



NHS Lincolnshire Integrated Care Board Public Board Meeting

**Tuesday, 26th November 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**.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 26th November 2024

Time: 9.30 am – 11.45 am

Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Dr Gerry McSorley, ICB Chair

AGENDA

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	Time
1. Introductory Items					
i)	Welcome, introduction and apologies		-	Dr Gerry McSorley	9.30
ii)	Confirmation of quoracy		-	Dr Gerry McSorley	
iii)	Declarations of Interest	Information	-	Dr Gerry McSorley	
iv)	Minutes of the previous meeting held on the 24 th September 2024	Approve	✓	Dr Gerry McSorley	
v)	Matters Arising, including Action Log	Note	✓	Dr Gerry McSorley	
2. Chair and Chief Executive Updates					
i)	Chair's Report	Note	-I	Dr Gerry McSorley	9.35
ii)	Chief Executive's Report - Budget Impact Joint Letter	Note	-	Mr John Turner	9.45
3. Key Updates					
i)	Public Health	Note	-	Professor Derek Ward	10.05
ii)	Healthwatch	Note	✓	Mr Navaz Sutton	10.15
4. Population Health Planning					
i)	Frailty Strategy Update	Assurance	✓	Mrs Sarah-Jane Mills, Mrs Lisa Foyster and Mrs Sarah Button	10.25
5. System Oversight and Assurance					
i)	Integrated Performance, Quality and Finance Report – October 2024	Assurance	✓	Mrs Clair Raybould/ Mr Martin Fahy/ Mr Matt Gaunt	10.40
BREAK AT 11.00 AM					
ii)	Process for Review of CQC section 48 (Calocane) Report	Assurance	✓	Mrs Sarah Connery	11.10
iii)	Winter Planning 2024/25	Assurance	✓	Mrs Clair Raybould and Mrs Rebecca Neno	11.20

Item	Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	Time	
6. Governance					
i)	Standards of Business Conduct and Conflicts of Interest Policy	Approve	✓	Mrs Jules Ellis-Fenwick	11.35
7. Committee Highlight Reports					
i)	<ul style="list-style-type: none"> • Service Delivery and Performance • System Quality and Patient Experience • Audit and Risk Committee • Primary Care Commissioning Committee (verbal) • East Midlands Joint Committee 	Assurance	✓	Committee Chairs	11.40
8. Information/Closing items					
i)	Risks identified during the course of the meeting	Consider	-	Dr Gerry McSorley	11.45
9. Date, Time and Venue of the next meeting					
	Tuesday, 28 th January 2025 at 9.30 am at Bridge House, Sleaford	Note	-	Dr Gerry McSorley	Close

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

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

Special Resolution - The Board will be asked to consider the following resolution:

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

**MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY,
24TH SEPTEMBER 2024 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA
MICROSOFT TEAMS**

PRESENT:	Dr Gerry McSorley	ICB Chair and Chair of the Primary Care Commissioning and Delegated Functions Committee
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	Ms Anita Day	Non-Executive Member
	Mrs Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Emma Rhodes	Deputy Director of Finance (on behalf of Mr Gaunt)
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Director for System Delivery
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS/ ATTENDEES	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Ms Charley Blyth	Director of Communications and Engagement
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mr Feargus Mack	Associate Director – Planning & Transformation (item 4 only)
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
APOLOGIES:	Mr Matt Gaunt	Director of Finance
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Margaret Pratt	Non-Executive Member and Chair of the Audit and Risk Committee
	Mrs Sharon Robson	Non-Executive Member

24/250 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire ICB Board and emphasised that whilst the meeting was being held in public it was not a public meeting. The meeting was being held both on a face to face basis and via Microsoft Teams. This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams.

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

The Questions and Answers facility was also 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.

242/251 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

24/252 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.**

24/253 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 30th July 2024 and agreed to:

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

24/254 MATTERS ARISING

Dr McSorley presented the Action Log which included two items, both of which were identified as complete.

24/255 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that he had attended a number of meetings on behalf of the Board since it last met. This included the regularly scheduled meetings which are hosted by Lincolnshire County Council (LCC) with senior colleagues, namely Councillor Martin Hill, Council Leader and Mrs Debbie Barnes, Chief Executive. Discussions on this occasion involved the new Dean of Lincoln Cathedral and it was a very engaging conversation about many of the shared issues that particularly public services face across Lincolnshire.

Other meetings he had attended included a number of both regional Chairs and national Chairs meetings, and as a point of note he would be joining the Chairs and Chief Executive's meeting the following day which was scheduled to take place in Leicester and was being hosted by the Midlands region. Mr Gaunt was also attending the event and participating in one of the panels looking at sustainability. Dr McSorley was sitting on one of the Chair panels looking at aspects of the future.

The Board was advised that Dr McSorley had the pleasure of meeting with Ms Sue Cousland, Chief Operating Officer, East Midlands Ambulance Service (EMAS) to gain a better understanding of their divisional arrangements in Lincolnshire. Linked to that the Board was asked to note the appointment of Mr Jeff Worrall as the new Chair of EMAS. Many colleagues will be aware of Mr Worrall from his previous roles within the NHS. A meeting would be arranged to take place with Mr Worrall in the coming months and Dr McSorley looked forward to working with him going forward.

Dr McSorley had supported Mrs Elaine Baylis, Group Chair (United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Hospitals NHS Trust referred to as Lincolnshire Community and Hospitals Group) and Mrs Karen Dunderdale, Group Chief Executive in the appointment of the Director of Finance post for the Group. An announcement on the appointment will follow in due course.

Further points to note:

- In the last month the proposed reviews of the ICB Non-Executive Members had taken place and the appropriate paperwork completed. Dr McSorley expressed his appreciation to colleagues for their support over the last year and positive contributions they have made to the working of the ICB in that time.
- Dr McSorley had received confirmation from the Department of Health and Social Care that his appointment as Chair of the ICB had been extended to the end of September 2025. As a result there is now a Non-Executive Member vacancy and the process to appoint a replacement would be looked at and confirmed in the coming weeks.
- Dr McSorley had commenced the annual observation of the ICB Board System Committees and was grateful to Mrs Pomeroy and Mrs Robson for the opportunity to attend the Finance and Resource and System Quality and Patient Experience Committee meetings. The intention is to join and observe the Service Delivery and Performance and Audit and Risk Committees in the coming months.

On a final note, the Board had previously been made aware of the proposal to rebuild the Glebe Park Practice in Lincoln and Dr McSorley was delighted to say that he would be at the practice on Thursday and meeting with staff. This was a piece of work that had been underway for some time and Dr McSorley expressed his appreciation to the Primary Care Team and the practice for bringing this about.

Dr McSorley advised that the name of the new centre for dental development has been renamed and is now LIDO – Lincolnshire Institute for Dental and Oral Health.

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

Chief Executive update

Mr Turner advised that he had a few points to highlight, but firstly wanted to congratulate Dr McSorley on his appointment as ICB Chair through to September 2025, which was very much welcomed by the Board and system partners in Lincolnshire.

Other points to mention, it has been widely reported that the NHS in England and indeed in the county continued to remain under significant operational pressures. Teams across Lincolnshire in Primary Care, Trust partners and other ICB partners continued to work really hard in an impressive way to respond to demand. Autumn had now commenced, and the Winter Preparation letter had now been received from NHS England and this would no doubt be reflected on later in the meeting by Mrs Raybould under the performance report. The three vaccination programmes in relation to COVID, flu and respiratory syncytial virus (RSV) had now commenced.

The Joint Committee on Vaccination and Immunisation (JCVI) had issued clear information on which groups of the population the vaccines should be made available to, and it was really important to encourage those individuals to take that up that offer.

In summary, the next six months are anticipated to be very challenging, but the Lincolnshire system is prepared and is in the best shape it can be.

The following points were highlighted for the Board:

- Congratulations were extended to the Group/United Lincolnshire Hospitals NHS Trust (ULHT) who have been granted teaching hospital status. This is a really significant achievement for the Trust and the collective reputation of Lincolnshire and will enable the development of the NHS workforce, provision of training, learning and education opportunities for all staff.
- Congratulations were also extended to Lincolnshire County Council, along with North and North East Lincolnshire Councils following the recent announcement by Angela Rayner, MP and Deputy Prime Minister of the sign off for the Greater Lincolnshire Devolution. The ICB was very supportive of the devolution and believes this will herald a step change for the county. Lincolnshire was now on track for the Mayoral elections to take place in May 2025.
- Lord Darzi recently published his report on the outcome of the investigation into the state of the NHS, which had featured significantly in the national media as well as across the NHS. The report is a frank assessment on the state of the NHS across the country and it sets a tone and approach for the 10-year health plan.
- Mr Turner along with Mrs Dunderdale, Mrs Connery, Professor Ward and Mr Martin Samuels, Executive Director of Adult Care & Community Wellbeing at Lincolnshire County Council attended a meeting in Birmingham with The Rt Hon Wes Streeting, Secretary of State for Health and Social Care on the 20th September 2024. It was both interesting and informative and it was evident he is open to dialogue, recognising there are significant lessons to be learnt across the NHS.
- Mr Turner had attended the latest NHSE national meeting of Chairs and Chief Executives on the 17th September. The main focus of the discussion had been on the Lord Darzi report, the 10-year health plan and operational matters such as elective care, emergency care, winter, vaccinations and financial challenges across the system. General practice was also discussed, including the PCN pilot work. Lincolnshire ICB is only one of seven ICBs across the country involved in that initiative and by being involved it has certainly raised the profile of the organisation. The other area was GP collective action which is clearly a challenge across the country and a developing situation in a fairly variable way, and it was evident there are significant concerns about the end position. Services for people with learning disabilities was also covered. It was well known that the life expectancy for someone with learning disabilities is below the average and in some parts of the country well below the national average. The Board will be aware from the information that has previously been shared by Mrs Williamson that work is underway in Lincolnshire on supporting people with learning disabilities through the health inequalities lens.
- The Secretary of State also reflected on his top three priorities at that meeting, which were prevention, out of hospital primary community neighbourhood team work and digital.
- As per Dr McSorley's update, Mr Turner would be attending the NHS Regional Midlands Chairs and Chief Executive's meeting on the 25th September.
- The previous week (18th September) Mr Turner and Dr Hindocha had attended the PCN Pilot launch in London with the NHSE team with the three PCNs from Lincolnshire involved and also other ICBs. Attendance was really positive with a number of people present and Mr Turner came away from the event feeling very uplifted, emphasising the earlier point that Lincolnshire is the only ICB across the Midlands region engaged in that piece of work.

- Following a thorough recruitment process Mrs Anne Lloyd has been appointed as the Director of System Workforce Transformation and would commence in post in early January 2025.
- The Board was aware that the ICB and LCC commissioned a strategic digital review which Professor Ward had oversight of, and a number of discussions had taken place on the outcome and how that is taken forward. The intention is to hold a system digital workshop in the same way as the one held earlier in the year on workforce and the arrangements for that were currently being considered.
- The Board had previously been briefed on the commitment made by the former Lincolnshire CCG to hold a public engagement exercise with the people of Stamford around future health provision in and around the area, specifically in light of the anticipated significant housing growth. The work on how that is going to be taken forward was almost complete and being led on by Mr Burnett and Ms Blyth and it is anticipated the process will have commenced by the time the Board next meets in November.
- The first meeting of the Strategic Oversight Group took place the previous day. This involves Mr Turner and Mrs Barnes undertaking a review of all the significant pieces of work being undertaken jointly by both organisations, such as the Section 75 work on prevention and the on-going Better Care Fund (BCF) by way of examples.
- Mr Turner had attended and been involved in various meetings including with the University of Lincoln on the development of the dental centre; with UKACTIVE around the physical exemplar ambition for the county; he had met with Alicia Kearns, MP and was scheduled to meet with Hamish Falconer, MP along with Mrs Dunderdale and Mrs Connery in the middle of October.

The Board considered the update. Councillor Woolley thanked Mr Turner for highlighting the engagement exercise work being progressed in relation to health care provision in Stamford; this was very much welcomed and no doubt the local residents would be delighted to hear this.

In respect of the NHSE letter about winter, the content appeared to place considerable emphasis on care being delivered at home as much as possible and Councillor Woolley sought clarification on how prepared the Lincolnshire health and care system is to realise that. Mr Turner referred back to Stamford and advised that the Board was aware that there were some other parts of the county where it was recognised about issues with housing growth and engagement will need to take place with those areas as well, specifically Spalding. There will no doubt be learning from the Stamford engagement process and that will be rolled out across other parts of the county.

Mr Turner advised that he would hand over to Mrs Raybould to respond to the question about winter planning but in short there was nothing new in the letter from NHSE; the emphasis on out of hospital community care is correct and reflective of the Secretary of State's key priorities. Mrs Raybould advised that the letter referred to implementing year two of the UEC Recovery Plan, which is very clear about preventing people from escalating in their care, but also ensuring that when they do there is an out of hospital response and there is a whole plethora of things available in the community. Work does need to be undertaken to better integrate those and there is a significant piece of work to be undertaken around the implementation of the Frailty Strategy. As part of the recent winter planning workshop bed provision was discussed with some already built in for quarter four, both in the community and acute. Consideration is being given as to whether that resource could be utilised in a different way. There were also three new published pieces of guidance on winter planning and some work would need to be undertaken to ensure the requirements of those were fully implemented, examples being virtual wards (referred to as out of hospital care).

Mr Turner referred to two questions received from members of the public. It was noted that the details of the questions and the associated responses would be attached separately to the minutes of the meeting.

The Board agreed to:

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

24/256

KEY UPDATES

Public Health

Professor Ward referenced the Secretary of State for Health and Social Care and advised that he would draw on the three key areas, which were care closer to home, move from analogue to digital and prevention rather than illness, and tie those into the work already taking place; some of which had already been alluded to by Mr Turner.

The first area to mention that the Board has discussed previously, is its ambition to focus on prevention and early intervention. Mr Turner referenced the Section 75 agreement, which is progressing and currently going through the legal process. The plan is to create a Section 75 to focus on prevention and early intervention with a key target around health inequalities which Professor Ward and Mrs Williamson were leading on. One of the proposals to be looked at from the funding perspective is around people with learning disabilities who, as referred to earlier by Mr Turner, have a significantly lower life expectancy and healthy life expectancy than the general population. There is a collectively funded Lincolnshire integrated lifestyle service in place (One You Lincolnshire) which helps people stop smoking, lose weight, become more physically active and change their diet. The proposal is to tailor a support offer for people with learning disabilities within that model to see whether help can be given to individuals, their families, their carers and their loved ones.

The second area to mention is an update on the digital work taking place. Whilst moving from analogue to digital seems straight forward for most people, this does appear to be a real cultural change in health and care. Work is taking place collectively across the system to address this and the next steps include holding a workshop in Sleaford and he was currently in the process of putting that together with Mrs Kathy Fulloway, ICS Digital Lead.

The final point to mention was in respect of Community and Primary Partnerships (CPP). Work continued to be progressed on a whole range of different areas. For example, there are specific geographies, down the East Coast and Boston who are really keen to do some work within that wider community and primary partnership framework. There are particular pathways that are being looked at in terms of redesigning those. This is being driven by individual clinicians and the public and people looking at factors they wish to see changed based on the information and intelligence available. A structure is being put in place to support this work. An update would be provided to the Board in due course.

Moving towards the winter period, the vaccination programme for flu and COVID is now live. The Board may recall that the Joint Committee for Vaccinations and Immunisations (JCVI) usually examine flu trends observed in the Southern Hemisphere in their winter period as this tends to provide valuable insights into what flu activity might occur in the UK during the upcoming winter period. The headlines are that whilst in the Southern Hemisphere flu season, most countries experienced similar levels of flu activity compared to trends observed in prior seasons, two countries in South America and Southern Africa experienced very high influenza virus detection levels. The majority of the flu activity has been primarily attributed to influenza A.

In summary, the level overall as far as the CDC has reported (the US health protection function) it has been a moderate flu season, but what remained consistent across all the regions is that flu still results in significant hospitalisations and mortality.

In the UK, the number of flu cases was relatively low and as expected for this time of year but was anticipated to increase over the next six weeks and will be closely monitored.

The Lincolnshire system was offering the flu vaccine to all front-line staff and LCC was offering this to everyone in the council whether they are eligible as part of the national programme or not.

There had been an increase in the number of COVID cases, which had peaked around June/July time. Current levels were pretty flat but expected to increase with the end of the summer holidays and children returning to school. The largest peak in the number of cases were generally seen at this time the previous year.

The COVID vaccination campaign kicks off on the 3rd October and those eligible will receive a telephone call/reminder. Vaccination uptake in previous years had been really positive and it was essential that was maintained; there is no room for complacency.

Mr Fahy advised that the Integrated Performance, Quality and Finance report included in the pack provided the detail on the flu vaccination campaign from the NHS perspective, but in short this commenced in Lincolnshire on the 1st September. The various cohorts were currently being worked through (such as young children and pregnant women). The key message for the public is that, as in previous years, there are numerous ways to have the flu vaccine, which is primarily delivered through primary care. Messages and reminders will be issued to all those individuals who are eligible to receive the flu vaccine.

The RSV vaccine is underway, having also gone live on the 1st September and the relevant cohorts eligible to receive that were currently being targeted, again with various options to have the vaccine as close to where people live as possible.

The COVID vaccination campaign had already been covered off by Professor Ward, but the same principles applied as flu in terms of messages and reminders to all those eligible to receive it.

Dr Hindocha advised that in respect of the RSV vaccine, there had been very positive uptake since it was launched the previous week.

Mrs Pomeroy referred to the flu vaccine take up by healthcare staff last year and what the ambition is for this year. Mr Fahy advised that whilst he did not have the specific figure for 2023 to hand, there was really good uptake. A considerable amount of joint work was taking place with the Group, LPFT and local authority colleagues to increase the numbers this year by making the vaccine accessible on numerous sites. The key message is the vaccine is free and Mr Fahy emphasised the need for people to come forward and take up the offer.

Healthwatch

Mr Sutton presented the latest Healthwatch report and advised that he would take this as read but wished to highlight some key areas to the Board for information. Firstly, Healthwatch had undertaken a couple of out-reach sessions and Mr Sutton wanted to focus on the feedback.

The service areas commented on the most in August 2024 were GP services, hospital services and dentistry. In terms of hospital services, the key theme was around communication which has been poor between families by way of an example. However, there has been an impact seen around the You Care, We Care to Call initiative and BBC Radio Lincolnshire had recently interviewed some nurses from ULHT and also Healthwatch on the impact that is having, so the feedback had slightly decreased and tended to focus on specific areas. These were being worked on jointly by Healthwatch and ULHT.

- Healthwatch had undertaken some work in the East Coast in respect of difficulties with access to appointments to try and understand the detail.
- A piece of work had been carried out in respect of inequalities – sensory loss. At the Lincolnshire Sensory Services Open Day in Boston, individuals with sensory loss

shared challenges in accessing healthcare, particularly around communication. Lack of understanding among NHS dentists was a key issue, with one patient being discouraged from bringing their assistance dog, causing anxiety. There is also a need for interpreters during dental appointments. Healthwatch will be working with the ICB on looking at the types of mechanisms that could be put in place to help those individuals.

- Healthwatch hosted a workshop to share findings from their respiratory health project, which included input from 230 participants. Attendees shared feedback, experiences, and updates on initiatives to improve respiratory health services in Lincolnshire. This information was currently being collated and the report, including the recommendations, would be shared within the next few weeks.
- To support the pharmaceutical needs assessment (PNA) and ensure that people's experiences are included in discussions about pharmaceutical services in the county Healthwatch launched a survey, which was currently live.
- Healthwatch had also undertaken a neurological survey which was due to close next week.
- Feedback received from the respiratory survey indicated there is a considerable amount of public engagement and response, but would it be good to obtain information from professionals and front line staff members. Workshops were being held as part of that work.
- With the neurological survey discussions had taken place with the ICB engagement team around how that could be circulated to all staff across the system with the aim of improving the response rate.
- For the final quarter of 2024 the focus would shift to mental health and a survey was due to go live on 1st October 2024.
- The next YourVoice@Healthwatch event was scheduled to take place on Wednesday, 23rd October 2024. The Healthwatch Annual Report will be shared at that event, and it will also focus on their previous impact and offer an opportunity to shape their future priorities.
- Healthwatch continued their enter and views and discussions had taken place with Mr Fahy about the potential to visit A&E. This followed on from visits to Care Homes and a number of out-reach sessions were now planned to focus on areas of gaps that had not been reviewed in the previous 12 months.
- Current areas of focus included infant feeding. This was coming to a conclusion and a report was due at the end of calendar year. This had now been moved into pelvic health and this will move into developing and considering what services look like across the county.
- Another area of focus was childhood vaccinations. There had been some challenges in obtaining feedback around that in light of the current GP collective action. A different approach had been taken with a public survey which had seen some traction.
- Oral health – some focused group work had been undertaken with LCC in the Boston area to understand needs in that area.

Professor Ward commented that it was really important to recognise the distinction in Lincolnshire between the areas where water is fluoridated and where it is not. Part of the work being undertaken with Healthwatch is to bring that to the fore. The North East region is currently in the process of going through a public consultation on expansion of the community water fluoridation in that area. This follows the Secretary of State's powers under the Health and Care Act 2022 to introduce, vary and terminate community water fluoridation schemes. It will be interesting to see the outcome of that public consultation.

Mrs Raybould referred to the intelligence being picked up in relation GP practices and access to appointments in the East of the county and advised that it would be helpful if Mr Sutton could link in with Ms Blyth outside of the meeting as the impact of the GP collective action is being monitored and collated.

Mr Sutton confirmed that the communications plan had been signed off the previous day and he was happy to report that Healthwatch Lincolnshire had secured the contract through to 2030. Dr McSorley offered his congratulations and that of the Board to Mr Sutton and the team.

Mrs Williamson thanked Mr Sutton for sharing the report, specifically the information about sensory element and wanted to acknowledge this is an area of focus for the inclusion health groups in the ICB.

The Board agreed to:

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

POPULATION HEALTH PLANNING

24/257

ANNUAL POPULATION HEALTH PLANNING CYCLE FOR 2024/25

Mr Mack joined the meeting at this point and introduced himself to those present. The Board was advised that the paper included in the pack and the supporting presentation had been prepared to set out the approach and associated process for the Lincolnshire population health planning work in 2024/25. This included how partners across the system are working together to meet the evolving needs of the Lincolnshire population, while making the most of collective resources.

Mr Mack presented a set of slides and ran through the content which covered the following areas:

- How the Lincolnshire system is working together: mindset and behaviours; principles; key shifts; language
- The strategic framework: strategy map; strategic priorities and success measures; Assumptions; the improvement planning and delivery cycle
- Deliverables and project plan: What is being done, when by whom
- Key building blocks and deliverables: intelligence; efficiency; demand & capacity modelling
- Governance and oversight arrangements: key groups; decision making

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

There have been two key shifts in the approach:

Longer term, strategy-driven:

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

Taking a more sophisticated approach to resource allocation:

- Proportionate universalism: resourcing and delivering universal services and interventions at a scale and intensity proportionate to the degree of need of the population segments (including Core20PLUS5)
- Not only looking at technical efficiency (doing things right – including the productivity agenda), but also allocative efficiency (doing the right things): this means understanding the current value of pathways and services and analysing how

resources should be shifted around the system to maximise the health gain for the Lincolnshire population

The Joint Forward Delivery Plan (JFP) will be refreshed and incorporated into the Operational Plan for 25/26.

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

In terms of assurance to the Board, monthly updates will be provided to the ICB Service Delivery & Performance Committee and the Finance & Resource Committee. These Committees will meet jointly to review plans. The Lincolnshire Leaders Group will act as the main approval body for NHS strategies, plans and final submissions to NHS England. The Lincolnshire Chief Executives will be the approval body for any draft submissions.

Dr McSorley thanked Mr Mack for his attendance and informative presentation and update and asked whether there were any questions. Ms Day sought clarification on where the continued feedback process featured within this as the strategy is developed, such as checking back with the population and the local communities that the agreed priorities are going to meet their needs. Mr Mack advised that this would feature as part of the on-going work with the ICB Communications and Engagement Team where it has been articulated how programmes at each stage of the development and delivery cycle. There were three specific function areas (system-wide communications and engagement support, personalisation team and also health inequalities). All three would work closely together to produce a co-production framework but it was appreciated the NHS has some ground to make up compared to other sectors. Ms Day suggested the presentation slides were amended to ensure the innovative, co-production piece of work is clearly visible, which was noted by Mr Mack.

Ms Blyth added to Mr Mack's comments, advising that it was really important to note that whilst co-production is incredibly valuable, this is only one element of the whole involvement piece. There are a number of different touch points to bring the wider and broader patient and public voice into the process and there are frameworks within the service reviews which take place on a day to day basis which is really valuable.

Mr Fahy referred to the set of core principles and advised that he was very supportive of the way this was laid out, particularly in terms of the population segmentation approach, specifically the 25 for children and adults and expressed his appreciation to those individuals and teams who have carried out this work. It was also very good to see the engagement with senior clinical leaders from across the health and care system.

Mr Burnett expressed his personal appreciation to Mr Mack for his work on pulling this all together across the system and getting it to this stage. It was a really great piece of work. In terms of the Board, it was important to emphasise this is not a perfect process, particularly in light of the late publication in year of the NHS Planning Guidance. Preparations were taking place for the planning process to be carried out in quarter four for 2025/26 subject to the Planning Guidance being issued in October/November.

This would hopefully provide more time for the population health planning and engagement work to be undertaken and inform the continuous planning cycle approach.

Mr Turner thanked Mr Mack and colleagues across the Trusts and the system for developing a sophisticated and intelligent approach to planning. The quality of the material presented at today's meeting and planning documentation is superb in terms of being easy to read and consistent in terms of overall style. As ever, it is essential to listen and engage with the Lincolnshire population and patients, clinicians and partners properly and this approach featured significantly as part of the process as described by Mr Mack and linked directly into the ICB Target Operating Model (TOM) and population health planning work currently being progressed. As referred to by Mr Mack, LLG will have oversight of bringing the planning process to a conclusion. Dr McSorley and Mr Turner are both members of LLG and will ensure the Board is kept regularly updated. Indications from NHSE were that they were hoping to publish the Planning Guidance as early as possible but given the moving parts nationally it was possible this may not potentially be until early in the New Year.

The Board agreed to:

- **Approve the draft Annual Population Health Planning Cycle for 2024/25.**

SYSTEM OVERSIGHT AND ASSURANCE

24/258

INTEGRATED PERFORMANCE, QUALITY AND FINANCE REPORT

Performance Section

Mrs Raybould presented the performance section of the Integrated Performance, Quality and Finance Report and advised that she would take the report as read but wished to highlight some key points. As a point of note, the report contained the latest published data, and as per usual practice a verbal update on the current position would be provided where available.

As referred to by Mr Turner in his update, from an operational perspective August had been fairly challenging across a number of areas, but equally there had been some sustained improvement.

Key areas highlighted:

- From an Urgent and Emergency Care (UEC) perspective, the position was below planned trajectory for four hour performance, which was 78% delivery by the end of March. All Types 4-hour performance for Lincolnshire ICB for August 2024 was 73.7%. There are a range of recovery actions in place to improve performance with a number of ICB key providers, with some specific actions for ULHT.
- ULHT was one of 19 Trusts up and down the country who have been receiving support from the national team in terms of UEC and the first meeting had taken place, which went very well. NHSE colleagues will be coming in to provide some on-ground support at Lincoln County Hospital which will assist in taking forward the actions that are already happening but also move those forward moving into winter.
- The Category Two mean for the ICB had also continued to show improvement and as part of hitting this target each Trust in the ICB area has agreed a set of handover trajectories and both ULHT and North West Anglia NHS Foundation Trust (NWAFT) were currently below trajectory. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) was not.
- Cancer - there continued to be sustainable improvement, which was really positive. The backlog had increased slightly in August with 185 patients waiting over 62 days which was higher than July where the position finished with 172. This was for a number of reasons including patients being unable to attend for appointments due to being on their summer holidays, but also as a result of staff annual leave
- The faster diagnosis standard was achieved in July, overall performance was 78.7% against the 75% standard.

- Planned care - elimination of 65 weeks remained a priority and it was expected that all providers would have cleared those by the end of September 2024 with some small exceptions. In Lincolnshire there is a day by day effort to achieve this, and the plan was to achieve that bar a small number of specialities (two larger ones and the other relatively small) which have a number of challenges, two of which the same position is reflected nationally, not specific to Lincolnshire. Lincolnshire is receiving support from Leicestershire Hospitals Trust and some others to help us with that.
- The number of patients waiting more than 78 weeks across all providers was three at the end of August, all were either due to patient choice or complexity of the clinical pathway.
- Mental Health - the NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in July. 95.4% of patients received their first treatment appointment within six weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- Children and Young People with eating disorders continued to show improvement. The national standard had not yet been achieved, but there was definite improvement in that area.

In terms of winter planning, as mentioned earlier in the meeting, a system wide planning event across health and care had taken place in August. A regional planning summit had also taken place, again with health and care colleagues. At that event, more information was provided in line with that referred to by Professor Ward in relation to expectations prevalence wise. This was being built in the planning refresh work currently being undertaken for winter. As per last year, there will be a regional assurance visit which was currently scheduled to take place in October.

GP collective action was mentioned in the report and as described by Ms Mills the last time the Board met this is a complex picture in that it is not as straight forward as previous industrial action undertaken. There are a range of actions that could be undertaken by a single GP or multiple GPs and practices. There is a system wide structure in place to oversee that and track any impact directly or indirectly and consider ways to mitigate, which is being managed using EPRR principles. There is not currently any huge impact evidence based but there are mechanisms in place to gather some of that information and there are indications of some linked impact.

The Board considered this section of the report and supporting verbal update. Ms Day referred to referred to the spark lines within the report and sought clarification on whether they were seven points of data/what period did they represent (how long was the trend in the report). Mrs Raybould advised that she would check this out and respond to Ms Day outside of the meeting.

Action: Mrs Raybould

Councillor Woolley sought clarification on where the information on the numbers of DNA appointments at practices is reported. Ms Mills advised that this information is routinely included in the Primary Care report which is regularly considered through the Primary Care Commissioning and Delegated Functions Committee, and also through the Primary Care Report presented to the Board.

Quality Section

Mr Fahy presented the quality section of report and advised that like Mrs Raybould he would take the report as being read but wished to highlight the following;

Insight and signals Quality and patient experience

- Care and Comfort in Emergency Departments - ULHT is currently implementing a quality improvement project called 'Care and Comfort' which is working to improve the

overall quality and safety of patient care and experience within the Emergency Departments and Urgent Care Centres.

- Discharge - A review and improvement project is also underway to provide assurance that the services provided from the discharge lounges at Lincoln County Hospital (LCH) and Pilgrim Hospital, Boston (PHB) are appropriate. This followed a small number of extended lengths of stay for some patients with complex needs and pathways. The work is ensuring the right overnight provision and care pathway enhancements.
- Lincolnshire Partnership NHS Foundation Trust (LPFT) are leading the system partnership work to ensure the recommendations of the CQC Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust (published March 2024) are considered for Lincolnshire Mental Health Services, with improvement actions facilitated where necessary in response. A separate report was included in the pack of papers which provided a greater level of detail and would be covered by Mrs Connery.

Primary care

- Primary care - GP Collective Action - GP members of the British Medical Association (BMA) voted in favour of 'collective action' which commenced 1st August 2024 and has no end date currently. ICS governance arrangements have been established, which include medical and nursing representation, system meetings are in place to monitor impact of this and respond accordingly. From a patient safety and quality perspective to date there have been no major issues identified.
- Concerns from the practices: headline summary, low level quality issues with Sutterton, Glebe Park and The Deepings which are being managed by the Primary Care & Nursing and Quality Team. All of those practices were making good progress with their recovery plans and had all recently been subjected to visits from the CQC and there was nothing to escalate at this stage. There was nothing to report by exception from a quality perspective from Pharmacy, Optometry and Dentistry (PODs).
- Serious incidents and Never Events - There were 2 Never Events reported by ULHT, these related to an incorrect site nerve block and a retained swab. Both Never Events are being investigated through the Patient Safety Incident Investigation process. There have also been two Never Events reported this year by NWAFT, one reported in May 2024, which was a wrong side block, and the Never Event reported in July 2024 was a retained temperature probe from a Le Fort osteotomy in April 2024 that did not cause any symptoms and was discovered through a routine follow up. It was removed by endoscopy.

