



Lincolnshire
Integrated Care Board



NHS Lincolnshire
Integrated Care Board

Annual Report and Accounts

1st April 2024 to 31st March 2025

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NHS Lincolnshire Integrated Care Board

**Annual Report and Accounts 1st April 2024
to 31st March 2025**

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Statement by the ICB Chair and Chief Executive

We welcome you to the third Annual Report for the NHS Lincolnshire Integrated Care Board which covers the period 1st April 2024 to 31st March 2025. This report gives an overview of our progress and performance during this period within our Integrated Care System (ICS). It also details how we continue to work with people and partners across Lincolnshire to integrate services so that we can improve people's health and wellbeing and reduce health inequalities.

The NHS in Lincolnshire works very closely with a wide range of partners across our county, including colleagues in local government, the care sector, the third sector, the further and higher education sectors and the police service. By working closely with our partners we know that we can have the best possible combined impact on the health and wellbeing of the people of Lincolnshire.

There is no doubt that in 2024/25, nationally and locally the NHS has continued to face multiple challenges. These include tackling the backlog of treatments and procedures, continuing to deliver effective services in a sustainable and affordable way, and supporting our increasingly aging population. These challenges have been exacerbated by issues such as industrial action, winter pressures including high numbers of cases of flu and respiratory viruses, along with major environmental incidents such as flooding. Despite these challenges, the Lincolnshire system has remained very focused on delivering its commitments as agreed through the 2024/25 planning arrangements.

At a national level there have been a number of significant developments in light of the outcome of the General Election in July 2024. These include:

- The Lord Darzi review of the NHS.
- The announcement to develop a national 10 Year Health Plan, which will include the Secretary of State's commitment to achieve three strategic shifts in healthcare to focus on Prevention; Neighbourhood Health; and Digital
- The national decision to abolish NHS England, and to also reduce ICB running costs by 50%
- The Government's commitment to increase investment in the NHS through the Comprehensive Spending Review.
- A renewed focus on delivery, transformation and productivity.

Within Lincolnshire the three national strategic shifts align fully with much of the work which has already been undertaken across the Lincolnshire ICS and also the Integrated Care Partnership (ICP) Strategy.

We are very proud of our collaboration within the ICB and with partners across Lincolnshire, and of the efforts made to ensure our services are the best they can be.

We will continue in this spirit as 2025 unfolds and further details emerge nationally in respect of the NHS. The ICB Board and the leadership team remain committed to supporting its staff as developments take place.

Locally, a significant milestone was reached towards the end of 2024, when Lincolnshire secured approval for a devolution deal for the establishment of the Greater Lincolnshire Combined Authority. Dame Andrea Jenkyns was elected as the first Mayor for Greater Lincolnshire on the 1st May 2025.

The ICB and Lincolnshire County Council have built a strong and effective working relationship over the past number of years and this has played a key part in our progress in 2024/25.

This Annual Report demonstrates continued strong progress across all key performance metrics including cancer, urgent and emergency care, waiting times, mental health, GP access and community dentistry. We would also particularly wish to highlight a number of achievements which have taken place in 2024/25 through strong local partnership working, such as:

- The opening of two new Community Diagnostic Centres in Lincoln and Skegness.
- Participation of three Lincolnshire Primary Care Networks (PCNs) - Lincoln Healthcare Partnership, Apex, and IMP in the national pilot for a new GP operating model (September 2024-March 2027).
- The Inaugural Armed Forces Symposium, held at RAF Cranwell in June 2024, with a second successful event in June 2025.
- The establishment of the Lincolnshire Institute for Rural and Coastal Health (LIRCH), - the first integrated/transdisciplinary research centre for Coastal and Rural Health Research.
- Construction of a new mental health in-patient unit at Norton Lea in Boston.

Further information about these and other achievements, is set out in the main body of this report. Whilst we are proud of the progress made, we remain focused on continually improving the quality of care received by our communities.

We wish to record our sincere thanks and appreciation for the dedication, professionalism, and hard work of health and care staff across Lincolnshire - in primary care, in Lincolnshire's hospitals, community and mental health services, in the East Midlands Ambulance Service, and within the ICB. Your efforts are deeply valued.

Following the publication of NHS England's planning guidance in January 2025, substantial work has been undertaken across the ICB and wider Lincolnshire system to develop our final system plan, which was submitted by the end of March 2025 in accordance with NHSE requirements. The annual planning round is always challenging, particularly this year given the overall economic climate and the significant operational and financial pressures facing the NHS. We are pleased that as a system we were able to build on learning from last year to inform and improve our approach.

For 2025/26 our priorities remain clear: to improve urgent and emergency care services, reduce waiting times for planned care and cancer care, tackle health inequalities, promote prevention, and enhance access to GP services, mental health support, and community dentistry.

In 2025 we have seen changes to the membership of ICB Board. We wish to thank Margaret Pratt, Non-Executive Director who stepped down at the end of 2024/25. Margaret made a valuable contribution during her tenure, and we wish her all the best for the future.

We warmly welcome Dr Phillip Earnshaw, who joined as a Non-Executive Director in March 2025, and Mr John Dunstan, who took up his role as a Non-Executive Director and Chair of the Audit and Risk Committee on the 1st April 2025.

We would also like to thank Councillor Wendy Bowkett, who served as the Local Authority Partner Member on the ICB, and Councillor Sue Woolley, Chair of the Health and Wellbeing Board and Integrated Care Partnership for their valuable contribution to the work of the Board in 2024/25 prior to them both stepping down in May 2025.

On a final personal note, both of us will be leaving the ICB during 2025 and we would both like to take this opportunity to express our sincere gratitude for all the hard work and support we have received from colleagues during our time in the NHS in Lincolnshire.

Thank you for your interest in this Annual Report, which has been prepared in accordance with the National Health Service Act 2006 (as amended 2012) Directions by NHS England in respect of Integrated Care Board's Annual Reports.



Gerry McSorley
ICB Chair



Mr John Turner
Chief Executive (Accountable Officer)

Performance report

Performance Overview

The purpose of this performance overview is to give a brief summary of the ICB, its purpose and activities, demographic profile, how we work in the health system, and with whom we have contracts. It also summarises our performance against key targets, risks to achieving our strategic objectives and what our main challenges have been this year. We have provided more detail on all these areas later in the report.



Who we are

NHS Lincolnshire Integrated Care Board (ICB) is a statutory body which came into being on the 1st July 2022, with the general function of arranging for the provision of services for the purposes of the health service in England in accordance with the Health and Care Act 2022.

The ICB is responsible for commissioning, or buying, the majority of healthcare services for the population of Lincolnshire. Those services include planned care, cancer care, emergency care, mental health, learning disability and Autism, maternity services, and community and GP services for our 819,837 registered patients across 81 GP practices. We commission services from a wide range of providers in and outside of Lincolnshire.

Lincolnshire is the fourth largest county in England, covering 5,921 square kilometres. The county is classified as one of the most rural in England by the Department for Environment, Food and Rural Affairs (DEFRA). Around 10% of Lincolnshire is below the mean high-water level. When looking at the highest astronomical tide level, this increases to 20%.

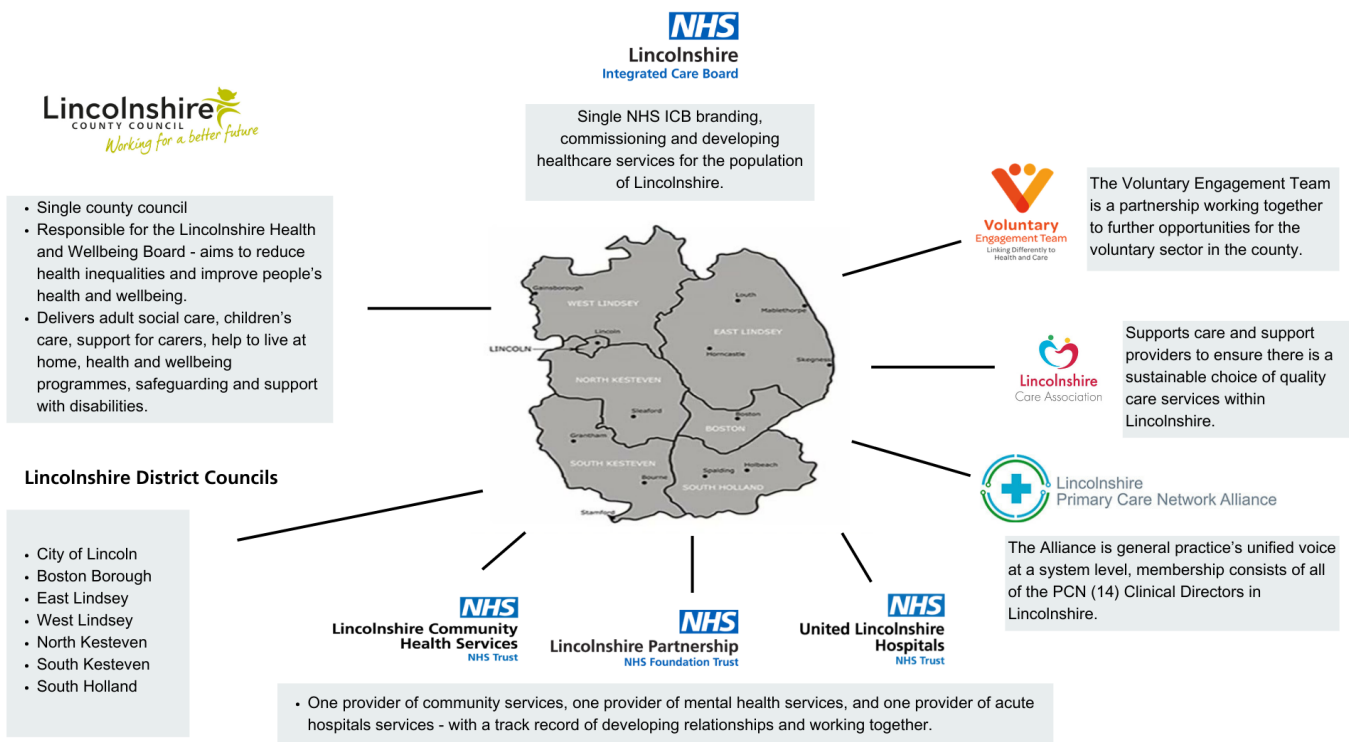
Lincolnshire's current population is predicted to be 791,978 in 2025 (this is different to the GP registered population figure shown opposite because more people are registered with a GP than the estimated number of residents in that area).

The population of Lincolnshire is expected to grow 10% by 2041. Most of Lincolnshire's population lives in rural areas, with around 70% living in villages or small towns. The largest city in Lincolnshire is Lincoln, which has a population of around 98,000 people.

A map of the geographical area covered by NHS Lincolnshire Integrated Care System is detailed opposite.

The Better Lives Lincolnshire Integrated Care System partners

Becoming an Integrated Care System (ICS) - through the Better Lives Lincolnshire ICS - is the next step on the ongoing evolution of this partnership and joint working as we seek to continue to deliver i) Improve Outcomes in Population Health; ii) Tackle inequalities in outcomes, experience and access; iii) Increase productivity and value for money; and iv) Help the NHS to support broader social and economic development - and address the systemic issues Lincolnshire faces.



The geographical area covered by the ICB is Lincolnshire, which is served by seven District and Borough Councils. The upper tier Local Authority is Lincolnshire County Council. The ICB has a Board which is made up of: Chair and Chief Executive, Director of Finance, Medical Director, Director of Nursing (Chief Nurse), Director for System Delivery, Non-Executive Members and Partner Members.

The ICB has regular participants at its Board meetings as set out below:

- Chair of the Health and Wellbeing Board
- Public Health Representative
- Director of Strategic Planning,
- Integration and Partnerships
- Director for System Delivery
- Director for Primary Care and Community and Social Value
- Director for Health Inequalities and Regional Collaboration
- Healthwatch Representative
- Voluntary and Care Sector Representative



For the period 1st April 2024 to 31st March 2025 the ICB Chair was Dr Gerry McSorley. The ICB Chief Executive (Accountable Officer) is Mr John Turner, who has overall responsibility for managing the work of the ICB.

Details of the names of the Board Members can be found under the Corporate Governance section of this report.

Our Purpose and Activities

Our vision and priorities shape who we are, how we work and help us to make the right decisions of behalf of people in Lincolnshire.

Our goal is to ensure that everyone living in Lincolnshire has the best possible health and wellbeing they can. To achieve this, we work alongside our health and care partners to provide people with access to quality healthcare and reduce the health inequalities that exist today.

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

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

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

There is no area within the Lincolnshire geographical area described as a 'Place' as per the terminology set out in NHS England national guidance. As a consequence, there are no 'Place' plans in Lincolnshire.

Integrated health and care at a local level in the county is primarily based on the Primary Care Network (PCN) geographical footprints.

Our Integrated Care System

The Health and Care Bill 2022 created ICBs and established in law the role of Integrated Care Partnerships (ICPs) as the Committee where health, social care, the voluntary sector and other partners come together as an ICS.

ICSs depend on collaboration and a focus on local populations as the driving forces for improvement.

They exist to achieve four aims:

- 1** improving outcomes in population health and healthcare.
- 2** tackling inequalities in outcomes, experience and access.
- 3** enhancing productivity and value for money.
- 4** supporting broader social and economic development.

The Lincolnshire ICB is part of the 'Better Lives Lincolnshire' (BLLLT) alliance, the name we use to describe Lincolnshire's Integrated Care System (ICS). ICSs are partnerships of organisations that work together to plan and deliver joined up health and care services which improve the lives of people who live and work in the area they serve.

The following partner organisations are part of the Lincolnshire ICS:

- East Midlands Ambulance Service NHS Trust (EMAS)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- United Lincolnshire Teaching Hospitals NHS Trust (ULTH)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire County Council (LCC)





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

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

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

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

Our main partners and providers

The ICB commissions services for its patients from a number of organisations, including:

- United Lincolnshire Teaching Hospitals NHS Trust (ULTH)
- Lincolnshire Partnership NHS Foundation Trust (LPFT)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG)
- North West Anglia NHS Foundation Trust (NWAFT)
- East Midlands Ambulance Service NHS Trust (EMAS)
- All GP practices in Lincolnshire

NHS 111 - the local provider of NHS 111 is Derbyshire Health United.

Non-Emergency Transport Services are provided by East Midlands Ambulance Service.

Other key partners include:

- Public Health
- Healthwatch
- Lincolnshire Health and Wellbeing Board
- Voluntary sector services

Our Strategies and Plans

Health and wellbeing strategy

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

A statutory duty under the Health and Social Care Act 2012 (amended by the Health and Care Act 2022) requires the local authority and the Integrated Care Board (ICB) to produce a Joint Health and Wellbeing Strategy (JHWS) for meeting the needs identified in the Joint Strategic Needs Assessment (JSNA). The purpose of the JHWS is to inform strategic commissioning for organisations that commission services to improve the health and wellbeing and reduce health inequalities of the people of Lincolnshire.

In Lincolnshire, Lincolnshire County Council (LCC) shares the same geographical boundary as the ICB. In line with the Health and Care Acts of 2012 and 2022, we are required to have both a Health and Wellbeing Board (HWB) and an Integrated Care Partnership (ICP). Whilst each is required to publish its own strategy, our local ambition is to align the HWB and ICP by connecting the JHWS and the ICP strategy whilst avoid duplication or gaps.

Each strategy retains its own identity with:

- The JHWS focusing on ‘the what’ – i.e. the population health and wellbeing priority areas the health and care system will focus on, based on the evidence in the Joint Strategic Needs Assessment; and
- The ICP strategy setting out ‘the how’ – i.e. the strategic enablers that the health and care system will focus integration efforts on, to support the delivery of the JHWS and its priorities, and the system’s overarching ambition and aims.

The shared system ambition is:

Underpinning the shared ambition, four aims have been identified that set the strategic direction for the health and care system in Lincolnshire. These aims are to:

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

Given the linkages between the strategies, and the integrated working between LCC and the ICB the two documents have a shared single introduction, attached contextual information about Lincolnshire, including health and wellbeing detail linked to the JSNA, and an overview of shared ambitions and aims, and information on how the two strategies fit together.

Joint oversight arrangements between LCC and the Lincolnshire ICB have been established to ensure the priorities outlined in the strategies and our joint working arrangements are delivered effectively.

Joint Forward Plan

The NHS Lincolnshire Joint Forward Plan describes the priorities that Lincolnshire NHS specifically will focus on over the next five years to meet the Lincolnshire population’s physical and mental health needs.

This remains in the context of the overall ICS ambition and aims, and so it too has been developed and will be delivered alongside our partners in Lincolnshire’s ICS.

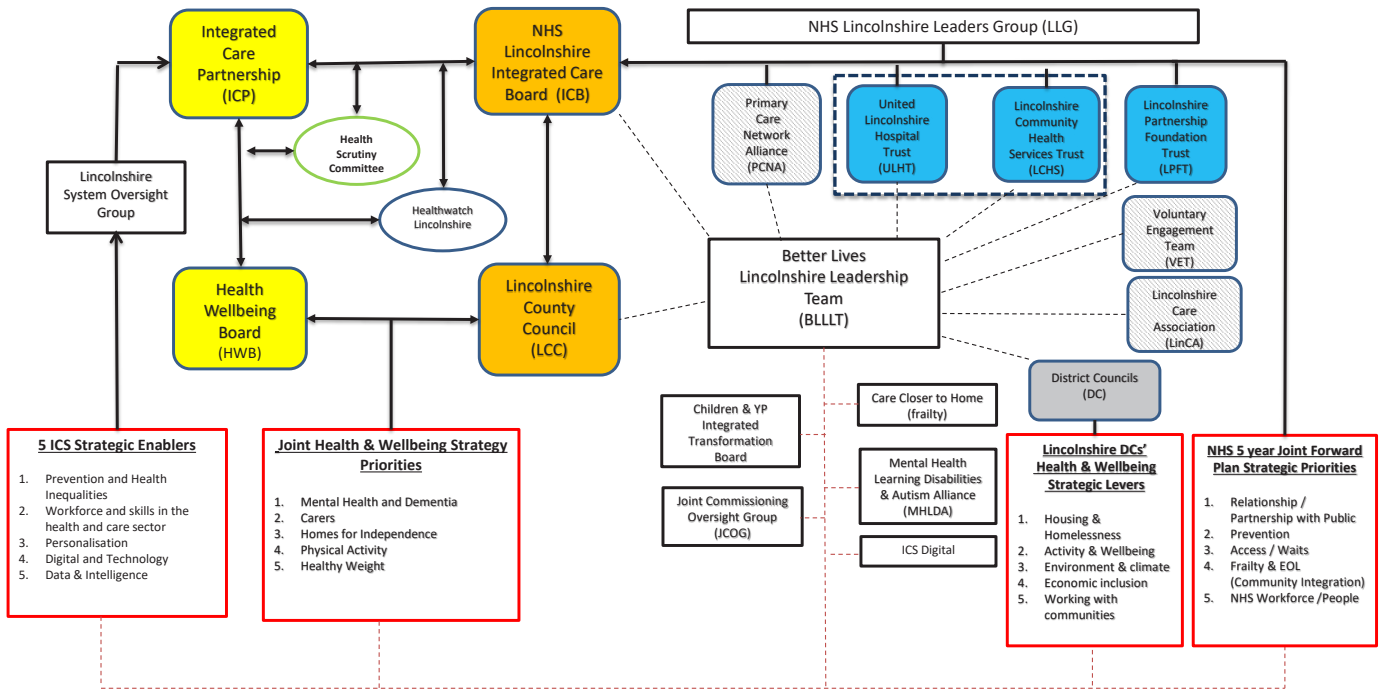
The details of all our Strategies and Plans can be found on the ICB website:

[Strategies and Plans - Lincolnshire ICB](#)

For the people of Lincolnshire to have the best possible start in life, and be supported to live, age, and die well.

The Better Lives Lincolnshire Landscape

Our integrated health and care system



Social, community and human rights issues

The ICB places a high priority on ensuring that it discharges its obligations as a good corporate citizen and takes into consideration its responsibilities towards serving and meeting the needs of local people, including safeguarding their human rights. We ensure equality and diversity run through our work as described in detail in our section on equality and diversity included later in this report.

Key risks

The population represented by Lincolnshire ICB has a higher level of complex health issues such as diabetes, coronary heart disease, and Chronic Obstructive Pulmonary Disease (COPD) than the national average. Similarly, the percentage of our population over the age of 65 with long-term conditions continue to be above the average in England.

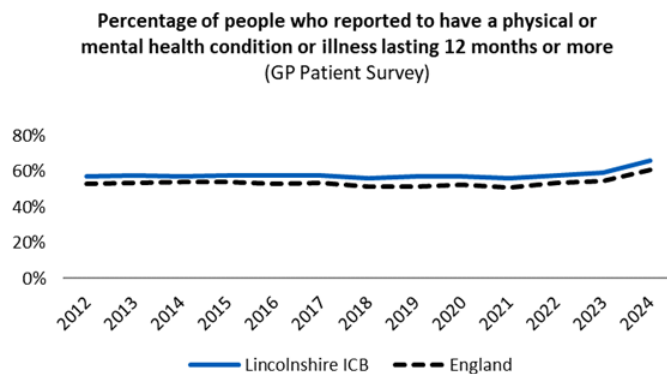
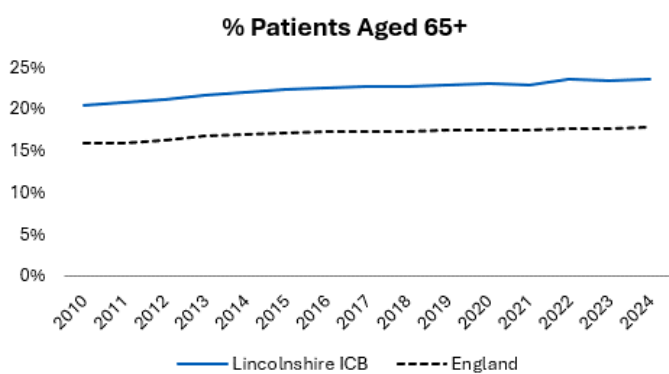
Furthermore, the index of multiple deprivation is much higher than national average, and this is important as life expectancy for men living in the most deprived areas is 73.5 years, compared with 83.2 years in the least deprived areas (a difference of 9.7 years). However, it is even longer than this in some of the more deprived parts of our county.

The COVID-19 pandemic starkly exposed these existing inequalities, and whilst they are key to our planning, they also continue to place pressure on the majority of our services.

Going Concern

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs' is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. As such the ICB has adopted a 'Going Concern' approach in the preparation of its annual financial statements, despite the issue of a report to the Secretary of State for Health and Social Care, under Section 30 of the Local Audit and Accountability Act 2014, as made by the ICB's external auditors. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.



Performance Summary – Chief Executive Statement

Over the past year, the NHS has continued to face sustained pressure across the system. This has been driven by ongoing disruption to routine care, a rise in mental health needs, increased demand for emergency services, and continued workforce challenges.

Despite these pressures, we have worked collaboratively with our health and social care partners to deliver meaningful progress. We have remained focused on meeting NHS constitutional standards and improving care for our population.

Reducing the elective care backlog has been a central focus across the NHS system. We have made significant headway in cutting long waits, enabling more patients to access the treatment they need, sooner.

Thanks to the professionalism and dedication of our staff, the ICB has consistently delivered care to more than 40,000 urgent and emergency patients each week. We are proud of this achievement, but we acknowledge that further progress is needed. Reducing waiting times and improving access to care remain key priorities.

Further detail is provided in the Performance Analysis section of this report, and under the ICB Chair and Chief Executive Foreword.

Performance Analysis

NHS Constitutional Targets

The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. NHS Lincolnshire ICB seeks compliance with the constitution in conjunction with our healthcare providers by

setting plans to deliver and requiring providers to provide remedial action plans where standards are not delivered.

The assessment of performance for each target is based on the following:

- Achieved/Not Achieved - Performance at or above the standard
- Improved/Not Improved - Performance improved from last year or remained the same/deteriorated

Indicator	Standard	Latest period	23/24 Performance (Mar '24)	24/25 Performance (Mar '25)	Trend
A&E Waiting Time	<4 hours	Not achieved	71.8%	73.7%	Improved
Ambulance Category One	<7 Minutes (life threatening)	Not achieved	00:09:13	00:08:37	Improved
Ambulance Category Two	<18 Minutes (emergency calls)	Not achieved	00:43:06	00:34:28	Improved
Ambulance Category Three	<2 Hours (urgent calls)	Not achieved	03:00:33	02:10:05	Improved
Ambulance Category Four	<3 Hours (less urgent calls)	Not achieved	02:44:04	02:15:27	Improved
Referral To Treatment Waiting Time	<18 Weeks	Not achieved	51.8%	55.5%	Improved
Patients Waiting 65 Weeks For Treatment	-	-	644	57	Improved
Patients Waiting 78 Weeks For Treatment	-	-	20	6	Improved
Diagnostic Test Waiting Time	<6 Weeks	Not achieved	73.9%	71.5%	Not Improved
Cancer - Faster Diagnosis Standard	<28 Days	Achieved	74.5%	77.2%	Improved
Cancer - First Treatment From Decision	<31 Days	Not achieved	89.3%	87.4%	Not Improved
Cancer - To First Definitive Treatment	<62 Days	Not achieved	61.1%	69.8%	Improved
Mental Health - Patients Accessing NHS Talking Therapies (Urgent)	<6 Weeks	Achieved	95.9%	98.1%	Improved
Mental Health - Patients Accessing NHS Talking Therapies (Routine)	<18 Weeks	Achieved	99.3%	99.4%	Improved
Mental Health First Episode Psychosis Treatment	<2 Weeks	Achieved	85%	74%	Not improved
Mental Health - Children/Young People with an ED (routine) that start treatment	<4 Weeks	Not achieved	70%	56%	Not Improved

How We Report Performance

NHS England assesses the performance of each ICB through a large number of national metrics. The performance measures (below) represent a cross section within the 2024/25 priorities and operational planning guidance.

These measures help us to monitor and improve the time patients have to wait to access services in Lincolnshire. They also tell us where we need to work with our partners to improve the care that our patients receive.

The monthly ICB Performance Report tracks a range of key metrics, offering insights into both challenges and successes. It explains the reasons behind any under performance and outlines the actions being taken to address them. At the same time, the report acknowledges areas where performance is strong or improving.

This monthly report is available to the public on the ICB website:

<https://lincolnshire.icb.nhs.uk/about-us/our-board-and-committees/icb-board-meetings/>

Planned Care

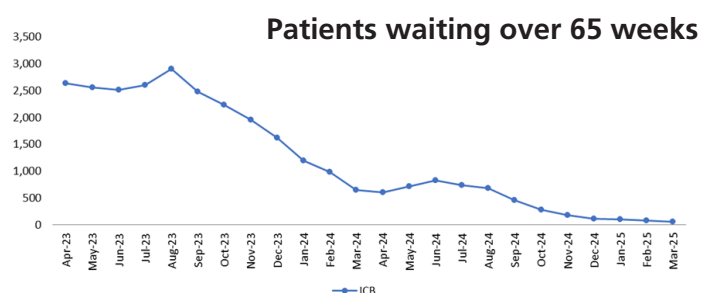
Referral to Treatment Time (RTT) Performance

Lincolnshire ICB works with a wide range of providers to increase capacity and improve the time patients wait for treatments. Recovery of waiting lists remained challenging with Industrial Action in the first half of the year also causing some disruption to routine services. This was more specifically related to the increased administration support required which then reduced time available to focus on managing waiting lists. This resulted in the number of patients waiting over 78 and 65 weeks not reducing as quickly as planned, however significant progress was made in the second half of the year with patients waiting over 65 weeks virtually eliminated.

The total waiting list size for Lincolnshire patients at all hospitals increased during the first half of 24/25 peaking at 115,699 in July 2024. However, there are signs that this is beginning to reduce as visible in the run chart below and was 113,174 in March 2025.



We continued to strengthen our oversight of patients waiting over 65 weeks with our main acute providers, and the number of patients waiting over 65 weeks has reduced from a peak of 2,902 in August 2023 to 57 in March 2025.



The focus for 2025/6 will be on reducing the number of patients waiting over 52 weeks and, as a minimum, achieve the national target of the volume of these patients making up no more than 1% of total patient waiting list.

In 2024/2025, the ICB Elective Activity Coordination Hub (EACH) continued to work in partnership with our main providers on a process of validation to support reduction in long waiting patients and overall waiting lists. This included contacting 16,878 patients to reassure them that they are on the waiting list, determine if they still require an appointment, offer them the most appropriate appointment for their needs and to transfer clinically suitable patients to alternative providers where waiting times are shorter if appropriate. This has significantly contributed to the reduction of patients waiting over 65 weeks across all clinical specialties.

Their efforts have been recognised in the following award submissions and achievements.

- Finalists for HSJ Patient Safety in Elective Recovery Award 2024.
- Commended in the Quality in Care Programme 2024 Awards for the Collaborative Impact on Reducing the Dermatology Patient Waiting Lists post-COVID Recovery (in conjunction with DMC Health Care).
- Collaborative Winners in the HSJ Best Elective

Care Recovery Initiative Award 2025 (in conjunction with DMC Health Care).

- Collaborative Winners in the HSJ Best Insourcing Initiative by an Independent Healthcare Provider Award 2025 (in conjunction with DMC Health Care).

The EACH has also continued engagement with GP practices to provide support and advice and to encourage them to fully utilising the service for all new Routine & Urgent Planned Care referrals to ensure patients are directed to the most appropriate place of care and offered a minimum of 5 choices where practicable. In total the EACH processed 108,301 referrals in 2024/2025 (increase 16,008 on 2023/24).

Outpatient Transformation

Over the past year, significant efforts have been made to further enhance outpatient services with a continued focus on improving both efficiency and patient experience. Key initiatives have included expanding Advice and Guidance (A&G) to GPs, helping to reduce unnecessary referrals, and increasing virtual appointments. We've also promoted Patient Initiated Follow Ups (PIFU) to minimise unnecessary visits and better utilise clinical time. The system continues to exceed A&G targets, with monthly usage consistently above 20%, surpassing the 16% target. The ICB has maintained over 25% for virtual consultations, ranking among the top performers nationally and regionally, and leading the Midlands. Efforts to expand and improve both PIFU and A&G are ongoing, with continued collaboration with clinical teams and specialties to enhance these services. Additionally, our involvement in the Midlands Elective Delivery Programme enables us to share best practices and drive improvements in clinical outcomes through the Getting It Right First Time (GIRFT) framework.

Optometry

The Electronic Eyecare Referral Service called Cinapsis went live during 2024. The system electronically connects the 73 Lincolnshire optical practices to the NHS for the first time, providing refined referral pathways by condition with condition specific referral templates for optical practices to use to improve quality of referrals. All optical practice referrals are processed through the single point of access in the Elective Activity Co-ordination Hub. These referrals are clinical triaged by a team of experienced optometrists who recommend where the patient should be

seen, 55% of routine referrals are diverted away from the over stretched Hospital Eye Service (HES) to the Community Optometrist Triage Assessment and Treatment Service (COTATS).

The local Trust accepts this clinical triage as their grading and processes the referral accordingly, saving valuable consultant time spent triaging high volumes of routine referrals.

During 24/25 a number of further improvements were made:

- Urgent Referrals are now processed through Cinapsis and the EACH, with referrals reaching the HES the same day they were referred which reduces risk and waiting times for patients. Further work is ongoing to refine the pathway e.g. certain conditions being sent to Eye Casualty
- Ophthalmology referrals made by GPs through to the EACH are added to Cinapsis and triaged to the correct service.
- In COTATS 3 independent prescribers started during the year with another 6 starting their training and another 4 registered for future courses. This prevents patients having to go their GP for a prescription.

The last piece of the referral jigsaw has seen the HES pilot a proposal to transform Optical Practice Eye Casualty referral pathway from a telephone call and paper administration to an electronic pathway. All referrals are risk stratified by the optometrist prior to referral to be seen same day, or within 24 hours, or within 7 days. The system identifies over 81 conditions that should be referred to Eye Casualty, providing clear guidance to the optical practices and Eye Casualty. The pilot is working extremely well with 99% of patients being seen in the agreed time frames.

Women's Health

Following the publication of a national Women's Health Strategy, the Lincolnshire ICB held their first Lincolnshire Women's Health Conference on the 8th November 2024 at the Lincolnshire Showground. This event was well attended and included presentations from Lincolnshire patients who kindly shared their personal experiences and health journeys. The ICB engagement team also presented the outcomes from over 100 community conversations which were held face to face in 11 different locations countywide and also via 8 online meetings. The outcomes included a common theme that women and girls felt they were lacking in trusted information to support their health.

As a result, the ICB (in conjunction with partners) has:

- Launched a women's health app which provides free advice and guidance for multiple conditions including Breast Pain Assessment and Care, Cervical Screening, Contraception, Domestic Violence and Sexual Trauma, Menopause Assessment and Treatment, Menstrual Problems Assessment and Treatment, Obstetrics and Gynaecology, Pelvic Organ Prolapse, Preconception Care, Sexually Transmitted Infections and HIV
- Increased the availability of Long-Acting Reversible Contraception to 68 GP practices across the County for both contraception and gynaecology purposes.
- Held two free Consultant-led Virtual Menopause Workshops available to anyone resident in Lincolnshire.
- Piloted Women's Health Hubs in 3 localities in order to assess outcomes to inform a future county-wide model.

Diagnostics

2024/25 has seen some very significant achievements for the Community Diagnostic Centre (CDC) programme, with the opening of the new Lincoln and Skegness CDCs, bringing the total to three CDCs across the county. This programme of work has extremely successful with the creation of some much needed state of the art facilities, comprising of 4 new MRI rooms, 4 CTs, 4 X-rays, 6 NOUS rooms, 4 echocardiology rooms, DEXA, dental X-ray, and a host of clinical rooms for the delivery of physiological measurement tests such as phlebotomy, ECGs, spirometry and FeNo.

As a result of the success of this programme more than 176,000 diagnostic tests are now due to be delivered in CDCs during 2025/26, in areas where previous access has either been non-existent or very limited. This allows patients to have their diagnostic tests in a more relaxed and patient friendly environment, significantly reducing travelling time and supporting the reduction of health inequalities in areas of deprivation or high demand.

Over the course of the next 12 months work in the CDC programme will continue with the development of a number of clinical pathways aimed at eliminating long waits, test duplication and reducing the need for patients to make multiple trips to different clinical settings to get their diagnosis.



In addition to this, work will continue to improve on the operational productivity and efficiency of CDCs by increasing utilisation of these facilities through the expansion of opening times in order to provide a 7 day, 12 hours per day service.

The CDC has had a significant impact on the levels of diagnostic activity now being carried out across the county, with an increase of 22% in December 2024 compared to December 2023 and 13% in January 2025 compared to the same month the previous year. This activity will continue to support the improvements of RTT performance and achievement of the 95% compliance target for people waiting less than 6 weeks for the diagnostic test.

Summary

Good progress has been made over the past 12 months in reducing waiting lists and implementing and expanding some services. This doesn't come without its challenges, but the ICB will continue to build on the progress made over the next year to improve waiting times and meet the requirements of the national 'Reforming Elective Care for Patients' plan.

Cancer Acute and Early Diagnosis

The past financial year has presented significant challenges as our operational teams have navigated the pressures of recovering from considerable backlogs. The simultaneous treatment of routine patients, many of whom have been waiting over 65 weeks, alongside cancer patients, has strained our available resources.

Despite these challenges, we have observed notable improvements across several key areas, leading to

enhanced times to diagnosis, treatment, and overall patient outcomes. We are proud to report that we have remained outside the NHSE Tiering system for cancer recovery. This achievement underscores the relentless efforts of our teams to improve both waiting times and the quality of care we provide to our patients.

Key Highlights

National Recognition

Our cancer care services have successfully maintained their status outside the NHSE Tiering system for over a year and are on track to continue this trend, indicating a strong commitment to addressing performance challenges.

Backlog Reduction

Changes in the metrics for measuring backlog show that our current number of patients waiting over 62 days stands at 266 including planned treatments.

Diagnosis Efficiency

Our performance on the 28-Day Faster Diagnosis Standard (FDS) has improved significantly, climbing from 74.5% in March 2024 to 77.2% in March 2025, which is now above the national standard of 75%. This increase means more patients are receiving timely updates on their diagnosis status.

Treatment Efficiency

The 31-Day Treatment Standard, which measures the time from a patient's decision to accept treatment to the actual treatment date, has decreased from 89.13% in March 2025 to 87.4% in March 2025.

Referral to Treatment Efficiency

The 62-Day Standard has improved from 61.1% in March 2024 to 69.8% in March 2025.

Overall Cancer Pathway Improvement

The total number of patients on a suspected cancer pathway in Lincolnshire remains stable at 3,279, reflecting our ongoing commitment to patient care.

Other achievements

Rapid Access Lung Cancer Pathway fully implemented following trial

We have successfully integrated a clinical triage stage between X-ray and CT scans, minimising unnecessary radiation exposure for patients. This innovation has reduced waiting times for first appointments from 21 days to less than 7 days.

Gynaecology Service Enhancements

Our Gynaecology Service has implemented a nurse specialist to triage all referrals, along with a dedicated pathway for patients experiencing unscheduled bleeding on HRT. This ensures that patients who do not require cancer pathways receive timely care, alleviating anxiety.

Lynch Syndrome MDT Implementation

We have established a multidisciplinary team (MDT) for patients identified with Lynch Syndrome following cancer surgery. Lynch Syndrome accounts for approximately 1,100 colorectal cancers annually, making it the most common hereditary colorectal cancer. With an estimated 175,000 individuals affected in the UK, of whom fewer than 5% are aware of their condition, early detection is critical. The National Institute for Health and Care Excellence (NICE) recommends that all colorectal cancer patients be tested for Lynch Syndrome.

By implementing national pathways, we enhance the potential for early detection and risk reduction treatments, benefiting both patients and their at-risk family members.

Prostate Pathway Enhancements

Significant work has been undertaken to streamline our prostate pathway. We have reached out to all patients who have been on a suspected prostate cancer pathway over the past decade to gather feedback on their experiences. An impressive 750 responses have been received, which will inform future developments in the pathway.

Screening Initiatives

We have launched multiple workstreams to encourage our population to engage with screening invitations. Notably, this year has seen a reduction in the lower age limit for bowel cancer

screening, allowing individuals aged 50 and 52 who are registered with a GP to automatically receive a home test kit every two years by post.

Staging Improvements

We are pleased to report that we have increased the percentage of patients receiving a cancer diagnosis at stages 1 and 2 from 53.9% to 55.7%. This improvement is crucial, as early diagnosis significantly enhances treatment options and outcomes for patients. Our ongoing efforts to raise awareness, improve screening processes, and facilitate timely referrals are vital components of this success, ultimately contributing to better prognosis and survival rates for those diagnosed with cancer.

Living with Cancer Programme

The Living with Cancer Programme continues to implement personalised care for people living with and affected by cancer across the county, via the Lincolnshire Living with Cancer Strategy 2023 - 2025.

The programme's aims are set by public and patient engagement, and the NHS Long Term Plan 2019 and align with the NHS Lincolnshire Joint Forward Plan 2023 – 2028, and the 'Better Lives Lincolnshire' Integrated Care Partnership Strategy 2024. To measure progress, the programme sets locally agreed key performance indicators.

The progress of the programme this year was impacted by several factors. Staffing within the programme was unstable, with several long-term vacant posts because of staff moving on or being seconded into different roles. However, the remaining team members focussed their work on priority tasks and the impact on progress was moderated. The continuing cost-of-living crisis and increasing number of patients with complex needs led to an upsurge in patient support requests from practitioners across the system. In December 2024 we reviewed the functions of the programme and streamlined the team to enable us to better carry out our functions and meet our priorities.

In ULTH, the team focussed their work on developing protocols and standard operating procedures for the roll out of Personalised Stratified Follow Up Pathways in breast, colorectal, prostate and some gynaecological pathways. These will give assurance on patient safety and are currently proceeding through governance in the Trust. The delivery of these follow-up pathways and remote monitoring

of patients transitioned fully to ULTH in March 2025. Patients' needs are being identified at different points on pathways by carrying out a holistic needs assessment (HNA), but there is further work to do with some cancer pathways to ensure patients have access to an HNA within 31 days of their cancer diagnosis.

The team are working with Heart of Lincoln Practice on Portland Street in Lincoln to test how standardised, easily understood treatment summaries are communicated to GPs and patients. Cancer Nurse Specialists and Cancer Care Co-ordinators in ULTH have been trained in Level 2 Psychological and Emotional Support, and a 'change in practice' has been approved by Adjustment to Professional Practice Group to promote a more proactive formal assessment of patients' psychological levels of need. Staff will ensure that patients who identify emotional concerns on their HNA are re-assessed using the Patient Health Questionnaire (PHQ9) and an Anxiety Test Questionnaire (GAD7) tools and then, if appropriate, referred to the service to best meet their needs. Sleep support for patients on the breast cancer pathway has been trialled, with a view to making this available on other cancer pathways.

The LWC Community team continued to strengthen collaboration with Primary Care, Community Health Services, Mental Health Services and wider system partners. Using HNA and patient engagement intelligence, we have focussed on improving access to support services which help people with their psychological and emotional, physical activity, financial support and sleep concerns. 60 primary care, community health and hospice staff have been trained in Level 2 Psychological and Emotional Support. The Level 4 East Midlands cancer Alliance Clinical Psychology Service reported that after 12 weeks of using the service, 91.89% of patients saw their depression alleviated and 78.95% patients saw their anxiety reduce. Most patients have reported an improvement in their quality of life. A total of 352 people have now taken part in 'Fighting Fit' cancer rehabilitation sessions which take place in Lincoln, Mablethorpe, Boston, Bourne, Grantham, Gainsborough and Market Rasen.

We have further developed and improved our website and, in addition to subject matter pages and the events calendar, we are adding an interactive map which features 300 community-based support services. The number of people using the website has increased, with an average of 687 users per month.

The team worked in collaboration with the ICB's Health Inequalities Programme to improve the

uptake of Faecal Immunochemical Tests (FIT) to screen for bowel cancer. We also jointly submitted a successful bid for funding from the East Midlands Cancer Alliance Advancing Cancer Equity Programme for community-based health equity projects. A large-scale survey of prostate cancer patients was carried out in January and February 2025, with over 840 responses to an online survey. This engagement will inform the prostate cancer pathway improvement taking place across the ICS. We worked with the ICS's Personalisation Programme and Rose Regeneration to develop a method of demonstrating a social return on investment of our work.

Celebrations

- The Macmillan Lincolnshire Living with Cancer Co-production Group celebrated its 5th birthday on 22nd May 2024.
- The 4th Lincolnshire Cancer Summit took place at the University of Lincoln Medical School on 12th June 2024.
- The Living with Cancer Dashboard was shortlisted for a 2024 HSJ Digital Award.
- The Living with Cancer Programme won the 2024 Royal College of Physicians Eric Watts Award for Excellence in Patient Participation and Engagement.
- Team members presented at the following national and international conferences – Development Economics Conference at the University of Lincoln on 25th June 2024, the Health and Care Analytics Conference in Telford on 23rd July 2024, the International Psych oncology Symposium World Congress 2024 in Maastricht, The Netherlands on 27th September 2024 and the Macmillan Professionals Conference in Cardiff on 7th and 8th November 2024.
- The Lincolnshire Macmillan Psycho-oncology Service was shortlisted for a Macmillan Excellence Award.
- The ULTH Cancer Personalisation Lead was highly commended in the 'It's All About People Awards' and The Bowel Screening Project won an 'It's All About People Award' at the Lincolnshire IAAP Conference on 3rd July 2024.
- Living with Cancer Personalisation Film for patients was launched in May 2024. <https://www.youtube.com/watch?v=RXrmjvebRZ0>
- The LWC Programme was shortlisted for an Active Lincolnshire Impact on Health Award.
- Team members participated in the 1st 'Cancer Can Do One' Podcast recording on 13th September talking about financial support.
- We started a collaboration with 'Movember' Charity aiming to improve sexual wellbeing for people living with prostate cancer.

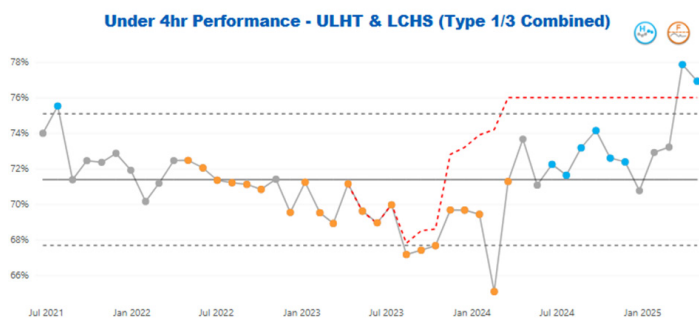
- A poster was presented at the European Cancer Summit in Brussels 21st/22nd November 2024, 'Delivering quality cancer care in rural and coastal settings: experiences of a large-scale transformation programme across an ICS.' The abstract for this poster was judged to be one of the top 16 abstracts and will be published in the Journal of Cancer Policy.
- A Financial Inequalities paper was submitted to Journal of Cancer Policy in February 2025 for peer review and decision on publication.
- Set up of Lincolnshire Prostate Cancer Support Group.

Urgent Care

The core standard for urgent and emergency care (UEC) is that patients should be seen, discharged or admitted from A&E within four hours. The national target for 24/25 is 78% of patients being seen and discharged within the 4-hour timeframe, by March 2025. Despite some challenges throughout the year, Lincolnshire continues to work collaboratively to achieve the target and although under plan currently is meeting the National Average and is back to 2021 levels.

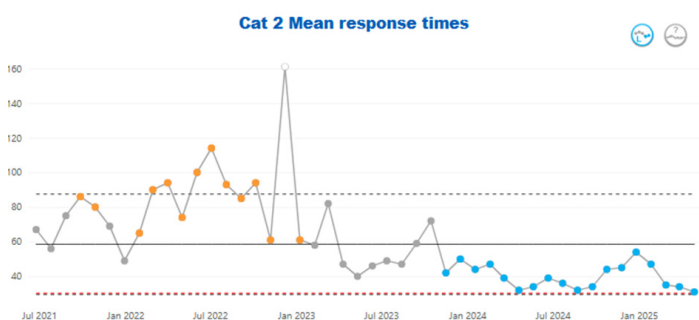


A&E admission, transfer, discharge within 4 hours (all types)



The second key metric that has been monitored and has been a priority for improvement in 2024/25 is the Ambulance Category 2 mean response time.

Category 2 mean response time



The EMAS Trust performance has not delivered the 30 min average requirement in 2024/25 although improvement has been made against 2023/24 performance data. However, the mean response time in Lincolnshire continues to perform better than the EMAS trust position.

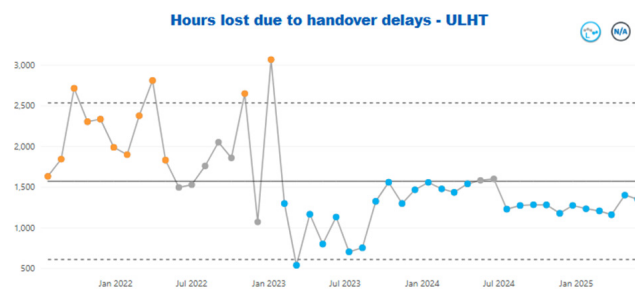
The Lincolnshire system has continued to experience pressure within urgent care throughout 2024/25.

Attendances have remained high throughout 24/25 with some elements of front door demand being above planned levels. For the constitutional 4-hour A&E target, Lincolnshire performance has remained close to the national performance although the latest reported percentage of patients being seen within 4 hours was 78.3% compared to 75% nationally (March 2025). The number of patients waiting over 12 hours in department reduced significantly in March 2025.

Ambulance Handover Delays at our acute sites have decreased in 2024/25 compared to previous years, and the number of hours lost for EMAS crews as a result have also reduced, freeing up crews to respond to people in the community. A continued focus on Call before Convey ensures we

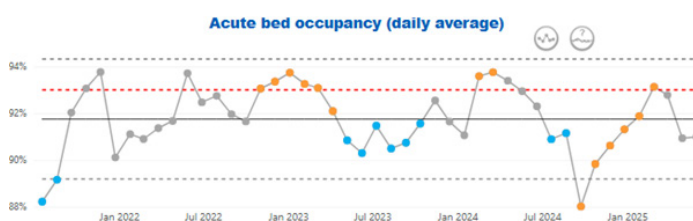
are identifying those patients that do not require a front door attendance but offered alternative support, and this is now embedded as business as usual and mandated for all care home patients. There has been a winter pilot of an LCHS clinician being based in EOC to also support reduced low acuity attendance by EMAS. The profile of lost hours at the United Lincolnshire Teaching Hospital sites is demonstrated below.

Lost Hours due to handover delay



The requirement in 2024/25 was to maintain acute bed occupancy levels of no more than 92% to support flow. The majority of the year occupancy has been below 92% and the report reflects a recent peak during January 2025 in line with winter pressures.

Acute bed occupancy (daily average)



A 45-minute ambulance handover model commenced at Lincoln County Hospital at the end of the year, which aims to further reduce handover delays, and once embedded this approach will be implemented at the Pilgrim site. Due to the work already done on handover processes over the year, the initial levels of performance were positive with >90% of ambulances at Lincoln County Hospital being handed over over in less than 45 minutes.

