



NHS Lincolnshire Integrated Care Board Public Board Meeting

**Tuesday, 25th March 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, 25th March 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
ii)	Confirmation of quoracy		-	Dr Gerry McSorley
iii)	Declarations of Interest	Information	-	Dr Gerry McSorley
iv)	Minutes of the previous meeting held on the 28 th January 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
ii)	Chief Executive's Report	Note	-	Mr John Turner
3. Key Updates				
i)	Public Health, including Director of Public Health Annual Report 2024	Note	-	Professor Derek Ward
ii)	Healthwatch	Note	✓	Mr Navaz Sutton
4. Population Health Planning				
i)	No specific items			
5. System Oversight and Assurance				
i)	Integrated Performance, Quality and Finance Report	Assurance	✓	Mrs Clair Raybould/ Mr Martin Fahy/ Mr Matt Gaunt
ii)	Board Assurance Framework	Assurance	✓	Mr John Turner/Mrs Sandra Williamson
6. Governance				
i)	No specific items			

7. Committee Highlight Reports					
i)	<ul style="list-style-type: none"> System Quality and Patient Experience Committee Service Delivery and Performance, including revised Terms of Reference East Midlands Joint Committee 	Approve	✓	Committee Chairs	
		Approve Assurance	✓ ✓		
8. Information/Closing items					
i)	Report on the ICB Annual Report 2024/25	Assurance	✓	Mrs Jules Ellis-Fenwick	
ii)	Risks identified during the course of the meeting	Consider	-	Dr Gerry McSorley	
9. Date, Time and Venue of the next meeting					
	Tuesday, 27 th May 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, 28th JANUARY 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
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee (Acting Deputy Chair)
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Margaret Pratt	Non-Executive Member and Chair of the Audit and Risk Committee
	Mrs Clair Raybould	Director for System Delivery
	Mrs Sharon Robson	Non-Executive Member and Chair of System Quality & Patient Experience Committee
	Dr Kevin Thomas	Partner Member, Primary Medical Services
	Mr John Turner	Chief Executive
REGULAR PARTICIPANTS/ ATTENDEES	Ms Charley Blyth	Director of Communications and Engagement
	Mr Pete Burnett	Director for Strategic Planning, Integration & Partnerships
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Anne Lloyd	Director of Workforce Transformation
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Value
	Mrs Rebecca Neno	Deputy Director, System Delivery (item 5 ii only)
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Professor Derek Ward	Public Health Representative
	Mrs Emily Ward	LVET Operation Lead (for item 4 only)
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
	Cllr Sue Woolley	Chair of the Health and Wellbeing Board

APOLOGIES: None received.

24/282 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 welcomed Mrs Anne Lloyd, the new Director of Workforce Transformation to her first ICB Board meeting. Anne commenced in post with the ICB at the beginning of January 2025 and it is great to have her here in Lincolnshire.

242/283 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

24/284 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.**

24/285 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 26th November 2024 and agreed to:

- **Approve the minutes as a true and accurate record of the meeting.**

24/286 MATTERS ARISING

There were no matters arising from either previous meetings or the last one held in November 2024. As such there was no Action Log included in the pack of papers.

24/287 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that to start with this is the first meeting of the Board in public in the current calendar year 2025. As will no doubt be highlighted during the meeting, it had been a remarkably busy and challenging period over the Christmas and New Year period, and certainly in the last few weeks for the NHS and partner organisations with a number of factors involved but specifically the number of flu, COVID, RSV and Norovirus cases, which had been significant. This had placed significant pressures on urgent and emergency care. On behalf of the Board Dr McSorley expressed his sincere appreciation to the great work of dedicated health and care staff in all sectors across the county in very pressured times.

Secondly, there were a number of points to bring to the Board's attention:

- Since the last Board meeting, colleagues attended a valuable All Boards session on December 11th, 2024. The event's written summary was produced and subsequently considered by the Lincolnshire Leaders Group (LLG) the previous week. The finalised document was circulated the day prior for the Board's review and colleagues distribution within their respective organisations.
- On behalf of the ICB and the Board, Dr McSorley has been involved in numerous important meetings since the Board's November gathering. These include sessions with the NHS Confederation, NHS England Chairs, NHS England Midlands Chairs, and various other stakeholders.
- Dr McSorley also had the privilege of visiting Dr Kevin Thomas' practice recently to discuss primary care matters and his role as the Partner Member, Primary Care. He expressed appreciation to Dr Thomas and his staff for their warm welcome.
- Additionally, Dr McSorley has undertaken several site visits, including attending the opening of the Lincoln Community Diagnostic Centre (CDC). This impressive service and facility for the greater Lincoln area has a calming atmosphere, and the staff demonstrated excellent care and sensitivity towards patients. Dr McSorley delighted in meeting the staff to learn about their accomplishments to date and future aspirations.
- Dr McSorley recently met with Councillor Martin Hill, Leader of LCC and Mrs Debbie Barnes, Chief Executive of LCC, as part of their regular meeting schedule, which went well.

On a final note, colleagues were aware Mrs Pratt would be leaving the ICB at the end of March 2025, and the appointment process for the appointment of two Non-Executive Directors (one to replace Mrs Pratt and the other for Dr McSorley's role following his appointment as ICB Chair) was well on track, with the interviews scheduled to take place on the 5th February 2025.

Councillor Bowkett commented that she had recently accompanied her husband as he needed to attend the Skegness CDC, and she was extremely impressed with the unit and the staff. It was well organised, well run and extremely clean; clearly a valuable resource to the East Coast.

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 reiterated the points made by Dr McSorley regarding the exceptional demands on the NHS throughout December and January. Factors such as cold weather and major flooding incidents compounded the challenges faced by the service, which was still expected to deliver on key priorities. Mr Turner expressed gratitude to all involved for their continued hard work and support during these difficult times.

Mr Turner highlighted the following from a national perspective:

- Nationally, the new government has been highly active, and the 10-Year Plan engagement process is in full swing at the national, regional, and local levels. The ICB Communications and Engagement Team has been hosting a series of public engagement sessions; once concluded, Mr. Turner will provide feedback to the Board.
- The Secretary of State for Health and Social Care has reiterated three key strategic priorities: prevention, neighborhood health, and the transition from analogue to digital.
- The Prime Minister has recently committed to a return to 18-week wait times for elective care and the launch of the national Elective Reform Plan. The ICB and the system are already engaged in discussions about positioning themselves to effectively address the challenges this will present.
- The Secretary of State for Health and Social Care's public statement about being 'ashamed' of some patient experiences, particularly in A&E, as well as the recently published RCN Report on the corridor care crisis, have prompted an upcoming national UEC (Urgent and Emergency Care) Plan expected to be published in the coming weeks.

- The ICB is currently one of the top performers in the Midlands region for overall UEC and Category 2 Ambulance Response, though it remains clear there is still significant work to be done.
- Nationally, there is a strong commitment to leveraging Artificial Intelligence (AI), with a particular focus on the public sector and the NHS, given the potential gains in efficiency and productivity. The ICB will be expected to engage with this strategically.
- The recently launched Devolution White Paper could have significant implications for the Lincolnshire ICB and its relationship with local government, which is seen as a valuable asset.
- Additionally, the establishment of a Mayoral Combined Authority is underway, with Lincolnshire's first Mayoral elections scheduled for May 1, 2025.
- The NHS England (NHSE) Planning Guidance for 2025/26 was eagerly anticipated. Last week, the ICB received details of the financial allocation it would receive for the upcoming fiscal year. While the full scope of the guidance remained unclear, it was likely to emphasise critical areas such as urgent and emergency care, elective care, mental health services, access to general practice, and dentistry.
- The Quarterly System Review Meeting (QRSM) with the NHSE Midlands Regional Team was scheduled for the following morning. The purpose of the meeting was to take stock of the ICB and system's performance over the last quarter. Mr Turner would be leading the review, along with Mrs Dunderdale, Mrs Connery, and other colleagues.
- Overall performance was good, but the team anticipated some challenges would need to be addressed and whilst there was no doubt the focus would remain on delivery for 2024/25, the team also anticipated being able to provide details on how the system is positioning itself to handle 2025/26.
- Mr Turner recently met with two local Members of Parliament - Alicia Kearns for Stamford and Caroline Johnson for Sleaford and North Hykeham. Both meetings were positive.
- Additionally, Mr Turner met with Jonathan Lofthouse, Chief Executive of the Northern Lincolnshire and Goole Hospitals NHS Trust (NLAG) as well as Hannah Coffey, Chief Executive of the North West Anglia NHS Foundation Trust (NWAFT).
- The previous week, Mr Turner and Dr McSorley also met with senior representatives from the East Midlands Ambulance Service (EMAS), which was a constructive meeting.
- Mr Turner expressed his congratulations to LinCA for successfully hosting the recent visit by the NHS England Chief Nursing Officer, as well as to ULTH for their successful hosting of the Chief Medical Officer and National Patient Safety Director visits.
- There was also a recent University Strategic meeting that discussed several key topics, including Medical School independence, the university's impressive research work - particularly along the East Coast, expansion into other healthcare education areas, and the ongoing priority development work in dentistry.

On a final note, Mr Turner advised there had been one question received from a member of the public on this occasion in relation to the use of Artificial Intelligence, which was read out and discussed by the Board. It was noted that the details of the question and response would be attached separately to the minutes.

Mrs Pratt inquired about planning for long-term sustainability in the context of innovation, creativity, and the appetite for change. Mr. Turner acknowledged this as an important question but advised that the Board would need to revisit it, as it involved balancing the delivery of long-term priorities with day-to-day operational needs. The ongoing 10-year planning process at the national level would provide the strategic framework for the NHS, and would likely feature innovation, transformation, and the leveraging of new technologies to address unwarranted variation. While the 2025/26 Planning Guidance was still forthcoming, it was expected to focus, as usual, on the next 12 months. It would be crucial to strike the right balance, drawing on the considerable development work in recent years around prevention, health inequalities, population health management, and community engagement, without compromising the ability to meet immediate priorities.

Ms. Day acknowledged the potential of AI but also identified some challenges. As an ICB, are there plans to proactively address these blockers across the system so that everyone can effectively embrace and benefit from the technology.

Mr. Turner shared that there are enthusiastic individuals within the system who are currently exploring the use of AI. However, it was emphasised that this work must be considered within a strategic framework. Lincolnshire does not currently have an AI Strategy, but one will need to be established in the coming year.

Dr Hindocha added that the implementation of AI must be grounded in a robust clinical governance framework. While there is no resistance to AI, it is crucial to ensure that patient safety is never compromised. At present, AI is being explored in dermatology, and there is an appetite across the system to adopt some of these technologies. However, there is a need to verify that the information generated by AI is accurate.

It is widely recognised that the advancement of AI must be undertaken within a sound clinical governance framework..

The Board agreed to:

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

KEY UPDATES

24/288

PUBLIC HEALTH

Professor Ward presented the usual verbal briefing from a Public Health perspective, and advised on this occasion it would cover three broad areas.

- The White Paper on Devolution, as referenced by Mr Turner, outlines the Government's ambitions for devolution and Mayoral elections. Lincolnshire is already undergoing this process, and the White Paper is progressing through Parliament with the expectation that the Statutory Instrument will be approved in the coming months. More details will follow, but the key development is the Mayoral elections in Lincolnshire scheduled for early May, which will coincide with the local elections.
- One significant aspect highlighted in the White Paper is the introduction of a new duty for Mayoral authorities related to health improvement and addressing health inequalities. While the specific details are not yet known, this is viewed as positive news from a public health perspective, though the details will need to be further explored. From Lincolnshire's perspective, a key priority for the combined Mayoral authority is expected to be economic growth, which could have a positive impact on the region. However, there is also a risk in terms of tackling health inequalities.
- The White Paper also outlines the Government's intention to move away from the current county and district council structure in favour of unitary authorities. The expectation is that these new unitary authorities will have a population of at least 500,000. Ongoing discussions are taking place between Lincolnshire County Council, the Districts, and North and North East Lincolnshire to determine the optimal structure, with the expectation that a new organization covering the entire Lincolnshire geography or a significant part of it will be in place by 2028.
- The integrated lifestyle service, "One You Lincolnshire," delivered by Five Tribe, has been approved for recommissioning by the LCC Executive Team. This service has expanded in recent years, with various successful pilot programs integrated into the core service. The majority of the funding comes from the LCC Public Health Grant, with the ICB contributing £0.5 million, and the intention is to further expand the reach of this service.
- Regarding health protection, the key infectious diseases discussed earlier in the meeting are showing an improving position with a reduction in the number of cases. This plays slightly into national policy.

The COVID inquiry Module One response was published last year and the Government the week before last issued its response to the recommendations from the COVID inquiry. One of the key recommendations that the Minister's taken on board is to have regular UK wide pandemic response centres.

The Board considered the update. Mrs Pratt commented that the membership of this body could potentially need to be reconsidered in light of the devolution and after the Mayoral elections, to best reflect the new local government landscape. Dr McSorley referred back to Professor Ward's observations about the timeline, noting that the current local structure was likely to remain in place for some time. The key point is that the Mayoral combined authority will soon be established in shadow form, with Mayoral elections taking place in early May. Professor Ward clarified that the proposal is for the combined authority to be a separate entity, consisting of two unitary authorities who will deliver all current services covering Greater Lincolnshire, as well as a combined authority covering the entire region.

Mr Turner advised that Mrs. Pratt was correct - the ICB will need to assess the impact of the Mayoral authority as it is implemented. While the Mayoral authority will not have a direct role in relation to the NHS, it does have responsibilities for areas like skills, employment, innovation and infrastructure, all of which could have overall benefits for the health of the Lincolnshire population. Although there will not be a direct impact on health, it is important to be aware of potential changes to the organization of local government in the county. Mr Turner's personal view is that the co-terminosity between the ICB and LCC is a significant asset and enabler of improved health and service delivery for the people of Lincolnshire. When the time is right, the NHS would want to make an appropriate case to continue this successful working arrangement.

Dr McSorley advised that no changes to Integrated Care Boards (ICBs) were anticipated, but the NHS would likely need to adapt its organisational boundaries to reflect the benefits of co-terminosity as much as possible.

Councillor Woolley reiterated Mr Turner's comments praising the co-terminosity in Lincolnshire and the benefits it generates, which other systems across the country envy. It is hoped that the strong, positive working relationships will continue well into the future.

The Board agreed to:

- **Note the Public Health update.**

24/289

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.

- Key themes from the feedback shared with Healthwatch included concerns about hospital services, particularly waiting times, as well as communication issues between different organisations when patients receive treatment at multiple hospitals. Healthwatch is exploring these themes further and will provide feedback to the Board once the analysis is complete.
- The report also included several positive comments. One detailed a recent positive hospital visit where the staff, services, and information provided were all exceptional. Similar positive feedback was received regarding care received through the A&E department at Pilgrim Hospital and St Barnabas.
- The feedback on GP services did not reveal any specific themes, tending to be more case-specific in nature.
- Regarding dentistry, concerns were raised about difficulties accessing both preventative and emergency dental care for residential patients, as well as the high cost of private dental care for the general public. It was proposed that these issues be considered as part of the upcoming review of dental services and potential service offerings.
- Positive comments were received about Mental Health Services, particularly the Op Courage programme for Armed Forces Veterans.

- Concerns were flagged about access to services and delays in obtaining HC2 forms (for free prescriptions) for asylum seekers due to rapid relocations. Healthwatch has been working with volunteer support workers and has been coordinating a communications message to providers on this issue.
- An incident was reported where incorrect access codes were provided for a defibrillator during a cardiac emergency. This highlights the importance of ensuring all defibrillators are properly registered and that access information is kept up-to-date.
- Healthwatch has mapped out various research projects based on public priorities, and the ICB Board has been kept informed on the progress of these initiatives. Board members are welcome to review the full reports if they wish and to recommend any areas to be explored in more depth for the 2025/26 period.
- Finally, Healthwatch Lincolnshire is hosting a Voice Conference on 12th February 2025 focused on the importance of the patient voice. Dr McSorley confirmed he will be attending.
- Report on Immunisations recently submitted to Public Health for their consideration.
- Current HW Lincs Focus – Infant Feeding (report finalised), Pelvic Health – survey due to close on the 3rd February.

The Board considered the update. Mrs Pomeroy referenced the asylum seekers and inquired whether primary care could assist with the identified issues regarding IDs and HC2 forms. Mrs. Mills responded and confirmed that primary care could provide the indicated assistance. Mr Turner added that this could also be addressed through the pharmaceutical route.

Mrs Kenson asked if there was a way to gain better insight into when the county would receive an influx of asylum seekers, in order to be better prepared. Mr Turner advised that the ICB is not always informed when asylum seekers are likely to be placed in the county. Mrs Raybould stated that when placements are planned, robust arrangements and processes are put in place, but the ICB has less visibility when influxes are random or occur at the county borders.

Mr Turner inquired whether the issue regarding defibrillators had been raised with Ms Sue Cousland, EMAS Chief Operating Officer. Mrs Raybould was unaware if it had been addressed, but noted a governance issue where defibrillators are placed but individuals/groups do not take responsibility for registration, maintenance, and updates. Mrs Raybould offered to follow up on this with Mr Sutton outside the meeting.

Mrs Raybould also wished to discuss the valuable insights provided by Healthwatch reports, and suggested Mr Sutton connect with Mr Burnett and Mr Mack in the Planning Directorate regarding the current 2025/26 planning work, if he had not done so already.

Mr Burnett, having previously worked at EMAS, advised that the ambulance service should be notified of any defibrillator-related changes, which he suspected was not occurring in some cases.

Mrs Dunderdale provided several comments. First, she acknowledged the emergency department waiting times, referenced earlier by Mr Turner, which were improving but still not at the desired level. Second, she noted the positive feedback regarding the pelvic health services midwife at ULTH, one of the few such services in the country. Lastly, she expressed interest in seeing the impact of the CDC on diagnosis and waiting times, having received incredibly positive feedback from those who accessed the service.

Mr Sutton confirmed that Healthwatch had conducted enter and view work for NHSE on the CDC, receiving positive feedback. The report's reference to diagnostics and waiting times was specific to conditions like fibromyalgia.

It was noted Mrs Williamson would pick up the dentistry issues outside of the meeting.

The Board agreed to:

- **Note the Healthwatch report.**

Mrs Emily Ward joined the meeting at this stage.

POPULATION HEALTH PLANNING

24/290

HEALTH INEQUALITIES – LVET GRANT FUND

Dr McSorley welcomed Mrs Emily Ward to the meeting, who is the LVET operational lead supporting this piece of work alongside members of the ICB Health Inequalities Team. A report was included in the pack of papers and would be supported by a presentation which Mrs Ward would run through.

To provide some context, Mrs Williamson advised that the '*NHS England, working in partnership with people and communities guidance*' clearly emphasised the importance of drawing on the knowledge and experience of the voluntary, community, faith, and social enterprise sectors. This approach had already been embedded in the Integrated Care Partnership (ICP) strategy for Lincolnshire, which aimed to enable strong connections between statutory bodies and the independent VCSE sector. The VCSE sector is deeply rooted in local communities, hence the reason the ICB approached them in terms of tackling health inequalities.

Tackling health inequalities requires a broad, cross-sector approach. The ICB has established a partnership to explore this, and a small grant fund will support initiatives focused on prevention, self-care, and amplifying the voices of underrepresented communities and addressing health inequalities.

Mrs Ward took the Board through the presentation which highlighted the following areas:

- The Core20PLUS5 Grant Criteria for health inequalities as well as the key inclusion groups.
- Applications received from across Lincolnshire.
- Successful applications.
- Outcomes so far

Mrs Jolly advised that the report and supporting presentation provided by Mrs Ward highlighted the real impact of those grassroots community groups. This work starts to provide a blueprint for the conversations that often take place about shifting the attention and doing things differently to achieve better results. The examples discussed demonstrate what could be accomplished with even a small amount of funding. This should inspire people to learn from these insights and translate the prevention agenda from conversation into tangible action.

Mrs Williamson advised that the next step is to build upon this foundation and develop a comprehensive approach for 2025/26 that aligns with the three key strategic shifts and planning guidelines mentioned.

Mrs Robson commented that to realise the full potential in terms of health outcomes and the cost-effectiveness it is important to consider the geographical spread of the initiative. In the initial phases, a large area of Lincolnshire was not going to benefit. Mrs Robson asked how the team were going to encourage the reach and also the spread of learning from these projects. Mrs Ward advised that when Q&A sessions were conducted during the fund's launch, it was beneficial to establish a baseline understanding of the voluntary sector's knowledge of health inequalities. Some groups were already working on these areas and demonstrated a clear grasp of the concepts. Others required more guidance and support to fully comprehend the subject matter. Moving forward, providing education and training for voluntary sector organisations will be crucial, now that the team has tangible evidence of what works. It is hoped to plant the seeds of this knowledge with other organisations as well and continue collaborating with partners to disseminate the message as widely as possible.

Mrs Williamson added that some of the criteria was quite specific on the 20% most deprived being one of the indicators, areas which did lend itself to some of the geographical spread being quite targeted. In summary, the project team is committed to expanding the reach, access, and impact of this initiative to address health inequalities comprehensively across the target populations.

Mrs Raybould inquired about the team's efforts to support unsuccessful applicants and help them succeed in the future. Mrs Jolly advised that only community groups that exist can be supported and there are gaps in provision in certain areas of the county. By bringing together the groups that are in place, learning from their skills and knowledge, and helping them to understand how to effectively address health inequalities is one of the challenges but also ensuring that the support and initiatives align with the broader health and equality agenda, while maintaining a balanced approach. In summary simplifying the process so that the community groups can easily access and deliver on the available opportunities, without becoming overly complicated.

Mrs Connery commented that it is really positive that the team is building its own evidence base in Lincolnshire. In the Mental Health Alliance, a review has been undertaken of spending across mental health, learning disability, and autism services, which totals £4.5 million. The team is considering a strategic umbrella framework to address the significant overlap in these areas. Notably, the return on investment evidence has shown a ratio of 4.3 to 1 on certain spending lines, demonstrating the impressive impact of these collaborative, data-driven initiatives.

Mr Gaunt declared a personal interest as he is friends with Heidi Dawson who is the lead for Glint which is one of the organisations referenced in the report. This was discussed and Dr McSorley noted the interest and took the decision to allow Mr Gaunt to participate in the discussion.

Mr Gaunt asked how the endeavour is best directed and channelled as it is really valuable, and how it can supplement and build upon existing initiatives in a complementary manner. Alternatively, could it potentially substitute certain activities the ICB might choose not to do under statutory provisions, while unlocking resources in a way that generates greater value and encourages grassroots community involvement. In summary Mr Gaunt was interested in exploring how the process can be improved moving forward, including identifying opportunities to better collaborate with partners, rather than relying on a competitive approach. Mrs Williamson thanked Mr Gaunt for his comments and suggested this would involve a wider discussion and would be better suited for consideration as part of a future Board Development Session, and the planning work for 2025/26.

Ms Day asked about the timescales and what happens to those projects at the end of the funding and how is that process is managed. Mrs Ward advised that the voluntary sector faces significant challenges across the board. However, some of the projects have successfully built sustainability in, for example one of them focused on acquiring tools and other resources to support the work. This has provided longevity through capital investment. Similarly, another project aimed to raffle off the finished product to generate funds. While they did not quite achieve their planned revenue target, there was a clear focus on making the project more sustainable. Many of the LVET members actively look out for relevant options they can access. Nonetheless, it is a challenge, and some projects will unfortunately come to an end despite these efforts.

Dr McSorley thanked Mrs Ward for her attendance at the Board, and commended the work which was really positive and demonstrated how simple things can have big impacts. Dr McSorley also thanked LVET colleagues too.

The Board agreed to:

- **Note the report.**

Mrs Ward left the meeting at this point.

SYSTEM OVERSIGHT AND ASSURANCE

24/291

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. 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.

Key areas highlighted:

- Dr McSorley and Mr Turner had already referenced the winter pressures that health and social care had experienced and as per Professor Ward's Public Health update there has been a high flu peak, which happened sooner than indicated in the Winter Plan which tested the system's resilience, but the system lived within the Plan and was able to manage the challenges for patients as best as possible.
- 4 hour target performance for January 2025 was 73.1% despite the challenging winter period, which is really positive and sitting slightly above the national average.
- The Category 2 mean response time for Lincolnshire was currently at about 50 minutes month to date. In the last few weeks that had reduced to below the 30 minute target on several days, which again is positive.
- Cancer - the backlog trajectory is off target with 272 patients waiting over 62 days at the end of November, 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 in December 2024 (as per the validated data) to 70%.
- The faster diagnosis standard was achieved in November, overall performance was 79.7% against the 75% standard.
- Planned Care - The ICB finished the end of December 2024 with 50 patients waiting over 65 weeks against the trajectory of 55. The trajectory to hit 41 for the end of January 2025 remained on target. This same position was not reflected in many other systems up and down the country.
- 52 week waits also continued to reduce which was a good position to start at in light of the Elective Reform Plan.
- The NHS Talking Therapies waiting times standards were both achieved in November. 97.8% of patients received their first treatment appointment within six weeks against the 75% standard, and 99.5% 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 75% in November (rolling 12 months) which is above the 60% standard.

Mrs Raybould added that it has been a really challenging period for mental health services, which winter generally is with people in crisis and demands for access to services but with the really positive work has been undertaken in the county the long waits that have been seen in other parts of the country have not been reflected in Lincolnshire. Currently there were only two out of area placements which is a significant improvement on the previous position reported to the Board.

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:

- It was previously reported to Board that the Care Quality Commission (CQC) undertook an unannounced visit to Lincoln County Hospital Emergency Department in October 2024.

- On 27th November 2024, the CQC also undertook an unannounced visit to Pilgrim ED, verbal feedback on the day was positive relating to patients, staff and service. CQC full reports were awaited.
- CQC also carried out an unannounced visit Lincolnshire Partnership NHS Foundation Trust (LPFT), Spalding Older Adult & Adult Community Team; and Boston Adult Community Team on 21st November 2024. No immediate feedback or concerns were raised during the visit. CQC report was awaited.
- In November 2024 NHSE wrote to all ICB and NHS providers regarding the implementation of Ambulance Handover Delays Initial Debrief Notification and also After Action Reviews. There is now a requirement to notify NHSE of any Ambulance handover delays of 8 hours and over and complete an initial review to identify any immediate contributory factors at system and/or provider level; assess if harm occurred as a result of the delay; and identify actions to be taken. The ICB is working with the Trust and system partners to ensure appropriate processes and governance are in place to meet these requirements. There have not been any breaches to date.
- Children and Young People (CYP) Services - there are currently a number of challenges within CYP services being managed due to a real increase in demand across almost all of the pathways, which had a knock on effect in meeting capacity. Mr Fahy wanted to bring to the attention of the Board and provide assurance about the positive oversight and work being undertaken to manage that backlog.
- The Quality Early Warning (QEW) process is progressing well and is currently on track to achieve the target of having all 81 practices with a completed baseline assessment by the 31st March 2025. 56 out of 81 practices have either completed the QEW's assessment or are in the process of completing. During quarter four of 2024/25, the Primary Care Quality team will be exploring the development of QEWs for use within Pharmacy, Optometry and Dentistry to ensure all four pillars of Primary Care are included in the process.
It is anticipated that these revised tools will be ready for use in Quarter one 2025/26.
- NHSE Midlands joined the ICB on the 27th November 2024 to undertake the annual Patient Safety Stocktake to explore, discuss and provide feedback on a range of Patient Safety initiatives both current and upcoming across the Lincolnshire system. The meeting was a whole system response with colleagues from the ICB and its healthcare providers who have specialised knowledge on a range of subjects supporting the meeting. The feedback from the NHSE team was positive across all of the subject areas with Research and Innovation, PIER (Prevention, Identification, Escalation & Response).
- Marthas Rule areas of particular note. The NHSE team advised the ICB that the PIER programme of work, whilst focussed around the acute sector at the moment, will encompass other types of provider over the coming year.
- Community Pharmacy Overview - NHSE have provided an overview of Community Pharmacy which is one part of Primary Care. The information highlights that for the period April – September 2024 NHS Community Pharmacy Teams across Lincolnshire have completed 17,000 blood pressure measures.
- The National Child Mortality database has recently published a report about child death rates in the ICB, broken down by age range (neonates, <1 year and 1-17 years), and averaged over the last 5 years. Over a 5-year period, Lincolnshire is below the national average death rate for all age groups.
- Fertility Policy - the fertility policy outlines the NHS supported treatments available to people looking to access fertility services within their area. Lincolnshire is working with ICBs across the East Midlands to develop a unified East Midlands Fertility Policy. NHS Derby and Derbyshire ICB are leading the engagement which finished on the 10th January. The feedback was now being worked through with a report on the outcome to be available in April 2025.
- Learning from lives and deaths - (LeDeR) is a service improvement programme funded by NHSE which aims to improve services for people with a learning disability and autistic people. The LeDeR Annual Report for Lincolnshire 2024 highlights findings and learning from LeDeR Reviews undertaken throughout the year and the ways in which the Lincolnshire system is delivering on local actions.

The full report was available on the website.

- Vaccination campaign had finished – really successful campaign and the ICB finished 3% above national average for flu and COVID.

The Board considered the quality section of the report. Mrs Robson referred to the LeDeR Annual Report as whilst the average age of death for these people is 65 compared to the rest of the population, in terms of the presentation of this it is a public report and there needs to be some context to this as there is really good work being carried out across the system. Mr Fahy advised that the full LeDeR report will be presented to the System Quality and Patient Experience Committee (SQPEC) and the Annual Report will be presented through the Adult Safeguarding Board.

Ms Day followed up on Mrs Robson's comments on LeDeR and thanked Mr Fahy for summarising some of the findings and whilst it was evident some good work had already been undertaken, inquired whether an Action Plan would be produced to address those and presented to and considered by SQPEC, which was confirmed as correct.

Mrs Connery referred to data quality and advised that the prevalence rate for learning disabilities in Lincolnshire based on GP registration seemed to be very low when compared to the national position, and it appeared some work needs to be undertaken to ensure the dataset is complete and accurate. Mrs Connery asked whether 65 is the average age nationally or specific to Lincolnshire. Mr Fahy confirmed this was the national average age.

Finance Section

Mr Gaunt advised that at the last Board meeting (at month seven) he had advised that the ICB was broadly on plan to deliver its financial duties and the system was slightly behind by £13m. At the time a risk assessment was being undertaken to understand baseline costs.

Since the intervening two months the financial position had continued to deteriorate from the month seven position. At month nine the ICB has reported a £1.7m deficit against a planned deficit of £0.2m.

This represents a £1.5m adverse variance against plan and a £0.3m deterioration in month (Month eight £2.7m reported deficit against a planned deficit at Month eight of £1.5m).

The Financial Plan was phased in a way that has resulted in the ICB reporting against a surplus plan position moving into the final quarter of the year. This net surplus position puts the ICB on track to break even. The plans have taken shape in a manner that has led to a run rate that, if continued, will result in an overspent position against cost plans, further widening the gap.

The most likely scenario the ICB is facing is a projected £13.5 million deficit position, after the removal of an allocation of funding for dentistry which is now looking more certain based on Mr Gaunt's discussions with NHS England.

The primary drivers of the ICB's costs deviating from the plan are the costs of individual funded packages of care for both physical and complex mental health conditions, out-of-area placements specifically related to mental health inpatient costs (which have recently decreased but remain volatile), and prescribing costs.

Regarding the capital position, at the start of this year the capital plan exceeded £116 million, which is the largest capital program the organisation has undertaken in recent memory. While this presented a daunting ask of ICB teams and partners, Mr Gaunt was pleased to report that the capital program is on track to be largely delivered, which is a great success story for the Lincolnshire population.

The ICB Board considered the report and agreed to:

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

Mrs Neno joined the meeting at this point to present the next item on the agenda.

24/292 EPRR ANNUAL REPORT 2024/25

Dr McSorley welcomed Mrs Rebecca Neno to the meeting who had joined the Board to present the Emergency Preparedness Resilience and Response Annual Report 2024/25. Mrs Pratt advised that the Audit and Risk Committee had considered the report in detail at its recent meeting and commended it to the Board.

Mrs Neno advised that she was absolutely delighted to attend the Board meeting to present the report, which as referred to by Mrs Pratt had been considered by the Audit and Risk Committee who had recommended that the Board support the findings from NHS England, which is that the ICB is fully compliant with all core standards during 2024/2025 and that the Board is assured that there is adequate resource available within the ICB to continue to fulfil the statutory duties as a Category One responder. This is positive news.

It was also important to mention the rest of the system, as whilst there had been great improvement in the ICB and it is a requirement to present the findings to the findings of the ICB Board, the rest of the system had moved the dial considerably in relation to EPRR, which means as a System it was now rated as Substantial.

Dr McSorley asked whether Mrs Raybould was confident about the resources being available to support this programme of work. Mrs Raybould confirmed she was content to provide that assurance to the Board, adding that a considerable amount of work had been undertaken to reshape some of the team in order to identify the relevant resources and no doubt that would be acknowledged by LCC colleagues in the room from a LHRP perspective.

Mr Turner expressed his appreciation to the EPRR team in bringing the ICB to this point, adding that as far as the team were aware, the ICB was currently the only one in the Midlands region to achieve this position, which was reflective of the challenging and hard work by the team involved.

The Board agreed to:

- **Note the contents of the report and acknowledge EPRR resourcing.**
- **Note the ICB EPRR policy, along with its commitments and associated processes.**
- **Agree NHS Lincolnshire ICB EPRR Core Standard Assurance position for 2024/2025 as Full.**

Mrs Neno left the meeting.

24/293 NHS AND ARMED FORCES UPDATE

Mr Burnett a report which provided the Board with an update on the work supporting the Armed Forces Family in Lincolnshire. Mr Burnett advised that he would take the report as read but wished to highlight some of the good work that has taken place both in the ICB and with wider system partners in terms of meeting the ICB's strategic duties around supporting Armed Forces colleagues, veterans and their families over the last 12 months.

