. Projected impact on patients and system partners

Benefits - Health inequalities & Prevention Programme workstreams:

- Increased equity of access, experience and outcomes for people from:
  - 20% most deprived areas
  - Black, Asian and ethnic minority backgrounds
  - health inclusion groups
  - other Lincolnshire population segments experiencing worse access, experience and outcomes

  (Measured through service / clinical data on service access, experience and outcomes)
- Prevention of ill health
- Earlier detection of conditions and modifiable risk factors to reduce impact and enable people to better manage their health conditions and live in good health as long as possible
- Understand barriers to service access and take-up

System outcome measures for Health Inequalities:

Reduction in Variance between Core20Plus populations and whole population against March 2022 baseline for:

- Life Expectancy
- Healthy Life Expectancy
- Disability-adjusted life years (DALYs)
- Obesity – CYP and adults
- Smoking prevalence
- Infant Mortality

Measures below – working in partnership with Programmes to deliver with HI focus on Core20Plus population:

- Ensuring annual health checks for 60% of those living with SMI (completion of the 6 Health Checks)
- Increase the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admission due to those exacerbations
- HIU service for 3 PCNS – working with targeted population group. Outcomes include reducing health inequalities and a reduction in avoidable emergency department attendances and non-elective admissions.
- Increase the uptake of all 8 health checks for those with Type 1 and Type 2 Diabetes and referrals to the NDPP and T2DAY

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Specific measures and targets for initiatives within HI Programme direct delivery:

Initiative	Outputs and Outcomes	
	Patients and Population	**System Partners**
HI within Bowel cancer pathway project	- Increase in uptake of FIT by 3 percentage points for 4 selected G.P Practices by 25/26 against 23/24 baseline	- Contributes to reduction in later stage cancer diagnosis
Elective Care outpatient waiting list project	- Reduction in waiting times of people living in 20% most deprived (IMD 2019) to align with overall population rates in specialities where there is a variance Timescales TBC	- Contributes to inclusive elective recovery
Improve ethnicity data quality /collection rates	-	Reduce the proportion of invalid ethnicity records to ≤ 10% by no later than September 2024
Smoking Dependency Service (workforce/community /acute/ MH outpatients)	- Number of referrals/self-referrals; - Number of quits at 4 weeks; - Number of quits at 12 weeks; Timescales TBC	- Supporting NHS staff to quit results in reducing absenteeism, ill-health treatment and loss of productivity - Reduction in smoking is related to reduction in LTCs, A&E attendances and hospital admissions
Health Inclusion Group workshops		- 18 workshop sessions delivered in 23/24 to 24/25 - Target 20 staff per session (360 staff places) - Increased awareness and understanding by workforce of the barriers faced by health inclusion groups; application of learning to service provision/design
Scoping of provision of Tier 3 Weight Management Services within Lincolnshire	- Increase in number of patients receiving treatment within Lincolnshire. - Reduction in patients required to travel outside of county for support	Reduction in obesity related hospital admissions and LTCs

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***I*nitiatives funded by HI Programme, delivered by other programmes**

Initiative	Outputs and Outcomes	
	Patients and Population	System Partners
High Intensity user project (delivery by Primary Care Community & Social Values Programme)	• 3 PCNs will be offering a High Intensity User Service by April 2024 (Trent, Boston and First Coastal PCN) • By June 2024 we will have reviewed other HIU provision to ensure it is in line with the national HIU framework	- Contributes to reduction in emergency admissions and A&E attendances
Vaccination/MECC inclusion offer (delivery by Primary Care Community & Social Values Programme)	• Retain and expand a central workforce which can offer Health Inequality work to support Primary Care with Core20Plus5 workplan and, where needed and agreed with practices, delivery of the other immunisations and vaccinations programmes currently delivered in Primary Care.	- PCNA led, where the need will be identified on a system level and a workplan put in place. Working with population health management data the team will be asked to support where Health Inequalities and operational pressures have been identified. Given the seasonal nature of vaccinations, it is expected that this will be the predominant activity for the team – with the targeted health inequalities work around 5 months of the year . Examples include supporting with Learning Disability and SMI health checks, LTC reviews and proactive holistic prevention work.
Long Term Conditions – equity in access and to support restoration of services (respiratory recovery) (delivery by Primary Care Community & Social Values Programme)	• Scope project/s to support HI lens within Long Term Conditions (Diabetes, CVD and COPD) on Primary & Secondary prevention actions during 2024/25	- TBC

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Benefits - JFP Priority 2: Living well, staying well:

Community

- People will live independently for longer, free from illness and disease.
- Those with long-term conditions will be supported to live the best life they can, and we will treat the person, not the condition.
- Detecting diseases, such as cancer, early on means we'll be able to slow down their progression, or in some cases even reverse them.
- Everyone will have equal access to excellent health and care services provided in a way that best suits them, particularly those from our most disadvantaged groups.
- All children will have the opportunity to reach their full potential and those with disabilities and long-term conditions will be able to lead a full and independent life.
- We will ensure our older population can live the life they want in older age, with the right support at home, in the community and through our services to stay well and manage health conditions proactively.

Workforce

- Preventing people from getting ill will be a high priority, and approaches to achieve this will be a key part of the person's journey, preventing or reducing the impact of illness and promoting healthy ageing. This will especially benefit those people at high risk of developing long-term physical and mental health conditions.
- Best practice and quality of care will be embedded in the person's journey.
- Using innovative models of service delivery, we will ensure that one size does not fit all; our approach to intervention will be appropriate to meet the needs of the most at-risk members of the population.
- We will work with people from across our population who have used services and can best help shape how they should look and feel.
- We will support staff to work alongside people, patients and communities to ensure that self-care is part of their everyday life, improving their health and wellbeing and helping them to manage long-term conditions.
- Staff will have access to information and resources so they can support people effectively, and the workplace culture will give them the confidence to have honest conversations with people that put them first.

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5. What's needed to make this happen

Input from providers

- Support staff to participate in workforce related initiatives e.g. HI Training events, HI Champions
- Commitment and support to roll out tools and approaches within processes and governance arrangements e.g. Health Equity Assessments

Requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities)

- Participation in relevant steering groups, workstream groups and project teams
- Embrace opportunities to embed within enabler approaches

Resource requirements: investment and non-financial

- Plan can be delivered with the continuation of the ringfenced Health Inequalities recurrent resource allocation and the SDF allocation to support the implementation of Tobacco Dependency Service
- Additional funding to support increase investment in prevention (primary, secondary, and tertiary prevention) which will support the JFP priority – living well, staying well – commitment 1% of ICB allocation.
- Development of differential / allocative resourcing methodology and incentives to address health inequalities - targeting resources to support transforming care models and pathways to improve access, experience and outcomes

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5. What's needed to make this happen

Scheme	Provider contributors	Requirements from enablers	Other support requirements	Resource requirements
Workstream: Embedding a system approach to health inequalities	LCHS/ LPFT/ ULHT/ LCC Public Health - Support staff to participate in workforce related initiatives e.g. HI Training events, HI Champions - Commitment and support to roll out tools and approaches within processes and governance arrangements e.g. Health Equity Assessments and take action to address inequalities identified in service access or outcomes - Continue to have named Health Inequalities Executive and operational leads (clinical leads where appropriate) and attend regular network meetings	Workforce – support to raise awareness and engage with staff Finance – development of resource allocation approach PHM & Personalisation – work in partnership e.g. support LACE and the quality improvement approach	ICS Transformation programmes & providers to provide monthly assurance reports on progress to HI Programme ICS Transformation programmes & providers – identifying How new services or redesign of services/ pathways will reduce health inequalities rather than just thinking about how a new service doesn't increase health inequalities.	Meeting rooms and facilitators for briefings, workshops and training
Workstream: Prevention	LCHS/ LPFT/ ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Membership of project teams - Staff resource to scope and implement	Finance business partner support with NHSE bidding process	ICS Transformation programmes & providers to provide monthly assurance reports on progress to HI Programme	NHSE funding (Tier 3 Weight Management; Workforce Tobacco Dependency Service)

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5. What's needed to make this happen

Scheme	Provider contributors	Requirements from enablers	Other support requirements	Resource requirements
HI performance and intelligence:	LCHS/ LPFT/ ULHT/ AGEM - HI Performance reporting embedded within provider organisations, ICB & system governance arrangements - Take action to improve HI data quality	PHM – PHM Reporting/ Data Suite – work in partnership to improve HI elements to ensure meets national and local HI requirements		
HI in clinical areas & cross cutting themes	LCHS/ LPFT/ ULHT/ LCC Public Health Provide staff input to project teams and scoping			
Digital Inclusion	LCHS/ LPFT/ ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Staff resource -membership of strategic Group, Collaboration Group and any task and finish groups/project teams - Provide regular data on digital provision/take-up	AGEM/PHM - data		
Inclusion Health	LCHS/ LPFT/ ULHT/ LCC Public Health/VCSE sector – LVET and other VCSE partners/District Councils - Staff resource -membership of strategic Group, Collaboration Group and any task and finish groups/project teams			

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6. What could make or break progress

Issues & blockers

- None at this time

Interdependencies with other programmes/organisations

- Dependent on all ICS transformation programmes, in particular CMHT Programme, CYP Transformation Programme, CYP MH Transformation Programme, Maternity and Neonatal Programme, Cancer Programme, Planned Care Programme, Primary Care, Community & Social Value (e.g. LTC (CVD, Diabetes, Respiratory), Frailty, HIU), provider trusts and partners for delivery of some elements of Core20plus5 (Adults and CYP), Five National Strategic Priorities for Health Inequalities, LTP Prevention High Impact Interventions and Joint Forward Plan Priority 2: Living well, staying well
- Specific interdependency with HI and PHM – including the development of working model with LACE

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Risk/ Challenges	Mitigation
Access to relevant data and intelligence – e.g. local sub county level /small area data ; health inclusion groups and other local plus groups	- Development of ICS joined data set and specific initiatives within plans for HI & Prevention Programme and Communication and Engagement Enabler Programme - Performance reporting to include HI metrics including measuring the slope index and relative index of inequalities in health service utilisation
Capacity within other transformation programmes, provider trusts and other partners to engage with, support and contribute to initiatives	- Early stage stakeholder engagement
Digital exclusion – national requirement to have digital inclusion strategy and implement action plan - strategy not currently in place ,therefore not currently at stage to implement action plan.	- System group has been established (Autumn 2023) to develop digital inclusion strategy and action plan – membership and active engagement of key system organisations. - Informal digital inclusion collaboration group has been formalised and repurposed to support development and delivery
Health Inclusion – national requirement to develop strategy and action plan	- System group will be established to develop strategy and plan with membership of key system partners
Operational pressures – capacity of providers to engage with work to reduce health inequalities; achievement of national programme targets prioritised difficult for providers to balance this requirement alongside addressing inequalities gap and finding solutions	- Early engagement with partners - Identify opportunities to align with other work within their plans so that HI is an integral part of this and embedded within this - Involve partners at early stage of scoping/project development - Provide project management support from within HI Team for priority pieces of work where capacity allows - Prioritise work programme to align with provider capacity where feasible/possible
Resource /allocation approach – challenge of balancing the need to meet population need/ address inequalities against current financial context	- Development of Health Inequalities Resource Allocation strategy and approach – targeted to addressing health inequalities (access, outcomes and experience - Implementation of resource allocation approach for 2024/25 planning – phasing to consider new investment and/ or additional allocations received in year with a plan developed for full implementation from 2025/26 - Embracing the principle of proportionate universalism where actions taken are universal, but with a scale and intensity that is proportionate to the level of disadvantage i.e., with more resource and effort (intensive support) into supporting the most deprived communities; vulnerable groups targeted to improve equity of access, excellent experience, and optimal outcomes.
Vacancies– currently carrying 3 vacancies which is impacting on the capacity of the team to deliver priorities - 1 x Health Inequalities Improvement Manager; 1 x Programme Support Officer; 1 x Engagement officer (hosted by the Communications and Engagement Team)	- Approval has been given to fill the Health Inequalities Improvement Manager and Engagement Officer vacancies – recruitment is in progress - Seek permission to recruit to Programme Support Officer vacancy with effect from April 2024

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7. Planning assumptions

Demand drivers

System-driven:

- That there are no significant changes in national policy/ask in relation to Health Inequalities and Prevention
- That there are no changes to LTP Prevention High Impact Interventions (CVD/Diabetes/Respiratory/modifiable Risk Factors)

Productivity, capacity & resource enablers and constraints

Finance

- That Health Inequalities SDF continues to be available and ringfenced for Health Inequalities
- Additional funding to support increase investment in prevention (primary, secondary and tertiary prevention) which will support the JFP priority – living well, staying well – commitment 1% of ICB allocation.
- Assumption we can recruit to vacancies in the future to support the developing work programme and expansion in 25/26

Capacity

- That system transformation programmes and providers have capacity to engage with initiatives
- Clinical Care Directorate identifies clinical leads for Health Inclusion (new requirement) and Health Inequalities and Prevention (under review) and that lead/s have capacity to support the programme.

8. Stakeholders

Key Stakeholders

- NHS Trusts: LCHS, ULHT, LPFT – key named Health Inequalities leads
- Health Inequalities PCN Leads identified in 12/14 PCNs
- VCSE – LCVS, VCS, LVET key partners on selected projects
- Public Health (PH) - The deputy chair for the HI Programme is from PH. Some of the HI programme's workstreams and projects are led in partnership with PH
- Local Authorities – South and East Lincolnshire partnership (Emily Spicer), North Kesteven District Council (Yvonne Rogers)
- Healthwatch
- System Transformation Programmes and Programme leads – with specific links to the Adult Core20PLUS 5 programme and projects; CYP Integrated Transformation Board – with specific links to the CYP Core20PLUS 5 programme and projects; MHLDA Alliance: specific links to the Adult Core20PLUS 5 programme and projects
- Clinical and Care Directorate and LACE
- Patients & carers: specific focus on identified 'Plus' & inclusion health population groups
- Other Enabler programme – for example Digital, PHM, Personalisation,

HI Programme/ Project Team:

- Health Inequalities Programme team is made up of; Assistant Director Health Inequalities x 1 FTE, Health Inequalities Improvement Manager x 1 FTE, Health Inequalities, Improvement Facilitators x 4 FTE, Health Inequalities Programme Support Officer x 1 FTE, Principal Analyst in Health Inequalities x 1 FTE. In addition to this the following posts will be recruited to in Q4; Health Inequalities Engagement Manager x 1 FTE and Health Inequalities Improvement Manager x 1 FTE.
- Finance lead – ICB Finance Business Partner (Debbie Hocknell)
- Engagement lead – ICB Strategic Communications and Engagement Lead Manager (Steph King) and ICB Engagement Manager (Nikki Pepper)
- Communications lead – ICB Marketing and Communications Manager (Tony Crowden)
- Clinical lead – Dr Simon Lowe, Clinical lead for Health Inequalities on behalf of PCN Alliance. Current on 'pause' to be reviewed in 2024
- Business Intelligence – AGEM, ICB Director of Intelligence & Analytics (Katy Hardwick) and ICB Head of Performance (Martin Bambro)

Primary Care, Communities & Social Value

SRO: Sarah-Jane Mills	Programme leads: Nick Blake - Primary Care; Sarah Button - Integrating Community Partnerships; Lisa Foyster – Integrating Specialist Care	Clinical/Technical Lead: Sunil Hindocha

1. Future state

Our vision

Enabling the people of Lincolnshire to live well, stay well, age well and die well by
- Proactively addressing health inequalities and focusing upon prevention
- Early identification and treatment of disease
- Creating integrated community-based multi –disciplinary teams who proactively manage long term conditions

Key ambitions

- Improve access to integrated primary care, by creating new and innovative models of care which will deliver the ambitions for improved access detailed within the 'Delivery plan for recovering access to primary care', improve quality of patient experience and outcome and create enhanced resilience of services and workforce. Transforming for tomorrow whilst delivering today.
- In partnership with PCNs develop integrated community-based, multi-professional and multi -agency teams with a view to delivering person-centred care, targeted to meet the identified need of local communities.
- To implement integrated pathways of care for patients with long term conditions including children and young people, people with mental health conditions and those with long term conditions including frailty and people at the end of their lives to support proactive identification, early intervention, personalised care planning and seamless management of deterioration

The case for change

Our overall aim is to create sustainable models/pathways of care outside of the hospital setting, which will improve patient outcomes and experience, in line with our ambitions and reduce year on year growth in demand for and therefore investment in, Urgent and Emergency Care.

General practice is the foundation of all our transformed pathways of care. It is the universal health offer to all our patients, from birth to death, for those that are healthy and those that are unwell. It represents a rich source of data and intelligence about the majority of our population allowing us to
- identify people who would benefit from our support before they become unwell,
- to target our care to prevent deterioration and loss of independence and
- to identify and address inequalities of outcome and experience.

Without sustainable primary care we will be unable to deliver our ambitions. However, across Lincolnshire, we are struggling to sustain the current model of delivery due to a combination of demographic changes, shortages of general practitioners and demand inflation. We will, therefore, whilst continuing to deliver access to appointments in line with nationally agreed performance targets, aim to create, in partnership with our key stakeholders, including patients and public, innovative, new models of care which deliver the right care, at the right time, in the right place.

The Primary Care Networks (PCNs) are central to supporting the design and delivery of this new landscape. Working with PCNs will enable us not only to improve access to care for those who are acutely unwell but also to build integrated care, in partnership with key stakeholders, for those with longer term health and care needs.

Our systemwide priorities detailed in 'integrating specialist services' have been driven by Population health management and inequalities data and intelligence, workforce data, performance data, local knowledge from our teams and partner agencies, patient and public feedback and the Care and Clinical Directorate's view of what will have the greatest impact locally.

Primary Care, Communities & Social Value

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1. Future state

The Case for change (cont.)

Our ambitions are driven by national and local guidance and frameworks including

- The major conditions framework, NHS England (2023)
- Delivery plan for recovering access to primary care, NHS England (2023)
- Next steps for integrating primary care, Fuller stocktake report, NHS England (2022)
- Providing proactive care for people living in care homes – Enhanced health in care homes framework, NHS England (2023)
- Joint forward plan – Lincolnshire Integrated Care Board (2023)
- NHS vaccination strategy, NHS England (2023)
- Proactive care: providing care and support for people living at home with moderate or severe frailty, NHS England (2023)
- Planning Guidance 24/25 NHS England (2024)
- Faster, simpler and fairer: our plan to recover and reform NHS dentistry, Department of Health and Social Care (2024)

Primary Care, Communities & Social Value

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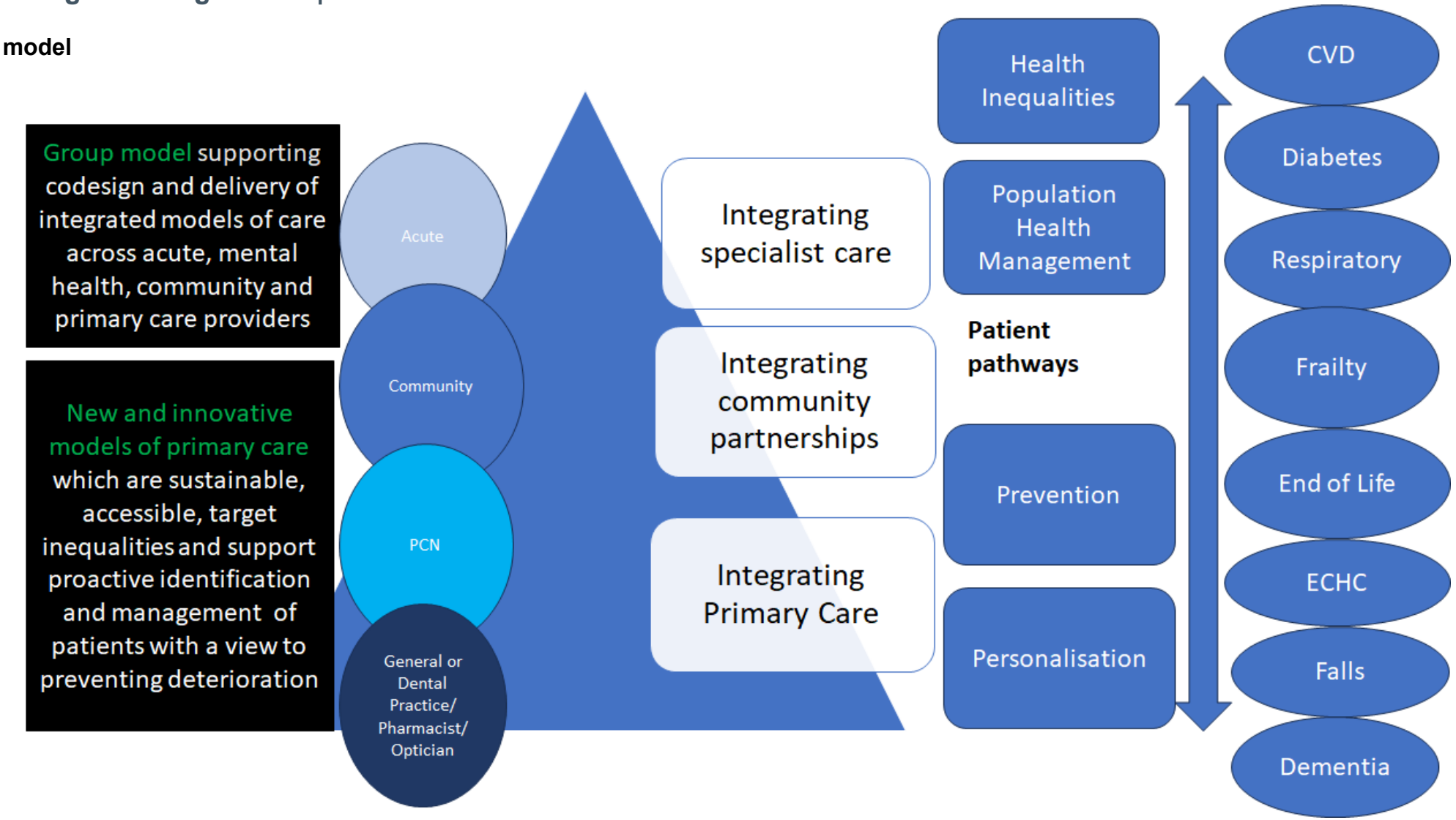
2. What's being done to get there | Overview

Our delivery model



Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Our key delivery objectives 2024-2029 are as follows

Integrating primary care delivering timely access to primary care – general practice, pharmacy, dental, optometry, today whilst designing and delivering new models of integrated primary care, with a view to creating a sustainable future.

Integrating primary care and delivering access

- Maintain and develop delivery of the business-as-usual elements of primary care commissioning – for general practice, dental, pharmacy and optometry to ensure services continue to deliver safe and timely access to care.
- Foster and develop Leadership across and communication between the LMC, LPC, LDC and LOC with a view to ensuring they are proactively represented in system wide fora and shared learning across the people they represent
- Improve access to community pharmacy services in line with Pharmacy First ambitions
- Empower patients to manage their own health by providing them with technology and information including innovative digital monitoring systems, access to online information, advice/guidance and consultations and access to their digital records via the NHS app
- Improve access to urgent same day primary appointments and planned appointments in line with national guidance and Lincolnshire ambitions.
- Improve productivity and reduce time wasting activities across primary care
- Improve collection, accuracy and utilisation of primary care data as a mechanism for enhancing quality of care, evidencing change and informing business cases.

Developing Partnerships to Support Primary Care Integration

- In partnership with providers (including General practices and pharmacy practices), PCNs, LMC, LPC, the public and our patients - design and implement new sustainable model/s of integrated primary care with a view to improving access, addressing inequalities and unwarranted variation, and enhancing proactive identification and management of long-term health conditions
- Deliver the Primary Care People Plan ensuring alignment to both the system workforce strategy and other national initiatives, with a view to creating a sustainable and resilient Integrated primary care workforce
- Develop a Lincolnshire framework for enhanced services which supports delivery of improved outcomes for patients, with a focus upon reducing growth in demand for acute based services
- Enhance our primary care estate to ensure it is fit for purpose and facilitates delivery of our vision
- Develop our digital capabilities across primary care with a view to enhancing patient experience and outcomes and being able to evidence change
- Improve quality of care in line with locally and nationally agreed best practice and initiatives
- Transform the conversation between primary care and the public by implementing a comprehensive programme of communication, engagement and co-production with a view to empowering our patients to be leaders in enhancing their own health and well-being.

Vaccinations

- Develop in partnership with key stakeholders, implement and evaluate a Lincolnshire-wide Vaccine Strategy to deliver the ambitions detailed within of the newly published National Strategy (December 2023)
- Undertake the required planning and actions to enable the ICB to assume delegated commissioning responsibility from NHS England
- Support providers to develop an integrated multi-disciplinary, multi-agency vaccination staffing model in line with ambitions detailed within the Strategy to enable delivery of agreed Key Performance Indicators

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating community partnerships developed around the PCN footprints to support their ongoing evolution to provide access to person centred care, delivered by multi-disciplinary and multi-agency teams, for local communities, reflecting population need.

PCN Development

- Develop different ways of working at PCN level to enable demand to be managed and/or capacity to be released, to support improved access to integrated primary care.
- Fully implement the PCN DES with a view to supporting improvements to population health via proactive identification, care coordination and case load management of patients with longer-term health and social care needs, evaluate impact with a view to enabling continuous improvement
- Further enhance leadership capability and capacity across the PCNs in line with the agreed Lincolnshire maturity framework.
- Continue to implement ARRS roles in line with national agreement and local priorities.
- Assess the impact of additional investment in primary care via ARRS roles. Utilise the associated learning to further develop a targeted investment strategy with the aim of supporting delivery of integrated pathways of care for agreed conditions.
- Develop and implement integrated pathways of care across primary and community care for therapy and nursing services to meet the specific needs of PCN populations
- Implement delivery plans for High Intensity Users and Social prescribing, in line with national best practice and evaluate impact.
- Build, implement and evaluate a Lincolnshire wide Quality Framework which supports learning, continuous improvement and transparency across stakeholders.

Integrating Care

- Implement case management and care co-ordination model to support delivery of PCN integrated primary and community teams
- Further develop the role of integrated neighbourhood teams, in line with the Fuller recommendations, with a view to enhancing the delivery of multi-disciplinary, multi-agency personalised care and improved patient outcomes and experience for the most complex patients
- Deliver Integrated community teams (community nursing and community therapy)
- Develop and implement the Integrated Communities Strategy (Strategic partnerships, link to Community Primary Partnerships)
- Codesign and implement a framework for working in partnership with the voluntary sector.

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating Specialist Care

delivers improved health outcomes, reduced health inequalities and reduced disease progression, enabling people to live well and die well. Implementing new integrated models of care, via a one team approach, transcending organisational boundaries, whilst adopting a more proactive and holistic approach informed by individual wishes and need. These new models are informed by our population health management intelligence, focus on prevention, early identification and diagnosis. They will deliver both timely, urgent care and long-term ongoing care and treatment for working age and older adults.

Ageing well – Older age

- Implement the Lincolnshire Frailty Strategy and associated delivery plans to reduce the onset and progression of frailty.
- Fully delivery the local Lincolnshire and national aspirations for the Enhanced Health in Care Homes (EHCH) programme, as outlined in the DES and the updated National EHCH framework (updated November 2023) to all care homes in Lincolnshire and evaluate the impact.
- Fully implement the Lincolnshire-wide Palliative and End of Life integrated care model rooted in primary care facilitating 24 -hour access to planned and responsive community-based care via a single point of access in line with agreed care plans supported by strategic commissioning arrangements for specialist palliative care.
- Deliver the proactive/primary care elements of the Lincolnshire Dementia strategy including the recovery of the dementia diagnosis rates. This work is led by LPFT.
- Implement the Lincolnshire Falls pathway such that people with the potential of falling are proactively identified and are proactive managed by timely and effective multi-disciplinary interventions including an effective falls response.
- Develop, embed and evaluate a Lincolnshire-wide Long-Term Condition Strategic Framework with a view to supporting:
  - Prevention and management of risk factors
  - Early and accurate complete diagnosis
  - Proactive care
  - Clinical Pathway Review
  - Integrated pathways of care
  - Other targeted improvement initiatives
- Deliver Transformation, Targeted and Transactional programmes of change in line with national "must do's" & guidance, best practice and local clinical priorities (effectiveness and impact) directed by our Lincolnshire Care and Clinical Directorate for:
  - Major conditions identified in the NHS LTP – Cardiovascular disease including Stroke, Diabetes and Respiratory
  - Other long-term conditions where opportunities are identified
- Review all commissioning arrangements to support and underpin service redesign

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating Primary Care

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Primary Care and delivering access	Access recovery and improvement																					
	Integrating urgent care																					
	Resilience framework																					
Developing partnerships	Contracting and Commissioning framework																					
	GP Strategy																					
	Pharmacy Strategy																					
	Dental Strategy																					
	Primary Care People Plan																					
	Estates Plan																					
	Digital implementation																					
	Vaccinations and immunisations																					

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating Community Partnerships

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Care	Community Integration - neighbourhood teams																					
	Integrated community nursing and therapies																					
	Developing strategic partnerships																					
PCN Development	PCN DES delivery																					
	PCN maturity																					
	ARRs utilisation																					
	Social prescribing																					
	High Intensity Users																					

Primary Care, Communities & Social Value

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3. What's being done to get there | Detail

Integrating Specialist Care

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating Specialist Care																						
Long Term Conditions	Long Term conditions - Prioritised Targeted Action Plans																					
Major Conditions - Respiratory	Clinical Pathway Review with prioritised improvement plans																					
Major Conditions - Diabetes	Clinical Pathway Review with prioritised improvement plans																					
Major Conditions - Diabetes	Primary and Secondary Prevention initiatives																					
Major Conditions - CVD	Integrated Cardiology																					
Major Conditions - CVD	Primary and Secondary Prevention initiatives																					

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Frailty	Ensure delivery of frailty strategy & plans, benefits realisation, comms and engagementand personalisation programme	Y														Implement continuous improvement, learning and refinement						
	Frailty - Integrated Care - Frailty hubs					Hub 1		Hub 2		Hub 3		Hub 4		Hub 5								
															Implement continuous improvement, learning and refinement							
	Frailty -Primary Care Phase 1 (Early Adopter PCNs)										Implement continuous improvement, learning and refinement											
	Frailty -Primary Care Phase 2 (PCN)																					
	Frailty - Proactive Care															Implement continuous improvement, learning and refinement						
Ageing Well - EHCH	Delivery of EHCH DES and implementation of EHCH Framework																					
Ageing Well - Falls - Proactive	Clinical review of and prioritised improvement plan																					
Ageing Well - Falls - Responsive	Improving community-based falls response services																					
Ageing Well - PEOL	Delivery of the new PEOL integrated operating model of care supported by a strategic commissioning framework																					

Primary Care, Communities & Social Value

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4. Projected impact on patients and system partners

Further work will be required to ensure mechanisms are in place to capture and share the assurance detailed below. Dashboards are either in development or are already in place and will be reviewed via the agreed governance infrastructure for PCC and CV.

The KPIs detailed below have been shared with the Clinical and Care Directorate for challenge and critical appraisal

Integrating Primary Care

Access

- 85% of patients, with an identified clinical need for an appointment, to receive one within 2 weeks of their contacting their practice by March 2025
- All patients will be able to communicate with someone within their practice, either virtually or via telephone, on the day they contact them and know how their enquiry has been dealt with by March 2025
- 100% of practices have enabled online patient appointment booking and cancelling, repeat prescriptions and access to care records by March 2025
- 100% of GP practices using CBT or system with the same functionality by April 2024
- 100% of practices using high quality online consultation tools by April 2025
- Pharmacy First will be in place by March 2024
- Lincolnshire Enhanced service framework co-designed and implementation mechanisms in place, with a view to enhanced services being a key enabler of our local priorities by July 2024
- Lincolnshire Dental strategy implemented, with associated improvements to access by March 2027
- Design and implement Lincolnshire Pharmacy strategy by March 2028

Transformation Integrating primary care

- Completed ‘big conversation’ with the public and key stakeholders including national teams and horizon scanning ‘think tanks’ with a view to creating a shared vision for the future model of integrated primary care for Lincolnshire by March 2025
- Integrated Primary Care Strategy including both digital and estates as enablers completed by June 2025
- Framework for appointing early adopter pilot practices/PCNs agreed December 2025
- Early adopters appointed and evaluation indicators agreed by March 2026
- Rollout plan agreed with implementation ongoing

Vaccinations

- Resilience
  - Retain and expand a central workforce which can offer support into Primary Care where needed to deliver seasonal and life-course vaccinations and be sufficiently flexible to provide a response to any outbreaks by March 2024
- Access
  - Develop a delivery model that meets the needs of the population and establish delivery points at the point of need by April 2025.
  - Co-administration of vaccines will be the default model by April 2025.
- Uptake
  - Agree system-wide uptake targets for all vaccination programmes by March 2024
  - Meet all vaccination uptake targets by March 2027
  - Identify variation in uptake between PCNs and develop and implement mechanisms to close the uptake gap, focusing on continuous improvement and learning by March 2027

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4. Projected impact on patients and system partners

Integrating Community Partnerships

Additional Roles Reimbursement Schemes (ARRS)

- Lincolnshire will have 392.50 WTE ARRS roles in place (this is Lincolnshire share of the 26,000 WTE manifesto commitment) by March 2024. At Month 8 Lincolnshire has 496.64 WTE, well above the end of year target.

High intensity Users

- 3 PCNs will be offering a High Intensity User Service by April 2024
- By June 2024 we will have reviewed other HIU provision to ensure it is in line with the national HIU framework

Social Prescribing

- A refreshed Social Prescribing model to be developed and commissioned from 1st April 2025

Primary Care Networks

- All PCN will have in place agreed objectives, aligned to system objectives by December 2024
- All PCN managers will have undergone a Leadership Programme delivered through an independent specialising in PCN Manager development by March 2024

Partnerships

- Strategic partnership model between ULHT/Primary Care/ICB agreed by June 2024
- Strategic partnership model with VCSE (LVET) agreed by June 2024
- Model of MDT working in place in every PCN by June 2026
- Integrated delivery models in place for community therapy and nursing in every PCN by June 2026
- Implement quality framework across all PCNs by June 2026

Integrating Specialist Care

Ageing well – older age

Frailty

- Reduce the progression from mild to moderate and moderate to severe Frailty by 5% by 2028
- Deliver the opportunity identified in the 'Bed Right Size' modelling to reduce the growth in numbers of beds from the 'do nothing scenario' by 70 beds by 2028

Enhanced health in care homes

- Reduce unplanned admissions of people living in a care home by 5% by 2026
- 90% of people living in a care home to have a PSCP in place by 2026
- 100% of care homes having access to weekly ward round with evidence of access to appropriate MDT working, including access to care coordination and social prescribing, supporting by access to shared record keeping by 2025
- By 2025 all relevant partners constitute the MDT across all PCN areas

Palliative & end of life care

- New commissioning and delivery model (lead provider) by Q2/3 2026
- To increase our recognition of people deteriorating from a life limiting condition – target average is 1.3% of the population by 2026
- 70% of people identified as being in the last year of life to have a care plan in place by 2025, 80% by 2026
- 10% reduction of the number of people in their last year of life who have an unplanned admission by 2026
- 80% of patients will receive within at least a 2-hour timeframe a response to their pain and symptoms by 2027

Dementia

- Recover the dementia diagnosis rates in those aged 65 and over to the national ambition level (66.7%) by 2025

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4. Projected impact on patients and system partners

Integrating Specialist

Ageing well – older age (cont.)

Falls

- 70% of high-risk fallers will have received a holistic falls assessment from an appropriately skilled professional and will have a proactive care plan in place by 2025
- 10% more patients stay at home post fall response by 2025
- 10% more patients who receive a falls response and need an onwards referral will access directly relevant diagnostics, SDEC or speciality teams by 2025CVD

Long Term Conditions – working age

Heart Failure

- 85% (90.8%) of the expected number of people with AF are diagnosed by 2029 (Joint NHSE/ PHE ambition)
- 90% (89.6%) of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029 (Joint NHSE/ PHE ambition)
- 80% (63.66%) of the expected number of people with hypertension are diagnosed by 2029 (Joint NHSE/ PHE ambition)
- 80% (57.9%) of the total number of people diagnosed with hypertension are treated to target as per NICE guidelines by 2029 (Joint NHSE/ PHE ambition)
- 65% (55.3%) of patients aged between 25 and 84 with a CVD risk score greater than 20% on lipid lowering therapies by 2026 (IFF)
- 85% (awaiting NACR (audit) January 24) of those eligible access cardiac rehabilitation by 2026 (Long Term Plan)
- 40 (20) Virtual Ward beds established for Heart Failure by 2025

Diabetes

- NDPP – No. of patients referred to service and No. of patient who achieve at least the first milestone on the programme (contract ends Nov 25):
- April 24 – Mar 25 = 5,200 referrals and 2,582 Milestone 1s (MS1)
- April 25 – Nov 25 = 3,450 referrals and 1,721 MS1s
- Remission - 250 patients per year/ 500 24/25 and 25/26
- T2DAY - 1,410 patients to be offered the service by 23/24 and 1,410 patients (plus growth) by 24/25

Respiratory

- Increase the number of patients with a diagnosis of COPD accessing pulmonary rehabilitation by 5% by 2025
- % COPD patients where diagnosis confirmed by spirometry (% and delivery date TBC)
- % of patients with a COPD review in last 12 months (% and delivery date TBC currently 83.5%)
- % COPD patients with flu immunisation (% and delivery date TBC currently 66.6%(respiratory))

Note:

(%) = actual
Further scoping required to confirm baselines and trajectories

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5. What's needed to make this happen

Key enablers

Refreshed governance	• Integrated Care Committee which has oversight of key programmes of activity, is responsible for system wide delivery, risk mitigation and horizon scanning to inform future direction of travel
Population Health Management	• Utilised across all programmes of work to proactively identify opportunities where intervention will have greatest benefit and to support ongoing assessment of impact
Workforce	• Agree the workforce requirements to support delivery of the programmes of activity • Develop delivery plans with a focus upon future planning, recruitment and retention, development of innovative career pathways and roles, culture and organisational development and education and training. • Develop shared programmes of both OD and training./education to facilitate integrated team working across organisational boundaries
Digital	• Programmes of work will be supported by cross cutting digital programmes of activity including systems to capture performance data, shared care records, digital monitoring technology, robotics and enhanced digital access to appointments and advice and guidance
Estates	• Primary and Community based estate is a key enabler in delivering integrated models of care and yet the current estate varies in suitability for its function.. Development of an Estate strategy will enhance understanding of availability, any additional capacity required to deliver key areas and work and support targeting of investment
Commissioning and Contracting	• Utilise a spectrum of contracting and commissioning arrangements including enhanced services to support delivery of integrated services across providers. This will include developing a rigorous and transparent approach to agreeing whether to reinvest, change the specification or disinvest dependent upon assessed population needs, national and local ambitions, resource availability, value for money and assessed performance, in line with national and international guidance and law
Personalisation	• Personalised care is a key thread which runs through out all the programmes delivered by PCC&SV. Supporting patients to jointly agree the interventions proposed, including empowering them to self-manage their conditions and access social prescribing and personal health budgets will support improved outcomes and experience
Quality Improvement	• Embracing an approach of continuous improvement with a view to enhancing quality of care, patient safety and experience based upon learning from delivery of services.
Communication and Engagement	• Ensuring staff, patients and the public are proactively involved in co-design and implementation of services and kept updated as to any changes.

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6. What could make or break progress

Key risks to delivery

- Workforce capacity negatively impacting resilience across primary and community care
- Variable levels of resilience across the provider landscape within primary care
- Rural geography impacting upon patients' ability to access services and the development of efficient models of delivery
- Insufficient programme management capacity to enable transformation across a variety of agendas at pace.
- Lack of clarity at a national level as to expected direction of travel with some areas of the portfolio
- GMS contract detail may cause deterioration in service and engagement from GP practices and PCNs
- Competing priorities such as operational pressures and requirements of other programmes of work impacting managerial and clinical capacity available to focus upon transformational change.
- Capacity to transform whilst delivering business as usual
- Shared commitment to change across both provider and commissioner organisations not always in place
- Difficulties in being able to demonstrate impact, including financial, of integration – some measures will be qualitative rather than quantitative.
- Variation in maturity of PCNs
- Maturing third sector
- Delay or lack of investment will impact the delivery of the benefits.
- Variation in ability to capture accurate data to evidence performance and delivery i.e., specific information regarding
- Commissioning and contracting arrangements are not always transparent and consistently implemented
- Financial position within the Lincolnshire Health and Social Care System may impact the ability to invest in transformation, in particular 'invest to save 'schemes.

7. Planning assumptions

Prioritisation of interventions across this portfolio has been driven by:

- National priorities/imperatives i.e. General Practice access targets, Delivery of ARRs roles, Cardio- vascular disease, EHCH
- PHM data identifying cohorts of patients with whom we can have the greatest impact i.e., Frailty, High Intensity Users
- Provider feedback and performance data gathered via the contracting process (this will be further developed into the future as part of the review of commissioning arrangements)
- Opportunities identified within the 'Bed right sizing 'analytics exercise to reduce the predicted growth in requirement for bed utilisation, driven by changes to both demographics and overall demand, from the do-nothing scenario – PEOL
- Requirements of other programmes i.e., Urgent and Emergency Care requirement to reduce demand at the front door by providing suitable and safe alternatives in the community and further developing prevention and proactive care

Key constraints to delivery:

- Available additional funding to support delivery of pilots and new community- based services with a view to investing to save
- Programme management capacity to deliver across a complexity landscape and a variety of interconnected programmes whilst managing the business of usual aspects of the job e.g. primary care commissioning activities and performance management/risk assessment of a wide range of community-based contracts, held with a wide variety of providers of varying size and organisational capacity and capability
- Risk appetite of the system partners to deliver new, innovative and as yet untried solutions and act as system trail blazers
- Bandwidth from partners to engage with pathway redesign whilst delivering against challenging business as usual targets, exacerbated by workforce challenges i.e., recruitment and retention and industrial action

Planning, scoping, implementation, and delivery will be coordinated by the Primary Care, Communities and Social Value ICB team, supported by programme management capacity, managerial and clinical expertise from the providers and analytic capability from both the CSU and the PHM team. Additional specialist capability and capacity may need to be externally procured where this does not exist within the system.

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8. Stakeholders

Stakeholder	Benefit	Engagement Requirement
Patients and the Public	• Improved access to primary care when acutely unwell • Early and proactive identification of longer-term health and care needs • Right treatment at right time by the right professional • Access to the right advice, guidance and information to support proactive self-management	• Willingness to engage with proactive management of their own health • Support to codesign services • Provision of regular feedback to support evaluation of services • Willingness to work in partnership with Health and Social care colleagues to access right services in right place
ULHT	• Reduction in attendances at ED • Reduction in number of bed days utilised • Fewer days between patient being 'discharge ready' and leaving the hospital • Co-development of innovative pathways away from the acute setting • Opportunity to test benefits of new group model	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Provision of programme management/QI capability and capability to support system wide change • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working • Willingness to explore, co-design and participate in new models of commissioning/Lead provider delivery models
LCHS	• Opportunity to deliver of newly commissioned services • Opportunities to integrate services with primary care • Opportunities to build upon existing services and secure financial sustainability • Opportunity to test benefits of new group model	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Provision of programme management/QI capability and capability to support system wide change • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working • Willingness to explore new models of integrated deliver with primary care colleagues with a view to meeting locally identified need • Willingness to explore, co-design and participate in new models of commissioning/Lead provider delivery models
Primary Care	• Opportunity to create sustainable models of delivery whilst maintaining income • Opportunity to create a sustainable workforce • Opportunity to create improved work life balance, manageable workload, and interesting case mix	• Willingness to explore and co-create new delivery models at both practice and PCN level • Willingness to undertake shared risk taking –financial, operational and reputational to support delivery of new models of care

Primary Care, Communities & Social Value

SRO: Sarah-Jane Mills	Programme leads: Nick Blake - Primary Care; Sarah Button - Integrating Community Partnerships; Lisa Foyster – Integrating Specialist Care	Clinical/Technical Lead: Sunil Hindocha

8. Stakeholders

Stakeholder	Benefit	Engagement Requirement
ICB	• Improved access to primary care • Improved delivery against nationally agreed performance against nationally agreed targets • Improved patient experience • Improved targeting of resource to gain greatest impact • Opportunity to support realisation of cost avoidance opportunities identified within the bed right sizing analysis • Opportunity to horizon scan with a view to understanding future requirements of the provider landscape and proactively manage the market	• Provision of financial support to allow new community-based initiatives to be piloted with a view to investing to save • Invest in programme management support to allow change to happen at pace. • Agree risk appetite and thresholds for exploring new operating models and new models of commissioning • Support development of workforce, information sharing and digital strategies to allow programme aspirations to be realised • Provide ongoing PMH support to allow populations to be identified and impact of change to be quantified • Provision QI and other support from the Care and Quality Directorate to allow new clinical pathways to be co-created, validated, critically appraised
LPFT	• Improved partnership and MDT working within the community setting to address both physical and mental health needs of patients • Opportunity to further enhance community-based model of delivery, reducing the need to inflate bed numbers, in a context of population growth	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Willingness to utilise workforce differently and to support introduction of innovative roles and different cross system ways of working
Voluntary Sector	• Opportunity to influence future direction of travel and pathways of care • Opportunity to deliver new services	• Provision of subject matter experts to support design of new models of care • Provision of data and intelligence to support service review • Willingness to utilise workforce differently • Willingness to support engagement with the public in innovative ways

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

1. Future state

Across Lincolnshire, current pressures on urgent & emergency care services remain high, further impacted by periods of Industrial Action. Additionally, demand upon all aspects of health & social care is expected to increase year-on-year due to population growth, the impact of an ageing population and the growing number of people living with Long Term Conditions. By 2030, it is predicted that in order to meet this inflated demand on non-elective care, costs will increase nationally by over 35%. Lincolnshire's age & deprivation profile suggests that the local increase is likely to be higher than that predicted nationally. As of 2021 the percentage of people aged over 85 in Lincolnshire represented 2.9% of the population against 2.4% of the East Midlands population. By 2041 this is projected to make up 4.9% of Lincolnshire's resident population and 4.1% of East Midlands.

The scope of the UEC programme includes the full UEC pathway of care, including discharge and intermediate care, and has significant crossover and interdependence with other system programme areas such as Primary Care, Community Services and Long-Term Condition management. It is important to acknowledge that some of the work to deliver the UEC strategy in Lincolnshire will be completed within other Programme areas, and some of the UEC funded initiatives will transition post mobilisation into BAU within other programme areas. . In order to ensure that patients receive seamless care regardless of where they choose to be cared for (particularly in border areas), close working with neighbouring systems is imperative to ensure that our registered population are able to access appropriate care (including across borders) in a timely way.

Additional publications that are interdependent with UEC programme delivery include:

- Lincolnshire Integrated Care System Strategy 2023-2028
- Health and Wellbeing Strategy and Joint Forward Plan 2023-2028
- Lincolnshire Frailty Strategy 2023
- Elective Recovery Plan
- ULHT ED Recovery Plan
- EMAS Recovery Plan
- Primary Care Access Recovery Plan
- Fuller Report
- GIRFT recommendations

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

2. What's being done to get there | Overview

The UEC Programme has four key elements to delivering its aims: Prevention; Out of Hospital Urgent Care; Front Door Flow; and In Hospital Care and Discharge, however not all aspects of transformation with sit directly within the UEC Programme. The Prevention elements of the pathway will be co-delivered within the PCCSV programme.

The UEC programme consists of the following:

- Delivery of the national UEC recovery plan, including implementation of all 10 High Impact Interventions
- Implementation of investment initiatives with full evaluations of impact
- Lincolnshire Intermediate Care Programme
- Reviews of existing services and pathways
- Agreement of GIRFT recommendations for implementation
- Utilisation of a robust UEC dashboard to aid decision making
- A recovery plan for delivery of the key UEC metrics that sit within the Group model with system assurance and support
- System focus on the improvement against and delivery of the CAT2 mean metric
- The delivery of the UEC elements of the system Bed Right Sizing plan
- Collaborative strategic and tactical/operational working with neighbouring systems on both transformation and BAU

The UEC Programme's governance structure is designed to support its oversight and delivery, with a Programme Delivery Group (PDG) meeting monthly and reporting into the Urgent and Emergency Care Partnership Board (UECPB). UEC projects and initiatives feed into PDG with the majority of these being captured and recorded on the ICB led Project Management Office (PMO) Aspyre.

Projects plans, milestones, deliverables, risks and issues etc. are recorded on an individual project basis and at programme level and are overseen by the UEC Programme enabling interdependencies and cross overs to be considered.

The current KPIs are the UEC performance metrics, but work will be completed in 2023/24 to finalise wider KPIs.

The governance is revisited and refreshed each year to ensure that it supports the requirements of the National Operational Planning process, and the system priorities each year. This includes specific task and finish group across the system to ensure that protected time and focus is in place to deliver the plans and requirements of the programme.

The UEC allocation in 2023/24 has been committed recurrently to a number of system initiatives, but these will be fully evaluated to understand impact and effectiveness in order to support decisions around ongoing and future prioritisation of investment for improved outcomes. This will be completed prior to the winter of 2024/25 so that maximum impact is achieved. The overall UEC investment is reported through the System Sustainability and Investment Panel.

The newly developed UEC Dashboard supports robust decision making and will be further developed to include benchmarking to ensure that all opportunities for improvement where there is any evidence of variation.

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

3. What's being done to get there - Detail

2023-2026

The Current UEC System Programme reflects the national recovery requirements, investment initiatives and local priorities for review of service provision and pathways of care. The UEC strategy in place currently covers 2023-2027.

High level ambitions for the UEC programme are:

- Support patients and professionals in accessing the right services in the right way
- Increased and improved communications with public and professionals
- Simplify the provision of services and access processes
- Review services on an ongoing basis to ensure continuous improvement and maximum impact with improved outcomes for patients
- Ensure that regionally commissioned services such as NHS 111 and EMAS are mobilised and delivered in such a way that supports the local pathways and ambitions of Lincolnshire
- Ensure that there are workforce and digital plans in place that support the delivery of the UEC programme and national requirements
- Deliver the UEC elements of the system bed rightsizing actions
- Support the full system focus on improving patient flow across all services
- Minimise the impact of UEC pressures on wider plans including Elective Recovery

10 High Impact Interventions:
The development and delivery of these initiatives are overseen on a monthly basis by the Programme Delivery Group and the Service Delivery and Performance committee with monthly review of progress. The self-assessment against requirements is revisited routinely to provide assurance of progress.

Achievement of the performance standards:
ULHT within the new group model arrangements in 2023 have established a programme of work with executive oversight to deliver the 4 hour performance standard and improve the 12 hour wait in department position. The focus on delivery of these standards will continue with ULHT continuing to lead on these areas of improvement reporting and assuring through UEC system governance. The ICB are a member of the ULHT internal improvement group meetings to represent the system for escalation and engagement/support. Action currently ongoing include revisiting escalation processes and operational management of patients on ambulances and in the department, as well as the flow of patients through the ward areas and on to discharge.

The improvement against the CAT2 mean position in Lincolnshire is supported by the above improvement plan, but the system Ambulance performance and alternatives to ED governance group further supports the delivery of an improved position through reduced conveyance and increased support to patients in community. This includes review of community pathways of care to ensure integrated delivery of services that support people in their own homes and increases in the availability of alternatives to ED. While Virtual Wards have now been implemented and embedded in 2023/24 work will continue to ensure that the specialist community service provision is sufficient to support delivery of VWs and that the appropriate digital infrastructure is available. The ULHT focus on alternatives to ED within acute services will continue to ensure maximum impact of utilisation of areas such as SDECs.

Frailty:
The UEC programme continues to include projects focussed on the frail cohort, nursing and care homes and touches on end of life care. While these initiatives form part of the UEC programme which has oversight and receives assurance, al frailty work is don't in conjunction with the Frailty Programme and the frailty leadership group has responsibility for the wider implementation. UEC supported frailty initiatives will continue to include Frailty SDECs and Frailty Assessment Units, expanding both with increased capacity and geographical coverage in line with population need.

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

3. What's being done to get there - Detail

Lincolnshire system approach to the Intermediate care ask:
The Lincolnshire Integrated Care Board (LICB) and Lincolnshire County Council (LCC) committed to exploring joint commissioning opportunities and building on the existing strengths within the current intermediate care system to make the best use of available resources and funding commitments (including BCF discharge funding). Moving towards a system-wide and outcome-based model which prevents unnecessary acute hospital admission, supports timely discharge and maximises independent living.

Strategic review of the current landscape and summary recommendations were endorsed by Chief Executives at the Better Lives Lincolnshire Leadership Team (BLL LT) meeting in May 23. System leads have defined a transformation journey to develop a shared delivery model for intermediate care with a pooled budget enabling collaborative commissioning with one partner holding contracting responsibility.

The next phase of the programme is to determine governance to drive and support delivery of the future model in a phased approach.

The focus of the model which has been developed is to deliver a therapy-led service where every patient can receive a standard level of therapy input, supported by the physical infrastructure and wider features to enable their reablement and rehabilitation.

2026-28

The detailed focus areas for 2026-2028 will be determined by the annual operational planning guidance but will continue to include:

- Delivery of national performance standards relating to UEC including 4 hour performance, ambulance response times, discharge metrics and community service response requirements.
- A focus on increasing care closer to home and reducing the requirement for patients to attend EDs in order to access services both in acute and community
- Evolution of simplified access for both patients and professionals (including HCP SPAs and NHS 111)
- Increased integration of services across pathways of care to ensure seamless care and less handoffs
- Move towards commissioning of pathways of care rather than individual services
- A focus on ensuring workforce and digital plans support the requirements of the UEC programme and provision

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
UEC	Capacity & Demand Schemes		P	I	D	D	D	D E	BAU	BAU	BAU	BAU	BAU	E	I	BAU	BAU	E	I	BAU	BAU	BAU
UEC	Delivery of High Impact Interventions		S	P	I	D	D	D E	D E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU
UEC	Discharge & Flow Programme		P	I	I	D E	D E	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU
UEC	Intermediate Tier Transformation		P	P	P	C	C	I	D	D E	D	BAU	BAU	BAU	BAU	BAU	BAU	E	D	BAU	BAU	BAU
UEC	Commissioner review of UTCs			S	C	C	I	D	D	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU	BAU	BAU
UEC	Furrther development and expansion of Virtual Wards		P	C	I	D	D	D	D	E	BAU	BAU	BAU	BAU	BAU	E	BAU	BAU	BAU	BAU	BAU	BAU
UEC	Review of UEC service specifications			S	P	C	I	I	I	I												
UEC	Bed Right Sizing UEC specific inititaives	X				S	P C	I	I	D	D	D	D	D								
UEC	Seasonal and operational planning			P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I	P I
UEC	UEC Digital Roadmap						S	P C	I	D												
UEC	UEC Workforce Roadmap							S	P C	I	D											

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
High Impact Interventions	Same Day Emergency Care		P	P	I	D	D															
High Impact Interventions	Frailty															Implement continuous improvement, learning and refinement						
High Impact Interventions	Inpatient Flow and LoS		P	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Community Bed Productivity and Flow		S	P	I D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Care Transfer Hubs		I	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Intermediate Care Demand and Capacity		P	P	P	C	C	I	D	D E	D	BAU	BAU	BAU	BAU	BAU	BAU	E	D	BAU	BAU	BAU
High Impact Interventions	Virtual Wards		D	D P	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D
High Impact Interventions	Urgent Commmunity response		E	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S	I	D	D	E S
High Impact Interventions	Single Point of Access			S	P	D	D	E S														
High Impact Interventions	Acute Respiratory Infection Hubs						E															

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

4. Projected impact on patients and system partners

- Improved patient experience – reduction in complaints from patients and professionals, reduction in long waits in EDs and in community for ambulance attendance. Reduction in the number of patients accessing acute services via EDs
- Improved patient outcomes – increase in the number of patients returning to their own home, reduction in long term care requirements, reduction in incidents reported within the UEC pathways
- Reduction in waiting times – in both UTCs and EDs with delivery of the 4-hour performance target and the wider time to first assessment and triage metrics
- Reduction in readmissions – fewer patients requiring re-admission following discharge from hospital
- Increase in the number of patients supported at home avoiding attendance at ED or hospital admission
- Reduction in acute length of stay and acute bed occupancy – ambitions to be developed as part of the planning round
- Reduction in agency/bank and locum spend

Robust system capacity and demand modelling will support the determinations of impact trajectories.

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
High Impact Interventions implementation and delivery	• C&D and BCF funding • Non recurrent regional funding • Additional System funding sources will be required • System transformation resource • System clinical resource • Additional workforce • PCCSV programme support	Support recovery of three key Tier 2 metrics: • 76% ED Performance • 12 hours in department • 30min CAT2 mean delivery Protect elective capacity Mitigate risk of harm and improve patient outcomes and experience	Deliver national performance standards. Mitigate Non Elective Growth Support protection of elective capacity and delivery of the elective recovery plan Mitigate risk of harm and improve patient outcomes and experience	To Be Determined	✓	✓	✓	✓
Capacity and Demand schemes (UEC and BCF investments)					✓	✓	✓	✓
Urgent Treatment Centre Commissioner Review	• UEC Programme capacity • PCCSV capacity • Primary Care support • ICB Contracting and Finance • Business Intelligence • PHM and Health Inequalities support • Comms & Engagement Support	Recommendations around commissioning intentions for future UTC commissioned services based on population need and addressing health inequalities	• Deliver national performance standards. • Mitigate Non Elective Growth • Support protection of elective capacity and delivery of the elective recovery plan • Mitigate risk of harm and improve patient outcomes and experience	To Be Determined	✓	✓		
Delivery of UEC elements of Bed Rightsizing recommendations	Awaiting confirmation of UEC elements and actions to determine inputs, outputs and outcomes						✓	

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Discharge and Flow Programme delivery	System wide: • C&D and BCF investment • Operational • BI • Contracting • LA ASC resource	Improvements in: Discharge quality Patient outcomes and experience Joint working and shared workforce Delivery of Discharge Date Ready Metric (DDR)	• Further improvements in discharge • Move to blended workforce model	TBC	✓	✓	✓	
Intermediate Tier Transformation implementation	System wide: • BCF investment • Operational • BI • Contracting • Commissioning and procurement • OD support • Consultancy support (Impower)	Scope and determine agreed plan and measurable patient outcomes	Full joint re-commission of the whole intermediate tier (health and care) Pooled budget ambition Improved intermediate care pathways with efficiency and financial improvements Improved patient outcomes and experience	TBC	✓	✓	✓	✓
Seasonal and Operational Planning	System wide: • Operational • Finance • BI • Strategic planning • Contracting • ICB UEC and wider programmes	Winter plan 2023/24 Operational Plan 2024/25 Commissioning intentions with rebased contract values and potentially updated IAPs	Summer and Winter plans Annual Operational Plans Commissioning intentions with rebased contract values updated and new specifications and potentially updated IAPs	Summer and Winter plans Annual Operational Plans Commissioning intentions with rebased contract values updated and new specifications and potentially updated IAPs	✓	✓	✓	

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Communications and Engagement – Public & Professional	• ICB and provider Comms & Engagement support	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased public understanding of how to access and utilise services	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased utilisation of most appropriate services first time	• Improved HCP and patient experience • Timely access to services • Increased care at home and reduced reliance on front door services • Increased utilisation of most appropriate services first time	✓	✓	✓	✓
Review of UEC service specification in ICB contracts with appropriate re-design and re-commissioning	• UEC programme commissioning capacity • ICB contract and finance capacity • Provider transformation capacity • Potential additional funding requirements (TBC)	System understanding of workplan for review of specification and capacity to support planned into ICB teams and providers High level commissioning intentions set	Revised specifications start to be CV'd into contracts Fit for Purpose services in line with updated health and care needs including consideration of health inequalities. Potential financial and workforce efficiencies	Revised specifications start to be CV'd into contracts Fit for Purpose services in line with updated health and care needs including consideration of health inequalities. Potential financial and workforce efficiencies	✓	✓	✓	✓
Scope, develop and implement: • UEC Digital roadmap • UEC Workforce roadmap	• UEC programme capacity • Digital programme capacity • People team capacity • Partner organisations transformation and digital capacity	Scoping Determine whether there is a need for full strategies of UEC specific roadmaps	UEC workforce and digital strategies or roadmaps completed and owned by the system. Commence implementation	Ongoing implementation	✓	✓	✓	

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

5. What's needed to make this happen

- Digital and IG support to ensure that innovative solutions are implemented to support provision of non-acute services such as Virtual Wards, CAS virtual assessment and stack pull capabilities and the integration of HCP SPA with wider partners such as EMAS
- Digital support to link services/partners to ensure that all care plans and current monitoring information is accessible to support decision making that keeps people at home with additional support
- Workforce support to move to more integrated use of workforce both across partner organisations and services to deliver seamless care without barriers or hand offs of patients. There are specific risks around some parts of the UEC pathway such as Frailty which needs focussed support through the PCCSV programme
- Workforce support to better plan for periods of escalation and to ensure that capacity is flexible to meet demand
- Continued engagement of partner transformation teams and operational teams with clinical support
- Future support from PHM to evidence impact and support stratification of priority cohorts within the pathway
- On-going recurrent allocation of the UEC investment made in 2023/24
- Comms and engagement support to continue with flexible and creative public and professional messaging

6. What could make or break progress

The UEC programme delivery and success is interdependent with the following:

- PCCSV programme prioritisation and delivery – Primary care, frailty and long-term condition management programme delivery are key to the success of the UEC programme delivery
- Elective recovery – UEC has the potential to impact delivery of the elective recovery plan and vice versa
- Enablers: Digital and Workforce
- System partners: ULHT, LCHS,LCC, LPFT, EMAS
- Neighbouring systems pressures

Risk/ Challenges	Mitigation
Workforce	Recruitment and retention as well as sickness and absence; reliance on agency and locum staff. Frailty workforce is a particular risk across the UEC and Frailty programmes
Industrial Action	
Increasing patient demand and acuity outstripping capacity	Continue to develop admission avoidance pathways and initiatives to provide more appropriate and timely support
Funding	Utilise additional national UEC and BCF monies to fund interventions with greatest impact
Public behaviours	Comprehensive comms and engagement strategy required
Rurality	Care closer to home will be adopted as a guiding principle when commissioning services with community hub-based models delivered in partnership with PCNs with Virtual Wards supporting patients to receive acute care at home

Urgent & Emergency Care

Programme: UEC	SRO: Clair Raybould	Programme lead: Rebecca Fieldsend	Clinical/Technical Lead: Anne-Louise Schokker

7. Planning assumptions

- A robust system demand and capacity plan is to be developed as part of the national operational planning process.
- Current assumptions are that we will plan to deliver national performance targets.

