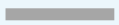
Health Inequalities Legal Duties Performance Report

NHS
Lincolnshire
Integrated Care Board

Confidential - Sensitive Information.

10/11/2025

Statement of Information on Health Inequalities - Summary Legend

	Increasing and getting better compared to 23/24
	Decreasing and getting better compared to 23/24 – OR the gap between certain groups is reducing and getting better compared to 23/24
	Increasing and getting worse compared to 23/24 – OR the gap between certain groups is increasing and getting worse compared to 23/24
	Decreasing and getting worse compared to 23/24
	No change or extremely small change compared to 23/24
	Can’t say if there has been an increase, decrease, or no change due to small counts or no baseline date to compare against (other indicator specific reasons may apply) compared to 23/24
	Increasing (can’t say if getting better or worse) compared to 23/24
	Decreasing (can’t say if getting better or worse) compared to 23/24

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic

Statement of Information on Health Inequalities - Summary Legend

	A health inequality has been identified through statistical testing – the inequality is decreasing and getting better compared to the position at 23/24
	A health inequality has been identified through statistical testing – the inequality is increasing and getting worse compared to the position at 23/24
	A health inequality has been identified through statistical testing – the inequality is similar to the position at 23/24
	No health inequality has been identified through statistical testing – the inequality is decreasing and getting better compared to the position at 23/24
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	No health inequality has been identified through statistical testing – the inequality is similar to the position at 23/24

Statement of Information on Health Inequalities - Summary (1/2)

Domain *Indicator*	Compared to 23/24 (Lincs average)	Sex	Age	Deprivation	Ethnicity
Elective Recovery					
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks	↑	↑	↓	↔	↑
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks	↓	↑	↓	↓	↓
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 weeks	↓	↓	↑	↓	↓
Size and shape of planned care waiting list (admitted & non admitted combined): 65+ weeks	↓	↔	↓	↓	↓
Elective activity vs. pre-pandemic levels for CYP and adults	↔	↔	–	↑	–
Urgent and Emergency Care					
Emergency admissions for under 19s	↓	↓	↓	↑	–
Respiratory					
Uptake of flu Vaccines	↓	–	↔	↑	↑
Uptake of COVID Vaccines (new data source for AW24 used)	N/A*	–	–	–	–
Mental Health					
Overall number of Severe Mental Illness (SMI) physical health checks – NEW BASELINE	N/A*				
Rates of total Mental Health Act detentions	↑	↓	↑	↓	↓
Rates of restrictive interventions	↑	↓	–	–	–
NHS Talking therapies (formerly IAPT) - Reliable Recovery	↔	↔	↑	↑	–
NHS Talking therapies (formerly IAPT) - Recovery	↔	↑	↓	↑	–
CYP Mental Health Access	↑	↑	↓	↓	–
Cancer					
% of cancers diagnosed at stage 1 and 2, case mix adjusted	↓	–	–	–	–
Maternity and neonatal					
Pre-term births under 37 weeks	↑	–	–	–	–

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic

Statement of Information on Health Inequalities - Summary (2/2)

Domain *Indicator*	Compared to 23/24 (Lincs average)	Sex	Age	Deprivation	Ethnicity
Cardiovascular Disease					
Stroke rate of non-elective admissions (per 100,000, age-sex standardised)	↑	↓	↑	↑	↑
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised)	↓	↑	↓	↓	↓
% 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	↓	↑	↑	↓	↑
% 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	↑	↑	↔	↑	↔
% 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	↔	↔	↑	↑	–
Diabetes					
Variation between % of people with type 1 diabetes receiving all 8 care processes	↑	↓	↑	↑	–
Variation between % of people with type 2 diabetes receiving all 8 care processes	↑	↑	↔	↑	↑
Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile to the NDPP	↔	↔	↔	↔	–
Smoking Cessation					
Proportion of adult acute inpatient settings offering smoking cessation services	↔	–	–	↑	–
Proportion of maternity inpatient settings offering smoking cessation services	↑	–	↑	↑	–
Oral Health					
Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under	N/A (Small counts)	–	–	–	–
Learning Disabilities and Autism					
Learning Disability Annual Health Checks	↔	↑	↑	↑	↔
Adult Mental Health inpatient rates for people with a learning disability and autistic people	↔	–	–	–	–

N/A* refers to a change in the reporting period in the data source, which makes a year-on-year comparison not possible - this will update once two full years' worth of data is available.

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic

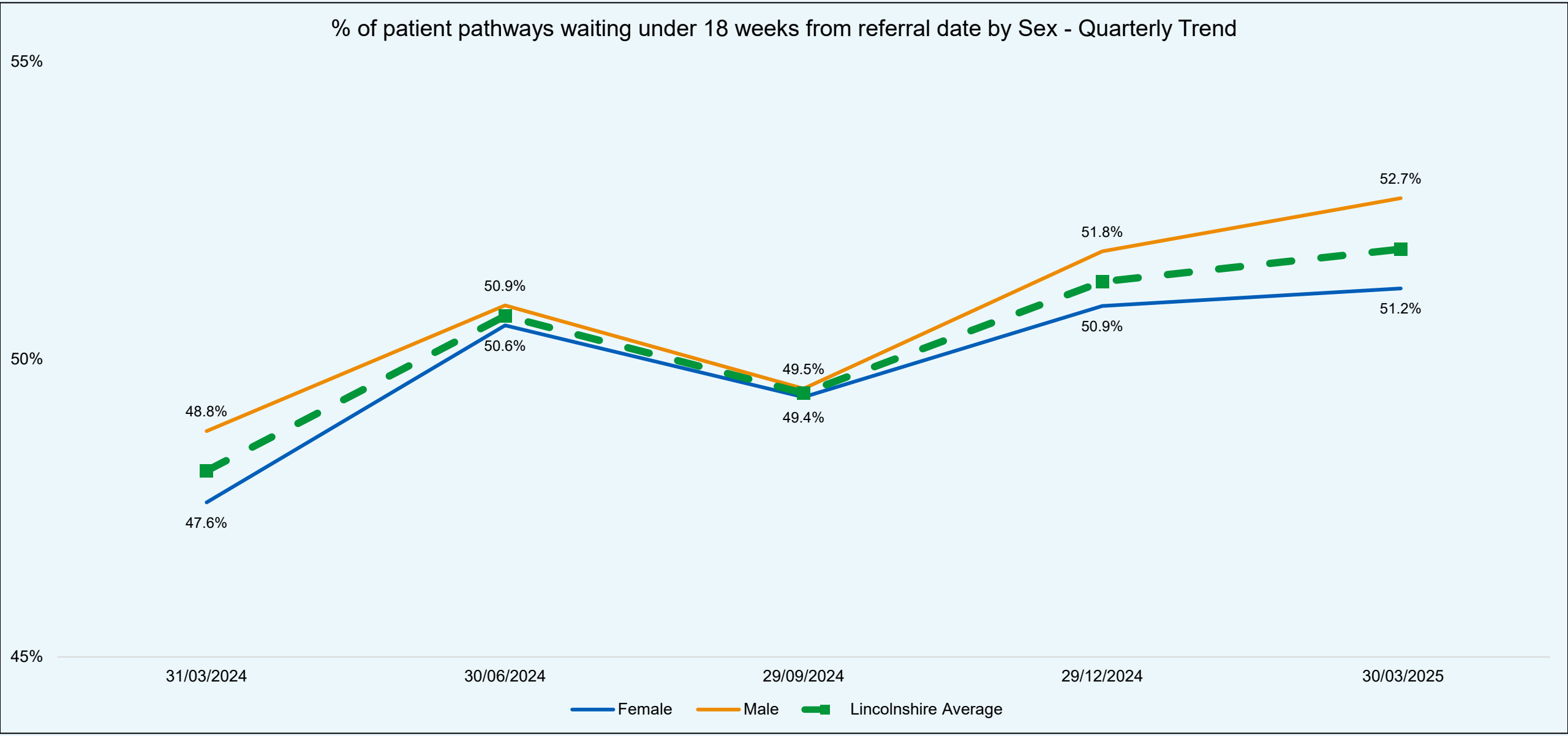
Elective Recovery Indicators – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Size and shape of planned care waiting list (admitted & non admitted combined): Under 18 weeks	↑	↑	↓	↔	↑
Size and shape of planned care waiting list (admitted & non admitted combined): 18 to 51 weeks	↓	↑	↓	↓	↓
Size and shape of planned care waiting list (admitted & non admitted combined): 52 to 64 week waits	↓	↓	↑	↓	↓
Size and shape of planned care waiting list (admitted & non admitted combined): 65+ week waits	↓	↔	↓	↓	↓
Elective activity vs. pre-pandemic levels for CYP and adults	↔	↔	—	↑	—

'Ethnicity' compares the White British/Irish population with all other ethnic minorities combined (excluding those whose ethnicity is 'Not Stated' or 'Unknown').

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic

Elective Recovery – Waiting Lists (under 18 weeks) by Sex



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (under 18 weeks) by Sex

At 30/03/25, 51.6% of those on a waiting list had been waiting under 18 weeks (57,407/110,717). This was a greater than the position at 31/03/24, where 48.1% of those on a waiting list had been waiting under 18 weeks (53,964/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for under 18 weeks . Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and 30/03/25 (the 'latest' reporting period).

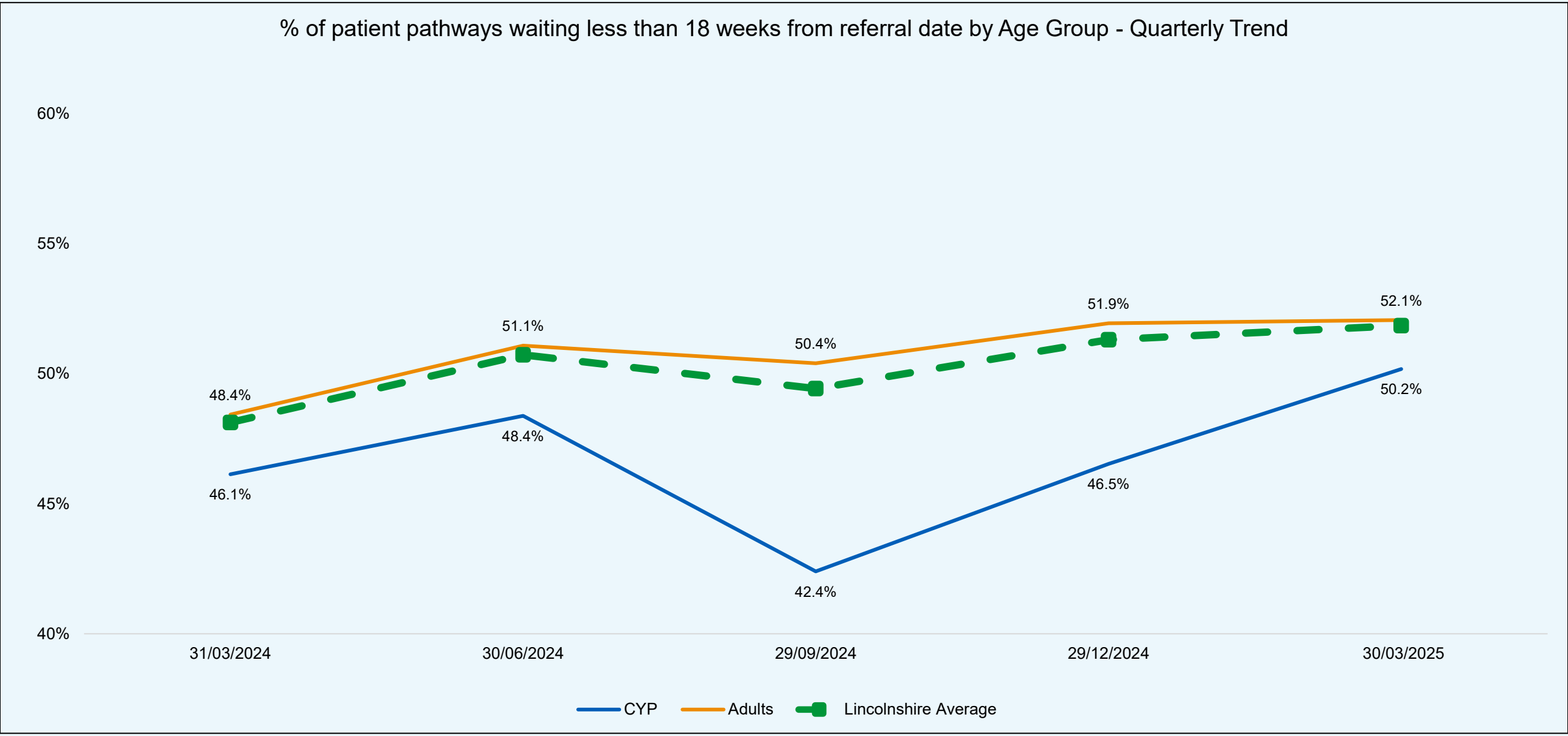
Males: There was an increase in the proportion of males who had been on an elective care waiting list under 18 weeks between 31/03/24 (48.8%; 23,733/48,640) and 30/03/25 (52.7%; 25,182/47,778). At each time point, males had a higher proportion of elective care patient pathways who had been on a waiting under 18 weeks compared to the Lincolnshire average. Further investigation may be needed to understand if there are certain specialties that account for a lower proportion of those on an elective care pathway who are waiting under 18 weeks .

Females: There was an increase in the proportion of females who had been on an elective care waiting list for under 18 weeks between 31/03/24 (47.6%; 30,137/63,319) and 30/03/25 (51.2%; 32,1385/62,782). At each time point, females had a lower proportion of elective care patient pathways who had been on a waiting under 18 weeks compared to the Lincolnshire average. Further investigation may be needed to understand if there are certain specialties that account for a lower proportion of those on an elective care pathway who are waiting under 18 weeks.

In relation to the latest reporting period (30/03/25), the difference in the proportion of males and females on an elective care pathway who had been waiting under 18 weeks was significantly different. This is an aggregated total across all specialties, and further investigation will be needed to understand if there are any specialties driving this different between males and females. Perhaps more important is that the severity of the condition for which a patient is on an elective care pathway is not considered in this analysis; it could be that a greater proportion of males have more urgent medical needs than females. This is one of many theories that may explain the phenomenon, which will need to be tested through a deeper examination of the elective waiting list data.

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Age Group



Sources: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Age Group

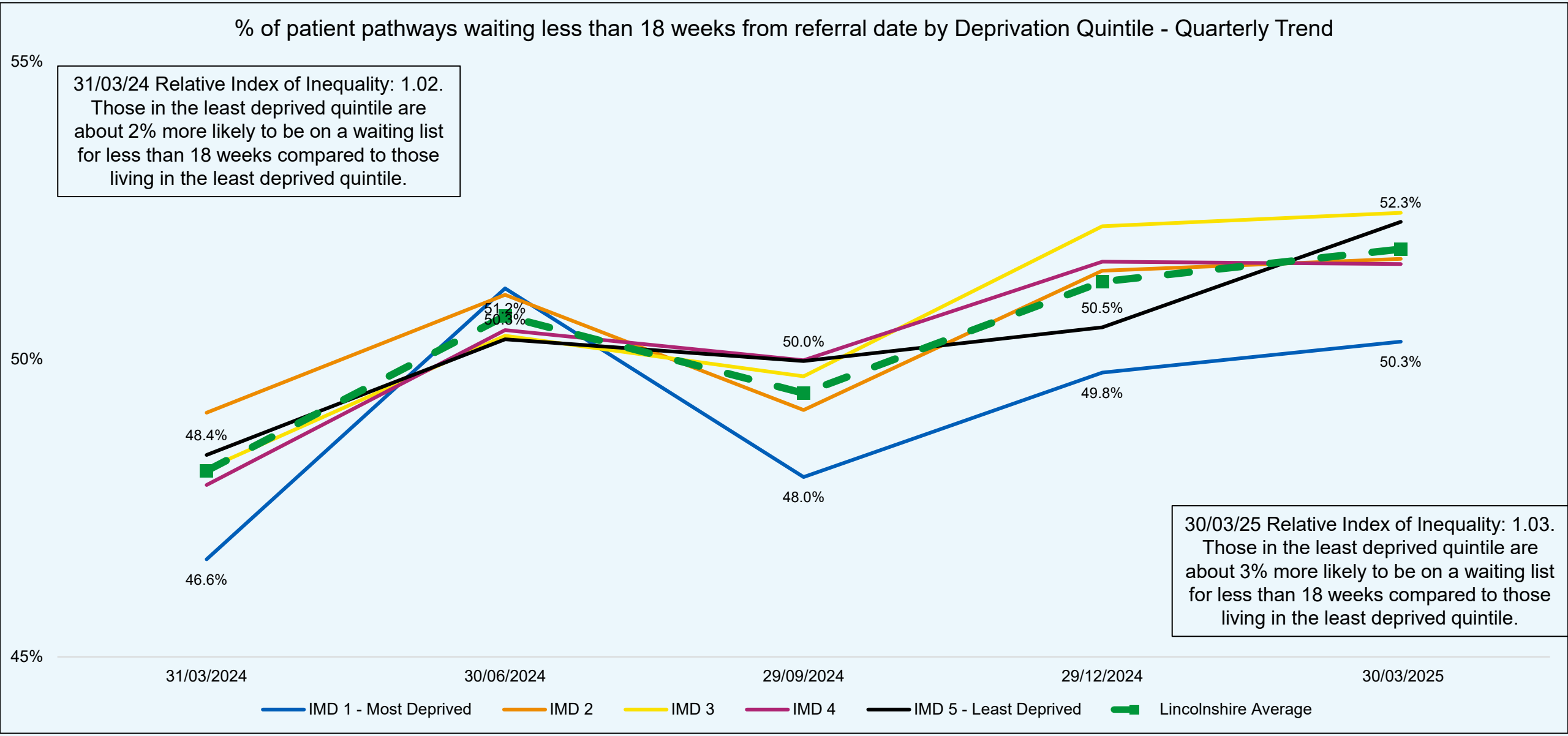
At 30/03/25, 51.6% of those on a waiting list had been waiting under 18 weeks (57,407/110,717). This was a greater than the position at 31/03/24, where 48.1% of those on a waiting list had been waiting under 18 weeks (53,964/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for under 18 weeks . Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and 30/03/25 (the 'latest' reporting period).

At the end of each quarter, there was a lower proportion of CYP (0 to 17 years) who had been on a waiting list less than 18 weeks. A lesser proportion of CYP population who were on a waiting list had been on a waiting list less than 18 weeks compared to the adult population (50.2%; 6,310/12,573 of CYP – compared to 52.1%; 51,097/98,144 of adults) as at 30/03/25. This trend was observed across each reporting period.

Compared to the baseline period, the gap between CYP and adults who had been on a waiting list less than 18 weeks decreased slightly from a 2.3 percentage point gap on 31/03/24, to a 1.9 percentage point gap on 30/03/25. This indicates a very slight improvement in the gap between adults and CYP who are waiting less than 18 weeks for an elective appointment.

Sources: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Deprivation



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Deprivation

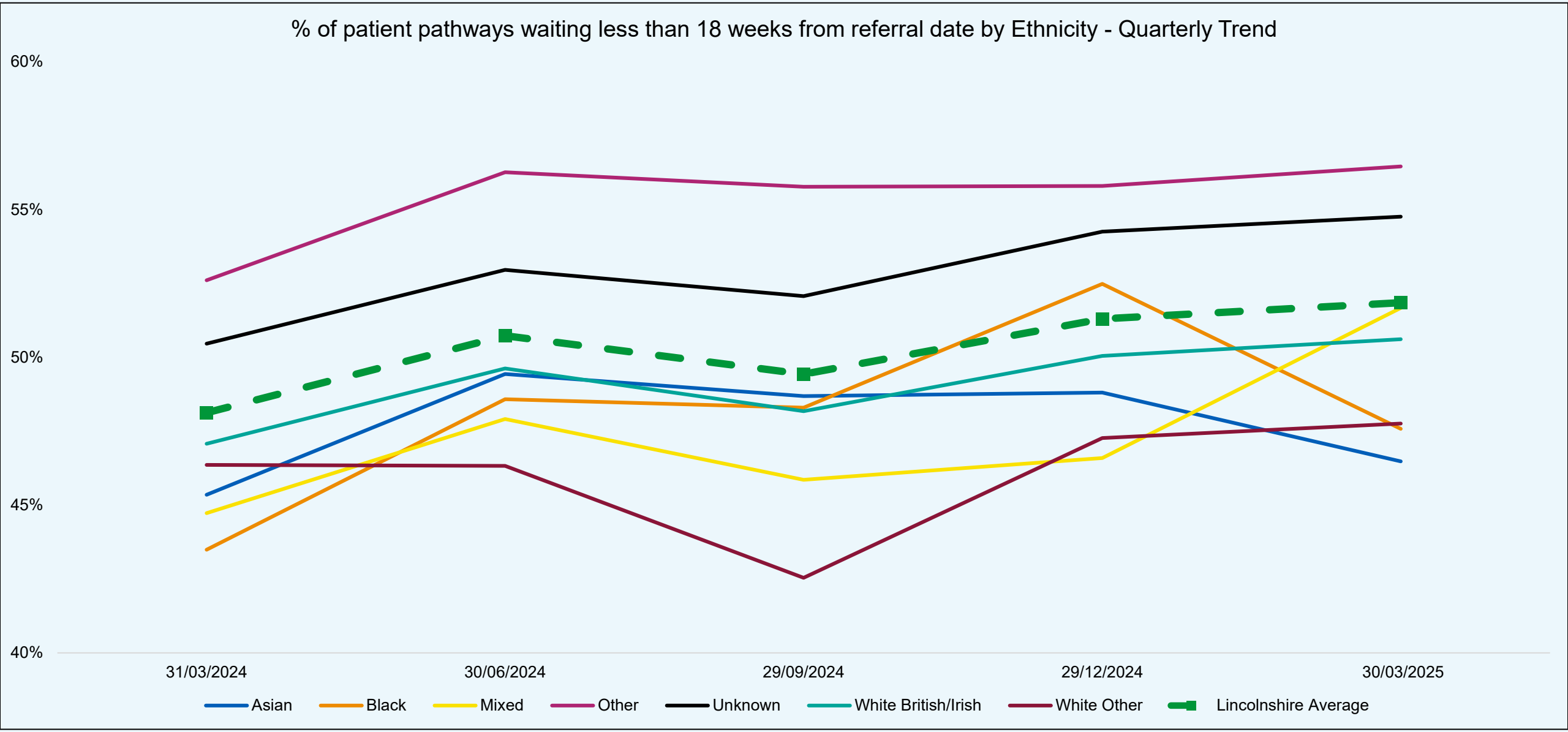
At 30/03/25, 51.6% of those on a waiting list had been waiting under 18 weeks (57,407/110,717). This was a greater than the position at 31/03/24, where 48.1% of those on a waiting list had been waiting under 18 weeks (53,964/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for under 18 weeks . Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and 30/03/25 (the 'latest' reporting period).

IMD Quintile 1 (Most Deprived): There was an increase in the proportion of who lived in one of the most deprived parts of the county who had been on an elective care waiting list for less than 18 weeks between 31/03/24 (46.6%; 7,786/16,694) and 30/03/25 (50.3%; 8,147/16,198). Readers should interpret this improvement with caution, as there have been fluctuations across the different reporting periods – although for three of the four reporting periods (those living in one of the most deprived parts of the county have the lowest proportion who were on an elective care waiting list for less than 18 weeks from the point of referral. This suggests there may be issues facing those living in the most deprived parts of the county in relation to elective care recovery; there may be an over-representation of those from more deprived parts of the county in specialties that have longer waits due to various factors.

IMD Quintile 5 (Most Deprived): There was an increase in the proportion of who lived in one of the most deprived parts of the county who had been on an elective care waiting list for less than 18 weeks between 31/03/24 (48.4%; 10,145/20,964) and 30/03/25 (52.3%; 10,671/20,400). Readers should interpret this improvement with caution, as there have been fluctuations across the different reporting. This suggests there may be issues facing those living in the least deprived parts of the county in relation to elective care recovery; there may be an over-representation of those from least deprived parts of the county in specialties that have longer waits due to various factors.

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Ethnicity



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (Under 18 weeks waits) by Ethnicity

At 30/03/25, 51.6% of those on a waiting list had been waiting under 18 weeks (57,407/110,717). This was a greater than the position at 31/03/24, where 48.1% of those on a waiting list had been waiting under 18 weeks (53,964/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for under 18 weeks . Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and 30/03/25 (the 'latest' reporting period).

At 31/03/24, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly higher proportion of the population who were on an elective care pathway for less than 18 weeks (50.3%; 7,202/14,319) than those from a White British/Irish background (47.1%; 36,079/76,677).

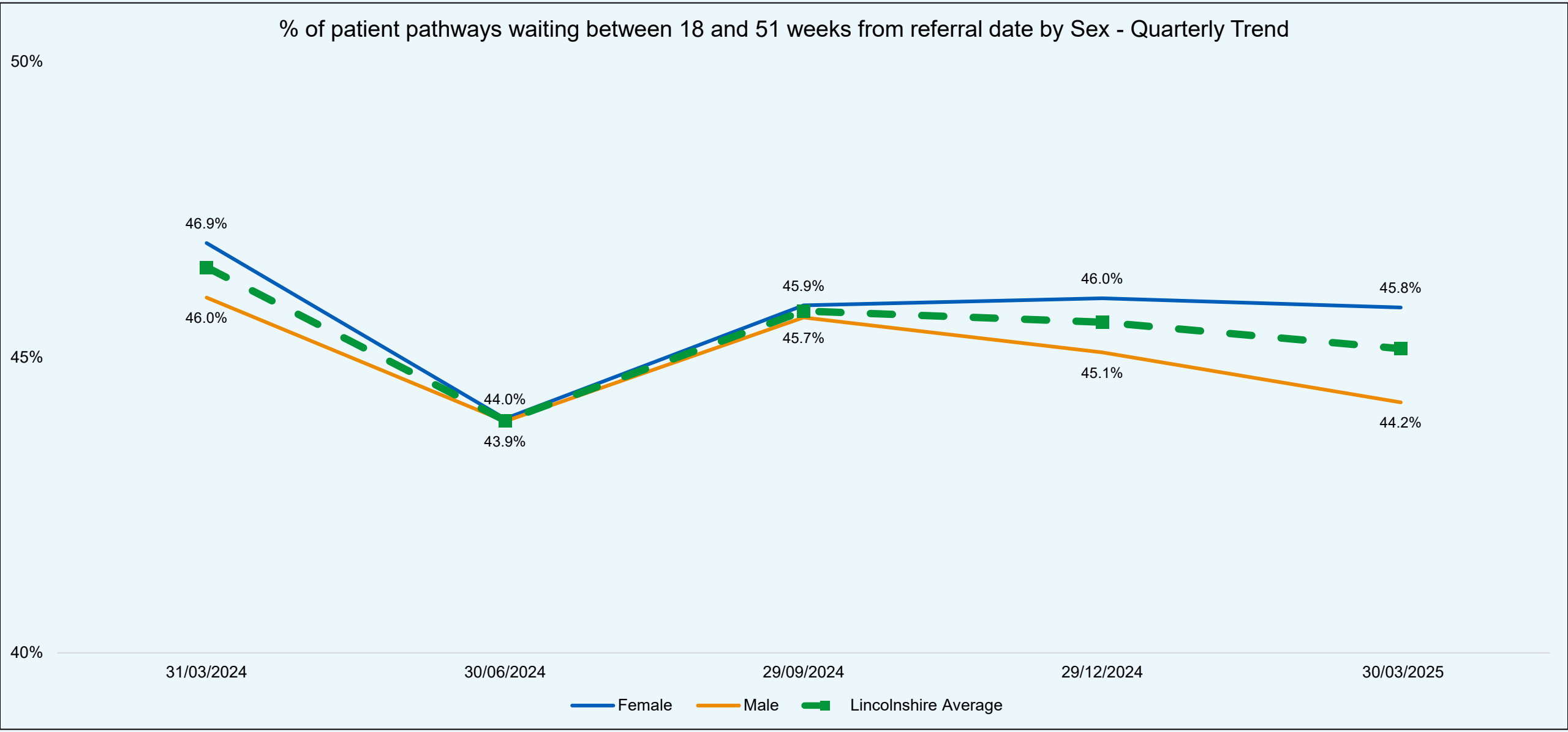
At 30/03/25, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly higher proportion of the population who were on an elective care pathway for less than 18 weeks (53.7%; 7,735/14,402) than those from a White British/Irish background (50.6%; 37,480/74,051).

The table below provides a breakdown by all major ethnic groups, comparing the positions at 31/03/24 and 30/03/25.