Quality and Patient Experience Thematic Update – Maternity and Neonates

- Overall, the Maternity and Neonatal Services are on track with delivery of the National requirements. The Three Year delivery plan is showing progress in all four themes and improvements (Listening to and working with women and families, with compassion. Growing, retaining, and supporting our workforce, Developing and sustaining a culture of safety, learning, and support and Standards and structures that underpin safer, more personalised, and more equitable care).
- Saving Babies Lives (SBL) now in version 3, awaiting the next publication of SBLV3.2. Compliance has been consistent in previous quarters.
- Clinical Negligence Scheme for Trusts (CNST) Year Five completed compliance on all 10 Safety Actions. Work is underway now for CNST Year Six submission in early 2025
- Midlands Heatmap Data which enables monthly oversight of triangulated data and is for the direct purpose of consolidating and sharing information within the regional footprint to identify and support improvements in the safety and quality of maternity and neonatal care has been progressive. ULHT have gone from Amber to Green within six months, which is really positive. The August 2024 heatmap highlighted Lincolnshire is the best performing within region. Congratulations to everyone involved.

- The appointment of a Digital Matron which provides the ICB with access to Maternity Incentive Schemes (MIS) and provides opportunities to bring about some additional improvement. There is commitment within the system for this to start to be implemented over the next few months.
- The Equity and Equality Strategy has been completed and shared with the Local Maternity and Neonatal Service (LMNS) members for comments with the final report due to be published within the coming weeks.

Mr Fahy advised that the vaccination programmes update had been covered earlier in the meeting, but to respond to Ms Day's question about whether there were any programmes in place to target pockets of poor take up in areas of low socio-economic deprivation, there is an understanding about how the ICB reaches out to communities to speak to them and understand what their needs are. An example being the work being undertaken with the family hubs. There is also the rapid response vaccination team in place which sits with colleagues in the Group. They are available to mobilise additional offers, whether that is pop up clinics by way of an example. Provision has been made so this can happen if need be but is currently not considered necessary as there is a considerable offer already in place with the bulk of vaccines delivered by primary care colleagues across all 81 practices, who by way of note should be thanked on record for their support. There is also a robust communications offer in place by way of how information is disseminated to the public.

Mr Sutton advised that the intelligence which comes out of their immunisations work is shared with the Vaccination Team and Public Health with meetings taking place every six weeks.

Finance Section

Mrs Rhodes presented the finance section of the report which covered the year to date position for month five. As per the other sections of the report, Mrs Rhodes would take the content as read and only highlight key areas with the detail discussed by the ICB Finance and Resource Committee which had met the previous week. The following points were highlighted:

- Year To Date Financial Position: The ICS' plan was to deliver a £15.2m deficit at month 5 and the ICS reported a deficit of £18.8m equating to a £3.6m adverse variance to the plan (£2.1m adverse variance to plan at month 4). The ICB has reported a year-to-date deficit of £2.1m. Against a planned deficit of £3.7m at month 5 this equates to a £1.6m favorable variance to plan (£2.5m favorable variance to plan at month 4).
- Outturn Financial Position: The ICS' plan is to deliver a break-even position against in year allocations and income for the full financial year. The outturn position at month 5 is to achieve this plan. The ICB expects to deliver a £4.7m surplus for the full year. This is in line with the agreed plan.
- Risk Position: The ICS overall plan reflected a level of net risk of £21.1m. A net risk of £11.1m has been reported at month 5, an improvement of £10.0m from month 4. Of the £21.1m net risks reported at month 4, £16.0m related to system investments and cost pressures identified in the plan. At the time of reporting £10.0m mitigations have been confirmed. Mitigations for the remaining £6.0m continue to be sought through the system wide 'four corners' rapid bridging the gap exercise.
- Mental Health Investment Standard (MHIS): The ICB remained on track to achieve this target at year end. This included the additional £2.8m related to the prior year under delivery.
- Cost Improvement Plan: At month 5 the ICS has reported £22.5m cost improvements against a plan of £20.9m equating to a £1.6m favourable variance to plan.
- The ICS has a full year Capital Departmental Expenditure Limit (CDEL) of £116.3m. The ICS is expecting to utilise £111.6m against this. This equates to a £4.6m underutilisation against CDEL. At the 31st of August the plan against this was £29.8m and the reported spend is £21.7m. This equates to a year-to-date under-spend of £8.1m.

The ICB Board considered the report and agreed to:

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

24/259

PROCESS FOR REVIEW OF CQC S48 (CALOCANE) REPORT

Mrs Connery presented a report which had been produced to provide the Board with assurance that there is a robust approach in place to review mental health services in Lincolnshire in the context of the Care Quality Commission's (CQC) section 48 review of Nottinghamshire Healthcare NHS Foundation Trust's care and treatment of Valdo Calocane.

The ICB and LPFT are taking the findings of this case extremely seriously and are jointly reviewing local services in line with a maturity index that has been issued by NHS England to support a local assessment of services in light of the learning and recommendations of the S48 review. This matrix will be completed and returned by the deadline of the 30th September 2024 having been subject to a number of governance processes and having been co-produced in terms of the submission between the ICB and LPFT.

It was worth noting that the matrix just formed one part of the review services in Lincolnshire. It is really important to ensure that any action taken in response to that is right for Lincolnshire and involves all system partners. The review is very much focused on what took place in Nottinghamshire Healthcare NHS Foundation Trust as a secondary mental health provider, but clearly other partners were involved in keeping people safe and supported in their communities.

The Board was advised Mr Calocane is classified as having a severe mental illness with a diagnosis of paranoid schizophrenia. The key point of note here was around poor engagement, particularly around medication and Did Not Attend (DNAs) as well with services and treatment and was sectioned under the Mental Health Act four times in two years.

The report contained information on the cohort of patients this review relates to, and it was important to note that homicide by people experiencing psychosis is rare.

Mrs Connery referred the Board to page two which detailed the number of short-term actions underway or planned to begin shortly in terms of reducing any potential risk and again, this was very much a system response between LPFT and the ICB, including working with Primary Care Alliance colleagues.

Page three of the report highlighted the governance process, along with details on specific timelines for action. A task and finish group has been established to develop and implement actions that will report into both the LPFT and ICB Quality Committees and to the LPFT and ICB Board as appropriate.

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

The intention is to bring a report to the ICB Board at its next formal public meeting in November setting out the Lincolnshire system response and any supporting recommendations.

On a final note, the health inequalities box in terms of the implications had not been completed in the report. For colleagues awareness, there is a document called the Patient Carer and Race Equality Framework which is very much about reducing inequalities through secondary mental health care and any response will take this account using that framework and methodology.

The Board considered the report and agreed to:

- **Note the report and the current position.**
- **Note that a further report would be presented to the Board in November.**

24/260

ICB BOARD ASSURANCE FRAMEWORK

Mr Turner advised that the Board was well aware that work has been underway for some time to revise the ICB Board Assurance Framework (BAF). The ICB Audit and Risk Committee has been regularly briefed on the progress on the development and establishment of the BAF, robust risk management arrangements and Risk Appetite.

The review process was now complete, and the revised document had been considered by the Audit and Risk Committee at the end of July who were very supportive of the revised format but agreed there were some gaps in the strategic risks which needed to be considered.

The Executive Team were asked to take the four strategic risks as identified in the BAF through the relevant Committees in August/September to ensure they were reviewed, and consideration was also given to the gaps. During August/September 2024 this has been actioned and the BAF has been presented to and reviewed by the Executive Team on two occasions, the Risk Management Group and the respective Board Committees. As a point of note, the BAF is a live document and is continuously reviewed and updated. The work to develop the gaps identified on areas such as digital and health inequalities would continue over the coming months.

On a final note, Mr Turner expressed his appreciation to Mrs Ellis-Fenwick and the governance team for their hard work and efforts in bringing the BAF to this point.

The Board considered the document and Ms Day asked whether the data/information was missing or incomplete at this stage in relation to health inequalities and supporting broader social and economic development. Mrs Williamson advised that the detail in relation to both risks had been drafted but needed to go through the internal governance review process and then considered by the Service Delivery and Performance Committee prior to inclusion in the next version.

Mrs Kenson and Mrs Pomeroy, both members of the Audit and Risk Committee, confirmed the document had been considered in detail over recent months and acknowledged the document is 'live' and subject to continuous review, and the individual risks have been through the relevant Board Committees for review, so the risk management arrangements were really starting to be embedded.

The Board agreed to:

- **Note the Board Assurance Framework.**

24/261

ICB RISK MANAGEMENT STRATEGY

Mr Turner advised that following on from the previous item the ICB governance team had been working to revamp the Risk Management Framework, Strategy and Policy following comments received by TIAA, the ICB internal auditors following completion of a review of the adequacy and effectiveness of the ICB's risk management arrangements in 2023/24

The revised document was presented to the Audit and Risk Committee for consideration at its meeting held on the 31st July 2024. The overall content was supported but with some amendments identified which have been actioned. The updated Risk Management Strategy was circulated to the Executive Team for comments in August and considered by the Risk Management Group at its meeting held on the 2nd September 2024. Some minor typographical amendments were noted and have been actioned.

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

As with the previous item, Mr Turner thanked Mrs Ellis-Fenwick and the governance team for their work and efforts on the development of the Risk Management Strategy.

The Board agreed to:

- **Approve the Risk Management Strategy.**

GOVERNANCE

24/262

AMENDMENTS TO ICB CONSTITUTION

Mrs Ellis-Fenwick advised that in July 2024 NHS England published updated governance guidance for ICBs to take account of wider legislative developments and issues that have arisen in implementation. As a result of the updated guidance, all ICBs are required to make amendments to their Constitutions.

The changes were highlighted for the Board's information.

- Ensuring one of the Non-Executive Board Members is identified as the Deputy Chair (cannot be the Audit Committee Chair).
- Ensuring one of the Non-Executive Board members is identified as the senior independent member.
- Expressing the Chair's period of office as a maximum, rather than a fixed term: to ensure drafting is compatible with the appointment where necessary of interim Chairs by NHS England with Secretary of State approval.
- Confirming that a proposal for the Chair or a Non-Executive to serve on the Board for longer than six years will be subject to rigorous review, and they will not serve as a Board member for longer than nine years in total: to ensure objectivity is maintained, aligned to the Code of Governance for providers.
- Updating references to procurement rules to take account of the introduction of the Provider Selection Regime.
- Removing clauses related to ICB establishment and updating cross-references to legislation.

Mrs Ellis-Fenwick advised that she had been through the changes and updated the ICB Constitution (as tracked throughout the document). The Board was asked to approve the proposed amendments to the ICB Constitution for submission to NHS England for formal sign-off.

The Board considered the document. Mr Turner advised that following ULHT being granted teaching hospital status, any reference in the Constitution to that organisation would also need amending to state United Lincolnshire Teaching Hospitals NHS Trust which was supported by the Board and noted by Mrs Ellis-Fenwick for action prior to submission of the Constitution to NHS England.

Action: Mrs Ellis-Fenwick

The Board agreed to:

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

24/263

ICB ANNUAL REPORT AND ACCOUNTS 2023/24

Dr McSorley presented the ICB Annual Report and Accounts 2023/24 and advised it was a very long and thorough document. Historically this document would have been presented as part of the Annual Public Meeting, but ICBs were not required to hold one this year; hence the document being presented in the Board meeting.

Dr McSorley asked whether the Board was happy to receive the document, which was a very impressive read. In terms of the actions and efforts of the ICB and its partners over the past year, the report contained and illuminated both some of the challenges and progress that has been achieved, and its great credit to colleagues throughout the health and care system for supporting the ICB in its work.

The Board was asked whether they had any comments. Ms Day advised that it was a great report and does the ICB credit but the one observation she would make for next year is in terms of the photographs in the document, which were not as diverse as she would want them to be. This was discussed and supported.

Mr Turner commented that the report is not just a reflection of the ICB, but also of the strength of the work being undertaken across the Lincolnshire integrated care system. There is a real sense of pride in the work system partners are doing together and this shines out of the report.

Mr Turner thanked Mrs Ellis-Fenwick for her leadership on the production of the Annual Report, recognising that it is a team effort involving colleagues from the Communications and Engagement Team and similarly to the finance team who work so hard on the accounts and audit process. It was really important for the Board to note its appreciation to everyone involved in producing such a quality document.

The Board agreed to:

- **Receive the Lincolnshire ICB Annual Report and Accounts, including the Annual Governance Statement and Remuneration Report for the year 1st April 2023 to 31st March 2024.**

24/264 COMMITTEE HIGHLIGHT REPORTS

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

- Service Delivery and Performance
- System Quality and Patient Experience
- Audit and Risk Committee

Mrs Kenson advised that the Service Delivery and Performance Committee had considered a number of items over the last few months for assurance purposes and filtered through before being presented to the Board.

The Board agreed to:

- **Note the reports.**

24/265 ANY RISKS IDENTIFIED

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

24/266 DATE AND TIME OF THE NEXT MEETING

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

Chair Signature

Date

Questions from the Board meeting held on 24th September 2024

Question One

Dear Lincolnshire ICB, I hope you would agree with me that prevention is better than cure? – Statement below sourced from the NHS. With this in mind, I would ask that your organisation supports our project to re-open Deeping Leisure Centre which has been closed since July 2021. A letter of support for the project would be helpful but if you had access to any funding sources or could point us towards any that would be incredibly helpful too.

We are happy to supply much more detail if required (we have a comprehensive business case document).

Exercise is the miracle cure we've always had, but for too long we've neglected to take our recommended dose. Our health is now suffering as a consequence.

This is no snake oil. Whatever your age, there's strong scientific evidence that being physically active can help you lead a healthier and happier life.

People who exercise regularly have a lower risk of developing many long-term (chronic) conditions, such as heart disease, type 2 diabetes, stroke, and some cancers.

Research shows that physical activity can also boost self-esteem, mood, sleep quality and energy, as well as reducing your risk of stress, clinical depression, dementia and Alzheimer's disease.

Looking after your physical health is key to supporting your overall health and wellbeing, including your mental health. One of the best things we can do for our mental health and wellbeing is to be active – it's a natural mood booster. Our bodies release feel-good hormones when we're active that can also reduce anxiety and stress and help us sleep better.

Response:

The ICB, along with Professor Derek Ward, Consultant in Public Health and his team are working very closely with colleagues in Active Lincolnshire, who under the aegis of the Integrated Care Partnership and Health and Wellbeing Board, are the system leaders in relation to physical activity. Some areas of Lincolnshire suffer from the lowest levels of physical activity in the whole country and across the county there is some significant work underway that Active Lincolnshire lead on and which has the ICB's full support. The ICB and Active Lincolnshire also have wider ambitions about doing much more outside of that current piece of work, including what is referred to as 'active thinking' and working with Sports England to try to attract more resource.

The ICB is completely supportive of all activities and approaches to increasing physical activity across the county and is happy to reiterate its support for that piece of work.

It is not the role of the NHS to directly fund individual leisure centres or similar services across the county, but the ICB was very supportive in terms of all leisure centres growing and developing and the ICB Board wanted to take this opportunity to wish the Deepings Community Leisure Centre the very best in its work and endeavours to reopen the service there.

Question Two

The PPG for Caythorpe and Ancaster Medical Practice are aware of anger and anxiety expressed by many patients, due to the announcement on the 11th September, that the 'Treatment Room Service' provided by the Practice will cease.

We would like to know what plans the ICB have for replacing this vital service, in our rural practice, when the current contract ends on Wednesday, 2nd October 2024. Who will provide the service to patients needing wound treatment following hospital treatment? Will the service from 2nd October cost more to fund than if it stays with GP surgeries in the district continuing to provide the service? If there is an anticipated cost increase, what would that be?

As a group we expect an answer to these questions by the 2nd October 2024.

We are holding an Open Meeting on Thursday, 3rd October at 6pm, for all patients who have expressed concerns. It would be very useful to have information to share with patients at the meeting.

Response:

Thank you very much for your recent enquiry to the Integrated Care Board meeting on 24th September in relation to the withdrawal of treatment room and wound care services at Caythorpe and Ancaster Medical Practice.

I completely understand that the decision made by the practice will be of concern for local patients, and I am sorry for any anxiety that this has caused.

By way of background, please allow me to make the following points:

i) The ICB has very high regard for the Caythorpe and Ancaster Medical Practice and the team of clinicians and staff there who we know work exceptionally hard to meet the needs of, and provide high quality care to, their patients. The practice is currently rated Outstanding by CQC. The ICB works closely with them and will continue to do all we can to support the practice.

ii) As has been widely covered in the national media, there has been a significant increase in patient demand for GP services since the pandemic. This is equally the case here in Lincolnshire as it is across the whole of England. All our GP practices have worked very hard to respond to the increased demand for their services. Alongside this, in recent years local GP practices in Lincolnshire have been signalling to the ICB significant concerns about growing financial pressures they are facing.

iii) The 81 GP practices in Lincolnshire each have a nationally determined contract (the national 'General Medical Services' (GMS) contract) for the vast majority of the services that they provide and the income that they receive. There are, however, a range of services, including Treatment Room wound management services, which are commissioned locally by the ICB, and have been for a long period of time. GP practices such as Caythorpe and Ancaster have raised their concerns about the price of these locally agreed 'enhanced' services over recent years. Unfortunately, the financial pressures that the NHS has been and continues to operate under means that the ICB has been constrained in our ability to respond.

More recently at a national level, following a vote which was undertaken in the early summer months, the General Practitioner Committee (GPC) of the British Medical Association, entered into dispute with the Government about financial and other matters, and is undertaking 'GP Collective Action'. As a result the GPC has provided advice to all GP practices in relation to options that each practice may choose to take as part of GP Collective Action. Withdrawing from locally enhanced services such as Treatment Room services, is one of the options. GP practices are quite within their contractual rights to provide notice to the ICB for these local services and consequently withdraw from providing them. The ongoing financial constraints that the NHS is operating under means that the ICB remains constrained in our ability to respond to our practices on this matter.

I hope that this information is helpful to you in understanding how the current situation has arisen.

In terms of ensuring that local patients who require wound care services (which are provided by nurses) are still able to access the care that they need, the ICB has arranged for this service to be provided from Grantham Health Clinic by Lincolnshire Community Health Services NHS Trust, with effect from 2nd October 2024. The ICB recognises that this will not be as convenient a location for patients as the local GP practice and we are sorry for this. It will, of course, be important for patients who require wound care to attend to have their care needs met. The ICB will carefully monitor how this new arrangement beds in and keep matters under close review.

In light of the decisions which local GP practices are making in relation to wound management and other services, the ICB is actively considering further steps it may need to take to ensure continued high quality care provision for patients into the future. As this work progresses, we will do all we can to ensure that the public, their representatives and Practice Participation Groups are engaged with any potential further changes.

Not Delivered
In Progress
On Track to Deliver
Complete

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 26 th November 2024
Agenda Item:	1 (iv)
Reporting Officer:	Dr Gerry McSorley, Acting ICB Chair

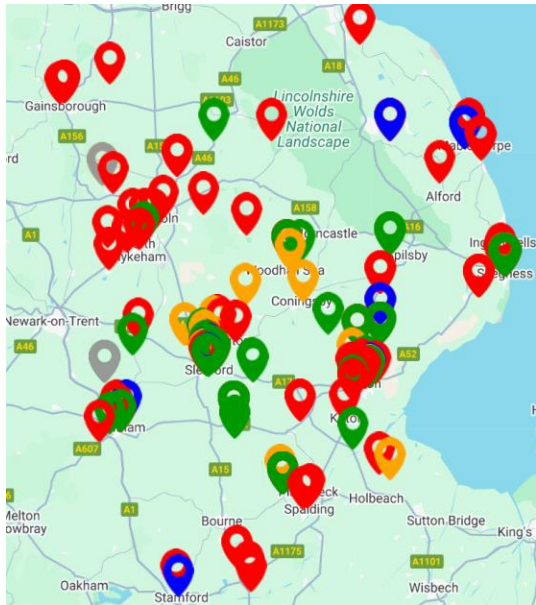
Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
24/09/24	24/255	Chief Executive Update	To respond to the questions submitted from two individual members of the public.	Mr Turner and Mrs Mills	August 2024	Both individuals have received full and detailed responses to the questions submitted.	Complete.
24/09/24	24/258	Integrated Performance, Quality and Finance Report	To check whether the spark lines in the report reflect seven points of data or what period do they represent/how long a trend.	Mrs Raybould	October 2024	Information provided.	Complete.

A woman with dark hair in a bun, wearing glasses and a black jacket with a white fur collar, is talking to a man with glasses wearing a pink shirt and a grey jacket. They are in a bright, modern building with large glass windows. A green and blue curved graphic is on the left side of the image.

ICB Board November 2024 Healthwatch Updates

healthwatch
Lincolnshire

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



September and October 2024

During September and October **228** people shared their experiences of health and social care with us. An additional **67** people have shared their experiences through our Mental Health Survey focusing on new fathers, military families, veterans and those working in farming and agriculture so far.

Out of the 228 experiences shared to our Information Signposting Team, **42% were negative** and **27% were positive**. The remaining were neutral, mixed or unclear.

The service areas commented* on the most during this time were:

- GP Services (46%)
- All Hospital Services (38%) - (7% of all comments were about A&E)
- Mental Health (11%)
- Social Care (10%)
- Dentistry (8%)

*Some comments relate to multiple service areas.

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

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

Mental health support for prisoners

- A case explored showed a prisoner frequently incarcerated for short sentences, reported ongoing struggles with depression and anxiety and feels that prison mental health services are inaccessible due to the shortness of their sentences.
- Despite a long history of mental health issues and hospitalisations, they feel overlooked by support systems, which only responded after they advocated for themselves.

Case Study

“On one of my many sentences here at HMP Lincoln Prison I really, really, did need help with my mental health. I could have done with a bit of support, a chat, you know to sit down with someone to have a talk with someone whom would listen, and give some advice about my problems. Only the mental health team would not see me. They reckoned I didn't have enough time left remaining on my sentence for them to offer help.”

I've got a long history of mental health issues and have been in psychiatric hospitals, 6 or 7 times. But I have not been admitted to a psychiatric hospital for a long time. I am always in and out of prison and if you were to ask me to list how many times, I would say over 30. I am only ever in prison for short periods of time. It seems that I never get the help I need, the mental health team and other services don't seem to offer the help I need. These services say that they don't have the proper amount of time to help me..”

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

Non-Emergency Patient Transport (NEPT)

- Elderly individual with severe mobility issues relies on NEPT for ambulance transfers to Grimsby Hospital but faced repeated failures, including three urgent appointment cancellations
- Healthwatch escalated the issue to EMAS and LICB after multiple transport failures.

Case Study

“My elderly relative lives in Fotherby near Louth. They have severe mobility problems such that they need ambulance transfer when attending important appointments at Grimsby Hospital. Spouse is unable to do the transfer themselves. They have had several occasions of a very poor service from the EMAS patient transfer service, exacerbated by the stress that the system provides of only being able to book an ambulance transfer to appointments. Their most recent difficulty regarded an urgent appointment -which took close on 3 weeks to be arranged by the hospital following the GP’s urgent referral. This appointment, on 10 Sept, needed to be cancelled around an hour before its time because EMAS couldn’t fulfil the appointment. The appointment was again cancelled last week, again within an hour of the due time [cancellation by the hospital]. The appointment has been rearranged for next week, 24 October. Remember, this is an urgent appointment from mid-August.”

Patient response - “Contacted by carer on Monday “IT HAS HAPPENED!!! Ambulance was on time to take spouse to hospital for a planned surgical treatment on Saturday morning last, and we were brought home on time, too. Thank you.”

Menstrual Health Survey

The Healthwatch Lincolnshire Menstrual and Menopausal Health Survey conducted in September 2024 gathered insights from 450 respondents about their experiences.

Findings presented at the system QPEC; report very well received – plans to escalate it to ensure findings are acted upon – keen to ensure this is embedded through Women's Health Hub steering group

Copy sent to all Primary Care Quality Assurance Group (PCQAG) members.

A copy of the report was on every table at the ICB's Women's Health Conference, quotes included in LCC presentation given on the day

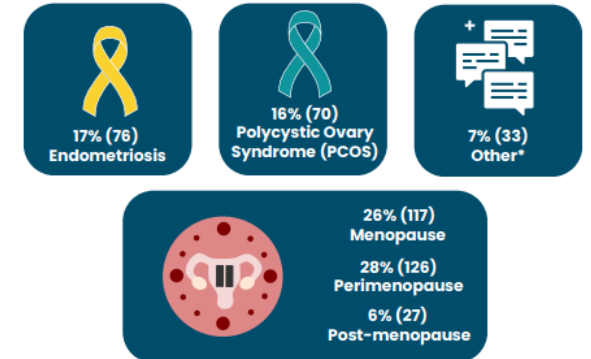
Feedback received on the day : “It should be essential reading”



Findings - Who shared their views?



The following relates to service users:



- 37% (167) work in health and/or social care
- 13% (59) considered themselves neurodiverse
- 10% (46) were carers
- 3% (14) belonged to the LGBTQ+ community
- 3% (12) were serving members of the armed forces or veterans
- 2% (11) work in farming or agriculture

*Other conditions included Premenstrual Dysphoric Disorder (PMDD), fibroids, adenomyosis and other conditions. A full breakdown of who shared their views can be seen in the demographics section of this report.

Neurological Health Survey

From July – September we focused on neurological health.

375 people shared their views on conditions such as: multiple sclerosis, Parkinson's disease, epilepsy, fibromyalgia, functional neurological disorder and chronic fatigue syndrome (CFS).

Some key headlines included:

- **Lengthy diagnostic process** for conditions like fibromyalgia and chronic fatigue syndrome (CFS), leading to prolonged periods of unmanaged symptoms that significantly impacted daily life, schooling, and ability to work
- Perceived **lack of knowledge about neurological conditions** among healthcare professionals, particularly in primary care
- **Limited availability specialist support in Lincolnshire**
- **Inconsistent signposting to services and support**

We will be holding a webinar 9th December to present the findings, if you would like to attend please contact info@healthwatchlincolnshire.co.uk

NEUROLOGICAL HEALTH

Healthwatch Lincolnshire wanted to understand individuals' experiences of health and care services that support people in Lincolnshire navigating a neurological conditions including multiple sclerosis (MS), epilepsy, fibromyalgia and chronic fatigue syndrome (CFS).

WE HEARD FROM
375
people

CONDITIONS
Respondents experiences related to the following conditions:
MS
ME/CFS
Fibromyalgia
Epilepsy
Brain Injury
Migraines
Functional Neurological Disorder (FND) and more...

DIAGNOSIS

1. Patients not being listened to - symptoms being dismissed
2. A lack of understanding of conditions both in terms of knowledge and empathy
3. Patients would present to their GP practice multiple times over months and years
4. Not getting a timely diagnosis resulted in some having to give up their jobs

As a result of these issues, some sought a private diagnosis

MEDICATION
71%
had struggled to get medication that worked for them.
This included issues with side effects, dosages and supply.

NEUROLOGICAL HEALTH

TREATMENT AND MANAGEMENT
Symptoms were mainly managed via medication. Signposting to support and referrals to other services appeared to be inconsistent. Service users also appeared to be unaware of what support is available and what could be beneficial. There was also a call for more holistic support recognising that everyone is different.

WHAT WORKS WELL?
While generally those who accessed specialist care, including MS nurses and consultants, praised its quality, not everyone was able to access such care.

WHAT COULD BE IMPROVED?

1. Listen to patients and show understanding
2. Increase healthcare professionals' knowledge of neurological conditions
3. Establish local specialist neurological centres, hubs, or clinics
4. Improve access to pain clinics and better pain management strategies
5. Provide clear information for patients on diagnosis, prognosis, and management
6. Offer holistic support, recognising that individuals are affected in different ways
7. Reduce waiting times for specialist support and offer interim support while patients wait

THANK YOU Thank you to everyone who shared their experiences.

Mental Health Survey

We have so far heard from **75 people**.

We are particularly keen to hear from:

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

We also want to hear from professionals who provide mental health support to these individuals.

This survey closes at the end of December.



The poster features the Healthwatch Lincolnshire logo at the top right. The main text reads 'Have Your Say on MENTAL HEALTH' in large, bold letters. Below this, it says 'Share your experiences...' and 'We want to hear from:' followed by a list: 'New fathers, farmers and military personnel'. The background includes an illustration of a person standing on a ladder inside a large blue head silhouette, with a target symbol and a heartbeat line.

healthwatch
Lincolnshire

Have Your Say on
**MENTAL
HEALTH**

Share your experiences...

We want to hear from:

- New fathers,
- farmers
- and military personnel



Patient Survey



Professional Survey

Targeted Projects

Pelvic Health

Running an online survey and conducting interviews to find out about the pelvic health experiences of people who are pregnant or have been pregnant in the past two years. Ends March 2025.

This is to support the ICB who is working to improve the pelvic health care that people receive during and after pregnancy.



Infant Feeding

Ended with 850 responses to the survey, have carried out 12 in-person interviews and supported a focus group.

Intelligence used to develop the communication materials, the report is going to LMNS in December.

Childhood Immunisations

End of November final engagement activity to take place – focus group.

Findings to be shared in December.

For more information

Healthwatch Lincolnshire
Rooms 33-35
The Len Medlock Centre
St George's Road
Boston
PE21 8YB

www.healthwatchlincolnshire.co.uk

t: 01205 820 892

e: info@healthwatchlincolnshire.co.uk

 @HealthwatchLinc

 [Facebook.com/HealthwatchLincolnshire](https://www.facebook.com/HealthwatchLincolnshire)

healthwatch
Lincolnshire

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	4 (i)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Frailty Strategy Update
Report Author:	Lisa Foyster, Head of Strategic Development – Ageing Well & LTCs Sarah Button, Head of PCN Transformation
Presenter:	Lisa Foyster, Head of Strategic Development – Ageing Well & LTCs Sarah Button, Head of PCN Transformation
Appendices:	Frailty Strategy Update

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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.

<p>Recommendations</p> <p>The ICB Board is asked to note and consider the information provided in this Older People’s Strategy Update which reports on the progress of the delivery of the strategy, how learning is captured which impacts future implementation of this, and other pathways. The update also provides specific considerations for the ICB Board and next steps.</p>
<p>Summary</p> <p>The Lincolnshire Older People’s Strategy has been co-produced with colleagues from across the health and care system, as well as patient and public representatives. It is based upon clinical evidence and best practice from elsewhere. Its key focus is prevention, proactive identification and management of Frailty, with a view to improving patient outcomes and experience, reducing overall deterioration, improving coordination of care and reducing unnecessary hospital admissions.</p> <p>In Lincolnshire, 182,654 people are over the age of 65, 102,284 people (56%) meet the Electronic Frailty Index (eFI) criteria for mild, moderate or severe frailty (August 2024).</p> <p>“Frailty is a condition in which the body’s physical and mental systems gradually decline and lose their in-built reserves and ability to respond to stressors. The condition makes people more vulnerable to functional change following illness and results in slower recovery from illness or injury. It becomes more common in older adults, but significant work has been undertaken to understand the health inequalities apparent where frailty occurs earlier in life. Frailty is a spectrum condition, which can progress from mild to moderate and severe.</p>

A minor illness such as flu, or a fall, can become a crisis for a person living with frailty.” (GIRFT, 2021)

The Older People’s Strategy focuses delivery on 5 key pillars:

- Pro- active Care
- Primary Care
- Single Point of Access
- Integrated Service
- Integrated Workforce

The progress against the delivery of the plans for each of the pillars is in the attached report.

How does this paper support the ICB’s core aims to:

Aim 1: Improve outcomes in population health and healthcare.	The frailty strategy’s aim is to reduce the risk of onset and progression of frailty.
Aim 2: Tackle inequalities in outcomes, experience and access.	Addressing Health Inequalities is a key component of the strategy and some of the projects within the plan are solely focused on health inequalities. One of the objectives of the strategy is to ensure that patients have equality of access to care and the same outcomes, regardless of where they live in Lincolnshire.
Aim 3: Enhance productivity and value for money.	Within the delivery plans there is an emphasis on how we make best use of resources that are available to us, whether that be voluntary or statutory sector services. This includes ensuring staff have the right skills and development for their role, and patients are able to access the person most appropriate to help them with their needs.
Aim 4: Help the NHS support broader social and economic development.	By addressing Older Peoples health and care needs from the point of general wellbeing to severe frailty, we are aiming to support broader social and economic development. An example of this is through increased social and community support (non-health related).

Conflicts of Interest

No conflict identified

Summary of conflicts

Not applicable

Risk and Assurance

Risks are managed by the Frailty programme and escalated to the Frailty Executive Leadership Group as required.

Implications (legal, policy and regulatory requirements)

Does the report highlight any resource and financial implications?

Yes, referenced in the presentation update.

Does the report highlight any quality and patient safety implications?

No, however there is a risk log for the programme which is reported to the Frailty Executive Leadership Group.

Does the report highlight any health inequalities implications?	Yes. One of the ambitions of the strategy is to work together strategically to integrate our different services for older people to provide a single joined-up pathway of care that will proactively reduce health inequalities, promote healthy aging and keeping well. We will address health inequalities by developing a targeted approach to service delivery, with a view to delivering equitable access, experience and quality care for all older people with frailty.		
Does the report demonstrate patient and public involvement?	Yes, the Frailty strategy was co-designed with patient and public involvement and the presentation update references initiatives co-designed by patient and public and patient involvement.		
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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Report previously presented at:			
An update of the Frailty Strategy was presented to the ICB exec meeting on the 26 th September 2024.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

Lincolnshire Older People's Strategy



What is Frailty?

