NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board

Public Board Meeting

Tuesday, 30th January 2024
at 9.30 am

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

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

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 30th January 2024
Time: 9.30 am
Location: The Boardroom, Bridge House, Sleaford

Deputy Acting Chair: Dr Gerry McSorley, Acting ICB Chair

AGENDA

ITEM NUMBER		ACTION	ENCLOSURE/ VERBAL	LEAD	TIME
1. INTRODUCTION					
i)	Welcome and Apologies		Verbal	Dr Gerry McSorley	9.30
ii)	Declarations of Interest		Verbal	Dr Gerry McSorley	
iii)	Minutes of the previous meeting held the 28th November 2023	Approve	Enclosure	Dr Gerry McSorley	
iv)	Matters Arising, including Action Log	Note	Enclosure	Dr Gerry McSorley	
2. CHAIR AND CHIEF EXECUTIVE UPDATES					
i)	Chair • Update and Overview	Note	Verbal	Dr Gerry McSorley	9.35
ii)	Chief Executive • Update and Overview	Note	Verbal	Mr John Turner	9.45
3. KEY UPDATES					
i)	Public Health	Note	Verbal	Professor Derek Ward	9.55
ii)	Healthwatch	Note	Enclosure	Mr Dean Odell	10.00
4. CORE PURPOSE 1: HEALTH INEQUALITIES (tackle inequalities in outcomes, experience and access)					
i)	Reducing inequalities for people with Severe Mental Illness (SMI)	Receive	Enclosure	Mrs Sandra Williamson/Mrs Sara Brine/Mrs Victoria Sleight	10.05
5. CORE PURPOSE 2: HEALTH OUTCOMES (improve outcomes in population health and healthcare)					
i)	Integrated Quality and Performance Report – October 2023	Receive	Enclosure	Mrs Clair Raybould/ Mr Martin Fahy	10.30
ii)	Update on the Clinical Directorate and the Research and Innovation Hub	Receive	Enclosure	Dr Sunil Hindocha/Mrs Louise Jeanes	10.40
iii)	Update on the Primary Care System Level Access Recovery Plan	Note	Enclosure	Mr Nick Blake/Dr Sunil Hindocha	11.00
BREAK AT 11.10 AM (10 MINUTES)					

6. CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY					
i)	Finance Report – Month Nine	Receive	Enclosure	Mr Matt Gaunt	11.25
7. CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE (help the NHS support broader social and economic development)					
i)	Lincolnshire ICB People and Communities Strategy	Approve	Enclosure	Mr Pete Burnett/ Mrs Steph King	11.30
8. GOVERNANCE					
i)	Delegation of Specialised Commissioning and update on the East Midlands ICB Collaborative Arrangements	Receive	Enclosure	Mrs Sandra Williamson	11.45
ii)	Report from the Primary Care Commissioning and Delegated Functions Committee meeting held on 20th December 2023	Receive	Enclosure	Dr Gerry McSorley	
iii)	Report from the System Quality and Patient Experience Committee (QPEC) meetings held on the 1st December 2023 and 9th January 2024	Receive	Enclosures	Mrs Sharon Robson	
iv)	Report from the Service Delivery and Performance Committee meetings held on the 15th November 2023 and 13th December 2023	Receive	Enclosure	Mrs Dawn Kenson	
v)	Report from the Audit and Risk Committee meeting held on the 26th January 2024	Receive	Verbal	Mrs Margaret Pratt	
9. INFORMATION /CLOSING ITEMS					
i)	Risks identified during the course of the meeting	Consider	Verbal	Dr Gerry McSorley	
10. DATE, TIME AND VENUE OF NEXT MEETING					
	Tuesday, 26th March 2024 at 9.30 am at Bridge House, Sleaford	Note	Verbal	Dr Gerry McSorley	Close

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

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

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

NHS
Lincolnshire
Integrated Care Board

MINUTES OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD MEETING HELD ON TUESDAY, 28th NOVEMBER 2023 AT 10.15 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	Acting ICB Chair and Chair of the Primary Care and Delegated Functions Committee and Deputy ICB Chair
	Mrs Sarah Connery	Executive Board Mental Health Member (until 11.00 am)
	Ms Anita Day	Non-Executive Director
	Mr Matt Gaunt	Director of Finance
	Mr Martin Fahy	Director of Nursing
	Dr Sunil Hindocha	Interim Medical Director
	Mr Andrew Morgan	Partner Member, NHS and Foundation Trusts
	Mrs Margaret Pratt	Non-Executive Director and Chair of the Audit and Risk Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Director
IN ATTENDANCE (REGULAR PARTICIPANTS)	Mr Nick Blake	Programme Director, Primary Care
	Ms Charley Blyth	Director of Communications and Engagement
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Jules Ellis-Fenwick	ICB Board Secretary and Head of Corporate Governance
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Rebecca Neno	Deputy Director for System Delivery (Winter Plan item)
	Mr Dean Odell	Healthwatch Representative
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
APOLOGIES:	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board

23/154 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire Integrated Care Board and apologised for the late start which was due to unforeseen circumstances.

Dr McSorley emphasised that whilst the meeting was being held in public it was not a public meeting. The meeting was being held both on a face to face basis and via Microsoft Teams as a Live Event. This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams. Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma which was published on the website.

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

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

23/155 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:
Mr Morgan declared an interest in Item 8 (i) Paediatric Service Change as the Chief Executive of United Lincolnshire Hospitals NHS Trust (ULHT). This was discussed and it was agreed that Mr Morgan would remain in the room when the item was considered but would not participate in the discussion or the decision.

Mrs Ellis-Fenwick advised that as Mr Morgan was the only Partner Member present and not able to participate in the decision, this would mean the Board would not be quorate for that item (as per 4.7 of the ICB Constitution one Partner Member must be present to meet quoracy requirements). As Mr Morgan has been disqualified from participating in a discussion by reason of a conflict of interest, he no longer counts towards the quoracy and neither Councillor Bowkett or Dr Thomas were present. However, in preparation for this potential situation, Councillor Bowkett and Dr Thomas had been contacted for their views and decision in relation to the paper prior to the meeting. Councillor Bowkett had responded in writing and confirmed her support for the recommendations and advised that she could join the meeting via the telephone for that specific item if required.

The Board agreed to:

- **Note the interest as declared.**

23/156 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 26th September 2023 and agreed to:

- **Approve the minutes as a true and accurate of the meeting.**
- **Note the communications briefing from the Annual Public Meeting held on the 28th September 2023.**

23/157 MATTERS ARISING

Dr McSorley presented the Action Log as included in the pack of papers. There were two actions both of which were identified as complete.

The Board agreed to:

- **Note the action log and supporting verbal update.**

23/158 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

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

There had recently been a change in the Secretary of State for Health and Social Care. The incoming MP Victoria Atkins' constituency is in Lincolnshire. There had also been some other changes to the Ministerial Team following a Cabinet reshuffle.

Dr McSorley advised that he had recently attended a range of key meetings since the Board last met, including Lincolnshire Leaders Group (LLG) held on the 22nd November (Planning Session and regular monthly meeting), Regional Chair Meetings, on-going meetings with Partner NHS Trust Chairs and Lincolnshire Leaders at Lincoln County Hall. Dr McSorley had also attended the Remembrance Day event.

The next meeting of the Health and Wellbeing Board and Integrated Care Partnership (ICP) was scheduled to take place on the 6th December and both Dr McSorley and Mr Turner planned to attend.

The interview process for the appointment of the Lincolnshire Group Chair had recently taken place, which Dr McSorley had been involved in. A suitable candidate had been identified and the details had been put forward for sign-off by NHSE. The outcome of their decision was currently awaited.

Dr McSorley referred to the recent endorsement of Lincolnshire's devolution arrangements at government level, having been announced by Lincolnshire County Council (LCC). The proposal for a combined Greater Authority for Lincolnshire and Greater Lincolnshire does not include health directly but health and wellbeing may experience significant benefits should it proceed. A briefing for system Board Members on the devolution was currently being arranged to take place in early January 2024.

On a final note, LCC received had confirmation of a Care Quality Commission (CQC) rating of good for Adult Social Services following a recent inspection. The report was very positive and referenced the strong partnership working in place in Lincolnshire.

Chief Executive update

Mr Gaunt that he was deputising for Mr Turner, and he had a number of items to highlight for the Board's information but first and foremost wanted to take the opportunity to recognise the dedication and hard work of staff across the health and care sector who continue to respond to the significant pressures which the NHS continued to face, particularly associated with industrial action and increased levels of demand. The country is now stepping into winter and the ICB along with its system partners have been working closely together on the preparation for this period. More information on this would be covered under the presentation of the Winter Plan later in the meeting.

The pack of papers included a letter from NHSE confirming formal notice of the Lincolnshire NHS transition to NHS Oversight Framework (NOF) Segment 3 and exit from the Recovery Support Programme (effectively out of finance 'special measures'). This was clearly excellent news for the ICB and system and signifies Lincolnshire's move out of the Financial Recovery Programme and is a marker of its improved long term financial sustainability. Well done to everyone involved.

Professor Derek Ward would be taking on an enhanced role as System Leader for the Community Primary Partnerships work. This was excellent news and ICB Board colleagues were very supportive of this news.

Mr Turner had recently attended a number of key meetings including the Active Lincolnshire Sport & Physical Activity Awards (top class work across the county); and Healthwatch Annual Public 'Question Time' event. Mr Morgan and Mrs Connery had also been present at this event which had been well attended and positively received.

The ICB's Emergency Preparedness, Resilience and Response (EPRR) Framework has received the highest level of accreditation, for which the team were commended. Congratulations was also offered to the Better Births team for their recent win of the Heath Service Journal's Military and Civilian Health Partnership Award with their submission about The Lincolnshire Military Project, a service which focuses on the support networks and local connections made available to military families in the county, many of whom do not have extended family and friend networks close to the military bases they live near in Lincolnshire.

In early November, Mr Turner and partner representatives attended a LCC hosted annual Urgent and Emergency Care (UEC) summit event. There is good support across the system for the joint work on winter preparedness being led by the ICB.

There has been a further, very constructive, meeting of the University & Health Strategic Partnership Group, which was attended by Mr Turner, Dr Hindocha, Professor Ward and Mrs Connery. There is lots of impressive work underway.

Mr Turner will be attending the next meeting of the University Court scheduled to take place on the 8th December 2023 (post meeting note – the meeting was cancelled) and also the North Kesteven Young People's Question Time in early December 2023.

On a final note, the Board was asked to note that Mr Martin Samuels had now commenced in post as the new Director of Adult Social Services at LCC.

Dr McSorley moved on to the two items referenced on the agenda, the first of which related to the NHS England » Sexual safety in healthcare – organisational charter. This had been published and all ICBs were being asked to formally sign up to this. The charter includes ten principles and actions and signing up involves committing to working towards these by July 2024.

This was discussed and it was agreed that the Board needed to be clear on the details of the ten pledges before signing up to them. Mrs Ellis-Fenwick would obtain more detail during the meeting and this item would be returned to at the end.

The next item related to a letter which sets out NHS England Midlands expectations of ICB Boards actions to support the ongoing challenge of reducing temporary staff costs. The letter was included in the pack of papers for information. The Board was requested to note the details.

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

Action: Mrs Ellis-Fenwick

The Board considered the update. The Board welcomed the positive news about the NOF 4 exit and commended all those involved on this excellent achievement. The Board also endorsed the comments about staff and system partners for their continued support and efforts over what will be a very difficult and challenging winter.

The Board agreed to:

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

23/159 KEY UPDATES

Public Health

Professor Ward provided a verbal update in relation to Public Health and advised that there were some specific areas to brief the Board on as follows:

- There had been one confirmed human case of a new strain of influenza in the UK (H1N2) The patient had been diagnosed when a routine swab which was taken following respiratory issues. They had since fully recovered and there was no known onward transmission. It was noted this is different to swine flu and there is no cause for concern in Lincolnshire nor in the UK.
- There was nothing specific to raise about influenza.
- There has been a gradual increase in the number of cases of measles in recent months and those who have not had vaccine were being encouraged to do so.
- Professor Chris Whitty, Chief Medical Officer, had recently published his Annual Report 2023 – health in an ageing society. Professor Ward's Director of Public Health Annual Report focused on ageing better in Lincolnshire, so the two documents sit well alongside one another. This would be presented to the ICB Board in the New Year.

The Board considered the update. Ms Day referred to the increase in the number of cases of measles and sought clarification on the current vaccination rates and how they compared to the position nationally and also the plans to address areas of inequality. Professor Ward advised that there is a specific programme in place for vaccinations which is via the Health Protection Board, which he Chairs. The latest figures would be reported via that Board in December/January.

Healthwatch

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

- 53% of the comments received related to mental health services, the majority of which were from the Healthwatch Community Mental Health Survey. Key themes included concerns over access to mental health support services, the resultant waiting times and the apparent lack of support whilst waiting. In contrast patients had also commended the life changing effect mental health services in Lincolnshire have had on them. The report is currently being put together and Healthwatch is working with Mrs Sarah Connery, Chief Executive and other colleagues at Lincolnshire Partnership NHS Foundation Trust (LPFT) on the final output. An update would be provided at the next ICB Board meeting.
- 41% of comments related to GP services. Many of these were case-specific and did not provide many broad overarching themes.
- COVID boosters and flu vaccination - People had expressed difficulties in being able to book an appointment for these vaccines, eligibility and location of vaccination sites. These concerns have been shared with the ICB and some of the issues related to the enthusiasm of members of the public to obtain their vaccine before local systems had been set up.
- Access to NHS dental services continued to be a top concern for many patients.
- A broad theme about many services this month was accessibility. Comments covered translation services in primary care, the environment of healthcare settings and preferences around communication.
- Healthwatch is aware of the NHSE Access and Information Standard Review, which is imminent, and that a number of practices had already implemented some or parts of this and with support from the ICB were developing their websites, specifically in relation to the learning disabilities aspects.

On a final note, Mr Odell wanted to take the opportunity to formally thank Mr Turner, Mrs Connery and Mr Morgan for their attendance and support for the Healthwatch Forward Vision Event which had taken place recently. The questions and answers received from members of the public will be shared shortly.

Dr McSorley thanked Mr Odell for his update and invited Mr Blake to comment on the Access and Information Standard Review. Mr Blake advised that the ICB Primary Care Team was working closely with practices and system partners to review the use of a set of standard templates on websites and for information for patients. Good progress is being made but there are a few practices which need to greater engage in that process.

Mrs Williamson was invited to comment on progress in the East Coast area in relation to dentistry access. Mrs Williamson advised that since the ICB received delegation from NHSE for Pharmacy, Optometry and Dentistry on the 1st April 2023, the key focus has been on the development of the Dental Strategy and the improvement in access on a short term basis but also in terms of long term planning. In the short term the ICB has been able to secure some additional access in areas where it has proved challenging to meet the routine needs of the local population. This is only an interim solution. Traditionally procurements usually take around 12-18 months to conclude and a procurement has just been completed in the Mablethorpe area. As a result an improvement in access in that area will start to be seen in the coming months.

Separate to that it has been agreed through the Primary Care Commissioning and Delegated Functions Committee to provide a deep dive update on progress of the Dental Strategy, which will be provided in early 2024. The Dental Strategy will then come to the Board for an update in terms of the four workstream areas, one of which is access.

Dr McSorley invited Mrs Connery to comment on the mental health waiting times. Mrs Connery advised that LPFT was working with Healthwatch to provide a detailed response to the comments received in the survey, but just for noting it had recently been reported in the Health Service Journal (HSJ) that LPFT currently has the lowest community waits when benchmarked against all other mental health providers.

The Board agreed to:

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

CORE PURPOSE 1: HEALTH INEQUALITIES

23/160 SMI HEALTH INEQUALITIES

Dr McSorley advised that due to unforeseen circumstances, the item listed on the agenda had been postponed until the January 2024 meeting.

CORE PURPOSE 2: HEALTH OUTCOMES

23/161 INTEGRATED QUALITY AND PERFORMANCE REPORT

Performance Section

Mrs Raybould presented the performance section of the Integrated Quality and Performance Report which predominately covered the reporting period September/October and advised that she would take the report as read but wished to highlight some specific points for the Board's attention. As the Board was aware, the Service Delivery and Performance Committee reviews reports on performance and delivery and detailed scrutiny occurs by service area alongside quality. This report contains the key constitutional targets and information will be provided verbally in the meeting where more recent data is available on key operational targets.

As a first point of note, the report included industrial action by the junior doctors and consultants (both separate and joint strikes). This took a huge amount of planning preparation and operationally on the day. Mrs Raybould paid tribute, particularly to ULHT, in being able to predominately manage their activity despite the challenges associated with the industrial action. Lincolnshire compared favourably to other areas up and down the country.

Mrs Raybould advised that in the reporting period the Urgent and Emergency Care (UEC) indicators demonstrated they were particularly challenged, which was in part due to the hangover from industrial action. However, there were some positive areas of improvement in relation to ambulance response times. The detail and actions were set out in the report.

Other areas highlighted included the successful protection of much of Lincolnshire's cancer activity during the recent industrial action periods, as well as the continued reduction of the cancer recovery backlog.

Challenges remain in some areas. Like the rest of the country, planned care performance has been impacted by industrial action. The main priority continued to be the elimination of 78 week waits. This continued to be challenging but is a much-improved position across all providers. Systems are now focused on virtually eliminating 65 week waits by the end of March 2024. The actual number of patients waiting over 65 weeks is now decreasing and the overall cohort who would reach 65 weeks by end of March is on trajectory to be zero. Again, the detail and associated actions were set out in the report.

In respect of diagnostics, the MRI part of the Community Diagnostic Centre (CDC) in Skegness was on track to open the first week of December, which was very positive.

Mental Health performance for NHS Talking Therapies has previously been challenging and remained slightly below plan but this had now improved, which was positive in light of the significant increase in referrals to that service. People experiencing their first episode of psychosis waiting to start a package of care had improved to 53%, previously having been 38%. All of the recovery actions put in place had now been completed. Mrs Raybould referred to the recent positive impact of LPFT's recruitment drives across their services.

The Board considered the performance part of the update. Mr Morgan referred to the very recent UEC improvement in performance and highlighted the ambulance handover element of that. Considerable efforts have been made to get ambulances back on the road as quickly as possible. This has increased the risk within the hospital by moving more people into cohort and loading areas as examples but is showing through in lower handover delays and therefore performance against the Category Two standard has improved. Similarly the 12 hour waits in the department are always unacceptable, but it is good that the number is declining and that needs to be kept in focus.

Ms Day referred to the recent opening of the Grantham UTC and sought clarification on whether any impact was yet being seen in terms of people diverting away from Lincoln. Mrs Raybould advised that the UTC had been open for almost a month now and whilst more patients were being seen with it being open 24/7, there had not been a material impact on other sites in Lincolnshire. This was expected because of the type of presentations UTC can receive. What has been seen is the use of the UTC by some of the periphery patients.

Mr Burnett added that the opening of the UTC had been phased with the first element being 24/7 but ambulances had not been expanded after 6.30 pm. This was scheduled to be reviewed at the end of the month. Overall, the new service seems to be working well and work continued to build on the next phase.

Mrs Pratt referred to the reduction in patient harm arising from improved flow and asked whether there was the opportunity to publish some of the findings as part of research in terms of what has worked well.

Mrs Raybould advised that every year a Winter Plan debrief has to be completed. As part of this year's it should be possible to show some tangible results following the improved patient flows. This would be picked up with Dr Hindocha as the Executive lead for research outside of the meeting.

Action: Mrs Raybould

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

Quality Section

Mr Fahy presented the Quality Section of the Integrated Quality and Performance Report and advised that he would take the same approach as Mrs Raybould and the Board had read the report. The following key points were highlighted from the patient safety quality perspective.

- The planned reopening of the Psychiatric Intensive Care Unit (PICU) has been delayed due to a legionella outbreak which is being carefully managed by the team at LPFT.
- ADHD has previously been reported to the Board in relation to the Rapid Quality Review process undertaken. Enhanced oversight arrangements have now been stood down and a framework for routine quality oversight established. The Care Quality Commission (CQC) undertook an unannounced inspection in August 2023, publication of the report is awaited.
- Primary Care – Caskgate in Gainsborough and Branston, near Lincoln. Caskgate continued to make good progress. Richmond practice was a new entry from a CQC point of view, having been subject to an inspection some time ago. The report had now been published and the practice identified as inadequate. The Quality Team are providing support and advice to the practice. Branston who were rated as inadequate by the CQC have now been re-inspected and now classed as good.
- There had been one new Never Event which did not result in any harm to the patient but there is some learning for the provider.
- NHSE undertook a Patient Safety stocktake with ICB nursing and medical leads in October 2023 to establish the current position against national and regional priorities; highlight areas for improvement; and identify support available. The ICB was able to provide a wide range of evidence in relation to the key lines of enquiry and feedback from the process was overall positive, with useful advice where there is opportunity to strengthen current Patient Safety arrangements.
- On 30th October 2023 NHSE Midlands undertook a visit with Lincolnshire Local Maternity and Neonatal System (LMNS) stakeholders. The regional team facilitated and guided discussions to identify national and local priorities and associated measures, to enable the LMNS to provide assurance to the ICB. Representatives from across the system participated in the visit to provide expertise and guidance in the development and implementation of local measures.
- There is a requirement for all practices to have a Support Level Framework diagnostic within the next 12 – 18 months. Further information on this would be covered under the Primary Care Access Recovery Plan update later in the meeting.
- A process for Health Professional Feedback is well established with general practice and a focus for learning themes from this continued. The Transfer of Care Hub are working to reduce incidence of these issues; and work is also taking place through the Medical Director interface meeting that has been re-established with primary and secondary Care.
- Work is taking place to scope the Freedom to Speak Up arrangements that need to be in place for primary care, that will align with the expectations set out by NHSE. Proposals will be considered through the Primary Care People Group.
- COVID-19 vaccinations – the ICB has exceeded the target set by NHSE and the service remained the best performing in the region, though there is always more work to do. Nationally, the vaccination period had now been extended to the 31st January 2024.

The Board considered the update. Mrs Robson referred to the Friends and Family Test where performance against the target had not been achieved for some time, and asked whether any collective work is being undertaken to address this. Mr Fahy advised that those types of conversations are taken up through the partnership meetings with each of the providers, which usually take place on a monthly basis. That aside Mr Fahy was happy to do a deep dive into this in light of the longevity of performance being below standard and provide more detail at the next Board meeting.

Action: Mr Fahy

Mrs Pratt referred to Freedom to Speak Up and asked whether the Board should receive an annual report on this. Mr Fahy advised that this was a fairly new arrangement and since he had been in post as the FTSU Guardian he had only dealt with two issues as the ICB had less than 400 staff and was not directly patient facing. Provider organisations tend to have higher numbers. The intention is to look at a system review and whether that takes place on a bi-annual or annual basis had not yet been agreed. There is also not a singular system lead established and Mr Fahy was aware other systems were currently scoping out that type of role. In terms of assurance to the ICB Board, once a full calendar year was complete a report would be presented to the Board.

Dr McSorley advised that it is currently unclear what NHSE expect of ICBs in terms of oversight for Freedom to Speak Up, and clarification is being sought. Regardless of that it was important to bring forward further information on the actions being taken in Lincolnshire rather than just waiting for guidance.

The ICB Board agreed to:

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

23/162 WINTER PLANNING 2023/24

Mrs Raybould introduced the next paper which had been produced to brief the Board on the work undertaken in preparation of Lincolnshire's Winter Plan, which had been developed collaboratively and influenced by national best practice, guidance issued by NHSE and learning from previous winters within the system. Mrs Rebecca Neno is the Winter Director supported by Mrs Raybould and had joined the meeting to run through the Winter Plan.

Mrs Raybould handed over to Mrs Neno, Winter Director, who provided a comprehensive overview of the Winter Plan and the work undertaken in getting to this point. This year, as per last year, the focus has been on the avoidance of patient harm by adopting an approach that focuses on clinical risk, as recommended by local clinicians at the clinical summits. This approach was commended by regional colleagues during the Winter Assurance visit that took place on 10th October 2023 as well as the comment that the plan was the most integrated the NHSE Midlands Regional Team had seen.

The primary risk to the plan is whether the content was sufficiently robust enough and that is articulated in the paper presented, and the Board had already discussed a number of clinical risk areas earlier in the meeting. Some additional modelling is being carried out to provide assurance which should be available later that week.

It was noted that the Winter Plan had been presented to and considered by a range of Committees including Service Delivery and Performance, Lincolnshire Leaders Group (LLG) and Better Lives Lincolnshire Leadership Team (BLLLT). The document would also be presented to the Integrated Care Partnership at its meeting later that month.

The Board considered the report. Mrs Robson advised that in the first instance she wanted to commend the document, which was a brilliant piece of work. Secondly, she referred to the section on community capacity and advised that she would have expected to see more information included around pharmacy and voluntary organisations and asked whether this was reflected elsewhere.

Mrs Neno advised that the detail was included in the underpinning work; there are limitations around what information can be incorporated into the main document. Community Pharmacy colleagues are working very closely with primary care, community services around prevention of admissions. The comments were noted though for consideration when developing the Winter Plan in 2024.

Mrs Raybould that there is a considerable amount of work that takes place which is referred to as normal business (operational all year round) which is not reflected in the Winter Plan, such as in community pharmacy and the voluntary sector; this is more around additionality. Community pharmacy can be a challenge in winter months and also on a daily basis in terms of access. However, nothing specifically had been flagged currently which would make a material difference to the plan.

Mrs Jolly confirmed that the voluntary sector has been involved in the planning and development of the Winter Plan and have a number of initiatives in place to support patients such as around discharge and admission avoidance. There is the potential to expand some of these if required.

Ms Day asked whether there is a separate document which sets out the risks and mitigations associated with the assumptions in the Winter Plan and what plans were in place to complete a Quality Impact Assessment (QIA) or Inequalities Assessment (IA). Mrs Neno advised that the biggest risk is the overwhelming of acute services, which would then impact on other services. The risks are detailed within the Board Assurance Framework (BAF) but not necessarily defined in terms of winter. Mrs Neno advised that she would take that away and have a look at the detail and ascertain whether completion of the assessments referred to is required.

Action: Mrs Neno

Dr McSorley referred to Single Point of Access (SPA) and asked for an update on progress. Mrs Neno advised that SPA went live the previous week and that is about health professionals being in people's homes trying to navigate admission avoidance. Via the governance arrangements put in place through the group model reporting is coming through on a daily basis on the positive impact that is having on admissions.

The Board agreed to:

- **Note, endorse and adopt the work undertaken in preparation of Lincolnshire's Winter Plan.**

23/163 PRIMARY CARE SYSTEM LEVEL ACCESS IMPROVEMENT PLAN

Mr Blake advised that following the publication of the *Delivery Plan for recovering access to primary care* in May 2023, ICBs are required to develop system-level access improvement plans. The Primary Care Access Recovery Plan (also known as the Delivery Plan for recovering Access to Primary Care) was published in May 2023 and sets out an ambitious package of measures and specifically covered for key areas, which were set out in the paper.

1. Empowering patients to manage their own health
2. Implementing Modern General Practice Access
3. Building Capacity
4. Cutting bureaucracy

Mr Blake presented the ICB Primary Care Access Recovery Plan and provided an overview of the content and progress to date. The Board was advised that the Lincolnshire plan aims to sets out the local delivery of the Primary Care Access Recovery Plan within the context of the Lincolnshire Joint Forward Plan and the development of the five-year system delivery plan. The longer-term plan includes the development and implementation of the Fuller recommendations on proactive and integrated care.

The initial focus of the System Level Access Improvement Plan is on access to GP practices: extension of community pharmacy services is included within the scope of the plan in relation to empowering patients and reducing demand on GP practices where care can be effectively and appropriately provided by a pharmacy. The intention is for all four pillars of primary care – GP practices, community pharmacy, community optometry services and dental practices to be included in future iterations of the plan, with a particular focus on developing the opportunities presented by the integration of primary care services.

The plan document (Appendix One to the report) described the local approach to delivering the key areas set out within the national Primary Care Access Recovery Plan and sits alongside three impact assessment documents:

- A Health Equity Assessment Tool (HEAT)
- An Equality Impact Assessment (EIA)
- A Quality Impact Assessment (QIA)

There has been good progress on delivery of the Primary Care Access Recovery Plan, and this is reflected in the Lincolnshire System Level Access Improvement Plan, the plan also sets out next steps. These will be updated as the plan is developed further.

The Board considered the update. Mrs Pratt firstly commended the Plan and acknowledged the work involved in getting it to this stage. Mrs Pratt asked whether there are arrangements in place for post implementation review on what works well, any gaps as examples and the timelines for completion. Thirdly, is there a bank system in place for workforce in Primary Care. Mr Blake advised that the plans will be reviewed with the PCNs with regular meetings taking place on a monthly basis. The focus is usually on areas such as quality and patient experience and access by way of some examples of performance metrics.

A data dashboard is also being developed to demonstrate outcomes. Another element is gaining a greater understanding of the feedback PCNs receive from patients and also the use of key pieces of intelligence. A review of the patient survey each year also takes place. In terms of the governance arrangements, updates will be provided through the Primary Care and Delegated Functions Committee. Regarding workforce, there is a bank system in place in primary care, although it is not currently particularly well used. There needs to better promotion and utilisation of this which is included as part of the People Plan.

Mrs Robson reiterated Mrs Pratt's comments about the plan; it is an excellent piece of work. In terms of the governance and oversight arrangements, Mrs Robson asked that consideration is given as to how this interfaces with the System Quality and Patient Experience Committee (SQPEC), which is pivotal to supporting this piece of work. Mr Blake acknowledged Mrs Robson's comments and advised he would look at the arrangements.

Ms Day advised that building on the questions from Mrs Pratt and Mrs Robson, she asked for clarification on the additional roles referred to, and also commented that the Plan was not as detailed as she would have expected in respect of quality of care, the associated governance arrangements and how the Board gains assurance around this. Mr Blake advised that he was happy to build on the quality side of the plan but assured the Board that a piece of work is taking place around training staff regarding taking on their additional roles.

Dr Hindocha advised that PCN Clinical Directors have a responsibility to ensure quality of care is provided by their staff. The ICB is in a better place than most because of the model that has been adopted with PCNs but this will continue to be built on.

Mr Odell advised that Healthwatch would be reporting data on the PCNs in its reports going forward and asked whether there are any specific timescales for completion of the work on population health needs. Mr Blake advised that population level plans are outside of the remit of this plan but this is being incorporated into the 5-year planning piece of work.

The Primary Care Team are also working with system partners on this area, recognising this is not just about primary care. There were no specific timelines for the completion of that piece of work.

Dr Hindocha and Professor Ward added that every PCN has its own population health profile and this is regularly refreshed. There will need to be an on-going conversation about how the approach is re-designed going forward in respect of population health needs.

Mrs Pratt asked how the Board is assured that Lincolnshire ICB is receiving its fair share of the allocation through the current East Midlands commissioning governance and delegated arrangements. Mrs Williamson provided an overview of the governance arrangements for the delegation of primary care and PODs and advised that she would follow-up on the comment made about fair shares of effort in relation to the East Midlands ICBs joint working arrangements outside of the meeting.

Action: Mrs Williamson

Following some further comments about the registered population and those who do not fit into this, and encouraging everyone to have a registered GP, Dr McSorley drew the discussion to a close.

The Board agreed to:

- **Note the progress on developing a local approach to improving the interface between primary and secondary care services in line with the Primary Care Access Recovery Plan and the recommendations of the Academy of Medical Royal Colleges.**

CORE PURPOSE 3: ENHANCE PRODUCTIVITY AND VALUE FOR MONEY

23/164 MONTH SEVEN – FINANCE REPORT

Mr Gaunt presented the finance report of the Lincolnshire Integrated Care System (ICS) and the ICB for month seven (up to 30th October 2023) and advised that the position remained largely unchanged since the previous update to the Board.

Mr Gaunt confirmed that the NHS in Lincolnshire was on track to deliver the cost improvement plans committed to at the start of the year. The measures to reduce run rate of agency expenditure were successful meaning the system would achieve a £17m (30%) reduction on an annualised basis, and that acute and community headcount had remained flat throughout the year. This pointed to a significant improvement in underlying productivity.

Mr Gaunt also clarified the unplanned costs due to the ongoing industrial action, inflationary pressures and prescribing costs remain challenging. Capital investment is behind plan currently but there was significant assurance that plans would accelerate in the final months of the year and capital funds would be fully utilised.

The Board considered the report, noting that the financial position was considered and scrutinised in great detail through the Finance and Resource Committee and also through the Finance Recovery Programme Board.

The Board considered the report and agreed to:

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

CORE PURPOSE 4: SOCIAL AND ECONOMIC VALUE

There was no specific item on this occasion under this heading.

In line with the discussion on conflicts of interest and quoracy under item 23/156, Mr Morgan confirmed that he would not participate in the discussion on the next item.

Dr McSorley noted that the Board was not quorate for the next item, but Councillor Bowkett had already given her decision on the paper, which was to approve the recommendations. It was agreed this would be formally noted in the minutes.

GOVERNANCE

23/165 PAEDIATRIC SERVICE REVIEW

Mr Burnett presented a paper which provided an update on the ULHT Paediatric Service at Pilgrim Hospital, Boston.

By way of background, the Board was advised that following significant challenges in the paediatric service over a number of years, the service model was temporarily adapted from a children's inpatient ward to a 12-hour Paediatric Assessment Unit in 2018. Over the last five years, the Family Health Division at ULHT has participated in a number of discussions with representatives of the community served by Pilgrim Hospital, to discuss the developing models of care. Their honest feedback on experiences in hospital was extremely helpful in supporting the development of an appropriate service model.

Now, five years on, improved staff recruitment and new ways of working have meant that the hospital can offer a full Children's Unit, which is an example of best practice, offering early assessment and enabling care for the majority of Boston-area children at the hospital. The service performance is also resulting in high levels of family satisfaction, low level of complaints and last year received a 'Good' rating from the CQC.

A public consultation was run between Monday 12th June 2023 and Monday 4th September 2023, asking whether this current model of care should be made permanent. The results had been reviewed which indicated overwhelming support for making this service model permanent.

Mr Burnett confirmed the paper had been presented, noted and endorsed by the ULHT Board. On that basis the ICB Board was asked to approve the service change to the Paediatric Service at Pilgrim Hospital Boston to make the temporary service model which has been in place since March 2019 the permanent model.

The Board considered the report. Mrs Robson asked whether the Senate's recommendation and comments around capacity and demand modelling and therefore sustainability had been progressed. Mr Burnett advised that the current model has been in place since March 2019 so has demonstrated its sustainability. Dr Hindocha advised that he would like to see this service replicated at Lincoln County Hospital as there was clear clinical evidence of how well it is operating. Separate to that, work was currently taking place with the clinical lead at ULHT and Public Health colleagues to consider the profile going forward, for example in five to ten years' time.

Mr Fahy followed on from Dr Hindocha's comments and advised that the metrics for the service in respect of mortality and co-morbidity had been reviewed and demonstrated an overall improvement in outcome and patient experience.

Mrs Raybould commented that this is a really good piece of engagement work and the team who were involved should be recognised for this and supported Dr Hindocha's comments about replicating this at Lincoln County Hospital.

Professor Ward advised that by way of assurance to the Board, and in support of Dr Hindocha's comments, Public Health have been involved in the work around predicting the current and future needs of children's services and population, and a Clinical Summit review, as referred to in the report, had also taken place which suggested Public Health engagement.