8. Stakeholders

- ULHT, LHCS, LPFT, EMAS, LCC
- Primary Care, Communities,& Social Value, Planned Care, MH and Cancer Programmes
- PCNs and wider primary care
- Social care commissioners and providers
- Patients and public
- Nursing and residential homes (LINCA)
- Voluntary sector
- Neighbouring commissioners/systems
- Midlands Regional Team
- NHS England

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Vision

The overall vision for the Lincolnshire system is to reduce waits for patients who require planned care and diagnostics to constitutional standards, improve patient access to these services and reduce inequalities across the county. In a recent patient and citizen survey (undertaken as part of the development of the Joint Forward Plan) 54% put improving waiting times for routine services such as diagnostic tests or operations as their top priority.

Background

Waiting times are still the most challenging aspect for elective recovery. Prior to the junior doctor industrial action, the Lincolnshire system was on track to eliminate waits of 78 weeks by the end of March 2023. Unfortunately, both this and the additional industrial action by consultants impacted on ability to achieve this, but the system is focussed on eliminating 78 week waits as soon as possible. ULHT as the main Acute Provider has multi-year programmes (Outpatient Improvement Programme & Productive Theatres Programme) to take forward the Elective Care improvements required which focus on key projects like High Volume Low complexity & Patient Initiated Follow Ups

National and Local Targets

Trajectories/targets up to March 2025 have been established nationally & locally as follows:

Eliminate 65 week waits by March 2024 and 52 week waits by March 2025.

- The system is ahead of trajectory to eliminate 65 week waits by March 2024.
- Local ambition to have <700 patients waiting more than 52 weeks by March 2024.
- The system will achieve the reduction in these waits sooner than in some specialties.
- No further national targets have yet been set. Local ambition is to achieve constitutional standard of 18 weeks by the end of this planning period and is shown on an incremental basis. The system will continue to work to reducing waiting times for all specialties ahead of this or any national targets set.
- The EACH will support longer waiting patients and their practices in managing their wait and looking for alternative options.

Increase patient choice.

- If patients are provided with greater choice at the point of referral the overall waiting list volume will reduce.
- If patients are provided with a proactive opportunity to move provider if waiting more than 18 weeks, the number of long waiting patients will reduce.
- National target to commence offering alternative Providers to patients waiting over 40 weeks from 31st Oct 2023 and extending to patients waiting over 18 weeks by Sept 2024. No national funding will be available to deliver this initiative.

Increase Activity.

Increasing activity delivered will also drive a reduction in waiting lists. Each of the providers across the system have been set individual activity targets for 2023/24 as follows:

- United Lincolnshire Hospitals Trust 116%
- Out of Area Providers Including Contracts with North West Anglia Foundation Trust and North Lincolnshire and Goole Trust 105%
- All other existing Independent Sector Providers 120%

To sustainably deliver the levels of patient activity required for 2024/25 onwards, all providers will need to increase productivity and efficiency of the services delivered. The detail of this will be part of annual planning rounds.

Demand Management.

- Reducing demand overall is a key priority to support waiting list reduction and the Elective Activity Coordination Hub (EACH) will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients.
- In addition, promoting self-care and increasing activity within community services will reduce demand on both secondary care services and primary care and this will be a focus for 2023-28.

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

National & Local References

- The NHS Planning Guidance for 2023/24
- The National agenda around Elective Recovery currently:
  - PRN00496: Elective Care Priorities
  - PRN00673: Protecting & Expanding Elective Capacity
- The National Agenda around Patient Choice:
  - PRN00507: Patient Choice
  - National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the Standing Rules”)
  - National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (“the PPCCRs”).
- The National agenda around Primary Care Recovery:
  - PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023
- The NHS Lincolnshire Joint Forward Plan 2023-2028 particularly around Priority 3: Improving Access

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

2. What's being done to get there | Overview

Eliminate 65 week waits by March 2024 and 52 week waits by March 2025.

All patients in the 65-week 'cohort' *(patients who, if not treated by 31 March 2024, will have breached 65 weeks*) will be given a first outpatient appointment before 31 October 2023 in most specialties to ensure their treatment pathway is completed by March 2024. Those more challenged specialties will be working towards a deadline of 31st December to ensure all patients have had their first outpatient appointment.

- Mutual aid will continue to be delivered predominantly from independent sector providers for challenged specialties, particularly for Gastroenterology and Dermatology.
- A new ENT weekend working proposal is to be implemented at ULHT. This will be evaluated and rolled-out to other specialties.
- Any learning from a national 'Going Further Faster' pilot will be reviewed and implemented where appropriate – national data not yet available. This pilot has focussed on eliminating 52 week waits sooner than the current March 2025 target.

Increase patient choice

- Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice. This will include a local communication plan with both practices and patients to complement the national communication campaign. This will also be aligned to the Lincolnshire Joint Forward Plan priority around improving access as it will help Lincolnshire patients understand their rights and how to access the care they require.
- Promote the Patient Initiated Digital Mutual Aid System (PIDMAS) which will, once available in October 2023, allow us to offer patients the ability to more easily and proactively 'opt-in' to move provider when they have been waiting over 40 weeks for care and meet the right criteria. This will be extended to all patients waiting over 18 weeks by Sept 2024.
- Ensure all opportunities to both request and offer mutual aid both within and outside of the DMAS system are regularly reviewed and progressed.
- Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all planned care patients both at point of referral and via PIDMAS.

Increase Activity

- ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies.
- Expand implementation of Getting It Right First Time (GIRFT) programme to other specialties.
- Expand the range of services and procedures to be delivered in the community and moved away from secondary care.
- Work with independent sector providers to deliver additional capacity where there are challenged specialties at our NHS providers
- Expand the programme of out-patient transformation and theatre utilisation to maximise capacity and efficiencies to reduce waiting times.
- Maximise capacity at the recently accredited Grantham Surgical Hub using HVLC principles as well as the planned increase to 2.5 session days.
- Implement and expand the estate strategy supporting modernisation and utilisation of space.

Demand Management

- Reducing demand overall is a key priority to support waiting list reduction and the EACH will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients. Currently 6 specialties are clinically triaged via the EACH, but a review is planned to determine priorities for 2024-28 to ensure both effectiveness and to maximise on opportunities to re-direct to more appropriate services.
- In addition, promoting self-care and increasing activity within community services will reduce demand on both primary and secondary care services and this will be a focus for 2023-28.

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Eliminate 65 week waits by March 2024 and 52 week waits by March 2025.

- Joint monitoring of long-waiting patients undertaken three times per week by ULHT/ICB and every two weeks with ISPs for assurance, to remove barriers and to source solutions where patients are undated.
- Close monitoring of patients waiting for specialist diagnostics etc. at out-of-area providers which may delay their overall pathway at ULHT.
- Monitoring of Lincolnshire patients at out-of-area Providers who may be suitable for repatriation into the Lincolnshire system.
- A rolling programme of Technical Referral To Treatment (RTT) Pathway validation for all patients waiting 12+ weeks to ensure they are on an appropriate pathway.
- A rolling programme by Providers and the EACH of administrative validation which includes contacting patients to ensure an appointment is still required.
- Continue with local mutual aid from independent sector providers particularly for Gastroenterology and Dermatology.
- Implement a new ENT weekend working proposal at ULHT, evaluate and roll-out to other specialties.
- Any learning from a national 'Going Further Faster' pilot will be reviewed and implemented where appropriate once data available. This pilot has focussed on eliminating 52 week waits sooner than the current March 2025 target. This is anticipated for Q4 2023/24.

Increase patient choice.

- Implement a system level plan for patient choice which ensures compliance with the regulatory requirements and raises the profile of patient choice.
- Promote the Patient Initiated Digital Mutual Aid System (PIDMAS) which will, once available in October 2023, allow us to offer patients the ability to more easily and proactively 'opt-in' to move provider when they have been waiting over 40 weeks for care and meet the right criteria. This will be extended to all patients waiting over 18 weeks by Sept 2024.
- Ensure all opportunities to both request and offer mutual aid both within and outside of the DMAS system are regularly reviewed and progressed.
- Promote the use of the Elective Activity Coordination Hub (EACH) which offers choice to all new planned care patients at point of referral and for delivering PIDMAS.
- Deliver a local programme of patient engagement and communication to ensure patients understand their options around choice and address transport issues where feasible to encourage patients to access the most appropriate provider with shortest waits.
- Maximise patient transport options by encouraging use of available resources including the national health care travel costs scheme, Non-Emergency Patient Transport Service and local alternative transport options.
- ICB Contract Team to develop an accreditation process for new providers to increase choice.
- A programme to reintroduce directly bookable appointments with Providers to increase choice as this is known to reduce missed appointments (previously known as Did Not Attend (DNA) and Was Not Brought (WNB)).

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Increase Activity/Capacity.

- ULHT will develop an overall clinical service strategy and establish a rolling programme of specialty clinical service strategies. For planned care ENT and Gastroenterology are the priority. The strategy will be developed in line with the Lincolnshire Academy of Clinical Excellence (LACE)
- Expand implementation of Getting It Right First Time (GIRFT) to other specialties. This the backbone of service re-design and implementation and is the core of the improvement work planned in Lincolnshire. NLAG, ULHT and NWAFT (as the main NHS providers) have all integrated the principles of the Getting It Right First Time (GIRFT)initiatives to a greater or lesser extent. At ULHT the GIRFT programme is a substantial part of the improvement plan building on the success of previous schemes such as the Trauma and Orthopaedic and Urology redesigns delivered in recent years to great success.
- Alongside this is a programme of out-patient transformation for maximising capacity and efficiencies to reduce waiting times plus an estate strategy supporting modernisation and utilisation of space. The estate strategy includes maximising capacity at the recently accredited Grantham Surgical Hub using HVLC principles.
- Expand the Community Surgical Scheme and other community services to increase number and type of procedures undertaken. Examples include women's health hub, extending community audiology from current age 50+ years down to 18+ years.
- The EACH will facilitate a programme of repatriation with ULHT for specialties with shorter waiting times.
- The ULHT Grantham elective hub is driving though elective activity and will in the future have 2.5 session days which should facilitate increased activity volumes.
- Reaching the GIRFT standards for High Volume Low Complexity will facilitate greater activity – e.g. 8 patients on cataract lists as a standard across all providers

Demand Management

- Reducing demand is also a key priority to support waiting list reduction and the EACH will continue to provide a system-wide single point of access for planned care referrals for Practices, Providers and Patients. This includes referral optimisation/demand management through primary care led triage, provision of specialist advice, application of the 10 interventions listed in the latest Evidence Based Interventions policy (List 3 published May 2023), ensuring Blueteq is widely used for requesting prior approval, maximising utilisation of ISPs and locally commissioned community services.
- The EACH will also support Onward Referrals where if a patient has been referred into secondary care and they need another referral the secondary care provider should make this for them rather than sending them back to general practice to a further delay before referred again. This will improve patient care, save time, and reduce bureaucracy for General Practice. The EACH will support by offering the patient an alternative choice of provider to access shorter waiting times for the onward specialty if appropriate.

Workforce

- The workforce will be encouraged to have a 'can do' approach which focuses on what matters to people and to think and act creatively to make things happen for them.
- Develop a variety of different workforce models utilising different skill sets and best practice including multidisciplinary teams to support one stop services.
- Within ULHT the Productive theatres programme has a workforce modernisation project which is focused on increasing skill mix of staff to have a more agile workforce to deliver elective care across all sites

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient Alternative Choice Offers(National Target using national digital PIDMAS system)				Start Oct 23 with patients waiting 40+ weeks & extends incrementally down to 18+ weeks by Sept 24. ICB led in partnership with providers using 'PIDMAS'																	
Eliminate 65 + week waits (National target)				All pts in this cohort to have a 1st OPA by 31/10/23 Oct to achieve no patients waiting 65wks+ by 31/03/24																	
<700 patients waiting 52+ weeks (local target) Eliminate 52 + week waits (National target)					<700 by Mar 24				0 by Mar 25												
Eliminate 40 + week waits (Local ambition – no targets set)													0 by Mar 26								
Eliminate 26 + week waits (Local ambition- no targets set)																	0 by Mar 27				
Eliminate 18 + week waits (Local ambition – no targets set)																					**0 by Mar 28**

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

Impact on Patients:

- Decreased waiting list – measured weekly via WLMDS submission.
- Decreased waiting times in line with, or better than, national trajectory - measured monthly via the national My Planned Care platform and the national electronic Referral Service.
- Reduction in harm caused by long-waits (measured through evaluation of harm reviews by Quality team)
- Increase in choice of Provider where appropriate – measured though the EACH and e-RS reports.
- Care closer to home where community services can be increased.
- Increasing the utilisation of the EACH gives patients a single point of access for all appointment queries – measured through EACH Practice utilisation reports and Practice visits.

Impact on System Partners:

Impact on system partners is being worked through as part of the current planning round and will be discussed when the annual planning guidance is released

5. What's needed to make this happen

- Increased activity within acute provider including reducing current inefficiencies. This is dependent on delivery of the improvements in the outpatient transformation and HVLC programmes.
- Increasing independent sector contracts to allow for equalising/reducing waiting lists by outsourcing, insourcing and transferring patients where patients can be treated quicker. This is being scoped as part of the 24/25 planning round.

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

6. What could make or break progress

Risk/ Challenges	Mitigation
Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds;	Requires system support for discharging patients who are medically fit.
Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.	
Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.	
Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.	
Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.	
Under delivery of the outpatient transformation and HVLC programmes	
Financial Recovery including 30% reduction in ICB running costs.	
Geography – difficult to source mutual aid due to travel distances.	
IT systems – Difficult to track total patient journey through ULHT as use different systems at each stage.	
Data quality issues	

There is an established system-wide governance programme: all risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

Planned Care & Diagnostics

Programme: Waiting List Reduction	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

7. Planning assumptions

- Current assumptions are that referrals remain static, and the system is working on using the available capacity to its maximum efficiency.
- That all national targets will be met, and remedial action will be implemented should performance be adverse to trajectories.
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally. Current baseline position is being assessed and trajectories developed. This is done via planning discussions which are currently underway with partners. National planning guidance for 24/25 is still awaited before finalising.

8. Stakeholders

Stakeholders

- Acute Providers
- Independent Sector Providers
- GP Practices
- Lincolnshire Clinical & Care Directorate (including Lincolnshire Academy of Clinical Excellence (LACE), Clinical & Care Academy (CCA) and Lincolnshire Learning Network (LLN))
- Health and Well Being Board

Project team

- ULHT COO & SRO for Planned Care
- ULHT Deputy COO, Planned Care & Cancer
- ULHT Head of Elective Access
- ULHT Clinical Lead for Planned Care
- ICB Planned Care and Diagnostic Programme Director
- ICB Deputy Planned Care Manager & EACH SRO
- ICB & ULHT Contracting Teams
- ICB Chief Medical Officer

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Outpatients

- It is widely discussed and highlighted in the NHS Long Term Plan that the current model of outpatient services is outdated and needs transforming to meet the current demands on the NHS. Over the next four years the Lincolnshire system will work together to develop new models of outpatient care including increasing the virtual offer as well as considering how artificial intelligence and other digital solutions could streamline services and make them more efficient.
- The ambition for the Outpatient Improvement Programme is to reduce risk of harm to patients as a result of excessive waiting times by recovering OP capacity in excess of 19/20 levels and to reduce the number of OP follow-up activity. This is at all providers to support the elective recovery with the short-term ambition at ULHT to increase new outpatient and outpatient procedure activity to 116% of 19/20 and the follow up reduction by 25%. This will be amended depending on national planning guidance and system need in future years. These ambitions will be delivered through a number of initiatives outlined in the NHSEI Personalised Outpatient Programme using the evidence-based principles, specialty guidance and framework of Getting It Right First Time (GIRFT).
- A project looking at the health inequalities around outpatient waits across the county is being developed through the latter half of 2023/24. The outcomes and any actions from this will be incorporated into future planning and outpatient improvement. This is not only looking at deprivation and access inequalities but is also scoping any inequalities between adults and children and young people.
- There are significant opportunities for digital improvements within the outpatient programme including electronic communication with patients, using automated robots for some simple communication, the ability to change appointments electronically, better interfaces with the NHS app and enhancing the offer of virtual consultations. The Electronic Patient Record (EPR) and Electronic Prescribing and Medicines Administration (EPMA) are key enablers in these improvement solutions. These are due to be implemented before 2028.
- There are opportunities to expand on the current Further Faster work which has produced a recovery plan to increase out-patient productivity. This plan identifies ENT, Cardiology, Ophthalmology, Trauma and Orthopaedics as the specialties with largest opportunities.
- It is accepted that the main opportunity is increasing the number of 1st outpatients and increasing the efficiency of clinics. This will support the elective recovery fund ambitions as well as the waiting list recovery. All of the above schemes will contribute to this, but there needs to be a focus on dating as many new referrals as possible. During 23/24 ULHT were flagged by NHSE as one of the highest providers in the region for undated first outpatients (63.3 % of the 65-week cohort as at 03/12/23). During 24/25 there will be an objective to reduce this as far as possible.

Ensure the out-patient improvement programme continues to align and expand on the NHSE Improving Elective Care Coordination for Patients (IECCP) Programme including the following:

Virtual Consultations

- Objective: To maintain virtual consultations at a minimum of 25% for all specialties (where clinically appropriate) in line with national requirements. To scope the opportunities for different options including clinicians being at one site and patients and outpatient nurses being at another site. This includes using GP practices and Community Diagnostic Centres. This would be better for patient as it would support access and reduce travel; and be better for the environment as it would reduce the number of patient journeys.

PIFU

- Objective: Average of all specialties to achieve 5% of all outpatient activity with stretch targets for those specialties that achieve this. This will support the ambition to reduce follow-ups in line with national requirements. It will also increase personalisation of care for patients including Personalised Stratified Follow-Ups for cancer patients.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

Specialist Advice

- Objective: Increase the pre referral specialist advice usage in line with National requirements which will enable patients to be given advice without the need of a referral to secondary care.
- Increase Provider level usage of specialist advice to at least 16% of new outpatient appointments and roll this out to all specialties enabling patients to be managed without the need for a referral which will help to reduce to waiting times. Where specialties are already achieving this, stretch targets will be discussed to ensure continuous improvement.
    - Whilst the majority of specialties offer A&G in ULHT, improvement is needed on the turnaround times to encourage increased uptake in primary care.
    - The remaining outpatient specialties at ULHT will fully engage with embedding and delivering advice and guidance.
    - NWAFT and NLAG specialist advice services are part of their system outpatient improvement plans. There is regular engagement between Lincolnshire and neighbouring systems to ensure any best practice and challenges are shared.
- Review of the specialist advice dashboard shows that the system has achieved over 30% specialist advice requests, with some months as high as 36%. The future assumptions are that current performance maintains for the post-referral specialist advice services.

Follow Up Reduction

- The system plans to reduce outpatient follow-ups in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024, thus increasing capacity and ensuring more outpatient first appointments are delivered. Reductions in future years will be considered in line with the national planning guidance and system requirements.

Increasing Clinic Utilisation

- To increase and maintain clinic utilisation to 95% via a variety of programmes including implementing the 6-4-2 Process, directly bookable appointments, and reducing missed appointments.

In/Out of scope

- Specialist Advice/ Virtual Consultations and Follow Up reductions – All Specialties in scope.
- PIFU – Majority of Specialties (Some Specialties are not suitable for PIFU, working with National team and Acute providers to identify those that are out of scope)
- Out of area providers will be monitored separately and performance managed through their own system governance.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

2. What's being done to get there | Overview

All acute providers are part of their system outpatient transformation programme. In Lincolnshire the ICB and ULHT work closely together to develop and implement improvement actions. ULHT have established an Outpatient Improvement Programme with resource of a Programme Delivery Manager and Project Managers who lead on the outpatient transformation schemes, including, Advice and Guidance, Virtual Consultations, Patient Initiated Follow Ups (PIFU) and outpatient follow up reduction. The project managers work closely with operational colleagues from the divisions to develop bespoke action plans for each specialty and monitor the implementation. The Outpatient Recovery Improvement Group is embedded within ULHT governance and has robust objectives and responsibility for delivering the necessary improvements. The Outpatient Programme of work also reports into the Planned Care and Diagnostic Programme Group at a system level.

The system are implementing the initiatives and opportunities both identified and outlined in the NHSEI Personalised Outpatient Programme using the evidence-based principles, specialty guidance and framework of Getting It Right First Time (GIRFT).

The system has monthly meetings with NHSE on the outpatient programme to provide assurance and understand if there is anything additional the system could be introducing. Both ULHT and ICB representatives are in regular contact with NHSE Subject Matter Experts and engage in best practice reviews and lessons learned.

Digital solutions to improve patient experience and improve the efficiency of outpatient services are already being scoped. Automated robots are due to be implemented for simple queries and to help patients navigate the outpatient booking processes, and the current outpatient patient portal is due to be linked to the NHS app in the next year.
Additional actions will be considered as part of the annual planning round once the 24/25 planning guidance has been released.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

Virtual Consultations

- The system are meeting the National requirement of 25% and the ambition is to maintain this performance.
- The data is regularly monitored to ensure the system maintain this usage.
- Further work to be done internally by providers to monitor on a specialty level to ensure those specialties who are not meeting the target increase their virtual consultation usage, where clinically appropriate.

Patient Initiated Follow Ups (PIFU)

- Re-visit specialties where PIFU is live to maximise utilisation.
- Explore opportunities with Divisions to rollout PIFU to the smaller specialties across the Trust and develop a programme and commence rollout where appropriate.
- Explore opportunities with Divisions for discharging/outcoming a patient to PIFU post ward stay/surgery and post-op and implement where appropriate.
- Explore opportunities to utilise available system funding for Remote Patient Monitoring
- Continue to engage with NHSEI Outpatient Transformation forums to share and disseminate best practice.
- Promote the utilisation and benefits of PIFU through communication and engagement.
- Conduct patient satisfaction surveys.
- PDSA the systems and processes that support the PIFU function.
- Continue to monitor and report on the PIFU utilisation against plan.

Specialist Advice

- Specialist Advice – Continue to perform better than the national target of 16% of new outpatient attendances; and work towards increasing the provider level usage. Where specialties are meeting the 16%, stretch targets will be agreed.
- Reviewing response times by specialty for A&G through e-RS for all providers. Actions to be agreed with each specialty where this is outside of the 48-hour response period.
- Develop a feedback process on the quality of advice and guidance responses. This will be done linking in with the Clinical and Care Directorate in the ICB.
- Review the conversion rates of A&G to referral and work with primary and secondary care to review pathways and agree necessary actions. This will be done across all providers where there are significant levels of Lincolnshire patient activity.
- Develop a communications plan to encourage take up within Primary care and to liaise with the Primary Care team on the PCN Impact and Investment Fund indicators.
- Benchmark performance across providers and specialties and learn from best practice. The system improvement plan is to now engage with those specialties that are not hitting the 16% target and plan to drive the use and response rates up.
- Development of an A&G tracking tool by ULHT to help with monitoring and pulling together a plan to continue those conversations with the specialities who are not hitting the 16%.

Increasing Clinic Utilisation

- 6-4-2 Process: Implement the 6-4-2 process for booking patient slots.
- Directly bookable: Expand directly bookable functionality to all major specialties (aligned to the GIRFT framework) allowing for appointments to be directly booked following patient choice discussions undertaken in the EACH. This will reduce DNAs and increase administration capacity within the Choice and Access team.
- Reducing Missed Appointments (Did Not Attend (DNA) and Was Not Brought (WNA): Expand on current programme to reduce Missed Appointments to <6% by implementing directly bookable slots as above, ensuring choice discussions are had with patients, utilising full digital functionalities to advise patients of appointment including text services and digital letters.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Outpatients	Virtual Consultations					Scoping once new planning guidance received																
Outpatients	PIFU					Scoping once new planning guidance received																
Outpatients	Specialist Advice					Scoping once new planning guidance received																
Outpatients	Follow Up Reduction					Scoping once new planning guidance received																
Outpatients	Increasing Clinic Utilisation					Scoping once new planning guidance received																

Targets for the above projects are set nationally. Current baseline position is being assessed and trajectories developed via planning discussions currently underway with partners. National planning guidance for 24/25 onwards is still awaited before finalising.

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Improved patient experience – reduction in complaints from patients and General Practice queries
- Reduction in waiting times – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Improved RTT performance – to support the national ambition to eliminate waits of 65 weeks of more by 31st March 2024
- Reduction in DNAs - this has been part of the national 'Action on Outpatients' programme and is embedded as a key enabler in ULHT's Integration and Improvement Plan
- Reduction in agency / bank and locum spend.
- Impact on system partners is being worked through as part of the current planning round

5. What's needed to make this happen

- Digital support from the System and ULHT to ensure innovative solutions are implemented to support booking processes. This includes support to suggest what could be done differently as well as the capacity and capability to move at pace when solutions have been identified.
- Engagement from clinicians and operational teams with the improvement programmes across the system (both primary and secondary care)

6. What could make or break progress

Interdependencies with other programmes/organisations

- Outpatient Improvement Programme – ULHT
- GIRFT
- NHSEI POP
- Digital programme

Challenges, Issues & Risks

- Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.
- Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.
- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.
- The PIFU target is measured against all outpatient New and Follow-up activity. There is a risk the target will not be met as some specialties are not suitable for PIFU but their New and F/up activity will still be included in the figures.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

Planned Care & Diagnostics

Programme: Outpatients	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

7. Planning assumptions

- Current assumptions are that referrals remain static and the system is working on using the available capacity to its maximum efficiency
- That all national targets will be met and remedial action will be implemented should performance be adverse to trajectories
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally. Current baseline position is being assessed and trajectories developed. This is via planning discussions currently underway with partners. National planning guidance is still awaited before finalising

8. Stakeholders

- Suganthi Joachim – Divisional Clinical Director, ULHT
- Sameedha Rich-Mahadkar - Director of Improvement & Integration, ULHT
- Sarah Brinkworth – System Planned Care & Diagnostic Programme Director, ICB
- Claire Probert - Deputy Director of Integration Directorate, ULHT
- Joanne Quigley – Programme Manager, ULHT
- Jade Nottingham – System Planned Care Project Manager, ICB
- Project Managers ULHT
- ICB Primary Care Leads
- Clinical and Operational resource needed for each specialty
- Digital leads

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

The vision for the high volume low complexity (HVLC) programme is to support the elective recovery and deliver the national ambitions around planned increase in day case procedures and theatre utilisation. This will be done through developing a system approach which utilises primary care and community services to support delivery in an integrated and seamless way.

The objective is to deliver the elective recovery by improving theatre utilisation and productivity in line with Getting It Right First Time (GIRFT) principles, reducing the backlog of patients waiting for operations and improving patient outcomes. The national HVLC programme focusses on six specialities (orthopaedics, ophthalmology, ENT, gynaecology, urology, general surgery) with the potential for additional specialities being added by the national team in future years.

The aim of the programme is to:

- Increase day case rates to 85% e.g. HVLC cataract should be 8 patients per training list or 10 patients per non training list
- Apply the British Association of Day Surgery recommendations – minimum of 85% of patients being treated as day case
- Improve Theatre productivity.
  - Improve average late start – aim to ensure all theatres start on time
  - Improve average early finish – aim to ensure that theatre capacity is fully utilised
  - Improved capped theatre utilisation.
  - Improve pre-op assessment for all specialities.

In/Out of scope:
Only the nationally identified specialities are within scope. The GIRFT recommendations will be used to drive change

2. What's being done to get there | Overview

- Driven by GIRFT ULHT have undertaken a review of the specialities to inform the future direction of travel and prioritise the programme of work.
- The system have taken part in gateway reviews for each of the six specialties under the HVLC programme as well as full system review meetings with the national GIRFT lead.
- The Trust have established a theatre productivity work programme to increase day case rates and theatre utilisation. There are formal governance arrangements behind this to discuss, challenge and escalate any issues.
- Grantham has been approved as a National Surgical Hub: As a surgical hub this needs to be developed to include a range of specialties, as well as improve sessional utilisation and expand to 7 day working. The system needs to ensure productivity and efficiency is increased over the next 5 years and to look at mutual aid opportunities and providing capacity to other systems.
- ULHT are scoping the potential for Louth to be the system ophthalmology Hub for HVLC.

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

- ULHT have established a theatre productivity programme with resource of a Programme Delivery Manager and Project Managers who lead on the theatre productivity schemes including, increasing day case rates, increasing theatre utilisation and improving pre-operative assessment. The project managers work closely with operational colleagues from the divisions to develop bespoke action plans for each area and monitor the implementation. The theatre productivity work programme is embedded within ULHT governance and has robust objectives and responsibility for delivering the necessary improvements.
- The system have engaged in gateway review meetings for all six HVLC specialties. These are chaired by the national GIRFT lead for that specialty and involve a presentation delivered by the relevant clinical teams. Action plans are then developed and monitored through quarterly review meetings with the national GIRFT lead. These action plans continue to be updated and new improvement actions identified.
- The Grantham surgical hub was given formal approval during 2023 and the delivery plan for future years includes expanding this to 7 day working and increasing the number of sessions per day. This is supported by the Productive Theatres programme at ULHT which is increasing theatre utilisation and day case rates. The intention over the next 4 years is to increase the range of specialties and procedures that take place in the hub and to support neighbouring systems with their elective recovery. Weekend working and 2.5 session days will become business as usual allowing maximum efficiency of the hub. There is a plan to increase day case surgery rates to ensure compliant with British Association of Day Case Surgery (BADS).
- ULHT are scoping the potential to use Louth Hospital as an ophthalmology hub. This worked well during the initial covid recovery and managed to support the backlog of review patients. More detailed work is needed to understand the benefits and challenges of developing this.

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q 4
HVLC & D/C						Scoping once new planning guidance received																

Targets for this programme are set nationally. Current baseline position is being assessed and trajectories developed This is via planning discussions currently underway with partners. National planning guidance for 24/25 is still awaited before finalising.

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Improvement in appointment times: patients will have a reduced wait for an outpatient appointment.
- Improvement in waiting times for surgery: patients will have a reduced wait for a surgical procedure.
- Improvement in quality outcomes – as system matures, so will the clinical experience and clinical outcomes improve.
- Increased productivity in day case procedures – completing more activity than before in the same time.
- Reduce the number of bed nights by utilising day case.
- Manage day case more effectively through Productive Theatres negating the risk of an overnight stay e.g.. schedule more complex day case first thing in the morning rather than last thing at night
- Reduce LOS following elective surgery by implementing discharge plans on admission e.g., for hip replacement – have physio and OT in place to mobilise patient on return from surgery, ensure appropriate adjustments had been made at home.
- If GIRFT principles are followed - it will ensure a positive impact on system partners in terms of increased activity, engaged workforce, reduce financial pressures improved patient satisfaction.
- Impact on system partners is being worked through as part of the current planning round

5. What's needed to make this happen

Input from providers

- Patients:
- Primary/Community Care:
- Optical Practices:
- Acute Service:
- 3rd Sector:

Requirements from

IT Connectivity

- Integrated technology
- Where possible multi-disciplinary team working (both in person and virtually)

Other support requirements: the ICS already engages well with many community assets – this needs to be business as usual across Lincolnshire

- 3rd sector
- Voluntary sector
- Community assets
- Volunteer sector

Planned Care & Diagnostics

Programme: High Volume Low Complexity & Day Case Rates	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

6. What could make or break progress

- Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.
- Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.
- Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity.
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

7. Planning assumptions

- Current assumptions are that referrals remain static and the system is working on using the available capacity to its maximum efficiency
- That all national targets will be met and remedial action will be implemented should performance be adverse to trajectories
- All planned care programmes are interdependent and contribute to the delivery of waiting list reduction. Targets for this are set nationally. Current baseline position is being assessed, and trajectories developed, via planning discussions currently underway with partners. National planning guidance is still awaited before finalising.

8. Stakeholders

- Patients
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Integrated Care Board
  - Planned Care
  - Primary Care
  - Cancer and E.O.L
  - Diagnostics
- Integrated Care System – Better Lives Lincolnshire

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

1. Future state

- Continued development on the expansion of CDC services at Grantham and the implementation of two new CDC facilities at Lincoln and Skegness to expand capacity for the main key diagnostic tests including MRI, CT, ECHO, NOUS, DEXA, and plain film, in addition to other services such as AAA, DESP and the delivery of some forms of chemotherapy in the east of the county.
- CDC capacity may be flexed to respond to regional demand if required. This additional capacity will support the natural increase in existing demand across the county, support the identification of unmet and hidden demand, reduce total waiting lists, improve 6ww and 13 ww compliance to meet the 85% and 95% targets in March 2024 and March 2025, and address the need to increase capacity in areas of inequality and deprivation.
- Scoping, feasibility, development and implementation of a fourth CDC facility in the Boston area of the county to respond to local demand and address the local needs in an area of deprivation and inequality.
- Delivery of a new endoscopy unit and PET CT unit in Lincoln will provide the required levelling up to 3.5 endoscopy rooms per 100,000 population over 50 years of age and support cancer targets with the provision of additional capacity
- Development of new patient booking system to enable patients to book appointments electronically once their referral has been vetted and approved by clinical teams. In addition to freeing up workforce time, the system will also provide flexibility for patients to arrange appointments which are convenient to them and provide them with a text reminder service to facilitate a reduction in DNAs. This will improve productivity and efficiencies across the system and. support a more effective system to maximise available capacity.
- Capitalise on new digital and technological opportunities with the utilisation of electronic systems to maximise existing capacity and increase clinical performance and efficiency with the implementation of remote scanning software such as RadCockpit to enable remote supervision and the introduction of artificial intelligence software in radiology to reduce times from referral to diagnosis.

2. What's being done to get there | Overview

- A CDC project group and related governance support meetings has been set up to oversee the development and implementation of the CDC facilities across the county, with ULHT being identified as a lead provider.
- Continued review and development of a robust communication and engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This will contribute to the ambition to address health inequalities, as well as being aligned to the Lincolnshire Joint Forward Plan ambition to improve access and support the public in understanding how best to access services.
- Continued review and interrogation of demand & activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites. This will be refined and continue throughout the during of the CDC project.
- Continued consultation and collaboration with existing and new system partners, including those from the independent sector, to ensure services are delivered effectively, efficiently and as productively as possible.
- Work with the System main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.
- Implementation of a 6-month trial of the SwiftQ booking process 6-month trial which is being funded by EMRAD and implemented by ULHT during 2023/24. Following the initial trial, we will support ULHT and EMRAD to progress an electronic booking process across the Trust as required.
- Implementation of the Rad Cockpit software which has been funded and approved as part of the CDC programme and progress the bids for AI funding to trial AI software in radiology.
- Continued engagement with both regional and national project leads for the CDC programme to maximise any additional opportunities for Lincolnshire patients. This will enable us to have advance notice and allow us time to be responsive and flexible in our design and implementation approach.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

3. What's being done to get there | Detail

- Appropriate governance structures have been put in place to ensure the CDC project addresses its aims and objectives to increase diagnostic capacity and provision across the county, support Covid recovery, improve accessibility for rural and deprived communities, contribute to the reduction of health inequalities, and maximise productivity and increase efficiencies across diagnostic service provision. This project has been ongoing since 2021 and is currently expected to continue until 2025 which is when the national project is planned until, however it is extremely likely that funding will continue beyond this point. A system project team has been identified to implement the agreed delivery plan, with collaboration from a wide range of stakeholders including NHS, local authority and independent sector provider colleagues, together with input from patients and members of the public through surveys, engagement events and a patient co-production group. Following the successful implementation of the CDC project, we will oversee the effective integration of CDC services into business as usual from 2025 onwards.

- Continued review and development of a robust communication and engagement strategy to ensure that the views, opinions and insights from stakeholders are at the core of the decision-making process to improve diagnostic provision and ensure that the needs of the community and the system are met. This includes the creation and ongoing development of a patient co-production group to support the plans for CDC provision across the county, together with a proactive engagement campaign to raise the profile of CDCs and seek further feedback, ideas and suggestions to improve services across the county. This will continue for the length of the project until 2025, following which a review will be undertaken to agree any further actions which may be required.

- Continued review and interrogation of demand and activity data to ensure that diagnostic capacity is being fully utilised and flexed as appropriate to ensure the maximisation of productivity and efficiency levels in existing CDC facilities, and to support optimal locations are identified for future CDC sites. This will be refined and continue throughout the during of the CDC project, as we gain more intelligence on the nature and demand of unmet need, hidden demand and clinical improvements in diagnostic advancements. Following the implementation of CDCs, the requirements for ongoing demand and capacity modelling will be embedded into day-to-day management processes and annual planning.

- Initial consultation and collaboration with existing and new system partners, including those from the independent sector, to support clinical pathways, enhance partnership working, increase diagnostic capacity and ensure good levels of productivity and efficiencies. This work has already commenced and will continue throughout the life of the CDC project. It is expected that continued collaboration with multiple partners will become the norm as we embrace provider collaboratives as a key component to system working, to support the planning, delivery and transformation of clinical services to meet the need of our community now and in future years.

- Work with the System main provider to ensure that development of the new endoscopy and PET CT facilities are delivered as planned.

- Review of the SwiftQ booking process 6-month trial which is being funded by EMRAD and implemented by ULHT during 23/24. Following the initial trial, which is being led by our main provider, continue to provide support to ULHT and EMRAD to progress the effective implementation of an electronic booking process across the Trust.

- Implementation of the Rad Cockpit software system to support remote supervision across CDC facilities, and trialling of AI software to enhance current radiology effectiveness and reduce times from referral to diagnosis.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CDC Programme	Grantham CDC																					
CDC Programme	Skegness CDC																					
CDC Programme	Lincoln CDC																					
CDC Programme	Boston CDC																					
Endoscopy	PET CT																					
Electronic Booking Process																						

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

4. Projected impact on patients and system partners

- Grantham CDC and development of additional facilities in Lincoln, Skegness and potentially Boston.
- Increasing diagnostic capacity to reduce waiting times, address unmet need and improve performance metrics. This will be for planned and unplanned care, as well as cancer pathways. By moving outpatient diagnostics off the main acute sites, capacity will be created to improve UEC pathways and for more complex patients include cancer and cardiac tests.
- Meet the aim to provide diagnostic tests to 85% of patients within 6 weeks by March 2024 and to 95% of patients by March 2025. Progress will be monitored and evaluated on monthly basis through analysis of patient waiting times data.
- Improve productivity and efficiency through the transformation of clinical pathways, with the provision of co-ordinated diagnostic testing and inclusion of new technology.
- Planned CDC activity for 2023/24 is likely to be in excess of 32,000 tests across 6 of the main modalities, with significant increases planned for 2024/25 and 2025/26 as the two new CDC facilities become fully operational, where it is anticipated that activity will be in excess of 150,000 tests in total for all three sites. To date the CDC programme has delivered more than 63,000 additional diagnostic tests at the Grantham site. CDC activity data is monitored weekly and reported through to internal system governance structures and national report databases.
- Increase in digital interoperability and connectivity across the system to provide greater information sharing between system partners and enable improved management of complex cases, in addition to providing patients with more choice when booking their appointments through an electronic system and at CDC sites which are closer to home and easy to access. Patient utilisation of CDC facilities and DNAs will be monitored to measure effectiveness and provide intelligence for future planning.

5. What's needed to make this happen

- System collaboration and local engagement with NHS and SP stakeholders to progress the CDC programme.
- Continued support from regional colleagues in the development of CDCs, sharing and learning from experiences.
- Continued revenue and capital funding from national CDC initiatives to support the CDC programme and other digital innovation.
- Collaboration with Regional workforce teams to support international recruitment and other workforce initiatives.
- Ongoing review and implementation of advancements in technology to improve efficiencies and maximise capacity of diagnostics.

Planned Care & Diagnostics

Programme: Diagnostics	SROs: Julie Frake-Harris & Clair Raybould	Programme lead: Sarah Brinkworth	Operational Lead: Damian Carter

6. What could make or break progress

- Non-elective pressures/capacity: Access to theatre capacity may be reduced due to competing Emergency and Elective pressures and insufficient provision of post op beds will have a negative impact on carrying out elective procedures thereby limiting the reductions in waiting list times. There will be a requirement for the system to support discharging patients who are medically fit at the earliest opportunity to maximise bed capacity and for the development of aligned clinical pathways to maximise efficiency and productivity of diagnostics at CDC site.
- Workforce: Significant workforce issues may arise due to high levels of sickness & absence; difficulties in recruitment and retention in key geographical areas and inability to recruit workforce with the required skills to staff new and existing clinical facilities. A reduction in existing workforce may also occur with staff moving into specialist roles and difficulties with/or the inability to recruit to more junior roles. There may also be a reluctance to undertake additional sessions due to exhaustion and a heavy reliance on locums or agency workers. Transformation planning requires the same clinical and operational staff as business as usual and industrial action may impact on availability of workforce, particularly in respect of the junior doctors and consultants. Failure to support the University of Lincoln Radiology courses as part of the CDC programme, may delay the future availability of qualified students and the ambition to encourage a locally developed workforce.
- Patient complexity: Disease progression of those patients waiting for treatment will result in longer operating time requirements, more clinical complications and longer recovery times. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.
- Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics & elective activity
- Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service may impact of elective recovery as diagnostic diagnosis is speeded up and diagnostic waiting lists are reduced.
- There is an established system-wide governance programme for planned care and diagnostics. All risk and mitigations are escalated via the Planned Care and Diagnostic Programme Group

7. Planning assumptions

Demand drivers:

- Demand for additional diagnostic capacity occurs as a result of population increases and the need to address significant inequalities which are present in a number of existing areas with high levels of deprivation and geographical challenges. It is anticipated that these areas hide significant unmet demand as patients live in areas of multiple deprivation and are unable to access existing services, which may require significant travel, due to a number of reasons including financial or socio-economic hardship.
- There is also a national focus for all systems to address large waiting lists with national targets being set to reach 85% and 95% of 6ww's by March 2024 & March 2025 respectively.

Productivity, capacity & resource enablers and constraints:

- Workforce: Availability of suitably trained and skilled diagnostic workforce is likely to limit the recruitment of NHS workforce to undertake all CDC roles, and there will therefore be a need to work collaboratively with the independent sector in order to fulfil the ambition to deliver all CDC tests as planned.
- Recruitment & retention within Lincolnshire is often challenging. As a result there will be collaboration with system, regional and national partners to increase the availability of skilled workforce through international recruitment initiatives, upskilling and retraining of existing workforce and developing links with the University of Lincoln School of Radiography to train and retain students within the local area.
- Digital: Exploration and development of digital solutions to maximise productivity and efficiency of NHS services. This includes electronic booking systems, utilisation of artificial intelligence systems and the use of remote supervision technology such as Radcockpit.

8. Stakeholders

- NHS Lincolnshire ICB
- United Lincolnshire Hospitals NHS Trust
- Regional and National NHSE Colleagues
- Regional System colleagues and Independent Sector Providers
- Wider Lincolnshire System NHS partners, including LCHS, PCNs, GPs
- Local Authority, including Public Health, Town, District and County Council colleagues
- Lincoln University colleagues
- CDC Co-production group; Patients and public stakeholders

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

1. Future state

Operational 1&2 years Cancer Care Vision

- All schemes identified will support the delivery of the Cancer Waiting times recovery. The next 2 years will see the programme for cancer recover to a pre-pandemic position. The focus will be on achieving the 28-day standard to 75%, reducing the backlog of patients waiting over 62 days, achieving the 31-day treatment standard and achieving the 62-day standard.
- The Lincolnshire Living with Cancer Strategy 2023 – 2025 is our 4th Strategy and sets out our approach and plans for the next 2 years with a forward view to 2028. It builds on the work carried out over the last seven years which was set out in the previous Living with Cancer Strategies. The approach put is 'we are creating a better and sustainable future for supporting people LWC, involving and integrating all relevant parts of the health and social care system, using the assets we already have, supporting people in the place they would like and in the way they would like, and placing people at the centre of everything we do.'
  - Return the number of people waiting for longer than 62 days to 217 by March 2024
  - Achieve 28-day Faster Diagnosis standard 75% by March 2024
  - Achieve Combined standard for 62-day performance 70% by 2024
  - Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways
  - Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations.
  - Implement new CUP pathway.
  - Finalise Galleri Trial 2024
  - Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.

Strategic 2-5 years

- Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.
- Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.
- Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.
- Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire
- Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening

National/local requirements

- Performance is driven by NHSE and is mandatory to achieve.
- EMCA set priorities for the year TLHC and BPTP are also mandated.

Evidence base

- NICE Guidance
- Personalisation guidance
- CWT Guidance
- LACE process
- ECAGs
- Speciality specific clinical evidence.

In/out of scope

- Liver Surveillance is out of scope.
- UGI Cytosponge pathway is out of scope.
- Capsule endoscopy is out of scope.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

2. What's being done to get there | Overview

- Currently in the NHSE assurance Tier one meeting weekly with NHSE to discuss performance and sustainability of improvement.
- ULHT and the system are leading Intensive Support meetings with the divisions to monitor 28-day performance backlog reduction and combined classic performance.
- Cancer recovery and delivery meetings overseeing acute improvement work with ULHT.
- All future improvement projects will be taken through the LACE where pipelines available.
- Wrapping SDF finances around delivery programme
- System wide working to develop projects.
- Living with Cancer Strategy
- Integrated Cancer Workforce Development Strategy
- Cancer Digital Strategy

Response to potential improvement opportunities

- All improvement projects follow a QI methodology to determine the warranted variation.
- All improvement projects are implemented a national agenda. e.g. performance

3. What's being done to get there - Detail

- 28-day FDS – 75% by March 2024
  - Actions - twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project manager working with ULHT to deliver improvement plan

- 31 Day - 96% -
  - Actions- twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- 62 Day Performance – 70% March 2024 –
  - Actions -twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- Backlog Reduction – 217 by March 2024-
  - Actions- twice week Intensive Support Meetings, Daily PTLs lead by ICB and Trust, 3 Specialist specific project managers working with ULHT to deliver improvement plan.

- Further deliverables with be set nationally for 2024/2025- As of 20th December
  - Actions - awaiting National Guidance for Cancer 2024/25 plan.

- Implement Personalised Follow Up Pathways (PFUP) with remote monitoring in further 4 pathways by March 2025-
  - Action- Adopt guidance protocols and SOPs and take through ULHT Governance, work with Clinical and Operational team to adopt PFUP and RMS as BAU. Continue Living with Cancer in the community to facilitate supportive self-management and community-based support.

- Ensure interdependence with the Planned care programme to ensure read across of productivity plans

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer	Return the number of people waiting for longer than 62 days to 217 by March 2024																					
Cancer	Improve performance for diagnosis and treatment standards– Achieve 28-day Faster Diagnosis standard 75% by March 2024 Achieve Combined standard for 62-day performance 70% by 2024																					
Cancer	Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways																					
Cancer	Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations																					
Cancer	Implement new CUP pathway																					
Cancer	Finalise Galleri Trial 2024																					
Cancer	Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.																					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cancer	Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.																					
Cancer	Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.																					
Cancer	Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.																					
Cancer	Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire																					
Cancer	Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening																					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

- Backlog reduction -Only impact on activity levels form the backlog reduction because as patients remain on the backlog, they may seek support form Primary care.
- FDS performance will see a reduction of the impact on primary care therefore they are not reliant, and they have been given a diagnosis/ removed from the pathway.
- PFUP 24/25 (26-28)- There may be increased activity for complex patient for LCHS, Primary care and patients may require access to psychological services in LPFT, increased demand in voluntary and community sector organisations.
- Colorectal pathway – will potentially increase uptake of bowel screening and impact on diagnostic services at ULHT in endoscopy/ histology- however a positive impact would be on reduction in emergency presentation via ED.
- CUP pathway - Reduce number of referrals from PC and visits to PC from the patient with revision of pathway.
- Galleri trial- Reduce visits to PC as patients being diagnosed through alternative route- it will however increase referrals to ULHT for diagnosis and treatment.
- Targeted Lung Health Checks- this programme has potential to have significant impact on PC due to the identification of incidental findings form the CT scans. It will increase number of referrals into ULHT for suspected Lung cancer which will have a knock-on impact of diagnostics and pathology, numbers indicate that there will be an increase in treatments at tertiary centre Nottingham which could lead to a backlog of patients awaiting treatments- this could impact on [patients requiring emotional and psychological support. Working up activity number to qualify problem.
- Model of Personalised care – Increased demand on community and voluntary sector services – increased demand for LPFT and LCHS with more complex patients supported out of hospital – reduce demand on ED presentations. Improved patient experience.
- PFUP protocols and Model of Working to support other LTCs specialities aligning with PIFU- 24-28- OPAs saved to reduce backlogs and waiting lists for all LTC pathways, increased demand on voluntary and community sector, reduce demand on PC. Improved patient experience.
- Actuarial modelling: System support from finance and Arden Gem/PHM to model pathway through form screening to treatments and understand impact across pathway.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Return the number of people waiting for longer than 62 days to 217 by March 2024	– Staffing; project, transformational and operational to continue BAUS whilst also implementing improvement – Clinical buy in and change in working practices – Funding; additional capacity	Reduce number of patients waiting over 62 days to 217.	Return performance back to pre-covid levels (and beyond)	Continue to reduce backlogs as far as possible.				
Improve performance for diagnosis and treatment standards	– Staffing; project, transformational and operational to continue BAU whilst also implementing improvement – Clinical buy in and change in working practices – Funding; additional capacity	– Ensure 28FDS performance reaches 75% by the end of March 2024	Return focus back to 62 day performance and meeting 62 day targets as laid out in new constitutional standards. - 62-day referral to treatment standard: combined performance of 70% by March 2025 - 28-day Faster Diagnosis Standard 77% by March 2025	Continue to improve performance and roll out early diagnosis interventions.				

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Implement Personalised Follow up Pathways (PFUP) with remote monitoring in further 4 pathways	- EMCA identify priority pathways. - ECAGs agree regional protocols - Clinical buy in - Staffing. - IT – procure next RMS Modules	PFUP and RM operationalised in 4 additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits.	PFUP and RM operationalised in 4 additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits.					
Scope, review and implement a health inequalities programme of work focussing on the Colorectal pathway to include improving staging outcomes, improve screening uptake and reduce emergency presentations	– Clinical buy in – Access to data held by screening programme – HIE to transform and implement changes.	Scoping, Data drill down, consultations, engagement with Coproduction groups,	Implement and measure Impact of coproduction groups	Delivery and evaluation				
Implement new CUP pathway	– Clinical buy in from Primary Care & Secondary Care. – Change in working practices & implementation of new pathway.	New streamlined pathway for CUP patients to ensure they are not delayed in getting a diagnosis.						

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Finalise Galleri Trial 2024	– Clinical buy in – Support from Cancer Team and pre diagnosis team	Lincolnshire patients will undergo final blood test to look for cancer markers aiding earlier diagnosis. Results will be reviewed and a decision made about long term.						
Targeted Lung Health Checks national priority- this will contribute to the ambition of the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer.	– Clinical buy in – Funding from EMCA – Procurement and contracting team support		Roll out of targeted lung health check programme leading to earlier diagnosis of lung cancer patients.					

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Implement and operationalise including remote monitoring PFUP in additional tumour pathways by 2028.	- EMCA identify priority pathways. - ECAGs agree regional protocols - Clinical buy in - Staffing. - IT – procure next RMS Modules		PFUP and RM operationalised in additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.	PFUP and RM operationalised additional pathways. OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.				
Implement NHS model of personalised care and personalised care elements for all people diagnosed with cancer in Lincolnshire by 2028.	- System buy in ICB, acute, PC, VCS. - Staffing. - Packages of funding for e.g. training.		Improved patient experience.	Improved patient experience.				
Scope, develop and commence transition of PFUP protocols and models of working to support other LTC specialities aligning with PIFU.	- Clinical buy in. - Staffing – recurrent funding for roles. - IT – RM systems.		OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.	OPAs saved reused at front end of pathways to reduce backlog and waits. Improved patient experience.				

Cancer

Programme: Cancer	SRO:	Programme lead: Sarah Brinkworth	Clinical/Technical Lead:

4. Projected impact on patients and system partners

Initiative	Inputs	Outputs and Outcomes			ICS aims			
		23/24	24-26	26-28	1	2	3	4
Scope and commence transition of personalised care models of working to support people living with other LTCs in Lincolnshire	- System buy in ICB, PC, VCS.		Improved patient experience	Improved patient experience.				
Scope the Economic Patient modelling (actuarial modelling) – proactive preventative care for colorectal screening	EOI with CRUK to support the work to be lead across system		Scope, Plan and Consultation, Implementation , Delivery and Impact	Evaluation				

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

5. What's needed to make this happen

Backlog/ FDS/ 31 day and 62 combined standards
- Maintain existing activity and staffing levels.
- Ensure GPs are referring appropriately.
- Recurrent investment required for colorectal CNS and navigator teams.
- Right sizing review of services as improvements are made.
- Histopathology – further review of roles in workforce to support national turnaround ambitions.
- SDF funding reviews to ensure monies being spent and impact – futures BCs identified and supported by the system

Patient initiated follow-up 2024-28
- ULHT to adopt guidance protocols and SOPs to make this BAU.
- Primary care to adopt / deliver quality improvement in Cancer Care reviews.
- Review number of Care co-ordinators in ULH/ PC/ Community
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programme e.g., volunteering.

Colorectal screening
- Support from the health inequalities teams
- Potential use of voluntary support to engage populations.
- The project is not at a stage where we understand the constraints to identify what finance streams are required.

CUP (carcinoma of unknown primary) pathway
- There is a concern but the projects is not at a stage to understand- but there may be an impact on demand – and therefore we may to increase workforce to deliver

Galleri trial
- Expected referral demand approx. 20 referrals across all specialities therefore the demand is spread and no impact on workforce or finance.

Targeted Lung Health Check
- 2023-28: over this period, we will anticipate to diagnose circa. 700 cancers
- Initial investment to screen these patients will come from national funding, however future funding will be from centralised commission as this will become part of the routine screening programme.
- Programme is currently scoping options to provide pilot study for Lincs and future provision for screening programme.

Model of Personalised care
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programmes e.g., volunteering.

PFUP protocols and Model of Working to support other LTCs specialities aligning with PIFU- 24-28
- Increase resilience and capacity and community sector.
- Adoption of personalised approaches across the system
- Collaboration with Health Inequalities team/ Personalisation team and PHM
- External funding required for specific work programme e.g., volunteering.

Actuarial modelling
- Funding required to support modelling from PHM.
- PHM to ensure access to datasets.