“Frailty is a condition in which the body’s physical and mental systems gradually decline and lose their in-built reserves and ability to respond to stressors. The condition makes people more vulnerable to functional change following illness and results in slower recovery from illness or injury. It becomes more common in older adults, but significant work has been undertaken to understand the health inequalities apparent where frailty occurs earlier in life. Frailty is a spectrum condition, which can progress from mild to moderate and severe. A minor illness such as flu, or a fall, can become a crisis for a person living with frailty.” (GIRFT, 2021)



The Case for Change

	Fit	Mild	Moderate	Severe	Total All
Over 65s with Frailty	80,370	59,607	27,498	15,179	182,654
Average Age	73	76	80	83	76
Average Number of Long Term Conditions	1.19	2.8	4.2	6.0	2.55
Finance PPPY - Total	£ 1,335	£ 3,233	£ 6,472	£ 13,706	£ 3,670
Total Contacts with Health & Care Systems Per Person Per Year (PPPP)	68.8	129.5	188.3	271.8	123.5
GP Appointments	33.91	51.31	64.34	80.32	48.03
GP Prescriptions	32.29	71.56	110.09	158.85	67.33
Outpatient Attendances	1.56	3.13	4.18	4.69	2.73
Elective Admissions	0.21	0.42	0.53	0.52	0.35
A&E Attendances	0.22	0.48	0.81	1.41	0.49
Emergency Admissions	0.04	0.14	0.32	0.74	0.17
Community Contacts	0.45	1.96	6.56	21.24	3.59
Mental Health Contacts	0.08	0.26	0.60	1.15	0.31
IAPTContacts	0.02	0.04	0.04	0.04	0.03
Social Care	0.05	0.24	0.83	2.77	0.45

Strategy and Delivery model - 5 pillars

- Created a Frailty Expert Reference Group (ERG) to oversee development of the strategy.
- Worked with the Care & Clinical Directorate, the Lincolnshire Academy for Clinical Excellence (LACE) and the ICB population health management (PHM) team to provide in depth analysis and research and a shared understanding of the case for change.
- Undertook a series of workshops between January and April 2023 with involvement from partners from across the system including public and patient representatives, to co-create the delivery model and principles contained within the strategy.
- The design principles consistent with the recommendation in the Fuller, ICB TOM “6 steps” and the key priorities for the NHS as outlined by the Secretary of State for Health.
- Governance mechanisms develop and in place to support delivery of the strategy.
- Delivery model focuses on 5 pillars

Proactive Care - Health Promotion, Self Care and Ageing Well

Prevention (Healthy Ageing), Personalised Care, Advice and Guidance

Primary Care

Anticipatory/Pro-active Care Framework.

Case finding using the Electronic Frailty Score (eFI) and the Clinical Frailty Score (CFS).

Care coordination and management.

Comprehensive Geriatric Assessments (CGA).

Holistic Assessment.

Personalised care and Support.

Pro-active Medicines Management.

Single Point of Access

Navigation and signposting.

Digital information sharing.

Senior clinical decision making.

Integrated Services

Bringing pathways together

Reduce duplication

Pro-active step-up care rather than crisis management

Community hubs of care closer to peoples' homes

Timely and proactive communication with primary and community care teams at discharge to support transition home

Integrated Workforce

A team of teams, with reduced duplication, shared purpose and an upskilled, specialist workforce



Proactive Care

- Universal for all older people, accessed at hubs in person, telephone or digitally.
- Healthy lifestyle e.g. keeping active, healthy diet, smoking cessation.
- Social support e.g. connecting with community activities, befriending, bereavement services, signposting.
- Accessing prevention opportunities e.g. vaccinations, screening, falls prevention.
- Accessing health checks and LTC check ups
- Addressing wider determinants e.g. housing, fuel poverty.
- Carer support.

Progress:

- Agreed the delivery model – directing older people to existing ‘signposting’ resources already commissioned across Lincolnshire, both face to face and via websites (Well – being Hubs, Connect to support , Active Lincolnshire and HAY Lincolnshire)
- Leaflets and film designed, based upon co-production work undertaken with older people, supported by ICB Engagement team. These form part of a broad internal and external communication campaign and ‘call to action’.
- Learning collated from ‘pop up events’ delivered by PCN early adopters, with a view to developing a consistent cross-organisation approach to promoting ageing well. Enhanced by sign posting to relevant resources and community assets, aimed at reducing duplication of effort. Resource developed to facilitate easier delivery of events
- Ageing Well Campaign launch
- Health intelligence updates for Well- being hubs, have been designed and consulted upon

The image features a low-angle shot of a dense forest of trees with autumn foliage in shades of yellow, orange, and green against a clear blue sky. A large, semi-transparent blue rectangular box is centered horizontally and vertically, containing the letters "NIHS" in a bold, white, sans-serif font. The letters are slightly italicized and have a consistent thickness throughout.

NIHS



Primary Care

- Identification and risk stratification using electronic Frailty Index (eFI)
- Validation and coding of frailty using Clinical Frailty Scale (Rockwood)
- Care Co-ordination
- Education and support to self manage
- Lifestyle advice and support (diet, exercise, alcohol, smoking)
- Connecting with community/interests
- Mental health assessment and support
- Carer identification and support
- Personalised care and support planning – what matters to me, strengths based
- MDT working and support
- Comprehensive Geriatric Assessment
- Rehabilitation
- End of life recognition
- End of life planning

Progress:

- 5 Early adopter PCNs are engaged in delivery the frailty strategy.
- All PCNs took part in co-designing the 14 interventions, with the support of a Clinical Reference Group, to be delivered in primary care with Early adopters selecting priority areas for focus, delivery and evaluation.
- Personalisation, Population Health Management and Health Inequalities are all embedded into the PCN approaches for improving outcomes for older people.
- PCNs have received training on co-production and are now co-producing local pathways with older people.
- PCNs are delivering ‘pop up’ events to engage with communities around how to ‘age well’. Populations traditionally harder to reach have been prioritised. A toolkit has been developed to help all PCNs in organising proactive care local events.
- PCNs have contributed to the development of a system-wide model for Comprehensive Geriatric Assessment (CGA) and the associated template and are establishing their own local multidisciplinary pathways to deliver and monitor the impact of these.
- PCNs are delivering interventions by utilising existing resources differently and working in collaboration with partners
- Population Health Management (PHM) linked data sets have enabled PCNs to identify mild, moderate and severely frail people and to prioritise patient cohorts for proactive assessment
- Dashboard co-designed, with a view to evidencing impact over time, supporting continuous improvement/learning and ensuring data-informed design making. This is a key element of the monthly reporting into the frailty governance infra-structure.



Primary Care Highlights

- The Elms at Torksey.
- Clinical review of risk stratified patients.
- British Geriatric Society Training and Comprehensive Geriatrics Assessment.
- Comprehensive Geriatrics Assessment template now published and in use on SystemOne.
- Use of PHM data to identify cohorts of patients for Comprehensive Geriatrics Assessment.
- EHCH – Enhanced Health in Care Home MDT working and developments in telehealth.



Integrated Care and Single Point of Access (SPA)

- Available 24/7 for all providers and clinicians.
- Prevents the need for multiple calls.
- Flexible and solution focused – ‘ we will take it from here’.
- Has access to patient record to support sharing of information and safe decision making.
- Facilitates clinician to clinician conversations and provision of advice and guidance.

Progress:

Frailty phone in place, as precursor to full SPA, managed by the Frailty team to support professionals to navigate patients to SDEC, virtual ward, etc. Call navigation pilot in CAS began in September 2024.

Frailty SDECs are operational at both Lincoln County and Pilgrim Hospitals, 5 days a week

20 virtual ward beds operational, supported by daily MDT, on weekdays.

10 new ACP trainees

ACP workforce model agreed to support across the Frailty pathway supported by a training package jointly developed with the University.

Workshop held with a broad variety of community and community hospital staff to explore the opportunities for developing the 5 Community hospital-based Frailty Hubs.

Highlights



Workforce

- Shared purpose and functions across teams to support more effective use of resources #Team Frailty.
- Shared vision and values.
- Flexible workforce deployment to support fluctuations in demand.
- Multidisciplinary workforce development programme underpinned by shared professional standards.
- Attractive career pathways to support recruitment, retention and sustainability.
- Shared pathways of care between primary, community and acute care underpinned by cross organisational training and digital information sharing.

Progress:

- **New systemwide electronic CGA template designed with partners from across all organisations including voluntary sector**
- **Nationally agreed, tiered training package adopted, post trialling and feedback from teams from across system**
- **CGA training developed based on feedback**
- **Supervision sessions developed and advertised – good uptake**
- **Lunch and learn sessions developed and adverted**
- Programme of team development across organisations initiated.
- T&F group launched by the system People team and KPMG to agree a co-ordinated and consistent approach for workforce planning across the frailty pathway in line with Lincolnshire planning requirements.

Highlights



How will we know we are making progress?

Frailty Programme

Outcomes: Rate Per Person Per Year (PPPY) last 12 months

Outcome	Line Chart
A&E Attendances	
Non Elective Admissions (NEL) - Emergency	
3 or More NEL admissions in 12 months	
NEL Total Length of Stay (LOS)	
Elective	
Elective Total Length of Stay (LOS)	
Out Patient Attendances (New and Follow up)	
GP Encounters	
GP Appointments	
Community	
Mental Health	

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Personalised Care and Support Plan agreed Mild: All	Aug 24	3.9%	-			3.9%	3.7%	4.1%
Review of Personalised Care and Support Plan Mild: All	Aug 24	2.5%	-			2.6%	2.5%	2.7%
PCSP Agreed or Reviewed Mild: All	Aug 24	6.5%	-			6.5%	6.3%	6.8%
Structured medication review Mild: All	Aug 24	40.5%	-			36.0%	33.7%	38.3%
MDT Mild: All	Aug 24	4.7%	-			4.2%	3.9%	4.4%
Social Prescribing Referrals Mild: All	Aug 24	4.5%	-			3.9%	3.7%	4.2%
Seen by Care coordinator Mild:All	Aug 24	9.3%	-			8.6%	8.2%	9.0%
Personalised Care and Support Plan agreed Moderate: All	Aug 24	8.2%	-			8.2%	7.8%	8.5%
Review of Personalised Care and Support Plan Moderate: All	Aug 24	5.6%	-			5.4%	5.1%	5.7%
PCSP Agreed or Reviewed Moderate: All	Aug 24	13.8%	-			13.6%	13.0%	14.1%
Structured medication review Moderate: All	Aug 24	45.9%	-			41.9%	39.9%	43.9%
MDT Moderate: All	Aug 24	8.9%	-			6.9%	6.1%	7.7%
Social Prescribing Referrals Moderate: All	Aug 24	6.3%	-			5.4%	5.0%	5.8%
Seen by Care coordinator Moderate: All	Aug 24	14.4%	-			13.1%	12.4%	13.7%
Personalised Care and Support Plan agreed Severe: All	Aug 24	18.5%	-			17.0%	15.9%	18.1%
Review of Personalised Care and Support Plan Severe: All	Aug 24	12.7%	-			11.3%	10.6%	12.0%
PCSP Agreed or Reviewed Severe: All	Aug 24	31.2%	-			28.3%	26.6%	29.9%
Structured medication review Severe: All	Aug 24	59.7%	-			56.9%	54.8%	59.0%
MDT Severe: All	Aug 24	14.5%	-			11.0%	9.5%	12.5%
Social Prescribing Referrals Severe: All	Aug 24	8.5%	-			7.5%	6.9%	8.1%
Seen by Care coordinator Severe: All	Aug 24	19.8%	-			18.3%	17.2%	19.3%



Lessons Learnt

- Lincolnshire has a huge wealth activities to keep older people mentally and physically well – however older people aren't always aware they are there or how to access them, or even if they are suitable for them.
- Working in partnership with partners and stakeholders we need to further foster, develop and build the capability and capacity of community-based assets with a view to reducing dependency on health-based interventions.
- There are further opportunities to target people from specific population groups, including those where there are known health inequalities, who have traditionally been less engaged, supporting them to proactively self-care and engage proactively with services.
- Language matters for clinicians, non-health providers and patients.
- Involve a wide range of people in the development of the training and the templates. We need to continue to invest time in training and supervision.
- Developing solution which support data sharing across the system remains complex.
- Effective teams and relationships require time to be nurtured and developed.
- PCN and General Practices are foundation health organisations within their local communities. PCNs taking a leadership role in agreeing service delivery models, ensures they are optimally shaped to meet the need of local populations, particularly when decisions are informed by PHM intelligence.
- PMH data has enabled a greater understanding of which patient cohorts will experience greatest impact in terms of resource utilisation from specific interventions allowing for targeting of activity.
- Despite having no funding directly attached to this work, PCNs have, supported by programme management expertise and capacity from the ICB, proactive engaged with this work over the past year. Flexibility to self-select priority work areas from an agreed range of options and adoption of a supportive collaborative/continuous improvement approach have been key to this.
- Changes to both leadership and organisational form have impacted pace of delivery of the SPA and Integrated Care workplan alongside the lack of funding agreed for developing the Community and Acute Frailty Hubs.
- A single system-wide business case for Frailty is required in line with the ICB 25/26 Planning requirements and agreed ICB timescales.
- Expectations of individual organisations and requirements to change need to be explicit to ensure commitment to implementation and that required actions are embedded within both organisational and individual objectives. This is especially important in a context of limited resources and competing priorities.



Considerations for the Integrated Care Board

- Frailty is part of the Integrated Community Care programme and leads our approach to building capacity and capability rooted in primary care.
- We need to connect better with social care and mental health where they are integral to the pathways.
- We need to ensure greater alignment of thinking across portfolios – UEC, Mental Health, End of life care, Planned care if we are to ensure successful delivery of complex pathways of care such as frailty, as they impact everybody's work.
- We need to clarify where does the role of health (NHS) begin and end.
- As we work through the TOM, we need to be explicit regarding roles of both commissioners and providers as these have not always been clear during this journey.
- We need to explicitly support 'pump priming' of investment into community and primary care as we implement new models of care and large-scale cultural change. This will allow us to proactively identify and treat patients, minimise their disease progression, reduce their dependency on acute care and increase value for patients and the taxpayer.



Next steps

- Evaluate the impact of proactive care work in progress.
- Use the lessons learned in the refreshing of the Frailty operational plans.
- Explore the benefits of utilising social finance to support the delivery plans.
- Roll out the primary care and integrated care work across the county utilising mechanisms to support shared learning and collaboration.
- Develop business case for the Older People's Strategy supported by the clinical evidence and PHM data and utilising the PHM forecasting tools.
- Develop mechanisms utilising the Shared Care Record to maximise the benefits both in terms of patient safety but also informed clinical decision making and record sharing across system partners
- Continue the work on workforce planning, ensuring lessons captured and disseminated and robust links are made with the Joint Forwarding Planning mechanisms
- Support the development of Team Frailty and the broader Organisational Development agenda with a view to reducing fragmentation and enhance cross organisation 'trust'
- Utilise lessons learnt from the implementation of the Older People's Strategy to inform other transformation programmes and the development of the GP strategy.
- Remain cognisant of national policy development that impacts on older people.

Questions?



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	05 (i)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Integrated Quality & Performance Report – November 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 <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
Recommendation or particular course of action, e.g., approve the strategy, endorse the direction of travel.	Assure the Board/Committee that controls and assurances are in place.	Receive and note implications, may require discussion to help share/develop item.	Note, for intelligence of the Board/Committee without in-depth discussion.

Recommendations

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

Summary

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

Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for October 2024 was 73% below the planned month trajectory of 76.3% (95% constitutional target) but higher than the regional average and in line with national performance.

- Category 1 mean response times for EMAS Trust was 09:40 minutes against a standard of 07:00 minutes during October 2024.
- The Category 2 mean response time for EMAS Trust was 58:01 minutes against an expectation of 30 mins (18:00 constitutional target), the Lincolnshire ICB EMAS Category 2 mean response time was 45 minutes for October 24, which was better than the regional average despite October being a challenging month due to acuity and demand.

Cancer

- 273 patients were waiting over 62 days at the end of September, this is now a combined target including consultant upgrades and is an improving position.
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral increased to 63.2% in September from 62.1% in August.
- The faster diagnosis standard was achieved in September, overall performance was 78.3% against the 75% standard.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals remains relatively static, although improvements are being made to reduce the longer waits.
- The number of patients waiting over 65 weeks was 458 at the end of September, a reduction from 680 in August.

Mental Health, Learning Disabilities & Autism

- Mental Health, Learning Disabilities & Autism
- The NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in September. 96.8% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 79% in September (rolling 12 months) which is above the 60% standard.
- Adult inpatients with learning disabilities or autism remain above trajectory at 35, compared to planned trajectory of 30.

Primary Care

- Recent CQC assessment took place at Gosberton Medical Centre on 28th October – 6th November and led to a warning notice being issued against Regulation 12 (1) of the Health and Social Care Act 2008. The ICB is working directly with the practice to support development of a robust action plan to meet the required improvements. The practice have until 25th November to respond to the notice and full CQC report is awaited.

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 <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Report previously presented at:	
Not applicable	
Is the report confidential or not?	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

Integrated Performance & Quality Report



Lincolnshire
Integrated Care Board

November 2024



20/11/2024

Contents

- Executive Summary [Page 3](#)
- Key to Charts [Page 4](#)
- Performance Dashboard [Page 5](#)
- Key Performance Data [Page 6](#)
- Quality [Page 10](#)

Executive Summary

Overview

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



Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for October 2024 was 73% below the planned month trajectory of 76.3% (95% constitutional target) but higher than the regional average and in line with national performance.
- Category 1 mean response times for EMAS Trust was 09:40 minutes against a standard of 07:00 minutes during October 2024.
- The Category 2 mean response time for EMAS Trust was 58:01 minutes against an expectation of 30 mins (18:00 constitutional target), the Lincolnshire ICB EMAS Category 2 mean response time was 45 minutes for October 24, which was better than the regional average despite October being a challenging month due to acuity and demand.



Cancer

- 273 patients were waiting over 62 days at the end of September, this is now a combined target including consultant upgrades and is an improving position.
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral increased to 63.2% in September from 62.1% in August.
- The faster diagnosis standard was achieved in September, overall performance was 78.3% against the 75% standard.



Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals remains relatively static, although improvements are being made to reduce the longer waits.
- The number of patients waiting over 65 weeks was 458 at the end of September, a reduction from 680 in August.



Mental Health, Learning Disabilities & Autism

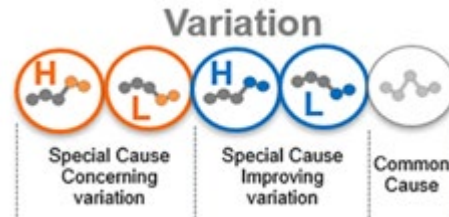
- The NHS Talking Therapies (previously IAPT) waiting times standards were both achieved in September. 96.8% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 79% in September (rolling 12 months) which is above the 60% standard.
- Adult inpatients with learning disabilities or autism remain above trajectory at 35, compared to planned trajectory of 30.



Primary Care

- Recent CQC assessment took place at Gosberton Medical Centre on 28th October – 6th November and led to a warning notice being issued against Regulation 12 (1) of the Health and Social Care Act 2008. The ICB is working directly with the practice to support development of a robust action plan to meet the required improvements. The practice have until 25th November to respond to the notice and full CQC report is awaited.

Key to Run Charts



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

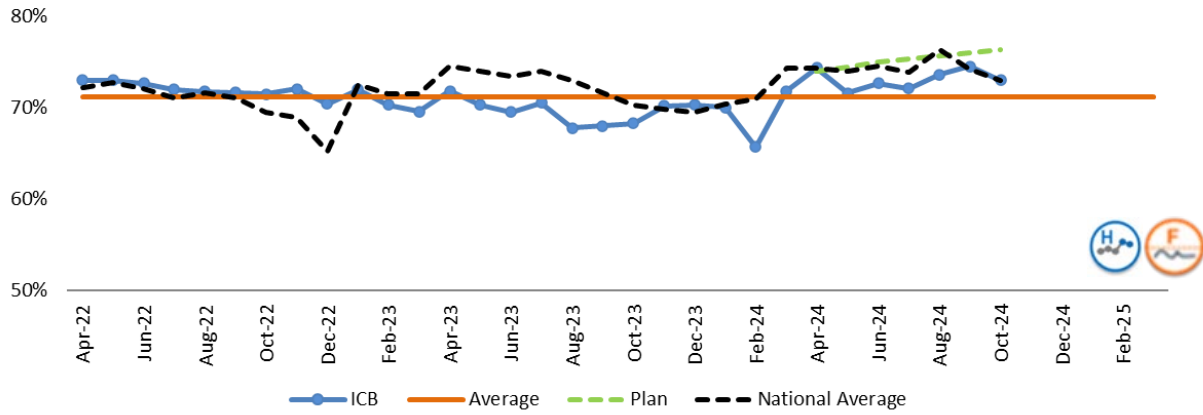
Lincolnshire ICB Performance Dashboard



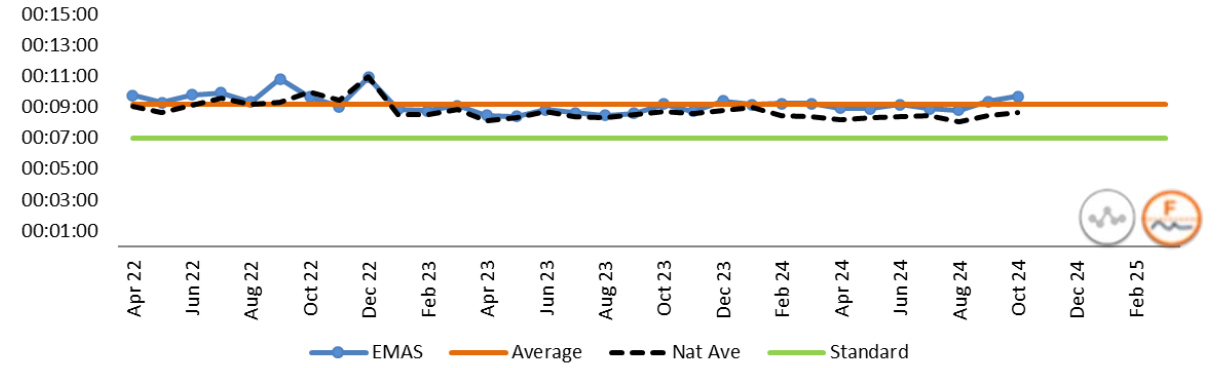
Trend

Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	76.3%	Oct-24	73.0%	72.0%	73.0%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Oct-24	00:09:40	00:08:56	00:08:38			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Oct-24	00:58:01	00:45:54	00:42:15			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	-	Sep-24	90.4%	89.5%	90.6%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	-	Sep-24	63.2%	63.4%	67.3%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	-	Sep-24	78.3%	75.2%	74.8%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	-	Sep-24	53.0%	56.4%	58.5%			
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)	-	-	Sep-24	0.40%	0.22%	0.30%			-
	Percentage waiting six weeks or less for a diagnostic test	99%	-	Sep-24	75.1%	75.1%	77.3%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q2 2024/25	26.6%	26.2%	22.7%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	Sep-24	96.8%	N/A	91.9%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	Sep-24	99.4%	N/A	99.1%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	Sep-24	79.0%	75.2%	72.4%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	Aug-24	66%	74%	69%			
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	Aug-24	83%	87%	75%			

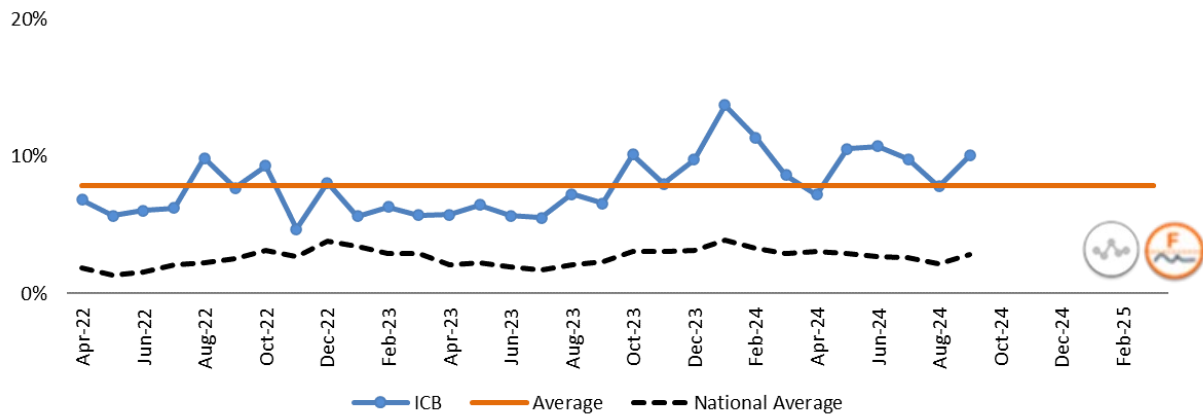
A&E admission, transfer, discharge within 4 hours (ICB)



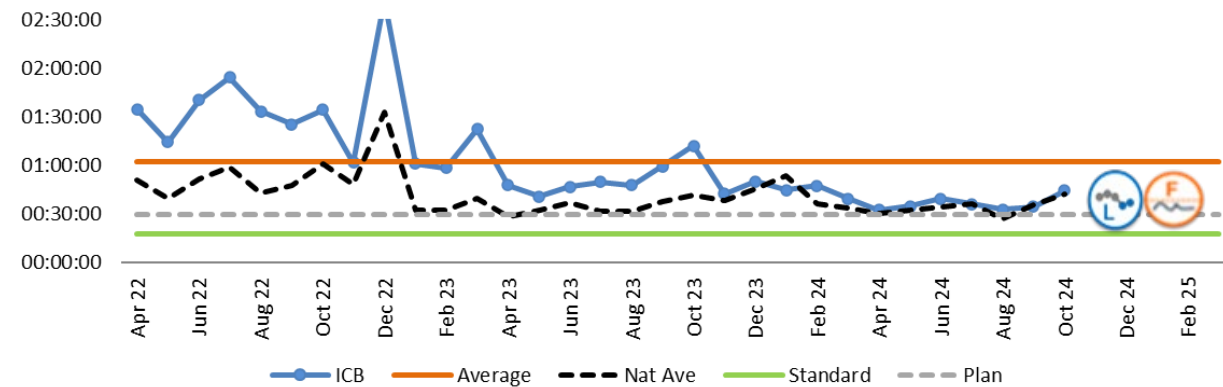
Ambulance response times - Mean response time- Category 1 (EMAS)



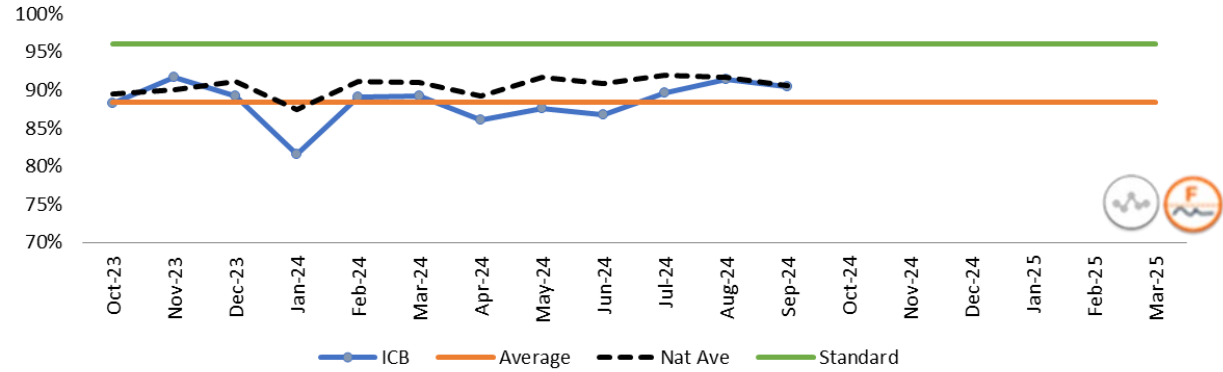
12+ hour delays from decision to admit (ICB)



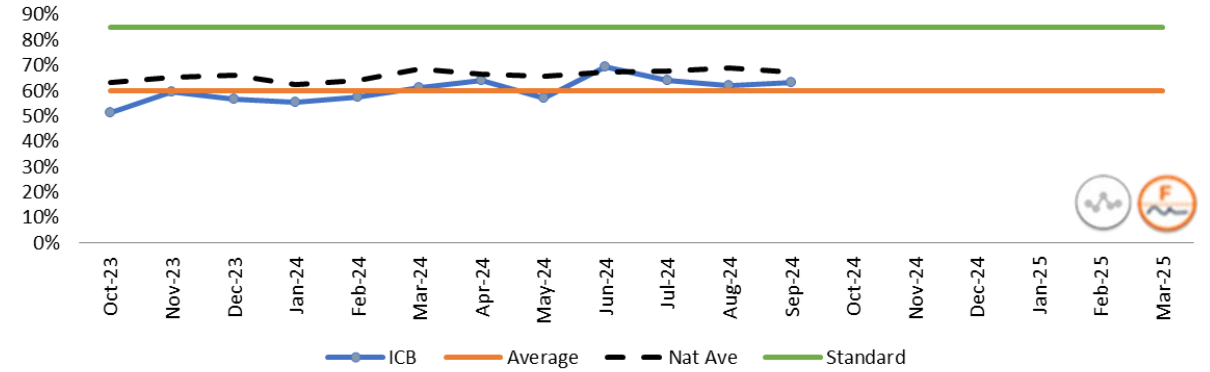
Ambulance response times - Mean response time- Category 2 (Lincs)



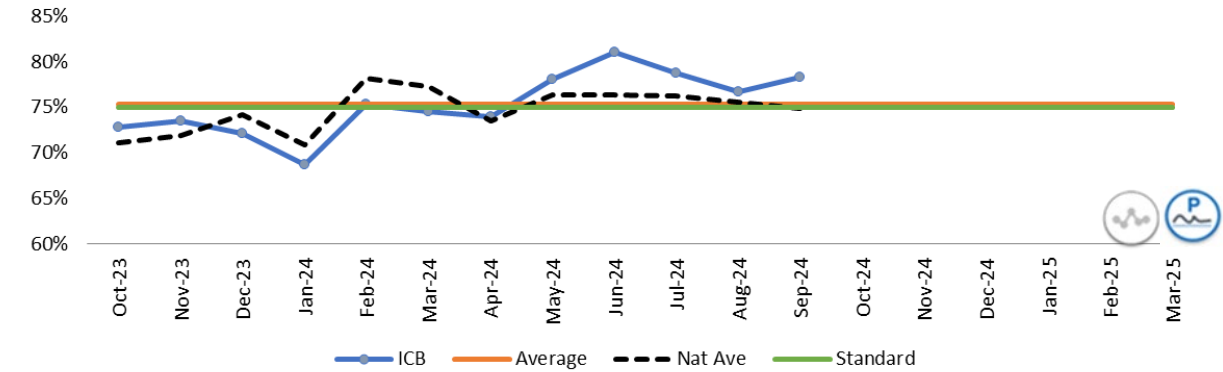
Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



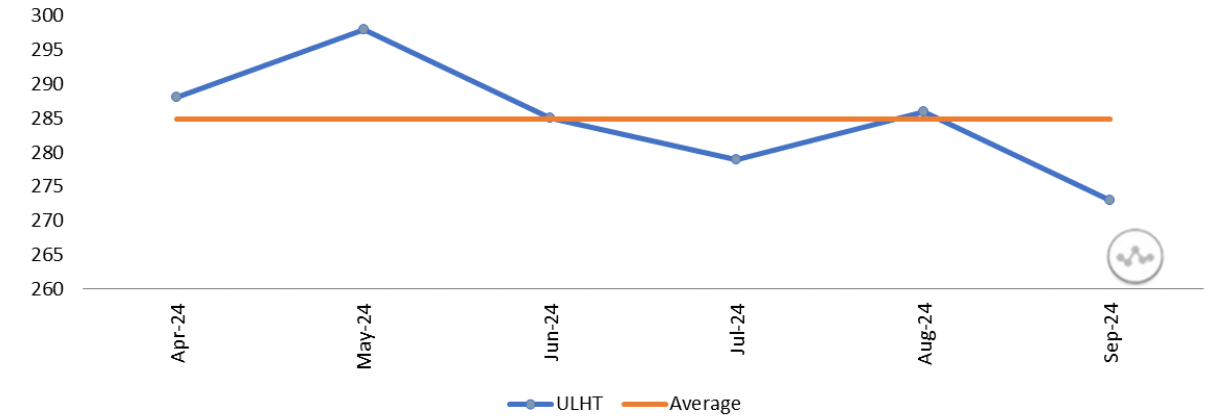
Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade (LICB)



