



NHS Lincolnshire Integrated Care Board Public Board Meeting

**Tuesday, 30th September 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.

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**.



Lincolnshire
Integrated Care Board

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Date: Tuesday, 30th September 2025

Time: 9.30 am

Location: The Boardroom, Bridge House, Sleaford

Chair of the meeting: Dr Gerry McSorley, ICB Chair

AGENDA

Item		Action Type (For Approval, Assurance, Discussion or Information)	Enc	Presenter	TIME
1. Introductory Items					
i)	Welcome, introduction and apologies		-	Dr Gerry McSorley	9.30 am
ii)	Confirmation of quoracy		-	Dr Gerry McSorley	
iii)	Declarations of Interest	Information	-	Dr Gerry McSorley	
iv)	Minutes of the previous meeting held on the 29 th July 2025	Approve	✓	Dr Gerry McSorley	
v)	Matters Arising, including Action Log (if appropriate)	Note	-	Dr Gerry McSorley	
2. Chair and Chief Executive Updates					
i)	Chair's Report	Note	-	Dr Gerry McSorley	9.35 am
ii)	Chief Executive's Report, including ICB Annual Assessment Letter 2024/25	Note	-	Mrs Clair Raybould	9.45 am
3. Key Updates					
i)	Public Health	Note	-	Professor Derek Ward	10.00 am
ii)	Healthwatch	Note	✓	Mr Navaz Sutton	10.10 am
4. Population Health Planning					
i)	Statement of Information on Health Inequalities	Assurance and Approve	✓	Mrs Sandra Williamson	10.20 am
5. System Oversight and Assurance					
i)	Integrated Performance, Quality and Finance Report	Assurance	✓	Mrs Rebecca Neno/ Mr Martin Fahy/ Mr Matt Gaunt	10.35 am
ii)	Winter Plan: Board Assurance Statements	Assurance and Approve	✓	Mrs Rebecca Neno	11.00 am
iii)	Stamford Engagement Report	Receive	✓	Dr Gerry McSorley	11.10 am

6. Governance					
i)	ICB Joint Transition Committee Highlight Report	Assurance	✓	Dr Gerry McSorley	11.20 am
ii)	ICB Annual Report and Accounts 2024/25	Receive	✓	Dr Gerry McSorley	11.25 am
7. Committee Highlight Reports					
i)	<ul style="list-style-type: none"> System Quality and Patient Experience Committee Service Delivery and Performance Committee Audit and Risk Committee 	Assurance	✓	Committee Chairs	11.30 am
8. Information/Closing items					
i)	Risks identified during the course of the meeting	Consider	-	Dr Gerry McSorley	11.45 am
ii)	ICBs Cluster Board meeting to take place on Thursday, 20 th November 2025 at 1.00 pm at Bridge House, Sleaford				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, 29th JULY 2025 AT 9.30 AM
AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS**

PRESENT:	Mrs Sharon Robson	Non-Executive Member, ICB Deputy Chair and Chair of System Quality and Patient Experience Committee (Chair for this meeting)
	Mrs Sarah Connery	Executive Board Mental Health Member
	Ms Anita Day	Non-Executive Member
	Professor Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Dr Phillip Earnshaw	Non-Executive Director and Chair of the Primary Care Commissioning Committee)
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Chief Executive
	Mr Martin Samuels	Partner Member, Local Authority (LCC)
	Dr Kevin Thomas	Partner Member, Primary Medical Services
REGULAR PARTICIPANTS/ ATTENDEES	Ms Charley Blyth	Director of Communications and Engagement
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mrs Anne Lloyd	Director of Workforce Transformation
	Mr Dean Odell	Healthwatch Representative
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Value
	Mrs Ellie Sadler	Living with Cancer Communities & QOL Programme Manager (item 4 only)
	Mrs Emma Townend	Interim Health Inequalities Programme Lead (item 4 only)
	Professor Derek Ward	Public Health Representative
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
APOLOGIES:	Councillor Steve Clegg	Chair, Health and Wellbeing Board
	Mr John Dunstan	Non-Executive Member and Chair of the Audit and Risk Committee
	Dr Gerry McSorley	ICB Chair
	Mr Navaz Sutton	Chief Executive Officer, HWLincs

25/330 WELCOME AND INTRODUCTIONS

Mrs Robson welcomed all those present to the ICB Board and advised that she would be Chairing the meeting in Dr McSorley's absence. It was emphasised that whilst the meeting was being held in public it was not a public meeting. These meetings were usually held both on a face to face basis and via Microsoft Teams but due to technical reasons outside of the ICB's control, it was not possible on this occasion to hold the meeting through the 'live event' facility. Mrs Robson apologised for any inconvenience caused.

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

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

25/331 CONFIRMATION OF QUORACY

Mrs Robson confirmed the meeting was quorate.

25/332 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

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

Declaration of Interest from Committees:
No items declared.

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

The Board agreed to:

- **Note no interests were declared.**

25/333 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 27th May 2025 and agreed to:

- **Approve the minutes as a true and accurate record of the meeting subject to inclusion of Mr John Dunstan, Non-Executive Member and Chair of the Audit and Risk Committee as being present.**

25/332 MATTERS ARISING

Mrs Robson presented the Action Log as included in the pack of papers and confirmed that the two items included were identified as complete.

25/333 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Mrs Robson advised that on the 3rd July, NHS England saw the publication of 'Fit for the Future: The Ten Year Health Plan for England'. The Plan outlines a bold, ambitious, and necessary new course for the NHS. Its aim is to seize the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients, through the three shifts of analogue to digital, hospital to community, and from sickness to prevention.

In line the plan it has been confirmed nationally that Lincolnshire ICB will cluster with Derby and Derbyshire and Nottingham and Nottinghamshire ICBs.

One of the key aspects of the Ten-Year Health Plan is the ambition to establish an Integrated Neighbourhood Health service across the country. Mrs Raybould, as ICB Chief Executive will also pick this up in her report.

Since the last Board meeting, Dr McSorley had attended numerous locally, regional and national meetings along with colleagues from Derby and Derbyshire and Nottingham and Nottinghamshire ICBs, and across the East Midlands, on the Government's reforms to the NHS.

Dr McSorley had also attended or supported the following:

- Attended the two ICB staff events held in early June.
- Undertaken a briefing for Councillor Steven Clegg as the County Council lead Councillor for the NHS (as well as adult social care).
- Briefed the new Mayor on current issues.
- Attended various regional and national Chair meetings.
- Met the leaders of West Lindsay District Council on services in the Gainsborough area
- Attended the Health and Wellbeing Board and Integrated Care Partnership Board
- Received visitors from the Ministry of Defence (more information will be provided by Mrs Raybould as part of her update).
- Undertaken the appraisals of the ICB Board Non-executive Directors.

Some final points of note, Dr McSorley has confirmed sign off of the annual assessment return for the Fit and Persons Test for voting members of the Board, all of whom comply with these regulations. This has been submitted to the NHSE Regional Director.

Since, the last Board meeting, the ICB had said farewell to Mr John Turner, former ICB Chief Executive whose last day with the organisation had been 17th June. Mr Turner was given a good send off and wished all the best for his future endeavours.

Finally, it has been a challenging period for our staff, who have worked exceptionally hard to deliver the operational plan for 2025/26 and much else besides, amid a period of great uncertainty for their futures. I want to recognise this hard work under these circumstances and extend my thanks from myself and the Board.

There were no questions received on Mrs Robson's update, who handed over to Mrs Raybould at this point to present the Chief Executive update.

Chief Executive update

Mrs Raybould presented her verbal briefing and referred to the publication on the 10 Year Plan for England as referred to by Mrs Robson under her update. This document sets out three major system shifts:

1. From hospital to community – with easier GP access, extended neighbourhood health centres, better dental care, and 24/7 mental health support.
2. From analogue to digital – including unified patient records, AI-enhanced services, and digital tools like the NHS app and online booking.
3. From sickness to prevention – with initiatives like home screening kits, weight loss services, and support for low-income families.

First step Neighbourhood Health Service Pilot

As part of the national ambition to bring care closer to home, all systems have been invited to express interest in the National Neighbourhood Health Improvement Programme. This initiative supports large-scale transformation, fosters national learning, and builds the culture and capability required to deliver truly localised health services.

While this is a national opportunity, Lincolnshire ICS is particularly well placed to be selected in Wave One, thanks to strong, co-terminus system working across the ICS, established foundations at both place and neighbourhood levels, a track record of collaborative, integrated care delivery

Dr Hindocha, Medical Director, is leading the ICB's application, supported by colleagues across the system.

NHS Reform

Following the March 2025 announcement regarding the NHS Operating Model, and as referenced by Mrs Robson, the formation of the DLN cluster, comprising three Integrated Care Boards (ICBs), has now been formally agreed. It is important to note that there are no plans to merge ICBs; each will continue to operate as a statutory body, retaining its legal responsibilities and local accountability.

In parallel, the Department of Health and Social Care has announced a new leadership structure, which will inform the alignment of responsibilities across national, regional, and system levels. The Model Region Blueprint is awaited and expected to provide further clarity on the division of responsibilities between regions and ICBs.

Recruitment is currently underway for a single Chair and Chief Executive Officer designate for the DLN (Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire) cluster. Once formal appointments are made, work will commence on developing the organisational structure across the combined footprint.

The Board will be kept updated as developments progress.

Oversight and Performance

The Board noted that the operational environment remains extremely busy, with the country currently on day five of BMA strike action. Mrs Raybould expressed her appreciation to all ICB staff and system partners for their preparation and response efforts, ensuring that patient safety remains paramount throughout.

Earlier this month, the ICB held its first Quarterly System Review Meeting (QSRM) for 2025/26 with the NHS England Midlands team. Initial feedback was positive, recognising Lincolnshire's stable delivery, strong risk management, and ongoing ambition to improve outcomes for the local population. The formal outcome of the review is awaited.

The Board was informed that the NHS Oversight Framework for 2025/26 is now in place and is expected to be published after the summer. While ICBs will not be segmented this year due to the scale of system change, performance will continue to be monitored across key metrics, including leadership and statutory duties.

The Board also noted receipt of NHS England's winter planning guidance. A national winter exercise is scheduled to take place in September to stress-test system plans. This will be presented to the Board in September as part of the routine Board assurance process.

National Maternity Review

Following meetings with bereaved families, the Secretary of State has announced a national investigation into maternity and neonatal services. A taskforce will be established, and the ICB will engage fully with this important piece of work.

Recognition and Thanks

On 30th June, Lincolnshire ICB welcomed representatives from the Ministry of Defence (MOD) to its headquarters to reflect on the successful delivery of Reception, Staging, Onward Movement (RSOM) at Beckingham Camp, delivered under Operation Lazurite. The visit highlighted the positive impact of collaboration between the MOD, local health services, and wider system partners in supporting Afghan evacuees who had assisted British forces in Afghanistan. During the event:

Subject to approval by the Board at its next meeting

- Commander Manish Tayal presented a commemorative plaque to the ICB.
- Commanders Challenge Coins were awarded to key team members from the ICB, K2 Healthcare, Ancaster and Caythorpe Surgery, Midwifery and Health Visiting teams, and Lincolnshire County Council.

This recognition reflects the exceptional commitment of teams across the system in delivering comprehensive health services during a critical resettlement operation. The final family departed Beckingham Camp on 26th June 2025, marking the conclusion of this important phase. The work undertaken was noted as a strong example of neighbourhood health in action.

The Board recorded its thanks to all teams involved, with particular recognition given to Ms Mills for her leadership, and Mrs Katherine Perrin from the Primary Care team, whose thoughtful liaison with health providers and other agencies has been instrumental in delivering coordinated and compassionate support throughout multiple resettlement schemes.

The Board also noted that the ICB has been awarded the Defence Employer Recognition Scheme Gold Award by the MOD. This prestigious award reflects the ICB's deep and ongoing commitment to the armed forces community in Lincolnshire, building on previous Silver and Bronze awards.

A special thank you was recorded to Mrs Jacqui Bunce, Armed Forces Lead, for her leadership in enabling this achievement, and to all staff involved in supporting armed forces colleagues.

It was further noted that Lincolnshire Partnership NHS Foundation Trust (LPFT) has also received the Gold Award this year, joining Lincolnshire Community Health Services (LCHS) and United Lincolnshire Teaching Hospitals NHS Trust (ULTH), who have previously achieved Gold. This collective recognition across the system is a testament to the strength of shared values and commitment to supporting those who serve.

On a final note, Mrs Raybould acknowledged the resilience and dedication of the ICB staff. Despite the uncertainty and changes ahead, they continue to deliver on the organisations 2025/26 priorities with professionalism and care alongside our partners. Mrs Raybould expressed her deep appreciation for their efforts, a sentiment that was shared and endorsed by the Board.

The Board considered the update. Ms Day asked whether there was any timeline for the dis-establishment of the ICB Board in its current format and the establishment of the ICBs Cluster Board. Mrs Raybould advised there was no specific timeline identified at the current time, but Cluster was expected to be in a shadow form from October with potentially the first meeting of the ICB's Cluster Board in November. Prior to that the Management of Change Policy needs to be finalised and go through the relevant governance process, which has not yet happened.

Mrs Raybould advised the Board that a number of questions had been received from two members of the public. In respect of the first question, while the points raised relevant themes around digital inclusion, medication access, and community support, all of which align with the ICB's strategic priorities, they also referenced a specific provider.

In line with the ICB's governance approach, it was noted that the organisation does not endorse individual providers. However, the themes raised will be considered as part of the ICB's ongoing work, and a written response will be provided following the meeting.

The second query was a comment, not a question, requesting a minor amendment to a previous Board response from May, which was noted for action by the ICB Board Secretary.

Action: Mrs Ellis-Fenwick

The Board considered the update and agreed to:

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

KEY UPDATES

25/334 PUBLIC HEALTH

Professor Ward provided a verbal update from the Public Health perspective and covered both the national and local perspective. Specific areas highlighted included:

- Publication of the 10 Year Plan with specific emphasis on prevention and the work being undertaken within Public Health.
- Preparations are underway for Exercise Pegasus, a Tier 1 national pandemic preparedness exercise scheduled to run from September to November 2025. Led by the Department of Health and Social Care (DHSC) and the UK Health Security Agency (UKHSA), the exercise will simulate a realistic pandemic scenario and test the UK's ability to respond across all levels of government.
- Local Government Outcomes Framework – Call for Feedback. Professor Ward to circulate the link to the documentation for inclusion in the minutes.

Action: Professor Ward

- <https://www.gov.uk/government/publications/local-government-outcomes-framework-call-for-feedback>

Dr Hindocha welcomed the emphasis on prevention in the 10-Year Plan, highlighting the broader value of health and referencing national concerns around measles-related deaths; it would be helpful for the Board to hear about this from a local perspective on this issue.

Professor Ward stressed that the 10-Year Plan is fundamental to the future of the country, noting that the current approach is unsustainable. He emphasised the importance of aligning with the Outcomes Framework.

Mr Gaunt commented that there will be a need to consider deployment of resources that supports that type of initiative and engagement, which Professor Ward advised feeds into the Outcomes Framework.

Place-based approaches, tailored to population needs, will also be a key focus in the coming years. Integration with the NHS App and the Neighbourhood Model was noted as increasingly important.

It was acknowledged that significant work has already been undertaken, as referenced in previous DPH (Director of Public Health) Annual Reports.

Mrs Pomeroy raised concerns about the long-term nature of prevention outcomes and questioned how investment would be managed, especially in the context of NHS funding pressures. Professor Ward responded with examples such as tackling high blood pressure and cholesterol, and promoting physical activity, describing this as a “paradigm shift.”

The Board considered the update and agreed to:

- **Note the Public Health update.**

25/335 HEALTHWATCH

Dr McSorley handed over to Mr Odell at this point to present the Healthwatch report.

Mr Odell advised that he would take the report as read but wished to highlight some key points for the Board's information. Between May and June 2025, 160 people shared their experiences of health and social care via the Information Signposting Service. Additionally, 153 carers and 24 care home managers contributed through targeted surveys. Breakdown:

- 59% of experiences were negative
- 16% were positive
- The remainder were neutral, mixed, or unclear

Mr Odell highlighted the key themes of the feedback received.

- GP Access: Ongoing collaboration with partners to promote alternative initiatives and prepare for upcoming changes in GP services.
- Hospital Services: Concerns raised about long waits for tests and treatments within the Hospital Trust and Group.
- Non-Emergency Transport: Reports of missed appointments due to transport failures; to be followed up with the provider and ICB colleagues.
- NHS Dental Access: One case highlighted successful facilitation of a timely appointment.
- Service Relocations:
 - Leg ulcer treatments moved from Beechfield to Gosberton, increasing travel time and patient transport costs along with reduced service capacity for volunteer drivers.
 - Stamford Hospital phlebotomy clinic experiencing delays and overcrowding due to GP surgeries ceasing blood test services.

Mr Odell advised that in terms of the next steps; the feedback highlighted, and other patient insights will be shared at the upcoming meeting of the Primary Care Commissioning Committee to support service planning and decision making.

Two further points of note from the report:

- Notable praise was received for care at Lincoln County Hospital and Pilgrim Hospital Board.
- Carer and care home manager surveys have informed current and future priorities, with satisfaction levels analysed by theme.

The Board considered the contents of the report. Mrs Raybould commented that the detail demonstrates the value of Healthwatch and emphasised the ICB's support in the context of the recent government announcement, whereby the intention is to dissolve Healthwatch up and down the country

The Board welcomed the feedback from the carers and noted that Healthwatch have a whole programme on gathering and acting on this information. It was really positive to see increased transparency around the feedback process.

Dr Earnshaw advised that the over-crowding at Stamford Hospital has recently been discussed by the ICB Primary Care Commissioning Committee and who are therefore sighted on the issues.

The Board agreed to:

- **Note the Healthwatch report.**

POPULATION HEALTH PLANNING

25/336 A presentation was delivered by Mrs Emma Townend (Interim Health Inequalities Programme Lead) and Mrs Ellie Sadler (Living with Cancer Communities & QOL Programme Manager) on the Bowel Cancer Screening Project led by the ICB. The project forms part of the ICB's statutory commitment to reduce health inequalities, aligning with the NHS 10-Year Plan.

The initiative focused on increasing bowel cancer screening uptake in the four most deprived GP practices in Lincolnshire, located in Skegness, Mablethorpe, and Gainsborough. Local data revealed a significant disparity in screening uptake between the most and least deprived populations (62% vs 70%).

A comprehensive engagement phase was undertaken, including a public survey (2,416 responses), face-to-face discussions (103 individuals), and targeted outreach to carers,

individuals with learning disabilities, and non-native English speakers. Insights gathered informed a co-production process facilitated by the organisation Every-One, resulting in a 10-week hyper-local advertising campaign and community events that engaged over 400 residents.

The project has led to embedded practices such as the use of prescription bag messaging and co-produced communication templates. It is being considered for wider application in future health inequality initiatives, including lung cancer screening.

The approach demonstrates a scalable, community-centred model for addressing healthcare inequalities through data-driven insight and local co-production.

The Board considered the report and reflected on the presentation. The Board commended the project as an excellent, co-produced piece of work and suggested it should be shared with Nottingham and Nottinghamshire and Derby and Derbyshire ICBs as part of the clustering arrangements, which was acknowledged and noted for action as appropriate.

Mrs Dunderdale highlighted the importance of recognising staff as residents and the value of sharing learning and resources across leadership teams and welcomed having a conversation with the team about sharing this with the Group Board, which was noted by Mrs Townend and Mrs Sadler

Mrs Kenson asked about GP practice involvement. It was confirmed that targeted practices, especially Marisco, were actively engaged.

Dr Earnshaw noted the project's alignment with Primary Care Networks and its value in identifying areas for targeted work.

Mr Fahy observed the project's clear impact and asked about ongoing evaluation and whether this will continue for a year or so and referred to the challenges about meaningful engagement. Mrs Sadler confirmed that while full data is not yet available, it is expected to come through in due course. She recognised the challenges around engagement, particularly the time required to involve stakeholders meaningfully. However, there was optimism that this would improve as neighbourhood health working becomes more embedded in local systems.

Mrs Raybould highlighted the project as a scalable example relevant to the 10-Year Plan and ICB functions and congratulated the team for their leadership and delivery. The importance of continuing to embed, evaluate, and share the learning from this work was strongly endorsed.

Mrs Townend and Ms Sadler left the meeting at this point.

Mrs Robson called a short break, and the meeting was adjourned at 10:56 and readjourned at 11:05 am

SYSTEM OVERSIGHT AND ASSURANCE

25/337

INTEGRATED PERFORMANCE, QUALITY AND FINANCE REPORT

Performance Section

Mrs Neno presented the performance section and advised that she would take the report as read and provide a verbal update on the latest data. It was noted that the Service Delivery and Performance Committee continues to review performance on a monthly basis and its next meeting was scheduled to take place the following day.

UEC

- All Types 4-hour performance for the ICB for June 2025 was 75%, in line with the planned month trajectory of 75%. July has been more challenged, but month to date is 73.6% which is slightly below the national average but above regional average.

Subject to approval by the Board at its next meeting

- The 45-minute initiative for ambulance handovers, overall, continues to perform well at NLAG (Northern Lincolnshire & Goole Hospitals NHS Trust, NWAFT (North West Anglia Foundation Trust) and ULTH.
- C2 performance continues to remain more positive.
- Slight uptick in some indicators due to the heatwaves in June and July but good recovery
- Fifth day of industrial underway, system planning has been strong, and the system has managed well keeping and cancellations to a minimum and protection of UEC pathways – a full look back will be completed.

Cancer

- 62-day standard 65.4% which is slightly above plan of 65.2%, this is below the national average but higher than the regional average.
- FDS slightly below the standard of 75% at 74.2% - Bank holidays in May caused some disruption
- The backlog is slightly higher due to May bank holidays, mainly driven by Colorectal which GIRFT are supporting with improvements.

Planned Care

- 65 weeks for May 14 and June 13, for this month similar forecast largely due to patient choice and or complexity and industrial action impacts.
- The total waiting list size for Lincolnshire patients at all hospitals reduced in May and is ahead of plan at system level,
- Just over 3,000 patients have been waiting over 52 weeks which equates to 2.9% of the total waiting list and is 0.6% adverse to plan. Worth noting that theatre productivity has significantly improved – now nearing top national quartile.
- Diagnostics recovery plans in place for some modalities.

Mental Health

- Talking therapies remains above plan and national average – some good performance
- Numbers of OOA continues to fluctuate but all being appropriate for some time now.

There were no questions received in relation to this section of the report.

Quality Section

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

- **Quality and Patient Experience Updates: LPFT:** The CQC conducted unannounced assessments on three LPFT wards in June 2025. Although the report is pending, LPFT has already begun addressing identified issues and is coordinating with the ICB to ensure quality oversight. The Board will continue to be kept updated.
- **Primary Care Insight and Signals: GP Practice Quality:** The QEWS (Quality, Early Warning System) programme continues to progress with more practices now showing an interest in participating.
- **Pharmacy, Optometry, and Dentistry (POD):** The Primary Care Quality Team and Quality Services Team are continuing to develop the incident reporting and management process for all commissioned POD (Pharmacy, Optometry and Dental) services. The first element of this programme is near final draft and includes a consistent approach to the Learning from Patient Safety Events (LSPSE) process. This will ensure all commissioned POD providers will use the same tools for incident reporting and learning.
- **Thematic Updates and Quality Improvement: Learning and Sharing:** A national review of patient safety published in July 2025 identifies six organisations and makes nine recommendations, including a revamp and revitalisation of the National Quality Board. HSSIB (Health Services Safety Investigations Body) to collaborate with DHSC (Department of Health and Social Care) to agree the scope of the investigations. The

hosting arrangements of the patient safety commissioner to be transferred to the MHRA (Medicine and Healthcare products regulatory agency). Functions related to staff voice, freedom to speak up, to be streamlined. Distinct role of national guardian no longer needed. The responsibility and accountability of commissioners and providers in the delivery and assurance of care to be streamlined.

- A national strategy for quality in adult social care will be developed.
- **10-Year Health Plan for England:** A chapter in the new plan stresses transparency in care quality, patient-focused metrics, and regulatory streamlining.
- **Quality Impact Assessment:** NHSE's June 2024 framework guides Quality Impact Assessments (QIAs) in health and care service changes. With the development of the Lincolnshire system Quality Equality Impact Assessment (QEIA), Lincolnshire's approach will be reviewed to align with this recently published guidance.
- **System Complaints Review:** The ICB, along with partners, has launched a quarterly complaints and PALS thematic review process coming through the individual organisations complaints and PALS process. The first report is due to be presented to the System Quality and Patient Experience Committee (SQPEC) in July 2025.
- **Maternity and Neonatal Quality:** Regional Performance: Lincolnshire received the best (lowest) rating in the Midlands heatmap for June 2025. Three trusts, including ULTH, are rated "blue.". Lincoln County Hospital specifically referred to. Strong leadership and collaboration in the Lincolnshire LMNS (Local Maternity and Neonatal Systems) Board were highlighted in the Perinatal Newsletter.
- **National Review and Benchmarking:** A rapid national maternity review has been initiated. Benchmarking by the Trust revealed no areas of concern.
- **Maternity Incentive Scheme:** Ongoing LMNS-led efforts aim to meet the scheme's safety requirements.
- **Insight Visits:** Assurance visits are currently in the process of being scheduled for September 2025, with terms of reference agreed.
- **Stillbirth Rates:** The ICB's stillbirth rate is higher than expected, but Trusts receiving Lincolnshire women (outside the county) report low rates. A deep dive is underway to investigate potential demographic or socioeconomic influences.

The Board considered the update.

Mrs Dunderdale commented that she was confident Mr Fahy meant to include Pilgrim Hospital, Boston when referring to ULTH, which was acknowledged as an oversight.

Professor Ward referred to quality in primary care and sought clarification on where this will sit in the future, acknowledging Mr Fahy might not be able to respond at the current time. Mr Fahy advised that at present he was not able to confirm the focus or lead for this area. Clarity is being sought on who holds formal oversight, and an update will be provided to the Board once the position becomes clearer.

The Board noted that rs Mills, Mr Fahy and Dr Hindocha absolutely understand the model that supports primary care improvement, and that intelligence will be fed into discussions.

Finance Section

Mr Gaunt presented the finance section of the report which covered the position as at month three and highlighted the following:

- Year to Date Position - The ICS reported a £11.2m deficit at Month three, which is in line with the submitted financial plan. The ICB reported a £1.1m deficit at Month three, also in line with its submitted plan. Workforce reductions are progressing but need to improve.
- Outturn Forecast - The ICS has a plan to deliver a break-even position against in-year allocations and income for the full financial year. At Month three, the ICS reported delivery of this plan.
-

Subject to approval by the Board at its next meeting

- Risks and Mitigations - The ICB has identified £19.5m of risk to delivery of its financial plan, with the main areas of concern being the delivery of the Cost Improvement Programme (CIP), prescribing, and Continuing Healthcare (CHC). Mitigations totalling £13.0m have been identified, resulting in a £0.4m adverse variance to plan.

The Executive Team have discussed the need to change approach and now entered into contract escalation, which potentially has sizeable implications.

Mr Gaunt advised that the ICB's contractual improvement target is completely defensible, and the organisation has completely adhered to the NHSE guidance; the only issue is 2025/26 we have not converted the productivity gains into a CIP (Cost Improvement Plan) target; hence now into contract escalation.

This position has been considered in considerable detail by the Finance and Resource Committee.

In summary, the ICB and ICS both delivered at month three, month four looks very challenging and could be up to as much as £2m off plan if nothing changes. CIP red rated schemes can hopefully realign.

The Board considered the contents of the report and subject to clarification on some of the wording in the report, agreed to:

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

GOVERNANCE

25/338 JOINT HIGHLIGHT COMMITTEE REPORT

Mrs Robson presented the highlight report from the ICB Joint Transition Committee Highlight Report.

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

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

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

All ICBs have received advice from the national legal team to amend clause 3.5 (Model constitution numbering) of the ICB constitution, so that they read to allow for joint CEO appointments for the clustering ICBs. The specific wording was set out in the report.

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

The Board agreed to:

- **Note the latest Joint Transition Committee Highlight Report.**
- **Approve the Joint Transition Committee Terms of Reference**
- **Note the amendment made to the ICB Constitution.**

25/339 COMMITTEE HIGHLIGHT REPORTS

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

System Quality and Patient Experience Committee

Mr Fahy presented the report from the latest System Quality and Patient Experience (SQPEC) meeting held on 23rd July and ran through the contents. The following areas were highlighted for the Board's information.

- System Quality Priority Register reviewed and confirmed to align with the Board Assurance Framework (BAF).
- Escalated items: acknowledge progress of pathways, ADHD (Attention Deficit Hyperactivity Disorder) and committed to review the Quality Strategy.

The Board considered the update. Dr Earnshaw queried whether the ICB has taken steps to assure the quality of private providers undertaking diagnostic services on its behalf. Mr. Fahy responded that a new range of providers is now in place, a clear due diligence process has been established and he is confident that the required level of assurance is in place, but this only applies only to providers directly engaged by the ICB.

Service Delivery and Performance Committee

Mrs Kenson presented a report which provided an update on the areas discussed at the Service Delivery and Performance Committee meetings held in May and June. The following points were highlighted:

- **Operational Plan Delivery:** Significant progress made with a unified approach (“one version of the truth”), credited to strong team development.
- **May Meeting:** One key risk identified - transition and Executive Directors' bandwidth due to competing priorities. This risk is now captured within the Board Assurance Framework (BAF).
- **June Meeting:** Urgent and Emergency Care (UEC) and Winter Planning Framework were reviewed and progressed.

Audit and Risk Committee

Mrs Robson provided a verbal report from the meeting of the Audit and Risk Committee meeting held on the 11th July 2025. The following points were highlighted for the Board's information.

- **Counter Fraud Annual Report:** The ICB is rated green against its 2024/25 Counter Fraud Workplan, meeting NHS Counter Fraud Authority standards.
- **New Legislation – Failure to Prevent Fraud Offence:** Effective 1st September 2025, organisations must show “reasonable” anti-fraud procedures to avoid liability. The Audit and Risk Committee will oversee compliance with the six Home Office principles.
- **Information Governance:** Quarterly Report: Cyber Assessment Framework-aligned DSP (Data Security and Protection) Toolkit submitted with ‘standards met’ and substantial assurance from TIAA auditors. Workplan Completion: All actions for June 2024–July 2025 completed; awaiting end-of-year report.
- **Primary Care Delegated Commissioning Review:** Final report provided reasonable assurance across General Medical, Pharmacy, Ophthalmic, and Dental services.
- **Year-End Audit Results:** Covered financial sustainability, governance, and efficiency. No material issues found in the NHS Lincolnshire ICB audit.
- **Audit and Risk Committee Forward Plan** for April 2025 to March 2026 received.

Mrs Pomeroy added that 2024/25 was the last year for the current External Auditors, namely Ernst and Young. The new auditors would commence later in the year, which is Mazars.

Mrs Kenson referred to the update on information governance and advised that the Committee had commenced the achievement of 95% compliance with the mandatory training and reiterated the point about the Counter Fraud Workplan submission, which was completely green rated. This was a really positive outcome.

East Midlands ICBs Joint Committee

Mrs Robson advised there was nothing to report to the Board in the public session.

The Board agreed to:

- **Note the Committee reports.**

INFORMATION/CLOSING ITEMS

25/340 ANY RISKS IDENTIFIED

The Board considered whether any new risks had been identified during the meeting.

Two risks were identified:

- Lack of assurance with CIP schemes.
- Risk around primary care quality, which would be addressed through the Joint Transition Committee.

25/341 DATE AND TIME OF THE NEXT MEETING

The next formal ICB Public Board meeting will take place on Tuesday, 30th September 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 29th July 2025

Topic: Population Health Planning / Digital Inclusion Strategy

Question 1:

"How does the ICB plan to ensure digital inclusion strategies directly support elderly, disabled, or digitally excluded patients in remote Lincolnshire areas who struggle with online access to prescriptions, appointment bookings, and healthcare communications? How can local businesses like xxxx offering face-to-face prescription logistics, partner to bridge this gap?"

Topic: Service Delivery and Performance / Integrated Care

Question 2:

"In light of the ICB's focus on improving community service delivery and integrated care, how is the Board addressing medication access delays for patients in isolated or pharmacy-deprived areas? Would the ICB consider working with trusted providers like xxxx to co-develop responsive medication delivery frameworks for those most affected?"

Topic: Health Inequalities / Community Support

Question 3:

"Given the ICB's emphasis on Core20PLUS5 and health equity, what role does the Board see for logistics partners like xxxx in supporting medicine access for underserved populations — including unpaid carers, new mothers, and people with sensory impairments who face difficulties collecting prescriptions or attending appointments?"

Topic: Governance / Sustainability and Innovation

Question 4:

"What mechanisms are in place to support the sustainability of small-to-medium enterprises like xxxx that provide innovative, person-centred healthcare services? Could the Board explore funding, commissioning, or partnership models that embed such services into Lincolnshire's long-term community care strategy?"

Topic: Healthwatch Feedback / Service Accessibility

Question 5:

"Recent Healthwatch reports highlighted transport challenges and service relocations affecting vulnerable patients. Could the Board consider supporting mobile or home-based pharmaceutical services to mitigate these impacts — particularly for elderly residents and those with mobility or income barriers?"

Response:

Thank you for your questions to the Board and for raising important themes around digital inclusion, medication access, and community support, particularly in relation to patients in rural and underserved areas of Lincolnshire.

As noted during the meeting, while the points raised relevant themes around digital inclusion, medication access, and community support, all of which align with the ICB's strategic priorities, they also reference a specific provider.

In line with the ICB's governance approach, it was noted that the organisation does not endorse individual providers. However, the themes raised will be considered as part of the ICB's ongoing work, and a written response will be provided following the meeting.

Question Two

Firstly, many thanks for answering my question from the previous Board Meeting on 26th May 2025, and for providing the written response published on pages 21/22 of this July's Public Board Meeting document, confirming that the Lincs Health and Care system do not dispense with any of the 4 types of intermediate care categorised by The National Audit of Intermediate Care, as laid out in the DHSC Care and Support

Statutory Guidance – these being 'crisis response', 'home-based intermediate care', 'bed-based intermediate care', and, 'reablement'. Extended thanks also goes to the input from the Local Authority, although the question posed was to Health and not the LA.

The question was intended to have been posed as a generic one, applicable to all, rather than a specific case, but I also thank you for your person-centric advice in this instance

I also note your closing comments in advising that PALS should be able to provide more specific details around the discharge process from your hospitals. Assuming that this is open to all, and not case specific, who should members of the public best approach in the event that PALS are not forthcoming with the information which you suggest?

PALS at Lincoln County Hospital have advised that they are "not involved in patient's care or (the) discharge process", so it would be prudent for members of the public to be made aware of who best to seek guidance and support from in your published response please.

Response:

The ICB's published response has been updated to reflect the following:

All of the ICB's system partners have a 'Contact Us' section on the websites. If PALS are not able to respond, members of the public can follow the NHS complaint process and or contact their local Healthwatch.

Failing that all patients can pick the phone and speak with primary care or the hospital or community team directly.

Not Delivered
In Progress
On Track to Deliver
Complete

ACTION LOG - PUBLIC

Date of Meeting:	Tuesday, 30th September 2025
Agenda Item:	1 (v)
Reporting Officer:	Dr Gerry McSorley, ICB Chair

Date of Meeting	Minute Number	Item	Action	Lead	Due	Updates	Status
29/07/25	25/333	Chair and CEO Update	Update response to a question from a member of the public at the May Board meeting.	Jules Ellis-Fenwick	August 2025	Response updated on the website.	Complete.
29/07/25	25/334	DPH Update	Professor Ward to provide the link to the Outcomes Framework document for circulation to the Board. Link to also be included in the minutes.	Derek Ward Jules Ellis-Fenwick	August 2025	Link circulated to the Board Members and also included in the minutes of the July meeting.	Complete.

Sent by email

Dr Gerry McSorley
ICB Chair
Lincolnshire Integrated Care Board

Julie Grant
Director of System Co-ordination and
Oversight, East Midlands
23 St Stephenson Street
Birmingham
B2 4JB

W: www.england.nhs.uk

31 July 2025

Dear Gerry

Annual assessment of Lincolnshire Integrated Care Board's performance in 2024/25

We are writing to you pursuant to Section 14Z59 of the NHS Act 2006 (Hereafter referred to as "The Act"), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making our assessment we have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that we have had with you and your colleagues throughout the year.

This letter sets out our assessment of your organisation's performance against those specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2024/25 financial year.

We have structured our assessment to consider your role in providing leadership and good governance within your Integrated Care System (ICS) as well as how you have contributed to each of the four fundamental purposes of an ICS. In each section of our assessment, we have summarised areas in which we believe your ICB is displaying good or outstanding practice and could act as a peer or an exemplar to others. We have also included any areas in which we feel further progress and performance improvement is required, detailing any support or assistance being supplied by NHS England to facilitate improvement.

In making our assessment we have also sought to take into account how you have delivered against your local strategic ambitions as detailed in your Joint Forward Plan. A key element of the success of Integrated Care Systems is the ability to balance national and local priorities together and we have aimed to highlight where we feel you have achieved this and where further specific work is required.

Thank you and your team for all of your work over this financial year, and we look forward to continuing to work with you in the year ahead.

Yours sincerely



Julie Grant
Director of System Co-ordination and Oversight – East Midlands

Cc: Dale Bywater, Regional Director, NHS England Midlands Region
Clair Raybould, Acting ICB Chief Executive, Lincolnshire Integrated Care Board

Section 1. System leadership and management

The ICB continued to confidently lead system working and integration, bringing together key partners to plan and deliver safe, effective, high-quality services to realise the collective ambition of improved health of the population. Of note is the excellent progress the ICB supported with United Lincolnshire Hospitals NHS Trust (UHLT) and Lincolnshire Community Health Services NHS Trust (LCHS), working as the Lincolnshire Community and Hospitals NHS Group, with the alliance group with the aim to deliver 'left shift' transformation.