- The NHS and the local RAF has developed a positive relationship which has been strengthened over recent years. On the 24th June 2024, an Armed Forces Symposium took place at RAF Cranwell which was attended by both serving Armed Forces personnel, veterans and representatives from the District County Council and the NHS. This provided a real opportunity to learn from each other, deepen relationships, share experiences, and to explore how this is taken forward together. A number of key aims were agreed at the event, which were set out in the paper.

- This included the development of a published strategy detailing the commitment across the NHS in Lincolnshire to the Armed Forces. Subject to funding, there may be a further symposium held later in the year.
- GP Veteran Friendly Practices - Veteran Friendly GP accreditation is a programme run by the Royal College of General Practitioners (RCGP) and NHS England to recognise and support practices in delivering the best possible care and treatment for patients who have served in the Armed Forces. As at 14th January 2025, 77.8% of practices within the Lincolnshire area were accredited, which is a positive improvement from 48% in January 2024. Five Primary Care Networks (PCNs) have all practices accredited. This ensures Armed Forces personnel and veterans can be signposted onto appropriate pathways, e.g. Op Courage.
- Step into Health - is a collaboration between NHS Employers, NHS England, Walking with the Wounded and The Royal Foundation. It provides support and guidance for NHS organisations to review and enhance recruitment practices, so they are able to attract members of the Armed Forces community, benefit from the transferable skills and values they bring to the workforce and showcase the NHS as the employer of choice. It is a programme which connects candidates from across the Armed Forces community with employers and new opportunities in the NHS. The ICB and all the NHS Lincolnshire Providers are signed up to the Programme. Led by ULTH the system has held six monthly open days with colleagues across the system meeting prospective candidates and show casing opportunities. Lincolnshire is seen as an exemplar system and the work has been presented at national webinars. In October 2024, there was a House of Lords reception celebrating 10 years of the programme. At the event ULTH won the Transition Support Award and another colleague was nominated and won the Outstanding Dedication Award. This demonstrated the strong level of partnership work taking place across Lincolnshire.
- Defence Employer Recognition Scheme – ULTH, EMAS and LCHS all have a Gold award status. The ICB and LPFT currently have a Silver Award, but the ICB is working on its Gold award submission by March 2025. Announcements will be made around 18th July 2025.

Mr Burnett concluded his update and advised that he was happy to take any questions. There were no questions received, but Dr McSorley took the opportunity to thank Mrs Bunce, the ICB Armed Forces Lead for her significant work in supporting this programme.

The Board considered the report and agreed to:

- **Note the report and the progress over the last 12 months.**

GOVERNANCE

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

24/294

COMMITTEE HIGHLIGHT REPORTS

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

- Audit and Risk Committee: Mrs Pratt advised that some changes had been made to the Internal Audit Plan for 2024/25 as an assumption had been made that some audits could be carried out jointly with other system partners, which had unfortunately not come to fruition. The second area related to social finance with the Committee having received a preview of the potential options for next year, and a review of the associated governance arrangements. It was positively received by the Committee.
- System Quality and Patient Experience: Mrs Robson referred to the positive work taking place in the Clinical and Care Directorate around neurology pathways, and commended Dr Hindocha's leadership on this area. The SQPEC had amended its Terms of Reference to reflect some minor changes in membership and the revised version was presented to the Board for approval.

Subject to approval by the Board at its next meeting

- Service Delivery and Performance – Mrs Kenson advised that she would take the report as read and was happy to respond to any questions.

Mrs Pratt referred to the Armed Forces and veteran work being a partnership piece of work and asked whether that programme reports through to the Service Delivery and Performance Committee. Mrs Kenson advised that the Committee focuses on the in-year delivery of the Operational Plan and the associated Key Performance Indicators (KPIs) but acknowledged that having reviewed the SQPEC TOR there does still seem to be some overlap between the two Committees. Dr McSorley advised that there is a review being undertaken by the ICB Executives of the operational Programme Boards and no doubt the outcome of that would feed into the remit of the Board Committees, which was also being considered.

Ms Day added that another area for consideration is health inequalities and where that reports to, so welcomed the review referred to by Dr McSorley.

The Board agreed to:

- **Note the reports and supporting verbal updates.**
- **Approve the revised Terms of Reference for SQPEC.**

24/295 ANY RISKS IDENTIFIED

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

24/296 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 25th March 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 26th November 2024

Question One

As the adoption of AI continues to shape the delivery of mental healthcare, what is the ICB's approach to leveraging these tools to enhance outcomes, improve efficiency, and ensure equitable access to services? Additionally, if you are a third-party that is able to support the ICB's strategy and priorities, who would be the best person to contact regarding this matter in the first instance?"

Response:

As mentioned by the Secretary of State for Health and Social Care, one of the top three shifts is moving from analogue to digital and part of that is Artificial Intelligence (AI). It would be fair to say that healthcare providers across Lincolnshire are exploring various AI opportunities.

For example, Lincolnshire Partnership NHS Foundation Trust (LPFT) has implemented a chatbot for their Talking Therapies service. Patients can interact with the chatbot, and the information is then uploaded into the clinical system, initiating a referral. This streamlined approach reduces the need for patients to repeatedly provide the same information, while also saving clinician time.

LPFT is also exploring the use of ambient recognition tools, which allow for conversations with patients to take place without the need for clinicians to type up notes on a laptop. This enhances the patient experience and frees up clinician time.

To realise the full potential of AI across the Integrated Care Board (ICB) and the Lincolnshire system, an AI strategy will need to be developed. However, this is not without risks, as the technology is advancing faster than the regulatory framework can keep up.

The ICB and Lincolnshire County Council also commissioned a review of the Digital Strategy the previous year, which contains which contains a considerable amount of material and information which is being worked through. This will provide further guidance. which will provide further guidance.

In summary, the use of AI presents significant opportunities to improve both efficiency and patient experience.

The ICB lead on digital is Mrs Kathy Fulloway, Chief Digital Information Officer.

Integrated care close to home: Creating healthy communities in Lincolnshire



Contents

Foreword	3
Executive Summary	4
1 Introduction	6
2 Lincolnshire's Population	9
3 Health and care in Lincolnshire	14
4 An opportunity to do differently and do better	18
5 Prevention and self-care, helping people to stay well for longer	24
6 Streamlined access and a shift towards technology	32
7 Personalised care through multidisciplinary teams	44
8 Conclusions and recommendations	52
Glossary	54

Foreword

Welcome to my sixth Annual Report as Director of Public Health for Lincolnshire.



In this Annual Report, I focus on community and primary health and care services, which are essential to the public's health. They support our wellbeing and enable us to access help with

our everyday health and care needs. The report draws on learning from some aspects of the previous two, bringing them together in a case for changing how we work together to integrate care closer to our homes.

My fourth Annual Report set out clearly how diverse Lincolnshire is, from our urban centres like Lincoln to our long beautiful, isolated coastline. My fifth Annual Report provided an insight into the challenges and opportunities to add more health to the older age of the people of Lincolnshire as they become a larger part of our population.

Primary care services, which provide almost 90% of the total NHS contacts each year in England, are often overshadowed by discussions about emergency departments and hospital care. Given there are more than six and a half thousand general practices in England, compared to 200 emergency departments, the debate needs to be rebalanced so that our primary and community care services receive the same attention as other services.

Demand in general practice and the rest of primary care is rising, partly due to an ageing population, partly because of improvements in what is possible in primary care, and partly because of additional hospital

asks for primary care and delays in hospital-based delivery. These changes in what we need and what can be provided by general practice are reflected in other primary and community health and care services and will continue with our ageing population.

Increased demand and pressures on primary and community health and care services are already creating problems with timely access to services, with both those seeking care and those providing it less satisfied with the way services work than they have ever been. These pressures can also be expected to widen existing health inequalities, as people with the greatest health needs but poorest access are likely to be most impacted.

The increasing demand and pressures can't be met by solely increasing spending. We must explore and develop new ways of working. We need to do this through creating new relationships between services and the communities and people they serve, redesigning services to be person-centered, whilst maximizing the effect of all our community assets.

This report presents a vision for reimagined primary and community health and care services, a vision which supports people to live life to the full for as long as possible through preventative care whilst helping people to effectively manage their health. It proposes some approaches to overcome the challenges we face. Welcome to my Annual Report; I look forward to discussing it with you over the coming months.

Executive Summary

In Lincolnshire, people are living longer but are doing so in poorer health. Around a quarter of Lincolnshire's residents are aged 65 and older, and this number is expected to rise by 41% by 2043.

Our over 85 population is projected to almost double over the same period. Lincolnshire residents have increasing long-term health needs, with more than half classified as having high needs or long-term conditions that require comprehensive support.

The diverse geography of the county, comprised of large rural and coastal areas with a wide spread of small communities, creates challenges for health and wellbeing. In addition, some communities in the north and east of the county experience high levels of deprivation, a significant driver of poor health.

Lincolnshire's health system must respond to these challenges and meet the growing health needs of our population. However, the current picture is one of an overburdened hospital system as pressures on A&E and waiting lists continue to mount. At the same time, demand for primary and community care services is ever increasing, without the investment to match.

While responsive and well-resourced hospital care is critical, a health system that is weighted towards treating ill health rather than preventing it is both unsustainable and ineffective. We face significant challenges, but we also have an opportunity to innovate and deliver care differently for our population. By prioritising prevention, not just treatment, providing people with the knowledge and skills they need to stay well for as long as possible and manage their conditions whilst moving care out of hospitals and into communities, we can make meaningful and sustainable improvements to health and wellbeing.

So, how do we redesign our health and care services to build a stronger relationship with the public, boost satisfaction, improve health outcomes, and reduce health inequalities?

While there is no shortage of examples of service models that try new ways to meet the growing health needs of populations, there is limited evidence on their effectiveness, and there is no one-size-fits-all solution. However, common promising practices emerge from the evidence that provide a set of priorities and principles for moving forward.

Prioritising prevention and supporting people to take the lead in their own care

Why treat people for illness if we can stop them from becoming unwell in the first place? By supporting people to live healthily and empowering them to take a lead in their own care, we have an opportunity to make drastic improvements to health and wellbeing. This is particularly important in Lincolnshire, with our ageing population, rising rates of long-term health conditions and significant health disparities. A focus on prevention means making it easy for people to adopt and sustain healthy habits, whilst giving them the skills and confidence they need to manage existing health conditions.

Streamlined access and a shift towards technology

Any redesign of primary and community health and care must make access to services easier and create more pathways to care, especially for those facing barriers. For the public, this means having more choice and flexibility in how they interact with the system based on their individual needs and preferences. Utilizing data and harnessing digital technology can help us to make the best use of the available resources, prioritise services, and streamline access. Digital inclusion must be at the backbone of these efforts to address barriers to the use of digital technology to ensure that no one is left behind.

Multidisciplinary teams (MDTs) bringing personalised care closer to home

Working together in MDTs at a neighbourhood level, professionals across the health and care system must provide joined-up and personalised care for patients. Patients with long-term health conditions are most likely to benefit from this approach. A focus on the person and not the service will require a change in culture but is essential for patients to receive care tailored to their needs. People must also play a key role in decision-making about their care to ensure that what matters to them is at the heart of their treatment plan.

What could this look like in Lincolnshire?

Changes to how we structure and provide health and care services will improve patient satisfaction and health and wellbeing, lead to efficiency gains for the system, and improve workforce retention. It is difficult to quantify what these impacts will be, but we can make estimates using data from existing models as a benchmark, to illustrate what we could achieve.

By deploying our workforce to support people to live healthy lives and equip them with the skills they need to better manage long-term health conditions, an estimated 723 deaths from cardiovascular disease could be prevented each year. Similarly, by encouraging people to take up recommended health and screening checks, we can identify health concerns early and achieve substantial increases in our cancer screening rates for early diagnosis and treatment, resulting in better survival rates.

Using Population Health Management approaches tested by the Foundry Healthcare Model; we can better prioritise resources and ensure appropriate pathways to care. In doing so, more than half a million unnecessary GP encounters could be avoided each year in Lincolnshire, resulting in a potential cost saving of over £4m annually. This would support our GPs by freeing up resources, allowing them to focus on patients with more complex needs.

Finally, by embracing MDT working and creating a culture of person-centred care, we can improve the patient experience, particularly for people living with long-term conditions. Using strategies similar to those used by the Jonkoping Model in Sweden, if we provide elderly residents with a package of comprehensive support at home and in the community when leaving hospital care, we estimate that nearly 600 people aged over 75 could avoid being readmitted to hospital within 30 days of discharge annually.

Recommendations

1. Develop new relationships with the public where they are supported to take the lead for their health and care.
2. Develop a renewed focus on prevention.
3. Harness digital technology to innovate the delivery of care and use digital inclusion to avoid leaving people behind.
4. Deliver person-centred care in neighbourhoods through integrated multidisciplinary teams.
5. Support and invest in our workforce to co-produce and embrace new models of care.

1 | Introduction

What is primary and community care?

General practitioners (GPs) have been key to the delivery of health and care services since the inception of the NHS, helping people address health needs that could not be fulfilled by informal caregiving.

The arrangement of general practice has changed greatly over the last 70 years. In its early stages, community nursing teams led by community doctors were vital to the delivery of primary and community care. As time passed and more diverse professions and disciplines joined these teams, single community nursing teams split into several smaller teams accountable to various clinical and managerial leaders. As hospital capacity and specialism under the NHS grew, the important role of general practice, which offers free care at point of delivery throughout a person's life, became overshadowed by hospital care. It was not until 1967 that the 'GP Charter' formally recognised general practice as a specialty.

Today, demand for care is at an all-time high due to increases in life expectancy and technical advances in the types of treatments NHS services can provide to people. While improvements in life expectancy allow people to enjoy extra years, as people live longer, they do so in poorer health and with greater dependency on health and care systems. Because of the significant increase in demand, support for managing individual health and care needs has shifted from hospital settings to primary and community care services, particularly for those with complex health issues.

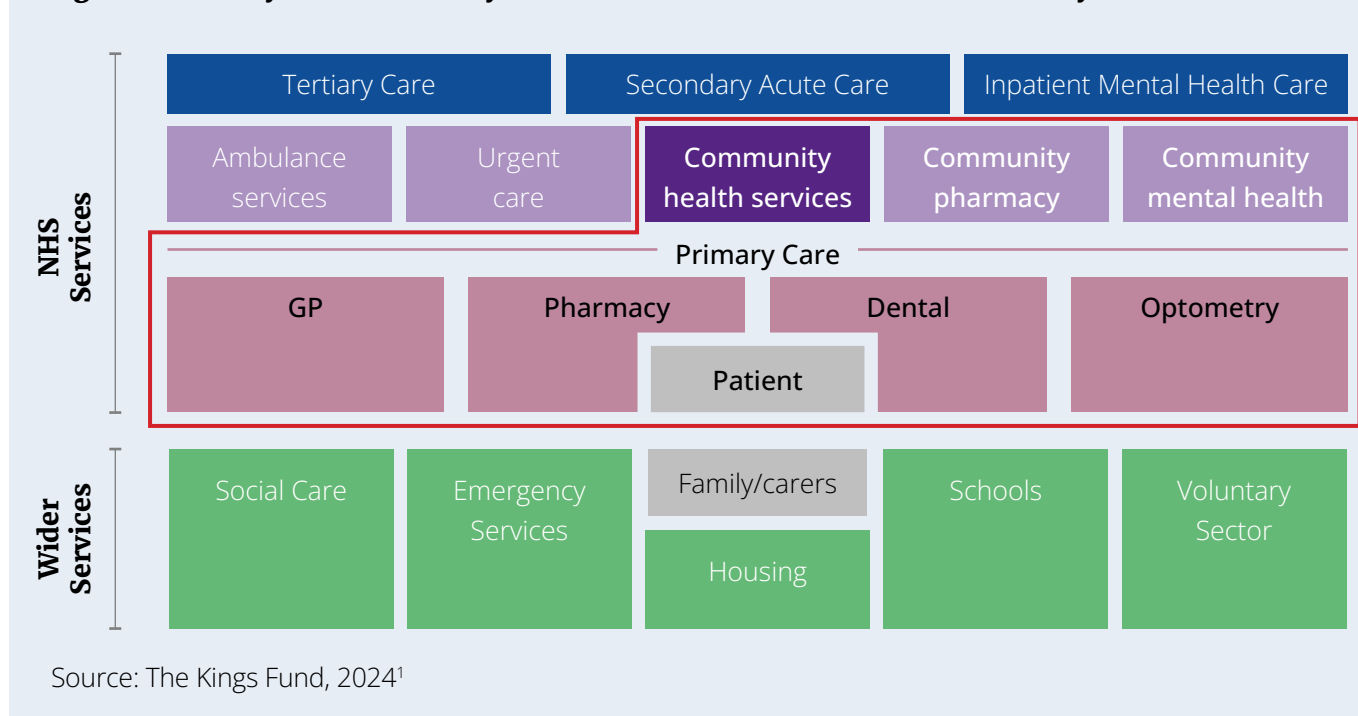
Primary and community care services within our health and care system are as depicted in Figure 1, the services of focus in this report are outlined in red.

Primary and community care services are generally offered in smaller local facilities close to people's homes. These services include GPs, dentists, opticians, pharmacies and community clinics. Primary and community care also refers to home based services delivered by nurses, physios, occupational therapists and a range of other professions.

Community pharmacies are typically located on high streets or in neighbourhoods and provide easily accessible medical advice and support for a range of minor illnesses, often on a walk-in basis. Community mental health services provide care and support for people with severe mental health needs as close to home as possible, including access to psychological therapies.

This report focuses on primary and community services. However, we acknowledge their connections to the wider system, in particular to adult social care which ties in closely with community care.

The increase in health needs and the improvements in the capabilities of primary care settings are not the only reasons for the increasingly stretched primary and community care sector. In some areas of the county it is harder to recruit people to the health and care jobs which need filling. For many of us the way our families work has changed rapidly, with more members of the family needing to do paid work and sometimes living long distances apart. These challenges and changes have resulted in more of us needing support more frequently from caregivers outside our family and friend groups.

Figure 1: Primary and community services within the wider health and care system

The state of primary and community care, now and into the future

A recent investigation found that the NHS in England is in critical condition². Our healthcare systems face the challenges of an ageing population and an increasing number of people with preventable diseases. We need a new approach central to which is the redesign of our primary and community care sector.

In Lincolnshire, our primary and community care sector is under-resourced at an Integrated Care System (ICS) level. Even with enough funding our services would struggle to meet the high demand due to difficulties in recruitment and retention. The allocation of resources does not meet the overall demand for services. This is felt most in the areas of our county with the highest need, the fewest personal and family resources, and the worst access to services.

Primary and community care is a cost-effective way to meet the needs of our population and alleviate pressures on an already strained hospital system. However, our current provision is at its breaking point. Something needs to change. Otherwise, we risk worsening inequalities, with communities facing the highest need and poorest access suffering the most.

This report makes the case for ongoing changes needed to tackle challenges in primary and community care. It presents evidence to indicate some general and specific approaches that could help bring about this change. Importantly, this report does not suggest a one-size-fits-all solution to the challenges we discuss. Instead, it highlights the common themes that are necessary for meaningful change.

These are:

1. A new relationship with the public where they are supported to take the lead for their care.
2. A renewed focus on prevention.
3. Harnessing digital technology to innovate the delivery of care and promoting digital inclusion to avoid leaving people behind.
4. Delivering person-centred care closer to home through integrated multidisciplinary teams.
5. Supporting and investing in our workforce and embracing new models of care.

References

Introduction

¹The Kings Fund, 2024, Community health services explained.

[Community Health Services Explained | The King's Fund \(kingsfund.org.uk\)](https://www.kingsfund.org.uk/communities/2024/02/community-health-services-explained)

²Department of Health and Social Care, 2024. Independent investigation of the NHS in England.

<https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england>

2 | Lincolnshire's Population

A diverse geography

Lincolnshire is the fourth largest county in England, with a diverse geography and population. The county has large rural areas, over 50 miles of coastline, and an urban centre in Lincoln which is the county's only city. Beyond Lincoln, the population centres around market towns of various sizes. Most areas are populated, which makes Lincolnshire different from other rural areas that have large areas of land with few people. This wide spread of small communities across the county adds complexity and additional costs to providing care locally. Lincolnshire's geography creates unique challenges for health and wellbeing, influenced by individual factors and broader structural conditions.



In urban areas, there are health risks linked to housing conditions and living arrangements. Vulnerable groups are often concentrated in small areas with an inadequate supply of suitable housing, overcrowded homes, and homelessness. These conditions can make people more vulnerable to health problems and increase the risk of poor health outcomes.

Coastal communities in Lincolnshire, like many others across the country, face a number of ongoing health challenges. Lower levels of education can limit life chances and health literacy. The high number of fast-food outlets and alcohol-based entertainment options increases exposure to unhealthy behaviours. Older adults from other parts of England moving to the coast is part of the reason why there are more older people in these areas than the average. A higher proportion

of these older people have poor health than the Lincolnshire average, too. This higher need, which is coupled with difficulties in recruiting and retaining skilled health workers, multiplies the challenge of meeting the additional needs of older people. These factors are hindered further by the seasonal nature of employment and the extra strain on the health system during holiday periods due to the influx of tourists.



Rural communities in Lincolnshire share similar challenges. Like coastal communities, it is hard to recruit and keep skilled health workers, plus there is some inward migration of older people with more complex health needs. The spread-out nature of rural populations means that accessing healthcare can be difficult and expensive, often requiring people to own a car or to have a higher income to travel to care providers, which can mask pockets of deprivation. Additionally, fewer than 1 in 10 homes in rural areas are considered affordable. Many homes in rural areas are older, less energy-efficient, and lack access to mains gas, the cheapest form of heating. These factors significantly increase exposure to drivers of ill health¹.



An ageing population

Lincolnshire has a resident population of nearly 770,000 people², with about 816,000³ people registered with local medical practices. Around a quarter (23%, or 180,157) of Lincolnshire's residents are aged 65 and older, and this number is expected to rise by 41% to 255,000 people by 2043. The number of people aged 85 and over is also projected to double⁴ in this period. People living longer than ever is a major achievement, and an active older population brings many benefits. Older people make significant contributions to their communities through work, volunteering, and caregiving. However, while people are living longer, they are also experiencing more ill health and complex needs. Roughly a quarter (27%) of those aged 65 or over struggle with everyday activities due to long-term illness⁵ and live with two or more long-term conditions¹. Health outcomes and life expectancy vary across the county. Differences in levels of deprivation result in the unequal distribution of ill health, driving health inequalities.

The effects of deprivation

At a county level, deprivation rates in Lincolnshire are similar to the national average, but this broad view hides the significant deprivation faced by many communities, particularly in the north and east of the county. For example, on the East Coast around 85% of the population of the First Coastal Primary Care Network (PCN), including Mablethorpe and Skegness, reside in areas in the most deprived fifth of the Index of Multiple Deprivation⁸. Deprivation is a key driver of health inequalities. Those living in the most deprived areas are more likely to experience poor health across a range of conditions and are more likely to develop multimorbidity earlier in life¹ and die young⁷. While national statistics provide an overall picture of deprivation, it is important to note that small pockets of deprivation can exist close to or within more affluent areas, which can sometimes mask the true scale of need. Therefore, an individualised approach must be taken in designing and delivering health and care services, regardless of location, with efforts to address inequalities embedded throughout.

Figure 2: Lincolnshire's over 65 population

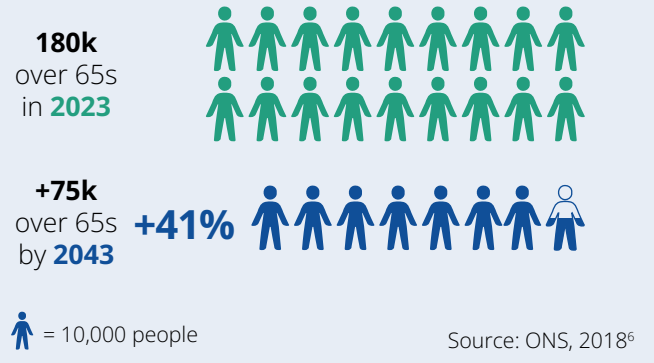


Figure 3: Life expectancy and healthy life expectancy at 65 in Lincolnshire

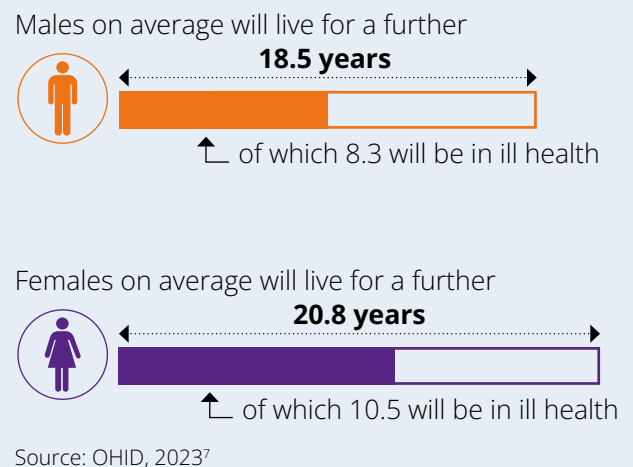


Figure 4: Deprivation* as a driver of inequalities in Lincolnshire



30% more likely to suffer from depression and 22% more likely to be obese



↓-7 years less** of life expectancy for females in the most deprived areas



25-35% greater likelihood of developing multimorbidity earlier in life



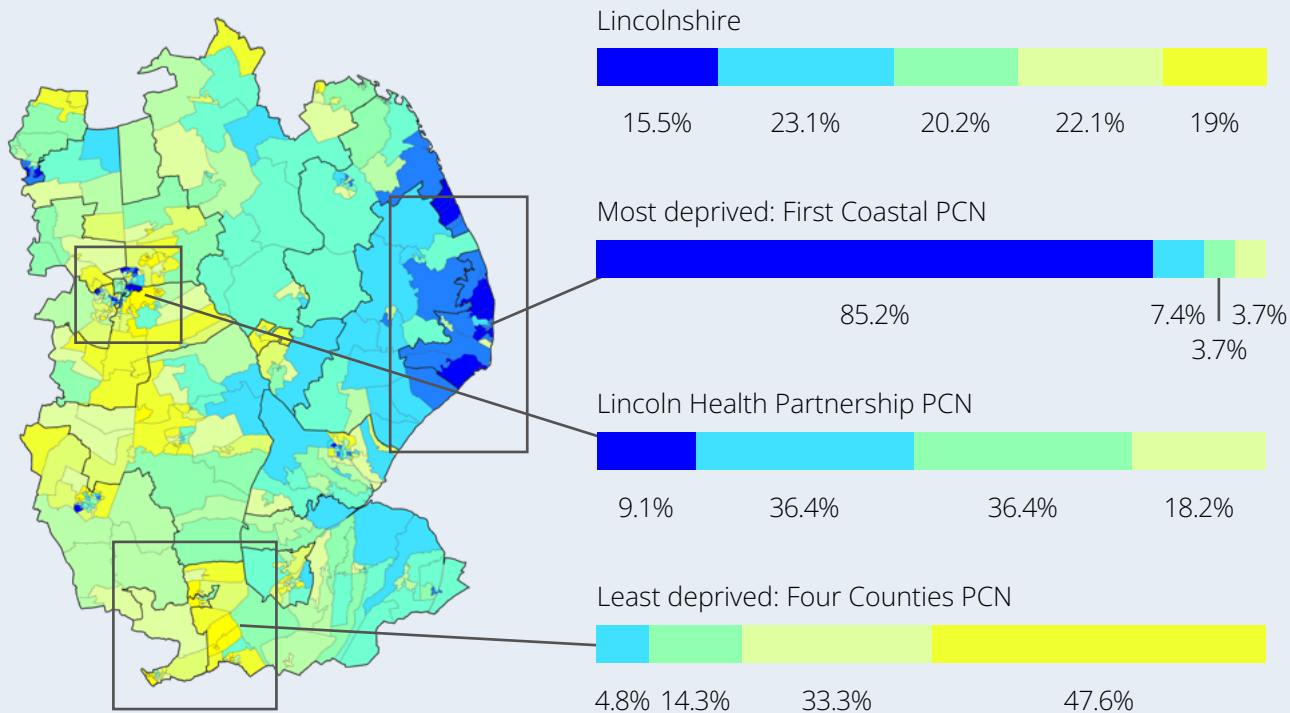
↓-9 years less of life expectancy for males in the most deprived areas

*Life expectancy at birth 2018-2020. Index of Multiple Deprivation (2019) used to define deprivation deciles.

**Least deprived decile compared to most deprived decile.

Source: ICS Joined Intelligence dataset, 2024³, OHID, 2023⁷

Figure 5: Deprivation across Lincolnshire



Source: GOV.UK, 2019⁷

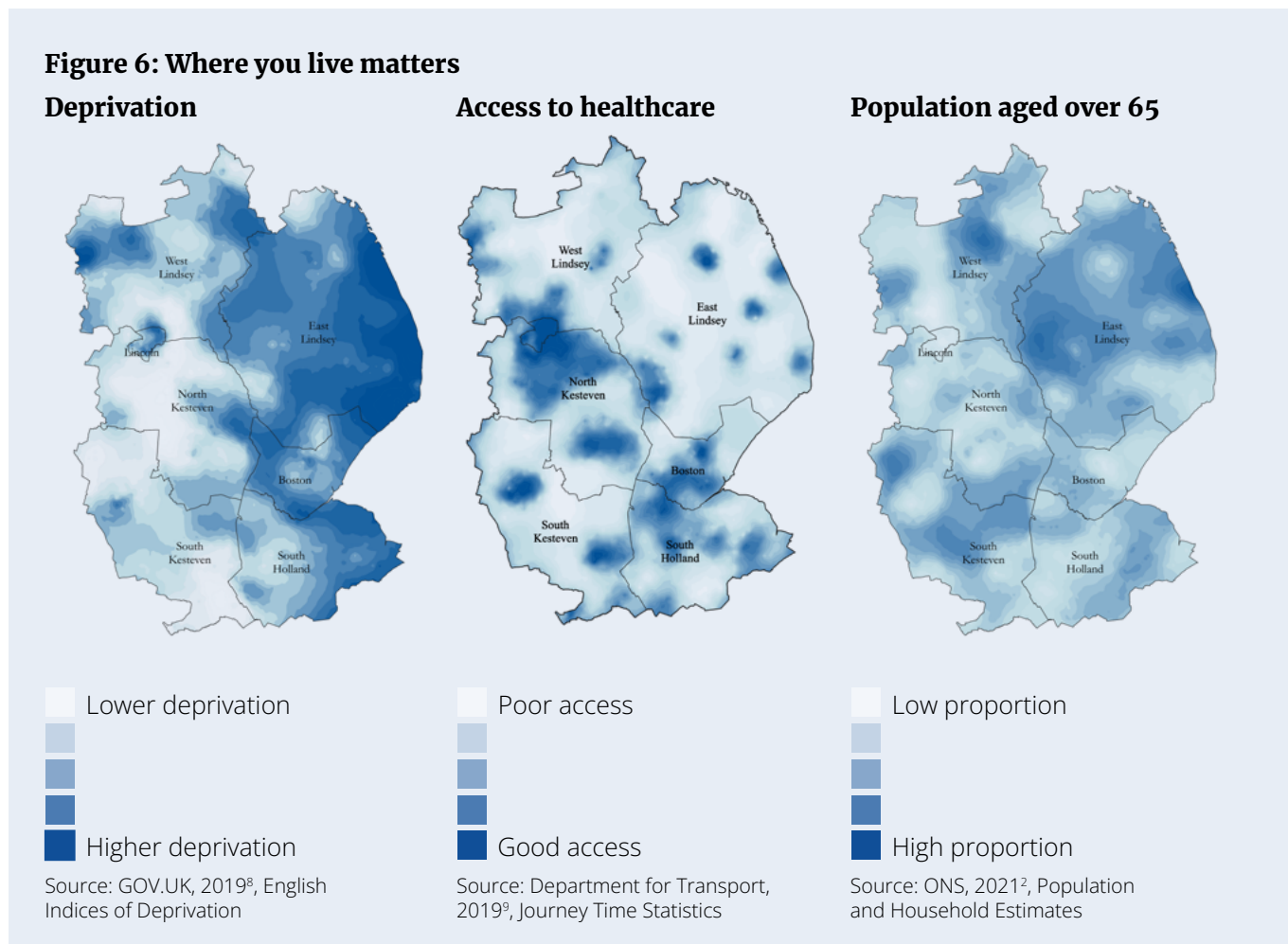
■ Quintile 1 (most deprived)
 ■ Quintile 2
 ■ Quintile 3
 ■ Quintile 4
 ■ Quintile 5 (least deprived)

Where you live matters

Where people live has a significant influence on health outcomes, influenced by the unique challenges of each location and access to health and care services. A map of healthcare access in Lincolnshire shows a gap between need and access. For example, some of the most deprived communities are located in coastal and rural areas where access to healthcare is poorest.

A key measure of healthcare access is how long it takes people to reach their nearest GP. In West Lindsey, a rural area, only a third of people can get

to a GP within 15 minutes by public transport or walking⁹. One promising tool to improve accessibility in rural and coastal areas is the expansion of digital platforms, like the NHS App. However, an assessment of digital exclusion shows a link between poor physical access and poor access to digital services^{10,11,12}. In our most deprived coastal areas, technology-enabled care may not always be a feasible solution*.



The ability of Lincolnshire's health and care system to meet the increased needs of an ageing population, close the gap between health needs and access, and reduce health inequalities presents a critical challenge but also an opportunity to bring care closer to the individuals and communities that need it the most.

*Digital exclusion measured using the Lincolnshire Digital Health Toolkit. This tool uses 3 data sources NOMIS, Experian Mosaic and ONS. 8 Themed areas are ranked and scored from most digitally excluded to least.

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3 | Health and care in Lincolnshire

Investment in primary and community care

Nationally and locally, primary care and community care are how most individuals interact with the health system. The demand on primary care is increasing, with an average of 876,000 GP appointments taking place every day. This is an increase of 34,000 appointments a day since 2018¹. Despite this increase, the Department of Health and Social Care's total spending on primary care between 2015 and 2021 fell¹. Conversely, between 2020 and 2021, spending on acute healthcare grew faster than other forms of NHS spending². Nevertheless, the pressures on A&E, beds and discharges continue to mount, presenting a significant challenge for healthcare³.