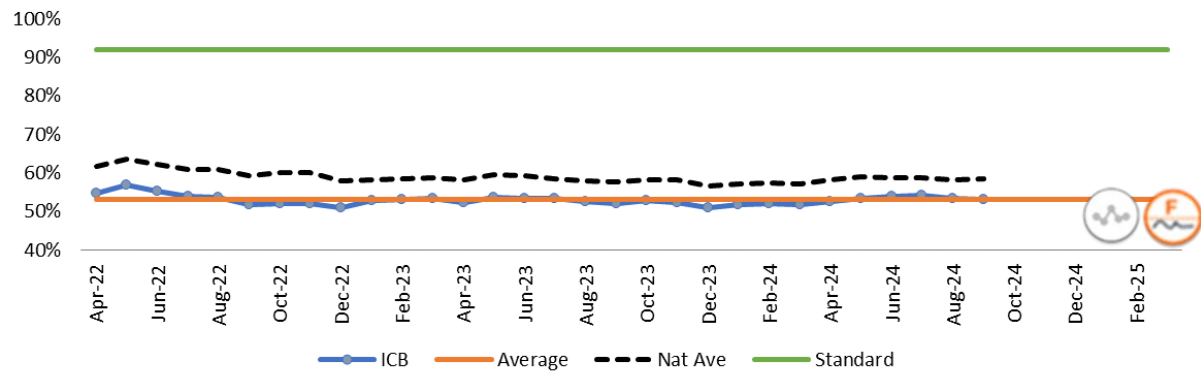
Faster Diagnosis Standard- % of patients told cancer diagnosis outcome within 28 days (LICB)



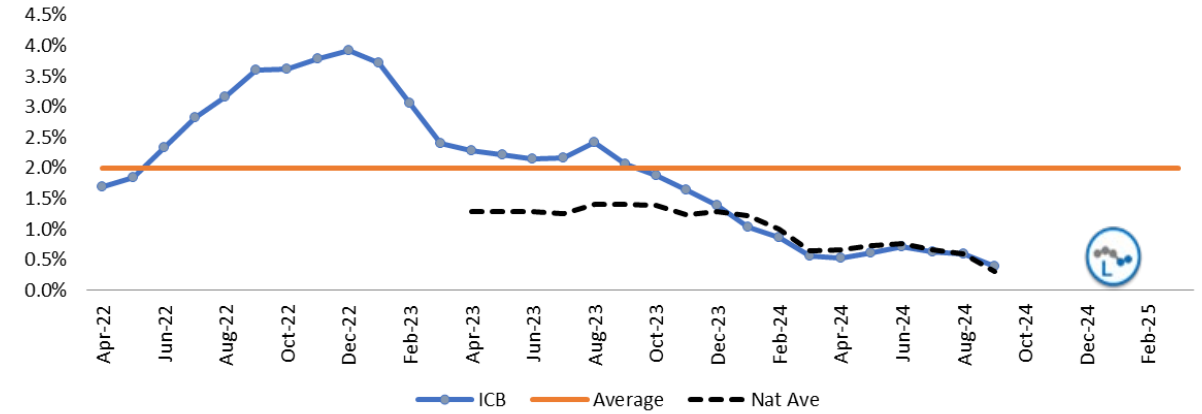
Total 62 Day Backlog (ULHT)



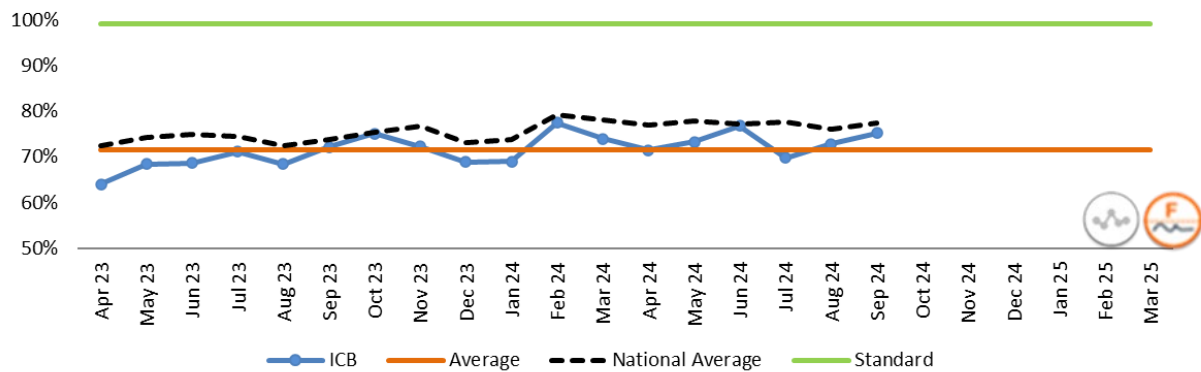
RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



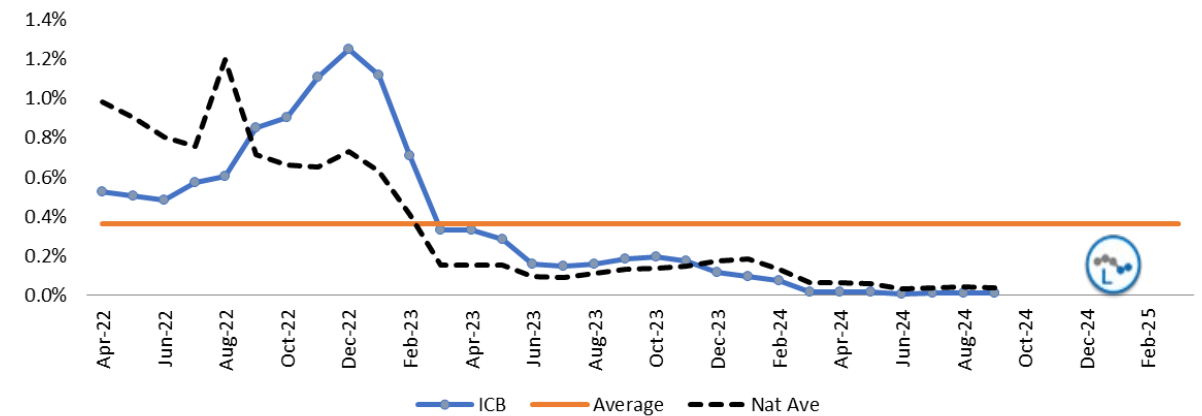
RTT- Patients waiting over 65 weeks for treatment (LICB)



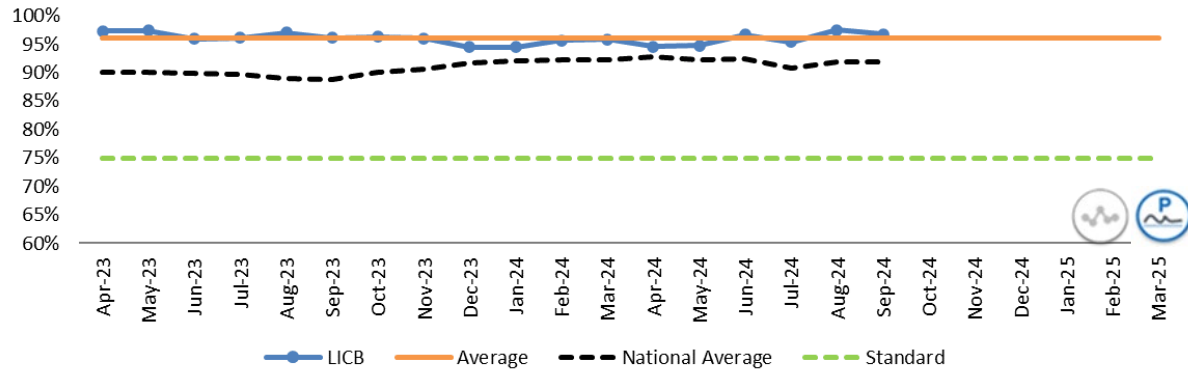
Percentage waiting six weeks or less for a diagnostic test (ICB)



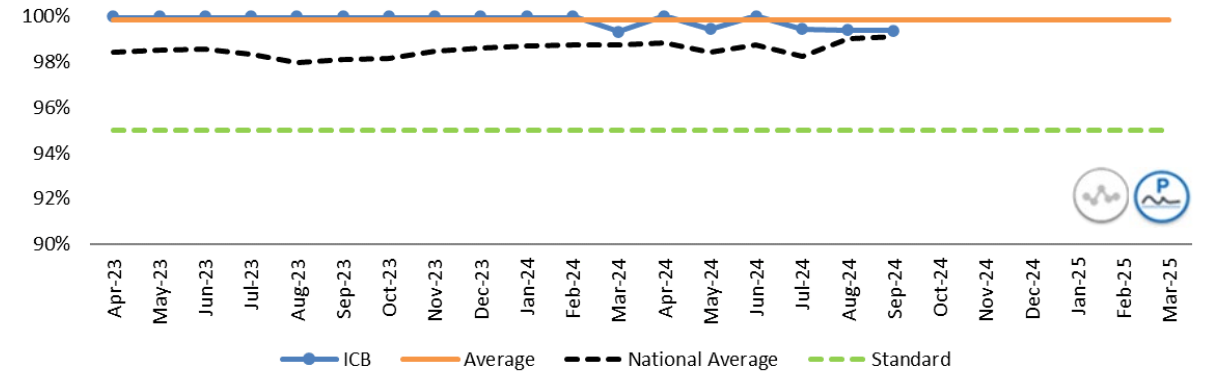
RTT- Patients waiting over 78 weeks for treatment (LICB)



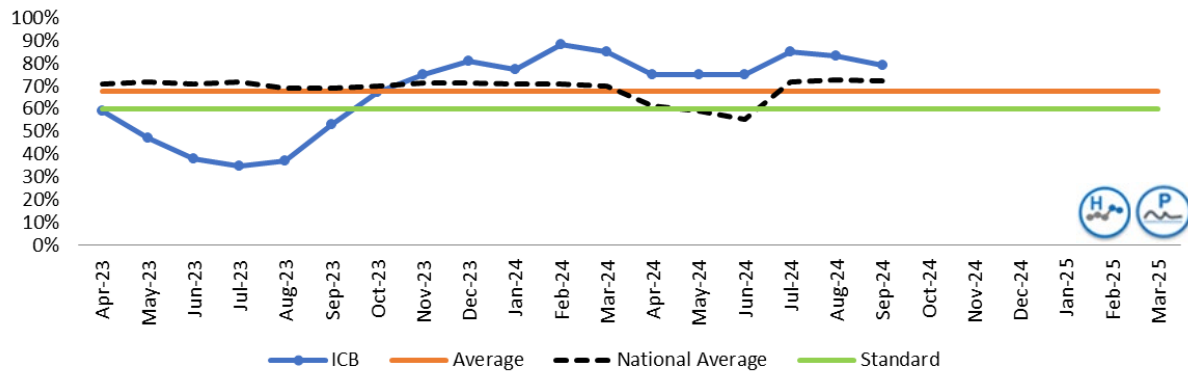
Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



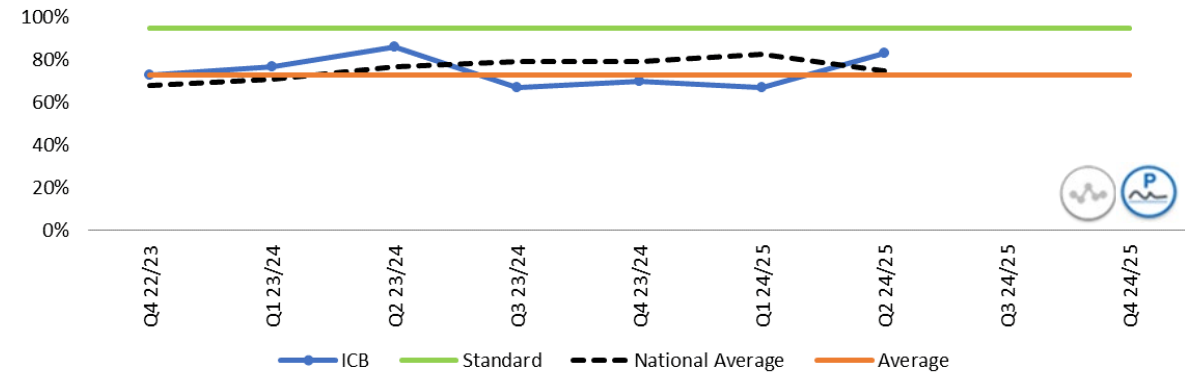
Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)



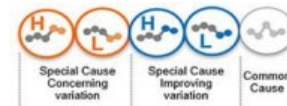
People experiencing first episode psychosis waiting to start a package of care (ICB)



CYP with an eating disorder (routine) that start treatment < 4 weeks of referral (rolling 12 months)



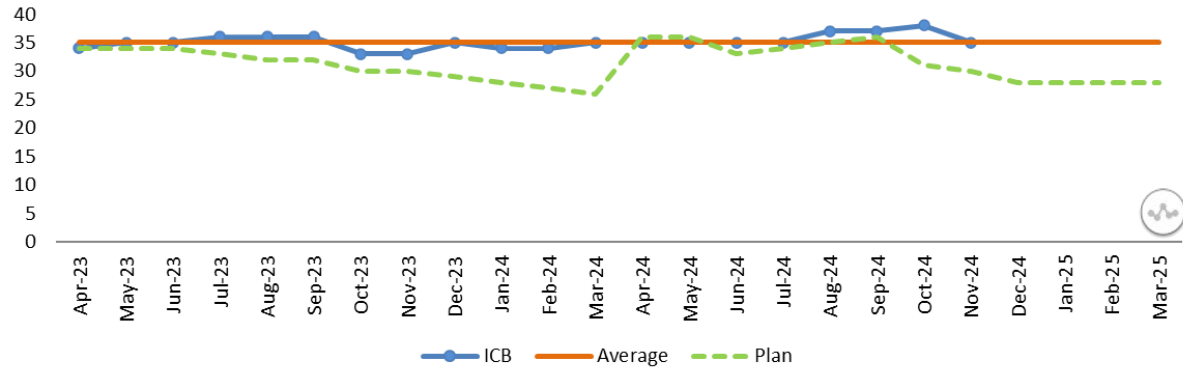
Lincolnshire ICB Quality Dashboard



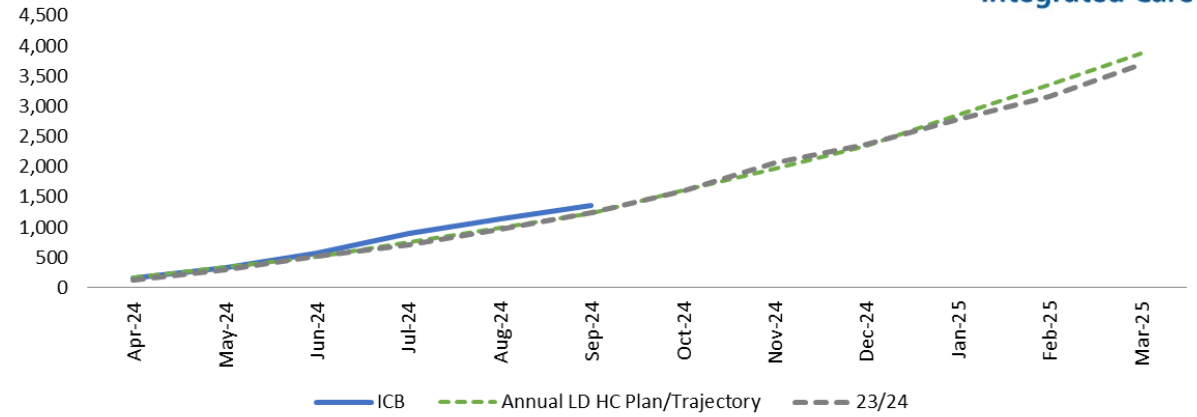
Programme	Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULHT)	0	Aug-24	2	N/A	N/A	-		
	Never events - YTD (NLAG)	0	Aug-24	0	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	Aug-24	2	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	-	Jul23 to Jun24	1.0609	1.0463	1.0041			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	Jul23 to Jun24	0.9714	1.0463	1.0041			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	Jul23 to Jun24	0.9938	1.0463	1.0041			
Infection, Prevention, Control	MRSA Cases (ULHT 12 month rate per 100,000)	-	Sep-24	0.29	1.03	1.01			
	C-Diff Cases (ULHT 12 month rate per 100,000)	-	Sep-24	29.55	31.05	28.07			
	E-Coli Cases (ULHT 12 month rate per 100,000)	-	Sep-24	37.74	38.14	37.89			
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)	30	Nov-24	35	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	990	Sep-24	1366	N/A	N/A			
Patient Experience	Patient experience of GP services (ICB)	-	2024	73.0%	N/A	74.0%			-
	Friends & Family Test: A&E Recommended (ULHT)	-	Sep-24	74.0%	N/A	79.2%			-
	Friends & Family Test: Inpatient Recommended (ULHT)	-	Sep-24	91.0%	N/A	94.0%			-
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)	-	Sep-24	88.0%	N/A	92.0%			-
	Friends & Family Test: Community Recommended (LCHS)	-	Sep-24	90.0%	N/A	95.0%			-
Friends & Family Test: Mental Health Recommended (LPFT)	-	Sep-24	93.8%	N/A	87.7%			-	
Primary Care	Primary Care CQC- percentage of practices rated as 'Inadequate' by CQC	0	Oct-24	1.2%	N/A	0.7%			
	Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC	-	Oct-24	7.4%	N/A	7.4%			-
	GP Appointments- Total appointments in GP practice	511,455	Sep-24	452,886	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	Sep-24	45.0%	N/A	43.2%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	Sep-24	87.5%	N/A	81.9%			
	Enhanced access minutes provided (ICB) (YTD)	1,099,696	Oct-24	1,657,141	N/A	N/A			
The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	Oct-24	86.8%	N/A	N/A				

Learning Disability & Autism

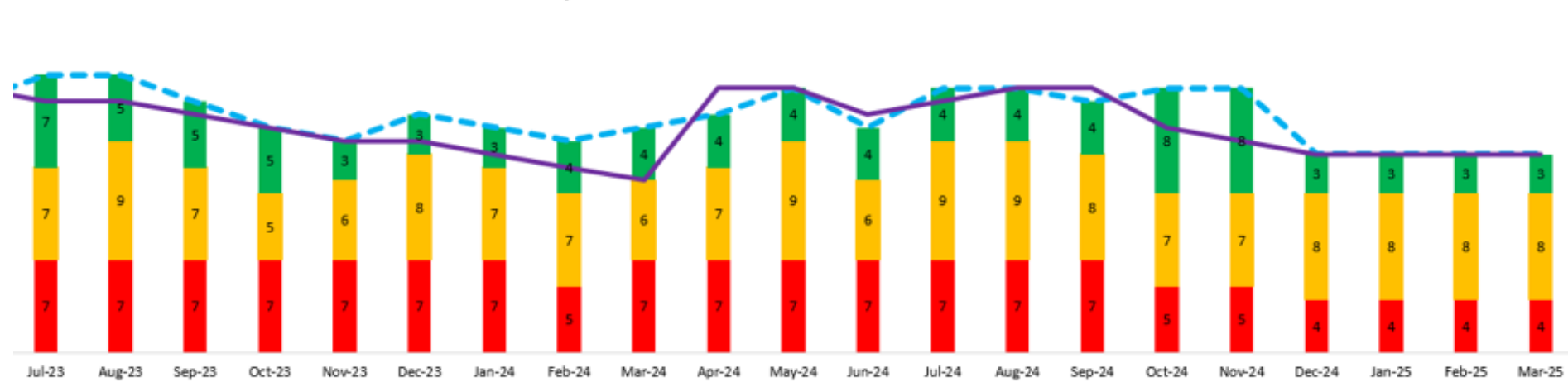
Inpatient care for adults with LD/autistic - Care commissioned by ICB. (Non Secure) and NHSE (Secure)



Learning Disability Healthchecks



LDA ICB Adult Inpatient Movement 2023/24 - 2024/25



Legal Framework / MM Judgement	--- (Dashed Blue)
Clinical illness - Appropriately placed	— (Solid Purple)
Market issues - Discharge plan in place	— (Dashed Green)

RAG RATING Key	
Legal framework - This is the barrier to the discharge and may prevent the discharge from happening for several years etc.	Red
a. Those on extended S17 leave granted under the MH Act	Red
b. Those on MM judgements which will state when the ruling applies to. Looking into capacity issues as well	Red
Clinical illness - Those clients where the needs are best met in a secure environment	Yellow
Market issues - This is where we should concentrate the discharges on, as it is the lack of placement to discharge to, which is the reason why they have not been discharged	Green

Insight and Signals – Quality and Patient Experience

Winter Assurance

The NHSE Winter Assurance visit took place on Friday 1st November which reviewed Lincolnshire's Winter Plan in which quality and risk management is a key element. This outlines that we want to ensure that people in our care as well as their families and carers are treated with kindness, dignity, respect and receive safe standards of care. The actions underway include ensuring the fundamental standards of care are in place in all settings at all times and ensuring plans are in place to maximise patient flow throughout hospitals seven days per week.

ULHT ED CQC Assessment

The Care Quality Commission (CQC) undertook an unannounced assessment at Lincoln County Hospital to review Urgent and Emergency Care Services. No immediate patient safety concerns were reported back to the Trust as a result of the visit. Whilst there was good patient care observed throughout the different areas within the department there were some initial actions identified which the Trust are taking forward including, ensuring that the National Early Warning Score process is fully embedded; improving access to trolleys in the ED to assist with patient flow; and review of staffing within the CDU escalation area. CQC report is awaited.

Independent Investigation of the National Health Service in England

The review undertaken by Lord Darzi was published September 2024 and cuts across all elements of the NHS. From a quality and patient experience perspective the focus is on quality implications linked to most of the main transformation programmes we would recognise in Lincolnshire i.e. maternity; children and young people; mental health; long term conditions; palliative and end of life; planned care; and urgent and emergency care with a particular focus on avoidable deaths in relation to cancer; cardiovascular disease; and suicide.

Childrens Commissioner Report

The Childrens Commissioner published a report in October 2024 on waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions https://assets.childrenscommissioner.gov.uk/wpuploads/2024/10/CCo-report-on-ND-waiting-times_final.pdf The report highlights the increase in demand for assessment and support within the context of wider challenges in relation to Special Educational Needs and Disabilities (SEND) and draws attention to the significant waits for assessment and diagnosis experienced by children and young people. Whilst this is a national report, from a Lincolnshire perspective there is recognition of the themes coming through the report and the need to focus work locally within this national context.

Summary Hospital Level Mortality Indicator (SHMI) (ULHT)

The SHMI indicator was updated nationally in May 2024 and now includes deaths attributed to Covid-19, which had previously been omitted. This may have contributed to a trending increase at ULHT since May which has continued this month. However, the trust remains in the 'as expected' range.

C-Diff Cases (ULHT)

ULHT & NWAFT have a higher trending C-Diff rate which is above the national average, however annual trajectories have now been published and most have increased from last year, reflecting the acknowledgement of a national increase in cases. ULHT are under their set trajectory.

Insight and Signals – Primary Care

Type of Provision	Practice	CQC Rating	Information to note
Primary medical care	Gosberton Medical Centre	Good	Recent CQC assessment took place 28 th October – 6 th November and led to a warning notice being issued against Regulation 12 (1) of the Health and Social Care Act 2008. The ICB is working directly with the practice to support development of a robust action plan to meet the required improvements. The practice have until 25 th November to respond to the notice and full CQC report is awaited.
Primary medical care	Richmond Medical Centre	Requires improvement	The ICB had noted a slower than expected improvement trajectory especially in the 'Safe' domain where the practice was rated inadequate. The ICB quality and primary care teams are working closely with the practice to ensure that improvement plans stay on track.
Primary medical care	All practices	N/A	The ICB Quality team is leading on the programme to improve the Primary Care position on antibiotic prescribing which remains as one of the more challenging systems in the country. Key themes and actions have been identified and will be reported into both System Quality and Patient Experience Committee and the Health Protection Board.

Medical Examiners

New Statutory Medical Examiner Process for Primary Care non-coronial deaths implemented from 9th September 2024. Highlighted improvements required from several General Practitioners regarding quality of death certificate and timeliness of issue/amendments. Primary Care Quality team supporting are Medical Examiners Officers to support Practices where issues have been identified. Webinar and FAQ available and provided to Practices on new process.

Quality Improvement

Childrens Safeguarding Front Door

Progress has been made with ensuring there is health representation at childrens safeguarding Front Door strategy discussions with appointment to ICB safeguarding practitioner post, due to start December 2024. Work is ongoing with the NHS Trusts to establish posts that will support sharing of information following approval of the Front Door business case. Access to GP records by ICB safeguarding practitioners, to inform Front Door strategy discussions, has been a key area of focus with the implementation of an ICB SystemOne safeguarding module and development of the necessary information sharing agreements. The ICB is in the process of writing to all GP practices to request the necessary permissions, in line with information governance requirements, to be able to utilise the SystemOne functionality.

Joint Targeted Area Inspections Preparations

Joint Targeted Area Inspections (JTAI) are undertaken in accordance with Section 20 of the Childrens Act 2004 by Ofsted; Care Quality Commission (CQC); His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS); and His Majesty's Inspectorate of Probation (HMIP). JTAs are used to evaluate multi-agency safeguarding arrangements and follow a theme. Work is taking place across the Lincolnshire Safeguarding Childrens Partnership (LSCP) and Lincolnshire Domestic Abuse Partnership (LDAP) to prepare should Lincolnshire be advised a JTAI is to take place in relation to the latest theme of children who are victims of domestic abuse. This theme focuses on:

- responding to children who are victims of domestic abuse, at the point of identification
- assessment, planning and decision-making in response to notifications and referrals of children who are victims of domestic abuse
- protecting, supporting and caring for children who are at risk of, or who have been victims of, domestic abuse
- preventing children from becoming victims of domestic abuse

Funeral Directors Compliance Check

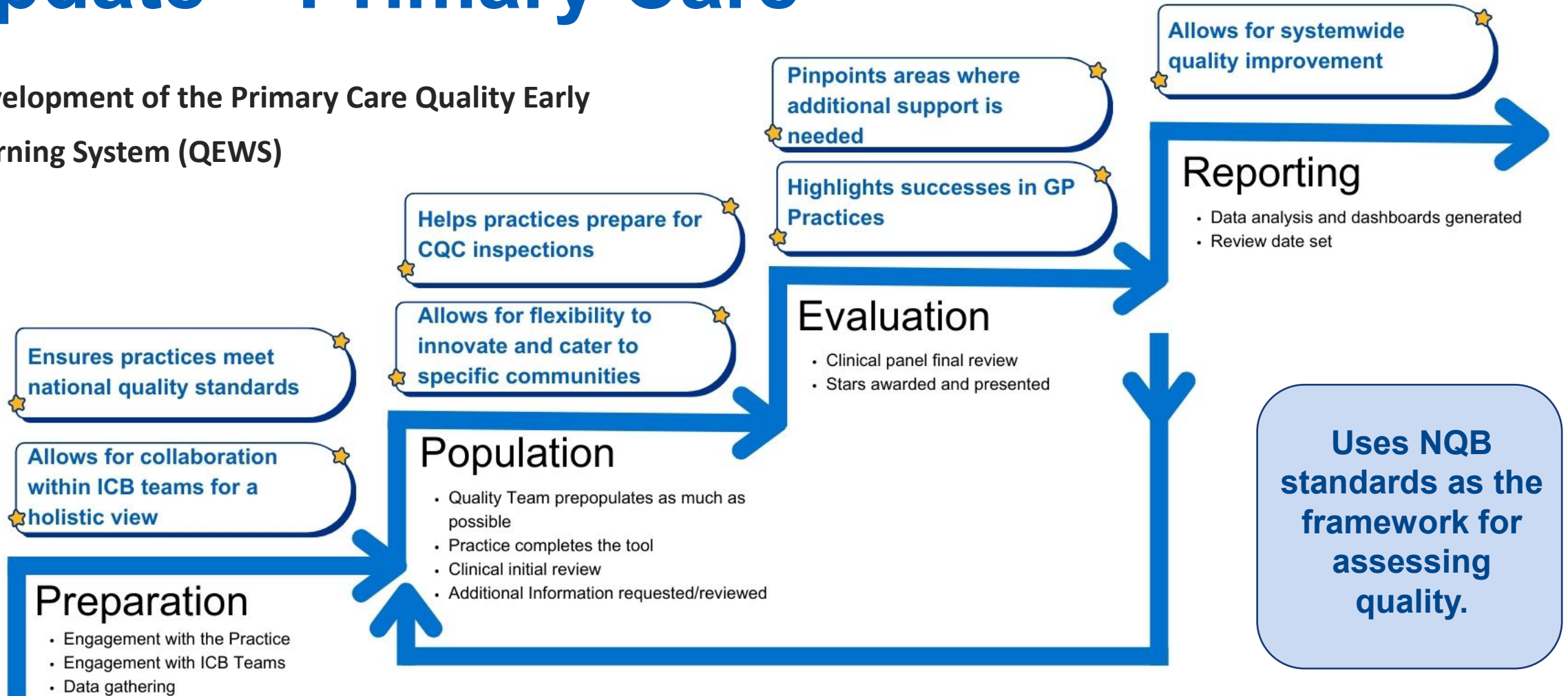
LCC Public Health have confirmed completion of assurance visits to all funeral homes in Lincoln with no significant concerns identified

Systemwide Learning Forums

A number of Systemwide learning forums have now been established with the intention of sharing learning themes across organisations. These forums include the Lincolnshire ICS Learning Meeting; Lincolnshire ICS Patient Safety Meeting; and Lincolnshire ICS Pressure Ulcer Learning Meeting. Whilst the forums are evolving there is positive engagement from System partners and these forums are recognised as important routes for disseminating learning and supporting quality improvement.

Quality and Patient Experience Thematic Update – Primary Care

Development of the Primary Care Quality Early Warning System (QEWS)



Vaccination Programmes – Seasonal & New

Seasonal Programmes

Flu

- The 2024 flu campaign began on 1st September for pregnant women and children, and 3rd October for all other cohorts.
- The start of the flu campaign for adults is later than previous years. This is due to evidence that the flu vaccine's effectiveness can wane over time in adults and flu virus circulation typically peaks in December or January
- The flu vaccine is delivered by General Practice, Community Pharmacies, SAIS and Maternity services in Lincolnshire, with support from LCHS Vaccination & Rapid Response Team (VRRT) for Health Inequalities groups.
- To date uptake in Lincolnshire is circa 49% compared to a regional position of 40%.

Covid-19

- The Autumn 2024 Covid-19 vaccination campaign began on 3rd October for all cohorts.
- The campaign is being delivered by PCNs, Community Pharmacies and VRRT where there are access gaps and to Health Inequalities groups
- VRRT will also be delivering Covid-19 vaccines within ante-natal clinics, and for Lincolnshire County Council care home and domiciliary care staff
- Lincolnshire now has 34 Community Pharmacies providing Covid-19 vaccination, this is an increase of 14 from Spring.
- Care home visits are continuing at pace, and they are all expected to have been visited by a vaccination team by the end of November.
- The uptake so far is lower than last autumn. To date uptake is circa 47%, against a regional picture of 34%.

New Programme

Respiratory Syncytial Virus (RSV)

- The RSV vaccination programme began on 1st September 2024.
- Maternity**
- The maternity programme is to mainly be delivered via maternity providers.
 - There are several options for ladies in Lincolnshire – ULHT led clinics based at Lincoln County and Pilgrim sites, or community-based clinics run by LCHS in family hubs in Skegness, Gainsborough and Spalding. or opportunistically by their own GP.
- Older Adult**
- The older adult programme is contracted to be delivered in General Practice, uptake by practice varies depending on their plan. Many have reduced the number of RSV appointments whilst they undertake Covid and Flu appointments.
 - The response for Lincolnshire from patients for this new vaccine, so far is a positive one. To date uptake is circa 33%.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (ii)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Process for Review of CQC section 48 (Calocane) Report
Report Author:	Mrs Sarah Connery, Chief Executive, LPFT and Executive Mental Health Member
Presenter:	Mrs Sarah Connery, Chief Executive, LPFT and Executive Mental Health Member
Appendices:	Lincolnshire system draft action plan

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

Recommendations
The Board is asked to, receive this paper and be assured there is a robust approach in place to review our services in the context of the Care Quality Commission’s (CQC) section 48 review of Nottinghamshire Healthcare NHS Foundation Trust’s care and treatment of Valdo Calocane and meet the requirements from NHSE in regards to governance and ICB oversight.
Summary
<p>Background</p> <p>Following the previous paper presented to the ICB Board on the 24th September, 2024, this paper provides an update on progress and meets the request from NHSE that the system action plan is shared within the ICB Public Board Meeting.</p> <p>https://www.england.nhs.uk/long-read/icb-review-of-intensive-and-assertive-community-treatment-for-people-with-severe-mental-health-problems/</p> <p>The CQC completed a section 48 review of Nottinghamshire Healthcare NHS Foundation Trust’s care and treatment of Valdo Calocane following the tragic deaths of three people. The CQC found a number of failings in Mr Calocane’s care and treatment which has led to recommendations to review a number of elements of service delivery to minimise the risk of this occurring again.</p> <p>As per the previous paper a Task and Finish group has been established to develop and implement the action plan. The first meeting was held 6th November 2024, with ICB, LPFT and an expert by experience. The group reviewed all available information from NHSE returns, the system maturity index and suggestions shared by various groups/committees to inform the action plan.</p>

Due to NHSE timeframes this action plan has not had scrutiny or approval of ICB and LPFT quality forums and is therefore included in draft format (appendix 1) and so could be subject to change.

