NHS Lincolnshire Integrated Care Board

Public Board Meeting

Tuesday, 27th May 2025 at 9.30 am

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

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

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 27th May 2025
Time: 9.30 am
Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Dr Gerry McSorley, ICB Chair

AGENDA

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
1. Introductory Items					
i)	Welcome, introduction and apologies		-	Dr Gerry McSorley	9.30 am
ii)	Confirmation of quoracy		-	Dr Gerry McSorley	
iii)	Declarations of Interest	Information	-	Dr Gerry McSorley	
iv)	Minutes of the previous meeting held on the 25th March 2025	Approve	✓	Dr Gerry McSorley	
v)	Matters Arising, including Action Log (if appropriate)	Note	-	Dr Gerry McSorley	
2. Chair and Chief Executive Updates					
i)	Chair's Report	Note	-	Dr Gerry McSorley	9.35 am
ii)	Chief Executive's Report	Note	-	Mr John Turner	9.45 am
3. Key Updates					
i)	Public Health	Note	-	Professor Derek Ward	10.00 am
ii)	Healthwatch	Note	✓	Mr Navaz Sutton	10.10 am
4. Population Health Planning					
i)	Lincolnshire Health and Care Digital Inclusion Strategy	Approve	✓	Mrs Sandra Williamson	10.20 am
5. System Oversight and Assurance					
i)	Integrated Performance, Quality and Finance Report	Assurance	✓	Mrs Clair Raybould/ Mr Martin Fahy/ Mr Matt Gaunt	10.40 am
ii)	Process for Review of CQC section 48 (Calocane) – Update Report	Assurance	✓	Mr Martin Fahy	11.05 am
6. Governance					
i)	Revised Standards of Business Conduct and Conflicts of Interest Policy	Approve	✓	Mrs Jules Ellis-Fenwick	11.15 am

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
ii)	Board Forward Plan 2025/26	Approve	✓	Dr Gerry McSorley	11.20 am
7. Committee Highlight Reports					
i)	• System Quality and Patient Experience Committee, including Patient and Public Involvement Annual Report 2024/25 • Service Delivery and Performance Committee • Audit and Risk Committee, including the Committee's Annual Report 2024/25 and revised Terms of Reference • East Midlands Joint Committee	Assurance Assurance Assurance and approve Assurance	✓ ✓ ✓ ✓	Committee Chairs	11.25 am
8. Information/Closing items					
i)	Register of Documents Sealed 1st April 2024 to 31st March 2025	Note	✓	Mrs Jules Ellis-Fenwick	11.35 am
ii)	Declaration of Interest Registers as at May 2025	Note	✓	Mrs Jules Ellis-Fenwick	
iii)	Risks identified during the course of the meeting	Consider	-	Dr Gerry McSorley	
9. Date, Time and Venue of the next meeting					
	Tuesday, 29th July 2025 at 9.30 am at Bridge House, Sleaford	Note	-	Dr Gerry McSorley	Close

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

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

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

MINUTES OF THE NHS LINCOLNSHIRE ICB MEETING HELD ON TUESDAY, 25th MARCH 2025 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	ICB Chair and Chair of the Primary Care Commissioning and Delegated Functions Committee
	Cllr Wendy Bowkett	Partner Member, Local Authority
	Mrs Sarah Connery	Executive Board Mental Health Member
	Ms Anita Day	Non-Executive Member
	Mrs Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Dr Phillip Earnshaw	Non-Executive Director (Chair of the Primary Care Commissioning Committee from 1st April 2025)
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Margaret Pratt	Non-Executive Member and Chair of the Audit and Risk Committee (part of the meeting only).
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Member and Chair of System Quality & Patient Experience Committee
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS/ ATTENDEES	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mr John Dunstan	Non-Executive Director (from the 1st April 2025)
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Anne Lloyd	Director of Workforce Transformation
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Value
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board
APOLOGIES:	Ms Charley Blyth	Director of Communications and Engagement
	Dr Sunil Hindocha	Medical Director
	Dr Kevin Thomas	Partner Member, Primary Medical Services

25/297 WELCOME AND INTRODUCTIONS

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

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma as published on the website. The Questions and Answers facility was also available during the Board meeting as part of the live event. Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

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

Dr McSorley advised that this was Mrs Pratt's last Board meeting with the ICB, as she would be stepping down as a Non-Executive Member and Chair of the Audit and Risk Committee at the end of March 2025. Dr McSorley expressed enormous thanks to Mrs Pratt who has been an excellent Board Member and Chair of the Audit and Risk Committee; she had brought a well of experience and knowledge, wit, charm and intellect to the Board discussions and indeed made an important and valued contribution. Mrs Pratt will be sadly missed, but no doubt Mrs Pratt will stay in touch, which was welcomed, and wished her best wishes for the future.

Dr McSorley welcomed Dr Phillip Earnshaw as a new Board Member, Non-Executive Member and NED and Chair of the Primary Care Committee. This was Phillip's first Board meeting having joined the ICB on the 1st March 2025.

Dr McSorley also welcomed Mr John Dunstan as a new Board Member, Non-Executive Member and new Chair of the Audit and Risk Committee. Mr Dunstan would commence with the ICB on the 1st April 2025.

All those present introduced themselves.

25/298 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

25/299 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

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

Declaration of Interest from Committees:
No items declared.

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

The Board agreed to:

- **Note no interests were declared.**

25/300 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 28th January 2025 and agreed to:

- **Approve the minutes as a true and accurate record of the meeting subject to the following amendment – numbering should commence with 25 (as in 2025), not 24 for 2024.**

25/301 MATTERS ARISING

There were no matters arising from either previous meetings or the last one held in January 2025. As such there was no Action Log included in the pack of papers.

25/302 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that today's public meeting is unusually short in light of significant workload and changes in the NHS, which Mr Turner would reflect on in his update and the need for the Board to commit additional time to the draft 2025/26 planning arrangements. Speakers and participants at the meeting were encouraged to be as concise as possible.

Since the last Board meeting colleagues were aware there have been some very significant national Government announcements regarding ICB running costs and future functions, as well as national changes relating to the Department of Health and Social Care (DHSC) and NHS England. Mr Turner would refer to this in greater detail as part of his update, but as ICB Chair Dr McSorley wanted to acknowledge the implications for all the ICB staff and also those within the provider organisations and recognised that this is an unsettling time for everyone concerned, particularly as there remain numerous questions that cannot yet be answered. The Board has huge regard for its staff and remains committed to responding with transparency and honesty, and to supporting them through this difficult time, as it has done previously. On behalf of the Board, Dr McSorley wanted to formally acknowledge its support for staff during this uncertain time about what the future may hold.

Dr McSorley advised that there were some general points to bring to the Board's attention:

- On behalf of the ICB and the Board, Dr McSorley has been involved in numerous important meetings on both a national and regional basis since the Board's January gathering. These included sessions with the NHS Confederation, NHS England Chairs, NHS England Midlands Chairs, and various other stakeholders.
- Dr McSorley as a representative of the ICB had attended the recent blessing of the new Mayoral Combined Authority, which took place a few weeks ago at Lincoln Cathedral. It was a very impressive event, well attended by a large number of significant public figures and politicians from the North and North East Lincolnshire and Lincolnshire County Council as well as others from public service.
- Dr McSorley had joined Mr Turner at a recent meeting with the West Lindsey District Council (WLDC) Leader, Deputy Leaders and Chief Executive to discuss health and NHS matters in the district, which had been a very productive meeting and thanked colleagues in WLDC for facilitating that discussion.
- Dr McSorley and Mr Turner would be attending the Primary Care Conference and Values event to recognise the enormous work undertaken by colleagues in primary care.
- The process to appoint the ICB Interim Chief Executive as Mr Turner's successor had now commenced.

On a final note, Lincolnshire County Council and other local authorities had now entered the pre-election period for the local county council elections, plus Mayoral election on the 1st May 2025.

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

Chief Executive update

Mr Turner echoed the points made by Dr McSorley and advised that he had a number of areas to share with the Board, but in the first instance wanted to pay tribute to and express his heartfelt appreciation to executive colleagues across the whole of the health system for their excellent work that had been undertaken for some time.

As is usual practice for this time of year, the task is on closing out the financial and performance year, which ends on the 31st March 2025 and ensuring the year is ended in the best possible position for the people of Lincolnshire and the tax payer, whilst at the same time addressing the challenges of the planning requirements for 2025/26.

Mr Turner advised that he wanted to particularly highlight excellent work the teams across the system have been undertaking on a wide range of fronts, including urgent and emergency care and elective care performance which are two of the key areas that have significant focus and jeopardy in relation to getting these right for the population. On UEC the Lincolnshire system continued to mark remarkably well compared to the rest of the Midlands region in terms of performance. In recent weeks this had placed the Lincolnshire system in the Top 10 for performance across the whole of the country. The Lincolnshire system also continued to make good progress in terms of elective performance and closing out 65 week waits.

Mr Turner advised that the last few weeks had been dominated by a number of national announcements, the majority of which the Board would have heard about in the media. In summary, the Government had announced the 50% reduction in programme and running costs for all ICBs, 50% reduction in staff costs at NHSE and 50% corporate growth cost in providers and the same for various regional collaborations, e.g. cancer services. This is all pointed at the organisation management of administrative corporate overheads, and this will need to take effect from the beginning of Quarter Three, which is the 1st October 2025. Understandably this has generated a considerable amount of concerns and unsettled NHS staff across the country. In addition, it had also been announced that NHSE will be abolished, and its functions taken into the Department of Health and Social Care.

Mr Turner emphasised that no specific details had been received in relation to any of the above announcements.

On the day this information was announced Mr Turner had undertaken a live staff briefing whilst attending a national meeting in London. Further staff briefings had taken place on Monday mornings in the last two weeks, as per usual practice. The detail will continue to be shared with staff as it becomes available.

It is clear that if the 50% is to be delivered, there will be redundancies across the service, but the specific detail on how that may work out was not known at this time. Needless to say ICB teams, are extremely anxious about this, in the same way teams up and down the country are, but it was really important to remain professional, keep calm and carry on, but the Board should not be under any illusion as to how much this has impacted on staff members the Board works with day in, day out.

Mr Turner advised that some initial conversations have taken place with his respective ICB Chief Executive colleagues in the East Midlands region and also across the country. Everyone is in the same position. The next meeting of the Midlands Leadership Team (MLT) is scheduled to take place on the 31st March where there will no doubt be discussions about potential options moving forward but the majority of this will be driven nationally.

In parallel with this, the vast majority of the current senior Executive Team members of the NHSE national team would be leaving at the end of March 2025, the details of which had recently been announced. NHSE last week had recently announced the details of the incoming team who will help lead the organisation's transition into the Department of Health and Social Care. The team – called the NHS Transformation Executive Team – will replace the current NHS England Executive Group and will support ongoing business priorities, statutory functions and day to day delivery. It will be led by Sir Jim Mackey as Chief Executive Officer.

Nationally, there has been understandable concern regarding the 2025/26 planning round. The end of February headline returns indicated several severe financial challenges that the NHS must address as a priority by the 1st April 2025.

In Lincolnshire specifically, Mr Turner paid tribute to how well the system leaders have collaborated effectively to address the planning and challenges. Excellent progress has been made despite facing very strong headwinds throughout this process.

Other areas of note for the Board:

- The results of the Staff Survey had recently been published. The ICB results demonstrated strong performance that has been consistent over the past several years. Work continues to maintain those positive outcomes, acknowledging fluctuations in performance are inevitable. It is particularly encouraging that the report in relation to the People Promise aspects show favourable results, especially considering the uncertainty surrounding the Target Operating Model (TOM) moving forward.
- Notably, Lincolnshire Partnership NHS Foundation Trust achieved exceptional staff survey results, ranking amongst the best nationally. Similarly, the Group was recognised as one of the top five most improved Trusts across the entire country.
- The Elective Activity Co-ordination Hub (EACH) Team, in collaboration with United Lincolnshire Teaching Hospitals NHS Trust, scooped two National Health Service Journal awards for their outstanding work on dermatology pathways. This recognition exemplifies how Lincolnshire's healthcare initiatives are increasingly gaining national recognition.
- The recently published UK Active report made significant reference to collaborative efforts with Active Lincolnshire to address physical health challenges across the local population. This is particularly important given that Lincolnshire ranks among the least physically active populations nationally.
- Mr Turner recently visited the new Community Diagnostic Centre (CDC) in Lincoln which represents an impressive facility, forming part of a comprehensive suite of CDCs including sites in Grantham and Skegness. The Board Members were encouraged to visit the site.
- The COVID inquiry has issued a comprehensive request to all ICBs for information, and the submission for Lincolnshire ICB is currently being worked through.
- The Lincolnshire Care Association (LinCA) Annual Awards ceremony will be taking place later that week providing an opportunity to recognise the exceptional contributions of colleagues throughout the care sector across the county. Mr Turner would be attending this along with other Board Members. It is always a very uplifting evening.

Mr Turner advised that two questions had been received from a members of the public, both in relation to the same subject matter, which were read out for the Board's information. It was noted that the questions and responses would be attached separately to the minutes of the meeting.

The Board agreed to:

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

	KEY UPDATES
25/303	**PUBLIC HEALTH**

Professor Ward advised that Directors of Public Health in England have a statutory duty to produce an independent report on the state of health of the people they serve on an annual basis. The Director of Public Health is leading a programme of work as part of the Council's leadership role in the Lincolnshire Integrated Care System to develop models and approaches to achieve integrated care as close to people's homes as possible.

Professor Ward presented his sixth Annual Report as the Director of Public Health which focused on Integrated care close to home: creating healthy communities in Lincolnshire. The report sets out the case for change, explores the evidence base and best practice knowledge for achieving this health and care system goal, and considers what this could mean for Lincolnshire.

Professor Ward advised that he would summarise the content in the spirit of keeping things succinct as requested by the Chair.

The following was highlighted:

- Lincolnshire's increasing older population.
- Where you live matters
- Deprivation as a driver of health inequalities
- Health and Care in Lincolnshire
- The importance of community and primary care
- An opportunity to do differently, and do better

The report identifies key principles and ways of working from national and international evidence of transformative approaches to delivering primary and community care and analyses how these may be relevant to the specific challenges in Lincolnshire. The report identifies some examples and initiatives that align well with these key principles and demonstrates what a transformed community and primary care offering could look like for Lincolnshire.

In conclusion, demand for care is at an all-time high due to people living longer but in more ill health, a burden of preventable diseases, challenges in the recruitment and retention of healthcare staff, and uneven access to services. Due to increased demand, support for managing needs has shifted to primary and community care services. By exploring new ways of delivering these services, it will be possible to improve the understanding of what really matters to people, better tailor services to meet their needs, prevent ill health and maximise the impact and efficiency of all of key assets.

The Board considered the report. Mrs Robson commented that the idea of integrated neighbourhood teams is not a new concept, having been part of one as a clinician over 20 years ago, but the difference now is the availability of intelligence, data sets and the digital technologies which could really push that model forward. Mrs Robson was interested in some of the case studies, such as Foundry Healthcare and asked whether any modelling had been undertaken and what savings could be made if it was undertaken with a pathway of care, such as frailty. Professor Ward advised that with regard to the compilation of the report, certain analytical work has been completed. There is no question there are some models and technologies which will have a positive impact on the budget within 12-18 months.

Mr Gaunt referred to Mrs Robson's comments and advised that in terms of the capacity and ability to undertake modelling there is currently not a lot of ground swell in the applications to be able to do that currently.

Mrs Kenson commented that the report contained so much interesting information and asked whether it would be possible to return to this as part of a Board Development Session at a later date. The Board agreed it was important to do this, particularly in the context of the three strategic shifts as recently outlined by the Secretary of State for Health and Social Care: from hospital to community care, from analogue to digital systems, and from treatment of illness to prevention and public health. These shifts will be outlined in the Government's 10-year plan for health.

The Board agreed to:

- **Note the Public Health update.**

25/304 HEALTHWATCH

Mr Sutton presented the latest Healthwatch report and advised that he would take this as read but wished to highlight some key areas to the Board for information.

- Between January and February 2025, 244 people shared their experiences of health and social care with Healthwatch. An additional 773 people have shared their experiences through Healthwatch access to GP services survey. The service areas commented on the most this month were GP Services, All Hospital Services, Social Care, Mental Health and Dentistry.
- There has been an increase in the number of responses on GP services, compared to previous reporting periods. A deep dive is underway to investigate whether there are pockets of good practice or not.
- Issues continue to emerge primarily regarding access to various services such as dentistry. All feedback and specific cases have been shared with providers and ICB colleagues, and collaborative efforts are underway to address these concerns where possible.
- Mr Sutton referred to the Healthwatch Information Management System (IMS) for patient voice, which generates monthly reports. Provider engagement has increased significantly, including both NHS and other service providers. This improved interaction facilitates closing the feedback loop and communicating outcomes to patients who have shared their experiences. The system is being enhanced to identify themes rather than just specific cases. Currently, eleven Healthwatch organisations nationally are utilising this system, which was developed in Lincolnshire. The local Healthwatch team are working with NHSE to ensure consistency in national reporting and comparisons. Through collaboration with ICB colleagues and Trusts, Healthwatch has started to develop a reporting mechanism that identifies emerging themes, as demonstrated by an example from February-March data showing satisfaction by service type and theme. This functionality will be shared in greater detail as it becomes fully embedded.
- Regarding non-emergency transport services, several cases were raised and addressed in collaboration with EMAS, the ICB, and PALS, resulting in solutions for most cases. Feedback has been provided to those who raised concerns. A trend has been identified on the East Coast related to rural challenges, older populations, and individuals who may be reluctant to persistently seek care.
- Mr Sutton highlighted ongoing work with GP practices, noting particularly positive feedback about the Glebe practice, Saxilby from outreach activities. The staff at the practice received significant praise, which has been acknowledged and shared with them.
- As previously mentioned a deep dive into GP access issues is underway. A SNAP survey has been conducted across the county, garnering over 800 responses thus far. This data provides intelligence on areas with both difficult and easier access to GP appointments. The team aims to reach 1,000 respondents before conducting a more focused investigation into specific challenges and good practices, with the intention of sharing this intelligence in the future.

Finally, Mr Sutton concluded his update with an update on their pelvic health work. The initial survey has been completed, data gathered, and a report produced. The primary recommendation centres on improving awareness and information provision earlier in the patient journey, as many individuals only learn about these services after giving birth or when issues arise. The team is organising focus groups with survey respondents to better understand how information should be presented and received, recognising that the issue often involves communication methods rather than service availability.

The Board considered the report and supporting verbal update. Mr. Turner reflected on the recent meeting with the Leader and Deputy Leader of West Lindsey District Council, during which they expressed concerns regarding access to GP services in their region, particularly in Gainsborough. Mrs. Mills shared the factual data with them, which demonstrated comparatively impressive statistics regarding same-day access, access within 48 hours, and access within two weeks by way of examples, which they were not aware of. An agreement was reached to share this information with them on a regular basis.

As the work by Healthwatch progresses, it is important to acknowledge that the actual performance of practices across Lincolnshire is generally commendable despite occasional variations. This was acknowledged by Mr Sutton who advised that he would seek to work with Mrs Mills in terms of the overlay of the public voice.

Dr McSorley added that it is equally important to be aware of what is occurring with the majority of patients as well as understanding the circumstances of outliers. This is because there may be unique issues the practices are experiencing or engaging in, which require attention rather than being obscured within an average that suggests overall satisfactory conditions.

The Board agreed to:

- **Note the Healthwatch report.**

25/305 POPULATION HEALTH PLANNING

There were no specific items for consideration under population health planning on this occasion.

SYSTEM OVERSIGHT AND ASSURANCE

25/306 INTEGRATED PERFORMANCE, QUALITY AND FINANCE REPORT

Performance Section

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

The following points were highlighted:

- The ICB is currently on track to deliver the 78% target for 4 hour performance, with yesterday's figures at 77.5%. As referenced earlier in the meeting by Mr Turner, ULTH is performing in the top 20% regionally and nationally regarding 4-hour metrics.
- There has been more than a 50% improvement in patients remaining in the emergency department for over five hours, which continues to be a key measure of harm. This represents a significant improvement, to which the mental health urgent access centre has made a substantial contribution to that position. Lincolnshire has not experienced any mental health outpatients waiting in emergency departments for extended periods of time.
- ULTH and NLAG and NWAFT – all implemented the 45 minute handover initiative which is essentially designed to make sure as many ambulances are handed over within a 45 minute period. ULTH performance currently was less than 3% waiting more than 45 minutes which compared to over 60% in January 2025.
- The same improvement had been seen at NLAG as well.
- Backlog figures in the report were quite high but had now returned to much lower levels with cancer now reaching target levels.

Dr McSorley commented that the collaborative work on ambulance handovers with provider colleagues is commendable, as expediting ambulance returns improves care for patients in the community and those requiring emergency treatment.

Quality Section

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

- **Insight and Signals section of the report – Local Area Partnership SEND Inspection -** Ofsted and CQC undertook a local area partnership SEND inspection in February 2025. The inspection took place over a 3 week period and involved partners across the Lincolnshire system including the Local Authority; Education; ICB; NHS Trusts; and the Lincolnshire Parent Carer Forum. Mr Fahy was pleased to report a favourable outcome of that inspection.
- **Ambulance Handover Delays Initial Debrief Notification & After Action Reviews** - Lincolnshire was required to provide its first submission to NHSE at the beginning of March 2025 for 8 hour breaches and it is positive to confirm this was a nil return.
- **Primary Care** – Nothing to report by exception on this occasion.
- The national Chief Nurse for Adult Social Care and NHSE's Chief Nursing Officer visited Lincolnshire in January 2025. The visit was hosted by Lincolnshire Care Association (LinCA) and was an opportunity to showcase areas of good practice within the county and reflect on ways to further improve integrated working.
- The Chief Midwifery Officer (CMO) for England, Kate Brintworth visited Lincoln County Hospital January 2025. During the visit there were a number of poster presentations outlining the improvement work that maternity services had implemented, and individual midwives were recognised for their work by the presentation of a number of prestigious CMO Silver Awards. Libby Grooby, ULTH Director of Midwifery who was retiring from her role was presented with the CMO Gold Award for her contribution to midwifery.
- **Thematic Update** – there is a focus on the Medicines Optimisation (MO) Team who have made some really significant progress, particularly with anti-microbial prescribing and as a result have moved up two positions from a national perspective.
- The MO Team have also undertaken support with wider prescribers. 84% of all practices have now had input from the team.
- 100% of pharmacies, operating from brick-and-mortar premises within Lincolnshire have signed up to deliver the Pharmacy First service. From April-December 2024, 34,672 Pharmacy First consultations were provided in Lincolnshire, saving approximately 6,000 hours of GP and other clinician time improving access to the local population.

The Board considered the Quality update. Dr McSorley and Mr Turner, Mrs Mills and colleagues who are involved with the PCN work being undertaken had a presentation the previous day from the national team representatives who are leading on Getting It Right First Time (GIRFT). Their presentation contained some very impressive data about reducing demand and picking up on Professor Ward's report about making a shift, consideration will need to be given about bringing these elements together of the work being done in primary and secondary care and the interface between both sectors. This was noted.

Finance Section

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

The end of the current financial year is six days away (31st March 2025) and whilst the financial report provides a high-level summary of Month 11, the focus has been primarily on the closing position. At this stage, there have been several developments in the outturn position. Board colleagues may recall the involved process undertaken concerning the break-even position, and it was flagged around the turn of the current year that the system would transition to a deficit approach, which was subsequently agreed with NHSE. Significant shifts have occurred since then, and consequently, the system will be reporting a deficit position of £25.3m

Some additional support funding has been received for both the system and the ICB, resulting in a year-end position approximately in line with the previous financial year. Substantial work needs to take place to finalise year-end positions across respective organisations, but the ICB is expected to conclude with a £9.5m deficit. It should be noted that a surplus plan had been set last year to offset deficits elsewhere, representing approximately a £14.2m shift away from the

planned position but at this stage, the current focus is on the net position and the £9.5m deficit, which represents an improvement on the previous year.

Regarding the Cost Improvement Plan (CIP), against the base target of £84.8m, performance will be within £3 million of that mark. This represents a new record in the level of CIP that has been implemented through partnership efforts.

With respect to capital expenditure, the year began with an unprecedented plan of £116.3m. The ICS is expecting to utilise £119.3m against this. This equates to a £3.0m overutilisation against CDEL. At the 28th February 2025 the plan against this was £95.3m and the reported spend is £83.2m. This equates to a year-to-date under-spend of £12.1m. This represents positive news as it supports enhanced estate facilities, CDC improvements, and A&E service enhancements. A similarly substantial year for capital clinical expenditure is anticipated ahead.

The ICB Board considered the report and agreed to:

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

25/307 BOARD ASSURANCE FRAMEWORK

Mrs Ellis-Fenwick presented the latest version of the Board Assurance Framework (BAF) which 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.

The ICB Audit and Risk Committee has been regularly briefed on the progress on the development and establishment of robust risk management arrangements for the ICB, including the development of the ICB Board Assurance Framework (BAF) and Risk Appetite. 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.

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. The outcome identified maintained the same level of reasonable assurance as per the previous financial year.

Mrs Pratt referenced the BAF regarding the alignment of strategic risks to ICB core aims and suggested that the ICB had understated its achievements, particularly concerning aim four. This aim states that the ICB's strategic risk management does not support broader social and economic development—a position with which Mrs. Pratt disagreed. She noted that the ICB and system workforce strategies, efforts to reduce reliance on bank and agency staff, and work to address health inequalities all contribute significantly to Lincolnshire's social and economic landscape. Mrs. Pratt remarked that many of these current initiatives, as evidenced in today's meeting, actively support broader development across the region. She therefore proposed that these contributions should be properly acknowledged in year-end position statement, which was acknowledged and noted for action moving forward.

Mrs Robson noticed a discrepancy in the risk appetite classification within the financial documentation. The initial section describes it as cautious, while the financial risk (numbered 004) categorised this as open and asked for clarification on this. Mrs Ellis-Fenwick advised that she would look into this outside of the meeting, to ensure consistency throughout the report.

Action: Mrs Ellis-Fenwick

The ICB Board agreed to:

- **Note the latest version of the Board Assurance Framework.**

GOVERNANCE

25/308 There were no specific items for consideration under governance on this occasion.

25/309 COMMITTEE HIGHLIGHT REPORTS

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

System Quality and Patient Experience

Mrs Robson presented the report from the Service Quality and Patient Experience Committee meeting held on the 5th March 2025. The contents were outlined for information and the Board was referred to the items for escalation, which were duly noted.

Service Delivery and Performance

Mrs Kenson presented the report from the Service Delivery and Performance Committee meetings held in January and February and outlined the contents. It was noted that the Committee had revised its Terms of Reference in respect of the membership, and these were attached for the Board's approval.

East Midlands Joint Committee

Dr McSorley presented the briefing report from the meeting of the East Midlands Joint Committee held on the 17th December 2024.

The Board agreed to:

- **Note the reports and supporting verbal updates.**
- **Approve the revised Terms of Reference for the Service Delivery and Performance Committee**

INFORMATION/CLOSING ITEMS

25/310 ICB ANNUAL REPORT AND ACCOUNTS 2024/25

Mrs Ellis-Fenwick advised that NHS Bodies are required to publish, as a single document, an Annual Report and Accounts (ARA). The Department of Health and Social Care Group Accounting Manual (DHSC GAM) 2024/25 sets out the requirements for the content of the ICB Annual Report. The report presented set out the process and specific dates in relation to the production of the ICB Annual Report and Accounts for 2024/25.

The Board agreed to:

- **Note the report.**

25/311 ANY RISKS IDENTIFIED

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

25/312 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 27th May 2025 at 9.30 am at Bridge House, Sleaford.

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

-- ---------------------------------
Chair Signature **Date**

Questions from the Board meeting held on 25th March 2025

Question One

As a Chair of a Local Lincolnshire GP Practice Patient Participation Group (PPG) I am very concerned about a recent communication that GP Practices from the 1st April will not be providing Treatment Room Services, to change dressings, remove stitches, clips or wound care dressing changes nor Ear Syringing.

Regrettably this letter that has been seen on Social Media and also sent to me as a Chair gives no indication for the provider of these replacement services across the County of Lincolnshire.

Can the Board please issue an updated Communication with the details and locations where these services will be provided for the Patients of Lincoln and Lincolnshire ahead of the start date of the 1st April 2025.

Question Two

With multiple GP practices now being unable to continue providing "treatment room services" from 31st March 2025, due to a lack of funding, what is the ICB doing to arrange urgent alternative arrangements?

Response:

The treatment room services are part of locally enhanced services, not the core national GP contract. For a number of years, the ICB has had a contractual arrangement with practices in Lincolnshire to provide these treatment room services. However, 15-18 months ago, some of the Lincolnshire practices determined that the resource they were receiving was insufficient to meet their costs and they withdraw this service. More recently, an increased offer was made, and many practices that had previously withdrawn from the service are now re-engaging. Despite the increased offer, a small number of practices have decided to withdraw from this service, some of the practices, but certainly not all, are in and around Lincoln.

The Primary Care Team was exploring options for replacement services, as this approach has been successfully implemented in other areas where this service was withdrawn. Clearly, this is not an ideal situation, as the aim has always been to support patients in receiving their care as close to home as possible, which was part of the philosophy behind the increased service offer.

Additionally, the details of both questions will be shared with Mrs. Mills, the Director of Primary Care, Social Value and Communities, so that she can personally respond to both individuals regarding the issues affecting their practices.

Aside from the treatment room services, the latest clinical guidance has indicated that ear syringing is no longer considered an appropriate intervention and will no longer be provided in the practices. However, there is an alternative service to which patients can be referred, although they will be encouraged to visit their pharmacy and seek self-care in the first instance.

ACTION LOG PUBLIC

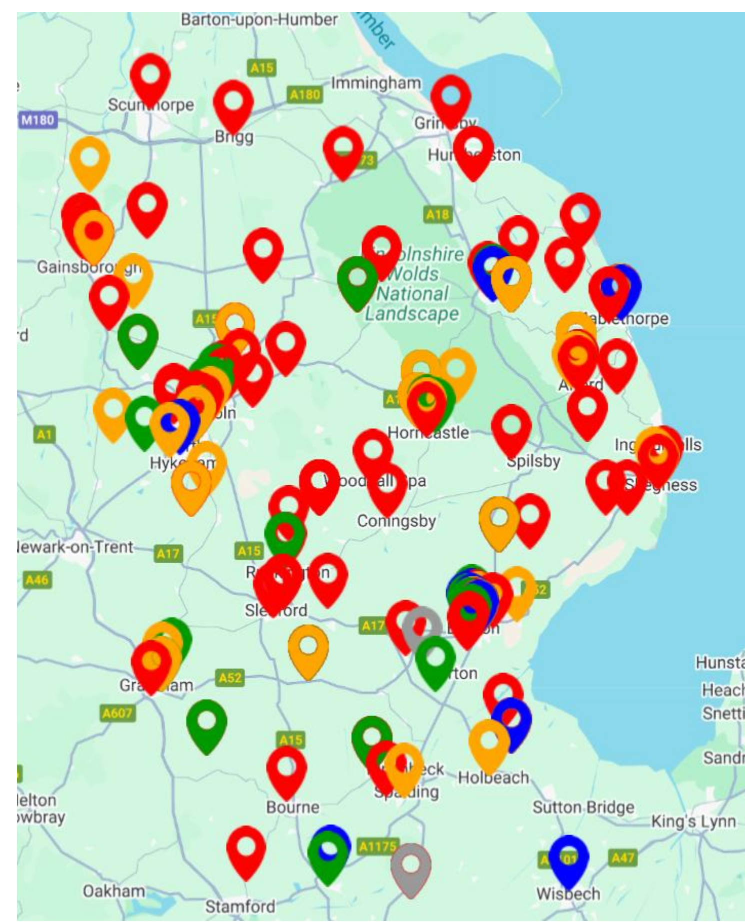
Date of Meeting:	**Tuesday, 27th May 2025**
Agenda Item:	**1 (v)**
Reporting Officer:	**Dr Gerry McSorley, ICB Chair**

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
25/03/25	25/307	Board Assurance Framework	To look at the risk appetite level for the finance risk (number 004) as it reflected differently within the document.	Mrs Ellis-Fenwick	April 2025	The risk appetite level has been amended in both areas of the BAF to state 'cautious'.	Complete.

ICB Update Healthwatch May 2025

healthwatch Lincolnshire

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



Location mapped using service postcodes.
Positive - green Negative - red Mixed - orange
Neutral - blue Unclear - grey

April and March 2025

Between April and March 2025, **317** people shared their experiences of health and social care with us. An additional **482** people have shared their experiences through our access to GP services survey.

Out of the 317 experiences shared with our Information Signposting Service, **56% were negative** and **14% were positive**. The remaining were neutral, mixed or unclear.

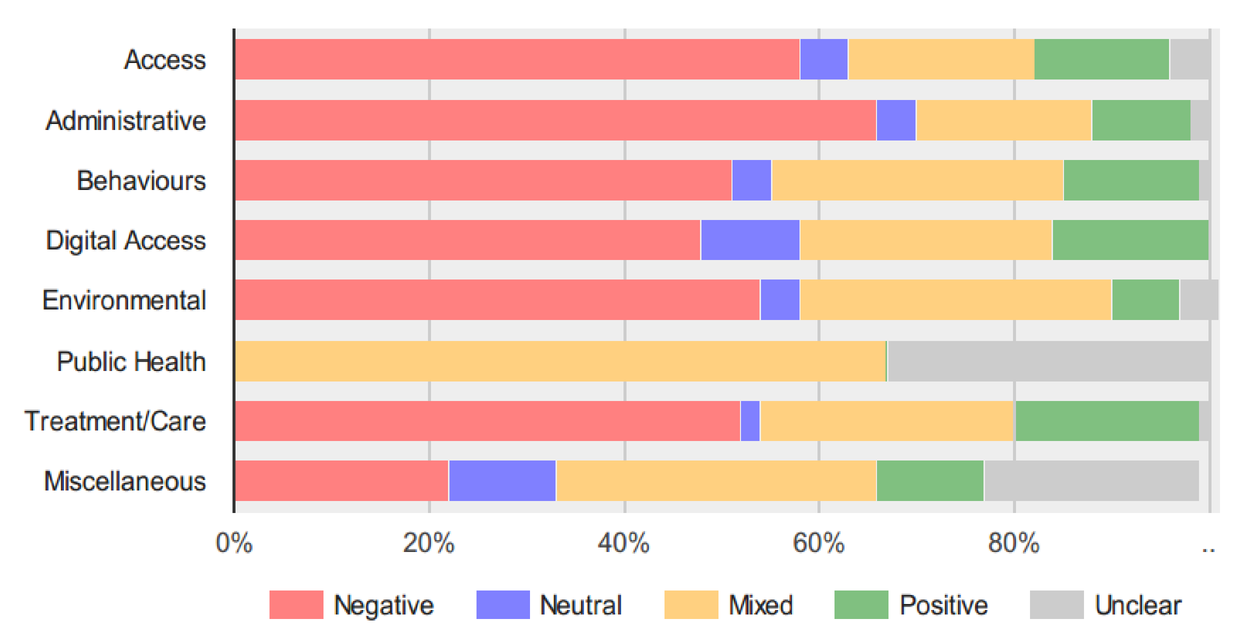
The service areas commented* on the most this month were:

- All Hospital Services (55%) - (8% of all comments were about A&E)
- GP Services (42%)
- Dentistry (10%)
- Patient Transport (10%)
- Mental Health (9%)

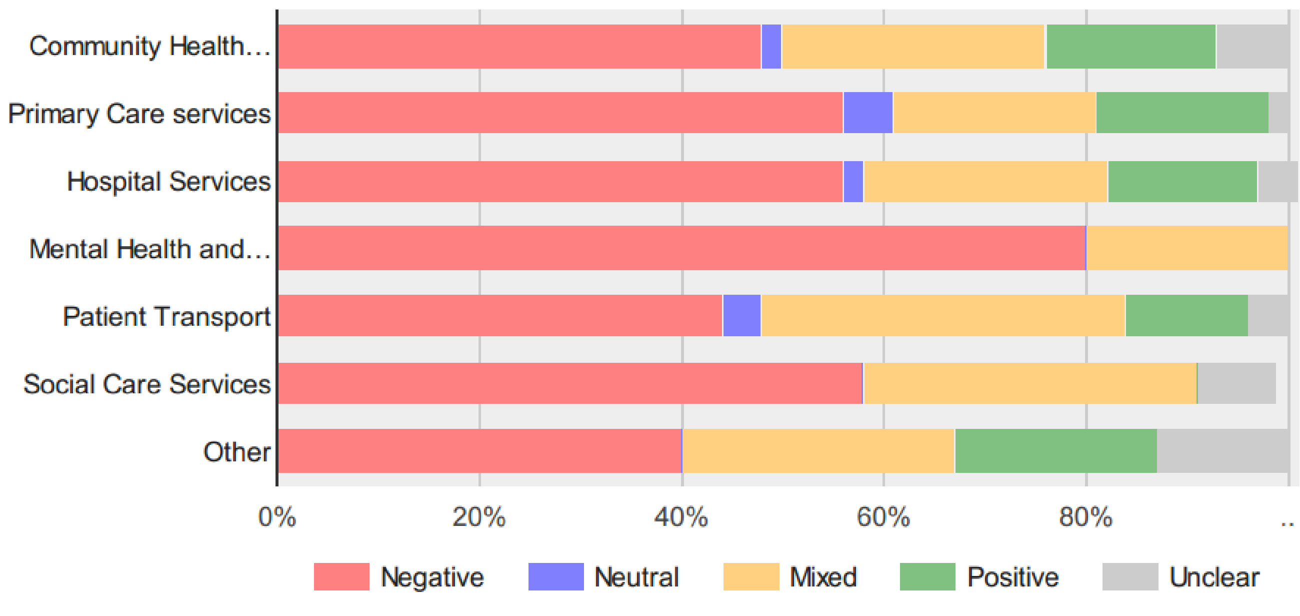
*Some comments relate to multiple service areas.

IMP sentiments and themes

Satisfaction by Theme



Satisfaction by Service Type



Dental care for cancer patients

"I am currently waiting for Radiotherapy for cancer which is scheduled for the middle of May. I require extensive dental treatment and my local dentist has quoted between £9800 and £13600 (private treatment). I cannot afford this but don't qualify for any benefits. It is possible that my immune system will be compromised during the coming months and in that event people are advised to get any dental issues resolved as soon as possible. My dentist is currently saying that they will be taking a new tranche of NHS patients in about two months, but this will take place during my radiotherapy and I am unlikely to be able to stand in the long queue for hours for registration outside the surgery which is what usually happens when new NHS slots become available.

Can you possibly help me to get an NHS dentist?"

Healthwatch Lincolnshire contacted several practices to support the individual. Under the circumstances, Winsover Dental Care in Mablethorpe registered them as an NHS patient.

Feedback and an appointment in the right timeframe has been secured for the individual.

Hospital services

- Communication
  - Late notice or multiple cancellations
  - Difficulty contacting departments
  - Information sharing between services
  - Inaccessible communication

Positive experience

"My 6 month old child a few weeks ago had a very high temperature it was not teething, had very bad nappies and not sleeping, so I was worried.. Called into the local pharmacy in Alford, they gave me some advice as it may be teething issues but stated that if I was worried with no improvement over the next few hours to take the baby to hospital.

There was no improvement so called Louth County Hospital who advised us to bring the baby across to them to examine . They took all our details over the phone . When we arrived, the receptionist had all of our information to hand and within 10 minutes we were called in. Baby had a very high temperature and was getting dehydrated. They got them on a drip and managed to cool them down. We were there for a few hours but eventually told that it was an ear infection and sent home with medication.

Whilst we were there the staff were amazing and made sure that we were informed and included and food and drink offered. They got a face to face appointment booked at the GP Surgery 2 days later to check on the baby who seemed to be improving . Great service , thank you !"

Neurological health report considerations

WE HEARD FROM

375

people

Provision of more information around causes of conditions, prognosis and management. This included holistic support to complement medication

Listening to service users and taking them seriously

Offer individualised holistic support

Establish local support groups

Ensure joined-up care with coordinated services

Reduce waiting times for specialist support and provide support to help people "wait well"

See full report via this link: Neurological Health Report

Mental health report

WE HEARD FROM

88

people

GROUP BREAKDOWN

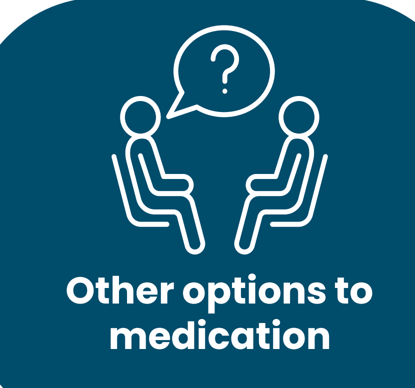
- 33 were veterans
- 15 were part of a military family
- 10 worked in farming, agriculture or horticulture
- 15 were new fathers

- **Stigma -** there was often a stigma around seeking mental health support amongst these groups.
- **Barriers to accessing support -** these included long waiting times, not meeting the criteria and lack of information.
- **Online resources -** online information was often easy to find and navigate but often generic.
- **From support to uncertainty -** some discussed sharp drop from receiving support to having little or no help once it ended.

Mental health report consideration

Quicker and easier access to support

More face-to-face support



Other options to medication

Holistic approach

Better joined up working

Better continuity of care

Better transition from support

Tackle root causes

Access to GP services

We heard from

1,255

people

64% Difficult

36% Easy

How easily can you get an appointment at your GP surgery?

Where was access easiest?
% easy

1. South Lincoln Healthcare - 63.0% (58)
2. K2 Healthcare Sleaford - 60.6% (60)
3. IMP - 53.1% (43)
4. K2 Healthcare Grantham and Rural - 50.6% (43)
5. Spalding - 44.4% (32)

Where was access hardest?
% difficult

1. Four Counties - 91.0% (131)
2. First Coastal - 82.8% (111)
3. Meridian - 74.3% (78)
4. Trent - 73.5% (25)
5. Boston - 72.3% (34)

Social Care – Healthwatch Carers Survey

Carers play a vital but often invisible role in society, helping people to live safely and independently.

Our survey will help us to better understand:

- The real-life experiences and challenges that carers face daily
- Barriers to support and services, including social care
- What support works well, and where improvements could be made
- Experiences of accessing care for the person being supported

Take the survey: https://www.smartsurvey.co.uk/s/ZJGGG2/

HWLincs engagement work

Pelvic Health

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

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

Childhood Immunisations

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

Hidden Voices

Delivery: June 2025 – December 2025

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

Communities of interest: Armed Forces Personnel, specifically:

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

For more information

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

www.healthwatchlincolnshire.co.uk

t: 01205 820 892

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Item 4 (i)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	4 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Lincolnshire Health and Care Digital Inclusion Strategy
Report Author:	Emma Townend, Interim Health Inequalities Programme Lead
Presenter:	Emma Townend, Interim Health Inequalities Programme Lead Jimmy Pryke-Walker, Head of Digital Health
Appendices:	Appendix 1 – Lincolnshire Health and Care Digital Inclusion Strategy Appendix 2 - Engagement Insight Report Appendix 3 – Presentation

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

Recommendations

The Board is asked to approve the Lincolnshire Health and Care Digital Inclusion Strategy.

Summary

Background and Context

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

Core20PLUS5 is a national NHS England (NHSE) approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' and identifies '5' focus clinical areas requiring accelerated improvement.

'Mitigating against digital exclusion' is one of the key NHSE strategic priorities in tackling health inequalities. As the NHS continues with the recovery and improvement of its services, it is vital that the broadest population can enjoy the benefits of digital health and digital transformation delivery ambitions. Realising these benefits without further widening healthcare inequalities requires action on multiple fronts:

- Designing person-centred and inclusive digital health approaches

- Promoting widespread adoption of digital health approaches
- Promoting digital inclusion – removing the barriers to digital approaches
- Providing and maintaining non-digital healthcare support, alongside digital health approach.

There is an expectation from the NHSE National and Regional teams that each system has a Digital Inclusion Strategy and plan to support this work. This is explicitly referenced in the NHSE 2025/26 priorities and operational planning guidance.

The Public Health Annual report 2023 and 2024 for Lincolnshire also highlighted the importance of working towards a digitally inclusive community.

In Lincolnshire 21.3% of the population live in the most digitally deprived areas. Public Health Intelligence have created a Lincolnshire Digital Health Toolkit in a bid to reduce digital exclusion in Lincolnshire by highlighting areas at greatest risk of being left behind because of digitalisation by including indicators that give greater granularity and context to Lincolnshire and its population. It shows that there are higher rates of digital exclusion in the more deprived areas in Lincolnshire, with Boston as the most digitally excluded, followed by Lincoln and East Lindsey.

Why is Digital Inclusion Important?
Digital channels offer the potential to enable greater equality in access to services. They can help to remove some of the practical barriers faced by individuals and enable more effective targeting of clinicians' time and expertise to the people who are most likely to need support.

While digital transformation of services can make it easier for some people to access healthcare, for others digital approaches can create extra barriers and make it difficult for people to adopt new ways of accessing services which can exacerbate health inequalities.

There are considerable benefits to people, the health and care system, economy and the environment if barriers can be removed for those who want but can't access digital services. It will also allow more resources to be targeted to those who for a variety of reason can't or won't access digital.

Strategy Development
The strategy development has been led by the Health Inequalities Programme and Lincolnshire Community and Hospitals Group (LCHG) for the Integrated Care System, working collaboratively with partners from across the system and people with lived experience.

It is based on the NHSE 'Inclusive digital healthcare: a framework for NHS action on digital inclusion' which highlights the importance of collaboration at different levels and across all sectors.

There are 6 main pillars in the strategy which are:

- **Access to devices and data** – led by East Lindsay District Council
- **Accessibility and ease of using technology** – led by ICB Digital Primary Care
- **Access to services** - led by ICB Digital Primary Care
- **Skills and capability** – led by LCHG
- **Beliefs and trust** – led by Lincolnshire County Council
- **Leadership and partnerships** – led by ICB Health Inequalities

The strategy outlines how the ambition is achieved and the priorities for 2025-28.

Lincolnshire digital inclusion personas will be developed to help support teams and organisations when designing or reviewing digital services. Personas will give a deeper insight into the users' needs and help understand the experiences and barriers of people experiencing digital exclusion, which are then tested and validated across the groups.

An ICS Digital Inclusion Strategy Oversight Group has been formed and meets on a bi-monthly basis to review and oversee the implementation of the strategy. It is led by the Health Inequalities Programme.

The Lincolnshire Health and Care Digital Inclusion Strategy has been presented to:

- ICS Digital and Information Executive Group
- LPFT's Digital and Data Committee
- LCHS Digital Executive Group
- LCHG Integration Committee
- LCHG Board
- ICB Health Inequalities Programme Board
- ICB Executive Group
- LCC Strategic DLT Group
- LCC Strategic Place Group

They are all in support of the strategy.

Public Engagement

To understand the views of people most at risk of digital inclusion some engagement was targeted with specific population groups which included older adults, people on lower incomes, unemployed, homeless, people seeking asylum, rural and coastal digitally deprived, people with 2 or more long term conditions and people whose main language is not English.

A total of 66 people were engaged with at a variety of community groups and locations. The insight showed that there are people who choose or cannot use online services for a variety of reasons, that access to data/devices is a barrier for some, confidence, skills and/or trust for others. The idea of having trained Digital Community Champions who could support people face to face was well received by many if it is in a local community setting. People in Mablethorpe and Skegness talked about existing local groups they knew of where they could get digital support should they need it. The idea of using the NHS App was welcomed by some and not by others with barriers of use mainly linked to digital skills, confidence and access to data and devices. The person experiencing homelessness who shared their views had different challenges and barriers. Further engagement is required with this population group as their needs will need to be addressed differently. This can form part of the Inclusion Health Strategy that is in development and led by the Health Inequalities Programme. The detailed engagement report can be found in **Appendix 2.**

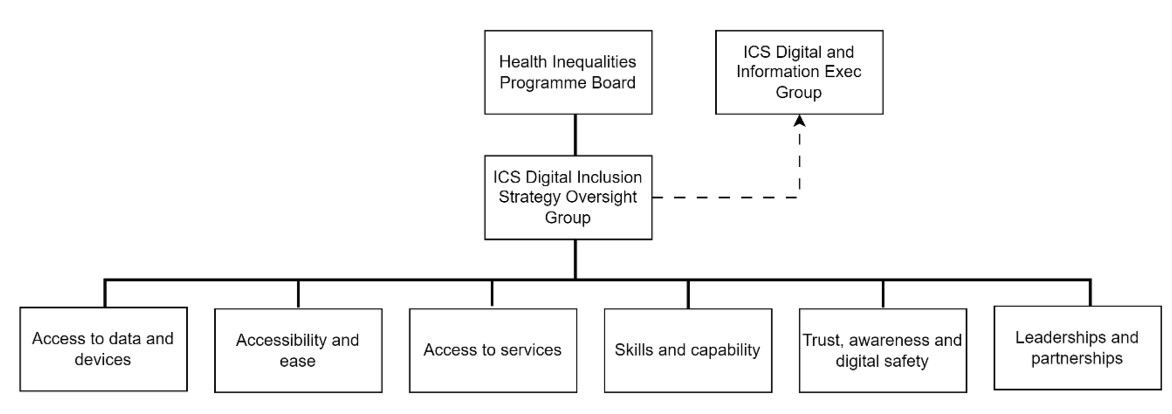
Engagement with communities most at risk of digital exclusion will continue to take place to ensure the implementation of the strategy is having the impact required and meeting the needs of Lincolnshire residents.

Evaluation of the Strategy

The LIRCH team (Lincoln Institute for Rural and Coastal Health, College of Health and Science) from University of Lincoln have been part of the working group and will lead the

evaluation of the strategy. They have facilitated 2 Theory of Change workshops with the pillar leads in 2025 to develop Logic Models and agree an initial collaborative project. The strategy will continue to develop through this process.

Governance



How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Improving digital inclusion positively impacts population health outcomes by reducing barriers to accessing health and care services and providing individuals with more access to healthcare information, services and resources. Digital inclusion can reduce social isolation and improve independence and health outcomes. It can also create capacity to support those who need it most.
Aim 2: Tackle inequalities in outcomes, experience and access.	Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. 'Mitigating against digital exclusion' is one of the key NHS England (NHSE) strategic priorities in tackling health inequalities. Digital exclusion can compound health inequalities by exacerbating challenges with access to healthcare, skills and capability to navigate and use services, and the general resources needed to lead a healthy life. The Digital Inclusion Strategy supports the reduction of healthcare inequalities.