The UEC programme in 2024/25 has remained focussed on delivery of the national plan for recovering urgent and emergency care, including the implementation of the 10 High Impact



Interventions with a focus on three key areas to support safe occupancy levels and reduced waiting times:

- attendance avoidance
- admission avoidance
- reduction in length of stay

The work on our front doors includes reviews of where and when patients present. There has been significant work on the integrated pathways of care across our co-located front doors, with further work underway to support reductions in the wait times and improve patient experience. This work includes expansion of Same Day Emergency Care capacity which will mean that more patients can be treated and discharged on the same day without an admission to an inpatient ward.

Over winter we have trialled a Frailty Short Stay unit at Pilgrim Hospital which resulted in shorter Length of Stay for frail patients and will be considered as part of our short stay model moving forward.

The System wide work on patient flow and discharge continues with a focus on early identification of patients who will require support on discharge and a review of our current transfer of care hub model. This work is closely linked to the system work focussed on development of an Intermediate Care Strategy for Lincolnshire.

Grantham UTC has now been operational for more than a year; it is open 24 /7 and receives patients who walk in as well as booked appointments via 111 and ambulance conveyances that are clinically appropriate. Along with all other UTCs it is profiled on the Waitless app that gives patients in Lincolnshire the ability to look for their nearest UTC and opening times plus the current wait times at the time of viewing. The app also gives a summary of the type of care offered at the facility allowing patients the opportunity to make sure they attend the right facility.

We continue to deliver Virtual Ward provision and a further two specialities have been introduced whilst maintaining the original number of beds. We continue to work on ensuring all virtual wards meet the virtual ward core components and meet the needs of the local population. The virtual wards provide care as an alternative to a hospital admission, or to help people return home at an earlier date.

The Urgent Community Response Service continues to support people to remain in their own home, responding to their needs within 2 hours. The Health Care Professional Single Point of Access (HCP SPA) is now in place and supports professionals across the system to access services that support patients either at home or by direct access to services.

Adult Mental Health and Dementia

Physical Health Checks for those with a Severe Mental Illness (SMI)

People with an SMI, such as schizophrenia, psychosis, or bipolar disorder, face one of the greatest health inequality gaps in England and are more likely to have one or more physical health conditions when compared to the general population. They experience physical illnesses more frequently and, in some cases, more severely; and they also have a considerably shorter life expectancy compared to those without a severe mental illness. Premature mortality in adults with an SMI has increased over recent years.

Based on data from 2018 to 2020, in England, people with SMI were around five times more likely to die prematurely than those who do not have a SMI. This level of inequality is seen for both males and females.

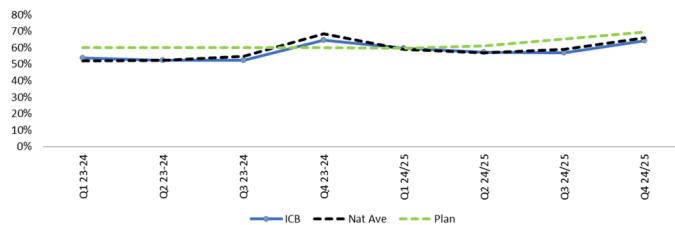
Using the Lincolnshire Joined Intelligence Data set (2025) we can see that our patients with an SMI will have an average of 3.7 Long Term Conditions, compared to 1.1 in the rest of the population. Patients are, for example:

- twice as likely to have Asthma
- 2.3 times more likely to be obese
- twice as likely to have diabetes
- 3.5 times more likely to have a fall
- 18.6 times more likely to have attempted suicide
- 1.6 times more likely to have chronic kidney disease.

The Lincolnshire workstream around this therefore seeks to ensure the completion of recommended physical health assessments for those with an SMI at least annually, offer and availability of appropriate recommended evidence-based interventions and embedding personalised and strength-based conversations and approaches into the Physical Health Check to improve health and wellbeing outcomes.

The ICB has a target set by NHS England to deliver the annual physical health check to 60% of patients on the SMI register (who are not in remission). We also set a local stretched target of 70% to be achieved by 31 March 2025. National data is only reported quarterly and at the end of quarter 3, the

% of 6 Physical Health Checks Completed



At the end of March 2025, health checks were delivered to 64.3% of our SMI population, an improvement from 57% in December 2024.

As physical health checks are measured on a rolling 12 month basis, it is usual to see a fall in activity in the first part of the year and then an increase in the final quarter as practices look to deliver their quality and outcomes framework targets.

The programme has several challenges. We need to ensure that those patients who do attend for their annual physical health check have a positive experience which includes meaningful conversation on what is important to them and support to engage in interventions where appropriate. We also have around 35% of our SMI population not accessing an annual physical health check, this equates to approximately 1800 patients.

It is important that we reach as many people as we can through new ways of engaging with people and delivering services.

In the past 12 months there has been extensive stakeholder engagement with our patients, carers, primary care, public health, VCFSE sector and other system partners. This has identified some key learning that we need to consider as part of any future services. The stakeholder feedback was shared with a small group of people with lived experience and from this we coproduced 'I would like' statements. The statements set out what is important to them, and we will use these statements as our guide to all aspects of this work programme to ensure we do not lose focus of the patient and carer and they remain at the heart the heart of their care.





'I would like a comprehensive annual health check that is underpinned by a personalised care planning approach. I would like the health check to be meaningful to me and for me to be supported to engage in interventions where appropriate and in a way that works for me.'

The overarching statement above is underpinned by a further 8 statements, of which the key themes include:

- building trust and relationships,
- skilled staff who listen and have time,
- telling their story once, listening to what is important to people
- a comprehensive, holistic check where physical and mental health have equal parity,
- services to make reasonable adjustments,
- to be part of developing their own care plan and have ownership of it,
- the carer to be part of their journey.

In October 2024 a 'Next Steps' workshop was held, with representation from all stakeholders. The aim was to identify potential solutions for improving the physical health care of patients.

The focus of our work in 2025/26 will include:

- Sharing the draft options paper with key stakeholders and people with lived experience and once an option is approved, drive forward an improved physical health care service across Lincolnshire which ensures that all SMI patients have equity of access to a high quality physical health care service reflective of the 'I would like' statements.
- Assess the need for further tailored services for specific patient groups within our SMI patient cohort (e.g. homeless, Substance Users, working age adults) and develop services to meet their needs.
- Development of promotional material to ensure patients, carers and professionals are aware of the right to an annual physical health check, and why it is important and how to access one.
- Working closely with our public health colleagues and VCFSE sector to ensure accessible interventions which help make a difference to outcomes for people.

Adult Community Mental Health Transformation (ACMH)

Lincolnshire was an early implementer site for Community Mental Health Transformation for adults and older adults and as such all 14 PCNs meet the criteria for being 'fully transformed'. The programme continues to embed the model and has had significant investment in workforce and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector.

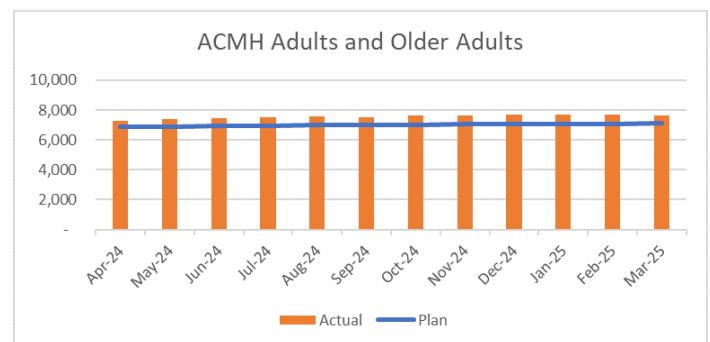
Dedicated focussed services including Community Rehabilitation, Adult Eating Disorders (AED) and Personality and Complex Trauma (PACT) services continue to be rolled out across the county as part of the transformation programme to support targeted cohorts of individuals to gain support across the entire continuum of care and in line with Adult and Older Adults Community Mental Health Framework, preventing people from falling through the gaps or experiencing cliff edges of treatment. The Personality and Complex Trauma Service are providing Dialectical Behavioural Therapy (DBT), Structured Clinical Management (SCM) and Occupational Therapy (OT) Programmes across the county and have started rolling out a Relational & Emotional Skills (RAES) Programme for more moderate presentation. Community Rehabilitation is mobilised across the county moving away from traditional inpatient rehabilitation to maximising independence of individuals and providing care in the community. The AED service has begun mobilisation to embed working at a Primary Care Level and invested into a specific VCFSE offer to support those individuals experiencing eating disorders at a community level.

The expansion of these dedicated focussed services will improve access but as the expansion of these are to be delivered across the financial year, we do not expect to see full year impact on the access target until the end of 2025/26.

Locality mental health teams have developed through alignment of community mental health teams with integrated place-based teams and Primary Care Networks. A review of outpatient appointments and the role of the Consultant Psychiatrists has also been undertaken alongside this, aligning and embedding Consultants within the Locality Mental Health Teams. A Locality Mental Health Team Framework is being developed to describe the transformed pathways and provision within the Locality Mental Health Team offer, across the whole continuum of care. Data is now flowing through Mental Health Services Data Set to capture activity across the range of providers

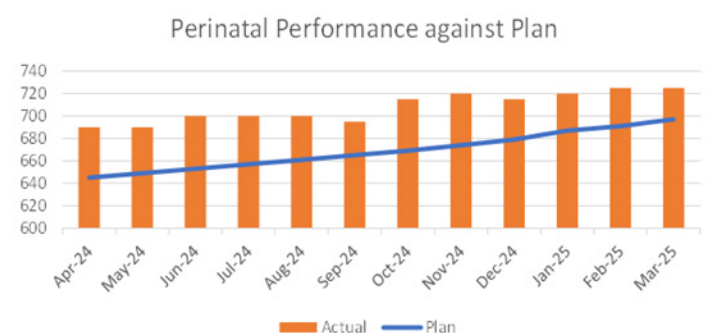
where possible. This data source will continue to grow to reflect meaningful activity undertaken and to demonstrate the social return on investment for the community wellbeing hubs and community connector roles. Data also continues to be monitored to support meeting the four week wait target with information sharing agreements and system interoperability being prioritised.

The 2025/26 plan continues to build on the success in the last few years and has been developed in response to the Primary Care mental health Profiles that were developed. These profiles are aligned to the population health data set to enable needs led services to be developed to manage capacity and to support the work to address health inequalities being identified. Performance has been above plan from April – 1 March 2025, with a few disciplines still to be included in the data. Chart included below.



Perinatal mental health services

This team achieved access in-line with planned access rates for every month in 2024/25. The Perinatal Access rate increased steadily since April 2024 from 9.2% to 9.6% in March 2025, above the National average (9.5%) but below the Midlands average (10.1%).



One of the challenges is that the number of live births in Lincolnshire has steadily decreased since 2013, from 10.4 live births per 1,000 population down to 8.6 per 1,000 in 2020. (OHID). Further data has indicated further decreases in the birth rate of 8.06% in 2021, 7.78% in 2022 and 7.35% in 2023 (last quarter predicted). As such achieving the expected targets for number of people support through specialist perinatal services is not expected to be achieved and we do not expect our workforce to grow beyond current establishment due to the continued birth rate decline but will continue to recruit to vacancies.

The team is well staffed, and patients do not experience any long waits to be seen. The Perinatal Trauma and Loss Team that was launched on 1st February 2024 has supported improved access. There will be continued activity to promote the service availability and awareness of referral pathways.

NHS Talking Therapies for anxiety and depression

The NHS Talking Therapies programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. It developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS and is widely recognised as the most ambitious programme of talking therapies in the world.

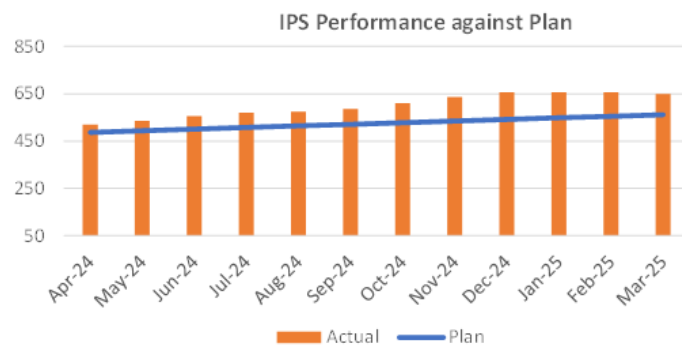
NHS Talking Therapies Reliable Recovery rate is at 48.1% and Reliable Improvement is 71.6% as of March 2025. 98.1% of people wait less than 6 weeks from referral to treatment.

The service is well staffed with very few vacancies and further staff commencing in post this month. The main risk relating to this service is the wait to second treatment, which has significantly improved during the year, with mitigation in place of outsourcing treatments and maximising our capacity.

Individual Placement and Support (IPS)

The Lincolnshire Individual Placement and Support (IPS) Employment Service offers encouragement and practical support to help people struggling

with their mental health to find suitable paid work, apply for a job and stay employed. Performance finished above plan for 2024/25, over the last 12 months; 650 people had attended face to face, telephone, video conferencing or talk type support.

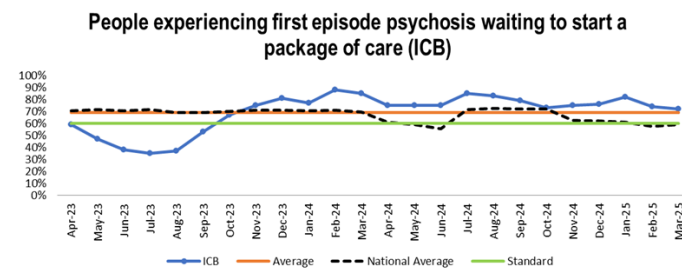


Early Intervention in Psychosis (EIP)

Following a challenging period for the service that saw significant vacancies and poor achievement against the two-week waiting time target, the service remodelled and recruited to the new model and with ICB investment, has become really well performing with sustained achievement of the two-week waiting time.

The service has focused on the quality standards for the service with a number of continuous quality improvement projects underway.

ICB EIP performance is significantly than the 60% target and the national average. Performance was in line with or above the Midlands average since April. In March 2025 ICB performance was 72%, the England average was 59.2% and the Midlands average was 71%.

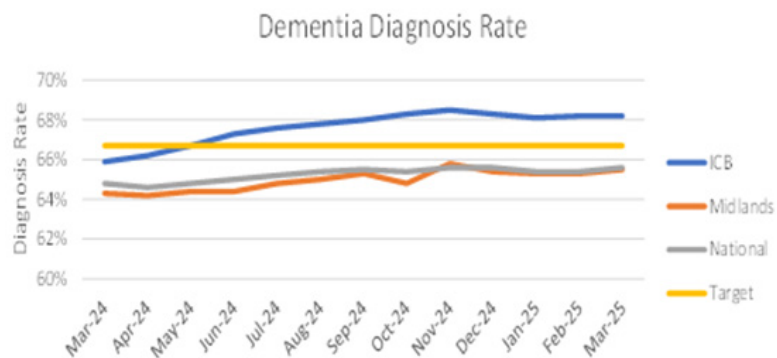


Dementia

The Dementia Diagnosis Rate (DDR) for Lincolnshire has improved over the last 12 months and for the first time exceeded the national reportable target with 66.7% of people over 65 estimated to have dementia expected to have a formal diagnosis. Performance is higher than both the Midlands and National average and has been consistently above the standard (66.7%) since May 2024. March 2025 performance was 68.3%, 1.6% above the national standard and 2.8% higher than the national average (65.6%).

As dementia prevalence is comparatively higher in Lincolnshire than the national average (8% in over 65s versus 5-6% nationally), we need to ensure it will continue to remain a priority within Lincolnshire. Over 75yrs will see the greatest increase of circa 87% (from 75,800 to 140,600). This cohort is the high-risk group for dementia with prevalence increasing with age. In addition, Lincolnshire also has a larger young-onset dementia population than average due to the largest age cohorts currently being those between 50-64 years. This commitment to prioritising dementia care in Lincolnshire will support us to mitigate risks around formal tracking of patients, planning of resources and will ensure we continue to have systems and processes in place to address this and any potential gaps including access to early diagnosis and high-quality care and support. We will also need to invest in prevention with the key focus to provide information on prevention of avoidable cases of dementia and offer support to people to make changes to lifestyle to address the modifiable risk factors for dementia.

Demand is continuing to grow proportionally both for core diagnostic services and for associated care and management of complex post-diagnostic needs. Our memory assessment services (MAS) for Lincolnshire requires ongoing development, investment and support to ensure we establish MAS model (in line with our regional partners) that can deliver against the full diagnostic and post-diagnostic memory assessment service pathway. This investment will ensure there is sufficient capacity to enable consistent delivery and monitoring of the pathway and enable predictive performance trajectories and improved outcomes for people. These outcomes will support the ICB to plan for transformation around clinical practice, including the requirement to deliver disease modifying treatments such as the use of emerging biomarkers, treatment delivery and safety monitoring, and develop a clinical pathway that would meet the needs of patients.



Achievements in 2024/25

Enhancing diagnostic capacity

There has been a lot of work and effort to increase the DDR, with additional temporary clinics on a Saturday in areas where waiting lists have been higher. Whilst this is not sustainable long term due to resource pressures, capacity has been increased through recruitment of additional staff in the Memory Assessment Service. This includes, Memory Assessment Practitioners with increased assessment and diagnostic output, two additional/dedicated Memory Assessment Service (MAS) Consultants and we have more recently recruited a MAS Service Manager who will lead on the development of diagnostic services for our Mental Health Trust - Lincolnshire Partnership NHS Foundation Trust.

Implementing DiADeM

Training has been provided by LPFT on use of the Diagnosing Advanced Dementia Mandate (DiADeM) diagnostic tool for diagnosing people living with advanced dementia in a care home setting to enable access to appropriate care. This was for staff in enhancing health in care homes teams and Community Mental Health Teams. This has seen an improvement in diagnosis in care homes in Lincolnshire from April 2023 from 2865 to 3395. We have implemented the DiADeM codes into RIO (electronic patient record system) at LPFT and will be using this to track people diagnosed using this tool to ensure we are improving diagnosis for people in care settings, we will also be working with GP practices to embed use of this code on system one.

Improving Data Accuracy

Working with our Information Lead at NHS Arden and GEM, we have been looking at data using the Population Health Management (PHM) linked data set to cross reference the GP register and have

identified 500 Lincolnshire people on the PHM tool who are not on their GP register, which can then be rectified. We are continuing to work with 10 practices to review patients to ensure they are coded correctly and have a care plan in place.

Primary Care Dementia Pathway Development

We have developed a primary care dementia pathway and handbook to support GPs in identifying people at risk and improve diagnosis.

The Recovery college

The Recovery college has developed a new course helping carers with their own wellbeing while in a caring role for people with Dementia. The course builds on real-life experiences and recognised self-help ideas—sometimes called a “wellbeing toolbox.” Carers used the principle of “What would I suggest or give a tip to another carer who is starting their own caring journey to help them stay well while caring for another?”

Reduction of Antipsychotic Medication

We have been working to review and reduce the unnecessary use of these medications and restore to pre pandemic performance levels. Lincolnshire performance is better than the national average

(see table below) but work in the area continues with our lead pharmacists working with Primary Care Networks to review patients on antipsychotic medication and look at alternative support pathways.

Age UK Lincoln and South Lincolnshire

Age UK Lincoln set up the I Forget service to support people with memory concerns and dementia. Training from LPFT for staff was provided initially to support the service startup. The service has been well received and has been fortunate to be funded by Age UK for another year, but work needs to continue to make the service sustainable for the future.

Young Onset Dementia Trail

LPFT are working in partnership with the Alzheimer’s Society, who are providing a 12-month pilot which will initially be trialled within the Boston Primary Care Network. Boston has been specifically chosen following an in-depth analysis of population health data, which indicates that the area has a higher-than-average number of individuals diagnosed with dementia under the age of 65. The aim of the service is to provide dementia support and information to people under the age of 65 years with a diagnosis of dementia (‘young-onset dementia’ (YOD)). There will also be a dedicated Psychological Intervention Facilitator/Transitional



% Dementia patients on Anti - Psychotics

Indicator	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
% on A/P med	8.82%	8.45%	8.59%	8.49%	8.38%	8.28%	8.12%	8.16%	8.22%	8.23%	8.05%	8.20%	8.45%
National Average	9.00%	8.89%	8.85%	8.87%	8.87%	8.83%	8.79%	8.78%	8.79%	8.78%	8.69%	8.73%	8.81%

Worker employed by LPFT who will specialize in associated mental health issues experienced by people with YOD. The service is also available to friends and family members, recognising the significant role they play in the lives of those with young onset dementia. Learning from the pilot will illustrate the benefits achieved and lessons learned for future support models.

- People that have a learning disability
- People from mid-life plus age and people that have a Mild Cognitive Impairment
- Health practitioners

The Joint Dementia Strategy for Lincolnshire has been developed in partnership with people living with dementia, their carers and families and is currently going through the sign off process and will be launched later this year

Prevention Offer for Lincolnshire

An all age resource has been developed for Lincolnshire that includes animations, leaflet providing information on the things that increase our risk of developing dementia, what we can all do to reduce our risks through lifestyle choices including where to go for support, there will be a marketing campaign during 2025 to promote the resource and use of this. Dementia risk will be embedded into other health campaigns, for example smoking, alcohol reduction, obesity.

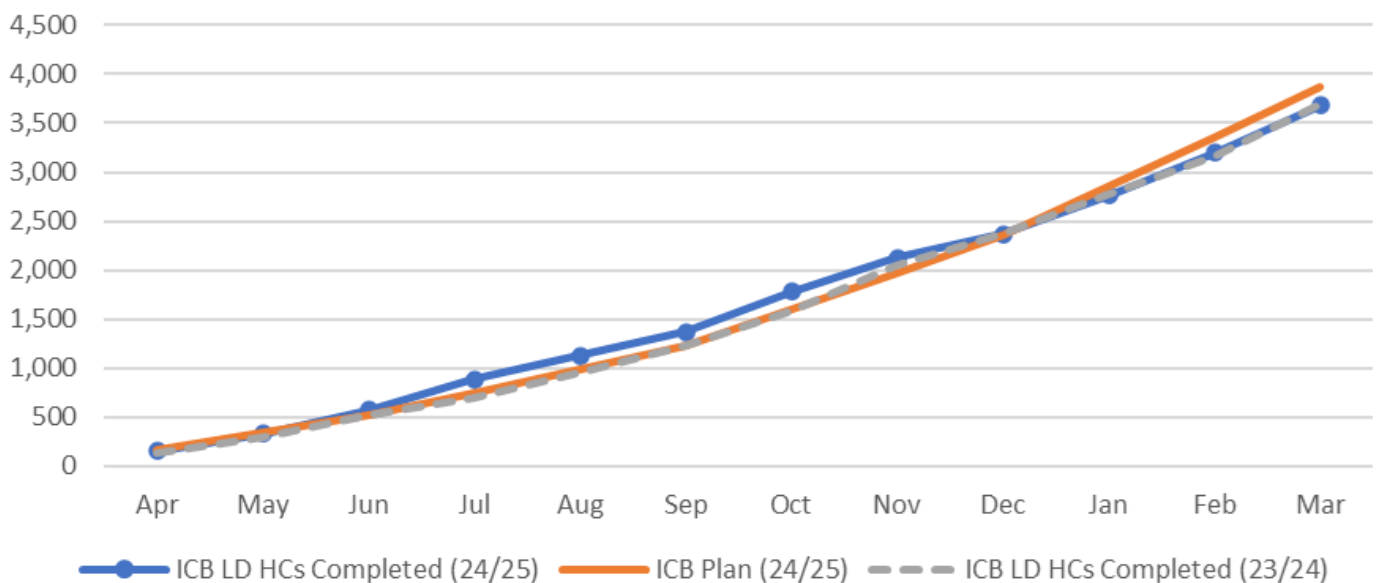
The animations are aimed at the following groups:

- Teachers/educators and parents for primary and secondary school aged children
- College, and university students

Learning Disability Annual Health Checks

Annual Health Checks support people with a learning disability stay well by helping to find health problems earlier and giving time to agree on the right care. The ICB has worked closely with primary care and system partners to refocus efforts on improving access to Annual Health Checks for people with a Learning Disability since 2020/21. The ICB surpassed the national ambition of at least 75% of people aged 14 or over with a learning disability having had an annual health check by March 2025, though was slightly below plan.

Learning Disability Health Checks Completed



Key Achievements

Armed Forces



The Armed forces Covenant is a promise by the Nation that those who serve or have served and their families are treated fairly. The Armed Forces Covenant is a part of the NHS Constitution. For healthcare the Covenant states that the Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. Those who are serving or have served should receive priority treatment where it relates to a condition that results from their service in the Armed Forces, subject to clinical need.

Legislation from the NHS Act 2006 and the Health and Care Act of 2022 gives NHS England (NHSE) and ICBs have specific responsibilities.

NHS England directly commissions all secondary care health services for serving personnel and families registered with Defence Medical Services and specific specialised services for veterans that, by law, NHS England must provide access to for those distinct populations across England.

These services are directly commissioned by NHSE with providers of secondary and specialised services and include:

- All secondary healthcare services
- Specialised Veterans Mental Health service – OP Courage
- Prosthetics

NHS England sets policy, national clinical and governance standards and service specifications which providers are contracted to deliver against.

The ICB commissions healthcare for veterans of Armed Forces veterans and their families registered with NHS GP practices. Due regard must be given to the health and social care needs of the Armed Forces community in the planning and commissioning of services. The ICB is expected to have appointed an Armed Forces health lead. Jacqui Bunce, Programme Director – Strategic Partnerships, Planning & Estate and Armed Forces Lead has that role for the ICB and takes the system role in terms of the Lincolnshire Covenant.

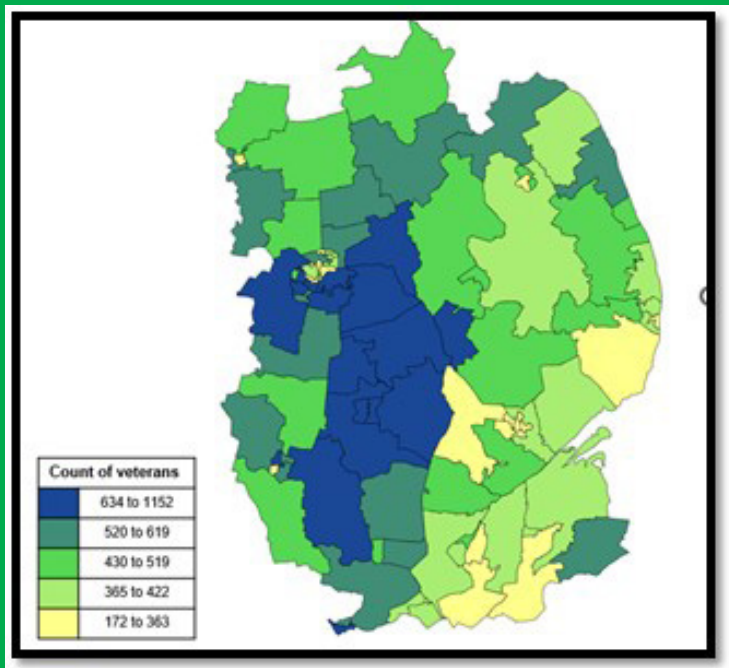


The Armed Forces Family picture nationally and in Lincolnshire

Data – National demographics:

- 2.4 M veterans in the UK
- Of these, over 50% are aged 75 or older. 85% are male.
- 2,500 who leave the Services on medical grounds per annum
- 750,000 UK Armed Forces veterans of working age residing in England and Wales
- 5.4 million adult spouses, partners, widowers and child dependants
- Each NHS GP will have around 30 + veterans on their list

The 2021 Census identified 44,812 veterans in Lincolnshire, along with serving personnel and the families of both who have and those who are serving, there is a significant number of Armed Forces family in Lincolnshire.

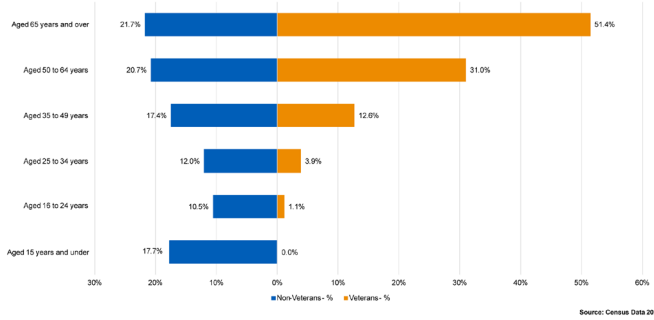


The dark blue areas represent the areas where the greatest number of veterans (across all ages) live in Lincolnshire.

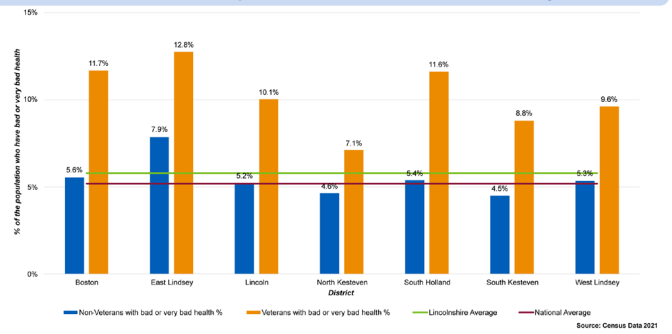
The area with the greatest number of veterans is in Coningsby and Woodhall Spa in East Lindsey.

There is a cluster of areas with a high number of veterans in North Kesteven. Nearly one-third of all veterans who live in Lincolnshire live in one of the areas marked in dark blue on this map (14129 out of 44812).

Lincolnshire Age Profile – Veterans compared to non-veterans



Lincolnshire: Veterans compared to non-veterans - Bad or very bad health



NHS Lincolnshire ICB achievements in the past 12 months:

Symposium

The NHS and the local RAF have developed a positive relationship which has been strengthened over recent years. Supporting our Armed Forces and veterans and meeting the Armed Forces Covenant commitment is a key priority across the whole of the NHS in England, for us in Lincolnshire as a ‘military county’ we attach particular importance to it.

Our ambition is for the NHS in Lincolnshire to be recognised as a leader in how we support our Armed Forces personnel, veterans, and their families. An inaugural annual event took place at RAF College Cranwell on 24th June 2024. This provided a real opportunity to learn from each other, deepen relationships, share experiences, and explore how we build forward together.

The following aims were agreed for the event:

- To confirm our aspirations/ambition/commitment regarding the NHS and Lincolnshire to be recognised as being a place that is doing the most/best to support the Armed Forces family.
- To share our intentions for a published strategy – detailing the commitment across the NHS in Lincolnshire to the Armed Forces and to hear what partners would like to see included within this.
- To hear and share current understanding of the Armed Forces Community in Lincolnshire with specific reference to those who have served (veterans)
- To hear about the experience of health

services for the Armed Forces Community, the challenges, and issues and to look at how things can be improved.

- To share the good practice that is happening in the county.
- To learn more about the pilot Op Community projects across the country and to discuss what an Op Community scheme could and should look like in Lincolnshire.

GP Veteran Friendly Practices

Veteran Friendly GP accreditation is a programme run by the Royal College of General Practitioners (RCGP) and NHS England to recognise and support practices in delivering the best possible care and treatment for patients who have served in the armed forces. [Veteran-friendly accreditation.](#)

It does not prioritise veterans over non-veterans patients. It does provide training and ongoing support to help practices identify their veteran patients and make the best use of the specific treatment pathways and other services that exist for veterans e.g. Op COURAGE, Op RESTORE. This is a voluntary initiative open to GP practices in England. Accreditation lasts for three years and requires GP practices to do the following.

- Ask patients registering with the surgery if they have ever served in the British Armed Forces.
- Code it on the GP computer system.
- Have a clinical lead for veterans in the surgery, to undertake dedicated training, stay up to date with the latest research and innovations, ensure that the practice is meeting the health commitments of the Armed Forces Covenant, and provide advice to colleagues, as well as possibly seeing veterans themselves.
- Practices should have a Care Quality Commission ‘good’ rating or higher.

As of 25 February 2025, 80.2% of practices within the Lincs ICB area were accredited, up from 49% in February 2024.

Step into Health

The Step into Health is a collaboration between NHS Employers, NHS England, Walking with the Wounded and The Royal Foundation.

Step into Health provides support and guidance for NHS organisations to review and enhance recruitment practices, so they are able to attract members of the Armed Forces community, and benefit from the transferable skills and values they bring to the workforce and showcase the NHS as the employer of choice. It is a programme which connects candidates from across the Armed Forces community with employers and new opportunities in the NHS.

The ICB and all the NHS Lincolnshire providers are signed up to the programme. Led by ULTH the system has held 6 monthly open days with colleagues across the system meeting prospective candidates and showcasing opportunities. Lincolnshire is seen as an exemplar system and the work has been presented at national webinars. In October 2024, there was a House of Lords reception to celebrate 10 years of the programme. At this event ULTH won the Transition Support Award and Mr Steve Martin who Chairs the ULTH Armed Forces Staff Network won the Outstanding Dedication Award.

Health Inequalities webinars

The Armed Forces are part of the ICB's CORE20PLUS5 health inequalities inclusion health groups. The ICB held a series of health inclusion workshop webinars for staff specifically around the Armed Forces community. These included population data and evidence; the work and role of our Military Maternity Navigator and an opportunity to highlight the Covenant and the health inequalities experienced by this group. There were speakers with lived experience who shared their stories and encouraged staff to reflect on their own practice to improve experience, outcomes, and access for the armed forces community.

Health data improvements

Supported by a data analyst from the Health Inequalities Team there has been considerable progress on understanding the needs of the Armed Forces Family. The 2021 census was the first time that specific questions had been asked and data is continuing to be released. There is still more that we need to do as a local NHS regarding data recorded on GP systems and linking this to hospital records and data sets for example. Data sharing was recognised at the Symposium as a key issue/barrier and is a priority for the coming year.

System leadership and advocacy

Since the ICB's development and the establishment of the ICB Lead role as part of the Programme Director's portfolio there has been a step change in the ICB's visibility and leadership. The ICB has been recognised for its work with the Armed Forces family, its advocacy and networking. A supporting statement for the Gold Employer Recognition scheme has been received from the Chair of the East Midlands Veterans Advisory & Pensions Committee (EMVAPC) who has stated how extremely impressed they had been by the ICB's commitment and support to the local AF community which stands above its peers.

Op Community – national engagement

As discussed above, although the ICB is not one of the seven pilot areas, Lincolnshire was invited to join the NHSE Operational Community Governance Group

Relationships with Defence Primary Care

Over the past year the ICB lead has continued to build links and partnerships with the Defence Medical Centres locally and regional Defence Primary Healthcare colleagues. This includes discussions on greater links with the Primary Care Network alliance and local GP practices. Several meetings have taken place. Work continues to strengthen relationships, improve pathways and data sharing.



Emergency Preparedness Resilience and Response (EPRR)

The ICB has now held Category One responder responsibilities for over two years. During this time the organisation has facilitated the development of system-wide EPRR capabilities and provided leadership in response.

Through the annual EPRR self-assessment, the ICB demonstrated full compliance across 47 core standards. These standards ensure that the ICB is able to meet the statutory duties and obligations of a Category 1 responder. This is an improved report from 2024 where we reported substantial compliance. The ICB will continue to seek and benchmark best practice within EPRR by maintaining full compliance in the future.

During 2024 a total of five incidents were declared by NHS organisations within Lincolnshire, with Business Continuity incidents being most common due to either loss of power or digital capability. The ICB also coordinated health responses in support of multi-agency partners across the Local Resilience Forum (LRF). Multi agency incident themes included both flooding and civil unrest.

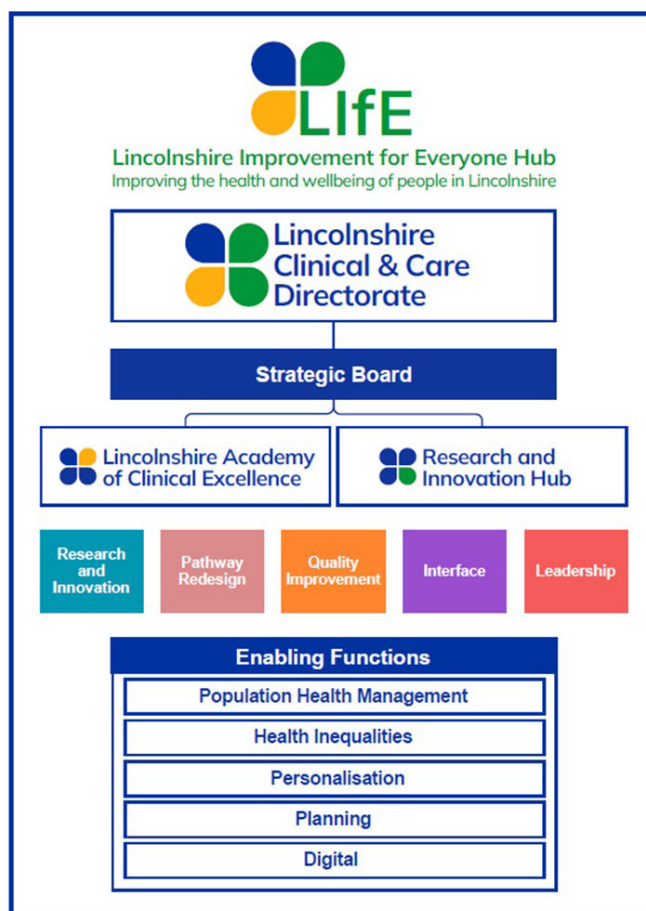
For two consecutive years the ICB has achieved 100% compliance in commander training. This training package is continuously updated to reflect the latest guidance and lessons learned from recent incidents. Core training fulfils both mandatory and optional requirements of the NHS EPRR Minimal Occupational Standards (MOS). In addition, commanders are provided a wide range of Continuous Professional Development (CPD) opportunities, which are well aligned to local and national risks landscapes.

Through joint working with Local Health Resilience Partnership (LHRP) members, joint arrangements have been developed which have been tested through system wide exercises, with a single response across organisational boundaries.

The ICB's Business Continuity arrangements have been developed through impact assessments and staff training. With support from EPRR, individual teams have developed bespoke business continuity plans which are fit for purpose should they be called upon.

Duty to obtain appropriate advice

The ICB has established the Clinical and Care Directorate (CCD) which includes senior clinicians and care sector leaders from medicine, nursing, allied health professionals, and adult and children's care services, supported by a management team.



The CCD's aim is to lead clinical and care professional excellence at all levels within the Integrated Care System (ICS), by convening appropriate expertise, coordinating care delivery informed by best practice, underpinned by population health, research and driven by data. The CCD is a small team and encompasses a range of knowledge, skills, leadership, and expertise from clinical, managerial, quality improvement, research, innovation, transformation and data intelligence.

The CCD aims to be the collective voice of all health and care professionals in Lincolnshire:

- Providing evidence-based decision-making, by well-led clinical professional groups.
- Having a greater influence on system decisions which impact upon clinical and care provision and quality.
- Ensuring that system, clinical and directorate priorities align.

Members of the directorate have a mandate from their organisations, to make decisions regarding clinical pathways and re-design, to ensure that clinicians and care professionals drive decision-making.

It is made up of clinical and care professional leaders from a diversity of backgrounds who are involved in decision-making throughout the integrated care system.

Together they help ensure the priorities, strategies and plans of the ICP and the ICB, fully connect with the needs and aspirations of people with lived experience and carers, and drive the strategic objectives of the system, whilst listening to the voice of local communities.

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

In 2024/25 the Strategic Board received 49 presentations of clinical priorities presentations across the ICS.

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

The first three parts make up the fundamentals of the Lincolnshire Academy of Clinical Excellence (LACE). These elements work closely together to ensure research, innovation, pathway redesign and quality improvement are at the heart of transforming clinical excellence and improving patient outcomes.

Interface is a forum for primary and secondary care clinicians to improve patient flow and care with the aim of reducing duplication, following best practice, and therefore improving patient care.

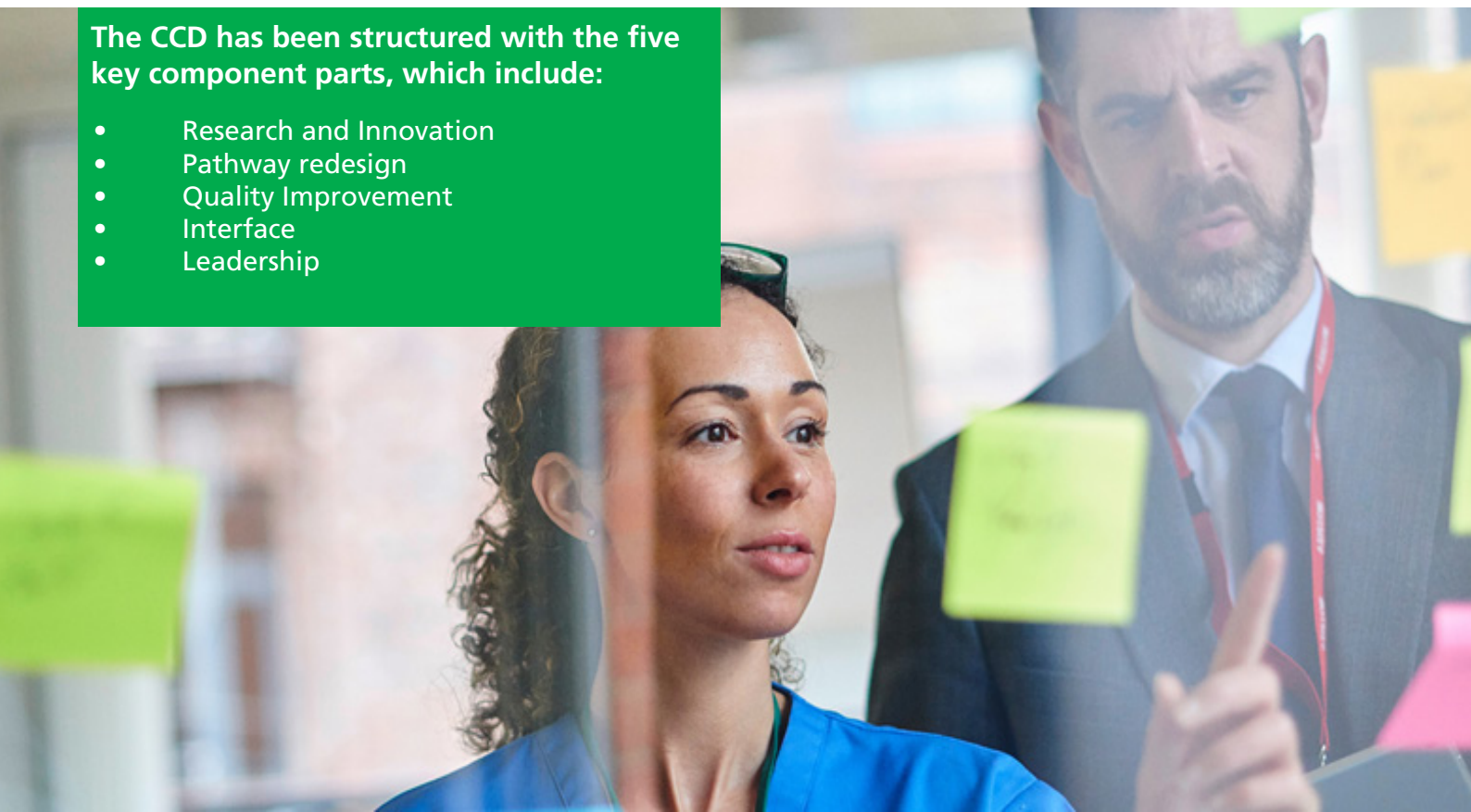
The leadership program will enable senior medical colleagues to develop together to lead clinical change in our system. We hope to create a pipeline for this development to secure succession planning.

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

The end-product will be a Lincolnshire framework which drives more effective improvement, agreeing common language and principles.

The CCD has been structured with the five key component parts, which include:

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



Interface working

In a collaborative approach, we have a clinically led Strategic Interface Group, with the purpose to identify ways in which we can improve the clinical interface and relationships between organisations. The primary and secondary care interface is a key component of the Primary Care Access and Recovery Plan, the group was established to include all clinical leads/Medical Directors from Lincolnshire partners as the opportunity for improved interface is much wider than just primary and secondary care. Following the publication of the Academy of Medical Royal Colleges guidance to support primary care capacity and access and Primary Care Access Recover Plan in 2023.

Some examples of the areas we have achieved are, the primary care contribution to the layout of specific cancer referral forms. The creation of FIT note clinical reference guides, example timeframes for the issuing of FIT notes following procedures in secondary care. Improving communication and access between secondary and primary care we have developed a Single Point of Contract.

The 'Red Tape Challenge' announced in October 2024, reinforces the drive to reduce bureaucracy with a focus on the 5 improvement areas. We continue our partnership approach and culture of continual improvement to achieve these.

Leadership Programme 2024/25

The ICB launched the Medical Leadership programme in 2024/25 led by Warwick Business School, Warwick University, the purpose of this programme was to begin a journey to create the environment to develop strong medical leaders. Thirty medical leaders were selected from the ICS including Medical Directors, Deputy / Associate Medical Directors, Clinical Directors, Director Public Health, Primary Care organisations and Primary Care Network leads.

The aim of this programme is to build strategic and systems leadership capability that enables senior leaders to:

- Understand and develop your own leadership style.
- Understand your role as a leader in the system.
- Lead patient centred quality improvement.

- Work effectively and collaboratively as a system leader.
- Develop and maintain trusting relationships.
- Be able to articulate and influence change.
- Work together to lead a project of system change.
- Navigate complexity.

The medical leaders took part in four modules and a final Capstone event held at the Shard. The modules included:

- Leading self and developing leadership principles as system leaders
- Leading improvement
- Leading in the system
- The Capstone Event

The leaders were invited to join one Action Learning Set to demonstrate and test the methodology learned during the programme, these included five live Strategic System priorities:

- Frailty
- Planned Care
- Long-Term Condition-Respiratory/ Diabetes
- Long-term enduring mental health conditions
- Same day access

The Capstone event gave the Action Learning sets the opportunity to present and share their progress on the system priority areas. The focus for the next year will be continuing to bring the medical leaders to a forum to continue to develop and also continue to monitor the progress of the ALS priorities, this will be coordinated through the CCD.

NHS IMPACT

The ICB is leading the work to support the implementation of the NHS IMPACT programme. IMPACT (Improving Patient Care Together) <https://www.england.nhs.uk/nhsimpact/> is the new, single, shared NHS improvement approach. The intention is to create the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients, and give better outcomes for communities. The ICB has been tasked to embed the five principles into the ICS. To support this work the ICB has commenced a System Improvement strategy/framework development that will convene system stakeholders to develop.

The proposed framework will focus on two main elements:

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

The Better Lives Lincolnshire Leadership Team endorsed the approach.

Lincolnshire Academy for Clinical Excellence LACE

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

ADHD update

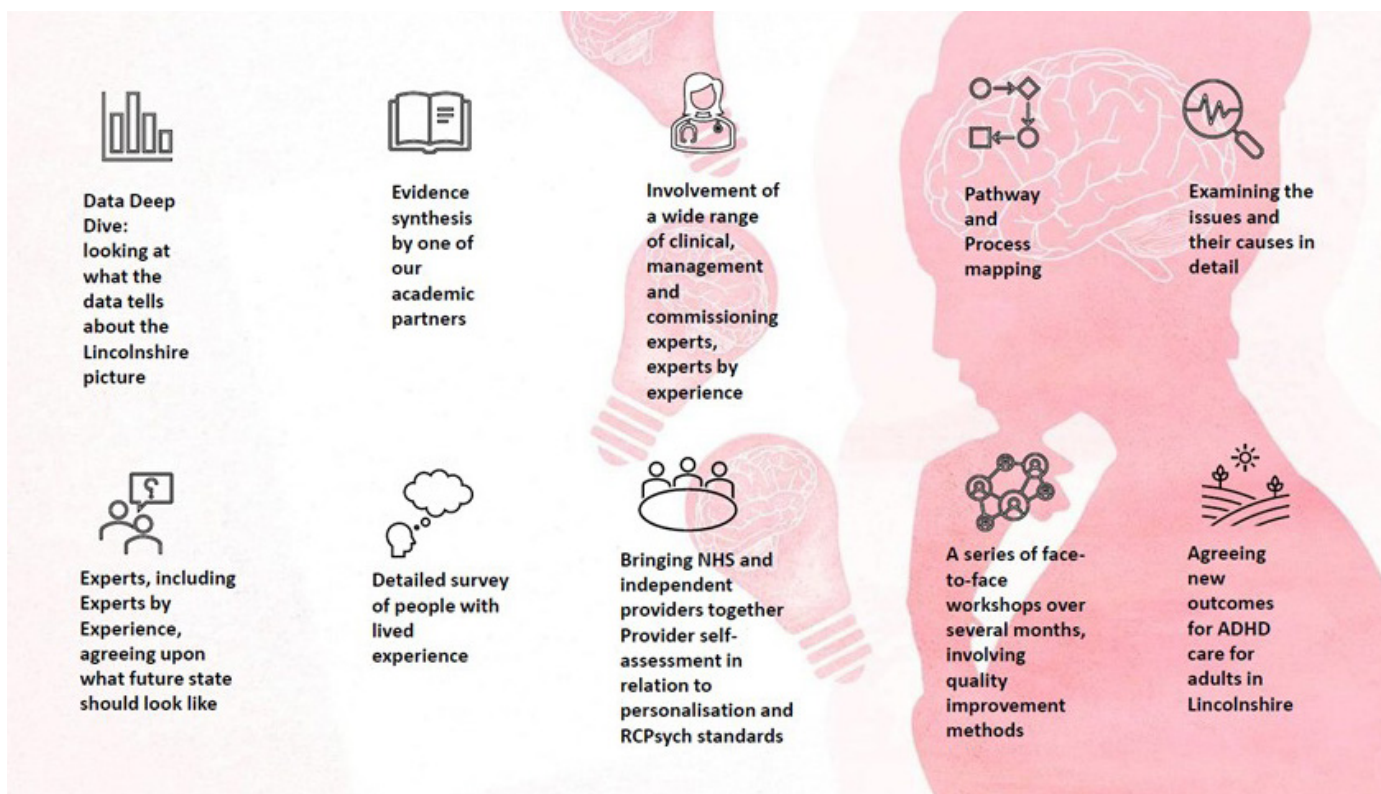
ADHD was the first pathway to follow the new LACE complex pipeline methodology. It was commissioned by the Mental Health, Learning Disabilities, Autism and CAMHS Commissioning Team. It was a testbed for the LACE method and pipeline of activities for detailed reviews. This included the development of an Expert Reference Group with a number of stakeholders attending four workshops. A detailed exploration of the issues, data, evidence, solution generation resulted in the development of a Lincolnshire ADHD high level strategy for Adults. This included a detailed reference dossier which describes the methodology and key outputs of the review.