The ICB demonstrated a sound understanding of the wider effects of its decision-making duty based on the 'Triple Aim' and is reflected in productive partnership working and effective public engagement. Governance processes continued to evolve and mature. Underpinning both the statutory and system governance arrangements are many joint working arrangements, including 'Better Lives Lincolnshire', that focus on delivery of care which supports the delivery of the "duty to have regard to wider effect of decisions" and the implementation of the 'Triple Aim'.

NHS England delegated direct commissioning functions for pharmaceutical, general ophthalmic services and dentistry to ICBs in April 2023. The ICB is a member of a formal Joint Commissioning Committee with 4 ICBs in the East Midlands to jointly exercise its delegated commissioning functions, which included some specialised commissioning services from April 2024. In August 2024, NHS England completed a primary care assurance framework which assessed the ICB as 'substantial', meaning that the ICB was discharging the delegated function safely, effectively and in line with legal requirements but one or two processes were not running effectively, exposing possible risk and issues in discharging the function. The ICB has continued to work towards 'full' assurance throughout the year.

All partners work collectively in strategic planning and decision-making including Lincolnshire County Council, voluntary, community and social enterprise. There continued to be comprehensive public involvement to progress the key priorities in the Joint Forward Plan with the objective to align the Health and Wellbeing Board and Integrated Care Partnership (ICP) by delivering the Joint Health and Wellbeing Strategy (JHWS) to avoid duplication or gaps in provision. Each strategy will continue to retain its own identity with the JHWS focusing on the 'what', i.e. the population health and wellbeing priority areas which the health and care system will focus on, based on the Joint Strategic Needs Assessment, and the ICP strategy setting out the 'how', i.e., the strategic enablers to support the delivery of the JHWS and the system's overarching strategic ambitions.

The system has a well-established Primary Care People Group with key stakeholders that agree the strategic Primary Care People Plan. The ICB brought together key stakeholders including PCNs, Community Pharmacies, NHS Trusts and Voluntary, Community and Social Enterprise providers.

The ICS consolidated the role of the Clinical and Care Directorate which includes senior clinicians and care sector leaders from medicine, nursing, allied health professionals, and adult and children's care services. Members have a mandate from their organisations to make decisions regarding transformation of pathways with the aim of reducing duplication, implementing best practice improving care.

The ICB continued to show excellent leadership for children and young people (CYP), with a cohesive team across the organisations working for children. CYP Boards are attended by regional leads and there is good communication of risks, challenges and highlights. The CYP Integrated Transformation Board continued to provide strategic oversight of services in Lincolnshire with the aim of transforming pathways across health and care incorporating education. The Board facilitates everyone working together, ensuring the voice of children and families is heard. The Board is aligned to the ICS and Long-term Plan with the aim of maximising health and wellbeing, reducing health inequalities and supporting a seamless transition into adulthood.

Section 2. Improving population health and healthcare

Overall, the system improved on most of its key metrics in 2024/25 but missed its plan ambitions in some cases. The system re-entered tiering performance management arrangements for planned care and diagnostics, cancer, and urgent and emergency care (UEC).

For the Cancer 62-day standard, the system delivered 71.3% against a plan of 70.3%, with a backlog position that has not materially changed since the previous year. It was encouraging to see that the Faster Diagnosis Standard (FDS) did perform well at 78.1% v a 77% plan, improving by 6.5% over the year.

Within elective, the system did not deliver its plan to achieve zero 65-week waits, with 11 at year end, however, it is recognised that it was close to delivery. Industrial action impacted delivery in the early part of the year, however, there was an improvement in the latter part of the year. ULHT was placed in performance Tier 2 in Quarter 3 2024/25 and exited in Quarter 4. Elective and cancer care delivery against plan remain an important focus for 2025/26.

We are encouraged to see the improvements made to your Adult Community Pathways, which have met the requirement of the Operating Plan to reduce Waiting List sizes and improve the number of 'Over 52 Week Waits'. However, the year-end outturn position does show growth on your CYP Community Pathways, therefore, you did not meet national expectations.

For Diagnostics, performance for those waiting less than 6-weeks was 75.5% against a plan of 92%. UHLT was placed in Tier 2 in Quarter 3 2024/5.

For UEC, Lincolnshire remained in Tier 2 for the whole year. There were aspects of strong performance to note, for example Lincolnshire was the seventh most improved A&E 4-hour performance during the year nationally, work on Winter Planning was exemplar and urgent treatment centres (UTC) are considered 'best practice'. However, key metrics were not delivered, and tiering remained in place. 12-hour waits improved to deliver 4.1% in March 2025 against a national target reduction to 5%. A&E 4-hour (all types) performance delivered 78.3% in March 2025 against a national target of 78%.

Strategically, the development of the Value Framework approach which aims to assess value and tackle prevention, and health inequalities was used to delivery elective recovery and a focus on CYP. It also supported difficult decisions during the development of the 2025/26 operational plan.

Lincolnshire holds a monthly Mental Health and Learning Disability Alliance and Autism Alliance executive meeting, with ICB and provider representation, for which there is good engagement. Areas of good practice include community Mental Health and Dementia diagnosis rate. Talking Therapy performance has improved over the year meeting national ambitions. Mental Health Support Teams are recognised following a National positive practice visit. The ICB faces a 2025/26 challenge in CYP access and didn't deliver against plan and should remain an area of focus for 2025/26.

Regarding Learning Disability and Autism, there is mixed evidence relating to the delivery of expectations in 2024/25, with variable performance across the indicators. The ICB delivered its 2024/25 plan for adult in patients, but the plan did not meet NHS England's expectations. The ICB also delivered the greatest in year reduction of adult inpatients (-25%). The ICB performed well in relation to CYP, although narrowly missed the target. Performance was below expectations in relation to pre- and post- admission Care and Treatment Reviews (CTRs) and in relation to LeDeR reviews and long-term segregation. Autism waiting times continue to be a challenge across the system and wider region. Annual Health Check performance was positive, with 98% receiving a health action plan. The ICB has been awarded NHS England capital for an accommodation scheme. However, there have been delays in identifying a suitable site as well as procurement for a provider.

Initiatives such as improved digital weight management and the Public Health-commissioned Integrated Lifestyles Service have been embedded as 'business as usual'. Vaccination performance continued to be high, with inclusion health work ongoing with key populations.

The ICB has a strong emphasis on quality to ensure that health services in Lincolnshire are of high quality and effective. The well-established Quality and Patient Experience Committee maintained oversight of the quality functions and responsibilities of the ICB, supported by the ICS Quality Group. In support of these, the ICB has two quality oversight groups - one for primary care and one for other providers. There are various initiatives and policies in place to support this, including an Incident Reporting Policy, a Quality Mark for learning disabilities, and a Performer Accreditation Policy.

Revised arrangements were implemented to oversee the prevention and health inequalities agenda at a system level. The System Quality and Patient Experience Committee maintained oversight of the ICB's quality functions and responsibilities. The ICS System Quality Group identifies and escalates issues, provides assurance, identifies themes and improvement support to system partners. Key themes were identified for specific focus in 2024/25 including UEC, reducing treatment delays across all pathways, palliative and end of life care, health protection, implementation of the Patient Safety Response Framework, CYP (including safeguarding) and continuation of work related to reducing pressure ulcers, falls prevention & response and workforce.

The ICB discharged its functions in line with the suite of national Standard Operating Procedures for the Safeguarding programme responsibilities and worked with strategic partners on the Children's Social Care reform pilot, with Lincolnshire as a wave one site. The ICB leads this work, and are presenting regionally and nationally, supporting other systems. The ICB Safeguarding Team has a high-profile visible Designated Doctor and strong Designated Nurse.

The ICB supported the system to develop the Health Inequalities framework to support the shift in care from an acute to community setting. The Health Inequalities strategy elements are embedded within the ICP and JFP documents. A Digital Inclusion Strategy is in the final stages of approval and will be published in 2025/26.

The Alliance model is now the key enabler for the Lincolnshire Community and Hospitals NHS Group to support delivery of the Department of Health 'Road to Recover' initiatives focussed on moving care from hospital to community, sickness to prevention and analogue to digital. The Alliance consists of three core areas: a partnership space to work with key partners in an innovative way to drive 'left shift'; transformation programmes of key services to deliver in community settings that do not need to be provided in an acute setting; and restructured care groups creating an alliance care group to host clinical support services excluding outpatients and cancer services.

Section 3. Tackling unequal outcomes, access and experience

The 'Statement of information on Health Inequalities' report published in June 2025 demonstrates how you are meeting the duties to understand the health inequalities in Lincolnshire and how to reduce them.

During 2024 there were significant challenges in the context of equality, inclusion and human rights, both locally and nationally. However, the ICB showed clear leadership during this disruption taking clear and demonstrable actions to support staff and patients, clarify the stance on zero-tolerance to racism, bullying and harassment and violence, highlighting the range of support available.

The Equality, Inclusion and Human Rights Annual Report 2024/25 demonstrates compliance with the Workforce Disability Equality Standard, Workforce Race Equality Standard and Equality Delivery System. Total scoring for 2024/25 was 26, which is an improvement on last year. The ICB is at the 'achieving' level.

Strategically, Lincolnshire's JFP recognises the role prevention can play in reducing health inequalities and increasing health equity. The ICB focused on promoting healthier lifestyles through the "Start Well, Live Well, Age Well" approach, supporting the development of the system-wide Prevention and Health Inequalities Executive Group between the NHS and Local Authority, with wider system partners. The Health Inequalities and Prevention Programme Board provided the necessary governance and decision-making framework for the programme, to ensure the delivery of its outcomes and benefits.

The Health Inequalities Framework for Action, developed in partnership with stakeholders, set out the principles which underpin this work and how the ICB will use resources to take practical action to reduce health inequalities and provide exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes in key areas of work. There is a clear approach to implementation of CORE20plus 5 programme and groups informed by Joint Strategic Needs Assessment and population health management data, supported by 5 ambassadors, the PCN Health Inequalities leads network, embedding Health Equity Impact Assessment Tools and Equality Impact Assessments into 'business as usual' working in partnership with local providers. The Health Inequalities and Prevention bulletin is produced and shared locally.

Plans were developed to address inequalities in the UEC pathway, using a collaborative data driven approach and engagement with service users, tackling inequalities in access to CYP Mental Health services, using a data driven approach and focussing on prevention and early identification.

Smoking cessation services are embedded in acute, community, mental health and maternity settings, with the position around smoking at the time of delivery having improved. Lincolnshire has the second highest number of quits in an acute provision nationally.

The Diabetes Prevention Programme oversaw the pathway in maternity services to facilitate referral for women with history of gestational diabetes.

Despite Lincolnshire having had the third lowest referral rate into the Digital Weight Management Programme nationally during the previous year, it was encouraging to see that during 2024/25, rapid progress was made in the number of eligible referrals into the programme, with the eligible referral rate consistently over 90%.

The Lincolnshire Maternity and Neonatal System produced an Equity and Equality Strategy to reduce health inequalities to improve equity for pregnant women from at-risk groups, including Black and Minority Ethnic (BAME) women and those living in the most deprived areas. This initially focuses on the largest groups experiencing the greatest inequalities and will move on to smaller geographic and population groups over time.

Women's health hubs were established 2024/25, however following review, activity ceased at the end of March 2025. However, the system has committed to developing and implementing plans to improve the healthcare of girls and women and reduce inequalities, and plans for 2025/26 include increasing the number common gynaecological conditions managed in the community

Lincolnshire Women's Health Conference involved patient experiences, presented community conversations and online feedback which has been used to launch the women's health app, virtual menopause workshops and GP women support services.

The Lincolnshire Living with Cancer Programme won the 2024 Royal College of Physicians 'Eric Watts Award for Excellence in Patient Participation and Engagement'.

Section 4. Enhancing productivity and value for money

It was disappointing that the system 2024/25 outturn was a deficit of £26.7m against a breakeven plan. The ICB delivered a deficit of £9.5m, £14.2m worse than plan. The ICB retained a planning

surplus to ensure it was able to balance finances across the system in 2024/25 but the level of pressures both within the system and main provider meant that despite good intentions and system collaboration, as demonstrated in previous years, it was unable to achieve plans. Total system efficiency delivery was £81.6m against the plan of £84.7m. The ICB delivery was £26.2m against a plan of £28.9m underachieving recurrent efficiencies by £2m. The system was 18.4% below 2019/20 productivity level but 1.5% up on 2023/24.

The ICB met the planning guidance requirements in relation to agency by achieving spend as a % of total pay against the baseline planned pay of 3.7%. Universal support included off framework removal and price cap spend reduction for Nursing and Allied Health Professionals staff groups. Good practice was seen with nurse rostering and medical bank.

However, evidence suggests that the ICB and system have not been realising all the Productivity and Efficiency opportunities available during 2024/25 and stronger focus is required in this area. New Implied Productivity Growth (YTD compared to the last year) is 1.0%, i.e. 1.0% more productive. New Implied Productivity Growth (YTD compared to 2019/20) -18.1%, i.e. 18.1% less productive

The ICS has a clear Research and Innovation Strategy with four principles aligned to national and local priorities, with goals to be delivered by 2029 and detailed implementation plans. Achievements of note during 2024/25 include the partnership with University of Lincoln to establish England's first integrated/transdisciplinary research centre for Coastal and Rural Health Research. This centre is tackling serious and urgent geographical inequities impacting on physical, mental, social, and economic health and wellbeing. Collecting and mapping high level information on key activities, workforce, infrastructure etc at each of ICS's organisations to support innovation and research is a priority piece of work, however, there is limited detail on progress and specific actions in relation to this project.

The ICB has a Strategic Research and Innovation Leaders Group with members from across the health and care system. This group has strategic and operational functions and oversees the progress of the ICS Research and Innovation Strategy and meets monthly.

The ICB piloted the Foundation Research Training programme in 2024 and has secured additional funding from the Regional Research Deliver Service (RRDS) and Lincolnshire County Council for redelivery of this programme. The ICB's Clinical and Care Directorate established an ICS Research Lead and a dedicated Project Support Officer.

The ICB continued to actively oversee and support digital maturity initiatives, including the strategic adoption of the Federated Data Platform (FDP) and planning for its system-wide utilisation. The ICB demonstrated delivery against its digital maturity plans in 2024/25. ULHT went live with the Care Coordination Suite for Inpatients and Outpatients via the FDP, demonstrating active product adoption and utilisation of a key FDP capability. ULHT is currently onboarding Optica onto the FDP. This represents substantial progress in establishing a modern, integrated data infrastructure and directly contributes to enhancing digital maturity within the system. Aspirations for 2025/26 include the continued effective utilisation and optimisation of these FDP products along with full onboarding of Optica and further embedding of FDP capabilities across the wider system.

The ICB successfully guided the transition from analogue to digital during 2024/25 in both primary care digitalisation and acute trust system implementation. All eligible GP Practices have successfully transitioned to high-quality cloud-based telephony. Online Consultation (OC) tools are available to all General Practices, with contractual arrangements secured for 2025/26 and ongoing work to ensure availability during core hours. The NHS App is promoted at ICB and local level, with uptake and usage continuing to increase at pace. Practices are actively refining processes based on new digital data availability. For secondary care, ULHT is procuring a new EPR with a planned go-live date in November 2026, indicating a major ongoing transformation.

In diagnostics, the system has progressed in the deployment of Pathology LIMS. This platform is planned to serve as the converged platform on which other trusts within the network will onboard when legacy contracts allow. For 2025/26, key expectations include continued progress on the ULHT EPR procurement and deployment, and the progressive onboarding of other trusts to the converged pathology LIMS platform.

Section 5. Helping the NHS support broader social and economic development

There is a history of joint working in Lincolnshire between the Local Authority, the NHS, and wider partners. The ICB demonstrated commitment in delivering engagement at all levels from working with community leaders at a neighbourhood level, through partnership working such as Lincolnshire's ICP – 'Better Lives Lincolnshire'.

Healthwatch and the Voluntary and Community Sector are integral members of Lincolnshire's ICB and ICP Boards, participating in various committees. Public Health and the Local Authority representatives also sit on the ICB. A representative of the Voluntary and Community Sector is also an integral member of Lincolnshire's ICB Board, an associate member on the ICP Board is on various committees alongside Public Health and Local Authority representatives sitting alongside representatives at every ICB board formally.

The ICB had a good spread of engaged members at their regular Green Board which helped embed the partnership ethos as well as engaging providers in their specific focus areas of work. The SRO remains an active member of the Midlands Green Board. Progress was made on most targets, despite not meeting several of these (for example nitrous oxide emissions reduction of 3.8%, not the 9% requirement, inhaler emissions reduced by 2.4%, against a planned 6%). It is noted that the system will face challenges with producing a Green Plan as per their statutory requirements due to uncertainty of the future operating model and other local changes. The ICB continues to work with its partners to make progress against core sustainability priorities such as reducing medical emissions and meeting use of low-emission vehicles targets.

The ICB undertook significant work, providing system leadership to deliver the Home Office requirement to plan for the provision of health services to asylum seekers at RAF Scampton and more recently Afghan refugees settling in the UK at Beckingham College. RAF Scampton was not mobilised, and Beckingham is due to close in June 2025, although the efforts of the ICB and system partners are commended.

Work continued to support the needs of the Armed Forces and veteran populations of Lincolnshire. The ICB hosted an annual symposium in June 2024, bringing together a wide range of partners at RAF Cranwell, to consider the specific needs of these groups and develop improved services.

The Lincolnshire ICB Prioritisation framework sets out the ICB's role as an anchor institution in improving social isolation by provision of local support network, the environment, e.g., use of CFC inhalers, reduction in pollution and economic productivity, e.g., enabling early return to employment, through four main objectives within the framework.

Conclusion

In making our assessment of your performance we have sought to fairly balance our evaluation of how successfully you have delivered against the complex operating landscape in which we are working. We are keen to continue to see progress towards a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them. We will continue to work alongside you in the year ahead, and we look forward to working with you to support improvement and performance throughout your system.

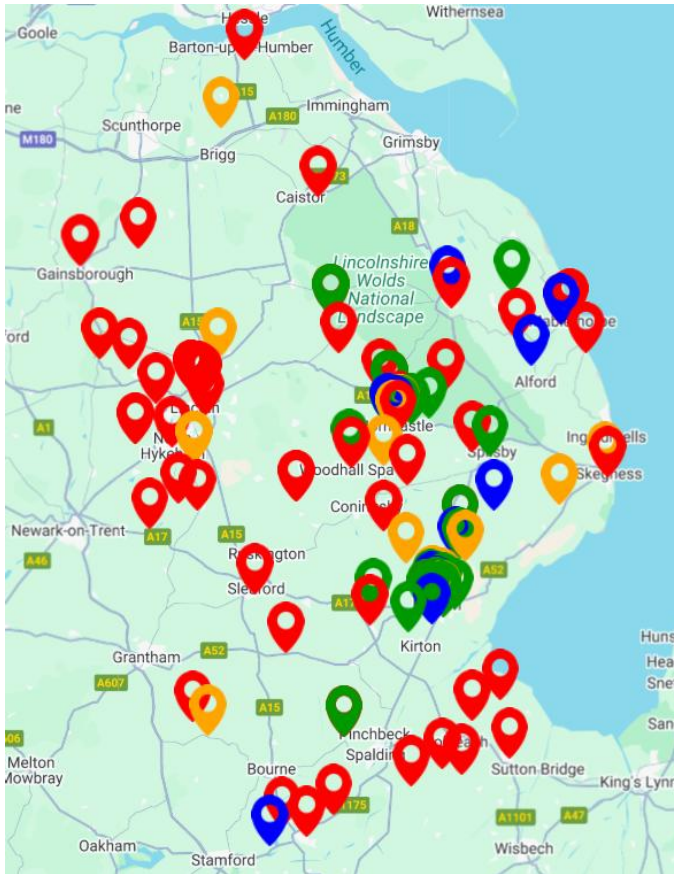
We ask that you share our assessment with your leadership team and consider publishing this alongside your annual report at a public meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments in line with our statutory obligations.



ICB Update Healthwatch September 2025

healthwatch
Lincolnshire

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



Location mapped using service postcodes.

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

July and August 2025

Between July and August 2025, **186** people shared their experiences of health and social care with us. An additional 61 (total 210) people shared their views through our carers and care home managers research project.

Out of the 186 experiences shared with our Information Signposting Service, **52% were negative** and **21% were positive**. The remaining were neutral, mixed or unclear.

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

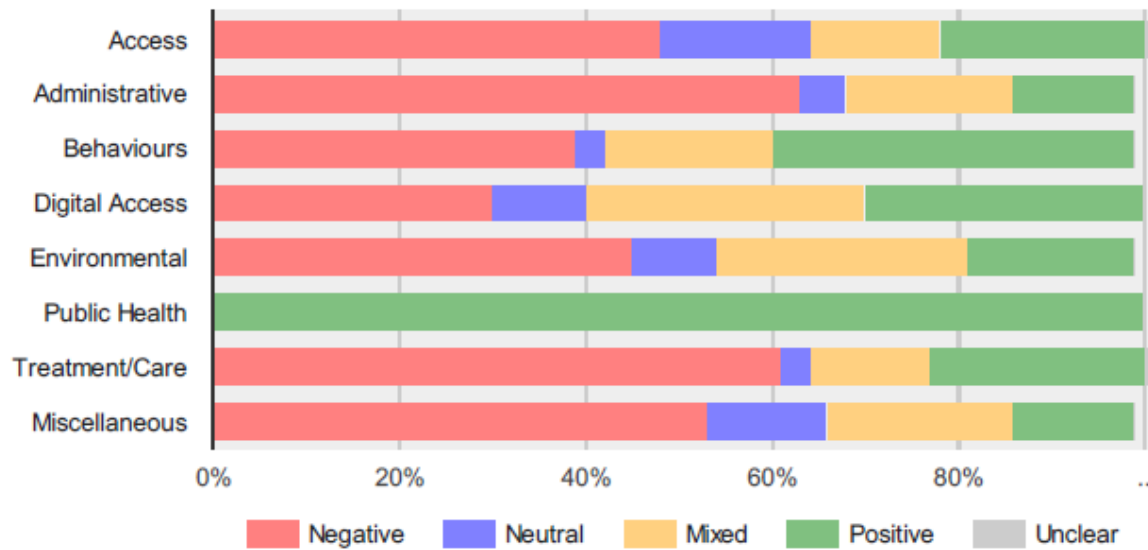
- All Hospital Services (52%) - (8% of all comments were about A&E)
- GP Services (51%)
- Mental Health (10%)
- Social Care (9%)
- Dentistry (4%)
- Patient Transport (4%)

*Some comments relate to multiple service areas.

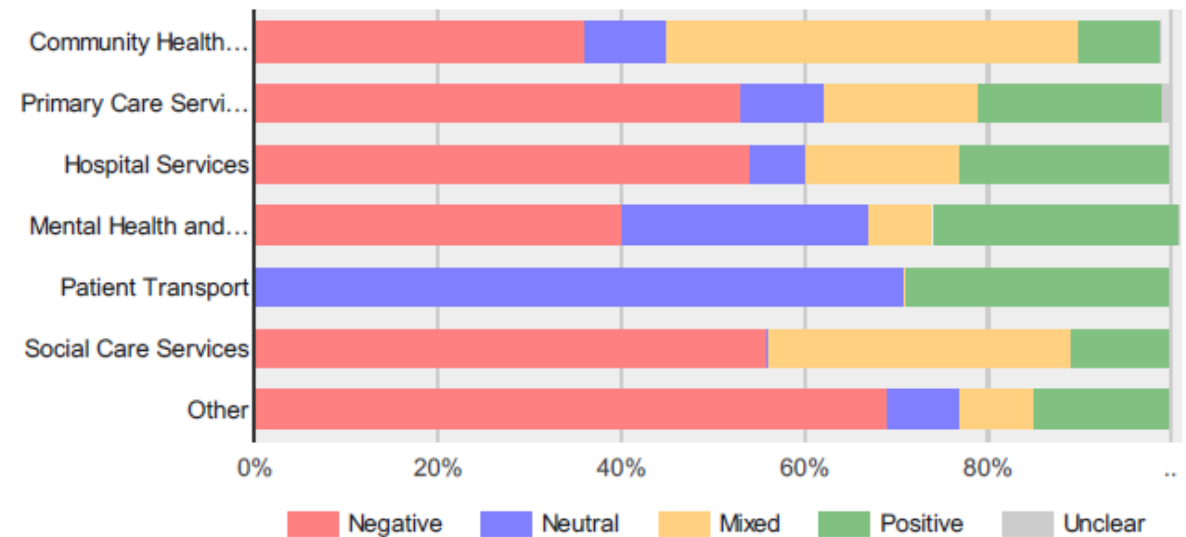


IMP sentiments and themes

Satisfaction by Theme



Satisfaction by Service Type



A&E waiting times

LincsOnline reported: *We have heard reports of patients waiting nearly 30 hours in Boston's Pilgrim Hospital while the waits at Lincoln County A&E have been even longer.*

We continue to receive comments about public concern around **long waits in A&E** across Lincolnshire.

Healthwatch Lincolnshire recognise and acknowledge the **suite of system-wide actions** being taken.

Healthwatch Lincolnshire will continue to seek assurance and receive updates through System Quality Patient Experience Committee.



Moving between child and adult services

18 year old who is palliative after having a rare heart condition all their life.

Carer shared the consistent struggles with accessing care between ages 16 - 18 whilst transitioning from children's to adult services.

"Paediatrics, say they are too old for them, so go to adult services and they say they are too young for their services, they need to be 18. They needed an operation and therefore needed an anaesthetic; no-one would do it neither paediatrics or adults."



Positive experiences

"Found breast lump one day. Saw GP next day. Hospital appointment in 7 days. Diagnosed within 4 weeks.

Only concern was from diagnosis to operation was 3.5 months.

*All staff have been very polite, kind and respectful and reassuring." – **The Deepings Practice***



"I had a thyroid scare and due to my ADHD I kept forgetting to call at 8am for an appointment. The surgery receptionist was very helpful and kind and made me an out of hours appointment for me in Alford.

The Doctor there was very kind and patient and sent me for blood tests and a scan. I was able to get the tests done the very next day and the scan just a few days later.

*Everyone was very patient with me and kind, but also efficient and I really appreciated the respect and compassion shown by all. The surgery in particular, they have recently undergone a much needed change in management and I was really pleased with how I was treated and the care I received." – **The Spilsby Surgery***

Positive experiences – Boston Pilgrim Hospital

“Chemotherapy Suite. Excellent service.”

“Breast clinic. Quick appointment. Very good communication. Nice staff.”

“Ward 7b. My parent received exceptional care at Boston Hospital in Lincolnshire. I cannot fault it.”

“A&E. Lovely new cubicle and lots of space. Staff very helpful – soon on my way.”

“Gynaecology. All went well. 3 named professionals were all lovely. Explained everything that needed to be done, very caring and professional.”

“Sent to X-Ray by my GP. Brilliant, clean, staff lovely and seen on time.”





78% (117) of carers had struggled over the past 12 months.

153 carers shared their views.

Challenges faced by carers



Loneliness and social isolation



Impact of caring on physical and mental health



Difficulties navigating the care system



Unaware of support available



Eligibility issues
(especially for financial help)



Difficult getting help



72% (99) did not feel supported as a carer.

Poor recognition of carers, their role, its challenges and impact

Carers often felt people did not understand what it was like being a carer:

- The impact it has on mental and physical health
- How hard it is finding support
- Financial struggles and the impact of the rising costs
- Guilt
- Loneliness.

We did find positive differences from those who had accessed the Lincolnshire Carers Service compared with those who had not



Challenges faced by care homes

Access to services



Dental services



Phsyios/OTs



Mental health services

Hospital discharge



Issues included:

- Poor communication
- Missing or incomplete paperwork
- Rushed discharges
- Discharged in the middle of the night
- Missing equipment and medication

57 care home managers shared their views.



60% (28)
not aware of the
**Community
Dental Services
(CDS) pathway.**

Praise for the Clinical Assessment Service (CAS) (urgent and emergency care)

“There is a marked improvement in urgent or out of hours care. Recent excellent example where a resident was kept in the home and avoided hospital admission.”

“The CAS service is very responsive.”



Current priorities

Sensory Impairment

In collaboration with ICB and LCC our focus has been on people with sight and/or hearing loss about:

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

Next steps

Our insights will support LCC learning and the ICB future engagement

GP Report: Co-produced final report with ICB , including You Said, We Did responses

Mental Health report: In review with LPFT

YourVoice@Healthwatch Event (Boston):
Date: Thursday 30 October, 10am – 1pm
Social Care focus, sharing our carers and care home managers report, Lincolnshire Carers Service and ILS consultation



State of Health, Care and Wellbeing in Lincolnshire – Barometer Survey

A population wide survey launching soon to take the **pulse of health and care** across the county.

We'll be asking about:

- Quality of care
- Experience with staff
- Overall satisfaction
- Access to services
- What works well
- What could be better

Linking in with the national Healthwatch England State of Health and Care Report.

We'll cover the following areas:

- Health Services
- Pharmacy Services
- Dental Services
- GP Services
- Social Care
- Wellbeing Services
- Community & Voluntary Sector

In collaboration with system partners including LCC, ICB, Our Shared Agreement, provider organisations and Voluntary organisations across Lincolnshire.

Results will be presenting at our VOICE Conference 2026.

Local Healthwatch Update

National Petition

Approx. 8,000 signatures and high return on local support (map)

Early Day Motions

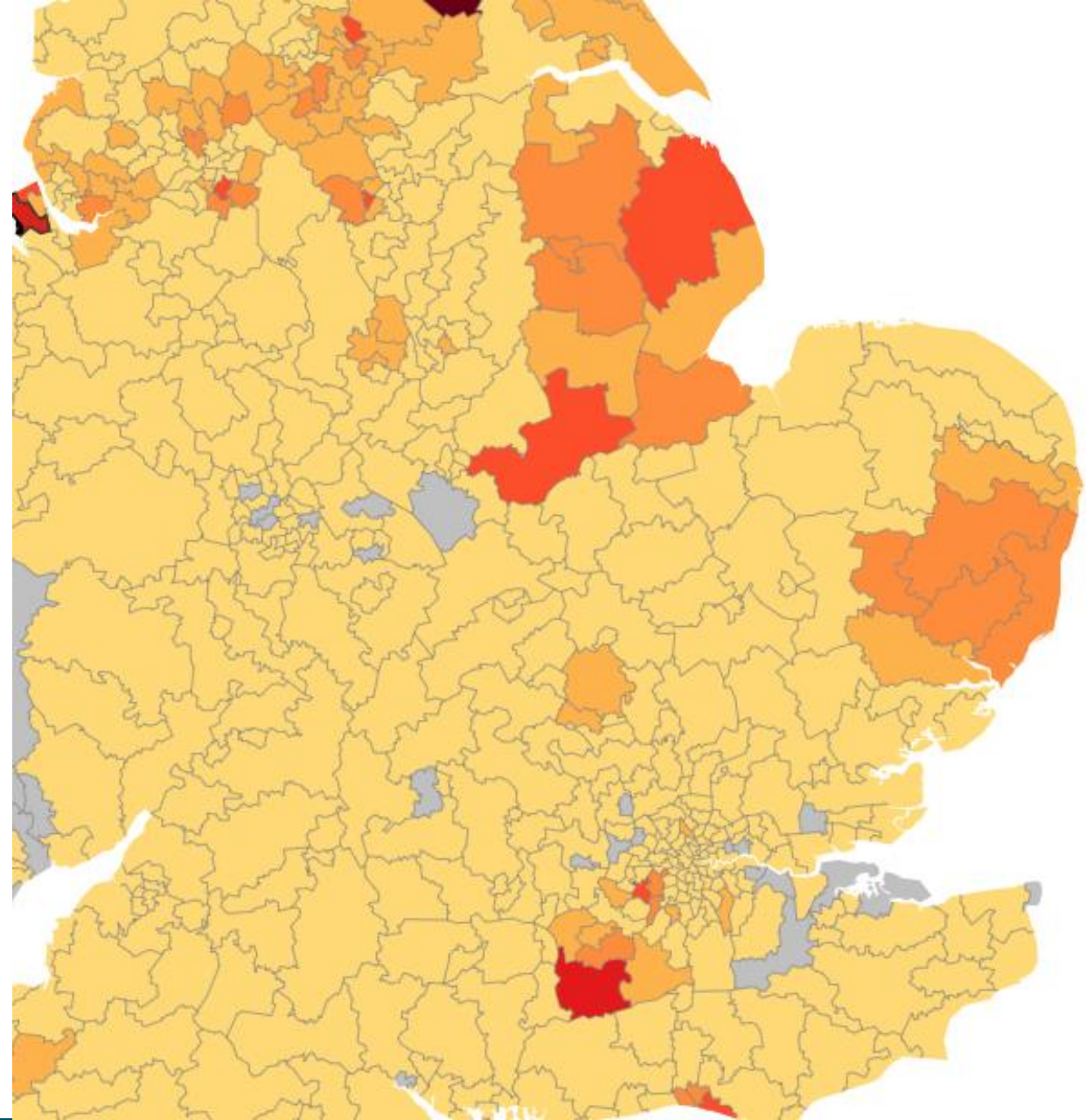
Two parliamentary EDM's tabled to raise concern around independent patient voice

Open Letter

Wes streeting officials to work with LHW

NHS England

Healthwatch England CEO appointed to NHSE Board



Accessibility (East Lindsey)

Purpose

To better understand the accessibility needs of people who live in or visit East Lindsey (part of East Lincolnshire). The feedback will be used to identify areas for improvement in accessibility.

Who It's For

Residents of East Lindsey and visitors to the coastal towns (e.g. holidaymakers, people visiting family/friends)

Survey link

<https://www.smartsurvey.co.uk/s/FLCZNU/>

Hidden Voices

Engagement: June 2025 – December 2025

95 armed forces personnel from the communities of interested have now fed back. We are pulling together focus groups and interviews to direct the development of future support and resources.

Communities of interest are Armed Forces Personnel who are specifically:

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

For more information

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healthwatch
Lincolnshire

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	4 (i)
Meeting Date:	30 th September 2025
Title of Report:	Statement of Information on Health Inequalities
Report Author:	Mrs Emma Townend, Interim Health Inequalities Programme Lead
Presenter:	Mrs Sandra Williamson Director of Health Inequalities, Prevention & Regional Collaboration
Appendices:	Appendix 1: Statement of Information on Health Inequalities Summary Report Appendix 2: Presentation Lincolnshire Health Inequalities Statement of Information Slides

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

- Approve the report to be published on the ICB website alongside the ICB Annual Report in September 2025.
- Note the priority actions for 2025/26 which will continue to be updated on as part of the operational plan delivery update.

Summary

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

NHS commissioners (NHS England and ICBs) are under specific legal duties to take account of health inequalities issues in the exercise of their functions.

Under duty s.13SA of the National Health Service (NHS) Act 2006 NHS England published (27th November 2023) its first Statement on Information on Health Inequalities which sets out requirements for ICBs (and trusts) to collect, analyse and publish information relating to health inequalities for the periods 2023/24 and 2024/25.

ICBs and Trusts are required, in their annual reports, to review the extent to which they have exercised their functions regarding the Statement and explain whether the information has been published, summarise the inequalities it reveals, and state how the information has been used in the relevant period to guide action.

This is the second statement on Health Inequalities produced by Lincolnshire ICB and will sit alongside the ICB Annual Report 2024/25, which describes our system wide approach to addressing inequalities in health and inequalities in healthcare. Underpinning all our approaches is the need to ensure we are collecting accurate and complete information.

The information contained within the summary report provides a comparison to baseline performance in 2023/24 and demonstrates where improvements have been made and where inequalities have worsened. It also identifies areas of focus to understand why those inequalities exist and what action is planned to address them in 2025/26.

While the work reported looks at the needs of many key groups it does not cover others which have been identified as Lincolnshire Core20PLUS groups such as people who are homeless, military personal and their families, military veterans and those from Gypsy Roma Traveller backgrounds or who are refugees. We are working with Business Intelligence and partners to further develop the Lincolnshire joint linked data set to include inclusion health in future statements on inequalities.

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

<p>Aim 1: Improve outcomes in population health and healthcare.</p>	<p>The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency and support ICBs and Trusts to use the data to shape and monitor improvement activity and drive improvement in the provision of good quality services, improving population outcomes and reducing healthcare inequalities.</p>
<p>Aim 2: Tackle inequalities in outcomes, experience and access.</p>	<p>Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which people are born, grow, live, work and age. These conditions influence how people think, feel and act and can affect both physical and mental health and wellbeing.</p> <p>Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs.</p>

	<p>NHSE's Healthcare Inequalities Improvement Programme vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes".</p> <p>Lincolnshire's Health Inequalities Programme Vision is "to increase life expectancy and quality of life for people living in Lincolnshire and reduce the gap between the healthiest and least healthy populations within our county".</p> <p>The duty to report on information on health inequalities enables the ICB to understand more about the populations it serves. Identifying groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and delivering targeted action to reduce healthcare inequalities.</p>
<p>Aim 3: Enhance productivity and value for money.</p>	<p>There is a clear business case for improving equity and that reducing health inequalities can even contribute to an improved financial position both in the short term and long term. For example focusing on understanding the reason for did not attends or could not attend in outpatients setting which are having an impact on Trusts productivity – may be as result of need for interpretation, or transportation issue and with some interventions to address the issues may not involve significant sums of money to fix could see a major reduction of was-not-brought within three months (example shared from a case study of Birmingham Women's and Children's NHS Foundation Trust).</p>
<p>Aim 4: Help the NHS support broader social and economic development.</p>	<p>Michael Marmot's work that calculated the treatment costs of health inequalities to be in the region of £5.5bn a year. Productivity losses in the economy due to health inequalities amount to £33bn, while a further £32bn a year is spent on higher welfare payments. Add to this the fact that those from the most deprived areas with lower life expectancy also exhibit the highest healthcare costs – helps support the social economic case.</p>
<p>Conflicts of Interest</p>	<p>Summary of conflicts</p>
<p>No conflict identified</p>	<p>N/A</p>

Risk and Assurance			
Risks are managed within the Health Inequalities Programme governance arrangements.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	Yes, resource to support ongoing monitoring will need to remain.		
Does the report highlight any quality and patient safety implications?	No		
Does the report highlight any health inequalities implications?	Yes – details provided within the appendix		
Does the report demonstrate patient and public involvement?	The Statement on Information on Health Inequalities includes a duty to publish information on health inequalities within or alongside annual reports in an accessible format.		
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:			
ICB Service and Performance Delivery Committee 24 th September 2025			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

Statement of Information on Health Inequalities Performance Summary Report



Lincolnshire
Integrated Care Board

Confidential - Sensitive Information.