Aim 3: Enhance productivity and value for money.	There is a clear business case for improving equity and that reducing health inequalities can contribute to an improved financial position both in the short term and long term. Improving digital inclusion is crucial for supporting the digital transformation needed as part of the shift from analogue to digital. Digital technologies can bring efficiencies that create capacity, allowing services the ability to cope with rising demand and maintain a choice of alternative ways to access services, including options for those who cannot or do not want to use digital health solutions.
Aim 4: Help the NHS support broader social and economic development.	Michael Marmot's work calculated the NHS treatment costs of health inequalities to be in the region of £5.5bn a year, productivity losses in the economy to £33bn, while a further £32bn a year is spent on higher welfare payments. The Digital Inclusion Strategy supports the reduction of health inequalities and broader social and economic development. Improving the population's skills, confidence and trust in using digital services will lead to improved financial inclusion for people with a wider choice of financial products and services, more access to education and employment opportunities.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	N/A
Risk and Assurance	
Risks are managed and are reported into the Health Inequalities Programme governance arrangements.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	Yes – details provided within the appendix
Does the report demonstrate patient and public involvement?	Yes-
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable

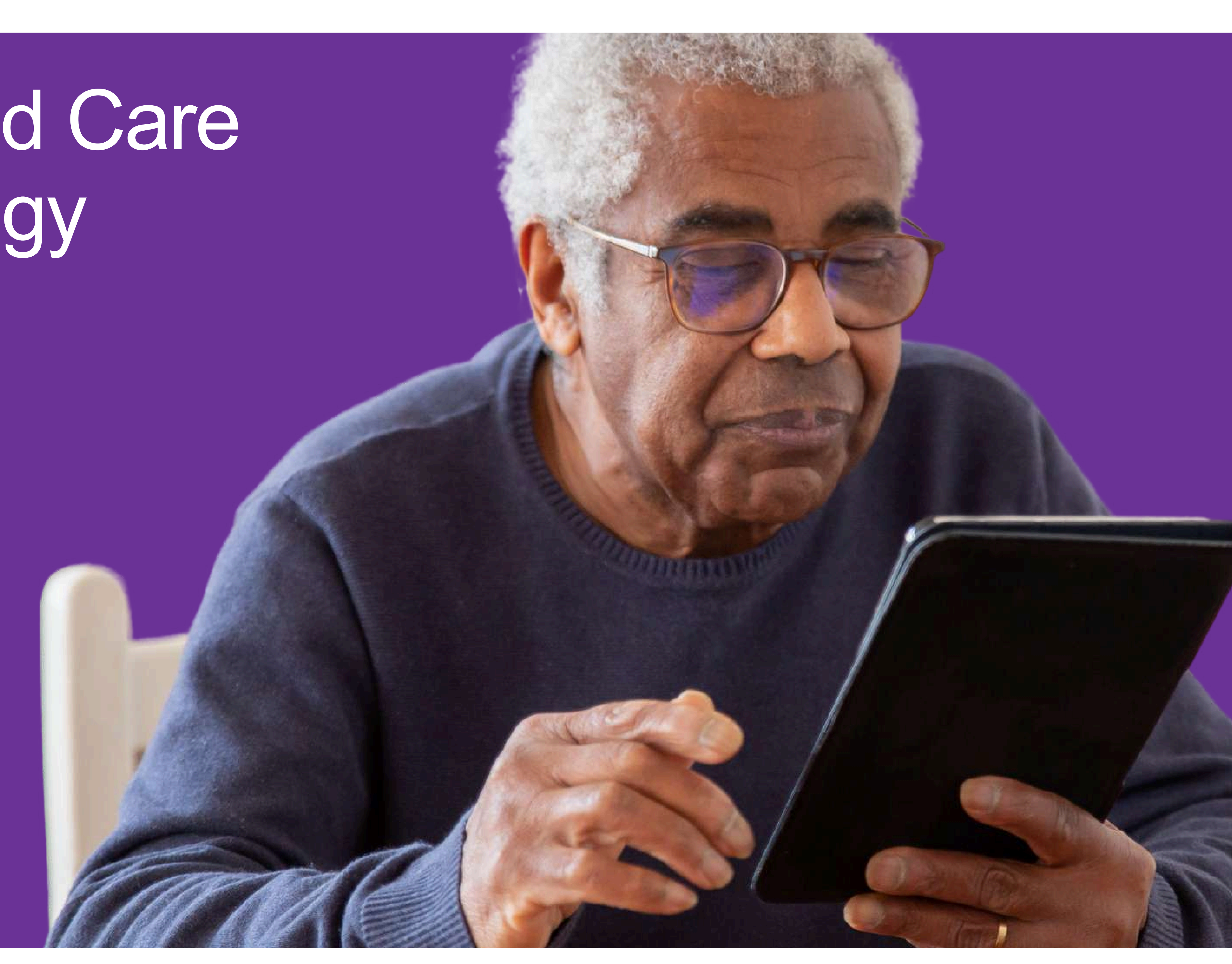
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable.			
Is the report confidential or not?			
Yes ☐ No ☒			

DRAFT V3.7

Lincolnshire Health and Care Digital Inclusion Strategy

2025 - 28

'Empowering people through digital inclusion in Lincolnshire'



Sandra Williamson

Director for Health Inequalities, Prevention and Regional Collaboration
Lincolnshire Integrated Care Board

Dan Dring

Deputy Director of Innovation
Lincolnshire Community Health Services

Kathy Fulloway

Chief Digital and Information Officer
Lincolnshire Integrated Care System

Foreword

Our Digital Inclusion Strategy for Lincolnshire has been developed with system wide organisations and people with lived experience and is part of the overall Integrated Care System's Digital Strategy. As part of our commitment to tackling health inequalities in Lincolnshire, our ambition is to improve digital inclusion. This applies to people who fall under the Lincolnshire Integrated Care system or those who access Lincolnshire services, including temporary residents who reside in Lincolnshire over the seasonal period, e.g. university students, tourists, caravan residents and Gypsy, Roma and Traveller communities.

The Digital Inclusion Strategy builds on the amazing 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 skills and the confidence to utilise digital health and care services and those who do not. For a large proportion of our population, accessing information and services online is now a part of everyday life, with many routinely using the internet for online shopping and banking due to the speed and convenience it gives. However, whilst there are many that embrace the digital offer, there are others in Lincolnshire that will feel excluded and unable to use online services for a variety of reasons. The Public Health Annual Report 2023 for Lincolnshire highlighted the importance of working towards a digitally inclusive community.

Ensuring digital and face to face options are considered in service provision will help us deliver equity of provision, improve access and meet the needs of the population we serve i.e. face to face access for those who cannot or do not want to access services digitally.

The Lincolnshire Integrated Care System is committed to deliver the vision **'Everyone in Lincolnshire who wants to be digitally connected to health and care services and the community will have the skills, accessibility and confidence to do so'** by supporting those people who can and want to become more digitally active and overcoming the barriers to digital inclusion we can help address health inequalities and avoid exacerbating them through increased reliance on digital.

Contents

Section 1

- Definition of Digital Inclusion and Digital Exclusion
- Barriers to Digital Inclusion
- Why is Digital Inclusion Important?
- Current picture in Lincolnshire

Section 2

- Our Purpose, Principles and Approaches
- Working in partnership

Section 3

- Strategy Pillars

Section 4

- Priorities

Appendices

- Appendix 1 - Strategic Context
- Appendix 2 - Glossary and Acronyms

Section 1: What we mean by Digital Inclusion?

Digital inclusion covers the following:

Digital skills

- Having the skills and confidence to use digital devices (such as computers or smart phones and the internet).

Connectivity

- Access to the internet through broadband, Wi-Fi and a mobile device.

Accessibility

- Services designed to meet all users' needs, including those dependent on assistive technology to access digital services.

Affordability

- Having the financial means to get online.

What we mean by Digital Exclusion?

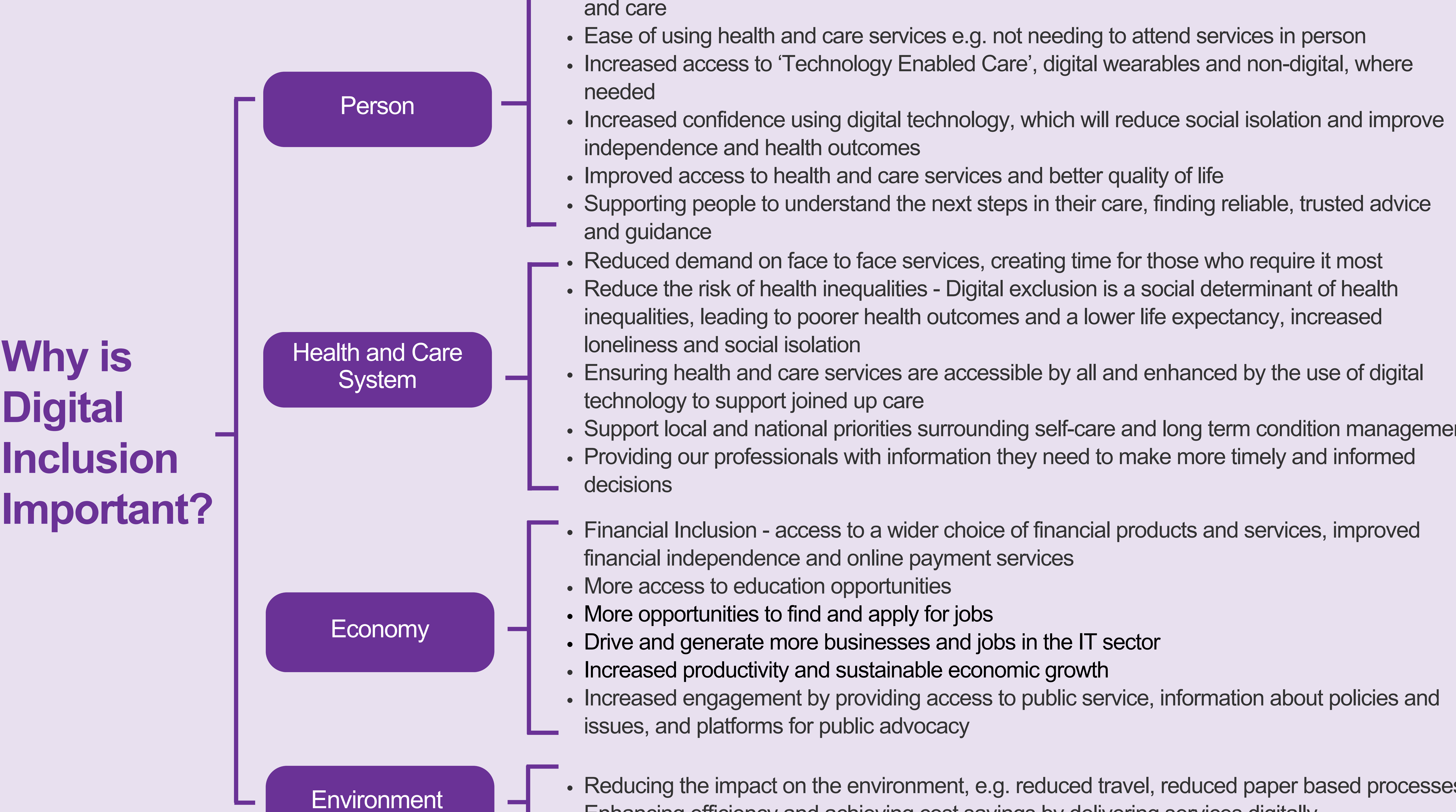
Digital exclusion refers to the lack of access, skills, capabilities needed to engage with digital devices or digital services.

4

Section 1: Barriers to Digital Inclusion

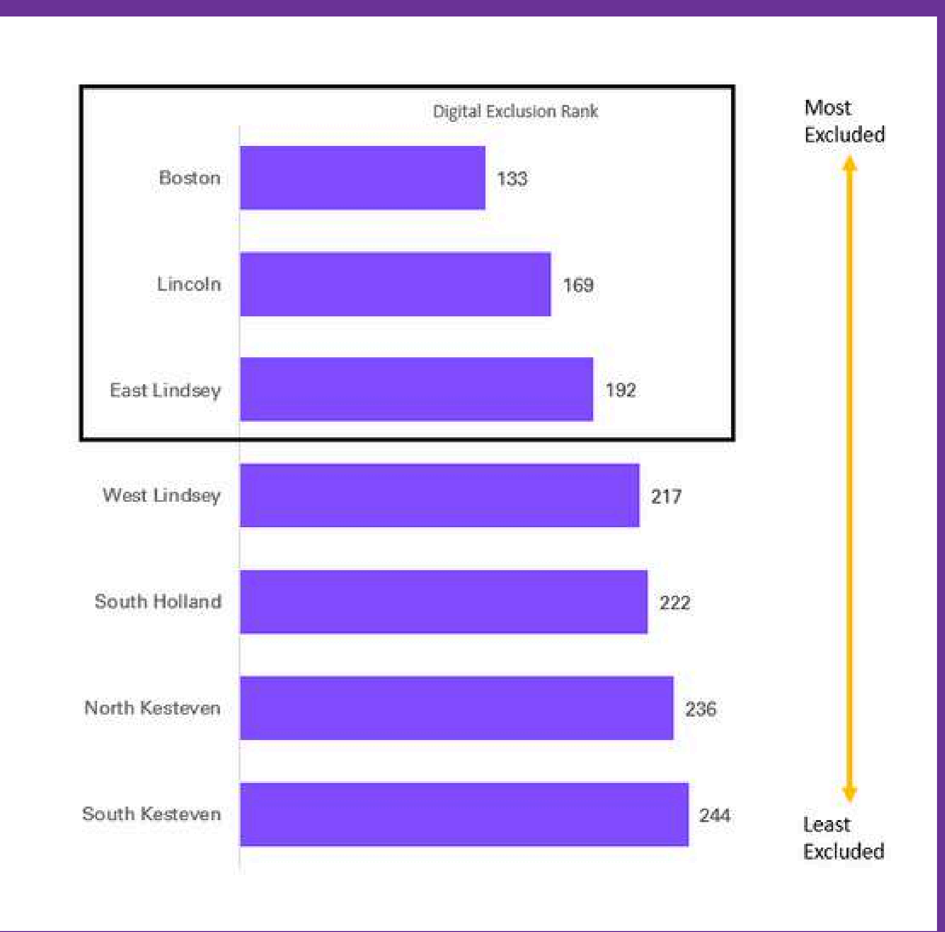
Below are some examples of reasons as to why some people are digitally excluded.

- Lack of skills, knowledge and confidence – using digital, benefits of digital, knowing what is already in place/available Wi-Fi and connectivity
- Access to devices with internet connectivity and Wi-Fi
- Attitudes and previous experience
- Affordability
- Language barriers
- Sensory and visual impairments
- Some physical disabilities
- People choosing to opt out of using digital technology due to choice
- Digital Safety including trust, safeguarding, fear of scams
- Infrastructure

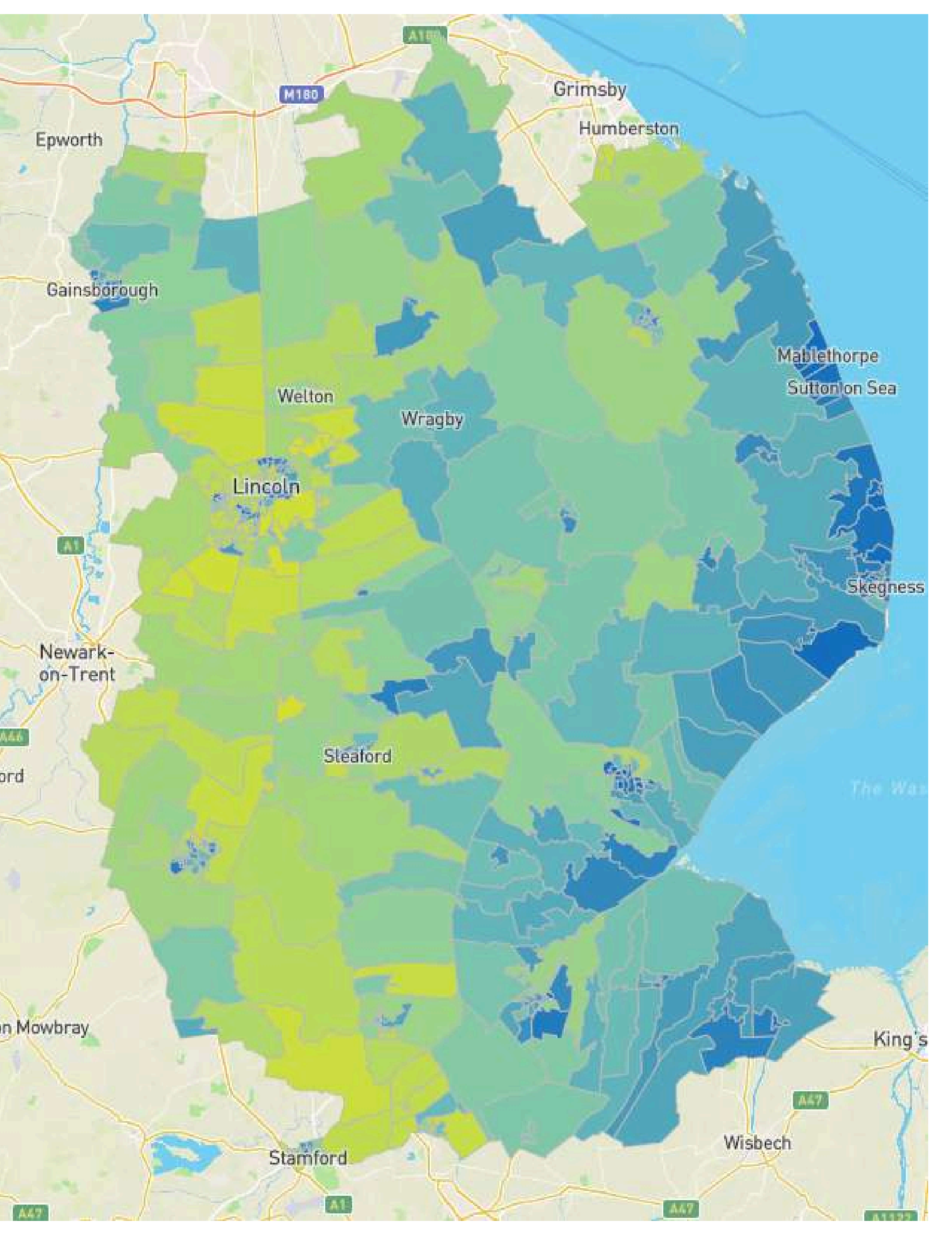

Why is Digital Inclusion Important?
Person
Empowering the individual, families and/or carers to take a more active role in their health and care
Ease of using health and care services e.g. not needing to attend services in person
Increased access to 'Technology Enabled Care', digital wearables and non-digital, where needed
Increased confidence using digital technology, which will reduce social isolation and improve independence and health outcomes
Improved access to health and care services and better quality of life
Supporting people to understand the next steps in their care, finding reliable, trusted advice and guidance
Health and Care System
Reduced demand on face to face services, creating time for those who require it most
Reduce the risk of health inequalities - Digital exclusion is a social determinant of health inequalities, leading to poorer health outcomes and a lower life expectancy, increased loneliness and social isolation
Ensuring health and care services are accessible by all and enhanced by the use of digital technology to support joined up care
Support local and national priorities surrounding self-care and long term condition management
Providing our professionals with information they need to make more timely and informed decisions
Economy
Financial Inclusion - access to a wider choice of financial products and services, improved financial independence and online payment services
More access to education opportunities
More opportunities to find and apply for jobs
Drive and generate more businesses and jobs in the IT sector
Increased productivity and sustainable economic growth
Increased engagement by providing access to public service, information about policies and issues, and platforms for public advocacy
Environment
Reducing the impact on the environment, e.g. reduced travel, reduced paper based processes
Enhancing efficiency and achieving cost savings by delivering services digitally

Section 1:
Current picture in Lincolnshire

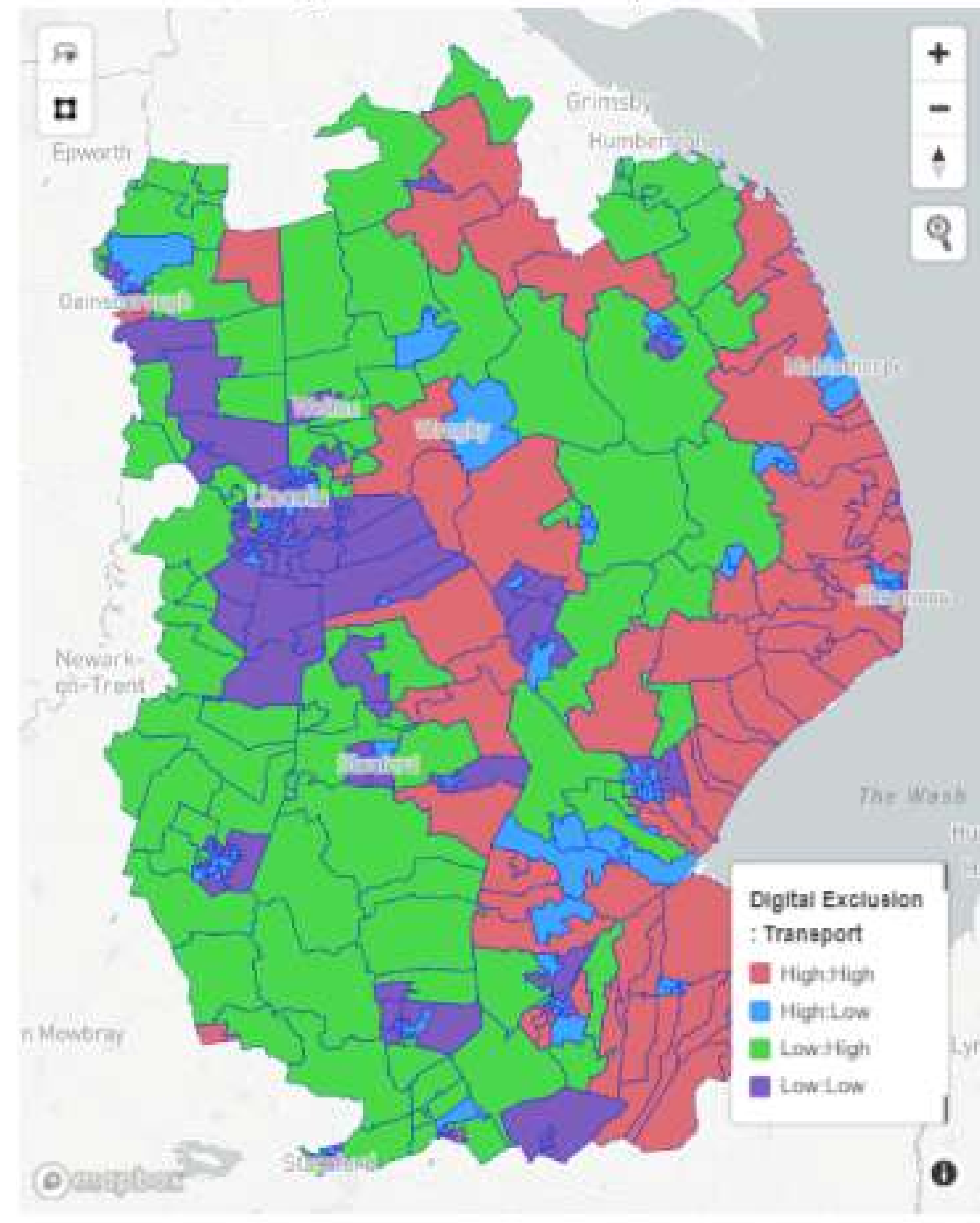
Intelligence is key to identifying areas which may be at risk of digital exclusion. The Lincolnshire Digital Health Toolkit has been created in a bid to reduce digital exclusion in Lincolnshire by highlighting areas at greatest risk of being left behind as a result of digitalisation by including indicators that give greater granularity and context to Lincolnshire and its population. It shows that there are higher rates of digital exclusion in the more deprived areas in Lincolnshire, with Boston as the most digitally excluded, followed by Lincoln and East Lindsey.



The map below shows the different levels of those at risk of Digital Exclusion across Lincolnshire.



The map below shows the combined effect of transport barriers and digital exclusion in Lincolnshire.



Source:
Lincolnshire Digital Health Toolkit, Public Health Intelligence

Section 1:
Current picture in Lincolnshire

We recognise that digital inclusion is a complex issue, and that those who are excluded are hard to define.

We acknowledge that anyone could be digitally excluded in their lifetime, at any time and that there is no one category of people who fit this label.

The "scale of potential of Digital Exclusion" in Lincolnshire infographic shows the groups who are more likely to be digitally excluded due to a range of different barriers.

In order to further explore, understand and target those who are likely to be digitally excluded, personas/profiles of representative people will be developed through engaging with communities. Personas are designed to give a deeper insight into people's needs and help understand the experiences and barriers of people experiencing digital exclusion. These are then tested and validated across the groups so that our communication and support offerings are tailored.

21.3% of Lincolnshire's population live in the most digitally deprived areas.

The scale of potential DIGITAL EXCLUSION in Lincolnshire

Digital inclusion/exclusion covers digital skills, connectivity and accessibility.
Some sections of the population are more likely to be digitally excluded than others.

In Lincolnshire:

193,532 people aged 65 years and over[1]

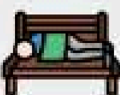
9,882 people live in a rural area and in the most digitally deprived areas [6, 9]

147,800 people with lower incomes[2]

23,189 people (registered with a GP in one of the costal areas live in one of the most digitally deprived areas [8,9]

13,710 people who are unemployed[3]

247,332 people with at two or more long-term conditions [7]



2,111 households were owed a relief duty under the Homelessness Reduction Act and require help to secure settled accommodation).[4]

163,470 people who live in the most digitally deprived areas in Lincolnshire[9, 10]

553 people who are seeking asylum[5]

66,807 people whose main language is not English [11]

1. Patients Registered at a GP Practice. NHS Digital - May 2024
2. NOMIS Annual Population Survey - October 2022 to September 2023
3. NOMIS Claimant Count for 16 to 64-year-olds - 2023 average
4. Ministry of Housing, Communities & Local Government: Tables on homelessness - April 2022 to March 2023
5. Asylum and Resettlement datasets, Home Office - April 2022 to March 2023
6. 2011 Rural/Urban Classification. Office for National Statistics and
7. Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB - March 2024
8. Coastal built-up areas, England and Wales, 2022 Built Up Area classification
9. Patients Registered at a GP Practice. NHS Digital - April 2024
10. Lincolnshire Digital Health Toolkit

Section 2:
Our Purpose

The Digital Inclusion Strategy aims to increase the number of people who are digitally included in their health and care and ensure that equitable access is made for those who cannot or choose not to engage in digital services/technology.

Our Principles and Approaches

- Clearly defined deliverables
- Person centred
- Value for investment
- Inclusive and adaptable
- Unified approach
- Simplicity
- Co-production approach
- Honest and brave
- Active listening
- Not leaving people behind
- Change what we can change!

Section 2:
Working in partnership

The **Digital Inclusion Strategy Oversight Group** has a wide range of skills, expertise and experience. This group has worked in partnership to develop this strategy.

This includes representatives from:

- City Council & County Council
- District Councils
- Financial Inclusion Partnership
- Healthwatch Lincolnshire
- NHS organisations across Lincolnshire
- People with lived experience
- Primary Care Networks
- University of Lincoln
- Voluntary Sector organisations

Lincolnshire
POLICE & CRIME COMMISSIONER
SAFER TOGETHER

Lincolnshire
Care Association

Section 3: Strategy Pillars

Vision

Everyone in Lincolnshire who wants to be digitally connected to health and care services and the community will have the skills, accessibility and confidence to do so.

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 use

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 to reduce health inequalities

Section 3: Strategy Pillars

Access to devices and data		
Why?	**How?**	**Outcomes after 3 years**
Everyone can access digital health and care services if they choose to and experience the benefits	• Volunteers with digital skills, information and support available at community hubs • Device bank - loan and replacement schemes • Assisted in person digital support and training available locally • Free public computer maps • Developing digital skills and confidence in our people • Awareness and promotion of current schemes and digital support such as social tariffs, subsidised data, data banks for free wifi and training • A digital front door/directory of what is available in Lincolnshire showing accredited schemes available • Ensure that there is a sustainable approach to enabling connectivity, particularly where devices are provided	**Impact on person** • Increased knowledge of schemes across the system so those who choose have access to devices and data • Improved skills and confidence to access digital services • Improved access to services • Increased choice for people **Impact on workforce** • Staff are able to signpost people to the correct resources/where to get help **Impact on the system** • Reduced demand on services, allowing those who can access digital to free up time for those who cannot **Measure of success** • Increased number of people accessing device and data banks, social tariffs and digital support and training

Section 3: Strategy Pillars

<table>
<tr><th colspan="3">Accessibility & ease of using technology</th></tr>
<tr><th>Why?</th><th>How?</th><th>Outcomes after 3 years</th></tr>
<tr><td>Increasing digital uptake in health and care services by ensuring things are clear, simple and accessible to use</td><td>• Digital health and care systems to be user friendly and accessible
• Accessible digital access for Health Inclusion and PLUS groups - adaptable formats and languages to be standard
• Enable a ‘digital first, not digital only’ approach
• Joined up partnership working with existing established programmes
• Co-production approach with people with lived experience
• Ensure feedback is acted on and any future service design complies with accessible information standard and NHS service standard</td><td>Impact on person
• Reduction in existing digital barriers for Health Inclusion and PLUS groups.
Impact on workforce
• Improved partnership working across the system
Impact on the system
• Reduced health inequalities for our Health Inclusion and PLUS groups (e.g. English as a second language)
• Reduced duplication/resource
• Improved digital services through a co-production approach
Measure of success
• User satisfaction surveys
• Feedback from Inclusion and Plus Groups
• Compliance with accessibility standards</td></tr>
</table>

Section 3: Strategy Pillars

Access to services

Why?	How?	Outcomes after 3 years
Providing face to face alternatives for those who are unable or don’t want to access health and care services digitally	• Understand which groups may need additional support through face to face channels • Health and care providers to offer face to face services to people who cannot/choose not to use digital services • Accessible digital and face to face platforms for future service designs and improvements • Ensure routine recording of preferences for modes of communication for people • The face to face health and care offer to be as good as the digital offer • Increase NHS app uptake and maximise its capability	**Impact on person** • Those who need to be seen face to face are, resulting in a more personalised approach • Improved experience as preferred methods of communications used • Benefits of using NHS app i.e. faster repeat prescriptions **Impact on workforce** • Improved staff satisfaction in role as they are able to offer the right service for individuals i.e. face to face/digital **Impact on the system** • Reduction in calls to GP Practices due to increased requests of repeat prescriptions through NHS app • Greater insight into preferred methods of communication for the local population **Measure of success** • Increased uptake of NHS App • User satisfaction surveys • Feedback from Inclusion and Plus Groups

Section 3: Strategy Pillars

Skills and capability

Why?	How?	Outcomes after 3 years
Everyone to have the skills to use digital health and care approaches with confidence	• Upskill staff and co-produce digital training that meets different learning styles and needs • Ensure that any ongoing digital training and support needs are included in workforce plans • Digital Community Champions available where needed to help people feel confident in using digital • Provide specific digital training for people in the community, working with local government, VCFSE organisations and the private sector	**Impact on person** • Increased access to Digital Champions • Increased knowledge, skills and confidence with their digital skills **Impact on workforce** • Increased knowledge, skills and confidence with their digital skills **Impact on the system** • Increased uptake of digital health and care services • Reduced Health Inequalities **Measure of success** • Pre and Post Training Assessments • Enrolment and completion rates • Demographic reach of training • Reach of Digital Community Champions

Section 3: Strategy Pillars

rust, Awareness and Digital Safety

Why?	How?	Outcomes after 3 years
People to understand and feel confident and safe using digital health and care approaches	• Transparency about how data is used and kept safe • Working in partnerships to ensure people are aware of trusted and accredited schemes available • Signposting to other services for more information • Resources in different languages and formats • Communication and monitoring the impact of using digital and the effects on other services • Digital Champions approach - offering consistent messages • Make digital health and care services relatable and seen to be used by 'people like me' through use of advocates and communications using everyday language • Ensure that new digital health and care pathways are at least as good as alternative non-digital service channels • Encourage peer support for people to build confidence and trust • Promote the benefits of using services online, tailoring messages to the identified personas	**Impact on person** • Increased trust and confidence in using digital health and care services • Understandable information and confidence around how data is being used • Improved knowledge on scam messages and less likely to be victims of fraud **Impact on workforce** • Increased consistency on safety messages and knowledge around scams **Impact on the system** • Increased uptake of digital health and care services leading to improved capacity for those who need it most **Measure of success** • Increased number of people accessing digital health and care services

Section 3: Strategy Pillars

eadership and Partnerships

Why?	How?	Outcomes after 3 years
Digital inclusion efforts are co-ordinated to avoid duplication and help to reduce health inequalities	• Shared vision, understanding and consistent language across all Lincolnshire organisations • Collective and agreed policies showing expectations of commitment • Interdependencies highlighted with other system wide strategies and programmes • Collect data and monitor health inequalities information impacting access to, experience of or outcomes from digital healthcare, including by gathering feedback from people about digital health and care services • Identify which community-centred roles in Lincolnshire can help connect people to digital information and support e.g social prescribing link workers, Age UK, community connectors, patient participation groups etc. • Create a network of Digital Inclusion Leads across the system	**Impact on person** • Improved access to digital support in the community • Improved digital service experience **Impact on workforce** • Improved advice and recommendations from Digital Inclusion Leads. **Impact on the system** • Greater insight on monitoring health inequalities • Reduced duplication across services and organisations • Reduced digital exclusion **Measure of success** • Digital Inclusion Strategy Pillar Leads in place across the system • Progress against Digital Inclusion Strategy priorities

Section 4: Priorities

Strategy Pillars				2025/26	2026/27	2027/28
Access to data and devices	Create Lincolnshire Digital Exclusion Personas	Communication and Engagement	Engagement and co-production with staff and public	Work with internet providers to discuss improving network coverage across Lincolnshire rural and coastal areas		
				Develop and implement communication and engagement plan to support promotion of current accredited schemes available e.g. social tariffs, subsidised data, data banks, digital training etc.	All organisations to review process of recycling/donation of old devices and technology and work together to develop equipment standards and a collective process	Review gaps of accredited schemes and ensure equitable provision across Lincolnshire
Accessibility and ease				All organisations to collaboratively look at accessibility of websites, user guides etc.	All organisations to review what digital offer/products are in place, current uptake and accessibility of these services and analysis of population groups who are not accessing digital services	Assess organisational readiness and appropriateness of use (through personas) so people can navigate and access pathways more easily
Access to services				Identify where people are being digitally excluded and use learning to influence immediate and future improvement	Use learning from findings in Year 1, build a simple and standardised engagement plan (for NHS app) for staff and patients	Use findings from NHS app to enhance other offers
				Face to face services as good as the digital offer		
Skills and capability				Identify advocates to lead on strategy and gather digital skills and capability insights	Development of digital training and engagement plan to address gaps and test with selected groups	Use learning to implement and expand digital training offer
Trust, awareness and digital safety				Establish working group to lead on trust, awareness and digital safety. Develop simple and clear communication messages around digital safety - all organisations to promote the same consistent messages.		
Leaderships and partnerships				Establish strategy pillar workstreams and leads with clearly defined deliverables and measures of success	Identify collective funding opportunities and develop business cases to support digital inclusion strategy	All organisations to maintain commitment of delivery. Evaluate impact of strategy and review overall objectives beyond 2027.
				Quarterly review of objectives and plan		

Appendix 1: Strategic Context

The digital landscape is an ever changing one for the Integrated Care System.

The below act as key drivers for the Digital Inclusion strategy:

National

- Inclusive digital healthcare: a framework for NHS action on digital inclusion
- NHS England Health Inequalities Improvement Programme - Mitigating against digital exclusion
- Department of Health & Social Care - A plan for digital health and social care
- The What Good Looks Like (WGLL) framework - Digital working in adult social care: What Good Looks Like
- The Minimum Digital Living Standard
- National Digital Inclusion Alliance
- The Darzi Report (2024)

Local

- The Integrated Care Partnership Strategy 2023
- Integrated Care Partnership Strategy - Digital Technology
- The Integrated Care Board 5-Year Forward Plan
- Our Shared Agreement
- Director of Public Health Annual Report 2023- Ageing Well
- Lincolnshire County Council (LCC) Customer Strategy – Customer Experience (Objective 3)
- Digital exclusion as a barrier to accessing healthcare: a summary composite indicator and online tool to explore and quantify local differences in levels of exclusion.

LONG TERM AIMS

LEADERSHIPS & PARTNERSHIPS

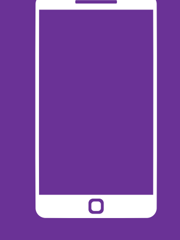
SHARED COMMITMENT AND VALUES

DIGITAL INCLUSION LEADS IN EACH ORGANISATION

CONNECT WITH COMMUNITY AND VCFSE ROLES

SUSTAINABLE APPROACHES TO ENABLING CONNECTIVITY

INCREASED USE OF DATA AND DEVICES



INCREASED AWARENESS OF CURRENT SCHEMES

ACCESSIBILITY & EASE

ACCESSIBLE SERVICES FOR HEALTH INEQUALITIES AND PLUS GROUPS

FRIENDLY & ADAPTABLE SERVICES

ADAPTABLE FORMATS & LANGUAGES

ACCESS TO SERVICES

FACE TO FACE FOR THOSE WHO CAN'T ACCESS DIGITAL

SIGNPOSTING TO RELEVANT SERVICES

FACE TO FACE TO OFFER AS GOOD AS THE DIGITAL OFFER

TRUST, AWARENESS & DIGITAL SAFETY

ADVOCATES

AWARENESS OF TRUSTED AND ACCREDITED SCHEMES E.G. DEVICE LOANING ETC

TRANSPARENCY ABOUT DATA AND HOW WE KEEP IT SAFE

SKILLS & CAPABILITY

UPSKILL STAFF AND CO-PRODUCE TRAINING

DIGITAL COMMUNITY CHAMPIONS

DIGITALLY EMPOWERED POPULATION

DIGITALLY ENABLED STAFF

Appendix 2: Glossary and Acronyms

Glossary

Assistive Technology is used to describe products or systems that support and assist individuals with disabilities, restricted mobility or other impairments to perform functions that might otherwise be difficult or impossible

Broadband is the 'always-on' way of connecting a computer to the internet using a copper, cable, fibre or wireless connection

Co-production is an equal partnership where people with lived and learnt experience work together from start to finish

PLUS groups are population groups, defined by integrated care systems (ICS), which experience poorer than average health access, experience and/or outcomes across their communities

Smartphone is a mobile phone that performs many of the functions of a computer, typically having a touchscreen interface, internet access, and an operating system capable of running downloaded apps

Social Tariffs are cheaper broadband and phone packages for people claiming Universal Credit, Pension Credit and some other benefits

Technology-Enabled Care is referred to as any digital solution that helps someone with their care and support. Also known as "assistive technology" or "assistive equipment".

Wi-Fi is a wireless networking technology that uses radio waves to provide wireless high-speed Internet access

Acronyms

GP: General Practitioner
ICB: Integrated Care Board
ICS: Integrated Care System
IT: Information Technology
LCC: Lincolnshire County Council
LCHS: Lincolnshire Community Health Services
LPFT: Lincolnshire Partnership Foundation Trust
NHS: National Health Service
PCN: Primary Care Network
ULHT: United Lincolnshire Hospitals Trust
VCSE: Voluntary, Community and Social Enterprise
VCFSE: Voluntary, Community, Faith and Social Enterprise

Digital Inclusion Strategy – Feedback report with groups most at risk of digital exclusion

21st April – 9th May 2025

Executive Summary

Introduction

The Health Inequalities Programme have led the development of a draft Lincolnshire Health and Care Digital Inclusion Strategy for 2024-27 with Lincolnshire Integrated Care System partners (ICS).

This is a plan for how we will help people use health and care services who don't or can't use things like websites, apps on a smartphone, computers, video calls, etc. This might be because they don't have a phone or computer, they might have one but don't know how to use it, or they don't want to use it.

We wanted to talk to groups who are at the highest risk of digital exclusion, and who might not use things like this at the moment.

Respondent profiles

- A total of 63 age responses were recorded from feedback participants. The **average age** was approximately **71 years**. Most respondents (approximately **69%**) were aged **60 or older**, indicating that feedback is largely being provided by older adults.
- We reached out to all stakeholders who currently work with or support people from our groups who are most at risk of digital exclusion. We sent links to an online survey, and also, community outreach took place for us to engage with people
- Our biggest response was from **Older adults**
- At the time of writing this report, we are still awaiting a response from two community groups *(Boston Lithuanian Community & Upbeat Communities) who* support people whose **main language is not English, Refugees** and **Asylum seekers.** We have had the survey translated into **Lithuanian** to aid the engagement.
- At the time of writing this report, we are still awaiting a meeting with LEAN (Lincoln Embracing All Nations) to gather feedback
- Two online meetings took place with factories, offering good opportunities to support the needs of our **migrant** and **rural population** accessing the NHS

Survey

- A **smartphone** is the most owned device; the biggest reason people don't use their devices is that **they don't want to**. Online banking received the highest response as to what people use their devices for.
- Please note that as the survey progressed, we received fewer responses to the questions.

Respondent Profiles – Digitally Excluded Groups

Digitally Excluded Group	Count
Older Adults	**50**
People on lower incomes	**7**
Unemployed	**4**
Homeless	**1**
People seeking asylum	**Awaiting Feedback**
Rural population and digitally deprived	**4**
Coastal population and digitally deprived	**11**
People with 2 or more long term conditions	**16**
Peoples whose main language is not English	**Awaiting Feedback**

Some people will represent more than 1 group

Other….	Count
Carer	**8**
Deaf Patient	**7**
Visual Impairment / Blind	**5**
Mental Health Conditions	**1**
Veteran	**1**
Dementia	**1**

Age in years	Count
20-39	**3**
40-49	**5**
50-59	**7**
60-69	**13**
70-79	**16**
80-89	**17**
90+	**5**
Answered	**66**

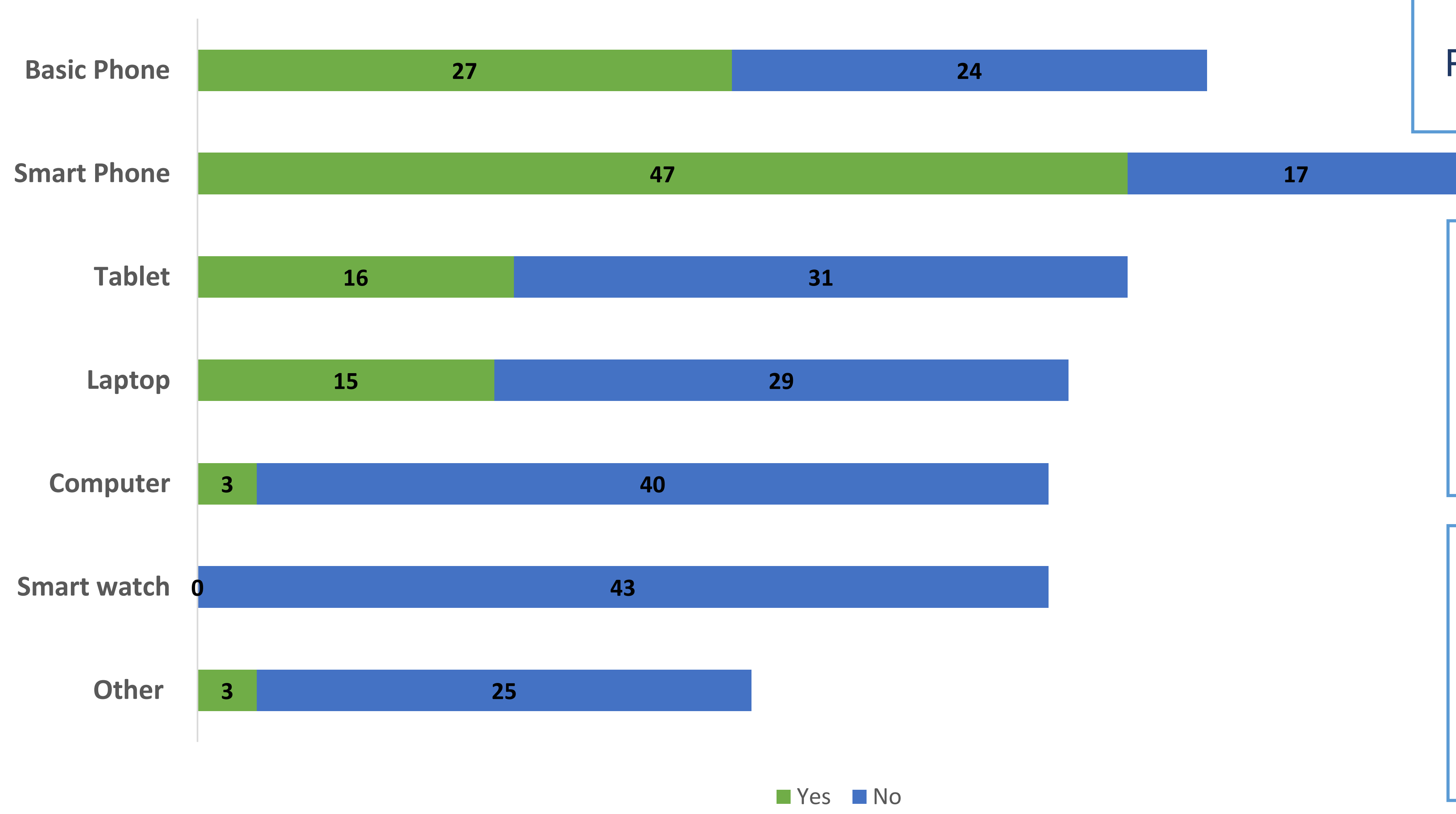
Promotion of Engagement

The below groups received the link to the online survey and/or in-person engagement from the engagement team:

Digitally Excluded Group	Engagement that took place
	Store house, Skegness Winnies Knitting Group, Skegness Age UK Friendship Group, Boston Salvation Army, Bourne Age Uk, Lincs
	Shared with James Ryan, Counsellor & Supporting people from underserved populations – Lincolnshire Talking Therapies Ruth Daly Roy, Upbeat Communities, Lincolnshire

Digitally Excluded Group	Engagement that took place
Rural population & digitally deprived	Worldwide Fruits Pilgrims LSRN
Coastal population & digitally deprived	The Store House, Skegness Coastal Centre, Mablethorpe Community Asses Lead at First Coastal PCN
People with 2 or more long term conditions	Hearing & Visual Coffee Morning, Bourne LPFT Dementia Carers Coffee Club, Navenby Memory Café, Fulbeck Salvation Army, Bourne Alzheimer's Society and Dementia Café, Boston Lincs Sensory Service Carers First, Lincolnshire Virginia House Day Centre, Louth
People whose main language is not English	Lithuanian Community, Boston *(still awaiting feedback)* LEAN (Lincoln Embracing All Nations) *(meeting pending)*

What devises people currently have



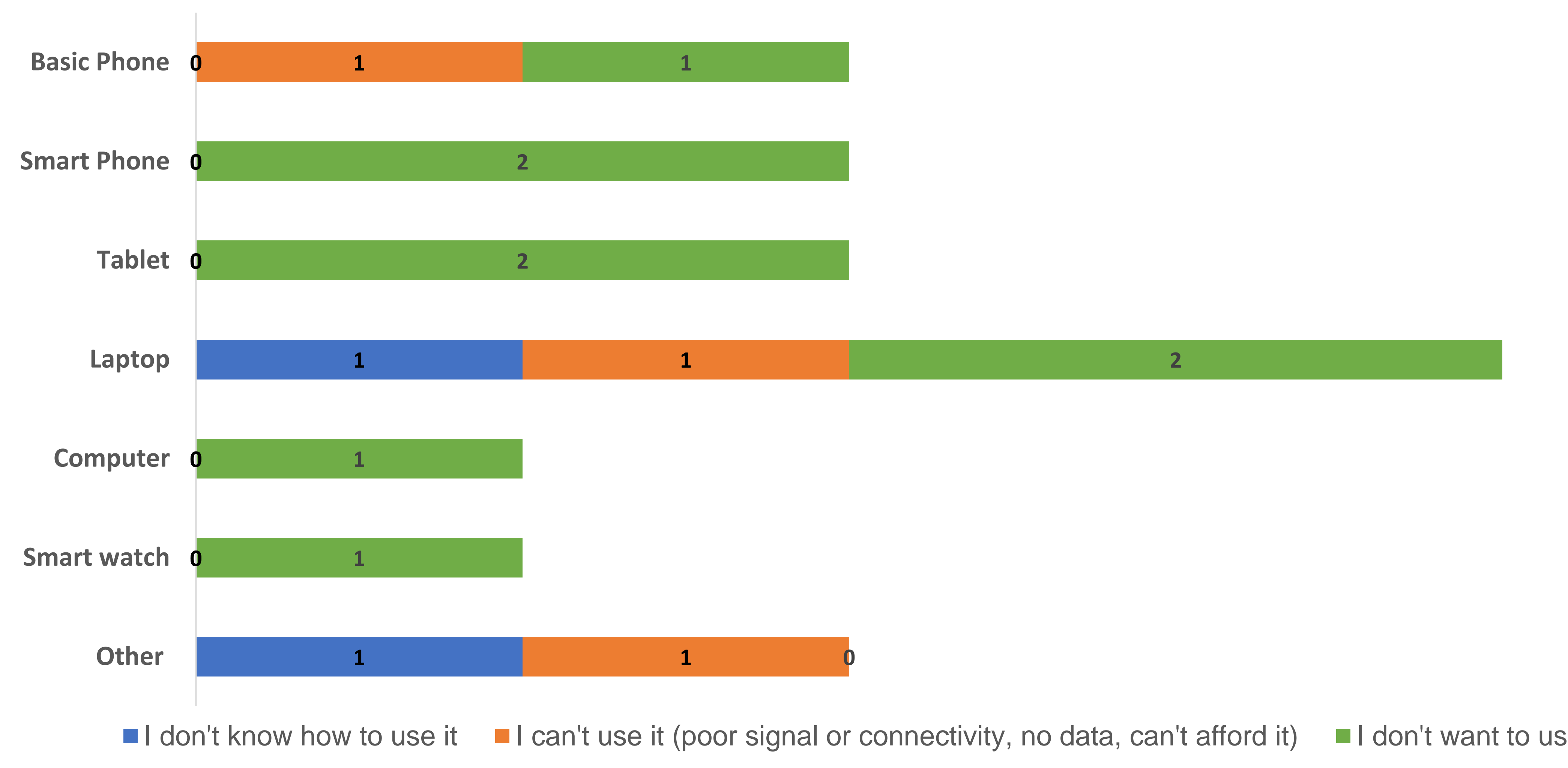
SMART PHONE is the most popular device that is currently owned by respondents. A BASIC PHONE is the second most popular device

Out of the 27 people who have a basic phone 21 of them are OLDER ADULTS

Out of the 47 people who have a smart phone 30 of them are OLDER ADULTS

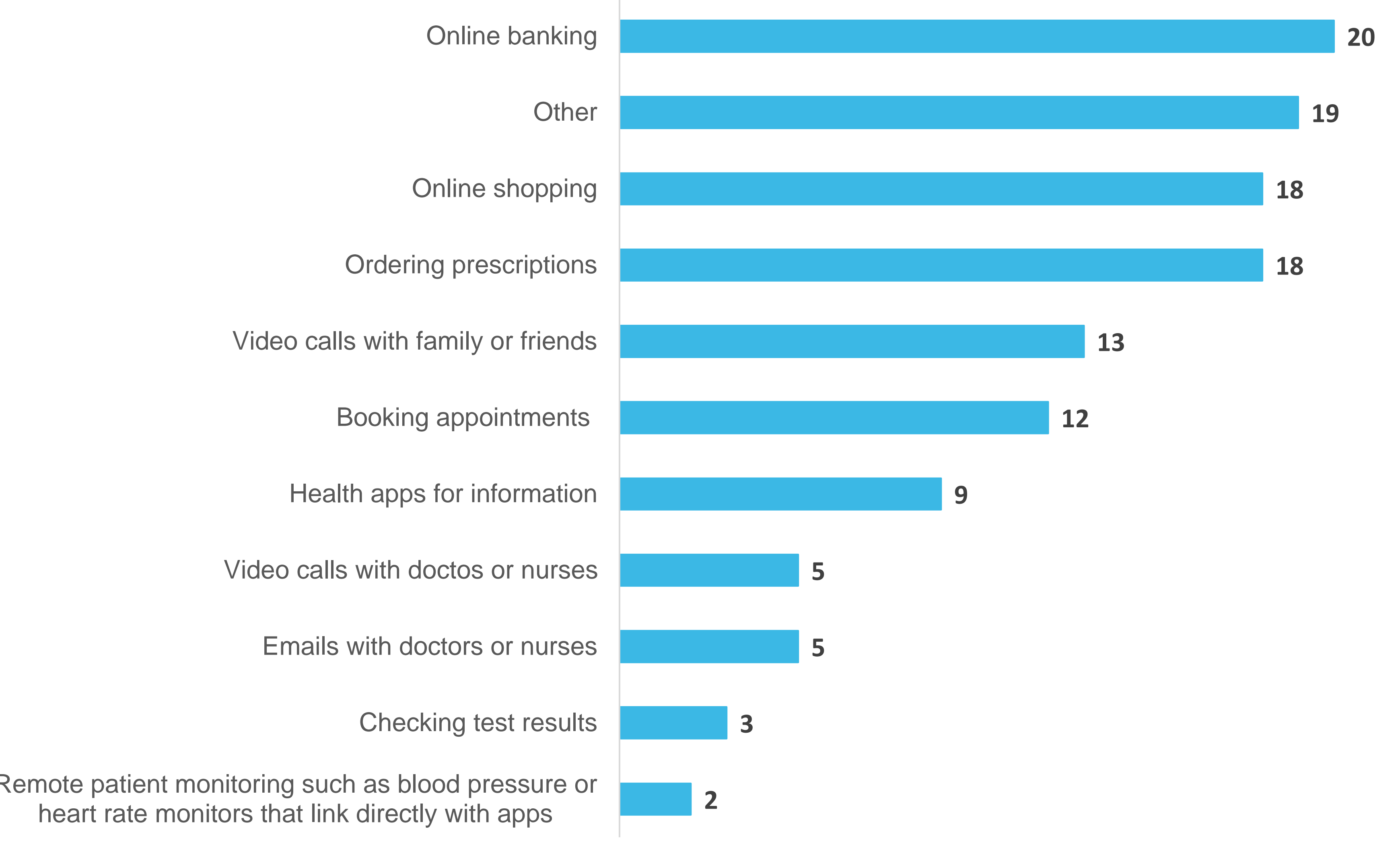
Q1 Do you have any of the following? – Have you got one?

