NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board

Public Board Meeting

Tuesday, 29th July 2025
at 9.30 am

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

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

NHS
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PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 29th July 2025
Time: 9.30 am
Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Mrs Sharon Robson, ICB Deputy Chair

AGENDA

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
1. Introductory Items					
i)	Welcome, introduction and apologies, Gerry McSorley, Sarah Connery, John Dunstan, Steven Clegg		-	Mrs Sharon Robson	9.30 am
ii)	Confirmation of quoracy		-	Mrs Sharon Robson	
iii)	Declarations of Interest	Information	-	Mrs Sharon Robson	
iv)	Minutes of the previous meeting held on the 27th May 2025	Approve	✓	Mrs Sharon Robson	
v)	Matters Arising, including Action Log (if appropriate)	Note	-	Mrs Sharon Robson	
2. Chair and Chief Executive Updates					
i)	Chair's Report	Note	-	Mrs Sharon Robson	9.35 am
ii)	Chief Executive's Report, including ICB Reform	Note	-	Mrs Clair Raybould	9.45 am
3. Key Updates					
i)	Public Health	Note	-	Professor Derek Ward	10.00 am
ii)	Healthwatch	Note	✓	Mr Dean ODell	10.10 am
4. Population Health Planning					
i)	Bowel Cancer Screening Project and Tackling Associated Health Inequalities	Assurance	✓	Mrs Sandra Williamson and Dr Sunil Hindocha	10.20 am
5. System Oversight and Assurance					
i)	Integrated Performance, Quality and Finance Report	Assurance	✓	Mrs Rebecca Neno/ Mr Martin Fahy/ Mr Matt Gaunt	10.45 am
6. Governance					
i)	ICB Joint Transition Committee Highlight Report: - Approve the Joint Committee Terms of Reference	Assurance and Approve	✓	Mrs Sharon Robson	11.00 am

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
	- Note an update to the ICB Constitution				
7. Committee Highlight Reports					
i)	• System Quality and Patient Experience Committee • Service Delivery and Performance Committee • Audit and Risk Committee (verbal update) • East Midlands Joint Committee	Assurance	✓	Committee Chairs	11.05 am
8. Information/Closing items					
i)	Risks identified during the course of the meeting	Consider	-	Mrs Sharon Robson	
9. Date, Time and Venue of the next meeting					
	Tuesday, 30th September 2025 at 9.30 am at Bridge House, Sleaford	Note	-	Mrs Sharon Robson	Close

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

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

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

NHS
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MINUTES OF THE NHS LINCOLNSHIRE ICB MEETING HELD ON TUESDAY, 27TH MAY 2025 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	ICB Chair and Chair of the Primary Care Commissioning and Delegated Functions Committee
	Mrs Sarah Connery	Executive Board Mental Health Member
	Ms Anita Day	Non-Executive Member
	Professor Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Dr Phillip Earnshaw	Non-Executive Director (Chair of the Primary Care Commissioning Committee)
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Member and Chair of System Quality & Patient Experience Committee
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS/ ATTENDEES	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Anne Lloyd	Director of Workforce Transformation
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Value
	Mr Jimmy Pryke-Walker	Head of Digital Health (item 4 only)
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Mrs Emma Townend	Interim Health Inequalities Programme Lead (item 4 only)
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
APOLOGIES:	Ms Charley Blyth	Director of Communications and Engagement

25/312 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the NHS Lincolnshire ICB Board. It was emphasised that whilst the meeting was being held in public it was not a public meeting.

The meeting was being held both on a face to face basis and via Microsoft Teams. This arrangement had been put in place to enable members of the public or staff to either attend and observe the meeting in person or digitally through MS Teams.

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma as published on the website. The Questions and Answers facility was also available during the Board meeting as part of the live event.

Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

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

25/313 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

25/314 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

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

Declaration of Interest from Committees:
No items declared.

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

The Board agreed to:

- **Note no interests were declared.**

25/315 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 25th March 2025 and agreed to:

- **Approve the minutes as a true and accurate record of the meeting subject to amendment of the numbering, which should be reflective of 2025, not 2024.**

25/316 MATTERS ARISING

Dr McSorley presented the Action Log as included in the pack of papers and confirmed that the one outstanding item relating to the Board Assurance Framework, had been completed. No further items were noted.

25/317 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley reported that since the last Board meeting, significant political changes had taken place following the 1 May 2025 local elections. These included:

- Dame Andrea Jenkyns elected Mayor of Greater Lincolnshire.
- Leadership of Lincolnshire County Council has passed to Councillor Sean Matthews of the Reform Group.
- Councillor Steven Clegg appointed Executive Member for Public Health and Adult Social Care.
- Councillor Richard Cleaver appointed as Chair of the Health Scrutiny Committee.

Dr McSorley advised that following the outcome of the recent local elections, two members had stepped down from the ICB Board in May 2025: Councillor Wendy Bowkett, who served as the Local Authority Partner Member, and Councillor Sue Woolley, Chair of the Health and Wellbeing Board.

The Board extended its sincere thanks to them both for their contributions and wished them all the best for the future.

Dr McSorley proposed, with the Board's agreement to send a letter to Councillor Bowkett and Councillor Woolley thanking them for their hard work and contributions to the Board, which was supported.

Action: Dr McSorley

National Developments:

Dr McSorley also reported on engagement with regional and national ICB Chair meetings, particularly in the context of the newly published ICB Blueprint and the Government's directive to reduce ICB staffing by 50%.

Local Developments:

In terms of local developments, Mrs Clair Raybould had been appointed as Interim Chief Executive, effective from the 18th June 2025. Dr McSorley, on behalf of the Board, welcomed her appointment.

Events Attended:

- Regional Quality System Review meeting with NHS England and a successful Health and Care 'All Boards' session on the 12th May 2025.
- Research and Innovation Conference at the University of Lincoln, which was a positive experience and Dr McSorley expressed his appreciation to everyone involved in organising the event.

Dr McSorley noted this was Mr Turner's last formal Board meeting, as he would be retiring from his role on the 17th June 2025. Dr McSorley advised that Mr Turner was an inspiration to all and had led with compassionate, deep and profound commitment to the people of Lincolnshire over a number of years but understood his reasons for moving on to pursue other things in his life.

Equally, Dr McSorley noted this was Mr Burnett's last formal meeting with the ICB as he was leaving to take up the role of Chief Strategy Officer with Leicester, Leicestershire and Rutland ICB from the 1st June 2025. Mr Burnett had taken the Board and Lincolnshire through huge amounts of strategic change and planning and was leaving an enormous legacy.

Mr Burnett thanked Dr McSorley for his kind comments and wished the ICB and the Board all the best for the future.

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

Chief Executive update

Mr Turner thanked the Chair and Board members for their kind words and provided his final report as Chief Executive, summarising key activities since the Board last met in March. Highlights included:

- The 2025/26 Operational and Financial Plan has been finalised and the organisation has now transitioned into the delivery phase. Regional colleagues have formally signed off the plan following a rigorous review process.
- Key Challenges – Mr Turner acknowledged significant challenges ahead, particularly in the areas of:
    - Urgent and emergency care targets
    - Planned care targets

- Financial targets
- Mental health services, including children's mental health
- Access to emergency community dental services

- The latest All Executives meeting took place in early May 2025. Monthly meetings will commence from mid-June to ensure alignment and coordination across all aspects of the plan. These meetings will also serve as a forum for collective risk management.
- The latest formal Quarterly System Review Meeting (QSRM) with the NHS England Regional Team was held on 7th May 2025, led by Regional Director, Mr Dale Bywater. The region commended the system's recent track record and emphasised the importance of continued delivery. Key points included:

  - Recognition of balanced financial planning with no unidentified cost improvements or deficit funding.
  - Commendation for urgent and emergency care performance, particularly the four-hour target and winter planning.
  - Lincolnshire was noted as the seventh most improved system nationally for four-hour performance.

- Mr Turner congratulated Dr Hindocha and colleagues for the successful Research and Innovation Expo. The event showcased a wide range of ambitious and impactful work across Lincolnshire, with strong support from University of Lincoln partners.
- The second annual Armed Forces Symposium is scheduled to take place on the 3rd June 2025 at RAF Cranwell. The event will focus on improving services for serving families and veterans in Lincolnshire.
- Two all-ICB staff events will be held next Wednesday, 4th June 2025. These will reflect on the past year's achievements and provide updates on the Model ICB Blueprint and next steps.
- Ongoing discussions and meetings have taken place regarding the Model ICB Blueprint work. A submission to the region is due by the end of the week.
- Professor Simon Ray, National Director for Heart Disease, is expected to visit Lincolnshire next month to review the system's work in this area.
- The NHS 10-year plan was expected to be published by the end of July 2025.

Mr Turner extended congratulations to Mrs Raybould on her new appointment and expressed gratitude to Mr Burnett for his support over the past five years. Personal thanks were also given to the Board for their support over his nearly three years as Chief Executive of the ICB, and nine years in Lincolnshire overall, with a specific mention to those individuals who had been with him from the start. The Chief Executive reflected on the journey, noting the over 108 Board meetings he had attended, and the collective success achieved through strong collaboration and governance. There will be significant challenges ahead and he will be watching closely.

Mr Turner advised that three questions had been received from members of the public. It was noted that the questions and responses would be attached separately to the minutes of the meeting.

(Note: Ms Mills had stepped out of the room at this point in the meeting) due to a prior diary commitment).

The Board considered the update and agreed to:

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

KEY UPDATES

25/318 PUBLIC HEALTH

Professor Ward provided a verbal update, supplementing Dr McSorley's earlier comments regarding recent changes at a local government level. It was confirmed that the new Executive

has been formally established, and the roles of each individual along with their portfolios had been confirmed and was detailed on the Lincolnshire County Council website.

- Councillor Sean Matthews was elected as the new Leader of the Council, with Councillor Rob Gibson as his deputy. Councillor Steven Clegg has been appointed as the lead for Adult Social Care supported by Maria Hume.
- The first formal council meeting was held the previous week on the 23rd May 2025.
- Briefings are currently being conducted with all Executive Councillors, including the Chief Councillor and the Leader, to ensure they have a clear understanding of their new Executive's priorities, particularly in relation to children's services. These briefings will inform the rollout of the Executive's strategic direction, especially in the area of care.
- There will be some changes around scrutiny models within the local authority, but the Health Scrutiny and Overview Committee is likely to continue. Discussions had not yet taken place within the local authority on who would be Chairing the Health and Wellbeing Board, Integrated Care Partnership and attendance at the ICB Board meetings. There are some meetings scheduled to take place in June and the discussions will review the current model and determine whether to proceed with these or pause until September, allowing time to assess the impact of these changes.
- Professor Ward acknowledged the scale of transformation underway, both within the Council and the NHS, while affirming that core responsibilities continue as usual.
- Professor Derek Ward also reported on ongoing pandemic preparedness activities and noted that flu vaccination campaigns would begin in September 2025. He highlighted Lincolnshire's continued role in the Combatting Drugs Partnership under Home Office funding and the restructuring of related strategic groups. He also referenced preparations being made within the County Council for expected local government reform over the next two years. The Board will be kept informed as that plays through.

The Board considered the update. Mr Gaunt referred to the additional funding mentioned by Professor Ward and sought clarification on whether this was to support the different types of action on drug dependency, or it is supplementing additional resources. It was clarified that this funding is not intended to supplement existing programmes, but rather to enhance the organisation's capacity to help individuals break the cycle of dependency.

The Board considered the update and agreed to:

- **Note the Public Health update.**

25/319 HEALTHWATCH

Mr Sutton presented the latest Healthwatch report and advised that he would take the report as read, but wished to highlight the following areas:

- 317 individuals had shared feedback this quarter, in addition to 500 further responses through the access to the GP services survey. The feedback primarily concerned hospital services, which emerged as the most frequently mentioned area. GP services and dentistry continue to reflect ongoing issues, particularly around access and appointment availability. Patient transport and mental health services were also highlighted, though these were largely isolated or ongoing cases.
- It was confirmed that all feedback has been shared with the relevant service providers. Two-way communication is in place to address the issues raised, and there are no current concerns requiring escalation. The team continues to work collaboratively with providers to resolve ongoing matters.
- An update was provided on the improvements made to the IMP (Information Management Patient) system, which now captures voice and intelligence data more effectively. A new dataset has been developed, offering a ranked overview of satisfaction themes, including access, administration, behaviours, and by service type. This data spans all services, not just individual providers. The latest IMP report will be shared with service providers and the Board in the coming month.

- A specific case was discussed involving a cancer patient who experienced difficulty accessing timely dental care. Healthwatch provided support, including direct outreach to dental practices. A newly opened dental provider responded positively and was able to assist the patient within the required timeframe. This was acknowledged as a success story, demonstrating effective collaboration and responsiveness.
- An emerging theme related to hospital services and communication around cancellations and delays (some being short notice from the provider, but also patients not being able to contact the right department to re-arrange or cancel their appointments). This pattern has not been observed in previous reports and will be investigated and monitored closely going forward.
- There had also been an influx of patients requiring support, such as accessing a translator.
- A parent recently sought medical help for their 6-month-old child. After initial advice from a local pharmacy in Alford, they were referred to Louth County Hospital. The child was seen within 10 minutes and treated. The parent praised the hospital staff for their excellent care, clear communication, and supportive approach.
- Ongoing pieces of work where the final reports had either been published or were in draft included mental health and neurological services.
- The report contained a summary of the outcome of the access to GP services; the headlines were summarised, and it was noted the report was in the process of being pulled together and would be shared for comments before publication.
- Social care – Healthwatch Carers Survey being undertaken.
- To conclude the briefing, updates were provided on key engagement areas. Firstly, the childhood immunisation project has now been completed. The final report has been submitted to Public Health and the ICB, and it was noted that the findings are already influencing future funding decisions, which was welcomed as a positive outcome.
- Secondly, the pelvic health project has progressed into its second phase. Phase two will involve running focus groups to test the usefulness and timing of these resources, with the aim of refining them further based on user feedback. This work is scheduled to begin over the summer.
- Lastly, a new project is being initiated in collaboration with the Armed Forces Covenant. This work will explore the experiences of serving personnel and their families, particularly those who may face additional challenges in accessing healthcare, whether on base or in the wider community. The project will extend existing signposting services and seek to identify improvements based on the needs and preferences of this group. It is expected to contribute valuable insights across multiple service areas.

The Board considered the report. Professor Dunderdale commented on the positive nature of the report which contained really good insight within it. In terms of the comments on hospital services, the issues were acknowledged around notices, cancellations and contact. With the amount of feedback received by them directly, it was surprising these types of issues had only recently surfaced. Plans were in place to tackle those concerns around process and some around digital. In essence the core issue stems from the organisation's struggle to manage the increasing volume of patients requiring care. There has been insufficient scaling to meet public expectations around access.

Professor Dunderdale added that the Group recognised the importance of meeting public expectations, particularly in terms of equitable access and addressing inequalities and thanked Healthwatch for their continued support, which truly helps guide improvements and ensures they stay focused on what matters.
Dr Earnshaw remarked that the report was very interesting and well-balanced. He particularly welcomed the observations on digital aspects, noting that when digital systems are implemented effectively, they perform well, contrasting with the challenges that arise when they are poorly executed.

Mr Dunstan referred to the feedback received on access to GP services and asked what action can be done and is being actioned by the ICB to address this. Dr Hindocha advised that there

are currently three national PCN pilots across this region, all of whom have embraced new models of technology. However, there is a need to be mindful of the need for balance, as not all patients or staff are ready to fully adopt it. Artificial Intelligence (AI) is being utilised to help shift those two key parameters, enabling a more personalised approach. Importantly, patients who prefer face-to-face appointments will continue to have that option.

There is now a GP Dashboard and that will be triangulated. In respect of the workforce element and an example being the First Coastal PCN, the lead GP is being supported along with the wider practice team, with plans to build on this foundation as things progress.

While there are still areas marked in red, it is encouraging to see that the ICB compares well nationally in terms of the proportion of face-to-face appointments that are offered. There is more work to do, but the early indicators are positive.

Professor Ward referred to childhood immunisation and commented that whilst this remains a regional responsibility, local involvement does not stop there. The local authority is carrying out targeted analysis to identify gaps and opportunities for improvement. In addition, the offer for carers and care homes is being enhanced to ensure coverage and access are equitable.

From a public health perspective, each care home now has a designated lead responsible for infection prevention and control. This structure helps embed best practices and strengthens our overall resilience in managing health risks in vulnerable settings.

Mr Turner highlighted the importance of access to GP services, reiterating his earlier comments that this remains one of the key performance targets for the ICB this year. Given the level of public interest, it is expected that the Health Scrutiny Committee (HSC) will wish to explore this further.

To build a comprehensive picture of GP access, this issue needs to be examined alongside a range of data sources, both quantitative and qualitative, including national metrics, local feedback, and softer intelligence. It is important to move beyond headline figures and delve into what is truly meant by terms such as “easy to access” or “hard to access.” Understanding the lived experience behind the data will be essential to driving meaningful improvement. No doubt the ICB Primary Care Commissioning Committee will continue to monitor this.

The Board agreed to:

- **Note the Healthwatch report.**

POPULATION HEALTH PLANNING

25/320 **Lincolnshire Health and Care Digital Inclusion Strategy**

Mrs Williamson introduced the next item on the agenda - Lincolnshire Health and Care Digital Inclusion Strategy and advised that the pack of papers contained a considerable amount of detail, but she would take it the Board have had the opportunity to review the content.

Mrs Williamson advised that the strategy has been developed collaboratively across the Integrated Care System (ICS), with input from system partners and people with lived experience. It was emphasised that the strategy is not solely about technology, but about improving accessibility to health and care services, empowering individuals to manage their well-being, and reducing health inequalities.
The strategy aligns closely with the Core20PLUS5 agenda and supports the three strategic shifts outlined recently by the Secretary of State for Health and Social Care: moving from treatment to prevention, enabling digital transformation, and delivering care in the community.

The Board noted that the strategy had been shaped by engagement with digitally excluded communities and is underpinned by six strategic pillars with assigned leads across partner organisations.

An ICS Digital Inclusion Strategy Oversight Group has been established to oversee implementation, and the strategy will be evaluated by the University of Lincoln's LIRCH team.

Mrs Williamson advised that the Board was asked to approve the Strategy but note that due to timing and sequencing of the meetings, it was scheduled to be received and considered by the Service Delivery and Performance Committee at its meeting taking place the following day. After that it would then be published on the ICB website

Mrs Williamson handed over to Mrs Emma Townend, Interim Health Inequalities Programme Lead and Mr Jimmy Pryke-Walker, Head of Digital Health who had joined the meeting for this item and ran through the presentation as included in the pack of papers.

The following was highlighted as part of the presentation:

- The Lincolnshire Health and Care Digital Inclusion Strategy has been aligned with NHSE's national priority to address digital exclusion and support the shift from analogue to digital services.
- Vision - Everyone in Lincolnshire to have the skills, access, and confidence to engage digitally with health and care services.
- Governance - A multi-agency Digital Inclusion Oversight Group was formed, involving partners from health, local government, voluntary sectors, academia, and people with lived experience.
- Strategy Pillars & Leads -
    - Access to devices/data – East Lindsey DC
    - Accessibility & service access – ICB Digital Primary Care
    - Skills & capability – Community & Hospitals Group
    - Digital safety & awareness – Lincolnshire County Council
    - Leadership & partnerships – ICB Health Inequalities Team
- Engagement Findings- 66 individuals from vulnerable groups highlighted key barriers: lack of devices, skills, confidence, and trust. Community-based digital support and champions were strongly endorsed. More signposting to training and resources is needed.
- Next Steps - ongoing implementation and collaboration to improve digital access, support, and inclusion locally.

The Board considered the contents of the documents and the presentation provided and praised the inclusive development approach and noted the importance of clear outcome measures, effective staff engagement, and governance alignment.

Mrs Kenson asked if there was a particular reason housing associations were not included as key partners. The Board was advised that East Lindsey District Council (ELDC) has started engaging with some housing providers. There is recognition that Housing Associations are well-positioned to support digital engagement and should be more formally integrated into the strategy.

Mrs Robson advised that the public health element of the Strategy is very clear but sought clarification on how the five Core20PLUS5 clinical priority areas (e.g. maternity, mental health) reflected in the governance structure. It was acknowledged that this linkage needs to be strengthened.

The strategy team confirmed they will ensure closer alignment between the digital inclusion work and relevant programme boards for adults and children, particularly where clinical inequalities are being addressed.

Mrs Pomeroy referred to the 66 participants in the engagement exercise and asked whether this was a sufficient amount of people to reflect the experiences of digitally excluded groups. It was acknowledged that whilst the 66 people provided valuable insights, broader engagement is

needed. The strategy team will continue engaging diverse communities, supported by the University of Lincoln and local representatives with lived experience.

Mr Burnett advised that he welcomed the report and acknowledged the work done so far, but emphasised the importance of ongoing engagement, rather than a one-off effort, and highlighted the need to continually refer back to the strategy when implementing the work, ensuring alignment with its core messages and objectives.

Mr Turner congratulated everyone involved in reaching this stage and echoed Mr Burnett's points and emphasised that this should be seen as part of an on-going relationship, not just a response to the engagement figure. Mr Turner recognised the complexity of engagement and that some individuals may want to be involved but are unable to for various reasons, others may not want to engage, whilst some stand to benefit significantly from being connected and the ICB has a responsibility to ensure they are connected. The strategy's vision uses the word "wants", which seemed slightly passive and asked whether we should be enabling those who do not yet want to engage digitally.

Mr Turner advised that he had a second point and asked what success will look like in 12 months' time, what are the measurable outcomes.

Mrs Townend advised that the wording reflects respect for individual choice, but the team acknowledged the importance of enabling access and building confidence. Many have the desire but face barriers like lack of knowledge or fear. The aim is to support as many as possible without creating pressure. In respect of what success looks like, the strategy includes a three-year action plan. Metrics will be developed to track digital engagement, service access, and equity in outcomes. Feedback requested that both digital and face-to-face access measures be included.

Mr Fahy expressed strong enthusiasm for the potential of digital solutions, particularly in the context of reaching dispersed and rural communities. It was noted that the strategy rightly highlights the East Coast as an area of significant digital exclusion, which also aligns with some of the most pressing population health challenges. Mr Fahy emphasised the need for a differentiated and proactive approach in engaging these communities.

Reflecting on public attitudes, Mr Fahy observed that while some individuals claim they are unable to engage digitally, they often do make contact through social media platforms. This contradiction suggests an opportunity to shift perceptions and build confidence in digital tools.

A specific plea was made regarding the NHS App, which has seen notable improvements and is now more functional and accessible. However, concern was raised about the inconsistency in user experience across different digital platforms provided by partners. Mr Fahy urged that future digital tools be designed with simplicity, consistency, and user enjoyment in mind. It was suggested that the success of social media platforms lies in their ease of access and intuitive design, principles that should be mirrored in health-related digital services.

Mr Gaunt raised a concern about how digital service strategies are framed, particularly in relation to resource allocation and staff guidanceand questioned whether the strategy promotes a pull model (where individuals choose digital services) or a push model (where digital services are actively promoted). Mr Gaunt emphasised the importance of how this framing influences frontline staff, especially given the fixed resource envelope and the potential implications for face-to-face service delivery.

Mrs Townend acknowledged Mr Gaunt's concern and emphasised the need for clear and consistent messaging to staff. It recognised the tension between offering genuine choice and managing resource constraints and agreed that the strategy must be communicated in a way that enables staff to guide service users toward effective digital options without removing choice. The importance of framing digital engagement as part of a broader system strategy was highlighted, ensuring that service delivery remains both person-centred and resource-aware.

It was noted that the strategy has not yet been shared with the new council leadership following the local elections, but discussions with new local authority leadership is planned over the next six weeks.

Mrs Jolly asked whether the outcomes measures reflect face to face access as well as digital success. This was acknowledged and discussed, and it was agreed that the measures will be revisited to ensure they capture positive experiences and access for those not using digital, not just uptake of digital tools.

Dr McSorley drew the discussion to a close.

The Board agreed to:

- **Endorse the strategy and emphasised the need for:**
- **Continued public engagement.**
- **Clarity around digital vs. face-to-face service access.**
- **Integration with broader health inequalities work.**

Ms Mills re-joined the meeting at this point. Mrs Emma Townend and Mr Jimmy Pryke-Walker left the meeting.

SYSTEM OVERSIGHT AND ASSURANCE

25/321 INTEGRATED PERFORMANCE, QUALITY AND FINANCE REPORT

Performance Section

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

The following points were highlighted:

Urgent and Emergency Care (UEC)

- Overall Performance: Lincolnshire achieved its UEC performance target for April and is broadly on track for May, despite the challenges of a three-week Easter period and two bank holidays.
- Ambulance Handover delays have continued to reduce following recent improvement work discussed at the last meeting. These improvements have been sustained, which is a positive development.
- The 45-minute target discussed previously which had been set off at Lincoln County Hospital, had now been implemented at Pilgrim Hospital, Boston and also North West Anglia NHS Foundation Trust (NWAFT) and Northern Lincolnshire and Goole's Hospitals NHS Trust (NLAG). Overall performance has been noted at regional level as mentioned. by Mr Turner earlier in the meeting.
- Category 2 mean - whilst performance had been a little bit volatile just over the last couple of weeks, it does remain really positive and the 12 hours in department had also significantly improved during April and May. Both of those are really significant harm indicators, so that was a real positive again for Lincolnshire.
- Performance remains strong with a 76.1% unvalidated May figure, trending towards the 78% national target.