Statement of Information on Health Inequalities Performance Summary Report

This document provides a simple summary of how well NHS Lincolnshire's Statement of Information on Health Inequalities is being delivered. It identifies indicators within the Statement of Information on Health Inequalities that are performing well and those where improvement is required.

Each indicator is stratified by Sex, Age Group/s, Deprivation Decile/Quintile, and Ethnicity. For further information and more detailed analysis, please consult the full Lincolnshire's Statement of Information on Health Inequalities.

An indicator is 'On Target' if there is a significant difference between sub-groups (such as least deprived and most deprived populations, or by sex) as measured by statistical testing and there has been a narrowing of the gap between sub-groups between 23/24 and 24/25.

An indicator is 'Off Target' if there is no significant difference between sub-groups (such as least deprived and most deprived populations, or by sex) as measured by statistical testing – even if there is a narrowing of the gap between sub-groups between 23/24 and 24/25.

An indicator is a 'Risk (off target)' if there is a significant difference between sub-groups (such as least deprived and most deprived populations, or by sex) as measured by statistical testing, and there has been no widening or narrowing of the gap between sub-groups between 23/24 and 24/25.

An indicator is a 'Risk (on target)' if there is a no significant difference between sub-groups (such as least deprived and most deprived populations, or by sex) as measured by statistical testing, and there has been no widening or narrowing of the gap between sub-groups between 23/24 and 24/25.

This report complements the data and analysis in the full and summary reports of NHS Lincolnshire ICB's response to the Statement of Information on Health Inequalities.

Statement of Information on Health Inequalities Performance Summary Report

Elective Recovery

On target	<ul style="list-style-type: none"> ✓ Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Age ✓ Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Sex, by Deprivation Quintile 	<ul style="list-style-type: none"> ✓ Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Sex ✓ Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Age ✓ Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Deprivation
Off target	<ul style="list-style-type: none"> • Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Sex • Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Age (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) • Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Deprivation 	<ul style="list-style-type: none"> • Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Sex • Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Deprivation (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) • Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Age
Risks	<ul style="list-style-type: none"> • Elective activity vs. pre-pandemic levels for CYP and adults by Sex (risk – off target) • Elective activity vs. pre-pandemic levels for CYP and adults by Deprivation (risk – off target) • Elective activity vs. pre-pandemic levels for CYP and adults by Ethnicity (risk – off target) 	<ul style="list-style-type: none"> • Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Ethnicity • Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Ethnicity • Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Ethnicity • Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Ethnicity
<p>Progress on identified actions from 24/25</p> <ul style="list-style-type: none"> • Health Inequalities LCHG working group set up with improved ethnicity coding identified as a key area of work. • Over 65 week waits for ENT reduced from 233 in April 2024 to 3 at the end of March 2025. • CYP ENT over 52 week waits reduced by 27% from a peak in August 2024 to March 2025. This has reduced further into 25/26. • A pilot project using algorithms to predict patients' likelihood of not attending their appointment was successful and further roll out is being explored for 25/26 		<p>Agreed actions for 25/26</p> <ul style="list-style-type: none"> • Enhancing the accuracy and comprehensiveness of ethnicity recording. • Investigate and address waiting list inequalities between male and female patient waiting times. • Targeted work on reducing the number of CYP missed appointments in ULTH. Missed appointments are almost twice as prevalent in the most deprived population. • Develop Health Inequality focussed plan based on Reforming Elective Care for Patients NHSE guidance.

Statement of Information on Health Inequalities Performance Summary Report

Urgent & Emergency Care

On target	✓ Emergency admissions for under 19s by Sex	
Off target	<ul style="list-style-type: none"> Emergency admissions for under 19s by Age (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) 	<ul style="list-style-type: none"> Emergency admissions for under 19s by Deprivation Decile
Risks	<ul style="list-style-type: none"> Emergency admissions for under 19s by Ethnicity 	

Progress on identified actions from 24/25

- Health Inequalities LCHG working group set up with improved ethnicity coding identified as a key area of work.
- Local Asthma dashboard created to identify trends.
- Using PHM, an Asthma workplan was developed which includes reducing UEC attendances for Asthma as a priority.
- Family Health Worker Pilot in A&E completed (Barnardo's) to reduce A&E attendances due to parental worries and difficulties in accessing other services and convenience of accessing services. Support, referral and/or appropriate signposting to other services given. Outcomes until end of January 2025 showed the pilot supported 30 children/families. A further programme evaluation is to be completed.
- Launched 7 Asthma Friendly Schools, which include:
Park Academy - Boston, Staniland Academy - Boston, St Peter at Gowts CofE Primary School - Lincoln, Wrangle Primary Academy - Boston, Grimoldby Primary School – Louth, Manor Farm Academy - North Hykeham.

Agreed actions for 25/26

- Enhancing the accuracy and comprehensiveness of ethnicity recording.
- Understand and address reasons for 20% most deprived CYP higher UEC activity.
- Use local Asthma dashboard to plan work with areas with higher UEC attendances and disparities.
- Implement Asthma workplan with stakeholders.
- Expansion of Asthma Friendly Schools.
- Explore availability to link National Child Measurement Programme to data dashboard.

Statement of Information on Health Inequalities Performance Summary Report

Respiratory

On target		
Off target	<ul style="list-style-type: none"> • Uptake of flu Vaccines by Age • Uptake of flu Vaccines by Deprivation • Uptake of flu Vaccines by Ethnicity 	<ul style="list-style-type: none"> • Uptake of COVID Vaccines by Age • Uptake of COVID Vaccines by Deprivation • Uptake of COVID Vaccines by Ethnicity
Risks		
<p>Progress on identified actions from 24/25</p> <ul style="list-style-type: none"> • Data accuracy and quality was, and remains, an area of focus with the national team with ICB feeding into data groups to identify areas to prioritise • Delivery model identified to target patients in areas of high deprivation, providing enhanced access and engagement sessions. • Worked with practices in areas of high deprivation to improve vaccination services provided including putting on additional pop-up/outreach clinics, working with community pharmacies to provide additional access. • There was a 0.5% of flu decrease in IMD quintile 1 from 23/24 to 24/25. 		<p>Agreed actions for 25/26</p> <ul style="list-style-type: none"> • Improve uptake of Flu and Covid 19 vaccinations in areas of high deprivation and those from a 'White - Other' background. • Work with NHSE vaccination team to improve quality of data from Federated Data Platform to allow more robust and detailed reporting. • Identify areas of low uptake where access for patients is an issue and work with local populations and community groups to identify locations what could be used for outreach and pop-up clinics. • Ensure that public facing materials are available in a range of languages and easy to read formats.

Statement of Information on Health Inequalities Performance Summary Report

Mental Health

On target	✓ NHS Talking therapies (formerly IAPT) - Reliable Recovery by Sex	✓ NHS Talking therapies (formerly IAPT) - Recovery by Sex
Off target	<ul style="list-style-type: none"> Overall number of Severe Mental Illness (SMI) physical health checks by Sex Overall number of Severe Mental Illness (SMI) physical health checks by Age Overall number of Severe Mental Illness (SMI) physical health checks by Deprivation Rates of restrictive interventions by Sex Rates of restrictive interventions by Age NHS Talking therapies (formerly IAPT) - Reliable Recovery by Deprivation NHS Talking therapies (formerly IAPT) - Recovery by Deprivation NHS Talking therapies (formerly IAPT) - Reliable Recovery by Age 	<ul style="list-style-type: none"> Rates of total Mental Health Act detentions by Sex (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) Rates of total Mental Health Act detentions by Age Rates of total Mental Health Act detentions by Deprivation Decile CYP Mental Health Access by Sex CYP Mental Health Access by Age CYP Mental Health Access by Deprivation NHS Talking therapies (formerly IAPT) - Recovery by Age
Risks	<ul style="list-style-type: none"> Rates of restrictive interventions by Deprivation Rates of total Mental Health Act detentions by Ethnicity 	<ul style="list-style-type: none"> NHS Talking therapies (formerly IAPT) - Reliable Recovery by Ethnicity NHS Talking therapies (formerly IAPT) - Recovery by Ethnicity CYP Mental Health Access by Ethnicity
<p>Progress on identified actions from 24/25</p> <ul style="list-style-type: none"> The data quality and data capture will continue to be improved to inform understanding about this cohort. This forms part of an inpatient Quality Improvement plan. Mental Health Services Dataset (MHSDS) ethnicity data quality consistently high and better than national average – however there has been a gradual reduction in 24/25 (ethnicity recording was 91.0% in April 2024, but 87.5% in March 2025). <p>SMI</p> <ul style="list-style-type: none"> Discussions with LPFT Traveller Link Worker to understand barriers and challenges to engaging with Traveller community completed. Co-produced options for alternative delivery model with people with lived experience developed focussing on an enhanced health check. Agreed Options paper and recommendations drafted late Feb 25 however plans put on hold due to withdrawal of funding. Paper shared with LMC and PCNA July 25. <p>Talking Therapies - LTT</p> <ul style="list-style-type: none"> LTT worked with the Travelling Communities Link Worker and now proactively outreaching to this community. This is also happening across migrant populations and in line with the PCREF work we are understanding what areas we need to focus on moving forward. LTT is seen as part of the continuum of care – the LMHT framework will reflect this. PCN professionals are reflected in the LMHT framework, and there are now Primary Care practitioners in place. Quality and referral monitoring is part of standard practice. 		<p>Agreed actions for 25/26</p> <ul style="list-style-type: none"> Improve ethnicity data quality for MHSDS Communications to staff to ensure relevant data fields are captured as far as possible Deep dive into data captured to better understand this cohort to develop early intervention and prevention initiatives. Continue to embed the Patient Race Equality Framework across LPFT Revision to Advocacy contract to ensure reporting outcomes by ethnicity <p>SMI</p> <ul style="list-style-type: none"> Develop reliable comprehensive practice SMI population profile data that can be mapped to SMI health check uptake. Data used to develop deep dive reports for PCNs and agree action plans. Investigate PCN Population Profile anomalies in practice registers. 'Proof of concept' testing of some elements of proposed new service, such as the enhanced health check and personalised care and support planning. Promotional material co-produced for patients, carers and professionals to raise profile of health checks. <p>Talking Therapies - LTT</p> <ul style="list-style-type: none"> Continuing to embed the roles in community and engage with those identified to date. Working through Partnership Groups in PCNs to ensure a network approach. Further investment into Talking Therapies skilled staff in line with business case and ensuring recruitment and retention into any existing vacancies. Roll out of the LMHT framework. Improve outcomes (both reliable recovery and recovery) for those from most deprived backgrounds

Statement of Information on Health Inequalities Performance Summary Report

Cancer

On target

- The data source provided by NHSE does not stratify cancer staging by health inequality characteristics

Off target

- The data source provided by NHSE does not stratify cancer staging by health inequality characteristics

Risks

- The data source provided by NHSE does not stratify cancer staging by health inequality characteristics

Progress on identified actions from 24/25

- Bowel Cancer Screening project completed. Tools and resources produced and rolled out. Awaiting long term data analysis to measure impact.
- Work ongoing to identify how improvements in clinical coding and recording of staging data can be made.
- Worked with MDT leads and key stakeholders for poorest performing tumour sites in terms of staging data to put improvement plans in place.
- Supported upskilling cancer screening services to deliver targeted HI focused projects.
- Lung Cancer Screening business case submitted.
- Commencement of targeted outreach education / cancer awareness at the Mosque in Lincoln.
- Educational / awareness video resource created in Polish for all cancer screening programmes.

Agreed actions for 25/26

- Utilise East Midlands Cancer Alliance 'Advancing Cancer Equity' Funds for Health Inequality VCFSE small grants focussed on access to diagnostics, treatment and survivorship.
- Staging - Reporting improvements continue to be a focus for ULHT in 2025/26.
- Target to improve early stage of cancer diagnosis by 3.3% in 25/26. From 54.6% to 59% -across 6 priority tumour sites.
- Commence activity from the Lung Cancer Screening programme in Q4 – taking a HI approach and focusing on delivery in areas of highest deprivation initially.
- Staging improvement to focus on 6 priority tumour pathways, plus timely presentation and screening uptake, and place-based improvements and improving the primary and secondary care interface.
- GP education – Delivery of training sessions to improve education/ awareness to improve referral practices.
- PCN engagement – Targeted support to deliver the Cancer DES by utilising the Cancer GP Dashboard data.
- Support the delivery in understating the population needs through data driven focused projects.
- Facilitate commissioning to support targeted projects that seek to address the lower uptake of cancer screening and timely presentation in underserved populations, identified through a population health management approach.

Statement of Information on Health Inequalities Performance Summary Report

Cardiovascular Disease

On target	✓ % of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy by Sex	✓ % of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy by Deprivation Quintile
Off target	<ul style="list-style-type: none"> Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Sex (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Age Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Deprivation Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Sex Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Age (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Deprivation Quintile (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) % of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy by Age. 	<ul style="list-style-type: none"> % of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Sex % of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Age % of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Deprivation Quintile (<i>indicator off target but there has been an improvement between 23/24 and 24/25</i>) % of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on LLT by Sex % of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on LLT by Age % of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on LLT by Deprivation Quintile
Risks	<ul style="list-style-type: none"> Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Ethnicity Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Ethnicity 	<ul style="list-style-type: none"> % of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy by Ethnicity % of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Ethnicity
<p>Progress on identified actions from 24/25</p> <ul style="list-style-type: none"> Health Inequalities LCHG working group set up with improved ethnicity coding identified as a key area of work which will support Stroke and Myocardial Infarction CVD indicators. Public Health and ICB collaborated to explore barriers and challenges related to hypertension monitoring and management. Targeted outreach and education have been delivered within local places of worship. The ICB worked jointly with public health to run the 'Know Your Numbers' campaign. A model targeting secondary prevention patients with high cholesterol was developed targeting high risk patients in IMD 1+2. Access improvement work continues with GP practices and PCNs: online consultation and appt management, SLF and GP Improvement Programme Support with targeted practices and public comms to minimise wasted appts and improve access through community pharmacy (e.g. identifying hypertension). Scoping was initiated to look at improving outreach to under-identified and undertreated hypertension populations in the most deprived areas and ethnic communities. A pilot was rolled out to enable patients who require IV Furosemide to be treated at home, reducing inequalities in access linked to deprivation and rurality. 		<p>Agreed actions for 25/26</p> <ul style="list-style-type: none"> Increased focus on identifying and addressing unwarranted variation into 2025/26 including development of variation dashboards e.g. using CVDPREVENT data. Primary Care to work with HI to review QOF variation. Primary Care to complete and develop an approach to target interventions to address health inequalities. Improving Secondary Prevention in Cholesterol Management Maintaining and Improving attainment in CVD prevent: Atrial Fibrillation; Cholesterol; Hypertension

Statement of Information on Health Inequalities Performance Summary Report

Diabetes

On target	✓ Variation between % of people with type 1 diabetes receiving all 8 care processes by Sex	
Off target	<ul style="list-style-type: none"> Variation between % of people with type 1 diabetes receiving all 8 care processes by Age Variation between % of people with type 1 diabetes receiving all 8 care processes by Deprivation Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile to the NDPP by Sex Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile to the NDPP by Age 	<ul style="list-style-type: none"> Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile to the NDPP by Deprivation Variation between % of people with type 2 diabetes receiving all 8 care processes by Sex Variation between % of people with type 2 diabetes receiving all 8 care processes by Age Variation between % of people with type 2 diabetes receiving all 8 care processes by Deprivation
Risks	Variation between % of people with type 1 diabetes receiving all 8 care processes by Ethnicity Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile to the NDPP by Ethnicity Variation between % of people with type 2 diabetes receiving all 8 care processes by Ethnicity	

Progress on identified actions from 24/25

- Access improvement work continues with GP practices and PCNs: online consultation and appt management, SLF and GP Improvement Programme Support with targeted practices and public comms to minimise wasted appts and improve access through community pharmacy.
- Well established Prevention Programme that has been running for several years and has been delivering consistently. Provider asked to source additional patients from more deprived quintiles and develop approach to ensure equitable outcomes. This will be mobilised in the subsequent year. Uptake from ethnic groups assessed and found to be proportionate where an ethnicity is recorded.
- T2 Diabetes Remission service was stood up in May 2024. Provider asked to source additional patients from more deprived quintiles and develop approach for 25/26 to ensure equitable outcomes.
- The T2DAY programme ran for a second-year last year, targeting 18–40-year-olds with established diabetes. Data submitted showed that an additional 420 patients had additional care processes completed or had been reviewed in clinic.
- Lincolnshire became one of the top referrers of women with a history of Gestational Diabetes Mellitus (GDM) to the National Diabetes Prevention Programme (NDPP), following targeted efforts.
- Evidence review conducted and data analysed on women with GDM. Work has been integrated into a broader PHM maternity dataset, supporting segmentation, targeted interventions, and a coordinated system-wide approach to reducing inequalities in maternity, including diabetes in pregnancy.
- Coordination with diabetes and obesity/weight management programmes strengthened by:
 - Integrated Referrals: Practices supported to identify and refer patients to the most appropriate programme.
 - Programme Oversight: Tier 2 services are regularly reviewed to ensure alignment with clinical pathways and NDPP criteria.
 - Workforce Development

Agreed actions for 25/26

- Primary Care to work with HI to review QOF variation. Primary Care to complete and develop an approach to target interventions to address health inequalities – especially in younger age groups and those in most deprived parts of county.
- Prevention and management of risk factors:
 - Continuation of Diabetes Prevention Programme (NDPP)
 - Continuation of NHS Type 2 Diabetes Path to Remission Programme
 - Implementation of Tier 3 Weight Management Service (Diabetes)
- Proactive care;
 - Improved coding in T1 diabetes to reflect T1 population more accurately
 - Improving diabetes care process completion and target attainment
 - Continuation of Type 2 Diabetes Adolescent & Young People Service (T2DAY) (Subject to agreement of funding)
- CGM & HCL implementation
- Integrated pathways of care:
 - Primary Care based Diabetes MDT with consultant input

Statement of Information on Health Inequalities Performance Summary Report

Smoking cessation

On target	<ul style="list-style-type: none"> ✓ Proportion of adult acute inpatient settings offering smoking cessation services by Deprivation (<i>indicator on target but there has been a deterioration between 23/24 and 24/25</i>) 	<ul style="list-style-type: none"> ✓ Proportion of maternity inpatient settings offering smoking cessation services by Age (<i>indicator on target but there has been a deterioration between 23/24 and 24/25</i>) ✓ Proportion of maternity inpatient settings offering smoking cessation services by Deprivation (<i>indicator on target but there has been a deterioration between 23/24 and 24/25</i>)
Off target		
Risks		

<p>Progress on identified actions from 24/25</p> <ul style="list-style-type: none"> • Acute service commenced March 2024 to support all inpatient wards at Lincoln County Hospital. • The community inpatient service fully rolled however, following staff resignations, coverage temporarily dropped to around 50%. • Comprehensive action plan aimed at reducing smoking during pregnancy and increasing the number of smokefree homes developed and agreed. • Integrated pathways with OYL now support seamless inpatient-to-community transitions, including up to 12 weeks of NRT and behavioural support. • NHS Pregnancy Incentive Scheme confirmed extension for 2025/26. This incentive-based approach is used alongside the core components of the STAAR service, which include robust data collection, clear referral pathways, and evidence of behavioural support and pharmacotherapy (e.g., NRT) being offered throughout the pregnancy journey. • From February 2025, the Maternity Tobacco Dependency Service (TDS) (STAAR Team) integrated the use of vapes into its service offer, complementing existing provision within LPFT. • LPFT's Smokefree Policy was updated in 2024, with the next review due in 2026. ULTH is developing a new group-wide policy. • Building on work with OYL around the COSTED model in A&E, lessons learned will inform potential expansion into outpatient settings. Service leads working with Targeted Lung Health Checks working group to explore opportunities for integrated pathways. 	<p>Agreed actions for 25/26</p> <ul style="list-style-type: none"> • Exploring expanded workforce offer in collaboration with Public Health and One You Lincolnshire (OYL). • Expansion of Community Hospital and Acute Hospital inpatient Tobacco Dependency Service • Approval and implementation of e-cigarettes/vapes available to patients within the NHS Tobacco Dependency Service. • BAU of LTP Tobacco Dependency Services – focus on performance with consideration of CORE20PLUS5 and how we support the Targeted Lung Health Check • Monitor data to ensure sustained improvement
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Statement of Information on Health Inequalities Performance Summary Report

Oral Health

On target	<ul style="list-style-type: none"> The counts for this indicator are too small to provide any meaningful insight when stratified by the health inequality characteristics
Off target	<ul style="list-style-type: none"> The counts for this indicator are too small to provide any meaningful insight when stratified by the health inequality characteristics
Risks	<ul style="list-style-type: none"> The counts for this indicator are too small to provide any meaningful insight when stratified by the health inequality characteristics

<p>Progress on identified actions from 24/25</p> <p>The Lincolnshire Oral Health Alliance Group (OHAG) workplan encompassed several projects specifically aimed at improving the oral health of children and young people:</p> <ul style="list-style-type: none"> Targeted supervised toothbrushing programme (Lincolnshire Smiles) was actively delivered. In March 2025, the programme was engaged with 27 settings (1,313 children participating). Toothbrushing packs and oral health advice were distributed to targeted populations, including Family Hubs and Holiday Activities and Food (HAF) programme settings. These resources were also integrated into some Local Authority services, such as child weight management programmes. Brief oral health training for staff delivering these services was included as part of the offer. Toothbrushing packs and oral health advice were provided during the 8–12-month checks conducted by Children’s Health. Collaborative work was carried out with early years settings and schools to promote oral health, including the delivery of a Sugar Pledge scheme in targeted locations (Defeat the Sweet). A variety of oral health campaigns were supported, including World Oral Health Day, National Smile Month and Mouth Cancer Action Month. 	<p>Agreed actions for 25/26</p> <p>The activities during 2024/25 will continue to take place. The work supports the delivery of the OHAG workplan, Lincolnshire Dental Strategy and the Lincolnshire ICP strategy. The Lincolnshire Oral Health Needs Assessment and refreshed JSNA will continue to inform the work during 2025/26. Some specific activities for 2025/26 include:</p> <ul style="list-style-type: none"> Toothbrushing packs and oral health advice to be extended to include 2-year-olds (delivered by Children’s Health). Continue to provide toothbrushing packs and oral health information to targeted groups. Continue to deliver the Lincolnshire Smiles programme and deliver the national rollout of targeted supervised toothbrushing programmes for children aged 3–5 years in early years settings located in the most deprived areas. Deliver the next National Dental Epidemiology Programme (NDEP) survey, targeting 5-year-olds (during the 2025/26 academic year). Support a number of national campaigns that promote oral health, for example, National Smile Month. Refresh the oral health chapter of the Lincolnshire Joint Strategic Needs Assessment (JSNA)
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Statement of Information on Health Inequalities Performance Summary Report

Learning Disabilities and Autism

On target		
Off target	<ul style="list-style-type: none"> • Learning Disability Annual Health Checks by Sex • Learning Disability Annual Health Checks by Age • Learning Disability Annual Health Checks by Deprivation 	
Risks	<ul style="list-style-type: none"> • Learning Disability Annual Health Checks by Ethnicity 	

Progress on identified actions from 24/25

- Access improvement work continues with GP practices and PCNs: online consultation and appt management, SLF and GP Improvement Programme Support with targeted practices and public comms to minimise wasted appts and improve access through community pharmacy.
- An all-day event took place in Sleaford on International Epilepsy Day with 71 attendees. Attendees enjoyed real life case studies on new MHRA regulations and anti-seizure medications Valproate and Topiramate.
- ICB hosted and co-produced a webinar with LPFT to promote awareness of the LeDeR Programme and highlighted cardiovascular disease as one of the top three causes of death of people with a learning disability nationally and locally.
- ICB LeDeR team hosted an Aspiration Pneumonia Webinar using the story of Robert, a fictional patient, to show the difference between a suboptimal (undesirable with negative outcomes), but realistic, pathway of care compared to an optimal (best practice with good outcomes) pathway of care.
- Sensory bags have been launched by ULHT funded by ULHT charities for all age patients with learning disabilities and autistic people who come into the Emergency Departments.
- A 2-year pilot scheme is fully in place since 2024 with an LICB commissioned 6 bedded residential unit for long stay patients who fall within the MM judgement and who are subject to MOJ conditions. The pilot has enabled x5 patients to live in the community under Long Term Section 17(3) leave.

Agreed actions for 25/26

- Improving uptake of LD Health Checks to be one of the areas of focus for HI VCFSE Grants.
- LD Friendly GP Practice Scheme reviewed and to be re-launched in May 2025.
- LICB are in the early stages of planning a Webinar - LeDeR - Suicide in Learning Disabilities, Autism and ADHD - focus upon prevention.
- A webinar is planned for early 2026 – People with a learning disability and autistic people - Bowel Health and Constipation.
- A webinar is planned for 2026 – People with LD and Autistic people – Drugs and alcohol / substance misuse.
- Task and finish group commenced work to review and update the Lincolnshire ICS DSR & CTR Policy – ICB and LPFT.

Statement of Information on Health Inequalities Performance Summary Report

Maternity and neonatal

On target

- The data source provided by NHSE does not stratify health inequality characteristics

Off target

- The data source provided by NHSE does not stratify by health inequality characteristics

Risks

- The data source provided by NHSE does not stratify by health inequality characteristics

Comparison table 2023/24 v 2024/25

Statement of Information on Health Inequalities indicators with an improvement in 24/25
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Age
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Age; by Deprivation Quintile
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Sex; by Deprivation Quintile
Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Sex; by Age; by Deprivation Quintile
Emergency admissions for under 19s by Sex; by Age
Rates of Mental Health Act (MHA) detentions for 22/23 and 23/24 by Sex
NHS Talking therapies (formerly IAPT) - Reliable Recovery and Recovery by Sex
Stroke rate of non-elective admissions (per 100,000, age-sex standardised), by Sex
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Age; by Deprivation Quintile
% of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Deprivation Quintile
Variation between % of people with type 1 diabetes receiving all 8 care processes by Sex

Statement of Information on Health Inequalities indicators with a deterioration in 24/25	
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Sex (FEMALES)	Emergency admissions for under 19s by Deprivation Decile (MOST DEPRIVED DECILES)
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Sex (FEMALES)	Rates of restrictive interventions by Sex (FEMALES); by Age (18-TO-19-YEAR-OLDS)
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Age (CYP)	CYP Mental Health Access by Sex (MALES); by Age (UNDER 10s); by Deprivation Decile (MOST DEPRIVED DECILES)
Uptake of flu vaccines by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Variation between % of people with type 1 diabetes receiving all 8 care processes by Age (UNDER 60s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Rates of Mental Health Act Detentions by Age (18-TO-19-YEAR-OLDS); by Deprivation Decile (MOST DEPRIVED DECILE)	Variation between % of people with type 2 diabetes receiving all 8 care processes by Sex (FEMALES); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
NHS Talking therapies (formerly IAPT) - Reliable Recovery and Recovery by Age (UNDER 25s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Proportion of adult acute inpatient settings offering smoking cessation services by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Age (OVER 60s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Proportion of maternity inpatient settings offering smoking cessation services by Age (UNDER 30s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Sex (MALES)	Learning Disability Annual Health Checks by Sex (MALES); by Age (UNDER 30s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
% of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Sex (MALES); by Age (18-TO-39-YEAR-OLDS)	% of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy by Age (40-TO-79-YEAR-OLDS); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy by Sex (FEMALES); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	

Statement of Information on Health Inequalities



Lincolnshire
Integrated Care Board

Sandra Williamson – Director for Health Inequalities, Prevention and Regional Collaboration



Background and Context

The [Statement on Information on Health Inequalities](#) is given by NHS England further to its duty under [section 13SA of the National Health Service \(NHS\) Act 2006](#) to publish a **Statement setting out a description of the powers available to relevant NHS bodies to collect, analyse and publish information**, and the views of NHS England about how those powers should be exercised in connection with such information.

NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed.

NHS England has a statutory duty to conduct an **annual assessment** of ICBs to include the extent to which they have fulfilled their statutory obligations around Health Inequalities.

This is a lever to **drive more complete and better-quality data collection** and **increase transparency** on progress tackling health inequalities in the long run.

Challenges

- Data quality issues relating to ethnicity limits the ability to accurately determine where there are health inequalities between different ethnic groups compared to white British/Irish population.
- The cancer staging data does not stratify cancer staging data by health inequality characteristics.
- The maternity data does not stratify pre-term births by health inequality characteristics.

Comparison table 23/24 v 24/25

Statement of Information on Health Inequalities indicators with an improvement in 24/25
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Age
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Age; by Deprivation Quintile
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Sex; by Deprivation Quintile
Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks by Sex; by Age; by Deprivation Quintile
Emergency admissions for under 19s by Sex; by Age
Rates of Mental Health Act (MHA) detentions for 22/23 and 23/24 by Sex
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Stroke rate of non-elective admissions (per 100,000, age-sex standardised), by Sex
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% of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Deprivation Quintile
Variation between % of people with type 1 diabetes receiving all 8 care processes by Sex

Statement of Information on Health Inequalities indicators with a deterioration in 24/25	
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks by Sex (FEMALES)	Emergency admissions for under 19s by Deprivation Decile (MOST DEPRIVED DECILES)
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks by Sex (FEMALES)	Rates of restrictive interventions by Sex (FEMALES); by Age (18-TO-19-YEAR-OLDS)
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks by Age (CYP)	CYP Mental Health Access by Sex (MALES); by Age (UNDER 10s); by Deprivation Decile (MOST DEPRIVED DECILES)
Uptake of flu vaccines by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Variation between % of people with type 1 diabetes receiving all 8 care processes by Age (UNDER 60s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Rates of Mental Health Act Detentions by Age (18-TO-19-YEAR-OLDS); by Deprivation Decile (MOST DEPRIVED DECILE)	Variation between % of people with type 2 diabetes receiving all 8 care processes by Sex (FEMALES); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
NHS Talking therapies (formerly IAPT) - Reliable Recovery and Recovery by Age (UNDER 25s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Proportion of adult acute inpatient settings offering smoking cessation services by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Stroke rate of non-elective admissions (per 100,000, age-sex standardised) by Age (OVER 60s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	Proportion of maternity inpatient settings offering smoking cessation services by Age (UNDER 30s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised) by Sex (MALES)	Learning Disability Annual Health Checks by Sex (MALES); by Age (UNDER 30s); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
% of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold by Sex (MALES); by Age (18-TO-39-YEAR-OLDS)	% of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy by Age (40-TO-79-YEAR-OLDS); by Deprivation Quintile (MOST DEPRIVED QUINTILE)
% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy by Sex (FEMALES); by Deprivation Quintile (MOST DEPRIVED QUINTILE)	

Key themes

Theme	Actions for 25/26 onwards	Prevention/access opportunity
<p>Males with significantly higher rate of myocardial infarctions and poorer hypertension management</p>	<p>Increase focus on addressing unwarranted variation including development of variation dashboards</p> <p>Primary Care to work with HI programme to review QOF variation. Primary Care to complete and develop an approach to target interventions to address health inequalities</p> <p>Improve secondary prevention in cholesterol management</p>	<p>Improve uptake and awareness of NHS Health Checks</p> <p>Explore opportunities for community pharmacy access for increased diagnosis and case finding</p> <p>Lifestyle choices – smoking, weight management, alcohol</p> <p>Long Term Condition management – ‘Know Your Numbers’ for hypertension management – targeted campaigns</p>
<p>Lower proportion of females (working age) have been on a waiting list for less than 18 weeks</p>	<p>Investigate and address waiting list inequalities between male and female patient waiting times</p> <p>Complete and present deep dive data analysis to Planned Care Board and LCHG Health Inequalities working group</p>	<p>Co-production opportunity to improve/enhance access following engagement to understand reasons for disparity</p>
<p>Children in more deprived areas have higher rate of emergency admissions</p>	<p>Understand and address reasons for most deprived CYP higher UEC activity</p> <p>Use local asthma dashboard to plan work with areas with higher UEC attendances and disparities</p> <p>Implement asthma workplan and expand asthma friendly schools</p>	<p>Work closely with public health to scope opportunities to tackle high rate of emergency admissions</p>

Key successes

- Over 65 week waits for ENT reduced from 233 in April 2024 to less than 10 at the end of March 2025.
- CYP ENT over 52 week waits reduced by 27% from a peak in August 2024 to March 2025.
- Family Health Worker Pilot in A&E completed (Barnardo's) to reduce A&E attendances due to parental worries and difficulties in accessing other services and convenience of accessing services. Pilot supported 30 children/families.
- Launched 7 Asthma Friendly Schools
- Respiratory - delivery model identified to target patients in areas of high deprivation, providing enhanced access and engagement sessions.
- Bowel Cancer Screening project completed. Tools and resources produced and rolled out.
- Lincolnshire became one of the top referrers of women with a history of Gestational Diabetes Mellitus (GDM) to the National Diabetes Prevention Programme (NDPP).
- Acute and Community Tobacco Dependency Scheme fully rolled out.
- A pilot was rolled out to enable patients requiring IV Furosemide to be treated at home, reducing inequalities in access linked to deprivation and rurality.
- Strengthening Health Inequalities (HI) leadership and embedding- HI LCHG working group established, MHDLDA Alliance includes specific workstream on tackling health inequalities, 120 systemwide HI Champions, HI annual training plan delivered.

Key actions for 2025/26

- Enhancing the accuracy and comprehensiveness of ethnicity recording.
- Investigate and address waiting list inequalities between male and female patient waiting times.
- Targeted work on reducing the number of CYP missed appointments in ULTH. Missed appointments are almost twice as prevalent in the most deprived population.
- Understand and address reasons for 20% most deprived CYP higher UEC activity.
- Use local Asthma dashboard to plan work with areas with higher UEC attendances and disparities.
- Expansion of Asthma Friendly Schools.
- Improve uptake of Flu and Covid 19 vaccinations in areas of high deprivation and those from a 'White - Other' background.
- Talking Therapies - Improve outcomes (both reliable recovery and recovery) for those from most deprived backgrounds.
- Commence activity from the Lung Cancer Screening programme in Q4 focusing delivery in areas of highest deprivation initially.
- Primary Care to work with Health Inequalities to review QOF variation. Primary Care to complete and develop an approach to target interventions to address health inequalities.
- Expansion of Community Hospital and Acute Hospital inpatient Tobacco Dependency Service.
- Continued strengthening of health inequalities leadership – HI reforming elective recovery plan, development of Inclusion Health Strategy and expansion of HI champions network and training offer.

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	05 (i)
Meeting Date:	Tuesday, 30 th September 2025
Title of Report:	Integrated Quality & Performance Report – September 2025
Report Author:	James Singleton, Performance Manager
Presenter:	Rebecca Neno- Deputy 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 August 2025 was 75.1%, above the planned month trajectory of 74% (95% constitutional target); this was also higher than the regional average performance.

- Category 1 mean response times for EMAS Trust was 08:56 minutes against a standard of 07:00 minutes during August 2025.
- The Category 2 mean response time for EMAS Trust was 37:43 minutes against an expectation of 30 mins (18:00 constitutional target).

Cancer

- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral was 64.4% in July 2025, below the planned month trajectory of 68.9%.
- The faster diagnosis standard was achieved in July, overall performance was 76%, against the 75% standard.

Elective backlog

- The total waiting list size for Lincolnshire patients at all hospitals was 109,873 in July, ahead of plan at system level. Both ULTH and NLAG were ahead of plan, but NWAFT were off-plan by around 2,000 patients.
- The ICB finished July with 2,662 patients waiting over 52 weeks which equates to 2.4% of the total waiting list. (0.4% adverse to plan).

Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies waiting times standards were both achieved in June. 97.3% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 100% 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 63% in June (rolling 12 months) which is above the 60% standard.
- The total number of adult inpatients with learning disabilities or autism was 35, above trajectory of 30.

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	
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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

September 2025



26/09/2025

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Executive Summary

Overview

The September 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 August where available.



Urgent & Emergency Care

- All Types 4-hour performance for Lincolnshire ICB for August 2025 was 75.1%, above the planned month trajectory of 74% (95% constitutional target); this was also higher than the regional average performance.
- Category 1 mean response times for EMAS Trust was 08:56 minutes against a standard of 07:00 minutes during August 2025.
- The Category 2 mean response time for EMAS Trust was 37:43 minutes against an expectation of 30 mins (18:00 constitutional target).



Cancer

- The percentage of patients receiving treatment for cancer within 62 days of an urgent referral was 64.4% in July 2025, below the planned month trajectory of 68.9%.
- The faster diagnosis standard was achieved in July, overall performance was 76%, against the 75% standard.



Elective backlog

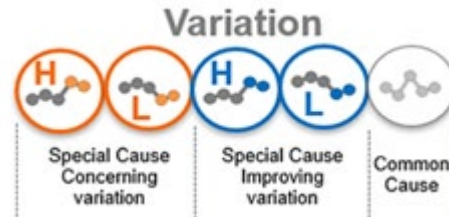
- The total waiting list size for Lincolnshire patients at all hospitals was 109,873 in July, ahead of plan at system level. Both ULTH and NLAG were ahead of plan but NWAFT were off-plan by around 2,000 patients.
- The ICB finished July with 2,662 patients waiting over 52 weeks which equates to 2.4% of the total waiting list. (0.4% adverse to plan).



Mental Health, Learning Disabilities & Autism

- The NHS Talking Therapies waiting times standards were both achieved in June. 97.3% of patients received their first treatment appointment within 6 weeks against the 75% standard, and 100% 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 63% in June (rolling 12 months) which is above the 60% standard.
- The total number of adult inpatients with learning disabilities or autism was 35, above trajectory of 30.