In Lincolnshire the figures tell a similar story. Spending on acute care significantly outweighs spending on primary care and community care combined.

Investment in community care can lead to lower hospital elective and non-elective admission rates, reduced ambulance conveyances, and decreased A&E attendance, therefore reducing pressure on secondary care services². Additionally, the estimated cost-saving potential from preventing hospital care through community care for a typical-sized Integrated Care System (ICS) is £25 million per year².

Long-term and complex health needs

More than half of Lincolnshire's population are classified as high need or have long-term conditions that require comprehensive support⁴. Over the last five years the number of patients presenting to care with long-term conditions increased by 11%, while the number of patients with high-complexity conditions nearly doubled (91%). Providing care to these groups cost over £1 billion in Lincolnshire over the last year alone⁴. This dramatic increase is not evenly distributed across the county, with 17 out of 81 GPs in Lincolnshire reporting having more patients with high needs than the average in Lincolnshire⁴. As life expectancy increases and the number of people with multiple long-term conditions rise, the need for a shift towards prevention rather than cure is more pressing than ever.

Only 4 in 10 people registered with a GP are considered generally healthy or in need of occasional acute illness care. 12% of these individuals are children, young people and maternal health cases⁵. It is important to ensure accessible and timely care is provided to this population, including follow-up and continuity of care when needed.

Figure 7: Lincolnshire's healthcare expenditure



Every year in Lincolnshire, we spend...

£785m on **acute care**
£302m on **primary care**
£117m on **community care**

Source ICS Joined Intelligence dataset, 2024⁴

Figure 8: Interactions with Lincolnshire's Health System



Acute care staff managed

420,139 emergency activity
123,366 elective admissions

between 2023-2024



GPs handle

21m
 patient encounters per year

Source ICS Joined Intelligence dataset, 2024⁴

Geography also has an impact on the use of healthcare services in Lincolnshire. People who live in urban areas are more likely to attend A&E, while those who live in rural and coastal regions are more likely to use elective admissions, outpatient appointments and GP services. On average, the healthcare system spends £125 more per person per year in rural areas compared to urban areas⁴. This difference in the use of healthcare services across the county highlights how the needs of the population vary depending on where they live.

Figure 9: Geographic patterns of healthcare usage across Lincolnshire

People who live in **urban** areas are most likely to

People who live in **rural** areas are most likely to



Attend A&E



Schedule appointments



Have lower healthcare expenditure



More frequently visit the GP



Have higher expenditure by £125 per person per year

Source ICS Joined Intelligence dataset, 2024⁵

Pressures on the workforce

Approximately 90% of NHS contact with the public in England takes place through primary care. Improvements in what services primary care can provide, demographic change, and delays in secondary care delivery have caused the demand on primary care to increase over the past decade. While the workforce has also grown over this time, it has not kept pace with demand.

Several factors contribute to this, including long training times, insufficient staff in training, and a trend towards partial or full-time retirement among existing staff.

The national shortage of GPs is particularly acute in Lincolnshire. GPs make up a smaller proportion of the workforce in the county than any other health and care system in the Midlands.

The reduction in new GPs entering the workforce has placed pressures on GP access as well as reducing satisfaction among both patients and the workforce. A recent national survey found that over half (51%) of the public expect access to GP services to worsen in the year ahead, and more than 1 in 3 (38%) anticipate a decline in the standard of care⁷. These figures signal low patient expectations.

Figure 10: Lincolnshire’s healthcare workforce

Pillars of service delivery



1

Acute Trust



60

Dental Practices



14

Primary Care Networks



112

Community Pharmacies



4

Hospitals



73

Optometry Practices



81

General Practices

Source: Primary Care People Group, 2024⁵

Total primary care workforce



458
GPs



755
Other patient roles*



349
Nurses



1,252
Administrative/
non-clinical

* Other patient roles: physiotherapists, paramedics, etc.

Prevention and early intervention

Figure 11: Levels of prevention



Source: Public Health Lincolnshire County Council, 2024

Primary prevention is key to addressing drivers of ill health and disease that are prevalent in Lincolnshire. Interventions such as vaccination campaigns and health education programmes, along with behavioural interventions such as those to help people stop smoking, are critical to reducing the risk of individuals developing long-term, high-need conditions

Secondary prevention is crucial to improving health outcomes. Screening and regular health checks enable early diagnosis when treatment is most effective. In Lincolnshire, screening rates for both bowel and cervical cancer are above average for England, while breast cancer screening

rates are slightly worse than the national average, highlighting some room for improvement⁸.

Finally, tertiary prevention is critical to support people to live as healthily as possible with conditions which are no longer suitable for curative treatment and care. Patients should be empowered to take a leading role in their own care and provided with the confidence and skills needed to ease symptoms and help them to live life to the fullest. Given the burden of long-term health conditions, these interventions are essential for improving the health outcomes of a significant number of people in Lincolnshire.

Figure 12: Preventable unhealthy behaviours across Lincolnshire



15%

of adults currently smoke

Source: GPPS, 2021⁹



68%

of adults are overweight or obese

OHID, 2021¹⁰



37%

of adults are physically inactive

OHID 2021¹¹



20%

of adults drink over 14 units of alcohol a week

OHID, 2021¹²

While Lincolnshire faces many challenges, these challenges also provide opportunities to deliver care differently for our population. As we strive towards transforming our health and care services, we must focus on improving the quality of life and health for all our residents for the full span of their life. In the words of Ashley Montagu, “the idea is to die young as late as possible”.

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4 | An opportunity to do differently and do better

As we have outlined, Lincolnshire's health system faces many challenges. However, these challenges offer a prime opportunity to redesign health and care services to build a stronger relationship with the public, boost satisfaction, improve health outcomes, and reduce health inequalities.

So, how should we redesign our services? What benefits may we derive? And how can we address any risks that come with new ways of working?

Primary care should be central to service redesign. Investing in primary and community care is a cost-effective way to meet the diverse needs of individuals. The World Health Organisation (WHO) states that primary care is essential for achieving Universal Health Coverage¹. In the UK, politicians, health experts, and organisations are calling for a shift away from a hospital-centric system to community-based services designed to improve health and wellbeing closer to home.

National guidance and recommendations

The national **NHS Long-Term Plan** sets out a vision for more coordinated, proactive and personalised care offered to individuals by the NHS². A key goal of the plan is to boost out-of-hospital primary and community care. **The Health and Care Act (2022)** builds on the Long-Term Plan by promoting cooperation between care organisations to deliver more joined-up care³. A main element of the Act is the formation of Integrated Care Systems, which bring together partners as a system-wide team to coordinate services.

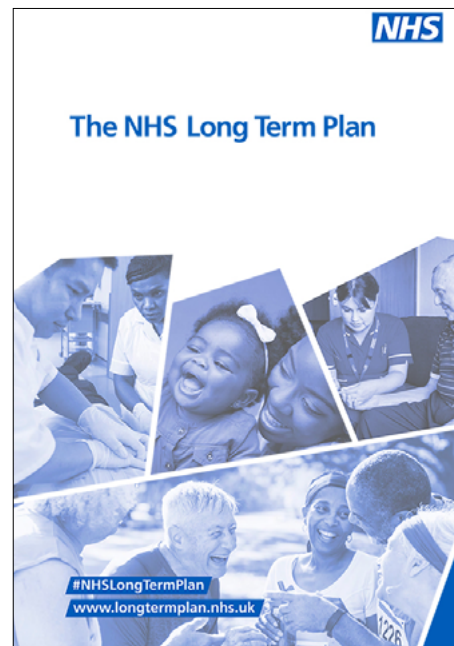
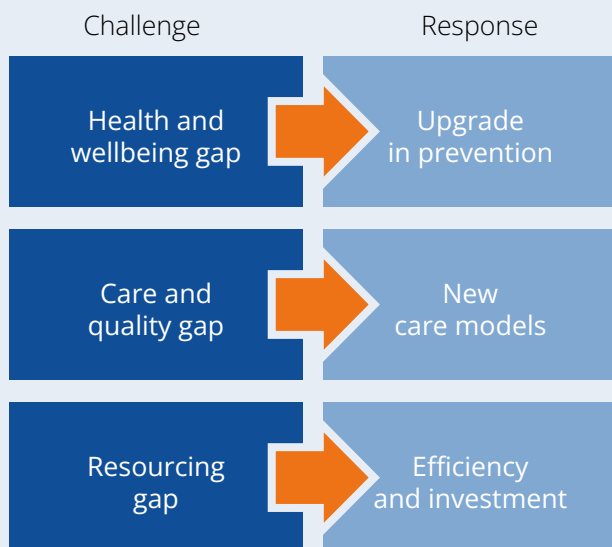


Figure 13: Transforming challenges into actions for positive change



Public Health Lincolnshire County Council, 2024

The Fuller Stocktake Report Next Steps for Integrating Primary Care (2022) is a review of ongoing integrated primary care projects commissioned by NHS England⁴. It has support from the leaders of 42 Integrated Care Systems, including Lincolnshire, and recommends that healthcare delivery should centre on three main principles⁵:

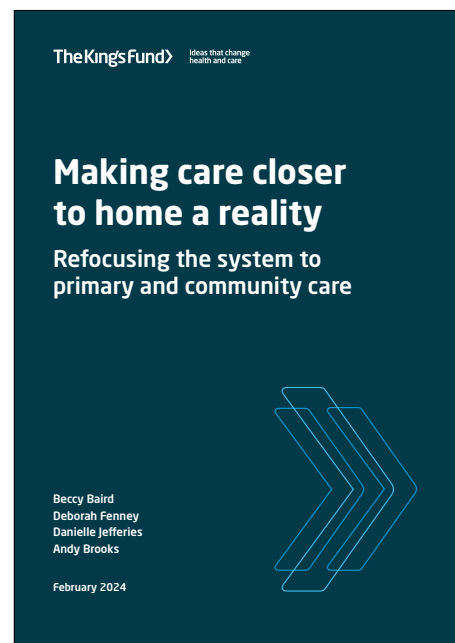
1. Streamlined access and providing choices about how to access care
2. Providing personalised care through multidisciplinary team working
3. Helping people to stay well for longer with a focus on prevention

The report recommends implementing these principles using integrated neighbourhood teams and fostering a culture of shared ownership to find new ways to improve the health and wellbeing of communities.



The recent Kings Fund Report, **Making Care Closer to Home a Reality (2024)**, identifies a lack of progress in moving health and care services from hospital to community settings. The report marked this as a critical failure caused by urgent problems taking priority over long-term issues that could be addressed by primary or community care services⁶. The Kings Fund recommends speeding up the implementation of integrated primary and community care through:

- Developing a skilled workforce of multidisciplinary teams
- Engaging with people and communities, understanding what matters most to them
- Ensuring flexibility to enable change to be made based on local needs



More recently, **the Darzi investigation into the state of the NHS** stressed that too much of the NHS budget is spent on hospitals, with too many people ending up in hospitals because not enough money is spent in the community⁷. The report identifies seven key themes central to reforming our NHS:

1. Re-engage staff and empower patients to take a leading role in their care
2. Shift care closer to home, with investment to make this happen
3. Embrace new neighbourhood models of care through multidisciplinary teams
4. Improve hospital productivity by improving patient flow out of hospital and into the community
5. Tilt towards technology to transform care
6. Ensure the NHS contributes to prosperity, getting more people off waiting lists and back into work
7. Reform to make the structure of healthcare deliver



Priorities for health and care in Lincolnshire

In Lincolnshire, our health strategies align with the national recommendations, and we have a significant focus on delivering effective primary and community care.

Our NHS Lincolnshire **Joint Forward Plan** focuses on increasing integrated care services that are designed around the person⁸. The plan sets several priorities to ensure that people are at the heart of care:

- Focusing on preventing ill health so people live and stay well
- Improving access and timely delivery of care, ensuring people receive the right care at the right time
- Fostering deeper relations with the public through integrated community-based care
- Building a happy and valued workforce



Building on the Joint Forward Plan, **Our Shared Agreement** is a commitment from the Lincolnshire Integrated Care Board to prioritise what matters most to the person receiving care instead of only discussing issues among healthcare professionals⁹. Our Shared Agreement commits us to work together, leverage patients' strengths and assets, and put people at the centre of care. Our Shared Agreement represents a fundamental change in how primary and community health and care services are provided in Lincolnshire.



Our Shared Agreement

Approaches to transform primary and community care

There is a broad consensus that we need new and innovative approaches to integrated primary and community care to meet the needs of our populations. However, the evidence base for implementing such integrated services is still developing, and there is no one-size-fits-all solution, especially for a diverse area like Lincolnshire.

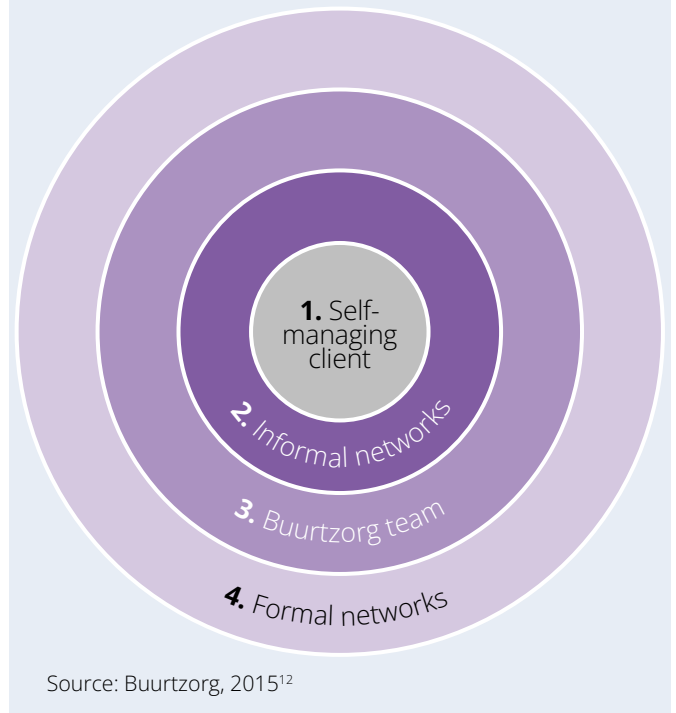
Despite countless examples of new models of primary care, a more substantial evidence base is needed¹⁰. While many new models have been evaluated and documented in case study reports, proof of their effectiveness is limited. Still, several new primary and community care models have gained traction and have been widely documented and replicated.

For example, in the Netherlands, the Buurtzorg home-care organisation has created self-managed neighbourhood nursing teams. These teams support patients to live independently at home and connect them with support networks within their communities. This innovative model provides both social and clinical care at home and has inspired similar approaches in 24 countries due to its adaptability¹¹. In Jonkoping, Sweden, the Esther model has set up multidisciplinary teams of health and care workers. These teams use a person-centred approach to improve the quality of life of their patients. This model has similarly been replicated beyond Sweden (see Chapter 7 for more information).

Closer to home in England, The Wigan Deal is a partnership-based model working across all public services to address wider determinants of health and improve health and wellbeing (see Chapter 5 for more information)¹³. Other models in England, such as the Modern General Practice Model, focus on reorganising services, prioritising needs and gathering important information to more efficiently allocate resources based on what people want and need¹⁴.

Figure 14: The Buurtzorg model of care

The Buurtzorg model of care starts with understanding the person and works outwards



After reviewing a wide range of models, evidence and guidance, several common themes appear in the literature. These themes inform criteria for initiatives that could significantly improve the delivery of primary and community care. Services should be:

- Locally driven, designed to meet the needs of local communities
- Person-centred, empowering patients to take a leading role in their care
- Built on the strengths and assets of individuals and communities.
- Designed through co-production with partners and service users
- Ensure whole system integration
- Commit to an integrated workforce and multidisciplinary team approach
- Reduce health inequalities, closing the gap between most and least deprived.

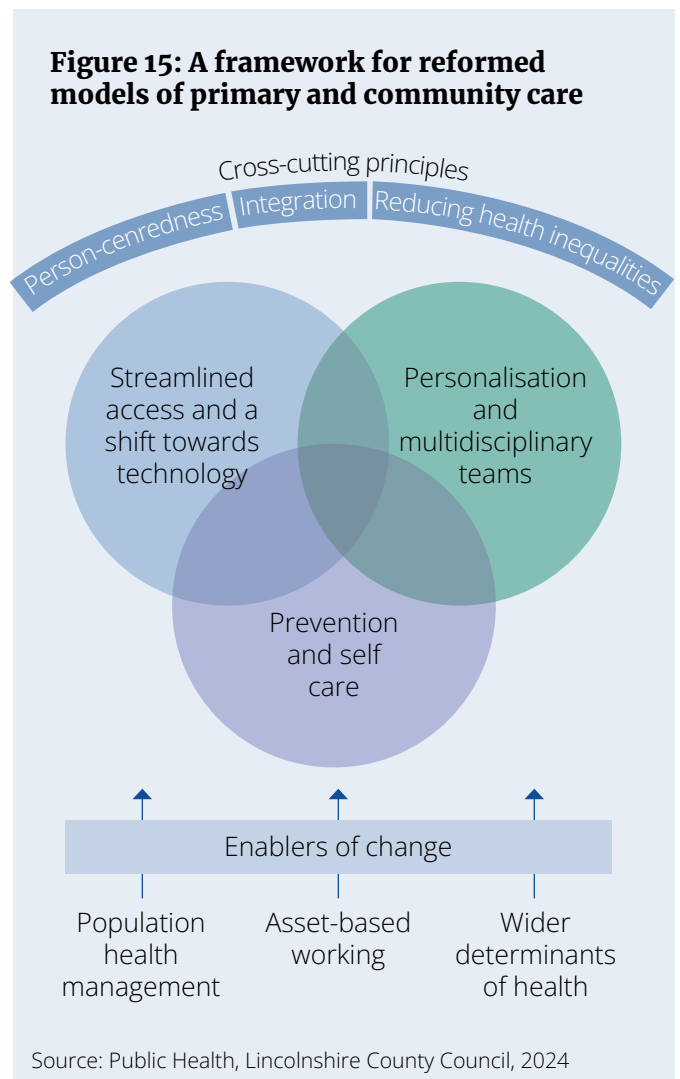
An opportunity to innovate

In the following chapters of this report, we will outline various models and initiatives that fit with our criteria. While many of these models are not new, they have yet to be widely implemented in Lincolnshire. These examples demonstrate what a transformed offering of community and primary care could look like for Lincolnshire.

We present different models drawn from the evidence base, organised according to the themes identified in The Fuller Stocktake Report (2022)¹⁵:

- Helping people to stay well for longer with a focus on prevention and self-care
- Streamlined access and a shift towards technology
- Providing personalised care through multidisciplinary team working

Cutting across these themes are the principles of person-centredness, integration and reducing health inequalities, which should be woven throughout new approaches to care. Promising practices and ways of working underpin these themes as enablers of change.



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5 | Prevention and self-care, helping people to stay well for longer

Taking proactive steps to stay healthy and practising self-care can help people stay well for longer and avoid health problems. This is particularly important in Lincolnshire, with our ageing population, rising rates of long-term health conditions, and significant health disparities. Focusing on prevention and self-care offers a huge chance to improve health and wellbeing, reducing the strain on health and care services.

Prevention and self-care involve taking care of our wellbeing, managing symptoms, and preventing health conditions from getting worse. By spotting and addressing health risks early on and encouraging healthy habits, we can prevent illness before it happens and save money on expensive treatments.

For individuals, this means learning the skills and gaining the confidence to take charge of their own health, better manage long-term conditions, and live healthier lives. For health professionals, this means building a deeper relationship with the public, moving from just treating and controlling conditions to working with patients, supporting and empowering them to take an active role in their own care. We should also work with communities to promote prevention efforts.

A joined-up approach to prevention

That prevention is better than cure is a long-accepted mantra in healthcare. In England, over 2,000 people aged over 65 are admitted to hospital each day for conditions that could have been treated earlier in the community or prevented altogether¹. Primary and community services play an essential role in preventing ill health. By working in partnership with communities, local authorities and the voluntary, community, faith and social enterprise sector (VCFSE) in a joined-up approach, we can focus on helping communities that need it most.

Communities are key in prevention efforts. They provide social connections, play a valuable support role, and can encourage good mental and physical health. Working with communities to design and implement prevention efforts can help provide more appropriate and effective ways of engaging people to improve their health and wellbeing. This includes finding ways to work in partnership with individuals and groups at most risk of poor health and utilising local community assets to develop and deliver interventions.

Enabler of change: Addressing wider determinants of health

A holistic approach to prevention targets the root causes of poor health, including social and environmental factors. To create healthy communities, we need the right building blocks to be in place, which include quality housing, good education and stable jobs. These wider determinants of health are often the main drivers of health inequalities. We can't expect to make any significant improvements to the health and wellbeing of our population without tackling these factors, and doing so requires close working relationships between the health and care sectors, local authorities, and public services.

For example, in Wigan, public services have been transformed in an approach known as the 'Wigan Deal'², which has built a shared way of working across all services in the area. Multi-agency work is led by the local authority, which works closely with the NHS, VCSE organisations, the police, housing, employment, and welfare services. Working together flexibly across organisations within local neighbourhoods has created opportunities to tackle the wider determinants of health and wellbeing in a coordinated way.

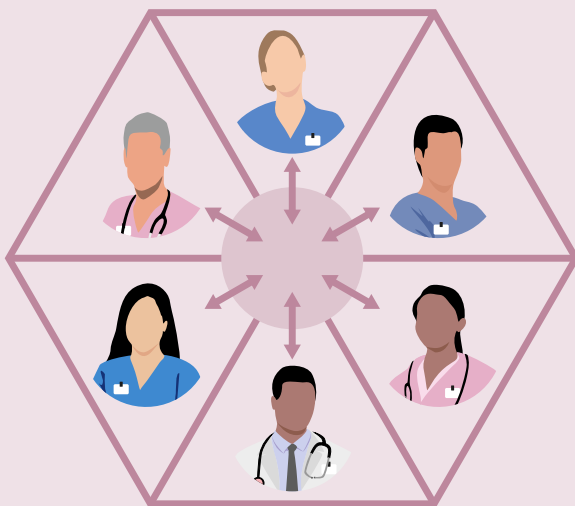
Case study: Community Health and Wellbeing Workers (CHWWs)

Developed in Brazil, the Community Health and Wellbeing Worker (CHWW) model is a household-level approach to preventative care. CHWWs are paid or voluntary members of the local primary care team. They are lay health workers recruited and trained to provide basic health and social care support to a defined area of up to 200 households³.

Figure 16: What are CHWWs?

Brazilian CHWW model

- Each CHWW supports:**
- Disease management
 - Promotion of healthy lifestyles
 - Public health campaigns
 - Antenatal and postnatal care
 - Reminders for vaccination schedules
 - Screening services
 - Adolescent and sexual health
 - Social care support
 - Appointment keeping
 - Medication compliance
 - Triage and referrals
 - Service navigation
 - Community engagement



Primary care clinic

- GP
- Nurse
- Nurse auxiliary

Micro area

- 150-200 households
- CHWW lives in micro area
- Full time role
- Every household visited once a month

Catchment area

- 1,000 households

Source: Macinko and Harris, 2015⁴

As members of their communities, CHWWs are sensitive to local conditions and wider determinants of health, enabling them to build trust and improve access in hard-to-reach areas⁵. CHWWs visit each household once a month to assess needs, conduct health promotion, aid with navigation of support services, triage, and make referrals.

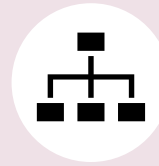
Figure 17: Barriers and facilitators to community health working



Local community presence to ensure equal access



Recruitment incentives



Local community presence to ensure equal access



Communication between CHWWs and wider system



Differing levels of skills and competencies



Continuous professional development opportunities

Source: Public Health Lincolnshire County Council, 2024

CHWWs is a World Health Organisation endorsed approach that has proven highly successful in relieving pressure on health systems⁶. In Brazil, the support provided by CHWWs to help people improve their health was associated with reductions in death from cardiovascular disease (34% decrease) and from heart disease (21% decrease)⁷. Pilots of the model are ongoing in cities across the UK, with early indicators suggesting increases in cancer screenings⁸, immunisation uptake⁶, and improvements in self-management for type 2 diabetes⁹ among visited households.

Self-care and self-management for health and wellbeing

Self-care refers to everything we do to take care of our own health and wellbeing, whether we are generally well or living with a health condition. This includes practising healthy behaviours to maintain good physical and mental health and self-management interventions to help manage and ease the symptoms of long-term conditions. Self-care approaches must be person-centred, providing options relevant to individual needs, preferences, and lived experience.

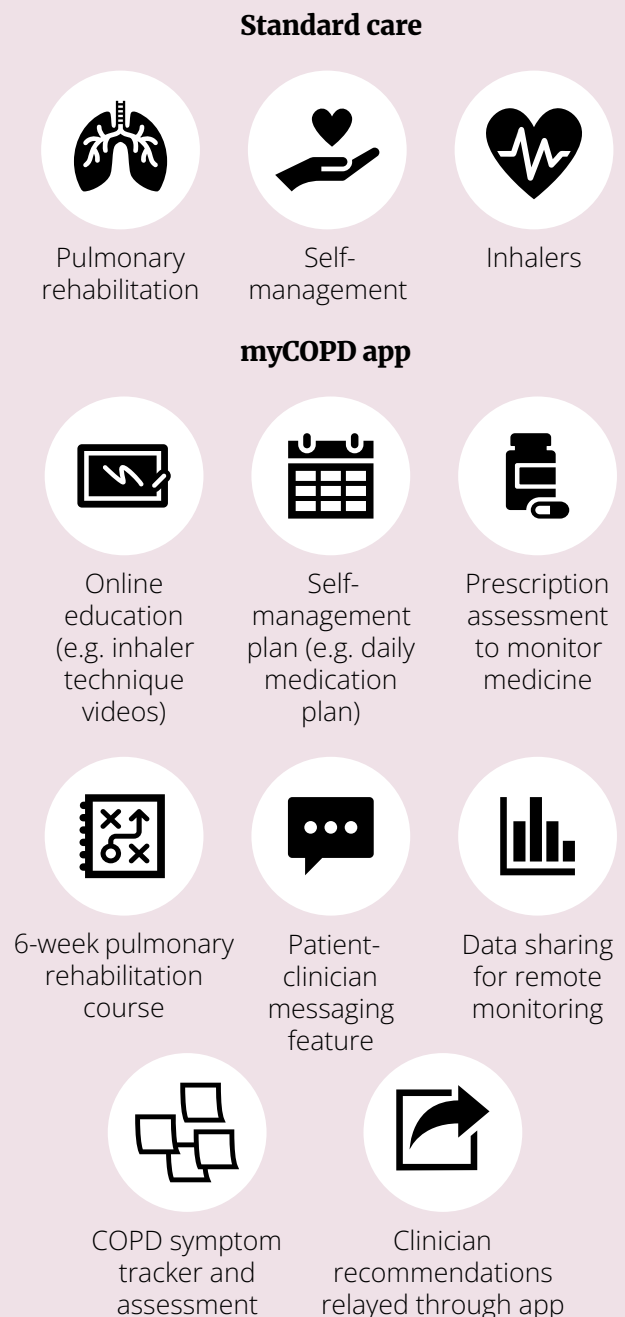
The promotion of self-care is not intended to remove responsibility or duty of care away from health professionals but rather should be incorporated as a complementary approach within a supportive health and care system. Primary and community care can play a role in enabling and facilitating self-care in the following ways:

- Accessible information and education:** Providing easy-to-access and understandable information and education about healthy practices tailored to those who need it the most. Digital approaches such as mobile apps and websites offer an opportunity to reach large audiences alongside traditional methods such as print media and in-person education sessions.
- Health coaching:** Supporting people to make more informed choices about their health and increase their ability and confidence to become active participants in their care, for example, by working with them to make plans and break down goals into manageable steps.
- Peer support:** Bringing people together with similar long-term conditions to support each other either on a one-to-one or group basis. Peer support can enable people to share their experiences and provide mutual support and advice for living life to the fullest with a long-term condition.

Case study: myCOPD Digital App

myCOPD is a digital application downloadable on any device designed to support people with chronic obstructive pulmonary disease (COPD) with the skills, confidence and knowledge to take the lead in their own care and self-manage their condition¹⁰.

Figure 18: MyCOPD app compared to standard COPD care



Source: Public Health Lincolnshire County Council, 2024

Due to limited resources and the nature of hospital care for acute COPD crises that prioritises the return of patients to home, many patients feel they need more support and advice to practice self-care effectively. myCOPD is intended to reduce face-to-face contact for patients who are comfortable receiving online or hybrid care delivery, alleviating demand while providing a quality alternative form of support.

Figure 19: Barriers and facilitators to app-based healthcare



myCOPD is used in multiple locations across England, Scotland, Wales and New Zealand¹¹. Early reviews of the model show that age, rurality and socioeconomic conditions do not prevent people from using the app¹², meaning it does not risk widening inequalities based on these factors. High engagement with the app produced improvements in inhaler technique⁸ and a moderate reduction in healthcare resource use¹⁰. Moreover, the app's pulmonary rehabilitation course works as effectively as face-to-face rehabilitation¹³. The National Institute for Health and Care Excellence (NICE) believes that myCOPD has promise for self-managing COPD, though the clinical benefit of the app is still to be determined¹⁴.

Source: Public Health Lincolnshire County Council, 2024

Application in Lincolnshire

How might a stronger focus on prevention and self-management impact the health and wellbeing of people in Lincolnshire? We can look at the impacts of the Community Health and Wellbeing Worker (CHWW) model to predict what the outcomes might be if we hire, train and use CHWWs throughout Lincolnshire.

In Lincolnshire, the mortality rate from all cardiovascular disease (CVD) in people aged 65 and older is 1,195 out of every 100,000 people. This is the 10th highest rate in England and much higher than the national average¹⁵. This number translates to 2,128 deaths each year. CHWWs have been linked to a reduction of 34% in mortality from cardiovascular disease through targeted health promotion and support for managing the disease. If we achieved a similar reduction in Lincolnshire, it would mean 723 fewer deaths from CVD each year.

CHWWs have also led to significantly higher rates of cancer screening. Screening is an important tool to help spot cancer at an early stage when it is most likely to be treatable. For example, research shows that over 90% of people survive bowel cancer when it is diagnosed at the earliest stage¹⁶.

If we raised screening rates by 82%, which is in line with other CHWW programmes⁸, we could expect to increase the proportion of the population screened for bowel cancer from 24% to 44%*. This would mean an additional 132,478 people screened over a 30-month period. If we achieved a similar increase in cervical screening, rates could rise from 34% to 62%. For breast screening, we could see a rise in screening rates from 13% to 24%.

Figure 20: What would the application of the CHWW model look like for Lincolnshire?



CHWWs could prevent

723

deaths from CVD annually



An increase in Lincolnshire screening rates by

82%

Could increase the number of people screened for cancer by*



70,968

for
breast cancer



132,478

for
bowel cancer



115,822

for
cervical cancer

*Based on: Breast: people screened in the last 3 years. Bowel: people screened in the last 30 months. Cervical: people aged 25-49 screened in the last 3.5 years or aged 50-64 in the last 5.5 years.

Data source: ICS Joined Intelligence dataset, 2024¹⁷

What integrated approaches to prevention could mean for a Lincolnshire family – the Archer’s Story

The Archers are a family of 2 adults and 2 school-aged children living in a Victorian terrace in one of Lincolnshire’s market towns. Both parents work but still sometimes struggle to make ends meet at times, especially in winter when their house is expensive to heat and never feels as warm and dry as they would want it to be.

In order to keep the house as warm as possible, they tend to keep it closed up tight during cold weather. They noticed last winter that small patches of mould had started to appear in the bedrooms, where condensation tended to linger. Dad, Martin, has COPD and his son Joshua has recently been diagnosed with asthma by his general practitioner and started on treatment.

The local integrated care team had been informed of Joshua’s asthma diagnosis and had decided to ask the local community health and wellbeing worker (CHWW) to offer the family a visit and help them plan for Martin and Joshua to stay as well as possible. The worker identified that they would both benefit from more information about their chest problems and from planning for how they could take care of themselves and act if things started to go wrong.

Their plans and their triggers for changing their medicines or seeking help, were devised with their health practitioners’ input. Martin’s individual plan was loaded onto the myCOPD app, and the CHWW helped Martin to be confident in using it to manage his condition. Both Martin and Joshua were supported to know how to take proactive steps in their plans when they needed to, rather than waiting until they were poorly enough to need healthcare input.

The CHWW, when visiting their home, had offered to help them identify things which may be increasing their risk of being poorly – and find solutions to help protect their health and keep them doing the things they loved.

As physical activity protects good lung health, the CHWW helped connect Martin to local physical activity opportunities and suggested that a conversation with the school about Joshua’s safe participation in PE might help with his plan. Both Martin and Joshua are now more active and feel safer, especially where some triggers of their COPD and asthma might be involved such as exertion in cold conditions.

As the Archers rented their house, they were able to get some advice from the local council about keeping the house warm and preventing condensation, damp and mould from forming, and they even got some help describing the improvements needed to the house to their landlord.

The Archers now feel much more in control of their own health and much more confident in self-managing to stop their COPD and asthma from getting out of control and needing time off work and school. The house is warmer and drier helping everyone to feel better.

Key points

- Prevention is better than a cure; it stops illness and disease before it occurs, reduces pressures on the health and care system, and helps people live well for longer.
- By working in partnership with communities to design and implement prevention efforts, we can find more effective ways to engage people, in particular those at most risk of poor health, to improve their health and wellbeing.
- A holistic approach to prevention is needed, focused on changing the conditions that drive poor health alongside individual factors to create healthy communities, including creating quality housing, good education, and stable employment.
- Primary and community care has a role in empowering people to lead their own care by providing accessible information and education, health coaching and facilitating peer support.
- Self-management approaches which can be facilitated by digital health, can support people living with long-term conditions in better managing their symptoms, preventing the progression of illness, and reducing the need for costly healthcare interventions.