Cancer

- Slight deterioration due to bank holiday-related disruption. Cancer backlog slightly above target 62 day waits - the backlog trajectory is slightly above target, which is not uncommon for this time of year.
- The faster diagnosis standard was achieved in March, overall performance was 77.2%, against the 75% standard.

Elective and Planned Care

- **65-Week Waiters:** On track to achieve national targets by end of April, with delays attributed to complex cases and patient choice.
- **52-Week Waiters:** Performance appears to be on plan for April (validation pending).

Mental Health and Community Services

- **Access for Children and Young People (CYP):** Below target. An action plan is in place, and remedial steps have been reported to the Service Delivery & Performance Committee.
- **Community Placements:** Significantly improved since the last report; progress being closely monitored.

The Board considered this section of the report. Dr Earnshaw referred to elective care and sought to understand the reasons behind over 52-week waiters. He also referred to diagnostics performance which seemed to be below expected levels, bearing in mind Lincolnshire having Community Diagnostic Centres. Mrs Raybould advised that the current 52-week wait position is being validated and will reflect in April's balance; this was not yet visible in the reported being considered by the Board at today's meeting. In terms of diagnostics, several action plans were place to get a number of modalities back on plan and there were some challenged areas, but performance for others was on track. Mrs Raybould advised she was happy to share this outside of the meeting with him directly or through the Service Delivery and Performance Committee, which was noted.

Quality Section

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

- The Vales is female mental health rehabilitation ward at LPFT. In response to quality concerns a Trust Executive led Quality Review Group was established to provide oversight of the required improvements, which includes senior ICB representation. Over the last few months a number of actions have been taken to address the quality concerns including increases in staffing; additional senior clinical support; and additional training for staff. However, recent review of progress has identified the improvements are not happening quickly enough and further work is required to embed the necessary changes.
- LPFT have therefore agreed to provide additional intensive support to the ward for a period of four weeks starting 12th May 2025. The Quality Review Group will continue to provide oversight of the impact of this additional support. Updates will be reported through the System Quality and Patient Experience Committee (SQPEC).
- The report has now been published for the Lincolnshire SEND Lincolnshire Local Area Partnership inspection that took place February 2025. The link to the report was included in the paper.
- There are only three outcomes: 1st being Positive experiences and outcomes, 2nd inconsistent experiences and outcomes and 3rd widespread and or systemic failings leading to significant concerns. Lincolnshire received an "Outcome 2
- SEND revisit, meaning some improvements are required. Identified issues include:
    - Speech and language therapy access
    - Neurodevelopmental assessment delays
- A cross-system working group is addressing the required improvements.
- Peterborough City Hospital, NWAFT: Reports have been published following the June 2024 CQC inspection of Medical Care, which was rated as rated Good overall
- Primary Care Quality:
    - Greater detail provided in the report as requested by Board members.
    - The enhanced quality support programme led by the Primary Care Quality Team as part of the Quality Early Warning Score (QEWS) process is currently proving to be effective. It has identified practices that require more urgent support i.e. below the required standard for the 'Safe' quality domain.

    - Three practices are currently being supported via this process with a further five to follow. Two practices have seen significant improvement in patient safety and quality following the enhanced support programme with one receiving a 'Good' rating from the CQC (the other practice will be assessed in the near future).
- ULHT (United Lincolnshire Teaching Hospitals NHS Trust):
    - Recent positive CQC ratings for medical care at Lincoln County Hospital noted and welcomed.
- A Lincolnshire ICS Clinical Policies Group has been established to provide a forum for reviewing; quality assuring and ratifying clinical policies and standard operating procedures (SOP) that are to be implemented in two or more of the represented organisations.
- As part of the 2025/26 planning work system interim documentation and process for Quality and Equity Impact Assessments (QEIAs) that involve two or more organisations have been agreed.
- One of the four CYP diabetes deliverables is reducing health inequalities in access to diabetes technology. ULTH feedback revealed some families could not afford mobile phones needed for the technology. Unused phones from a previous NHSE-funded app trial were repurposed. A governance agreement enabled transfer of these phones to LCHG. A pilot will begin with the CYP diabetes team to provide phones to families in need.
- Vaccination programme – really good progress is being made and a significant number of people in Lincolnshire continue to access vaccines. Nationally Lincolnshire continues to perform very well.

Finance Section

Mr Gaunt advised that as per Mrs Raybould's and Mr Fahy's updates he would take the finance section of the report as being read but wished to highlight the following points for the Board's information.

- Year To Date Financial Position - The ICS delivered a £4.8m deficit in Month One which was in line with the YTD plan. The ICB's element of the Month One position was also on plan with a reported a £0.214m deficit. Quality and performance delivery is strong as referred to by Mrs Raybould and Mr Fahy.
- The ICB has identified risks to delivery of the 2025/26 plan of £31.6m. Main risks being Cost Improvement Delivery, Prescribing and CHC. Mitigations of £25.1m result in a net risk of £6.5m. The ICS has an overall net risk of £33.9m.

Mr Gaunt emphasised the need to keep on track of key controls, such as workforce which at Month One was over by around 150 whole time equivalents (wte), which was most likely being driven through bank staff. This was the only real issue to report at this stage.

- The ICS has a full year cost improvement plan of £163.18m. At Month One the ICS has reported delivery of £9.012m cost improvements against a plan of £9.151m equating to a £0.139m adverse variance to plan.
- The ICS has a full year Capital Departmental Expenditure (CDEL) Limit of £138.2m. £37.9m of this relates to Business As Usual (BAU). The remainder of the capital is predominately for specific projects – the largest being £43.0m for the ULTH Frontline Digitalisation Programme (Electronic Patient Record). The ICS is expecting to utilise all of this allocation.

The Board considered the finance update and Mr Dunstan asked what percentage 150 WTEs represented of the total. Mr Gaunt estimated it to be around 1%. Bank along with agency staff cost premium rates. If this trend continued over the course of the year it could lead to costs reaching the low millions.

The ICB Board considered the report and agreed to:

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

25/322 PROCESS FOR REVIEW OF CQC SECTION 48 (CALOCANE) UPDATE REPORT

Dr McSorley advised that Mrs Connery was not present at the meeting so Mr Fahy would be presenting the next item on the agenda

Mr Fahy advised that following a previous paper presented to the ICB and Lincolnshire Partnership NHS Foundation Trust Boards in November and December 2024 respectively, the paper presented provided an update on progress to date and identified next steps in relation to Lincolnshire's response to the CQC, NHSE and independent enquiry into the care and treatment of Valdo Calocane and the tragic deaths of three people in Nottinghamshire.

The CQC completed a section 48 review of Nottinghamshire Healthcare NHS Foundation Trust's care and found a number of failings in Mr Calocane's care and treatment which led to recommendations to review a number of elements of service delivery to minimise the risk of this occurring again.

The report provides a very helpful definition of these cohorts of patients. Psychosis is an illness where people may or may not go on and develop other conditions, such as schizophrenia. This cohort includes individuals presenting with psychosis (diagnosed or not), who often struggle to engage with routine care, are at high risk of relapse and serious harm, have complex social needs, frequently experience co-occurring issues such as substance misuse, may have had traumatic interactions with services or the justice system, and are often the subject of concern from family or carers.

The key challenge for all systems is ensuring a clear understanding of the care and support available for individuals presenting with complex psychosis-related needs, particularly those who may not engage with routine services.

A series of audits were conducted by LPFT, reviewing over 200 patients current cases, which identified those patients in the Lincolnshire system were all receiving appropriate care overseen by Locality Mental Health Team MDTs. The review reinforced the need for a dedicated intensive/assertive support function, as current team capacity limits adherence to national standards (e.g. smaller caseloads, frequent contact, inpatient in-reach). No immediate safety concerns were found, but some risks were noted, as set out in the report.

A total of 177 patients with two or more MHA detentions in the past two years were identified. Of these, 34 patients were reviewed in detail—including all with four or more detentions (20 patients) and a random sample of those with two (six patients) and three (eight patients) detentions. All reviewed patients were actively engaged with a range of services, including inpatient care, crisis teams, early intervention, forensic and community teams. No specific gaps in care were found, and good practice was noted in voluntary sector engagement. However, care could be strengthened through a dedicated intensive support function.

96 patients were reviewed where DNA was the last contact. None met the criteria for intensive/assertive support. Most had evidence of proactive follow-up (calls, letters, MDT discussions). Some documentation lacked clarity on discharge decisions, and staff have been reminded to improve this. Monitoring will continue.

Last two points to highlight to the Board - following a review of incidents relating to this cohort of patients, no concerns were identified. Senior Mental Health Practitioners reviewed caseloads across all PCNs. Three patients meeting the cohort criteria were identified and referred to LPFT. No issues were reported with referral acceptance.

The report highlighted the need to re-establish Assertive Outreach Teams to improve engagement with hard-to-reach patients.

There are a number of pre-existing workstreams where the needs of people requiring intensive/assertive support needs to be considered, the task and finish group has asked for regular updates from these forums in terms of meeting the needs of this cohort, including housing, dual diagnosis, and carer support

On a final note, a system-wide learning event was held in April, and an updated plan will be presented to the ICB Board and LPFT Trust in June, with a formal action plan to NHS England in July. The Board was asked to receive the report.

The Board considered the report. Dr Earnshaw advised that the paper provided a good level of assurance for the Board, and expressed interest in this area as he is a Non-Executive Director of a mental health trust in another area, and he would be interested in hearing more about the timelines for assertive outreach development. The report also referred to family engagement, which is absolutely critical as often these people get very isolated. The one area he was concerned about related to the IT systems and their role in accurately identifying the cohort. Mr Fahy acknowledged the limitations with IT systems, particularly around identifying and flagging patients within this cohort. While audits confirmed good care once patients were identified, concerns remain about the ability to flag them consistently and accurately across systems. Interoperability challenges persist between mental health and primary care systems. Although Lincolnshire has strong shared care record processes, work is ongoing to improve flagging mechanisms so primary care can easily identify cohort patients and seek appropriate advice, particularly from senior mental health clinicians.

Dr Thomas praised the report and assurance but highlighted the chaotic nature of the cohort's lives, frequent movement, and gaps in care transfer. He stressed the need for better communication between Trusts and primary care to prevent patients from becoming lost in the system.

Mrs Robson advised that she found the report reassuring but stressed the importance of engaging families and carers, and ensuring this is reflected in risk management processes and broader mental health support pathways and handover to providers outside of Lincolnshire.

Professor Dunderdale acknowledged the report's detail and assurance but raised concerns about the imbalance of focus on LPFT, highlighting the need for the ICB Board to address primary care risks more explicitly.

It was agreed that these points will be fed into the Task and Finish Group for ongoing follow-up and action.

Mr Turner sought clarification that the report provided a description of the action plan relating to the intensive/assertive support cohort but that the full action plan itself was not included. This was confirmed as correct by Mr Fahy; the report has been considered by LPFT, but not yet formally approved by their Board.

This was discussed and the Board agreed that they were not in a position to formally endorse the action plan at this meeting. Given the absence of a public Board meeting in June, and the requirement to meet the NHSE deadline, the Board agreed to note the update report and delegate authority to Mr Turner as Chief Executive and relevant Executive Directors to oversee and ensure the final action plan reflects the discussion and feedback from this meeting. Further clarification and assurance will be sought outside of the meeting.

In summary, colleagues were assured on the progress to date and thanked the leads / partners for all the work taken forward on behalf of the system. There were two issues flagged that need strengthening on the action plan. The first being digital flags and the ability for primary care to have them so they can identify this patient cohort on SystmOne. The other was handover from mental providers external to Lincolnshire.

It was noted that Mr Fahy would feedback this information to Mrs Connery outside of the meeting.

Action: Mr Fahy

The Board agreed to:

- **Note the report.**
- **Delegate endorsement of the Action Plan for submission to NHSE to the ICB Chief Executive and appropriate Executive Directors once the areas identified above had been incorporated.**

GOVERNANCE

25/323 STANDARDS OF BUSINESS CONDUCT AND CONFLICTS OF INTEREST POLICY

The Board received a report outlining updates to the ICB's Standards of Business Conduct and Conflicts of Interest Policy. Following the publication of updated NHS England guidance on Managing Conflicts of Interest in the NHS (17 September 2024), the ICB policy was reviewed and amended by the Board Secretary and Deputy Board Secretary to ensure compliance. The revised version was approved by the Board at its meeting on 24 November 2025.

Subsequent to this, an internal audit conducted by TIAA recommended additional changes, including updates to reflect the commencement of the Procurement Act on 24 February 2025 and several minor amendments. These changes have been incorporated and highlighted in the updated policy document.

The Board was now asked to approve the revised policy for inclusion in the ICB Governance Handbook and for publication on the ICB website and intranet. The updated policy will also be communicated to staff, who will be required to familiarise themselves with its content.

The Board agreed to:

- **Approve the revised ICB Standards of Business Conduct and Conflicts of Interest Policy.**

25/324 BOARD FORWARD PLAN 2025/26

The Board received the draft Forward Plan for 2024/25, outlining a structured programme of business aligned with agreed meeting dates. The plan supports effective governance, strategic delivery, and financial oversight, while ensuring timely scrutiny without imposing undue administrative burden. Board members were invited to provide any comments or amendments. A final version will be circulated for information.

The Board agreed to:

- **Note the document will be kept 'live' in light of recent national announcements about the NHS Reforms and the change in role of ICBs.**
- **Note any amendments will be incorporated as appropriate with the updated version circulated to the Board for information.**

25/325 COMMITTEE HIGHLIGHT REPORTS

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

System Quality and Patient Experience Committee

Mrs Robson presented the report from the meeting of the System Quality and Patient Experience Committee (SQPEC) which took place on the 23rd April 2025 and outlined the contents.

It was noted that the ICB People and Communities Involvement Annual Report 2024/25 had been attached separately to the report. This document reflected the ICB's statutory duties to involve patients and the public in service planning and decision-making.

It showcases examples of engagement providing public visibility of involvement activities.

SQPEC had agreed to endorse the report for ratification by the Board prior to publication.

Service Delivery and Performance Committee

Mrs Kenson presented the report from the meeting of the Service Delivery and Performance Committee April meeting and summarised the contents.

Mrs Kenson highlighted that the Committee had received a detailed update and reviewed the approach to developing the Winter Plan, its implementation and outcomes, along with learning points.

In conclusion, the Committee felt that the system had operated effectively over winter and had been more integrated than in previous years.

Looking ahead, Mrs Kenson advised that attention is now turning to the 2025/26 plan, and that delivery will be monitored using the new metrics scheduled for discussion at the next meeting taking place the following day.

Audit and Risk Committee

Mr Dunstan presented the report from the meeting of the Audit and Risk Committee which took place on the 17th April 2025 and outlined the contents.

It was noted that Audit and Risk Committee Annual Report 2024/25, including Self-Assessment was attached to the report along with the revised Terms of Reference – which the Board was asked to approve.

East Midlands ICBs Joint Committee

Dr McSorley presented the briefing from the meeting held on the 15th April 2025 and outlined the contents.

The Board agreed to:

- **Note the Committee reports.**
- **Ratify the ICB People and Communities Involvement Annual Report 2024/25.**
- **Approve the revised Terms of Reference for the Audit and Risk Committee.**
- **Receive the Audit and Risk Committee Annual Report 2024/25 and self-assessment.**

INFORMATION/CLOSING ITEMS

25/326 REGISTER OF DOCUMENTS SEALED 2024/25

In line with the ICB's Constitution and Delegated Financial Authority Limits, the Board was informed of the arrangements for the use of the organisational Seal. No documents required signing and sealing during the 2024/25 period. The Board noted this update.

The Board agreed to:

- **Note the report.**

25/327 DECLARATION OF INTEREST REGISTERS – MAY 2025

The Board received the Declaration of Interest Registers for 2024/25 (as at May 2025). The ICB continues to uphold its responsibility for managing public resources with transparency and accountability, in line with Section 14Z30 of the NHS Act 2006.

The Standards of Business Conduct and Conflicts of Interest Policy remains in place – as considered earlier in the meeting, with registers of interest published on the ICB website and reviewed regularly by the Audit and Risk Committee.

Following recent personnel changes, Mr John Dunstan, Chair of the Audit and Risk Committee, has been confirmed as the ICB's Conflicts of Interest Guardian.

25/328 ANY RISKS IDENTIFIED

The Board agreed that no new risks had been identified during the meeting.

It was noted that when updating the ICB objectives for 2025/26, a review of the Board Assurance Framework (BAF) will be undertaken to address related risks, potentially as part of the next Board Development Session on 24th June 2025.

Planning and the structure for that session would take place outside of the meeting, with consideration given to incorporating topics around the BAF and risk management.

25/329 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 29th July 2025 at 9.30 am at Bridge House, Sleaford.

The Board agreed the following resolution:

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

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Chair Signature **Date**

Questions from the Board meeting held on 27th May 2025

Question One

I note with great interest, on account of my geriatric mother currently being an inpatient at Lincoln County Hospital (LCH) following a Failed Discharge from Scunthorpe General Hospital (SGH), your recent Intermediate Care Strategy 2025-2030 Engagement Survey.

In noting that the survey closed for review on 29th April 2025, I would like to enquire if the findings and final report have been released internally to the ICB, and if those findings have subsequently resulted in any substantial changes to the 4 main types of Intermediate Care available at LCH? Changes which Lincoln constituents and/or Lincolnshire County residents have not yet been informed of?

The National Audit of Intermediate Care categorises 4 types of intermediate care, as laid out in the DHSC Care and Support Statutory Guidance – these being 'crisis response', 'home-based intermediate care', 'bed-based intermediate care', and, 'reablement'. (These categories are also referenced around pages 239/240 of the LICB Public Board Papers – May 2025).

In paying respect to the above references, my query is why, at a recent 'best decisions' meeting at LCH, would there be a failure to recognise the existence of at least one of the 4 categories established, namely 'home-based intermediate care'?

Even when specifically questioned about 'home-based intermediate care' (the recent provision of 'reablement' being inadequate and inappropriate, given the patient's vulnerability and healthcare needs - resulting in a hospital readmission), the response presented at the meeting was to suggest that 'home-based intermediate care' does not exist, and I quote, "home-based reablement it's called here in Lincoln County Hospital".

Would this reduction in provision be unique to LCH, because whilst it was recognised and understood that needs could be met at home with a support package of Intermediate Care, those care options were being limited to 'reablement' only ("up to [a maximum of] 4 weeks"), which arguably fails to pay respect to, and would seemingly not comply with, the principles within the aforementioned DHSC Care and Support Statutory Guidance, nor legislation laid out in section 2 of the Care Act 2014?

If it proves to be that there have indeed been no substantial changes to the 4 main types of Intermediate Care, or the provision of therein at LCH, would the ICB consider putting robust training programmes in place to support staff in better understanding Intermediate Care, and moreover, to promote health equity for patients and carers, and minimise the likelihood of failed discharges and readmissions?

Response:

Thank you for your question, I can confirm that following our recent Intermediate Care Engagement exercise that we are currently reviewing the responses and using these as we create an Intermediate Care Strategy for Lincolnshire, this work is still underway. In reference to your other queries.

I understand that you have received a response from Adult Social Care via the ICB Engagement Team as attached (Listed below in blue).

The response from Lincolnshire County Council:

Thank you for your query, you are correct in how you outline the components of Intermediate care. Although the predominant provider of intermediate care in the home in the Lincolnshire Health and Social Care system is the Home Based Reablement Service; there is another

service provided by health colleagues and as you rightly point out bed-based care. The Adult Social Care team are aware of this and may have been speaking specifically about how they had assessed the need of the individual being discussed, but we will ensure that they are reminded of the full range of services available.

We work on a Home First principle and will always work to support someone to return to their home where it is safe to do so. Not all care on discharge from hospital is considered to be intermediate, if the multi-disciplinary team are unable to identify goals that this support could achieve and there is an assessed long term need, longer term care may be recommended to support the individual, again through Health or Social Care.

It is difficult to comment on what has been said by a colleague without understanding the particular situation where an MDT was held, however, Catherine Paterson, Area Manager, would be happy to discuss individual details if you would like to make contact with her catherine.paterson@lincolnshire.gov.uk

Our system provides intermediate care for up to four weeks as we believe that this allows time for the teams working with individuals to identify, set and achieve goals effectively. However, we do work with individuals and recognise that some take less time and occasionally some take more, that is open to discussion and if not appropriate to remain with one service, individuals can move to another intermediate care tier for further support, for example moving from bed based intermediate care to home based. Our goal is always to maximise independence.

Please do contact Catherine Paterson if she can provide any further information or reassurance.

Further response:

While it is not possible to comment on individual patient care and individual discharges, we can confirm that the Lincolnshire Health and Care system do jointly commission services to support patients on discharge from hospital, both in their own homes and in bed-based services. In Lincolnshire we work to the Home First principle, meaning that wherever possible we support people back to their own home at the point of discharge, with a variety of support offers to meet their needs.

Services are commissioned to meet all four categories of Intermediate Care in Lincolnshire jointly by health and the Local Authority and are available to our hospital-based Transfer of Care Hub staff to support discharges but may be referred to using local service names. Our Transfer of Care hub assess need through a holistic MDT approach and as we have a variety of home-based intermediate care services locally, they will determine the most appropriate service to meet the presenting needs.

If you would like more specific details around the discharge process for your mother, as we don’t access patient information, we would advise you contact the PALS service at Lincoln County Hospital who will be able to review the detail. Their contact details are as follows:

Contact us by email

If you would like to contact PALS by email you can email ulth.pals@nhs.net

Contact us by telephone

We have two front of house PALS services located at Lincoln County Hospital and Pilgrim Hospital.

Lincoln County Hospital

Located near Main Reception
Telephone: (01522) 707071

Pilgrim Hospital

Located in Main Reception
Telephone: (01205) 446243

Question Two

Can you please stop the waste of the resource for MRI, CT scans and X Rays having to be redone because the results do not cross county borders.

My wife needed the above but we could not have them done in Lincolnshire as she was being treated in Sheffield, 3 years ago.

This month, I had the above scans done in Lincoln, saw the consultant in Hull and am having to have them done again in Hull because the consultant could not access the results.

All this results in a waste of precious resources and a delay in my treatment, leading to a deterioration of my condition, thus delaying my recovery, requiring more support to get back to fitness.

Response:

Thank you for your comments in relation to the duplication of scans for patients being seen in the NHS outside of Lincolnshire.

For hospitals within the East Midlands, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) are able to share scans with other hospitals immediately (e.g. in Nottingham, Leicester and Derbyshire). This is done via a shared piece of software and requires no input by the hospital that performed the scan. This has been through rigorous data protection and information governance processes and has been well established for several years.

We also have the facility to share images with any other provider in the Country (including Scotland). This is done through the Image Exchange Portal and all hospitals have this. It requires a hospital to send an electronic request to the hospital where the scan was performed detailing what information is needed. ULTH receive several hundreds of these each week and all are responded to within 48 hours. There is regular image sharing between ULTH with both Hull and Sheffield.

If you would like us to look into whether a request was made for your scan, then please let us know. We can arrange for your personal details to be taken for us to investigate further.

Question Three

Please can you confirm if Lincolnshire ICB will be funding Phlebotomy at Lakeside Health Practice to alleviate the long queues at Stamford Hospital?

Response:

The 81 GP practices, including Lakeside, in Lincolnshire each have a nationally determined contract (the national 'General Medical Services' (GMS) contract for the vast majority of the services that they provide and the income that they receive. There are, however, a range of services, which are commissioned locally by the ICB, these are referred to as enhanced services.

Phlebotomy is an enhanced service that the ICB commissions locally. We are keen for practices to provide these services, but the decision as to whether they wish to, is made by the practice team who will determine whether they are able to deliver this service alongside their core contract. The ICB Primary Care Team meet regularly with colleagues at Lakeside and will discuss with them whether they would consider providing phlebotomy services as the funding arrangements are in place to support this.

We appreciate that having to access services such as phlebotomy at locations other than your GP practice is not as convenient for patients. We also understanding that there has been a recent increase in demand for phlebotomy at Stamford hospital and that this has meant there has been an increase in waiting times. We are sorry for this and would like to reassure you that we are exploring opportunities to improve access.