Summary of Action Plan

As stated, due to tight timescales we are presenting a draft version of the action plan, that will further iterate as we make progress with the Task and Finish Group. The action plan can be broken down into themes:

- Establishment of meetings and governance – Task and Finish group established and governance arrangements described below.
- Business Care/Options appraisal – The Lincolnshire system does not have a dedicated intensive and assertive treatment service or function, it is absorbed into existing teams. NHSE are clear that a separate service/function should exist with staff dedicated to this. We have completed a return to NHSE with indicative costs for such a service and await feedback. In the meanwhile a detailed business case/options appraisal is being developed.
- Data and intelligence – we have no clear method to identify the patients who meet the specified criteria for this cohort and so a digital flag is needed. We will be reviewing a number of patients from a completed manual data collection exercise to inform further plans and improvements, as well as reviews of repeat Mental Health Act detentions and incidents. We will be reaching out to primary care and other stakeholders to capture information on patients not under the care of LPFT.
- Connection to existing workstreams and wider stakeholder engagement – A number of the elements for improving and enhancing the care for people in this cohort are covered by existing work streams and programmes. We will map out and connect to these to reduce duplication. This includes support for families carers, dual diagnosis, personalised care and support planning, accommodation and housing, psychological therapies. This cohort of patients are likely to present in a number of places and sadly often the criminal justice system, therefore wider partner engagement will be vital going forward.
- Review of SOPs and clinical guidelines and embed in practice – Service SOPs, clinical guidelines and pathways across community and inpatient wards to be reviewed, enhanced or developed where required, in particular an MDT approach to care planning and discharge – ensuring that disengagement is never the stand alone reason for discharge. Documentation alone is not enough and we will work to ensure these principles are not only documented but also fully embedded in practice.
- Support for patients and staff – this has been a difficult time for users of our services who have seen and heard in the press some of the negativity around service delivery and people experiencing psychosis. We want to ensure we are supporting our population and also our staff who work in our services.

In terms of actions taken to date and future dates:

Action	Date	Lead	Complete
ICB Board Briefing Paper	24/09/2024	Sarah Connery (LPFT CEO)	Yes
Review and sign off of NHSE assessment return by LPFT Executive Team Meeting	25/09/2024	Nick Harwood (Director of Community Services)/Sharon Harvey (Chief Nursing Officer)	Yes
Review, sign off and submission of NHSE assessment return by ICB	30/09/2024	Sara Brine	Yes
NHSE return presented to LPFT Quality Committee for assurance	08/10/2024	Sharon Harvey (Chief Nursing Officer)	Yes
Task and Finish group mobilised (& associated governance set up)	October, 2024	Nick Harwood (Director of Community Services)	Yes
LPFT and ICB Quality Committees joint review of action plan delivery	November 2024 with ongoing updates	Sharon Harvey (Chief Nursing Officer - LPFT) Martin Fahy (Chief Nursing Officer - ICB)	No

Receipt and Consideration of action plan as a result of assessment to ICB Board	November 2024	Sarah Connery (LPFT CEO)	Today's meeting
NHSE webinar	10/12/24	ICB/LPFT	No
NHSE review of action plan progress	July, 2025	ICB/LPFT	No
NHSE review of action plan progress	January, 2026	ICB/LPFT	No

The action plan will be monitored through the Task and Finish Group, reporting into LPFT Quality Governance Group with regular updates provided to LPFT Quality Committee, with overarching governance sitting with the ICBs SQPEC. Updates will be provided to ICB and LPFT Execs and Boards as requested or required.

The recommendation is for the ICB Board to receive this paper and be assured there is a robust approach in place to review our services in the context of the CQC reports and requirement to share the system action plan in the ICB Public Board Meeting has been met.

How does this paper support the ICB's core aims to:

Aim 1: Improve outcomes in population health and healthcare.	The assessment will support identification of service provision gaps for this highly stigmatized cohort
Aim 2: Tackle inequalities in outcomes, experience and access.	People with serious and enduring mental illness have barriers to accessing services and assertive outreach models help to facilitate engagement
Aim 3: Enhance productivity and value for money.	Keeping people safe and supported in their communities will deliver better VFM than inpatient models of care
Aim 4: Help the NHS support broader social and economic development.	Like suicide, the societal cost of homicide is substantial not only in financial terms for services but also the perpetual emotional impact for families, friends and staff

Conflicts of Interest

No conflict identified

Summary of conflicts

Risk and Assurance

As identified within the paper.

Implications (legal, policy and regulatory requirements)

Does the report highlight any resource and financial implications?	To be ascertained through the review.
Does the report highlight any quality and patient safety implications?	Considerable implications if care pathways are not robust.
Does the report highlight any health inequalities implications?	No
Does the report demonstrate patient and public involvement?	Yes in use of lived experience voice within stakeholder events and going forward.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Assertive Outreach models are based around visits to peoples places of safety within their communities – which has implications for travel and carbon footprint.

Inclusion

Has a Data Protection Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

Report previously presented at:

Not applicable.

Is the report confidential or not?

Yes

No

Intensive and Assertive Treatment Action Plan

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	RAG rating	Comments	Evidence
14	A number of actions were identified from the review	To establish a task and finish group to respond the findings of the review	Nick Harwood	Nov-24	Green	Group established	
1	The Lincolnshire Mental Health system does not have a dedicated Assertive/Intensive team or service, the pathway is incorporated into its CMHTs	To develop a business case/options appraisal for an assertive/intensive support dedicated function. Options to include outcome of patient reviews and consider risk of no change, realignment of services to meet needs to investment in dedicated function	Steve Skinner	Apr-25	Yellow		

2,3	The review identified a lack of ability to establish those requiring assertive/intensive support	To use the alert function in Rio to identify this cohort of patients, process maps to be updated and communication to staff, consideration of shared care records and interoperability, consider data, trends, DNA patterns, early warning metrics	Steve Skinner/Simon Kelshaw	Dec-24		
1,3	To understand current position and treatment pathways	CMHT Service Managers have identified the patients currently in the service who meet the criteria for this cohort of patients. A sample of 20% of these patients will be reviewed and findings summarised for the group. We will also hold patient engagement sessions to	Steve Skinner	Dec-24		

		hear the voice of our service users				
1,3	To understand current position and treatment pathways	All patients who have had multiple MHA detentions over the past 2 years have been identified and will be reviewed to further understand the treatment of this cohort of patients	Steve Skinner	Dec-24		
1,3	To understand current position and treatment pathways	Review of sample of patients where a DNA was the last appointment prior to discharge, 20 cases initially and then review themes	Steve Skinner	Dec-24		

1,3	To understand current position and treatment pathways	Identify any patients meeting the criteria for this cohort who are only receiving care from primary care, Senior Mental Health Practitioners in Primary Care to review	Steve Skinner	Dec-24		
1,3	To understand current position and treatment pathways	Review of PSIIIs, Datix, incidents regardless of level, near misses in relation to patients meeting the criteria both LPFT patients and those receiving care elsewhere	Steve Skinner	Dec-24		
1,3	Pathway of care needs development	Longer term care pathway under development, to be finalised	Steve Skinner	Apr-25		
1,3	Needs of this cohort are considered in SOPs	To review LMHT/inpatient/EIP SOP review, to ensure clear articulation of pathway for this cohort of patients and that	SOP owners	Jan-25		

		DNA is not a reason for discharge				
1, 4, 11	Review of inpatient pathways for this cohort	Review to consider, appropriate discharge pathways for this cohort of patients, ensuring MDT approach, robust community care plan, consideration of long term medication and use of CTO	Lee Wing	Jan-25		
1,3	Review of CYP/OAs and EIP transitions	To ensure within transitions from CYP and EIP services this cohort is given due consideration with robust transfer of care	Paula Jelly, Amelia Harding, Steve Skinner	Jan-25		
1,3	Accommodation/homelessness	The system has recruited to a Housing Lead, the post-holder will be asked to ensure robust housing support for this cohort of patients	Victoria Sleight	Apr-25		

4	Psychological therapies	Open Dialogue, family interventions and CBT-P incorporating into long term pathway, review of capacity to be completed	Rebecca Blacker	Jan-25		
4	Substance misuse	To ensure with Lincolnshire Recovery Partnership, specifically for this cohort of patients, to be considered by the Dual Diagnosis working group, coproduction of the long term care pathway	Sam Smith	Jan-25		
12	Family/carer engagement	To co-produce principles for family/carer engagement through established working groups, to seek support from Council of Lived and Learnt experience	Divisional Quality Leads	Jan-25		

6,9	Care planning	To ensure working group for personalised care and support planning considers the needs of this cohort of patients, including risk assessment and safety planning	Connor McGee	Jan-25		
4	LDA	To review care and treatment provided by the LDA services in relation to this cohort of patients and ensuring representation in relevant forums	Amelia Harding	Jan-25		
7	Clinical care policy	The Trusts Clinical Care Policy requires updating in relation to DNAs and describing the care for this cohort of patients	Mark Halsall	Dec-25		
4	Forensics	To review care and treatment provided by the Community Forensics services in relation to this cohort of patients and	Amelia Harding	Dec-25		

		ensuring representation in relevant forums				
10	Health inequalities	To ensure health inequalities for this cohort of patients are addressed as part of the system work	Sara Brine	Apr-25		
8	Wider stakeholder engagement	To work with partners of the support and care of patients, including A&E/acute hospital, police, EMAS, VCSFE sector	Nick Harwood	Apr-25		
5	Support for staff	Create space/additional supervision for our staff who have any concerns about practice or therapeutic risk taking and encourage Multi-Disciplinary Team discussions and joint decision making for complex individuals.	Rebecca Blacker	Dec-24		

12	Support for patients	Communication to people using our services, their families/ carers and our staff members who are supporting patients with psychosis, as they may be worried by the recent coverage of this, as well as ensuring we hear the patient/carer voice in our review.	Steve Skinner	Dec-24			
----	----------------------	--	---------------	--------	--	--	--

Domains

- 1 Function of assertive outreach / intensive case management
- 2 Discharge from services
- 3 Data
- 4 Clinical Pathways
- 5 Workforce
- 6 Risk assessment and safety planning
- 7 Legislation
- 8 Interface with other services
- 9 Recovery and personalisation

- 10 Meeting the needs of diverse populations
- 11 Medication management
- 12 Experts by Experience
- 13 Discharge from services
- 14 Governance

DRAFT



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	05 (iii)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Lincolnshire ICS Winter Plan 24/25
Report Author:	Rebecca Neno, ICB Deputy Director for System Delivery & Winter Director
Presenter:	Rebecca Neno, ICB Deputy Director for System Delivery & Winter Director
Appendices:	Winter Plan 24/25

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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

Board Members are asked to consider work undertaken in preparation of Lincolnshire's winter plan and advise any other areas of consideration for inclusion

Summary

The Lincolnshire Integrated Care System (ICS) Winter Plan for 2024/25 has been developed collaboratively and influenced by national winter guidance issued by NHS England as well as applying learning from previous winters within our local system, regionally and nationally.

During the summer of 2024, the Lincolnshire system experienced sustained levels of demand following the winter period and did not experience the usual small dip in activity. We must ensure that our services can respond to the expected increases in demand over winter and that resilience can only be achieved through continued partnership working across the health and care system. As partners of the Lincolnshire ICS we are committed to working together to manage these challenges and ensure that our population can access safe services and have good outcomes with a positive experience.

The purpose of this Winter Plan is to highlight the local assumptions for winter and set out our planned response to manage the urgent care and patient flow pressures that the system will inevitably experience. The plan is designed to supplement the ongoing improvements and developments in urgent care in line with the National Urgent and Emergency Care Recovery Plan and is inclusive of those requiring both physical and mental health care.

During August 2024 NHS England Midlands Regional team shared a set of Key Lines of Enquiry (KLOEs) to support development of local winter plans. The plan clearly outlines the system risks for winter, mitigations and any residual risks following mitigations.

The plan has been presented at the following events, committees, and forums and was formally submitted to NHS England Regional Team on 23/10/24, as well as being the cornerstone of our Winter Assurance Event during November led by the NHS Regional Team:

MEETING	DATE
UEC Partnership Board	04/10/24
ICB Executives	10/10/24
CEOs	16/10/24
ICB SD&P Committee	23/10/24
Lincolnshire Leaders Group	23/10/24
NHS E Regional Assurance Visit	01/11/24
HOSC	06/11/24
BLLLT	13/11/24
ICB Public Board	26/11/24

The Winter Plan 24/25 clearly sets out the actions and schemes that will be delivered during winter 24/25 and describes the governance mechanisms to help identify early issues and the need for course corrections.

How does this paper support the ICB's core aims to:

Aim 1: Improve outcomes in population health and healthcare.	This plan aligns with the core purpose of an Integrated Care System which is to improve outcomes in population health and healthcare.
Aim 2: Tackle inequalities in outcomes, experience and access.	The winter plan will support health and care services to build capacity and operational resilience for winter for the benefit of patients and service users.
Aim 3: Enhance productivity and value for money.	The plan highlights multiple actions being taken to integrate services across Lincolnshire to enhance productivity and maximize value for money.
Aim 4: Help the NHS support broader social and economic development.	Not applicable.

Conflicts of Interest

Summary of conflicts

No conflict identified

Risk and Assurance			
The winter plan will support performance improvement and achievement of planning targets which have been agreed, but acknowledging constitutional targets remain in place.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	No – the plan is funded within financial envelope available.		
Does the report highlight any quality and patient safety implications?	Yes – the plan highlights risks of delivery and relevant mitigations.		
Does the report highlight any health inequalities implications?	Yes – the plan details where we are using opportunities to level up services, e.g. mental health service provision on the east coast.		
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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Report previously presented at:			
As listed above.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			



Lincolnshire
Integrated Care Board

Lincolnshire Integrated Care System

Winter Preparedness

2024-2025



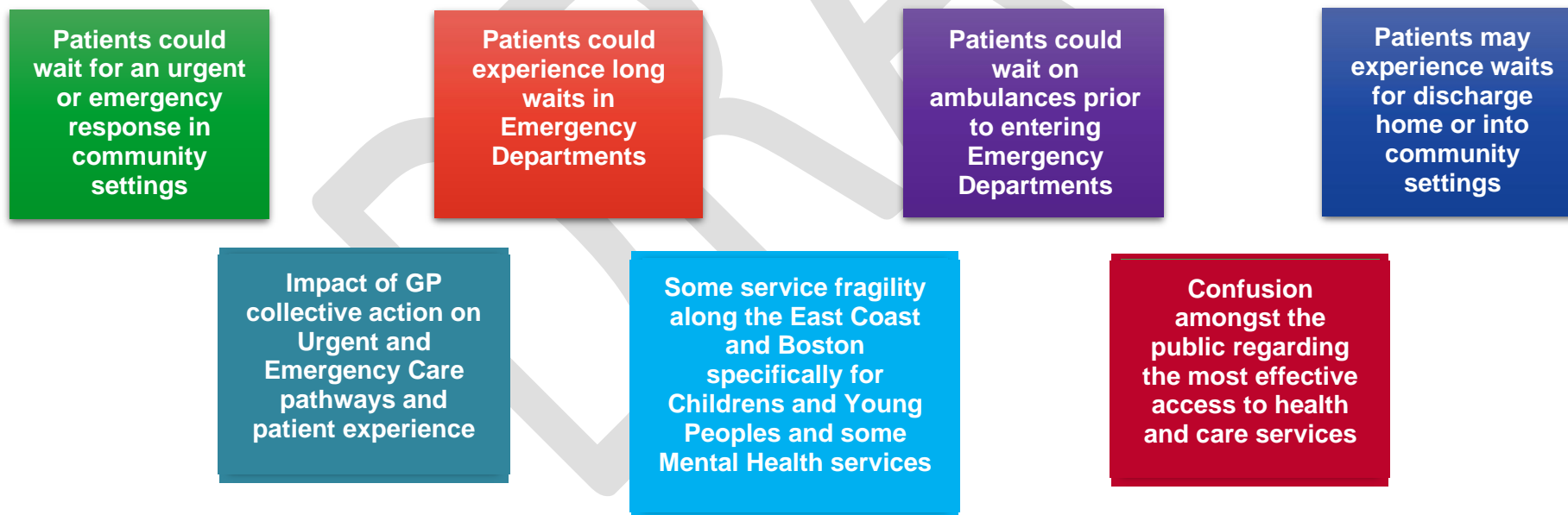
Executive Summary

The Lincolnshire Integrated Care System (ICS) Winter Plan for 2024/25 has been developed collaboratively and influenced by national winter guidance issued by NHS England as well as applying learning from previous winters within our local system, regionally and nationally.

During the summer of 2024, the Lincolnshire system experienced sustained levels of demand following the winter period and did not experience the usual small dip in activity. We must ensure that our services can respond to the expected increases in demand over winter and that resilience can only be achieved through continued partnership working across the health and care system. As partners of the Lincolnshire ICS, we are committed to working together to manage these challenges and ensure that our population can access safe services and have good outcomes with a positive experience.

The purpose of this Winter Plan is to highlight the local assumptions for winter and set out our planned response to manage the urgent care and patient flow pressures that the system will inevitably experience. The plan is designed to supplement the ongoing improvements and developments in urgent care in line with the National Urgent and Emergency Care Recovery Plan and is inclusive of those requiring both physical and mental health care. During August 2024 NHS England Midlands Regional team shared a set of Key Lines of Enquiry (KLOEs) to support development of local winter plans.

This year we have again focussed on the avoidance of patient harm by adopting an approach that focuses on clinical risk, the main areas of risk in the Urgent and Emergency Care pathway are as follows:



Contents

1. Introduction
2. Context
3. Preparation for Winter 2024/25
 - 3.1 Capacity and Demand Reviews
 - 3.2 Trends, Forecasts and Impact of Infectious Disease
4. Winter Response
 - 4.1 Primary and Community Care
 - 4.2 Hospital Care & Discharge
 - 4.3 Mental Health
 - 4.4 Children & Young People
 - 4.5 Specific Support for Care Homes
5. System Working and Escalation
 - 5.1 System Co-ordination Centre
 - 5.2 Escalation and Assurance
6. Workforce
7. Quality and Risk Management
 - 7.1 Risk Management
8. Communication
9. Conclusion & Evaluation

1. Introduction

Integrated care is about ensuring that people get the help and support they need, joined up across local councils, the NHS, and other local partners. It removes traditional and historical divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care and over the years we have recognised the importance of all local health and care providers and commissioners working together to provide the best services we can.

This document outlines the Lincolnshire collective response to urgent and emergency care during anticipated peak times of demand, during winter, to ensure patients get the safest, most effective, and efficient services responding to their need. This winter we recognise the importance of managing patients wherever appropriate and safe to do so including within their own homes or usual place of residence, providing health and care in an integrated way and relying less on acute inpatient services. This plan sets out how we will ensure services provided by each of the partners that make up our system will be resilient through this winter. We have arrangements across all Lincolnshire ICS partners to manage patient flow between our services. Working together, we use the Operational Pressures Escalation Level (OPEL) system which identifies the actions we all need to take when we are under increased pressure.

We learned much from the pandemic and from our response during that time and importantly it demonstrated that, on a day-to-day basis, all our partner organisations in Lincolnshire are stronger and better when we work more closely together. We have a shared commitment and determination to ensure people are cared for in the right place at the right time, so that they can achieve the best health outcomes.

During 2024 we have continued to deliver our system Urgent and Emergency Care strategy and our overall vision for Urgent and Emergency care in Lincolnshire is:

“System Partners in Health and Care from across Lincolnshire have together committed to support people who present to our services in an emergency or with urgent needs to access safe, seamless, compassionate and timely care in the right place from the right team.”

The recent review by Lord Darzi highlighted nationally several key themes for the 10-year health plan which align to our vision, including:

- Engagement of staff and empowerment of patients
- Shift care closer to home
- Simplify care delivery
- Increase use of technology

In addition, we continue to ensure that our clinical ambitions detailed below are at the forefront of all Urgent and Emergency Care service delivery and any improvement work undertaken.

- ✓ **Our team members have optimal time and resources to provide great care, in line with agreed professional standards.**
- ✓ **Our patients and team members are treated with respect, kindness, and compassion.**
- ✓ **Our teams work collaboratively across the whole system, to join up care in a way which matters to our patients and those who matter to them.**
- ✓ **All patients are cared for in an appropriate and safe environment, minimizing the risk of hospital acquired infection and harm.**
- ✓ **Patient records are shared across clinical teams to enhance patient safety and reduce the need to share the same information multiple times.**
- ✓ **Where possible care is delivered 'closer to home,' if patients need a stay in hospital, they are admitted quickly to the right bed to meet their clinical needs and when they are ready, they are discharged home without delay.**
- ✓ **Our culture is one of learning and continuous quality improvement.**

As a system we will work together to drive delivery of the plans set out in this document, managing risk and daily patient flow between all our partners through our System Co-ordination Centre who, along with our Winter Director, will ensure a continuous focus on this plan so we deliver the safest, most appropriate care we can, for the population of Lincolnshire, over the winter months.

2. Context

The purpose of this winter plan is to demonstrate the Lincolnshire system approach to operational management of winter, detailing the specific pressures anticipated for our system and how we intend to mitigate them to ensure we deliver our vision for Urgent and Emergency Care across the county.

Urgent and Emergency Care continues to be under significant pressure both locally and nationally and we have faced our busiest summer for many years with increasing numbers of people attending our Emergency Departments and Urgent Treatment Centres as well as high levels of wider system demand within primary, community and mental health care. Despite the growing demand for urgent care services, we have made some notable improvements for our population with a marked improvement in overall category 2 ambulance response times and a reduction in handover delays from our ambulance service (East Midlands Ambulance Service) to our acute provider (United Lincolnshire Hospital Trust). However, there is still much more to do, alongside delivering our commitments in relation to cancer care, elective (those needing operations) and outpatient care, maternity and children's and young people's care, as well as mental health care and support for those with, learning disabilities and autism.

Planning assumptions for the upcoming winter have been informed by data and insights from the UK Health Security Agency (UKHSA). Infectious diseases such as Influenza, Covid-19, and Norovirus typically place increased strain on health and care services during the winter months. While the expected profiles of these common infectious diseases for winter 2024/25 are not yet fully understood, early planning assumptions are based on a cyclical pattern, with a likely early impact like that of the previous winter. To manage the associated risks, the Lincolnshire system has implemented the following measures:

- ✓ **Arrangement with our community provider to prescribe influenza prophylaxis to those meeting the clinical requirements.**
- ✓ **Covid 19 Medicines Delivery Unit (CMDU) moving to 7-day service for winter.**
- ✓ **Care Home Infection Prevention and Control (IPC) support including local outbreak management support, with dedicated Senior Health Protection Nurse for each setting.**
- ✓ **Integrated Health Protection approach across the system and Infection Prevention and Control collaborative in place.**
- ✓ **Integrated Care Board (ICB) engagement in all outbreak meetings across the system.**

As we navigate the post-pandemic landscape, our focus remains on protecting those in society who are at a higher risk of severe Covid 19 infection and other infectious diseases. To achieve this, we continue to implement planned and targeted vaccination programmes across the county. Ensuring

a sustainable Covid 19 vaccination programme is a crucial aspect of health protection, and we are committed to making vaccination services accessible to all eligible groups. The Lincolnshire Covid 19 vaccination programme has been highly successful, achieving excellent uptake amongst our population, and we take pride in continuing to be one of the best performing systems both regionally and nationally.

Our vaccination strategy includes:

- ✓ **Care home residents and staff to be prioritised early in the programme and Covid 19 vaccination to begin by 3rd October 24.**
- ✓ **Covid 19, and influenza vaccination delivery through a combination of Primary Care Networks and their GP Practices and Community Pharmacies providing local access to vaccinations.**
- ✓ **Respiratory Syncytial Virus (RSV) programme commenced 1st September 24 for those aged 75 – 79 years old delivered by GP Practices.**
- ✓ **Assurance that we have a skilled and competent workforce to deliver the programmes safely.**
- ✓ **Delivery of a co-ordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and incorporates appropriate health advice/screening where appropriate.**
- ✓ **Provision of dedicated clinics for at-risk children and our school based programme for all eligible Primary and Secondary school children in Lincolnshire.**
- ✓ **A robust staff vaccination plan, delivered at various locations across the county which champions peer to peer vaccinations.**
- ✓ **A dedicated Immunisation programme team will monitor performance and ensure all eligible cohorts have access to a vaccination, this includes coordination of a roving vaccination model to deliver to housebound patients, care homes and other settings.**

Uptake targets for Covid 19 vaccination are 76% of all eligible cohorts and we expect to achieve or exceed this based upon previous performance. The influenza vaccination programme starts in October for adults aged over 65 and those identified as at risk and in September for our eligible school age children. All 82 General Practices across Lincolnshire will be offering influenza vaccine with most offering them alongside Covid 19 vaccines.

3. Preparation for Winter 2024/25

Building on our learning from last winter, and the work undertaken throughout the year including our Urgent and Emergency Care Strategy and the Urgent and Emergency Care prioritisation work completed by all system partners, the following preparatory work and actions has been undertaken:

- **May:** Finalisation of 24/25 operational plan assumptions around capacity and demand plans including winter period.
- **May:** Review of winter learning at Urgent and Emergency Care System Leadership Group and Service Delivery and Performance Committee
- **July:** System clinical and quality meeting facilitated by the ICB Medical Director in response to the 'Maintaining focus and oversight on quality of care and experience in pressurised services' letter from NHS England.
- **August:** System Winter Workshop to review the anticipated requirements of the NHS England winter letter 24/25, respond to winter Key Lines of Enquiry (KLOEs) for the NHS England Midlands Region and determine and agree priority areas of focus for the Lincolnshire winter plan.
- **August:** Formal response to the regional winter KLOEs with high levels of assurance.
- **September:** System attendance at the NHS England Midlands regional winter event with early indications of national expectations.
- **October:** Local confirm and challenge of the system winter plan and finalisation of any winter initiatives.

In July 2023, NHS England wrote to all Integrated Care Systems setting out the national approach to [deliver operational resilience across the NHS this winter](#), building on the Urgent and Emergency Care Service (UEC) Recovery Plan published in January 2023, which was followed up in May 2024 with a year 2 plan to build on learning from year 1.

In September 2024, NHS England published the winter and H2 priorities letter which set out expectations of the NHS to support people to stay well and to maintain patient safety and experience, <https://www.england.nhs.uk/long-read/delivering-operational-resilience-across-the-nhs-this-winter/>. The letter provides focus in relation to performance metrics and this plan has been developed to support our key performance targets including our category 2 ambulance response times, ambulance handover delays and the time people wait in our Emergency Departments.

In addition, the letter specifically requests that we review progress against the 10 High Impact Interventions for Urgent and Emergency Care which were originally detailed as part of the Urgent and Emergency Care Recovery Plan. A self-assessment against the national framework has been completed and provides strong assurance against 9 of the interventions with them all either increasing their maturity score, compared to the assessment completed last year, or remaining the same with ongoing improvement where the score was already high. The exception to this is the provision of Acute Respiratory Infection (ARI) hubs which were in place as a pilot last winter. A review and evaluation of that pilot has been undertaken and a new model for winter 2024/25 is in development.

3.1 Capacity and Demand Reviews

Capacity and Demand assumptions for Winter 2024/25 were originally submitted as part of our operational plan for 24/25 earlier in the year, however, we continuously revisit and challenge our original modelling assumptions both using the current activity and performance data, and when new interventions are mobilised for changes and improvements made to ensure that they are rebased using shared learning. Working across system partners we will undertake dynamic reviews of demand and capacity modelling to understand and manage winter pressures effectively, minimise excessive delays in the Emergency Departments including waits for admission and ambulance handover delays.

Throughout the winter period we will continue to refine and redefine modelling work considering:

- **Further Urgent and Emergency Care programme and winter initiatives as they come online together with assessing our assumptions for level of impact.**
- **The impact GP Collective Action.**
- **The position against recovery plans for Elective and Cancer activity and performance.**
- **The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19 and RSV.**
- **Met Office forecasting for excessive cold weather periods, as a predictor of increased respiratory conditions and falls.**

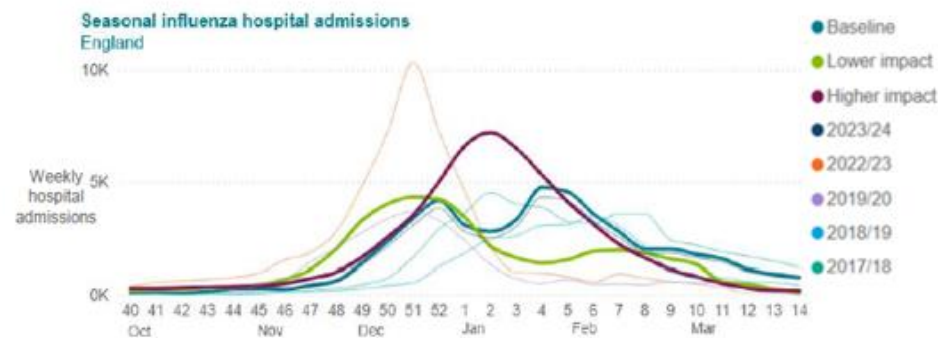
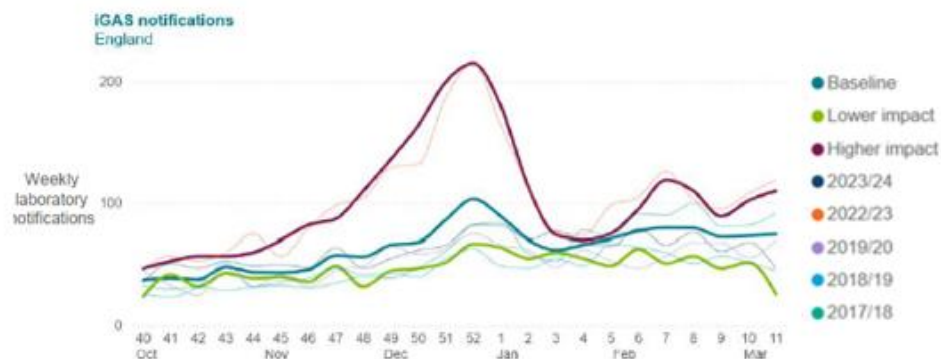
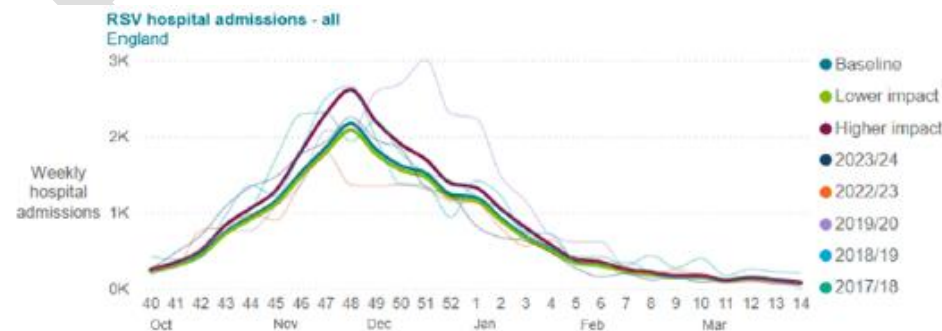
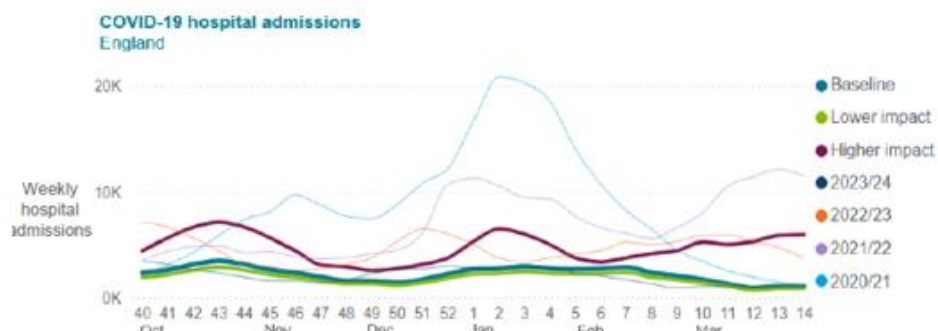
The capacity and demand modelling continues to suggest three key areas of focus for our system during winter which are critical in ensuring our urgent care system can manage the anticipated pressures:

- **Attendance Avoidance**
- **Admission Avoidance**
- **Reduced Length of Stay**

3.2 Trends, Forecasts and Impact of Infectious Disease

Predicting trends and peaks in demand during the winter period is crucial for mitigating risks and managing system pressures. However, it remains challenging to accurately forecast what the winter 2024/25 period may look like in terms of Covid 19, Respiratory Syncytial Virus (RSV), Invasive Group A Streptococcal (iGAS) disease and Influenza. Despite this uncertainty, the transmission levels of viral respiratory pathogens in late summer were as expected, suggesting that we are likely to see similar levels this winter as in recent years.