The findings were used to inform the development of two new service specifications: referral management and the assessment, diagnosis and treatment of ADHD.

Adult (16+) Neurodevelopment (ADHD (Attention Deficit Hyperactivity Disorder and Autism) Referral Management Service.

Adult (16+) ADHD (attention deficit hyperactivity disorder) Assessment and Post Diagnostic Treatment Service.

Aim and Objectives	LINCOLNSHIRE'S HEALTHCARE STRATEGY FOR ADULTS WITH ADHD	
	Outcomes	Outcome Measures
We aim to improve the quality of life for adults and young people with ADHD in Lincolnshire, by delivering high quality, evidence-based, accessible, and person-centred care.	Access All patients and referrers receive and can access clear and timely information regarding the care pathway and their progress with respect to their diagnosis and treatment. All patients have access to readily available information to support them to administer their own self-care.	Percentage of people reporting receipt of information post-referral. Percentage of people reporting receipt of information at the point of referral.
We will develop a streamlined, coherent, and co-produced care pathway.	Referral Clear, transparent, easy to understand referral criteria that's available to everyone, utilising an electronic referral management system integrating numbers and data comprehensively.	Percentage of accepted/declined referrals. Number of transitions from other services.
We will develop an intelligence-led, dynamic pathway for diagnosis and management.	Single Point of Access All patients are assessed and commence treatment where appropriate within 18 weeks.	Number and percentage complying with the Referral To Treatment target.
We will ensure clear communication across the pathway, for all stakeholders.	Assessment All patients undergo an assessment that follows a standardised assessment framework which includes a suite of tools available to the provider/assessor and ensures that assessments meet standards as recommended by NICE and the Royal College of Psychiatrists.	Number of patients assessed. Number of assessments that follow the standardised framework (annual clinical audit and post-assessment patient feedback)
We will address the following areas of the care pathway:	Treatment/Monitoring All patients have a co-produced care and support plan completed with a clinician, regardless of organisational barriers, and it includes biological, social, and psychological interventions. All patients receive an annual review to safely and stably monitor their condition.	Percentage with an ADHD diagnosis that have a care plan, (via feedback from patients, providers, clinical audit and contract monitoring). Percentage of reviews completed within 12 months.
	Discharge All patients will have control of their care and support and are empowered to make their own choices. All patients and relevant healthcare professionals will receive a copy of the discharge letter to the GP.	Percentage of discharges and why e.g.: DNA, self-discharge, violence/aggression, etc. Number of discharges that were joint decisions between patient and provider.
	Transition All people aged 16 and upwards with ADHD will experience a seamless transition from paediatric to adult services. There will be no gaps in treatment for anybody with ADHD, regardless of age. All patients will have personalised care and support which enables them to make their own choices with regards to their own care and treatment.	Number of referrals to adult services from Community Paediatrics. Percentage of people with ADHD that transition from Community Paediatrics to adult services. Number of 16-18-year-olds which are treated as new referrals. Number of complaints and serious incidents.



Feedback of the review process from the team and stakeholders was incredibly positive and will be used to continuously improve how the LACE team can support in future.

Respiratory

The Head of Strategic Development – Ageing Well and Long Term Conditions, Primary Care, Communities and Social Value Directorate requested a review of the respiratory clinical pathway. Following a scoping exercise it was agreed that the nature of the request met the criteria for the academy's high complexity pipeline (Pipeline 3) which is a detailed pathway review involving a series of facilitated activities, face to face with an Expert Reference Group, progressing through the five stage of the pipeline.

Following agreement from the Strategic Board, the decision-making arm of the Clinical and Care Directorate, the review was initiated and facilitated by the Lincolnshire Academy of Clinical Excellence (LACE), the operational and delivery arm of the Clinical and Care Directorate.

The following areas were included in the scope of the review:

- Clinical pathway for COPD, Asthma, Interstitial lung disease (ILD) and Bronchiectasis

- General practice
- Community services
- Secondary care
- Core services

- Proactive care model for managing Acute Respiratory Infection for Winter
- Digital opportunities
- Current clinical guidance, policy, and best practice
- Current data and metrics
- Post-COVID service was recognised as being out of scope for this review.

The outcomes for the review were:

- A high-level future state clinical map for respiratory patients' interventions across Lincolnshire
- Review of best practice evidence in relation to current provision
- Identifying priority areas to focus on to gain the biggest impact.
- A series of six face-to-face, half-day workshops were delivered over a period of several months from August 2023 to November 2024. The workshops included a mixture of detailed presentations and group activities using quality improvement tools and techniques to define and understand the problems with the care pathway in detail before collectively agreeing the desired future state.

The below groups were in attendance, and all contributed to the workshops.

- Lived experience of Respiratory services in Lincolnshire
- Commissioning of Respiratory services
- Community respiratory team
- General practice
- Secondary care respiratory team
- Personalisation
- Urgent and Emergency Care
- Pharmacy
- Clinical decision-making and delivery at system level
- Clinical pathway review and delivery
- Quality improvement methodology
- Data analysis

The outcomes of the workshop identified key priority areas to focus on, this included a 'what does good look like for Lincs' and the interventions needed to work on to reach this clinical pathway, a proactive care model winter initiative, digital opportunities and enhancements needed in the workforce.

The top 6 recommendations from the clinical pathway were:

- Spirometry
- Consistent approach for Nitric oxide for asthma patients
- COPD and ASTHMA proformas primary care
- Pulmonary rehab
- Proactive care model
- Respiratory MDT for the system

Once LACE conducted their review the SRO signed off the dossier and presented the findings at strategic board, the next steps for this programme will be to start a project team working group and implement the recommendations set out.

UEC Clinical Audit Programme

Following a review of Urgent and Emergency Care (UEC) services in Lincolnshire the Integrated Care System (ICS) UEC Clinical Reference Group requested the development of a clinical audit programme to identify opportunities for quality and service improvement. It originally followed on from the 'missed opportunity' audit which identified areas for improvement in the use of clinical pathways and referrals to emergency departments.

The UEC Clinical Reference Group provides direction for discussion; proposals, and approval of the audit programme which includes the scope, deliverables, outputs, and timeframes of workstreams.

The audit programme is a clinically led process used to inform pathway redesign and development.

The audit programme involves a multi professional clinical audit team from the ICS who complete a retrospective review relevant to focused area. A qualitative analysis of patient records and supporting information is completed with findings used to shape transformation work being undertaken by the ICS to integrate care by identifying any gaps or areas of development.

The audit team includes members from:

- NHS Lincolnshire Integrated Care Board
- Lincolnshire Community Health Services NHS Trust
- United Lincolnshire Teaching Hospitals NHS Trust
- Lincolnshire Partnership Foundation NHS Trust
- East Midlands Ambulance Service NHS Trust
- Lincolnshire County Council.
- Other system partners if required, e.g. 'LIVES' and DHU 111

The focus in 2024/25 was supporting the UEC recovery plan with key areas including two Clinical Assessment Service-learning events and a discharge audit at Lincoln County Hospital, with a further audit of virtual wards planned for March 2025. The results were presented to the UEC Clinical Reference Group as commissioner of the programme, with an agreement for rapid shared learning through relevant clinical effectiveness groups in a timely manner to support planning and implementation of changes.

In 2024, LACE was asked to continue the programme and provide future support and facilitation of the UEC audits.

The programme was reviewed in January 2025 and will continue to provide an integrated approach to support service and pathway reviews to inform system-wide planning, continuous improvement strategies and quality assurance within UEC services. It was agreed for monitoring of outputs through patient, staff and stakeholder engagement, with any pathway redesign and development, including appropriate levels of engagement when services are being developed or changes made.

The review also highlighted the need to showcase examples of good practice and support wider shared learning through local, regional, and national networks.

Further audits planned for 2025/26 include urgent treatment services and further Clinical Assessment Service events.

Musculoskeletal Physiotherapy (MSK)

The latest programme of work that the LACE has been asked to support is a review of the Any Qualified Provider (AQP) Musculoskeletal (MSK) Physiotherapy. This is a request from the Primary Care, Communities and Social Values Directorate for LACE to support a review of current services.

MSK conditions are highly prevalent in UK society. These conditions can range in severity from mild acute conditions to long-term chronic conditions. Conditions can negatively affect an individual's quality of life, and as such, identifying the most appropriate interventions and care delivery model are an area of priority. It was agreed at Strategic Board that this would be the next area of focus for support from LACE.

The initial stage of this review will involve the development of an MSK physiotherapy Clinical Reference Group with various stakeholder and subject matter experts.

A minimum of three workshops will provide opportunities to review current clinical evidence and feedback from patients, public and staff to develop updated referrals pathways, different approaches and types of support for patients.

The findings will support the development of a revised service specification that will ensure the service offer improves outcomes and experience for patients.

Duty to promote innovation

Our ICS has strong links with the Health Innovation East Midlands (HEIM) and as part of this working relationship a two-year fixed term ICS Innovation Lead post commenced in April 2024, funded by HEIM. The role is designed to support innovation, help develop a culture of innovative and curious thinkers, as well as link with ICS counterparts across the East Midlands and beyond. HEIM was established by NHS England in 2013, as one of 15 organisations across England acting together as the innovation arm of the NHS, bringing together partners from across all sectors involved in health and care including the NHS, social care and Public Health, patients, research, third sector and industry, to identify, test and spread new technologies and better ways of working.

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

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

Below are listed examples of work that has taken place in the last year within the Lincolnshire ICB (in collaboration with partners) to help develop our innovation culture.



Health and Care Innovation Course

June 2024 saw the second Health and Care Innovation Course delivered in partnership with HIEM and the University of Lincoln, who also hosted the course. The four-day course was opened to all health and social care staff across the East Midlands region. Participants used the Health Innovation Expedition approach: New ideas in Health & Social Care as the innovation vehicle, attendees are empowered to innovate more effectively and are given the tools to navigate the complexities of getting ideas developed, adopted, and spread throughout the NHS and social care settings. Attendees work on innovative solutions to current clinical challenges in four workshops.

The final day saw a culmination of the course with participants pitching their problems and innovative solutions to a select panel in a Dragons Den style manner, receiving guidance, support and advice on how to progress.

April 2024 saw the launch of the ICS Research and Innovation Strategy, signalling the first-time innovation has stood as a system focus and priority. Further development work through 2024 and into 2025 has seen the initial stages of aligning innovations and innovative opportunities to system problems and the forthcoming System Improvement Framework for Lincolnshire.

A Second Expedition In Health & Social Care Innovation

A Bottom-up Revolution in Health & Social Care Innovation

In 2023 the University of Lincoln and the Lincolnshire Allied Health Professionals Research and Innovation Network ran The Health and Care Innovation Expedition Course to solve real issues in frontline health and social care. Beyond upskilling and empowering participants, the outcomes from this were above and beyond expectation. A real and meaningful network of health and care professionals was created, and teams continue to develop their course projects into real innovations. Building on this success, we ran the course again in June and July 2024 using new team project case studies, building in an extra session in response to feedback, and hosting an event to bring together the cohorts from both years to begin creating a genuine Innovation Champion Network for the East Midlands.



UNIVERSITY OF LINCOLN

Health Innovation East Midlands | Research and Innovation Hub | Health Innovation East Midlands

Dr Colin Bevan, Kirsten Gray & Paul Holman

The Offer

- The **Health Innovation Expedition™** is a multifaceted, fast-paced, interactive and interdisciplinary course that takes participants on a real innovation journey in health and social care. Teams apply new knowledge and techniques to real health and care unmet scenarios.
- In 2024, we ran the course over 5 days. The feedback was extremely positive with some unexpected outcomes:
 - The creation of a genuine and meaningful network of enthused and engaged innovation champions across the East Midlands
- For 2024 we introduced some changes based on feedback
- The two days teaching was split into three to enable more networking and face to face team working on their scenarios.
- Engaging the new ICS leads across the different counties, we created new and relevant unmet scenarios.
- Created an online followup event for the 2023 and 2024 cohorts to meet and build a network

The Cohort

We again invited social care colleagues, nurses, midwives, pharmacists, health scientists and Allied Health Professionals from across the East Midlands, early career researchers from across the University of Lincoln whose research interests lay in health and pre-reg MSc physiotherapy students.

Across the East Midlands
20 – Lincolnshire
4 – Derbyshire
3 – Northamptonshire
1 – Nottinghamshire

Multi-discipline attendance

- 7 – AHP
- 0 – Nurse
- 4 – Social Worker
- 2 – Educator
- 2 – ACP
- 4 – Student
- 1 – Assistant Psychologist
- 1 – Physiotherapist
- 1 – Physiotherapist Technician

Cross-sector Attendance

- 2 – AHS Community
- 8 – Academics
- 5 – AHS Acute
- 4 – NHS Mental Health
- 3 – Private Healthcare
- 1 – NHS Primary Care

• In total, 28 participants completed the course. Nobody was able to attend from Leicestershire

The Expedition

- Over three Fridays, interactive workshop based learning took the cohort through the Innovation Process. On the second and third sessions, the afternoon was given over to team working
- After a 2-week gap, the teams pitched their developed virtual solutions to a panel of industry experts - The Dragons!

Feedback & Next Steps

- Teams are continuing to develop their innovation concepts, supported by their Integrated care Systems Leads and Health Innovation East Midlands (HIEM).
- We are exploring means to support this newly developing Innovation Champion Network to support their Innovation Leads in maintaining awareness of Innovation and a pipeline of new ideas.

Exceeded expectations. Expected to be a 'showing key we could have done better' thought we might actually be given projects and the freedom to develop on jobs

It was brilliant, I learnt so much

Exceeded expectation. I learnt a lot and the experience of working in a team to produce a project idea for innovation was invaluable. It has given me the impetus, the contacts, the information, and the basic skills to develop my ideas

Yes I learned a lot and was inspired by what is already happening around innovation in healthcare, and the potential for more

Yes the course was more than I expected. It was informative and delivered well.

• For some video feedback, please click on the links:

The Participants

2023 Cohort

Dragons

Academic Participant

Transforming Wound Care

Healing wounds more quickly for housebound patients

Using the National Wound Care Strategy Programme (NWCSP) recommendations, Health Innovation East Midlands has worked with the Lincolnshire Community Health Services (LCHS) team to transform the pathway for non-ambulatory/housebound non-diabetic patients with lower limb wounds. Through implementing the new pathway, including an in-depth initial assessment by specifically trained staff, this previously marginalised patient cohort now has access to evidenced based treatments earlier, resulting in quicker healing and much improved quality of life, as well as restoration of independence.

Implementation

Utilising knowledge base, evidence and learning from Health Innovation East Midlands, the LCHS community tissue viability nursing team took just under three months to select the programme team, develop their programme plan, identify the patient caseload, and begin to implement the training. A review of current services confirmed LCHS' existing leg wound clinics met most of the recommendations but that they had been unable to provide the service that they wanted to for housebound, non-ambulatory and care home residents with lower limb wounds, so a new pathway and referral process was developed. This was particularly an issue in the coastal area of the First Coastal PCN footprint (Skegness and Mablethorpe), which has an elderly and infirm demographic, and clinicians struggled with being able to meet the needs of this cohort. The team aimed for 80% of patients to be assessed within two weeks from referral.

Outcomes

The team ensured that each patient received a ninety-minute, full initial assessment in their own home, from a highly trained community Tissue Viability Nurse and had a comprehensive treatment plan created for them. This was followed by regular further visits and four-weekly assessments to review progress. Treatment has become more evidence based and standardised and both patient

and staff experience has been improved. The LCHS team worked further with the Health Innovation Network (HIN) Transforming Wound Care (TWC) team around collecting data and a new template for recording patient's wounds progress, and core metrics such as healing rates and number of patients in strong compression was developed. This has been added to by the development of an electronic system for collecting the data, which makes reviewing the team's performance much easier. This has also been shared with the Health Innovation Network (HIN) Transforming Wound Care (TWC) team and has added to the ability for other sites to collect the same data.

Results

Almost 20% of patients are being healed within twelve weeks from the initial assessment, despite some having wounds for over eighteen months prior to the new pathway. These patients have previously been marginalised by being unable to attend the wound care clinics. The support and care they receive from this new pathway has greatly enhanced their care and transformed lives. Patients are delighted with the pathway change, as they are now able to receive gold standard, evidence-based care within their homes and are healing more speedily than they may have. Some of the patients have also become more mobile and have been able to transfer to being treated at the outstanding leg wound clinics. This has meant that they are able to meet with other patients, peer learn and understand that they are not the only ones with leg wounds, another benefit to their quality of life. By implementing the programme, the team have saved up to 240 hours of clinical time, a huge amount for such a small team. This in turn frees up staff to assess and treat new patients earlier than they previously would have been able to, further increasing the opportunities for the wounds to heal more quickly. If the programme is able to be spread to this patient cohort across the county, there is the potential for releasing over five thousand hours of clinical time, along with potential cost savings of £1.5 million.

Implementation of an Integrated Lipid Nurse Specialist service for patients with established cardiovascular disease

With a high incidence of atherosclerotic cardiovascular disease (ASCVD) within Lincolnshire, an opportunity existed to do something different with HIEM estimates showing that an improvement in cholesterol management has potential impacts of 33% reduction in non-fatal CVD events, 22% reduction in CVD mortality and financial savings to the NHS of £1.06m per 10,000 people annually.

Funding of £100,000 was successfully applied for through the NHSE "Going Further, Faster" programme to pilot a concept of an Integrated Lipid Nurse Specialist service by recruiting 2 Lipidology Specialist Nurses (LSN's).

In December 2024 data showed 53.48% of patients in Lincolnshire with a cardiovascular disease were achieving their recommended cholesterol targets (<2.6mmols in non-HDL or <2.0mmols in LDL), highlighting both the problem and scope of improvement.

The service set about bridging the gap between primary, community and secondary care, and improve patient outcomes at greatest cardiovascular risk from high levels of Low-Density Lipoprotein (LDL) cholesterol by:

- Reviewing, updating and agreeing the secondary prevention pathway
- Implementation of clinics in secondary care
- Provision of primary care support
- Reducing risk in secondary prevention patients

A collaborative programme ensued with LCHS, ULTH, Primary Care and expert patient experience involved, in addition to project leadership from the ICB and HIEM.

Secondary Prevention Pathway

A Lincolnshire specific pathway was produced by the LSNs for secondary prevention of cholesterol management, which was supported by GP's who welcomed the inclusion of the lipid lowering effect of various therapies, which is the first item in the GP toolkit.

Primary Care Support

An ICB wide referral form was created and disseminated by the LSN's to enable primary care to refer eligible patients to a virtual clinic.

A GP toolkit was developed to include the local pathway, referral form and information on the Manchester search tool, in addition to informative webinars from a consultant endocrinologist.

Patient's received their own toolkit to assist with activation and engagement. Education sessions, both face-to-face and virtual, were held across primary care and community services by the LSNs.

A 'Know your cholesterol results' card was created to help patients understand their results.

Secondary Care Clinics

Clinics were implemented a 6hour/once a week telephone clinic for patients who were on a consultant review list. This created additional time for the consultant to complete initial patient assessments. Secondary Care also has access to a mini-MDT where patients can be escalated from community caseload to consultant discussion.



Reducing Risk for Secondary Prevention Patients

The LSNs utilised the 'Greater Manchester CVD Prevention – Lipid Searches' to stratify patients into appropriate and manageable cohorts. This allowed for groups of patients to be referred into LSN clinics and then sent telephone appointment letters for a 30-minute consultation.

The clinic has referred 451 patients into the service, with 236 currently receiving active care management. The DNA (Did Not Attend) rate is as low as 7%. A total of 52 patients have been identified as candidates for injectable therapy. Of the 105 patients identified as statin intolerant, 26 have successfully commenced statin treatment.

Impact

- The waiting time for an initial appointment with a lipidology consultant has fallen from 58 weeks to 13 weeks in the year of the programme of work.
- Increase of trust, confidence and knowledge across the whole system to deliver best practice.
- Strengthening and solidifying of relationships across the ICS between partners.
- Improved GP activation with practical support, limiting the burden of unnecessary admin, fostering good relationships, and making the subject matter interesting.
- 66% of patients who engage with the service achieve the ESC target of 1.8mmol/L on discharge (graph below), with other patients achieving significant reductions, and reaching their maximum tolerated doses and therefore achieving much better cardiovascular

protection. It should be noted that this would have been higher had the target recommended in QOF of 2.0mmol/L been used.

Developing a Culture of Innovation

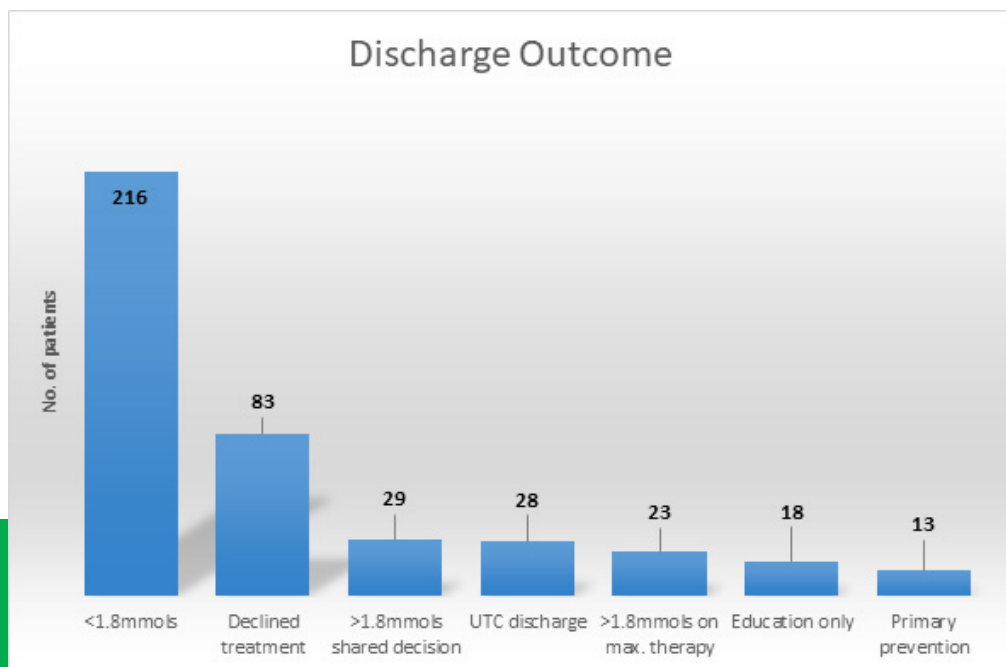
In the last year we have engaged with our local universities to help foster a culture of innovation and curiosity in our next generation of health and social care staff by giving them crucial skills and confidence to make changes both as part of their learning but also once in practice.

Introduction to Innovation modules have been introduced into a number of courses to help students identify their problems and focus on innovative solutions to drive measured improvement.

Future Opportunities and Developments

We continue to seek opportunities to align ourselves with system led problems and assist with the identification of innovations or innovative pathways as part of a wider solution.

Funding opportunities have been explored with a successful bid made to bring in an innovative solution towards helping patients wait well for surgery, with digital enablement of their pre-habilitation to aid successful outcomes and reduce on-the-day theatre cancellations.



Duty in respect of research

ICBs have a statutory duty around the facilitation and promotion of research in matters relevant to the health service, and the use in the health service of evidence obtained from research. Following our Research and Innovation Hub launch and publication of our ICS Research and Innovation Strategy in April 2024, we have continued to strengthen our research community across Lincolnshire in order to fulfil this duty. Our Research and Innovation Hub has been the vehicle for driving the research and innovation agenda across Lincolnshire and has started to create a step change in our systems research and innovation culture.

Our Research and Innovation team has grown in 2024/25. Our ICS Research Lead post has become a substantive role within the ICB's Clinical and Care Directorate, and with funding from the East Midlands Regional Research Delivery Service (Previously Clinical Research Network) we have also recruited a Project Support Officer. Through recurrent funding streams we intend to recruit to a Grant Development Officer post imminently. This role will be responsible for horizon scanning for research opportunities, maximising the potential financial gains to the system available through research, and supporting the capability for successful grant writing within the ICB and system partners.

We have continued to maintain research delivery excellence in cardiology, haematology, mental health, pre-hospital, gambling and addiction. Within primary care the East Midlands Regional Research Delivery Network (RRDN) ranks 2nd nationally for recruitment to studies with 12,835 participants, an increase from 8,000 in 2023/24. Lincolnshire is currently 3rd in East Midlands with 42% (35/84) of GP practices on the RSI (Research Sites Initiative) scheme and 2,146 recruits. Five more GP practices have signed up for the 2025 RSI scheme and one new dental practice, adding to the two existing practices participating in 2023/24.

We have continued and built on our close working partnership with the University of Lincoln, engaging with colleagues and students within their colleges and schools, with particular reference to the Medical School, School of Health

and Care Sciences, School of Psychology and School of Geography. In recognition of our close partnership, our ICS Research Lead has been awarded an Honorary Senior Fellowship in Health and Care Professions Research. An Honorary Senior Fellowship is one which is awarded to an individual of national academic and/or professional standing, whose association with the University will support its academic endeavour and provide a source of advice and wise counsel in that discipline.

We are an active partner in the work programmes associated with the University's successful E3 bid, which has established England's first integrated/transdisciplinary research centre for Coastal and Rural Health Research: Lincoln Institute for Rural and Coastal Health (LIRCH). This centre is tackling serious and urgent geographical inequities impacting on physical, mental, social, and economic health and wellbeing. The centre has been built on the excellence and demonstrated success of the Lincoln International Institute for Rural Health (LIIRH) through synergised and scaled up connections with Lincoln's Community and Health Research Unit (CaHRU), The Lincoln Clinical Trial Unit (LinCTU) and the Development, Inequality, Resilience and Environments (DIRE) group from the Department of Geography. This is part of the strategy to significantly increase our research capacity.

For the first time this year, we have been a co-applicant on a large Wellcome Trust application with LIRCH, which if successful will be investigating heat to mental health outcomes and the socio-ecological 'multi-hazard' pathways that characterise coastal, rural, and urban areas.

Building on the success of our Hub launch last year, we will be delivering our Research and Innovation Conference 'Strengthening our Research and innovation Community' in May 2025. This event will be an opportunity for our ICS organisation and system partners to come together to showcase and celebrate our successes and reaffirm our ambitions for the future direction of research and innovation within Lincolnshire. This event will also be an opportunity for us to showcase to industry partners.

ICS Research and Innovation Strategy



Lincolnshire ICS Research & Innovation Strategy 2024-2029



Our ICS Research and Innovation Strategy (2024) was co-developed during a series of collaborative workshops with senior leaders in our system, partners and our public. Our five-year strategy is ambitious and reflects our commitment to ensuring that research and innovation is embedded in our core business rather than being an add-on. By 2029 we want to be a leading county for rural and coastal research.

Our four strategy principles align with national and local priorities and goals. By 2029 Research and Innovation will:

- Reflect the needs of our communities.
- Be built on collaborative, co-ordinated, and trusted partnerships.
- Have research, innovation and evidence embedded in everything we do.
- Be delivered by a sustainable, capable, and confident workforce.

We have now moved into the implementation phase of the strategy and have created four principle working groups. These groups comprise of an ICS Executive, a representative from our Research and Innovation Leaders Group and Clinical and Care Directorate, and our Project Support Officer. These groups are helping to establish the priorities, timeframes, and outcomes to measure success and impact against each principle and are identifying the stakeholders that will be required to participate in the subsequent programmes of work to deliver our strategy.

Research and Innovation Leaders Group

Last year the ICB brought together the research and innovation leaders from across our health and care system to create a strategic Research and Innovation Leaders Group. The Group continues to meet monthly and has grown in membership. There is representation from our research and innovation leaders across the NHS, Lincolnshire County Council, universities (University of Lincoln and Bishop Grosseteste University), voluntary sector and wider partners. Its continued purpose is to provide strong and effective leadership and

partnership working across the health and care system, with a commitment to supporting the combining of expertise and resources to foster and deploy research and innovations to deliver better health and wellbeing outcomes to the people of Lincolnshire. This group continues currently to have strategic and operational functions and oversees the progress of the ICS Research and Innovation Strategy.

System mapping

A priority piece of work was to collect high-level information on key activity, workforce, high-level groupings, and infrastructure at each of the organisations that form part of the Lincolnshire Integrated Care System (ICS). By mapping the activity, the aim was to support a collaborative approach across the ICS whilst recognising that research and innovation activity, expertise, infrastructure and interests may vary across organisations. The information is currently being evaluated by the University of Lincoln and will then be used by the Research and Innovation Leaders Group to map research and innovation capabilities, challenges, areas of synergy, relationships and areas for future collaboration between the ICS Research and Innovation partners. This mapping has created a baseline for which we can further monitor and measure our progress.

NHS England Metrics

For the last nine months we have been participating in NHSE Developing Research Metrics Working Group. Initially the aim of the metrics was to support ICBs in their statutory duty towards research, support commitment to the Long-Term Plan, support commitment to the Government's response to the Lord O'Shaughnessy's review of commercial clinical trials, and to deliver on discussions had since 2019 that identified the system need for change. However, the subsequent refined purpose was to develop research metrics to

support discussion and decision-making at two ICB Board meetings per year in the form of quantitative metrics (dashboard) and supplementary contextual and qualitative (narrative) information to provide a clearer understanding of the richness/complexity of research activity. Areas for improvement and strengths to celebrate should be identified.

Lincolnshire was selected as one of 11 trial sites across England and has provided detailed feedback throughout the trial versions. The metrics are due to be published in 2025, and we look forward to continuing to work with NHSE and the working group, as we continue to participate in the development of the metrics implementation plan.

Research capacity and capability building

Throughout 2024/25 we have continued to develop, deliver, and support capacity and capability building amongst our workforce and public. We have secured collective funding of over £100,000 from the Regional Research Delivery Network (RRDN), NHSE, the University of Lincoln and other ICS organisations to develop and deliver these new and innovative initiatives.

In 2024 we piloted the Foundation Research Training Programme. The programme was created following survey feedback from our Allied Health Professionals (AHPs) and Lincolnshire County Council (LCC) workforce. The programme was joint funded by the RRDN, LCC and ULTH and delivered by the University of Lincoln. The programme was a

huge success with 126 colleagues from across our ICS and Lincolnshire County Council participating.

Following the success of the programme we have secured additional funding from the RRDN and Lincolnshire County Council and will be delivering the programme again, with the University of Lincoln, starting at the end of March 2025. In 2026, if successful with their re-tender, NIHR ARC (Applied Research Collaborative) East Midlands will be adopting the programme to scale to the East Midlands region.

In February 2025 the ICB and University of Lincoln came together in partnership with Nottingham University Hospitals, University of Nottingham, University Hospitals Leicester, and the University of Leicester to submit an application to deliver the new NIHR Health and Care Professional Internship Programme. This is a huge step forward for Lincolnshire and we will look forward to delivering the one-year programme over three years with our partners in September 2025, if the application is successful.

Research delivery: delivering the NIHR portfolio research trials, has historically been the majority of the research activity conducted within Lincolnshire, and is an area that has challenges due to workforce capacity and capability. The Research and Innovation Hub co-ordinated and supported the delivery of the NIHR Principal Investigators Essential Training, which supports the development of Principal Investigators that are responsible for delivering a research trial at a site and ensuring that the trial protocol is followed. This was the first time that the

THE FOUNDATION RESEARCH TRAINING PROGRAMME

A foundational research training programme for colleagues from Lincolnshire County Council and across all Lincolnshire Health and Social Care organisations was delivered from March – September 2024. No prior knowledge of research was required. The training programme was for all staff (registered and unregistered), aimed to develop research and ignite passion and interest in research, growing research skills and knowledge across Lincolnshire.

Background

Lincolnshire's Allied Health Professionals (AHPs) don't research as they were selected to be the highest priority for the Lincolnshire County Council research survey in 2022. The highest priority for the Lincolnshire County Council research survey in 2022 was the highest priority for the Lincolnshire County Council research survey in 2022. The highest priority for the Lincolnshire County Council research survey in 2022 was the highest priority for the Lincolnshire County Council research survey in 2022.

Timeline:

- 11 May 2024: Research Skills and Knowledge Workshop (10:00 am - 12:00 pm)
- 16 May 2024: Research and Health Professional Development (10:00 am - 12:00 pm)
- 20 May 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 27 May 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 31 May 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 01 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 05 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 09 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 13 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 17 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 21 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 25 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 29 June 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 03 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 07 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 11 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 15 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 19 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 23 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 27 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 31 July 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 04 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 08 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 12 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 16 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 20 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 24 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 28 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 31 August 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 03 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 07 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 11 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 15 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 19 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 23 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 27 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)
- 30 September 2024: Researching for Funding for Health and Social Care (10:00 am - 12:00 pm)

ON AVERAGE

- Participants with completed research training were 100% more likely to be involved in research activities.
- Participants with completed research training were 100% more likely to be involved in research activities.

FOR DID YOU

- Participants with completed research training were 100% more likely to be involved in research activities.
- Participants with completed research training were 100% more likely to be involved in research activities.

PER WORKSHOP

- Participants with completed research training were 100% more likely to be involved in research activities.
- Participants with completed research training were 100% more likely to be involved in research activities.

Workshop Feedback

- The session is very relevant to my current role and will help me to improve my research skills.
- The session is very relevant to my current role and will help me to improve my research skills.

Networking Event Feedback

- The session is very relevant to my current role and will help me to improve my research skills.
- The session is very relevant to my current role and will help me to improve my research skills.

Next Steps

- Feedback shows an appetite and enthusiasm for informal networking opportunities to give connections and provide space for time for collaboration.
- Work on a "Research Links" network to share research related information and learning opportunities.
- Publication of the external evaluation report outlining what worked well as well as learning for next time.
- Use ongoing follow-up evaluation to see if 6 months will be time to evaluate how they feel about the training in their job roles and identify any further training or development needs.
- The session has generated a training need for foundational research training across our Lincolnshire workforce – planning to bring place to our similar training in 2025.

Thanks to our Funders: NIHR, Research Delivery Network, Lincolnshire County Council, United Lincolnshire Hospitals NHS Foundation Trust, University of Lincoln.

Partners: The programme was jointly developed by LCC and ICB (Integrated Care System) in partnership with the University of Lincoln, who are delivering the initiative in a bid co-funded by the Clinical Research Network East Midlands (CRNEM), Lincolnshire County Council and ULTH. The course is designed to help research training across the region and delivery from across a range of organisations.

After Space of Thanks and Credit to our funders: The programme was jointly developed by LCC and ICB (Integrated Care System) in partnership with the University of Lincoln, who are delivering the initiative in a bid co-funded by the Clinical Research Network East Midlands (CRNEM), Lincolnshire County Council and ULTH. The course is designed to help research training across the region and delivery from across a range of organisations.

RRDN had delivered the training to an ICS, and 38 colleagues attended, a record for the East Midlands RRDN. We are planning further courses for 2025.

The REN Programme, launched and recurrently funded by DHSC in 2022, aims to increase diversity in research participation through the development of research engagement networks with communities who are often underserved by research, and by ensuring diversity in research is considered by integrated care systems (ICSs). Lincolnshire's REN is led by Lincolnshire Voluntary Enterprise Trust

(LVET) but has wide reaching members within the steering group. This year has seen 12 out of 36 successful applications by community individual or groups to our Health, Social Care and Wellbeing Research Fund. Dovetailing with REN we secured RRDN funding to develop Lincolnshire's Research Charter. The Charter has been co-produced with wide engagement across our communities and will set the expectation for people getting involved in research. The work with our communities has been inspirational and aligns to our Research and Innovation Strategy, and our ICS and ICB priorities.

Primary Care, Communities and Social Value

The key ambitions of the Primary Care, Communities and Social Value Directorate are to:

- Improve access to integrated primary care, by creating new and innovative models of care which will deliver the ambitions for improved access detailed within the 'Delivery plan for recovering access to primary care', improve quality of patient experience and outcome and create enhanced resilience of services and workforce. Transforming for tomorrow whilst delivering today.
- In partnership with PCNs, develop integrated community-based, multi-professional and multi-agency teams with a view to delivering person-centred care, targeted to meet the identified need of local communities.
- To implement integrated pathways of care for patients with long-term conditions including children and young people, people with mental health conditions and those with long-term conditions including frailty and, people at the end of their lives to support proactive identification, early intervention, personalised care planning and seamless management of deterioration.

Key to achieving these ambitions is integration across service and organisational boundaries, working in partnership with our staff, patients and the public to co-design pathways of care and to drive up experience and outcomes, adopting an approach of continuous improvement and learning and maximising the benefit of our investments to ensure we gain greatest impact.

Over the last year the ICB, together with colleagues from across primary care, has supported developments to provide improved access to

healthcare services, promote continuity of care for people with longer-term needs and increase proactive and preventative interventions that enables people to stay healthy.

Primary Care Access Recovery Plan

Work on delivering the Primary Care Access Recovery Plan (also known as the Delivery Plan for Recovering Access to Primary Care) began in May 2023 and continued into 2024/25. The key aims of the Plan are to improve patient access to their GP practices by addressing the 8.00am rush for an appointment and for people to understand what's happening next when they contact their practice.

The national plan covers four key areas:

- Empowering patients to manage their own health
- Implementing Modern General Practice Access
- Building Capacity
- Cutting bureaucracy

Empowering Patients

People can refer themselves into a range of community services in Lincolnshire and don't need to ask their GP practice to refer them: this includes podiatry, weight loss services, community equipment services, falls services and community audiology services.

Work on self-referrals continues to progress well with improvements in data reporting giving a clearer picture of how people are using self-referral

opportunities and work with Patient Participation Groups to develop information to raise public awareness. Around 3,000 people per month self-refer into health services in Lincolnshire, this roughly equates to around 1,000 GP practice clinical hours saved over the year, releasing more appointments for people who need to see a GP practice clinician.

The Pharmacy First service launched on 31 January 2024 – this means people can receive treatment for a range of common conditions without the need for the patient to see a GP e.g. shingles, acute earache and sore throats. This aims to improve access to care for patients and to help GP practices reduce demand for conditions where treatment can be provided by a pharmacy. Raising public awareness of the community pharmacy extended service offer has increased the number of people accessing care directly from their pharmacy, the ICB has also worked with pharmacies and urgent care services so people can be directed to their pharmacy for care instead of attending an Urgent Treatment Centre this is expected to reduce waits and improve people's experience of care. Pharmacy First saved an estimated 3,700 GP practice hours over the first half of 2024/25.

The NHS App supports people in managing their health and care with GP practices making access to online patient records, appointment booking and ordering prescriptions available over the App. GP practices also enabled online registration, new patients can now register with a GP practice online making the process simpler and quicker as well as reducing administration for practices.

Implementing Modern GP Practice Access

There has been ongoing engagement from GP practices and Primary Care Networks on supporting patient access. The number of appointments offered by practice continued to grow in 2024/25 with 4.75 million appointments provided by GP practice in Lincolnshire by the end of January 2025, 4% more than the same period the previous year. The Health Insights Survey indicates that people in Lincolnshire find it easier to access their GP practice than the national average with 85% describing it as 'easy' compared to 78% nationally. Work on developing a GP Strategy for Lincolnshire got underway this year with engagement across the health and care system and with the public. Around 2,400 people fed back on their experience of GP

services and how they might like to access care and treatment in future – improving telephone access, extended access hours and keeping online access open for longer were two of the most frequent responses. All GP practices in Lincolnshire have now moved to a digital telephone system, this will make contacting a practice by telephone quicker and easier with less dropped calls and options such as call-back so people don't need to wait in a queue. Working with practices to continue to improve telephone access will remain a priority area of work. In addition to digital telephone systems, all GP practices have access to online consultation tools with the number of online appointments available doubling over 2024 to around 1,000 per day across the County. Some practices have implemented Total Triage systems with all patients contacts triaged by a senior clinician, local experience indicates this means more patients are offered an appointment that day and GP practices are better able to manage demand. The ICB is sharing local learning from this work across GP practices.

The ICB continues to support practices to improve patient experience and access through effective care navigation with reception teams trained to guide people more effectively to the right clinician or service or to manage the health and wellbeing effectively themselves where appropriate – 94% of GP practices took part in care navigation training over 2024/25.

Building Capacity

Work on delivering the Lincolnshire Primary Care People Plan progressed over the year with the number of GPs in Lincolnshire increasing by 25 full time roles between April and December 2024 giving a total of 474 full time equivalent GP capacity. This is mainly due to the high conversion rate of trainees to GPs in the county and the targeted support being given to practices for recruitment and retention activities. Nationally GP trainees and locums are reporting less availability of opportunities and NHSE has brought in a GP Additional Roles Reimbursement Scheme (ARRS) initiative for newly qualified GPs to gain funded employment until end March 2026 – this has seen five new GPs employed to date in Lincs, with more planned. Use of ARRS funding has improved again this year with Primary Care Networks making good use of the additional funding to increase primary care capacity – around 97% of the £20 million funding available is forecast to be used in 2024/25.



convenient retail based location. The team is working together with colleagues to develop a proposal to build a new, purpose-built Integrated Health and Care Centre (IHCC) in Boston town centre. This is being developed in the form of an outline business case. The project team in the ICB is working in collaboration with Boston Borough Council (BBC) and others. The key aim is to provide a well-designed multi-service facility, primarily focusing on primary and community

placed based, proactive, preventative care; whilst recognising the health needs of local people and addressing inequalities.

Cutting Bureaucracy

Clinical leaders from across the health system have continued to develop the interface programme work which aims to free up GP practice time to focus on patient care by improving how community and hospital teams work with GP practices. Lincolnshire has a well-established collaborative approach with vision and strategic themes agreed and a defined programme of work developed. Key achievements over the year include developing guidance for hospital clinicians on issuing fit notes, improving messaging and online access to information for patients waiting for a hospital appointment, developing training and education opportunities focused on themes from the interface work programme and developing a clinician behavioural charter.

Primary Care Estate

The ICB supports the development and funding of general practice estate in Lincolnshire. The ICB has an established Primary Care Estates Group which supports the routine governance arrangements for reimbursed general practice estate. The Group supports the resilience and development of primary care estate, including oversight and governance in relation to the NHS General Medical Services - Premises Costs Directions. The Group has supported the development of a number of business cases.

The ICB is pleased to confirm that the relocation of Glebe Park Surgery in Lincoln is on track for early 2025/26, supporting improved estate to support service delivery and access for patients, in a

The Group also has oversight of plans for use of Section 106 funding within general practice. Section 106 of the Town and Country Planning Act 1990 allows local authorities to enter into a legal arrangement with a developer to ensure that appropriate funding is available to mitigate any impacts arising from housing development on health infrastructure. The ICB applies for funding on behalf of general practice and works with practices to ensure they utilise funds when they become available.

The ICB continues to support a number of practices across the county to develop plans to improve and expand their sites with the available funding. The ICB also successfully applied for NHS England capital funding to support improvement works for numerous practices in the county, to support improvements to the GP premises to expand clinical capacity which will take effect both in this financial year and next. As part of the Lincolnshire System Infrastructure and Investment Group, Primary Care estate is a key part of the Infrastructure Strategy that has been under development. Lincolnshire ICS has developed a draft Infrastructure Strategy which articulates the high-level programme case for the significant investment that is needed and without which our clinical vision and strategies will not be delivered.

The Strategy takes account of the need to transform and integrate services, and ensuring that we have a population, place-based needs approach aligning to our digital strategies and the rural and coastal challenges that we have.

Delegated Services

With effect from 1 April 2023, the ICB took on delegated responsibility from NHSE for the commissioning of Primary Care Pharmaceutical Services, Primary Ophthalmic Services and Primary and Community Dental Services. This is in addition to GP services which were already delegated to the ICB.

This means that all primary care commissioning sits with ICBs, providing a key enabler to our ambitions to better support integrated care and improved population health by joining up care pathways in order to plan and deliver better health and care for local populations.

The responsibility for planning, performance, finance, quality and service improvement transferred from NHS England to ICBs upon delegation. NHS England will continue to have oversight and will set standards and service specifications for the services and the ICBs will commission services within the existing national contractual frameworks and regulations.

The aim is to achieve better health for everyone, better care for all patients, efficient use of NHS resources locally, and support broader social and economic development.

Community Pharmacy

The ICB is progressing the development of a community pharmacy strategy, in partnership with the local authority and Community Pharmacy Lincolnshire, to develop community pharmacy within Lincolnshire. This will endeavour to support resilience, improve access for patients and to improve integration with general practice.

Pharmacy First Service (Clinical Pathways)

The Pharmacy First service commenced on 31 January 2024 and builds on the Community Pharmacist Consultation Service (CPCS) which has run since October 2019. The new Clinical Pathways element of the service is for common conditions and involves pharmacists providing advice and, where clinically appropriate, treatment in the form of over the counter and NHS prescription-only medication (normal prescription charges may apply). All Lincolnshire 'in-person' community pharmacies are offering the Pharmacy First Service,

What can be treated?

- ✓ **Sinusitis**
Aged 12+
Blocked nose, headaches, facial pain
- ✓ **Sore Throat**
Aged 5+
Pain, swelling, difficulty swallowing
- ✓ **Ear Infections**
Aged 1-17
Ear pain, fever, discharge
- ✓ **Infected Insect Bites**
Aged 1+
Swelling, redness, pus
- ✓ **Impetigo**
Aged 1+
Red sores, blisters, oozing
- ✓ **Shingles**
Aged 18+
Painful rash, blisters, sensation
- ✓ **Urinary Tract Infection (UTI)**
Women aged 16-64
Pain when urinating to pee

as well as several of the Lincolnshire Distance Selling Pharmacies. The service is available for patients meeting the service criteria through presenting to the pharmacy as well as through referral from NHS providers, including GPs. Prior to the launch of Pharmacy First, patients had to visit their GP to access prescription only medicine, meaning the service improves access to care for patients as well as reducing demand for GP appointments where conditions can be provided by a pharmacy.

The ICB has worked closely with GP practices and Community Pharmacies to implement referral pathway to support utilisation of the service. The current ICB focus is increasing public awareness of the service and self-referral options through developing local resources.

Blood Pressure Check Service (Hypertension)

The NHS Long Term Plan focuses on tackling health inequalities and the prevention of ill health, with an aim to prevent 150,000 strokes and heart attacks caused by cardiovascular disease (CVD).

Early detection of elevated blood pressure (hypertension) is vital to achieve this as it allows quick diagnosis and treatment, reducing the risk of stroke and heart attack. The Community Pharmacy Blood Pressure Check Service allows Community Pharmacy staff to take blood pressure readings under supervision of a pharmacist.

The service has two stages:

- Identifying people at risk of hypertension and offering them a clinical blood pressure reading (takes place at the pharmacy).
- Where clinically indicated, offer patients a continuous BP reading over an extended time frame using an Ambulatory Blood Pressure Monitor (ABPM).

The service aims to:

- Identify people with high blood pressure who have previously not had a diagnosis of hypertension.
- Support GPs and at their request, undertake 'clinic consultation' readings and ABPMs.
- Promote healthy lifestyle behaviours to patients.
- Support the use of wider pharmacy staff skill mixing.

In Lincolnshire, all 'in-person' Community Pharmacies are signed up to provide this service.

Oral Contraception

The Oral Contraception Service gives patients the option of being able to have a confidential consultation with a Community Pharmacist rather than visiting their GP or sexual health clinic for:

- Ongoing monitoring and supply of oral contraception prescriptions.
- Initiation of oral contraception (including switching to alternative forms of oral contraception).

The service offers patients more choice, supports the role community pharmacies have in improving patient access to treatments and frees up primary care capacity for more complex assessments. Approximately 75% of pharmacy contractors (86 of 115 pharmacies) in Lincolnshire are currently signed up to provide the Oral Contraception service. The ICB is working closely with the Local Pharmaceutical Committee, Community Pharmacy Lincolnshire, and community pharmacies across Lincolnshire to increase pharmacy contractors signed up to offer this service.