The reasons why people DON'T use their device



Q1 Do you have any of the following? – If YES, but don't use it, please tell us why?

What people are currently using their devices for



This data shows that people mostly use their device for ONLINE BANKING

19 people selected OTHER. Most of these reasons relate to health matters

OLDER ADULTS use their devices mostly for ORDERING PRESCRIPTIONS & ONLINE BANKING

Q2) Do you use any of your devices for the following?

Other Reasons why respondents use their device

Health Reasons	Other	Does not use / needs assistance
Uses AskMyGP to contact Doctors surgery to book appointments which works really well. Got an appointment the next day at my Surgery.	Uses digital - google for ordering taxi's	Only have basic mobile phone for emergencies. (was switched off)
Just calls via phone when needed for a healthcare appointment	Gaming	Only use for emergencies
Would like to book appointments but GP practice at won't allow him to	Texting and phone calls	No, Son does everything for me on his phone. I do not own or have access to one.
Would use for booking appointments but is unable to at their GP surgery.	Uses for Facebook but not health and would not be interested	Do not use mobile phone for on-line services.
Text from Doctors		Not interested in booking online for health appointments
Only time use phone is for ordering prescriptions by telephoning GP practice and contacting District Nurses for wife		
Text messages about hospital appointments		
Wanted to know how to order prescriptions, so Age UK digital trainer was showing them how to do this via the NHS App		

ACCESS TO DEVICES AND DATA:

We want everyone to be able to have a device they can use and the confidence to be able to use it. It will take time, but we're thinking of things like volunteers in your community who can show you how to use a computer, or laptops you could borrow; free SIM cards if you get certain benefits or places where you can go for free Wi-Fi etc.

Do you think things like this would be useful for you?

Digitally Excluded Group	Yes, current Ideas are useful	No, not useful	Other Suggestions
Older Adults	• Does not currently have a computer but would use one if provided. • Does not need access to devices or internet, as home Wi-Fi is available. • Would benefit from someone showing how to use apps. • Would find support helpful. • Needs more confidence using technology; currently struggles. • Interested in learning but prefers face-to-face interaction.	• Does not want to engage with digital technology and is content using a landline. • They are already able to use their existing devices but prefer to make phone calls, as it provides reassurance that tasks are completed. • Technology causes anxiety, particularly when ordering prescriptions, and they only wish to use their phone for texting. • They feel too frightened to use digital devices for health and care purposes. • Memory challenges are a barrier to learning new digital skills. • They prefer face-to-face communication and believe they are too old to start learning new technologies. • Concerns include potential misuse of digital services, fear of scams, and the unreliability of IT systems. • Physical impairments such as poor vision and hearing loss make digital engagement unsuitable. • While they personally do not use technology, their husband does; however, they note that systems often fail and that technology evolves too quickly for older adults to keep up.	• Existing digital support services are available at the Coastal Club in Mablethorpe, where many people attend to receive help from staff and use laptops to access the internet. • There is a need for a simple, easy-to-follow booklet tailored to different devices to support learning. • The respondent is unsure how to book appointments online and does not understand how the process works, particularly when using a smartphone.

ACCESS TO DEVICES AND DATA:

We want everyone to be able to have a device they can use and the confidence to be able to use it. It will take time, but we're thinking of things like volunteers in your community who can show you how to use a computer, or laptops you could borrow; free SIM cards if you get certain benefits or places where you can go for free Wi-Fi etc.

Do you think things like this would be useful for you?

Digitally Excluded Group	Yes, current Ideas are useful	No, not useful	Other Suggestions
People on lower incomes	• The respondent is very interested in participating but has limited financial means. • They lack confidence in using digital technology. • They already own a phone and have Wi-Fi at home, so do not require equipment or internet access. • They would benefit from support in learning how to use apps and other digital tools.	• Prefers to make phone calls, as it provides reassurance that tasks are completed. • Their current phone does not support the use of apps. • They have mobile data and do not require internet access.	• Currently relies on their son for help but would find it beneficial to have someone else available to teach them. • All their devices are either second-hand or too outdated to support the latest software. • Internet speed and connection quality are poor due to living in a rural area.
Unemployed	• They are currently on benefits and struggle to afford mobile data. • They only use a basic phone and do not have Wi-Fi at home. • They are very interested in digital support but have limited financial means. • They have the NHS app but are unable to use it fully due to difficulties obtaining the required access code from their doctor.	• Already has access to both a smartphone and laptop. • Accessing the internet is not an issue for them	• Would require support and guidance to set up digital services. • They currently do not have an email address
Homeless	• Knows how to use a phone but currently does not have access to a smartphone or tablet. • They are experiencing homelessness, and their device was stolen.		• Highlights that it is not always possible for people to have access to digital equipment, especially in challenging circumstances. • They currently have to borrow a phone in order to access essential services like ordering prescriptions. • Emphasises the importance of having alternative, non-digital options available.

ACCESS TO DEVICES AND DATA:

We want everyone to be able to have a device they can use and the confidence to be able to use it. It will take time, but we're thinking of things like volunteers in your community who can show you how to use a computer, or laptops you could borrow; free SIM cards if you get certain benefits or places where you can go for free Wi-Fi etc.

Do you think things like this would be useful for you?

Digitally Excluded Group	Yes, current Ideas are useful	No, not useful	Other Suggestions
People seeking asylum	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Rural population and digitally deprived	• Unsure about participating but is open to the idea. • They are generally comfortable using technology. • However, they struggle with receiving and responding to text messages from the surgery, as they cannot get it to work properly.	• Is not interested in digital services. • They have significant accessibility challenges, including poor vision and hearing loss, making digital technology unsuitable for them.	• Their devices are all second-hand or too outdated to support current software requirements. • They experience poor internet speed and connection quality due to living in a rural area.
Coastal population and digitally deprived	• Currently on benefits and struggling to afford mobile data. • They only use a basic phone and do not have Wi-Fi at home. • They are interested in digital support but lack confidence in using technology. • In a separate context, they mention already having a phone and home Wi-Fi, but would benefit from someone showing them how to use apps and digital tools. • They have the NHS app but are unable to use it fully due to difficulties obtaining the required access code from their doctor.	• Has access to devices and no issues accessing the internet. • They prefer to make phone calls for communication. • They lack confidence with technology and find it confusing and intimidating. • They are registered blind and have significant visual impairment. • They enjoy walking to the surgery, as it can be their only opportunity for social interaction.	• The respondent would need support and guidance to set up digital services, as they currently do not have an email address. • While they can ask their son for help, they would find it beneficial to have someone else available to teach them.

ACCESS TO DEVICES AND DATA:

We want everyone to be able to have a device they can use and the confidence to be able to use it. It will take time but we're thinking of things like volunteers in your community who can show you how to use a computer; or laptops you could borrow; free SIM cards if you get certain benefits or places where you can go for free Wi-Fi etc.

Do you think things like this would be useful for you?

Digitally Excluded Group	Yes, current Ideas are useful	No, not useful	Other Suggestions
People with 2 or more long term conditions	• Does not currently have a computer but would use one if provided free of charge. • They are interested in engaging with digital services. • Borrowing a laptop when needed would be helpful. • They suggest that community volunteers could assist by showing how to use the NHS app and how to book appointments online.	• Does not want to use a laptop or computer, preferring to speak with people directly by phone or face to face. • They emphasise that their disinterest is not due to inability but personal choice. • They have significant accessibility challenges, including poor vision and hearing loss, making digital tools unsuitable. • They already have Wi-Fi and devices and feel NHS resources should not be spent on items like free SIM cards when hospitals are under strain. • They would not make use of digital support services.	
Peoples whose main language is not English	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Other	• Does not currently have a computer but would use one if provided free of charge. • They are interested in digital support, though there is some uncertainty. • They believe it would be helpful for people to have access to a large, preferably touchscreen, screen to make usage easier and clearer. • While free SIM cards could be useful for others, they do not personally need one.	• Experiences psychosis and, as a result, has difficulty trusting others. • They are the primary carer for their wife, who has dementia, and therefore cannot leave the home to attend learning sessions or receive in-person support.	

ACCESSIBILITY AND EASE OF USE:

We want to make it really easy and clear to understand how to access our health and care services using phones or computers etc. This might mean different formats, different languages and making sure it is all user friendly.

Does that sound like it would be helpful to you?

Digitally Excluded Group	Yes, it does sound helpful	No, it wouldn't be helpful	Other Suggestions
Older Adults	• Is partially sighted and can enlarge text on a mobile phone but is registered blind and still finds using screens uncomfortable. • They have discovered and use a free app called *Bixby*, which reads out text messages and emails. They feel this type of tool should be more widely promoted. • They are a carer for their blind husband and would like him to be able to access digital services independently when she is unavailable. • They attempted to use online booking but found it frustrating due to the system repeatedly returning to the start, leading them to give up. • They emphasise the need for digital tools to be user-friendly, with: • Simple, clear instructions • Easy navigation • Clear, simple language • Visual consistency (e.g., screens matching instructions or images) • They would welcome more volunteers to help people learn and use digital tools effectively.	• Not interested in learning how to use digital technology and does not want to use it. • They are satisfied with their current access to services and do not wish for any changes. • They are unaware of what digital options are available but are not interested in exploring them. • They do not require different languages or formats, as long as information is in plain English without technical jargon. • They would not read a leaflet or guide and would prefer information to be explained in person. • At this stage in life, they would not use digital services and feel nothing could persuade them otherwise. • They strongly prefer face-to-face communication.	• Clear guidance is needed on what digital tools can be used for which services, and how to use them. • Instructions should be simple, with step-by-step guidance and minimal complexity. • Visual aids, such as pictures instead of text, would help make information more accessible. • Interfaces should avoid requiring too many clicks, passwords, or codes. • Booklets should be available that explain everything in plain, simple terms. • There should be greater awareness and promotion of the NHS App. • The respondent feels there are health inequalities, noting that veterans receive more support and training. • Recommends a simple touchscreen app acting as a "one stop shop" with easy access to: • NHS Services • Family and Friends • Police

ACCESSIBILITY AND EASE OF USE:

We want to make it really easy and clear to understand how to access our health and care services using phones or computers etc. This might mean different formats, different languages and making sure it is all user friendly.

Does that sound like it would be helpful to you?

Digitally Excluded Group	Yes, it does sound helpful	No, it wouldn't be helpful	Other Suggestions
People on lower incomes	• Feels confident using digital technology but is unsure about certain aspects and would need more information. • They attempted to use the online appointment booking system but found it frustrating, as it kept restarting, leading them to give up. • They believe making systems more user-friendly would be helpful. • They are open to trying again if they have a better device and reliable reception.		• Prefers user-friendly devices. • They emphasise the importance of keeping digital tools simple and easy to use.

Unemployed	• Information must be easy to understand and not overly technical, as the respondent's husband is dyslexic and they have difficulty reading.
	• They require content in simple language due to challenges with comprehension and information retention.
	• Despite these needs, the respondent feels confident using digital tools.
			• I prefer to call instead of reading or writing.
			• I find it difficult to understand written information.
			• Calling helps me explain things more clearly. It makes sure things are done correctly, like:
			  • Booking appointments
			  • Explaining what's wrong with me

Homeless	• I know how to use these things (e.g. devices or tools). I just don't always have access to one when I need it		• I would still like the option to walk into places. • I prefer to speak to someone in person when needed.

ACCESSIBILITY AND EASE OF USE:

We want to make it really easy and clear to understand how to access our health and care services using phones or computers etc. This might mean different formats, different languages and making sure it is all user-friendly.

Does that sound like it would be helpful to you?

Digitally Excluded Group	Yes, it does sound helpful	No, it wouldn't be helpful	Other Suggestions
People seeking asylum	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Rural population and digitally deprived	• I'd be willing to give it a try if, the reception is good, and I have a better device • Things would be easier if they worked properly	• Not interested at the moment. • I wouldn't use it at this time in my life.	• User-friendly devices
Coastal population and digitally deprived	• I am registered blind, and on some screens, I can see larger fonts, but I still don't want to use these systems. • It needs to be easy to understand and not too technical, my husband is dyslexic, and I don't read very well, I struggle to understand and take in information • It would depend on where the support is located • It should be user-friendly, I tried using the online appointment system, but it kept restarting, so I gave up • I might try if I had clear step-by-step instructions, I struggle when the screen doesn't match the instructions or pictures, I don't know what to press, so I abandon it	• Not interested • I wouldn't be able to see it properly	• Please make it simple. • I prefer to call because I struggle to read and understand written information. • Calling helps make sure things are done correctly, like, booking appointments and explaining what's wrong with me

ACCESSIBILITY AND EASE OF USE:

We want to make it really easy and clear to understand how to access our health and care services using phones or computers etc. This might mean different formats, different languages and making sure it is all user-friendly.

Does that sound like it would be helpful to you?

Digitally Excluded Group	Yes, it does sound helpful	No, it wouldn't be helpful	Other Suggestions

People with 2 or more long term conditions	• Husband calls on behalf of the patient because the patient is Deaf and cannot use the phone. He once waited 2 hours on the phone. We are unable to book appointments online.
	• Appointments are difficult for the d/Deaf community. There are support sessions, but they are only fortnightly, which is hard for urgent needs.
	• Telephone appointments are not possible due to hearing loss.
	• Cannot call back to rearrange appointments.
	• Carers have limited time, and waiting on the phone uses up their dedicated time.
	• Can receive text messages but cannot reply. Silent Sounds offers a reply text service, but it can't change appointments.
	• The patient is blind and cannot see numbers on a mobile phone. Has a device and recently discovered the Bixby app, which reads out texts and emails. It's free and should be promoted more.
	• Support is also needed for people who don't speak English.
		• I wouldn't read a leaflet or a how-to guide.
		• I would prefer it to be explained by a person.
			• Make sure the system doesn't crash and doesn't have too many pages to click through
			• Deaf patients need to book an interpreter for appointments. If they miss an appointment, they go to the bottom of the list.
			• NHS staff should check patient records, even when it says the patient is Deaf, they still call to cancel appointments.
			• Patients can see missed calls but can't hear messages.
			• Need enough time to book an interpreter.
			• The d/Deaf community uses DA Languages, but response times are slow. One patient waited 2 months for a reply about an urgent appointment
			• The d/Deaf community often feels isolated
			• In Thailand, a university has a disability centre where:
			  • All disabilities are supported in one place
			  • Different agencies work together
			  • This kind of collaboration is missing here

ACCESSIBILITY AND EASE OF USE:

We want to make it really easy and clear to understand how to access our health and care services using phones or computers etc. This might mean different formats, different languages and making sure it is all user-friendly.

Does that sound like it would be helpful to you?

Digitally Excluded Group	Yes, it does sound helpful	No, it wouldn't be helpful	Other Suggestions
Peoples whose main language is not English	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*

Other	• Wife books appointments for her husband, who has dementia.
	• Husband calls on behalf of a Deaf patient, but he once waited 2 hours on the phone; we are unable to book appointments online.
	• The respondent must go in person to the GP surgery because they can't hear on the phone.
	• Appointments are very difficult for the d/Deaf community.
	• There are fortnightly support sessions, but they're not helpful for urgent needs.
	• Telephone appointments are not possible due to hearing loss.
	• Can't hear the phone ringing or return calls to rearrange appointments.
	• Carers have limited time, and waiting on the phone takes up that time.
	• Can receive text messages but can't reply, Silent Sounds offers a reply text service, but it can't change appointments.
	• Yes, this kind of support would be very helpful.
	• Would be willing to try if, the reception is good and I had a better device
	• It needs to be simple and easy to use.
		• The daughter says her parents are not interested in using digital tools.
		• They wouldn't find it useful.
			• Devices should be user-friendly.
			• There should be more face-to-face support, especially for mental health issues.
			• A simple touchscreen app is suggested, acting like a one-stop shop, with access to:
			  • NHS Services
			  • Family and friends
			  • Police

ACCESS TO SERVICES:

We also want to encourage people to use the NHS app more for things like ordering repeat prescriptions – this will free up more face to face appointment times for patients who can't or don't want to us their phone or computer for appointments.

How do you think this would work for you?

Digitally Excluded Group	Yes, this would work for me	No, this would not work for me	Other Suggestions
Older Adults	• Yes, would use digital tools for booking appointments. • Already uses the GP app for this. • Has tried booking online but sometimes can't. • Would use it if my phone allowed. • Uses it a bit but still prefers face-to-face contact. Sometimes technology doesn't work, so end up calling instead. • Orders prescriptions but worries if it's done correctly. • Planning to learn how to use the NHS App for prescriptions. • If it were simple to understand, would be happy to use it. • Already uses it and finds it easy. • Does repeat prescriptions but says: getting appointments is hard unless you go to the GP in person. • Would like to be able to read test results.	• Prefers walking to the surgery; enjoys getting out and seeing people. • Not interested in using digital tools or learning how to use them. • Believes the very elderly don't use apps, thinks not everyone wants to do things online. • Has a smartphone but only uses Facebook, doesn't want to clutter the phone with unfamiliar apps. • No internet access. • Prefers using the telephone and speaking to someone to book appointments. • Wouldn't use digital tools; would only get frustrated or annoyed. • Doesn't know what the NHS App is. • Doesn't trust online systems – worries about it crashing, and my orders not going through, and I will miss medication • Feels more confident calling, knowing it's done properly. • Likes going to the local pharmacy; it gets them out and allows for social interaction. • Doesn't trust apps; gets frustrated when they crash or don't work. • Prefers putting prescriptions in the letterbox, it's simple and gets them out. • Has vision problems, so can't see well enough to use digital tools.	• The new GP app is more complicated to use. • The NHS needs to unify systems so all records and processes are on the same platform. • Staff shouldn't rely on patients having smartphones to take photos for online consultations. • Doctors need to be on board with using digital systems. • There should be someone available to educate the user's wife on how to use the system.

ACCESS TO SERVICES:

We also want to encourage people to use the NHS app more for things like ordering repeat prescriptions – this will free up more face to face appointment times for patients who can't or don't want to us their phone or computer for appointments.

How do you think this would work for you?

Digitally Excluded Group	Yes, this would work for me	No, this would not work for me	Other Suggestions
People on lower incomes	• Uses the system at home but can't use it when out due to lack of mobile data. • Uses it a little but prefers face-to-face interaction. Sometimes technology doesn't work, so ends up calling instead. • Tried booking blood tests but couldn't access the system. • Already uses it to order prescriptions. • Would try using it but has low concentration. • Thinks it might be helpful for others. • It would work if medication could be posted to them.		• Make it simple • At the moment, I am happy with my surgery arrangements, but happy to have improved services, if the new devices make life easier.
Unemployed	• I would need to be shown how to use it. • I do use it at home, but I don't always have mobile data, so I can't use it when out and about.	• It wouldn't work for me. • I prefer doing things face-to-face. • I don't read well, and my husband is dyslexic. • I'd worry about ordering or asking for the wrong thing online. • I don't have internet access or any family to help. • I like doing things face-to-face because I have a lot of issues and can't face doing things online.	• Winnies have laptops available for free use.
Homeless	• I don't have a phone, so I can't use digital services myself. • It would be helpful if support service staff (like Probation, Project Compass, LRP) could use their systems to do these things for us.		• Let people talk on my behalf

ACCESS TO SERVICES:

We also want to encourage people to use the NHS app more for things like ordering repeat prescriptions – this will free up more face to face appointment times for patients who can't or don't want to us their phone or computer for appointments.

How do you think this would work for you?

Digitally Excluded Group	Yes, this would work for me	No, this would not work for me	Other Suggestions
People seeking asylum	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Rural population and digitally deprived	• It would work for me if I could have my medication posted to me.	• My daughter handles everything for me, so I'm not interested in doing it myself. • I can't see very well, so I wouldn't be able to use it	• I'm currently happy with my GPS arrangements. • I'm open to improved services if new devices make life easier.
Coastal population and digitally deprived	• I walk to the surgery and don't want this to change – I enjoy getting out and seeing people. • I would need to be shown how to use digital tools. • I use it a little but still prefer face-to-face interaction. • Sometimes technology doesn't work, so I have to call instead. • I order prescriptions, but I worry if I've done it right. • I tried booking a blood test but couldn't access the system. • I would try using it, but I have low concentration.	• Not interested in using digital tools. • I prefer to do things face-to-face. • I don't read well, and my husband is dyslexic. • I'd worry about ordering or asking for the wrong thing online. • I don't have internet access or any family to help me. • I like doing things face-to-face because I have a lot of personal issues and can't face doing things online.	• Winnies offers free laptop access for people to use. • The system should be simple to use, reliable. It should work all the time for everyone

ACCESS TO SERVICES:

We also want to encourage people to use the NHS app more for things like ordering repeat prescriptions – this will free up more face to face appointment times for patients who can't or don't want to us their phone or computer for appointments.

How do you think this would work for you?

Digitally Excluded Group	Yes, this would work for me	No, this would not work for me	Other Suggestions
People with 2 or more long term conditions	• Have tried booking appointments online but was unable to. • Haven't looked into it further. • Prefer to ring the practice and speak to someone. • Like knowing the appointment is booked correctly.	• Respondent's daughter books appointments; I wouldn't use the system myself. • Prefer to speak to someone to book appointments. • I can't see very well, so I wouldn't be able to use it. • I like to walk to my GP and hand it in; it gets me out and about. Sometimes I might go a few days without seeing people.	• The NHS needs to unify systems, so all records and processes are on the same platform. • Recommend creating an internal NHS Lincolnshire in-house interpreter service. • Currently, the d/Deaf community uses external services like Topps Language Solutions (Leeds), Silent Sounds, and Language Line. • Dementia patients require face-to-face appointments.
Peoples whose main language is not English	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Other	• Have tried using the NHS App, but it's always unavailable when trying. • Would use it for booking appointments. • Already use it for repeat prescriptions. • Getting an appointment is very difficult unless visiting the GP practice in person. • Do not have internet access to use the app consistently.	• Walks to the surgery and doesn't want this to change; enjoys getting out and seeing people. • Does not take medication. • Not interested in using the system. • Prefers the 'old-fashioned way'. • Prefers to speak to someone to book appointments. • Would like to be able to read test results.	• There are issues for the d/Deaf community when going on holiday; unclear what interpreter options are available outside Lincolnshire. • The d/Deaf community is familiar with Lincolnshire-based interpreters. • Currently happy with surgery arrangements. • Open to improved services if new devices make life easier.

SKILLS AND CAPABILITY:

We want everyone to have the skills to be able to use digital technology for their health and care needs with confidence. To do this we will train Digital Community Champions and others in your local community who could support you

Do you think you would go to someone in your community to get help to learn how to use technology?

Digitally Excluded Group	Yes, I would access this support	No, I would not access this support	Other Suggestions
Older Adults	• Works at Order of St John supporting patients in the community feels it would be a fantastic idea. • Thinks it's a great idea and worth a try. • Might work, depending on the location. • Would love to learn how to use different things but needs someone to show them; currently relies on daughter, who doesn't teach them. • Anxiety would make participation difficult. • Can't get out of the house. • Would attend if transport to the venue is available. • Would use it if held in a familiar setting like Mablethorpe Coastal Centre. • Wouldn't attend a special group just to learn, support must come to existing groups. • Believes it would be very good for the community. • Thinks training would be useful. • Would help those who are interested.	• Not interested in using digital services. • Feels skilled enough to access what is needed already. • Wouldn't use it personally but understands others might. • Relies on daughter as a digital champion. • Happy with current way of doing things, sees no reason to change. • At 90 years old, doesn't want to learn new things now. • At 62, believes it's hard to learn new tricks at this age. • Wouldn't be able to see the devices once back home. • Already has the necessary knowledge. • Avoids community settings due to heart and breathing issues, and to stay away from bugs. • Has memory loss and struggles to remember new things. • Prefers to maintain independence by doing things the familiar way	• Will need more than one session, doesn't always grasp things the first time. • Having a leaflet would be helpful. • Online 'how-to' videos would be useful. • Training needs to be face-to-face. • Should be accessible for all ages.

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Do you think you would go to someone in your community to get help to learn how to use technology?

Digitally Excluded Group	Yes, I would access this support	No, I would not access this support	Other Suggestions
People on lower incomes	• Would be interested but doesn't feel support is currently needed. • Thinks the idea sounds like it could work well. • Would love to learn how to use different things but needs someone to show them. • Currently relies on daughter for help, but she doesn't explain how to do things.	• Doesn't think it would be beneficial due to difficulty remembering things.	• Would need more than one session or visit, doesn't always "catch on" the first time. • Having a leaflet to take home would be useful. • Online help and support would be beneficial.
Unemployed	• Needs an actual person to demonstrate how to do it, then allow hands-on practice. • Wouldn't be able to follow booklets or leaflets. • Thinks it would be helpful. • Prefers learning in a group setting rather than one-to-one. • Needs someone patient who can take the time to show things clearly.		• A video with someone explaining and providing tutorials would be helpful. • Different versions would be needed for different operating systems. • Not all phones look the same, which can be confusing.
Homeless		• No, support not needed. • Already knows how to use it. • The main issue is difficulty accessing it at times.	

SKILLS AND CAPABILITY:

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Do you think you would go to someone in your community to get help to learn how to use technology?

Digitally Excluded Group	Yes, I would access this support	No, I would not access this support	Other Suggestions
People seeking asylum	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Rural population and digitally deprived	• Yes, I would use this		• Online help and support is needed or would be useful
Coastal population and digitally deprived	• Needs an actual person to demonstrate and then allow hands-on practice. • Cannot follow booklets or leaflets. • Thinks it would be helpful and prefers a group setting over one-to-one. • Needs someone patient who can take the time to explain. • Participation would depend on the location. • Would love to learn how to use different things but needs guidance. • Currently relies on daughter, who does things for them but doesn't show how.	• Would not use the service. • Not interested. • Wouldn't be able to see the device once back home. • Feels more confident communicating by phone or face-to-face.	• A video with someone explaining and providing tutorials would be helpful. • Different versions are needed for different operating systems, as phone interfaces vary and can be confusing. • Would need more than one session to fully understand.

SKILLS AND CAPABILITY:

We want everyone to have the skills to be able to use digital technology for their health and care needs with confidence. To do this we will train Digital Community Champions and others in your local community who could support you

Do you think you would go to someone in your community to get help to learn how to use technology?

Digitally Excluded Group	Yes, I would access this support	No, I would not access this support	Other Suggestions
People with 2 or more long term conditions	• Interested in learning. • Thinks it's a good idea. • Strongly supports the idea of champions helping to support people. • Would potentially take part, but it needs to come to an existing group rather than expecting them to attend elsewhere.	• Not interested. • Feels that at 62, it's too late to learn new things.	
Peoples whose main language is not English	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Other	• Works at Order of St John, supporting patients in the community. Thinks it's a fantastic and good idea. • Strongly supports the idea of champions helping to support people. • Believes it would be very good for the community	• Not interested in learning. • Happy with how things are currently. • Only uses phone in emergencies and doesn't plan to change that. • Unable to leave the house due to being a carer for wife with dementia and remains uninterested.	• Online help and support

TRUST, AWARENESS AND DIGITAL SAFETY:

We also want people to understand and feel confident and safe using digital technology for example being really clear with you where your data is held and what it's used for

Do you think if you were more trusting in digital technology you would use it more?

Digitally Excluded Group	Yes, I would use it more	No, I would not use it	Other Suggestions
Older Adults	• Dislikes having to enter a password in the NHS app. • Would use it, already trusts technology. • Concerned about recent supermarket hacking, but unsure how it affects health records. • Would use it, but it is very slow with technology. • Might use it. • Has a background in IT systems and trusts IT if it is a well-built and tested system. • Is cautious due to a family member being scammed and prefers using passwords. • Acknowledges that people are frightened of video calls; media coverage of scams increases fear. • Relies on daughter but is potentially open to using it. • Trusts the apps currently used. • Emphasises the need for accurate digital records; had a letter sent to the wrong address.	• Not interested and unsure about using digital services. • Doesn't need to use it currently, prefers calling 111 and avoids contacting the GP. • Very afraid of scams, won't answer calls from withheld numbers. • Doesn't trust what isn't understood. • Recent supermarket hacks (e.g., M&S, Co-op) have increased distrust, prefer phone communication. • Trusts technology to some extent but not for health matters, prefers asking questions and ensuring things are done right, like booking appointments. • The issue isn't just trust but also struggles to see things clearly. • Might have considered using technology more in the past, but recent events have caused reluctance. • Prefers speaking to people, concerned about the loss of human interaction. • As an older person, sometimes doesn't speak to anyone all day and values personal contact.	• Have staff available to answer questions. • Ensure the system is as secure as possible.

TRUST, AWARENESS AND DIGITAL SAFETY:

We also want people to understand and feel confident and safe using digital technology for example being really clear with you where your data is held and what it's used for

Do you think if you were more trusting in digital technology you would use it more?

Digitally Excluded Group	Yes, I would use it more	No, I would not use it	Other Suggestions
People on lower incomes	• Trusts digital systems and tries to use them for most things in life. • Recent supermarket hacking incidents are a concern, though unsure how it would affect health records. • Personally, has no trust issues with digital systems.	• No, I wouldn't	• NHS improve cybersecurity
Unemployed	• Already trusts digital systems but doesn't want to use them for everything related to health. • Acknowledges that concerns about digital use are understandable. • Tries to use digital tools for most things in life. • Has no trust or data safety concerns personally.		
Homeless		• People are concerned about digital safety and cookie policies when using online systems, especially for healthcare. • A key issue is having to accept terms and cookies before accessing GP appointment booking sites. • The main worry is that third parties might access their personal health data.	

TRUST, AWARENESS AND DIGITAL SAFETY:

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Do you think if you were more trusting in digital technology you would use it more?

Digitally Excluded Group	Yes, I would use it more	No, I would not use it	Other Suggestions
People seeking asylum	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Rural population and digitally deprived	• Yes, I would		• NHS improve cybersecurity.
Coastal population and digitally deprived	• I do trust it. • I just prefer not to use it for everything related to my health. • I don't have any trust or data security concerns. • The recent hacking of supermarkets is worrying. • I'm unsure how such incidents would affect health records. • I suppose there's always some level of worry.	• No, I wouldn't use it. • I'm not interested. • It's not about trust; the issue is that I can't see things. • I might have considered using technology more, however, the recent hacks of M&S and the Co-op have made me reluctant.	

TRUST, AWARENESS AND DIGITAL SAFETY:

We also want people to understand and feel confident and safe using digital technology for example being really clear with you where your data is held and what it's used for

Do you think if you were more trusting in digital technology you would use it more?

Digitally Excluded Group	Yes, I would use it more	No, I would not use it	Other Suggestions
People with 2 or more long term conditions	• Dislikes having to enter a password in the NHS app. • Has a background in IT systems and would trust technology if it's built and tested properly. • Currently relies on their daughter for support. • Potentially open to using the technology themselves in the future.	• No, I don't think I would use it. • I'm happy sticking with what I've always done, as it has always worked. • As an older carer with many responsibilities, I don't have the time or mental space to learn something new. • There are so many scams nowadays, it's hard to know what's safe and what isn't.	• The patient is blind and prefers visiting the bank in person due to security concerns. • Would require face-to-face training. • Would not engage with leaflets or online videos for learning.
Peoples whose main language is not English	*Awaiting feedback*	*Awaiting feedback*	*Awaiting feedback*
Other	• Dislikes having to enter a password in the NHS app. • Many people are very frightened of video calls. • Negative news stories about scams discourage people from using digital technology. • Scams are becoming more advanced. • There should be more emphasis on why people shouldn't answer calls from unknown numbers.	• No, I wouldn't use it. • It's not about trust ; the issue is that I can't see things. • I sometimes feel like I'm being watched through digital technology. • I can be too trusting of websites, which adds to my concern.	• Continuity is important. • The NHS should improve its cybersecurity

Respondent's response to anything else they think we can do to make things easier…..

Support needs to be local and, in the community, where people are familiar with

More signposting is needed for computers, access to devices and training

Work with GPs to inform patients what is available online – not everyone uses social media to find this out

If things are simple, I can do them

Prefers to have it in writing, especially when caring for someone, so they can refer to it

Services always assume we are all IT literate. My wife is to an extent but limited by anxiety issues when using new tech.

It's not about making them easier; it's about understanding that people won't always have access to them.

Is there anything missing? Is there anything else you think we need to know to make using phones, computers or data easier for you?

Feedback from Other Sources

Feedback from Equality, Diversity and Inclusion Strategy Engagement

- **Digital Exclusion**: Many people, especially in rural areas like Lincolnshire, lack access to the internet or mobile phones, which creates barriers to accessing services and participating in online board meetings.
- **Age Discrimination**: Older adults often struggle with digital technology and feel excluded. They need more support and alternative (non-digital) ways to access services and information.
- **Public Engagement**: Current board meetings do not allow public questions, which contradicts the NHS Constitution. There is a call for more transparency and public involvement.
- **Communication Accessibility**: Information should be provided in plain English with clear phone contact options for those without digital access.
- **Support for New Mothers**: Flexible appointment times, including evenings, would help parents who prioritise childcare.
- **Staff Training**: NHS staff should be equipped to use technology effectively to assist patients.
- **Equal Rights for Pensioners**: Older citizens feel forgotten and need better access to services, especially through non-digital means.
- **Rural Inclusion**: Villages and hamlets are often overlooked. More face-to-face engagement is needed post-COVID.

Engagement with the Agri-food Sector

Issues / Challenges

- Higher than 50% Eastern European workforce; however, over the last 3 years, people have come globally, including some global students who bring over their families on working visas
- 17 different languages; most of the technology within the production line translates into their language, and high use of pictures
- Low literacy levels in their language and low English skills
- Low levels of GP registrations, and they do not understand how the NHS works, need education on how the health system works in the UK
- Generally, do not trust government organisations; therefore, do not trust the NHS.
- Most of the workers have a mobile phone and use their phones for social media and the WhatsApp app.
- Free Wi-Fi in the canteen
- Staff health, absence management, most people find the NHS confusing, and there is a lack of communication

Opportunities

- Are keen to partner with the NHS
- Open to piloting on-site NHS digital access sessions (e.g., "Digital Roadshow" in canteen), will provide multilingual staff support
- Interest in co-developing a digital literacy programme
- Would be happy to work with us to find a way to communicate with employees about the NHS.
- They have a robust induction process where they could provide information on health services, e.g. explanation of how the NHS works, how to register with a GP, NHS Health App, etc

Lincolnshire Health and Care Digital Inclusion Strategy Update

Emma Townend- Interim Health Inequalities Programme Lead

Jimmy Pryke-Walker – Head of Digital Health

27th May 2025

Context and Background

Digital exclusion refers to the lack of access, skills, capabilities needed to engage with digital devices or digital services.

Digital inclusion is one of the five national NHSE Health Inequalities Strategic Priorities **"Mitigate against digital exclusion".** NHSE produced 'Inclusive digital healthcare: a framework for NHS action on digital inclusion'.

Developed a **Lincolnshire Health and Care Digital Inclusion Strategy** with organisations across the ICS and with people with lived experience.

Strategy supports **'Analogue to Digital'** key shift

Ambition is to improve digital inclusion by addressing the digital divide between those who have full access, confidence and skills to utilise digital health and care services and those who do not.

Vision

‘Everyone in Lincolnshire who wants to be digitally connected to health and care services and the community will have the skills, access, and confidence to do so’.

Approach

Created a Digital Inclusion Strategy Oversight Group which includes representatives from:

- District Councils
- Healthwatch
- Lincoln City Council
- Lincolnshire Community Health Services
- Lincolnshire County Council
- Lincolnshire Integrated Care Board
- Lincolnshire Partnership Foundation Trust
- Lincolnshire Voluntary Engagement Team
- Lincs Care Association
- Lincs Digital
- People with lived experience
- Police and Crime Commissioner
- Primary Care Networks
- St Barnabas Hospice
- United Lincolnshire Teaching Hospitals
- University of Lincoln (LIRCH team)

Strategy Pillars

- **Access to data and devices -** led by East Lindsay District Council
- **Accessibility and ease -** led by ICB Digital Primary Care team
- **Access to services -** led by ICB Digital Primary Care team
- **Skills and capability -** led by Lincolnshire Community and Hospitals Group
- **Trust, Awareness and Digital Safety-** led by Lincolnshire County Council
- **Leaderships and partnerships**: led by ICB Health Inequalities team

Engagement

- Engagement was conducted with with people most at risk of digital inclusion - older adults, people on lower incomes, unemployed, homeless, people seeking asylum, rural and coastal digitally deprived.

- A total of 66 people were engaged with at a variety of community groups and locations across Lincolnshire.

- **The insight showed:**
  - ➢ There are people who choose or cannot use online services for a variety of reasons
  - ➢ Access to data/devices is a barrier for some, confidence, skills and/or trust is for others.
  - ➢ People in some Coastal areas talked about digital support on offer and this being promoted.
  - ➢ The idea of having trained Digital Community Champions was well received.

Support needs to be local and, in the community, where people are familiar with

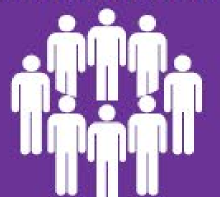
More signposting is needed for computers, access to devices and training

LONG TERM AIMS

LEADERSHIPS & PARTNERSHIPS

SHARED COMMITMENT AND VALUES

CONNECT WITH COMMUNITY AND VCFSE ROLES


DIGITAL INCLUSION LEADS IN EACH ORGANISATION

SUSTAINABLE APPROACHES TO ENABLING CONNECTIVITY

INCREASED USE OF DATA AND DEVICES

INCREASED AWARENESS OF CURRENT SCHEMES

ACCESSIBILITY & EASE

ACCESSIBLE SERVICES FOR HEALTH INEQUALITIES AND PLUS GROUPS

FRIENDLY & ADAPTABLE SERVICES

ADAPTABLE FORMATS & LANGUAGES

ACCESS TO SERVICES

FACE TO FACE FOR THOSE WHO CAN'T ACCESS DIGITAL

SIGNPOSTING TO RELEVANT SERVICES

FACE TO FACE TO OFFER AS GOOD AS THE DIGITAL OFFER

TRUST, AWARENESS & DIGITAL SAFETY

ADVOCATES

AWARENESS OF TRUSTED AND ACCREDITED SCHEMES E.G. DEVICE LOANING ETC

TRANSPARENCY ABOUT DATA AND HOW WE KEEP IT SAFE

SKILLS & CAPABILITY

UPSKILL STAFF AND CO-PRODUCE TRAINING

DIGITAL COMMUNITY CHAMPIONS

DIGITALLY EMPOWERED POPULATION

DIGITALLY ENABLED STAFF

Item 5 (i)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Integrated Quality & Performance Report – May 2025
Report Author:	James Singleton, Performance Manager
Presenter:	Clair Raybould- Director for System Delivery Martin Fahy- Director of Nursing Emma Rhodes – Deputy Director of Finance
Appendices:	Performance, Quality & Finance Report

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

Recommendations

1. To note the key issues set out in the paper and the actions in place to support improvement.
2. To discuss any areas the Board would like Committees to seek further assurance on.

Summary

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

Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for April 2025 was 78.3%, above the planned month trajectory of 77% (95% constitutional target); this was also higher than the regional and national average performance.
- Category 1 mean response times for EMAS Trust was 08:37 minutes

against a standard of 07:00 minutes during April 2025.

- The Category 2 mean response time for EMAS Trust was 31:38 minutes against an expectation of 30 mins (18:00 constitutional target). The Lincolnshire ICB Category 2 mean response time continued to remain better than the EMAS trust position.

Cancer

- The backlog trajectory is off target with 266 patients waiting over 62 days at the end of March, this is now a combined target including consultant upgrades.
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral increased to 69.8% in March from 56.6% in February '25.
- The faster diagnosis standard was achieved in March, overall performance was 77.2%, against the 75% standard.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals reduced from 113,353 in February to 113,175 in March, a decrease of 178.
- The ICB finished March with 57 patients waiting over 65 weeks against the zero plan- this was a reduction from 83 in February.

Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies waiting times standards were both achieved in March. 98.1% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.4% received their first treatment appointment within 18 weeks, against the 95% standard.
- The percentage of people experiencing first episode psychosis receiving treatment within 2 weeks or less was 74% in February (rolling 12 months) which is above the 60% standard.
- Adult inpatients with learning disabilities or autism were in line with trajectory at 31.

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

Risk and Assurance

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

Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	No		
Does the report highlight any quality and patient safety implications?	Quality and patient safety implications directly associated with the issues outlined in this report are set out in the body of the report.		
Does the report highlight any health inequalities implications?	Health inequalities implications directly associated with the issues outlined in this report are set out in the body of the report.		
Does the report demonstrate patient and public involvement?	Not applicable- although through normal operations there has been engagement and communications directly particularly in relation to winter pressures		
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable		
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an equality impact assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable			
Is the report confidential or not?			
Yes ☐ No ☒			

Integrated Performance, Quality & Finance Report

May 2025

21/05/2025

Contents

- Executive Summary — Page 3
- Key to Charts — Page 4
- Performance Dashboard — Page 5
- Key Performance Data — Page 6
- Quality — Page 10
- Finance — Page 19

Executive Summary

Overview

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

Urgent & Emergency Care

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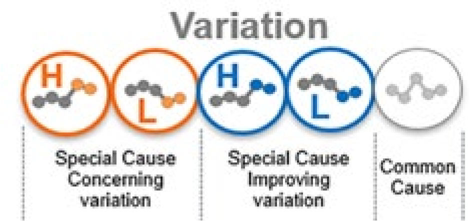
- Adult inpatients with learning disabilities or autism were in line with trajectory at 31.

Key to Run Charts



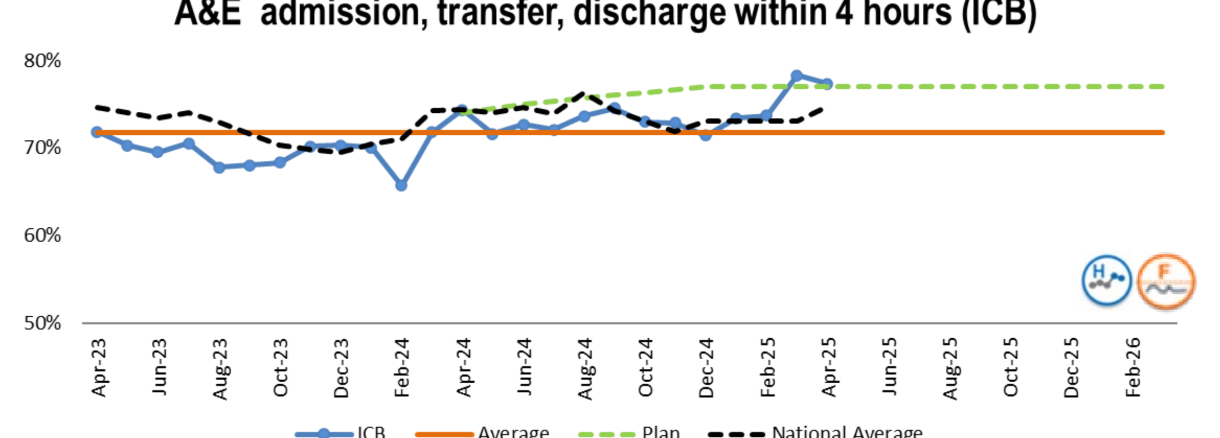
	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process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

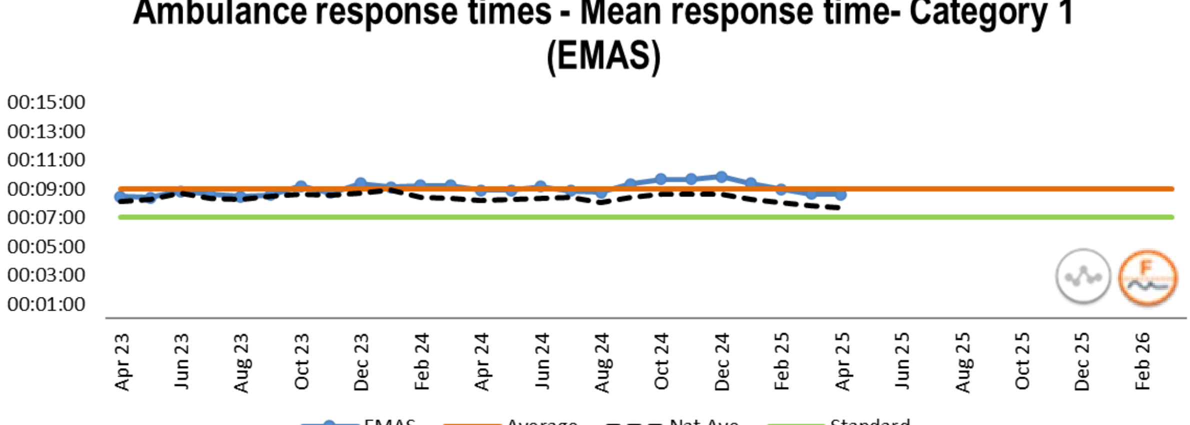
Lincolnshire ICB Performance Dashboard

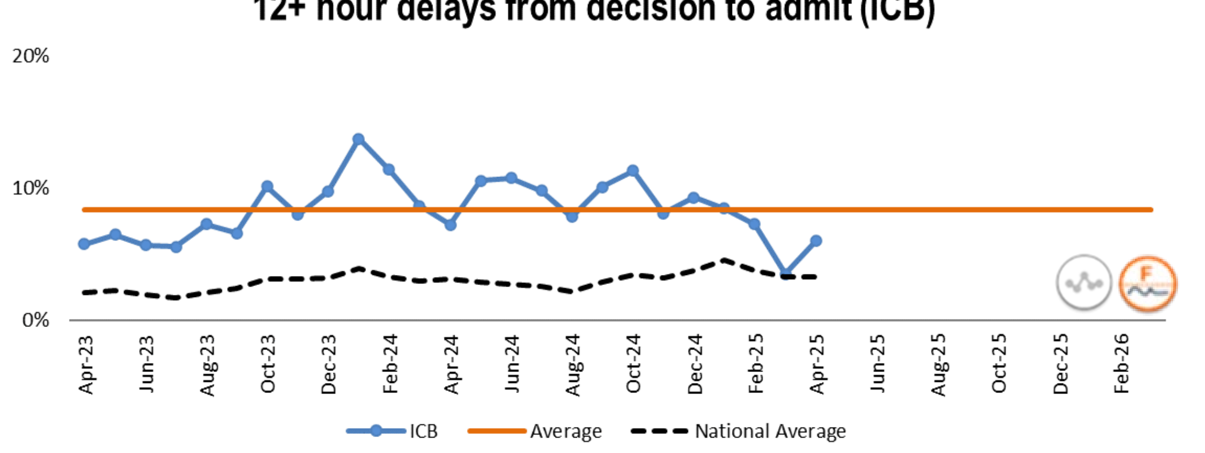
Special Cause Concerning variation
Special Cause Improving variation
Common Cause

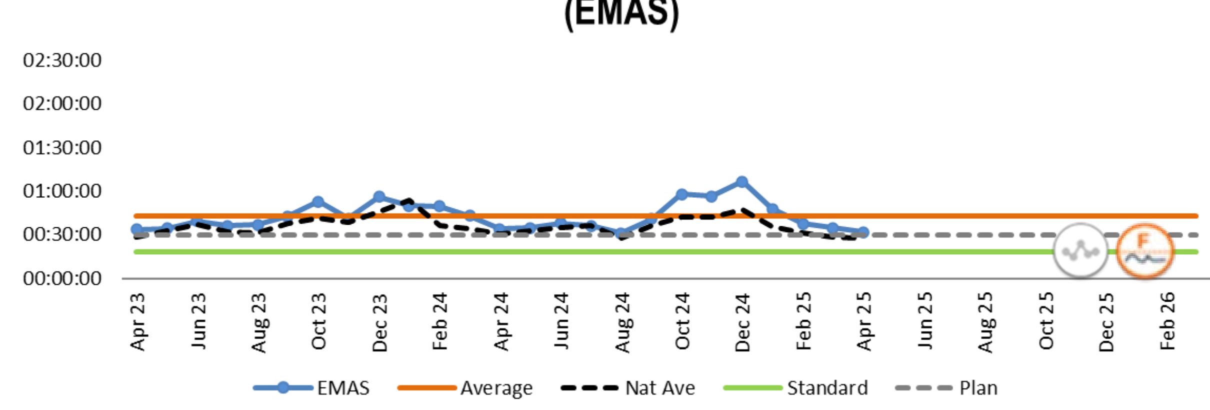
Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	77.0%	Apr-25	78.3%	73.1%	73.0%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Apr-25	00:08:37	00:08:07	00:08:37			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Apr-25	00:31:38	00:26:12	00:27:34			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	-	Mar-25	87.4%	90.3%	91.4%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	-	Mar-25	69.8%	67.2%	71.4%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	-	Mar-25	77.2%	78.4%	78.9%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	-	Mar-25	55.5%	57.3%	59.8%			
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)	-	-	Mar-25	0.05%	0.07%	0.10%			-
	Percentage waiting six weeks or less for a diagnostic test	99%	-	Mar-25	71.5%	78.1%	81.6%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q4 2024/25	30.6%	31.1%	23.5%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	Mar-25	98.1%	N/A	89.9%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	Mar-25	99.4%	N/A	98.4%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	Feb-25	74.0%	72.1%	57.8%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	Feb-25	*	79%	77%			-
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	Feb-25	53%	70%	78%			

