County Offices
Newland
Lincoln
LN1 1YL

29 November 2021

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 7 December 2021 at 2.00 pm in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Chief Executive

MEMBERS OF THE BOARD

Lincolnshire County Council: Councillors: Mrs S Woolley (Executive Councillor NHS Liaison, Community Engagement, Registration and Coroners) (Chairman), Mrs W Bowkett (Executive Councillor Adult Care and Public Health), Mrs P A Bradwell OBE (Executive Councillor Children's Services, Community Safety and Procurement), K H Cooke, W H Gray, R J Kendrick, C E H Marfleet and Mrs S Rawlins

Lincolnshire County Council Officers: Heather Sandy (Executive Director of Children's Services), Glen Garrod (Executive Director of Adult Care and Community Wellbeing) and Professor Derek Ward (Director of Public Health)

District Council: Councillor Richard Wright

NHS Lincolnshire Clinical Commissioning Group: Sean Lyons and John Turner (Vice-Chairman)

Healthwatch Lincolnshire: Sarah Fletcher

Police and Crime Commissioner: Marc Jones

Lincolnshire Partnership Foundation NHS Trust: Kevin Lockyer and Sarah Connery

United Lincolnshire Hospitals NHS Trust: Elaine Baylis and Andrew Morgan

Lincolnshire Community Health Services NHS Trust: Elaine Baylis and Maz Fosh

Primary Care Network Alliance: Dr Sunil Hindocha

ASSOCIATE MEMBERS (Non-Voting):
Jason Harwin, Lincolnshire Police
Oliver Newbould, NHS E/I
Emma Tatlow, Voluntary and Community Sector

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 7 DECEMBER 2021

8 Information Items

8a **Spending Review 2021 and Autumn Budget** 97 - 102

(To receive a report from Councillor Sue Woolley, Chair, Lincolnshire Health and Wellbeing Board, which provides the Board with a summary of the key announcements from the Spending Review and Autumn Budget and what they mean for the health and care system)

8b **Update on Population Health Management Implementation in Lincolnshire** 103 - 108

(To receive a report from Katy Thomas, Head of Health Intelligence, Public Health Division, which provides the Board with an update on the progress towards implementing a Population Health Management approach in Lincolnshire)

8c **Action Log of Previous Decisions** 109 - 110

(For the Board to note decisions taken since June 2021)

8d **Lincolnshire Health and Wellbeing Board Forward Plan** 111 - 114

(This item provides the Board with a copy of the Lincolnshire Health and Wellbeing Board Forward Plan for the period 7 December 2021 to 27 September 2022)

Democratic Services Officer Contact Details

Name:	**Katrina Cope**
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Please note: for more information about any of the following please contact the Democratic Services Officer responsible for servicing this meeting

- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details set out above.

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Lincolnshire Health and Wellbeing Board on Tuesday, 7th December, 2021, 2.00 pm (moderngov.co.uk)

All papers for council meetings are available on:
https://www.lincolnshire.gov.uk/council-business/search-committee-records

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
28 SEPTEMBER 2021

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs W Bowkett (Executive Councillor Adult Care and Public Health), Mrs P A Bradwell OBE (Executive Councillor Children's Services, Community Safety and Procurement), K H Cooke, W H Gray, R J Kendrick and C E H Marfleet.

Lincolnshire County Council Officers: Glen Garrod (Executive Director of Adult Care and Community Wellbeing) and Professor Derek Ward (Director of Public Health).

District Council: Councillor Richard Wright.

NHS Lincolnshire Clinical Commissioning Group: Sean Lyons and John Turner (Vice-Chairman).

Healthwatch Lincolnshire: Nicola Clarke.

Lincolnshire Partnership Foundation NHS Trust: Sarah Connery.

Police and Crime Commissioner: Marc Jones.

United Lincolnshire Hospitals NHS Trust: Andrew Morgan.

Lincolnshire Community Health Services NHS Trust: Maz Fosh.

Associate Members (non-voting): Emma Tatlow (Voluntary and Community Sector).

Officers In Attendance: Alison Christie (Programme Manager, Strategy and Development), Katrina Cope (Senior Democratic Services Officer) (Democratic Services).

The following officers joined the meeting remotely via Teams:

Semantha Neal (Assistant Director, Prevention and Early Intervention), Tracy Perrett (Head of Hospitals and Special Projects) (Adult Care and Community Wellbeing) and Andrea Kingdom (Area Manager for Hospitals and Special Projects).

Lee Johnson (Lincolnshire Police) attended the meeting as an observer.

11 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs S Rawlins, Heather Sandy (Executive Director – Children's Services), Sarah Fletcher (Healthwatch Lincolnshire), Kevin Lockyer (Chair – Lincolnshire Partnership Foundation NHS Trust), Sunil Hindocha (Chair – Primary Care Network Alliance), Elaine Baylis (Chair – United Lincolnshire Hospital NHS Trust and Lincolnshire Community Health Service NHS Trust), Oliver Newbould (NHS England/Improvement), and Jason Harwin (Lincolnshire Police).

The Committee noted that Nicola Clarke (Healthwatch Lincolnshire) had replaced Sarah Fletcher (Healthwatch Lincolnshire) for this meeting only.

12 DECLARATIONS OF MEMBERS' INTEREST

There were no declarations of members' interest made at this point in the meeting.

13 MINUTES OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD MEETING HELD ON 22 JUNE 2021

RESOLVED

That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 22 June 2021 be agreed and signed by the Chairman as a correct record.

14 ACTION UPDATES

RESOLVED

That the Action Updates presented be noted.

15 CHAIRMAN'S ANNOUNCEMENTS

The Chairman extended congratulations to Maz Fosh, who had been appointed as the Chief Executive of Lincolnshire Community Health Services NHS Trust.

RESOLVED

That the Chairman's announcements presented be noted.

16 DISCUSSION ITEMS

16a Covid-19 Update

The Chairman invited Derek Ward, Director of Public Health, to provide an update on the current Covid-19 position in Lincolnshire.

The Board was advised that the England infection rate was currently at 330 per 100,000 population and that the Lincolnshire rate of infection was at 344 per 100,000 population. It was reported that overall, the case rate was being driven by school based cases.

The Board noted further that during the previous three days (as up to 25 September 2021) the Lincolnshire local data had seen the rate of infection increase to 384 for the whole of the population of Lincolnshire. It was noted further that the rate for the over sixties was at 219; the rate for 4 to 11 year olds was 743 and that the rate for 12 -16 year olds was at 2,270. The figures presented clearly identified that overall the rates were being driven by secondary school aged children and that this group was currently in the process of receiving their first Covid-19 vaccinations.

It was reported that schools were receiving support from the Public Health Team.

The Board noted that at the moment the number of patients requiring hospital admission was not seeing the same increase in numbers, as most cases had experienced no symptoms, or mild symptoms.

It was highlighted that as at the 15 September, United Lincolnshire Hospital NHS Trust (ULHT) had 53 Covid-19 in-patients; as at 22 September - 47 Covid-19 in-patients; and as at 28 September 2021 - 37 Covid-19 in-patients.

During discussion, the Board raised some of the following comments:

- Whether the number of Flu cases was going to be tracked in a similar way to Covid-19. The Board was advised that the data would be available and that this information could be reported back to the Board. It was reported that some GP's had already started Flu vaccination programmes in Lincolnshire; and that other GP's would be starting the programme shortly;
- One member enquired whether the Covid-19 in-patients in ULHT hospitals had received their vaccinations. It was reported that of the 37 Covid-19 inpatients currently in ULHT hospitals, 24 had received two doses of the vaccine. The Board noted that the message being given was to make sure the residents of Lincolnshire get their Covid-19 vaccination; and
- It was reiterated the importance of Hands, Face, Space, particularly in a school environment. Some concern was also expressed on the gathering of young people in public spaces. The Director of Public Health agreed to draft a note to be circulated to all Lincolnshire schools to reaffirm the basic message of Hands, Face and Space.

RESOLVED

That the verbal update on Covid-19 be received and noted.

16b Integrated Care System Update

The Chairman invited John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group to present the report, which provided an update on the Integrated Care System (ICS) Legislation update.

The Board was reminded of the background to the ICS and to the current position with regard to legislation and NHS England/Improvement published guidance.

Appendix A to report provided the Board with details relating to: the legislation roadmap; the ICS recent developments; documents to support transition to a statutory ICS; the local context, the Lincolnshire System Development Plan; a summary of the ICS Group 1 Guidance and Key Actions; Integrated Care Board functions; Interim guidance on functions and governance of Integrated Care Partnerships; Integrated Care Board designate appointments; and key Integrated Care Board development milestones.

In conclusion, the Board was advised that work was on going to translate and adapt the guidance into the Lincolnshire System and that in readiness for the next meeting; work would be done to look at evolving the current Terms of Reference for the Board.

During discussion, the Board made some of the following comments:

- Reassurance was given that work would be undertaken to ensure the system worked for the residents of Lincolnshire;
- How the partnership would look after residents in the south of the County, as the south of the County bordered three other ICS's. Reassurance was given that currently there was good relationships with all bordering neighbours and that this effective partnership arrangement would continue, as it would in the north of the County;
- The benefit of capitalising on the procurement and commissioning of services across the NHS and other partnership organisations. The Board was advised that the challenge was for a more joined up partnership, to ensure that the ICS was at the centre of local communities across the County, and that advice would be taken from the County Council and District Councils as to how this could happen;
- The need for a Lincolnshire model;
- Details concerning the recruitment process for the position of Chair of the ICS Board. It was reported that the position had been advertised nationally and that of the 42 systems, 25 had Chairs in place, and that Lincolnshire was still awaiting the outcome of the recruitment campaign. It was highlighted that details concerning the recruitment and the Terms of Reference could be made available to members of the Board; and
- Closer partnership working arrangements of health and social care and the ICS going forward.

RESOLVED

That the Integrated Care System update be noted.

16c Lincolnshire Mental Health Services

The Board received a presentation from Sarah Connery, Chief Executive Officer, Lincolnshire Partnership NHS Foundation Trust (LPFT) regarding Mental Health in Lincolnshire.

Councillor Mrs S Woolley (Chairman) left the meeting at 3.02 pm.

John Turner (Vice-Chairman) in the Chair

The presentation made reference to: the significant increasing demands across a number of services, these services were highlighted as: the Crisis Services; early intervention in psychosis, perinatal mental health; sexual assault services, children and young people mental health/eating disorders; adult eating disorders and Autism diagnosis.

The presentation also advised of how the service had expanded and transformed to meet demands, with particular reference being made to community mental health. The Board noted the partnership had been strengthened with primary, secondary and the voluntary sectors with the implementation of community based teams; the embedding of social prescribers and with investment in the voluntary, community and social enterprise sector. Reference was also made to the staff wellbeing hub; and how the system worked in Lincolnshire.

During consideration of the presentation, the Board raised some of the following points:

- Whether the mental helpline was seeing repeat callers or unique callers. It was reported that the adult helpline was seeing a significant amount of repeat callers; and from early analysis it had been identified that the service was being used as support for a certain percentage of the population;
- Vacancy rates for the Trust. It was noted that the Trust's vacancy rate was significant for both consultants and qualified nurses. It was noted further that at the moment the Trust had around a 20% vacancy rate for both roles. It was highlighted that the Trust was trying to be innovative in its approach to recruitment, working with Health Education England for international recruitment and by investing in existing staff to grow their own. The Trust was also working with the University of Lincoln regarding apprenticeships and nursing qualifications. It was also highlighted that the Trust was working across the East Midlands area to develop a competency framework. It was also noted that the Trust had found it difficult to recruit staff for in-patient wards; which was a new role with great development opportunities;
- It was raised that with staff shortages there was a reliance on bank nursing staff and medical staff. Further information was sought as to how the Trust was addressing the medical staff shortage. The Board was advised that international recruitment was being followed as a way of increasing the number of consultant staff. The Trust had

also introduced a Development Associate Specialist role in hard to recruit areas; investment had also been made in non-medical prescribers. The Board was advised that the amount spent on locums was tracked to ensure sustainability and that locums were engaged on longer contracts to help with continuity. It was noted what was trying to be avoided was the onset of a price war;

- Lack of provision on the east coast of Community Teams. The Board noted that at the moment there was a pilot site in the Boston area and as resources and recruitment allowed the pilot would be replicated across the County. Reference was also mentioned to the Dementia Home Treatment Team and that further information would be shared with the Board following an evaluation of the service;
- Lack of community mental health services in rural areas; and the need to ensure that local people had a local service that they could access. There was recognition that some services needed to be centralised, and that the whole point of community working was to be working alongside GP's and the voluntary sector to provide a universal service within the community. Clarity was sought as to when initiatives would be available across the County. The Board was advised that currently there was access to cafes, community hubs, and the helpline. It was highlighted that there was a pilot being undertaken in Boston, Lincoln and Gainsborough. It was noted that the Chief Executive Officer would provide more detailed information regarding mental health services for the Board to consider at a future meeting;
- The use of digital. The Board noted that digital technology was embedded in the organisation; digital access to psychological therapies; and that 95% of interventions were digital; and
- The excellent work of voluntary groups with regard to mental health issues.

The Chairman on behalf of the Board extended thanks to the Chief Executive Officer LPFT for her presentation.

RESOLVED

That the presentation on mental health services be received and that further detailed information concerning mental health service provision be presented to a future meeting of the Board.

Councillor Mrs P A Bradwell OBE left the meeting at 3.28pm.

16d Joint Strategic Asset Assessment Update

Consideration was given to a report from Sem Neal, Head of Prevention and Early Intervention, which provided the Board with an update on the Joint Strategic Asset Assessment.

Due to technical difficulties, the Chairman invited Derek Ward, Director of Public Health (who was present in the Chamber) to present the report to the Board.

It was reported that a Joint Strategic Asset Assessment was intended to support communities and commissioners to address the health and wellbeing needs identified in the Joint Strategic Needs Assessment (JSNA).

The Board noted that the report outlined the progress that had been made in developing a register of physical assets which would be mapped to create a more visible overview of needs and opportunities, to become a sustainable, meaningful and useful tool for asset-based community development to support thriving communities and healthy lifestyles.

Details of the first phase of the project were shown on page 44 of the report pack. It was noted that nearly two thousand physical assets had been recorded to date. It was noted further that the register would be included on the Connect to Support website.

The next phase was to increase details about the assets and to overlay travel options and access routes, which would enable people to organise community events, see where to base new or existing groups and services and to see where there were gaps in service.

During consideration of the item, the Board raised the following comments:

- The enormity of the task across the County and the need to ensure that the right assets are highlighted. It was felt that a direction of focus was paramount to the websites success. It was noted that it was still work in progress and that the more the site was utilised the better it would become;
- One member highlighted that some of the district council assets contained on the website had incorrect email addresses;
- It was reported that a lot of work was on going with the Connect to Support team regarding physical activity, and the link to open spaces for physical activity to feed in to Let's Move Lincolnshire, a platform due to go live at the end of October. It was highlighted that data into Connect Support could become amplified and shaped for people to become more active, whilst trying not to duplicate data; and
- One member sought information as to how the Connect to Support platform was being utilised and by whom. The Board was advised that web analytics information was available and could be shared with Board. It was noted that the purpose of the platform was to target groups who would not be able to get information from any other source. There was also recognition of the need to make sure that the general public were aware of the assets available.

RESOLVED

That the progress made to develop the Joint Strategic Asset Assessment be received and that the comment by the Board be noted.

17 INFORMATION ITEMS

17a The importance of community beds in transitional care both for Covid positive and Covid negative patients and the positive impact these have on Acute Hospital Trusts

RESOLVED

That the report presented concerning the importance of community beds in transitional care both for Covid positive and Covid negative patients and the positive impact these have on acute hospitals trusts be noted.

17b An Action Log of Previous Decisions

RESOLVED

That the Action Log of Previous Decisions as presented be noted.

17c Lincolnshire Health and Wellbeing Board Forward Plan

Members were invited to put forward items for inclusion in the Board's forward plan.

During discussion the following suggestions were made:

- More information on mental health services; and
- Update on the Let's Move Lincolnshire initiative

RESOLVED

That subject to the addition of the suggestions reference above, the Forward Plan presented be received.

The meeting closed at 3.55 pm.

Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
22.06.21	**8a**	**Terms of Reference & Procedure Rules & Responsibilities of Board Members** It was agreed that consideration would be given to the setting up of a working group to look into the membership of the ICS partnership.	This will be considered as part of developing the ICS Partnership.
	8b	**Lincolnshire's Joint Strategic Needs Assessment** Further Discussion concerning Autism. Inclusion of air quality and neurological conditions.	The additional issues highlighted at the Board meeting have been fed back to the project group and will be built into the review process.
	9b	**Integrated Care Systems (ICS) legislation Update** Workshop to be arranged with wider partner, once restrictions have been lifted.	A workshop session is expected to be held later in the year.
28.09.21	**16a**	**Covid-19 Update** The Director of Public Health agreed to draft a note to be circulated to all Lincolnshire schools to reaffirm the basic message of Hands, Face and Spa; and for Flu data to be reported back to the Board.	An update on Flu is provided in December's Chairman's Announcements
	16b	**Integrated Care Systems Update** The Chief Executive, NHS Lincolnshire CCG agreed to circulate Recruitment details for the post of Chair of the ICS Board.	Details of the application pack for the Integrated Care System Chair can be found at https://www.england.nhs.uk/non-executive-opportunities/wp-content/uploads/sites/54/2021/07/ICS-Chair-Applicant-Pack-1.pdf
	16c	**Lincolnshire Mental Health Services** Further information to be circulated to the Board with regard to mental health services.	Further details on mental health services were circulated to HWB members by email on 30 September 2021.
	16d	**Joint Strategic Asset Assessment Update** Information was sought as to how the Connect to Support platform was be utilised and by whom.	An update on Connect2Support is provided in December's Chairman's Announcements
	17c	**Lincolnshire Health and Wellbeing Board Forward Plan** Suggested items for inclusion of the Forward Plan More information on mental health services; and Update on the Let's Move Lincolnshire initiative	The Forward Plan has been updated to include these items.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD – 7 DECEMBER 2021

CHAIRMAN'S ANNOUNCEMENTS

Chief Executive Appointed to the Integrated Care Board

I am pleased to report that John Turner has been appointed as the new Designate Chief Executive Officer of the NHS Lincolnshire Integrated Care Board (ICB), due to be established in April 2022.

John, who is currently the Chief Executive of NHS Lincolnshire Clinical Commissioning Group (CCG) has been appointed following a comprehensive recruitment process, led by NHS England and NHS Improvement (NHSE&I). John will be accountable for the development of the long-term plan for the ICB and, through this, for delivering improvements in the quality of patient care, patient safety, health inequality, workforce productivity and financial health for the population of Lincolnshire.

I would like to congratulate John on his appointment and look forward continuing to work in partnership to develop the county's Integrated Care System.

The next step will be to recruit a Designate Chair, as well as Non-Executive Members and Executive Directors to the ICB.