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Prevention and self-care, helping people to stay well for longer

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*Note: Estimated projected figures presented are intended for illustrative purposes only. Screening data is based on performance indicators produced by NHSE. Bowel cancer screening data counts people who have had a screening in the past 30 months and have not had a subsequent 'refused' code. Cervical screening data counts people aged 25-49 who have had a screening in the last 3.5 years or aged 50-64 in the last 5.5 years and have not had a subsequent 'refused' code. Breast screening data counts people who have had screening in the past 3 years. The data provided is the number of individuals who have had each type of screening.

6 | Streamlined access and a shift towards technology

Given the challenges of accessing health services and the growing long-term health needs outlined in Chapters 2 and 3, any redesign of primary and community health and care services must make access easier and create more pathways to care, especially for those facing barriers.

For the public, this means having more choice and flexibility in how they interact with the health system based on their individual needs and preferences. Some people will prefer to continue seeing the same healthcare provider, others will want same-day urgent care, and many may value convenient, timely and accurate health information and advice. Patients should be able to quickly access the service that is right for them and connect with the practitioner who can best meet their needs.

For clinicians, like GPs and community pharmacists, an intelligent and joined-up way of working would help them to make the best use of the available resources and free up capacity. By harnessing digital technology, services can be prioritised, and access can be streamlined. This will reduce the pressure on general practice while ensuring high-quality care and patient satisfaction.

Streamlined access

In Lincolnshire, our primary and community health and care system is delivered by a wide range of providers, each offering a variety of services. However, often these providers do not work together. Patients frequently do not know where to go to access the service that is right for them, resulting in GPs being

the first contact. This can be a problem as other healthcare services, like pharmacists, might be more suitable for their needs. This leads to inefficiencies, delays in receiving care, and low patient satisfaction.

Data shows that around 1 in 6 GP appointments could be avoided if patients used other providers¹. By improving partnerships and making better use of the information we have about the people we serve, we can streamline access to services and deliver more personalised care. Strategies to achieve this include:

- **Single team Primary Care Networks (PCNs):** made up of local general practices and providers working as one team to provide easy access to urgent same-day care and advice from healthcare professionals across a range of disciplines. This 'networked' approach pools resources, reduces service overlap, saves resources and ensures patients within the 'networked' area have equal access to care.
- **Simple and effective triaging:** should be easy for patients to access and use, correctly identifying patient needs and directing them to the right place and provider on first contact, preventing onward referrals and reducing pressures on GPs.
- **Using data to understand demand and capacity:** knowing how much demand there is and how much capacity providers have can help us improve services and make better use of our resources. By collecting data on demand and capacity, GPs can arrange their availability around peaks in demand, ensure a good mix of urgent and routine appointments and understand which conditions should be prioritised for in-person visits right away.

Enabler of change: Population Health Management

Population Health Management (PHM) is a process which uses current and historical health data to understand health needs. It focuses on finding the reasons behind poor health outcomes and identifies groups that are at risk. This helps plan and deliver targeted interventions and personalised care pathways to improve patient access and make better use of our resources². PHM is an essential tool for addressing the wider determinants of health and reducing health inequalities².

Lincolnshire is leading the way in using PHM with the most comprehensive Joined Intelligence Dataset in the country. We have achieved full population coverage within our ICS Joined Intelligence Dataset, thanks to the engagement

from every GP practice within our ICS. PCNs and GP practices can access this dataset to investigate and act upon its information.

One example of how we use PHM is through segmenting the Lincolnshire population based on their health needs. Figure 21 illustrates how this is done, with each person represented once in the data based on a health issue they have that has the highest need. Our PHM segmentation helps us better understand the needs of our population, sources of demand and health outcomes. This understanding allows us to design timely interventions and tailored services for our communities.

Figure 21: Lincolnshire population segmented by health characteristics

Generally Healthy	Acute Episodic	Long-term conditions	High Needs	End-of-life Care
351,092	9,012	405,911	42,123	8,212
At risk: 93,823	Major episodic: 8,385	Moderate frailty: 17,624	Severe frailty: 13,502	Cancer: 950
Children and maternity: 98,146	High-intensity use: 627	Big six*: 93,774	High complexity: 24,692	Non-cancer: 7,262
Low risk: 159,123		Disability: 7,621	Dementia: 3,929	
		Mental Health: 150,645		
		Musculoskeletal conditions (MSK): 52,589		
		Living with illness**: 83,658		

*Big six: cancers, chronic kidney disease, diabetes, heart failure, stroke, and chronic respiratory disease

**Living with illness: other long-term conditions not listed within subsegments

Source ICS Joined Intelligence dataset, 2024⁵

Case study: Foundry Healthcare Lewes, Primary Care Network

Foundry Healthcare, a PCN in Lewes, East Sussex, operates an innovative PHM approach designed to reduce unnecessary wait times and referrals, ensuring patients receive the right care from the right person the first time.

Segmentation

Foundry Healthcare utilises population segmentation to identify patients needing faster, reactive care for one-off problems or a proactive, continuous approach to care. This segmentation is informed by patient data such as medical conditions or age².

Figure 22: Foundry Healthcare PCN patient segmentation

Reactive Care		Proactive Care	
Green	Amber	Red	
Patients that are generally well where continuity is less important	Patients with ongoing conditions where continuity is important	Patients with complex needs where continuity of care is very important	
Patient ↓ Call handler ↓ Any GP immediate call back ↙ ↘ 60% 40% Supported to self care GP face to face Managed on phone Nurse face to face	Patient ↓ Call handler ↓ Named GP ↙ ↘ 60% 40% Supported to self care GP face to face Managed on phone Nurse face to face	Single point of contact ↑ ↓ Patient Care plan Case manager Care coordinator/navigator Named nurse Named GP/geriatrician Community health coaches	

Source: Tempo GP Networks, 2023²

Prioritisation

The PCN utilises a patient prioritisation system that assigns patients a priority level based on the urgency of their needs to define demand within each population segment, ensuring timely care for those who need it most². Patients are assigned a priority level based on the urgency of their needs:

- 1 • **On the day** e.g. acute illness, urgent prescription requests, urgent ongoing issues
- 2 • **In a week** e.g. less urgent new illness, ongoing problems, medication queries
- 3 • **In a month** e.g. non-urgent new illness, follow up, results
- 4 • **Within 6 months** e.g. some types of chronic disease reviews
- 5 • **In a year** e.g. routine reviews.

Source: Tempo GP Networks, 2023²

Demand and capacity modelling

The capstone of Foundry's data-centric approach is its in-house demand capacity modelling tool, which integrates rostering, workforce planning, and patient demand metrics³. This tool is used across its three practices to help staff understand real-time demand to make the most of their resources².

PCN integration

Foundry Healthcare PCN has combined resources from three GP practices, integrated their computer systems, and created hubs to speed up care. Foundry's multidisciplinary hub includes diagnostics, mental health services, community nurses, and third-sector organisations. This allows for in-house triaging and for tests to be conducted before GP appointments⁵. The 'Green Hub' within the PCN's Urgent Treatment Centre provides consultation and reactive care for 'Green' patients by GPs, paramedics and physiotherapy practitioners². Factors like practice size, distance to a GP, and delays in speaking to a GP or nurse can influence hospital attendance and admissions³. Foundry's partnership and intelligence-led approach has the potential to address these factors.

Successes

Since commencing operation in 2019, Foundry Healthcare has reduced avoidable appointments from 7% to 4.5%². The PCN has also seen higher patient satisfaction⁴ and improved staff retention, with only a 4% turnover⁵. These successes have come after overcoming several challenges, including the cultural shift of getting single practices to work together as a larger network and dealing with limited workspace due to team growth.

However, some challenges still persist, including patients having difficulty in contacting the practice and 90% of patients not knowing which healthcare team they are assigned to³.

Figure 23: Foundry Healthcare PCN successes

Between 2018 and 2023, Foundry Healthcare PCN reported:



A possible reduction of 12,480 bed days



A possible reduction of 751 A&E visits



A possible reduction of 720 locum GP sessions



A possible reduction of 170 ambulance conveyances

Source: KSS AHSN, 2023⁴

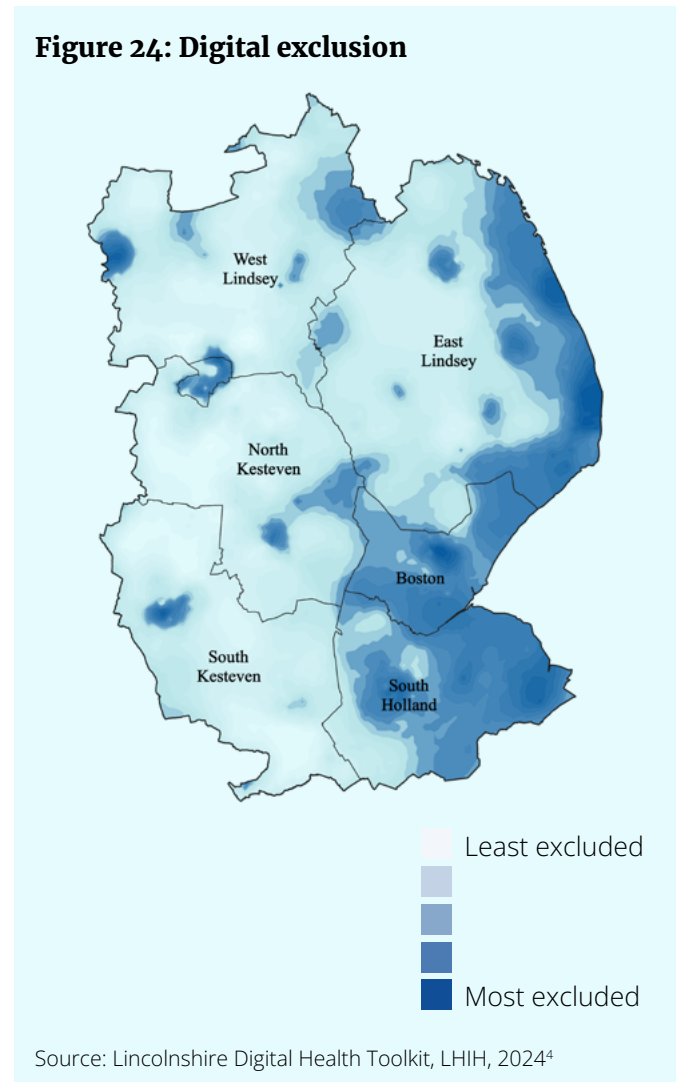
Technology-enabled care

Our health and care system should reflect the diversity of our population by providing a range of different ways to access care. Some people prefer to visit their family GP for face-to-face appointments, while others may choose to get health information and advice through digital platforms. No matter how care is provided, we must ensure that our approach is inclusive and considers the challenges people face in accessing care due to their location, skills, and resources.

The recent Darzi investigation into the state of the NHS recommends that we “tilt towards technology” to improve productivity⁶. The increasing popularity of the NHS app indicates that people are interested in digital health solutions. It has more than twice as many users as Netflix’s 16.7 million subscribers⁷. Registration and use of the NHS app has steadily increased throughout 2023 and 2024, with almost 80% of the population now registered⁸. Digital-first models of care use video consultations, email, and web chat as the main ways to access healthcare. These options provide patients with a convenient and secure way to engage with their primary care providers.

While digital-first care may work for some individuals, we must recognise the risk of digital exclusion, leaving others without access and worsening existing health inequalities. To avoid this, it’s essential to support and empower those who could benefit the most from technology-enabled care. Any effort to introduce this type of care must address barriers to use, such as opportunity, access, knowledge and skills⁹. The system-wide implementation of the new Lincolnshire Digital Inclusion Strategy 2024-2027 will be crucial to achieving this.

Figure 24: Digital exclusion



Case Study: 100% Digital Leeds

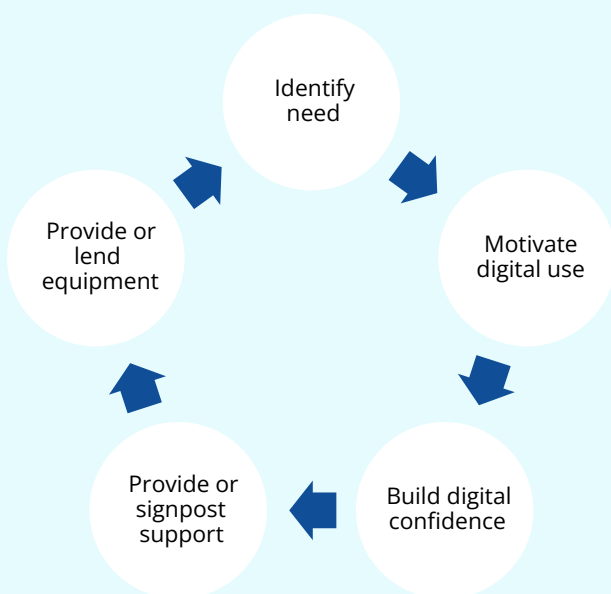
100% Digital Leeds is a partnership model involving health and care organisations and the voluntary, community, faith and social enterprise sector (VCFSE) with the goal of improving digital inclusion across Leeds⁸. Widespread digital inclusion means people can make informed choices when accessing services and that there is equal opportunity to use digital tools².

The 100% Digital Leeds partnership approach allows a better understanding of the different needs, preferences, and barriers specific groups have to digital care to co-produce solutions⁸.

Digital Health Hubs

The 100% Digital model is facilitated by Digital Health Hubs, community spaces staffed with volunteers to provide supportive environments where people can learn about and build confidence with health-related information, technology, and resources for free¹¹. The hubs are designed to encourage social activity and peer learning while addressing individual needs¹².

Figure 25: Digital Health Hub service provision



Source: Public Health Lincolnshire County Council, 2024

Cross Gates and District Good Neighbours Scheme (CDGNs) Hub

CDGNs was the first charity to launch a Digital Health Hub in Leeds. In 2020, the charity had 1,200 members over 60, with most attendees at their weekly wellbeing sessions living with long-term health conditions¹⁰. Members required support to use digital platforms or felt apprehensive about using technology. CDGNs successfully raised awareness about accessing healthcare online, introducing members to the NHS app and online GP systems while encouraging the usage of digital wellbeing apps such as bus timetable apps to help them avoid waiting in the cold¹⁰.

Figure 26: Barriers and facilitators to Digital Health Hubs



Source: Public Health Lincolnshire County Council, 2024

Successes

In 2023, 15% of the partners working with 100% Digital Leeds supported over 20,000 people¹¹. Out of these, 8,000 individuals participated in one-on-one or group skills sessions¹¹. The model provided 12,000 SIM cards with free calls and texts to people experiencing data poverty and loaned over 1,000 devices¹³. On a larger scale, these efforts have encouraged people to take the lead in managing their health through digital resources¹⁴ and given transient communities easier access to services, reducing the number of appointments and demand for services⁹.

Community-embedded care

While technology-enabled care is a critical tool in our arsenal, it is not a silver bullet. We still need to provide in-person pathways to care in our communities, close to people's homes, to ensure equal access. We are already trying new approaches in Lincolnshire. For example, the Joint Aches and Pains Hub in Grantham. This program brought together services for people with musculoskeletal (MSK) conditions in a health village setting¹⁵.

Community pharmacies also offer an opportunity to provide more convenient access to healthcare services. They can help with healthy eating, exercise, quitting smoking, monitoring blood pressure, providing contraception, and giving flu and COVID vaccinations. The new Pharmacy First service further expands the range of services community pharmacies offer, providing care for seven common conditions¹⁶. In general, people have a positive view of community pharmacies, with 90% stating they would feel comfortable seeing a community pharmacist for a minor illness¹⁷.

In Lincolnshire, there is a wide range of services provided by community pharmacies, but we have not yet fully assessed how well these services are carried out and whether everyone can access them easily. There are other factors that might limit access to these services. For instance, many general practices in Lincolnshire dispense medicines directly to their patients. While this helps people get their medicines, these dispensaries do not provide the same broad range of direct access services as community pharmacies.

Application in Lincolnshire

By applying the approach of the Foundry Healthcare model, we can explore how to better manage the health and care needs of people in Lincolnshire.

Lincolnshire's Strategic Segmentation model divides the population into five main groups and several sub-groups based on their health characteristics (see Chapter 6, [page 34](#)). This model helps us understand and predict health needs. However, the needs of each segment must be met by integrated and simple service pathways.

Foundry Healthcare offers a model which translates a Strategic Segmentation model into a set of integrated services. Figure 27 illustrates how we could align Lincolnshire's population segments into a Foundry-like service structure, using three colour-coded categories: Red, Amber and Green (RAG), which guide the approach to service delivery to be taken.

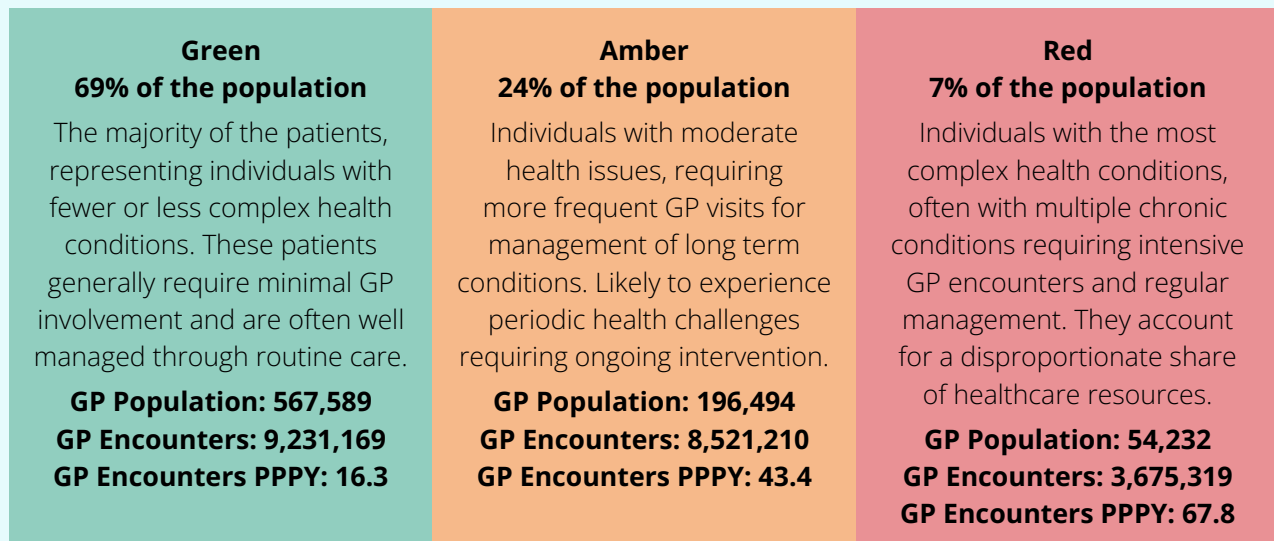
Figure 27: Lincolnshire’s strategic segmentation model mapped to a RAG service delivery approach

Reactive		Proactive				
Green		Amber			Red	
Generally Healthy	Acute Episodic	Long-term conditions			Long-term conditions	End-of-life Care
Low complexity	Low complexity	Low/Middle complexities			All complexities	All complexities
Low risk	Major episodic	Low	Moderate frailty	Middle	Severe frailty	Cancer
At risk	High intensity	Low	Big six	Middle	High complexity	Non-cancer
Children and maternity		Low	Disability	Middle	Dementia	
Healthy		Low	Mental health	Middle		
		Low	MSK	Middle		
		Low	Living with illness	Middle		

Source: Public Health Lincolnshire County Council, 2024

Using this RAG rating system, Lincolnshire’s PCNs and GPs can better prioritise their resources by focusing on patients who need the most care while ensuring appropriate care pathways for those with fewer healthcare needs. This approach can improve patient outcomes, control costs, and support our workforce by more efficiently managing workloads.

Figure 28 shows the breakdown of the RAG rated GP population in Lincolnshire. It includes the total number of GP encounters and the calculated number of GP encounters per person per year (PPPY). The table highlights how different population segments influence demand on GP services. Those in the Red group interact with their GP most often, while those in the Green group interact the least.

Figure 28: Foundry model RAG rated GP Population in LincolnshireData source: ICS Joined Intelligence dataset, 2024¹⁸

Foundry Healthcare used this segmentation approach to target and reduce potentially avoidable appointments. By helping patients manage their own health, improving digital access and offering alternative care pathways, Foundry Healthcare lowered avoidable GP appointments from 7% to 4.5%².

What would be the impact if we adopted a similar approach to delivering health and care across PCNs in Lincolnshire? Applying these estimates to Lincolnshire shows we could reduce unnecessary GP encounters*. Patients in Lincolnshire have over 21.4 million GP encounters each year. If we apply the national average of 16% avoidable appointments to these encounters¹. We could avoid more than 3.4 million of these encounters each year.

If GPs across the county were to employ the strategies utilised by the Foundry Healthcare Model, we could feasibly achieve a similar percentage point decrease in avoidable appointments, from 16% to 13.5%. This would mean over 535,000 GP encounters could be avoided each year, representing a potential cost saving of over £4m annually.

Figure 29: What would application of the Foundry Healthcare model look like for Lincolnshire?

A reduction in avoidable GP encounters to

13.5%

could result in...



A reduction of over

535,000

unnecessary GP encounters



Equating to a cost saving of:

£4m

annually

Data source: ICS Joined Intelligence dataset, 2024¹⁷

What technology enabled care could mean for an acutely ill Lincolnshire resident – Antony’s Story

Antony is a 60-year-old man who loves his rural life on the edge of Lincolnshire Wolds; he is generally well, although he lives with type 2 diabetes, which he manages with diet and physical activity. Having finished his week at work, he arrives home on a Thursday evening before the Easter weekend with a niggling headache, which he treats with the small stock of over-the-counter painkillers he keeps at home.

By Friday morning, his headache was worse, and he started to feel a bit nauseous. Recalling a session at his local Digital Health Hub a month prior, Antony accessed the NHS 111 website and ran through his symptoms. After answering the screening questions, which he knew would help diagnose the problem and direct him to the correct actions, he found that he may have a migraine. Antony takes note of the self-care advice, changes to a different painkiller, and rests up, noting the ‘red flags’ he should watch out for, which he shares with his partner.

Things have not improved by Sunday, and Antony’s partner goes back to the NHS 111 site for more advice. The system now advises that a conversation with a 111 practitioner be conducted. A few hours later, Antony receives a call, and the practitioner undertakes a telephone assessment, which also indicates a migraine and rules out any red flags for more serious illnesses such as stroke. The practitioner advises of a specific pain killer, which can be purchased under the supervision of a pharmacist and tells Antony where the nearest pharmacies are on the bank holiday weekend.

Antony’s partner takes him to the nearest pharmacy armed with the assessment from NHS 111, purchases the recommended painkiller and returns home to rest. The pain is much better by Monday morning, but the nausea is worse. As Anthony is classed as an ‘amber’ person, he is directed to a remote consultation with a general practitioner who, having checked his diabetes control was not affected, sends a prescription for medicine for his nausea to the pharmacist.

Anthony starts to feel better quite quickly and makes a full recovery within the next 24 hours.

Key Points

- Providers working together as a single integrated team can reduce service overlap and make it easier for people to access care.
- Using data and Population Health Management approaches to understand health needs can help us invest our resources more wisely and develop targeted interventions that lead to better care, a more supported workforce and happier patients.
- Providing technology-enabled care while ensuring equal access can improve health outcomes, remove barriers to care and reduce health inequalities.
- Offering person-centred, face-to-face, community-based care closer to people’s homes is key to reducing digital exclusion and empowering individuals to take the lead in their own care.

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*Note: Estimated projected figures presented are intended for illustrative purposes only. The development of a comprehensive analytical model remains a challenge due to the lack of a robust methodological framework and baseline data. We acknowledge the limitations of using external audit forms for identifying avoidable appointments and the restriction in applying these to a large GP population of over 800,000. We also acknowledge the limitations of equating GP appointments to GP encounters.

7 | Personalised care through multidisciplinary teams

A common theme among new models of primary and community health and care is a strong focus on personalised care and multidisciplinary team (MDT) working. These two aspects work hand-in-hand – patients are provided with personalised support tailored to their needs from an appropriate health worker, who works as part of an integrated and multi-professional team.

Patients with long-term health conditions are most likely to benefit from a joined-up and personalised approach to care. Patients are empowered to play a key role in decision-making about their care, to ensure that what matters to them is at the heart of their treatment plan.

A personalised and multidisciplinary approach enables health professionals to work closely with other providers in primary and community care, as well as with other partners in the healthcare system. This encourages a culture of shared learning and quality improvement, providing staff with the opportunity to build their professional skills and empowering them with decision-making authority. MDT working has been linked to greater job satisfaction among health professionals, in turn leading to improved retention within organisations..

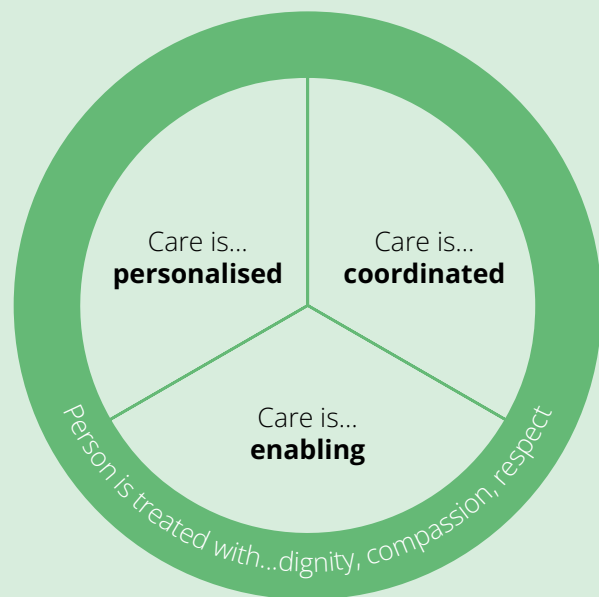
Care with the person at the centre

Personalised care places the patient at the centre of health services, focusing on their specific needs. This means taking into account the individual's preferences, values and needs when making clinical decisions and providing care that is respectful and responsive to them.

The Health Foundation identifies four principles of person-centred care (Figure 30)¹:

1. Affording people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalised care, support or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

Figure 30: The Health Foundation's four principles of person-centred care



Source: The Health Foundation, 2014¹

Person-centred care benefits not only the patient but also health professionals and the wider health system. Evidence suggests that when people play a bigger role in decision-making around their treatment and care, they are more likely to stick to their treatment plans, take their medicines correctly, and are less likely to use emergency services¹.

Personalised care and support planning for people with long-term conditions is one way to put the principles of person-centred care into practice. Through this approach, health professionals undertake shared decision-making with patients - asking what matters to them, supporting them to set goals,

and jointly working to identify treatment options that will best meet their needs and preferences.

Lincolnshire's Integrated Care System is committed to personalised care and support planning as a way of working across all services. Steps are already being taken to achieve this, including promoting the co-production of service design and providing personalised care and support planning training for staff.

For person-centred care to work effectively, it must be a system-wide approach. It's not just a tool or a role for a set number of individuals. It is a philosophy that should underpin the planning and delivery of all health services.

Case study: Esther Model, Jonkoping, Sweden

In Jonkoping County, Sweden, the Esther model uses voluntary multidisciplinary teams made up of caregivers, clinicians, patients and families². This is part of an obsessively person-centred approach designed to support independence and improve quality of life³.

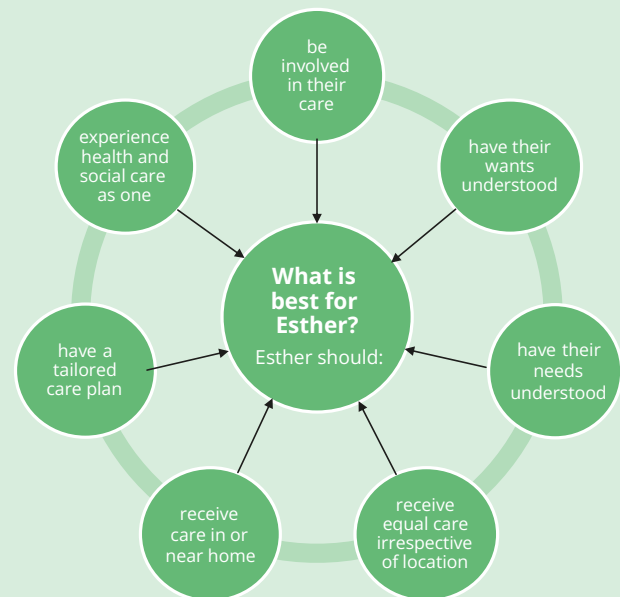
What is Esther?

"Esther" refers to a symbolic person with complex care needs who requires coordination and integration between the hospital, primary care, home care and community care.

The Esther model functions as a network of health and care providers and organisations. Each organisation participates voluntarily as an equal partner and must consider its role in coordinating care with the next provider and what information needs to be shared to ensure Esther's smooth journey through the care system⁴.

Figure 31: What is best for Esther?

Under the Esther model, providers should guide care provision by asking "what is best for Esther".



Source: Public Health Lincolnshire County Council, 2024

Esther Cafes

To involve Esther in the design of care, patients and service providers gather at regular Esther café summits to learn and improve based on the lived experiences of patients with health and social care services⁵. These cafes focus on the challenges and issues faced from Esther's perspective rather than that of a professional⁶.

Esther Coaches

The Esther model builds a culture of continuous quality improvement through specially trained clinical and administrative staff from participating organisations³. These staff act as improvement coaches trained in quality improvement and client focus. Their role is to improve workforce skills, model best practices, and promote resource efficiency.

Figure 32: Barriers and facilitators to person-centred approaches to care



Source: Public Health Lincolnshire County Council, 2024

Successes

The Esther model has been linked to several positive changes in Jonkoping. There was a reduction in hospital readmission rates, a decrease in hospital length of stay for surgery from 4 to 3 days, and a drastic reduction in length of stay for rehabilitation from 19 to 9 days between 2009 and 2014⁵. However, a lack of comparative information makes it difficult to attribute these improvements exclusively to the model⁵.

Integrated neighbourhood teams

The idea of organising care through integrated neighbourhood teams is not new in Lincolnshire. However, the focus here is not on past or current models, but on what evidence and guidance say about these essential building blocks for integrated, personalised care.

Two prominent reports have called for the establishment of integrated neighbourhood teams for health and care delivery in England, embracing MDT working and promoting shared ownership for the health and wellbeing of communities⁷.

Integrated neighbourhood teams are made up of a wide range of professionals from different organisations across health and care and the voluntary sector, all working together at a neighbourhood level to provide coordinated care focused on the needs of the patient. These teams typically include GPs, district nursing, mental health professionals, pharmacists, social prescribers, social care and other council services.

The organisation of the health and care workforce into MDTs like Integrated Neighbourhood Teams, is required for the successful delivery of person-centred care. MDT working helps break down barriers in a health system that has traditionally been fragmented and difficult for patients to navigate.

For the individual this means benefitting from continuous support from a dedicated team of health professionals who get to know their needs, circumstances, and preferences. These professionals work together to provide care as close to home as possible. MDTs are not set up to manage every single health condition, but rather, they are designed to provide a holistic and personalised approach to care. Services may include:

- Support to individuals with chronic conditions through ongoing monitoring, treatment, and education
- Rehabilitation services to help individuals regain independence after illness
- Social care support to assist with social factors that influence health, including housing, financial issues, and social isolation.

Case study: An Accelerated Cluster Model, Cardiff Southwest

The Cardiff Southwest Primary Care Cluster (CSWPCC) is a group of 11 neighbouring general practices delivering health services to a population of 74,000 people across an area with high levels of deprivation⁸. CSWPCC has developed an 'Accelerated' cluster model that makes use of all its local assets, bringing them together in a multidisciplinary team to improve patient engagement with community services, promote good health, prevent ill-health and reduce emergency admissions.

Discharge hub

CSWPCC set up a discharge hub to identify and contact potentially vulnerable patients within 48 hours of hospital discharge to address unmet needs and offer support from providers. Dedicated pharmacists staff the hub to resolve any medication issues promptly, and a Cardiff council worker manages any household adaptations or meal provision. From 2020 to 2021, the cluster discharge hub contacted nearly 5,000 patients and completed over 3,000 medicine reviews⁸.