Ethnic Group	% waiting less than 18 weeks as at 31/03/24	% waiting less than 18 weeks as at 30/03/25
Asian	45.4% (278/613)	46.5% (297/639)
Black	43.5% (147/338)	47.6% (167/351)
Mixed	44.7% (297/664)	51.7% (340/658)
Other	52.6% (4,971/9,449)	56.5% (5,449/9,651)
Unknown	50.5% (10,665/21,134)	54.8% (12,192/22,264)
White British/Irish	47.1% (36,079/76,677)	50.6% (37,480/74,051)
White Other	46.4% (1,509/3,255)	47.8% (1,482/3,103)

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Sex



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Sex

At 30/03/25, 45.1% of those on a waiting list had been waiting between 18 and 51 weeks (49,984/110,717). This was similar to the position at 31/03/24, where 45.5% of those on a waiting list had been waiting between 18 and 51 weeks (52,168/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 18 and 51 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

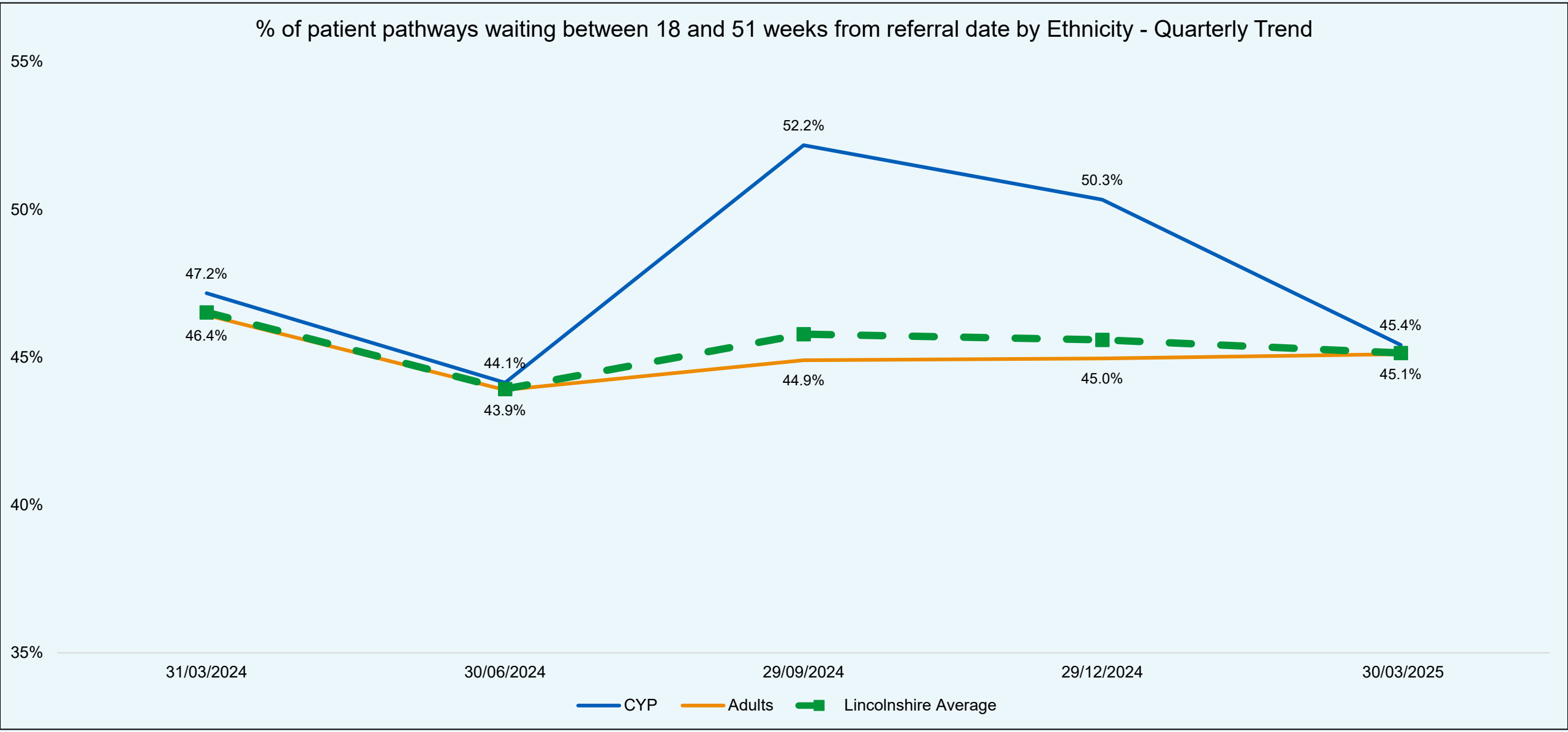
Males: There was a decrease in the proportion of males who had been on an elective care waiting list between 18 and 51 weeks between 31/03/24 (46.0%; 22380/48,640) and 30/03/25 (44.2%; 21,136/47,778). At each time point across the reporting periods, males had a lower proportion of elective care patient pathways who had been on a waiting list between 18 and 51 weeks compared to the Lincolnshire average. Further investigation may be needed to understand if there are certain specialties that account for a lower proportion of those on an elective care pathway who are waiting between 18 and 51 weeks.

Females: There was a decrease in the proportion of females who had been on an elective care waiting list between 18 and 51 weeks between 31/03/24 (46.9%; 29,718/63,319) and 30/03/25 (45.8%; 28,782/62,782). At each time point across the reporting periods, females had a higher proportion of elective care patient pathways who list between 18 and 51 weeks compared to the Lincolnshire average. Further investigation may be needed to understand if there are certain specialties that account for a higher proportion of those on an elective care pathway who are waiting between 18 and 51 weeks.

In relation to the final reporting period (30/03/25), the difference in the proportion of males and females on an elective care pathway who had been waiting list between 18 and 51 weeks was significantly different. This is an aggregated total across all specialties, and further investigation will be needed to understand if there are any specialties driving this different between males and females. Perhaps more important is that the severity of the condition for which a patient is on an elective care pathway is not considered in this analysis; it could be that a greater proportion of males have more urgent medical needs than females. This is one of many theories that may explain the phenomenon, which will need to be tested through a deeper examination of the elective waiting list data.

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Age Group



Sources: Waiting Lists Minimum Data Set (WLMDS); Lincolnshire CYP 'Was Not Brought' dashboard - Athena

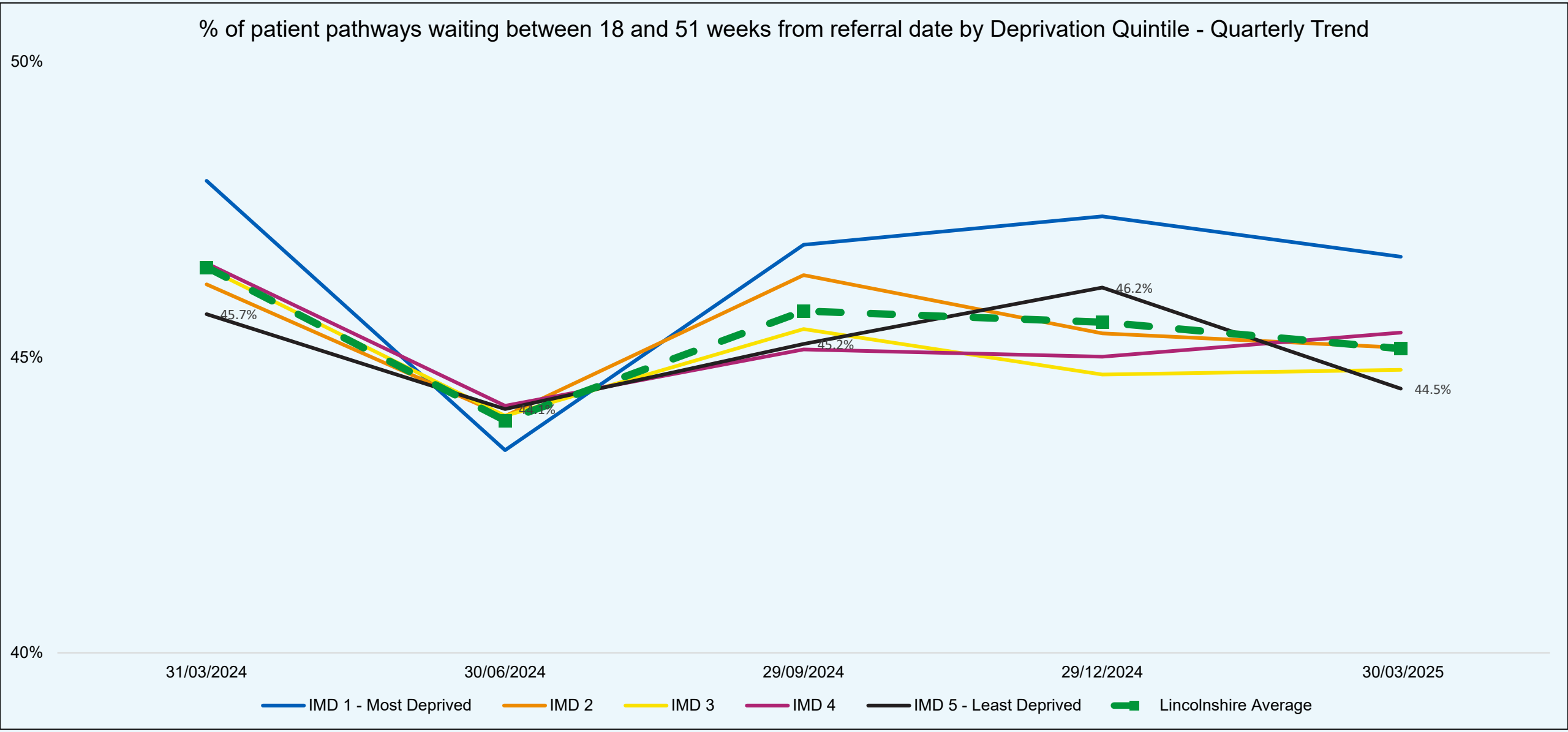
Elective Recovery – Waiting Lists (18 to 51 week waits) by Age Group

At 30/03/25, 45.1% of those on a waiting list had been waiting between 18 and 51 weeks (49,984/110,717). This was similar to the position at 31/03/24, where 45.5% of those on a waiting list had been waiting between 18 and 51 weeks (52,168/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 18 and 51 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At the end of each quarter, there was a higher proportion of CYP (0 to 17 years) who had been on a waiting list between 18 and 51 weeks. At 30/03/25, a higher proportion of CYP population who were on a waiting list had been on a waiting between 18 and 51 weeks compared to the adult population (45.4%; 5,710/12,573 for CYP compared to 45.1%; 44,274/98,144 for adults) – although this difference was minimal and reduced noticeably from the position at the end of September 2024, where the difference was 7.3 percentage points.

Sources: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Deprivation



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Elective Recovery – Waiting Lists (18 to 51 week waits) by Deprivation

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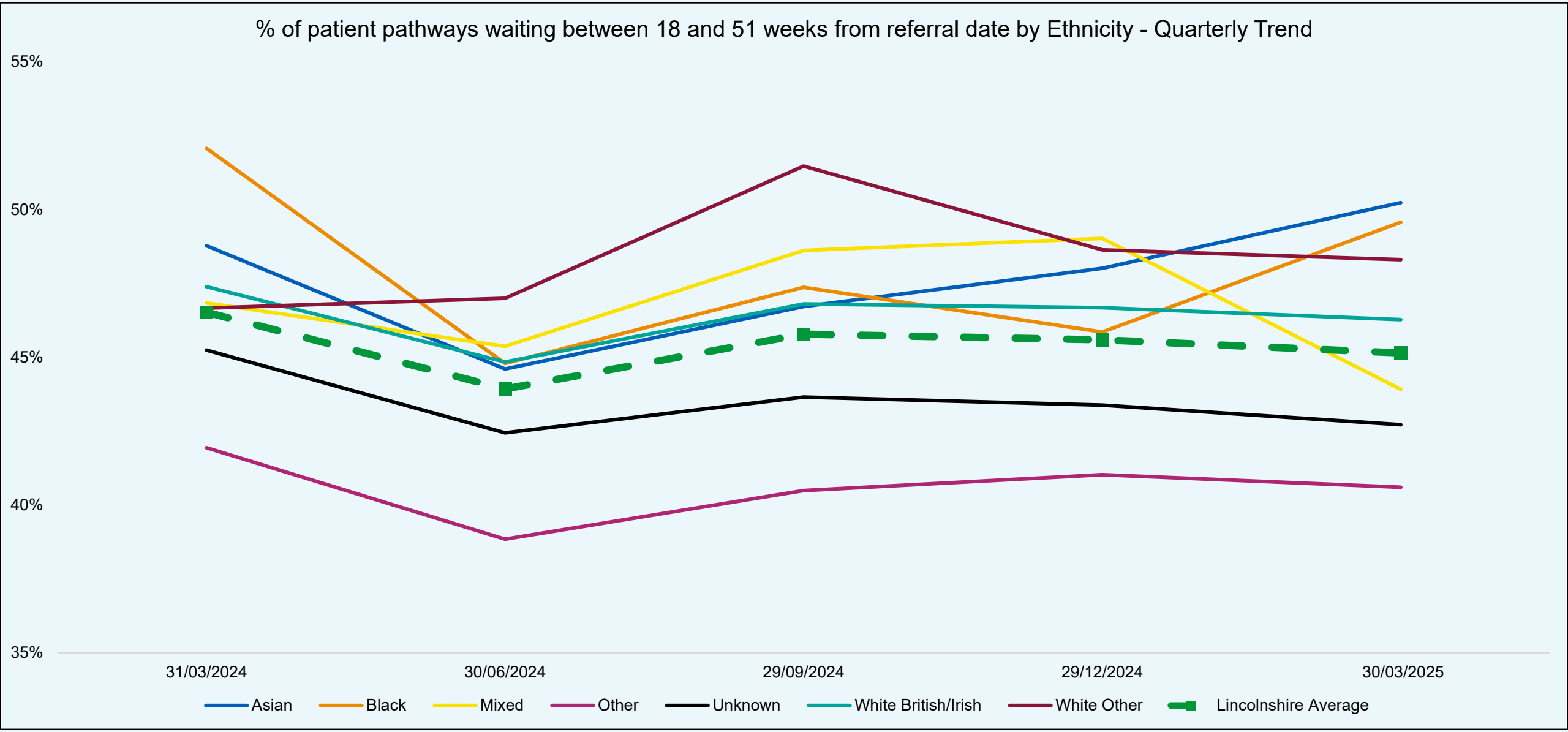
IMD Quintile 1 (Most Deprived): There was a decrease in the proportion of who lived in one of the most deprived parts of the county who had been on an elective care waiting list between 18 and 51 weeks between 31/03/24 (48.0%; 8011/16694) and 30/03/25 (46.7%; 7,565/16,198). Readers should interpret this finding with caution, as there have been fluctuations across the different reporting periods – although for three of the four reporting periods, those living in one of the most deprived parts of the county have the highest proportion who were on an elective care waiting list between 18 and 51 weeks from the point of referral. This suggests there may be issues facing those living in the most deprived parts of the county in relation to elective care recovery; there may be an over-representation of those from more deprived parts of the county in specialties that have longer waits due to various factors.

IMD Quintile 5 (Least Deprived): There was a decrease in the proportion of who lived in one of the least deprived parts of the county who had been on an elective care waiting list between 18 and 51 weeks between 31/03/24 (45.7%; 9587/20964) and 30/03/25 (44.5%; 9,072/20,400). Readers should interpret this finding with caution, as there have been fluctuations across the different reporting. This suggests there may be issues facing those living in the least deprived parts of the county in relation to elective care recovery; there may be an over-representation of those from least deprived parts of the county in specialties that have longer waits due to various factors.

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Ethnicity



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (18 to 51 week waits) by Ethnicity

At 30/03/25, 45.1% of those on a waiting list had been waiting between 18 and 51 weeks (49,984/110,717). This was similar to the position at 31/03/24, where 45.5% of those on a waiting list had been waiting between 18 and 51 weeks (52,168/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 18 and 51 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At 31/03/24, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly lower proportion of the population who were on an elective care pathway between 18 and 51 weeks (43.8%; 6,268/14,319) compared to those from a White British/Irish background (47.4%; 36,338/76,677).

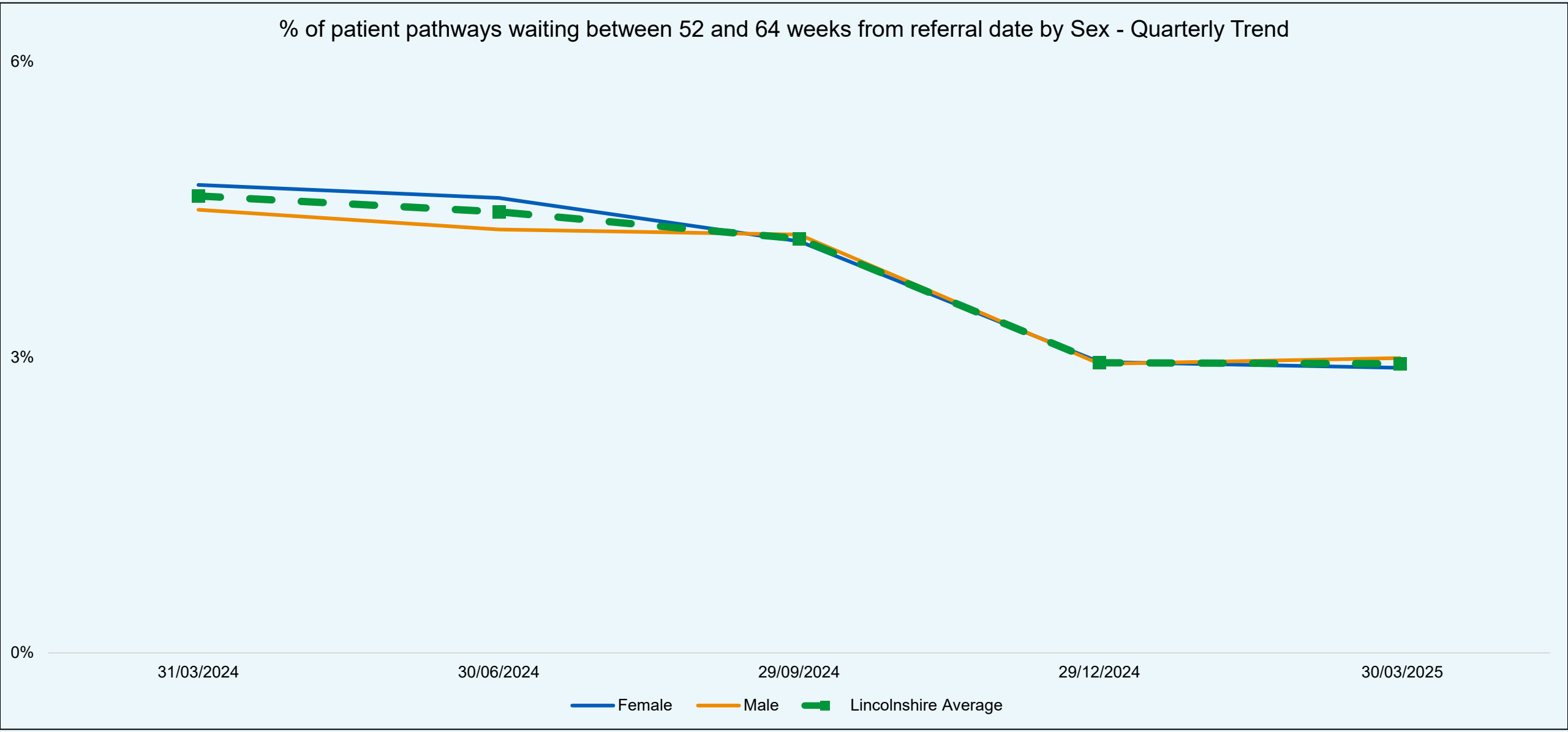
At 30/03/25, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly lower proportion of the population who were on an elective care pathway between 18 and 51 weeks (43.1%; 6,202/14,402) than those from a White British/Irish background (46.3%; 34,270/74,051).

The table below provides a breakdown by all major ethnic groups, comparing the positions at 31/03/24 and 30/03/25.

Ethnic Group	% waiting between 18 and 52 weeks as at 31/03/24	% waiting between 18 and 52 weeks as at 30/03/25
Asian	48.8% (299/613)	50.2% (321/639)
Black	52.1% (176/338)	49.6% (174/351)
Mixed	46.8% (311/664)	43.9% (289/658)
Other	41.9% (3,963/9,449)	40.6% (3,919/9,651)
Unknown	45.2% (9,562/21,134)	42.7% (9,512/22,264)
White British/Irish	47.4% (36,338/76,667)	46.3% (34,270/74,051)
White Other	46.7% (1,519/3,255)	48.3% (1,499/3,103)

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Sex



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Sex

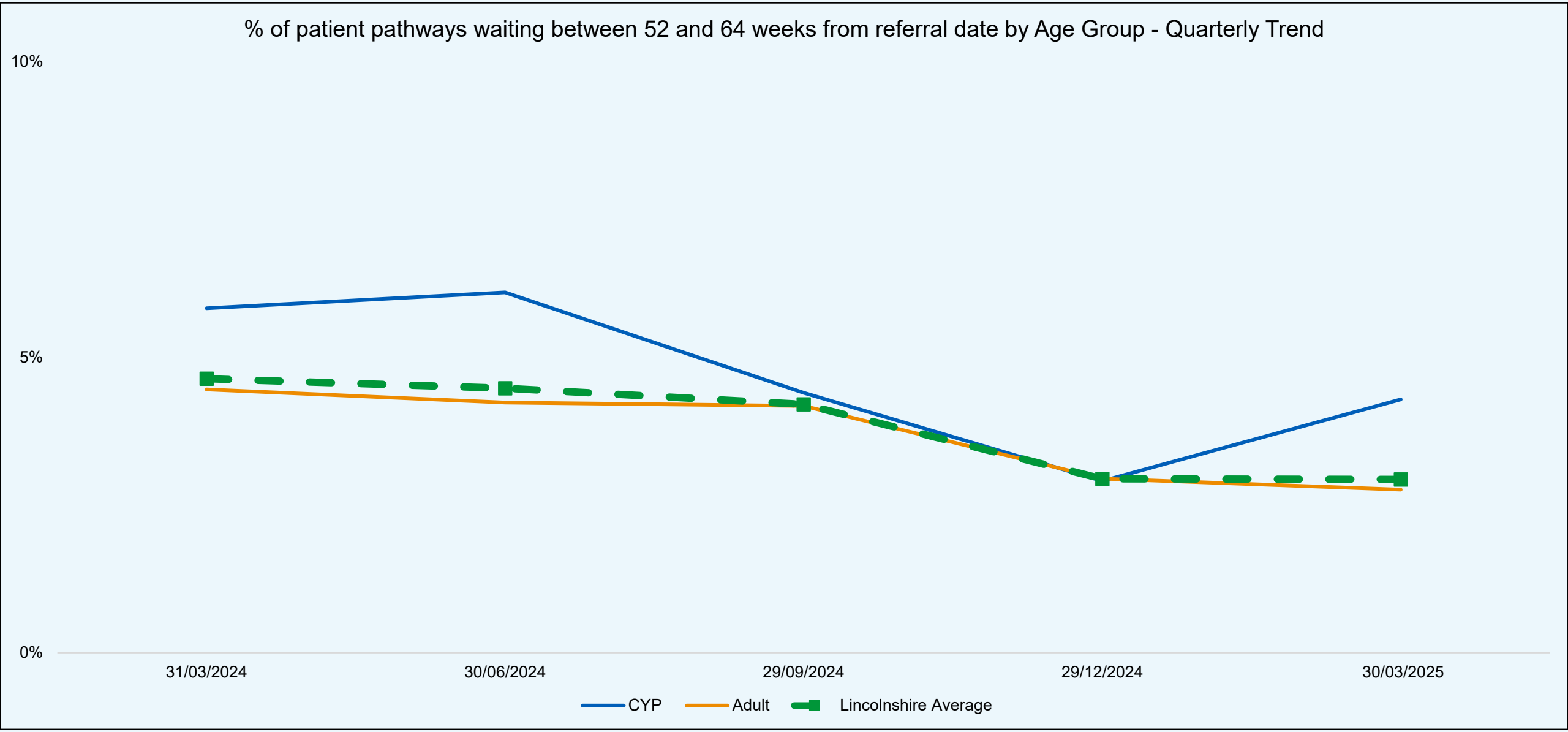
At 30/03/25, 2.9% of those on a waiting list had been waiting between 52 and 64 weeks (3,250/110,717). This was a decrease on the position at 31/03/24, where 4.6% of those on a waiting list had been waiting between 52 and 64 weeks (5,201/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 52 and 64 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

Males: There was a decrease in the proportion of males who had been on an elective care waiting list between 52 and 64 weeks between 31/03/24 (4.5%) and 30/03/25 (3.0%).

Females: There was a decrease in the proportion of females who had been on an elective care waiting list between 52 and 64 weeks between 31/03/24 (4.8%) and 30/03/25 (2.9%).

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Age Group



Sources: Waiting Lists Minimum Data Set (WLMDS); Lincolnshire CYP 'Was Not Brought' dashboard - Athena

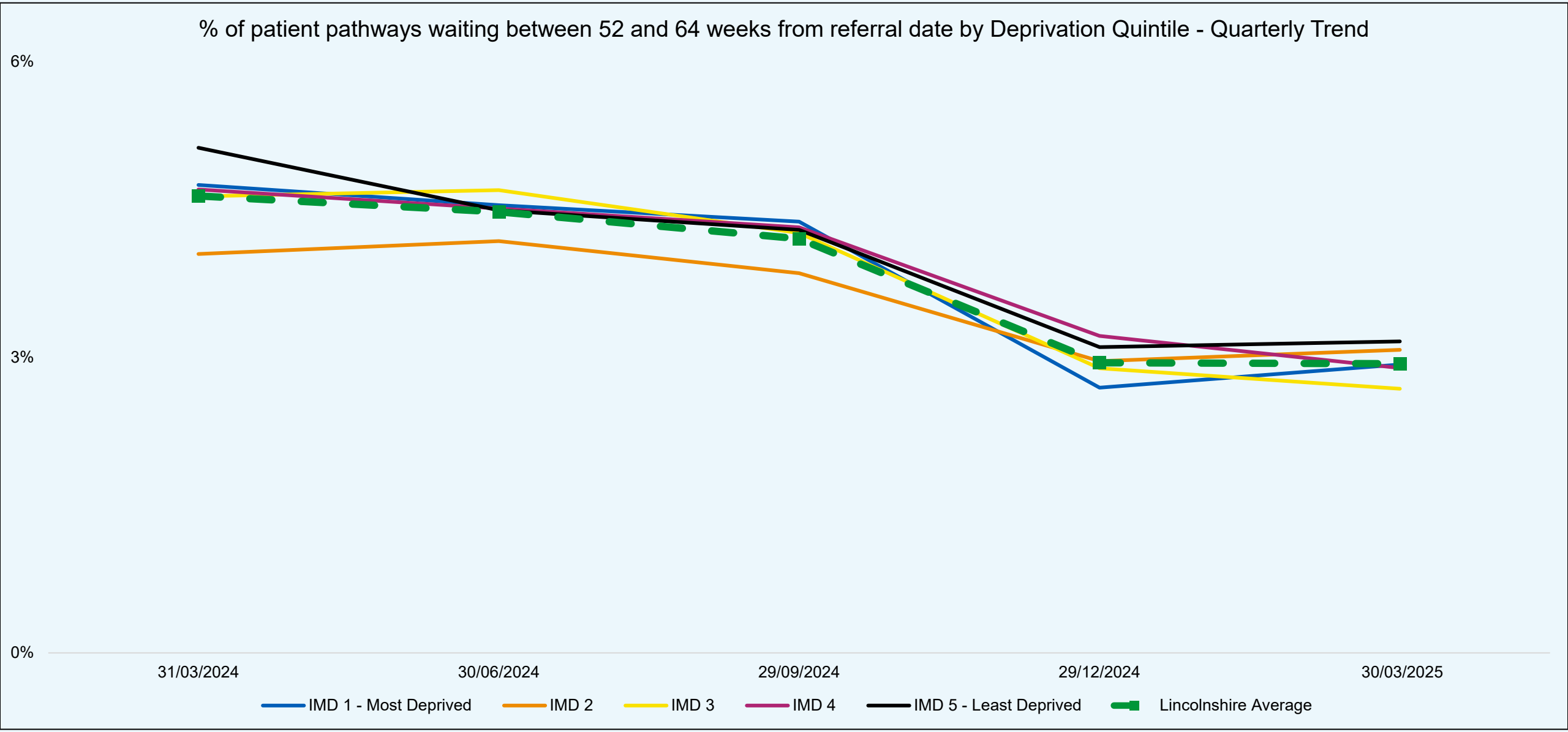
Elective Recovery – Waiting Lists (52 to 64 week waits) by Age Group

At 30/03/25, 2.9% of those on a waiting list had been waiting between 52 and 64 weeks (3,250/110,717). This was a decrease on the position at 31/03/24, where 4.6% of those on a waiting list had been waiting between 52 and 64 weeks (5,201/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 52 and 64 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At the end of each quarter, there was a higher proportion of CYP (0 to 17 years) who had been on a waiting list between 52 and 64 weeks. A higher proportion of CYP population who were on a waiting list had been on a waiting between 52 and 64 weeks compared to the adult population (4.3% of the CYP population waiting between 52 and 64 weeks; 2.8% of the adult population waiting between 52 and 64 weeks).

Sources: Waiting Lists Minimum Data Set (WLMDS); Lincolnshire CYP 'Was Not Brought' dashboard - Athena

Elective Recovery – Waiting Lists (52 to 64 week waits) by Deprivation



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Deprivation

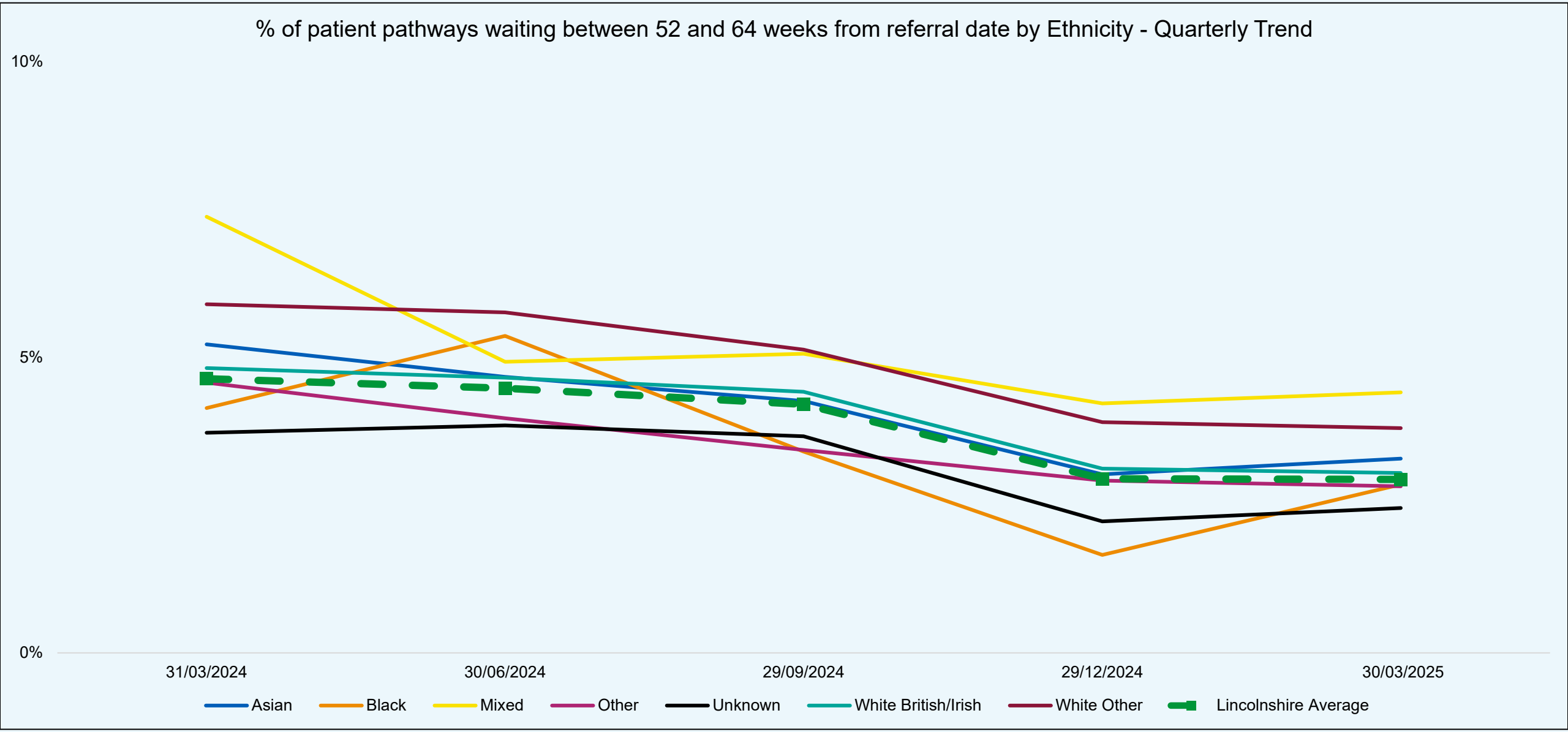
At 30/03/25, 2.9% of those on a waiting list had been waiting between 52 and 64 weeks (3,250/110,717). This was a decrease on the position at 31/03/24, where 4.6% of those on a waiting list had been waiting between 52 and 64 weeks (5,201/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 52 and 64 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

IMD Quintile 1 (Most Deprived): There was a decrease in the proportion of who lived in one of the most deprived parts of the county who had been on an elective care waiting list between 52 and 64 weeks between 29/06/25 (4.8%; 793/16694) and 30/03/25 (2.9%; 474/16,198).