Key to Run Charts



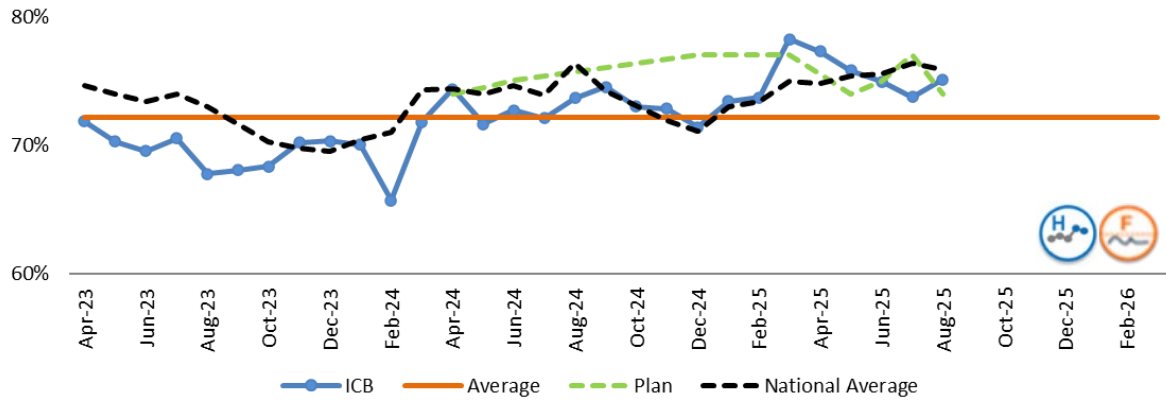
Variation/Performance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	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

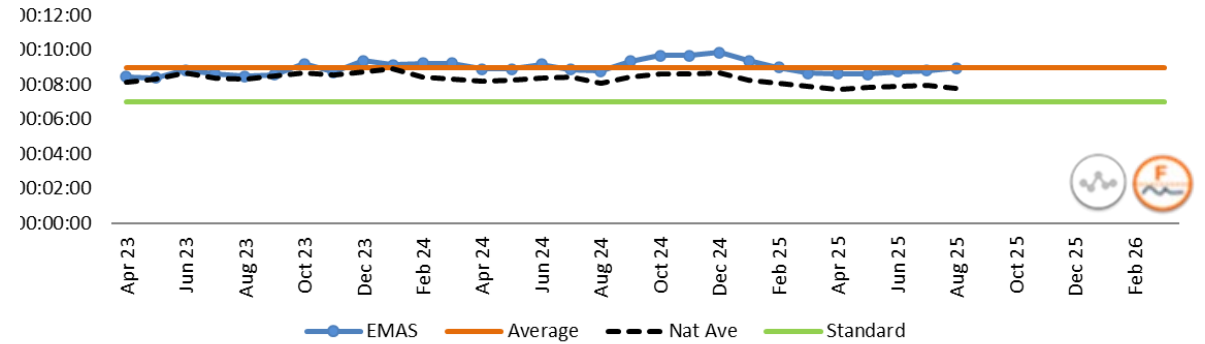


Programme	Indicator	Standard	Plan	Period	Performance	Midlands	England	Trend		
								Sparkline	Variation	Assurance
Urgent & Emergency Care	A&E admission, transfer, discharge within 4 hours (ICB)	95%	74.0%	Aug-25	75.1%	73.9%	75.9%			
	Ambulance response times - Mean response time- Category 1 (EMAS)	00:07:00	-	Aug-25	00:08:56	00:08:15	00:07:47			
	Ambulance response times - Mean response time- Category 2 (EMAS)	00:18:00	00:30:00	Aug-25	00:37:43	00:27:50	00:27:03			
Cancer	Patients receiving treatment for cancer within 31 days of decision to treat	96%	93.1%	Jul-25	90.8%	90.7%	92.4%			
	Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade	85%	68.9%	Jul-25	64.4%	65.6%	69.2%			
	% of patients told cancer diagnosis outcome within 28 days (ICB)	75%	78.6%	Jul-25	76.0%	75.7%	76.6%			
Elective Care	RTT: % of incomplete pathways within 18 weeks	92%	55.6%	Jul-25	56.6%	60.0%	61.3%			
	Patients waiting over 52 weeks for treatment (ICB) (% of total ICB waiting list size)	-	2.05%	Jul-25	2.42%	2.28%	2.59%			
	Percentage waiting six weeks or less for a diagnostic test	99%	-	Jul-25	71.0%	75.2%	78.1%			
	% of patients not treated within 28 days of last minute elective cancellation (ULHT)	0.8%	-	Q1 2025/26	28.9%	31.1%	22.3%			
Mental Health	NHS Talking Therapies access - first treatment appointment within 6 weeks (ICB)	75%	-	Jul-25	97.3%	N/A	89.9%			
	NHS Talking Therapies access - first treatment appointment within 18 weeks (ICB)	95%	-	Jul-25	100.0%	N/A	98.9%			
	People experiencing first episode psychosis waiting to start a package of care (ICB)	60%	-	Jul-25	63.0%	48.9%	69.7%			
	CYP with an ED (urgent) that start treatment < 1 week of referral (rolling 12 months)	95%	-	Jun-25	*	65%	64%		-	-
	CYP with an ED (routine) that start treatment < 4 weeks of referral (rolling 12 months)	95%	-	Jun-25	71%	66%	72%			

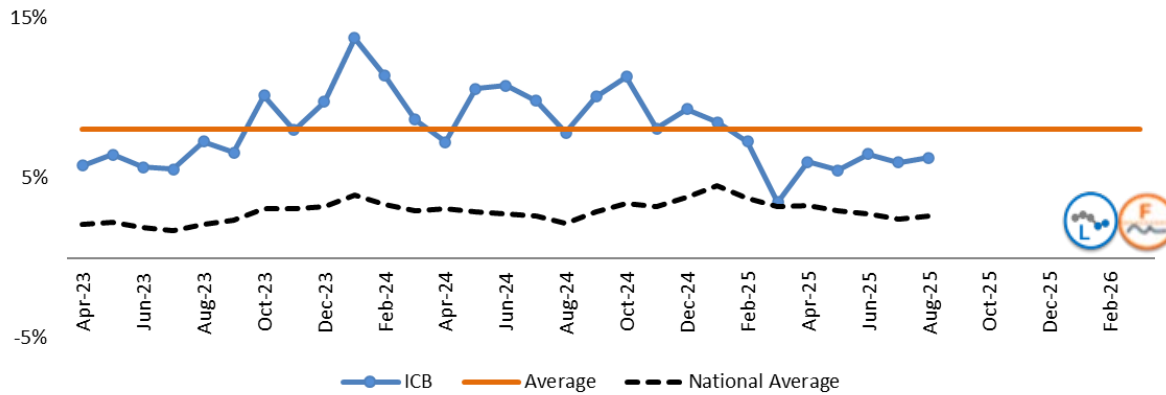
A&E admission, transfer, discharge within 4 hours (ICB)



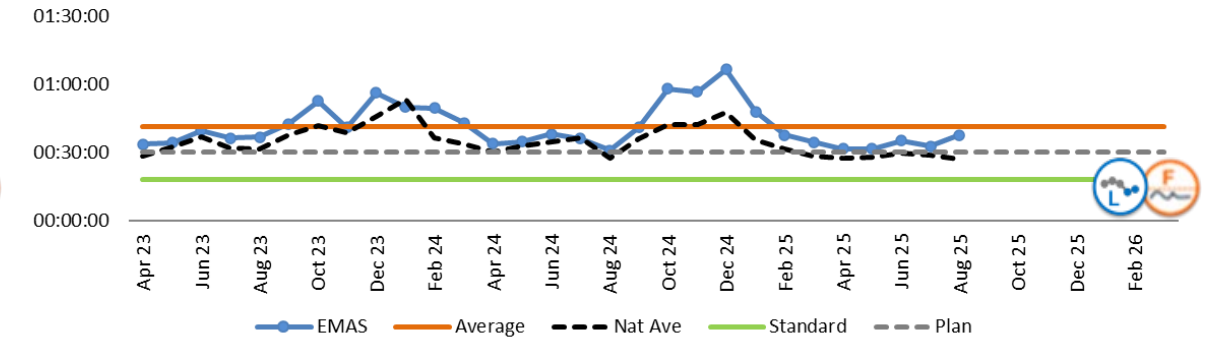
Ambulance response times - Mean response time- Category 1 (EMAS)



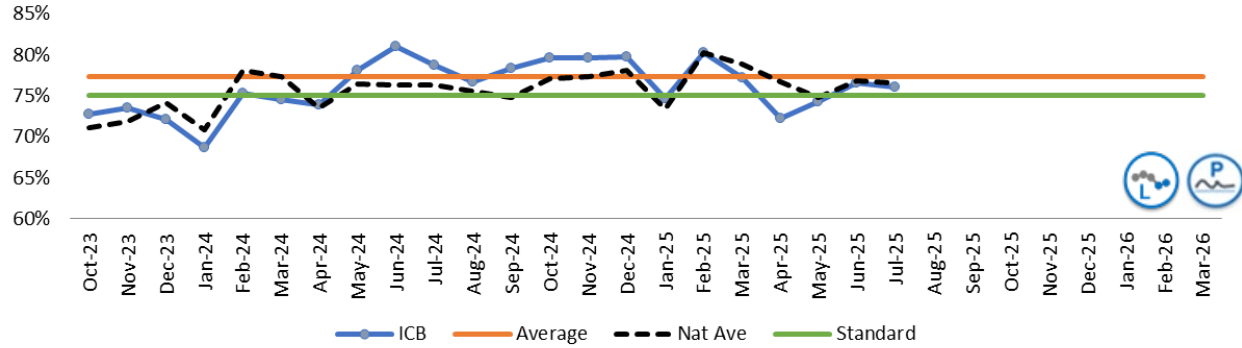
12+ hour delays from decision to admit (ICB)



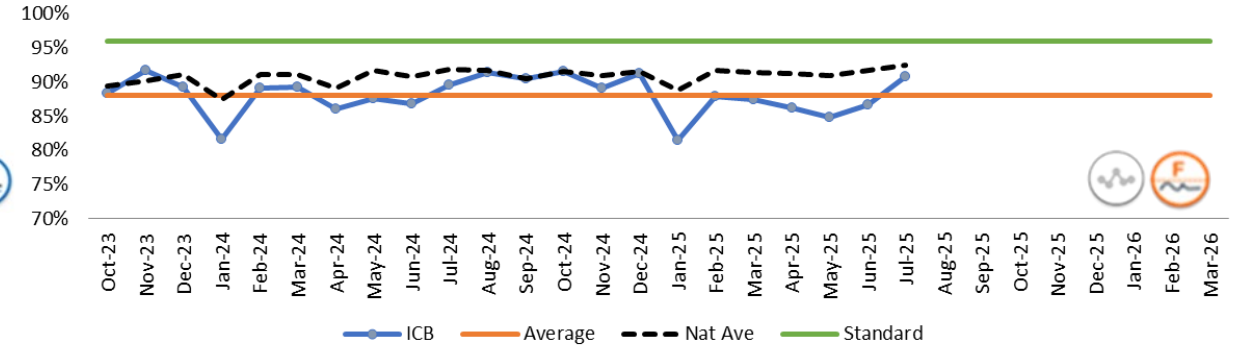
Ambulance response times - Mean response time- Category 2 (EMAS)



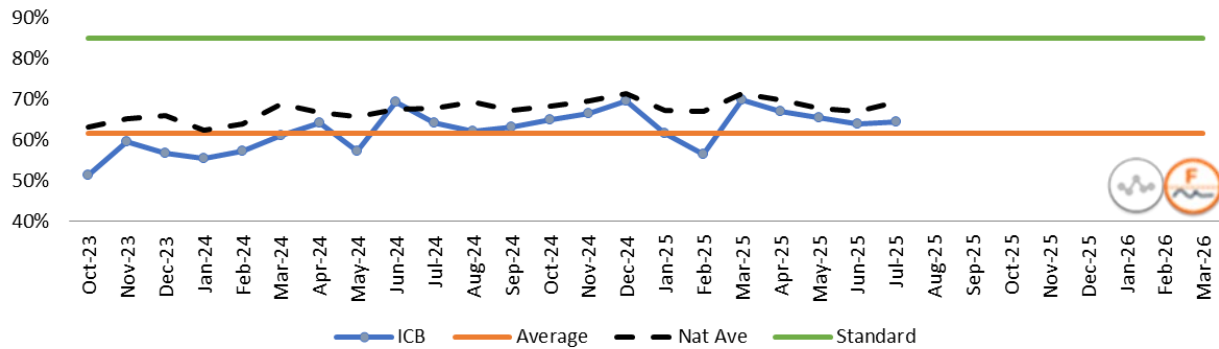
Faster Diagnosis Standard- % of patients told cancer diagnosis outcome within 28 days (LICB)



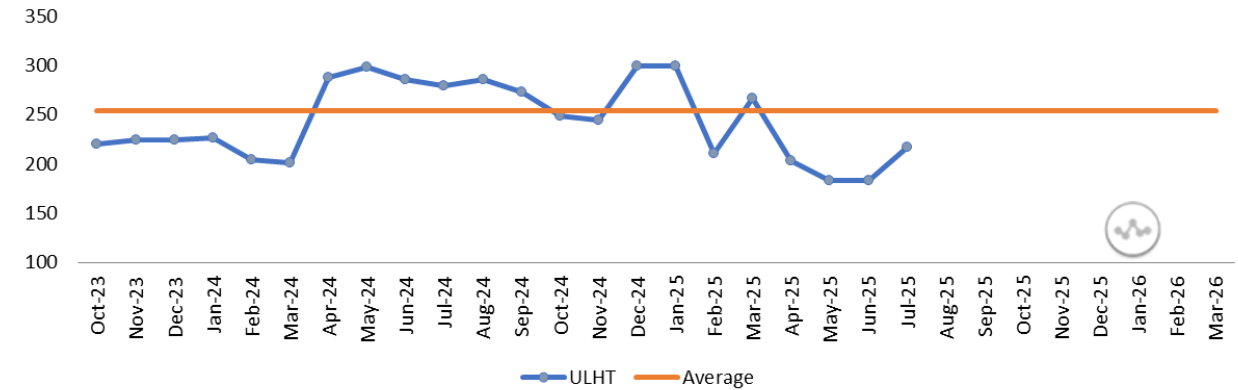
Patients receiving treatment for cancer within 31 days of decision to treat (LICB)



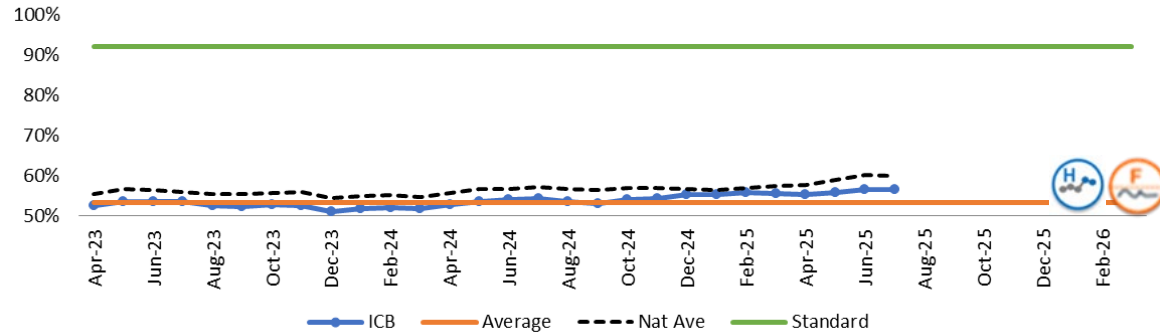
Patients receiving treatment for cancer within 62 days of an urgent referral or consultant upgrade (LICB)



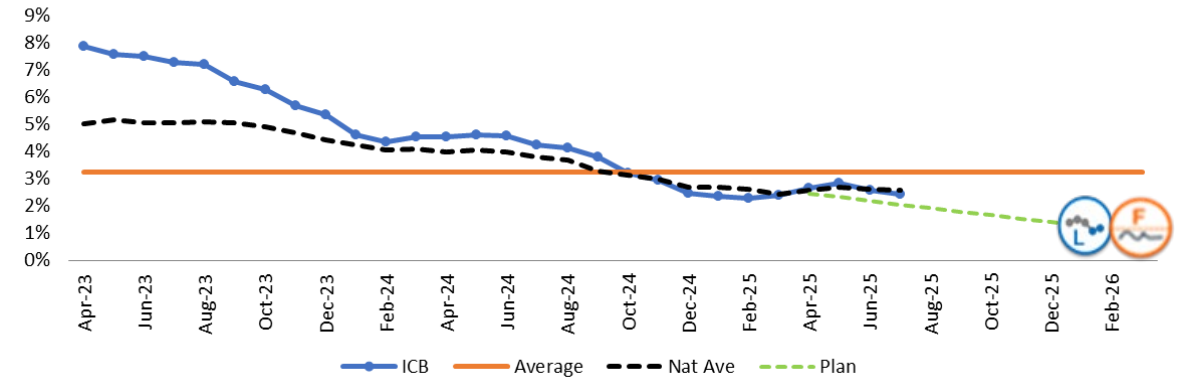
Total 62 Day Backlog (ULHT)



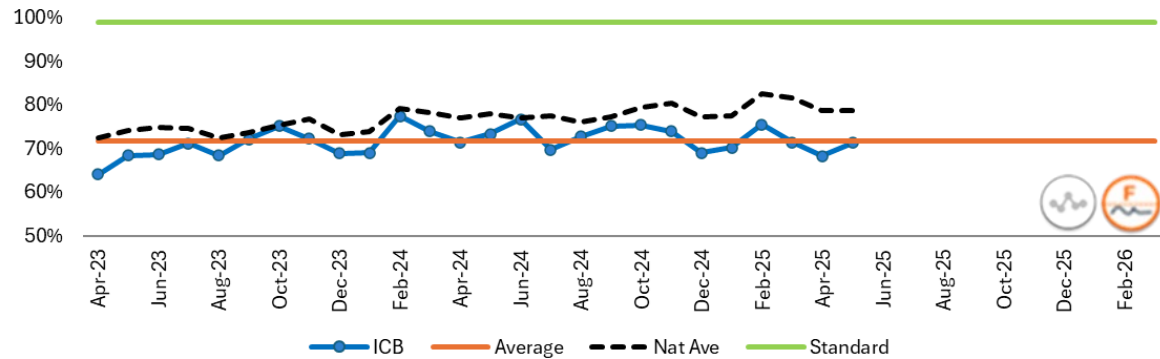
RTT- Patients waiting 18 weeks or less from referral to hospital treatment (LICB)



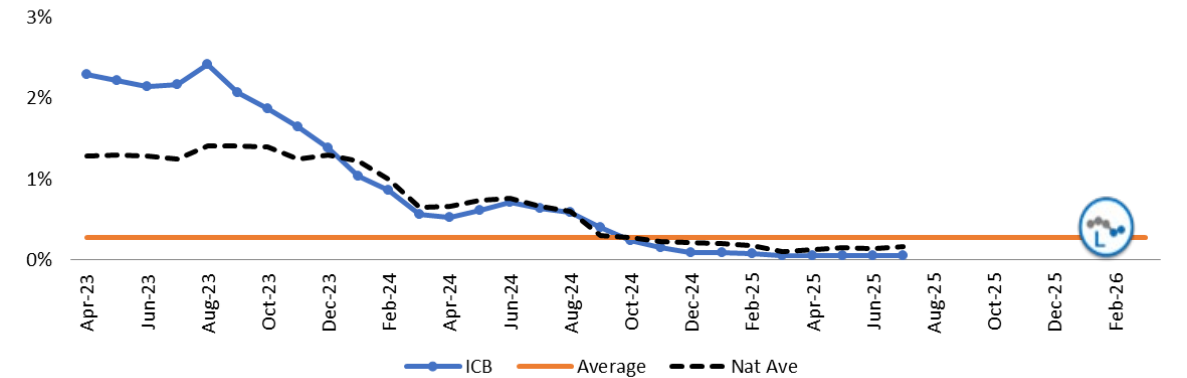
RTT- Patients waiting over 52 weeks for treatment (LICB)



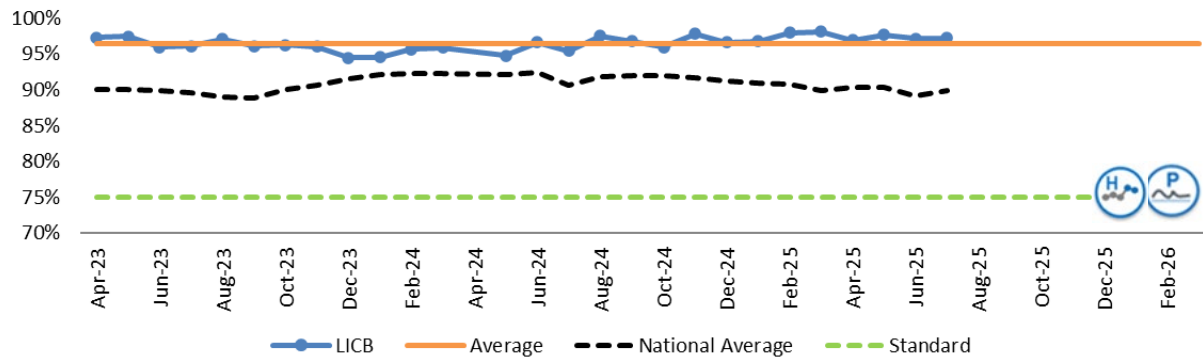
Percentage waiting six weeks or less for a diagnostic test (ICB)



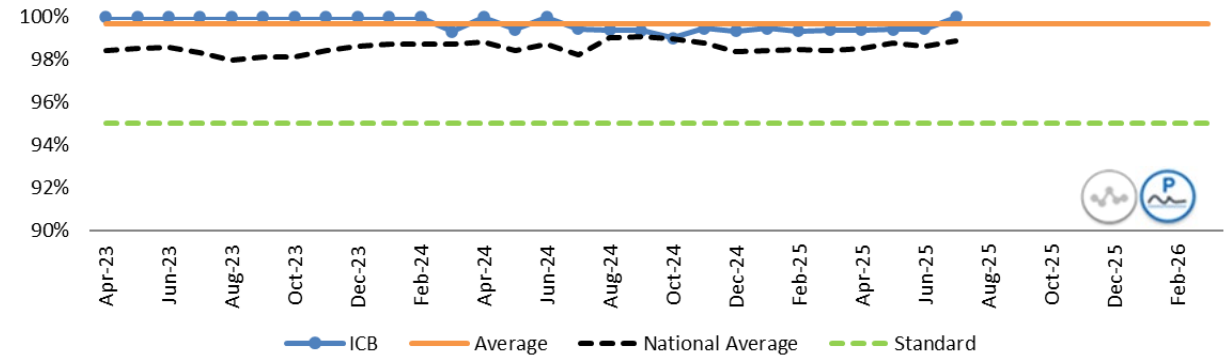
RTT- Patients waiting over 65 weeks for treatment (LICB)



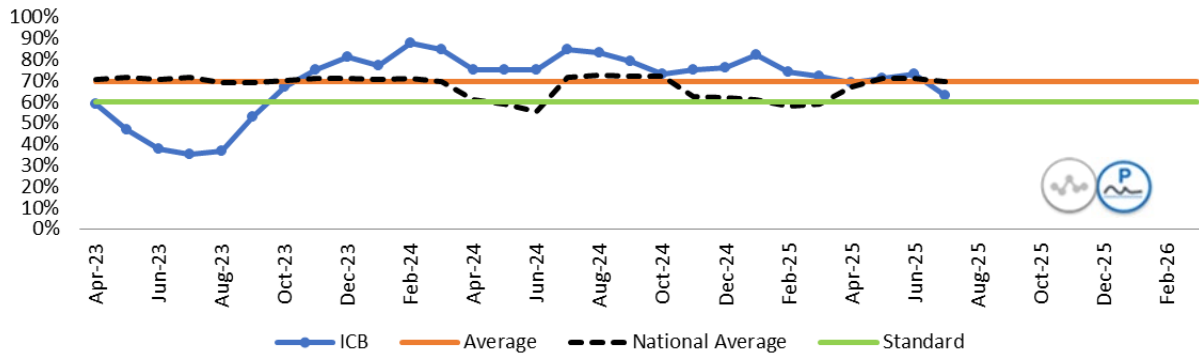
Talking Therapies: First treatment appointment within 6 weeks of referral (ICB)



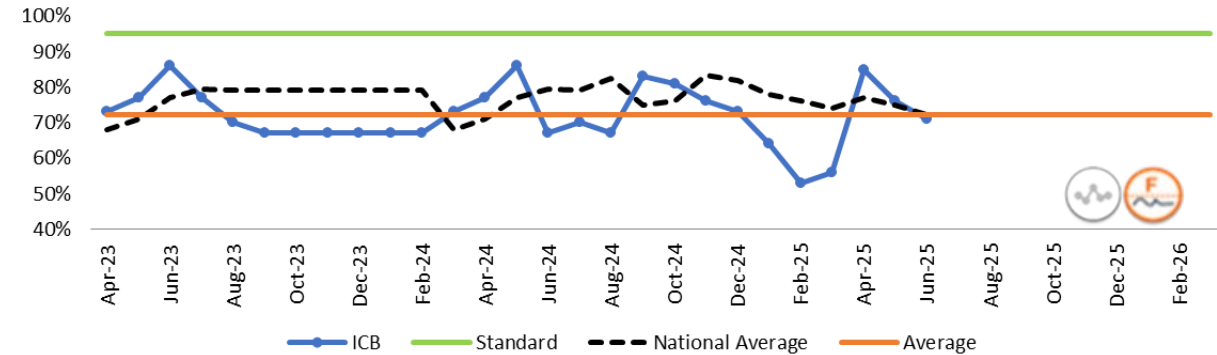
Talking Therapies: First treatment appointment within 18 weeks of referral (ICB)



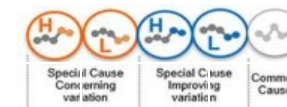
People experiencing first episode psychosis waiting to start a package of care (ICB)



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



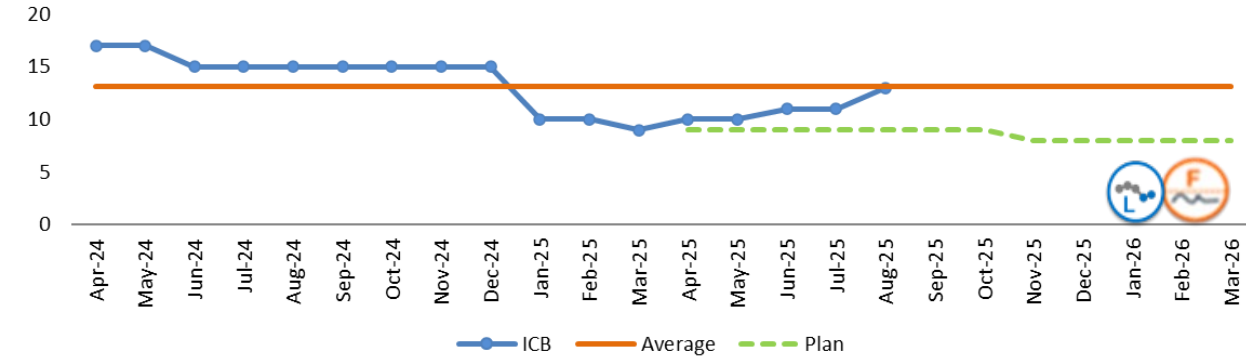
Lincolnshire ICB Quality Dashboard



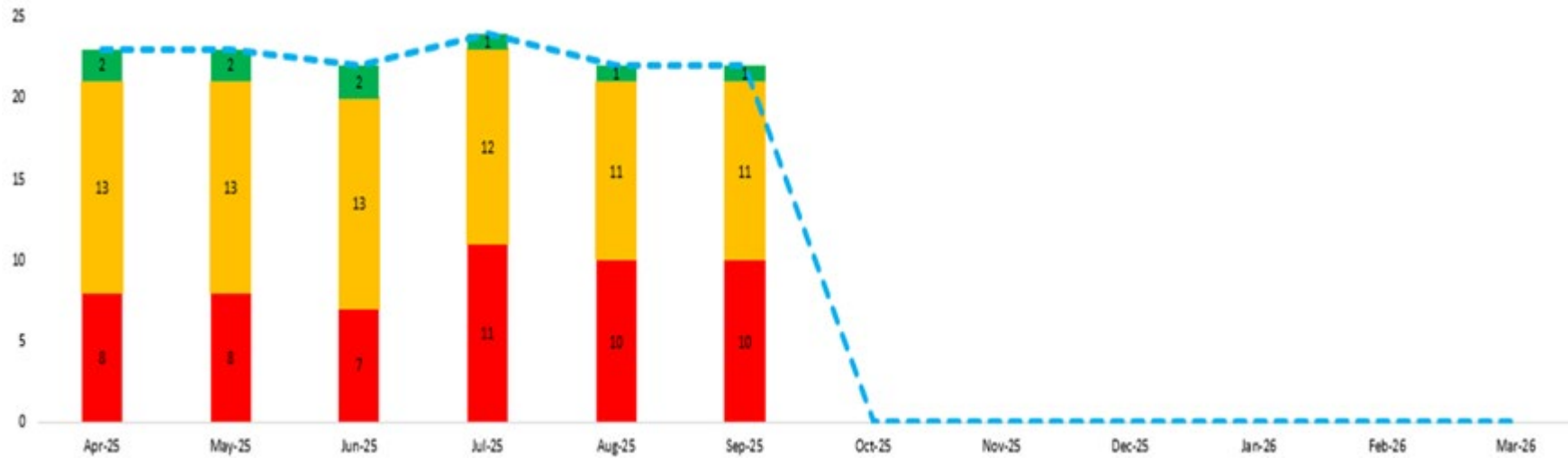
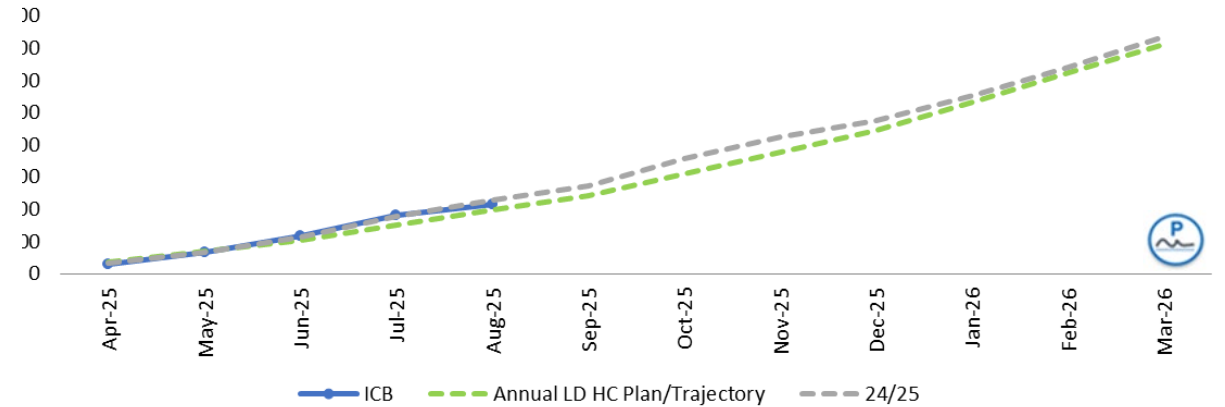
Programme	Indicator	Standard/ Plan	Period	Performance	Midlands	England	Trend		
							Sparkline	Variation	Assurance
Incidents	Never events - YTD (ULTH)	0	Jul-25	0	N/A	N/A	-		
	Never events - YTD (NLAG)	0	Jul-25	3	N/A	N/A	-		
	Never events - YTD (NWAFT)	0	Jul-25	3	N/A	N/A	-		
Mortality	Summary Hospital Level Mortality Indicator (SHMI) (ULTH)	-	May24 to Apr25	1.0750	1.0777	1.0045			
	Summary Hospital Level Mortality Indicator (SHMI) (NLAG)	-	May24 to Apr25	1.0118	1.0777	1.0045			
	Summary Hospital Level Mortality Indicator (SHMI) (NWAFT)	-	May24 to Apr25	1.0000	1.0777	1.0045			
Infection, Prevention, Control	MRSA Cases (ULTH 12 month rate per 100,000)	-	Jul-25	0.89	1.25	1.47			
	C-Diff Cases (ULTH 12 month rate per 100,000)	-	Jul-25	29.83	32.91	31.56			
	E-Coli Cases (ULTH 12 month rate per 100,000)	-	Jul-25	45.19	39.45	40.79			
Learning Disability	Inpatient Care for adults with a learning disability or LD & autistic (adults)	9	Aug-25	13	N/A	N/A			
	Inpatient Care for autistic adults (with no learning disability)	21	Aug-25	22	N/A	N/A			
	Inpatient care for children with LD/autism - Under 18s	2	Aug-25	3	N/A	N/A			
	Cumulative Learning Disability Healthchecks (ICB)	983	Aug-25	1,071	N/A	N/A			
Patient Experience	Patient experience of GP services (ICB)	-	2025	73.0%	N/A	75.0%			-
	Friends & Family Test: A&E Recommended (ULTH)	-	Jul-25	71.0%	N/A	80.0%			-
	Friends & Family Test: Inpatient Recommended (ULTH)	-	Jul-25	89.0%	N/A	95.0%			-
	Friends & Family Test: Community Recommended (LCHS)	-	Jul-25	88.0%	N/A	95.0%			-
	Friends & Family Test: Mental Health Recommended (LPFT)	-	Jul-25	91.0%	N/A	88.0%			-
Primary Care	Primary Care CQC- percentage of practices rated as 'Inadequate' by CQC	-	Aug-25	1.2%	N/A	0.4%			
	Primary Care CQC- percentage of practices rated as 'Requires Improvement' by CQC	-	Aug-25	7.4%	N/A	4.4%			-
	GP Appointments- Total appointments in GP practice	500,317	Jul-25	501,045	N/A	N/A			
	GP Appointments- time from booking to appointment same day	-	Jul-25	44.8%	N/A	44.2%			-
	GP Appointments- time from booking to appointment < 2 Weeks	85%	Jul-25	86.9%	N/A	81.8%			
	Enhanced access minutes provided (ICB) (YTD)	1,096,847	Aug-25	1,165,114	N/A	N/A			
	The percentage of available GP enhanced access appointments utilised (ICB) (YTD)	80%	Aug-25	87.6%	N/A	N/A			

Learning Disability & Autism

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



Cumulative Learning Disability Healthchecks (ICB)



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.
Clinical illness	- Those clients where the needs are best met in a secure environment
Market issues	- this is where we should concentrate the discharges on, as it is the lack of placement to discharge to, which is the reason why they have not been discharged

Insight and Signals – Quality and Patient Experience

Lincolnshire Community Equipment and Wheelchair Services:

From 1st August 2025 a new provider, Millbrook Healthcare, is in place for both Community Equipment and Wheelchairs replacing NRS Healthcare who went into liquidation. LCC continue to lead on the contract for these services. Due to the speed of the transfer to the new provider and the contingency arrangements that needed to be put in place an ICB led tactical cell was established to provide oversight and monitor impact over the transition period; this has recently been replaced by a recovery cell. These arrangements include consideration of harm related to any potential delays in equipment and wheelchair provision.

LPFT:

CQC issued a section 29A Warning Notice July 2025 in relation to rapid tranquillisation and restraint following the unannounced inspection that took place in June 2025. LICB led Quality Review meeting took place on 30th July which reviewed the CQC findings, actions taken, current position and next steps, to ensure the embedding of actions. A further meeting is due to take place October 2025 to review progress. Publication of CQC report is awaited.

ULTH:

CQC reports following unannounced assessments to Lincoln County and Pilgrim Hospital Emergency Departments were published this month. Urgent and Emergency Services at both hospitals were rated as Requires Improvement [Lincoln County Hospital - Care Quality Commission](#); [Pilgrim Hospital - Care Quality Commission](#). The reports highlight areas for improvement, however, also reflect for both sites that throughout the assessment staff were observed treating people with kindness, empathy, compassion and respect for privacy and dignity.

Insight and Signals – Primary Care

GP Practice quality:

- The Quality Early Warning Score (QEWS) programme is now becoming a routine process within GP practices with more participating each month. Processes are in place to manage start dates for those practices wishing to commence.
- Cliff Villages Medical Practice and Spilsby Practice are still currently receiving enhanced support via the QEWS process. Issues relate to changes in partnership arrangements; changes required to CQC registrations; and quality and safety concerns. These practices will be supported to achieve a good level in the 'Safe' domain prior to proceeding with the other quality domains.
- Due to ongoing CQC assessments in primary care the ICB has been able to demonstrate that QEWS results align well to the published CQC outcome reports

Pharmacy, Optometry and Dentistry (POD) quality:

- The Primary Care Quality Team has made good progress with the development of the QEWS process for Dental providers delivering NHS services. The final draft of the Dental QEWS tool is being discussed with a local Dentist for operational scrutiny prior to being processed for final approval within the system.
- Once the Dental QEWS tool is approved, the team will move on to a Pharmacy QEWS tool.
- The Primary Care Quality team are continuing to work with the Quality Services team to develop the incident reporting and management process for all commissioned POD services. This will ensure that all commissioned POD providers will use the same tools for incident reporting and learning using both PSIRF and LfPSE processes and will align to system incident management methodologies.

Insight and Signals – Primary Care

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

Metric	Target (25/26)	YTD (Jul)
GP appointments – total provided	5,902,651	1,860K (24k below plan YTD)
GP appointments - % within two weeks of contact	85%	87%
Patient experience of GP contact – rated as ‘Easy’	85%	83% (1% above plan YTD)
Same day confirmation	85%	75% (2% below plan YTD)
Preferred professional	71%	57% (5% below plan YTD)
Pharmacy First – total consultations	68,108	28K (7K above plan YTD)
Urgent Dental Appointments – total provided	46,580	10K (5K below plan YTD)
Units of Dental Activity delivered	786,810	274K (2K below plan YTD)
Adult patients seen by a dentist within 24 months - %	251,659/Qu	245K
Child patients seen by a dentist within 12 months - %	85,459/Qu	87K

Delivery of urgent dental appointments is significantly below plan year-to-date (YTD) – current demand is lower than expected and work is underway to promote the services. This is a regional and national issue.