Urgent Care

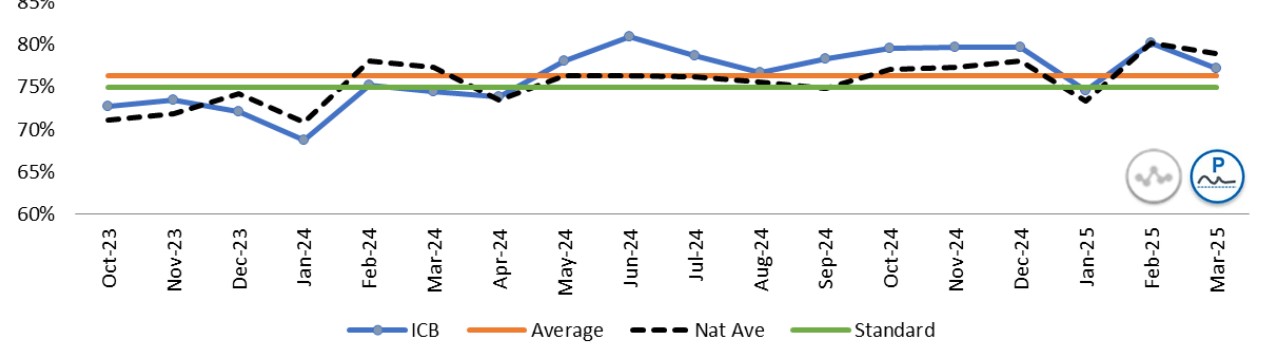


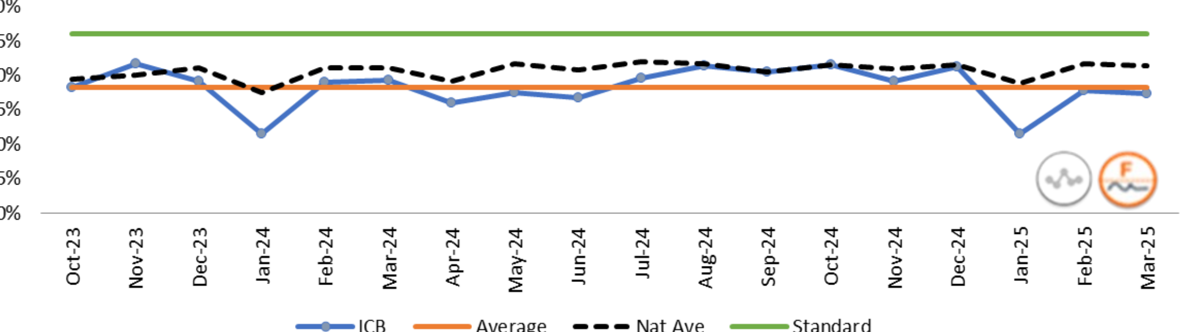


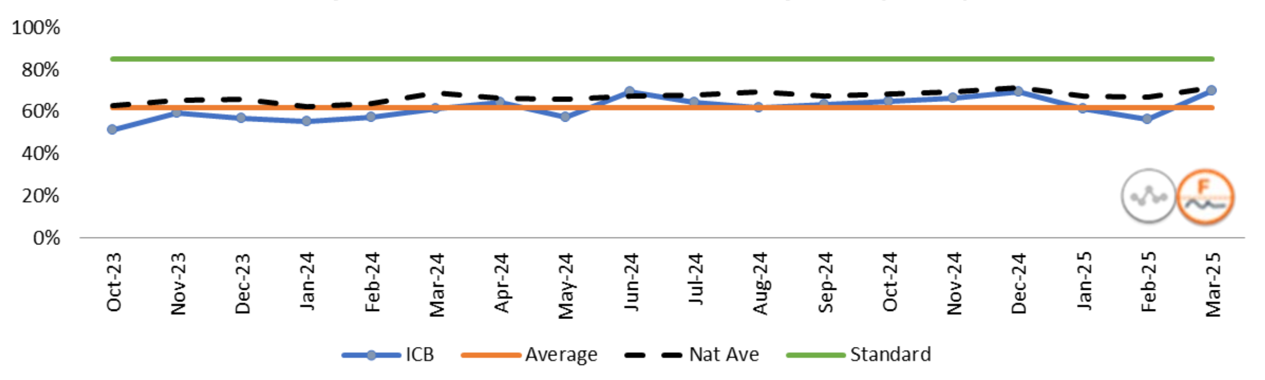


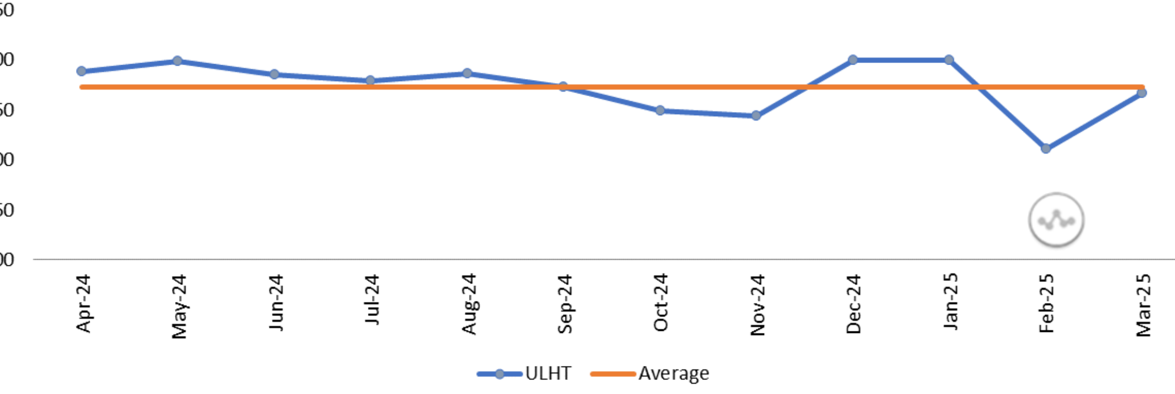


Cancer

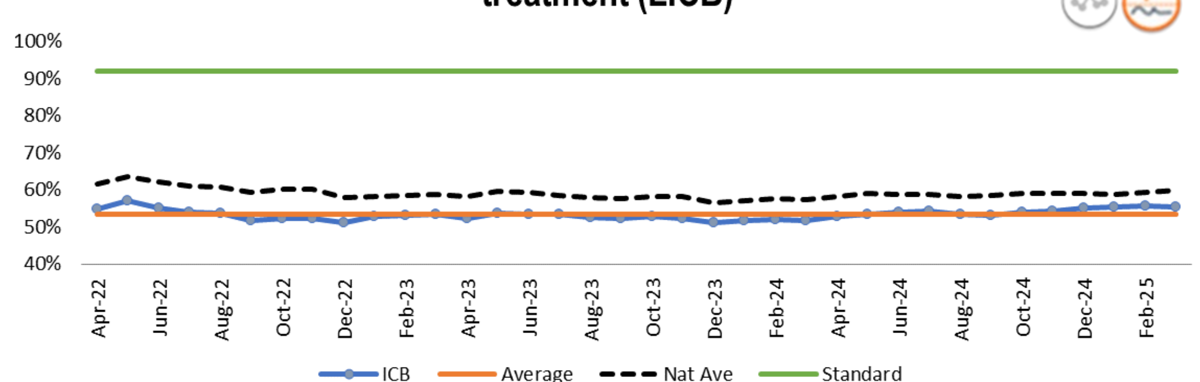


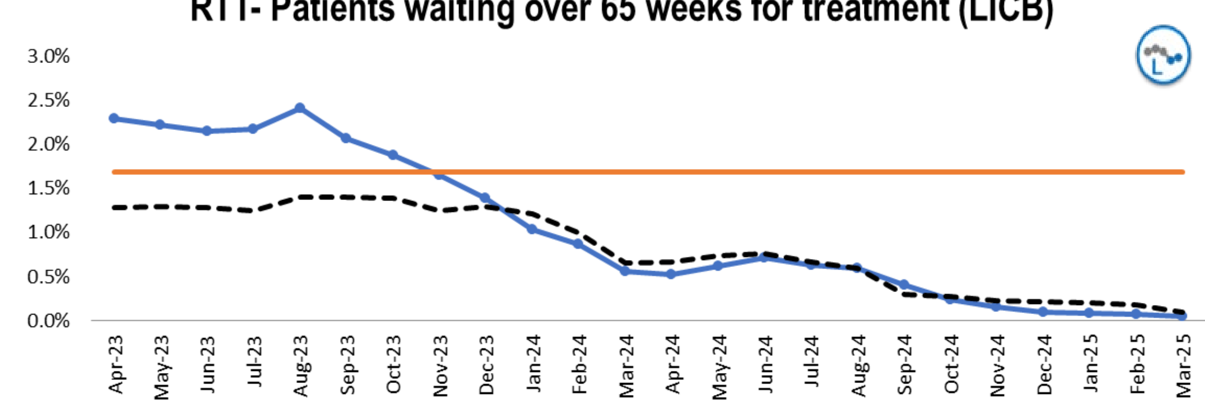


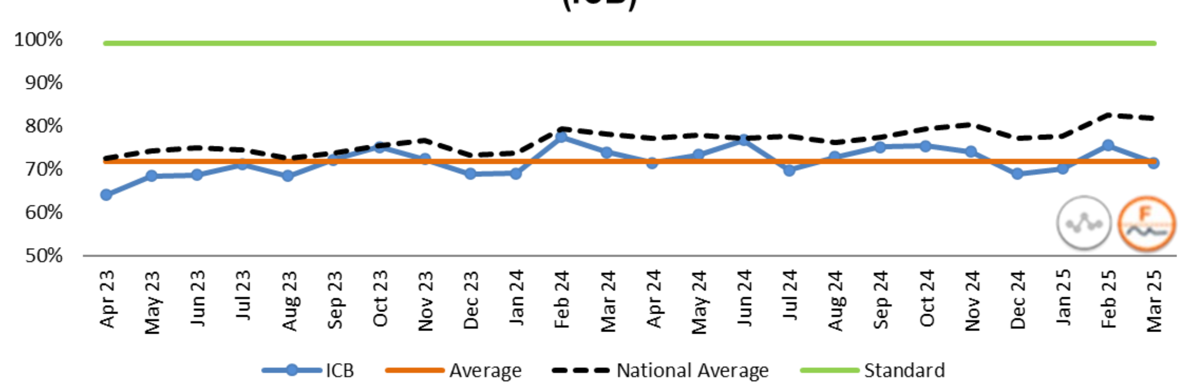


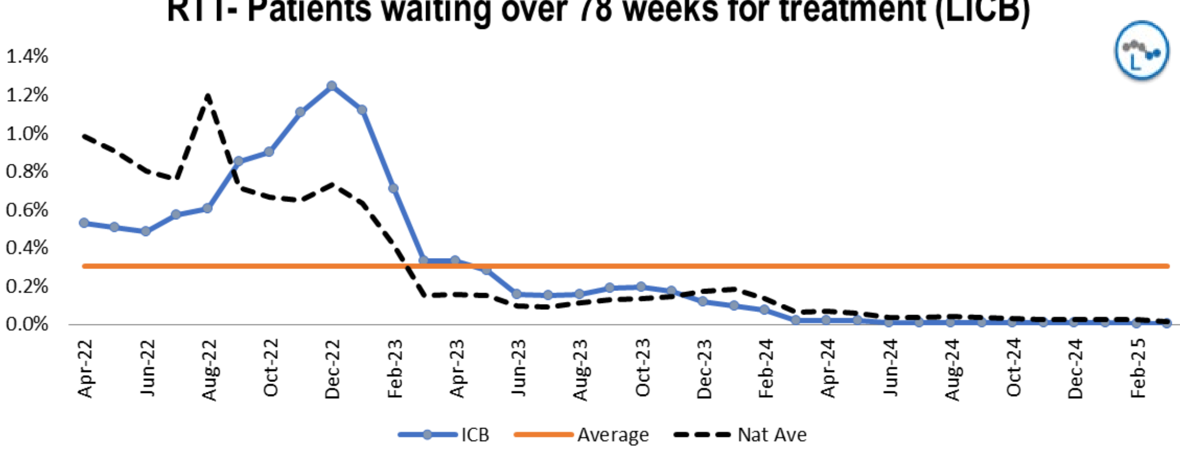


Elective Care

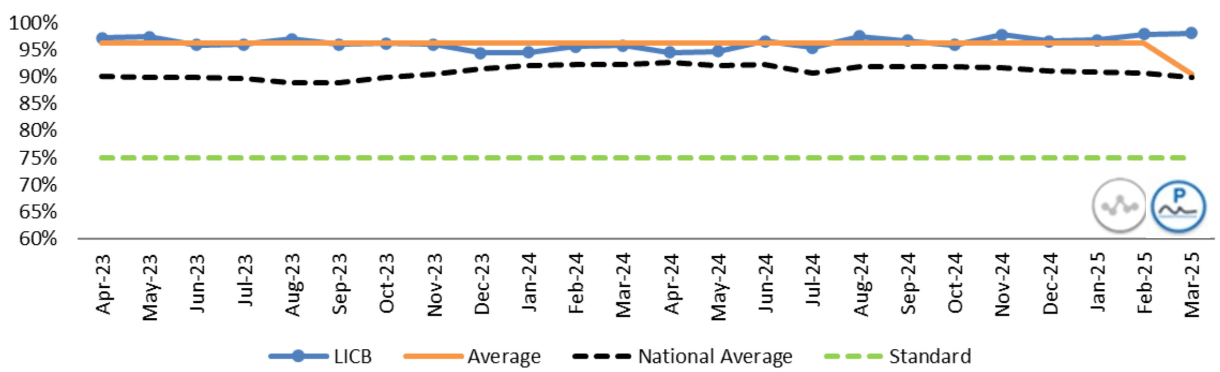


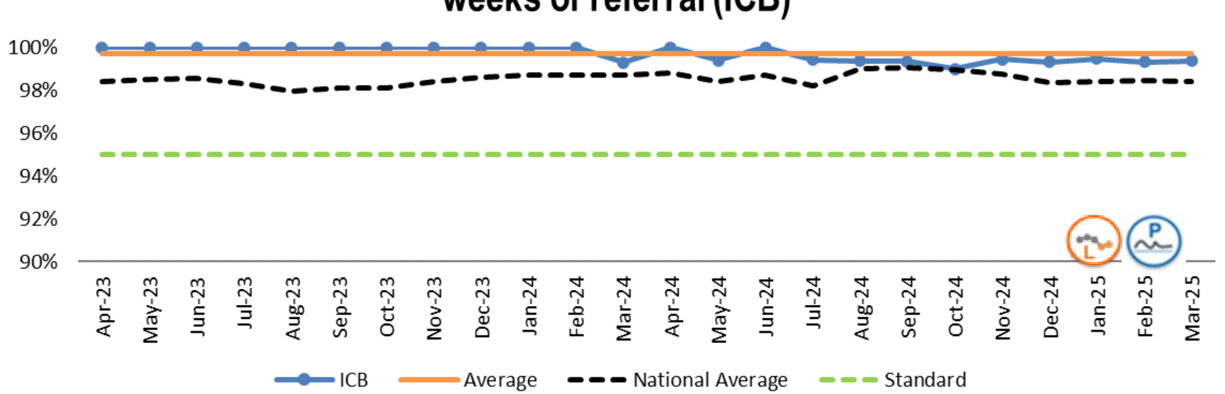


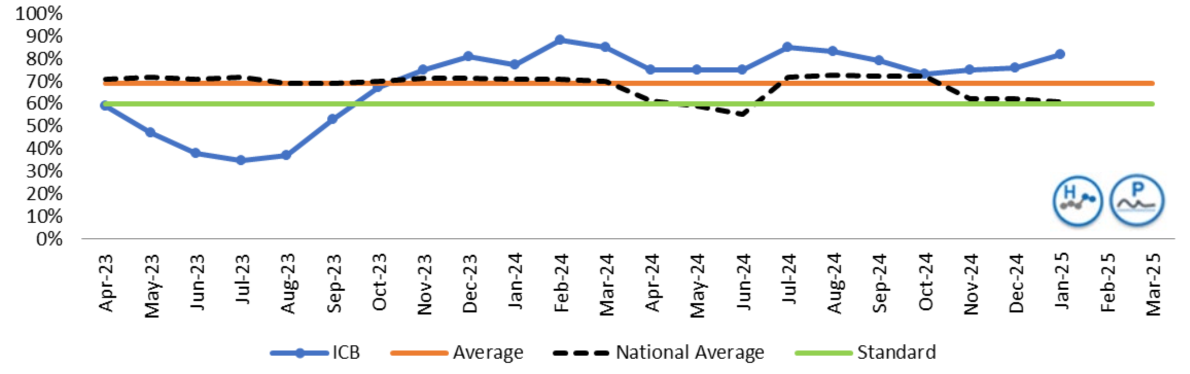


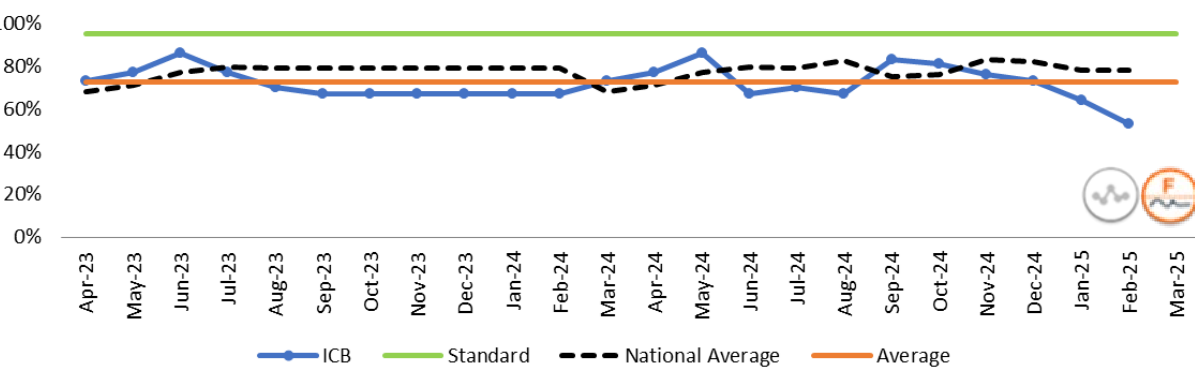


Mental Health







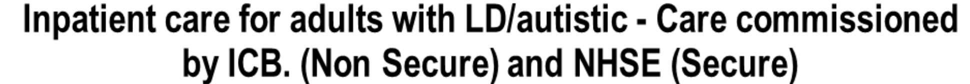


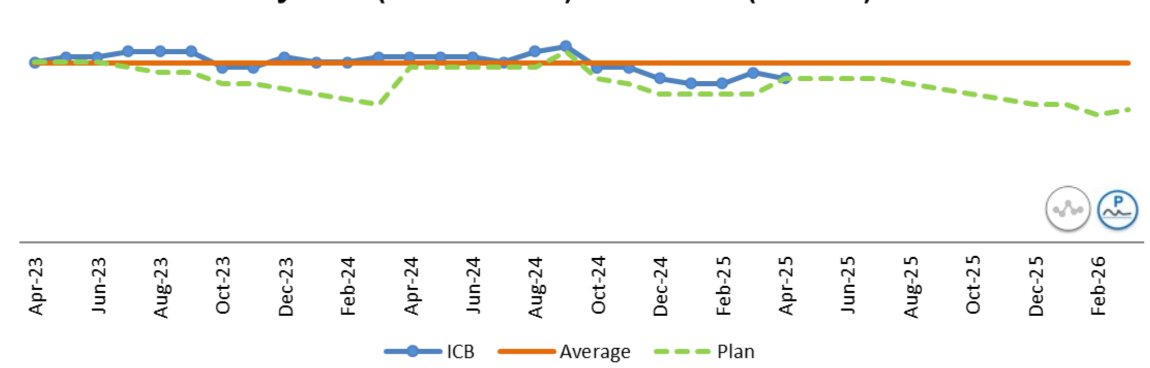
Lincolnshire ICB Quality Dashboard

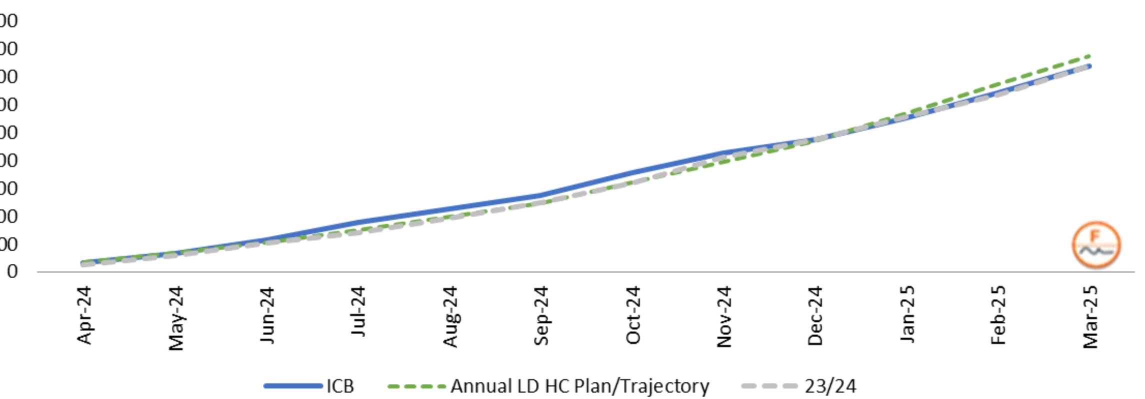
Special Cause Concerning variation | Special Cause Improving variation | Common Cause

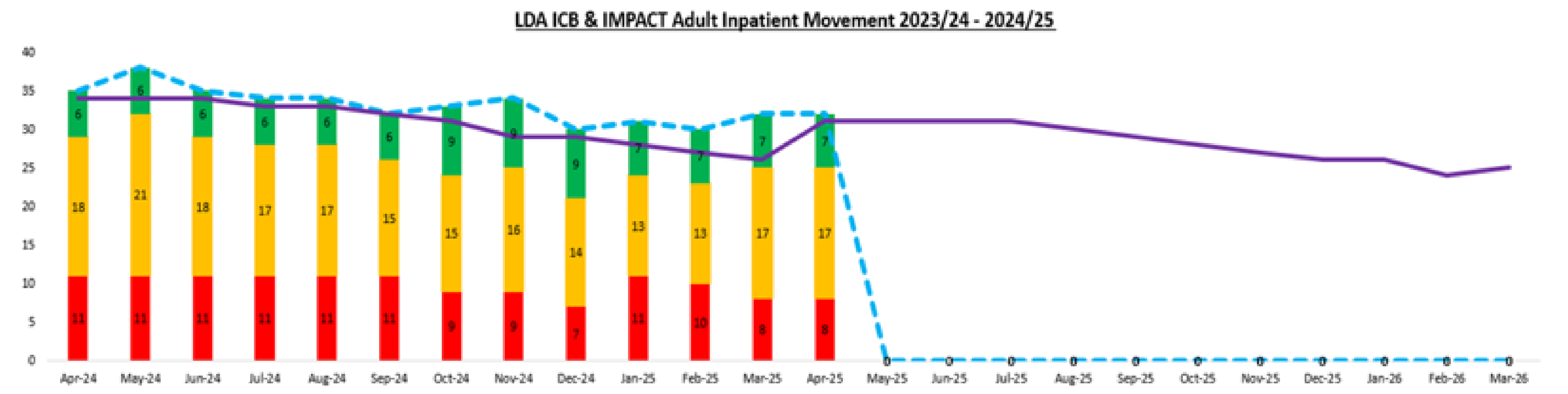
Programme	Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULHT)	0	Mar-25	4	N/A	N/A	-		
	Never events - YTD (NLAG)	0	Mar-25	1	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	Mar-25	7	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	-	Jan24 to Dec24	1.0934	1.0617	1.0038			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	Jan24 to Dec24	1.0078	1.0617	1.0038			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	Jan24 to Dec24	1.0012	1.0617	1.0038			
Infection, Prevention, Control	MRSA Cases (ULHT 12 month rate per 100,000)	-	Mar-25	0.30	0.86	1.02			
	C-Diff Cases (ULHT 12 month rate per 100,000)	-	Mar-25	29.11	34.45	32.57			
	E-Coli Cases (ULHT 12 month rate per 100,000)	-	Mar-25	43.38	43.38	38.00			
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)	31	Apr-25	31	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	3,863	Mar-25	3,681	N/A	N/A			
Patient Experience	Patient experience of GP services (ICB)	-	2024	73.0%	N/A	74.0%			-
	Friends & Family Test: A&E Recommended (ULHT)	-	Jan-25	72.9%	N/A	79.8%			-
	Friends & Family Test: Inpatient Recommended (ULHT)	-	Jan-25	89.9%	N/A	94.3%			-
	Friends & Family Test: Maternity Recommended (Birth) (ULHT)	-	Jan-25	N/A	N/A	91.1%			-
	Friends & Family Test: Community Recommended (LCHS)	-	Jan-25	91.3%	N/A	95.0%			-
	Friends & Family Test: Mental Health Recommended (LPFT)	-	Jan-25	92.4%	N/A	87.8%			-
Primary Care	Primary Care CQC- percentage of practices rated as 'Inadequate' by CQC	-	Mar-25	1.2%	N/A	0.4%			
	Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC	-	Mar-25	7.4%	N/A	7.4%			-
	GP Appointments- Total appointments in GP practice	479,160	Feb-25	448,205	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	Feb-25	44.0%	N/A	44.2%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	Feb-25	86.6%	N/A	82.1%			
	Enhanced access minutes provided (ICB) (YTD)	2,199,392	Mar-25	2,727,012	N/A	N/A			
	The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	Mar-25	87.9%	N/A	N/A			

Learning Disability & Autism

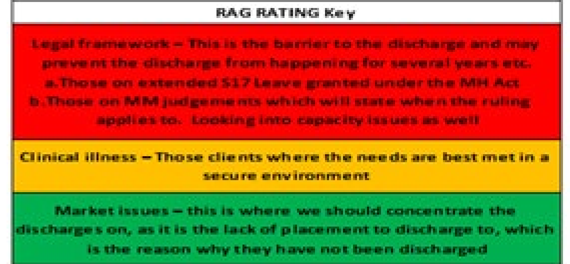








Legal Framework / MM Judgement	Actual Trajectory
Clinical illness - Appropriately placed	Submitted Trajectory
Market issues - Discharge plan in place	



Insight and Signals – Quality and Patient Experience

The Vales, LPFT:

The Vales is female mental health rehabilitation ward at LPFT. In response to quality concerns a Trust Executive led Quality Review Group was established to provide oversight of the required improvements, which includes senior ICB representation. Over the last few months a number of actions have been taken to address the quality concerns including increases in staffing; additional senior clinical support; and additional training for staff. However, recent review of progress has identified the improvements are not happening quickly enough and further work is required to embed the necessary changes. LPFT have therefore agreed to provide additional intensive support to the ward for a period of 4 weeks starting 12th May 2025. The Quality Review Group will continue to provide oversight of the impact of this additional support.

Lincolnshire Community Equipment Service:

Lincolnshire guidelines for the provision of community equipment within care homes were revised and relaunched January 2025. Feedback indicates this has caused some confusion regarding the offer of equipment and what is expected in terms of provision to meet need in care homes. Work is taking place between LCHS and LCC to understand impact of the change and highlight whether there is a risk of harm as a result of the change. Escalation of concerns have also been shared with LCC commercial team to highlight the need for clarification with care homes.

SEND Inspection:

The report has now been published for the Lincolnshire SEND Lincolnshire Local Area Partnership inspection that took place February 2025 Lincolnshire County Council - Open - Find an Inspection Report - Ofsted. The outcome of the inspection is *'The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). The local area partnership must work jointly to make improvements'.* The report highlights many areas of good practice and recognises the strength of the Partnership. Work is taking place across the Partnership to ensure appropriate actions are in place to address areas for improvement, from a health perspective these relate primarily to difficulties in waiting times for speech and language therapy services and neurodevelopmental assessments but also reference to access to nursing support in special schools; accessing primary care; and oversight of 18-25 annual health checks.

Peterborough City Hospital, NWAFT:

Reports have been published following the June 2024 CQC inspection of Medical Care (Including older people's care) and Urgent and Emergency Services. Medical care was rated Good overall and in all domains except Safe where it was rated as Requires Improvements Peterborough City Hospital HTML report for assessment LAP-01163 - Medical care (Including older people's care) - Care Quality Commission; Urgent and Emergency Services were rated as Requires Improvement overall and for Safe and Responsive domains, with Good for Effective, Caring and Well Led Peterborough City Hospital HTML report for assessment LAP-01163 - Urgent and emergency services - Care Quality Commission.

Insight and Signals – Primary Care

GP Practice quality:

The enhanced quality support programme led by the Primary Care Quality Team as part of the Quality Early Warning Score (QEWS) process is currently proving to be effective. It has identified practices that require more urgent support i.e. below the required standard for the ‘Safe’ quality domain.

3 practices are currently being supported via this process with a further 5 practices to follow.

2 practices have seen significant improvement in patient safety and quality following the enhanced support programme with one receiving a ‘Good’ rating from the CQC (the other practice will be assessed in the near future).

Pharmacy, Optometry and Dentistry (POD) quality:

The Primary Care Quality Team is continuing the development of the QEWS process for POD providers. This will be a lighter touch version compared to the General Practice model due to the limited functions provided by POD providers.

The Primary Care Quality team and Quality Services team are working to improve incident reporting and management for all commissioned POD services. This will allow for a consistent reporting structure for incidents and will provide for an ‘off the shelf’ process for incident management meaning providers will be given the tools they need to manage incidents in their respective settings. The plan is to have an online pod cast type training package to sit alongside this process to further support providers to better investigate and learn from incidents.

Insight and Signals – Primary Care

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

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

Learning and Sharing

Establishment of ICS Clinical Policies Group:

A Lincolnshire ICS Clinical Policies Group has been established to provide a forum for reviewing; quality assuring and ratifying clinical policies and standard operating procedures (SOP) that are to be implemented in 2 or more of the represented organisations i.e. ICB; LCHG; LPFT; St Barnabas; and LCC (Public Health and Adult Care only). The intention is to support the development of clinical policies that work across organisations involved in patient pathways of care, by streamlining the processes for approval.

Establishment of System Review Group for QEIAs:

As part of the 2025/26 planning work System interim documentation and process for QEIAs that involve 2 or more organisations was agreed. A System group is currently in operation to review the QEIAs developed as part of proposed schemes for this years planning round. Learning from this years planning process will be used to inform the development of a sustainable System approach to QEIAs

CYP Cerebral Palsy Framework:

Lincolnshire is participating in a recently established NHSE CYP Cerebral Palsy Implementation Group which will work with volunteer ICBs to carry out a baselining exercise over 2025/26, using the published national commissioning framework as a benchmark for standard of care, along with mutually agreed list of metrics. It is anticipated this exercise will help bring to light the services required for children and young people within the local system and, where possible, across the wider regional landscape. The implementation group will be used as a space to share learning and best practice and to support scale-up more widely.

CYP Diabetes:

One of the 4 deliverables for CYP diabetes is "*Reducing Health Inequalities in accessing diabetes technology*". Feedback from the ULTH diabetes team highlighted some families were unable to use diabetes technology as they could not afford a mobile phone to support it. CYP with diabetes are a priority for commencing on hybrid closed loop technology as this supports better controlled diabetes and thereby reducing risk of complications of diabetes.

In response to this feedback work was undertaken to utilise mobile phones, that were previously purchased with NHSE money to be used for an app trial and no longer in use. A governance agreement was put in place to facilitate the transfer of for phones to LCHG who will commence a pilot with the CYP diabetes team, in providing the phones to any family that requires it to support access to diabetes technology. A charity will provide free sim cards for 6 months which then have a low cost monthly fee (£5) thereafter. The phones will have an app for monitoring the diabetes, which can also provide information to the CYP team about the CYP diabetes, and also NHS supported diabetes apps to provide information and advice about managing diabetes.

Quality and Patient Experience Thematic Update – UEC

In addition to the information about quality concerns from patient safety incidents there is regular review of what is being reported by patients through Healthwatch pertaining to Urgent and Emergency Care (UEC) Services. This information is reported to the Urgent and Emergency Care Programme Board as well as being triangulated with all available other quality surveillance information (e.g. patient safety incidents, complaints, friends and family feedback, visits, relevant surveys such as CQC) to determine focus areas for improvement work within and across organisations. Each Healthwatch issue being considered by the respective organisation too for mitigating action where necessary.

In Healthwatch reports received October/December 2024 and February/March 2025 some of the areas highlighted were:

- EMAS – Positive feedback about ambulance crews.
- 111 – Staff listen but would like the staff to have a better understanding of chronic illness
- 111 – Option given was to go to Spalding UTC but patient cannot drive. Advised to call GP who advised to call 111. When called 111 back the GP practice did not have any appointments left.
- Louth UTC – Parent had recently downloaded Waitless App which said quicker to go to a UTC than ED. Went to Louth and was seen within 45 minutes of their arrival. Very happy with the service and the advice given by staff.
- EMAS & ED Boston – Long wait for an ambulance and in ED by an elderly person who had a fall. Staff were very kind and extremely busy.
- ED Lincoln - Long wait for a bed which was upsetting and uncomfortable. Concern that there were insufficient staff and that patients were missing care.
- ED Lincoln – Carer was not involved in discussion and decision for their relative with dementia
- ED Lincoln – The waiting room was overcrowded with really ill people, understaffed. Concern raised that due to long wait exposed them to infections.
- ED Boston – Patient was treated well. Nothing was ready for when transport arrived, and patient nearly had to have transport rescheduled.
- ED Grimsby – Patient had been in a chair all night since the previous afternoon with no food or drink offered until next morning. Discharged early evening when the last bus had gone so patient had to sort out a taxi. No discharge information given.

Quality and Patient Experience Thematic Update – UEC cont.

Work that is being undertaken to improve patient experience includes:

- Development of community service pathways to prevent the need to attend UEC services for example the catheter pathway.
- A ‘traffic light system’ in place to support the ‘off load’ and flow of patients from ambulances to ED at Lincoln.
- Care and comfort work to embed access to food, drink and toilets. Care and comfort packs are now provided to allow patients to freshen up whilst waiting
- Having a bleep system in place to enable relatives/carers to be with patients when being assessed / treated if unable to stay with the patient in the ED.
- Collation of patient stories following complaints to enable greater sharing and learning of lessons from patient feedback.
- Use of QR codes to obtain real time feedback from those patients waiting in ED

Vaccination Programmes – Seasonal & New

Seasonal Programmes

Covid-19

- The Spring 2025 Covid-19 vaccination campaign began on 1st April for all cohorts and completes on June 17th.
- The campaign is being delivered by PCNs, Community Pharmacies and VRRT where there are access gaps. Maternity and healthcare staff are not eligible.
- Lincolnshire has 35 Community Pharmacies providing Covid-19 vaccinations, this is an increase of 14 from Spring 2024.
- All of Lincolnshire care home residents will be offered a Covid vaccine prior to the end of the programme, so far 53% of Lincolnshire's care homes are considered completed.
- Nationally uptake is expected to reduce again when compared to last year's figures, Lincolnshire has seen the same trend with this year's uptake currently sitting at 49%. Lincolnshire uptake across all eligible cohorts is higher than the national and regional position.

New Programme

Respiratory Syncytial Virus (RSV)

- The RSV vaccination programme began on 1st September 2024.

Maternity

- The maternity programme is to mainly be delivered via maternity providers.
- There are several options for ladies in Lincolnshire – ULHT led clinics based at Lincoln County and Pilgrim sites, or community-based clinics run by LCHS in family hubs in Skegness, Gainsborough and Spalding, or opportunistically by their own GP. Approx 1 third are choosing to access an RSV vaccination via their own GP.

Older Adult

- The older adult programme is contracted to be delivered in General Practice, uptake by practice varies depending on their plan.
- The response for Lincolnshire from patients for this new vaccine, so far is a positive one. To date uptake on the catch-up programme is over 70%.

Finance: Summary Financial Position (1)

Year To Date Financial Position

The ICS delivered a £4.8m deficit in month 1 which was in line with the YTD plan.

The ICB's element of the month 1 position was also on plan with a reported a £0.214m deficit.

Risks and Mitigations

The ICB has identified risks to delivery of the 2025/26 plan of £31.6m. Main risks being CIP delivery, Prescribing and CHC. Mitigations of £25.1m result in a net risk of £6.5m.

The ICS has an overall net risk of £33.9m.

Data source: Immform, LA Assurance dashboard.

Finance: Summary Financial Position (2)

Cost Improvement Plan

The ICS has a full year cost improvement plan of £163.18m.

At month 1 the ICS has reported delivery of £9.012m cost improvements against a plan of £9.151m equating to a £0.139m adverse variance to plan.

Capital

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

The ICS is expecting to utilize all of this allocation.

Item 5 (ii)

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (ii)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Process for Review of CQC section 48 (Calocane) Update Report
Report Author:	Nick Harwood, Director of Operation for Adult Community Services
Presenter:	Martin Fahy, Chief Nurse
Appendices:	N/A

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

Recommendations

The ICB Board is asked to note the update report.

Summary

Background

Following a previous paper presented to the ICB and LPFT Boards in November and December 2024 respectively, this paper provides an update on progress to date and identified next steps in relation to Lincolnshire's response to the CQC, NHSE and independent enquiry into the care and treatment of Valdo Calocane and the tragic deaths of three people in Nottinghamshire.

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

https://www.cqc.org.uk/press-release/cqc-publishes-final-part-special-review-mental-health-services-nottinghamshire

Subsequently an independent enquiry has published its findings.

https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2025/02/independent-investigation-into-the-care-and-treatment-provided-to-vc.pdf

The government has since announced a judge-led public enquiry.

A definition of the cohort of patients has been provided by NHSE as below:

1. Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
2. May not respond to, want to or may struggle to access and use 'routine' monitoring, support and treatment that could minimise harm
3. Are vulnerable to relapse and/or deterioration with serious related harms associated (esp but not limited to violence and aggressions)
4. Have multiple social needs (housing, finance, self-neglect, isolation etc)
5. Likely present with co-occurring problems (eg drug and alcohol use/dependence)
6. May have had negative (eg harmful and/or traumatic) experiences of mental health services or other functions of the state (eg the criminal justice systems)
7. Concerns may have been raised about by family/carers

Assessment

As a system a Task and Finish group has been established to develop and implement Lincolnshire's action plan (Appendix 1). The first meeting was held 6th November 2024, with ICB, LPFT and experts by experience. The group has reviewed all available information from NHSE returns, the system maturity index and suggestions shared by various groups/committees to inform the action plan. The group has subsequently met each month to continue to develop and implement required actions and add to it as further recommendations have been made. Whilst the formal governance of this work will report through the Quality committee Structure (The Task and Finish group reports into LPFTs Quality Committee and onward to LPFT and ICB Public Boards), Oversight of the action plan will be monitored through the Trusts Performance, Delivery Oversight Group which the Chief Nursing Officer, Chief Medical Officer and all Directors are members of.

Update on action plan

The action plan can be summarised as below:

Casefile audits for understanding current practice, for assurance and learning

A number of reviews of individual patients have taken place as per below:

1. *Review of patients identified by teams as meeting the criteria for intensive/assertive support* – 215 current cases were reviewed, all of which were deemed to be in receipt of appropriate care and support overseen by the Locality Mental Health Teams MDTs. The review identified further justification of the need for a dedicated intensive/assertive function due to limited capacity in the teams to fully meet the national requirements of smaller cases sizes, more contacts per week, proactive engagement and inpatient in-reach. No specific patient safety concerns were identified; however issues were identified that could lead to them:
   - *i.* In reach to inpatient wards and attendance at ward rounds was not always possible for LMHT staff due to clinicians having caseloads above the recommended levels. In teams such as CRT and PACT where caseloads are reduced there was positive engagement in ward rounds and providing in reach. 13 current inpatients at the time of review.
   - *ii.* History of violence or persistent offending was high in this cohort, 90 of the 215. Implications for staffing in providing home visits (2 staff needed to visit 42% of patients identified)

iii. Accommodation needs identified for 52 of the 215. Unstable accommodation know factor to increase clinical risk.

2. *Review of patients with repeat Mental Health Act detentions* – All patients with 4 or more inpatient MHA detentions in the last 2 years have been reviewed and a sample of patients detained 2 or 3 times in this period. 177 patients with 2 or more MHA detentions were identified by the data team, from this cohort 34 patients were reviewed in total. We reviewed all with 4 (20) and above detentions and random sampled those with 2(6) or 3(8) sections. All patients had active care and support from a variety of services and contact being sustained despite the challenges of presentation. Service pathways being accessed, Inpatient, MHLS, CRHT, PACT, CRT, EIP, LMHT, IPS, CJL&D, Community Forensic Team, Transforming Care, LD Services, Older Adults CMHT, Prison Services (Reconnect). No specific gaps were identified, good practice was identified in terms of connection to VCSFE sector, however the care could be improved by a dedicated intensive/support dedicated function.

3. *Review of all patients where DNA was the last contact* – a review of 96 patients where DNA was the last contact with a patient has been carried out. No patients were identified who would have met the I/A criteria and in many cases proactive follow up attempted, through telephone calls, opt in letters and evidence of MDT discussion. There were examples where notes were not always clear in terms of decision making for discharge and MDT approach to this, staff have been sent a reminder about this and we will continue to monitor.

4. *Review of incidents relating to this cohort of patients* – The current incident reporting system does not allow for easy identification of incidents relating to this cohort of patients, met with divisional quality leads and no issues identified through manual searches. Consideration to be given to highlighting this cohort of patients in the new system.

5. *Patients in primary care* – Our Senior Mental Health Practitioners in Primary Care were asked to review primary care caseloads to identify anyone in this cohort not being supported by LPFT, there were 3 patients identified and referrals recommended, otherwise these workers described no issues with these patients being accepted by LPFT. This was across all PCNs.

Development of business case

Lincolnshire does not have a dedicated Intensive/Assertive service, this function was merged with our Community Mental Health Teams many years ago. NHSE guidance suggests that a dedicated service or function is best practice to allow for small caseloads, proactive engagement and enhanced support. To this end a business case in under development which will be reviewed by the task and finish group when complete. Without an AO function risks and gaps remain, which can be mitigated by actions being taken, but do not replace the need for this dedicated function, the gaps include smaller caseloads, to allow dedicated time to proactively engage with these patients, inpatient in reach.

Identification/Information sharing

It was established we had no clear method of identifying this cohort of patients and have therefore added an alert to LPFT's Electronic Patient Record, ongoing work is required to ensure this alert is routinely used.

The group has discussed the need for more adequate information sharing outside of the LPFT clinical record, the care portal is the suggested method. Further we are looking at how we use available data to consider trends, DNA patterns, early warning metrics. Further thought is required in regard to sharing of concerns outside of health services.

Pathways of care

The task and finish group has focused on a number of areas in relation to the pathways of care, including psychological therapies, inpatient care and discharge planning, transitions between services, forensic services, children and young people. This will continue to be worked on and developed.

Other workstreams

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

1. Housing and accommodation, for the Housing Oversight Group to consider this group and feedback
2. Dual Diagnosis working group, to ensure this cohort of patients that often have co-terminus drug and/or alcohol misuse issues and considered in the work and pathways being developed
3. Family and carer support, for existing groups/lead to consider this group in their work and feedback to the task and finish group. An additional action from the independent investigation was to ensure providers have a strategy for family/carer engagement, this will be discussed further in the group and assurance sought that LPFT has or is working on this clearly articulated strategy

Support for staff and patients

The group is very minded that the recent press around the incident in Nottinghamshire is likely to have had a profound impact on people with psychotic illnesses and the staff that deliver care.

We will be asking our service users, their families and experts by experience in various forums for their contribution to the messaging we would aspire to deliver in regard to reassurance about care and to challenge any stigma.

For staff we are looking to provide a safe, reflective space for any concerns/worries to be expressed, this will in time extend to education and supervision around the unique needs of this cohort of patients.

Wider stakeholder engagement

The group have identified a number of wider stakeholders that are vital to the success of the care of these individual and will be extending invite to the group in due course, including police, EMAS, ULHT, VCFSE sector.

Other areas for focus

1. The action plan is continuing to work up plans in regard to ensuring community staff engage with their patients whilst inpatients which has been an issue for many years,

a separate working group has been established to review this led by the Adult Community Division Service Managers

2. Review of medication management, we now have a pharmacy rep on the task and finish group alongside a Consultant Psychiatrist
3. Health inequalities workstream to consider this cohort of patients and their unique needs
4. Links to wider work in relation to personalised care and support planning.

System/NHSE timeline

- System learning event held on the 1st April
- Updated action plan to be presented to ICB and Trust Public Boards by June 2025
- Action plan to be presented to NHSE in July 2025

Additional considerations for LPFT and system from review of Independent Enquiry

The below have been identified from the Independent Enquiry that although will be incorporated within the Lincolnshire action plan are wider than the Intensive/Assertive Task and Finish Group and so will require updates and support from the relevant departments, as such SRO's have been listed for each action will be held to account through the action plan oversight, the action plan will be updated to reflect this:

- Risk Assessment and Management: Improve systems to identify, evaluate, and communicate risk across care settings. A system solution is required for this and sits with our Digital and Data Team. SRO: Director of Digital and Data
- Information Sharing: Enhance interoperable systems for timely sharing of clinical information across all care settings. As above. SRO: Director of Digital and Data
- Ensure systems are investigating incidents in line with the Patient Safety Incident Response Framework (PSIRF) and ensure lessons are embedded in clinical practice. This sits with the Patient Safety team and Divisional Quality Leads. SRO: Director of Nursing and Quality
- Family Engagement: Define and develop positive family engagement strategies in collaboration with those with lived experience. This requires a clear policy within LPFTs Clinical Care Policy, to be led by the Trust's Quality Improvement and Assurance Lead for Experience of Care SRO Director of Nursing & Quality
- Communication Processes: Review and evidence the effectiveness of communication across all system partners involved in mental health care. Lincolnshire ICB
- Governance Framework: Develop structures to identify and communicate potential issues and risks, ensuring system-wide learning. The Trusts Triangulation of Learning and Continuous Improvement forum led by the Director of Nursing and Professions are being asked to consider this action and work across the system. SRO Director of Nursing and Professions
- Policy Updates: Ensure all Trust policies are current, with clear guidance for escalation when key deliverables are not met. All policy owners to review. SRO: Trust Secretary

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	The assessment will support identification of service provision gaps for this highly stigmatized cohort.
Aim 2: Tackle inequalities in outcomes, experience and access.	People with serious and enduring mental illness have barriers to accessing services and assertive outreach models help to facilitate engagement.

<table>
<tr><td colspan="3">Aim 3: Enhance productivity and value for money.</td><td colspan="2">Keeping people safe and supported in their communities will deliver better VFM than inpatient models of care.</td></tr>
<tr><td colspan="3">Aim 4: Help the NHS support broader social and economic development.</td><td colspan="2">Like suicide, the societal cost of homicide is substantial not only in financial terms for services but also the perpetual emotional impact for families, friends and staff.</td></tr>
<tr><td colspan="3">Conflicts of Interest</td><td colspan="2">Summary of conflicts</td></tr>
<tr><td colspan="3">No conflict identified</td><td colspan="2"></td></tr>
<tr><td colspan="5">Risk and Assurance</td></tr>
<tr><td colspan="5">As identified within the paper.</td></tr>
<tr><td colspan="5">Implications (legal, policy and regulatory requirements)</td></tr>
<tr><td colspan="3">Does the report highlight any resource and financial implications?</td><td colspan="2">To be ascertained through the review.</td></tr>
<tr><td colspan="3">Does the report highlight any quality and patient safety implications?</td><td colspan="2">Considerable implications if care pathways are not robust.</td></tr>
<tr><td colspan="3">Does the report highlight any health inequalities implications?</td><td colspan="2">No</td></tr>
<tr><td colspan="3">Does the report demonstrate patient and public involvement?</td><td colspan="2">Yes in use of lived experience voice within stakeholder events and going forward.</td></tr>
<tr><td colspan="3">Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)</td><td colspan="2">Assertive Outreach models are based around visits to peoples places of safety within their communities – which has implications for travel and carbon footprint.</td></tr>
<tr><td colspan="5">Inclusion</td></tr>
<tr><td>Has a Data Protection Impact Assessment been undertaken?</td><td>Yes
☐</td><td>No
☐</td><td colspan="2">N/A
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<tr><td>Has an equality impact assessment been undertaken?</td><td>Yes
☐</td><td>No
☐</td><td colspan="2">N/A
☒</td></tr>
<tr><td>Has a Quality Impact Assessment been undertaken?</td><td>Yes
☐</td><td>No
☐</td><td colspan="2">N/A
☒</td></tr>
<tr><td colspan="5">Report previously presented at:</td></tr>
<tr><td colspan="5">Progress Report presented to the ICB Board in November 2024.</td></tr>
<tr><td colspan="5">Is the report confidential or not?</td></tr>
<tr><td colspan="5">Yes ☐ No ☒</td></tr>
</table>

Item 6 (i)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Standards of Business Conduct and Conflicts of Interest Policy - amended
Report Author:	Jules Ellis-Fenwick, Board Secretary Sarah Bates, Deputy Board Secretary
Presenter:	Jules Ellis-Fenwick, Board Secretary
Appendices:	Standards of Business Conduct and Conflicts of Interest Policy

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

Recommendations

The Board is asked to approve the revised ICB Standards of Business Conduct and Conflicts of Interest Policy.

Summary

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

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

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

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

In light of the publication of this updated guidance, the ICB Board Secretary and Deputy Board Secretary reviewed the ICB Standards of Business Conduct and Conflicts of Interest Policy and made a number of amendments to bring the policy in line with this guidance. The Board received and approved the revised version at its meeting held on the 24th November 2025.

Since that time the ICB has been subject to an internal audit review by TIAA (its internal auditors) who requested amendments to the actually reflect the date of the Procurement Act which came into force on the 24th February 2025 and also some minor amendments throughout. **This has now been updated and the changes highlighted in yellow – as per the attached Policy.**

The ICB Board is asked to consider the revised document and approve this for inclusion in the ICB Governance Handbook and publication on the ICB website and intranet. The updated guidance will also be communicated to staff who will be required to familiarise themselves with the content.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	It is essential that the ICB establishes effective arrangements for managing conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes towards the achievement of the four core aims.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.
Aim 4: Help the NHS support broader social and economic development.	As above.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
No specific risks identified.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Not applicable.
Does the report highlight any quality and patient safety implications?	Not applicable.
Does the report highlight any health inequalities implications?	Not applicable.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an Equality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
Not applicable.			
Is the report confidential or not?			
Yes ☐ No ☒			

NHS LINCOLNSHIRE INTEGRATED CARE BOARD

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

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Status	Final
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Date	

Document history			
Version	**Date**	**Author**	**Comments**
1	July 2022	Sarah Bates, Deputy Board Secretary	Final version
2	October 2024	Sarah Bates, Deputy Board Secretary	Updated following publication of national guidance. This guidance replaces the previously issued Policy taking into account the changes introduced by the Health and Care Act 2022, specifically the establishment of Integrated Care Boards and the introduction of the Provider Selection Regime.
3	February 2025	Sarah Bates, Deputy Board Secretary	Policy updated in line with the latest government update and that the Procurement Act has been delayed and will now come into effect on 24th February 2025.

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1. Introduction

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

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

2. Background

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

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

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

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

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

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

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

This guidance:

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

3. Aims of the Policy

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

This policy is intended to:

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

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

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

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

4. Scope of the Policy

4.1 Staff

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

This policy will apply to:

- All NHS Lincolnshire ICB employees, including full and part-time staff, staff on sessional or short term contracts, students or trainees (including apprentices), agency and seconded staff
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors

- All members of the NHS Lincolnshire ICB, including Committee, Sub-Committee, Co-opted members, appointed deputies, advisory group members, Joint Committees, (who may not be directly employed or engaged by the organisation) and any members of Committees/groups from other organisations

Action for staff
DO • Familiarise yourself with this policy and your organisational policies and follow them. • Use your common sense and judgement to consider whether the interests you could have affect the way taxpayers' money is spent. • Regularly consider what interest you have and declare these as they arise. If in doubt, declare.
DON'T • Misuse your position to further your own interests or those close to you. • Be influenced or give the impression that you have been influenced by, outside interests. • Allow outside interests that you hold to inappropriately affect the decisions you make about spending taxpayers' money.

4.2 Actions for the ICB

Action for Organisations
DO • Ensure that you have clear and well communicated processes in place to help staff understand what they need to do • Identify a team or individual with responsibility for:- - Reviewing current policies and bringing them in line with this guidance. - Providing advice, training and support for staff on how interests should be managed. - Maintaining register(s) of interests. - Auditing policy, process and procedures relating to this guidance at least every three years.
DON'T • Avoid managing conflicts of interest. • Interpret and deploy this guidance in a way that stifles the collaboration and innovation that the NHS needs.

4.3 Implementation

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

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

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

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

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

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

- Whistleblowing Policy
- Disciplinary Policy

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

4.4 Training

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

5. What are Conflicts of Interest?

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

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

A conflict of interest may be:

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

Interests fall into the following categories:

Financial Interests	Non-financial professional	Non-financial personal	Indirect interests

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

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

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

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

- An advocate for a particular group of patients.
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared).
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE).
- Engaged in a research role.
- Development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
- GPs and Practice Managers, who are Members of the Board or Committees of the ICB, should declare details of their roles and responsibilities within their GP Practices.

- **Non-Financial Personal Interests**: This could include for example, where the individual is:
  - A voluntary sector champion for a provider.
  - A volunteer for a provider.
  - A member for a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
  - Suffering from a particular condition requiring individually funded treatment.
  - A member of a lobby or pressure group with an interest in health and care.

- **Indirect Interests**: (as those categories are described above) for example:
  - Spouse/Partner.
  - Close relative e.g., parent, grandparent, child, grandchild, or sibling.
  - Close friend; or
  - Business partner.

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

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

It should be noted that:

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

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

6. Identification, Declaration and Review of Interests

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

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

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

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

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

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

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

Declaring and Registering Interests

The ICB maintains registers of the interests of:-

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

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

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

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

All declarations will be entered in the registers.

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

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

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

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

Standards of Business Conduct

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Register of Interests

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

The ICB keeps a Register of Interests for the following:

- **All ICB employees**, including:

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

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

- **Members of the ICB Board, including (but not limited to):**

  - Executive Directors
  - Non-Executive Members
  - Partner Members

- All members of the ICB's Committees, Joint Committees, Sub-Committees and Advisory Groups

7.1 Decision Making Staff

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

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

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

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

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

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

The Register of Interests template is attached at Appendix Two.

8. Appointing Board or Committee Members

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

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

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

9. Role of Non-Executive Members

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

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

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

10. Conflicts of Interest Guardian

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

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

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

11. Outside/Secondary Employment

What are the issues	The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided. Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which

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

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

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

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

12. Governance and Decision-Making Processes

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

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

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

13. Procedure for Meetings

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

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

14. Minute Taking

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

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

15. Management of Interests – advice in specific contexts

15.1 Strategic Decision-Making Groups

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

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

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

For the ICB these groups are:

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

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

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

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

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

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

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

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

These groups should adopt the following principles:

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

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

- If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

    - Requiring the member to not attend the meeting.
    - Excluding the member from receiving meeting papers relating to their interest.
    - Excluding the member from all or part of the relevant discussion and decision.
    - Noting the nature and extent of the interest but judging it appropriate to allow the member to remain and participate.
    - Removing the member from the group or process altogether.