IMD Quintile 5 (Least Deprived): There was a decrease in the proportion of who lived in one of the least deprived parts of the county who had been on an elective care waiting list between 52 and 64 weeks between 29/06/25 (5.1%; 1075/20964) and 30/03/25 (3.2%; 645/20,400).

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Ethnicity



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (52 to 64 week waits) by Ethnicity

At 30/03/25, 2.9% of those on a waiting list had been waiting between 52 and 64 weeks (3,250/110,717). This was a decrease on the position at 31/03/24, where 4.6% of those on a waiting list had been waiting between 52 and 64 weeks (5,201/112,130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for between 52 and 64 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 18 week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At 31/03/24, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly lower proportion of the population who were on an elective care pathway between 52 and 64 weeks (5.0%; 719/14,319) compared to those from a White British/Irish background (4.8%; 3,695/76,677).

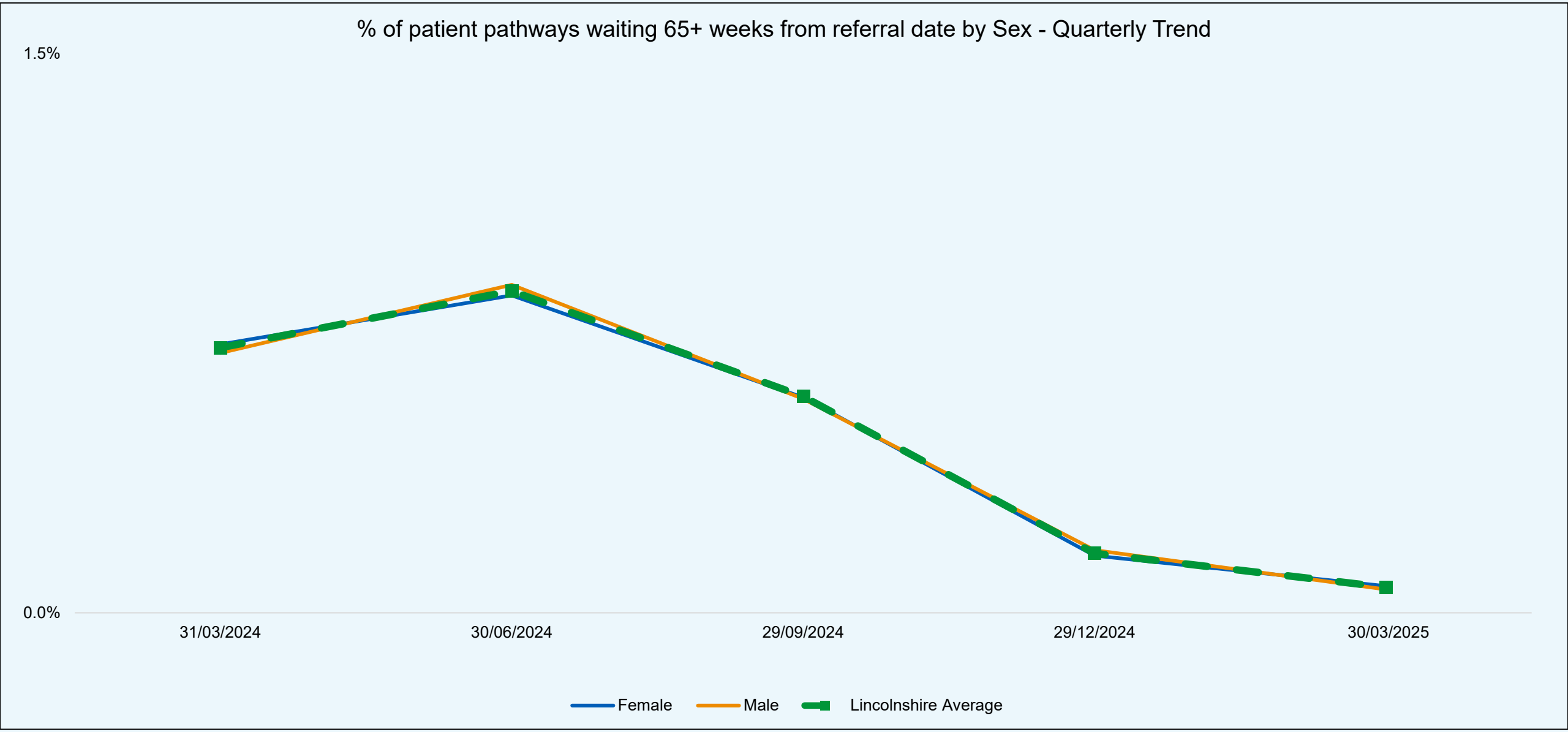
At 30/03/25, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a significantly lower proportion of the population who were on an elective care pathway between 52 and 64 weeks (3.1%; 450/14,402) than those from a White British/Irish background (3.0%; 2,254/74,051).

The table below provides a breakdown by all major ethnic groups, comparing the positions at 31/03/24 and 30/03/25.

Ethnic Group	% waiting between 52 and 64 weeks as at 31/03/24	% waiting between 52 and 64 weeks as at 30/03/25
Asian	5.2%	3.3%
Black	4.1%	2.8%
Mixed	7.4%	4.4%
Other	4.6%	2.8%
Unknown	3.7%	2.5%
White British/Irish	4.8%	3.0%
White Other	5.9%	3.8%

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Sex



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Sex

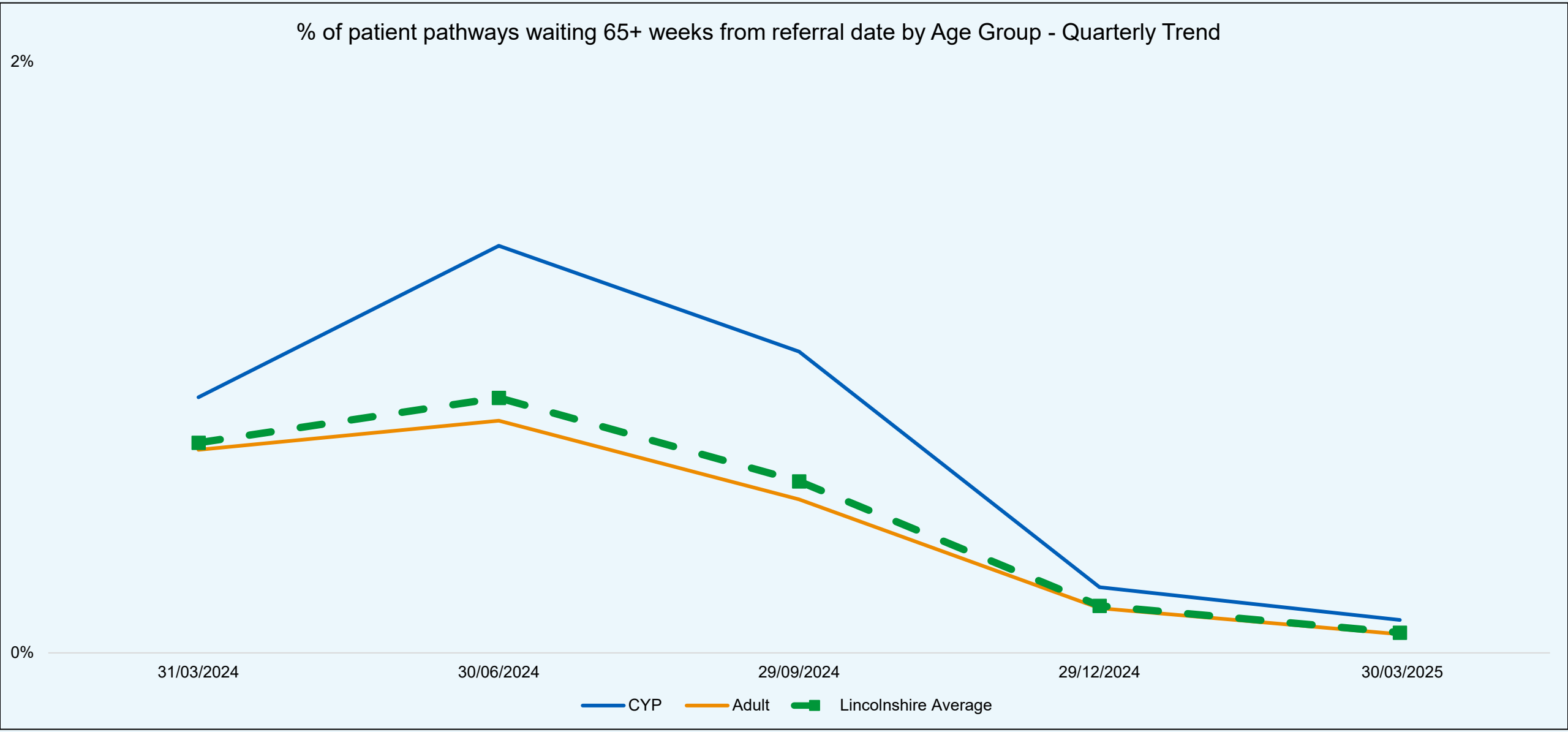
At 30/03/25, 0.1% of those on a waiting list had been waiting more than 65 weeks (76/110,717). This was a decrease on the position at 31/03/24, where 0.7% of those on a waiting list had been waiting more than 65 weeks (797/112130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for more than 65 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 65+ week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

Males: There was a decrease in the proportion of males who had been on an elective care waiting list between 52 and 64 weeks between 31/03/24 (0.7%; 339/48640) and 30/03/25 (0.1%; 30/47,778).

Females: There was a decrease in the proportion of females who had been on an elective care waiting list between 52 and 64 weeks between 31/03/24 (0.7%; 456/63319) and 30/03/25 (0.1%; 45/62,782).

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Age Group



Sources: Waiting Lists Minimum Data Set (WLMDS)

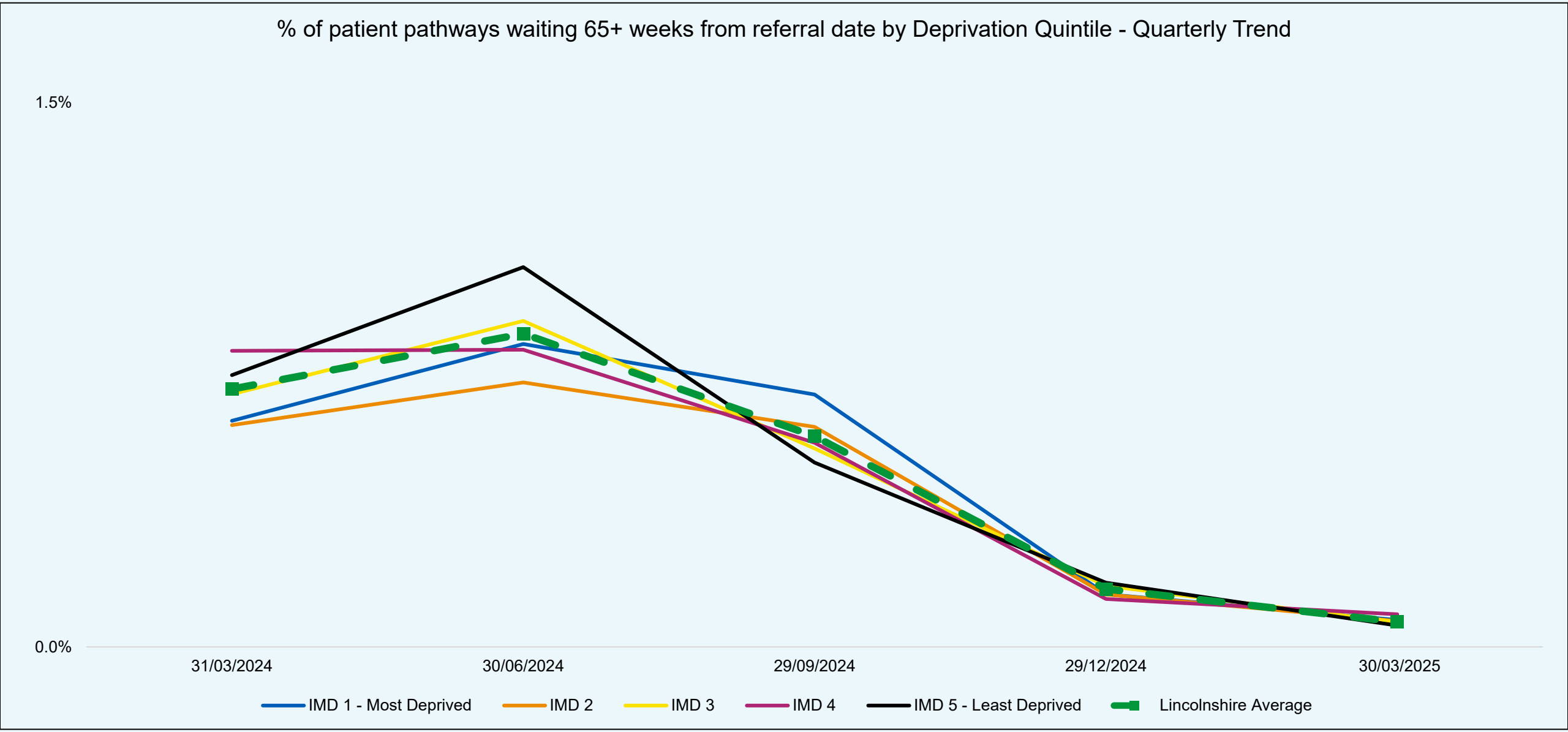
Elective Recovery – Waiting Lists (65+ week waits) by Age Group

At 30/03/25, 0.1% of those on a waiting list had been waiting more than 65 weeks (76/110,717). This was a decrease on the position at 31/03/24, where 0.7% of those on a waiting list had been waiting more than 65 weeks (797/112130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for more than 65 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 65+ week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At the end of each quarter, there was a higher proportion of CYP (0 to 17 years) who had been on a waiting list 65 weeks or longer. As of 30/03/25, the proportion of CYP population who were on a waiting list longer than 65 weeks compared to the adult population was similar (0.1%; 14/12,573 for CYP compared to 0.1%; 62/98,144 for adults).

Sources: Waiting Lists Minimum Data Set (WLMDS); Lincolnshire CYP 'Was Not Brought' dashboard - Athena

Elective Recovery – Waiting Lists (65+ week waits) by Deprivation



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Deprivation

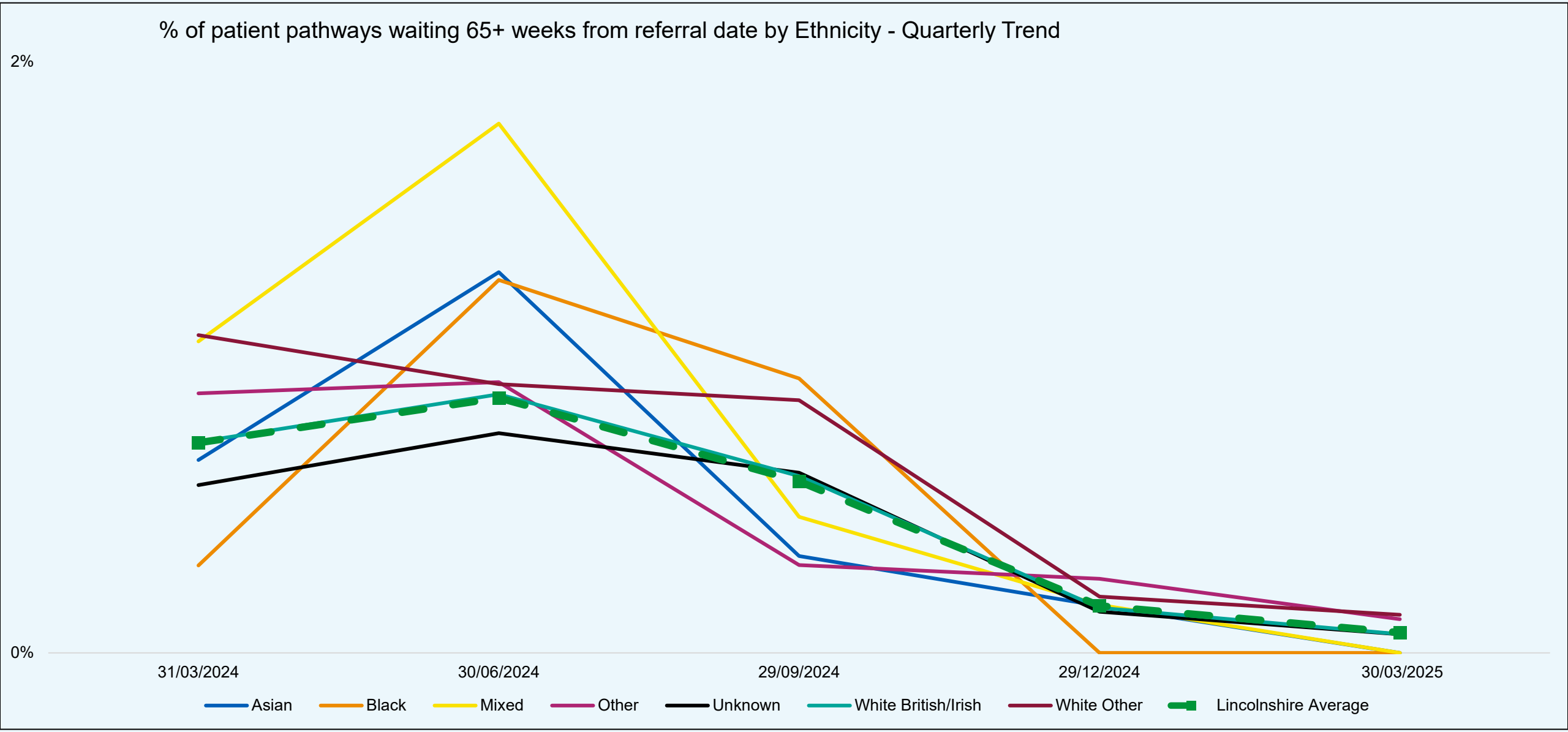
At 30/03/25, 0.1% of those on a waiting list had been waiting more than 65 weeks (76/110,717). This was a decrease on the position at 31/03/24, where 0.7% of those on a waiting list had been waiting more than 65 weeks (797/112130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for more than 65 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 65+ week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

IMD Quintile 1 (Most Deprived): There was a decrease in the proportion of who lived in one of the most deprived parts of the county who had been on an elective care waiting list more than 65 weeks between 31/03/24 (0.6%; 104/16694) and 30/03/25 (0.1%; 12/16,198)

IMD Quintile 5 (Most Deprived): There was a decrease in the proportion of who lived in one of the least deprived parts of the county who had been on an elective care waiting list more than 65 weeks between 31/03/24 (0.7%; 157/20964) and 30/03/25 (0.1%; 12/20,400).

Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Ethnicity



Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Waiting Lists (65+ week waits) by Ethnicity

At 30/03/25, 0.1% of those on a waiting list had been waiting more than 65 weeks (76/110,717). This was a decrease on the position at 31/03/24, where 0.7% of those on a waiting list had been waiting more than 65 weeks (797/112130). Please note, those who were on an elective care pathway may still be on the same care pathway at time of publication of this report. This chart should be complemented with more recent data and other initiatives that aim to increase the proportion of people who are on an elective care pathway for more than 65 weeks. Readers should also be aware the figures presented in this chart is an aggregation of all those on an elective care waiting list, and that there are likely to be significant variations in how specialties are performing in relation to 65+ week waits between referral and treatment. This chart should therefore be used as a starting point to ask further questions. There have been fluctuations across the four different time points, but for this report, a comparison is made between the situation as at 31/03/24 (the 'baseline' period') and the situation at 30/03/25 (the 'latest' reporting period).

At 31/03/24, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a similar proportion of the population who were on an elective care pathway for 65+ weeks (1.0%; 130/14,319) compared to those from a White British/Irish background (0.7%; 547/76,677).

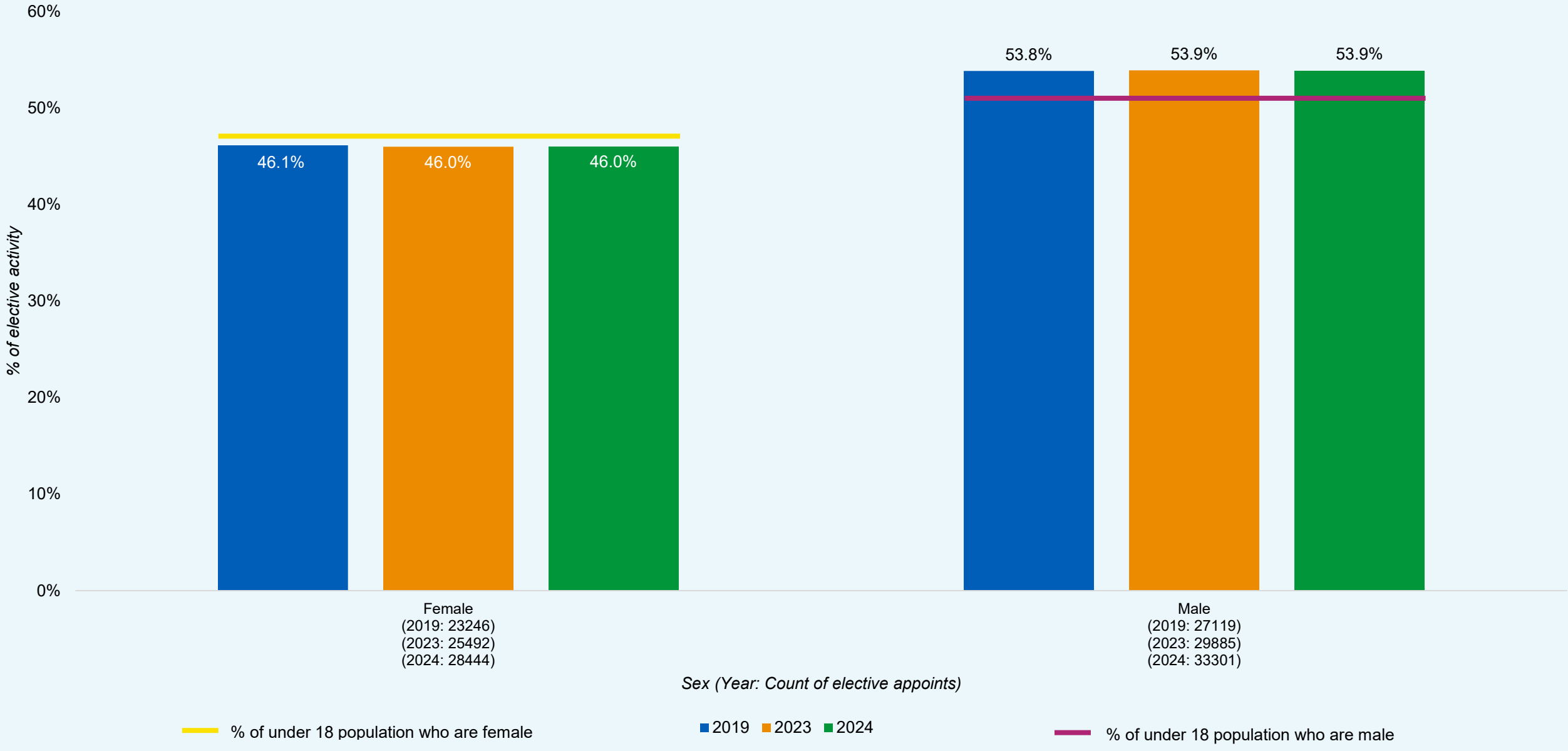
At 30/03/25, pooling the data for those from an Asian, Black, Mixed, Other, and White Other populations showed a similar proportion of the population who were on an elective care pathway for 65+ weeks (0.1%; 15/14,402) than those from a White British/Irish background (<0.1%; 47/74,051).

The table below provides a breakdown by all major ethnic groups, comparing the positions at 31/03/24 and 30/03/25.

Ethnic Group	% waiting 65+ weeks as at 31/03/24	% waiting 65+ weeks as at 30/03/25
Asian	0.7%	0.0%
Black	0.3%	0.0%
Mixed	1.1%	0.0%
Other	0.9%	0.1%
Unknown	0.6%	0.1%
White British/Irish	0.7%	0.1%
White Other	1.1%	0.1%

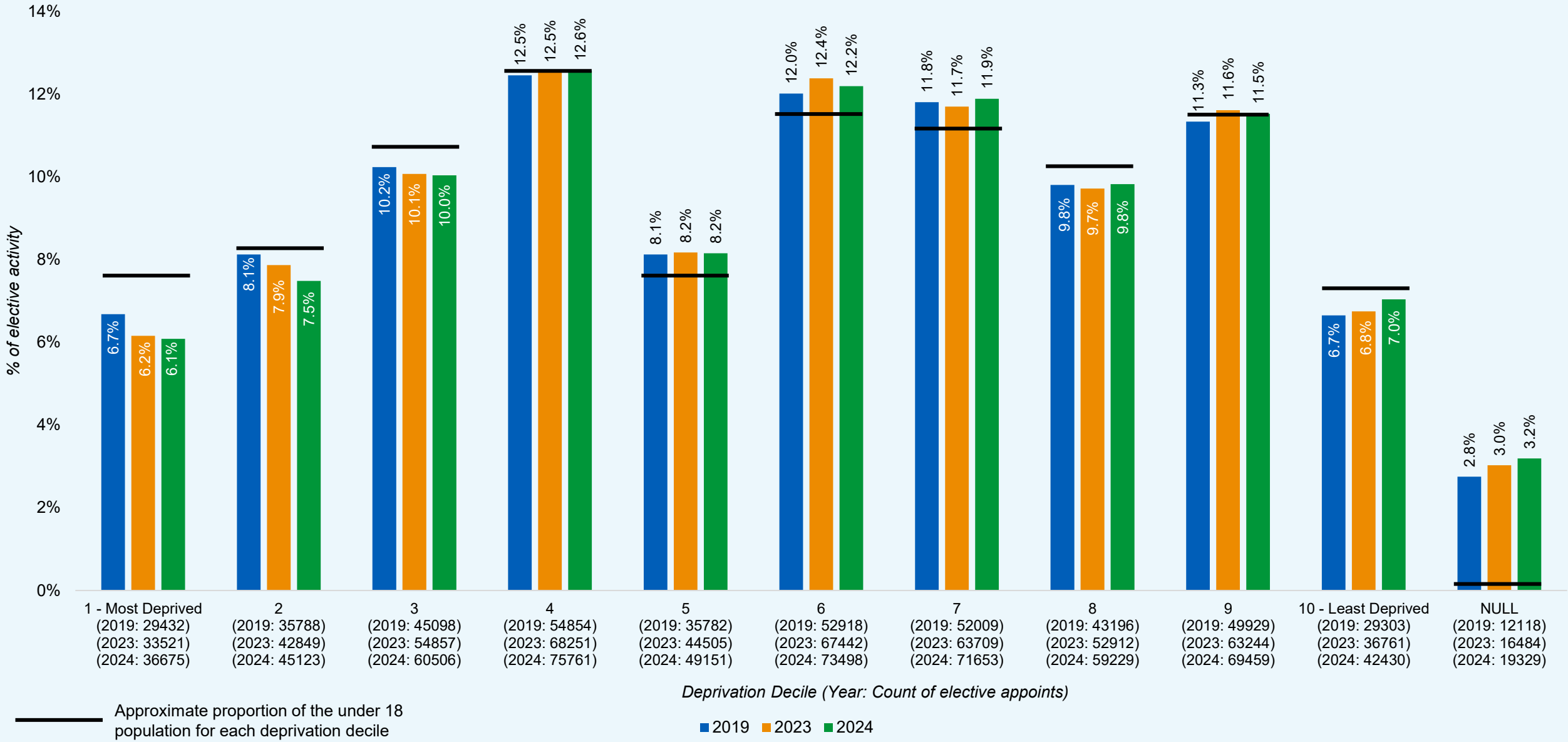
Source: Waiting Lists Minimum Data Set (WLMDS)

Elective Recovery – Elective activity vs pre-pandemic levels for under 18s by Sex



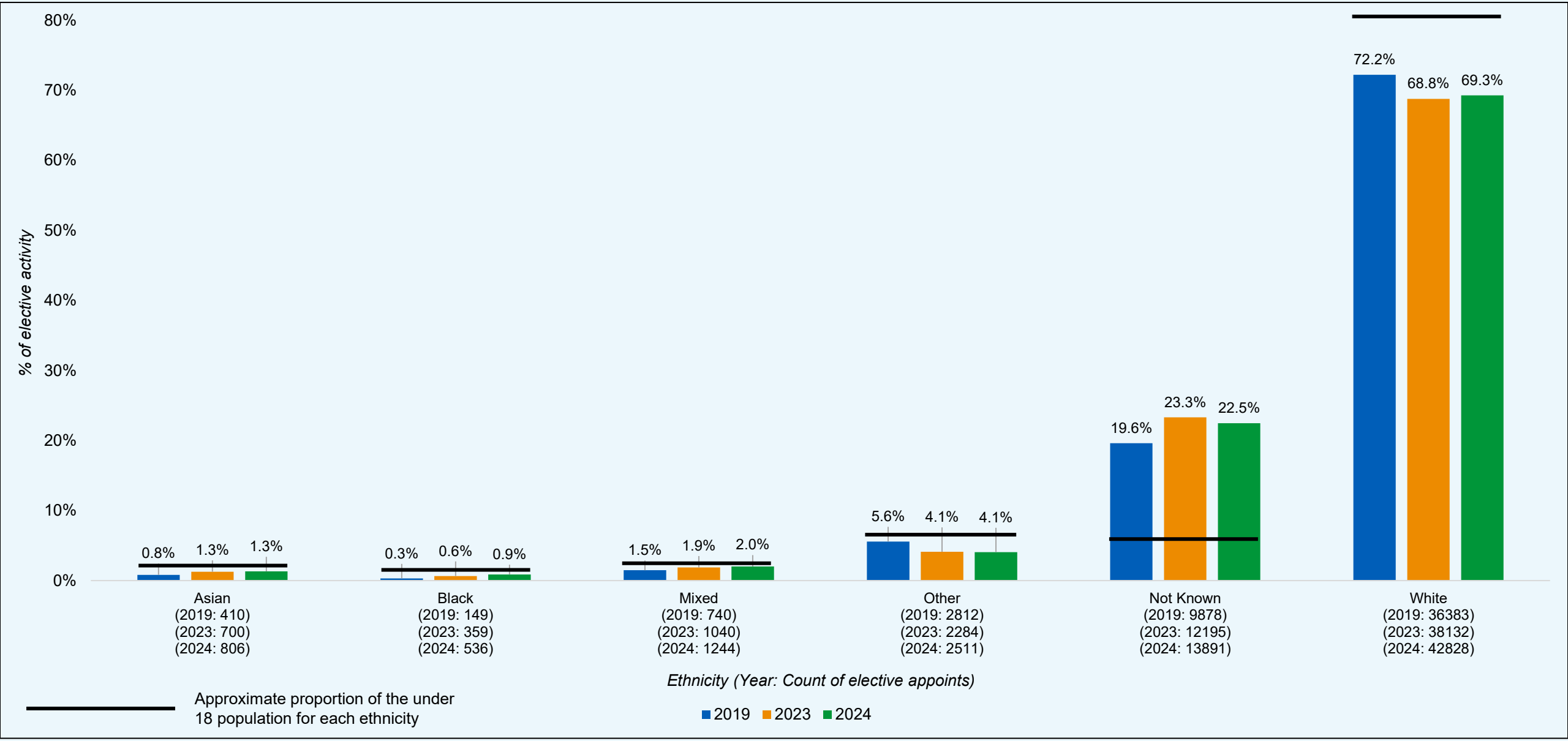
Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Elective activity vs pre-pandemic levels for under 18s by Deprivation Decile