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Risks / Challenges	Mitigation
Non-elective pressures/capacity: Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit.	Working closely with ED teams – ensuring decision making is considered and impact is understood
Workforce: Significant workforce issues including sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual; industrial action impact particularly the junior doctors and consultants.	System adoption of Integrated Cancer Workforce Development Strategy 2023 – 2025 and development of subsequent strategies. Focus on recruitment and retention of staff and training and support of existing staff. System adoption of Aspirant Cancer Career and Education Development programme.
Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists.	Clinical review meetings prioritising patients based on clinical need are undertaken regularly. The backlog is continuing to decrease beyond expectations of NHSE therefore the number of patients having lengthy waits is also reducing.
Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity	Regular communication between planned care and cancer teams will allow for a better understanding of demand for diagnostic services. It will also allow us to work collaboratively to identify bottlenecks and adjust capacity where possible based on demand fluctuations. Clear clinical criteria are also available to ensure patients are prioritised based on clinical need. By working collaboratively, we can also develop improvement initiatives to potentially enhance efficiency & quality of diagnostic services.
Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service.	Work is ongoing to improve pre-operative assessment services within ULHT. Agreement has been reached that cancer patients will always take priority for pre op assessment capacity.
Financial Recovery including 30% reduction in ICB running costs	Cancer is funded by external source – however unsure when this funding will come to an end, recurrent funding for posts following Alliance funding needs to follow governance process to ensure recurrent funding
Geography – difficult to source mutual aid due to travel distances	Living with Cancer Programme takes whole system, place-based, asset-based and person-centred approach. Emphasis on supporting patients closer to home in own communities and meeting patient needs including transport issues. Implementation personalised follow up pathways and remote monitoring for clinically suitable patients.
IT systems – Difficult to track total patient journey through ULHT as use different systems at each stage	Implementation of Care Portal across the Lincolnshire system.
Data quality issue	Commissioned Insource a company who will provide validation of PTL

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

7. Planning assumptions

Productivity, capacity & resource enablers and constraints:

- Workforce: This does not take into consideration any Industrial Action - NHSE have been clear that we should plan based on no industrial action taking place.
- Digital: System Digital Programme implements digital solutions which are adopted system wide; Deployment of Care Portal and Patient portal .
- Finance: Cancer receives an allocation from EMCA each financial year to support programme and recovery 23/24 circa 3 million- awaiting allocation for 24/25, committed 1.5m already that will be covered plus further allocation. Align with planned care ERF as part of planned care activity. ULHT has identified further Colorectal roles for Navigators and XCNS that need recurrent funding currently awaiting to go through CRIG

8. Stakeholders

Stakeholders

- Acute Providers
- GP Practices
- Lincolnshire Clinical & Care Directorate (including Lincolnshire Academy of Clinical Excellence (LACE), Clinical & Care Academy (CCA) and Lincolnshire Learning Network (LLN))
- Health and Well Being Board
- LVET Board
- It's all about People Board
- Health Inequalities Board

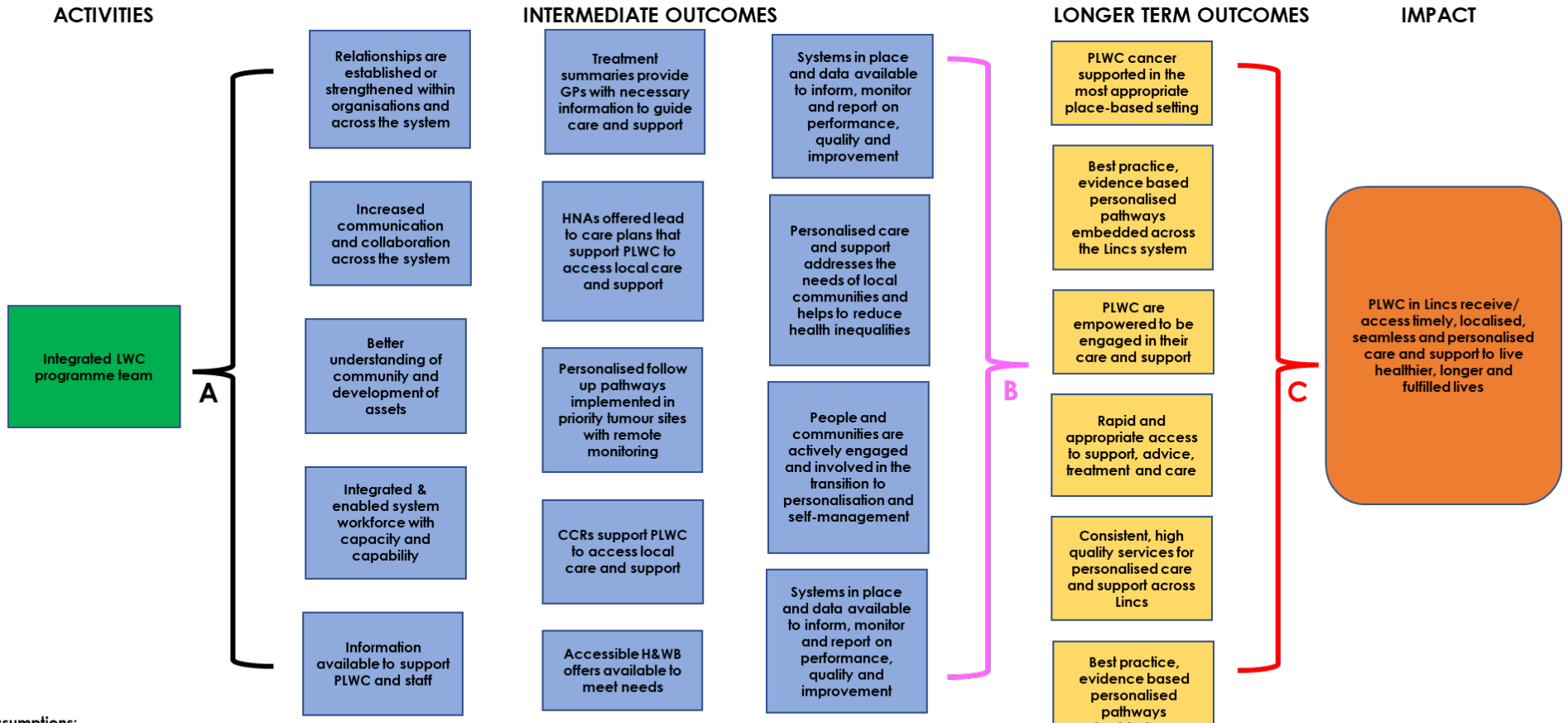
Project team

- ULHT COO & SRO for Cancer
- ULHT Deputy COO, Cancer
- ULHT Clinical Lead for Cancer
- ICB Cancer Programme Director
- ICB Deputy Cancer Programme Manager
- Macmillan Living with Cancer Programme Manager
- ICB Chief Medical Officer
- ULHT Cancer Lead

Cancer

Programme: Cancer	SRO: Clair Raybould	Programme lead: Louise Jeanes	Clinical/Technical Lead: Ciro Rinaldi

Theory of Change Model for Living with Cancer Programme



Assumptions:

- Health and care staff across the system will collaborate and work in an integrated way
- There is the capacity for people to come together to work in new and different ways
- Clinicians and their teams engage in changes and improvements
- Senior system stakeholders sign up to and see the benefits of the outcomes and impact to the system as a whole
- System level governance processes provide support and authorisation for transformational change
- Current and future IT systems will support required data requirements and alignment

Pathways of change

A	Programme level activities set the standard for, inform, infiltrate and support the integrated approach projects take
B	Integrated system communications, relationships and understanding leads to joined up and long-term place based personalised care and support outcomes
C	Evidence of longer-term outcomes influences and drives a significant impact on the lives PLWC across Lincolnshire

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

1. Future state

On 30 March 2023 NHS England published its three year delivery plan for maternity and neonatal services.

The plan sets out a series of actions for Trusts, ICBs and NHS England to improve the safety and quality of maternity and neonatal services with a focus on personalised care and equity and equality.

It combines a number of existing maternity and neonatal requirements including the original Better Births (2016) report, the Long-Term Plan (2019), Ockenden (2020 and 2022), East Kent (2022), Saving Babies Lives Care Bundle v2, CSNT requirements, MBRRACE reports, BAPM7, Neonatal Critical Care Review (NCCR) and equity/race related guidance.

The report sets out the 12 priority actions for Trusts and systems for the next three years, across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

The strategic agenda for Neonatal Care

The Neonatal Critical Care Review sets out key findings and an action plan for locally led improvements to neonatal services and works together with system partners, to ensure the best outcomes for babies and their families. Addressing these recommendations in collaboration with the East Midlands Neonatal Operational Delivery Network are the foundation for Neonatal care in Lincolnshire together with LMNS Neonatal workstream.

2. What's being done to get there | Overview

Our focus will be on the report's four key pillars, as below.

- **Listening to women and families with compassion** which promotes safer care.
- **Supporting our workforce** to develop their skills and capacity to provide high-quality care.
- **Developing and sustaining a culture of safety** to benefit everyone.
- **Meeting and improving standards and structures** that underpin our national ambition

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

3. What's being done to get there - Detail

Our focus will be on the report's four key pillars, as below.

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Maternity and Neonatal	3 Year Delivery plan Theme 1: Listening to Women																					
	3 Year Delivery plan Theme 2: Workforce																					
	3 Year Delivery plan Theme 3: Culture and Leadership																					
	3 Year Delivery plan Theme 4: Standards																					
	Neonatal Critical Care Review																					
	Personalisation																					
	Saving babies lives																					
	Continuity of Carer (Full implementation)																					
	PMH / MMH																					
	Equity and Equality – Strategy to be published March 2024																					
	Maternity Tobacco Dependency Service																					
	Digital / Data																					
	Co-Production																					
	3 Places of Birth Choice																					
	Maternal Medicine Network (Uni. Leicester Hosp. Lead on delivery)																					
Please Note:	- **3-year delivery plan with 1-year technical guidance.** - **The Maternity and Neonatal Programme is Nationally prescribed.**																					

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

4. Projected impact on patients and system partners

The maternity and neonatal programme is scheduled by the NHSE 3-year delivery plan, benefits measured through the LMNS assurance framework and challenges escalation to QPEC for executive oversight.

Listening to and working with women and families with compassion

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.

Growing, retaining, and supporting our workforce

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.
  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale

Developing and sustaining a culture of safety, learning, and support

- Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

Standards and structures that underpin safer, more personalised, and more equitable care

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care
  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment, enabling maternity services to have an overview of progress in this area.

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

5. What's needed to make this happen

- Collaborative and transparent compliance to national guidelines with providers
- Enablers:
  - Digital
  - Estates
  - Workforce
  - Business intelligence
  - Population health management,
  - Personalisation
  - Education
  - ODN
  - Co-production,
  - Active Lincolnshire
  - Voluntary sector,
  - Public health
  - Health inequalities
- Resource requirements:
  - Finance investment – NHSE (Core and Transformational) commitment to the maternity and neonatal programme, recurrent and non-recurrent funding.
  - Non-financial: capacity, leadership, data and data-sharing, commitment to the LMNS.

6. What could make or break progress

- Discourse and inability to work collaboratively and transparently between ICB/s and Trust.
- Sustainable funding, to include maternity and neonatal service provision.
- Digital infrastructure.
- Implementation of new MIS.
- Insufficient funding to support smoking in pregnancy at time of delivery and smokefree homes.
- Financial infrastructure to develop three birth choice.
- Financial and workforce commitment to offer continuity of care.
- Data sharing
- Consistency of training compliance in all professional bodies.
- Collaborative and transparency of workforce planning.

Maternity & Neonatal

Programme: Maternity and Neonatal	SRO: Martin Fahy	Programme lead: Sue Jarvis/ Clare Brumby	Clinical/Technical Lead:

7. Planning assumptions

- 3 Year Delivery Plan
- Better Births Vision
- Joint Forward Plan

8. Stakeholders

- Throughout this strategy we have described how we are already working collaboratively to design and deliver integrated maternity and neonatal care. We bring together representatives from a wide range of organisations to develop our work plans whilst working towards establishing shared clinical and operational governance arrangements to enable cross-organisational working and ensure the care we provide is seamlessly the right care in the right place, at the right time.

- System members at Board level and LMNS subgroup level include, provider United Lincolnshire Hospital NHS Trust, 0-19 Services/Health Visiting, Children's Centres and Early Years inclusive of the new Family Hubs project, Steps2Change, Primary Care, Community Health, voluntary sector, Education, MNVP, Healthwatch, Active Lincolnshire, Mental Health Services, East Midlands Neonatal Operational Delivery Network and members of the Integrated Care Board Programme team and varying specialities.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

1. Future state

The Children and Young People (CYP) programme is an integrated programme of work bringing together key partners in Children and Young People's health and well-being.

The Lincolnshire Integrated Care Board (LICB) works collaboratively with Lincolnshire County Council (LCC) including Children's Services, Public Health Directorates, and key providers within the East Midlands region.

The LICB and LCC jointly fund and oversee a Children's Integrated Commissioning Team (CICT) who undertake part of the programme for CYP.

The work of the programme is overseen by the CYP Integrated Transformation Board (ITB) which has a mission statement: 'Everyone working together to maximise the health and wellbeing of all children and young people, ensuring the voice of children and families is heard throughout our work'.

One of LICB's key objectives is 'Improving the health of children and young people' reflecting the LICB's commitment to CYP in Lincolnshire.

All projects within the CYP programme Joint Forward Plan for 2023 – 28 will support 'Improving Access' to the right health support for local CYP. This may be through increasing the capacity of CYP that can be supported in services, making services more accessible for CYP with SEND, or making CYP services more accessible in local communities.

The CYP programme has recently been formalised and most of our priorities are in their infancy and/or scoping phase. Improving access is a thread which runs throughout our priorities, the advantage point being for a newly established programme, is the opportunity to develop/improve existing and/or new services for CYP with improving access at the forefront of all we do.

Headline actions for the CYP programme are:

- Develop our services so that they align with the needs of our CYP population.
- Develop the teams that deliver these services to our CYP with a range of skills and expertise relevant to the service offer.
- We will strive to simplify the processes for accessing health services for CYP.
- We will support CYP to understand the health care they require and how best to access it

Detailed individual Project Delivery Plans providing, considering 'Improving Access' if relevant, underpin this programme plan

The CYP programme incorporates national and regional priorities and there is a key focus on ensuring our local priorities are addressed. This is informed by the intelligence we gather about the local population we serve, the communities they live in, our stakeholder partners and the staff who deliver the services.

The CYP programme also incorporates CYP safeguarding transformation work, which sits under the responsibility of Lincolnshire Safeguarding Children's Partnership. This work is a fundamental part to meeting the needs of our local CYP.

The programme continues to be driven by data and intelligence, including an evolving use of population health management information to ensure work being undertaken understands and addresses health inequalities within our CYP population within Lincolnshire.

The national CYP Core 20 Plus 5 programme outlines the key priorities from a health inequalities perspective. The 5 clinical priorities for CYP are, Asthma, Diabetes, Epilepsy, Oral Health, and Mental Health. The CYP programme directly aligns to these priorities.

New national deliverables are expected relating to the CYP Core 20 Plus 5 programmes, which will support our CYP programme further, for example, improving transition pathways and co-production with CYP and their families in capturing the CYP voice.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

1. Future state

Transition from children's services into adult's services will be an integral part of consideration for all our projects. NICE guideline NG43 defines transition as "the purposeful and planned process of supporting young people to move from children into adults' services". (Please see current updated NICE guidance received Transition from children's to adults' services).

In the NHS Long Term Plan, NHS England have committed to moving to a 0–25-year service model where appropriate to enhance CYP's experience of health, continuity of care and outcomes, and experience of transition between services.

This model encompasses a comprehensive offer for 0-25-year-olds that spans mental health and physical health services for children, young people, and young adults.

A framework is due to be published by NHSE providing principles, models, and resources to help set up a 0-25-year service model and will also come with deliverables that ICBs will be expected to report progress against.

The CYP programme will look to develop some key principles for transition that we will be looking for sign off from the ICB and provider Trusts that will address the issues of continuity and in some cases gaps in service.

Whilst this sits within the CYP programme, it is important to emphasise that the biggest changes will need to happen within adult services and often in the way adult services are commissioned or delivered with differences in criteria causing challenges for patients and families as they transition into adult services.

There are further local improvements to CYP services that are out of scope of this CYP programme. These include a review of: -

- The Children's 0-19 Health Service (LCC)
- CYP Mental Health, Learning Disability and Autism programme (LCC)
- Lincolnshire Maternity Neonatal Service (LICB)
- Urgent Emergency Care (LICB)

All these services/programmes provide updates into the CYP ITB and have their own governance arrangements that oversee delivery of their respective plans.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

2. What's being done to get there | Overview

- We have established strong integrated governance, co-chaired by the LICB and LCC and partnership working across system partners.
- We have a jointly funded CICT that has been in place since 2017 that works alongside the CYP LICB team and the ITB.
- We have a co-chaired CYP Integrated Commissioning Steering Group that jointly plan and oversee commissioning related activity across LICB and LCC including Public Health, CICT and the Children's Strategic Commissioning Service.
- We directly report into Regional and National CYP Integrated Transformation Board.
- We are working with the Lincolnshire Safeguarding Childrens Partnership (LSCP) to understand and respond to the safeguarding needs of our CYP.
- We have set out our next 5-year priorities specific to our CYP population in Lincolnshire.
- We are improving our understanding of health inequalities for our local CYP population. LICB are leading a project to analyse health inequalities for CYP, and this will enable system partners to identify any gaps in support, to better target existing services and develop new services where needed.
- We have identified current issues with services and are responding rapidly to make improvements, for example, focused work on reducing waiting times for CYP Speech and Language Therapy (SALT) and further LCIB investment to reduce waiting times for CAMHS treatment which is demonstrating positive shift in 50+% reduction in CYP waiting over 12 weeks.
- We are working with the Planned Care Team Elective Recovery Programme to improve waiting times for CYP needing elective surgical procedures. This involves partnership working with our acute trusts. One key area of focus is the Outpatients Waiting List project which is being led by the LICB Health Inequalities team. Our LICB CYP team are supporting this work.

Summary of our identified CYP Projects 2023-28:

- Children Strategy Discussions - CS Front Door.
- Diabetes.
- CYP Child Protection Medicals.
- Clinical Intervention in Schools Review.
- Asthma.
- Epilepsy.
- CYP Therapy Review.
- CYP Voice/Data Intelligence.
- Children's Community Nursing (CCN) Review.
- Palliative End of Life Care for Babies, Children & Young People (BCYP).
- Integration of assessment Processes and support for CYP with Special Education Needs and Disabilities (SEND).

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Highlighted below are KEY deliverables & milestones taken from each Project. Approx' dates for completion of Milestones are identified below within each priority and further embedded within the table below which gives a summary of the identified CYP Project phases. Detailed individual Project Delivery Plans underpin this programme plan.

Children Strategy Discussions 'Front Door'

Deliverables:

- Present key findings within a Business Case including any recommended changes; analysis of options; resource and cost requirements to ensure health meets its statutory responsibilities under Working Together (2023).
- Proceed through governance pathways for approval.
- To produce a robust joint Information Sharing Agreement.
- Provide interim measures for health representation at Strat discussions
- Address the outstanding red rated 'issue' on the LSCP risk and issues log regarding sharing of health information at children's front door safeguarding strategy meetings.

Milestones:

- Business case presented to the Directors of Nursing on 31 October 2023 for agreement on preferred model and route for financial decision making.
- Operational processes for the interim measures to be reviewed end Q3 2023-2024 and again Q4 2023-2024
- Business presented to the Investment Panel on 19 January 2024
- Business case to be presented to Finance and Resources Committee February 2024
- In view of the financial requirement associated with the changes it is anticipated that Q1 2024-2025 would be a realistic date for implementation

Diabetes

Deliverables:

- Reduce variation of care to ensure CYP have equal accesses to all care processes. December 2024.
- Increase CYP utilising technology to manage and control their Diabetes. March 2025.
- CYP with Diabetes having access to psychological support services. March 2025.
- Improve awareness and health outcomes of CYP with Type 2 Diabetes. March 2025.

Milestones:

- Pathways across primary and secondary care reviewed and updated to address gaps and/or changes in clinical guidance. March 2024.
- ULHT CYP Diabetes dashboard to be created so that CYP activity can be monitored and highlight any areas of concern. June 2024.
- An increase in establishment of CYP diabetes services to enable increased support for CYP with diabetes; achieving care processes, education and training in schools/nurseries to support CYP with diabetes in settings. March 2024.
- Community connectors group to be established to engage with CYP/parents/carers for views on variation in care provided and access to technology.
- Raise awareness by implementing a communication plan and timeline for health messaging.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Child Protection Medicals

Deliverables:
- Decision regarding model for delivery of capacity and capability required to consistently deliver timely Child Protection medicals to required standards.
- Draft initial business plan.
- To offer 2 appointments a day (Mon - Fri) for child protection medicals, which would be 3 days a week at Lincoln County Hospital and 2 days a week at Boston Pilgrim Hospital.

Milestones:
- Preliminary discussions to be held with consultant community paediatricians as they are more suited to undertaking child protection medicals for specific conditions such as severe neglect; whilst acute paediatricians are more likely to see children suspected of having sustained a non-accidental injury.
- Business plan to be produced by ULHT (expected to be in Q4 of 2023-2024).
- Decision regarding route for financial decision making.
- Delivery and impact shall be monitored and reviewed end of Q2 of 2024-2025.
- An evaluation phase will follow by latest Q4 2024-2025.

Clinical Intervention in Schools Review

Deliverables:
Project activity and deliverables shall align with expectations cited within the seven nationally identified Key Lines of Enquiry:
- Model Delivery Approach
- Staffing and Competencies
- Clinical Intervention Framework.
- Service Planning and Monitoring
- Transport
- Transition
- Commissioning

Milestones:
- The design of a necessary model for Lincolnshire shall take place over January – June 2024.
- A recommended model shall be presented for approval to all partners and stakeholders by latest December 2024.
- Full implementation of an agreed model shall take place between latest January – June 2025.
- Delivery and impact shall be monitored and reviewed over July – September 2025 by LICB, LCC, Special Schools and through engagement with the relevant cohort of parents/carers/CYP.

Asthma

Deliverables:
- An integrated care pathway for CYP Asthma. March 2024.
- Access to diagnostic hubs and/or community spirometry and FeNO testing. April 2024.
- Implementation of NHSE National Asthma Bundle. March 2025.
- To improve the outcomes of CYP with Asthma, including difficult to manage Asthma; there will be an increase in the workforce establishment of CYP community respiratory services. March 2025.

Milestones:
- Primary Care Pathway reviewed. March 2024.
- Secondary Care Pathway reviewed - incorporating A&E, inpatient, outpatient, and discharge. December 2024.
- Developing clinical asthma network to support updates and education around asthma. June 2024.
- Business case to be created for CYP respiratory team by ULHT. June 2024

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

3. What's being done to get there - Detail

Epilepsy

Deliverables:

- Reduce variation in care- all CYP with epilepsy to have access to an Epilepsy Specialist Nurse, timely access to care and procedures to ensure NICE guidance compliance. December 2024.
- To improve the outcomes of CYP with Epilepsy and enabling the service to be NICE guidance compliant; there will need to be an increase in the workforce establishment of CYP community Epilepsy service. December 2024.
- CYP with epilepsy will have access to appropriate mental health and psychological support services. March 2025.
- All CYP who meet criteria for tertiary neurology referral should have timely access to the relevant tertiary specialist with expertise in managing complex epilepsy. March 2025.
- Improved transition between CYP and adult epilepsy services. March 2025.

Milestones:

- A review of Secondary Care Pathways to identify gaps in service and improve delivery of current service. June 2024.
- Business case to be completed for the CYP Epilepsy service. March 2024.
- A review of mental health support service available for CYP with Epilepsy and identify gaps in service delivery. March 2024.
- Secondary care dashboard to be completed to support review and audit of current cases, unplanned admission numbers, treatment. June 2024.
- Epilepsy to be part of a wider transition group that needs to support improved transition from CYP to adult providers. January 2024.
- Engagement with tertiary services to agree pathways and referral processes, including provided with outreach services. March 2024.

CYP Therapy Review

Deliverables:

- Carry out full Review of CYP Therapy services across the system, urgently starting with the SALT service.
- Engage with service users and system partners to review and co-produce necessary improvements across the health, care and education system to ensure CYP are seen/supported by the right therapist, at the right time, in the right place.
- Explore whether specification amendments are required.
- Develop fully costed Business Cases, presenting an improved low-level-need universal offer, an improved targeted offer and a fit-for-purpose specialist offer for CYP with assessed complex speech and language needs.
- Seek formal decision for recommended changes.
- Implement approved changes
- Produce fully costed Commissioning Plan and Delivery Implementation Plan.

Milestones:

- Review current SALT pressures, gap analysis, options appraisal and trajectory planning. Engage SALT service users and system partners to co-produce necessary improvements. Explore whether SALT specification amendments are required. Produce fully costed SALT Business Case. Seek formal decision. Implement. Begin scope of cross-cutting CYP therapy services: specialist physiotherapy and OT services (both Children's Services and ICB). January – March 2024.
- Monitor delivery and impact of new SALT service. Begin planning and engagement activity with partners and service users across physiotherapy and OT. Explore whether current specification amendments are required. Produce fully costed Business Case for physiotherapy & OT, including evaluation of new SALT service. Seek formal decision. SALT becomes business as usual. April – March 2025
- Implementation of any agreed change across all CYP Therapy services. April – June 2025.
- Create processes to record and monitor success/failings and impact of delivery, make small, approved changes if necessary. July – September 2025.
- Evaluation of all CYP Therapy services to ensure fit-for-purpose, make small, approved changes if necessary. October – December 2025.
- All CYP Therapy services become business as usual. January – March 2026.

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3. What's being done to get there - Detail

CYP Voice/Data Intelligence

Deliverables:

- Development of joint processes to use information gathered from service users and data to inform and shape service delivery.
- Mapping of current CYP groups and engagement activity already taking place across the system.
- Gap analysis.
- Development of joint communication and engagement methods to provide information that can be effectively analysed.
- Build a process to use the analysed intelligence to support positive change and future development.
- Finalising an Integrated dashboard for CYP with SEND, including health data – national guidance expectation.
- Identifying opportunities to improve the quality of intelligence in our integrated dashboard for SEND, including health data through use of the ICS Joined Intelligence Dataset.
- Identifying essential CYP related data flows to add value to the existing ICS Joined Intelligence dataset.
- Redesign current systems and governance to allow flows of the necessary information.
- Establish skills and capacity required to create continued intelligence mapping and analysis that can lead to effective evaluation for positive change.

Milestones:

- Investigate the legal basis and appropriate information governance required for data sharing across the system. Seek current levels of data intelligence and service user engagement to establish what is working well, where there are gaps and what feasible improvements need to be made.
- CYP Voice: Establish what is meant by 'lived experience'. Data Intelligence: Implement the Integrated dashboard for SEND including health data. Scope activity to incorporate information from the ICS dataset that will add value. October 2023 – March 2024.
- CYP Voice: Co-produce effective ways to engage with CYP and their families to hear their lived experiences and what matters to them. Co-produce future templates and processes to be shared across the system, to be populated and returned for early analysis and to test draft design. Data Intelligence: Evaluate and monitor the Integrated Dashboard for SEND including health data to ensure full commitment and continued input from identified LCC and Health representatives. Design and implement a jointly agreed review process for the Integrated Dashboard for SEND, including health data. April – December 2024.
- CYP Voice: Facilitate and host communication, engagement and participation activity events across the system to test draft designs with service users and partners. Make necessary amends. Seek approval. Data Intelligence: Work with LICB's Intelligence & Analytics Division to ensure CYP data is being captured from across the system and that information collated is accurate and can be easily reviewed for analysis to aid future planning.
- Write, seek approval, share a robust joint Information Sharing Agreement: January 2025 – September 2025
- Implement approved recommendations, including expectation to monitor success or failings ahead of evaluation phase during which small changes can be made where necessary. October 2025 – June 2026.

Children and Young People

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3. What's being done to get there - Detail

Children's Community Nursing Service

Deliverables:

- CCN service to be enabled to deliver services which are reflecting best practice clinical guidance.
- Achievement of UEC deliverables associated with funding allocation to provide an out of hours support service.
- CYP/parent/carer voice will be captured to support and maintain ongoing service improvement.

Milestones:

- Review of National policy and current recommendations/guidance to ensure our CCN service is fully NICE guidance and legally compliant. Q1 24/25.
- Options appraisal paper to be written to present different service models for provider consideration. Q4 25
- A gap analysis of current service provision/pathways completed; identification of key areas where service improvement is required. Completed Q3 23.
- The CCN service to have access to electronic records system for improved information sharing across partners and to provide a safe and effective 24/7 out of hours service. Q4 25.
- Development of an electronic platform to capture CYP/parent/carer voice across specialist support areas and develop performance metric reporting. Q4 25.

Palliative End of Life Care for Babies, Children & Young People

Deliverables:

- Right care at the right time in the right place for BCYP who require PEOLC.
- LICB to provide PEOLC service offer for BCYP within Lincolnshire.
- PEOLC for BCYP to be NICE compliant in providing 24/7 out of hours specialist clinical support/advice rota for fellow professionals who are managing end of life for BCYP. Fulfilling ICB statutory requirements.
- LICB to implement allocation of NHSE grant for registered CYP Hospices providing PEOLC by April 2025.

Milestones:

- Scoping of available BCYP PEOLC providers across Lincolnshire to improve care provision, access and choice of venue of death for BCYP. Q1 25.
- LICB to provide a mid-year report to NHSE in 2024/2025 to evidence how funding has been distributed to BCYP hospice providers. Q3 24/25.
- Ensure the service is engaging and capturing the CYP voice alongside performance metrics agreed with CYP hospice providers. Q4 25.
- PEOLC Medical Consultant Lead to provide support for the CCN core service as well as the PEOL caseload across Lincolnshire, fulfilling NICE compliance and statutory requirement for ICB's for BCYP who require PEOLC.

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3. What's being done to get there - Detail

Integration of assessment processes and support for CYP with Special Education Needs and Disabilities (SEND)

Deliverables:

- Scope and plan review elements required within three sub-categories:
    - Education, Health, and Care (EHC) SEND process.
    - Independent Placements for CYP with SEND.
    - Children's Continuing Care (CC) Review for CYP with SEND.
- Write and present relevant governance documents for consideration and approval e.g., NHS Case for Change, LCC Briefing Paper.
- Write further required governance documents, e.g., Business Case, Commissioning Plan and Delivery Implementation Plan for fully costed change.
- Facilitate engagement activity with all Stakeholders, including service users to ensure co-production.

Milestones:

- Mapping full scope of required work and individuals required to support the work across all three elements. April – June 2025.

July 2025 – March 2026:

- SEND EHC process: Audit developed health-led quality assurance process. Explore how health partners could review draft EHC Plans that have a health contribution before Plan is finalised. Review system response to SEN and partnership responsibility for CYP in 52-week placements.
- Independent Placements for CYP with SEND: Review local arrangements which may need to be revised to respond to the SEND National Standards. Review and evaluate the commissioning of independent residential placements (mainly respite) following hospital discharges including inpatient for CYP that are not Children in Care – explore possible expansion of Adults' brokerage process.
- Children's CC Review for CYP with SEND: Review of current policy and process to ensure delivering best practice and best collaborative use of resources. Research and benchmarking against other ICB areas. Review process for allocation of funding and develop improvements based on findings. Design a single joint panel process for all CC reviews.

April – December 2026

- Present review findings and recommended models for change.
- Seek approval and commitment from all partners.

January – December 2027

- Implementation of approved recommendations, full delivery of new models including expectation to monitor success or failings ahead of evaluation phase during which small necessary changes can be made.

Children and Young People

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q 2	Q3	Q4	Q1	Q 2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CYP	CS Front Door	See separately shared FRP																				
CYP	Diabetes																					
CYP	CYP Child Protection Medicals																					
CYP	Clinical Intervention in Schools Review																					
CYP	Asthma																					
CYP	Epilepsy																					
CYP	CYP Therapy Review																					
CYP	CYP Voice/Data Intelligence																					
CYP	Children's Community Nursing Review																					
CYP	Palliative End of Life Care BCY																					
CYP	Integration of assessment processes and support for CYP with SEND																					

Children and Young People

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4. Projected impact on patients and system partners

The high-level outcomes of this programme will be:

- Improved access to services.
- Improved safety and effectiveness.
- Care in the most appropriate environment and as close to home as possible.
- Improved experience for CYP and their families.
- Improved health and wellbeing outcomes.
- Reducing health inequalities.
- Fully integrated and seamless services.
- Smooth and safe transition into adult services.

Detail for each Project is included within the individual project plans

The projected impact on patients and system partners will include:

- Improved access to services for CYP and families, CYP will be supported closer to home.
- Health can meet its statutory safeguarding responsibilities.
- CYP services are NICE compliant, aligned to best clinical practice.
- Measured reduction in complaints and negative feedback from our CYP, their parent/carer and our stakeholder partners.
- It is anticipated that system risks will reduce and, for example in relation to Childrens Front Door, mitigation is in place to address current red rate issue; CYP with SEND, there will be an anticipated reduction in Tribunals that have a health provision component.
- The projected impact of a reduction in complaints, negative feedback and Tribunals will result in bolstering our LICB reputation and improving services and health outcomes for our CYP of Lincolnshire.
- A workforce focused on delivering highly safe and effective care is evidenced in recruitment and retention of staff and results in our CYP receiving quality healthcare services from motivated and invested staff.
- We are aware that nationally there are recruitment workforce challenges, and this may restrict our ability to deliver improvements. For example, the LICB is aware that the region requires a consultant with a special interest in PEOLC for BCYP. This is a gap in service provision which can impact on our BCYP and our system partners to provide NICE compliant PEOLC for our BCYP in Lincolnshire.
- We will need to work closely with our partners where it is a known area of workforce challenge. We will need to be innovative and develop models to “grow our own” and review and revise skill mix to maximise workforce capacity and effectivity.
- It is anticipated that as models of care are developed, cases for change will be worked up for each of the Projects, which shall include consideration of how existing resources can be used most appropriately to address need within the context of new models of care, alongside the development of business cases where there is a recognised need in terms of resource gap to meet the needs of our local CYP.
- It is understood that there may be opportunities as the ICS develops, to establish new ways of working, for example a ULHT/LCHS Group Model of partnership working is evolving, with likely opportunities for better integration of services which the programme will look to capitalise on and to ensure we maximise on the areas of improvement presented to us.
- We know there are changes to some funding streams, for example, BCYP hospice funding allocation changes, where the responsibility for allocation of hospice funding is proposed to devolve from NHSE to ICBs in April 2025. There will need to be consideration of how the LICB meets its commissioning responsibilities within the context of these funding stream changes and to meet NICE compliance and statutory requirements for BCYP PEOLC.
- Financial investment is sought for Child Strategy Discussions – CS Front Door

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5. What's needed to make this happen

- Providers are already fully engaged through the CYP ITB. However, we will be reliant on the clinical expertise and service leads for the technical input into the programme and some of this may require consideration of backfill requirements if there is a need to protect what are often very small and fragile services within CYP specialties. The success of the programme is also dependent on engaging the primary care pathways effectively and as such we will require input from primary care/clinical leads/GPs.
- Health partners are fully engaged in Safeguarding Partnerships relevant to CYP i.e., Lincolnshire Safeguarding Childrens Partnership (LSCP); Safer Lincolnshire Partnership (SLP); and Lincolnshire Domestic Abuse Partnership (LDAP). To support safeguarding transition requirements collaboration is also taking place with Lincolnshire Adult Safeguarding Board (LSAB).
- The programme is fully engaged with Population Health Management (PHM) and the Health Inequalities team, however there is significant work required to develop the required level of data and analytics to be able to ensure the focus is directed in the areas it is needed. We are aware of this and are working closely with our internal LICB partners, Public Health and LCC in resolving this issue.
- It is likely that any increase in workforce will require additional estate and infrastructure to support the increase and enable our staff to work effectively.
- There are some very specific interdependencies with local authority services that will need to be considered especially within Children's Services' Social Care, SEND, Education and Children's Health Services.
- Due to the specialist nature of certain CYP care pathways the engagement and ability to interface with tertiary care providers will be critical to successful programme delivery.
- There is an identified need for acute provider partners to undertake digital transformation. This will align services affected with our regional neighbours and offer seamless communication and information sharing between integrated key partner services.
- All the priorities are reliant on existing financial funding. The only business case being presented is that of strategy discussions for Children – CS Front Door. It is likely as the programme develops that additional funding may be required, particularly as investment in CYP services has been limited and there is evidence of growing demand across several pathways. The programme will always seek to maximise existing funding as a priority before seeking additional funding.

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6. What could make or break progress

- Workforce availability, a nationally recognised ageing workforce, recruitment, retention, and attraction of specialist posts into the region – the CYP programme continues to support provider initiatives to increase workforce and improve retention.
- Financial challenges across the system, creating a lack of assurance that the funding can be utilised in the right area – throughout our CYP priorities we aim to review existing services to explore cost efficiencies and to continue to influence utilisation of funding in the right areas.
- Data and analytical support for the programme – the CYP programme is working with provider and ICB data analytical teams, including the population health management approach to ensure data and intelligence informs our key priorities.
- Digital transformation impacting on services across the system. A lack of alignment to share critical information between providers to support timely management of cases and prevent unplanned escalation – the CYP programme continue to work with providers to support with the implementation of an electronic platform for records and to highlight the issue nationally with NHSE.
- Delivering equity of service across large rural areas – the JFP action of 'Improving Access' will run throughout all our CYP priorities, ensuring we are meeting the headline actions and determinants of access.
- Increasing demand on existing services seen post Covid-19 pandemic – within the CYP programme's wider strategic priorities, we support the UEC programme and the elective recovery/planned care programme. Our priorities are focused on those areas of service delivery for CYP which have seen an increased prevalence post COVID 19 pandemic E.g., Epilepsy, Asthma and Diabetes.
- New themes of service demand on CYP healthcare concerns not acutely evident before the Covid-19 pandemic – the CYP programme continues to work with partner agencies to explore and examine key health themes which are developing post Covid-19 pandemic.
- A lack of system wide engagement with integration of services due to competing priorities such as operational pressures and priorities of other programmes of work pertinent to their own organisation. Acute providers working to a reactive cycle rather than having the space to be preventative – strengthened working relationships between CYP programme and key partners continues with regular updates from each organisation, coming together in a joined-up approach to ensure focus remains on prevention where possible and improving service offer for BCYP. CYP programme team to be involved in development and implementation of change – this is a system wide issue and we have escalated within our system the fact that we are a fragile programme with a limited workforce. Our priorities are set over 5 years which will allow the time required to make the case for change and effectively improve service offers.
- Fragmented programme that has co-dependencies with other programmes that may have differing priorities. e.g., PEOLC, Planned Care, Primary Care, LCC commissioned services, Education, UEC – this is a fundamental issue for the CYP programme; however, our children's integrated commissioning team are better together and includes NHS and LCC to work in partnership to support each other to progress our own CYP programme's priorities.
- Transition between children and adult services – this relates to ALL Projects. The Transition ICS Network will bring together key partners from CYP and Adult services. Transition is everybody's business and will require a system wide approach. This work is supported by NHSE frameworks and deliverables expected for all ICB's.
- Clinical lead capacity for meaningful involvement in the programme – the clinical capacity to support transformation is limited. The CYP programme strives to work with our clinical experts, utilising skill set and experience across the workforce capacity.
- Clarity and delay of national funding streams from NHSE required which directly pauses transformation work – we continue to escalate to NHSE leads.
- Co-production with CYP, their families and key stakeholders is vital, and we will need to ensure there is appropriate capacity and capability to undertake meaningful co-production work – utilising existing established CYP voice networks, for example, Lincolnshire Young Voices and the Lincolnshire Parent/Carer Forum as a template for effective co-production and collation of our CYP voices.
- If the development of services relies on additional financial investment and if this is not agreed, then it may mean that pathways cannot be fully implemented or are delayed, and this may limit the outcomes delivered.

Children and Young People

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7. Planning assumptions

Demand drivers:

- Increased demand and evolving new presentation of health themes since Covid 19 pandemic on CYP services.
- Increased waiting lists for CYP.
- Identified gaps in meeting statutory responsibilities following changes to legislation.
- Identified gaps in service delivery to meet the demand of the changing landscape for CYP services.
- Provider; System; and Partnership risk registers.
- Workforce pressures in recruitment and retention of experienced, specialist skillset in Lincolnshire.
- National CYP Transformation Programme Deliverables and reporting (NHSE).
- Palliative and End of Life Care: statutory guidance for ICBs and devolvement of funding accountability (NHSE).
- Admission avoidance/ED attendance.

Productivity, capacity & resource enablers, and constraints:

Workforce:

- National shortage and regional shortage of key workforce and professions such as medical, nursing, AHP and psychologists.
- Often recruitment into new roles is filled by staff in existing roles which then leads to fragility in existing roles (e.g., ward-based nurses moving into community roles) it also impacts on bringing fresh skillset/experience into the region. Retention challenges of newly qualified paediatric nurses within the region and the timely availability of vacancies made available to newly qualified nurses.

Finance:

- It is anticipated that significant investment will be required to support the development of the CYP programme.
- Clarity and delay of national funding streams which directly pauses transformation work is required.

Service capacity & productivity:

- Partly unknown at this stage whilst Projects are within the pre-scoping phase.
- We are aware of service capacity issues which are directly highlighted to the LICB. For example, we know we have issues with service demand and workforce capacity in our SALT waiting lists for CYP.

Estates:

- Each Project will have different considerations in relation to estate space. The complexity of who owns and who pays the respective estate will add an additional dimension that will need to be worked through.

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8. Stakeholders

Stakeholders

- LCHS, LPFT, ULHT
- St Andrew's BCYP/Adult Hospice
- Rainbows BCYP Hospice
- NHSE
- Other NHS Trusts (Tertiary Centres)
- General Practice
- EMAS
- Children's Services, including Social Care, SEND and Education (LCC)
- Children's Health Services (LCC)
- Police
- Lincolnshire Parent Carer Forum
- CYP engagement, e.g., Lincolnshire Young Voices
- Other ICBs/Commissioners within the Midlands region

(Stakeholders will be different for each identified Project – please see project plans).

Work Programme team

- Vanessa Wort (LICB) Associate Director of Nursing & Quality
- Terry Vine (LICB) Deputy Director of Nursing & Quality/CYP Programme Lead
- Russell Outen-Coe (LICB) Designated Clinical Officer for Children and Young People with Special Educational Needs and Disability
- Sonia Currier (LICB) Children & Young People Programme Manager
- Becky Adgar (LICB) Children & Young People Commissioning Manager
- Linda Dennett (LCC) Assistant Director Childrens Health & Commissioning
- Charlotte Gray (LCC) Head of Service – Children's Strategic Commissioning
- Lucy Gavens (LCC) Consultant in Public Health
- Rosemary Akrill (CICT) Integrated Commissioning Programme Manager
- Joanne Fox (CICT) Integrated Commissioning Senior Programme Officer
- Rebecca Thompson (CICT) Integrated Commissioning Programme Officer

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Diabetes Logic Model

Inputs

- Specialists with diabetes knowledge & leadership skills – acute and community paediatricians; specialist nurses; pharmacist/medicines management
- Psychological services
- Transition nurse(s)
- Education/schools representatives
- Programme Management
- Clinical input – primary & secondary care
- Co-production – with clinicians; CYP; and families/carers
- Support from community and voluntary organisations
- Data analytics – including support from Public Health Managements
- Finance (inc. funding opportunities)
- Digital support

Activities

- Review of NICE guidance and definition of national standards, including medication optimisation and implementation of Continuous Glucose Montioring (CGM)
- Mapping to understand gaps in access to service/support (equity & equality)
- Establish datasets and use to understand prevalence and outcomes in Lincolnshire; quality of care; trends across PCNs, including referral data;
- Develop care pathway for Lincolnshire that includes - Establishing role of primary care, including wider role of PCNs; early diagnostic /pre diagnostic support/medicines management input; accessible support for CYP and families, including social prescibing to support increased activity and reduce childhood obesity.
- Review available training & education for clinical and care professionals; schools; CYP & families/carers
- Review transition arangements and identify how will respond to identified gaps/challenges.
- Information resource for CYP, parents/carers and professionals to access.

Outputs

- Commissioned pathway of care in line with national best practice.
- Increased confidence of earlier recognition and diagnosis of type 1 and type 2 diabetes.
- Access to psychology services for CYP with diabetes who require support.
- Increase in confidence to manage diabetes of CYP, Parents/carers and education provision.
- Increase in understanding of the condition – CYP networks, in particular schools; activity/social groups
- Seamless transition through CYP services to adult services, seen by a reducation in the unplanned admissions and increased stability of diabetes in 16-25 year old age group.
- CYP utilising diabetes technology to support management of their condition.
- Diabetes data and intellifgence readily available to ensure that care is meeting the needs of CYP.
- Professionals and staff will work collaboratively and co-ordinate care through agreed pathways.
- CYP referred to and have access to phsycial activites and healthy eating to enable them to prevent type 2 diabetes developing.

Outcomes

- CYP will have the information they need to manage their care and Parents/Carers will have increased confidence in managing the child/young persons condition.
- Increase in the use of Continuous Glucose Monitoring and Insulin pumps, particularly in the most deprived population and ethnic minorities.
- Increase in the percentage of those achieving an HbA1c <48 mmol/mol
- Increase in number of children offered dietetic appointment.
- Increase in muber of children accessing psychological support.
- Increase in number of children with Type 1 & 2 diabetes receiving all NICE care processes
- Reduction in the number of CYP presenting in ED with diabetes and unplanned admissions to the ward
- Reduction in childhood obesity

Impact

Children and Young People (Parents/carers of) with diabetes will be empowered to manage their diabetes and improve their quality of life and there will be a reduction in health inequalities related to diabetes.

Children and Young People

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Asthma Logic Model

Inputs

- Specialists asthma knowledge & leadership skills
- Public Health capacity & capability
- Staff time – health; social care; education; housing etc.
- Programme management capacity
- Data analytics capacity & capability
- Information sharing agreements
- Digital support
- Comms & engagement

Activities

- Confirm system asthma lead & governance arrangements
- Establish Lincolnshire asthma network; paediatric severe asthma network
- Benchmark Lincolnshire services against regional & national
- Map pathway of care – primary, secondary, tertiary
- Implement asthma bundle and adherence to minimum standards of care
- Develop joint policy between healthcare & education
- Develop joint policy between healthcare and local authority re CYP asthma and living conditions and air quality
- Staff CYP asthma training at level appropriate to role across health and education
- Professionals share appropriate asthma resources with parents/carers, including smoking cessation (needs to link in to LMNS smoking cessation work)
- Implementation of community Spirometry testing and asthma diagnosis for CYP.
- Information resource for CYP, parents/carers and professionals to access.

Outputs

- CYP receive appropriate care and support across healthcare and education with asthma pathways in place and used appropriately.
- Diagnostic hub is in place and sees all CYP who meet criteria.
- Compliance with asthma bundle and minimum care standards .
- All CYP with asthma will have an asthma plan in place that is reviewed annually.
- Parents/Carers of CYP living in homes with poor indoor airquality will be able to access advice and support to make imrpovements. Reduced reports of poor indoor airquality impacting on CYP asthma exacerbation.
- Parents and carers are motivated to stop smoking-Lower rates of smoking in parents/carers of CYP with asthma.
- Resources will be available for CYP, parents/carers to access to support their education around asthma.
- Education settings will have a strategy in place to support students with asthma.

Outcomes

- CYP will have the information they need to manage their care and Parents/Carers will have increased confidence in managing the child/young persons condition.
- Professionals and staff will work collaboratively and co-ordinate care through agreed pathways.
- > A reduction in the number of CYP presenting in ED and unplanned admissions with asthma, particularly in children aged 2-10 years; mixed ethnicity; and those living in most deprived quintile.
- > An increase in the number of CYP having annual asthma reviews
- > A reduction in the number of children being prescribed more than 3 reliever inhalers a year.
- > A reduction in the number of children having an exacerbation of asthma requiring inpatient stay

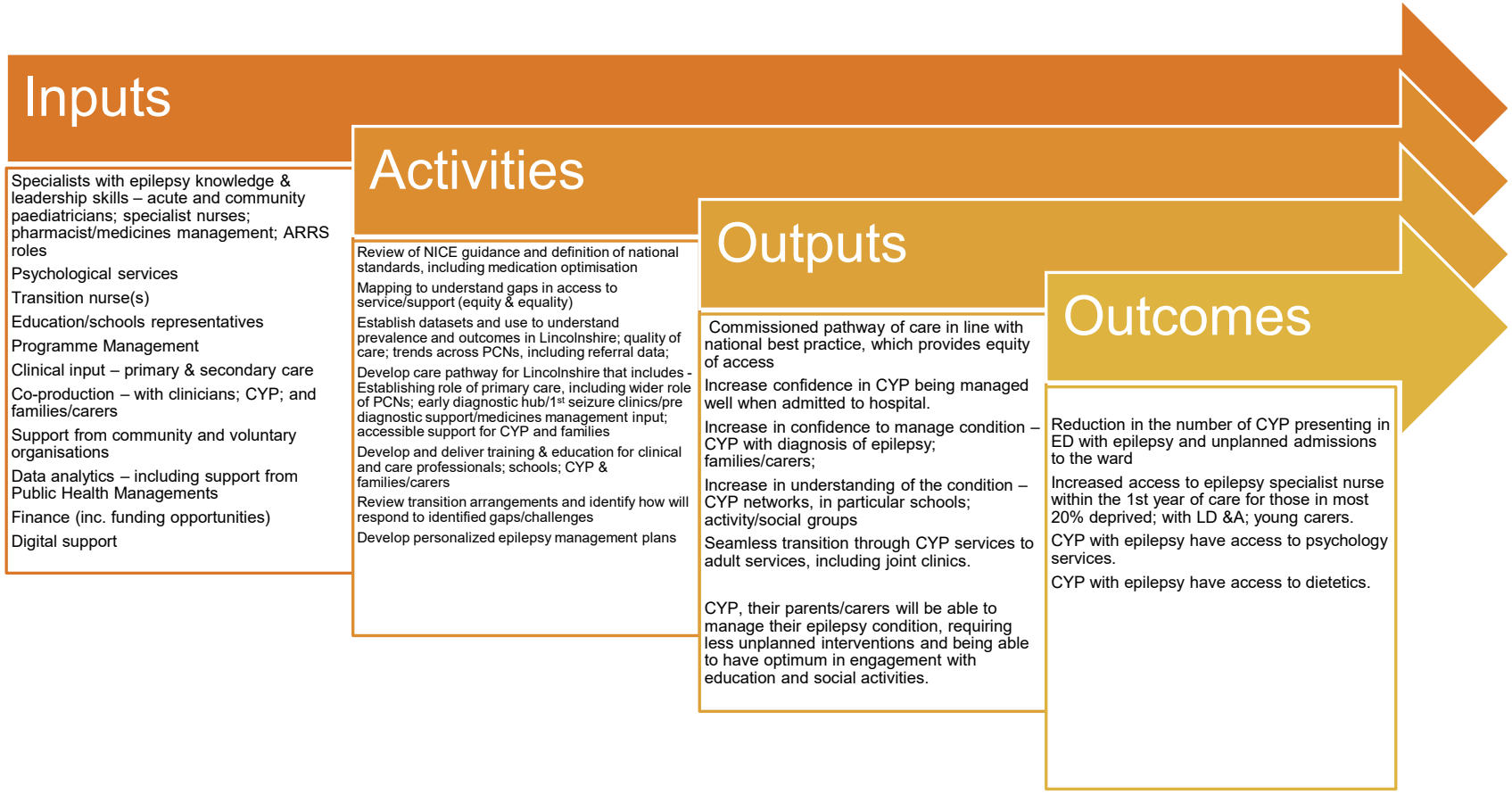
Impact

Children and Young People (Parents/carers of) with Asthma will be empowered to manage their asthma and improve their quality of life and there will be a reduction in health inequalities related to asthma.

Children and Young People

Programme: Children and Young People (CYP)	SRO: Martin Fahy	Programme lead: Terry Vine Author: Becky Adgar	Clinical/Technical Lead: TBC

Epilepsy Logic Model



Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

1. Future state

There is a wide range of local and national evidence demonstrating a need for greater parity of children and young people's (CYP) mental health (MH) support, both in relation to physical health support and adult mental health support, based on a fast-growing need over recent years, exacerbated by the recent pandemic. The Lincolnshire Joint Strategic Needs Assessment's (JSNA) children mental health and emotional wellbeing topic sets out the evidence and need for transformation and development of these service in Lincolnshire. Half of all life-long mental health problems in the UK start before the age of 14 and three quarters start before the age of 25. Before the pandemic, the prevalence of mental disorders in children aged 5 to 16 was already increasing from 1 in 9 (2017) to 1 in 6 (2020). Anxieties caused by lockdowns, school closures, isolation from peers, bereavement, and the stresses on families have increased pressures. Demand modelling suggests that 1.5 million children nationally may need new or additional mental health support as a result of the pandemic. Risk and protective factors for mental health and wellbeing are well documented and include childhood abuse, trauma, or neglect, social isolation or loneliness, experiencing discrimination and stigma, social disadvantage, or poverty, bereavement, or being a long-term carer for someone. Understanding these factors can help us to target prevention activity to support mental health and wellbeing.

This CYP MH programme delivery plan is aligned under the Lincolnshire system Mental Health, Dementia, Learning Disability and Autism (MHDLDA) Alliance vision: *'Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'*. It primarily supports the JFP priority around 'Improving Access', but also supports the health inequalities programme around 'Living Well, Staying Well', 'Integrating Community Care' through more join-up with Primary Care, and growing our 'Workforce' in Lincolnshire.

As part of the NHS Long Term Plan, published in 2019, and NHS Mental Health Implementation Plan 2019/20 – 2023/24, the NHS made a commitment that funding for CYP mental health services will grow faster than overall NHS funding, total mental health spending and each Integrated Care Board's (ICB) spend on mental health. It sets out the following priorities and ambitions for CYP mental health:

- Invest in expanding access to community-based mental health services
- Boost investment in CYP eating disorder services
- All CYP experiencing a mental health crisis will be able to access crisis care 24/7
- Embed mental health support for CYP in schools and colleges through MHSTs
- Develop new services for CYP who have complex needs that are not currently being met
- Develop a new approach to mental health services for 18-25-year-old's, supporting transition to adulthood.

Rather than set new ambitions for CYP MH, the NHS Planning Guidance for 2023/24 focuses on the need to make further progress in delivering the ambitions above in the NHS Long Term Plan and to continue transforming for the future. We will also align to the priorities across the Integrated Commissioning Strategy for SEND, the Lincolnshire Health and Wellbeing Strategy, Suicide Prevention Strategy, and work towards the ten year 'No Wrong Door' vision: https://www.nhsconfed.org/publications/no-wrong-door.

For the purposes of this programme delivery plan, it includes all CYP mental health services that are jointly funded by Lincolnshire County Council and Lincolnshire ICB. It does not include commissioned services that do not provide mental health support to CYP (except where they relate to transition to adult services), CYP mental health services outside of Lincolnshire (e.g. regional F-CAMHS), Tier 4/specialist inpatient mental health provision, adult and older people's mental health plans, and learning disability and autism/neurodevelopmental or dementia specific programmes.

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

2. What's being done to get there | Overview

In order to enable CYP to Start Well, we will:

- Ensure CYP stay healthy through increased public mental health promotion and prevention by building resilience, creating mentally healthy communities and maximising community assets and support/advice, including online and digital
- Empower parents/carers and professionals working with CYP to better identify and respond to their emotional wellbeing and mental health concerns, including more focus on perinatal mental health and parent-infant relationships during early years
- Increase access to timely and effective early intervention support or advice at the right level, in school or in their communities, so that problems are identified early and all CYP who need help, including those with complex needs, can do so
- Ensure that all CYP who are suffering from mental illness can access high-quality, evidence-based and timely mental health assessment and support in their community
- Avoid unnecessary specialist and acute mental health related hospital admissions, particularly for CYP with a learning disability and/or autistic CYP, by providing responsive assessment and support for CYP in mental health crisis, with appropriate community-based treatment, or facilitating prompt discharge or supporting transition where admission is unavoidable
- Work to embed seamless pathways between CYP and adults' mental health services to ensure smooth transitions between them.
- Much of the work for the CYP MH work programme will be driven through the CYP MH Transformation Programme. The vision, aims and objectives of programme are:

Vision	*'Together with CYP in Lincolnshire, we will review and transform services to improve emotional wellbeing and mental health support for CYP and families, enabling them to live independent, safe, well and fulfilled lives in their local communities.'*

Aims	Priority Objectives
We will focus on improving support for CYP and their families in relation to: • Public mental health promotion, prevention, community and early intervention support • Empowering parents/carers and professionals working with CYP to better identify and respond to their emotional wellbeing and mental health concerns • Increasing and improving access to community based emotional wellbeing and high-quality, evidence-based and timely mental health assessment and support • Avoiding unnecessary specialist and acute mental health related hospital admissions, particularly for CYP with LD and Autistic CYP.	The transformation programme will consider a wide-range of cross-cutting factors, including: • Understanding needs across Lincolnshire, equalities and population health management • Ensuring thee is the right capacity and skills of community support and mental health trained professionals to meet the needs of Lincolnshire CYP • Engage CYP and families and ensuring their views are used to help shape and co-produce services • Ensuring professionals work together, supported by integrated pathways, to provide the right support to CYP at the right time and remove barriers to co-delivery of support • Making the best use of the funding, workforce and other resources available to us so that services are sustainable and represent best value.

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

3. What's being done to get there - Detail

Programme	Initiative	Milestones		Timescales
CYP MH Transformation	Review CYP MH services	Understand local needs and intelligence; identify best practice, benchmark against evidence-based best practice; CYP and Family views; current service performance - to help shape future service provision		March 2024
	Design CYP MH Services	Using the review phase outcomes, design and agree new service models and appropriate sustainable funding		March 2025
	Implement CYP MH Services	New service models implemented; increase access; reduce demand on specialist services; reduce inpatient admission; improved community support available		March 2028
Prevention and Community Assets	Night Light Café pilot	Evaluation and development of longer-term model		August 2024
Early Intervention	Online MH support service recommissioning	Recommissioned service to continue offer of online/out of hours support and reduce pressure on statutory services		March 2024
	Primary care CYP MH Practitioner pilot roll-out	Evaluation and development of longer-term model		Ongoing
	CYP counselling offer pilot	Evaluation and development of longer-term model		March 2025
	On-going delivery and expansion of MHSTs	50% of pupils in county have access to MHSTs by 2025	Waves 7 and 8	January 2024
			Wave 10	January 2025
			Wave 12	January 2026
Community Specialist Mental Health	Investment to increase staffing and reduce waiting times in community specialist mental health support	Reduced waiting times for specialist mental health support; increased support for CYP whilst waiting, reduced staffing turnover in community specialist mental health services		March 2025
	Introduce ARFID pathway/CAMHS Eating Disorders	Pathway in place; further areas of development identified		March 2025
	Complex Needs Service review	Review of sustainability of service		March 2025
Urgent and Emergency Care	CYP MH liaison in Lincoln and Boston	Review and evaluation to develop longer term model		March 2025
	MHUAC all-age pathway	Reduced presentation of CYP in A&E (those with mental health needs), increased access to 24/7 mental health crisis support and assessment for CYP and families		March 2025
	Kooth digital online pilot	Review and evaluation to develop longer term model		March 2025
	Crisis respite	Reduction of inpatient admission; reduction of delayed discharge from inpatient; reduction of CYP in care in unregulated placements		TBC
Transitions Pathways	Ensuring transitions are seamless between CYP & adult MH services	Pathways in place		Ongoing

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CYP MH Transformation	N/A																					
Prevention and Community Assets	Night Light Café pilot																					
Early Intervention	Online mental health support service recommissioning																					
	Primary care CYP MH Practitioner pilot roll-out																					
	CYP counselling offer pilot																					
	Waves 7 and 8 MHSTs in Spalding, Sleaford, Grantham																					
	Wave 10 MHST in North Kesteven and South Lincoln area																					
	Wave 12 MHST planning and roll-out																					
Community Specialist Mental Health	Investment to increase staffing and reduce waiting times in CAMHS																					
	Introduce ARFID pathway/ CAMHS Eating Disorders																					
	Complex Needs Service review																					
Urgent and Emergency Care	CYP mental health liaison in Lincoln and Boston																					
	MHUAC all-age pathway																					
	Kooth digital online pilot																					
	Crisis respite																					
Transition Pathways	Ensuring transitions pathways are seamless between CYPMHS and AMHS																					

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients and Population	System Partners
Night Light Café pilot	- Increased access to out-of-hours crisis support in the community	- Reduced demand on CYP crisis services - Reduced A&E attendance and admissions of CYP for MH related problems
Online mental health support service recommissioning	- Continued access to early intervention support - Continued access to out-of-hours online support	- Reduced demand on face-to-face CYP MH services - Reduced escalation of need requiring specialist MH support
Primary care CYP MH Practitioner pilot roll-out	- Increased access to CYP mental health support in primary care - Improved MH patient journey and experience via primary care	- Better CYP mental health pathways from primary to secondary care services
CYP counselling offer pilot	- Increased access to early intervention support	- Increased CYP workforce
On-going delivery and expansion of MHSTs	- Increased access to low-moderate MH support in schools/colleges - More Lincolnshire CYP have good emotional wellbeing and MH, teaching them self-care skills to develop and strengthen their own emotional resilience - More CYP with early indicators of emotional wellbeing and/or MH needs are supported in their education settings and prevented from needs escalating - Reduced health & wellbeing gap to prevent further widening of inequalities	- Better identification of good practice in education settings; improved whole-school approach to emotional wellbeing & MH; Better pathways via education into MH support - Increased knowledge, skills & confidence of the education workforce - Increased CYP workforce - Fewer CYP require alternative/more specialist educational provision or statutory intervention (unless appropriate to meet their identified educational needs)
Investment to reduce waiting times in community CAMHS	- Reduced waiting times for specialist mental health support - Increased support for CYP whilst waiting for treatment	- Reduced staffing turnover in community specialist mental health services - Increased CYP workforce
Introduce ARFID pathway/ CAMHS Eating Disorders	- Increased access to specialist mental health assessment and treatment for CYP presenting with ARFID	- Reduced A&E attendance of CYP for physical health problems related to eating disorders
Complex Needs Service review	- Reduced risk of CYP with complex needs or behaviours escalating and negatively impacting on their life chances	- Better integrated care available in the community for CYP with complex presentations, who may be engaging in risk-taking behaviours - Lincolnshire better able to meet the holistic needs of CYP with complex needs, including children in care and those in the youth justice system
CYP mental health liaison in Lincoln and Boston	- Increased access to 24/7 mental health crisis support and assessment for CYP and families	- Reduced A&E attendance of CYP for MH related problems
MHUAC all-age pathway	- Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA - Increased access to 24/7 mental health crisis support and assessment	- Reduced A&E attendance of CYP for MH related problems
Kooth digital online pilot	- Increased access for CYP to support during MH crisis	- Reduced A&E attendance of CYP for MH related problems
Crisis respite	- Increase in hospital admission avoidance and shorter stays (if admission is unavoidable) for all CYP, including those with LDA	- Reduced A&E attendance and admissions of CYP for MH related problems - Reduced delayed discharges from inpatient for CYP - Reduced CYP in care in unregulated placements
Seamless CYP and Adult MH transitions pathways	- Improved patient journey and experience for 18-25-year-olds from CYP to Adult mental health services	- Better CYP mental health pathways for 18-25-year-olds from CYP to Adult services

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

4. Projected impact on patients and system partners

Measures of success include:

- Increase in CYP accessing CYP MH Services (1+ contact) as per national and local recovery target (10,000 in 2023/24)
- 35% of CYP accessing 2+ contacts with CYP MH services in Lincolnshire
- 95% of routine eating disorder referrals seen within 4 weeks
- 95% of urgent eating disorder refers seeing within 1 week
- Reduction in referrals not accepted into CYP MH services
- Reduction in re-referrals within 6 months of discharge
- 80% of CYP demonstrating improved outcome where they have two or more paired outcome scores
- Increased confidence of parent/carers and children's workforce in Lincolnshire who access training (target 90% or more reporting increased confidence)
- Reduction in number of CYP admitted to MH inpatient (no more than 2 GAU)
- 95% of CYP seen by CYP MH services within target timescales (timescales vary depending on service and routine or urgent/emergency).