Figure 33: CSWPCC service offering

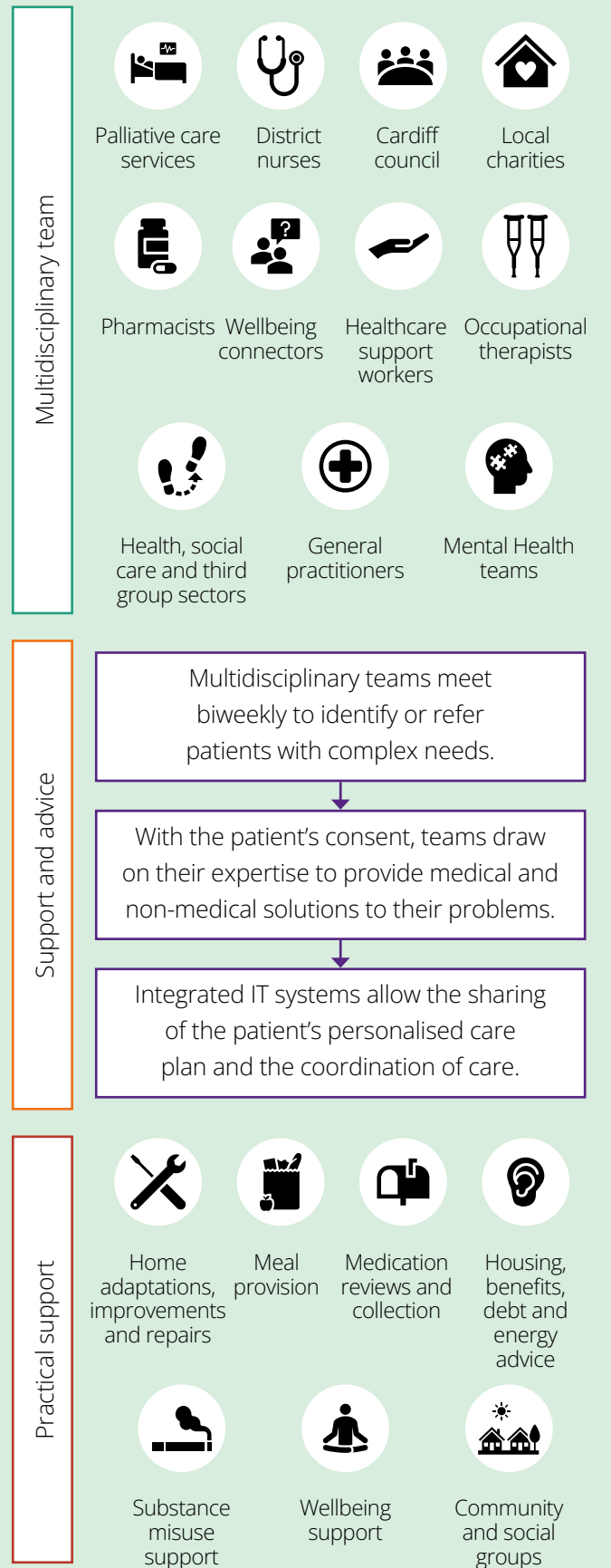
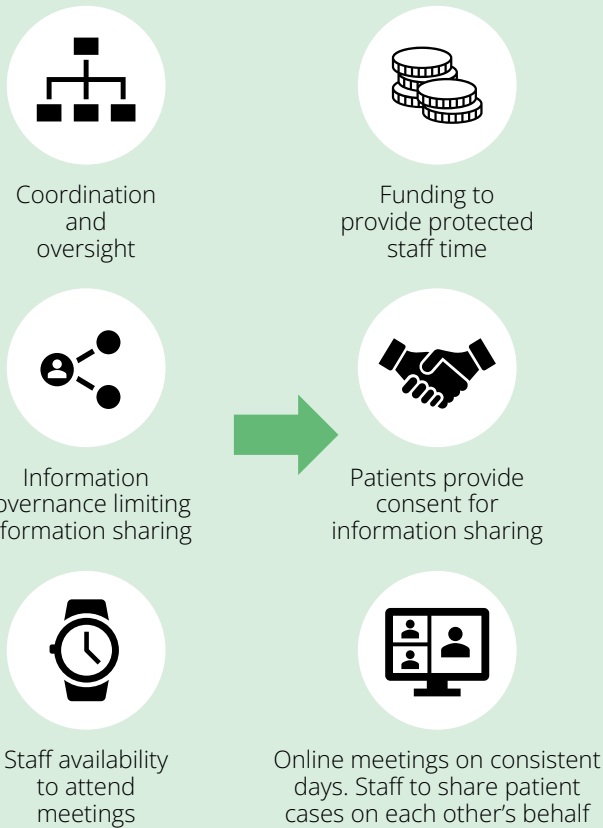


Figure 34: Barriers and facilitators to multidisciplinary team working



Source: Public Health Lincolnshire County Council, 2024

Successes

Research suggests that the CSWPCC's preventative approach has been successful in improving staff satisfaction and reducing GP attendance and hospital admission. Between 2019 and 2021, the multidisciplinary team discussed 592 unique patients, observing a 20% reduction in GP contact after issuing support and advice⁸. The accelerated cluster model was also linked to 800 avoided monthly referrals for assessment and a 50% reduction in monthly emergency bed days⁸.

Person-centred, integrated mental health care

Mental health and wellbeing care needs should also be met using a person-centred MDT approach. In Lincolnshire this is already being put into practice through the mental health transformation programme, which brings together the voluntary, community, faith and social enterprise (VCFSE) sector alongside primary and secondary care partners to improve mental health care. People with lived experience are involved in all aspects of the programme, and personalised care is embedded throughout.

The mental health transformation team includes a variety of roles, such as psychologists, pharmacists, primary care mental health practitioners, social prescribing link workers and peer support workers. A range of community wellbeing hubs, satellite clinics, and outreach provision cover the county. This includes "Night Light Cafes" to provide face-to-face help when people are struggling in the evening. Volunteers with lived experience help make decisions about how the hubs are run and what they provide locally.

Evidence demonstrates that multidisciplinary teams provide better holistic care and increase access to all services available across the health and care, social, and voluntary sectors. In doing so, they lead to improved health by supporting individuals and their care teams to more effectively manage long-term conditions, improve recovery rates, and provide help early before more serious health issues occur. This is a more efficient way to deliver care, reducing costs for the health system and improving patient satisfaction.

Enabler of Change: Asset-based working

Asset-based approaches to health and care seek to build on the existing strengths of individuals and communities. Instead of focusing on what is missing or wrong, these approaches value and nurture local and personal strengths.

This could include investing in local voluntary sector organisations to increase the scale and impact of their activities, multi-agency working with police, housing and employment services to address wider determinants of health or building the skills of health professionals to encourage innovation and positive risk-taking.

A successful example of this approach is the Buurtzorg model in the Netherlands, where self-managed nursing teams provide home-based social and clinical care⁹. Buurtzorg nurses are valued as assets and given a high level of autonomy in their work. They work to the top of their license and have the professional freedom to make independent decisions about what is best for their patients. The nurses make the most of the resources available to the individual patient by creating a support network of family, friends, and community and build the capabilities of the patient themselves to make independent living possible. This has resulted in high rates of job satisfaction among the nurses alongside high levels of patient satisfaction¹⁰.

Application in the Lincolnshire context

How might this approach be applied to support Lincolnshire's goal of integrating care closer to people's homes? Many of the assets and services described in the models above are already in place. However, the approaches outlined here require services to be integrated in ways which make them work as a single system under a single leadership, regardless of the organisation name on their ID Badge. It requires all people involved in a patient's care to be

able to see and contribute to their patient record and care plan, with the most appropriate person in the neighbourhood team ensuring continuity of care by responding to the needs of the patient over time. It also requires specialty team members to provide rapid response to the most urgent needs.

In the community of Tranås, as part of the Jonkoping Esther Model, a "Welcome Back Home" package was introduced for patients being discharged from hospital. This included systematic follow-up within 72 hours of patients being discharged and social care staff being present when patients returned home to make sure they had food, a clean bed, the right equipment and medication, and a personal alarm. Following its implementation, hospital readmission rates within 30 days of discharge for patients aged 65 and older dropped from 17.4% to 12.1%.

Noting that the demography and living conditions in Lincolnshire are not exactly like those in Jonkoping, if we were to use a similar approach in Lincolnshire, we could achieve a meaningful reduction to hospital readmission rates, outlined in Figure 35*.

Figure 35: What would the application of the Esther model look like for Lincolnshire?



In Lincolnshire

3,275

people aged over 75 are readmitted to hospital within 30 days of discharge annually



A reduction in hospital readmissions to a rate of

12.1%

could result in...



580

fewer readmissions within 30 days of discharge annually

Data source: NHSE, 2024¹¹

What integrated neighbourhood care could mean for an elderly Lincolnshire resident - Helen's Story

Helen is 83 and lives alone in a small bungalow, which she chose as she has a range of back and lower limb problems which make stairs impossible for her. She is fiercely independent, but her mobility problems mean she depends on her children to support her wish to stay at home, whatever happens.

She has a number of long-term conditions requiring multiple medications, giving her side effects, which has led to the occasional fall at home in the past. Her neighbours are great at keeping an eye on her, and to help her maintain her independence, her son funds a telecare alarm system, which includes an intelligent monitored medicines dispenser.

Helen has a first-name relationship with the health care assistants attached to her neighbourhood team, and these workers know what is normal for her and what her preferences are for her care when she needs it. Under the supervision of a registered nurse, they check in with Helen and her informal carers on a regular basis and take any issues she has back to the team.

Recently, Helen had a fall whilst trying to hang out some washing on a blowy autumn day. She hates drying her washing indoors, and being able to do this is really important to her. Through the neighbourhood team, Helen's support following her fall was easily coordinated, with immediate care for a small wound treated by the nursing team. A team member with some expertise in falls prevention was with Helen a few days later, looking at the layout of her routes around the bungalow and advising on changes.

The local pharmacist had already been asked to review her medicines again. The GP made the necessary changes, while the nurses attending to her wound dressing ensured Helen and her family understood and implemented the changes.

The local council made an appointment with Helen to talk about levelling the route from the back door to the washing line and ordered, through their Wellbeing Service, a smart little basket for laundry designed to attach to her walker that had already been provided by the integrated Occupational Therapy team. At no point was care provided outside of the community and primary setting to manage this episode of falling for Helen, nor to plan to reduce future risk in line with her choices.

Within no time, Helen's life returned to normal, and she could more safely hang out her laundry when the weather allowed. Her healthcare team were able to confirm through the shared records that everyone involved had restored routine contact with Helen.

Key Points

- Delivering person-centred care benefits both individuals and the wider health system. It can lead to improved adherence to treatment plans, correct use of medicines and reduced use of emergency services
- Person-centred care is a philosophy that requires a change in culture across the entire system with the approach embedded in the planning and delivery of all services
- Multidisciplinary teams provide an efficient way to deliver care by increasing accessibility to all services available across the health and care, social, and voluntary sectors, while improving patient satisfaction
- Using an asset-based approach provides an opportunity to invest in and upskill the health workforce. By valuing the skills and expertise of all cadres of health professionals and giving them a high level of autonomy in their work, staff satisfaction can be increased.

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*Note: Estimated projected figures presented are intended for illustrative purposes only. The development of a comprehensive analytical model remains a challenge due to the lack of a robust methodological framework and baseline data. We acknowledge the limitations of the baseline data for emergency readmissions to hospital within 30 days of discharge, which is only available by age bands <16 years, 16+ years, 16-74 years, and 75+ years.

8 | Conclusions and recommendations

Conclusions

The overall population trends for Lincolnshire show that we have made significant progress in increasing life expectancy for children born today. We should take pride in this achievement but be mindful that far too many people spend these extra years in poor health.

Without us all agreeing to take faster and more ambitious action for change, the results of this ongoing trend will be difficult to accept. More and more of us will stay unwell for longer periods of our lives, creating demands for support from health and care services which cannot be met either financially or by our equally ageing workforce.

The actions required to start counteracting our population's growing health needs and ensure our health and care system's future ability to meet demand are less evidenced than we may like. However, many approaches have been known for some time that we can start embedding now.

In line with this report's emphasis on putting people at the heart of care, let's frame our conclusions around what is important to a person, what they require for their care, and what we conclude they need.

More focus on prevention at all stages of life and wellbeing is key to reducing and delaying our risks of poor health. None of us should be unsure of the best ways to protect our own health and where to find trusted sources of information, advice and support.

When we need some support, we need our own networks of friends and family to be around to lend a hand, and we should have easy access to community-based health workers near where we live who can assist us.

Many of us make use of digital tools to access this help. It's important that more of us are supported in making effective use of technology to do everything from learning how to manage our own health to knowing where to look when we are poorly. We need more than just some of us to be encouraged to go digital when we have evidence of the benefits that digital can have for the unconnected people in our county.

Services need to be closer to where we live and work, and they should work together as one system, or where this is not possible as simple systems. These systems need to be centred on what we need and what matters to us, from the top level of design down to the conversations we have with people.

Some of us will have health needs that are so changeable day to day that we will benefit from having people with an interest in our health keeping in touch with us. This group can include family, friends, carers and healthcare workers who know what is normal for us and will help us spot when things are changing for the worse. When this happens, they will see it and agree with us on what we want to happen to enable us to stay where we have chosen to live.

In this report, we have described the unique challenges our county faces and laid out the case for change in primary and community healthcare delivery as a starting point to address these. We have described several approaches we can start implementing now, and the following recommendations indicate areas where we might begin to make these changes.

Recommendations

1. Develop new relationships with the public where they are supported to take the lead for their health and care.

- ⇒ Treat personalisation and the person-centred design of services as a culture change initiative, not just a service add-on, and build on work that has already begun under the personalisation programme.
- ⇒ Promote self-care practices and build peoples skills and confidence to self-manage their long-term health conditions to help ease symptoms and improve quality of life through interventions such as health coaching and digital health apps.

2. Develop a renewed focus on prevention.

- ⇒ Redesign a service or pathway for better health outcomes and include self care and prevention at every stage of the redesign
- ⇒ Develop more systematic approaches to prevention and self-care by transforming our wide range of 'social prescribing' roles into a network of Community Health and Wellbeing Workers who work in communities to promote healthy behaviours and support self-care.
- ⇒ Systematically address wider determinants of health at an agreed population level through partnership working between the health and care sectors, local authorities, and public services. Focus first on people whose health needs are closely linked to social and environmental factors.

3. Harness digital technology to innovate the delivery of care and use digital inclusion to avoid leaving people behind.

- ⇒ Speed up and scale up the use of digital technology to improve access to health and care information and services. Make digital-first models the preferred entry point for people to access health and care and use digital apps to support them in self-care and self-management.
- ⇒ Integrate digital inclusion approaches in all

health and care initiatives that use technology. For example, provide resources, spaces and opportunities for people to learn skills and build confidence in using health-related technology.

4. Deliver person-centred care closer to home through integrated multidisciplinary teams.

- ⇒ Build on the work of primary care networks to develop integrated teams to triage, assess, refer and treat people.
- ⇒ Extend current efforts to integrate teams of different disciplines and sectors to incorporate all primary and community services at an agreed population level. Evidence would suggest at a population level of 60,000-100,000 people.
- ⇒ Take forward the design of a system-wide 'Green' channel for people with one-off or newly presenting health and care issues, with an easy-to-navigate digitally driven triage, advice and sign-posting front end.
- ⇒ Streamline pathways into care into the smallest number of pathways possible, avoiding creating specialist or niche pathways unless safety considerations demand it. Make them simple for people and practitioners to navigate and use effectively.

5. Support and invest in our workforce to co-produce and embrace new models of care.

- ⇒ Through the establishment of multidisciplinary teams, systematise partnership working and shared learning among health professionals and wider system partners for skills building and quality improvement.
- ⇒ Give health workers the professional freedom to make independent decisions about what is best for their patients, encourage them to innovate, and support them in positive risk-taking in order to make possible the implementation of new, person-centred models of care.

Glossary

Community Health Care – Community health teams support people with complex health and care needs to live independently in their own home for as long as possible. Additionally, services include promotion services such as school health services and health visiting. They are made up of a wide variety of professionals including community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers. (NHS England)

Community Pharmacy – Community pharmacies offer a more convenient way to access healthcare that includes support for healthy eating, exercise, stopping smoking, monitoring your blood pressure, contraception, and flu and covid vaccinations. (NHS England).

Digital Exclusion – This covers three things: Digital skills – being able to use digital devices such as computers and the internet; Connectivity – access to the internet through broadband, wi-fi, and mobile phone; and Accessibility – Services designed to meet all users' needs, including assistive technology. (NHS Digital)

Health Inequality – Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. (NHS England)

Health Literacy – Health literacy is a two-sided issue, comprising both an individual's ability to understand and use information to make decisions about their health and care, and a 'systems issue', reflecting the complexity of health information and the health care system. There is a strong social gradient in the population, with lower levels of health literacy much more common among the socially and economically disadvantaged. (NHS England)

Integrated Care System (ICS) – ICSs are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 ICSs across England, covering populations of around 500,000 to 3 million people. (The King's Fund)

Multidisciplinary Teams (MDTs) – A group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users. MDTs are used in both health and care settings. (NHS England)

NHS Confederation – The membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. (NHS Confederation)

Office for Health Improvement and Disparities (OHID) – OHID is part of the Department of Health and Social Care (DHSC) and focuses on improving the nation's health so that everyone can expect to live more of life in good health, and on levelling up health disparities to break the link between background and prospects for a healthy life. (OHID)

Person-centred Care – Focusing care on the needs of the individual. Ensuring that people's preferences, needs and values guide clinical decisions and providing care that is respectful of and responsive to them. Health and wellbeing outcomes need to be co-produced by individuals and members of the workforce working in partnership, with evidence suggesting that this provides better patient outcomes and costs less to health and care systems. (Health Education England)

Personalised Care – Personalised care represents a new relationship between people, professionals and the system. It happens when we make the most of the expertise, capacity and potential of people, families and communities. (NHS England)

Population Health Management (PHM) – PHM improves population health through data-driven planning and the delivery of proactive care to optimise health outcomes. This means moving to a proactive system that focuses on interventions to prevent illness, reduce the risk of hospitalisation, and address inequalities across England in the provision of healthcare. (NHS England)

Primary Care – Primary care services provide the first point of contact in the healthcare system and includes: General practice; Community pharmacy; Dentistry; and Eyecare. (NHS England)

Primary Care Network (PCN) – PCNs are made up from groups of neighbouring general practices brought together to work at scale. This means they should have a greater ability to recruit and retain staff; manage financial and estate pressures; provide a wider range of services to patients; and to more easily integrate with the wider health and care system. (The King's Fund)

Secondary Care – These are services provided by medical specialists who in general do not have first contact with the patient. This includes: Planned or elective care – usually in a hospital; Urgent and emergency care, including 999 and 111 services, ambulance services, hospital emergency departments, and out-of-hours GP services; and Mental health care. (NHS Digital)

Segmentation – Data segmentation is the process of taking the data you hold and dividing it up and grouping similar data together based on the chosen parameters so that you can use it more efficiently to understand the health needs of the population. (Experian)

Self-care – Self-care is about keeping fit and healthy, understanding when you can look after yourself, when a pharmacist can help, and when to get advice from your GP or another health professional. (NHS England)

Tertiary Care – Tertiary care is highly specialist treatment, such as: Neurosurgery, Transplants, Plastic Surgery, and Secure forensic mental health services. (NHS Digital)

Voluntary, Community, Faith and Social Enterprise (VCFSE) – Partnership working between voluntary, community, faith and social enterprise (VCFSE) organisations and ICSs to improve health and care outcomes. (NHS England)



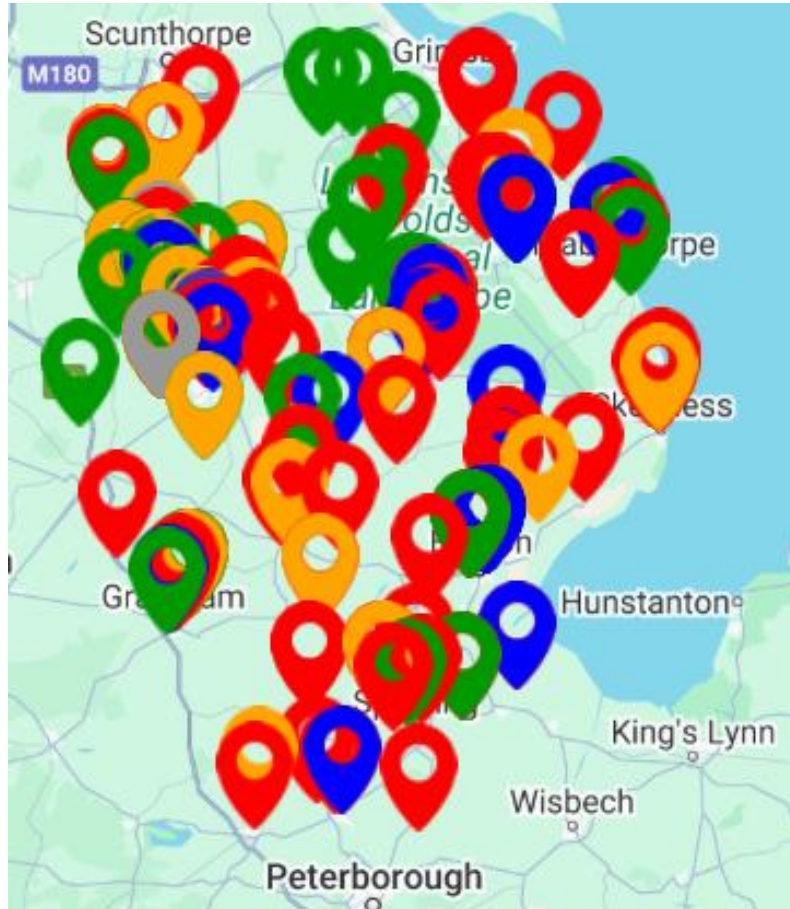
Lincolnshire County Council
County Offices, Newland, Lincoln, LN1 1YL
www.lincolnshire.gov.uk

A woman with dark hair in a bun, wearing glasses and a black jacket with a white fur collar, is talking to a man with glasses and a dark jacket over a light pink shirt. They are in a bright, modern building with large glass windows. A green and blue curved graphic is on the left side of the image.

ICB Board March 2025 Healthwatch Updates

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

January and February 2025

Between January and February 2025, **244** people shared their experiences of health and social care with us. An additional **773** people have shared their experiences through our access to GP services survey.

Out of the 244 experiences shared with our Information Signposting Service, **55% were negative** and **21% were positive**. The remaining were neutral, mixed or unclear.

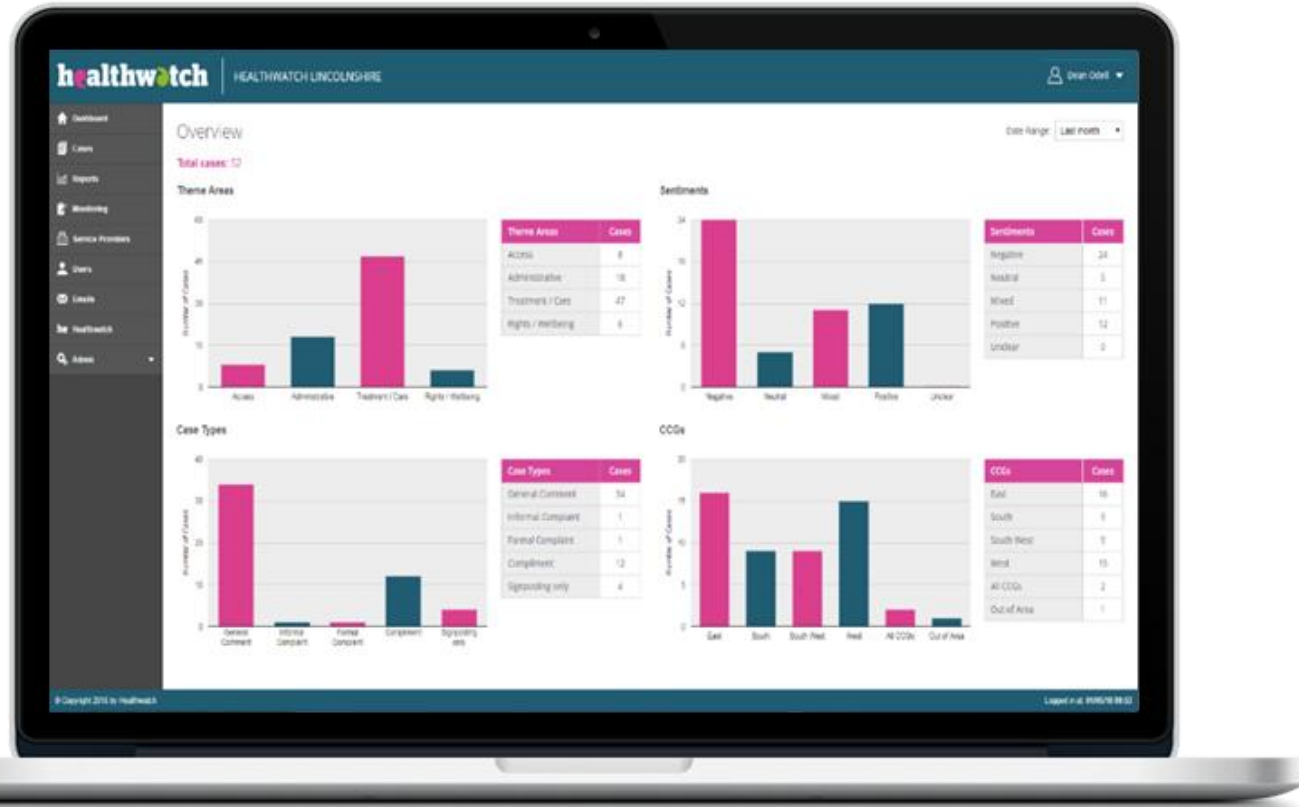
The service areas commented* on the most this month were:

- GP Services (48%)
- All Hospital Services (33%) - (5% of all comments were about A&E)
- Social Care (16%)
- Mental Health (9%)
- Dentistry (9%)

*Some comments relate to multiple service areas.



IMP System – Local Healthwatch



Cases

Primary Care services

East Locality x 27

- 20 x General Comment
- 2 x Formal Complaint
- 5 x Compliment

General Comment

1. Case 14393 (20-02-2025)
PCN: First Coastal
Providers: Beacon Medical Practice
Beacon Surgery Skegness. I have Rheum hundreds of proven allergies. My body is places. Hardly anything works on me. So appointment and given up. The only thing called review and diet was simply asked Glad I learnt medicine and have a PhD in accountant, I am 82 now. I also have a high no one can help me with. I cannot even g

Amend statement...

Notes / Questions

Signposted and given information to contact satisfactory resolution to contact LICB. in support.

Our Helpline is run by trained bereavement affected by grief.

We'll give you space to talk about your fe

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

Access

Statistics

Total cases: 76
Cases responded to within 3 days: 75 out of 75 (100%)

Theme Areas

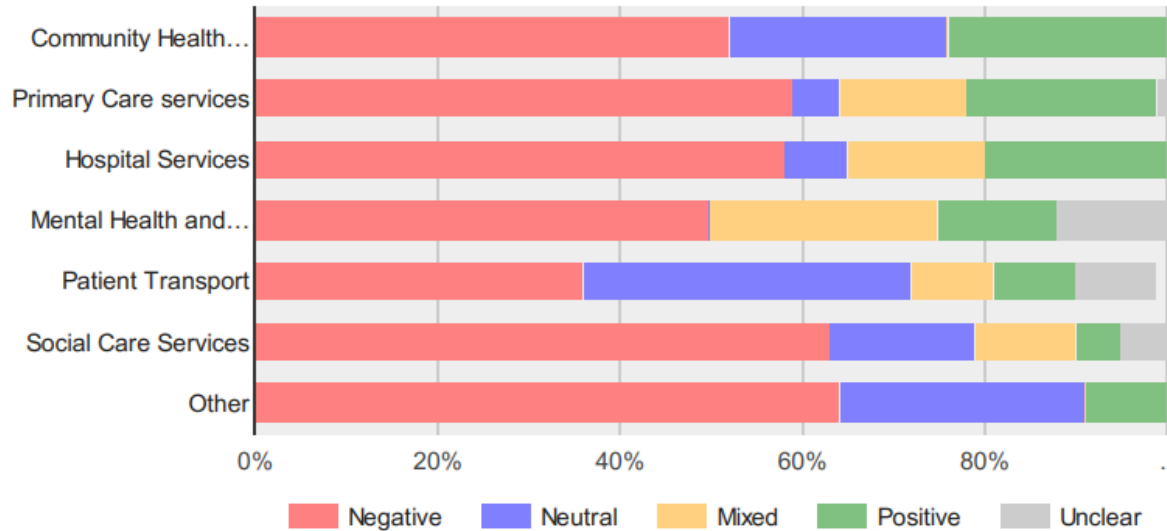
Theme Areas	Cases
Access	76
Administrative	40
Behaviours	11
Digital Access	6
Public Health	1
Treatment/Care	52
Miscellaneous	1

Sentiments

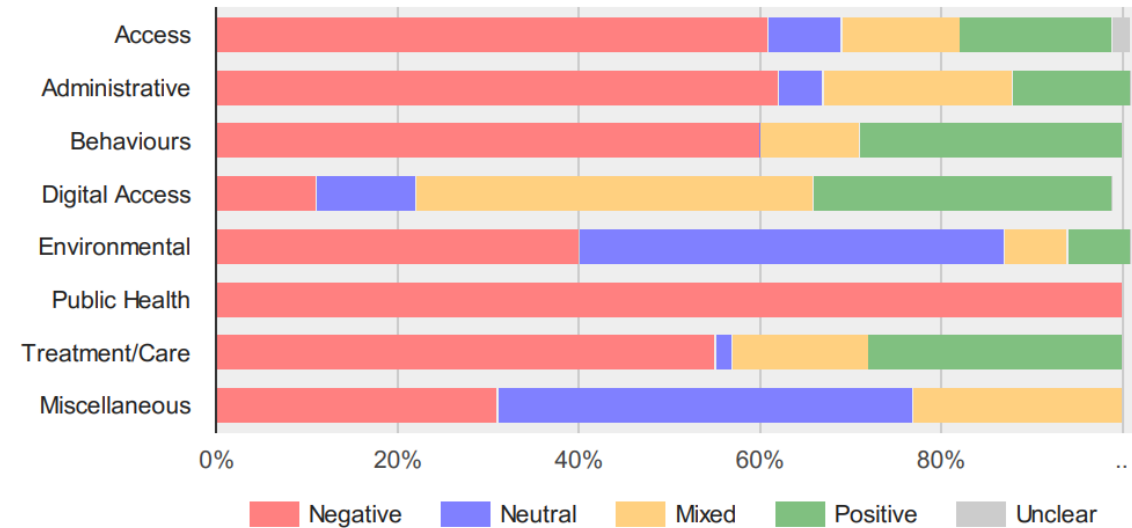
Sentiments	Cases
Negative	47
Neutral	2

Sentiments and themes

Satisfaction by Service Type



Satisfaction by Theme



Non Emergency Transport Service (NEPTS)

The feedback received covered several key themes:

- Eligibility
- Access barriers
- Communication and information gaps
- Service reliability and delays
- Impact on vulnerable patients
- Treatment and wellbeing concerns

"My 90+ year-old relative was left waiting for hospital transport for over 30 hours. It kept getting cancelled, and eventually, they were taken home at 2am in the morning."

"I was denied transport despite requiring a stent procedure at Lincoln County Hospital. I was told I was ineligible because I was not disabled and did not receive benefits, without being provided any alternative solutions."

Provider Responses and Actions Taken

Healthwatch Lincolnshire escalated several cases to relevant authorities, including East Midlands Ambulance Service (EMAS), the Integrated Care Board (ICB) and the Patient Advice and Liaison Service (PALS).

Some cases were jointly reviews and flagged as priority, ensuring that patients received transport required.

- **Rural Challenges:** Residents in more remote areas highlighted issues with transport to healthcare services, making it harder to access timely support.
- **Older Population Impact:** Concerns were raised that older individuals in these areas may be less persistent in seeking care, risking delayed diagnoses and poorer health outcomes.
- **Pharmacy and GP Coordination:** Gaps in communication between pharmacies and GP services often left patients feeling unsure of the next steps in their treatment journey.

*Individual at The Storehouse, Skegness.
“Expressed concern and frustration that recently had a Urinary Tract Infection (UTI), went to local Pharmacy and prescribed antibiotics, told to return if did not get better. After a week, the symptoms were no better, so returned to Pharmacy, who advised to see GP. Tried for 4 weeks to get Emergency appointment with GP. On the fifth week presented at GP in the early morning, crying, told by receptionist there was no appointments, felt very unwell so was seen by a Clinician in waiting room. Taken by Clinician into a room and seen. Worried about older population who would not persist if unwell with getting an appointment.”*

Positive Community Engagement

Praise for:

- **The Glebe Practice, Trent** – easy access, caring and friendly staff
- 11 comments praising the surgery and service



"I had an appointment with a named GP about an ongoing problem. As usual they were very professional, caring and did their utmost to help."

"The triage system they use for booking appointments is very good. Used it several times for myself and my children and cannot fault it so far."

"Very good experience at my appointment to see the doctor. I went with a mole I was worried about and the doctor straight away put my mind at ease. They were very thorough and was good at explaining everything to me. I was given information needed to look out for which was very helpful. Overall, it was a very pleasant visit, and the doctor was very kind and understanding of my concerns."

"I feel I am always listened to and understood. I do not struggle to get an appointment for myself or my children."

"One of the best doctors I've met, easy to talk to, they listen and really helps in the most friendly yet professional way. Made plenty of time for me and has improved my quality of life!! Nothing could have been better."

Access to GP Services

- Over 800 responses to date
- Survey link:
<https://www.smartsurvey.co.uk/s/HWLincolnshireGPSurvey25/>
- Closes 28th March



Initial Trends: PCN Areas

Access - %DIFFICULT	Access - %EASY
Four Counties – 86% (31)	South Lincoln Health Care – 63% (40)
First Coastal – 83% (85)	Sleaford – 63% (40)
Meridian – 75% (59)	IMP – 62% (24)

Scan the QR
code to
complete!



Current HWLincs Focus

Pelvic Health

To help develop the Perinatal Pelvic Health Service, we are working with Better Births to gather intelligence on pelvic health knowledge and experiences people go through.

Phase one

216 people shared their views



Key themes

- Many were **never given any information about pelvic health** during pregnancy
- Around half **were not confident that they knew** the key symptoms or **signs of pelvic health problems** during pregnancy
- More than half stated they were **not offered information about things you could do** while pregnant **to reduce risks of pelvic health problems**
- Half were **never asked about their pelvic health postpartum**

Key Recommendation

Need for greater awareness and information about pelvic health, signs, symptoms, prevention and where to get support

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

e: info@healthwatchlincolnshire.co.uk

 @HealthwatchLinc

 [Facebook.com/HealthwatchLincolnshire](https://www.facebook.com/HealthwatchLincolnshire)

healthwatch
Lincolnshire



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (i)
Meeting Date:	Tuesday, 25 th March 2025
Title of Report:	Integrated Quality & Performance Report – March 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 <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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 February 2025 was 73.7%, below the planned month trajectory of 77% (95% constitutional target) but this was higher than the regional and national average performance.

- Category 1 mean response times for EMAS Trust was 08:58 minutes against a standard of 07:00 minutes during February 2025.
- The Category 2 mean response time for EMAS Trust was 37:43 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 299 patients waiting over 62 days at the end of January, this is now a combined target including consultant upgrades.
- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral decreased to 61.5% in January from 69.5% in December '24.
- The faster diagnosis standard was not achieved in January, overall performance was 74.6%, just below the 75% standard.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals increased from 113,769 in December to 114,401 in January, an increase of 632.
- The ICB finished January with 99 patients waiting over 65 weeks against the zero plan- this was a reduction from 107 in December.

Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies waiting times standards were both achieved in January. 96.8% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 99.5% 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 82% in January (rolling 12 months) which is above the 60% standard.
- Adult inpatients with learning disabilities or autism remain above trajectory at 30, compared to planned trajectory of 28.