Not Delivered
In Progress
On Track to Deliver
Complete

NHS
Lincolnshire
Integrated Care Board

ACTION LOG - PUBLIC

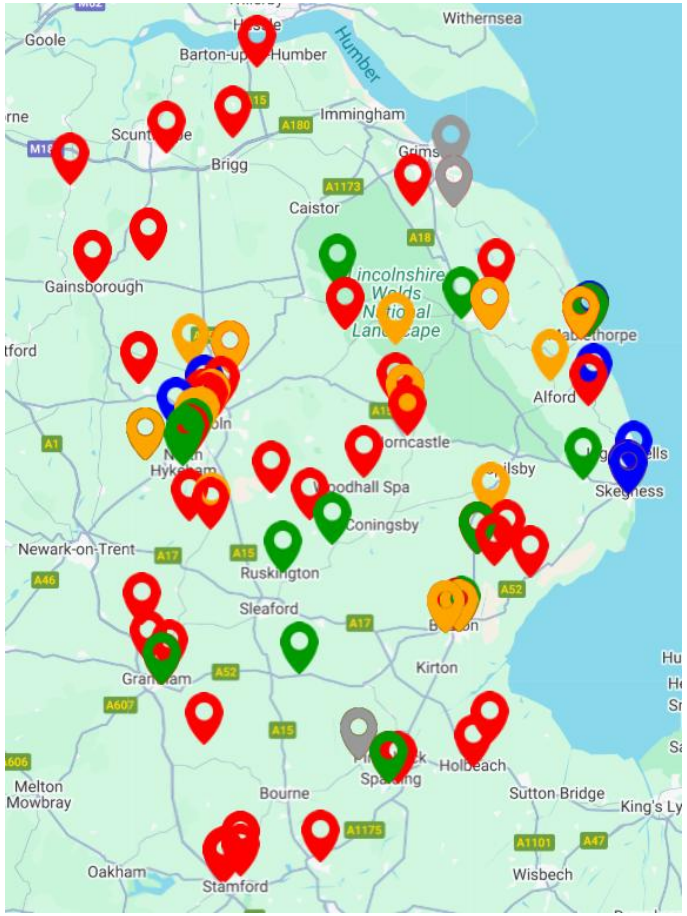
Date of Meeting:	**Tuesday, 29th July 2025**
Agenda Item:	**1 (v)**
Reporting Officer:	**Dr Gerry McSorley, ICB Chair**

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
27/05/25	25/317	Chair's update	To write to Councillor Bowkett and Councillor Wooley expressing appreciation for their hard work and contributions to the ICB Board.	Dr McSorley	June 2025	Letters issued.	Complete.
27/05/25	25/321	Process for review of CQC Calocane) update report	To feedback the comments received to Mrs Connery from the Board for inclusion in the Action Plan prior to submission.	Mr Fahy	June 2025	Feedback provided as summarised during the meeting.	Complete.

ICB Update Healthwatch July 2025

healthwatch Lincolnshire

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



Location mapped using service postcodes.

Positive - green **Negative - red** **Mixed - orange**
Neutral - blue **Unclear - grey**

May and June 2025

Between May and June 2025, **160** people shared their experiences of health and social care with us. An additional 153 carers and 24 care home managers shared their views through our carers and care home managers survey.

Out of the 160 experiences shared with our Information Signposting Service, **59% were negative** and **16% were positive**. The remaining were neutral, mixed or unclear.

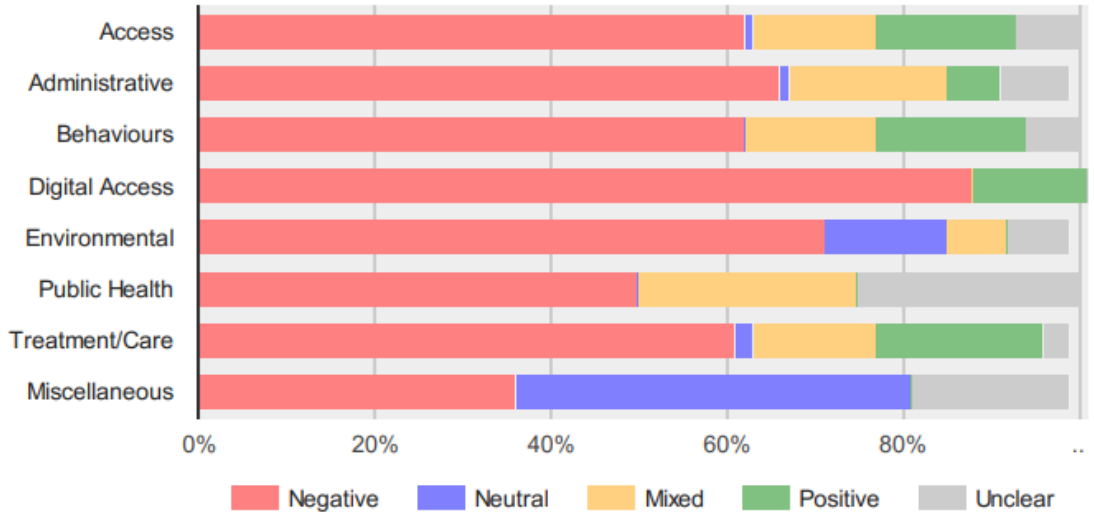
The service areas commented* on the most this month were:

- GP Services (54%)
- All Hospital Services (44%) - (9% of all comments were about A&E)
- Social Care (16%)
- Mental Health (6%)
- Dentistry (5%)
- Patient Transport (4%)

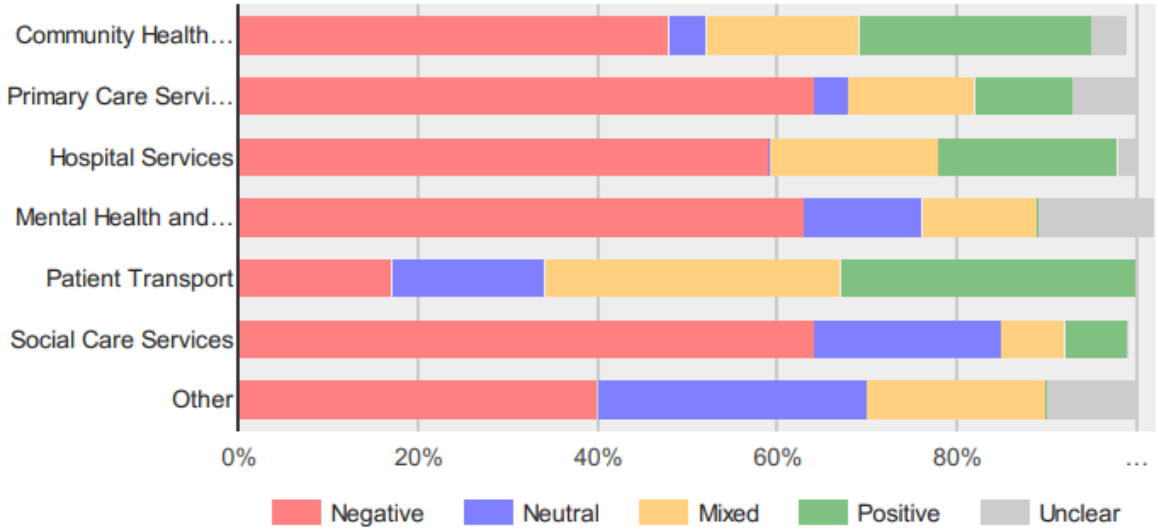
*Some comments relate to multiple service areas.

IMP sentiments and themes

Satisfaction by Theme



Satisfaction by Service Type



Dental care for cancer patients

healthwatch Lincolnshire

Patient Comment

Their NHS Dental practice in Coningsby was advised that the practice is now going to become 'private' and therefore the cost of the treatment offered (capped tooth) would increase from £200-£300 to £1000+

The sibling, although diagnosed with cancer, is continuing to work part-time and is 61yrs old, not on benefits and cannot afford the price stated but would be happy to pay the initial NHS price originally quoted. Has tried to get PIP however, has been informed that as they can speak they are not entitled to this, so has to carry on working even when they have physical disabilities.

The caller has contacted many dental practices to enquire if their sibling could register with them but all to no avail with many being dismissive and uncaring, suggesting that the sibling simply have the tooth removed.

Healthwatch Lincolnshire contacted several practices to support the individual. Under the circumstances, Wyberton and Winsover Dental Care in Mablethorpe offered to help.

An appointment in the right timeframe has been secured for the individual.

Relocation of services

- Patients have raised concerns about service relocations causing inconvenience, increased costs, and reduced accessibility.
- One patient flagged the recent change where leg ulcer treatments are no longer provided at Beechfield, requiring travel to Gosberton. This results in a significantly longer journey, increased patient transport costs, and reduced service capacity for volunteer drivers.
- Another patient reported delays and overcrowding at Stamford Hospital's phlebotomy clinic due to GP surgeries no longer offering blood tests. Patients are queuing from as early as 7.30am and often waiting outside with limited seating or shelter.

Next Steps:
We will be sharing these and other patient comments in more detail at the upcoming PC3 meeting to inform service planning and decision-making.

Positive experiences

healthwatch Lincolnshire

Boston Pilgrim Hospital

"I suffered a major cut to my hand severing a tendon to my thumb. I attended Boston Pilgrim Hospital on Monday afternoon and was sent through urgent care . I was seen by several people quickly, cleaned up and wound dressed. I was told to go home and expect a call tomorrow morning regarding surgery. The next day at 9 am I was called and asked to attend the trauma unit . By 1.30 pm I was in theatre for tendon repair and wound stitched up. Everyone involved was wonderful , what more could I have asked for."

Lincoln County Hospital

"Spouse would like to thank the very kind and caring Nurse in charge of Coronary Care Unit on the night shift who let me wait on the ward, updated me on the procedure every 15 mins and progress, answered all my questions, gave and offered me lots of cups of teas and biscuits and let my grown-up children who had travelled a long way see their parent. They made a very emotional and worrying time a little easier."

Social Care – Healthwatch Carers Survey

healthwatch Lincolnshire

153 carers shared their views. Some initial headlines:

45% had **not received information** about the support available for carers.

72% did not feel supported as a carer.

59% said the **rising cost of living** has impacted on their ability to be a carer.

Full analysis of the findings is underway and will be discussed next time.

Social Care – Healthwatch Care Home Manager Survey

healthwatch Lincolnshire

We are reaching out to care home managers across Lincolnshire to understand the:

Current challenges

Access to services

Good practice

Take the survey:
https://www.smartsurvey.co.uk/s/OS0A8G/

Current and future priorities

healthwatch Lincolnshire

Sensory Impairment

We want to hear from people with sight and/or hearing loss about:

- Access to health and care services
- Communication challenges
- What truly inclusive care looks like

Help us shape this project:
Share your insight, networks, or lived experience

State of Health & Care in Lincolnshire – Barometer Survey

A major survey launching soon to take the *pulse of health and care* across the county. We'll be asking:

- What's working well?
- What are the key pressures?
- What needs to change?

Help us shape this project:
Share your insight, networks, or lived experience

HWLincs engagement work

Pelvic Health

Based on the findings from the first phase of the project, an information pack has been produced for distribution to new mothers.

Participant recruitment is underway for phase two, where focus groups will aim to gather feedback on these materials and explore the recommendations coming out of phase one.

Childhood Immunisations

"The work on the imms programme has given us some amazing insight in how we can better deploy services to meet demands, based on the HWLincs work."

Hidden Voices

Delivery: June 2025 – December 2025

Aim: Increase the understanding of mental health and wellbeing challenges of Armed Forces minority groups, identifying gaps in support, and promoting prevention and early intervention strategies.

Communities of interest: Armed Forces Personnel, specifically:

- Members of LGBTQ+ community
- Ethnic minorities
- Those with a disability or long-term health condition
- Carers
- Their families

For more information

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healthwatch Lincolnshire

Item 4 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	4 (i)
Meeting Date:	Tuesday, 29th July 2025
Title of Report:	Bowel Cancer Screening Project - Practical application of tackling Health Inequalities
Report Author:	Mrs Emma Townend, Interim Health Inequalities Programme Lead
Presenter:	Mrs Sandra Williamson, Director for Health Inequalities, Prevention and Regional Collaboration Mrs Emma Townend, Interim Health Inequalities Programme Lead Ms Ellie Sadler, Living with Cancer Programme Manager
Appendices:	Appendix 1 – Lincolnshire Bowel Cancer Screening Project Evaluation Appendix 2 – Presentation

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

Recommendations

The Board is asked to receive and note the approach to tackling health inequalities that was used in a Bowel Cancer Screening Project as a practical example of targeted, place-based action to address Core20PLUS5 priorities. This report sets out the method, approach, and outcomes of the work and highlights its relevance for wider system learning and practical application of how to address health inequalities.

Summary

Background and Context

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

One of the core aims of the NHS Long Term Plan was to reduce healthcare inequalities. The recently announced NHS 10 Year Health Plan for England builds on this by setting out a vision for a 'reimagined NHS' that will be designed to tackle inequalities in both access and health outcomes. The strategic shift from a focus on sickness to prevention supports this vision, but it will only be effective if it is underpinned by proportionate universalism, ensuring that interventions are universal but scaled according to need.

Core20PLUS5 is a national NHS England (NHSE) approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' and identifies '5' focus clinical areas requiring accelerated improvement. Early cancer diagnosis is one of the 5 clinical areas as it is one of the biggest contributors to the life expectancy inequality gap between the most and least deprived populations in the U.K. The aim is for 75% of cases to be diagnosed at stage 1 or 2 by 2028.

In Lincolnshire, almost double the number of people from the 20% most deprived areas are more likely to die from cancers considered preventable than those living in the least deprived areas. On average there are 42,886 new cases of bowel cancer diagnosed each year in the UK (2016-2018 average), making it the fourth most common cancer. Bowel cancer is the most common cancer in Lincolnshire.

The national bowel screening programme invites people aged 50 to 74 to complete a Faecal Immunochemical Test (FIT) every two years. Significant disparities exist in screening uptake nationally and across the county with people living in the most deprived areas less likely to take up the screening offer. Nationally, survival rates differ significantly based on the stage at which the disease is diagnosed – over 90% of people diagnosed at stage 1 survive at least five years, compared to around 10% at stage 4. People living in the most deprived areas are disproportionately likely to be diagnosed late or via emergency presentation (such as in A&E).

Beyond the immediate health benefits, earlier diagnosis also supports economic resilience by reducing avoidable illness and maintaining workforce participation in communities already facing disadvantage.

In 2022, local analysis showed 62% of people in the most deprived quintile completed their bowel screening, compared to 70% in the least deprived. Lower uptake is particularly evident in coastal and some urban communities such as Skegness, Mablethorpe, and Gainsborough. This analysis also showed that the 20% most deprived population in Lincolnshire is twice as likely to be diagnosed with cancer during a visit to A&E, and the 20% most deprived population has more late-stage cancer diagnoses than the 20% least deprived (point gap: 3.7%).

The Health Inequalities bowel screening project began in June 2023 and was delivered over two years as a joint priority for the Health Inequalities and Cancer Programmes. It was designed to understand the specific barriers to screening uptake in the most deprived communities, and to co-produce practical solutions with local people to address them thus increasing screening rates. The project aligns closely with one of the NHS's strategic key shifts: moving from treatment to prevention.

Initial data analysis identified four GP practices with more than 70% of their population living in IMD deciles 1 and 2 where bowel screening was below the Lincolnshire average. These were: Marisco Medical Practice, Beacon Medical Practice, Hawthorn Medical Practice, and Caskgate Street Surgery.

Engagement

A digital survey 'Let's Talk Bowel Cancer Screening' was sent to eligible patients registered at the identified GP Practices via text message with 2,416 responses received – the highest response rate for any ICB survey at that time. Of these, 100 people identified as non-responders or irregular completers, with 90 living in the most deprived deciles.

The digital survey was accompanied by local face-to-face drop-in sessions and a telephone number to offer feedback.

Targeted engagement followed with a specific focus on carers, people with learning disabilities, and those who do not speak English as a first language. A total of 316 people gave their views face to face or via telephone. This engagement provided direct insight into people's reasons for not completing their bowel screening. Seven core themes emerged from the engagement phase:

- I forgot / I don't have time
- I find it embarrassing
- I know someone who had cancer / I'm scared
- It won't work, I have other conditions
- I don't understand
- What's the point?
- What if it says I have cancer?

Co-Production

Every-One were commissioned to organise and facilitate co-production for the project. In Mablethorpe, a small but dedicated co-production group was formed of people who had registered interest during the engagement phase. The group were presented with the themes from engagement and asked which ones they wished to address first, and their ideas became the beginning of a 10-week marketing/education campaign. The group co-produced myth-busting posters and educational postcards using locally resonant language and imagery. These materials were adapted for use in Skegness and Gainsborough following further community feedback in those areas.

Outputs from the project included:

- Prescription bags featuring co-produced wording (e.g., *"The poo test is quick and easy to do. Make the time because you are worth it.")* which were well-received by patients. These have generated interest from other Primary Care Networks (PCNs) who are now looking to adopt the same approach in their local areas.

- A non-responder bowel screening letter was developed as part of the project. This has been translated into Lincolnshire's top 6 spoken languages and has been made available as a template for all Lincolnshire GP practices.

- Myth-busting posters and campaign materials created by local co-production groups which have since been adapted and used as part of the Lincolnshire Bowel Cancer Awareness Month.

- Pop-up events in shopping centres and market stalls engaging with over 400 people where the team wore "poo emoji" hats and provided education with a light-hearted tone, which was a key desire of the co-production group. Town crier also attended.

- A resource document to support carers of people with learning disabilities in care homes and supported settings, and an educational video for people with learning disabilities were also developed.

For people with learning disabilities, the project also scoped 'invitation intervention' (supporting people at the time of invite) and scoped future implementation of a 'non-responder intervention' (supporting people when they have not responded to their invite) model which is being taken forward by the Cancer Programme in 2025/26.

Evaluation of the Project

The evaluation highlights how a community-centered, co-produced approach can tackle structural barriers to screening and achieve culture change at a hyper-local level. While further data is needed to assess long-term impact, the project model has already influenced GP Trailblazer Fellowship projects on cervical and breast screening to upskill staff and improve uptake. Additionally, the project model will be used for targeted lung cancer screening work and other projects led by the Health Inequalities and Cancer Programmes in 2025/26.

The project is still awaiting complete data to fully evaluate its impact, however qualitative insight and real-time feedback from people within the communities indicates great engagement and, in many cases, a willingness to complete screening following speaking to the team.

Lessons Learnt

- There was initial concern about low engagement from deprived communities and reluctance to discuss bowel screening, but people were willing to talk, and the face-to-face engagement drop-in session in Skegness was particularly popular.

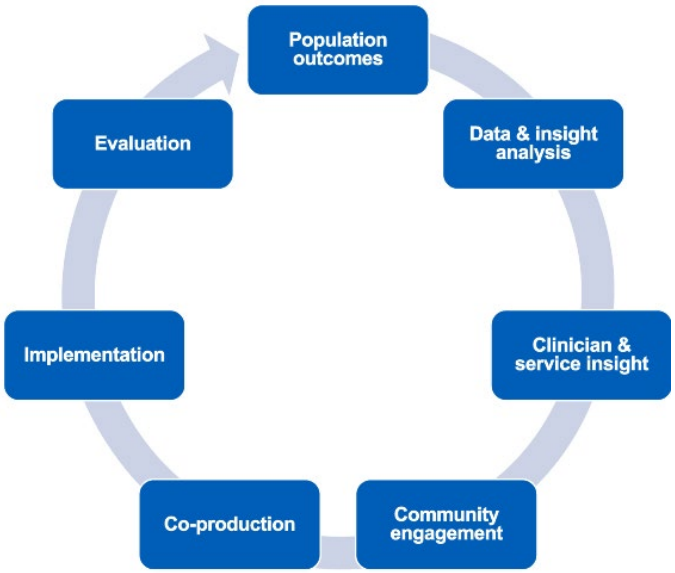
- There is a huge importance to not rely solely on digital methods to engage with people as this can unintentionally exclude a significant number of individuals.

- A key success of the project has been understanding that a hyper localised campaign resonates with people, and they appreciate the time spent understanding their barriers and making small differences to make materials more relevant to their local areas. Being physically present in towns through pop-up events and direct outreach to local businesses was beneficial for campaign visibility.

- Another key success was placing local people at the centre of the project; through in-depth engagement, the team gained a strong understanding of community barriers, co-designed materials with a light-hearted tone shaped by a co-production group and shared useful insights with other programmes and workstreams.

Broader Application

This is an adaptable, scalable and practical approach using data and insight with a community centred co-production approach at its core which can be replicated to tackle healthcare inequalities in Lincolnshire.



How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Early cancer diagnosis is one of the 5 clinical areas in the CORE20PLUS5 approach to addressing Health Inequalities. It is one of the biggest contributors to the life expectancy inequality gap between the most and least deprived populations in the U.K. Earlier identification of bowel cancer in high-risk groups by increasing awareness and confidence in completing bowel screening will support improvement in population health and outcomes. The approach taken in the bowel screening project can be used in other projects to tackle health inequalities which will support improving outcomes in population health.
Aim 2: Tackle inequalities in outcomes, experience and access.	The Health Inequalities bowel screening project looked to address a known disparity in screening uptake between the most and least deprived population groups. Improving early diagnosis in working-age adults in deprived communities can extend years of life and healthy life expectancy. The approach used can be replicated to address other inequalities in outcomes, experiences and access in Lincolnshire.
Aim 3: Enhance productivity and value for money.	Early-stage diagnosis significantly reduces treatment costs and the likelihood of unplanned admissions. Enabling more people to screen from home empowers more people to engage with preventative care, freeing up clinical resources and reducing the need for more complex, higher cost, later-stage interventions.

Aim 4: Help the NHS support broader social and economic development.	Michael Marmot's work calculated the NHS treatment costs of health inequalities to be in the region of £5.5bn a year, productivity losses in the economy to £33bn, while a further £32bn a year is spent on higher welfare payments. Reducing health inequalities in screening delivers broader economic benefits by helping people stay well, remain economically active in the workforce, and contribute to productivity while also reducing reliance on welfare or health services.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	N/A

Risk and Assurance
Risks were managed and reported into the Health Inequalities Programme & Cancer Programme governance arrangements.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	Yes – how to address them
Does the report demonstrate patient and public involvement?	Yes
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable

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

Report previously presented at:
N/A

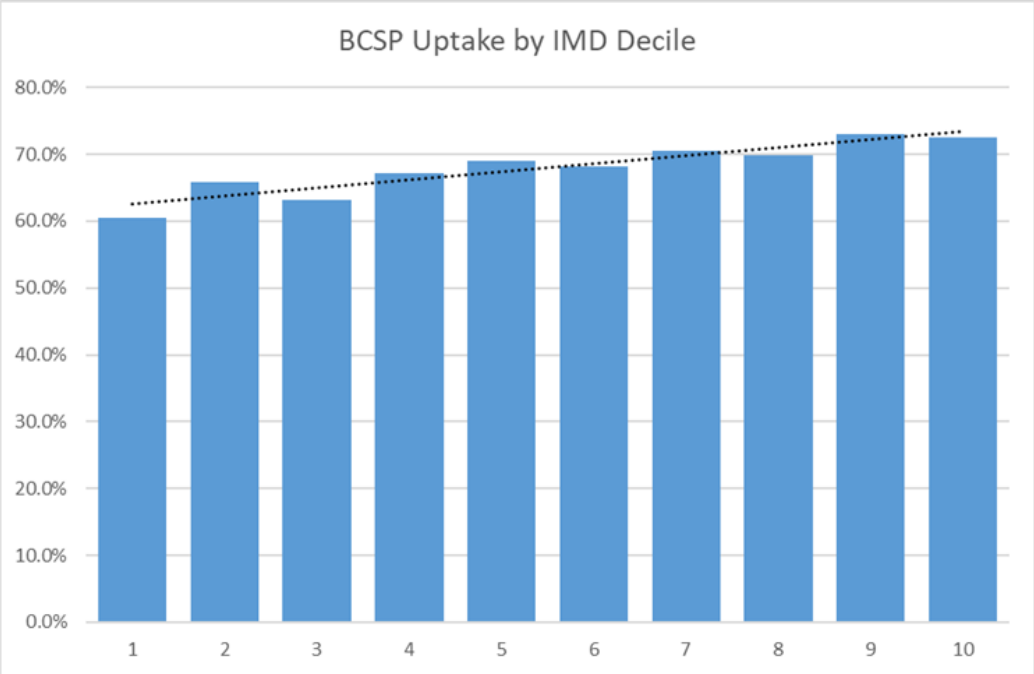
Is the report confidential or not?
Yes ☐ No ☒

NHS
Lincolnshire
Integrated Care Board

HEALTH INEQUALITIES BOWEL CANCER SCREENING PROJECT – EVALUATION REPORT

1. Introduction and Background

An initial data analysis in 2022 showed that in Lincolnshire, **62%** of the 20% most deprived population completed their two-yearly Bowel Screening, whereas **70%** of the 20% least deprived population completed theirs, showing a clear link between deprivation and uptake rate:



The Health Inequalities Bowel Cancer Screening Project commenced in June 2023 and was aimed to address health inequalities related to bowel cancer screening and increase the uptake of bowel screening among people living in the most deprived areas of Lincolnshire. Data indicated that screening uptake was lower in these communities, though the underlying reasons were not well understood. This project sought to explore and identify these reasons. At the start of the project, the eligibility age to be invited to complete bowel screening was 56 to 74 years old, although this reduced to 50 years old in November 2024. People aged over 74 and 11 months can proactively call the national Bowel Cancer Screening Helpline to request a test.

Initially, the project focused on understanding the challenges and barriers experienced by individuals who had not completed their bowel cancer screening using the Faecal Immunochemical Test (FIT), specifically within the seven most deprived GP practices in Lincolnshire: Marisco Medical Practice, Beacon Medical Practice, Hawthorn Medical Practice, Caskgate Street Surgery, Cleveland Surgery, Abbey Medical Practice, and Lindum Medical Practice. The project's scope later changed to the four GP practices with the highest proportion (over 70%) of their registered populations living in the 20% most deprived population in Indices of Multiple Deprivation (IMD) deciles 1 and 2. These are:

- Beacon Medical Practice
- Marisco Medical Practice
- Caskgate Street Surgery
- Hawthorn Medical Practice

The project aimed to identify groups with the lowest screening uptake through data analysis and to engage with these cohorts to:

- Listen to and better understand the barriers and challenges preventing screening completion;
- Work with people living in the identified GP catchment areas to co-produce solutions to encourage and support individuals to participate in screening.