The Board agreed to:

- **Approve the service change to the Paediatric Service at Pilgrim Hospital Boston on the basis that the service provision and patient outcomes and experience have improved since the changes were made.**

23/166 UPDATE ON RISK APPETITE AND THE BOARD ASSURANCE FRAMEWORK

Mr Gaunt presented a report which provided an update on progress and development of the ICB's Risk Appetite and Board Assurance Framework (BAF) along with actions going forward.

It was noted that the Board held a Development Session on the 24th October with a focused workshop on Risk Appetite and the BAF. A follow-up session of the Board Risk Workshop has been arranged to take place on the 19th December 2023 which will consider progress on the development of the Risk Appetite and the latest version of the BAF, with an expectation that mitigations and controls will be much clearer.

In terms of system risk, there is work to do to understand the current levels of risk appetite as it is acknowledged these are likely to be different across the provider Trusts and also the ICB. Work has commenced with a view to summarising risk appetite across the provider Trusts and the ICB as a useful positioning for the Audit Chairs to consider.

The Board agreed to:

- **Note the report and progress to date.**

23/167 PRIMARY CARE COMMISSIONING AND DELEGATED FUNCTIONS COMMITTEE

Dr McSorley presented the report from the Primary Care Commissioning and Delegated Functions Committee meeting held on the 18th October 2023 and outlined the contents. The only item for escalation was the Primary Care Access Recovery Plan, which had already been considered in detail as a separate item earlier in the Board meeting. There was nothing further to add.

The Board agreed to:

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

23/168 SYSTEM QUALITY AND PATIENT EXPERIENCE COMMITTEE

Mrs Robson presented the report from the System Quality and Patient Experience Committee meeting held on the 20th October and advised that she would take the report as read, but wished to highlight the following points of escalation:

- Following on from the focus on the recommendations from the Audit and Risk Committee to strengthen the role of the Committee, the latest meeting had focused on risk and further development of the System Risk Register and development of the System Quality Strategy.
- Oliver McGowan (on Mental Health, Learning Disabilities and Autism) mandatory training for all staff was now available on-line through the Electronic Staff Record (ESR) system. The Board Members, if not already done so, were encouraged to complete this training, which is very enlightening. A System Operational Group had been established to oversee this piece of work. Mr Fahy is the Senior Responsible Officer for this group.
- As detailed in the performance report, the largest number of serious incidents related to pressure ulcers. In relation to Learning from Incidents, Lincolnshire Community Health Services NHS Trust (LCHS) had undertaken a Pressure Ulcer Thematic review which had identified some underlying themes, which were set out in the report.
- LPFT are undertaking a thematic review in relation to suicide prevention and research into rural and coastal mental health.
- ULHT's patient led assessment of clinical enrolment (referred to as PLACE) had shown a marked improvement across all sites which had placed the Trust in an improved position nationally.

The Board agreed to:

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

23/169 SERVICE DELIVERY AND PERFORMANCE COMMITTEE

Mrs Raybould presented a report from the Service Delivery and Performance Committee meetings held on 20th September 2023 and 18th October 2023 and advised that she would take this as read but referred the Board to the escalation items.

- Acknowledgement of the increasing collaboration across the system and group model.
- Data quality issues across providers and the possibility of exploring a shared Business Intelligence (BI) function (under the provider review corporate services workstream).
- Communication to and from patients across the system – for example, reducing DNAs for outpatient appointments/GP appointments etc. – is there a strategy for effective two-way communications?

Mrs Raybould provided a short explanation of the items escalated and the work being undertaken to progress the data quality issues and improve communication.

The Board considered the report and agreed to:

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

23/170 AUDIT AND RISK COMMITTEE

Mrs Pratt presented the report from the Audit and Risk Committee meeting held on the 14th November 2023 and provided a brief summary of the key items discussed. There was one item to highlight to the Board for information:

- Risk around improving assurance about how the ICB assures itself regarding the interface with partners. The External Auditors had brought to the Committee's attention areas of concern around the Better Care Fund (BCF), Continuing Healthcare (CHC) and Personal Health Budgets (PHBs). It was understood these areas were being picked up by the ICB Executives directly with Lincolnshire County Council colleagues.

Mr Fahy advised that the additional detail and assurance being sought in relation to CHC had been picked up as part of a meeting which had taken place with local authority colleagues earlier that week. As a result the additional information sought will be forthcoming as they now understand the ask.

The Board considered the report and agreed to:

- **Note the report.**

23/171 ANY RISKS IDENTIFIED

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

Dr McSorley referred the Board back to the Sexual Health Charter and 10 pledges, the details of which had been circulated to the Board for information. The Board was asked to confirm its endorsement and sign up to the Sexual Health Charter and the ten pledges, which was agreed.

23/172 DATE AND TIME OF THE NEXT MEETING

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

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Chair Signature **Date**

Not Delivered
In Progress
On Track to Deliver
Complete

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

Date of Meeting:	**Tuesday, 30th January 2024**
Agenda Item:	**1 (iv)**
Reporting Officer:	**Dr Gerry McSorley, Acting ICB Chair**

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
	23/158	ICB Chair and Chief Executive Update	To publish the question and response received on the ICB website, attach the details to the minutes of the meeting and issue to the individual who submitted the details.	Mrs Ellis-Fenwick	December 2023	Question and response published on the website. Details attached to the minutes. Response emailed to the member of the public who submitted the details.	Complete
28/11/23	23/161	Integrated Performance Report	Director for System Delivery to liaise with the ICB Medical Director outside of the meeting regarding the opportunity to demonstrate tangible results following the improvements in patient flow.	Mrs Raybould and Dr Hindocha	Spring 2024	This will be picked up as part of the Winter Debrief which will take place in Spring 2024. The debrief will be considered through the UEC Programme Board and then report to the System Delivery and Performance Committee.	Complete in relation to the Board.

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
28/11/23	23/161	Integrated Performance Report	To look into the Friends and Family Test and establish whether any collective work is taking place where the targets are not being achieved.	Mr Fahy	January 2024	Included as an item for discussion and action at the next System Quality Group. The outcome will be reported to SQPEC when complete.	Complete in relation to the Board.
28/11/23	23/162	Winter Plan	Winter Plan - the risks identified are not currently explicit within the BAF. Mrs Neno to look into this to ensure the risks are reflected in the BAF and ascertain whether completion of the assessments is required.	Mrs Neno	January 2024	The strategic risk in the BAF relating to delivery of operational targets has now been removed and transferred to the Corporate Risk Register as this is operational rather than strategic in nature. It has been confirmed that completion of a QIA and IA in relation to the Winter Plan is not required.	Complete.
28/11/23	23/163	Primary Care System Level Access Improvement Plan	Mrs Williamson to follow up the comment made about fair shares of effort in relation to the East Midlands ICBs Joint Working Arrangements outside of the meeting.	Mrs Williamson	January 2024	Closed.	Complete in relation to the Board.

Questions from the Board meeting held on 28th November 2023

Question One

In the response to Health Watch the representative of the Lincoln Medical Committee states that there were 400,000 appointments in GP Practices each month. Is there any information about how many of those were face to face appointments with a doctor?
If there is how many were there, please?

In the same document it is stated that 'Most GPs work 10 – 12 hour days and if you are the last patient of 100 that day, fatigue can effect decisions and your GP does not want to do something that may risk your safety.'

I have been told that the designated appointment time for a patient is 10 minutes.
I presume GPs have to fulfil administrative responsibilities and take some time to eat, so I cannot work out how they see 100 patients, even in a twelve hour day. (6 x12=72)
Could you explain this, please?

Response:

Thank you for your questions.

In response to the first question, in September 2023 GP practices provided a total of 469,000 appointments, 335,000 (70%) were face-to-face. Of these, 93,400 were provided by a GP (with the rest provided by nurses and other staff) .

The second question would require a response from colleagues at the Local Medical Committee (LMC) as the quote came from one of their representatives, but the example of a GP seeing 100 patients in a day was indicative and, even then, its assumed that not all would be face-to-face contacts: some will be online or via telephone and would not take 10 minutes necessarily e.g. GP triages an online contact and refers the patient to another professional within the practice team for follow up.

healthwatch Lincolnshire

Monthly Report December 2023

Contents

Location of comments:

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

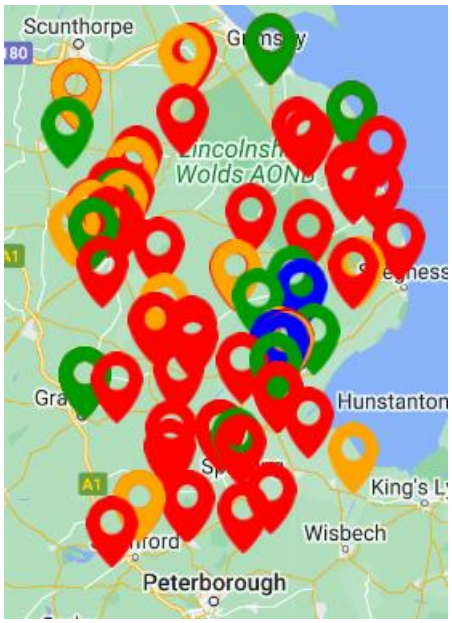
Positive - green

Negative - red

Mixed - orange

Neutral - blue

Unclear - grey



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

it starts with YOU

Overview

Monthly Report

During November 2023 Healthwatch Lincolnshire received **116** patient experiences directly to our Information Signposting Team. This is a summary of the key themes raised by patients, carers and service users during November 2023 about services in Lincolnshire.

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

#SpeakUp

Overall Sentiment

15% of all comments were **positive**
64% of all comments were **negative**
4% of all comments were **neutral**
16% of all comments were **mixed**

November 2023 – Feedback Service Themes Sentiment

39%

Hospital Services (All services)

33%

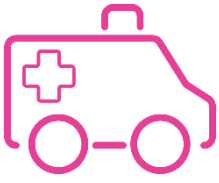
GP Services

5%

Community Health Services

9%

Accident & Emergency



0%

Patient Transport

9%

Dentistry

48%

Mental Health & Learning Disabilities

5%

Social Care

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

Mental Health

This month many of the experiences shared related to Mental Health. These experiences came in via our Community Mental Health Survey.

With the aim of gaining greater insight into peoples' experiences of community mental health services in Lincolnshire, Healthwatch Lincolnshire launched two surveys. One was for services users (both adults and children) which received **91** responses. **70** people shared their view on adult services and 19 on children's services. The second survey for professionals received **20** responses. **10** respondents disclosed they worked in mental health services and 10 worked in other sectors.

Key Findings

Key findings from the surveys are outlined in the main body of the report, offering a broad overview of the participants' experiences and concerns.

- **67% of respondents found it "difficult" to access adult services.**

Both service users, parents/carers, and professionals highlighted consistent concerns, with long waiting times being the most significant issue.

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

It is important to recognise that many had positive experience of services including, Steps2Change [now known as Lincolnshire Talking Therapies], Crisis, Community Mental Health Teams and the Eating Disorder Service.

You can read the full report and the response from LPFT Lincolnshire Partnership NHS Foundation Trust (LPFT) here. https://www.healthwatchlincolnshire.co.uk/report/2023-12-15/community-mental-health-services-report-dec-2023

NHS Dentistry

Access to NHS dental services continues to be a top concern for many patients. We continue to hear from patients who have been trying to access NHS dental services in the county for years. The only option available currently appears to be to pay for private treatment. However, many cannot afford this and this is likely to worsen existing health inequalities. We heard this month from a pensioner who would have to 12 months for NHS denture work but could have the same work done as a private patient within 24 hours.

"Recent dental treatment Broadway Dental Surgery as an NHS patient. Patient has an existing lower denture, needed to have three lower teeth removed and denture adjusted to take account of the change, i.e., have 3 teeth added to the denture.

The dentist informed the patient there is a 12-month wait for NHS denture work or they could have the adjustment made in 24-hours privately at a cost of £440, but no charge for the teeth removal work. The tooth removal and denture addition should be covered under band 2 at £70.70.

The patient paid the £440 because they couldn't go for a year without a denture. But patient currently raising a pension credit application as only on a pension of £803 per month, so to pay £440 is a bit much."

"Patient looking for NHS dentist in Boston for 6 years in that time has not been to dentist."

"The situation in Lincolnshire is so bad I have been trying to find an NHS dentist for 15 years my teeth are so bad it's affecting my general health, I have managed to find a dentist in South Yorkshire have my first appointment soon total cost of all the treatment will be just over 300 pounds , quotes I had in Lincolnshire ranged from 3000 Upto 5000 pounds at unaffordable private dentists, I just can't get my head around how people can afford that kind of money it's not fair the people in Lincolnshire have to pay rip off prices."

GP Services

This month the feedback we received about GP services related mainly to access and accuracy and medical records. Neither of these issues appeared to be related to a specific GP Practice.

Concerns relating to access included:

- Getting through to a practice over the phone and subsequent waiting times to speak to a receptionist
- Access options – some of those who shared their experiences felt pressured into having to use online access option such as askmyGP which either due to personal preference or accessibility reasons did not feel appropriate

"Patient has been informed that the Surgery have changed the way they do their appointment systems, now in the main can only use AskMyGP, received a text message a few weeks ago about this, however, spouse did not and both registered with their individual contact details, so wonders how many other patients have not received this information. Also with AIS what about those patients who do not have access to any form of internet or mobile phones, how are they being informed of the changes. Understands that patients can still call and the reception staff will input into AskMyGP and that it will be open from 8am Monday - Friday, however a patient noticed that on trying to go on AskMyGP this morning, that it was closed at 9am. Understands the difficulties faced on a daily basis but concerned how this will effect those who need access and will have to try everyday to get through."

"I have to wait on the telephone to get an appointment. Once I get through , or when I have to call later appointments full. No problems once I get appointment. Telephone system does not work well. Experience rated good except for phone system."

"Would like to see my GP face to face not over the phone. Also the system to get an appointment where you have to get on the phone before 8 am to get an appointment. But then you find you are 33 in the queue. If you go round to the surgery you get told you have to book by phone."

"How do people get an appointment at this surgery? It is impossible to get through on the telephone. If you ring through, the phone will just keeping ringing and the calls are not being picked up. If you go in, you are not made to feel unwelcome and told to book online or ring through. This week the online service was available for 6 minutes only on Monday morning and then only 44 minutes on Tuesday morning."

Also this month concerning GP services, we heard from three individuals who had concerns about the accuracy of their medical records.

"Patient needed a copy of their medical notes to apply for a blue badge and bus pass, on receiving a copy of their notes, they found a number of errors within the medical notes, some information is missing on their medical history and other areas has incorrect information on as 'common law partnership' where spouse had passed away a couple of years ago, so was quite distressing."

"Patient was looking through their NHS App and noticed that there was an DNR highlighted in purple on their records, unable to find out who placed it on there. Has spoken with the surgery who did not know and can't take it off. Patient contact NHS England who also stated they could not take it off as have no access to the system, but to make contact with all their consultants to see if one of them placed it on their NHS app records. Patient commented the surgery are very good and have looked after both spouse and patient very well, just would like to know how to get this off their records as very concerned."

"Patient had a previous diagnosis of Paranoid Schizophrenia dating back from 2015, patient did not have an assessment for this and feels this has been medical negligence. Moved to Scotland where they were seen by a psychiatrist where they had an assessment in August 2021, the Consultant provided a letter stating the patient did not have this condition. Now finding it difficult for any GP surgery to remove the diagnosis from their records, even though the letter has been provided. Has been informed that Scotland is outside the UK! and so this letter does not stand. Wants to get a job and carry on with their career they were doing prior to the diagnosis in 2015."

We also heard from one caregiver struggling to access post bearevement support for a young child.

"P Patient reports that spouse died last October. Contacted GP about 5 months ago to get counselling for young children under 10 years. GP offered medication for patient but could not give medication to the children. GP gave patient telephone number that they got from the internet . Tried this not working. Found someone to talk to, they said no counselling available in Lincolnshire for children under 10 years old. Found someone in Bourne, too far away. Winstons Wish sent some pamphlets, that's all. Still looking for someone local. Describes experience as poor."

Positive Stories

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

"Patient reports positive experience with Urgent Treatment Centre at Pilgrim Hospital. They had hurt their foot and was treated very quickly."

**"My spouse and I attended. They were seen, assessed, saw doctor who prescribed antibiotics which I collected from pharmacy in just over an hour.
Please tell us about your experience (e.g. what went well?) - Everything
How easy was it to access the help and support you needed? - Very easy
How would you describe your experience of care? - Good**

"Had to take my elderly parent who is hard of hearing, diabetic and suffering from repeated UTIs (Urinary Tract Infections) to the UTC yesterday. Waiting times low, staff very happy and treatment explained by a very nice Dr in a way parent could understand. Had several tests and these results were explained very timely. From triage to seeing a Dr was 15 minutes, fabulous. On being informed that parent was diabetic, tea and biscuits were given a few times to ensure parent was hydrated etc and family member also offered tea. Parent was given a private room so they could get some peace and quiet.

Ultrasound department staff so friendly and chatty to put parent at ease. Can't praise them highly enough. Parent hates having to go to hospital and this experience has made it easier should the need arise in the future. Parent will require a referral to Urology, which their GP surgery will need to do."

"Once a year I attend the Asthma clinic at Old Leake Surgery, I find the service very good, but transport to the surgery is difficult as I don't drive."

"I put an online medical concern in this morning on e-consult. Received a phone call about an hour later, appointment made to see a GP in the next 30 minutes, referral would be sent and all done and dusted. I have never had any concerns with my surgery, always felt they put the patient at the core and appointments provided in a timely manner. Fabulous service."

"They are an AskMyGP practice and to date, when I have requested an appointment or had a query on AskMyGP, I have always received a same day appointment. For example, last week, @9.30am I submitted a request for an appointment with a specific GP, to discuss a recent A&E attendance. Within 10 minutes, a receptionist had phoned me and given me a face-to-face appointment for 11am. If I have ever needed to phone them for something that doesn't feel appropriate for AskMyGP, it is easy to get through on the phone and the reception staff are always friendly and helpful. The surgery is extremely well regarded by the community it serves and I have never had anything but excellent care from any member of staff; it really is a jewel in the crown of Lincolnshire Primary Care services."

"Patient provided positive experience following treatment for breast cancer at Lincoln County Hospital. So fast, so quick, everything from being diagnosed, check up mammograms, biopsies, scans and lastly the operation they all went well. Nurses doctors they're all good kind caring people. Bless them all."

"Patients relative admitted to A&E at Lincoln County Hospital. Positive experience, was assessed, treated within 5 minutes for sepsis. Young child having to wait with relatives as no other childcare, given food and drinks which patient was surprised about but very pleased with. Patient very pleased with experience and outcome."

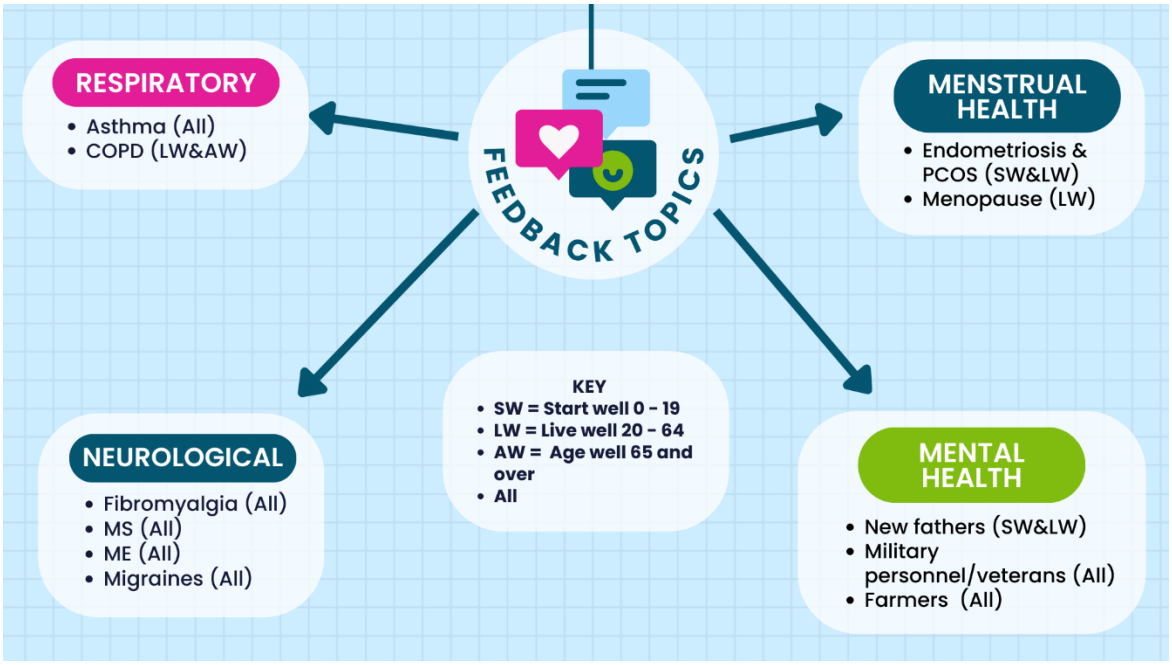
"Patient has a good experience with Paediatrics as now has ADHD (Attention Deficit Hyperactivity Disorder) diagnosis for their child. Very pleased as can now get the right treatment for them."

"Patient experience at the Colposcopy Department at Pilgrim Hospital rated as very good. Dr and their staff were extremely kind, informative, as I was anxious and worried. I originally was hoping for Lincoln County Hospital as I live in Lincoln. Once at Pilgrim, I was glad that I was referred to Pilgrim."

Healthwatch Lincolnshire Update

Campaigns for 2024

Healthwatch Lincolnshire has strategically chosen to prioritise **menstrual health, respiratory conditions, neurological conditions**, and **mental health** in its upcoming 12-month focus.



This decision is driven by a commitment to amplify the voices of individuals and communities that are often underrepresented or unheard in healthcare discussions.

By addressing these specific themes, Healthwatch Lincolnshire aims to broaden its engagement across diverse areas and populations, fostering a more inclusive dialogue on health issues.

Moreover, this targeted approach aligns with the organisation's overarching goal of addressing health inequalities, allowing them to proactively contribute to a more equitable and comprehensive healthcare landscape in Lincolnshire.

This approach will also allow us to reach diverse population groups as outlined in our Annual Plan, hearing the voices of Health and Social Care Staff, those with physical and/or sensory impairment, young people, Veterans, and those impacted by social isolation and digital exclusion.

What will we do with the experiences shared?

We act as a critical partner to health and care service providers and commissioners across Lincolnshire, using what people have told us as the basis for this relationship.

We want the views and experiences of local people to shape the services they provide and influence the decisions they make.

To do this, we analyse what local people are telling us to identify trends and issues. We then talk to commissioners and service providers about what is working well and what could be improved.

Our unique powers under the Health and Social Care Act 2012 mean we are involved in decision-making, and commissioners and service providers should listen to what we say. We have a seat on the Lincolnshire Health and Wellbeing Board and are involved in various other local health and care boards and working groups so that people's views can influence the work of these groups.

We will continue to champion the meaningful involvement of users and carers in the design, delivery and decision-maki of health and care services and will encourage providers to use co-production approaches to design and develop their services. The introduction of the Lincolnshire Integrated Care System will result in significant changes to how the NHS is managed. We will continue to play an active role in this to ensure service users' voices are heard at all levels of NHS decision-making.

To read more about our campaigns for 2024, please click here.

Enter and View Activity

Healthwatch Lincolnshire is pleased to announce that we have been selected by Healthwatch England to carry out two Enter and View Visits in the new year. These visits will be to Grantham Community Diagnostic Centre (CDC) and Skegness Urgent Treatment Centre.

The purpose of this activity is to understand the experiences of people attending CDCs for diagnostic tests and the experiences of staff working in CDCs.

We will continue to undertake Enter and View visits in Lincolnshire Care Homes in 2024 – in January we will publish the reports from our last 3 visits.

Volunteering

November was a relatively quiet month for our volunteers with the total volunteering hours being 23 hours. Nine events were attended, meaning **this year we've covered 221 events so far - an amazing achievement, thank you to everyone.**

This is what our brilliant volunteers have been up to (events they have attended):

- Fenside Health and Wellbeing Fair.
- Louth Dementia Alliance virtual coffee morning
- PLACE event at Stamford Hospital
- St Barnabas Coffee morning
- Sensory Services Coffee Morning Sleaford attended
- Our volunteers have also been helping us with admin work, proofreading documents and volunteer recruitment planning.

Demographics

In addition to location data, for those who consent, we are now able to collect demographic data from the individuals who contact our Information Signposting Officer.

Demographic	Number of people	Demographic	Number of people
Age		**Ethnicity**	
13 to 15	**1**	**Black / Black British: Any other Black / Black British background**	**1**
16 to 17	**1**		
18 to 24	**3**	**White: British/English/Northern Irish/Scottish/Welsh**	**32**
25 to 49	**17**		
50 to 64	**20**		
65 to 79	**8**		
80+	**2**		
Gender		**Carer**	**21**
Male	**15**	**Disability**	**19**
Female	**35**	**Long term condition**	**20**

S

healthwatch

Healthwatch Lincolnshire
Rooms 33-35
St Georges Road
Boston
Lincs
PE21 8YB

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

Item 4 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED BOARD

Agenda Number:	4 (i)
Meeting Date:	30TH January 2024
Title of Report:	Reducing inequalities for people with Severe Mental Illness (SMI)
Report Author:	Victoria Sleight – Head of Community Mental Health Transformation, LPFT Sara Brine – Head of Mental Health Transformation, LICB Rachel Rogers - Programme Manager for Physical Health in Severe Mental Illness, LICB David Stacey – Public Health Programme Manager, LCC
Presenter:	Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration Victoria Sleight – Head of Community Mental Health Transformation, LPFT Sara Brine – Head of Mental Health Transformation, LICB
Appendices:	Reducing inequalities for people with SMI slide set

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

Recommendations

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

Summary

Background

Some people have far poorer mental health than others. In many cases, those same people have less access to effective and relevant support for their mental health. When they do get support, their experiences and outcomes are often poorer, in some circumstances causing harm. This 'triple barrier' on mental health inequality affects large numbers of people from different sections of the population.

Reducing health inequalities in severe mental illness (SMI) is a complex issue that requires a multi-faceted approach.

Some of the ways to reduce health inequalities in SMI:

- **Improving access to physical health care:** Improving access to physical health care is an important outcome measure for tackling health inequalities in people with SMI.
    - This can be achieved by providing annual physical health checks, improving access to physical health interventions such as smoking cessation, and integrating physical and mental health care and improving the management of chronic physical health conditions.
- **Reducing premature mortality**: Reducing premature mortality in people with SMI is a key outcome measure for tackling health inequalities.

  Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes, and hypertension. It is estimated that for people with SMI, two in three deaths are from physical illnesses that can be prevented.
- **Reducing the incidence of cardiovascular disease and diabetes:** Reducing the incidence of cardiovascular disease and diabetes is an important outcome measure for tackling health inequalities in people with SMI.
- **Reducing stigma and discrimination**: People with SMI may experience stigma and discrimination, which can lead to reduced access to physical health care and poorer health outcomes.
- **Improving awareness and training among health care professionals:** Health care professionals may lack awareness and training in the physical health needs of people with SMI, which can lead to a lack of appropriate care and treatment.

National Context

Public Health England reports that patients with severe mental illness (SMI) experience significant physical health inequalities.

- Younger patients (aged 15-34 years) with SMI diagnosed with three or more physical health conditions show the highest level of inequality. They are five times more likely to have three or more physical health conditions than the general population.
- It is estimated that for people with SMI, two in three deaths are from physical illnesses that can be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes, and hypertension.
- Data shows that people with severe mental illness (SMI) die up to 20 years younger than the general population, from preventable physical health conditions such as cardiovascular disease, diabetes, and cancer.

Local Context

The Public Health Fingertips Mortality profile data (2018-2020) shows that adults with an SMI in Lincolnshire are at four times higher risk of premature mortality than adults without an SMI.

The burden of physical ill health is higher in people with severe mental illness (SMI). This burden affects both quality of life and mortality. They are less likely to have their physical health needs met, including identification of health concerns and appropriate, timely screening and treatment.

As an example, amongst those with SMI, it is estimated that two-thirds of deaths are due to preventable physical illnesses such as cardiovascular disease. Compared to the general population adults with SMI aged 15-74 years are:

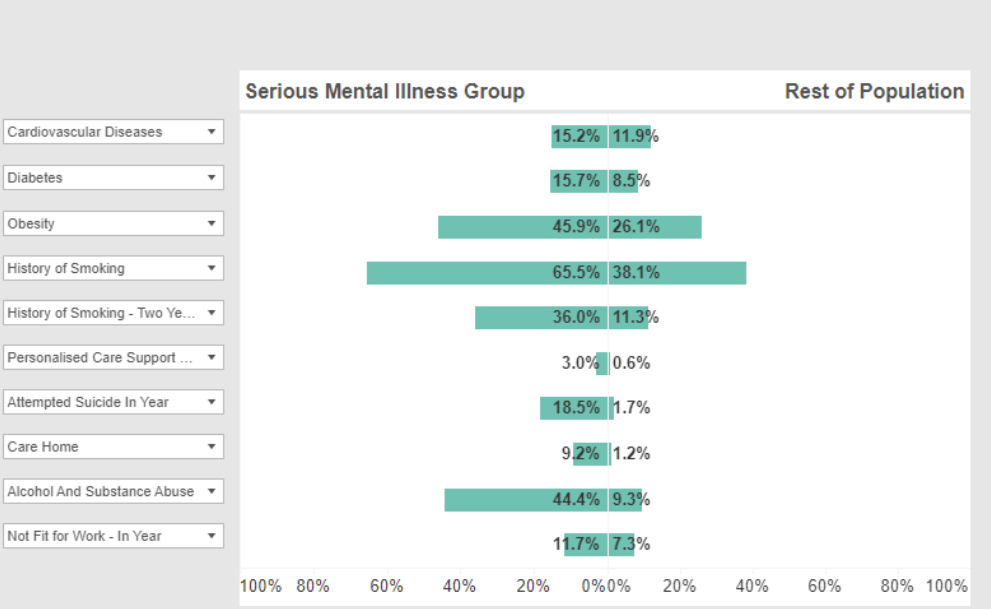
- 1.8 times more likely to be classified as obese;
- 1.9 times more likely to have diabetes;
- 2.1 times more likely to have chronic obstructive pulmonary disease; and
- 1.6 times more likely to suffer a stroke (Source: Health Matters).

Using the Lincolnshire ICS Joined Intelligence Dataset, we can show further analysis of our SMI cohort.

Table 1 shows how our SMI adult patients compare to the rest of our adult population against certain characteristics or diagnosis. For example:

- Lincolnshire SMI patients are around twice as likely to have diabetes and obesity but for CVD there is only a small increase in patients with an SMI.
- History of smoking in the last 2 years shows SMI patients are 3 times more as likely as the rest of our population.
- When it comes to alcohol and substance misuse SMI patients are nearly 5 times more likely to have this co-occurring condition as our general population.

Table 1 Comparison of SMI patient characteristics compared to the rest of the Lincolnshire Adult Population



The Population Health Management data also showed that the SMI population is over twice as likely to attend A&E as the general population and had more than double the GP encounters (GP encounters covers all activity, not just appointments).
Lincolnshire ICB continues to work with our other health and social care colleagues to develop meaningful data sets and analysis to support this area of work.

How can we improve the physical health of patients with SMI?
There are several ways to improve the physical health of patients with severe mental illness (SMI):

- **Annual physical health checks:** The National Institute for Health and Care Excellence (NICE) recommends annual physical health checks for people with SMI.

These checks can help identify physical health conditions early and ensure that patients receive appropriate care and treatment.

NHS England's approach to reducing health inequalities – Core20PLUS5 – included a focus on annual physical health checks for people living with SMI.

- But the checks are only the first step. On their own, checks can't improve health outcomes for people with SMI or address the longstanding inequalities in care – not unless they are accompanied by the right support and follow up interventions.

- **Improving access to physical health interventions**: Primary care can improve the physical health of those with SMI by supporting a proactive engagement process for physical health checks, including those patients from health inclusion groups , supporting access to physical health interventions such as smoking cessation, and supporting the prevention agenda, for example, immunizations and cancer screening.
- **Integrating physical and mental health care**: Integrating physical and mental health care can help improve the physical health of patients with SMI. This can be achieved by providing physical health care in mental health settings, improving communication between primary and secondary care, and ensuring that patients receive coordinated care.

The Lincolnshire Mental Health, Dementia, Learning Disabilities and Autism Alliance (MHDLDA) has a clear vision to:

> *"Together we will promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities."*

A key priority for the alliance is to understand Lincolnshire's inequalities and challenge our understanding so that we are better able to support those people most at risk. To do this to best effect, it is vital that there is a focus on prevention and early intervention, maximising independence, improving quality and access, and ensuring that outcomes are meaningful to the individual and integrate physical and mental health care.

The Prevention Concordat for Better Mental Health, led by the Office for Health Improvement and Disparities, is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health has been shown to make a valuable contribution to achieving a fairer and more equitable society.

As a signatory to the Prevention Concordat for Better Mental Health Lincolnshire ICB has committed to reducing mental health inequalities by taking action to address protective factors (such as early years support, good education, good quality and affordable housing, good quality work, etc) as well as addressing risk factors for poor mental health (such as discrimination, socio-economic inequalities, child neglect and abuse, unemployment, poor quality housing and work, etc).

Led through the MHDLDA, we do this by focusing our effort on

- Needs and Assets assessment: effective use of data and intelligence: Having a clear understanding of the key mental health issues affecting local communities, and which specific interventions should be prioritised to best meet local needs.
- Partnership and alignment: Local organisations and populations working together across sectors to align plans and undertake joint or complementary programmes of work.

- Translating need into deliverable commitments: Ensuring that high-level strategic aims to promote better mental health are translated into actions and integrated into operational plans across a range of organisations.
- Defining success outcomes: Having a clear understanding of how to measure outcomes in preventing mental health problems and promoting good mental health, and which would be most relevant to the local community.
- Leadership and accountability: Ensuring that the wide range of organisations are involved in better mental health and are held to account for jointly agreed actions, with clear leadership and direction.

Current progress on Physical Health Checks

A key priority for the ICB is to ensure that SMI patients receive their physical health checks to ensure that any physical health conditions are identified early to receive the right care and treatment.

The following indicators comprise a comprehensive assessment for the SMI Health checks target, as long as they are all carried out within the preceding 12-month period:

- Blood pressure check
- BMI recorded.
- Alcohol consumption recorded.
- Lipid profile recorded (if prescribed anti psychotics/ Cardiovascular conditions/smoke or within certain BMI criteria)
- Blood glucose or HbA1c recorded.
- Smoking status

As of September 2023, QOF data showed that there were 6770 patients with an SMI registered with GP practices in Lincolnshire, this includes those in remission. This equates to 0.84% of our GP registered population.

For the purposes or reporting under the 'Core 20 plus 5', there were 5044 SMI patients eligible for the 'physical health in severe mental illness' (the most significant variance to the QOF register being the exclusion of those in remission). This equates to 0.621% of our GP registered population. Just over 52% of those eligible for an SMI physical health check had received all 6 elements at the end of September 2023.

Table 2 below shows that a significant number of patients have not yet received all six physical health checks, and although there is still time for more patients to receive their health checks this year, we will not achieve the NHSE target which is approximately 89% of the SMI register. It is a priority for the ICB to understand the reasons behind this and to identify ways in which we can support patients to receive all six health checks. This is because receiving all six physical health check aids the early identification of potential physical health conditions, interventions can then be agreed with health care professionals to stop the issues becoming more serious, and thus reducing the inequality gap. The data shows:

- that approximately 10% of SMI patients had not received a single physical health check and a further 20% had received between 1 and 3 physical health checks.
- The least likely group to get a physical health check are those with Psychosis – with the gap between those who have had all 6 checks being 3%. Patients with Bipolar are most likely to have had all six physical health checks.