Hypertension Case Finding Pilot in Dental and Optometry Settings

In November 2024 Lincolnshire ICB mobilised a pilot to undertake opportunistic hypertension case finding by dental and optometry providers.

The pilot was developed with the support of the Lincolnshire Optical Committee, Lincolnshire Dental Committee, Lincolnshire Pharmacy Committee and Lincolnshire Medical Committee and is due to run until the end of July 2025. The development

and mobilisation of this pilot is the first time in Lincolnshire that all 4 primary care pillars have collaborated, resulting in the generation of innovative solutions in areas such as IT, referral pathways and establishing communication links between provider areas that will support future projects. The service also supports green agendas through bringing services back to high streets and closer to home for patients.

There are seven providers of the pilot in Lincolnshire in areas that were identified as being of greatest need, addressing often neglected health inequalities, including those arising from deprivation, geography and transportation and supports patients who fall into the "seldom heard" and Core20Plus5 groups.

In the short time the pilot has been running, 39% of the readings taken were identified as being out of range and requiring further investigation, with 3.9% of these being classed as very high BP readings requiring urgent same day treatment.

Dental Services

From the 1st April 2023, the ICB took over delegated responsibility for commissioning dental services from NHS England, whilst responsibility for oral health improvement remains with local authorities. To support this transition, a dental strategy for Lincolnshire was created to provide a framework for the ICB and its partners to support action over the next three years, aimed at improving oral health and dental services through a 'whole system' approach. Stakeholders involved in the development of this strategy agreed on a bold vision of creating oral health and dental services which promote the prevention of dental diseases and meet the needs of the people of Lincolnshire now and in the future. Through a series of workshops, four key themes for the strategy were agreed:

- Developing the dental workforce
- Improving access to dental services
- Increasing the focus on prevention
- Strengthening the integration of oral health into wider health and care services

Three cross-cutting themes were also agreed:

- the need to address health inequalities as the golden thread running across all pillars of our strategy, drawing on the CORE20PLUS5 inequalities framework for adults, and children and young people.

- maximising the use of evidence, data, and intelligence to improve oral health.
- enhancing leadership and creating an environment that fosters developing the culture of pride and accomplishment within and across all members of dental teams across Lincolnshire.

All of this sits under one overarching principle, that patients and the Lincolnshire public are at the heart of everything we do. The ICB has continued to ensure improved outcomes for patients in line with the Strategy and refreshed Oral Health Needs Assessment completed in 2024.

A new dental contract within Mablethorpe was mobilised in September 2024, providing improved dental access to the east coast of Lincolnshire. The ICB continues to work closely with the local authority to support prevention initiatives. Workforce development is also a priority, with the ICB funding additional places for recruitment incentive schemes. The ICB is also working with the University of Lincoln and partners across the Integrated Care System (ICS) to explore plans for a Lincolnshire Institute of Dental and Oral Health. It is envisaged that the Institute will support with the training and development of dental professionals across the county with a view to attracting, upskilling and retaining the local dental workforce required to ensure that those in need have access to oral health services.

Ophthalmic Services

The ICB is responsible for commissioning optometry services, which supports the ICB's aim to achieve better health for everyone, better care for all patients and efficient use of NHS resources locally. The ICB is working closely with the Lincolnshire Local Optical Committee, Local Eye Health Network and other stakeholders to develop a refreshed Eye Health Needs Assessment during 2025/26 to support commissioning development and to support access for patients in the county.

Frailty

The Lincolnshire Older People's Strategy was agreed early in 2024, co-produced with colleagues from across the health and care system, as well as patient and public representatives. It is based upon clinical evidence and best practice. Its key focus is prevention, proactive identification, treatment and management of frailty, with a view to improving patient outcomes and experience, reducing overall deterioration, improving coordination of care and to reduce unplanned acute activity.

To make delivery of the strategy manageable we designed a delivery model of 5 pillars (prevention, neighbourhood, a single point of access, integrated care and workforce) with specific areas of focus but also connected around a population not the intervention. Governance and programme arrangements have been put in place to support this approach.

Our early successes have included:

- Launch of Ageing Well Campaign to encourage connecting people to their local community network.
- Five Early Adopters Primary Care Networks (PCN) have engaged in delivery the strategy with initiatives including:
- Community events targeting specific cohorts to raise awareness and engage people in prevention opportunities.
- Clinical review of patients following risk stratification using eFI (electronic frailty index).
- Use of population health management data to identify cohorts of patients for proactive offer of strength based assessments leading to interventions such as Comprehensive Geriatric Assessment and Personalised Care and Support Planning and review.
- Through the Enhanced Health in Care Homes (EHCH) framework, multi-disciplinary team (MDT) working has been introduced and telehealth developments in care homes have progressed.
- A Comprehensive Geriatric Assessment template, co-designed by colleagues from primary care and Trusts, is currently in use supported by locally developed training.
- The introduction of a nationally agreed tiered training package from the British Geriatrics Society Training.
- Frailty same day access centres are operational at both Lincoln County and Pilgrim Hospitals; 20 virtual ward beds are supported by daily MDTs and an intake of 10 new advanced care practitioners (ACP) trainees.
- Introduction of a population health dashboard which captures both process and outcome measures across the frailty spectrum, and which drills down to PCN level.
- Scoping of a Frailty Proof of concept in a PCN, that once tested and proven can be rolled out across all PCNs in the Lincolnshire system.

We have learnt lessons in our first year of implementing the five year strategy notably that Lincolnshire has a huge wealth of activities to keep older people mentally and physically well. However, older people are not always aware they are there or how to access them, or even if

they are suitable for them. By working in partnership with partners and stakeholders we need to further foster, develop and build the capability and capacity of community-based assets with a view to reducing dependency on health-based interventions. Additionally, there are further opportunities to target people from specific population groups, including those where there are known health inequalities, who have traditionally been less engaged, supporting them to proactively self-care and engage proactively with services.



Our frailty work has seen a refresh in connections with Enhanced and Better Care in Care Homes programmes alongside our falls programme of work which has seen the implementation of telehealth supporting Multi-Disciplinary Team (MDT) working, building community of practice forums with staff, stakeholder and partners to improve education and knowledge as well as supporting improved connections and workforce integration.

Palliative and end of life care (PEOL)

Building on the operating model and transformation plan we developed for palliative and end of life care in Lincolnshire in 2022, we have agreed our five year Palliative and End of Life Care Strategy, for adult ages, based on clinical evidence and national guidance, whilst using local intelligent sources on population data and needs to personalise care during 2024. By moving to a new model of care outlined in this strategy we will address the needs of patients, families and carers for those who would benefit from PEOL care. This strategy takes an ambitious and transformative approach to delivery of fully integrated PEOL care to ensure accessible, equitable, sustainable, responsive, personalised PEOL care for adults, for all ethnic or social groups, areas or settings and for disadvantaged groups including those diagnosed with frailty, dementia, learning disability and severe mental illness.

The delivery model to implement this strategy focuses upon five key specific but connected areas:

Enhanced Care - People, families and carers will be supported to access enhanced care including complimentary therapies, support groups, practical

support in accessing housing or the benefits system and emotional and psychological support including some bereavement services provided by experienced workforce.

Core Care - Includes all health and care teams who provide direct palliative and end of life patient care.

Single Point of Access – A Single Point of Access (SpOA) for palliative care needs provides access 24/7 through a single point of contact and coordination of (planned, unplanned, specialist and in-patient) care, for adults with a palliative diagnosis, families (all ages), carers (all ages) and professionals.

Integrated Specialist Care - Includes specialist and targeted palliative care services working as a single team across organisational boundaries under an integrated specialist palliative care clinical, quality and service leadership.

Workforce - A single team, working across organisational boundaries.

During 2024/25 we have strengthened coordination of care such that planned referrals will be managed alongside unplanned referrals, through a single point of access for palliative patients. This provides access 24/7 to clinical triage for people, carers and their families and integrated with community response teams. We have designed a strategic commissioning arrangement for integrated specialist palliative care during 2024, where services will work as a single team across organisational boundaries under an integrated specialist palliative care clinical, quality and service leadership. Introduction is expected during 2025/2026. We have designed a tiered training and education package for palliative care for introduction in 2025. We continue to support ongoing operational sitrep and Operational Pressures Escalation Levels (OPEL) reporting to the system for PEOL and review policies and Standard Operating Procedure (SOPs) through system and organisational governance.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a national initiative, developed by the Resus Council UK. ReSPECT gives people and those important to them, a voice through the opportunity to discuss choices and wishes and develop a personalised escalation and treatment plan should they be in an emergency where they are unable to speak for themselves. In Lincolnshire we have introduced a system wide ReSPECT policy and standard operating procedure alongside audit tools and training and education resources supported by a clinical reference group.

Our work continues supported by a system clinical specialist palliative leadership group and other connected forums including ReSPECT clinical reference group, co-production group and Quality and Patient Safety Group as well as various quality improvement groups.

Long Term Conditions

Our Long Term Conditions programme has prioritised performance in cardiovascular disease, diabetes and respiratory disease, in alignment with national policy, and performance targets.

In respect of cardiovascular disease, we have continued to refine our approach to delivering integrated cholesterol management services, for patients with established cardiovascular disease. As part of recovery from the pandemic the lipid specialist nurses saw patients waiting for an outpatient clinic appointment. This accelerated the pace at which we were able to reduce the backlog for lipid clinics, returning treatment times to be in line with national standards.

We have continued to innovate heart failure services, building on the foundations of the virtual ward, and rapid access clinics established in preceding years. Patients attending hospital are now receiving maximum tolerated doses of medication in line with the latest evidence basis within a community setting. We have initiated a pilot giving patients access to medication in their own homes that normally would only be provided in a hospital setting. We will evaluate this initiative in the summer 2025.

In respect of diabetes, we have mobilised the Type 2 remission programme (also known as the low calorie diet) for a further year and continued to deliver on the prevention programme (further information in relation to these programmes can be found in the prevention section).

We have continued to roll out the Type 2 Diabetes in Adolescent and Young people service, targeting patients under 40 (who are shown to be less well controlled). We also commissioned and mobilised our Type 2 Diabetes Structured Education programme, to provide face to face options for education.

We continue to support a cross-organisational group that review performance in respect of the uptake of new technologies, such as Hybrid-Closed Loop systems, and target performance in obtaining care processes and treatment targets.

In respect of respiratory conditions, we undertook a review in line with the Joint Forward Plan 2023-28, given the ambitions to deliver CORE20Plus5 priorities, the major conditions framework and the operational risks identified at each point along the pathway - prevention, access, early detection and diagnostics, treatment including specialist care.

The review set about engaging a cross section of experts and stakeholders to review the current clinical respiratory pathway, in line with best practice evidence, and was completed across a number of sessions, and produced recommendations and the approval of next steps. This includes further scoping of changes in clinical pathways, a proactive model of care to support a winter response, approach to countywide diagnostics, a review of pulmonary rehabilitation, and establishment of MDTs.



Environmental Matters



Delivering A Net Zero NHS was published in October 2020. Each Trust and System were required to produce a Green Plan. The Lincolnshire System Plan was published in November 2022.

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

The UKHSA published its Health Effects of Climate Change report, State of Readiness report in 2023 with the apt acronym of HECC. It gives an overview of how climate change is affecting health, and the extent to which it will do so in the future.

Each provider and the ICB's Primary Care Team have produced their own plans, which are to be refreshed in 2025. The new NHS Green Plan guidance was published on 4th February 2025. This updated guidance supports systems and trusts to refresh their Green Plans for the next three-year cycle with the aim of:

- prioritising interventions that support world-leading patient care and population health, and reduce inequalities, while tackling climate change and broader sustainability issues
- supporting NHS organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers
- ensuring every NHS organisation supports the ambition to reach net zero carbon emissions, reflecting learning from delivery to date

Service changes can significantly contribute to reducing our carbon footprint as an additional benefit alongside productivity, patient experience, quality and financial benefits as outlined below:

- Changes to asthma inhaler prescribing. This is an area where the Medicines Optimisation Team and colleagues in primary care have been working together. New formulary has been agreed and progress is being made. Prescribing of low carbon preventer inhalers as a proportion of all preventer inhaler prescribing has improved. The Lincolnshire percentage is 48.65% compared to the national average in July 2024 of 47.66 %.
- Another example is cardiac rehabilitation now offering online digital exercise sessions, saving travel costs and time for patients and therefore reducing CO2 emissions.
- The Primary Care 10 Point Practice Plan was presented to Practice Patient Participation

Groups (PPGs) in October where there was a discussion on how to promote and engage with practices on this.

- Greener NHS is a standing item on the ICB update to primary care, the following is included in every update which is shared with practices twice a week.
- There is a section on the ICB website regarding Greener Practice Greener NHS - Lincolnshire ICB. There are specific primary care resources at Greener Practice – UK’s primary care sustainability network, which is a site specifically for GP Practices and practices are encouraged to look at the wide range of resources that can support them to make sustainable change.
- The Primary Care directorate share greener newsletters, promoting training including events such as Sustainability Education for Nurses working in primary care and general practice settings in the Midlands, free carbon literacy training and shared details of Greener Practice High Quality and Low Carbon Asthma Care.

Sustainability West Midlands has been working with Lincolnshire County Council to develop a Climate Adaptation Plan for Lincolnshire, to give the county a long-term plan to adapt against the impacts of climate change on a broad range of areas covering infrastructure, health and wellbeing, natural environment and the economy. The NHS has contributed to the development process so far.

Recognising the challenges regarding the need to develop an EV charging network across Lincolnshire NHS colleagues worked with One Public Estate partners to create and participate in a Systemwide workshop in June 2024. This covered areas such as local policy context, Infrastructure needs including power sources, health inequalities and challenges of a rural and coastal county, charging policies etc. The outputs have been shared and further work will be through the county wide Sustainability Managers Group that the NHS sustainability managers attend.

Taskforce on Climate-related Financial Disclosures (TCFD)

The Department of Health and Social Care Group Accounting Manual (DHSC GAM) has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies stemming from HM Treasury’s TDFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope one, two and three greenhouse emissions under TDFD requirements as these are computed nationally, by NHSE.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability requirements on a phased basis up to the 2025/26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following ‘pillars’: Governance, Risk Management and Metrics and Targets. These disclosures are provided below and set out in the Lincolnshire System Green Plan as referred to on page 57.

The ICB continues to follow climate change guidance issued to the NHS and Government Bodies in our procurement and contracting activities. This includes guidance set out in the Procurement Policy Note – Taking Account of Social Value in the Award of Central Government Contracts and in the NHS guidance: Applying net zero and social value in the procurement of NHS goods and services.

Information on the ICB’s use of energy and water is detailed below for the period 1 April 2024 to 31st March 2025.

Bridge House	
	£
Utilities - Electricity	17,601
Water	1,737
Total Spend	19,338

Improvements in Quality

Quality Governance

The ICB has a duty under the Health and Social Care Act 2022 to improve the quality of services and to ensure patient safety and positive patient experience.

To aid achievement of these duties the Integrated Care Board has an established Quality and Patient Experience Committee (QPEC) as the Committee which maintains oversight of the quality functions and quality responsibilities of the ICB.

The Committee meets bi-monthly, is chaired by the ICB Non-Executive Director with responsibility for Quality and is attended by the ICB Medical Director and the ICB Director of Nursing (Chief Nurse);

the ICS main NHS organisation's respective Non Executives who lead on Quality plus their counterpart Executive Quality Leads; also with leads from Public Health and Healthwatch.

Supporting QPEC is the Integrated Care System Quality Group (SQG) which establishes the escalated areas of system partner concern pertaining to Quality and the actions being taken to address identified concerns with subsequent escalation to the ICB QPEC for awareness and to provide assurance on the mitigating actions. The main purpose of the SQG is to ensure there is quality concern escalation and to ensure quality improvement support is given from relevant system partners as needed and also for assurance to all the organisation Quality Leads represented, that required improvement actions are being addressed effectively either by individual organisations or collaboratively where necessary.

In support of QPEC and SQG the ICB has two established quality oversight groups for all providers one for primary care providers and one for all other provider types. In addition, ICB Quality Team staff members who support the quality functions of the ICB are aligned with all providers across primary and secondary care. These officers also attend provider local quality committees or meet regularly with their allocated providers so aware of and able to support with any areas of quality concern.

The work of the ICB Quality Team members is aided by intelligence gathered about quality from wide ranging and established processes, for example via patient safety incident reporting from providers; escalation on patient safety concerns from providers; through quality dashboards; through complaints received; through information provided by Healthwatch and other patient voice avenues; from regulators and health and care education and through many other sources.

Some of our providers are under an enhanced level of surveillance and support from the ICB and other partners because of previous regulator and/or ICB performance and quality concerns. For these providers the ICB Quality Leads attend dedicated Quality Review Meetings with the provider at a frequency indicated by the level of concern. Also undertaking where relevant quality visits to seek assurance on actions or any other quality/ safety concerns. Direct support is given to the organisation where required to facilitate quality improvement.

Quality Priorities

The System Quality and Patient Experience Committee and the supporting Quality infrastructure outlined above has identified several theme areas which have required ongoing system focus for quality improvement in 2024/2025:

- Right place, right care, right time for care within Urgent and Emergency Care (UEC) with a need to maintain focus on patient access to services, care closer to home, reducing unnecessary hospital attendance and admission and long lengths of stay in hospital post-admission.
- Reducing care treatment delays within both unplanned and planned care pathways within tertiary, secondary and community care services for both adults and children. Where necessary ensuring robust harm review processes for patients waiting a long time for treatment.
- Palliative and end of life care (PEOL) including continued work to improve advanced care planning plus Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) discussions and documentation.
- Health Protection – with a continued focus on infection prevention and control.
- Ongoing work to reduce the incidence of pressure ulcers through a system improvement group established to collectively progress this work.
- Ongoing work to improve falls prevention and response.
- Implementation of the Patient Safety Incident Response Framework across the system.
- Capacity constraints within specific Children and Young People Services.
- Safeguarding developments.
- Continued workforce challenges across many services, requiring a constant focus on staff health and wellbeing, plus recruitment and retention initiatives.

Lots of this improvement work continues to occur through respective system programme boards and within and across our providers, supported by provider and ICB quality team members and will be further highlighted in the relevant sections of this report e.g., UEC, Cancer, Elective, POEL, Children and Young People, the work of the People Board.

Specific areas which come under the direct responsibility and/or are extensively supported by the ICB Nursing and Quality Team are covered in more detail below.



Urgent and Emergency Care Quality Initiatives

The Urgent and Emergency Care (UEC) Clinical Audit Programme has identified opportunities for quality improvement within the delivery of UEC in Lincolnshire. The programme provides an integrated approach to support service and pathway reviews to inform system-wide planning, continuous improvement strategies and quality assurance within UEC services.

In May 2024 an Intelligent Dispatch workshop was held, which was followed in July and October 2024 by Clinical Assessment Service (CAS) workshops. The focus was around triage and escalation processes as well as pathway reviews to ensure the right clinician, at the right time, first time. Actions for improvement have included a triage question template, care home training, and a review of the chest pain, abdominal pain, and catheter pathways.

In response to the NHSE letter regarding maintaining focus and oversight on quality of care and experience in pressurised services, an audit on discharge was undertaken in September 2024 which identified areas for improvement including the need to ensure that a discharge on admission approach is taken. An audit on virtual wards took place in March 2025.

The monitoring of ambulance handover delays (8 hours or more) and after-action reviews for people experiencing long delays including 48 and 72 hours in Emergency Departments is now in place to identify key learning points and any actions required.

During February 2025, system partners have been working on developing protocols to implementing 45-minute ambulance handovers. This started at Lincoln County Hospital in March 2025 and will follow on at Pilgrim Hospital Boston.

Mental Health - Acute Inpatient Service Quality

The ICB has been part of the Mental Health Host and Home pilot led by NHS England. The Mental Health Host and Home Integrated Care Board guidance sets out the enhanced responsibilities of a host ICB for quality oversight and monitoring of specialist non secure mental health acute inpatient NHS and independent provision in their geographical area. The expectations of the role of the home ICB for the oversight of the care of people placed in a mental health unit outside of the ICB geography

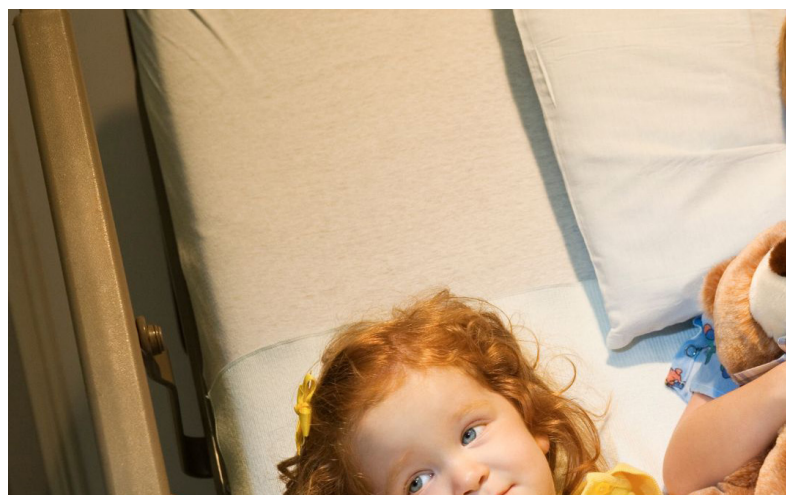
where the person is ordinarily resident is also given. Working with the ICB MHLDA team and LPFT these enhanced responsibilities for quality oversight and monitoring arrangements for mental health acute inpatient provision were reviewed using a quality assurance baseline tool. This identified adaptations and enhancements required locally to provide early warning signs of any quality and safety issues.

Planned Care and Diagnostics

The Community Diagnostic Centres (CDCs) at Skegness and Lincoln opened November and December 2024 respectively and are purpose built with state-of-the-art scanning equipment including an interactive 'kitten scanner' which helps children prepare for scans and has had a significant impact on reducing general anaesthetics given to children needing MRIs. The CDCs provide access to a variety of diagnostic tests and procedures and support the reduction of these being provided within acute services. Working with Primary Care Networks (PCNs) to provide phlebotomy there is the potential for other services to be developed due to the clinic spaces available. Service users are increasing and positive patient feedback has been received.

The Nursing and Quality team actively engage with programme leads and groups regarding quality concerns and improvements, as well as lessons learnt from Never Events, sharing information to ensure system-wide learning. These groups have included Weight Management Clinical Reference Group, Termination of Pregnancy Services and, more recently, Nutrition and Hydration Steering Group, ensuring there is continued engagement with provider staff.

Engagement with provider organisations has also taken on a problem-solving approach with existing services to support the review and development of these services across community and secondary care. This has included quality review visits to develop an understanding of the population requirements whilst considering the constraints the services work within.



Palliative and End of Life Care (PEOL)



The Nursing and Quality team are active members of the system-wide PEOL Quality group and worked jointly with system colleagues to develop the terms of reference for the group.

The Quality Team has supported several pieces of work through the PEOL Quality group agenda including:

- Standardisation of PEOL terms and definitions
- Review of PEOL prescribing
- Development of a system-wide Care after Death policy
- Endorsement and implementation of the End of Life Care at home leaflet for carers
- Participation in a clinical reference group for ReSPECt which strives to improve education around high quality ReSPECt conversations and documentation of these.

The Lincolnshire System Mortality Group has been re-established with the purpose being to act as a strategic mortality overview group and to provide strong oversight of patient deaths and shared learning throughout the Lincolnshire ICS. This brings together stakeholders from across Lincolnshire to review themes, trends and concerns arising from each organisation's mortality reviews whilst identifying key lessons and requirements for change and to record these for reporting and further dissemination.

Infection Prevention and Control

Infection Prevention and Control with safe environments of care for patients and staff continued as a vital focus in 2024/25, due to the continued prevalence of seasonal respiratory illnesses and a national rise in cases of Norovirus. The ICB assisted in the protection of public health through the work of our Health Protection Team.

The ICB Health Protection Team (HPT) works on behalf of the ICB to ensure good infection prevention systems and processes are in place for NHS commissioned providers in both Primary and Secondary care services.

The ICB acts as system leaders for IPC and Health Protection in Lincolnshire, ensuring whole system engagement in managing, maintaining and monitoring infection prevention and control in



healthcare settings and to support the wider public health of the population by coordinating the health response to communicable disease outbreaks in Lincolnshire.

The work of this team covers three work streams, Infection Prevention and Control (IPC), Communicable Disease Control, and Vaccinations and Immunisation and therefore during this year the work of this team has continued to be of paramount importance.

2024/25 saw a continuation of “business as usual” following the pandemic, and a continued focus on proactive, rather than reactive health protection work. The Health Protection Team undertook assurance reporting and supportive visits with commissioned providers, supporting and assessing compliance against the Health and Social Care Act (2008) Code of Practice for Infection Prevention and Control, updated 2022.

Each Lincolnshire Trust (ULTH, LCHS and LPFT) receives at least a quarterly visit from the team and for all other providers, the aim is to visit most services annually, with additional visits for IPC advice during renovation work and accreditation of Primary Care Surgical Scheme premises as required. The team also monitor compliance of Trusts outside of the Lincolnshire border that the ICB commissions services from.

The outcomes of visits were positive with generally good compliance to IPC standards. Where issues were identified the team has worked with the relevant provider to advise and support mitigating actions.

Working with the Primary Care Quality Team the Health Protection Team began implementing QEWS (Quality Early Warning Score) method of

assessment and monitoring for general practice providers in October 2024. This method aligns with the National Quality Board’s quality statements that reflect the expectations of safe, effective, efficient, sustainable, positive patient experience and well led. Infection prevention and control is a topic that sits within the “Safe” domain.

Engagement from most providers has been positive with the team maintaining a supportive approach with providers in order to enhance engagement. The QEWS process is currently being further developed to be able to apply to all Primary Care providers, including higher risk areas, such as dentistry.

The HPT has re-launched a Link Practitioner support network for primary care, which was well attended prior to COVID. Efforts to re-engage with GP practices has seen the team offering both virtual and face to face Link Practitioner sessions and has seen a steady increase in attendance since the pandemic. The purpose of this network is for the ICB HPT to provide IPC training and development, conferences, peer support and an online platform for sharing of information.

Over the last year, the team identified a framework for integrated working with the Local Authority Health Protection Team, which has provided an arena for shared learning and opportunities to explore public engagement and proactive health promotion and protection as well as allowing for a more responsive process for managing outbreaks in care homes in Lincolnshire.

The HPT has supported the system to keep local guidance on living with respiratory illness, as well as management of patients with suspected or confirmed infectious diseases up to date and relevant, with Acute Respiratory Illness (ARI)



planning an item on the System IPC Group Agenda. The Lincolnshire pathways that have been produced by the team were highlighted by NHSE and UKHSA as being a good example of Integrated, system working and have been shared with other ICBs in the region.

The HPT attend regular briefings and webinars to ensure that the Lincolnshire processes are clear and in line with national and regional guidance and have led small scale, local exercises to test the processes in place. The team have also taken part in larger exercises in conjunction with external agencies to measure preparedness for pandemic infection and other infection incidents. The team continues to support the Influenza and Covid-19 vaccination campaigns and has been working closely with the ICB Vaccination and Immunisation Team. In September 2024, the two teams attended Fresher's Week at the University of Lincoln and engaged with new students, providing advice and guidance on age related vaccinations.

The team has attended several conferences and other training events relevant to health protection, to ensure that the staff are qualified and competent to provide up to date advice and guidance to system partners.

The team has increased resource to manage both the expected demand and the unexpected remit of the Health Protection function i.e. communicable disease outbreaks. Support from the Vaccination and Rapid Response Team (VRRT) has been crucial in being able to provide a rapid response to care home Influenza outbreaks, with all notifications being managed within 24 hours and antivirals issued to those who were eligible. 2024/25 has seen an unprecedented rise in outbreaks of acute respiratory infection in Lincolnshire care homes which would have been a challenge to respond to without the input of the Rapid Response Team. As an addition to the response, the team have also offered COVID and Influenza vaccination to care home staff whilst on the premises, and issuing antivirals for residents. Avian Influenza also presents a risk in Lincolnshire, due to the number of poultry farms in the region. The VRRT have supported the ICB HPT outbreak response by attending the affected farms and issuing antivirals to staff who have been exposed to infected birds prior to diagnosis. This swift action ensures the risk of spread of Avian Influenza to humans remains low within the county.

The HPT attend and engage with the Lincolnshire System Antimicrobial Stewardship Group, with a focus to support appropriate antimicrobial

prescribing in primary and secondary care and public messaging encouraging the appropriate use of antimicrobials. The Lead Nurse also chairs the Lincolnshire System Sepsis Group and the Lincolnshire System Infection Prevention and Control Group, in a bid to encourage whole system working to improve outcomes for patients living in Lincolnshire.

ICB Healthcare Associated Infections

The annual data for 2024/25 will not be available for interrogation until mid-April 2025, however, current data shows the system to be above trajectory for clostridioides difficile (C.diff), escherichia coli (E. Coli), Klebsiella species, MRSA and MSSA, which reflects the national picture to date. Cases of P. aeruginosa are currently under trajectory. The Health Protection Team are awaiting a peer review of C.diff cases that have occurred over the year to identify themes to share across the system and targeted improvement work to reduce future cases.

A system IPC subgroup has been established to co-ordinate a collaborative approach towards reducing Gram negative infections, as well as a system wide Antimicrobial Stewardship group with the aim of optimising antimicrobial prescribing, which is expected to have a positive impact on C.diff rates, particularly in the community.

Tissue Viability

Pressure damage remains the highest reported serious incident theme in Lincolnshire, often affecting patients and people in receipt of care in a variety of settings including hospitals, care homes and domiciliary care. A 4-year Integrated Care System (ICS) Quality Improvement (QI) programme of work was established in 2023 with the intention of reducing the prevalence and impact of pressure damage. The priorities within the ICS Tissue Viability and Pressure Ulcer Prevention Quality Improvement programme align to the Lincolnshire Safeguarding Adult Board (LSAB) 2022-2025 prevention priority 'preventing and or limiting the impact of pressure sores (across NHS and independent sector providers)'.

Progress has been made through 2024/2025 and work has included staff engagement across the Lincolnshire ICS, including NHS Trusts, local authority, care homes, domiciliary providers and primary care and the establishment of a co-production group following patient and public engagement activity. Feedback from staff and the public has been used to inform the priorities within

each of the workstreams, in particular the need to focus on training and education opportunities across all providers within the ICS and the need for accessible prevention information and messaging aimed at patients, public and informal carers.

Examples of the achievements of the Quarter 1 (Q1) programme during 2024/25 include:

- Publication of updated LSAB information to reflect requirements set out in national best practice pressure ulcer risk assessment guidance [lsab-policy-and-procedures.pdf](#). This information is applicable to all providers within the Lincolnshire ICS.
- As part of the national Stop the Pressure week in November 2024 a learning event brought together representatives from across the ICS to share good practice. The event was supported by a week's programme of activities and a series of podcasts to facilitate sharing of information and learning to those unable to attend the one day face to face event.
- An ICS Pressure Ulcer Learning Group has been established and this group are currently looking at how learning can routinely be made more widely available across all staff within Lincolnshire health and care organisations.
- Data across the ICS has been reviewed to understand information reported through a variety of routes. This work has highlighted a range of measures that could be used by the programme to measure impact of the work being undertaken and it is anticipated initial measures will be used for reporting and to set trajectories for improvement from early 2025/26.

Falls Reduction and Response

A Lincolnshire Falls Summit took place in June 2024 to celebrate the falls prevention and response achievements including:

- the extension of the falls response services in the overnight period through the LIVES Falls Response Service and Age UK provision to limit the incidence of long lie falls in all areas in the community.
- proactive falls prevention initiatives by Primary Care Networks (PCNs).
- the roll out of a 2-year strength and balance training by One You Lincolnshire.
- focused work and initiatives across inpatient services.

- systemwide falls training and resource provision led by Care in Lincs including a number of Falls Ambassador workshops to ensure the principles of good practice related to falls are integrated into everyday practice across all care settings.

A newly formed Falls Community of Practice supports the development and delivery of the falls work programme with the ongoing focus on proactive falls prevention, consolidation and further development of the falls pathway and the further streamlining of the falls response. A workshop with system partners took place in October 2024 and work continues to standardise the falls response.

Patient Safety

During 2024/25 the ICB has continued to work with the providers of healthcare to Lincolnshire patients to embed the principles of the Patient Safety Incident Response Framework. The aim to ensure that there are effective systems and processes in place to respond to patient safety incidents, for the purpose of learning and improving patient safety.

In collaboration with health and social care colleagues across Lincolnshire, Lincolnshire ICB has developed two key Lincolnshire-wide meetings to underpin the Patient Safety Incident Response Framework and the broader patient safety agenda. The Lincolnshire-wide Patient Safety Meeting aims to support the embedding of effective patient safety culture across Lincolnshire; providing a forum to encourage collaborative working across health and social care, sharing knowledge, expertise, and resources to support broader improvements in patient safety.

The Lincolnshire-wide Learning Meeting provides a forum through which learning from patient safety incident responses can be shared; opportunities for collaborative working/quality improvement can be explored, supporting the continued cultural shift to learning and improvement, as defined within the Patient Safety Incident Response Framework.

Within 2024/25 Lincolnshire ICB has continued to work with providers in the review of the Patient Safety Incident Response Plans, in support of the 'sign off' process for these.

Aligned to the Primary Care Patient Safety Strategy, within 2024/25 Lincolnshire ICB has also participated in the Patient Safety Incident Response

Pilot for primary care led by the Health Innovation Network (HIN). Participation in the pilot focused on development of patient safety incident review tools for use in primary care and feedback on development of Patient Safety Incident Response Framework Training for primary care.

The ICB has continued to promote the nationally mandated Learning from Patient Safety Events System (LFPSE) to the healthcare providers across Lincolnshire. This included the development of a 7 minute briefing document for primary care on LFPSE and how to access an account. Work has continued within the ICB to establish mechanisms to review the patient safety incident data contained within LFPSE; the aim to triangulate the information with intelligence secured through other data sources across the ICB.

Martha's Rule – 2024/25

Martha's Rule is a major patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to.

The three components of Martha's Rule are:

- Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
- All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
- This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

Martha's Rule will help improve both the quality and safety of care for patients whose condition is worsening. Better identification and management of deterioration is one of NHS England's key priorities in improving patient safety.

2024/25 has been the initial roll out of this programme with a number of pilot sites (acute hospitals) including ULTH implementing Martha's Rule.

As the Martha's Rule programme gathers pace, future years will see this expanded to include other health care settings and specialities including



paediatric, neonatal, mental health (physical health) and community services.

The initiative will empower patients, families, carers, and staff to ensure that their concerns are listened to and acted upon. It will also empower staff to have the ability to raise concerns outside of official escalation channels, and to ask for additional support if it is required.

The ICB is an integral part of this important, large, and complex programme of patient safety work which has an anticipated completion date of 2029.

Primary Care

ICB Primary Care Quality Team

During April and May 2024, the ICB Nursing and Quality directorate restructured to best address current quality priorities and portfolios of work. This included the forming of four defined quality portfolios of work aligned to the ICB programmes of work. One of the four portfolios was dedicated to Primary Care Quality at system level thus removing the more locality based approach used in previous years.

This new way of working allowed the now dedicated Primary Care Quality team to re-set the quality assurance and oversight function by discontinuing the three locality based monthly quality meetings and moving to just one countywide monthly quality meeting for Primary Care. This meeting provides the escalation information through the Primary Care Commissioning Committee, System Quality and Patient Experience Committee and the System Quality Group.

The establishment of the primary care quality framework in 2024 gave the primary care quality team a defined process of support and escalation of any concerns with clear governance processes. This was used throughout 2024/25 to support GP practices including the use of the Rapid Quality Review (RQR) element with the support of the ICB Chief Nurse.

Quality Early Warning Score (QEWS)

The newly formed Primary Care Quality Team commenced with a programme of designing a clear, transparent, fair and robust process of quality assessment and support (initially for GP practices). This process developed into the Primary Care Quality Early Warning Score (QEWS). This process included looking at all six quality domains as defined by the National Quality Board (NQB) namely 'Safe, Effective, Well led, Positive experience, Sustainable and Equitable. QEWS is a set of quality metrics that fit within the six overarching quality domains and can be used to both recognise good quality achievements and where gaps are to highlight areas where quality improvements can be made. It also provides a useful repository for CQC related evidence as the quality requirements are similar in nature.

This comprehensive quality support process has been widely accepted across the ICB, the Lincolnshire

Local Medical Committee (LMC) and by GP practices alike. The LMC assisted with contributing to the overall process so that it gave practices the best opportunities for quality improvement.

The 'Safe' domain includes aspects of care including regular review of care plans and medications as well as infection prevention and control and incident management amongst other safety parameters. A practice is required to attain a pre-determined score in 'Safe' prior to being able to progress with the rest of the QEWS process and this control element means that any practice with safety concerns will be urgently prioritised for support from the ICB Primary Care Team.

Another important aspect of QEWS relates to the 'Positive patient experience' domain where information is gathered from various sources including Healthwatch, CQC, the ICB Complaints Team, Patient Participation Groups and National Patient Surveys etc. This is assessed and rated as part of the QEWS scoring process.

Once all six domains have been populated by the GP practice, a report is produced by the ICB Primary Care Quality Team, and a star rating is agreed with certificates presented to the GP practice team. The final report identifies areas where quality improvements can be made and the ICB Primary Care Quality Team works directly with the GP practice team to support with these recommendations. As these are completed the GP practice can demonstrate continuous quality improvement. This demonstrates that QEWS also operates a quality improvement cycle and will run continuously repeating every two years with a full reassessment.

The next phase in the development of QEWS is to produce a similar bespoke QEWS tool for pharmacies, optometrists and dentists so that all four pillars of primary care will be covered and offered support as needed.

Support to GP practices

Over the past year a number of practices have needed enhanced quality support from the ICB, Local Medical Committee and system partners. The requirements ranged from support with Care Quality Commission (CQC) action plans through to assisting with patient safety issues. The following practices received enhanced support in 2024/25:

Sutterton Practice – following an issue that highlighted several clinical records held incorrect information resulting in a rapid quality review and an extensive clinical safety review. This process was satisfactorily concluded in late 2024.

Gosberton Surgery – after a challenging CQC assessment in August 2024 which led to an improvement notice being issued, the ICB Primary Care Quality Team worked directly with the practice to rapidly progress and demonstrate improvements. The practice was re-assessed by the CQC in November 2024 and improvements were evidenced. At the time of writing the CQC report of the re-assessment is still to be published, however, the indications are that good progress had been made.

The Sidings Practice – In late 2023 the Sidings Medical Practice received a poor CQC assessment with an inadequate rating in both ‘safe’ and ‘well led’ domains giving them an overall inadequate rating. ICB teams have met regularly since with the senior leadership in Omnes Healthcare Ltd, who run the Sidings Medical Practice to ensure that improvement actions were being progressed. The practice was re-assessed by the CQC in early 2025 and the published outcome of that reassessment is awaited.

Caskgate Street Surgery had made improvements to their previous inadequate rating meaning when they were re-assessed in April 2024, they had improved to a ‘Good’ rating. This was a significant quality improvement journey and the practice team worked hard to ensure the required improvements were made.

Richmond Medical Practice received an overall ‘Requires Improvement’ rating from the CQC when assessed from October to December 2023, and has worked hard to continue to make the improvements required. The ICB Primary Care Quality Team continues its close working relationship with the practice team, and they are working through the QEWS process.

Pharmacies, Optometrists and Dentists (POD’s) quality plans

The ICB has taken on delegated responsibility for the wider Primary Care Services of Pharmacy, Optometry and Dentistry. From a quality perspective the ICB Primary Care Quality Team are working with the hosted East Midlands Primary Care Team and other East Midlands ICBs via a shared Quality Forum where quality for these services can be assured. In addition to this, the ICB Primary Care

Quality Team is developing the QEWS process so that each area will have a bespoke QEWS narrative that is relevant, fair and proportionate. This will be completed within the next financial year.

Development programmes for the primary care workforce

The Lincolnshire-wide General Practice Nurse Reference Group has continued to support programmes in the primary care medical setting. The Lincolnshire Training Hub has made good progress with its programmes including:

- The Career Start programme for nurses who are newly qualified or new to general practice.
- The Trainee Nurse Associate programme in general practice which is achieving favourable rates when compared to numbers within our local NHS Trusts.
- The Return to Practice Programme for general practice nurses.
- Planning an annual GPN conference and GPN awards.
- Supporting the process for allocating workforce development funding across practices based on a training needs analysis and commissioning well evaluated training programmes.
- Running a mentorship programme for those on Career Start, including Nurse Associates.
- Continuing to champion general practice as a place to work at universities, colleges and schools.

In terms of future ways of working and how the landscape will develop in the primary care arena, the development of the primary care workforce will see an increasing importance and relevance to increase its effectiveness as part of the integrated care model.

Maternity and Neonatal Services

The Lincolnshire maternity and neonatal services need to respond to each person’s unique health and social situation, with tailored support, so that care is safe and personal for all. Between October 2023 to February 2024 we spoke and engaged with over 150 families, over 50 organisations and multiple staff groups across Lincolnshire, reoccurring themes and trends were fed back to us through the engagement events.

In collaboration with all services supporting the pregnancy pathway, the Local Maternity and

Neonatal System (LMNS) have facilitated a multi-agency holistic approach based on the health needs and experience of pregnant women with an aim to reduce health inequalities. This has facilitated production of our new Equity and Equality Strategy for Maternity and Neonatal Services, and this defines how over the next 3 years, we aim to improve equity for pregnant women from at-risk groups, including black, Asian and minority ethnicity (BAME) and those living in the most deprived areas. Initially we are focussing on the largest groups experiencing the greatest inequalities and will focus on smaller geographic and population groups over time. This enables us to develop the pregnancy pathway to achieve outcomes, access and experience the same for all, and a working environment where all perinatal staff are treated equally.

Through embedding collaboration, and co-production in our approach we unlock benefits for our population, our people, and our system, and these will include:

- Pregnant women consistently achieve health outcomes that are as good as those who currently have the best outcomes.
- Babies and infants consistently receive the best possible start in life.
- Staff teams having consistently high levels of support to flourish and feel satisfied in their work.
- Staff and service users proactively involved in co-production – to ensure services are matched to population need.

Through embedding equity and equality along the maternity pathway the long-term system benefits will include improved health and quality of life, and ultimately reduced demand, and reduced cost to health and social care services by giving families the best start in life.

Overall the maternity and neonatal Services are on track with delivery of the national requirements:

- The Three Year. Delivery Plan for this service is showing progress in all four required themes including improvements now implemented in reference to the Pelvic Health Service, for which a Midwife Lead is now recruited. Further work has progressed to ensure the 'patient voice' is heard and a golden thread through improvements to services. Our Maternity and Neonatal Voice Partnership Lead is working in collaboration with the system to ensure there is effective support to true co-production, capturing a 'we said' 'you did' approach. Maternity triage is also being enhanced to align

with the nationally recommended Birmingham Symptom-specific Obstetric Triage System (BSOTS) model of care.

- Saving Babies Lives (SBL) remains in version three, the next iteration is still to be published. Compliance with this Quality Improvement and Assurance tool has been consistent in previous quarters, with regular and robust review of evidence to ensure transparency of any risks to compliance. We are currently assured with a total compliance of 96% across the 6 elements with the next report due in the coming months.
- Clinical Negligence Scheme for Trusts Year six compliance review has been completed with Trust being compliant on all but one of the 10 Safety Actions. The Trust have submitted non-compliance as instructed by RCOG and NHR with an evidence review pending that may alter compliance favourably, with hopefully agreement that due to high levels of assurance being submitted on all other areas that the mitigation and actions taken will suffice to agreeing to full reimbursement of funds associated with the scheme. This matter has been through all internal and ICB governance trails as part of escalation and Senior Responsible Officer (SRO) of the programme is fully sighted. CNST Year seven is due to be published by end of April 2025.
- Assurance Insight Visits were undertaken in September 2024 by LMNS ICB colleagues in collaboration with Trust colleagues at ULTH – the visits to both sites were a success and a final report submitted to NHSE Midlands Region for oversight of recommendations and celebrations. Due to continued progress regional input was not required on this round of visits.
- Midlands Heatmap Data which enables monthly oversight of triangulated data and is for the direct purpose of consolidating and sharing information within the regional footprint to




identify and support improvements in the safety and quality of maternity and neonatal care has been progressive. ULTH have gone from amber to green within six months and are currently the top performing Trust in the NHSE Midlands Region.

- A Digital Matron has been appointed and a new Maternity Information System 'Badgernet' has begun implementation at ULTH. Audit of this new system will commence following the first 6 months to ensure effectiveness.
- The new Infant Feeding Strategy led by LCC and supported by the LMNS has been commenced.

Children and Young People

The Children and Young People (CYP) programme is an integrated programme of work bringing together key partners in Children and Young People's health and wellbeing. The ICB works collaboratively with LCC, NHS provider Trusts, public health, primary care and the voluntary sector. The work of the programme is overseen by the CYP Integrated Transformation Board which is co-chaired by the ICB and LCC in partnership.

The CYP programme incorporates the NHSE CYP Transformation Programme alongside local priorities which have been informed by the intelligence we gather from the local population we serve, the communities they live in, our stakeholder partners and the staff who deliver the services. The programme continues to be driven by data and intelligence and population health management information has been used in our work for asthma, long Covid and palliative and end of life care for babies, children and young people. This ensures the work we are undertaking understands and addresses health inequalities in our CYP population in Lincolnshire and our capacity is directed at the right areas of focus.



The voice of children and young people is integral to the work we do, and we are looking at ways for us to further engage and co-produce with those that use our services.

We have seen the demand on children's healthcare services continue to increase, something that started rising sharply since the pandemic and is a reflection of national picture and not just a challenge in Lincolnshire. This has given the programme some

urgency as we recognise the huge potential impact on children and young people and families who are having to wait. Our priority areas include addressing waiting times for Speech and Language Therapy and for neurodiversity diagnosis.

Transition from children's services into adult's services is an integral part of consideration for all our projects. We know that when young people move into adulthood it can be a very challenging time for them and their families with services delivered in different ways. The CYP programme has set up a system wide transition network that has developed key principles for transition that will support addressing the issues of continuity and in some cases gaps in service. Whilst this sits within the CYP programme, often the biggest changes will need to happen within adult services due to differences in the way adult services are commissioned or delivered and as such we work closely across all work programmes within the ICB.

The CYP programme reflects the NHSE CYP priorities as set out in the CYP Core20Plus5 and transformation work which remains focused on delivering against the asthma, diabetes, epilepsy plans.

This year we have launched Asthma Friendly Schools guidance which all schools in Lincolnshire can use to support them in becoming an accredited Asthma Friendly School.

Elective recovery including an equitable recovery for CYP is reflected in our programmes to ensure we are sighted as an ICB on areas of elective recovery waits for CYP in Lincolnshire. An example this year of key partnership working was in a Super Saturday clinic for CYP who were waiting to be seen by a Dermatology specialist. Feedback received from our service users and their families was very positive and we had 100% attendance due to plenty of parking and the clinic being held on a weekend day.

Locally we have some very specific challenges of children and young people not attending for appointments, which are categorised as "Was Not Brought (WNB)". The ICB is leading on a focus group through our Health Inequalities programme. Partnership working with our providers using population health data to fully understand the reasons behind this and how we can improve our current position.

Lincolnshire hosted a Family Support Worker in Emergency Department ED pilot. Provided by Barnardo's and funded by NHSE. Learning from

the pilot has led to increased awareness and a training need for ED staff around the holistic needs surrounding CYP and a better understanding of community services who are well placed to offer further support. Locally we have high numbers of repeat attendees of 0-4's in ED. The ICB has a focus on CYP re attendees and a working group is being established to support this area of need.

Special Education Needs and Disabilities (SEND)

In the ICB, our vision for children with Special Educational Needs and Disabilities (SEND) is that they are supported, feel safe physically and emotionally, are included and accepted within their community and lead happy and fulfilled lives. We continue to be proud to place the individual care needs of children and young people at the very heart of what we do.

Lincolnshire reflects the national picture of exponential demand on services, with increasing numbers of requests for support. Despite a challenging national picture, we are proud of the commitment and dedication of our teams across the NHS to provide excellent care, and we celebrate our strong relationships and collaborative working with our partner organisations and families to improve the lives of young people with SEND in the county.

The Designated Clinical Officer (DCO) for Children and Young People (CYP) with SEND team ensures that the Integrated Care Board meets its statutory responsibilities. The post is hosted by the ICB and supported by the Chief Nurse, Executive Lead for CYP and SEND, NHS Lincolnshire ICB. The DCO and Associate Designated Clinical Officer (ADCO) for SEND in Lincolnshire have achieved several key actions in 2024/25 this activity supports the continued areas of work that focus on the delivery of the ICB's statutory duties described in the SEND Legislation (SEND Code of Practice 2015) which states that the DCO team must:

- Work with the local authority to contribute to the Local Offer. This is a directory of services available online and designed to support CYP, families and professionals navigate the SEND landscape.
- Commission services jointly for CYP (up to age 25) with SEND, including those with Education Health and Care Plans (EHCPs).
- Have mechanisms in place to ensure practitioners and clinicians will support the integrated EHC needs assessment process and tribunal process.