The project was a priority within the Health Inequalities and Cancer Programme's 2023/24 Operational Plan, with both programmes working collaboratively to deliver it. The project was due to run for two years, with an evaluation to be completed by 30th June 2025.

Due to limited access to timely quantitative data, this evaluation focuses primarily on the project's immediate qualitative impact. Feedback and lessons learnt have been proactively captured during the project lifecycle, supported by one-to-one reflections and opportunities within project meetings to share insight to support this evaluation.

2. Executive Summary

This evaluation report reviews the Health Inequalities Bowel Cancer Screening Project, a targeted health inequalities initiative delivered across some of the most deprived communities in Lincolnshire. The project aimed to improve understanding of the barriers preventing individuals from completing bowel cancer screening using the Faecal Immunochemical Test (FIT), and to co-produce practical solutions that could support increased uptake.

The project focused on four GP practices with more than 70% of their registered patient population living within Index of Multiple Deprivation (IMD) deciles 1 and 2. Initial efforts to define and analyse a data-driven cohort were hindered by delayed access to key datasets, inconsistencies in GP coding, and national restrictions on screening system data. As a result, the project evolved flexibly, moving into engagement activities before full cohort identification had been completed.

Engagement activities included a combination of digital surveys, face-to-face sessions, phone interviews, and community drop-ins. These reached a broad cross-section of the population, including underrepresented groups such as carers, people with learning disabilities, and non-English speakers. Insights gathered revealed a range of barriers including misunderstanding of the test, digital exclusion, fear of results, and confusion over whether test kits had been received.

Co-production efforts were strongest in Mablethorpe, where local residents supported the design of myth-busting campaign materials, including posters, postcards, and educational displays. These outputs were adapted and rolled out in Skegness and Gainsborough. Outputs from the project included an online & printed media campaign, bespoke double-sided prescription bags, and posters designed with local communities. The project team received great engagement and found that physically attending locations to distribute campaign materials (eg. posters) to be very beneficial.

While robust quantitative data was not available within the project timeline, there is qualitative evidence of increased engagement and positive reception from local communities. Pop-up events reached over 430 people and efforts to engage groups with additional barriers, such as carers and people with learning disabilities, resulted in tailored outputs including an educational video, easy-read materials, and a resource document to support carers of people with learning disabilities to help facilitate completion of bowel screening in this cohort of people.

The project group met regularly with good attendance, engagement and buy-in from stakeholders. Clinical support from the ULTH Bowel Cancer Screening Hub was essential and offered additional expertise for the project. Escalations were managed and addressed where appropriate, and regular updates were made to both Cancer and Health Inequalities boards

This evaluation highlights both the successes and limitations of the project. It offers a valuable model for community-led, place-based approaches to support projects, especially where quantitative data access is limited. A follow-up review is recommended once relevant screening and staging data becomes available, to assess longer-term quantitative impact of the project.

3. Project Objectives and Expected Outcomes

The following objectives and outcomes were identified in the Project Initiation Document (PID)

Project Objectives

- Identify cohorts of people who have the lowest uptake of the FITs from the CORE20 in the selected GP practices by end September 2023.
- Identify the barriers/challenges/reasons that prevent the identified cohort/s from completing the FIT
- Identify solutions to overcome the barriers/challenges/reasons that prevent the identified cohort/s from completing the FIT
- Implement solutions to overcome the barriers/challenges/reasons that prevent the identified cohort/s from completing the FIT
- Evaluate the solutions to overcome the barriers/challenges/reasons that prevent the identified cohort/s from completing the FIT
- Increase the number of FIT completed by the identified cohort/s

Project Outcomes

- There is an increase in the number of people in the identified cohort completing their bowel screening.
- Understand barriers experienced by people within the target cohort/s in relation to completing bowel screening
- There is a reduction in barriers for people within the target cohort/s in relation to completing bowel screening
- People within the target cohort/s are more engaged in bowel cancer screening
- Gained valuable insight from seldom heard groups

Additional Scope

- Reducing the number of people being diagnosed with bowel cancer at Stage 3 or 4; Increase in diagnoses at Stage 1 or 2.
- Reducing the number of people being diagnosed with bowel cancer in A&E

4. Stage 1 – Data Analysis

The project team for the Bowel Cancer Screening Project was formed from colleagues across Lincolnshire Integrated Care Board (ICB)'s Health Inequalities, Cancer and Engagement teams, Primary Care Networks, Macmillan, Every-One, the University of Lincoln, the East Midlands Cancer

Alliance, the Lincolnshire Voluntary Engagement Team, and NHS England, with clinical representation from the ULTH Bowel Cancer Screening Team.

A decision was made to commence a project to address the uptake of screening for those living in the 7 most deprived GP practices in Lincolnshire:

- Abbey Medical Practice – Lincoln
- Caskgate Street Surgery – Gainsborough
- Cleveland Surgery – Gainsborough
- Hawthorn Medical Practice - Skegness
- Lindum Medical Practice – Lincoln
- Marisco Medical Practice – Mablethorpe
- Beacon Medical Practice - Skegness

The project commenced Stage 1 – Data Analysis in June 2023. Data was analysed from 2 data sources: Lincolnshire Population Health Management Reporting Suite (PHM) and the Bowel Cancer Screening System (BCSS).

There was a four-month delay in accessing Bowel Cancer Screening Service data to establish an appropriate cohort of 20% most deprived populations ("CORE20") to engage with, due to the requirement of a new Data Sharing Agreement between Lincolnshire Integrated Care Board (LICB) and United Lincolnshire Teaching Hospitals Trust (ULTH).

During this stage, it was found that information about those with abnormal screening was easily available. However, data for non-responders or those that had declined screening was difficult to obtain due to the following reasons:

<u>BCSS Data</u>

- NHS England restricted access to Lincolnshire Bowel Screening Data with no local availability to national datasets, information only available at a broad regional level.

- Lincolnshire Integrated Care Board (ICB) access to BCSS data contained no essential granular detail / no NHS numbers

- United Lincolnshire Teaching Hospitals (ULTH) access to BCSS data provided data available at GP Practice level, but only age / gender available. No NHS numbers and only grouped numbers of those invited and responded.

<u>PHM Reporting Suite</u>

- GP practices were cross-coding symptomatic FIT patients and screening FIT patients, and there were no standardised codes, therefore making the data sporadic and inaccurate.

- This data does have Ethnicity, Age, Gender and IMD.

- The indicator of someone having completed bowel screening captured whether someone had ever completed bowel screening, not whether this was within the last two years.

A success for the project team is that a development request was made to the PHM team so that the analysis tool recognises where someone has completed their bowel screening within the last 2.5 years, instead of pulling through all data which only confirmed whether someone had ever completed their test or not. This will enable data analysts to download monthly data to monitor

uptake, although a limitation of this is that it does not give a monthly breakdown, only an average over the last 2.5 years.

Due to delays in accessing the BCSS data, an exception report was submitted to the Health Inequalities Senior Responsible Officer (SRO), as the timeframe for resolution was unclear. In the meantime, it was recommended that engagement activity begin with a broadly identified patient cohort. The proposed focus was on GP-registered patients who had not completed their bowel screening and who live in IMD 1 and 2 areas, specifically within the four GP practices where more than 70 percent of the registered population falls within the 20 percent most deprived nationally, as outlined in the table below. This recommendation was approved by the Health Inequalities SRO.

G.P Practice	Location	% of G.P registered population that live in IMD 1 and 2	Bowel Cancer Screening % uptake
Marisco Medical Practice	Mablethorpe	**77.2%**	66%
Beacon Medical Practice	Skegness	**83%**	66%
Hawthorn Medical Practice	Skegness	**77.8%**	64%
Caskgate Street Surgery	Gainsborough	**71.7%**	60%
Cleveland Surgery	Gainsborough	59.4%	65.5%
Abbey Medical Practice	Lincoln	29.6%	48%
Lindum Medical Practice	Lincoln	56.8%	62%
			Lincs Av 72%

Once access was granted to BCSS data, a further deep dive commenced using July 2022-June 2023 data.

% and No. of patients completing/not completing FITs in the 7 most deprived GP Practices

Time Period: Jul 22 - Jun 23

GP Practice	% of patients completing FIT	% of patients NOT completing FIT	No. of patients NOT completing FIT
Beacon Medical Practice	64.52%	35.48%	1418
Hawthorn Medical Practice	62.81%	37.19%	1226
Marisco Medical Practice	64.87%	35.13%	1217
Cleveland Surgery	62.65%	37.35%	626
Caskgate Street Surgery	62.72%	37.28%	604
Lindum Medical Practice	63.90%	36.10%	417
Abbey Medical Practice	47.94%	52.06%	405

Conclusion:
The table shows that the GP Practices with the highest number of people not completing the FIT are Beacon, Hawthorn and Marisco Medical Practices. These are the 3 coastal practices suggesting that this is a geographical hotspot.

- Of those who did not complete screening, 52% are male and 48% are female.

- People aged 60-64 years old had the lowest uptake

- Ethnicity data showed that the largest group of people not completing their screening is White British and Irish (79%). Lincolnshire's average was 72%, although there was a caveat that there was inconsistency and inaccuracy in how GP practices record data.

It was concluded that Beacon, Marisco and Hawthorn had the highest number of people not completing their screening and therefore this suggested a geographical hotspot, especially being a high deprivation area on the East Coast. Overall, there was no correlation identified between having a co-morbidity and completion of bowel screening.

This data analysis supported the decision made to initially focus on the four GP practices with 70% of their patient list living in the 20% most deprived areas. This later became the confirmed focus for the project's lifecycle.

Lessons Learnt

There were limitations in what available data provided and how it could be analysed to support the identification of a cohort, as no data source gave a full enough picture. Nationally, there was a delay with the BCSS data between activity and the data being validated/available.

Although GP practice data was advised by NHS England to be the best and most current source of information, the project team was aware of variation in coding across GP practices and in any case, was unable to access this data to support project evaluation.

This remains an issue, although the update to the PHM Pathfinder tool may make the impact of similar future projects easier to track.

5.	**Stage 2 – Engagement**

Pre-Engagement

While awaiting confirmed data sources and analysis, initial pre-engagement activities took place during August, September 2023 across Gainsborough, Mablethorpe, Skegness and Lincoln.

The project team conducted face-to-face engagement in public venues located near the seven GP practices identified for the project. These areas were selected based on the assumption that there would be good representation from individuals aged 56 to 74.

A total of 45 individuals were spoken to during this initial phase:

- Lincoln – 5 people
- Gainsborough – 19 people
- Skegness – 14 people
- Mablethorpe – 7 people

Of those, 43 had completed their bowel screening test. Although this was a small sample and not all participants were registered with the target GP practices, valuable feedback was gathered regarding motivations and barriers to completing the test.

Those spoken to suggested that future engagement in Gainsborough should focus on better promoting local support groups, especially for those without internet access. Suggested venues for co-production

include community spaces such as Marshall's Yard, the Town Hall, and Gainsborough Library. In Skegness, The Storehouse (particularly on Thursdays) was highlighted as a suitable location, while in Mablethorpe, local Facebook groups and the Coastal Centre were identified as useful for promotion and hosting. No attendees indicated a need for incentives to participate. In Lincoln, more targeted work was needed due to the city's distinct areas. Barriers to screening highlighted included fear of results, negative experiences with previous tests, illness, and challenges accessing GP appointments.

Online Survey

Stage 2 of the project commenced in October 2023, led by Nikki Pepper, Engagement Officer at Lincolnshire ICB. In November 2023, a digital survey was developed. The identified cohort of four GP practices with 70% or more of their population registered in IMD 1 and 2 sent texts to eligible patients inviting them to complete the "*Let's Talk About Bowel Cancer Screening"* online survey.

- Beacon and Caskgate sent texts to all patients aged 56-74 that live in IMD 1 and 2
- Marisco and Hawthorn sent texts to all patients aged 56-74 within their practice

Out of the 13,838 survey invitation text messages sent to eligible people, 2,416 responded. 100 out of 2,416 participants (4%) reported that they had not completed bowel cancer screening or only completed it occasionally. Of these, 90 individuals (90%) lived in Index of Multiple Deprivation (IMD) deciles 1 and 2.

It is important to interpret this data within the context of the project. The focus of this engagement was to hear from patients living in IMD 1 and 2 within the four most deprived GP practices in Lincolnshire, where over 70% of the registered population falls within these deprivation categories. As part of the project brief, the four participating GP practices were asked to send the survey specifically to patients in IMD 1 and 2. Beacon and Caskgate practices followed this instruction in full.

Due to limited time and resources, the ICB did not routinely issue paper surveys. However, it was identified that approximately 15% of patients at Marisco Medical Practice, Beacon Medical Practice, Hawthorn Medical Practice, and Caskgate Street Surgery did not have a registered mobile phone number and were therefore unable to engage with the digital survey.

Paper Survey

A paper survey was considered as an alternative engagement method to reach individuals less able to respond digitally. It was identified that 2,200 people could benefit from receiving a paper version, and although the survey was finalised, several barriers emerged. These included the need for an Information Governance-approved provider and a Data Protection Impact Assessment (DPIA) with each participating practice.

Additional challenges related to how responses would be received and recorded. While funding was secured to cover return postage, complications around postage mark accounts also caused delays. By the time these issues had been resolved, it was no longer feasible to proceed with this engagement method ahead of the co-production phase and a decision was made by the project group not to proceed. This learning was shared through a report to the Health Inequalities Programme Board.

Face-to-Face Sessions

In February 2024, face-to-face *"Let's Talk Bowel Cancer Screening"* drop-in sessions were scheduled to mitigate against digital exclusion:

- Skegness – 13th February 2024 – 24 people total – 15 not completed bowel screening
- Gainsborough – 16th February 2024 - 3 people – all completed bowel screening

- Mablethorpe – 22nd February 2024 – 24 people total – 8 not completed bowel screening

Further face-to-face engagement took place at community groups including Sutton on Sea - Warm Space and High Street, Deaf Sensory group, Gainsborough Marshall's Yard and Mablethorpe Library – Warm Space.

The face-to-face engagement was a vital aspect of the project, offering the team a valuable opportunity to address clinical queries and provide reassurance. One participant shared that she had not completed her bowel screening due to persistent diarrhoea. Following an explanation that the test could still be carried out under these circumstances, along with guidance on how to request a replacement kit from the project team, she proceeded with the screening. The results showed no cause for concern. This marked an early success for the project.

In total during the engagement phase, 2732 people engaged overall – 2416 via the digital survey, 103 face-to-face, and 213 via e-mail or phone.

Themes

Across engagement methods, 57 people gave the reason for not completing screening that "I didn't get a test in the post". A further seven core themes from engagement were identified:

- **I forgot / I don't have time**
- **I find it embarrassing**
- **I know someone who had cancer / I'm scared**
- **It won't work, I have other conditions**
- **I don't understand**
- **What's the point?**
- **What if it says I have cancer?**

Co-Production Interest

20 people in Mablethorpe and Skegness that did not or only sometimes completed bowel screening gave their contact details and advised they wanted to participate in workshops, focus groups or one-to-one interviews. Unfortunately, the group did not identify anyone in Gainsborough willing to participate.

Additional Engagement

Following the initial engagement phase, the project team analysed responses, and a decision was made to explore some communities in more detail

- **People with learning disabilities** were not represented in the online survey, nor in attendance at face-to-face drop-in sessions

- **People who did not speak English as their first language** were not represented in the online survey or in attendance at face-to-face drop-in sessions.

- **Carers.** The online survey showed over 1 in 5 people that did not, or only sometimes completed Bowel Screening were carers (21%), but no carers visited the drop-in session in Skegness, potentially indicating that carers may not be able to leave their cared-for-person to attend in person events.

Additionally, the project received a request to explore if there was a health inequality in completion rates for people recorded as having a severe mental illness (SMI). The GP practice data showed that uptake was higher for this population group and therefore this work request was not taken any further.

	Patients aged 56-74 coded with severe mental illness on SMI register	Patients aged 56-74 coded with severe mental illness that have NOT completed bowel screening	Patients aged 56-74 coded with severe mental illness that HAVE completed bowel screening	Practice Average Completed Bowel Screening
Beacon	64	6 (9.4%)	58 (90.6%)	66%
Hawthorn	51	9 (17.6%)	42 (82.4%)	64%
Marisco	53	2 (4%)	51 (96%)	66%
Caskgate	35*	13 (37.1%)	22 (62.9%)	60%

Lessons Learnt

Before the project commenced, there was a perception that there would not be great engagement with our most deprived communities and they may not be willing to talk about bowel screening, yet people were happy to talk and the face-to-face drop-in session in Skegness was especially popular. The online survey had the greatest response rate of all surveys the ICB had issued up until that time.

The most common theme identified is that some people believe they have not received a test and give this as the reason for not completing it. However, this could be for a number of reasons including postal issues, not realising they had received it as well the test not being sent due to a system issue. Through data analysis and engagement, it was identified that a small cohort of people aged 59 years old had not been sent test kits in the post as they were missed when the eligibility age was lowered from 60. This cohort was picked up as they reached their 60th birthday.

A lesson learnt was to be mindful of causing unintentional distress. By sending out the 13,000+ online survey text invites, three people were upset by this messaging as their families had been affected by Bowel Cancer. The Engagement Lead personally apologised to each of these people for the unintentional upset caused.

The project identified and understood the barriers experienced in trying to distribute a paper survey, for which the project team did not manage to achieve the distribution of the hard-copy survey within the timescales of each stage. These lessons learnt have been appropriately documented and escalated.

6. Stage 2.1 – Engagement - People who do not speak English as first language

During the engagement phase, the project team expected to hear from people who did not speak English as their first language due to the demographic profile of the GP Practices, however this cohort was not reflected in the original engagement. Practice data showed that although there were small numbers, there was a health inequality in this group at Beacon Medical Practice and Hawthorn Medical Practice. Polish was the first language most spoken in this cohort.

	Patients aged 56-74 with English NOT as first language	Patients aged 56-74, with English NOT as first language that HAVE completed bowel screening	Patients aged 56-74, with English NOT as first language that have NOT completed bowel screening *living in IMD 1&2*	Practice Average Completed Bowel Screening
Beacon	78	39 (50%)	35	66%
Hawthorn	34	21 (38.2%)	19	64%
Marisco	15	11 (73.3%)	3	66%
Caskgate	25	16 (64%)	8	60%

A text message was translated into the top four spoken languages (Lithuanian, Polish, Romanian, Russian) to invite people recorded as not completing bowel screening, which was sent by all four practices to people recorded as not having completed their screening and speaking the four chosen languages:

> *"We notice that you have not completed your bowel cancer screening test that is sent to your house in the post. We would like to have a friendly chat with you over the phone about this and answer any questions you have. We can arrange for an interpreter to be on the call if you would like. Please text (xxxxxx) or email us at licb.involveus@nhs.net to arrange a telephone call."*

Unfortunately, nobody responded to this text. Further engagement took place. Despite best efforts by the engagement lead to find engagement opportunities with community groups and locations where people with English not as their first language would be in Skegness, Mablethorpe and Gainsborough, this was not successful. Consequently, the project team decided to extend engagement efforts to Boston and South Holland, where there are more established communities. The team attended events and networked with professional colleagues from:

- Albert Bartlett Factory, Boston
- Centenary Church, Boston
- Boston Lithuanian School
- South Lincolnshire Rural Primary Care Network (PCN)

A total of 19 people were engaged, 11 of whom had not completed their bowel screening. Key themes and reflections emerging from this engagement included:

- Language is critically important for those who do not speak English as their first language. Feedback highlighted that the term "screening" is perceived as an invasive procedure in Lithuania, rather than something that can be done at home, thus discouraging participation.
- 9 of the 11 people spoken to who had not completed screening were male. Common reasons included lack of knowledge about the screening test, reluctance to discuss bowel health, low prioritisation, and fear.
- Participants expressed a desire for reminders when they had not completed the test, alongside information about the preventative benefits of screening in their native languages.
- The bowel screening test kit itself was visually recognisable, and even participants with limited English clearly knew what it was.
- Providing educational materials about bowel screening in an individual's native language, using familiar and non-threatening terminology, may increase their likelihood of participation.

New professional connections were made with Albert Bartlett Factory, which advised that much of their workforce is bilingual and would be keen to support future initiatives.

A letter template, created collaboratively between Marisco Medical Practice and the project team, and reviewed by the Mablethorpe co-production group, was translated by Language Line into the top six non-English spoken languages in Lincolnshire according to the 2021 Census (Bulgarian, Latvian, Lithuanian, Polish, Romanian, and Russian). The translated letters were reviewed by native speakers from the Lincolnshire workforce and distributed as a Lincolnshire-wide resource through Primary Care.

The project team explored further options including:

- Developing videos to support individuals who do not speak English as their first language, showing footage of someone completing the test, alongside professionally translated scripts delivered by AI.
- Developing leaflets and posters in the top six identified languages.
- Considering additional languages prevalent in Lincolnshire but not included among the top six recorded in the Census, such as Ukrainian, Pashto, and Farsi.

Unfortunately, due to unexpected financial constraints, the project team could not progress these options during the lifecycle of the project. Scoping is underway to ascertain whether these options can be progressed in this financial year through the Cancer programme.

Recommendations:

- Expand the development and use of visual resources (e.g., videos, leaflets, posters) in selected languages to support screening uptake among individuals who do not speak English as their first language.

- Ensure that translated materials are reviewed by native speakers to guarantee cultural resonance and appropriateness.

7.	Stage 2.1 – Engagement - Carers

Following Stage 2 of the engagement, the project team sought to explore a theme that had emerged earlier in the process: that carers were less likely to complete their bowel screening than the wider population. The aim was to better understand the barriers behind this and inform future engagement efforts. A more targeted approach was therefore undertaken across Lincolnshire between July and September 2024.

A survey was distributed by Carers First to individuals who identified as carers. Ten responses were received. One respondent noted they had not received the survey, while the remaining nine provided positive feedback. Of the 36 people engaged at events in Lincoln, Grantham and Boston, six reported they had not completed the bowel screening test.

An evening Teams meeting was held on Wednesday 29 May, specifically for carers, facilitated by Ellie Sadler, Living with Cancer Programme Manager in Lincolnshire ICB and Vicky Thomson, Chief Executive of Every-One. Unfortunately, no carers attended. Following this, it was agreed that future engagement should take place within existing carer spaces. Plans were made to collaborate with Suzanne Marriott from the Health Inequalities Team to attend established carers groups and informal gatherings, with the aim of holding conversations and gaining insight.

Some themes for not completing screening were:

- Not receiving the screening kit despite wishing to complete it

- Prioritising the needs of the person they are caring for over personal health

- Sensitivity due to a loved one currently undergoing treatment for bowel cancer

- A participant who had recovered from bowel cancer three years ago but had not received another test kit

- Some carers expressed fear of a positive result, as this might affect their ability to continue providing care

Not all carers identify as such, meaning their status may not be accurately recorded in data systems. Despite considerable effort, it was difficult to find carers who had not completed their bowel screening. Many carers attending support groups were proactive and had already completed the test, indicating that perhaps people not completing screening were also not attending the support groups.

Findings from this engagement were presented at Carer's Priority Delivery Group on Tuesday 26th November 2024. This group suggested a poster and/or video materials could be developed with carers and distributed through carer's champions and social media. It was agreed that a line on screening would be added to a future draft of a letter being sent to carers as part of Carers' Rights Day and a further suggestion was a one-page document for all screening programmes.

It was recognised that the conversations with carers about barriers to healthcare, access, and outcomes extended beyond bowel screening alone. The insights shared by carers were relevant to many areas of healthcare, suggesting that the engagement could contribute to broader work on improving access and support for carers across the health system. Due to financial constraints, a decision was made not to pursue this work further as part of the Bowel Cancer Screening Project and to feed this engagement into wider pieces of work with Carers.

Recommendation:

- Engagement insight with carers to be fed into wider Primary Care work to address healthcare barriers for carers.

8. Stage 2.1 – Engagement and Solutions - Learning Disabilities

People with learning disabilities were another cohort that the project team expected to hear from during the engagement phase, and therefore further work was done to understand barriers to completing screening for this group. This work was led by Cath Koutna, Cancer Project Manager in Lincolnshire ICB and reported back into the main project. Dr Nick Bigwood was completing a GP Trailblazer Fellowship at the time of this project and his work was pivotal in gaining access to GP practice data from Caskgate Street surgery.

Analysis of GP practice data identified that there was a health inequity for people with learning disabilities, with a lower percentage of people with learning disabilities completing screening compared to the GP practice average.

	Patients aged 56-74 with a LD	Patients aged 56-74, with a LD that HAVE completed bowel screening	Practice Average Completed Bowel Screening	Patients aged 56-74 with a LD that have NOT completed bowel screening *living in IMD 1&2*
Beacon	35	21 **(60%)**	66%	100%
Hawthorn	12	4 **(33%)**	64%	63%
Marisco	29	12 **(41%)**	66%	59%
Caskgate	22	11 **(50%)**	60%	55%

Dr Nick Bigwood, GP at Caskgate Surgery and Deborah Winn, Care Co-Ordinator at First Coastal PCN did a deep dive of engagement to people recorded as not having completed their bowel screening on their Learning Disabilities register. Of four people spoken to at home, two declined to

speak, but none could recall receiving their bowel screening kit in the post and both responders stated they would not want help from family due to embarrassment.