Conntect2Support Data

At the last meeting, Board Members asked for further information on how the Connect2Support platform is utilised and by whom. A summary of user statistics between October 2020 - October 2021 is as follows:

- 18,846 users, of which 18,391 were new users of the site
- 98,846 individual page views
- The majority are users located in London*, Lincoln and surrounding regional areas (*this data is derived from user IP addresses so may not reflect the actual location of the website visitor)
- Just over 16,000 users landed on the site via direct access, rather than via organic searches or referral from other sites
- 54% of users accessed the site using a desktop, 39% using a mobile and 7% with a tablet
- The most visited pages (excluding the website homepage and the landing pages for Information and Advice, and directors):
    - Mental Health
    - Home Care Agencies and Care Homes
    - Blue badge scheme and parking
    - Councils in Lincolnshire
    - Activities and Events

Flu Data

Also at the last meeting, Members asked for an update on the flu data. At the time of writing this update, in the latest weekly figures flu positivity remains low nationally (0.3% of samples were positive for flu). Whilst this percentage is slightly higher in the East Midlands, it is still at a low level (0.5%). Positivity is marginally higher than last year at the same time, but it is still lower than the level seen in 2019/20. Vaccination is continuing in primary care with uptake being broadly as expected at this time of year. Ongoing analysis of uptake by cohort is undertaken weekly with a particular focus on inequalities linked to evidence from the COVID-19 vaccination programme.

NHS Lincolnshire Clinical Commissioning Group Chair

NHS Lincolnshire Clinical Commissioning Group (CCG) have announced that Sean Lyons, NHS Lincolnshire CCG Chair, will be leaving the CCG on 31 December 2021, prior to him taking up the role of Joint Chair at North Lincolnshire and Goole NHS Foundation NHS Trust and Hull University Teaching Hospital NHS Trust on 1 February 2022.

On behalf of the Health and Wellbeing Board I would like to thank Sean for everything he has done to support closer partnership working in Lincolnshire. I would like to congratulate Sean on his new role and wish him well for the future.

Dr Gerry McSorley, CCG Vice Chair, has agreed to step in as Chair from 1 January 2022 for the anticipated final 3 months of the CCG's existence up to 31 March 2022 to support the transition into the new Integrated Care Board arrangements from 1 April 2022.

LGA Sport and Physical Activity: Leadership Essentials

As part of the Sport England and LGA Leadership Essentials programme, the LGA ran a series of workshops in November for members with responsibility for, or a strategic interest in, physical activity. On 5 November 2021, I provided a presentation at the second session on understanding the health and social care landscape and working with partners to improve health and wellbeing.

Pharmaceutical Needs Assessment (PNA) 2022

In my last Chairman's Announcements, I informed Board Members that due to Covid-19 the Department of Health and Social Care (DHSC) had further delayed the need to republish our next PNA until 1 October 2022. On 29 September 2021, DHSC published revised PNA guidance to support Health and Wellbeing Boards to develop and update the PNA. The PNA Steering Group is currently reviewing the new guidance and will restart the PNA process in January 2022, with the intention to bring the draft assessment to our meeting in March prior to the formal 60-day consultation exercise.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Executive Director - Adult Care and Community Wellbeing

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Better Care Fund (BCF) 2021/22 Planning Round**

Summary:
The BCF planning guidance was published 30 September 2021 to inform the development of plans for expenditure within the current financial year. There was a requirement to submit plans before 16th November 2021 to enable the national assurance process to progress. Plans need to be approved by the HWB, however there is a well-established principle for interim approval by the chair/vice chair of the HWB to meet the deadline and formal retrospective approval sought at the earliest opportunity, The Lincolnshire BCF planning documents are attached to this paper and was submitted to the national team for assurance. It is recommended that the HWB approve the plans.

Actions Required:
The Lincolnshire Health and Wellbeing Board are asked to approve the 2021/22 BCF plan.

1. Background

The HWB have recently received reports regarding the BCF 24 May 2021 and 22 June 2021. This paper confirms the national requirements regarding the BCF for the current financial year. It is recognised that this plan considers a period which is already into Q3 and is unlikely to be assured by the national team until Q4. There is an expectation that there will be a need for an end of year report on outcomes, however this has not been confirmed by the national team yet.

The BCF Policy Framework was published 19 August 2021 which confirmed the minimum funding allocation for the CCG contribution to the Lincolnshire BCF and the 4 national conditions. However, it was not until 30th September that the BCF planning guidance was published. This confirmed what information was required by the national assurance team, the metrics required and the templates for plans to be used. This planning guidance also confirmed the deadline for submission of the plan being 16th November 2021. As in previous years it was confirmed that the HWB would be required to approve plans, however due to meeting schedules it was confirmed as acceptable to seek delegated authority from the chair/vice chair of the HWB with retrospective approval sought at the earliest opportunity.

The value of the BCF in Lincolnshire has increased from £254m in 2019/20 to £261m in 2020/21 and £269m this year. The funding comprises 5 areas as highlighted in the table below.

Funding Source	**Value**
Minimum CCG contribution	£58.5m
IBCF (direct grant to LCC)	£33.25m
Additional CCG Contribution	£83.9m
Additional LCC contribution	£86.7m
DFG	£6.98m
Total	£269m

Included as appendices to this report is the Lincolnshire BCF numerical plan and a BCF narrative plan. The templates used have been provided by NHS England. Plans will be assured by the region by 7th December and approval letters returned from 11 January 2022. All section 75 agreements need to be signed and in place by 31 January 2022.

The national team have confirmed that plans should only be rejected if:

- Plans are not agreed between LCC and LCCG.
- The national conditions are not met:
    - Plans agreed by the HWB.
    - Agreed NHS contribution towards Adult Social Care.
    - Agreement to invest in NHS out of hospital services.
    - Local partners should ensure that they have an agreed approach to support safe and timely discharge, including ongoing arrangements to embed a home first approach.

All the national conditions have been met in Lincolnshire.

2. Conclusion

The 2021/22 BCF planning round should be viewed as a continuation of previous years plans. There is an expectation that going forward central government will move to multi-year spending plans to provide a degree of stability and allow for more innovative plans to be considered. It is recommended that the HWB approve the BCF plans for 2021/22.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The BCF schemes within the plan, directly contribute to addressing health inequalities and the joint health and wellbeing strategy.

4. Consultation

The Lincolnshire BCF plan has been developed with stakeholder engagement and consultation.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	BCF numerical plan
Appendix B	NCF narrative plan with governance diagram

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Gareth Everton (Head of Integration and Transformation), who can be contacted on gareth.everton@lincolnshire.gov.uk.

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Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Lincolnshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Lincolnshire	£6,976,486
DFG breakerdown for two-tier areas only (where applicable)	
Boston	£632,715
East Lindsey	£2,039,523
Lincoln	£851,990
North Kesteven	£910,537
South Holland	£772,382
South Kesteven	£975,298
West Lindsey	£794,041
Total Minimum LA Contribution (exc iBCF)	**£6,976,486**

iBCF Contribution	Contribution
Lincolnshire	£33,249,463
Total iBCF Contribution	**£33,249,463**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Lincolnshire	£86,648,846	Existing Section 75 agreements for LD, CAMHS,
Total Additional Local Authority Contribution	**£86,648,846**	

CCG Minimum Contribution	Contribution
NHS Lincolnshire East CCG	£19,807,580
NHS Lincolnshire West CCG	£17,146,578
NHS South Lincolnshire CCG	£11,964,528
NHS South West Lincolnshire CCG	£9,570,630
Total Minimum CCG Contribution	**£58,489,316**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Lincolnshire East CCG	£83,897,668	CCGs merged in 2020-21 however the drop down
		Existing schemes: MH, equipment service, CAMHS,
Total Additional CCG Contribution	**£83,897,668**	
Total CCG Contribution	**£142,386,984**	

	2021-22
Total BCF Pooled Budget	**£269,261,779**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Lincolnshire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

NHS Lincolnshire CCG (LCCG), Lincolnshire County Council (LCC), Lincolnshire Community Health Services (LCHS), Lincolnshire Partnership Foundation Trust (LPFT), Lincolnshire Care Association (LinCa), The Voluntary and community sector Engagement Team (VET) and District Councils. Lincolnshire has a history of successful BCF planning and delivery with oversight from the health and wellbeing board. Throughout 2020/21 and so far this year, there has been continuous involvement with the above stakeholders to guide the development and ongoing iteration of the BCF plan for 2021/22. VET has developed into a community interest company who have member organisations to represent the wider heath and social care voluntary, community and social enterprise sector. The Lincolnshire BCF manager is a member of the VET board and uses this forum to engage with the sector. All stakeholders listed are represented at the Lincolnshire health and wellbeing board and receive regular updates on the development of the BCF plan.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The Lincolnshire Health and Care system has a history of close collaboration and integrated working. There are a range of priorities for 2021-22 however these all coalesce around the plans to embrace the opportunities for further integration with the introduction of the ICS.

Governance and Structure: The Lincolnshire system has already agreed that the ICS Partnership Board will be a further iteration of the HWB. Membership of the ICSPB has been extended to include the VSCE sector. Plans for 2021/22 include appointing to a Managing Director to lead the development of a Lincolnshire Health & Care Collaborative.

Sustainable Independent Provider Market: A new home care prime provider service mobilised 1 October 2021, which has seen additional investment from the BCF to assist workforce recruitment and retention issues. LinCa as the strategic partner is leading an external workforce strategy to support the sector.

Discharge to Assess: All system partners are working in collaboration around the "home first partnership" and a workstream to deliver care closer to home. This priority is delivering workstreams to affect change such as bringing together the main occupational therapy services into a single service with a focus on home first. The system is exploring the adoption of a "somerset" type model for discharge to assess to further embed the principles that people need to return home rather than into residential bed based provision. The system has appointed a System Flow Director to lead this work.

There may appear to be a disconnect between the BCF schemes/expenditure plans with a relatively low proportion of schemes identified with the "domiciliary care" category and the plans to improve discharge outcomes in relation to national condition 4. However the nature of historical funding settlements has meant that schemes have evolved and it is difficult to disaggregate larger schemes into sub categories that do provide domiciliary home care services in addition to residential and other community support e.g. scheme 10, 18, 25, 26, 34.

Proactive Care: Working with PCNs around PHM to identify cohorts of individuals who may benefit from a personalised approach to care and support planning. Working with individuals to prevent or delay a crisis and potential hospital admission. The PCNs are developing structures and services to operate in a more proactive way. This includes increased community pharmacy and social prescribing.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Lincolnshire system has 1 upper tier local authority, 1 CCG, 7 district councils and NHS providers who operate within the Lincolnshire geographical boundaries. There is cross border activity with secondary care use in neighbouring counties, but generally the system activity is contained within the Lincolnshire health and wellbeing board (HWB) area. Overarching governance of the BCF is via the HWB; however there is a wider governance structure in place.

Housing: Lincolnshire has a Housing, Health and Care Delivery Group (HHCDG). This is a subgroup of the HWB and brings together partners across the system around the housing agenda. DFG elements of the BCF are considered at this group, alongside wider issues such as housing elements of the transforming care agenda, housing standards, accessible design, and energy.

Joint Commissioning: The Joint Commissioning Oversight Group (JCOG) is a joint commissioning committee with executive representation from LCCG and LCC. Strategic intentions around joint commissioning is established in this group which inform the BCF development.

Finance: Officers from LCCG and LCC meet regularly to monitor the delivery of the BCF and financial allocations.

Section 75 boards. Each section 75 agreement which underpins the BCF (mandatory and additional schemes) have a Section 75 oversight group. This includes a Learning Disabilities Partnership Board, Community Equipment Partnership Board, Mental Health Partnership Board and Unplanned Care Partnership Board.

Appendix A shows the governance diagram for the Lincolnshire Health and Wellbeing board and the different subgroups with the lead organisation for each.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Lincolnshire has established a Joint Commissioning Oversight Group JCOG with the strategic intention of ensuring joint commissioning delivers outcomes for the people of Lincolnshire. A current priority being the procurement of a new fully integrated community equipment service with a pooled budget. Technology and the design of joint approaches to technology enabled care is also a live issue.

Lincolnshire has a system personalisation board which drives the growth of personalised approaches with a focus on integration:

Workforce: A 2 year programme is underway with a focus on embedding strengths based approaches across the system. This has started at the adult care customer service centre with new tools developed for a strengths based initial conversation. This has been extended into the wellbeing service delivered by the District Councils, Carers service, Cardiac rehab service, learning disability team, mental health team and locality adult care teams. 360 practitioners have been part of the health and wellbeing coaching programme with 8 practitioners progressing onto becoming accredited coaches. The ultimate aim of this work being to develop a workforce across health and care that understand the benefits of personalised care and have the skills to deliver this. In the medium term this work will increase capacity within the system to influence others and provide a champions network of early adopters.

Social Prescribing: The voluntary sector engagement team have been commissioned to provide strategic support to the development of social prescribing across Lincolnshire. This includes hosting a new electronic recording system which is integrated into primary care data systems. The aim of this work being to bring together a disparate group of practitioners who operate under the banner of “social prescribing”. The funding of designated posts through PCN created a risk of silo approaches. Funding a coordination and development role within the VCSE sector has enabled a more consistent approach to be developed. This includes the reporting of outcomes through a shared social value engine to demonstrate return on investment.

Care and support planning: Lincolnshire has a care portal, which is a system for accessing shared data sources. Within the care portal we have developed a personalised care and support planning module for sharing plans with system partners. This supports the idea of people only telling their story once and the personalised plan following them through the system

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Lincolnshire system partners have recognised that further work is required to ensure that the national hospital discharge policy and the adoption of a true home first discharge to assess way of working is fully implemented and embedded. The work is being taken forward by the home first partnership D2A delivery group reporting to the patient flow programme and the Urgent care partnership board. Data is used for improvement and key metrics shared across the system with an emphasis on continually improving patient outcomes.

The system has received a peer review from the LGA and ECIST and although the observations and recommendations were varied, the key message was around the scarcity of reablement and domiciliary care leads to unnecessary short and long term placements in residential care and community health beds, which result in poor outcomes for people and patients.

We are agreeing how to rapidly work together to deliver the recommendations of the report, prioritising the creation of increased pathway 1 capacity to increase the reablement, rehabilitation and recovery offer for patients leaving bedded care. This is reflected in the planned BCF schemes with an investment in out of hospital services, reablement, and domiciliary care services.

We will be aiming to consistently achieve the following:

- 95% of patients discharged to their own home/usual place of residence via pathway 0 and 1. Supported by the HART (Hospital Avoidance Response Team) service, integrated pathway 1 offer, 2 hour urgent care response and admission avoidance services. Emphasis on reducing hospital acquired functional decline by focussing on effective pre-hospital intervention, reducing acute length of stay if admitted, use of criteria to reside, expected dates of discharge, and daily monitoring of 7, 14 and 21 day stranded and super stranded.

- 98% of patients who no longer meet the criteria to reside to be pulled into community capacity (health & social care services) within 24 hours. We will monitor:

1. Flow out of hospital – demand for pathways, capacity on pathways, actual discharges and wait times
2. Activity on pathways – LOS, outcomes (as patients move from pathways), demand for long term care and readmissions. Number of people who remain in their own home 91 days after discharge.

A number of BCF schemes are highlighted within the plan which support safe, timely and effective discharge. These range from making increased funding available for home care providers, providing intermediate care (bed based and home based) to trusted care home assessors in the hospital.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Lincolnshire recognises the importance of having a safe, secure and warm home on people's health and wellbeing. The focus on this in the JSNA has been enhanced with 2 chapters on 'Housing Standards and Unsuitable Homes' and 'Insecure Homes and Homelessness'.

Several new posts shared across the System have been created: Strategic Lead – Healthy and Accessible Homes and housing intelligence officers. In addition the district councils are funding a County Housing [Homelessness] Partnerships Co-ordinator.

In 2021 the Housing, Health and Care Delivery Group reviewed its membership, terms of reference and delivery plan. It also published Lincolnshire Homes for Independence – a blueprint for helping people with care and support needs to live independently in a home of their own. Objectives in the blueprint are arranged in to four categories: Understanding needs and opportunities; Housing for people with care and support needs; Helping people remain in their current home; Helping people find and move to a new, suitable home

The delivery plan contains actions to help achieve the above objectives. Numerous actions are of relevance to the Better Care Fund plan, including updating the market position statement on homes for working-age adults with care and support needs; and updating the extra care housing delivery programme, continuing to progress this programme.

There has been a common Lincolnshire Discretionary Housing Assistance Policy developed with the intention that all district councils will adopt this under the Regulatory Reform Order. This supplements mandatory DFG making provision to top-up the maximum of £30,000 and for a range of aids, adaptations, and improvements to ensure people stay safe, warm and well. This can help to move to a suitable home (relocate) and help reduce delayed transfers of care (DTOC). District councils can also retain additional discretionary policies under the RRO, such as to waive the means test for mandatory DFG for works costing below a certain level; which some do. In addition, opportunities to deliver items such as stairlifts and modular ramps through the Integrated Community Equipment Service rather than through DFG are being explored.

Lincolnshire is a strategic partner with the national Centre for Ageing Better and has been involved in the Good Home Inquiry that it commissioned and published. Numerous workshops, focus groups and interviews have been held to better understand what residents want and need and to define and map 'housing' services.

In 2021/22 the DFG funding has been passed in its entirety to the District Councils.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Lincolnshire has a strong and comprehensive partnership approach to addressing health inequalities via the developing Integrated Care System. NHS Lincolnshire are working closely with the Director of Public Health – who has a statutory role in reducing health inequalities – to embed an agreed approach to addressing inequalities throughout the Health & Care System.

A Health Inequalities Governance Structure for the ICS has been created and has representation from across the system. A health inequalities plan will be developed by March 2022

The priority groups in Lincolnshire are the 'Core20' – the 20% most deprived communities – as well as those people with protected characteristics who experience inequitable outcomes. Primary, secondary and tertiary prevention will be addressed with a 'proportionate universalism' approach adopted, where universal services are offered with additional resource targeted at those who experience inequalities in health.

The One You Lincolnshire service – jointly funded by the CCG – remains a key means of addressing inequalities in health via primary prevention, with an expanded adult weight management offer in place designed to address inequalities.

The HEAT (Health Equity Assessment Template) Project has been established to pilot and roll out training and support to use the tool in 2021/22 across organisations and transformation programmes. 3 pilots identified – CVD, Smoking – Maternity and long COVID.

A Prevention work stream has been established to take forward NHS LTP priorities regarding health inequalities (Tobacco dependency, alcohol, healthy weight and TB). Smoking is the single biggest contributor to inequalities in life expectancy, and a Smoking steering group (multi agency) is in place with a focus on smoke free pregnancy and inpatient pathways.

Population Health Management is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. In Lincolnshire a Population Health Management Development Programme has started, which seeks to bring together opportunities through the BCF and a wider integrated system approach to reducing health inequalities.

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Integrated Care System Update**

Summary:

This report provides an update on the development of Integrated Care Systems (ICSs).

Actions Required:

Note the current position in relation to ICS legislation.

1. Background

ICB Target Operating Model

A significant focus of work following the publication of the guidance has been to set out the Target Operating Model for the Lincolnshire Integrated Care Board (ICB) from 1st April 2022, set in the context of the ongoing evolution of the Better Lives Lincolnshire Integrated Care System (ICS).