Non-Statutory activity update includes:

- Continued Development of Clinicians SEND Education Programme.
- Development of the online Sensory, Processing Difficulties Programme and now with additional workshops on Demand Avoidance and Neurodiversity and Burnout.
- Co-development of the Special Schools Programme Health Strategy Proposal and supporting the implementation of Clinical Interventions in educational settings programme.
- Lincolnshire Young Voices is a group of young people with Special Educational Needs and/or Disability who are Experts by Experience. This group, co led by the DCO for SEND and SEND Programme Manager in the Local Authority, has been developed for CYP with SEND to share their voice and is part of the widening participation strategy. This year saw LYVs delivering a series of Anti-bullying workshops and compiling a report around Transport services for CYP with SEND which is effecting change across the system.
- Maturity Matrix and ICB Readiness - Throughout the period 2024 - 2025, the DCO team has submitted or been interviewed around a series of eight comprehensive self-assessment tools for the Integrated Care System's transition from CCG with a particular focus on governance and infrastructure around SEND. As an ICB, the Lincolnshire system was rated as 'Green' and as such we are only one of two systems in the East and West Midlands to do so.

The DCO team have supported the development of the Lincolnshire Integrated dashboard for SEND in collaboration NHS and Local Authority partners which is a public facing SEND performance data dashboard and we have successfully implemented the LICB SEND Quality Assurance Framework.

Finally, we have recently supported the Joint CQC/Ofsted Inspection of SEND Provision in Lincolnshire.

Safeguarding

ICBs have a statutory responsibility, set out in primary legislation and statutory guidance, to safeguard adults, children, young people, and Looked After Children. NHS Lincolnshire ICB is committed to promoting the safety of all at risk of abuse or neglect, employing a safeguarding team which comprises of specialist safeguarding practitioners and designated professionals, including medical, nursing, and administrative staff to support this function. The team works proactively to support

and respond to local, regional, and national safeguarding priorities, disseminating learning and considering the implications of the ever-evolving safeguarding landscape on the Lincolnshire system.

Safeguarding is a collective responsibility, whilst individuals and organisations have distinct roles, the system cannot operate effectively unless individuals and organisations work together. Oversight of local partnership safeguarding arrangements is provided by the Lincolnshire Safeguarding Adults Board (LSAB), the Safer Lincolnshire Partnership (SLP), the Lincolnshire Domestic Abuse Partnership (LDAP), and the Lincolnshire Safeguarding Children Partnership (LSCP). NHS Lincolnshire ICB is represented at all levels of work within these, providing leadership for safeguarding through attendance to the strategic boards, and sharing specialist knowledge and expertise through the active participation of the ICB safeguarding team in sub-groups, audit processes, statutory reviews (Child Safeguarding Practice Reviews, Serious Adult Reviews and Domestic Abuse Related Death Reviews (previously called Domestic Homicide Reviews)), and specific task and finish groups.

The ICB Safeguarding Team has continued to engage positively with the GP practices across Lincolnshire to further enhance safeguarding knowledge and skills. The team has established strong and productive working relationships with primary care colleagues, through the provision of level three safeguarding training, facilitation of GP forums, the production of a bi-monthly safeguarding newsletter and the recent development of safeguarding webinars, which the team continues to add to. The newsletter enables current safeguarding information to be shared, and the forums provide an opportunity for peer supervision and professional challenge. The team also works directly with practices, such as offering advice and support on individual cases or submissions for statutory reviews.

In 2024/25 partners have continued to work proactively towards safeguarding priorities. Examples of work relevant to Lincolnshire are provided below, this list is not exhaustive but evidences the broad spectrum of work undertaken to protect children and young people at risk of harm and abuse

In 2022 the LSCP reviewed Lincolnshire processes against the recommendations made in the national reports published into the murders of Arthur Labinjo-Hughes and Star Hobson. It identified that health was not always appropriately represented at strategy discussions, the purpose of which is to determine a child's welfare and plan rapid future

action if there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm (Working Together 2023 <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>). The health safeguarding system worked closely to identify how best to address this to improve the sharing of health information to better support risk assessment and decision making. A business case was developed to reflect the preferred model of implementation, which involves recruitment of additional staff to NHS health agency's safeguarding teams, which was agreed in September 2024.

Recruitment to these positions commenced, and continues, but the ICB successfully recruited and started attending as a health representative to strategy discussions in January 2025.

The ICB's safeguarding team continues to lead on the implementation and promotion of ICON across Lincolnshire, working closely with health and wider partners to promote the initiative. ICON is an evidence-based programme aimed at preventing abusive head trauma in babies and stands for I – Infant crying is normal; C – Comforting methods can help; O – It is OK to walk away; N – Never, ever shake a baby. In 2024/ 25 to raise awareness of ICON the team commissioned an eight-week media promotion programme via local radio stations, supported ICON Awareness Week (September 2024) which included the lighting up of local landmarks, such as Boston Stump, and working in collaboration with Lincolnshire Police to produce a video <https://vimeo.com/1014711567>

Research provides extensive evidence of the poorer health outcomes experienced by Looked After Children and Care Leavers when compared to their non-care experienced peers. NHS Lincolnshire ICB continues to work with partners to support and improve services for this cohort of vulnerable children and young people. In August 2023, ICB funding of prepayment prescription certificates for Care Leavers aged 18 – 25 years, an initiative progressed by the safeguarding team, was rolled-out. This initiative continues, with the safeguarding team managing requests and continuing to work with wider agencies to promote the scheme.

In 2023 Lincolnshire County Council was chosen by the government to be a wave one Local Authority Families First for Children (FFC) Pathfinder site, which are part of the government's Children's Social Care implementation strategy, Stable Homes, Built on Love. There are four key reform strands to the Pathfinder that are being delivered as a whole system transformation: overarching system level reform, including multi-agency safeguarding

arrangements; family help; child protection; and family networks. The ICB safeguarding team has been, and will continue to be, actively involved in the progression of the Pathfinder work, from the initial co-design to implementation and evaluation phases. This is an exciting opportunity for Lincolnshire as learning from the county will support national decision-making and changes to practice.

Working Together to Safeguarding Children (2023) sets out how the three safeguarding partners will work together with other agencies to safeguard and promote the welfare of children. As one of these safeguarding partners, NHS Lincolnshire ICB works in partnership with the police and the Local Authority to co-ordinate their safeguarding services: acting as a strategic leadership group in supporting and engaging others and implementing local and national learning including from serious child safeguarding incidents.

To demonstrate how the NHS has performed against this duty, and to see the LSCP priorities, please see link below to LSCP Interim Annual Report 2023-2024, LSCP Constitution 2025 and the LSCP Business Plan 2022 – 2025 (<https://www.proceduresonline.com/trixcms2/lincolnshirescp/local-resources/>).

Local Resources

Section 11 of the Children Act (2004) places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

The LSCP undertakes an audit every three years across all partner agencies to gain assurance that this duty is being met. Section 11 was completed in 2024 and NHS Lincolnshire ICB passed with 100% of the criteria being rated as green evidencing ICB compliance with the required functions as set out in Working Together to Safeguard Children 2023.

The Safeguarding Accountability and Assurance Framework (SAAF) (updated July 2024) [NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework](#). identifies core duties across the lifespan of safeguarding for individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

Responsibilities for safeguarding form part of the statutory functions for each organisation and its executive board must ensure effective discharge of this. The ICB has contractual requirements and assurance processes for safeguarding with all its

providers, the safeguarding team are continually looking at ways to improve the quality of assurance methods to support providers, reduce replication and ensure the focus is on positive outcomes for patients and communities.

NHS Lincolnshire ICB's Annual Safeguarding Report ([Documents Library - Lincolnshire ICB](#)) explains how the ICB follows the assurance processes set out in the SAAF. The ICB can confirm compliance to the statutory functions and assurance processes set out in the SAAF- legislation and mandatory reporting, duties, roles and responsibilities of staff, and commissioning and assurance of NHS services.

All Age Continuing Care

The ICB has continued to maintain a good performance within All-age Continuing Care. Most eligibility decisions for Continuing Health Care (CHC) have been made within 28 days, with those falling outside of the 28 days not exceeding 12 weeks. Children's and Young People's Continuing Care has worked collaboratively with Social Care and Education partners to ensure children and young people are assessed for continuing care eligibility and a decision made within 12 weeks from referral.

There is also robust processes in place for Discharge to Assess for patients requiring CHC on hospital discharge, with the CHC being part of the discharge hub ensuring any CHC service blocks are addressed for patients.



There have been continued workforce challenges in the team due to illness and vacancies, which has required the team to build on last year's restructure and work differently. An ongoing consequence of this has been a backlog position with annual reviews including those referred into the service on Fast Track Funding. To address this there has been utilisation of an external provider to address priority reviews and thereby ensure for the CHC team an acceptable trajectory for clearance of any outstanding reviews and workload.

The team has also undergone a deep dive into Fast Track referrals with the consequence being a review of the training offer and improved screening of fast track referrals which has improved Fast Track referrals ensuring people are referred at the right time in their health journey.

In order to avoid the need to spot purchase care placements for individuals, the ICB Continuing Healthcare Team has in preference to this a contractual arrangement with particular domiciliary and care home providers. This contractual process ensures the ICB can ensure care providers have good quality standards both through the application process to be on this contract and through ongoing quality monitoring. In 24/25 the contract for our care home providers was re-procured by the ICB aided by our aligned Clinical Support Unit (CSU). This re-procurement took several months as it involved engagement events with the providers and stakeholders, service specification improvement and revision before the necessary weeks of the actual procurement exercise. We were pleased that once again many individual care home providers

applied for this contractual arrangement, which will be in place from April 25 for several years and will ensure they are our preferred providers, as they continue to meet the defined specification, which guarantees quality care provision for our residents when this care is needed. The work of our ICB Continuing Healthcare Team, ICB Finance and Contracting colleagues and colleagues involved from Arden Gem CSU to progress this re-procurement is gratefully acknowledged here, as to is the support provided by our County Council, Lincolnshire Care Association and the providers themselves.

Care Homes

Through the Better Care in Care Homes Programme the ICB continues to work with relevant system partners to ensure a network of support is available for care homes and domiciliary care providers supporting the delivery of the programme workplan. The Care Home and Home Care Quality Forum which meets bimonthly continues to provide the opportunity for health and care colleagues to share any concerns and initiatives relating to care homes and home care.

The Whzan Blue Box enables care homes to share digitally with their primary care clinical team key information to support ongoing management of long-term conditions and shorter interventions such as medication changes. Over 60 care homes are actively using the kit with usage doubling in the last 12 months due to active support.

An inventory of lifting equipment held and used in care homes for falls was undertaken in June 2024. The Raizer chair is the most common form of lifting equipment reflecting the distribution of 80 chairs for care homes previously. Other lifting equipment used by care homes include lifting cushion, slings, hoists and stand aids. Many care home staff are fully trained in using the equipment they have. The Care Home Information Pack includes guidance on falls response and which service to contact and when.

A Better Care in Care Homes workshop took place in February 2025, which focused on falls which provided an opportunity to identify areas of improvement around reducing the risk of falls and the response in care homes. Further workshops will take place during the next year which will focus on key priorities such as the Clinical Assessment Service for Care Homes, RESPECT and prescribing.



Working with People and Communities

This section provides a brief overview of our involvement activities – for full details and evidence of our adherence to the statutory Duty to Involve, please read this alongside our Lincolnshire ICB's People and Communities Involvement Annual Report 2024/25 which is on our website (<https://lincolnshire.icb.nhs.uk/documents/annual-reports-and-accounts/people-and-communities-involvement-reports/>).

All of our involvement work is underpinned by our 10 principles in the Lincolnshire ICB People and Communities Strategy.

Our Commitment

The ICB is fully dedicated to involving patients, the public, partners, and key stakeholders in the development of services, ensuring they are at the heart of everything we do. We recognise that working in partnership is essential for empowering patients to have more choice and control over their health. Through these collaborations, we gain a better understanding of the health needs of our population, leading to improved health outcomes. The Health and Care Act 2022 has encouraged partners within Integrated Care Systems (ICSs) to unite and work towards enhancing both physical and mental health outcomes, with a focus on the needs, experiences, and aspirations of the people and communities they serve. It also tasked the Lincolnshire Integrated Care Partnership (ICP) with developing an Integrated Care Strategy aimed

at helping the people of Lincolnshire achieve the highest quality of health and wellbeing for themselves, their families, and their communities. As part of the ICP, we are committed to working together to reach this goal. Community engagement and involvement are key priorities within the strategy, reflecting our commitment to finding new ways to engage and collaborate with our residents, communities, and their representative groups. We aim to ensure they have a strong voice, the independence to make decisions and solve problems, and the opportunity to thrive. We will continue to enhance our approach to engagement and involvement, making it easier for people to share their views and ensuring that what we do has the support of our communities and addresses a wide range of needs.

Legal Duty for Involvement

As specified in section 14Z45 of the Health and Care Act 2022, the ICB has fulfilled its public involvement responsibilities by ensuring there are provisions for engaging the public in the planning of commissioned services and the development and consideration of proposals for changes to commissioning arrangements that may affect service delivery. By listening to the local community and working alongside their representatives, we can enhance the decisions we make and ensure that we are considering the health needs of residents in Lincolnshire. The ICB is committed to ongoing improvement in how we involve our communities



and values the feedback we receive. It is crucial to us that the public sees the impact of their input in shaping local services and understands how much we appreciate all feedback and engagement. Our approach is guided by the values outlined in our Constitution and the principles set out in our People and Communities Strategy, which detail how we will collaborate with people, communities, and our partner organisations, as well as patient representatives, to continuously strengthen this work.

Governance and Assurance Information

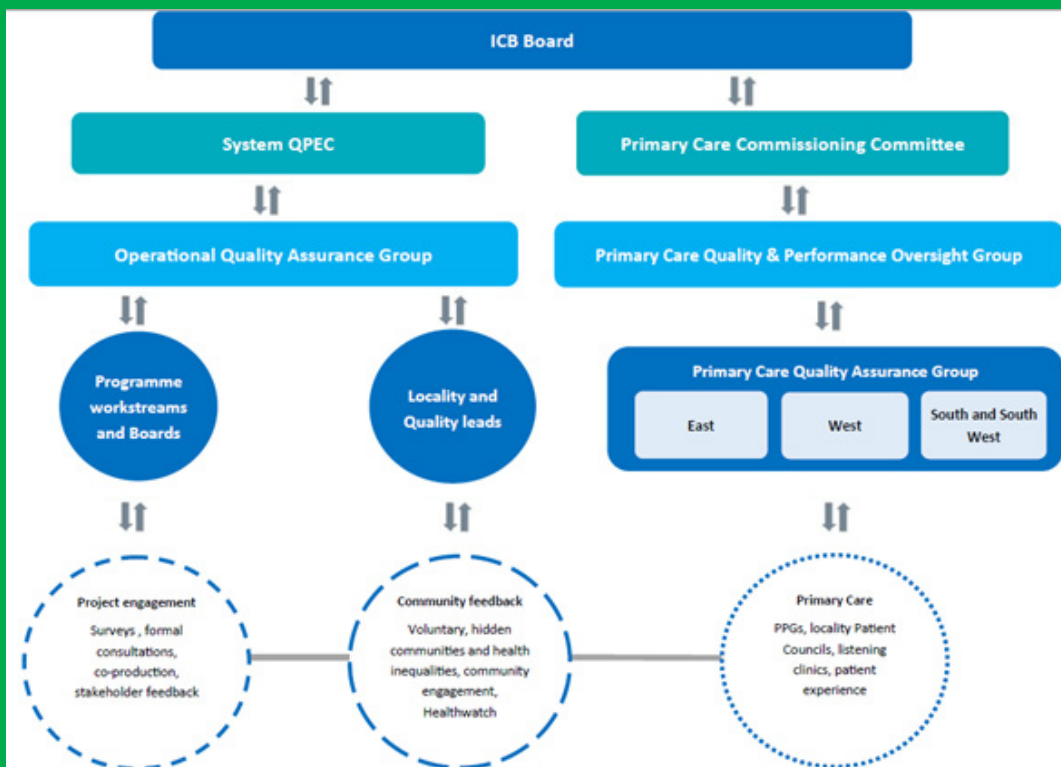
Timely and meaningful involvement is a priority for us, and a strong framework, with clear structures and assurance processes, plays a key role in making sure that patients and communities are central to our decision-making.

- Our ICB Constitution clearly states our guiding principles about public involvement and is available to view on our website.
- Our involvement function is part of the ICB's Strategic Planning, Integration and Partnerships team, ensuring patients and our communities are at the heart of service development, improvement, and transformation. Strong links are maintained with the ICB Nursing and Quality Team to align patient experience and involvement with quality and safety.
- Full analysis and reports of our involvement activities including any differences in equality or health inequality group are shared with project and programme leads to help inform,

shape and steer their programmes of work so those changing and improving services are hearing feedback from people and communities directly.

- Details of our involvement and outcomes of this are reported to the ICB Operational Quality Assurance Group Meeting with escalation as required to the System Quality Committee or to our Primary Care Commissioning Committee (PCCC) if it is regarding a primary care service.
- In 2024/25 we have developed the Lincolnshire Voices report, presented to the System Quality and Patient Experience Committee. This aims to bring all insight and engagement feedback from across the ICB and provider Trusts as well as Healthwatch and partner organisations into one place, reported consistently and triangulated to identify key areas of focus for the Committee to consider. This continues to improve and will include a review of all complaints and patient experience feedback to provide a holistic view of what we are hearing in Lincolnshire.
- Our System Quality and Patient Experience Committee also review our People and Communities Involvement Annual Report and monitor our delivery plan for our People and Communities Strategy.
- Feedback from our engagements and consultations is also reported into our Board meetings to inform decision making on large projects.

The ICB's Continuous Listening Model demonstrates how all feedback is reported into the governance structures and evidences the difference it makes.



ICB Working with People and Communities Strategy in practice

Our strategy outlines our commitment to involving people and communities across Lincolnshire, emphasising the diverse ways we involve individuals, groups, and communities. We will ensure that our methods and approaches are inclusive and tailored to meet the needs of all of Lincolnshire's population and stakeholders, enabling everyone to have their say. To achieve this, it is essential that we identify and understand who our stakeholders are and determine the most effective ways to communicate and engage with them on an individual basis. This is further supported by conducting Equality and Health Inequality Impact Assessments, ensuring that all voices within our community have the opportunity to be heard.

The ICB has adopted the ten principles outlined by NHS England in the ICS design framework. These principles, developed through collaboration with systems nationwide, will form a cohesive foundation across the ICS when implemented effectively, whether involvement takes place at the neighbourhood, place, or county-wide level. By delivering these principles, we will demonstrate our commitment to the constitution. Our comprehensive Lincolnshire ICB People and Communities Involvement Annual Report 2024-25 details the progress we have made in achieving these principles.

Our System Quality and Patient Experience Committee (SQPEC) were overwhelmingly supportive of the strategy and agreed for an annual delivery plan of involvement and engagement to be presented and agreed by SQPEC as part of the operational planning process as well as receiving regular reporting of feedback and outcomes.

Using insight and data to inform our work

We acknowledge the diversity within our communities, recognising differences in health needs, access to services (both digital and in-person), and the preferred methods of engagement. All of our commissioning and involvement activities are grounded in a thorough understanding of our population, service users, their experiences, and the people who support them. We leverage the knowledge, relationships, networks, and strong connections that our partner organisations have with local communities to ensure a comprehensive, system-wide approach to involvement. By utilising

established and proven engagement opportunities, we aim to identify the most suitable partner with the strongest relationships to lead these conversations. Collaborating with our partners strengthens our collective messaging and involvement efforts. In addition to coordinating care, we are aligning our engagement and experience initiatives to enhance the patient journey and empower collaborative system working.

We support our programme teams in fostering these connections and ensure that Equality Impact Assessments, Quality Impact Assessments, and Health Inequality Impact Assessments (HEAT) are conducted to fully understand the people and communities who may be affected by any changes. The insights and diverse perspectives of these communities are vital for enabling Lincolnshire ICB to address health inequalities and other challenges faced by health and care systems.

Our Insight Database consolidates findings from involvement activities across the NHS and partner organisations, creating a strong foundation of intelligence and experiences that inform work programmes, involvement planning, and decision-making. We are continually exploring the most effective ways to maximise this valuable feedback and are currently evaluating options in collaboration with key stakeholders, including the Lincolnshire Voluntary Engagement Team (LVET - a network of voluntary, community, faith-based, and social enterprise organisations across Lincolnshire), the University of Lincoln, District and County Councils, our Research Hub, and others. Together, we are working to share feedback and insights on a unified platform.

How we reach diverse, potentially excluded and disadvantaged groups

Our ICB Involvement Team has embedded a dedicated team member to focus on addressing health inequalities, implementing consistent best practices, and empowering the people and communities of Lincolnshire to engage in every aspect of our work. This approach, placing people and communities at the center of tackling health

inequalities, will be replicated across all priorities and programmes. We have also reviewed and updated our survey questions on equality and health inequalities to ensure we understand who is engaging with us, allowing us to proactively reach out to those who are not yet involved.

To support digital engagement, we are expanding our database of over 11,000 individuals, groups, and communities, enabling us to reach out directly and invite them to participate in our work. This helps us target all demographics, including those less likely to get involved, such as people with caring responsibilities, those in full-time employment, residents of rural areas, and individuals experiencing health inequalities or living in specific geographic regions.

Equally important is our effort to reach those who cannot or do not wish to engage digitally. We ensure that we meet people where they are by attending local events and community gatherings such as fun days, college fresher fairs, and local networking events. This enables us to reach a broad audience, including potentially hidden communities. We also host events in specific areas to proactively engage with communities facing inequalities and provide incentives to encourage their participation, maximising involvement. At these events, we distribute various materials, both in-person and via social media, to highlight the different ways people can get involved with the ICB or our partners. These materials are also translated into key languages when necessary.

Our ICB Health Inequalities Team has also developed a Digital Inclusion Strategy which aims to improve digital inclusion – improving access, experience and outcomes for people in Lincolnshire is essential to closing the health inequality gap. Whilst access to digital services is now the 'norm', there are still many high risks groups that are digitally excluded. The Digital Inclusion Strategy for Lincolnshire has been co-produced with system wide organisations and patient representatives. The Strategy builds on work undertaken by organisations across the Lincolnshire Health and Care system towards a digitally inclusive community and aims to address the digital divide between those who have full access, the confidence and skills to utilise digital services and those who do not. The Lincolnshire Integrated Care System is committed to deliver the vision 'To ensure everyone in Lincolnshire has the opportunity to be digitally connected and confident ensuring no one is left behind' where every resident has equitable access to digital resources

enabling everyone who chooses to participate fully in their health and care. We are undertaking ongoing engagement with our digitally excluded communities to ensure this strategy delivers the solutions they need to support implementation and delivery.

We also recognise the importance of other programmes in engaging communities and are working alongside LVET (Lincolnshire Voluntary Engagement Team) to promote diversity in research participation, as well as collaborating with our Primary Care Network Alliance to increase public engagement in primary care. We tap into the knowledge, relationships, networks, and strong ties that our partner organisations have with local communities to ensure a holistic, system-wide approach to involvement and enable broadening of our reach. By utilising established and effective engagement opportunities, we strive to identify the best partner with the strongest connections to lead these conversations. Working together with our partners strengthens our collective messaging and involvement efforts and reaches groups we may not have an existing relationship with.

How we work with partner organisations

Lincolnshire has a long-standing history of collaboration between the Local Authority, the NHS, and a wide range of partners. We have put significant effort into building the relationships necessary to help the people of Lincolnshire achieve the highest quality of health and wellbeing for themselves, their families, and their communities. The ICB recognises the importance of working alongside our partners to foster a collaborative approach in involving our communities and benefiting from the established, trusted relationships they have with the people of Lincolnshire. By working together, we are able to reach diverse groups in various ways and have meaningful conversations with them through trusted individuals. Our strong partnerships with voluntary, community, and social enterprise organisations also allow us to commission them to carry out certain tasks on behalf of the ICB.

- The ICB is committed to delivering engagement at all levels from working with community leaders at a neighbourhood level or through partnership working such as Lincolnshire's Integrated Care Partnership - Better Lives Lincolnshire.

- Healthwatch are key partners and will act as a critical friend, as well as representing an independent view of the patient and public voice. Healthwatch are an integral member of Lincolnshire's ICB Board and ICP Board as well as sit on various committees.
- A representative of the voluntary and community Sector is also an integral member of Lincolnshire's ICB Board, an associate member on the ICP Board as well as sitting on various committees.
- Public Health and Local Authority representatives sit alongside representatives at every ICB Board formally.
- Our provider and primary care colleagues are part of our extended team and therefore are integral to the development and delivery of our shared strategic priorities.
- Our day-to-day processes and systems have been established to work across involvement and participation teams within the ICB and NHS provider Trusts across Lincolnshire. Joint working enables us to collaborate and reduce duplication, leveraging the links we all have with their patient groups and memberships while supporting each other.
- We have established a Lincolnshire Engagement Leads Steering Group with representatives from our district and county councils, LVET (Lincolnshire Voluntary Engagement Team), Healthwatch, University of Lincoln, Research Hub, Personalisation and Health Inequalities Teams. This group meets monthly to scope joint working opportunities, reduce duplication, share best practice, support each other's engagement and involvement projects and identify opportunities for collaboration such as development of a master stakeholder analysis tool and process flowchart.
- We will engage with our Health Overview and Scrutiny Committee on potential service changes, enabling them to consider whether it is a substantial and significant service change requiring consultation process. We will work to assure them that healthcare is planned and delivered in ways that reflect needs and aspirations of local communities, plans for substantial service changes are reasonable and that everyone has equal access to services.

At a local level, we continue to strengthen our relationships with community groups and support organisations to help us connect with individuals and communities. We collaborate closely with groups and venues offering warm spaces, foodbanks, and services to local residents, as well as working with individuals such as Islamic leaders, social prescribers, and community connectors. These partners bring valuable experience and established

links to people we might not otherwise be able to reach. Our work with both local and countywide partners is further detailed in the Lincolnshire ICB People and Communities Involvement Annual Report 2024/25.

Seeing the impact of participation

It is crucial that our extensive involvement efforts are both meaningful and impactful, ensuring the public can see that their contributions are making a tangible difference. Here are some examples of our involvement activities from the past year:

- Delivery of local engagement across Lincolnshire to feed into the development of the National 10 Year Plan.
- A robust process of surveys, interviews, and co-production with women of all ages including young people at school to inform development of our Women's Health Hubs in Lincolnshire.
- Attendance at various events, community groups and meetings alongside surveys gathering feedback to inform the development of the NHS Lincolnshire GP Strategy.
- Support to the MMR vaccination uptake project, engaging with Gypsy, Roma, and Traveller (GRT) community due to their lower vaccine uptake. Partnering with Lincolnshire Travellers' Initiative, a charity working with the GRT community, our engagement supported promotion of opportunities and understanding barriers and opportunities.
- Targeted engagement and community conversations in Stamford alongside a review of existing insight and feedback to review and evaluate the long-term shape of health services in Stamford and the surrounding areas in light of the significant projected population growth.
- Engagement with our staff, people and communities to help shape Lincolnshire's Equality, Diversity and Inclusion Strategy, ensuring that we are focusing on the right priorities and making a difference for our staff and communities.
- Working in collaboration with other ICBs in the region to develop one collaborative Fertility Policy across the East Midlands.
- Delivery of engagement via surveys, local events and co-production activities to understand how we can support people in Lincolnshire to live well for longer as part of our Older People's Strategy.
- Focused engagement with our people, communities and staff to understand transgender and non-binary views and experiences to help shape the Gender Identity Framework which will

set out the expected standards for gender non-conforming people when accessing services and receiving care.

- Ongoing work with our Palliative and End of Life co-production group to co-design content and format of the PEOL website, bereavement survey and strategy implementation.
- Support to the Living with Cancer Programme to understand experiences from people diagnosed with prostate cancer and their family and carers, to review the prostate cancer pathway and help us to make the right improvements to the service to ensure people in Lincolnshire receive the best possible advice, care, and treatment for prostate cancer.
- Continued engagement in the pressure ulcers and tissue viability services programme to improve the quality of services, standardisation and communications campaign informed by staff and public surveys as well as our co-production group.
- Ongoing engagement with our Patient Participation Groups within GP practices through series of locality and countywide patient council meetings.

How we enable and support those who want to get involved

The ICB offers various opportunities to encourage involvement, and our teams, embedded within the ICB and ICS, are supported by a robust network of individuals and community groups who initiate and contribute to our work. NHS Provider Organisations support Patient Panels and Patient Experts, who regularly influence and help shape service developments across the system. Additionally, many of our programmes are incorporating co-production groups, bringing together individuals with lived experience to ensure patients remain at the heart of the services we provide.

At the local level, we are focused on further strengthening our relationships with community groups and support organisations to better connect with individuals and communities. We work closely with groups and venues that provide warm spaces, foodbanks, and other essential services to local residents, and also collaborate with individuals such as Islamic leaders, social prescribers, and community connectors. These partners offer valuable experience and established connections, helping us reach people we might not

otherwise be able to engage with. Our dedicated engagement lead who is embedded within the Health Inequalities Team continues to build and strengthen relationships with key communities to build trust and involvement.

We effectively promote opportunities to learn more about our work, participate in other engagement programmes, and join specific co-production groups through our surveys and community outreach.

All opportunities are shared on our social media channels and website, as well as distributed through our Involvement Bulletin. The bulletin was created to reduce engagement fatigue by consolidating information in one place, which is then sent out bi-weekly to our stakeholder and patient group database. It has grown significantly, becoming widely distributed, increasing participation in ICB engagement, and sharing information and involvement opportunities from our provider Trusts and other partner and community organisations such as Healthwatch and EveryOne, a Lincolnshire based charity who develop and deliver a range of person-centred projects.

Our involvement activities are also supported by robust social media promotion and the development of the Nextdoor platform, which serves as a key tool for sharing events and engagement opportunities. Additionally, we have produced specially designed leaflets and pull-up banners with our email address and QR codes to offer further opportunities for people to sign up and get involved in the ICB at all the events we attend.



Social Media and engaging with the local population

Digital engagement with our local communities

The ICB strongly supports the use of social media as a positive communication channel, to provide members of the public, partners and other stakeholders with information about what we do and the services we commission.

We use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders; giving them a chance to participate and influence decision making. Social media is a fantastic opportunity for us to listen and have conversations with a wide and diverse range of people, especially with hard to reach groups. It not only allows us to make announcements, e.g. health news, service information, upcoming events, it allows people to respond to whatever we post and encourage two-way conversation and feedback to improve the ongoing development of our services and to inform, engage, educate and inspire our local communities.

One of our key communication tools, which is often a first port of call for the public, is the ICB website. We are continually reviewing and developing our online presence to ensure that people can easily access information about the ICB, our system partners and programmes, latest news, events, engagement opportunities and the services available to them.

Between the 1st April 2024 and 31st March 2025 we had 126K users/visitors and 665K page views on our website. The most popular entrance to our site was via our homepage and our most popular pages were those with information about our vaccination programme in Lincolnshire 'Grab a Jab Lincolnshire'. The ICB social media channels saw an increase in reach, engagement, and new followers in this period. Our posts reached over 1.8M users with an engagement rate of 3.28%. The ICB gained 1,836 new followers across our social platforms.

By using organic and paid promotions, the ICB's channels have seen a significant increase in reach, impressions and engagements such as shares, likes, link clicks, and inbound messages and comments from followers and members of local communities. Our most engaging social media posts are those that are people - centred, stories and spotlights on our amazing teams working together to improve Lincolnshire's health and wellbeing. As part of our ongoing social media strategy, we will work on more people-centred content and grow our audience with the help of key stakeholders and influencers.

We are now working as a system across our local NHS, working better together in Lincolnshire to inform, engage and involve our local community.

Our ICB Involvement Team fully advocates for using social media as a positive platform to share upcoming events and engagement opportunities, ensuring everyone has the chance to have their say, while also recognising that not all people living within our communities will have access, or would prefer not to use social media, so the team also works hard ensuring that we also offer other opportunities such as visiting local communities and support groups.

The Involvement Team have successfully continued to use Facebook and Nextdoor platforms throughout 2024 to reach our people and communities.

On NextDoor, we promoted 29 engagement activities and campaigns reaching a total of 128,756 members across 98 posts with a total of 1,101,134 impressions. Our "top post" was our GP strategy engagement with 30,104 impressions.

Improving Health, Reducing Health Inequalities and Prevention

Reducing Health Inequalities (HI)

The Lincolnshire Integrated Care Board (ICB) has a legal duty under Section 14Z35 of the Health and Care Act (2022) to reduce inequalities between persons with respect to their ability to access health services; and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The Act also places duties on the ICB to:

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

The ICB is also required to collect, analyse and publish information relating to health inequalities in line with NHS England's Statement on Information on Health Inequalities. [See LICB's Statement of Information on Health Inequalities.](#)

To do this effectively, the ICB works with its partner organisations to reduce health inequalities and embeds this requirement into its commissioning strategies and policies. Lincolnshire is deeply engaged in addressing health inequalities, through the local authority, NHS trusts and wider sector partners already being represented on both the Integrated Care Board (ICB) Board and the Integrated Care Partnership (ICP), with inequalities prominently identified as one of the key challenges for the health and care system and the population. We have a shared Joint Health and Wellbeing Strategy in place informed by Lincolnshire Joint Strategic Needs assessment (JSNA) and Global Burden of Disease. Our ambition for the Better Lives Lincolnshire, by 2030 is 'for the people of Lincolnshire to have the best possible start in life, and be supported to live, age and die well'. Our System Joint Forward Plan recognises the role prevention can play in reducing health inequalities and increasing health equity.

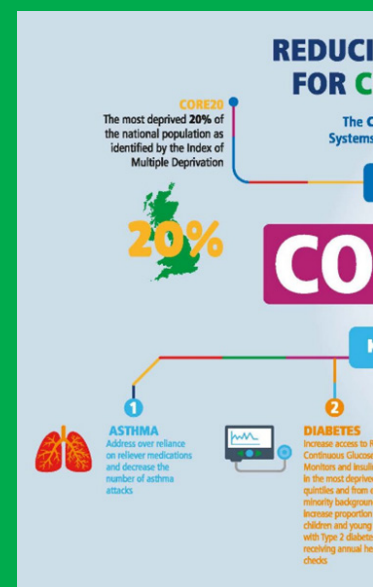
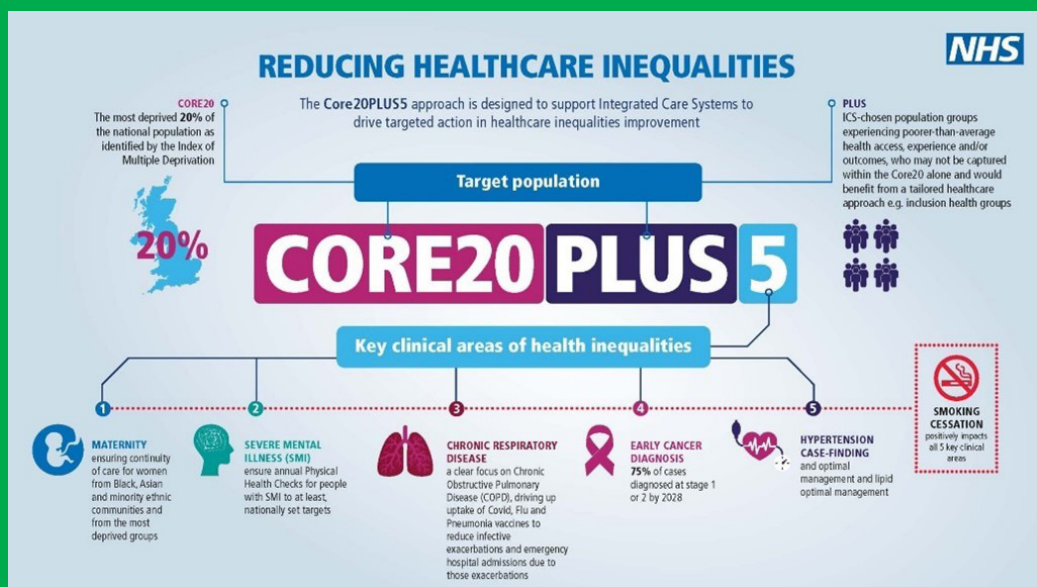
During 2024/25, the ICB has achieved this in five ways:

- Strengthening the governance around prevention and health inequalities.
- Improving data and insight to understand health inequalities.
- Strengthening Population Health Management approaches.
- Adopting the Core20PLUS5, the national NHS England approach to inform action to address healthcare inequalities at system level for both adults and children.
- Using the health inequalities funding to address specific identified inequalities.

National

Nationally, NHS England has outlined an approach to support the reduction of health inequalities at both national and system level. Providing exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. The approach described below – 'CORE20PLUS5' defines a target population cohort and identifies '5' focus clinical areas for accelerated improvement. This approach has been embedded within our Health Inequalities and Prevention Programme.



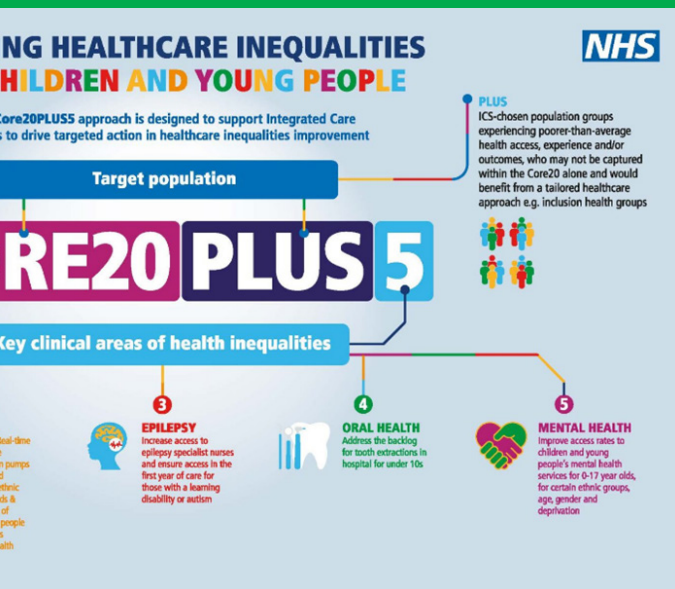


Within Lincolnshire our 'CORE20PLUS5' are:

- The 20% most deprived communities as identified by the Index of Multiple Deprivation (IMD) – just over 121,000 patients (14.8% of Lincolnshire patients).
- Plus – People from ethnic minority backgrounds (approximately 159,000 patients, 19.4% of Lincolnshire patients), with the largest ethnic minority group being “Other Ethnicity” (8.4%) - with ‘Other’ being any ethnicity other than Asian, Black, Mixed, or White background.
- ICS locally determined population groups (evidence and insight based) experiencing poorer-than-average health access, experience, and/or outcomes who may not be captured within the CORE20 alone and would benefit from a tailored health care approach.
- Adult key groups identified for Lincolnshire include Gypsy, Roma and Traveller groups, people experiencing homelessness, rural and coastal communities, farming, military families and carers.
- For children and young people this also includes children in care, care leavers, those in the justice system, those not in education, children with special educational needs and disabilities.
- Adults and children and young people with mental health conditions, learning disabilities and autism are also more likely to experience health inequalities.

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

- Priority 1: Restore NHS services inclusively.
 - By understanding waiting lists, Did Not Attend (DNAs) and cancellations (all broken down by ethnicity and IMD quintiles).
- Priority 2: Mitigate against digital exclusion.
 - By ensuring providers offer face to face care to patients who cannot use remote services and assessment of the impact of digital consultation channels on patient access.
- Priority 3: Ensure datasets are completed and timely.
 - By prioritising improved recording and collection of ethnicity data across all settings of clinical data.
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes.
 - Through increased uptake of COVID-19 and flu vaccinations, ongoing management of long-term conditions and Annual health checks for people with learning disabilities.
- Priority 5: Strengthen leadership and accountability.
 - Systems and providers should have a named executive for tackling health inequalities.



health outcomes e.g. impact of jobs or housing on people’s health.

Vision:

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

Approach:

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

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



Actions to address Health Inequalities

Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs. ICBs have a core general duty to arrange healthcare services to meet reasonable requirements for the people for whom it is responsible. Addressing health inequalities therefore is a key priority for the ICB. Understanding the causes and drivers of health inequalities and identifying opportunities for action across the ICS will help us do this effectively. Effective action to address health inequalities in Lincolnshire will require a coordinated and whole system approach, with targeted prevention work using Population Health Management (PHM) as an enabler. PHM data will help the system to identify areas of focus and individuals or communities for targeted interventions. Linked datasets will provide insight into current and future population needs, allow targeted action to prevent ill health and reduce health inequalities, and enable the delivery of better coordinated care and better use of scarce resources. It will enable us to move from data to action and have much greater impact than could be achieved previously.

Reducing health inequalities and improving health equity is everyone’s business and will be a “golden thread” - shifting to equality of outcomes for all by connecting the dots between the wider determinants of health and the population’s

Wider Determinants:

Actions to improve ‘the causes of the causes’ such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.

Prevention:

Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity.

Access to Effective Treatment, Care and Support:

Actions to improve the provision of and access to healthcare and the types of interventions planned for all - for example ensuring there are health inequalities impact assessments for all commissioned services.

Working with Partners to Tackle Health Inequalities

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

Our work is informed by:

1. Governance structure

The effectiveness of our response depends on a system approach, recognising the need for action by all partners across the whole range of factors that influence and determine inequalities. It will also depend on our ability to become increasingly sophisticated and systematic in the way that we use data and insight to build our understanding of our population's health and wellbeing needs – with a view to understanding how need varies between groups and at different levels of our system, as well as what groups and communities are impacted most by inequalities.

With this in mind, we have in place a system-wide Prevention and Health Inequalities Executive Group between Lincolnshire's NHS and Local Authority with wider partners to reduce the avoidable inequity in people's health across the county. It oversees and delivers on the health inequalities and prevention priorities identified in the Joint Forward Plan and Integrated Care Partnership Strategy.

The ICB Health Inequalities and Prevention Programme aim to improve life expectancy and quality of life for people in Lincolnshire, while narrowing the gap between the healthiest and least healthy populations in the county.

The Health Inequalities and Prevention Programme Board provides the necessary governance and decision-making framework for the programme, ensuring the delivery of its outcomes and benefits. The Board oversees seven workstreams, each of which reports directly to the Health Inequalities and Prevention Programme Board. The Core20PLUS5 clinical areas for adults and CYP report to the Board for information.

The Children and Young People's Integrated Transformation Board meets bi-monthly and

provides strategic oversight of CYP services in Lincolnshire, with the aim of transforming pathways across health and care incorporating education. The Board is responsible for monitoring delivery of Lincolnshire CYP CORE20PLUS5 responsibilities. Responsibility for delivery of the Lincolnshire Local Transformation Plan (CYP Mental Health) sits with the MHLDA Programme Board, however, CYP Integrated Transformation Board ensures there is appropriate CYP representation and support to the programme.

2. Embedding a System Approach to Health Inequalities

- Development of Health Inequalities Champions network in 2024 with over 100 colleagues across Lincolnshire's health and care system who are passionate about addressing health inequalities.
- PCN Health Inequalities Leads Network has met quarterly, bringing together dedicated colleagues from each PCN to share key updates, learning and best practice.
- Five CORE20PLUS5 Ambassadors were accepted on NHS England Cohort 3. These Ambassadors form local, regional and national networks and promote the importance of reducing HI and ensuring equitable access, excellent experience and optimal outcomes for all - particularly CORE20PLUS populations. A further cohort is planned for 2025/26.
- Business Partners from the ICB Health Inequalities team continue to work alongside key programmes across the system. They work closely with Programme leads to embed Health inequalities and identify opportunities to reduce HI.
- The Health Inequalities and Prevention Bulletin is distributed bi-monthly system wide and provides relevant local and national updates, training opportunities, useful statistics and case studies highlighting work being done in Lincolnshire to address health inequalities, with an average reach of 500 viewers per issue.
- A working group was established with Lincolnshire Community Hospitals Group to embed a health inequalities approach within the Lincolnshire acute and community hospitals. It aims to work collaboratively with the workforce to tackle, address, highlight

and educate staff on the importance of Health Inequalities. A high-level maturity matrix to understand the baseline and set ambitions for 2025/26 has been developed and there are four established workstream groups which support the ambitions within the matrix.

- A system MHD LDA Health Inequalities Workstream was set up in 2024 with colleagues from LPFT, Public Health, LICB and the VCFSE sector. It aims to address disparities in healthcare access, outcomes and experience for people with mental health conditions, dementia, learning disabilities and autism.
- The Lincolnshire Health Inequalities Community of Practice was refreshed in 2024/25 and is an information repository available to all health and care staff with resources to understand health inequalities, local and national data, tool and templates and a discussion forum to ask any questions to members of the workspace.
- All service re-designs, business cases and project initiation documents (PIDs), new services and procurement exercises undergo a process of Equality Impact Assessment (EQIA). The use of Health Equity Assessment Template (HEAT) has been embedded within the ICS planning process, investment decisions and ICS governance arrangements in 2024/25
- A strategic system approach to addressing health inequalities was developed in partnership with Public Health. It aims to enable service improvement and address Health Inequalities by supporting health provider teams and ICS transformation programmes in Lincolnshire through supporting robust Health Inequalities intelligence (analysis, insights and research), Health Equity Assessment Tool and engagement support.



3. Fundamentals to Health Inequalities

- Delivery of Training Plan for 24/25 included educational workshops for Lincolnshire PLUS Groups – Coastal communities, people experiencing homelessness, rural and farming communities, people with a severe mental illness and people with autism and neurodiversity, as well as a new Introduction to Health Inequalities session.
- Plans in 2025/26 include providing further programmes of Health Inequalities Training and Development including Inclusion Health Groups, Health Literacy and the Health Equity Assessment Tool (HEAT).

HI Performance and Intelligence

- The annual update of the Statement of Information on Health Inequalities report – otherwise known as the ‘Legal Duties’ report will be published alongside the ICB Annual Report. This report consists of a variety of indicators across eleven domains (domains include elective care, cardiovascular disease and mental health, amongst others). This updated report will identify where there is potential health inequalities experienced in Lincolnshire ICB.
- There has been a sustained improvement in the recording and reporting of ethnicity in the Community Services dataset and the Emergency Care dataset, for Lincolnshire Community Health Services. This has been acknowledged regionally and nationally. There are plans to improve ethnicity recording and reporting in all datasets in ULTH, LCHS, and LPFT in 2025/26.
- One of the main objectives for 2025/26 is to develop a comprehensive dashboard focussing on the five key clinical areas for adults and children. This will facilitate proactive data driven actionable insights to target areas for reducing health inequalities.

HI in Clinical Areas and Crosscutting Themes

- We have worked with programmes to deliver against five national HI priorities and 5 clinical priority areas within CORE20PLUS5 for Adults and Children and Young People. The HI Bowel Cancer Screening Project is an example of this. We used data in the first instance to establish the correlation between deprivation and bowel

screening uptake and have since focused on understanding the key barriers and challenges that prevent people from completing their bowel screening in the four most deprived GP Practices in Lincolnshire. In 2024/25, the multi-agency project group collated themes from an extensive period of engagement to co-produce solutions with local people, with a localised focus, to encourage increased uptake of bowel screening.

- People who frequently attend A&E are few in number but their impact on the health system is significant. The High Intensity Use (HIU) service is defined as 'vulnerable individuals who use healthcare more than expected'. In Lincolnshire a HIU service launched in September 2023 in Trent PCN funded by the Health Inequalities Programme. While the range of drivers behind HIU of A&E is very broad, there are certain demographic and socioeconomic characteristics that precipitate a specific pattern of A&E attendances. The most common age groups are those aged 20 to 29, live in deprived areas, have poor physical and mental health, drug and alcohol issues, housing insecurity including homelessness, have suffered a sudden crisis and are lonely and socially isolated. Research has shown a clear link between HIU of emergency services and wider inequalities. The HIU service in Trent has been jointly evaluated and expanded into a further 2 PCNs with plans under way for further roll out across Lincolnshire in 2025/26.

Working with our communities to take action to reduce healthcare inequalities

- Insight from engagement with people and communities and a co-production approach is central to our work.
- The ICB was successful in the Wave 4 CORE20PLUS5 Connectors Programme. Voluntary Centre Services (VCS) is the delivery partner, and the focus has been on Children and Young People with Diabetes. This project has been successful in engaging with our Children and Young People with Type 1 Diabetes and their parents and has helped identify barriers across the county for access, experiences and outcomes which are being worked through.
- A Health Inequalities Voluntary, Community and Social Enterprise (VCSE) Grant Fund has been passported to Lincolnshire Voluntary Engagement Team (LVET) to run phase two in 2024/25. Phase Two has been successful in implementing 8 community projects to support reducing health inequalities across Lincolnshire.
- In 2024/25 the Personalisation Programme continued to work with people with lived experience, partners and communities to develop the 'Our Shared Agreement' ambition – developing a better relationship with the people in Lincolnshire and the Health and Care system. This is built on the five foundations
 1. Being Prepared to do things differently
 2. Understanding what matters to ourselves and each other
 3. Working together for the wellbeing of everyone
 4. Conversations with and not about people
 5. Making the most of what we have available to us
- Working in this way will help to improve outcomes for people and health inequalities in Lincolnshire.
- In 25/26 we will work with identified population groups to understand the reasons for higher UEC activity and co-produce targeted communications to encourage selected communities to access the right care in the right place.