Learning and Sharing

CNO Professional Strategy:

NHSE have launched a programme of work to develop a Chief Nursing Officer (CNO) Professional Strategy [NHS England » Professional strategy for nursing and midwifery](#). A regional event is being held in Birmingham on 16th September 2025 to help inform development of the strategy, Lincolnshire has nominated representatives from LPFT, LCC and LinCA to participate in the event. Lincolnshire nominations are reflective of our understanding locally of the contribution nursing and midwifery makes across our system, not just within the NHS.

Health and Care Careers Event:

A partnership approach to a Health and Care Careers event on 7th July 2025 brought together Lincolnshire Training Hub, Talent Academy, University of Lincoln, LICB, LCC, ULTH and LPFT. The event targeted Key Stage 3 (KS3) students with the intention of showcasing the breadth of opportunities available within healthcare and encouraging students to consider pursuing a healthcare career in the future.

The event received excellent feedback from students and teachers who attended and feedback was provided as to how the event could be improved/made more accessible, which will be used to inform future events. The aspiration is to hold a system-wide collaborative health and care careers event for KS3 students on an annual basis to encourage and inspire a future generation of healthcare workers across Lincolnshire.

System Quality and Equality Impact Assessment (QEIA):

In August 2025 System Quality Group approved a proposal for a System QEIA process and associated documentation. The proposals have been developed between LICB, LCHG and LPFT and will allow for a systematic and co-ordinated approach to QEIAs where service and pathway developments/redesign or cost efficiency schemes affect 2 or more NHS organisations. Whilst the Trusts will retain their existing documentation and processes for QEIAs for internal decision-making processes, the intention is to now undertake work to align LICB QEIA policies, processes and documentation with those agreed for the System.

Quality and Patient Experience Thematic Update: Children and Young People

- **Asthma Diagnostic pathway in CDCs** - Piloted in Skegness and now being rolled out to Lincoln and Grantham. This addresses long standing issues with no service. Countywide provision will be available once all CDCs are in place.
- **Epilepsy 12 Audit** - Lincolnshire/ULTH is no longer a negative outlier. There are however still capacity issues and additional epilepsy specialist nurses are required to meet relevant national standards.
- **SEND OFSTED/CQC Local Area Partnership Inspection** - Took place in February 2025. Issues for health were around quality of health input into EHCPs; neuro diversity pathway/community paediatric waits; and speech and language therapy waits. The partnership were already aware of these issues and were taking steps to address. Partnership improvement plan in place and regular meetings to monitor progress. The partnership can expect to be inspected in 3 years. Lincolnshire have not been placed in special intervention by Department of Education and NHSE as assured with our response.
- **Speech and language therapy**– LCHS are currently engaging with stakeholders and public on a proposed new drop in model working with Family Hubs which it is anticipated will reduce waiting times.
- **Cardiology** – Work ongoing with Specialised Commissioning, UHL, ULTH and ICB to address waiting times and ensure sustainable model is in place for the future.
- **Tier 2 Continence** - Recommissioning of Tier 2 CYP continence provision is taking place
- **Was Not Brought** – Lincolnshire has a high percentage of children that are not brought to hospital. Some targeted work is taking place, engagement work has launched to understand reasons for this.
- **Transition into adult services** – ICB Position Statement has been agreed. Work ongoing in Trusts.
- **Implementation of CYP Neighbourhood Teams (NHT)** - CYP Integrated Transformation Board Development Session was held 15 July focusing on CYP NHT implementation. Looking at population health management data to determine priority areas. Requirement to have at least one in place by March 2026.
- **CYP Integrated Commissioning Team** – Currently reviewing priorities and workplan to ensure reflect local issues and new expectations set nationally e.g. development of CYP neighbourhood teams, cerebral palsy national transformation, and complication of excess weight clinics(CEWS)

Winter 2025 vaccination programmes

- Covid**
- All cohorts commence 1st October
 - Winter cohort now aligns with the Spring cohort
 - Care homes will be monitored
 - No healthcare workers

- Flu**
- Children and maternity commence 1st September
 - Care homes will be monitored
 - All long stay inpatients will be offered a vaccine.
 - All patients being discharged from hospital to care homes will be offered a vaccine.
 - All other cohorts 1st October
 - Frontline healthcare workers.

- Delivery**
- Primary care
 - LCHS Vaccination Rapid Response Team (VRRT)
 - Local Pharmacies
 - Trust colleagues, ULTH, LPFT and LCHS, EMAS

- Comms**
- Localise systemwide comms produced and shared
 - Cartoon style short videos produced
 - Focus on healthcare workers, age 2-3, over 65's and maternity.
 - Lincolnshire Grab a job page continues to be the most visited ICB page.

UEC winter plan Requirement	Detail
Improve frontline staff flu uptake by 5% nationally	There is a particular focus on this this year. A survey was conducted post 24/25 with senior leaders within healthcare in Lincolnshire, this was to see the process through a different lens and to garner opinions on what could be improved upon across the system. Two main recommendations are, system wide comms with new messaging around side effects of the vaccine and how to manage these, a short training course developed and delivered by providers specifically for leaders, this will allow leaders across the system to champion and lead by example when it comes to discussing vaccines. Lincolnshire would need to increase by 2% to be inline with a 5% rise nationally.
Strengthen the childhood flu vaccination offer	Piloting GP delivery of flu vaccinations in nursery and early years settings in areas of low uptake. Working on local comms and marketing materials to promote the flu vaccine for children, focused on the ease of the nasal spray vaccine based on a successful Public Health Scotland campaign. Education for Early Years settings in the form of webinar/s in partnership with Public Health to improve confidence of Early Years staff in promoting the flu vaccine for young children.
Local campaigns to target those in clinical risk groups	The East Coast is a significant low uptake area for all vaccinations, and winter vaccinations are no exception. Help and support will be provided to support primary care from LCHS VRRT . We have 6 Pharmacies in these areas leading to a wide choice of access, vaccine scepticism and education around vaccination requires addressing in these areas. Further engagement from the local primary care providers with support from LCHS VRRT will support with this. The pneumococcal polysaccharide vaccine (PPV) and respiratory syncytial virus (RSV) respiratory project over the summer to increase uptake prior to the winter and allow vaccine conversations with at risk patients who remain unvaccinated, this would not have happened on this scale prior to this.
Achieve 60% uptake for routine RSV vaccination	LCHS VRRT will utilise the year-round funding they have, by undertaking a timed piece of work, utilising the outreach model that has been successful with the Winter vaccination programmes. Working directly with selected GP practices, they will offer engagement visits and discussions and vaccinations at convenient times and locations, such as the GP surgery or, available community spaces.

Finance: Summary Financial Position (1)

Year To Date Financial Position

The ICS reported a £18.6m deficit at Month 5 which was £3.8m adverse variance from the submitted financial plan of £14.7m deficit.

The ICB reported a £3.3m deficit at Month 5 which equated to a £3.9m adverse variance from the planned £0.6m surplus.

Outturn Financial Position

The ICS' plan is to deliver a break-even position against in year allocations and income for the full financial year. At Month 5 the ICS reported delivery of this plan.

The ICB has a plan to deliver a £3.72m for the full financial year. At Month 5 the ICB reported delivery of this plan.

Risks and Mitigations

The ICB has identified risks of £29.6m to delivery of the plan for the financial year. Main risks being delivery of CIP, Prescribing and CHC. Mitigations of £16.9m result in a net risk of £12.7m.

The ICS has an overall net risk of £28.6m.

Finance: Summary Financial Position (2)

Cost Improvement Plan

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

At Month 5 the ICS has reported delivery of £54.6m cost improvements against a plan of £53.8m equating to a £0.8m favorable variance to plan.

Capital

The ICS has a full year Capital Departmental Expenditure (CDEL) Limit of £133.1m. £37.9m of this relates to Business As Usual (BAU). The remainder of the capital is predominately for specific projects – the largest being £43.0m for the ULTH Frontline Digitalisation Programme (Electronic Patient Record).

The ICS is expecting to spend £139.4m. This overspend is due to notified additional capital allocations and is therefore expected.



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	05 (ii)
Meeting Date:	Tuesday, 30 th September 2025
Title of Report:	Lincolnshire ICS Winter Plan 2025/2026
Report Author:	Mrs Rebecca Fieldsend, UEC System Programme Lead
Presenter:	Mrs Rebecca Neno, ICB Deputy Director for System Delivery & Winter Director
Appendices:	Winter Plan 2025/2026 ICB Board Assurance Statement

To approve <input checked="" 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

Board Members are asked to consider work undertaken in preparation of Lincolnshire's winter plan for 25/26 and approve the Board Assurance Statement for Winter in line with national requirements.

Summary

The Lincolnshire Integrated Care System (ICS) Winter Plan for 2025/26 has been developed collaboratively and influenced by national and regional Urgent and Emergency Care (UEC) guidance issued by NHS England, as well as applying learning from previous winters within our local system, regionally and nationally.

During the summer of 2025, the Lincolnshire system continued to experience increased levels of demand aligned to the seasonal pattern of visitors to our East Coast. We must ensure that services can respond to the expected increases in demand over winter and resilience can only be achieved through continued partnership working across the health and care system. As partners of the Lincolnshire ICS, we continue with our commitment to working together to manage these challenges and ensure that our population can access safe services and have good outcomes with a positive experience.

The purpose of this Winter Plan is to highlight the early local assumptions for winter and set out our planned response to manage the urgent care and patient flow pressures that the system will inevitably experience.

The plan is designed to supplement the ongoing improvements and developments in urgent care in line with the National 25/26 Urgent and Emergency Care Plan and is inclusive of those requiring both physical and mental health care.

During June 2025 NHS England Midlands Regional team shared a set of Key Lines of Enquiry (KLOEs) to support development of local winter plans and supported local and regional stress testing of winter plans, the outputs of which have supported development of this final plan.

The plan has been presented at the following events, committees, and forums and was submitted as a first draft to NHS England's Midlands Regional Team.

Version	MEETING	DATE
1 st Draft	UEC Partnership Board	01/08/2025
1 st Draft	Submission to NHS England Regional Team	01/08/2025
1 st Draft	Local Stress Test of Winter Plan	04/09/2025
2 nd Draft	ICB Executives	11/09/2025
2 nd Draft	UEC Partnership Board	12/09/2025
2 nd Draft	Regional EPPR Stress Test of Winter Plan	17/09/2025
Final Draft	Service Delivery & Performance Committee	24/09/2025

The Winter Plan 25/26 clearly sets out the actions that will be delivered during winter and describes the governance mechanisms to help identify early issues and the need for course corrections.

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

Aim 1: Improve outcomes in population health and healthcare.	This plan aligns with the core purpose of an Integrated Care System which is to improve outcomes in population health and healthcare.
Aim 2: Tackle inequalities in outcomes, experience and access.	The winter plan will support health and care services to build capacity and operational resilience for winter for the benefit of patients and service users.
Aim 3: Enhance productivity and value for money.	The plan highlights multiple actions being taken to integrate services across Lincolnshire to enhance productivity and maximise value for money.
Aim 4: Help the NHS support broader social and economic development.	Not applicable.

Conflicts of Interest

No conflict identified

Summary of conflicts

Risk and Assurance

The winter plan will support performance improvement and achievement of planning targets which have been agreed, but acknowledging constitutional targets remain in place.

Key risks for winter 2025/2026 are detailed within the plan but can be summarised as follows:

- Patients could wait for care in community, or within front door services.
- Patients could experience delays in discharge

<ul style="list-style-type: none"> • Some service fragility continues along the East Coast and Boston area. • Impact of Industrial Action • Workforce levels due to national NHS and local organisational changes and the ability to utilise winter funding where additional workforce would be required. 			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?	No – the plan is funded within financial envelope available, however the ability to maximise use of the winter funding could be impacted by workforce.		
Does the report highlight any quality and patient safety implications?	Yes – the plan highlights risks of delivery and relevant mitigations.		
Does the report highlight any health inequalities implications?	Yes – the plan details where we are using opportunities to level up services, e.g. mental health service provision on the east coast.		
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 checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Report previously presented at:			
As listed above			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			



Lincolnshire
Integrated Care Board

Lincolnshire Integrated Care System

Winter Preparedness

2025-2026



Executive Summary

The Lincolnshire Integrated Care System (ICS) Winter Plan for 2025/26 has been developed collaboratively and influenced by national and regional Urgent and Emergency Care (UEC) guidance issued by NHS England, as well as applying learning from previous winters within our local system, regionally and nationally.

During the summer of 2025, the Lincolnshire system continued to experience increased levels of demand aligned to the seasonal pattern of visitors to our East Coast. We must ensure that services can respond to the expected increases in demand over winter and resilience can only be achieved through continued partnership working across the health and care system. As partners of the Lincolnshire ICS, we continue with our commitment to working together to manage these challenges and ensure that our population can access safe services and have good outcomes with a positive experience.

The purpose of this Winter Plan is to highlight the early local assumptions for winter and set out our planned response to manage the urgent care and patient flow pressures that the system will inevitably experience. The plan is designed to supplement the ongoing improvements and developments in urgent care in line with the National 25/26 Urgent and Emergency Care Plan and is inclusive of those requiring both physical and mental health care. During June 2025 NHS England Midlands Regional team shared a set of Key Lines of Enquiry (KLOEs) to support development of local winter plans and supported local stress testing of winter plans, the outputs of which have supported development of this final plan.

This year we continue to focus on the avoidance of patient harm by adopting an approach that focuses on clinical risk, the main areas of risk in the Urgent and Emergency Care pathway are as follows:

- Patients could wait for an urgent or emergency response in community settings.
- Patients could experience waits in Emergency Departments and Urgent Treatment Centers (UTC).
- Patients could wait on ambulances prior to entering Emergency Departments.
- Patients may experience waits for discharge home or into community settings.
- Some service fragility continues along the East Coast and Boston area, specifically in relation to Children and Young People and some Mental Health services.
- Impact of Industrial Action on urgent and emergency care pathways, planned care provision and patient experience.
- Workforce levels due to national NHS and local organisational changes

Contents

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 - 3.2 Trends, Forecasts and Impact of Infectious Disease
 - 3.3 Workforce
4. Winter Response
 - 4.1 Primary and Community Care
 - 4.2 Hospital Care & Discharge
 - 4.3 Mental Health
 - 4.4 Children & Young People
 - 4.5 Specific Support for Care Homes
5. System Working and Escalation
 - 5.1 System Co-ordination Centre
 - 5.2 Escalation and Assurance
6. Quality and Risk Management
 - 6.1 Risk Management
7. Communication
8. Conclusion & Evaluation

1. Introduction

Integrated care is about ensuring that people get the help and support they need, joined up across local councils, the NHS, and other local partners. It removes traditional and historical divisions between hospitals, community services and family doctors, between physical and mental health, and between NHS and council services. In the past these divisions have often meant that some people experienced disjointed care and over the years we have recognised the growing importance of all local health and care providers and commissioners working together to provide the best services we can.

This document outlines the planned Lincolnshire collective response to urgent and emergency care during anticipated peak times of demand over winter, to ensure patients get the safest, most effective and efficient services responding to their need. We continue to recognise the importance of managing patients wherever most appropriate and safe to do so including within their own homes or usual place of residence, providing health and care in an integrated way and relying less on acute and inpatient services. This plan sets out how we will ensure services provided by each of the partners that make up our system will be resilient through this winter. We have arrangements across all Lincolnshire ICS partners to manage patient flow between our services. Working together, we use the Operational Pressures Escalation Level (OPEL) system which identifies the actions we all need to take when we are under increased pressure.

Experience through the pandemic and in the following years demonstrated that, on a day-to-day basis, all our partner organisations in Lincolnshire are stronger and better when we work more closely together. We have a shared commitment and determination to ensure people are cared for in the right place at the right time, so that they can achieve the best health outcomes.

The national Urgent and Emergency Care plan 2025/26 built on the previous review by Lord Darzi and highlights several key focus areas including:

- From treatment to prevention
- From hospital to community
- High quality emergency care
- Improving flow through hospitals
- Ending 12 hour waits
- Mental Health teams leading from the front
- Whole system approach to improving patient discharge
- From analogue to digital

In addition, we continue to ensure that our clinical ambitions detailed below are at the forefront of all Urgent and Emergency Care service delivery and any improvement work undertake.

- ✓ **Our team members have optimal time and resources to provide great care, in line with agreed professional standards.**
- ✓ **Our patients and team members are treated with respect, kindness, and compassion.**
- ✓ **Our teams work collaboratively across the whole system, to join up care in a way that matters to our patients and those who matter to them.**
- ✓ **All patients are cared for in an appropriate and safe environment, minimising the risk of hospital acquired infection and harm.**
- ✓ **Patient records are shared across clinical teams to enhance patient safety and reduce the need to share the same information multiple times.**
- ✓ **Where possible care is delivered 'closer to home'; if patients need a stay in hospital, they are admitted quickly to the right bed to meet their clinical needs and when they are ready, they are discharged home without delay.**
- ✓ **Our culture is one of learning and continuous quality improvement.**

As a system we will work together to drive delivery of the plans developed and set out in the Lincolnshire System Winter Plan, managing risk and daily patient flow between all our partners through our System Co-ordination Centre who, along with our Winter Directors, will ensure a continuous focus on the plan so we deliver the safest, most appropriate care we can, for the population of Lincolnshire, over the winter months.

2. Context

The purpose of this winter plan is to demonstrate the Lincolnshire system approach to operational management of winter, detailing the specific pressures anticipated for our system during a time of national change and how we intend to mitigate them. Urgent and Emergency Care continues to be under significant pressure both locally and nationally and we anticipate another busy end to summer with increasing numbers of people attending our Emergency Departments and Urgent Treatment Centres as well as high levels of wider system demand within primary, community and mental health care. Despite the growing demand for urgent care services, at the start of 2025/2026 we made some notable improvements for our population with improvement in overall category 2 ambulance response times and a reduction in handover delays from our ambulance service (East Midlands Ambulance Service) to our acute provider (United Lincolnshire Teaching Hospitals NHS Trust). However, there is still much more to do, alongside delivering our commitments in relation to cancer care, elective (those needing operations) and outpatient care, maternity and children's and young people's care, as well as mental health care and support for those with, learning disabilities and autism.

Planning assumptions for the upcoming winter will continue to be informed by data and insights from the UK Health Security Agency (UKHSA) as they become available. Infectious diseases such as Influenza, Covid-19, and Norovirus typically place increased strain on health and care services during the winter months. While the expected profiles of these common infectious diseases for winter 2025/26 are not yet fully understood, early planning assumptions are based on a cyclical pattern, with a likely early impact in line with last winter.

To manage the associated risks, the Lincolnshire system has implemented the following measures:

- ✓ **Arrangement with our community provider to prescribe influenza prophylaxis to those meeting the clinical requirements.**
- ✓ **Care Home Infection Prevention and Control (IPC) support including local outbreak management support, with dedicated Senior Health Protection Nurse for each setting.**
- ✓ **Integrated Health Protection approach across the system and Infection Prevention and Control collaborative in place.**
- ✓ **Integrated Care Board (ICB) engagement in all outbreak meetings across the system.**

Our focus remains on protecting those in society who are at a higher risk of severe Covid 19 infection and other infectious diseases. To achieve this, we continue to implement planned and targeted vaccination programmes across the county. Ensuring a sustainable Covid 19 vaccination programme is a crucial aspect of health protection, and we are committed to making vaccination services accessible to all eligible groups. The Lincolnshire Covid 19 vaccination programme has previously been highly successful, achieving excellent uptake amongst our population, and we take pride in continuing to be one of the best performing systems both regionally and nationally.

Our vaccination strategy includes a focus on:

- Workforce Vaccination
- School age Children
- Pre-school Children
- Care home and Housebound patients
- Respiratory

Workforce

Our staff vaccination model will ensure that staff across Health and Care can access influenza vaccination through a combination of peer-to-peer vaccination, drop-in clinics and planned clinics covering 7 days. Staff can also access vaccination through community pharmacies. The Lincolnshire target agreed by our immunisation Programme Board has been set at 45% which is an increase of 2% on last year's uptake, and in line with the national Urgent and Emergency

Care Plan for 25/26. Achievement of this stretch target would ensure influenza vaccination rates in Lincolnshire would be 5% above the national figure for 24/25 and help protect our workforce and the people they work with from the effects of the illness.

Clinical at-risk groups

We have completed extensive work to identify our clinical at-risk groups along with our areas of deprivation where vaccine uptake is typically lower resulting higher risk for those already deemed at risk. Within Lincolnshire these areas include Lincoln, Gainsborough, and along the East coast.

The East Coast is a significant low uptake area for all vaccinations, and winter vaccinations are no exception. Dedicated support from our mobile vaccination team will support primary care in these areas to help reach our population who otherwise may not come forward. In addition, we have 6 Pharmacies in these areas leading to a wider choice of access. We will ensure communication are targeting at risk clinical groups during the influenza campaign and providers will take a 'Making Every Contact Count' (MECC) approach. The Pneumococcal Polysaccharide Vaccine (PPV) and Respiratory Syncytial Virus Vaccine (RSV) respiratory project over the summer has focused on increasing uptake prior to the winter period and deliver early vaccine conversations with at risk patients who remain unvaccinated.

Respiratory

Alongside existing primary care programmes we will undertake a timed piece of work, utilising the outreach model that has been successful with the Winter vaccination programmes. Working directly with selected GP practices, we will offer engagement visits, discussions and vaccinations at convenient times and locations, such as the GP surgery or, available community spaces. Increasing the uptake of PPV and RSV is a multifaceted effort that requires collaboration between commissioners public health officials, primary care, healthcare providers, and the community. By implementing these plans, we can enhance the protection of individuals and communities from severe respiratory diseases, improving health outcomes and quality of life as well as reducing, GP contacts and ultimately hospital admissions.

Vaccination Communication Plan

- Sharing of local influenza messaging across the system and all local partners
- Senior leadership from across the system to promote vaccine uptake
- Regular reporting of uptake levels both at a system level and individual provider level
- Executives are contacting staff individually to encourage uptake of winter vaccinations
- Ensuring that influenza messages are shared in appropriate languages and easy to read versions to our public
- Digital communication materials being developed that will be used throughout the programme
- Ensuring that national and local communications are aligned
- Specific communications for individual cohort groups which will be shared with stakeholders
- Information for clinical staff to be shared to prompt open conversations in team meetings, staff huddles etc

3. Preparation for Winter 2024/25

Building on our learning from last winter, and the work undertaken throughout the year the following preparatory work has supported development and agreement of the winter plan:

- **April:** Finalisation of 25/26 operational plan assumptions around capacity and demand plans including winter period
- **May:** Review of winter learning at Urgent and Emergency Care Partnership Board
- **June:** Development and submission of response to NHSE regional KLOEs
- **July:** System attendance at the NHS England Midlands winter webinar
- **July:** System Winter planning session
- **July:** System clinical and operational leadership meeting facilitated by the ICB Medical Director, Chief Nurse and Deputy Director for System Delivery to agree key areas of focus for development and inclusion in final winter plan.
- **August:** Draft winter plan submission to NHS England regional team, and continued development of final system winter plan
- **September:** Local stress testing of the draft winter plan with Lincolnshire operational colleagues and EPRR leads.
- **September:** Stress testing by NHS England Midlands Regional Team of draft winter plans.
- **September:** Board reviews of final draft winter plans and submission of board assurance statements.

In June 2025, NHS England Midlands regional team wrote to constituent Integrated Care Systems (ICS) setting out a regional approach to winter planning. In July 2025 NHS England national team set out the national expectations around winter planning detailing an expectation that draft winter plans are developed by the end of August and then stress tested with regional teams during September. Following the exercise, Boards must sign off plans and submit Board Assurance Statements by 30th September 2025. This requirement has been built into the local timelines, ensuring adequate governance, for development, testing, assurance and sign off of the Lincolnshire System Winter plan as detailed below:

Version	MEETING	DATE
1 st Draft	UEC Partnership Board	01/08/2025
1 st Draft	Submission to NHS England Regional Team	01/08/2025
1 st Draft	Local Stress Test of Winter Plan	04/09/2025
2 nd Draft	ICB Executives	11/09/2025
2 nd Draft	UEC Partnership Board	12/09/2025
2 nd Draft	Regional EPPR Stress Test of Winter Plan	17/09/2025
Final Draft	Service Delivery & Performance Committee	24/09/2025
Final Draft	ICB Public Board	30/09/2025
Final Draft	Health Overview and Scrutiny Committee for Lincolnshire	19/11/2025

3.1 Capacity and Demand Reviews

Capacity and Demand assumptions for Winter 2025/2026 were originally submitted as part of our operational plan for 25/26 earlier this year, however, we continuously revisit and challenge our original modelling assumptions both using the current activity and performance data, and when new interventions are mobilised or changes and improvements made to ensure that they are rebased using shared learning. Working across system partners we will continue to undertake dynamic reviews of demand and capacity modelling to understand and manage winter pressures effectively, minimise excessive delays in the Emergency Departments including waits for admission and ambulance handover delays.

Data analysis has been recently undertaken at system level to understand the Health Inequalities within Urgent and Emergency Care pathways. This has informed the development of the winter plan and to support identification of gaps and risk. Patient engagement is planned to understand the reasons behind disproportionate use by some groups and interventions and communications tailored based on feedback. In addition, throughout summer the system has specifically revisited demand and capacity assumptions in line with the regional winter letter quantitative ask and has supported identification of priority areas of risk to develop mitigation and prioritise limited financial resource investment into winter initiatives. While the demand and capacity metrics have been fully modelled, there is ongoing work to do to revisit and refine demand and capacity ahead of and during winter to ensure that our model which currently includes assumptions, is updated with actual demand and capacity levels.

The workforce forecasting work also continues and is a detailed piece of work. System partners and stakeholders including operational, activity, digital and workforce colleagues have been engaged through a system task and finish group. The System is working with a strategic workforce planning tool and will utilise this further to finalise assumptions and resource needed.

The capacity and demand modelling continues to suggest three key areas of focus for our system during winter which are critical in ensuring our urgent care system can manage the anticipated pressures:

- **Attendance Avoidance**
- **Admission Avoidance**
- **Reduced Length of Stay**

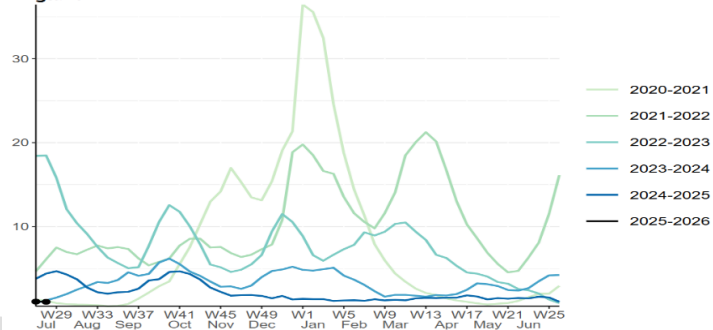
Throughout the winter period we will continue to refine and redefine modelling work considering:

- **Further Urgent and Emergency Care programme and winter initiatives as they come online together with assessing our assumptions for level of impact.**
- **The impact of Industrial Action.**
- **The position against recovery plans for Elective and Cancer activity and performance.**
- **The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19 and RSV.**
- **Met Office forecasting for excessive cold weather periods, as a predictor of increased respiratory conditions and falls.**

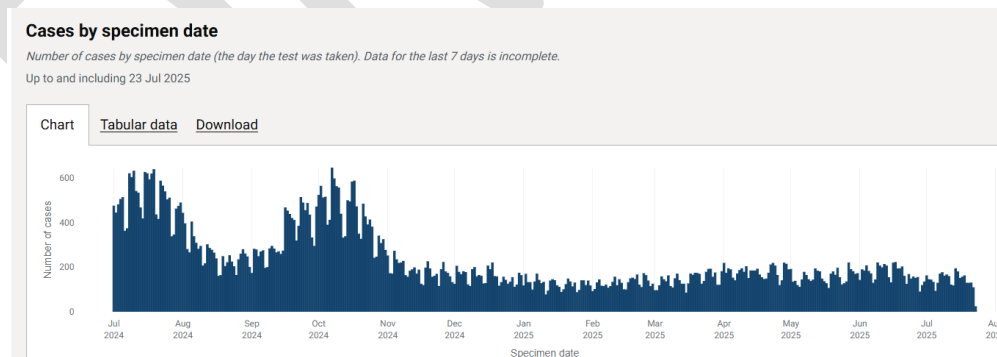
3.2 Trends, Forecasts and Impact of Infectious Disease

Predicting trends and peaks in demand during the winter period is crucial for mitigating risks and managing system pressures. However, it remains challenging to accurately forecast what the winter 2025/26 period may look like in terms of Covid 19, Respiratory Syncytial Virus (RSV), Invasive Group A Streptococcal (iGAS) disease, Influenza and Measles. Despite this uncertainty, the transmission levels of viral respiratory pathogens in summer are as expected, suggesting that we are likely to see similar levels this winter, as in recent years. Weekly epidemiology will be analysed and shared across the system, including threat assessments, to better predict system pressure this winter. Current data suggests that we are likely to see highest rates of Influenza, Covid 19 and RSV during December and into January. This period coincides with Christmas, New Year, and the re-opening of schools, which aligns with hospitalisation and disease notification trends from previous years, as illustrated in the charts below. Last winter, RSV followed the expected 6-week epidemic pattern, peaking in November and December, with the highest admission rates in the 0–4-year age group. Nationally, influenza activity in 23/24 was lower but observed over a longer period, resulting in fewer hospitalisations compared to previous influenza seasons.

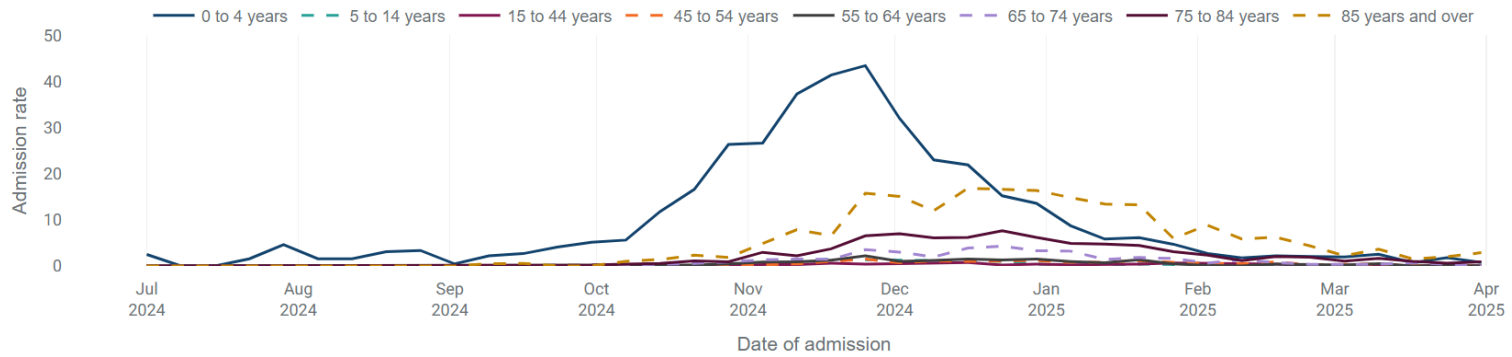
Figure 6. Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population reported through SARI Watch mandatory surveillance, England



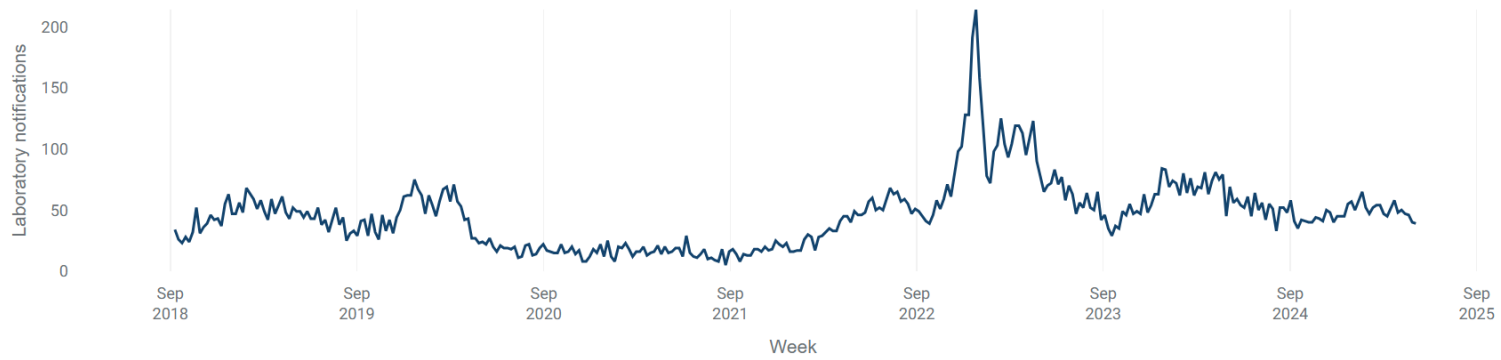
Covid 19 admissions to hospital across the Midlands during 2024/25 followed a cyclical pattern which is likely to continue throughout winter 2025/26.



Covid hospital admissions, England - 17 July 2025 Covid and Influenza report

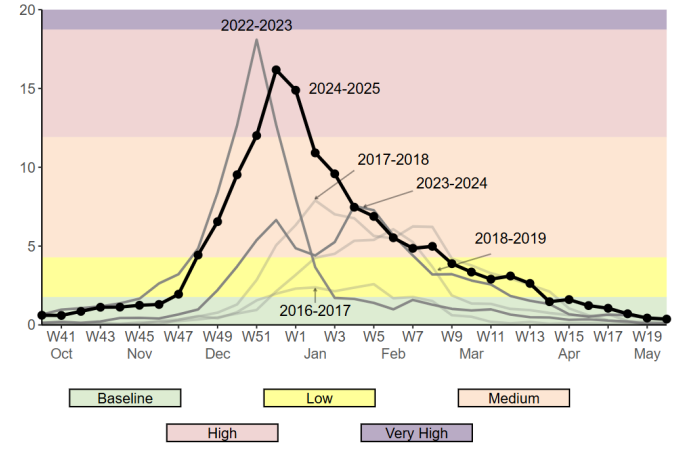


RSV hospital admissions rate by age, England (excluding Intensive Care Units (ICUs) and High Dependency Units (HDUs)) - up to and including 31 March 2025, from RSV dashboard

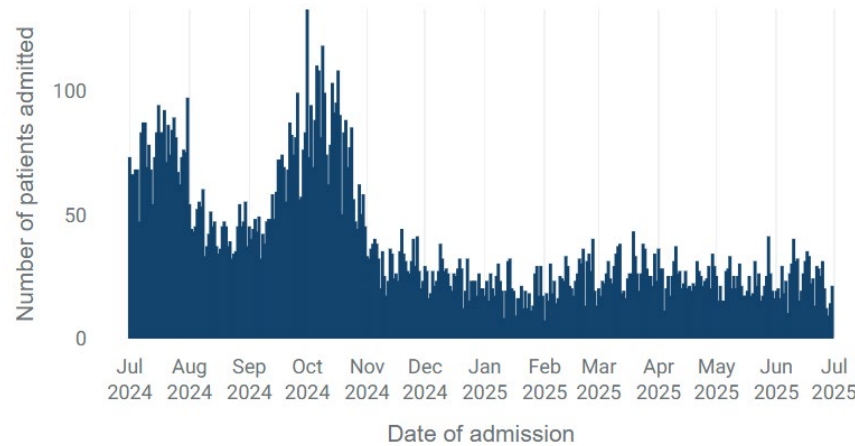


iGAS weekly laboratory notifications - up to and including week beginning 5 May 2025, from iGAS dashboard

Figure 26. Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, reported through SARI Watch sentinel surveillance, England [note 15]



Influenza hospital admissions - from 22 May 2025 Covid and Influenza report



Daily number of Covid-19 patients admitted to hospital, Midlands - up to and including 30 June 2025, from Covid dashboard

Norovirus has been higher across the East Midlands and England during the summer months, which is seasonally atypical, however at this time there is nothing to suggest that the typical winter presentation will not occur. Measles cases are now rising after a significant outbreak across England in early October 2023, primarily centred in Birmingham. To date, Lincolnshire has reported minimal cases. Our focus remains on our preventative work which

includes robust infection, prevention, and control measures, alongside targeted vaccination campaigns, to prevent and contain any potential outbreaks within the county. As cases rise across the Midlands there is an increase in the likelihood of cases within Lincolnshire. Pertussis (whooping cough) cases have remained stable over the summer period but may increase in the autumn. These outbreaks are believed to be linked to reduced exposure during the Covid 19 pandemic and declining vaccine uptake. Effective vaccination campaigns, particularly targeting pregnant women, are crucial in preventing and controlling potential cases.

All respiratory syndromic data will be analysed weekly to ascertain significant changes in prevalence and incidence, as well as short-term trajectory. This data will be shared across the system fortnightly, or on a needs basis based on likely impact, to ensure the system is informed on potential future demand caused by communicable diseases. System wide plans are in place to mitigate risks associated with both respiratory and other communicable diseases which may pose a threat this winter. This includes plans for respiratory viruses (Covid, flu, RSV, pertussis, and others), Mpox, measles, and other vaccine preventable diseases. All plans include proactive and reactive elements, ensure that the system is doing all they can to increase vaccination uptake, cascade key messages of how to keep yourself well, whilst also planning for significant outbreak response.

3.3 Workforce

The Lincolnshire system operational plan included a workforce plan which has considered the need to ensure a flexible workforce across winter to meet the changing needs of activity that the system may possibly face. It aligns to current vacancy control measures put in place across the system which ensures all vacancies, especially patient facing roles, undertake a quality impact assessment with a view of Executives determining the need to actively recruit or to consider alternatives including skill mix. The system has seen positive results in addressing the vacancies and reducing the overall need for agency through additional strategies such as implementing rota clinics to support staff to maximise capacity and resource. Flexible working practices continue to be embedded altogether seeing a continued positive downward trajectory for turnover levels.