The summary of the key developments together from the work that has been carried out to date has been set out in Appendix A. It is a working document to prompt discussion, share thinking and test alignment, and therefore subject to ongoing review and development.

The contents have been developed through the ICS Development Group, which is made up of Executives from all partner NHS organisations – it presents an articulation of current local system thinking in the context of the recently published national guidance on ICS development.

Constitution

The first draft of the constitution has been submitted to NHS England on the 15th November. Key to this process was to outline the composition of the Integrated Care Board. The draft submission outlined the following board members:

Non-Executives

1 x Chair
5 x Non-Executive – including Audit and Remunerations Committee Chair

The main principles being the currently the expectation is that there will be 6 Committees of the ICB Board identified through function mapping and governance arrangement work. These committees will be the 'engine' of the ICB Board, and therefore all need a dedicated Independent NED Chair with the exception of the Remuneration Committee which will Chaired by an Independent NED who also chairs one of the other committees.

Executives

1 x CEO
1 x Director of Finance
1 x Nursing Director
1 x Medical Director

Kept to the minimum expectation of executive posts in line with the national descriptions.

Partner Members

1 x Local Authority
1 x NHS Trust
1 x Provider of Primary Medical Services

The Lincolnshire ICS is co-terminus with the Lincolnshire County Council, therefore 1 LA partner bringing their knowledge and perspective

A partner member from Primary Medical Services to bring perspectives from primary care providers/PCNs and a partner member from the Lincolnshire Provider Collaborative which will be the vehicle for local service delivery, design, and transformation.

Integrated Care Board Recruitment

The recruitment to the Chair role was unfortunately not successful, NHSEI guidance is expected shortly to outline the process for recruiting to the role.

The CEO recruitment process has now been completed and John Turner was successful to be appointed to the role.

The approach to the other statutory board roles pay grades have not yet been agreed which is delaying the recruitment process, namely if the pay scale will be set nationally or locally. If set nationally there is currently no agreement on the process for setting the pay scale which will either be a percentage of the CEO salary or through a job banding process. This has delayed the recruitment processes so it is now anticipated that interviews will not take place until early 2022.

Non-Executive pay scales have also not been agreed but systems have been advised to go out at risk and start recruiting to these posts with an indicative pay scale. Once NHSEI have approved the proposed number of Non-Executives outlined in the draft constitution the recruitment process will be able to commence.

Naming Convention

The ICS had to submit the naming convention for the different elements of the Integrated Care System in line with national guidance. The legal name was none negotiable and laid down by NHSEI. All three names needed to include Lincolnshire and the ICB public name had to also include NHS.

Based on the limited options the submission for Lincolnshire outlined the following:

Legal Name of ICB: NHS Lincolnshire Integrated Care Board (this is defined by NHSEI)
Public name of ICB: NHS Lincolnshire Integrated Care Board
Name of ICS: Better Lives Lincolnshire
Name of ICP: Lincolnshire Integrated Care Partnership

2. Conclusion

The Health and Wellbeing Board are asked to note the current position in relation to forthcoming ICS legislation.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The JSNA and JHWS will be used to inform the development of the ICS.

4. Consultation

Not applicable.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Integrated Care Board (ICB) – Target Operating Model

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Pete Burnett who can be contacted on 07814 515180 or peter.burnett4@nhs.net

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Better Lives Lincolnshire

Lincolnshire Integrated Care Board
Target Operating Model

This is a working document to prompt discussion, share thinking and test alignment; and therefore subject to ongoing review and development

Purpose & status of document and contents

Purpose & status of document
The purpose of this document is to set out the Target Operating Model for the Lincolnshire Integrated Care Board (ICB) from 1st April 2022 , set in the context of the ongoing evolution of the Better Lives Lincolnshire Integrated Care System (ICS). It is a working document to prompt discussion, share thinking and test alignment; and therefore subject to ongoing review and development . The contents have been developed through the ICS Development Group, which is made up of Executives from all partner NHS organisations – it presents an articulation of current local system thinking in the context of the recently published national guidance on ICS development.

Change agenda

Lincolnshire ICS Organisational Change Agenda

To help establish a shared understanding and ambition for the development of the Better Lives Lincolnshire Integrated Care Board (ICB) a change agenda has been developed. An overview of this is set out below, with further detail on subsequent pages…

From…

A fragmented health and care system

WHICH FOR THE PEOPLE OF LINCOLNSHIRE MEANS:

- *A lack of ownership of the overall, and continuing, health and care of people.*
- *A focus on reactive treatment, rather than proactive intervention and preventative action.*
- *People visiting different services, that are not entirely integrated and do not communicate with each other efficiently across the whole care cycle.*

To…

A thriving integrated care system

WHICH FOR THE PEOPLE OF LINCOLNSHIRE MEANS:

- *Services organised around patients that span professional boundaries – fewer hand offs and less bureaucracy for people to manage*
- *Care and support is focused on delivering the outcomes that are important to people*
- *Care providers are collectively responsible for the full cycle of care - **their key objective is 'how can we best deliver outcomes for people together'?***

Lincolnshire ICS Organisational Change Agenda

From…

A fragmented health and care system

Commissioning

Commissioning activity is transactional
NHS Commissioners undertake a number of activities that are 'low value' and do not drive population health changes

Separate health and social care commissioning
Local Authority and CCG commission services separately and pool only very small amounts of funding associated with Better Care Fund

Provision

Limited integration across providers
Good working arrangements, however integration across care settings, including with social care, remains limited

Providers receive fees for services / parts of pathways
Providers predominantly incentivised to deliver distinct service components through activity-based contracts

WHICH FOR THE PEOPLE OF LINCOLNSHIRE MEANS:

- *A lack of ownership of the overall, and continuing, health and care of people.*
- *A focus on reactive treatment, rather than proactive intervention and preventative action.*
- *People visiting different services, that are not entirely integrated and do not communicate with each other efficiently across the whole care cycle.*

Lincolnshire ICS Organisational Change Agenda

To…

A thriving integrated care system

- *Improve outcomes in population health and healthcare*
- *Tackle inequalities in outcomes, experience and access*
- *Enhance productivity and value for money*
- *Help NHS support broader social & economic development*

Integrated Care Partnership & Integrated Care Board

Provide a whole system view of population health needs and inequalities

Set clear strategic direction using outcomes, KPIs and care standards for improvement

Ensure collective accountability between all partners for whole system quality, performance and finances

Shared:

- **accountability**
- **outcomes**

Provider Collaboration & Partnership

Decide how outcomes, KPIs and standards will be delivered through operational delivery and service/pathway redesign & transformation

Deliver outcome, KPI and care standards based contracts for specific populations incl. capitation, pool funds, and risk shares

WHICH FOR THE PEOPLE OF LINCOLNSHIRE MEANS:

- *Services organised around patients that span professional boundaries – fewer hand offs and less bureaucracy for people to manage*
- *Care and support is focused on delivering the outcomes that are important to people*
- *Care providers are collectively responsible for the full cycle of care - **their key objective is 'how can we best deliver outcomes for people together'?***

ICB function principles

Better Lives Lincolnshire - Integrated Care Board Functions

To support the Lincolnshire Integrated Care System consider and develop its approach to discharging the functions of the Lincolnshire Integrated Care Board, a working draft of a functions grouping for the ICB has been developed based on a local interpretation of the '*functions of the integrated care board*' and '*statutory functions to be conferred on ICBs*' set out in the recently published guidance …

Population Health Planning

- Population Health Intelligence
- Strategic Planning & Integration
- Joint Resource Management
- Resource Allocation & Distribution
- Functions Delegated from NHSEI
- Public Involvement & Engagement

System Oversight & Assurance

- Service Delivery & Performance
- Quality
- Financial/ Resource Management
- Emergency Planning

Delivering Integrated Care

- Service Delivery, Redesign and Transformation
- People and Culture
- Data and Digital

Note: Function groupings are based on national guidance – these could be added to with local views/perspectives

See Appendix 1 for more detail on Lincolnshire Integrated Care Board functions

Better Lives Lincolnshire - Integrated Care Board Functions

Discussions with and feedback from stakeholders has identified the following principles for informing and shaping how the Lincolnshire ICB's functions should be delivered…

1. The ICB should be a slim organisation focussed on outcome gain improvement, strategic planning, agreeing system priorities and resource allocation – transformation, service redesign and pathway improvement should be the accountability of provider organisations (delivered through the provider collaborative).

2. The ICB should bring a greater emphasis on collaboration and driving a shared purpose, including the establishment of oversight mechanisms to provide system assurance, and avoid being drawn into the operational detail – accountability for whole system delivery and performance should sit between all partners.

3. ICB arrangements should be proportionate to facilitate transparent decision-making and empower decision making at the point of maximum positive impact to achieve the best outcomes for patients - to enable this statutory partner organisations will need to align their decision-making arrangements.

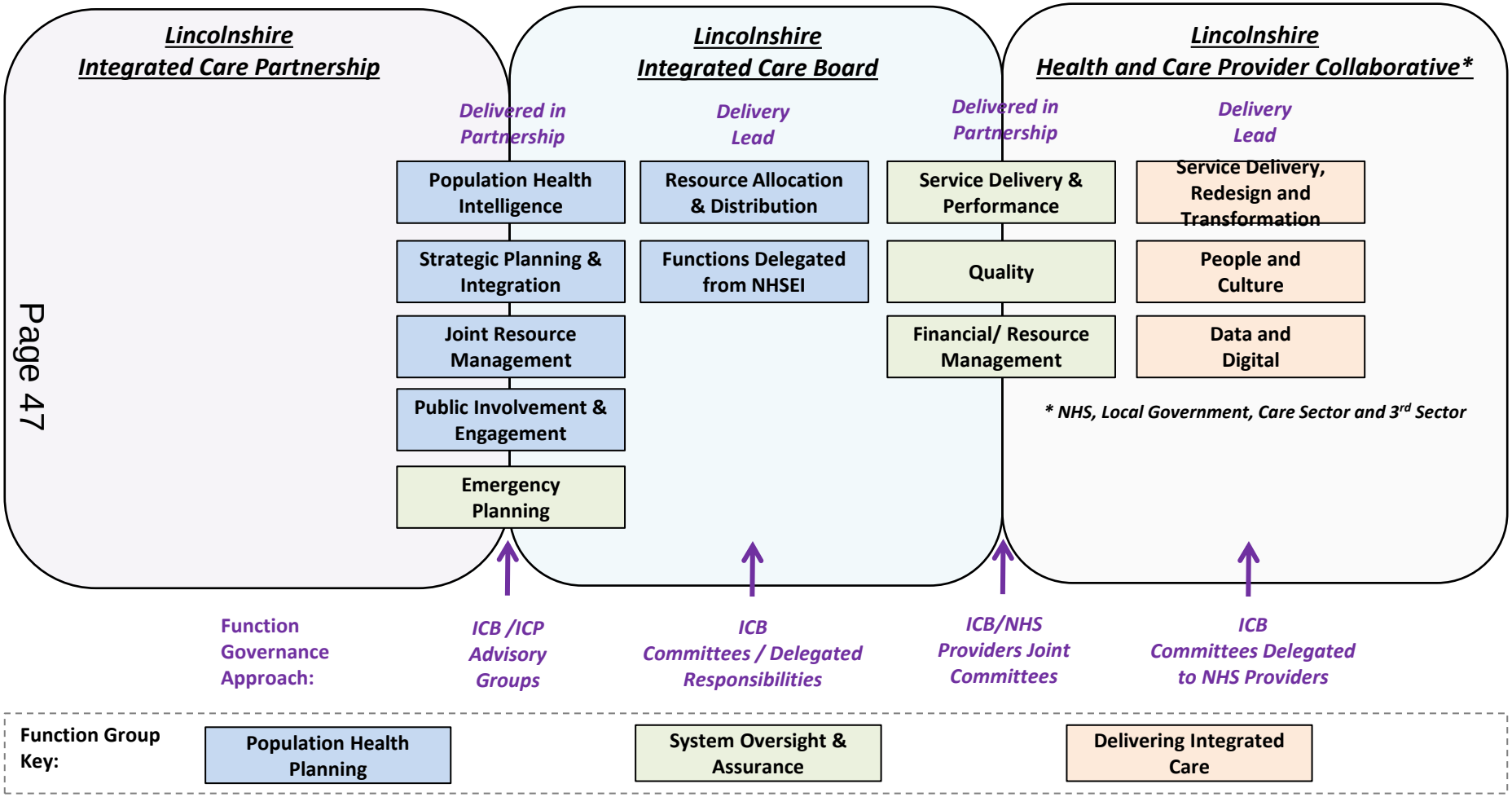
4. To drive the integration of health and care provision and ensure the NHS plays a full part in the wider social and economic development and environmental sustainability, the ICB should work in partnership with the Local Authority.

5. Support functions need to be the responsibility of the organisation they are trying to support. i.e. digital integration is to support front line staff, people board focused on workforce development of providers.

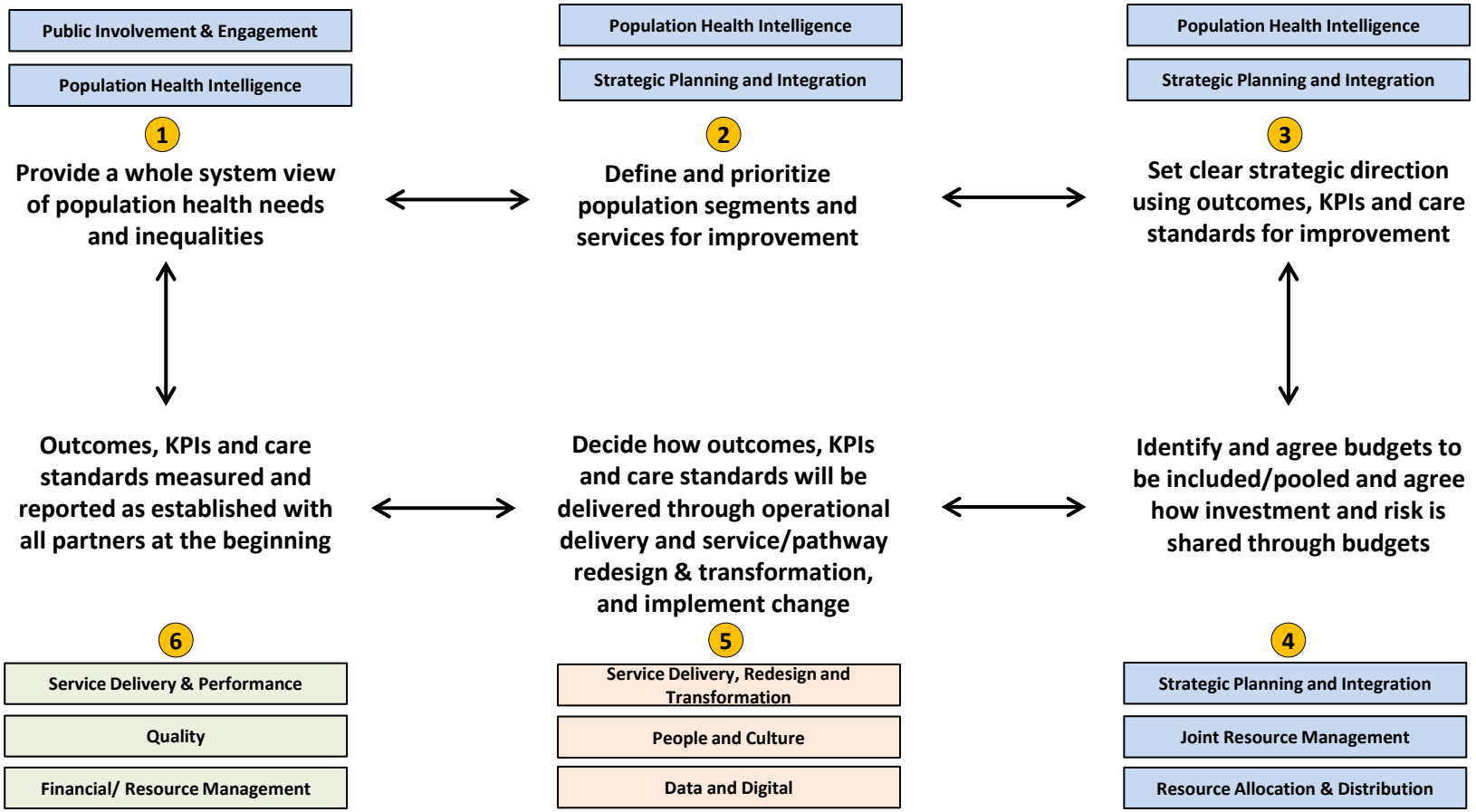
ICB function map and committee & advisory groups

WORKING DRAFT: BLL - ICB Function Map

Taking the functions groupings described earlier and applying the principles for how the Lincolnshire ICBs functions should be delivered, a high level function map has been produced …



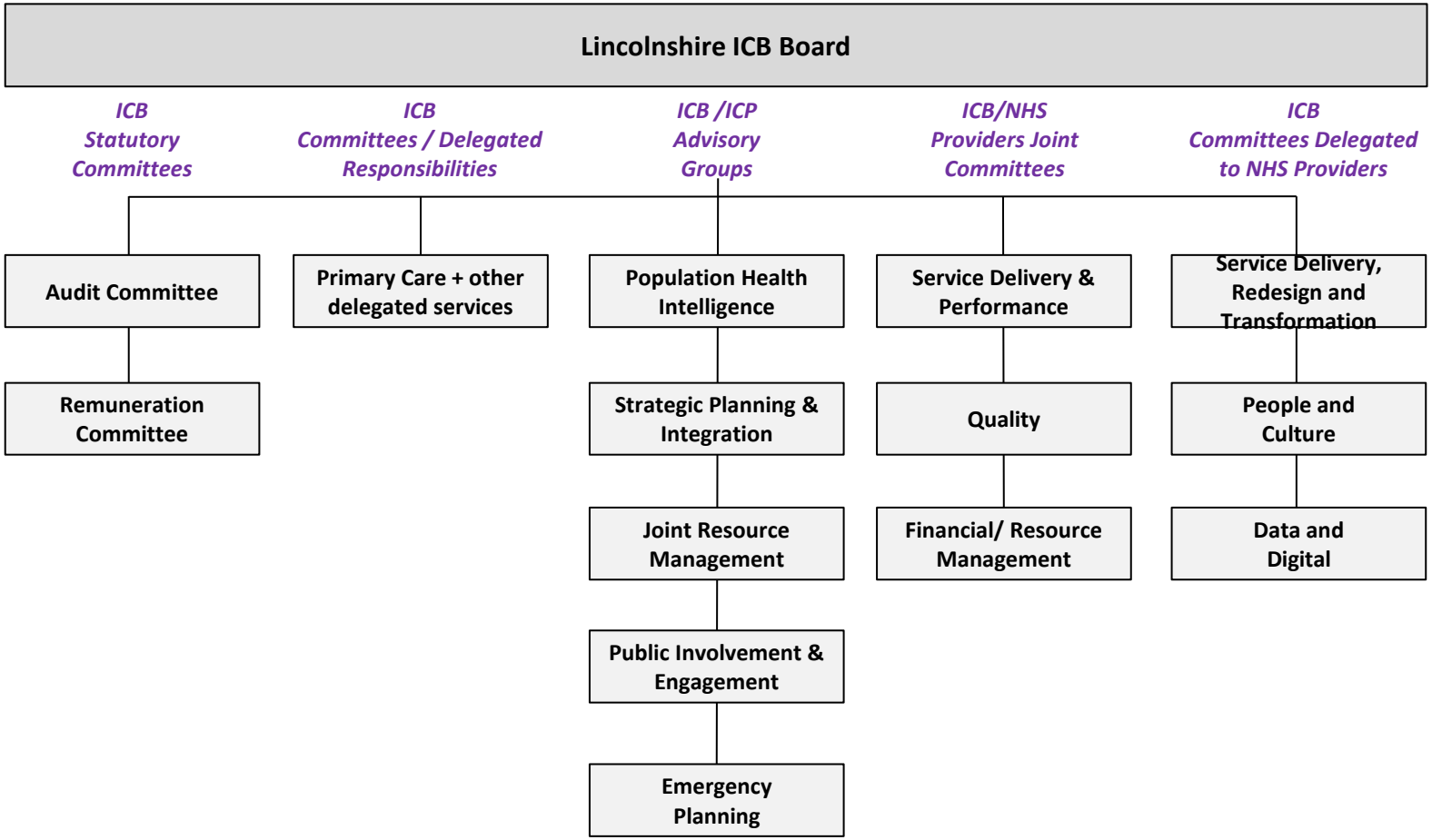
WORKING DRAFT: BLL - ICB Function Map: 'in action' to drive integration