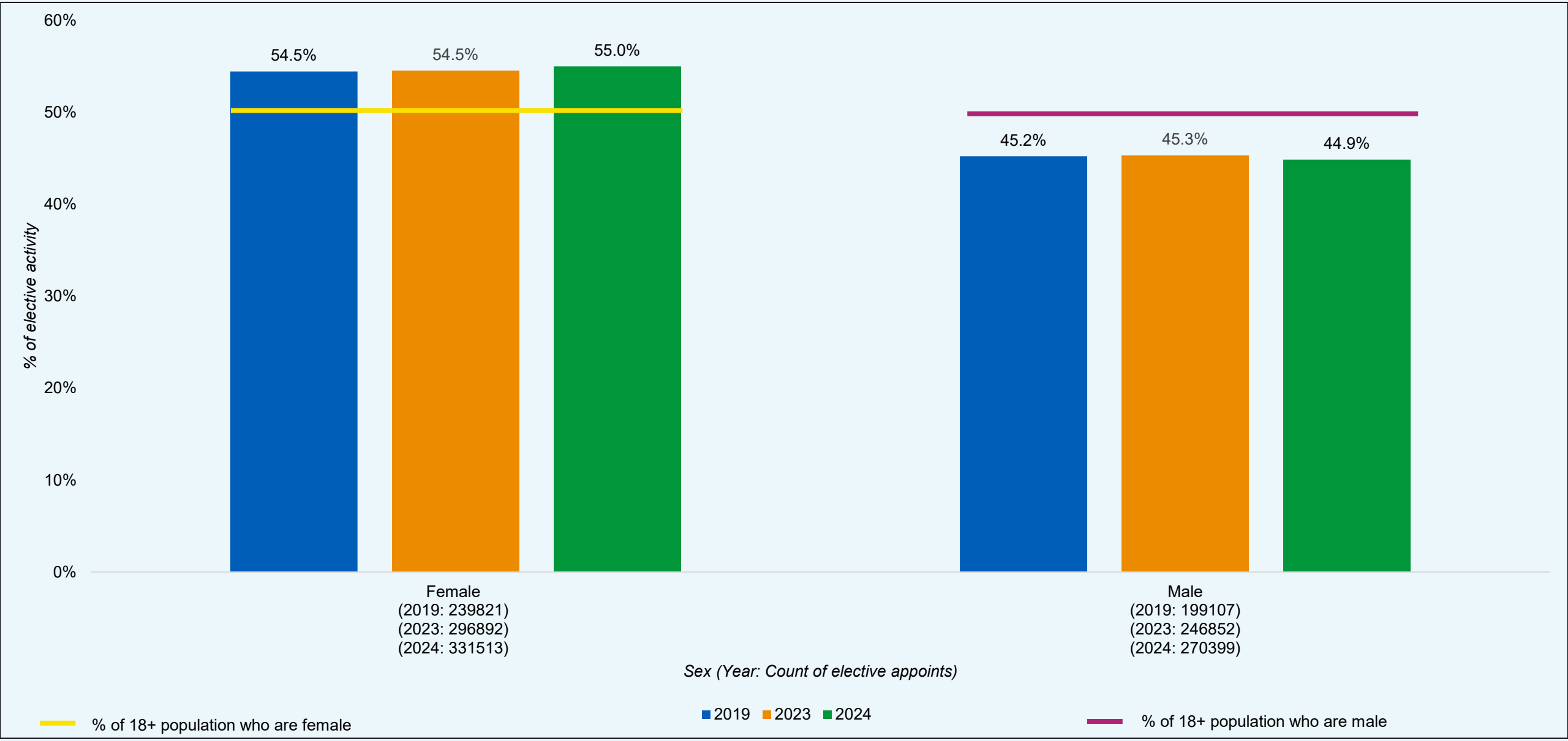
Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Elective activity vs pre-pandemic levels for under 18s by Ethnicity



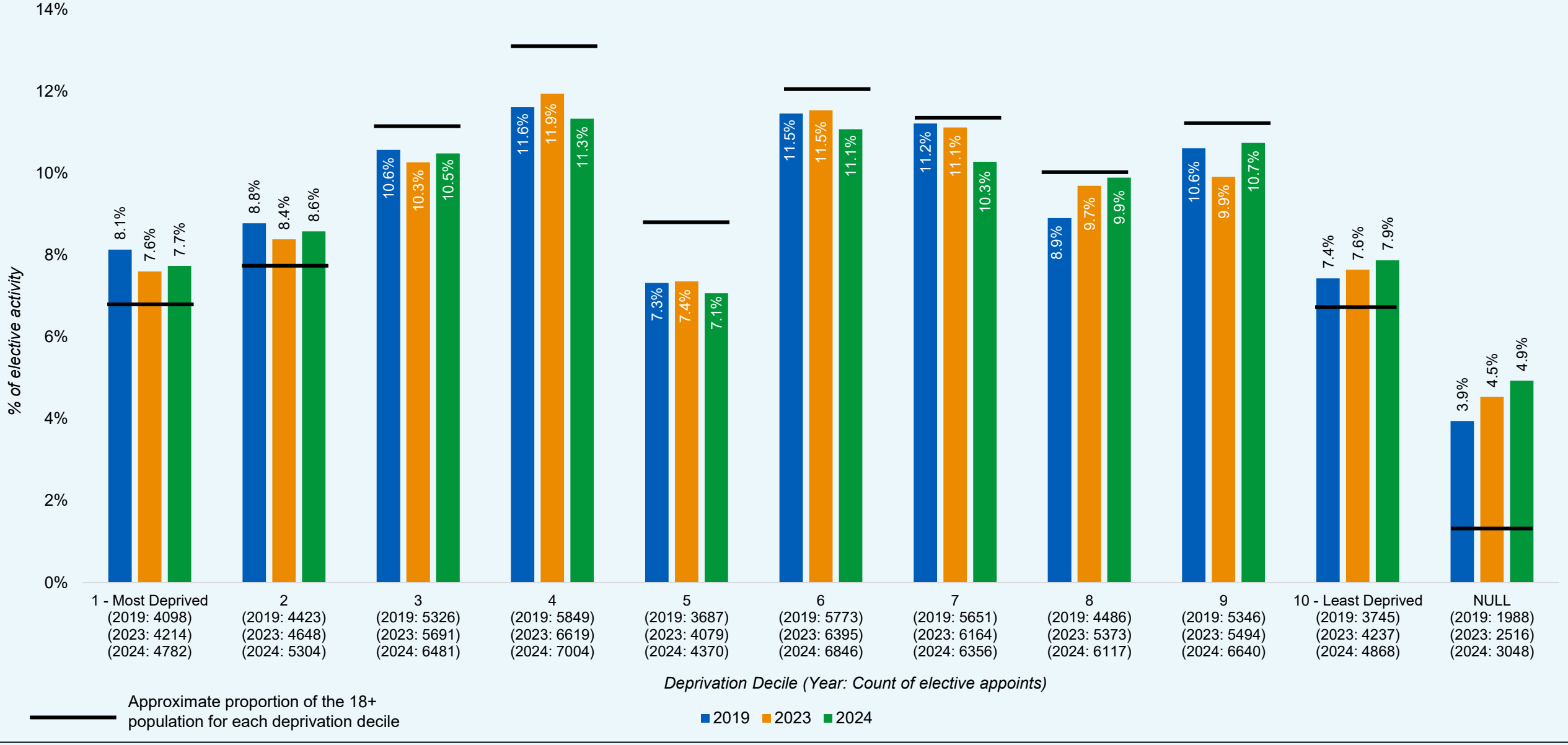
Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Elective activity vs pre-pandemic levels for over 18s by Sex



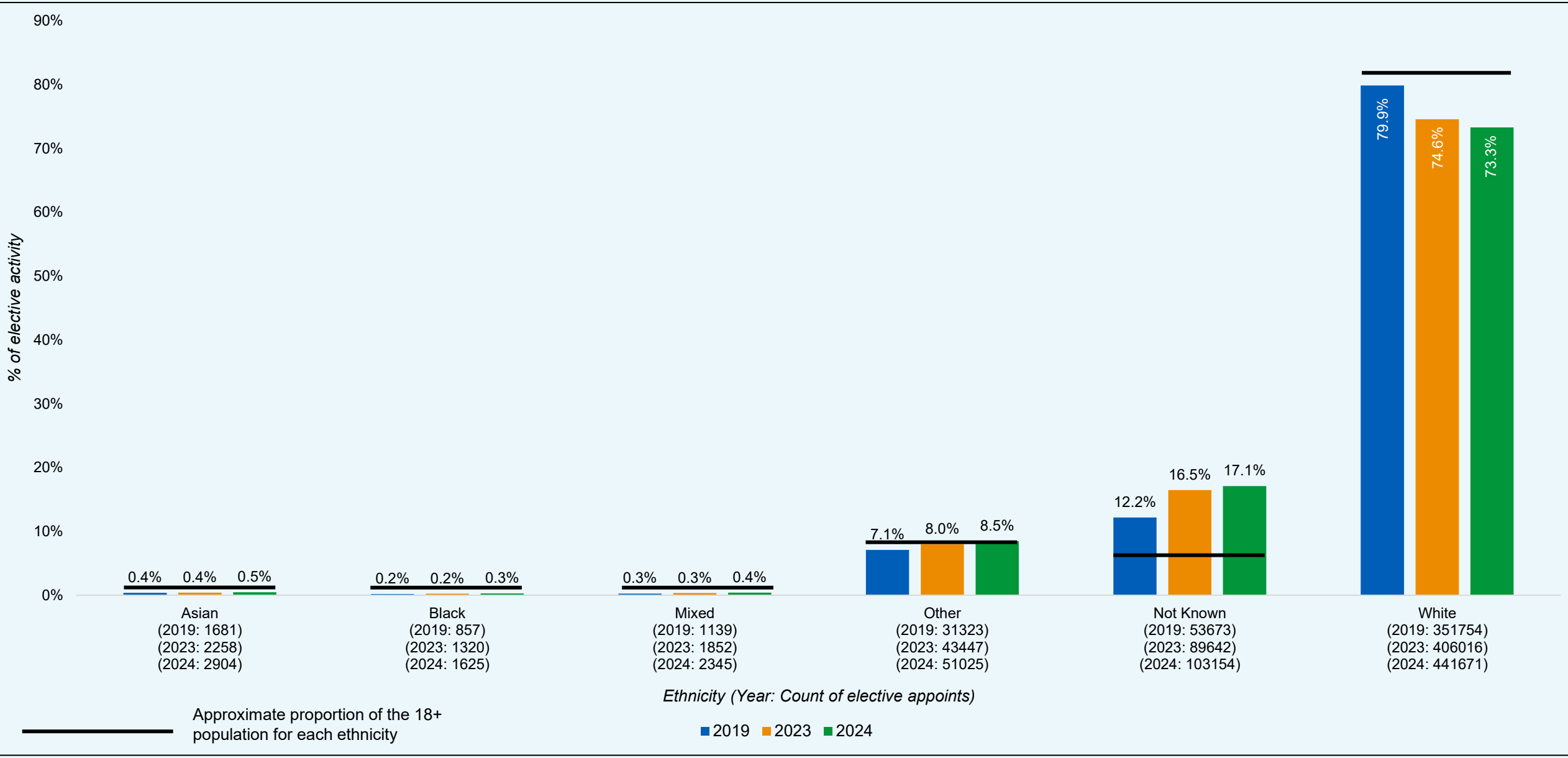
Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Elective activity vs pre-pandemic levels for over 18s by Deprivation Decile



Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Elective activity vs pre-pandemic levels for over 18s by Ethnicity



Sources: Secondary Use Services (SUS) Elective Activity dataset. 2019, 2023, 2024; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Elective Recovery – Domain Summary

Age: While the proportion of those on a waiting list who are waiting less than 18 weeks from the date of referral has increased overall between 31/03/24 and 30/03/25 (46.1% to 50.2% for CYP; 48.4% to 52.1% for adults), there is still a significant gap between CYP and adults. This sustained disparity indicates a potential systemic issue in access to timely treatment for children and young people. The proportion of CYP and adults who have been waiting longer than 65 weeks is also similar, with both cohorts seeing 0.1% of those on a waiting list waiting longer than 65 weeks.

Sex: While the proportion of those on a waiting list who are waiting less than 18 weeks from the date of referral has increased overall between 31/03/24 and 30/03/25 (48.8% to 52.7% for males; 47.6% to 51.2% in females), there is a widening gap in the proportion of males and females who are waiting less than 18 weeks. The proportion of males and females who have been waiting longer than 65 weeks since referral to treatment is the same; approximately 0.1% of females and males on a waiting list had been waiting longer than 65 weeks as at 30/03/25.

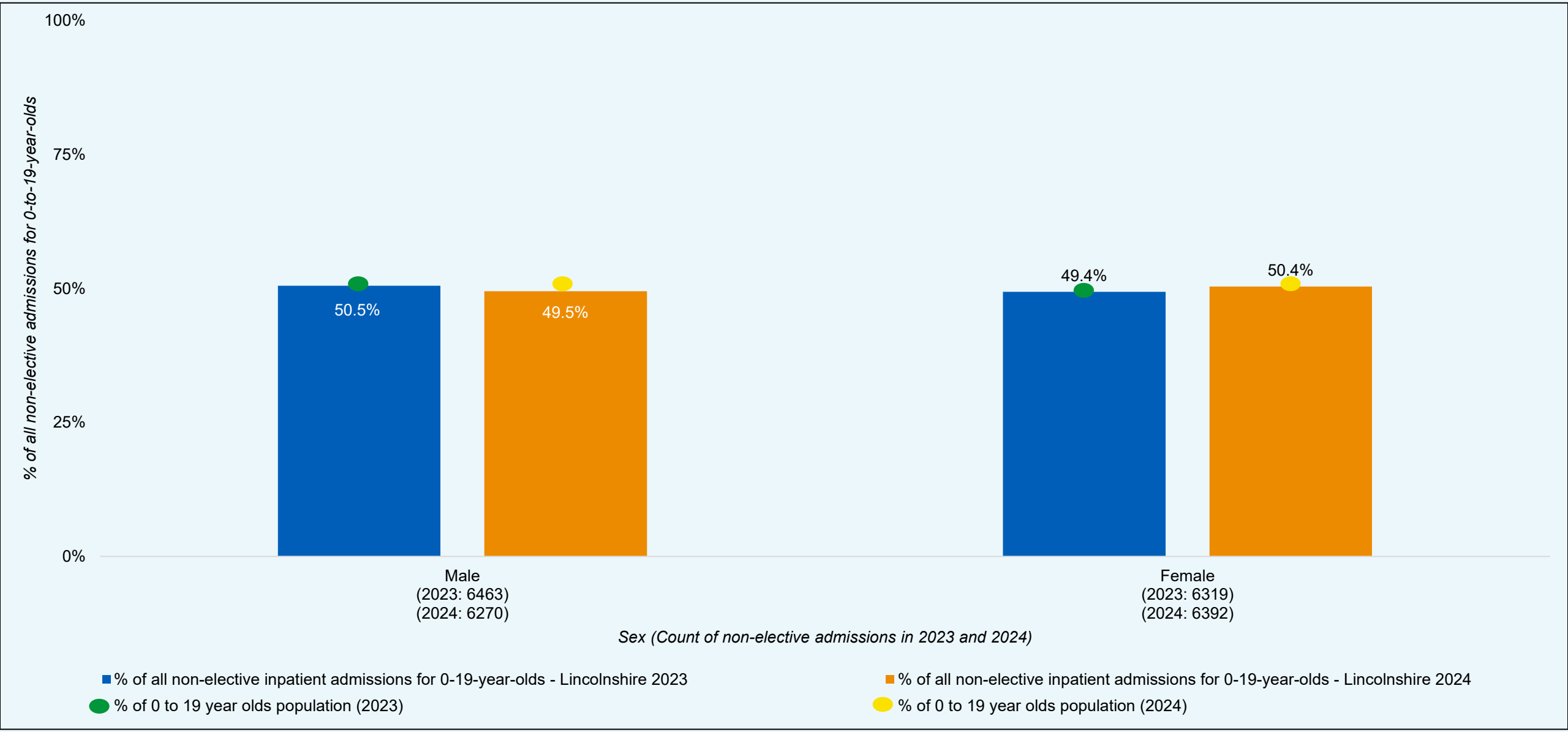
Deprivation: The proportion of those on a waiting list who are waiting less than 18 weeks from the date of referral has increased overall between 31/03/24 and 30/03/25, and the latest time period suggests there has been a narrowing of the gap between those from the most and least deprived parts of the county who are waiting less than 18 weeks. The gap between the most and least deprived who have been waiting longer than 65 weeks also appears to have closed, with little to separate between those living across all deprivation quintiles.

Ethnicity: The count and proportion of patients whose ethnicity is Unknown (this includes instances where a patient is asked their ethnicity but does not state it, as well as instances where the patient's ethnicity is not recorded) has increased from 18.8% at 31/03/24 to 30/03/25. This raises concerns about ethnicity recording and reporting getting worse in ULTH settings.

Urgent and Emergency Care Indicator – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Non-Elective admissions for under 19s	↓	↓	↓	↑	—

Non-Elective admissions for under 19s by Sex – 2023 and 2024



Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Sex – 2023 and 2024

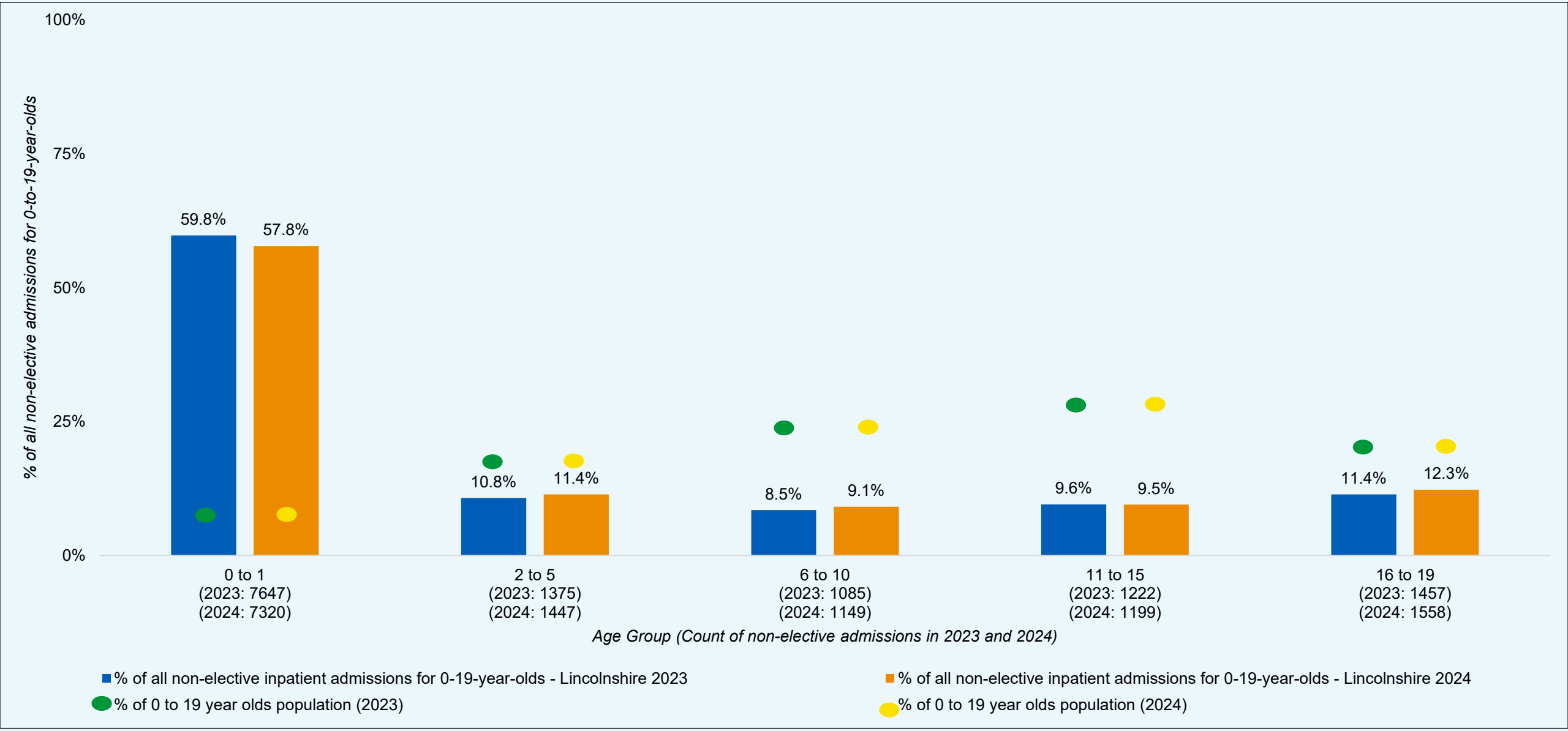
Analysis of non-elective hospital admissions for children and young people aged 0 to 19 has revealed a subtle shift in the proportion of admissions by sex between 2023 and 2024. In 2023, males accounted for 50.5% of all non-elective admissions, despite making up 51.1% of the 0-to-19-years population. Meanwhile, females accounted for 49.4% of admissions but represented only 48.9% of the population. In 2024, this trend continued, with the proportion of male admissions decreasing to 49.5% while their population share remained at 51.0%, whereas female admissions increased to 50.4% despite females making up just 49.0% of the population. While these differences are relatively small, they may indicate a gradual shift towards a higher proportion of non-elective admissions among females in this age group.

This pattern may reflect changes in the types of conditions leading to hospitalisation, differences in healthcare-seeking behaviour, or broader societal and health-related factors that disproportionately affect young females.

While the differences between males and females who had a non-elective admission in 2023 and 2024 are small, ongoing monitoring will be important to determine whether this trend continues and to understand the underlying causes. Identifying the specific conditions contributing to these changes could provide valuable insights to inform healthcare planning and targeted interventions where necessary.

Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds (2023 and 2024)

Non-Elective admissions for under 19s by Age Group – 2023 and 2024



Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Age Group – 2023 and 2024

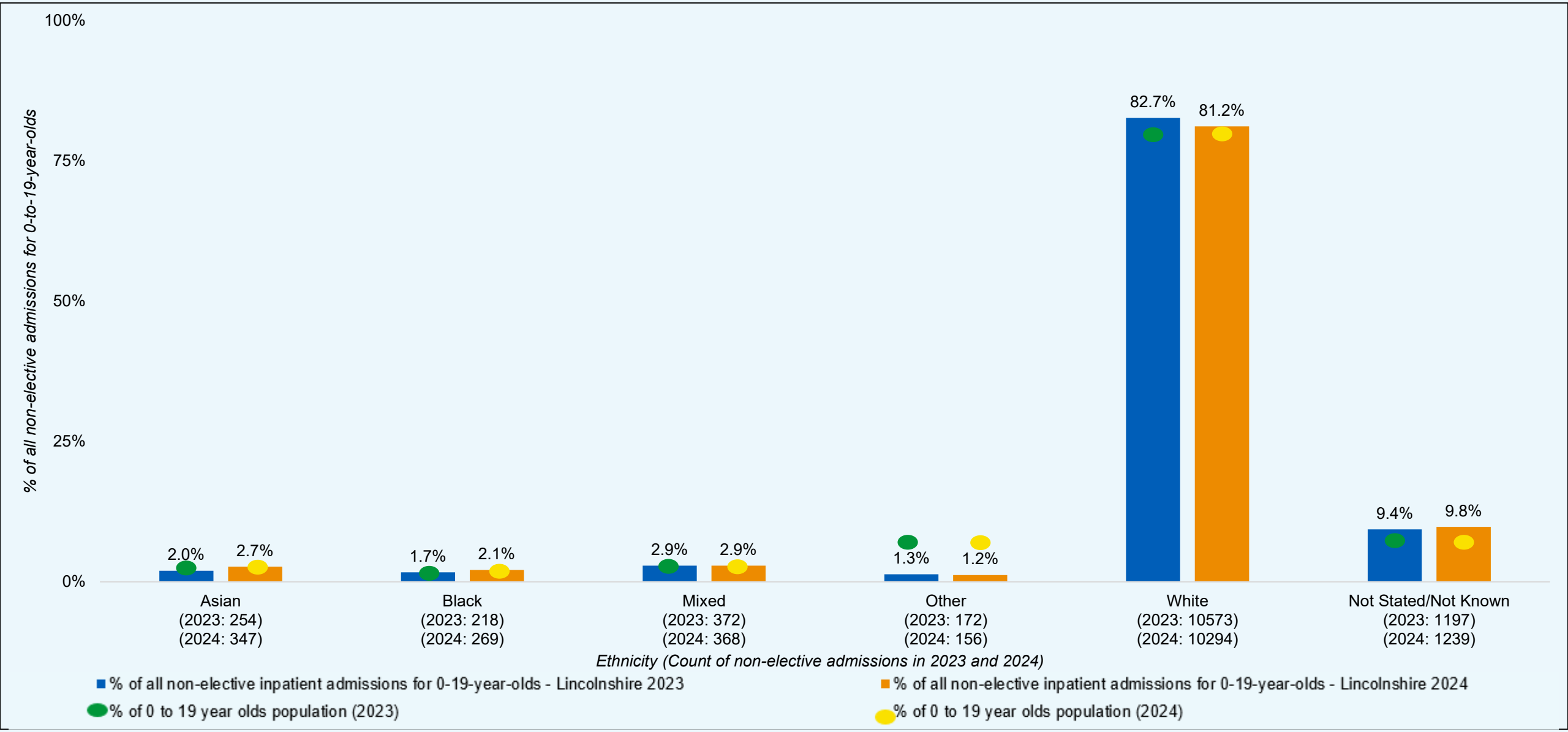
Children between the ages of 0 and 1 accounted for a disproportionately high number of non-elective admissions in 2023 and 2024, compared to other age groups. This is perhaps unsurprising considering newborn children are particularly vulnerable to a range of medical conditions compared to older children and teenagers. Clinical professionals are more likely admit a young child, even if their symptoms are not as severe as those in an older child or an adult. There is likely to be a tendency for healthcare staff to err on the side of caution if there is the potential for a seemingly routine illness to develop into something more serious. This is likely something new parents are likely to experience as well, thinking it is safer to attend an acute setting rather than wait to see their GP. Admissions are quite likely in the case of newborns where there were difficulties surrounding the birth, which may contribute to the phenomenon.

While there is a drop of 2 percentage points from 2023 to 2024 in the proportion of non-elective admissions attributed to 0-to-1-year olds (59.8% in 2023; 57.8% in 2024), a longer-term analysis will be needed to determine if this is a genuine decrease in the proportion of non-elective admissions attributed to 0-to-1-year olds or whether this is a natural variation.

It should be noted there was a slight increase in the number and proportion of non-elective admissions attributed to 2- to 5-year-olds, and to 16- to 19-year-olds. Again, a longer-term analysis will be needed to determine if this is indicative of an increase, or whether this is natural variation.

Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Ethnicity – 2023 and 2024



Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Ethnicity – 2023 and 2024

Between 2023 and 2024, the majority of non-elective admissions continue to be among White children. This is perhaps unexpected considering the overall population of Lincolnshire is White.

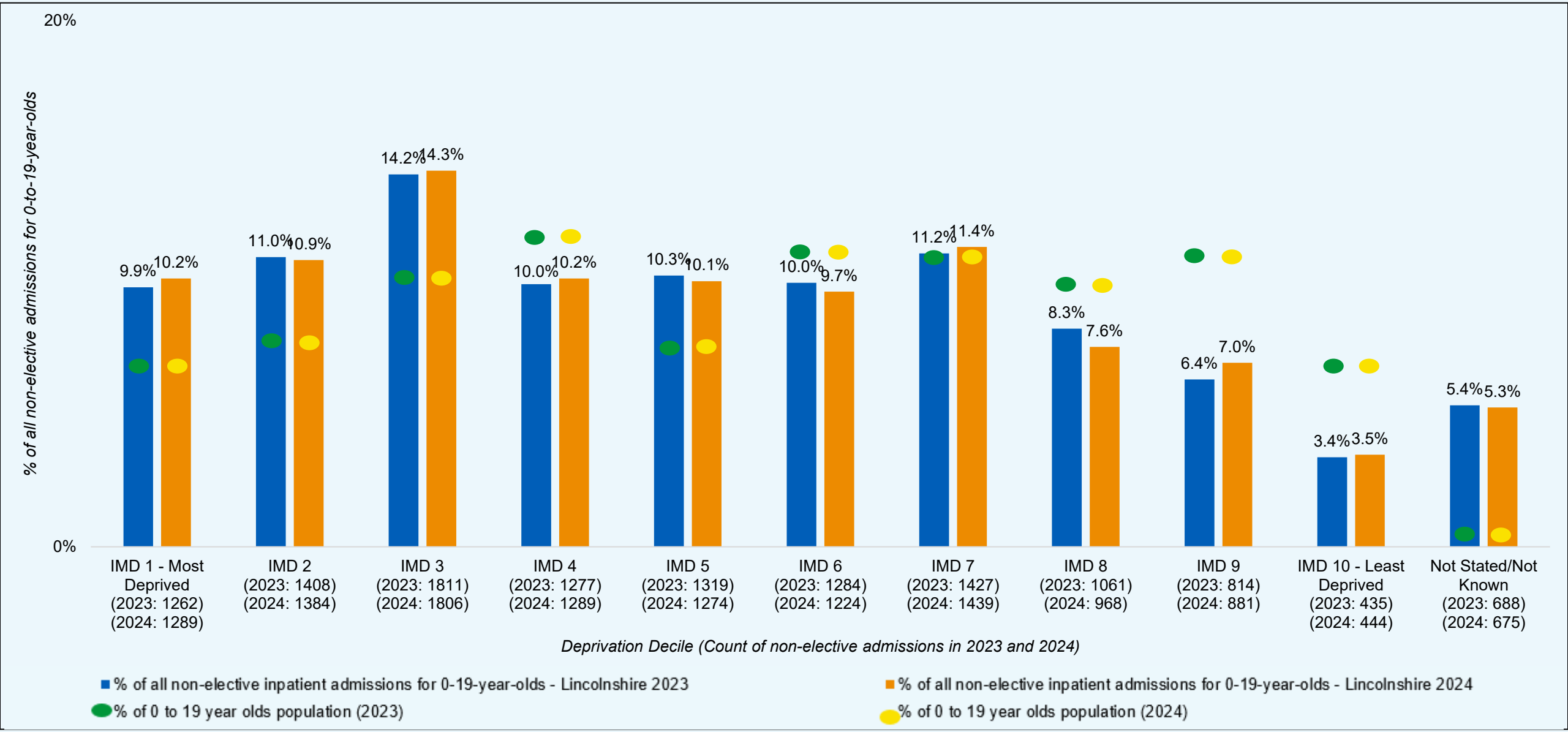
Children from an Asian and Black background noticed a slight increase in the proportion of non-elective admissions from 2023 to 2024. A longer-term analysis is needed to determine if this is indicative of a growing trend, or whether it is natural variation. Without a population breakdown of children aged 0 to 19 years stratified by different ethnicities, we do not know if this increase is due to an increase in the number of children from an Asian or Black background living in Lincolnshire from 2023 to 2024.