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

5. What's needed to make this happen

There are a number of schemes covered in this plan which will likely require additional financial resource. The majority would go through the MHDLDA planning process for prioritisation and will be identified where possible within the MHIS. .

Initiative	Funding Plans
Night Light Café pilot	Non-recurrently funded pilot. Would look to fund recurrently beyond pilot timescales and expand to other areas of the county via CYP MH Transformation or MHIS
Online mental health support service recommissioning	Recurrently funded by LCC with non-recurrent top-up from S75 pooled fund until March 2026. Would look to fund recurrently beyond pilot via CYP MH Transformation or MHIS.
Primary care CYP MH Practitioner pilot roll-out	Recurrent funding available for partial funding towards 4 FTE Primary Care CYP MH Practitioner posts, 2 currently recruited. Further posts could be funded via further national ringfenced investment, specific ARRs funding, MHIS or CYP MH Transformation.
CYP counselling offer pilot	Currently funded via deferred S75 income, beyond pilot would look to fund via recurrent S75 income or MHIS.
MHSTs	Funded via direct allocation from NHSE as new Waves are rolled-out. Would need to ensure continued allocation should funding become part of ICB baseline.
Reducing comm CAMHS waits	Recurrent funding fully released and invested.
Introduce ARFID pathway/ CAMHS Eating Disorders	Recurrent funding from SDF allocated to CYP-EDS and development of CYP ARFID pathway, need to ensure continued allocation once SDF moves into ICB baseline.
Complex Needs Service review	Funded directly by NHSE Health and Justice to LCC, currently agreed until March 2028. Beyond this date we may receive further national funding, otherwise we need to consider local funding via CYP MH Transformation or MHIS.
CYP mental health liaison in Lincoln and Boston	Recurrent funding from the ICB for Boston MHLS has been agreed via the Urgent Care Delivery Board. Lincoln MHLS is non-recurrently funded and it is a likely a similar business case will need to be drafted and considered to continue supporting urgent and emergency MH attendance at A&E.
MHUAC all-age pathway	Recurrent funding committed for staffing of MHUAC to deliver an all-age pathway. Capital funding in the process of being agreed to create a CYP only space within the existing facility.
Kooth digital online pilot	Non-recurrently funded pilot (regional funding). If agreed to continue in Lincs, we would look to fund recurrently beyond pilot via CYP MH Transformation or MHIS.
Crisis respite	Proposals for a crisis respite provision, jointly-funded by LCC and the ICB, are currently being developed. Capital investment is currently being sought initially; the proposals would include joint revenue funding from LCC/ICB.
Seamless CYP and Adult MH transitions pathways	Recurrent SDF funding is currently being used to fund transition posts, however further transitions work would likely be funded via CYP or Adult Community MH Transformation or MHIS.

- The CYP MH programme has sufficient support from finance colleagues, workforce, digital and business and performance analysis colleagues.
- Primary Care and Education sector support is key to delivery against the CYP MH Transformation Programme, more so for aspects related to improving early identification and access to early intervention, developing mentally healthy community. The CYP Urgent and Emergency Care activity will need to be aligned to the wider UEC pathways and LA plans around development of local residential accommodation for CYP, so will require involvement from LCC and ULHT, for example.
- We are working with the ICB around the health inequalities workstream using a PHM approach to work across MHDLDA, which will involve colleagues from the wider system (population health management, public health, health inequalities, PCNs etc). However, we are making sure health inequalities are considered as part of the CYP MH programme, across all workstream areas

Mental Health & Dementia

Programme: Mental Health - Children and Young People	SRO: Charlotte Gray/Eve Baird	Programme Lead: Kevin Johnson / Amy-Louise Butler	Clinical/Technical Lead: Adaeze Bradshaw

6. What could make or break progress

Financial Investment
- Financial impact e.g. if MHIS is not achieved, which is a minimum expectation.
- Current//future plans presented largely require recurrent investment to be realised.
- Year on year increases in demand require additional capacity requirements through investment.

Workforce
- Lack of available workforce to fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging. Time to train and upskill the workforce is also key here.
- Alternative roles and new roles are being introduced more and more frequently and feature again in planning for 2024/25 and beyond. Non-registered professionals are increasingly being used within workforce models.
- Use of digital continues to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention.
- Parity of CYP MH roles with Adult MH roles requires recurrent investment to support recruitment and retention within CYP services.

System Capacity
- Lack of capacity from system colleagues, such as primary care, to be able to support development and delivery of the workstreams.
- Other parts of the system working in a siloed way, developing competing or cross-cutting pathways or processes, for example, without the opportunity to work together.

Drivers/Policy Changes
- National or local direction of travel may change – post long-term plan expectations/new policy, greater understanding of local needs or future health or social infrastructure changes. Lincolnshire health and social inequalities are a challenge that need to be taken into account.

Interdependencies with Other Key Programmes
- LCC Families First DfE Pathfinder Programme
- LCC Family Hubs Programme
- Integrated Commissioning Strategy for SEND
- Children and Young People's Integrated Transformation Programme
- Community MH Transformation for adults and older adults.

7. Planning assumptions

- Workforce will continue to be challenging to recruit into certain professions such as psychiatry, psychology and nursing posts – using alternative posts to attract and retain staff including rotational posts, Children's Wellbeing Practitioners (CWPs), Clinical Associate Psychologist (CAPs) etc.
- Demand for services will continue to rise – this is evidenced by individual services by year-on-year increases in referrals. If strategies to fully recruit are successful, then investment will currently continue to meet demand for the foreseeable future, given continued growth in areas such as MHSTs.
- We will continue to have an increase in the mental health investment standard (MHIS) each year
- Assumption that local VCFSE organisations are able to support initiatives and 'scale up' in line with transformation plans
- Assumption that we will work together as an Integrated Care System (ICS).

8. Stakeholders

Key stakeholders beyond Lincolnshire County Council (LCC) Children's Services (Lead Commissioner), Lincolnshire Partnership NHS Foundation Trust (Lead Provider) and NHS Lincolnshire ICB include:
- LCC (Public Health)
- LCC (Adult MH Commissioning)
- Education sector
- NHS England
- Lincolnshire Primary Care and Primary Care Network (PCN) Alliance
- Parent/carers and CYP (particularly those with lived experience)
- Voluntary, Community, Faith and Social Enterprise (VCFSE) sector
- United Lincolnshire Hospitals NHS Trust (ULHT)

All stakeholders are engaged to varying degrees in the relevant individual initiatives outlined in this plan, and/or as part of the wider CYP MH Transformation Programme, via the Workstreams or Programme Governance groups.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

1. Future state

As set out in the NHS Planning Guidance for 2023/24 we need to make further progress in delivering the key ambitions in the NHS Long Term Plan and we need to continue transforming for the future. We will also ensure we are strategically aligned with the Joint Forward Plan, LPFT Trust Strategy, Health and Wellbeing Strategy and Better Lives Lincolnshire Plan. The vision is to deliver a five-year roadmap for adults and older adults Mental Health services which is part of the MHDLDA Alliance vision: '*Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'*. We are also working towards the ten-year vision outlined in the No Wrong Door document published by the Centre for Mental Health and NHS Confederation.

We will:

- Work to embed seamless pathways between children and young people's and adults' mental health services to ensure smooth transitions between them
- Continue to improve the range of strength-based community assets for mental health and wellbeing services, helping build resilience and reduce the need for acute, specialist or inpatient services and that there is "no wrong door" to services
- Work to improve access to services for those that do require them, ensuring they are a quality, evidence-based offer
- Ensure that people know how to access help and support that matters to them and respects their needs, assets, wishes and goals
- Reduce the stigma surrounding suicide and ensure a range of provision to support people so as not to lose hope and contemplate suicide as the only option, thereby reducing the rate of suicide in the county
- Ensure that we work together to better understand Lincolnshire's mental health inequalities so that services are needs led and funding is utilised to support services at a locality level through a PHM approach
- Work to embed seamless pathways between adults and older adults' mental health services to ensure smooth transitions between them
- Aim to improve uptake of physical health checks for those with SMI over the next two years, ensuring timely follow up and intervention to reduce the risk of dying prematurely.
- Utilise evidence-based practice to ensure continuous improvement and best outcomes for people, through adherence to the coproduced 'Together We Will' statements.

For the purposes of this programme plan it includes all adults and older adults' mental health and wellbeing provision. It does not include children and young people's plans, except transitions, learning disability and autism/neurodevelopmental or dementia specific programmes, which are detailed in separate plans. We are however ensuring alignment between them through the MHDLDA Alliance which has been formed through core strategic partners.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

2. What's being done to get there | Overview

Prevention and Early Intervention: • Roll out of the Mental Health Prevention Concordat Plan • Continued development of alternative MH crisis provision. and Holistic health for the homeless expansion	The MH Prevention concordat promotes evidence-based planning and commissioning to improve mental health and wellbeing and reduce inequalities. The plan includes 5 domains: Understanding local need and assets; Working together; Taking action on prevention/promotion of MH&WB and to reduce mental health inequalities; Defining success/measuring outcomes; Leadership & Direction. Develop and maintain crisis alternatives provision/ MH support for homeless via expanded HHH Team. JFP Priorities: New relationship with the public; Living well/staying well; Improving Access; Delivering Integrated Community Care
Transformation of Community Services: • Model development • Care provision • Data and outcomes • Workforce • PACT and CRT services • IPS and EIP service improvements • Adult Eating Disorders pathways • Physical Health Checks for those with SMI	Commitment to achieve and embed the LTP objectives including the NHSE Roadmap for community transformation. Plans include: Increased investment into community-based provision targeting those areas most in need around suicide prevention and adult mental health and wellbeing; development of a MH VCFSE strategy – to build resilience, generate volunteering opportunities and improve sustainability of provision; continued investment into primary care roles and developing a primary care strategy to support locality mental health team provision; increase workforce and improve pathways for IPS/EIP services; continued growth of CRT and PACT services; further development of the adult eating disorder pathways including prevention & early intervention; developing local model for SMI Health checks delivery including interventions to support aiming to reduce premature mortality and reduce co-occurring conditions. JFP Priorities: New relationship with the public; Living well/staying well; Improving Access; Delivering Integrated Community Care; Happy and Valued Workforce.
Mental Health Urgent and Emergency care: • MH UEC Pathways review and CRV provision • 111 option 2 service Provision • Boston Liaison service • Options appraisal/business case for East Coast provision • Right Care Right Person (RCRP) Programme	Review of the prevention and early intervention alternatives and acute provision of MH UEC including demand and capacity modelling to ensure seamless pathways are in place; NHS111 to be the first point of contact for anyone in a mental health crisis. Implement a Single Virtual Contact Centre for calls to 111 and 999 and a mandated Interactive Voice Response option (SPA); expanding the MH urgent assessment provision to the east of the county. Introduce Cloud contact centre. Working with Lincs Police and wider stakeholders to implement national RCRP programme. JFP Priority: Improving Access
Inpatient services: • OT and Carer liaison • Out of area reduction • Inpatient review	Continuing to monitor the need for out of area provision and reviewing local inpatient services to improve quality and access for those needing it. Introducing additional roles to ensure therapeutic provision is available. JFP Priorities: Living Well/Staying Well; Happy and Valued Workforce
• NHS Talking therapies: Improve Access and experience • Perinatal Services: Improve Access and experience • Neuropsychology: Remote assessment pathway • Psycho-oncology: Assistant psychologist capacity • ME/CFS Pathway: Increase capacity to meet demand	Increasing workforce within NHS Talking therapies, including supervision & long-term condition pathways, to reduce waits for first and follow-up appointments, looking at digital options. Improving waiting times for perinatal services & ensuring provision meets need. Increase capacity to meet local demand, reduce waiting times & improve patient experience in neuropsychology, psycho-oncology, ME/Chronic Fatigue service design and development. Ensuring model for dual diagnosis meets the needs of the Lincolnshire population. JFP Priority: Improving Access

This will be underpinned by a health inequalities workstream aiming to improve equality, across MHDLDA in Lincolnshire using a Population Health Management approach.

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

3. What's being done to get there - Detail

Work Stream	Initiatives	Milestones	Timing	Lead org	Stakeholders
Prevention and Early Intervention	Mental health prevention concordat plan	Plan progression	March 2025	Public Health	ICB; LPFT
	Crisis alternatives	Provision evaluation/impact; pathway review; options developed	March 2025	ICB	LPFT; VCSE
Community including Transformation Programme	Model development	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC
	Care provision	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC; VCSE
	Data and outcomes	NHSE Roadmap measures of success	March 2024	LPFT	ICB; LCC; VCSE; PC
	Workforce	NHSE Roadmap measures of success	March 2024	LPFT	ICB; VCSE
	Dedicated focused services (CRT, PACT)	NHSE Roadmap measures of success	March 2024	LPFT	ICB
	Adult eating disorders	NHSE Roadmap measures of success	March 2025	LPFT	ICB
	Physical Health checks for those with SMI	Increase uptake; interventions and pathways developed	March 2025	ICB	LPFT; Public Health
	Perinatal, NHS Talking Therapies, IPS, EIP	Access targets; experience of services	March 2025	LPFT	ICB
Inpatient	Out of area reduction	Target achievement	On-going	LPFT	ICB
	Inpatient review/ commissioning framework	Quality improvements identified and in place	March 2025	LPFT	ICB
Urgent and Emergency Care	MH UEC pathway review including Centre for Rape Victims	Recommendations in place	March 2025	LPFT	ICB; ULHT; EMAS
	111 Option 2 pathway	Services developed and mobilised	March 2024	LPFT	ICB; 111
	MH Hospital Liaison Service (Boston)	Service business case developed and approved for investment	March 2025	LPFT	ULHT; ICB
	Right Care Right Person	Pathways identified and agreed; resource in place	March 2025	Lincs Police	LPFT; ICB; LCC
	MH UAC expansion east coast	Service business case; developed service	March 2025	LPFT	ICB; ULHT
Specialist Areas	Neuropsychology: Remote assessment pathway	Service business case developed and approved for investment	April 2024	LPFT	LPFT, ICB
	Psycho-oncology	Service business case developed and approved for investment	April 2024	LPFT	LPFT, ICB
	ME/CFS pathway	Service business case developed and approved for investment	April 2024	LPFT	LPFT, ICB
	Dual Diagnosis	Strategy in place; progress reported	tbc	LPFT, LCC	ICB

Mental Health & Dementia

Programme: Adult Mental Health	SRO: Sarah Connery LPFT; Richard Eccles LICB	Programme leads: ICB: Sara Brine; LPFT: Matt Broughton	Clinical/Technical Leads: Dr Girish Kunigiri; Dr Kaval Patel

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Prevention and Early Intervention	MH prevention plan	No																				
	Crisis alternatives	No																				
Community inc Transformation Programme	Model development	No																				
	Care provision	No																				
	Data and outcomes	No																				
	Workforce	No																				
	CRT & PACT	No																				
	Adult eating disorders	No																				
	SMI Health checks	No																				
	IPS, EIP	No																				
	NHS Talking therapies	No																				
	Perinatal	No																				
Inpatient	Out of area reduction	No																				
	Inpatient review	No																				
Urgent and Emergency Care	UEC pathway R/V	No																				
	111 pathway	No																				
	CRV/EMAS	No																				
	Right Care Right Person	No																				
	MHUAC East expansion	No																				
Specialist Areas	Neuropsychology	No																				
	Psycho-oncology	No																				
	ME/CFS	No																				
	Dual Diagnosis	No																				

Mental Health & Dementia

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4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients & Population	System Partners
Mental health prevention concordat plan	Inequalities are reduced; people are more responsible for their own care; disease burden is reduced. Reduce variation in outcomes of patients receiving interventions	Integrated working across the system.
Crisis alternatives	Reduction in suicide rate. People better supported in communities. Improved self-efficacy.	Reducing number of people with Mental ill health needing to attend A&E, primary care and secondary MH services
ACMH Transformation: Model development and Care provision; Data and outcomes; Workforce Dedicated focused services (CRT, PACT)	Locality MH Teams embedded countywide; Adheres to 6 key principles of co-produced commissioning. Access to holistic practitioners and evidence-based practice embedded. Increased access to psychological therapies, CRT and PACT services for those who need them; Organisations take a personalised approach to care, offering choice to accommodate the wide range of individual needs. Number of people who have had 2 or more contacts with transformed model of care meets LTP target	Greater skill mix in community settings including primary care, community MH Teams and VCSE. MHPs have been recruited in each PCN and are delivering brief interventions where appropriate, working with other PCN based roles to help address the holistic needs of people with complex MH problems & facilitating onward access to mental & physical health & biopsychosocial interventions. A more sustainable VCFSE sector. All PCNs transformed within the NHSE Roadmap definition.
Adult eating disorders	Increased access to AED services across the county providing the right care at the right time in the right place;	Greater skill mix in community settings including primary care, community AED Teams and VCSE All PCNs fully transformed within definition of NHSE Roadmap.
SMI Health checks	People with SMI are offered a comprehensive physical health check every year, with an increasing number taking up the offer and follow-up support; Target to deliver 4507 SMI Physical health Checks by 31.3.24.	Increased capacity to deliver physical health checks available
Perinatal, NHS Talking Therapies, IPS, EIP	Increased access to quality services; CMH services and Talking Therapies/PMH services work collaboratively, to ensure people seeking support are provided with that support; People with a suspected first episode of psychosis can start treatment within 2 weeks of referral; All people aged 14 –65 years can access EIP services, as well as provision and effective pathways for people with an at-risk mental state;	All IPS providers are supported to expand access and are set up to receive referrals from all appropriate sources. Every service user should be able to access suitable evidence-based psychological therapies;
Out of area reduction	More people supported within Lincs; reduced inappropriate adult acute bed days out of area.	

Mental Health & Dementia

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Mental Health & Dementia

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4. Projected impact on patients and system partners

Measures of success will include:

- Increase the number of adults and older adults accessing NHS Talking Therapies treatment
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Work towards eliminating inappropriate adult acute out of area placements
- Improve access to perinatal, EIP and IPS mental health services
- Achieve the local plan trajectory for SMI Health checks by 2025/26
- Improve the outcomes, access and experience for people accessing mental health and wellbeing services in Lincolnshire
- Reduction in waiting times
- Positive service user feedback
- Experts by experience are embedded in everything we do
- ‘Together we will’ statements realised
- JSNA Challenges better addressed
- Benefit realisation of MHDLDA Alliance Priorities

Benefits and impacts of these improvements on system partners include as follows:

- Anticipated reduction in A&E attendances in Boston where mental ill health is the only presenting condition
- Reduced impact on Police having to convey patients, freeing up policing time and improving productivity
- Anticipated reduction in Primary Care presentations for mental health and wellbeing concerns and/or more community-based provision available to provide support
- Increased uptake of SMI Health checks which may increase numbers requiring intervention or support but will ultimately aim to reduce co-occurring conditions and improve the risk of dying prematurely
- Continued increase in investment into the VCFSE, supporting resilience and sustainability
- Reduction in demand on certain secondary care mental health services so that they are able to provide responsive (reduced waiting times) and high-quality services giving good clinical outcomes for patients
- Positive experiences for patients, families and carers.
- Reduction in waiting times
- No wrong door
- Reduction of caseloads in secondary care so more time can be spent with people that require it
- Left shift to prevention and improvement in self-efficacy

Mental Health & Dementia

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5. What's needed to make this happen

- There are a number of schemes above which require additional financial resource which will go through the MHDLDA planning process for prioritisation and will be identified where possible within the MHIS.
- The programme has sufficient support from finance colleagues, workforce, digital and business and performance analysis colleagues.
- Primary Care support is key to delivery against the community transformation programme elements including adult eating disorders pathways and SMI Health checks programmes, in particular. The MH UEC pathway review will need to be aligned to the wider UEC pathways and require involvement from ULHT and EMAS, for example. The 111 workstream initiative is part of a national programme roll out but will impact on the incumbent provider (DHU).
- We are developing our own health inequalities workstream using a PHM approach to work across MHDLDA but will involve colleagues from the wider system (population health management, public health, health inequalities, PCNs etc) to ensure synergy and integrated working for maximum outcomes.

6. What could make or break progress

Financial Investment

- Financial impact e.g. if MHIS is not achieved, which is a minimum expectation.
- Plans presented largely require investment to be realised.
- Productivity gains have been made for many years through various initiatives such as skill mixing, digital options and more recently outsourcing opportunities, however year on year increases in demand require additional capacity requirements through investment.

Workforce

- Lack of available workforce to fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging. Time to train & upskill the workforce is also key
- Alternative roles and new roles are being introduced more and more frequently and feature again in planning for 2024/25 and beyond. Non-registered professionals are increasingly being used within workforce models.
- Use of digital continues to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention. Plans for the Neuropsychology remote assessment pathway typify this.

System Capacity

- Lack of capacity from system colleagues, such as primary care, to be able to support development and delivery of the workstreams
- Other parts of the system working in a siloed way, developing competing or cross-cutting pathways or processes, for example, without the opportunity to work together.
- Working in a siloed way such as system interoperability.

Drivers/Policy Changes

- National or local direction of travel may change – post long term plan expectations/new policy, greater understanding of local needs or future health or social infrastructure changes.
- Lincolnshire health and social inequalities are a challenge that need to be taken into account.

Mitigations include:

- Prioritisation process determined by MHDLDA process based on core pre-agreed principles so funding will be determined over a phased approach
- A range of skill mix, retention and staff wellbeing initiatives are in place to recruit and support workforce
- Integrated working opportunities with system partners in a more proactive way to avoid siloed working
- Working closely with NHSE colleagues to understand national direction of travel and priorities to ensure plans are responsive and timely

Mental Health & Dementia

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7. Planning assumptions

- Workforce will continue to be challenging to recruit into certain professions such as psychiatry, psychology and nursing posts, although alternative roles are being considered, attraction initiatives are being explored and skill mix is being embedded
- Demand for services will continue to rise – this is evidenced by individual services by year-on-year increases in referrals – a demand and capacity exercise is being undertaken across divisions to understand this better
- We will continue to have an increase in the mental health investment standard and will be able to invest at least this amount as a minimum each year
- Assumption that local VCFSE organisations are able to support initiatives and 'scale up' in line with transformation plans – support is proposed to be put in place to provide a sounder and more stable VCFSE sector, with a MH VCFSE strategy in development
- Assumption that outsourcing of some activity will continue, for example NHS Talking Therapies. This will be subject to available, evidence-based alternatives
- Assumption that we will work together as an integrated care system, as per the system planning provider alignment working groups.

8. Stakeholders

- ICB
- LPFT
- LCC
- VCSE
- Primary care
- Public health
- ULHT
- EMAS
- 111

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

1. Future state

The pending Major Conditions Strategy will aim to improve health outcomes and better meet the health and wellbeing needs of local populations. The strategy will recognise challenges facing society, specifically around multimorbidity in ageing populations. The strategic framework, which will underpin the final strategy, focuses action on:

- Primary prevention: acting across the population to reduce risk of disease
- Secondary prevention: halting progression of conditions or risk factors for an individual.
- Early diagnosis: to identify health conditions early, to make treatment quicker and easier.
- Prompt and urgent care: treating conditions before they become crises
- Long term care and treatment in both NHS and social care settings

We want to develop a Dementia Strategy for Lincolnshire- that will have a key focus on prevention of avoidable cases of dementia, improving experience of people being diagnosed and living with dementia and championing participation, innovation, and research.

The vision for the Dementia Programme is to work in partnership; Promote person-centred coordinated care and support, ensure access to information, advice and health and care services, and that this supports of all those living with dementia and their carers when and where they need it. Early identification of people with memory concerns, and ensure waiting times for assessment are timely, fair, and equitable across all our communities. That all people have access to information and advice to age well and reduce their risk of dementia.

Dementia is the leading causes of death in England and Wales in 2022. Dementia has a profound impact on the person with dementia's life, their family, and friends and the communities in which they live. Although age is the strongest known risk factor for dementia, dementia does not exclusively affect older people. Young onset dementia (defined as the onset of symptoms before the age of 65 years) accounts for up to 9% of cases.

Early detection, diagnosis and intervention can also lead to improved treatment and quality of life outcomes that delay onset of complex needs and institutionalisation.

Nationally there are 900,000 people living with dementia in the UK, and by 2025 it is expected that there will be over 1 million people living with dementia and by 2040 this could be 1.6 million.

In Lincolnshire there are currently 8300 people living with a confirmed diagnosis of Dementia, with 7948 (95.8%) people being 65+ the average age being 82, of this number there are 5829 (72%) of people that have Comorbidities, and there are also 352 (4.2%) people in Lincolnshire that have young onset dementia (under the age of 65). Dementia prevalence is predicted to increase across Lincolnshire in all districts over the next 5 years, and based on the projections provided by POPPI, in Lincolnshire the population is expected to grow by 11% by 2041, with 30% of the population to be over 65.

There are 1873 people in Lincolnshire that are identified as having a Mild Cognitive Impairment (MCI); Patients without a Dementia Diagnosis. Follow up by the GP is not mandatory, but there is an opportunity to do some focused work with people to make informed lifestyle choices to prevent and delay the progression to dementia, and to identify any other underlying causes for memory loss.

Research shows that supporting brain health and reducing dementia risk is not only the right thing to do – it could also save money for the public purse. Preventing dementia by targeting just three specific risk factors – tackling high blood pressure, providing hearing aids, and helping people to quit smoking – could save the economy £1.9 billion per year and reduce the number of cases of dementia by nearly 10%. Only 34% of UK adults think it's possible to reduce their risk of dementia. Health and care professionals can promote evidence-based messages to middle-aged adults to help reduce their risk of getting dementia.

There are national requirements to improve Dementia Diagnosis Rate (DDR). The current DDR for Lincolnshire is 65% in comparison with the national standard of 66.7%.

Reduction of inappropriate Antipsychotic (AP) prescribing for people with dementia, to be restored to pre-covid levels - NHSEI Target, this increased during covid, Lincolnshire ICS to be under/in line with National average and not an outlier.

For purposes of this programme, it includes all people diagnosed with dementia, carers, people with mild cognitive impairment, people at risk of developing dementia, which includes people with a learning disability and autism, it does not include adults or older adults with mental health, or frailty, which are detailed in separate plans. However, there will be overlaps that we will ensure there is alignment between them through the MHDLDA Alliance which has been formed through core strategic partners.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

2. What's being done to get there | Overview

Dementia Strategy development-

- The approach to developing the strategy has been to have conversations with people with dementia, their carers, those who live in Lincolnshire and our partners in health, social care the Voluntary, Community and Social Enterprise (VCSE), about their experience of health and care services and the impact of covid, what we should focus on to improve the care and support we provide. We have discussed all areas of dementia care, from activities aimed at preventing dementia, through to care at the end of people's lives.
- Co-production and Engagement with the people of Lincolnshire is fundamental to the development of dementia care pathways and support to empower all people affected by dementia this will continue through the life of the strategy.
- The strategy will be finalised and be launched at the beginning of 2024, a delivery plan for the strategy will be developed and will include clear actions to ensure that we achieve the changes required to improve dementia care and support for people affected by dementia, including clear information, advice, and support on reducing the risk of getting dementia.
- The following areas of work have been identified as things we need to do, whilst developing the new strategy for Lincolnshire once in place there will be other actions required to ensure we continue to make improvements needed.

Prevention

- Focused prevention programme aimed at raising awareness of the importance of good brain health across all age and reducing the risk of dementia. Encouraging people to take up the offer of health checks. Utilising health inequalities data to support delivery.
- Even though there is no cure for dementia the most recent updated study on dementia prevention published (Lancet, 2020) found that around 40% of dementia cases worldwide might be attributable to 12 potentially modifiable risk factors. As such a proportion of predicted dementia is potentially preventable, by tackling the identified risk factors that we can change, such as smoking, diet, physical activity, and social isolation.
- Smoking is one of the biggest risk factors for dementia and can double an individual's risk, because it causes narrowing of blood vessels in the heart and brain, and oxidative stress, which damages the brain.

Primary Care

- DDR Target: Nationally mandated DDR target of 66.7% - Lincolnshire DDR average is at 65%, primary care are looking at ways of working that will improve diagnosis and the DDR target for Lincolnshire. DDR Task and finish Group recently established. Review and develop the dementia pathway/s to support people identified with Mild Cognitive Impairment (MCI).
- Antipsychotic Medication*:* Reduction of inappropriate Antipsychotic (AP) prescribing for people with dementia. Lincolnshire ICS to be under or in line with National average. Appropriate use of antipsychotic mediation and use of Nonpharmacological treatment
- All people diagnosed having a health care plan and care plan medication review in the preceding 12 months

Lincolnshire Partnership NHS Foundation Trust (LPFT) Memory Assessment Service

- To have a standalone memory assessment service (MAS) for Lincolnshire. LPFT memory assessment services benchmarked regionally via NHSEI MAS audit. Feedback from that identified LPFT MAS as an outlier for being delivered within generic Community Mental Health (CMHT) model, rather than as a stand-alone service function.
- Demands of Older Peoples CMHT continue to rise year on year in-line with known predictive demographics of Lincolnshire as an ageing county. Lincolnshire currently has circa 180,000 + over 65s. This is predicted (Office National Statistics) to increase by 46% to 250,000 by 2041.
- People will receive faster diagnosis and this development would also support County Wide DDR attainment and associated QoF levels for GPs.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

2. What's being done to get there | Overview

Dementia (Memory) Support Service

- Assess the need for service and identify priorities and future service requirement and procurement for the current Dementia Support Service for Lincolnshire. Lincolnshire County Council Commission the 'Dementia Support Service' for Lincolnshire, the service is due to come to the end of its contract in October 2024.
- The system in Lincolnshire undertook a multi-agency review of the Dementia pathway and support services in 2021, this was given to the rise in demand, cost, and the ageing population. One of the key recommendations for this was to have a pathway wide 'One Stop Shop' dementia support service to be developed as a single point of access. Consideration of the findings and recommendations of the report will need to be taken account of in this review.
- There is now an opportunity for system partners including VCSE to work collaboratively to consider the options available to support an appropriate pathway for dementia in Lincolnshire that will meet the needs of the population. This needs to include options for where this may need to be an integrated service (no wrong door) and how this will be funded.
  - Ensure appropriate peri-diagnostic support and care planning is available for all those with dementia, to avoid crisis and unnecessary hospital admissions.
  - Ensure dementia services are appropriately resourced and sufficient to meet dementia related population health and care need.

Complex Dementia – managing challenging behaviour (all settings)

- Improved offer of support for carers and care staff to support people with challenging behaviour, to develop protocols to support managing challenging behaviour in all settings across Lincolnshire, people with complex dementia to have improved health and care outcomes, and improve support for the workforce with awareness, advice, training.
  - To implement the role of Dementia Ambassadors in care homes
  - Appropriate use of antipsychotic mediation and use of Non pharma logical treatment
  - Improved offer of support for carers and care staff to manage challenging behaviour.

Palliative and End of life Care (PEoLC)

- Promote care planning whilst people can communicate their needs and wishes, to increase awareness that dementia can reduce life expectancy, supporting people to complete an advanced care plan and ReSPECT (Recommended Summary Plan for Emergency Treatment and Care) form. Increased number of people with dementia dying at their usual place of residence.

Developing specialist Young Onset Dementia (YOD) pathway for Lincolnshire

- New Pathway to be implemented*:* To ensure timely and appropriate diagnosis and support the development of age-appropriate support and care for people including information, resources and advice on the issues specifically faced by working age adults, that can help them remain active and living well in the community.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

To note: The new strategy with its delivery plan will have a clear project plan encompassing the workstreams below that will set out key deliverables and milestones, the Dementia programme board will have responsibility to oversee this.

Dementia Strategy development:

- We have spent a period of time having conversations and working with to people with dementia, their carers, and families and our partners in health, social care the VCSE sector, about their experience if health and care including the impact of covid, this has been this has been to help us establish our goals and identify what actions we need to take to improve the care and support we provide to people, so far we have used what people have told us to develop the draft goals for the strategy and we will continue to work collaborative to finalise the strategy.
- Completed a period of engagement on the draft strategy goals with system partners, people affected by dementia including Dementia UK and the Alzheimer's Society this will be reviewed to further develop the final draft strategy.
- Members of the Dementia programme Board (DPB) and people with lived experience are working together with the population health management team to develop a logic model identifying our activities and outputs including long/medium/short-term outcomes for the strategy delivery plan, utilising the intelligence/data to support this work.
- We are working with DAAs/DFCs this is to re-establish themselves to form a Dementia Network for Lincolnshire and be part of the DPB, these groups pay a pivotal role in our communities to improve local support and access to services for people and will support development and delivery of the dementia strategy action plan.
- Every-One have been and continue to support development of the strategy by supporting people to share their experience and have their voices heard, they are establishing a network of people with lived experience to work collaboratively with the DPB to identify opportunities for coproduction and codesigning service.

Prevention

Task and Finish group established with the following remit of work.

- Developing information and advice for people on preventing avoidable dementia encouraging people to age well,
- Highlighting the 12 modifiable diseases that increase the risk of dementia by embedding this into other associated public health campaigns.
- Raising awareness across the life course of what's good for the heart is good for the brain by developing a resource of video/animations, and marketing campaign, this will be accessible for the public and for professionals to use across health, care, and education. A quotation/tender exercise has started to find an organisation to develop the brief for the animations.
- Review and develop protocols to encourage uptake of NHS health checks and ensure risks associated with dementia including early signs of dementia are recognised ensuring appropriate advice and support is available.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

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Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
New Joint Dementia Strategy JFP: PRIORITY 1: A new relationship with the public	Strategy - co-produced.	Coproduced final draft strategy.	Jan 24	LPFT	LCC/Every-one/ICB/VCSE/DPB
		Governance process to sign off Strategy.	Feb 24		
		Launch Strategy	Mar 24		
	Logic model developed	Completed logic model encompassed into strategy	Feb 24	LPFT	ICB
	Establish baselines for data and metrics	Data sets for Dementia	Feb 24	Arden Gem	LPFT/ICB
		Develop a dashboard for data	Feb 24	Arden Gem	
	Reset the Dementia Programme Board – Board focus.	TOR for the dementia Core Dementia team and the Dementia Programme Board	Feb 24	LPFT	ICB/ULHT/LCHS/VCSE
		Reset membership for the DPB	Feb 24		
	Dementia Network for Lincolnshire	DAAs/DFCs re-established.	Mar 24	DAAs/DFCs	LPFT /ICB
		Dementia Network for Lincolnshire and be part of the DPB	Feb 24	DAAs/DFCs	
	Coproduction people with lived experience.	Established a network of people with lived experience	Feb 24	LPFT	DPB/LCC/Every-one/ICB/VCSE
	Delivery Action plan – coproduced	Delivery Plan implemented	Apr 24		
	Project Management tool and metrics developed	Metrics set and dashboard developed	Apr 24		
Prevention Offer for Dementia JFP: PRIORITY 1: A new relationship with the public PRIORITY 2: Living well and staying well	Prevention - Task and finish group - Focused prevention programme raising awareness of the importance of good brain health across all age and reducing the risk of dementia.	Plan developed to identify prevention offer to reduce the risk of dementia.	Sep 23	LPFT	LPFT/LCC/ICB/PCN/VCSE
		Information & advice available for use across the system - preventing avoidable dementia and ageing well.	Apr 24		
		12 modifiable risks that increase the risk of dementia embedded into other associated public health campaigns.	Apr 24		
	What's Good for the Heart is Good for the Brain-Universal bespoke resource	Animation resource developed.	April 24		
		Marketing plan developed	Apr 24		
	Health Checks – increased number of HC and information on what to expect.	Info available on health checks inclusive of risks for dementia	Mar 24		
	Health Checks - ensure risks associated with dementia including early signs of dementia are recognised ensuring appropriate advice and support is available.	Assessment guidance/training available for practitioners carrying out HC.	July 24		
		Plan developed to incentivise GPs undertaking health checks	July 24		

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
DDR Target to be improved. JFP: PRIORITY 3: Improving access	Diagnosis - Care Homes (DiADeM assessment). EHCH work programme develop process supporting and increasing the use of DiADeM tool in care homes tool including potential development dementia ambassador's programme.	Embedded as part of the primary care dementia pathway for patients with advanced/severe presentation of dementia in care homes.	July 24	PCN (Support by ICB	LPFT/PCNs/LinCA/LCC
		Test project in one PCN area to establish a clear process and measure impact. Pilot lead by Frailty Nurse Specialist as part of the Lincolnshire Health Partnership PCN Enhanced Health in Care Home (EHCH) Team.	Apr 24		
		The pilot written up and presented at PCN Alliance to support rolling out across PCNs in Lincolnshire care homes.	May 24		
		The Dementia Assessment Referral to GP (DeAR GP) promoted, Care Homes to identify people who are showing signs of dementia.	Mar 24		
	Improve number of people diagnosed.	DDR Task and finish Group	Oct 23	PCN (support by ICB)	ICB/PCNs/LPFT/ Arden Gem
		Implemented pathway and road map for people with MCI	Oct 24		
		All practices provided with the information about the dementia quality toolkit (DQT) available on both EMIS and SystmOne and advised to run this annually	Oct 23		
		Annual review - patients with mild cognitive impairment (MCI) has been embedded as part the locally developed primary care dementia pathway and MCI annual follow up	Oct 24		
		GP handbook produced and launched across primary care - support case finding/MCI referral.	Jan 24	PCN (support by ICB)	
		Primary Care - All people diagnosed having a care plan and care plan medication review in the preceding 12 months.	Dec 24	PCN (support by ICB) /LPFT	
		NHS digital primary care dementia data and local data sets dashboard produced	Jan 24	Arden Gem	

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
LPFT Memory Assessment Service JFP: PRIORITY 3: Improving access	Standalone Memory Assessment Management Service reduce the waiting time for memory assessment appointment and diagnosis	Fully costed business case submitted.	Nov 23	LPFT	ICB/PCNs
		Project plan considering outcome from the BC	Apr 24	LPFT	
		Provision of memory clinics within GP surgeries	Mar 24	LPFT	
Dementia (Memory) Support Service JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Assess the need for service and identify priorities and future service requirement and procurement for the current Dementia Support Service for Lincolnshire.	Plan established for the 'Dementia Support Service' review.	Oct 26	LCC	LPFT/ICB/VCSE/ PWLE

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Antipsychotic Medication - Appropriate use of antipsychotic mediation and use of Non pharma logical treatment JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	In line with the National priority, a cross organisational task and finish group (LPFT, ICS, Primary Care, Arden Gem) has been running and has reduced AP prescribing in dementia back to the targeted pre-pandemic levels. Lincolnshire ICS to be under/in line with National average and not an outlier BPSD pathways reviewed and updated (NICE guidance, including AP prescribing)	AP Task and Finish Group established.	Sep 23	MMO (ICB)	PCN/LPFT
		Audits across primary care and care homes to identify where and why medication was initiated, frequency and quality of mediation reviews.	Nov 23		
		Secondary care BPSD Pathway – aligned to PC pathway. Updating pathways and non-pharmacological options/actions.	Feb 24		
		Primary care BPSD > CD + PC Clinical lead.	Oct 23		
		Refocus key ethos of AP review. Clear down-titration process/protocol (linked to 6-week review).	Oct 23		
		Clear GP discharge information standards. Review, discontinuation & re-access processes.	Oct 23		
		Digital Quality Outcomes framework	Nov 23		
		Reduction of antipsychotic medication restored to pre pandemic levels - Data from NHS digital	Apr 24		
Complex Dementia – managing challenging behaviour all settings. JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Review and develop education and training programmes	To implement the role of Dementia ambassadors in care homes	Aug 24	LPFT/LCC	ICB/LCC/LinCA/Arden Gem
		Education and training resource available.	Oct 24		
		Increased number of staff accessing training and a qualified upskilled workforce.	Dec 24		
	Cross organisational task and finish group for the appropriate use of Antipsychotic Medication detailed plan to manage this to better and support people with dementia and people in caring roles to manage challenging behaviour.	Reduction of the number of people being inappropriately admitted to hospital - PHM Data	Dec 24		
	The recovery college and carers developing training to support carers in their caring roles.	Improved offer of training and support for carers to manage challenging behaviour.	Dec 24		

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

3. What's being done to get there | Detail

Workstreams	Initiatives	Milestones	Timing	Lead Org	Stakeholders
Palliative and End of Life JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Review the Palliative and End of Life Care offer to support people with dementia, PEOL Delivery Group to agree how to strengthen the PEOL offer for people with dementia. Enhanced Health in Care Homes is dedicated to improving PEOL for people in care homes of which dementia patients are covered	Improved identification of people that are at end of life	Oct 24	PEOL delivery group (ICB)	ICB/LPFT/ULHT/ PCNs
		Improved offer of palliative care for people living with dementia	Oct 24		
		Increased number of people with Advanced Care Plan and with a ReSPECT form. NHS digital primary care dementia data	Dec 24		
		Increased number of people with dementia dying at their usual place of residence. NHS digital primary care dementia data	Dec 24		
	Competence framework to be developed in personalised palliative and end of life care across all care settings – including care professionals, unpaid carers, and volunteers.	Training programmes support staff and carers	Dec 24	PEOL delivery group (ICB)	
	PHM robust data -	Baseline established and data set for monitoring and reporting	Mar 24	Arden Gem	
Specialist Young Onset Dementia (YOD) pathway for Lincolnshire. JFP: PRIORITY 3: Improving access PRIORITY 4: Integrated community care	Develop dementia diagnosis and support pathway for working age adults (<65)	Working group established to resume.	Jan 24	LPFT	PCNs/VSCE/ PWLE
		New Pathway established and implemented.	Dec 24		

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q 4
	Dementia Strategy																					
Dementia	Prevention agenda	No																				
Dementia	DDR Target	No																				
Dementia	Antipsychotic Medication	No																				
Dementia	Memory Assessment Service	No																				
Dementia	Dementia (Memory) Support Service	No																				
Dementia	Complex Dementia – managing challenging behaviour (all settings)	No																				
Dementia	Palliative and End of life Care (PEoLC)	No																				
Dementia	Develop specialist Young Onset Dementia (YOD) pathway for Lincolnshire	No																				

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

4. Projected impact on patients and system partners

There is strong strategic alignment with Joint Health and Wellbeing Strategy and the MHDLDA Alliance which prioritises dementia as areas for development and improvement.

Initiative	Benefits	System Partners
Dementia Strategy	• Clear vision and priorities for Lincolnshire to improve dementia support for the people of Lincolnshire. • People are aware of what we will be doing to achieve our delivery plan. • Opportunities of people to coproduce and design service. • Raise awareness and understand dementia better and encourage people to seek help. • Reduce people's fear and misunderstanding of people with dementia. treatment, care and support as needed after the diagnosis.	• Strategic direction for all partners • Clear delivery plan that can be measured and evaluated. • Professionals will be more aware of dementia and will understand dementia better. • Give clarity on treatment, care and support as needed before and after the diagnosis.
Prevention agenda	• People better informed on the modifiable risk factors and what they can do to self-care and reduce their risk of developing dementia. • Targeted supported for people who may be at risk and actively promote physical activity and exercise interventions. • Improved access to health checks and services that can advise and support on preventative measures.	• Increase the number of people having a health check. • Education for GPs and practitioners on the 12 modifiable risk factors, in carrying out health checks. • Reduced demand on statutory services. • Identification of high-risk groups to increase social, cognitive, and physical activity, and vascular health.
DDR Target	• Patients will receive faster diagnosis. • Timely diagnosis means that patients are not waiting as long, which in turn reduces their (and their families) anxiety and can lessen impact on wider health and care services, for example on primary care. • Equitable service and wait times across all district's groups and communities, taking account of health inequalities	• DDR exceeding national target of 66.7% Lincolnshire 65.1% • County Wide DDR attainment and associated QoF levels/payments to GP's. • Reduced demand on statutory services.
Reduction in the use of Antipsychotic Medication	• Reduce the risk of falls and stroke. • Improved cognition • Improved mobility	• Reduction of antipsychotic medication restored to pre pandemic levels - Data from NHS digital. • Reduce the number of patients on anti-psychotics, National average 9% Lincolnshire 8.8% currently. • Reducing hospital admissions

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

4. Projected impact on patients and system partners

Initiative	Benefits	System Partners
Memory Assessment Service	• Early detection, diagnosis and intervention can also lead to improved treatment and quality of life outcomes that delay onset of complex needs and institutionalisation. • Increased diagnosis rates are central to access for post-diagnostic support and planning for dementia. This is inclusive of advanced care and treatment decisions that can impact down-stream service use and access. • Timely intervention and treatment resulting in better outcomes; Ensures co-morbid conditions are recognised and treated. • Education programmes for carers and people who receive the diagnosis	• Reduce unnecessary attendance A&E and hospital admission which can be stressful for the person with dementia, • Staff have skills to support more complex dementia diagnostic. • Development of skills and pathways required for more complex dementia diagnostic groups such as young-onset dementia, dementia in Parkinson's disease/Learning Disabilities/Huntington's disease etc. that currently go under-served and can lead to out of area expenditure and resource usage. • Reduced demand on statutory services. • Increased number of staff available to support people accessing dementia assessment. • Improved recruitment and retention of staff • Reduce caseloads for CMHT
Dementia (Memory) Support Service	• Ensures people with dementia and relatives are aware of appropriate services and support which might extend independent living. • Increased access to the right support at a time when needed. • No wrong door approach -system work better together.	• Reduced demand on statutory services. • Improved resource and support in the system • Knowledge of services available to signpost and support people
Complex Dementia – managing challenging behaviour (all settings)	• People being cared for competently and compassionately in their usual place of residence. • Carers better able to continue their caring role. • Carers and unpaid carers are adequately supported to continue to care for the person in their usual place of residence. • Carer training/awareness on understanding behaviours and how to manage.	• Reduce unnecessary attendance A&E and hospital admission. • Local health and care partners – including staff from Primary Care Networks – working in a more joined-up way, through sharing information and working as one multi-disciplinary team. • Improved recruitment and retention of the workforce, that have to skills needed to support people with dementia. • Upskilled workforce – competent and confident • Support within the system for the workforce to manage difficult dementia behaviours
Palliative and End of life Care (PEoLC)	• Palliative support available from the point of diagnosis that includes people having the right support when it is needed and at the end of life • People and families, being able to live good lives and be independent for longer. • Remain closer to loved ones. • Receive one-to-one support. • Cared for by specialists. • Personalised symptom relief. • Peace of mind for the family.	• Less crises and reduced hospital admissions • Better planning and use of system resources • NHS digital primary care dementia data • Increased number of people with dementia dying at their usual place of residence. • Increased number of people with Advanced Care Plan and with a ReSPECT form.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

4. Projected impact on patients and system partners

Measures of success	Baseline Date	Current – Oct 2023 unless stated	Target 27/28
Increase in DDR	Oct 2023	65.1%	66.7%
Improve the DDR in practices in the Rural Group 80% and over	Oct 2023	55.2% average DDR	66.7%
Reduce the disparity in diagnosis between the 4 localities	Oct 2023	Locality Data: West (70.6), South (64.9%), Southwest (62.5), East (62.3%),	66.7%
Follow up and identify those with an MCI (Memory and Cognitive Problems)	Oct 2023	1873 (MCI) Lincs Rate Per 1000 9.8 England Rate per 1000 12.6 Prevent/Reduce the likelihood of those with an MCI from being diagnosed with dementia?	Plan in place to identify and support those with an MCI at each practice.
Follow up and identify those with Memory and Cognitive Problems (50-65)	Aug 23	4613	Plan in place to identify and support those with a Memory and Cognitive problem at each practice.
Increase in Health Check 5 year (50-65)	Aug 2023	64,419/172,289 (37.3%)	50%
Decrease of average time to assessment	Nov 2023	14.29 weeks	6 weeks
Decrease in the average time to diagnosis.	Nov 2023	23.25 weeks	Year on year reduction
Reduction in the waiting List (MAMs)	Oct 2023	1,400 – 1,600	200
Primary Care - Increase in the number of Dementia Care Plans	Oct 2023	2732	Maintain performance in line with or above the England Average
Primary Care - % Care Plan	Oct 2023	Lincolnshire 57%, England Average 59.9%	Maintain performance in line with or above the England Average
Increase in the number of Medication Reviews	Oct 2023	4761	Maintain performance in line with or above the England Average
Primary Care - % Care Plan and Medication Reviews	Oct 2023	Lincolnshire 33%, England Average 32.1% (QAF Indicator)	Maintain performance in line with or above the England Average
Reduction in Anti-Psychotic Prescribing	Oct 2023	Lincs 8.84%, England Average 8.8%	Maintain performance in line with or below the England Average - lower is better
Increase in people with advanced Care Plan & ReSPECT form	Aug 2023	35.6%	Year on year increase
Palliative Care (% of registered Dementia)	Oct 2023	Lincs 20% England 18%	In line with or above the England Average
Increase in those with dementia diagnosed in Nursing Homes	Oct 2023	Lincs 2% National Average 8.1% - Aug 2023	In line with or above the England Average
Review ethnicity data, those with a dementia diagnosis recorded as not defined is very high – highest in the Midlands	Nov 23	41.8% of all diagnosis recorded as not defined. 63/8138 were BAME (0.77%)	In line with the Midlands Average – Best performance Stoke on Trent and Staffordshire 0.2% not defined.

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

5. What's needed to make this happen

Initiative	Contributors	Enablers	Resource
Dementia Strategy	All System Partners	HEAT Plan Baseline data for Dementia – Dashboard Logic Model - clear metrics Active executive support Active engagement with people with lived experience on service design Opportunities for cases for change – Business plans Early risk analysis and ongoing risk management, Evaluation plan	Parity of investment – financial and non-financial
Prevention agenda	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils	HI, PHM data	Funding; Committed Staff resource. Clear programme of priorities Integrated working for maximum outcomes
DDR Target	LPFT, PCNS	Standalone memory service Workforce DDR Data Sets and MCI Data	Integrated working for maximum outcomes
Reduction in prescribing Antipsychotic Medication	LPFT, PCNS	Education and training plan PHM Data sets	
Memory Assessment Service	ICB, LPFT, PCNs	Workforce Digital programme – tools Specialist support Active engagement with people with lived experience on service design HEAT Plan	Funding Workforce
Dementia (Memory) Support Service	LCC, All System Partners	HEAT Plan VCSE; Workforce Active engagement with people with lived experience on service design	Pooled funding to offer a one stop shop. VCSE investment Commissioning
Complex Dementia – managing challenging behaviour (all settings)	LPFT, ULHT, LCHS, LCC, LiNCA	Workforce; Education and Training Plan Active engagement with people with lived experience on service design Dementia Ambassadors	Workforce Funding
Palliative and End of life Care (PEOL)	ULHT, LCHS, Palliative Service (St Barnabas)	Specialist workforce; Education and Training Plan Active engagement with people with lived experience on service design	Possible funding – to assess needs. Workforce

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

6. What could make or break progress

Interdependencies

Other programmes and organisations that support the success of the Dementia Programme:
Frailty Programme; Adult MH programme; Personalisation programme; Digital Programme; EHCH delivery group; PEOL delivery group; LCC/ICB/ULHT/LCHS/VCSE; DAA/DFCs

Risks

Risks/Challenges	Mitigation
Funding: Business case for funding a standalone memory service unsuccessful People continue to wait longer for memory assessment/waiting list grow Access to new treatments when available delayed (outcomes for patients are maximised with early detection, diagnosis, and treatment.) Carers unable to cope with supporting the person with memory issues	Review current memory services resource and restructure where possible to improve offer for memory assessment.
	Memory clinics in communities (GP surgeries, village halls)
	Explore opportunities for funding to increase staffing needed to support memory services
	Work with the EHCH programme to increase the use of DiADem tool in care homes
	Work with people who have lived experience to develop service design to meet needs
	Carer support services aware of needs of people caring for someone with dementia – including mental health services support, case for change – business case developed
Recognising the importance of the VCSE sector, VCSE unable to provide that level of resources required across the county without investment from health and social care.	Work with partners/commissioners to map and identify gaps in services and what's needed to support people in their communities, to give clarity and guidance to the sector (LCC Market Position Statement)
	Work with DAAs and DFCS to gain support to from communities and identify barriers to access service and support, ensure they are part if the DPB
	Work with DPB/colleagues to complete business cases for investment/support changes needed and agree escalation routes
	Identify funding opportunities both non-recurrent and recurrent, signpost and support the VCSE sector and groups to apply
	Support VCSE to diversify and system to share knowledge and skills within the sector (provision of training)
Transport and housing being inadequate to serve our communities, to ensure access to hospital appointments, support and services needed is fair and equitable. Ensure that people with dementia can live independent at home for longer and feel safe, supporting dementia friendly communities. Getting to hospitals is particularly difficult for people without a car or who are living in places with inadequate public transport options. This lack of access can lead to missed health appointments and associated delays in medical interventions both of which limit their ability to access public transport and to travel longer distances to reach specialised health services and hospitals.	Work with Health Inequalities Team to identify inequalities for Lincolnshire and map these to support the dementia programme, include metrics to measure the impact and share with colleagues in housing and transport
	Work with partners in housing and transport and share information on inequalities and explore options to improve access and accommodation that is adequate/appropriate.
	Work with health colleagues to improve access to services for rural and deprived communities and people from BAME, farming and traveller communities
	HEAT tool to be developed and used to support the delivery of changes to be made

Mental Health & Dementia

Programme: Dementia	SRO: Paula Jelly	Programme lead: Gina Thompson	Clinical/Technical Lead: Collins Esiwe

7. Planning assumptions

- Reduced waiting times for assessment and diagnosis, reduced waiting lists, people have an advanced care plan increases, early intervention for people diagnosed with dementia or that have MCI, reduced staff caseloads, sickness and retention of staff is stable - investment and funding are made available – development of a standalone MAMs services and community assets to support people waiting a diagnosis.
- Increased staffing levels for dedicated resource for dementia assessments, will need to work with other services on current staffing needs and resources available.
- Demands of older people mental health and dementia services continues to rise year on year in-line with known predictive demographics of Lincolnshire as an aging county and this will require additional capacity requirements through investment. Will need to work with public health partners to address wider health needs and prevention strategies to reduce the need for services and promote better self-care.
- Staff will have the competency to support people living with dementia -education and training for staff to support them to feel valued and confident in their roles, work with colleagues in the system to share skills and knowledge across partners and develop a resource for workforce competencies and education/training plan, have dementia ambassadors available across the county, fulfil recruitment intentions. This is a particular challenge in certain types of registered professions, but also in certain parts of the county (East Coast) where recruitment can be more challenging.
- Recruitment of staff in LPFT, and recruitment and retention in the care sector, skills to manage complex dementia.
- Use of digital will continue to be a focus in terms of both productivity but also as a mechanism to support recruitment and retention.
- People living in care homes having a diagnosis and have support available that meets their needs, support primary care to case find and identify capacity in PCNs to diagnose advanced dementia in the community via Diadem.
- National or local direction of travel may change greater understanding of local needs or future health or social infrastructure changes to be able to future forecast and plan services/finances, work to continue with colleagues in health inequalities and PHM team to develop the logic model and identify the priorities for the dementia programme and develop and dashboard for measuring this.

8. Stakeholders

Initiative	Stakeholders	Key People (more to be confirmed)
Dementia Strategy	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils, DAAs/DFCs, People with lived experience	Gina Thompson, Ramesh Prema, Katie Faherty
Prevention agenda	LCC Public health, PCNS, VCSE, HI/PHM teams, District Councils, members of the public	Andy Fox, Paul Johnson
DDR Target	Public, LPFT, PCNs	Dr Collins Esiwe, Dr Neal Parkes
Reduction in prescribing Antipsychotic Medication	LPFT, PCNs,	Dr Collins Esiwe, Dr Neal Parkes Vlad Cucuiu, Kiran Hewitt
Memory Assessment Service	ICB, LPFT, PCNs, People with lived experience	Paula Jelly, Dr Collins Esiwe, Jackie Tyson
Dementia (Memory) Support Service	People with lived experience, LCC, LPFT, ICB, VSCE, District Councils	Paula Jelly, Clare Kirk, Jackie Tyson, Vicky Lee, Karen King
Complex Dementia – managing challenging behaviour (all settings)	ICB, LCC, ULHT, LCHS, VCSE	Dr Collins Esiwe
Palliative and End of life Care (PEOL)	ICB, LCC, ULHT, LCHS, VCSE, St Barnabas	Katie Faherty, Kerry Bareham, Tom Rose, Palliative delivery programme members

Project team

- Paula Jelly, Collins Esiwe, Gina Thompson, Members of the Core team Dementia Programme Team and the DPB members

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

1. Future state

NHS Planning Guidance for 2023/24 sets out that further progress should be made in delivering on the NHS Long Term Plan key ambitions. This Programme Delivery Plan will align against the published priorities of the NHS Lincolnshire Joint Forward Plan 2023-28, in addition to more targeted documents such as the Model Service Specification for the Transforming Care Programme and 'Building the Right Support' and the National Service Model for Transforming Care.

Note: Learning Disabilities and Autism (LDA) are not set out in the Health and Wellbeing Strategy and Better Lives Lincolnshire Plan as a priority, however the LDA Programme will aim to link into these documents when appropriate, specifically around health inequalities. For example, the Autumn / Winter Vaccinations for People with a Learning Disability work recently produced.

The MHDLDA Alliance Vision states: 'Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities'.

The overarching aim and benefit of the LDA programme of the Lincolnshire System is;

Currently when individuals need placing in specialist hospital provision, there is an increased reliance out of area service delivery. In the future individuals with LDA service needs will be able to remain closer to home and networks, whilst accessing the right support locally. The Lincolnshire system are developing local services with a view to specialist support and delivery models and reducing the reliance on inpatient care out of county. This will help to ensure that the Lincolnshire system meets the national agenda in individuals accessing care and treatment closer to home whilst reducing the rate per m in hospital provision. This leads to person centred quality support and improved patient experience whilst meeting the national targets.