Hey Skegness!

Received your Bowel Cancer Screening test in the post? Let's talk about it...



Don't waste time, complete your poo test today.

The National Bowel Cancer Screening programme (postal) helps to spot bowel cancer before symptoms start, when it's most treatable. Don't delay, complete your home test today.

For your free test kit, please call 0800 707 60 60

Restoring services inclusively

We continue to restore, recover and deliver our elective services in a fair and equitable way. Our population health management insights reporting has been developed to support our annual update of the Statement of Information on Health Inequalities report and has been further developed to dissect and overlay a lens to our waiting list but also at speciality level. This has been valuable in providing a more granular understanding of our demand profile. This means we have been able to:

- Evaluate the impact of elective recovery plans on addressing any identified or unresolved disparities in waiting list or access to services.
- Provide a more granular understanding of where inequity and inequalities offer different challenges and response, and where we can target specific health inequalities across our system.
- We will implement the health inequality focussed actions set out in the NHSE Reforming Elective Care for Patients guidance which sets out to deliver the 18-week standard equitably and inclusively for all adults, children and young people whilst also addressing geographical variation for people living within disadvantaged groups.
- Plans for 2025/26 include the following projects;
 - Lincolnshire is a national outlier for CYP elective care Did Not Attend (DNA's) and from initial data analysis there is a clear correlation between deprivation and children who are not brought to their appointments. The Health Inequalities Elective Care DNA Project will have a primary focus on CYP DNA's within ULTH and aim to understand the barriers and challenges parents/carers face in bringing their child to an appointment and coproduce solutions to overcome these.
 - Serious Mental Illness (SMI) physical health checks for people with severe mental illness with a focus on people with alcohol/substance use and or people experiencing homelessness. The project aims to look at the barriers/challenges people in this group face in attending their annual physical health check and to co-produce recommendations to the SMI Programme.

Taking digital exclusion

In 2024/25, we established a new Digital Inclusion Strategy Oversight Group made up of system wide partners. A total of 4 face to face workshops were held to develop the draft Lincolnshire Health and Care Digital Inclusion Strategy and action plan. At the workshops, collaborative discussions were held to map the existing work happening across Lincolnshire, identify what currently works well in and what gaps or what work is further required to ensure digital equality and inclusion for Lincolnshire's citizens. Priorities across six pillars have been established for a 3-year priorities action plan. Our identified 6 pillars align with the national 'Inclusive digital healthcare: a framework for NHS action on digital inclusion'. The six pillars are:

- Access to devices and data- Everyone can access health and care digital services if they choose to and experience the benefits.
- Accessibility and ease of use- Increasing digital uptake in health and care services by ensuring things are clear, simple and accessible to us.
- Access to services-Providing face to face alternatives for those who are unable or don't want to access health and care services digitally.
- Skills and capability- Everyone to have the skills to use health and care digital approaches with confidence.
- Trust, Awareness and Digital Safety -People to understand and feel confident and safe using digital health and care approaches.
- Leadership and Partnerships -Digital inclusion efforts are co-ordinated to avoid duplication and help reduce health inequalities.

We have identified six pillar leads from different organisations to lead on the work and we have also formally commissioned the University of Lincoln (Lincoln Institute for Rural and Coastal Health) to lead on the evaluation of the strategy. We have started the socialisation of the strategy and formal sign off by the Lincolnshire Health and Care System is expected early 2025/26.

There are many stakeholders that work to reduce digital inclusion, for example; Lincs Digital are a local Lincolnshire Charity based in Horncastle who offers digital support and services to the community covering East Lindsey, Boston and South Holland. This includes getting one to one assistance and helping boost people's confidence with technology which is very important in tackling digital inclusion. Lincs Digital have also been part of the oversight group, which links in closely with some of the six pillars.

Inclusion Health

In 2024/25 we continued to develop and deliver a series of Health Inclusion Workshops which aim to educate the Lincolnshire workforce on the health inequalities faced by inclusion health and PLUS groups, and provide an insight into how the experience, access and outcomes may differ to the rest of the population. The workshops have all been co-produced and are co-facilitated with people with lived experience and subject matter experts. A total of 212 staff from across the system have attended the workshops. In 2024/25, we delivered the following Health Inclusion workshops;

- Gypsy, Roma, and Traveller
- Coastal Communities
- Autism and Neurodiversity
- People Experiencing Homelessness
- Rural Communities
- People with Serious Mental Illness
- Carers

What has become apparent from developing the workshops is the absence of data we have for some Health Inclusion groups which hides the health inequalities experienced by them. Utilising the NHSE Health Inclusion Framework we are developing a Health Inclusion Strategy for Lincolnshire in partnership with stakeholders from across the Lincolnshire system in 2025/26.

Following a review of our training offer it includes an 'Introduction to Health Inequalities' session.

In December 2024, the team co-facilitated a community-based Lincolnshire Travellers Health Event which promoted vaccinations and wider health support for Travelling communities. This event led to positive engagement, vaccine uptake, and consent for future immunisations. Parents received valuable information, and key connections were made to support ongoing healthcare access. A further event is planned for 2025/26.

System Approach to Prevention

Prevention is vital for the NHS and a healthier society. It reduces health inequalities, improves population health, and enhances quality of life. The ICB focuses on promoting healthier lifestyles through the "Start Well, Live Well, Age Well" approach.

Tobacco control remains key to our work. Whilst the proportion of smokers are reducing in Lincolnshire, we have higher proportions of smokers in our Core20PLUS5 population groups.

We have implemented the NHS Tobacco Dependency Programme across all our Trusts, and our community pharmacies provide smoking cessation services alongside our local authority commissioned services – One You Lincolnshire.

Tobacco Dependency Services

The Tobacco Dependency Service (TDS) has been instrumental in helping numerous patients quit smoking and maintain a smoke-free lifestyle. Originally supporting maternity and mental health patients, the service has now expanded its reach to include acute and community inpatients.

Upon admission, the service identifies smokers and conducts a thorough pre-quit assessment to tailor the most effective treatment plan. With the patient's consent, each TDS provides ongoing support and Nicotine Replacement Therapy (NRT) to ensure a higher success rate in quitting smoking. Additionally, all sites under the TDS are strictly smoke-free, creating a healthier environment for everyone involved.

• Inpatients - Acute, Community and Mental Health

Services are provided to inpatients by the Tobacco Dependency Service at ULTH, and the QUIT Team for LPFT and LCHS. These services support patients to not only engage in making a quit attempt but also to reduce harm and ensure a more comfortable inpatient stay. In addition, work is underway as part of a pilot to integrate Cytisine, a highly effective smoking cessation pharmacotherapy, into the existing Acute and Mental Health NHS Tobacco Dependency Service.



- **Maternity: United Lincolnshire Teaching Hospitals NHS Trust (ULTH)**

From a variety of locations across Lincolnshire the STAAR (Stop Smoking Team, Advice, Action & Refer) Team offer a specialised Tobacco Dependency Service focused on supporting pregnant women and their families to quit smoking. The team provide personalised support to expectant mothers. They offer advice, action plans, and referrals to help women quit smoking, thereby improving health outcomes for both mothers and babies. The service includes monitoring carbon monoxide levels, which can be harmful during pregnancy, and providing resources to manage withdrawal symptoms and cravings for the duration of their pregnancy.

- **Local Authority Stop Smoking Services**

One of the key strengths of the 'in-house' Tobacco Dependency Service is its integration with community support systems. After discharge, patients can continue their quit journey with the help of the Local Authority Stop Smoking Service, which offers up to 12-weeks of behavioural support and free Nicotine Referral Therapy (NRT). This seamless transition from hospital to community increases the likelihood of long-term success in quitting smoking.

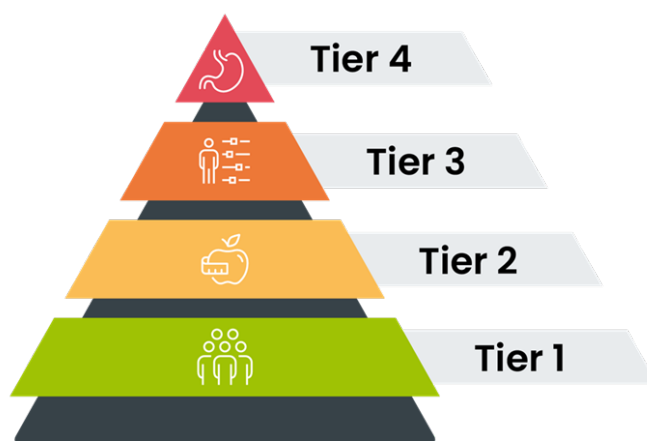
Weight Management Services

Tackling obesity and providing effective Specialist Weight Management Services is a top priority for the ICB, as promoting these services is vital for enhancing health outcomes, lowering NHS expenses, and ensuring accessible support for rural residents. Addressing obesity requires a comprehensive and varied approach, which is highlighted in our Joint Forward Plan: Lincolnshire System Leaders Board. There is a Healthy Weight Partnership that has been created by the Joint Lincolnshire Health and Wellbeing Board to help everyone stay at a healthy weight: [06B Joint Health and Wellbeing Strategy.pdf](#)

Working in partnership with our local public health teams we collaboratively tackle obesity and promote healthier lifestyles through coordinated efforts. Implementing comprehensive weight management programmes, such as the NHS Digital Weight Management Programme, and supporting local organisations like Active Lincolnshire we encourage healthy lifestyle changes including healthy eating and improved physical activity opportunities across Lincolnshire.



Nationally, weight management services are organised into four tiers of support, which help both adults and children.



- **Tier 1:** Universal Interventions targeting general population or individuals at risk of obesity through advice on healthy eating, physical activity, and lifestyle.
- **Tier 2:** Lifestyle Management for individuals who are overweight or obese and may have risk factors for chronic diseases. This includes the NHS Digital Weight Management Programme (DWMP) One You Lincolnshire (OYL) Integrated Lifestyle Service, NHS Diabetes Prevention Programme (NDPP) and the NHS Type 2 Diabetes Path to Remission Programme (T2DR).
- **Tier 3:** Specialist Weight Management for patients with obesity (BMI >30 or higher, with additional health complications).
- **Tier 4:** Bariatric Surgery and Interventions for individuals with severe obesity (BMI > 40, or >35 with commodities) who have not succeeded in other interventions or require treatment to prevent further deteriorations in obesity-related health conditions.



Specially for the population of Lincolnshire, Tiers 1 and 2 are provided within the county. For tier 3 and 4, patients are referred to University Hospital of Derby and Burton (UHDB) as the specialist centre. Patients under this service do not access weight loss injectables but are offered a 12-month personalised plan and wrap around care.

An NHS Weight Management Steering Group was set up in 2024 to oversee this NHS LTP prevention priority. The Steering Group links in with the Lincolnshire's Healthy Weight Partnership and NHS system partners (programme interface) to address issues of unhealthy weight in Lincolnshire, and this is managed through representation of key stakeholders at each group.

A Clinical Reference Group is supporting the development of a local Tier 3 model. Work is also underway on a clear pathway for accessing Tirzepatide by June 2025, following NICE recommendations.

In addition, and as a key component in facilitating access to Tier 3 weight management services, efforts continue to engage with all GP practices across Lincolnshire to raise awareness of the Tier 2 services.

At the start of the New Year, we initiated a comprehensive campaign to promote Tier 2 weight management services. With the aim to ensure residents of Lincolnshire and beyond had the opportunity to lead healthier lives and reduce the prevalence of obesity-related health issues.



[Lose weight - Lincolnshire ICB](#)

This campaign and the work undertaken with GP practices has successfully contributed to the increased awareness of NHS Digital Weight Management Programme (DWMP), which in turn has seen referrals increased five-fold compared to last year.

Diabetes Prevention Programme

Type 2 Diabetes Prevention and Remission in Lincolnshire

Type 2 Diabetes prevention is a national and local priority. The Healthier You NHS Diabetes Prevention Programme (NDPP) is designed to help prevent the onset of the condition for those at high risk, which includes people with 'Pre-Diabetes' (Non-Diabetic Hyperglycaemia) and women with a history of Gestational Diabetes. The Provider of the NDPP in Lincolnshire is Xyla.

Eligible individuals are offered a behavioural intervention which supports and motivates them to reduce their risk of developing Type 2 Diabetes through a reduction in their blood glucose parameters. Participants are shown the importance of managing their nutrition, activity, stress and sleep and how this can impact their glucose levels. This knowledge empowers participants to choose small, sustainable changes to improve their own health outcomes based on what they learn throughout the Programme.

The NDPP is available to patients with a history of Gestational Diabetes (GDM) as approximately 1 in 2 women who have had GDM will go onto develop Type 2 Diabetes within 5-10 years. We have therefore developed a system approach to prevention in Lincolnshire for Gestational Diabetes. We are working closely with our Maternity and Neo-Natal Service to establish the touch points in the system where we can share the message and advocate referrals. Procedures have been developed in Primary and Secondary Care to raise awareness of the potential implications of GDM and to promote uptake onto the NDPP.

Path to Remission Programme

The NHS Type 2 Diabetes Path to Remission Programme (T2DR) is a joint initiative between NHS England and Diabetes UK and has been available in Lincolnshire since April 2024. This programme provides a low calorie, total diet replacement treatment for people who are living with Type 2 Diabetes and obesity or who are overweight. The overall aim of this intervention is to promote weight loss in those that are overweight and recently diagnosed with Type 2 Diabetes, achieving remission wherever possible. The provider of the NHS Type 2 Diabetes Path to Remission Programme in Lincolnshire is Xyla.

Eligible participants are offered low calorie, total diet replacement products, including soups and shakes, consisting of 800 to 900 kilocalories a day for 12 weeks. Alongside this, participants will receive support and monitoring for 12 months, including help to re-introduce food after the initial 12-week period. This support will provide participants with the help and advice they need throughout every stage of the programme. Participants will be closely supported by their local GP practice – for example, if medication needs to be changed.

In response to the NHS Long Term Plan, the ICB and system partners have developed a systematic population health approach to reducing health inequalities and addressing unwarranted variation in care. Together with the provider of the NDPP and T2DR, Xyla, we are working to increase referrals and uptake of the programmes, particularly for those patients within health inequality cohorts such as those within the most deprived areas of the County. In addition, Xyla and the ICB are collaboratively liaising with practices to understand any barriers to referrals and/or uptake.

We support a cross-organisational group that reviews the uptake of new technologies, such as Hybrid-Closed Loop systems, and targets performance in care processes and treatment goals.

Measles, Mumps and Rubella (MMR) Vaccines

The MMR vaccine is given by primary care in two doses: first at 12 months and a booster at three years four months. The World Health Organization recommends that at least 95% of children be immunised with two doses of MMR to prevent outbreaks and protect those who cannot be vaccinated (herd immunity). The UK had previously eliminated measles, but declining vaccine uptake has led to a resurgence. National uptake of the MMR vaccine is at its lowest level in over a decade with an average of 85%.

Primary Schools

In January 2023 the UK Health Security Agency (UKHSA) declared a national incident over a surge in measles cases across the country, the cases were mainly seen in children aged 10 and under. Following this information Lincolnshire decided to act to increase MMR uptake rates in our lowest vaccinated schools, with the overarching aim to prevent outbreaks and associated morbidity. Schools were contacted and a webinar arranged to explain why this work was being implemented.

All schools agreed to participate. Nursing staff contacted all parents of those children identified as not fully vaccinated allowing for conversations to gain consent or alternatively to find out why parents refused vaccinations. By offering the vaccinations in school time it was anticipated that we would see an increase in uptake as generally vaccine campaigns delivered in schools are seen as accessible and convenient for families. Schools also have good relationships with parents/carers. The information gained from discussions with parents who did not want to give consent will help to underpin our future vaccination work.

Primary Care Networks

Following the work in primary schools, the focus moved to additional clinics through school holidays working with GP practices and PCNs with lowest uptake of MMR. Areas of lowest uptake were predominantly in more ethnically diverse and lower IMD, highlighting the health inequalities which impact on vaccination rates. Parents were contacted by telephone to offer an appointment either at their GP practice or an off-site clinic. Approaches were adapted using some of the learning from the schools programme. Long conversations were able to be held with hesitant parents to discuss the importance of vaccination.

Additionally a potential cohort of at-risk young people were identified on the east coast where there is a large population of migrants working in factories and farms who were missing one or both doses of MMR vaccine. Working with the local GP practices, clinics were offered to a cohort of 18-25 year olds who may have been vulnerable in the event of an outbreak. Materials were translated into the most commonly spoken languages and circulated to employers and their HR teams.

These initiatives have supported a preventative approach in Lincolnshire, by vaccinating more of the population potentially at risk from Measles. This targeted approach reduced the likelihood of Measles outbreaks in Lincolnshire overall, reducing the potential impacts on people's health, protecting livelihoods and saving lives.

Continuation of this type of vaccination work is vital for protecting individuals and communities in Lincolnshire. Keeping high vaccination rates ensures these dangerous diseases remain rare and prevents avoidable outbreaks.

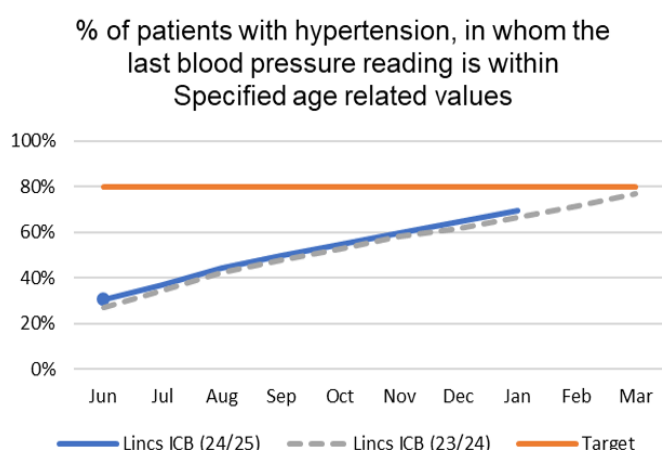
Cardiovascular Disease

We have refined our integrated cholesterol management services for patients with established cardiovascular disease. During the pandemic recovery, lipid specialist nurses helped reduce the backlog for outpatient clinic appointments, bringing treatment times back in line with national standards.

Hypertension

Lincolnshire excels in identifying and managing hypertension. In 2023/24, 150,190 patients were diagnosed with hypertension, making our prevalence rate the highest in the country at 18.3%. NHSE has set targets for all ICBs to manage blood pressure to age-related targets (140/90 for those aged 79 and under, and 150/90 for those aged 80+). This year, the target is for 80% of diagnosed patients to meet these thresholds. We are on track to meet this target with two months remaining in the year, currently performing approximately 2% above the national average.

To further improve hypertension management, we are collaborating with Health Innovations East Midlands to create a cardiovascular disease (CVD) champions community of practice. This initiative will support clinical colleagues in sharing best practices and exploring additional opportunities to enhance care. We are also addressing health inequalities by engaging with communities that are not meeting their age-related targets, with plans to continue this work through 2025/26.



Cholesterol Management

For primary prevention in cholesterol management, we have developed a pathway for Lincolnshire and produced a series of educational videos by our lead consultant. These videos cover topics such as primary prevention and advice and guidance, encouraging GPs to follow locally agreed pathways.

Our pilot project with lipid specialist nurses has emphasized optimal cholesterol management, even though their primary focus is on secondary prevention. The latest CVD Prevent data shows that we are performing above the national average in managing patients with a Cardiovascular (QRISK) score of 20% or greater, ensuring they receive lipid-lowering therapy.

These efforts reflect our commitment to improving cardiovascular health and reducing the burden of hypertension and cholesterol-related conditions in Lincolnshire.

Heart Failure Services

We have continued to innovate our Heart Failure services, building on virtual wards and rapid access clinics. Patients now receive maximum tolerated doses of medication in community settings, based on the latest evidence. We have also piloted a program to provide hospital-grade medication at home, with an evaluation planned for Summer 2025.

Respiratory Conditions

In line with the Joint Forward Plan 2023-28, we reviewed our respiratory care pathway to meet CORE20Plus5 priorities, the major conditions framework, and operational risks. This review involved experts and stakeholders and resulted in recommendations for next steps, including:

- Changes in clinical pathways
- A proactive model of care for winter response
- Countywide diagnostics approach
- Review of pulmonary rehabilitation
- Establishment of multidisciplinary teams (MDTs)

These initiatives reflect our commitment to improving health outcomes and delivering high-quality.

Equality, Inclusion and Human Rights (EHIR)

Equality, Inclusion and Human Rights (EIHR) – Annual Report 2024/25

2024 was an extremely busy and challenging year for equality, inclusion and human rights. The race riots of August 2024, for a short while, negatively disrupted the flow of work. Many staff felt unsafe and shocked at what was taking place in UK towns and through social media, however, the ICB and system leaders were quick to react. Email correspondence was sent to all ICB staff highlighting our organisational stance on zero tolerance to racism, bullying, harassment and violence and reiterated information about the different types of support and assistance that was available to any staff adversely impacted by the situation. Whilst the riots were a distraction, they weren't a deterrent, EIHR work progressed through the implementation of action plans relating to the different compliance standards. Equality data collection and analysis, EIHR related training and the development of policies and new frameworks became even more important.

Examples of EIHR achievements in 2024 that demonstrate the ICB compliance to **the Equality Act 2010, Public Sector Equality Duty (PSED)** include:

EDS Standards and Compliance Frameworks

Workforce Race Equality Standard (WRES): The WRES report 2024 and action plan 24-25 was published before the deadline of 31st October 2024 and work continued on implementation of actions. One particular area of concern that was highlighted in 2023/24 data (WRES indicator 2) showed likelihood of white candidates being appointed from shortlisting compared to Black Minority Ethnic candidates is 3.32 compared to 1.32 in 2022/23. This is moving further away from the ratio of 1. Actions around the promotion of the systemwide Recruitment and Selection Toolkit have been incorporated into the WRES action plan to address this in the coming year.

A WRES task and finish group was set up to implement the action plan and the following has been achieved as a result of this work:

- Production of a Zero Tolerance Statement to tackle bullying, harassment and violence in the workplace. This statement was communicated widely to all staff.
- Development and delivery of Anti-racism training
- Development and delivery of Tackling Bullying and Harassment in the Workplace training.

Workforce Disability Equality Standard (WDES): ICBs are now required to implement WDES as part of the NHSE Workforce Improvement Plan – high impact area 3. The ICB conducted this work for the first time in 2024, by collecting and analysing relevant data up to March 2024. A report and action plan was published in October 2024 on the ICB EIHR webpage. One area of concern (WDES indicator 6) highlighted that 12.50% of staff 'with disability' feel pressure from their manager to come to work despite not feeling well. 11.11% of staff 'without a disability' feel pressure from their managers to come to work despite not feeling well which is 1.73% above the median of 9.38%. The action plan includes development of activities to help managers to have caring conversations with staff especially those with disabilities.

Both the above reports/action plans are published on the LICB EIHR webpage: [Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB under workforce reports.](#)

Equality Delivery System (EDS): During 2024, work was conducted in relation to the three EDS domains, for which data was collected and analysed for period April 2023-March 24 and action plans for 2025/26 were developed.

Domain 1 – Commissioned or Provider Services. Work took place on one service area around Children and Young People area of diabetes. Data/

evidence was collected and analysed against the four outcomes of this domain through a task and finish group.

Domain 2 – Workforce Health and Wellbeing. Evidence was collected and analysed in line with the four outcomes of this domain and an action plan produced to address gaps.

Domain 3 – Inclusive Leadership. Information was collected via a questionnaire to leaders’ band 6

and above asking for details about EDI activities/ initiatives they were involved in during this period. A random sample of substantive Board or prime committee papers from April 2023 to March 2024, were also collected. Papers that identified equality-related impacts, through analyses or other assessments were defined, and how negative impacts were mitigated, monitored, and managed.

EDS scoring of the three domains

Domain 1 outcomes and scoring	Domain 2 outcomes and scoring	Domain 3 outcomes and scoring
1A: Patients (service users) have required levels of access to the service (2 – Achieving) 1B: Individual patients (service users) health needs are met (1 – Developing) 1C: When patients (service users) use the service, they are free from harm (3 – Excelling) 1D: Patients (service users) report positive experiences of the service (3 – Excelling)	2A: When at work, staff are provided with support to manage their Health and Wellbeing (2 – Achieving) 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source (2 – Achieving) 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (3 – Excelling) 2D: Staff recommend the organisation as a place to work and receive treatment (2 – Achieving)	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities (3 – Excelling) 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed (3 – Excelling) 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients
Domain 1 score = 9	Domain 2 score = 9	Domain 3 score = 8

Total scoring for 2024 EDS came to 26, which was higher than the year before, which was 23.5. **The ICB is at the ‘achieving’ level** (those who score between 22 and 30, adding all outcome scores in all domains, are rated as Achieving). This has been the result of a number of improvements over the year across the three domains – highlighted in the individual reports available on the LICB website under ‘our Equality Delivery System – [Reports’ Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB](#)

Accessible information Standard (AIS): Health care services need to ensure that the information they provide to those who may have a disability, impairment or sensory loss is in accessible formats and in response to specific needs and requirements. Information about the AIS has been updated on the EDI webpage and circulated to system providers reminding them of their responsibilities for implementation. [Accessible Information Standard August 2024 \(icb.nhs.uk\)](#) .

The implementation of AIS by NHS provider Trusts continues to be measured through the Schedule 6 quality assurance process and reported back to the ICB Operational Quality Assurance Group (OQAG) every six months. NHSE is currently revising its AIS and we are waiting the imminent release of the new standard, which will be communicated widely to ICB staff and system providers, and training offered on its effective implementation.

EIHR Training and Development

Throughout 2024/25 we continued to deliver the following EIHR training sessions linked to the ICB objective four, the EDS domain 2 action plan for 2024-25 and WRES action plan 2024/25 and NHS EDI Workforce Improvement Plan:

- EIA training refresher sessions
- Tackling Bullying and Harassment in the Workplace
- Let's Talks Tackling Racism and Discrimination in the Workplace.

Up to 80 staff participated in one or more of the above training sessions and LICB was 87.27% compliant with mandatory EDI training.

Further to the above, staff have participated in tier one and two Oliver McGowan training on Learning Disability and Autism – aiming to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability.

New Policies and Frameworks

Zero Tolerance Statement

The Zero Tolerance Statement was developed to remind us of the importance of dealing with unacceptable behaviour and promoting a culture of civility and respect for all staff and service users. The statement aims to protect people from different protected characteristics and socially excluded groups and includes important links to relevant anti-harassment/discrimination policies and organisations that provide advice and support. The final statement was circulated to all LICB staff and published on the [LICB internet ICB HR 020 - Zero Tolerance Statement](#) and intranet. Further work also commenced on identifying what system partners were doing to tackle unacceptable behaviour with view to having a systemwide approach to Zero Tolerance. This work will be continued throughout 2025.

Gender Identity Equality Framework (GIEF)

Work commenced on the Lincolnshire systemwide Gender Identity Equality Framework, which aims to provide practical 'best practice' guidance to enable Lincolnshire system providers and clinicians to understand the needs of trans and gender diverse patients, and support the delivery of fair, equitable and inclusive services. This framework is intended for use by all NHS organisational staff and there is also commitment from St Barnabas, who have been involved in the work, to adopt for their organisation. The Framework will be launched in 2025.

For more information about our EIHR work please visit the equality webpage of the LICB Website: [Commitment to Equality, Inclusion and Human Rights - Lincolnshire ICB](#)



Compliments, Concerns and Complaints

Valuing Patient Experience

NHS Lincolnshire Integrated Care Board (LICB) values the opportunity to hear what people think about the services we commission, and we use feedback to support decisions about services. We analyse complaints and monitor the themes and trends to promote learning. This information is reviewed in conjunction with other quality metrics to drive quality improvement and is used to further support the schedule of quality assurance visits which improves patient experience and patient outcomes.

Breakdown of formal complaints

Quarter 1	38
Quarter 2	27
Quarter 3	41
Quarter 4	35
Total	141

During April 2024 to March 2025, we received 141 formal complaints, both directly from patients or their family, the public, and from Members of Parliament on behalf of their constituents. Since 1st July 2023, figures include formal complaints for LICB Primary Care Services which are managed by the East Midlands Hub, (hosted by NHS Nottingham and Nottinghamshire ICB).

The ICB views compliments, concerns, and complaints as a valuable source of information and we use this as part of our ongoing monitoring for services we commission.

We ensure that we acknowledge all feedback received, making sure that any concern or complaint response is dealt with compassionately, effectively and in a timely manner.

To prevent informal concerns escalating to formal complaints, we endeavour to resolve concerns by either providing the information needed or signposting the complainant to the appropriate department or organisation to enable direct contact and response.

Our responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

By the end of the reporting period 1st April 2024 to 31st March 2025, of these 141 formal complaints, 10 were upheld, 17 were partially upheld, 30 were not upheld, 37 were closed as not pursued, which leaves a total of 47 being carried forward.

Principles for Remedy

The ICB continues to use the Principles for Remedy for NHS Complaints, as set out by the Parliamentary and Health Service Ombudsman (<https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy>).

This identifies good practice with regards to providing remedies for patients wishing to make a complaint and these are supported by the ICB:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

The ICB has adopted all six principles of remedy in the development of our complaints handling procedure and they form a core part of the ICB's Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments.

The Policy clearly sets out the organisation's process for handling complaints in order for the ICB to meet statutory requirements and how the ICB takes responsibility, acknowledges failures, provides an apology, and uses the learning from any complaint investigation to improve their services.

Freedom of information

The Freedom of Information Act 2000 (FOI) gives people a general right to access information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability among public sector bodies and to facilitate a better public understanding of how they carry out their duties, why they make the decisions they do and how they spend public money.

Exemptions deal with instances where a public authority may withhold information under the FOI Act or Environmental Information Regulations.

Exemptions mainly apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement or harm commercial interests.

Requests are handled in accordance with the terms of the FOI Act and in line with best practice guidelines from the Information Commissioner's Office and the Ministry of Justice.

In line with the requirements of the FOI Act, the ICB has a comprehensive Publication Scheme to make information about the ICB readily available to the public without the need for specific written requests. However, from 1st April 2024 the ICB processed 378 requests covering the following work streams:

- Commissioning and Procurement
- Continuing Healthcare
- Corporate information
- Estates
- Finance
- Workforce information
- Communication and Technology
- Individual Funding Requests
- Medicines Management
- Mental Health
- Policies
- Primary Care
- Services/treatments
- Statistical Information



Financial Summary

The annual accounts of the ICB have been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by the NHS Commissioning Board, in respect of Integrated Care Boards' annual accounts. The accounts have been prepared on a 'going concern' basis to show the long-term commitment to healthcare services.

This is described at note 1.1 to the accounts. The annual accounts are detailed in full from page 133 in this report.

The level of accuracy used in financial reporting for the ICB is informed by the materiality concept. A transaction can be material by the impact it has on the financial duties of the ICB, but also the reputational and legal implications for the ICB and its internal and external stakeholders. Where judgements and estimates have been made in the preparation of the financial statements, the concept of materiality has been used. However, it should be noted that the concept of materiality has not been applied to disclosures required by law and accounting guidance: precise figures have been used for these disclosures.

ICBs are set a Revenue Resource Limit (RRL) by NHS England that represents the maximum that can be spent in the year. This is used to inform the financial plan for the year. The ICB agreed an initial plan with NHS England to deliver a £4,688,000 under-spend against its in-year RRL. The actual outcome for the year was a £9,514,953 deficit at 31st March 2025,

which equates to £14,202,953 adverse variance against the revised financial plan.

The ICB therefore failed to meet its financial breakeven duty in 2024-25. Under the National Health Services Act 2006 the ICB has not discharged its duties under sections 223GB to 223N (financial duties).

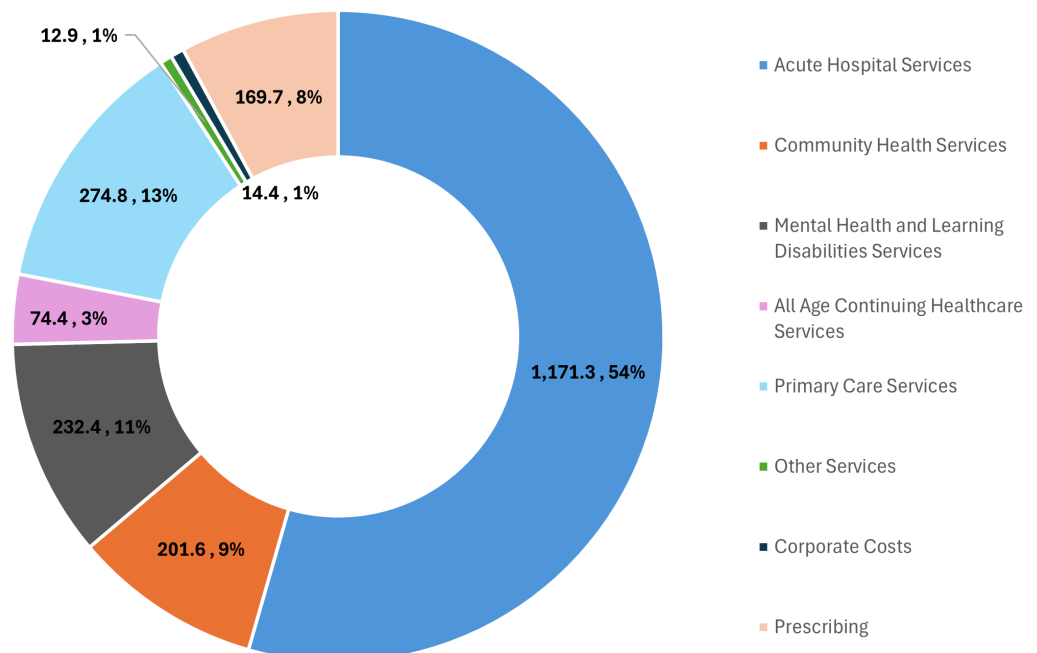
The wider Lincolnshire NHS system (including the ICB and NHS providers) made a deficit against allocation and income for the full year in 2024/25 of £26,739,953. The financial plan agreed at the outset of the financial year with NHS England was to deliver a break-even position against income and allocations therefore the Lincolnshire system delivered £26,739,953 worse than plan.

The financial outlook for 2025/26 is challenging, and a Financial Recovery Programme is in place for the Lincolnshire system.

The ICB's plan for 2024/25 did not contain any planned capital resource use but £60,000 capital resource was received in year and the ICB spent £57,909 against this capital allocation.

The ICB also had a capital allocation for Primary Care Services GP IT goods. Spend against this allocation is not recorded in the accounts of the ICB as all costs are reimbursed by NHS England and all assets are recorded in NHS England's accounts in line with their capital plan.

2024/25 Analysis of Net Expenditure (£m)



Summary Headline Financial Information

NHS Lincolnshire ICB's delivery of its financial targets for 2024/25 as follows:

	Financial Year Ending 31 March 2025		
	Integrated Care Board £m	Lincolnshire Provider (Excluding Income from ICB) £m	Total Lincolnshire Integrated Care System £m
Revenue Resource Limit	£2,142.0	£255.1	£2,397.1
Net Operating Expenditure	£2,151.5	£272.3	£2,423.8
Surplus/(Deficit)	(£9.5)	(£17.2)	(£26.7)

The ICB managed its administration functions within the allocated Running Costs Allowance of £14,504,000.

Cash payments were also managed within the Maximum Cash Drawdown limit as allocated by NHS England.

The ICB is an approved signatory to the Prompt Payment Code. This initiative was devised by the Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses.

Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute. Approved signatories undertake to:

- pay suppliers on time;
- give clear guidance to suppliers and resolve disputes as quickly as possible;
- encourage suppliers and customers to sign up to the code.

In the NHS, performance is measured by the Better Payment Practice Code which requires the ICB to pay at least 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The ICB is fully compliant with the code, with around 99.9% of non-NHS invoices paid within 30 days. Full details are given in Note 6 to the accounts.

The operating expenditure of the ICB can be split into two types:

- Programme – this is expenditure on the purchase of healthcare. The ICB had £2,127,526,000 programme allocation. It spent 99.8% of its total resources on programme expenditure.

- Administration – costs that are not for the purchase of healthcare but relate to the direct running costs of the ICB. The ICB underspent on its Running Costs allocation. The ICB spent 0.7% of its total resources on administration expenditure.





Mental Health

The Mental Health Investment Standard (MHIS), set by NHS England, requires all ICBs in England to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year.

In Lincolnshire, we are committed to improving the mental health and wellbeing of our local people. The Lincolnshire system has invested in improving mental health and learning disabilities facilities and services for several years which has resulted in some areas of expenditure reducing due to more efficient and effective services now being delivered in a more appropriate care setting. In 2024/25 NHS Lincolnshire spent £167,927,608 equating to 7.9% of its programme allocation on Mental Health Services which represented a 7.1% growth in expenditure on mental health services spend in Lincolnshire. The Lincolnshire system therefore delivered against the Mental Health Investment Standard target for the financial year.

Mental Health Spend (£m)	£167.9
ICB Programme Allocation (£m)	£2,127.5
Mental Health Spend as a proportion of ICB Programme Allocation	7.9%

John Turner
 ICB Chief Executive (Accountable Officer)
 17th June 2025

The Accountability Report

Corporate Governance Report

Members report

The Members' Report has been prepared by ICB Board.

The Board is responsible for ensuring the ICB has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the ICBs principles of good governance.

The ICB Board consists of the ICB Chair, the Chief Executive, Director of Finance, Director of Nursing, Medical Director, Director for System Delivery, six Non-Executive Directors, three Partner Members representing NHS and Foundation Trusts, Local Authority and Primary Medical Services, senior managerial support and representatives from Public Health, Healthwatch, Health and Wellbeing Board and Voluntary Sector.

Dr Gerry McSorley was the ICB Chair for the reporting period 1st April 2024 to 31st March 2025. Mr John Turner has been the Chief Executive (Accountable Officer) for the reporting period 1st April 2024 to 31st March 2025.

The composition of the Board and the Audit and Risk Committee through the year and up to the signing of the Annual Report and Accounts (including advisory and Non-Executive Directors) is outlined in this section. Details of members of other committees and sub-committees are set out in the Annual Governance Statement (AGS).

Board Members

Name	Role
Clr Wendy Bowkett	Partner Member, Local Authority
Mrs Sarah Connery	Executive Board Mental Health Member
Ms Anita Day	Non-Executive Director
Professor Karen Dunderdale	Group Chief Executive and Partner Member, NHS & Foundation Trusts (from 1st July 2024)
Dr Phillip Earnshaw	Non-Executive Director and Chair of the Primary Care Commissioning Committee (from 1st March 2025)
Mr Matt Gaunt	Director of Finance
Mrs Dawn Kenson	Non-Executive Member, Chair of Service Delivery and Performance Committee and Acting Deputy ICB Chair
Mr Martin Fahy	Director of Nursing (Chief Nurse)
Dr Sunil Hindocha	Medical Director
Dr Gerry McSorley	ICB Chair (for the full year)
Mr Andrew Morgan	Group Chief Executive and Partner Member, NHS & Foundation Trusts (to 30th June 2024)
Mrs Julie Pomeroy	Non-Executive Member, Chair of Finance and Resource Committee and Remuneration Committee
Mrs Margaret Pratt	Non-Executive Director and Chair of the Audit and Risk Committee
Mrs Clair Raybould	Director for System Delivery
Mrs Sharon Robson	Non-Executive Director and Chair of the Quality and Patient Experience Committee
Dr Kevin Thomas	GP and Primary Medical Services Representative
Mr John Turner	Chief Executive

Regular Participants

Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
Mrs Michele Jolly	Voluntary and Care Sector Representative
Mrs Anne Lloyd	Director of Workforce Transformation
Mrs Sarah-Jane Mills	Director for Primary Care and Community & Social Values
Mr Navaz Sutton	Healthwatch Representative
Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
Professor Derek Ward	Public Health Representative
CLr Sue Woolley	Chair of the Health and Wellbeing Board

Committees

In order to discharge its duties effectively, the Board has a number of formally constituted Committees as set out in the ICB Constitution and Corporate Governance Handbook, which includes the Scheme of Reservation and Delegation.

The ICB Board has two statutory Committees. They ensure the ICB is compliant with statutory responsibilities and functions.

- Audit and Risk Committee (ICB Committee)
- Remuneration Committee (ICB Committee)

The ICB has also established a further Committee to enable the members to make collective decisions on the review, planning commissioning and procurement of Primary Medical Services (PMS) within the ICS area under delegated authority from NHS England to ICBs.

- Primary Care Commissioning and Delegated Functions Committee (ICB Committee)

The Board has also established three other Committees to assist it within the discharge of its functions. These Committees are set out below:

- Finance and Resource Committee (ICB Joint Committee)
- Quality and Patient Experience Committee (ICB Joint Committee)
- Service Delivery and Performance Committee (ICB Joint Committee)

These Committees are ICB Joint Committees with the three provider partner organisations in Lincolnshire. They are Chaired by an ICB Non-Executive Director and include Non-Executive Director representation from each of the three provider organisations – Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and United Lincolnshire Hospitals NHS Trust.

All Board Committees are accountable to the ICB Board and report to the Board on how they discharge their responsibilities.

A table detailing the ICB Non-Executive Director membership of the Board Committees is detailed below:

Committees and NEMs	Gerry McSorley (GM)	Dawn Kenson (DK)	Julie Pomeroy (JP)	Margaret Pratt (MP)	Sharon Robson (SR)	Anita Day (AD)	Phillip Earnshaw
Audit and Risk		X	X	X (Chair)	X	X (attendee)	
Remuneration	X	X	X (Chair)	X (attendee)	X	X	X
Primary Care Commissioning and Delegated Functions	X (Chair up to 28th February 2025)		X				X (Chair from 1st March 2025)
Service Delivery and Performance		X (Chair)					
Quality and Patient Experience					X (Chair)		
Finance and Resource Committee			X (Chair)				

Audit and Risk Committee - Chair, Mrs Margaret Pratt (up to 31st March 2025)

The Audit and Risk Committee meets at least four times a year and is chaired by the Non-Executive Director with lead responsibility for governance. The Committee has met **six times** between 1st April 2024 to 31st March 2025 and has had **95%** attendance from Non-Executive Directors. All meetings were quorate.

The Audit and Risk Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all activities that support the ICB in achieving its objectives.

A key purpose of the Audit and Risk Committee is to monitor the integrity of the ICB's financial statements and assure itself that relevant risks, particularly financial, are appropriately identified and managed within a robust system of internal control. The Audit and Risk Committee is also responsible for seeking appropriate assurance on arrangements for counter-fraud and audit work programmes.

The Audit and Risk Committee has been attended by, and updates have been received from, the ICB's Internal and External auditors as well as its Counter Fraud Service at each meeting along with updates on Information Governance. The Audit and Risk Committee also receives regular updates on the development of risk management systems for the ICB including the development and establishment of the Board Assurance Framework in line with the ICB Strategic Risks.

During the period 1st April 2024 to 31st March 2025 the Committee has regularly provided reports to the ICB Board and has produced its Annual Report covering the period 1st April 2024 to 31st March 2025 and a Self-Assessment.

The membership of the Audit and Risk Committee for the period 1st April 2024 to 31st March 2025 comprised:

Name	Role
Mrs Margaret Pratt	Audit and Risk Committee Chair and Non-Executive Director
Ms Anita Day	Non-Executive Director (attendee)
Mrs Dawn Kenson	Non-Executive Director
Mrs Julie Pomeroy	Non-Executive Director
Mrs Sharon Robson	Non-Executive Director

The following people are also in attendance:

Mr Matt Gaunt, Director of Finance
Mrs Emma Rhodes, Deputy Director of Finance
Mrs Julie Ellis-Fenwick, ICB Board Secretary
Internal Audit representatives, TIAA
External Audit representatives, Ernst and Young
Local Counter Fraud Specialist, Audit Yorkshire

Mr John Dunstan was appointed as the new Chair of the Audit and Risk Committee from the 1st April 2025.

Remuneration Committee – Chair, Mrs Julie Pomeroy

The Remuneration Committee meets as required throughout the year and is chaired by one of the ICB Non-Executive Directors. The Remuneration Committee met **five times** between 1st April 2024 to 31st March 2025 and has had 92% attendance from Non-Executive Directors. All meetings were quorate.

The Committee's main role is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B of the NHS Act 2006, which in summary is to:

- Confirm the ICB Pay Policy including adoptions of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Directors.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

Further information on the membership and attendance by the Non-Executive Directors of the Remuneration Committee is detailed on page 118.



Primary Care Commissioning and Delegated Functions Committee – Chair, Dr Gerry McSorley

The Primary Care Commissioning Committee (PCCC) is Chaired by one of the ICB Non-Executive Directors. The Committee has met six times between 1st April 2024 to 31st March 2025 and has had **88%** attendance from the Non-Executive Directors. All meetings were quorate.

The Primary Care Commissioning Committee has also held two Development Sessions during the period 1st April 2024 to 31st March 2025.

The Committee is accountable to the ICB Board and reports to the Board on how it discharges its responsibilities.

During the period 1st April 2024 to the 31st March 2025 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

Finance and Resource Committee – Chair, Mrs Julie Pomeroy

The Finance and Performance Committee is Chaired by one of the ICB Non-Executive Directors. The Committee has met **11 times** between 1st April 2024 to 31st March 2025 and has had **71%** attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of the ICB;
- Financial performance of NHS organisations within the ICB footprint.

During the period 1st April 2024 to the 31st March 2025 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

System Quality and Patient Experience Committee – Chair, Mrs Sharon Robson

The Quality and Patient Experience Committee (QPEC) is chaired by one of the Non-Executive Directors.

The Committee has met **seven times** between 1st April 2024 to 31st March 2025 and has had **73%** attendance from Non-Executive Directors. All meetings were quorate.

The Quality and Patient Experience Committee conducts its role in a number of ways including scrutinising the clinical effectiveness of commissioned health care providers both in and out of the county. This work involves crosschecking multiple sources of information that the ICB receives, such as complaints data, patient experience feedback, performance data, incidents, infection rates and staffing levels.

The Committee can make recommendations, oversee corrective actions and provides assurance to the ICB Board that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the ICB does.

During the period 1st April 2024 to the 31st March 2025 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

Service Delivery and Performance Committee – Chair, Mrs Dawn Kenson

The Service Delivery and Performance Committee is chaired by one of the Non-Executive Directors.

The Committee has met **11 times** between 1st April 2024 to 31st March 2025 and has had **75%** attendance from Non-Executive Directors. All meetings were quorate.

The Committee was established to provide leadership and direction in supporting the Lincolnshire NHS system to drive forward the delivery of the agreed strategic priorities, monitor the impact of their delivery and provide oversight

to the systems approach to planning. The key focus of the Committee is on progress and delivery of the Lincolnshire NHS system strategic priorities and operational plan; this being a sub-set of the broader Integrated Care Strategy.

During the period 1st April 2024 to the 31st March 2025 the Committee has regularly provided reports to the ICB Board and has completed a Self-Assessment of its performance.

As referred to in the Annual Governance Statement, after each Board Committee meeting an assurance report is prepared and presented to the Board for consideration. This includes a summary of items discussed and any areas for escalation. The presentation of these reports ensures the Board receives timely information rather than waiting for the presentation of full minutes.

Register of Interests

The ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure, and be able to evidence, that these decisions secure the best possible services for the population it serves, the Board must demonstrate accountability to relevant stakeholders (particularly the public), and probity and transparency in the decision-making process. A key element of this assurance involves management of conflicts of interest with respect

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

As required by the Health and Social Care Act 2022, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

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

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



In light of the publication of this updated guidance, the ICB Standards of Business Conduct and Conflicts of Interest Policy was reviewed and made a number of amendments to bring the policy in line with this guidance. The ICB Board at its meeting held on 26th November 2024 considered and approved the revised version for inclusion in the ICB Governance Handbook and publication on the ICB website and intranet. The updated guidance has also been communicated to staff.

In accordance with section 14Z30(2) of the NHS Act 2006 registers of interests are recorded in the ICB Registers of Interests which is published on the ICB website.

One of the requirements of the statutory requirements for an ICB is to identify a Conflicts of Interest Guardian. The ICB's Conflict of Interest Guardian is Mrs Julie Pomeroy, Non-Executive Director.

The Conflicts of Interest Guardian is responsible for:

- Being a safe point of contact for employees or workers of the ICB to raise any concerns in relation to the policy.
- Acting as a conduit for GP practice staff, members of the public and healthcare

professionals who have any concerns regarding conflicts of interest.

- Providing support, independent advice and judgement on non-publication of conflicts and minimising risks.
- Providing advice on minimising the risk of conflicts of interest.

Personal data related incidents

There have been no ICO reportable data protection breaches for the ICB in 2024/25. Further details of the ICB's Information Governance arrangements can be found within the Annual Governance Statement. Further details of the ICB's Information Governance arrangements can be found within the Annual Governance Statement.

Modern Slavery Act

NHS Lincolnshire ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

John Turner
ICB Chief Executive (Accountable Officer)
17th June 2025

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Lincolnshire Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Mr John Turner to be the Accountable Officer of NHS Lincolnshire Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Lincolnshire Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my ICB Accountable Officer Appointment Letter.