Table 2: Analysis of the number of patients receiving each of the 6 physical health checks.

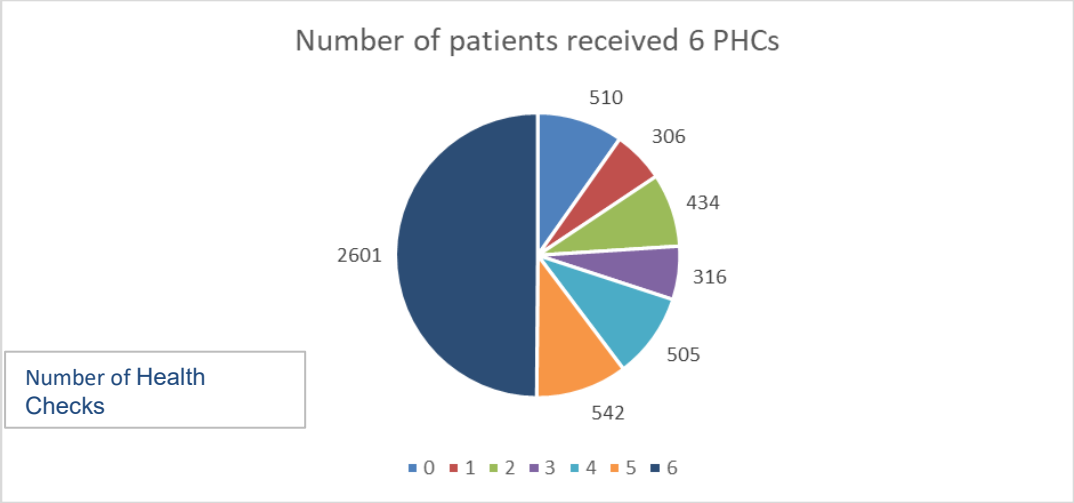


Table 3 below shows that almost 50% of the SMI patients are in the higher deprivation quintiles. Further analysis of those SMI patients who had received all 6 physical health checks versus those who have not is shown in table 5.

Table 3 Deprivation Quintile of the SMI population

Deprivation Quintile	1	2	3	4	5
% Split	23.4%	26.0%	20.5%	18.2%	11.9%

Table 4 below shows that 84% of patients are recorded as White – British & Irish.

Table 4 SMI population by ethnicity

Ethnic Group	Other Ethnic Groups	White - British & Irish	White - Other	Asian	Black	Mixed	Unknown
% Split	8.0%	84.1%	3.0%	0.4%	0.5%	2.7%	1.3%

Analysis of SMI patients who had received all 6 physical health checks (table 5) shows that in deprivation quintile 1, 46% had received all 6 physical health checks against 54% not having received them, however, there was a similar split for quintile 5 suggesting deprivation may not significantly impact on whether you do or do not take up your health check. Similarly, there was little variation when you consider ethnicity.

Further analysis of this data will be undertaken in the coming months to understand if there is a link between deprivation and ethnicity and whether you take up your offer of a health check or not.

Table 5 Analysis of SMI patients who had received all 6 health checks by deprivation quintile and ethnicity.

Deprivation Quintile	Most				Least
Ethnicity	1	2	3	4	5
Yes	46.43%	52.05%	52.11%	51.37%	46.91%
1 - White	38.96%	45.43%	46.06%	46.11%	41.36%
2 - Mixed	0.34%	0.38%	0.28%	0.00%	0.46%
3 - Asian or Asian British	0.00%	0.15%	0.28%	0.42%	0.00%
4 - Black or Black British	0.34%	0.46%	0.28%	0.32%	0.77%
5 - Chinese or Other Ethnic Groups	0.17%	0.15%	0.09%	0.00%	0.15%
Not Recorded	6.63%	5.48%	5.14%	4.53%	4.17%
No	53.57%	47.95%	47.89%	48.63%	53.09%
1 - White	45.17%	40.64%	41.47%	40.74%	46.45%
2 - Mixed	0.25%	0.46%	0.09%	0.42%	0.15%
3 - Asian or Asian British	0.17%	0.38%	0.28%	0.32%	0.31%
4 - Black or Black British	0.42%	0.61%	0.28%	0.53%	0.15%
5 - Chinese or Other Ethnic Groups	0.17%	0.08%	0.28%	0.42%	0.46%
Not Recorded	7.39%	5.78%	5.50%	6.21%	5.56%

To support people with SMI to access annual physical health checks and to understand more about the impact and need to do so, there is now a dedicated programme manager in place for this area of work to drive this agenda forward. The work plan aims to deliver the following:

- Continued improvement in the number of adults receiving an SMI physical health check, including looking at how we can target those not currently taking up the offer of a health check.
- Ensuring the delivery of or referral to appropriate recommended interventions.
- Ensuring that personalised and strength-based conversations and approaches are embedded into the health check and their care and treatment.

The Focus and Key Actions for the next 3 years are:

The Lincolnshire Integrated Care System is committed to improving the physical health of the local SMI population, in order that together we can challenge the status quo and reverse the current trajectory of escalating morbidity and mortality rates in these vulnerable patients.

- Resolving data completeness and reporting issues as already discussed with NHS England. (Note: These will not be fully resolved until April 2024 when NHSE move away from manual submission and re-issue guidance.)
- Work is under way to have in place data sharing arrangements between primary and secondary care and the feasibility of a shared register is being explored. Validation of SMI registers is also being explored.
- Stakeholder engagement to understand why patients do/do not engage with SMI health checks and barriers to accessing them with a view to having an evaluation report to feed into development of options for provision of health checks.
- Targeted support to practices who are under performing to explore reasons for this and explore where further support can be provided.
- To understand why there are a high number of partial health checks with the aim of supporting practices to reduce these.

- Development of communications material for practices to raise the profile of SMI health checks and development of a reporting framework to share data with practices and PCNs on their performance against the NHSE and local targets.
- To develop interventions to help support those individuals with an SMI to manage their physical and mental health – supporting early intervention and supporting people to engage with regular physical health checks in order to identify and treat risk factors and prevent longer term complications.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Tackling health inequalities for those with a diagnosis of SMI will support improving outcomes in population health.
Aim 2: Tackle inequalities in outcomes, experience and access.	It outlines the approach that is being taken to tackle inequalities for those with a diagnosis of SMI.
Aim 3: Enhance productivity and value for money.	Through the utilisation of a PHM approach, we anticipate that we will be able to target the need where it is greatest for those with a diagnosis of SMI.
Aim 4: Help the NHS support broader social and economic development.	Through ensuring that there is a Mental Health informed society which enables greater understanding of inequalities faced by those with a diagnosis of SMI. Economic development in Lincolnshire will be supported through investment into wider organisations to support with meaningful interventions, education and promotion of self-efficacy.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	Not applicable.

Risk and Assurance
There is a risk that if inequalities for those individuals with an SMI are not addressed, that the healthy life expectancy gap and associated quality of life, will widen further in Lincolnshire.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Continued and sustained resource is required to support those individuals with a diagnosis of SMI and to ensure that consideration is given to all to pay attention to their MH and wellbeing across their life course.
Does the report highlight any quality and patient safety implications?	Not applicable.
Does the report highlight any health inequalities implications?	The report highlights the approach that is being taken to tackle health inequalities for those with an SMI.
Does the report demonstrate patient and public involvement?	As noted in the report
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Continued work to pay attention to the Lincolnshire System Greener NHS Plan will be given due consideration when working with all organisations that support those with an SMI.

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

Report previously presented at:

Not applicable.

Is the report confidential or not?

Yes ☐ No ☒

Lincolnshire Community Mental Health & Wellbeing Transformation

Reducing Inequalities for People with Severe Mental Illness

Sara Brine, Head of Mental Health Transformation, ICB
Victoria Sleight, Head of Community Mental Health Transformation, LPFT

WHAT WE WILL TALK ABOUT

1. Mental Health Dementia Learning Disabilities and Autism Alliance - The Vision
2. The Lincolnshire Prevention Concordat
3. Working within a Population Health Approach to reduce Health Inequalities for those with an SMI
4. What the data tells us
5. SMI Physical Health Checks
6. Case Study
7. Any Questions?

Lincolnshire Community Mental Health & Wellbeing Transformation

Lincolnshire Community Mental Health & Wellbeing Transformation

Vision

Together we will…

promote wellbeing for all and enable people with a mental illness, dementia, learning disability or autism to live independent, safe and fulfilled lives in their local communities .

Lincolnshire Community Mental Health & Wellbeing Transformation

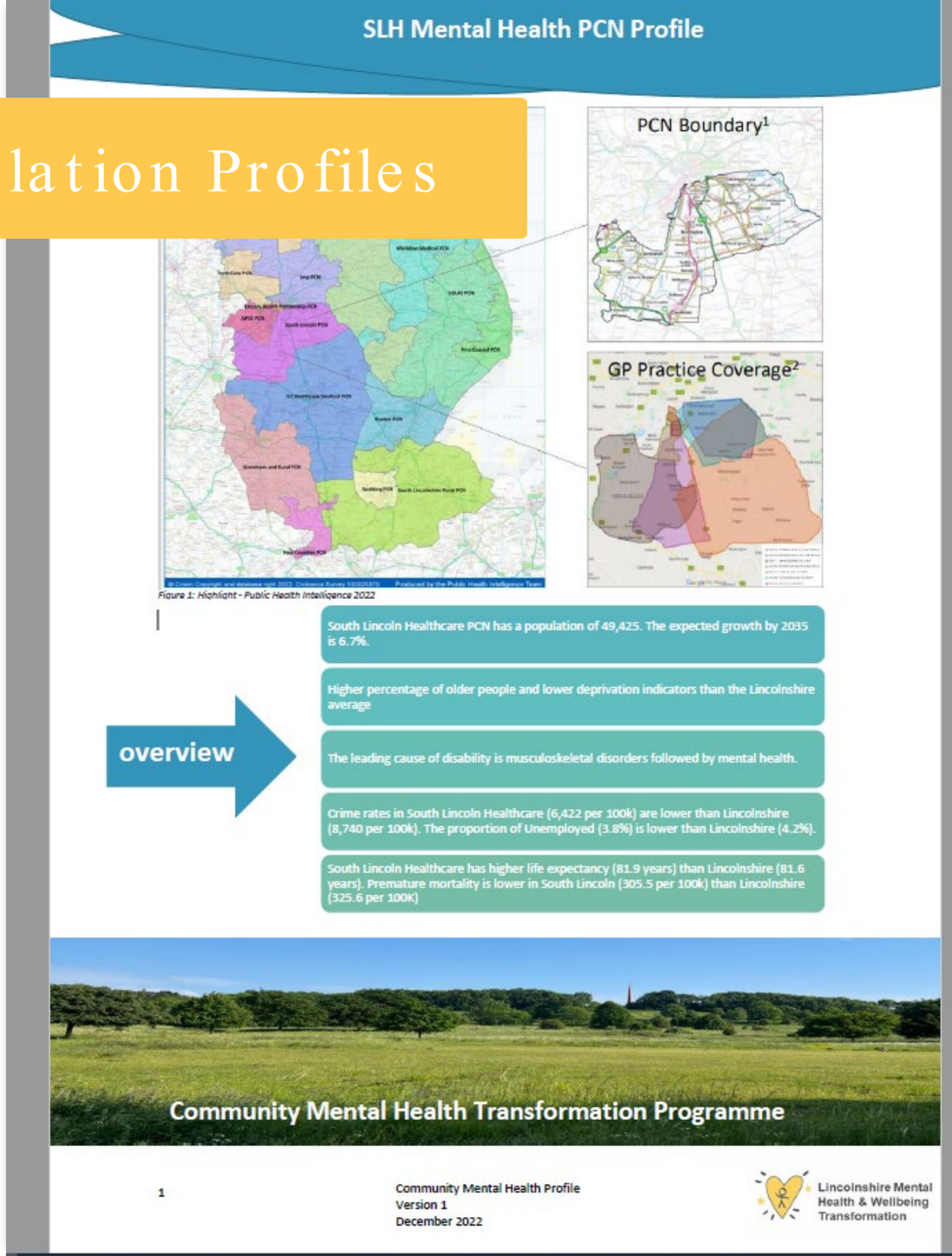
Prevention Concordat for Better Mental Health

Concordat Domain	Example Local Actions
Understanding local needs and assets	• JSNA and PCN profiles produced and being reviewed. • MHWCIF and Suicide Prevention Funded projects.
Working together	• Mental health promotion campaigns across partners on shared messages, linked to MHDLDA priorities. • Suicide Prevention Strategy to be published.
Taking action on prevention/promotion of mental health and well-being and tackling inequalities	• Five Ways to Wellbeing Framework for good mental health. • System training offer via adult health transformation programme. • Embedding prevention in SMI Health Check programme.
Defining success and measuring outcomes	• Seven domain framework published by OHID in Fingertips here. • Seek to support this with research evidence locally.
Leadership and accountability	• Prevention Concordat Delivery Group with representatives from MHDLDA along with district councils and experts by experience

Lincolnshire Community Mental Health & Wellbeing Transformation

Mental Health Population Profiles

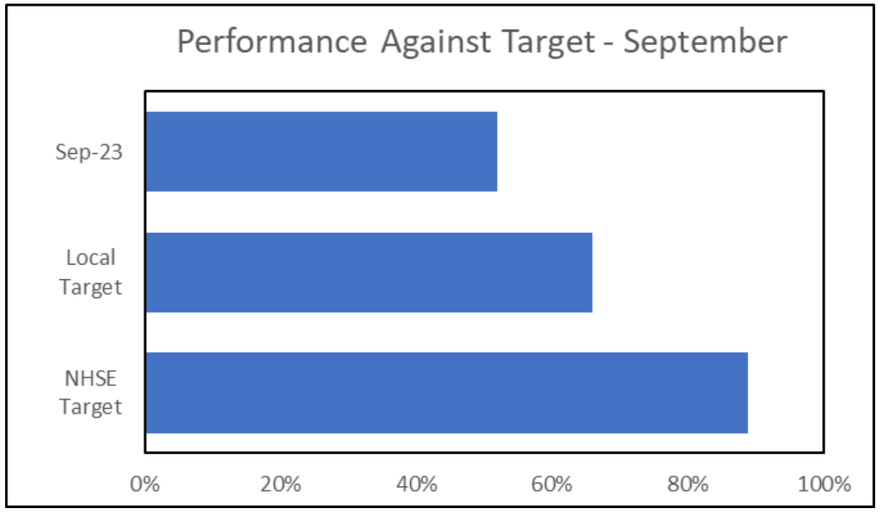
- Evidence base to ensure that we are funding in the right way
- Ensures that we address Health Inequalities at a locality level
- Developing a Health inequalities workstream using a PHM approach.
- Enables systemic working within communities
- Working with NHSE to lead and support other areas to develop

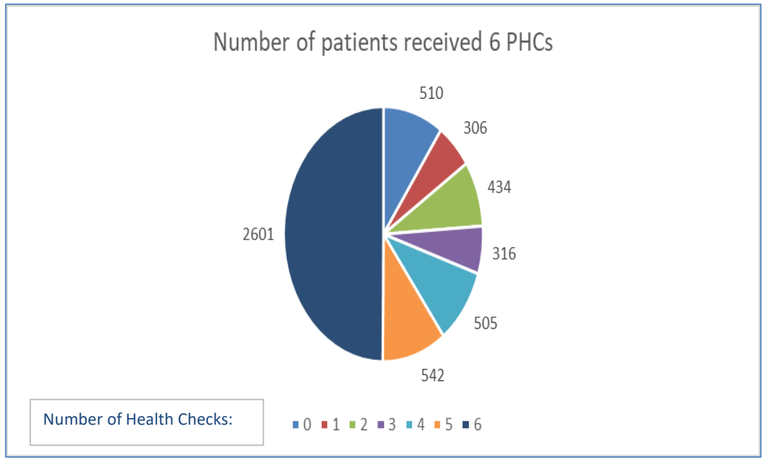


Lincolnshire Community Mental Health & Wellbeing Transformation

SMI Physical Health checks Current Performance

Lincolnshire ICB has an NHSE target to deliver 4507 SMI physical health checks by 31 March 2024.





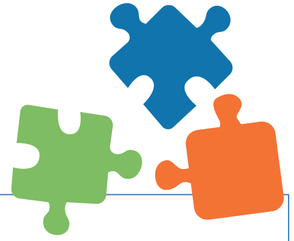
Domain	Number of people have had this aspect completes	% of people that have had this aspect completed, who are on SMI register (5044)
Alcohol	3,601	71.4%
Blood Glucose	3772	74.8%
Blood Lipids	3619	71.7%
Blood Pressure	4001	79.3%
BMI weight	3597	71.3%
Smoking	4923	97.6%
Full PH check	2638	52.2%

- This NHSE target is 89% of the current SMI register of 5044 (excluding those in remission).
- This is a challenging target. Last year the ICB achieved 58% and performance at the end of September is at 52%.
- The ICB has drawn up a revised 3 year plan which has been submitted to NHSE. This includes a local target to deliver 66% of health checks by the end of the current year.
- Not all patients are receiving all 6 health checks. Partial checks do not count toward the NHSE target and it will also mean that not all patients physical health conditions are understood or being appropriately managed.

Based on national data published on the 9th of November 2023- 'People on the GP mental health register at 30th September 2023 to have received health checks in the preceding 12 months' Physical-Health-Checks-SMI-Q2-2023-24.xlsx (live.com)

Lincolnshire Community Mental Health & Wellbeing Transformation

Next Steps



Some of the Challenges:

- Capacity within primary care to deliver more health checks
- Capacity to support meaningful and person-centred interventions that make a difference to this patient cohort, ultimately reducing their health inequality
- Enabling practices to be able to engage with patients to attend SMI health checks and support patients to understand the benefits of attending their health checks on a regular basis
- Varying levels of partial health checks within practices, meaning that the health check does not count toward the NHSE target. This therefore means that not all patients physical health needs are understood and may not be fully managed by the individual and their care team
- To develop interventions that help support individuals with an SMI to manage their physical and mental health

Focus and Key Actions:

There is a detailed action plan for this programme of work covering the next 3 years which is regularly updated and shared with the Lincolnshire Physical Health in SMI Steering Group. Current priorities include:

- Work is under way to have in place data sharing arrangements between primary and secondary care and the feasibility of a shared register being explored. Validation of SMI registers being explored, including whether funding can be provided to support practice to undertake a one-off validation exercise.
- Stakeholder engagement to understand why patients do/do not engage with SMI health checks and barriers to accessing them with a view to having an evaluation report to feed into development of options for provision of health checks.
- Targeted support to practices who are under performing to explore reasons for this and whether further support can be provided.
- To understand why there are a high number of partial health checks with the aim of supporting practices to reduce these.
- Development of communication and engagement material for practices to raise the profile of SMI health checks and development of a reporting framework to share data with practices and PCNs on their performance against the NHSE target.

Lincolnshire Community Mental Health & Wellbeing Transformation

About Carl “I want to get a life back for me and my son”

Who is Carl?

- Dad to a 3 year old
- Previously in the army
- Self employed prior to CPM
- Close to his father
- Proud independent 50 year old
- Likes socialising – having a laugh
- Enjoys movies, gaming, diamond art, Important to have a purpose
- Loves travel
- Incredibly driven, kind and funny

Carls personalised and prioritised goals:

- **To be more independent**
- **To manage own mental health more independently and remain abstinent from alcohol**
- **To live in appropriate independent home**
- **To be an active part of the community “ I want to give back”**

Considerations and understanding the wider context:

- Functional Neurological Disorder
- CPM central pontine myelinolysis – Brain injury - right sided) dense weakness, speech difficulty, poor mobility, seizures, right hand non functioning, dependent upon care support for all transfers and personal care
- Impaired memory and some symptoms of cognitive deterioration (due to high levels of anxiety and depression with feelings of significant hopelessness and frustration impacting upon ability to self advocate.
- History of Personality disorder, Anxiety and Depression and Alcohol dependency
- Extensive history within MH services acute services
- Limited social network
- Living in residential care home following hospital admission for a brain injury as did not have a home to be discharged to.

Lincolnshire Community Mental Health & Wellbeing Transformation

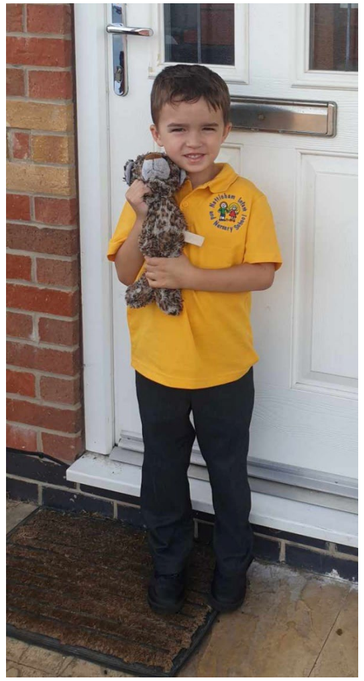
What we did:

- Holistic Assessment
- Personalised care plan
- Carls Prioritised Goals and plan
- Referral to advocacy
- Education for mental health and physical health conditions and management
- Safeguarding – medication and care
- Dialectical Behavioural Therapy and Cognitive Behavioural Therapy based interventions
- Wheelchair referral
- Equipment review and provision
- Upper limb rehab (previously hand therapy practitioner)
- Activities of Daily Living rehab
- Housing – identified and obtained
- Reports for applications
- Signposting to information
- Consistent communication and collaboration with the wider network

Lincolnshire Community Mental Health & Wellbeing Transformation

12 months later……

- Has remained in settled own warden controlled flat – with option for supported living.
- Worked with social prescribing team to connect to community opportunities
- Purchased a scooter to increase independence and take control of his physical and mental health and wellbeing.
- Enrolled onto the Development Plus truth Poverty commission, feeling accomplished in giving back to the community and in being productive.
- Mental health is stable – insight and skills developed to manage independently no carers required.
- Increased independence, confidence and self-esteem.
- Has son to stay regularly – is happy in his personal life.
- Advocates for self and others
- Carl is going on a cruise next year!



QUESTIONS?

Item 5 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (i)
Meeting Date:	30th January 2024
Title of Report:	Integrated Quality & Performance Report – January 2024
Report Author:	James Singleton, Performance Manager
Presenter:	Clair Raybould- Director for System Delivery Martin Fahy- Director of Nursing
Appendices:	Performance & Quality Report

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

Recommendations

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

Summary

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

Urgent & Emergency Care

- The percentage of Lincolnshire patients seen at the ULHT and LCHS sites (T1 & T3) within 4 hours was 69.7% in December against a plan of 73.2%. The overall ICB performance was 70.3% against the revised national target of 76% by end March 24 (95% constitutional target).
- Ambulance mean response time for EMAS Trust: Category 1 was 09:23 minutes against a standard of 07:00 minutes. Category 2 mean response time was 56:09 minutes against a target of 18 mins.
- The Lincolnshire CAT2 response time was better than the EMAS trust average at 49:57. The expectation is that on average all Category 2 calls should be responded to within 30 mins by the end of March 2024.

Cancer

- At the end of December, 224 patients were waiting over 62 days, the same as in November.
- The percentage of patients being told their cancer diagnosis outcome within 28 days increased to 73.5% in November from 72.8% in October
- The percentage of patients receiving treatment for cancer within 31 days of decision to treat increased to 91.7% in November from 88.3% in October

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals decreased by 1164 to 118,422 in November.
- The number of patients waiting more than 78 weeks decreased by 24 to 207 in November.

Mental Health

- The NHS Talking Therapies (previously IAPT) access rate was 15.6% in November (cumulative position)- the standard is 33% by March 2024. This was above plan for the month of November (2.37% against 2% plan) but below the cumulative plan (22%)
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less increased to 75% in November (rolling 12 months)- above the 60% standard and an improvement from 67% in October

Primary Care

- Bourne Galletly had a CQC inspection report published in December and have been rated 'outstanding'.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	✔
Aim 2: Tackle inequalities in outcomes, experience and access.	
Aim 3: Enhance productivity and value for money.	
Aim 4: Help the NHS support broader social and economic development.	
Conflicts of Interest	**Summary of conflicts**

No conflict identified	

Risk and Assurance

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

Implications (legal, policy and regulatory requirements)

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

Inclusion

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

Report previously presented at:

Not applicable

Is the report confidential or not?

Yes ☐ No ☒

Integrated Performance & Quality Report

NHS
Lincolnshire
Integrated Care Board

January 2024

25/01/2024

NHS
Lincolnshire
Integrated Care Board

Contents

Executive Summary

Overview

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

NHS Lincolnshire Integrated Care Board

Urgent & Emergency Care

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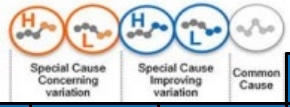
Lincolnshire ICB Performance Dashboard

NHS Lincolnshire Integrated Care Board



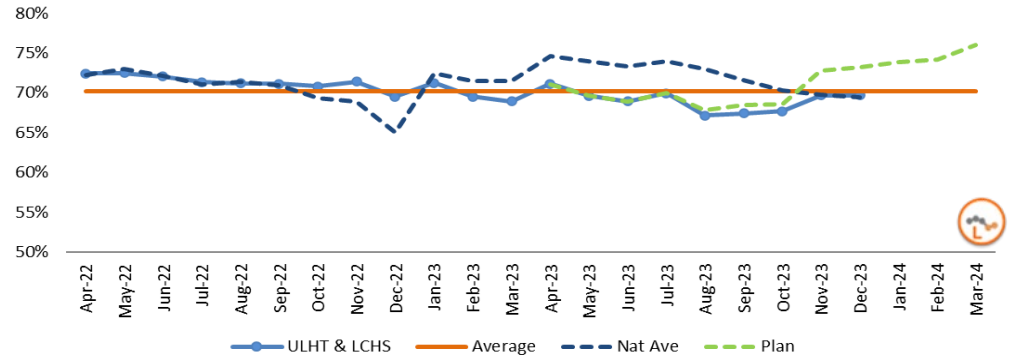
Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend	
								Sparkline	Variation
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ULHT+LCHS)	●	73.2%	Dec-23	69.7%	68.4%	69.4%		
	A&E admission, transfer, discharge within 4 hours (ULHT+LCHS+SMG)	●	76%	Dec-23	70.3%	68.4%	69.4%		
	Ambulance response times - Mean response time- Category 1 (EMAS)	●	00:07:00	Dec-23	00:09:23	00:08:47	00:08:44		
	Ambulance response times - Mean response time- Category 2 (EMAS)	●	00:18:00	Dec-23	00:56:09	00:51:11	00:45:57		
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	●	96%	Nov-23	91.7%	87.9%	90.1%		
	Patients receiving treatment for cancer within 62 days of an urgent GP referral	●	85%	Nov-23	59.5%	60.0%	65.2%		
	% of patients told cancer diagnosis outcome within 28 days (ICB)	●	75%	Nov-23	73.5%	74.1%	71.9%		
Planned Care	RTT: % of incomplete pathways within 18 weeks	●	92%	Nov-23	52.4%	56.0%	58.3%		
	Percentage waiting six weeks or less for a diagnostic test	●	99%	Nov-23	72.3%	72.2%	76.7%		
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)		-	Nov-23	1.65%	1.10%	1.24%		
	Patients waiting over 78 weeks for treatment (ICB) (% of total ICB waiting list size)		-	Nov-23	0.17%	0.15%	0.00%		
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	●	0.8%	Q2 23/24	21.48%	28.2%	23.0%		
Mental Health	NHS Talking Therapies access - people that enter treatment (ICB)	●	2.20%	Nov-23	2.37%	N/A	1.85%		
	NHS Talking Therapies- recovery rate (ICB)		50%	Nov-23	47.7%	N/A	49.6%		
	People experiencing first episode psychosis waiting to start a package of care (ICB)	●	60%	Nov-23	75.0%	N/A	71.2%		
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	●	95%	23/24 Q2	89.3%	N/A	N/A		
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	●	95%	23/24 Q2	57.1%	N/A	N/A		

Key Performance Updates January 2024

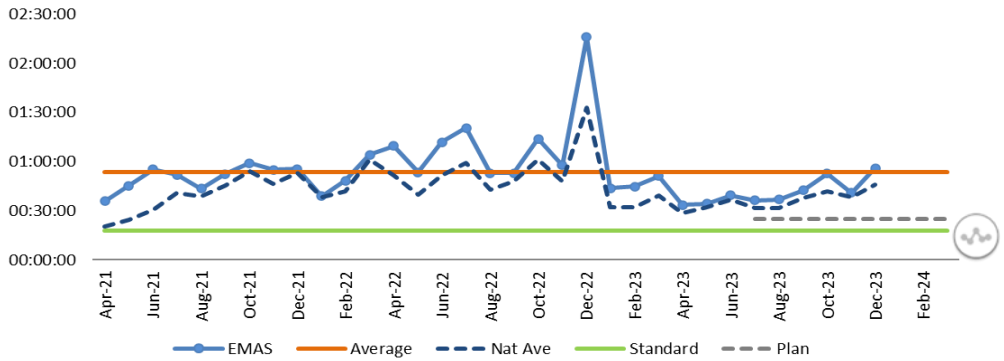
Programme	Indicator	Cause Identified	Key Actions Being Taken
Urgent Care	4 hour performance at all types A&E departments (ULHT & LCHS)	• All Types ICB (T1 & T3) performance across all Lincolnshire UTC and ED sites for December was 70.3% against a plan of 73.2%. • This was impacted by the ULHT T1 performance • Into January the overall T1 & T3 performance has increased month to date to 73.5% against a January plan of 73.9%.	• Group model ED recovery plan delivery, maximising community occupancy rates, MADE events and additional out of hospital capacity in place to improve flow and reduce time in departments. • National 100 day sprint to commence focussed on achievement of the 76% performance target in March 24.
Cancer	Cancer 62 day backlog	• The backlog position has increased slightly and currently stands at 224, we remain below our projected trajectory with the ask from NHSE to get to 217 by the end of March 2024. • The slight increase has been caused by reduced capacity over the Christmas period and the impact of junior doctors strikes. • All tumour sites have seen a reduction in backlog apart from gynaecology, H&N and Urology, colorectal continues to account for the largest percentage of the backlog at 25%, second largest being gynaecology accounting for 17% of the backlog.	• ULHT / ICB continue to lead an intensive support programme for cancer focussing on 28-day Faster Diagnosis Standard and patients waiting over 62 day backlog. Focus is on 8 specialities Colorectal, Urology, H&N, Lung, UGI, skin, gynae and Breast. • Investigating a HRT pathway and education for Primary Care to further support gynae performance. • New lung went live on the 4th December, initial finding demonstrate that the new pathway changes have meant that we have undertaken 399 CT less scans than we did in the previous month whilst using the old pathway with radiological conversion rates remaining stable.
Planned Care	Patients waiting over 78 weeks for treatment	• Systems are now focussed on virtually eliminating 65 week waits by the end of March 2024. The actual number of patients waiting over 65 weeks is now decreasing and the overall cohort who would reach 65 weeks by end of March is on trajectory to be zero. • Patients are being offered the opportunity to move Provider where they have been waiting over 40 weeks and meet certain criteria as part of a national programme. However, uptake is low due to geography and limitation on distance patients are willing to travel.	• An outpatient sprint is underway at ULHT for Q3 with a focus on increasing clinic slot utilisation, reducing DNAs, increasing PIFU rates and reintroducing directly bookable new appointments. • Additional capacity is being provided both internally and via mutual aid from alternative providers for most challenged specialties including Gastroenterology and ENT.
Mental Health	NHS Talking Therapies Access	• A significant element of the service increasing access rates is for two thirds of the extra referrals coming from the long-term conditions pathway, access to training has been a challenge to ensuring there is enough staff working in this part of the service.	• Service to complete demand and capacity exercise to fully understand required capacity to increase access and ensure waiting times are minimised.

Urgent Care

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



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



NHS Lincolnshire Integrated Care Board

Current system pressures

- T1 performance has shown deterioration through November and December and has failed to achieve the trajectory since July.
- All Types (T1 & T3) performance across ULHT & LCHS sites for December was 69.7% against a plan of 73.2%. Into January this performance has increased month to date to 73.5% against a January plan of 73.9%.
- CAT2 30 mean performance for Lincolnshire ICB performance remains over 30mins. The December position was 49:57 minutes which was a deterioration on the November position but remains in line with our average over the last 3 years.
- Pressures within the system have included increased staff sickness, IPC impact, the impact of late December IA as well as the usual seasonal increases in demand during winter.
- Two hour ambulance handover delays in December decreased, and the average clinical handover time in December also decreased to 35:51. Post Handover average handover times in December have increased slightly
- There were 2182 patients waiting more than 12 hours in departments in December. This is a deterioration against the November position which was 1791 (a 22% increase).