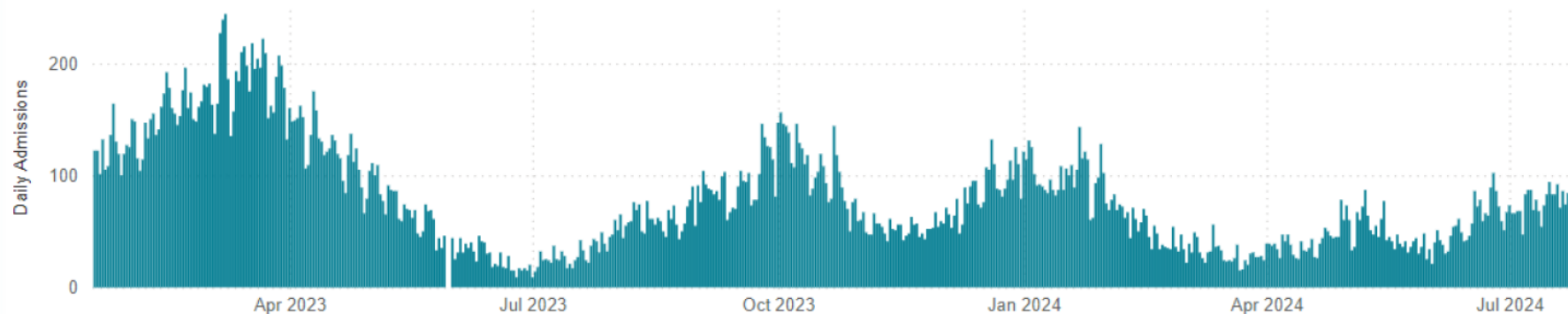
This suggests that we are likely to see highest rates of Influenza, Covid 19 and RSV during late December and early January. This period coincides with Christmas, New Year, and the re-opening of schools, which aligns with hospitalisation and disease notification trends from previous years, as illustrated in the charts below. Last winter, RSV followed the expected 6-week epidemic pattern, peaking in November and December, with the highest admission rates in the 0–4-year age group. Nationally, influenza activity in 23/24 was lower but observed over a longer period, resulting in fewer hospitalisations compared to previous influenza seasons.



Covid 19 admissions to hospital across the Midlands during 2023/24 followed a cyclical pattern which is likely to continue throughout winter 2024/25.

Daily number of COVID-19 patients admitted to hospital

Midlands data



Norovirus has been higher across the East Midlands and England during the summer months, which is seasonally atypical, however at this time there is nothing to suggest that the typical winter presentation will not occur.

Measles cases are now declining after a significant outbreak across England in early October 2023, primarily centred in Birmingham. To date, Lincolnshire has reported minimal cases. Our focus remains on our preventative work which includes robust infection, prevention, and control measures, as long with as targeted vaccination campaigns, to prevent and contain any potential outbreaks within the county.

Pertussis (whooping cough) cases have remained stable over the summer period but may increase in the autumn. These outbreaks are believed to be linked to reduced exposure during the Covid 19 pandemic. Effective vaccination campaigns, particularly targeting pregnant women, are crucial in preventing and controlling potential cases.

All respiratory syndromic data will be analysed weekly to ascertain significant changes in prevalence and incidence, as well as short-term trajectory. These data will be shared across the system fortnightly, or on a needs basis based on likely impact, to ensure the system is informed on potential future demand caused by communicable diseases.

System wide plans are in place to mitigate risks associated with both respiratory and other communicable diseases which may pose a threat this winter. This includes plans for respiratory viruses (covid, flu, RSV, pertussis, and others), Mpox, measles, and other vaccine preventable diseases. All plans include proactive and reactive elements, ensure that the system is doing all they can to increase vaccination uptake, cascade key messages of how to keep yourself well, whilst also planning for significant outbreak response.

4. Winter Response

Over the last two years NHS systems have received financial investment for service improvement and additional monies to provide short term winter services. This year, money was received as part of our overall financial allocation at the beginning of the financial year to aid planning and to allow systems to continue to fund those initiatives implemented over the last two winters in a sustainable way.

Within Lincolnshire we have used our allocation to fund:

- ✓ **Community services to support attendance and admission avoidance and to help patients be cared for in their own homes or usual place of residence.**
- ✓ **Children and young people (CYP) services, both within community settings and within our Emergency Departments.**
- ✓ **Capacity within our Urgent Treatment Centres, Emergency Departments and Same Day Emergency Care (SDEC) units.**
- ✓ **Jointly commissioned with Lincolnshire County Council, Active Recover Beds with Primary Care and Adult Care support.**
- ✓ **Capacity for those patients being discharged from hospital that require rehabilitation services (Pathway One).**
- ✓ **Extra acute and community bed capacity to be used during times of surge.**
- ✓ **Capacity to support discharge processes across acute and community settings.**
- ✓ **Extra transport capacity to support hospital discharge.**
- ✓ **Additional therapy support to patients in community hospitals to increase flow**
- ✓ **Additional support for patients, their relatives and carers who have been discharged from our Emergency Departments not requiring admission to hospital.**
- ✓ **Enhanced pharmacy support for those with complex illness following discharge from hospital.**
- ✓ **Development of cardiology and respiratory Hot Clinics to reduce unnecessary admission to hospital.**
- ✓ **Increased Mental Health support for those living in Boston and the east coast localities.**

4.1 Primary and Community Care

Whilst the impact of GP Collective Action remains an unquantifiable risk the impact on Urgent and Emergency Care pathways could be significant, to support mitigation the Integrated Care Board has introduced a system framework for monitoring, identification of early impact and to ensure a coordinated response to any escalations.

There is an ongoing review of Primary Care Network (PCN) plans to make sure that these are being optimised ahead of winter. The work on self-referral pathways is also continuing to promote and increase utilisation. Supporting use of online consultation tools will enable access and reduce system demand.

The ongoing expansion of community capacity and increase in utilisation of community services is key in delivering our ambition to reduce reliance on acute services. We know that increasing numbers of patients are accessing our Urgent Treatment Centres and demand across community services is growing. Wherever possible we continue to work with wider system colleagues to ensure that wherever appropriate and safe to do so we are accessing alternatives to attendance and admission, supporting people in their own home or within community settings through:

- ✓ **Consistent risk stratification of patients to proactively identify and support those that are vulnerable and frequent users of our services by Care Co-ordinators within Primary Care Networks and neighbourhood teams.**
- ✓ **Maximise utilisation of our 2-hour Urgent Community Response (UCR) service and other community-based admission avoidance pathways.**
- ✓ **Maximise utilisation and capacity of Virtual Wards across Lincolnshire.**
- ✓ **Single Point of Access (SPoA) for Health Care Professionals (HCPs) to help navigate admission avoidance pathways including ambulance crews calling for community support before conveying to an Emergency Department.**
- ✓ **Integration of the Lincolnshire Clinical Assessment Service, the East Midlands Ambulance Service (EMAS) Emergency Operations Centre and the LIVES falls service to support timely and appropriate responses to people in the community.**

We have heard clearly from our clinicians that attendance and admission avoidance pathways need to be simplified and the introduction of the Lincolnshire Single Point of Access (SPoA) will further support simplification of access with professionals across the system not needing to know which service they need. The SPoA was established during winter 23/24 and has continued to develop and is now available 24/7 and fully integrated into our system. A full operational and clinical review of our Virtual Wards is currently underway to ensure that we can maximise this capacity, fully, over winter, and we recognise the opportunity to increase the step-up utilisation to enable patients to be supported at home without the need for a hospital attendance.

Frailty care and support continues to be a focus for Lincolnshire and this year we have developed a delivery model to implement the Lincolnshire Older Peoples Strategy which focuses on 5 connected pillars, Proactive Care, Primary Care' Single Point of Access, Integrated Services, and an Integrated Workforce.

To date we have progressed the following which will help support our older adult population:

- ✓ **Communications plan which will launch in October to support older people to age well including directing people to existing services, campaign leaflets, films, pop up events, and published service details.**
- ✓ **14 pro-active care interventions to support older people living with frailty with harder to reach populations prioritised.**
- ✓ **Frailty specific acute same day emergency care.**
- ✓ **Centralised point of access, via our Single Point of Access for Health Care Professionals for all frailty needs.**
- ✓ **Training for our workforce on undertaking comprehensive geriatric assessments (CGAs) to commence in October.**

4.2 Hospital Care and Discharge

Planning for effective hospital care and discharge must start at the point of arrival at one of our hospitals. Whilst we have made some significant improvements to ambulance handover delays, we are committed to ongoing improvements, so our patients receive safe and effective care in a timely way and delays are reduced to minimum. Over the winter period ambulance crews will have continued direct access to a range of alternative settings where clinically safe to avoid an Emergency Department.

Where patients are admitted to inpatient areas for care we will ensure that they are discharged in a timely way with the correct level of support and with full assessments taking place outside of the hospital setting. The ethos of Discharge to Assess (D2A) is well embedded within the system which means we should have capacity and skill available to make patient assessments in their own home rather than in a hospital setting, and to wherever possible and safe to do so, support patients in their own home rather than in a bedded service.

Ahead of winter, system partners have implemented new processes to improve community bed outcomes, and support efficiency and flow. This includes clinician to clinician referrals pulling the most appropriate patients for therapy beds and supporting maximising Discharge to Assess capacity, flexible support for social care led Active Recovery Beds and piloting an Assertive In Reach service as well as Therapy at the Front Door to maximise Discharge to Assess discharges from our Emergency Departments rather than following an inpatient stay.

In addition, we will also:

- ✓ **Reduce the number of patients experiencing long waits in our Emergency Departments by ensuring our senior clinical decision makers are available at our front doors and undertake rapid improvement cycles (sprints).**
- ✓ **Maximise utilisation and impact of our Clinical Navigators employed by East Midlands Ambulance Service (EMAS) to ensure people arriving on ambulances are directed to the most appropriate place within the hospital.**
- ✓ **Ensure dedicated space within our Emergency Departments is available so that in times of escalation people can still access hospital care and not be waiting on ambulances unnecessarily.**
- ✓ **Minimise delays for people being discharged from hospital across all pathways supported by our Transfer of Care Hubs and our non-emergency transport service which will respond to the growing requirements for additional support that patients need upon discharge from hospital.**

4.3 Mental Health

The implementation of the Mental Health Urgent Assessment Centre in Lincolnshire continues to be a great success and ensures that those patients with a mental health need only, do not need to attend our hospital Emergency Departments and instead they can attend a more appropriate environment which provides a better patient experience and improved outcomes. The service now delivers an all-age model of care, further supporting our Emergency Departments and Urgent Treatment Centres with Children and Young People presenting with a mental health need this winter.

Patients in Lincolnshire will continue to be supported by robust crisis and home treatment teams and the integration of those services with NHS 111 option 2 Mental Health service was introduced in the early summer. This provides 24/7 Mental Health advice and increases capacity for our crisis teams who were managing these calls previously. Crisis house capacity and 'Crisis Café' provision is in place across the county.

Two crisis response vehicles are in operation across our county to respond to those with urgent mental health needs alongside a trained nurse who is based within the Police Control Room to support any calls and required response to 999.

We also invest in our Voluntary, Community and Social Enterprise (VCSE) partners over the winter period by creating warm spaces within our wellbeing hubs, allowing our community connectors to establish targeted additional capacity in the form of initiatives to support people over the winter period, alongside additional capacity in some of our wider mental health and wellbeing VCSE projects which provide activities tackling suicide prevention, social isolation, befriending or other wellbeing support.

Key activities to increase resilience of the winter period include:

- ✓ **Employing dedicated staff to run the Crisis Vehicle Response (CVR) and Police Control Room (PCR) functions.**
- ✓ **Expanding alternatives to specialist crisis services, including the expansion of crisis cafes across the county.**
- ✓ **Expansion of Voluntary, Community and Social Enterprise support to create warm spaces within our wellbeing hubs.**
- ✓ **Online resource to help people to navigate support and training - www.haylincolnshire.co.uk**
- ✓ **Integrate Mental Health Support with NHS111 and supplement the local mental health helpline.**
- ✓ **Mental Health Urgent and Emergency Care champions to raise awareness, provide visibility and interface with system partners.**
- ✓ **Reducing the number of patients experiencing long waits in our Emergency Departments by ensuring our senior clinical staff are available to support decisions.**

4.4 Children and Young People

Children and Young People with physical and mental health needs are a priority cohort for the Lincolnshire system this winter. We have continued with last year's investment in both paediatric support in our Emergency Departments and we continue with our recruitment plans to increase our Child and Adolescent Mental Health service capacity in the Boston and east coast localities.

We have recently secured a pilot for Family Support Workers at Lincoln County Hospital funded by Barnardo's, these Family Support Works will support those who have attended with low level illness at either our Emergency Department of Urgent Treatment Centre, as well as supporting Children and Young People who attend with asthma by organising access a post exacerbation review and annual review at their GP practice.

4.5 Care Homes

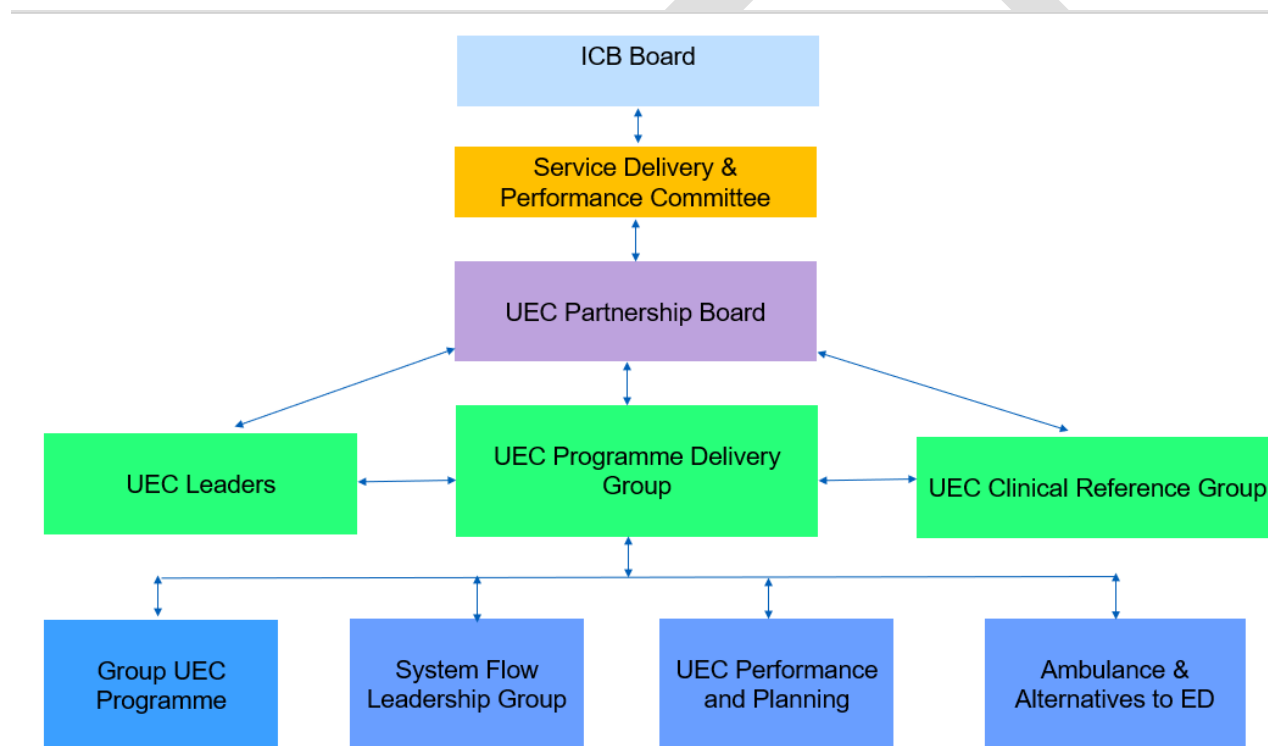
Keeping people well at home is a key strategic component of the Lincolnshire 'Home First' strategy and that includes people where a care home setting is their own home and usual place of residence. When those living in care homes become ill, staff have swift access to health care support. In Lincolnshire the Clinical Assessment Service (CAS) has a dedicated service (CAS for care homes) available for care home staff where senior clinical advice can be accessed swiftly. We have also invested in CAS this year with increased capacity and skill set that will further support care home staff and wider system professionals to support people without the need for inpatient care wherever appropriate and safe to do so. Digital telehealth has also been available across Lincolnshire for several years but during this winter period we will ensure that this strategy is maximised.

Each care home has an identified 'wrap around' PCN led Enhanced Health in Care Homes Team which undertakes weekly meetings with the care home and Multi-Disciplinary Team (MDT) discussion to proactively manage any identified patients who may have health concerns. Each care home is aligned to a Primary Care Network and with a named clinical lead. This is in addition to a named Nurse through the Local Authority Health Protection Team. Leading into the winter period all care homes will receive regular updates with detailed information on how to manage seasonal illnesses which will include guidance related to testing for COVID-19 and other Acute Respiratory Infections and pathways for escalation to the Local Authority and other Health partners. Seasonal webinars are being offered to all Adult Social Care settings in addition to the core education offer providers receive through the IPC Link Champion Programme and there will continue to be access to advice and guidance through the Local Authority Health Protection Duty Desk during the week and UKHSA East Midlands Team Out of Hours.

Falls in care homes remains a priority and this year 80 care homes have received raiser lifting equipment from the Integrated Care Board to assist with Falls response. An overarching policy has been agreed to assist with staff training, which is almost complete and will complement our bespoke commissioned falls service across our county.

5. System Working and Escalation

The Integrated Care System Urgent and Emergency Care Partnership Board (UECPB) has strategic responsibility for overseeing the development and mobilisation of robust winter capacity and resilience plans for Lincolnshire. The Performance and Planning Group has operational responsibility to monitor performance over winter and plan, accordingly, escalating as required. Our governance arrangements are detailed fully below:



Whilst the Urgent and Emergency Care Partnership Board meets monthly, the Urgent and Emergency Care Leaders Group and the Urgent and Emergency Care Clinical Reference Group meet weekly over the winter period, providing strategic and clinical leadership and guidance whilst maintaining oversight of system pressures and risk.

5.1 System Co-ordination Centre

System Co-ordination Centres (SCC) were introduced across England in 2022 to ensure the safest highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services.

The Lincolnshire SCC ensures that there is robust oversight of all system pressures and is operational 8am – 8pm, 7 days per week, reporting to the ICB Deputy Director for System Delivery with escalation to the Director for System Delivery and Senior Responsible Officer for Urgent and Emergency Care. After 8pm a full operational handover to ICB Strategic and Tactical On Call Commanders ensures full visibility of pressures and risk going into the overnight period. On-call commanders in the ICB attend provider escalation calls throughout the overnight period as required for support in addition to usual escalation processes and are also able to rapidly convene system calls as required.

The Lincolnshire SCC lead on monitoring demand, capacity and pressure within the system as follows:

- ✓ **Daily system calls 0930 and 1300hrs, these facilitate early warnings of current and potential issues that are logged, and actions raised for that day.**
- ✓ **Level of escalation for each provider discussed on system calls, including reasons for level and how we can work as a system to de-escalate where necessary.**
- ✓ **Extra system calls added if continued high demand.**
- ✓ **Attendance at Regional Reporting and Escalation Call each day.**
- ✓ **Continued monitoring of demand using a range of digital options and dashboards including but not limited to SHREWD Resilience dashboard and East Midlands Ambulance Service arrivals screen to pre-empt any delays.**

In addition to the operational management of the system the SCC also have dedicated staff to help rapidly diagnose issues, complete lessons learnt through rapid cycles of improvement, this is a fundamental element of the SCC as we strive to improve our performance across the county and ensure our patients receive timely access to Urgent and Emergency Care.

The SCC continually monitors systems pressures through reviewing data and daily calls with system partners to review new and emerging risks. It has clinical leadership and Standard Operating Procedures to ensure consistent escalation into the ICB nursing and quality leads. In periods of escalation nursing and quality leads join system calls to provide clinical input and oversight. Over the winter period the SCC will continue to facilitate collaboration between system partners to enact resource sharing and resource flexing to increase flow out of acute settings.

5.2 Escalation and Assurance

The use of the NHS Operational Pressure Escalation Levels (OPEL) Framework and associated Action Cards are fundamental to the delivery of assurance and governance for our system. Managed by our System Coordination Centre through daily calls which provide a focal point of operational escalations and support and by working collaboratively with our system partners to resolve daily issues and challenges. Our SCC and partners utilise the framework to ensure the correct level of response and urgency which is vital to ensuring a consistent system response which can be benchmarked with other systems.

Executive level leadership for winter is in place with weekly oversight by our system Urgent and Emergency Care Leaders Group which is chaired by the ICB Winter Director for Lincolnshire. Our Chief Executive Officers, along with our Chief Operating Officers and ICB Winter Director meet twice weekly to consider Urgent and Emergency Care issues and oversee delivery and response as well as monthly updates by the Winter Director to the Service Delivery and Performance Committee during the winter season for oversight and assurance from our Non-Executive Directors.

6. Workforce

When we consider workforce we do this through two lenses, firstly how our workforce feel, particularly when under pressure and making sure they have the right support to remain well and in work and secondly how we will move our workforce around where needed if critical services are understaffed. Keeping our staff well this winter is part of supporting residents and patients across the system. All organisations are putting a strong emphasis on the importance of having wellbeing conversations with team members to support their physical and mental health and signposting them to our services across the system where necessary. We are providing the following support to our people:

- ✓ **Ensuring that managers are having the right conversations with their teams and signposting appropriately.**
- ✓ **Influenza and Covid 19 vaccinations will be made available to all eligible staff.**
- ✓ **Continuing to operate a hybrid way of working which includes, for those that can, a mixture of working from home and office based.**
- ✓ **Our system Wellbeing Hubs, provided by our Mental Health Trust have a range of support from financial wellbeing to mental health support and ideas for physical activity.**
- ✓ **Each organisation has an Employee Assistance offer which staff can access as well as Occupational Health services.**
- ✓ **We have a number of cultural ambassadors, Mental Health First Aiders and Mentors across the system who are all offering their support for one-to-one conversations where needed.**

We have a Memorandum of Understanding in place across the Lincolnshire health and care system which allows the sharing of workforce across individual organisations. This was used successfully during the Covid 19 pandemic and would be utilised again to mitigate against any potential escalation in demand or shortage of workforce.

7. Quality and Risk Management

People in our care as well as their families and carers deserve to be treated with kindness, dignity and respect and receive safe standards of care. There is a shared responsibility across all our services to ensure quality (patient safety, experience, and outcomes) and we are working with partners to:

- ✓ **Provide alternatives to Emergency Department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.**
- ✓ **Maximising in hospital flow with timely discharge regardless of the pathway a patient is leaving hospital or a community bedded facility on.**
- ✓ **Ensuring that all care settings have the basic standards of care in place based on CQC fundamental standards. This includes a project called 'Care and Comfort' which is improving the overall quality and safety of patient care and experience within our Emergency Departments and Urgent Treatment Centres.**
- ✓ **Working to ensure safe timely discharge out of Emergency Departments and out of hospital.**
- ✓ **Reviewing services and providing feedback to ensure quality is maintained.**

7.1 Risk Management

The system Urgent and Emergency Care programme maintains a risk register which is routinely reviewed as part of programme delivery but also in the context of winter, the Winter Director will have ownership of any risks in relation to this plan, overseen by the Urgent and Emergency Care Leaders Group.

As identified, there are several unknown variables now that are likely to be influential on the success of our winter plan and the ability of the system to deliver safe and effective care during the winter period. These include:

- Measuring the impact of rapid improvement initiatives across the system and whether they deliver the assumed improvement.
- The potential unquantified impact of GP Collective Action
- The position against Elective and Cancer Recovery plans.
- The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19, RSV and potential impact of national threats such as Mpox.
- Met Office forecasting for excessive weather including:
 - The potential for flooding in Lincolnshire as a result of heavy rainfall
 - Cold weather periods and the impact of national changes to the eligibility for Cold Weather Payments, as a predictor of increased respiratory conditions.

As a result, the overarching risk remains:

'As a result of demand exceeding capacity and despite investment and service developments detailed within this plan, we may still be unable to mitigate against all risks, previously outlined, to ensure our patients receive safe, timely and accessible care'.

8. Communication

The Urgent and Emergency Care Winter Communications Plan for 2024/25 aims to co-ordinate the joined-up communications work already happening across Lincolnshire into a single point of reference for stakeholders. This iteration of the plan includes specific actions around the winter period and 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 will originate both from system partners and the national team who produce dedicated winter campaigns and resources. The objectives of this plan are to:

- ✓ **Raise awareness of the wide range of services that are available across Lincolnshire.**
- ✓ **Prioritise the ‘talk before you walk’ message about seeking the right service for your care needs.**
- ✓ **Ensure that those who should be attending our facilities do so and are not dissuaded by messaging.**
- ✓ **Normalise the discharge conversation when in a hospital setting.**
- ✓ **Use staff communications to promote the patient safety message for improving Urgent and Emergency Care performance**
- ✓ **Put in place a trusted series of comms actions when the system is in an escalated position**
- ✓ **Using social marketing techniques to deliver a targeted behavioural change approach which will supplement our standard communications support**

Our communications delivery will adhere to the following principles:

- Speak as one local Lincolnshire voice.
- Seek to influence behaviour through behavioural change/social marketing techniques.
- Prioritise signposting to appropriate services.
- Ensure that staff well-being messaging is a key part of our communication.
- Ensure that mental health is a key part of our messaging.

This winter, we have segmented our approach into five key areas:

1. Talk before you Walk

Use of national '111 First' messaging and localised campaigns (including the use of local case studies) encouraging patients to seek the right service for their care need. This will include:

- Localised talk before you walk campaign using a series of local patient case studies to encourage people to think about their choices and behaviours in making a decision about how to access care
- Promoting use of the WaitLess App
- Educating the population to think pharmacy first
- Promoting the use of NHS 111/ NHS 111 online
- Promoting the mental health element of NHS 111, alongside other local emotional support helplines and walk in at mental health urgent assessment centre
- Working with primary care to highlight the most appropriate place/s to signpost patients to

2. Core communications approach

Including delivery of our Warning and Informing Emergency Preparedness Resilience and Response (EPRR) responsibilities and promotion of vaccination programmes, prevention, and self-care campaigns.

This will include use of national resources around the below, as well as internal and external communications, as required, around specific Lincolnshire projects:

- Discharge communications - utilising Where Best Next and resources
- Admissions avoidance messaging
- Promotion of the vaccinations programme for both Covid19 and Influenza
- Promotion of the importance of looking after our own mental wellbeing
- Ordering medications early for Christmas and New Year Bank Holidays

3. Escalation management approach

Our reactive and escalation communications approach will be taken in line with system escalation levels, as described below:

Operational Pressures Escalation Levels	
OPEL 1 & 2	<p>Messaging posted on social media in line with usual organisation and system social media plans. Plans to incorporate seasonal messaging, including:</p> <ul style="list-style-type: none"> • Promotion of the range of services that are available • Promotion of Hay Lincolnshire and Night Light cafes • Promotion of WaitLess • Promotion of self-care • Promotion of NHS 111 online and NHS 111 • Promotion of mental health helplines and urgent assessment centre • Promoting pharmacies and what they can offer
OPEL 3	<p>Messaging posted on social media as above, plus a slight reduction in organisational focused message, and increased posts on:</p> <ul style="list-style-type: none"> • Accessing services locally • Discharge messaging – internally and externally <p>Where there is an identifiable specific cause of increased pressure, which public messaging can influence, unique social media content will be developed and shared.</p>
OPEL 4	<p>Messaging posted on social media as above and paid for targeted social media activity to be stepped up where there is prolonged pressures or industrial action and would be requested by Strategic Command meetings. Where there is a clear group/location needed to be targeted, communications colleagues to step this up sooner at their discretion.</p> <p>System to stand down non-urgent messaging on social media and unite behind key messaging agreed with tactical/ops leads. This will incorporate any key asks of the public. Wider distribution through ICS partner channels e.g. local authority, fire, police, VCSE to be encouraged.</p> <p>Social media response to be developed in line with the agreed key messages, may include a short clip from a designated spokesperson, image/text, infographic, stories – this will depend on time pressures and professional advice given by communications team.</p> <p>Work with local media to push messaging.</p> <p>Next Door to be used as an additional channel to reach specific neighbourhoods. We will offer proactive/reactive media interviews from representatives.</p>

4. Data-driven behavioural change campaign

Using data and insight to develop a social marketing behavioural change campaign, focussed on those demographics and conditions which we know are driving significant attendances to our Urgent and Emergency Care services. We will extend the work we undertook in 23/24 on this element of our communications, incorporating the learnings from our campaign reporting process, updated data, intelligence gathered through an extensive public engagement exercise on Urgent and Emergency Care as well as our recent strategy engagement and insights database. We will continue to liaise with our involvement, informatics and public health colleagues in the development of this. This year we will again focus on the ages 0-4 as the highest attending group, but also include messages targeting 75-79 year olds, as this group is also known to be high attenders.

We will use creative and graphic elements developed as part of the 23/24 winter campaign to retain familiarity and recall but building upon these to incorporate updated intelligence and data for this winter, we will ensure we use the right messaging in the right style, via the right platforms and media to optimise our impact.

5. Staff communication

Internal communications will be incredibly important to us this year. We know that, together, our staff make up a significant proportion of the Lincolnshire population. They have a direct ability to impact performance, and of course they are also significant influencers across their peers, family and friends.

This year we will focus on two new aspects to our staff communications. These will complement the existing approach of informing and educating our staff regarding the winter schemes, performance and rationale for the winter plan.

The first is a greater focus on patient safety. We know this is a national emphasis this year, and it has always been at the forefront of our work in Lincolnshire. The difference this year will be the prominence of this messaging element alongside our performance information.

The second is the treatment of messaging to our staff. This year we will incorporate more 'story-telling' and emotive angles to our messages to staff. This again will work alongside our informative, succinct and action focused messages, but by introducing more emotive approaches which highlight the importance and impact of every single person's actions, and elevating the feel of personal responsibility and impact, we intend to test the response of our colleagues, adapting as we progress through the winter campaign.

9. Conclusion & Evaluation

Our winter plan will be monitored via our governance routes and operationally, daily, through the System Co-ordination Centre activities and specifically via:

- ✓ **System oversight through the Urgent and Emergency Care Partnership Board and associated sub governance groups**
- ✓ **Weekly live oversight of the winter period via the Urgent and Emergency Care Leaders Group, chaired by our Winter Director, with escalation where required.**
- ✓ **Ongoing monitoring of Demand and Capacity to understand performance and delivery over the winter period and the impact of existing, planned and any further initiatives and change.**
- ✓ **Performance and Planning Group review of performance and activity including impact of interventions monthly.**
- ✓ **Urgent and Emergency Care Partnership Board review of the Urgent and Emergency Care performance dashboard monthly.**

This winter plan sets out the starting point for the management of winter 2024/25 in Lincolnshire across the health and care system. We acknowledge that our assumptions around demand and the impact of the planned initiatives and interventions may not be completely accurate at this point, but we will ensure ongoing dynamic review of demand, capacity, and impact of interventions.

We will utilise all available resource to ensure that we are delivering safe and accessible services to our patients and that we improve their experience and outcomes. The Urgent and Emergency Care programme governance will ensure that there is robust oversight of the delivery of this plan, with both strategic and clinical leadership and guidance. We will review the plan early next year to ensure we can identify the learning and impact in preparation for winter 25/26 and to secure ongoing service development and improvement for our population.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	06 (i)
Meeting Date:	Tuesday, 26th November 2024
Title of Report:	Standards of Business Conduct and Conflicts of Interest Policy
Report Author:	Jules Ellis-Fenwick, Board Secretary Sarah Bates, Deputy Board Secretary
Presenter:	Jules Ellis-Fenwick, Board Secretary
Appendices:	Standards of Business Conduct and Conflicts of Interest Policy

To approve <input checked="" type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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 revised ICB Standards of Business Conduct and Conflicts of Interest Policy.

Summary

NHS Lincolnshire ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure, and be able to evidence, that these decisions secure the best possible services for the population it serves, the Board must demonstrate accountability to relevant stakeholders (particularly the public), and probity and transparency in the decision-making process.

A key element of this assurance involves management of conflicts of interest with respect to any decisions made. NHS Lincolnshire ICB manages conflicts of interest as part of its day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, Parliament and taxpayers that NHS Lincolnshire ICB commissioning decisions are robust, fair, transparent and offer value for money.