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

15.2 Procurement

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

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

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

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

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

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

The Procurement Act 2023 ("Procurement Act") is expected to come into force with effect from 24th February 2025, at which point it will replace the PCR. Organisations will need to take all reasonable steps to identify, and keep services under review, in relation to any procurement under the Procurement Act any conflicts of interest or potential conflicts of interest. "Conflict of interest" is defined for the purposes of the Procurement Act. The Procurement Act will impose new duties on organisations with regards to the assessment and management of conflicts of interest.

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

legal requirements relating to conflicts of interest and procurement decisions.

16. Gifts

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

Overarching Principles

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

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

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

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

What are the issues?	Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviours if not handled in an appropriate way. A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.
Principles and rules	Overarching principle applying in all circumstances: • Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors: • Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. • Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total and need not be declared. *the £6 value has been selected with reference to existing industry guidance issues by the ABPI. Gifts from other sources (e.g., patients, families, service users): • Gifts of cash and vouchers to individuals should always be declined. • Staff should not ask for any gifts, regardless of value. • Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e., to an organisation's charitable funds), not in a personal capacity. Staff should declare such gifts and provide a clear reason as to why it was considered

	be treated in the same way as single gifts over £50 where the

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

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

17. Hospitality

What are the issues?	Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of "traditional" working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviours. Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.
Principles and rules	Overarching principles applying in all circumstances: • Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. • Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. • Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these. **Meals and Refreshments** • Under a value of £25 may be accepted and need not be declared. • Of a value between £25 and £75* may be accepted and must be declared. • Over a value of £75* should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept. • A commonsense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

Principles and rules	

What should be declared	

18. Sponsored Events

What are the issues	Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.
Principles and rules	• Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS. • During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation. • No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. • At the ICB's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event. • The involvement of a sponsor in an event should always be clearly identified in the interest of transparency. • ICBs should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

	A declaration form is at Appendix Eleven.
What should be declared	• Organisations should maintain records regarding sponsored events in line with the above principles and rules.

19. Other Forms of Sponsorship

19.1 Sponsored Research

What are the issues?	Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.
Principles and rules	• Funding sources for research purposes must be transparent. • Any proposed research must go through the relevant health research authority or other approvals process. • There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. • The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service. • Staff should declare involvement with sponsored research to their organisation. • The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
What should be declared	Staff should declare: • their name and their role with the ICB Board. • a description of the nature of the nature of their involvement in the sponsored research. • relevant dates. • any other relevant information (e.g., what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

19.2 Sponsored Posts

What are the issues	

Principles and rules	

What should be declared	this policy.

20. Shareholdings and other Ownership Issues

What are the issues	Holding shares or other ownership interests can be a common way for staff to invest their personal time money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role within an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give risk to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.
Principles and rules	• Staff should declare, as a minimum, any shareholdings and other ownership interests in a publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

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

21. Patents

What are the issues?	The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.
Principles and rules	• Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation. • Staff should seek prior permission from their organisation before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources of intellectual property. • Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role within the ICB Board. • A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Any other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

22. Loyalty Interests

What are the issues?	As part of their jobs staff members need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by a formal process or managed via any contractual means – it can be as simple as having informal access to people in senior positions. However, loyalty interest can influence decision making. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship, they have rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.
Principles and rules	Loyalty interests should be declared by staff involved in decision making where they: • Hold a position of authority in another NHS organisation, or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role. • Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money. • Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners. • Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities. • Where holding loyalty interest gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role within the ICB Board. • Nature of the loyalty interest • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy.

23. Donations

What are the issues?	
Principles and rules	
What should be declared	• Organisations should maintain records in line with their wider

24. Clinical Private Practice

What are the issues	Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves. Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be

	managed. These provisions around declarations of activities are equivalent to what is asked of all staff in section 12 on Outside Employment.
Principles and rules	Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including: • where they practice (name of private facility) • what they practice (specialty, major procedures). • when they practice (identified sessions/time commitment) *Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice atwork/contracts/consultanttermsandconditions.pdf Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed): • Seek prior approval of their organisation before taking up private practice. • Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work. • Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non- Divestment_Order_amended.pdf Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf** **These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch.9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf Where clinal private practice gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role with the ICB Board. • A description of the nature of the private practice (e.g., what, where and when you practice, sessional activity, etc). • Relevant dates. • Any other relevant information (e.g., action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

25. Personal Conduct

Lending or Borrowing

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

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

Gambling

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

Trading on Official Premises

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

Collection of Money

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

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

Bankrupt or Insolvent Staff

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

Arrest or Conviction

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

Political Activities

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

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

Social Media

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

26. Standing Financial Instructions and Scheme of Reservation and Delegation

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

27. Prevention of Corruption and the Bribery Act 2010

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

- Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and 2) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;

- The new corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

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

28.1 Raising Concerns and Reporting Breaches

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

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

- Conflict of Interest Guardian
- ICB Board Secretary

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

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

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

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

Following investigation the ICB will:

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

28.2 Taking action in response to breaches

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

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

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

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

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

This includes:

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

28.3 Learning and transparency concerning breaches

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

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

29. Professional Regulatory Sanctions

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

Civil Sanctions

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

Criminal Sanctions

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

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

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

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

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

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

Reputational Consequences

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

30. Equality and Diversity Statement

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

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

31. Monitoring Compliance and Effectiveness of the Policy

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

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

Appendix One (a)

Declaration of interest for ICB members and employees

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

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

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

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

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

Signed: **Date:**
Signed: **Position:** **Date:**
(Line Manager or Senior ICB Manager)

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

Types of conflicts of interest

<table>
<tr><th>Type of Interest</th><th>Description</th></tr>
<tr><td>Financial Interest</td><td>This is where an individual may get direct financial benefits (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a commissioning decision. This could, for example, include being:
• A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model.
• A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
• A management consultant for a provider; or
• A provider of clinical private practice.
This could also include an individual being:
• In employment outside of the ICB
• In receipt of secondary income.
• In receipt of a grant from a provider.
• In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider.
• In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
• Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).</td></tr>
<tr><td>Non-Financial Professional Interests</td><td>This is where an individual may obtain a non-financial professional benefit (a benefit may arise from the making of gain or avoiding a loss) from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:
• An advocate for a particular group of patients.
• A clinician with a special interests e.g., in dermatology, acupuncture etc.:
• An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared).
• An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE).
• Engaged in a research role.
• The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
• GPs and practice managers, who are members of the Board or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.</td></tr>
<tr><td>Non-Financial Personal Interests</td><td>This is where an individual may benefit (a benefit may arise from the making of gain or avoiding a loss) personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:
• A voluntary sector champion for a provider.
• A volunteer for a provider.
• A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation.
• Suffering from a particular condition requiring individually funded treatment.
• A member of a lobby or pressure group with an interest in health and care.</td></tr>
<tr><td>Indirect Interests</td><td>This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). This should include:
• Spouse/Partner
• Close relative e.g., parent, grandparent, child, grandchild or sibling.
• Close friend
• Business partner</td></tr>
</table>

Appendix One (b)

Declaration of interest for ICB members and employees

'No Change' Form

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

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

Please tick below:

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

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

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

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

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

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

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

Appendix 2

Template for recording any interests during meetings

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

Appendix 3

Declaration of gifts and hospitality

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

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

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

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

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

Appendix 4

Declarations of Commercial Sponsorship

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

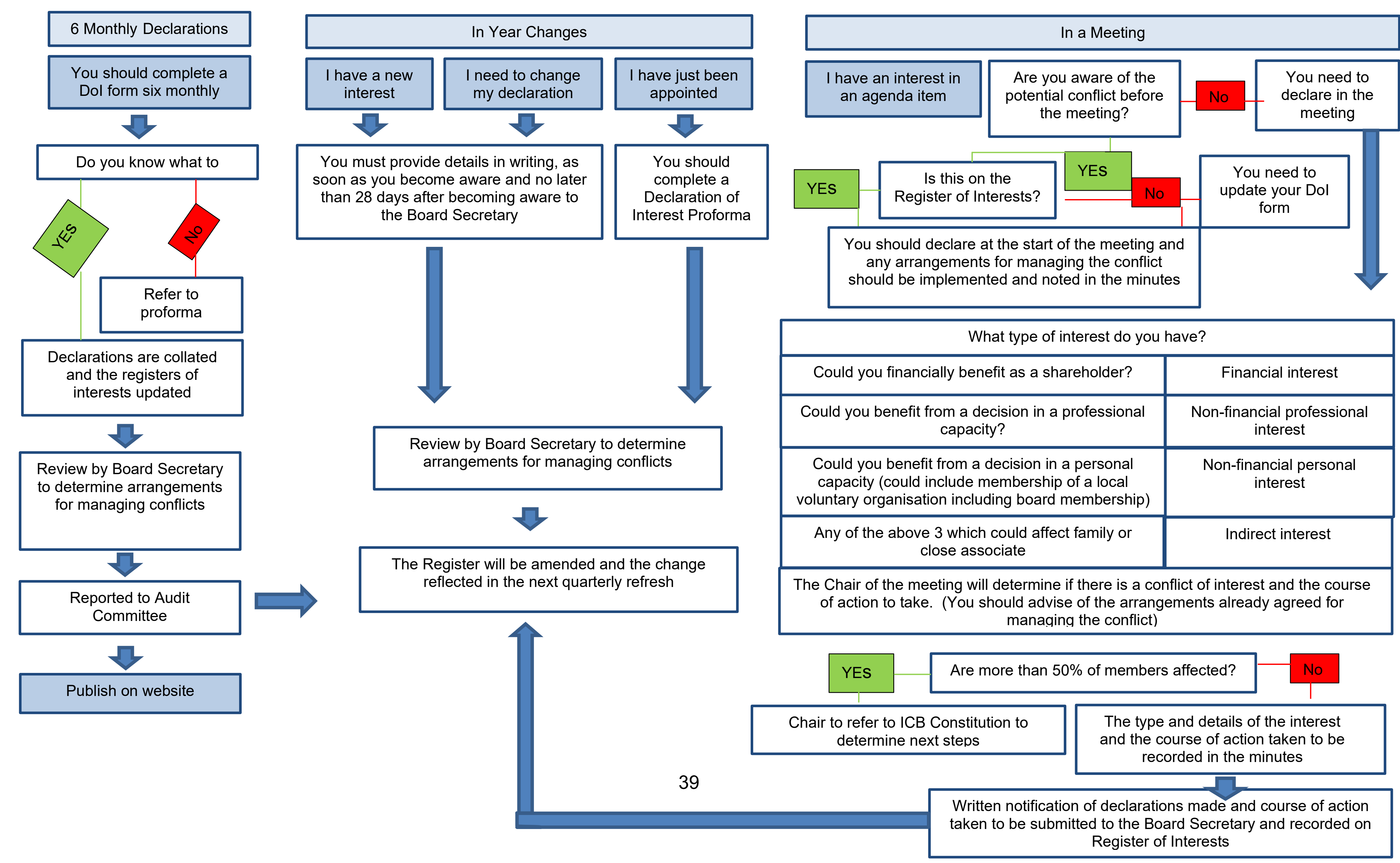
The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third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

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

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

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

Appendix 5



Item 6 (ii)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (ii)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Board Forward Plan 2025/26
Report Author:	Gerry McSorley, ICB Chair Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Dr Gerry McSorley, ICB Chair
Appendices:	Appendix 1 - Board Forward Plan

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

Recommendations

The ICB Board is asked to:

- Consider the Board Forward Plan for 2025/26 and identify any amendments/comments, noting this document will be kept 'live' in light of recent national announcements about the NHS Reforms and the change in role of ICBs.
- Note any amendments will be incorporate as appropriate with the updated version circulated to the Board for information.

Summary

Good governance practice dictates that Boards and Committees should be supported by a Forward Plan of business that sets out a coherent overall programme for meetings, specifically identifying the reports which will be regularly presented for consideration.

The Forward Plan is one of the key components in ensuring that the Board is effectively carrying out its role in leading the organisation and has plans in place to deliver its strategy and achieve a balanced budget position. It is also a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that does not place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

The Board Forward Plan has been prepared based on the Board meeting dates agreed for 2024/25 and reflects good practice.

The Board is asked to consider the document and identify any amendments/comments which will be incorporated as appropriate. The final document will be then circulated to the Board for information.

Development Session

The following sessions have been arranged to date:

DATE AND TIME	TOPIC
Tuesday, 25th June 2025	To be confirmed.
Tuesday, 26th August 2025	To be confirmed
Tuesday, 28th October 2025	To be confirmed.
Tuesday, 23rd December 2025	To be confirmed.
Tuesday, 24th December 2025	To be confirmed.

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

Conflicts of Interest	Summary of conflicts
No conflict identified	

Risk and Assurance
No specific risks identified in relation to this paper.

Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	No.
Does the report demonstrate patient and public involvement?	No.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No

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

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

BOARD FORWARD PLAN
2025/26

ITEM	27/05/25	29/07/25	30/09/25	25/11/25	27/01/25	31/03/25
1. INTRODUCTION						
i) Welcome and apologies	✓	✓	✓	✓	✓	✓
ii) Confirmation of Quoracy	✓	✓	✓	✓	✓	✓
iii) Declarations of Interest	✓	✓	✓	✓	✓	✓
iv) Minutes of the previous meeting (for approval)	✓	✓	✓	✓	✓	✓
v) Action Log (Matters Arising)	✓	✓	✓	✓	✓	✓
2. CHAIR AND CHIEF EXECUTIVE UPDATES						
i) Chair update	✓	✓	✓	✓	✓	✓
ii) Chief Executive update	✓	✓	✓	✓	✓	✓
3. KEY UPDATES						
i) Public Health	✓	✓	✓	✓	✓	✓
ii) Healthwatch	✓	✓	✓	✓	✓	✓
4. POPULATION HEALTH PLANNING						
i) Health Inequalities (standing item) - Lincolnshire Health and Care Digital Inclusion Strategy (May)	✓	✓	✓	✓	✓	✓
5. SYSTEM OVERSIGHT AND ASSURANCE						
i) Integrated Performance, Quality and Finance Report	✓	✓	✓	✓	✓	✓
ii) Winter Planning			✓			
iii) Calocane Update Report	✓					
6. GOVERNANCE						
i) ICB Annual Report and Accounts 2024/25			✓			
ii) Board Assurance Framework			✓			✓
iii) Amendments to the ICB Governance Handbook		✓				
iv) Board Forward Plan 2025/26	✓					

ITEM	28/05/25	30/07/25	24/09/25	26/11/25	28/01/25	25/03/25
7. COMMITTEE HIGHLIGHT REPORTS						
i) Report from the System Quality and Patient Experience Committee (QPEC)	✓	✓	✓	✓	✓	✓
ii) Report from the Service Delivery and Performance Committee	✓	✓	✓	✓	✓	✓
iii) Report from Audit and Risk Committee	✓		✓	✓	✓	✓
i) Briefing Summary of the East Midlands Joint Committee Meetings	✓	✓	✓	✓	✓	✓
iv) Audit and Risk Committee Annual Report 2024/25	✓					
8. INFORMATION / CLOSING ITEMS						
i) Register of Documents Sealed 1st April 2024 to 31st March 2025	✓					
ii) Declaration of Interest Registers as at May 2025	✓					
iii) Risks identified during the course of the meeting	✓	✓	✓	✓	✓	✓

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	Item 7 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	System QPEC (Quality and Patient Experience) Committee
Report Author:	Sharon Robson, Non-Executive Director (Chair) Martin Fahy, ICB Chief Nurse Sarah Bates, Deputy Board Secretary
Presenter:	Sharon Robson, Non-Executive Director (Chair)
Appendices:	People and Communities Involvement Report 2024-25

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

Recommendations

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

Summary

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

- **Lincolnshire System Priorities Quality Register:** the Register was shared with members. It was noted that there had no significant changes since the previous iteration and that following the comments made at the last meeting the RAG rating has been removed. The main areas to note include the Urgent and Emergency Care pathway and the seasonal effects with the East Coast population, Elective, Workforce and Finance challenges and Primary Care. It was agreed that the Register would be refreshed to include the core thresholds and updated by the end of the month. Discussions took place regarding the financial risks and that this area require additional detail in light of this year's financial challenges.

- **Quality Strategy:** it was noted that there have been several iterations of the Strategy made available. It was agreed that the latest version would be shared with members for review and comment along with the implementation plan.

- **ULTH – Infection Prevention and Control:** it was reported that concerns had been highlighted in relation to infection prevention and control standards at ULTH following an NHSE visit in September 2024, ICB Quality visit in December and ICB Health Protection visit in March 2025.

  It was discussed that consideration is being given to a peer review with a fellow Trust and that a mobilisation recovery plan is developed and presented at a future meeting for additional assurance. It was agreed the monitoring, oversight and assurance would be managed through the contracting processes.

- **Lincolnshire Voices Report and Patient and Public Involvement Annual Report:** members were referred members to the NHS Lincolnshire ICB People and Communities Involvement Annual Report for 2024-25 noting that the ICB has a statutory duty to involve patients and the public when planning commissioned services which would have an impact on service delivery and the decisions which would have an impact on services.

  It was noted that the report showcases examples of the work undertaken and will be ratified by the ICB Board at its public meeting in May 2025. The public will have an opportunity to see the evidence of where patient and public engagement took place.

  A discussion ensued regarding patient and public surveys and that the ICB had not routinely published full reports in detail. It was discussed that it would be beneficial to share such information to demonstrate the "you said – we did" going forwards particularly when respondents had taken the time to provide feedback. It was agreed that a summary of future survey responses would be made available to the public via the website as well as the full detail and analysis shared with relevant programme teams and at the SQPEC meetings.

  Members agreed to endorse the NHS Lincolnshire ICB People and Communities Involvement Annual Report 2024-25 and noted that this would be ratified at the ICB Board meeting in May 2025. This is attached separately to this report.

  It was noted that the Lincolnshire Voices report summarises the feedback heard within Lincolnshire for Q4 2024-2525 and that future reports would include complaints and patient experience information. The report includes a collection of general patient experience of care and some specific highlighted areas. This is the first publication of the report that includes the Healthwatch feedback.

- **Urgent Emergency Care Clinical Audit Programme:** It was reported that the clinical audit programme was commissioned by the UEC Clinical Reference Group back in April 2023 following a review of UEC services in Lincolnshire. A subsequent review of the ICS UEC Clinical Audit Programme took place in January 2025.

  The initial request was to follow up on the ECIST 'missed opportunity' audit which identified irregularities in the use of clinical pathways, inappropriate referrals to Emergency Departments and the need to reduce activity through EDs instead of Assessment units or Same Day Emergency Care which identified similar findings and opportunities for learning. Discussions took place regarding those patients that had been subject to over 12 hour waits in ED and that harm reviews had been undertaken. Further discussions ensued regarding understanding the delays and challenges at both the front and back door. It was highlighted that by having a Discharge Hub with representatives from across the system will seek to address this area. It was reported that plans are being developed to audit the Virtual Wards.

- **Director of Public Health Annual Report:** a copy of the latest Director of Public Health Annual Report was shared with members. Key highlights to note included the:

  - Demographics for Lincolnshire and life expectancy and that by 2043 this is expected to increase by 41%.
  - Management of long term conditions and the associated challenges.
  - The spend comparison for acute "v" primary care.
  - Profiling of personalised care through multi-disciplinary teams, community assets and the utilisation of evidence and care closer to home.
  - The recommendations were highlighted which included:

    1. Developing new relationships with the public where they are supported to take the lead for their health and care.
    2. Developing a renewed focus on prevention.
    3. Harnessing digital technology to innovate the delivery of care and use digital inclusion to avoid leaving people behind.
    4. Delivering person-centered care closer to home through integrated multidisciplinary teams.

5. Supporting and investing in the workforce to co-produce and embrace new models of care.

- **LMNS (Local Maternity and Neonatal System) Deep Dive:** an update was provided on the LMNS programme which is aimed at improving the quality, safety, and equity of Maternity and Neonatal Care as part of the NHS Long Term Plan including:-

  - **Safer:** Reducing the rates of stillbirths, neonatal deaths, maternal deaths, and brain injuries in babies.
  - **More Personalised:** Ensuring that care is tailored to the individual needs of women, babies, and families.
  - **More Equitable:** Addressing disparities in care and outcomes among different population groups.

  It was reported that the local priorities for the programme include the:-

  - Continued reduction in smoking in pregnancy and increase smoke free homes.
  - Translation – implementation of Card Medic APP.
  - New Maternity Information System - Badger system.
  - Listening to families – targeting seldom heard and hard to reach families. (MNVP Chair term of office ends in December 2025).
  - Infant feeding Strategy including Latch on Lincolnshire Campaign.
  - Improving efficiencies, reviewing data i.e. Deep Dive into Emergency and Elective Sections.

  An update was provided on the success, challenges and the future plans.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** there were no significant concerns or issues reported.

- **Lincolnshire Partnership NHS Foundation Trust Highlight Report:** it was reported that there is an emerging concern with the LDA Liaison Team. Members were asked to feedback any concerns to the Trust.

- **East Midlands Ambulance Service NHS Trust Highlight Report:** there were no significant concerns or issues reported.

- **System Partners – Local Authority Update:** there were no significant concerns or issues reported.

- **Primary Care Highlight Report**: there were no significant concerns or issues reported.

- **Operational Quality Assurance Group (OQAG) Update & Clinical Policies Sub-Group Terms of Reference:** it was noted that there had been minor changes to the Clinical Policies Sub-Group Terms of Reference. Members agreed to approve these.

Items for escalation to the ICB Board:-

- Assurance to be sought regarding the infection, prevention and control measures at ULTH acknowledging that there is further work to do.
- It was agreed that a summary of future patient and public involvement survey responses would be made available to the public via the website as well as the full detail and analysis shared with relevant programme teams and at the SQPEC meetings.
- The Committee agreed to consider receiving Patient Stories at future meetings.
- Urgent and Emergency Care Audit and the progress made to date.
- Director of Public Health Annual Report noting that deprivation is a major driver of inequality and that the promotion of self-care is vital.
- A deep dive was received on the Local Maternity and Neonatal System highlighting the key priorities.

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

Conflicts of Interest	Summary of conflicts
No conflict identified	

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

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

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

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

Is the report confidential or not?
Yes ☐ No ☒

People and Communities Involvement Report 2024-25

April 2025

Foreword

Welcome to the 2024/25 Annual People and Communities Involvement Report for the Lincolnshire Integrated Care Board (ICB). This report summarises the diverse range of involvement activities undertaken throughout the year, highlighting the significant impact of community voices on the design and delivery of healthcare services in Lincolnshire.

Fundamental to our approach is the belief that hearing from people and communities can truly transform how services are designed and delivered. By actively engaging with patients, carers, representatives and the wider public, we ensure that our healthcare system is responsive, inclusive, and aligned with the needs of those it serves.

This year's report focuses on the various involvement activities carried out, showcasing the breadth and depth of the ICB's engagement efforts and the difference it has made. It also emphasises the importance of involving people in decision-making processes, illustrating how their insights and experiences contribute to better health outcomes and more effective service provision.

We invite you to explore the report and discover how people's and communities' feedback has shaped the projects and service delivery, driving improvements and fostering a healthcare environment that values and prioritises the voices of its community.

Thank you
ICB Engagement Team

Introduction

Throughout the report we have demonstrated how Lincolnshire Integrated Care Board (ICB) has met our statutory duties for involvement and are delivering our Lincolnshire People and Communities Strategy

The NHS Constitution sets out a clear message that the NHS should put patients and the public at the heart of everything it does – this annual involvement report explains how we have fulfilled our public involvement duty and gives an outline of how we work with people and communities and involve people in our decision making.

When we describe 'Our People and Communities in Lincolnshire', we mean our:

- residents
- people who access care and support (and those who do not)
- unpaid carers
- families
- staff
- stakeholders
- partner organisations
- community champions and leaders

About this document

Throughout this report, you will find numerous examples of the engagement and involvement activities that took place during the year 2024-25.

The report demonstrates the reasons behind the Integrated Care Board's (ICB) efforts to engage with people and communities, highlighting the positive impact these initiatives have had.

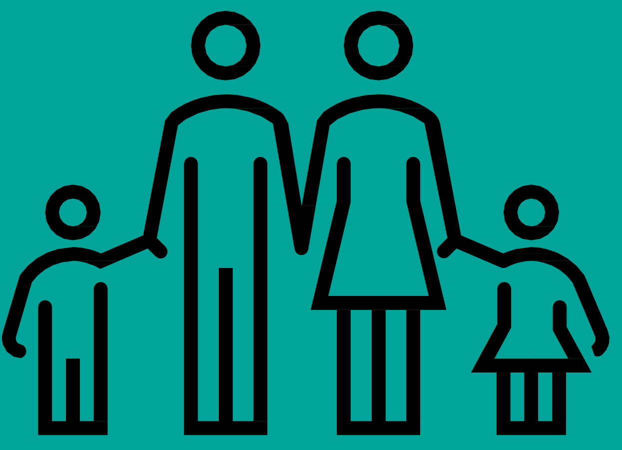
By showcasing these activities, we aim to illustrate the tangible differences made in various communities.

The focus of the report is our activities and the difference they've made. Towards the end of the report we provide more detail on our ICB, how we work collaboratively across Lincolnshire and explain our Statutory Duty to Involve our people and communities.

Contents

- Foreword and introduction
- About this document
- How the ICB listens and involves our people and communities
- Showcasing our involvement activities: Examples of activity and best practice
  - Wider population projects and activities
  - Involving people within Primary Care
  - Involving Health Inclusion Groups
  - Community Development
  - Current involvement projects
- About us and why we involve people and communities
- Working with others
- Using resources, insight, data
- Conclusion

How the ICB listens and involves people and communities



On the following pages, the examples presented demonstrate how the ICB is delivering the involvement principles set out in our People's and Communities Strategy.

These involvement activities also demonstrate:

- How we have met our involvement duties
- How we are delivering on our people and communities strategy
- How we have proactively reached out into the community
- How we have worked with many partners across the sectors to encourage inclusive involvement
- How we have involved people and communities who face health inequalities
- How working with diverse communities can make a difference

Our commitment to involving people and communities

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

Delivering the following principles demonstrates and evidences our commitment to involving our people and communities.

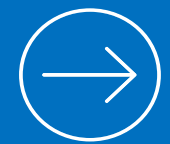
1. Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS

2. Start engagement early when developing plans and feed back to people and communities how their involvement has influenced activities and decisions.

3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect

4. Build relationships with excluded groups, especially those affected by inequalities

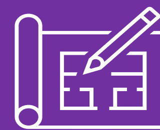
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners



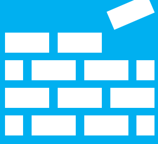
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust

7. Use community development approaches that empower people and communities, making connection to social action

8. Use co production, insight and engagement to achieve accountable health and care services.



9. Co produce and redesign services and tackle system priorities in partnership with people and communities.



10. Learn from what works and building on the assets of all ICS partners networks, relationships, activity in local places.

Our impact in numbers

The numbers highlighted opposite showcases the engagement activities throughout the year. The total number of communities visits we reached was 56.

Survey participant numbers also hit a milestone with over 10,000 individual response across members of the public and staff.

Our social media posts reached 1,843,529 users, making 2,053,630 post impressions in users timelines, with an engagements rate of 3.28%. The ICB gained 1,450 new followers across our social platforms.

Additionally, the number of new bulletin sign-ups grew by 387 with most of these individuals aged under 25 due to our work over the year at freshers fayres and colleges to reach our younger population.

These figures underscore the successful efforts in enhancing community involvement and outreach.

33 surveys published

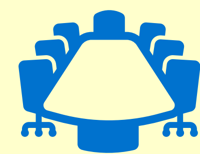
10 online meetings with 81 attendees

10,240 survey responses received (including 407 staff responses)

Attended **32** events

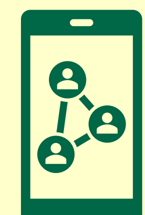
56 community visits

Spoke to **1256** people in the community



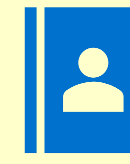
42 co-production meetings with 66 attendees

3 Patient Council meetings held & 9 Locality PPG meetings



Social media reached **1,843,529** users. Gained **1,450 new** followers

9,967 contacts on newsletter distribution list



11,000+ on stakeholder database

387 signed up to receive the bulletin

ICB Engagement

Showcasing our engagement and involvement: demonstrating best practice and the difference it makes.

This section highlights the various activities and initiatives that the ICB has undertaken to engage with communities effectively.

These examples demonstrate our commitment to good practice and the positive impact of the efforts of the ICB's involvement team and various projects.

Through these activities, we have ensured that the voices of our patients and the public are heard, valued, and acted upon, fostering a culture of inclusivity and continuous improvement.

These activities are described in more detail on the following pages.

10 year plan

GP Strategy

Frailty & Older People

Women's Health Hubs

AQP MSK

Bowel Screening teachable moment

Community Diagnostic Centres

EDI strategy

Gender Identity

Experience of Care

Continuing Healthcare Policy

Continuing Healthcare Equity of Choice

Our Shared Agreement

Pain Management

Palliative and End of Life Care

Pressure Ulcers

Respiratory Care

Prostate Cancer

Lincolnshire maternity & Neonatal

Lincolnshire maternity military partnership

Special Educational Needs and Disabilities

Click on the tiles to go to more examples of involvement within specific projects and programmes

Click this symbol to return to this page

10 Year Plan

In October, the government launched a national conversation about the future of the NHS, inviting everyone to share their experiences via the Change NHS portal. This initiative aims to help shape the NHS 10 Year Health Plan. NHS England outlined a programme of tiered engagement, encompassing national, regional, and local activities.

Lincolnshire ICB led and coordinated local engagement and promotion across the system.

To support this, the government and NHS England developed a "workshop in a box." This framework was designed for use and adaptation, allowing local organisations to tailor it to their needs. It focuses on the three areas of change called shifts identified by the Secretary of State: prevention, digital transformation, and community care.

NHS organisations used the "workshop in a box" to facilitate conversations with staff and contribute their views to the national portal.

The 10 year plan will be built around three proposals, called shifts and will be the focus of the engagement:

- **Moving more care from hospitals to communities** moving care from hospitals into homes, closer to the places people live and their community
- **Making better use of technology** using digital technology promises faster, higher quality, more connected care.
- **Preventing sickness, not just treating it** preventing rather than simply treating sickness will keep people healthier for longer

Our approach

- The ICB planned and coordinated activities across LCHS, LPFT & ULTH
- Desktop exercise to utilise previous valuable insight and feedback
- Produced Lincolnshire relevant materials and media
- Adopted NHSE's "workshop in a box" to assist delivery of engagement
- Utilised existing planned activities and visited known community groups
- Ensured underrepresented communities received targeted communications to promote the survey

1 2 3 4 5 6

Engaging our communities

- Promoted national survey through networks and engagement bulletin
- Had a united social media campaign
- Visited 5 communities
- Spoke to 99 people
- Held 3 online events
- Presented at ICB's Patient Council
- Presented at ULTH's Patient Panel

Working together across Lincolnshire's NHS

- ICB lead the engagement activity working closely with three trusts ensuring a unified approach
- Engagement colleagues all had a share of the activities to deliver
- All feedback was collated and submitted via the ICB
- Worked with existing contacts to publicise the national survey

The difference it made

- Our Lincolnshire's populations voice contributed to the national 10 yea plan
- Marketing materials were produced to encourage participation in national survey – "make Lincolnshire heard" – video created
- Collaboration across the NHS organisations ensured effective engagement in a short timeframe
- A single report was produced and shared amongst the organisations
- Worked with LVET and Healthwatch Lincolnshire and shared materials
- Collectively the survey was promoted to encourage participation.

GP Strategy

The NHS in Lincolnshire recognised that primary care services are under considerable pressure with inequalities in outcomes experienced by patients, workforce gaps and high workload. It was agreed that we needed to work differently across the whole health and care system to manage these pressures and develop a Primary Care Strategy to support this.

The strategy is guided by national policies, tailored local plans, continuous insights, and feedback from the people and communities across Lincolnshire. It also involved the collaboration of primary care staff and wider system partners.

Our aim is to support the delivery of our vision for health and care: ensuring that the people of Lincolnshire have the **best start in life and are supported to live, age, and die well** (Lincolnshire's Integrated Care Strategy (ICS) vision).

We would love to hear your experiences and feedback in order to help inform and shape GP services in Lincolnshire

We are interested in hearing about various aspects of your healthcare experiences, including how you manage minor illnesses, long-term conditions, and major health concerns. Where do you go to seek advice, care and treatment? How easy or difficult it is to book appointments?

How to Participate:
We invite you, your friends, and family members to take a few minutes to complete our survey.

- Visit: www.bit.ly/GPservicesLincolnshire
- Alternatively scan this QR code with your camera phone to access the survey online

SCAN ME

Public & Patient participation

Engagement on GP strategy

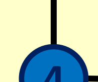
- ICB engagement team developed and lead on the activities included in the engagement plan.
- Included activities to ensure those underrepresented communities had opportunities to get involved.
- Produced promotional leaflets and posters to hand out.
- Conducted a scoping exercise, reviewing all existing insight gathered previously in relation to Primary Care.

Public and stakeholder involvement

- Visited **31 community meetings and events** reaching **705 people**
- Engaged with underrepresented communities such as those from deprived areas, LGBTQ+, people with mental health concerns and English as a second language
- Produced an online survey promoted through existing networks, ICB engagement bulletin and social media

Received **2466 responses to the survey**

- All feedback was collated into a report for consideration.



The aim of the engagement

The aim of the engagement was to find out:

- Challenges faced by the public when trying to access Primary Care
- Perceived impacts on communities across Lincolnshire
- What's most important about primary care
- How people with minor or major conditions currently access primary care

The difference it made

- Feedback from this engagement informed and shaped the development of the GP Strategy for Lincolnshire and how future services will be delivered
- The engagement report was considered by Primary Care Leads and Clinicians, PC3, as well as teams working on the development of the GP Strategy in Lincolnshire.
- Stakeholders are fully informed and aware of the challenges faced by patients
- Increased engagement with local communities
- Delivery plan developed

Frailty & Older People

Public & Patient participation

The Lincolnshire Integrated Care System partnered with health and wellbeing organisations across the county to promote healthy ageing and reduce the risk of onset and progression of frailty.

This collaborative effort encourages older adults to stay active, continue doing the things they love and maintain social connections, all key factors in supporting independence and reducing the risk of onset and progression of frailty.

It was recognised that a campaign of communications and messages were required to enable people to access useful information and services.

Aims of the campaign

The campaign was designed for adults over the age of 65 and the key aims were to:

- Signpost and provide information on how to access activities to support people to **age well**.
- Signpost to **local wellbeing hubs**
- Encourage the importance of **keeping well**
- Encourage the importance of continuing to **do the things you love** when you get older
- Create awareness around the things carers/family/friends/neighbours can do to **support/help ageing.**

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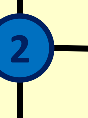
Public & Patient participation

The aim of the co-production group

- ICB engagement team established and led a frailty co-production group
- Members of the public were approached to support the production of the information campaign
- The aim of the work with the co-production group was to understand what information and support people want to receive as they age, what motivates them to keep well for longer

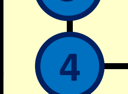


The difference it made

- Fully engaged co-production group
- Creation of a marketing campaign that aligns to the target audience, co-produced with members of the public and the programme team to encourage people to 'Age Well'
- Materials produced include videos, social media posts, leaflets and a signposting booklet
- The ICB Engagement team were finalists for the 'Co-producing Together Award' in the Lincolnshire Care Awards for their work on this project.

Co-production

- **180 people aged over 60** expressed an interest in being involved in our engagement activities to support the frailty programme.
- **14 people joined our co-production group** to help produce a marketing campaign.
- Held **two face to face co-production meetings and one online co-production meeting**
- The group also explored the most appropriate ways to reach people is and how to motivate those who are not already involved in activities to join.



Material produced

Link to the videos:

- Let's Age Well!
- Let's Age Well - Walking Football
- Let's Age Well - Alison

Social media post examples below:

Women's Health Hubs

In July 2023, the Women's Health Strategy for England set out the 10 year ambitions for boosting the health and wellbeing of women and girls, and for improving how the health and care system listens to women by using a life course approach.

The strategy encourages the expansion of women's health hubs across the country to improve access to services and health outcomes. These hubs will bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities.

In Lincolnshire, the integrated care system (ICS) will work together to provide these services by establishing Women's Health Hubs.

We involved women and girls throughout the whole of the process to ensure we set up the services in the right way that meets their needs in a rural county.

Public & Patient participation

Co-production

- March 2024, we recruited 10 members to join the co-production group
- The aim of the group was to discuss the requirements of Women's Health Hub
- First meeting consisted of 2 clinicians, programme director, project manager, 4 members of the public and 2 engagement leads

The difference it made

- Discussed the stages of a woman's life
- Gave insight into the type of advice, guidance, care and treatment needed for each stage
- Considered several solutions - both digital and physical hubs
- Looked at best practice being delivered elsewhere
- This work informed the next stage of the involvement process

Surveys

- Ran a survey over Summer 2024
- Views of women and girls gathered through social media to encourage participation
- Received over 1,100 responses
- Shared with over 10,000 stakeholders

Community conversations

- Visited 11 groups across Lincolnshire
- Met with 120 people and discussed women's health hubs
- Held 6 online meetings - during the day and in the evening. 31 people attended
- Leaflets promoting the survey were distributed during community visits

The difference it made

- Insights from both the surveys and face-to-face conversations continues to influence the steering group.
- Design of the digital hub has been procured based on feedback
- 3 pilot Women's Health Hubs have been launched in local communities taking into consideration that Lincolnshire is a large county and travel can be difficult
- Connections with a school have been made and the ICB will continue to work with the students in the future

Women’s Health Hubs

The national strategy sets out the priority areas related to specific conditions or areas of health where issues or opportunities were highlighted.

These are:

- Menstrual health and gynaecological conditions
- Fertility, pregnancy, pregnancy loss and postnatal support
- Menopause
- Mental health and wellbeing
- Cancers
- Health impacts of violence against women and girls
- Healthy ageing and long term conditions
- Implementation and monitoring progress

The ICB’s involvement team are supporting the Women’s Health Hubs’ project team to have access to a range of information and feedback from Women in Lincolnshire.

Click here to see the national Women’s Health strategy

Working with others

Women’s Health Conference

7

- In November 2024, Lincolnshire held it’s first Women’s Health Conference
- Findings from the engagement activities were presented at the conference
- The attendees were from across the county including clinical leads, service providers, voluntary / community sector.
- Attendees heard two patient stories during the conference - a member of the co-production group and a young woman

8

Working with schools

9

- As part of the community visits, we visited a girl's school in Grantham
- Students produced a video about what they wanted to see for Women’s Health
- This was presented at the Steering group and sparked a good debate about the future of Women’s health and the importance of the younger voice.

10

What now …

11

- Work continues to map gaps identified in the feedback with delivery plan
- Further engagement activities are being planned with groups such as BAME women and travellers
- Plans to gather feedback on digital hub

12

The difference it made

- Work carried at the has informed the start of Lincolnshire’s Women’s Health Strategy
- Hearing from the patients' stories has changed the way clinicians practice in the future
- Working with the girls’ school in Grantham has informed the way with connect with young people
- The engagement report is used to inform the delivery plan
- Public feedback is at the heart of this programme of work

Hearing one of the patient stories at the Women’s Health Conference 2024

AQP MSK Physiotherapy

The AQP MSK Physiotherapy Service is provided from several locations and providers (both NHS and private providers who hold an NHS contract) across Lincolnshire. There are currently 13 providers offering services both in a community and hospital setting in the county. AQP stands for Any Qualified Provider Scheme. It means that, after a GP refers a patient, the patient can choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.

The current service enables patients with a diagnosed Musculoskeletal condition to be referred for Physiotherapy treatment, this may be for a single session or multiple appointments.

A review of the MSK physiotherapy service was undertaken to ensure that it was commissioned based on clinical evidence for treatment and sought views. We also wanted to ensure that any service commissioned was based on the current models of care which includes assessments and diagnosis by First Contract Practitioners, use of digital tools and technology, and the use of group rehabilitation.

Public & Patient participation

1. Our approach

- Engagement plan developed to outline the approach
- Stakeholder analysis undertaken
- Engagement undertaken early in the service review to gather current experiences in addition to views on future service delivery

2. The difference it made

The findings were analysed and reported to:

- The AQP MSK working group for full consideration in the programme
- The ICB Executive Board as part of the service review
- The AQP MSK Physiotherapy Clinical Reference Group to shape the discussions around the future service provision and draft service specification

3. Exploring the future service with public and stakeholders

- A patient/public survey and staff/stakeholder survey were developed to ensure that the voices of patients, public, staff and key stakeholders were considered in the development of service specifications and new contracts for MSK services
- Both surveys were open from beginning of October – end of January 2025.
- 390 responses received from patients and members of the public
- 86 responses received from staff and stakeholder survey

Bowel Screening - Teachable moment

Public & Patient participation

The Teachable Moments project for the Rapid Access Bowel Cancer Pathway, was initiated by a Colorectal Advanced Clinical Practitioner in ULTH at Lincoln. It aims to provide supportive resources and information to individuals who underwent diagnostic tests for suspected bowel cancer but did not receive a cancer diagnosis.

The goal is to educate people on the procedures they experienced and encourage lifestyle changes to reduce future risks. The resources produced were also designed to be shared with family and friends to promote healthier choices.

Funded by the cancer team in the ICB, the project involved collaboration with the ULTH patient and reader panels for feedback. The resources were produced and ready for distribution on 31st March 2025. An impact survey will be conducted in the first quarter of 2025/26 to assess the project's benefits.

1. The approach

- Secured funding to create resource
- Commissioned Turbine Creative to create resources
- Commitment to co-produce the resources
- Recruited volunteers through ULTH's people panel to assist with co-production and design

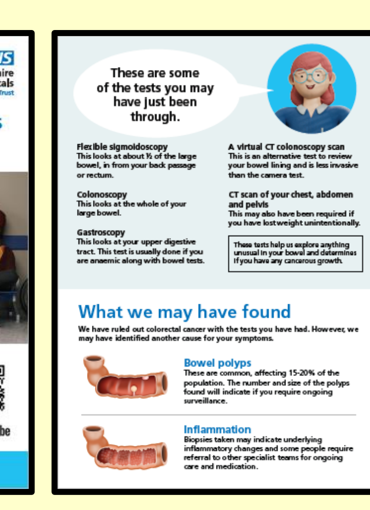
2. The difference it made

- A leaflet and animations were produced
- Example pages below
- Including members of the public in the working group enabled the design team to create information that is more meaningful and relevant to a wider audience
- The video is on the NHS Lincolnshire ICB YouTube channel: https://youtu.be/BtJE9MS--nY?si=-swtBZ6Nj15UGIHs

3. Co-producing materials

- Initially recruited 4 people to help with design and production
- Reduced to 2 dedicated members of the public throughout the process
- Met as a group with Turbine Creative to work through their design and content
- Gave feedback and critiqued the content, design visuals, background music for animation and design of the characters.

4.



(Examples of the two of the pages in the leaflet)

Community Diagnostic Centres

Public & Patient participation

Experience-based design – Part 2

The experience-based design (EBD) approach is a method aimed at enhancing the experiences of patients by capturing their interactions with healthcare services. This approach involves examining both the practical and emotional journeys individuals undergo when engaging with specific pathways or services.

In accordance with NHS England requirements, part one of the EBD study started at Grantham Community Diagnostic Centre (CDC) early last year (January 2024). The feedback collected during this phase led to a successful bid for funding and several significant improvements at the CDC, including the installations of water stations and televisions in waiting rooms, enhanced signage throughout the site, and the addition of artwork around the building.

As part of our ongoing commitment to this programme of work, we conducted the study again (part two) to continually monitor patient experiences and assess the impact of the improvements implemented in part one.

1 EBD engagement approach

- ICB Engagement team lead part 2 of the experience-based design study for Grantham CDC.
- Part 2 had to be conducted with 6 – 9 months of part one.
- The aim of this approach is to understand how patients 'felt' at each stage of their journey and to identify areas for improvement to improve the patient experience

2 The difference it made

- The report collated the responses from the engagement exercise
- This was reported to both NHS England and Lincolnshire CDC programme group.
- Patients were very satisfied with both the level of care received at Grantham CDC and the facilities available. In particular, patients commented on the 'welcoming and friendly atmosphere' and how they were put at ease by staff.

3 Public and patient engagement

- Produced promotional leaflets and posters to display in Grantham CDC
- Designed and published posts across social media channels to increase response rate
- Worked with CDC staff to display and promote the survey
- **Received 52 responses** to the patient experience survey

4

Equality, Diversity & Inclusion Strategy

In April 2024, Lincolnshire Integrated Care Board approved and published its four Equality, Diversity and Inclusion (EDI) objectives that the ICB will focus on over the next four years (2024 28). These four objectives were:

Objective 1: Leaders to drive the Equality, Diversity and Inclusion agenda and create a sense of belonging for our workforce and the diverse communities we serve.

Objective 2: Strive to be more compassionate, diverse and inclusive by fostering an ethos of wellbeing, inclusion and belonging.

Objective 3: Improve our knowledge and understanding of health inequalities within the local population and strengthen our approach to tackle health inequalities in Lincolnshire health care system.

Objective 4: To comply with the Lincolnshire Integrated Care Board Equality, Diversity and Inclusion responsibilities and ensure that there are tools in place to monitor the impact of the way we fulfil our ICB duties.

Engagement included only objectives 1, 2 and 4 (engagement on objective 3 will be more specific and undertaken by the Health Inequalities Team).

Public & Patient participation

1 Engagement on strategy

The engagement ran between 9 January and 23 February 2025. A survey was produced to help us understand:

- Whether there was a need for additional objectives or changes
- What matters most to the public and staff when it comes to equality, diversity, and inclusion.
- What improvements could be made

2 The difference it made

- Feedback received from the public, staff and stakeholders shaped the Equality, Diversity and Inclusion Strategy for Lincolnshire Integrated Care Board

3 Our approach

- Developed a Communications and Engagement Plan.
- Alternative formats of the survey were offered. Surveys were posted to those unable to access the survey online.
- Survey promoted through the ICB's stakeholder database and partners' networks.
- Worked jointly with the Health Inequalities Team to ensure full engagement over all four objectives

4 The difference it made

- Findings of the engagement reported to Lincolnshire Integrated Care Board Equality Forum.
  The findings from the report has shaped the ICB's Equality, Diversity & Inclusion Strategy for objectives 1, 2 and 4.
- An EDI Strategy delivery plan developed.
- Engagement helped to ensure that the Lincolnshire Integrated Care Board is focussing on the right priorities and take actions that will make a difference a positive impact on our workforce and improve outcomes for the local population

5 The response

- 95 responses to the public survey – including responses from community groups and voluntary organisations.
- 10 responses to the staff and stakeholder survey.
- Public, Staff and Stakeholder Engagement report completed

6

Gender Identity

The ICB is committed to making sure that all staff and individuals who require health and social care services in Lincolnshire have confidence that these services are responsive, inclusive, person-centred, and built on our principles of compassion, dignity, respect, and safety.

We recognise that working in and accessing health and social care services as a transgender or non-binary person can sometimes be a challenging experience.

The Involvement Team engaged from 4 July to 23 September 2024 to inform the Gender Identity Equality Framework, which will establish standards for gender non-conforming individuals accessing services and receiving care.

Public & Patient participation

1. Aims of the engagement

- Gather feedback on what works well and what needs improvement for transgender and non-binary patients
- Invite participation from patients, families, and staff to develop the Gender Identity Equality Framework by sharing their stories & experiences.
- Understand staff perspectives on effective practices and areas needing improvement.
- Identify ways to enhance staff experiences and knowledge
- Define characteristics required for an excellent service for transgender and non-binary patients

2. The response

- Received 104 responses to public survey
- Received 38 responses to the staff survey
- Established a Gender Equality Framework project group with a range of stakeholders.
- Engagement report produced.
- 61 patients, family / carers and 8 members of staff expressed an interest in be involved in future work

3. Our approach

- Established a Gender Identity Equality Framework sub-group.
- Developed a Communications and Engagement Plan.
- Produced and distributed 779 promotional fliers and posters.
- Engaged the Lincolnshire population through digital methods, community events, and conversations, targeting LGBTQ+ groups.
- Attended Lincoln Pride, Skegness Pride and university/college fresher events.
- Produced two surveys: one public-facing and one for staff

4. The difference it made

- Increased engagement with the LGBTQ+ community.
- Feedback shaped the Gender Identity Equality Framework, pending approval.
- Framework discussed at Trans Day of Visibility on 31 March 2025.
- Launching Gender Equality Identity Co-production Group in early 2025.
- Lived experience contributors will help to develop training packages
- Communicated to survey participates who expressed an interest in further involvement
- Reported findings to the Gender Equality Framework Group.
- Fully engaged and collaborative working demonstrated. Stakeholders engaged and aware of patient and staff challenges.
- Established working groups to drive improvements.

Experience of Care

The Equality Forum run by the ICB is also attended by all three NHS Trusts in Lincolnshire.

As part of the Forum's Equality and Diversity Action Plan, it was identified that we needed to understand whether accessing NHS services was different for certain sectors of our communities. For example, those who identify as having a protected characteristic.

This resulted in a survey being created to explore the barriers and challenges of accessing an NHS service.

Public & Patient participation

1 Our approach

- The survey, **launched in June 2022**, has been ongoing throughout 2024/25, with **data and findings analysed monthly.**
- We actively promote this survey via our website, social media, our involvement bulletin "The Contributor," and at our face-to-face events.
- As we analyse the data and responses, we aim to reach out to underrepresented communities, those we seldom connect with, and individuals who identify as having a protected characteristic

2 The difference it made

- Feedback received has been instrumental in shaping and informing other programs of work. For example, insights have been applied to enhance digital services, transition care from hospitals to communities, and support prevention initiatives, all contributing to the 10-year plan engagement. Further insights were gathered to help inform the GP strategy.
- The analysis is conducted monthly and reported to System Quality Patient Experience Committee (SQPEC) on a quarterly basis, as well as the ICB's Operational Quality Assurance Group meeting.
- This type of engagement helps us to maintain a continuous engagement cycle and another avenue to gather valuable insights.
- We use this survey to signpost people when they want to feedback to ICB / trusts and no other appropriate forum is available.

3 Year-round engagement

- During 2024/25, we had 270 responses.
- 164 patients were happy to share their experiences through patient stories.
- 116 patients have signed up to receive our involvement bulletin every fortnight.
- Monthly reports are produced.
- The survey continues to be promoted through the involvement bulletin..

4

Continuing Healthcare in care homes

NHS Continuing Healthcare (CHC) is a package of ongoing care that is arranged and funded by the NHS for people who are eligible after assessment of their health and social needs.

Continuing Healthcare can be provided in a variety of settings outside hospital, such as in your own home or in a registered care home.

The contract for the NHS continuing health care provided at registered care homes expires on 31 March 2025.

Public & Patient participation

Engagement on CHC policy

- Engaged with the public and staff between 26 June 2024 and 11 August 2024 to understand their views to help shape the continuing healthcare service in care homes before the procurement process.

The response

- Developed a Communications and Engagement Plan
- Produced promotional materials
- 37 staff attended staff engagement events (2 online; 1 face to face)
- Received 7 responses to the public survey.
- Received 11 responses to the staff survey.
- Received one email
- 4 people (3 members of public and 1 staff) expressed an interest in being involved further
- Established a Continuing Healthcare Care Homes Project Group
- Engagement findings analysed and report produced

The difference it made

- Fully engaged Continuing Healthcare Care Homes Project Group.
- Findings of the engagement were reported to the Continuing Care Programme Board.
- Findings of the engagement help the re-procurement process by shaping the service specification
- 78 providers registered interest in the tender and 43 applications were received. Of the 43 applications, these equated to 82 care homes (47 nursing and 35 residential homes

Continuing Healthcare – Equity and Choice policy

NHS Continuing Healthcare (CHC) is a package of ongoing care that is arranged and funded by the NHS for people who are eligible after assessment of their health and social needs.

The ICB undertook engagement on proposed changes to the Continuing Healthcare Equity and Choice Policy.

Service users, their friends, family and representatives, the public and staff were encouraged to share their views during the engagement.

Public & Patient participation

1 Engagement on CHC policy

- Engaged with the public and staff for a seven-week period between 2 October 2024 and 19 November 2024 to understand their views to help inform the new Continuing Healthcare Equity and Choice Policy and understand what impact the new arrangements might have.