UEC Recovery Plan actions

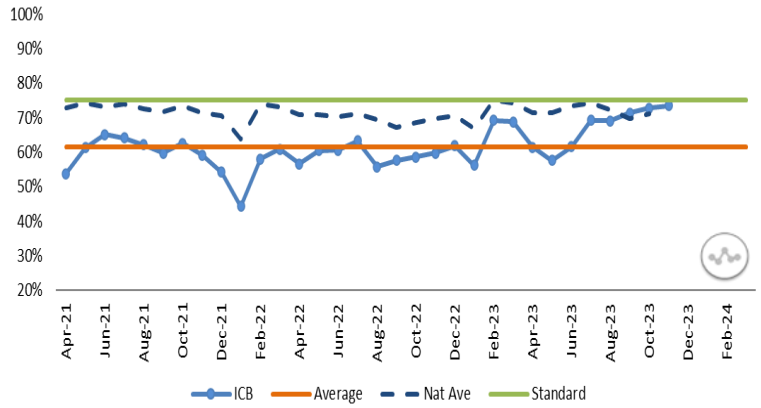
The system focus includes:

- Recovery from the impact of Industrial Action
- Additional Active Recovery Bed, acute and community escalation bed capacity opened for Q4
- Ongoing use of cohorting in line with revised SOP and with risk assessments ongoing for increased cohorting capabilities
- Increased OOHs Clinical Site Manager capacity across acute sites
- Ongoing planned MADE events and mini-MADE type events where and when required
- EMAS Trust review of re-establishing IT links to CAS for CAT3 validation to consider potential increases in volume.
- Implementation of Group UEC programme Group to continue to deliver both the ED recovery plan and elements of the UEC GIRT Visit recommendations that sit within the group.
- Continued focus on criteria led discharge and SAFER processes, including Medically Optimised v Discharge Ready dashboard and daily oversight and review of delayed discharges of care.
- Whole system launch and adoption of the recently revised transfer of care policy, with a focus on choice, supported by a robust system communications plan.
- Focus on maximising system capacity to 95% occupancy

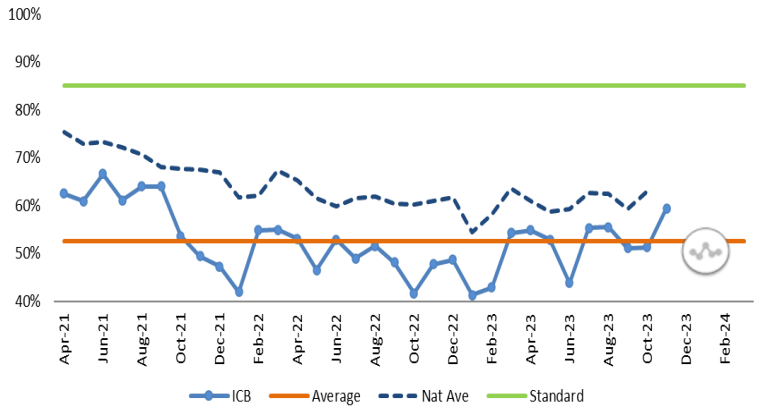
Cancer

NHS Lincolnshire Integrated Care Board

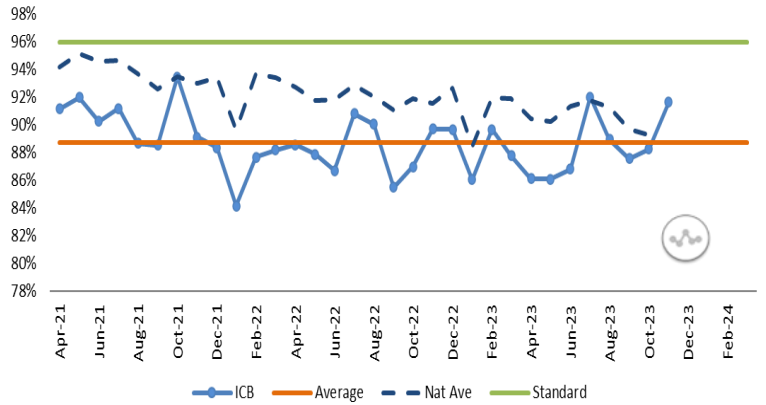
% of patients told cancer diagnosis outcome within 28 days (ICB)



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



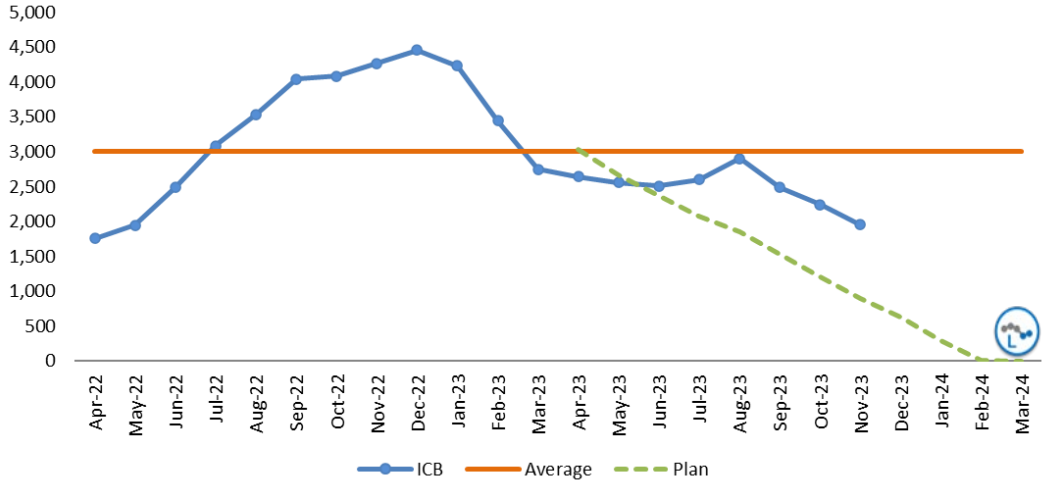
Patients receiving treatment for cancer within 62 days of an urgent GP referral (ICB)



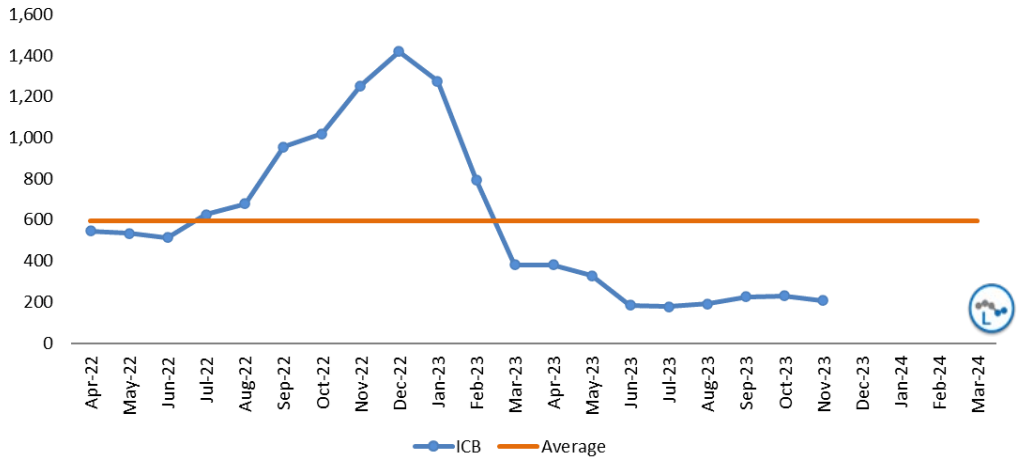
Current system pressures	Actions to recover
• The backlog position currently stands at 224, we remain below our projected trajectory with the ask from NHSE to get to 217 by the end of March 2024. • The slight increase has been caused by reduced capacity over the Christmas period and the impact of junior doctors strikes. • All tumour sites have seen a reduction in backlog apart from gynaecology, H&N and Urology, colorectal continues to account for the largest percentage of the backlog at 25%, second largest being gynaecology accounting for 17% of the backlog. • A number of tumour sites are struggling to meet 28 FDS – gynae, urology and colorectal are areas of concern. • All tumour sites are experiencing pathology delays, some turnaround times are around the 13 day mark making it very difficult for some tumour sites to meet 28FDS. • Teams are continually juggling competing priorities.	• ULHT / ICB continue to lead an intensive support programme for cancer focussing on 28-day Faster Diagnosis Standard and patients waiting over 62 day backlog. Focus is on 8 specialities Colorectal, Urology, H&N, Lung, UGI, skin, gynae and Breast. • Gynaecology trial pathway changes have demonstrated an improvement in waiting times for 1st appointments and increased FDS performance, the trial has been signed off at system level to continue as BAU. Staffing the new step down clinics beyond the trial is proving difficult as existing workforce are tired and reluctant to cover extra clinics. • Investigating a HRT pathway and education for Primary Care to further support gynae performance. • 3 nurses have been recruited into the gynaecology service however it will take around a year to train them to undertake scoping work which will release consultant capacity. • Two new pathologists have been recruited and start in post this week. • New lung went live on the 4th December, initial finding demonstrate that the new pathway changes have meant that we have undertaken 399 CT less scans than we did in the previous month whilst using the old pathway with radiological conversion rates remaining stable. • Daily PTL meetings are in place with colorectal and urology teams to ensure patients are moving through their pathways in a timely manner.

Planned Care

Patients waiting over 65 weeks for treatment (ICB)



Patients waiting over 78 weeks for treatment (ICB)



NHS Lincolnshire Integrated Care Board

Current position

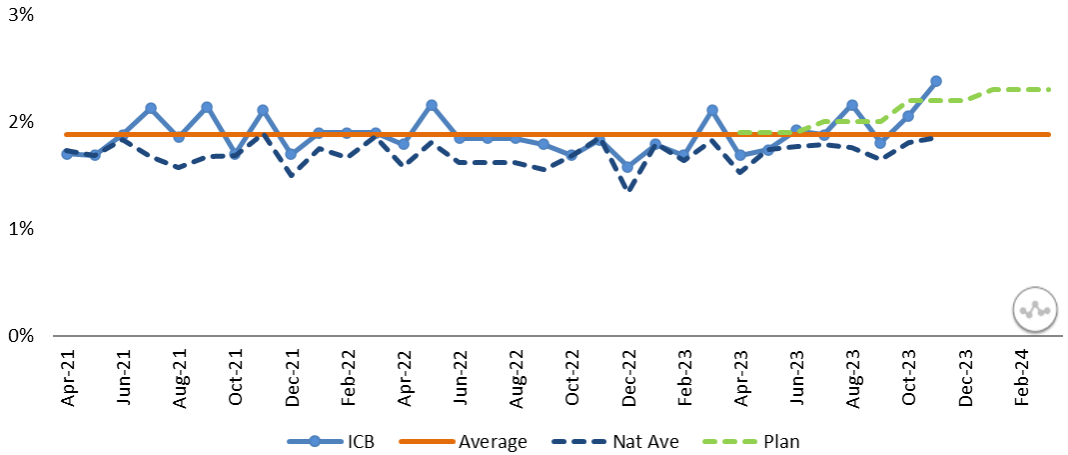
- Main priority continues to be the elimination of 78 week waits. This continues to be challenging but is a much-improved position across all Providers.
- Systems are now focussed on virtually eliminating 65 week waits by the end of March 2024. The actual number of patients waiting over 65 weeks is now decreasing and the overall cohort who would reach 65 weeks by end of March is on trajectory to be zero.
- Patients are being offered the opportunity to move Provider where they have been waiting over 40 weeks and meet certain criteria as part of a national programme. However, uptake is low due to geography and limitation on distance patients are willing to travel. Patients continue to exercise their right to choose even if this may mean waiting longer for an appointment.
- The national ambition for diagnostic recovery is for 95% of patients to be seen within 6 weeks by March 2025. Within Lincolnshire we are also working to a regional ambition of 85% of patients to be seen within 6 weeks by March 2024.

Actions to recover

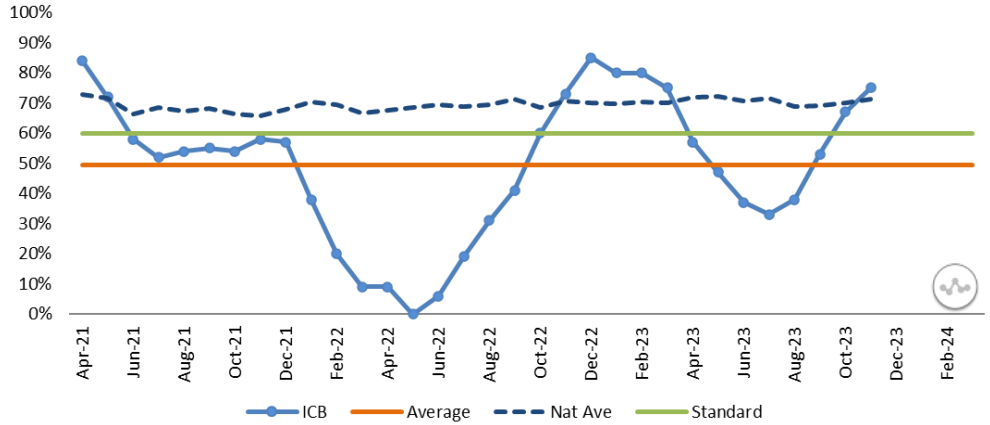
- All Providers are focused on outpatient recovery as this continues to be the biggest area of challenge nationally and is still where most patients are currently waiting.
- An outpatient sprint is underway at ULHT for Q3 with a focus on increasing clinic slot utilisation, reducing DNAs, increasing PIFU rates and reintroducing directly bookable new appointments.
- NWAFT are now achieving above national standard for majority of the outpatient standards.
- NLaG remain ahead of trajectory to eliminate 65 week waits and have a local target to eliminate 52 week waits by March 24 ahead of the national ambition.
- System performing well on providing specialist advice to GPs and is consistently above the national target of 16% of new outpatient attendances.
- Additional capacity is being provided both internally and via mutual aid from alternative providers for most challenged specialties including Gastroenterology and ENT.
- Validation of waiting lists has continued to ensure that those patients given appointments are clinically required. This is for both outpatients and diagnostic tests.
- Percentage of patients seen with 6 weeks for a diagnostic test has improved 5% on previous month.
- Echo, endoscopy and non-obstetric ultrasound continue to be the current areas of challenge, however remedial actions are in place and improvement in outcomes are being seen.

Mental Health

NHS Talking Therapies- Access (ICB)



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



Lincolnshire Integrated Care Board

Current position

NHS Talking Therapies

- The service has 15 current vacancies with 18 new trainees starting in October, who will have reduced but increasing activity.
- A significant element of the service increasing access rates is for two thirds of the extra referrals coming from the long-term conditions pathway, access to training has been a challenge to ensuring there is enough staff working in this part of the service.
- Waiting times are longer than we would like for treatment, the balance is to ensure this is addressed and not only increasing the numbers to meet the access rate.
- According to modelling the service remains short of 30 staff even when all vacancies are filled and trainees up to capacity to meet national target and 16 staff for the local target.

Early Intervention in Psychosis

- The service was relying on bank and agency to meet the 2 week target and issues with staff availability saw the decline in performance, this has been addressed through recruitment of permanent assessment clinicians and therefore this is now improving
- August and September are showing well above target, this was reflected in the rolling 12-month figure in October (67%). Based on the latest local data for October performance was 85%.
- Recruitment has been successful and the service nearly entirely recruited to, including posts in the most recent business case. The service now has lots of new staff and we working with the team closely to help them mature, patient are safe and being cared for, we are now open to referrals from all parts of the county, as we had to step down in some areas and the activity picked up by our other teams.
- In all a significantly improved position, next phase of the work is to ensure compliance with NCAP audit, which are the quality measures for the service, for example CBT-P, family therapy, employment, education, physical health, carers support, outcome measures.

Actions to recover

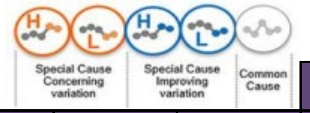
NHS Talking Therapies

- Recent relaunch event and promotional activity (Oct 2023)
- To appoint to a new role to ensure promotion and comms and working closely with primary care to ensure all people suitable for the service are referred or signposted to the service. (Feb 2024)
- Ensuring enough staff are trained in long-term conditions, this is now a requirement for all new staff into the service when they have gained relevant experience. (March 2024)
- Service to complete demand and capacity exercise to fully understand required capacity to increase access and ensure waiting times are minimised. (March 2024)
- Work to secure further expansion to meet the suggested staffing numbers from NHSE, currently 30 staff short. (March 2024)
- Training places allocated to reduce vacancies

Early Intervention in Psychosis

- Actions to recover have been achieved and now above target, this has now been seen in the rolling figure which is now above target, monthly performance is now being consistently achieved.

Lincolnshire ICB Quality Dashboard

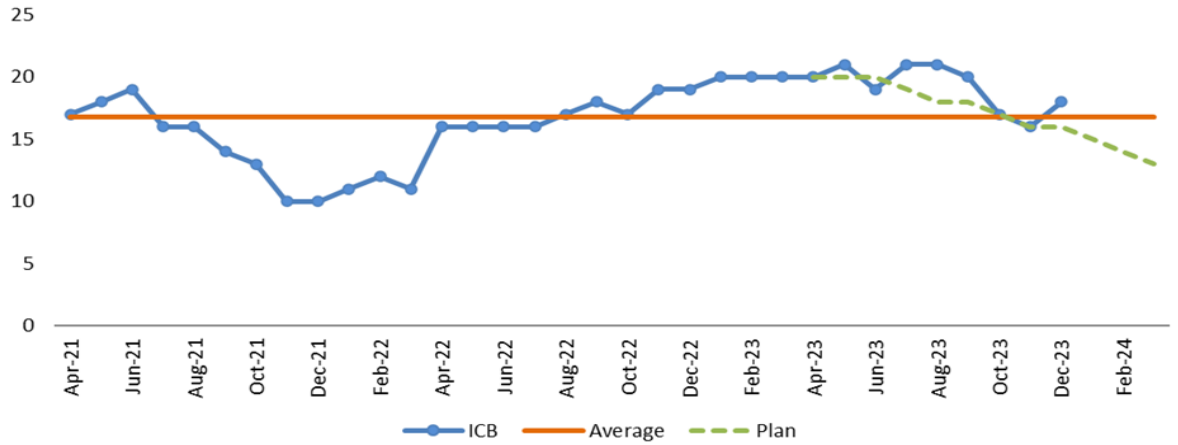


Programme	Indicator	Constitutional Standard	Standard/Plan	Period	Performance	Midlands	England	Trend: Sparkline	Trend: Variation
Incidents	Never events (ULHT)		0	Nov-23	0	N/A	N/A		
	Never events (NLAG)		0	Nov-23	0	N/A	N/A		
	Never events (NWAFT)		0	Nov-23	0	N/A	N/A		
	Serious Incidents (ICB)		-	Dec-23	19	N/A	N/A		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)		-	Aug-23	1.0333	1.0218	1.0019		
	Hospital Standardised Mortality Ratio (HSMR) (ULHT)		100	Sep-23	95.35	N/A	N/A		
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)		-	Aug-23	1.0202	1.0218	1.0019		
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)		-	Aug-23	1.0320	1.0218	1.0019		
Infection, Prevention, Control	MRSA Cases (ICB 12 month rate per 100,000)		-	Nov-23	0.30	0.54	0.90		
	C-Diff Cases (ICB 12 month rate per 100,000)		-	Nov-23	23.35	28.17	27.76		
	E-Coli Cases (ICB 12 month rate per 100,000)		-	Nov-23	30.74	36.44	38.30		
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)		16	Dec-23	18	N/A	N/A		
	Cumulative Learning Disability Healthchecks (ICB)		1799	Nov-23	2057	N/A	N/A		
Patient Experience	Patient experience of GP services (ICB)		-	2023	70.9%	N/A	71.3%		
	Friends & Family Test: A&E Recommended (ULHT)		-	Nov-23	77.4%	N/A	78.5%		
	Friends & Family Test: Inpatient Recommended (ULHT)		-	Nov-23	91.1%	N/A	94.4%		
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)		-	Nov-23	100.0%	N/A	93.6%		
	Friends & Family Test: Community Recommended (LCHS)		-	Nov-23	90.1%	N/A	95.0%		
	Friends & Family Test: Mental Health Recommended (LPFT)		-	Nov-23	94.4%	N/A	88.0%		
Primary Care	Primary Care CQC- number of practices rated as 'Inadequate' by CQC		0	Jan-24	2	N/A	N/A		
	Primary Care CQC- number of practices rated as 'Requires Improvement' by CQC		-	Jan-24	3	N/A	N/A		
	GP Appointments- percentage seen by a GP		33.8%	Nov-23	33.3%	N/A	N/A		
	GP Appointments Mode- percentage seen face to face		66.8%	Nov-23	69.4%	N/A	N/A		
	GP Appointments- time from booking to appointment same day		23.2%	Nov-23	41.7%	N/A	N/A		
	GP Appointments- time from booking to appointment < 2 Weeks		80.7%	Nov-23	77.5%	N/A	N/A		
	Enhanced access provision per 1000 of the PCN adjusted population (ICB)		60	Nov-23	67.8	N/A	N/A		
	The percentage of available GP enhanced access appointments utilised (ICB)		80%	Nov-23	69.5%	N/A	N/A		

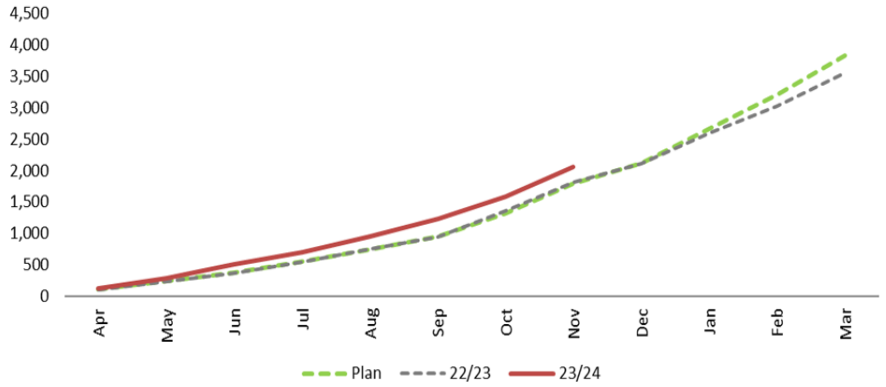
Learning Disability & Autism

NHS Lincolnshire Integrated Care Board

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



Learning Disability Annual Health Checks (ICB)



Current system pressures	Actions to recover
LD Inpatients • There are currently 18 LDA ICB Inpatients, 2 above the planned trajectory of 16 • There are currently 17 LDA IMPACT inpatients, 4 above the planned trajectory of 13. • There are currently 0 LDA children & young people (CYP), with a planned trajectory of 2. • Work with NHSE Provider Collaborative on process and better ways of working together so that data is accurate and timely. • Lincolnshire ICB continue work with the provider market to find the most appropriate accommodation for those LDA cohort with discharge plans in place [RAG-rated GREEN]. • Learning from Safe and Well Reviews and Care (Education) and Treatment Reviews amongst others drive the strategic and operational planning for the Lincolnshire LDA cohort of patients. **LD Annual Health Checks** • Delivery YTD (up to the end of November) is 2057 Health Checks, ahead of the YTD plan (+258).	**LD Inpatients** • Transforming care Liaison service recruitment ongoing. • DSR and Community CTR process working well with significant impact on admission rates (98% avoidance with Community CTR). • Inherent Jurisdiction work remains ongoing to support and provide legal framework for discharges. • Ongoing work between ICB and LCC with current and new providers for appropriate community accommodation that suits the needs of the LDA cohort. • Future provision work ongoing to feed market requirements. • Long Term Section 17 Leave pilot has been approved by EO Investment Board and will commence in Dec 23. • Ashley House being considered as therapeutic respite for 16-25 year olds. **LD Annual Health Checks** • Regional data has flagged a relatively low level of health actions plans recorded for Lincolnshire patients – this will be picked this year to understand whether this is a coding issue, to review the quality of HAPs and support practices to improve where required.

Insight and Signals – Quality and Patient Experience

CYP Speech and Language Therapy (SLT):

CYP SLT is provided by LCHS who escalated concerns regarding extended waiting times to the CYP Integrated Transformation Board in October 2023. Whilst the position in Lincolnshire is similar to the regional and national picture, decisions communicated by LCHS regarding interim changes to service criteria highlighted concerns regarding unintended consequences from system partners. Multi-agency meetings have now taken place and consensus on way forward has been agreed.

Lymphoedema:

In July 2023 concerns were escalated by LCHS, provider of the specialist Lymphoedema Service regarding the size of the caseload and ability to meet the increasing demand. A number of actions were taken to stabilise the situation, however, work between LCHS and the ICB has highlighted the need for a wider programme of work to consider how best to meet the needs of patients with lymphoedema; chronic oedema; and leg ulcers, to ensure appropriate pathways of care are in place with sufficient capacity and capability to meet identified need. A 'Lower Limb Summit' is being planned for early in 2024 to bring together key stakeholders to scope the challenges, opportunities and solutions for these pathways of care.

ADHD 360:

CQC undertook an unannounced inspection August 2023 and the report published 15 December 2023 rates ADHD 360 as Requires Improvement (RI) overall – RI for Safe and Well led; Good for Effective, Caring and Responsive.

The wider piece of work Lincolnshire Academy of Clinical Excellence (LACE) are undertaking to review the Lincolnshire ADHD pathway has commenced.

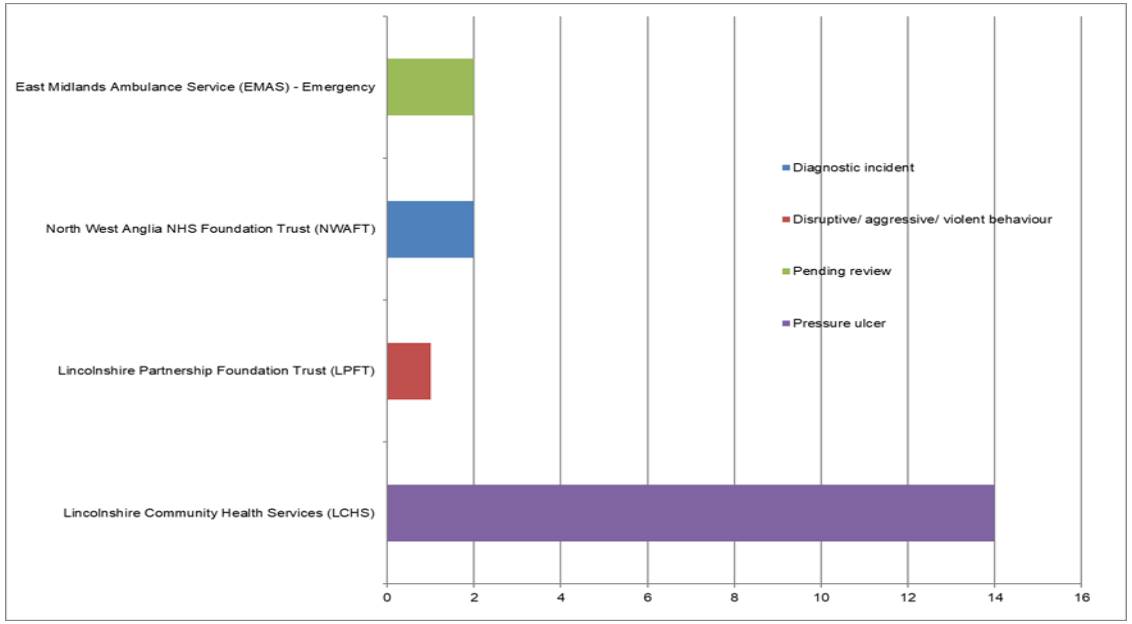
RAF Scampton:

The ICB is continuing to work with system partners to ensure plans to safely mobilise services at RAF Scampton are in place.

Insight and Signals – Primary Care

Practice	CQC Rating	Information to note
Caskgate	Inadequate	CQC published report 2nd August 2023 following inspection of the Practice 24th May 2023. The report rated the practice as Inadequate and the CQC issued section 29 warning notices 7th June 2023. Areas of concern relate to safeguarding; medicines management; oversight of prescribing practice; Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts; patient records; secure storage of patient notes and other confidential documentation; and premises safety. The Practice have responded appropriately to CQC level of concern and extensive support plan now in place with ICB and LMC. The support plan has included regular meetings with the Practice senior team to help support the improvement plan. Specialist support from Medicines Optimisation, Safeguarding and Infection, Prevention and Control. Additional funding agreed through Section 96 funding to support resilience and delivery of the CQC action plan, including locum funding; coding and workflow; Advance Nurse Practitioner capacity; and note summarisation. Long term estate strategy is being developed for the practice with the ICB engaging with local partners to identify possible solutions.
Richmond Practice	Inadequate	The Practice had an inspection 25 May 2023 and the CQC report published 13 October 2023 rates the Practice as Inadequate overall, with Inadequate in Safe and Well Led; Requires Improvement for Effective and Responsive; and Good for Caring. The CQC have placed the Practice into Special Measures; warning notices were issued 27 June 2023 relating to Safe Care and to Governance. Concern areas identified relate to infection prevention and control, emergency response, resuscitation (DNACPR) documentation and outstanding patient reviews. A support plan is in place and the Practice are responding positively. This has included the ICB meeting regularly with the senior team to help support their improvement plan and specialist support from Infection Prevention and Control; and Nursing and Quality Teams to support new lead nurse. CQC undertook a further inspection early December 2023, report awaited.
Bourne Galletly Medical Practice	Outstanding	CQC report published 8 December 2023, following inspection in August, rates the Practice as Outstanding overall, with Outstanding for Caring, Responsive and Well Led; and Good for Safe and Effective.

Insight and Signals- Serious Incidents



- There has been a total of (n=19) serious incidents reported between 5 December 2023 and 9 January 2024. This represents an increase when compared to the previous report (n=12). The increase in reporting is attributed to an increased recording of pressure ulcer serious incidents (n=14), in comparison to (n=8) in the previous report.
- The reporting rate of serious incidents may in part be affected by organisations transitional work from the Serious Incident Reporting Framework to the Patient Safety Incident Response Framework. Full transition to the Patient Safety Incident Response Framework commenced from 1 October 2023 for some organisations, with all organisations managed under the NHS Standard Contract required to transition by 31 March 2024.
- To date EMAS, ULHT and NWAFT have transitioned to PSIRF. As a result, these organisations no longer report serious incidents. Although, it is noted that incidents identified as Patient Safety Incident Investigations (PSII) will continue to be reported on STEIS temporarily, and as such will be captured where appropriate within future reports.

- Pressure ulcers continue to account for most of the serious incidents reported in relation to care provided to Lincolnshire patients. As referenced above (n=14) pressure ulcer incidents have been reported this month, all pressure ulcer serious incidents had been reported by LCHS.
- There has been a single serious incident reported by LPFT this month, this is reflective of the serious incident reporting rate of the previous month. The single serious incident reported related to disruptive/aggressive and violent behaviour.
- In addition, it is noted that there were a few serious incidents reported in relation to Lincolnshire patients by other providers:
  - EMAS – There were 2 incidents reported by EMAS on the national STEIS Serious Incident Reporting System. These incidents are being managed as Patient Safety Incident Investigations under PSIRF.
  - NWAFT – There were 2 diagnostic serious incidents reported by NWAFT prior to their transition to PSIRF.

Quality Improvement

- Lincolnshire ICB established Freedom to Speak Up (FTSU) arrangements during Q4 of 2022/23, following launch of the ICB FTSU policy December 2022. ULHT, LCHS and LPFT all have well established FTSU arrangements in place. In March 2023 NHS England highlighted ICBs/ICSs should be starting to consider what FTSU looks like for Primary Care. Liaison has been taking place with NHSE regarding expectations and it is anticipated further information to clarify expectations in relation to FTSU for Primary Care and ICSs will be published by March 2024.
- Working Together to Safeguard Children 2023 was published in December Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk). Amendments made by the Children and Social Work Act 2017 to the Children Act 2004 strengthen this already important relationship by placing new duties on the police, integrated care boards (ICBs) and the local authority, as statutory safeguarding partners. Safeguarding partners are under a duty to make arrangements to work together, and with other partners locally, including education providers and childcare settings, to safeguard and promote the welfare of all children in their area. The framework also requires, for the two child death review partners (the local authority and the ICB), to make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for those not normally resident in the area. This document replaces Working together to safeguard children (2018).
- It has previously been reported to Board that Lincolnshire is nationally one of three Families First for Children (FFC) Pathfinders Families first for children (FFC) pathfinder programme and family networks pilot (FNP) - GOV.UK (www.gov.uk). This work is being led through LCC with input and support from health and police as statutory partners. Significant work has been undertaken in the co-production phase of the programme and the Linclonshire Pathfinder Implementation Plan was submitted to the Department for Education in December 2023.
- NHSE have re-issued the *Midlands Region: CYP De-escalation Process* which is intended to facilitate multi-agency response across Systems where CYP with complex mental health needs present within an urgent care setting and where usual pathways are not able to respond due to capacity or demand issues. Review of this guidance and individual cases within Lincolnshire over recent months highlights the positive, collaborative, multi-agency approach organisations within the system now take to ensure the needs of CYP with complex needs are appropriately met.
- NHSE Midlands have developed professional and minimal standards of care relating to patients awaiting handover on the back of ambulances outside acute hospital trusts. ICB nurse and medical directors were asked to confirm that they accepted the document and that it will adhered to within acute trusts for their respective systems by 29 December 2023. Confirmation has been received from EMAS that these standards are in place and working well in Lincolnshire.

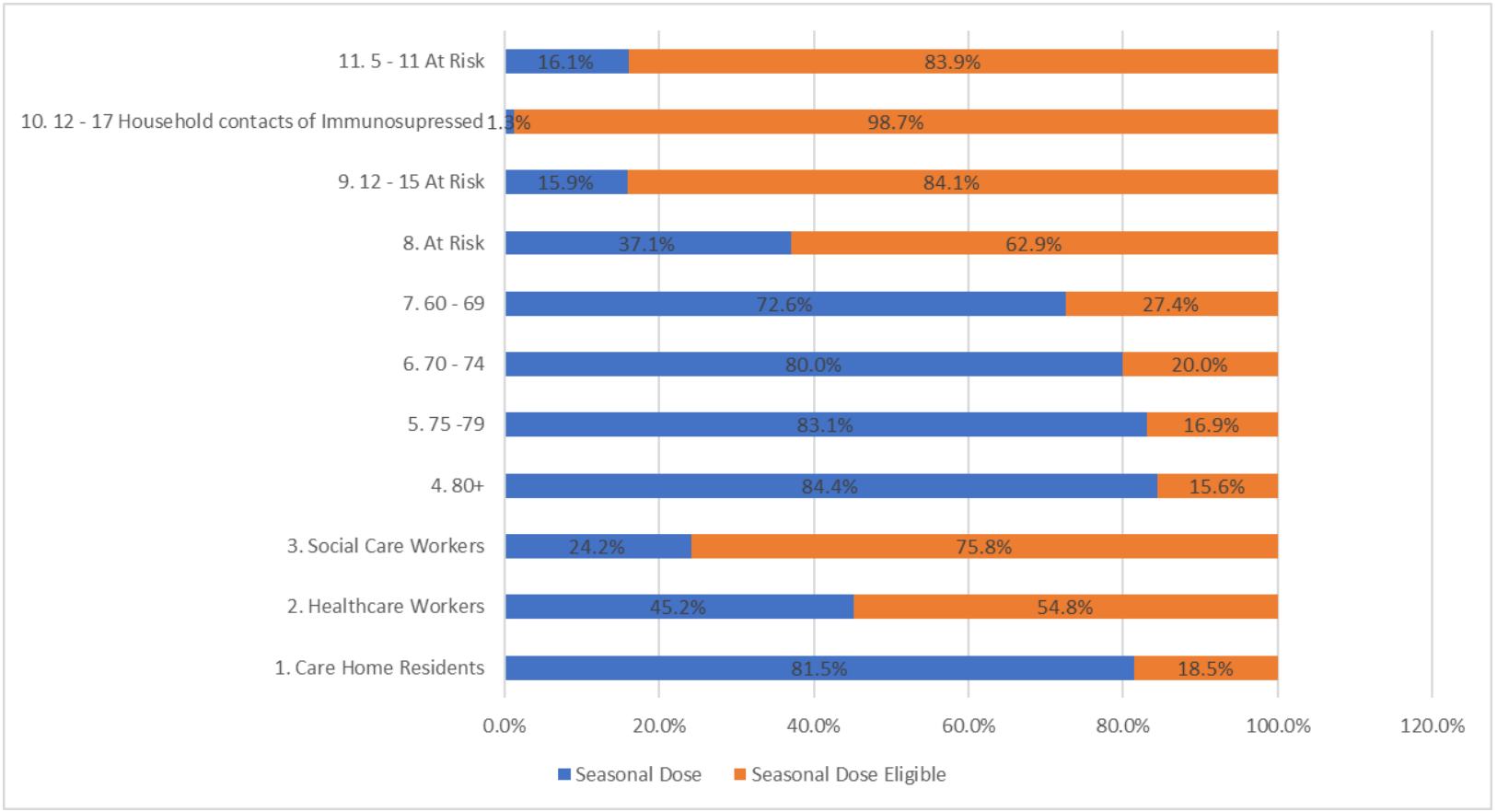
Quality and Patient Experience Thematic Update – Learning Disability & Autism

- The care of people with a learning disability has evolved over time, with a move away from the 'medical' to a 'social' model. The social model says that disability is caused by the way society is organised, rather than by a person's impairment or difference. It looks at ways of removing barriers that restrict life choices for disabled people. When barriers are removed, disabled people can be independent and equal in society, with choice and control over their own lives by addressing those attitudes and providing support for people with a disability, the aim is for those people to take part in society in the same way as people without a disability – that is, without discrimination.
- The NHS Long Term Plan commits to improving outcomes for people with a learning disability (NHS England, 2019). A person-centred approach is important when delivering care to people with a learning disability, which means that care should be tailored to the individual's needs, strengths and preferences (National Institute for Health and Care Excellence, 2018a).
- In 2021 safe and wellbeing reviews (SWRs) were set up by NHS England as part of the response to a safeguarding adults review (SAR) and subsequent report concerning the deaths of 3 inpatients at Cawston Park, published on 9 September 2021. They were all adults with learning disability; Joanna and Jon were also autistic. They died in Cawston Park hospital after long inpatient stays.
- The primary purpose of the SWRs was to assess whether people with a learning disability and autistic people who were being cared for in a mental health inpatient setting were safe and well. Reflecting on the learning from Cawston Park, and other reports and reviews, the SWRs also focused on physical health, meaningful activities for patients, and putting actions in place where there were concerns in these areas. In addition, they sought to understand what was and wasn't working well for people in hospital and identify opportunities to improve. The SWRs included:
    - a review of the individual's care, education and treatment review (C(E)TR) and care programme approach (CPA) records
    - conversations with the individual's family and/or advocates (where permission was given, and people were available)
    - a review of people's safety, physical health, mental health and quality of life
    - face-to-face visits with individuals, which included the requirement for a "sit and see" element not previously specified in review processes
    - oversight of the review by an integrated care system (ICS) panel
- Continued monitoring of the implementation of recommendations is undertaken on a quarterly basis by the system wide Oversight panel. The Oversight panel's overall aim is to co-ordinate and support activity (and where necessary formal intervention) so that implementation, outcomes and actions of C(E)TRs are targeted when needed.
- It provides ICS level;
    - input, oversight and accountability from senior ICS officials
    - partnership working and fresh perspectives from stakeholders with diverse expertise
    - the identification of good practice for replication in other areas
- The ICS Assurance and Oversight panel should also review the escalated C(E)TR report and actions, assure themselves that the person is safe and well, and consider if any further action is needed to support the person's progress or discharge.