As required by the Health and Social Care Act 2021, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

On the 17th September 2024 NHS England issued updated guidance on Managing Conflicts of Interest in the NHS. This guidance is intended to protect patients, taxpayers and staff and to cover health services in which there is a direct state interest.

It replaces and updates the NHS-wide guidance 'Managing conflicts of interest in the NHS', issued in 2017, to take account of changes introduced by the Health and Care Act 2022, specifically the establishment of Integrated Care Boards and the introduction of the Provider Selection Regime.

<p>It is applicable to the following NHS bodies:</p> <ul style="list-style-type: none"> • Integrated Care Boards (ICBs) • NHS Trusts and NHS Foundation Trusts • NHS England <p>In light of the publication of this updated guidance, the ICB Board Secretary and Deputy Board Secretary have reviewed the ICB Standards of Business Conduct and Conflicts of Interest Policy and made a number of amendments to bring the policy in line with this guidance. All changes have been tracked in red for ease of reference.</p> <p>The ICB Board is asked to consider the revised document and approve this for inclusion in the ICB Governance Handbook and publication on the ICB website and intranet. The updated guidance will also be communicated to staff who will be required to familiarise themselves with the content.</p>			
How does this paper support the ICB's core aims to:			
Aim 1: Improve outcomes in population health and healthcare.	It is essential that the ICB establishes effective arrangements for managing conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes towards the achievement of the four core aims.		
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.		
Aim 3: Enhance productivity and value for money.	As above.		
Aim 4: Help the NHS support broader social and economic development.	As above.		
Conflicts of Interest		Summary of conflicts	
No conflict identified			
Risk and Assurance			
No specific risks identified.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	Not applicable.		
Does the report highlight any quality and patient safety implications?	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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Report previously presented at:			
Not applicable.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

NHS LINCOLNSHIRE INTEGRATED CARE BOARD

STANDARDS OF BUSINESS CONDUCT AND CONFLICTS OF INTEREST POLICY (INCLUDING HOSPITALITY, GIFTS AND SPONSORSHIP)

ICB document reference:	ICB CORPORATE 001
Name of originator/author:	Jules Ellis-Fenwick – Board Secretary
Date of approval:	1 st July 2022
Name of responsible Committee:	ICB Board
Responsible Director/ICB Officer:	John Turner
Category:	Corporate Governance
EIA undertaken:	No
Date issued:	1 st July 2022
Review date:	1 year from issue date - reviewed October 2024
Target audience:	All staff
Distributed via:	Email, Website, Intranet

Document Control Sheet

Document Title	Standards of Business Conduct and Conflicts of Interest Policy
Version	2.0
Status	Final
Authors	Jules Ellis-Fenwick, ICB Corporate Board Secretary & Sarah Bates, ICB Deputy Board Secretary
Date	

Document history			
Version	Date	Author	Comments
1	July 2022	Sarah Bates, Deputy Board Secretary	Final version
2	October 2024	Sarah Bates, Deputy Board Secretary	Updated following publication of national guidance. This guidance replaces the previously issued Policy taking into account the changes introduced by the Health and Care Act 2022, specifically the establishment of Integrated Care Boards and the introduction of the Provider Selection Regime.

Contents

Document Control Statement	2
Policy Statement	3
1. Introduction	4
2. Background	4
3. Aims of the Policy	5
4. Scope of the Policy	5
5. What are Conflicts of Interest?	7
6. Identification, Declaration and Review of Interests	10
7. Register of Interests	12
8. Appointing Board or Committee Members	14
9. Role of Non-Executive Members	14
10. Conflicts of Interest Guardian	14
11. Outside/Secondary Employment	14
12. Governance and Decision-making Processes	15
13. Procedure for Meetings	16
14. Minute Taking	16
15. Management of interest – advice in specific contexts	16
- Strategic Decision Making Groups	16
- Procurement	18
16. Gifts	19
17. Hospitality	20
18. Sponsored events	21
19. Other forms of sponsorship	22
20. Shareholdings and other ownership issues	23
21. Patents	24
22. Loyalty interests	25
23. Donations	26
24. Clinical Private Practice	26
25. Personal Conduct	28
26. Standing Financial Instructions and Scheme of Reservation and Delegation	29
27. Prevention of Corruption and the Bribery Act 2010	29
28. Raising concerns and reporting breaches	29
- Taking action in response to breaches	30
- Learning and transparency concerning breaches	31
29. Professional Regulatory Sanctions	31
- Civil Sanctions	31
- Criminal Sanctions	31
- Reputational Consequences	31
30. Equality and Diversity Statement	32
31. Monitoring Compliance and Effectiveness of the Policy	32
Appendix 1a - Declaration of Interests Form for ICB Members and Employees	33
Appendix 1b - Declaration of Interests No Change Form	35
Appendix 2 - Template for recording interests during a meeting	36
Appendix 3 - Declarations of Gifts and Hospitality	37
Appendix 4 - Declarations of Commercial Sponsorship	38
Appendix 5 - Flowchart for reporting Declarations of Interest	39

1. Introduction

This policy sets out clear and robust procedures on how NHS Lincolnshire ICB (Integrated Care Board) will manage conflicts of interest. This policy should be read in conjunction with the following documents:

- Managing conflicts of interest in the NHS: Guidance for staff and organisations.
- NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association – Shared principles on conflicts when ICBs are commissioning from member practices (December 2014)
- The Nolan Principles
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA)
- The Seven Key Principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code
- NHS (Procurement, Patient Choice and Competition (No2)) Regulations 2013
- ICB HR policies

2. Background

NHS Lincolnshire ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure, and be able to evidence, that these decisions secure the best possible services for the population it serves, the Board must demonstrate accountability to relevant stakeholders (particularly the public), and probity and transparency in the decision-making process.

A key element of this assurance involves management of conflicts of interest with respect to any decisions made. NHS Lincolnshire ICB manages conflicts of interest as part of its day-to-day activities. Effective handling of such conflicts is crucial for the maintenance of public trust in the commissioning system. Importantly, it also serves to give confidence to patients, providers, Parliament and taxpayers that NHS Lincolnshire ICB commissioning decisions are robust, fair, transparent and offer value for money.

The policy has been developed in accordance with guidance issued by NHSE.

Every year the taxpayer entrusts NHS organisations with over £190 billion to care for millions of people. This money must be spent well, free from undue influence.

The Health and Care Act 2022 (the Act) gave integrated care systems (ICSs) legal underpinning, with integrated care boards being established as statutory bodies with legal powers and responsibilities. The Act signalled a clear shift in the way health and care is organised in England and better enables organisations to work collaboratively with each other, local authorities, industry and other public, private and voluntary bodies. Partnership working is fundamental if we are to meet challenges faced by the health and care sector, but conflicts of interest must still be carefully managed to maintain the confidence and protect the interests of patients and taxpayers.

Organisations and the people who work with, for, and on behalf of them (referred to as 'staff' in this guidance) want to manage these risks in the right way. For clarity, references to 'staff' in this document include those who are not employees but have a formal role in organisational decision-making, in particular board and sub-/committee members.

By implementing this guidance staff and organisations will understand what to do to take the best action and protect themselves from allegations that they have acted inappropriately.

This guidance:

- Sets out consistent principles and rules for managing conflicts of interest
- Provides simple advice to staff and organisations about what to do in common situations
- Supports good judgement about how interests should be approached and managed

3. Aims of the Policy

The aim of this policy is to protect both the organisation and the individuals involved from any appearance of impropriety and demonstrate transparency to the public and other interested parties. All Board, Committee and Sub-Committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

This policy is intended to:

- Ensure staff are aware of the need to act impartially in all of their work
- Protect all staff against the possibility of accusations of corruptive practice
- Uphold the established principles of business conduct within the NHS and the public sector
- Uphold the reputation of NHS Lincolnshire ICB and its staff in the way it conducts its business
- Ensure staff do not contravene the requirements of the Bribery Act 2010
- Uphold the principles of openness

The intention of this policy is to maintain the highest standards of probity and to provide assurance that any relationships entered lead to clear benefit for the NHS, and that they represent value for money. In order for this to be achieved the process must be conducted in the context of openness and within the Code of Conduct for NHS Managers.

This policy reflects the seven principles of the Nolan Committee (the 7 principles of public life):

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty and
- Leadership

4. Scope of the Policy

4.1 Staff

At NHS Lincolnshire ICB we use the skills of many different people, all of whom are vital to our work. This includes people of differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

This policy will apply to:

- All NHS Lincolnshire ICB employees, including full and part-time staff, staff on sessional or short term contracts, students or trainees (including apprentices), agency and seconded staff
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- All members of the NHS Lincolnshire ICB, including Committee, Sub-Committee, Co-opted members, appointed deputies, advisory group members, Joint Committees, (who may not be directly employed or engaged by the organisation) and any members of Committees/groups from other organisations

Action for staff

DO

- Familiarise yourself with this policy and your organisational policies and follow them.
- Use your common sense and judgement to consider whether the interests you could have affect the way taxpayers' money is spent.
- Regularly consider what interest you have and declare these as they arise. If in doubt, declare.

DON'T

- Misuse your position to further your own interests or those close to you.
- Be influenced or give the impression that you have been influenced by, outside interests.
- Allow outside interests **that you hold to** inappropriately affect the decisions you make **about spending** taxpayers' money.

4.2 Actions for the ICB

Action for Organisations

DO

- Ensure that you have clear and well communicated processes in place to help staff understand what they need to do
- Identify a team or individual with responsibility for:-
 - Reviewing current policies and bringing them in line with this guidance.
 - Providing advice, training and support for staff on how interests should be managed.
 - Maintaining register(s) of interests.
 - Auditing policy, process and procedures relating to this guidance at least every three years.

DON'T

- Avoid managing conflicts of interest.
- Interpret and deploy this guidance in a way that stifles the collaboration and innovation that the NHS needs.

4.3 Implementation

The NHS Lincolnshire ICB will ensure that all employees and decision-makers are aware of the existence of this policy by:

- An introduction to the policy being given during local induction for new starters to the organisation.
- An annual reminder of the existence and importance of the policy delivered via internal communication methods; and
- An annual reminder to update declaration forms sent to all members of the NHS Lincolnshire ICB and any other Committee, Sub-Committee, or decision-making or advisory group.

Individuals to whom this policy applies will be personally responsible for ensuring that they:

- Are familiar with its provisions.
- Do not knowingly place themselves in a position which creates a potential conflict between their individual and personal interests and their ICB duties.
- Comply with the procedures set out in the policy including making declarations of potential or actual conflicts of interest where necessary; and
- Attend any conflict of interest training made available to them.

If applicable, individuals should also refer to their respective professional codes of conduct relating to conflicts of interest.

NHS Lincolnshire ICB will view instances where this policy is not followed as serious and may take disciplinary action against individuals, which may result in removal from office in accordance with the provisions of the NHS Lincolnshire ICB constitution and/or dismissal. The following ICB policies (as amended) will apply to breaches of this policy where appropriate:

- Whistleblowing Policy
- Disciplinary Policy

Where appropriate the ICB will support its Non-Executive Members in participating in any governance training programmes offered by NHSE/I.

4.4 Training

All ICB employees, Board Members, Committee and Sub-Committee members involved with ICB business will complete the mandatory on-line Conflicts of Interest training at Induction and then on an annual basis.

5. What are Conflicts of Interest?

For the purposes of this policy a conflict of interest is defined as:

‘A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold’.

A conflict of interest may be:

Actual	Potential
There is a material conflict between one or more interests.	There is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see **any** potential conflict. However, caution is always advisable because others may see it differently. **It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.**

Interests fall into the following categories:



	Interests	interests	
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.	Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career.	Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.	Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common-sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

- **Financial Interests:** Could include for example:-
 - A director, including a non-executive director, or senior employee of a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model.
 - A shareholder (or similar ownership interests), a partner or owner of a private or not for profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
 - A management consultant for a provider or
 - A provider of clinical private practice.

This could also include an individual being:

- In employment outside of the organisation.
- In receipt of secondary income.
- In receipt of a grant from a provider.
- In receipt of any payments for example honoraria, one-off payments, day allowances or travel and subsistence) from a provider.
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

- **Non-Financial Professional Interests:** This may, for example, include situations where the individual is:

- An advocate for a particular group of patients.
 - A GP with special interests e.g., in dermatology, acupuncture etc.
 - An active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared).
 - An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE).
 - Engaged in a research role.
 - Development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
 - GPs and Practice Managers, who are Members of the Board or Committees of the ICB, should declare details of their roles and responsibilities within their GP Practices.
- **Non-Financial Personal Interests:** This could include for example, where the individual is:
 - A voluntary sector champion for a provider.
 - A volunteer for a provider.
 - A member for a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
 - Suffering from a particular condition requiring individually funded treatment.
 - A member of a lobby or pressure group with an interest in health and care.
 - **Indirect Interests:** (as those categories are described above) for example:
 - Spouse/Partner.
 - Close relative e.g., parent, grandparent, child, grandchild, or sibling.
 - Close friend; or
 - Business partner.

A declaration of interest for a “business partner” in a GP Partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP Partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interest will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

It should be noted that:

- **The above categories and examples are not exhaustive** and the ICB will exercise discretion on a case-by-case basis.
- **The possibility of the perception of wrongdoing**, impaired judgement or undue influence shall also be considered a conflict of interest for the purposes of this Policy and should be declared and managed accordingly; and
- **Where there is doubt as to whether a conflict of interest exists**, it should be assumed that there is a conflict of interest and declared and managed accordingly.

Where an individual has any queries with respect to conflicts of interest they should seek advice from the ICB Corporate Board Secretary.

6. Identification, Declaration and Review of Interests

The ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not (and do not risk appearing to) affect the integrity of the ICB's decision making processes.

The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB website.

All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

All delegation arrangements made by the ICB under section 65ZS of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

Where an individual, including any individual directly involved with the business or decision making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest that could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provision of this Policy.

The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

- Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
- Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
- Support the rigorous application of conflict of interest principles and policies.
- Provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
- Provide advice on minimising the risks of conflict of interest.

Declaring and Registering Interests

The ICB maintains registers of the interests of:-

- Members of the ICB
- Members of the boards committees and sub-committees.
- Its employees.

In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website. Registers of interest of decision making staff will be declared annually in a prominent place on the ICB website.

All relevant persons must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

All declarations will be entered in the registers.

The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

Interests (including gifts and hospitality) of decision making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historical interests and offers/receipts of gifts and hospitality for a minimum of six years after the date on which it expired.

The ICB's published register of interests states that historical interests are retained by the ICB for the specified timeframe and details who to contact to submit a request for this information.

Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

Standards of Business Conduct

Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:-

- Act in good faith and in the interests of the ICB.
- Follow the Seven Principles of Public Life; set out by the Committee on Standard sin Public Life (the Nolan Principles).
- Comply with this Policy and any requirement set out in the policy for managing conflicts of interest.

Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the Policy.

The ICB will support staff to understand that having interests is not in itself negative, but not declaring and managing them is.

All staff must declare any interest and declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to the ICB. Therefore, declarations should be made:

- On appointment within the ICB.
- When a person moves to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise.
- Some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision-making staff'.

Because of their influence in the spending of taxpayers' money, the ICB will ensure that decision-making staff are prompted to update their declarations of interest or make a nil return, at least annually.

The following non-exhaustive list describes who these individuals are likely to be:

- Executive and non-executive directors who have decision-making roles which involve the spending of taxpayers' money (equivalent roles in different organisations carry different titles and these should be considered on a case-by-case basis)
- Members of advisory groups which contribute to direct or delegated decision-making on the commissioning or provision of taxpayer-funded services
- Those at Agenda for Change band 8D and above (reflecting guidance issued by the Information Commissioner's Office with regard to freedom of information legislation)

- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clerical staff involved in decision-making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.
- There may be occasions where staff declare an interest but upon closer consideration it is clear that this is not material and so does not give rise to the risk of a conflict of interest. The team or individual responsible for managing organisational policy should decide whether it is necessary to transfer such declarations to an organisation's register(s) of interests.

The Chief Executive has overall accountability for the ICB's management of conflicts of interest.

Where the new role or outside employment may be perceived to be, or will result in, a conflict of interest, prior approval must be sought from the individual's line manager. The ICB reserves the right to refuse permission where it believes a conflict will arise which cannot be effectively managed. Please read the ICB Secondary Employment Policy for further detail.

Individuals will declare any interest that they have, in relation to the exercise of the commissioning functions of the ICB as soon as they become aware of it and in any event no later than 28 days after becoming aware. Any changes to interests declared must also be registered within 28 days of the relevant event, or knowledge of a relevant event, by completing and submitting a new declaration form.

Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent during the course of a meeting, they must make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter. A flow chart for declaring interests at six months, in year changes and in a meeting is shown at Appendix 13.

Members and employees of the ICB and/or NHSE completing the declaration form must provide sufficient detail of each interest so that a member of the public would be able to clearly understand the sort of financial or other interest the member or employee has and the circumstances in which a conflict of interest with the business or running of the ICB and/or NHSE/I might arise, the potential implications and why the interest needs to be registered.

Where members declare interests, this shall include the interests of all relevant individuals within their organisation who have a relationship with the ICB and/or NHSE/I and who would potentially be in a position to benefit from the ICB's decisions.

The declaration of interest form is attached at Appendix 1 (a) and includes information on the types of interest to be declared.

If any assistance is required in order to complete the declaration form, then the member or employee should contact the ICB Corporate Board Secretary, NHS Lincolnshire ICB.

7. Register of Interests

The ICB shall keep and maintain a Register of Interests (the 'Register') of all those interests declared. Conflicts of interests shall be reported to the ICB Corporate Board Secretary/Manager who shall update the Register whenever a new or revised interest is declared. The ICB Corporate Board Secretary must ensure that the Register includes sufficient information about the nature of the interest and the details of those holding the interest.

The ICB keeps a Register of Interests for the following:

- **All ICB employees**, including:
 - All full and part time staff.
 - Any staff on sessional or short-term contracts.
 - Any students and trainees (including apprentices).
 - Agency staff; and
 - Seconded staff.

In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this policy, as if they were ICB employees.

- **Members of the ICB Board, including (but not limited to):**
 - Executive Directors
 - Non-Executive Members
 - Partner Members
- All members of the ICB's Committees, Joint Committees, Sub-Committees and Advisory Groups

7.1 Decision Making Staff

Some staff members are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of the role. For the purposes of this policy these people are referred to as 'decision making staff'.

The following non-exhaustive list describes decision making staff members in NHS Lincolnshire ICB to be:

- All ICB Board Members.
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services such as working groups involved in service redesign or stakeholder engagement that will affect future provision of services.
- Members of ICB Committees and Sub-Committees
- Members of procurement (sub) Committees.
- Those at Agenda for Change Band 8d and above
- Management, administrative and clinical staff who have the power to enter into contracts on behalf of the ICB; and
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

The Register shall be formally reviewed on an annual basis to ensure that the Register is accurate and up to date, or earlier where relevant and published on the ICB's website at www.lincolnshireICB.nhs.uk by the ICB Corporate Board Secretary at the ICB's headquarters.

All relevant individuals will be contacted annually and asked to confirm whether their interest has changed or not, in which case they will be asked to complete a No Change Form (Appendix One (b)).

Any interest will remain on the public register for a minimum of six months after the interest has expired. In addition, the ICB will retain a private record of historic interests for a minimum of six years after the date on which it expired.

The Register of Interests template is attached at Appendix Two.

8. Appointing Board or Committee Members

NHS Lincolnshire ICB shall consider whether conflicts of interest should exclude individuals from being appointed to the Board or to a committee or sub-committee of the ICB.

Such consideration shall be made on a case by case basis depending on the nature and extent of the interest, in particular whether the individual (or a family member) could benefit from any decisions made and whether the interest relates to such a significant area of business such that the individual would be unable to make a full and proper contribution.

Any individual who has a material interest in an organisation which provides or is likely to provide substantial business to a ICB (either as a provider of healthcare or commissioning support services) shall not be a member of the Board.

9. Role of Non-Executive Members

Non-Executive Members play a critical role in ICBs, providing scrutiny, challenge and an independent voice in support of robust decision-making and management of conflicts of interest. They also Chair a number of ICB Committees, including the Audit & Risk Committee and Primary Care Commissioning Committee.

By statute, ICBs must have at least two Independent Non-Executive Members.

National guidance also stipulates that the Primary Care Commissioning Committee must have a Chair and Vice Chair.

10. Conflicts of Interest Guardian

To further strengthen scrutiny and transparency of the ICBs decision-making processes, all ICBs should have a Conflicts of Interest Guardian (akin to a Caldicott Guardian). This role should be undertaken by the Chair of the Audit & Risk Committee and in NHS Lincolnshire ICB this is one of the Non-Executive Members.

In collaboration with the ICB's Governance Lead the Conflicts of Interest Guardian:

- a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
- b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
- c) Support the rigorous application of conflict of interest principles and policies.
- d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
- e) Provide advice on minimising the risks of conflicts of interest.

11. Outside/Secondary Employment

What are the issues

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which

relate to bodies likely to do business with an organisation.

Principles and rules

- Staff should declare any existing outside employment on appointment, and any new outside employment when it arises to their Line Manager. Please read the Secondary Employment Policy for further detail.
- Where a risk of conflict of interest is identified, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment.
- Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even if this does not give rise to risk of a conflict. Nothing in this policy prevents such enquiries being made.

What should be declared

- Staff name and their role within the ICB Board.
- A description of the nature of the outside employment (e.g., who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g., action taken to mitigate against a conflict, details of an approvals given to depart from the terms of this policy).

Examples of work which might conflict with the business of the ICB including part-time, temporary and fixed term contract work include:

- Employment with another NHS body.
- Employment with another organisation which might be in a position to supply goods/services to the ICB including paid advisory positions and paid honorariums which relate to bodies likely to do business with the ICB.
- Directorship e.g., of a GP federation or non-executive roles.
- Self-employment, including private practice, charitable trustee roles, political roles and consultancy work, in a capacity which might conflict with the work of the ICB or which might be in a position to supply goods/services to the NHS.

Staff should declare to their Line Manager any existing outside/secondary employment on appointment, and new outside/secondary employment when it arises. Please read the Secondary Employment Policy for further detail.

12. Governance and Decision-Making Processes

The ICB will review, on an annual basis, its governance structures for managing conflicts of interest to ensure that the arrangements reflect current guidance and are appropriate, particularly in relation to any co-commissioning roles which the ICB proposes to undertake. This will include consideration of the following:

- The make-up of its Board and committee structures (including, where relevant, the approach set out below for decision-making in delegated commissioning of primary care).
- Whether there are sufficient management and internal controls to detect breaches of the ICB's Standards of Business Conduct and Conflict of Interests Policy, including appropriate external oversight and adequate provision for whistleblowing.

- How non-compliance with policies and procedures relating to conflicts of interest is being managed (including how this will be addressed when it relates to contracts already entered into). As well as actions to address non-compliance, the ICB will have procedures in place to review any lessons to be learned from such cases by the ICB's Audit & Risk Committee conducting an incident review.
- Reviewing and revising approaches to the ICB's register of interests.
- Whether any training or other programmes are required to assist with compliance, including participation in the training offered by NHSE/I.

13. Procedure for Meetings

The principles and general provisions for managing conflicts of interest and transparency prior to and during meetings and procuring services are set out in section nine of the NHS Lincolnshire ICB Constitution.

The Chair of a meeting of the ICB's Board or any of its Committees, Sub-Committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage it. Where the Chair is conflicted the Vice Chair is responsible for deciding the appropriate course of action.

14. Minute Taking

It is imperative that the ICB ensures complete transparency in its decision making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the Chair must ensure the following information is recorded in the minutes:

- **Who has the interest?**
- **The nature of the interest and why it gives rise to a conflict**, including the magnitude of any interest.
- **The items on the agenda to which the interest relates.**
- **How the conflict was agreed to be managed**; and
- **Evidence that the conflict was managed as intended** (for example recording the points during the meeting when particular individuals left or returned to the meeting).

15. Management of Interests – advice in specific contexts

15.1 Strategic Decision-Making Groups

Many organisations use boards (or committees and sub-committees of boards), advisory groups and procurement panels to make key strategic decisions or recommendations about things such as:-

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively.

For the ICB these groups are:

- ICB Board
- ICB Executive Team
- Audit and Risk Committee

- Quality Committee
- Finance Committee
- Service Delivery and Performance Committee

It is important that the interests of those who are involved in these groups are documented and understood. Organisations must therefore identify relevant strategic decision-making groups and ensure they operate in a manner consistent with the following principles, which reflect wider standards of good governance.

Organisations should manage interests sensibly and proportionately. If an interest presents an actual or potential conflict of interest then management action is required.

Some common-sense management principles should be adopted by organisations which, for the purposes of this guidance, are referred to as 'general management actions':

- requiring staff to comply with this guidance
- requiring staff to proactively declare interests at the point they become involved in decision-making
- considering a range of actions, which may include:
 - deciding that no action is warranted
 - restricting an individual's involvement in discussions and excluding them from decision-making
 - removing an individual from the whole decision-making process
 - removing an individual's responsibility for a whole area of work
 - removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role
- keeping an audit trail of actions taken
- Each case will be different. The general management actions, along with relevant industry/professional guidance should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.

However, there are a number of common situations which can give rise to risk of conflicts of interest, these being:

- gifts
- hospitality
- outside employment
- shareholdings and other ownership interests
- patents
- loyalty interests
- donations
- sponsored events
- sponsored research
- sponsored posts
- clinical private practice

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.
- Terms of reference for such groups should refer to the organisation's policy and procedures

for managing conflicts of interest and should set out any specific requirements which apply to the group.

- If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:
 - Requiring the member to not attend the meeting.
 - Excluding the member from receiving meeting papers relating to their interest.
 - Excluding the member from all or part of the relevant discussion and decision.
 - Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
 - Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk. The composition of groups should be kept under review to ensure effective participation.

15.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

The ICB will keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

The Provider Selection Regime (PSR) came into force on 1 January 2024. The PSR is a set of rules for procuring health services which are designed to be a more flexible and proportionate decision-making process for selecting providers to deliver healthcare services.

The ICB needs to comply with the PSR when arranging for the provision of relevant care services, either on their own or as part of a mixed procurement.

The ICB will take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement processes under The Health Care Services (Provider Selection Regime) Regulations 2023 ('PSR Regulations'). The definition of conflicts of interest for the purposes of the PSR is set out in regulation 21 of the PSR Regulations. The ICB should note the specific carve-out from the definition in regulation relating to ICB board members.

Organisations need to comply with the rules on public procurement set out in the Public Contracts Regulations 2015 (PCR) when arranging for the provision of goods and services that are not "relevant health care services", unless they form part of a "mixed procurement", which meets the test for the application of the PSR.

The Procurement Act 2023 ("Procurement Act") is expected to come into force later in 2024, at which point it will replace the PCR. Organisations will need to take all reasonable steps to identify, and keep services under review, in relation to any procurement under the Procurement Act any conflicts of interest or potential conflicts of interest. "Conflict of interest" is defined for the purposes of the Procurement Act. The Procurement Act will impose new duties on organisations with regards to the assessment and management of conflicts of interest.

For the avoidance of doubt, nothing in this section or this guidance waives or modifies any existing

16. Gifts

This section applies to all individuals listed in sections 4.1 and 7 of this policy.

Overarching Principles

The ICB should not accept gifts that may affect, or be seen to affect, their professional judgement.

Any personal gift of cash or cash equivalents (e.g., vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declared, whatever their value and whatever their source, and the offer which has been declined must be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.

All the individuals listed in section 4.1 need to consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the ICB or their GP practice.

This is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence, collusion or canvassing.

What are the issues?	<p>Staff in the NHS offer support during significant events in people’s lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviours if not handled in an appropriate way.</p> <p>A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.</p>
-----------------------------	--

Principles and rules	<p>Overarching principle applying in all circumstances:</p> <ul style="list-style-type: none"> • Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. <p>Gifts from suppliers or contractors:</p> <ul style="list-style-type: none"> • Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. • Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total and need not be declared. *the £6 value has been selected with reference to existing industry guidance issues by the ABPI. <p>Gifts from other sources (e.g., patients, families, service users):</p> <ul style="list-style-type: none"> • Gifts of cash and vouchers to individuals should always be declined. • Staff should not ask for any gifts, regardless of value. • Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e., to an organisation’s charitable funds), not in a personal capacity. Staff should declare such gifts and provide a clear reason as to why it was considered
-----------------------------	--



permissible to accept the gift, alongside the actual or estimated value.

- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared

- Staff name and their role with the ICB Board
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g., circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

The ICB’s form for declaring “Gifts and Hospitality” is provided at Appendix Nine. The Register of Gifts and Hospitality template is attached at Appendix Ten.

17. Hospitality

What are the issues?

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of “traditional” working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviours.

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

Principles and rules

Overarching principles applying in all circumstances:

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these.

Meals and Refreshments

- Under a value of £25 may be accepted and need not be declared.
- Of a value between £25 and £75* may be accepted and must be declared.
- Over a value of £75* should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation’s register(s) of interest as to why it was permissible to accept.
- A commonsense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

*The £75 value has been selected with reference to existing industry guidance issues by the ABPI.

Principles and rules

Travel and accommodation:-

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the ICB itself might not usually offer, need approval by senior staff (e.g., the ICB governance lead or equivalent), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type.
- A non-exhaustive list of examples includes:
 - Offers of business class or first-class travel and accommodation (including domestic travel); and
 - Offers of foreign travel and accommodation.

What should be declared

- Staff name and their role with the ICB Board.
- A description of the nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g., action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

18. Sponsored Events

What are the issues

Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.

Principles and rules

- Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the ICB's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- ICBs should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.



- Staff should declare involvement with arranging sponsored events to the organisation.
- All declarations made under this section must be made promptly and within no more than 10 working days of the date of the offer. A declaration form is at Appendix Eleven.

What should be declared

- Organisations should maintain records regarding sponsored events in line with the above principles and rules.

19. Other Forms of Sponsorship

19.1 Sponsored Research

What are the issues?

Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.

Principles and rules

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to their organisation.
- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.

What should be declared

- Staff should declare:
- their name and their role with the ICB Board.
 - a description of the nature of their involvement in the sponsored research.
 - relevant dates.
 - any other relevant information (e.g., what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

19.2 Sponsored Posts

What are the issues

Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Principles and rules

- Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

20. Shareholdings and other Ownership Issues

What are the issues

Holding shares or other ownership interests can be a common way for staff to invest their personal time money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role within an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give risk to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.

Principles and rules

- Staff should declare, as a minimum, any shareholdings and other ownership interests in a publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.



- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.
- Where shareholdings or other ownership interests are declared and give rise to the risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role within the ICB Board.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

21. Patents

What are the issues?

The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed.

However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.

Principles and rules

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation.
- Staff should seek prior permission from their organisation before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation’s own time, or uses its equipment, resources of intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role within the ICB Board.
- A description of the patent or other intellectual property right and its ownership.
- Relevant dates.
- Any other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

22. Loyalty Interests

What are the issues?

As part of their jobs staff members need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by a formal process or managed via any contractual means – it can be as simple as having informal access to people in senior positions. However, loyalty interest can influence decision making.

Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship, they have rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

Principles and rules

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation, or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities.
- Where holding loyalty interest gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role within the ICB Board.
- Nature of the loyalty interest
- Relevant dates.
- Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

23. Donations

What are the issues?

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer, the NHS holds formal and informal partnerships with national and local charities. **Staff will, in their private lives, undertake voluntary work or fundraising activities for charity.** A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

Principles and rules

- **Acceptance of** donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for an organisation or is being pursued on behalf of that organisation's registered charity (if it has one) or other charitable body and is not for their own personal gain.
- Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared

- Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.

24. Clinical Private Practice

What are the issues

Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.

Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be

managed. These provisions around declarations of activities are equivalent to what is asked of all staff in section 12 on Outside Employment.

Principles and rules

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- where they practice (name of private facility)
- what they practice (specialty, major procedures).
- when they practice (identified sessions/time commitment)

*Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003:

https://www.bma.org.uk/-/media/files/pdfs/practical_advice_atwork/contracts/consultanttermsandconditions.pdf

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines:
https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf**

**These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch.9 of the Terms and Conditions – Consultants (England) 2003:

https://www.bma.org.uk/-/media/files/pdfs/practical_advice_atwork/contracts/consultanttermsandconditions.pdf

Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the ICB Board.
- A description of the nature of the private practice (e.g., what, where and when you practice, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g., action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Lending or Borrowing

The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

Gambling

No member of staff may bet or gamble when on duty or on NHS and ICB premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

Trading on Official Premises

Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non NHS ICB interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

Collection of Money

Charitable collections must be authorised by the ICB Corporate Board Secretary. Other flag day appeals are not permitted. Collection tins and boxes must not be placed in offices.

With line management agreement collections may be made among immediate colleagues and friends to support small funding raising initiatives (e.g. Jeans for Genes Day and Children in Need) and raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, new job or birthdays.

Bankrupt or Insolvent Staff

Any member of staff who becomes bankrupt or insolvent must inform their line manager and Human Resources as soon as possible. Staff members who are bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the handling of money.