Function Group Key: Population Health Planning | System Oversight & Assurance | Delivering Integrated Care

WORKING DRAFT: BLL - ICB Board Committee and Advisory Group Structure

Based on the high level ICB function map, an ICB Board committee and advisory group structure has been drafted…



ICB Board composition

WORKING DRAFT: BLL - ICB Board Membership

In light of the draft ICB Board committee and advisory group structure that has been co-created with stakeholders from across the Lincolnshire Integrated Care System, and reflecting discussions with system partners on ICB Board composition, a working draft of the Lincolnshire ICB Board membership has been developed in partnership with system stakeholders…

13 Lincolnshire ICB Board

6 Non Executives	4 Executives	3 Partner Members
1 Chair	1 Chief Executive Officer	1 Local Authority
5 Independent non-executive directors	1 Chief Finance Officer	1 Provider of Primary Medical Services
	1 Chief Nursing Officer	1 NHS Trust
	1 Chief Medical Officer	

Rationale for ICB Board Member Composition

- 6 Committees of the ICB Board identified through function mapping and governance arrangement work
- These committees will be the 'engine' of the ICB Board, and therefore all need a dedicated Independent NED Chair with the exception of the Remuneration Committee which will Chaired by an Independent NED who also chairs one of the other committees

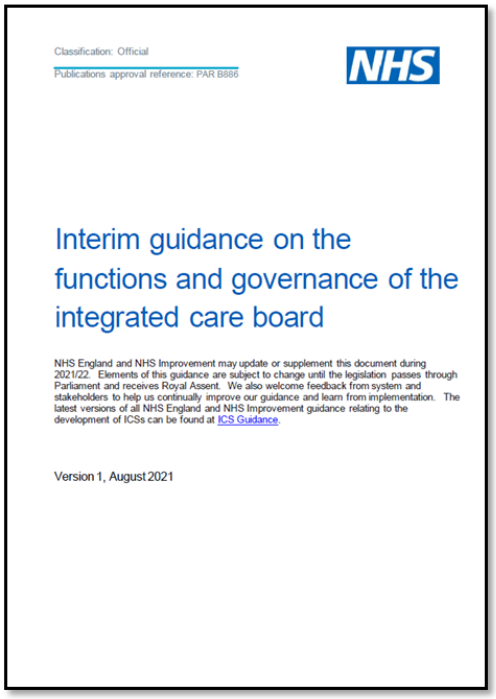
- Executive Board member roles in line with national description

- The Lincolnshire ICS is co-terminus with the Lincolnshire County Council, therefore 1 LA partner bringing their knowledge and perspective
- 1 partner member from Primary Medical Services to bring perspectives from primary care providers / PCNs
- 1 partner member from the Lincolnshire Provider Collaborative which will be the vehicle for local service delivery, design and transformation

Appendix

Better Lives Lincolnshire - ICB Functions (1)

The 12 functions of the integrated care board identified in the guidance have been aligned to the proposal for the Better Lives Lincolnshire ICB function map…



Classification: Official

Publications approval reference: PAR B886

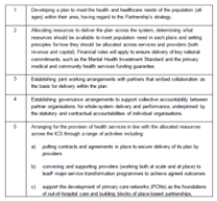
NHS

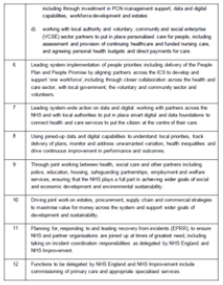
Interim guidance on the functions and governance of the integrated care board

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

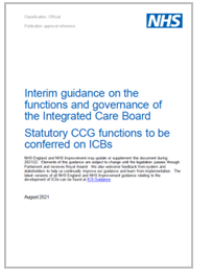
Version 1, August 2021

1. Functions of the integrated care board (12)





2. Statutory CCG functions to be conferred on ICBs (c.150)



NHS

Interim guidance on the functions and governance of the Integrated Care Board

Statutory CCG functions to be conferred on ICBs

3. Delegating direct commissioning functions to ICBs

The alignment of these 12 functions is set out in more detail in the following pages…

Better Lives Lincolnshire - ICB Functions (2)

Note: Additional local definitions could also be added

Alignment of functions of the ICB to the Better Lives Lincolnshire ICB function map…

Population Health Intelligence

- Macro population health data management (8)
- Macro patterns of health and social care utilisation (8)
- Predictive modelling / trend analytics (8)

Strategic Planning & Integration

- System vision and outcomes framework (1)
- LTP / Strategy – plan to meet health and care needs of the population (1)
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery (3)
- Ensure NHS plays a full part in wider goals of social and economic development and environmental sustainability (9)

Joint Resource Management

- Allocate resources to deliver the plan across the system, determining what resources should be available to meet population need – financial rules will apply to ensure delivery of key national commitments, such as MH investment Standard and the primary medical and community health services funding guarantee (2)

Public Involvement and Engagement

Resource Allocation and Distribution

- Allocate resources to deliver the plan across the system, determining what resources should be available to meet population need – financial rules will apply to ensure delivery of key national commitments, such as MH investment Standard and the primary medical and community health services funding guarantee (2)
- Put contracts and agreements in place to secure delivery of its plan by providers (5a)

Function Group Key: Population Health Planning | System Oversight & Assurance | Delivering Integrated Care

Better Lives Lincolnshire - ICB Functions (3)

Note: Additional local definitions could also be added

Alignment of functions of the ICB to the Better Lives Lincolnshire ICB function map…

Functions Delegated From NHSEI	System Delivery & Performance	Quality	Financial / Resource Management	Emergency Planning
• Commissioning of primary care (12) • Commissioning of specialised services (12)	• Whole system delivery and performance accountability (4)	• Whole system quality accountability (4)	• Whole system finance and resource accountability (4)	• Planning for, responding to and leading recovery from incidents (EPRR) (11)

Function Group Key: Population Health Planning | System Oversight & Assurance | Delivering Integrated Care

Better Lives Lincolnshire - ICB Functions (4)

Note: Additional local definitions could also be added

Alignment of functions of the ICB to the Better Lives Lincolnshire ICB function map…

Service Delivery Redesign & Transformation

- Convening and supporting providers to lead major service transformation programmes to achieve agreed outcomes (5b)
- Support development of PCNs as building blocks of care (5c)
- Put in place personalised care for people, including assessment and provision of CHC and funded nursing care, and agreeing PHB and direct payments (5d)*
- Drive joint work on estates, procurement, supply chain and commercial strategies to maximise VFM and support wider goals(8)

** Currently a lack of clarity in guidance to the extent this can be delegated*

People & Culture

- Lead system implementation of people priorities including delivery of People Plan and People Promise by aligning partners to develop and support 'one workforce' incl. through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers (6)

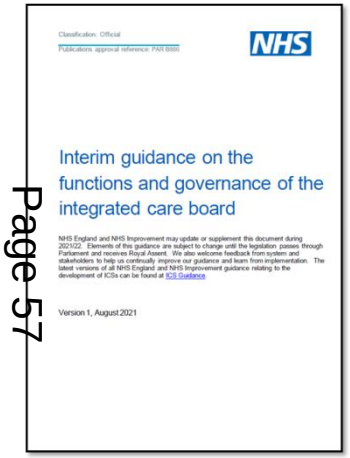
Digital & Data

- Lead system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and put the citizen at the centre of their care
- Use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continues improvement in performance and outcome (8)

Function Group Key: **Population Health Planning** | **System Oversight & Assurance** | **Delivering Integrated Care**

Better Lives Lincolnshire - ICB Functions (5)

The CCG statutory functions to be conferred to ICBs have also been aligned to the proposal for the Better Lives Lincolnshire ICB function map…


Classification: Official
Publications approval reference: PAR 8886

NHS

Interim guidance on the functions and governance of the integrated care board

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, August 2021

1. Functions of the integrated care board (12)

2. Statutory CCG functions to be conferred on ICBs (c.150)


NHS

Interim guidance on the functions and governance of the Integrated Care Board

Statutory CCG functions to be conferred on ICBs

3. Delegating direct commissioning functions to ICBs

To prepare to discharge the statutory functions conferred on ICBs, ICB appointed leaders, supported by CCGs will need to work through the list of statutory functions with a view to ensuring that:

- There will be capacity in the ICB to carry out the activities needed and make appropriate decisions, in respect of each statutory function, so that it can continue to be discharged effectively;
- Responsibility for exercising the statutory functions, or different aspects of the statutory functions, has been apportioned between ICS and place level, each ICB will be able to choose the level at which to plan and make decisions as long as the ICB can ensure that its statutory functions are being discharged appropriately;
- There is sufficient capability available to discharge statutory functions as staff move from their current organisation to the ICB;
- There is due regard for any statutory guidance in relation to the functions, including guidance that will be updated ahead of April 2022.

The alignment of these functions together with a view from stakeholders of those that could be delegated to provider organisations is set out in more detail in the following pages…

Better Lives Lincolnshire - ICB Functions (6)

Population Health Intelligence	Strategic Planning and Integration	Joint Resource Management
• *N/A*	• Commissioning plan incl. revisions (but is a system plan) (1,2) *	• Powers to do anything calculate to facilitate, conductive or incidental to another function (8)
	• Prepare a JSNA and Joint Health and Wellbeing Strategy (4,5) *	• Power to make grants (16)
	• Duty to have regard to assessments and strategies (6) *	• Establishment of pooled funds (76)
	• Ensure choice of health service provider offered and publicise/promote patient choice info (35,36) *	• Comply with NHSEI direction in respect of spending allotted monies and paying monies arising from disposals or valuations to NHSEI (83)
	• Exercise of function jointly with other ICBs, combined authorities, Local Health Boards (75,77,79) *	• Use monies designated for integration for that purpose aka Better Care Fund (84)
	• Agree arrangements for support with SoS (81) *	• Power to raise additional income, undertake fundraising, invest in companies & enter externally financed development agreements (91,92,93)
	• Power to apply to become a Care Trust (82) *	• Power to enter into agreements for furthering sustainable development of countries other than UK or improving welfare of their populations (151) *
	• Duty as to reducing inequalities (103)	
	• Duty as to patient choice (105)	
	• Duty to promote innovation and in respect or research, education & training and integration (107-110)	
	• Duty to have regard to guidance on commissioning published by NHSEI (111)	
	• CCG duty to make available facilities to university medical or dental schools for the purposes of clinical teaching and research (112) *	
	• Duty to cooperate with other NHS bodies, Local Authorities and Prison Service (114-116) *	

*** Identified in guidance as not exercisable by trust(s) under delegation**

**** Identified by local stakeholders as could be delegated to trusts***

Better Lives Lincolnshire - ICB Functions (7)

Public Involvement and Engagement

- Consultation about commissioning plan (3) *
- *Public involvement and consultation (43)* *
- Engagement with Health Overview and Scrutiny Committees (44) *
- Duty to promote involvement of each patient (104) *

Resource Allocation and Distribution

- Provides for existence of CCGs and provides that their general function is arranging for the provision of services for the purpose of the health service (7)*
- Power to (a) enter into agreements, (b) acquire and dispose of property and (c) accept gifts (9)
- Duty to arrange for provision of services or facilitate to meet the reasonable requirements of people for whom it has responsibility (10)
- Power to arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service (11)
- Performance of functions outside England (12)
- Refer a dispute concerning an NHS contract to the Secretary of State (13)
- *Provision of vehicles for disabled people (14)* *
- *Agreeing to make facilities available to providers or eligible voluntary organisations (15)* *
- *Supply of goods and services to local authorities (17)* *
- Responsibility for payment to providers (20)
- *Pay medical practitioner for examination under Part 2 of the Mental Health Act 1983 (33)* *
- *Arrangements between NHS bodies and local authorities (73)* *
- *Power to recover charges owed to an NHS body as a civil debt and any reduction/remission/payment which was not due to a person as a civil debt (89,90)* *

Functions Delegated From NHSEI

- *Exercising functions jointly with, or delegated by, NHSEI (74)* *
- Exercise of functions by, or jointly with, NHS England (78) *

*** Identified in guidance as not exercisable by trust(s) under delegation**

**** Identified by local stakeholders as could be delegated to trusts***

Better Lives Lincolnshire - ICB Functions (8)

ICB Corporate Functions	Emergency Planning	Service Delivery and Performance
• Functions of audit and remuneration committee (48) *	• Role in respect of emergency planning (45) *	• Provide documents and information to NHSEI for purposes of performance functions (70) *
• *Register of interests of conflicts of interest (49)* *	• Comply with directions from SoS in respect of an emergency (46) *	• Co-operate with NHSEI and other ICB where it is subject to performance related directions from NHSE (72) *
• Appointing persons to be employees (53) *	• Partner in local counter-terrorism (121) *	
• Annual report (54) *		
• Prepare annual accounts (55) *		
• Constitutional arrangements (58-62, 66, 67) *		
• *Provide information to NHSE & SOS, assist with fraud investigations and disclosure information related to its functions to 3rd parties (95, 96, 97, 98)* *		
• *Duty to have regard and promote the NHS Constitution (99, 117)* *		
• *Duty to exercise functions effectively, efficiently and economically (100)* *		
• *Duty to obtain appropriate advice (106)* *		
• Duties in relation to Local Audit and Accountability 2014 (132-136) *		
• Audit or examination of English NHS charity accounts (137) *		
• Duties in relation to Freedom of Information Act 2000 (152) *		

*** Identified in guidance as not exercisable by trust(s) under delegation**

**** Identified by local stakeholders as could be delegated to trusts***

Better Lives Lincolnshire - ICB Functions (9)

Quality

- Assessment and provision of NHS CHC (22) *
- Cooperate with LA on assessments of CHC eligibility (23) *
- Nominate members for Independent Review panels and implement decisions (24, 25) *
- Assess and secure provision of nursing care (26) *
- Pay for NHS funded nursing care on an urgent basis (29) *
- Duties in relation to personal health budgets (30) *
- Direct payments for health care (31) *
- *Commissioning after-care services (32)* *
- *Provide prescribed forms and pre-paid envelops in respect of notices of births (34)* *
- Duties in relation to individual funding requests (42) *
- Duties relating to Additional Learning Needs and Education Tribunal (Wales) Act 2018 (118-120) *
- Duties relating to Care Act 2014 (122-124) *
- Duties relating to Social Services and Wellbeing (Wales) 2014 (125) *
- Duty to participate in Anti-Social Behaviour Care Reviews (126) *
- Duties in relation to the Children's Act 2004, and Children & Families Act 2014 (113, 127-131) *
- Public sector equality duty (138) *
- Providing relevant services for adults with autistic spectrum disorders (139) *
- Duties relating to Education and Skills Act 2008 (140) *
- Duties relating to Childcare Act 2006, Children Act 2004, Education Act 1196 and Children Act 1989 (142-148, 159-163) *
- Duties relating to Domestic Violence, Crime & Victims Act 2004, Criminal Justice Act 2003, Crime & Disorder Act 1998, and Domestic Abuse Act 2021 (149, 150, 154-158, 158)*
- Duties relating to Disabled Persons Act 1986 (164) *

Financial / Resource Management

- Ensure organisational financial balance and comply with financial requirements set by NHSEI directions (85) *
- Comply with revenue and capital resource limits set by NHSEI (86) *
- Publish details of how it has spent a quality payment from NHSEI (87)
- Comply with restrictions on use of support monies and other support resources provided by NHSEI under this section (88)

*** Identified in guidance as not exercisable by trust(s) under delegation**

**** Identified by local stakeholders as could be delegated to trusts***

Better Lives Lincolnshire - ICB Functions (10)

Service Delivery, Redesign and Transformation	People and Culture	Digital and Data
• *Measures to secure the continued provision of commissioner requested services (21)* *	• *N/A*	• *N/A*
• *Make arrangements for appointment with specialist for patients urgently referred with suspected cancer (39)* *		
• *Duty to offer alternative provider for treatment for suspected cancer (40)* *		
• *Arrangements with SoS in respect of the exercise of public health functions (80)* *		
• *Duties relating to provision of MH services under the Mental Health Act 1983 (165-167)* *		
• *Meet maximum waiting times standard and offer assistance re waiting times (37, 41)* *		

* **Identified in guidance as not exercisable by trust(s) under delegation**

* ***Identified by local stakeholders as could be delegated to trusts***

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Cllr Sue Woolley, Chair, Lincolnshire Health and Wellbeing Board and John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Integrated Care Partnership**

Summary:
This report provides a summary on the recent guidance issued by the Department of Health and Social Care (DHSC) and the Local Government Association (LGA) on Integrated Care Partnerships (ICPs). Along with Integrated Care Boards (ICBs), an ICP will be statutory element of Integrated Care Systems (ICSs).

Actions Required:
To note the current position in relation to the development of ICPs.

1. Background

1.1 Context

In September 2021, the DHSC issued a series of guidance documents to support the implementation of Integrated Care Systems, including Integrated Care Partnership (ICP) Engagement Document: Integrated Care System (ICS) Implementation. This document focuses on the role of the ICP within the statutory arrangements for the ICS. It sets out the key areas for consideration by the local stakeholders responsible for establishing ICPs from April 2022. Elements of the document are subject to change until the Health and Care Bill passes Parliament and receives Royal Assent. A summary of the ICP guidance is provided in Appendix A.