Covid-19 Vaccinations

NHS Lincolnshire Integrated Care Board

System Uptake of Eligible Population 65.35%



Update

- The Autumn booster programme went live 11th September 2023 with Care Home visits and is due to run until 31st January 2024 (this has been extended from previous end date of 17th December 2023)
- This is being be delivered in partnership by PCNs, the Mass vaccination centres, the Hospital Hub and Community pharmacies, as has been the case in previous phases of the vaccination programme.
- The following groups are eligible for an Autumn booster covid vaccination
  - aged 65 or over
  - pregnant
  - aged 5 to 64 years and at high risk due to a health condition
  - aged 5 to 64 years and at high risk due because of clinical vulnerabilities
  - aged 5 to 64 years and live with someone who has clinical vulnerabilities
  - aged 16 to 64 years and are a carer
  - living or working in a care home for older people
  - frontline health and social care workers

*Data correct as at 8/1/2024

Item 5 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (ii)
Meeting Date:	30th January 2024
Title of Report:	Update on the Clinical Directorate and the Research and Innovation Hub
Report Author:	Mrs Louise Jeanes: Lincolnshire Academy for Clinical Excellence (LACE) Academy Lead and Cancer Programme Director Mrs Kirsten Guy: ICS Research Lead
Presenter:	Dr Sunil Hindocha NHSICB Medical Director Mrs Louise Jeanes: Lincolnshire Academy for Clinical Excellence (LACE) Academy Lead and Cancer Programme Director Mrs Kirsten Guy: ICS Research Lead
Appendices:	Presentation – Clinical and Care Directorate and the Research and Innovation Hub

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

Recommendations

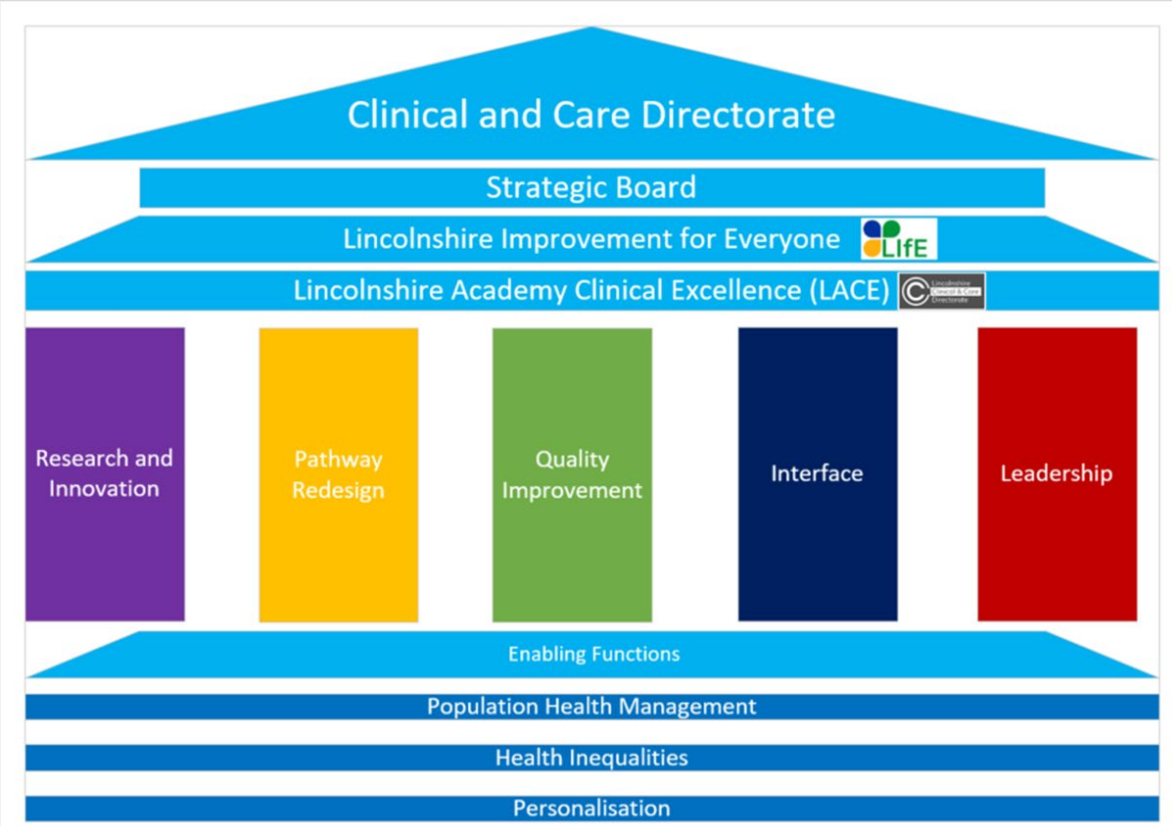
This section should identify any recommendations the Board/relevant Committee/group is being asked to make.

This report is to provide the Board with an update on the development and progress of Lincolnshire Academy of Clinical Excellence (LACE) and the Research and Innovation programme.

Summary

Include background to the paper/information, summary of discussions held (if applicable), options developed and commissioning rationale.

The Clinical and Care Directorate will be the collective voice of all health and care professionals in Lincolnshire. It will provide evidence-based decision-making by well-led clinical professional groups.



The Clinical and Care Directorate and Lincolnshire Academy for Clinical Excellence (LACE) aligns with the five principles set out in the NHSE&I guidance: '*Building strong integrated care systems everywhere'* (Sep 2022)

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

Quality Improvement

The Quality Improvement programme was endorsed by the Better Lives Lincolnshire Team.

- The **ambition** is the development of a cohesive approach to improvement, learning and innovation at a Lincolnshire ICS system level under the banner of LIfE: Lincolnshire Improvement for Everyone.
- The **purpose** is improving the health and wellbeing of people in Lincolnshire, by supporting the delivery of our long-term population health improvement goals as well as care delivery: helping meet today's challenges, while shaping the landscape of tomorrow
- The **added value** of working as a system: facilitating stronger collaboration across organisations and more effective scaling of innovation; using existing assets and the expertise that exists in Lincolnshire.

- The **mindset**: shifting the focus from assurance to improvement, which is everyone's business; adopting learning health and care system concept; understanding the relationship between investment and outcomes.
- The **end-product**: a framework which drives more effective improvement. The emphasis is very much on framework, agreeing common language and principles.
    - The proposed framework will focus on two main elements:
        - Creating the conditions for change: identifying goals, priorities and resources; building relationships and trust; seeing diverse expertise as an asset; developing shared system leadership
        - Enabling the planning and delivery of changes across the system
- Links with Q , The Health Foundation and NHS Confederation - Peer learning support programme and opportunity to test Q framework in Lincolnshire.
- The **proposed approach** to making this happen: Set up a working group; Link in with the national support offers; Draft up the framework, building on our work to date; Test and refine the framework.

A review of ADHD Services for Adults
Commissioned by the Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team. This has provided a:

- Testbed for the LACE method and pipeline of activities for detailed reviews.
- 4 workshops (1&2 completed) including clinical and operational experts as well as people with lived experienced, together comprise the Expert Reference Group. 3/4 private providers engaged and in attendance.
- Detailed exploration of the issues, data, evidence base, solution generation resulting in a high-level strategy by March 2024.
- Detailed evaluation of each stage of the method and pipeline: Very positive feedback from participants and commissioning team, thus far.

Programmes completed.

- Colorectal – Rapid Access Colorectal Pathway
- Lung Cancer Pathway
- Gynae Cancer pathway – PMB
- Histopathology
- Licensing of anastrozole for primary prevention of breast cancer

Future Programmes

- Planned Care Respiratory Pathway
- Targeted Lung Health Check
- Haematology
- Pathology Review
- Children and Young People's (CYP) Work Programme
- System Infrastructure and Investment Strategy
- Use of ultrasound scans in Primary Care for diagnosing groin hernias
- Transition Services for CYP
- Liver Pathways (UGI)
- Research, Evaluation and Quality Improvement in Palliative and End of Life Care
- UGI research project (Palliative Care MDT)

Please find links below that take you to and

Dr Zara Pogson ULHT Respiratory Physician https://youtu.be/kJmHmXwJd7k
Dr Sunil Hindocha NHS ICB Medical Director - https://youtu.be/T6G8nePsHxI

Research and Innovation

ICS Research Leaders Group has been established and builds on established research partnerships within our ICS. The Group will meet monthly with representation from research leaders across the NHS, Lincolnshire County Council, Universities, voluntary sector and wider partners.
Purpose: To provide strong and effective partnership working across the health and care system and a commitment to maximising shared research opportunities to deliver better health and wellbeing outcomes to the people of Lincolnshire.
This group will have strategic and operational functions and will oversee the development of the ICS Research Strategy.

ICS Research and Innovation Strategy is in development, for publication in March/April 2024. The Health and Care Act 2022 sets new legal duties on ICBs around the facilitation and promotion of research, and the use in the health service of evidence obtained from research. ICSs are strongly encouraged to develop a research strategy that aligns to or could be included in their integrated care strategy.
Our Research and Innovation strategy will be co-produced during 2 strategy development workshops in February, with representation from across our ICS. We are also holding a public contributor workshop.
The working principals for the strategy are:

1. Reflects the needs of our communities
2. Collaborative, co-ordinated and trusted partnerships
3. Research embedded in everything we do
4. Delivered by a sustainable, capable and confident workforce

The Implementation plan will follow and be published in 2024.

Research and Innovation Hub and website launch will take place on 17th April at the University of Lincoln. All our ICS, local and regional partners, national speakers and the Lincolnshire public will come together to showcase and celebrate Research and Innovation.

Research and Innovation Hub LIfE
Lincolnshire Improvement for Everyone
Improving the Health and Wellbeing of people in Lincolnshire

We will launch the Strategy and the new Hub website which will be initially Public facing. Content is being co-produced during 2 workshops.

Capacity and Capability Building: Research Training Programme is a foundation research training programme, delivered in partnership with the University of Lincoln, for colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations. The programme has been created following survey feedback from our Allied Health Professionals (AHPs) and Lincolnshire County Council (LCC) workforce.

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

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

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Evidence is key to improvement. The programmes support the delivery of our

	long-term population health improvement goals
Aim 2: Tackle inequalities in outcomes, experience and access.	The programmes of work have health inequalities, population health management and personalisation as enabling functions within the Clinical and Care Directorate structure.
Aim 3: Enhance productivity and value for money.	The programmes will facilitate stronger collaboration across organisation, utilising existing assets and expertise that exists in Lincolnshire
Aim 4: Help the NHS support broader social and economic development.	The links with inequalities and improving health outcomes and will impact the broader socio economic factors
Conflicts of Interest	**Summary of conflicts**
No conflict identified	N/A

Risk and Assurance
No risks associated with the risk register.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	N/A
Does the report highlight any quality and patient safety implications?	N/A
Does the report highlight any health inequalities implications?	No
Does the report demonstrate patient and public involvement?	No however the approach incorporates co-producing and co-design
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	N/A

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

Report previously presented at:
Not applicable

Is the report confidential or not?
Yes ☐ No ☒

Clinical and Care Directorate

NHS
Lincolnshire
Integrated Care Board

Lincolnshire Improvement for Everyone
Lincolnshire Academy for Clinical Excellence

Louise Jeanes Programme Director Cancer and LACE Academy Lead
Kirsten Guy ICS Research Lead

25/01/2024

Vision

The Clinical and Care Directorate will be the collective voice of all health and care professionals in Lincolnshire.

It will provide evidence-based decision-making by well-led clinical professional groups.

Principles for Effective Clinical and Care Leadership- Setting the foundation

Alignment with the five principles set out in the NHSE&I guidance: '*Building strong integrated care systems everywhere'* (Sep 2022)

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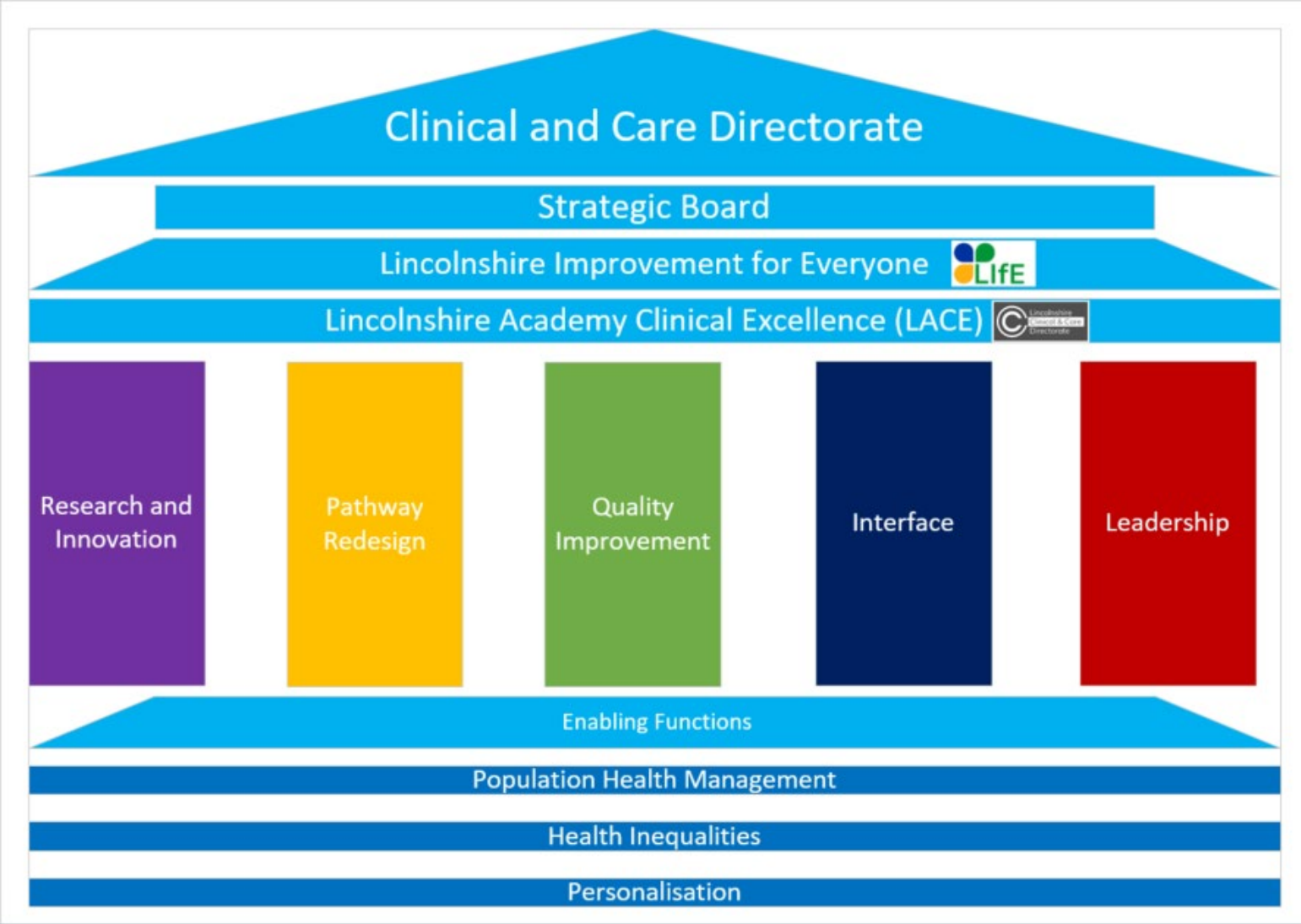
5. Identifying, recruiting and creating a pipeline of clinical and care professional leaders

Clinical and Care Directorate



Driving Quality Improvement across Lincolnshire ICS

- The Better Lives Lincolnshire Leadership Team endorsed the approach
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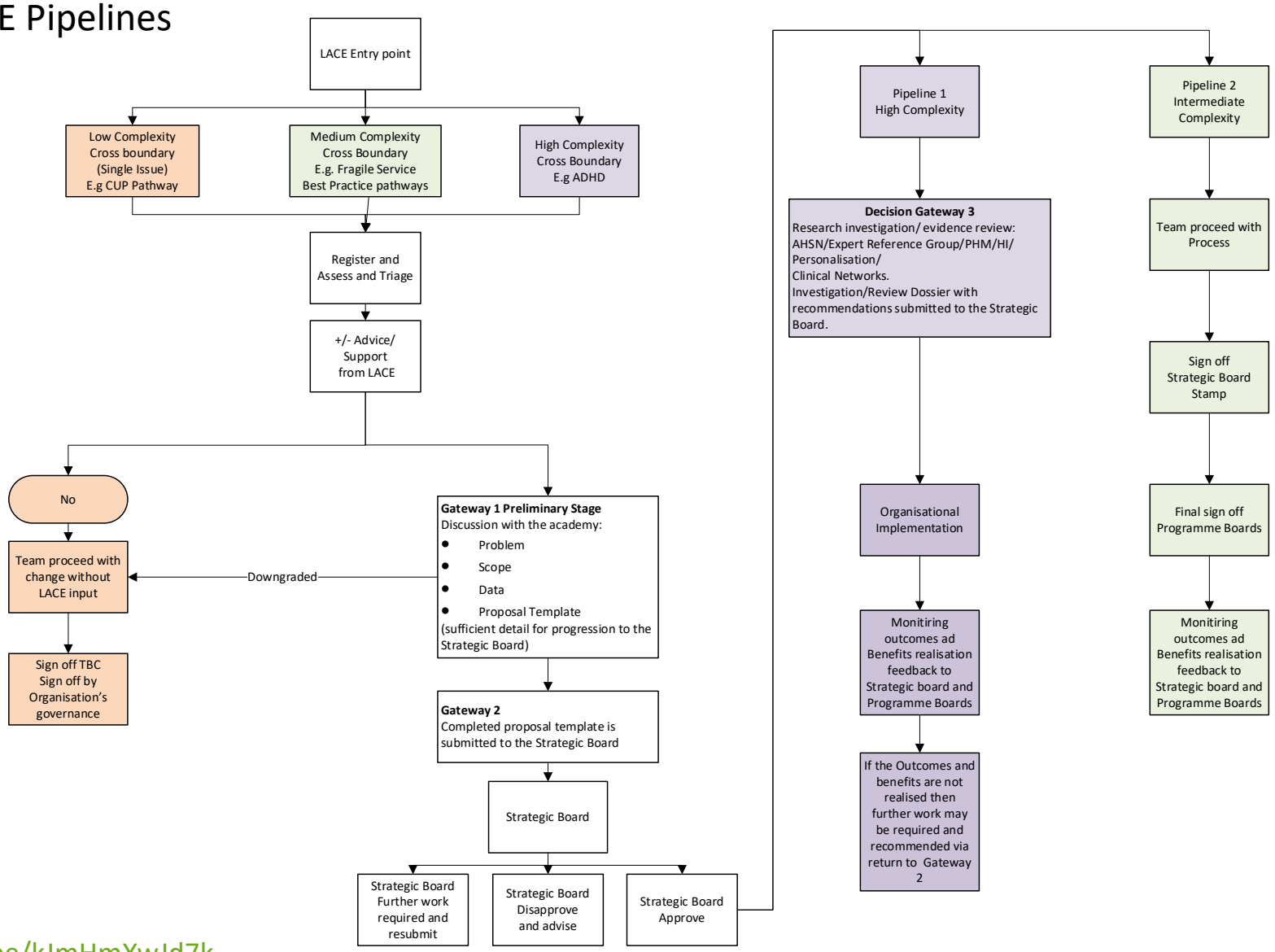
- The **purpose** is improving the health and wellbeing of people in Lincolnshire, by supporting the delivery of our long-term population health improvement goals as well as care delivery: helping meet today's challenges, while shaping the landscape of tomorrow
- The **added value** of working as a system: facilitating stronger collaboration across organisations and more effective scaling of innovation; using existing assets and the expertise that exists in Lincolnshire
- The **mindset**: shifting the focus from assurance to improvement, which is everyone's business; adopting learning health and care system concept; understanding the relationship between investment and outcomes
- The **end-product**: a framework which drives more effective improvement. The emphasis is very much on framework, agreeing common language and principles.
    - The proposed framework will focus on two main elements:
        - Creating the conditions for change: identifying goals, priorities and resources; building relationships and trust; seeing diverse expertise as an asset; developing shared system leadership
        - Enabling the planning and delivery of changes across the system
- Links with Q , The Health Foundation and NHS Confederation - Peer learning support programme and opportunity to test Q framework in Lincolnshire
- The **proposed approach** to making this happen: Set up a working group; Link in with the national support offers; Draft up the framework, building on our work to date; Test and refine the framework

LACE Pipelines for Improvement

LACE Pipelines



Dr Zara Pogson ULHT Respiratory Physician https://youtu.be/kJmHmXwJd7k
Dr Sunil Hindocha NHS ICB Medical Director - https://youtu.be/T6G8nePsHxI

Review of ADHD Services for Adults

- Commissioned by the Mental Health, Learning Disabilities, Autism & CAMHS Commissioning Team.
- Testbed for the LACE method and pipeline of activities for detailed reviews.
- 4 workshops (1&2 completed) including clinical and operational experts as well as people with lived experienced, together comprise the Expert Reference Group. 3/4 private providers engaged and in attendance.
- Detailed exploration of the issues, data, evidence base, solution generation resulting in a high-level strategy by March 2024.
- Detailed evaluation of each stage of the method and pipeline: Very positive feedback from participants and commissioning team, thus far.

LACE Programmes

Colorectal – Rapid Access Colorectal Pathway

Lung Cancer Pathway

Planned Care Respiratory Pathway

Histopathology

Haematology

Pathology Review

Licensing of anastrozole for primary prevention of breast cancer

Targeted Lung Health Check

Children and Young People's (CYP) Work Programme

System Infrastructure and Investment Strategy

Use of ultrasound scans in Primary Care for diagnosing groin hernias

Transition Services for CYP

Liver Pathways (UGI)

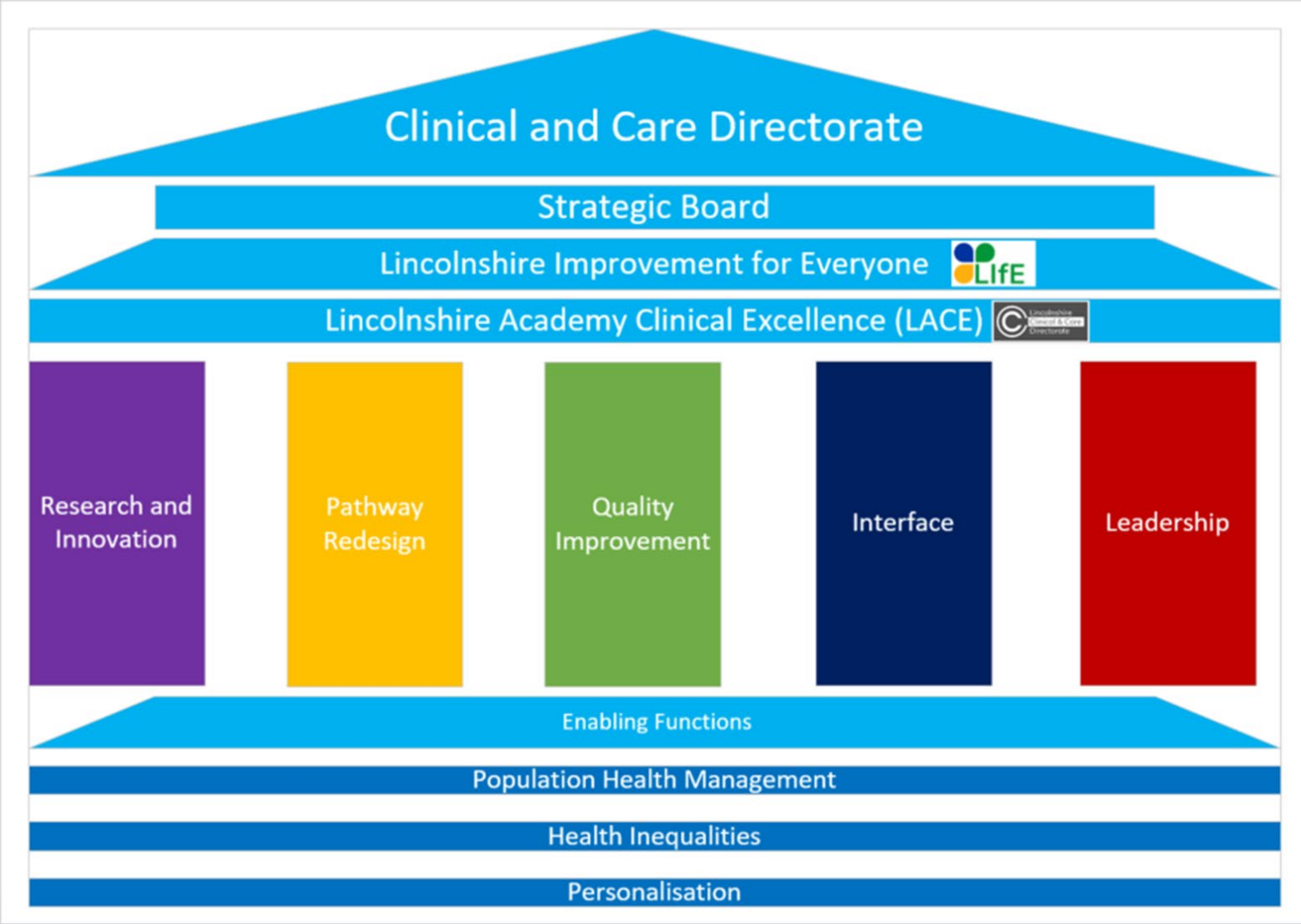
Research, Evaluation and Quality Improvement in Palliative and End of Life Care

UGI research project (Palliative Care MDT)

Whats Next?

- Socialisation
  - Execs
  - SMOG
  - How?- Mapping the connections-
    - Community of Practice for Registered Nurses
    - GPNurse Forum
    - AHP Council
    - PCN Alliance
  - What?- Mapping the priorities –
    - Clinicians
    - Patient Voice
    - Clincal and Care Directorate
  - Where?- Delivering across the ICS-

Clinical and Care Directorate



ICS Research Leaders Group

- Inaugural meeting was held in early January 2024 and builds on established research partnerships within our ICS. The Group will meet monthly with representation from research leaders across the NHS, Lincolnshire County Council, Universities, voluntary sector and wider partners.

Purpose: To provide strong and effective partnership working across the health and care system and a commitment to maximising shared research opportunities to deliver better health and wellbeing outcomes to the people of Lincolnshire.

This group will have strategic and operational functions and will oversee the development of the ICS Research Strategy.

ICS Research & Innovation Strategy

Research and Innovation LIfE
Lincolnshire Improvement for Everyone
Improving the Health and Wellbeing of people in Lincolnshire

- The Health and Care Act 2022 sets new legal duties on ICBs around the facilitation and promotion of research, and the use in the health service of evidence obtained from research.

Our ICS Research & Innovation Strategy is in development, for publication March/ April 2024.

It will set out our collective Research & Innovation vision and ambition for the next 5 years.

- Our strategy will be co-produced during 2 strategy development workshops in February, with representation from across our ICS. We are also holding a public contributor workshop.
- The working principals for the strategy are:

1. Reflects the needs of our communities
2. Collaborative, co-ordinated and trusted partnerships
3. Research embedded in everything we do
4. Delivered by a sustainable, capable and confident workforce

Research & Innovation Hub

Research and Innovation Hub

LIfE

Lincolnshire Improvement for Everyone

Improving the Health and Wellbeing of people in Lincolnshire

We will launch the ICS Research & Innovation Strategy and Research & Innovation Hub website. This website will initially be focused on the Public. It will be a resource where the Public can find out about health and care research, why it is important, what is happening in Lincolnshire and how to get involved.

It will then evolve to include sections for our Workforce, Researchers and Research Leaders.

The Public content is being co-produced by the Public who have been invited to 2 online workshops. This has been extremely well received.

Hub Launch

SAVE THE DATE

17 04 24

At the University of Lincoln

All our ICS, local and regional partners, national speakers and the Lincolnshire public will come together to showcase and celebrate Research and Innovation.

Research Training Programme: Background

Research and Innovation Hub
LIfE
Lincolnshire Improvement for Everyone
Improving the Health and Wellbeing of people in Lincolnshire

- A Lincolnshire wide Allied Health Professions (AHP) research survey was conducted at the end of 2022 and into 2023. Lincolnshire County Council conducted a subsequent research survey amongst their workforce.
- There were large correlations with the findings which, from reviewing other research studies, could also be applied to nursing and other non-medical professions.
- Our colleagues needed time within their working day to undertake research activities and they needed research training.
- Funding was sourced and has been received from the Clinical Research Network East Midlands (CRNEM), LCC and ULHT.

Research Training Programme

Research and Innovation Hub
LIfE
Lincolnshire Improvement for Everyone
Improving the Health and Wellbeing of people in Lincolnshire

- A foundation research training programme, delivered in partnership with the University of Lincoln, for colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations.
- Starting at the end of March, the training will be 8 online sessions over 5 months culminating in a celebration market place event to explore the 'what next'.
- No prior knowledge of research required.
- For all staff (registered and unregistered).

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

Item 5 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED BOARD

Agenda Number:	Item 05 (iii)
Meeting Date:	30th January 2024
Title of Report:	Primary Care Access Update
Report Author:	Nick Blake, Programme Director – Primary Care
Presenter:	Nick Blake, Programme Director – Primary Care
Appendices:	

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

Recommendations

The Board is recommended to:

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

Summary

Primary Care System Level Access Improvement Plan background

The Primary Care Access Recovery Plan (also known as the Delivery Plan for Recovering Access to Primary Care) was published in May 2023 and sets out sets out an ambitious package of measures to tackle the "8am rush" for patients to contact their GP practice for an appointment and help improve satisfaction with access to their GP practice.

The national Plan covers four key areas:

1. Empowering patients to manage their own health
2. Implementing Modern General Practice Access
3. Building Capacity
4. Cutting bureaucracy

ICBs were required to submit Primary Care System Level Access Improvement Plans (SLAIP) to public board meetings over October and November with a further update mandated in January or February 2024. The Lincolnshire plan was approved by the ICB Board on 27 November.

It is recognised that the plan will be develop iteratively over time – this report provides an update on the local delivery and development of the plan over December 2023 and January 2024. As noted in the presentation of the plan to the Board in November, the Access Improvement Plan should be considered within the context of the Joint Forward Plan and developing System Operational Plan with access improvement providing a foundation for the development of integrated primary care.

Monthly delivery and performance reports are provided to the Primary Care Commissioning Committee.

Delivery update

1. *Empowering patients*

Work on self-referral pathways is progressing – the aim is to increase the number of people self-referring by 50%, this equates to 66 self-referrals per month by March 2024 with around 40-50 self-referrals each month currently. A significant number of self-referrals aren't recorded accurately currently so improving recording is key focus alongside promoting self-referral – information is already available, and a further communication campaign is planned for February.

The Pharmacy First service is due to launch on 31 January 2024 – this combines the GP community pharmacy referral scheme with an extended range of conditions that pharmacies can treat with prescription only medicines without the need for the patient to see a GP e.g. shingles, acute ear ache and sore throats. There has been good progress with pharmacy engagement in Lincolnshire with 94% of pharmacies currently signed up to deliver the service. Work is underway with GP practices and pharmacies to put systems in place and support referral pathways and communication between pharmacies and GP practices. The ICB will be promoting the service using national communication resources when these are available.

Referral rates from GP practices to the current pharmacy referral scheme are relatively low with 26% of practices making a referral in December 2023. Rurality, access to community pharmacies, use of locum pharmacists and the high level of dispensing practices (GP practices who dispense prescriptions to their patients) in Lincolnshire make performance improvement challenging – work is underway to promote the service to practices and to support pharmacies train up staff, so they are able to offer the service consistently.

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

2. *Implementing Modern GP practice access*

There has been good progress on supporting GP practices move to digital telephone systems, the national deadline for all practices currently using analogue systems to sign a contract with a digital system provider by 15 December was met. Work is ongoing to support practices moving to digital system by April 2024 alongside supporting practices who already have digital phone systems to have access to the full range of functionality such as call-back, this means patient scan request a call and don't need to wait on the phone.

Online consultation systems are available to GP practices and funded by the ICB up until the end of March when this will move to national funding – 72 GP practices are fully compliant with NHSE requirements, the ICB is supporting the remaining nine practices with training and support on system optimisation available. The ICB is also working with Lincolnshire County Council on digital inclusion to support patients make use of digital access opportunities, e.g., working with Patient Participation Groups to support and assisting other patients learning about using digital access and online tools such as askmyGP.

The ICB Primary Care and Quality Teams are supporting GP practices review how they can improve access and services using the national Support Level Framework (SLF) diagnostic tool – this uses a questionnaire with follow up conversations to identify areas of good practice and areas to be developed. Practice visits to underpin the approach began in January, five practices have also completed the Framework through engagement with the national GP Improvement Programme.

The plan is on track for 25% of practices to complete the SLF in 2023/24 and the remainder in 2024/25.

More GP practice appointments are available than pre-covid – there were 487,816 appointments in November 2023 compared to 349,500 in November 2019.

3. Building capacity

Staff numbers in GP practices are increasing – there are 18% more full time equivalent posts in GP practices now when compared to 2019. The main increases in staff numbers relate to Primary Care Network additional roles e.g. clinical pharmacists, physiotherapists, mental health practitioners and social prescribers. There has been a reduction in the number of GP partners but his offset by more trainee and salaried GP posts. Ongoing development of the primary care workforce is supported and underpinned by the Primary Care People Plan.

Work with Primary Care Networks (PCN) to make use of Additional Roles funding to expand the primary care workforce has progressed over 2023/24. PCNs plan to have 450 full time equivalent additional roles staff in post by the end of March 2024, this is above the Lincolnshire proportion of the manifesto commitment of 26,000 roles in post. Current forecast underspend against the total available funding for Lincolnshire (around £20 million) is £1.7 million, work is ongoing with the PCN Alliance to minimise underspend – a proportion of the underspend relates to in-year recruitment so this will not be recurrent in 2024/25. NHSE have now advised that PCN additional roles underspend cannot be transferred to other PCNs and all PCNs should be within their indicative additional roles budget.