Current State - Future State – Work – Outcomes - Value

We will:

- Work so that individuals with a learning disability and/or autistic people will be able to remain closer to home and networks, whilst accessing the right support locally and in the community.
- Develop services with a view to deliver localised specialist support and reduce the reliance on inpatient care and out of county services, in line with NHSE targets of rate per million.
- Improve quantity and quality of LD Annual Health Checks to improve health outcomes.
- Develop access services for people with a Learning Disability and Neurodiverse people so that services can be accessed more easily, and their health life expectancy increases in line with the general population.
- Work so that the population can access services (physical and mental health) more easily and that their healthy life expectancy increases in-line with the general population.
- Work for a reduction in health inequalities will be supported with more LDA friendly GP practices being accredited.
- Ensure neurodiverse individuals will be supported to live well and independently where possible, but when they do require specialist mental health services, the services will be accessible and tailored to the needs of these individuals.
- Work so that people receive timely access to service (i.e., maximum 12 week wait for initial appointment) and early diagnosis across all ages.

Scope

In scope – LDA programmes of work for adults and CYP
Out of scope – Mental Health (except those with Mental Health and LDA)

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

2. What's being done to get there | Overview

MHLDA Planning

- All services have been asked to complete a planning template which details their plans for 2024/25. These update and build on the same exercise which was completed during the 2023/24 planning round, as we move towards a continual cycle of operational and strategic planning development and iteration.
- The planning templates ask services to consider their existing position and future needs in terms of performance, quality, workforce, demand, estates, digital/informatics, inequalities, finance, national drivers (i.e., policy, legislative and guidance changes), strategic alignment and impact on the wider system. This supports services to identify plans and 'gaps' needed to improve areas of existing deficit. Where services are requesting additional resourcing or investment, a second stage of planning development will take place throughout October 2023 to develop cases for change. Finally, all cases for change will be subjected to a scoring prioritisation framework to 'order' in priority any cases for change which are developed so that any future investment availability can be directed accordingly to developments in a prioritised fashion.
- Alongside this, Senior Operational Managers in LPFT have developed a list of 20+ ambitions to achieve in 5 years' time. Whilst this list is subject to further development and iteration, the long-term vision is for Learning Disability and neurodiversity service planning to be integral to system development.

Learning Disability Review:

There was an overall Learning Disability review in 2021/22 and 2022/23. The specialist Learning Disability services within LPFT are currently undergoing a service transformation review which is in 2 phases:

- Urgent care support for LDA.
- Community.

LPFT Staff Engagement

Ongoing engagement with LPFT staff across all service areas to identify gaps and opportunities in ensuring that service users with Learning Disabilities and Neurodivergent individuals receive equitable services. A case for change is being created in September 2023 and this will identify a number of improvement projects across all services. These will include:

- A case for change is in development for the Learning Disability physical health liaison pathway.
- A case for change is in development reviewing lead commissioner responsibilities to maximise existing resources.
- A case for change is currently under review for the NHSE Capital bid for LDA which commenced in August 2023. A decision will be made week commencing 25th September 2023 as to the preferred option which will lead to a business case with a view to work commencing in 2024/25.

Accommodation Strategy

A short-term plan and accommodation strategy is being developed in September 2023 to inform accommodation requirements for the LDA programme. This includes wider creative market engagement which will lead to several procurements with the market for 2024/25 to give a planned approach.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

2. What's being done to get there | Overview

LDA Roadmap

The 3-year roadmap for LDA identified several schemes which are now business as usual for the integrated care system and include:

- Purple light Epilepsy toolkit benchmarking and case for change for the specialist LDA Epilepsy pathway.
- Lincolnshire LeDeR programme including quarterly system wide webinars.
- Section 17 pilot as part of the accommodation strategy will inform future commissioning intentions and market development.
- Development of all age community support for Lincolnshire Autistic Community and family/carers.
- Sensory Environment work within the wards.
- CYP key workers.

Dynamic Support Register

Learning taken from the Dynamic Support Register (DSR) which informs all age admission avoidance where clinically appropriate to do so and continual review of the DSR and system wide process.

Neurodivergent Pathways:

As part of the LDA service review, there is a focus on neurodivergent pathways, which for ADHD and Tic's Tourette's are supported in the independent sector via the out of area treatments panel (OATs).

Currently Tics Tourette's and Functional Neurological Disorder (FND) and Acquired Brain Injury (ABI) pathways remain as OATs with services commissioned on a spot purchase basis. During 2024/25 evaluation of both the CYP and Adult OATs panels will determine whether this meets the needs of Lincolnshire citizens or whether cases for change are required.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

3. What's being done to get there | Detail

The LDA programme is working on several schemes and projects to support the overarching vision described above and to align with the NHS Lincolnshire Joint Forward Plan priorities. These schemes and projects are detailed below:

LPFT LDA Service Review. **JFP Priorities 2/3/4 – Living Well and Staying Well, Improving Access, Integrated Community Care**

- LPFT are carrying out a service transformation review in 2 phases. Many of the schemes and projects detailed in this section have / will come out of this review. The review will identify gaps and opportunities within LDA pathways.
- Scope of the LDS75 agreement with LCC is well established and although it is mature and with LPFT services, the pathways may not necessarily be meeting the overall needs of our citizens who are accessing mainstream LD services. E.g., People with mild LD and those who are autistic or have neurodivergent needs.
- Although both cohorts of individuals are under the umbrella of the Transforming care programme, they have very different needs, and it is a likely mainstreaming within the ICS. Where the service is now in 2024 is very different to that in 2016.

Physical Health Liaison Pathway. **JPF Priority 3 - Improving Access**

- The focus of this scheme is to provide hospital and community staff with training on the support needs of patients with LD and to offer advice and support to individuals and their carers during their hospital admission.
- A business case was proposed in Q2, describing 4 options to meet and exceed the commissioned physical health liaison service specification standards. The recommended option is to expand the service to meet the commissioned service requirement as detailed in the LD service specification. This will lead to reduced (Inappropriate) demand on emergency departments and acute hospital admissions and a reduction in health inequalities for LDA citizens. It will increase the quality of annual health checks. There are interdependencies through the rollout of the Oliver McGowan Training.

Lead Commissioner. **JFP Priorities 3/4/5 - , Improving Access, Integrated Community Care and A happy Valued workforce.**

- Work is ongoing between LICB and the Local Authority (Lincolnshire County Council (LCC)) to produce the Lead Commissioner policy for complex case, of which LDA is a part. Other parts include Responsible Commissioner and Section 117 Aftercare. This policy will then stipulate process for future commissioning and procurement of complex case.
- We are currently working on a Market Position Statement for the health packages within Lincolnshire, where we have seen an increase in growth over the past 5 years, both in terms of demand and supply being created against Lincolnshire system direction of travel.
- A case for Change is in development reviewing Lead Commissioner responsibilities to maximise existing resources in line with the review of LDA services currently being conducted by LPFT and LICB. Ongoing work to meet service demands ensuring that the staffing resource is used effectively whilst ensuring staff are developed, valued and retained. The workforce within lead commissioner is our internal workforce across key partners but it forms a valuable thread in each of the main workstreams.

Accommodation Strategy including a Capital Bid for new LDA Accommodation - **JFP Priorities 1/3/4 – A new relationship with the public, Improving Access and Integrated Community Care**

- The Accommodation Strategy is a joint strategy across all key partners in Lincolnshire reviewing the current supply and demand of care provision across all services in Lincolnshire to meet the current level of demand. This includes developing the market to meet LICB requirements in line with our overarching commissioning plans to meet both current and expected demand. It is ensuring the market are developing services in line with both the LICB and wider system requirements. From an LICB perspective, this is growing community provision to support LDA discharges from long stay hospitals and meeting the increasing number of community services to meet our statutory responsibility in providing s117 aftercare.
- A Capital Bid will be submitted to NHSE by June 2024 with a view to work commencing in 2025/26. The Capital Bid is to develop 4/5 units of accommodation for LDA clients based on several criteria within the capital bid process. A Case for Change is currently under review which is evaluating several options which include new-build developments and development of existing buildings across Lincolnshire. Following a decision being made in early 2024, a business case will then be produced in readying us for submission in June 2024. The Capital Bid is a system bid being produced with input from key partners including LCC and LPFT.

Learning Disabilities & Autism

Programme: Learning Disability and Autism	SRO: Martin Fahy	Programme lead: Richard Eccles	Clinical/Technical Lead: Catherine Keay

3. What's being done to get there | Detail

SDF – LeDeR. -JFP Priority 2 - Living Well and Staying Well

- The Lincolnshire Learning from Lives and Deaths of people with a Learning Disability and/or Autistic People (LeDeR) programme has been actively improving since its origins in 2022/23. Governance Panels occur on a bi-monthly basis and there are multiple LeDeR Reviewers stationed around the system.
- Q2 saw the successful appointment of a LeDeR Band 4 dedicated administrator and there is work ongoing to increase the reviewer cohort by bringing in external reviewers on a bank basis as it is a priority area to have LeDeR reviewers approved. This is a focus area being driven by NHSE LDA Midlands. Further webinars to be introduced on a cost neutral basis.

SDF – Epilepsy LDA Pathway ICS. - JFP Priority 3 – Improving Access

- The Epilepsy Purple Light Toolkit was produced in the FY. In early Q3 a webinar was jointly hosted between LICB and SUDEP Action charity to increase awareness of epilepsy and LDA and future commissioning plans. From this webinar, workstreams to implement the SUDEP Action checklist into Annual Health Checks has commenced and My Life in Epilepsy.
- This is a prime example of co-produced commissioning which has been extended to the wider ICS, with an enhanced offer for Expert by Experience (EBE) and looking at the Epilepsy prevalence in Learning Disabilities.
- Implementation of Commissioning Guidance was launched 14/11/2023 and there is ongoing health inequalities work. Lincolnshire is a pilot site and developing further links to the health inequalities workstreams and all age pathways.

Expansion of DSR inc. Self-Assessment. JFP Priorities 2/3 – Living Well and Staying Well, Improving Access

- The Dynamic Support Register (DSR) is going through a review process to meet developing NHSE and local requirements, including work to identify and improve on the population who should be on the DSR but are not (Self-Assessment). All age and moving of 38-to-52-week school placements avoiding inappropriate hospital admissions.

ADHD Pathway LACE Project. JFP Priority 3 – Improving Access

- The Lincolnshire Clinical Academy of Excellence (LACE) are supporting LICB with the identification of a new ADHD Pathway for the system.
- Q1 and Q2 involved gathering of the reference group and stakeholder analysis. Surveys have been sent to patients to gather evidence and data and a workshop is planned for the end of Q3 to define the issues and concerns. Another workshop will take place in Q4 for best practice evidence and then 2 further workshops in Q4 for solution generation and strategy agreements.
- Report and recommendations will then be produced by LACE in Q1/Q2 of FY 2024/25, with implementation following from that.

Virtual Autism Hub. - JFP Priority 3 – Improving Access

- In the latter part of 2023/24 LPFT are mobilising the Lincolnshire Virtual Autism Hub. This initiative aims to reduce health and societal inequalities experienced by autistic people and their families/carers by providing easily accessible community support, signposting and a level of advocacy. The Hub will also represent the voices and views of an underheard community in Lincolnshire and ensure this cohort of the population are fairly represented. Providing employment opportunities within the hub which can have positive impact on individuals' mental health.
- 2024/25 will be the first full year of operation for this new service. It is expected that the service will require at least two years of operational experience to learn and iterate before a formal evaluation. A PDSA approach will be taken within the first two years.

CYP Autism Diagnostic Pathway. JFP Priority 3 – Improving Access

- Carry over to early Qtr. 1 2024/25, as consultation ongoing in Qtr. 3/4 of 23/24.

Learning Disabilities & Autism

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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	No.	Project	FRP	2023/24				2024/25				2025/26				2026/27			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LD – LPFT	1	LPFT LDA service review	No																
LD – LPFT	2	Physical Health Liaison Pathway	No																
LD – LPFT/LICB	3	Lead Commissioner	No																
LD - LICB	4	Accommodation strategy	No																
LD – LICB	4a	Capital Bid - LDA accommodation	No																
LD – LICB	5	SDF – LeDeR	No																
LD – LICB	6	SDF – Epilepsy LDA pathway ICS	No																
LD - LPFT	7	Expansion of DSR	No																
LD - LICB	8	LACE project ADHD	No																
LD - LPFT	9	Virtual Autism Hub	No																
LD - LICB	10	CYP Autism Pathway	No																

Learning Disabilities & Autism

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4. Projected impact on patients and system partners

Initiative	Outputs and Outcomes	
	Patients & Population	System Partners
LPFT LDA Service review	Improved patient experience	Case for Change
LPFT Physical Health Liaison pathway	Improved patient experience and access to pathway.	Expanded workforce and mobilisation
Lead Commissioner	N/A	Clearer pathway of working. Supports market development
Accommodation Strategy market development & improvement	Review of existing provision. Increased capacity in the market and greater choice for personalisation.	Market stimulation and Case for Change for Capital Bid.
SDF - LeDeR	Review and implement learning.	N/A
Epilepsy LDA Pathway ICS	Development of pathway and mobilisation of such.	Epilepsy Toolkit webinars.
Expand DSR Inc. Self notification	Improved access.	Improved access for system partners to DSR.
LACE ADHD project	Improved pathway development and access to ADHD services.	Recommendations of pathway.
Virtual Autism Hub	Improved access and experience for autistic people.	Clearer direction for primary and secondary care to signpost people with autism to appropriate pathways.

ADHD Pathway has not been included. The reason for the non-inclusion is that the LACE ADHD project aim is to scope the appropriate pathway. Until outcomes from this project are known, the ADHD pathway initiative cannot be planned or started.

Learning Disabilities & Autism

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5. What's needed to make this happen

Scheme	External contributors	Requirements from enablers	Other support requirements	Resource requirements
LPFT LDA Service Review	LPFT	Client engagement/Experts by Experience		Staffing input
Physical Health Liaison Pathway	LPFT / ULHT	Workforce		Additional funding – business case produced
Lead Commissioner	LCC / LPFT	Legal agreement	Training on workforce / Educating providers	Dependant on outcome – additional finance staffing of maybe up to 2 FTEs B4/5
Capital Bid for new LDA Accommodation	NHSE / LCC / LPFT	Additional joint funding	Support at Board meetings / Project support	Additional funding to support the project. Scheme circa £2m and additional staffing support of maybe 1-2 FTE on fixed term B7
Accommodation Strategy	LCC / Districts	Embed strategy through framework/procurement	Staffing	Staffing – Will need to see an increase in contracting/procurement of maybe 2-3 FTE B6/7
SDF - LeDeR				Reviewer staffing which may result in external staff being recruited.
SDF – Epilepsy LDA Pathway ICS	Primary Care / SUDEP Action		Primary Care Network liaison for checklist distribution	
Expansion of DSR	Community LDA			
LACE Project ADHD	Primary Care	Data gathering engagement		Extra staffing as required when pathway has been identified
CYP Autism Pathway	LPFT / Primary Care	To come from action plan in development	To come from action plan in development	To come from action plan in development
Virtual Autism Hub	LPFT / Primary Care			Dependant on PDSA process

Learning Disabilities & Autism

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6. What could make or break progress

Scheme	Interdependencies	Issues and Blockers	Challenges and Risks
LPFT LDA Service Review	LPFT		Lack of LDA in key policy priorities (H&WS / BLL Plan)
Physical Health Liaison Pathway	Adult LD Service	Lack of funding	Recruitment of staff / Significantly higher patient referral numbers / High number of inappropriate referrals
Lead Commissioner	LCC / LPFT		Lead Commissioner policy cannot be agreed upon
Capital Bid for new LDA Accommodation	LCC	LCC accommodation strategy	Case for Change not accepted
Accommodation Strategy	LCC	Provider market producing provision against requirements	Provider market continue to work in silo from recommended strategy
SDF - LeDeR	LPFT / ULHT	Reviewer capacity	Unable to recruit to key posts
SDF – Epilepsy LDA Pathway ICS	SUDEP Action	Primary Care understanding	
Expansion of DSR	LPFT	ICS Interoperability	
LACE Project ADHD	LACE / Chosen provider/pathway	Workforce capacity	Unable to find appropriate pathway
CYP Autism Pathway	LCC / LPFT		Increase in demand outweighs current pathway work
Virtual Autism Hub	LPFT		PDSA uncovers issues outside of scope to be changed

General risks across all schemes

- The ability to recruit staff due to a shortage in Lincolnshire across both health and social care in both the public and private sector. If recruitment is made in one area, it is often at the detriment of another area. Both LICB and LPFT have been carrying a number of vacancies for some time.
- Changing priorities at national level in what ICBs will be doing as key priorities and lack of funding may impact on all schemes. For example, letter PRN00942_Letter Addressing the Significant Financial challenges created by industrial action in 2023/24, and immediate actions to take, dated 08/11/2023.

Learning Disabilities & Autism

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7. Planning assumptions

- Demand will continue to rise in all sectors (LD, Autism, Neurodiverse), with specific increases in neurodiverse demand, such as ADHD, Tics and Tourette's Syndrome. The impact of COVID-19 is being monitored and analysed as part of the overall growth in demand seen within the MHLDA service.
  - 9 months of 23/24 a 19.2% (81) increase in MHLDA patients that are supported in core services
  - 9 months of 23/24 a 23.9% (519) increase in ADHD patients that receive an ADHD service
  - 9 months of 23/24 a 16.2% (5) increase in Tics/Tourette patients that receive a service
  - 9 months of 23/24 a 25.4% (101) increase in s.117 aftercare patients that receive a service
- Funding will remain available through SDF and other schemes to improve output in LDA.
- Assumption that funding will remain constant with this financial year and will not reduce.
- The capital scheme is subject to LICB being successful in its application for funding with NHSE and the ability to access additional national funding schemes.
- Community-based provision will continue to be seen as the most appropriate service delivery model for those with a learning disability and/or autism. However, the cost of community provision in some cases is higher and that then results in schemes being taken to the investment panel for approval.
- National and local policy will continue and will include current themes regarding LDA.
- Workforce vacancies will get filled and workforce sickness will continue in line with local trends. However, internal LICB vacancies are governed by workforce panels on a post-by-post basis and the sustainability of workforce is measured in line with the overall ICS workforce strategy
- The ICS will continue in its current makeup (ICB/LPFT/ULHT etc) and will continue to work together in an aligned way to meet the overall ICS vision.

Learning Disabilities & Autism

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8. Stakeholders

Scheme	Project Team	Lead Person	Stakeholders
LPFT LDA Service Review	LPFT	LD LPFT	LICB / LPFT / LDA population
Physical Health Liaison Pathway	LPFT	LD LPFT and LD ULHT	LICB / LPFT / ULHT / UEC / LD services
Lead Commissioner	LICB / LPFT / LCC	AD LD at LCC/ MHLDA Director LICB	LICB / LPFT / LCC
Capital Bid for new LDA Accommodation	LICB / LPFT / LCC	Pooled Fund Manager LICB & Property LCC	LICB / LPFT / LCC
Accommodation Strategy	LICB / LCC	LD LCC/MHLDA LICB	LICB / LCC
SDF - LeDeR	LICB	MHLDA LICB	LICB / LPFT / Primary Care / ULHT
SDF – Epilepsy LDA Pathway ICS	LICB	MHLDA LICB	LICB / Primary Care
Expansion of DSR	LPFT	LD LFPT/MHLDA LICB	LPFT / LICB
LACE Project ADHD	LICB	Chief Commissioning Manager LICB	LICB / Primary Care / ADHD Provider market
CYP Autism Pathway	LPFT/LCC	Autism Lead LPFT/Childrens Commissioning LCC	LPFT / LICB / Primary Care / Provider Market
Virtual Autism Hub	LPFT	Autism Lead LPFT	LPFT / Primary Care / Secondary Care / Autism Charities/Providers

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

1. Future state

There are 10 separate streams within our planning. We also expect to have an eleventh plan looking at an overhaul of the Lincolnshire Joint Formulary which underpins all of our work. This is currently being scoped.

Primary care cost efficiencies

- To improve the cost-effectiveness of primary care prescribing in Lincolnshire to the point where we can justify all of the variance in prescribing spend between Lincolnshire and the national average.
- Prescribing data shows that Lincolnshire spends more per weighted patient than other areas in our region and the national average. NHSE have challenged the high prescribing in Lincolnshire compared to national average. We know that Lincolnshire has a higher-than-average ageing population, some areas of high deprivation, high rates of smoking in some areas, high levels of obesity; all of which are determining factors to higher disease/long-term condition burden. This is demonstrated as Lincolnshire have high prevalence in 7 of the 8 QOF LTCs. Lincolnshire also has one of the highest numbers of dispensing practices in England, who's priorities may not align with ours due to their business needs, so can be more challenging to affect desired change.
- Understanding how that affects prescribing in Lincolnshire is important in understanding where savings to prescribing costs can be made without detrimental effect on our patient health outcomes or increased need for secondary care inpatient services. Through promotion of self-care and education encouraging patient access to community pharmacy, reducing requests for GP appointments. Freeing up NHS resources to deliver prevention agenda and promote access to the most appropriate clinical service. This programme looks at primary care prescribing in Lincolnshire ICB for both GP and non-GP prescribers.

Community Pharmacy Integration

- To integrate community pharmacy services with primary and secondary care after the Pharmacy, Optometry and Dental delegation into Integrated Care Boards to enable cross sector collaboration and better patient experience. The aims of Community Pharmacy Clinical Services are to 'optimise patient outcomes by delivering high-quality, evidence-based clinical services that are accessible, patient-centred, and cost-effective.
- These will be delivered by collaborating with healthcare professionals within primary and secondary care, organisations, and local communities. We are striving to enhance the role of community pharmacists in delivering holistic care, improving medication safety, promoting public health, and reducing health inequalities.
- The Community Pharmacy Integration plan has the dual objective of delivering medicines optimisation services to residents of Lincolnshire and provision of clinical pharmacy services to all 14 Primary Care Networks (PCN) in Lincolnshire.
- This will be achieved through embedding work with stakeholders in Primary Care, Secondary Care, Local Pharmaceutical Committee, and other relevant stakeholders within Lincolnshire ICS by delivering the services, pilots, and projects in the Pharmacy Integration Fund (PhIF).

Medicines Optimisation

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1. Future state

MO Engagement within the system

- To have optimal visibility to the system and each individual sector, organisation and contractor as the leadership for medicines optimisation and pharmacy in Lincolnshire.
- To have excellent engagement with all Lincolnshire GP practices and to engage with them on a regular basis via multiple routes.
- To have raised the profile of medicines optimisation within the Lincolnshire system with all partners and stakeholders that have any link to prescribing so that medicines optimisation is considered whenever the Lincolnshire ICS plans actions that involve medicines, and the medicines optimisation teams are fully integrated into conversations and planning that is in any way linked to medicines and prescribing.
- To build on an emerging reputation across the system as the leading team and valuable service providing advice and support with all aspects on medicines and prescribing across the Lincolnshire system. This will build and cement new and effective relationships with our GP partners and support shared decision-making with our patients.
- To fully engage with PCNs and their pharmacy staff to align priorities and maximise the impact of this workforce in achieving medicines optimisation goals.
- To have an excellent level of engagement across the interface between primary and secondary care where medicines and prescribing happens to facilitate smooth patient transitions between care settings.
- To build and grow current engagement and integration with all pharmacy partners over the next few years to achieve seamless system working and work closely with emerging services e.g. IP pathfinder sites.
- To be able to link into patient groups as an integral part of planning and delivery of MO work. This should cover the whole of the Lincolnshire system for Medicines Optimisation, medicines and prescribing. This is an essential element to enable other MO workstreams.

Secondary Care Procurement

- Timely inputting of contract implementation – proactive. Review and choose the right contract at the right time. Manage to run stocks down in the run-up to contract change. Review of non-contracted items to ensure ongoing effective purchasing.
- Start doing off-contract claims (Commercial Medicines Unit, DHSC). Potential devolvement of specialised commissioning from NHS England's Specialised Pharmacy Service
- In scope: Across 3 main hospitals, 2 OPD dispensaries, Boole aseptics unit in Lincolnshire across thousands of drug lines.

Biosimilars

- To ensure that Lincolnshire ICS supports and implements safe and cost-effective use of biosimilars where they are recommended for treatment.
- For secondary care use and prescribing of biosimilar drugs a process is in place to support identification of new biosimilars, assure supply, assess, aspects of safety, resource required (across the system), training, SOPs, homecare arrangements etc and implement safe transition for patients (and clinicians) from originator products to biosimilar products in a timely way and in line with other ICSs.
- For primary care prescriber biosimilars, an agreed scoping and implementation process is adopted to assess clinical requirements, resource needs, product supply assurance and route of supply, assess aspects of safety, training (clinician and patient) setting for switch, follow up required and any other aspects needed to be taken into account for safe and effective transition from originator brand to biosimilar products in a timely way and in line with other ICSs.
- Implement switching of originator brands to biosimilars by drug as they become available.

Medicines Optimisation

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1. Future state

Antimicrobial Stewardship

- There is an antimicrobial strategy for Lincolnshire 23-25 . The aim is to create and maintain a unified approach and service standards across the patient facing stakeholders of AMS Lincolnshire. The measures of which will be employed across the interface and partnerships to improve patient outcomes.
- These are to:
  - Encourage prudent use of antimicrobials
  - Improve understanding of antimicrobial stewardship amongst healthcare professionals
  - Optimise infection management and control elements of good antimicrobial prescribing
  - Reduce spread of infection and incidence of HCAIs
  - Limit the development of resistant organisms
  - Limit the incidence of Gram Negative blood stream infections (GNBSIs)
  - In line with the Strategic Aims of Antimicrobial Prescribing and Medicines Optimisation (APMO): To improve patient outcomes, safely reduce human exposure to antimicrobials, reduce antimicrobial resistance and reduce environmental impact and waste. Through reducing demand, reducing exposure, and optimising infection management.
- Strategic Objective A: National directives to reduce inappropriate antimicrobial prescribing across Lincolnshire, require work towards targets:
  - Primary care:
    - Total number of antimicrobials per STAR-PU per year to be < 0.871
    - Broad-spectrum antimicrobials (co-amoxiclav, cephalosporins and fluoroquinolones) to make up < 10% of the total number of antibacterial items prescribed in primary care
    - National target – 75% or more of total amoxicillin prescriptions to be 5-day courses.
  - Secondary care
    - Achieving target of <40% patients receiving IV antimicrobials past the point at which they meet oral switch criteria. This target has already been reached. The aspiration now is to reduce further to <15% Annual consumption of Antimicrobials from the watch and reserve categories to reduce by 10% compared to a baseline year of 2017.
- Strategic Objective B: Surveillance and measuring:
  - To share antimicrobial prescribing data at least every 6 months, with healthcare staff and patient facing settings (primary and secondary care), in order to highlight prescribing habits and trends.
  - Data highlights to include antimicrobial consumption levels, as well as other national priorities such as antimicrobial management of UTI, IV to oral switch, length of antimicrobial courses, as well as position against national targets.
- Strategic Objective C: Facilitate and promote means of improving Antimicrobial Stewardship across Lincolnshire, through:
  - Correct application of diagnostics in infection management
  - Documentation of indication for antimicrobial prescriptions (Primary care SNOMED or read codes, Secondary care Electronic Prescribing and Medicines Administration or prescription charts)
  - Antimicrobial prescribing practices and Key Performance indicators
  - Timely and effective review of antimicrobial prescriptions, recurrent infections, and AMR risk
- Strategic Objective D: Awareness and utilisation across all stakeholders, of local and national antimicrobial stewardship tools/resources, highlighted, developed or procured via AMS Lincolnshire, to help achieve these objectives.

Medicines Optimisation

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1. Future state

Quality and Safety in medicines and prescribing

- A functional medicines safety network which will bring together Medication Safety leads from across the Lincolnshire System with the aim to improve medication safety, discuss local incidents and events, discuss system wide medication risks, share learning and good practice, work towards the National Patient Safety Strategy & the NHS Medication Safety Improvement Plan together providing support for each other.
- To provide a cross sector platform for ongoing improvement in medication safety, encouraging collaborative working to reduce harm to patients and service users. The network will influence the way Medication Safety incidents are managed with the new National Patient Safety Strategy. How they are reported on and how we can improve them in line with the Patient Safety Incident Response Framework (PSIRF).
- Have a rolling programme of quality & safety activities that promote the highest standards of medicines safety & quality prescribing, having identified issues relating to medicines safety that require action and have plans in place. A comprehensive process to monitor ICB controlled drug use to ensure they are being prescribed in line with safety guidance to minimise harm
- National Medicines Safety Priorities 2021-24 – Reduce severe, avoidable medication related harm by 50% by 2024 through: Optimise Leadership in Medicines Safety, Optimise Safer Systems, Safer use of High-risk Medicines. 'It is vitally important for NHS England and the wider health community to continue to learn the lessons from the Shipman Inquiry especially with its many parallels to the Francis Inquiry in terms of patient safety and ensuring local intelligence is used effectively to safeguard patients and the public.' (NHSE). More than 237 million medication errors are made every year which costs the NHS upwards of £98 million and more than 1700 lives lost. 38% of the errors are from Primary Care with 42% from Care Homes. Errors are made at every stage of the process: 54% being made at point of administration, 21% during prescribing & 16% from dispensing errors
- The most common medications causing hospital admissions were NSAIDs, anti-platelets, Diuretics, epilepsy medications, cardiac glycosides and beta blockers. 80% of the resulting deaths were caused by GI bleeds from NSAIDs, aspirin or warfarin. It is estimated that 66 million potentially clinically significant errors occur per year, 71.0% of these in primary care. This is where most medicines in the NHS are prescribed and dispensed. Prescribing in primary care accounts for 33.9% of all potentially clinically significant errors. Fulfilling our statutory responsibilities to improve safety for our population in line with our responsibilities as stated by NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England. NHS England » The NHS Patient Safety Strategy

Medicines Optimisation

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1. Future state

Aseptic production

- For the purpose of this document, Aseptic Preparation is defined as reconstitution of an injectable medicine or any other aseptic manipulation when undertaken within aseptic facilities to product a labelled ready-to-administer (RtA) presentation of a medicine, in accordance with a prescription provided by a practitioner, for a specific patient. Typically, aseptic preparations are personalised or low volume products that large pharmaceutical companies would not be able to provide such as chemotherapy, monoclonal antibodies, injectable nutrition and clinical trials medicines.
- The Pharmacy Aseptic Services project described in this document aims to create a Lincolnshire Pharmacy Hub facility to prepare large scale injectable aseptic medicines in line with the recommendation on “Transforming NHS Pharmacy Aseptic Services in England” document. This will create a collaborative regional hub for aseptic services to have the ability to support spoke facilities across the region to ensure safe, high quality and resilient supplies by 2026/2027 in line with NHSE vision and recommendations.
- This will also free up significant nursing staff for care enabling and enable more care closer to home.
- Opportunity number 5 “Standardising Product Formulations of Aseptically Compounded Medicines” of the National Medicines Optimisation Opportunities 2023/2024 released recently by NHSE also request that NHS Trusts collaborate to develop regional aseptic hubs. The document states that systems should: 1. Prioritise purchase of licensed RtA products where available. 2. Maximise the use of nationally standardised aseptic products. 3. Increase batch production and ordering and reduce patient-specific production and ordering. 4. Collaborate to develop a strategy and business case(s) for the development of MHRA authorised regional aseptic hubs to produce aseptically compounded RtA injectable medicines, and for local hospital pharmacy aseptic units to maintain high quality services for ultra-short shelf-life products, clinical trials and complex innovative and bespoke treatments. Associated workforce plans will be required.
- Prioritise purchase of licensed RtA products where available. The department already purchases licensed RtA aseptic products where available at all times and will continue to do so. (out of scope)
- Maximise the use of nationally standardised aseptic products. The department also use nationally standardised aseptic products when possible. All the chemotherapy products are standard aseptic products and follow the national chemotherapy dose banding tables. (out of scope)
- Increase batch production and ordering and reduce patient-specific production and ordering. The department outsources aseptically prepared batch products when possible. The current pharmacy aseptic unit does not hold a MHRA licence and therefore cannot prepare batch products. (In scope).
- Collaborate to develop a strategy and business case(s) for the development of MHRA authorised regional aseptic hubs to produce aseptically compounded RtA injectable medicines, and for local hospital pharmacy aseptic units to maintain high quality services for ultra-short shelf-life products, clinical trials and complex innovative and bespoke treatments. Associated workforce plans will be required. ULHT in collaboration with the system, aims to develop a strategy and a business case for the development of a Lincolnshire MHRA aseptic hub as described in this document. (In scope).
- Scope: This document covers the preparation and supply of aseptic preparations only. Non-aseptic products are outside of the scope of this project. Currently, the ULHT Pharmacy Aseptic Unit only prepare and supply aseptic medicines to ULHT. However, the development of the Lincolnshire aseptic services hub aims to manufacture and supply aseptic medicines for the system and outside of Lincolnshire.

Medicines Optimisation

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1. Future state

Antidepressant reduction

- Addressing inappropriate antidepressant prescribing as per MOO - NHS England » National medicines optimisation opportunities 2023/24
- To continue efforts to deliver the objectives as defined by the Mental Health CRG (shared with the Opioid and polypharmacy CRGs) whilst under the directions of the SDP. Prescribing in line with NICE, system and MH Trust guidelines. Reduction/discontinuing long term unnecessary antidepressants.

Pharmacy Workforce

- The Integrated Pharmacy and Medicines Optimisation (IPMO) Programme is an NHSE/I mandated requirement for integrated care systems (ICS) and will define how the use of medicines will be used optimally to deliver best outcomes for patients, in a number of priority therapeutics areas.
- This structural evolution brings significant changes within the world of pharmacy and for pharmacy healthcare professionals, both great opportunities and challenges. Therefore, it is imperative that Lincolnshire has a pharmacy workforce that is competent, skilled, adaptive, able and inclusive to deliver the best quality patient care it can.
- The Pharmacy Workforce Programme is aims to meet the workforce challenges that the changing pharmacy landscape presents, as well as increasing recruitment and retention into Pharmacy roles across Lincolnshire
- The national programme is in response to the needs of the population and being able to deliver effective, high-quality services in a cost-effective way. At a local level, Lincolnshire has difficulties recruiting and retaining Pharmacy staff due to a number of factors such as: attracting new people to Lincolnshire as a coastal and rural region, career development and progression, lifestyle and diversity of roles. The Pharmacy faculty is producing a plan to help address these barriers.
- In scope: All Pharmacy workforce transformation; Out of Scope: Medicines Optimisation.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

2. What's being done to get there | Overview

Primary care cost efficiencies

- We are planning several workstreams to establish what our variation in prescribing is. We will analyse the data to understand how much is driven by volume of prescribing and how much is cost/price driven.
- We then plan to link to other data sets through PHM to understand how much of our prescribing variance can be explained through population, prevalence and outcome data; how much is driven by the national prevention directives. Compiling a case for warranted variation.
- We are also investigating where cost is the driver and what actions can be taken to change prescribing behaviours to mitigate cost-driven prescribing variation. Prioritising areas to tackle with tailored plans over the coming years.
- Additionally ensuring the ICB has assessed and signed up to industry-offered rebates where they fulfil the terms of our policy, continued use of Optimise Rx messages to influence prescribing at the point of initiation and review to generate new prescribing savings, understanding when patents expire on drugs that are widely used in Lincolnshire to ensure we optimise the use of generic prescribing where clinically appropriate.

Community Pharmacy Integration

- The Community Pharmacy Programme plans to integrate Community Pharmacy Services into the NHS Lincolnshire ICB through the delivery of the clinical services including, Discharge Medicine Service, Community Pharmacy oral contraception Pilot, Community Pharmacy oral contraception advanced Tier 1 service- Ongoing supply, Community Pharmacy oral contraception Tier 2 pilot- Initiation of oral contraception, Community Pharmacy Consultation skills (CPCS), NHS Community Pharmacy Blood Pressure Check Service (formally known as Hypertension Case finding Service), Smoking Cessation Advanced service, Community Pharmacy- Independent Prescribing Pathfinder program, Palliative care drug stockist scheme, Community Pharmacy Extended Care Service.
- The role of the Community Pharmacy Clinical Lead (CPCL) post was implemented to establish community pharmacies as integral healthcare providers, driving the transformation of primary care services. The CPCL role involves the implementation, assurance, and clinical governance of community pharmacy clinical services across Lincolnshire ICS. The CPCL role is funded until 31/03/2024 and business case is needed to make this role substantive to continue implementation of the Primary access and recovery plans, NHS community Independent Prescribing pathfinder program and ensure improved outcomes and delivery of the Pharmacy First service.

MO Engagement within the system

- The MO Team have been building relationships with GP practices since the pandemic. We now need to build on this and learn what works and what doesn't work as well. Engagement and working relationships across the primary/secondary care interface are growing and this will be one of the benefits of establishing IPMO and APC transformation.
- Continued work to raise awareness of MO within ICB Teams so that service/pathway development, contracting and other work takes account of medicines optimisation and includes resource from the MO Team wherever decisions are made concerning medicines and prescribing.
- Get involved in existing patient forum groups to encourage 2-way engagement on MO issues.

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2. What's being done to get there | Overview

Secondary Care Procurement

- Lenalidomide: This was a complex change due to the pregnancy prevention aspect that required setting all Pharmacies and consultants up on the Pathfinder system. Now complete.
- Deferasirox – Switch has been implemented
- Etanercept – Legacy usage of originator brand – patients who were not appropriate or switched back due to clinical reasons
- Pemetrexed – Planned
- Bortezomib – Planned
- Lanreotide – Planned
- Thalidomide – Planned
- Tacrolimus – Planned
- Botulinum Toxin – buying a mix of products based on clinician direction (not in scope for this workstream)
- Infliximab - Legacy usage of originator brand – patients who were not appropriate or switched back due to clinical reasons.
- Human Immunoglobulin - buying a mix of products based on clinician direction (very influenced by national supplies and allocations). Other lines where savings could be achieved by changing purchasing patterns. Summary of work – overview of the approach, plans or strategies that are/will be delivering this change.

Biosimilars

- Development of a biosimilar switch policy/protocol for ULHT to initiate and implement safe use of biosimilars (stronger governance).
- Identify and highlight what resource is needed to support and implement work as per this policy.
- Ongoing and support appropriate use of biosimilars in the clinical setting – (this has been initiated but more work needed
- Benchmarking Lincolnshire with other ICBs to understand where there is variance in biosimilar uptake and investigate the reasons for this. NHSE are directing the optimisation of biosimilar uptake work through their national MO priorities list.
- Current insulin biosimilar work being scoped and will link with the newly formed system diabetes CRG. Keep track of our out of area providers intentions and implementation.

Antimicrobial Stewardship

- Strategic objectives are supported by 4 strategic objectives including work on Antimicrobial Prescribing Guidelines, audit, monitoring, reporting and benchmarking, education, training and development, system wide engagement with antimicrobial stewardship initiatives and campaigns, engaging with partner organisations to develop collaborative approaches.

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2. What's being done to get there | Overview

Quality and Safety in medicines and prescribing

- *Medicines Safety:* We are setting up a medicine's safety network encompassing all partners – this group will dictate the future strategy and plan. Working towards recruiting a primary care quality and safety pharmacy lead post. Reviewing medicines related data entries on Datix, monitoring type of incidents and creating learning from incidents. Liaison with NHSE POD Team around drug incidents reported by community pharmacies.
- *Controlled Drugs:* Strengthen Local Intelligence Network around the management and use of controlled drugs in Lincolnshire. Engaging as a healthcare commissioner and member organisation to ensure that arrangements to provide services that involve, or may involve, the management or use of controlled drugs by relevant individuals or designated bodies comply with the regulations. Engaging as a healthcare commissioner and member organisation to ensure all reasonable steps are taken to improve patient and public safety with regards to the safe and secure handling, management and use of controlled drugs.
- *Opioids:* The mission is to provide education and support for all those living with persistent pain in Lincolnshire, whilst promoting safe and rationale prescribing and deprescribing of opioid medication in line with the National Medication Safety Improvement Plan.
- *Valproate – Safe Prescribing:* New guidelines for prescribing of valproates coming into effect January 2024, cross system working required to implement the changes and develop local guidance to ensure the safe prescribing of valproates for women of child-bearing potential and men under 65 years old.

Aseptic production

- The build of a pharmacy aseptic unit in January 2023 in partnership with LSIP (Phase 1), with close proximity to the University of Lincoln School of Pharmacy and the University's own partnership with ULHT, has been identified as an exemplar of collaborative aseptic delivery. A case study has been published by NHSE and the project team.
- This project aims to develop a business case for Phase 2, in which the service aims to develop a pharmacy aseptic hub to supply aseptic medicines beyond ULHT into the wider ICS and region, contributing to the NHS England's Infusions and Special Medicines Programme aspirations of a hub and spoke mode. Phase 2 provides the opportunity to expand to an income generation model thereby facilitating a commercial opportunity through collaborative working. This shall ensure future demand for aseptic products can be met and provide opportunities for patients to receive care closer to home.
- Final plans for the hub will be based on the business case development but will include: Batch production of aseptic products to supply outside of ULHT, Scope for chemotherapy, antibiotics (CIVAs) and Advanced Therapeutically Medicinal Products (ATMPs). The phase 2 project is currently in the scoping and planning phase. A Phase 2 Steering Group has been established to investigate the opportunities that NHSE investment in Lincolnshire would bring.

Antidepressant reduction

- Ensure new prescriptions in line with good practise standards and system guidelines.
- Provide education and training opportunities to upskill prescribers in treatment of depression.
- Identify patients in primary care for reduction, stopping if long term and ineffective.
- Discussion as to how the previous work carried out within the CRG under the SDP will be continued.

Medicines Optimisation

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2. What's being done to get there | Overview

Pharmacy Workforce

- A pharmacy faculty group has been meeting for 12 months with project management since February 2023. The Pharmacy Faculty has achieved the following: Clarity of purpose and plan for the group. Successful engagement with senior people in key organisations from across Lincolnshire and the region including Health & Social Care providers, NHSE, Education Institutes, ICB. Regular reporting now in place from all key partners that has enabled a strategic understanding of the challenges, opportunities, risks and issues.
- Pharmacy workforce numbers are being flowed to the ICB, and this process is being strengthened to ensure accuracy and efficiency. Following a Faculty away day in September 2023, a number of workstreams and milestones have been identified with a strategy and plan being produced.
- The areas of focus through the workstreams are: Marketing and Attraction, Recruitment, Training and Placements, Career Mapping. The evidence-base for prioritising the above work streams is the faculty dashboard that has been in place since May 2023, capturing provider activity, risks, challenges and local improvement programmes. The priorities have evolved from the ongoing challenges that were discussed at the Faculty Away Day. In this instance issues have been identified in a risk register, mitigations of which have informed our Workforce plan.

Medicines Optimisation

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3. What's being done to get there | Detail

Primary care cost efficiencies

- *Prescribing Data Deep Dive:* continue and complete this work that investigates where variation in prescribing is cost-driven. Working group from MO Team to risk-assess the findings and RAG rate them for priority. Plans to be developed for individual areas of prioritised prescribing, working with system partners and stakeholders. Plans will include foundation/infrastructure actions (understanding pathway and source of initiation, making formulary changes, reviewing and updating local guidance)
- *Enhanced Scheme for primary care prescribers:* Compiling a list of all the switches we are aware of that may reduce prescribing spend. Asking practices who sign up to our planned Enhanced Scheme to choose a percentage of these switches to make to achieve a percentage of the total potential opportunity. Year 1 = 24/25 to replace part-year prescribing incentive scheme (23/24) The scheme will have engagement and quality elements in additional to cost-savings elements. (links to Engagement Plan and Quality and Safety Plan) (branded generic prescribing is not condoned at a national level as it adversely affect generic drug tariff prices)
- *Rebates:* Research available rebates for 24/25, review against policy and sign up for those that meet criteria. Monitor and claim rebates at the end of each quarter.
- *Patent expiries:* track drug patent expiries. Develop an action plan review dependant on the drug - make any changes to formulary, local guidance etc. through APC/PACEF identify additional opportunity made through switching brand to generic prescribing, promote this generic prescribing with GP practice prescribers.
- *Optimise Rx:* Continue to use and promote Optimise Rx with primary care prescribers. This may be part of the planned Enhance Scheme. Identify non-GP practice prescribing centres and implement use of Optimise Rx for these centres where appropriate (needs digital clinical system in place). BAU work rolling to review messages and adapt to local use, stand down messages to avoid message fatigue, re-introduce and develop new messages to support other areas of the MO primary care workplan.
- *Stoma review scheme:* Continue with current offer in 24/25, promoting this service with GP practices through engagement activities. Also in 24/25, scope to upgrade this service to offer annual review for every stoma patient being managed in primary care. Implementation timetable dependant on scoping and planning exercise.
- *ONS:* Build on scoping exercise due to complete in 23/24. Develop plan to source dietitian resource to review patients on ONS in care homes, primary care after discharge from hospital on ONS and if successful, roll out to the general patient population on ONS. Also link to ONS use in LPFT. 25/26 planning to scope gastrointestinal projects.
- *OTC/Self care:* Scoping in the remainder of 23/24. This is a large transformational piece of work planned for the next 4-5 years. Previous work in this area has not always been sustained and COVID and the recent cost-of-living issues have caused progress to reverse. 24/25 plans to assess this in 'topics' and select a fixed number of topics to concentrate on each year. There are foundation actions and enablers to put in place including a comms campaign for both prescribers and patients. A restrictive formulary for all self-care items so that necessary prescribing of these areas is most cost-effective products only. Plan for each topic individually with support from MO team, resources, monitoring and may be included in planned Enhanced Scheme

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3. What's being done to get there | Detail

Community Pharmacy Integration

- *Discharge Medicines Service (DMS):* The NHS Discharge Medicines Service aims to integrate care between secondary care and community pharmacy and enhance relationships between general practice and community pharmacy. DMS links to 2 of the 5 systems priorities - Living well and Staying well and Improving Access as it optimises the use of medicines while facilitating shared decision making and reduce harm from medicines over transfers of care. The NHS Discharge Medicines Service became a new Essential service within the Community Pharmacy Contractual Framework (CPCF) on 15th February 2021. As an essential service, all community pharmacy contractors in Lincolnshire ICS must provide the service. Within the LICS, the Lincolnshire Partnership Foundation Trust (LPFT) is currently the only trust referring into DMS. Lincolnshire Community Hospital trust (LCHS) has begun a pilot referring into DMS and the acute trust, that should roll-out over time. United Lincolnshire Hospital Trust is yet to implement the digital tools needed to allow DMS referrals into community pharmacies. IPMO needs to address the barriers to DMS at ULHT, that include radical change to current service and significant investment to implement the changes needed to support DMS implementation. The CPCL is currently working with ULHT and the digital team to facilitate implementation of DMS and escalating the risks in appropriate risk registers within ICB and ULHT.
- *Community Pharmacy Contraception Service:* Following the 2021 NHS England a pilot involving pharmacies offering repeat supplies of oral contraception to people who had previously had the medicine prescribed, where 16 community pharmacies located within Lincolnshire signed up. Building on this, from April 2023, community pharmacy started to manage oral contraception for women through the NHS Pharmacy Contraception Advanced Service Tier 1 - ongoing supply of oral contraception and the NHS Pharmacy Contraception Advanced Service Tier 2 - initiation of oral contraception (PILOT). The CPCL and LPC are working with relevant stakeholders such as GPs, Pharmacy contractors and universities increasing engagement around the service using Comms such as posters to encourage more uptake of this Tier 1 service. Additionally, work has being done to increase more Tier 1 community pharmacies sign up to deliver Tier 2 initiation of oral contraception as the service progresses from pilot phase to an advanced service. From 1st December this service will transition into the Pharmacy Contraception Service (advanced service). From this date the service incorporates initiation and repeat supplies of oral contraception. The NHS pharmacy contraception service forms an integral part of improving access, a fundamental part of Lincolnshire system priorities. Any pharmacy registering to provide the service from that date onwards must provide the full service, i.e. both initiation and repeat supplies. As part of service changes within the community pharmacy contractual negotiations, a 'bundling approach' is being phased in, and by March 2025 it is anticipated that most pharmacies will be providing this advanced service.
- *Community Pharmacy Consultation skills (CPCS):* Originally launched 29th October 2019, the NHS Community Pharmacist Consultation Service enables general practices to refer patients for a minor illness consultation via CPCS. The service connects patients who have a minor illness or need an urgent supply of medicine with a community pharmacy. CPCS is a key part of the Lincolnshire system priority improving access by integrating community pharmacy into the wider self-care agenda (interdependent with Primary Care Prescribing Cost Efficiencies) and improving relationships between community pharmacy and general practice. Work is currently being done through the CPCL, ICB staff working with relevant stakeholders such as LPC and LMC to improve relationships between practices and general practice. The target is to increase GP CPCS to an average of 500 a month from 40 practices from the current level of 384 consultations from 26 practices. In addition, working with ICB digital teams to fix streamer tool and start referrals from all UECs in Lincs to CPCS. From 31st January 2024 (subject to IT systems being in place, CPCS will be integrated into the new Pharmacy First advanced service.
- *Pharmacy First:* The three elements to the Pharmacy First service, which is expected to launch 31st January 2024 *(subject to appropriate digital systems being in place to launch the service). The Pharmacy First service in its entirety forms an integral part of system priorities Improving access and living well and staying well.

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3. What's being done to get there | Detail

Community Pharmacy Integration (cont.)

- *Blood pressure Check service:* The NHS Community Pharmacy Blood Pressure Check Service supports risk identification and prevention of cardiovascular disease (CVD). Lincolnshire ICB is working to expand the BP check service, through utilisation of PCARP funding to support contractors who have signed up but not delivering the service to address any concerns/barriers. The CPCL and LPC are working with to work with contractors with low BP check figures to increase output. CPCL will work with 4 identified pathfinder sites to expand BP check service as all pathfinder sites will be providing CVD prevention model, which links in with the BP check service. Finally, we aim to expand BP check service innovatively by cross sector working with other HCP such as Optometrists who can refer patients with HTN changes in the eye to community pharmacy BP check service
- *NHS community pharmacy smoking cessation service:* The NHS Long Term Plan focuses on the importance of preventing avoidable illness and more active management of the health of the population. It suggests that, as smoking cessation is specifically identified as a key service that can improve the prevention of avoidable illness, existing services can be expanded to further support patients who are looking to quit smoking, as well as those affected by second-hand smoke. The NHS community pharmacy service links into system priority, living well and staying well, in addition it links in system ambition of reducing harm in patients and reduction in smoking in pregnancy if household members of an expectant mother takes up the service. This programme is working with tobacco dependency group within the ICB, acute and mental health sector to achieve a referral route for smoking cessation referrals from hospitals and other secondary care settings into community pharmacy, improving integration of community pharmacy and providing patients with better health outcomes closer to home.
- *NHS Community Pharmacy Independent Prescribing Pathfinder Programme:* NHS England is developing a programme of pilot sites, across integrated care systems enabling a community pharmacist prescriber to support primary care clinical services. The Community Pharmacy independent prescribing pathfinder programme forms an integral part of Improving access and Integrated Community care which are fundamental parts of system priority. In addition, the Cardiovascular Disease (CVD) prevention model aligns with system ambition of CVD prevention in relation to lipid management.. 1. Minor illnesses associated with acute Ear, Nose and Throat conditions - The LICB intend to utilise the skills of community pharmacist IPs working in collaboration with local general practices to address urgent patient need for help, advice and possible intervention relating to acute ENT conditions. 2. Cardiovascular disease (CVD) prevention- identifying more people with undetected risk factors of CVD such as high blood pressure, raised cholesterol and atrial fibrillation. This clinical model aims to prescribe statins for patients with raised cholesterol, identify any undiagnosed hypertension utilising existing BP check service and identify patients with undiagnosed irregular heart rates/rhythms. 3. Acute Conditions (CPCS+) - Utilise pharmacist IP qualification to clinically assess, diagnose and prescribe for minor illness conditions such as skin conditions.
- *Palliative Care Drugs Stockist Scheme:* We are working to ensure there continues to be a good geographical coverage of this service, which provides increased access to palliative care medicines through a network of community pharmacies who keep an agreed list of drugs in stock. We currently have 20 pharmacies signed up to the scheme. The palliative care drug stockist scheme forms an integral part of integrated community care- one of the 5 JFP priorities
- *Community Pharmacy Extended Care Service: The* service aims to provide patients access to self-care advice and treatment of a range of conditions, and, where appropriate, can be supplied with antibiotics or other prescription-only medicines (POMs) to treat their condition. A working group is addressing gaps in the provision of extended care services, its effect on the 'Pharmaceutical need assessment' and if any similar services can be commissioned.
- *Primary Care Access and Recovery Plans (PCARP):* The delivery plan for recovering access to primary care was launched in May 2023, which forms an integral part of the Improving access system priority. Many of the above schemes feed into this e.g.:1. Launch of Common condition service (CCS) otherwise referred to as Pharmacy First. 2. Expand pharmacy oral contraception (OC) advanced service and Blood Pressure (BP) check services. 3.Utilise existing community Pharmacy services- GP CPCS and Midlands Extended Care Service. 4.Improve digital connectivity between pharmacies and practices. NHS England is currently working to provide interoperable digital solutions to improve digital connectivity between pharmacies and general practice. This will improve safety and quality and unable to determine specific financial savings.

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3. What's being done to get there | Detail

MO Engagement within the system

- APC transformation and establishment as part of the medicines governance framework. Provision of focused medicines optimisation meetings for individual practices to talk about medicines optimisation and how our team might support them with their priorities in this area, sharing information, resources and data, listening to issues and providing advice on specific medicines and prescribing issues.
- Establishing an annual or biannual visit pattern offer to improve contact and dialogue. Support GP practice engagement in a variety of ways through a planned enhanced scheme. Engage more regularly with our GP Clinical Leads, Medical Directors, Deputy Medical Directors, sharing our MO strategy and plans and welcoming their input and advice on engagement with GP practices in their localities.
- Continuation and development of Prescribing Forum meetings for primary care prescribers and primary care practice and PCN pharmacy staff, with renumeration.
- Continuation and development of support for prescribing queries from healthcare professional in Lincolnshire through MO inbox.
- Review of some other engagement and communication activities e.g. medicines optimisation newsletter. Initiate an escalation process where practices are very resistant to MO engagement. The initial stages will be internal within the MO Team but will allow information on non-engagement to be shared with the ICB where there are specific identified examples and issues. Work on engagement with other ICBs has commenced but will be built on. MO team members allocated to support pathway design, contracting and any development work that involves medicines and prescribing. Work on engagement through interface between primary and secondary care through further development of IPMO group and increased transparency that comes with working closer together. Exploring best options for patient engagement to ensure regular involvement of patients with medicines optimisation decision-making.

Secondary Care Procurement

- For each drug individually, understand where there are the most potential savings – Exend+ system. Work through understanding what needs to be done to put the change in place (e.g. injectable chemo is complex due to stability and worksheet changes, tacrolimus as brand specific, inhalers as branded needing formulary changes and local adoptions to support new prescribing).

Biosimilars

- Current policy/protocol development for biosimilar implementation at ULHT has been written and had first round of internal feedback– expected ratification in April 2024. Resource plan/business case to support resource needed for biosimilar implementation
- Identifying biologic patent expiry and biosimilar expected launch dates through SPS – horizon scanning. For each individual drug - Identify expected access, available drug levels and required actions to secure local supply (sometimes this information comes in with little notice and NHSE allocations – may be resource dependant). Implement the expected biosimilar implementation policy/protocol. Expected Future biosimilar drugs – Ustekinumab (2024/25), Tocilizumab (2024/25), Aflibercept (2025/26), Vedolizumab (2026 anticipated).

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3. What's being done to get there | Detail

Antimicrobial Stewardship

- Strategic Objective A: ONGOING timeline
  - **Primary care** - Data being shared 3 monthly with GP practices, highlighting trends and engaging prescribers. Positive results being noted in practices being visited. - Training and newsletters facilitating with insight to evidence base, tools/resources available and progress. Guidelines reviewed to reflect evidence base and local microbiology trends to support his. Optimise Rx and formulary updated in accordance with guidelines. Microguide navigation edited to make it more user friendly. Looking into development of clinical decision tools for primary care. e.g. Helicobacter pylori as complex decision-making and exploring other useful indications/initiatives that could be supported with clinical decision tools on Microguide.
  - **Secondary care** - IVOS CQUIN efforts and introduction of evidence based clinical decision tools, annual audit plans, addition to prescribing standards to include IVOS. - Sharing divisional data on antimicrobial use at top level for accountability to ASSG. Pilot evidenced effectiveness of approach. Guidelines reviewed to reflect evidence base and local microbiology trends to support his. Microguide awareness reminders sent regularly. All specialties invited to input on quality and prescribing improvement projects to tackle inappropriate antimicrobial use. Multiple QIPs overseeing clinical teams throughout Trust, led by Antimicrobial Pharmacy Team. Ongoing developments to training packs/sessions accessible for all levels of prescriber or healthcare staff.
- Strategic Objective B: ONGOING timeline Sharing consumption data and IVOS CQUIN findings via ASSG with divisional leads on board for secondary care, bespoke divisional surveillance shared at top level in divisions to cascade to specialties and feedback initiatives being taken. Effect of implementation being noted in the top-level reports to close the loop. Example Positive effect noted from efforts so far. Primary care surveillance distributed to GPs every 3 months, breaking down prescribing habits and trends. Position against national standards highlighted in all primary care reports.
- Strategic Objective C: Facilitate and promote means of improving Antimicrobial Stewardship across Lincolnshire, through: Secondary care implemented ePMA with mandating of indication from a specific dropdown list to ensure correct level of detail, regular reminders and teaching sessions, educational messages re correct diagnostics around UTI, chest infection, C.diff infection and various others. Advising on correct sampling, plans for incorporating information into clinical decision tools re diagnostics and sampling. Exploring with regional NHSE AMR links about how to implement further improvements and resources in primary care, potential for introducing coding to primary care prescriptions, etc to enable clinical checks in community pharmacies and auditing of local data. Secondary care prescribing practices picked up from audit plans and presentations, captured via Clinical Governance mechanisms and meetings. Encouraging individual specialties to set up own independently, with support from Antimicrobial Consultant. Mapping out plans for AMR Clinics for timely and effective review of antimicrobial prescriptions, recurrent infections, and AMR risk based on specific criteria and evidence base. Will look to cover Penicillin allergy de-labelling and testing in this. - Reviewing resource and provision from Antimicrobial or Clinical microbiology teams in Lincolnshire. AMR SRO to look at whether alternative models of delivery can be implemented. Examples put forward include advertising for Lincolnshire specific consultant microbiologists (outside of Pathlinks contract as this is a key challenge in stretching the resource available to Lincolnshire ICB), or creating antimicrobial Pharmacist, Technician, Nurse and support roles to lessen the gap in resource and increase stewardship. Also explore a system set up or Antimicrobial Stewards in each practice or healthcare facility.
- Strategic Objective D: Regular microguide reminders and developments. Increasing awareness, engagement and stakeholder representation and accountability via AMS Lincolnshire. Ensuring local resources such as formulary status, Optimise Rx and Ardens etc. The latter is not aligned with local guidance and is creating variation in practice. Timely review of national updates and guidelines and implementation into local guidelines, policies and training within an appropriate timeframe. This will improve safety and quality and unable to determine specific financial savings.

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3. What's being done to get there | Detail

Quality and Safety in medicines and prescribing

- *Medicines Safety:* We are awaiting monies to be released from ULHT disinvested MOCH service to fund agreed Pharmacy Quality and Safety Lead within the ICB to lead much of this work. This has been escalated and we plan to have this post filled during 24/25 – Job description agreed and banded, permission to recruit given pending release of monies. Detailed planning underway between Chief Pharmacist ICB (YS) and Chief Pharmacist LCHS (SB) to agree agenda items and areas for discussion – most pertinent quality and safety issues. Incident review and management in individual providers as normal. Weekly/2-weekly review of primary care related medicines incidents. Working closely with the patient safety team. Including Quality and safety elements in the planned primary care prescribing enhance scheme. Implementation of the Discharge Medicine Service across ULHT to feed into Community Pharmacy, build working relations & improve patient outcomes
- *Controlled Drugs:* Liaison with NHSE CDAO office regarding controlled drug prescribing and monitoring in Lincolnshire. Plan for robust Controlled Drug monitoring process within the LICB MO team 6 monthly reporting. Improving patient outcomes and reducing harm by picking out irregular prescribing of controlled drugs, excessive quantities and inappropriate high doses. Support NHSE with their routine monitoring. Support practices with the safe storage and prescribing of controlled drugs.