The health and wellbeing of our workforce continues to be a priority, and for quarter one we have evidenced that we are achieving our plan. The holistic system health and wellbeing offer together with individual providers employee assisted programmes and further training and education for both staff and managers alike, is ensuring that staff feel appropriately supported through their absences and supported when returning to work with a view of sustaining attendance and mitigating future occurrences with prevention strategies/assessments. These include but are not limited to:

- People Promise ethos embedded across all providers including primary care
- Improved and meaningful health and wellbeing conversations which takes account of personalisation – “what matters to you” rather than “What is the matter with you”
- Communication and Engagement relating to prevention e.g. importance of hydration
- Access to Mental Health First Aiders and Freedom to Speak Up Guardians as well as Cultural Ambassadors
- Improved access and success of flexible working arrangements, e.g. hybrid working (home/office), carers leave, flexible hours.

Furthermore, the recent independent Occupational Health Review and the new appointment of a Business Manager is seeing an improvement in service delivery as recommendations are implemented and will play a significant part in engaging with the workforce alongside managers and executives to promote and encourage vaccination uptake. We have agreed a Memorandum of Understanding and/or Honorary Contracts which is in place across the health and care system which allows the sharing of workforce across individual organisations. This has been strengthened since the Covid 19 pandemic and would be utilised again to mitigate against any potential escalation in demand or shortage of workforce.

As part of our demand and capacity planning for winter, we have system wide visibility of weekly forecasts of staffing levels including assumptions around absence due to illness and industrial action, the options for surge staffing and our expected deployment of bank and agency staff, acknowledging the constraints of the workforce levels this year. This was a detailed piece of work, involved all relevant stakeholders including operational, activity, digital and workforce colleagues through a task and finish group. We have worked with a strategic workforce planning tool and will be looking to utilise this further to revisit our assumptions and resource needs. We will use our current governance structures for workforce to regularly monitor and assess/modify plans accordingly. It is however important this year to acknowledge that we will start the winter period with a very different workforce baseline compared to previous years and with some key services going through workforce change. Given current plans it is likely we will be unable to increase workforce levels over the winter period as we have done in previous years and we expect continued national scrutiny on headcount in light of national NHS change.

4. Winter Response

Previously NHS systems have received financial investment for service improvement and additional monies to provide short term winter services. Last year and again this year, this money was received as part of our overall financial allocation at the beginning of the financial year to aid planning and to allow systems to continue to fund those initiatives implemented over the last two winters in a sustainable way. This however means that there is no additional funding available for winter this year.

As part of the operational planning process early in the year, the system identified a small pot of funding to utilise for any additional winter initiatives, acknowledging that workforce to deliver any additionality would be challenging. Following further review of the gaps identified in the Demand and Capacity work, the system has been through a process with winter directors to identify priority interventions, the associated impact and then prioritise the small amount of available investment. Additional surge beds in acute are already built into the bed plan for the winter period and our priority areas for investment include:

- Paediatric pathways and increased clinical capacity at our front doors
- Respiratory clinical capacity and Acute Respiratory Infection pathways
- Transport capacity
- Attendance and admission avoidance initiatives across community
- Discharge support

4.1 Primary care, Community Care and Neighbourhoods

Primary Care, community services and the developing neighbourhood approach in Lincolnshire are all key to our ability to support attendance and admission avoidance and to reduce the reliance on acute services. We know that increasing numbers of patients are accessing our GP practices, community pharmacies, Urgent Treatment Centres and that demand across community services is growing.

We continue to work with across the system to ensure that where appropriate and safe to do so we are accessing alternatives to attendance and admission, supporting people in their own home or within community settings through:

- ✓ **Consistent risk stratification of patients to proactively identify and support those that are vulnerable and frequent users of our services.**
- ✓ **Maximise utilisation of our 2-hour Urgent Community Response (UCR) service and other community-based admission avoidance pathways.**
- ✓ **Maximise utilisation and capacity of Virtual Wards across Lincolnshire.**
- ✓ **Single Point of Access (SPoA) for Health Care Professionals (HCPs) to help navigate admission avoidance pathways including ambulance crews calling for community support before conveying to an Emergency Department.**
- ✓ **Integration of the Lincolnshire Clinical Assessment Service, the East Midlands Ambulance Service (EMAS) Emergency Operations Centre and the LIVES falls service to support timely and appropriate responses to people in the community.**
- ✓ **Implementation of an Acute Respiratory Infection pathway.**

Our practices continue to utilise Population Health Management tools along with general data analysis and risk stratification to identify those individuals who would benefit from proactive and preventative intervention and there are specific projects in PCNs focused on frailty, social prescribing and high intensity users which will support people in the community.

The primary care programme will continue to provide focussed support to primary care services to optimise available capacity and reduce system pressure by providing care in the right place at the right time.

Priority areas include:

- ✓ **Supporting 111 direct booking for GP appointments**
- ✓ **Promote the use of the NHS app to patients and carers for access to services online**
- ✓ **Working with PCNs to maximise enhanced access capacity availability building on current strong utilisation**
- ✓ **Ongoing support to GP practices and PCNs to develop and implement business continuity mitigation plans**
- ✓ **The General Practice Improvement Programme (GPIP) and Practice Level Support (PLS) approach is targeting practices with capacity and access variation over Q3**
- ✓ **Supporting practices and PCNs to implement online consultation for October - sharing best practice from local early adopter practices, public comms campaign in development**
- ✓ **Focus on care management processes across primary care and secondary care pathways including discharge from acute care through the system Interface programme**
- ✓ **Increasing the use of Pharmacy First – targeted UTC comms campaign, direct referral from urgent care settings and promoting in rural areas**

There are also some additional GP pilot schemes in place focused on:

- Increased face to face appointments for chronic disease management
- Improved medication management
- Improved same day access

We continue to focus on further integration of our primary and community services, including streamlining access to support for health and care professionals through our Single Point of Access (SPoA). We have refined pathways between NHS111 and our Clinical Assessment Service (CAS), to ensure that people are not asked to attend Emergency Departments unless they cannot be supported in the community. Frailty care and support continues to be a focus for Lincolnshire and this year we have developed a delivery model to implement the Lincolnshire Older Peoples Strategy which includes optimising the interface between primary care and urgent and emergency care services that can support primary care when they need to escalate for an urgent intervention.

To date we have progressed the following which will help support our older adult population:

- ✓ **14 pro-active care interventions to support older people living with frailty with harder to reach populations prioritised**
- ✓ **Frailty specific acute same day emergency care units on both acute sites**
- ✓ **Recently strengthened centralised point of access, via our Single Point of Access for Health Care Professionals for all frailty and palliative needs supporting referrals into neighborhood palliative teams**
- ✓ **24 hour falls response in place**
- ✓ **Step up support into Active Recovery Beds**
- ✓ **Training for our workforce on undertaking Comprehensive Geriatric Assessments (CGAs).**
- ✓ **Work with Care Homes through the Enhanced Health in Care Homes programme using data and intelligence for focused support and including promoting the use of CAS for Care Homes**
- ✓ **Adult Social Care strengths-based approaches to supporting people to remain at home and where required emergency respite.**
- ✓ **Project Compass – a focus on Homelessness run by a charitable organisation supporting people who are rough sleeping to access other specialist provision such as housing and substance misuse services.**

4.2 Mental Health

The implementation of the Mental Health Urgent Assessment Centre in Lincolnshire continues to be a great success and ensures that those patients with a mental health need only, do not need to attend our hospital Emergency Departments and instead they can attend a more appropriate environment which provides a better patient experience and improved outcomes. The service delivers an all-age model of care, further supporting our Emergency Departments and Urgent Treatment Centres with Children and Young People presenting with a mental health need this winter.

Patients in Lincolnshire will continue to be supported by robust crisis and home treatment teams and the integration of those services with NHS 111 option 2 Mental Health service is now embedded. This provides 24/7 Mental Health advice and increases capacity for our crisis teams who were managing these calls previously. Crisis house capacity and 'Night Light Café' provision is in place across the county. Night Light Cafés are safe spaces that offer an out-of-hours, non-clinical support service and are staffed by teams of trained volunteers who are available to listen. They can also provide signposting advice and information on other organisations that may be able to help with specific needs. These are a free service that help people to have better access to face-to-face help when they are struggling in an evening, or at weekends, when practices and community mental health teams are less readily available, and A&E may not be appropriate for their needs. Two crisis response vehicles are in operation across our county to respond to those with urgent mental health needs alongside a trained nurse who is based within the Police Control Room to support any calls and required response to 999.

Key initiatives to increase resilience over the winter period include:

- ✓ **Crisis Vehicle Response (CVR) and Police Control Room (PCR) functions.**
- ✓ **Alternatives to specialist crisis services, including the Night Light cafes across the county.**
- ✓ **Maintain Voluntary, Community and Social Enterprise support to our wellbeing hubs.**
- ✓ **Online resource to help people to navigate support and training - www.haylincolnshire.co.uk**
- ✓ **Mental Health support through NHS111**
- ✓ **Mental Health Urgent and Emergency Care champions to raise awareness, provide visibility and interface with system partners.**
- ✓ **Reducing the number of patients experiencing long waits in our Emergency Departments by ensuring our senior clinical staff are available to support decisions.**

4.3 Children and Young People

Children and Young People both with physical and mental health needs continue to be a priority cohort for the Lincolnshire system this winter. We have continued with last year's investment in both paediatric support in our Emergency Departments and we continue with our recruitment plans to increase our Child and Adolescent Mental Health service capacity in the Boston and East Coast localities, acknowledging the difficulties in recruitment. This year we have focused on training of Urgent Treatment Centre staff in paediatric conditions to increase skill set and confidence to avoid unnecessary Emergency Department attendances.

The children's health service supports our focus on reducing under five-year-old attendances where appropriate through:

- Support with social media messaging
- 3–4-month top tips groups supporting parents with minor illness and accident prevention
- Focus on childhood immunisation

4.4 Hospital Care and Discharge

Planning for effective hospital care and discharge must start at the point of arrival at one of our acute or community hospitals. Whilst we have made some significant improvements to ambulance handover delays, we are committed to ongoing improvements, so our patients receive safe and effective care in a timely way and delays are reduced to minimum. Over the winter period ambulance crews will have continued direct access to a range of alternative settings where clinically safe to avoid a hospital attendance.

Throughout 2025/26 there has been a focus on review of front door pathways, with an ambition to fully integrate co-located Urgent Treatment Centers and Emergency Departments, and to further develop our Same Day Emergency Care (SDEC) units and assessment units to ensure that only those people that

need the facilities and skill of an Emergency Department attend or remain in the Departments. We aim to convey, refer or direct patients directly to the unit most appropriate for their care rather than Emergency Departments being the default point of access.

Where patients are admitted to inpatient areas for care we will ensure that they are discharged in a timely way with the correct level of support and with full assessments taking place outside of the hospital setting. The ethos of Discharge to Assess (D2A) is well embedded within the system which means we should have capacity and skill available to make patient assessments in their own home rather than in a hospital setting, and wherever possible and safe to do so, support patients in their own home rather than in a bedded service. In 2025/26 we have focused on increasing our capacity to support people in their own homes and these plans will continue to deliver increased capacity ahead of winter. We have agreed a local target of discharging all complex or supported discharge patients within 48 hours of being ready for discharge. This not only reduces delays for the patient and improves the patient experience and outcomes but also reduces the average length of stay across inpatient wards.

Ahead of winter, system partners continue to work together to develop and implement new processes to improve discharge processes and support efficiency and flow. This includes four priority areas:

- Introduction of the Optica system – to support management and oversight of patient discharges
- Further development of our Transfer of Care Hubs
- A focus on demand and capacity to have a single understanding of need and available resource at any time for those requiring additional support upon discharge from hospital
- A focus on early discharge planning

Our ambitions this winter include:

- ✓ **Reduce the number of patients experiencing long waits in our Emergency Departments by embedding a single front door approach on our acute sites, maximising use of SDECs and assessment areas.**
- ✓ **Maximise utilisation and impact of our Clinical Navigators employed by East Midlands Ambulance Service (EMAS) to ensure people arriving by ambulances are directed to the most appropriate place within the hospital.**
- ✓ **Ensure dedicated space within our Emergency Departments is available so that in times of escalation people can still access hospital care and not be waiting on ambulances unnecessarily.**
- ✓ **Pro-actively plan discharges supported by processes focused both on pre-emption and on long stay**
- ✓ **Minimise delays for people being discharged from hospital across all pathways supported by our Transfer of Care Hubs and our non-emergency transport service which will respond to the growing requirements for additional support that patients need upon discharge from hospital.**

People in our care as well as their families and carers deserve to be treated with kindness, dignity and respect and receive safe standards of care. There is a shared responsibility across all our services to ensure quality (patient safety, experience, and outcomes) and we are working with partners to:

- ✓ **Provide alternatives to Emergency Department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.**
- ✓ **Maximising in-hospital flow with timely discharge regardless of the pathway a patient is leaving hospital or a community bedded facility on.**
- ✓ **Ensuring that all care settings have basic standards of care in place based on CQC fundamental standards.**
- ✓ **Working to ensure safe timely discharge out of Emergency Departments and out of hospital.**
- ✓ **Reviewing services and providing feedback to ensure quality is maintained.**
- ✓ **Ensure that patient experience is heard throughout their UEC journey, and that feedback is built into our improvement work.**

5.1 Infection Prevention and Control

Infection Prevention and Control is a key focus of winter, with anticipated impact of multiple infectious disease and anticipated outbreaks across all parts of the Urgent and Emergency Care pathway. Plans are in place for 7-day Infection, Prevention and Control cover over the winter period with provider teams already working 7 days per week. Escalation processes are in place with outbreaks managed as per agreed action cards and a rapid response team can be mobilised outside of working hours. Co-horting and escalation plans are in place across providers and system plans will continue to be reviewed and updated to capture latest guidance and best practice as well as local agreements for triggers. With support of the Lincolnshire Health Protection team a RAG rated scheme has been developed to strengthen existing arrangements over the winter period and to pre-empt outbreaks and potential impact of IPC with service specific local interventions to be agreed. This will allow us to directly respond to IPC risks in a proportionate but effective way.

5.2 Risk Management

The system Urgent and Emergency Care programme maintains a risk register which is routinely reviewed as part of programme delivery but also in the context of winter, the Winter Director will have ownership of any risks in relation to this plan, managed by the Winter Delivery group and reporting into the Urgent and Emergency Care Partnership Board. As identified, there are several unknown variables that are likely to be influential on the success of our winter plan and the ability of the system to deliver safe and effective care during the winter period.

These include:

- Measuring the impact of rapid improvement initiatives across the system and whether they deliver the assumed improvement.
- The potential unquantified impact of Industrial Action
- The position against Elective and Cancer plans.
- The emerging assumptions and projections around infectious diseases such as Influenza, Covid 19, RSV and potential impact of threats such as measles and tuberculosis.
- Met Office forecasting for excessive weather including:
 - The potential for flooding in Lincolnshire as a result of heavy rainfall
 - Cold weather periods and the impact of national changes to the eligibility for Cold Weather Payments, as a predictor of increased respiratory conditions.

Additionally, the System Clinical Reference Group will develop a local Clinical Risk Framework for use over the winter period, focused both on management of risk but also in application of risk thresholds during periods of increased pressure or surge.

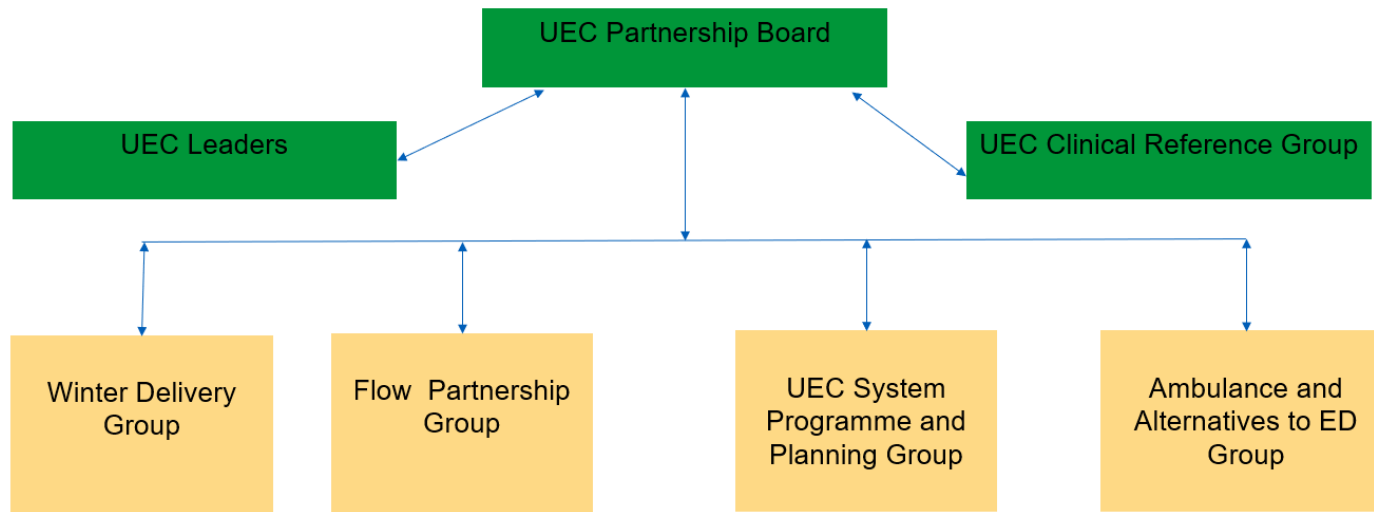
As a result, the overarching risk remains:

'As a result of demand exceeding capacity and despite investment and service developments detailed within this plan, we may still be unable to mitigate against all risks, previously outlined, to ensure our patients receive safe, timely and accessible care'.

6. System Working and Escalation

Our Urgent and Emergency Care Partnership Board (UECPB) has strategic responsibility for overseeing the development and mobilisation of robust winter capacity and resilience plans for Lincolnshire. The Programme and planning subgroup has responsibility for development of those plans and the Winter Delivery Group has operational responsibility to monitor delivery of the plan and performance, escalating as required.

Our governance arrangements are detailed fully below:



Whilst the Urgent and Emergency Care Partnership Board meets monthly, the Urgent and Emergency Care Leaders Group and the Urgent and Emergency Care Clinical Reference Group meet weekly over the winter period, providing strategic and clinical leadership and guidance whilst maintaining oversight of system pressures and risk.

6.1 System Co-ordination Centre

System Co-ordination Centres (SCC) were introduced across England in 2022 to ensure the safest highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services.

The Lincolnshire SCC has been fully embedded into the system since then and ensures that there is robust oversight of all system pressures and is operational 8am – 6pm, 7 days per week, reporting to the ICB Deputy Director for System Delivery, System UEC SRO and Winter Director. After 6pm an operational handover to ICB Strategic and Tactical on-call commanders ensures full visibility of pressures and risk going into the overnight period. On-call commanders in the ICB attend provider escalation calls throughout the overnight period as required for support in addition to usual escalation processes and are also able to rapidly convene system calls as required.

The Lincolnshire SCC lead on monitoring demand, capacity and pressure within the system as follows:

- ✓ **Daily system calls 0930 and 1300hrs, these facilitate early warnings of current and potential issues that are logged, and actions raised for that day.**
- ✓ **Level of escalation for each provider discussed on system calls, including reasons for level and how we can work as a system to de-escalate where necessary.**
- ✓ **Extra system calls added if continued high demand.**
- ✓ **Attendance at Regional Reporting and Escalation Call each day.**
- ✓ **Continued monitoring of demand using a range of digital options and dashboards including but not limited to SHREWD Resilience dashboard and East Midlands Ambulance Service arrivals screen to pre-empt any delays.**

In addition to the operational management of the system the SCC also have dedicated staff to help rapidly diagnose issues, complete lessons learnt through rapid cycles of improvement, this is a fundamental element of the SCC as we strive to improve our performance across the county and ensure our patients receive timely access to Urgent and Emergency Care.

The SCC continually monitors systems pressures through reviewing data and daily calls with system partners to review new and emerging risks. It has clinical leadership and Standard Operating Procedures to ensure consistent escalation into the ICB nursing and quality leads.

In periods of escalation nursing and quality leads join system calls to provide clinical input and oversight. Over the winter period the SCC will continue to facilitate collaboration between system partners to enact resource sharing and resource flexing to increase flow out of acute settings.

6.2 Escalation and Assurance

The use of the NHS Operational Pressure Escalation Levels (OPEL) Framework and associated Action Cards are fundamental to the delivery of assurance and governance for our system. Managed by our System Coordination Centre through daily calls which provide a focal point of operational escalations and support and by working collaboratively with our system partners to resolve daily issues and challenges. Our SCC and partners utilise the framework to ensure the correct level of response and urgency which is vital to ensuring a consistent system response which can be benchmarked with other systems. The Lincolnshire System has revisited and updated the local escalation thresholds and triggers for winter.

Executive level leadership for winter is in place with weekly oversight by our system Urgent and Emergency Care Leaders Group which is chaired by the ICB Winter Director for Lincolnshire. Our Chief Executive Officers, along with our Chief Operating Officers and ICB Winter Director meet twice weekly to consider Urgent and Emergency Care issues and oversee delivery and response.

7. Communication

The Urgent and Emergency Care Winter Communications Plan for 2025/26 aims to co-ordinate the joined-up communications work already happening across Lincolnshire into a single point of reference for stakeholders. This iteration of the plan includes specific actions around the Winter period and has been developed as a whole Lincolnshire NHS communications system, with all partners signed up to supporting and delivering the activities within it. Communication resources will originate both from system partners and the national team who produce dedicated Winter campaigns and resources. The key objectives of the plan are to:

- ✓ **Raise awareness of the wide range of services that are available across Lincolnshire.**
- ✓ **Prioritise the 'talk before you walk' message about seeking the right service for your care needs.**
- ✓ **Ensure that those who should be attending our facilities do so and are not dissuaded by messaging.**
- ✓ **Normalise the discharge conversation when in a hospital setting.**
- ✓ **Use staff communications to promote the patient safety message for improving Urgent and Emergency Care performance**
- ✓ **Put in place a trusted series of comms actions when the system is in an escalated position**
- ✓ **Using social marketing techniques to deliver a targeted behavioural change approach which will supplement our standard communications support**

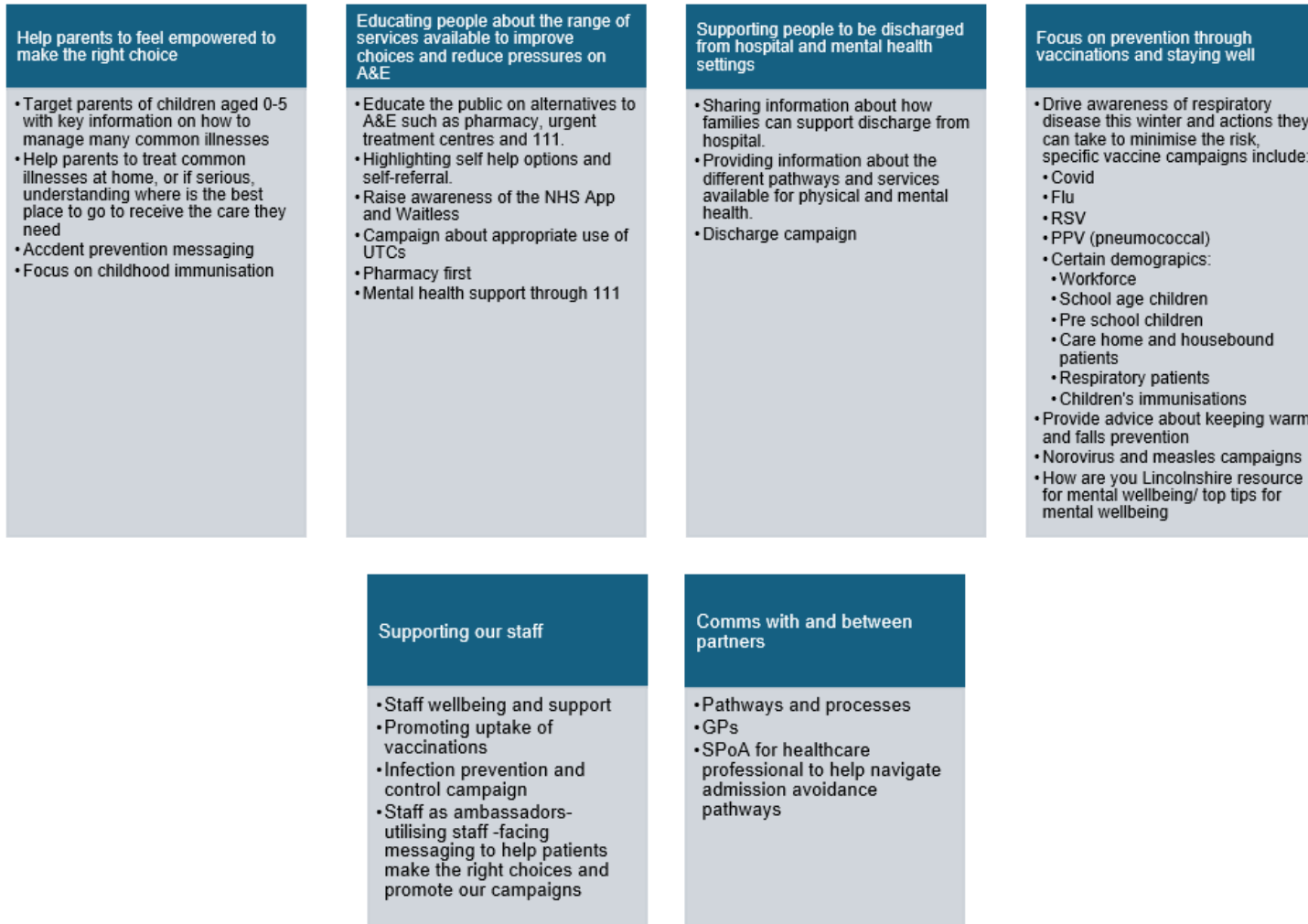
The key public messages include:

- Your NHS is here for you this winter.
- Contact NHS111 online or phone 111 to be directed to the right service for your needs.
- Use the NHS App to book appointments with your GP team, order repeat prescriptions or find health information.
- Find out more about the range of services available to you this winter: [Choose Well Lincolnshire - Lincolnshire ICB](#)
- Find out how to stay well this winter: [Stay Well Lincolnshire - Lincolnshire ICB](#)
- Stay well this winter by taking up your offer of vaccination for winter illnesses if you are eligible.
- We have information and advice to help you and your family stay well this winter.
- You can help family and friends to be discharged from hospital.

Our communications delivery will adhere to the following principles:

- Speak as one local Lincolnshire voice.
- Seek to influence behaviour through behavioural change/social marketing techniques.
- Prioritise signposting to appropriate services.
- Ensure that staff well-being messaging is a key part of our communication.
- Ensure that mental health is a key part of our messaging.

This winter, we have segmented our approach into five key areas:



Based on learning from the winter 2024/25 campaign, we will take the following approach:

- Develop a shared system activity plan to keep track of each organisation's work and join efforts where possible.
- Joint work with Lincolnshire County Council on staying well, mental wellbeing, keeping warm, falls prevention and vaccination communications.
- Data collated from last year has evidenced that messages about hospitals being busy rarely cut through. We need to focus on how people can access the right service and only escalate messaging on social media when absolutely critical. A pressures protocol has been developed to manage this. (Appendix A)
- Using national assets, but in a limited way as they don't get traction on social media

Core communications approach

Including delivery of our Warning and Informing Emergency Preparedness Resilience and Response (EPRR) responsibilities and promotion of vaccination programmes, prevention, and self-care campaigns. This will include use of national resources around the below, as well as internal and external communications, as required, around specific Lincolnshire projects:

- Supporting people to stay well this winter by increasing vaccination uptake rates (COVID, flu, RSV, PPV/pneumococcal).
- Informing people about which services are most appropriate for their needs and illnesses to reduce pressures on services.
- Educate parents about children's health and wellbeing.
- Educating people about services and support available to help when they are discharged from hospital or a mental health setting.
- Supporting a focus on the three key areas of focus in the system winter Plan- Attendance avoidance, admission avoidance and reduced length of stay

Escalation management approach

If the system is under additional pressure, we can step-up a greater level of communications activity to encourage people to choose alternative services. Data and research shows, that messages about alternative services land better with the public and have more impact than telling them that particular services are busy. **Communications teams will share messages about alternative services but will not routinely publish messages saying A&E is busy or the system is under pressure.**

- ICB/LCHG/LPFT comms leads will activate a 'pressures meeting' between the three organisations to plan for additional communications activity during particularly busy periods. Any one of the three organisations can decide to step up this process if they feel that there is a particular level of pressure that would benefit from a system response. The ICB will then cascade the approach to the wider system comms group.

The table below shows the possible actions that can be taken when different thresholds are met.

Situation	Lead Agency	ICB Actions	Provider* Actions	Partner** Actions
Provider OPEL 3	Provider	No action	Publish appropriate public facing materials	No action
Provider OPEL 4	Provider	If requested by provider, circulate provider communication assets to wider partners and ask for them to be shared Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Publish appropriate public facing materials and provide to ICB to circulate to wider partners if appropriate Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Share messaging as requested
Provider Critical Incident	Provider	Comment on public facing materials and ensure that NHSE Regional communications team are also able to comment. Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Publish appropriate public facing materials and provide to ICB to circulate to wider partners. Share with ICB the messages they are giving to staff / stakeholders Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Share messaging as requested
System OPEL 3	ICB	Winter messages will be shared as a matter of course. No additional action.	Share winter messages as part of system winter plan	Share winter messages as part of system winter plan
System OPEL 4	ICB	Publish appropriate public facing materials and circulate to wider partners and ask for them to be shared. Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Tailor ICB messaging to current organisational status Step up additional comms meeting with ICB / LCH / LPFT if judged that a system response is needed	Share messaging as requested
System Critical Incident	ICB	Publish appropriate public facing materials and circulate to wider partners and ask for them to be shared. Consider social media advertising and press release. Identify system spokesperson / people for interview. Cascade messages to relevant teams / general practice / internal comms. Stakeholder messaging. Step up additional comms meeting with ICB / LCH / LPFT or consider wider comms cell with relevant organisations.	Tailor ICB messaging to current organisational status Share with ICB the messages they are giving to staff / stakeholders	Share messaging as requested

System OPEL 3

- BAU: Organic social media signposting to 111 Online, UTCs and Community Pharmacy as part of system winter communication plan

System OPEL 4

- Increasing the level of organic social media activity
- Request partner communications leads share messages via their channels.
- Step up additional comms meeting if judged that a system response is needed.

System Critical Incident

- As above plus
- Step up additional comms meeting or consider wider comms cell with relevant organisations.
- Social media advertising
- Press release using template
- Identify key spokesperson / people
- Website article
- Internal news, including general practice
- Stakeholder update

Staff communication

Internal communications will be incredibly important, again, to us this year. We know that, together, our staff make up a significant proportion of the Lincolnshire population. They have a direct ability to impact performance, and of course they are also significant influencers across their peers, family and friends. We will encourage the uptake of the Flu vaccination across the whole system workforce.

This year we will focus on

- Staff wellbeing and support
- Promoting uptake of vaccinations
- An infection prevention and control campaign
- Staff as ambassadors- utilising staff -facing messaging to help patients make the right choices and promote our campaigns

8. Conclusion & Evaluation

Our winter plan will be monitored via our governance routes and operationally, daily, through the System Co-ordination Centre activities and specifically via:

- ✓ **System oversight through the Urgent and Emergency Care Partnership Board and associated sub governance groups.**
- ✓ **Weekly live oversight of the winter period via the Urgent and Emergency Care Leaders Group, chaired by our Winter Director, with escalation where required.**
- ✓ **Ongoing monitoring of Demand and Capacity to understand performance and delivery over the winter period and the impact of existing, planned and any further initiatives and change.**
- ✓ **Programme and Planning Group review of performance and activity including impact of interventions monthly, with escalation and assurance to Winter Directors.**
- ✓ **Urgent and Emergency Care Partnership Board review of the Urgent and Emergency Care performance dashboard monthly.**

This winter plan sets out the approach for the management of winter 2025/26 in Lincolnshire across the health and care acknowledging that our assumptions around demand and the impact of the planned initiatives and interventions may not be completely accurate at this point, but we will ensure ongoing dynamic review of demand, capacity, and impact of interventions.

We will utilise all available resource to ensure that we are delivering safe and accessible services to our patients and that we improve their experience and outcomes. The Urgent and Emergency Care programme governance will ensure that there is robust oversight of the delivery of this plan, with both strategic and clinical leadership and guidance. We will review the plan early next year to ensure we can identify the learning and impact in preparation for winter 26/27 and to secure ongoing service development and improvement for our population.



Winter Planning 25/26

Board Assurance Statement (BAS)

Integrated Care Board (ICB)





Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Integrated Care Board's (ICB) name.

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025**.

Section A: Board Assurance Statement


Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.		For assurance at ICB Board on 30/09/2025
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	Quality team involvement in development and testing of the plan. QEIA has been developed and is in final review.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	All system stakeholders have been engaged in the development, testing and approval of the winter plan. Partner organisations' own winter plans will underpin this system plan and have now all been approved by their respective boards.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	This was completed locally on the 4 th September and then at the regional even on the 17 th September. Learning from both sessions has been further discussed through local governance groups and incorporated in the final winter plan.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Rebecca Neno Deputy Director for System Delivery & Lincolnshire Winter Director Rebecca.neno@nhs.net

Integrated Care Board:	NHS Lincolnshire ICB
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<i>Plan content and delivery</i>		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	TBC	To be confirmed 30/09/2025
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	TBC	To be confirmed 30/09/2025 The system has undertaken robust modelling of both demand and capacity across the three scenarios of baseline, moderate and extreme pressure, the outputs of which have been used to inform testing of the plan. While there is an acknowledgement that during periods of extreme pressure the level of demand will be greater than the level of capacity, this plan underpinned by provider plans sets both the risks identified and the mitigating actions planned. A winter risk register will be held by the winter delivery group, overseen by the system winter director.
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	TBC	To be confirmed 30/09/2025 The Lincolnshire SCC is fully embedded within the ICS and operates 7 days per week, 8am to 6pm, with robust handover to on-call arrangements outside of operating hours. The SCC will operate across the full winter period with the exception of Christmas Day

ICB CEO/AO name	Date	ICB Chair name	Date
To be complete following board review			

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
<p>1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.</p>	Yes	<p>The Lincolnshire System has a robust vaccination plan in line with national expectations. Vaccination has been a key element of the development and testing of the plan.</p> <div data-bbox="1272 671 1330 735" style="text-align: center;">  </div> <p style="text-align: center;">Vaccination Trajectories.pptx</p>
<p>2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.</p>	Yes	<p>The ICB has over summer target people with known respiratory conditions and who were outstanding RSV & PPV vaccinations and have delivered in excess of 1200 vaccinations throughout July to September. This is expected to reduce the likelihood of RSV and pneumonia conditions in this cohort. Our plans include a number of outreach sessions in areas where we know there is a high prevalence of co-morbidities which will further support our core offer.</p> <p>Antivirals are available for patients year round. We have an outbreak response resource to support respiratory outbreaks and this team supply antivirals in care home outbreak scenarios.</p>

		Additionally, the system has developed a preventative care model targeted at COPD patients at greater risk of respiratory infection. Including care planning, rescue packs, referral to pulmonary rehab and advice and guidance around lifestyle. These patients are provided with an escalation plan.
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	Our practices continue to utilise Population Health Management tools along with general data analysis and risk stratification to identify those individuals who would benefit from proactive and preventative intervention and there are specific projects in PCNs focused on frailty, social prescribing and high intensity users which will support people in the community.
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	Yes	The system has undertaken robust modelling demand model covering the whole winter period and for each of the three scenarios. This was shared with all system partners to inform development of organisations' winter plans .
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	This formed part of the system modelling, and was shared with all system partners. Discharge profiles and assumptions are routinely discussed through system calls and within the flow partnership group.
6. Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Yes	Elective demand is routinely monitored through existing forums and the requirements of the operational planning guidance are monitored through routine board and programme assurance
Leadership		

7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	The ICB and system partners has a robust on-call arrangements in place that have been well tested. Rota's routinely include clinical leaders.
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	All OPEL escalation triggers monitored In real time through SHREWD and the SCC has a dedicated duty operational manager reviewing SHREWD 7 days per week 8am-6pm. All on-call commanders have access to SHREWD and the system escalation framework has been reviewed to ensure full alignment with the national OPEL framework.



PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	05 (iii)
Meeting Date:	Tuesday, 30 th September 2025
Title of Report:	Stamford Engagement Report
Report Author:	Steph King, Engagement Lead, NHS Lincolnshire ICB Lauren Eason, Engagement Manager, NHS Lincolnshire ICB
Presenter:	Charley Blyth, Director of communications and engagement, NHS Lincolnshire ICB
Appendices:	<ol style="list-style-type: none"> 1. Health and Care needs in Stamford- Survey and Community Discussions Feedback Report 2. Health Scrutiny response 3. Stamford GP Surgery response

To approve <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	To receive and note <input checked="" 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 ICB Board is recommended to:

- Note the feedback from the public captured in the Stamford Engagement Report; to be included in the strategic planning process by all system partners for the five-year plan / neighbourhood health / clinical strategies

Summary

Lincolnshire ICB has a statutory 'duty to involve' as outlined in section 14Z45 of the NHS Health and Care Act 2022. The duty requires the ICB to have in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery; and decisions which would have an impact on services.

The report provides an overview of our engagement activities undertaken between November and January to gather feedback and experiences from the residents of Stamford about their health and care services now and in the future as the population grows.

The ICB Engagement Tteam undertook discussions with the public and various community groups between 7th January and 31st January, attending 12 community meetings/events across Stamford, including underrepresented communities such as those with mental health issues, long-term conditions and English as a second language.

Running alongside the face-face engagement was an online survey, that has been widely promoted to gather views from local people about what they think about health and care services in Stamford now, as well as what they think the impact of population growth will be on these services. 726 responses were received.

- **84% (585)** of 695 respondents find it **difficult** to access services.
- Just **under one half (47%, 322)** of respondent's access services outside of Lincolnshire. The key reasons for doing so include lack of local availability, long waiting times, quality of care and proximity of services.
- **65% of 678** respondents think that there are health and care services needed in their community **NOW** which are not currently provided. Such as NHS dentists, GP practice and increased access to mental health support.
- **90% of 687** respondents think that there are health and care services needed in their community **IN THE FUTURE** which are not available now. Such as GP services, NHS dentist and the facilities to handle emergencies locally.
- Dental services, mental health and management of long-term conditions are the **most important** health issues facing the Stamford community.
- **64% (459)** of respondents do not feel very well informed/informed at all about health and care services.
- **595 (85%)** have access to private transport. **42 respondents (6%)** do not have access to any transport.