4. Cutting bureaucracy

The key work for the ICB is improving the interface between primary and secondary care services, meetings have been set up within the Care and Clinical Directorate to identify and address quality and operational interface issues. Work is ongoing to develop a behavioural concordat alongside work on improving processes for patients to receive fit notes where required.

Dr Colin Farquharson (Medical Director - ULHT) is one of two clinical representatives for the Midlands region at the national NHS England interface forum.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The SLAIP should support all four of the ICB's core aims – detail is included within the appended SLAIP document.
Aim 2: Tackle inequalities in outcomes, experience and access.	The SLAIP should support all four of the ICB's core aims – detail is included within the appended SLAIP document.
Aim 3: Enhance productivity and value for money.	The SLAIP should support all four of the ICB's core aims – detail is included within the appended SLAIP document.
Aim 4: Help the NHS support broader social and economic development.	The SLAIP should support all four of the ICB's core aims – detail is included within the appended SLAIP document.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	N/A

Risk and Assurance

There are no specific risks or issues identified beyond those associated with the delivery of the plan – these are managed through ICB governance and as set out within assurance section of the SLAIP.

Implications (legal, policy and regulatory requirements)

Does the report highlight any resource and financial implications?	Yes, a range of additional funding underpins and supports delivery of the Primary Care Access Recovery Plan and is summarised by NHSE here: NHS England » Primary care service development funding and general practice IT funding guidance 2023/24.
Does the report highlight any quality and patient safety implications?	The Access Recovery Plan aims to improve quality of care.
Does the report highlight any health inequalities implications/	A HEAT has been completed for the System Level Access Improvement Plan.
Does the report demonstrate patient and public involvement?	This is referenced within the Plan. Further engagement through the ICB's Patient Council is ongoing with a co-production group now running. Further development of engagement and co-production is included within the SLAIP.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No.

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

Report previously presented at:

Not applicable – the Primary Care System Level Access Improvement Plan for Lincolnshire was presented to the Board on 27 November 2023.

Is the report confidential or not?

Yes ☐ No ☒

Item 6 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (i)
Meeting Date:	30th January 2024
Title of Report:	System Financial Management Report December 2023 (Month 9)
Report Author:	Rebecca McCauley, Senior Finance Business Partner
Presenter:	Matt Gaunt, Director of Finance
Appendices:	Appendix 1: Lincolnshire Integrated Care Financial Position Appendix 2: Lincolnshire Integrated Care System Income & Expenditure Summary Appendix 3: Lincolnshire Integrated Care Board Income & Expenditure Analysis

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

Recommendations

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

Summary

Summary Financial Position

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

Through the Month 9 reporting cycle, the ICS moved the forecast position to that agreed with NHS England as part of the 2023/24 half 2 (H2) financial reset process to a £27.4m deficit. Actions to enable delivery of this reset outturn are being closely monitored via the FRP Programme Board.

Year To Date Financial Position

The H2 financial reset plan was for the ICS to deliver a deficit at month 9 of £43.9m which represents a £12.1m adverse variance to the initial 2023/24 plan. The ICS reported delivery against this plan at month 9.

The H2 financial reset plan was for the ICB to deliver a deficit of £30.3m at month 9 which represents a £13.6m adverse variance to the initial plan for 2023/24. The ICB reported delivery against this plan at month 9.

Outturn Financial Position

The ICS' H2 financial reset plan is to deliver a £27.4m deficit for the full financial year. The outturn position is to achieve plan.

This represents a £12.0m adverse variance against the £15.4m planned deficit at the outset of the year.

The ICB expects to deliver a £14.8m deficit by 31st March 2024. This is in line with the H2 financial reset plan. The initial plan at the beginning of the year was for the ICB to deliver a £2.4m surplus for the full year so the position reported at month 9 is a £17.2m adverse variance against this plan. Excess pricing pressure on prescribing is driving most of the deficit.

Risks and mitigations

The ICS has identified £10.0m of risks within its reported outturn position. After mitigations this provides a net risk position of zero. The ICS is assuming that any impact of industrial action will be funded centrally and assumes that the ICS will receive allocations, in quarter four, that were anticipated within the H2 financial reset plan.

Efficiencies

At month 9 the ICS delivered £49.3m in efficiencies which equates to a £0.1m adverse variance against the £49.4m plan. The full year plan is to deliver efficiencies of £78.9m and the outturn at month 9 was to deliver this plan. The ICS Financial Recovery Plan constituted £55.0m of the total efficiency requirement.

Capital

The ICS is reporting an £8.1m underspend against its year-to-date plan of £19.8m due to slippage on some projects. At month 9 the ICS is planning to overspend by £20.6m against its £32.6m full year Capital Allocation. This is due to the impact of the intra-NHS Right of Use asset liability reassessments in-year relating to NHS Property Services. It is expected that these will be excluded from the ICS' Capital Departmental Expenditure Limit.

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

Mental Health Investment Standard (MHIS)

At the 31st of December 2023, the ICS is expecting to achieve its MHIS target for 2023/24. The target spend for the year is £154.2m and the ICS is committed to meeting this target.

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

Better Payment Practice Code

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

ICB Financial Duties

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

The table below demonstrates delivery against the key financial duties as at month 9.

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

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

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

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

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

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

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

Appendix 1 – Lincolnshire Integrated Care Financial Position

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Year To Date				Full Year			
	Plan	Actual	Variance		Plan	Outturn	Variance	
	£m	£m	£m	%	£m	£m	£m	%
United Lincolnshire Hospitals NHS Trust	(18.3)	(18.7)	(0.4)	(0.1%)	(20.8)	(23.1)	(2.3)	(0.3%)
Lincolnshire Partnership NHS Foundation Trust	3.3	4.7	1.4	1.2%	3.0	6.8	3.8	2.3%
Lincolnshire Community Health Services NHS Trust	-	0.4	0.4	0.4%	-	1.3	1.3	1.0%
Lincolnshire ICB	(16.7)	(30.3)	(13.6)	(1.0%)	2.4	(14.8)	(17.2)	(1.0%)
ICS Total (inclusive of December and January Industrial Action)	(31.8)	(43.9)	(12.1)	(0.9%)	(15.4)	(29.7)	(14.3)	(0.8%)
Industrial Action Costs	-	(0.5)	(0.5)	0.0%	-	(2.4)	(2.4)	0.0%
Surplus/deficit before December and January Industrial Action	(31.8)	(43.5)	(11.7)	(36.7%)	(15.4)	(27.4)	(11.9)	(77.4%)

Appendix 2 – Lincolnshire Integrated Care System Income & Expenditure Summary

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Forecast Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	(1,312.7)				(1,763.3)			
ICB Net Expenditure								
Acute Services	681.7	680.4	1.3	0.2%	916.5	919.0	(2.5)	(0.3%)
Mental Health Services	151.8	153.3	(1.6)	(1.0%)	204.3	207.3	(3.0)	(1.5%)
Community Health Services	130.9	135.1	(4.2)	(3.2%)	170.4	176.9	(6.5)	(3.8%)
Continuing Care Services	44.2	46.6	(2.4)	(5.5%)	60.1	63.8	(3.7)	(6.2%)
Primary Care Services	133.5	148.0	(14.5)	(10.9%)	179.3	197.3	(17.9)	(10.0%)
Memo: Prescribing	117.5	129.7	(12.2)	(10.4%)	157.1	171.8	(14.7)	(9.4%)
Other Commissioned Services	5.6	5.2	0.4	6.6%	7.4	7.1	0.4	5.0%
Other Programme Services	3.7	3.7	0.0	0.1%	5.7	5.5	0.2	3.8%
Reserves / Contingencies	(1.5)	(0.4)	(1.1)	70.9%	(20.7)	(22.7)	2.0	(9.5%)
Delegated Primary Care Commissioning	167.8	160.6	7.2	4.3%	222.2	209.4	12.8	5.8%
ICB Running Costs	11.8	10.5	1.3	11.1%	15.8	14.6	1.2	7.3%
Total ICB Net Expenditure	**1,329.4**	**1,342.9**	**(13.6)**	**(1.0%)**	**1,761.0**	**1,778.1**	**(17.2)**	**(1.0%)**
ICS Providers I&E - Adjusted Financial Performance								
Income	(783.3)	(796.3)	13.0	1.7%	(1,048.2)	(1,061.1)	12.9	1.2%
Pay	548.8	554.7	(5.9)	(1.1%)	731.3	737.6	(6.3)	(0.9%)
Non-Pay	244.6	251.8	(7.2)	(3.0%)	327.8	333.8	(6.0)	(1.8%)
Non Operating Items	5.0	3.4	1.6	31.1%	6.8	4.6	2.3	33.2%
TOTAL Provider Surplus/(Deficit)	**(15.1)**	**(13.6)**	**1.4**	**9.6%**	**(17.8)**	**(14.9)**	**2.8**	**16.0%**
TOTAL ICS Surplus/(Deficit)	**(31.8)**	**(43.9)**	**(12.1)**	**38.1%**	**(15.4)**	**(29.7)**	**(14.3)**	**0.8%**
ICS Providers - Industrial Action								
Impact of Industrial Action in December & January	-	(0.5)	(0.5)	0.0%	-	(2.4)	(2.4)	0.0%
TOTAL ICS Surplus/(Deficit) Excluding Impact of Industrial Action	**(31.8)**	**(43.4)**	**(11.6)**	**(36.6%)**	**(15.4)**	**(27.4)**	**(11.9)**	**(77.4%)**

Appendix 3 – Lincolnshire Integrated Care Board Income & Expenditure Analysis

System I&E Analysis	Year to Date				Full Year			
	Net Expenditure Plan £m	Net Expenditure Actual £m	Net Expenditure Variance £m	Net Expenditure Variance %	Net Expenditure Plan £m	Net Expenditure Outturn £m	Net Expenditure Variance £m	Net Expenditure Variance %
System Revenue Resource Limit	**1,312.7**				**1,763.3**			
ICB Net Expenditure								
Acute Services	**681.7**	**680.4**	**1.3**	**0.2%**	**916.5**	**919.0**	**(2.5)**	**(0.3%)**
Acute services - NHS	652.2	646.4	5.9	0.9%	879.5	867.1	12.4	1.4%
Acute services - Independent/commercial sector	22.3	25.6	(3.3)	(14.7%)	27.6	35.1	(7.5)	(27.2%)
Acute services - Other non-NHS	1.5	3.2	(1.7)	(110.3%)	1.9	9.0	(7.1)	(367.9%)
Acute Services - Other Net Expenditure	5.7	5.3	0.4	6.3%	7.5	7.8	(0.3)	(4.7%)
Mental Health Services	**151.8**	**153.3**	**(1.6)**	**(1.0%)**	**204.3**	**207.3**	**(3.0)**	**(1.5%)**
MH Services - NHS	87.9	90.4	(2.6)	(2.9%)	118.5	122.3	(3.8)	(3.2%)
MH Services - Independent / Commercial Sector	28.6	25.5	3.1	10.7%	38.5	35.6	2.9	7.6%
MH Services - Other non-NHS	34.1	36.6	(2.4)	(7.1%)	45.6	47.3	(1.7)	(3.8%)
MH Services - Other net expenditure	1.2	0.8	0.4	31.2%	1.7	2.1	(0.5)	(28.1%)
Community Health Services	**130.9**	**135.1**	**(4.2)**	**(3.2%)**	**170.4**	**176.9**	**(6.5)**	**(3.8%)**
Continuing Care Services	**44.2**	**46.6**	**(2.4)**	**(5.5%)**	**60.1**	**63.8**	**(3.7)**	**(6.2%)**
Primary Care Services	**133.5**	**148.0**	**(14.5)**	**(10.9%)**	**179.3**	**197.3**	**(17.9)**	**(10.0%)**
Prescribing	117.5	129.7	(12.2)	(10.4%)	157.1	171.8	(14.7)	(9.4%)
Other Primary Care Services	16.0	18.3	(2.3)	(14.1%)	22.3	25.5	(3.2)	(14.4%)
Other Commissioned Services	**5.6**	**5.2**	**0.4**	**6.6%**	**7.4**	**7.1**	**0.4**	**5.0%**
Other Programme Services	**3.7**	**3.7**	**0.0**	**0.1%**	**5.7**	**5.5**	**0.2**	**3.8%**
Reserves / Contingencies	**(1.5)**	**(0.4)**	**(1.1)**	**70.9%**	**(20.7)**	**(22.7)**	**2.0**	**(9.5%)**
Delegated Primary Care Commissioning	**167.8**	**160.6**	**7.2**	**4.3%**	**222.2**	**209.4**	**12.8**	**5.8%**
Primary Medical Services	121.2	90.0	2.0	2.2%	158.0	156.0	2.1	1.3%
Delegated Dental, Ophthalmic and Pharmacy Services	46.5	41.7	4.8	10.4%	64.1	53.4	10.7	16.7%
Dental Services	27.4	22.4	5.0	18.1%	38.7	28.0	10.7	27.7%
Ophthalmic Services	5.4	5.7	(0.3)	(5.9%)	7.4	7.4	-	0.0%
Pharmacy Services	13.8	13.6	0.2	1.4%	18.0	18.0	-	0.0%
ICB Running Costs	**11.8**	**10.5**	**1.3**	**11.1%**	**15.8**	**14.6**	**1.2**	**7.3%**
Total ICB Net Expenditure	**1,329.4**	**1,045.9**	**(10.7)**	**(1.0%)**	**1,761.0**	**1,778.1**	**(17.2)**	**(1.0%)**
TOTAL ICB Surplus/(Deficit)	**(16.7)**	**(30.3)**	**(13.6)**	**(1.0%)**	**2.4**	**(14.8)**	**(17.2)**	**(1.0%)**

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	30th January 2024
Title of Report:	NHS Lincolnshire ICB People and Communities Strategy
Report Author:	Steph King, Engagement Lead, NHS Lincolnshire ICB
Presenter:	Pete Burnett, Director of Strategic Planning, Integration and Partnerships, NHS Lincolnshire ICB
Appendices:	NHS Lincolnshire ICB People and Communities Strategy

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

Recommendations

The ICB Board is recommended to:

- Note the content of the paper and the process taken to develop and evaluate the ICB People and Communities Strategy
- Approve the ICB People and Communities Strategy.
- Agree to receive the Annual People and Communities Involvement Report at the Board ahead of its publication.

Summary

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

This People and Communities Strategy demonstrates how the ICB will meet its legal duties, through understanding and empowering local communities, ensuring the patient and public voice is at the heart of service design and decision making. The strategy is dynamic in nature, flexing in accordance with the needs and feedback of the local communities. Therefore, some of the content is well established and progressed work, and some references are intended developments.

The strategy outlines how the ICB will involve people and communities, supporting health inequalities and achieve the aim of 'building a common purpose', involving people in all stages of service development, design, change and decision making. It has been developed during various stages in partnership with our communications and engagement leads across our NHS partner organisations and with our LICB Strategy and Planning team.

The ICB will continue to develop the strategy with People and Communities in Lincolnshire; ICS partners including Healthwatch, VCSE organisations, stakeholders and community groups; key system partners such as leads for Equality and Diversity, Personalisation and Shared Decision Making and Health Inequalities and System leaders who will champion and embed this work.

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

Delivering the principles will demonstrate and evidence the ICB's commitment to involving people and communities and this is evidenced through our ICB People and Communities Involvement Annual Report 2022-23 and future annual reports.

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

In reviewing the strategy SQPEC also agreed to:

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

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

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Engagement and involvement can support identification of healthcare needs and aspirations of communities, ensuring that the patient voice is at the heart of service development and delivery.
Aim 2: Tackle inequalities in outcomes, experience and access.	Engagement and involvement can highlight and identify inequalities and work with impacted groups to mitigate barriers to improve outcomes, experience and access.
Aim 3: Enhance productivity and value for money.	Services developed and shaped by patient, public, staff and stakeholder involvement are delivered more efficiently and utilised more effectively
Aim 4: Help the NHS support broader social and economic development.	Engagement and involvement enables people and communities to shape

	programmes of work across the ICS and provides them with skills and experience to become a local champion and voice in their local areas.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Demonstrates assurance to minimise risk 0002: The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.

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?	Yes, it demonstrates the ICB commitment and approach to involving Lincolnshire's People and Communities, therefore meeting its Statutory Duty to Involve
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not Applicable

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

Report previously presented at:
System Quality & Patient Experience Committee 9 January 2024

Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

Lincolnshire Integrated Care Board

People and Communities Strategy

Our commitment to involvement

January 2024

Version 1.2

CONTENTS

Our Lincolnshire People and Communities Strategy has been developed during various stages in partnership with our communications and engagement leads across our NHS partner organisations and with our strategy and planning team.

We will continue to test this strategy and develop it further with our:

- People and Communities in Lincolnshire
- Our ICS partners including Healthwatch, VCSE organisations, stakeholders and community groups
- Key system partners such as leads for Equality and Diversity, Personalisation and Shared Decision Making and Health Inequalities
- System leaders who will champion and embed this work

1. CONTEXT AND INTRODUCTION

The Lincolnshire ICB Constitution sets out the legal duties and principles we will adhere to when developing and maintaining arrangements for public involvement. This People and Communities Strategy demonstrates how we will deliver these to understand and empower our communities, ensuring the patient and public voice is at the heart of service design and decision making. The strategy is dynamic in nature, flexing in accordance with the needs and feedback of our communities. Therefore, some of the content is well established and progressed work, and some references are intended developments.

Our People and Communities in Lincolnshire: residents, people who access care and support (and those who do not), unpaid carers, representatives and families. We also commit to proactively involving those with health inequalities or who are seldom heard, staff, stakeholders and partner organisations.

ICB legal duties on public involvement

14Z45 - Public involvement and consultation by integrated care boards

In line with section 14Z44(2) of the 2006 Act, Lincolnshire ICB will ensure that we involve patients, their carers, representatives and the public and communities in

- The planning of commissioning arrangements
- The development and consideration of proposals
- Changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
- Decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

In addition to these legal duties, our formal consultations will also meet Governments four tests for service change and the additional NHS England test on changes to bed numbers. If we decide to involve people through a formal consultation before reaching an ICB decision then the ICB will make sure the process is fair and proportionate and consistent with common law principles, including the following four rules (Gunning Principles), which if followed, are designed to make consultation fair and a worthwhile exercise:

- that consultation must be at a time when proposals are still at a formative stage.
- that the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response.
- that adequate time is given for consideration and response; and
- that the product of consultation is conscientiously considered when finalising the decision.

14Z52 – Joint forward plans for integrated care board and its partners
This duty requires the ICB to prepare a five-year joint forward plan ("forward plan") before the start of each financial year and sets out what the plan must cover. This plan must include how the ICB proposes to involve people.

Section 14Z54 NHS Act 2006 imposes a duty on the ICB and its partner NHS trusts and NHS foundation trusts to consult "the group of people for whom the integrated care board has core responsibility" (defined in the Health and Care Bill) and "any other persons they consider it appropriate to consult":

- when preparing the forward plan; or
- revising the forward plan in a way they consider to be significant.

Local Health and Wellbeing Boards will be involved in the preparation of the plan by providing them with a copy of it and consulting them on whether it takes proper account of each joint local health and wellbeing strategy in the period to which it relates.

The published plan will include a summary of the views expressed by stakeholders who were consulted, an explanation of how those views were taken account of and statements of the opinions of all consulted Health and Wellbeing Boards.

Click here to see Health and Care Act 2022

Click here to see Health Act 2006

Other duties which link to our approach to involvement

NHS Constitution
The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled and pledges which the NHS is committed to achieve, many of which are enshrined in law. One of these rights is the right to be involved in your healthcare and the NHS directly or through representatives.

Click here to see Lincolnshire ICB constitution

The Public Sector Equality Duty – The Equality Act 2010
The Equality Act 2010 promotes fair treatment of people regardless of any protected characteristic they may have. All of our communications and involvement activities will take this into account, paying due regard to those with protected characteristics and ensuring that they have equitable opportunity to be involved.

Click here to see public sector equality duty

Duties as to reducing health inequalities – s.14Z34 NHS Act 2006
We are also under a duty to have regard to the need to reduce inequalities between persons in respect of access to and outcomes from health services. We will factor this into our involvement activities by making sure we are considering how to involve individuals who are disproportionately affected by health inequalities.

Annual reporting – s.14Z58 NHS Act 2006
The ICB must prepare an annual report on how it has discharged its functions in the previous year including the duty to involve the public at s.14Z45 NHS Act 2006.

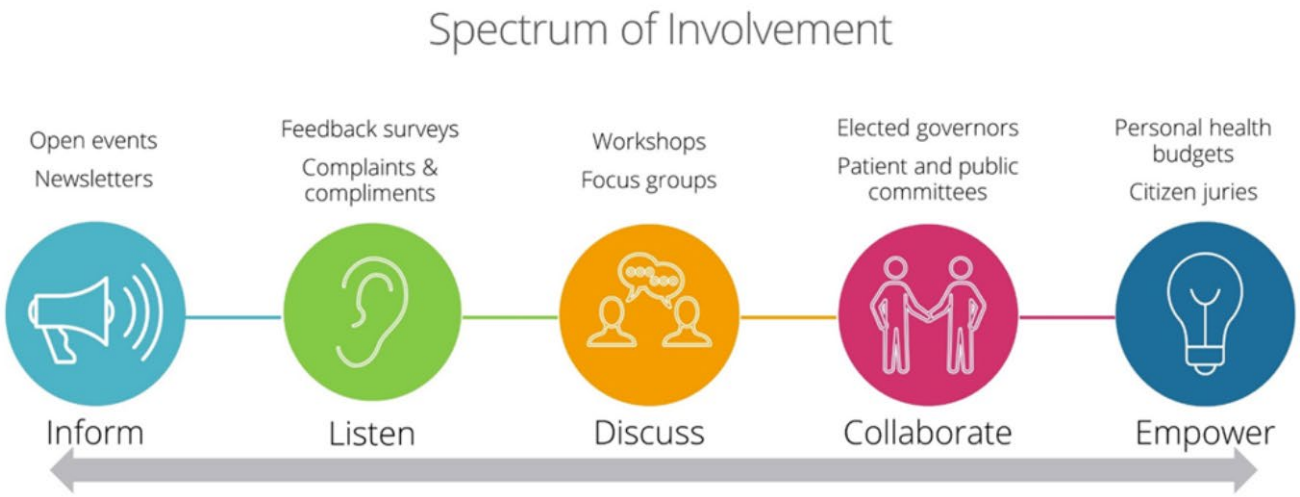
Duty to promote involvement of each patient – s.14Z36 NHS Act 2006
The ICB must, in the exercise of its functions, promote the involvement of people, patients, and their carers and representatives in decisions which relate to:

(a) the prevention or diagnosis of illness in the patients, or
(b) their care or treatment.

What we mean by involvement

NHS England defines involvement as: "Public involvement in commissioning is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals, and decisions about service. Different approaches will be appropriate, depending on the nature of the commissioning activity and the needs of different groups of people."

Involvement of our people and communities will run throughout our commissioning arrangements, from identifying the need to make changes to co-production and empowerment. Involvement can be in the form of information provision, engagement, consultation and co-production.



We will deliver this by ensuring our involvement:

- ✓ Focuses on people and what matters to them
- ✓ Is at an early, formative stage
- ✓ Is tailored to individual audiences
- ✓ Creates opportunities where they do not currently exist for voices that aren't always heard
- ✓ Embeds co-production at the start
- ✓ Driven by insights, patient experience and data for a solid evidence base
- ✓ Triangulates with quality and patient experience
- ✓ Works across the system and not in silo organisations
- ✓ Informed by patient experience and insight
- ✓ Open and transparent with clear, communicated outcomes

How we will involve people and communities

We have a variety of ways we can involve people and communities on an individual, group and community basis. We will ensure that our methods and approaches are inclusive and tailored to all of the Lincolnshire population and stakeholders so they can have their say. To do this it is important that we recognise and understand who our stakeholders are and the most effective way to communicate and engage with them by undertaking stakeholder mapping and analysis.

Involvement activities could include surveys, focus groups, listening clinics, workshops and events. All of our engagement and consultation activities will be supported by appropriate and proportionate communications which can be translated into the languages required, and in alternative formats such as easy read, large print, braille/recordings etc if required.

We will also work in partnership with local support organisations who have established links to reach wider sections of the population and who are focused on providing access and amplifying the voice of hidden and hard to reach people of Lincolnshire.

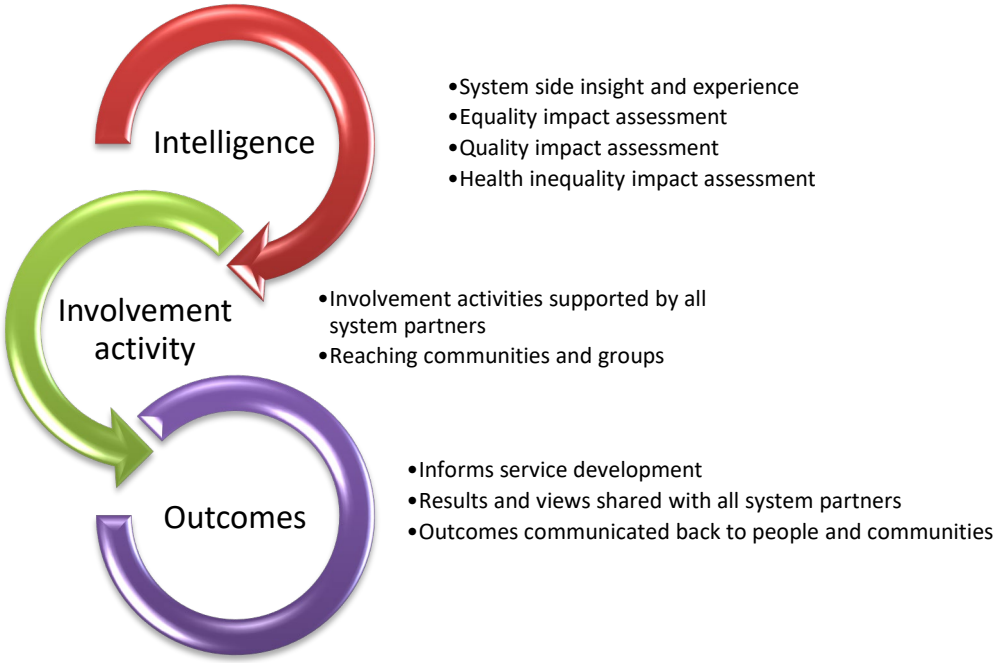
Understanding our people and communities

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

All of our commissioning and involvement activities will be built on a solid understanding of our population, service users, their experiences and the people that support them. We will utilise the knowledge, relationships, networks and strong links our partner organisations already have with our communities to ensure a fully holistic, system approach to involvement. We will use existing and tested opportunities to engage and communicate and seek to identify the best partner with the best

relationship to lead the conversation. Working as partners will strengthen our collective messages and involvement activities. As well as joining up care, we will join up our engagement and experience work to capture and improve the patient journey and use this to empower joined up system working.

We will support our programme teams to make these links and ensure Equality Impact Assessments, Quality Impact Assessments and Health Inequality Impact Assessments (HEAT) are undertaken to fully understand the people and communities we serve who may be impacted by any changes along with monitoring the on going impact of any change The insights and diverse thinking of people and communities are essential to enabling Lincolnshire ICB to tackle health inequalities and the other challenges faced by health and care systems.



Headline Demographics

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.

Lincolnshire is a unique county: it boasts a diverse landscape of sandy beaches, lush woodland, rolling fields and bustling communities. It is the proud home to some of the greatest traditional English seaside resorts in the country and Britain's Best Small City.

Lincolnshire is one of the largest counties in England but has relatively few residents – its total population is 768,400 (Census 2021). However, its population density is 129 people per square kilometre, around a third of the average for England.

Residents are spread across the city of Lincoln, market towns and rural and coastal areas. A predominantly rural county, Lincolnshire has no motorways, little dual carriageway and 80 kilometres of North Sea coastline.

Socially the county is diverse too, with some of the most affluent and most deprived areas in the East Midlands. Some of our wards are among the poorest in Europe, our population is older than the English average and we have proportionally more adults aged over 75 than elsewhere in England. The number of people in this age range in Lincolnshire is expected to increase significantly over the next 20 years.

The general pattern of deprivation across Lincolnshire is in line with the national trend in so much that the urban centres and coastal strip show higher levels of deprivation than other parts of the county. Resort towns, such as Skegness and Mablethorpe, are among the 10 per cent most deprived localities in England. All this means it's challenging to deliver high-quality healthcare across the county.

POPULATION

Lincolnshire's population is

768, 364

(Census 2021)

129
people per km²
(Census, 2021)

9.5%
Population projection by 2040
(ONS, 2018)

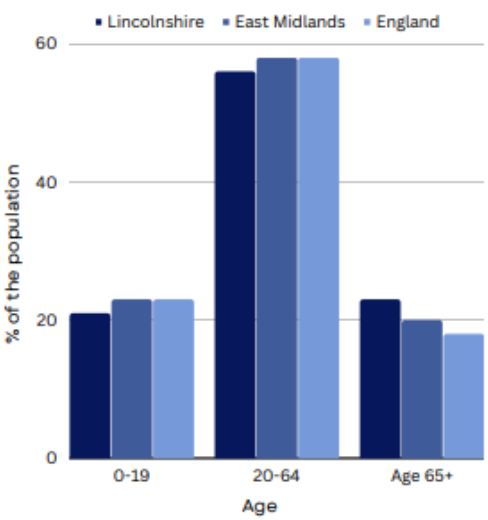
6,559
Births recorded
(ONS, 2021)

9,128
Deaths recorded
(ONS, 2021)

813, 119
Patients are registered with a GP practice in Lincolnshire
(NHS England, Feb 2023)

Age

(Census 2021)

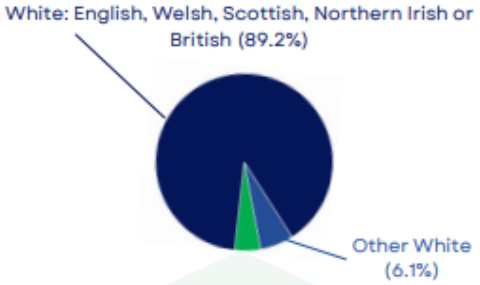


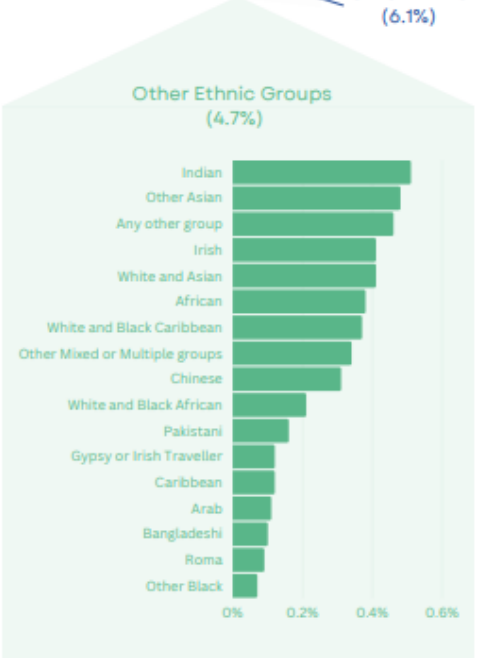
Sex

(Census 2021)

Ethnicity

(Census 2021)





19.1% have a disability (26.8% of households)

304, 863 people are married or in a civil partnership

2.7% identify as lesbian, gay, bisexual, pansexual or queer

14, 921 (1.9%) follow a religion other than Christianity

8.71% use a main language which is not English

(Census 2021)

Health Inequalities

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

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

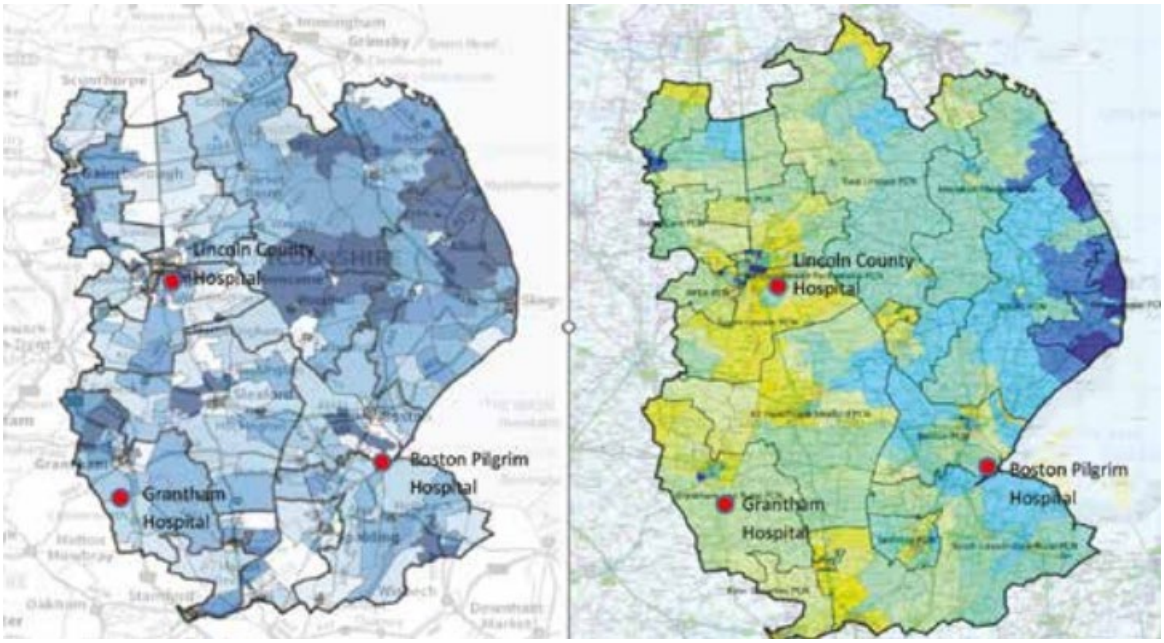
While most of our population enjoys good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than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

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

The Chief Medical Officer's annual report 2021: Health in Coastal Communities, elucidates these challenges and specifically references the east coast, for example, communities in Skegness and Mablethorpe. According to 'The Centre for Towns' measures these conurbations rank: 1st (Mablethorpe) & 4th (Skegness) in the 20 most deprived places in England and Wales.

Mablethorpe is fifth in the top 20 places for social isolation. It is already known that residents of such communities find access to healthcare problematic, face a declining bus network and experience poor broadband relative to the major cities/ urban areas.

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



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

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

Core20

The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – 120k patients, 15% of Lincolnshire population. Index of Multiple Deprivation (IMD)

PLUS

- ICS locally determined population groups (evidence and insight based) experiencing poorer-thanaverage health access, experience, and/ or outcomes who may not be captured within the CORE20 alone and would be benefit from a tailored health care approach – key groups identified for Lincolnshire include travellers, people who are homeless, rural, and coastal communities, farming and military families.
- Plus – People from a black, Asian and ethnic minority communities (101k patients, 13% of Lincolnshire), with the largest ethnic minority group being "any other white background" (8.2%) - a significant proportion of this group is people from an Eastern European background.