The biggest decrease between 2023 and 2024 was observed in children from a White background, from 82.7% in 2023 to 81.2% in 2024. It should be noted this category does not differentiate between White British, White Irish, or White Other populations. A longer-term analysis is needed to determine if this is indicative of a growing trend, or whether it is natural variation. Without a population breakdown of children aged 0 to 19 years stratified by different ethnicities, we do not know if this decrease is due to a decrease in the number of children from a White background living in Lincolnshire from 2023 to 2024.

The increase in the Unknown category may indicate some data recording challenges or shifts that need to be addressed to ensure accurate monitoring.

Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Deprivation – 2023 and 2024



Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds

Non-Elective admissions for under 19s by Deprivation – 2023 and 2024

Between 2023 and 2024, the overall distribution of non-elective admissions for 0-to-19-year-olds in Lincolnshire ICB by deprivation decile remains broadly similar, though there are some shifts in proportions.

The comparison between 2023 and 2024 suggests that non-elective admissions continue to be more concentrated in the more deprived deciles, with a persistent peak in decile 3. Small shifts in some middle-to-lower deciles indicate slight variations, but no dramatic changes in the deprivation profile of admissions.

A limitation of these charts is the lack of a comparator population to determine if those from more deprived areas of Lincolnshire account for a disproportionately higher number of non-elective admissions. Without knowing the population breakdown of 0- to 19-year-olds stratified by deprivation decile, we cannot compare to determine if the slightly higher proportion of non-elective admissions is reflective of the overall population.

Source: CYP Inpatient Dashboard – Non-Elective admissions for 0-19-year-olds (2023 and 2024)

Urgent and Emergency Care – Domain Summary

Age: A pattern which has sustained from 2023 to 2024 concerns the much higher prevalence of children aged 1 and under who account for almost two-thirds of all non-elective hospital admissions. This is a well-recognised trend and likely reflects the heightened vulnerability of infants to acute illnesses, infections, and complications related to birth or early development. Infants are more likely to be hospitalised as a precaution due to their limited ability to communicate symptoms and the potential for rapid deterioration.

Sex: Non-elective hospital admissions among children and young people show a subtle but consistent shift by sex between 2023 and 2024. In 2023, males accounted for 50.5% of admissions despite making up 51.1% of the population, while females accounted for 49.4% of admissions against a 48.9% population share. By 2024, this gap widened slightly: male admissions fell to 49.5%, and female admissions rose to 50.4%, despite no change in their respective population proportions. Although the differences are small, the trend suggests a gradual increase in the proportion of admissions among females.

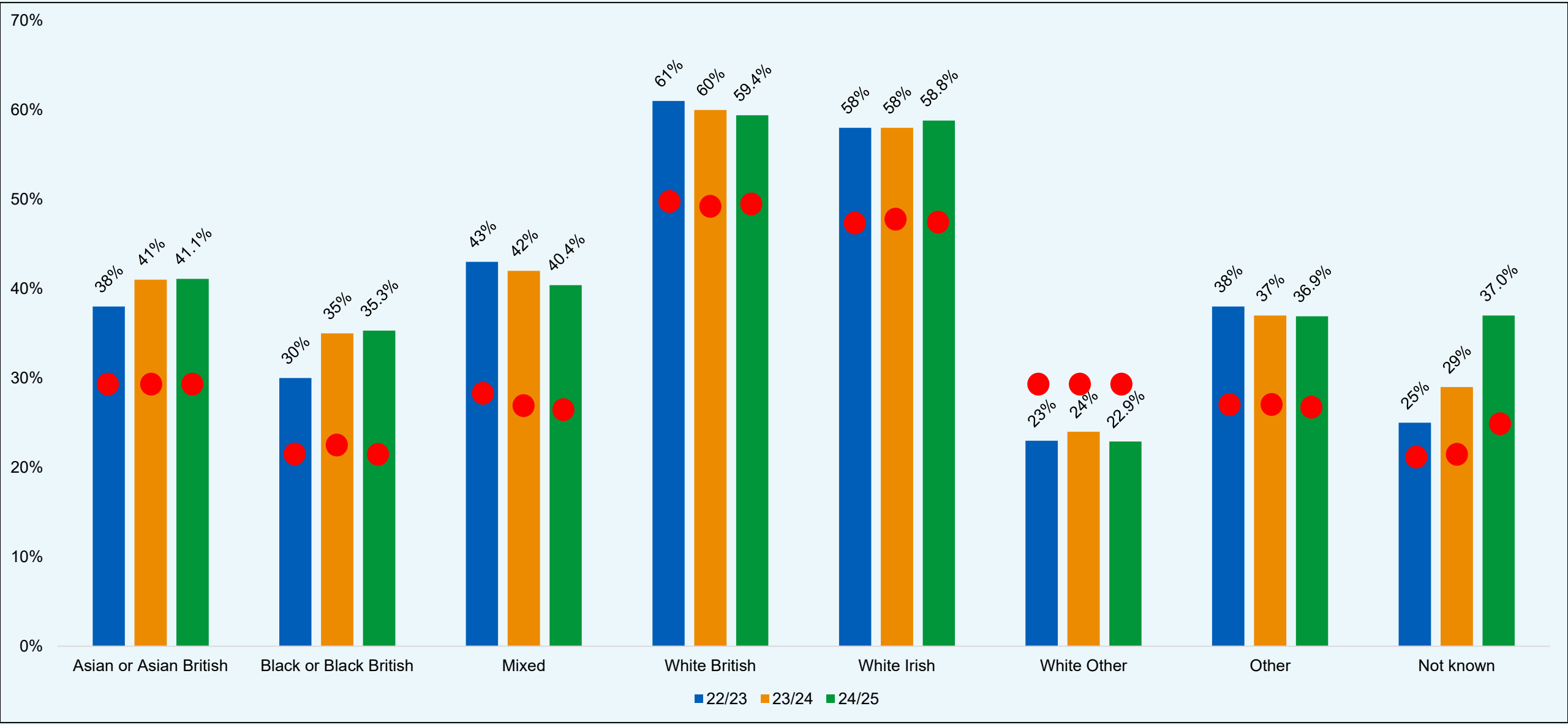
Deprivation: Non-elective hospital admissions in children and young people tend to be over-represented in those children living in the more deprived parts of the county. This could be partly explained by the increased likelihood of children from more deprived parts of the county experiencing poorer health and less proclivity to seek preventative behaviours, which may result in an increased rate of attendance at emergency departments. Other behavioural factors, such as proximity to emergency departments and an increased likelihood to be seen outside working hours (instead of going to primary care settings), may partly explain this

Ethnicity: The main takeaway concerns the high proportion of non-elective admissions that come from those where no ethnicity has been captured. This points to a larger and well-known issue concerning secondary care setting in capturing ethnicity.

Respiratory Indicators – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Uptake of flu vaccines	↓	—	⟺	↑	↑
Uptake of COVID vaccines	N/A	—	—	—	—

Flu Vaccines by Ethnicity (broad ethnic groups)



Approximate national value for category

Source: Health Inequalities Improvement Dashboard

Flu Vaccines by Ethnicity (broad ethnic groups)

The Lincolnshire average has remained quite consistent for 22/23, 23/24, and 24/25, although there has been a slight drop in the 24/25 period (which could be attributed to the fact we are not through a complete season).

For the Asian or Asian British group, vaccine uptake increased from 38% in 22/23 to 41% in 23/24, which maintained in 24/25.

The Black or Black British group showed a more pronounced increase from 30% in 22/23 to 35% in 23/24, maintaining that level in 24/25. This suggests a sustained improvement in vaccine uptake.

The Mixed ethnic group showed a gradual decline in uptake, starting at 43% in 22/23, decreasing slightly to 42% in 23/24, and further dropping to 40.4% in 24/25.

The White British group consistently reported the highest uptake levels, although there is a small but steady decline over time. Uptake was at 61% in 22/23, falling to 60% in 23/24, and further to 59.4% in 24/25. While this decline is marginal, it may signal a need for continued engagement to maintain historically high participation rates.

The White Irish group maintained a stable uptake rate of 58% across all three reporting periods (increasing slightly to 58.8% in 24/25), demonstrating a consistent engagement with the flu vaccination program.

The White Other group exhibited minimal fluctuation, with uptake at 23% in 22/23, a slight increase to 24% in 23/24, and returning to 23% (22.9%) in 24/25. This relatively low uptake compared to other groups may suggest underlying challenges such as language barriers, vaccine hesitancy, or access issues that need further exploration. This may partly be explained by the significant population of those from an Eastern European background.

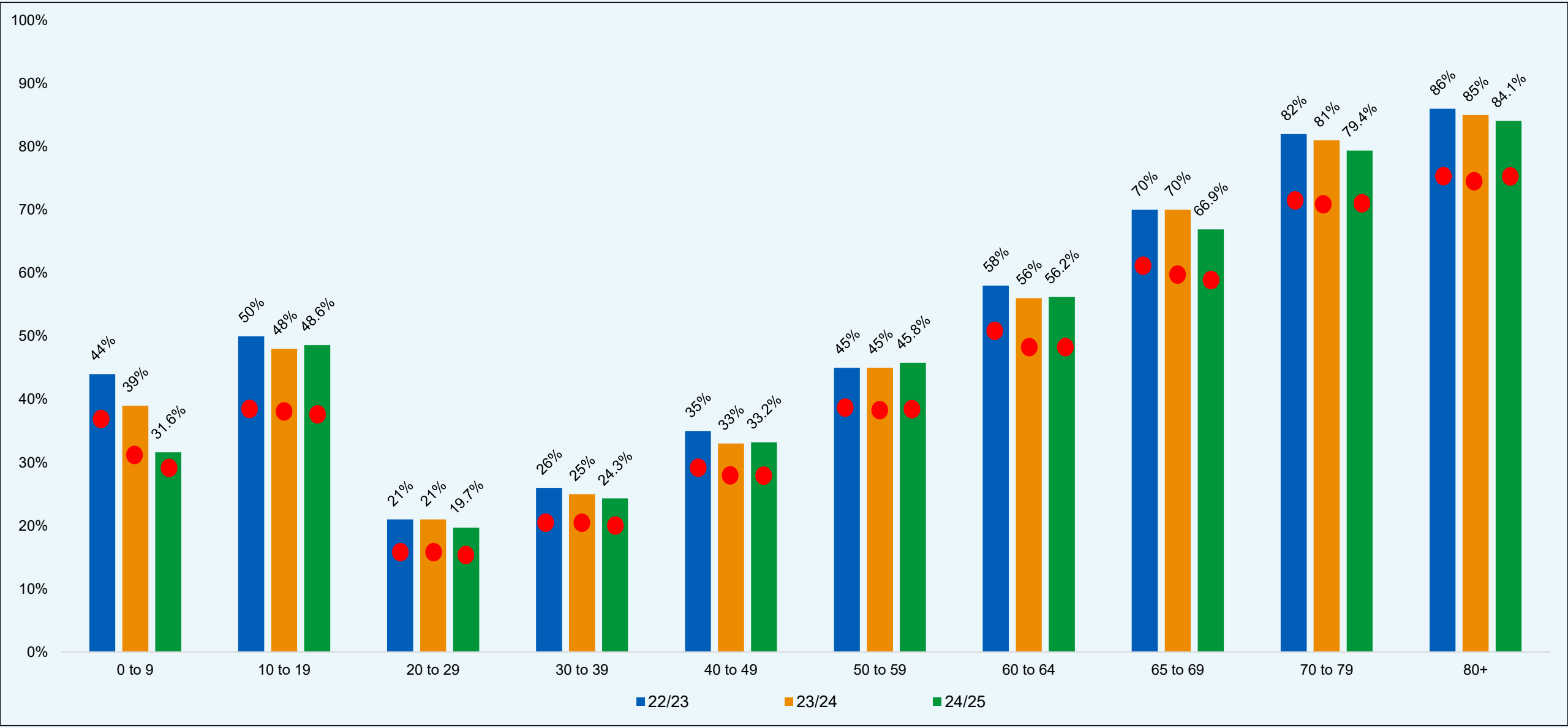
The Other ethnic category showed a slight decline from 38% in 22/23 to 37% in both 23/24 and 24/25 (36.9%), suggesting that uptake in this group has stabilized but at a lower level than the initial period.

Those for whom there was no ethnicity available saw the most noticeable increase, rising from 25% in 22/23 to 29% in 23/24, and further to 37% in 24/25. This points to a broader, but well known , issue concerning ethnicity data quality.

Overall, the trends indicate that while some ethnic groups have shown improvement in flu vaccine uptake, the uptake is noticeably lower in those from an ethnic minority. Further work may need undertaking to understand why the rates of flu vaccine has stayed relatively low. It should be noted that those from an ethnic minority in Lincolnshire tend to have small numbers which can skew the results. Unfortunately, the data source does not provide counts so we are unable to determine in which ethnic minority group this is likely to be the case. It should also be noted the cultural beliefs those from ethnic minorities have in relation to vaccinations; this may provide an explanation for some, but not for all. Engagement work with relevant professionals and communities will be imperative in understanding the observed disparities above. Data on more detailed ethnic groups can be made available on request; these have not been disaggregated due to space.

Source: Health Inequalities Improvement Dashboard

Flu Vaccines by Age groups



Approximate national value for category

Source: Health Inequalities Improvement Dashboard

Flu Vaccines by Age groups

The flu vaccine uptake trends across three reporting periods (22/23, 23/24, and 24/25) demonstrate a clear and expected relationship with age, where older age groups consistently show higher vaccination rates compared to younger cohorts. This is perhaps an expected finding, considering the vulnerability experienced by older populations to respiratory illnesses such as flu over the winter months.

In the youngest age group, 0 to 9 years, uptake has steadily declined over the three periods, dropping from 44% in 22/23 to 39% in 23/24, and further to 35% in 24/25.

A similar trend is observed in the 10 to 19 years group, where uptake decreased from 50% in 22/23 to 48% in 23/24, and again slightly to 47% in 24/25. These declines may indicate potential challenges in engaging younger age groups and their guardians in the vaccination programme.

The 20 to 29 years group continues to show the lowest uptake levels, with a near-flat trend: 21% in both 22/23 and 23/24, before decreasing slightly to 20% in 24/25.

Similarly, the 30 to 39 years group has remained relatively stable at 26% in 22/23, followed by 25% in both 23/24 and 24/25. These consistently low rates suggest that younger adults may not perceive the flu vaccine as necessary or may face barriers to access.

The 40 to 49 years group shows a slight decline from 35% in 22/23 to 33% in 23/24, then a minor recovery to 34% in 24/25.

The 50 to 59 years group has remained relatively stable, with uptake at 45% in both 22/23 and 23/24, increasing slightly to 46% in 24/25. These trends suggest that vaccine engagement efforts may be having some effect, though uptake remains moderate.

A more pronounced increase is evident from the 60 to 64 years group onward. Uptake in this cohort was 58% in 22/23, then dipped slightly to 56% in 23/24 before recovering to 57% in 24/25.

The 65 to 69 years group displayed a small but steady decline, from 70% in both 22/23 and 23/24 to 68% in 24/25.The highest uptake levels are observed in the older populations.

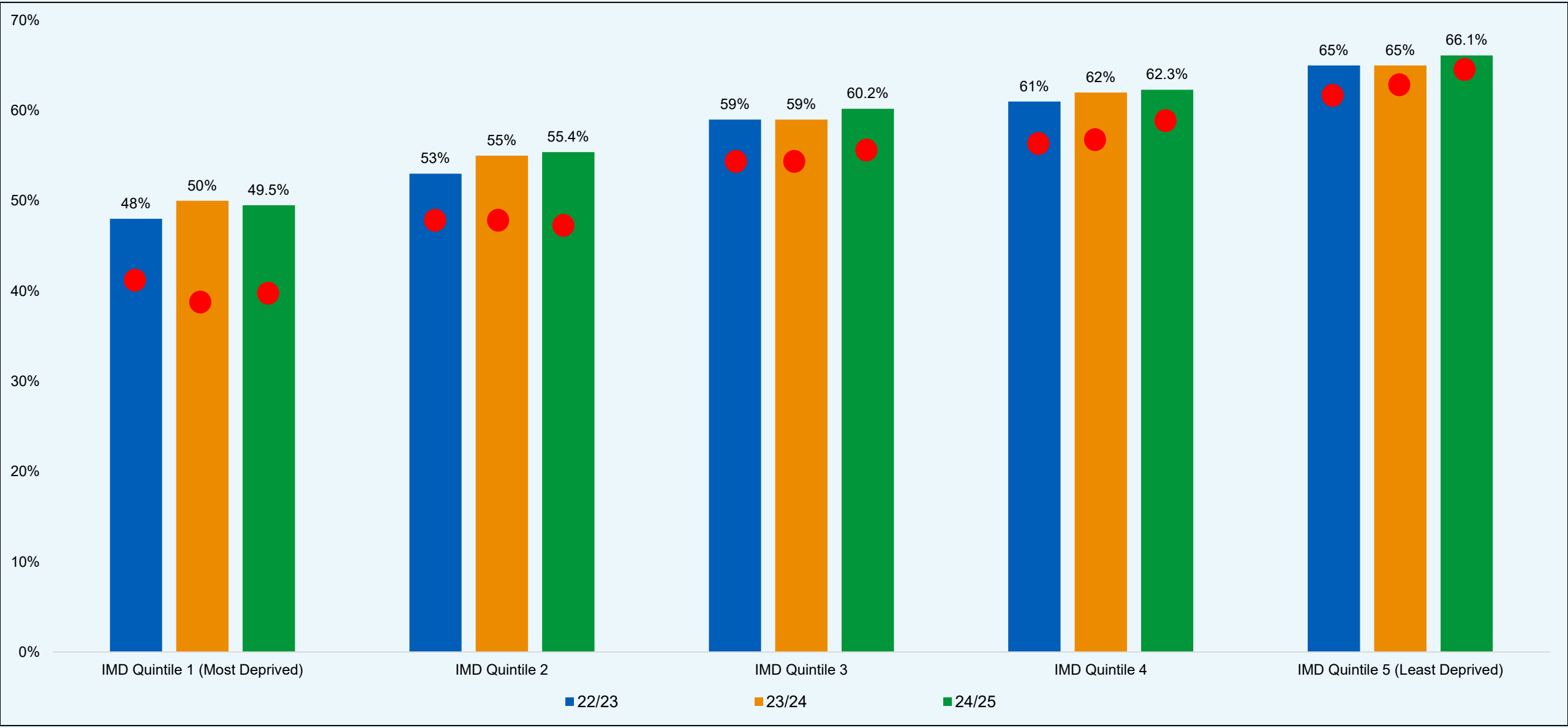
The 70 to 79 years group had a strong uptake of 82% in 22/23, which slightly declined to 81% in 23/24 and 80% in 24/25.

the 80+ years group had the highest engagement, with uptake at 86% in 22/23, followed by small declines to 85% in 23/24 and 84% in 24/25. While these are still high levels of uptake, the slight downward trend may suggest a need for continued reinforcement of messaging among older adults.

Overall, the data highlights a strong correlation between age and vaccine uptake, with older groups maintaining significantly higher participation rates than younger ones. The key areas of concern appear to be the declining rates among children and younger adults, as well as the small but consistent downward trends across all age groups.

Source: Health Inequalities Improvement Dashboard

Flu Vaccines by Deprivation Quintile



Approximate national value for category

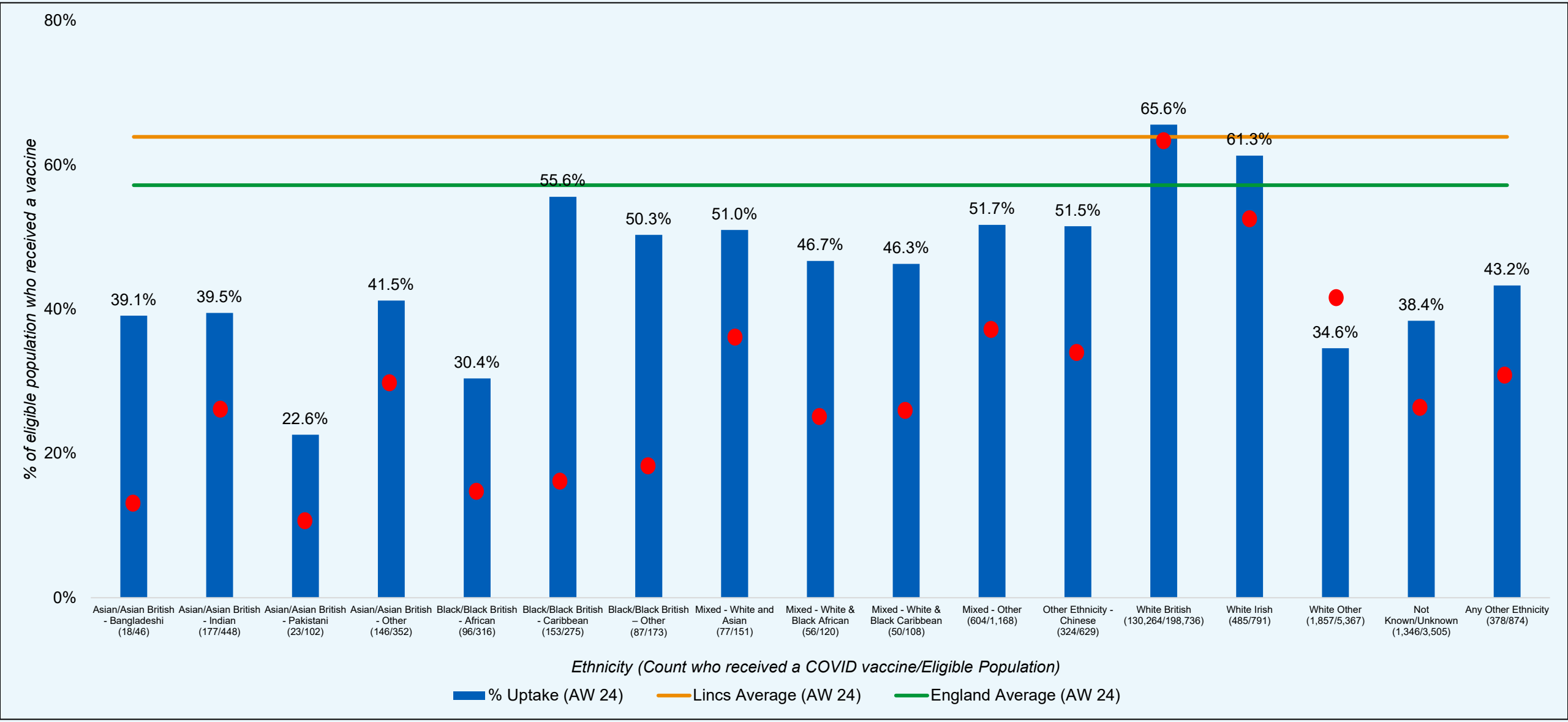
Source: Health Inequalities Improvement Dashboard

Flu Vaccines by Deprivation Quintile

The flu vaccine uptake trends across the three reporting periods (22/23, 23/24, and 24/25) demonstrate a clear and consistent relationship between deprivation and vaccination rates. People who live in most deprived areas of Lincolnshire (IMD Quintile 1) consistently have the lowest levels of vaccine uptake, whereas those in the least deprived areas (IMD Quintile 5) show the highest uptake. This pattern remains stable across all three reporting periods, highlighting a potential health inequality – although further exploration may be needed to determine what might be influencing the lower uptake in those living in more deprived areas. There is between a 15 percentage point and 17 percentage point difference in flu vaccine uptake across the three reporting periods. The magnitude of the difference in flu vaccine uptake suggests there are issues that need to be explored and understood in order to improve the flu vaccine uptake.

Source: Health Inequalities Improvement Dashboard

COVID Vaccines by Ethnicity (broad ethnic groups)



Approximate national value for category

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

COVID Vaccines by Ethnicity (broad ethnic groups)

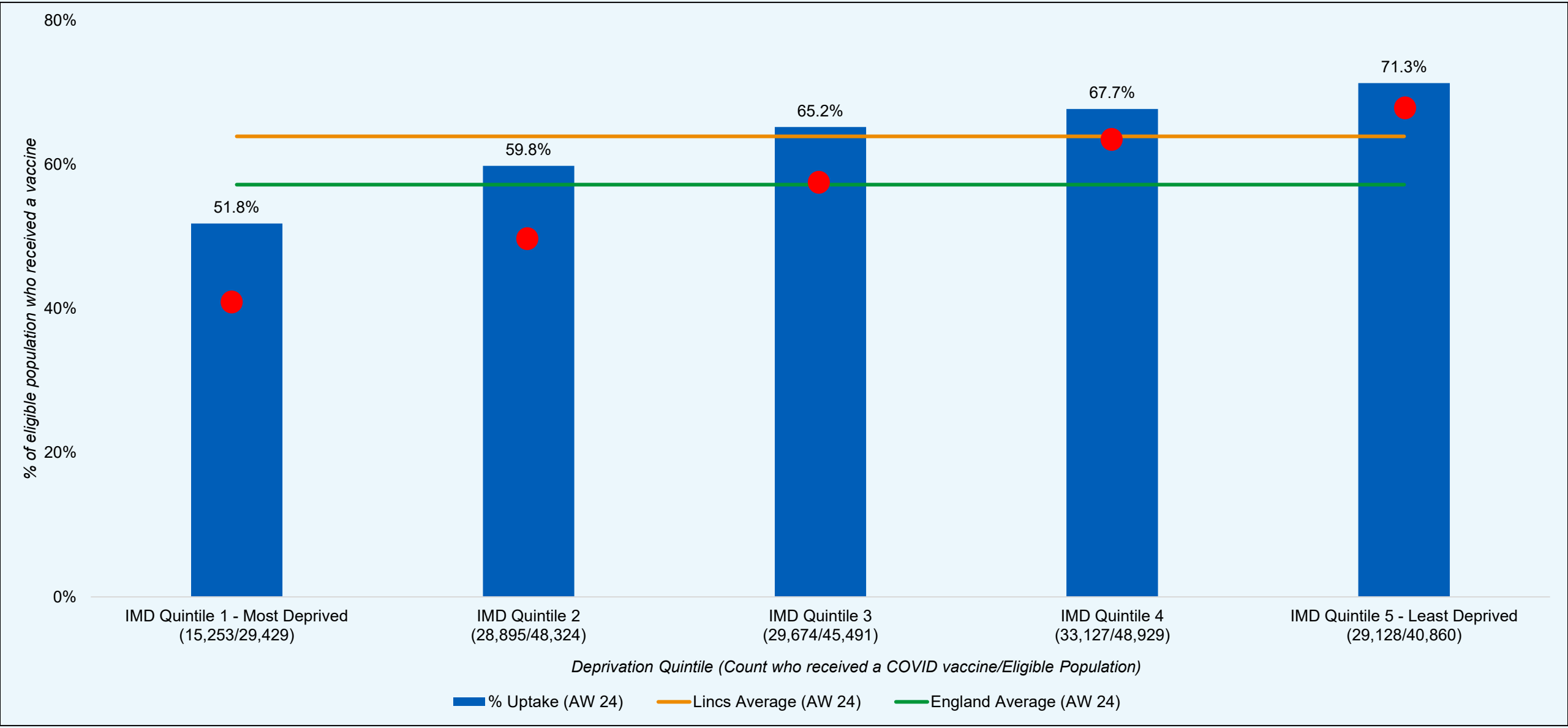
This chart presents the uptake of COVID-19 vaccinations across different ethnic groups within Lincolnshire ICB for the period between 03/10/24 and 31/01/25 (referred to as the AW24 period). The Lincolnshire average is 63.87% of receiving a COVID vaccine in this time; however, the data is not stratified by different doses (first dose, second dose, booster doses). Please note, these figures exclude those who are frontline healthcare workers, and social care workers.

What is evident is the variation experienced by the different ethnic groups in Lincolnshire when it comes to receiving a seasonal COVID vaccine. The highest proportion is observed in the White British and White Irish populations; only those from a White British population (when stratified by ethnicity) had a higher uptake compared to the Lincolnshire and national average.

One ethnic group that jumps out as having the lowest uptake is those from a Pakistani background – only 16.1% of this population received a COVID vaccine in the AW24 period (69 out of a possible 359 of the eligible population). There are likely to be a myriad of factors that explain this difference in outcomes, such as vaccine hesitancy, accessibility to locations to receive a vaccine, or other cultural behaviours towards vaccines (particularly COVID vaccines).