For patients with carers (mostly in care home, one at home), the biggest issue was independent patients using the bathroom but not understanding the significance of the test and not willing to collect a sample. Dr Nick Bigwood also spoke to care homes about the bowel screening test. Residents' post is first read by care staff and actioned, so senior care staff should write in patient's diary that the screening kit has been received and ensure it is completed.

In First Coastal PCN, it was established that there was a health inequality for people with learning disabilities in care homes and supported settings. By contrast, only three people with learning disabilities living in the community had not completed their screening. Therefore, Deborah Winn focused on engaging with people with learning disabilities living in care homes and their carers. Some of the barriers identified were:

- Lack of staff awareness about the screening programme and process.
- Poor management of post, especially where residents receive mail directly and staff are unaware of contents.
- Residents' limited understanding or awareness of the screening's purpose, leading to refusal or non-engagement.
- Anxiety or distress triggered by unfamiliar requests or changes to routine.
- Incontinence or being bedbound, complicating the sample collection process.
- Privacy preferences of independently toileting residents make it difficult for staff to support timely sample collection.

Some immediate actions were taken following the deep dive. Deborah Winn contacted the Bowel Cancer Screening Helpline to make enquiries around reasonable adjustments for people with learning disabilities. Deborah supported care home staff to request further bowel screening tests for those who had not responded to their invitation and organised for these to be sent out alongside an easy read document. Patient records were adjusted for everyone in the cohort (people with learning disabilities living in care homes) to ensure reasonable adjustments were made, and the appointment ledger was annotated to prompt clinicians undertaking Learning Disability Health Checks to discuss bowel screening.

Several solutions were identified and developed:

Educational Video

An educational video to support people with learning disabilities to complete their bowel screening was developed, based on a script used in a similar educational video developed in Hull. Lincolnshire ICB's Expert by Experience, Lorraine Abbott kindly agreed to read the script in the video - Bowel Cancer Screening for People with Learning Disabilities. This was a great success for the project as Lorraine is a local person with lived experience of learning disabilities and having bowel cancer, participating in a video for the residents of Lincolnshire. The video was published in March 2025, and it is too early to fully evaluate this resource due to its recent distribution, but it has received positive feedback from colleagues working with people with learning disabilities.

However, this is a resource which can be utilised and promoted during awareness events such as Bowel Cancer Screening Awareness Month each year and awareness campaigns to support people with learning disabilities.

Resource Document

A sub-group of key stakeholders including clinical staff across the Lincolnshire health and care system was set up with a view to repurposing a document authored by North East and Cumbria ICB to create a resource document suitable for staff in Lincolnshire working with people with learning disabilities. Led by Cath Koutna and Dr Nick Bigwood, the document was carefully authored with a particular focus on consent and best interests for people with learning disabilities.

The document was socialised at various presentations in November 2024, including the Learning Disabilities Leadership Business Meeting, ICB Cancer Learning Disability Webinar, East Lindsey PCN Enhanced Health in Care Homes forum and the Virtual Registered Managers meeting. The document had a positive reception, and feedback was received from Mark Turton at LinCA that care home staff found it clear and easy to follow.

The final document, *"Improving Uptake of Bowel Screening for People with Learning Disabilities"* was ratified on 28th April 2025 and distributed as a Lincolnshire-wide resource. Due to the recent publication of this document, it is not possible to evaluate the impact of this project output, however feedback has been unanimous in that it is seen as a supportive, easy to understand resource.

Invitation Intervention

Invitation intervention gives people with learning disabilities additional support to access bowel screening. This is reliant on GP practices in Primary Care sending details of people with learning disabilities registered at the practices to the central screening hub, this can be done across the county.

Two GP practices were able to do this, but due to GP Collective Action (a form of coordinated non-participation by GP practices), two practices did not share data during the life cycle of the project. As a Lincolnshire-wide scheme, this work will be taken forward by the Cancer Programme in Lincolnshire ICB to encourage GP practices to share their data with the Bowel Screening hub to facilitate this intervention which will reduce barriers for people with LD completing bowel their screening.

Non-responder intervention

Non-responder intervention is offered by the Bowel Screening hub and is a proactive model used in Nottinghamshire and Leicestershire where people with learning disabilities are supported to return their bowel screening kit. The project team presented to the Lincolnshire Partnership Foundation Trust (LPFT) Leadership Team to discuss replicating this approach in Lincolnshire, however, the Learning Disabilities teams are more aligned to the specialist services team in Lincolnshire instead of Primary Care which is the case in Nottingham and Leicestershire.

The model in Nottinghamshire and Leicestershire is more primary care based. They have one Primary Care Learning Disability contact for the bowel cancer screening hub to support the non-responder intervention. Lincolnshire is more aligned to specialist services and have a Multidisciplinary Team (MDT) referral process, which relies on the person with learning disabilities giving consent prior to being contacted, whereas in Nottinghamshire and Leicestershire they do not require consent.

However, in May 2025, a potential solution was identified whereby Cath Koutna from the project team linked together colleagues from the ULTH Bowel Cancer Screening Programme team who planned to call people with learning disabilities and other additional needs prior to their kit being

received, with Michael Philip at the East Midlands Bowel Screening Hub who facilitates implementation of the non-responder intervention within a county. This will create an essential wrap-around support service for people with learning disabilities, and resource within the ULTH Bowel Cancer Screening Programme team has been identified to take this forward without additional funding. It is anticipated that the service will go live in 2025/26 and is considered a success of the project's wider work.

Impact

A limitation of the evaluation of this workstream is that the project team has been unable to secure recent data analysis to demonstrate the quantitative outcomes of this work. However, presentations on the project's work around learning disabilities have encouraged awareness and by presenting at one forum/board, awareness has grown and led to further invitations to other forums/boards by word of mouth. A further success of this workstream is the strengthening of professional relationships within the Lincolnshire system in work supporting better outcomes for people with learning disabilities. Going through the process, the sub-group built networks and joined people up that had not met before.

A strong resource base has been developed collaboratively with stakeholders including the educational video featuring Lorraine Abbott, Expert by Experience and the "*Improving Uptake of Bowel Screening for People with Learning Disabilities"* resource document. These resources are beneficial for all of Lincolnshire as well as the original hyper-localised focus of the project.

Further to this, in Meridian PCN, as a direct result of hearing a presentation on the work around learning disabilities, one care co-ordinator replicated the engagement in their patch and found that there were 6 people with learning disabilities who had not completed their bowel screening, and they successfully offered support to all six people to facilitate this.

Lessons Learnt

Although people with learning disabilities were expected to face increased barriers to completing bowel screening, the extent of the work required with this group went beyond the original project scope. Initially anticipated as a smaller, bespoke workstream within the project, it evolved into a much larger portfolio that could have stood alone as a separate project. Although not originally scoped as a standalone project, the importance and impact of this workstream justified its full integration into the Bowel Cancer Screening Project.

Recommendation:

- GP practices to be encouraged to share details of people on their LD register with Bowel Screening Hub so that "invitation intervention" can be put in place

- Launch of "non-responder intervention" in Lincolnshire to follow-up with people with learning disabilities who have not completed their screening.

Both of these recommendations will be taken forward by the Cancer Programme in 2025/26.

9.	Co-Production & Implementation

Stage 3 - Co-Production commenced in May 2024, and the charity Every-One was commissioned to organise and facilitate co-production sessions. During the engagement phase, between digital, phone and face-to-face engagement, 39 people registered an interest in co-production, but only 16 responded positively to state they were still interested in taking part. Unfortunately, nobody in Gainsborough expressed an interest in forming a co-production group.

In Mablethorpe, the small but engaged group first met on 21st May 2024. The group was presented with the seven core themes from engagement and asked what solutions they felt could be put in place to address these.
The group felt it was important to address all of the themes, but felt core messaging should include:

- Not using not being able to get a GP appointment as an excuse – if you have symptoms, they will see you
- Visual works better than a lot of words
- Focus on myth busting
- Might not have symptoms, so the test can catch it early
- People need to see the new test to see that it is different and easier than the old one.
- Use the message of 'time'. Make time to do the test, find the time, costs nothing! 2 minutes could save your life.
- Be clear on why it is important to do the test.
- It is easier to do than the breast screening test etc

Potential outputs and actions identified by the group were:

- A large-scale version of the bowel screening test instructions
- Display in GP practices to show the practicalities of doing the test.
- A stand / display in local shop – e.g. Tesco and to get there for 8am, as in summer season, locals shop early to avoid tourists.
- Posters for shop windows, supermarkets, backs of toilet doors and village halls

The group chose which output they would like to prioritise and decided to work on a poster to support myth busting and to encourage people to complete their screening. The group suggested putting over the following messages:

- Use the colour scheme from the Lincolnshire Cancer Support website and logo
- Have an A4 format design
- Use accessible language like "poo"
- Have fun imagery such as the "poo emoji" to be accessible and eye-catching
- Speech bubbles saying "do the poo test" or dispelling myths – "test your poo, it's easy to do," "take the time to do the test"
- Phone number/helpline details to request a test.

In September 2024, the group refined the suggestions further. They suggested that a poster to address each of the seven reasons / myths that were identified through the engagement / survey stage. This would then facilitate a golden thread between what people said the barriers are, through to the myth busting campaign. The group suggested wording to address each theme and potential imagery, suggesting local imagery where possible so that images feel more relevant to Mablethorpe.

- *"The poo test is quick and easy to do. Make the time because you are worth it. "*
- *"No mess, no fuss! The test is different now and so easy to do."*
- *"You don't need to bury your head in the sand. The sooner you know the better. "*
- *"The poo test is simple and pain-free."*

- *"It's better to know. You are worth it."*

The group also agreed to develop a short and snappy postcard, with one side comprising bullet points to address the seven themes from engagement.

The group felt that pop-up educational events and a media campaign would be beneficial, something very local and specific to their community and commenced outside of tourist season (October 2024 to March 2025). Some ideas as incentives for people to visit the stall were:

- Give aways – labelled toilet rolls as freebies, a "poo-shaped" sticker
- Decorate the stall with toilet rolls
- Postcard
- 6-foot display banner
- Balloons
- Demonstration kit to show how screening is done.

A banner, sticker and postcard were co-produced and designed in time for the pop-up event in Mablethorpe on 10th October.

In Skegness it was challenging to find a date that worked for everyone invited. Of the nine people contacted, one gave a tentative maybe, four said they were interested in supporting the project but could not commit to a date, and four did not respond. Unfortunately, therefore, no one attended the first session on 21st May 2024.

A second session was held on 19th June 2024 where a couple were happy to participate but were hoping to be directed by the professionals in the session instead of adopting a co-production approach. This session was helpful as the couple offered views on local imagery which could be used for campaign materials in Skegness, although unfortunately they did not attend further sessions.

Despite extensive attempts to mobilise a Skegness co-production group in August and September through e-mails and phone calls, future sessions were cancelled due to a lack of interest, with the decision by the project team to utilise the co-production work in Mablethorpe as inspiration for Skegness and Gainsborough solutions.

Ideas for posters, pop-up events and a media campaign developed by the Mablethorpe group were used a framework for solutions in these areas. Mock-up designs and ideas were developed by the project team for these areas and taken out to existing support groups in Skegness (Storehouse) and Gainsborough (Everyone Active) for feedback/comments on the materials and messaging contained in them. Significant changes were made to the materials to localise them for these areas based on this feedback, local people supported the team to find new locations to distribute campaign materials to, and the project team received feedback celebrating the use of local imagery. By December 2024, all the designs were completed, signed off and printed for distribution.

In Mablethorpe, a true co-production approach was evidenced through a clear link between engagement activity, themes gathered, ideas from the group and eventual products. While a true co-production group was not established in Skegness or Gainsborough, a community-informed engagement approach was adopted. Materials co-produced in Mablethorpe were adapted based on structured feedback from support groups and residents to ensure local relevance in Skegness and Gainsborough.

The project team reflected that there was a loss of people between survey and co-production and that future consideration should be given to how people's interest is captured at the survey stage and how to translate that into direct involvement.

It may be the case that the lack of interest was due to participants not having a direct interest or personal connection with the subject matter of not completing screening. The project team only asked people who reported that they had not completed their screening to register their interest in co-production opportunities, therefore limiting the pool of people to be involved. Members of the project team have reflected that shifting the focus from people who had not completed bowel screening to a wider scope of people from local communities to share knowledge and insight may have yielded a better response.

Lessons Learnt:

The project team has reflected that the initial parameters were restrictive. A broader community focus may have led to greater local buy-in for co-production instead of using a strict criterion of people who had not completed their bowel screening.

10. Additional Products

Letter to Non-Responders

During the lifecycle of the project, Emily Cooke, Cancer Care Co-Ordinator at Marisco Medical Practice approached the project team with a drafted letter to send to people who did not respond to their bowel screening invitation. This was re-drafted by the project team and reviewed by the Mablethorpe co-production group. The letter draft was distributed as a Lincolnshire-wide resource in October 2024 and was translated into six additional languages on request of Boston Primary Care Network.

Prescription Bags

The project group received funding to distribute bespoke design prescription bags as part of the project solutions. Although this idea came from the project team, the design incorporated wording and themes from the Mablethorpe co-production outputs.

The double-sided prescription bags which were distributed to ten pharmacies in the Skegness, Mablethorpe and Gainsborough areas for a 10-week period. The target population of these pharmacies aligned closely to the eligibility age for bowel screening.

It is difficult to evaluate the impact of the prescription bags as people may not cite these as an explanation as to why they completed screening, however, when pharmacies were visited and the bags were present, pharmacy staff commented on the bold design and that it “stood out”.

11. Implementation - Media Campaign

Poster Distribution

Suzanne Marriott, Health Inequalities Engagement Manager and James Allen, Health Inequalities Improvement Facilitator started to distribute campaign posters in Mablethorpe on 12th December 2024 to locations which were suggested by the co-production group including supermarkets, pubs, social clubs, pharmacies, GP practices, health services, community spaces, libraries, sheltered accommodation and many more. Great conversations were had with local people and feedback was received. Posters featuring local imagery, such as the Leisure Centre, were particularly well-received.

A lady told the team that after seeing the project team at the pop-up stall, she thought *“I must do that test that I’ve got sitting on the side*” – and she did, receiving clear results, expressing her thanks.

A lady in a pub advised both she and her husband had received tests but completed them as they *"hadn't managed to do it yet"* but reflected *"I can't put these posters up and then not do it myself – I'm going to go home and do it tonight!".*

The team decided that where venues were not open or unable to be accessed, posters would be sent with a covering letter, this would incur the cost of a stamp. A lesson learnt for Gainsborough and Skegness distribution was to have a stock of cover letters and envelopes on-hand so that these could be put through post boxes with no additional cost.

Following on from Mablethorpe, the project team distributed posters in Skegness on 29th January 2025. The group asked for feedback from a craft group at the Storehouse on where posters could be distributed in local settings

The project team again received feedback that local imagery was popular, with posters such as the Jolly Fisherman and The Clock Tower being popular. One commented, "*some of these posters could be anywhere – but these are truly local and the heartbeat of Skegness, I'll take these*". Conversations with local people allowed the team to visit other additional venues they were not aware of previously.

Finally, posters were distributed in Gainsborough and surrounding villages, utilising feedback from the pre-engagement activities in September 2023 and an exercise group at Gainsborough Leisure Centre to inform locations where these could be displayed. As with Mablethorpe and Skegness, the localised imagery was popular, and hyper-localised posters resonated the best with local people.

Local Advertising

The project team also secured advertisements at Marshall's Yard in Gainsborough, Gainsborough Life Magazine, Sutton-on-Sea TROVE Magazine and Mablethorpe TIDINGS Magazine. Unfortunately, magazines in Skegness did not respond to requests from the project team.

Lessons Learnt:

A key success of the project has been the understanding that a hyper localised campaign resonates with people, and they appreciate the time spent in understanding their barriers and making small differences to make materials localised.

Another key lesson was that it was extremely beneficial for the project team to be physically present to distribute posters, to talk to local businesses and venues to explain the project's work, the meaning behind the posters/marketing materials and the importance of displaying them, instead of sending out posters in the mail with a cover letter.

12. Implementation - Pop-Up Events

Mablethorpe – 10th October 2024

A light-hearted pop-up education event was a key idea from the Mablethorpe Co-Production group, and a date was set for 10th October 2024 with a short turn-around time. The group suggested using the market for a very local feel and suggested to invite the Town Crier, who attended and gave three shout-outs during the day to bring attention to the stall. Members of the project team attended with clinical representation from the ULTH Bowel Cancer Screening Programme to support with clinical queries, and a member of the co-production group also came to support.

Using steer from the Co-Production group, goody-bags were put together with an educational A6-size postcard, bowel cancer information leaflets, and a toilet roll with a "poo emoji" sticker containing details of the national Bowel Cancer Screening helpline.

Over 170 people were engaged with throughout the day and the mood was light-hearted, with project team members wearing “poo emoji” hats. The project team had a demonstration screening kit on the stall which helped to demonstrate the process to people.

Lessons learnt from this event were that visuals were important, goodie bags attracted people to the stand and the poo emoji hats were a great talking point to draw people in. QR codes on banners and materials felt ineffective as people did not have their phones to hand and the best engagement was just through talking and engaging with people. The time of year was crucial – by October, tourists had gone home, and the event was focused on the local community.

Using this learning, the group agreed that pop-up events in Skegness and Gainsborough would be beneficial, with Skegness next followed by Gainsborough, as it would be beneficial to catch Skegness residents outside of the tourist season.

Gainsborough – 14th January 2025

In November 2024, Suzanne Marriott asked a local exercise group for suggestions on where an event could be held, and they suggested either Marshall’s Yard or the local market. Following the success of the market stall in Mablethorpe, the project team chose to book an event in Gainsborough for 14th January 2025. Members of the project team supported by the ULTH Bowel Cancer Screening Hub attended the stall, with free shout-outs on local radio stations to promote the event.

The team engaged with 60 people and handed out goody bags. There was a slower pace than the Mablethorpe stall, the market had lower attendance overall, but people were engaged and gave great feedback and supported the work. Incidentally, the pop-up event occurred on the same day as a national news item on Good Morning Britain to promote the eligibility age of bowel screening being reduced to 50 which multiple people referenced on the stall.

Skegness – 11th February 2025

A key recommendation of the Mablethorpe co-production group was to hold an event outside of tourist months, and so it was important to hold a pop-up educational event during this timeframe for Skegness. Unlike Mablethorpe and Gainsborough, there was no town market in Skegness and the market in nearby Ingoldmells was closed for winter. Therefore, the project team utilised insight from the pre-engagement phase and conversations with a craft group at the Storehouse to identify The Hildred’s Shopping Centre as a location for a pop-up event. The project team were again supported by colleagues from the ULTH Bowel Cancer Screening Hub who provided clinical expertise and demonstration props.

This pop-event was a great success with excellent footfall. 200 goody-bags given out, lots of people asking for advice/clinical questions and many people reported they would now complete screening or give information to loved ones to take the test following conversations with the team. Many older people had grandchildren with them, stickers were a great conversation starter by encouraging the grandparents to talk to the team.

Across the three events, the project team engaged with more than 430 people. Key lessons across the events included the importance of visual and physical resources to capture interest, and the limited effectiveness of QR codes compared to face-to-face conversation. The inclusion of clinical staff at all three events enabled on-the-spot answers to clinical screening queries, building trust and credibility. The timing of events outside of peak tourist seasons helped to ensure engagement with year-round residents, aligning with the project’s aim of targeting local communities.

13.	Implementation - Wider Impact

GP Trailblazer Fellowships – Breast and Cervical Screening

The GP Trailblazer Fellowship scheme is a national development scheme for early-career GPs to undertake and develop their skills around understanding and addressing health inequalities. The process followed within this project – analyse data, engage with local communities, co-produce solutions and evaluate impact has been used as a template to support GP Trailblazer Fellowship projects during 2024/25 to increase the uptake of breast screening at Birchwood Medical Practice (Lincoln) and cervical screening at Abbey Medical Practice (Lincoln).

Lessons learnt from the project around engagement - making sure to use non-digital methods, using clear and simple language, making sure that inclusion health and PLUS groups (the 'PLUS' in Core20PLUS5 refers to population groups experiencing the greatest health inequalities) are appropriately represented have also been shared.

Further Distribution of Support Materials

Excess materials (posters, postcards) developed during the lifecycle of the project have been utilised for other workstreams and the project team has already supported requests from Bateman's Brewery and the Co-Op for posters to be put up in those areas. Additionally, spare postcards and stickers were given to the ULTH Bowel Cancer Screening Programme team to use at Lincolnshire pop-up events during Bowel Cancer Screening Awareness month in April 2025.

Bowel Cancer Screening Awareness Month - Lincolnshire Campaign

Lincolnshire ICB re-purposed the designs of posters developed by the project team's co-production group for the Bowel Cancer Screening Awareness month in April 2025 to create a Lincolnshire-branded version, utilising the wording developed with the co-production group.

In addition, a press release was created addressing the barriers to access collated from the project's engagement phase: https://lincolnshire.icb.nhs.uk/take-the-screening-test-when-offered-bowel-cancer-awareness-month/

Award Winners

The project team accepted the Co-Production Award at the It's All About People awards in September 2024, recognising the team's efforts to actively involve people from local communities in the development of solutions and including them in the decision-making progress.

14. Financial Costs

In total, the project spent **£14,951** during the lifecycle of the project. All figures include VAT.

Double-sided prescription bags – £3,960.00

Online & printed media campaign - £1,675.79

Translation of letters into additional languages - £159.41

Co-production facilitation (Every-One) - £9,000.00

15. Summary of Key Insights and Lessons Learnt

Stage 1 – Data Analysis

- Limitations in what available data provided and how it could be analysed to support the identification of a cohort, as no data source gave a full enough picture. Nationally, there was a delay with the BCSS data between activity and the data being validated/available.
- GP practice data was advised by NHS England to be the best and most current source of information, there is variation in coding across GP practices.
- Data quality and availability remains an issue, although the update to the PHM Pathfinder tool may make the impact of similar future projects easier to track.

Stage 2 – Engagement

- There was initial concern about low engagement from deprived communities and reluctance to discuss bowel screening, but people were willing to talk, and the face-to-face drop-in session in Skegness was particularly popular.
- The online survey achieved the highest response rate of any survey issued by the ICB to date.
- A common barrier identified was people believing they had not received a test kit, due to reasons such as postal issues, lack of awareness, or system errors.
- Analysis revealed that a cohort of 59-year-olds had not received kits when the eligibility age was lowered from 60; they were only picked up upon turning 60.
- A key lesson learnt was the importance of avoiding unintentional distress; three individuals were upset by the bowel screening survey text due to personal loss, and the Engagement Lead issued personal apologies.
- The project faced challenges in distributing the hard-copy survey within the required timescales; this barrier and associated learning have been recorded and escalated.

Stage 3 – Co-Production & Implementation

- The project team has reflected that the initial parameters were restrictive. A broader community focus may have led to greater local buy-in for co-production instead of using a strict criterion of people who had not completed their bowel screening.

Project Process

- Difficulty in establishing a data-driven cohort at the project's outset limited the ability to quantitatively measure success, especially as the bowel screening eligibility age was lowered from 56 to 50 during the project.

- Early one-to-one meetings with key stakeholders helped secure buy-in, supported engagement, and improved project managers' understanding; this approach has since been adopted in developing both the Digital Inclusion Strategy and Inclusion Health Strategy.

- While people with learning disabilities were recognised as potentially facing additional barriers, the work required with this group exceeded initial expectations and scope.

- Originally planned as a smaller, bespoke workstream, the learning disability element evolved into a significant area of work that could have stood as a separate project but was successfully integrated into the main Bowel Cancer Screening Project due to its importance and impact.

Wider Programme & System Level

- Following challenges in distributing a paper survey, Emma Townend and Stephanie King delivered a "Barriers to Engagement" paper to the Health Inequalities Programme Board. This paper highlighted issues with online surveys, digital exclusion, and key learning from the project. Future projects can use this learning to plan mitigation strategies earlier.

- There is a huge importance to not rely solely on digital methods to engage with people as this can unintentionally exclude a significant number of individuals.

- A key success was placing local people at the centre of the project; through in-depth engagement, the team gained a strong understanding of community barriers, co-designed materials with a light-hearted tone shaped by a co-production group, and shared useful insights with other programmes and workstreams.

- A key success of the project has been the understanding that a hyper localised campaign resonates with people, and they appreciate the time spent in understanding their barriers and making small differences to make materials localised.

- The project's approach is applicable to wider programmes, promoting the use of varied engagement models to understand barriers before designing solutions; this learning has informed 2024/25 GP Trailblazer Fellowship projects to increase breast screening uptake at Birchwood Medical Practice and cervical screening at Abbey Medical Practice in Lincoln.

- Smaller printed materials (postcards, A4 posters) were found to be more effective and versatile than larger formats like A3, which many venues lacked space to display.

- Being physically present in towns through pop-up events and direct outreach to local businesses was beneficial for campaign visibility, though many expected poster locations (e.g. shops, public toilets, post offices) were often unwilling to display materials.

16.	**Assessment of Project Outcomes**
Where outcome measures relied on qualitative insight due to the absence of reliable quantitative data, evidence has been captured narratively, using engagement volume, feedback themes, and anecdotal examples.	

1. **There is an increase in the number of people in the identified cohort completing their bowel screening.**

Unable to assess. Due to the difficulty in accessing measurable, quantitative data, it is not possible to understand if the project has achieved this. However, the project team received multiple instances of feedback from people who directly referenced speaking to the project team or receiving education as explicit reasons for completing or intending to complete their bowel screening.