Disclosures: Letter issued to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014 as made by the ICB's External Auditors.

John Turner
ICB Chief Executive (Accountable Officer)
17th June 2025

Annual Governance Statement

1st April 2024 - 31st March 2025

Lincolnshire ICB (QJM)

Introduction and Context

NHS Lincolnshire Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

Between the 1st April 2024 and 31 March 2025, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Lincolnshire Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) ("the Act") and in my Lincolnshire Integrated Care Board's Accountable Officer Appointment Letter.

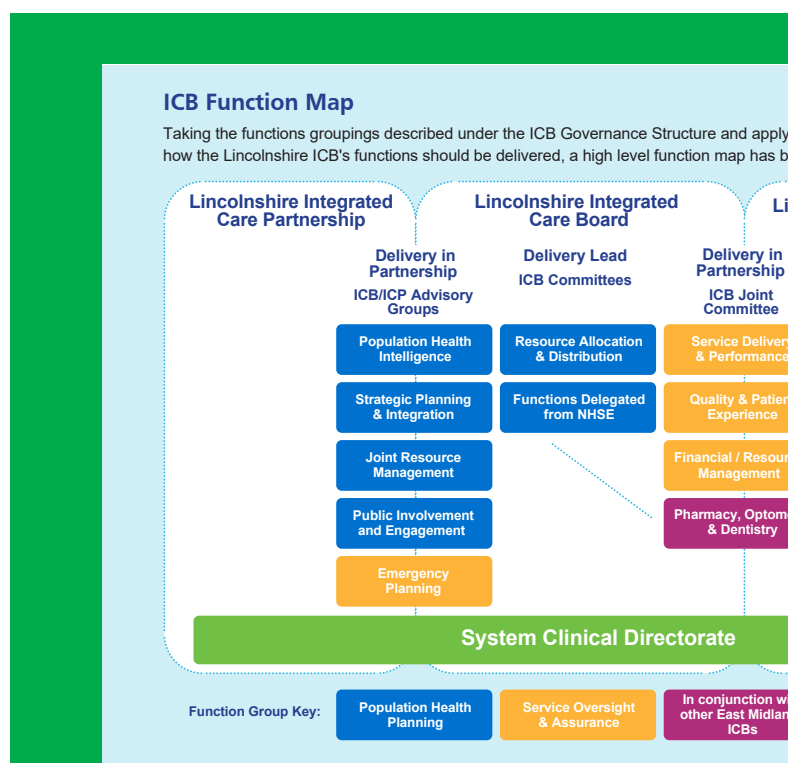
I am responsible for ensuring that the Lincolnshire Integrated Care Board is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Integrated Care Board as set out in this governance statement.

Governance arrangements and Effectiveness

The main function of the ICB Board is to ensure it has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB is legally required to have a Constitution which sets out the statutory framework within which the ICB operates. The ICB Constitution was approved by NHS England in line with 'The Integrated Care Boards (Establishment) Order 2022. The ICB Constitution was last amended in October 2024 to reflect changes requested by NHS England following the publication of updated governance guidance for ICBs to take account of wider legislative developments and issues that have arisen in implementation.

The Constitution is supported by documents which provide further detail on governance arrangements in the ICB. These include Standing Orders, Scheme of Reservation and Delegation and associated financial authority limits. These documents are reviewed regularly.



The ICB Governance Structure is supported by the ICB Functions and Decisions Map to facilitate transparent decision-making and foster the culture and behaviours that enable system working. It demonstrates which key decisions are delegated and taken by which part or parts of the system. It gives the ICB Board and me as Accountable Officer assurance that all decisions made by and on behalf of the ICB fit within a clear structure of accountability culminating at the ICB Board as the statutory body.

The ICB's Committee structure supports the ICB's governance processes and ensures that there is effective monitoring and accountability arrangements for the systems of internal control. The Terms of Reference for these Committees have been reviewed during the year to ensure robust governance and assurance arrangements are in place and that they remain appropriate for the ICB.

The ICB Board ensures that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. The ICB Board sets the ICB's vision, values and strategic objectives, and formulating strategies, plans and policies. The ICB Board then holds the organisation to account for the delivery of these, ensure that the organisation operates with openness, transparency and candour, and seeks assurance that systems of control are robust and reliable and that statutory duties are being met. The Board is also responsible for creating a healthy culture within the organisation and the wider system through its interaction with system partners.

The Board has met in public on a bi-monthly basis during 2024/25. Six Board meetings were held in public from 1st April 2024 to 31st March 2025. The Board had **87%** attendance from all Members. All meetings were quorate, and any decisions made were exercised in line with the ICB Constitution and Standing Orders including the Scheme of Reservation and Delegation.

The Board has performed effectively throughout the period 1st April 2024 to 31st March 2025 in ensuring good governance around the ICB's decision making processes and in setting up a robust Committee structure to manage areas of risk and priority for the ICB. The ICB has a duty to keep under review the skills, knowledge and experience that it considers necessary for members of the Board to possess (when considered together) in order for the Board to effectively carry out its functions (Duty 14Z49). The Board members are subject to statutory and mandatory training.

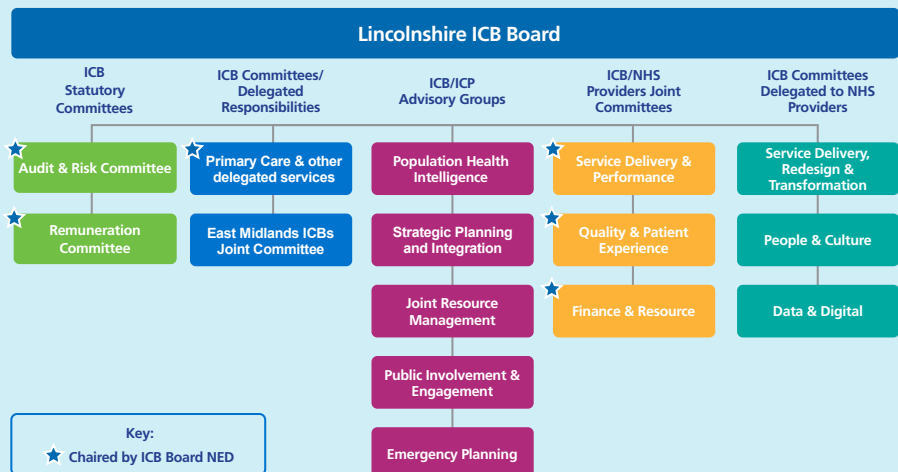
The Board is committed to assessing and improving its own performance. All members of the Board are able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and have established credibility with all stakeholders and partners. The ICB understands that the Board must work collaboratively with system partners to deliver its core purpose and meet the triple aim.

There have been some changes to the Board Members in 2024, including confirmation of appointment of the ICB Chair, a new Partner Member for NHS and Foundation Trusts and a new Non-Executive Director in March 2025, which has further strengthened the skill mix of the Board.



ICB Governance Structure

The diagram below highlights how ICB Board Members and Participants/Observers link to the wider system governance.



Board Performance and Development

The ICB Board Members have a regular opportunity to reflect on and evaluate their own performance through Development Sessions, to support focus on individual and collective roles, responsibilities and enhancing leadership skills. These sessions are aimed to support members of the Board to function more effectively as a Board in its own right and also collaboratively with Partners.

Board Development Sessions in private are held on the alternate months to the formal meetings in public and provide protected time to develop understanding of key strategic issues. The Board has held five Development Sessions in 2024/25, which provide considered a number of topics, which provided further assurance about the developing governance of the ICB.

The Board also receives regular information and briefings enabling members to gain greater clarity on national guidance/changes in legislation and the impact on the ICB's business; to develop further insight into performance issues with key providers; and enhance their knowledge on specific topics.

Board members' attendance record is positive for both the Board Development Sessions and Board meetings. All Board meetings held in public have been quorate with all or the majority of Board Members being present.

Board Committees

Information on the Board Committees, including their key responsibilities, membership, attendance records and highlights of their work during the period 1st April 2024 to 31st March 2025 is detailed in the Board report.

As Accountable Officer I rely on the effective operation of the Committees and gain assurance through the reports which are produced following each meeting and presented by the respective Non-Executive Director Committee Chairs. These reports detail items of particular note, areas of risk and points of escalation for consideration.

Annual assessment of Integrated Care Boards

Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making their assessment they consider evidence from the ICB's Annual Report and Accounts; available data; feedback from stakeholders and the discussions that have taken place with ICB Chair and ICB colleagues throughout the year.

In respect of the ICB Annual Assessment for 2023/24, the ICB received formal feedback in July 2024 which covered how effectively the ICB has led the local NHS system and its contribution to each of the four purposes of an ICB. The feedback also summarised an assessment of performance during the 2023/24 financial year. The comments received from NHSE reflected that 2023/24 had been the first full year the ICB had been in operation, as well as the first year of the Joint Forward Plan (as referred to earlier in this report). In making their assessment, NHSE had sought to balance fairly their evaluation of how successfully the ICB had delivered against the complex operating landscape in which it is working. The overall outcome was positive and NHSE indicated they were keen to continue to see progress towards a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them.

In April 2025 NHS England published the details of the Assessment Framework for 2024/25. Building on the approach used for 2023/24, NHS England regional teams will use the ICB's Annual Report as one of its key sources of evidence for the 2024/25 assessment. The ICB has taken this into account when preparing this Annual Report. NHS England will issue the 2024/25 Annual Assessment outcome letters to ICBs in August 2025.

UK Corporate Governance Code

Whilst NHS Bodies are not required to comply with the UK Code of Corporate Governance, for the period 1st April 2024 to 31st March 2025, the ICB has applied the principles of the UK Code of Corporate Governance as considered relevant to the ICB including drawing on other best practice available. This does not mean the ICB is voluntarily applying the code. This is evident, for example through the following:

- A clear division of responsibilities between the Board and the Executive Team responsibilities for running the organisation. The Chair was responsible for leading the Board and ensuring it is effective in its role and organising appropriate development and support for the Board's role.
- The Committees of the Board consisted of a balance of skill, knowledge, independence, and experience for them to carry out their duties and responsibilities. Three of the six Board Committees include representatives of system partners, giving assurance of system-wide consideration of issues and risks.
- In the main, information was supplied to the Board and its Committees in advance of meetings and of a quality that enables the ICB to discharge its duties.
- The Board assessed the nature of the extent of the significant risks it is willing to take in achieving the strategic objectives of the ICB, and it maintains a sound system of risk management and internal control, and
- The Remuneration Committee had oversight of the arrangements in relation to policy on the Remuneration members of the Board.

Discharge of Statutory Functions

The NHS Lincolnshire ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provides the necessary capability and capacity to undertake all of the Integrated Care Board's statutory duties.

Further information can be found in the performance section of the Annual Report on how the ICB has discharged its general duties as per sections 14Z34 to 14Z45 and 14Z49 of the NHS Act 2006 (as amended).

Risk management arrangements and effectiveness

A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. Effective risk management ensures processes are in place to proactively identify, understand, monitor and address current and future risks; both operationally and strategically.

This integrated risk management system includes the Risk Management Strategy which summarises the ICBs approach to the management of strategic and operational risks across the statutory organisation. The strategy also references how risk arrangements within the ICB will interface with other key areas of the system and with system partners. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the ICB objectives.

The Risk Management Strategy was reviewed during 2024 and the content strengthened to reflect comments received from the ICB's Internal Auditors, TIAA during the 2023/24 audit review of the ICB's risk management arrangements. The Board approved the revised version at its meeting held on the 24th September 2024. The Risk Management Strategy is in line with and has adopted the following principles of risk management as set out in guidance provided by ISO 31000: 2018 – Risk Management Principles and Guidelines, which are a widely adopted set of principles and guidelines.

To support the Risk Management Strategy a 'Summary on a Page' was produced and approved by the ICB Risk Management Group in November 2024. This document gives a brief overview of the risk process.

The Board Assurance Framework (BAF) is aligned to the ICB's strategic aims and objectives and provides the Board with confidence that the ICB has identified its strategic risks and has robust systems, policies and processes in place that are effective and driving the delivery of its strategic objectives. Risk

appetite has been determined for each risk in line with the Risk Management Strategy. All strategic risks are owned by an Executive Director of the ICB and are aligned to a specific Board Committee, all of whom have played a critical role in the review and management of risks.

The BAF content is regularly reviewed by the Executive Team and each responsible Board Committee and has been updated on a regular basis throughout 2024/25.

Operational risks are captured within the ICB's Corporate Risk Register (CRR) and are owned by members of the ICB's Senior Leadership Team. The CRR is reviewed by the Executive Team and the Risk Management Team and updates, mitigations and scores are tracked for evidence of effectiveness and improvement.

The Audit and Risk Committee has been briefed regularly on the progress and the development and establishment of robust risk management arrangements for the ICB, including the development of the BAF and CRR and Risk Appetite.

TIAA, the ICB's internal auditors carried out an audit review of the adequacy and effectiveness of the ICB's risk management arrangements including how it interfaces with ICS wide risk management structures in 2024/25. This review also considered the extent to which risk management arrangements are linked to the ICS whilst ensuring accountability at the ICB. It was acknowledged that progress has been made since the last review of the BAF and risk management arrangements in 2023/24. The outcome identified adequate and effective risk management arrangements provide the ICB Board with reasonable assurance that systems underpinning risk management are effective and can be relied upon to provide assurance that the main risks to the achievement of the ICB's key strategic objectives are managed appropriately.

As Accountable Officer this provides me with assurance that the ICB has sound and effective risk management arrangements in place.

Capacity to Handle Risk

As stated above, the overall responsibility for the management of risk lies with me as the Accountable Officer and the operational implementation with the Executive Team. The Risk Management Strategy is owned by the Board and is responsible for overseeing the delivery of our strategy and

is supported in this regard by the work of its committees, which review risks within their remit. The Board gains independent assurance of the effectiveness of its risk management processes through internal audit and the external audit programmes of work as well as through its Audit and Risk Committee.

However, risk is the business of all staff, and managers are expected to lead by example by ensuring that risk management is acknowledged and embedded throughout the organisation and across the system. Over the last year there has been a continued increase in awareness at all levels in the organisation of the importance and relevance of risk management to operational processes. This has been through the implementation of the updated Risk Management Strategy, Summary on a Page, establishment of a page on guidance to risk as part of the staff intranet site and the implementation of Risk Management and Governance Training.

An exercise has also been undertaken during 2024/25 to map out every system-wide Programme Board and substructure so the members of the Audit and Risk Committee can assure themselves that governance arrangements are in place to escalate risks to the responsible ICB Board Committee, and these are captured on the relevant Committee Forward Plan.

Part of the review has included the establishment of a standard Terms of Reference template to ensure consistency across Programme Boards. This includes a structure demonstrating clear reporting lines and mechanisms for managing risks and conflicts of interest. Items of risk for escalation to the Board is also included as standard on all Committee and group agendas. The arrangements for reporting and monitoring risks across the ICB will be further strengthened in 2025/26 to ensure discussions are fully embedded across the ICB Committees and groups.

Risk Assessment

The assessment of risks is a continual process and both the BAF and CRR are 'live' documents. The Board regularly receives assurance about the controls and assurances that are in place to mitigate individual risks through reports from the responsible Committees. The Board also receive assurance reports from the Audit and Risk Committee on the effectiveness of the risk management arrangements across the organisation. The Audit and Risk Committee are supported in gaining assurance on

risk management activity and effectiveness by the Risk Management Group.

All risks with a rating above 12 collectively make up the CRR that is reported to Executives and the Audit and Risk Committee for oversight and assurance.

During 2024/2025 the key risks faced by the ICB included:

1. Risk of financial deterioration in the ICS which could see a reduction in scope and quality of services.
2. Increased risk to the sustainability and resilience of GP practices which could impact on patient access to care.
3. Upgrade of Oracle ledger as part of national processes which could result in lack of access.
4. Disruption of systems and loss of information due to cyber-attack.
5. Current arrangements are not compliant with Working Together (2023) statutory guidance based on good practice due to lack of health input, which could affect decision making in strategy discussions, which is an increased risk to CYP.
6. Health is not meeting its statutory obligation under Working Together (2018; 2023). Local Authority may not be in possession of all health information to inform decisions.
7. Statutory duties are not being fulfilled under the health and wellbeing of Looked After Children (2015) due to health assessments not being completed within statutory timelines.

The responsibilities of risk owners are set out in the Risk Management Strategy. This ensures understanding around the expectation of the management of risks. Risk owners are expected to keep the risk as up to date as possible and ensure existing controls and mitigating actions are in place to reduce the risk from coming to fruition.

Other sources of assurance

Internal Control Framework

A system of internal control is in place in the Integrated Care Board to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The ICB system of internal control allows risk to be managed to a reasonable level rather

than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Audit and Risk Committee has specific responsibility for reviewing, managing and reporting risk to the Board. There are controls in place to comply with good practice and these are audited by internal and external auditors each year. The internal audit programme covers key areas of the ICB business on a risk-assessed basis to review the ICB's compliance with agreed policies and procedures. In 2024/25 the Head of Internal Audits opinion on the efficacy of the operation of internal controls is that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

Where internal audit assess that controls require improvement; or where compliance with agreed controls needs to be strengthened, management agree the actions to be taken and are then held accountable for delivering the agreed improvements. The Audit and Risk Committee monitor the delivery of agreed improvements against the timescales agreed by management.

Where services are provided by joint committees with other ICBs, the Lincolnshire ICB relies on the assessment of the host ICB's internal auditor as to whether reliance can be placed on the operation of internal controls.

Data Quality

The data used by the Board is based on the NHS national data sets. All data is checked for accuracy and is automated to avoid errors and inconsistency. To ensure consistency, procedures are documented and regularly reviewed. There have been no data quality issues reported between the period 1st April 2024 to 31st March 2025.



Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information, and special category data.

The NHS Information Governance Framework is supported by Data Security and Protection Toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The ICB submitted an interim baseline in December 2024 and made a final submission on 30 June 2025 in line with national process.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

The ICB does not use any business critical models at this time and will continue to review any models that it uses in the future to ensure quality assurance of such models.

Third party assurances

The ICB receives assurance through reports from audits performance on other organisations that provide services to the ICB. For the period 1st April 2024 to 31st March 2025 the ICB has received reports relating to:

- NHS Business Services Authority – Dental Payments Process System (ISAE 3402 Type II Report)

- NHS Business Services Authority – Electronic Staff Record (ISAE 3000 Type II Report)
- NHS Business Services Authority – Prescription Payments Process System (ISAE 3402 Type II Report)
- NHS Shared Business Services Ltd – Finance and Accounting (ISAE 3402 Type II Report)
- NHS Shared Business Services Ltd – Employment Services (ISAE 3402 Type II Report)
- NHS Shared Business Services Ltd – Procurement Services (ISAE 3402 Type II Report)
- Deloitte – Finance, Payroll and Non-Clinical Procurement (Type II Report)
- Deloitte – Calculating Quality Report Service (CQRS) National (Type II Report)
- NHS England – Primary Care Support (ISAE 3402 Type II Report)
- NHS England – Type II ISAE 3000 Controls Report on the Extraction of General Practitioner Date Services

In reviewing the above reports, I have noted that, with the exception of the Shared Business Service 2024/25 International Standard of Assurance Engagement 3402 audit (ISAE3402), which was undertaken by Deloitte, provided an unqualified audit across all core services (Finance and Accounting, Employment Services and Non-Clinical Procurement) except for two control objectives for which a qualified opinion was provided. A qualified opinion was also provided for: NHS England – Primary Care Support. However, the reports findings identified that the opinions have been qualified on the basis of a relatively small number of exceptions. Overall, opinion for both reports was that “the control objectives stated were achieved and operated effectively throughout the period 1st April 2024 to 31st March 2025.

The majority of these exceptions have already been actioned or plans put in place to rectify these.

Overall, the ICB is satisfied with the management responses provided in relation to these exceptions and the actions being implemented to address them. Further information on the outcome of the Third Party Assurances are set out later in the Annual Governance Statement under the Head of Internal Audit Opinion.



Control Issues

The ICB has implemented governance, risk management and internal control processes and subjected them to scrutiny through the various Committees of the Board. In the Month Nine Governance Statement some control issues were highlighted in relation to the financial position and key quality and performance targets.

Oversight and management of these has been primarily through the Board, its Committees and supporting governance structure which includes representatives from partners across the ICS.

Information on the ICB year-end financial position and performance in relation to the key constitutional targets and standards are detailed under the Performance and Finance Sections of the Annual Report and include the actions taken to resolve or mitigate against these areas.

Review of economy, efficiency and effectiveness of the use of resources

The ICB set a Financial Plan as agreed by the ICB Board. The effectiveness of the use of resources and financial performance of the ICB was monitored on a monthly basis by the System Finance and Resource Committee, the Executive Team and the Board. Corporate risks in respect of financial performance and use of resources are captured in the Board Assurance Framework, Corporate Risk Register and the programme level risk logs.

In addition, performance of providers and commissioned services was monitored in the main through the System Service Delivery and Performance Committee and the System Quality and Patient Experience Committee.

During the year, the Financial Plan was amended. The revised plan indicated that the ICB would deliver a deficit for the financial year, which was agreed with NHS England. The ICB therefore failed to meet its financial breakeven duty in 2024/25, resulting in the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014 as made by the ICB's External Auditors and a qualified regularity opinion being provided.

Commissioning of Delegated Specialised Services

NHS Lincolnshire ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the Delegation Agreement (DA) are being met.

Where there were known compliance issues, the ICB leadership collectively with other ICBs through multi-ICB working arrangements has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance should NHS England or a third party (e.g. external auditors) ask for such evidence.

In 2023/24 the ICB received delegated authority from NHSE for commissioning and contracting of Pharmacy, Optometry and Dentistry (PODs), in addition to the previous delegation of primary medical care services.

The East Midland ICBs (Derby and Derbyshire, Leicester Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) agreed in 2023 to collaborate in areas that are most effectively undertaken at scale. Working at scale adds value to common goals, whilst retaining local ICB population health sensitivity where appropriate.

NHSE and the East and West Midlands ICBs agreed to formalise collaborative working arrangements by entering into Joint Working Agreements, and in doing so established a governance framework consisting of collaborative Joint Committees, groups, subgroups and hosted teams through which the work is undertaken, and delegated authorities discharged.

All decisions are through formal joint committees, ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another.

As Accountable Officer I attend the meetings of the East Midlands Joint Committee along with the ICB Chair. The Director for Health Inequalities, Prevention and Regional Collaboration is the ICB Executive Lead for both PODs and joint working across the East Midlands. Regular reports and updates are provided to the Board and as Accountable Officer I am satisfied that the governance framework is operating satisfactorily.

On the 5th December 2024, the NHS England Board approved the 11 Midlands ICB application for the delegation of the final specified specialised acute and Mental Health Learning Disability and Autism Services (MHLDA) to the Midlands ICBs.

For services delegated in 2024/25, a Finance and Contracting Subgroup and a Finance Working Group has been operating throughout 2024/25 where assurance of performance, reporting and planning has had full ICB engagement. These groups will continue to oversee financial governance into 2025/26 including oversight and engagement of the detailed planning process for existing delegated services and those to be delegated from April 2025.

The ICB Board at its meeting held on the 25th March 2025 approved the progression to the formal delegation of the final specialised acute and mental health learning disability and autism services to the Midlands ICBs.

Delegation of ICB Functions

The ICB has not formally delegated any of its functions either internally or externally.

Counter fraud arrangements

For the period 1st April 2024 to 31st March 2025 counter fraud services was provided by Audit Yorkshire (Yorkshire and Scarborough Teaching Hospitals NHS Trust).

The Counter Fraud Service (CFS) works with the ICB to conduct a self-assessment of the position against the NHSCFA Counter Fraud Functional Standard Return (CFFSR) which is approved by the Audit and Risk Committee and submitted to NHS Counter Fraud Authority on an annual basis.

The executive lead role for Anti-Fraud and Anti-Bribery and Corruption sits with the Director of

Finance (as a member of the ICB Board). The CFS attends the regular meetings of the Audit and Risk Committee, providing formal updates against an agreed annual programme of activities.

The 2024/25 Counter Fraud Functional Standard Return has identified that the ICB is rated green.

Head of Internal Audit Opinion

For the period 1st April 2024 to 31st March 2025, the ICB along with its NHS system partners in Lincolnshire have contracted with TIAA for internal audit services. Following completion of the planned audit work for the financial year for the ICB the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

1. Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
2. The basis for forming the opinion is as follows:
 - An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
 - An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for NHS England/Department of Health purposes, e.g. any reliance that is placed upon Third Party Assurances. The NHS Shared Business Service 2024/25 International Standard of Assurance Engagement 3402 (IASE3042) undertaken by Deloitte provided an unqualified audit across all the core services provided by the NHS SBS (Finance and Accounting), Payroll and Non-Clinical Procurement) except for two control objectives (B3: Invoices raised are valid, accurate and processed in a timely manner; and B4: Credit notes raised are valid, accurate and processed in a timely manner)

for which a qualified opinion was provided. The ICB also receives assurance through reports from audits performed on other organisations that provide services to the ICB.

For the period 1st April 2024 to 31st March 2025 the ICB has received reports relating to Arden and GEM CSU (Finance and Payroll), Capita Business Services (Primary Care Support England), NHS Business Service Authority (Electronic Staff Record), NHS Business Services Authority (Prescription Payments to Pharmacists and Student Bursaries) and NHS England (Processing of General Practitioner Data Services).

We have noted that where exceptions were identified in the reports, management responses have been provided in relation to these exceptions, with the actions already implemented by the respective management or plans put in place to rectify these.

There are no matters to bring to your attention which have had an impact on the Head of Internal Audit Opinion.

The Audit and Risk Committee approved the Internal Audit plan 2024/25 that had been developed in conjunction with the ICB Executive Team.

During the period 1st April 2024 to 31st March 2025, Internal Audit issued the following audit reports:

Primary Care Delegated Commissioning - Pharmacy, Ophthalmic and Dentistry	Reasonable Assurance
Data Security Protection Toolkit (DSPT)	Substantial Assurance
Fit and Proper Persons Test	Reasonable Assurance
Contract Management	Reasonable Assurance
Key Finance Systems	Reasonable Assurance
Collaboration and Partnership Working	Reasonable Assurance
Addressing Health Inequalities and Population Health Management	Reasonable Assurance
Risk Management and BAF	Reasonable Assurance
Primary Care Recovery Plan	Reasonable Assurance
Conflicts of Interest	Reasonable Assurance
Business Continuity (EPRR)	Reasonable Assurance

The Audit and Risk Committee acknowledges the risks identified in the reports presented and the associated recommendations. For the period 1st April 2024 to 31st March 2025 all audit actions were monitored. A report was provided to each meeting of the Audit and Risk Committee on the actions that remained outstanding, and the progress made to date.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the Integrated Care Board who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principal objectives have been reviewed.

I have also been provided with assurance through the Executive Team meetings, Board and Board Development Sessions that the necessary plans and governance arrangements were in place for the satisfactory delegation of the final specified specialised acute and Mental Health Learning Disability and Autism Services (MHLDA) which took place on the 1st April 2025.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

As alluded to earlier in the performance section of the Annual Report the significant internal control issues that have been identified relates to financial controls in relation to the statutory duty to break-even.

The financial environment continues to prove challenging for the ICB and many other ICBs across the country. For 2025/26 the ICB has a surplus plan of £3.7m. The ICS has a break-even plan. However this is with a very challenging efficiency programme and work continues to identify recurrent efficiency savings for 2025/26 and future years.

John Turner
Chief Executive (Accountable Officer)
17th June 2025

Remuneration and Staff Report

Remuneration Report

The ICB has prepared a Remuneration Report containing information about director's remuneration. This report is in respect of the senior managers of the ICB. Some of the information in the report is part of the annual audit of the accounts, and this is indicated when it applies in the title of each section.

The definition of "senior managers" is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Integrated Care Board. This means those who influence the decisions of the ICB as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.'

The tables on subsequent pages of this report summarise the remuneration (excluding National Insurance contributions) and pension status of the ICB's Board members and other senior managers for the period 1st April 2024 to 31st March 2025. Prior year comparators are for the period 1st April 2023 to 31st March 2024.

The ICB's Remuneration Committee, which is a Committee of the Board, ensures that remuneration is both equitable and fair throughout the organisation. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17-19 of Schedule 1B to the NHS Act 2006, i.e., to confirm the ICB Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including Board Members) and Non-Executive Directors. It also ensures that the ICB's most senior managers are appropriately and fairly rewarded for their contributions, conforming to the ICB's probity and financial integrity as part of the corporate governance arrangements.

Remuneration Committee

The membership of the Remuneration Committee and their attendance at meetings throughout the period 1st April 2024 to 31st March 2025 was as follows:

Mrs Julie Pomeroy	Non-Executive Director and Chair of the Remuneration Committee
Dr Phillip Earnshaw	Non-Executive Director (from 1 March 2025)
Mrs Dawn Kenson	Non-Executive Director and Acting Deputy ICB Chair
Dr Gerry McSorley	ICB Chair
Mrs Margaret Pratt	Non-Executive Director (in attendance)
Mrs Sharon Robson	Non-Executive Director
Ms Anita Day	Non-Executive Director

There were five meetings of the Remuneration Committee held between 1st April 2024 and 31st March 2025 and further information on attendance is included in the Annual Governance Statement.

Arden & GEM CSU are contracted by the ICB to provide professional Human Resource advice to the ICB. Arden & GEM advice was paid for as part of their overall contract; no fee or other payment was made to any individual employed by Arden & GEM.

Policy on the Remuneration of Senior Managers

The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions.

Duties of the Remuneration Committee

For the Chief Executive, Directors, and other Very Senior Managers:

- determine all aspects of remuneration including but not limited to salary, pensions, and cars;
- determine arrangements for termination of employment and other contractual and non-contractual terms.

For all staff (including senior managers):

- determine the ICB pay policy (including adoption of pay frameworks such as Agenda for Change);
- oversee contractual arrangements;
- determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of national guidance.

To avoid any conflict of interest in respect of Non-Executive Directors who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by a

Remuneration Panel – the details and membership of the Panel are set out in the ICB Governance Handbook. The Non-Executive Directors are not part of this process.

The notice period for executive directors is six months and the arrangements for compensation payments for early termination of contract will comply with NHS regulations. The remuneration for executive directors does not include any performance related bonuses and none of the executives receive personal pension contributions other than their entitlement under the NHS Pension Scheme.

Remuneration of Very Senior Managers

Employment terms for a Very Senior Manager (VSM) or member of the ICB's Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the ICB. Remuneration for VSM employees is informed by the ICB Executive Pay Framework. The ICB has a robust process in place, using the current version of the VSM Pay Framework (published in March 2022). The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Directors from the Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual VSM pay review guidance from NHS England and annual Agenda for Change pay circulars to ensure parity where appropriate.



Salaries and Allowances [Audited]

Salaries and allowances for the senior managers of the ICB from April 2023 to March 2025 are shown in Tables 1a and 1b below. The notes describe principles which apply to both tables.

Salaries and Allowances Notes

1. Total remuneration includes salary and non-consolidated performance-related pay as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
2. None of the ICB's senior employees are entitled to performance related bonuses.
3. There were no payments or awards made to past senior managers, payments made for loss of office during the periods shown or payments to anyone who was not a senior manager but has previously been a senior manager at any time.
4. All pension related benefits show the increase in 'lifetime' pension which have arisen in the relevant period. The sum reported reflects the amount by which the annual pension received on retirement age has increased in the year multiplied by 20 (the average number of years a pension is paid to members of the NHS pension scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
5. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band (£'000) 45-50.
6. Where an employee has been in post for part of the year, their pay and pension amount are time apportioned to reflect their time in post with the ICB. Any start and end dates are shown in the notes.
7. The calculation of pension related benefits includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.

Table 1a: Salaries and Allowances for the period April 2023 to March 2024

Name and title	April 2023 to March 2024					
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	120-125	0	0	0	10-12.5	130-135
Mr Andrew Cash, Chair	25-30	0	0	0	0	25-30
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	45-50	0	0	0	0	45-50
Mr Martin Fahy, Director of Nursing	140-145	100	0	0	0	140-145
Mr Matt Gaunt, Director of Finance and Deputy Chief Executive	170-175	0	0	0	72.5-75	245-250
Dr Sunil Hindocha, Medical Director	170-175	0	0	0	0	170-175
Mrs Dawn Kenson, Non-Executive Director and Acting Deputy ICB Chair	15-20	800	0	0	0	15-20
Dr Gerry McSorley, Non-Executive Director and Acting ICB Chair	50-55	700	0	0	0	50-55
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	120-125	0	0	0	0	120-125
Professor Sir Jonathan Van-Tam, Non-Executive Director	0-5	0	0	0	0	0-5
Mrs Julie Pomeroy, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Margaret Pratt, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Anita Day, Non Executive Director	5-10	0	0	0	0	5-10
Mrs Sharon Robson, Non-Executive Director	5-10	0	0	0	0	5-10
Mrs Clair Raybould, Director for System Delivery	135-140	0	0	0	35-37.5	170-175
Mr John Turner, Chief Executive	185-190	0	0	0	0	185-190
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	120-125	0	0	0	0	120-125

Notes to Table 1a

The ICB was unable to appoint a permanent medical director until approval of the terms and conditions for the post were received from NHS England. Dr Sunil Hindocha worked with the ICB on an interim basis in this role through an off-payroll engagement with the Heart of Lincoln GP practice. The value reflected in the above table was the amount paid or payable to the Heart of Lincoln GP practice from April 2023 to March 2024.

All postholders reported above were in post for the full year with exception to the following:

- Sir Andrew Cash, Interim Chair – left the ICB on 31 August 2023.
- Professor Sir Jonathan Van-Tam, Non-Executive Director – left the ICB on 22 May 2023.
- Mr Simon Evans, System Director for Clinical Integration and Leadership Development – left the ICB on 11 August 2023.
- Mrs Sharon Robson, Non-Executive Director - started working with the ICB on 14 August 2023.
- Mrs Anita Day, Non-Executive Director - started working with the ICB on 1 September 2023.

Note that £313 relates to work done by Mrs Robson for the Maternity team. This is outside of her normal Non-Executive role.

The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.

Table 1b: Salaries and Allowances for the period April 2024 to March 2025

Name and title	April 2024 to March 2025					
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	130-135	0	0	0	20-22.5	150-155
Mrs Anita Day, Non-Executive Director	10-15	0	0	0	0	10-15
Dr Phillip Earnshaw, Non-Executive Director	0-5	0	0	0	0	0-5
Mr Matin Fahy, Director of Nursing	145-150	0	0	0	12.5-15	160-165
Mr Matt Gaunt, Director of Finance and Deputy Chief Executive	180-185	0	0	0	0	180-185
Dr Sunil Hindocha, Medical Director	165-170	0	0	0	40-42.5	210-215
Mrs Dawn Kenson, Non-Executive Director and Acting Deputy ICB Chair	20-25	400	0	0	0	20-25
Dr Gerry McSorley, ICB Chair	65-70	0	0	0	0	65-70
Mrs Anne Lloyd, Director of Workforce Transformation	30-35	0	0	0	115-117.5	145-150
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	130-135	0	0	0	10-12.5	140-145
Mrs Julie Pomeroy, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Margaret Pratt, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Sharon Robson, Non-Executive Director	15-20	0	0	0	0	15-20
Mrs Clair Raybould, Director for System Delivery	140-145	1,000	0	0	0	140-145
Mr John Turner, Chief Executive	260-265		0	0	0	260-265
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collaboration	130-135	0	0	0	15-17.5	145-150

Notes to Table 1b

All postholders reported above were in post for the full year with exception to the following:

- Mrs Anne Lloyd, Director of Workforce Transformation - started working with the ICB on 1 January 2025.
- Dr Phillip Earnshaw, Non-Executive Director - started working with the ICB on 1 March 2025.

Note that £1,875 relates to work done by Mrs Robson for the Maternity team. This is outside of her normal Non-Executive role.

The expenses shown relate to travel costs which were outside the normal limits for non-taxable refund.

Pension recycling payments for the Chief Executive

Where senior employees have opted out of the NHS Pension Scheme for tax reasons, employers may introduce a policy to pay any unused employer contributions as additional salary. This is often known as recycling contributions. This initiative has been introduced in the NHS to reflect growing concern about some doctors and senior managers reducing their hours or even leaving the NHS altogether.

Pension recycling aims to tackle this issue. The idea is that senior staff who opt out of the NHS Pension Scheme in order to avoid a tax issue should still be entitled to the employer's contribution they would have received in the scheme. That way, they can continue to work – and progress their careers – as normal, without facing a tax problem or missing out on an important element of their remuneration.

It has been determined that the ICB Chief Executive John Turner qualifies for pension recycling payments in line with NHSE advice. This

decision has gone through several governance steps including assessment by the Remuneration Committee. Approval for these payments was given during the 2024/25 financial year and is backdated to July 2022 (the start of the ICB).

Hence, there was back pay of £41,070 relating to prior years. The pension recycling remuneration for 2024/25 is £24,642.

All these payments (in year pay and back pay) are included in the disclosures in Table 1b, 'Salaries and allowances for the period end 31 March 2025'.

The back pay has been excluded from the Fair Pay disclosures in respect of:

- the percentage change from the previous financial year in respect of the highest paid director, and;
- the remuneration of the highest paid director in the pay ratio analysis.

This has been done for compliance with the principles in the Hutton Review of Fair Pay which only wanted to report the impact of changes in pay policy rather than one-off adjustments

Non-cash remuneration: benefits in kind

Employees can receive non-cash benefits which must be reported to HMRC each year on a P11D form. These include discounted services or goods, vouchers (including childcare vouchers), living accommodation, travel allowances, company cars, vans, bikes or other vehicles available for private use, low-cost loans, private insurance, professional fees and subscriptions.

None of the senior managers received benefits in kind during the period April 2023 to March 2024, nor did they in the year April 2024 to March 2025.

Pension benefits [Audited]

Most of the senior managers do not have pensionable pay, either because they have opted out of the pension scheme or because (for non-executive directors) their engagement does not qualify as pensionable pay. Figures for the remaining staff for April 2023 to March 2025 are shown in Tables 2a and 2b below. The notes describe principles which apply to both tables.

Pension Benefit Notes

1. The below information is based on data provided by the NHS Pensions Agency.
2. The employer's contribution rate to pension benefits was 20.68% of pensionable pay from April 2023 to March 2024, and in the financial year from April 2024 to March 2025.
3. Pension figures included in the table below are for senior managers that have pensions paid directly by the ICB and include all of their NHS service, not just pension payments that related to the year in question.
4. Where an employee has been in post for part of the year their pension amount is time apportioned to reflect their time in post.
5. Staff are able to make additional voluntary contributions alongside their regular contributions.
6. The Department of Health and Social Care Group Accounting Manual confirms that where a senior manager has opted out of the pension arrangements for the whole of the year, no pension figures should be reported. This guidance has been applied to **Tables 2a and 2b for Mr John Turner**, who chose not to be covered by the pension arrangements during either reporting period.
7. The calculation of the real increase in Cash Equivalent Transfer Value includes allowance for employee contributions. It should be noted that on some occasions a small proportion of the employee contributions relates to a previous financial period.
8. The benefits and corresponding Cash Equivalent Transfer Value disclosed in Table 2 below **does not allow for any potential adjustment in relation to the McCloud judgement.**

Table 2a: Pension Benefits for the year ended 31 March 2024

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024	Lump sum at pension age related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 1 April 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0-2.5	0	40-45	0	442	131	633	0
Mr Simon Evans, System Director for Clinical Integration and Leadership Development	0	5-7.5	25-30	70-75	388	29	509	0
Mr Martin Fahy, Director of Nursing	0	17.5-20	70-75	200-205	1,369	183	1,708	0
Mr Matt Gaunt, Director of Finance and Deputy Chief Executive	2.5-5	0	40-45	0	552	161	792	0
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	0	35-37.5	55-60	160-165	1,111	206	1,446	0
Mrs Clair Raybould, Director for System Delivery	0-2.5	37.5-40	35-40	95-100	534	198	805	0
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collection	0	35-37.5	45-50	125-130	753	191	1,036	0

Some staff are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero. This applies to Mr Simon Evans, Mr Martin Fahy, Ms Sarah-Jane Mills and Mrs Sandra Williamson.

Table 2b: Pension Benefits for the year ended 31 March 2025

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 1 April 2024	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Pete Burnett, Director of Strategic Planning, Integration and Partnerships	0-2.5	0	45-50	0	633	17	707	0
Mr Martin Fahy, Director of Nursing	0-2.5	0	75-80	210-215	1,708	31	1,870	0
Mr Matt Gaunt, Director of Finance and Deputy Chief Executive	0	0	45-50	0	792	0	834	0
Dr Sunil Hindocha, Medical Director	2.5-5	0	0-5	0	0	32	53	0
Mrs Anne Lloyd, Director of Workforce Transformation	0-2.5	0	5-10	0	0	20	84	0
Ms Sarah-Jane Mills, Director for Primary Care and Community and Social Value	0-2.5	0	60-65	165-170	1,446	25	1,583	0
Mrs Clair Raybould, Director for System Delivery	0-2.5	0	35-40	90-95	805	0	850	0
Mrs Sandra Williamson, Director for Health Inequalities and Regional Collection	0-2.5	0	50-55	130-135	1,036	20	1,141	0

Negative values are not disclosed in this table but are substituted with a zero. This applies to Mr Martin Fahy, Mr Matt Gaunt, Ms Sarah-Jane Mills, Mrs Clair Raybould and Mrs Sandra Williamson.

The following definitions are provided for the pension tables above.

Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with ‘SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008’.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

There have been no compensation payments for early retirement or for loss of office during the period April 2024 to March 2025 (and there were none in the period from April 2023 to March 2024).

Payments to past directors

There have been no payments to past directors.

Fair pay disclosures [Audited]

Percentage change in remuneration of highest paid director

Entities are required to disclose pay ratio information and detail concerning the percentage change in remuneration for the highest paid director.

Percentage changes from 2023-24 to 2024-25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	18.7%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	8.3%	n/a

There are no material transactions other than salaries and allowances. In general, salaries for directors of the ICB have been set in advance in accordance with prevailing policies and guidance.

The increase in 2024/25 over the previous year would have been 42.7% if all payments for pension

recycling had been included. However, we are now following new Department of Health guidance including clause para 3.108 of the Government Accounting Manual so we exclude material back pay. The back pay would have added a further 25% to the disclosed percentage change.

The remaining 18.7% increase in the salary for the highest paid director comes from 13.7% relating to new payments for pension recycling {as described in the notes to Table 1b above) and 5% for the 2024/25 pay award.

The pay award for most other staff followed Agenda for Change agreements.

Staff received the pay award for 2024/25, being a 5.5% increase in basic pay for all pay points. This general increase of 5.5% has been increased further by an increase in the average grade of staff. The average salary falls within the Band 7 salary range. There has been a 0.8% increase in the proportion of staff above this grade, including 15.4 wte more staff in the most senior pay bands, Band 8b to Executive level.

The overall impact was an average increase of 8.3% in staff pay.

Comparatives from the previous year are shown below.

Percentage changes from 2022-23 to 2023-24	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	2.7%	n/a
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2.7%	n/a

Pay ratio information

In 2024/25 no employees received remuneration in excess of the highest-paid director / member (and also none in the previous period April 2023 to March 2024).

As at 31 March 2025, remuneration ranged from £2,500 to £222,500 (March 2024: £2,500 to £187,500) using midpoints of the bands based on

annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is normally further broken down to disclose the salary component (but for the ICB salary is the only component, so no further breakdown is presented). The banded remuneration of the highest paid director in the Integrated Care Board in the financial year 2024-25 was £220-225,000 (April 2023 to March 2024, £185-£190,000) based upon gross earnings in March 2025. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2023-24	25th percentile	Median	75th percentile
Total remuneration (£)	27,596	43,200	50,952
Salary component of total remuneration (£)	27,596	43,200	50,952
Pay ratio information	6.79	4.37	3.68
2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	29,114	44,962	56,454
Salary component of total remuneration (£)	29,114	44,962	56,454
Pay ratio information	7.64	4.95	3.94
2024-25 without Pension Recycling	25th percentile	Median	75th percentile
Total remuneration (£)	29,114	44,962	56,454
Salary component of total remuneration (£)	29,114	44,962	56,454
Pay ratio information	6.83	4.42	3.52

The main change comes from the increase in the salary of the highest paid director for pension recycling: this has increased all the ratios in 2024/25.

When the pension recycling is removed there are no significant changes in the ratios between years. The small shift to higher banded staff in 2024/25 has slightly increased the ratio at the 25th percentile and slightly reduced the ratio for the 75th percentile.

The median pay ratio is about 4.4 for both years. This is consistent with the pay, reward and progression policies for the ICB's employees because:

- staff are paid in accordance with Agenda for Change regulations;
- the skill mix of staff to deliver ICB objectives requires a mix of professional, senior and administrative staff which is under regular review;
- the pay of the highest-paid director is set by the Remuneration Committee in line with national benchmarks.

When the one-off back pay for pension recycling is included then all the ratios increase accordingly. However, they will fall back to normal levels next year.

Exit Packages for the year ending March 2025 [Audited]

There was one exit package agreed in the financial year 2024/25 (but there were none in the period April 2023 to March 2024) as shown in the tables below. This was a contractual payment in lieu of notice.

Table 1: Exit Packages for the financial year April 2024 to March 2025

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	1	£6,700	1	£6,700	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	00	0	0	0	0	0	0	0

Table 2: Exit Packages for the financial year April 2023 to March 2024

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	£'s	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
More than £200,000	0	0	0	0	0	0	0	0
Total	00	0	0	0	0	0	0	0

Reporting of redundancy and other departure costs is in accordance with the provisions of the Agenda for Change redundancy policy. Exit costs in this note are accounted for in full in the year of departure. Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS pensions scheme. Ill-health retirement costs

are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Other Departures

There was one other departure during 2024/25 as disclosed in Table 1 below (but there were none in the period April 2023 to March 2024).

Table 1: Other Agreed Departures for the year ending March 2025

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	1	6,700
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	0	0

As a single exit package can be made up of several components (each of which will be counted separately in this Note) the total number above will not necessarily match the total numbers in Note 4.4 Exit Packages which will be the number of individuals.

* Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments

Table 2: Other Agreed Departures for the period April 2023 to March 2024

	Agreements	Total Value of Agreements
	Number	£'s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total	0	0

requiring HMT approval".

**Includes any non-contractual severance payment made following judicial mediation, and any relating to non-contractual payments in lieu of notice.

There were no non-contractual payments (£0) made to individuals where the payment value was more than 12 months of their annual



Staff Report [Audited]

Staff Engagement

As we moved into our second year of activity the ICB, our teams continued to help shape our future direction to ensure that our services help support our partner organisations and the wider Lincolnshire Integrated Care system.

We continue to engage with staff on a weekly basis through our regular Team Talk Live briefing which enables our Chief Executive to provide a weekly overview of ICB activity and also enables colleagues to attend as weekly guest speakers to provide an overview of services that individual teams undertake. This is supplemented by our weekly Team Talk newsletter which ensure that our staff have a further opportunity to be kept up to date with weekly activity across the organisation.

Our Staff Engagement Group (SEG) continues to meet monthly. This meeting provides a forum for staff representatives to make suggestions or improvements for the organisation. In addition to their internal focus, members of SEG also run and assist with charitable causes for both national campaigns and the local community. In December 2024, SEG and our staff undertook a campaign to raise vital supplies for Sleaford foodbank and our staff made voluntary donations as part of this campaign.

We were able to continue to run our annual half day staff events and this year we held three events to ensure that all our employees had the opportunity to attend. These half day sessions enabled staff to hear from the ICBs Senior Leadership Team and the ICB Chief Executive on a range of topics which included an opportunity to personally thank staff for their contributions and to celebrate some of the work that the ICB has both delivered and supported. As part of our wider engagement work, our teams also provided feedback looking at improving team working, career pathways and succession planning. In respect of the later the ICB intends to share these outputs with its system partners as part of wider system working across the health and social care landscape in Lincolnshire.

As part of the work undertaken in the previous year, we continued to make improvements to our intranet to make information more accessible and through the improvements made in the previous year to support new staff during the first few months of employment by providing the opportunity to attend a newly established corporate induction session.

2024 Staff Survey

269 (72 %) of our staff completed the NHS National Staff Survey which represented an increase of 2% from the previous year. This is a pleasing result as the average completion rate for surveys across all NHS organisations is on average 50%.

The ICB scores very well against other ICBs for most questions. In many, the ICB scores more than 3% better than the ICB average. In areas covered by the NHS People Promise (e.g. compassion and inclusion, morale, staff engagement), the ICB scores extremely well with no areas showing red as being noticeably below the ICB average but with a number significantly above.

We will be exploring with our staff engagement team how we can make further improvements when the next survey is launched in the autumn as well as continuing with ongoing work from the previous year's survey.

Throughout the year our HR team have worked with the Executive Team and line managers to support the ICB with a number of pieces of project work including reviewing arrangements for Safeguarding and Disclosure and Barring Checks, the roll out of the Oliver McGowan national training programme to all staff and as well as supporting the organisation with a review of its vacancy control processes.