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

COVID Vaccines by Deprivation Quintile



Approximate national value for category

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

COVID Vaccines by Deprivation Quintile

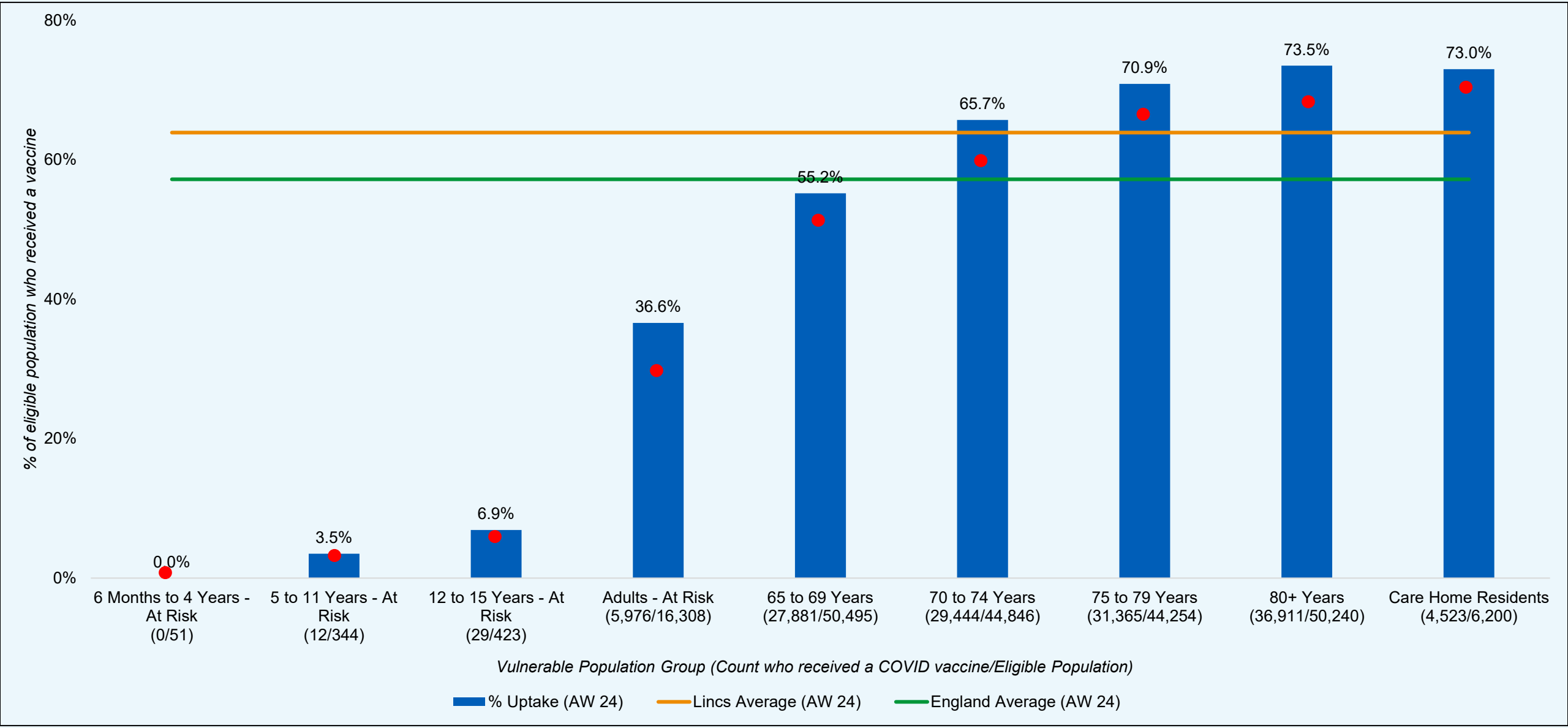
This chart presents the uptake of COVID-19 vaccinations across different ethnic groups within Lincolnshire ICB for the period between 03/10/24 and 31/01/25 (referred to as the AW24 period). The Lincolnshire average is 63.87% of receiving a COVID vaccine in this time; however, the data is not stratified by different doses (first dose, second dose, booster doses). Please note, these figures exclude those who are frontline healthcare workers, and social care workers.

A clear relationship can be observed between vaccine uptake and deprivation – vaccine uptake increases as deprivation decreases. About 1 in every 2 people (51.8% - 15,253/29,429) who live in the most deprived quintile who were eligible to receive a vaccine in AW24 received a COVID vaccine, compared to about 7 in every 10 people (71.3% - 29,128/40,860) who live in one of the least deprived parts of the county in AW24. Uptake then steadily rises across the quintiles, with the least deprived group demonstrating the highest uptake, above both the Lincolnshire and national average. This trend suggests that individuals in more affluent areas are more likely to receive the vaccine compared to those in more deprived communities. There are likely to be a myriad of factors that explain this difference in outcomes, such as vaccine hesitancy, accessibility to locations to receive a vaccine, or other cultural behaviours towards vaccines (particularly COVID vaccines).

The Slope Index of Inequality has been calculated as 32.9 - meaning that the absolute gap in vaccine uptake from the most deprived quintile to the least deprived quintile is 32.9% (if a 'line of best fit' was applied to the chart, there would be a 32.9% difference between the modelled uptake between the most and least deprived). The Relative Index of Inequality has been calculated at 1.80. This means the relative likelihood of those receiving a vaccine is about 80% more likely in those living in the least deprived areas than it is in those living in the most deprived areas.

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

COVID Vaccines by Vulnerable Populations



Approximate national value for category

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

COVID Vaccines by Vulnerable Populations

This chart presents the uptake of COVID-19 vaccinations across different ethnic groups within Lincolnshire ICB for the period between 03/10/24 and 31/01/25 (referred to as the AW24 period). The Lincolnshire average is 63.87% of receiving a COVID vaccine in this time; however, the data is not stratified by different doses (first dose, second dose, booster doses). Please note, these figures exclude those who are frontline healthcare workers, and social care workers.

The initial observation is the very low uptake in COVID vaccines for children under the age of 15 who receive a COVID vaccine in this period. There are likely several reasons for this, such as the perceived benefits of receiving a COVID vaccine in a population who may experience less severe COVID symptoms.

Source: FDP Vaccines Dashboard (data extracted 10/04/25)

Respiratory – Domain Summary

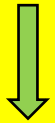
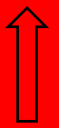
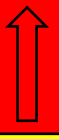
Age: Those under the age of 30 tend to have a significantly lower seasonal uptake of flu and COVID vaccines compared to older age adults. One of the reasons for this may be the younger population do not feel as at risk of flu and COVID compared to the older populations, but further work will need undertaking to understand this observation.

Sex: The data was not stratified by sex.

Deprivation: A consistent trend observed showing those from the most deprived parts of Lincolnshire have a lower uptake of seasonal flu and COVID vaccines compared those living in the least deprived parts of the county.

Ethnicity: Those from ethnic minority backgrounds have a significantly lower uptake of seasonal flu and COVID vaccines compared to the White British/Irish population. The Asian population have a particularly lower uptake, although attention should also be paid to the White Other population who have a lower uptake of seasonal flu and COVID vaccines compared to the national White Other uptake. The data source does not provide count data to allow us to understand if the proportion of those whose ethnicity is not recorded has improved or worsened compared to 23/24.

Mental Health Indicators – One Page Summary (24/25)

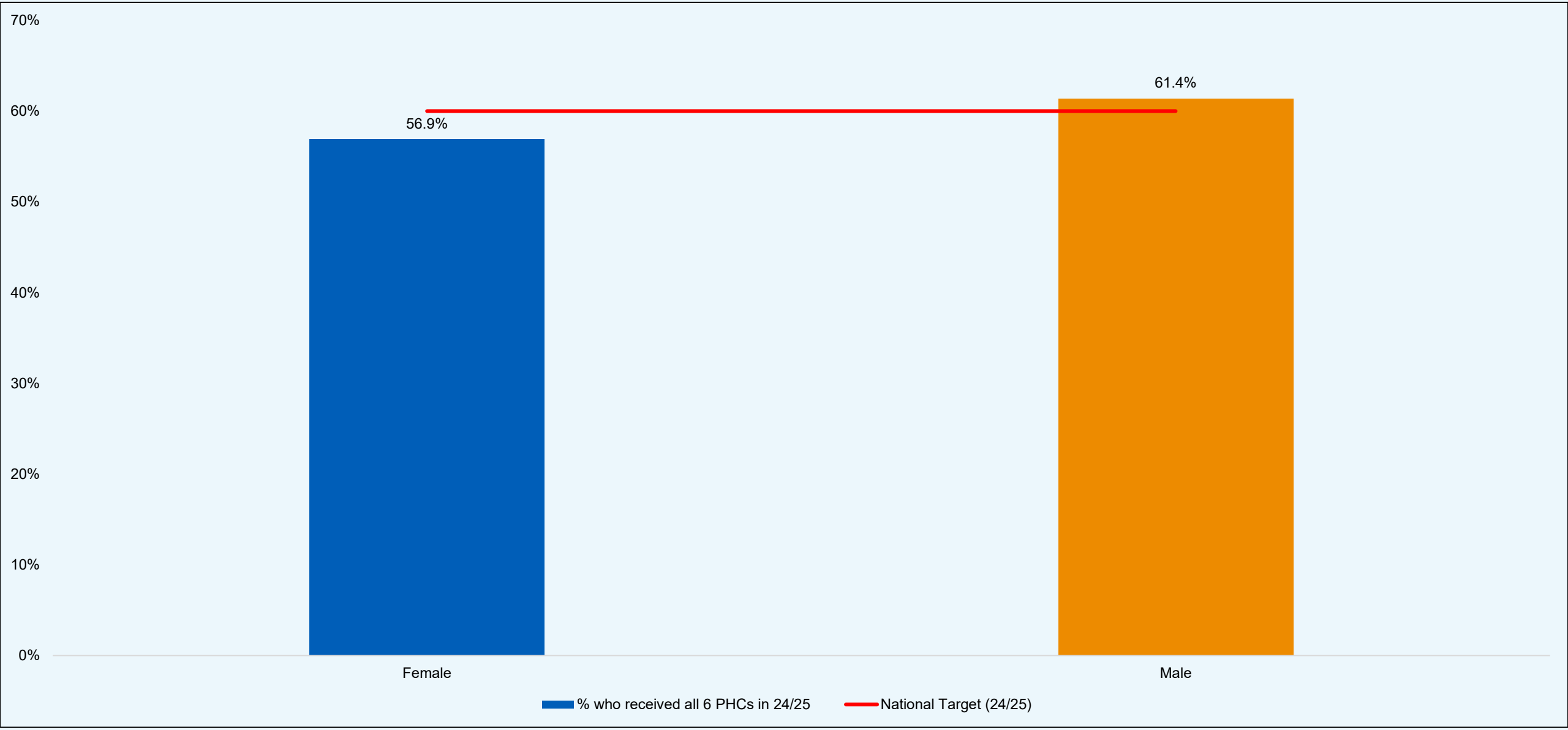
Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Overall number of Severe Mental Illness (SMI) physical health checks	N/A – New baseline				
Rates of total Mental Health Act detentions					
Rates of restrictive interventions					
NHS Talking therapies (formerly IAPT) - Reliable Recovery					
NHS Talking therapies (formerly IAPT) - Recovery					
CYP Mental Health Access					

Health Checks for people with Severe Mental Illness (SMI) by PCN

PCN	01/04/21 to 31/03/22	01/04/22 to 31/03/23	01/04/23 to 31/03/24	01/04/24 to 31/03/25
Apex				71.0% (220/310)
Boston				63.2% (240/380)
East Lindsey				75.0% (240/320)
First Coastal				52.5% (320/610)
Four Counties				69.8% (150/215)
Grantham and Rural				69.5% (330/475)
Imp				61.2% (300/490)
K2 Healthcare Sleaford				73.6% (265/360)
Lincoln Health Partnership				49.2% (160/325)
Meridian Medical				64.9% (185/285)
South Lincoln				62.3% (165/265)
South Lincolnshire Rural				75.0% (345/460)
Spalding				67.9% (190/280)
Trent Care				50.7% (185/365)
Lincolnshire ICB Average	***45.6% (1966/4313)***	***58.2% (2957/5082)***	***64.5% (3272/5071)***	***64.3% (3300/5135)***
England Average	***42.8% (226583/529093)***	***58.5% (313022/535204)***	***59.9% (361210/527556)***	***66.5% (315118/473976)***

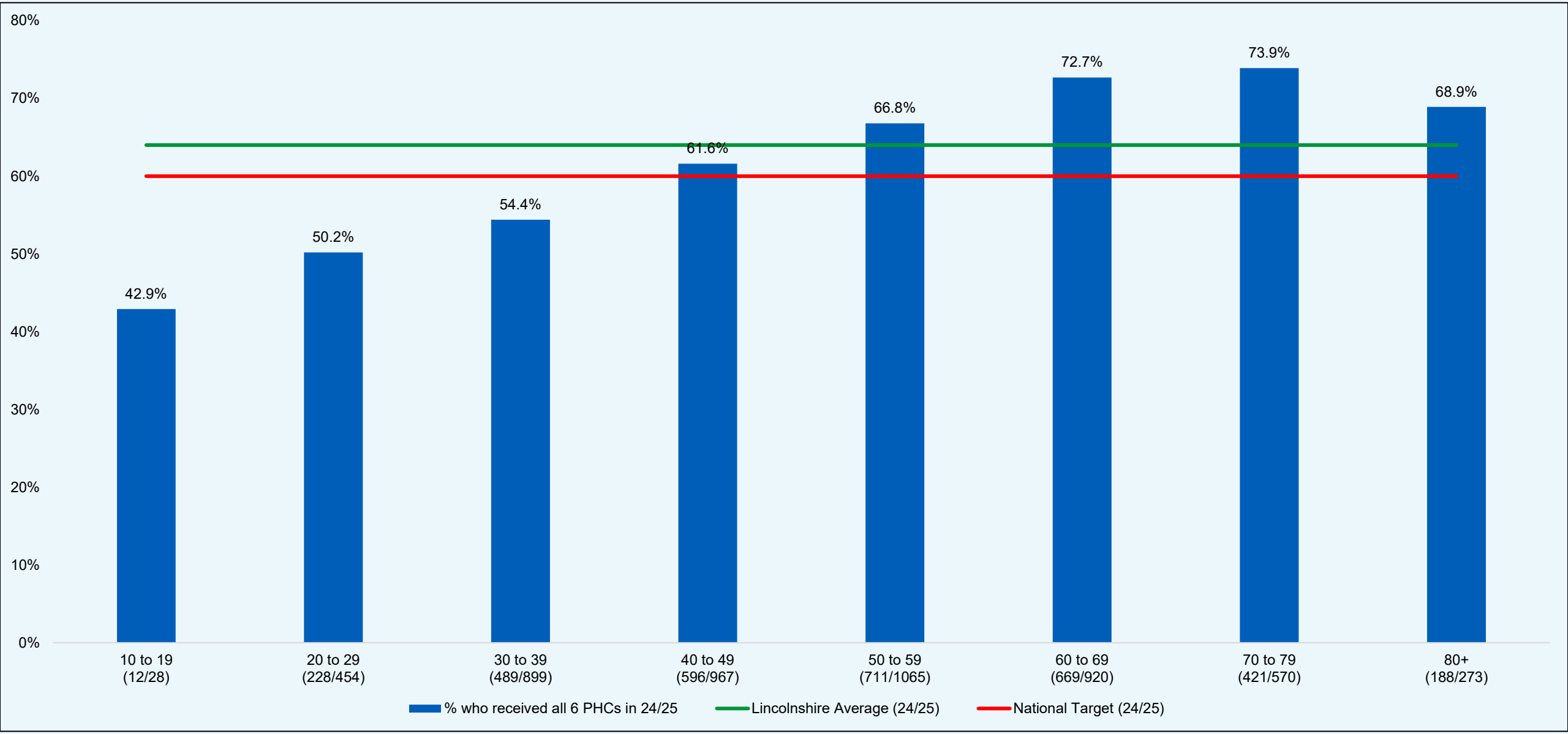
Sources: Physical Health Checks for People with Severe Mental Illness (21/22; 22/23; 23/24); Physical Health Checks for People with Severe Mental Illness

Health Checks for people with Severe Mental Illness (SMI) by Sex



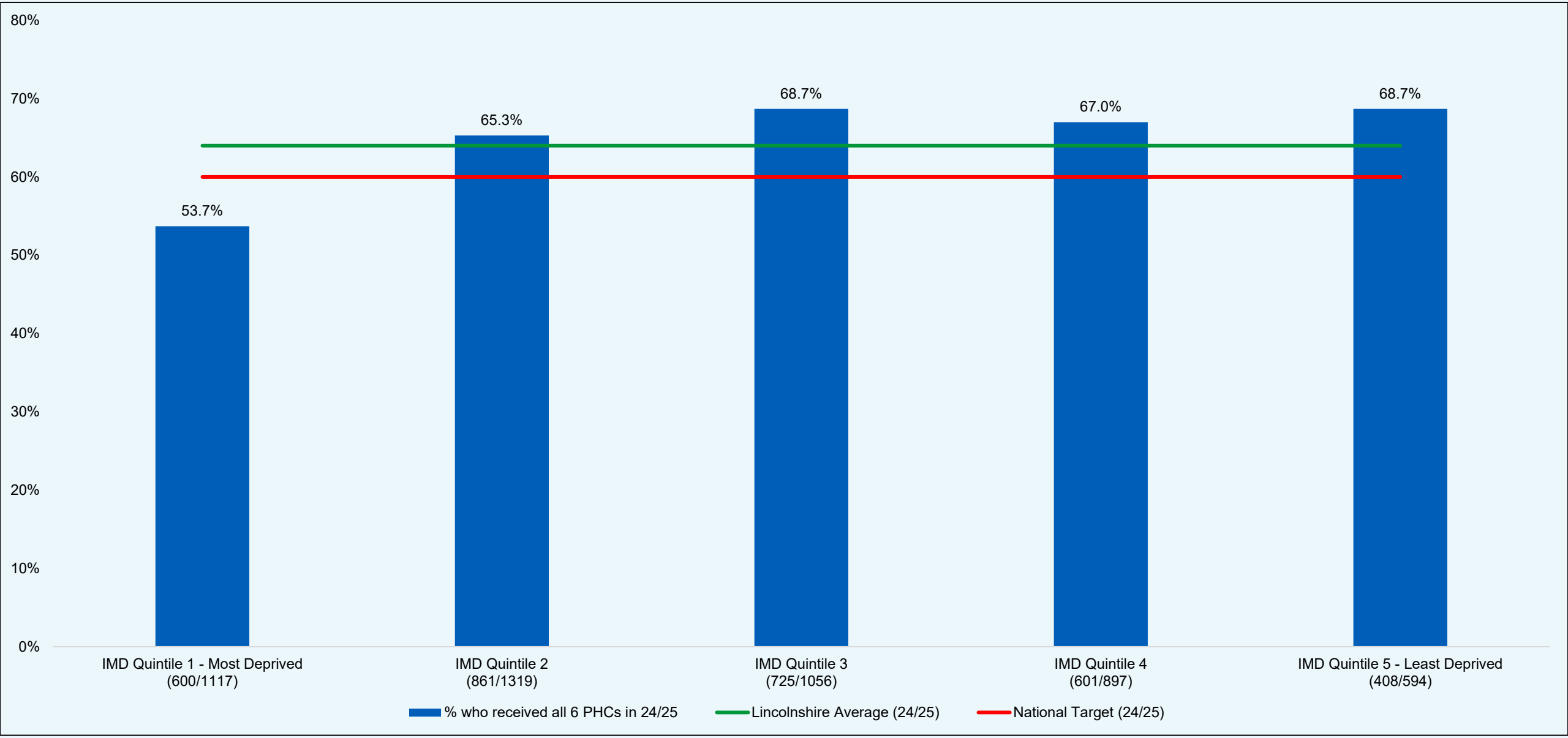
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Health Checks for people with Severe Mental Illness (SMI) by Age Group



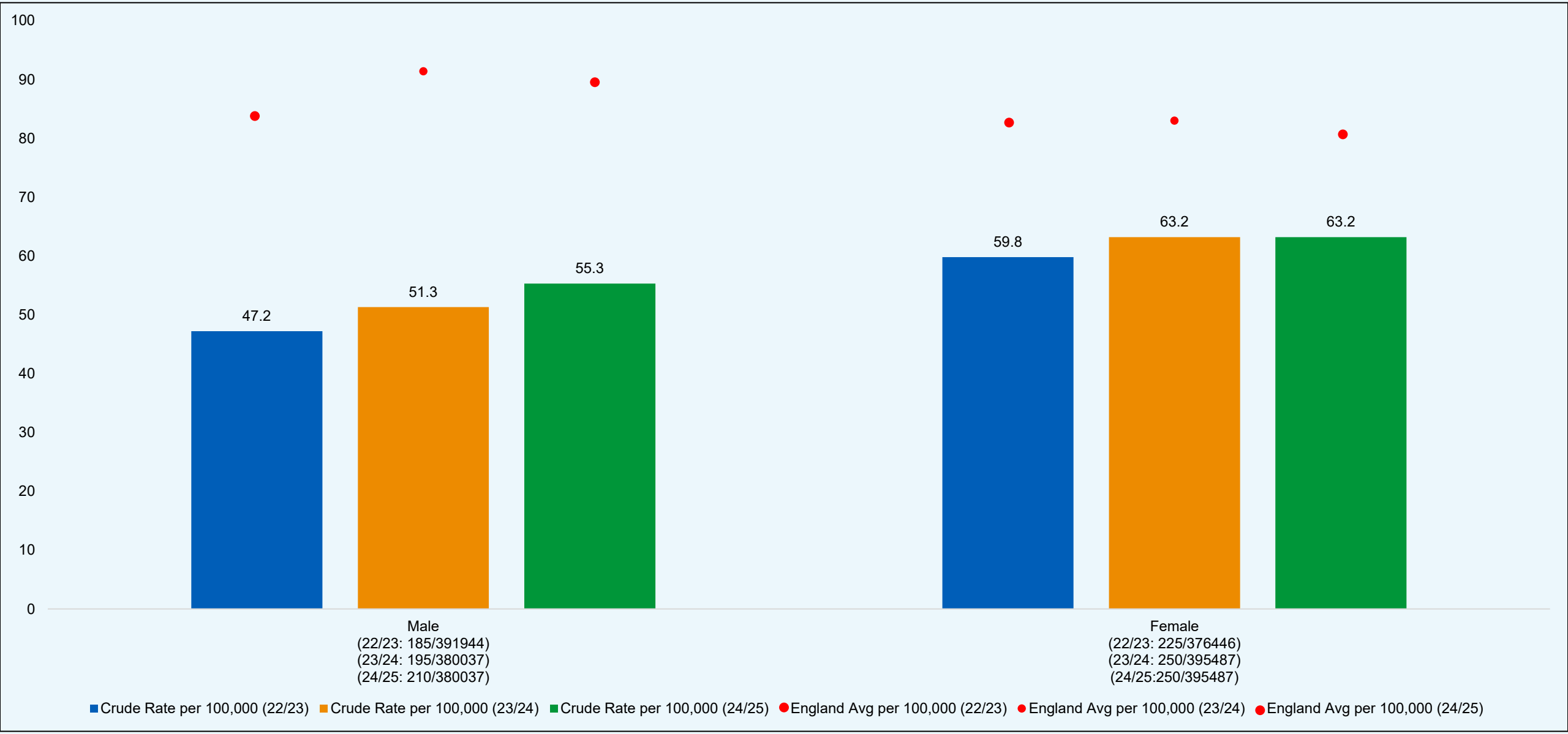
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Health Checks for people with Severe Mental Illness (SMI) by Deprivation Quintile



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Sex



Sources: Mental Health Act Statistics 22/23 (Tables 1i and 1j); Mental Health Act Statistics 23/24 (Tables 1i and 1j);

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Sex

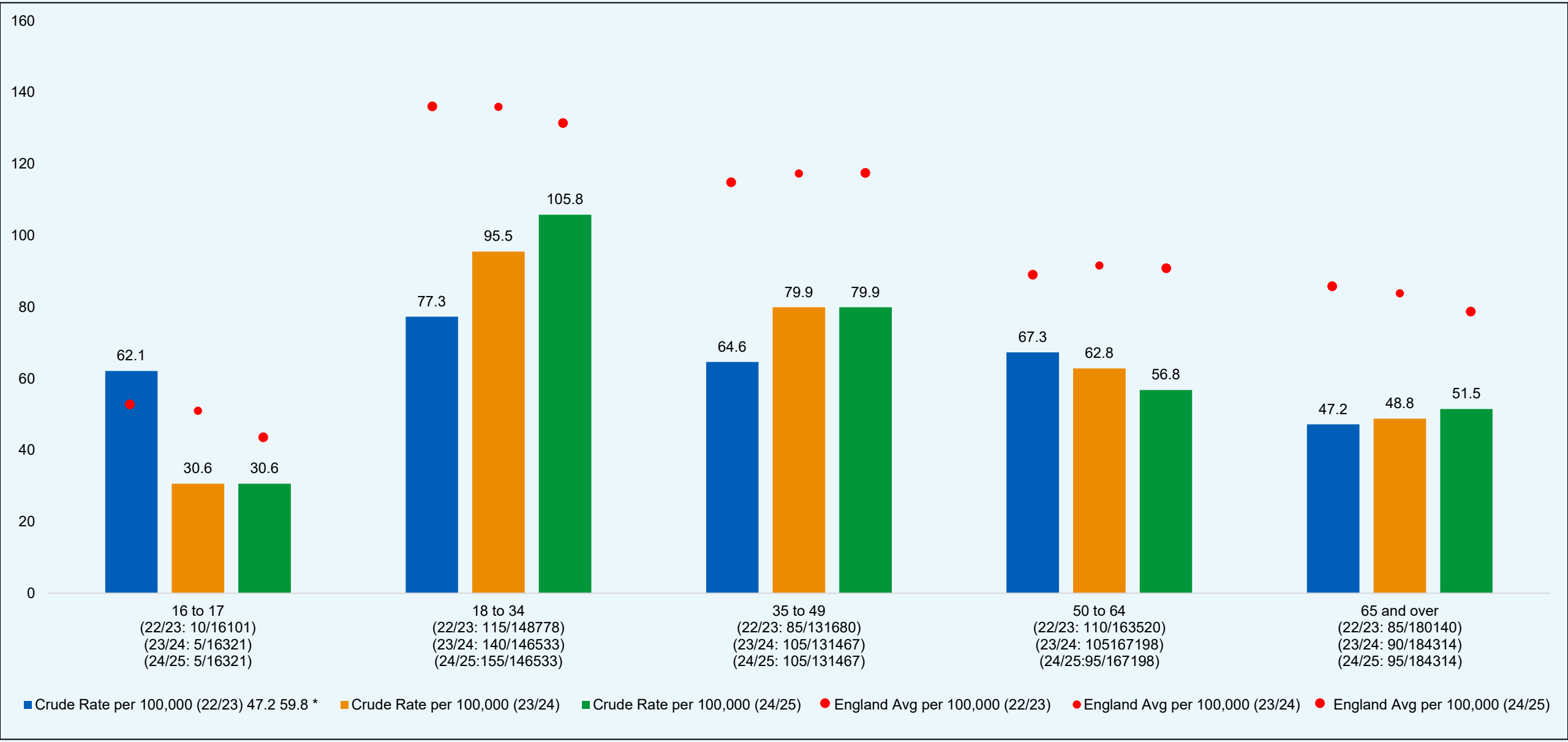
In 23/24, the crude rate of MHA detentions in Lincolnshire ICB was 57.4 per 100,000. When we split the data by sex, we can see that females have a higher crude rate of MHA detentions than males, a difference of 11.9 more MHA detentions per 100,000.

In 24/25, the crude rate of MHA detentions in Lincolnshire ICB was 59.3 per 100,000 (an increase of 1.9 MHA detentions per 100,000 in 23/24). Females accounted for 63.2 MHA detentions per 100,000 and males accounting for 55.3 MHA detentions per 100,000 – a difference of 7.9 more MHA detentions per 100,000.

This suggests there has been a narrowing of the gap between males and females who are subject to an MHA detention – explained by the increase in the rate of males subject to an MHA detention and no change in the rate of females subject to an MHA detention.

As the rate presented is a crude rate, it may be that the overall male and female populations respectively have been used which may not be the most appropriate because it may hide significant differences in the risk between the male and female population. For example, the female population may have a greater number of people who are more likely to be of an age where a detention under the Mental Health Act is likely. There are likely to be differences in the population distribution of males and females across the different deprivation deciles as well; as other analyses show, there is a higher crude rate of people who are from deprived areas who are detained under the Mental Health Act.

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Age Group



Sources: Mental Health Act Statistics 22/23 (Tables 1i and 1j); Mental Health Act Statistics 23/24 (Tables 1i and 1j)

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Age Group

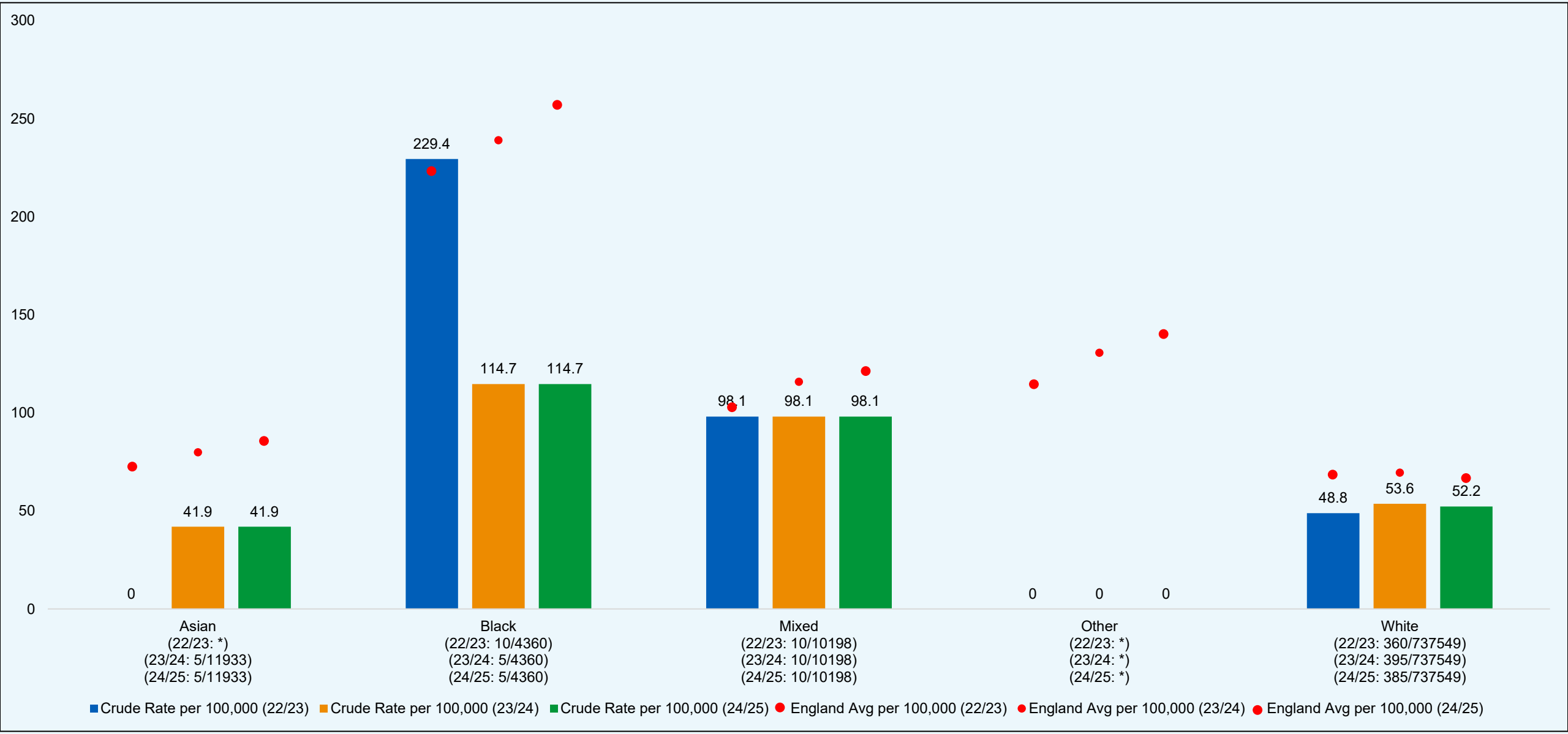
In 23/24, the crude rate of MHA detentions in Lincolnshire ICB was 57.4 per 100,000. When we split the data by age group, we can see those between the ages of 18 and 34 have the highest crude rate (95.5 per 100,000), with 16- to 17-year-olds accounting for the lowest crude rate (30.6 per 100,000).