Aseptic production

- Feasibility and scoping of the project is currently being undertaken by the project steering group. Project deliverables, milestones, FRP plans, and phasing will be shared once agreed. This will improve safety and quality and unable to determine specific financial savings.

Antidepressant reduction

- Needs planning/discussion at IPMO.

Pharmacy Workforce

- *Work Stream One: Marketing and Attraction:* All Pharmacy marketing and attraction work centralised. Annual careers events calendar in place with input and participation from all providers. Standardised Pharmacy promotion material across all medium in place. 'Be Lincolnshire campaign fully utilised and adapted to include Pharmacy roles, in place.
- *Work Stream Two: Career Development Pathways:* Lincolnshire wide professional journey maps including produced including: Entry and progression points clearly defined for each role. Training and skills needed for each role clearly articulated. Creative career development opportunities outlined i.e. split posts. Mentoring/Coaching, teaching, leadership and management development offers clearly defined. Standardisation of entry requirements and Job descriptions. Define entry points for older workforce and emphasise equality in recruitment process.
- *Work Stream Three: Training and Placements*: Establish baseline data including number of placements available across the system, and conversion rate for people who train locally and stay. Strengthen placement activity across whole system by implementing processes enable university and placement providers to plan, prepare, and provide good quality placements. Processes in places including SOP to capture placement activity undertaken and core competencies gained for everyone. Explore introducing central team of assessors with standardised assessments. Develop student passports aligned to harmonise competencies i.e. JD's, T & C's.
- *Work Stream Four: Recruitment:* System wide collaboration on common vacancies established. Cross-sector posts introduced and advertised. Recruitment programme linked to marketing and attraction work stream outlining key activity i.e. roadshows with same day application / interview. Programme in place for welcoming national and international recruits to Lincolnshire. System level incentive scheme introduced highlighting incentives offered by each provider i.e. golden handshake, relocation package, pay General Pharmaceutical Council fees, leadership course offer.
- *Additional Work Stream: Workforce Modelling:* Work with providers and ICB to establish workforce baseline, cross reference with population need, over next five years and produce year on year expansion trajectory.

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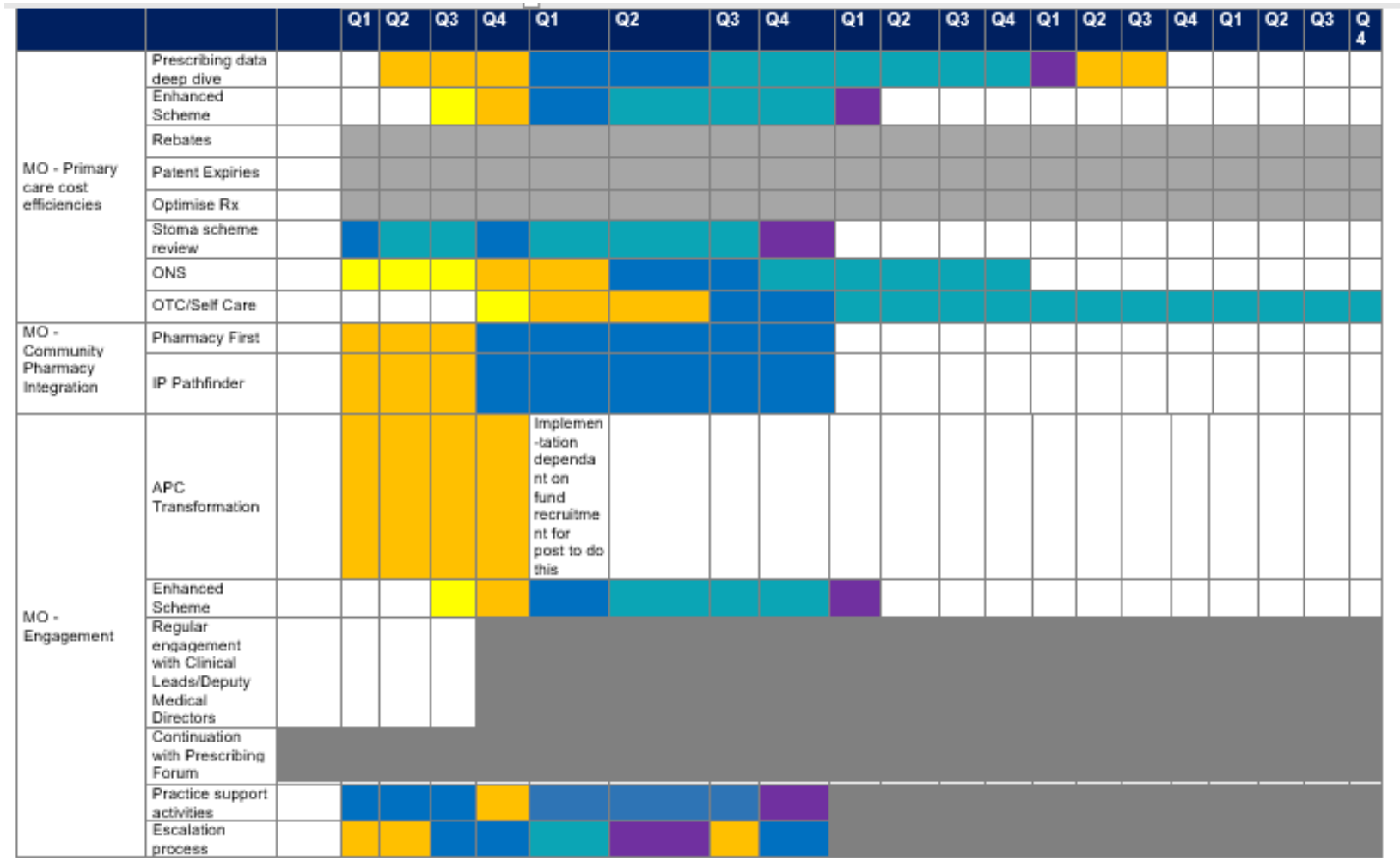
Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU



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Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Medicines Optimisation	Procurement – Secondary care																					
	Biosimilars																					
MO – AMS	Objective A Primary																					
	Objective A Secondary																					
	ePMA surveillance function																					
	ePMA indications																					
	Coding primary										Local pilot?											
	AMR clinics									2pilot												
	Micro/Abx staff																					
	Ardens template corrections																					
MO – Quality and safety	*Cannot commit to detailed phasing until Lead Pharmacist is in place*																					
Medicines Optimisation	Aseptic production																					
	Antidepressant reduction																					
	Pharmacy Workforce																					

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Primary care cost efficiencies

- Patients: reducing harm from medicines through offering safe and cost-effective alternatives. Measured through acceptance rates on Optimise Rx, reduction in medicines-related incidents, reduction in admissions with primary coding as medicines-related and improvement in practice response/actioning of red Eclipse Live alerts. Reduction in cost to the system, freeing up resources and capacity to improve patient services and patient. Savings measured as reduction in prescribing spend (specified areas) – caveat is underlying increase in drug prices and volume.
- Prescribing Data Deep Dive – Benefits will be potentially financial for primary care prescribing spend if areas are identified that are unwarranted variation and can be changed. This will be measures by ePACT2 data to show decrease in spend in these areas compared to baseline.
- Enhance Scheme switch savings – Benefits will be qualitative and financial for primary care prescribing spend on successful completion of work in line with planned Enhanced Scheme by GP practices who sign up. Measured by ePACT2 data/activity reporting from practices as decrease in spend or evidence of change to demonstrate resulting prescribing savings
- Rebates – benefits will be financial only for primary care prescribing spend (provider rebates – unclear where they are reported in currently)
- Patent Expiries – benefits will be financial only across the system prescribing spends. Primary care measured as reduction in spend through ePACT2 reporting. Unclear how reporting on hospital/provider use will be reported.
- Stoma Review Service – Quality benefits to patients will be improving their care by regular reviews of their stoma needs and ensure they receive the correct products to support ongoing stoma management. Financial benefits through limiting ordering to correct quantities and essential products. Reporting will be from the stoma nurse on completion of reviews in each practice who signs up, changes made and resulting monthly savings. Primary care only. ICS
- ONS – This work will be in collaboration with ULHT dietitians but is not expected to impact on ULHT prescribing or services. Quality benefits to patients will be review of ONS products and deprescribing is no longer needed. Financial savings will be reported by activity and changes to prescribing made at reviews to calculate prescribing savings delivered.
- OTC/Self-care – Benefits will be mainly financial. This is a difficult area to measure using ePACT2 as areas of prescribing are very large and many variables. Still working up how to measure financial savings if this is part of the panned Enhanced Scheme. Impact on patients may be negative if they are asked to buy medicines that they have previously been obtaining on prescription and if they live a distance away from a community pharmacy and have extra travel to obtain self-care medicines (most of this prescribing is expected to be for patient who do not usually pay for their prescriptions). This will have a negative impact for patient who may not be able to afford these medicines in areas of high deprivation. Will impact Community Pharmacy contractors – higher workload/demand for already struggling community pharmacies, but increased income through medicines sales.

ICS Aim to deliver transformational change in order to improve health and wellbeing.

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Community Pharmacy Integration

Improved patient outcomes measured as number of consultations within community Pharmacy (PharmOutcomes) Impact on system partners will be reduction in GP appointments. Improved communication of changes made to a patient's medicines in hospital and its aims to improve patients' understanding of their medicines and how to take them following discharge from hospital.

- DMS also aims to reduce hospital readmission by reducing risk of medication related harm and hospital readmissions.
- Every 10 community pharmacy consultations undertaken following a DMS referral from secondary care will prevent one readmission. Even if readmitted it will reduce the length of stay by six days (data by NHSE).
- Offer people greater choice where they can access contraception services and create extra capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments.
- CPCS - relieve pressure on the wider NHS by providing patients with accessible and swift consultation with an appropriate HCP a Community Pharmacist via Telephone or face to face consultation at the local community pharmacy, re-enforcing the message of 'Right Clinician, Right Time and Right place'.
- Increase identification of hypertension and to refer those with suspected hypertension for appropriate management.
- Promote healthy behaviours to service users.
- IP pathfinder presents a unique opportunity for community pharmacy to redesign current pathways and play an increasing role in delivering clinical services in primary care.
- Develop and utilise clinical skills and capabilities of community pharmacists to facilitate quicker and more convenient access to safe and high-quality healthcare, including the prescription of appropriate medicines for minor illness, addressing health issues before they get worse, providing monitoring of long-term health conditions and preventing ill-health.
- Community pharmacy Extended Care Service provides increased accessibility for patients to seek advice and treatment, and act as an alternative to seeking treatment via a prescription from their GP or Out of Hours (OHH) provider, walk in centre or accident and emergency department.
- Digital connectivity aims to improve the following: Access Record-Improve access of CP to view medical history in GP patient record to support the consultation (very vital for IP pathfinder and common conditions service); Consultation Template- Capture details of Pharmacist consultation (e.g., notes, outcomes, meds issued) particularly useful for oral contraception, IP Pathfinder and BP check service. Reduces duplication of sending clinical details via emails for practice to action. Update Record- Send post consultation reports back to GP systems to update the record.
- Payment & Data API- Dataflows to enable renumeration and national reporting on meds

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefit patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

MO Engagement within the system

- Impact on patients – Open up a channel of direct communication with our patients, where patients feel able to share their stories and contribute to developing services which are tailored to individual communities and influence decisions made about their medicines, taking into account the health inequalities agenda. This will contribute to improved patient outcomes through increased service user participation. Measured with patient surveys and participation in decision-making agendas with medicines optimisation.
- Benefits of improved engagement with GP practice will benefit primary care prescribers in support with their prescribing and medicines optimisation questions and concerns, which can be either resolved within the MO Team or directed to the relevant part of the system that can support. Measurement of success will be tracked through satisfaction survey and feedback. Impact can also be measured through the number of practices participating in annual practice visit.
- Benefits to primary care providers in organising system specialist speaker education for prescribers through Prescribing Forums and other organised events.
- Mutual sharing of plans through IPMO will benefit all partners through core joined up collaborative working success will be measured through the shared strategy and workplan and its successful delivery. Escalation process should allow the right level of intervention is given where practices are very reluctant to engage. Success will be measures in the number of escalations that are satisfactorily resolved.
- Benefits to ICB teams through MO Team involvement in service/pathway design/development and contracting will be that potential issues and difficulties that may lead to barriers or difficulties in prescribing provision can be identified and mitigated at the initial stages. Reduction of non-formulary prescribing that may result in higher/unwanted prescribing spend may also be minimised. Managing the expectations of patients and improving understanding of medicines optimisation.
  ICS aim – Tackle inequalities and inequity of service provision to meet the population needs. ICS aim – Take collective action on health and wellbeing across a range of organisations. ICP Strategy Priority Enabler 4.

Secondary Care Procurement

- Financial savings for Lincolnshire ICS, (Potential contracted drug as per CMU should guarantee a certain level of supply), more robust supply for patients, possibility of impact to primary care, but depends on formulary amendments e.g. brand to generic

Biosimilars

- The benefits of this work are financial to the system as biosimilars are less expensive than originator brand biologics. Opportunity to review the patient and optimise their medication and access pathway. With any biosimilar switch, there is an impact on resource initially for clinical teams to perform the switch in addition to the supporting resource within the (ULHT) pharmacy team. Strengthen system approach to implementation and ongoing management of biosimilars through collaborative working, including out of area acute providers.

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Antimicrobial Stewardship

- Reduced likelihood of infection-related hospital admissions – measurement through hospitals information systems – quarterly surveillance,
- Reduced likelihood of antimicrobial resistance – measurement through microbiology data – quarterly surveillance
- Reduced consumption of high-risk antimicrobials – measurement pharmacy prescriptions quarterly surveillance,
- Expected reductions in GP presentations for recurrent infection – to be explored then aim to tie in to quarterly surveillance. First need to set up a process of capturing and measure SNOMED codes as one potential on prescriptions. Also measure volume of antibacterials via ePACT2, EMAS and UTCs should see reduction in pressured due to deteriorating patients and sepsis – explore EMAS and UTC/LCHS surveillance data – quarterly,
- Reduced pressure on social care services with reduced length of stay in hospital (deconditioning) – explore LCC data – quarterly,
- Better patient engagement with AMR and selfcare/self-reporting – Measurement in demonstrating improved equality in care and seeing ePACT2 data showing less variation in prescribing practices across areas of deprivation vs less deprived – quarterly. As get new initiatives up and running, such as AMR clinics, would do patient experience surveys and follow up of primary and secondary outcomes on impact (TBC)

Quality and Safety in medicines and prescribing

- This will support patients to live well and stay well by reducing the risk of harm from medications. This will be measured by monitoring medicines-related incidents and admission coding within the hospital. Sharing system learning and creating a safer environment for patients & reduced admissions due to medicines-related complications. The Medicines Safety Network will function as a group working together to identify and make recommendations on how to reduce preventable medication-related harm within the organisations and across the integrated care system. Influencing the way medicines safety incidents are managed within the National Patient Safety Strategy. Sharing and learning from safety events across the Lincolnshire health economy.
- Reduce secondary care admissions due to medicines related harm. Opioid work benefits - Reducing secondary care admissions due to opioid overdose or increased anticholinergic burden,
- Reducing the number of falls due to opioid side effects or increased anticholinergic burden (links to system ambitions and the Lincolnshire Older People's 5-year Strategy),
- Reducing the harm to patients from medicines by reducing polypharmacy, increased risk of addiction, overdose, Improving patient outcomes by optimising their pain management techniques increasing their quality of life

Medicines Optimisation

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4. Projected impact on patients and system partners

All schemes will benefits patients by reducing harm from medicines, helping patients to live well and stay well, improve access to the right care and so improve patient outcomes.

Aseptic production

- Improved chemotherapy capacity: Improved chemotherapy capacity and delivery in line with cancer strategy.
- Improved patient clinical outcomes through improved availability and distribution of aseptic products.
- Improved patient experience by enabling care closer to home. The manufacture of Outpatient Intravenous Antimicrobial Therapy (OPAT) will reduce the length of patient stay in hospital and increase capacity within the system. Patients will also be free from the risk of hospital acquired infections, leading to faster recovery, overall improving the quality of care. Ability to meet current gaps in Central IV Additive Service (CIVAs) and monoclonal antibodies for non-cancer. These products are currently being prepared by nurses. Investing in pharmacy aseptic facilities to make CIVA's reduces the risk for patient associated with errors and frees up nursing time for direct patient care.
- Improved productivity and efficiency within the service through batch manufacturing and automation. Removes the need for all products to be patient specific, leading to efficiencies in supply and cost reductions for the system through batch production. Improved employment opportunities across Lincolnshire (pharmacy, scientific etc.).
- Increased of flow of revenue funding to Lincolnshire ICS, as there is a significant gap in the market for selling aseptic medicines. Development of a centre of excellence for pharmacy aseptic services: application for an IMP licence, may attract workforce to Lincolnshire, giving the opportunity for collaborative working with other organisations, for instance University of Lincoln.

Antidepressant reduction

- Prescribing in line with NICE for depression. No prescribing for mild depression. Reduction for long term ineffective Rx – need services to support de-prescribing.

Pharmacy Workforce

- Successful implementation of the programme will result in a workforce that meets the needs of the local population, by reducing vacancy rates, increasing retention, and improving staff satisfaction across all Providers. Results will be measured by establishing an annual trajectory to increase Pharmacy roles and measuring against achievement of targets.
- Other measures will include workforce data such as recruitment, retention and promotion figures. This programme is enabling system partners to work in collaboration on challenges faced by all providers by centralising activity and working together where appropriate i.e. cross sector posts, central recruitment.

Medicines Optimisation

Programme: Medicines Optimisation	SRO: Dr Sunil Hindocha	Programme lead: Yinka Soetan (Claire Hart)	Clinical/Technical Lead: Yinka Soetan/IPMO

5. What's needed to make this happen

Primary care cost efficiencies

- Internal MO resource to run reports, data analysis, expert review and narrative, planning actions and project management.
- Input from providers as specialist input into formulary can guidance changes via APC/PACEF.
- Support for programme management from IPMO and clinical support/peer representation from our primary care prescribers.
- PHM and BI support to build up context through complimentary data sets.
- Support from F&BP to work up the financial elements of the scheme and assist reporting. Clinical/peer support in developing the scheme to represent primary care prescribers.
- Contracting and procurement teams and F&BP to support ongoing use of software.
- MO resource to update and review messaging and other maintenance requirements.
- Input from digital team in review of market products, developments, and opportunities in 25/26-26/27 to ensure best use of digital medicines optimisation tools.
- ULHT Stoma Nurse input into providing current service and capacity to build/extend.
- PCN dietitian for current pilot, workforce for further dietitian resource to fulfil project plan.
- May require Contract Team input if using any 3rd party provider.
- Input from ULHT dietitian team for clinical advice and support, input into formulary and guidance changes
- Comms and engagement support needed for projects over the lifespan of this work with regular information and campaigns to raise awareness of self-care.
- Health inequalities support to ensure our planned work has no detrimental effect on health inequalities in Lincolnshire.
- Community Pharmacy engagement, understanding their role and what impact it will have on their workload/resource and link into Primary Care Directorate to align priorities.
- Investment to pay for this scheme would come from identified savings.

Community Pharmacy Integration

- Financial Investment and business case will be needed to ensure the role continues for the remainder of the pathfinder program. 1WTE B8c and 1WTE B7.
- Support from NHSE midlands and national team
- Support from East midlands POD team- to investigate any contractual issues/breach. Need more Implementation support hours on top of NHSE funded hours- to facilitate implanting GP-CPCS, Contraception, BP checks.
- Additional project management support to deliver NHS Community Clinical services
- B.I to create a PCARP dashboard focusing on clinical pharmacy services data.
- Comms team launching of the GP facing website advising of which CP is delivering which advanced service. Add details for community pharmacies delivering advanced services onto the ICB webpage.

MO Engagement within the system

- Awareness of the MO Team offer to other ICB Teams and willingness from them to engage.
- IPMO cohesion as a leadership group to direct and support collaborative working across the system.
- Support from ICB and GP clinical leads with engagement strategies and ideas. Support from ICB where specific engagement issues are identified. Support from ICB/system Comms, Engagement Teams and patient experience teams.

Secondary Care Procurement

- Identified need for more staff resource to sure up the current team (recruitment in progress). Additional staff resource needed to release more senior staff to proactively manage contracts and other identified procurement gaps.
- Need good supply chain and available drug stocks within the UK.
- Quality assurance process/specialist to ensure safe drug supplies (quality and safety).
- Specific resource dedicated to off-contract claims.

Medicines Optimisation

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5. What's needed to make this happen

Biosimilars

- Input from providers, requirements from enablers (e.g. digital, estates, workforce, PHM, personalisation and health inequalities), other support requirements, resource requirements: investment and non-financial.

Antimicrobial Stewardship

- AMS system leader, Wider and more focussed engagement and surveillance from AMS Lincolnshire stakeholders. Patient Safety Partner of AMS Lincolnshire Group,
- Digital support and contractual support for Ardens, SystmOne and EMIS to develop indication and allergy status on prescriptions (SNOMED) and updating Ardens templates,
- Financial/business case for initiating antimicrobial clinics across Lincolnshire, which will also enable penicillin allergy reviews (with future aspiration for sensitivity testing).
- Increase in Antimicrobial/Microbiology staffing resource and support across Lincolnshire ICS (not yet scoped) [ICS planning require a business case and need to know when this is expected]
- System-wide Comms and Primary Care support for public campaigns including information in CPs, GP practices, public areas etc. Successful recruitment of 1WTE B8b quality and safety pharmacy lead for the ICB

Quality and Safety in medicines and prescribing

- Financial Investment - ICB Medicines Optimisation Quality and Safety Lead Pharmacist, Band 8b – Release of funding from MOCH disinvestment from ULHT agreed in Feb 2023,
- IPMO engagement and collaboration on medicines quality and safety.
- Digital needs.
- PHM data on safety and quality consequence (If available)
- ICB to continue commissioning Eclipse Live
- Engagement from GP practices to use the new Learning from Patient Safety Events (LFPSE) incident reporting tool. Inclusion of quality prescribing elements in the planned Enhance Scheme

Aseptic production

- Financial investment for ICS – Aseptics Workforce (TBC). Financial Investment: Business case to be developed to bid for the 2024/2025 NHSE Aseptic Services Capital: Build and workforce. Workforce plan to be developed. System and NHSE support.

Antidepressant reduction

- Need for antidepressant reduction to be prioritised and GP practice pharmacists to be allocated time for this work
- MH expertise, education and training for GP's and prescribers, PCN pharmacists, practice pharmacists, healthcare professionals resource and other mental health workers.
- Patient information resources as available in MH Services to also be available to primary care (choice and medication and MH Trust medicines information support/expertise).
- Financial resource to enable hyperbolic prescribing for de-prescribing – liquid preparations can be very expensive.

Pharmacy Workforce

- Continued engagement with activity taking place in the faculty meeting and work stream groups
- ICB People Team – Support needed on workforce modelling to produce annual trajectory of growth based on population need, and provider capacity to recruit and train
- Long term Programme Management support as funding from NHS England is on a temporary basis.

Medicines Optimisation

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6. What could make or break progress

Primary care cost efficiencies

- Low level/lack of engagement from GP practices and primary care prescribers with the MO Team will affect the success of the planned Enhanced Scheme, Stoma, Optimise Rx, ONS and self-care work. If we cannot improve the level of Practice engagement, delivery of potential savings will be profoundly reduced. This lack of engagement may be due to conflicting priorities, no allocated practice resource to carry out the necessary work, historic and underlying reputation and engagement issues.
- MO Team staff vacancies will reduce the resource available to progress some of these work areas and may lead to slipped timelines. There are two essential agreed posts that are not currently filled (Quality and Safety and APC development) (refer to 2/23/24 planning templates) that are needed to lead and put in place essential framework required to deliver on MO programmes. This will also release current staff who are covering some of these crucial duties to work on these schemes, particularly engagement. The monies for these posts are currently not released from an agreed disinvestment with ULHT for a MOCH service no longer provided or delivering.
- Resource and management arrangements for Lincolnshire Joint Formulary need to be bolstered as the current arrangement does not support the reviews, changes and updates needed to underpin many of the above schemes.
- No renewal of Optimise Rx Contract in short-term (Feb 2024) and review of market products in longer-term.
- The LICB position on rebates need to be agreed at an Exec level before this can go ahead.

Community Pharmacy Integration

- Current ongoing issues facing community pharmacy with staffing/workforce are likely to mean that they are unable to offer some of these services; advanced services are optional but are likely to be ‘bundled’ in the future, meaning pharmacies will be required to provide Pharmacy First (including CPCS), the Pharmacy Contraception Service **and** Hypertension Case Finding together if they wish to offer any of these.
- Lack of funding to pay for Community Pharmacy Clinical Lead Post – without this post, further development with this programme will cease. Lack of funding for the Community Pharmacy Project Manager, also funding for this post needs to be full time and permanent. Strong engagement from LPC is needed – this is delicate as community pharmacies face unsurpassed challenges in providing services in current times, and the LPCs are representative organisations (not providers)
- Unplanned pharmacy closures due to workforce pressures and permanent community pharmacy closures. Geographical area(s) without a community pharmacy would be unable to deliver any of the clinical services to those patient populations.
- Not enough independent prescribers in Community Pharmacy at the current time, and challenges in undertaking this training (time, finding supportive Designated Prescribing Practitioners, cost)
- Continued steer needed at a national / NHS England level. Workstreams involving or continuing to be led by the Health Innovation Networks Diversification of Community Pharmacy workforce- technicians taking up more advanced roles, working with PGDs.

Medicines Optimisation

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7. Planning assumptions

Primary care cost efficiencies

- OTC/Self-care will direct patient from GP practice to community pharmacy – will need to establish whether workload will be manageable for community pharmacy, ONS and Stoma schemes rely on specialist dietitian and stoma nurse workforce.
- Savings on prescribing spend will be factored into primary care prescribing budget calculations.
- Cross-organisation joint working: Current Staff vacancies within MO Team will be filled as monies from ULHT disinvestment will be released to fund these.

Community Pharmacy Integration

- No more significant pharmacy closures, common condition
- Service will be launched early 2024, digital connectivity (GP connect) between general practice and Community pharmacy is launched and maintained.
- Community Pharmacy Workforce within Lincolnshire doesn't significantly deplete.
- Working relationship exists between general practice and Community Pharmacies.

MO Engagement within the system

- Assumes ICB MO Team are able to recruit to current vacancies.
- Workforce shortages in provider trusts are addressed with robust mitigation
- Assumes IPMO group continue to develop shared workplan and strategy.

Secondary Care Procurement

- Demand for drugs will remain stable.
- Current staffing resource remain stable – including sickness levels
- No major changes with drug suppliers
- Availability of workspace needed to accommodate any new staff.

Biosimilars

- Stable patient population using these drugs
- Stable workforce (recruitment, retention and sickness)
- Homecare companies have capacity and workforce
- Products come to market with similar arrangements to originator brands
- Price reductions on all emerging biosimilars, which may not materialise when they confirm the biosimilar prices
- Availability of workplace for any new staff needed as per business case

Medicines Optimisation

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7. Planning assumptions

Antimicrobial Stewardship

- Population/patient-driven demand: Existing demand or need in primary care will be ongoing and increasing as awareness of AMS and resources increase. Prime example in AMR clinics, and function of such clinics will evolve as demand does. Development of AMR: assuming no viral pandemics, but that AMR will continue to develop. Even if we manage to stall development locally, travel and relocation, and microbial evolution make this a confident assumption. Hence, we need to take mitigating actions knowing the situation will get worse, in order to contain harm to patients and the health economy.
- System-driven demand: National policy and focus sustained for last few years and increasing. Hence increases demand with additional performance targets; expectation of embedded practice requires sustained focus and resource for those workstreams due to nature of healthcare staff turnaround, patient movement, life-span of efforts. Service improvements of currently sub-standard set-up requires building to baseline before can build beyond. Areas of deprivation in Lincolnshire require additional effort as access to healthcare and patient health beliefs are impacted. Move to electronic and virtual settings impacts on implementation and progress (some positive, some negative). New infections arising from change in environmental circumstances will drive demand (epidemics, climate change, polluted waters, refugee camps) changes in care settings (secondary to primary, virtual wards, etc).
- Digital: Embedding & spreading existing initiatives (such as ePMA in secondary care); Deploying new solutions (such as SNOMED codes on primary care prescriptions to allow clinical checks in community pharmacy settings). Ability to tap into existing digital platforms at point of care or patient access.
- Finance: allocation & position – CIP targets are unlikely to be realised in this workstream, as patient improved outcomes, or reducing financial burden of Antimicrobial Resistance cannot be captured as a preventative measure, or by avoided hospital stays, interventions such as surgical procedures, etc. set up of additional digital features will require some short-term funding for set up and potential increase in subscription fees for digital solutions and packages that enable this.
- Need for centralised resource including Antimicrobial Specialists or Microbiologists will be most cost efficient but require funding. Need for AMR clinics will need finance lead support and contract lead support in business case, set up of service, tariffs, etc.
- Assuming (calculating) tariffs to cover cost of running the clinics in most cost-efficient manner. Inflation on all the above. ERF, SDF and capital assumptions
- Shortage of healthcare staffing is also increasing need for alternative and cost/workforce efficient initiatives that enable strategic planning for system benefit in reducing need for acute and emergency healthcare presentations.
- Estates will be required to house additional staffs and initiatives such as clinics. Exploration of existing estates such as healthcare centres would still need to be scoped and reimbursed.
- Assuming system set up will address challenges such as information governance, improved synchronisation of communications systems and workforces.

Medicines Optimisation

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7. Planning assumptions

Quality and Safety in medicines and prescribing

- ICB Meds safety resource. Patient safety events number stable. Robust process for reviewing medicines related incident reporting.
- Resource available from LCHS and LPFT.
- Financial resource available for recruiting to the LICB post.
- All partners fully engaging with the Medicines Safety Network.

Aseptic production

- Increasing demand- cancer demand in the Trust is increasing by 10% annually and demand in aseptic preparation is predicted to increase as a proportion of global drug spend and injectable medicines sales are growing at 7.3%. Alongside the growth of core chemotherapy and parenteral nutrition, there is a need to anticipate future demand for advanced therapy medicinal products (ATMPs), such as gene therapy, growth in clinical trials, and potential to address the sizeable unmet need for central intravenous additives (CIVAs) and monoclonal antibodies (MAbs).
- Workforce: the service delivery relies on reliable and sustainable workforce. Digital: relevant digital and IT systems such as robotics for batch manufacturing required.
- Finance: successful business case.
- Estates: location to build and build of the facility.

Antidepressant reduction

- Not yet discussed

Pharmacy Workforce

- None stated

Medicines Optimisation

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8. Stakeholders

Primary care cost efficiencies

- *Prescribing Data Deep Dive:* Project Team – MO resource. Stakeholders – GP prescribers, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP, IPMO
- *Enhance Scheme savings:* – Project Team – MO resource. Stakeholders – GP prescribers, ICB primary care team, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP, Community Pharmacy, IPMO.
- *Rebates:* Project Team – MO resource. Stakeholders – APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, F&BP, PrescQIPP, IPMO
- *Patent Expiries:* – Project Team – MO resource. Stakeholders – APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, F&BP, IPMO.
- *Optimise Rx:* Project Team – MO resource. Stakeholders – ICB contract Team, F&BP. Digital Team, IPMO.
- *Stoma Review Service*: Project Team – MO resource. Stakeholders – GP practices, ULHT stoma nurses, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, wider MO Team for practice engagement and support.
- *ONS:* Project Team – MO resource. Stakeholders – clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, F&BP (Contract Team) input if using any 3rd party provider.
- *OTC/Self-care:* Project Team – MO resource. Stakeholders – GP prescribers, clinical specialists from provider trusts, APC/PACEF, Lincolnshire Joint Formulary Team, IPMO, Clinical Leads, PHM, F&BP Comms and engagement team Health inequalities partner, Community Pharmacy (LPC).

Community Pharmacy Integration

- Project team are – CPCL and Project Manager
- Stakeholders – NHSE/I, NHSE Midlands Region Team, Community Pharmacy Lincolnshire (LPC), GP practices, PCNs, Community Pharmacy contractors, AHSN, Secondary Care colleagues, community care colleagues, Lincolnshire IPMO, Patients/carers, pharmaceutical industry, pharmacy suppliers/wholesalers.

MO Engagement within the system

- Project Team are MO Team,
- Stakeholders – GP practices, PCNs Primary Care Prescribers, Pharmacy Leadership colleagues from partner organisations, community pharmacy, LMC, LPC, ICB teams involved in developing services/pathways and contracting, Comms Team, Engagement Team, Patients.

Secondary Care Procurement

- Project team – ULHT Pharmacy Procurement Team.
- Stakeholders – wider ULHT Pharmacy Team, ULHT wards, departments, clinics and theatres, ULHT Finance Team, Lincolnshire ICB, Drugs suppliers and wholesales, East Midlands Procurement Collaborative, Patients, NHSE/I, CMU.

Biosimilars

Project team – High-Cost Drugs and Homecare Team ULHT
Stakeholders, HCD Contract Monitoring Group, Clinical Teams (ULHT), Senior Pharmacy Management Team ULHT, DTC, PACEF/APC, IPMO, Finance Teams, Patients.

Medicines Optimisation

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8. Stakeholders

Antimicrobial Stewardship

- Project team – AMS Lincolnshire*, with expert 'guidance' from ULHT Consultant Antimicrobial Pharmacist and Antimicrobial Team, ICB Antimicrobial lead, Programme leads, and AMR SRO for Lincolnshire.
- Stakeholders - BMI Healthcare, East Midlands Ambulance Service, Lincolnshire Community Health Services, Lincolnshire County Council, Lincolnshire ICB Medicines Optimisation Team, Lincolnshire LMC Ltd, Lincolnshire Partnership NHS Trust, Lincolnshire Local Pharmaceutical Committee, LIVES, NHS England, NHS Lincolnshire ICS/ICB, Office for Health Improvement and Disparities, PathLinks Microbiology, St Barnabas, UK Health Security Agency, United Lincolnshire Hospitals NHS Trust.

Quality and Safety in medicines and prescribing

- Project team – LCHS Chief Pharmacist LICB Chief Pharmacist, Quality and Safety Pharmacists/Technicians, ICB, ULHT, LPFT, LCHS.
- Stakeholders – ULHT, LCHS, LPFT NHSE Midlands Central, We are With You, Notts Healthcare, EMAS, Lincs Police, CQC, GPhC, LCC, LPC, Lincs Air Ambulance, Private providers

Aseptic production

- Project team: ULHT: ULHT executive sponsor, CSS, Pharmacy, R&I, Cancer, Strategic projects, IID, Finance, Digital, HR, Procurement, CDH programme director, Lincolnshire Science and Innovation Park (LSIP), Local Enterprise Partnership, LICB, LCHS, LPFT, Lincoln University, Lincolnshire County Council, Health Innovation Network, NHSE, Pharmacy representation from other NHSE organisations outside of ULHT
- Stakeholders: ULHT, IPMO, LICB, NHSE, University of Lincoln.

Antidepressant reduction

- Project team – lead = GP; MH pharmacist' consultant psychiatrist senior PCN pharmacist.
- Stakeholders - patients prescribed antidepressants, all prescribers, IPMO.

Pharmacy Workforce

- Project team: Lincolnshire Pharmacy Workforce Faculty Group
- Stakeholders TBC

People & Workforce

People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

People Board

System partners meet quarterly

Oversees delivery and seeks assurance against the People plan

Oversees and signs off on Workforce Development Fund

Receives highlight report for information from Workforce Board so that a single People report can be submitted to SDPC

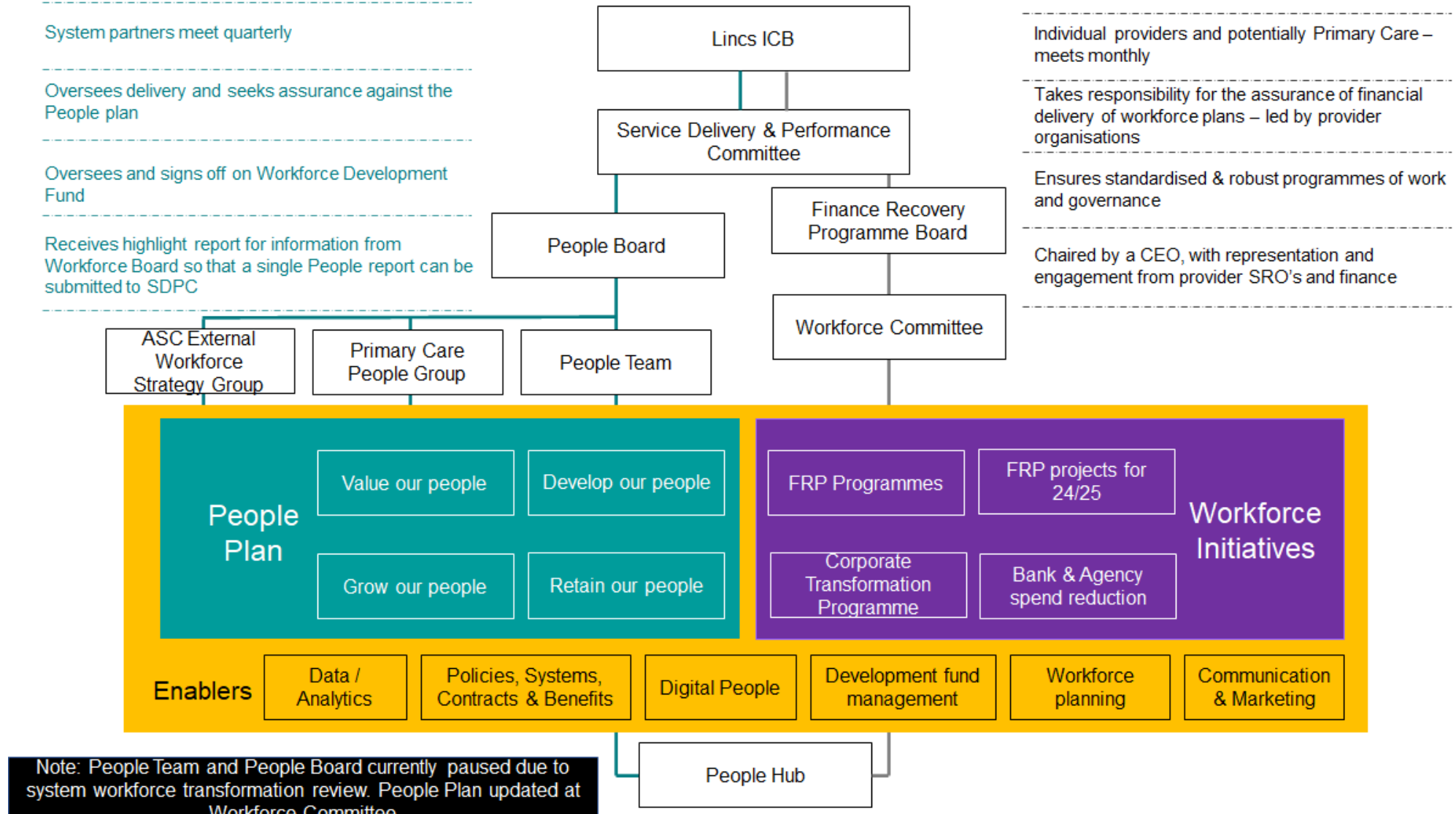
Workforce Committee

Individual providers and potentially Primary Care – meets monthly

Takes responsibility for the assurance of financial delivery of workforce plans – led by provider organisations

Ensures standardised & robust programmes of work and governance

Chaired by a CEO, with representation and engagement from provider SRO's and finance



Note: People Team and People Board currently paused due to system workforce transformation review. People Plan updated at Workforce Committee

People & Workforce

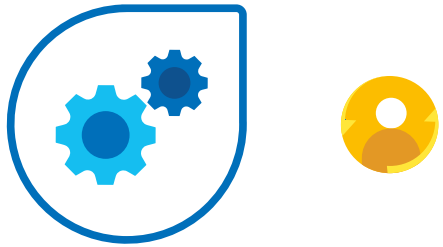
People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

Value our People

- Work together across the system to deliver against the **six high impact actions** set out in the equality, diversity and inclusion improvement plan for the NHS
- Embed a **compassionate culture** built on civility, respect and equal opportunity through inclusive recruitment, Just Culture, Allyship and system-level networks
- Develop and launch system-wide consistent **health and wellbeing services**

Grow our People

- **Widen access** of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships.
- Engage with higher education institutions to support students, **placement capacity** and maximise accreditation of recognition of prior learning (RPL)
- Adopt **new recruitment practices** and systems in line with the outcomes of the national programme to overhaul NHS recruitment.
- Embed strategic workforce planning through enhanced systems and processes



Develop our People

- **Increase placement capacity and experience** to support increased training places in the NHS.
- Develop multi-professional, system-based **rotational clinical placement** models to increase capacity.
- Agree the system level **Leadership Development & Talent framework**
- Fully embed **digital technology in training pathways**, to support more efficient and effective ways of learning and improved learner experience
- Offer **blended learning programmes** to which integrates technology and digital media with traditional classroom-based learning

Retain our People

- Continue to embed the **People Promise** elements to enhance staff experience
- Agree and publish a consistent system-wide offer of **benefits offer** for our people
- Continue to focus on **flexible working** as a means of retaining our staff
- Work with specific staff groups/network through pilot **projects** (stay conversations, flexible working etc)
- Continue to strengthen our **pastoral care for International Recruits** across the system

People & Workforce

People & Workforce	SRO: Claire Low	Programme lead: Saumya Hebbar	Clinical/Technical Lead:

Financial Recovery Programme initiatives

- Identify and **agree opportunities** for agency reduction across providers
- **Progress identified projects** already part of the plan
- **Negotiate rates with agencies** to better comply with the NHS cap and framework guidance

Bank & Agency Spend reduction schemes

- Focus on improving **off-framework** usage and **cap compliance** across provider organisations
- **Identify avenues of saving** based on submitted weekly returns

Financial Recovery projects for 24/25

- Reduce sickness management spend by up – to 1% across providers
- Continue to enhance **medical productivity** through a focus on effective rostering & job planning
- Explore income generating opportunities through apprenticeships
- Review apprenticeship spend across providers/partners to see how much can be retained within the system
- Expand the **Refugee Doctor Programme** initiative to maximize benefits

Corporate Transformation Programme

- Agree scope of the project – **identify processes** across individual provider organisations
- Agree **operating model** for each process and obtain sign off
- **Implement new operating model**

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

1. Future state

Across the system, digital and information are enablers that aim to

- Ensure strong foundations for technology-enabled care
- Drive digital readiness and digital inclusion
- Use intelligence to empower decision making and improve outcomes
- Enable improved health and care delivery and outcomes
- Provide public facing digital services

Out of scope

Any digital change that requires funding or digital/information team resources that is not accounted for in the portfolio described below will require prioritisation against existing schemes and changes to the described portfolio to reallocate resources or funding to areas of most need

System Review February – May 2024

A system-wide digital review was initiated in February 2024 and is scheduled to conclude in May 2024. This aims to determine our level of ambition and what good looks like for digital enablement. The review will help inform how we prioritise and determine the digital initiatives that support us achieving our wider priorities and objectives for the Integrated Care Partnership. This may need us to revisit our governance, our current work programme and our operating model as we consider any recommendations in support of best practice and getting the most out of our resources to improve digital maturity and support transformation using digital solutions

2. What's being done to get there | Overview

A portfolio of work will meet those objectives:

- Digital Social Care Records
- Improve cybersecurity
- Improve technical infrastructure
- Improve technical capabilities for collaboration
- Technology enabled care (remote monitoring, virtual wards, etc)
- Robotic Process Automation
- Handover of maintenance and support of the reporting platform from external arrangements
- Determine requirements for social prescribing digital solution
- Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services

Proposed but currently unfunded

- Development of the Lincolnshire Care Record
- Scope an online go-to resource for the population to navigate health, care and wellbeing
- Integration of digital systems
- Develop framework to assess and address digital skills readiness (staff or population)
- Support areas with digital solutions that enable business change (such as People and Workforce)
- Introduce shared system intranet
- Use operational data to provide intelligence at a system level
- Replacement of the reporting platform
- Access for clinicians to LACE evidence base

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

2. What's being done to get there | Overview

Other work influencing system capabilities

ULHT	• Delivery of Electronic Patient Record • Electronic Document Management System • Change of Maternity System • Digital Outpatient appointment management • Community Diagnostic Centres
LCHS	• Single Point of Access
LPFT	• Rio EPR review • Cloud Data Warehouse Procurement and Implementation
Primary Care	• Online consultations • Digital telephony • Accelerated access to records
Cancer Team	• Chatbot integration to Lincolnshire Cancer Support Website

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Digital Social Care Records																						
Development of the Lincolnshire Care Record	• In context launch from clinical systems • Add LCHS inpatient and UTC activity • Add LPFT medicines • Add pathology and radiology results from NWAFT • Add pathology and radiology results from NLAG • Add GP and walk-in radiology from ULHT • Include Somerset cancer data • Include social prescribing data • Include Child Health data from LCC • Use national record locator to find records in other ICS Care Records		**Tasks will be scheduled when funding is identified**																			

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Scope an online go-to resource for the population to navigate health, care and wellbeing	• Provide population login and view of health record in Lincs Care Record • Provide gastro patient facing online capability							Recruit post to facilitate work														
Improve cybersecurity	• Network Access Control • Proxy Server implementation • Replace network firewalls																					
Improve technical infrastructure	• Cloud strategy • Cloud implementation • Network upgrades • Wi-Fi improvements • Telephony switch to digital • Storage area network (files and email storage)																					
Integration of digital systems																						
Improve technical capabilities for collaboration							Investigation and improvement															

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop framework to assess and address digital skills readiness																						
Technology enabled care	• Remote monitoring in care homes • Virtual Wards		Care home delivery				Pilot in virtual wards		Business case for wider adoption		Further rollout											
Robotic Process Automation							Initial use cases ULH															
Support areas with digital solutions that enable business change (such as People and Workforce)																						
Introduce shared system intranet			No funding identified																			
Use operational data to provide intelligence at a system level	• Dashboard for UEC • Dashboard for end of life																					
Handover of maintenance and support of the reporting platform from external arrangements							Business case															

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

3. What's being done to get there | Detail

Scoping	Planning	Consultation	Implementation	Delivery & impact	Evaluation	BAU

Programme	Project	FRP	2023/24				2024/25				2025/26				2026/27				2027/28			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Replacement of the reporting platform																						
Determine requirements for social prescribing digital solution																						
Access for clinicians to LACE evidence		No funding identified																				
Delivery of Customer Relationship Management system in LCVS																						

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

4. Projected impact on patients and system partners

Digital Social Care Records	Digital systems will support electronic transfers of data which are faster and more secure to speed up discharge and improve decision making across pathways of care. Care Homes without digital systems are unlikely to be rated Good or Outstanding
Development of the Lincolnshire Care Record	Those delivering direct patient care will have the information they need when and where they need it to make decision that improve patient outcomes and reduce risk for our workforce.
Scope an online go-to resource for the population to navigate health, care and wellbeing	The population will be supported in keeping well, avoiding admissions, accessing health and care services only when needed making best use of resources and supporting choice and access and reducing health inequalities.
Improve cybersecurity	Protect our services from cyber-attack, without which patients would come to harm and avoid breaches of information including patient information, recovery costs and reputational damage.
Improve technical infrastructure	Provide the infrastructure that enables a modern, mobile workforce and patients to access online services.
Integration of digital systems	Joining up information enables better decision making for best use of resources and better patient outcomes.
Improve technical capabilities for collaboration	Provide the digital solutions for staff to collaborate and operate as a system.
Develop framework to assess and address digital skills readiness (staff or population)	Having the digital skills required to use digital health solutions will capitalise on opportunities for efficiency and effectiveness, improve staff morale and patient satisfaction.
Technology enabled care (remote monitoring, virtual wards, etc)	Will reduce the need for travel and make most efficient use of resource and expertise across geographical areas in the context of rising demand on services.

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

4. Projected impact on patients and system partners

Robotic Process Automation	Improve processes through speed and efficiency, freeing up staff to deal with more complexity
Support areas with digital solutions that enable business change (such as People and Workforce)	To maximise the opportunities that digital has to support business change, improved process and efficiencies.
Introduce shared system intranet	Join up information across teams making it searchable, joining up address books, sharing knowledge, sharing learning
Use operational data to provide intelligence at a system level	Decision making can take into account system level benefits, supports service transformation and planning
Handover of maintenance and support of the reporting platform from external arrangements	Ensures that at the end of the Optum contract the maintenance and ongoing development of the joined intelligence dataset does not cease
Replacement of the reporting platform	Ensures that at the end of the Optum contract access to the joined intelligence dataset is still possible
Determine requirements for social prescribing digital solution	Informs a system level decision on where information needs to be captured, how it is shared to support PHM, health and care delivery, and reporting
Access for clinicians to LACE evidence base	Putting research and evidence into practice to achieve best outcomes for patients
Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services	Ability to manage information that supports third sector support into health and care and social prescribing

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

5. What's needed to make this happen

	Funding source to be identified	Comments on resource	Engagement and sponsorship
Digital Social Care Records	£490k if years 1 and 2 remain outstanding		ICP
Development of the Lincolnshire Care Record	£240k		ICP
Scope an online go-to resource for the population to navigate health, care and wellbeing	£100k		All ICS organisations
Improve cybersecurity	£500k		NHS organisations
Improve technical infrastructure	£300k		NHS organisations
Integration of digital systems	£100k		NHS organisations
Improve technical capabilities for collaboration		To be undertaken by existing digital teams	NHS organisations
Develop framework to assess and address digital skills readiness (staff or population)	£80k		All ICS organisations
Technology enabled care (remote monitoring, virtual wards, etc)	£500k		ICP
Robotic Process Automation	£200k		NHS organisations
Support areas with digital solutions that enable business change (such as People and Workforce)	£60k		NHS organisations
Introduce shared system intranet	£100k		NHS organisations
Use operational data to provide intelligence at a system level	To be scoped		NHS organisations
Handover of maintenance and support of the reporting platform from external arrangements	To be scoped		ICP
Replacement of the reporting platform	To be scoped		ICP
Determine requirements for social prescribing digital solution		Workshops needed	ICP
Access for clinicians to LACE evidence base	To be scoped		NHS organisations
Delivery of Customer Relationship Management system in Lincolnshire Community and Voluntary Services	Already funded		All ICS organisations

Digital

Digital	SRO: TBC	Programme lead: Kathy Fulloway	Clinical/Technical Lead:

6. What could make or break progress

- Lack of funding
  - Nationally digital transformation funding becomes available in year and has little protection and so may be subject to review at any time, which we have seen occur with connected care record funding, for example. This means that forward planning is hampered as there is little certainty and the reliance then is predominantly on local business cases to be made.
- Lack of resources
  - There are currently limited resources with roles dedicated to system digital work – a Chief Digital Information Officer, a Programme Manager for the Lincolnshire Care Record, a business partner who supports Primary Care and a project manager who supports Shared Care Plans. This leaves significant areas of opportunity without sufficient capacity to undertake business partnering, needs assessment, business case creation and solution design and business analysis that would support improvements through technology, as well as the delivery, coordination and programme management of wider digital transformation opportunities such as remote monitoring for which there is no dedicated resource.
- Insufficient capacity for business change
  - It is well evidenced that the resources required to deliver digital initiatives, support change adoption and work through business change associated with new initiatives is often underestimated. We do not have dedicated business change support for digital transformation at a system level and need to ensure this is built into all relevant business cases. Coordination of digital transformation needs dedicated resource at a system level to ensure that business change is realistic, safe and controlled. Without this, an operational area could attempt to adopt multiple changes at the same time risking delivery, causing stress for staff, increasing risk for patients, and incurring unnecessary cost – undertaking change in a coordinated and controlled way ensures that planned benefits are delivered.
- Political change
  - A change in government may introduce policy changes and affect funding opportunities.

7. Planning assumptions

- External funding awarded continues to be available (e.g. Frontline Digitisation, cyber allocation)

Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

1. The **Lincolnshire Strategic Infrastructure and Investment Group** (LSIIG) is now well established and provides the forum for discussions regarding the Strategic Infrastructure Plans and capital schemes that are being developed.
   a) There is an Operational Estates Group, chaired by the LPFT/LCHS Associate Director for Estates & Facilities which meets monthly and, by exception reports into LSIIG
   b) The Financial Recovery Estates and Facilities workstream sits within the remit of the Operational Group and reports into LSIIG.
   c) Whilst capital allocations across the system are siting with the Financial Leaders Group there are strong links between the two Groups with several representatives sitting on both. LSIIG receives a monthly report from the System Finance Lead **Building for Health.** Taken as a whole the NHS is one of the largest landowners in England. Through its role as an anchor institution, the NHS has an opportunity to intentionally manage its land and buildings in a way that has a positive social, economic and environmental impact. The effects of good management can improve the health and wellbeing of communities and reduce health inequalities.

2. NHSE (NHS England) has summarised the key-ways estates and facilities can play their role in reducing health inequalities in their 10 building blocks for building for health. NHS England » Building for health. The building blocks can be applied to all aspects of estates management including in the:
   a) delivery of new healthcare buildings, for example through the New Hospital Programme or the development of community diagnostic centres
   b) modernisation of NHS facilities
   c) prioritisation of investment
   d) management of the use of NHS buildings and spaces
   e) disposal' or repurposing of facilities the NHS no longer needs – the NHS Estates and facilities workforce action plan (2022) sets out ways to address estates workforce needs
   f) The NHS Net Zero Building Standard, published on 22nd February 2023, provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. Developed together with healthcare, industry, and sustainability partners, the Standard will support the NHS to get ready for and align with UK Government building requirements, as well as meet its commitments to deliver a net zero health service by 2045. The NHS became the world's first health service to commit to becoming net zero in response to the profound threat to health presented by climate change.

3. **Lincolnshire Infrastructure and Investment Framework**
   a) Lincolnshire ICS (Integrated Care System) has significant issues with the current estate, and this is impacting on our ability to deliver and transform patient care and provide the best possible environment for our patients and staff. Collectively we recognise that a "do nothing/do minimum" approach is not sustainable and therefore we need to attract significant capital investment over the next 15 years.
   b) The infrastructure plans we are developing set out our ambitions to modernise our NHS infrastructure; providing care in the right way, in the right place to meet need. This takes account of the need to transform and integrate services and ensuring that we have a population, place-based needs approach aligning to our digital strategies and the rural and coastal challenges that we have across Lincolnshire.
   c) This work estimates the capital cost ask of £1.94bn (at today's prices). Without Lincolnshire being recognised as a national priority, it is unlikely to attract significant funding and enable the transformation required to enable a healthier population supported by high-quality health and care services that benefit everyone. We were not successful in any of our expressions of interest for the New Hospital Programme, submitted in 2021.

Estates

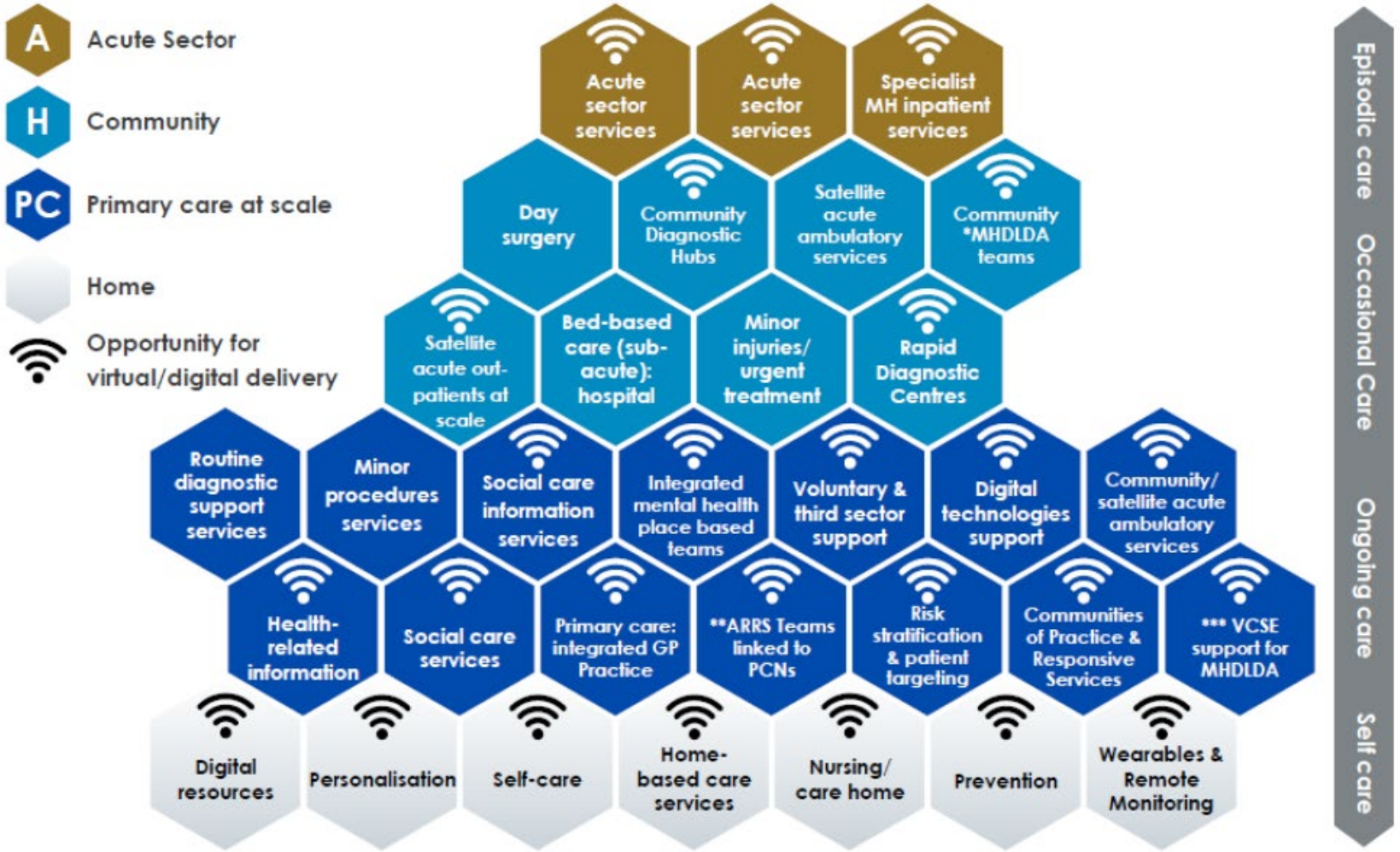
Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

d) Lincolnshire ICS has developed a strategic framework which articulates the high-level programme case for the significant investment that is needed and without which our clinical vision and strategies will not be delivered.

e) It is an iterative framework that will enable each Trust and Primary Care to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs across Lincolnshire.

f) It is supported by a suite of technical documents that are saved on the System NHS Futures Page.

g) It helps the ICSs (Integrated Care Systems) to aggregate and prioritise requirements against other system demands for capital. We are working to agree the key priorities for the next 5 to 10 years using a scenario model to ensure that we focus on developing those business cases that can be “oven-ready” for funding as it becomes available



Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

4. Current and recent Capital Developments

a) In December 2022 **Grantham Hospital** opened a new £5.3million modular building which includes two operating theatres, along with their associated preparation rooms, utility facilities and a six-bed recovery.

b) **Lincoln County Hospital**. The £5.6m expansion of the Emergency Department Resuscitation area opened in January 2023. It contains eight treatment cubicles, all fitted with patient hoists and the latest equipment needed to provide life-saving support for patients.

c) **Pilgrim Hospital Boston**. The work has started on the Boston Urgent and Emergency Care. The £37.9m development includes the demolition of the existing H-block building and the erection of a two-storey extension with a full refurbishment. It will more than double in size and include state of the art innovations and infection prevention control measures, have more cubicles to treat patients and a bigger resuscitation zone for the sickest patients. It will also include a separate area dedicated to providing emergency care for the hospital's youngest patients and their families and have more training rooms for staff.

d) **Mental Health Wards**

- In June 2023 LPFT opened two new mental health inpatient 19 bed wards - Ellis and Castle on the Lincoln County Hospital site. All patients have separate ensuite accommodation for our patients. They all have ground floor access to a courtyard area for peace and quiet. The £25m development includes outdoor environment which offers major benefits to our patients helping to support their recovery. The design of the new wards has been shaped using feedback from patients, carers and staff as part of our 'Building Together' programme
- In December 2023 LPFT received NHSE full business case approval for a new 19-bed mixed-gender inpatient ward at the Norton Lea site in Boston

e) **Community Diagnostic Centres (CDCs).** The first opened in Grantham in 2022 and business cases have been approved for two further sites in Lincoln and Skegness. These modular builds will open in 2024.

f) **PE21 Boston.** Since 2015, Boston Borough Council (BBC) and the NHS have driven forward a passionate partnership vision for health/wellbeing regeneration. BBC has successfully secured £14.8m from the Government Levelling Up Fund to kick-start regeneration and secure further investment to the heart of the town centre.