2. **Understand barriers experienced by people within the target cohort/s in relation to completing bowel screening**

The project achieved this objective by engaging with people from local communities, as well as undertaking additional engagement with people who do not speak English as their first language and carers, utilising face-to-face, telephone and digital methods.

3. **There is a reduction in barriers for people within the target cohort/s in relation to completing bowel screening**

The project achieved this objective by providing information and education in a variety of formats for local residents to understand, holding local pop-up events, the development of a reminder letter translated into six additional languages, and development of written and visual resources to support people with learning disabilities to complete their bowel screening.

4. **People within the target cohort/s are more engaged in bowel cancer screening**

The project achieved this objective, although it is hard to quantifiably measure. The project team received a great amount of engagement and buy-in at all stages of the project, with this information being used to shape and inform project development. People within local communities shared that they were pleased the project team had gone out to them and valued their opinion and time.

5. **Gained valuable insight from seldom heard groups**

The project met this objective by engaging with seldom heard groups and proactively reaching out to them, instead of expecting them to reach out to the project team.

6. **Reducing the number of people being diagnosed with bowel cancer at Stage 3 or 4; More people diagnosed at Stage 1 or 2.**

Unable to assess due to delays in reporting, this will be reviewed in a follow-up evaluation in 6-9 months' time.

7. **Reducing the number of people being diagnosed with bowel cancer in A&E**

Unable to assess due to delays in reporting, this will be reviewed in a follow-up evaluation in 6-9 months' time.

At the start of the project, there was a potential disbenefit identified that if the project was a success this may disbenefit services linked to Bowel Cancer Screening (ULTH and the Regional Screening Hub) if they experience a sudden increase in demand (including additional needs from identified

cohort i.e., learning disabilities, interpreters etc) and may not have capacity to cope with it. However, the Bowel Cancer Screening Hub have not advised of any issues resulting from the project.

17. Summary of Recommendations

People who do not speak English as their first language

- Expand the development and use of visual resources (e.g., videos, leaflets, posters) in selected languages to support screening uptake among individuals who do not speak English as their first language.
- Ensure that translated materials are reviewed by native speakers to guarantee cultural resonance and appropriateness.

These recommendations will be taken forward by the Cancer Programme.

Carers

- Engagement insight with carers to be fed into wider Primary Care work to address healthcare barriers for carers.

This recommendation will be taken forward by the Health Inequalities & Prevention team.

People with learning disabilities

- GP practices to be encouraged to share details of people on their LD register with Bowel Screening Hub so that “invitation intervention” can be put in place
- Launch of “non-responder intervention” in Lincolnshire to follow-up with people with learning disabilities who have not completed their screening.

These recommendations will be taken forward by the Cancer Programme.

Follow-Up Evaluation

- Due to the limitations in access to quantitative data to support the evaluation, a follow-up review to incorporate quantitative data should be completed in 6-9 months’ time.

This recommendation will be taken forward by the Health Inequalities & Prevention team.

18. Conclusion

This evaluation highlights significant successes in the Bowel Cancer Screening Project, particularly the robust community engagement, co-produced localised solutions, and valuable insights gained from seldom-heard groups. Despite challenges accessing quantitative data during the project lifecycle, qualitative evidence strongly indicates increased community engagement, reduced barriers, and a positive shift in attitudes towards screening.

Key strengths include extensive stakeholder collaboration, culturally sensitive outreach, and innovative approaches tailored to the needs of diverse and disadvantaged groups. Nevertheless,

critical gaps remain, particularly in securing reliable quantitative data to assess long-term impact fully.

To consolidate and build upon the project's achievements, it is essential to implement the recommendations provided, particularly in relation to improving quantitative data collection, expanding multilingual and culturally resonant resources, and maintaining a consistent presence within communities.

Ultimately, this project sets a valuable precedent for future projects aimed at addressing health inequalities. A follow-up evaluation incorporating comprehensive quantitative analysis would be beneficial to definitively measure this project’s longer-term impact on bowel cancer screening uptake and early diagnosis rates in Lincolnshire. This work lays the foundation for a more inclusive, community-led approach to future projects across Lincolnshire and beyond.

Practical application of tackling Health Inequalities

NHS
Lincolnshire
Integrated Care Board

Emma Townend – Interim Health Inequalities Programme Lead

Ellie Sadler – Living with Cancer Communities & QOL Programme Manager

29th July 2025

Background and Context

- ICBs have a duty and responsibility to reduce health inequalities.
  Recently announced NHS 10 Year Plan sets out a vision for a 'reimagined NHS' that will be designed to tackle inequalities in access and health outcomes.

- HI Bowel Screening project is an example of an approach to address health inequalities.

- In Lincolnshire, almost double the number of people from the 20% most deprived areas are likely to die from cancers considered preventable than those living in the least deprived.

HI Bowel Cancer Screening Project

Nationally, there is a correlation between deprivation and bowel screening uptake – the higher the deprivation, the lower the uptake.

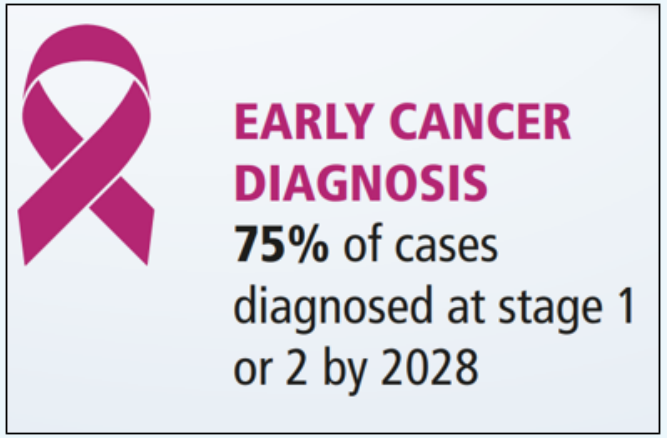
Local analysis showed 62% of people in the most deprived quintile completed their bowel screening, compared to 70% in the least deprived.

This project focussed on increasing the uptake of bowel screening in the **4 most deprived GP practices** in Lincolnshire, located in Skegness, Mablethorpe and Gainsborough.

It sought to understand the **challenges** and **barriers** that prevent people from completing bowel screening through:

- **Engagement -** listening to understand the reasons why people do not complete screening
- **Co-producing solutions** with people to encourage and enable them to complete screening

CORE20 PLUS 5



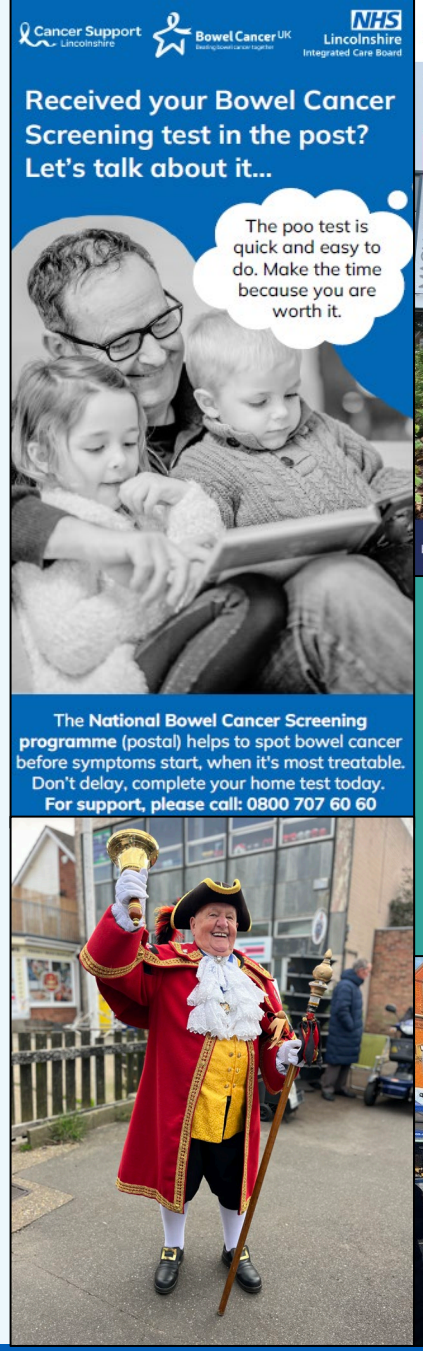
Engagement Phase

- Robust engagement phase to understand the challenges and barriers faced by people who have not completed their bowel screening.
- Online 'Let's Talk About Bowel Cancer' survey sent to people registered at the 4 practices received 2416 responses
- Face-to-face engagement in libraries and community settings in Skegness, Mablethorpe & Gainsborough, meeting with 103 people.
- A further 213 people offered response via email/telephone.
- Targeted engagement with carers, people with LD and people who English was not first language

1	I forgot / I don't have time	• Didn't think it was important • I don't have any time to myself to do the test • I forgot / just didn't get round to it • I just keep putting it off
2	I find it embarrassing	• Don't like the thought of doing the test • I don't want anyone to have to help me do the test • I don't like going to the doctors anyway
3	I know someone who had cancer / I'm scared	• A family member has had bowel cancer so I don't want to know if I have it • I have already had bowel cancer • I go to other screenings but not the bowel cancer one as a family member had it. • I am scared I might need a colonoscopy
4	It won't work, I have other conditions	• Didn't think it was important • I have other conditions, so the test won't work • I have had another type of cancer that affect me going to the loo • I am having treatment for something else, so not done the test • I am disabled so cannot do the test
5	I don't understand	• I don't have any symptoms so don't need it • It will do me harm • I don't understand how to do the test
6	What's the point?	• What's the point as I can't see a GP anyway • If I am going to kick it, I'm going to kick it!
7	What if it says I have cancer?	• Didn't think it was important • I am frightened of the results • How will I cope if I have cancer? • I'm worried

Co-Production

- Every-One were commissioned to organise and facilitate co-production. Co-Production group set up on East Coast to review themes from engagement and develop solutions.
- Group co-produced a 10-week advertising campaign across Skegness, Mablethorpe and Gainsborough.
- Group provided local insight into what is important for local people, where promotional materials could be displayed, what time of day would be best to engage with local people, and what time of year (avoiding tourist season).
- Hyper-localised approach resonated with local people who appreciated that NHS had taken time to visit and understand the communities.
- Pop-up events held in Mablethorpe, Skegness & Gainsborough engaging with 400 people. Town crier in attendance in Mablethorpe with great engagement.



Embedded Practice and Wider Application

Embedded Practice

- Prescription bags – other PCNs looking to replicate
- Co-produced non-responder bowel screening template letter
- Posters used as part of wider Lincolnshire Bowel Cancer awareness campaign

Wider Application

- GP Deprivation Fellowship cancer projects – upskilling staff
- Approach used in 25/26 health inequalities projects
- Opportunity to use in Lung Cancer Screening

This is an adaptable, scalable and practical approach using data and insight with a community centred co-production approach at its core which can be replicated to tackle healthcare inequalities in Lincolnshire.

Item 5 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (i)
Meeting Date:	Tuesday, 29th July 2025
Title of Report:	Integrated Quality & Performance Report – July 2025
Report Author:	Mr James Singleton, Performance Manager
Presenter:	Mrs Rebecca Neno- Deputy Director for System Delivery Mr Martin Fahy- Director of Nursing Mr Matt Gaunt, Director of Finance and Deputy Chief Executive
Appendices:	Performance, Quality & Finance Report

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

Recommendations

The Board is asked to:

1) Note the key issues set out in the paper and the actions in place to support improvement.
2) Discuss any areas the board would like committees to seek further assurance on.

Summary

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

Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for June 2025 was 75%, in line with the planned month trajectory of 75% (95% constitutional target); this was also higher than the regional average performance.

- Category 1 mean response times for EMAS Trust was 08:45 minutes against a standard of 07:00 minutes during June 2025.
- The Category 2 mean response time for EMAS Trust was 35:10 minutes against an expectation of 30 mins (18:00 constitutional target).

Cancer

- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral decreased to 65.4% in May from 66.9% in April '25.
- The faster diagnosis standard was not achieved in May, overall performance was 74.2%, against the 75% standard.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals reduced to 110,536 in May, ahead of plan at system level with ULTH, NLAG and NWAFT also ending May ahead of plan at provider level.
- The ICB finished May with 3,191 patients waiting over 52 weeks (507 adverse to plan) which equates to 2.9% of the total waiting list. (0.6% adverse to plan).

Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies waiting times standards were both achieved in May. 97.7% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 71% in May (rolling 12 months) which is above the 60% standard.
- The total number of adult inpatients with learning disabilities or autism was in line with trajectory at 31.

Primary Care

- The 2025 GP Survey results were published in July. For the key question "overall, how would you describe your experience of your GP practice?", 73% of Lincolnshire ICS patients chose 'very good' or 'good'- this was the same result as in 2024.

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

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

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

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

Report previously presented at:
Not applicable

Is the report confidential or not?
Yes ☐ No ☒

Integrated Performance, Quality & Finance Report

NHS
Lincolnshire
Integrated Care Board

July 2025

25/07/2025

Contents

Executive Summary

NHS Lincolnshire Integrated Care Board

Overview

The July 2025 ICB OQAG quality, performance and finance report incorporates constitutional standards, quality and safety measures, finance and elective recovery activity, and presents system performance updated to June where available.

Urgent & Emergency Care

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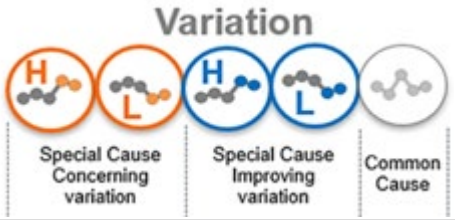
Key to Run Charts

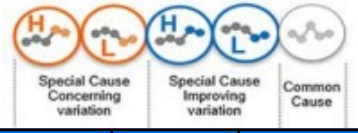
NHS Lincolnshire Integrated Care Board



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

Lincolnshire ICB Performance Dashboard

NHS Lincolnshire Integrated Care Board

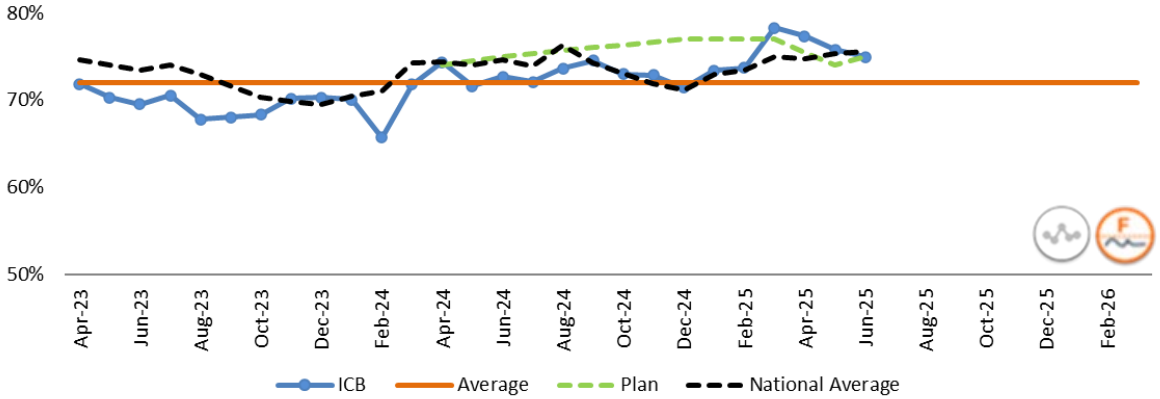


Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	75.0%	Jun-25	75.0%	73.5%	75.5%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Jun-25	00:08:45	00:08:18	00:07:55			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Jun-25	00:35:10	00:28:23	00:29:37			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	92.2%	May-25	84.8%	88.6%	91.0%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	65.2%	May-25	65.4%	63.7%	67.8%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	77.9%	May-25	74.2%	75.3%	74.8%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	54.4%	May-25	55.8%	58.8%	60.9%			
	Patients waiting over 52 weeks for treatment (ICB) (% of total ICB waiting list size)	-	2.32%	May-25	2.84%	2.45%	2.68%			
	Percentage waiting six weeks or less for a diagnostic test	99%	-	May-25	71.3%	74.5%	78.0%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q4 2024/25	30.6%	31.1%	23.5%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	May-25	97.7%	N/A	90.3%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	May-25	99.4%	N/A	98.8%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	May-25	71.0%	75.0%	71.0%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	May-25	*	79%	77%			-
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	May-25	76%	63%	75%			

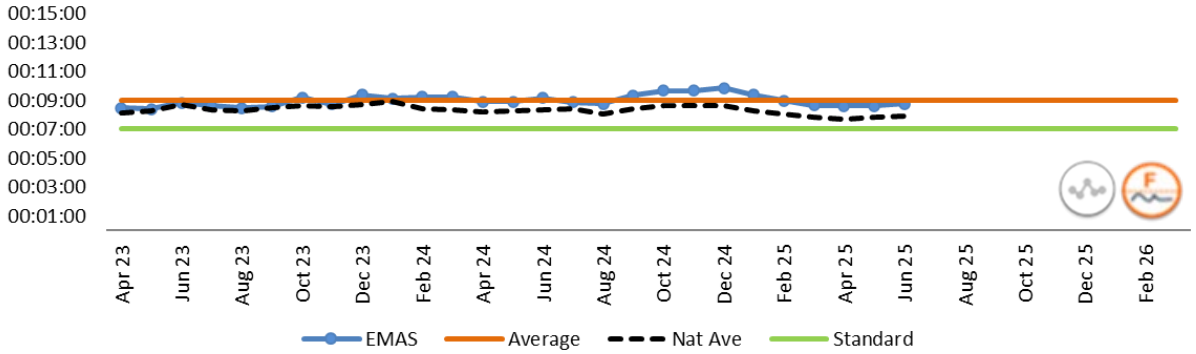
Urgent Care

NHS Lincolnshire Integrated Care Board

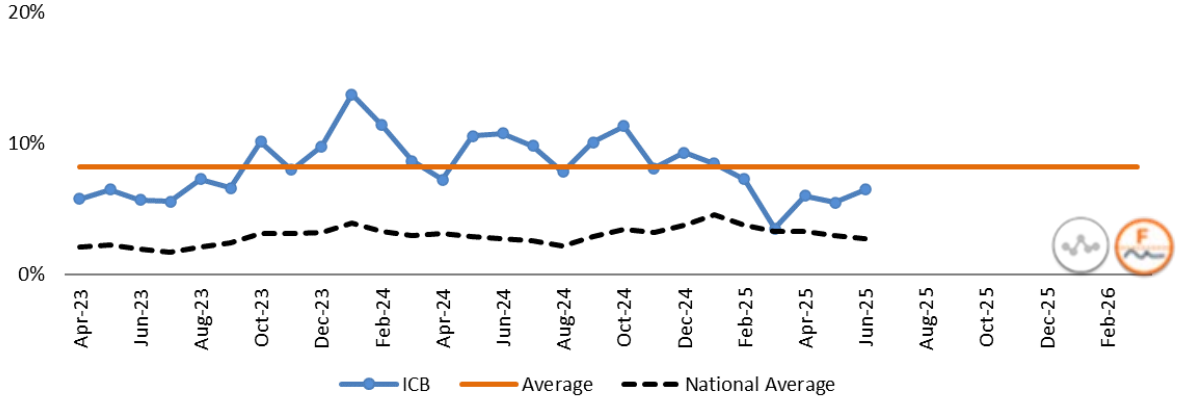
A&E admission, transfer, discharge within 4 hours (ICB)



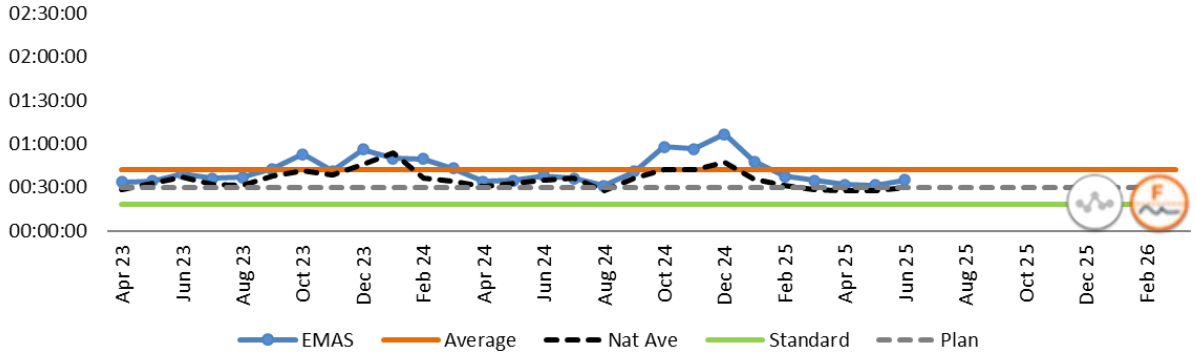
Ambulance response times - Mean response time- Category 1 (EMAS)



12+ hour delays from decision to admit (ICB)



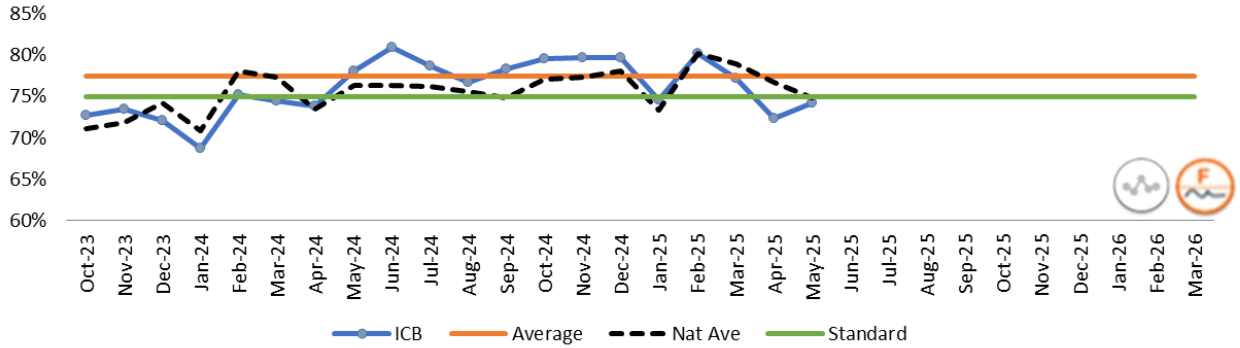
Ambulance response times - Mean response time- Category 2 (EMAS)



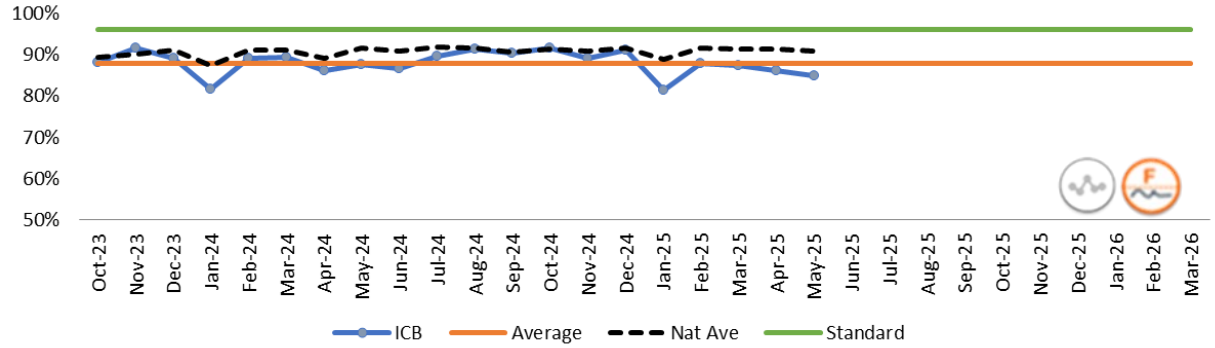
Cancer

NHS Lincolnshire Integrated Care Board

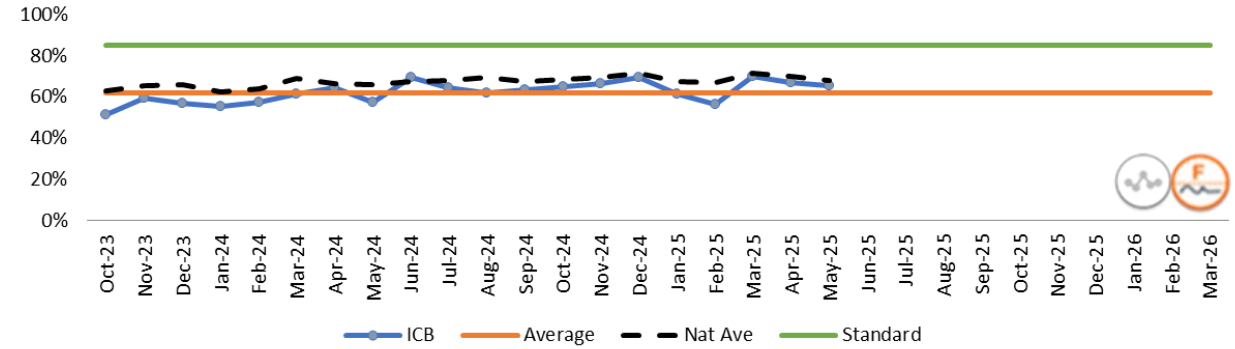
Faster Diagnosis Standard- % of patients told cancer diagnosis outcome within 28 days (LICB)