In 24/25, the crude rate of MHA detentions in Lincolnshire was 59.3 per 100,000. When we split the data by age groups, we can see those between the ages of 18 and 34 have the highest crude rate (105.8 per 100,000), with 16- to 17-year-olds accounting for the lowest crude rate (30.6 per 100,000).

Focussing on the 18- to 34-year-olds, it appears the gap has increased between all other age groups in 24/25 compared to the gap in 23/24. This appears to be driven by the increase in the crude rate of MHA detentions in 18- to 34-year-olds, and much smaller changes in other age groups (mainly reductions and no changes, with the exception of those aged 65 and over when the crude rate slightly increases).

A potential explanation for the higher proportion of 18 to 34 year olds who have an MHA detention is that they live in more deprived areas – and subsequent analysis shows those from a more deprived background have a higher rate of MHA detentions. A further analysis taking account of multiple variables is needed to understand if there is a genuine inequality; it is also likely there are other explanations as younger populations may be more susceptible to mental health issues that require being detained under the MHA compared with older age groups.

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Ethnicity



Sources: Mental Health Act Statistics 22/23 (Tables 1i and 1j); Mental Health Act Statistics 23/24 (Tables 1i and 1j)

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Ethnicity

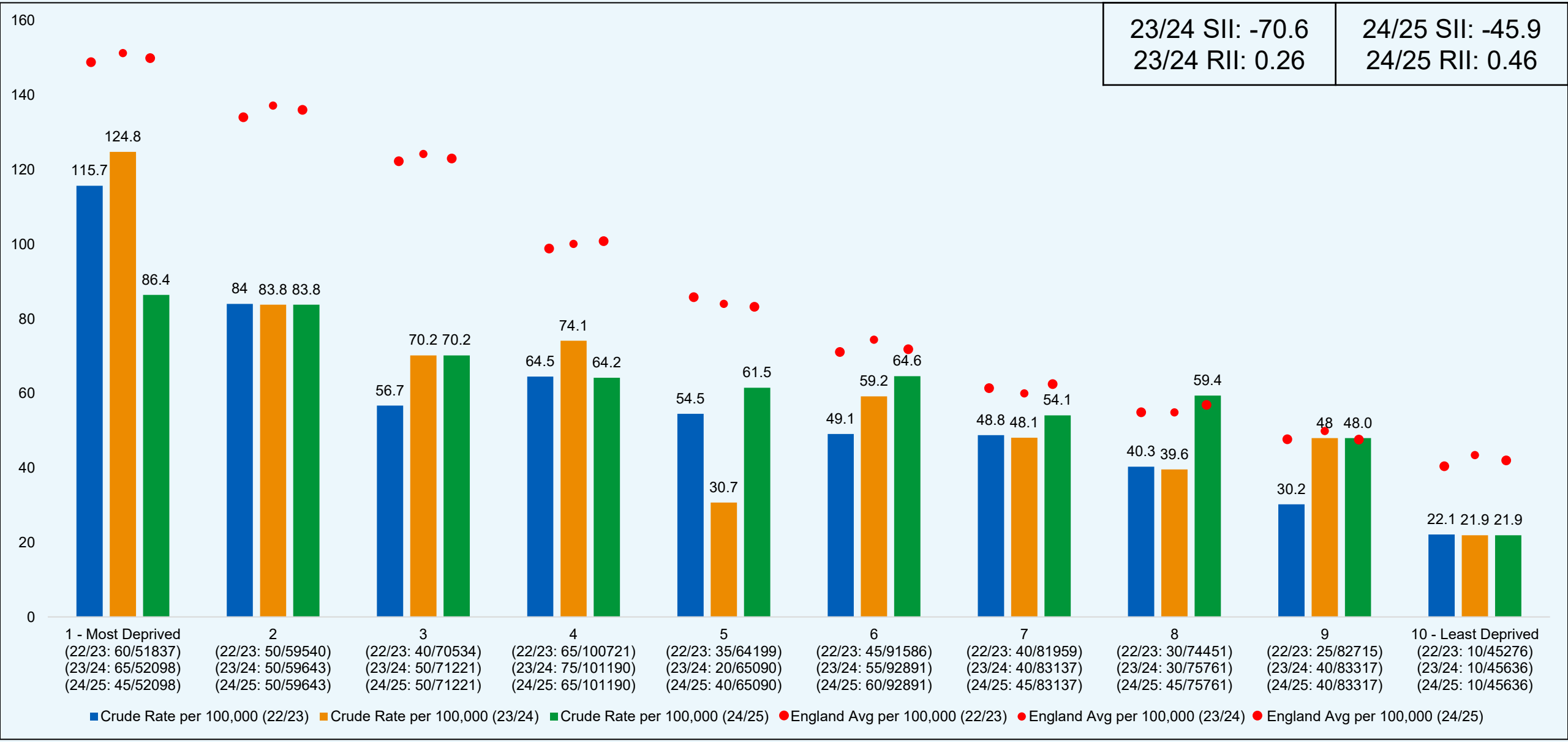
In 23/24, the crude rate of MHA detentions in Lincolnshire ICB was 57.4 per 100,000. When we split the data by ethnicity, we can see those from a black background had the highest rate of MHA detentions at 114.7 per 100,000.

In 24/25, the crude rate of MHA detentions in Lincolnshire was 59.3 per 100,000. When we split the data by ethnicity, we can see those from a black background had the highest rate of MHA detentions at 114.7 per 100,000.

It should be noted the small counts involved which can provide a misleading picture. The rate from those from an Asian, Black, and Mixed background stayed the same from 23/24 to 24/25, whereas the rate for those from a White background slightly decreased from 53.6 per 100,000 to 52.2 per 100,000.

As the rate presented is a crude rate, this may not be the most appropriate because it may hide significant differences in the risk between the different ethnic populations. For example, those from a Black background may live in more deprived areas of the county – and from following slides, we will see that people living in the most deprived parts of the county have a higher rate of MHA detentions than those who live in less deprived areas of Lincolnshire. It is not beyond the realms of imagination to think there is a higher proportion of those from an ethnic minority background who live in more deprived areas.

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Deprivation Decile



Sources: Mental Health Act Statistics 22/23 (Tables 1i and 1j); Mental Health Act Statistics 23/24 (Tables 1i and 1j)

Rates of Mental Health Act (MHA) detentions for 23/24 and 24/25 by Deprivation Decile

In 23/24, the crude rate of MHA detentions in Lincolnshire ICB was 57.4 per 100,000. When we split the data by deprivation decile, we can see a clear relationship where those who live in the most deprived parts of the county have a noticeably higher rate of MHA detentions than those who live in the least deprived parts of the county – in fact, this rate is about 5 times greater in those who live in the most deprived decile than those who live in the least deprived decile.

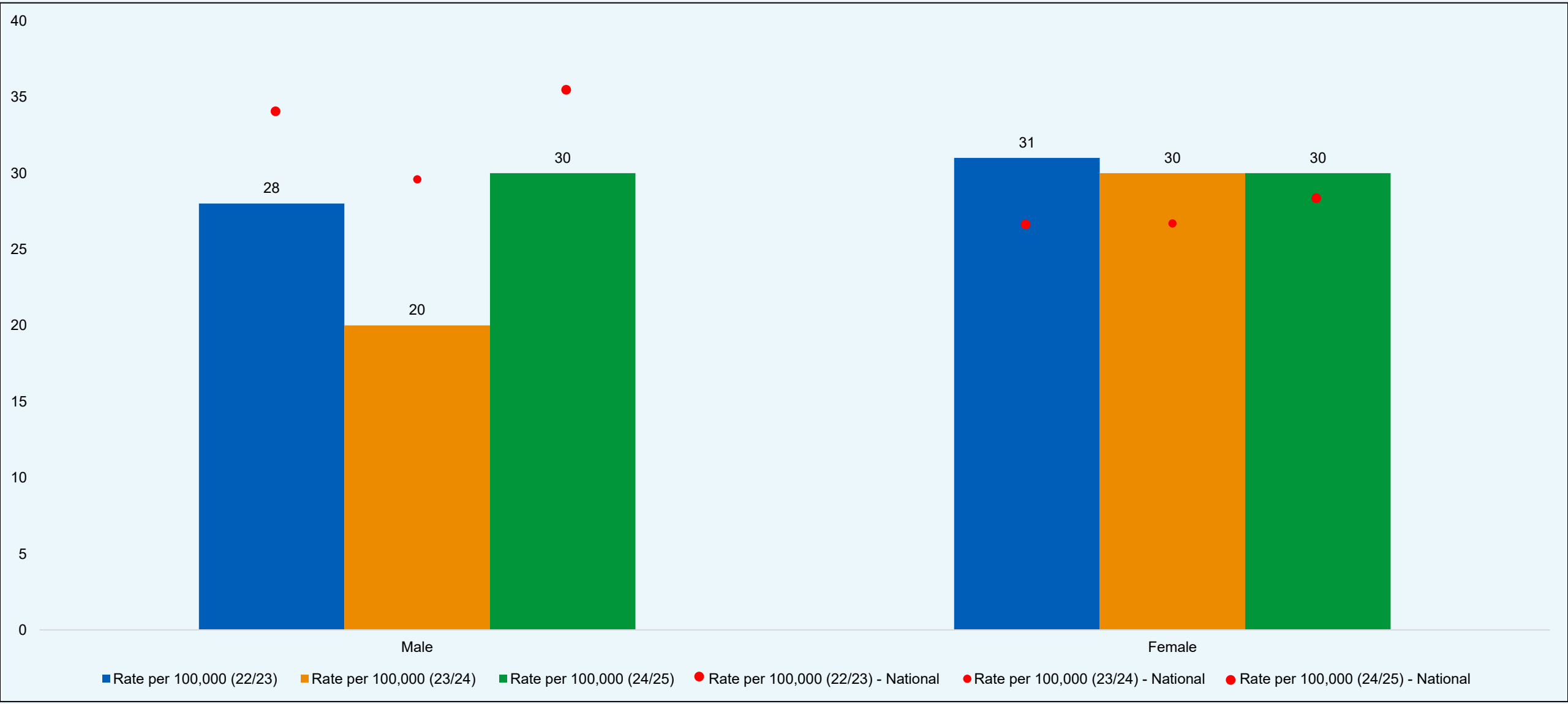
In 24/25, the crude rate of MHA detentions in Lincolnshire ICB was 59.3 per 100,000. When we split the data by deprivation decile, we can see a clear relationship where those who live in the most deprived parts of the county have a noticeably higher rate of MHA detentions than those who live in the least deprived parts of the county – in fact, this rate is about 4 times greater in those who live in the most deprived decile than those who live in the least deprived decile.

In 23/24, the Slope Index of Inequality was -70.6 per 100,000. This means that as deprivation decreases, the rate of MHA detentions decreases, and the rate is quite significant. If we were to plot a line of best fit, the value in the least deprived decile would be 70.6 per 100,000 lower than the value in the most deprived decile. The Relative Index of Inequality was 0.26. Trying to put this as simply as possible, it means that those in the most deprived parts of the county are approximately 75% more likely to be detained under the Mental Health Act than those living in less deprived parts of the county.

In 23/24, the Slope Index of Inequality was -45.9 per 100,000. This means that as deprivation decreases, the rate of MHA detentions decreases, and the rate is quite significant. If we were to plot a line of best fit, the value in the least deprived decile would be 45.9 per 100,000 lower than the value in the most deprived decile. The Relative Index of Inequality was 0.46. Trying to put this as simply as possible, it means that those in the most deprived parts of the county are approximately 50% more likely to be detained under the Mental Health Act than those living in less deprived parts of the county.

This shows a small improvement in the gap between those from the most deprived and least deprived areas who are subject to an MHA detention, largely driven by the reduction of MHA detentions in those from the most deprived decile.

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Sex



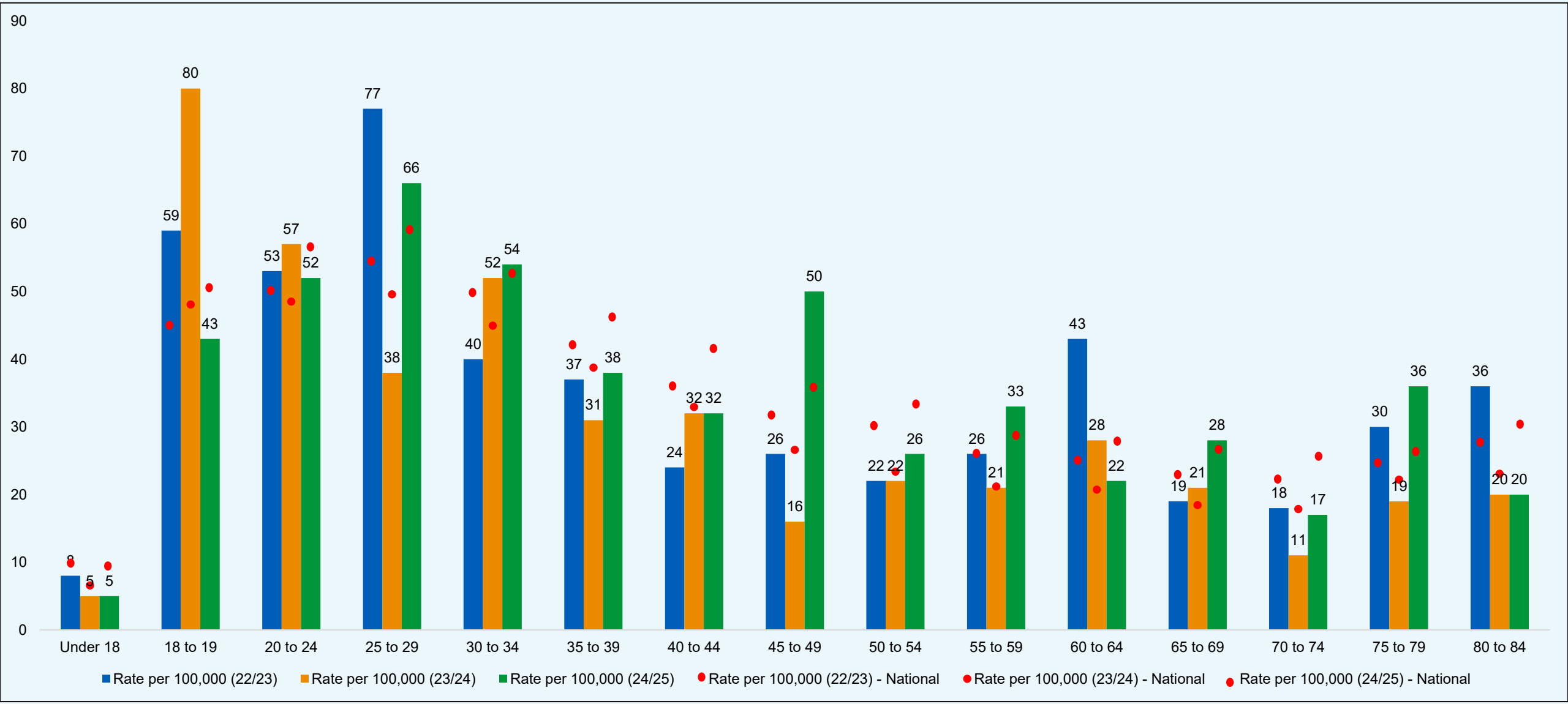
Sources: Mental Health Bulletin 22/23 (indicator 7d); Mental Health Bulletin 23/24 (indicator 7d); Mental Health Bulletin 24/25 (indicator 7d)

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Sex

Between April 2024 and March 2025, there were 30 restrictive interventions per 100,000 of the population in contact with NHS funded secondary mental health, learning disabilities and autism services in Lincolnshire ICB. This is an increase from a rate of 25 restrictive interventions per 100,000 between April 2023 and March 2024. In 23/24, females had a higher rate of restrictive interventions than males (30 per 100,000 for females; 20 per 100,000 for males); but in 24/25, the rate of restrictive interventions for males and females was 30 per 100,000. It should be noted that the rate of restrictive interventions in males in Lincolnshire ICB has been lower than the national average for males, whereas the rate of restrictive interventions for females in Lincolnshire ICB has been higher than the national average for females.

The use of crude rates across stratifications such as sex, age group, ethnicity, and deprivation decile can be misleading because crude rates do not adjust for the underlying demographic composition of each subgroup. Different subgroups can have varying age distributions or other risk factors that inherently influence the likelihood of being subject to a restrictive intervention. For instance, if one ethnic group has a higher proportion of younger individuals compared to another, a crude rate may inadvertently attribute differences to ethnicity rather than to age-related risk factors. This methodological flaw means that any inequalities we observed might reflect differences in population structure rather than true differences in service-related outcomes. Presenting crude rates without age-standardisation (or other forms of adjustment) prevents a fair comparison across groups, particularly when the groups are not demographically equivalent. This can lead to misinterpretation, where a higher crude rate in one group might be driven by its demographic profile rather than by systemic issues or inequalities within the services provided.

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Age Group



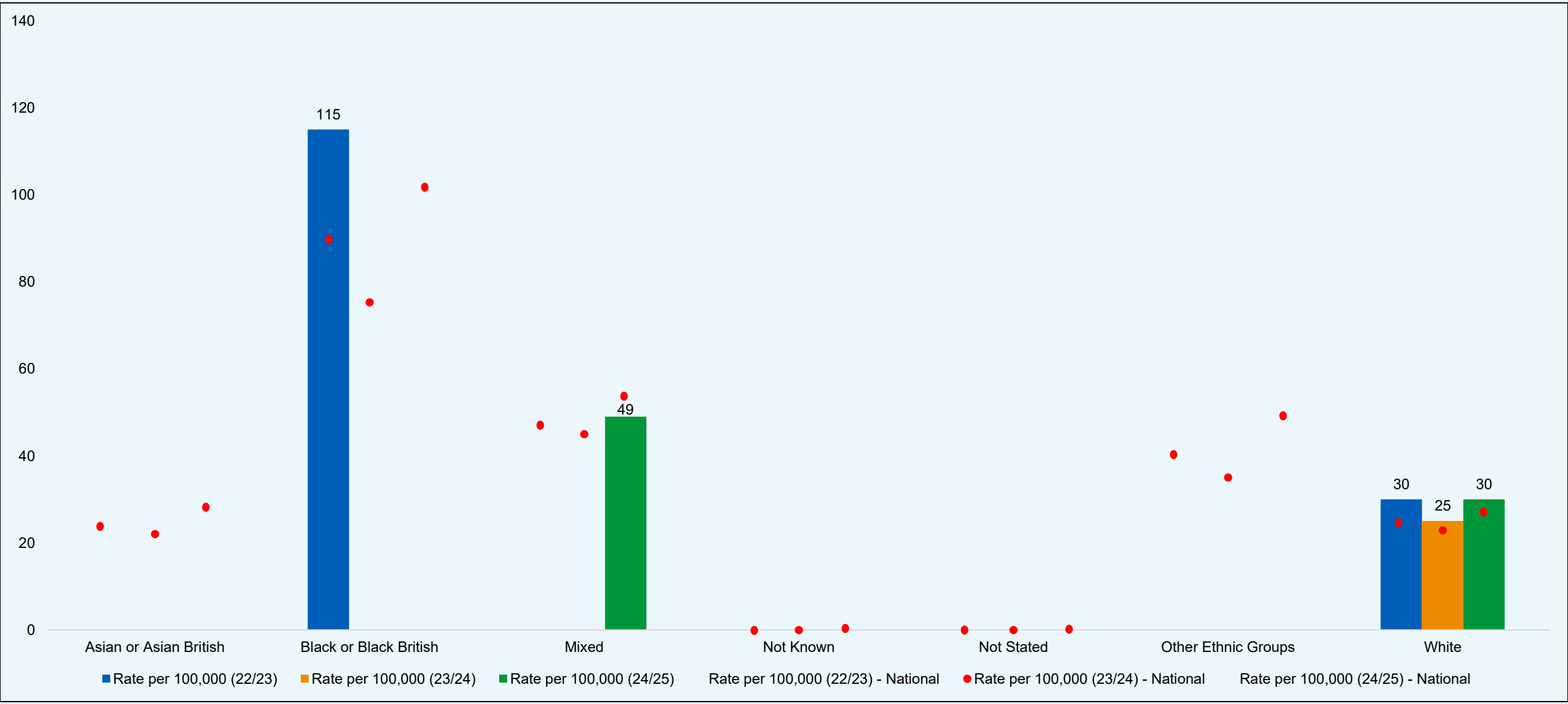
Sources: Mental Health Bulletin 22/23 (indicator 7d); Mental Health Bulletin 23/24 (indicator 7d); Mental Health Bulletin 24/25 (indicator 7d)

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Age Group

Between April 2024 and March 2025, there were 30 restrictive interventions per 100,000 of the population in contact with NHS funded secondary mental health, learning disabilities and autism services in Lincolnshire ICB. This is an increase from a rate of 25 restrictive interventions per 100,000 between April 2023 and March 2024.

Between 2023/24 and 2024/25, the overall crude rate of restrictive interventions per 100,000 population remained relatively stable across most age groups, though several notable shifts are apparent. The most striking increase occurred among young adults aged 25 to 29, where the rate rose sharply from 38 to 66 per 100,000, moving from well below to above the national average. A similar upward trend is seen in the 30 to 34 and 45 to 49 age groups, both of which increased considerably from the previous year and now exceed or match national levels. In contrast, rates for 18- to 19-year-olds and 20- to 24-year-olds both fell, aligning more closely with or slightly below national figures, suggesting some reduction in restrictive practices among younger adults. Among older adults, trends were mixed: some groups such as 55 to 59 and 65 to 69 saw increases from 21 to 33 and from 21 to 28 respectively, while others, including 60 to 64 and 70 to 74, remained stable or declined. The under-18 and 80 to 84 categories were unchanged at 5 and 20 per 100,000 respectively, consistent with the national picture. Overall, the 2024/25 data indicate widening variation between age groups, with particularly marked rises in early and mid-adulthood compared to the more stable or modest rates observed in both the youngest and oldest cohorts.

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Ethnicity



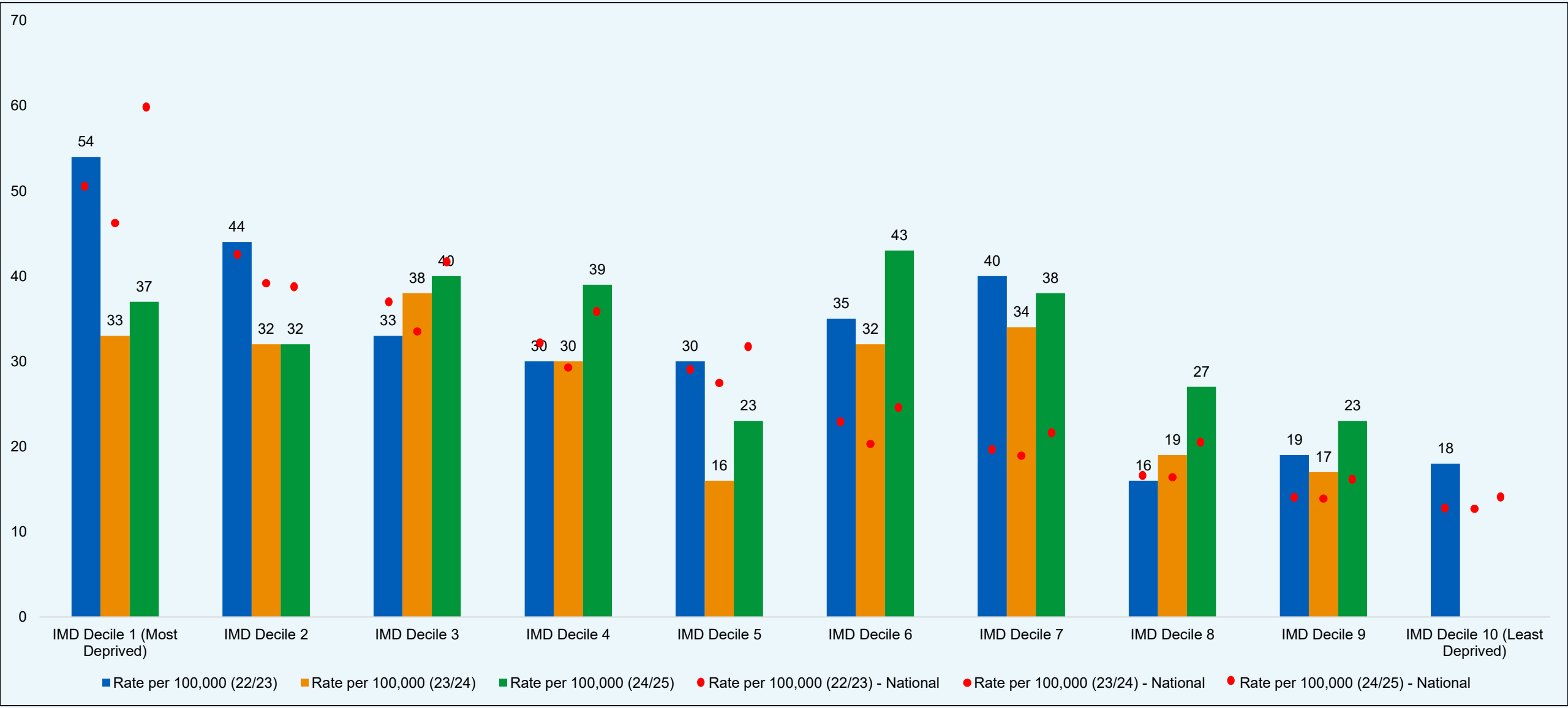
Sources: Mental Health Bulletin 22/23 (indicator 7d); Mental Health Bulletin 23/24 (indicator 7d); Mental Health Bulletin 24/25 (indicator 7d)

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Ethnicity

Between April 2024 and March 2025, there were 30 restrictive interventions per 100,000 of the population in contact with NHS funded secondary mental health, learning disabilities and autism services in Lincolnshire ICB. This is an increase from a rate of 25 restrictive interventions per 100,000 between April 2023 and March 2024.

It is difficult to provide any conclusive narrative for this chart considering the crude rate has been suppressed (likely due to low counts). It is worth noting the drop for those from a Black or Black British background decreased from 115.8 per 100,000 in 22/23 to a lower number that could not be disclosed in 23/24 and in 24/25. We do not know the reasons for this, and considering the counts are quite low, natural variation cannot be discounted as a reason. There may have been service improvements or other reasons for this drop. It is worth noting the rate overall increased from 25 per 100,000 in 23/24 to 30 per 100,000 in 24/25. It is also worth noting that the White population in the Lincolnshire ICB has a higher rate than the White rate for England overall.

Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Deprivation Decile



Sources: Mental Health Bulletin 22/23 (indicator 7d); Mental Health Bulletin 23/24 (indicator 7d); Mental Health Bulletin 24/25 (indicator 7d)

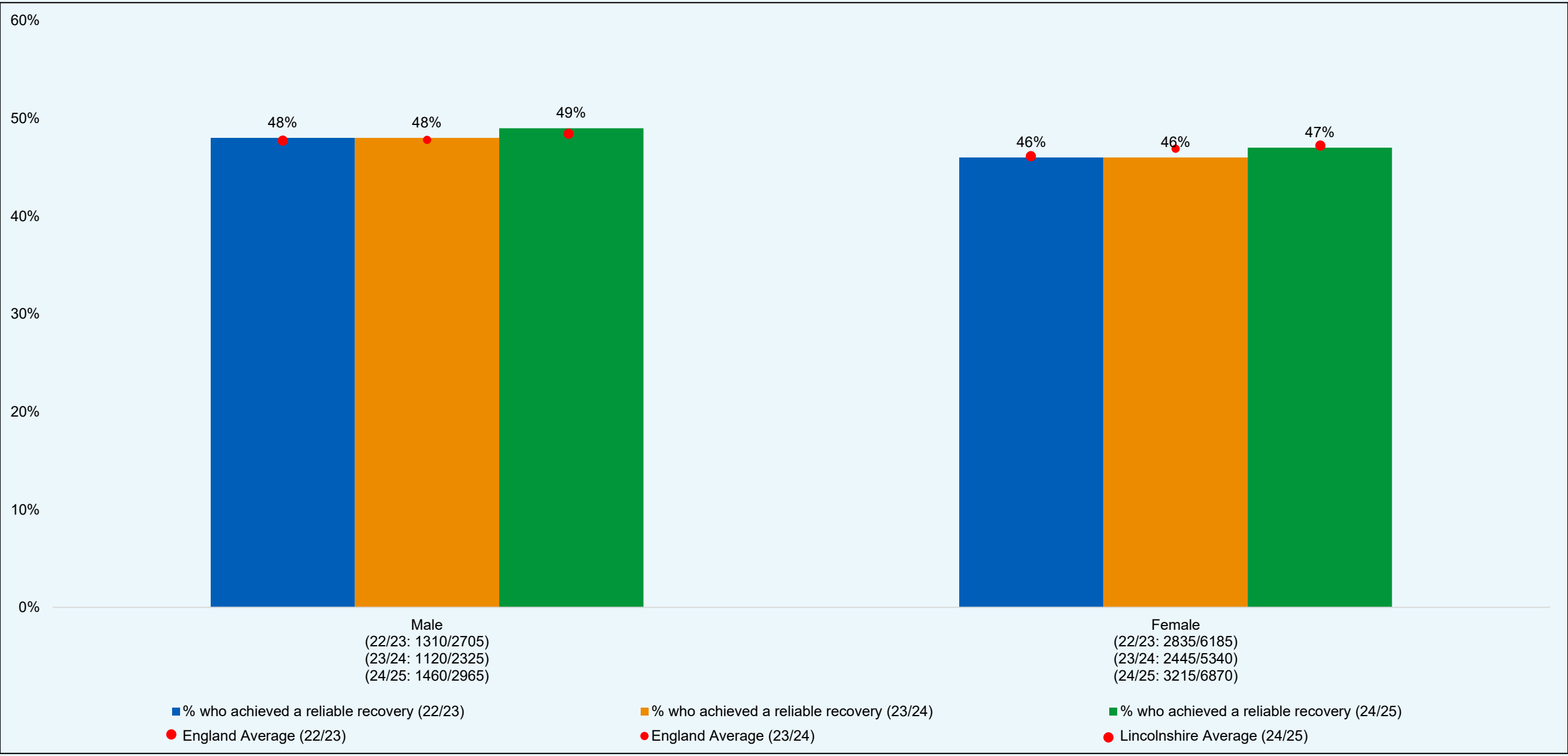
Crude rate of people subject to a restrictive intervention in contact with NHS funded secondary mental health, learning disabilities and autism services per 100,000 population by Deprivation Decile

Between April 2024 and March 2025, there were 30 restrictive interventions per 100,000 of the population in contact with NHS funded secondary mental health, learning disabilities and autism services in Lincolnshire ICB. This is an increase from a rate of 25 restrictive interventions per 100,000 between April 2023 and March 2024.