- The Levelling Up Fund is specifically designed to secure capital investment in infrastructure that has the potential to improve lives and give people pride in their communities. Boston's Rosegarth Square masterplan, forming part of PE21, seeks to revitalise and repurpose the area between the river Witham and the bus station - particularly focusing on the area of the former Dunelm/B&M building and the vacant Crown House building.
- The ICB (Integrated Care Board) has secured £650,000 to fund the business case for an integrated health and care centre, potentially on the PE21 site. The work is underway with the business case due to be completed summer 2024.

Estates

Strategic Estates	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

5. Primary Care Network Estates Strategies

a. There has been a programme to support Primary Care Network Estates strategies. Community Health Partnerships (CHP) worked with the National Association of Primary Care (NAPC) on behalf of NHS England, to produce a Primary Care Network (PCN) Estates Toolkit to provide PCNs (primary care networks) with a flexible framework and support process for producing robust primary care investment plans with clear priorities that align to wider ICS strategies.

b. The toolkit had two objectives:

- To enable each PCN to identify and prioritise their estate optimisation, disinvestment, and subsequent capital investment requirements to address population health priorities and future service needs.
- To support the production of capital investment plans for PCNs and places and help ICSs to aggregate and prioritise local primary care investment requirements against other system demands for capital.

c. CHP commissioned advisors to work with the Lincolnshire PCNs.

d. The work has been finalised and is being socialised within the system to confirm the Primary Care priorities.

Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

On 1 July 2022, the NHS became the first health system to **embed** net zero into legislation, through the Health and Care Act 2022.

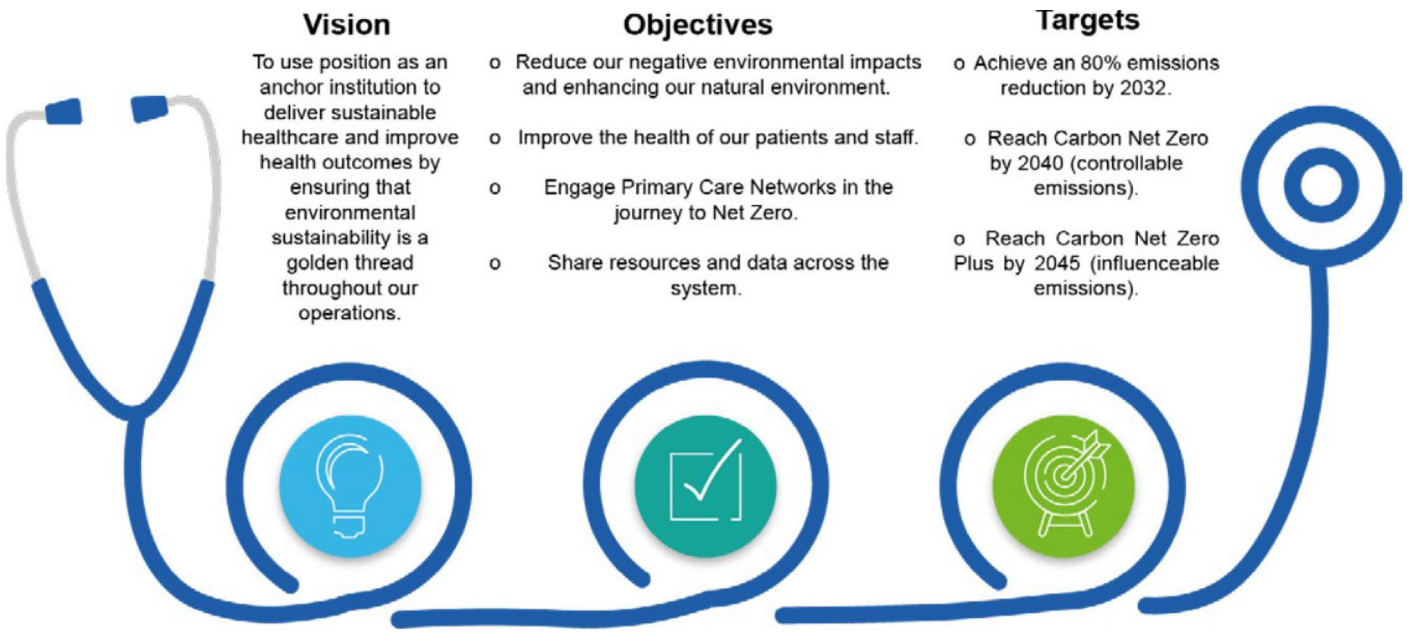
- This places **duties** on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.
- The Act **requires** commissioners and providers of NHS services specifically to address the net zero emissions targets.
- It also **covers** measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

The UKHSA published their first Health Effects of Climate Change report, with the apt acronym of HECC. It is an important overview of exactly how climate change is affecting health, and the extent to which it will do so in the future.
To support this net zero ambition, each trust and integrated care system should have a Green Plan which sets out their aims, objectives, and delivery plans for carbon reduction. ICB plan approved November 2022

The Greener NHS programme is arranged in a number of workstreams:

- Models of care -
- Workforce -
- Medicines -
- Estates and facilities -
- Travel and transport -
- Supply chain -
- Adaptation -
- Research and innovation -
- Digital -
- Data and analytics

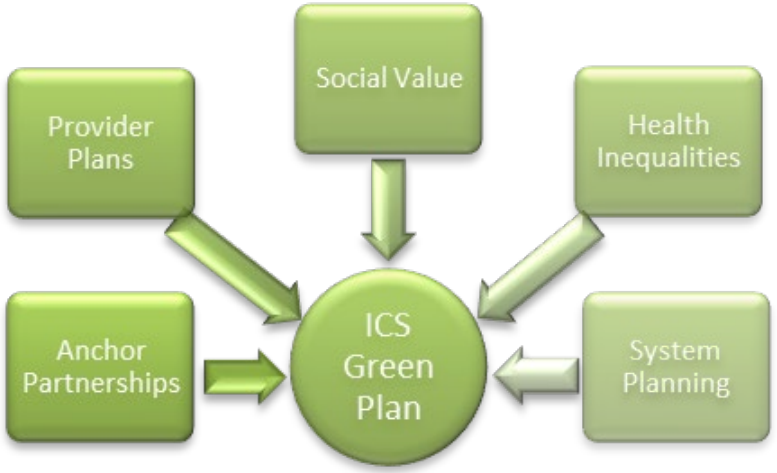
The Lincolnshire System Greener NHS Plan's vision, objectives and targets:



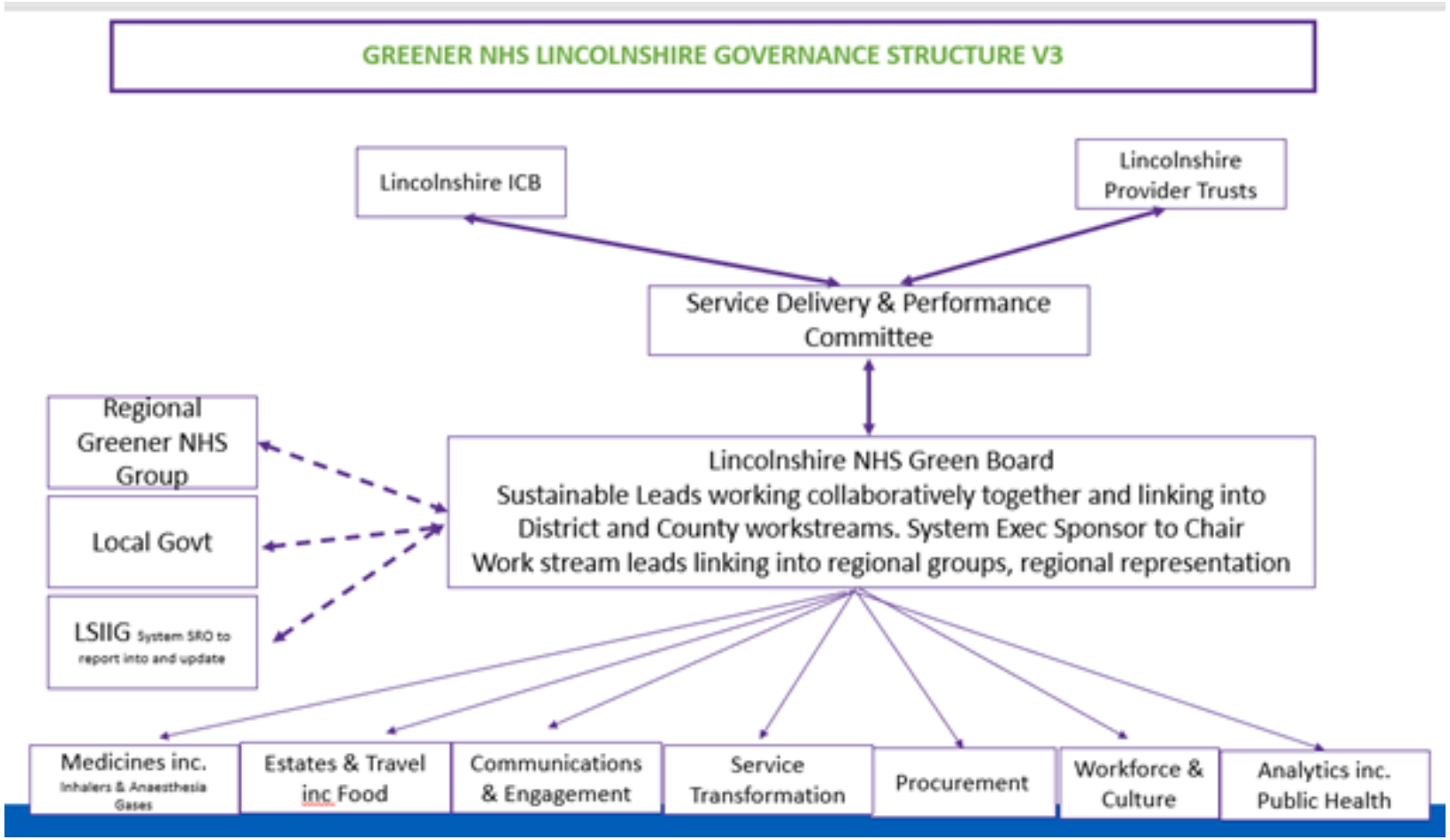
Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

The Lincolnshire NHS approach is as follows:



The Governance structure for the Lincolnshire Greener NHS is as follows:



Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

Areas of work include:

	• Work to deliver the NHSE Travel & Transport Strategy recognising the challenges in a rural and coastal county • NHS England » Net Zero travel and transport strategy • Working with District and County Council colleagues on EV charging
	• We have reduced the proportion of desflurane anaesthesia gas used in surgery to less than 5% of overall volatile anaesthetic gases with the aim to eradicate this completely. • Reducing the emissions associated with nitrous oxide waste, in line with the Standard Contract. • Reducing the CO2e impact of inhalers -this is part of the Primary Care Green Plan
	• Ensure plans are in place to phase out fuel oil as a primary heat source [in NHS Secondary Care sites], • Ensure all new builds and retrofits over £15m are compliant with the Net Zero Hospital Buildings Standards • ULHT and LPFT have bid for Public Sector Decarbonisation Scheme (PSDS) funding to improve the estate and reduce the Trusts carbon footprints
	• Ensuring that the Green Agenda is incorporated into all staff inductions across the system. • Work towards all staff complete the ESR training. • As the system leadership changes are embedded and the Group Model Established agree the Board leadership for the Green Agenda and appropriate awareness and training for Boards
	• All new NHS procurements include a minimum 10% net zero and social value weighting as per the PPN06/20 and PPN06/21 Greener NHS » Applying net zero and social value in the procurement of NHS goods and services (england.nhs.uk) • Achieving a 50% reduction in use of office paper by 2025 compared to baseline, and ensuring ICSs and NHS trusts only purchase 100% recycled content paper for all office and non-office-based functions by 2025.

Each provider Trust has its own Green Plan and assurance process. A final draft Primary Care Green plan is being socialised. The final draft version is already on the primary care intranet.
The primary care bulletin now includes a specific 'GREEN' section. Communications are being aligned to any national 'GREEN' event so we can promote with Practices.

Work will be completed by March 2024 on a system Carbon Footprint assessment. This will show the progress that has been mad, where we are on our net zero journey. This work is needed to support the trajectory planning needed to ensure we are able to meet the national net zero targets.

The communications leads across the System meet regularly to agree campaigns and responses to national and regional green messaging opportunities.

The Programme Director for Partnerships, Planning and Strategic Estate is working with colleagues in the County Council regarding climate change and climate mitigation. There is a proposal for setting up a Lincolnshire Climate Adaptation Forum which the NHS will be part of.

There are also countywide sustainability discussions the Greater Lincolnshire Strategic Infrastructure Group and the Greater Lincolnshire One Public Estate Board, both of which the NHS is represented by the Programme Director. This work includes energy, waste and EV charging

Greener NHS

Greener NHS	SRO: Sarah Connery	Programme lead: Jacqui Bunce	Clinical/Technical Lead:

System Maturity Assessment

As systems continue to take on greater collaborative responsibility for the delivery of a Net Zero NHS, programme performance issues should be addressed as close to the system as possible. Whilst regional teams will continue to have a role in managing programme development and performance; this responsibility should shift to the system as it matures.

In order to better align the regional Greener programme assurance regime with that of other regional programmes, the Midlands Greener programme will implement a system tiering model in 2024/25.

System programmes will be assessed based on their maturity within 7 domains and 4 criteria. Each domain will be weighted and based on the assessment criteria from each domain, a score will be generated, to divide systems into overall programme maturity tiers, from 1 (Emerging) through to 4 (Thriving).

The maturity assessments will be agreed between the system and the Regional team before the end of the financial year 2023/24 and this will confirm the level of “support” for 2024/25

Section 4: Planning, delivering and evaluating our service improvement

a) Intelligence: Opportunity identification, measurement and evaluation
b) Our system improvement framework
c) System governance arrangements

Intelligence generation and opportunity identification

The Lincolnshire ICS Joined Intelligence Dataset is one of the most advanced in the country. It combines record level, pseudonymised data from across some of our largest primary, secondary and acute care services including hospital, community, mental health, general practice and adult social care data. The dataset continues to be expanded, to include more essential data sources that help our ICS and decision makers to understand the needs, causes, outcomes and disparities of our populations.

Sub-licencing processes have been established so that our ICS partners and GP practices can access joined, pseudonymised data via our Optum Reporting Suite. This expands the analytical capacity we have across our ICS to maximise the value of the dataset and to enable PCNs and practices to investigate cohorts and outcomes within their own populations and act upon the intelligence. Support to access, interpret and utilise the intelligence continues through training programmes and access to skilled analysts.

Intelligence from the Joined Dataset is being used across the ICS at local level to identify opportunities, develop interventions, target support and evaluate outcomes, and at the system level to inform strategy development and major transformation. The ICS analytics community is being supported through a programme of learning and development opportunities, including peer to peer support.

The work is closely aligned with activities across the system including the development of the ICS Digital, Data and Technology Strategy and the development of data and intelligence platforms such as the Lincolnshire Health Intelligence Hub (https://lhih.org.uk) and Athena, AGEM's imminent replacement for their GEMIMA system.

Together these activities begin to change the way that the ICS intelligence and analytics community can work together. Opportunities for collaboration are increased through shared priorities and access to a shared, joined dataset, which provides a system view of activity as well as understanding of journeys and outcomes for cohorts of the population and individuals.

The way that analysts work with decision makers is also changing. The joined dataset and technical capabilities allow analysts to directly support decision making processes and discussions, moving understanding on much more quickly than ever before. Opportunities for improvement in outcomes for cohorts of the population can be quickly identified, and understanding of the characteristics and health service behaviours of those cohorts can be provided which can be key in developing interventions and alternative provision to improve outcomes. Cohorts can then be identified in primary care for direct intervention, and the impacts of intervention evaluated.

Short- and Medium-Term Priorities

- Continued understanding of the joined data that we have, its further development and improvement, and its best use
- Appropriate widening of the ICS Joined Intelligence Dataset.
- Continued onboarding of users.
- Intelligence & analytics workforce development.
- Continued support to end users of data and intelligence to encourage best use through action learning.
- Increasing collaboration across the ICS Intelligence & Analytics capacity.
- Development of new intelligence provision through the software and tools available within Athena
- Continued joint development of the Lincolnshire Health Intelligence Hub https://lhih.org.uk

Developing our system improvement framework

1. The driving ambition

Our ability to deliver on the ICS mandate to improve health and care at scale rests to a significant degree on the success of our collaboration.

As health and care services concurrently try to focus on longer term population health ambitions while addressing immediate challenges, we are increasingly thinking of improvement through the lens of system working.

Historically, the majority of improvement efforts have been focused on organisations and the services they provide, concentrated on acute hospital services and reliant on central direction.

Our ambition is to re-balance this thinking and develop Lincolnshire into a dynamic self-improving system that:

- Aligns top-down pressures for improvement relating to strategy, accountability and resource allocation with
  - understanding what matters to people and communities: not only responding to public preferences but also how we engage with people as empowered partners – which is intrinsically linked with the 'Our Shared Agreement' work developing a new social contract with Lincolnshire citizens; not only involving individual groups who have a particular need around care, but also looking at whole populations and working with communities to address inequity
  - responsiveness to staff: generating approaches to improvement that are owned by those doing the work – understanding that real change happens in real work
  - Incorporating peer-to peer learning, challenge and support, both within our system and beyond
- Supports the delivery of our big, bold population health improvement goals as well as care delivery; collaborating across all ICS partners to tackle the wider determinants of health and wellbeing; adopting appropriate methods – learning from other sectors e.g. unlocking community power to transform public services
- Reaches the parts of the health and care system that have not previously benefited from investment in improvement capabilities and resources
- Adopts the learning health system concept, which is focused on systematic, intelligence-driven improvement and predicated on the development of high-quality measurement and analytical capability
- Knows itself inside out in terms of understanding: population health needs; capacity and capability; developing a clear understanding of the relationship between investment and outcomes
- Legitimises improvement: achieving a culture shift with the emphasis on commitment not compliance, where improvement is everyone's business
- Enables stronger collaboration across organisations and more effective scaling of innovation
- Harnesses the power of the collective: making the most of all the resources and the expertise that exists in Lincolnshire, so the sum is greater than the individual parts

Developing our system improvement framework

2. The intended end-product

The Better Lives Lincolnshire Leadership Team has agreed to and is committed to the development of a framework that provides a cohesive approach to improvement, learning and innovation. This will focus on two main elements: creating the conditions for change; delivering transformation.

The emphasis is very much on framework rather than something overly prescriptive: agreeing common language and principles; incorporating a suite of resources and tools that can be best matched to the people involved and the problem that is being tackled; ensuring visibility of all the various support offers.

Creating the conditions for effective, sustainable improvement

- Creating collective understanding, vision and leadership
  - Co-creating a vision and narrative for change – considering the legacy and learning of previous improvement efforts; Assigning responsibility and building shared ownership for improvement; Building leadership support; Engaging all partners & communities – building relationships
- Aligning operating models to direct and enable improvement
  - Building consensus on what is best done at system level; Aligning resources and priorities; Balancing demand for rapid results & systemic transformation; developing goals and ability to measure progress; redesigning management systems to enable improvement
- Fostering the capability, connections and culture needed to learn and improve
  - Understanding current expertise and assets; Building skills and space; creating collaborative learning structures, networks and communities; ensuring learning is systematic

.

Enabling the planning and delivery of changes across the system, to transform care and improve outcomes

- System-wide diagnosis and redesign of pathways
  - Taking a whole population view of needs, inequities & assets; managing system shifts in infrastructure; diagnosing and redesigning end-to-end pathways and service models
- Continuously improving quality and service performance
  - Supporting work by service level teams; Understanding and optimising performance of the system as a whole; adapting roles, ways of working, metrics and linked systems
- Identifying and embedding innovations to meet future needs of the system
  - Understanding the current situation and desired futures; Identifying priority gaps and innovations; testing, experimenting, scaling and embedding innovations

This framework would encompass all assets, support offers and improvement methodologies e.g. Clinical & Care Directorate (leadership, pathway redesign & research & innovation), population health management; health inequalities; personalisation; provider improvement resource

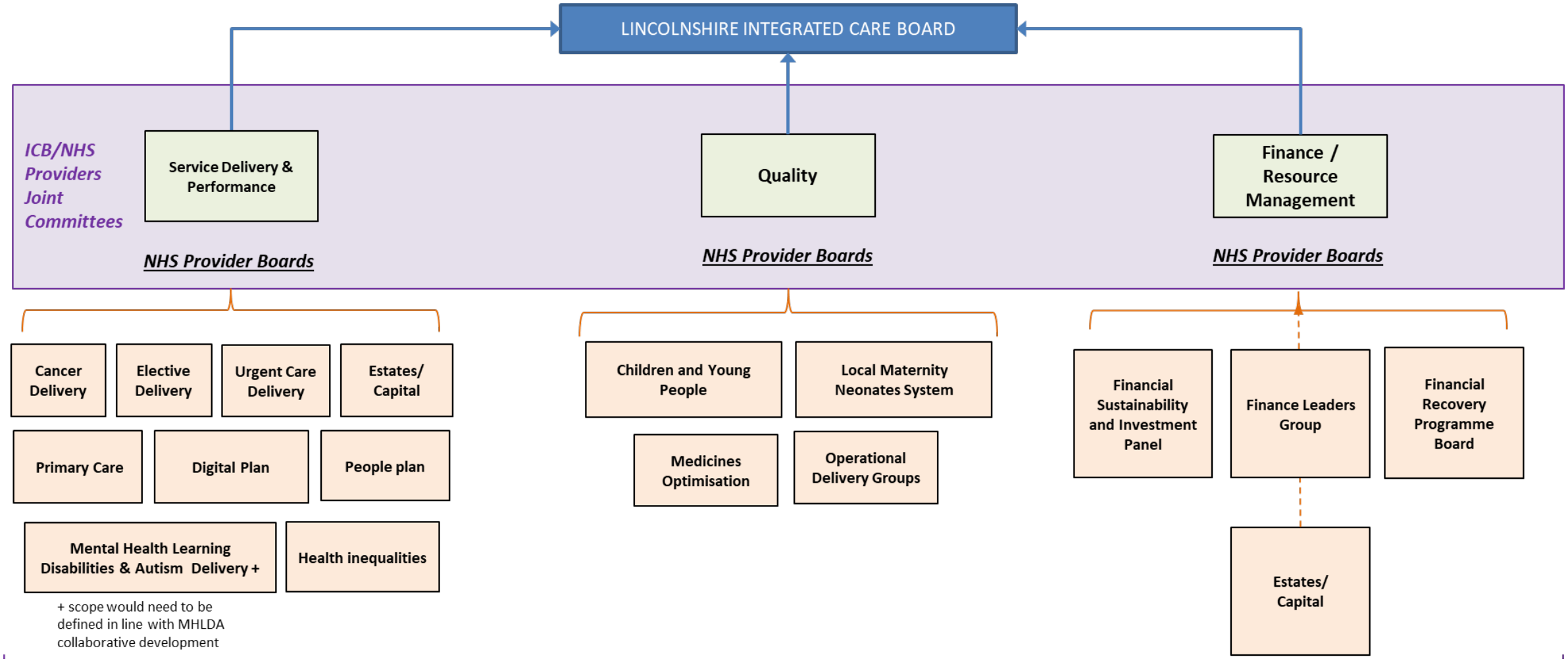
Developing our system improvement framework

3. The approach to making this happen

The headline plan for progressing this work is:

1a) Set up a working group Building on the QI Strategy working group membership, with representatives from: Lincolnshire County Council – Adult Social Care and Children's Services; Lincolnshire Integrated Care Board; United Lincolnshire Hospitals NHS Trust; Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; Lincolnshire Primary Care Network Alliance; Lincolnshire Voluntary Executive Team; Lincolnshire Care Association; University of Lincoln 1b) Link in with the national support offers i.e. The Health Foundation and the NHS Confederation	March – April 2024
2) Draft up the framework - Building on and incorporating our work to date (e.g. QI and research Strategy development work; Integrating the LACE/PHM/Personalisation/Health inequalities offers; ADHD project) - Reflecting the outcomes of the NHS IMPACT self-assessment completed by the Lincolnshire NHS Trusts and Lincolnshire County Council (both Adult Social Care and Children's Services) - Using the Q framework, incorporating Lincolnshire's improvement assets & capabilities	April – May 2024
3) Test the framework on two system transformation initiatives Selection criteria: - Involvement of as many ICS partners as possible - Strategic fit: system priority; potential to improve outcomes for key population segments - Likelihood of success; requisite capacity in place - Helpful timescales – still yet to start but scheduled for Q1 2024/25 Proposed initiatives: - Children & Young People asthma (Children & Young People programme) - Respiratory (Integrating Specialist Care programme in the Primary Care, Community & Social Value portfolio)	June 2024 onwards

Overall system governance & oversight



Monthly reports covering

- Activity & Performance: delivery against the national objectives and other national metrics/LTP commitments (P132-136)
- Workforce: actual v planned trajectories for substantive, bank and agency
- Finance: existing FRP delivery against plan headlines; other key financial headlines: run rate; projected March 2024 position

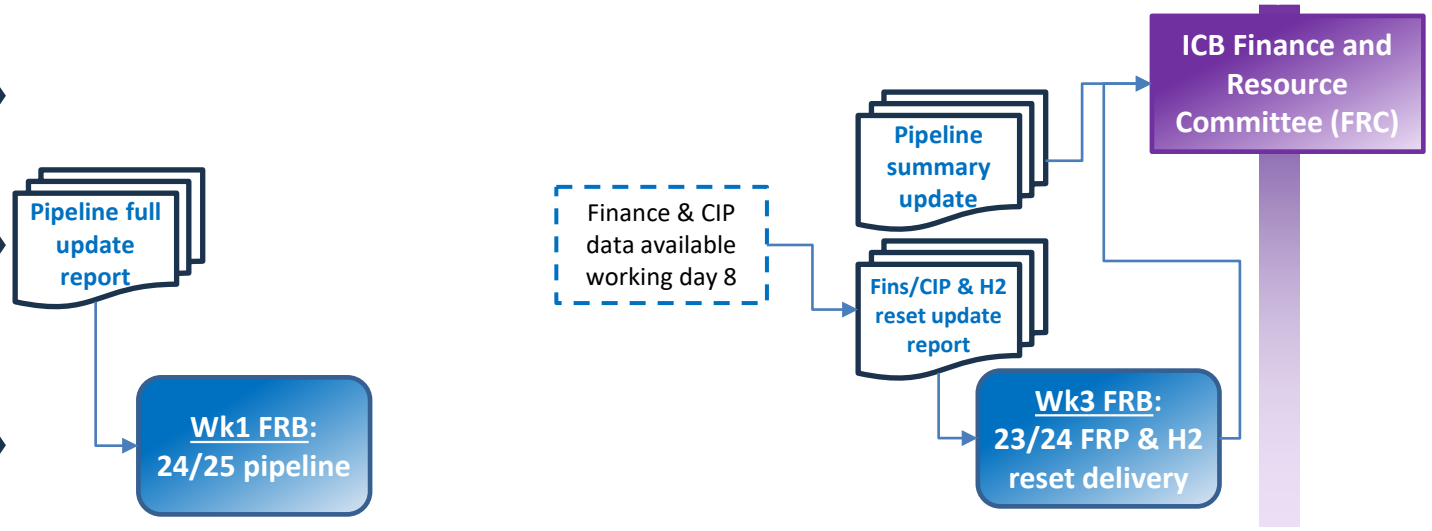
Financial Programme Recovery Board meetings: Phase 2

Week 1	Week 2	Week 3	Week 4	[Week 5]

ICB FRP oversight meetings

Core data and reporting

Financial Recovery Board (FRB) meetings



Progress review meetings with SID

Pipeline area deep dives as requested by wk1 FRB

Pipeline progress catch ups with all providers and cross cutting workstreams (indicative timings)

Attendance at key provider and workstream assurance meetings as useful to provide constructive check and challenge and assurance

Key FRB agenda items

Week 1 FRB agenda and attendees

Area	Commentary
ICB (30 mins)	ICB (30m)
Providers: 1:45hrs	LPFT:30m; LCHS:30m; ULHT:45m
Cross system work streams (1 hr)	To include pipeline workforce & longer term H2 reset actions
Notes	*To include break*

Week 3 FRB agenda and attendees

Area	Commentary
ICB (30 mins)	ICB (30m)
Providers: 1:45hrs	LPFT:30m; LCHS:30m; ULHT:45m
Items	*To include H2 reset workforce delivery.*

Core FRB attendees

Area	Board attendees
ICB	CFO and/or SID; CMO/ CNO; COO or equivalent
Providers	At least two Exec Dirs: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Area	Board attendees
ICB	CFO and/or SID; CMO/ CNO; COO or equivalent
Providers	At least two Exec Dirs: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Financial Programme Recovery Board meeting approach: Phase 2

Week 1 FRB Pipeline - agenda and attendees

30 mins	ICB	• Key actions update; • Update on FRP scheme delivery; • Productivity update;
30 mins	LPFT	• Per Group agenda below
30 mins	Work-streams 1	• Updates on workstream pipeline development progress for 24/25;
	Break	
30 mins	Work-streams 2	• Workforce medium long term • Focus areas as requested by FRB
1 hour 15 mins	Group: LCHS	• Key actions update; • Pipeline progress updates/phasing; • Ideation & delivery approaches; • Key opportunity areas (deep dives); • Productivity update (key areas); • AOB • *Outcome: FRB requests for further assurance.*
	Group: ULHT	

Organization	Board attendees
• ICB	• CFO and/or SID; CMO/ CNO; COO or equivalent
• Providers	• At least two Executive Directors: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Week 3 FRB H2 reset and pipeline - agenda and attendees

30 mins	ICB	• Key actions update; • H2 reset actions and delivery update;
30 mins	LPFT	• Per Group agenda below
30 mins	Work-streams	• Workforce short term controls (H2 reset); • Exception reporting for Workstream updates with 23/24 FRP impact;
	Break	
1 hour	Group: LCHS	• Key actions update; • H2 reset actions and delivery update • Delivery progress on full year FRP CIPs • Getting to recurrent run-rate impact of 24/25 schemes • AOB • *Outcome: FRB requests for further assurance.*
	Group: ULHT	

Organization	Board attendees
• ICB	• CFO and/or SID; CMO/ CNO; COO or equivalent
• Providers	• At least two Executive Directors: CFO, COO; CMO/CNO; CPO; & relevant CIP leads

Item 8 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (ii)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Delegation of 59 Specialised Service to ICBs
Report Author:	Mrs Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration
Presenter:	Mrs Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration
Appendices:	Delegation Agreement for Specialised Services Memorandum of Understanding and Collaboration Agreement Appendix One – Delegated Financial Authority Limits

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

Recommendations

The Board is asked to:

- Approve authority to progress to the formal Delegation of the 59 Specialised Services approved by the NHS England Board on the 6 December 2023 and the associated documents attached to this report.

Summary

1.1 Since April 2023, the Midlands ICBs and NHS England have operated under statutory joint working arrangements to commission specified Specialised services. This has included 59 Acute Specialised Services identified in the Specialised Commissioning Roadmap (May 2022) as suitable and ready for delegation.

1.2 Following an agreed due diligence process it is recommended that the 11 Midlands ICBs support formal delegation of the 59 services in April 2024. This is in line with the ICB readiness submission to NHS England though the pre-delegation assessment framework and the subsequent NHS England Board approval in December 2023.

1.3 National policy requires ICBs to work in formal collaboration regarding Specialised Services. This responsibility, it is proposed, will be enacted through the East and West Midlands Joint Committees. However. the decision to move from joint working to formal delegation is a decision for each statutory ICB Board. Given the NHS

England Board decision and policy direction, all Boards who do support the recommendation will be enabled to progress.

1.4 All ICBs are expected to receive the delegation of all agreed Specialised Services (Acute, Mental Health and Learning Disabilities, and Vaccinations) by no later than April 2025. The proposed phasing of delegation, with 59 services proceeding in April 2024, provides the Midlands ICBs with the opportunity to build experience in commissioning these services with a developmental safety net of a transitional year. NHS England will provide significant support to ICBs from 2024 to 2025 as they take on these delegated functions.

1.5 The delegation of the 59 Acute specialised services is too individual ICBs, however, the formal Delegation Agreement requires ICBs to collaborate in a multi-ICB partnership. The Delegation Agreement must therefore be supported by a Collaboration Agreement and Commissioning Standard Operating Framework, which includes NHSE as a partner in their continued role in commissioning retained services. The approach supports the requirement to consider the cross-system population needs that support safe and sustainable care in specialised provision.

1.6 The Midlands have developed a joint Memorandum of Understanding as a part of the suite of delegation documents, setting out our collaborative commitment to working together to maximise the benefits of delegations for patients, populations and across complex pathways.

2. Responsibilities and Accountabilities

2.1 The delegation of specialised commissioning does not change the accountability for these services as this remains with NHS England.

2.2 Upon delegation the services become the responsibility of the 11 Midlands ICBs. As noted, the ICBs are required to commit to working together to commission these services. NHS England remains a partner in this process and is responsible for the commissioning of retained specialised services.

3. Benefits of delegation

3.1 The primary purpose of delegation is to benefit the care provided to patients across their care pathways, improve access and reduce inequalities for whole populations. There is a significant opportunity to ensure that the disconnect between the commissioning of specialised services through NHS England and the local commissioning bodies is removed.

3.2 The clinical leaders across ICBs and NHSE have identified the delegation benefits as follows:

Equity of access for all patients: There is good evidence that this varies across geographies with those further from specialised provision less likely to have access. Delegation provides the opportunity to understand access and consider outcomes and value across pathways.

Whole pathway approach: Joining up the whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing pressure on specialised services.

In addition, this ensures any proposed changes in specialised services are planned

with interdependent local services; this could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.

Facilitation of whole pathway transformation across ICS footprints as new services are introduced: It will allow implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

3.3 An example of the benefits of delegation is set out below:

Renal Services

The need for **renal dialysis** can be reduced by ICBs focusing on identifying those at risk for developing kidney disease and its progression. New treatments are now available to delay progression which if systematically implemented should reduce population dialysis and transplantation needs.

Currently planning and delivery are separate between primary and tertiary care and more local solutions could be developed. More integrated commissioning of specialised renal services would make innovations easier by:

- The same people and organisation being responsible for commissioning both the specialised (e.g. dialysis) and non- specialised (GP led) parts of the patient pathway ensuring complete clinical join up of pathway.
- Budgets could be pooled which creates more of an incentive to prevent renal progression, promotion of home therapies to reduce transportation costs and prompt referral for renal transplantation.
- Wider service provision could be included more easily e.g. psychological support and welfare support.
- Services can be tailored around the needs of local populations helping to address health inequalities.
- Those who do need specialist services will still be able to access them in line with national standards and policies.

4. Summary of the due diligence process

4.1 The 11 ICB and NHS England have been working together throughout 2023/24 through formal joint working arrangements. This has enabled ICB specialised services leads to understand and work alongside NHSE teams, making informed decisions on finance, quality and commissioning and contracting.

4.2 The approach to the transition process for delegation has been led through joint working groups covering finance, governance, clinical quality, strategic commissioning, and planning. This approach was informed by the design principles and operating model set by ICB CEOs.

4.4 The comprehensive national safe delegation checklist, which all regions utilise to provide joint ICB and NHS England assurance on deliverables for safe delegation, has guided the approach to due diligence. In addition, learning from the POD delegation, an additional process was agreed and led in the Midlands including ICB and NHSE leads. The summary due diligence reports have focused on four key domains and have been received by the East Midlands and West Midlands Joint Committees. The due diligence domains are set out below:

- **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in 24/25.
- **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
- **Resources** – staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role.
- **Benefits and opportunities** – Clarity on the benefits of proceeding with delegation in 24 /25. This assessment must also consider the missed opportunity that may accrue through delay to delegation.

There has been a level assurance met against each of these domains.

4.5 The joint working groups have co-produced several key documents that support the delegation of these services, these include:

Delegation Agreement: Nationally mandated document setting out the formal legal requirements of delegation.

Memorandum of Understanding (MoU) and Collaboration Agreement 2024/25
The MoU sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHS England Midlands. The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process. The Collaboration Agreement, which is between the 11 ICBs and NHS England sets out how ICBs will make joint decisions through delegation of responsibility to the existing Joint Committees in the East and West Midlands, how they will commission the services and the financial framework in which they operate including the operation of a pooled fund between the 11 ICBs to manage financial risks across the Midlands. The agreement also sets out how NHS England will work with the ICBs on services that have been identified as suitable for future delegation but are not yet being delegated. The initial agreement is for one year in which it will be reviewed prior to further service delegation.

5 Future arrangements

5.1 **Decision Making**
On agreement of individual ICBs to accept the delegation of the 59 Specialised Acute service lines, Boards are asked to support the delegation authority for decisions related to these specialised services through to the Joint Committees, established through the Joint Working Agreement in operation in the East and West Midlands. Terms of Reference have been amended from the Joint Working Agreement arrangements to reflect this change. The committees have authority to establish appropriate subsidiary arrangements to support the efficient operation of those services, which will include establishing appropriate delegations to enable day-to-day decision making through sub-groups, details of these subsidiary arrangements are summarised in the Collaboration Agreement and will be formally ratified by the Joint Committees at their first meeting after 1 April 2024.

5.2 **Finance Subgroup -** A Joint Finance and Contracting Subgroup reporting to the Committees that will oversee the financial framework.

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services which will be transferred to the Host

ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this is articulated in detail in the Collaboration Agreement.
NHS England will commit to continue to regularly review the overall financial position and risks with ICBs and ensure the retained services and 59 acute delegated services are reviewed together.

5.3 **Quality Subgroup -** Quality will be overseen by the Specialised Commissioning Quality Group. The group will provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues, and risks that are recurrent and/ or have an impact wider than individual ICSs.

5.4 **Midlands Specialised Services Commissioning Subgroup** – A multi-disciplinary group that oversees the design, development, planning, transformation, improvement, and reduction of inequalities for the effective delivery of services.

5.5 During 2024/25 the ICBs and NHS England will continue to develop and share expertise through a clearly defined joint workplan to including quality, finance commissioning and planning.

5.6 In line the agreed governance framework ICBs should add the following to their Scheme of Reservation and Delegation and SFI's (where applicable): 'Delegated Specialised Commissioning - Decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.'

6. Recommendation

6.1 In summary ICBs have been jointly working with NHS England throughout 23/24 to commission acute specialised services and gain an understanding of the risks and issues.

It is proposed that Midlands ICBs work together and receive an initial delegation of 59 Acute Specialised in 2024/25. This will enable ICBs to have the benefit of learning and developing their approach in a phased manner before the full delegation of further specialised services (including Mental Health and Learning Disabilities) and immunisation and vaccination services in 2025/26.

The ICB Board is asked to approve the following:

- Delegation of the defined set of 59 specialised acute services to the ICB on the 1 April 2024 and associated Delegation Agreement.
- Note the Memorandum of Understanding and Collaboration Agreement between the ICBs in the Midlands and NHS England to manage the delegated services.
- Note the required changes to the ICB's Scheme of Reservation and Delegation and Delegated Financial Authority Limits (as per Appendix One) to reflect the arrangements for delegation.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The key objective of delegation is to join up fragmented pathways to improve

	outcomes for patients.
Aim 2: Tackle inequalities in outcomes, experience and access.	Breaking down organisational barriers across pathways of care will help reduce health inequalities.
Aim 3: Enhance productivity and value for money.	Working at scale will add value to common goals.
Aim 4: Help the NHS support broader social and economic development.	Adopting a population health approach which is sustainably led and supports inclusive growth.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance

Specialised commissioning has the potential for significant variation in spend levels due to the high cost of procedures. As with the delegation of POD services, consideration is being given to establishing a financial risk framework which governs the way in which risk is managed.

The focus of the risk share is a pooled resources enabling risks to be understand and managed.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes
Does the report highlight any quality and patient safety implications?	Not applicable to this paper.
Does the report highlight any health inequalities implications?	Yes.
Does the report demonstrate patient and public involvement?	Not applicable to this paper.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

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

Report previously presented at:

Briefings on the delegation of specialised services has been presented to the Board in September 2023 and January 2024. Internal briefings for the Non-Executive Director has also been provided.

Is the report confidential or not?

Yes ☐ No ☒

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS LINCOLNSHIRE ICB INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Lincolnshire ICB in relation to Specialised Commissioning Functions

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Clause heading and number Page number:

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Lincolnshire ICB
Area	Lincolnshire
Date of Agreement	[Date]
ICB Representative	[Insert details of name of manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 31);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

DALE BYWATER

REGIONAL DIRECTOR - MIDLANDS

(for and on behalf of NHS England)

Signed by **NHS Lincolnshire Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] NHS Lincolnshire Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

2.1 This Agreement is to be interpreted in accordance with Schedule 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. BACKGROUND

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.4 consider how in performing their obligations they can address health inequalities;

5.1.5 at all times exercise functions effectively, efficiently and economically;

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England

from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England

for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements;

10.15.2 the payments to be made by each partner and how those payments may be varied;

10.15.3 the specific Delegated Functions which are the subject of the arrangements;

10.15.4 the Delegated Services which are subject to the arrangements;

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.15.6 the arrangements in place for governance of the pooled fund; and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this

agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 15 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.6, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS

England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in

relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Schedule 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement;

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably

practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 *(Termination)*) except that the provisions referred to in Clause 29 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance and Sharing Provisions*).

30. COSTS

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. SEVERABILITY

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

“Administrative and Management Services”	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
“Agreement”	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
“Agreement Representatives”	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
“Annual Allocation”	means the funds allocated to the ICB annually under section 223G of the NHS Act;
“Area”	means the geographical area covered by the ICB;
“Assurance Processes”	has the definition given in paragraph 3.1 of Schedule 3;
“Best Practice”	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in

	the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and

	the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.5 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;
"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement;

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services;

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

8.5.2 effective introduction of new medicines;

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies;

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 Individual Funding Requests

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

17.3.2 robust and defensible, with conflicts of interests appropriately managed;

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

1.1. In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2. This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3. The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4. The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1. NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

6.2. NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1. Clinical Commissioning Policies;

6.2.2. National Specifications, including National Standards for each of the Specialised Services.

7. Clinical Networks

7.1. Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

7.3.3. maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

7.3.7. agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2. NHS England shall manage all complaints in respect of the Reserved Services.

9. Commissioning and optimisation of High Cost Drugs

9.1. In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.1.5. provide input into national procurement, homecare and commercial processes;

9.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

9.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

9.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3. NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18. Provider Selection and Procurement

18.1. In relation to procurement, NHS England shall be responsible for:

18.1.1. setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

18.1.2. monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services; and

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

19.1.5. provide guidance on quality and clinical governance matters and benchmark available data;

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

19.1.9. identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

20.1.1. development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

20.1.2. production of national commissioning products and tools to support commissioning of Specialised Services;

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

21.1.4. providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2. Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific

and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4. Lawful basis for sharing

4.1. The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7. Governance: Staff

7.1. The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Parties shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Party becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection

Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7. In particular, each Party shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

8.7.4. permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9. The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10. The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in

accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10. Governance: Quality of Information

10.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

None – local terms are described as part of the Collaboration Agreement and Operating Framework which includes a pooled budget established by the ICBs

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

SCHEDULE 9: Developmental Arrangements

SCHEDULE 10: Administrative and Management Services

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Memorandum of Understanding
&
Collaboration Agreement
For the Delegation of Acute Specialised Services
2024-2025

Memorandum of Understanding (MoU)
Delegation of Acute Specialised Services
2024-2025

1.0 Introduction

This Memorandum of Understanding (MoU) sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHSE Midlands.

The MOU covers the year 2024-25 and is referred to as the transitional year. In this year 59 Acute Specialised Service Lines will be formally delegated (Subject to Board Approval). The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process.

The Midlands are committed to working together to achieve best outcomes promoting pathway integration and parity of access to drive improvements in population health.

Our aim in this transitional year is to set out the practical ways in which we will work together to mitigate any potential risks and issues and to develop a strong operating model for the future.

2.0 Principles

This MOU is a statement based on principles of co-operation between all organisations including:

- To build strong relationships and an environment based on trust and collaboration.
- To seek to continually improve whole pathways of care and to design and implement effective and efficient integration.
- To share information and best practice and work together to identify solutions, eliminate duplication of effort, mitigate risks, and promote value.
- To have regard to each other's needs and views
- To work within the intentions set out within the Delegation Agreement.
- To commit to continue to work together during 2024/25 to build on the foundation from statutory joint working and learn lessons from previous delegation.

3.0 Responsibilities and Accountabilities

The delegation of specialised commissioning does not change the accountability of the services lines and functions remaining with NHS England.

Upon delegation the services become the responsibility of the 11 Midlands ICBs who are required to commit to working together to commission these services. NHSE remains a partner in this process and is also responsible for the commissioning of retained specialised services.

ICB responsibilities for the delegated services are as follows:

- All delivery is conducted in the name of the ICB, and legal liabilities are the ICBs.
- Decisions in relation to the commissioning and management of the delegated services
- Planning delegated services for the population, including carrying out needs assessments
- Undertaking reviews of delegated services in respect of the population
- Supporting the management of the specialised commissioning budget for delegated services

- Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate

NHSE accountabilities and responsibilities for the delegated services are as follows:

- Remains politically accountable to the Secretary of State and parliament, although not directly legally responsible for any shortcomings or delivery failures.
- Has continued responsibilities to support the ICBs in their delegated responsibilities providing guidance and expertise.
- NHSE could be subject to judicial review and challenge.

Joint consideration will be given to the development of a future concordat to underpin future joint working arrangements from 2025/26.

4.0 Pre delegation assurance requirements

A robust programme of work has been underway (jointly managed between NHSE and the ICBs) throughout the year to oversee the delegation of services from April 2024.
Over and above, this work it was agreed that additional due diligence requirements would be enacted to ensure ICBs have all the necessary assurance to allow them to sign off at ICB Boards in March 2024. These include the following:

- **Sender /Receiver Summary report -** One of the key documents to be produced will be a summary of the safe delegation checklist report completed by NHSE (as the sender organisation) approved by the joint working groups summarising the following:
    - Performance – activity /waiting lists against trajectory /improvement plans.
    - Contracts – outstanding issues/disputes
    - Procurements
    - Operational work programme
    - Risk register and mitigations
    - Corporate – complaints /litigations/FoIs
    - Finance – investment /cases
    - Responsibilities around high-cost drugs and devices

- **Service Profiles** – including assessment of quality and fragile services by ICB. This report will be available prior to Board sign off and updated for April 2024.
- **Finance** – Risk managed through a Pooled Fund approach between ICBs in 2024/25, working closely with NHSE to manage the overall financial position of specialised services recognising differential growth between retained and delegated services.
- **Quality Assurance Framework** – outlines the transitional arrangements for quality assurance responsibilities.
- **Benefits of delegation** – set out the practical examples of the benefits of delegation for patients.

Note: current ICB performance analysis already includes specialised activity data

5.0 Working arrangements of the teams /functions in 2024/25

The Specialised Services Standard Operating Framework sets out who the Midlands Specialised Commissioning team are and how they will operate.
This team is committed to the following:

- Agreeing individual joint priorities recognising the breadth of commissioning responsibility for delegated and retained functions. The Director posts will have a single set of priorities on behalf of the 11 ICBs and NHSE.

- Delivering an agreed work plan for the actions agreed for delegated services and retained services.
- Improving specialised services health inequalities through delivering recommendations in the health inequalities strategy.

The team will progress:

- New approaches to working with ICB colleagues to ensure a shared leadership model and learning to enable expertise in specialised services, and system expertise to be combined to improve outcomes.
- Full engagement in joint development opportunities to ensure that the experience across Programmes of Care is maximised and opportunities to drive value are realised.
- Explore ways to further support the staff through the transitional year to maintain the workforce.
- Develop new ways of working during the transition year to reflect the changing environment.

In the transitional year, executive and operational leadership for the Operating Framework will be through:

- A Specialised Services Executive Group (including the East and West ICB CEO Strategic Leads for Specialised Commissioning and the NHSE Regional Director of Commissioning Integration
- A multi-professional Specialised Services Senior Leadership Team function including input from Midlands Specialised Commissioning and East and West ICB professional executive leads.

Recognising 2024/25 as a transitional year prior to delegation of further services, the Operating Model Working Group (OMG) will be responsible for the joint planning for this next phase of delegation, with assurance and escalation through the joint Delegation and Transfer Programme Board and direction from the ICB CEOs/NHSE development sessions.

Decision making will be through ICB Boards and the NHSE Regional Support Group. Connectivity between the current and future agendas will be ensured through the Specialised Executive Group and reports to the Joint Committees.

6.0 Finance and Governance

Formal governance will be through the East and West Midlands Joint Committees who will formally stand-up a sub-group of the committees, these being:

- Midlands Acute Specialised Services Group – Commissioning including Planning Development, Transformation, and Reducing Inequalities
- Finance and Contracting Group – Financial Management and Financial Planning
- Specialised Commissioning Quality Group – Quality Oversight and Assurance

In addition, advisory groups including, the Collaborative Clinical Executive Group will provide clinically lead transformation and improvement advice guidance and recommendations for pathway re-design.

To ensure the integrated planning and decision making around the needs of the Midlands populations, these forums will consider NHSE Midlands retained functions as well as delegated functions; however, decision making for retained functions will be through the Midlands Commissioning Group and / or National Commissioning Group, as appropriate.
The Director of Specialised Commissioning will represent the perspectives of the East and West Midlands Joint Committees at the national NHSE Delegated Commissioning Group.

Finance
During the transitional year it is recognised that the management of financial risks across all ICBs will be mitigated through working with NHSE through several routes:

- Pooled fund arrangements

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services being transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this will be articulated in detail within the Collaboration Agreement.

- Joint contractual meetings

There will be close working relationships across NHSE/ICBs with the aim to have a single contractual meeting with providers to understand the whole position.

The specialised services contracts are operated on a block basis – for the elements of the contracts covered by the block, commissioners will have no financial exposure to activity variance. In 24/25 Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk to commissioners associated with the application of ERF.

There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

There remains a potential risk at an ICB and regional level of variance against contract and budget for these services. A contingency of 0.5% will be held in the Pooled budget to manage in year financial risk to mitigate the impact of variable service financial risks.
NHSE will commit to continue to regularly review in partnership with ICBs the overall financial position and risks and ensure the retained /59 acute services are reviewed together.

Data protection – to support and enable the appropriate sharing of information and data to facilitate joint working a DPIA will be approved and signed by each ICB in March 2024 which will be supported by and included in a dedicated schedule within the Collaboration Agreement

Complaints and FoI – All complaints received (on average circa 5-7 per annum across the whole Specialised portfolio including retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 2024/25, with reports to the Tier 2 subgroups. Both the FoI and complaints process will be detailed in the Commissioning Team Agreement and Operating Framework for 2024/25.

The Midlands Specialised Commissioning Team will operate on behalf of all the 11 ICBs and NHSE. It is recognised that relationships and new ways of working will take time to develop but there is a commitment to increasing focus towards and with systems, ensuring increasing shared ownership, access to subject matter expertise and, wherever possible. reducing points of contact for systems and providers. Any changes and/or recruitment will be jointly agreed and coordinated through the joint leadership team.

The Specialised Services Networks are a Midlands resource, whose work plans, reflecting operational and strategic priorities, will be agreed through the Collaborative Clinical Executive and MASCG on behalf of the Joint Committees. The funding/resources for these networks remains with NHSE and will not be delegated to ICBs in 2024/25.
The Specialised Clinical Services Strategy will inform the 2025/26 specialised services operational plan and the priorities for transformational activity. It is currently being jointly developed and is scheduled for completion by the end of Qtr. 2. The Clinical Services Strategy will be agreed through formal governance and subject to final approval by the Joint Committees.

7.0 Development plan

It is recognised that over and above the due diligence requirements put in place to support the delegation process we will commit to putting in place a development plan for 2024/25.

This will clearly set out the key deliverables agreed between ICBs and NHSE to further develop a robust operating model.
The development plan will be initiated and developed through executive and operational working sessions planned from April 2024.

This will be developed further.

Priority Objectives	Commitments to date	Joint SROs
Culture / OD – team development	Develop joint OD plans Collaborative recruitment	Karen Helliwell, Sarah Prema, Alison Kemp
Clinical Strategy	Clinical Networks Agreed clinical strategy and action plan Clinical benefits and outcomes	Clara Day. Nilesh Sanganee, Colette Marshall
Contracting	Integrated performance reporting Integrated commissioning intentions for 2025/26 Integrated contracting a	Ali Kemp, East and West rep leads to be confirmed
Finance	Analysis of impact of differential local pricing in spec com contracts. Reconciliation of Trust cost base between core and specialised services. Impact of needs-based allocations and convergence from 2025/26.	Madi Parmer, Jon Cooke, East CFO To be confirmed

8.0 Assurance

A national assurance framework has been developed and published that provides an approach to assurance that will minimise significant additional contacts and maximise existing NHSE assurance arrangements. ICBs will be requested to self-assess aspects of delivery of specialised provision. The collaborative agreement however sets out how integrated working will be delivered in 2024/25 and ensure that risk is jointly understood, and mitigation is managed through agreed governance.

9.0 Review process during 2024/25

This MoU and Collaboration Agreement will be subject to quarterly review within the ICB CEO Time Out Sessions and reported to Joint Committees.
A formal review will be coproduced and progressed in Q3/402024/25 in preparation for revised agreements, including further delegations, in advance of 2025/26.
There is a commitment to a formal post transactions review in 2026/27

END

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THIS AGREEMENT is made on the first day of April 2024

BETWEEN:

(1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(3) **NHS Leicester, Leicestershire & Rutland Integrated Care** Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(4) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("Northamptonshire ICB"); and

(5) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(6) **NHS Birmingham & Solihull Integrated Care Board** of First Floor, Wesleyan, Colmore Circus, Birmingham, B4 6AR ("Birmingham & Solihull ICB"); and

(7) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

(8) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and

(9) **NHS Coventry & Warwickshire Integrated Care Board** of Westgate House, Market St, Warwick CV34 4DE ("Coventry & Warwickshire ICB"); and

(10) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and

(11) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Winton House, Stoke Road, Stoke-on-Trent ST4 2RW ("Staffordshire & Stoke-on-Trent ICB"); and

(12) **NHS England** of Quarry House, Quarry Hill, Leeds, LS2 7UE (acting under the name NHS England) (**"NHS England"**).

each a "Partner" and together the "Partners".

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the "ICBs", and "ICB" shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

(B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.

(F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default)* below.

2. PRINCIPLES AND AIMS

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of Services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2 consider how, in performing its obligations, it can address health inequalities;

2.1.3 at all times exercise functions effectively, efficiently, and economically; and

2.1.4 act always in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.2.5 to act at all times, ensure the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.2.6 to act at all times in accordance with the scope of their statutory powers; and

2.2.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' aims are:

2.3.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through

designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non-Pooled Fund.

3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:

3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.2.2 Establishment of the following Joint Working Arrangements:

- Establishment of a Commissioning Team in accordance with Clause 5.1 through which agreed Delegated Services may be commissioned [as set out in the Commissioning Team Agreement and Standard Operating Framework];
- Delegation of responsibilities by the ICBs to the two Joint Committees for the East and West Midlands established under existing multi-ICB Joint Working Agreements;
- Approval of the three schemes for the commissioning of delegated specialised services for the East and West Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
- Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.

4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.

4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).

4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.

4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:

4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;

4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;

4.6.4 perform all commissioning obligations with all due skill, care and attention;

4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. COMMISSIONING TEAM

5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (*Commissioning Team Arrangements*).

6. STAFFING

6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and/or the Commissioning Team Agreement and Standard Operating Framework.

7. JOINT COMMITTEE

7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.

8. GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

13.4.1 a new Pooled Fund;

13.4.2 a new Individual Scheme; or

13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:

14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or

14.2.2 becomes aware of any security breach,

in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.

14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.

14.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of

Law, including the Data Protection Legislation in respect of any Personal Data.

14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.

14.8 Schedule 5 *(Further Information Governance and Sharing Provisions)* makes further provision about information sharing and information governance.

15. IT INTER-OPERABILITY

15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17. FREEDOM OF INFORMATION

17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the FOIA or EIA Information in response to a specific request under FOIA or EIR, in which case:

17.2.1 each Partner shall provide the other Partners with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

19. CONFIDENTIALITY

19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

19.2 Subject to Clause 19.3, the receiving Partner agrees:

19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;

19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

19.3.1 in connection with any Dispute Resolution Procedure;

19.3.2 to comply with the Law;

19.3.3 to any appropriate Regulatory or Supervisory Body;

19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;

19.3.5 to NHS bodies for the purposes of carrying out their functions; and

19.3.6 as permitted under any other express arrangement or other provision of this Agreement.

19.4 The obligations in Clause 19 will not apply to any Confidential Information which:

19.4.1 is in or comes into the public domain other than by breach of this Agreement;

19.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Partner; or

19.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.

19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.

20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;

20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.

20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

20.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

20.6 Each ICB must:

20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

21.1 Where any dispute arises between the ICBs in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.

21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.

22. BREACHES OF THE AGREEMENT

22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).

22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:

22.2.1 waive their rights in relation to such non-compliance;

22.2.2 ratify any decision;

22.2.3 terminate this Agreement in accordance with Clause 23 *(Termination and Default)* below; or

22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 *(Dispute Resolution).*

23. TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be

required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

24.1.7 termination of this Agreement shall have no effect on the liability, rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

24.2 The provisions of Clauses 14 (*Data Protection*), 1717 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

27. THIRD PARTY RIGHTS

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

28. NOTICES

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

28.2 Notices by email will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

29. ASSIGNMENT AND SUBCONTRACTING

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

30. SEVERABILITY

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. WAIVER

31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

32. STATUS

32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

33. ENTIRE AGREEMENT

33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

34. GOVERNING LAW AND JURISDICTION

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

36. COUNTERPARTS

36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by John Turner .....

for and on behalf of NHS Lincolnshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Amanda Sullivan .....

for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Dr Caroline Trevithick .....

for and on behalf of NHS Leicester, Leicestershire & Rutland Integrated Care Board (Signature)

.....