The guidance builds on the principles for ICPs set out in the NHSE's ICS Design Framework (published on 16 June 2021) and should be read alongside wider ICS guidance on the establishment of the Integrated Care Board. The establishment in law of an integrated NHS and local authority model for ICSs places ICPs on a statutory footing and aims to build on exiting partnership arrangements across the system. As a statutory committee of the ICS, ICPs will:

- be required to be established in every system;

- have a minimum membership required in law; and
- be tasked with producing an integrated care strategy for their area.

The expectation is that ICPs will play a critical role in ICSs, facilitating joint action to improve health and care outcomes and influencing the wider determinants of health. It will act as a forum to enhance relationships between the leaders across the health and care system with wider statutory and non-statutory stakeholders. The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:

- helping people live more independent, healthier lives for longer;
- taking a holistic view of people's interactions with services across the system and the different pathways within it;
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services;
- improving the wider social determinants that drive these inequalities, including employment, housing, education, environment and reducing offending; and
- improving the life chances.

ICPs will also be expected to enable partners to plan for the future and develop strategies to enable the use of available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector or organisation alone. These strategies should reflect the priorities of all partners with a particular focus on the wider determinants of health.

1.2 Timings and Establishment of ICPs

As the ICP is a core element of the statutory arrangements for the ICS it cannot fully function without an ICP being in place. Therefore, subject to the passage of the legislation, each ICS is expected to have at least an interim ICP in place for April 2022. In practical terms, the ICP will be established jointly by the ICB and local authority, so the guidance recognises that the ICP may not be formally established until the ICB designated chair and Chief Executive are in place. Therefore, as a minimum, the following arrangements need to be in place for April 2022:

- ICP chair appointed – the guidance does not set any national expectations for the appointment or remuneration of the ICP chair beyond stating that this should be a fair and transparent process adhering to the normal expectations of appointing public positions and agreed by the ICB and local authority
- a committee of at least statutory members (i.e., the ICB and local authority)
- an agreement between the ICB and local authority on how the ICP will be resourced and supported

From April 2022 the following is needed:

- Sub committees and governance structures confirmed and linkages with other governance structures formalised.
- Agreement on the wider membership of the ICP – the expectation is that full membership will be agreed and the ICP will be fully operational by September 2022.
- Agreement on how the Integrated Care Strategy will be developed and approved - this includes deciding if the existing Joint Health and Wellbeing Strategy (JHWS) fulfils the requirements for an Integrated Care Strategy.

- Work to develop, refine and formally agree the strategy will need to start in earnest from April 2022. The process will need to involve significant engagement and take account of the Joint Strategic Needs Assessment (JSNA).

1.3 Relationship between the ICP and HWB

The requirement for the Health and Wellbeing Board remains at an upper tier level to bring together NHS, local authorities, and wider partners to develop a JSNA and JHWS for their local population. The guidance emphasises the importance of HWBs at a place level whilst, on the other hand, the ICP is designed to support partnerships and integrated working across places at a system level. The guidance refers to the relationship between the ICP and HWB differing from place to place depending on the scope and maturity of partnership working. The emphasis in the guidance assumes that an ICS area contains more than one HWB. Obviously, this is not the situation in Lincolnshire, as the ICS area is coterminous with the HWB.

The guidance makes it clear that the HWB can not act as an ICP, but reference is made to considering how existing arrangements, such as the HWB, provides an opportunity to build greater alignment between different partners and communities and to ensure effective joined up decision making. For example, by agreeing common membership for the ICP and the HWB and streamlining arrangements for holding meetings to allow different sets of business to proceed in a more coordinated way.

1.4 Next Steps

Planning for the Lincolnshire ICS is being progressed by the NHS Senior Leaders Board (SLB) in conjunction with the Better Lives Lincolnshire Executive Team (BLLET). As discussed in the previous agenda item, planning for the implementation of the ICB is already well under way and are now at a stage for discussions to start on the development of the ICP. The local desire is to keep the governance arrangements as simple as possible and to ensure they work for Lincolnshire. Therefore, to ensure Lincolnshire can meet the minimum requirements for an ICP by April 2022, engagement with partners will need to take place in earnest between now and February 2022 to progress the development of the ICP. Potential areas for consideration include:

- How do we structure the ICP/HWB governance?
- How will the arrangements be resourced and supported, including who will provide secretarial support?
- What is the overlap of membership between the HWB and ICP?
- What is the process for electing the ICP chair?
- Is the current JHWS fit for purpose to meet the needs for an Integrated Care Strategy – if not, what arrangements need putting in place to develop an Integrated Care Strategy during 2022?

Formal proposals, including the ICP terms of reference and governance arrangements will be presented to the HWB at the meeting in March 2022.

2. Conclusion

Subject to the legislation completing its progress through Parliament, ICS will become statutory from April 2022. Alongside the establishment of the ICB, Lincolnshire will also be required, as a minimum, to have an interim ICP in place by this date. The ICP needs to be fully established by September 2022.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Both the ICB and ICP will be required to take account of the JHWS and JSNA in developing their plans.

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Integrated care partnership (ICP) – initial expectations for the role of ICPs within Integrated Care Systems

6. Background Papers

Document	Where this can be accessed
Integrated Care Systems: Design Framework (June 2021)	https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
Integrated Care Partnership (ICP) engagement document: Integrated Care System (ICS) implementation (September 2021)	https://www.gov.uk/government/publications/integrated-care-partnership-icp-engagement-document/integrated-care-partnership-icp-engagement-document-integrated-care-system-ics-implementation

This report was written by Alison Christie, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

APPENDIX A

INTEGRATED CARE PARTNERSHIP (ICP) – initial expectations for the role of ICPs within Integrated Care Systems

1. Principles of ICPs

The ICP will work, foremost, on the principle of a statutorily equal partnership between the NHS and local government to work with and for their partners and communities. The focus of the ICP will be on building shared purpose and common aspiration across the whole system. The guidance invites local systems to consider the following 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working through difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.
5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives and reduce health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the Triple Aim (better health for everyone; better care for all and efficient use of resources); the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

2. Opportunities for ICPs

The government's guidance is not prescriptive as ICPs will be a dynamic element of the ICS and will need to build on the assets that already exist in the community and wider system. The creation of ICPs is expected to present the opportunity to:

- build on existing governance structures such as Health and Wellbeing Boards, and support newly forming structures to ensure governance and decision making are proportionate, support subsidiarity and avoid duplication across the ICS;
- drive and enhance integrated approaches and collaborative behaviours at every level of the system;
- foster, structure and promote an ethos of partnership and co-production, working in partnership with communities and organisations within them;
- address health challenges that the health and care system cannot address alone such as tackling health inequalities and the underlying social determinants that drive poor health outcomes;
- continue working with multiagency partners to safeguard people's rights and ensure people are free from abuse or neglect and not deprived of their liberty; and
- develop strategies that are focused on addressing the needs and preferences of the population including specific cohorts such as babies, children and young people, or ageing populations.

3. Mandatory requirements for ICPs

The ICP will be a statutory committee of the ICS, not a statutory body, and as such its members come together to take decisions on an integrated care strategy, but it does not take on the functions from other parts of the system. DHSC has chosen to minimise the level of prescription around ICPs in the primary legislation allowing local flexibility on the structure and operation of the ICP. However, the 5 guiding expectations set out in the NHSEI ICS Design Framework for ICPS are:

a) ICPs are a core part of ICSs, driving their direction and priorities - to create the dynamic relationship and collaborative leaderships between the ICB and ICP the guidance expects:

- ICBs and LAs will establish the ICP and be statutory members, in partnership with wider system stakeholders
- ICSs will ensure the constitution and governance of the ICB and ICP is aligned, and agreed by local government and other partners
- Partners responsible for delivering the priorities of the ICP's Integrated Care Strategy will also be members of the ICP and therefore able to hold each other to account
- ICBs and LAs will have regard for the ICP's Integrated Care Strategy when developing their plans and priorities and should consider how assurance can be provided to the ICP on delivery
- ICBs, LAs and other partners should share intelligence with the ICP in a timely manner to ensure the evolving needs of the local health service are widely understood and opportunities for at scale collaboration are maximised
- Leadership and accountability are important in the relationship between the ICB and ICP. Some ICSs may choose to appoint a single chair of the ICB and ICP whilst others may choose to have 2 chairs. The model is for local determination.

b) ICPs will be rooted in the needs of people, communities and places – to help places continue to improve outcomes, ICPs should build on work already done at place level and encourage decisions to be taken as close as possible to the communities and people they affect. The Bill builds on the important role for HWBs at place level, which will remain legally distinct from ICPs. Both the ICB and ICP will be required to take account of the JHWS and JSNA in developing their plans. Membership and system roles of the HWB and ICP is flexible to best suit local circumstances. As a minimum the guidance expects ICPs to have:

- input from Directors of Public Health and other clinical/professional experts to ensure a strong understanding of local needs
- input from representatives of adult and children's social services. Input from local social care providers will also be needed
- relevant representation from other local experts, through HWB chairs, primary and community care representatives and other professional leads
- appropriate representation from any providers of health, care and related services
- appropriate representation from the VCSE sector and from people with lived experiences of accessing health and social care services
- a representative from Healthwatch to bring senior level expertise in how to do engagement and to provide scrutiny.

It is not a requirement for all of the above stakeholders to be 'members' of the ICP committee. The key is that opportunities for co-production and expert input into ICP strategies are available, this could be through sub committees or dedicated public meetings.

c) ICPs create a space to develop and oversee strategies to improve health and care outcomes – ICPs will set priorities for improving system wide health and care outcomes, while also championing the principle of subsidiarity and empowering local decision making. The ICP and place based partners will need a mechanism to determine which issues are dealt with where and be informed by local population wants and needs, and specific communities identified through population health management data.

d) ICPs will support integrated approaches and subsidiarity – the ICP will be in a position to identify opportunities for wider partnerships to strengthen the collective approach to improving longer term health and wellbeing outcomes. The ICP is expected to actively champion integrated approaches and look for opportunities to embed and accelerate joined up strategies.

ICPs will set the strategic direction and workplan for organisation, financial, clinical and informational integration. For example:

- shared vision and purpose
- integrated provision – so that people receive seamless care across health, social care, housing, education and other public services and between different NHS providers
- integrated records – for example using shared electronic care records
- integrated strategic plans – for example, bringing NHS and public health experts together to make a joint plan for improving health outcomes
- integrated commissioning of services – strengthening the partnership between LAs and the ICB
- integrated budgets – for example using Section 75 arrangements to manage or support pooled budgets across the NHS and LAs
- integrated data sets – which all partners can contribute and have access to in order to inform planning and the delivery of services

It will be up to ICPs to work with HWBs and other place-based partnerships to determine the integrated approach that will best deliver holistic and streamlined care. Further guidance on the duty to co-operate will be issued at a later date to support ICPs and the wider system in meeting this expectation.

4. NEXT STEPS

ICSs are being asked to take forward the following five steps in partnership with local government:

i. Recognise that it is for the NHS and LAs – as the statutory partners in each ICS – to start the process jointly of creating an ICP in preparation for legislation
ii. Reach agreement between NHS and LA leaders as to how the ICP will be established and a secretariat resourced, at least during the 2021/22 transition year
iii. Ensure that the statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders
iv. Appoint an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent and jointly supported decision-making process
v. Determine key questions to be resolved for that particular system but not limited to the following:
    - What kind of chair would best galvanise the system behind its common aims and what is the process for appointment?
    - Who might constitute an ICP committee that might galvanise the ICS and how should those individuals be chosen?
    - What would be required to deliver an inclusive approach to engagement, in terms of methods, resourcing and public reporting?
    - To what extent can existing structures be used or adapted to create the ICP so as to build on what happens already?
    - To what extent do existing ICS plans meet the requirement for a health and care strategy and how might they be refreshed?
    - How might the ICP meet the ten principles set out in Section 1 of this Appendix?

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Active Lincolnshire.

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Let's Move Lincolnshire**

Summary:

Let's Move Lincolnshire (LML) is the countywide vision for a more physically active county and forms the physical activity strand of the Joint Health and Wellbeing Strategy. The initial blueprint was launched in 2018. Due to the impact of the pandemic, the new 'Uniting the Movement' ten-year national vision for a more active nation and the emerging Integrated Care System (ICS) priorities around population health, the LML strategy is being reviewed and refreshed to ensure it is fit for purpose and there is a shared vision that is enabling, activating and aims to make communities stronger.

Alongside the strategy refresh, a resident facing website is being developed that will showcase and signpost to all options to be active; groups, sessions, outdoor spaces and clubs across the county.

Actions Required:

- For the Health and Wellbeing Board to review the presentation, consider the most efficient method of collaboration with the board into the LML strategy development process between now and March.
- For the board to consider how system partners can support embedding the strategy and vision into the ICS and work of health care system partners.

1. Background

The presentation in Appendix A will be presented to the Health and Wellbeing Board at the meeting. It provides an overview on:

- How active is Lincolnshire?
- Uniting the Movement – Sport England's ten-year vision to transform lives and communities through physical activity.

- Let's Move Lincolnshire – the whole system approach to creating a more active county

2. Conclusion

Let's Move Lincolnshire is the countywide vision for a more physically active county and forms the physical activity strand of the Joint Health and Wellbeing Strategy. This report provides on the review of the Let's Move Lincolnshire Strategy to ensure it remains fit for purpose.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Evidence from the Joint Strategic Needs Assessment is used to inform the Physical Activity priority in the Joint Health and Wellbeing Strategy.

4. Consultation

This is the first phase of a collaborative consultation process being led by Active Lincolnshire and the University of Lincoln that is intended to reach over 100 stakeholders plus Lincolnshire residents.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Uniting the Movement in Lincolnshire

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Emma Tatlow, who can be contacted on emma.tatlow@activelincolnshire.com

UNITING THE MOVEMENT IN LINCOLNSHIRE

HEALTH AND WELLBEING BOARD - NOVEMBER 2021

#EveryMoveCounts

CONTENTS

01. ACTIVE LINCOLNSHIRE

A charity funded by Sport England to deliver the Uniting the Movement strategy locally.

Our role is to influence and enable system partners to build physical activity back into every day lives.

Underpinned by inequalities, inclusivity and accessibility.

OUR PURPOSE

- Providing positive experiences and accessible opportunities for everyone to be active at every stage of life
- Championing and advocating for the positive power that physical activity and sport has on our lives and our communities
- Addressing social and health inequalities through the provision of relevant physical activity
- Ensuring everyone understands and recognises that movement matters
- Driving and influencing change to embed physical activity in policies, strategies, decisions and education

HOW ACTIVE IS LINCOLNSHIRE?

INACTIVE	*Less than 30 mins/week*	30.2%
FAIRLY ACTIVE	*30-149 mins/week*	11.8%
ACTIVE	*150+ mins/week*	58%

% age of the Lincolnshire population.

190,000

INACTIVE people in Lincolnshire (Moving less than 30 minutes a week)

1 in 6 of this group are doing nothing at all

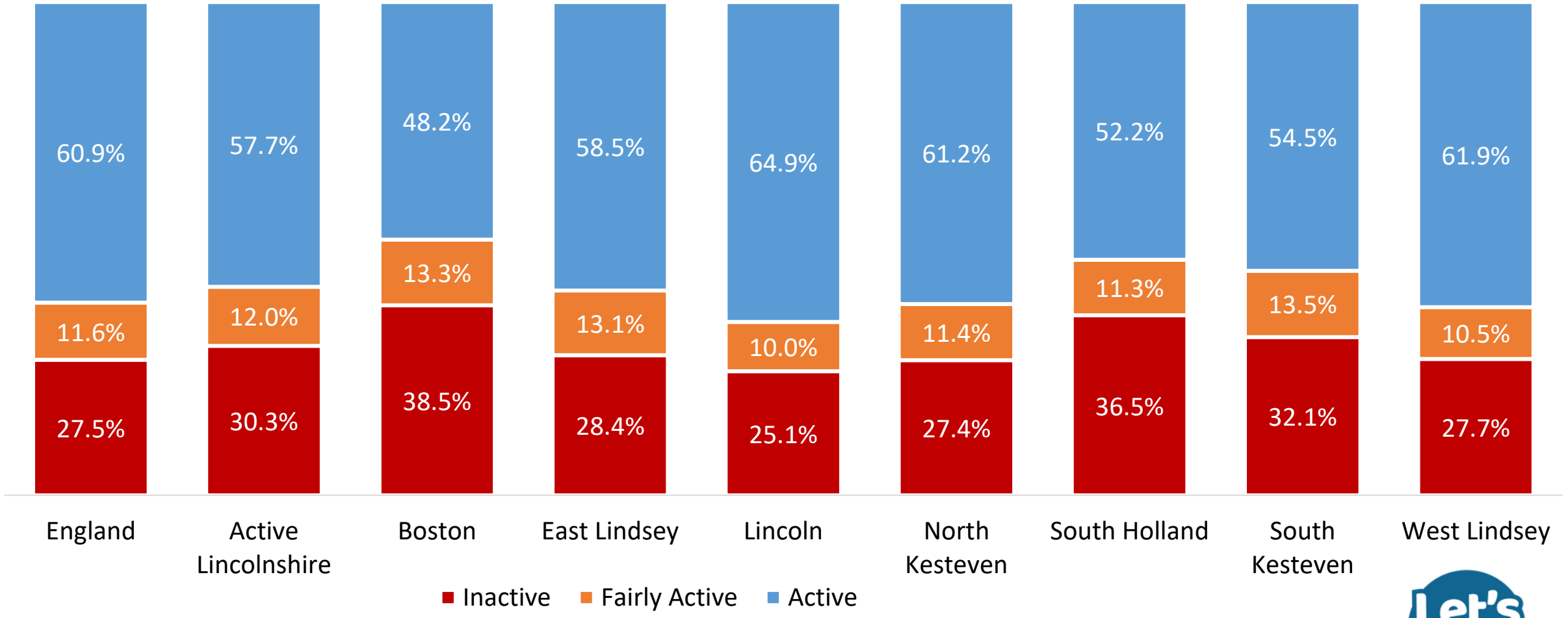
30.2%

That's nearly a third of the whole adult population

50.1%

Of people with a limiting illness or disability are INACTIVE

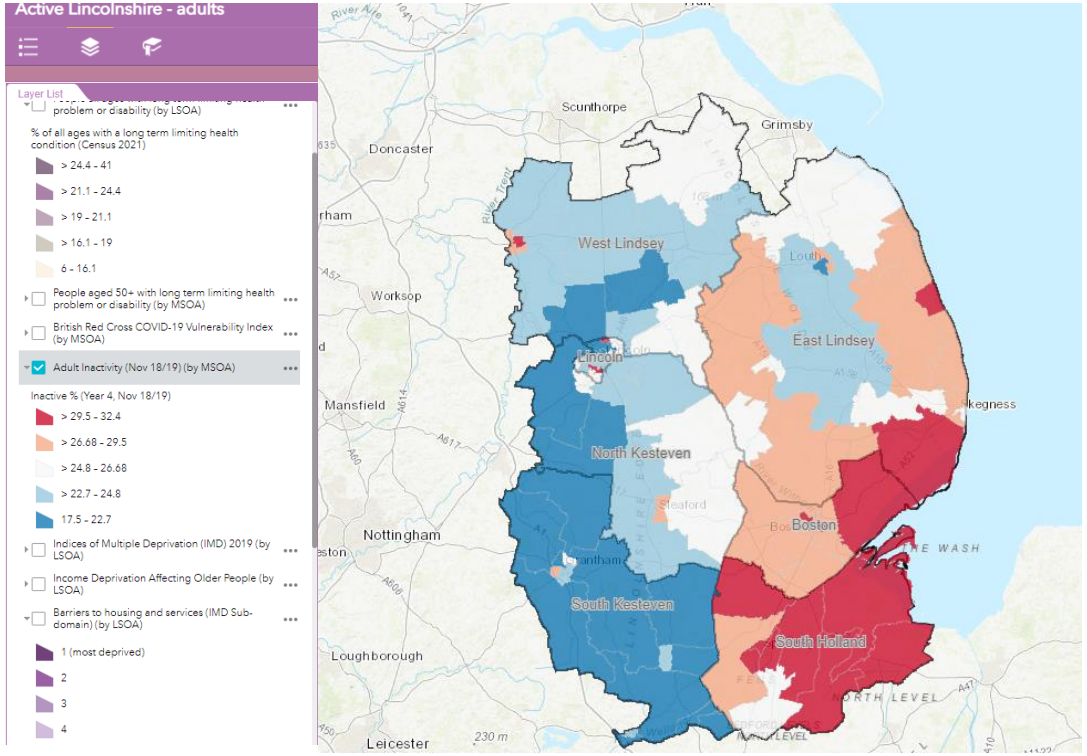
ACTIVITY LEVELS OF WHOLE POPULATION – MAY 2020 – MAY 21



ACTIVITY LEVELS ADULTS

- Larger proportion of older people
- Inactivity levels increasing among the over 55's
- More people with limiting illness
- More people from lower socio economic groups
- Less people from ethnic minority groups