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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Report previously presented at:			
Not applicable			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

Integrated Performance, Quality & Finance Report



Lincolnshire
Integrated Care Board

March 2025



21/03/2025

Contents

- Executive Summary [Page 3](#)
- Key to Charts [Page 4](#)
- Performance Dashboard [Page 5](#)
- Key Performance Data [Page 6](#)
- Quality [Page 10](#)
- Finance [Page 16](#)

Executive Summary

Overview

The March 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 February where available.



Urgent & Emergency Care

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Elective backlog

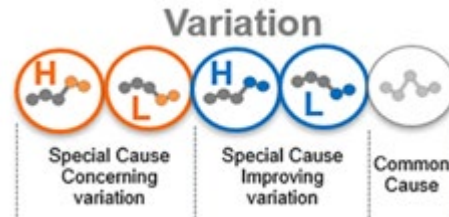
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Mental Health, Learning Disabilities & Autism

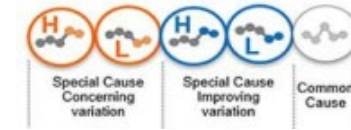
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- Adult inpatients with learning disabilities or autism remain above trajectory at 30, compared to planned trajectory of 28.

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!	

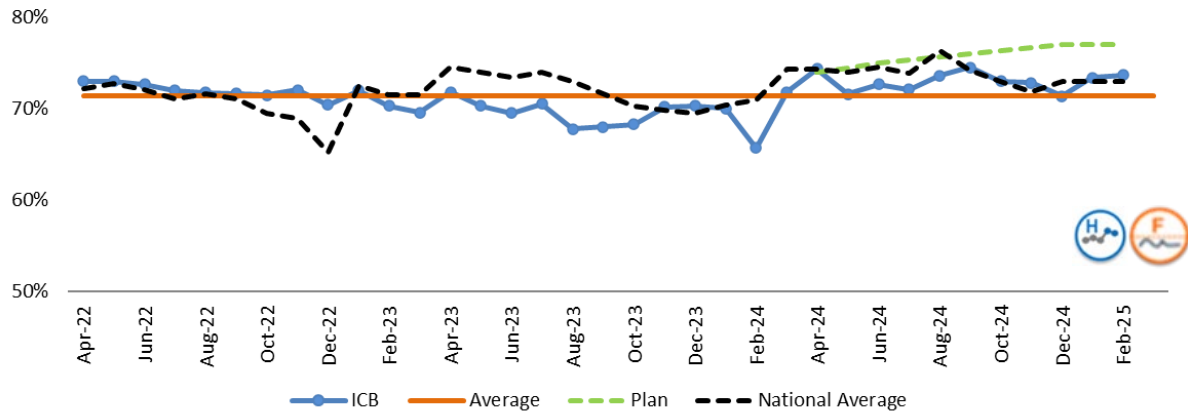
Lincolnshire ICB Performance Dashboard



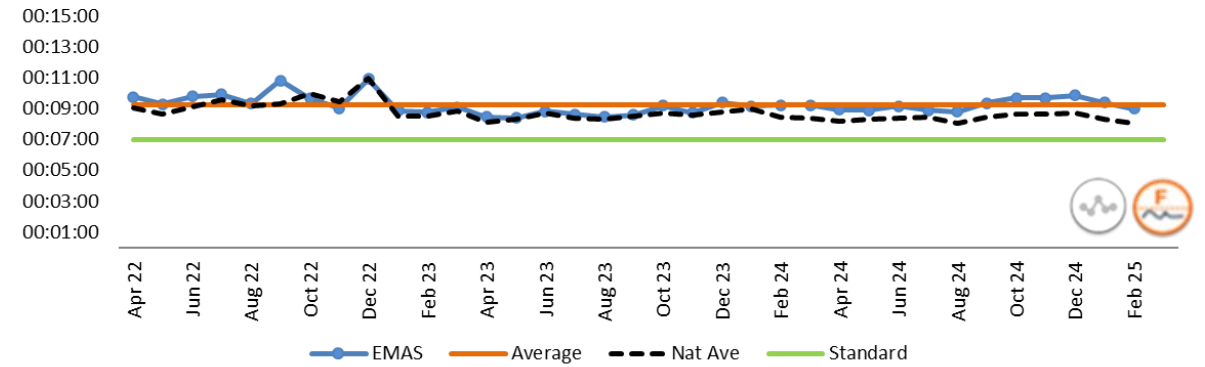
Trend

Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	77.0%	Feb-25	73.7%	72.3%	73.0%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Feb-25	00:08:58	00:08:24	00:08:04			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Feb-25	00:37:43	00:31:31	00:31:22			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	-	Jan-25	81.5%	87.0%	88.8%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	-	Jan-25	61.5%	62.5%	67.3%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	-	Jan-25	74.6%	73.1%	73.4%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	-	Jan-25	55.3%	56.5%	58.9%			
	Patients waiting over 65 weeks for treatment (ICB) (% of total ICB waiting list size)	-	-	Jan-25	0.09%	0.10%	0.20%			-
	Percentage waiting six weeks or less for a diagnostic test	99%	-	Jan-25	70.2%	74.8%	77.6%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q3 2024/25	28.3%	28.4%	21.4%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	Jan-25	96.8%	N/A	91.0%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	Jan-25	99.5%	N/A	98.4%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	Jan-25	82.0%	71.3%	61.0%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	Jan-25	*	80%	81%			-
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	Jan-25	73%	80%	82%			

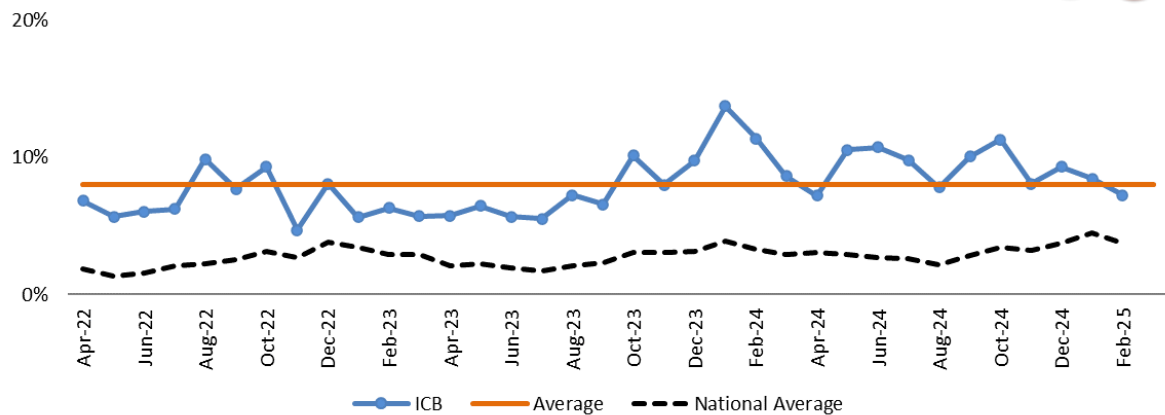
A&E admission, transfer, discharge within 4 hours (ICB)



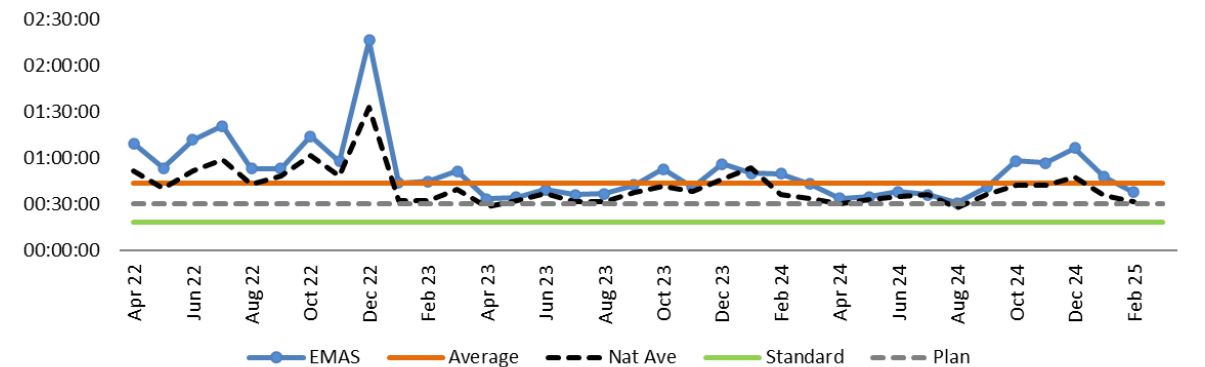
Ambulance response times - Mean response time- Category 1 (EMAS)



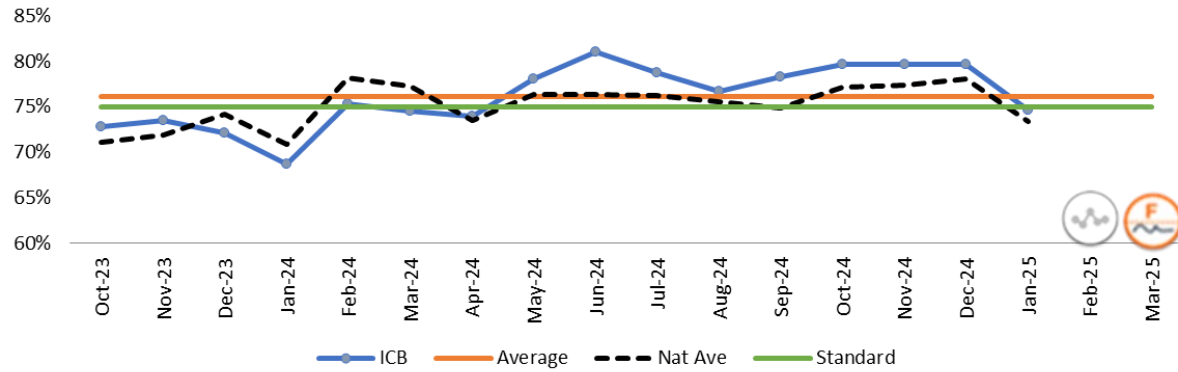
12+ hour delays from decision to admit (ICB)



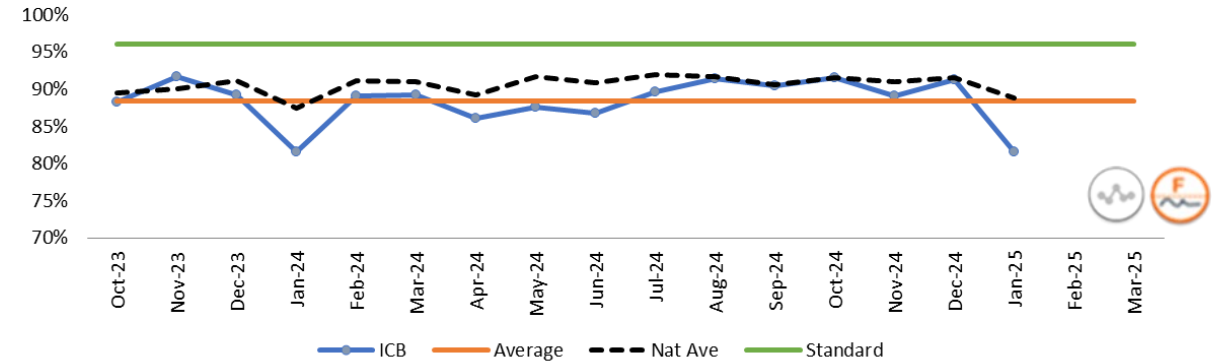
Ambulance response times - Mean response time- Category 2 (EMAS)



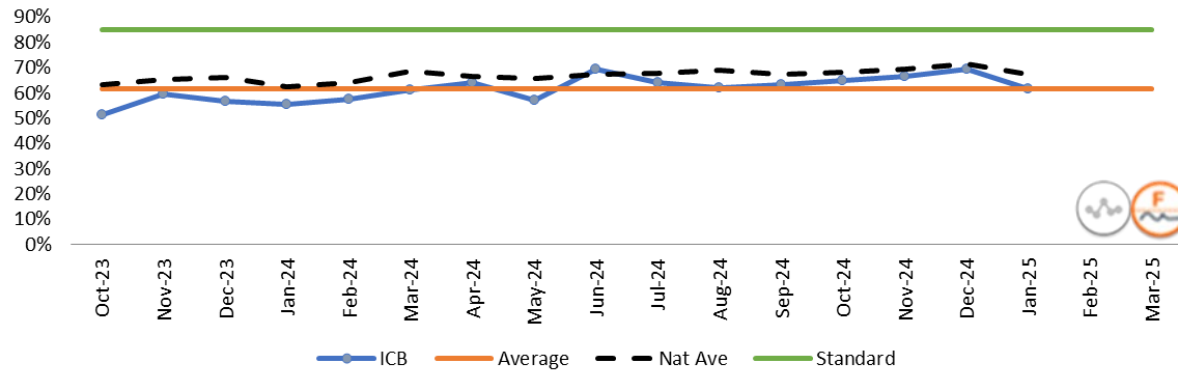
Faster Diagnosis Standard- % of patients told cancer diagnosis outcome within 28 days (LICB)



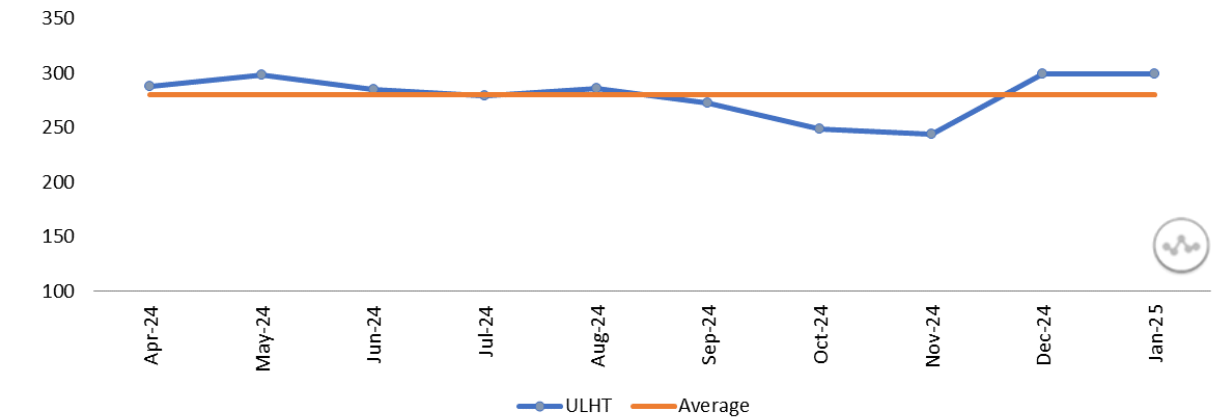
Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



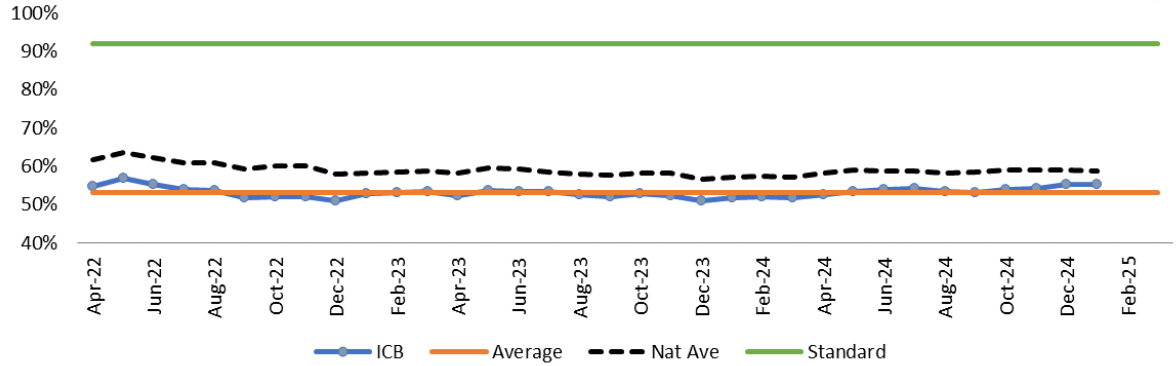
Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade (LICB)



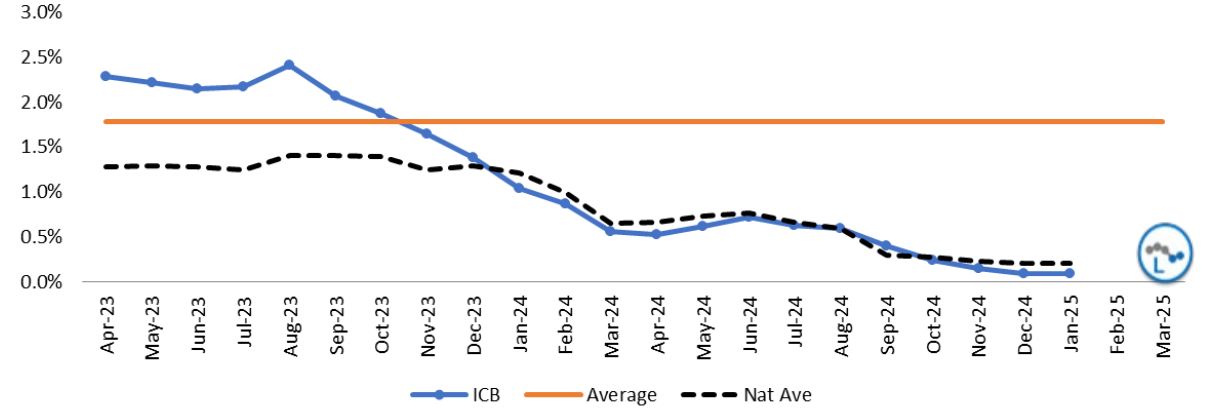
Total 62 Day Backlog (ULHT)



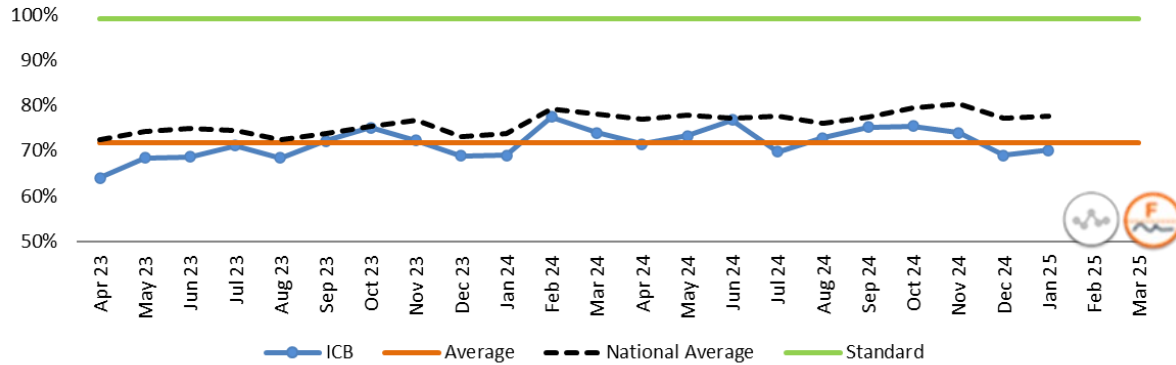
RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



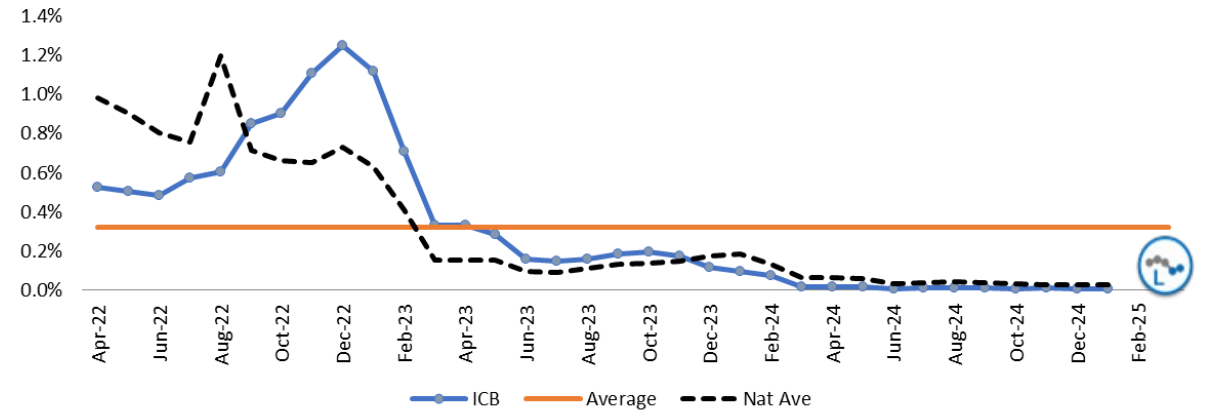
RTT- Patients waiting over 65 weeks for treatment (LICB)



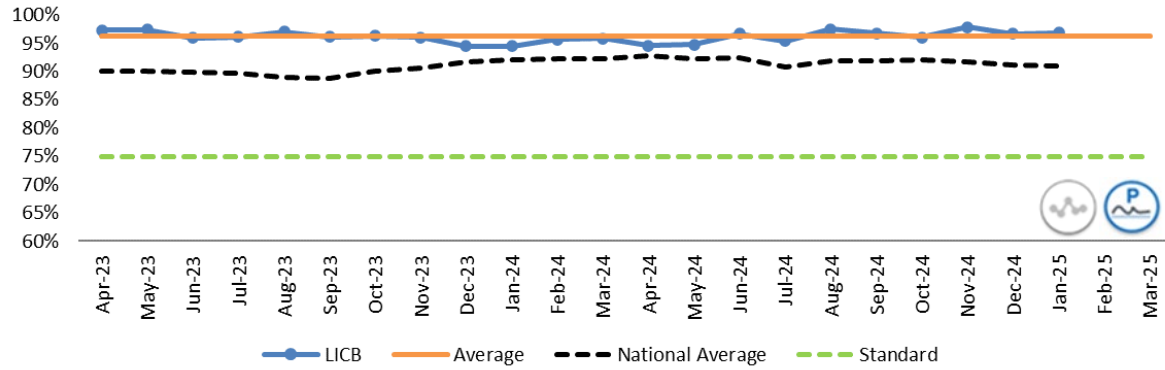
Percentage waiting six weeks or less for a diagnostic test (ICB)



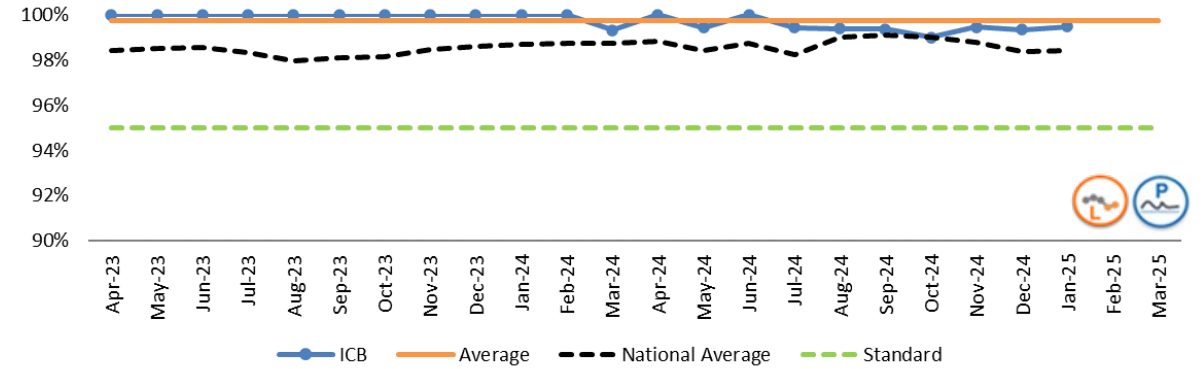
RTT- Patients waiting over 78 weeks for treatment (LICB)



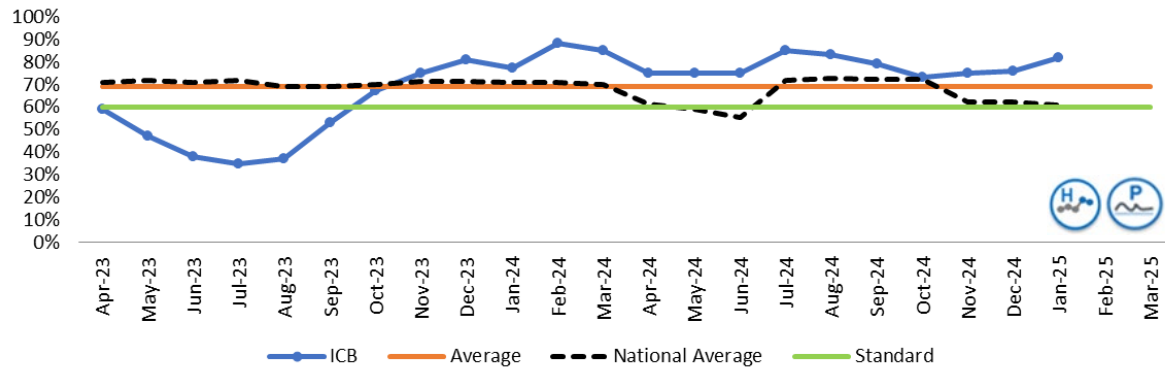
Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



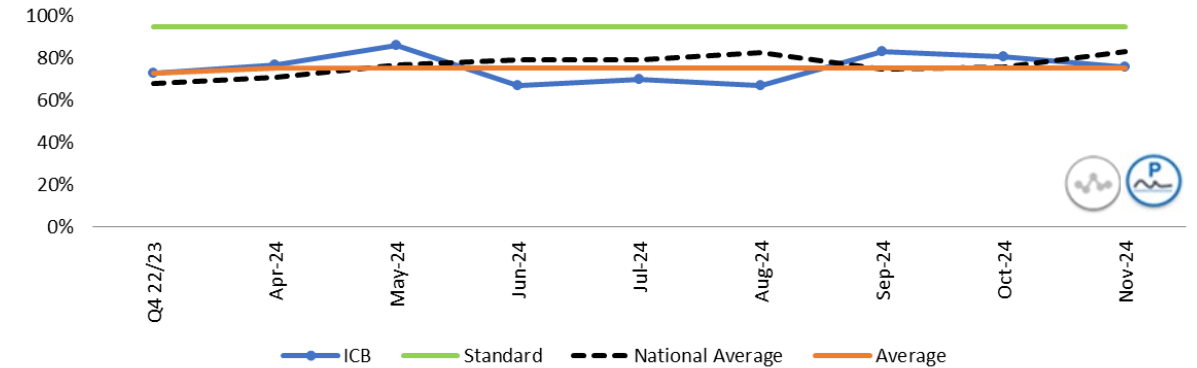
Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)



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



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



Lincolnshire ICB Quality Dashboard



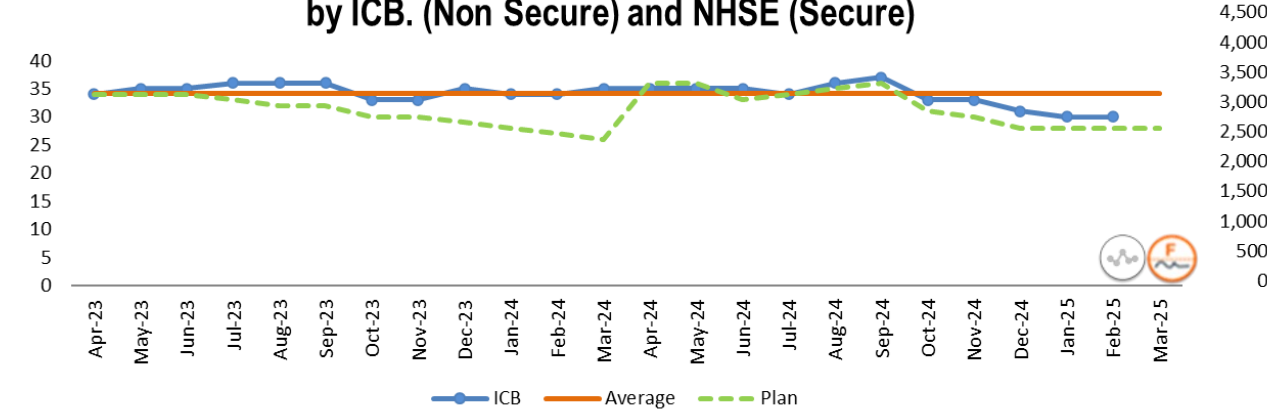
Programme	Indicator	Standard /Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULHT)	0	Jan-25	3	N/A	N/A	-		
	Never events - YTD (NLAG)	0	Jan-25	1	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	Jan-25	7	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULHT)	-	Nov23 to Oct24	1.0935	1.0542	1.0036			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	Nov23 to Oct24	0.9825	1.0542	1.0036			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	Nov23 to Oct24	1.0073	1.0542	1.0036			
Infection, Prevention, Control	MRSA Cases (ULHT 12 month rate per 100,000)	-	Jan-25	0.30	1.06	1.06			
	C-Diff Cases (ULHT 12 month rate per 100,000)	-	Jan-25	30.74	33.94	32.44			
	E-Coli Cases (ULHT 12 month rate per 100,000)	-	Jan-25	44.63	44.63	32.00			
Learning Disability	Number of inpatient care for people with a learning disability and/or autism (ICB)	28	Feb-25	30	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	3,358	Feb-25	3,202	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	0.5%			
	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	Jan-25	496,502	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	Jan-25	45.5%	N/A	44.8%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	Jan-25	87.2%	N/A	82.7%			
	Enhanced access minutes provided (ICB) (YTD)	2,199,392	Jan-25	2,291,667	N/A	N/A			
	The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	Jan-25	88.0%	N/A	N/A			

Learning Disability & Autism

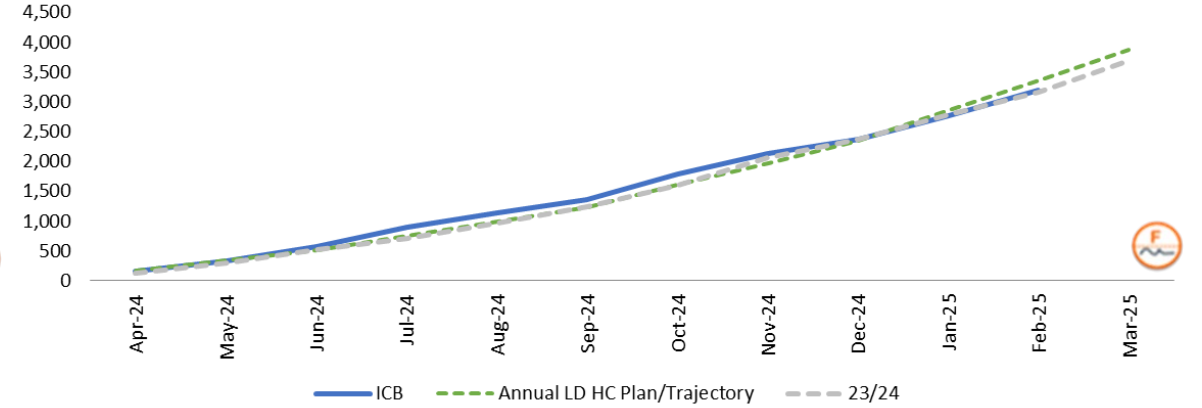


Lincolnshire
Integrated Care Board

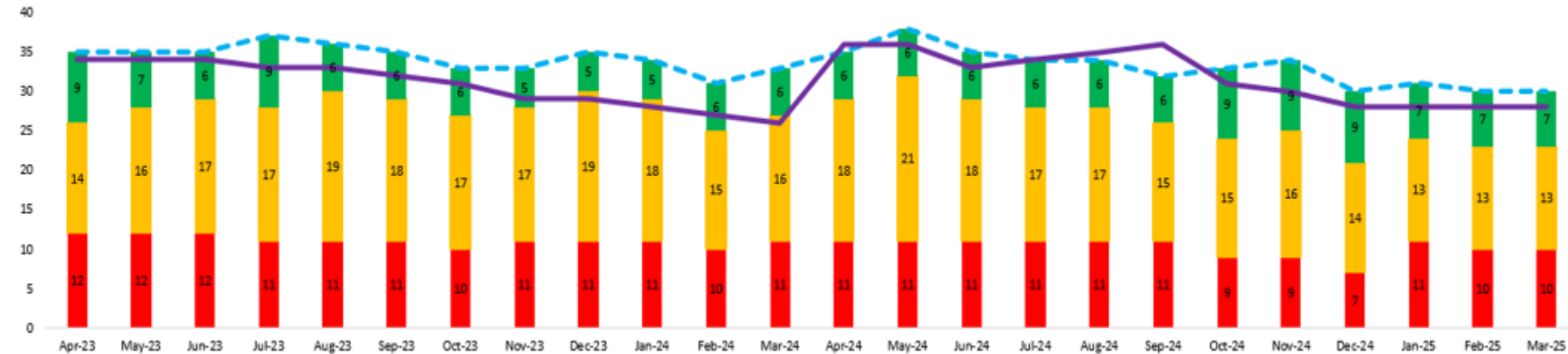
Inpatient care for adults with LD/autistic - Care commissioned by ICB. (Non Secure) and NHSE (Secure)



Cumulative Learning Disability Healthchecks (ICB)



LDA ICB & IMPACT Adult Inpatient Movement 2023/24 - 2024/25



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

RAG RATING Key	
Legal framework - This is the barrier to the discharge and may prevent the discharge from happening for several years etc. a. Those on extended S17 Leave granted under the MH Act b. Those on MM judgements which will state when the ruling applies to. Looking into capacity issues as well	Red
Clinical illness - Those clients where the needs are best met in a secure environment	Yellow
Market issues - this is where we should concentrate the discharges on, as it is the lack of placement to discharge to, which is the reason why they have not been discharged	Green

Insight and Signals – Quality and Patient Experience

Local Area Partnership SEND Inspection

Ofsted and CQC undertook a local area partnership SEND inspection 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. The inspection process highlighted the commitment to partnership working and collaboration across organisations to demonstrate the positive work that is happening here in Lincolnshire. The inspection report is awaited.