2 The difference it made

- Feedback has helped to shape the NHS Continuing Healthcare Choice and Equity Policy.
- Stakeholders are fully informed and aware of public and staff views.
- Personal stories were shared.
- Findings of the engagement were reported to the Continuing Care Programme Board.
- The Programme Board approved the policy and agreed to complete all the recommendations contained within the report

3 The response

- Developed a Communications and Engagement Plan including frequently asked questions.
- 8 attended a public engagement event including service user representative and stakeholders.
- 8 attended a staff engagement event with attendees from home care providers, care homes, ICB and LPFT.
- Fully engaged system Project Team.
- Received 27 responses to the public survey.
- Received 7 responses to the staff survey.
- 12 respondents would like to hear more about ways that they can get involved in shaping NHS services.
- Engagement findings analysed and report produced

Our Shared Agreement

Our Shared Agreement is a movement to create a better relationship between people and health and care in Lincolnshire.

We all want the best life for ourselves and those we care for, whatever our age or stage of life.

Our Shared Agreement is making this happen for everyone. It's helping health, care, people, and communities to work together in new ways. We're sharing knowledge, building skills and confidence, and forming relationships that help us live our best lives.

Our Shared Agreement is built on **Five Foundations**, which were co produced by people with lived experience and colleagues from across the health and care system.

They have been designed to help demonstrate what a better relationship is and could look and feel like for both citizens and the health and care workforce.

Launching Our Shared Agreement

- In March 2024, colleagues and people with lived experience presented Our Shared Agreement to the Better Lives Lincolnshire Leadership team
  - Launched at the 'It's All About Conference and Expo' in July 2024
- Officially launched by **Debbie Barnes**, Chief Executive of Lincolnshire County Council, and **John Turner**, Chief Executive of NHS Lincolnshire ICB

1

2

The difference it made

- The presentation secured support and commitment to Our Shared Agreement, which is now at the heart of Lincolnshire's Better Lives Lincolnshire ICP Strategy & NHS Lincolnshire Joint Forward Plan

MHDLDA

- Our Shared Agreement has been embedded in the Mental Health, Dementia, Learning Disability and Autism Alliance (MHDLDA)
- The Mental Health Transformation programme have fully embedded Our Shared Agreement and the Five Foundations throughout their work

3

4

The difference it made

- People with lived experience are part of the MHDLDA Executive group and all its delivery groups.
- The Celia Evershed Fund, established for local VCFSE organisations, honours Celia's passion for improving lives in Gainsborough.
- Community Mental Health and Wellbeing Hubs exemplify Foundation 3 (**) successfully supporting local communities with advice, opportunities, and friendship

Joining the movement

- A range of Our Shared Agreement and Five Foundations digital and print assets have been developed – see Z-Card opposite.
- These assets help our It's All About People Champions, stakeholders, partners, workforce, and the public to build awareness and encourage others to 'Join the movement' and use the Five Foundations in their work

5

6

Our Shared Agreement

** Foundation 3: *'Working together for the wellbeing of everyone'*

Collecting people's stories

Colleagues, teams, services, organisations, and communities have been working in ways that align with Our Shared Agreement for many years. There is a need to showcase and share the great work that is going on across Lincolnshire.

The **It's All About People website** is one of the locations where people can learn more about Our Shared Agreement and read, listen to or watch peoples' stories and experiences of health and care.

Telling peoples' stories is the most powerful methods to explore the importance of Our Shared Agreement and how working in a personalised and strengths-based way can improve outcomes for people, the health, care and wellbeing workforce and the wider system.

Even though I am a severely learning-disabled wheelchair user, I can weight bear for short periods of time. Using the 5 Foundations has allowed me to achieve a life that is more normal and is worked around what I love.

Foundation 1 - Being prepared to do things differently
I can access and use a recumbent tricycle.

Foundation 2 - Understanding what matters to ourselves and each other
I can get out into the countryside on a local cycle track and see nature around me, including the animals I enjoy seeing, such as birds, rabbits and squirrels.

Foundation 3 - Working together for the wellbeing of everyone
My support company worked with my Mum, the NHS and Social Services to get appropriate equipment to help me get onto and off the trike safely and easily. This meant my physical well-being was improved as well as my mental health.

Foundation 4 - Conversations with and not about people
I was involved in all the meetings that led to choosing appropriate equipment, and how it should be used.

Foundation 5 - Making the most of what we have available to us
Even though I need 24-hour support, all the equipment and staff training has meant that I can go out for rides not only with my mum but also with staff who support me. This means I can go out on my trike more often than I could if my mum was the only person who could take me.

Without the 5 Foundations my life would be dramatically restricted

Pain Management

Medicines optimisation involves various activities to ensure medicines are used effectively for the best results. It aims to help individual patients and larger groups by managing illnesses now and preventing them in the future.

The goal is to provide safe and effective medicines that are also cost-efficient for the NHS. It focuses on putting patients at the centre of their care and encourages them to make decisions about their medicines, whether prescribed or over-the-counter.

The goal of Medicines Optimisation Team at the ICB is to help patients to:

- improve their outcomes;
- take their medicines correctly;
- avoid taking unnecessary medicines;
- reduce wastage of medicines;
- and improve medicines safety.

As part of this work the team are working with patients around pain management and pain medication and has established a patient Reference Group, to support and guide our local projects.

Public & Patient participation

1

Establishing Patient Reference Group

- Recruited volunteers through an expression of interest process
- Guidelines produced to explain to applicants what to expect by being involved
- People were asked to complete an application
- Received a small number of applications who were recruited on the group
- Terms of reference agreed

2

Patient Reference Group

- Everyone recruited to the group all live in Lincolnshire and have experience of living with pain
- The group has met several times since the summer
- Aim to meet every 2 months
- The group will discuss project related topics.
- So far, the have given feedback on the online content for pain management
- Members of the Patient Reference Group have all been invited to take part in activities run by the project, such as pain café or empowered relief workshop to gather feedback to shape future activities.

Pain Management sessions

A number of activities have been held for people who live with pain. These activities are:

- Lincolnshire Pain Cafe
- Lincolnshire Sleep School
- Lincolnshire Eating for Pain
- Lincolnshire Empowered Relief

Lincolnshire Sleep School

- Three session workshop, ran twice in 2024 and planned again for June 2025.
- Currently the only resource for CBTi in Lincolnshire
- 82 registrations and 50 participants over the three sessions in winter 2024

Lincolnshire Eating for Pain

- Ran in November 2024 as an extension of Lincolnshire Pain Café.
- Session facilitated again for March 2025 to 12 patients (without direct advertising)

Lincolnshire Empowered Relief

Interesting to learn about how we process pain

This session provides excellent understanding of how relaxation exercise can calm our nervous system and help counteract pain.

- 10 sessions run since July 2023
- 225 participants attended
- 3 presenters trained

Mindfulness meditation to concentrate on the breath was perfect as it gives me a tool to take with me wherever I am.

This session has provided the last piece on the puzzle of how to manage my pain.

Lincolnshire Pain Cafe

Gaining an understanding of the processes of pain and looking at ways to help my pain

Hearing about other people's struggles and how they cope.

- 15 monthly sessions run since December 2023
- 209 participants
- 50 places booked on Live Well With Pain training
- 2 Face to Face Pain Cafes running in Lincolnshire

Palliative and End of Life Care

Palliative care and end of life (PEOL) care is support for people who are in the last months or years of their life.

PEOL care should help people to live as well as possible until they die and to die with dignity. People providing the care should consider people's wishes and preferences to help them live as well as possible until death.

In May 2024, the Engagement Team took on the role of leading the Lincolnshire Palliative and End of Life Care Co-production Group. Co-production brings people with experience of using services together with those who deliver them to work together to design services and make things better for everyone.

Working with the PEOL co-production group gives the ICB the opportunity to understand the importance of care at this time in people's lives from the perspective of patients, family members and carers.

Public & Patient participation

Our co-production approach

1

- To lead and facilitate the Lincolnshire Palliative and End of Life Care Co-production Group.
- To help support the delivery of the Palliative and End of Life Care Strategy and work programme.
- To understand people with lived experience including families, carers and stakeholders' thoughts, experiences and ideas in order to improve palliative and end of life care

2

The difference it made

- Fully engaged Co-production Group.
- Families and carers, provider and hospice views have been incorporated to help improve end of life and palliative care services.
- Feedback from the Co-production Group has led to updates and improvements to the Lincolnshire Palliative and End of Life Care website, which users have positively welcomed
- The Palliative and End of Life Care survey, launching in Spring 2025, has been reviewed and improved by the Co-production Group. This third annual survey will help compare progress and enhance services, with full analysis to identify trends for future improvements
- There is potential for increasing membership of the co-production group through the survey.
- The Co-production Group have reviewed, supported, made suggestions and provided ideas on the Palliative and End of Life Care Strategy 2023/28

Pressure Ulcers

The System Quality Group in Lincolnshire is committed to improving the experience for people who have been affected by pressure ulcers and those who care for them, as well as improving their quality of life.

A previous engagement exercise with staff and stakeholders had identified that there was a difference in provision across organisations in Lincolnshire. This feedback was considered by the standardising care work stream and further engagement was required to understand the reasons for this variation.

The aim of this engagement was to gather feedback on experiences of delivering or supporting care for those affected by pressure ulcers so that we can share and standardise lots of the great work that's already happening and work with stakeholders to make improvements in areas highlighted in the report.

Stakeholder participation

1. Engagement on pressure ulcers and tissue viability

- ICB engagement team sits on the pressure ulcer and tissue viability (PUTV) steering group to advise best practice
- Agreed to produce a survey to explore with stakeholders how care and treatment could be standardised

2. The difference it made

- Previous engagement work identified a need of further investigation
- PUTV steering group decided to proceed with further engagement to assist with standardisation of care and treatment of pressure ulcers

3. Working with the co-production group

- Co-production group has been recruited and formed to assist the workstream with key areas of work
- Have met twice and assisted with the survey questions to ensure the questions made sense and covered all the relevant points

4. The difference it made

- Stakeholders were involved from the beginning and recognised the importance of engagement – this helped with socialising of the survey and increased participation
- Members of the public were able to guide the questioning through co-production group

5. The response

- Survey sent directly to stakeholders and staff asking them to complete
- **107 members of staff/stakeholders** completed the survey
- **26 staff/stakeholders volunteered** to be more involved in the Standardisation of Care Workstream

6. The difference it made

- The feedback informed the pressure ulcer and tissue viability steering group and the standardisation of care workstream.
- Meeting held with the Standardising care workstream to pull out actions to complete based on feedback from the from the survey
- A communications plan has been developed following the feedback from the survey

Respiratory Care

Public & Patient participation

The Clinical Care Directorate sought to undertake a review of Respiratory services in Lincolnshire to understand current experiences and possible areas for improvement.

The aim of the engagement was to gather feedback from the public on:

- Their views on accessing respiratory services
- What is working well and what requires improvement within the service
- Experiences of care and patient outcomes

1. Review of respiratory care

- A survey was produced to gain feedback from patients with lived experienced of respiratory problems such as shortness of breath, a cough or an existing condition such as asthma or other lung condition
- The ICB engagement team worked with the project team for respiratory services to give advice and guidance for the engagement exercise.
- The project team were able to promote the survey and analysed the survey results and lead their own patient workshops

2. The difference it made

- All survey results were collated and used to inform the review and make recommendations for improvements to the care pathway for adults with respiratory symptoms and conditions.
- 4 workshops held with patients with lived experience - as part of this work, the programme team set up some workshops, providing the volunteers the opportunity to meet face to face and sit around the table with service leads to share experiences and help shape and design the services going forwards.
- Feedback from the survey and workshop reported into steering group from consideration, actions and delivery plan developed based on feedback gathered.

3. The response

- **309 responses to the survey**
- **96 people volunteered** to play a more active role in the programmer of work
- The **respiratory team held 4 workshops**, bringing together patients with lived experience and service leads to help shape the service

Prostate Cancer

Following feedback received via patient experience and through the engagement for the Living with Cancer Strategy 2023-28, the prostate cancer pathway was identified as an area of focus that requires review.

This review sought to investigate and identify current or recent patient experience and to work closely with patients, carers, clinicians, and others involved in the delivery of this service to improve the care, treatment and advice that patients receive.

1 Aims of the engagement

The aims for involvement members of the public within this project were to:

- Understand people's experiences on the prostate cancer pathway
- Explore the differences in experience for different population groups and communities
- Identify what works well and opportunities for improvements
- Invite patients to have a more active role in future developments of the programme
- Analyse the results of the engagement to redesign elements of the pathway with people with lived experience

2 Our approach

- The engagement team lead and facilitated the involvement activities for the project
- Fortnightly task group meetings held with the project team to ensure progress
- Engagement plan developed
- Co-produced the survey with the Macmillan Living with Cancer co-production group
- Sent information to 5000 patients referred for prostate cancer diagnosis in the last 5 years, inviting them to complete a survey
- Promotional posters sent to all pharmacies and GPs across Lincolnshire

3 The response

- This project will continue into Spring 2025
- At the beginning of March 2024 the survey was closed and the analysis started
- Received 868 responses to the survey
- 209 volunteers expressed an interest to be more involved with the project
- The results and draft report will be discussed thoroughly with the co-production group

4 Next steps

- The engagement report will inform the review of prostate cancer services in Lincolnshire and guide future improvements.
- Focus groups will analyse survey themes like geographical areas and common characteristics.
- Patients with lived experience will collaborate with clinicians and service teams to review pathways and identify improvement opportunities

Lincolnshire Maternity and Neonatal Programme

This year-long campaign, launched on 24 June to coincide with UK National Breastfeeding Week, was a commissioned by Lincolnshire County Council to:

- Increase awareness of the importance of breastfeeding.
- Provide information to new parents and pregnant individuals about breastfeeding support.
- Encourage businesses to be more supportive of breastfeeding in the workplace.

Several public engagement activities took place as part of this campaign.

1 Breastfeeding survey

- HWLincs were commissioned to gather information on Lincolnshire families breastfeeding journeys and experiences.
- 850 responses to the survey.
- Findings from the survey informed the Lincolnshire Infant Feeding Strategy for 2025 -2032.

2 Campaign materials

- Interviews were held with parents who attended local breastfeeding groups. This information was used to inform the key messages of the campaign and online resources created to provide breastfeeding support for families.
- Campaign materials featured local women and men and were advertised through various media channels, including radio, local press, social media, and an ITVX advert

All the materials and the women who supported the campaign can be seen at:

Breastfeeding | Better Births Lincs

Lincolnshire Maternity and Neonatal Programme

The Lincolnshire ICB Maternity and Neonatal program team works with partners to make maternity and neonatal care fair and equal for everyone.
We aim to provide safe, personalised, compassionate, professional, and family-friendly services. What happens during pregnancy and early childhood affects health throughout life, so it's crucial to work together to ensure healthy pregnancies.
Our team is dedicated to giving women the information they need to make informed decisions and providing support tailored to their needs. We focus on listening to the hopes and fears of the women in Lincolnshire.

Here are some of the ways we've connected with women in Lincolnshire.

International Students & Workers

- Concerns about maternity support for international students and workers led to the creation of online and printable resources
- The concerns focused on financial support and awareness of maternity pathways for pregnant women who have moved to Lincolnshire from outside the UK.
- The resources were developed together with local organisations including United Lincolnshire Teaching Hospitals Trust and local universities.
- Two webpages were created on the Better Births website for international students and the workforce, with printable formats distributed to relevant services and provider

International students| Better Births Lincs
International workforce | Better Births Lincs

Co-designed Postnatal Leaflet

- A diverse group of Lincolnshire mothers joined a focus group to co-design a postnatal toolkit on infant feeding.
- Led by the LMNP's Communications and Engagement Lead together with specialist midwives from United Lincolnshire Teaching Hospital Trust,
- The discussions focused on the content, style, and layout of the leaflet. By co-designing it with mothers, we ensured it is accessible to all families.
- The resulting leaflet is now available to all mothers, helping them get off to the best start with feeding, caring for, and comforting their baby. It addresses the challenges breastfeeding mothers may face, providing guidance and supporting information.
- It offers support and information for mothers who choose to combi-feed or formula-feed.

Public & Patient participation

Breastfeeding across borders

- During conversations with breastfeeding groups, the Communications and Engagement Lead identified a disparity in support for mothers who gave birth outside Lincolnshire, particularly at Diana, Princess of Wales Hospital in Grimsby.
- To address this, a working group was formed, including representatives from Grimsby Hospital's Specialist Midwives team and Lincolnshire County Council's Infant Feeding and Early Years team.
- The collaborative approach led to a successful strategy and information-sharing system, improving support for breastfeeding women in Lincolnshire

Lithuanian Group

- A day with the Lithuanian Community Group in Boston, revealed key insights into communication and cultural differences in maternity services.
- Findings included: Lithuanian mothers are more likely to breastfeed due to extended maternity leave, and Lithuanian families face challenges like long working hours, poor health from low-paid jobs, and limited English skills.
- These insights highlighted the need for flexible healthcare delivery, multilingual literature, and translation services. Similar needs were noted for Polish families

Lincolnshire Maternity and Neonatal Programme

LMNP has worked with partners to improve engagement with Black and Asian families in Lincolnshire. In 2024, a working group was formed to improve maternal health outcomes for these families, as women of black ethnicity remain at a higher risk of maternal death to white women.

The group aims to raise awareness of cultural differences and identify steps to support these communities effectively and includes representatives from various Lincolnshire Maternity and Neonatal System providers.

In November 2024, the Lincolnshire Maternity and Neonatal programme team led activities to engage with these communities, identifying groups to connect with and building relationships with community leaders to better hear the voices of Black and Asian families.

A "Coffee and Conversation" event was run to start the conversation.

Aim and purpose of the day

1

- This was our first event for families in the Black and Asian communities in Lincolnshire. We focussed on Lincoln because we had established relationships in the area and recognised this was a good place to pilot the engagement activities.
- The purpose was to gather insight and feedback from Black and Asian women and their families of their maternity experiences.

2

Who attended

- 13 women from Black & Asian families
- Lincolnshire Maternity and Neonatal team
- Lincoln County Hospital Maternity staff
- Health Visitors
- Family and Baby workers
- Women's Health programme team

The difference it made

- Made families aware that we want to listen to their concerns
- Increase awareness of the support families can access

We gained an understanding of:

- The support families want and need
- How they want to receive that support
- Preferred methods of communication
- The cultural differences of maternity practices for families moving from outside the UK
- What works well and areas for improvements

- Some improvements have already been initiated in the delivery of maternity services.

Lincolnshire Maternity and Neonatal Programme

Digital engagement

The LMNP has seen an increase in engagement across all their digital platforms and the Better Births website.

Work has continued to improve and grow our digital connection to people and families across Lincolnshire.

This has included increased regularity of our posts this year and have developed a strong brand image to enhance our identity and trust in our content.

[Better Births Lincolnshire]

Better Births Facebook

- The Facebook page has seen a significant increase in engagement
- The reach has grown by 69.9%,
- Content Interactions are up: Comments, likes, shares, etc., are up by 55.9%.
- The number of times links in posts have been clicked has increased by 38.5%.
- 50% more people are visiting our page compared to last year.
- The number of followers on our page has decreased by 1.9%, however, those visiting our page are interacting and engaging more with our content.

Better Births Instagram

- The reach on our pages has dropped over the year
- There has been an increase in the content interaction, link clicks by those that visit our page.
- This indicates that the posts we are publishing are engaging and informative.
- We posted 403 Posts
- Increased our followers by 42% to 130

Better Births Website

The top 5 pages viewed for 2024 were:

1. Homepage – This is probably popular as its where people register their pregnancy. – 11,246 visits
2. Care during pregnancy – 2289 visits
3. Finding out you are pregnant – 1992 visits
4. Birth and beyond – 1750 visits
5. Breastfeeding – 1568 visits

Lincolnshire Maternity and Neonatal Programme

Beach in the Park

The ‘Beach in the Park’ is an annual family fun day run in Boston by Boston Borough Council.

Over recent years the beach has proved popular with families and offers a great opportunity for friends to get together while the children play.

This is a fantastic opportunity to connect with families from the Boston area who use our maternity services.

This free, two-day event saw many families stop by to chat and take advantage of our infant feeding tent.

1 Aim and purpose of the day

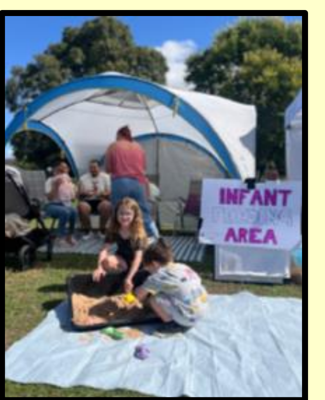
- Provide an opportunity for families to share their experiences
- Raise awareness of services who can provide support.
- Promote breastfeeding
- Promote the new Infant Feeding Support team.

2 Who attended

- Families from across Lincolnshire
- Lincolnshire Maternity and Neonatal Voice Partnership Lead
- Infant feeding support workers
- Family and Baby Team
- Lincolnshire Maternity and Neonatal programme team
- Community and Voluntary organisations

3 The difference it made

- Listened to families concerns and raised awareness. Heard their experiences and stories
- Provided a safe space for breastfeeding.
- Increased awareness of the support / services for families e.g. LMNVP
- Information was reported back to local maternity services to support service improvements
- Helped illustrate the pregnancy journey for local families, highlighting differences in maternity services across countries.
- Improved our communication methods with families from other cultures to remove barriers.



Lincolnshire Maternity Military Partnership

The Lincolnshire Military Maternity Project (LMMP) provided essential support to military personnel, veterans, and reservists residing in the county. Our efforts focused on enhancing the maternity journey for mothers and their families, while actively working to prevent discrimination resulting from postings, separations, and deployments.

Over the past 12 months, our Military Care Navigator has supported 196 families, addressing a wide range of needs. We are proud to have celebrated the births of 150 babies, with an additional 25 families currently expecting. Unfortunately, 11 of these births resulted in miscarriage, infant death, or stillbirth.

Additionally, the Military Care Navigator is assisting 10 families who are pursuing pregnancy through IVF, IUI, and other fertility treatments.

Engagement activities and support for military families

Our engagement activities and support for military families have taken various forms:

- **Assistance with SEN Children**: Helped identify and place nursery and school options for children with Special Educational Needs (SEN).
- **IVF and Fertility Treatments**: Military families face challenges with IVF and fertility treatments due to their nomadic lifestyle. Transferring care between locations requires managing different IVF systems and keeping Military GPs informed, adding stress during an already sensitive time.
- **Shared Paternity Leave**: Shared paternity leave becomes complicated when both partners are in the military or when one partner is a civilian. We assist in resolving policy crossovers to ensure smooth transitions.
- **Waiting List Transfers**: Moving to Lincolnshire can result in losing a place on a waiting list, requiring a new referral and starting over. We work closely with outpatient staff and consultants' secretaries to facilitate these transitions, extending support to families moving out of the area.
- **Support for Single Military Mothers**: We provide extensive support to single military mothers, such as those with newborn twins and no local family, by connecting them with available groups and helping with primary care registration.
- **Military Housing Issues**: We liaise with the Military Housing allocations team to ensure timely housing allocation for newly pregnant servicewomen, achieving a 100% success rate in preventing moves during late pregnancy.
- **Clinical Care Transfers**: We manage the transfer of clinical care for service families posted into or out of the area, ensuring all necessary teams are notified and connections are made for seamless transitions.

Continuing to nurture relationships with agencies across Lincolnshire including:

Military Connections:

- GP Practices (clinical and administrative staff)
- Welfare Teams
- SSAFA (Soldiers, Sailors, and Airmen's Families Association)
- HIVE (unit's community hub)
- Chaplaincy Centres
- Health and Wellbeing Committee
- Physiotherapy Departments
- Department of Community Mental Health (DCMH)
- Gymnasium (ante/postnatal sessions)
- Human Resources (HR) on all units
- Numerous veteran agencies

Local and Regional Non-military connections:

- All maternity units and midwives
- Community midwives and matrons
- Consultant midwives
- Health visitors
- All GP practices in Lincolnshire (via postal and email campaigns)
- Children's centres
- Perinatal Mental Health Team

Special Educational Needs and Disabilities (SEND)

In the ICB, our vision for children with Special Educational Needs and Disabilities (SEND) is to ensure they are supported, feel safe both physically and emotionally, are included, and lead happy lives.

We continue to be proud to place the individual care needs of children and young people at the heart of what we do. The Designated Clinical Officer (DCO) for Children and Young People with SEND ensures the Integrated Care Board meets its responsibilities and demonstrates it long standing commitment to the SEND community, such as through Lincolnshire Young Voices (LYV) meetings and events.

Lincolnshire Young Voices, a group of young people with SEND, co led by the DCO and SEND Programme Manager in the local authority, has been developed for children and young people with SEND to share their voices and is part of the SEND widening participation strategy. This year, LYV focused on Anti bullying workshops and improving Transport Services for CYP with SEND in Lincolnshire.

Lincolnshire Young Voices

Anti-bullying

- LYV developed a series of workshops delivered in Anti-Bullying Week 2024 (ABW) to support the NHS Suicide Prevention strategy.
- The ABW workshop was delivered by the LYV teams' committee members and the groups Co-Chairs in seven educational settings
- In total 16 sessions were delivered
- Over 170 students attended

The difference it made

- . The workshops evaluated positively, and the resources are available on the LYV webpage Lincolnshire Young Voices – Lincolnshire County Council.
- Follow Lincolnshire Young Voices on Facebook for more information

Transport

- LYV generated a survey which was primarily aimed at those with SEND and young person focused
- Survey received a mix of positive and negative responses
- LYV presented their findings to the Enhanced Partnership with senior managers from LCC Transport and bus operators
- Co-chair presented survey findings to Highways and Transport Scrutiny in January 2025

The difference it made

- Following the presentation to Highways and Transport Scrutiny the co-chair had a follow up 1:1 discussion with local bus operators
- They have agreed to adding an additional wheelchair bay to their buses
- A meeting has been held with BusUserUK to discuss the future design of buses – they also agreed to an additional wheelchair bay to their fleet.

Working with key stakeholders

- To support families, parents and carers of young people with Sensory Processing Differences SEND delivered a series of supporting resources and specialist workshop called the Sensory Processing Difficulties Programme

The difference it made

- In response to family's feedback, for 24/25 we added two additional workshops on Demand Avoidance and Neurodiversity and Burnout. These have evaluated very positively and been hugely popular
- Sensory processing difficulties :: Lincolnshire Children's Therapy Services

Primary Care

Within the ICB, Primary Care has dedicated support from a Primary Care Communications and Involvement Team to ensure ring-fenced capacity to fully involve our patients in the development of services.
The team has supported service changes within Primary Care, ensuring meaningful engagement and consultation takes place with patients, carers and communities.

Examples of our work this year include:

- Listening to patients and communities by holding **listening clinics**
- Ensuring communities can have their say in **new developments**
- Involvement of patients in the proposed **change of GP premises**
- Setting up a **Primary Care co-production group**
- Public engagement on **Enhanced Access Hub**
- **Co-ordinated partners feedback** to ensure the patient's voice is heard
- Supported **Primary Care Networks** engagement
- Continued to support **Patient Participation Groups and Patient Council**

Click on the tiles to go to more examples of involvement within specific projects and programmes

Patient Council

Patient Council & Locality Meetings

Patient Participant Groups

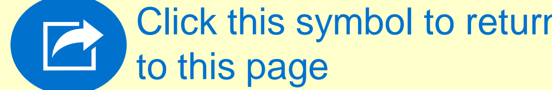
Supporting PPGs

Listening clinics

Digital Co production group

Wainfleet premises

Boston PCN Enhanced Services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Patient Council

The voices of the PPGs and the patients they represent are heard within the ICB through our bi monthly Patient Council meetings. The meetings rotate every two months between the three Locality Patient Council meetings and the County wide meeting.

At the Locality Patient Council meetings there is opportunity for PPGs to share feedback about local NHS services within their locality. These meetings are attended by PPG representatives in each locality, the Primary Care Engagement Manager and ICB Locality Quality Leads.

At the County wide meeting, the ICB share updates, current programmes of work and campaigns and opportunities for PPGs and their communities to get involved. These are held online and are attended by Lincolnshire's PPG representatives, ICB's Involvement Team, Associate Director of Nursing and Quality and key staff.

Feedback from these meeting are reported into the ICB Operational Quality Assurance Group meetings, and Primary Care Quality Assurance Group and Oversight meetings, with any issues escalated to the System Quality and Patient Experience Committee and Lincolnshire ICB Board.

Public & Patient participation

1. Our approach

- These are conducted on a bi-monthly basis; three countywide Patient Council meetings and nine Locality Patient Councils over 12 months.
- This year, there has been two extra-ordinary Patient Council meetings:

1. October 2024 meeting to discuss the Armed Forces Covenant, Veteran Friendly Practices, Green Agenda and ICB Medicines Campaign.
2. January 2025 additional session held regarding the PPGs involvement in the NHS 10 year plan.

2. The difference it made

Feedback from these meetings is reported to:

- ICB Operational Quality Assurance Group
- Primary Care Quality Assurance Group
- Appropriate project teams and committees.
- Any significant issues are further escalated to the System Quality and Patient Experience Committee and the Lincolnshire ICB Board.

3. Engaging with patients

- In October, together with the PPGs, the ICB reintroduced the Patient Council Feedback Form to enhance the two-way feedback process for Locality Patient Councils. These meetings aim to receive patient feedback from GP practices via their PPG chair / rep. It encourages accurate collection of insights and experiences between meetings, documenting their sources. They can also capture key discussions from Locality Patient Council meetings to record and share this information with their practices, PPGs and, patients

4.

- Patient Councils will be reviewed in 2025/26 to improve their reach and effectiveness.

Patient Council and Locality Meetings

Public & Patient participation

Countywide Patient Council

ICB Project teams have updated the Patient Council on their projects and engaged PPGs in various ways, influencing:

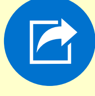
- ✓ Health Inequalities: Co-produced staff workshops on Mental Health, Alcohol & Substance Misuse, Asylum Seekers, Carers, Farming Communities, Temporary Residents.
- ✓ Women's Health Hubs: Provided updates, shared feedback, and disseminated surveys.
- ✓ PPG Awareness Week (03–09 June 2024): Partnered with PPGs to create materials, celebrate contributions, and attract new representatives.
- ✓ GP Strategy Engagement: Gathered feedback to shape the ICB's GP strategy and encouraged wide engagement.
- ✓ Pharmacy First Service: Collected feedback to improve and promote the service.
- ✓ Armed Forces Covenant & Veteran-Friendly Practices: Raised awareness of veteran-friendly GP practices.
- ✓ Green Agenda: Engaged PPGs in sustainability discussions.
- ✓ Medicines Waste Campaign: Sought feedback to shape the campaign.
- ✓ Primary Care Updates: Informed PPGs on funding, service changes, new initiatives, and developments.
- ✓ NHS Ten-Year Plan: PPG involvement helped shape the national plan

Locality meetings

During locality meetings our PPGs have:

- ✓ Gave feedback and raised concerns over access to NHS funded services such as dentistry, capacity issues, new housing developments impacting access, pharmacy staff shortages, access to GPs, secondary care waiting lists
- ✓ Sought clarity over new roles in Primary Care
- ✓ Enquired about ambulance performance and response times in East County.
- ✓ Asked about upcoming NHS campaigns or changes.
- ✓ Emphasised the importance of local community services.
- ✓ Requested update on COVID vaccination plans.
- ✓ Queried consistency of involvement across PCNs with PPGs
- ✓ Scrutinised NHS communications and engagement approaches
- ✓ Want consistency of engagement across PCNs
- ✓ Sharing tips on recruiting for PPGs

Patient Participation Groups (PPGs)



Ongoing support has been provided by the ICB to GP Practices with their contractual requirement to have a Patient Participation Group (PPG). These achievement highlight the significant role of the PPGs in improving healthcare services and community engagement.

PPG achievements

Patient Experience:
- Conducted surveys and reviewed national GP survey results to develop improvement plans.

Community Communications:
- Established Facebook pages, newsletters, and information boards.
- Highlighted primary care roles and promoted ICB campaigns.
- Shared updates via local platforms.

Digital Support:
- Supported new online consultation tools and organised digital drop-in sessions.
- Improved digital processes with the ICB Primary Care Digital team.

Presenting Representative Feedback:
- Organised sessions and online forums for patient feedback.
- Attended community groups for diverse views.

Reducing DNAs:
- Partnered with practices to reduce missed appointments.

Reducing Medication Waste:
- Beechfield PPG's "Medication Amnesty" collected unused medications worth £3,500.

Youth Engagement:
- Recruited youth representatives and approached community leaders for feedback.

Community Transport Schemes:
- Some PPGs run effective car schemes, receiving excellent feedback.

Promoting PPGs:
- Many PPGs arranged Annual Public Meetings and participated in PPG Awareness Week 2024.

Support to Practices:
- Assisted during COVID-19 and flu clinics, supported communications, and participated in CQC inspections.

Health and Wellbeing events

- **Washingborough PPG:** Organised two Carers Coffee events.
- **Beechfield PPG:** Held CPR and defibrillator training, digital support sessions, and large health awareness events.
- **Long Bennington PPG:** Conducted wellbeing walks, safeguarding training, home visits, and dementia group sessions.
- **Marisco Medical Practice PPG:** Provided refreshments, hearing aid services, and promoted the 'Message in a Bottle' campaign.
- **South Locality PPGs:** Hosted the "Love Your Heart" event.
- **Gosberton PPG:** Collaborated with an aqua therapy centre and held community events.
- **Bourne, Spalding, and Deepings PPGs:** Organised a health and social care event at Bourne Corn Exchange.
- **Glebe Park Surgery PPG:** Held a bake sale and gained Armed Forces Accreditation.
- **Tasburgh Lodge Surgery PPG:** Hosted social sessions for PPG Awareness Week.

Supporting PPGs

Ongoing support continues for our GP Practices in meeting their contractual requirement to establish a Patient Participation Group (PPG). Audits have continued throughout this year to identify practices needing additional assistance to reinstate their groups or increase attendance from a diverse patient population.
Support meetings and participation in PPG meetings have been carried out to help practices fulfil their PPG obligations and to recruit new representatives to ICB meetings such as the patient councils and digital co production group.
The ICB's involvement team, together with practices, have actively supported PPGs in recruiting new members, including younger individuals. One PPG has successfully recruited sixth formers to their PPG.
The ICB continues to promote its PPG toolkit, offering guidance, resources, and templates to support best practices and encourage innovation in PPGs as well as promote PPG training offers.

Public & Patient participation

Our Approach

1

- During 2024/25 various PPG support meetings have taken place with the ICB's Primary Care Engagement manager as well as attendance at PPG meetings.

2

The difference it made

This work has contributed to more inclusive and well-supported PPG engagement with the NHS in Lincolnshire:

- **Improved Compliance** – GP practices are receiving ongoing support to meet their contractual requirement of having a Patient Participation Group (PPG). The PPG audit has shown that 93% of practices have an active PPG or are looking to re-establish a group.
- **Better Representation** – Increased diversity and engagement in PPGs, ensuring broader representation of patient populations.
- **Enhanced Recruitment** – Successful efforts in attracting new members, including younger people.
- **Best Practice Promotion** – Continued use of the ICB toolkit to provide guidance, support, and resources for PPGs, resulting in improved patient

3

Supporting PPGs

- Share good practice
- Provide support for recruitment
- Give advice on how PPG can engage their patient population e.g. visits community groups, virtual PPGs, approaching schools
- Developed a PPG Toolkit which contains templates for Terms of Reference, agendas; contains helpful information

4

[Resources for Patient Participation Groups (PPGs) - Lincolnshire ICB]

Listening Clinics

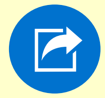
Listening Clinics enable the ICB and its member practices to hear feedback directly from their registered patients.

By visiting a practice and talking to patients we can ask them about their experiences of healthcare.

Each Listening Clinic event is promoted widely to encourage as many patients as possible to attend and share their experiences of healthcare or complete an online survey if preferred.

Patient stories and feedback are recorded and helps form part of information considered when looking in depth at a service or service provision.

The final report is shared with the relevant teams and organisations which develop actions to improve quality, service delivery and the patient experience.



Public & Patient participation

1. East Lindsey Medical Group

- The ICB worked with East Lindsey Medical Group to hold a listening clinic in July 2024 to understand the concerns and challenges their patients faced in accessing services.
- As well as the listening clinic held in the practice, patients were offered other ways to give feedback - an online survey and telephone survey

2. Our Approach

- Designed approach for the listening clinic with practice
- Created promotional poster for listening clinic; promoted poster and survey on practice website & Facebook
- The practice sent a text to a sample of patients about event and survey
- Featured in Engagement Bulletin and promoted on the ICB's social media and website
- Shared with East Lindsey Public Health Officer who shared with key stakeholders
- Posted on Nextdoor four times in July, gaining over 18,000 impressions

3. Engaging with patients

- 19 attended the listening clinic
- 160 responses to online survey
- Initial feedback was reported to the practice on the day of the listening clinic and a full report was provided

4. The difference it made

- Practice fully engaged in the Listening Clinic
- Feedback will be used to improve services within the practice
- Public were able to speak to ICB staff about their concerns.
- Practice discussed the results with their PPG

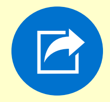
Digital Co-production Group

The Primary Care Digital Co-Production Group established from the Primary Care Co-Production meetings.

The group was formed to bring together PPGs with an interest in digital initiatives, working collaboratively to enhance patient access to digital tools and services in General Practices across Lincolnshire.

The digital co-production meetings take place regularly online.

The group includes PPG representatives, ICB Primary Care Digital leads, and members of the ICB Primary Care Communications and Engagement team.



1 Aims of the co-production

- The aim of the group is to enhance collaboration between patients and primary care practices to maximise the value derived from available digital systems.
- This Group will serve as a platform for sharing best practice, innovative strategies, and ideas, creating an environment of co-production and partnership

2 The difference it made

- Feedback from these meetings has been shared with the relevant regional, local, and national NHS digital development forums, as well as with the NHS App team and NHS England.
- Activities and achievements of the Digital Co-production group can be found on the following page.

3 Our approach

- Recruited PPG reps to sit on co-production group
- Held seven meetings in last 12 months
- Agreed to meet every six weeks
- PPG reps, GP practice representative, ICB Digital project lead, Primary Care Comms and Engagement leads sit on the group

4

Digital Co-Production Group achievements

The Groups' achievements 2024/25

The group have:

- ✓ Co-produced NHS App Registration Posters – in response to patients' difficulties registering on the NHS App the group worked with the ICB Primary Care Communications team and created and distributed posters "How to Register with the NHS App – 4 Easy Ways". This also included a poster to support practice staff.
- ✓ PPGs have supported practices implementing new online consultation tools i.e. by setting up a help desk and creating "how to guides".
- ✓ PPGs have organised digital drop-in sessions to assist patients with practice online consultations tools and the NHS App which the ICB digital team has supported.
- ✓ Promoted the Lincolnshire County Council's "Connect to Support website"
- ✓ Helped to promote the digital sessions arranged by Lincs Digital in their local community.
- ✓ Influenced the Lincolnshire Integrated Care System Digital Inclusion Strategy. Two PPG reps sat on the strategy development group meetings. The strategy was presented to the group in March 25.
- ✓ Asked the ICB to speak with NHSE to instigate future invitations to NHS App Webinars enabling the patient voice being heard.
- ✓ Helped to develop the self-referral section of the ICB's website, leading to improvements and further awareness of initiatives

Further achievements

Patient Participation Groups (PPGs) and Self-Referral Information Development

In July 2024, a co-production meeting with PPGs was held to develop self-referral information on the ICB website, aligning with the Primary Care Access Recovery Plan.

A draft webpage was shared for review, and feedback was gathered during the meeting. PPG members provided insights on accessibility and useability and discussed ways to promote self-referral opportunities across Lincolnshire.

As a result, the website was improved to enhance user experience, and further awareness initiatives were identified.

Moving forward, the website and self-referral information will continue to be developed to ensure they remain accessible, up-to-date, and responsive to patient needs.

Wainfleet GP Premises

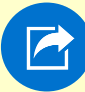
NHS Lincolnshire Integrated Care Board proposed to permanently close the NHS premises in Wainfleet which had been temporarily closed since routine GP services provided by Hawthorn Medical Practice were paused in 2020.

Following a paper presented at the Primary Care Directorate meeting in August 2024, a decision was made to approve a public consultation exercise to explore patient views on the future use of the NHS premises at Wainfleet.

The aim of this exercise was to consult with and seek community views including patients and other key stakeholders on the ICB's proposal to permanently close the NHS premises in Wainfleet.

Following the consultation exercise the ICB made the decision to permanently close the NHS premises in Wainfleet in December 2024.

Public & Patient participation



Our approach

1

- In August 2024 a public consultation exercise was approved by Primary Care Directorate
- A communications and engagement plan was developed by the ICB Primary Care and Communications and Engagement team which included leaflets; website information, social media assets.

2

The response

3

- Patient survey open between 11 Sep-21 Oct 2024 (online & paper versions)
  - Received 148 responses
  - Poster to advertise the events - translated into 7 different languages
- Three engagement events held; Two held on 24 Sept at Skegness Rugby Club (PM and evening); 25th Sept at Wainfleet Methodist Community Centre (AM)
  - Staff from the ICB and Hawthorn Medical Practice attended and were available to answer questions
- Consultation report was produced and presented to the ICB Primary Care Business Management Group in December 2024.

4

The difference it made

- ICB compliant with statutory public Involvement duty.
- In December 2024, the Business Management Group (BMG) received consultation report
- Approval from the BMG to close Wainfleet site
- A strong commitment from BMG to use the consultation feedback for service development. The ICB approved the proposal with the following conditions to ensure patient concerns were addressed:
  - Following consultation events, localised promotion of the Pharmacy First service reassured patients that eligible free NHS prescriptions would remain free.
  - Increased promotion of PCN's Enhanced Access appointments informed patients about evening and weekend availability.
  - Hawthorn Medical Practice received funds for a new phone system with a call-back function and uses an online consultation tool (eConsult) for appointment requests and test results

Boston PCN Enhanced Services

Boston Primary Care Network (PCN) proposed to move the Enhanced access appointments from the Siding Medical Practice to Parkside Medical Centre. These appointments were held in the evenings on weekdays and on Saturday.

The PCN wanted to make better use of staff to support the Enhanced Access Service so their proposal also included that they could deliver the service through the PCN rather than using an external provider, and that improvements to the service delivery would be better managed.

It was proposed that patients would be offered additional types of appointments, like cervical smears and childhood vaccines in the evenings and on weekends which should encourage increased uptake.

A consultation exercise took place to look at the proposed changes.

Our approach

1

- The PCN approached the ICB in January 2024 to discuss changing the provision of the Enhanced Access service.
- A formal proposal was submitted in June and reviewed through the ICB's governance process in July.
- Agreed to undertake patient and public engagement prior to the ICB making a final decision.
- A communications and engagement plan was developed by the ICB Primary Care and Communications and Engagement team which included leaflets; website information, social media assets.

2

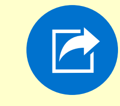
The response

3

- Patient survey open between 5 Aug–16 Sept 2024 (online & paper versions)
- Received 355 responses
- Poster to advertise the events - translated into 7 different languages.
- Two Engagement Events held at The Len Medlock Voluntary Centre on 29 August 2024, where 9 people attended.
- Staff from the ICB, Boston PCN and Greyfriars and Parkside surgeries were available to answer questions
- Consultation report was produced and presented to the ICB Primary Care Business Management Group in October 2024.

4

Public & Patient participation



- ICB compliant with statutory public Involvement duty.
- Report presented to the Business Management Group (BMG) in Oct 2024.
- Approval from the BMG for the proposal to go ahead and move the enhanced access service to Parkside Medical Centre
- BMG committed to using consultation feedback for service development. The ICB approved the proposal conditions to address patients concerns:
    - The PCN will promote all available patient transport schemes.
    - Telephone and/or video consultations will be offered through Enhanced Access
    - Provide clear parking instructions
    - Staff will offer appointments across all available sites as part of standard practice.
    - Ensure consistent and clear communication and promotion

Health Inequalities

What are health inequalities?

Health inequalities are **avoidable and unfair differences** in health between different groups of people. They are not random but are determined by circumstances largely beyond an individual's control. These inequalities can involve differences in:

- Health status, including life expectancy and health conditions
- Access to care, such as availability of treatments
- Quality and experience of care, including patient satisfaction
- Behavioural / lifestyle risks, like smoking rates, alcohol consumption, diet, and physical activity
- Wider factors affecting health, such as jobs, housing, education, and access to welfare services

Differences in health status and its determinants can be experienced by people grouped across four factors:

- Socio-economic factors (e.g., income, availability of work)
- Geography (e.g., region, urban/rural/coastal areas)
- Specific characteristics (e.g., sex, ethnicity, disability)
- Socially excluded groups (e.g., people experiencing homelessness)

In Lincolnshire, health levels vary significantly, with considerable gaps between different areas and groups within the population.

What are we doing in Lincolnshire?

NHS Lincolnshire Integrated Care Board has a team of dedicated professionals, who work with the health and social care providers to reduce health inequalities across Lincolnshire. They use the NHS England approach Core20PLUS5 for adults and for Core20PLUS5 children and young people. They work closely with Public Health (Lincolnshire County Council) to reduce the gap between the healthiest and the least healthy populations within Lincolnshire. The ICB is committed to hearing from communities and individuals who may be experiencing these inequalities and have a dedicated resource to engage and involve communities in these projects.

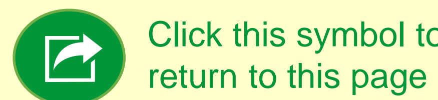
For more information: Reducing health inequalities - Lincolnshire ICB

Bowel screening

Lung Health Check

Gypsy, Roma and Traveller

Click on the tiles to go to these examples of involvement within the health inequalities programme of work



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Bowel Screening

The Health Inequalities Bowel Screening project aims to address the lower uptake of bowel screening in Lincolnshire's most deprived areas.

The project seeks to understand the reasons behind this inequality and committed to co-produce solutions with those affected.

Previous engagement, back in 2023/24, identified small pockets of our population that were not taking up the opportunities for bowel screening.

This year, the Health Inequalities team began engaging with non-English speaking communities and carers to understand and address their specific challenges around bowel screening.

Public & Patient participation

Talking to our communities – Non-English speaking

1.

- Community engagement targeted non-English speakers. The "Let's Talk About Bowel Cancer Screening" survey was redistributed to 25 individuals identified by One You Lincolnshire
- Worked with Boston Lithuanian School and a Health and Wellbeing Coach from South Lincs Rural PCN, who reached out to bowel cancer screening non-responders
- Spoke to 19 people at 3 locations, 10 of had not completed their bowel screening. Among those, languages spoken included Polish (5), Russian (2), Lithuanian (2), and one unknown

2.

The difference it made

- Gained additional insight by working with partners such as the school and PCN
- The project group is now exploring how to continually reach this population.
- Translating educational materials into other languages and filming educational video content is being considered.
- Insight revealed that language are crucial for non-English speakers, feedback indicated that "screening" is perceived as invasive in Lithuania, discouraging participation
- We were able to ascertain that the bowel testing kit was easily recognisable as a visual aid, and those with limited English skills clearly understood what it was

Talking to our communities – Carers

3.

- The Let's Talk About Bowel Cancer Screening survey redistributed through social media via Carer's First, received 10 responses
- Spoke to 36 at 3 carers events across Lincolnshire

4.

The difference it made

- Spoke to 6 people who had not completed their bowel screening and encouraged participation
- The project group will collaborate with the Carer's Priority Delivery Group to investigate the barriers and challenges carers face with bowel screening, based on the insights gained

Lung Health Checks

The Targeted Lung Health Checks program offers individuals aged 55 to 74 with a history of smoking the opportunity to undergo a lung health assessment.

Those identified as at risk of lung cancer may be referred for a low-dose CT scan of the chest as part of the screening process.

The objective of the engagement exercise was to help shape a new Lung Cancer Screening Programme in Lincolnshire.

The aim

- To identify potential uptake or not of screening checks
- To understand reasons for uptake or not of screening checks
- To identify what would encourage uptake of screening checks
- To identify a reasonable travel time for Targeted Lung Health Checks & other possible screening programmes.
- To identify the mode of transport that will be used.
- To identify preferred locations of screening checks
- Identify any health inequalities which might be widened due to the location of Target Lung Health Checks

Our approach

- Created an online survey
- Distributed to our stakeholder database that includes groups from the following; LGBT, BAME, Disability, Carers, Young people, Older people, Faith and Religious and various community groups across Lincolnshire
- Worked with Partners to widen distribution e.g. One Lincolnshire; Public Health, Travellers Initiative, Project Compass, local community leaders and Framework Charity
- 382 responses received.

The difference it made

- The involvement report was presented to the Lung Cancer Screening programme team
- Information gained from the survey supported the assumptions regarding travel – patients should travel not more than 30 minutes
- Scoping opportunities to procure the service
- Findings in the service will assist procurement process / service specification
- Insight gained in the survey will inform potential sites of mobile units
- Further work will carry on in 2025/26

Gypsy, Roma & Traveller

The Health Inequalities team supported the ICB's Vaccination Team with their MMR increased uptake project. This work aimed to target groups with lower vaccination rates including the Gypsy, Roma, and Traveller (GRT) community.

Feedback was gathered from the GRT community on barriers to vaccination. Partnering with Lincolnshire Travellers Initiative (LTI), the focus shifted to secondary school immunisations.

Together, an event was planned to provide information and gather feedback.

Public & Patient participation

Aim of the event

- Successfully engage with GRT community
- Be a friendly and approachable point of contact for the travelling community
- Use culturally sensitive communication methods to gain trust and build relationships
- Understand concerns and health needs
- Support individuals in asking questions and voicing concerns.
- Promote health services in a way that respects the community's values.
- Distribute leaflets and resources in an accessible way
- Clarify misconceptions about vaccinations, screenings, or other health services.
- Support health professionals in delivering key messages

1

2

3

4

The difference it made – on the day

Vaccination Team:

- Administered one nasal flu vaccine .
- Distributed vaccine leaflets to 7 parents.
- Obtained consent for a home visit to vaccinate a Year 9 child with autism
- Secured parental consent for upcoming school vaccinations (Yr 9 & Yr 10)
- Advised a parent to check a Year 7 child's vaccine history.
- Two children (Yr9) consented to future vaccines
- A parent consented to MenACWY and HPV A 21-year-old was advised to seek the HPV vaccine from her GP.

Oral Health Team:

- Involved several children in teeth cleaning demonstrations
- Distributed free toothbrushes and toothpaste

The difference it made – long term

- Building trust between the NHS and GRT community.
- Receiving feedback on healthcare professionals and services.
- Distributing health leaflets in appropriate literature.
- Identifying barriers to healthcare access.
- Securing commitment from professionals for future collaboration and events.
- Planning future events for summer 2025

Community Development

People and communities are at the heart of everything the ICB does. Working with people and communities is crucial to creating a health and care service that offers personalised care tailored to individual needs and works for everyone. The ICB aims to involve people from different places, cultures, nationalities, ages, and genders.

By being visible and accessible when we visit all corners of the county, we allow people to approach the ICB with their concerns, ideas, and feedback. This direct interaction builds trust and strengthens communities' relationships.

Maintaining existing connections is as important as forming new ones ensuring that the community feels supported over time. It also allows the team to build on previous successes and address ongoing needs effectively.

The ICB's engagement team believes that building new connections with community groups such as schools, young people, and underrepresented populations is crucial. By reaching out to underrepresented groups, the team ensures that diverse voices and perspectives are included in community discussions and decision-making processes. This helps create a more inclusive environment where everyone feels valued and heard.

LGBTQ+ communities

Skegness 999 day

Digital Outreach for Community Connection

Make connections

Stay connected

See the difference

Working with Schools

HWLincs VOICE conference 2025

A day in the life of …. the ICB involvement team

ICB Involvement bulletin

Click on the tiles to go to more examples of involvement within specific projects and programmes

Click this symbol to return to this page

LGBTQ+ Communities

Attending community events is vital for connecting with people from underrepresented groups.

In November 2024, the Transgender Remembrance Day was held.

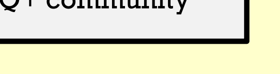
During the day, the ICB was asked how it is capturing the voice of LGBTQ+ communities.

Since the event the Involvement Team has actively sought to improve connections with LGBTQ+ communities and work will continue in 2025/26.