5

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

1. Maternity

- Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. Severe mental illness (SMI)

- Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. Chronic respiratory disease

- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis

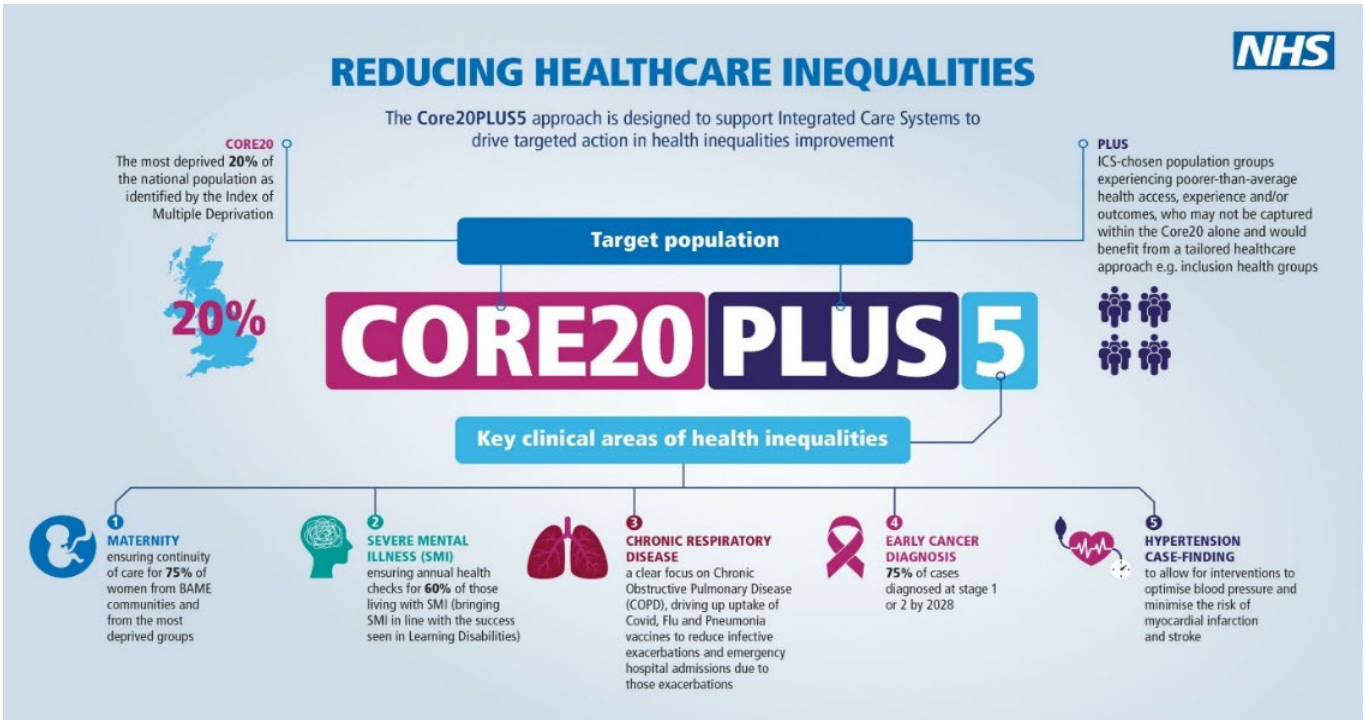
- 75% of cases diagnosed at stage 1 or 2 by 2028.

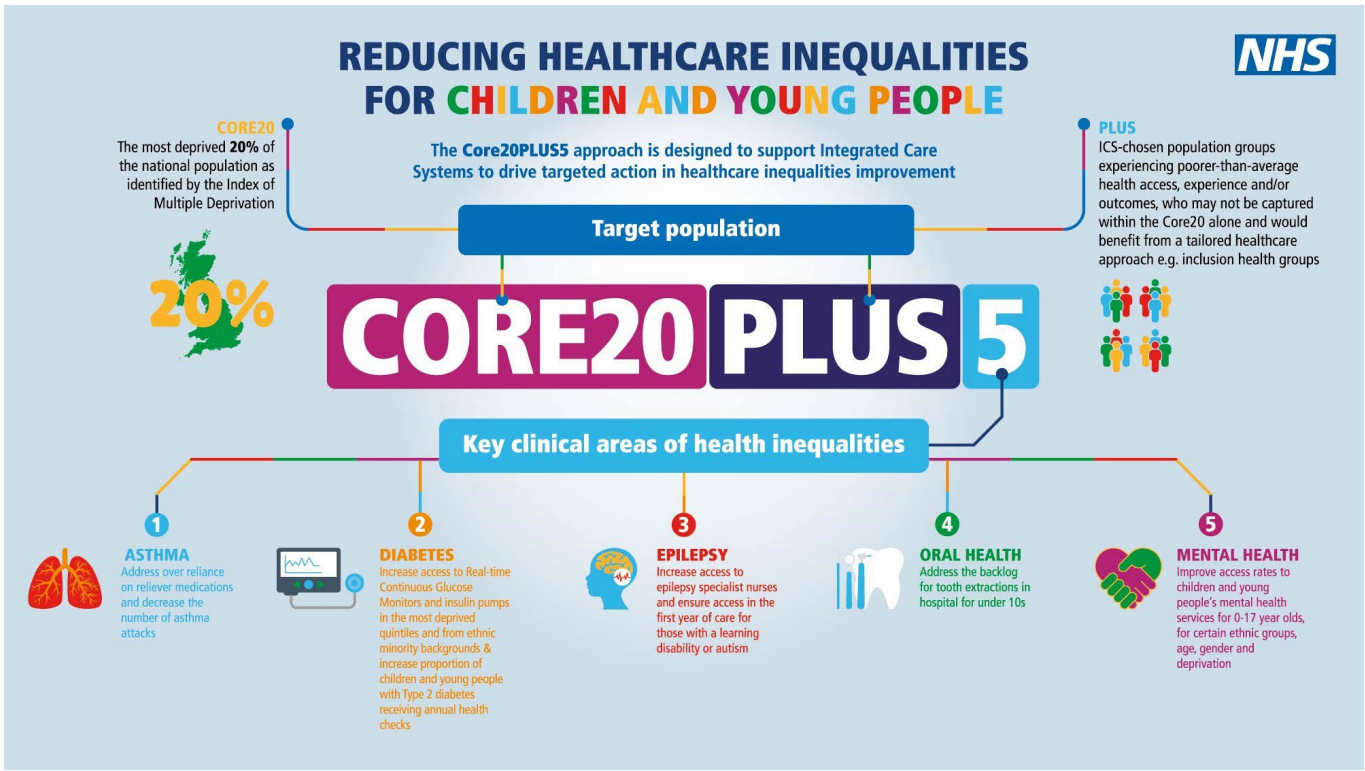
5. Hypertension case-finding and optimal management and lipid optimal management

- To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The local areas of focus in Lincolnshire are:

- Farming and Rural
- Temporary residents
- Travellers
- Military families
- Eastern European communities
- Coastal communities


NHS
REDUCING HEALTHCARE INEQUALITIES
The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement
CORE20
The most deprived 20% of the national population as identified by the Index of Multiple Deprivation
20%
Target population
CORE20 PLUS 5
PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups
Key clinical areas of health inequalities
1 MATERNITY
ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups
2 SEVERE MENTAL ILLNESS (SMI)
ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
3 CHRONIC RESPIRATORY DISEASE
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4 EARLY CANCER DIAGNOSIS
75% of cases diagnosed at stage 1 or 2 by 2028
5 HYPERTENSION CASE-FINDING
to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke


NHS
REDUCING HEALTHCARE INEQUALITIES
FOR CHILDREN AND YOUNG PEOPLE
The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement
CORE20
The most deprived 20% of the national population as identified by the Index of Multiple Deprivation
20%
Target population
CORE20 PLUS 5
PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups
Key clinical areas of health inequalities
1 ASTHMA
Address over reliance on reliever medications and decrease the number of asthma attacks
2 DIABETES
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks
3 EPILEPSY
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism
4 ORAL HEALTH
Address the backlog for tooth extractions in hospital for under 10s
5 MENTAL HEALTH
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

How involvement will support Health Inequalities

Our NHS System Engagement Team will have a dedicated team member to support tackling health inequalities, embedding consistent, best practice activities and empowering Lincolnshire's people and communities to be involved in all aspects of the programmes.

This approach of putting people and communities at the heart of tackling our health inequalities will be replicated across all priorities and programmes. Our people and community representatives will have clear roles and responsibilities within our programmes, governance and decision-making processes.

Especially important is to use the learning from the Covid19 Pandemic and the strengthened relationships with our partner organisations, reduction of duplication, collective responsibility to reach out to the people and communities we share using the best methods and links available regardless of organisational boundaries.

This will continue to evolve through the ICS as we embed shared working and governance processes such as development of the Lincolnshire System Partnership Communications and Engagement Steering Group with attendance from Healthwatch, VCSE partners, local authority partners etc.

2. AIMS AND PRINCIPLES

AIM: to build a common purpose

Our legal duties and commitments are clear – people and communities need to be involved in all stages of service development, design, change and decision making.

Our ambition to achieve this is illustrated well using the model from NHS Confederation's 'Building Common Purpose, Learning on engagement and communications in integrated care systems'.

How Lincolnshire ICB will involve people and communities to deliver our principles

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

Delivering our principles will demonstrate and evidence our commitment to involving our people and communities.

 1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS	We will deliver this by: ▪ Through the continued development and evolvement of the 'shared agreement' work outlined in the Joint Forward Plan. ▪ Patient and community representative attendance at key Committees and meetings ▪ Continued development of Patient and Community Partners, integral to the decision making in all NHS organisations e.g. Patient Safety Partners; Expert Patient Groups; Co-production groups. ▪ Continued strengthening of our Involvement Champions who will monitor this strategy and plan, it's achievements and outcomes ▪ Oversight by our governance structure to ensure delivery of our statutory duties to involve
 2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	We will deliver this by: ▪ Providing guidance and training for Executive teams and decision makers; contracting teams when they start to look at changes to services; programme boards to ensure involvement is integral to all projects ▪ Ensuring involvement advice and support is accessible for our staff and partners with clear promotion of the team, dedicated email and telephone contact details to access to our team ▪ Continued strengthening of our community and stakeholder databases and involvement channels to increase reach to our population ▪ Regular, clear and timely updates on our involvement activities ▪ Development of interactive involvement web-based platform to share involvement opportunities and outcomes
 3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if	We will deliver this by: ▪ Development and increased partnership contribution to our Involvement Insight database ▪ Continuing to link with our provider quality leads to understand the day-to-day feedback and incorporate it into our understanding of our community's needs ▪ Continue to monitor the experiences of our people and communities using our ongoing Experience of Care survey

change is having the desired effect	▪ Linking with feedback collected by others such as Healthwatch and Patient Participation Groups
 4. Build relationships with excluded groups, especially those affected by inequalities	We will deliver this by: ▪ Dedicated involvement resource for Health Inequalities Programme to ensure all programmes and HI workstreams are informed by the voices of service users, public and communities ▪ Continue community development work to strengthen links with community groups such as our Traveller Link Worker, Neighbourhood Leads, Eastern European communities and faith groups ▪ Continued strengthening of our stakeholder database, inviting groups and communities to join to enable ongoing engagement
 5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners	We will deliver this by: • Working with our partners across the ICS to support Integrated Care Partnerships to have representation from local people and communities in priority setting and decision-making forum • Work with our partners to develop a system-wide Insight Database, collating feedback and experiences from people and communities across all channels and organisations to inform our involvement activities and decision making. • Commissioning partners such as Healthwatch and Every-One to enable collaborative engagement
 6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust	We will deliver this by: • Remaining connected with our partner communications teams, and informing their work, as well as gaining their support for involvement messaging and priorities • Encouraging staff across the system to play their part in involvement, not only harvesting information and data for us to consider, but sharing opportunities and encouragement to the service users they see to engage
 7. Use community development approaches that empower people and communities, making connection to social action	We will deliver this by: • Retaining our close working relationships with local authority and district council colleagues, as well as voluntary and third sector teams to create as far reaching and relevant connections as possible

8. Use co-production, insight and engagement to achieve accountable health and care services.	We will deliver this by: • Our involvement activities will be built on insight and patient experience • Triangulate patient experience, quality and involvement • Working with the personalisation team in developing the approach to co-production to ensure the outcomes drive improvement in services • Continued development of system wide survey and analysis software, Qualtrics and development of system wide Insight Database
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.	We will deliver this by: • Utilising our governance and reporting structure to ensure that public and community feedback is heard and referenced by our strategic and operations colleagues • Having an involvement representative present at the ICB board to identify service redesign opportunities • Placing involvement representatives alongside operational colleagues in early strategic discussions • Embed co-production as a 'business as usual' approach to service review and design
10. Learn from what works and building on the assets of all ICS partners – networks, relationships, activity in local places.	We will deliver this by: • Our routine system involvement steering group, at which all ICS partners are invited to share best practise and leverage assets and networks to broader advantage • Leveraging the relationships our partners and community groups have with their service users and communities

How Lincolnshire ICB will involve individuals

The ICB also has a duty to promote involvement of each patient (s.14Z36 NHS Act 2006) in decisions which relate to the prevention or diagnosis of illness in patients or their care or treatment. We will do this by strengthening shared decision making and personalisation approaches.

Figure 1: NHS England shared decision making Implementation Framework

Lincolnshire ICS – Working Together

There is a long history of joint working in Lincolnshire between the Local Authority, the NHS, and wider partners. We have worked hard to build the relationships needed to support the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families, and their communities. We are pleased with the progress we have made and are confident we have developed the right principles and values to guide us.

However, we know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. We also know that to have the best chance of achieving this we need to think and work differently with each other and with our communities.

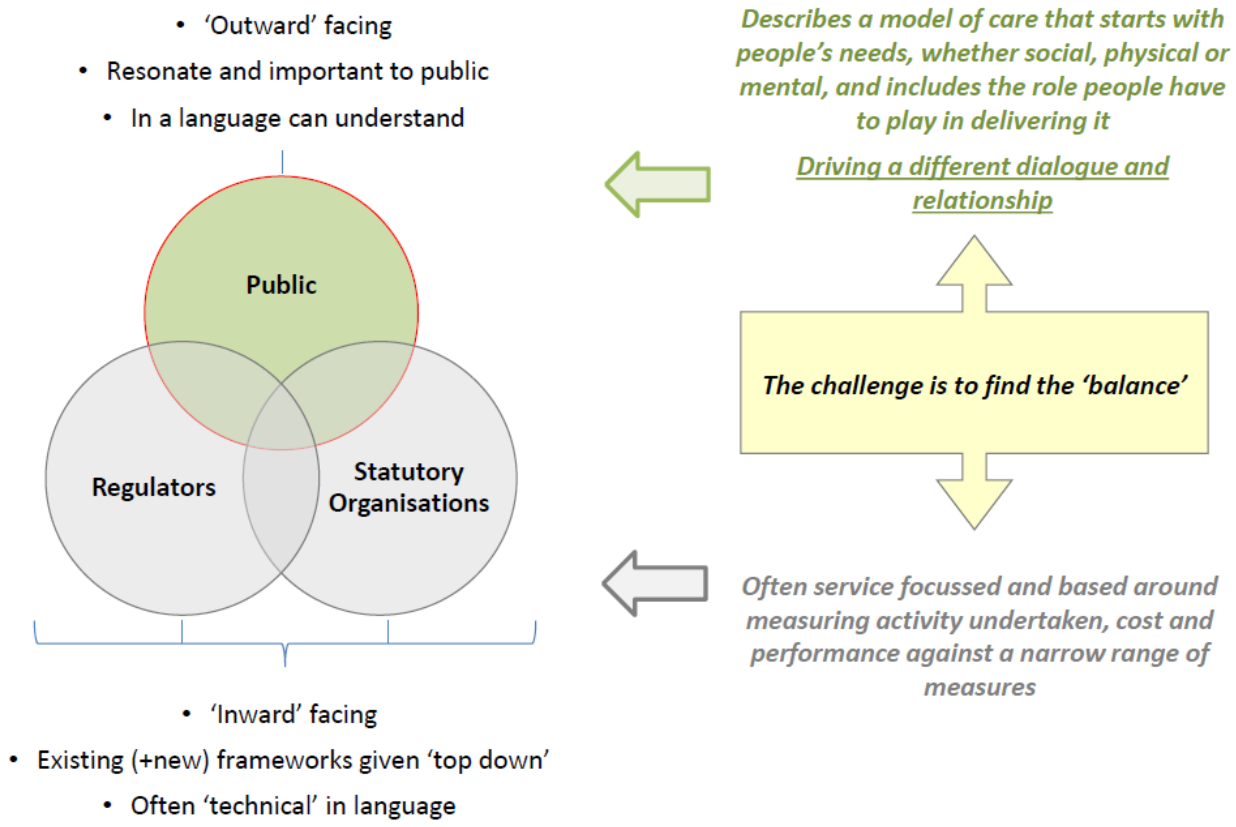
Together we will:

- **Create a shared agreement**
    - Work together with the public about what the best wellbeing, care and health for Lincolnshire looks like, as well as learn how staff across the NHS and its partners can confidently adopt new ways of working in their daily work.
    - Demonstrate the impact this new relationship could have on staff and people by highlighting where it is working well so we can build on strengths.
- **Support shared decision making**
    - Helping people to make informed decisions about their care and treatment and delivering this with a focus on what matter most to them, their family, and carers. This includes asking 'what matters to you?' on a routine basis and learning from work already being done in some services and communities.
- **Develop and design services together**
    - Build stronger relationships with the public, volunteers, and community groups, working alongside them to improve health and care services.
    - Include all sectors of society including hard-to-reach groups, creating safe and inclusive spaces to give everyone the confidence to contribute to discussions and use our new relationship with the public as a framework for developing and designing services together.
- **Work with people and their families to manage their own health and wellbeing**
    - Better understanding of how well patients can manage their own health and support them to be more independent and make positive changes to their lifestyle as well as introducing health and wellbeing coaches to work with individuals to better manage their own care.
    - Using care coordinators to work with people and their carers to identify what is important to them and creating groups of people with similar needs who can support each other.

More recently there has been a committed increase in the strength and effectiveness of this partnership working. However, we know we have more to do. We need to continue the journey we have started to ensure the best health and care in Lincolnshire and we know this needs to:

- Be done through engaging and listening to the local population
- Describe a new relationship between the health & care system and the people of Lincolnshire, where individuals play an equal part in their health, well-being and care

Why are we doing this?...



The purpose of this programme of activity is so that, together with the public, we can build a shared view and agreement on what **the best health and care for Lincolnshire** looks like.

As a result, we will be able to describe a new relationship, and the roles health & care providers and the local population have to play in this, show that what's important to people is being achieved and set out how success should be measured and how learning should be used, including:

- The local population's views and experiences on progress and impact
- Engaging local people in the process of analysing results and working out what this means for services, people and communities
- This will provide the foundations for meaningful ongoing engagement and dialogue with the people of Lincolnshire and empowering them to be part of delivering the best health and care for Lincolnshire.

This fully integrated approach is a progression for the county and the below summarises the initial outcomes of this co-production emphasis.

Better Lives Lincolnshire – our shared agreement

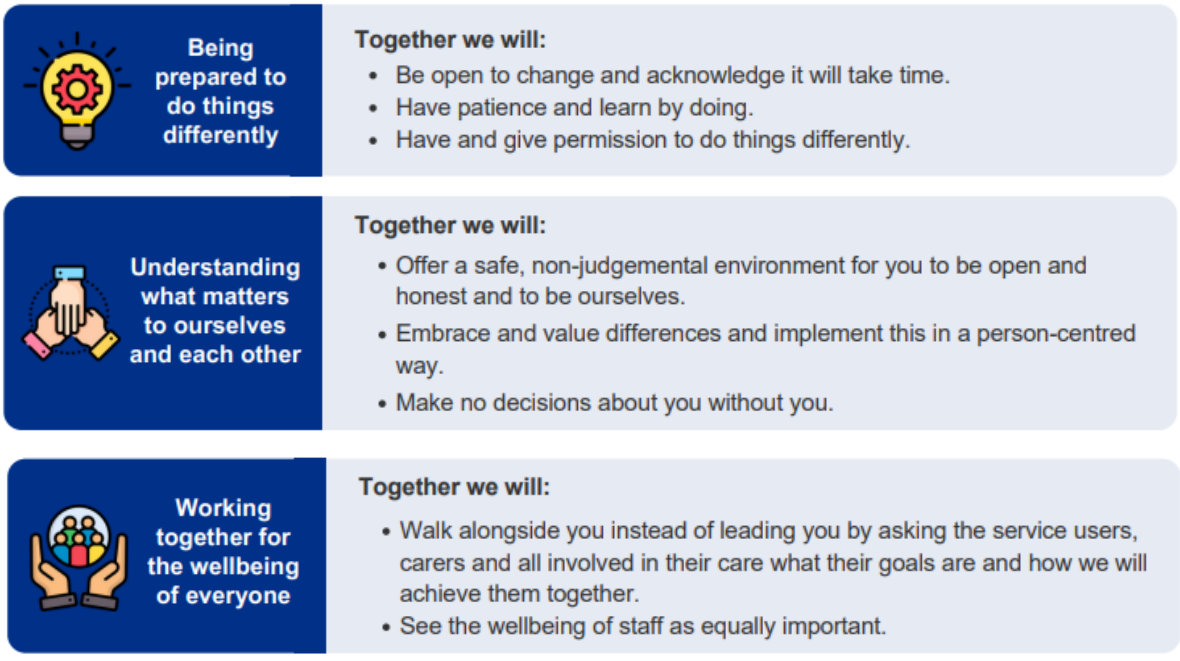
Over a few years, the people of Lincolnshire have been sharing their views on their health and care and how it could be improved via a number of involvement opportunities: Joint Health and Wellbeing Strategy for Lincolnshire 2017; The Lincolnshire Public 'Talk About' NHS Long term Plan 2019; Healthy Conversation 2019; NHS Lincolnshire Citizen Panel Survey 1 - personalised Care 2021; Engagement Team Summer Roadshows 2022; and The NHS Lincolnshire Joint Forward Plan 2023-28. This feedback has been used to develop a **Shared Agreement.** This describes **a new relationship between the health & care system and the people of Lincolnshire**, where individuals play an equal part in their health, well-being, and care.

This shared agreement is one of our priorities of the NHS Lincolnshire Joint Forward Plan 2023-28. – 'a new relationship with the public'.

Together with the people of Lincolnshire, we want to build a shared view and agreement on what the best wellbeing, care and health for Lincolnshire looks like.

At its core this will describe and illustrate the foundations of a new relationship.

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



Conversations with and not about people

Together we will:

- Recognise the importance of active listening and having time to make choices.
- Do what we say we will do, in an environment of openness and honesty.
- Offer information, knowledge and skills.

Making the most of what we have available to us

Together we will:

- Be honest about what is and isn't available.
- Recognise our own strengths and opportunities.
- Recognise support starts with the individual, family and community.
- Actively support communities to best manage their health and wellbeing.

3. ROLES, RESPONSILIBITIES AND RESOURCES

Our teams

The ICB have an experienced and dedicated **Engagement Team**, providing strategic advice and guidance, management of involvement activities within priority programmes and development of building blocks to provide a solid basis of relationships and links with our people and communities.

The Engagement Team have developed strong links across all NHS organisations in Lincolnshire – the ICB, Acute Hospital Trust, Community Hospital Trust, Mental Health Trust and the associated provider collaborative programmes. NHS providers have their own statutory duties under s.242 NHS Act 2006 when considering service changes, and the teams work collaboratively to deliver this duty to involve following these approaches and principles in this strategy. Its ethos is 'system first' and will continue to develop and undertake involvement with the people and communities of Lincolnshire, regardless of organisational boundaries. Key developments such as our Citizens Panel, Insight Database and online Engagement Hub are created for all organisations and not just the ICB. As the ICS evolves and matures over time, we will explore ways of encouraging greater collaboration across the system, sharing these mechanisms and opportunities with our other ICS partners.

Beneficially, our ICB Communications and Engagements teams work alongside colleagues ring fenced for programmes such as Better Births, Continuing Healthcare, Lincolnshire's Provider Collaborative and Mental Health, Learning Disabilities and Autism Alliance. This arrangement is supported by all partners in the system as it ensures consistent and continuous approaches are received by our shared public and service user groups. It also means that team members have strong links and visibility of quality groups across the system, meaning that data, intelligence and feedback reported in each inform activity and priorities within the ICB, such as service change proposals. Finally, our in reach to place, at multiple levels is enhanced through this arrangement.

The **Personalisation team** is made up of colleagues from health, social care and the VCSE sector, with people with lived experience volunteering to support the work. The team are leading on the 'Our Shared

Agreement' and are the enablers and facilitators who are developing and exploring new relationships and ways of working between the people of Lincolnshire and the Health and Care workforce.

Our **patient experience and complaints teams** work closely with the Engagement Team to share insights and data which is vital to understanding how our patients are experiencing services and highlighting any emerging themes or issues. This is triangulated and reported into the Quality and Safety Committee.

Supported by our people and communities

Our teams embedded within the ICB and ICS are supported by a strong network of people and community groups who initiate and contribute to our work.

Our **Involvement Champions** are advocates for the groups and communities they represent. They will work with us to test our plans and strategies, monitor progress and evaluate outcomes. They support our engagement with local people and communities by sharing messages and gathering feedback to create a two-way communication process between the ICB and their communities.

Our **Citizen Panel** aims to be reflective of people and communities in Lincolnshire, taking part in surveys about planning and improving local health and care services.

Patient Participation Groups - (PPGs) are designed to give patients and practice staff the opportunity to meet and discuss issues and opportunities and supporting their wider practice population to get involved and increase understanding in their healthcare services. PPG representatives come together as a Lincolnshire **Patient Council** where they feed the views of their practice patients into the ICB and are involved in programmes and projects.

NHS Provider Organisations support **Patient Panels** and **Patient Experts** to regularly influence and shape the work of the system service developments.

Supported by our partners communities

Healthwatch are key partners and will act as a critical friend, as well as representing an independent view of the patient and public voice. Healthwatch will be integral members of Lincolnshire's ICB Board and ICP Board as well as sit on various programme steering groups to support and undertake some engagement activities.

A representative of the **Voluntary and Community Sector** will also be an integral member of Lincolnshire's ICB Board and an associate member on the ICP Board.

Public Health and **Local Authority** representatives sit alongside our involvement board representative at every ICB board formally. This is supported by their membership of the ICS communications and

involvement steering groups, to which members from across the system are invited to participate as collaborative leaders, to share best practise and leverage assets and networks to broader advantage.

Our provider and primary care colleagues for part of our extended team and therefore are integral to the development and delivery of our shared strategic priorities.

We will engage with our **Health Overview and Scrutiny Committee** on potential service changes, enabling them to consider whether it is a substantial and significant service change requiring consultation process. We will work to assure them that healthcare is planned and delivered in ways that reflect needs and aspirations of local communities, plans for substantial service changes are reasonable and that everyone has equal access to services.

Co-production in Lincolnshire

Co-production is people working together to make things better for all. It is an authentic relationship built on respect and honesty between people who access services and those who design and deliver services.

It is an approach that values everyone's lived experience, bringing people together to shape and improve the things that matter to them for the benefit of the people of Lincolnshire.

The Better Lives Lincolnshire Integrated Care System (ICS) has an ambition to be recognised as excellent at 'co-producing' health and care with communities, citizens, patients, carers, and families across Lincolnshire.

Work is underway to embed co-production approaches across the system. It will require a real change in ethos and behaviours at all levels of health and care in Lincolnshire and it will necessitate a shift in power dynamics accompanied by positive risk taking and individual / systemic reflexivity.

4. PEOPLE AND COMMUNITIES IN ICB GOVERNANCE AND WORKSTREAMS

The voice of people and communities is integral to the functions and governance of the ICB, ensuring their voices are heard to have the biggest impact and improve outcomes. Strong links with quality and patient experience and insight will inform all levels of the ICB through programmes, priorities and decision making.

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

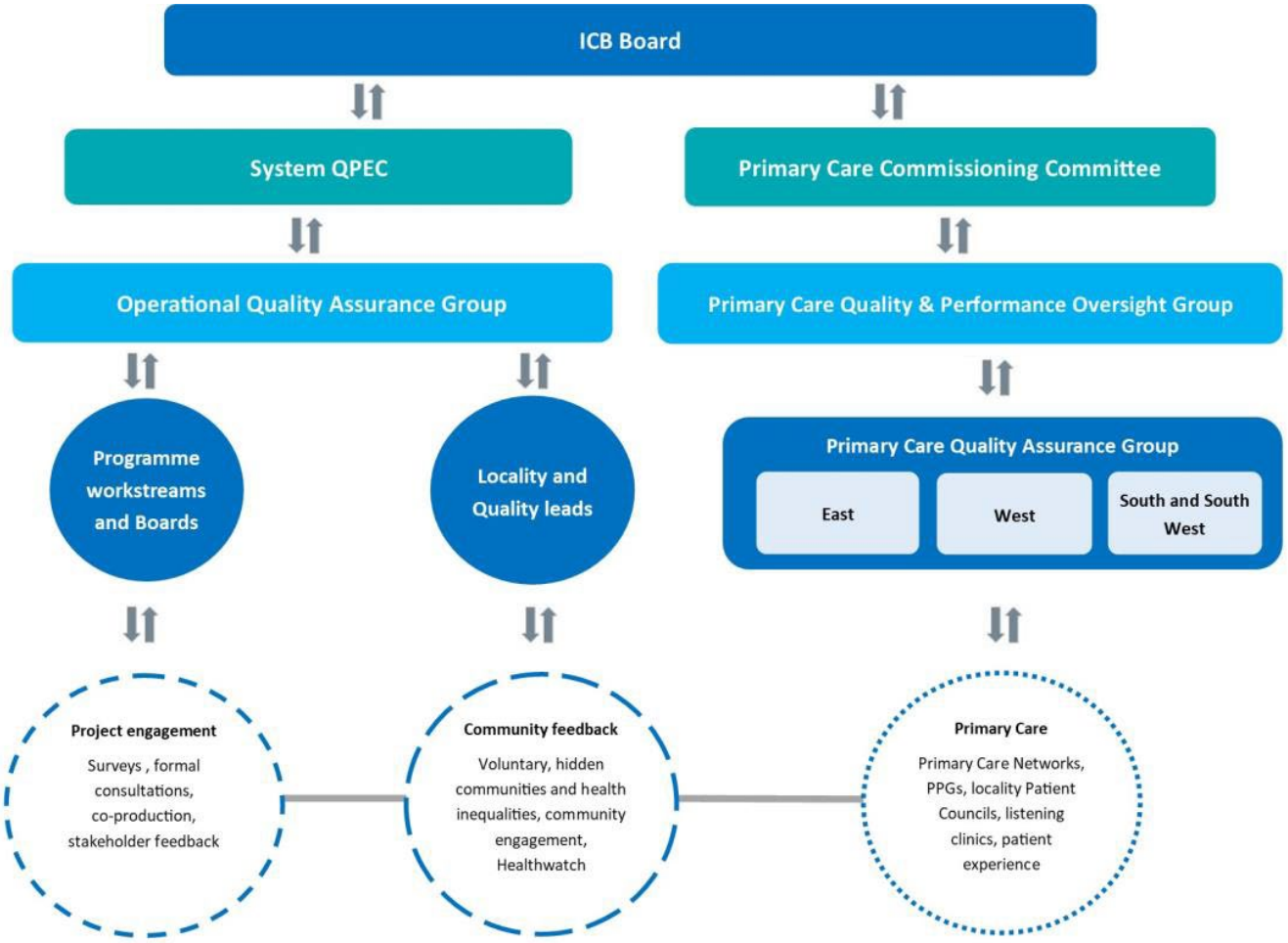
Reports on the outcomes of our engagement activities are reported to the ICB Operational Quality Assurance Group Meeting with escalation as required to the System Quality and Patient Experience Committee (QPEC) and to our Primary Care Commissioning Committee (PCCC) if it is regarding a GP surgery. Feedback from programme specific engagement is also shared with our project leads to help shape and steer their programmes of work.

Feedback from our engagement activities and consultations is also reported into our Board meetings to inform decision making on large projects and programmes of work.

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

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

How we report and listen to the feedback we've heard:



5. MONITORING AND EVALUATING THE STRATEGY

We want to develop a way of measuring involvement and the impact it has in a meaningful way. One of our key priorities for 2024-25 will be to develop a framework and process with people and communities to do this, recognising that it will mean different things to different people.

Working with system wide communications and engagement groups, we will ensure feedback is triangulated and reported into the most appropriate programme board or ICB committee to drive change and is actionable at the most appropriate level.

Regular reporting into the ICB and the wider ICS is essential to demonstrate progress against plans and to evidence the outcomes of involvement, culminating ultimately at the ICB Board, championed by our senior leaders. We will communicate this using several established methods including our website, Engagement Bulletin and via partner organisations.

All feedback from involvement activities will be collated on our System Insight Database.

Item 8 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (i)
Meeting Date:	30th January 2024
Title of Report:	Briefing on the delegation of Specialised Commissioning and update on the East Midlands ICB Collaborative Arrangements
Report Author:	Amanda Sullivan, Nottingham and Nottinghamshire ICB
Presenter:	Mrs Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration
Appendices:	N/A

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

Recommendations

To note the briefing on the East Midlands ICB Collaborative Arrangements and overview of the approach to Specialised Commissioning.

Summary

The purpose of this paper is to:

a) Provide the ICB Board with high level information of the East Midlands Collaborative Arrangements and to;
b) Provide the ICB Board with overview of the approach to Specialised Commissioning.

1. Update on East Midlands collaboration

1.1 Purpose and Principles

The East Midland ICBs (Derby and Derbyshire, Leicester Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) have agreed to collaborate in areas that are most effectively undertaken at scale.

A key operating principle for the collaboration is that working at scale should add value to common goals, whilst retaining local ICB population health sensitivity where appropriate. Distributed leadership across all five members is also a key component.

1.2 Scope

The collaborative arrangements cover:

- NHSE delegated commissioning responsibilities to ICBs (pharmacy, optometry, dentistry [PODs])
- Oversight of future NHSE commissioning delegations (including specialised commissioning, vaccinations)
- Other East Midlands wide commissioning policy (eg non-specialised, initially assisted reproduction)
- 111 and ambulance commissioning
- Commissioning Committee governance
- Commissioning Support Units
- Strategic partnerships with East Midlands bodies (including Local Government Association, Association of Directors of Adult Social Services, Cancer Alliance, clinical networks)

1.3 Leadership and Governance

A tiered committee structure has been established as the mechanism for joint decision making (Appendix 1). Tier 1 is an oversight and strategy setting function, with CEO and Chair membership.

Tier 2 undertakes operational commissioning functions and makes most of the commissioning decisions. Although decisions are made jointly, each ICB representative applies local knowledge to the development and approval of decisions. Tier 3 provides subject matter expertise for quality, finance and contracting in support of tier 2 decision making. Tier 3 groups have considerable technical and subject matter expertise.

ICB Boards have delegated POD commissioning decisions to the tiered committee structures, so this function is exercised jointly. ICB Boards can also choose to delegate additional specific decisions to the joint structures. A recent example of this is the outcome of the 111 procurement.

1.4 Hosting Arrangements

Nottingham and Nottinghamshire ICB is the East Midlands host for the POD team and will host the East Midlands Cancer Alliance from April 2024. A hosting agreement is in place and the host responsibilities are:

- Staff transferred to the host (employing) ICB under TUPE arrangements, with shared liability across the five East Midlands ICBs.
- Staff within the hosting arrangements operate on behalf of all five ICBs and commissioning decisions / operations are exercised jointly through the joint governance arrangements.
- The host ICB determines the continuous professional development and provides line management support to the hosted team.

1.5 Distributed leadership arrangements

Each ICB contributes to the work of the East Midlands Collaborative through a number of routes:

- Each CEO has specific lead sponsor responsibilities, meaning that they lead collaborative work in their area and can represent the views of all five ICBs. The CEOs meet monthly, alternately in person and via Teams.

- An executive group has been established, with a nominated executive director for each ICB. This group enables discussion and agreement of preferred approaches and helps to gain alignment. The frequency of meetings depends on the work schedule at that time. Lead executives also attend joint working groups with NHSE, particularly concerning delegations and areas of joint working with NHSE.
- Each ICB contributes some of their leadership capacity to support the collaborative. This may be to support the work of their CEO lead sponsor or it may be to provide expertise into the committee tiers.