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. Learning from long wait harm reviews has highlighted a low harm theme in relation to pressure ulcers. ULTH are undertaking work to address the areas of learning from this theme highlighted through the review process and there is opportunity for wider system learning to be incorporated into the Lincolnshire ICS Tissue Viability and Pressure Ulcer Prevention Quality Improvement programme.

The Vales

The Vales is a female rehabilitation ward providing care to patients with complex mental health needs. LPFT have established a strategic quality group which includes representation from the ICB to provide oversight of a quality improvement programme currently being undertaken by the Trust.

Right Care Right Person

Following publication of NHS guidance in November 2024 Lincolnshire ICB have been working with colleagues from Lincolnshire Police in order to hand over lead agency roles and responsibilities to the ICB, work is underway to set out the governance of the project under the Urgent and Emergency Care programme.

Insight and Signals – Primary Care

Type of Provision	Practice	CQC Rating	Information to note
Primary care	Enhanced services practices	N/A	<p>Phlebotomy services Some GP Practices have escalated concerns regarding ability to provide service in 2025/26 within current funding</p> <p>Treatment room services 14 practices currently not providing this service with further practices indicating they will be unable to continue to provide if the funding offer is not increased.</p> <p>The ICB is exploring options for these services as a matter of urgency.</p>
Primary Care	Cliff Villages surgery	Good	The ICB had noted that there was a change in clinical quality and performance. The ICB Primary Care Quality team has engaged with the practice and is working to support with an improvement plan. The practice have responded well to this support offer and improvement progress is being made.
Primary care	The Sidings practice	Inadequate	In late 2023 the Sidings practice was assessed by the CQC and given an inadequate rating. They also received improvement notices. The Practice was re-assessed by the CQC November 2024. ICB Primary Care Quality team intensive support in place with the practice. CQC report awaited..

Quality Improvement

Adult Social Care and NHSE Chief Nurses Visit

The national Chief Nurse for Adult Social Care and NHSEs 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 ICB will work with LiNCA to co-ordinate how identified areas for future development are taken forward.

NHSE Chief Midwifery Officer Visit

The Chief Midwifery Officer (CMO) for England, 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..

System Response to Acute Respiratory Infections

As part of the Integrated Health Protection Team, the response to outbreaks of acute respiratory infections (ARI) this winter has demonstrated cross system working involving the ICB and LCC Health Protection Teams, UKHSA and the LCHS Vaccination Rapid Response Team. The introduction of the Vaccination Rapid Response Team has enabled the Health Protection function in Lincolnshire to respond to outbreaks in a timely and effective way, removing barriers for prescribing of treatments and prophylaxis.

Lincolnshire System Mortality Group

The Lincolnshire System Mortality Group has been (re)-established bringing together stakeholders from across Lincolnshire to review themes, trends and concerns arising from each organisation's mortality reviews. This will provide an opportunity to identify and share lessons learnt as well as any areas of change that may be required.

Since the launch of the legislation in relation to Medical Examiners reviewing all community and acute deaths within scope, the service has been experiencing several difficulties particularly in relation to Primary Care. This has been formally raised with the Regional Medical Examiner Team.

Lincolnshire Nursing & Midwifery Community of Practice – Nursing & Midwifery Excellence

The Nursing & Midwifery Community of Practice (COP) brings together senior nursing and midwifery leaders from across Lincolnshire and includes representatives from a range of organisations including ICB incorporating Primary Care; NHS Trusts; LCC; Independent Providers; and Lincoln University. The COP is currently overseeing a piece of work to develop a Nursing & Midwifery dashboard which will allow individual organisations to assess themselves across the NHSE Midlands 6 pillars of Excellence, which include local accreditation; shared decision making; meaningful recognition and staff wellbeing; quality improvement and patients safety; and research and innovation. Information from the participating organisations will provide an opportunity to share good practice and highlight system improvement opportunities.

Quality and Patient Experience Thematic Update- Medicines Optimisation (MO).



Improving Quality Prescribing – The MO Team have supported prescribers to improve the Lincolnshire ICB position in 2024/25 on: overall antibiotic volume prescribed, reducing course length for amoxicillin, doxycycline and urinary tract infection treatment. We have also improved on reduction in the use of Methotrexate 10mg tablets (cytotoxic medicine with important safety parameters). Lincolnshire has improved two positions on the NHSE target of total antimicrobial prescribing relative to other ICBs.



Supporting Our Prescribers – In 2024/25 the MO Team received and responded to 491 prescribing and medicines management queries (as of early March). The Team visited 68 (84%) of our practices in 24/25 (100% of practices in East Lincolnshire) and provided a Medicines Optimisation Enhanced Scheme (MOES) including Engagement, Quality, Safety and Cost-Efficiency elements. MO continue to ensure regular Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) meetings and are also moving forward with development of an Area Prescribing Committee (APC) for Lincolnshire.



Medicines Education – There is a quarterly Prescribing Forum event online with a local keynote speaker to talk about an aspect of prescribing and medicines optimisation.

The MO Team are heavily involved in the Opioid Clinical Reference Group and have facilitated and run 13 practice teaching sessions to 115 staff in 17 practices on opioid tapering. For patients, the group has run 15 monthly Pain Cafes for a total of 209 participants (Since Dec 23) including 2 face to face sessions and had 50 bookings for our Live Well with Pain training; all under the clinical leadership of Dr Graham Dunthorne. In 2024/2025 Lincolnshire system has reduced high dose opioid prescribing by 6.4%.



Supporting Patient Experience – MO are project managing the Stoma Review service, which has been running for a couple of years now and offers stoma reviews by a specialist stoma nurse to practices, ensuring patients are receiving the right stoma products for their specific needs ((colostomies, ileostomies, or urostomies), promote patient satisfaction, and improve the quality of life for those living with stomas.

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. In addition, pharmacies in Lincolnshire have provided 2,235 oral contraception consultations improving women's access to contraception and reducing unwanted pregnancies.



For 25/26, as well as continuing much of this work, the MO Team aim to have sufficient skilled pharmacy professionals to fully input into system pathways and build medicines governance into all contracts to ensure safe and effective use of medicines in the Lincolnshire system. The Team will continue building on engagement with GP practices and further development of MOES, sharing MO priorities. A key area is the quality and safety of medicines agenda and co-ordination of system medicines optimisation in Lincolnshire.

Finance: Summary Financial Position (1)

Year To Date Financial Position

The ICB has reported a £8.0m deficit at Month 11 against a planned surplus of £3.0m. This represents a £11.0m adverse variance against plan and a £6.3m deterioration in month (Month 10 £1.7m reported deficit against a planned surplus at Month 10 of £1.3m).

The ICS' YTD plan was to deliver a £4.8m deficit at month 11 and the ICS reported a deficit of £25.3m equating to a £20.5m adverse variance to the plan (£35.7m adverse variance to plan at month 10 representing a £15.2m improvement in month).

Outturn Financial Position

The ICB planned to deliver a surplus for the year of £4.8m and expects to deliver a £9.5m deficit. This represents a £14.2m adverse variance from plan. This position has improved by £4.0m due to the receipt of additional £4.0m funding to support financial pressure that has crystallised in the ICB position.

The ICS planned to deliver a break-even position against in year allocations and income for the full financial year. At the 28th of February 2025 the ICS is reporting a £23.9m adverse variance against this plan.

Finance: Summary Financial Position (2)

Cost Improvement Plan

At Month 11 the ICS has reported £68.3m cost improvements against a plan of £72.8m equating to a £4.4m adverse variance to plan.

The ICS has a full year cost improvement plan of £84.8m and expects to deliver cost improvements of £81.5m by the financial year-end which is a £3.2m adverse variance to plan.

Capital

The ICS has a full year Capital Departmental Expenditure (CDEL) Limit 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 of February 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.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	5 (ii)
Meeting Date:	Tuesday, 25 th March 2025
Title of Report:	ICB Board Assurance Framework
Report Author:	Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Mr John Turner, Chief Executive Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	Board Assurance Framework

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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:

- Consider the ICB Board Assurance Framework.

Summary

Background

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 Board Assurance Framework is aligned to the ICB's strategic aims and objectives and provides the Board with confidence that the ICB has identified its strategic risks and has robust systems, policies and processes in place that are effective and driving the delivery of its strategic objectives. Risk appetite has been determined for each risk in line with the Risk Management Strategy. All strategic risks are owned by an Executive Director of the ICB and are aligned to a specific Board Committee, all of whom have played a critical role in the review and management of risks.

The BAF content is regularly reviewed by the Executive Team and each responsible Board Committee and has been updated on a regular basis throughout 2024/25.

TIAA, the ICB's internal auditors carried out an audit review of the adequacy and effectiveness of the ICB's risk management arrangements including how it interfaces with ICS wide risk management structures in 2024/25. This review also considered the extent to which risk management arrangements are linked to the ICS whilst ensuring accountability at the ICB. It was acknowledged that progress has been made since the last review of the BAF and risk management arrangements in 2023/24.

The outcome identified adequate and effective risk management arrangements provide the ICB Board with reasonable assurance that systems underpinning risk management are effective and can be relied upon to provide assurance that the main risks to the achievement of the ICB's key strategic objectives are managed appropriately.

The latest version of the BAF is presented for the Board's consideration.

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.

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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

Report previously presented at:

Updates and progress reports on the development of the BAF and Risk Appetite have regularly been presented to the Audit and Risk Committee and Executive Team meetings. The BAF was presented to the Board in September 2024.

Is the report confidential or not?

Yes No



NHS LINCOLNSHIRE ICB BOARD ASSURANCE FRAMEWORK

FEBRUARY 2025

The Board Assurance Framework (BAF) sets out the principal risks to the achievements of the Integrated Care Boards (ICBs) strategic objectives. The BAF is also a primary source of evidence in describing how the ICB is discharging its responsibility for internal control.

The BAF further sets out the controls in place to manage the risks and the assurances available to support judgements as to whether the controls are having the desired impact. The BAF additionally describes the actions to further reduce each risk.

Version	Date	Author	Comments
1.0	Sep-24	Karen Bates and Jules Ellis-Fenwick	New BAF designed
2.0	Jan-25	Karen Bates	Version control added and alignment of BAF strategic risks to ICB Core aims tab included
3.0	Feb-25	Karen Bates	Added a review date box and minor formatting change

RISK APPETITE MATRIX

RISK APPETITE LEVEL	0 NONE	1 MINIMAL	2 CAUTIOUS	3 OPEN	4 SEEK	5 SIGNIFICANT
RISK TYPES	Avoidance of risk is a key organisational objective.	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL <i>How will we use our resources?</i>	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY <i>How will we be perceived by our regulator?</i>	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY <i>How will we deliver safe services?</i>	We have no appetite for decisions that may have an uncertain impact on quality.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL <i>How will we be perceived by the public and our partners?</i>	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no change of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE <i>How will we be perceived by the public and our partners?</i>	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

NHS Lincolnshire ICB Risk Appetite in Five Domains

DOMAIN	STRATEGIC LEAD	RISK APPETITE	THRESHOLD SCORE
Financial	Director of Finance	Cautious	12
Regulatory	Board Secretary	Cautious	12
Quality	Chief Nurse	Cautious	12
Reputational	Director of Strategic Planning, Integration and Partnerships	Cautious	12
People	Director of People & Organisational Development	Cautious	12

RISK APPETITE	DESCRIPTION
Minimal	Avoidance of any risk or uncertainty. Every decision will be with the aim of terminating the risk
Cautious	Preference for safe delivery options but is able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk
Open	Open to consider all options and take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward. Likely to choose an option that has a greater reward and accepts some loss
Seek	Eager to be innovative and take on risk to achieve strategic objectives. Will choose the option with greater reward and will accept any loss at the price for the reward
Significant	Confident is setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

NHS Lincolnshire ICB Strategic Objectives


Delivery of key 24/25 operational and financial objectives (as per 2024/25 Plan as agreed with NHSE)	Create a 'high performing' ICB and ICB Board	Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners
<ul style="list-style-type: none"> → UEC 78% and Cat2 30 mins → Planned Care 65 weeks → Cancer 62 days → Learning Disabilities and SMI Health Checks → System Financial Plan 24/25 	<ul style="list-style-type: none"> → Complete and implement the outputs of the Audit Yorkshire Board Development work → Undertake a shadow 'ICB CQC' assessment exercise and implement findings → Finalise the design of the new ICB Target Operating Model, and agree and mobilise implementation plan with partners → Support implementation of new ICP Partnership Board arrangements → Implement EDI Annual Plan and develop Strategic EDI Plan 	<ul style="list-style-type: none"> → Further develop and deepen integrated health and care system partnership working ('lock step' partnerships) → Implement a 'step change' in Prevention activities in line with shared commitment and resource plan with Lincolnshire County Council → Lead with partners implementation of 24/25 actions as per the Health Inequalities Strategy → Support the development of CPPs, including the development of 'pilot' CPPs → Develop a 'GP Strategy' for Lincolnshire and participate in NHSE supported ICB 'testing' of new GP delivery hypothesis → Complete and implement recommendations of System Digital Review → Implement the agreed recommendations of System Workforce Review → Establish joint Health & Care and Lincolnshire Colleges & Universities Partnership, Strategic Ambition and 24/25 Action Plan

NHS Lincolnshire ICB Alignment of Strategic Risks to ICB Core Aims

Strategic Risks	Aim 1 : To improve outcome in population health & healthcare	Aim 2 : To tackle inequalities in outcomes, experience and access	Aim 3 : To enhance productivity and value for money	Aim 4 : To help the NHS support broader social and economic development
The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.	✓			
There is a risk that we fail to create a culture which supports transformation of services and address health inequalities which leads to no improvement or a deterioration in outcomes for our population		✓		
Maintain and improve the quality of commissioned care and improve patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services.			✓	
The ICB is unable to create and implement a workforce strategy so services continue to operate unsustainably with significant fragility in day to day operation.			✓	
ICB is unable to devise and implement a sustainable service improvement and financial recovery plan to remove unwarranted variation and consequently continues to operate without full autonomy.			✓	

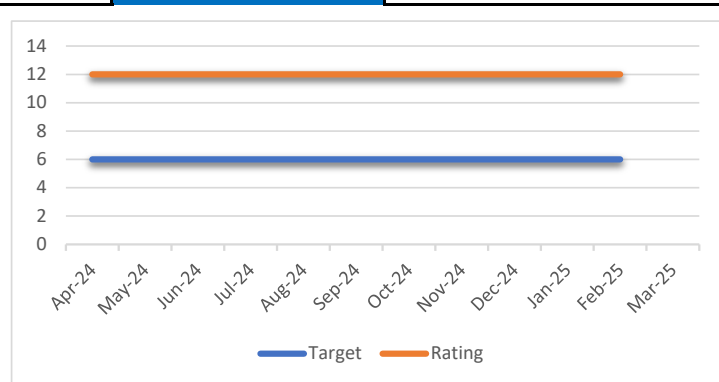
BAF Ref - 0001	STRATEGIC OBJECTIVE : Delivery of key 24/25 operational and financial objectives.	PRINCIPAL RISK : Maintain and improve the quality of commissioned care and improve patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services.	RISK DOMAIN : Quality	CURRENT SCORE 9 ↔
Executive Risk Owner	Chief Nurse	Assurance Committee	System QPEC	Date added to BAF 01 April 2023
Risk Applies to ICB	Risk applies to ICS			
	✓			
		CQC DOMAIN	RISK APPETITE 2: Cautious	
		LAST REVIEW DATE	3rd February 2025	
LAST REVIEW NARRATIVE:				
RISK RATING	Impact	Likelihood	Total	
Initial	4	4	16	
Current	3	3	9	
Appetite	3	2	6	

Positive Assurance & Key Controls in Place		Gaps in Control and/or Assurance	
<p>Integrated Performance and Quality Report to every Board</p> <p>Quality governance arrangements in place which meet the expectations set out in the National Quality Board (NQB) Shared Commitment to Quality; and National Guidance on Quality Risk Response and Escalation in Integrated Care Systems i.e. SQPEC and SQG plus PCCC for Primary Care</p> <p>NHS Trust providers are represented at SQPEC and SQG and report by exception where quality concerns/risks</p> <p>System Quality Priorities Register in place and reviewed at every SQPEC and SQG meeting. Risk log in place for Operational Quality Assurance Group (OQAG) and process for escalating individual risks to quality to SQPEC where appropriate</p> <p>Delegated responsibility for detailed oversight of commissioned providers through OQAG; and Primary Care Quality Assurance Group (PCQAG) with regular upward reporting to SQPEC and for PCQAG to PCCC</p> <p>LICB Framework for Primary Care General Practice Quality Support and LICB Framework for Quality Assurance and Improvement of Providers of NHS Services in place - oversight through PCQAG and OQAG</p> <p>ICB Quality Lead Officers aligned to contracted service providers and quality representation at Contract Oversight Group</p> <p>ICB quality leads assigned to key transformation programmes to ensure consideration of the quality implications of current and future state.</p>		<p>Limitations of nationally available data and information to support effective quality monitoring across all commissioned pathways of care. Where national data is available it focuses on NHS trusts only</p> <p>Visibility of data relevant to quality metrics for all transformation programmes across the system.</p> <p>Sufficient capacity within ICB quality team to pick up extended remit for Primary Care (including Pharmacy, Optometry & Dental).</p> <p>Non contracted activity; or where LICB is not the lead commissioner are not always visible to the ICB quality team</p>	
Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
ICB Quality Strategy being refreshed to outline current key priorities as agreed through SQPEC	01 April 2024	WM	Additional capacity has been sourced through CSU to support development of Quality Strategy
Further develop quality dashboard information locally as access to national data becomes available e.g. inclusion of data for neighbouring trusts; independent providers	Ongoing	VW/KS	NHSE Quality Indicators are used to provide dashboard for OQAG which includes national patient experience surveys where available. Primary Care Quality Team have established QEW (Quality Early Warning) system for GP practices which is currently being rolled out to all practices, baseline expected to be completed by end of Q4 2024/25. Further work will be undertaken to explore what QEW for PODs could look like within capacity available in Primary Care Quality Team.
Recruitment to existing vacant posts within ICB Quality Team to ensure sufficient capacity	01 July 2024	MF	Recruitment paused due to need to realign budget
Embed Contract Oversight Group (COG) processes to ensure appropriate oversight of all potential quality contract risks	01 November 2024	VW	Complete - Nursing & Quality Team represented at every COG meeting, process in place to ensure OQAG quality risks of 12 and above are included in COG summary information; processes in place to escalate and reflect quality concerns on COG risk log; feedback from COG is a standard agenda item at OQAG
Process for 'tiering' providers being worked through at COG which will align levels of oversight required depending on size and complexity of contract.	Q1 2025/26		This is being led by contracting but quality is part of COG and will contribute to the development and then consider how this can support further improvements in quality oversight of all contracts

BAF Ref - 0003	STRATEGIC OBJECTIVE : Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners.	PRINCIPAL RISK : The ICB is unable to create and implement a workforce strategy so services continue to operate unsustainably with significant fragility in day to day operation..	RISK DOMAIN : Quality	CURRENT SCORE 12 
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Executive Risk Owner	Director of Workforce Transformation	Assurance Committee	Workforce Group	Date added to BAF	01 April 2023
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Risk Applies to ICB	Risk applies to ICS
	✓



CQC DOMAIN	RISK APPETITE
	2: Cautious

RISK RATING	Impact	Likelihood	Total
Initial	3	4	12
Current	3	4	12
Appetite	2	3	6

LAST REVIEW DATE	3rd February 2025
LAST REVIEW NARRATIVE:	

Positive Assurance & Key Controls in Place	Gaps in Control and/or Assurance
<p>Focussed work on fragile services (with organisational input including Acute, Community, Mental Health, Primary and Social Care) and alignment with the future service delivery model is progressing.</p> <p>People Promise and retention agenda is reducing the turnover of staff in the region. Work ongoing to embed People Promise into business as usual when funding ceases in March 2025.</p> <p>Workforce Committee established, meeting monthly, chaired by System CEO, and attended by key stakeholders including NHSE representation discussing workforce data, insight, key lines of enquiry, providing rigour over workforce establishment and controls.</p> <p>Providers contributing to system workforce planning. Regular monitoring through workforce dashboard/operational planning.</p> <p>Established Director of Workforce Transformation filled, post holder took up duty in January 2025.</p> <p>Work accelerating and good engagement to programme plan on pilot area of frailty for system workforce planner (supported by KPMG).</p> <p>Lincolnshire Health, Care and Education partnership established with 5 project teams established and operational.</p>	<p>Absence of a holistic overview and workforce strategy.</p> <p>People Board temporarily suspended due to wider system pressures means wider system health and care focus is progressing in pockets.</p> <p>Ongoing operational and financial pressures presents a risk to further deterioration in staff health, wellbeing and morale that may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB. This may, in turn, result in further increases to levels of sickness and vacancies within the organisation.</p> <p>System workforce planning challenges (operational, transformational shift in delivery, and financial) may not address medium to longer term strategic workforce, education and planning needs. This may lead to issues with skills, workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting meaningful system data into a single place to support ICS workforce planning and projections.</p>

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
Develop a system workforce strategy	01 November 2025	Anne Lloyd	Initial scoping taking place aligned with NHSE planning guidance to develop framework
Review workforce data, reporting tools and governance	01 April 2025	Anne Lloyd	Review of reporting tools and data progressed in January 2025, key decision required on contract by March 2025. Workforce Committee discussed and endorsed review
Deliver Lincolnshire System Workforce Planner (supported by KPMG) and links to Workforce Productivity agenda	01 April 2025	Mark Ratley	Programme plan in place and on track
Deliver full benefits of Health and Education Strategic Partnership to sustain long term strategic approach to system wide employability across the partnership (incorporating Working Well, Connect to Work and Get Britain Working).	01 December 2025	Anne Lloyd	Board is established and meetings are set. 5 project teams ToRs signed off and work progressing across the system

BAF Ref - 0004	STRATEGIC OBJECTIVES : Delivery of key 24/25 operational and financial objectives.	PRINCIPAL RISK : The ICB is unable to devise and implement a sustainable service improvement and financial recovery plan to remove unwarranted variation and consequently continues to operate without full autonomy.	RISK DOMAIN : Financial	CURRENT SCORE 20 ↑																																							
Executive Risk Owner	Director of Finance	Assurance Committee	Finance & Resource Committee	Date added to BAF 01 April 2023																																							
Risk Applies to ICB	Risk applies to ICS	<table border="1"> <caption>Rating vs Target Data</caption> <thead> <tr> <th>Month</th> <th>Target</th> <th>Rating</th> </tr> </thead> <tbody> <tr><td>Apr-24</td><td>8</td><td>12</td></tr> <tr><td>May-24</td><td>8</td><td>10</td></tr> <tr><td>Jun-24</td><td>8</td><td>10</td></tr> <tr><td>Jul-24</td><td>8</td><td>10</td></tr> <tr><td>Aug-24</td><td>8</td><td>10</td></tr> <tr><td>Sep-24</td><td>8</td><td>10</td></tr> <tr><td>Oct-24</td><td>8</td><td>16</td></tr> <tr><td>Nov-24</td><td>8</td><td>16</td></tr> <tr><td>Dec-24</td><td>8</td><td>16</td></tr> <tr><td>Jan-25</td><td>8</td><td>16</td></tr> <tr><td>Feb-25</td><td>8</td><td>16</td></tr> <tr><td>Mar-25</td><td>8</td><td>20</td></tr> </tbody> </table>		Month	Target	Rating	Apr-24	8	12	May-24	8	10	Jun-24	8	10	Jul-24	8	10	Aug-24	8	10	Sep-24	8	10	Oct-24	8	16	Nov-24	8	16	Dec-24	8	16	Jan-25	8	16	Feb-25	8	16	Mar-25	8	20	CQC DOMAIN
Month	Target			Rating																																							
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Jan-25	8	16																																									
Feb-25	8	16																																									
Mar-25	8	20																																									
✓	✓	RISK APPETITE 3: Open																																									
RISK RATING	Impact	Likelihood	Total	LAST REVIEW DATE 6th February 2025																																							
Initial	4	3	12	LAST REVIEW NARRATIVE: Lincolnshire ICB Finance & Resource Committee (F&RC) reviewed December outturn position which indicated an ICB deficit of £13m driven by excess Continuing Healthcare costs, prescribing and out of area placements. The FRC escalated to January Board meeting this position and the Board approved a series of actions which will restrict cost growth in CHC and prescribing by reducing supply of service for medicines available over the counter and applying care package costs in certain situations.																																							
Current	4	5	20																																								
Appetite	4	2	8																																								

Positive Assurance & Key Controls in Place	Gaps in Control and/or Assurance		
<p>In the latest annual review letter the ICB is commended for the strength of the financial governance process and the contribution this has made to system financial improvement</p> <p>The Financial Recovery Programme (FRP) led by ICB DoF is in year 2 of operation and has coordinated partners to build a CIP plan that targets financial improvement of £84m. The programme is overseen by FRP Board which meets twice monthly and reports into the ICB Finance and Resource Committee (FaRC), with monthly reporting into the Lincolnshire Leaders Group. The ICB has developed a robust and detailed FRP tracker which reports against plan, in-year delivery, recurrent FYE and risk on each individual programme.</p> <p>The FRP Board provides robust challenge on YTD delivery and forecast with a clear explanation of risks.</p> <p>The ICB DDoF coordinates the production of a monthly system finance report which is received by FaRC with issues escalated to ICB Board, the same report is shared at partner Finance Committee or Boards.</p> <p>The ICS has a single Internal Audit function and has agreed a system-wide Internal Audit programme.</p>	<p>The ICB has flagged to NHSE that it will fail to meet it's financial objectives to achieve balanced financial position with three significant drivers, CHC, prescribing and Mental Health out of area costs. Taking the three areas in turn:</p> <ul style="list-style-type: none"> - CHC - number and hours of care per package have increased year on year. - Prescribing - the delivery of CIP is behind where it needs to be and national drugs shortages in specific areas are driving up prices - Out of Area Costs - the trend of the last two years of reducing reliance on out of area placements has reversed this year due to a combination of high inpatient occupancy for Lincolnshire facilities and sustained demand on community resources. <p>The system financial position worsened considerably in Q3 and the ICB Executives identified issues in transparency across the system in respect of agreement of investment in service growth and management of risk, and the construct of the plan and the pace of creating CIP.</p>		
Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
Closing the financial planning gap work concluded, and agreement reached on how the 2024/25 financial plan is de-risked to go to FaRC for approval.	31/08/2024	Director of Finance	£10m closed through the 'bridging the gap' work, with a route to recover the remaining £6m through enhanced workforce controls and service reviews.
Approval and resourcing of a review of BCF effectiveness 1st phase: Learning Disability/ Intermediate care	31/07/2024	Director of Finance	Intermediate care and LD reviews were completed and was presented to a meeting of the CEOs of the LICB and LCC
Proposal for medium term planning process for approval by ICB executive	31/08/2024	DoF/DoSPIP	Medium term planning process socialised and approved across the system.
Preparation of a forecast view of establishment WTE, Band and agency projections based on current trajectories and known additions to WTE.	31/10/2024	Workforce Committee Chair	Workforce bridge has been produced
Preparation of a risk adjusted outturn position based on extrapolated workforce position	31/10/2024	Director of Finance	Risk adjusted outturn position presented to December FR&C and Board
Proposed mitigations plan for risk adjusted extrapolated workforce position	15/11/2024	Director of Finance/ System Executive group '4 Corners'	ICB mitigations prepared to improve present delivery
Agreement to actions on low value interventions	28/01/2025	ICB MO/DOF	Board agreed actions set out
Lessons learnt process prepared for LICB to support improvement actions and 2025/26 planning round	30/01/2025	Director of Finance	Lessons learnt agreed by ICB Execs

BAF Ref - 0005	STRATEGIC OBJECTIVES : Tackling inequalities in outcomes, experience and access and delivering our operational plan	PRINCIPAL RISK : There is a risk that we fail to create a culture which supports transformation of services and address health inequalities which leads to no improvement or a deterioration in outcomes for our population	RISK DOMAIN : Financial	CURRENT SCORE 12 ↔
Executive Risk Owner	Director of Health Inequalities, Prevention & Regional Collaboration	Assurance Committee	Service Delivery & Performance Committee	Date added to BAF 01 December 2024
Risk Applies to ICB	Risk applies to ICS			CQC DOMAIN
✓	✓			RISK APPETITE 3: Open
RISK RATING	Impact	Likelihood	Total	LAST REVIEW DATE 1st December 2024
Initial	4	3	12	LAST REVIEW NARRATIVE:
Current	4	3	12	
Appetite	4	2	8	

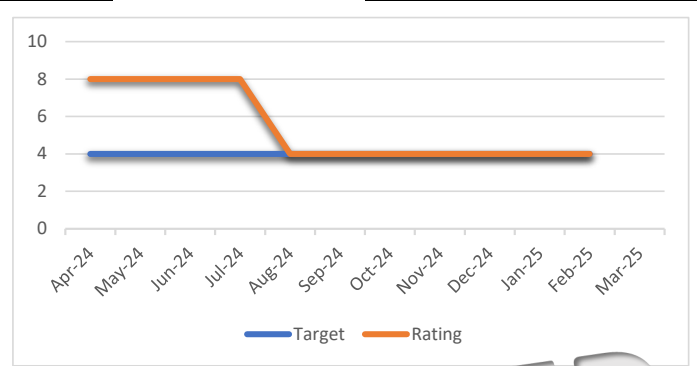
Positive Assurance & Key Controls in Place	Gaps in Control and/or Assurance
<p>Plans: JFP, ICP Strategy and HWB Strategy in place (Health Inequalities embedded) . The ICB receives natioanl health inequalities funding. This funding has been ring fenced to ensure the financial investment occurs in each financial year to support addressing the health inequalities and continued focus on Core20PLUS5 for adults and children & young people. Digital Inclusion Strategy developed for Lincolnshire</p> <p>Processes: embedding Health Inequalities approach to Strategic Planning - through core20PLUS5 and population segmentation model; consultation and engagement activities targeted activity to reach out to identified ICB Core20PLUS5 and inclusion groups; system approach to business case and investment prioritisation includes target focus to address Core20PLUS5 and utilising HEAT . Transformation / service specific HI projects focus to address Core20PLUS5.</p> <p>Governance & Reporting: Health Inequalities Programme governance reporting to Service Delivery & Performance Committee. Routine updates to the ICB Board - standing agenda item to receive progress on addressing health inequalities. Core20Plus 5 health inequalities stock take to NHSE and reporting through QSRM. NED for HI identified and arrangements in place to meet its duty to report - Annual Accounts Report, Information standards and people and communities involvement report</p> <p>Resources: Dedicated team that manages HI system objectives and delivery actions in the operational programme plan. Training and support - e.g. HEAT, Inclusion workshops and bi-monthly HI bulletin. Networks established across the system - PCN HI Network; HI leads and champions recruited across the system</p> <p>Intelligence and insight: Lincolnshire Joined Intelligence Data set (comprehensive person-level, linked dataset) is in place - which allows whole person, whole cohort, whole population, whole system understanding, supporting opportunity identification, evaluation, options appraisal, personalisation, health equity & equality, major system change. Cornerstone of Population Health Management and includes Health Inequalities reporting suite</p>	<p>Governance: Gap identified in oversight & governance arrangements in relation to ICP and JFP priority (Living well, staying well) - Prevention and Health Inequalities and the alignment with other key enabler programmes e.g. Personaliation, Digital, Intelligence</p> <p>Resources: Gap identified in HI and Prevention enabler support to the Clinical and Care Directorate and support to Strategic Planning and Programmes.</p> <p>Absence of approach to allocation of resources to address health inequalities from the full ICB allocation. Currently targeted resouce based on previous SDF value - has been maintained as ring fenced budget to support addressing Health Inequalities. Prevention funding identified but currently paused and unclear if this will be available for 2025/26</p> <p>Intelligence & Insight: Gap in routine performance reporting at relevant Programme Boards to include HI specific metrics to support assurance on legal duties to Service Delivery & Performance Committee & ICB Board. Information to inform future commissioning arrangements/ contract where targeted improvement projects/ interventions or focus is required to specific population groups. Further development of the HI reporting suite in Lincolnshire Joined Intelligence Dataset. Legal duties information produced on 6 monthly and annual process for assessment of all mandatory indicators to support SD& P Committee and will be presented to ICB Board as part of annual reporting on HI.</p>

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month
Establishment of the Lincolnshire Strategic Oversight Group (LSOG)	Q2 2024/25	LCC - Alison Christie/ ICB - Pete Burnett	First meeting held on 23rd September; 2nd meeting on progress presented at the December 2024. Joint update by Sandra Williamson (ICB) and Andy Fox (LCC) - on <u>prevention and health inequalities</u>
Establishment of the Prevention & Health Inequalities Executive Group (sub group reporting to the Lincolnshire Strategic Oversight Group)	Q1 2024/25	Sandra Williamson (ICB) and Andy Fox (LCC)	Executive group established and initial meeting to review prevention priorities. Current reviewing / reset purpose to align with national planning priorities and immediate local priorities.
Establishment of Virtual Health Inequalities Hub (joint LCC and ICB)	Q4 2024/25	Sandra Williamson (ICB) and Andy Fox (LCC)	Model agreed between LCC and ICB - to support the 5 fundamentals of Health Inequalities, Review with Clinical and Care Directorate and other enabler functions ready for implementation from April 2025 - proposal to test the process with one of key service pathway changes (MSK). Implementation of the 3 tier approach during Q4 and support to the strategic planning process and the Clinical and Care <u>directorate in the prioritisation framework</u>
Development of Weighted Value Framework to support reallocation of resources	Q1 2025/26	John Doherty and Emma Rhodes (ICB)	Work as comended on approach to Health Inequalities resource allocation and development of weighted value framework which would enable assessment of exisiting services in terms. In year slippage on HI budget - plans on hold until end of March due to pause and will be reviewed for implementation from April 2025.
Development of routine performance reporting to include core HI metrics and compliance with legal duties	Q4 2024/25	ICB Intelligence lead with HI Intelligence lead	Work in progress based on Q3 performance to be shared with the relevant programme committees during Q4. Expecting the national development of the ICB standard reporting suite to support legal duties during Q4. Information to be used to form the reports for the ICB Board in Q1 2025/26.