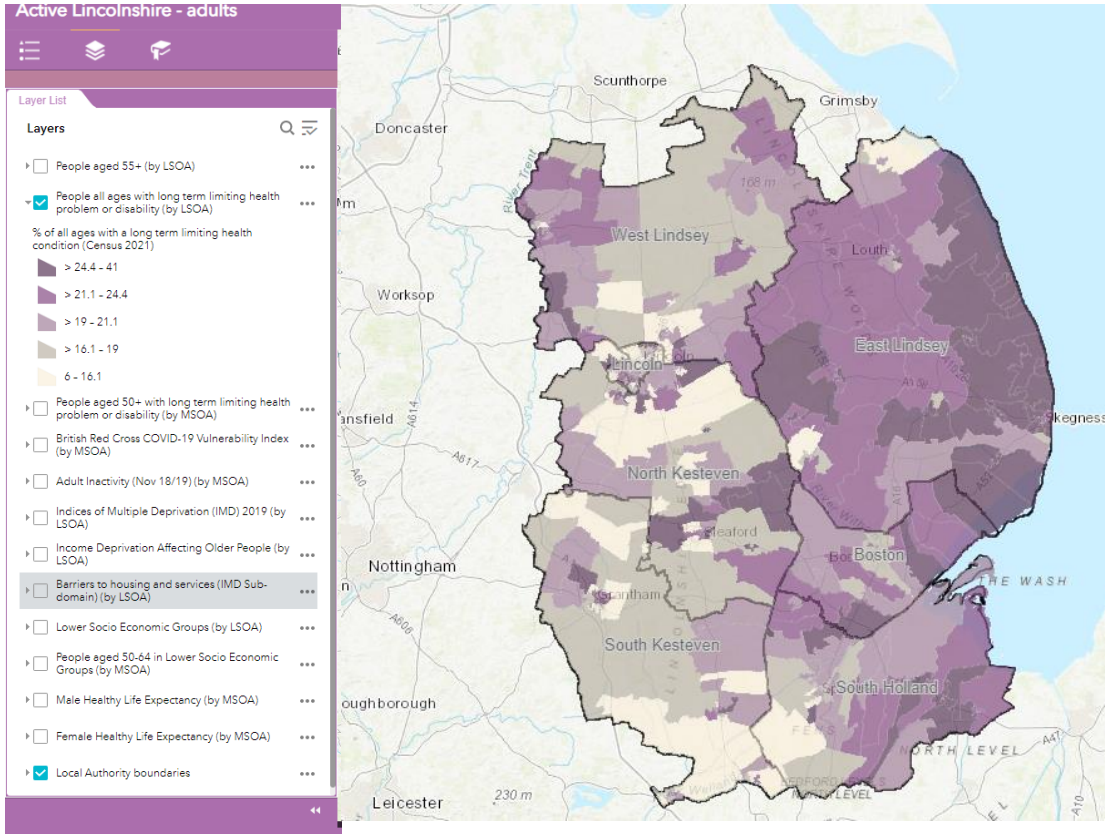
DATA: [Source Sport England Active Lives survey – Adult inactivity levels] ***Click on map to see digital version.***



ACTIVITY LEVELS & HEALTH CONDITIONS

- 50% of people with limiting illness or disability are inactive (compared to 23% of those without)
- Proportion of people reporting long term health conditions in Lincolnshire is higher than national average (for long term pain, chronic conditions, mobility, dexterity, mental health).

DATA: [%age of all ages with long term limiting health condition or disability] ***Click on map to see digital version.***



ACTIVITY LEVELS CHILDREN

- Only half of our children are doing enough activity to benefit their health and development
- Children from low family affluence are less likely to be active
- Girls (all ages) are less active than boys
- Enjoyment and understanding of PA positively impacts activity levels

DATA: Children & Young People Activity levels

48.9%
Active – 60+ mins / day

25.2%
Fairly Active – 30-59 mins / day

25.9%
Less Active – less than 30 mins / day

ACTIVITY, HEALTH & WELLBEING

TACKLING INEQUALITIES

£240,000 additional SE Funding to AL

58 projects funded across Lincs

54 of those supported people with a long term health condition and / or people with a disability

Delivered by 17 organisations.

SOME OF THE FUNDED PROGRAMMES:

Lincolnshire CVS – Seated exercise and Tai Chi for People with **COPD**

Louth & District archery club – soft archery for People with **Learning Disabilities** and complex needs

Mental Health Runner – Supporting 45 out- patients of **mental health** services within Lincoln through running

Stepping Stones Theatre - weekly walking programme for **mental health** support group in Gainsborough; installed a 'Buddy bench' encouraging walk & pause to talk.

Lincoln City Foundation & Macmillan 'Fighting Fit' **cancer** programme.

Tonic Health – 'Movement 4 memory' seated exercise to the **dementia** café. 32 sessions recorded also shared on YouTube

02

UNITING THE MOVEMENT

SPORT ENGLAND TEN YEAR VISION TO TRANSFORM LIVES AND COMMUNITIES THROUGH PHYSICAL ACTIVITY

#EveryMoveCounts

1. RECOVER & REINVENT

Recovering from the biggest crisis in a generation and reinventing as a vibrant, relevant and sustainable network of organisations providing sport and physical activity opportunities that meet the needs of different people.

2. CONNECTING WITH HEALTH & WELLBEING

Strengthening the connections between sport, physical activity, health and wellbeing, so more people can feel the benefits of, and advocate for, an active life.

3. CONNECTING COMMUNITIES

Focusing on sport and physical activity's ability to make better places to live and bring people together.

4. ACTIVE ENVIRONMENTS

Creating and protecting the places and spaces that make it easier for people to be active

5. POSITIVE EXPERIENCES FOR CHILDREN AND YOUNG PEOPLE

Creating and protecting the places and spaces that make it easier for people to be active

UNITING THE MOVEMENT
5 BIG ISSUES

2. CONNECTING WITH HEALTH & WELLBEING – AMBITION

‘We want sport and physical activity to be at the heart of how we all think about the nation’s - and our own - health and wellbeing. But we can only do this if we effectively respond to changing demographics, trends in health and the things that can make it even harder to be active for people with poorer health – for example, limited inclusive or accessible opportunities to get active.

It shouldn’t matter that you’re 35 or 65, live with two health conditions or are in perfect health – the right range of opportunities, experiences and support should be available and for everyone.
We must also recognise when people with more challenging health needs may need extra support or new and different ways to take part.

If we do this right, we can stop health problems arising in the first place and help people to age well. We could also then support people to manage problems when they do arise and be active for as long as possible.

We also want to harness the collective power of all the organisations focused on health outcomes. If health is everyone’s business, then so is sport and physical activity.

The opportunity and ambition here is big and success could be things like physical activity in care homes becoming a priority, physical activity being embedded in mental health policy and services for children, physical activity advice being included in the every day conversations of front-line NHS staff, or products that help people monitor their own health becoming more widely available.

We also want to strengthen the connection and collaboration between sport and physical activity and the health system at every level, so more people are recommended or referred into activity. This journey should be easy, personalised and supported, to increase that individual’s likelihood of becoming and staying active.
These changes could impact greatly on participation and health and play a role in prevention, tackling inequalities and mitigating the impact of Covid-19.

UNITING THE MOVEMENT
HEALTH & WELLBEING

Our work to support Healthcare Professionals

Moving Healthcare Professionals Programme in partnership with OHID

- **Physical Activity Clinical Champion training** – 32,000 Healthcare Professionals now trained
- Moving Medicine launched a module on **Parkinson's** and **Hospital Deconditioning. Peri-operative Ca** recently **re** module will be launched shortly.
- OHID are currently analysing the feedback from a recent **Roundtable on Physical Activity in HCP Undergraduate Training** to determine opportunities and approaches to embed Physical Activity into the undergraduate curriculum
- The **Active Hospitals** Community of practice launched on the 8th of September with 16 hospitals represented. Contact safeera.ahmed1@nhs.net to join the Community of Practice

03

LET'S MOVE LINCOLNSHIRE

WHOLE SYSTEM APPROACH TO CREATING A MORE ACTIVE COUNTY

#EveryMoveCounts

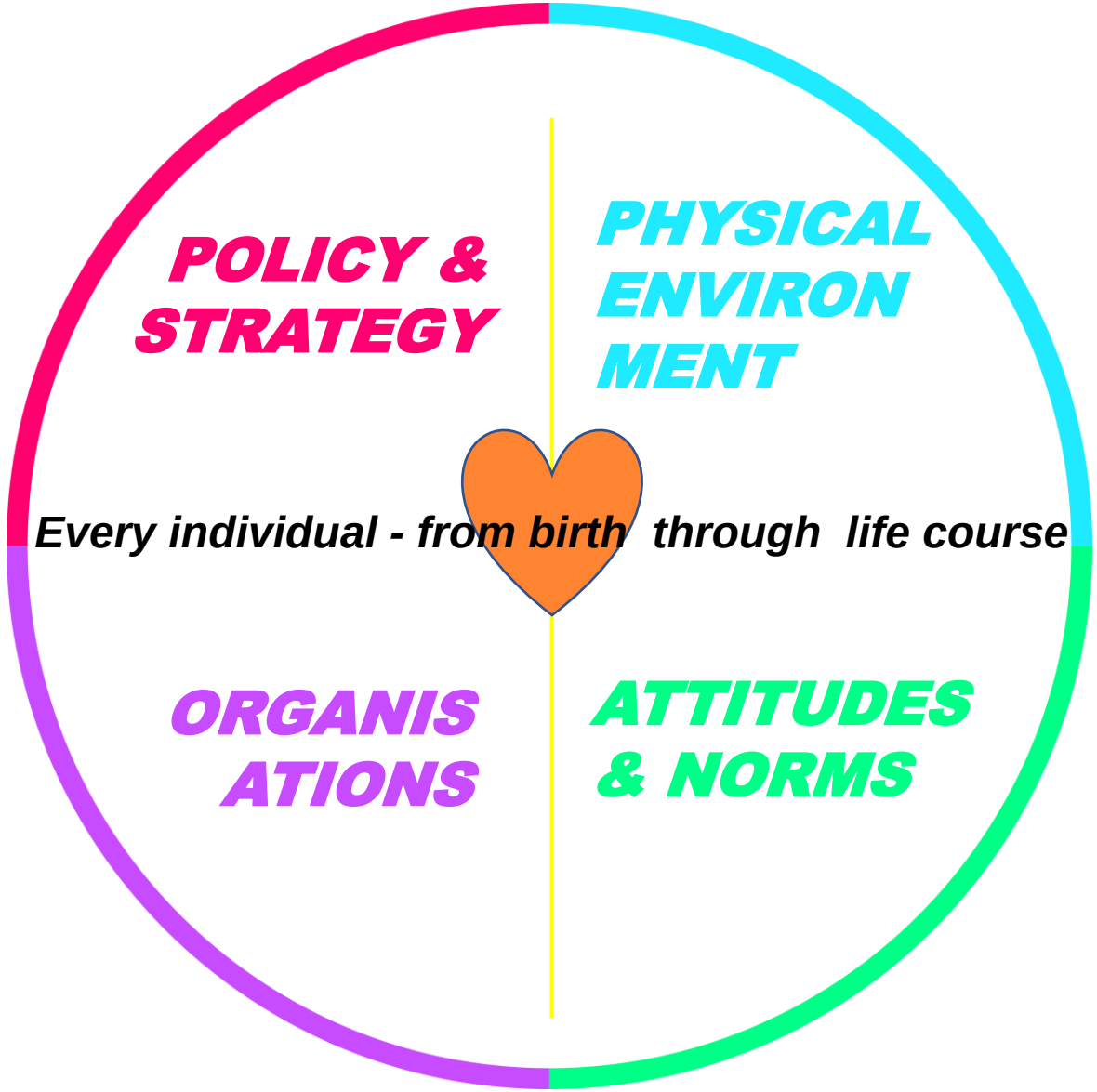
A WHOLE SYSTEM APPROACH

POLICY & STRATEGY

- Planning, highways, infrastructure
- Statutory bodies, funding
- ICS / Health care system
- Levelling up / inclusive growth
- Skills and employability
- Accessibility & inclusion

ORGANISATIONS

- Connecting people to options to be active
- Relevant sport, club and activity provision
- Schools, workplaces, community and voluntary sector
- Healthcare system partners



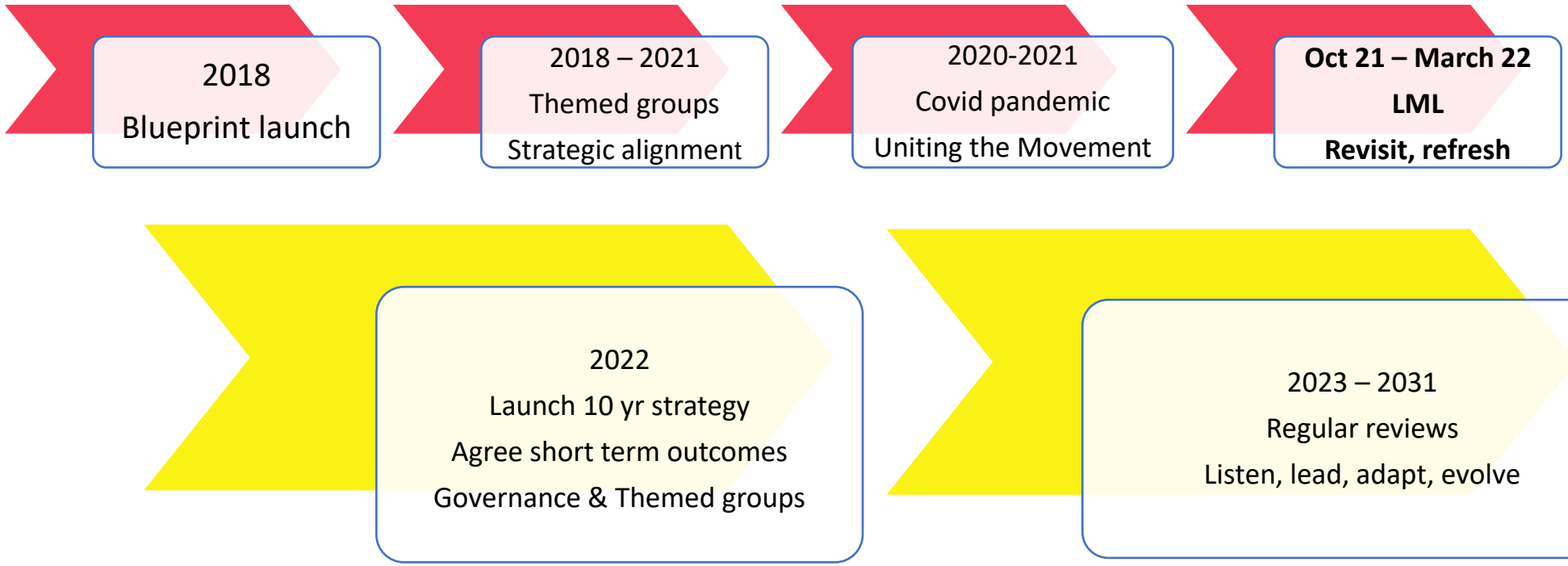
PHYSICAL ENVIRONMENT

- Access to blue & green spaces, natural environment
- Access to walking & cycling
- Safe places and spaces
- Accessible options to be active
- Cultural, heritage

ATTITIDUES & NORMS

- Being active is enjoyable part of everyday life
- Support, endorse, champion moving more
- ‘People like me’; permission to change behaviours
- Supported through life

LET'S MOVE LINCOLNSHIRE – TIMELINE



Vision To improve people's lives through habitual physical activity

Mission Everyone in Lincolnshire is leading a physically active life, regardless of age, wealth, gender, ability or circumstance

Goals

Active Society	Active Place	Active People	Active Systems
Enhancing understanding of, and appreciation for, the many benefits of regular physical activity, according to ability and at all ages	Creating environments for people, of all ages, to have equitable access to safe places and spaces, in which to take part in regular physical activity	Providing opportunities and programmes, across many settings, to help all people and communities to take part in regular physical activity	Creating the leadership, governance & partnerships, plus workforce capabilities across sectors to use resources in a more coordinated way to reduce sedentary behaviour

Intended outcome Lincolnshire will become the most active county in England where physical activity is part of everyday life

Benefits of physical activity

Physical wellbeing	Mental wellbeing	Social & community development	Individual development	Economic development

Let's move LINCOLNSHIRE

VERSION 1 - LML BLUEPRINT LAUNCHED IN 2018

A SHARED VISION

How do we respond to Uniting the Movement locally?

How we give a voice to and understand communities and people's lived experience?

How we engage with the people we want to support to be more active?

How can we all use physical activity to contribute to a happier, healthy, more prosperous society?

HOW?

Listen, learn understand; what worked in LML? What didn't.