Community Development

1. Action required

- Understand current contacts for LGBTQ+ communities
- Worked with networks and NHS trusts to understand contacts within the county
- Understand the best methods of involving the LGBTQ+ community



2. The difference it made

- Full understanding of current connections of LGBTQ+ communities
- Increase our reach into these communities
- Updated the ICB's stakeholder database with new contacts
- Given assurance to ICB's Associate Directors and Equality Forum
- Made a commitment to continue this work into 2025/26 to ensure all communities have the opportunity to be involved and heard

3. Action taken

- Involvement team met with two associate directors within the ICB; Chair of the Equality Forum and the Adverse Incident and Risk Officer to highlight the challenge received Discussed the current forms of communication and engagement
- Connected the county's community connectors to discuss their connections and reach within their communities
- Worked with Equality lead and patient experience leads in other organisations to understand how the patient voice was being captured

4

Skegness 999 Day

The ICB involvement team spends time in communities reaching out to people to encourage involvement and participation, often speaking those who wouldn't normally get involved.

The 999 day in Skegness has been a successful way of meeting residents and visitors to the area. It also gives the team chance to network with other emergency services colleagues throughout the day.

Due to the success of previous years the Skegness 999 day is a firm favourite in the diary and gives us the opportunity to reach out into the community, and we are also able to represent the NHS at the Emergency Services Day.

Community Development

1. Aim of day

- Priority to connect with Skegness residents about the GP Strategy
- Encourage residents to take part in the survey
- New connections made within the community and families
- Signed people up to receive the involvement bulletin
- Able to signpost residents to services
- Handed out leaflets about getting involved in the NHS

2. The difference it made

- Informed local community of GP Strategy to encourage participation
- Engaged with numerous community members who were seeking guidance and information.
- Collaborated with colleagues from various parts of the county
- Discussing the crucial role of shaping both current and future NHS services

3. Activity on the day

- Handed out 31 leaflets for GP strategy
- Able to assist individuals with queries around some NHS services such as Dental, Primary Care
- Promoted current surveys and engagement opportunities
- Encourage sign-up to engagement bulletin
- Signposted people to mental health services

Engaging Young Adults

Involving different age ranges of Lincolnshire's population is vital to the success of great engagement.

Engaging with young adults to better understand their health needs is a priority for the ICB's engagement team.

Building on last year's success, the engagement team attended Freshers' Fayres at some of our local colleges and universities.

In September 2024, the team visited:

- Lincoln College
- Grantham College
- Boston College
- Bishop Grosseteste University

Community Development

1 Aim of the engagement

The aim of the engagement was to:

- Inform younger people how they could get involved in local NHS services.
- Speak to students about their experiences of accessing and receiving NHS services.
- Sign up students to receive our fortnightly engagement bulletin "The Contributor".
- Promote engagement opportunities that were running at the time such as the GP strategy, women's health and gender identity engagement.
- Work in partnership with teams across the ICB such as the Covid Vaccinations Team.
- Help promote and encourage vaccinations and gather feedback on whether students were up-to-date with their vaccinations and if not, the reasons for this

2 Outputs of the events

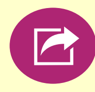
- We utilised funding won by the ICB's engagement team **to incentivise engagement activities**. This allowed us to purchase **water bottles and tote bags** to encourage students to sign up to receive our engagement bulletin.
- Over the course of four events, **271 students** signed up to receive our bulletin.
- Spoke with many students, college staff and teachers, connected with partner organisations to develop relationships and system working.

3 The difference it made

- Improved relationships with college and university staff
- Increased engagement with young adults, already seen an increase in the number of students completing our surveys.
- We learned successful ways of interacting with students.
- Attending the fresher's fayre and incentivising the conversations has helped us to increase the diversity and age range of our involvement database.
- The team has been invited back to future college events

4

Working With Schools



Public & Patient participation

We recognise the importance of proactively involving Lincolnshire's young adults in our work and the different approaches needed to reach them. Their insights, innovative ideas, and experiences are crucial for developing future services.

As part of the Women's Health project, we reached out to Kesteven and Grantham Girls' School, where we had previously visited during the NHS Joint Forward Plan engagement. We arranged a lunchtime meeting with students, primarily from the sixth form, along with some younger students. Our goal was to discuss their experiences accessing health services as young women in Lincolnshire.

Engagement on the day

- We spoke to 14 female students, accompanied by three tutors.
- All the students were engaged and very vocal in sharing their experiences and invested in how these services could improve in the future.
- The time spent with the students was truly beneficial, and the engagement continued beyond the meeting, which was great.

The difference it made

- One student agreed to present at the annual Women's Health conference in November 2024 (see picture).
- Her compelling story captivated the audience and set a positive tone for the afternoon workshops.
- The presentation was well-received and sparked meaningful discussions.
- On hearing her story, one consultant pledged to change the way they practiced in the future

- Additionally, the students at the Girls' School created a video presentation to share their views on Women's Health.
- This was presented to the Women's Health Steering Group in December 2024, leading to great discussions about the importance of participation from all ages.
- Video can be seen via Vimeo - click here

The difference it made – long term

- This initiative has helped us build a solid relationship with Kesteven and Grantham Girls' School, and they are keen to assist with future projects

A day in the life of … the ICB involvement team

The role of an involvement officer for the ICB is varied and takes the team all over the county speaking to patients and communities. This is how we spent one of our days in November 2024 at the Women's Health Conference 2024 …

"Today was a full, rewarding day as I represented the ICB's involvement team at the Lincolnshire Women's Health Conference. My role was to present the report from the summer's engagement activities—a culmination of countless hours dedicated to gathering community feedback through surveys, community conversations, and online events.

The conference was bustling with energy. As I listened to the opening welcome and local and national speakers, I kept reminding myself that my turn was coming soon. When my name was announced, I stood up and approached the stage, feeling a mix of nervousness and excitement.

With a dry mouth and a slight tremor, I took a few deep breaths and forced a smile. I started by introducing myself and my role, then cracked a small joke about eating lots of cake during the process, which made the audience chuckle and eased the tension within me. This allowed me to focus on sharing what really mattered: the women's voices of Lincolnshire. It was heartening to see so many faces concentrating on the feedback from the report, with nods and gestures indicating they were hearing familiar stories and content.

In the afternoon, patient stories took centre stage. Hearing from women I'd met during our engagement activities was especially moving. Sam, a committed member of our co-production group, and Naomi, a student from Grantham, shared deeply personal stories that resonated with the audience. Their experiences reaffirmed the importance of our work; the voices from our communities truly make a difference.

Facilitating workshop discussions later in the day was both challenging and thrilling. The tables buzzed with conversation, proving that people are passionate about shaping health services in Lincolnshire. Keeping everyone on topic was tough, but the energy and investment in discussing women's health issues were profound.

As the day wound down, I stayed to chat with many attendees who shared positive feedback about the conference. It was heartwarming to hear that they had enjoyed the day, felt heard, and were eager to stay involved.

Packing up, Naomi – the student presenter - shared that a gynaecological consultant had approached her, expressing how deeply moved and inspired they were by her story. They said it would change the way they practice in the future.

This is why I do this work!

I left the venue exhausted but deeply satisfied, grateful to have been part of such an engaging day that highlighted the power of community voices in driving change."

Digital Outreach

The ICB 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 offer opportunities for genuine, open, honest, and transparent engagement with stakeholders, giving them a chance to participate and influence decision making. Through social media, we can listen and have conversations with a wide and diverse range of people, especially within communities.

It not only allows us to make announcements such as health news, service information, and upcoming events, but it also enables people to respond to our posts, encouraging two way conversation and feedback. This helps improve the ongoing development of our services and informs, engages, educates, and inspires our local communities.

One of our key communication tools, often a first port of call for the public, is the ICB website. We continuously review and develop 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.

Between the 1st April 2024 and 31st March 2025 we had **125,548 active users/visitors** and **664,895 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 1,843,529 users**, making **2,053,630 post impressions in users timelines**, with an **engagements rate of 3.28%.** The ICB **gained 1,450 new followers** across our social platforms.

Digital Outreach

In 2024 25 we have continued to use the social media application, Nextdoor, to share information and engage with members of the public.

We have used this platform for:

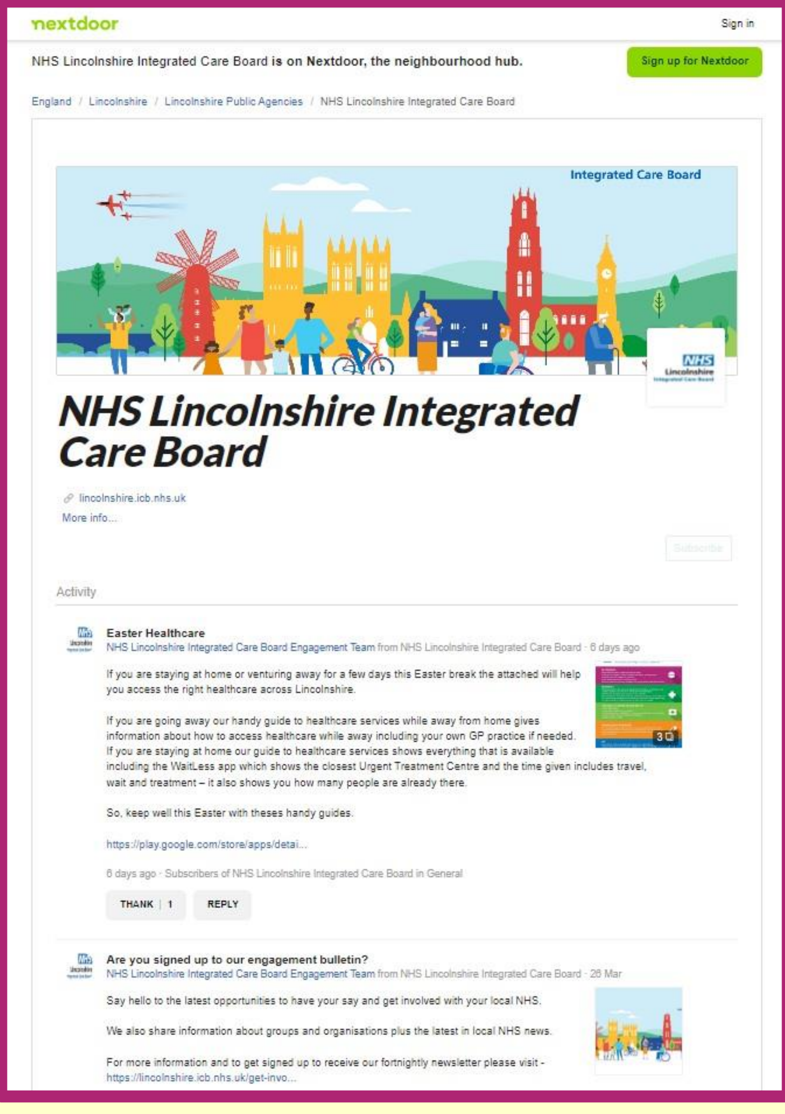
- Publishing live surveys and questionnaires
- Sharing urgent health messages
- Promoting health campaigns
- Promoting GP Listening clinics and consultations
- Sharing details of flu and COVID vaccinations
- Highlighting bank holiday opening times for pharmacies
- Sharing public health messages and events

We have promoted **29 engagement activities** 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.**

This app allows us to reach many more people than before, benefitting from the ability to target areas and 'neighbourhoods' for more direct communication. This has been particularly useful when posting about consultations and local events.

nextdoor



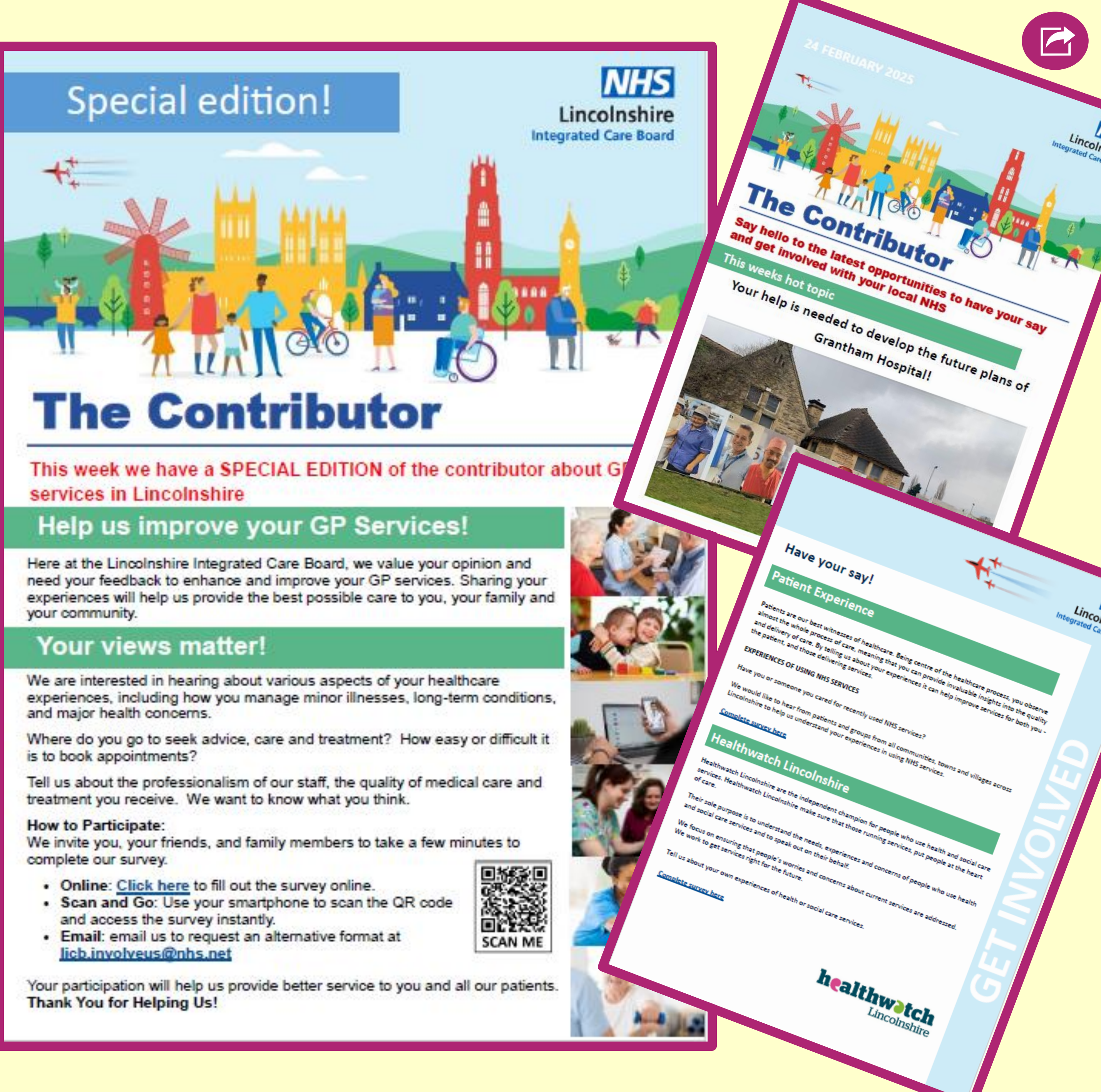
ICB Engagement Bulletin

The Contributor is a fortnightly newsletter that is produced and distributed by the Integrated Care Board (ICB) to over 11,000 contacts. It is shared in collaboration with Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services (LCHS), and United Lincolnshire Teaching Hospital (ULTH) to broaden its reach across their networks.

The primary purpose of **The Contributor** is to advertise involvement opportunities within the NHS, such as surveys, latest news and community events.

Additionally, it features activities from other organisations, including Healthwatch, Lincolnshire County Council, and various voluntary and community organisations to support and encourage participation in their engagements.

This newsletter aims to promote community engagement and encourage participation in projects and engagement opportunities that contribute to the improvement of health and social care services.



HWLincs VOICE Conference 2025

HWLincs is a charity undertaking engagement, research and evaluation to provide insights and recommendations that drive positive change and impact in health, social care and wellbeing. They work with charities, businesses, non profit organisations, the NHS, government departments and more, to deliver contracts and projects in wellbeing and social change.

On 12th February HWLincs held their first **HWLincs VOICE Conference** and the ICB were invited to participate**.**

The ICB were involved in various ways throughout the day. In the morning, our Director of Communications and Engagement illustrated how the ICB involves communities and works closely with partners such as HWLincs.

Additionally, we participated in the **Seldom Heard Communities** workshop where we presented our engagement with health inclusion groups such as the gypsy, roma and traveller communities. In another workshop, the ICB highlighted its collaboration with HWLincs as part of our Lincolnshire maternity and neonatal programme.

We were also part of the 'marketplace' where we teamed up with **LPFT, LCHS and ULTH** to showcase examples of good practice across the NHS.

Picture 1: Lincolnshire Maternity and Neonatal (ICB) presentation
Above photos courtesy of HWLincs – see [HWLincs VOICE Conference 2025]

Picture 2: Suzanne and James (ICB) following their presentation on Seldom Heard Communities
Picture 3: Charley, ICB Director of Communication and Engagement

Pictures of the NHS stand in the marketplace area with Bex (LPFT), Steph (ICB) and Linda (LPFT)

Current Engagement Activity

This section of the report highlights the ongoing engagement projects initiated in 2024/25, which will carry on into 2025/26.

Whilst some of the projects have made substantial progress and others only just starting, the full impact of these engagement activities will not be realised until later in 2025/26.

This section provides an overview of the projects, their objectives, and the anticipated outcomes, reflecting our commitment to continuous improvement and active community involvement.

SMI Physical Health Checks

Newland Health Centre

Stamford Healthcare

Gluten free Products

Specialised Weight Management

Intermediate Care Public & Staff engagement

Fertility Treatment

Click on the tiles to go to more examples of involvement within specific projects and programmes

Click this symbol to return to this page

Stamford Healthcare

Lincolnshire ICB have undertaken engagement 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. This included working with key stakeholders and engaging the local public to help shape the future strategic direction.

The key aim of this involvement was to understand the public opinions on the long-term growth and its potential impact on health and access to NHS Services in Stamford. This will help to shape the long-term priorities of future healthcare.

Public & Patient participation

Engagement in Stamford

- Our approach involved engaging with the people of Stamford and the surrounding area to understand the communities' needs and aspirations for their healthcare and to ensure our health service remains fit for the future.
- Our activities involved undertaking specific and targeted public engagement across Stamford and the surrounding areas to ensure each community has an opportunity to share their thoughts.

The response

- The Engagement team lead and facilitated all involvement activities throughout the programme of work
- 726 responses to the survey
- Visited 12 community groups
- Handed out over 1,000 promotional leaflets

Working with key stakeholders

- ICB's Director of Strategy convened a stakeholder meeting from Stamford area to discuss the engagement and seek feedback

The difference it made

- The analysis of the feedback and survey will take place in April 2025
- Once compiled the report will be discussed at ICB Board and senior executives
- Engage local population – willing to discuss their concerns and suggestions for Stamford
- Further outcomes and impacts of this engagement will be identified once the report is complete

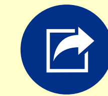
SMI Physical Health Checks

The Serious Mental Illness Health Checks project aim to identify and understand the barriers and challenges faced by individuals with severe mental illness (SMI) who also have alcohol/substance use issues or are experiencing homelessness when accessing physical health checks at their GP.

The engagement started towards the end of 2024/25 and will continue into 2025/26. It aims to work with identified groups to hear first-hand the challenges and barriers they have.

The aim of the project is to co-produce recommendations for the SMI physical health programme tailored to their needs. Opposite is some of the engagement that has been carried out so far.

Current engagement activity



1 Engagement at Framework – Medlock House in Boston:

- Attended an MDT meeting at Medlock House, a Rough Sleeping Accommodation facility.
- The meeting included professionals from Framework and the rough sleeping team from the South & East Lincolnshire Councils Partnership.
- Discussed the challenges clients face when accessing health checks at GP practices.
- Spoke with two residents supported by Framework to understand the specific barriers they encounter when trying to attend their annual health checks

2 Engagement with Project Compass in Lincoln:

- Spent three consecutive days at Project Compass, a shelter providing food, hot drinks, washing facilities, and access to support workers for the homeless.
- Built relationships with community members experiencing homelessness.
- Listened to the challenges and barriers preventing them from accessing their SMI physical health checks.
- Identified additional barriers to accessing GPs for other medical concerns.

3 Engagement with Lincolnshire Recovery Partnership (LRP)

- Spent the day with the rough sleeper team at Corner House, a 15-bed unit supporting individuals with complex needs, where residents typically stay for around nine months to work toward independence.
- Met with the healthcare assistant to discuss health assessments conducted at LRP.
- Spoke with staff members providing drug and alcohol support to service users

4 The difference it made

- Too early to feel the impact of the engagement work so far
- Future engagement planned to date, to visit Restore in Skegness and Lincolnshire Recovery College
- More engagement is planned in 2025/26 and the impact will be seen later in this year.

Newland Health Centre – closure of branch site

Heart of Lincoln Medical Group (HLMG) submitted a proposal to the ICB to close the Portland Branch Site at Newland Health Centre. This request by the ICB Business Management Group meeting on 5 March 2025.

The group approved the recommendation to allow GP Partners to proceed to 'Stage 3 – Involvement of Patients and Key Stakeholders,' as outlined in the Branch Closure Guidance.

Following this decision, the ICB Primary Care and ICB Primary Care Communications and Engagement teams supported the practice with their public engagement and consultation process, which will run from 11 March to May 5, 2025. During this time, patients registered at the practice are invited to share their views before a final decision is made by the ICB.

Current engagement activity

1. Our approach

- In March 2025 a public consultation exercise was approved by ICB Business Management Group
- A communications and engagement plan was developed by the ICB Primary Care and Communications and Engagement team which included leaflets; website information, social media assets.

2. The difference it will make

- The ICB is compliant with statutory public involvement duty.
- The Business Management Group (BMG) will receive the consultation report with all the patient feedback
- The report will give BMG an understanding of patient consensus regarding the views of patients

3. Engaging with patients

- Patient survey opened on 11 March and will run until 5 May 2025
  - Patients are being encourage to participants and share their view with the ICB and the practice
- Online survey opened on 11 March and has been advertised through the ICB and practice and PPG
- Paper versions of the survey have been made available
- 3 public events have been planned with 2 already held
  - 17 March
  - 18 March
  - 3 May

4.

Intermediate Care

Intermediate care is a short term service that helps people regain independence after a hospital stay or if they are at risk of being admitted to a hospital or a care home. It can be offered to help people recover from an illness, certain types of treatment, a fall, or an accident. It consists of therapeutic intervention that is provided by trained staff and usually limited to 6 8 weeks.

There are 4 main types known as reablement, crisis response, home based, and bed based. Intermediate care can take place in your own home, in a care home or in an acute or community hospital.

In March 2024, Lincolnshire County Council, Lincolnshire Integrated Care Board, and associated partners started to review the intermediate care provision across the county.

Two surveys were launched at the end of March one for members of the public and one for staff to complete. Full analysis and key findings will be reported in quarter one of 2025/26.

Fertility Treatment

NHS Lincolnshire Integrated Care Board was part of a review of fertility treatment in the East Midlands where there are five areas that provide fertility services:

- NHS Derby and Derbyshire ICB
- NHS Nottingham and Nottinghamshire ICB
- NHS Northamptonshire ICB
- NHS Leicester, Leicestershire and Rutland ICB
- NHS Lincolnshire ICB

The aim of this work was to review how people currently access fertility treatments in each area and to create one policy for the whole of the East Midlands. This will make accessing treatment easier and fairer.

Lincolnshire ICB collaborated with the other ICBs in the region. A single survey for the East Midlands was produced and hosted by NHS Derby and Derbyshire ICB. East Midlands Fertility Review. The review addressed differences in access such as age, Body Mass Index (BMI), and the number of treatment cycles available. It also considered access for same-sex couples, individuals with children from previous relationships, and single people.

The survey was open throughout November and December to give individuals the opportunity to provide feedback on the suggested proposals and how these proposals may impact them. In Lincolnshire, we promoted the survey through our bulletin, social media, and website. We worked with members of public who were interested in the review and was able to supply the information and links to the survey, enabling them to share across their networks. We encouraged participation from across Lincolnshire.

At the end of March, the survey results were being analysed, and it is expected that the results of the engagement exercise will be available in the first quarter of 2025/26.

Specialist Weight Management Service

The Lincolnshire Healthcare system is dedicated to continuously improving services, and a key component of this is through patient feedback and engagement.

An area of focus for 2025/26 is services for those who are overweight (including obesity), and in Lincolnshire, 67.6% of adults are classified as overweight or obese, which is higher than the national average of 63.5% in England.

A survey has been launched and is targeting all people (including friends and family) who have accessed local weight management support.

The survey is asking questions in relation to any weight support programmes that people have tried, campaigns and information they have received and the services they potentially would use in the future.

Gluten Free Products

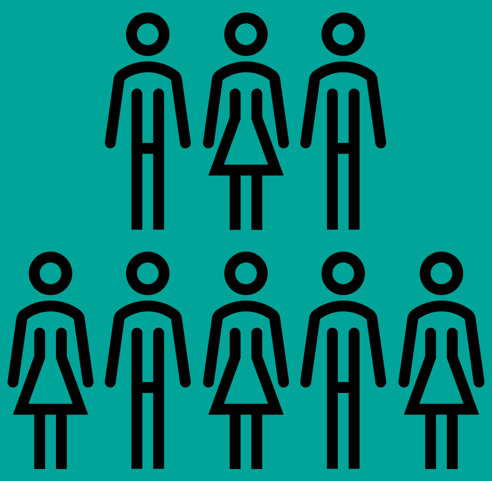
The Lincolnshire NHS is proposing a change in the availability of gluten-free bread and flour on prescription.

Currently, we provide our patients, including those diagnosed with coeliac disease and dermatitis herpetiformis, with up to eight units of gluten-free bread or flour on prescription a week.

Lincolnshire NHS are reviewing the prescribing of gluten-free products in order that we might safely limit the volume of prescriptions. This means that for as many people as safely possible, we would stop prescribing gluten-free products altogether (though for any people for whom this change would not be clinically safe, we would continue to support prescriptions).

We have launched a survey to help us understand the impact of this proposal. The feedback received through this survey will inform the future shape of this service and the provision of gluten-free products in the county.

About us and why we involve people and communities



This following section of the report covers:

- About us, Lincolnshire Integrated Care Board
- Population data about Lincolnshire
- The reasons why we involve people and communities
- Our legal duty
- Our Governance and Assurance

About us in Lincolnshire

The **NHS Lincolnshire Integrated Care Board** (ICB) was established on the 1st July 2022 to arrange the provision of services for the purposes of the health service in England in accordance with the Health and Care Act 2022. It is a statutory organisation bringing the local NHS together to improve Lincolnshire's health and wellbeing.

The Integrated Care Board and Lincolnshire County Council have established a joint committee known as an **Integrated Care Partnership**. This Partnership has developed an Integrated Care Strategy which sets out how the needs identified in the Joint Strategic Needs Assessment for Lincolnshire are being met by the NHS and local authority.

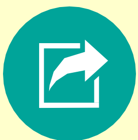
Our **Integrated Care Systems** (ICSs) is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. In Lincolnshire, our ICS is known as **Better Lives Lincolnshire –** for more information click here.

Click here to see ICP strategy

Click here to see ICB membership details

Click here for more information on the ICP

NHS Lincolnshire Integrated Care Board



The ICB will use its resources and powers to achieve clear progress on its aims, working in partnership 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.

The ICB is committed to involving people and communities together with local stakeholders in the development of services and identifying priorities. The details of how we involve and engage our residents can be found in the ICB's People and Communities Strategy (see below). The ICB aims to improve local health services and respond to the health needs of everyone in the area by ensuring patients and the public are at the heart of all our decision making.

The ICB has an experienced and dedicated Involvement Team, providing strategic advice and guidance, managing involvement activities within priority programmes and developing the building blocks to provide a solid basis of relationships and links with our people and communities.

Click here to see ICB's People and Communities Strategy

About our county, Lincolnshire

- Lincolnshire is the **4th largest county** in England with an area of 5,921 sq. km.
- It has **768,364 residents (2021) and 813,119 GP registered patients (Feb 2023)** dispersed across city, market towns, rural and coastal areas. The nature of our geography and communities make up alone is incredibly diverse and varied.
- **Lincolnshire is predominately rural**, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.
- **The population is on average older than the population of England and the East Midlands**. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
- The combination of an **ageing population, a rural geography and areas of high socio-economic deprivation** defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age

The age range 0 15 makes up 15.6% of the population, whilst the other sections of the population aged 16 64 and 65+ years and over make up 61.0%, and 23.4% respectively.

Disability

26.8% of households in Lincolnshire have one person or more with a long term disability.

Ethnicity

89.2% of residents identify themselves as White British with a significant 6.1% identifying as White Other. The non white population makes up 4.9% of the total population.

8.71% use a main language that is not English

Gender

According to the 2021 census, Lincolnshire's population was 768,364, with 51% females and 49% males.

Religion

Christians make up the largest group 53.7%, followed by those who do not have religion at 38.3%.

Other responses: Muslim (6.5%); Hindu (1.7%) ; Jewish (0.5%); Sikh (0.9%) and Buddhist (0.5%)

Sexual Orientation

89.55% of the population are straight or heterosexual; 1.22% gay or lesbian; 1.26& are bi sexual; with other sexual orientations include pansexual (0.2%), asexual (0.06%), queer (0.01%) and other (0.02%)

The 2021 census has been the first time sexual orientation information was collected.

Why we involve people and communities

The ICB is fully committed to involving patients, the public, partners and key stakeholders in the development of services and ensuring they are at the heart of everything we do.

We understand that partnership working is key to empowering patients to have more choice and control over their own health. Through these partnerships, we can better understand the health needs of our population, resulting in improved health outcomes.

The Health and Care Act 2022 mobilised partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes, ensuring they are informed by the needs, experiences and aspirations of the people and communities they serve.

It also required the Lincolnshire Integrated Care Partnership (ICP) to develop an Integrated Care Strategy to support the people of Lincolnshire to enjoy the highest quality health and wellbeing for themselves, their families and their communities, and as part of the ICP we are dedicated to working together to achieve this.

- The Lincolnshire ICB Constitution sets out the legal duties and principles we will adhere to when developing and maintaining arrangements for public involvement
- Our People and Communities Strategy demonstrates how we will deliver our duties to understand and empower our communities
- Listening to the patient and members of public that use our services help us understand the needs of the communities that we serve
- By giving local people and partners a voice, we can make sure that the services meets the needs of the local community
- The Integrated Care Board has a legal duty to involve patients and the public in decision making and service development.
- There are clear standards for public engagement to shape decisions, monitor quality and to set priorities

Involvement can be in different ways:

Our legal duty to involve

As outlined in section 14Z45 of the NHS Act 2006 and amended by The Health and Care Act 2022, the ICB has discharged its public involvement duty by having in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery; and decisions which would have an impact on services.

By listening to local people and co-producing with them or those who represent them, we can improve the decisions we make and ensure we are considering the health needs of Lincolnshire residents.

The ICB is continuously improving and developing the ways we can involve our communities. It is important to us that the public sees how their feedback has helped to shape local services and how much we value all feedback and engagement.

We do this is as set out in our values which are outlined in our Constitution and the principles detailed in our People and Communities Strategy. This explains how we work with people and communities and continue to develop and strengthen this with our partner organisations and patient representatives.

To see our other legal duties and responsibilities:

Click here to see Lincolnshire ICB constitution

Click here to see public sector equality duty

Click here to see Health and Care Act 2022

Click here to see Health Act 2006 **

*** Health Act 2006 covers:*

- *Duties as to reducing health inequalities – s.14Z34 NHS Act 2006*
- *Annual reporting – s.14Z58 NHS Act 2006*
- *Duty to promote involvement of each patient – s.14Z36 NHS Act 2006*

Governance and assurance

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

Reports on our involvement activities and the feedback gathered from these are reported to the ICB Operational Quality Assurance Group, the System Quality and Patient Experience Committee (SQPEC) and to our Primary Care Commissioning Committee (PCCC) if it is regarding a GP surgery.

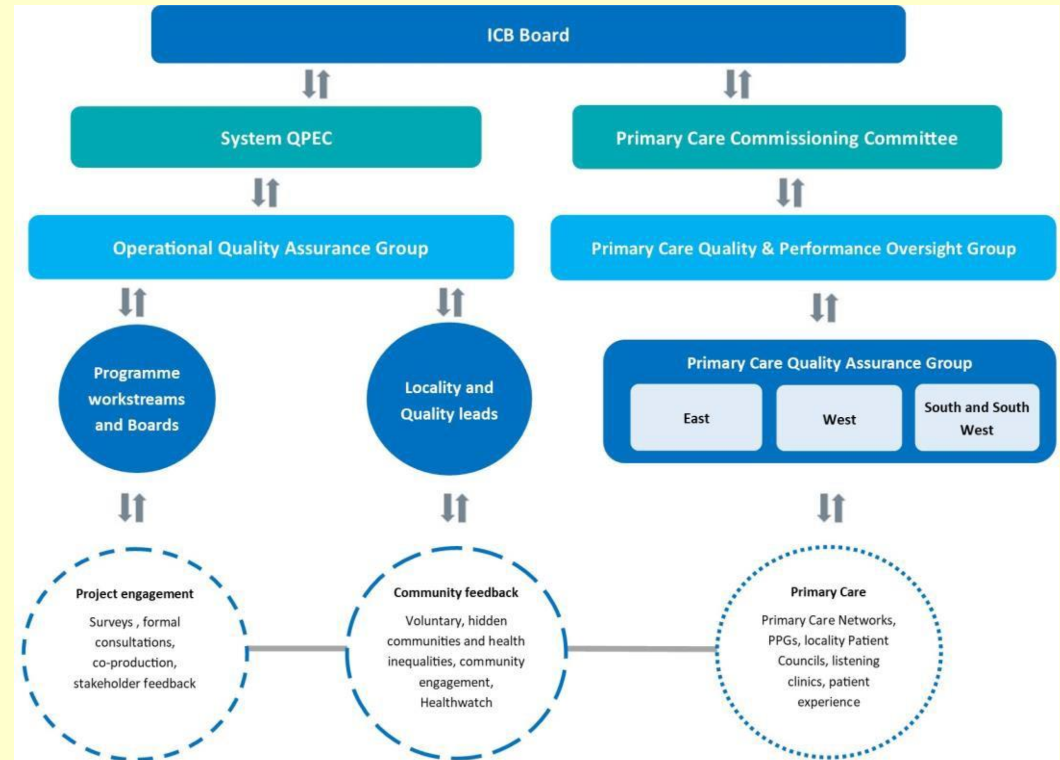
SQPEC also review our People and Communities Involvement Annual Report and monitor our delivery plan for our People and Communities Strategy.

Feedback from programme specific engagement including any differences in equality or health inequality group is also shared with our project leads to help shape and steer their programmes of work. **See diagram opposite.**

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

In 2024/25 we 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.

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



Working with others

This section of the report highlights the importance of collaboration across sectors including the NHS, partner organisations and the voluntary and community sector.

It describes the necessity of joint working emphasising how sharing and combining time, insights and resources can lead to the best outcomes.

By working together, we can ensure that our efforts are more effective, efficient, and impactful, ultimately enhancing the health and wellbeing of the Lincolnshire community.

Working 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 Lincolnshire 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.

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.

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.

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

Better Lives Lincolnshire – our shared agreement

Over a few years, the people of Lincolnshire have been sharing their views on their health and care and how it could be improved via a number of involvement opportunities:

Joint Health and Wellbeing Strategy for Lincolnshire 2017; The Lincolnshire Public 'Talk About' NHS Long term Plan 2019; Healthy Conversation 2019; NHS Lincolnshire Citizen Panel Survey 1 - personalised Care 2021; Involvement Team Summer Roadshows 2022; and The NHS Lincolnshire Joint Forward Plan 2023-28.

This feedback has been used to develop our **Shared Agreement.** This describes **a new relationship between the health & care system and the people of Lincolnshire**, where individuals play an equal part in their health, well-being, and care.

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

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

At its core this will describe and illustrate the foundations of a new relationship which have been developed by working with people from Lincolnshire:

Our partners in ICB governance

Healthwatch sit on ICB Board as patient representative

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

Engaging with Health Overview and Scrutiny Committee

We engage with HOSC on potential service changes, enabling them to consider whether it is a substantial and significant service change requiring consultation process. We 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.

Public Health and Local Authority representatives at ICB board meetings

Representatives sit alongside our involvement representative at every ICB board formally. Meet the ICB Board

Voluntary and Community Sector

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

Primary Care and Provider Organisations

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

Supporting each other by joined up working

Our day-to-day processes and systems have been established to work across involvement, participation and engagement 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 our patient groups and memberships while supporting each other.

The involvement leads across the ICB and Provider Trusts meet on a fortnightly basis to share good practice, coordinate activities and resources and offer support to each other. We are also working across our communications and involvement teams to scope ideas of how we can join up even more of our work and activities going forwards.

Sharing resources

We share survey software across all NHS organisations this is called Qualtrics.
We have created an **Insight Database**, storing multiple examples of activities and feedback. This is available to all NHS organisations.
Working practices such as templates are shared.

Training

Training across all involvement leads regularly takes place such as Qualtrics training, induction and refresh; co-production training; stakeholder mapping etc

Joined up approach

We join up our engagement activities with our partners to 'go out once' to local groups and communities to reduce consultation and engagement fatigue.

Sharing good practice

The ICB involvement team co ordinated the refresh of the equality monitoring questions and orchestrated the production of the health inclusion questions.
All involvement leads across the NHS worked together to decide on the final set of questions to be used across the county.
Click here for more info.

Joined up working across Lincolnshire

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 Lincolnshire, 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.

The Lincolnshire Co-production Conversation Group (LCCG)

This group brings together colleagues from across the ICS (NHS, LCC, VCFSE) and people with lived experience with a shared passion for co-production. Work continues in this group to develop a Co – Production guiding framework and set of principles which is accessible and meaningful to all.

Healthwatch Lincolnshire Liaison meetings

Regular meetings have been established to plan and agree future work programmes across the Lincolnshire system. This will support alignment of engagement activities and reduce duplication, enabling targeted Healthwatch support for key programmes of work.

How insight and data have been used by the ICB to inform its work with people and communities

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 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.

The involvement team supports programmes within the ICB to ensure that sufficient involvement activities have been undertaken to inform the following assessments:

- Equality Impact Assessments
- Quality Impact Assessments
- Health Inequality Impact Assessments (HEAT)

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.

As a commissioning organisation we have access to the Lincolnshire Health Intelligence Hub (LHIH) where the latest demographic information can be found including the Census data, Director of Public Health Annual report and Joint Strategic needs assessment.

Click here to visit the LHIH website

How the ICB is insight led

When planning any engagement activities, we review the **JSNA data held on the Lincolnshire Health Intelligence Hub, our own insight database and information held by the project team** so that the involvement activities are appropriate.
We utilise our own stakeholder database to reach out to population e.g. connecting with some areas online, others via existing community groups, others via foodbanks etc

Healthwatch Lincolnshire provides the ICB **a monthly report of the information and insight** that has gathered by Healthwatch through engaging with individuals and communities. This information is widely circulated within the ICB and shared with colleagues in primary care.

For primary care, the feedback is reported into the countywide Primary Care Operational and Quality Assurance Group who look at service delivery, quality and standards.

Feedback is used to monitor quality of services and helps address any issues with the quality of primary care medical services. The ICB has carried out listening clinics and discussed with practices.

Insight database. In 2022-23**,** the ICB led the development and creation of an Insight Database by pulling together all the findings, data and information from engagement activities across the ICB and NHS partner organisations. This database provides a solid base of intelligence and experiences which are shared to inform programmes of work and decision making.

A central hub for collating and storing insight gathered across Lincolnshire health organisations, it is easily accessible to a wide variety of professionals to inform decision making. It will hold (non-sensitive) data as themes or topics, including the originator of the source of information. The system aims to provide a simple, user-friendly solution for identifying reports and has the potential to be accessed widely in the future to increase understanding and reduce system-wide duplication.

Our general aims are to:

- Support the use of a variety of methods for gathering insight, moving away from an over-reliance on surveys to methods that nurture and use existing relationships.
- Support collaboration between organisations around gathering insight by enabling links to be made between individuals/organisations who are working on the same area or are wanting the answers to the same questions. Maximising scarce resource.
- Collect and organise insight being gathered across the system to make it easily accessible and searchable.

Strategy Development and Population Health Management

Population Health Management (PHM) is an approach which helps us understand people's health and care needs and how they are likely to change in the future. It aims to improve physical and mental health outcomes, reduce health inequalities and help us live our extra years in better health.

PHM uses historical and current data about people's health and how they are using health and care services to design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time.

It involves the crucial role of communities and local people, the NHS and other public services including councils, schools, housing associations and social services working together to join up services for people by sharing information, resources and goals. This lets us tailor services to the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

Working with communities and partner organisations in Lincolnshire we are looking at the challenges we face and the opportunities we have to improve the physical and mental health outcomes and wellbeing of people living in Lincolnshire.

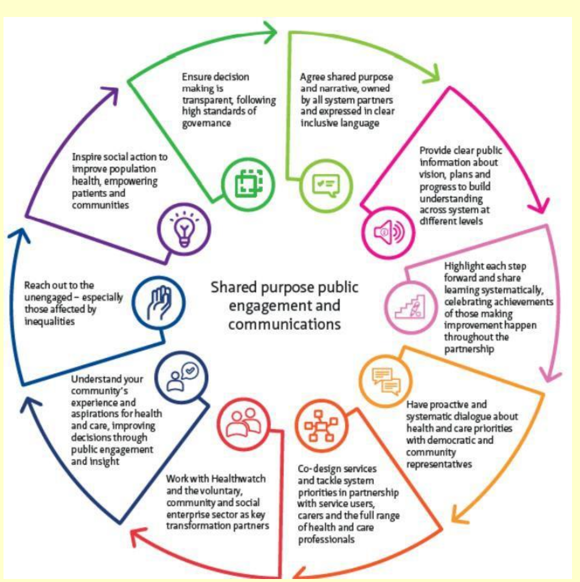
Click here for more information on population health management

Integral to all this work is the **communications and engagement with patients, the public, staff and stakeholders.**

Work is underway to embed this approach into our strategy development and management to provide a robust base of knowledge and insight to all our plans.

Engagement, patient experience and co-production will be embedded throughout the modelling for PHM and strategic planning to enable timely and meaningful involvement with our communities and ensure their voice is central to the ICB planning and service design.

Our legal duties and commitments are clear – people and communities need to be involved in all stages of service development, design, change and decision making. Our ambition to achieve this is illustrated well using the model from NHS Confederation's 'Building Common Purpose, Learning on engagement and communications in integrated care systems



A big thank you

The year 2024-25 has been a remarkable period of growth and engagement for our community.

The numerous activities and initiatives undertaken have not only strengthened our connections with communities, stakeholders and members of the public but also demonstrated the profound impact of our efforts.

As we look ahead, we remain committed to fostering even deeper relationships and continuing to make a meaningful difference. We extend our heartfelt gratitude to everyone who has contributed to these successes and look forward to another year of collaboration and progress.

Thank you to everyone who has taken the time to support the NHS.

The ICB Involvement Team.

Item 7 (i)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Update from the Service Delivery & Performance Committee for April 2025
Report Author:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	

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

Recommendations

The Board is asked to note and consider this report.

Summary

1. Winter Review

The Committee received a detailed update which reviewed the approach to developing the Winter Plan, its implementation and outcomes, along with learning points.

The key headlines were:

- It was a risk-based Winter Plan, developed with system partners across health and care, with the prime focus being on residents/patients. Oversight of the plan was through UEC governance and daily operational oversight via the System Coordination Centre.
- System leadership of the delivery of the Plan and management of winter pressures were overseen by the weekly UEC Clinical Reference Group and the UEC Leaders Group, this being led by the System Winter Director and supported by clinical and operational leaders.
- The Plan was fully mobilised and enacted with additional break-glass options developed and implemented during peaks in pressure and an EMAS critical incident.
- Processes were in place for any significant delays that could cause harm to patients, including long wait harm reviews for 8-hour ambulance breaches and waits over 48

- hours within emergency departments. Lincolnshire did not experience any 8-hour handover delays during Winter 2024/25.
- There was ongoing delivery of the 10 High Impact Interventions for UEC as the bedrock of the Plan.
- Agility and the ability to course-correct were key components, these were achieved via system governance, for example, having a Clinical Assessment Service Practitioner within the EMAS Emergency Operations Centre, having additional Winter Emergency Department doctors to support discharge and the creation of a discharge cell.

Winter 24/25 Performance

- Performance Target – the 78% target for 4-hour performance (all types) was achieved in March 2025.
- Wait Time Improvement – the number of patients waiting 12 hours in the emergency department has been reduced.
- CAT2 Mean Improvement – improvement in CAT2 Mean times has been maintained and Lincolnshire has become the sixth most improved system year-to-year which has attracted £5m worth of capital funding.
- The System Coordination Centre achieved benchmarkable status.

In conclusion, the Committee felt that the system had operated effectively over winter and had been more integrated than in previous years. Whilst performance had been challenging at times, the system recovered quickly which had minimised impact on patients. The Committee noted areas that had been identified for further transformation this year ahead of next winter, for example in intermediate care.

System working has been highlighted as a key strength in Lincolnshire and continues to be commended by the NHS England Regional Team.

2. 2024/25 Year End Highlights

The Committee received a presentation of the 24/25 performance outturn position using a mixture of validated and unvalidated data across key indicators.
The key points to highlight are:

- Elective Care – significant progress has been made across all main providers and 65wk waits, whilst not fully eliminated, were in single figures and largely due to patient choice.
- Cancer – the cancer backlog trajectory was met along with the faster diagnosis standard.
- Urgent and Emergency Care – 4hr performance trajectory was met and average handover times have significantly improved.
- Mental Health – the number of Out of Area Placements has improved with further plans in place. Completed treatment for Talking Therapies was above target.

3. 2025/26 Lincolnshire Operational Plan

The 2025/26 Lincolnshire Operational Plan was presented to the Committee and the contents were noted.

- The system was compliant with the delivery of a balanced net system financial position.
- The system was compliant with the key delivery indicators.

- A lessons learned exercise had taken place and the learning from this was, and will further be used, in the development and implementation of this Plan.

Concerns were raised in relation to the financial pressures and the resultant reduction in the workforce following the recent government announcement. It was felt that it would be difficult to further develop services and improve productivity when there was a reduction in the number of staff.

The Committee agreed that the plan was excellent but acknowledged that there are challenges surrounding the delivery of the plan.

4. Month One Position against Plan

The Committee received a verbal update using the month to date unvalidated data for key indicators in the following - UEC, Elective, Cancer, Diagnostics and Mental Health.

The full year validated outturn is expected in May and by the June meeting, data for the new metrics for 2025/26 would be available.

There was no performance exceptions or risks to highlight or escalate to the ICB Board at this point.

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

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

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	7 (iii)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Audit & Risk Committee Update
Report Author:	Ms Karen Bates, Assistant to the Board Secretary Mrs Jules Ellis-Fenwick, ICB Board Secretary Mr John Dunstan, Non-Executive Member and Chair of the Audit and Risk Committee
Presenter:	Mr John Dunstan, Non-Executive Member and Chair of the Audit and Risk Committee
Appendices:	N/A

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

Recommendations

The Board is asked to note the update and progress.

Summary

The Audit & Risk Committee meeting held on 17th April 2025 focused on a number of areas including the following:

- 2024/25 External Audit Update
- Governance Report
- IG Quarterly Update Quarter Three
- Update on the ICB Risk Management Arrangements
- Audit Yorkshire Counter Fraud Update Progress Report
- Audit Yorkshire Draft 2025/26 Fraud Plan
- TIAA SICA Report including IA reports:
    - Risk Management and BAF
    - Primary Care Recovery Plan
    - Conflicts of Interest
    - Business Continuity
- TIAA Indicative Audit Strategy 2025-2027 and Annual Plan 2025/26

- TIAA Interim Head of Internal Audit Opinion
- ICB Annual Report and Account Key Dates including Draft Annual Governance Statement
- Accounting Policy Pages
- Draft Audit & Risk Committee Annual Report 2024/25 including Committee Self-Assessment

Key points for noting were as follows:

External Audit Update 24/25
The audit plan for 2024/25 had been shared which highlighted the audit risks, and which will continue to be updated and reflected upon. There was also a risk highlighted around how the ICB deficit had arisen and how this was communicated through the Board. also a

Audit and Risk Committee Terms of Reference

The Committee received and approved its Terms of Reference, which had been updated to reflect the Committee now having oversight of Emergency Preparedness Resilience and Response (EPRR). It was noted these would need to be presented to the Board for approval – **Terms of Reference with tracked changes in red attached.**

Governance Report
The latest versions of the Declaration of Interest and Hospitality Registers were presented and noted. The Committee agreed to approve the write off of £300 to the Local Resilience Forum (LRF) due to delegates (senior Executives) non-attendance because of the sprint week.

IG Quarterly Update – Quarter Three
10 of the 35 outcomes remain outstanding. Staff training is currently at 90%. The four audits chosen by the ICB will commence at the beginning of May. Two low level incidents reported, which have been classed as low level/near misses.

Update on the ICB Risk Management Arrangements
The annual risk management audit has taken place and the outcome for this year was reasonable assurance, showing some improvements from 2023/24.

Audit Yorkshire Counter Fraud Update Progress Report
The long standing Personal Health Budget (PHB) investigation continues with a breakthrough where the value has increased and we are now working towards a prosecution file. Due to the investigation ongoing they were three days over plan.

Audit Yorkshire Draft 25/26 Fraud Plan
The plan is mostly the same as last year. Agreed to have the same number of days as last year.

TIAA SICA Report
Four audits have been completed: Risk management and BAF; Primary care recovery plan; Conflicts of interest; and Business continuity. All received a reasonable level of assurance There are a number of audits still in progress. The proposed audit across the system did not take place during the year and these days were assigned to alternative topics which are largely underway.

Update on Internal Audit Plan
Conflict of Interest – this had moved on significantly prior to the meeting. Module One Training has now been added to the mandatory suite of training. The constitution makes it clear that the COI Guardian should be the Chair of the Audit & Risk Committee and this role will now transfer from Julie Pomeroy to Mr John Dunstan

Collaborative Working – guidance was sought as things had changed considerably since the audit was undertaken. The planning work has been all consuming which has prevented some actions from moving forward. It was suggested that these actions are included as part of the ongoing changes. This was agreed by the members and Chair.

TIAA Indicative Audit Strategy 25-27 and Annual Plan 2025/26
The plan was shared with a caveat that this plan is likely to change in line with the risk profile moving forward. It was recommended that the plan remain widely risk based, giving the coming challenges over the next year.

ICB Annual Report & Accounts Key Dates Including Draft Annual Governance Statement
The Annual Governance Statement (AGS) had been shared and it was noted that Mrs Pratt, the ex-Chair of the Audit and Risk Committee had taken opportunity to make amendments prior to leaving, along with the other NEDs. Some areas still require completion, including the Head of Internal Audit Opinion. Nothing of note to flag. The report will be submitted as part of the Annual Report by 9.00 am on the 25th April 2025.

Accounting Policies Page
The content is prescribed by NHSE. There were no material changes since last year.

Audit and Risk Committee Annual Report 2024/25

The Committee received its draft Annual Report for 2024/25 along with the associated Self-Assessment. No amendments were identified to the Annual Report but a change was requested to the Self-Assessment in relation to the Committee receiving information on performance.

It was noted that the Audit and Risk Committee Annual Report would be presented to the Board at its meeting on the 27th May, along with the Self-Assessment. **These documents are attached to the report.**

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

Risk and Assurance	
AS indicated in the report.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	No
Does the report highlight any quality and patient safety implications?	No
Does the report highlight any health inequalities implications?	No
Does the report demonstrate patient and public involvement?	No. Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	No. Not applicable.

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

Report previously presented at:
Regular updates provided to the Board.
Is the report confidential or not?
Yes ☐   No ☒

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Audit and Risk Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website as part of the ICB Governance Handbook, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a Non-Executive Committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. AUTHORITY

2.1 The Audit and Risk Committee is authorised by the Board to:

- Investigate any activity within its Terms of Reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:

3. PURPOSE OF THE COMMITTEE

3.1 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

3.2 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.3 The Audit and Risk Committee has no executive powers, other than those delegated in the SoRD and specified in these Terms of Reference.