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

Aim 1: Improve outcomes in population health and healthcare.	Engagement and involvement can support identification of healthcare needs and aspirations of communities, ensuring that the patient voice is at the heart of service development and delivery.
Aim 2: Tackle inequalities in outcomes, experience and access.	Engagement and involvement can highlight and identify inequalities and work with impacted groups to mitigate barriers to improve outcomes, experience and access.
Aim 3: Enhance productivity and value for money.	Services developed and shaped by patient, public, staff and stakeholder involvement are delivered more efficiently and utilised more effectively
Aim 4: Help the NHS support broader social and economic development.	Engagement and involvement enables people and communities to shape programmes of work across the ICS and provides them with skills and experience to become a local champion and voice in their local areas.
Conflicts of Interest	Summary of conflicts
No conflict identified	

Risk and Assurance

Demonstrates assurance to minimise risk 0002 (archived): The ICB fails to engage effectively with the population of Lincolnshire to help inform effective service provision in the county.

Implications (legal, policy and regulatory requirements)

Does the report highlight any resource and financial implications?	Not Applicable
Does the report highlight any quality and patient safety implications?	Not Applicable
Does the report highlight any health inequalities implications?	Not Applicable
Does the report demonstrate patient and public involvement?	Yes, it demonstrates the ICB commitment and approach to involving Lincolnshire's People and Communities, therefore meeting its Statutory Duty to Involve
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:

Lincolnshire ICB Executive meeting Thursday 11 September 2025

Is the report confidential or not?

Yes No

Health and Care needs in Stamford Survey and Community Discussions Feedback Report

25 November – 31 January 2025



Introduction

The purpose of this report is:

1. To provide an overview of our engagement activities undertaken between November and January to gather feedback and experiences from the residents of Stamford about their health and care services now and in the future as the population grows
2. To present findings from our online survey and community conversations

The NHS Lincolnshire ICB engagement team undertook discussions with the public and various community groups between 7th January and 31st January, attending 12 community meetings/events across Stamford, including underrepresented communities such as those with mental health issues, long-term conditions and English as a second language. Running alongside the face-face engagement was an online survey, that has been widely promoted to gather views from local people about what they think about health and care services in Stamford now, as well as what they think the impact of population growth will be on these services. 726 responses were received .

This report highlights both the activities undertaken and the results of this engagement. The feedback received has been analysed across all population groups and health inequality and equality categories. Where they exist, differences are highlighted within the report. This report is split into two sections; detailed feedback from the survey and key themes from community conversations held across Stamford.



**Do you live in Stamford and
the surrounding areas?**

Tell us about what is important to you

in your local health and care

services.

Executive summary

Based on the demographic data provided, the highest level of response came from **females** and those **aged 60-69**, closely followed by age 70-79.

73% (530) of respondents have **live in Stamford**, just over three quarters (**77%**) of respondents would **class their health** as **very good/good**, and **60%** state that they have a **long-term condition**.

Stamford health and care needs now and, in the future

- **84% (585)** of 695 respondents find it **difficult** to access services.
- Just **under one half (47%, 322)** of respondent's access services outside of Lincolnshire. The key reasons for doing so include lack of local availability, long waiting times, quality of care and proximity of services.
- **65% of 678** respondents think that there are health and care services needed in their community **NOW** which are not currently provided. Such as NHS dentists, GP practice and increased access to mental health support.
- **90% of 687** respondents think that there are health and care services needed in their community **IN THE FUTURE** which are not available now. Such as GP services, NHS dentist and the facilities to handle emergencies locally.
- Dental services, mental health and management of long-term conditions are the **most important** health issues facing the Stamford community.
- **64% (459)** of respondents do not feel very well informed/informed at all about health and care services.
- **595 (85%)** have access to private transport. **42 respondents (6%)** do not have access to any transport.

Section 1

Overview of engagement activities and promotion



Overview of engagement activities

The following section describes the engagement activity undertaken for the GP Strategy:

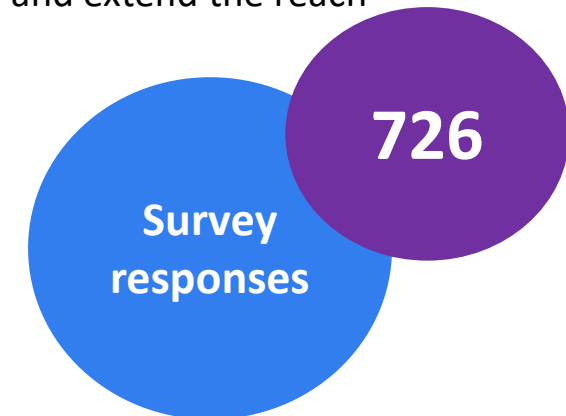
- Attended **12 groups/events** across Lincolnshire, reaching **582** people
- **726 responses** to the survey

Survey

The survey ran alongside the face-to-face engagement activities and was available in different formats on request. It was available on the NHS Lincolnshire ICB and other partner websites. The link was also shared with the ICB engagement stakeholder database of 10,000 contacts.

The survey was regularly promoted through various channels including:

- Social media across the ICB and Trust accounts, as well as requests sent to Lincolnshire partners to share and extend the reach
- Featured in **5** fortnightly NHS Lincolnshire ICB engagement bulletins and **2** Primary care bulletins
- Nextdoor online forum
- Providers' member databases and staff networks
- Posters shared with Lincolnshire's PPGs
- Via leaflets and posters with QR codes and links handed out during face-to-face engagement activities



Out and about in Stamford

Throughout the engagement period we incorporated several different activities to speak to members of the public such as attending existing community groups, online survey and leafleting.

Each activity was chosen to enable us to reach as wide and varied population as possible to ensure that all voices in our community were given an opportunity to be heard.

Whilst we already have an established database of local and community groups based on protected characteristics, we also recognized the importance of proactive and targeted engagement with underrepresented groups. Where possible we tried to attend existing group meetings to further promote opportunities for involvement and gather their views.



Out and about in Lincolnshire

The below table details the locations and groups we visited (continued on the next page):

Date	Group	Number of people reached
7 th January	Stamford Fibromyalgia Group Long-term conditions	8
15 th January	Communita Chatter Older people	11
17 th January	Friday Connect Mental health, economically disadvantaged, older people	31
	Multinational Stay and Play Toddler group, parents, English as second language	10
	Knit and Natter Group Older people	12
	Leafleting at Stamford Market / leaflet drops All	347 (leaflets handed out)

Out and about in Lincolnshire

The below table details the locations and groups we visited (continued the next page):

Date	Group	Number of people reached
21 st January	Coffee and a Chat Dementia Support	9
	Lakeside PPG AGM Meeting All	Approx 120
23 rd January	Stamford Autism Group Disability	13
	Tea and Chat Older people	7
	Makers Mental Health	4
28 th January	Stamford Cancer Support Group Long term illness	10

Promotion of engagement

NHS Lincolnshire Engagement Bulletin

The NHS Lincolnshire ICB Engagement Team produces a fortnightly bulletin which is distributed to a variety of community and voluntary groups, Patient Participation Groups, support groups, stakeholders and people who have subscribed via the NHS Lincolnshire ICB website.

Information and the link to the survey was promoted in the 'This week's hot topic' section of the engagement bulletin and was distributed to around 10,000 contacts on the ICB engagement teams stakeholder database.

The Stamford engagement survey featured in **5 editions** of the bulletin.

Nextdoor Online Forum

The NHS Lincolnshire ICB engagement team uses the Nextdoor online forum to help encourage participation and increase completion of various surveys and questionnaires. The total reach of the NHS Lincolnshire ICB Nextdoor account is 110,269 members spanning across 471 'neighbourhoods' enabling us to reach a variety of communities, villages and towns across Lincolnshire.

6 posts were published on Nextdoor. The table below demonstrates the total number of impressions (people that saw each particular post):



The Contributor

Say hello to the latest opportunities to have your say and get involved with your local NHS

This weeks hot topic

NHS to launch engagement exercise on health and wellbeing services in Stamford

The NHS in Lincolnshire is launching a new engagement exercise to understand the health needs and aspirations of Stamford people, to ensure that health services remain fit for the future.

In 2021, the then NHS Lincolnshire Clinical Commissioning Group (CCG), now replaced by NHS Lincolnshire Integrated Care Board (ICB), agreed to review and evaluate the long-term shape of health services in Stamford and surrounding areas in light of significant projected population growth in the area.

Fast forward three years and the work undertaken previously by the CCG with local stakeholders and Stamford communities is something the ICB wants to engage local people on.

Nextdoor promotion	Impressions
25 November - 31 January 2025	53,800

Promotion of engagement contd.



Do you live in Stamford and the surrounding areas?

Tell us about what is important to you in your local health and care services.

Please complete our survey by 31st January 2025



Visit lincolnshire.icb.nhs.uk/engagement-stamford

If you need the survey in an alternative format, require help completing it, or you would prefer to speak to our team about your experiences, please contact the Engagement Team: icb.involveus@nhs.net

Leaflets

We created a leaflet to provide a versatile and tangible means to:

- Build awareness of the survey
- Signpost/link people to the survey
- Provide the engagement team with a means of engaging with members of the public and passing information at community meetings and other events
- Leaflets were also left at several venues across Stamford during face-to-face engagements

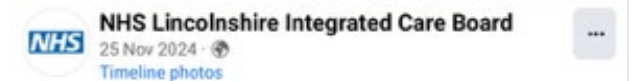
Social media and website activity

NHS Lincolnshire ICB Communications team's used Facebook to push traffic towards the survey on the website. The team posted:

5 Facebook posts, reaching 10,972 people and generating 93 reactions and 1354 clicks through to the survey

2049 people visited the webpage - [NHS Public Engagement – Stamford and surrounding area - Lincolnshire ICB](#)

They also drafted posts in the system Hootsuite to enable providers to duplicate and share across their channels and tagged in providers to some of the posts which were shared across provider organisations.



Do you live in Stamford and the surrounding areas? We want to hear from you!

As we plan for the future, we want to understand what matters most to you about local health and care services. Share your thoughts and help us create services that work for everyone.

Take part in our survey here: https://nhslincolnshire.qualtrics.com/jfe/form/SV_3UxilbDc3LsxTgy

Find out more: <https://lincolnshire.icb.nhs.uk/nhs-to-launch-engagement-exercise-on-health-and-wellbeing-services-in-stamford/>

Promotion of engagement contd.

Online survey distribution

The Communications and Engagement teams across the ICB and three providers trusts distributed the online survey link to a range of people outlined in the below table.

To enable us to provide more opportunities for the public staff and stakeholder to find out about the survey and have their say, we also asked partners and community organisations to share the survey link with their members, groups and wider communities. **The groups in the right box and on the following page received the distribution via NHS comms cascade or the ICB engagement bulletin/ primary care bulletin.**

Audience	Distribution
Staff and internal	LCHS (2,630 via staff bulletin) ULHT (10,000 via staff intranet) LPFT (shared via staff intranet) NHS Lincolnshire ICB (420 via Team Talk News and staff Facebook) GPs and Primary Care via the Primary care bulletin (approx. 650) Stamford PPGs

Audience	Distribution
Voluntary Engagement Teams	Age UK Lincoln and S Lincs Age UK Lindsey Alzheimer's UK Active Lincolnshire YMCA Healthwatch LIVES Lincolnshire CVS Every-one Walnut Care LACE Housing Butterfly Hospice Action for Children South Kesteven Blind Society Framework Housing St Barnabas

Promotion of engagement contd.

The below groups received the distribution via NHS comms cascade or the engagement bulletin:

Audience	Distribution
Health Partners	Lincolnshire Resilience Forum
Community stakeholders including volunteer groups, support groups etc. via the engagement bulletin	<p>LPFT involvement database— 430 (service uses, carers, staff, voluntary sector reps & public supporters)</p> <p>Community, voluntary and support groups</p> <p>BAME communities</p> <p>LGBT Communities</p> <p>Carers</p> <p>Older people groups</p> <p>Young people groups</p> <p>Eastern European communities</p> <p>Disability groups (mental and physical)</p>

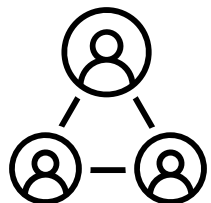
Audience	Distribution
District Councils inc. elected members and staff	<p>City of Lincoln Council</p> <p>Boston Borough Council</p> <p>East Lindsey Council</p> <p>West Lindsey Council</p> <p>North Kesteven Council</p> <p>South Kesteven Council</p> <p>South Holland Council</p>
Local Employers	<p>University of Lincoln</p> <p>Anglian Water</p> <p>The Environment Agency</p>
Public sector providers	<p>Lincolnshire Police and Crime Commissioners</p> <p>Lincolnshire Police</p> <p>Lincolnshire Fire and Rescue</p>

Respondent Profiling

Where respondents live	%	Count
I don't live in Stamford, and I don't use health services there	1%	8
I live in the surrounding villages of Stamford and use health services there	20%	146
I don't live in Stamford, but I do use the health services in Stamford	6%	42
I live in Stamford	73%	530
<i>Answered</i>		726

Health rating	%	Count
Very good	16%	116
Good	61%	440
Poor	16%	114
Very poor	7%	50
Don't know	1%	6
<i>Answered</i>		726

Long term conditions	%	Count
Yes	60%	430
No	38%	271
Don't know	3%	20
<i>Answered</i>		721



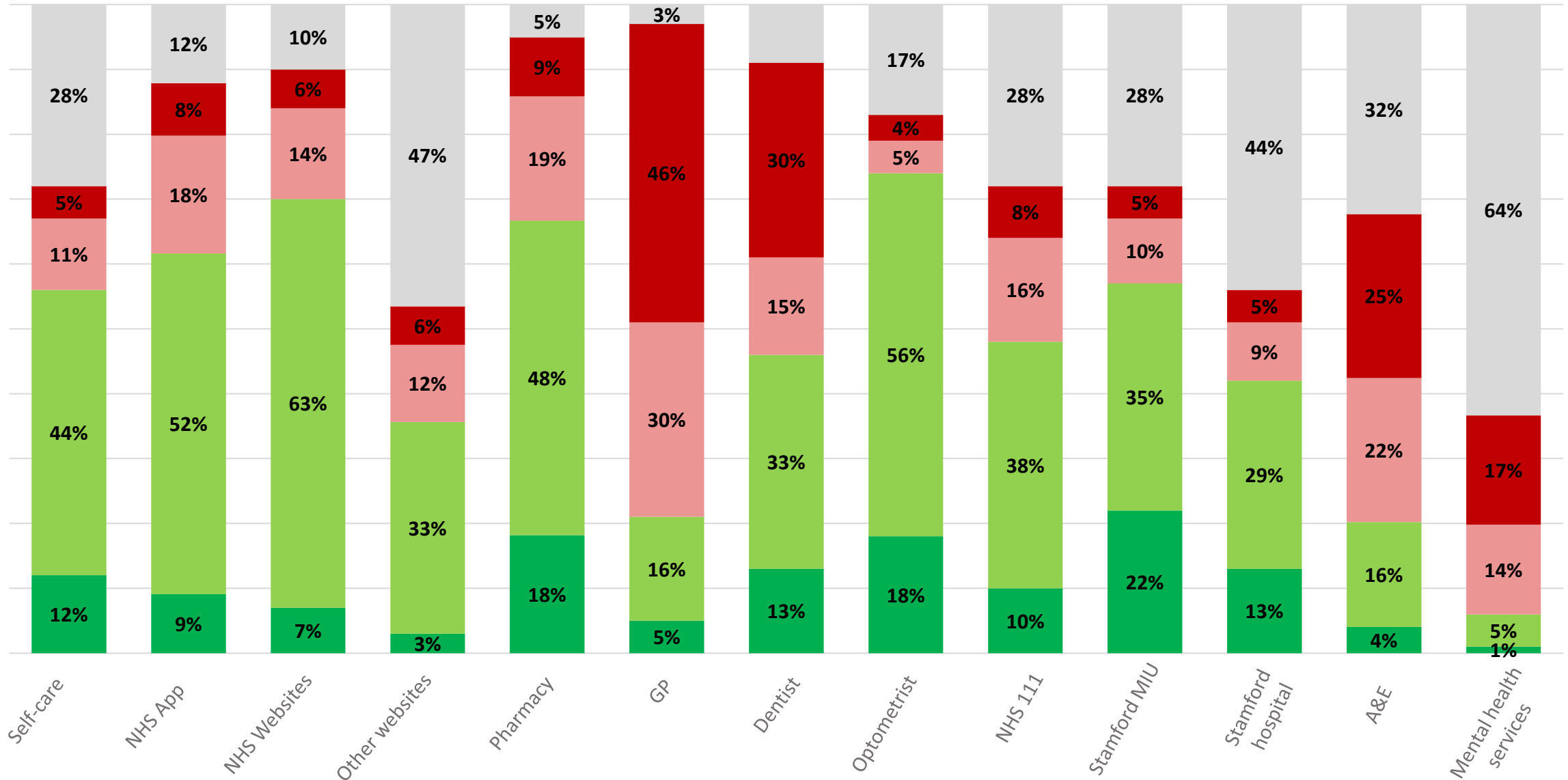
Section 2

Health care needs now
and in the future



Respondent satisfaction with various services

■ Strongly agree
 ■ Agree
 ■ Disagree
 ■ Strongly Disagree
 ■ Don't know



How many times respondents have used each service in the last 12 months

	1-2	3-4	5-6	6+	Not used/don't know
Self-care	25%	14%	5%	11%	45%
NHS App	23%	20%	11%	32%	15%
NHS websites	28%	24%	12%	23%	13%
Other websites	17%	11%	7%	14%	51%
Pharmacy	15%	16%	10%	53%	7%
GP	38%	25%	13%	17%	7%
Dentist	53%	21%	3%	2%	21%
Optometrist	65%	8%	1%	1%	25%
NHS 111	39%	15%	5%	3%	39%
Stamford MIU	43%	7%	1%	1%	47%
Stamford Hosp.	30%	11%	2%	2%	55%
A&E	36%	8%	2%	2%	53%
Mental Health	14%	2%	0%	3%	80%

84% (585) of 695 respondents find it **difficult** to access services.

The below table details the main services they find difficult to access and the reasons why.

Services respondents find difficult to access and why	
GP	<ul style="list-style-type: none"> • Challenges in booking appointments, especially for non-urgent issues. • Long wait times, difficulty in getting through, and issues with phone queues. • Problems with online booking systems, lack of available slots, and technical difficulties. • Unhelpful and sometimes rude interactions with reception staff.
Dentist	<ul style="list-style-type: none"> • Lack of NHS dental services, long waiting lists, and high costs for private dental care.
Mental health	<ul style="list-style-type: none"> • Long waiting times for services, inadequate support, and reliance on online courses.
Pharmacy	<ul style="list-style-type: none"> • Busy and often out of stock of common medications.
Hospital / A&E	<ul style="list-style-type: none"> • Long waiting times and overcrowded facilities. • Extended waiting periods for consultant appointments and specialist services. • Challenges related to the location of services, requiring travel to access care.

Just **under one half (47%, 322)** of respondent's access services outside of Lincolnshire. The key reasons for doing so include lack of local availability, long waiting times, quality of care and proximity of services. A **higher proportion** of respondents **with a disability** use services outside of Lincolnshire compared to those who don't have a disability.

Services	Reasons for accessing these outside of Lincolnshire
Hospitals	<ul style="list-style-type: none"> Many respondents mentioned accessing services at Peterborough City Hospital, Addenbrookes Hospital, and Hinchingsbrooke Hospital for various treatments including A&E, oncology, rheumatology, and maternity care.
GP services	<ul style="list-style-type: none"> Some respondents use GP services in nearby areas like Empingham and Wansford due to dissatisfaction with local services.
Specialist clinics	<ul style="list-style-type: none"> Services such as neurology, orthopaedics, and cardiology are accessed at hospitals outside Lincolnshire due to the lack of local availability or long waiting times.
Dental services	<ul style="list-style-type: none"> A significant number of respondents travel to nearby areas like Peterborough, Rutland, and even as far as Hertfordshire to access NHS dental services due to the unavailability of local NHS dentists.
Mental health services	<ul style="list-style-type: none"> Respondents mentioned accessing private mental health services outside Lincolnshire due to long waiting lists and inadequate local support.
Emergency services	<ul style="list-style-type: none"> Many respondents use A&E services at Peterborough City Hospital as it is the nearest facility offering emergency care.
Pharmacy	<ul style="list-style-type: none"> A few respondents mentioned using pharmacies outside Lincolnshire for better accessibility and availability of medications.

Aspects of health and care services in Stamford that respondents feel work well

Stamford Hospital

Well-regarded for its services, including MIU, blood tests, X-rays, and outpatient clinics. The hospital is seen as a significant local asset that saves travel to larger hospitals.

GP services

Positive feedback about the quality of care once patients get an appointment. Some respondents mentioned improvements in GP services over the past year.

Community and support services

Support groups are mentioned as beneficial for various health conditions, providing motivation and support

Accessibility and convenience

Some respondents find booking GP appointments easy, especially using online services. The NHS App is frequently mentioned as a useful tool for ordering prescriptions and checking results

Specialist services

Positive experiences with physiotherapy services at Stamford Hospital. Private dental services are frequently mentioned as working well. Some respondents are satisfied with their NHS dental care, though availability is limited.

Aspects of health and care services in Stamford that respondents feel **need improving**

GP Services

The most frequently mentioned area needing improvement. Issues include difficulty in getting appointments, lack of face-to-face consultations, and poor communication. Many respondents suggest the need for additional GP surgeries to cater to the growing population and provide competition to the existing service provider.

NHS Dentists

There is a significant demand for more NHS dental services. Many respondents report difficulty in accessing NHS dentists and having to resort to private dental care.

Mental health services

Improved access to mental health support is needed, with shorter waiting times and better follow-up care.

Appointment booking

The current system for booking GP appointments is widely criticized. Respondents suggest the need for a more efficient and user-friendly system, including the ability to book appointments in advance and reducing the reliance on the 8am scramble for slots.

Out of hours

There is a demand for extended hours for the Minor Injuries Unit and the introduction of an Urgent Care Centre to provide more comprehensive out-of-hours care.

Support for vulnerable groups

Better support for elderly, disabled, and digitally excluded individuals is needed to ensure they can access healthcare services effectively.

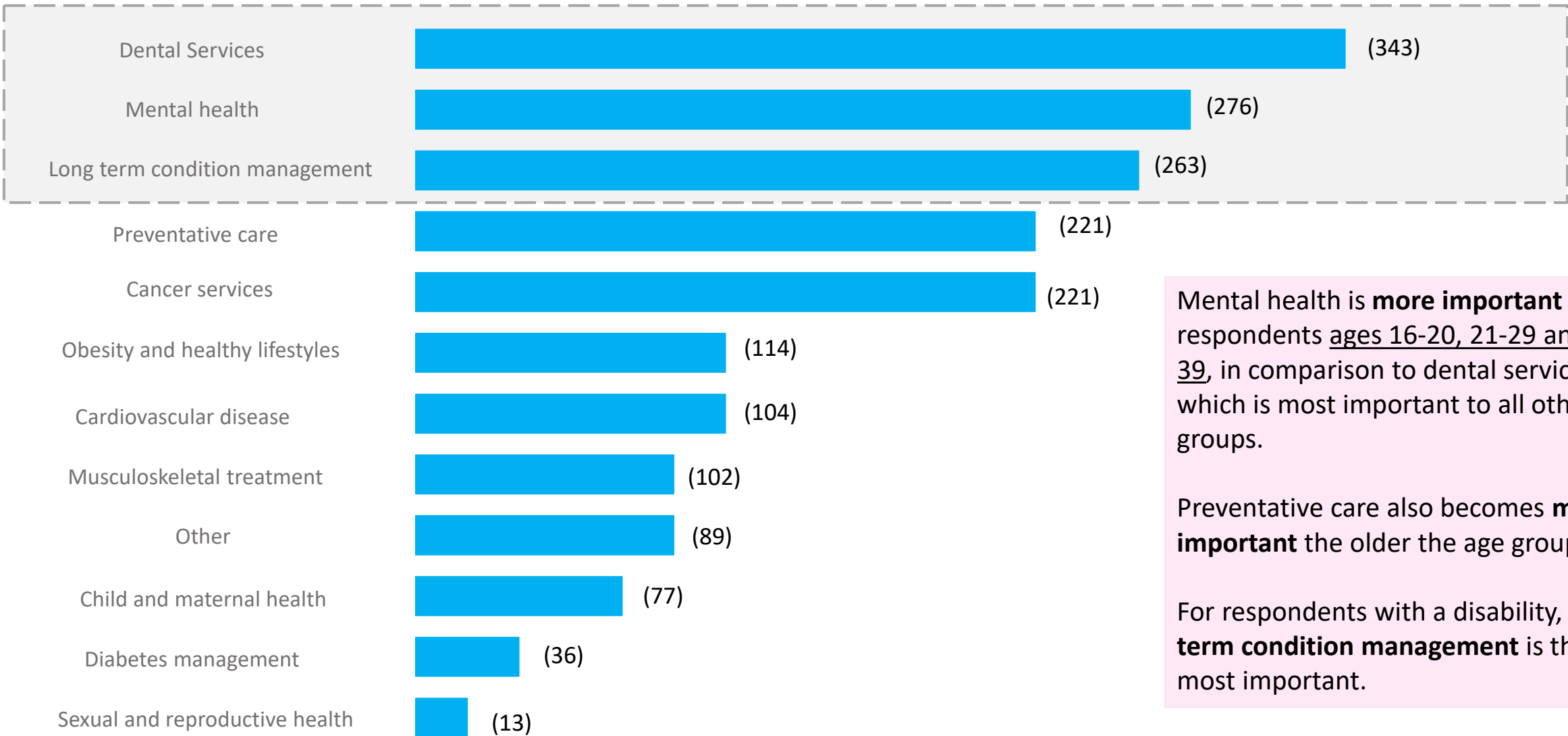
65% of 678 respondents think that there are health and care services needed in their community **NOW** which are not currently provided. **8% (54) don't**, and **27% (182) don't know**.

Theme	Feedback
NHS dentists	<ul style="list-style-type: none"> Many respondents highlighted the lack of NHS dental services, with some mentioning they haven't seen a dentist in years.
GP services	<ul style="list-style-type: none"> There is a strong demand for more GP appointments, face-to-face consultations, and additional GP surgeries to accommodate the growing population.
Mental health services	<ul style="list-style-type: none"> Increased mental health support, including face-to-face consultations and services for children and teenagers, is a recurring theme.
Walk-in clinics	<ul style="list-style-type: none"> Several respondents expressed the need for walk-in clinics and urgent treatment centres that are accessible outside of regular GP hours.
Specialist services	<ul style="list-style-type: none"> There is a call for more specialized services such as CBT therapy for children, gynaecologists, and pain management clinics.
Accessibility	<ul style="list-style-type: none"> Easier access to services like wheelchair support, blood tests, and minor injuries units is needed, especially for those without transport.

90% of 687 respondents think that there are health and care services needed in their community **IN THE FUTURE** which are not available now. **1% (9) don't**, and **9% (60) don't know**.

Theme	Feedback
GP services	<ul style="list-style-type: none"> • There is a strong demand for additional GP surgeries and more GP appointments to accommodate the growing population.
NHS dentists	<ul style="list-style-type: none"> • Many respondents highlighted the need for more NHS dental services, as the current provision is already insufficient.
Urgent and emergency care	<ul style="list-style-type: none"> • There is a call for an urgent care centre and a 24/7 A&E department to handle emergencies locally.
Mental health services	<ul style="list-style-type: none"> • Increased mental health support, including services for children and teenagers, is seen as essential.
Specialist services	<ul style="list-style-type: none"> • There is a need for more specialized services such as maternity wards, gynaecologists, and pain management clinics.
Community support	<ul style="list-style-type: none"> • Enhanced support for carers, better coordination of health and social care, and services to combat loneliness were mentioned.

Dental services, mental health and management of long-term conditions are the most important health issues facing the Stamford community.



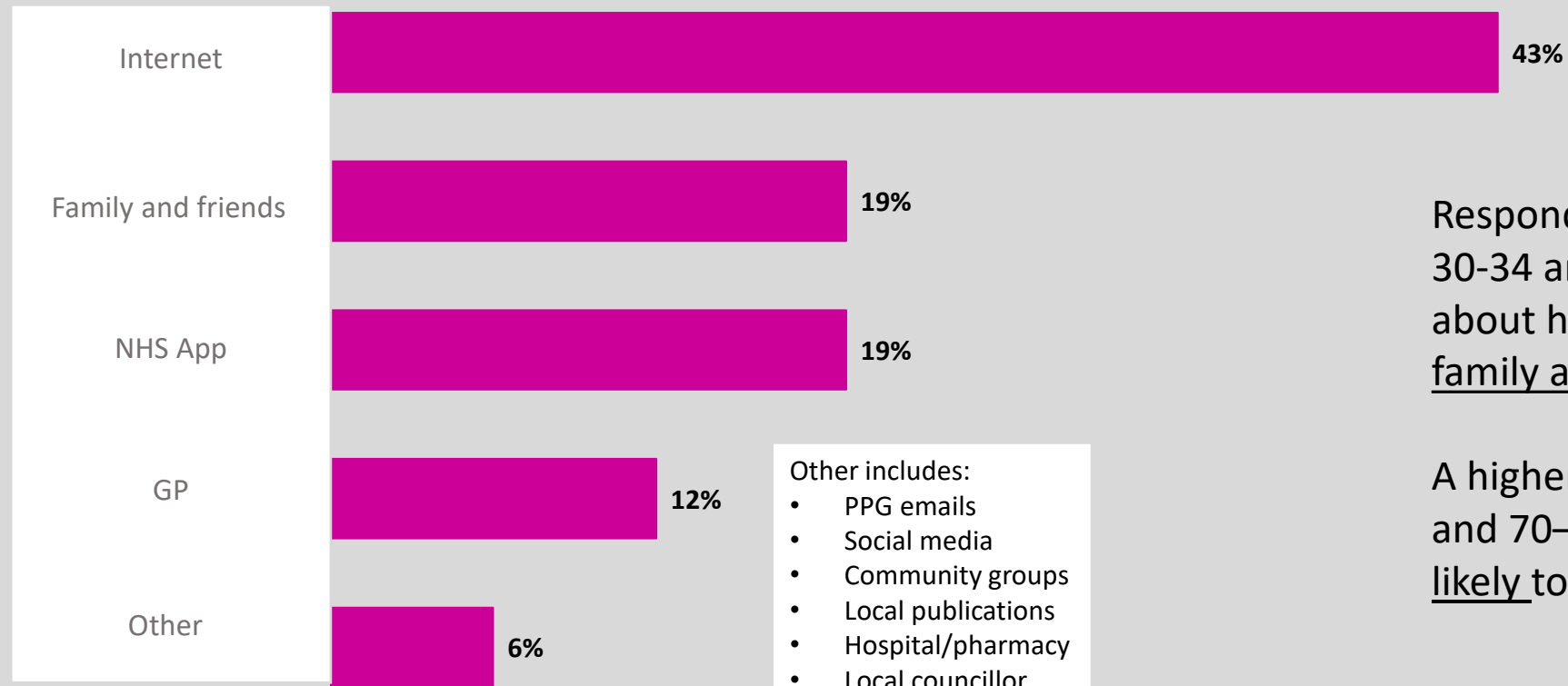
Mental health is **more important** for respondents ages 16-20, 21-29 and 35-39, in comparison to dental services which is most important to all other age groups.

Preventative care also becomes **more important** the older the age groups are.

For respondents with a disability, **long term condition management** is the most important.

64% (459) of respondents do not feel very well informed/informed at all about health and care services. **35% (246)** feel well informed/very well informed. A higher proportion of 30–34-year-olds feel **less informed** than the other age groups.

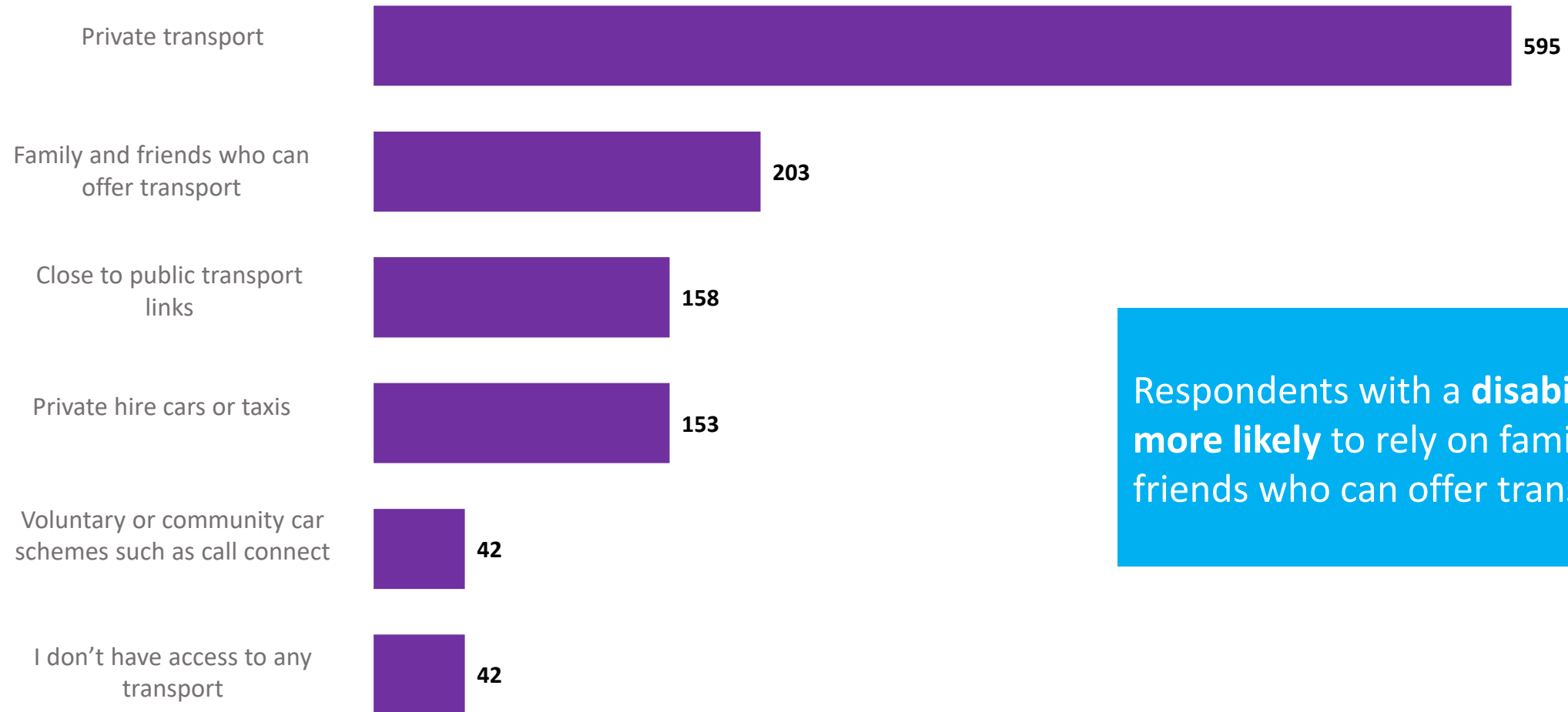
The below graph details how respondents usually find out about health and care services in Stamford.



Respondents aged 20-29 and 30-34 are more likely to find out about health services through family and friends.

A higher proportion of 55-59- and 70–79-year-olds are more likely to use the NHS App.

Of the **702** respondents who answered this question **595 (85%)** have access to private transport. **42 respondents (6%)** do not have access to any transport.



Respondents with a **disability** are **more likely** to rely on family and friends who can offer transport.

Other comments and suggestions

Residents of Stamford have expressed significant concerns about the current state of health and care services. The main issues include difficulty accessing GP and NHS dental services and the need for better mental health support. There is a strong call for expanding healthcare infrastructure to meet the needs of the growing population, including more GP surgeries, a 24/7 A&E department, and better use of Stamford Hospital. Additionally, there is a need for improved support for the elderly and vulnerable, and better communication systems that do not rely solely on digital technology.

The below table details other comments and suggestions in relation to health and care services in Stamford:

Theme	Feedback
GP services	<ul style="list-style-type: none"> • Difficulty in getting appointments, long waiting times, and the need for more GP surgeries. • Concerns about the quality of care, with many feeling that the service has deteriorated over the years.
NHS Dentist	<ul style="list-style-type: none"> • Significant issues with accessing NHS dental services, with many residents unable to find an NHS dentist
Mental health services	<ul style="list-style-type: none"> • A need for better mental health services, including more accessible and comprehensive support.

Other comments and suggestions contd.

Theme	Feedback
Infrastructure and resources	<ul style="list-style-type: none">• The current infrastructure is seen as inadequate to support the growing population.• Calls for more healthcare facilities, including a 24/7 A&E department and better use of Stamford Hospital.
Community and social care	<ul style="list-style-type: none">• Enhanced support for the elderly and those with complex needs, including better coordination of health and social care services.
Communication and technology	<ul style="list-style-type: none">• Issues with the reliance on digital systems for appointments and communication, which can exclude older and less tech-savvy residents

Section 3

Community conversations

The engagement team carried out more detailed conversations with different communities in Stamford to gather feedback and experiences about their health and care services now and in the future.



What services respondents feel **work well** in Stamford

The below table details the key themes and feedback heard, those detailed at the top are mentioned the most and those at the end, the least.