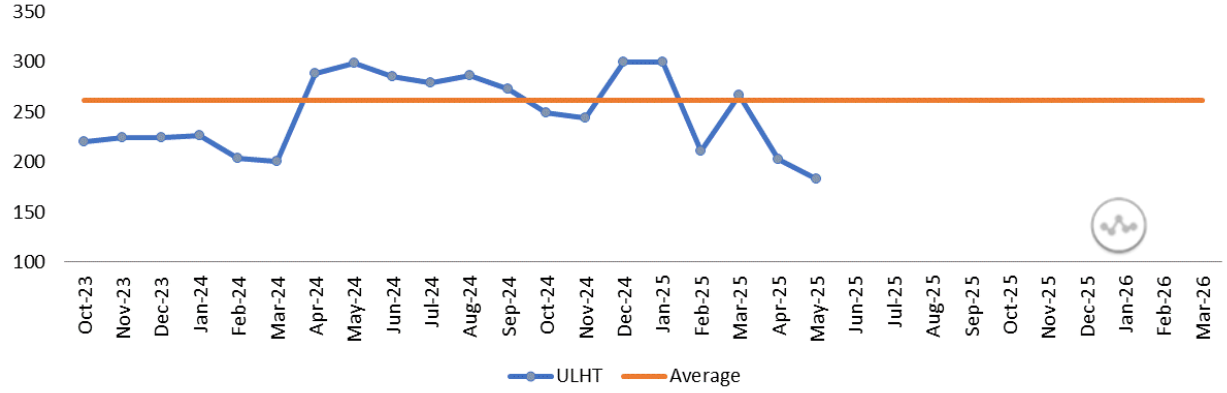
Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



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



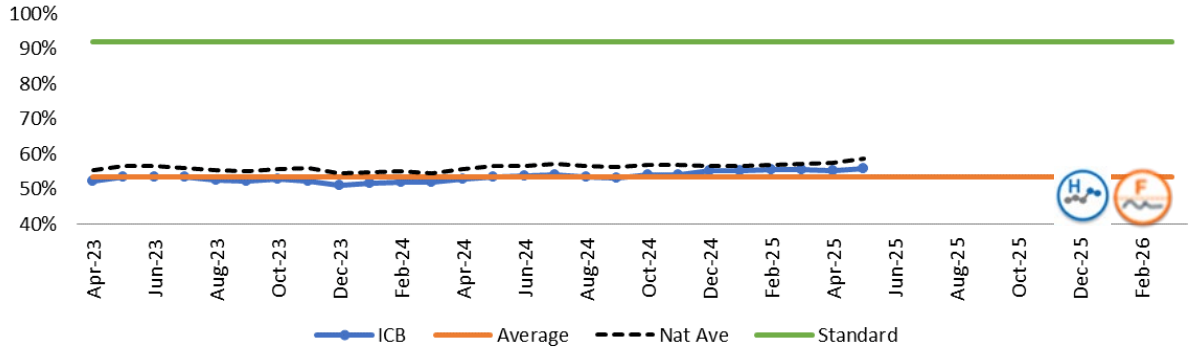
Total 62 Day Backlog (ULHT)



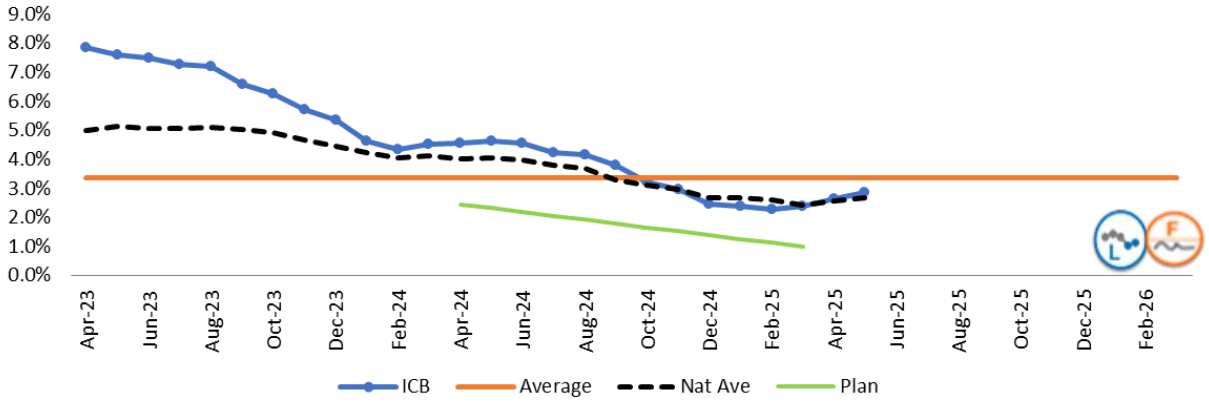
Elective Care

NHS
Lincolnshire
Integrated Care Board

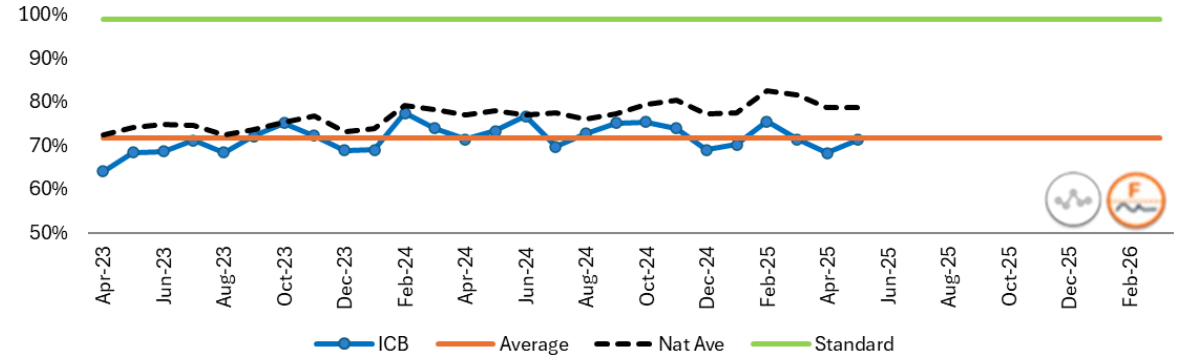
RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



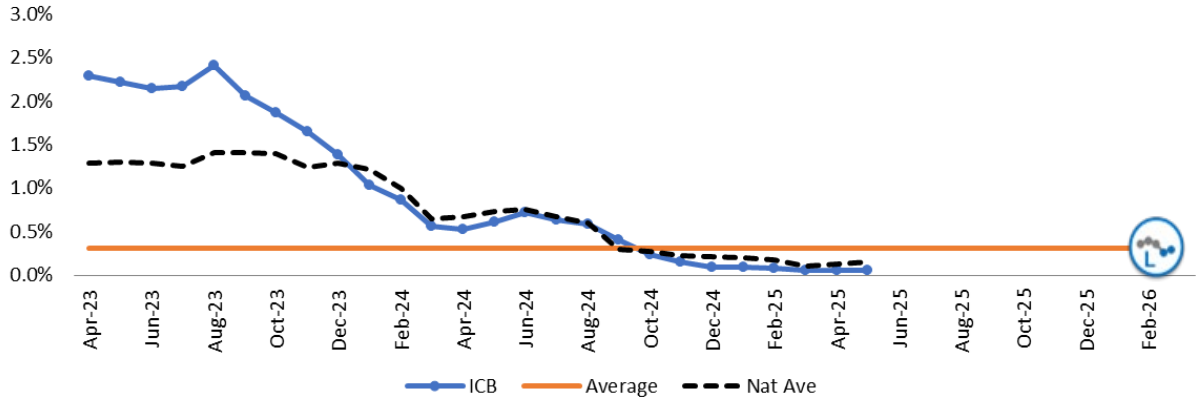
RTT- Patients waiting over 52 weeks for treatment (LICB)



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



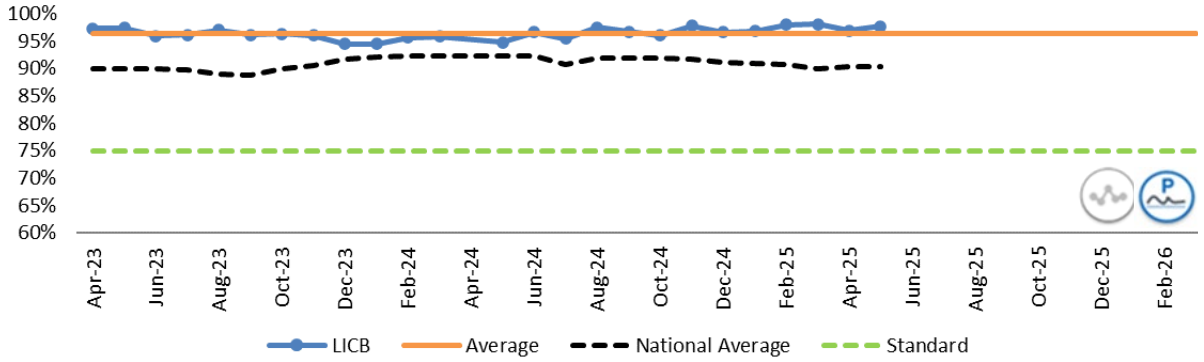
RTT- Patients waiting over 65 weeks for treatment (LICB)



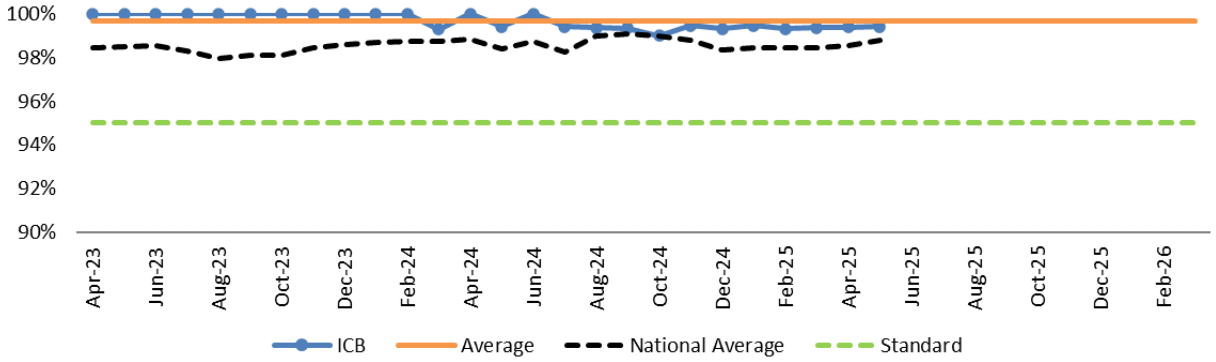
Mental Health

NHS Lincolnshire Integrated Care Board

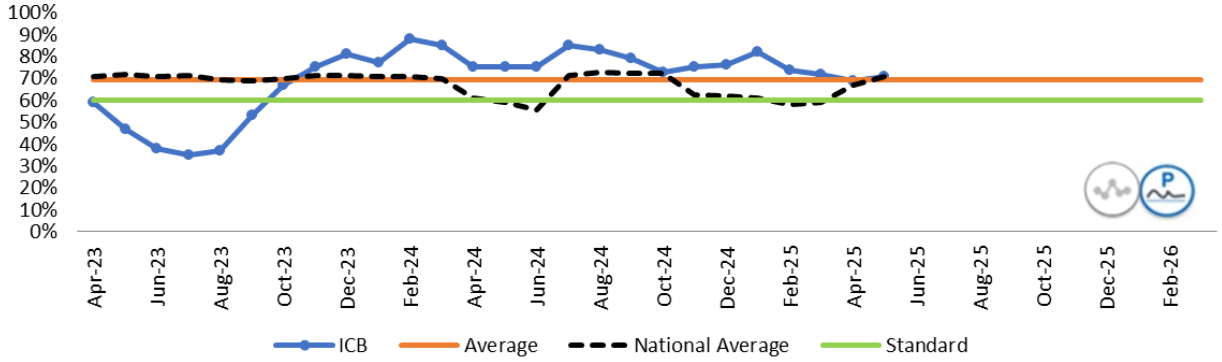
Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



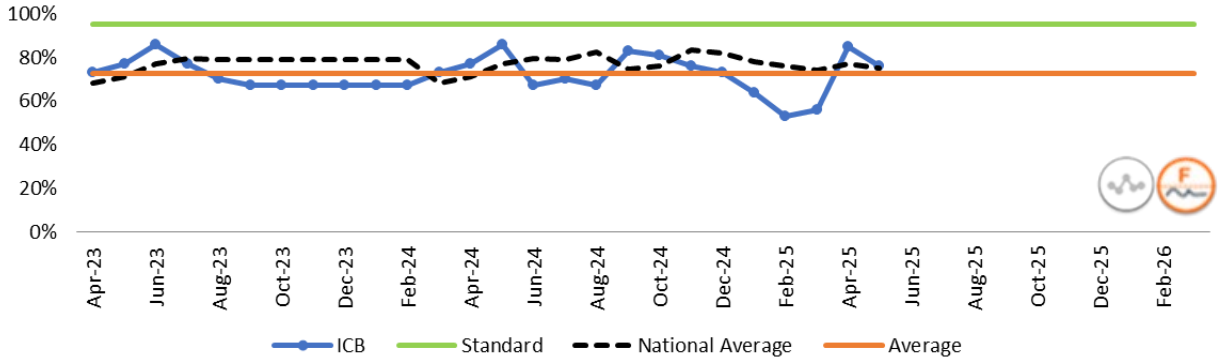
Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)



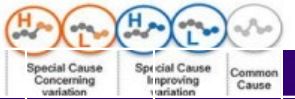
People experiencing first episode psychosis waiting to start a package of care (ICB)



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



Lincolnshire ICB Quality Dashboard

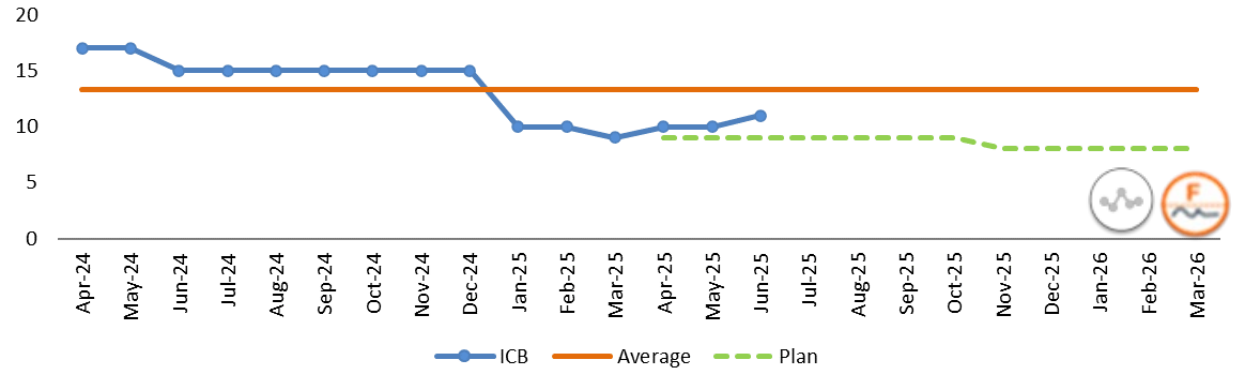


Programme	Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULHT)	0	May-25	0	N/A	N/A	-		
	Never events - YTD (NLAG)	0	May-25	2	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	May-25	2	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	-	Mar25 to Feb25	1.0847	1.0673	1.0032			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	Mar25 to Feb25	1.0287	1.0673	1.0032			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	Mar25 to Feb25	1.0106	1.0673	1.0032			
Infection, Prevention, Control	MRSA Cases (ULHT 12 month rate per 100,000)	-	Mar-25	0.30	0.86	1.02			
	C-Diff Cases (ULHT 12 month rate per 100,000)	-	Mar-25	29.11	34.45	32.57			
	E-Coli Cases (ULHT 12 month rate per 100,000)	-	Mar-25	43.38	43.38	38.00			
Learning Disability	Inpatient Care for adults with a learning disability or LD & autistic (adults)	9	Jun-25	11	N/A	N/A			
	Inpatient Care for autistic adults (with no learning disability)	22	Jun-25	20	N/A	N/A			
	Inpatient care for children with LD/autism - Under 18s	1	Jun-25	1	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	516	Jun-25	581	N/A	N/A			
Patient Experience	Patient experience of GP services (ICB)	-	2025	73.0%	N/A	75.0%			-
	Friends & Family Test: A&E Recommended (ULHT)	-	May-25	67.8%	N/A	80.0%			-
	Friends & Family Test: Inpatient Recommended (ULHT)	-	May-25	89.8%	N/A	94.5%			-
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)	-	May-25	N/A	N/A	92.0%			-
	Friends & Family Test: Community Recommended (LCHS)	-	May-25	89.0%	N/A	95.0%			-
	Friends & Family Test: Mental Health Recommended (LPFT)	-	May-25	92.0%	N/A	88.0%			-
Primary Care	Primary Care CQC- percentage of practices rated as 'Inadequate' by CQC	-	Jun-25	1.2%	N/A	0.4%			
	Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC	-	Jun-25	7.4%	N/A	4.5%			-
	GP Appointments- Total appointments in GP practice	511,457	May-25	443,086	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	May-25	44.8%	N/A	44.2%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	May-25	87.0%	N/A	81.8%			
	Enhanced access minutes provided (ICB) (YTD)	448,710	May-25	466,310	N/A	N/A			
	The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	May-25	85.7%	N/A	N/A			

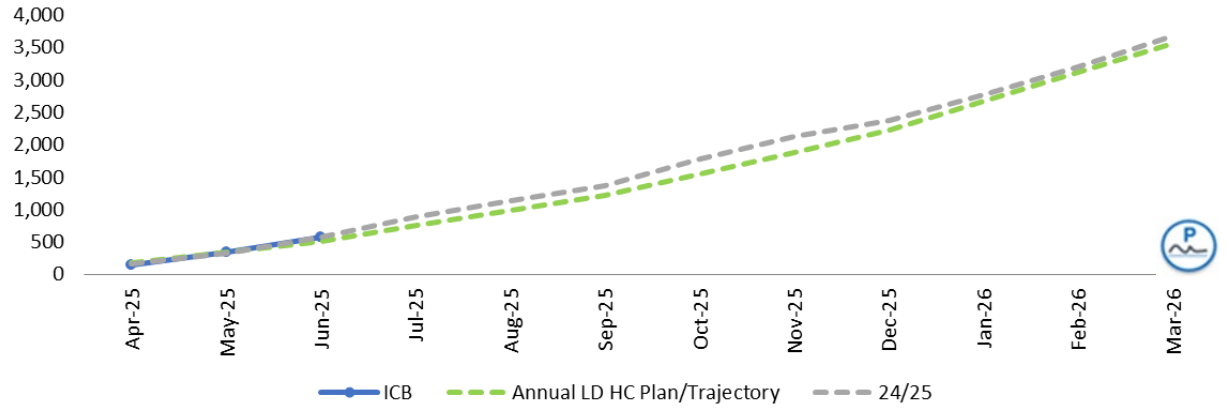
Learning Disability & Autism

NHS Lincolnshire Integrated Care Board

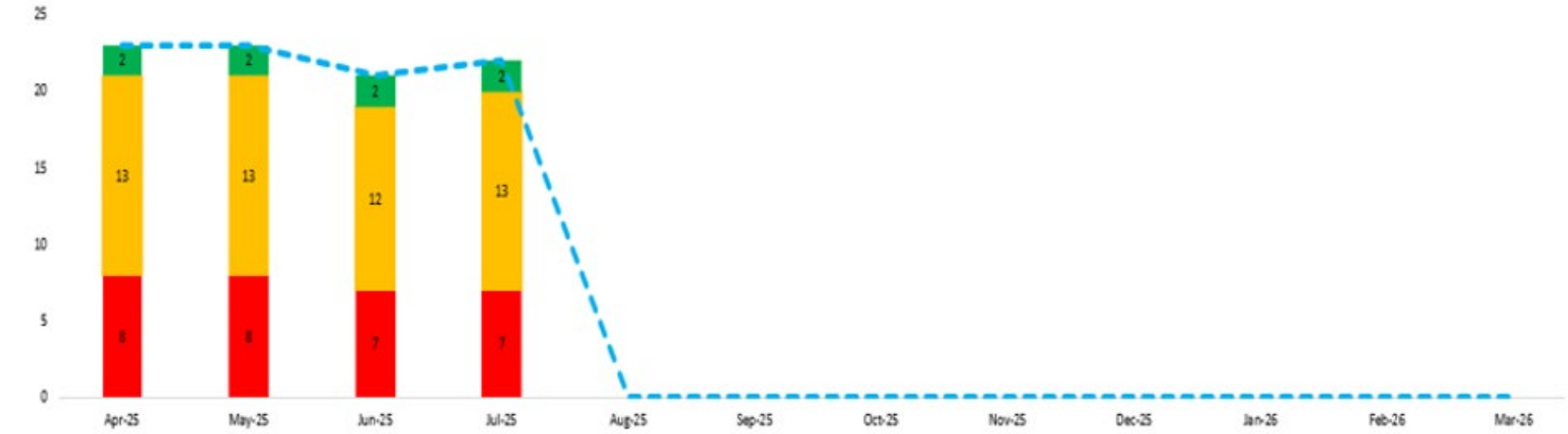
Inpatient Care for adults with a learning disability & autistic (adults)



Cumulative Learning Disability Healthchecks (ICB)



LDA ICB Adult Inpatient Movement



Legal Framework / MM Judgement	Actual Trajectory
Clinical illness - Appropriately placed	Submitted Trajectory
Market issues - Discharge plan in place	

RAG RATING Key

Legal framework – This is the barrier to the discharge and may prevent the discharge from happening for several years etc.
a.Those on extended S17 Leave granted under the MH Act
b.Those on MM judgements which will state when the ruling applies to. Looking into capacity issues as well

Clinical illness – Those clients where the needs are best met in a secure environment

Market issues – this is where we should concentrate the discharges on, as it is the lack of placement to discharge to, which is the reason why they have not been discharged

Insight and Signals – Quality and Patient Experience

LPFT:

CQC undertook unannounced assessments on 3 wards at LPFT on 17 and 18 June 2025 (ward 12, Ellis and Castle wards), report is awaited however the Trust have responded to a number of issues highlighted by the CQC. LPFT are working closely with LICB to ensure appropriate quality oversight arrangements are in place.

NRS:

A number of challenges with the provision of community equipment and wheelchair service have been identified. The ICB is working with LCC who lead on this contract, to address the current and emerging issues

Paediatric Audiology:

A number of issues relating to providers of paediatric audiology to the Lincolnshire population have been highlighted over the last year. Work is being undertaken through the Planned Care and Diagnostic programme to ensure there is consideration of impact given the inter-dependencies on Lincolnshire patient pathways, this will include impact on quality.

Insight and Signals – Primary Care

GP Practice quality:

- The Quality Early Warning Score (QEWS) programme continues to progress with more practices showing an interest in participating. It is now necessary to manage the process using a queueing system with anticipated start dates for those practices wishing to commence.
- 3 practices are still currently receiving enhanced support via this process.
- Some of the initial delays in completing QEWS for some practices is their own wish to push for the highest 5 star award. This has increased the quality of services in these practices and is a welcome and unexpected development.

Pharmacy, Optometry and Dentistry (POD) quality:

- The Primary Care Quality Team is continuing the development of the QEWS process for POD providers. A large part of this process will include accessing remote evidence without the reliance on providers to directly populate their evidence files.
- The Primary Care Quality team and Quality Services team are continuing to develop the incident reporting and management process for all commissioned POD services. The first element of this programme is near final draft and includes a consistent approach to the Learning from patient safety events (LFPSE) process. This will ensure that all commissioned POD providers will use the same tools for incident reporting and learning.

Insight and Signals – Primary Care

Below are a set of performance metrics that will be used for 2025/6. In most areas, there is a requirement for improvement to meet this years' targets.

Metric	Target (25/26)	YTD
GP appointments – total provided	5,902,651	- (5.6M 24/25)
GP appointments - % within two weeks of contact	85%	87% (Mar '25)
Patient experience of GP contact – rated as 'Easy'	85%	81% (Apr'25)
Same day confirmation	85%	71% (Apr '25)
Preferred professional	71%	72% (Apr '25)
Pharmacy First – total consultations	68,108	- (42K, M11 24/25)
Urgent Dental Appointments – total provided	12,012	-
Units of Dental Activity delivered	786,810	- (775,446, 24/25)
Adult patients seen by a dentist within 24 months - %	251,659/Qu	- (242K, Q4 24/25)
Child patients seen by a dentist within 12 months - %	85,459/Qu	- (80K, Q4 24/25)

Learning and Sharing

Review of patient safety across the health and care landscape:

This report published July 2025 Review of patient safety across the health and care landscape - GOV.UK considers whether there are overlaps and gaps in functions across 6 identified organisations and makes 9 recommendations including a revamp and revitalisation of the National Quality Board.

Fit for the future: 10 Year Health Plan for England:

Publication of the 10 Year Plan Fit for the future: 10 Year Health Plan for England includes a chapter focusing on 'A new transparency of quality of care' with a particular emphasis on putting patients at the heart of understanding quality; clearer accountability and incentives; and more streamlined intelligence based regulation.