4. MEMBERSHIP AND ATTENDANCE

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than four members of the Committee who are Non-Executive Members of the Board (and ideally will be the Chairs of three of the Board's Committees – Finance, Performance and Quality).

4.3 Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

4.4 Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice chair

4.5 In accordance with the Constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.

4.6 The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will ideally not be a member of any other committee.

4.7 Committee members will appoint a Vice Chair of the Committee who will be one of the Non-Executive Members of the Board.

4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Finance or their nominated deputy;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;

4.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

4.12 The Chief Executive should be invited to attend the meeting at least annually.

4.13 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

Attendance

4.14 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

4.15 Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Access

4.16 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit and Risk Committee.

5. MEETINGS QUORACY AND DECISIONS

5.1 The Audit and Risk Committee will meet not less than four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of three independent Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

6.1 The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

6.2 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

6.3 To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

6.4 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

6.5 To have oversight of system risks where they relate to the achievement of the ICB's objectives.

6.6 To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

6.7 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.8 To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

6.9 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

6.10 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

6.11 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

6.12 To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Risk Committee's own areas of responsibility.

6.13 To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

6.14 To have responsibility for the oversight of Emergency Preparedness Resilience and Response (EPRR) within the ICB.

6.15 To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter Fraud

6.16 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

6.17 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

6.18 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

6.19 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

6.20 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

6.21 To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

6.22 To receive regular updates on IG compliance (including uptake & completion of data security

training), data breaches and any related issues and risks.

6.23 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

6.24 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

6.25 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial Reporting

6.26 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

6.27 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

6.28 To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

Conflicts of Interest

6.29 The Chair of the Audit and Risk Committee will be the nominated Conflicts of Interest Guardian.

6.30 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

6.31 Where a member of the Committee is aware of an interest, conflict or potential interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

6.32 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflicts of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting.

6.33 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

6.34 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing conflicts of interest, and may result in suspension from the Committee.

Management

6.35 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

6.36 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

6.37 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

6.38 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

6.39 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

7. ACCOUNTABILITY AND REPORTING

7.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

7.2 The Audit and Risk Committee will be required to:

a) Provide a written report to the Board following each meeting outlining the key matters discussed, any points for escalation, assurance and/or decision and/or any new areas of risk. The Chair of the Committee shall attend the Board (public meeting) to present the report.
b) A Committee Chair may also request an Executive lead to attend the Audit and Risk Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail.

7.3 The Audit and Risk Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

8. BEHAVIOURS AND CONDUCT

ICB Values

8.1 Members will be expected to conduct business in line with the ICB values and objectives.

8.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's

Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

8.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

9. SECRETARIAT AND ADMINISTRATION

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

10. REVIEW

10.1 The Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of Review:

ANNUAL REPORT OF THE AUDIT AND RISK COMMITTEE 1st APRIL 2024 TO 31ST MARCH 2025

1. PURPOSE

The purpose of this report is to brief the Board on the work of the Audit and Risk Committee during the last financial year. This report covers the period 1st April 2024 to 31st March 2025.

This report therefore outlines how the Committee has complied with the duties delegated by the Board through its Terms of Reference and identifies key actions to address developments in the Committee's role.

The Audit and Risk Committee considered the report at its meeting held on 17th April and approved the document for submission to the ICB Board.

2. BACKGROUND

The Audit and Risk Committee is established with approved Terms of Reference that are aligned with the NHS Audit Committee Handbook published by the HFMA and the Department of Health.

3. OPERATION OF THE COMMITTEE

The Committee met six times in the year and discharged its responsibilities for scrutinising the management of risk and controls, which affect all aspects of the ICB's business.

The membership of the Audit and Risk Committee for the period 1st April 2024 to 31st March 2025 comprised of:

Name	Role	Period
Mrs Margaret Pratt	Non-Executive Director – Chair of the Audit and Risk Committee	Full year
Mrs Julie Pomeroy	Non-Executive Director, and Conflicts of Interest Guardian and Chair of the Finance and Resource Committee	Full year
Mrs Dawn Kenson	Non-Executive Director and Chair of the Service Delivery and Performance Committee	Full year
Mrs Sharon Robson	Non-Executive Director and Chair of the System Quality and Patient Experience Committee	Full year

The following chart details attendance by the Non-Executive Directors during the year:

	31/05/24	25/06/24	31/07/24	04/09/24	13/11/24	17/01/25
Margaret Pratt	✓	✓	✓	✓	✓	✓
Julie Pomeroy	✓	✓	✓	✓	✓	✓
Dawn Kenson	✓	✓	✓	✓	✓	✓
Sharon Robson	✓	x	✓	✓	✓	✓

The following people were also in attendance:

Mr Matt Gaunt, 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

The Chair of the Committee has reported to the Board following each meeting and presented an Escalation Report.

4. PRINCIPAL REVIEW AREAS

4.1 Governance, Risk Management and Internal Control

The aim of the Audit and Risk Committee is to provide one of the key means by which the ICB ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the Officers of the ICB and members of the Board.

In discharging these duties, the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (Annual Governance Statement) which are supported by the Head of Audit opinion and other opinions provided.
- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs and reviewing the reliability and integrity of these assurances.
- The adequacy of relevant policies, legality issues and the Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The ICB identifies, evaluates and controls its risks through the Committee structure it has in place. The ICB embeds risk management through:

- The ICB Committees (including the Audit and Risk Committee)
- Risk Management Group
- Board Assurance Framework (BAF)
- Corporate Risk Register (CRR)
- Policies and Procedures
- Standing Financial Instructions, Scheme of Reservation and Delegation (including Delegated Financial Authority Limits) and Standing Orders

All staff are responsible for the identification and management of risk appropriate to their own role in the organisation. The use of Quality Impact Assessments, Privacy Impact Assessments, Data Protection Impact Assessments and Equality Impact Assessments as part of the ICB project management framework also helps to identify risks.

The Audit and Risk Committee and the Board have been regularly briefed on the progress and the development and establishment of robust risk management arrangements for the ICB, including the development of the ICB Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Risk Appetite.

The BAFs 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 in 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.

An internal audit review of the adequacy and effectiveness of the ICB's risk management arrangements including how it interfaces with the ICS wide risk management structures has been carried out in 2024/25. The outcome of the review identified adequate and effective risk management arrangements provide the ICB Board with confidence 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 effectively managed.

The overall assessment was Reasonable Assurance.

CCG and ICB Annual Reports 2023/24

During 2024/25 the Committee reviewed and recommended approval to the Board of the ICB Annual Report and Accounts for the period 1st April 2023 to 31st March 2024. This document included the Annual Governance Statement.

The Annual Report and Annual Accounts 2023/24 was subject to detailed scrutiny by the ICB's external auditors and submitted to NHS England once finalised. The Annual Report and Accounts was published on the ICB's website in September 2024 in line with national requirements.

5. LINCOLNSHIRE AUDIT CHAIRS AND DIRECTORS OF FINANCE

The Audit Chairs and Directors of Finance of the ICB and the NHS partner organisations have met on two occasions during 2024/25 to discuss common themes and audit services.

6. INTERNAL AUDIT

During the period 1st April 2024 to the 31st March 2025 the Internal Audit Service was provided by TIAA.

At year end good progress was made and all agreed ICB internal audits took place, and the associated reports were provided. All recommendations and timescales identified in the reports

have been agreed and Executive Directors identified as the responsible person for each of those to promote timely completion of the work.

Following discussions at the November 2024 Audit and Risk Committee regarding the inability of TIAA to undertake four system wide audits in the approved 2024/25 internal audit plan, TIAA and the ICB finance colleagues attended the ICB's Executive Team meeting on 5th December 2024 to discuss the delivery of the 2024/25 plan. The Executive Team recommended that the four system wide audits be replaced with other audits. The change to the annual plan was approved by the Audit and Risk Committee in January 2025.

Completion of the ICB Internal Audit Plan for 2024/25 has ensured the ICB has been provided with evidence for the Head of Internal Audit Opinion as part of the statutory annual accounts process and for inclusion in the Annual Governance Statement.

7. EXTERNAL AUDIT

The External Audit Service was delivered by Ernst and Young.

The External Audit work can be divided into two broad headings:

a) To audit the financial statements and provide an opinion thereon;
b) To form an assessment of the ICB's arrangements for its use of resources.

The Committee considered the external audit plan including the risks identified by the external auditors and their planned response to them, together with progress reports throughout the year. The Committee also met separately with the auditors to ensure there were no issues the auditors wished to raise privately.

The external auditors also provided regular technical updates throughout the year.

8. COUNTER FRAUD

The Local Counter Fraud service was provided by Audit Yorkshire for the period 1st April 2024 to 31st March 2025.

The Committee has reviewed and agreed the Counter Fraud Plan and has discussed and noted regular updates by Audit Yorkshire during the reporting period 1st April 2024 to 31st March 2025. Recommendations have been logged on a tracker document and reviewed by the Committee at each meeting.

9. REVIEW FOR THE PERIOD 1ST APRIL 2024 TO 31ST MARCH 2025

The work programme of the Committee for the period 1st April 2024 to 31st March 2025 was aligned to the Annual Plans agreed with External Audit, Internal Audit and Counter Fraud.

The Committee has completed a Self-Assessment of its work, which is attached to this report for consideration by the ICB Board.

10. CHAIR'S OVERVIEW AND CONCLUSION

In conclusion, the Committee has met its duties delegated by the Board and would like to thank all members and attendees for their contribution over the period this reports covers.

John Dunstan
Non-Executive Director and
Chair of the Audit and Risk Committee
April 2025

AUDIT AND RISK COMMITTEE

SELF-ASSESSMENT QUESTIONS 2024/25

	Area/Question	Yes	No	Comments/Action
	Composition, establishment and duties			
1	Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	Yes		
	Effective Functioning - Committee			
2	Does the Committee review its progress and outputs?	Yes		
3	Does the Committee review its risks regularly?	Yes		The Audit and Risk Committee has received regular updates on the continued development of the ICB's risk management arrangements and has also periodically considered the Corporate Risk Register and Board Assurance Framework.
4	Does the Committee report regularly to the Board through verbal and written reports and make clear recommendations where necessary, including escalating items for consideration?	Yes		Either a verbal update or written report is presented to the Board immediately following the Audit and Risk Committee meeting.

5	Does the Committee effectively monitor, or ensure monitoring of, agreed actions, e.g. by use of an Action Log?	Yes		
6	Has the Committee formally considered how it integrates with other Committees and groups?	Yes		Membership includes ICB Chairs of the three System Board Committee's. There is a separate informal forum of the Audit chairs.
7	Does the Committee receive timely and appropriate feedback from its Sub-Committees/groups?			Not applicable
8	Dos the Committee provide clear direction to its Sub-Committees/groups?			Not applicable
	Effective Functioning – individual members			
9	Do members appropriately challenge Executives and management on critical and sensitive matters?	Yes		
	Compliance with the law and regulations governing the NHS			
10	Does the Committee have a mechanism to keep it aware of topical issues?	Yes		
11	Does the Committee have a mechanism to keep it aware of legal and regulatory issues?	Yes		The Committee is reliant of External Audit, Internal Audit and counter-fraud briefings.
	Assurance			
12	Does the Committee receive timely information on performance concerns?	Yes		Where appropriate, such as in relation to the performance of internal and external auditors.
13	Are all these reports clear, concise and readily understood?	Yes		As and when received.
	Other Issues			
14	Is there anything else you'd like to raise about the Committee and it's role? Please tell us here.		No	

Briefing Summary of the East Midlands Joint Committee Meeting held on Tuesday 15 April 2025

1. **Purpose**
   1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 15 April 2025.
   1.2. Confirmation of Chair Arrangements

2. **Summary of Agenda Items**
   2.1. <u>Confirmation of Chair</u>
   The Committee approved that Kathy McLean (Chair of NHS Derby & Derbyshire ICB and NHS Nottingham & Nottinghamshire ICB) will remain as Chair of the Committee until 31 March 2026.

   2.2. <u>Primary Care Finance and Assurance Report</u>
   The Committee received the report for **ASSURANCE.** Confirmation was received that all contracts for Intermediate Minor Oral Surgery had been extended for a further 6 months with no detrimental impact to patient care, and that following the announcement of the Governmental manifesto commitment to secure additional urgent dental care appointments the East Midlands had approached the market through an Expression of Interests exercise and are currently achieving a 75% uptake against the East Midlands target. With a view to securing the remaining 25 % a Phase 2 “Flexible Commissioning” Expression of Interest is to commence through which existing providers of General Dental Services will be able to apply to convert current underperformance into urgent care activity with subsequent stabilisation follow ups.

   Work continues on the Community Pharmacy Strategy with a multi-stakeholder event planned for 10 April 2025, with the aim of completing the strategy by summer 2025.

   2.3. <u>Specialised Commissioning Services Integrated Assurance Report</u>
   The Committee received the report for **ASSURANCE.** The Committee heard the progress made at Tier 2 regarding collective action to maintain Paediatric Spinal Cord Injury, Surgical Sperm Retrieval, Environmental Controls and Specialist Prosthetics and Neonatal provision. Confirmation was received that as of month 11 delegate service were running at a surplus of £11 million across the East Midlands, with frozen reserves now released into ICB allocations and reinstated into the opening baselines for 2025/26. There were no immediate quality issues for escalation, but it was noted that the outcomes of a deep dive into Thrombectomy would be presented to an upcoming meeting.

2.4. Specialised Commissioning Strategic Brief

The Committee **RECIEVED** confirmation that all ICBs had been approved for the further delegation, all delegation agreements have now been completed, and **RECEIVED** the delegated duties from each member ICB. The Committee **NOTED** the work being undertaken at Tier 2 regarding Mental Health, Learning Disability and Autism, specifically that governance proposals would be presented to the next meeting and the confirmation of the contracting model through a Lead Provider/ Collaborative Provider structure.

The Committee **NOTED** the 2025/26 Operational Plans are being presented to the April Tier 2 meetings and would flow through to the next meeting, further discussion was had regarding to developing the horizon scanning / further forward-thinking planning agenda.

2.5. National Rehabilitation Centre Briefing

The Committee **RECEIVED** an update on the National Rehabilitation Centre, notably that the build was nearing completion (scheduled for August 2025). Primary focus for discussion lay with the need for urgent consideration into how value could be achieved considering changes to funding models (Neuro) and the wider challenge across the NHS. A Task and Finish Group is to be established to facilitate consideration of the way forward and inform a wider commissioning strategy to drive value from 2026/27 and beyond. The Committee asked that a briefing note be prepared for all ICB Boards.

2.6. 111/999 Governance Arrangements

The Committee **NOTED** the progress with agreement of contracts, and the further need for all ICBs to agree to the revised governance proposals.

2.7. NHS Reforms

The formal meeting of the Committee ended with only ICB Chairs and Chief Executive Officers remaining to undertake an informal development session focused on progressing the ICBs / East Midlands response to the NHS Reforms.

3. Recommendation

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

Item 8 (i)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (i)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Register of Documents Sealed in 2024/25
Report Author:	Mrs Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Mrs Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	N/A

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

Recommendations

The Board is asked to note the paper and its contents.

Summary

To inform the Board of the details of documents signed and sealed during the period 2024/25.

The ICBs Constitution (Standing Orders) and Delegated Financial Authority Limits set out the arrangements for use of the organisation's Seal. Documents are usually required to be sealed in the following circumstances:

- All contracts for the purchase/lease of land and/or building.
- All contracts for capital works exceeding specified limits.
- All lease agreements where the annual lease exceeds beyond five years.
- Any other lease agreement where the total payable under the lease exceeds certain limits.
- Any contract or agreement with organisations other than NHS or other government bodies
- including local authorities where the annual costs exceed or are expected to exceed specified limits.

All documents that include the words 'executed as a deed' must be signed and sealed.

The following individuals are authorised to authenticate use of the Seal by their signature

- Chief Executive
- Director of Finance
- Any senior officer authorised by the Chief Executive

The Board is asked to note that no documents were required to be signed and sealed in 2024/25.

How does this paper support the ICB's core aims to:	
Aim 1: Improve outcomes in population health and healthcare.	Not applicable.
Aim 2: Tackle inequalities in outcomes, experience and access.	Not applicable.
Aim 3: Enhance productivity and value for money.	Not applicable.
Aim 4: Help the NHS support broader social and economic development.	Not applicable.
Conflicts of Interest	**Summary of conflicts**
No conflict identified	
Risk and Assurance	
No risks identified.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	Documents are presented for sealing by the Chief Executive when they exceed the limits as identified in the ICB Delegated Financial Authority Limits.
Does the report highlight any quality and patient safety implications?	Not applicable.
Does the report highlight any health inequalities implications?	Not applicable.
Does the report demonstrate patient and public involvement?	Not applicable.
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Not applicable.

Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has an equality impact assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Has a Quality Impact Assessment been undertaken?	Yes ☐	No ☐	N/A ☒
Report previously presented at:			
No			
Is the report confidential or not?			
Yes ☐ No ☒			

Item 8 (ii)

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (ii)
Meeting Date:	Tuesday, 27th May 2025
Title of Report:	Declaration of Interest Registers – May 2025
Report Author:	Mrs Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Mrs Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	Declaration of Interest Registers 2024/25 (dated May 2025)

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

Recommendations

The Board is asked to:

- Note the Declaration of Interests Registers as at May 2025.

Summary

The purpose of this report is to present the Declaration of Interest Registers for 2024/25 9as dated May 2025).

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 ICB must demonstrate accountability to relevant stakeholders, particularly the public, and probity and transparency in the decision making process.

As required by section 14Z30 of the NHS Act 2006, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, and do not risk appearing to affect the integrity of the ICB's decision making processes.

The ICB has established a Standards of Business Conduct and Conflicts of Interest Policy. This policy sets out clear procedures to deal with situations where an officer/member has a conflict of interest and is included in the ICB Governance Handbook available on the ICB website.

14Z30(2) of the NHS Act 2006 registers of interest are recorded in the ICB Registers of Interests which is published on the ICB website and is shared and considered by the ICB Audit and Risk Committee at each meeting.

One of the requirements of the statutory requirements for an ICB is to identify a Conflicts of Interest Guardian. Following a recent change in personnel of the ICB Non-Executive Directors, the ICB's Conflict of Interest Guardian has been confirmed as the Chair of the Audit and Risk Committee, namely Mr John Dunstan.

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

Risk and Assurance
No specific risks identified.

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

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

Report previously presented at:
Not applicable.

Is the report confidential or not?
Yes ☐ No ☒

DECLARATION OF INTERESTS REGISTER AS AT MAY 2025

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

ICB BOARD

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To				
Blyth, Charley (not a Board Member - attendee)	Director of Communications and Engagement (Attendee)	Nil								Jul-22	Apr-25	22 April 2025	N/A
Bowkett, Wendy Councillor (Board Member) - Resigned May 2025	LCC Partner Member	Nil								Jul-22	Apr-25	May 2025	N/A
Burnett, Pete (not a Board Member - regular participant)	ICB Director of Strategic Planning, Integration & Partnerships (Participant)	University Hospitals Leicester				Indirect	Wife is Director of Midwifery and Deputy Chief Nurse at University Hospitals Leicester	Jan-23	Ongoing	Apr-24	Apr-2025	17 April 2025	Note and declare
		Nottinghamshire ICB				Indirect	Mother in law is a Primary Care Commissioning Manager	Feb-20	Ongoing				Note and declare
		Health Innovation East Midlands				Indirect	Sister-in-law employed in a Project Management role	Jul-22	Ongoing				Note and declare
		NEMS - interst not declared in April 2025 review. Retain for 6 months.				Indirect	Sister-in-laws partner is a Finance Manager for NEMS.	Jul-22					Note and declare
		Nottingham University				Indirect	Brother-in-law's partner is a technician	Jul-22	Ongoing				Note and declare
Connery, Sarah (Board Member)	Chief Executive, LPFT - Executive Member, Mental Health	Lincolnshire Partnership NHS Foundation Trust		✓			Chief Executive			Jul-22	Apr-25	14 May 2025	Declare and note accordingly
Day, Anita (Board Member)	Non-Executive Member	East and North Hertfordshire Teaching NHS Trust	✓				Chair	Jan-24		Jan-24	Apr-25	17 April 2025	Note and declare
													Note and declare
		NHS Providers:	✓				Ad-hoc Speaker/Chair on national training events	2022					Note and declare
		East & North Hertfordshire NHS Trust	✓				Chair	2024					Note and declare
		Good Governance Institute:		✓			Member of Faculty	2020	Ongoing				Note and declare
Dunderdale, Karen	Group Chief Executive	Lincolnshire Community Hospitals NHS Trust and United Lincolnshire Hospitals NHS Trust	✓				Director of NHS Partner Organisation	2024	Ongoing	Aug-24	Apr-25	22 April 2025	Note and declare
Dunstan, John (Board Member)	Non-Executive Director	KnowCarbon		✓			Contracted via John Dunstan Limited as CFO	Apr-25	Ongoing	Apr-25	Apr-25	Apr-25	Note and declare
		John Dunstan Limited		✓			Sole Director and Owner of Pivate Unlisted Company that provides professional services	Apr-25	Ongoing	Apr-25	Apr-25		Note and declare
		Our Learning Cloud Limited		✓			Non-Executive Director	Apr-25	Ongoing				Note and declare

Earnshaw, Phillip (Board Member)	Non-Executive Director	Humber Teaching NHS Foundation Trust	✓				Non-Executive Director	01-Mar-25	Ongoing	Apr-25	Apr-25	01 April 2025	Note and declare
		Conexus (GP Federation in Wakefield)	✓				Non-Executive Director	01-Mar-25	Ongoing				Note and declare
		Five Towns PCN in Wakefield	✓				Clinical Director	01-Mar-25	Ongoing				Note and declare
		Phillip Earnshaw Ltd	✓				Owner	01-Mar-25	Ongoing				Note and declare
		Wakefield District Health and Care Partnership (West Yorkshire ICB)			✓		Member	01-Mar-25	Ongoing				Note and declare
		Prince of Wales Hospice, Pontefract			✓		Trustee	01-Mar-25	Ongoing				Note and declare
Ellis-Fenwick, Jules (not a Board Member - attendee)	Board Secretary and Head of Corporate Governance (Attendee)	Sleaford Medical Group			✓		Registered patient			Jul-22	Apr-25	22 April 2025	No direct decision making responsibilities in respect of primary care but will declare interest where appropriate in any meetings where the practice is discussed.
						Indirect	Husband is a Bricklayer and Contractor who sometimes undertakes work on NHS premises.		Ongoing				No direct decision making responsibilities in respect of primary care or estates.
Fahy, Martin (Board Member)	Chief Nurse	RCN		✓			Member	Jun-20		May-24	Apr-25	17 April 2025	Note and declare
Gaunt, Matt (Board Member)	Director of Finance	Nil	N/A	N/A	N/A				Ongoing	May-24	Apr-25	06 May 2025	N/A
Hindocha, Sunil (Board Member)	Medical Director	Heart of Lincoln Medical Group	✓				Partner in a Practice in the ICB	Apr-22	Ongoing	Apr-24	Apr-25	24 April 2025	Declare and note
		Lincoln City Foundation			✓		Chair	Jul-21	Ongoing				Declare and note
		Lincoln City Football Club	✓				Board Member	Jun-21	2015				Declare and note
		Timeless Partnership	✓				Previous Member	2009	Ongoing				Declare and note
Jolly, Michele (not a Board Member - regular participant)	Voluntary and Care Sector Representative (Participant)	Lincolnshire Voluntary Engagement Team - LVET			✓		Deputy Chair	Feb-20	Ongoing	Jul-22	Apr-25	22 April 2025	Declare and note
		LinCA			✓		Deputy Chair Lincolnshire Care Association	Apr-15	Ongoing				Declare and note
		Age UK (Lincoln and South)			✓		Chief Executive	Apr-07					Declare and note
		Age England Association			✓		Deputy Co-Chair	May-19	Ongoing				Declare and note
		Cliff House Medical Practice			✓		Registered Patient	1998	Ongoing				Declare and note
Kenson, Dawn (Board Member)	Vice Chair	Trent Valley Surgery			✓		Registered patients - spouse and self	Jul-21	Ongoing	01/07/2022	01/04/2025	17 April 2025	Declare and note
		Turning Point	✓				Non-Executive Director	Jan-23	Ongoing				Declare and note
		Turning Point Services Limited	✓				Non-Executive Director	Mar-23					Declare and note
Lloyd, Anne	Director of Workforce Transformation	Nil								Feb-25	New appointment Feb 2025		

McSorley, Gerry (Board Member)	Chair/Non-Executive Member	Nil								Jan-25	Apr-25	17 April 2025	Note
Mills, Sarah-Jane (not a Board Member - regular participant)	Director for Primary Care and Community and Social Value (Participant)	Active Lincolnshire	✓				Trustee/Director	Jun-23		Aug-23	Apr-25	24 April 2025	Withdraw from discussions/decisions regarding contract awards relating to the core activities of the charity.
		Lincoln University Student Union			✓		Trustee	Aug-24		Aug-24	Apr-25		Withdraw from discussions/decisions regarding contract awards relating to the core activities of the charity.
Pomeroy, Julie (Board Member)	Non-Executive Member	Oxford Cannabinoid	✓				NED Chair	May-21		Dec-24	Apr-25		Declare and note
													Declare and note
		Dillistone Group Plc	✓				NED and shareholding <1%	01/04/1990					Declare and note
		Nemaura Medical Inc and Consultant to Nemaura Pharma Ltd	✓				Shareholding <1% and some consultancy	2006					Declare and note
		General	✓				General investments in various public companies (all<1%) but no involvement with business						Declare and note
		Daughter and Son in law are both doctors in training in the East Midlands				Indirect	Daughter and Son in law are both doctors in training in the East Midlands						Declare and note. Withdraw from any discussions if the company is involved.
		Nottingham City Care Partnerships	✓				Non-Executive Director	May-24	On-going				Declare and note
Pratt, Margaret (Board Member) resigned March 2025	Non-Executive Member	Royal Norfolk and Suffolk Yacht Club			✓		Trustee	Jun-23	On-going	Apr-24			Declare and note
													Declare and note
		Lowestoft Yacht Haven Ltd			✓		Director	Jun-23	On-going				Declare and note
		NHS Pension Land Rover Pension State Pension	✓				Not applicable	On-going	On-going				Raise awareness of potential interest on perceived conflict in all instances. Redaction from inspections and as appropriate in Lincs ICB.
		Senior Financial Governance Assessor, NHSE, Employee 0.6 WTE	✓				Senior Financial Governance Assessor, NHSE, Employee 0.6 WTE	On-going	On-going				Declare and note. No direct conflict of interest as other ICB does not sit within Midlands region.
		Mid and South Essex FT NED	✓				Non-Executive Director (office holder)	On-going	On-going				Declare and note
		CIPFA Member and representative. CCAB Ethics Working Group		✓			Mermber and Representative	On-going	Ongoing				Declare and note
		Hermitage Primary School			✓		Coopted Governor	Dec-23	2024 - retired 12/24				Declare and note
		Wensum Park View Management Co Ltd	✓				Company Secretary	Jul-05	Ongoing				Declaration and redaction if appropriate
		OKRA Consulting Ltd	✓				Director	Oct-18	On-going				No clients with links to ICB or Lincolnshire.
		OKRA Associates Ltd - Director	✓				Director - private company	2009					Declare and note
Raybould, Clair (Board Member)	Interim Chief Executive	Nil								May-24	Apr-25	22 April 2025	Nil
Robson, Sharon (Board Member)	Non-Executive Member	Local Maternity and Neonatal System Meeting.	✓				Chair	Nov-23	Present	Dec-24	Apr-25	22 April 2025	Declare and note as appropriate

Sutton, Navaz	Chief Executive Officer, HWLincs	HealthWatch		✓			Attendance at the board is that of an advisory role and one that provides independent public voice to represent the residents of Lincolnshire.	Ongoing	Ongoing	Dec-24	Apr-25	22 April 2025	Declare and note as appropriate
Thomas, Kevin (Board Member)	Primary Care Partner Member	Market Rasen Practice	✓				GP Partner	Aug-13	Ongoing	May-24	Apr-25	21 April 2025	Declare and note accordingly Declare and note accordingly
		East Lindsey PCN	✓				Clinical Director	Aug-19	Ongoing				Declare and note accordingly
		Spouse is a salaried GP at a Lincolnshire practice and employee of ULHT				Indirect	Spouse is a salaried GP at a Lincolnshire practice and employee of ULHT	Aug-18	Ongoing				Note and declare.
		RCWT Property Ltd	✓				Company Director	Nov-20	Ongoing				Note and declare.
		East Lincolnshire Primary Care Ltd	✓				Company Director	Mar-22	Ongoing				Note and declare.
		Lincolnshire Training Hub	✓				Workforce Lead	Apr-21	Ongoing				Note and declare.
		Lincolnshire PCNA		✓			Deputy Chair	Apr-22	Ongoing				Note and declare.
Turner, John (Board Member)	Chief Executive	Nil	N/A	N/A	N/A	N/A	N/A			Jul-22	Apr-25	18 April 2025	N/A
Ward, Professor Derek (not a Board Member - regular participant)	Director of Public Health - Lincolnshire County Council (Participant)	University of Lincoln		✓			Visiting Professor	Apr-20	Ongoing	Jul-22	Apr-25	09 May 2025	Note and declare
Williamson, Sandra (not a Board Member - regular participant)	Director for Health Inequalities and Regional Collaboration (Participant)	Sidings Practice			✓		Registered Patient and family registered patients at the Practice.	Ongoing	Ongoing	May-24	Apr-25	08 May 2025	Note and declare.
		Boston College			✓		Governor	Ongoing	Ongoing				Note and declare.
		Boston West Academy School			✓		School Governor	Sep-17	Ongoing				Note
Woolley, Sue (not a Board Member - regular participant)	Health and Wellbeing Board Representative (Participant)	Lincolnshire County Council	✓				Cabinet Member - resigned from role May 2025. Chair of the H&WB resigned from role - June 2025 - retain for 6 months	Ongoing		Jul-22	Apr-25	22 May 2025	Note and declare. Note and declare.
		South Kesteven District Council			✓		Elected Member - Self	Ongoing					Note and declare.
		United Lincolnshire Hospitals NHS Trust				Indirect	Close family member is employee of ULHT (son)	Ongoing					Note and declare.
		NHS Liaison					Shadow Portfolio Holder	Ongoing					
		Bourne Galletly Practice				Indirect	Registered patient	Ongoing					Note and declare.

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

AUDIT AND RISK COMMITTEE

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To				
Dunstan, John (Board Member)	Non-Executive Director	KnowCarbon		✓			Contracted via John Dunstan Limited as CFO	Apr-25	Ongoing	Apr-25	Apr-25		Note and declare
		John Dunstan Limited		✓			Sole Director and Owner of Pivate Unlisted Company that provides professional services	Apr-25	Ongoing	Apr-25	Apr-25		Note and declare
		Our Learning Cloud Limited		✓			Non-Executive Director	Apr-25	Ongoing	Apr-25	Apr-25		Note and declare
Ellis-Fenwick, Jules (not a Board Member - attendee)	Board Secretary and Head of Corporate Governance (Attendee)	Sleaford Medical Group			✓		Registered patient			Jul-22	Apr-25	22 April 2025	No direct decision making responsibilities in respect of primary care but will declare interest where appropriate in any meetings where the practice is discussed.
						Indirect	Husband is a Bricklayer and Contractor who sometimes undertakes work on NHS premises.						No direct decision making responsibilities in respect of primary care or estates.
Fleming, Shaun	Local Counter Fraud Specilaist	NHS Humber and North Yorkshire ICB				Indirect	Wife is a Contracts Officer					06-May-25	
Gaunt, Matt	Director of Finance, NHSL ICB	Nil	N/A	N/A	N/A								N/A
Kenson, Dawn (Board Member)	Vice Chair	Trent Valley Surgery			✓		Registered patients - spouse and self	Jul-21	Ongoing	01/07/2022	17-Apr-25	17 April 2025	Declare and note
		Turning Point	✓				Non-Executive Director	Jan-23	Ongoing				Declare and note
		Turning Point Services Limited	✓				Non-Executive Director	Mar-23	Ongoing				Declare and note
Lazenby, Philip	TIAA	Nil											
Moss, Steven	Audit Yorkshire - Head of Anti-Crime Services	Nil											
Pomeroy, Julie (Board Member)	Non-Executive Member	Oxford Cannabinoid	✓				NED Chair	May-21					Declare and note
		Dillistone Group Plc	✓				NED and shareholding <1%	01/04/1990					Declare and note
		Nemaura Medical Inc and Consultant to Nemaura Pharma Ltd	✓				Shareholding <1% and some consultancy	2006					Declare and note
		General	✓				General investments in various public companies (all<1%) but no involvement with business						Declare and note
		Daughter and Son in law are both doctors in training in the East Midlands				Indirect	Daughter and Son in law are both doctors in training in the East Midlands						Declare and note
		Nottingham City Care Partnerships	✓				Non-Executive Director	May-24					Declare and note. Withdraw from any discussions if the company is involved.
Pratt, Margaret (Board Member) resigned March 2025	Non-Executive Member	Royal Norfolk and Suffolk Yacht Club			✓		Trustee	Jun-23	On-going	Apr-24			Declare and note
		Lowestoft Yacht Haven Ltd			✓		Director	Jun-23	On-going				Declare and note
		NHS Pension Land Rover Pension State Pension	✓				Not applicable	On-going	On-going				Declare and note
		Senior Financial Governance Assessor, NHSE, Employee 0.6 WTE	✓				Senior Financial Governance Assessor, NHSE, Employee 0.6 WTE	On-going	On-going				Raise awareness of potential interest on perceived conflict in all instances. Redaction from inspections and as appropriate in Lincs ICB.
		Mid and South Essex FT NED	✓				Non-Executive Director (office holder)	On-going	On-going				Declare and note. No direct conflict of interest as other ICB does not sit within Midlands region.
		CIPFA Member and representative. CCAB Ethics Working Group		✓			Mermber and Representative	On-going	On-going				Declare and note
		Hermitage Primary School			✓		Coopted Governor	Dec-23	Ongoing				Declare and note
		Wensum Park View Management Co Ltd	✓				Company Secretary	Jul-05	4 - retires 12				Declare and note
		OKRA Consulting Ltd	✓				Director	Oct-18	Ongoing				Declaration and redaction if appropriate
		OKRA Associates Ltd - Director	✓				Director - private company	2009	On-going				No clients with links to ICB or Lincolnshire.

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

FINANCE & RESOURCE COMMITTEE

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To				
Cecchini, Dani	Non-Executive Member (ULHT)	Carer's First Charity			✓		Trustee Board member of Carer's First Charity	Oct-24	`				Declare and note as appropritate.
Doherty, John	Associate Director of Finance – Recovery Programme, NHSL ICB	United Lincolnshire Hospitals NHS Trust/Group											
Gaunt, Matt	Deputy Chief Executive/Director of Finance	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A				N/A
Antunes Goncalves, Paul	Chief Fiannce Officer												
Hill, Dave - left April 2025	System Improvement Director, LICB	Simplifico Ltd	✓				Decisions by the ICB relating to the continuation or otherwise of financial improvement support from Simplifico Ltd, the limited company through which my services are provided to LICB.	Octover 2023					Not to be part of the ICB decision making process relating to continuation or otherwise of support from Simplifico Ltd.
Platts, Mark	Chief Finance Officer (LPFT)	Lincoln College Board					Board Governor and Chair of the Finance Committee	03/11/2020					
		Listed Director of Lincoln College group subsidiary companies as declared below: •FE Resources (Lincoln) Ltd •Lincoln College Corporate Support Solutions Ltd •Deans Sport Health & Leisure Ltd •Lincoln Academy Limited •Lincoln College Commercial Holdings Ltd •Human Alchemy Ltd •The Drill Hall Lincoln Ltd •The Old Bakery Lincoln Limited			✓		Director	01/01/2023	Ongoing				Declare and note as appropritate.
Pomeroy, Julie (Board Member)	Non-Executive Member	Oxford Cannabinoid	✓				NED Chair	May-21					
		Dillistone Group Plc	✓				NED and shareholding <1%	01/04/1990					
		Nemaura Medical Inc and Consultant to Nemaura Pharma Ltd	✓				Shareholding <1% and some consultancy	2006					
		General	✓				General investments in various public companies (all<1%) but						
		Daughter and Son in law are both doctors in training in the East Midlands				Indirect	Daughter and Son in law are both doctors in training in the East Midlands						
		Nottingham City Care Partnerships	✓				Non-Executive Director	May-24					
Rhodes, Emma	Assistant Director of Finance, NHSL ICB	Nil											
Shadlock, Gail	Non-Executive Member, LCHS												
Wilde, Sam	Director of Finance & Business Intellligence (LCHS)	Lincolnshire Community Health Services NHS Trust	✓				Director						
		HFMA Costing for Value Institute Council		✓			Member	Oct-19					
		Chair - Community Services Reference Group - NHS Benchmarking Network		✓			Chair	Nov-20					
		NHS Benchmarking Network Steering Group		✓			Co-Chair	May-22					
Wright, Chris		Allchild		✓			Trustee	Jul-22					
		Better Society Capital Ltd	✓				Non-Executive Director	Jul-18					
		Catalyst Choices Community Interest Company	✓				Non-Executive Director	Jul-20					
		We are Juno CIC	✓				Non-Executive Director	Jul-22					
		Jobs22 Limited/Expert Advisor					Non-Executive Director	May-22					
Jonathan Young	Director of Finance & Digital	United Lincolnshire Hospitals NHS Trust	Nil										

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

PRIMARY CARE COMMISSIONING AND DELEGATED FUNCTIONS COMMITTEE

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To				
Baker, Reid	LMC Medical Director (Observer)	LMC		✓			Medical Director	Feb-22	Ongoing				Open declaration of COI and removing self from discussions when necessary.
		East Lindsey PCN	✓				Co-Clinical Director	May-19	Ongoing				Open declaration of COI and removing self from discussions when necessary.
		Woodhall Spa New Surgery	✓				GP Partner	Aug-13	Ongoing				Open declaration of COI and removing self from discussions when necessary.
		East Lincolnshire Primary Care Trust	✓				Director	Nov-22	Ongoing				Open declaration of COI and removing self from discussions when necessary.
Bates, Sarah	Deputy Board Secretary (attendee)	West Lindsey District Council	✓				Election Officer	Present					Note, no mitigation necessary
		The Glebe Practice, Saxilby			✓		Registered Patient	Present					Note and declare.
Bunce, Jacqui	Programme Director – Partnerships, Planning and Strategic Estate	Member of Skillington Village Hall Committee			✓		Member	2018	Ongoing				Note and declare.
Day, Anita	Non-Executive Director	NHS Providers:	✓				Ad-hoc Speaker/Chair on national training events	2022	Ongoing				Note and declare
		East & North Hertfordshire NHS Trust	✓				Chair	2024	Ongoing				Note and declare
		Good Governance Institute:		✓			Member of Faculty	2020	Ongoing				Note and declare
Earnshaw, Phillip (Board Member)	Non-Executive Director (Chair)	Humber Teaching NHS Foundation Trust	✓				Non-Executive Director	01-Mar-25	Ongoing				Note and declare
		Conexus (GP Federation in Wakefield)	✓				Non-Executive Director	01-Mar-25	Ongoing				Note and declare
		Five Towns PCN in Wakefield	✓				Clinical Director	01-Mar-25	Ongoing				Note and declare
		Phillip Earnshaw Ltd	✓				Owner	01-Mar-25	Ongoing				Note and declare
		Wakefield District Health and Care Partnership (West Yorkshire ICB)			✓		Member	01-Mar-25	Ongoing				Note and declare
		Prince of Wales Hospice, Pontefract			✓		Trustee	01-Mar-25	Ongoing				Note and declare
Fahy, Martin	Chief Nurse	RCN		✓			Member	Jun-20	Ongoing				Note and declare
		Local Dental Committee	✓				Chair	Jul-23	Ongoing				Note and declare

Hume, Kenneth	Clinical Advisor LPM	United Lincolnshire Hospitals NHS Trust	✓				Orthodontist	Jul-23	Ongoing				Note and declare
		British Dental Association		✓			Member	Jul-23	Ongoing				Note and declare
		Portman Dental Care	✓				Dentist	Jul-23	Ongoing				Note and declare
Jenks, Paul	Vice Chair of PCQAG/Member of Prescribing and Clinical Effectiveness Forum/Member of the Clinical and Care Diretorate	Boots	✓				Healthcare Capability Manager and Pharmacist	Apr-24	Ongoing				Note and declare
		Community Pharmacy Lincolnshire	✓				Chair	Apr-10	Ongoing				Statutory Representative Organisation with a role to liaise and negotiate with NHS commissioners, and therefore
		Centre for Pharmacy Postgraduate Education	✓				Tutor	Apr-09	Ongoing				Note and declare
		Royal Pharmaceutical Society Expert Advisory Group		✓			Member	May-21	Ongoing				Note and declare
		National Pharmacy Competency Group		✓			Member	May-21	Ongoing				Note and declare
		Council of the East Midlands Clinical Senate					Member	Feb-24	Ongoing				Note and declare
		NHS Dental Practice				Indirect	Spouse is a Manager of a Dental Practice	Jul-24	Ongoing				Note and declare
Latham, Green Tracey	Chief Officer for Community Pharmacy	Community Pharmacy Lincolnshire	✓				Chief Officer	Jul-05	Ongoing				Note and declare
		University of Lincoln		✓			Senior Visiting Fellow	Jul-05	Ongoing				Note and declare
		D&T Latham-Green	✓				Freelance Consultant	Jun-05	Ongoing				Note and declare
Martin, Wendy	Associate Director of Nursing	Maternail and Childhealth Care Advocacy International	✓				Trustee - international medical charity that works with in-country	2010	Ongoing				Conflict unlikelt with CCG activity, but if any potential
McSorley, Gerry (Board Member)	Chair/Non-Executive Member	Nil								Jan-25	Apr-25	17 April 2025	Note
Mills, Sarah-Jane (not a Board Member - regular participant)	Director for Primary Care and Community and Social Value (Participant)	Active Lincolnshire	✓				Trustee/Director	Jun-23	Ongoing	Aug-23	Apr-25	24 April 2025	Withdraw from discussions/decisions regarding contract awards relating to the core activities of the charity.
		Lincoln University Student Union			✓		Trustee	Aug-24		Aug-24	Apr-25		Withdraw from discussions/decisions regarding contract awards relating to the core activities of the charity.
Nicholls, Anna	Head of Service – General Medical Advice and Support Team (GMAST)												
Odell, Dean	Contract Officer, HealthWatch	Nil											
Pilton, Kate	LMC Representative	LMC		✓			Director	2016	Date				Declare and note accordingly
Pomeroy, Julie (Board Member)	Non-Executive Member	Oxford Cannabinoid	✓				NED Chair	May-21					
		Dillistone Group Plc	✓				NED and shareholding <1%	01/04/1990					Declare and note
		Nemaura Medical Inc and Consultant to Nemaura Pharma Ltd	✓				Shareholding <1% and some consultancy	2006					Declare and note
		General	✓				General investments in various public companies (all<1%) but no involvement with business						Note and declare.
		Daughter and Son in law are both doctors in training in the East Midlands				Indirect	Daughter and Son in law are both doctors in training in the East Midlands						Note and declare.
		Nottingham City Care Partnerships	✓				Non-Executive Director	May-24					Note
Rhodes, Emma	Assistant Director of Finance												Note and declare
		Everyone Cares, Lincolnshire Board Trustee			✓		Trustee	2018	Ongoing				Note and declare.

Warren, Colin	HealthWatch Representative	Lincolnshire Partnership NHS Foundation Trust			✓		Governor	2024	Ongoing					Note and declare.
Williamson, Sandra	Director of Health Inequalities and Regional Collaboration	Sidings Practice			✓		Registered Patient	Ongoing						Note and declare.
		Sidings Practice			✓		Family Registered Patients	Ongoing						Note and declare.
		Boston West Academy School			✓		School Governor	Sep-17	Ongoing					
		Meadow Edge Care Home			✓		Grandparents are Residents	Apr-19	Ongoing					
Woolley, Sue (not a Board Member - regular participant)	Health and Wellbeing Board Representative (Participant)	Lincolnshire County Council	✓				Cabinet Member - resigned from role May 2025. Chair of the H&WB resigned from role - June 2025 -	Ongoing		Jul-22		Apr-25	22 May 2025	Note and declare. Note and declare.
		South Kesteven District Council			✓		Elected Member - Self	Ongoing						Note and declare.
		United Lincolnshire Hospitals NHS Trust				Indirect	Close family member is employee of ULHT (son)	Ongoing						Note and declare.
		NHS Liaison					Shadow Portfolio Holder	Ongoing						
		Bourne Galletly Practice				Indirect	Registered patient	Ongoing						Note and declare.

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non Financial Professional Interest	Non Financial Personal Interest			From	To				
Day, Anita	Non-Executive Member	NHS Providers:	✓				Ad-hoc Speaker/Chair on national training events	2022					Note and declare
		East & North Hertfordshire NHS Trust	✓				Chair	2024					Note and declare
		Good Governance Institute:		✓			Member of Faculty	2020					Note and declare
Kenson, Dawn (Board Member)	Vice Chair	Trent Valley Surgery			✓		Registered patients - spouse and self	Jul-21	Ongoing				Declare and note
		Turning Point	✓				Non-Executive Director	Jan-23	Ongoing				Declare and note
		Turning Point Services Limited	✓				Non-Executive Director	Mar-23	Ongoing				Declare and note
Lloyd, Anne	Director of Workforce Transformation	Nil											
McSorley, Gerry (Board Member)	Chair/Non-Executive Member	Nil											Note

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD
SYSTEM QUALITY AND PATIENT EXPERIENCE COMMITTEE

Name	Current position(s) held in the organisation i.e. Board member, Committee member, Member Practice, employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To				
Bailey, Professor Di	Non-Executive Member (LPFT)	Nottingham Trent University					Emeritus Professor of Mental Health at Nottingham Trent University	Ongoing					Declare and note.
		Lincolnshire Partnership NHS Foundation Trust					Non-Executive Director	Ongoing					Declare and note.
Connolly, Jim	Non-Executive Director, LCHS	Riverside Consultants Ltd	✓				Owner/Director (provider of consultancy support to NHS and Adult Social Care)	Ongoing					Note. Company undertakes not to bid for work originating from the Lincolnshire system.
		Riverside Consultants Ltd					Owner/Director Riverside Coaching and Consultancy Ltd (provider of consultancy support to Health and Social Care and Individual Coaching)	Ongoing					
		CQC		✓			Special Advisor	Ongoing					Note and declare. Removal from any CQC visits within the Lincolnshire systems or providers where there are significant patient flows
		NHSE/I				Indirect	Spouse is Associate Director of Nursing with NHSE/I	Ongoing					Note and declare. Not to be engaged in any executive process involving NHSE/I.
		Jim Connolly Photography				Indirect	Owner/Director	Ongoing					No mitigation required
		K2 Services	✓				Contractor of Services with K2 healthcare in relation to the provision of vaccination services.	Jan-21	Ongoing				Ensure that Jim is not involved in any commissioning decisions in relation to the provision of Vaccination services
Cousland, Sue	East Midlands Ambulance Service NHS Trust	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil				
Dunderdale, Karen	Director of Nursing/Deputy CEO - ULHT Director of Nursing, Quality and AHP's LCHS	Nil	Nil	Nil	Nil	Nil	Nil						
Fahy, Martin	Chief Nurse	RCN		✓			Member	Jun-20	Ongoing				Note and declare
Harvey, Sharon	Lincolnshire Partnership NHS Foundation Trust, Director of Nursing and Quality	NHS Partnerships at Psyomics				Indirect	Husband is Director	Feb-23	Ongoing				Note and deckare
		Guidelines Expert Advisors Panel for NICE		✓			Member						Note and deckare

		NHS England National Quality Oversight Group for Learning Disability and Autism		✓			Member						Note and deckare
Helley, Kathryn	Director of Clinical Governnace, ULHT	Nil	Nil	Nil	Nil	Nil	Nil						
Hindocha, Sunil	Medical Director, NHSL ICB	Heart of Lincoln Medical Group				Indirect	Spouse is a GP in a Member Practice.						Declare and note.
		Lincoln City Foundation			✓		Chair of Trustees						Declare and note.
Martin, Wendy	Associate Director of Nursing, NHSL ICB												
Odell, Dean	Contract Co-ordinator Healthwatch	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil				
Robson, Sharon (Board Member)	Non-Executive Member	Local Maternity and Neonatal System Meeting.	✓				Chair	Nov-23	Present	Sep-23	Apr-25	13 May 2025	Delcare and note as appropriate
Schokker, Anne-Louise	Medica Director, LPFT	Nil	Nil	Nil	Nil	Nil	Nil						
Williamson, Sandra (not a Board Member - regular participant)	Director for Health Inequalities and Regional Collaboration (Participant)	Sidings Practice			✓		Registered Patient and family registered patients at the Practice.	Ongoing					Note and declare.
		Boston College			✓		Governor	Ongoing					Note and declare.
		Boston West Academy School			✓		School Governor	Sep-17	Ongoing				Note
Wort, Vanessa	Associate Director of Nursing, NHSL ICB	Nil	Nil	Nil	Nil	Nil	Nil						

REGISTER OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

SERVICE DELIVERY & PERFORMANCE COMMITTEE

Name	Current position(s) held in the ICB i.e. Board member, Committee member, Member Practice, ICB employee or other	Declared Interest (Name of organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Date Declaration Made	Change Update Request Sent	No Change Reported & Date	Action taken to mitigate risk
			Financial Interest	Non Financial Professional Interest	Non Financial Personal Interest			From	To				
Bailey, Professor Di	Non-Executive Member (LPFT)	Nottingham Trent University					Emeritus Professor of Mental Health at Nottingham Trent University	Ongoing					Declare and note.
		Lincolnshire Partnership NHS Foundation Trust					Non-Executive Director	Ongoing					Declare and note.
Buik, Sarah	Non-Executive Director	United Lincolnshire Hospitals NHS Trust	✓				Associated NED	Aug-22	Ongoing				Declare and note
		Lincolnshire Community Health Services NHS Trust	✓				Associated NED	Aug-24	Ongoing				Declare and note
		Cranfield Trust			✓		Volunteer	Aug-24	Ongoing				Declare and note
		Horncastle Medical Group				Indirect	Spouse and self registered patients	May-17	Ongoing				Declare and note
Burnett, Pete (not a Board Member - regular participant)	ICB Director of Strategic Planning, Integration & Partnerships (Participant)	University Hospitals Leicester				Indirect	Wife is Director of Midwifery and Deputy Chief Nurse at University Hospitals Leicester	Jan-23	Ongoing				Note and declare
		Nottinghamshire ICB				Indirect	Mother in law is a Primary Care Commissioning Manager	Feb-20	Ongoing				Note and declare
		Health Innovation East Midlands				Indirect	Sister-in-law employed in a Project Management role	Jul-22	Ongoing				Note and declare
		NEMS					Sister-in-laws partner is a Finance Manager for NEMS.	Jul-22					Apr 2024+L9:L13
		EMAS - Nottinghamshire				Indirect	Brother-in-law's partner is a technician	Jul-22	Ongoing				Note and declare
Fradgley, Daren	Group Chief Integration Officer/Deputy Group CEO	Lincolnshire Community and Hospitals Group				Indirect	Partner - Deputy Chief Nurse Birmingham Childrens Trust	Apr-24	Ongoing				Declare and note
Kenson, Dawn	Non-Executive Member	Frimley Health NHS Foundation Trust	✓				Senior Independent Director	Jun-15	Mar-24				Declare and note
		Trent Valley Surgery			✓		Registered patients - spouse and self	Jul-21	Ongoing				Declare and note
		Turning Point	✓				Non-Executive Director	Jan-23	Ongoing				Declare and note
		Turning Point Services Limited	✓				Non-Executive Director	Mar-23	Ongoing				Declare and note
Landon, Caroline	Group Chief Operating Officer, Lincolnshire Community and Hospitals Group	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
Neno, Rebecca	Deputy Director System Delivery, NHSL ICB	Allied Health South Lincolnshire				Indirect	Husband works as a Specialist Neighbourhood Nurse	Apr-22					Exclude from any commissioning decisions in relation to role or orgnisation.
Raybould, Clair	Director of System Delivery, NHSL ICB	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A				N/A
Dr Rich-Mahadkar, Sameedha	Director of Improvement & Integraton, ULHT	Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A				N/A
Shadlock, Gail	Non-Executive Member (LCHS)	United Lincolnshire Hospitals NHS Trust					Interim Non-Executive Director	Mar-22					
		Eastlight Community Homes					Non-Executive Director	May-22					