(Date)

SIGNED by Toby Sanders .....

for and on behalf of NHS Northamptonshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Chris Clayton .....

for and on behalf of NHS Derby & Derbyshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Philip Johns .....

for and on behalf of NHS Coventry & Warwickshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Mark Axcell .....

for and on behalf of NHS Black Country Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Trickett .....

for and on behalf of NHS Herefordshire & Worcestershire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by David Melbourne .....

for and on behalf of NHS Birmingham & Solihull Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire & Stoke-on-Trent Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Whitehouse .....

for and on behalf of NHS Shropshire, Telford & Wrekin Integrated Care Board (Signature)

.....

(Date)

SIGNED by Roz Lindridge .....

For and on behalf of NHS England (Signature)

.....

(Date

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	[means 1 April 2024];
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: . Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or . Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"**Delegated Commissioning Group**" **"DCG"**	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
"Dispute Resolution Procedure"	the procedure set out in Clause 21 (*Dispute Resolution*);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (*Scope of the Arrangements*);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"FOIA or EIR Information"	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (*Governance Arrangements*);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;

"ICB Reserved Functions"	Where there is any delegation of an ICB's Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Individual Scheme"	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
"Joint Committee"	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee;
"Joint Commissioning"	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
"Joint Working Arrangements"	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead Partner"	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
"Loss"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;

"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5 *(Further Information Governance and Sharing Provisions)*;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's Commissioning Functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;
"Non-Pooled Funds"	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
"Operational Days"	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"Partners"	means the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Pooled Funds"	means any pooled fund established and maintained by the Partners as a pooled fund;
"Population"	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	means the arrangements entered in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC;

ii. NHS England;

iii. the Department of Health and Social Care;

iv. NICE;

v. Healthwatch England and Local Healthwatch;

vi. the General Medical Council;

vii. the General Dental Council;

viii. the General Optical Council;

ix. the General Pharmaceutical Council;

x. the Healthcare Safety Investigation Branch; and

xi. the Information Commissioner;

"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means NHS England Reserved Functions or ICB Reserved Functions;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the Partners;
"Scheme Specification"	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
"Services"	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
"Service Contract"	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 *(Further Information Governance and Sharing Provisions)*
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;

"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Standard Operating Framework"	means the agreement(s) that sets out the arrangements for a Commissioning Team;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
"Triple Aim"	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
"Underspend"	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint Committees

1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through the Joint Committees established by the ICBs through Joint Working Agreements between NHS Lincolnshire Integrated Care Board, NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Leicester, Leicestershire and Rutland Integrated Care Board, NHS Northamptonshire Integrated Care Board and NHS Derby and Derbyshire Integrated Care Board (the "East Midlands ICBs") and NHS Birmingham and Solihull Integrated Care Board, NHS Black Country Integrated Care Board, NHS Coventry and Warwickshire Integrated Care Board, NHS Herefordshire and Worcestershire Integrated Care Board, NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the "West Midlands ICBs")

1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committees are detailed in the Joint Working Agreements between the East and West ICBs. They set out that the two Joint Committees will have delegated authority on behalf of the East and West ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.

1.3. In recognition that effective collaboration may require aligned decisions from all the partners, the Joint Committees may consider meeting 'in common' where this is appropriate and will ensure that decisions by either the East or West Joint Committee that impact on the other are made having taken relevant views from the other committee into account.

1.4. The NHS England regional team will continue to work jointly with the Joint Committees on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committees.

1.5. The subsidiary arrangements established by the Joint Committees will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committees and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Joint Subgroups

2.1. There will be three joint subgroups established by the partners to support these arrangements, these being:

- **Midlands Acute Specialised Commissioning Group (MASCG)**
- **Specialised Commissioning Quality Group**
- **Finance and Contracting Group**

2.2. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCG)** a Joint Sub-Group established by all the partners to make decisions on both the delegated and retained services.

2.3. The role of MASCG will be to support the partners and the Joint Committees in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities.

2.4. MASCG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.

2.5. Each of the partners will appoint a member of MASCG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.

2.6. **Specialised Commissioning Quality Group –** This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.

2.7. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.

Subgroups reporting to East and West Joint Committees

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team via the

Commissioning Team Arrangements and Standard Operating Framework.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision -making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

3.5. The Commissiong Team will retain Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.

3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,

3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group. Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.

4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making, including on quality matters.

4.3. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the

quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.

4.4. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.

5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:

(a) the Oversight and Assurance Framework published by NHS England;

(b) any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and

(c) any other relevant NHS oversight and assurance guidance;

collectively known as the "Assurance Processes".

And that the ICBs must:

(a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

(b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.

(c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.

(d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England,

including metrics and detailed reporting in accordance with the Terms of Reference.

Appendix 1 – MASCG Terms of Reference

Document name:		Midlands Acute Specialised Commissioning (MASC) Group/ Terms of Reference	
Senior Responsible Owner (SRO):		Alison Kemp	
Lead:		Jon Currington	
Author:		Mel Harris, Peter McKenzie	
Version	1.5	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes
0.1	28/02/23	Initial template
0.2	08/03/23	Incorporating JC/MD edits
1.0	02/08/23	Updated by JC to include financial limits as requested by Joint Committees and non-material amendments for clarity and consistency.
1.1	30/01/24	Amendments to align with ICB Collaboration Agreement for 2024/25
1.2	02/02/24	JM review and update
1.3	05/02/24	JM review and Update
1.4	06/02/24	PMcK review and update including JC Feedback
1.5	21/02/24	Version for approval in Collaboration Agreement

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Matt Day		Regional Director Specialised Commissioning and Health and Justice		0.2
Formal Midlands Acute Specialised Commissioning Group	Approved		17/03/23	0.2
Delegation Governance Working Group				0.2
East Midlands Joint Committee	Approved		20/06/23	0.3
West Midlands Joint Committee	Approved		14/07/23	0.3
Midlands Commissioning Group				0.3

Related documents

Title	Owner	Location
ICB Collaboration Agreement for Specialised Services	NHSE & 11 Midlands ICBs	
East Midlands Joint Committee Terms of Reference	NHSE & 5 EM ICBs	
West Midlands Joint Committee Terms of Reference	NHSE & 6 WM ICBs	

Document control

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Midlands Acute Specialised Commissioning Group (MASCG) Terms of Reference 2024/25	
Introduction and purpose	From April 2024, NHS England delegated responsibility to the eleven Integrated Care Boards ("the ICBs") in the Midlands region for commissioning 59 Prescribed Specialised Services (the "delegated services"). To discharge these duties the ICBs and NHS England have developed a collaboration agreement that sets out that the individual ICBs will delegate responsibilities to the existing East and West Joint Committees (JC) established under the Joint Working Agreements between the ICBs. The two JCs are defined as Tier I Bodies and their responsibilities for the delegated services are set out in their Terms of Reference. NHS England will continue to be responsible for other Prescribed Specialised services, including 29 services designated as suitable but not yet ready for delegation to the ICBs (the "retained services") and will seek input from the ICBs into the commissioning of Retained Specialised Services. NHS England will continue to have budgetary responsibility and holds accountability and responsibility for high-cost drugs within specialised services. NHSE and ICBs will collaborate in the commissioning of high-cost drugs via joint working arrangements. The Collaboration Agreement sets out that the ICBs and NHSE will establish the Midlands Acute Specialised Commissioning Group (MASCG) as a Joint Sub-group to support the JCs and NHSE in the effective and efficient commissioning of both the delegated and retained services. MASCG will have delegated decision-making authority from both JCs and NHS England and will provide joint oversight for the commissioning of all Prescribed Acute Specialised Services for the population of the Midlands.
The Terms of Reference	These Terms of Reference are intended to support effective collaboration between NHS England and ICBs acting through MASCG. They set out the roles, responsibilities, membership, decision-making powers, and reporting arrangements of the MASCG in accordance with the Collaboration Agreement. The MASCG will operate under the limitations of the delegated authority given to it by the East and West Joint Committees (for the delegated services) and NHS England Standing Financial Instructions (SFI) (for the retained service) . This will include authority to make decisions of a value up to £2.5 Million for contract variations and extensions for directly commissioned healthcare services and up to £2.5 million for clinical

	and non-clinical business cases. Values above this will be referred upwards to the JCs and/or authorised decision makers in NHS England as appropriate.
Role of the Group	The role of the MASCG is to support the JCs and NHS England in discharging their duties with respect to prescribed specialised services safely, effectively, efficiently and economically. The MASCG will achieve this through: • Determining the appropriate structure of the MASCG; ▪ Making decisions in relation to the planning and commissioning of delegated and retained specialised services and working collaboratively on any associated commissioning or statutory functions, for the population within the scope of the agreed authority for the group; ▪ Making recommendations to the Joint Committees and NHS England as appropriate in relation to decisions required for delegated and retained specialised services that fall outside the scope of the agreed authority for the group; ▪ Making recommendations on the population-based financial allocation and financial plans for delegated and retained Specialised Services to the Joint Committees and NHS England as appropriate; ▪ Oversight and assurance of all specialised services, either directly or through Tier 3 sub-groups, in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with specialised services providers where there are quality or contractual issues and escalating these issues to the Joint Committees and NHS England when required; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of joint specialised services within the remit of the Group and consistent with national, regional and ICS plans, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies in relation to all specilaised services including Provider Collaboratives and the Cancer Alliances, and working closely across regional footprints, where there are cross-border patient flows to providers; ▪ Engaging effectively with stakeholders, including patients and the public, and involving them in decision-making; ▪ Obtaining appropriate clinical advice and leadership, including through Clinical Reference Groups and relevant Clinical Networks;

	▪ Linking in with the NHS England National team in order to implement policies, initiatives and service specifications; ▪ Supporting longer-term planning for both delegated and retained services; and ▪ Discussing any matter which any member of the Group believes to be of such importance that it should be brought to the attention of the Group. The Group must adhere to these Terms of Reference but may otherwise regulate its own procedures.
Accountability and reporting	The MASCG is a joint sub-group, established in line with the Collaboration Agreement between the eleven Midlands ICBs and NHS England and is formally accountable to the JCs for delegated services and to the NHS England Midlands Commissioning Group (MCG) for retained services. It will report to the Joint Committees and the MCG after each meeting and make recommendations and escalate issues when required.
Membership	The core membership of the MASCG will comprise one representative of each of the eleven ICBs, nominated by the respective Chief Executive Officer with authority to participate in the collective decision-making of the Group on behalf of their organisation and the Regional Director of Specialised Commissioning, NHS England Midlands. A named substitute may be nominated to attend if a core member of the MASCG is unavailable or unable to attend or because they are conflicted. Core members must ensure that their substitute is fully authorised to act on their behalf. The MASCG will be supported by the NHS England Midlands Acute Specialised Commissioning (MASC) Team including: • Chief Medical Officer for Commissioning • Head of Acute Specialised Commissioning • Deputy Director of Nursing and Quality • Heads of Finance • Regional Pharmacy Lead • Consultants in Public Health • Head of Business Intelligence • Head of Planning • Acute Commissioning Leads Subject matter experts will also support the MASCG from core ICB functions including the offices of the Chief Medical Officers, Chief Nursing Officers and Chief Finance Officers. During 2024/25 (until transfer of staff) this will include nominated ICB Quality and Finance leads on behalf of all the ICBs of the West (6) and the East (5) whose role will be to provide a liaison between MASCG and the Finance and

	Quality sub-groups established to support Joint Commissioning arrangements. The ICBs will agree who will attend the Group, which Include members of the Clinical Collaboration Forum from these functions, and they will be invited on a standing basis. Individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the MASC Group's work at the discretion of the Chair. A list of the members will be made available.
Chair	MASCG will be co-chaired by the Regional Director, Specialised Commissioning, NHS England Midlands and an ICB representative elected from the core membership. The co-chairs will arrange cover in their absence.
Meetings	MASCG shall meet monthly with arrangements to meet face-to-face and virtually. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the MASCG shall prepare a of meetings and work programme for the forthcoming year.
Quorum	The MASCG shall be quorate if the Chair, or their nominated deputy is present together with representation from the ICBs from the Joint Committee that any decisions on the agenda relate to. In urgent circumstances, consideration will be given by the Chair to make decisions which significantly impact an ICB or ICBs not present subject to confirmation of support of the relevant ICB or ICBs outside of the meeting. These situations, together with the outcome will be formally recorded in the minutes.
Decisions and voting arrangements	The decision-making arrangements for the Group will be in line with the delegated authority provided to it by the Joint Committees and NHS England. Items for decision will clearly indicate the source of the authority for the decision which will determine which members will be eligible to participate in the decision-making for that item: - • For items on behalf of the East Midlands Joint Committee this will be the core representatives from Derby and Derbyshire, Leicester, Leicestershire and Rutland, Lincolnshire, Nottingham and Nottinghamshire and Northamptonshire ICBs; • For items on behalf of the West Midlands Joint Committee this will be the Core representatives from Birmingham and Solihull, Black Country, Coventry and Warwickshire, Herefordshire and Worcestershire, Shropshire Telford and Wrekin and Staffordshire and Stoke-on-Trent ICBs;

	• For items on behalf of NHS England this will be the Regional Director Specialised Commissioning and Health and Justice in consultation with the other core members. Items for decision that impact more than one group of eligible members will be decided by all those eligible members. MASCG shall aim to make decisions by consensus of the eligible core membership wherever possible. Where this is not possible the Chair will check whether all the information is available to make a decision or if there are alternative options that may offer an acceptable solution. The core members must ensure that matters requiring a decision are anticipated, and that sufficient time is allowed prior to Group meetings for discussions and negotiations internally and between ICBs and other partners to take place. Where possible papers will be co-developed and jointly sponsored by NHS England and the ICBs. At the discretion of the Chair, where it is not possible to make a decision at the meeting decisions may be deferred to the next meeting or, with appropriate consultation with eligible core members, to take a decision outside of the meeting. Where it has not been possible, despite the best efforts of the core membership, to come to a consensus decision the Chair may decide that a decision may be escalated to the relevant Joint Committee or MCG as appropriate, supported by detail of the issues raised and further steps taken.
Conduct and conflicts of interest	Members of the MASCG will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct, Nolan Principles and relevant organisational policies. Where any core member of the MASCG or the MASC Team or observer has an actual or potential conflict of interest in relation to any matter under consideration by the MASC Group, that individual must declare that interest and take appropriate action to manage the conflict, which could include not participating in the discussion or voting at meetings (or parts of meetings) in which the relevant matter is discussed. The Chair will be responsible for making final decisions on the appropriate management of conflicts of interest.
Confidentiality of proceedings	All members in attendance at a MASCG are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the MASCG.
Publication of notices, minutes and papers	The MASC Multi-Disciplinary Team of NHS England shall provide sufficient resources, administration and secretarial support for the proper organisation and functioning of the Group.

	The co-chair(s) (or in the absence of the co-chairs, the person covering for them) shall see that notice of meetings of the MASCG, together with an agenda listing the business to be conducted and supporting documentation, is issued one week, (seven calendar days), prior to the date of the meeting. The proceedings and decisions taken by the MASCG shall be recorded in minutes, and those minutes circulated in draft form having been reviewed by the person who presided at the meeting within two weeks of the date of the meeting. The MASCG shall approve those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be in place for the 2024/25 transitional year only. Updated Terms of Reference will be in place to reflect post April 2025 arrangements.

SCHEDULE 3: INDIVIDUAL SCHEMES

Part 1– East Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE EAST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the East Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the 59 delegated specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the East Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners of this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the East Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the East Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are set out in the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts
- 2 x Section 75 contracts (in collaboration with Northants & Lincs Local Authorities for HIV)

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10. STAFF

10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out Schedule 6 of the ICB Collaboration Agreement.

11. ASSURANCE AND MONITORING

11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12. AUTHORISED OFFICERS

12.1. The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Lincolnshire ICB	John Turner
Nottingham & Nottinghamshire ICB	Amanda Sullivan
Leicester, Leicestershire & Rutland ICB	Dr Caroline Trevithick
Northamptonshire ICB	Toby Sanders
Derby & Derbyshire ICB	Dr Chris Clayton

Partner	Name of Authorised Officer – Tier 1
NHS England	Roz Lindridge

13. INTERNAL APPROVALS

13.1. The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14. REGULATORY REQUIREMENTS

14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

15.1. Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2. A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 2 – West Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE WEST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the West Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England delegates to the ICBs the statutory function for the commissioning of the 59 delegated specialised services. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the West Midlands ICBs geographical footprints.

2.4 There are currently no planned changes to the services in 2024/25.

3 PARTNERS

3.1 The partners to this scheme are as recorded in the main Collaboration Agreement.

3.2 The partners of this scheme are NHS England, The Black Country ICB, Staffordshire & Stoke ICB, Shropshire Telford & Wrekin ICB, Coventry and Warwickshire ICB, Herefordshire & Worcestershire ICB and Birmingham & Solihull ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the West Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in a Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the West Midlands Joint Committee as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are contained within the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.

- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9 NON FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2 The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11 ASSURANCE AND MONITORING

11.1 The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12 AUTHORISED OFFICERS

12.1 The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Coventry & Warwickshire ICB	Philip Johns
The Black Country ICB	Mark Axcell
Herefordshire & Worcestershire ICB	Simon Trickett
Birmingham & Solihull ICB	David Melbourne

Partner	Name of Authorised Officer – Tier 1
Staffordshire and Stoke on Trent ICB	Peter Axon
Shropshire Telford and Wrekin ICB	Simon Whitehouse
NHS England	Roz Lindridge

13 INTERNAL APPROVALS

13.1 The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14 REGULATORY REQUIREMENTS

14.1 Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15 COMPLAINTS

15.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 3– Retained Services Scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR RETAINED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England in 2024/25 but identified as suitable for future delegation to Integrated Care Boards (ICBs) in the future.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients by working collaboratively on the Retained Functions in preparation for future delegation and integration with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has identified that the statutory function for the commissioning of the specialised services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2024/25 it will involve the ICBs in the of these functions being, in summary:

(a) decisions in relation to the commissioning and management of the services;

(b) planning for the services for the population, including carrying out needs assessments;

(c) undertaking reviews of services in respect of the population;

(d) supporting the management of the specialised commissioning budget for the services;

(e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within Appendix 2 of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners for joint working within this scheme are NHS England, Birmingham and Solihull ICB, Black Country ICB, Coventry and Warwickshire ICB, Herefordshire and Worcestershire ICB, Shropshire, Telford and Wrekin ICB, Staffordshire and Stoke-on-Trent ICB, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB

4 THE ARRANGEMENTS

4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the East Midlands Joint Committee and the West Midlands Joint Committee established via a Joint Working Agreements between the ICBs.

4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted in 2024-2025 by NHS England. Details of which are set out in a commissioning team agreement between all parties.

4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.

5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committees where appropriate.

5.3 The exercise of NHS England functions in consultation with the Joint Committees will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the East Midlands Joint Committee and West Midlands Joint Committee when exercising that authority.

5.4 NHS England will report on the delivery of the functions under this scheme to the East Midlands and West Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

6.2.1 The scheme will be administered by the Commissioning Team.

6.2.2 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
- The contracts will be funded by NHS England.
- The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for the services will be retained by NHS England.

11 ASSURANCE AND MONITORING

11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

APPENDIX 1 – LIST OF CONTRACTS HELD WITH PROVIDERS IN 2023/24

Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contracts

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

APPENDIX 2 RELEVANT SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients	05C	Specialist augmentative and alternative

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	with complex physical disabilities (excluding wheelchair services) (adults and children)		communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: POOLED FUND MANAGEMENT

1 ESTABLISHMENT OF A POOLED FUND

1.1 The ICBs have agreed to establish and maintain a mutual agreement pooled fund arrangement for in-year financial management of Schemes 1 and 2 of Schedule 3 of this agreement, with a defined contribution based on the allocation received will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands.

The monies held in a Pooled Fund may only be expended on the following:

- the Contract Price;
- Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing in accordance with the relevant Scheme Specification;
- Approved expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification.
(collectively known as "Permitted Expenditure")

1.2 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes all contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.

1.3 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.

1.4 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

1.5 Birmingham & Solihull ICB on behalf of the Midlands shall be the Partner responsible for:

- Holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
- Providing the financial administrative systems for the Pooled Fund; and
- The manager of the Pooled Fund (“Pooled Fund Manager”) will be the Director Specialised Commissioning of Finance
- Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. ICB population-based allocations have been developed on the basis of current contractual commitments as demonstrated in the document “ICB Baseline Development”.

2.2. All ICB 2024/25 opening baselines have been updated for 2023/24 variable activity levels and precommitments.

2.3. All ICB 2024/25 opening baselines are in recurrent financial balance and there is no risk exposure from opening contract baselines for 2024/25.

2.4. The specialised services contract is operated on a block basis and there is no financial exposure to activity variance through the block contract.

2.5. Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk associated with the application of ERF. There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.6. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

2.7. There remains risk at an ICB and regional level of variance against contract and budget for these services.

2.8. ICBs hold contracts with providers outside the geographical boundary of the Midlands. It is expected that there will be consistency between planning assumptions and contractual growth across regions, but there is a risk that differential application of growth by other NHS England regions will impact on partners to this agreement.

2.9. A contingency of 0.5% will be held to manage in year financial risk to mitigate the impact of variable service financial risks and consequences of cross regional contractual commitments.

2.10. The use of a Pooled Fund will mitigate in year fluctuation at ICB level for variable services within delegated specialised services.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the Pooled Fund,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

3.2. The Partners may agree to the virement of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

4. FINANCIAL CONTRIBUTIONS

4.1. The pooled fund shall initially operate for the financial year 2024/25. Should the scheme be continued into future years, the Financial Contribution to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners.

4.2. Unless otherwise agreed, no provision of this Agreement shall preclude the Partners from making additional contributions to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the budget statement as a separate item.

4.3. ICBs will pay contributions to the Pooled Fund for Specialised Services to the identified Host ICB.

4.4. Contributions will be the equivalent of the allocation for delegated specialised services or an amount specified by the payments schedule calculated by the specialised commissioning team.

Table of contributions to be added once final 2024/25 allocations have been confirmed.

Partner	**Name of CFO**	**Contribution to the Fund**
Coventry & Warwickshire ICB		
The Black Country ICB		
Herefordshire & Worcestershire ICB		
Birmingham & Solihull ICB		
Staffordshire and Stoke on Trent ICB		
Shropshire Telford and Wrekin ICB		
Lincolnshire ICB		
Nottingham & Nottinghamshire ICB		
Leicester, Leicestershire & Rutland ICB		
Northamptonshire ICB		
Derby & Derbyshire ICB		

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Host Partner for the relevant Pooled Fund shall, through the Specialised Commissioning Team Fund Manager, manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

6. CAPITAL EXPENDITURE

6.1. Pooled Funds shall not be applied towards any one-off expenditure on goods or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

7. POOLED FUND FINANCIAL GOVERNANCE

7.1. The partners in the Pooled Fund shall make monthly payments of one twelfth of the Pooled Fund contributions by the 5th of the month.

7.2. The Specialised Commissioning Team will manage specialised services through the host ledger managing financial risk across all Partner ICBs.

7.3. All contractual payments including variable adjustments will be managed by the Specialised Commissioning Team through the single joint Specialised Commissioning contract in line with the Contracting Standard Operating Procedure.

7.4. In year financial management will be undertaken at a multi ICB level across eleven ICBs in the Midlands region, mitigating the risk of variation between systems.

7.5. Regional financial variances (under or overspend) would be mitigated through the application of local financial management and the use of the contingency held by the Host, as agreed by partners, to minimise exposure to financial fluctuation.

7.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

8. POOLED FUND FINANCIAL REPORTING AND ASSURANCE

8.1. The Joint finance subgroup will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

8.2. ICB level in year financial reporting will show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.

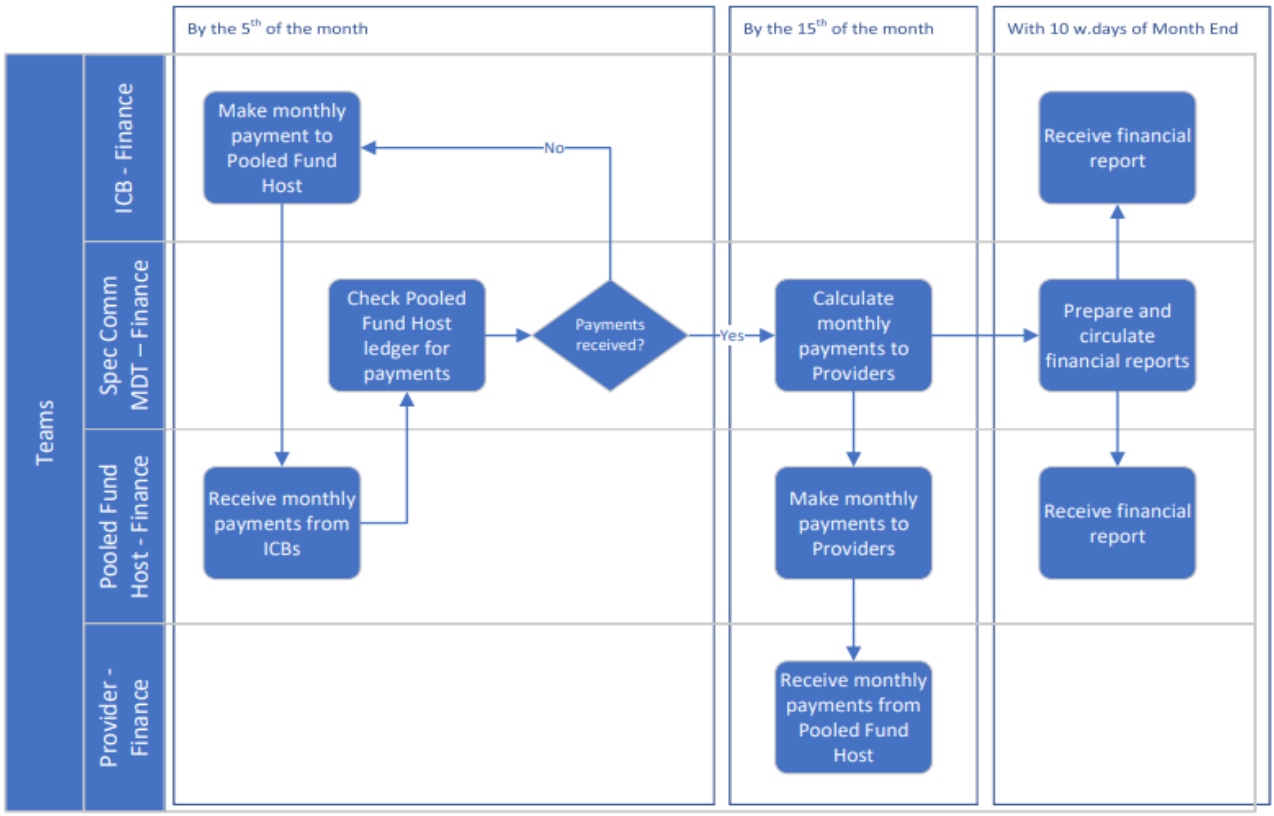
8.3. Performance reporting will be developed at an ICB and multi ICB level to enable local intelligence on performance in delegated specialised services.

8.4. The Specialised Commissioning Team on behalf of the Host will prepare quarterly memorandum finance reports at individual ICB level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.

8.5. Year-end reporting will be prepared in line with nationally produced annual accounts timetables recognising any locally agreed requirements.

8.6. As part of the year end process the Specialised Commissioning Team will prepare reconciliation journals to update individual ICB ledgers with detailed Provider level expenditure in line with Pooled Fund contributions.

8.7. Financial Flow arrangements are illustrated below



PART B: OTHER FINANCIAL ARRANGEMENTS

9. BUDGETARY DELEGATION

9.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements. Initial approval limits, subject to the agreement of the Joint Committees are set out in Annex 1 to this schedule.

9.2. ICBs have agreed to delegate budgetary responsibility to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement and are set out in Annex 2 to this schedule.

9.3. For 2024/25, the specialised commissioning team will be employed by NHS England on behalf of the partner ICBs. From 2025/26 the specialised commissioning team will be employed by the Host ICB.

10. AUDIT ARRANGEMENTS

10.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the 2024/25 audit plan.

10.2. In 2024/25 Specialised Commissioning Team responsible for the management of specialised commissioning resources will continue to be employed by NHS England but will access the ledger of the Host ICB to process transactions for specialised services.

10.3. In 2024/25 the Host ICB will commission a specific review of the financial control, governance and assurance of the Specialised Commissioning Team delivered service to provide assurance to ICBs that the controls in place for specialised services are robust.

11. FINANCIAL MANAGEMENT

11.1. Financial transactions for the 59 delegated specialised services will be processed through the Oracle ISFE ledger system of the Host ICB. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.

11.2. Financial monitoring reports will be produced by the NHSE hosted Specialised Commissioning Team on behalf of the ICBs. The team, for 2024/25, will provide financial support to ICBs for delegated services and NHSE for retained and highly specialised services.

11.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.

11.4. Monthly budget reporting with variance analysis and forecasting will be provided the Joint Finance Subgroup, Host ICB, and Partner ICBs including:

- ICB reporting based on pool contribution,
- Overall pool financial performance report to be shared with all ICBs,
- Management and review of reserves and investments.

Annex 1 to Schedule 4

Commissioning Decisions Budgetary Delegation Schedule

Description of Delegation (All Delegations are Annual Values)	**Delegated Limits**		
	Director of Specialised Commissioning	**MASCG**	**Joint Committees**
Approval of extensions to contracts and contract variations	N/a	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** within **existing budget envelope**	Unlimited		
Approval of business cases for investment for **existing services** with **additional investment**	Up to £1m	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** with **new investment**	Up to £1m	Up to £2.5m	Above £2.5m

Annex 2 to Schedule 4

Operational Budgetary Delegation Schedule

Contract award, signature and variation		
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Signature of contracts and contract variations, within the approved budget.		
Delegated Limit Limits are annual values	Up to £2m	Unlimited
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised commissioning).

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning **or** Director of Commissioning Finance (Specialised) **And** Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning	MASCG

Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.		Director of Commissioning Finance (specialised)	

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;

1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Partners' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Services.

4. Lawful basis for sharing

4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be always handled on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. To achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. considering carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Partners shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement between the Partners.

7. Governance: Staff

7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4. Each Partner shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5. The Partners shall ensure that:

7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;

7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall co-operate in exploring alternative strategies to avoid the use of Personal Data to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.

8.4. If any Partner becomes aware of:

8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or

8.4.2. any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by Law or any regulatory body; and

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context, and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. Each Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display, or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Partner to transfer the Relevant Information to any third party;

8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors, or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted, and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated, or amended from time to time.

11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a crosscut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

13. Governance: Single Points of Contact

13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: COMMISSIONING TEAM AGREEMENT and STANDARD OPERATING FRAMEWORK

COVERED UNDER A SEPARATE AGREEMENT - COMMISIONING TEAM AGREEMENT AND OPERATING FRAMEWORK

Appendix One - Detailed Scheme of Delegation for Specialised Services (Phase 1) in NHS Lincolnshire ICB

Background

From 1 April 2024 Lincolnshire ICB will take on delegated responsibility for 59 Acute specialised services.

There is a national project to ensure the safe and effective delegation of these functions from NHS England to ICBs. There will be a central team that moves from NHS England to Birmingham and Solihull ICB, who continue to process specialised transactions across the region, creating continuity in service delivery and maintaining economies of scale. This "hosted function" will need access to the Oracle Ledger in each ICB. As part of this process, authorisation limits for the hosted function will need to be agreed by each ICB.

This paper seeks approval for the governance arrangements around Specialised operational staff, confirming the authorisation limits which will be created within Oracle.

The authorisation limits reflect existing arrangements for NHS England staff. The same set of limits are being presented to all ICBs so that Specialised staff can continue to do the work they are doing now, with responsibility for processing and improving transactions based on the grade of each role.

Managing the risks of external staff having access to the ICB Ledger

Access within Oracle cannot be limited to a range of cost centres. Hence, staff in the hosted function will in theory have the ability to approve transactions beyond the scope of the specialised cost centres.

The ICB will have several mitigations in place.

- The existing hierarchy in Oracle directs transactions to Lincolnshire ICB staff, and escalation of transactions remains within the ICB management structure. Hence, specialised staff would not have the ability to gain access to mainstream ICB transactions.
- Specialised transactions could be coded to other ICB functions by mistake. This is no different to the processing of all transactions that the moment. The risk of this coding is mitigated by careful management of code combinations within Oracle. This is supplemented by scrutiny of all transactions by the finance business partner teams.
- The ICB intend to run additional reports to review transactions approved and the authorising manager by cost centre. This will highlight any transactions approved by the hosted function which are not within the POD cost centre range.
- More fundamentally, there will be audit review and assurance of Specialised services in line with statutory requirements.

Principles used in the Detailed Scheme of Delegation

- The hosted function will manage the day-to-day operation of the scheme of delegation for specialised transactions, but the main principles are the same as for the ICB: authority sits with the role rather than the person and escalation is upwards in the organisational structure.
- As part of the overarching governance arrangements, each ICB is expected to provide a Specialised lead who is able to take decisions on behalf of the whole ICB at East Midlands 'tier 2' Joint Commissioning Group. Hence, the Director for Health Inequalities, Prevention and Regional Collaboration (currently Sandra Williamson) should have unlimited financial delegated authority across specialised cost centres.

Some points will be emphasised to the hosted function to make sure there is clarity about roles and responsibilities. The ICB will:

- confirm that Specialised staff are authorised to exercise their delegated authority limits within their own departments only;
- highlight specific issues in the ICB Governance Handbook where separate limits apply, e.g, £10,000 limit for professional fees, e.g., reporting of losses and special payments;
- confirm that Specialised staff should lead compliance with NHS England requirements such as prior approval before using non-clinical agency staff.

Revised Detailed Scheme of Delegation

In addition to the delegation in the ICB governance arrangements described in Appendix One, it is recommended that the ICB introduce further levels of delegation for Specialised staff in the hosted function and updated limits for the Director for Health Inequalities, Prevention and Regional Collaboration as shown in Table 1 below.

Table 1: Specialised Detailed Scheme of Delegation

Role	Healthcare,NHS Provider	Healthcare,Non-NHS Provider	Non-Healthcare
Level A manager	Up to £200,000	Up to £200,000	Up to £200,000
Level B manager	Up to £100,000	Up to £100,000	Up to £100,000
Level C manager	Up to £50,000	Up to £50,000	Up to £50,000
Level D manager	Up to £30,000	Up to £30,000	Up to £30,000
Level E manager	Up to £10,000	Up to £10,000	Up to £10,000
Level F manager	Up to £5,000	Up to £5,000	Up to £5,000
Director for Health Inequalities, Prevention and Regional Collaboration	Unlimited	Unlimited	Unlimited

Level A	Other Directors (VSM/ESM) and equivalent, including Senior Civil Service Grade 2
Level B	Agenda for change Band 8d and 9 and equivalent, including Senior Civil Service Grade 1
Level C	Agenda for change Band 8a - 8c and equivalent, including Civil Service bands 6 and 7
Level D	Agenda for change Band 7 and equivalent, including Civil Service SEO
Level E	Agenda for change Band 6 and equivalent, including Civil Service HEO
Level F	Agenda for change Band 5 and equivalent, including Civil Service CS/EO

- The new arrangements should take effect from 1 April 2024.
- Staff in the hosted function will be advised of exceptions to the limits above that they need to be aware of, and also that they can only process transactions across the Specialised cost centre range.
- Compliance with these arrangements will be monitored by the ICB and any exceptions will be raised at the East Midlands Joint Commissioning Group as well as the ICB Audit and Risk Committee.

Item 8 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (iii)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Emergency Preparedness Response & Resilience (EPRR) 2023/24 Update
Report Author:	Ross Noble, EPRR Lead, NHS Lincolnshire ICB
Presenter:	Clair Raybould, Director for System Delivery, Executive Lead for EPPR, NHS Lincolnshire ICB
Appendices:	EPRR Update

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

Recommendations

The Board is asked to note the contents of the report for organisational assurance.

Summary

This paper will provide an update of the ICBs statutory duties in relation to Emergency Preparedness Resilience and Response. Specifically, this paper will focus on:

- EPRR Assurance 2023/24
- Local Health Resilience Partnership
- Training & Exercising
- Incident Response
- Lessons Learned
- Business Continuity

How does this paper support the ICB's core aims to:

Aim 1: Improve outcomes in population health and healthcare.	EPPR is core requirement and function of the ICB to ensure that as a category one responder our duties can be delivered to expected standards, this will support improvements in population health during incidents.

Aim 2: Tackle inequalities in outcomes, experience and access.	EPPR is core requirement and function of the ICB to ensure that as a category one responder our duties can be delivered to expected standards, no impact on health inequalities.
Aim 3: Enhance productivity and value for money.	EPPR is core requirement and function of the ICB to ensure that as a category one responder our duties can be delivered to expected standards, no impact on productivity and value for money.
Aim 4: Help the NHS support broader social and economic development.	EPPR is core requirement and function of the ICB to ensure that as a category one responder our duties can be delivered to expected standards, no impact on broader social and economic development.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance

An ICB EPRR Programme risk log is maintained by the ICB EPRR Oversight and Assurance Group with any risks escalated to the ICB Risk Management Group for inclusion on the ICB Risk Register as per policy.

System risk log is maintained by the Health Emergency Planning Operational Group with any risks escalated to the Local Health Resilience Partnership (LHRP) as per policy.

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

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

Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☒	N/A ☐

Report previously presented at:
Not applicable.

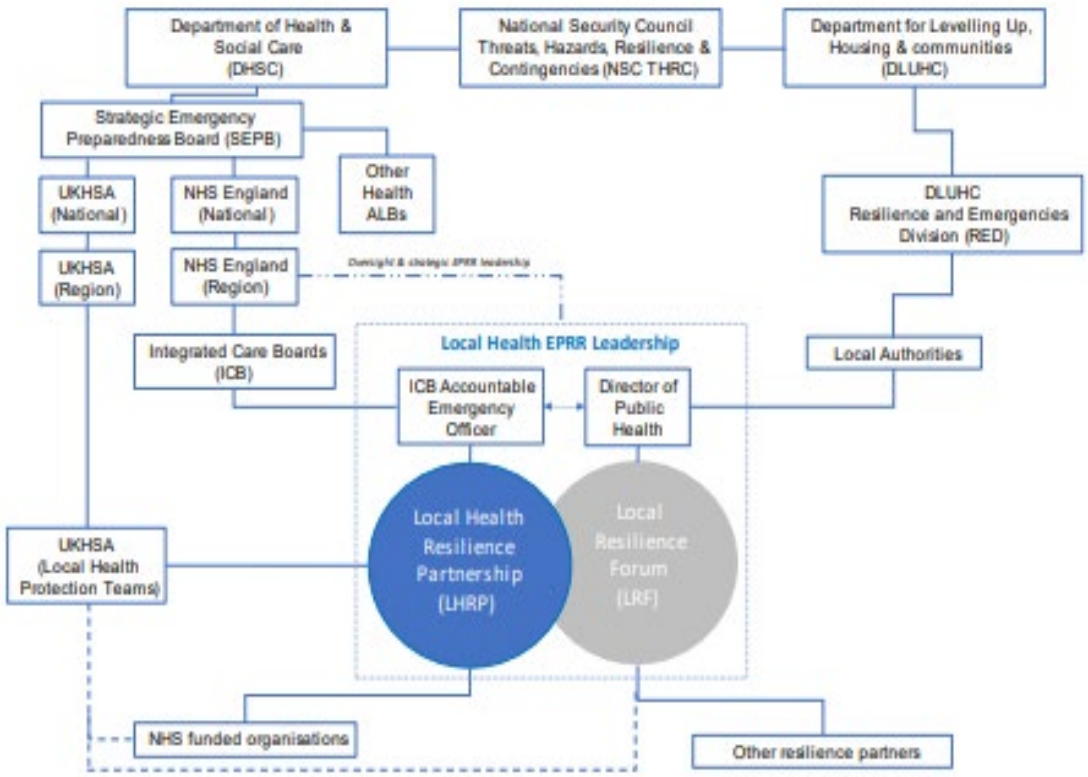
Is the report confidential or not?
Yes ☐ No ☒

Emergency Preparedness Response & Resilience (EPRR) 2023/24 Update

During its second year the ICB has seen establishment of resource and positive outcomes from an effective work programme. The category 1 responder responsibilities acquired as an ICB continue to underpin the continuous improvement of the EPRR programme.

The ICB has continued to collaborate with other category 1 & 2 responders through the Local Resilience Forum (LRF) and Local Health Resilience Partnership (LHRP). The relationships built within these groups have contributed to successful coordination in response during multiple incidents over the past 12 months.

The diagram below details how the duties of the ICB are part of the wider health economy responsibilities and the reporting structure into the regional, national and department teams.



Core Standards 2023

All NHS organisations are required to undertake a self-assessment against the 2023 updated core standards relevant to their organisation. The annual EPRR self-assessment provides an assurance that NHS organisations are working to meet their EPRR statutory duties and obligations. The applicable core standards vary between organisations depending on the type of services they deliver.

For the ICB this assessment is against 47 core standards which are mandated by NHS England. The standards are segregated into domains such as Governance, Training and Response. NHS organisations must then demonstrate their compliance against each applicable standard. The ICB was assessed as substantially compliant in 2023 by achieving 89% compliance across domains. As planned, this is a significant improvement from non-compliance which was reported in 2022.

The ICB EPPR Oversight and Assurance Group that was established in 2022 continues to ensure effective challenge and scrutiny to the ICB core standards process and wider EPPR work programme.

Local Health Resilience Partnership

Jointly led with Director of Public Health, the LHRP has built system wide arrangements to support an interoperable response if needed.

As a Category 1 responder, the ICB is now expected to provide a system leadership role in response along with fulfilling its own duties. As there is a mixture of categorised responders across health, the partnership has now formed a Local Resilience Forum (LRF) representation agreement. This outlines the NHS interface with the LRF ensuring effective coordination within a multi-agency response.

Lessons learned from live responses showed the need for a more effective mechanism of alerting the wider health economy upon incident declaration. The partnership has recently completed a system alerting framework which can now be incorporated into partner response arrangements.

The partnership has recently formed the *LHRP Risk Management Group.* This group has selected risks, wider than those which may be health owned, from the national risk register. Risks such as, malicious acts, flooding, loss of utilities, and industrial action have all been included. Although in most cases the likelihood may not be managed, we are able to potentially manage the impact and identify where joint arrangements may be of benefit.

Training & Exercising

The EPRR team continue to train and develop ICB commanders to a standard aligned with EPRR Minimum Occupational Standards (MOS). In the last year we have achieved 100% compliance in commanders attending ICB training.

Both Strategic and Tactical commanders are receiving training opportunities within health and multi-agency groups to promote interoperability. Training packages also incorporate national and community risk registers to best prepare commanders whilst acknowledging the common consequences of emergencies.

ICB and United Lincolnshire Hospitals NHS Trust (ULHT) both sent commanders to Cambridge and Peterborough to partake in a multi-agency exercise. *Exercise Eastgate* tested arrangements in place to respond to a failure of Reinforced Aerated Autoclaved Concrete (RAAC) structure. Although not present within the Lincolnshire system, this exercise enabled us to exercise our mutual aid arrangements to neighboring systems.

Seasonal preparedness exercises continue to take place with the last being *Exercise Orios Revenge*. This focused on winter preparedness with any lessons being factored into future response arrangements.

Measles was identified as an increasing risk with incidence being reported elsewhere in the region. At short notice, several scenarios were exercised jointly with health protection colleagues across organisations. This also enabled the ICB to test its latest version of the *Infectious Disease and New & Emerging Pandemic Plan.*

Incident Response

Since April 2023 there have been multiple incidents declared along with multi agency responses. During this time the NHS has experienced 9 periods of Industrial Action within its workforce, where EPRR capabilities have been utilised to enhance levels of coordination.

Storms Babet & Henk required a health response which was led by ICB commanders with EPRR support. Some of this response involved the rapid identification of vulnerable persons within flood impacted communities. ICB commanders also supported organisations in the temporary loss of premises due to flooding.

On the 15th December 2023, ULHT experienced an IT outage which impacted services across the system. Lessons have been learned in relation to the co reliance on servers and the importance of early alerting to other organisations.

In early August 2023, health organisations were part of a multi-agency response to a go- kart arena where over 50 persons were treated for suspected carbon monoxide poisoning. Lessons have been shared with multi agency colleagues to support a better understanding of health coordination and service capability. Recently this has been included within a health contribution shared at a Local Resilience Forum professional development day.

On 30th January 2024, the water supply to Lincoln County Hospital was temporarily interrupted. Business Continuity arrangements were invoked within the community and acute trust under the coordination of ICB commanders.

Lessons Learned

The EPRR team continue to identify, track, embed, and share learning from national, regional, and local sources. All EPRR response arrangements receive annual review which incorporate any lessons learned, with the option to revise immediately should there be a critical lesson identified.

Since April 2023, 38 lessons have been progressed and embedded within the latest response arrangements. 9 lessons remain outstanding with an action plan against each.

Business Continuity

The transition to ICB has required a full review of Business Continuity arrangements to ensure organisational resilience with the responsibility of Business Continuity transferring to the EPPR portfolio during 2023/24.

High level Business Impact Assessments (BIAs) for all directorates are approaching completion. These will influence service level BIAs where progress is already being made. The completion of BIAs have enabled the development of a corporate business continuity plan with further plans to be completed in the near future.

Service level leads from across the ICB will be identified and provided with training to support the ongoing development and maintenance of BC arrangements. This will help ensure bespoke assessments and plans for each area of the organisation.

It has been identified that further work is required to develop a process whereby we gain assurance of commissioned our provider’s / supplier’s business continuity plans.

Four Key Performance Indicators (KPIs) have been developed for Business Continuity.

Moving forward, these will be monitored through the ICB EPRR Assurance & Oversight Group.

- Business Impact Assessments Completed
- Business Continuity Plans Completed
- Number of Trained Staff (Business Continuity Leads)
- Exercises Completed

Item 08 (v)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (v)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Update from the Service Delivery & Performance Committee – January and February 2024
Report Author:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	None

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

Recommendations

The Board is asked to note and consider this report.

Summary

<u>January 2024</u>
UEC High Impact Interventions / Winter Plan Delivery Update

The ED recovery plan focused on group improvement of the three key Tier 2 metrics. Overall the performance against all metrics has improved with some impact of system pressures and industrial action. The ED recovery plan and the patient flow improvement actions across acute and community health services now form part of the group UEC programme approach and was embedded in system governance.

As part of the system winter plan there was a commitment to delivering the planned capacity for Virtual Wards and increased occupancy levels. The level of capacity available was now in line with plan (152 beds) and occupancy daily was between 80% and 89%.

Three Acute Respiratory Hubs were mobilised across Lincolnshire ahead of winter in order to support the management of respiratory illness over the winter period.

The system has delivered the planned core and escalation bed commitment within the winter plan and an additional 21 surge beds have been agreed and are available for planned use as required.

Implementation of a pilot HCP Single Point of Access (SPA) is underway to support system partners to manage patients closer to home and directly into appropriate services without the need for attendance or admission at hospital.

The relatively good position in respect of the maturity of the system's High Impact Interventions was noted.

Winter Communications Approach
The UEC/Winter Communications Plan for 2023/24 was presented, this builds on previous plans and aims to co-ordinate the joined-up communications work already happening across Lincolnshire into a single point of reference for stakeholders. The plan has been developed as a whole Lincolnshire NHS communications system, with all partners signed up to supporting and delivering the activities within it. Communication resources would originate both from system partners, and the national team who produce dedicated winter campaigns and resources.

Digital Update
System Delivery Review was presented noting 'Digital and Technology' as an enabler in the integrated care strategy. The enabler would be key in delivering effective health and care services to the population of Lincolnshire.

The ICB have commissioned a review to help shape the themes and approach within the Digital and Technology Enabler to ensure a coordinated approach across the system and create a shared ambition and high-level delivery plan over the next 3 to 5 years.

Planning Guidance
The guidance has not yet been released by NHS England but the proposal was that there would be an interim submission and then a final submission. Once received, the Service Delivery & Performance Committee would work jointly with the Finance & Resource Committee on the final submission at the start of May.

February 2024
UEC High Impact Interventions/Winter Plan Delivery Update

Further updates were provided in relation to the High Impact Interventions, including the HCP SPA pilot with a proposal to extend funding for this further and allow development of this initiative across Primary Care and the Voluntary Sector.

Health Inequalities
The work underway within the ICB to produce information which meets the requirements outlined within the NHS England Statement on Information on Health Inequalities was presented for assurance.

Length of Stay and Flow through hospitals
A presentation was given regarding Discharge performance within ULHT.

SAFER is a national initiative used across the NHS to drive discharges. The SAFER fundamentals fall into five categories of which one was regarding patients and their family/carers being actively involved in the decision making with regards to discharge.

The Integrated Discharge Hub has now been in place for some time and work is ongoing with regards to Home First Partnership. The fundamental ethos surrounding home first was to decide the best place for a patient whether this be in their own bed or within a community bed.

H2 Elective Recovery
There were 48 patients currently waiting 78 weeks or over, this was likely to be down to 12 patients by the end of February, with a plan to hit zero by the end of March. This was subject to there being no further industrial action.

65 week waits were also doing well with good progress made and recognised by NHSE. At the end of January there were 650 patients waiting against an original planned trajectory of 924. By the third week of February, this had reduced to 487 patients.

Items for Escalation to the ICB Board
There were no items for escalation to the ICB Board by the Committee in January and February 2024

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
See main body of report.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Yes - Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable			
Is the report confidential or not?			
Yes ☐ No ☒			

Item 8 (vi)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (vi)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	Audit & Risk Committee Update
Report Author:	Mrs Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance
Presenter:	Mrs Margaret Pratt, Non-Executive Director and Chair of the Audit and Risk Committee
Appendices:	N/A

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

Recommendations

The Board is asked to note the update and progress.

Summary

The Audit & Risk Committee met on the 19th March 2024 and considered a number of items:

- SICA Report including update on outstanding Internal Audit actions.
- Internal Audit Report:
  - Financial Management
  - Implementation of Projects & Post Implementation Review
  - Key Financial Controls
  - Risk Management & BAF
  - Workforce Planning – Running Costs Reductions
- Draft Head of Internal Audit Opinion
- Draft Strategy & Internal Audit Plan 2024/25
- Update on Actions – External Audit
- External Audit Planning Report
- Counter Fraud Update Progress Report
- Draft Counter Fraud Plan 2024/25

- Draft Accounting Policies for the 2024/25 Accounts
- Recovery Support Programme; Outcomes Update
- Update on the ICB Board Assurance Framework and Risk Management Arrangements
- ICB Annual Report and Accounts Key Dates 2024
- Draft Annual Governance Statement 2023/24
- Draft Audit and Risk Committee Annual Report 2023/24, including Committee Self-Assessment
- Governance Report

In summary, all legacy internal audit recommendations are now closed. Five internal audit reports have been issued – all rated as Reasonable Assurance, including key financial controls and the ICB Risk Management and Board Assurance Framework. The draft Head of Internal Audit Opinion has been issued and in light of the progress made with the Internal Audit Plan.

External Audit planning for the end of year process is well developed and on track. The process for the production of the ICB Annual Report is in train and an initial draft of the Annual Governance Statement was noted by the Committee, with a further draft to be issued in the next week for comments.

The draft Accounting Policies for the 2024/25 Accounts were reviewed and noted along with the Recovery Support Programme (Outcomes update).

The Committee considered the latest Counter Fraud Update report and proposed plan for 2024/25. The final version will be presented to the Committee at its next meeting in May.

The Committee considered its draft Annual Report 2023/24, along with associated Self-Assessment, and subject to amendments/comments, this will be re-presented at the next meeting in May and then submitted to the Board for approval.

The standard Governance Report was presented, with no hospitality/sponsorship or losses to report. There were two waivers noted along with one staff member change to the Declaration of Interest Registers.

There were no particular areas of escalation to the Board.

Terms of Reference

At the January 2024 meeting, the Committee reviewed its Terms of Reference which are presented with tracked changes for the Board's approval and inclusion as part of the Corporate Governance Handbook.

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

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

Risk and Assurance
As indicated in the report.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Not applicable.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

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

Report previously presented at:
Regular updates provided to the Board.

Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Audit and Risk Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

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

1.3 The Committee is a Non-Executive Committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. AUTHORITY

2.1 The Audit and Risk Committee is authorised by the Board to:

- Investigate any activity within its Terms of Reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:

3. PURPOSE OF THE COMMITTEE

3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.3 The Audit and Risk Committee has no executive powers, other than those delegated in the SoRD and specified in these Terms of Reference.

4. MEMBERSHIP AND ATTENDANCE

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than ~~three~~four members of the Committee who are Non-Executive Members of the Board (and ideally will be the Chairs of three of the Board's Committees – Finance, Performance and Quality)~~.~~

4.3 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

4.4 Members will possess between them knowledge, skills and experience in~~:~~ accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice chair

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

4.6 The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will ideally not be a member of any other committee.

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

4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

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

- Director of Finance or their nominated deputy;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;

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

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

4.12 The Chief Executive should be invited to attend the meeting at least annually.

4.13 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance

4.14 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

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

Access

4.16 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit and Risk Committee.

5. MEETINGS QUORACY AND DECISIONS

5.1 The Audit and Risk Committee will meet not less than four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

Quorum

5.4 For a meeting to be quorate a minimum of three~~two~~ independent Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

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

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

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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

6. RESPONSIBILITIES OF THE COMMITTEE

6.1 The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

6.2 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

6.3 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

6.4 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

6.5 To have oversight of system risks where they relate to the achievement of the ICB's objectives.

6.6 To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

6.7 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.8 To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

6.9 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

6.10 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

6.11 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

6.12 To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Risk Committee's own areas of responsibility.

6.13 To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

6.14 To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter Fraud

6.15 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

6.16 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

6.17 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

6.18 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

6.19 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

6.20 To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

6.21 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

6.22 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

6.23 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

6.24 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial Reporting

6.25 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

6.26 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

6.27 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

Conflicts of Interest

6.28 The Chair of the Audit and Risk Committee will be the nominated Conflicts of Interest Guardian.

6.29 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

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

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

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

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

Management

6.34 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

6.35 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

6.36 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

6.37 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

6.38 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

7. ACCOUNTABILITY AND REPORTING

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The Audit and Risk Committee will be required to:

a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.
b) A Committee Chair may also request an Executive lead to attend the Audit and Risk Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail.

7.3 The Audit and Risk Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

8. BEHAVIOURS AND CONDUCT

ICB Values

8.1 Members will be expected to conduct business in line with the ICB values and objectives.

8.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

8.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

9. SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

10. REVIEW

10.1 The Committee will review its effectiveness at least annually.

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

Date of approval:

Date of Review:

Item 9 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	9 (i)
Meeting Date:	Tuesday, 26th March 2024
Title of Report:	ICB Annual Report and Accounts Key Dates 2024
Report Author:	Mrs Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance
Presenter:	Mrs Jules Ellis-Fenwick, ICB Board Secretary and Head of Corporate Governance
Appendices:	Not applicable

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

Recommendations

The ICB Board is asked to:

- Note the process and specific dates in relation to the production of the ICB Annual Report and Accounts for 2023/24 including the ICB Annual Assessment.
- Note the identified lead for each section.

Summary

NHS Bodies are required to publish, as a single document, an Annual Report and Accounts (ARA). The Department of Health and Social Care Group Accounting Manual (DHSC GAM) 2022/2023 sets out the requirements for the content of the ICB Annual Report, which must follow the three-part structure as detailed below:

- The Performance Report, which must include an overview and performance analysis.
- The Accountability Report, which must include a Corporate Governance Report, Remuneration and Staff Report and Parliamentary Accountability and Audit Report*.
- The Annual Accounts

**This section is not applicable to ICBs as they do not report directly to Parliament.*

The Health and Care Act 2022 requires ICBs to:

- Explain how the ICB has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 (general duties of ICBs)

- review the extent to which the ICB has exercised its functions in accordance with plans published under forward plans and capital resource use plans.
- review the extent to which the ICB has exercised its functions consistently with NHSE's latest statement about how functions relating to inequalities information should be exercised.
- reviewing any steps the ICB has taken to implement any joint local health and wellbeing strategy it is required to have regard to.

Key changes to ICB annual reports resulting from the 2023/24 Group Accounting Manual (GAM).

PES requirements have been incorporated into the 2023/24 Group Accounting Manual.

Additional Requirements for ICBs

The 2023/24 GAM sets out additional requirements for ICBs relating to the reporting of gender distribution, business information and details of members, the membership body and governing body.

The Accountable Officer is required to sign and date the Performance Report, Accountability Report and the Statement of Financial Position.

ICBs are required to publish their full Annual Report and Accounts in accordance with the arrangements notified via the ICB SharePoint Pigeon Holes.

NHSEI has issued details of the key deadline dates and submission process for the Year End Accounts and Annual Report as follows:

- Month 9 Governance Statement Return – **to be submitted on 19th January 2023** (including nil returns) – **complete.**
- A full copy of the draft Head of Internal Audit Opinion (to allow regional assurance activity to commence) - **to be submitted by 3rd March 2023 – complete.**
- Draft ICB Annual Report (excluding accounts and staff information), updated Head of Internal Audit Opinion, completed NAO disclosure checklists - **to be submitted by 9.00 am on the 24th April 2024.**
- Full audited and signed ICB Annual Report and Accounts - **to be submitted by 9.00 am on the 28th June 2024.**

Preparing for 2023/24 Integrated Care Board Annual Assessment

NHS England has a statutory duty to undertake an annual assessment of each Integrated Care Board following the end of each reporting year.

The 2023/24 assessment will be similar in approach to 2022/23 with the core structure being the four purposes of an ICS alongside the system leadership role of ICBs: so the five (4+1) headline objectives of ICBs. These headline objectives of ICBs will be mapped to the 8 statutory duties of ICBs which are required in legislation to be considered in the assessment.

Building on the approach used for 2022/23 NHS England regional teams will use the ICBs Annual Report as the key source of evidence for the 2023/24 assessment. By making ICBs aware of this intention at this earlier stage this should facilitate appropriate tailoring of the Annual Report to the structure of the annual assessment. It is acknowledged that the Annual Report has a wider remit, and we will ensure ICBs have the opportunity to put forward additional evidence where the information, or the way in which this is presented, might not be relevant for the Annual Report but is appropriate to consider for the annual assessment.

Given the timing requirements of the assessment it is likely that the draft Annual Report submitted around 24 April 2024 will be used for the assessment, but final versions will be considered for any remaining gaps in assurance, by exception.

In respect of the ICB Annual Report and Annual Assessment for 2023/24 all agreed identified leads were agreed by the Executive Team and then contacted by the ICB Board Secretary to inform them of this years' requirements and to advise of the deadline date for submissions.

Members of the ICB Communications and Finance Teams will be supporting the Board Secretary with production of the ICB Annual Report.

NHSE will consider the contents of the draft Annual Reports and in line with findings of interim certification, advise whether ICBs should submit an updated draft of the Annual Reports to support final certification or identify comments/suggestions to enhance the content.

The Audit and Risk Committee will be required to consider and recommend approval of the submission of the final audited version of the ICB Annual Report and Accounts 2023/24. It is proposed that the Audit and Risk Committee considers the final version at an extraordinary meeting on the 25th June 2024 and recommends the Board approves the final versions for submission at its meeting on 25th June 2024 (prior to the Development Session) – specific timings to be confirmed.

ICBs will be required to publish the final version of the ICB Annual Report and Accounts in full on the website by 5.00 pm on 23rd September 2024.

ICBs are also required to hold an Annual Public Meeting at which the ICB Annual Report and Accounts should be presented (this has to take place within six months of the end of the previous financial year – **as in by 5.00 pm on 30th September 2024)**.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The requirements on the content of the Annual Report covers off all four key aims of the ICB and comprehensive information will be included to that effect.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
No specific risks identified.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	There will be some resource implications associated with the cost of the design of the Annual Report and Accounts.
Does the report highlight any quality and patient safety implications?	Not applicable to this report.

Does the report highlight any health inequalities implications?	Not applicable to this report.
Does the report demonstrate patient and public involvement?	Not applicable to this report.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable to this report.

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

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