Evidence led

Focus on inequalities

Do with and not to

Collaborate & co-create

Innovate

Evaluate, evolve

Communicate

Harness digital

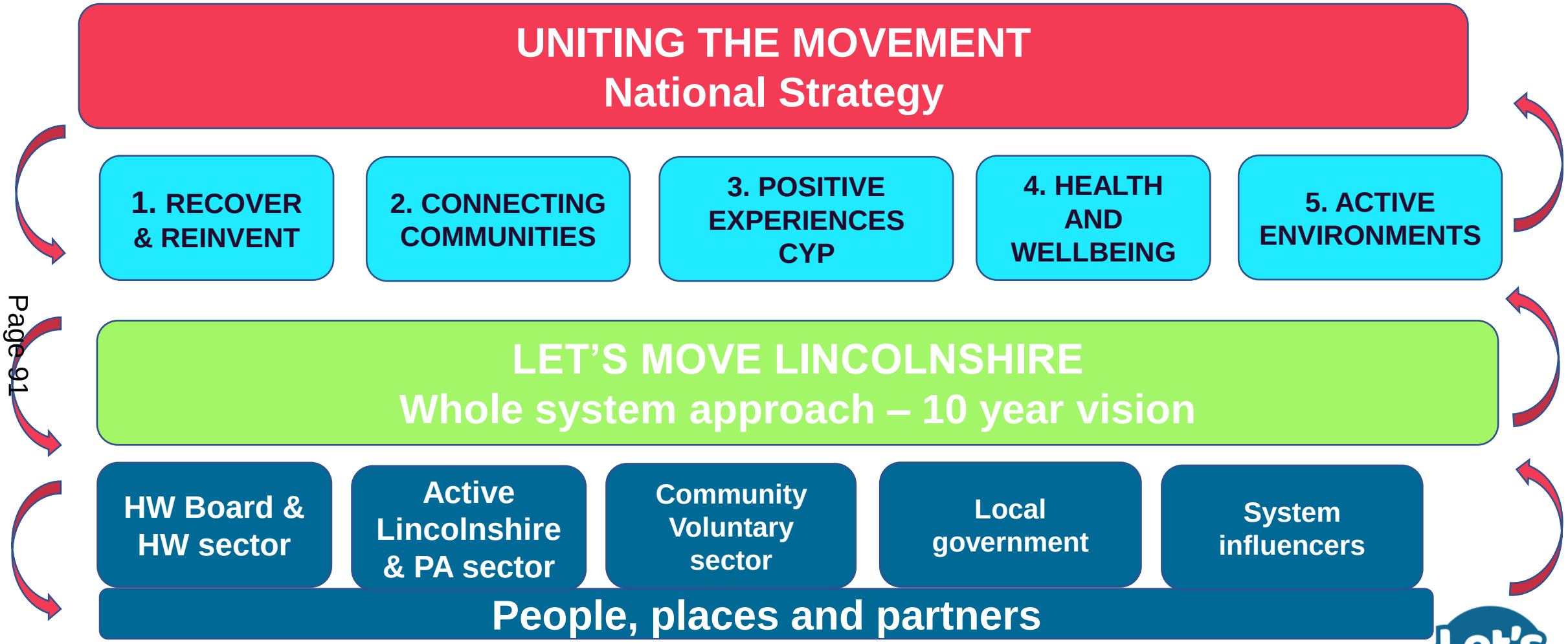
Monitor impact

WHY?

To bring about long term transformational change; to people, places and systems

Enabling, activating & making communities stronger

To be relevant to local need


UNITING THE MOVEMENT
National Strategy
1. RECOVER & REINVENT
2. CONNECTING COMMUNITIES
3. POSITIVE EXPERIENCES CYP
4. HEALTH AND WELLBEING
5. ACTIVE ENVIRONMENTS
LET'S MOVE LINCOLNSHIRE
Whole system approach – 10 year vision
HW Board & HW sector
Active Lincolnshire & PA sector
Community Voluntary sector
Local government
System influencers
People, places and partners

AWARENESS AND COMMS

- Inspiring content to encourage people to move more
- Trusted good quality source of information
- Developed with people of Lincolnshire

WHY?

To provide a rich resource of information – often hard otherwise to find

Showcase the wide range and breadth of activities on offer

Change perceptions – its not all about sport

Show ‘people like me’

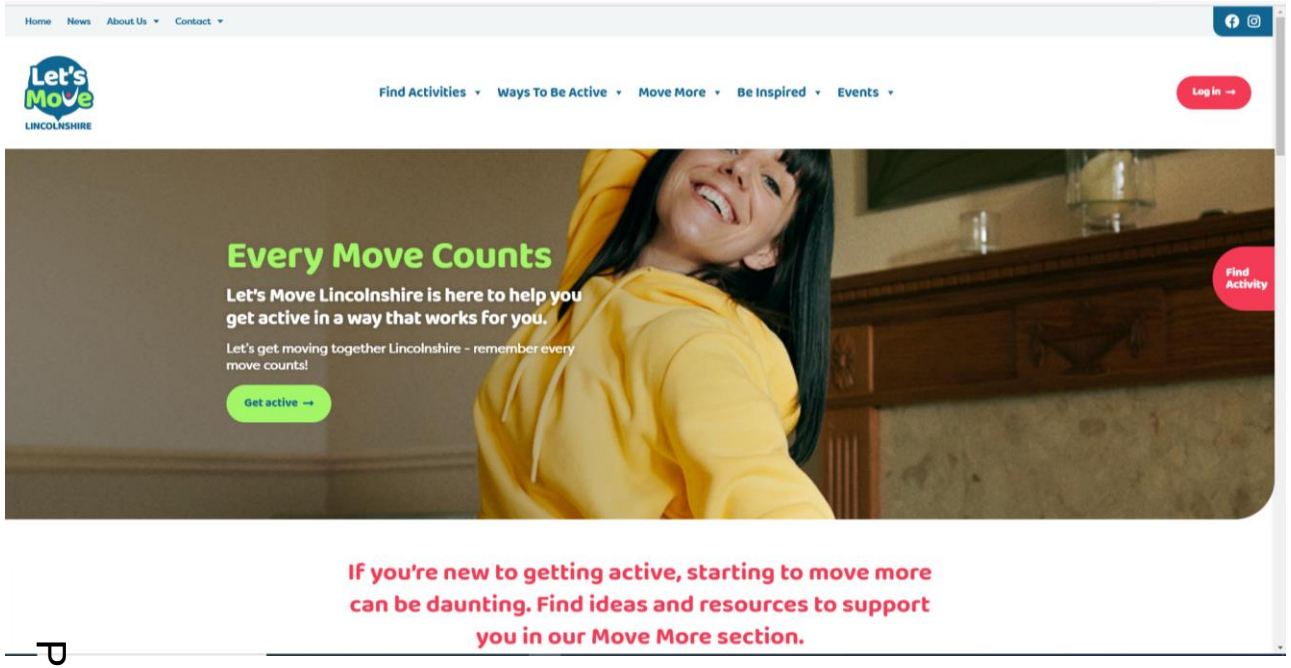
Showcase Lincolnshire’s assets

HOW?

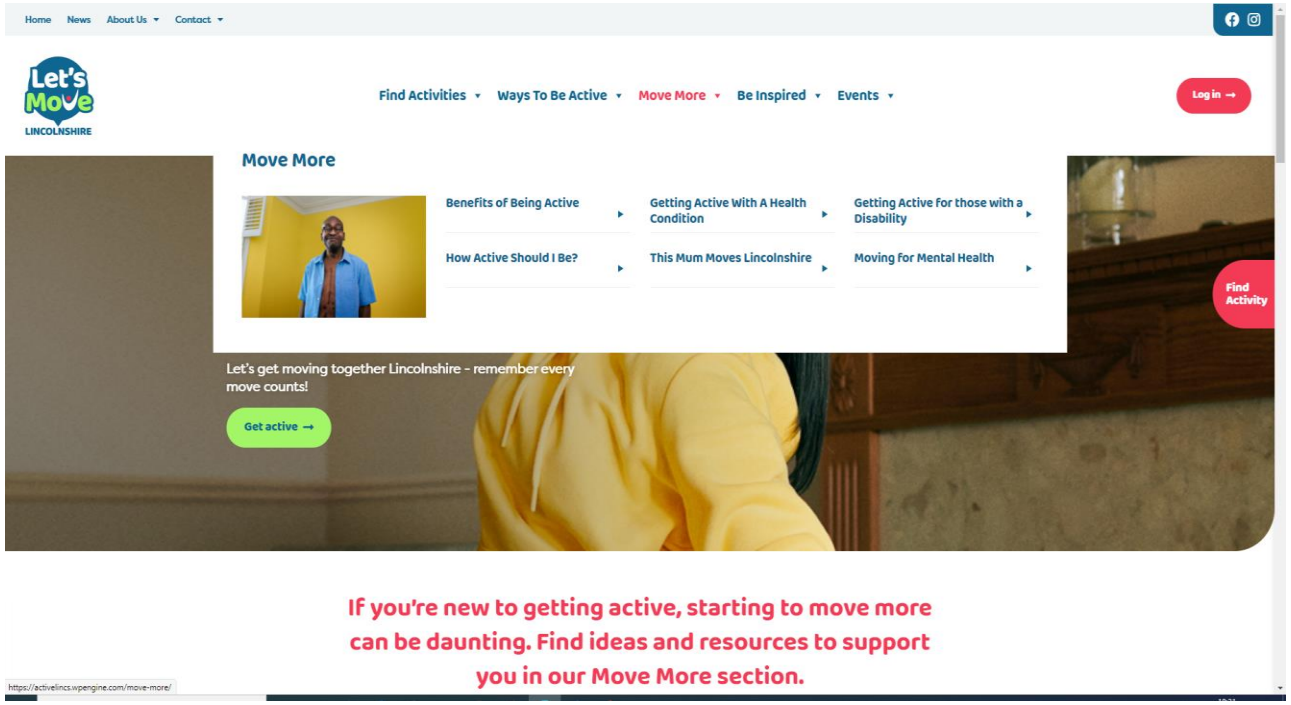
LetsMoveLincolnshire website

Using ‘open data’

Shareable via third party platforms



If you're new to getting active, starting to move more can be daunting. Find ideas and resources to support you in our Move More section.



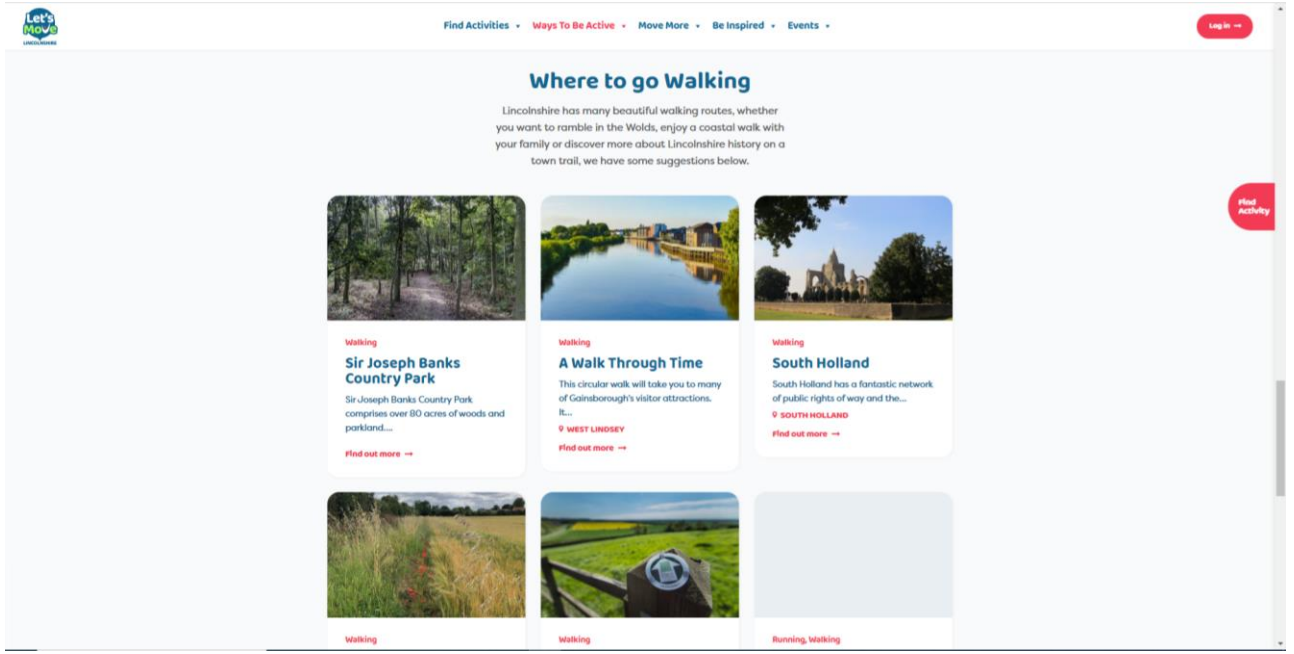
If you're new to getting active, starting to move more can be daunting. Find ideas and resources to support you in our Move More section.

COLLABORATION NEXT STEPS

HWB: Engagement on strategy development

Agreement for future monitoring / evaluation / learning and evolution of strategy

Sharing and awareness of website



Thank you

Emma.tatlow@activelincolnshire.com

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Cllr Sue Woolley, Chair, Lincolnshire Health and Wellbeing Board

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Spending Review 2021 and Autumn Budget**

Summary:

On 27 September 2021 the Chancellor of the Exchequer delivered the Spending Review (SR21) and Autumn Budget. This paper summarises the key and announcements and what they mean for the health and care system.

Actions Required:
This report is for noting.

1. Background

On 27 October 2021 the Chancellor of the Exchequer delivered the Spending Review (SR21) and Autumn Budget. The latter sets out the Government's taxation and public expenditure plans for the year ahead, and SR21 confirmed resource and capital budgets for the three years 2022-23 to 2024-25. Further details may also emerge as a result of the Local Government Finance Settlement in December.

1.1 Key Headlines

- Core spending power will increase by £8.5bn (3% per annum in real terms) by 2024/25.
- The council tax referendum limit is to remain at 2% and the Adult Social Care (ASC) Precept at 1% per annum.
- The Local Government Departmental Expenditure Limit (LG DEL) will increase by £3.6bn by 2024/25 – 30% in real terms. This includes £1.5bn per annum of new grant funding (the distribution will be confirmed at the Local Government Settlement in December).
- There will be no separate compensation for Covid-19 tax losses relating to 2021/22.

- A cumulative £3.6bn for Adult Social Care (ASC) reform will be routed through local authorities within the LG DEL (the remaining £1.7m will support social care and come from the DHSC DEL).
- The Public Health grant will rise by inflation equating to an additional £0.5bn nationally.
- Funding for rough sleeping of £639m by 2024/25 was confirmed.
- £1.8bn was set out for housing supply, this includes £300m locally led grant funding to unlock smaller brownfield sites and £1.5bn to regenerate underused land.
- £2.6m of capital funding for school places was confirmed for children with Special Educational Needs and Disabilities.
- £3.8bn of additional skills funding and £550m for adult skills was confirmed by 2024/25.

1.2 Commentary

The SR21 and Autumn Budget provided a return to multi-year financial plans after two consecutive year events. Overall, the Chancellor announced substantial spending commitments accompanied by confirmation of an increase in the overall tax burden.

Despite the announcement to increase National Insurance to fund a Health and Care Levy, funding for adult social care remains an area of concern. The Local Government Association (LGA) commented:

'It is disappointing that the Chancellor has not provided additional funding to address existing pressures on adult social care services and not increased public health funding in real terms. We remain concerned that the money allocated to social care from the Health and Care Levy will be insufficient to fund reforms. The potential rise in local government core spending power over the next three years will also be dependent on councils increasing council tax by three per cent per annum.'

In terms of the Public Health Grant Fund, the LGA stated:

'The lack of a real terms increase in public health grant funding, despite this incredibly challenging period is very disappointing and makes it harder to address the stark health inequalities exposed by Covid-19 to level up our communities. Keeping people healthy and well throughout their lives reduces pressure on the NHS, social care, criminal justice and the benefits system.'

The NHS Confederation commented that the funding announced in the Budget was a start but fell short of the £10bn need in England to address the scale of the challenges facing the NHS. It stated:

'Covid-19 has shown how much non-healthcare related factors impact health and care. But this Budget doesn't do enough to address the issues. We welcome the first projects for the Levelling Up Fund and Community Ownership Funds. However, there is scope to do more with further funding to support people in their communities, pre-empt them needing care and improve the nation's health. We await further detail in the forthcoming Levelling Up White Paper.'

2. Conclusion

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

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

The JHWS and JSNA should be used to inform service planning and spending decisions.

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Spending Review 2021 and Autumn Budget Summary

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use in the preparation of this report.

This report was written by Alison Christie, Programme Manager, who can be contacted on alison.christie@lincolnshire.gov.uk

SPENDING REVIEW 2021 & AUTUMN BUDGET SUMMARY

1. Local Government Funding

This section summarises key relevant changes to local government funding based on the Spending Review documentation issued on 27 October 2021. Full details on local government funding will be confirmed in the Provisional Local Government Finance Settlement (PLGFS) in December.

- Core spending power for local authorities is estimated to increase by £8.5bn from £50.4bn in 2021/22 to £58.9bn in 2024/25 – an average of 3% per annum in real terms.

Council Tax

- The main Council Tax referendum threshold will be confirmed at the PLGFS in December, but the SR states it is 'expected to remain at 2 per cent per year'.
- Local authorities with social care responsibilities are expected to be able to increase the adult social care precept by up to 1% per year.

Adult Social Care (ASC) Reform

- The ASC funding reforms previously announced in September 2021 have been confirmed in the Budget. These will be funded through the Health and Social Care Levy on National Insurance contributions.
- Of the 45.4bn for ASC over SR21, only £3.6bn will go directly to local authorities (via the LG DEL) to implement the charging reforms and support local authorities to better sustain their local care market by moving towards a fairer cost for care. Further detail will be set out by the government in due course.
- The remaining £1.7bn will come from the DHSC DEL over three years to improve the wider social care system, including the quality and integration of care.
- Of this, £500m will be invested in adult social care workforce, and further investment to improve the quality of services and integration with the NHS.
- Additional funding expected to be announced through the PLGFS to ensure local authorities are able to meet core pressures in ASC.

Covid Response

- £9.6bn over the SR21 period for key Covid-19 programmes and related health spending. This will allow for a continued Covid-19 vaccination and booster programme to help to maintain high levels of immunity. The government will set out further detail about the approach during the SR21 period in due course.

Public Health

- Maintain the Public Health Grant in real terms over the SR21 period.
- Continued £100m investment per year to help people achieve and maintain a healthy weight.
- Investing in the Start for Life offer for families reaching an additional £66m in 2024/25, including breastfeeding advice and parent infant mental health support.

2. Government Departmental Resource Spending

This section summarises the key relevant funding announcements which will impact on the wider determinants of health and health inequalities which have not been covered in the section above.

- Departmental spending will increase by £150bn a year by 2024/25 (£90bn in real terms) (3.8% a year on average over the Parliament).

- All government departments will receive real terms increase in spending over the SR period.
- Budget 2020 announced plans to deliver over £600bn of gross public investment over the next five years; SR21 confirms a total of £100bn of investment in economic infrastructure over the SR period.
- £1.7bn was confirmed via the first round of the Levelling Up Fund in 105 projects.
- The Levelling Up White Paper will be published shortly and will provide further information on the government's plans to enable more areas to agree devolution deals.