Staff Composition

We monitor a number of human resource indicators, including staff sickness rates, vacancy rates and staff turnover. This allows us to explore further management of such issues and to gain assurance around the proactive support offered to staff regarding their health and wellbeing. We are pleased to report that our average hourly days lost has decreased from 7.30 days for the period 1st April 2024 to 7.23 days as at the end of March 2025. As an organisation we will continue to monitor absence and address any trends.

Staff Turnover

The cumulative turnover rate for the ICB staff in for the period 1st April 2024 to 31st March 2025 was an average of 10.98%. The ICB uses a variety of source documents including exit interview data and feedback from the NHS staff survey to identify what steps it needs to take to monitor this figure to reduce turnover. The results of these surveys are analysed at regular intervals and any specific trends or concerns will be reviewed by the ICB's senior management team who will ensure that any recommendations are implemented accordingly.

Staff Composition Table

Payscale	Gender	WTE	Bank Staff
Band 2	Female	2.69	1
	Male	2.00	
Band 3	Female	30.54	
	Male	11.80	
Band 4	Female	32.66	
	Male	5.00	
Band 5	Female	30.20	
	Male	6.60	
Band 6	Female	40.78	1
	Male	13.00	
Band 7	Female	55.05	
	Male	10.60	
Band 8a	Female	39.19	
	Male	11.00	1
Band 8b	Female	14.59	
	Male	11.78	
Band 8c	Female	15.13	
	Male	6.00	
Band 8d	Female	3.80	
	Male	5.00	
Band 9	Female	6.60	1
	Male	4.00	1
Board Members	Female	1.00	
	Male	4.00	
GP/Clinical Leads	Female	0.85	
	Male	2.15	
VSM	Female	3.00	
	Male	1.00	
		370.01	5

An analysis of staff numbers and cost is provided at note 4.1 and 4.2 to the accounts. As they are part of the statutory annual accounts disclosures, these figures are subject to audit

Staff Headcount

	Female		Male		Total	
	Headcount	% of workforce	Headcount	% of workforce	Headcount	% of workforce
Board Members	1	0.25%	4	0.99%	5	1.23%
Senior Managers (Band 8C and above)	31	7.65%	17	4.20%	48	11.85%
Other Members of staff	271	66.91%	81	20.00%	352	86.91%
Total	303	74.81%	102	25.19%	405	100.00%

Sickness absence table

Sickness absence table	
	April 2024 - March 2025
Total Days Lost	2546
Total Staff Years	352
Average Working Days Lost	7.2

Staff Policies

We have established a set of policies for the ICB which are based on best practice. This year we have developed and implemented a new DBS Policy, a Sexual Safety Policy, a Secondary Employment Policy and a Zero Tolerance statement. We will continue to develop further policies as the need arises and as new employment legislation emerges.

In addition, we continue to develop our intranet content to make sure that staff have access to these policies and other up to date information. This particularly helps our new starters quickly settle into the organisation. This work will continue as we move towards our new share point page for HR content which will make accessing content more straightforward and easier.

All of our staff are encouraged to meet with their line manager to have a regular one-to-one. Additionally, we have in place an annual appraisal process where more in depth discussions take place to enable managers and employees to discuss performance wellbeing and career development.

The ICB recognises that in order for the NHS to meet its further workforce challenges it has to regularly review how it recruits and retains staff ensuring that it both meets the needs and desires of its workforce while meeting the operational needs of the service. In addition to our apprenticeship scheme for new entrants, we continue to support pathways to support existing staff in their professional development which will help develop the skills of our managers and future leaders. This development has been undertaken within an agreed financial envelope through the statutory apprenticeship levy without any additional costs to the ICB.

The ICB works with its partners across Lincolnshire and has an agreed Lincolnshire People Plan which supports four key pillars; valuing our people, growing our people, developing our people and retaining our people.

To support the Lincolnshire People Plan our Organisational Development Team have focused development opportunities for the ICB workforce. There have been a range of initiatives which have included support for first time/inexperienced managers a development programme for support staff as well as separate events that have taken place throughout the year including a new induction programme and short courses for chairing meetings.

Health and Wellbeing

The ICB places significant emphasis on making sure that the wellbeing of its staff is placed at the heart of everything we do and is aligned with the wider Lincolnshire system and NHS People Plan. In addition to our established occupational health and employee assistance programme, the ICB offers its staff a wide range of wellbeing support from the wider Lincolnshire ICS system for both physical and mental health (this year, in conjunction with our EAP we launched our Wisdom app which is available to all staff to support their wider wellbeing at work and at home.

Any new wellbeing initiatives are announced at our weekly briefing and further detail is provided on our wellbeing hub on our HR intranet page which is accessible to all staff. Further support to staff is available from our HR team and we encourage all our managers to have conversations with staff as part of their one to one and appraisal

process. Staff who have been absent through ill-health have a return-to-work interview with their manager to identify any concerns and ensure that any additional support that may be required is provided.

When people leave the ICB, Line Managers ensure that employees complete an online exit questionnaire which enables the organisation to take account of feedback so that it can develop and grow as an organisation.

Recruitment and new appointees

We believe our benefits offer to staff is competitive and enables the ICB to remain an employer of choice within the Lincolnshire System. We have recently introduced a long service award scheme and we have promoted the roll-out of the NHS ESR app which enables staff to access information on the go without having to wait until they are next in the office. This has proved particularly popular with staff who have peripatetic roles.

We continue to support disabled people and we are a Disability Confident Employer.

We are committed to:

- inclusive and accessible recruitment
- communicating vacancies
- offering an interview to disabled people
- providing reasonable adjustments
- supporting existing employees

Our equality information is available on our website. This information is part our public commitment to meeting the equality duties placed upon us. NHS Lincolnshire is Mindful Employer and is a signatory to the Mindful Employer Charter.

Off Payroll Engagements

Table 1: Length of all highly paid off-payroll engagements

For all highly paid off-payroll engagements as of 31 March 2025, greater than £245 per day:

	Number
Number of existing engagements as of 31 March 2025	2
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

Table 2: New Off Payroll engagements

For all off-payroll appointments engaged at any point between 1 April 2024 and 31 March 2025, greater than £245 per day:

	Number
The number of off-payroll workers engaged between 1 April 2024 and 31 March 2025	2
Of which:	
The number not subject to off-payroll legislation	0
The number subject to off-payroll legislation and determined as in-scope of IR35	0
The number subject to off-payroll legislation and determined as out-of-scope of IR35	2
The number of engagements reassessed for compliance or assurance purposes during the year	2
of which the number of engagements that saw a change to IR35 status following review	0

Note: A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 3: New Off Payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025.

	Number
The number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year	16

Freedom to Speak Up Guardian

Our Freedom to Speak up Guardian is Mr Martin Fahy, who is our Director of Nursing. He is supported by Mrs Vanessa Wort, who is the ICBs Freedom to Speak up Lead and our Associate Director of Nursing.

The ICB is committed to conducting its business with honesty and integrity. It expects all staff to maintain high standards in accordance with its

Constitution and will continue to maintain and develop a culture of openness and accountability and a supportive environment, in which staff can raise any issues or concerns in a timely manner.

The ICB has in place a Freedom to Speak Up Policy which is in line with national guidelines for Freedom to Speak Up. This year the ICB has recruited additional volunteers to act as our Freedom to Speak Up Champions to ensure that all our teams have an appropriate point of contact to support them should they raise a concern.

Trade Union Facility Time

The ICB does not have any designated trade union representatives and is reporting a nil return under the Trade Union (Facility time Publication's requirements) Regulations 2017.

Conclusion

We once again want to give thanks to all our staff in what has been another very busy year. Our staff are a vital asset in supporting the healthcare system across Lincolnshire helping to build effective relationships with our partner organisations but more importantly helping to shape first class services in Lincoln for our patients, service users and residents.

The senior leadership team and in particular our Chief Executive Mr John Turner wishes to place on record his personal gratitude for the hard work, commitment and dedication of all the teams in the ICB and to thank them for their unwavering support.

Expenditure on Consultancy

Consultancy spend from 1st April 2023 to 31st March 2024 was £586,166

Consultancy spend from 1st April 2024 to 31st March 2025 was £208,458.45.

Parliamentary Accountability and Audit report

The ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at page 133 onwards. An audit certificate and report is also included in this Annual Report.

John Turner
ICB Chief Executive (Accountable Officer)
17th June 2025

Financial Statements

Entity name:	NHS Lincolnshire Integrated Care Board
This year	2024-25
Last year	2023-24
This year ended	31 March 2025
Last year ended	31-March-2024
This year commencing:	01-April-2024
Last year commencing:	01-April-2023

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Explanatory Foreword to the Accounts

NHS Lincolnshire Integrated Care Board (ICB) received an in-year Revenue Resource Limit (allocation) of £2,142,030,000 in 2024-25. The ICB however had a reduction to allocation of £5,609,000 representing the former Lincolnshire CCGs historic deficit brought forward. In total, the ICB received a funding allocation of £2,136,421,000 for 2024-25.

As set out in these accounts, the ICB incurred net expenditure of £2,151,544,953 during 2024-25 which was higher than the ICB's Revenue Resource Limit by £9,514,953 (as demonstrated in Note 41 to the accounts).

As at 31 March 2025 the ICB had net liabilities of £69,290,366. This does not indicate a weak financial position. NHS England provides cash to ICBs only when required to meet its liabilities. As the ICB has liabilities in excess of its assets, it has a negative taxpayers' equity. This represents a common position for Integrated Care Boards since it is inappropriate to draw down cash in advance of need and funding is made available to meet the net liabilities of the ICB as they become payable.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

The financial plan for 2025/26 has been agreed by NHS England and funding has been received to deliver the plan.

Mr John Turner
Chief Executive
17 June 2025

**Statement of Comprehensive Net Expenditure for the year ended
31 March 2025**

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(24,187)	(23,362)
Other operating revenue	2	(0)	(141)
Total operating income		(24,187)	(23,503)
Staff costs	4	24,897	22,245
Purchase of goods and services	5	2,150,344	1,832,956
Depreciation and impairment charges	5	67	67
Provision expense	5	217	(2,306)
Other operating expenses	5	198	166
Total operating expenditure		2,175,722	1,853,127
Net Operating Expenditure		2,151,535	1,829,624
Finance cost	10	10	12
Net expenditure for the Year		2,151,545	1,829,636
Total Net Expenditure for the Financial Year		2,151,545	1,829,636
Other Comprehensive net Expenditure		-	-
Total other comprehensive net expenditure		-	-
Comprehensive Net Expenditure for the year		2,151,545	1,829,636

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the organisation and credited to the General Fund. The cash available in year from NHS England was £2,138,876,193 and the in year allocation was £2,142,030,000.

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 136 to 160 were approved by NHS Lincolnshire Integrated Care Board on 17 June 2025 and signed on its behalf by:

Chief Executive
Mr John Turner

**Statement of Financial Position as at
31 March 2025**

		2024-25	2023-24
	Note	£'000	£'000
Non-current assets:			
Property, plant and equipment	12	58	-
Right-of-use assets	13.1	217	284
Total non-current assets		275	284
Current assets:			
Trade and other receivables	17	13,224	24,252
Cash and cash equivalents	20	7	37
Total current assets		13,231	24,289
Total current assets		13,231	24,289
Total assets		13,506	24,573
Current liabilities			
Trade and other payables	23	(82,185)	(80,778)
Lease liabilities	13a	(68)	(68)
Provisions	30	(361)	(152)
Total current liabilities		(82,613)	(80,998)
Total Assets less Current Liabilities		(69,107)	(56,425)
Non-current liabilities			
Lease liabilities	13a	(162)	(227)
Provisions	30	(21)	(14)
Total non-current liabilities		(183)	(241)
Total Assets less Total Liabilities		(69,290)	(56,666)
Financed by Taxpayers' Equity and other reserves			
General fund		(69,290)	(56,666)
Total taxpayers' equity:		(69,290)	(56,666)

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 136 to 160 were approved by NHS Lincolnshire Integrated Care Board on 17 June 2025 and signed on its behalf by:

Chief Executive
Mr John Turner

**Statement of Changes In Taxpayers' Equity for the year ended
31 March 2025**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(56,665)	(56,665)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(2,151,545)	(2,151,545)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	(2,151,545)	(2,151,545)
Net funding	2,138,920	2,138,920
Balance at 31 March 2025	(69,290)	(69,290)
	General fund £'000	Total reserves £'000
Changes in taxpayers' equity 2023-24		
Balance at 01 April 2023	(88,710)	(88,710)
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(1,829,636)	(1,829,636)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	(1,829,636)	(1,829,636)
Net funding	1,861,680	1,861,680
Balance at 31 March 2024	(56,666)	(56,666)

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 136 to 160 were approved by NHS Lincolnshire Integrated Care Board on 17 June 2025 and signed on its behalf by:

Chief Executive
Mr John Turner

**Statement of Cash Flows for the year ended
31 March 2025**

	Note	2024-25 £'000	2023-24 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(2,151,545)	(1,829,636)
Depreciation and amortisation	5	67	67
Interest paid / (received)		10	12
(Increase)/decrease in trade & other receivables	17	11,028	(15,135)
Increase/(decrease) in trade & other payables	23	1,349	(14,281)
Provisions utilised	30	-	(290)
Increase/(decrease) in provisions	30	217	(2,306)
Net Cash Inflow (Outflow) from Operating Activities		(2,138,875)	(1,861,569)
Net Cash Inflow (Outflow) from Investing Activities		-	-
Net Cash Inflow (Outflow) before Financing		(2,138,875)	(1,861,569)
Cash Flows from Financing Activities			
Net Funding Received		2,138,920	1,861,680
Payments in Respect of Finance Lease		(75)	(75)
Net Cash Inflow (Outflow) from Financing Activities		2,138,845	1,861,605
Net Increase (Decrease) in Cash & Cash Equivalents	20	(30)	36
Cash & Cash Equivalents at the Beginning of the Financial Year		37	1
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		7	37

Notes 1 to 43 form part of these financial statements.

The financial statements on pages 136 to 160 were approved by NHS Lincolnshire Integrated Care Board on 17 June 2025 and signed on its behalf by:

Chief Executive
Mr John Turner

Notes to the financial statements**1 Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICB's) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

As at 31 March 2025 the ICB had net liabilities of £69,290,366. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of Integrated Care Boards is currently unchanged. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

The financial plan for 2025/26 has been agreed by NHS England and funding has been received to deliver the plan.

It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2025/26 and Integrated Care Board published allocations can be found on the NHS England website for 2025/26. The commissioning of health services (continuation of service) will continue after 31 March 2025.

Our considerations cover the period 12 months beyond the date of authorisation of issue of these financial statements. Considering the information summarised above, the Board have a reasonable expectation that the Integrated Care Board will have adequate resources to continue in operational existence.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These financial statements have been prepared under the historical cost convention modified to account for certain financial assets and financial liabilities.

Due to rounding of transactions, in some places. There may be minor rounding differences in relation to casting/cross casting in these accounts.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint arrangements

Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator, it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

The Integrated Care Board has entered into a pooled budget arrangement with Lincolnshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Learning Disabilities, Child and Adolescent Mental Health, Community Equipment and Proactive Care in the Community. Note 35 to the financial statements provides details of the income and expenditure.

The pool is hosted by Lincolnshire County Council. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The Integrated Care Board reviews the Section 75 agreements to determine which party has control over the services being delivered, in accordance with IFRS 11 and the accounting policy at 1.4 for joint arrangements.

The Integrated Care Board has considered the NHS lead commissioning arrangement under IFRS 15 Revenue from Contracts with Customers for all elements contained within the individual section 75's and has concluded that the Integrated Care Board is acting as both the 'principal' and the 'agent' for different parts of the arrangement and should therefore account for gross expenditure and income arising from the arrangement within the financial statements and the net expenditure and income arising from the agreement respectively.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board. NHS Lincolnshire Integrated Care Board considers it has only one operating segment, that is commissioning of healthcare services.

1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service is recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 4.72% is to be applied for new leases commencing, or relevant lease modifications or remeasurements being remeasured in the 2024 calendar year under international financial reporting standard (IFRS) 16.

Lease payments included in the measurement of the lease liability comprise

Fixed payments;

Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;

The amount expected to be payable under residual value guarantees;

The exercise price of purchase options, if it is reasonably certain the option will be exercised; and

Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13.2 The ICB as Lessor

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

When the Integrated Care Board is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the ICB's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.

Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.14 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.15 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate (as published on the <https://www.gov.uk/> website) as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.17 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Integrated Care Board does not meet the qualification criteria for this scheme.

1.19 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.20.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.20.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.20.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.20.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.21.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.21.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.24 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.25.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- It is appropriate to prepare the accounts on a 'going concern' basis.
- Continuing healthcare claims (CHC) prior to 31 March 2013 and which relate to the population of the Integrated Care Board are not directly recognised in the accounts, rather, they are managed via a national risk pool. There is no contribution to the risk pool by Integrated Care Boards in 2024-25. Payments for claims from NHS Lincolnshire Integrated Care Board residents are made by the Integrated Care Board but are recharged to the central NHS England risk pool.
- That all contract, and other, arrangements are correctly assessed for risk to exposure to additional expenditure that may require provision in accordance with the relevant International Accounting Standard (IAS 37).
- That all arrangements containing leases have been correctly identified in accordance with the relevant interpretation issued by the International Financial Reporting Standard (IFRS 16).
- The Better Care Fund reporting has been agreed with Lincolnshire County Council. This is shown on a net accounting basis in the accounts. Note 35 Joint arrangements - interests in joint operations provides further detail.

1.25.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In the application of the Integrated Care Board's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily available from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions used are continually reviewed. Revisions to accounting estimates are recognised in the period from which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The most significant area of estimation uncertainty relates to the estimation of accruals for healthcare in the latter months of the year for which actual data was not received prior to the closure of the accounts. The material accruals relate to the provision of healthcare by the private sector mainly relating to the provision of Continuing Healthcare and Mental Health complex case provision where the BroadCare system is used to inform forecasts for contracts at individual patient level. In addition, the estimation of accruals for Primary Care Prescribing relies on the forecasting methodology of the Business Services Authority (BSA).

Provisions have been made for the Integrated Care Board's liability for Continuing Healthcare for nursing care provided after 1 April 2013. Claims have been made by the public where they have borne the nursing costs but believe that there was a health need which should have been met by the Integrated Care Board. Each case has its own set of circumstances and appeals can be made against the initial ruling.

1.26 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

There were no new International Financial Reporting Standards that impacted on the financial year ended 31 March 2025 for NHS Lincolnshire Integrated Care Board.

1.28 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The application of IFRS 17, IFRS 18 and IFRS 19 would not have a material impact on the accounts for 2024-25, were they applied in the year.

2 Other Operating Revenue

	2024-25	2023-24
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	23	49
Prescription fees and charges	12,262	11,785
Dental fees and charges	10,914	10,264
Other Contract income	943	1,185
Recoveries in respect of employee benefits	45	79
Total Income from sale of goods and services	24,187	23,362
Other operating income		
Other non contract revenue	0	141
Total Other operating income	0	141
Total Operating Revenue	24,187	23,503

Revenue does not include allocation or cash received from NHS England. This is drawn down directly into the bank account of the Integrated Care Board and credited to the General Fund.

NHS Lincolnshire ICB certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

	2024-25			2023-24		
	Income £'000	Full Cost £'000	Surplus / (Deficit) £'000	Income £'000	Full Cost £'000	Surplus / (Deficit) £'000
Prescription fees and charges	12,262	(204,095)	(191,833)	11,785	(203,890)	(192,105)
Dental fees and charges	10,914	(38,778)	(27,864)	10,264	(30,428)	(20,164)
Total fees and charges	23,176	(242,873)	(219,697)	22,049	(234,318)	(212,269)

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective is to collect charges from those patients that do not meet the eligibility criteria for free prescriptions and dental treatments.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2024/25, the NHS prescription charge for each medicine or appliance dispensed was £9.90. However, the majority of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months or £114.50 for a year. A number of other charges were payable for wigs and fabric supports.

NHS dental charges fall into 3 bands dependent on the level and complexity of care provided. Those who meet the eligibility criteria for exemption are not required to pay such charges. In 2024/25, the charge for Band 1 treatments was £26.80, for Band 2 was £73.50 and for Band 3 was £319.10.

3 Disaggregation of Revenue - Income from sale of good and services (contracts)

Source of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	Total £'000
	NHS	-	-	-	484	44
Non NHS	23	12,262	10,914	459	1	23,659
Total	23	12,262	10,914	943	45	24,187

Timing of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000	Total £'000
	Point in time	-	12,262	10,914	-	-
Over time	23	-	-	943	45	1,011
Total	23	12,262	10,914	943	45	24,187

Integrated Care Board revenue is entirely from the supply of services. NHS Lincolnshire Integrated Care Board receives no revenue from the sale of goods.

The contract income that has been recognised was not included within the opening balances of contract liabilities.

There is no contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2024-25			2023-24		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	18,375	593	18,968	16,585	465	17,050
Social security costs	2,043	-	2,043	1,990	-	1,990
Employer Contributions to NHS Pension scheme	3,803	-	3,803	3,128	-	3,128
Apprenticeship Levy	75	-	75	76	-	76
Termination benefits	8	-	8	-	-	-
Gross employee benefits expenditure	24,304	593	24,897	21,780	465	22,245
Less recoveries in respect of employee benefits (note 4.1.2)	(45)	-	(45)	(79)	-	(79)
Total - Net admin employee benefits including capitalised costs	24,259	593	24,853	21,701	465	22,166
Less: Employee costs capitalised	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	24,259	593	24,853	21,701	465	22,166

4.1.2 Recoveries in respect of employee benefits

	2024-25			2023-24		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue						
Salaries and wages	(36)	-	(36)	(69)	-	(69)
Social security costs	(4)	-	(4)	(7)	-	(7)
Employer contributions to the NHS Pension Scheme	(4)	-	(4)	(2)	-	(2)
Total recoveries in respect of employee benefits	(45)	-	(45)	(79)	-	(79)

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	333.00	32.55	365.55	334.87	27.81	362.68
Of the above:						
Number of whole time equivalent people engaged on capital projects	-	-	-	-	-	-

4.3 Exit packages agreed in the financial year

	Compulsory Redundancies		Other Agreed Departures		Total	
	Number	£	Number	£	Number	£
Exit packages agreed in the financial year ended 2024-25	-	-	1	6,700	1	6,700
Exit packages agreed in the financial year ended 2023-24	-	-	-	-	-	-

NHS Lincolnshire Integrated Care Board agreed one exit package for the financial year ended 31 March 2025 (2023-24, nil). The payment was a contractual payment in lieu of notice and totalled £6,700.19. The expense has been recognised in full in 2024-25 and relates wholly to 2024-25. There were no other agreed departures during the financial year.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Where the Integrated Care Board has agreed early retirements, the additional costs are met by the organisation and not by the NHS Pension Scheme. Ill health retirement costs are met by the NHS Pension Scheme and would not be included as an exit package agreed in the year. Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. For the financial year ended 31 March 2025 NHS Lincolnshire Integrated Care Board did not have any ill health retirements (2023-24, nil).

Zero non-contractual payments (£0) were made to individuals where the payment value was more than 12 months' of their annual salary for the financial year ended 31 March 2025 (2023-24, £0).

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report; this was nil for the financial year ended 31 March 2025 (2023-24, £0).

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Integrated Care Board is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrolls the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2025 there were 416 employees employed by the Integrated Care Board (31 March 2024: 389), of these 353 are members of the NHS Pension Scheme (31 March 2024: 336) , 13 are enrolled within NEST (31 March 2024: 14) and 50 are not currently contributing through a workplace pension scheme (31 March 2024: 39).

5. Operating expenses

	2024-25	2023-24
	Total	Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs; CSUs and NHS England	4,216	6,625
Services from foundation trusts	386,909	330,045
Services from other NHS trusts	1,015,858	798,330
Services from Other WGA bodies	30	40
Purchase of healthcare from non-NHS bodies	291,810	264,057
General Dental services and Personal Dental Services	38,778	30,428
Prescribing costs	174,114	174,265
Pharmaceutical services	31,127	29,625
General Ophthalmic services	7,937	7,597
GPMS/APMS and PCTMS	187,661	176,447
Supplies and services – clinical	50	71
Supplies and services – general	2,148	2,115
Consultancy services	208	586
Establishment	3,624	3,465
Transport	56	2,349
Premises	3,618	3,627
Audit fees	265	250
Other non statutory audit expenditure:		
Internal audit services	89	81
Other services	63	21
Other professional fees	1,414	2,269
Legal fees	344	135
Education and training	24	528
Total Purchase of goods and services	<u>2,150,344</u>	<u>1,832,956</u>
Depreciation and impairment charges		
Depreciation	67	67
Total Depreciation and impairment charges	<u>67</u>	<u>67</u>
Provision expense		
Provision release	217	(2,306)
Total Provision expense	<u>217</u>	<u>(2,306)</u>
Other Operating Expenditure		
Chair and Non Executive Members	161	157
Clinical negligence	6	7
Expected credit loss on receivables	28	(5)
Other expenditure	3	6
Total Other Operating Expenditure	<u>198</u>	<u>165</u>
Total operating expenditure	<u><u>2,150,825</u></u>	<u><u>1,830,882</u></u>

Statutory Audit is provided by Ernst & Young LLP. The fees, inclusive of non-recoverable VAT, for the period reported was £265,200. This includes £13,200 charges that relate to the audit for the financial year ending 31 March 2024 (inclusive of VAT).

The Integrated Care Board contracts with its auditors provides for a limitation of the auditor's liability of £2,000,000.

Internal audit services are provided by TIAA Limited, fees for the reported financial year were £89,100 exclusive of reclaimable VAT.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	59,961	573,066	53,478	532,146
Total Non-NHS Trade Invoices paid within target	59,099	569,915	52,797	527,944
Percentage of Non-NHS Trade invoices paid within target	98.56%	99.45%	98.73%	99.21%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,861	1,486,323	1,431	1,189,143
Total NHS Trade Invoices Paid within target	1,859	1,486,322	1,424	1,189,112
Percentage of NHS Trade Invoices paid within target	99.89%	100.00%	99.51%	100.00%

The NHS aims to pay at least 95% of all NHS and non-NHS invoices within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The performance for 2024-25 demonstrates this was achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2024-25 £'000	2023-24 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	-	-

The Integrated Care Board did not incur any interest charges from the late payment of commercial debts during 2024-25 (2023-24, nil).

7 Income Generation Activities

The Integrated Care Board did not undertake any income generation activities where full cost exceeds £1 million or services were otherwise disclosed in Note 2, Operating Revenue, to the financial statements for the Financial year ended 31 March 2025 (2023-24, nil).

8. Investment revenue

The Integrated Care Board received no investment revenue for the financial year ended 31 March 2025 (2023-24, nil).

9. Other gains and losses

Other gains and losses are largely associated with the disposal of fixed assets, and changes in the value of financial assets and liabilities. The Integrated Care Board had no such gains or losses for the financial year ended 31 March 2025 (2023-24, nil).

10. Finance costs

Finance costs are principally associated with interest charges on loans, PFI contracts and LIFT contracts. The Integrated Care Board doesn't have any of these arrangements. The Integrated Care Board has finance costs relating to interest expenses on lease liabilities associated with the rental of corporate premises for financial year ended 31 March 2025.

10.1 Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	10	12
Total interest	10	12
Total finance costs	10	12

11. Net gain/(loss) on transfer by absorption

Absorption accounting is explained in paragraph 1.3 of Note 1 (Accounting Policies). NHS Lincolnshire Integrated Care Board had no gains or losses on transfer by absorption during 2024-25 (2023-24; nil).

12. Property, plant and equipment

	Information technology £'000	Total £'000
2024-25		
Cost or valuation at 01 April 2024	-	-
Additions purchased	58	58
Cost/Valuation at 31 March 2025	58	58
Depreciation at 31 March 2025	-	-
Net Book Value at 31 March 2025	58	58
Purchased	58	58
Donated	-	-
Government Granted	-	-
Total at 31 March 2025	58	58
Asset financing:		
Owned	58	58
Total at 31 March 2025	58	58

The Integrated Care Board did not own any property, plant or equipment for the year ended 31 March 2024 but acquired information technology during the financial year ending 31 March 2025.

There were no additions to assets under construction, no donated asset, no Government granted assets and no revaluations during the year (2023-24, nil).

12.1 Temporary idle assets

The net book value of temporarily idle assets was as follows:

	2024-25 £'000	2023-24 £'000
Information technology	-	-
Total	-	-

13 Leases

13.1 Right-of-use assets

	2024-25		2023-24	
	Buildings excluding dwellings £'000	Total £'000	Buildings excluding dwellings £'000	Total £'000
Opening cost or valuation	418	418	-	-
Reversal of impairments	-	-	-	-
Transfer (to) from other public sector body	-	-	418	418
Closing cost or valuation	418	418	418	418
Opening depreciation	-	-	67	67
Charged during the year	134	134	67	67
Reclassifications	67	67	-	-
Transfer (to) from other public sector body	-	-	-	-
Closing Depreciation	201	201	134	134
Closing Net Book Value	217	217	284	284

The right-of-use asset reported above relates to one building that is leased from from NHS Property Services Ltd within the NHS England Group.

13.2 Lease liabilities

	2024-25 £'000	2023-24 £'000
Opening Lease liabilities	(295)	(358)
Interest expense relating to lease liabilities	(10)	(12)
Repayment of lease liabilities (including interest)	75	75
Closing Lease liabilities	(230)	(295)

13 Leases cont'd

13.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25	Of which: leased from DHSC group bodies	2023-24	Of which: leased from DHSC group bodies
	£'000	£'000	£'000	£'000
Within one year	(75)	(75)	(75)	(75)
Between one and five years	(169)	(169)	(244)	(244)
After five years	-	-	-	-
Closing Balance	(244)	(244)	(319)	(319)
Effect of Discounting	14		24	
Included in:				
Current lease liabilities	(68)		(68)	
Non-current lease liabilities	(162)		(227)	
Total	(230)		(295)	
Balance by counterparty				
Leased from NHS Property Services		(244)		(319)
Closing Balance		(244)		(319)

There are no future cash outflows that the Integrated Care Board is exposed to that are not recognised in the lease liabilities.

13.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024-25	2023-24
	£'000	£'000
Depreciation expense on right-of-use assets	67	67
Interest expense on lease liabilities	10	12

13.5 Amounts recognised in Statement of Cash Flows

	2024-25	2023-24
	£'000	£'000
Total cash outflow on leases under IFRS 16	75	75

There are no restrictions or covenants imposed by the lease agreement and there are no sale and leaseback transactions for the financial year 2024-25 (2023-24, nil).

14 Intangible non-current assets

The Integrated Care Board did not hold any intangible non-current assets for the financial year ended 31 March 2025 (2023-24, nil).

15 Investment property

The Integrated Care Board did not hold any investment property for the financial year ended 31 March 2025 (2023-24, nil).

16 Inventories

The Integrated Care Board had no inventories for the financial year ended 31 March 2025 (2023-24, nil).

17.1 Trade and other receivables

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS receivables: Revenue	1,939	-	139	-
NHS accrued income	1,243	-	6,958	-
Non-NHS and Other WGA receivables: Revenue	511	-	1,194	-
Non-NHS and Other WGA prepayments	2,324	-	2,685	-
Non-NHS and Other WGA accrued income	2,581	-	3,522	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	4,212	-	8,156	-
Expected credit loss allowance-receivables	(34)	-	(6)	-
VAT	235	-	1,470	-
Other receivables and accruals	211	-	133	-
Total Trade & other receivables	13,224	-	24,252	-
Total current and non current	13,224	-	24,252	-

Included above:

Prepaid pensions contributions

-

17.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	200	9	42	99
By three to six months	-	58	-	6
By more than six months	-	17	-	8
Total	200	83	42	113

**Trade and other
receivables -
Non DHSC
Group Bodies**

17.3 Loss allowance on asset classes

Balance at 01 April 2024

Lifetime expected credit losses on trade and other receivables-Stage 2

Allowance for credit losses at 31 March 2025

	£'000	£'000
Balance at 01 April 2024	(6)	(6)
Lifetime expected credit losses on trade and other receivables-Stage 2	(28)	(28)
Allowance for credit losses at 31 March 2025	(34)	(34)

17.4 Provision Matrix on lifetime credit loss

Non NHS Debt (excluding other DHSC group bodies)

	2024-25 Lifetime expected credit loss rate £'000	2024-25 Gross Carrying Amount £'000	2024-25 Lifetime expected credit loss £'000
Current	-	382	-
1 - 30 days	-	4	-
31 - 60 days	-	5	-
61 - 90 days	-	-	-
Greater than 90 days	-	74	34
Total expected credit loss	-	465	34

18 Other financial assets

The Integrated Care Board had no other financial assets for the financial year ended 31 March 2025 (2023-24, nil).

19 Other current assets

The Integrated Care Board had no other current assets for the financial year ended 31 March 2025 (2023-24, nil).

20 Cash and cash equivalents

	2024-25 £'000	2023-24 £'000
Opening Balance	37	1
Net change in year	(30)	36
Closing Balance	7	37
Made up of:		
Cash with the Government Banking Service	7	37
Cash and cash equivalents as in statement of financial position	7	37
Total bank overdrafts	-	-
Closing Balance	7	37

Patients' money held by the integrated care board, not included above

-

21 Non-current assets held for sale

The Integrated Care Board has no non-current assets held for sale to disclose for the financial year ended 31 March 2025 (2023-24, nil).

22 Analysis of impairments and reversals

The Integrated Care Board had no impairments or reversals for the financial year ended 31 March 2025 (2023-24, nil).

23 Trade and other payables

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS payables: Revenue	4,908	-	5,602	-
NHS payables: Capital	58	-	-	-
NHS accruals	7,098	-	3,412	-
Non-NHS and Other WGA payables: Revenue	12,188	-	7,666	-
Non-NHS and Other WGA accruals	36,214	-	41,085	-
Social security costs	239	-	224	-
Tax	267	-	212	-
Other payables and accruals	21,213	-	22,577	-
Total Trade & Other Payables	<u>82,185</u>	<u>-</u>	<u>80,778</u>	<u>-</u>
Total current and non-current	<u>82,185</u>		<u>80,778</u>	

Included above are liabilities of £0, for people, due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,099,758 outstanding pension contributions at 31 March 2025 (£945,978 at 31 March 2024). This includes amounts related to GP pensions £756,425 (£648,059 at 31 March 2024) and outstanding contributions to the NHS Pension Scheme £341,882 (£296,251 at 31 March 2024) and NEST scheme contributions £1,450 (£1668 at 31 March 2024).

24 Other financial liabilities

The Integrated Care Board had no other financial liabilities for the financial year ended 31 March 2025 (2023-24, nil).

25 Other liabilities

The Integrated Care Board had no other liabilities for the financial year ended 31 March 2025 (2023-24, nil).

26 Borrowings

The Integrated Care Board had no borrowings for the financial year ended 31 March 2025 (2023-24, nil).

27. Private finance initiative, LIFT and other service concession arrangements

The Integrated Care Board had no private finance initiative, LIFT and other service concession arrangements for the financial year ended 31 March 2025 (2023-24, nil).

28. Finance lease obligations

The Integrated Care Board had no finance lease obligations for the financial year ended 31 March 2025 (2023-24, nil).

29. Finance lease receivables

The Integrated Care Board had no finance lease receivables for the financial year ended 31 March 2025 (2023-24, nil).

30 Provisions

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
Continuing care	46	15	41	14
Other	315	6	111	-
Total	361	21	152	14
Total current and non-current	382		165	

	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2024	-	54	111	165
Arising during the year	-	61	278	339
Utilised during the year	-	-	-	-
Reversed unused	-	(55)	(68)	(122)
Balance at 31 March 2025	-	61	321	382
Expected timing of cash flows:				
Within one year	-	46	315	361
Between one and five years	-	15	6	21
Balance at 31 March 2025	-	61	321	382

Continuing Care

The Integrated Care Board is responsible for liabilities, legal and financial elements relating to NHS Continuing Healthcare claims connecting to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups (1 April 2013). The total value of NHS Continuing Healthcare provision at 31 March 2025 is based on live claim cases, including appeals, and has been evaluated based on historical experience of claim success rates and average rates within the Integrated Care Board and legacy Clinical Commissioning Groups and is £61,312.

Under the accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the former Clinical Commissioning Groups. The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare claims relating to periods of care since the establishment of the former Lincolnshire Clinical Commissioning Groups.

Other

The Integrated Care Board included other provisions for the following:

- Remedial building works at primary care premises.
- Mental Health Investment Standard audit fees for the 2023/24 financial year where the timing of committed expenditure was unknown.
- Stranded costs resulting from a termination of a contract
- Employees excess travel costs following the closure of the Cross O'Cliff premises
- Pension costs.
- Legal fees and clinical negligence costs.

31 Contingencies

	2024-25 £'000	2023-24 £'000
Contingent liabilities		
Continuing Healthcare	478	376
Net value of contingent liabilities	<u>478</u>	<u>376</u>

The Integrated Care Board is responsible for liabilities, legal and financial, relating to NHS Continuing Healthcare (CHC) claims for periods of care since the establishment of the Integrated Care Board and former Clinical Commissioning Groups. The Integrated Care Board has provided for the anticipated costs of continuing care claims (see Note 30 Provisions) where it is probable that it will incur costs. Note 31 Contingencies discloses the difference between the estimated value of claims and the recorded provisions as £478,230 as at 31 March 2025.

Contingent assets

The Integrated Care Board had no contingent assets as at 31 March 2025 (2023-24, nil).

32 Commitments

The Integrated Care Board had no capital or other financial commitments for the financial year ended 31 March 2025 (2023-24, nil).

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Lincolnshire Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Lincolnshire Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Lincolnshire Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Lincolnshire Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Lincolnshire Integrated Care Board and internal auditors.

33.1.1 Currency risk

The NHS Lincolnshire Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Lincolnshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The NHS Lincolnshire Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS Lincolnshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Lincolnshire Integrated Care Board revenue comes parliamentary funding, NHS Lincolnshire Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33 Financial instruments cont'd

33.1.4 Liquidity risk

NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

33.1.5 Financial Instruments

As the cash requirements of NHS integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS integrated care board's expected purchase and usage requirements and NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

33.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	Financial Assets measured at amortised cost 2023-24 £'000
Trade and other receivables with NHSE bodies	2,878	1,519
Trade and other receivables with other DHSC group bodies	423	8,902
Trade and other receivables with external bodies	7,397	9,681
Cash and cash equivalents	7	37
Total Closing Balance	10,706	20,140

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	Financial Liabilities measured at amortised cost 2023-24 £'000
Trade and other payables with NHSE bodies	179	613
Trade and other payables with other DHSC group bodies	11,886	8,397
Trade and other payables with external bodies	69,614	71,627
Private Finance Initiative and finance lease obligations	230	-
Total at 31 March 2025	81,909	80,637

33.4 Maturity of Financial Liabilities

	Payable to Department of Health and Social Care Group 2024-25 £'000	Payable to Other Bodies 2024-25 £'000	Total 2024-25 £'000
In one year or less	12,065	69,844	81,909
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2025	12,065	69,844	81,909

	Payable to Department of Health and Social Care Group 2023-24 £'000	Payable to Other Bodies 2023-24 £'000	Total 2023-24 £'000
In one year or less	9,010	71,627	80,637
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2024	9,010	71,627	80,637

34 Operating segments

NHS Lincolnshire Integrated Care Board considers it has only one operating segment: commissioning of healthcare services.

35 Joint arrangements - interests in joint operations

Information is disclosed in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

The 2024-25 pooled budgets are for Learning Disabilities, Child and Adolescent Mental Health Services (CaMHS), Proactive Care and Integrated Community Equipment Services (ICES). These budgets are predominantly hosted and managed on a day to day basis by Lincolnshire County Council, in instances where this is not the case the Integrated Care Board jointly host and manage. As a commissioner of healthcare services, the Integrated Care Board makes a contribution to the pool which is then used to purchase healthcare services. The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement in line with the 2024-25 Group Accounting Manual and as defined in IFRS 11.

The pooled budget represents contributions to the areas of identified spend; it is quite likely that the respective organisations have spend relating to the schemes over and above these contributions.

All cash is transacted by all parties in the month concerned. There are no outstanding cash balances or liabilities at each period end for all organisations concerned.

Lincolnshire County Council is responsible for the production of memorandum accounts for the pooled budget. These will not be produced until after the publication of the Integrated Care Board's accounts.

The Integrated Care Board's share of the income and expenditure as handled by the pooled budgets for the financial year ended 31 March 2025 were:

	NHS Lincolnshire Integrated Care Board	Lincolnshire County Council	Total Pooled Budget	NHS Lincolnshire Integrated Care Board	Lincolnshire County Council	Total Pooled Budget
	2024-25 £'000	2024-25 £'000	2024-25 £'000	2023-24 £'000	2023-24 £'000	2023-24 £'000
Income						
Section 75 - Proactive Care	-	(14,218)	(14,218)	-	(13,833)	(13,833)
Section 75 - Integrated Community Equipment Services	-	(4,611)	(4,611)	-	(4,178)	(4,178)
Section 75 - Wheelchair Services	-	(2,525)	(2,525)	-	-	-
Section 75 - Learning Disabilities	-	(35,504)	(35,504)	-	(31,678)	(31,678)
Section 75 - Child and Adolescent Mental Health	-	(18,827)	(18,827)	-	(16,481)	(16,481)
Partnership Framework	-	(103)	(103)	-	(102)	(102)
	-	(75,789)	(75,789)	-	(66,272)	(66,272)
Expenditure						
Section 75 - Proactive Care	27,807	53,591	81,399	27,422	51,647	79,069
Section 75 - Integrated Community Equipment Services	4,611	4,738	9,349	4,178	3,224	7,402
Section 75 - Wheelchair Services	2,525	-	2,525	-	-	-
Section 75 - Learning Disabilities	35,504	68,102	103,606	31,678	61,472	93,150
Section 75 - Child and Adolescent Mental Health	18,827	1,785	20,612	16,481	725	17,206
Partnership Framework	103	102	205	102	102	204
	89,378	128,318	217,696	79,861	117,170	197,031
Assets	-	-	-	-	-	-
Liabilities	-	-	-	-	-	-
Grand Total	89,378	52,529	141,907	79,861	50,898	130,759

Wheelchair services was a NHS Lincolnshire Integrated Care Board managed contract in 2023-24. The contract transitioned to Lincolnshire County Council's control in 2024-25.

36 NHS Lift investments

The Integrated Care Board had no Lift investments for the financial year ended 31 March 2025 (2023-24, nil).

37 Related party transactions

During the reported period none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Lincolnshire Integrated Care Board, other than those set out below (transactions identified were not with the member but between the Integrated Care Board and the related party).

Details of related party transactions with individuals for the financial year ended 31 March 2025 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Dr Sunil Hindocha	Heart of Lincoln Medical Group	3,692	-	-	-
Dr Sunil Hindocha	Lincoln City Foundation	10	-	-	-
Ms Dawn Kenson	Turning Point	-	37	-	-
Ms Julie Pomeroy	Nottingham City Care Partnership	25	-	2	-
Total at 31 March 2025		3,727	37	2	-

Details of related party transactions with individuals for the financial year ending 31 March 2024 are as follows:

Board Member	Related Party Name	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Dr Sunil Hindocha	Heart of Lincoln Medical Group	3,915	-	-	-
Total at 31 March 2024		3,915	-	-	-

The Department of Health & Social Care is regarded as a related party. During the reported period the Integrated Care Board had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. For example:

- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Arden and Greater East Midlands Commissioning Support Unit

Details of such organisations with whom the Integrated Care Board had contracts with for the financial year ended 31 March 2025 are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	2024-25 £'000	2024-25 £'000	2024-25 £'000	2024-25 £'000
Cambridge University Hospitals NHS Foundation Trust	14,820	-	-	-
Cambridgeshire & Peterborough NHS Foundation Trust	1,513	-	-	11
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	1,781	-	-	-
East Midlands Ambulance Service NHS Trust	53,916	2	68	-
Hull University Teaching Hospital NHS Trust	9,858	-	-	-
Lincolnshire Community Health Services NHS Trust	123,473	216	670	8
Lincolnshire Partnership NHS Foundation Trust	131,051	41	-	-
NHS Arden And Gem CSU	6,126	7	-	-
NHS England	-	3,673	-	812
Norfolk & Norwich University Hospitals NHS Foundation Trust	1,612	-	-	-
North West Anglia NHS Foundation Trust	110,263	-	-	-
Northern Lincolnshire And Goole Hospitals NHS Foundation Trust	70,890	-	32	-
Nottingham University Hospitals NHS Trust	57,753	9	-	-
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust	16,519	-	-	-
Royal Papworth Hospital NHS Foundation Trust	7,310	-	-	0
Sheffield Childrens NHS Foundation Trust	4,476	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	5,488	-	-	-
Sherwood Forest Hospitals NHS Foundation Trust	5,965	-	-	-
United Lincolnshire Hospitals NHS Trust	725,211	197	73	2,037
University College London Hospitals NHS Foundation Trust	1,607	-	-	110
University Hospitals Of Derby & Burton NHS Foundation Trust	3,374	-	-	-
University Hospitals Of Leicester NHS Trust	30,946	60	-	23
Total at 31 March 2025	1,383,952	4,205	843	3,001

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies, namely Lincolnshire County Council.

NHS Lincolnshire Integrated Care Board also has material transactions with all the GP Practices within its locality and membership.

The Integrated Care Board has not made any provision for doubtful debts for any of the above related parties.

38 Events after the end of the reporting period

There have been no post Statement of Financial position events which have had a material effect on these financial statements.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of Integrated Care Boards is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. Integrated Care Boards are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year. It is expected that Lincolnshire Integrated Care Board will move into a clustering arrangement with other Integrated Care Boards. Lincolnshire Integrated Care Board will continue as a single legal entity during the financial year ending 31 March 2026.

39 Losses and special payments

39.1 Losses

The total number of NHS Integrated Care Board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Administrative write-offs	2	0	1	0
Total	2	0	1	0

During the financial year 2024/25 NHS Lincolnshire Integrated Care Board had 2 losses relating to write off of credit balances totalling £152.

39.2 Special payments

	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Compensation payments	1	3	-	-
Extra Contractual Payments	1	0	-	-
Total	2	3	-	-

The Integrated Care Board made 2 special payments in the financial year totalling £2,725. One consolatory payment to a patient for £2,500 and one reimbursement to a patient for independent sector treatment costs for £225.

40 Third party assets

The Integrated Care Board did not have any third party assets for the financial year ended 31 March 2025 (2023-24, nil).

41 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).

NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target £'000	2024-25 Performance £'000	2024-25 Duty Achieved	2023-24 Target £'000	2023-24 Performance £'000	2024-25 Duty Achieved
Expenditure not to exceed income	2,166,217	2,175,732	No	1,838,257	1,853,139	No
Capital resource use does not exceed the amount specified in Directions	60	58	Yes	-	-	-
Revenue resource use does not exceed the amount specified in Directions	2,142,030	2,151,545	No	1,814,754	1,829,636	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	14,504	14,438	Yes	16,166	15,504	Yes

The Integrated Care Board's external auditors have issued a Section 30 referral under the Local Audit and Accountability Act 2014 due to revenue resources use exceeding the amount specified in the directions, resulting in a £9,514,953 deficit.

42 Analysis of charitable reserves

The Integrated Care Board did not hold any third party assets during the financial year ended 31 March 2025 (2023-24, nil).

43 Impact of International Financial Reporting Standards

See Note 1.28.

Independent Auditor's Report



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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Lincolnshire Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 43, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Lincolnshire Integrated Care Board as at 31 March 2025 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.



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Other information

The other information comprises the information included in the Annual Report and Accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the Annual Report and Accounts.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

Matters on which we are required to report by exception

We are required to report to you if:

- we issue a report in the public interest under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025; or
- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception:

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

At 31 March 2025, Lincolnshire Integrated Care Board had a deficit of £9.52 million against its Revenue allocation for the financial year.



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Under section 223GC(1) of the National Health Service Act 2006, an ICB must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

We therefore referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that Lincolnshire Integrated Care Board, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We are required to modify our report as we are making a referral to the Secretary of State under s30 of the Local Audit & Accountability Act 2014.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 107, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In



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addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Lincolnshire Integrated Care Board is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit, and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. We also assessed the susceptibility of the ICB's financial statements to material misstatement in relation to the risk of fraud in expenditure recognition, specifically those entries and adjustments that understate expenditure accrual balances at the year-end.
- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Board and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.
- We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing postings in the general ledger that fell outside of the standard transactions process flow.
- We addressed our fraud risk related to understatement of expenditure accruals by undertaking testing to gain assurance over the completeness and valuation by performing overall analytical reviews to identify unusual movements, testing accrual balances, and assessing expenditure estimates for management bias. We conducted cut-off testing to ensure transactions were recorded in the correct financial year and evaluated unrecorded liabilities for completeness. Furthermore, we examined the Agreement of Balances with reported figures and employed data analytics to identify any irregular trends and perform risk-based journal testing.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.



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We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended).

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Qualified opinion in regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them, except for the incurrence of expenditure in excess of the specified revenue resource limit.

The ICB has an incurred deficit of £9.52 million for the 2024/25 financial year.

We referred this matter to the Secretary of State on 21 June 2025 under section 30 of the Local Audit and Accountability Act 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of NHS Lincolnshire Integrated Care Board.

Use of our report

This report is made solely to the members of the Board of NHS Lincolnshire Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham
Date: 23 June 2025



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