BAF Ref - 0002	STRATEGIC OBJECTIVE : Maximise the opportunities to enhance our health and care system to the benefit of our population, patients, workforce and partners.	PRINCIPAL RISK : The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.	RISK DOMAIN : Quality	CURRENT SCORE 4 ↔
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Executive Risk Owner	Director of Strategic Planning, Integration and Partnerships	Assurance Committee	System QPEC	Date added to BAF	01 April 2023
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Risk Applies to ICB	Risk applies to ICS
✓	



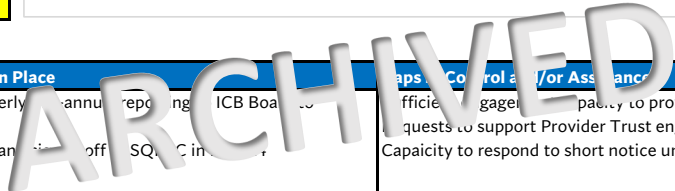
CQC DOMAIN	RISK APPETITE
	2: Cautious

RISK RATING	Impact	Likelihood	Total
Initial	4	2	8
Current	4	1	4
Appetite	4	1	4

LAST REVIEW DATE	6th February 2025
LAST REVIEW NARRATIVE:	
The risk remains stable as a 4 as the key controls remain in place. There has been a reduction in staff due to maternity leave however the team have cover in place.	
Following discussion at Execs on 6 February 2025, it has been agreed to archive the risk.	

Positive Assurance & Key Controls in Place

Quarterly reporting of engagement activities and feedback to QPEC and quarterly annual reporting to ICB Board to offer assurance and evidence of adhering to statutory duties to involve. People and Communities Strategy updated and 24/25 delivery plan developed and signed off at SQPEC in May 24. Involvement Annual Report 23/24 signed off at SQPEC in May 24. Engagement team aligned to key programmes of work to ensure involvement included in any changes to services. Recruited to the Health Inequalities engagement lead role which is now a permanent position. Engagement lead sits on some Programme Boards to steer involvement opportunities. Engagement lead a member of the Operational Quality Assurance Group and attendance at SQPEC. Presentation of Lincolnshire Voice report at SQPEC from March 25 to collate all intelligence, feedback, complaints etc. Involvement reporting to LICB Board being scoped. Public facing Involvement webpages being developed and improved to evidence outcomes of engagement. Ongoing development of relationships with key stakeholders, partner organisations and community groups to facilitate engagement. Building of stakeholder database - currently 11,000 patient, public, stakeholders and groups we engage directly with. Embedded regular engagement channels - fortnightly engagement bulletin sent to 11,000 database and shared with Provider Trusts and partners to share; regular use of social media and Nextdoor app. Lincolnshire Engagement Leads Steering Group established with LCVS, Local Authorities, University of Lincoln, Research, Personalisation and key partners to develop a system wide approach to engagement (led by LICB Engagement Lead). Exploring system wide approach to sharing involvement insight alongside Health Inequalities and PHM data to ensure robust baseline for future engagement. Service Change protocol agreed by all organisations which should identify the requirement for involving and engaging.



Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on mitigations due this month

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	07 (i)
Meeting Date:	Tuesday, 25th March 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:	N/A

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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 5th March 2025 and focused on the following agenda items:

- Lincolnshire System Priorities Quality Register:** the Register was presented, it was noted that this had been updated and that further updates have been included in relation to Urgent and Emergency Care Pathways, Care Homes and Verification of Death risks. Work is taking place to reformat the Register and this will be shared at the Committee in the new financial year.
- ICB Board Assurance Framework and Corporate Risk Register:** the Board Assurance Framework and Corporate Risk Register were shared with members. It was noted that the risk in relation to quality detailed on the Framework relates to maintaining and improving the quality of commissioned care and improving patient outcomes, ensuring these are not adversely affected due to insufficient or delayed access to services. The current risk score is 9.

In terms of the Corporate Risk Register it was reported that there are currently three risks aligned to SQPEC. Two relate to Children's safeguarding strategy discussions and statutory responsibilities under Working Together (2023) to ensure that there is appropriate representation by health practitioners who are trained and experienced in the assessment of complex situations at the Front Door. The third is in relation to Health and Well-Being of Looked After Children (2015) which identifies the statutory requirements for undertaking health assessments, which are currently not being completed within the statutory timescales.

It was agreed that following discussions at SQPEC regarding the Medical Examiner service this will also be included on the Register.

- **Children and Young People (CYP) Scoped Risks:** following on from the previous meeting the Children and Young People risks were shared. It was noted that these pertain to three areas:
 - Clinical Interventions
 - Access and Waits
 - Delivery of Core 20+5

It was reported that an Analytics Business Partner has recently been established within the Team and that this may highlight further areas for inclusion. Discussions took place regarding engaging with CYP and it was noted that a model is currently being developed to strengthen how we hear their voice and that work is taking place with partner organisations to develop this.

- **HSSIB – Investigation Report – Safety Management: Accountability Across Organisational Boundaries:** the HSSIB report was presented which is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to the management of patient safety risks across organisational boundaries. It was noted that this investigation has explored the understanding of the pathways of care for patients whose care involves engaging with providers in primary, secondary and community care and with integrated care systems. Work will be undertaken to map Lincolnshire’s position and highlight any areas for improvement.
- **Deep Dive – LeDeR - (Learning from lives and deaths - People with a Learning Disability and Autistic People):** a detailed update was provided on the Mental Health, Learning Disability, Dementia and Autism Alliance governance arrangements and the risks associated with the Transforming Care programme.

An update was provided on the Skirbeck Lodge and how this facility is having a positive impact on the lives of citizens receiving care in this accommodation.

An update was provided on the Learning from lives and deaths - people with a learning disability and autistic people (LeDeR) which is an NHS England led improvement programme which aims to improve outcomes and services for people with a learning disability and autistic people. LeDeR shows that people with a learning disability and autistic people die earlier on average than other people, and do not always receive the same quality of care.

An update was shared on the progress made within Lincolnshire and that 62 adult LeDeR notifications were received Jan 2024 - Nov 2024 showing an overall decrease of seven notifications compared to 2023. The three main causes of death for people diagnosed with a Learning Disability [LD] and/or Autism were Aspiration Pneumonia, Cancer and Cardiovascular Disease. 61% of deaths occurred in a hospital setting, an increase of 10% from 2023. 13% of deaths occurred in a care home setting, a decrease of 25% from 2023.

Discussions took place regarding the programme and the significant amount of work undertaken and the progress that had been made.

- **Lincolnshire Voice** – the first Lincolnshire Voice report was shared with members and it was noted that the report brings together all the feedback, patient experiences and stories received and has been summarised into key themes and details a holistic view. It was noted that for the period October 2024 to December 2024 2,700 people had been reached and that from the feedback received work is taking place to address the “so what” and the outputs from the engagement work to make the necessary changes. It was highlighted that for the June 2025 meeting a detailed update is due to be provided on Complaints and that this will be presented based on the top three themes from across the Lincolnshire NHS organisations.

- **HealthWatch Update:** a presentation was shared on the research activities undertaken in 2024. It was reported that the activities had focused on four main areas:-
 - Menstrual health and the menopause.
 - Mental health.
 - Respiratory.
 - Neurological.

Discussions took place regarding the content of the presentation and that going forward this detail will be aligned to the Lincolnshire Voice workstream and utilised as a fundamental listening foundation for shared learning.
- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** an update was provided on the Medical Examiner role and since the launch of the legislation, which requires the review of all community and acute deaths, the service has been experiencing several difficulties in relation to Primary Care delays and quality of referrals. The current position to date shows that 158 community deaths and 42 acute deaths awaiting processing. It was noted 62 of the 158 deaths have been referred back to the GP.
- **Lincolnshire Partnership NHS Foundation Trust Highlight Report:** it was noted that there are currently ongoing quality concerns regarding The Vales and that the Trust have established a strategic quality oversight group with ICB colleagues as core members in order to understand and develop actions to make the necessary improvements. .
- **East Midlands Ambulance Service NHS Trust Highlight Report:** it was reported that the position continues to improve in stages however the Division is still unable to consistently achieve regional CAT2 30minute target (2024/25). In terms of the previous discussions regarding Verification of Death and the change to NHS Pathways this has resulted in EMAS no longer attending to verify expected death.
- **System Partners – Local Authority Update:** it was noted that the Director of Public Health Annual Report had recently been published and that an update would be provided at a future meeting.
- **Primary Care Highlight Report:** an update was provided on the Sidings Practice and that the Practice had been subject to a recent CQC re-inspection. The outcome of the report is awaited..
- **Operational Quality Assurance Group (OQAG) Update:** it was noted that the update had included information relating to three commissioned providers where there are escalated concerns that impact on quality and actions being taken in response to these concerns. In addition, information received from subject matter expert (SME) reports relate to Infection Prevention and Control and Patient Safety Learning Response.
- **System Quality Group Update:** it was reported that LPfT had raised an issue in relation to the interpretation services and that work is taking place to address this area.
- **System Clinical Policies Group Terms of Reference:** the Terms of Reference (TOR) and System policy template was shared with members. Members agreed to approve these.
- **Enhanced Services Programme:** an update was provided on the Enhanced Services Programme and a risk in relation to the future provision of Phlebotomy and Treatment Room services in primary care. Work is taking place on developing a new commissioning model and a number of options are being explored.

Items for escalation to the ICB Board:			
<ul style="list-style-type: none"> • Medical Examiner capacity issues and impact this is having in terms of the current backlog. • There are a number of risks highlighted in relation to the Children and Young People's services and safeguarding responsibilities. • Enhanced Services programme and the associated risks with the future provision of services. • HSSIB – Investigation Report – Safety Management: Accountability Across Organisational Boundaries and the work required to achieve full assurance of Lincolnshire's position. • Acknowledgement of the work and progress made with the Transforming Care agenda and the development of the Children's autism pathway redesign, Mental Health Learning Disability and Autism and LeDeR - (Learning from lives and deaths - People with a Learning Disability and Autistic People). • Acknowledge the continuous feedback model work and the engagement activities that have taken place with recognition this is still developing. • Consideration of Patient Stories at future Board meetings. 			
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.			
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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Report previously presented at:			
The Board receives regular reports from each of its Committees at every meeting.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			



**PUBLIC MEETING OF THE NHS LINCOLNSHIRE
INTEGRATED CARE BOARD**

Agenda Number:	7 (i)
Meeting Date:	Tuesday, 25 th March 2025
Title of Report:	Update from the Service Delivery & Performance Committee for January & February 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:	1. Terms of Reference 2. Committee Self-Assessment

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
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

January 2025

Board Assurance Framework (BAF) – A new risk relating to Health Inequalities had been added to the ICB BAF and this Committee was responsible for its oversight.

Discussions took place on the BAF and the importance of alignment between the BAF for each provider and that of the ICB was emphasised.

Key Performance Targets:

Mental Health

- Currently the system is on track to meet the end of year target for the majority of the metrics with the exception of Children and Young People (CYP) and Out of Area Placements (OAP). Improvement work is ongoing in both areas.
- Dementia Diagnosis rates had been over target for seven consecutive months and were expected to remain on track throughout the remainder of the year.
- SMI Health checks were just below plan but there were no concerns with regards to achieving the metric at this point.

Elective

- 78 weeks - just one patient remained outstanding at the end of December who, due to illness, could not be admitted for treatment as planned. The patient has been rebooked for January.
- 65 weeks – 50 patients remained to be treated at the end of December against an expectation of 55. Lincolnshire therefore came in under trajectory which was well received.
- The January forecast for 65 weeks was 41 patients and the team was confident it would achieve this figure, subject to patient choice or illness.
- 52 weeks - The 52 weeks list continues to reduce well, currently there were approximately 1,800 patients waiting.

Diagnostics

- At the recent Planned Care Board there had been in depth conversations with regards to diagnostics and the recovery action plans that are in place for some of the modalities that are under performing. For assurance purposes, all of these are being progressed.

Cancer

There was real sustained improvement but there had been an increase in the backlog since December due to the Christmas period and UEC pressures. There had been an increase from 190 to approximately 282. This figure was being monitored closely.

- 28-day FDS, which is one of the key metrics for December, was 70.7% which was an improvement in November. This was looking positive from both a regional and national perspective.

UEC

- The data showed performance for January for four hours in A&E was 74.5% which was very encouraging and was 3% above the regional and national average.

Winter Update

- The winter plan was now fully mobilised and enacted with additional break-glass options developed and implemented during peaks in pressure.
- A new service pilot was implemented during Q3 to deliver full integration of Urgent Community Responses within the EMAS Emergency Operations Centre. Initial indications are that this was working well and has been expanded at times of peak demand.
- There has been a refocus on discharge governance with a spotlight on improved processes and efficiency, and reduced length of stay. There has also been a focus on ambulance handovers on both acute sites with a 45m handover process development underway.

Dashboard - The monthly performance dashboard was discussed particularly in the context of providing assurance over trajectories across the rest of the year.

Planning – update provided:

- The Planning Guidance for 2025/26 was still to be released. It was expected that this would be released at the end of January.
- Publication of the Reforming Elective Care Plan. This was wide ranging with implications for multiple service transformation programmes and corporate support functions. This would be coordinated via the System Planning Group with an initial

baseline assessment and then a range of actions which would inform the 2025/26 plans and beyond.

- Publication of the Planning Support Pack which confirms the national planning approach, timetable and expectations.

There was to be an initial headline plan submission on 27th February and the full plan would then need to be submitted on 27th March.

Reforming Elective Care

A presentation was given regarding Reforming Elective Care for patients. There are four focus areas:

- Empowering patients – giving patients more choice and control
- Reforming delivery
- Delivering care in the right place
- Aligning funding, performance oversight and delivery standards.

February 2025

Committee Terms of Reference & Self-Assessment

The Committee reviewed and approved some minor amendments to its Terms of Reference – these are attached to this report for ICB Board approval.

The annual Committee Self-Assessment (also attached) was agreed by the Committee.

Planning Submission

A presentation was given with regards to the 2025/26 Planning submission. In-depth discussions took place about the initial planning submission that was scheduled for the 26th February 2025.

Winter Update

A verbal update was given with regards to winter. Overall winter was relatively stable but there were a number of caveats to this as the system was still 'in winter'. When compared to neighbouring systems Lincolnshire was performing well.

Performance Escalations

There were no formal escalations, updates were provided on:

Cancer

- Performing well on all cancer metrics with the exception of 62-day performance. The position was challenging and Lincolnshire was not the only system in this situation. The year end position would not be achieved but Lincolnshire was in the top three most improved systems for 62-day performance over the last 12 months with a 11.1% improvement.
- 78 weeks – There are no 78ww patients left.
- 65 weeks – Stretch target set at 33 patients, at present Lincolnshire's trajectory was expecting to reach 41.

UEC

- Data across Tier 1 and Tier 3 activity has been clarified with NHSE and alongside the work that was being undertaken with the national RIO programme, good improvement has been seen. For the last seven days 4-hour performance nationally was 70.1%, regionally was 70.2%, Lincolnshire was 74.1%. Lincolnshire had been benchmarked in the top quartile for all types of performance.

Virtual Wards

- Excellent improvement to reach 100% occupancy.

Learning Disability and Autism

- March to December data showed Lincolnshire in the top quartile for the first time in relation to autism inpatients.

Dashboard - The monthly performance dashboard was discussed particularly looking at vaccination and screening rates across PCN footprints and the implications of this within the current diagnostic strategy development.

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 <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an Equality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

Report previously presented at:

Not applicable

Is the report confidential or not?

Yes No

NHS LINCOLNSHIRE INTEGRATED CARE BOARD SERVICE DELIVERY AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

The Service Delivery and Performance (the Committee) is established by the Integrated Care Board (the Board or ICB) and will be a joint Committee between the ICB and NHS providers in accordance with the ICB Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is an ICB Non-Executive Member Chaired Committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee is a non-statutory meeting established to provide leadership and direction in supporting the Lincolnshire NHS system, to drive forward the delivery of the agreed strategic priorities, monitor the impact of their delivery and provide oversight to the systems approach to planning. The focus of the Committee will be on progress and delivery of the 'Lincolnshire NHS System strategic priorities and operational plan' this being a subset of the broader Integrated Care Strategy.

All group members will promote identified initiatives and issues within organisational governance structures.

3. AUTHORITY

The Service Delivery and Performance Committee is a formal Committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Service Delivery and Performance Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution. Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Committee Members are:

- ICB Non-Executive Member (Chair)
- Non-Executive Directors from each Lincolnshire NHS Organisation (with 1 as the Deputy Chair)
- ICB Director of System Delivery
- ICB Director of Strategic Planning, Integration and Partnerships
- Two Nominated Directors responsible for Strategy, Planning and/or Operations, one from LHCG (the Group, covering ULTH and LCHS) and one from LPFT.

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:

Attendees are SRO's, Programme Leads relevant to the Committee's work.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussions of particular matters.

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to Chair the Committee.

Committee members will appoint a Vice Chair of the Committee who will be one of the Non-Executive Members of a provider Board.

The Chair will be responsible for agreeing the agenda and ensuring that matters discussed meet the objectives as set out in the Terms of Reference.

5. MEETING QUORACY AND DECISIONS

The Service Delivery and Performance Committee shall usually meet on a monthly basis (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

50% attendees from the membership outlined above – including at least Two NEDs and at least one Executive Director.

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.

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.

Members must attend 75% of the committee meetings.

Decision making and voting.

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

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

The responsibilities of the Service Delivery and Performance Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Assurance of system operational planning process and outputs (A).
- Review the integrated care system's service delivery and performance against its annual plan, and monitor any necessary corrective planning and action, escalating significant system issues that cannot be resolved (A).
- Identify key risks affecting the delivery of agreed plans to rectify issues, with significant risks being escalated (D, A).
- Review and monitor those risks on the ICB's Board Assurance Framework which relate to service delivery and are allocated to the Committee for oversight, ensuring the ICB is kept informed of any significant risks and mitigation plans in a timely manner.
- Provide timely information and make recommendations to the ICB Board and NHS Provider Boards on service delivery and performance issues where these impact at a system level. (A)
- Monitor the effectiveness of the integrated care system's service delivery and performance reporting systems (A).
- Ensure the 'behaviours' agreed by system partners are in fact being adopted and adhered to. The Committee will 'call out' any system partner who is not doing so. (A)

7. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

All committees and sub-committees are listed in the Scheme of Reservation and Delegation (SoRD). Each Committee and Sub-Committee established by the ICB operates under terms of reference and membership agreed by the Board or the relevant Committee who the Board has delegated the power to make further delegations to Sub-Committees. All terms of reference are published in the ICB Governance Handbook.

The Service Delivery and Performance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded.

As a Committee that fulfils delegated functions of the ICB, the Service Delivery and Performance 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 Committee to discuss significant risks or matters or issue arising from internal audit reports in greater detail.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. 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

Members must demonstrably consider the equality and diversity implications of decisions they make on the citizens of Lincolnshire.

9. DECLARATIONS OF INTEREST

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.

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.

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.

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.

10. SECRETARIAT AND ADMINISTRATION

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.
- Membership will be considered as part of TOR review processes.
- 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.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

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.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review: February 2025

DRAFT

BOARD COMMITTEE

SELF ASSESSMENT QUESTIONS – 2024/25

	Area/Question	Yes	No	Comments/Action
	Composition, establishment and duties			
1.	Does the Committee have written Terms of Reference that adequately define the Committee's role in accordance with relevant guidance?	X		
2.	Have the Terms of Reference been reviewed during the year (either as good practice or to take into account governance developments and the remit of other Committees within the ICB)?	X		
3.	Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	X		
4.	Does the Committee have an annual work plan of matters to be dealt with during the year, and which have informed the content of its meeting agendas?	X		Standing items each month in addition to a flexible approach to allow deep dives into areas of current underperformance, highest risk, national/regional focus or specific local initiatives.
5.	Has the Committee met the appropriate number of times to deal with planned matters, development and liaison?	X		
6.	Are the Committee papers distributed in sufficient time for members to give them due consideration?	X		In the main, yes, occasionally some papers are late additions and performance data is provided as soon it is available.

7.	Has the Committee been quorate for each meeting this year?	X		
Effective Functioning – Committee				
8.	Does the Committee review its own effectiveness periodically?	X		
9.	Does the Committee review its operational risks regularly and also any risks to the ICB's strategic objectives as set out in the Board Assurance Framework where they have been assigned to the relevant Board Committee?	X		
10.	Does the Committee report regularly to the Board through verbal and written reports and make clear recommendations where necessary, including escalating items for consideration?	X		
11.	Does the Committee effectively monitor, or ensure monitoring of, agreed actions, e.g. by use of an Action Log?	X		
12.	Has the Committee formally considered how it integrates with other Committees and groups?	X		There is regular feed in from provider committees and programme boards and the cross over with system Quality, Primary Care and Finance committees is frequently discussed. A more joined up (less duplicated) approach is currently under review.
13.	Does the Committee receive timely and appropriate feedback from its Sub-Committees/groups?			N/A – the Committee does not have any sub-committees as such, but regular feedback is received from operational and programme leads and from providers' committees and programme boards when appropriate.
14.	Does the Committee provide clear direction to its Sub-Committees/groups?			N/A – only as appropriate in discussions as above (see 13)
Effective Functioning – individual members				
15.	Do members appropriately challenge Executives and management on critical and sensitive matters?	X		
Compliance with the law and regulations governing the NHS				
16.	Does the Committee have a mechanism to keep it aware of topical issues?	X		Regular updates provided by executives on regional and national issues and monthly data and programme updates are provided on local issues, challenges and delivery risks.
17.	Does the Committee have a mechanism to keep it aware of legal and regulatory issues?	X		Frequent executive input on the latest requirements and progress on plans, developments and delivery in response to these.

Assurance				
18.	Does the Committee receive timely information on performance concerns?	X		Monthly updated performance data and risk escalations etc..
19.	Are all these reports clear, concise and readily understood?	X		
Other Issues				
20.	Is there anything else you'd like to raise about the Committee and it's role? Please tell us here.	X		The Committee's remit is very large with numerous delivery priorities. Even with monthly meetings for over three hours, it is not possible to cover everything in the Operational Plan with the optimum frequency and depth. The developing accountability framework and a more integrated approach to assurance and proactive escalation across the system is needed to ensure all areas of delivery are actively and regularly reviewed.

Briefing Summary of the East Midlands Joint Committee Meeting held on Tuesday 17 December 2024

1. Purpose

- 1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 17 December 2024.

2. Summary of Agenda Items

2.1. Emergency Ambulance & NHS 111 Service Contract Governance

The Committee **NOTED** the outstanding in year contract negotiations for NHS 111 and Emergency Ambulance Services had been concluded and contracts forwarded for signature. Derby and Derbyshire Integrated Care Board (ICB) continues to work with partner ICBs whose Boards are yet to approve delegation of 111/999 matters to the Joint Committee, the Committee **NOTED** this position.

2.2. Primary Care Finance and Assurance Report

The Committee received the report for **ASSURANCE**. Primary focus of discussion lay with progress on delivery against non-recurrent Dental recovery activity (out to market) and expressions of interest in the Dental Recruitment Incentive Scheme 2024/25, year to date financial delivery and year end claw back of underspend by NHS England, month on month increases in utilisation of the Pharmacy First programme and progress with the implementation of the Eyecare Electronic Referral System.

2.3. Specialised Commissioning Services Integrated Assurance Report

The Committee received the report for **ASSURANCE** with focus of discussion being progress on establishing priority transformation programmes and the focus on 2025/26 planning requirements, allocation/ accounting processes for 2025/26, progress with a deep dive into Head and Neck Cancer services, operational pressures on PICU services, and mitigation of risk associated with the prescribing of high-cost drugs.

2.4. Strategic Commissioning – East Midlands 3 Year Dental Commissioning Plans

The Committee **APPROVED** the 3 Year Dental Strategic Commissioning Plans and **NOTED** the wider work being progressed regarding broader/ longer term planning.

2.5. Specialised Commissioning Strategic Brief

The Committee **NOTED** the brief in relation to progress on the delegation of services and the strategic impact of delegation of Mental Health, Learning Disability and Autism services aligned to the Provider Collaborative Model. The Committee heard how activity is being co-ordinated through the regional Operating Model Group (OMG) which takes representation from all 11 ICBs, and how the circulation of single consistent messaging from the central function to individual ICBs is being managed.

Further work is required on financial models and governance arrangements with the aim of seeking ICB approval for delegation and collaboration prior to April 2025.

2.6. National Commissioning Support Unit Operating Model

The Committee NOTED the verbal update on the national NHS Commissioning Support Unit Operating Model programme. Discussion focused on the consolidation of Commissioning Support Units and opportunities to enhance improve consistency/quality of provision and value for money. Further engagement between CEOs will inform the regions contribution to this work.

2. Recommendation

2.1. This briefing summary is provided for information to be noted.



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	8 (i)
Meeting Date:	Tuesday, 25 TH March 2025
Title of Report:	ICB Annual Report and Accounts Key Dates 2025
Report Author:	Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Jules Ellis-Fenwick, ICB Board Secretary
Appendices:	

To approve <input checked="" type="checkbox"/>	For assurance <input type="checkbox"/>	To receive and note <input type="checkbox"/>	For information <input type="checkbox"/>
Recommendation or particular course of action, e.g approve the strategy, endorse the direction of travel.	Assure the ICB Executives that controls and assurances are in place.	Receive and note implications, may require discussion to help share/develop item.	Note, for intelligence of the ICB Executives without in-depth discussion.

Recommendations

The Board is asked to:

- Note the process and specific dates in relation to the production of the ICB Annual Report and Accounts for 2024/25.
- Note the identified lead for each section.

Summary

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, which must follow the three-part structure as detailed below:

- The Performance Report, which must include an overview and performance analysis.
- The Accountability Report, which must include a Corporate Governance Report, Remuneration and Staff Report and Parliamentary Accountability and Audit Report*.
- The Annual Accounts

**This section is not applicable to ICBs as they do not report directly to Parliament.*

The Health and Care Act 2022 requires ICBs to:

- Explain how the ICB has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 (general duties of ICBs).
- Review the extent to which the ICB has exercised its functions in accordance with plans published under forward plans and capital resource use plans.

- Review the extent to which the ICB has exercised its functions consistently with NHSE's latest statement about how functions relating to inequalities information should be exercised.
- Reviewing any steps the ICB has taken to implement any joint local health and wellbeing strategy it is required to have regard to.

For the reporting period ending 31 March 2025 the Public Expenditure System (PES) paper has been incorporated into the GAM.

Additional Requirements for ICBs

Additional requirements for ICBs relating to reporting of gender distribution, business information and details of members, the membership body and governing body (ICB Board).

Guidance on 'Taskforce on Climate-related Financial Disclosures' (TCFD). Required disclosures relate to the 'Governance', 'Risk management' and 'Metrics and Target' pillars, noting that ICBs are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements, as these are computed nationally by NHSE.

New disclosures required in the Annual Governance Statement for ICBs who have signed a Delegation Agreement with NHSE and taken on full commissioning responsibilities for delegated services. These disclosures, relating to ICB compliance with core commissioning requirements.

Signatures and Key Dates

The Accountable Officer is required to sign and date the Performance Report, Accountability Report and the Statement of Financial Position.

ICBs are required to publish their full Annual Report and Accounts in accordance with the arrangements notified via the ICB SharePoint Pigeon Holes.

NHSEI has issued details of the key deadline dates and submission process for the Year End Accounts and Annual Report as follows:

- Month 9 Governance Statement Return – **to be submitted by 21st January 2025** (including nil returns) – **complete**.
- A full copy of the draft Head of Internal Audit Opinion (to allow regional assurance activity to commence) – **complete**.
- Draft ICB Annual Report (excluding accounts and staff information), updated Head of Internal Audit Opinion, completed NAO disclosure checklists - **to be submitted by 9.00 am on the 25th April 2025**.
- Full audited and signed ICB Annual Report and Accounts - **to be submitted by 9.00 am on the 23rd June 2025**.

Preparing for 2024/25 Integrated Care Board Annual Assessment

NHS England has a statutory duty to undertake an annual assessment of each Integrated Care Board following the end of each reporting year.

At the time of writing guidance is awaited from NHSE on the approach that will be taken for the period 2024/25 and the timescales involved. Whilst this is awaited, and in the spirit of not wishing to delay the commencement of the production of the ICB Annual Report 2024/25, it is proposed that content is pulled together based on the previous year's assessment which had a specific focus on the following ICB statutory duties:

System Leadership	<ul style="list-style-type: none"> duty to take appropriate advice. duty to consult patients and the public about decisions that affect them. 	
Improving population health and healthcare	<ul style="list-style-type: none"> duty to improve the quality of services. 	
Tackling unequal outcomes, access and experience	<ul style="list-style-type: none"> duty to reduce inequality of access and outcome. 	
Enhancing productivity and value for money	<ul style="list-style-type: none"> financial duties duty to facilitate, promote and use research. 	
Helping the NHS to support broader social and economic development	<ul style="list-style-type: none"> duty to have regard to the effect of decisions (The “triple aim”) duty to contribute to wider local strategies. 	

Leads have been identified for each section of the Annual Report as set out below. Once NHSE have issued their guidance on the ICB Annual Assessment for 2024/25 the requirements for the content of the ICB Annual Report 2024/25 will be updated accordingly.

Performance Report	Lead
Chairs and Chief Officer Foreword	Board Secretary
Introduction to Performance Report	Board Secretary
Performance Overview and Analysis (which includes a section on Mental Health and Children and Young People (CYP) Safeguarding)	Performance Leads with oversight from relevant Executive Directors
Key Achievements	All Executives/Supporting Teams/Board Secretary
Duty to take appropriate advice.	ICB Medical Director
Duty to facilitate, promote and use research.	ICB Medical Director
Duty to consult patients and the public about decisions that affect them.	Director of Strategic Planning, Integration and Partnerships (or appropriate deputy)
Duty to contribute to wider local strategies.	Director of Strategic Planning, Integration and Partnerships (or appropriate deputy)
Environmental Matters	Board Secretary/NHSPS/ICB Estates Lead
Duty to Improve the Quality of Services	Chief Nurse and Quality/Chief Nurse Lead
Engaging People and Communities, including social media	Communications and Engagement Leads
Primary care, Communities and Social Value	Director for Primary Care, Communities and Social Value
Reducing health inequality, which includes Population Health Management and duty to reduce inequality of access and outcome.	Director for Health Inequalities, Prevention and Regional Collaboration and Programme Director, PHM
Duty to have regard to the effect of decisions (The “triple aim”)	Director for Health Inequalities, Prevention and Regional Collaboration
Equality and Diversity	Equality Lead, Arden GEM and Associate Chief Nurse
Financial Review	Finance Leads
Principles for Remedy and Complaints	Complaints Lead

Freedom of Information	FOI Lead, Arden GEM
Accountability Report	Lead
Members Report (composition of committees etc)	Board Secretary
Statement of Accountable Officer's Responsibilities	Board Secretary
Register of Interests, Personal Data Related Incidents, Modern Slavery Act	Board Secretary
Annual Governance Statement	Board Secretary
Personal data related incidents/Data Quality/ Information Governance	IG Lead
Remuneration and Staff Report	Board Secretary/HR Leads/Finance Leads
Annual Accounts	Lead
Annual Accounts	Finance Leads
Auditor's Report	External Audit

In respect of the ICB Annual Report 2024/25 all agreed identified leads were contacted by the ICB Board Secretary on **Friday, 7th February 2025** to inform them of this years' requirements and to request that all submissions, where possible and acknowledging that some data will not be available until April/May, was submitted by **5.00 pm on Friday, 7th March 2025. This process is now complete.**

The draft template has been produced and was submitted to the design members of the Communications and Engagement Team to produce a draft designed version by **Friday, 28th March 2025 – which remains on track.**

Any amendments can then be incorporated in preparation for consideration by the Audit and Risk Committee at their meeting on the 17th April prior to submission of the updated draft ICB Annual Report for 2024/25 on the 25th April 2025.

Members of the ICB Communications and Finance Teams will be supporting the Board Secretary with production of the ICB Annual Report.

NHSE will consider the contents of the draft Annual Reports and in line with findings of interim certification, advise whether ICBs should submit an updated draft of the Annual Reports to support final certification or identify comments/suggestions to enhance the content.

The Audit and Risk Committee will be required to consider and recommend approval of the submission of the final audited version of the ICB Annual Report and Accounts 2024/25. As the submission date for the final version of the Annual Report and Accounts is Monday, 23rd June and the Board is not scheduled to meet until the 25th June, extraordinary meetings of both the Audit and Risk Committee and the Board will need to take place the week commencing the week commencing the 16th June. Dates are currently being considered.

ICBs will be required to publish the final version of the ICB Annual Report and Accounts in full on the website at **5.00 pm on 30th September 2025.**

ICBs are also required to present the ICB Annual Report and Accounts at meeting held in public meeting by **5.00 pm on 30th September 2025.**

How does this paper support the ICB's core aims to:

Aim 1: Improve outcomes in population health and healthcare.

The requirements on the content of the Annual Report covers off all four key aims of the ICB and comprehensive information will be included to that effect.

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	
Failure to deliver the Annual Report and Accounts in the form prescribed, or to the national timetable, or the submission of inaccurate material will likely result in a qualified audit opinion.	
Implications (legal, policy and regulatory requirements)	
Does the report highlight any resource and financial implications?	The production of the Annual Report and Accounts has been accounted for within the ICB budget.
Does the report highlight any quality and patient safety implications?	The Annual Report will include a detailed section on quality and reference any patient safety implications as per the requirements of the DHSC GAM and associated template.
Does the report highlight any health inequalities implications?	The Annual Report will include a detailed section on Health Inequalities as per the requirements of the DHSC GAM and associated template.
Does the report demonstrate patient and public involvement?	The planning process for the production of the Annual Report and Accounts is an administrative issue and service users, carers and local people will not have been involved. The Annual Report content will reflect on the work undertaken by the ICB in conjunction with patients and members of the public.
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 <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
Report previously presented at:	
Not applicable.	
Is the report confidential or not?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	