What works well	Feedback
GP practices and nurses	<ul style="list-style-type: none"> • Stamford GP Practice: Patients are generally happy with the services, especially the nurses who are praised for their competence and care. Examples include a nurse who facilitated a doctor's consultation for back issues and another who managed to drain fluid from a patient's knee. • Lakeside Practice: Positive feedback on the quality of care once seen, with specific mentions of good experiences with the physiotherapist and handling of a child's eye issue. <i>"Happy with everything at the moment. Once you get in at the doctors, happy with the clinical care provided."</i>
Hospitals	<ul style="list-style-type: none"> • Peterborough Hospital: Noted for its excellent staff and quick service in A&E, with a patient being in and out within 4 hours. • Stamford Hospital: Positive feedback for minor injuries service, blood tests, and local clinics, including COVID clinics. <i>"Stamford Hospital very good for bloods etc and you don't pay for parking."</i>
Specialist services	<ul style="list-style-type: none"> • Cancer Care: High praise for cancer care at Peterborough and Royal Marsden hospitals, with specific mentions of excellent support groups and personalized care. • Physiotherapy: Positive experiences at Stamford Hospital for physiotherapy, highlighting good quality of care

What services respondents feel **work well** in Stamford contd.

The below table details the key themes and feedback heard, those detailed at the top are mentioned the most and those at the end, the least.

What works well	Feedback
Pharmacies and prescriptions services	<ul style="list-style-type: none"> • Stamford Pharmacy: No trouble reported, with efficient service. • Online Prescription Services: The NHS App and GP practice online services work well for ordering prescriptions • Home Delivery: Some patients benefit from having prescriptions delivered to their home.
Screening and preventative care	<ul style="list-style-type: none"> • Bowel Cancer Screening: Works well, with patients receiving and undertaking tests. • Breast Cancer Screening: Detected through routine mammograms, leading to early intervention. • Regular Health Checks: Patients appreciate being sent information about health checks and having regular asthma checks.
Technology and communication	<ul style="list-style-type: none"> • NHS App: Used effectively for ordering prescriptions, checking results, and accessing medical records. • Text Message Service: Works well for communication with GP practices, including sending photos for remote diagnosis. <i>"The text message service works well at GP practice. Has received a call back in the past was unable to get to phone so then sent a text message."</i>

What respondents feel could be **improved** in Stamford

The below table details the key themes and feedback heard, those detailed at the top are mentioned the most and those at the end, the least.

Theme	Feedback
Access to GP services	<ul style="list-style-type: none"> • Difficulty in Getting Appointments: Many patients find it challenging to secure GP appointments, often needing to call multiple times or visit the practice in person. • Telephone and Online System: There are significant issues with the telephone and online systems, including long wait times and difficulties navigating new online consultation tools. • Continuity of Care: Patients express the need for continuity of care, preferring to see the same doctor consistently to avoid repeating their medical history
Dental services	<ul style="list-style-type: none"> • Lack of Availability and High Cost: There is a shortage of available NHS dentists in Stamford, leading to long waits and high costs for dental care.
Transport and accessibility	<ul style="list-style-type: none"> • Challenges in Reaching Hospitals: Patients face difficulties accessing hospitals, particularly Peterborough Hospital, due to inadequate transport links and long travel times.
Support for elderly and non-digital users	<ul style="list-style-type: none"> • Difficulty with Digital Services: Elderly patients and those without access to digital technology struggle with online services and prefer receiving information in writing. <i>“I don’t use a computer and cannot do it over the phone, so I have to pay £10 each way in a taxi to order and then pick up prescription as they don’t allow you to order now over the telephone.”</i>

What respondents feel could be **improved** in Stamford

The below table details the key themes and feedback heard, those detailed at the top are mentioned the most and those at the end, the least.

Theme	Feedback
Mental health services	<ul style="list-style-type: none"> • Lack of Support and Follow-up: There is a noted lack of support and follow-up for mental health needs, with patients feeling unsupported since before the COVID-19 pandemic
Pharmacy services	<ul style="list-style-type: none"> • Issues with Medication Availability: Patients report problems with pharmacies not having all prescribed items available and difficulties obtaining necessary medications.
Hospital services	<ul style="list-style-type: none"> • Concerns about Stamford Hospital: There are concerns about the underutilization of Stamford Hospital and the need for more local services such as scanning and clinics.
General healthcare concerns	<ul style="list-style-type: none"> • Impact of Population Growth: The increasing population in Stamford is putting additional strain on healthcare services, with concerns about the infrastructure's ability to cope. • Staffing and Resources: There is a need for more doctors and dentists to meet the growing demand for healthcare services.

Section 4

Equalities Monitoring



Survey respondent demographics

Sexual orientation	%	Count
Heterosexual	62%	863
Gay	5%	14
Lesbian	5%	10
Bisexual	14%	22
Prefer not to say	10%	75
Prefer to self-identify	5%	20
<i>Answered</i>		1004

Physical disability or mental illness expected to last more than 12 months	%	Count
Yes	54%	408
No	44%	335
Prefer not to say	1%	11
<i>Answered</i>		754

Caring responsibilities	%	Count
Yes	30%	298
No	70%	706
Prefer not to say	0%	0
<i>Answered</i>		1004

Gender	%	Count
Male	32%	338
Female	66%	694
Intersex	0%	0
Non-binary	0%	1
Prefer not to say	2%	18
<i>Answered</i>		1051

Gender reassignment	%	Count
Yes	1%	4
No	98%	559
Prefer not to say	1%	6
<i>Answered</i>		569

Survey respondent demographics

Age	%	Count
16-20	0%	2
21-29	1%	11
30-39	5%	50
40-49	8%	85
50-59	17%	180
60-69	31%	328
70-79	29%	301
80-89	7%	73
90+	1%	6
Prefer not to say	1%	6
<i>Answered</i>		1042

Ethnicity	Responses	
Bangladeshi	0%	0
Indian	1%	5
Pakistani	0%	0
Any Other Asian Background	0%	0
African	0%	0
Caribbean	0%	0
Any Other Black Background	0%	0
White and Asian	0%	3
White and Black African	0%	2
White and Black Caribbean	0%	3
Any Other Mixed Background	0%	0
White British	93%	980
White Irish	1%	6
Any Other White Background	3%	27
Chinese	0%	1
Gypsies/Travellers/Roma	0%	4
Any Other Ethnic Group	0%	1
Rather not say	2%	26
<i>Answered</i>		1058

Religion	%	Count
Christianity	60%	599
No Religion	17%	166
Atheist	13%	129
Buddhist	0%	1
Jewish	0%	1
Any other religion	2%	24
Prefer not to say	8%	81
<i>Answered</i>		

Pregnancy	%	Count
Yes	1%	4
No	98%	585
Prefer not to say	1%	3
<i>Answered</i>		592

Survey respondent demographics

Health inequality information	%	Count
Have served in the UK's regular or reserved armed force	66%	103
Currently working in the Farming/ agricultural industry	5%	7
Have worked in the Farming/ agricultural industry	17%	27
Currently homeless	0%	0
Have experience of being homeless	7%	11
Currently serving in UK's armed forces	2%	3
Refugee, immigrant or asylum seeker	1%	2
Previous experience of being a refugee, immigrant or asylum seeker	1%	2
<i>Answered</i>		155

Employment status	%	Count
Employed full time	20%	213
Employed part time	10%	108
Homemaker	2%	16
Not employed and looking for work	0%	5
Not employed and not looking for work	3%	29
Retired	56%	592
Self employed	5%	48
Student	0%	4
Prefer not to say	1%	15
Other	2%	18
<i>Answered</i>		569

To: John Turner
Chief Executive,
NHS Lincolnshire Integrated Care
Board

Councillor Carl Macey,
Chairman of the Health Scrutiny Committee
for Lincolnshire
County Offices, Newland, Lincoln, LN1 1YL
Telephone: 07886 450082
Email: CllrC.Macey@lincolnshire.gov.uk

19 February 2025

Dear John,

STAMFORD HEALTH ENGAGEMENT EXERCISE

This letter sets out the response of the Health Scrutiny Committee for Lincolnshire to the ICB's Stamford Health Engagement Exercise.

Introduction

The Lincolnshire town of Stamford is close to three other counties and three other integrated care board (ICB) domains; and its local community hospital is operated by a hospital trust based outside the county. Whilst extensive additional housing is planned in Stamford, there is also additional housing planned just outside the Lincolnshire boundary. In an ideal world, lines on maps should not impact the NHS, a national service, but it is regrettable, as explained below, that access to a national service can be affected in this way.

The Health Scrutiny Committee for Lincolnshire acknowledges that NHS Lincolnshire ICB is working with neighbouring NHS entities, in particular Leicester, Leicestershire and Rutland ICB and would like to see this collaboration delivering meaningful outcomes following this engagement exercise.

The Committee recognises that Stamford is viewed as an area of relative affluence, with more than half of the population lying in the least deprived areas of England, with no Stamford residents living in the most deprived areas. However, there are small pockets of poverty and deprivation in the town, and the Committee would not wish to see these overlooked in the delivery of local health services.

The Committee's views on specific issues are set out below:

Impacts of New Housing Developments

In Stamford, there are 2,350 new homes awaiting construction for which planning permission has already been granted and also the further growth envisaged in the revised South Kesteven District Council Local Plan. On this basis, the Committee would like NHS Lincolnshire ICB keep all health provision in the town under continuous review, to reflect the actual increased population and demands, so that there is a proportionate enhancement of all health services in the town.

Access to Out-of-Hours GP Services

Where patients who live in Stamford are registered with a GP practice outside Lincolnshire, in effect in another ICB area, for example Leicester, Leicestershire and Rutland, NHS funding arrangements mean that the patient's per capita funding is passed to that ICB, not NHS Lincolnshire ICB. The Committee understands that this principle is fundamental to the NHS's funding arrangements for ICBs. This in turn means that people who live in Lincolnshire, but are registered at a GP practice outside the county, cannot access the out-of-hours GP services provided in Lincolnshire. As a consequence, these residents cannot access out of hours at Stamford and Rutland Hospital, their local community hospital and this creates concern in Stamford, which as stated above is surrounded by three counties, and three ICB areas. This matter has been raised previously with NHS Lincolnshire ICB, and the Committee believes that this creates an inequality in terms of access to out of hours services. The Committee wants to formally record its concerns as part of this engagement exercise, as this has negative impact on the health of the people of Stamford, and the Committee would like to ask whether the ICB can suggest ways that that this inequality can be overcome.

Stamford and Rutland Hospital Minor Injuries Unit

Stamford and Rutland Hospital Minor Injuries Unit is open Monday to Friday from 9 am to 5 pm, and averages 23 attendances for each week-day. It is operated by North West Anglia NHS Foundation Trust and commissioned by NHS Lincolnshire ICB. As Stamford Minor Injuries Unit is not designated as an urgent treatment centre, its activity cannot be included in any national data collected towards meeting the four-hour national A&E standard. This is because NHS England has determined that only designated urgent treatment centres (and A&E departments) can provide data that support the achievement of the four hour A&E standard. Irrespective of whether it supports national data, the Committee would like to see NHS Lincolnshire ICB continue to commission the Stamford Minor Injuries Unit from North West Anglia NHS Foundation Trust, as it is a valuable resource for the residents of the town.

Potential for an Urgent Treatment Centre in Stamford

Further to the above, the Committee supports the principle of establishing an urgent treatment centre in Stamford, provided that it could be justified on the basis of urgent care needs. When the outcomes of the Stamford Engagement Exercise are published, the Committee would prefer that it include an initial assessment by the ICB on whether there is sufficient demand to merit an urgent treatment centre in Stamford, and the consequent allocation of NHS resources. While the Committee understands that many urgent treatment centres operate on a 24/7 basis, the national specification requires stand-alone urgent treatment centres to be open between the hours of 8am and 8pm, seven days per week, with 24/7 centres provided only where urgent care needs are clearly demonstrated. It has been suggested that an urgent treatment centre in Stamford would address the access to out of hours GP services outlined above. However, the Committee recognises that only a 24/7 urgent treatment centre would be a solution to this issue.

Stamford and Rutland Hospital – Range of Services

Stamford and Rutland Hospital, which is operated and managed by North West Anglia NHS Foundation Trust, provides nearly 600 day-case surgeries and nearly 18,000 outpatient appointments each year. The Committee would not wish to see any services currently provided by the Trust at the hospital relocated to Peterborough City Hospital. As a community hospital site, Stamford and Rutland Hospital is a valuable resource and can support the delivery of health (and other) services as close to home as possible.

Funding

The Committee was advised on 4 December 2024 that any major developments in the health service in Stamford, such as an urgent treatment centre, would require significant additional funding, which would not necessarily be available without a detailed evaluation of need. In effect this means the engagement exercise could lead to small-scale improvements, which can be achieved without additional funding. It is important that the engagement exercise delivers benefits, as the Committee would not wish to see it become a ‘tick box’ exercise, with no clear outcomes. The Committee would like to see the ICB’s response to the engagement exercise set out how the ICB is going to plan for population increases and other demands on the health service in Stamford.

Health Engagement Exercises in Other Parts of Lincolnshire

The Committee fully supports NHS Lincolnshire ICB’s intention that similar engagement exercises will be undertaken elsewhere in Lincolnshire in the coming years, and the lessons learned from the Stamford exercise can be used elsewhere. There are areas in Lincolnshire where the levels of poverty and deprivation present serious challenges to the delivery of health services, and similarly there are areas of significant housing growth in other parts of the county,

which present different challenges. We fully support these engagement exercises as a means of enabling local residents to put forward their views and ideas, and would like to see tangible outcomes as a result.

The Committee looks forward to the outcomes of the Stamford health engagement exercise being presented at a future meeting.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Carl Macey', is positioned below the closing text.

Councillor Carl Macey

Chairman of the Health Scrutiny Committee for Lincolnshire

CllrC.Macey@lincolnshire.gov.uk



The Stamford Surgery

Sheepmarket and St Mary's Sites

licb.involveus@nhs.net

peter.burnett4

via email

28 January 2025

Dear colleagues

Health Care Needs in Stamford – public engagement exercise for Stamford, and surrounding areas

Thank you for the opportunity to respond to the ICB's engagement exercise about health provision in Stamford.

We are responding on behalf of the Stamford Surgery, Sheepmarket and St Mary's sites. Many of our staff live and work in the local area and so also use local health services.

In 2021, our surgery was struggling with the retirement of several of our partner GPs, difficulties recruiting, and the impact of Covid. We received a poor CQC rating which also impacted our reputation and ability to recruit.

We have been on a significant improvement journey since then. We have invested heavily in recruiting the best staff and have increased our number of doctors as well as those involved leadership of the site.

We have worked closely with our Patient Participation Group, and surveyed our patients regularly to help us focus on the areas that matter to them, mainly access and communication. The national GP Patient Survey from January 2024 and published in July 2024 showed a 25% increase in satisfaction with our practice.

We are continuing to regularly review and improve our systems and processes to enhance access and are examining best practices for managing on-the-day demand.. We have reworked our website to be more user friendly and changed our online consultation provider. We have worked with our patients on these initiatives as well.

Like most practices, some roles such as reception, remain a challenge in terms of recruitment, but we are now fully staffed with clinicians and have recruitment and retention strategies to help our staff develop and stay with us. We have also taken part in the national GP staff survey, and we look forward to reviewing the responses once they are published and making any changes that may come from that.

We are pleased to see that overall; the life expectancy and healthy life measures are good for our patients. We work hard on early diagnosis and prevention interventions so that we can help our patients stay well for longer. For example, you show that there is a relatively high prevalence of

asthma which may be because we have better diagnosis as we have an excellent specialist respiratory nurse identifying these patients.

We provide a full range of commissioned services, including women's health services and minor surgery. We also support five large care homes with patients with complex needs. This may explain some of the data you have shown in relation to medication, as Stamford has a relatively older population and many care homes.

In terms of prescribing for musculoskeletal conditions, we do have many people on waiting list for hospital procedures and physio services, as well as an active sporting community in Stamford, making injuries common. Physiotherapy capacity is limited locally, so this could be an area for the ICB to consider.

We also find that we do have a community of younger people struggling with addiction and there is no service for them, locally. The nearest hub is Grantham which is a struggle for many to access. Outreach to Stamford would support these patients better.

Like practices nationally we have seen a significant increase in mental health presentations and while we manage these patients well in the community, there are some who wait a long term for referral to specialist services. Investment in mental health would help this group towards recovery.

In terms of population growth, with our increase in clinical staffing, we are confident we would be able manage more registrations at our practice. We do have concerns about the condition of the building at the St Mary's site, but we are working with the main leaseholder and the ICB to ensure this is resolved soon.

We welcome the chance to respond to this engagement exercise and we look forward to hearing the outcome in due course.

Yours sincerely

Dr Gavin Cattigan
Dr Sian Dronfield
Dr Kate Tizzard
Dr Katherine Berry
Dr Jean Moon
Dr Hannah Waddingham
Dr Mena Khela
Dr Romek Wiles

The GP Partners at The Stamford Surgery

Joint ICB Transition Committee Highlight Report

Meeting Date(s):	11 July 2025, 21 July 2025, and 12 August 2025
Committee Chair:	Jon Towler, Non-Executive Director, NHS Nottingham and Nottinghamshire ICB (11 and 21 July) Margaret Gildea, Non-Executive Member, NHS Derby and Derbyshire ICB (12 August)

Item	Summary
1. Management of Change Business Case	<p>The Joint Committee has overseen development of the ICB Cluster Management of Change Business Case, which included analysis of a range of potential options for meeting national requirements, taking into account affordability, based on financial modelling and cost mitigation plans, while ensuring legal compliance and optimisation of staffing structure design.</p> <p>When considering the Business Case, members noted that a national voluntary redundancy scheme had yet to be approved and national guidance on accounting treatment for redundancies was awaited.</p> <p>The importance of taking a fair and compassionate approach to the management of change process was stressed in discussions.</p> <p>Members also noted the need for a risk sharing agreement to be developed across the three ICBs in relation to redundancy costs and ongoing salary costs.</p>
2. ICB Cluster Operating Model	<p>The Joint Committee has received regular updates regarding progress in developing the ICB Cluster Operating Model. Initial work has been completed to assess the most appropriate scale of delivery for all ICB functions and activities; this has included work across the Midlands Region to consider potential efficiencies through larger scale delivery options. A series of multi-disciplinary 'confirm and challenge' sessions are underway to test the work completed to date.</p>

Item	Summary
	<p>Members were assured that good progress is being made; however, delays in the publication of the Model Region Blueprint and other national guidance relating to ICB function transfers were noted as impacting on further development in some areas.</p>
<p>3. Transition Programme Plan Progress</p>	<p>The Joint Committee has received routine updates at all meetings regarding progress against the ICB Transition Programme Plan.</p> <p>Members were assured that the Programme Plan is largely on track, albeit delays in national guidance/publications and delayed confirmations of the Chair designate and Chief Executive designate appointments have impacted progress in some areas.</p> <p>To date the Joint Committee has focused much of its time on the development of the management of change process and ICB Cluster Operating Model. These areas are now progressing well, and the Joint Committee is turning its attention to the developing governance arrangements for ICB clustering.</p> <p>In discussions, members stressed the importance of supporting staff wellbeing and noted that constructive engagement with Trade Unions had commenced, with staff communications plans in place to ensure timely and transparent updates. Members also noted the importance of preserving corporate memory during the transition period.</p>
<p>4. Transition Risk Log</p>	<p>The Transition Risk Log has been reviewed by the Joint Committee at every meeting.</p> <p>The highest scoring risks relate to the design of the new operating model, affordability of redundancies, staff perceptions of change, and delivery of in-year priorities. The mitigations for many of the risks relate to the finalisation of the management of change process and the design of the ICB cluster operating model.</p> <p>New risks have emerged during the period around commissioning support unit (CSU) service continuity, and the in-year implementation of new financial ledgers.</p>



PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	6 (ii)
Meeting Date:	Tuesday, 30 th September 2025
Title of Report:	ICB Annual Report and Accounts 2024/25
Report Author:	Mrs Jules Ellis-Fenwick, ICB Board Secretary
Presenter:	Dr Gerry McSorley, ICB Chair
Appendices:	ICB Annual Report and Accounts 2024/25

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 Board/Committee that controls and assurances are in place.	Receive and note implications, may require discussion to help share/develop item.	Note, for intelligence of the Board/Committee without in-depth discussion.

Recommendations

The ICB Board is asked to:

- Receive the Lincolnshire ICB Annual Report and Accounts, including the Annual Governance Statement and Remuneration Report for the year 1st April 2024 to 31st March 2025.

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) 2023/24 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.

Additional Requirements for ICBs

The 2024/25 GAM sets out additional requirements for ICBs relating to the reporting of gender distribution, business information and details of members, the membership body and governing body.

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

The ICB was required to submit the full audited Annual Report and Accounts by 9.00 am on Monday, 23rd of June 2025, which was actioned.

ICBs are required to present in a public meeting the final version of the ICB Annual Report and Accounts and publish the document in full on the website by 5.00 pm on 30th of September 2025; hence presentation of the document at today's Board meeting.

The Board is requested to receive the ICB Annual Report and Accounts for 2024/25 for publication on the ICB website.

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

No conflict identified

Summary of conflicts

Risk and Assurance

No specific risks identified in relation to this paper and the Annual Report and Accounts.

Implications (legal, policy and regulatory requirements)

Does the report highlight any resource and financial implications?	The report includes a section on Financial Summary and also the ICB Annual Accounts (Financial Statements).
Does the report highlight any quality and patient safety implications?	Yes, as reflected in the main body of the Annual Report.

Does the report highlight any health inequalities implications?	Yes, as reflected in the main body of the Annual Report.		
Does the report demonstrate patient and public involvement?	Yes, as reflected in the main body of the Annual Report.		
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)	Yes, there is a section on environmental matters and climate change within the Annual Report.		
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"/>			

PUBLIC MEETING OF THE NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	07 (i)
Meeting Date:	Tuesday, 30 th September 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 9th September 2025 and focused on the following agenda items:-

- Lincolnshire System Priorities Quality Register:** it was noted that the Register had been updated highlighting the addition of the community equipment and wheelchair services as an emerging risk. It was discussed that operational improvements had been noted however it was recommended that ongoing monitoring continue to eliminate potential or actual harm. The register had also been refreshed with updated tolerance levels and members were invited for future suggestions/additions.
- Medical Examiner and Verification of Death:** an update was provided on the Medical Examiner service, reporting significant improvements in the turnaround times and efficiency processes with ongoing collaboration to address remaining challenges.
- Lincolnshire Voice Report:** The report was presented which included patient feedback on communication, access to services, and pain management. A query had been raised regarding the absence of community pharmacy feedback, it was noted that whilst no specific engagement had been conducted, general feedback was positive, and future reports would aim to address this gap. Discussions ensued regarding the feedback received and that it would be beneficial to demonstrate "You Said/We Did" to show that the ICB had responded to the feedback. It was agreed that future iterations of the report would include this detail.

- **Care of a Deceased Baby – Mortuary Audit:** an update was provided on the regional report received on the care of deceased babies and mortuary audit. Colleagues were asked to review local governance and oversight arrangements and provide an update at the next meeting. It was confirmed that the Group undertakes regular reviews and that the Human Tissue Authority inspection outcomes make recommendations through the quality committee, ensuring actions are tracked and reported.
- **Safeguarding Update:** a comprehensive update was provided on safeguarding including improvements in health representation at strategy discussions, access to GP records, and child death review processes. It was reported that significant progress in appointing staff to meet statutory requirements for health representation at children's strategy discussions had been made though some operational challenges and recruitment gaps remain. In terms of the child death review processes five key recommendations had been noted from the overview panel, including targeted weight management for pregnant women, driving safety for young drivers, and suicide prevention information for families.
- **Deep Dive Cancer Programme:** a detailed presentation was provided on the cancer programme, outlining performance metrics, pathway improvements, early diagnosis initiatives, and challenges related to operational capacity and funding. An update was provided on the performance metrics, noting current standings against national targets and an increase in the 62-day backlog, with ongoing efforts to address these challenges. In terms of the pathway improvement initiatives end-to-end reviews of urology and colorectal pathways have led to streamlined processes, reduced delays, and enhanced patient engagement, with further work planned for capacity and demand analysis.

In relation to screening and early diagnosis the aim is to increase early-stage cancer diagnosis rates, focusing on six tumour sites and implementing innovative projects such as self-request chest x-rays and lung cancer screening. An update was provided on the Living With Cancer and Personalisation workstream and that efforts continue to embed personalised care and support for people living with cancer, including holistic needs assessments and addressing wider determinants of health.

- **Lincolnshire Community and Hospitals NHS Group Highlight Report:** an update was provided on the forthcoming Patient Safety Day activities. In terms of the recent CQC inspections it was reported that improvements have been noted for infection, prevention and control processes.
- **Lincolnshire Partnership NHS Foundation Trust Highlight Report:** it was noted that work is ongoing in terms of the quality improvements pending the CQC report publication.
- **East Midlands Ambulance Service NHS Trust Highlight Report:** it was reported that internal efficiency work is ongoing particularly for Category 2 targets pre and post-handover. Work is commencing with the annual flu campaign commencing in October 2025 of which will be extended beyond the usual 10 week window concluding at the end of March 2026. It was noted that the Trust have successfully recruited 12 Specialist Practitioners to support community care.
- **Primary Care Highlight Report:** an update was provided on the ongoing quality concerns at two GP Practices including partnership and CQC registration issues, with daily monitoring and escalation plans in place. Subsequent to this a review of all registration details for GP Practices will be undertaken. Work is taking place to develop a Quality Early Warning Systems tool for Dental Practices and once this has been undertaken will be completed for Community Pharmacy and Optometry ensuring that all four pillars of primary care have been completed.
- **Operational Quality Assurance Group (OQAG) Update:** further discussion took place regarding the previous discussions and the stabilisation of the community equipment and wheelchair services and the transition from a tactical to a recovery cell, and ongoing quality monitoring. Concerns had been raised regarding the St Andrews Inpatient facility and subsequent to this a full and detailed review has been undertaken by the Mental Health and Learning Disability Team.

An issue had been raised in relation to the Group and the reporting of Mixed Sex Accommodation breaches and since corrective action has taken place this has seen an increase in the number of breaches reported.

Further concern was reported in relation to the process for reporting primary care complaints and that this is currently managed by East Midlands however due to staffing capacity challenges support is no longer able to be provided by East Midlands. Work is taking place to understand the number of Lincolnshire complaints and the associated timelines. It was agreed that this area would be added to the Risk Log.

- **System Quality Group:** it was noted that the last meeting had taken place on 28th August 2025 whereby discussions had focused on updated documentation to support Equality Impact and Quality Impact Assessments. An update had also been provided on the PSIRF progress and latest Never Event detail.
- **Future Committee Structure and Governance Arrangements:** discussions took place regarding the forthcoming changes to the quality and oversight committee structures due to the new ICB cluster arrangements, highlighting the need to ensure continuity of risk management and partnership working during the transition.

Items for escalation to the ICB Board:-

- The Lincolnshire System Priorities Quality Register was received highlighting the addition of the community equipment and wheelchair services as an emerging risk, noting operational improvements but recommending ongoing monitoring for potential or actual harm.
- The Committee received the Lincolnshire Voices report and the discussions that took place regarding the feedback received and strengthening future iterations of the report to demonstrate “You Said/We Did” to show that the ICB had responded to the feedback.
- The Committee received the Regional Quality Group ICB oversight and assurance in relation to the care of products of conception and babies and infants after death. Colleagues were asked to review local governance and oversight arrangements and provide an update at the next meeting
- A detailed Safeguarding update was provided including an update in relation to the child death review processes and the five key recommendations noted from the overview panel.
- A comprehensive update was shared with members on the Cancer Programme including pathway improvement initiatives and end-to-end reviews of urology and colorectal pathways. An update was also shared on the work taking place to support screening and early diagnosis.
- A review is being undertaken across primary care to review CQC registration details at all GP Practices.
- It was agreed to include the risk in relation to the management process for primary care complaints and the associated regional resource challenges.

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

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

Conflicts of Interest		Summary of conflicts	
No conflict identified			
Risk and Assurance			
A System Risk Register and ICB Risk Register is in place of which is shared at the meeting.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?		No	
Does the report highlight any quality and patient safety implications?		Assurance received where concerns highlighted appropriate actions are in place	
Does the report highlight any health inequalities implications?		Health inequalities considered in all aspects of the work programme.	
Does the report demonstrate patient and public involvement?		Patient and public involvement and engagement is embedded within the System QPEC.	
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)		No	
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes <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 NHS LINCOLNSHIRE
INTEGRATED CARE BOARD**

Agenda Number:	07 (i)
Meeting Date:	Tuesday, 30 th September 2025
Title of Report:	Update from the Service Delivery & Performance Committee for July and September 2025
Report Author:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Presenter:	Dawn Kenson – Non-Executive Director and Chair of Service Delivery & Performance Committee
Appendices:	

To approve <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

July 2025 Committee

1. Mental Health Transformation Progress

The Committee was presented with an update on the first year's progress of the Mental Health, Dementia, Learning Disability and Autism (MHD LDA) Inpatient Quality Transformation Plan, as part of a three-year vision published in July 2024. The overarching aim of the plan is to deliver local, inclusive, person-centred care that enables individuals to live well in their communities. Prevention and reduced reliance on inpatient settings are central ambitions.

Key achievements included:

- establishment of governance and resourcing
- implementation plan approved.
- piloting of a new care model at Ash Villa
- improved data analytics with demand and capacity modelling commenced.

Priorities for the next two years include:

- System-wide implementation of co-produced care models
- Further reduction in out-of-area placements
- Strengthened workforce and estate planning.
- Greater alignment with housing, emergency mental health and prevention initiatives.

The Committee endorsed the Year One progress report and approved it for publication by 31 July 2025, as requested by NHS England.

2. Performance Report

The Committee discussed various items by exception:

Mental Health - efforts to discharge long-stay patients were affecting the inpatient length of stay metric due to how data is captured. However, these efforts are expected to enhance flow and reduce delays long-term.

Elective and Diagnostic Performance - there has been an increase in 52-week waits and pressures highlighted in diagnostics, particularly in audiology and echocardiography. Mutual aid and contract escalations were being explored to improve the position.

A notable improvement was reported in DEXA scanning at ULTH, credited to workforce investment and service redesign.

Urgent and Emergency Care - National Cat 2 ambulance targets remain challenging for Lincolnshire, with rurality and staffing constraints playing a key role. It was confirmed that operationally, good resilience was demonstrated during the recent junior doctor strikes.

Also highlighted to the Committee was the launch of the Life and Limb triage pathway.

Cancer - concerns were raised over the 62-day cancer backlog, with the system exceeding its trajectory by 47 patients. A new Head of Cancer had been appointed, and a colorectal pathway transformation was underway. The dermatology 31-day target was also flagged due to seasonal pressures and workforce capacity.

Digital Strategy and Governance

The Committee discussed the coordination of digital developments across the Lincolnshire system and agreed to receive a future update for assurance on:

- NHS App and AI implementation
- Digital strategy alignment across providers
- Performance enablement through technology

Seasonal Pressures - the Committee discussed recurring summer pressures, especially at Skegness UTC, and supported the development of a data-led Summer Plan to mitigate the impact from population surges.

Board Assurance Framework – Health Inequalities

The Committee had an in-depth discussion regarding Risk 005 (Health Inequalities) within the Board Assurance Framework. A shift in risk framing was agreed, moving from culture creation to sustainability and prioritisation. The risk appetite was reaffirmed as 'Open' and the current risk rating as Amber (score of 12).

The revised risk narrative with mitigations and any gaps in assurance will return to the Committee in September.

September 2025 Committee

1. Winter Plan 2025/26

The Committee was presented with the final draft of the system-wide Winter Plan, developed with full system engagement and reviewed by the UEC Partnership Board. Key highlights included:

- Early Planning - Commenced in July 2025 which was earlier than previous years.
- Modelling Scenarios - Baseline, escalation, surge, and super surge scenarios were modelled.
- National Guidance - NHS England anticipates moderate to severe surge levels.
- System Risks - Identified risks include delays in care access, discharge, industrial action, East Coast fragility and workforce pressures.
- There was no additional national winter funding but there were some local ring-fenced funds from UEC and BCF allocations for which schemes were in the process of being prioritised.
- There were a number of outstanding actions - IPC RAG ratings, RSV working group, clinical risk framework and the finalisation of provider plans.

The Committee endorsed the Winter Plan subject to final sign-off by the Group Board and clear articulation of risks (particularly funding and workforce) in the submission to the ICB Board.

2. Performance Report

The Committee received a summary update with regards to the system performance report, highlighting:

- Finance - Month 5 forecast remains at break-even.
- Workforce – Cross system reduction from 102 WTE to 60 WTE over plan.
- Elective Recovery - Time to first appointment on track; 52-week waits slightly off trajectory.
- Cancer: - 62-day performance below plan; funding applications in the pipeline to enable improvements through extra clinics etc.
- UEC - 4-hour performance recovered in August; 12-hour waits, and ambulance handovers still remain problematic, focus is on actions for improvement in September.
- Primary Care - Dental activity below plan but expected to recover.
- Mental Health - CYP access below trajectory; improvement work ongoing.
- Digital & Transformation - Most of the programmes are on track but some slippage noted.

Committee members expressed concern over visibility of recovery trajectories and sustainability of improvements. Assurance was provided that productivity programmes are underway, with supporting modelling and recommendations.

3. Health Inequalities

The Committee were presented with an updated Health Inequalities Risk (Risk 005 on the BAF) and the Annual Health Inequalities Report.

The key points were:

BAF

- Risk Reframing - Focus has shifted from embedding culture to sustaining transformation and reducing outcome gaps.
- The risk score was maintained at 12 (Amber) due to the paused enabler workstream associated with ICP governance and unknown future structures.

Subject to minor corrections and inclusion of a review date, the Committee approved the updated Health Inequalities Risk (Risk 005) for inclusion in the ICB BAF.

Annual Report

- Demonstrated improvements in elective recovery and emergency admissions for under-19s. Areas of deterioration included flu vaccination uptake and mental health access.
- Data Quality - Ethnicity coding remains a challenge; improvements are ongoing.
- Future Focus - Targeted interventions for males with CVD, females on waiting lists and children in deprived areas.

The Committee agreed to recommend that the ICB Board approve the Annual Report for publication alongside the ICB Annual Report in September 2025.

4. Forward Planning and Closure

The Committee acknowledged that the October meeting would be the final session before transition to new governance arrangements. A handover template will be completed to ensure continuity of oversight and risk management.

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

No conflict identified

Summary of conflicts

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 <input type="checkbox"/> No <input checked="" type="checkbox"/>			

PUBLIC MEETING OF NHS LINCOLNSHIRE INTEGRATED CARE BOARD

Agenda Number:	07 (iii)
Meeting Date:	Tuesday 30 th September 2025
Title of Report:	Audit & Risk Committee Update Report
Report Author:	Ms Karen Bates, Assistant to the Board Secretary Mrs Jules Ellis-Fenwick, ICB Board Secretary Mr John Dunstan, Non-Executive Member and Chair of the Audit and Risk Committee
Presenter:	Mr John Dunstan, Non-Executive Member and Chair of the Audit and Risk Committee
Appendices:	N/A

To approve <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 update and progress.

Summary

The Audit & Risk Committee meeting held on 11th September 2025 focused on a number of areas including the following:

- Update on the ICB Risk Management Arrangements
- Governance
- Audit Yorkshire Counter Fraud Update Progress Report
- TIAA SICA Report Including Final Internal Audit Reports
- Outstanding IA Actions
- Updated IA Plan 25/26
- Ernst & Young Annual Report 24/25
- ISFE2 ICB Ledger Implementation

Key points for noting were as follows:

Update on the ICB Risk Management Arrangements

The Corporate Risk Register and BAF were reviewed; a recent Board Development Session introduced a “super risk” related to clustering, now incorporated into the BAF. Work is underway to strengthen governance, including developing a joint risk management policy, BAF and CRR across the cluster.

Governance Report

The latest versions of the Declaration of Interest and Hospitality Registers were presented and noted.

Audit Yorkshire Counter Fraud Update Progress Report

Audit Yorkshire updated that there were no new referrals; ongoing investigation at critical stage, potential police involvement. One new fraud alert received (gift card scams); key personnel notified. Counter Fraud Authority Annual Report reviewed; fraud risk register under rationalisation. 2025/26 counter fraud plan on track; current investigation remains the priority.

TIAA SICA Report Including Final Internal Audit Reports

Three reports issued with reasonable assurance (Continuing Healthcare, Cost Improvement Plans, Key Financial Controls). Some older audit actions remain outstanding; pragmatic review proposed to assess relevance and alternative outcomes.

Outstanding IA Actions

As of 31 August, three audit actions were overdue but near completion, with evidence pending and confirmed that all three actions are now fully completed, providing assurance to the Committee.

Updated IA Plan 25/26

Proposed internal audit plan presented for formal approval. Two audits cancelled and 19.5 audit days brought forward from the previous year included. Four new audits scoped and ready for formal APM Memoranda.

Ernst & Young Annual Report 24/25

Formal closure of the annual Value for Money (VfM) review confirmed. Commentary consolidates findings from all audit reports with minimal changes. VfM summary focuses on three pillars: financial sustainability, governance, and efficiency/economical use of resources.

ISFE2 ICB Ledger Implementation

ISFE Ledger scheduled to go live 1 October; training and cutover activities are on track. Organisational readiness rated green; confidence of delivery rated amber due to lack of trial environment. Staff encouraged to attend offices in October for hands-on learning and peer support. Contingency plans in place.

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

Aim 1: Improve outcomes in population health and healthcare.	The Board’s committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Aim 2: Tackle inequalities in outcomes, experience and access.	As above.
Aim 3: Enhance productivity and value for money.	As above.

Aim 4: Help the NHS support broader social and economic development.	As above.		
Conflicts of Interest		Summary of conflicts	
No conflict identified			
Risk and Assurance			
A indicated in the report.			
Implications (legal, policy and regulatory requirements)			
Does the report highlight any resource and financial implications?		Not applicable.	
Does the report highlight any quality and patient safety implications?		Not applicable.	
Does the report highlight any health inequalities implications?		Not applicable.	
Does the report demonstrate patient and public involvement?		Not applicable.	
Does the report demonstrate consideration has been given to the Lincolnshire System Greener NHS Plan? (which can be found here)		Not applicable.	
Inclusion			
Has a Data Protection Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has an equality impact assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Has a Quality Impact Assessment been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input checked="" type="checkbox"/>
Report previously presented at:			
Regular updates provided to the Board.			
Is the report confidential or not?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			