Arrest or Conviction

A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line manager and Human Resources.

Political Activities

Any political activity should not identify an individual as an employee of the ICB. Conferences or functions run by a party political organisation should not be attended in an official capacity, except with prior written permission from the Chief Executive.

On matters affecting the work of the ICB, staff members should not make political speeches without first discussing it with the Chief Executive of the ICB.

Social Media

If staff use social networking sites (such as Twitter and Facebook), they should ensure that they have read and fully understood the Computer Systems Use Policy and Social Media Protocol.

26. Standing Financial Instructions and Scheme of Reservation and Delegation

All ICB staff must carry out their duties in accordance with the ICB's Standing Financial Instructions and Scheme of Reservation and Delegation. These documents set out the statutory and governance framework in which the ICB operates and there is considerable overlap between the contents of this policy and the provisions of the ICB's Standing Financial Instructions and Scheme of Reservation and Delegation. ICB staff must at all times refer to and act in accordance with these documents and the ICB Constitution to ensure the correct processes are followed. In the event of any doubt, ICB staff should seek advice from their line manager or the ICB Corporate Board Secretary. In the event of any conflict arising between the details of this policy and the Standing Financial Instructions and Scheme of Reservation and Delegation, the provisions of these documents and the ICB Constitution will prevail.

27. Prevention of Corruption and the Bribery Act 2010

The Bribery Act 2010 replaces the fragmented and complex offences at common law, and in the Prevention of Corruption Acts 1889-1916. This broadly defines the two sections below:

- Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and 2) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;
- The new corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

Any suggestion or suspicion of corruption or fraudulent practice should be reported to the Local Counter Fraud Specialist – as detailed in the Countering Fraud and Corruption Policy.

28.1 Raising Concerns and Reporting Breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach can report these concerns to any of the following:

- Conflict of Interest Guardian
- ICB Board Secretary

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the ICB Whistleblowing Policy which is available on the ICB website.

The ICB Corporate Board Secretary, or any other senior officer identified by the Conflict of Interest Guardian shall assess the breach and formally arrange for it to be investigated

The findings will be reported to the Conflicts of Interest Guardian who will then submit the findings to the Audit & Risk Committee. The Audit & Risk Committee has responsibility for determining the most appropriate course of action.

The ICB will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the ICB will:

- Decide if there has been or is potential for a breach and if so, what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the Trust should be made aware
- Take appropriate action as set out in the next section

28.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the ICB and could involve ICB leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and ICB auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the Trust and its staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Staff who fail to disclose any relevant interest or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the ICB can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach.

This includes:

- Employment law action against staff, which might include Informal action (such as reprimand or signposting to training and/or guidance). Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

28.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit and Risk Committee every six months.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published as appropriate, or made available for inspection by the public upon request.

29. Professional Regulatory Sanctions

Statutorily regulated healthcare professionals who work for, or are engaged by, organisations are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. The ICB will consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate be struck off by their regulator as a result.

Civil Sanctions

If conflicts of interest are not effectively managed, organisations could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. If a decision-maker has a conflict of interest, then the decision is also potentially vulnerable and could be overturned on judicial review. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal Sanctions

Failure to manage conflict of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implication for the organisation concerned and linked organisations, and the individuals who are engaged by them. The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:-

- Fraud by false representation.
- Fraud by failing to disclose information.
- Fraud by abuse of position.

In these cases, an offender's conduct must be dishonest and their intention must be to make a gain, or cause a loss, (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine and can be committed by a body corporate.

The Bribery Act 2010 makes it easier to tackle this offence in public and private sectors. Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate.

Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

The offences of bribing another person or accepting a bribe carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

Reputational Consequences

A failure to manage conflicts of interest (including the perception of such a failure) can lead to reputational damage and undermine confidence in the integrity of the decision-making process and give the impression that the organisation or individual has not acted in the public interest.

30. Equality and Diversity Statement

NHS Lincolnshire ICB is committed to ensuring that it treats its employees fairly, equitably and reasonably and that it does not discriminate against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs, sexual orientation, gender reassignment, marriage or civil partnership, pregnancy or maternity or race.

Any concerns or issues with the contents of this policy, or difficulties understanding how the policy relates to individuals in their roles should be directed to the ICB Corporate Board Secretary.

31. Monitoring Compliance and Effectiveness of the Policy

This policy will be reviewed on a yearly basis by the ICB Corporate Board Secretary and Board. All groups and individuals to whom this policy applies will be reminded of its contents and Register of Interests on an annual basis. The ICB Corporate Board Secretary will take any action necessary as highlighted by the review.

Conflicts of Interest Management will also be the subject of an independent review by the ICB's Internal Audit Team.

Declaration of interest for ICB members and employees

Name				
Position within, or relationship with the ICB (or NHSE/I in the event of joint committees)				
Detail of interests held (complete all that are applicable)				
Type of interest* *see reverse of form for details	Description of interest (including, for indirect interests, details of the relationship with the person who has the interest)	Date Interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a Senior ICB Manager)

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisations’ policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and, in the case of ‘decision making staff’ (as defined in the statutory guidance on managing conflicts of interest for ICBs) may be published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable, and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal or internal disciplinary action may result.

Decision making staff should be aware that the information provided in this form will be added to the ICB’s registers which are held in hardcopy for inspection by the public and published on the ICB’s website. Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will held in hardcopy for inspection by the public and published on the ICB’s website and must inform the third party that the ICB’s privacy policy is available on the ICB’s website. If you are not sure whether you are a ‘decision making’ member of staff, please speak to your line manager before completing this form.

This paragraph applies to decision making staff only. I do/do not (delete as applicable) give my consent for this information to be published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed:

Signed:
(Line Manager or Senior ICB Manager)

Position:

Date:

Date:

Please return to: ICB Deputy Board Secretary, NHS Lincolnshire ICB, Unit 16, Bridge House, Lions Way, The Point, Sleaford, NG34 8GG or via email to s.bates@nhs.net.

Types of conflicts of interest

Type of Interest	Description
Financial Interest	<p>This is where an individual may get direct financial benefits (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a commissioning decision. This could, for example, include being:</p> <ul style="list-style-type: none"> • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model. • A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; or • A provider of clinical private practice. <p>This could also include an individual being:</p> <ul style="list-style-type: none"> • In employment outside of the ICB • In receipt of secondary income. • In receipt of a grant from a provider. • In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider. • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	<p>This is where an individual may obtain a non-financial professional benefit (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients. • A clinician with a special interests e.g., in dermatology, acupuncture etc.: • An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared). • An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE). • Engaged in a research role. • The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or • GPs and practice managers, who are members of the Board or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.
Non-Financial Personal Interests	<p>This is where an individual may benefit (a benefit may arise from the making of gain or avoiding a loss) personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</p> <ul style="list-style-type: none"> • A voluntary sector champion for a provider. • A volunteer for a provider. • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation. • Suffering from a particular condition requiring individually funded treatment. • A member of a lobby or pressure group with an interest in health and care.
Indirect Interests	<p>This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include:</p> <ul style="list-style-type: none"> • Spouse/Partner • Close relative e.g., parent, grandparent, child, grandchild or sibling. • Close friend • Business partner

Declaration of interest for ICB members and employees

‘No Change’ Form

The Register of Interests and Declaration of Interest Form are attached to the email accompanying this form.

A description of the type of interests can be found on the next page of this form.

Please tick below:

I have reviewed my published entry in the Register of Interests and confirm there are no changes.

If you are unable to tick the statement above, you will need to make a new Declaration of Interest using the form provided in the email.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable, and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal or internal disciplinary action may result.

Examples of when a new form must be filled out include but are not limited to:

- Undertaking any new role or responsibility within the ICB or within a member practice (change of job title necessitates a new form)
- Joining/leaving a Federation or
- Becoming involved in a procurement process

First Name/Surname		Job Title	
Signature		Date	
First Name/Surname: (Line Manager or Senior ICB Manager)		Job Title	
Signature		Date	

Please return to: ICB Deputy Board Secretary, Lincolnshire ICB, Bridge House, Unit 16, The Point, Sleaford, Lincs NG34 8GG or via email at s.bates@nhs.net.

Appendix 2

Template for recording any interests during meetings

Report from <insert details of sub-committee/ work group>	
Title of paper	<insert full title of the paper>
Meeting details	<insert date, time and location of the meeting>
Report author and job title	<insert full name and job title/ position of the person who has written this report>
Executive summary	<include summary of discussions held, options developed, commissioning rationale, etc.>
Recommendations	<include details of any recommendations made including full rationale> <include details of finance and resource implications>
Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)	<Provide details of the QIA/EIA. If this section is not relevant to the paper state 'not applicable'>
Outline engagement – clinical, stakeholder and public/patient:	<Insert details of any patient, public or stakeholder engagement activity. If this section is not relevant to the paper state 'not applicable'>
Management of Conflicts of Interest	<Include details of any conflicts of interest declared> <Where declarations are made, include details of conflicted individual(s) name, position; the conflict(s) details, and how these have been managed in the meeting> <Confirm whether the interest is recorded on the register of interests- if not agreed course of action>
Assurance departments/ organisations who will be affected have been consulted:	<Insert details of the people you have worked with or consulted during the process :
Report previously presented at:	<Insert details (including the date) of any other meeting where this paper has been presented; or state 'not applicable'>
Risk Assessments	<insert details of how this paper mitigates risks- including conflicts of interest>

Declaration of gifts and hospitality

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of Gift/Hospitality	Estimated Value	Supplier/Offeror Name & Nature of Business	Details of Previous Offers or Acceptance by this Offeror/Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or Accepted?	Reason for Accepting / Declining	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable, and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

This paragraph applies to decision making staff only. I do/do not (delete as applicable) give my consent for this information to be published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed: _____ **Date:** _____
Signed: _____ **Position** _____ **Date:** _____
 (Line Manager or Senior ICB Manager)
 Please return to: ICB Deputy Board Secretary, NHS Lincolnshire ICB, Unit 16, Bridge House, Lions Way, The Point, Sleaford, NG34 8GG or via email to s.bates@nhs.net.

Declarations of Commercial Sponsorship

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of sponsorship	Estimated Value	Supplier/Offeror Name and Nature of Business	Details of Previous Officers or Acceptance by this Offeror/Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or Accepted	Reason for Accepting or Declining	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 5 working days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal professional regulatory or internal disciplinary action may result.

I **do/do not (delete as applicable)** give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

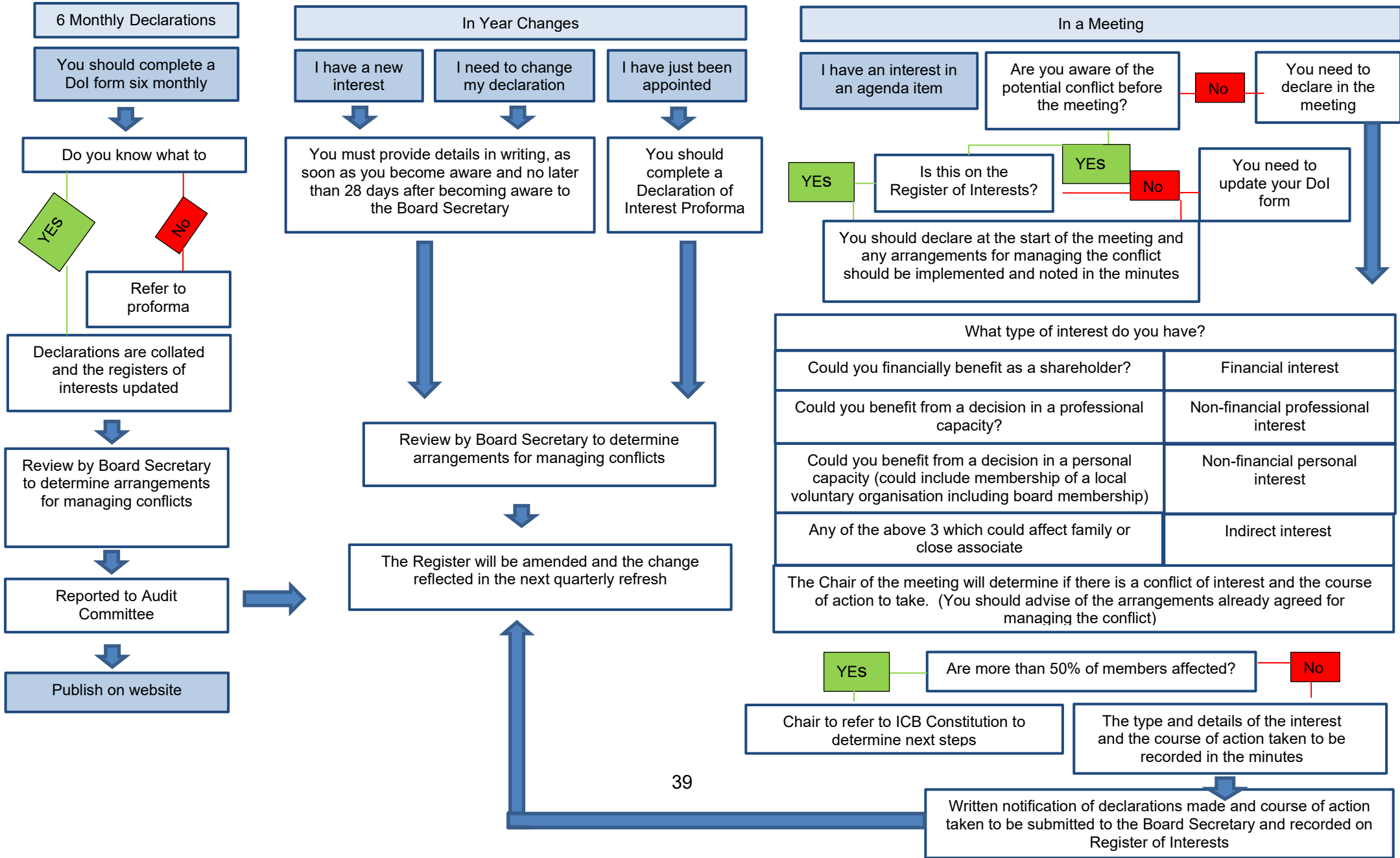
Signed: _____ Date: _____
 Signed: _____ Position: _____ Date: _____

(Line Manager or a Senior ICB Manager)

Please return to: ICB Deputy Board Secretary, NHS Lincolnshire ICB, Unit 16, Bridge House, Lions Way, The Point, Sleaford, NG34 8GG or via email to s.bates@nhs.net

Appendix 5

Declarations of Interest Flowchart





**PUBLIC MEETING OF THE NHS LINCOLNSHIRE
INTEGRATED CARE BOARD**

Agenda Number:	07 (i)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Update from the Service Delivery & Performance Committee for September and October 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:	N/A

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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

September 2024

Winter Planning – The Committee received an update on the Winter Planning letter which was sent to ICBs on 16th September advising that it remains essential in H2 that systems continue their work to deliver their agreed 2024/25 plans. The letter also details that there would be no additional funding available.

The letter focusses on three key areas:

- Planning & Financial Framework
- Supporting People to stay well
- Maintaining patient safety and experience

The ICB are in the process of updating the winter plan for 2024/25 and there are three areas of focus: - Attendance Avoidance, Admission Avoidance and Reduced Length of Stay.

In addition to the winter plan the ICB received an assurance visit from NHSE with regards to the System Co-ordination Centre (SCC) which was highly commended.

Planning – The key planning tasks for September through to October were outlined and progress reported:

- The Initial Intelligence Pack has been developed and published, analysts and programme leads have been briefed.
- Prioritisation Workshop (01/10/2024): For collective analysis of the data and identification of the priority areas and support requirements.
- Development of Headline proposals – Informed by the intelligence pack and outputs of the workshop and current JFP Delivery Plans, follow up analysis to develop evidence base for headline proposal and options appraisal.
- System Review – Headline proposals considered collectively (4 corners approach).
- System Demand & Capacity Modelling – Phase 1 Winter Planning, with focus on UEC pathway, understanding demand factors, bed numbers and including 'out of hospital' services.

Discussions also included the possible implications of the findings and recommendations from the following publications:

- Lord Darzi's Report on the State of the National Health Service in England
- People Power Lessons from the Health Care Response to the Grenfell Tower Fire by the Kings Fund.

Dashboard - The monthly dashboard was discussed particularly in the context of providing assurance over performance trajectories across the rest of the year.

GP Collective Action – At the present time, the action was not having a significant impact on the wider healthcare system, though close monitoring is in place to support mitigation of any future risks.

October

Out of Area Placements (OOA)/Discharges – the Committee received a detailed presentation on Inappropriate Out of Area Placements for Mental Health patients.

The performance target for OOA is zero, in previous years Lincolnshire has performed well, but during 2024/25 there have been significant pressures and the current capacity has been outstripped by demand. This has resulted in spot purchasing of out of area provision and made the zero-target unachievable.

The Committee received assurance on a wide range of activities to improve this position, with discussions having taken place across inpatient and community services to improve performance on admission avoidance, care and treatment on wards, ensuring the right type of bed capacity was in place, increasing discharge accommodation and aftercare support.

These actions form part of the larger programme of work across community, urgent care and inpatient services, aiming to support the achievement of wider strategic ambitions for provision and delivery.

Dashboard - The monthly dashboard was discussed, particularly in the context of providing assurance over performance trajectories across the rest of the year.

Winter Planning – An update was provided in relation to the Winter Plan development. The plan was designed to complement the ongoing improvements in Urgent Care (in line with the National Urgent and Emergency Care Recovery Plan), covering those requiring both physical and mental health care. During August, NHS England Midlands Region shared a set of Key Lines of Enquiry (KLOES) to support the development of local winter plans. The plan outlines the updated system risks for winter, mitigations and any residual risks following mitigation.

65 Weeks – An update was given with regards to 65 weeks and the continuing focus to reduce the waiting list as efficiently as possible.

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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

Report previously presented at:

Not applicable

Is the report confidential or not?

Yes No

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	07 (ii)
Meeting Date:	Tuesday, 26th November 2024
Title of Report:	System QPEC (Quality and Patient Experience) Committee
Report Author:	Sharon Robson, Non-Executive Director (Chair) Martin Fahy, ICB Chief Nurse Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	N/A

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

Recommendations

The Board is asked to note the oversight and assurance work of the Committee.

Summary

The System Quality and Patient Experience Committee took place on 6th November 2024 and focused on the following agenda items:

- **Lincolnshire System Priorities Quality Register:** the latest detail was shared with members and it was noted that two new risks had been added to the register in relation to:-
 - Quality and Timeliness of Medical Cause of Death Certification (Primary Care)
 - Increasing frequency of medicines shortage

It was agreed that the risk in relation to the Initial Healthcare Assessments for Looked After Children would be included on the SQPEC and Corporate Risk Registers.

- **HealthWatch Update:** a presentation was provided on menopause and menstrual health. It was noted that as part of the governance arrangements and the Women's Health Strategy each ICB is required to have a Women's Health Hub in place. It was reported that the findings would be shared at Lincolnshire's first Women's Health conference taking place on 11.11.24. An update was provided on the background, the engagement process and that 450 users had shared their views, common themes, diagnosis and symptoms, mental health and that the impact is not fully acknowledged, examples of good practice and areas for improvement. It was agreed that a further update would be presented to the Committee in approximately six months' time.
- **Process of Review for CQC Section 48 (Calocane) Report:** it was noted that work is ongoing in ensuring that there are appropriate oversight arrangements. It was discussed that a system learning event is in the process of being arranged.

- **Dental Provision Update:** it was reported that the Oral Health Needs Assessment has been completed and that a summary would be presented at the next meeting, the detail has also been used to inform the Dental Recovery Plan. An update was provided on the national initiatives and the implementation of the new UDA rates and the incentive schemes to attract dentists to the profession. Discussions took place regarding the national mandate and the provision of access to urgent dental treatment and accessing this through the 111 service. It was further discussed that there has been a decrease in the number of contacts and complaints received for access to urgent dental treatment and that further work is required to support access to routine treatment.
- **Medicines Optimisation Presentation/Update:** a presentation was provided on the Medicines Optimisation work, issues and mitigations. It was noted that the Medicines Optimisation programme describes a variety of activities that ensure medicines are used in the best way, to gain the optimal benefit for individual patients and for wider population groups, both now (managing illness) and for the future (primary and secondary prevention). To deliver Medicines Optimisation effectively, there needs to be engagement across the system to ensure patients receive the best drug treatments through the whole of their health journeys. The Medicines Optimisation Group is responsible for managing Medicines Optimisation issues at a system level through 4 pillars:-
 - Quality and Safety
 - Digital and Innovation
 - Cost Efficiency and Sustainability
 - Workforce

Discussions took place regarding the prescribing of antibiotics, issues with the Joint Formulary due to capacity and concerns regarding the prescribing of controlled drugs and the monitoring processes of central alerts. Issues were raised regarding the governance processes and that further work is required to strengthen this area.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** it was highlighted that since the last meeting a Never Event was reported in October which relates to wrong mole removal within the Dermatology outpatient department at Lincoln County Hospital. An update was provided on the unannounced CQC visit to the Emergency Department at Lincoln Hospital and that the formal report is expected imminently. It was reported that the community part of our Group has been granted the Defence Employer Recognition Scheme (ERS) Gold Award and the Patient Safety Team were invited by Health Innovation East Midlands to share their learning and experience of seeing the impact of Patient Safety Partners in October 2024. Lastly it was noted that the Trust has been awarded Teaching Trust status.
- **Lincolnshire Partnership NHS Foundation Trust Highlight Report:** it was reported that currently the Vales Inpatient Rehab Service is paused to admissions which is due to the current levels of acuity on the ward and the challenges related to staffing pressures. It was noted that a communication plan is currently in development with the LPFT communications team of which will focus on the core principles of PSIRF and the shift away from the SI process and the move towards a culture of shared learning from incidents. An update was provided on the LPFT Patient Awards and Staff Awards and that a number of staff and patients were recognised for the excellent work they have done and the positive changes they have made within their areas of work.
- **East Midlands Ambulance Service NHS Trust Highlight Report:** an update was provided in relation to the signed contract and that the impact will remain on Work Force Plan for 2025/26 as no external training will be undertaken. There continues to be focus on efficiency targets on scene and as part of the focus an audit has been undertaken on the inter facility transfers. It was noted that the Trust has been awarded Gold status for the work with the military and honorary contracts.
- **System Partners – Local Authority Update:** it was reported that three cases of Mpox have been reported nationally and that work is taking place with partners on engaging with the population deemed to be at risk. It was noted that there has been one outbreak of influenza reported in a Care Home.

- **Primary Care Highlight Report:** it was noted that there are five Practices across Lincolnshire that are currently receiving enhanced support. An update was provided on the Sutterton Practice and the work that has taken place on the clinical safety review. The Practice team have worked exceptionally hard to review over 1500 patients whilst continuing to deliver day to day primary review. It was noted that Lincolnshire is one of the few systems to have made suitable provision for primary care providers to be fit tested for FFP3 respirators. The ICB has made an offer to Practices to have staff trained in being able to carry out fit testing for their own area or PCN. The ICB has also provided fit testing equipment and a supply of FFP3 masks to Practices. This is above the national ask for ICB's to support their primary care providers with area of work.
- **Operational Quality Assurance Group (OQAG) Update:** it was reported that work is ongoing with NRS Healthcare and the provision of wheelchairs and that the level of complaints has decreased over the last month. It was noted that there are 18 risks on the OQAG register with two new risks being added recently for the LPFT Community Mental Health Team and the waiting times associated with the neurodiversity pathways. An update was provided on the system shared learning and good practice on pressure ulcers.
- **System Quality Group Update:** an update as given on the work with Public Health and the completion of assurance visits to all funeral homes in Lincoln with no significant concerns identified. It was noted that a thematic discussion had taken place in relation to the National Education and Training Survey & GMC National Training Survey 23/24 Overview. In addition, a thematic review was undertaken in relation to the Urgent and Emergency Care pathway and the work with the head injury pathway.
- **Terms of Reference (ToR):** the ToR for the Committee were presented. Discussions took place regarding the Vice Chair arrangements and a Non-Executive Director assuming this role in the absence of the Chair.
- **Revised Cycle of Business/Planner:** the Business Planner was presented for information.

Items for escalation to the ICB Board:-

- The Lincolnshire System Priorities Quality Register was presented and discussions took place regarding the risk associated to the Initial Healthcare Assessments for Looked After Children.
- A presentation was received from HealthWatch on menopause and menstrual health. Discussions took place regarding the governance processes and the link to the Women's Health Hub.
- A presentation was given on the Medicines Optimisation programme and the risks identified with the gaps in service provision.
- The highlight reports for the system organisations were presented and the following noted:-
 - Lincolnshire Community Hospitals Group: recent unannounced CQC visit to the Emergency Department.
 - Lincolnshire Partnership NHS Foundation Trust: a recent Patient Awards and Staff Awards had taken place and that a number of staff and patients were recognised for their excellent work they have done and the positive changes they have made.
 - East Midlands Ambulance Service NHS Trust: the continued efforts and focus on the improving performance standards.
 - Primary Care: the significant amount of work undertaken at the Sutterton Practice to address the backlog and the roll out of the provision of FFP3 respirators and the associated training for general practice.
- The Oral Health Needs Assessment has been completed and this will inform the Dental Recovery Plan.

<ul style="list-style-type: none"> The Terms of Reference for the Committee were received and it was agreed that these would be refreshed. 			
How does this paper support the ICB's core aims to:			
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.		
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.		
Aim 3: Enhance productivity and value for money.	As above.		
Aim 4: Help the NHS support broader social and economic development.	As above.		
Conflicts of Interest		Summary of conflicts	
No conflict identified			
Risk and Assurance			
A System Risk Register and ICB Risk Register is in place of which is shared at the meeting.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	No		
Does the report highlight any quality and patient safety implications?	No		
Does the report highlight any health inequalities implications/	Health inequalities considered in all aspects of the work programme.		
Does the report demonstrate patient and public involvement?	Patient and public involvement and engagement is embedded within the System QPEC.		
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No		
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Report previously presented at:			
The Board receives regular reports from each of its Committees at every meeting.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	07 (iii)
Meeting Date:	Tuesday, 26 th November 2024
Title of Report:	Audit & Risk Committee Update
Report Author:	Ms Karen Bates, Assistant to the Board Secretary Mrs Jules Ellis-Fenwick, ICB Board Secretary Mrs Margaret Pratt, Non-Executive Member and Chair of the Audit and Risk Committee
Presenter:	Mrs Margaret Pratt, Non-Executive Member and Chair of the Audit and Risk Committee
Appendices:	N/A

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

Recommendations

The Board is asked to note the update and progress.

Summary

The Audit & Risk Committee meeting held on 13th November 2024 focused on a number of areas including the following:

- Governance Report
- Update on the ICB Risk Management Arrangements
- Update re POD & Spec Com
- Audit Yorkshire Counter Fraud Update Progress Report
- TIAA SICA Report
- Internal Audit Report - Key Financial System
- HFMA Governance Checklist – Update

Key points for noting were as follows:

Governance Report

The latest versions of the Declaration of Interest and Hospitality Registers were presented and noted. The Committee was also briefed on the reasons for making two special payments; both were approved.

IG Quarterly Update – Quarter One

The main focus of work had been the new data security and protection toolkit. Changes are expected around format and requirement for the period 2024/25 and this is currently being reviewed to formalise a work plan for the year. There will now be 12 outcomes to be audited on where the ICB can choose an additional four.

Update on the ICB Risk Management Arrangements

An update was provided on the ICB Risk Management arrangements, including the latest position on actions identified following the internal audit review of the adequacy and effectiveness of the ICB's risk management arrangements in 2023/24 including how it interfaces with the ICS wide risk management structures. It was noted that all actions were now complete.

Update re POD & Spec Com

The Committee considered a paper and supporting oral update setting out reasons for a delay in completing internal audit recommendations and to agree extension dates for each of the overdue recommendations, which was agreed. Further work is in hand to seek to streamline assurances about the operation of controls operated through Joint Committee arrangements.

Audit Yorkshire Counter Fraud Update Progress Report

Progress was reported on two against long-standing investigations. A PHB case has now closed and no further action will be taken. Comms will be shared around International Fraud Awareness Week.

TIAA SICA Report

One report had been finalised since the previous meeting on Key Financial Systems. The Committee was pleased to note that reasonable assurance had been provided on the operation of controls. It noted that a further report was in draft around Health Inequalities which is awaiting management comments. The Committee noted with concern the number of planned audits planned for completion in the remainder of the financial year; and also the difficulties said to have been encountered in rolling out system-wide assurance reviews. The new internal audit code of practice was included in the report.

HFMA Governance Checklist – Update

A plan has been formulated to improve the scores on the HFMA governance checklist. The action plan arising has been endorsed by TIAA.

How does this paper support the ICB's core aims to:

Aim 1: Improve outcomes in population health and healthcare.	
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	

Conflicts of Interest		Summary of conflicts	
No conflict identified			
Risk and Assurance			
A indicated in the report.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?		If yes, include the details otherwise state 'No or Not Applicable'	
Does the report highlight any quality and patient safety implications?		If yes, include the details otherwise state 'No or Not Applicable'	
Does the report highlight any health inequalities implications?		If yes, include the details otherwise state 'No or Not Applicable'	
Does the report demonstrate patient and public involvement?		If yes, include the details otherwise state 'No or Not Applicable'	
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)		If yes, include the details otherwise state 'No or Not Applicable'	
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
Report previously presented at:			
Regular updates provided to the Board.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

Briefing Summary of the East Midlands Joint Committee Meeting held on Tuesday 15 October 2024

1. Purpose

- 1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 15 October 2024.

2. Summary of Agenda Items

2.1. Chair Arrangements

The Committee **APPROVED** Kathy McLean, Chair of NHS Nottingham and Nottinghamshire ICB and Chair of NHS Derby and Derbyshire ICB, be appointed as Chair for the remainder of the year and that a new Chair will be appointed in April 2025.

2.2. Feedback from Chief Executives Development Session in June

The Committee **NOTED** the update from the Chief Executives development session at which they considered opportunities to enhance the operational and governance arrangements of this regional collaborative model. Emphasis was placed on opportunities to improve the delegated / decision making structure, wider leadership engagement (beyond the membership), and a collective desire to shift the focus to an “improvement agenda”. It was agreed to establish a Joint Committee Development Session to progress this work collectively.

2.3. 111/999 Decision Making Update

The Committee **NOTED** the paper seeking approval of a proposed the future 111/999 operational/ governance structure proposal paper was yet to be considered by all partners. It was agreed for Chief Executives of those remaining to support its presentation and for the outcomes to be confirmed at the December meeting.

2.4. 111 / 999 Contract 2024/25 Update

The Committee received an update on the contractual positions for both 111 and 999 services, **NOTING** whilst service provision is maintained there are material matters relating to resourcing that remain outstanding. It was agreed that a further update should be presented to the Committee in December.

2.5. Primary Care Finance and Assurance Report, and Dental Commissioning Plans

The Committee received the report for **ASSURANCE**. Primary focus of discussion laid with the underlying financial position, current provision of Dental Services and the work being undertaken to increase capacity within the region, planning for the coming years inclusive of progress being made with the Oral Needs Assessment and Dental Commissioning Plans (expected for approval December 2024), development of a Community Pharmacy Strategy within the next six to twelve months, and plans to undertake an Eye Health Needs Assessment in Q4 prior to developing the Eye Health Strategy.

2.6. Specialised Commissioning Services Integrated Assurance Report and Draft Acute Clinical Strategy

The Committee received the report for **ASSURANCE** with focus of discussion being on the 59 delegated services, progress toward delegation of the currently retained services, and the

working relationships and governance between NHSE and ICB and within the tiered East Midlands governance structure pre and post delegation in 2025.

The Committee **SUPPORTED** the development of the strategic agenda and its alignment to inter-region and multi-region pathway transformation. The Committee were provided with the key drivers for change inclusive of engagement and informed of the key areas of opportunity being Paediatrics, Oncology, Neonates and Cardiovascular. It was agreed the December meeting should receive a strategy progress update with a focus on Fragile Services.

2.7. Chief Medical Officers Group Update.

The Committee received an overview and **NOTED** the work being undertaken through the East Midlands Chief Medical Officers Group, specifically the work undertaken collaborative with the Specialised Commissioning Team. The Group confirmed supported for the 4 priority areas set out in the Specialised Services Acute Clinical Strategy. It was agreed for the group to remain engaged with the Committee to support clinical considerations on services that fall within the remit of the Committee.

2.8. East Midlands Fertility Policy Review and Case for Change

The Committee received a presentation on the work undertaken to review all existing policies, the multi ICB engagement undertaken, and the resultant case for change as it applied to each area. The Committee were asked to consider and support the direction of travel to a single East Midlands Fertility Policy that would see all East Midland ICBs commissioning against the same policy, and the proposed next step of moving to pre-engagement preparation. The Committee gave its **SUPPORT** to the work undertaken and proposals made.

3. Recommendation

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