Department for Levelling UP, Housing and Communities (DLUHC)

- The DLUHC settlement provides a £2.6bn case increase over the Parliament to £8.9bn in 2024/25, which represents an annual 4.7% increase in spending above inflation.
- £35m was confirmed to strengthen local delivery and transparency, including procurement and commercial capacity and establishing the Audit Reporting and Governance Authority (ARGA).
- SR21 confirms a settlement for housing of nearly £24bn up to 2025/26. This includes:
    - An additional £1.8bn for housing supply, with £300m locally led grant funding for local authorities to unlock smaller brownfield sites for housing and £1.5bn to regenerate underused land, deliver transport links and community facilities and unlock 160,000 homes in total.
    - Reconfirms £11.5bn investment through the Affordable Homes Programme (2021/26).
- £639m resource funding by 2024/25 for rough sleeping.

Department of Health and Social Care (DHSC)

- The DHSC settlement provides a £43.9bn cash increase in core resource spending over the Parliament to £177.4bn in 2024/25, which is equivalent to a real terms growth rate of 4.1% on average over the SR21 period.
- Capital spending is set to increase by £4.2bn in cash terms over the Parliament to £11.2bn in 2024/25, which is a 3.8% real terms growth rate over the SR21 period. This includes:
    - £2.3bn for increased diagnostic capacity, including funding for 100 new community diagnostic hubs
    - £2.1bn to support the innovative use of digital technology
    - £1.5bn over the SR21 period for new surgical hubs, increase bed capacity and equipment to help elective services recover.
- The NHS England and Improvement budget will rise from £136.1bn in 2021/22 to £162.6bn in 2024/25, an average annual growth of 3.8% in real terms. The government plans to spend over £8bn over the SR21 period to tackle the elective backlog, as announced as part of the Health and Social Care Levy.
- £5bn for health-related research and development which includes £40m of new investment in social care research.
- £300m over the SR21 period to complete the programme to replace mental health dormitories with single en-suite rooms and £150m over the SR21 period to invest in NHS mental health facilities linked to A&E and to enhance patient safety in mental health units.
- The government reaffirmed commitment to recruiting 50,000 new nurses and promised an increase in funding to increase the size and training of NHS staff. However, the budget doesn't set out in detail how this will be funded.
- Mental health funding includes:
    - A new budget of £150m over a three-year period to invest in NHS mental health facilities linked to A&E and to enhance patient safety in mental health units
    - £201m in 2024/25 for family support services, including £18m to create family hubs in 75 local authorities, supporting infant and paternal mental health
    - The budget also reaffirms the commitment to provide 50 million more appointments in primary care but does not identify any new funding.

Department of Education (DfE)

- The DfE settlement provides an additional £4.7bn cash increase in core resource funding by 2024/25

- Provides £1.8bn specifically for education recovery including:
    - £1bn Recovery Premium for the next two academic years for primary and secondary;
    - £324m in 2024/25 for additional learning hours for 16 -19 year olds.
- £3.8bn by 2024/25 on skills, which includes:
    - £1.6bn by 2024/25 for 16-19 year olds education;
    - £2.7bn for apprenticeships and further improvements for employers;
    - £208m by 2024/25 for early years education, childcare and family services.

Department for Transport (DfT)

- The DfT settlement includes £8.5bn cash increase over the Parliament to £26.2bn in 2024/25 (1.9% real terms growth rate per year on average over the SR21 period).
- Funding to boost connectivity across all parts of the country.
- £2bn of investment in cycling and walking over the Parliament, including £710m of new active travel funding.
- £620m of additional investment to support the transition to electric vehicles.

Department of Work & Pensions (DWP)

- DWP resource settlement provides a £1.2bn increase over the Parliament to £6.9bn in 2024/25. This is equivalent to a real terms growth rate of 1.3% per year on average between 2019/20 and 2024/25. The department will receive 1.5bn in capital funding over the SR21 period.
- Building on the Plan for Jobs and £3.6bn of additional funding provided at SR20, the settlement provides more than £6bn over the SR21 period. This includes:
    - Continuing the Restart scheme to provide up to 12 months of support to long term unemployed people;
    - Continuing to invest over £900m for each year of the SR on work coaches;
    - Funding approximately £10m a year in the Sector Based Work Academy Programme;
    - Funding to extend the Kickstart scheme to March 2022 investing over £60m over next three years in the Youth Offer;
    - A further £90m to extend the Job Entry Targeted Support Programme;
    - £99m over the next three years to expand work coach support in Universal Credit (UC) to help people progress once in work;
    - Over £20m over the next three years for a new, enhanced offer for claimants aged 50 and over;
    - £339m per year for the continued funding of existing disability employment programmes such as the Access to Work Scheme and the Work and Health Programme;
    - An additional £156m over the SR21 period to provide job finding support for disabled people, with a focus on additional work coaches.
- SR21 supports the government's plan to complete the rollout of UC by March 2025.

Lincolnshire COUNTY COUNCIL Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health, Lincolnshire County Council & Matt Gaunt, Deputy Chief Executive, Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Update on Population Health Management Implementation in Lincolnshire**

Summary:
This paper is provided for information, and it updates on progress towards implementing a Population Health Management (PHM) approach in Lincolnshire

Actions Required:
To review the content of the report which provides a brief background to the programme and progress to date.

1. Background

Context

Health and care services are under unprecedented, unsustainable demand. With systems currently designed to treat, manage, and care for those who become ill, pressures can only be addressed through prevention and intervention in the causes of ill-health, alongside improvements in effectiveness and efficiency of care pathways. There is a need to move to a system designed to enhance population health and tackle inequalities, optimising health over an individual's life span and across populations and generations.

Population Health Management (PHM) allows us to do this, using new intelligence to address the wider determinants of health and health inequalities and inform decisions on need, supply and demand, quality, effectiveness, and efficiency. It requires a shift in culture, alongside new processes, systems, and intelligence. It also requires joint working, outside of health and care, for

example with economic partners, district councils, communities, businesses, the voluntary sector and all those who influence the wider determinants of health.

Bringing the right people together to talk about their population, informed by intelligence, can only be achieved with the necessary infrastructure of data, systems and governance, but it will only be successful if the right culture is in place. With these enablers, PHM improves health, quality, effectiveness, and efficiency, making best use of our collective resources.

Benefits

There are a wide range of benefits from taking a PHM approach, including:

- Better understanding of population need and future demand to inform service planning, commissioning and workforce strategies.
- More effective, transformative treatment and intervention.
- Better individual and population prevention and targeting.
- Design of new models of care to target the right conditions and risks, in the right way, at the right time.
- Identification of system weaknesses & opportunities.
- Evaluation of pathways and services, including costs through delivery and outcomes, supporting effective joint commissioning, decommissioning and transformation.
- Shared vision and development of solutions.
- Higher quality decision making.
- Drives major system change.
- Improved health and reduced pressure on services.

Examples:

- Identifying individuals whose needs are not being met, and providing services to avoid escalation of conditions, later presentation, more costly treatment and poorer patient outcomes.
- Targeting wider groups of patients with specific characteristics to enable intervention in rising risk (for example diabetes, hypertension or before a fall).
- Comparison of outcomes for different groups to identify the most appropriate pathways through our system, leading to better targeting of interventions, referral and treatment pathways, and social care services.
- Informing commissioning and delivery options and incentivising beneficial provider behaviour.
- Informing service provision for vulnerable or difficult to engage cohorts.
- Supporting investment in prevention and wider determinants (for example, through understanding the role of housing condition or tenure in respiratory ill health, occupation or industry in Musculo-skeletal (MSK) issues, or occupation or employment type in equity of access to services or health outcomes).

Progress to Date

Following investigation and socialisation of the concepts of PHM, work began at the start of 2021 to establish the approach in Lincolnshire. System Senior Responsible Officers were identified (Derek Ward, Director of Public Health and Matt Gaunt, Deputy Chief Executive of Lincolnshire CCG) and local governance structures were established, including a formal PHM Implementation Board with representation from across Integrated Care System (ICS) organisations and partners. The Implementation Board has since met regularly to review progress and set direction, with updates to the Better Lives Lincolnshire Executive Team (BLLET) to ensure alignment with the Long-Term Plan (LTP) of the ICS, the System Improvement Programme and work on health inequalities and personalisation.

Leads for the Lincolnshire programme have engaged with regional and national PHM groups and other systems, and our Lincolnshire ICS is part of the Midlands Decision Support Network which provides peer to peer networking, a regional analytics programme and an analyst workforce development programme.

Lincolnshire ICS has successfully joined wave 3 of the NHSEI PHM Development Programme which supports the implementation of a PHM approach through data readiness, workforce development and facilitating the right conversations to transform health and care delivery. The programme will create a core understanding of PHM across the system within those that have participated, patient success stories highlighting the benefits and impacts of the approach and a plan for how to approach PHM at the system level with emerging understanding for how finance and incentives can align to patient outcomes.

During the 'readiness' phase of the NHSEI programme, national and local data flows have been established, alongside appropriate information assurance frameworks, which have allowed us to create a record level, pseudonymized, joined dataset for intelligence purposes. This includes data from hospital care, mental health and community health services, waiting list data and primary care, with 100% sign up from the GP practices in the seven Primary Care Networks (PCNs) involved in the first phase of sharing (accounting for around half of the population of Lincolnshire).

Through the NHSEI programme, Action Learning Sets (ALSs) take place over 22 weeks to March 2022, supporting development of a PHM approach across system leadership, analytics, finance & place and primary care networks. At the time of writing, the first ALSs have taken place in each workstream, including the five PCNs taking part in the full programme (Marina, Trent, First Coastal, South Lincolnshire Rural and Market Deeping & Spalding). There has been agreement to focus on MSK in the finance & place workstream, and discussions have started, informed by new intelligence, to decide the cohort of interest and to shape an intervention or change. In the PCN workstreams, clinicians are being guided through the intelligence so they can identify a focus of interest for each. The PCNs will then work with their local Multidisciplinary teams to design an intervention for their chosen cohort and test it out.

An ICS PHM Intelligence & Analytics group has also been established to facilitate joint working and to ensure that the development needs of our shared analyst capacity are understood and can be met, in part through our newly established Analyst Network.

Next Steps

Participation in the NHSEI PHM Development Programme will continue until March 2022. A roadmap will be developed that scales this approach so that it can have a measurable impact on patient outcomes, patient experience, professional job satisfaction, reduced per capita spend and reduced health inequalities. Local decision-making processes will be mapped to allow any appropriate consolidation, to continue processes that have proved beneficial whilst reducing any duplication through parallel, historic arrangements.

Work will be undertaken with BLLET to ensure that the ongoing capacity required for the production of intelligence and application of intelligence informed decision making through PHM is met. This will be informed by regional and national recommendations in relation to minimum ICS PHM intelligence provision and local Decision Support Units.

Linkages will continue to be strengthened between PHM intelligence and PHM application to ensure that the ICS can continue to make good quality decisions based on the best insight. This will include the development of a programme of intelligence work focussed on priority decisions on commissioning, transformation and partnership working.

The work will continue to be aligned with other workstreams, including the System Improvement Programme.

2. Conclusion

PHM implementation has been progressing at pace throughout 2021, in large part through involvement in the NHSEI PHM Development Programme, and the Board will continue to receive updates throughout the programme of implementation.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

A PHM approach will contribute vital understanding that it has not previously been possible to create. This will be used to improve the content of Lincolnshire's JSNA and therefore to inform strategic decision making, supporting delivery of the JHWS.

4. Consultation

Consultation has taken place with ICS partners via BLLET and wider partner organisations via the ALSs. No public consultation has been required in relation to PHM implementation itself, however it may be required in the future by specific, individual, service transformation programmes.

5. Appendices

None.

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Katy Thomas, who can be contacted at: katy.thomas@lincolnshire.gov.uk

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Health and Wellbeing Board – Decisions from 22 June 2021

22 June 2021	**1**	**Election of Chairman** That Councillor Mrs S Woolley (Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners) be elected Chairman of the Lincolnshire Health and Wellbeing Board for 2021/22.
	2	**Election of Vice-Chairman** That John Turner (Chief Executive of NHS Lincolnshire Clinical Commissioning Group) be elected as Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2021/22.
	5	**Minutes of the Lincolnshire Health and Wellbeing Board meeting held on 9 March 2021** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 9 March 2021 be agreed and signed by the Chairman as a correct record, subject to the addition of Sarah Connery, Acting Chief Executive, Lincolnshire Partnership NHS Foundation Trust being added to the list of those in attendance at the meeting.
	6	**Action Updates** That the Action Updates presented be noted.
	7	**Chairman's Announcements** That the Chairman's Announcements presented be noted.
	8a	**Terms of Reference & Procedure Rules, Roles and Responsibilities** That the Terms of Reference, Procedural Rules and Board Member's Roles and responsibilities as set out in Appendix A to the report be agreed.
	8b	**Lincolnshire's Joint Strategic Needs Assessment** 1. That the report presented be noted. 2. That the redevelopment of Lincolnshire's JSNA using a life course approach as set out in Appendix A be agreed. 3. That the importance of the JSNA be promoted by members within their respective organisations to ensure active engagement in the review process. 4. That the outline timescales as detailed at paragraph 4.1 be noted.
	8c	**Lincolnshire Pharmaceutical Needs Assessment 2022** 1. That the process and requirement to produce a revised Pharmaceutical Needs Assessment (PNA) by 31 March 2022 be noted. 2. That the Terms of Reference for the Lincolnshire PNA Steering Group as detailed in Appendix A be received. 3. That the Project Plan setting out the timeline for producing the Lincolnshire PNA as detailed in Appendix B be received.
	8d	**Better Care Fund Final Report 2020/21** That the Better Care Fund Final Report 2020/21 be approved.
	9a	**Update on Covid-19** That the verbal update be received and noted.
	9b	**Integrated Care Systems (ICS) legislation Update** That the current position in relation to ICS legislation be noted.
	9c	**Housing, Health and care Delivery Group Delivery Plan**

		1. That the Housing, Health and Care Delivery Plan as presented be noted. 2. That the actions where Board member organisations will be lead partner, or part of a delivery team; and, along with HHCDG representatives, ensure appropriate representation to achieve those actions be noted. 3. That the comments raised by the Board be noted.
	10a	**An Action Log of Previous Decisions** That the Action Log of Previous Decisions as presented be noted
	10b	**Lincolnshire Health and Wellbeing Board Forward Plan** That the Lincolnshire Health and Wellbeing Board Forward Plan presented be noted.
	13	**Minutes of the Lincolnshire Health and Wellbeing Board Meeting held on 22 June 2021** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 22 June 2021 be agreed and signed by the Chairman as a correct record
	14	**Action Updates** That the Action Updates presented be noted.
	15	**Chairman's Announcements** That the Chairman's announcements presented be noted.
	16a	**Covid- 19 Update** That the verbal update on Covid-19 be received and noted.
	16b	**Integrated Care System Update** That the Integrated Care System update be noted.
	16c	**Lincolnshire Mental Health Services** That the presentation on mental health services be received and that further detailed information concerning mental health service provision be presented to a future meeting of the Board.
	16d	**Joint Strategic Asset Assessment Update** That the progress made to develop the Joint Strategic Asset Assessment be received and that the comment by the Board be noted.
	17a	**The importance of community beds in transitional care both for Covid positive and Covid negative patients and the positive impact these have on Acute Hospital Trusts** That the report presented concerning the importance of community beds in transitional care both for Covid positive and Covid negative patients and the positive impact these have on acute hospitals trusts be noted.
	17b	**An Action Log of Previous Decisions** That the Action Log of Previous Decisions as presented be noted.
	17c	**Lincolnshire Health and Wellbeing Board Forward Plan** That subject to the addition of the suggestions reference above, the Forward Plan presented be received.

Lincolnshire Health and Wellbeing Board Forward Plan December 2021 to September 2022

Items for the Lincolnshire Health and Wellbeing Board are shown below:

7 December 2021, 2pm, Council Chamber, County Offices, Newland Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Better Care Fund To receive a report on behalf of the Executive Director of Adult Care and Community Wellbeing asking the Board to agree the BCF 2022/23 plan.	Gareth Everton Head of Integration and Transformation	Decision
Covid-19 Update To receive a verbal update on the current Covid-19 situation in Lincolnshire	Derek Ward Director of Public Health	Discussion
Integrated Care Board To receive a report from NHS Lincolnshire CCG on the ongoing development of Lincolnshire's Integrated Care Board	John Turner Chief Executive NHS Lincolnshire CCG	Discussion
Integrated Care Partnership To receive a report on behalf of Better Lives Lincolnshire (Integrated Care System) on the development of an Integrated Care Partnership for Lincolnshire	Cllr Sue Woolley, Chair, Lincolnshire HWB and John Turner Chief Executive NHS Lincolnshire CCG	Discussion
Let's Move Lincolnshire – update To receive a report from Active Lincolnshire on the Let's Move Lincolnshire Strategy and programme	Emma Tatlow Chief Executive Active Lincolnshire	Discussion
Spending Review and Budget Briefing Paper – implications for the health and care system in Lincolnshire	Cllr Sue Woolley, Chair, Lincolnshire Health and Wellbeing Board	Discussion
Population Health Management To receive an update report on Population Health Management Programme	Katy Thomas Head of Health Intelligence Public Health Division	Information

Lincolnshire Health and Wellbeing Board Forward Plan December 2021 to September 2022
Planned items for future Lincolnshire Health and Wellbeing Board are shown below:

29 March 2022, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report on the PNA and agree the draft Pharmaceutical Needs Assessment (PNA) 2022 document for consultation	PNA Steering Group	Decision
All Age Autism Strategy To receive the final draft of the strategy for sign off.	To be confirmed	Decision
Integrated Care System Update To receive a report from NHS Lincolnshire CCG on the ongoing development of Lincolnshire's ICS	John Turner Chief Executive NHS Lincolnshire CCG	Discussion
Director of Public Health Annual Report 2021	Derek Ward Director of Public Health	Discussion
Mental Health Services in Lincolnshire – update (to include Dementia Home Treatment Service) To receive an update on Mental Health Services in Lincolnshire	Sarah Connery Chief Executive, LPFT and Nick Harwood	Discussion
Rural Proofing for Health Toolkit To receive a report on behalf of the Executive Director for Adult Care and Community Wellbeing which introduced the Rural Services Network's Rural Proofing for Health Toolkit. The Board is asked to decide whether to recommend its use in service development and decision-making processes.	Sean Johnson Programme Manager Public Health Division	Discussion
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information
14 June 2022, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive a report on the outcome of the statutory consultation exercise	PNA Steering Group	Discussion
Carers – JHWS Update To receive a report from the Carers Priority Delivery Group on the Carers Priority	Sem Neal, Assistant Director	Discussion
Better Care Fund update To receive an information report on behalf of the Executive Director for Adult Care and Community Wellbeing, on the BCF.	Gareth Everton Head of Integration and Transformation	Information

27 September 2022, 2pm, TBC		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Lincolnshire Pharmaceutical Needs Assessment To receive the final Pharmaceutical Needs Assessment for the Board to approve prior to the publication by 1 October 2022.	PNA Steering Group	Decision

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