The collaborative has considered appointing designated programme support capacity, but this has been put on hold considering the current financial and running cost allowance constraints. This will be reconsidered in future months, now that the new CEO is in place for Leicester, Leicestershire and Rutland ICB.

Lead areas are distributed as follows:

ICB	Lead Area
Derby and Derbyshire	NHS111, Ambulance Services
Leicester, Leicestershire and Rutland	Specialised Commissioning (linking with Birmingham & Solihull ICB as combined East and West hosting organisation).
Lincolnshire	Broader collaboration with Local Authority, Cancer Alliance and Cardiovascular Disease and Respiratory (CVD-R) Clinical Network and Commissioning Policies
Northamptonshire	Collaborative governance and Commissioning Support Unit arrangements.
Nottingham and Nottinghamshire	Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs) and vaccinations.

1.6 Additional collaborative working

There are some collaborative arrangements across the whole of the Midlands Region. The Midlands Leadership Team meets fortnightly and is chaired by the Regional Director. Members include regional executives and ICB CEOs.

The Midlands Decision Making Network is a membership learning and development collaborative for analyst development and joint analytical programmes.

ICBs are also collaborating at a sub-East Midlands level where this makes sense. For example, Leicester Leicestershire and Rutland ICB formally collaborate with Northampton where this makes sense in terms of shared provider leadership. Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICBs are beginning to collaborate on skills pipelines and workforce planning and meet jointly to consider further opportunities linked to the forthcoming devolution deal.

2. Specialised Commissioning

2.1 Background

The Health and Social Care Act 2022 enabled NHS England to delegate some of its commissioning to other NHS bodies along with its statutory finances and liability to follow the function that is delegated.

On the 6th December the NHS England Board approved plans to delegate 59 specialised acute services to the Midlands, North West and East regions. The remaining regions will continue with Joint Working until delegation in April 2025.

The overarching aim is to better align specialised services with ICBs responsibilities for population health management and integrating care.

2.2 Planning arrangements

Planning arrangements to enable delegation arrangements to be effective in the East Midlands are well advanced. These arrangements are being progressed on a partnership basis between the East Midlands ICBs, West Midlands ICBs and NHS England.

2.3 Further Delegation

Equally the Midlands ICBs and NHSE Midlands are working closely together in terms of further specialised and vaccination services which are currently due to be delegated in 2025.

2.4 Finance

The budget for these services will be transferred to ICBs upon delegation. ICB Directors of Finance and NHS England, through the finance working group are developing mechanisms for financial governance.

2.5 Delegation Process

Delegation agreements will be between individual ICBs and NHS England, who will be required (through clause 8 in the delegation agreement) to form joint working arrangements with other ICBs within a Multi-ICB footprint. This will be supported by formal ICB Collaboration Agreements which will be between the East ICBs and the West ICBs.

The Multi-ICB commissioning footprints for the Midlands are:

- East Midlands (Notts and Nottinghamshire ICB, Derby and Derbyshire ICB, Lincolnshire ICB, Leicester, Leicestershire and Rutland ICB, and Northamptonshire ICB)
- West Midlands (Birmingham & Solihull ICB, the Black Country ICB, Shropshire, Telford and Wrekin ICB, Staffordshire & Stoke-on-Trent ICB, Herefordshire and Worcestershire ICB, Coventry and Warwickshire ICB).

The ICB Board will receive a detailed report and proposal at its March 2024 meeting in relation to confirming the arrangements for the 59 specialised services. The Delegation Agreement will cover matters such as:

- Governance arrangements
- Financial arrangements
- Joint committees
- Information governance and sharing
- Commissioning hub arrangements

The Delegation Agreement and Collaboration Agreement will need to be approved by ICB Boards before the end of March 2024.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The key objective of delegation is to join up fragmented pathways to improve outcomes for patients.
Aim 2: Tackle inequalities in outcomes, experience and access.	Breaking down organisational barriers across pathways of care will help reduce health inequalities.
Aim 3: Enhance productivity and value for money.	Working at scale will add value to common goals.
Aim 4: Help the NHS support broader social and economic development.	Adopting a population health approach which is sustainably led and supports inclusive growth.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Specialised commissioning has the potential for significant variation in spend levels due to the high cost of procedures. As with the delegation of POD services, consideration is being given to establishing a financial risk framework which governs the way in which risk is managed. The focus of the risk share is a pooled resources enabling risks to be understand and managed.

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

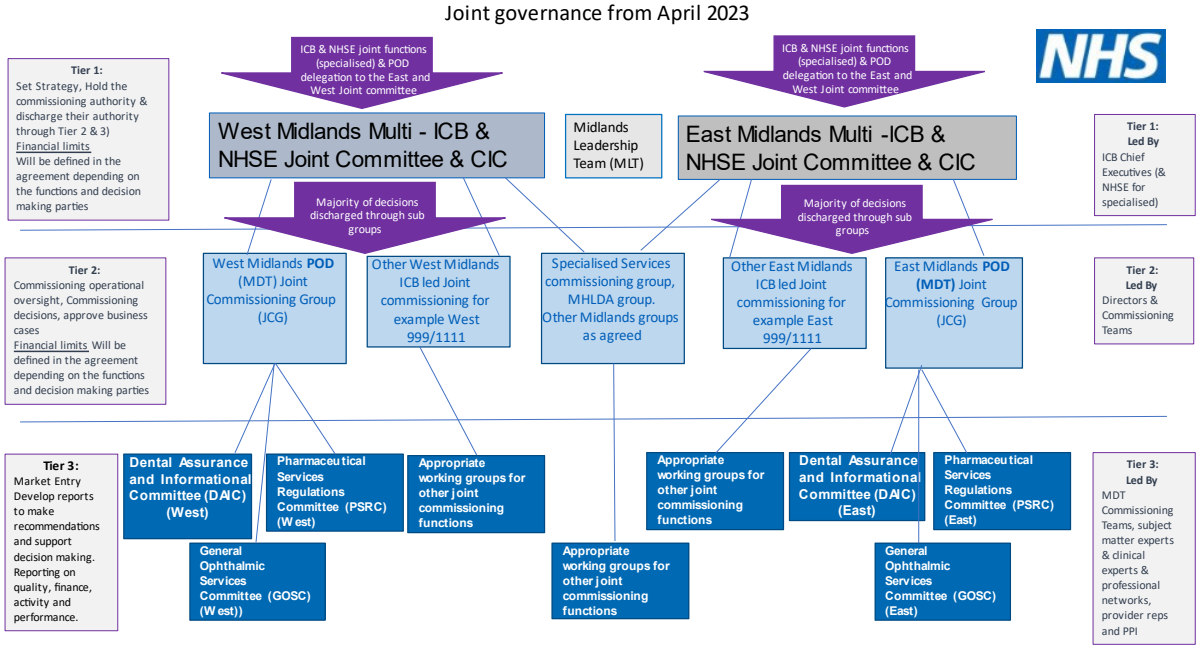
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an equality impact assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

Appendix 1

Joint governance from April 2023



Item 8 (ii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (ii)
Meeting Date:	30th January 2024
Title of Report:	PCCC Public Committee
Report Author:	Dr Gerry McSorley, Chair Sarah-Jane Mills, Director of Primary Care, Community & Social Value Sarah Bates, Deputy Board Secretary
Presenter:	Dr Gerry McSorley, Chair
Appendices:	N/A

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

Recommendations

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

Summary

This paper provides an update on the discussions that took place at the Public Primary Care Commissioning Committee (PCCC) held on 20th December 2023.

- **Director of Primary Care, Community and Social Value**: an update was provided on the current public consultation that is taking place regarding the proposed closure of the Springcliffe Branch site.

  In relation to the Bourne Galletly Practice it was noted that the Practice had recently received the outcome of the CQC inspection and rated as Outstanding.

  In terms of spirometry it was noted that an expression of interest form for delivery of the service has been issued on a Primary Care Networks (PCN) footprint basis.

  In relation to digital, all Practices moving from analog to digital telephony have selected a supplier ahead of the 15 December deadline, supporting Practices to ensure contracts are signed and submitted before the deadline is a priority.

  An update was provided on the progress on delivery of the Covid booster campaign which is a positive position across Lincolnshire with the County ahead of the national and regional performance by patient cohort.

- **Primary Care Access Recovery Plan Presentation:** a presentation was provided on the Primary Care Access Recovery Plan that has two key ambitions:-

  1. To tackle the 8.00 am rush.
  2. Patients know how their contact will be managed on the day they contact their GP Practice.

  It was noted that the Plan has four areas of work focusing on:-

  - **Empowering patients:** Supporting patients to manage their own health and care, by rolling out tools and technology that give accurate and trusted information, and expanding services offered by community pharmacies.

  - **Modern GP Access Model:** Enabling patients to know on the day how their request will be handled, based on clinical need and preference for appointment type, reducing long waits on the telephone and providing patients with more timely information.

  - **Building Capacity in Primary Care:** Ensuring general practice is utilising all resources to manage increasing demand, managing more patient requests and optimising the use of the full practice team.

  - **Cutting Bureaucracy:** Reducing the time spent by practice teams on low-value administrative work and improving join up between primary and secondary care services, to give teams more time to focus on patients' clinical needs.

- **Delegation of the Pharmacy, Optometry and Dental Services Update:** it was reported that since Spring the ICB took over the responsibility for Pharmacy, Optometry and Dental services.

  It was noted that work continues with the mobilisation of the Mablethorpe Dental Practice and that this is due to open in the new year. In addition, work continues with promoting the extended out of hours service for routine dental care.

  In relation to Community Pharmacy as part of the Primary care access recovery plan the Pharmacy First Scheme is due to be launched in January 2024 which will provide patients access to professional health care advice, treatments, and medicines for common illnesses in participating pharmacies without the need for an appointment.

- **Quality Patient Experience and Effectiveness:** a presentation was provided on the quality oversight mechanisms for primary care. It was noted that the Pharmacy, Optometry and Dental service contractors transferred to the ICB in April 2023 and that the operational day to day assurance processes are hosted by the Nottingham and Nottinghamshire ICB.

  An update was given on the quality assurance mechanisms for General Practice, the levels of support available including (Level 1 – Routine Practice Support, Level 2 – Enhanced Quality/Primary Care Team support and Level 3 – Intensive Quality and Primary Care Support.

  It was reported that in terms of General Practice there are two Practices with Inadequate CQC ratings and three Practices with CQC Required Improvement ratings. In addition, GP concerns regarding current financial pressures and potential effects on service delivery continue to be raised. In terms of dental and pharmacy continued service challenges remain of which these mainly relate to workforce.

  In terms of the feedback received from HealthWatch this has highlighted continued concerns with GP Access and NHS Dental Service Provision.

- **Risk Register Update:** it was noted that there had been no significant changes to the Risk Register since the last month. The risk in relation to energy costs and the impact on GP Practices has recently reduced following a review of the impact on individual Practice viability.

Items for escalation to the ICB Board include:- • No items for escalation.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Provides details of actions being taken to ensure access to high quality primary care that is essential to ensuring individuals receive timely treatment for acute conditions, support to manage any long-term condition and proactive access to interventions that will help them to stay well for longer.
Aim 2: Tackle inequalities in outcomes, experience and access.	Ensures that there is equal access to primary care for all and that where there are factors that create health inequalities that there are targeted plans to address these.
Aim 3: Enhance productivity and value for money.	Provides assurance that additional investment provided represents value for money and secures the ongoing provision of effective primary health care that is the foundation of a productive health system.
Aim 4: Help the NHS support broader social and economic development.	Strong primary care service provision supports the general health and wellbeing of the local population which in turn enables them to support the local economy. Primary care services are delivered in local communities and provide employment opportunities for local people
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
Practices have been identified and included on the Risk Register.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Yes, where required additional funding has been provided by the ICB to facilitate additional support to vulnerable Practices as appropriate, where not covered via existing funding routes.
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	No
Does the report demonstrate patient and public involvement?	Patient and public engagement processes are utilised to secure patient experience information for each Practice that informs the Quality Risk Rating and Quality Improvement actions.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	N/A

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

Report previously presented at:
The Board Committees regularly present reports including items for escalation and risks identified to each Board meeting.
Is the report confidential or not?
Yes ☐ No ☒

Item 8 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (iii)
Meeting Date:	30th January 2024
Title of Report:	System QPEC (Quality and Patient Experience) Committee Update
Report Author:	Sharon Robson, Non-Executive Director (Chair) Martin Fahy, Director of Nursing Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	N/A

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

Recommendations

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

Summary

The System Quality and Patient Experience Committee meeting in January 2024 focused on the following agenda items:

- **Lincoln System Quality Priorities Register:** an update was provided on the current system priorities highest areas for concern include Urgent and Emergency Care pathways, elective pathways back, workforce challenges. The medium rated priorities relate to primary care including access, CQC inadequate rated GP practices, the quality and accuracy of recording in the palliative and end of life ReSPECT forms, lack of access to NHS dental provision, care homes in special measures with the CQC and the associated quality issues, effective timely communications with patients, low rayed quality issue were, successful roll out of the PSIRF (Patient Safety Incident Response Framework) and pathway specific issues in Children and Young Peoples (CYP) e.g. access to SALT, low uptake of some vaccines, access to special epilepsy nurses.

  Discussions took place regarding the priorities and the performance monitoring of these areas versus the Service Delivery and Planning Committee. It was agreed that a review would be undertaken to align the priorities of both Committees and identify key areas for future deep dive review and discussion.

- **Board Assurance Framework:** an update was provided on the quality risks including:

  - **Risk 1:**
    Maintaining and improving the quality of commissioned care and improving patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services.

  - **Risk 2:**
    The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.

  Discussions took place regarding the BAF risks, the controls, gaps, mitigations and the continuous cycle of assurance. Members agreed to support the oversight of these BAF risks with regular updates being provided at the Committee by the relevant ICB programme boards.

- **System Quality Strategy:** it was noted that additional resource has been identified from the Commissioning Support Unit to refresh the Strategy, future drafts will be shared with members for discussion and review in the coming months.

- **HealthWatch Update:** an update was provided on the proposed HealthWatch campaigns for 2024 (listed below). In addition, it was noted that a survey has recently been launched on mental health, endometriosis, poly-cystic ovarian syndrome and menopause and to date 99 responses had been received. Future campaigns include:

  - April – June 2024 – Chronic Obstructive Pulmonary Disease and Asthma.
  - July – Sept 2024 – Neurological, Multiple Sclerosis, Myalgic Encephalomyelitis, Migraines and Fibromyalgia
  - Oct – Dec 2024 - New Fathers, Military Personnel/Veterans and Farmers.

  It was highlighted that there has been an increase in the number of contacts and complaints received relating to lack of NHS dental access.

- The ICB **People and Communities Strategy:** it was noted that one of the key controls as part of the Board Assurance Framework is engaging with the population of Lincolnshire to help inform effective service provision in the county. Subsequent to this the People and Communities Strategy has been produced which sets out the framework to support this area, the duties whilst ensuring that the public voice is at the heart of everything.

  It was noted that regular updates on progress are shared at the Operational Quality Group and that the Committee would receive quarterly updates. Discussions took place regarding the governance mechanisms and the role of both forums and that the Strategy would benefit from additional detail being included. Furthermore, the inclusion of a Foreword from the Chair/Chief Executive was discussed and agreed by members that this would also be beneficial.

- **Financial Reset Update:** an update was provided in relation to the H2 reset and that this has been signed off by NHSE and a control total and deficit of c £27m agreed of which the ICB needs to remain within. It was noted that a copy of the Quality Impact Assessments that relate to the H2 reset would be provided at the next meeting. An update was given in relation to the high agency costs and spend and that strengthened processes have been put in place to manage this area. It was agreed that a regular financial update would be provided at the Committee.

- **Infection, Prevention and Control Update:** a deep dive presentation took place in relation to the Infection Prevention and Control work stream within the integrated Health Protection functions of both LCC (Lincolnshire County Council) and NHS Lincolnshire ICB (Integrated Care Board).

It was noted that the Health Protection Teams assess compliance evidence to ensure providers have the appropriate infection prevention and control systems and processes in place to provide good quality, clean, safe care in accordance with Regulation 12 of the Health and Social Care Act 2012 and other key national and local policies. The Team also provide support to LCC and the ICB on assurance of commissioned services, communicable disease incidents and outbreaks, system level support and coordination, health protection activities and support quality improvement projects. Discussions took place regarding the C Difficile and E Coli targets and that Lincolnshire is not an outlier in these areas and that the Lincolnshire trend mirrors the national performance which has seen uptake in infections rates across the UK.

- **Highlight Report from ULHT:** it was reported that in terms of the quality and safety high risk relating to the inability to deliver diabetes pathways this has now reduced to a moderate risk due to additional staffing now in place.

  An update was provided on the learning from incidents and the joint work across the system, particularly with LCHS which has made a significant difference to patient pathways whilst addressing the pressures. Discussions took place regarding the joint working and the Group model across LCHS and ULHT and it was felt that the Highlight Reports would continue to be individual reports until the formal organisation merger commencement date in April 2024.

- **Highlight Report from LPfT:** an update was provided in relation to the re-opening of the PICU unit (Psychiatric Intensive Care Unit) which has identified legionella within the hot water system most recent water identified lower rate of legionella however further sample results required before the unit can re-open. It was reported that there are currently three Out of Area male patients in PICU provision.

  In terms of LPfT internal process for learning from incidents it was noted that a mapping process has commenced on how patient experience data is gathered and used.

  An update was provided on the recent Good News stories and that a national award was presented to the Lincoln Core CAMHS (Child and Adolescent Mental Health Service) who were crowned Psychiatric Team of the Year: Children and Adolescents at this year's Royal College of Psychiatrists Awards. Furthermore, for accreditation The Wolds has successfully achieved the Quality Network for Mental Health Rehabilitation Services accreditation with the Royal College of Psychiatrists.

- **Highlight Report from LCHS:** an update was provided on the fire compartmentalisation at Skegness Hospital and that plans and mitigations are in place. It was noted that in relation to the Boston Urgent Treatment Centre – estates as part of transition to the new UTC. Immediate safety concerns have been addressed and actions in place and that this is being supported by ULHT partners.

  In relation to quality improvement initiatives it was noted that the PSIRF process have been fully implemented and that work is taking place across the system to recruit Patient Safety Partners.

- **Highlight Report Primary Care:** an update was provided in relation to the Caskgate Practice and that the Practice is likely to be reinspected by the CQC in February 2024. In terms of the Richmond Practice it was noted that the Practice had been reinspected in early December. The Sidings Medical Practice had recently been inspected by the CQC and issued with warning notices and the full outcome report is awaited. It was noted that the Bourne Galletly General Practice had been inspected by the CQC and received an Outstanding rating.

- **Upward Report from Operational Quality Assurance Group:** it was reported that currently there are four commissioned providers where there are escalated quality concerns and actions being taken in response to these concerns. The providers relate to:

- LCHS - Lymphoedema Service; Children & Young People (CYP) Speech & Language Therapy (SLT); and Community Nursing
- ULHT - Outpatient Rehabilitation
- AJM Healthcare
- LIVES

An update was provided in relation to CAMHS and that national analysis of Children and Young People data has highlighted Lincolnshire median wait for first appointment is 60 days which is 180 days less than the national median and places Lincolnshire as second best in England. Whilst it is recognised there is still work to do there was acknowledgement of the significant achievement of the teams and the impact of investment decisions made in 2022.

- **System Quality Group Update**: it was noted that a further meeting has not taken place since the last update at the Committee in December 2023.

- **Planning for the Future Development Session:** it was discussed that the planned meeting date in March 2024 would be utilised as a Development session. Members were asked to share suggested topics with the ICB Director of Nursing and a draft agenda would be circulated.

Items for escalation to the ICB Board:

- Review the current work programme and potential Deep Dive topics future priority areas, Palliative and End of Life Care and NHS Dental access.
- Read across to take place with the Service Delivery and Planning Committee teasing out the pertinent quality issues.
- Review of the two quality risks on the Board Assurance Framework, they were endorsed by the Committee.
- The Committee endorsed the new ICB People and Communities Strategy acknowledging the ICB's duty to engage with the public.
- The Committee received a Deep Dive presentation into the work undertaken by the Infection Prevention and Control Team.
- The committee noted the national award presented to the Lincoln Core CAMHS (Child and Adolescent Mental Health Service) who were crowned Psychiatric Team of the Year: Children and Adolescents at this year's Royal College of Psychiatrists Awards.
- Bourne Galletly Practice and the recent CQC rating of Outstanding.
- Young People data highlighted the Lincolnshire median wait for first appointment is 60 days which is 180 days less than the national median and places Lincolnshire as second best in England.

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

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Patient and public involvement and engagement is embedded within the System QPEC.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

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

Report previously presented at:
The Board receives regular reports from each of its Committees at every meeting.

Is the report confidential or not?
Yes ☐ No ☒

Item 8 (iii)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (iii)
Meeting Date:	30th January 2024
Title of Report:	System QPEC (Quality and Patient Experience) Committee Update
Report Author:	Sharon Robson, Non-Executive Director (Chair) Martin Fahy, Director of Nursing Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	N/A

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

Recommendations

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

Summary

The System Quality and Patient Experience Committee meeting in December 2023 focused on the following agenda items:

- **System Priorities Quality Risk Register:** a copy of the System Priorities Quality Risk Register was presented. It was noted that the main areas of concern relate to Urgent and Emergency Care, elective waiting times, cancer treatment, waiting lists and the workforce challenges. An update was provided on the medium rated risks including Palliative and End of Life Care, ensuring advanced care planning is in place and good quality ReSPECT forms available. In addition, dental and primary care access and the CQC Inadequate ratings for Care Homes.

  Discussions took place regarding the format of the System Priorities Register and it was agreed that this captured the system wide risks. It was agreed that two additional areas would be added in relation to the financial reset and the impact on equality and quality impact assessments. Furthermore, the Register would include the detail highlighting the current and past performance month on month.

- **System Quality Strategy:** a copy of the former CCG Quality Strategy was presented. Discussions took place that this needs to be refreshed, co-produced and be subject to a confirm and challenge process. It was agreed that a Task and Finish Group would be formed to scope the development of the Strategy and that the revised version would be presented at a future Committee meeting.

- **HealthWatch Update including the Urgent Emergency Care Visit:** the findings following the HealthWatch visit to the Urgent and Emergency Care Treatment Centres was presented for information. It was discussed that the report demonstrates areas of good practice and it was agreed that the findings within the report would be shared with the relevant staff.

- **Highlight Report from ULHT:** an update was provided on the implementation of the PSIRF process and that a review of the evidence highlighting the key themes and trends would be undertaken for systematic investigation. It was noted that in terms of the Learning from Incidents process concerns had been raised regarding the quality of care of patients by partners who had been accompanying to the Trust. In order to learn from these, a meeting has been arranged for the concerns and experiences to be shared with a view to making the necessary improvements.

  An update was provided on the streamlined complaints process and that over the last 12 months the process has been redesigned and within 12 months, the overdue complaints have reduced from 120 to six and currently 84% of complaints are responded to within the required timescale. Discussions took place regarding the key themes of the complaints and that these mainly related to communications, delays with treatment, attitude of staff and behaviours. It was agreed that a system review of the learning from complaints would take place to highlight and identify key themes.

- **Highlight Report from LPfT:** it was reported that the PICU (Psychiatric Intensive Care Unit) had identified high legionella counts within the hot water system and that future occupation will be dictated by the subsequent water sample results. Three consecutive clear results are required in order for the water system be deemed safe enough for reoccupation. In terms of the quality improvement initiatives it was noted that funding has been secured via NHSE to pilot a Patients Voice Guardian.

- **Highlight Report from LCHS:** it was noted that an emerging theme that had been highlighted related to Palliative Care patients and End of Life pathways of care resulting in out of hours escalations. In terms of Childrens Speech and Language Therapy it was reported that demand continues to exceed capacity and that options are being explored as a system. In relation to learning from incidents it was noted that a thematic review for missed fractures in Urgent Treatment centres had been undertaken identifying learning around partnership working with radiography colleagues, clinical decision tools, skills/competency and reattendance. In terms of the Lymphoedema Service it was noted that actions are supporting an improving position.

- **Highlight Report from EMAS:** an update was provided on the findings following a recent staff engagement event of which the main focus related to End of Life pathways and the quality of ReSPECT forms. It was reported that in terms of the performance significant improvements had been made and that this had been due to the implementation of the NHS pathways in November 2023 and that anticipated outputs include reduction in C2's with more appropriate dispositions for lower acuity patients.

  Concerns were highlighted in terms of the workforce, poor skill mix and that Lincolnshire is an outlier in being under resourced. It was noted that funding has been secured to appoint a dedicated Workforce Lead to improve and strengthen this area.

- **Highlight Report Primary Care:** it was reported that the Caskgate GP Practice is making good progress with the actions identified following the CQC inspection. In terms of the Branston Practice the Practice has made significant improvements and is now rated as good. The Richmond Medical Practice CQC inspection report was published Oct 2023 and actions are being taken to address the areas of concern and a re-inspection visit by CQC planned for early December.

It was noted that the Board had recently signed off the Primary Care Recovery Plan. Concerns still remain with workforce challenges and access to primary care and dental services. An update was provided in relation to the implementation of the three Acute Respiratory Infection Hubs which are in operation seven days a week.

- **Upward Report from Operational Quality Assurance Group:** it was noted that in terms of LCHS and the Lymphodema service, the Trust are undertaking work to stablise the situation whilst wider system work is undertaken to review referral pathways. In addition, fortnightly meetings now in place between LCHS and ICB to review progress and plan for a 'Lower Limb Summit' in the new year.

  In terms of feedback from intelligence and Subject matter Experts it was noted that there has been a total of three Never Events reported in Quarter two with two maternal deaths reported by Northern Lincolnshire and Goole Hospitals NHS Trust. An update was provided in relation to the feedback heard from through the Continuous Listening Model activities and that the main topics of feedback received via the various engagements are ability to contact services, both at primary care and secondary care level and the lack of dental services in Lincolnshire.

  In relation to Mixed Sex Accommodation (MSA) Breaches it was noted that NWAFT have been reporting high rates of MSA breaches (249 for reporting period Sept 2023) compared to single digit numbers for all other Lincolnshire providers. ULHT Medication incidents reported as being 'omitted or delayed medicines' – improvement in performance. Learning Disability and Autism (LDA) it was reported that at 23 November 2023 a positive position in relation to LD health checks – 1233 against plan of 957 (Sept 2023 data) and the number of inpatient care for people with LDA – 17 against plan of 17 (October 2023 data). There are currently no CYP with LDA as part of Transforming Care Programme – the last patient was discharged August 2023 and no admissions since this date.

  Discussions took place regarding the membership of the Committee, and it was agreed that a representative from the Health Inequalities team would be invited to future meetings. It was also agreed to expand the membership of the Committee to include representation from the Medicines Management Team and a Health Inequalities representative.

- **System Quality Group Update**: an update was provided on the system Tissue Viability and Pressure Ulcer Prevention Quality Improvement Programme. An update was provided in relation to the LCC Health Visiting service and the current constraints regarding full Healthy Children Programme & Antenatal provision.

- **Planning for the Future Development Session:** discussions took place regarding the frequency of the future meetings and holding 1-2 development sessions a year. It was noted that the next meeting will focus on Infection, Prevention and Control.

Items for escalation to the ICB Board:

- The committee agreed to adopt the Quality Priorities Register as the SQPEC system risk log.
- The committee will receive the system H2 finance reset QI & EI assessments in the January meeting.
- Formation of a Task and Finish Group to co-produce the Quality Strategy.
- ULHT complaints process and the streamlined approach that has been taken.
- LPfT and the piloting of the Patient Guardian role and the subsequent evaluation.
- LCHS and the issues raised relating to the end of life pathways and out of hors escalations.
- EMAS and the wider system working with UEC pathways, significant improvements have been made with recent performance.
- Three Acute Respiratory Infection hubs in primary care with Lincolnshire as the only system across the region to have implemented this.
- Access to timely dental care remains challenging.

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

Risk and Assurance
A System Risk Register and ICB Risk Register is in place of which is shared at the meeting.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Patient and public involvement and engagement is embedded within the System QPEC.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

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

Report previously presented at:
The Board receives regular reports from each of its Committees at every meeting.

Is the report confidential or not?
Yes ☐ No ☒

Item 8 (iv)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (iv)
Meeting Date:	30th January 2024
Title of Report:	Update from the Service Delivery & Performance Committee (November and December meetings)
Report Author:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	None

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

Recommendations

The Board is asked to note and consider this report.

Summary

November 2023

At the November meeting, the Committee received various updates for consideration: -

Lincolnshire System UEC Tier 2 Position
NHS England have developed a tiering system for UEC with support and advice provided, and fortnightly meetings are held with the regional team to review the actions the system has undertaken for improvement with particular focus on: Type 1 4hr performance (Lincoln & Boston sites), patients waiting more than 12 hours in ED's and Category 2 mean response times.

The Committee reviewed the ongoing work across both ULHT and the system to directly improve delivery based on these metrics and re-prioritise the actions that will make a direct impact.

An update on the 23/24 Core Programme Initiatives was provided - there were a number of initiatives due to commence within Q4 – Active Recovery Bed surge x 20, Community

Paediatrics Expansion, CAMHS expansion, ED Paediatric Hub. The remainder of the initiatives were either fully implemented or are in a phased implementation whilst waiting on substantive workforce.

ICS Clinical Audit
The audit was a retrospective review of the patient journey for a sample of patients who waited longer than 12 hours in ED, looking at the cause for delay and any potential impact with a view to identifying areas for improvement and exploring the utilisation of more appropriate pathways.

The Committee reviewed the findings of the audit and the follow up actions which would be used to help shape further transformation work being undertaken by the ICS.

Discharge and Flow Update
The measures in place to improve discharge rates were reviewed - the success of the daily oversight regime had significantly increased occupancy of community beds and reduced the number of patients in interim beds awaiting a package of care.

Winter Plan
The plan was presented to the Committee to highlight the predictions for winter demand and set out the planned response This included the extra initiatives, capacity and information needed to manage the urgent care and patient flow pressures that the system will inevitably see.

Performance Dashboard
The monthly dashboard was discussed, particularly in the context of delivering the winter plan whilst also providing assurance over performance trajectories to year end.

December 2023
The December Committee considered various presentations and reports:

Making Data Count Presentation
The Committee received a presentation from the Senior Lead at NHSE on the advantages of analysing performance data using Statistical Process Control to improve visibility and take account of normal and unusual variation. This leads to more meaningful interpretation and effective subsequent action.

The Committee supported having a consistent approach to presenting and using data across the system and will now progress this approach further.

UEC High Impact Interventions
As part of the NHSE H2 reset, there is a requirement to complete a monthly board assurance report with regards to 10 defined high impact interventions supporting Urgent and Emergency Care and to demonstrate progress in implementing these.

In July 2023, the system UEC Leaders undertook a self-assessment of maturity for these and reported the outcomes to the regional team for onward sharing with the national team. The 10 high impact interventions that were part of both the UEC recovery plan and the winter letter are: - Same Day Emergency Care; Frailty; Inpatient Flow and length of stay (Acute); Community bed productivity and flow; Care Transfer Hubs; Intermediate Care Demand and Capacity; Provision of Virtual Wards; Urgent Care Response; Single Point of Access and Acute Respiratory Infection Hubs.

Overall the system has progressed well, no areas were rated ‘red’ and there were no escalated areas of concern.

Prioritised implementation work continues to optimise the impacts of these interventions.

Winter Plan Delivery
The committee received a verbal update regarding the winter plan and noted that it had been presented at the previous Public ICB Board and was now in the public domain with a supporting communications plan. There was a degree of risk in relation to flu and Covid with more clarity awaited with regards to the potential surge of flu and respiratory viruses and the subsequent modelling for Lincolnshire.

The upcoming industrial action dates were noted in respect of junior doctors, this would have an impact on the winter plan delivery and ongoing risk assessments were being completed.

Elective Recovery
The current position in respect of planned care was considered and it was noted that good progress has been achieved with a lower number waiting 78 weeks than previously projected and significant reductions for those waiting 65 weeks and 52 weeks. The target to eliminate 65 week waits by the end of March 2024 was on track and progress on this had been recognised at both regional and national levels with a resultant reduction in the national oversight requirement, however, it was noted the potential impact of the industrial action confirmed for January was a significant risk to maintaining this. Further work was also taking place on DNAs (Did Not Attend) and outpatient letters to ensure all clinic capacity was fully utilised.

Diagnostics
The Committee reviewed the performance of Diagnostic activity and was updated on the implementation of robust weekly monitoring processes across the system. The ongoing remedial activity was producing significant improvements and it was noted that DM01 in October at ULHT was the highest it had been since prior to the pandemic. Echo 13-week waits have reduced from over 6,000 in November 2022 to 2000 in September 2023. The actions that are in place are continuing to reduce this further. Mobile MRI activity will commence during December at the temporary CDC sites on the East Coast and Lincoln.

Children & Young Children (CYP) including Mental Health Services
The CYP Programme in Lincolnshire benefits from an integrated approach with partnership working underpinning all the joint/integrated decision making in terms of the CYP priorities. The team work closely with a wide range of partners including Public Health, LCHS, LPFT, the Third Sector, Lincolnshire Parent Carers Forum and Lincolnshire Young Voices.

The CYP Integrated Transformation Board provides strategic oversight of CYP services in Lincolnshire with the aim of transforming pathways across health and care and incorporating education. The membership of the board was across all partners.

Alongside the board sits the Children's Integrated Commissioning Team with LCC and the ICB forming a steering group to discuss, escalate, resolve and explore the existing CYP priorities and scope out future opportunities.

The current forward plan has 12 priorities as outlined in the System Plan for 23-28 for CYP and includes reviews of services such as Children's Community Nursing, CYP Therapies, CYP UEC and CYP Elective Recovery Programme. Ongoing work supports delivery of the Core 20 Plus 5 approach to reducing health inequalities for those that live in the 20% most deprived areas and those that belong to vulnerable groups such as not in education, care leavers, those in the social justice system and those with protected characteristics. This focusses on asthma, diabetes, epilepsy, oral health and mental health.

CYP Mental Health
The Committee received a detailed update on significant progress with access and waiting times for CYP across Lincolnshire, covering the provision of services through the Online Mental Health Support Service, Healthy Minds Lincolnshire, Mental Health Support Teams, Complex Needs Service, CAMHS, CAMHS Community Crisis and Enhanced Treatment Team, and Transforming Care/CYP Key working.

Based on national data, Lincolnshire's median wait for first appointment was just over 8 weeks which almost 26 weeks less than the national median and making Lincolnshire the 2nd best performing ICS in England.

ICB investment has helped reduce waiting times which had increased significantly following the pandemic. There was a 43% reduction in CYP waiting for treatment from May 2022 to September 2023 and a 53% reduction in CYP waiting more than 12 weeks for treatment from May 2022 to September 2023.

For the Eating Disorder Service, the average wait from urgent referral to treatment in Q1 and Q2 2023/24 was less than a week, with 100% CYP seen within the 1-week target (no breaches). The average wait from routine referral to treatment was 1 week, also with 100% of CYP seen within the 4-week target.

The LCC team have developed excellent working relationships with the ICB Mental Health Team, LPFT and ULHT and with the additional investments made, the significant improvement in performance was commended. The recruitment pipeline was encouraging and work will continue on crisis provision, respite provision and enabling CYP to receive more services within the Lincolnshire area.

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

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

Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	Yes - Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

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

Report previously presented at:
Not applicable

Is the report confidential or not?
Yes ☐ No ☒