Quality impact assessment framework:

NHSE published a quality impact assessment framework June 2024 NHS England » Quality impact assessment framework. The framework provides good practice principles and guidance for undertaking quality impact assessments (QIAs) as part of the decision-making process for planning, approving and implementing changes to health and care services or when commissioning new ones. With the development of Lincolnshire system QEIA approach the framework will be reviewed to ensure the evolving system QEIA process and ICB expectations align with this recently published guidance

System Complaints Thematic Report:

LICB has worked with LCHG; LPFT; and EMAS to establish a process for quarterly review of the themes coming through the individual organisations complaints and PALS processes. An initial report will be presented to July 2025 System Quality and Patient Experience Committee (SQPEC) with the intention of triangulating intelligence from this thematic approach with wider patient experience information and system quality priorities. A schedule of regular reporting will be agreed with SQPEC.

Joint Response to Care Home Quality Concerns:

LICB has well established processes in place with LCC for oversight of quality and any emerging concerns with Lincolnshire care homes. Response to a recent escalated concern highlighted where improvements could be made to quality visits, which take place to ensure residents safety and wellbeing are being maintained where quality concerns are identified. LICB safeguarding team has worked with LCC to review the process and strengthen the quality visit approach undertaken by the partnership.

Quality and Patient Experience Thematic Update – Maternity and Neonatal

- **Regional heatmap for June** – Lincolnshire continues to have the lowest rating (with low being positive) for the whole of the Midlands region. There are now 3 trusts including ULTH that are rated “blue”.
- **Regional Perinatal Newsletter** – Noted strong collaboration, organisation and chairmanship of the Lincolnshire LMNS Board. It was felt that exceptional leadership drove quality and safety improvement in maternity and neonatal services.
- **National Maternity Review -** A rapid national investigation into NHS maternity and neonatal services has been ordered by Health and Social Care Secretary. Benchmarking completed by Trust, no areas of concern highlighted.
- **Maternity Incentive Scheme Safety Actions** – Work is ongoing through the LMNS to ensure appropriate focus to meet scheme requirements
- **Insight Visits** – Annual assurance visits booked in for September 2025 with terms of reference agreed.
- **Lincolnshire stillbirth rate** – LICB showing higher levels than expected through MBRRACE data. ULTH has low rates. 1634 women birthed outside of the county mainly at North West Anglia Foundation Trust, North Lincolnshire and Goole and to a lesser extent Queen Elizabeth Kings Lynn. A review of the MBRRACE data for these Trusts show them all to have below expected stillbirth rates and not flagging on their perinatal dashboards. LICB team are undertaking further deep dive to ascertain if any specific flags for Lincolnshire women that choose to deliver outside of county such as socioeconomic reasons. However, the LMNS is assured that there are no issues with our provider Trusts that we can identify.

Quality and Patient Experience Thematic Update – Maternity and Neonatal cont.

- **Capacity of Programme Team** – There are current capacity constraints within the team which is requiring prioritisation of workstreams and those that need to be paused.
- **NHS 10 Year Plan** – there are opportunities for Maternity & Neonatal services with a focus on artificial intelligence, Continuity of Carer, prevention and population well-being, training and retention, shift from hospital to community.

Finance: Summary Financial Position (1)

NHS Lincolnshire Integrated Care Board

Year To Date Financial Position

The ICS reported a £11.2m deficit at Month 3 which was in line with the submitted financial plan.

The ICB reported a £1.1m deficit at Month 3 which is in line with the submitted plan.

Outturn Financial Position

The ICS' plan is to deliver a break-even position against in year allocations and income for the full financial year. At Month 3 the ICS reported delivery of this plan.

The ICB has a plan to deliver a £3.72m for the full financial year. At Month 3 the ICB reported delivery of this plan.

Risks and Mitigations

The ICB has identified risks of £19.5m to delivery of the plan for the financial year. Main risks being delivery of CIP, Prescribing and CHC. Mitigations of £13.0m result in a net risk of £6.5m.

The ICS has an overall net risk of £24.5m.

Finance: Summary Financial Position (2)

NHS Lincolnshire Integrated Care Board

Cost Improvement Plan

The ICS has a full year cost improvement plan of £163.2m.

At Month 3 the ICS has reported delivery of £30.5m cost improvements against a plan of £30.2m equating to a £0.4m adverse variance to plan.

Capital

The ICS has a full year Capital Departmental Expenditure (CDEL) Limit of £138.2m. £37.9m of this relates to Business As Usual (BAU). The remainder of the capital is predominately for specific projects – the largest being £43.0m for the ULTH Frontline Digitalisation Programme (Electronic Patient Record).

The ICS is expecting to utilise all this allocation.

Item 6 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (i)
Meeting Date:	Tuesday, 29th July 2025
Title of Report:	ICB Joint Transition Committee Highlight Report
Report Author:	Mrs Sharon Robson, Non-Executive Director and ICB Deputy Chair Ms Clair Raybould, Chief Executive Mrs Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Mrs Sharon Robson, Non-Executive Director and ICB Deputy Chair
Appendices:	Appendix A – Joint Transition Committee Terms of Reference

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

Recommendations

Summary

Terms of Reference

The Joint Committee reviewed and endorsed its terms of reference for onward presentation to the three ICB's Boards for approval in July 2025.

Members noted that the Joint Committee's primary role was to oversee the transition to a new ICB cluster operating model, seeking assurance on development and delivery of the transition programme plan and the management of transition risks.

It was agreed that fortnightly Joint Committee meetings would continue for three months to maintain momentum, to be reviewed again in September 2025.

The Board is asked to approve the Joint Transition Committee Terms of Reference as attached at Appendix One.

Transition Planning and Financial Modelling

The Joint Committee oversaw the development of the ICBs' planning submissions to NHS England by 30 May 2025, ahead of approval by each ICB's Board. The submissions responded to the mandate to reduce ICB management costs to £18.76 per head of population (subsequently uplifted to £19.00 per head). Members discussed the need to balance national guidance, strategic commissioning needs and talent retention/development, and the importance of establishing robust governance arrangements for the ICB cluster was also emphasised during discussions.

A three-phase transition programme was agreed:

- Phase 1: Operating model design and management of change.
- Phase 2: Function transfer aligned with the Model ICB Blueprint.
- Phase 3: Establishment of the future strategic commissioning form.

Transition Programme Architecture

Members reviewed and approved the programme management arrangements for the transition programme. This included the establishment of an ICB Transition Programme Group that would oversee the work of five operational workstreams: operating model design; management of change; governance; finance; and stakeholder communications.

Members noted the importance of having a single, fair and transparent management of change process and a clear vision across all ICBs to underpin the process. Members also discussed concerns relating to short delivery timelines that were dependent on national guidance and processes and the capacity of staff to manage both transition requirements and their day-to-day duties.

Members were assured that a detailed programme plan with milestones and interdependencies was in development, which would be finalised ahead of the next meeting. This would form the basis of future assurance reporting to the Joint Committee.

Transition Risk Log

The Joint Committee considered an initial set of transition risks and noted that a consolidated risk log for the ICB cluster was in development, which would be finalised ahead of the next meeting.

ICB Constitution

All ICBs have received advice from the national legal team to amend clause 3.5 (Model constitution numbering) of the ICB constitution, shown in blue below, so that they read as follows allowing joint CEO appointments for the clustering ICBs.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if:
a) any of the disqualification criteria set out in 3.2 apply
b) subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board.

The Board is asked to note this amendment has been made to NHS Lincolnshire ICB Constitution and the updated version has been shared with the NHSE Regional Team and published on the ICB website.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	It is essential that the ICB establishes effective arrangements for managing conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-

	making processes towards the achievement of the four core aims.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	

Risk and Assurance
No specific risks identified.

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

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

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Joint ICB Transition Committee – Terms of Reference

1. Introduction/ Purpose	The Joint ICB Transition Committee ("the Joint Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Joint Committee is to oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. Due to the nature of the Joint Committee's role, it will be time-limited in its establishment, with the Boards of the ICBs determining the appropriate timeframe for the Joint Committee to be dis-established. The Joint Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from employees of the ICBs and all employees of the ICBs are directed to co-operate with any request made by the Joint Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	a) Oversee the establishment of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe. b) Oversee the development and implementation of a fit for purpose ICB operating model. This will include ensuring that the proposed new model: • Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB Blueprint, based on a robust 'make, buy, share' assessment across relevant geographies. • Delivers required efficiencies and is affordable within the financial allocation for the ICBs. • Is developed taking into account the feedback from the combined workforce of the ICBs, as appropriate. c) Oversee the development and implementation of fair and transparent exit and workforce change processes for ICB

	staff, in line with national guidance and local policy requirements, working in conjunction with each ICB's Remuneration (and Human Resources) Committee, as appropriate. This will include oversight of appropriate training and development and health and wellbeing initiatives for ICB staff to ensure they are well supported throughout the transition process. d) Oversee the establishment of effective governance arrangements to support the period of transition the new ICB operating model, and to ensure its ongoing effectiveness. e) Oversee the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process. f) Oversee the identification and management of risks relating to the transition process and future ICB operating model. g) Oversee arrangements for the safe transition of any transferred functions.
3. Membership	The membership of the Joint Committee will be comprised as follows: *NHS Derby and Derbyshire ICB:* a) Two Non-Executive Members of the Board b) Chief Executive c) Executive Director Lead for Transition *NHS Lincolnshire ICB:* d) Two Non-Executive Members of the Board e) Chief Executive f) Executive Director Lead for Transition *NHS Nottingham and Nottinghamshire ICB:* g) Two Non-Executive Members of the Board h) Chief Executive i) Executive Director Lead for Transition *Attendees* The Joint Committee may invite a range of Senior Managers from each ICB to attend meetings to support the Joint Committee in discharging its responsibilities.
4. Chair and deputy	The Boards of the ICBs will appoint a Non-Executive Member to be Chair of the Joint Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Joint Committee's Non-

	Executive membership will be nominated to deputise for that meeting.
5. Quorum	The Joint Committee will be quorate with a minimum of six members, to include at least one non-executive and one executive member from each ICB. If any Joint Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	It is expected that at the Joint Committee's meetings, decisions will be reached by consensus and a vote will not be required. Any decisions taken will be record in the minutes of the meeting. If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the Joint Committee. Otherwise, decisions will be taken by simple majority.
7. Meeting arrangements	The Joint Committee will initially meet on a fortnightly basis, in line with the pace of change requirements. The required frequency of meetings will be kept under review and adjusted as appropriate as the transition period progresses. Members of the Joint Committee are expected to attend meetings wherever possible. The Joint Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Joint Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Joint Committee to be open to the public. Secretariat support will be provided to the Joint Committee to ensure the day-to-day work of the Joint Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than three calendar days in advance of meetings and will be distributed by the secretary to the Committee. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and will be ratified by agreement of the Joint Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Joint Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as

	ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Joint Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Joint Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Joint Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Joint Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Joint Committee is accountable to the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. The Joint Committee will provide assurance to the Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, through submission of Committee Highlight Reports, summarising items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	Due to the focus of the Joint Committee's work and the nature of emerging guidance, these terms of reference will be kept under review on an ongoing basis to ensure continued fitness for purpose. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 29th July 2025
Title of Report:	Update from the Service Delivery & Performance Committee for May and June 2025
Report Author:	Mrs Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Mrs Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	

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

Recommendations

The Board is asked to note and consider this report.

Summary

May 2025 Committee

1. Board Assurance Framework (BAF)

The Committee received a comprehensive report on the Health Inequalities risk within the BAF. The key focus included concerns around the allocation and utilisation of resources and gaps in oversight related to key priorities under the Joint Forward Plan.

The discussion included:

- Funding Challenges: Although funding for health inequalities was allocated, not all resources were being utilised. A lack of system-wide resource allocation beyond previously targeted SDF allocations was noted.
- Governance Gaps: Misalignment between prevention initiatives and enabler programmes was identified. The Lincolnshire System Oversight Group was established to bridge coordination issues.

- Data Development: Work on the Health Inequalities (HI) reporting suite in the Lincolnshire Joint Intelligence Dataset progressed, with metrics expected in Q1 2025/26.
- Legal Duties Report: Initial data from a legal duties' perspective revealed improvements across priority areas. However, flu vaccine uptake and early cancer diagnosis rates declined, warranting further review.

A clear need was recognised for metric development that aligns with Lincolnshire's local context rather than solely national indicators, particularly as we transition to neighbourhood-based care and continue to embed essential cultural change.

2. Digital Inclusion Strategy

An overview of the Digital Inclusion Strategy was provided, noting it had been presented to the ICB Board on 27th May 2025.

The Committee acknowledged that co-production with stakeholders had strengthened the strategy's foundation with suggestions to partner with housing associations and community stakeholders for improved outreach.

3. 2024/25 Performance Close-out

Key highlights were reported, noting that the ICB had finished the year strongly across several areas:

- Elective Care - ULTH ended the year with only seven patients waiting over 65 weeks and none over 78 or 104 weeks.
- Lincolnshire ranked best regionally for long waits.
- Diagnostic performance fell to 68.3%, with Audiology and Echo underperforming.
- Cancer - Backlog targets were met. 62-day performance was above target; FDS required further improvement but 62-day performance exceeded plan at 66.9%.
- Urgent Care - March performance exceeded the 78% national target. There were temporary dips due to seasonal factors, but recovery was timely and effective.

4. 2025/26 Operational Plan Update and Monitoring Proposal

A proposal was presented to streamline performance monitoring for 2025/26 through a new, single integrated report. The report will align with national priorities and will incorporate risk assessment, recovery narratives and dashboard data. The Committee approved the proposal, agreeing it would reduce duplication and improve oversight.

5. Month 2 Performance Update and Escalations

An update was provided on the latest position:

- Urgent Care – Despite seasonal disruptions, recovery was noted. SDEC expansion at Lincoln was underway.
- Planned Care**:** 65-week and 52-week waiters were near plan. ENT services remained a challenge.
- Diagnostics: Issues continued in Audiology and Echo, while MRI/CT showed improvement.
- Cancer: FDS stood at 72.6% (against a 77% target), with 62-day performance exceeding targets.

- Mental Health: Out-of-Area placements showed improvement. Concerns were raised over the limited utility of national metrics in reflecting service complexity and interdependencies, including numbers of inpatients ready for discharge who were awaiting supported living/care packages.
- Dashboard**:** Issues in vaccine uptake among pregnant women were flagged.

New Risks Identified:

The upcoming changes to ICBs with accompanying uncertainty at regional level was raised as a key delivery risk, particularly noting the additional workload this was putting onto Executives. Internal mechanisms to articulate, mitigate as best possible and monitor this evolving risk were endorsed.

June 2025 Committee

1. Urgent and Emergency Care (UEC) Recovery Plan & Winter Planning Framework

The Committee received a comprehensive presentation with regards to the UEC Recovery Plan and Winter Planning Framework.

Key themes included national priorities:- reducing ambulance handover delays, increasing community-based interventions, integrating mental health into emergency care, and ensuring 4-hour A&E target adherence for children and young people.

Regional Key Lines of Enquiry submission was due by 4th July 2025 with draft Winter Plan submission by 1st August 2025.

Priority actions were identified as: System-wide focus on impactful improvements; testing plans to increase out-of-hospital urgent care and aligning capital investment and national improvement resources with local need. Mrs Neno was confirmed as Winter Director.

A system wide workshop was scheduled for 16th July to identify any gaps and support development of the demand and capacity model, the challenges of potential industrial action and uncertainty around the epidemiology data at this stage were highlighted.

Regional assurance and stress-testing/refinement of the plan would follow in September.

The Committee was concerned over the tight timescales and operational burden of the requirements and stressed the need to maintain focus on patient outcomes and staff.

The engagement and active involvement of local authority partners in the planning was confirmed in respect of social care provision and housing-related discharge issues.

2. Performance Report

A new revised performance report format was presented to the Committee. The new report has integrated data on finance, workforce, and operational delivery.

The next iteration of the report would include transformation shift metrics.

Key Updates from the report included:

- Financial constraints remain a limiting factor for improvement actions.

- Pharmacy First was progressing well.
- Urgent dental access improving; year-end targets expected to be met.
- Patient Listening Clinics planned to support qualitative improvements.
- Mental Health, Dementia, LD & Autism:- CYPMH services now on plan; Talking Therapies and perinatal services undergoing reviews of referral and recovery rates.
- Planned Care Performance
    - Lincolnshire best in Midlands for 78-week waits (zero breaches).
    - 65-week performance strong; focus on 52-week waits
    - ENT and audiology remain constrained specialties.
- Health Inequalities:
    - No significant disparities overall, though gynaecology and deprivation-related access issues are under review.
- Communications & Access:
    - Work underway to modernise patient letters and streamline communications
- Theatres & RTT:
    - Theatre productivity has significantly improved (now nearing top national quartile).
    - RTT performance improving, but DNA rates remain a challenge.
- SDEC investment of £4 million in place for winter preparedness.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience, and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
See main body of report.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications/	Yes - Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Not applicable.

Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.		
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable			
Is the report confidential or not?			
Yes ☐ No ☒			

Item 7 (i)

NHS
Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 29th July 2025
Title of Report:	System QPEC (Quality and Patient Experience) Committee
Report Author:	Mrs Sharon Robson, Non-Executive Director (Chair) Mr Martin Fahy, ICB Chief Nurse Ms Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	N/A

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

Recommendations

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

Summary

The System Quality and Patient Experience Committee took place on 23rd July 2025 and focused on the following agenda items:-

- **Lincolnshire System Priorities Quality Register and Board Assurance Framework:** the Lincolnshire System Priorities Quality Register was shared with members. It was noted that the Register had been updated to include a tolerance level column. An update was provided on the high rated risks which included:-

  - Access and long waits for services.
  - Discharge delays.
  - Workforce challenges.
  - Financial challenges.

  In terms of the Board Assurance Framework it was reported that these reflect those detailed on the Lincolnshire System Priorities Quality Register. In addition to this the Framework includes detail in ensuring that there are robust processes in place for public engagement and involvement, transforming the culture to address health inequalities, organisational transition and the associated uncertainty changes.

- **Quality Strategy:** it was noted that the Quality Strategy had been refreshed taking into account the recent publication of the NHS Ten Year Plan. Members were asked for feedback in order to produce the final iteration for sharing at the next meeting.

- **Lincolnshire Voice Report:** the latest Lincolnshire Voice report was shared with members. The report includes detail in relation to general feedback, complaints, Patient Advice and Liaison Service and the Healthwatch neurological and general feedback reports.

  Areas to note include long waiting times for follow up and hospital appointments and GP appointments, poor communications in particular for referrals and care plans. HealthWatch feedback includes issues relating to non-emergency patient transport, communication issues particularly on the East Coast between pharmacies and GP's.

  It was noted that the report is evolving and also encompasses information relating to health inequalities which will highlight key emerging themes. Discussions ensued regarding the next steps and the "so what" actions required to address the challenges highlighted and improve service areas.

- **Neuro-Diversity Pathways and Progress with the Contract:** an update was provided on the neuro-diversity pathways for children and young people and adults. It was noted that the adult work stream is predominantly focused on ADHD however there is an increase in the number of requests and referrals for functional neurological disorder as well.

  At the moment, ADHD activity continues to increase with a current caseload of 4,000 which is an increase of 300 active patients from last month, currently approximately 26 referrals a day are being received. There is also an increase in referrals for treatment where the patient has chosen to have their diagnosis through a private route, which can then cause additional complexities as some providers only offer a diagnostic service and do not offer titration of medication or treatment.

  It was noted that work is taking place with contracting colleagues as there are currently a number of providers who have expressed an interest in becoming an accredited provider in Lincolnshire. The plan is to have more providers on board which will increase capacity and facilitate a more timely process for approving triage referrals and seeing patients. Despite the current capacity constraints, Lincolnshire has some of the lowest waiting lists for adults.

  In terms of the children's pathway, work is ongoing to support the autism and ADHD pathways with a focus on the social communication pathway. A review was undertaken last year which identified recommendations across the system and subsequent to this a model was developed. This has been subject to a full business case for additional capacity to manage the increased demand and improve the patient pathway. This is now being progressed through the Weighted Value Framework process.

- **Children and Young People Integrated Transformation Board:** a detailed presentation was provided on the Children and Young People programme including updates in relation to:-

  - ***Asthma*** – the diagnostic pathway in Community Diagnostic Centres; Asthma Friendly School Accreditation - seven schools now accredited; and work is also taking place to utlilise population health management data for asthma.
  - ***Epilepsy*** –a business case has been developed for additional Epilepsy Specialist Nurse capacity; work is taking place between tertiary and secondary care providers to improve epilepsy pathway; and confirmed a harm surveillance process is in place and there is regular audit of triage.
  - ***Diabetes*** – the role of Community Connectors; and highlighted a scheme providing mobile phones for closed loop systems where families are unable to afford mobile phones for their children to facilitate better access to digital support.
  - ***SEND Local Area Partnership Inspection*** - the outcome of the recently published Ofsted and CQC inspection was that *'The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with SEND. The local area partnership must work jointly to make improvements'*. Positive observations were highlighted in terms of strong partnership working between partners and the determination to improve services. Work had already commenced to address the areas for improvement.

- ***Clinical interventions in Special Schools*** - on site special school nursing service at St Francis provided by ULTH. The current situation is that children with the most complex needs have to travel across the county to St Francis when special schools closer to home cannot meet their needs. The service has been reviewed, however significant investment would be needed to increase provision across the county.

- ***Children and Young People Waiting Lists*** – Specific work is taking place in relation to Cardiology, Speech and Language Therapy and Community Paediatrics; other specialities such as ENT and Dermatology are being managed through the Planned Care and Diagnostic programme.
- ***Other areas of work*** –CYP continence; winter planning; children's community nursing review; palliative and end of life care; and was not bought.

- **Deep Dive into Health Inequalities:** a Deep Dive was provided on the work taking place to support Health Inequalities. It was noted that as part of the Integrated Care Strategy one of the key enablers is the prevention of health inequalities work stream. Taking this work forward there is a focus on prevention and early intervention which aligns to the recently published Ten Year Plan.

  For every indicator, it was noted that there is a significant amount of qualitative information and consideration needs to be given to creating the quantitative information. It was reported that when looking at some of the ICP outcomes the next stage is to finalise where there are gaps ahead of sign off and opportunity to publish a report.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** it was noted that work is ongoing regarding improving the Medical Examiner service however there are still some delays occurring with individual GP Practices.

  The CQC carried out an unannounced inspection of the Emergency Department at the Lincoln site on 16th July 2025, report is awaited.

  A Patient Safety Day is scheduled to take place on 15th September 2025.

- **Lincolnshire Partnership NHS Foundation Trust Highlight Report:** it was noted that an unannounced CQC inspection to Castle, Ellis and Wards 12 had recently taken place and it was noted that the Trust have a robust CQC action plan with regular reporting in place with good progress being made. Furthermore, a Quality Review meeting chaired by Martin Fahy to provide oversight and assurance is due to take place at the end of July 2025.

  In relation to The Vales female rehabilitation ward which was subject to an additional quality review process that the ICB supported, meetings have been stood down and a full assurance report will be presented at the next Trust Quality Committee for oversight and monitoring.

- **East Midlands Ambulance Service NHS Trust Highlight Report:** an update was provided on the deep dive review into the PALS, complaints and IR1 forms and the audit is nearing completion. This has provided an insight into the patient voice and a review of the reporting and managing of these incidents. Changes have been made to streamline the reporting processes and encourage crews to use the system as it reduces the amount of time on completion of forms.

  Work is also taking place in relation to the Care Bundles which is a project that has been ongoing for some time. A programme of work has also commenced to improve the appropriateness and quality of safeguarding referrals.

- **System Partners – Local Authority Update:** it was noted that the local authority is due a CQC assurance visit of Adult Care Services in September and that work is taking place in readiness for the visit.

  In terms of the recent NHS Ten Year Plan publication, work is taking place in relation to the Neighbourhood Health proposals and a submission is being prepared by the ICB who are ensuring that it is reflective of the collaboration across the system.

- **Primary Care Highlight Report**: an update was provided on the high risk rated Practices and actions being taken to address the identified concerns

- **Operational Quality Assurance Group (OQAG) Update:** detail was presented for April 2025 – July 2025. The report included information relating to six commissioned providers where there are escalated concerns that impact on quality and actions being taken in response to these concerns.

  It was noted that the report references the review being undertaken by the Planned Care and Diagnostic programme in relation to wider Paediatric Audiology issues to understand inter-dependencies on pathways of care for Lincolnshire patients.

- **System Quality Group:** the minutes of the last System Quality Group had been included for information.

Items for escalation to the ICB Board:-

- Acknowledgement of the progress of work for adult and children neurodiversity pathways
- Acknowledge the progress being made with the Children and Young People Programme.
- Opportunity to comment on the Health Inequalities work.
- Lincolnshire Partnership NHS Foundation Trust CQC unannounced visit, and action being taken to address areas of concern highlighted.
- Recent unannounced CQC visit to Lincoln County Emergency Department, report awaited
- The draft Quality Strategy had been shared with members for comments.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.

Conflicts of Interest	**Summary of conflicts**
No conflict identified	

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

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	Assurance received where concerns highlighted appropriate actions are in place
Does the report highlight any health inequalities implications/	Health inequalities considered in all aspects of the work programme.
Does the report demonstrate patient and public involvement?	Patient and public involvement and engagement is embedded within the System QPEC.

Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

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

Report previously presented at:

The Board receives regular reports from each of its Committees at every meeting.

Is the report confidential or not?

Yes ☐ No ☒