Between 2022/23 and 2024/25, the rate of restrictive interventions per 100,000 population shows a broadly consistent relationship with deprivation, though some notable changes emerge over time. Overall, rates remain highest in the most deprived deciles and lowest in the least deprived, indicating a continuing social gradient. However, while the overall pattern is stable, the magnitude of difference between the most and least deprived has narrowed slightly in 2024/25 due to moderate reductions in the most deprived deciles and increases among some of the middle deprivation groups.

When presenting these figures, several limitations arise that could significantly affect how the data are interpreted. First, there is a lack of transparency regarding both the numerator and the denominator: without clear definitions of what constitutes a “restrictive intervention” in the numerator and which population exactly is represented in the denominator, any conclusions drawn may be based on mismatched or incomplete information. For example, if the numerator includes all recorded instances of restrictive interventions without accounting for repeat interventions on the same individual, and the denominator is simply the total population rather than the number of individuals in contact with these specific services, the resulting rate could either exaggerate or underestimate the true incidence.

% of people at caseness who had a ‘Reliable Recovery’ outcome once they accessed NHS talking therapies by Sex



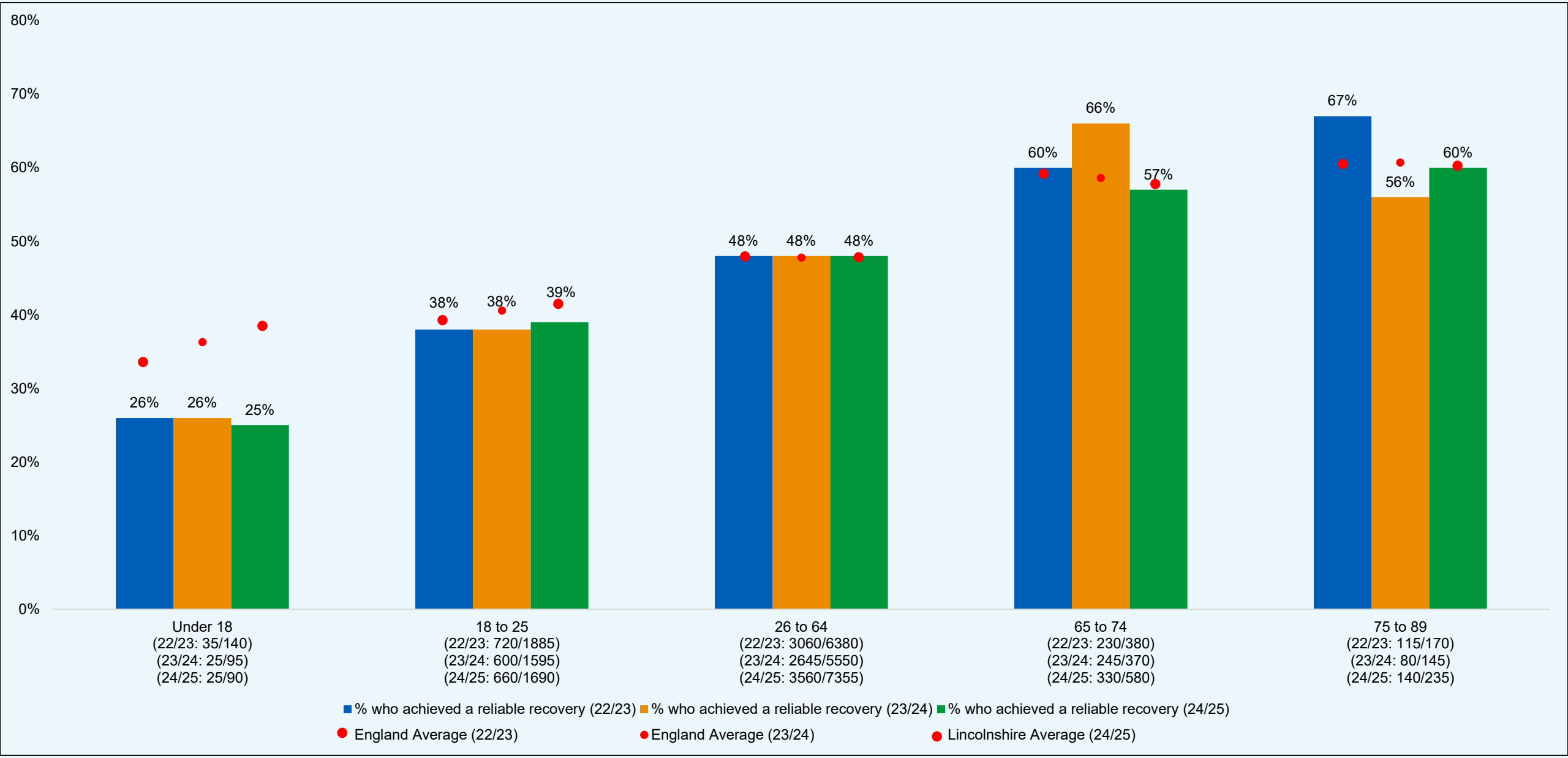
Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

% of people at caseness who had a ‘Reliable Recovery’ outcome once they accessed NHS talking therapies by Sex

Between April 2023 and March 2024, 47% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘reliable recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, and there has been significant improvement in their conditions. This is an increase of 1 percentage point from 46% in 23/24.

There was a slight difference observed between males and females in both 23/24 and 24/25 who achieved a reliable recovery, with males having a slightly higher proportion of those who achieved a reliable recovery (49%) compared to females (47%). This gap of 2 percentage points stayed the same in 23/24. It should be noted that in both reporting periods, males only accounted for approximately a third of all talking therapy referrals. This difference in referral rates may have a bearing on the observed outcomes. Men are generally less likely to seek psychological support due to a range of factors, including social stigma around mental health, reluctance to acknowledge emotional difficulties, and differences in help-seeking behaviours. As a result, the men who do engage with talking therapies may present with more severe symptoms, be more motivated to engage with treatment, or have fewer alternative coping mechanisms compared to women, which could influence their reliable recovery rates. Conversely, the higher referral rate among women might mean that a broader spectrum of severity is represented in female participants. This could include individuals with more complex or long-standing mental health conditions, which may make achieving reliable recovery more challenging.

% of people at caseness who had a ‘Reliable Recovery’ outcome once they accessed NHS talking therapies by Age Group



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

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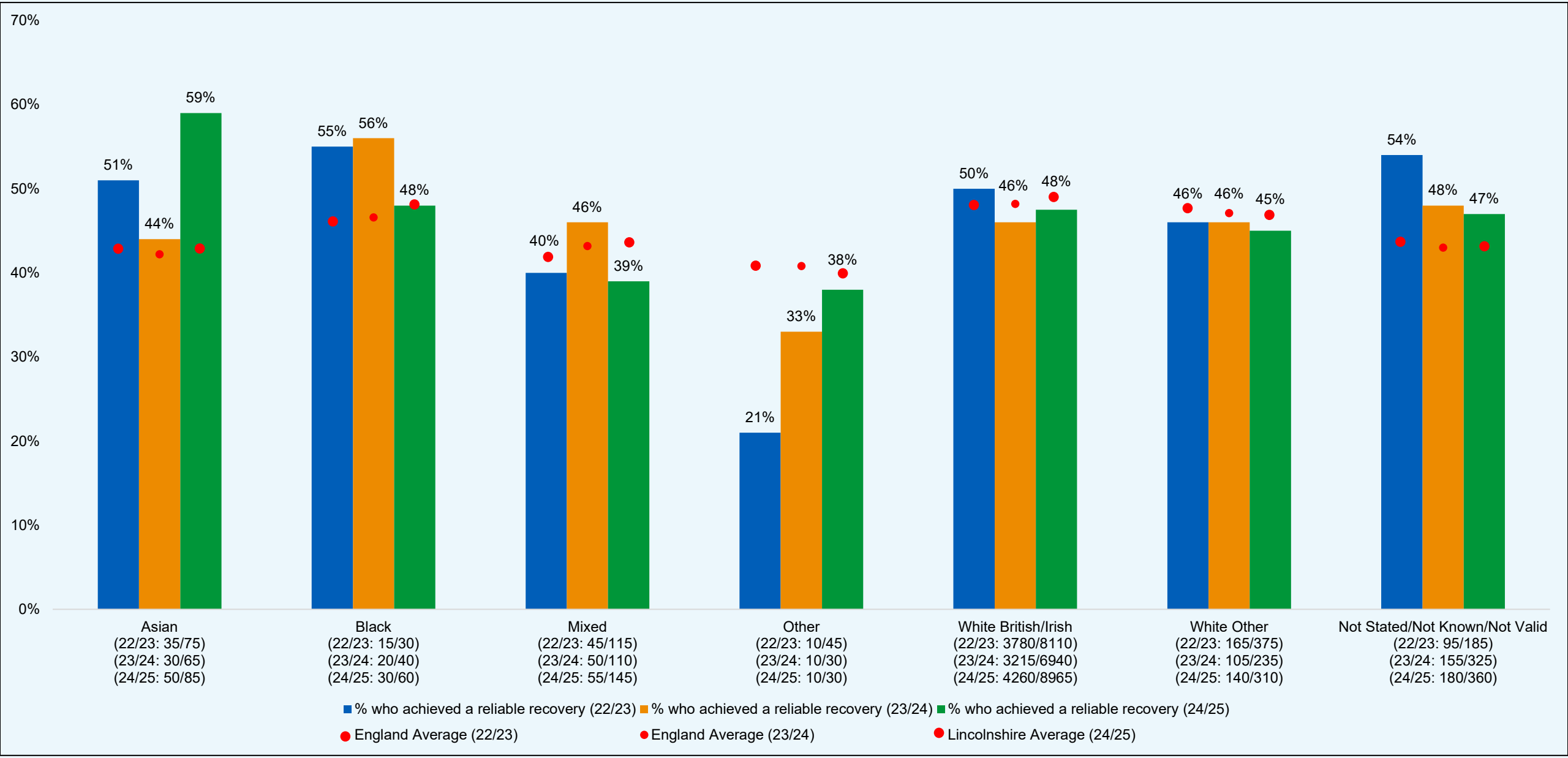
The proportion of individuals achieving a reliable recovery varies across age groups. Broadly, we see an increase in reliable recovery rates with age, with the highest rates observed in the 65-74 and 75-89 age groups. Conversely, the lowest rates are seen among the youngest cohort (under 18s), followed by the 18-25-year-old group.

The number of individuals receiving talking therapy also varies significantly by age. The younger (under 18) and older (75-89) age groups have a relatively small number of referrals compared to working-age adults (26-64). These smaller sample sizes may contribute to more variable reliable recovery rates, as minor changes in outcomes can have a disproportionate effect when dealing with smaller numbers. For example, if only a small number of individuals in the youngest or oldest age groups achieve a reliable recovery, the percentage change may appear larger than in the middle age groups, where a greater number of people access therapy. This variability can sometimes make trends appear more pronounced than they actually are.

% of people at caseness who had a ‘Reliable Recovery’ outcome once they accessed NHS talking therapies by Ethnicity



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

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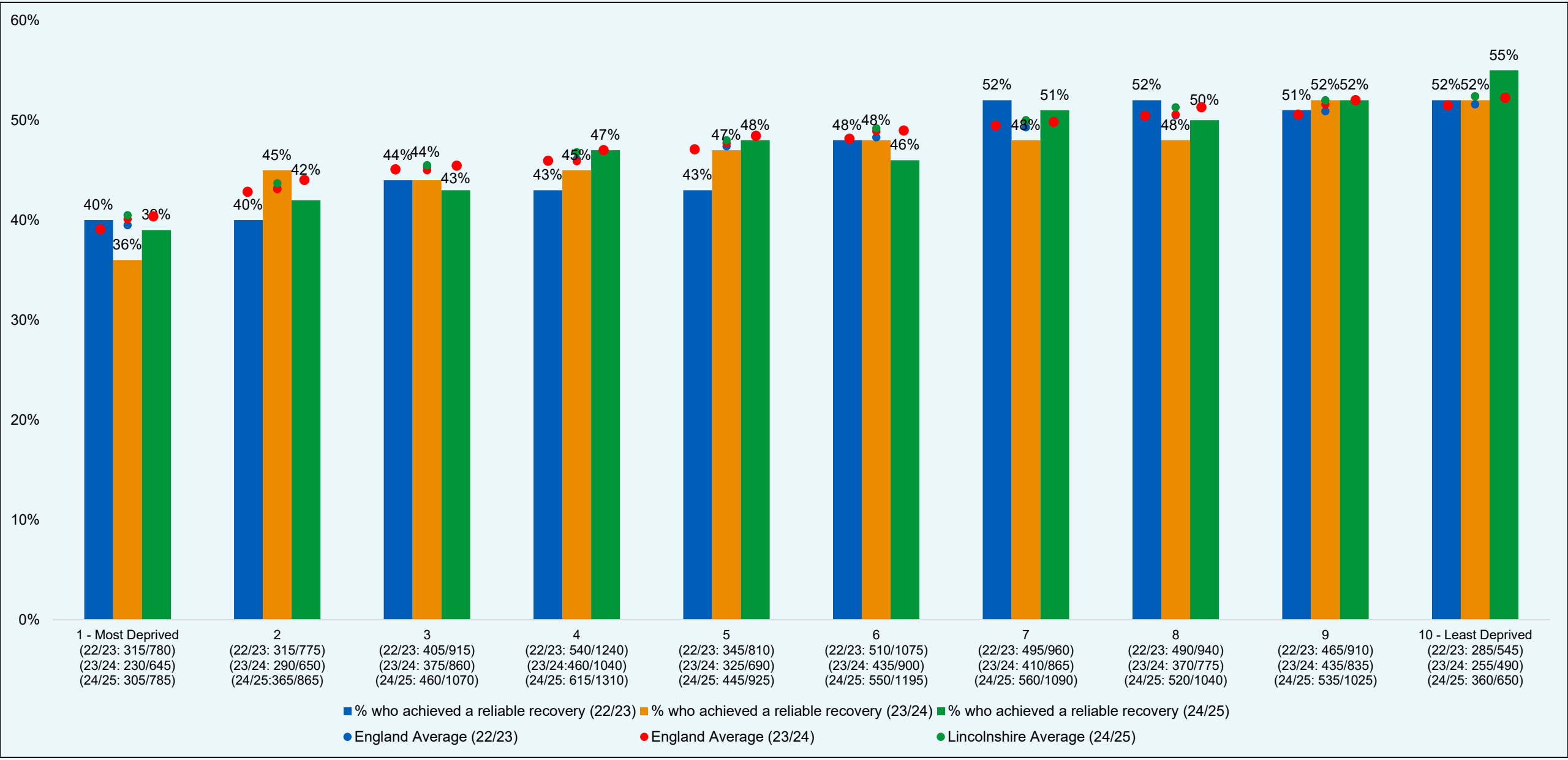
The proportion of individuals achieving a reliable recovery varies across ethnicities. Considering many of the ethnic minority groups have very low counts compared to the White British population (both in terms of the numerator and the denominator), this makes it difficult to determine whether there are genuine health inequalities in achieving a reliable recovery by ethnicity. The small counts also make a year-on-year comparison difficult.

% of people at caseness who had a 'Reliable Recovery' outcome once they accessed NHS talking therapies by Deprivation Decile



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

% of people at caseness who had a ‘Reliable Recovery’ outcome once they accessed NHS talking therapies by Deprivation Decile

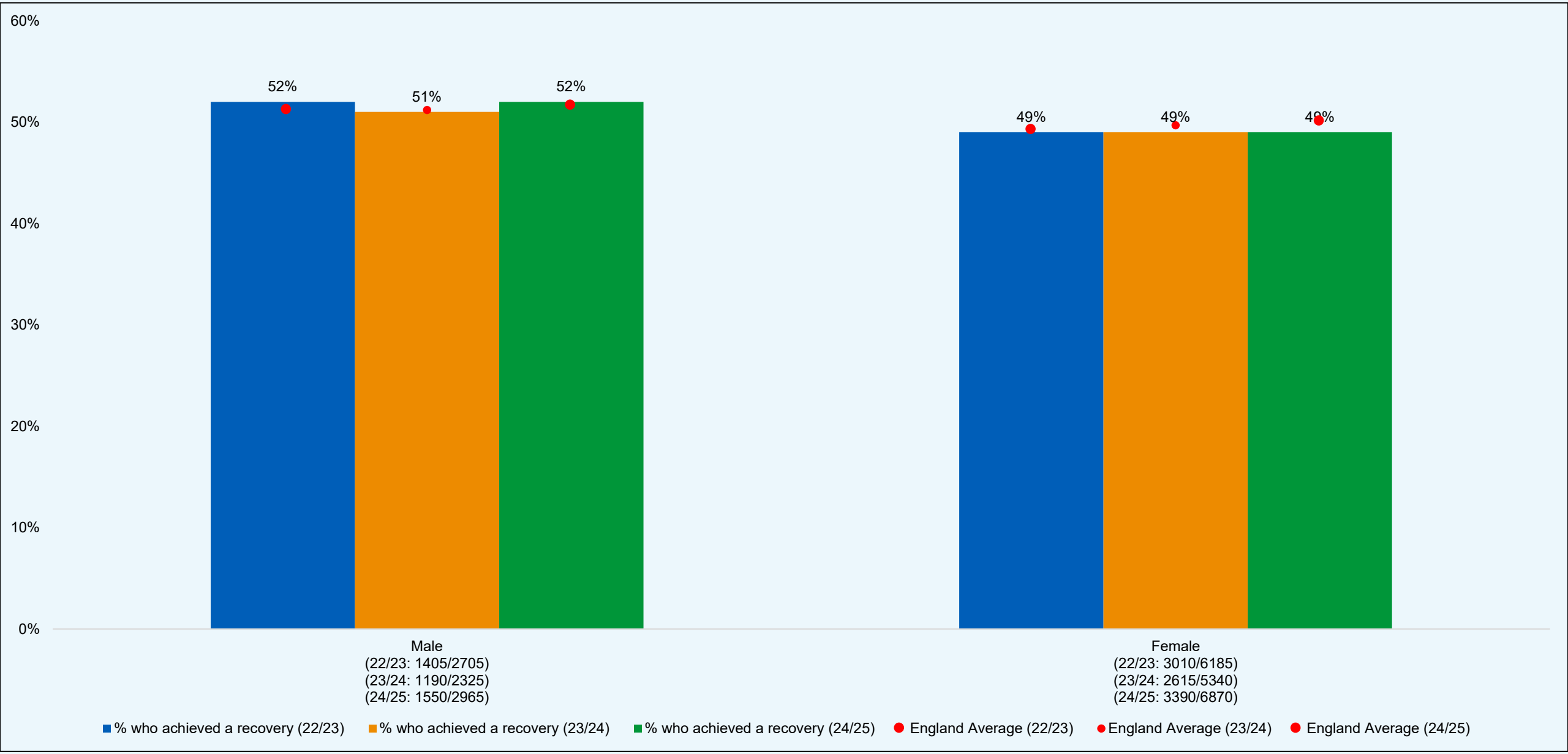
Between April 2023 and March 2024, 47% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘reliable recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, and there has been significant improvement in their conditions. This is an increase of 1 percentage point from 46% in 23/24.

The proportion of individuals achieving a reliable recovery varies across deprivation deciles. The main conclusion from this chart is that the difference in those achieving a reliable recovery is worse in those in the most deprived parts of the county, and better in the least deprived parts of the county. The gap between the most deprived and the least deprived stays at 16 percentage points in 24/25 (most deprived decile had 39% who achieved a reliable recovery; least deprived decile had 55% who achieved a reliable recovery).

For 23/24, the Slope Index of Inequality (SII) is 12.94%; this means those who live in the least deprived parts of the county have, on average, a 12.94% higher probability of achieving a reliable recovery outcome compared to those living in the most deprived parts. The Relative Index of Inequality is 1.33; this means that, on average, people who live in less deprived areas are approximately 33% more likely to achieve a reliable recovery than those in the most deprived parts of the county. This suggests that deprived is associated with poorer outcomes following therapy, and those living in more affluent areas have better reliable recovery rates. There may be other factors driving this observation, such as the severity of anxiety or depression with which those in more deprived areas present.

For 24/25, the Slope Index of Inequality (SII) is 14.50%; this means those who live in the least deprived parts of the county have, on average, a 14.50% higher probability of achieving a reliable recovery outcome compared to those living in the most deprived parts. The Relative Index of Inequality is 1.36; this means that, on average, people who live in less deprived areas are approximately 36% more likely to achieve a reliable recovery than those in the most deprived parts of the county. This suggests that deprived is associated with poorer outcomes following therapy, and those living in more affluent areas have better reliable recovery rates. There may be other factors driving this observation, such as the severity of anxiety or depression with which those in more deprived areas present.

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Sex



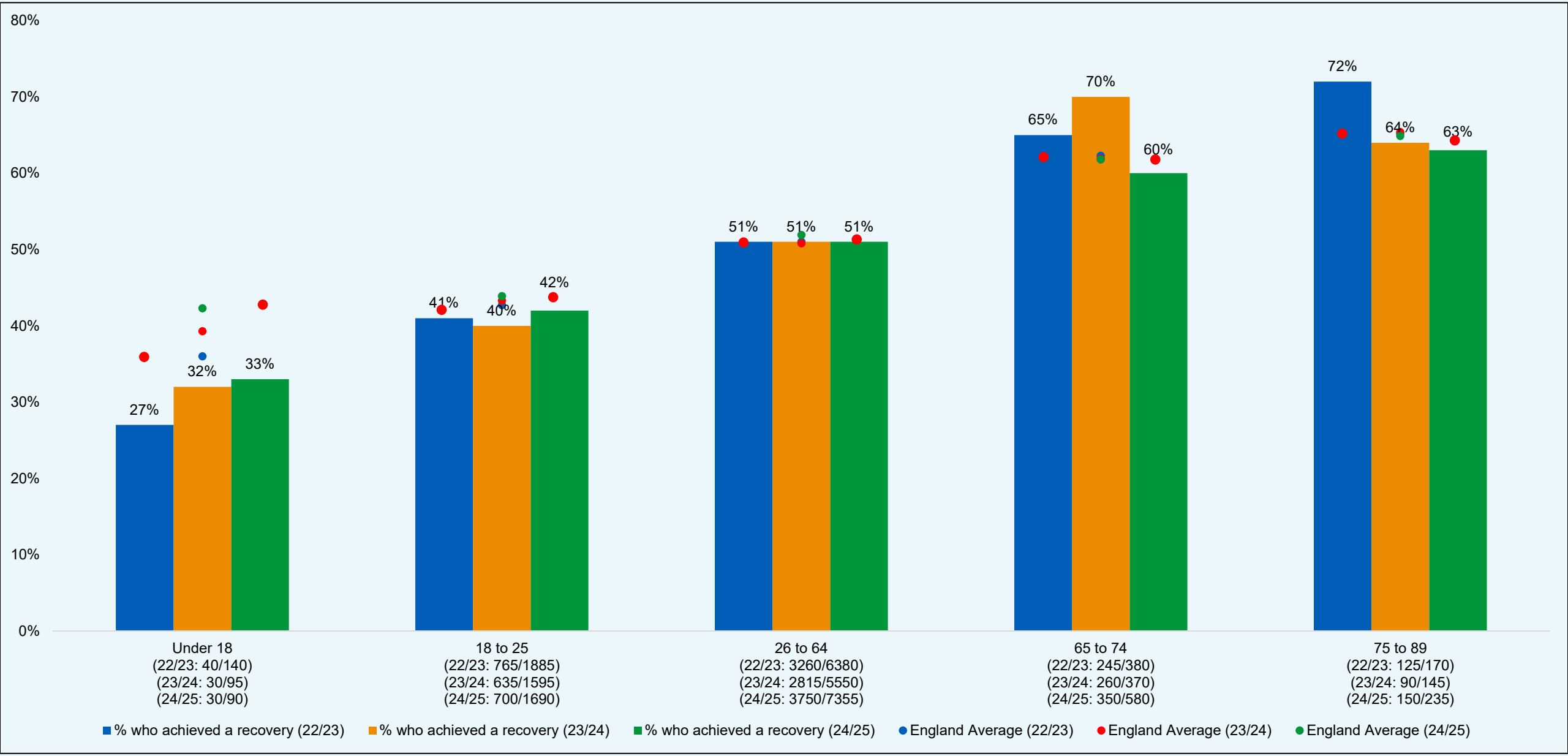
Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Sex

Between April 2023 and March 2024, 49% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This increased to 50% in 23/24.

There was a slight difference observed between males and females in both 23/24 and 24/25 who achieved a recovery, with males having a slightly higher proportion of those who achieved a recovery (51%) compared to females (49%) in 23/24. This gap widened slightly in 24/25, with 52% of males achieving a recovery and 49% of females achieving a recovery outcome. If should be noted that in both reporting periods, males only accounted for approximately a third of all talking therapy referrals. This difference in referral rates may have a bearing on the observed outcomes. Men are generally less likely to seek psychological support due to a range of factors, including social stigma around mental health, reluctance to acknowledge emotional difficulties, and differences in help-seeking behaviours. As a result, the men who do engage with talking therapies may present with more severe symptoms, be more motivated to engage with treatment, or have fewer alternative coping mechanisms compared to women, which could influence their recovery rates. Conversely, the higher referral rate among women might mean that a broader spectrum of severity is represented in female participants. This could include individuals with more complex or long-standing mental health conditions, which may make achieving recovery more challenging.

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Age Group



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

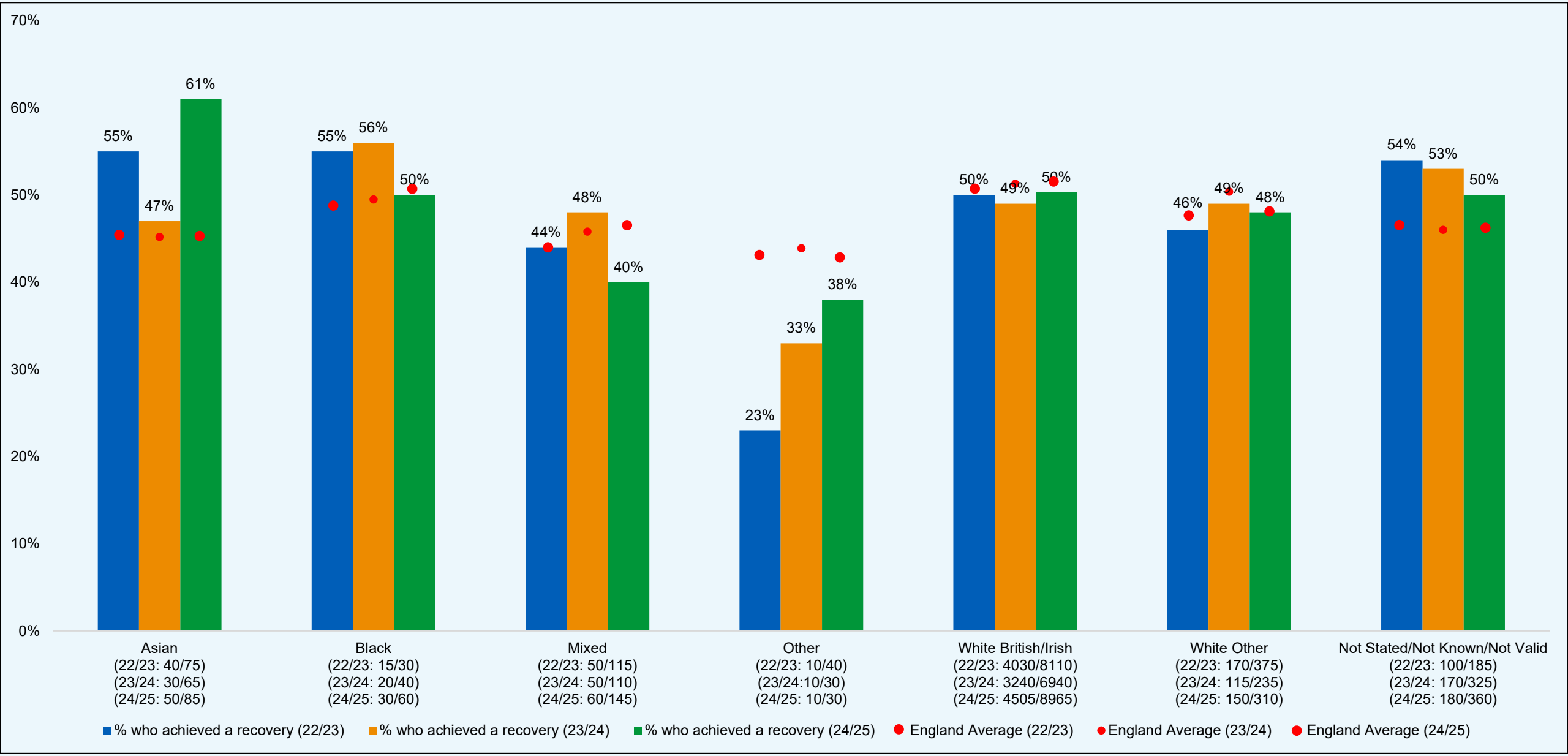
% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Age Group

Between April 2023 and March 2024, 49% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This increased to 50% in 23/24. **Under 18s had a significantly lower proportion who achieved a recovery compared to all other age groups.**

The proportion of individuals achieving a recovery varies across age groups. Broadly, we see an increase in recovery rates with age, with the highest rates observed in the 65-74 and 75-89 age groups. Conversely, the lowest recovery rates are seen among the youngest cohort (under 18s), followed by the 18-25-year-old group. A noticeable change from 23/24 to 24/25 is observed in the older age groups, where there was a decrease of 10 percentage points and 1 percentage point respectively for 65-to-74-year-olds and 75-to-89-year-olds. There was also a 1 percentage point increase and 2 percentage point increase observed in under 18s, and 18 to 25-year-olds respectively – indicating a slight narrowing of the gap between younger and older groups who achieve a recovery outcome from 23/24 to 24/25.

The number of individuals receiving talking therapy also varies significantly by age. The younger (under 18) and older (75-89) age groups have a relatively small number of referrals compared to working-age adults (26-64). These smaller sample sizes may contribute to more variable recovery rates, as minor changes in outcomes can have a disproportionate effect when dealing with smaller numbers. For example, if only a small number of individuals in the youngest or oldest age groups achieve a recovery, the percentage change may appear larger than in the middle age groups, where a greater number of people access therapy. This variability can sometimes make trends appear more pronounced than they actually are.

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Ethnicity



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

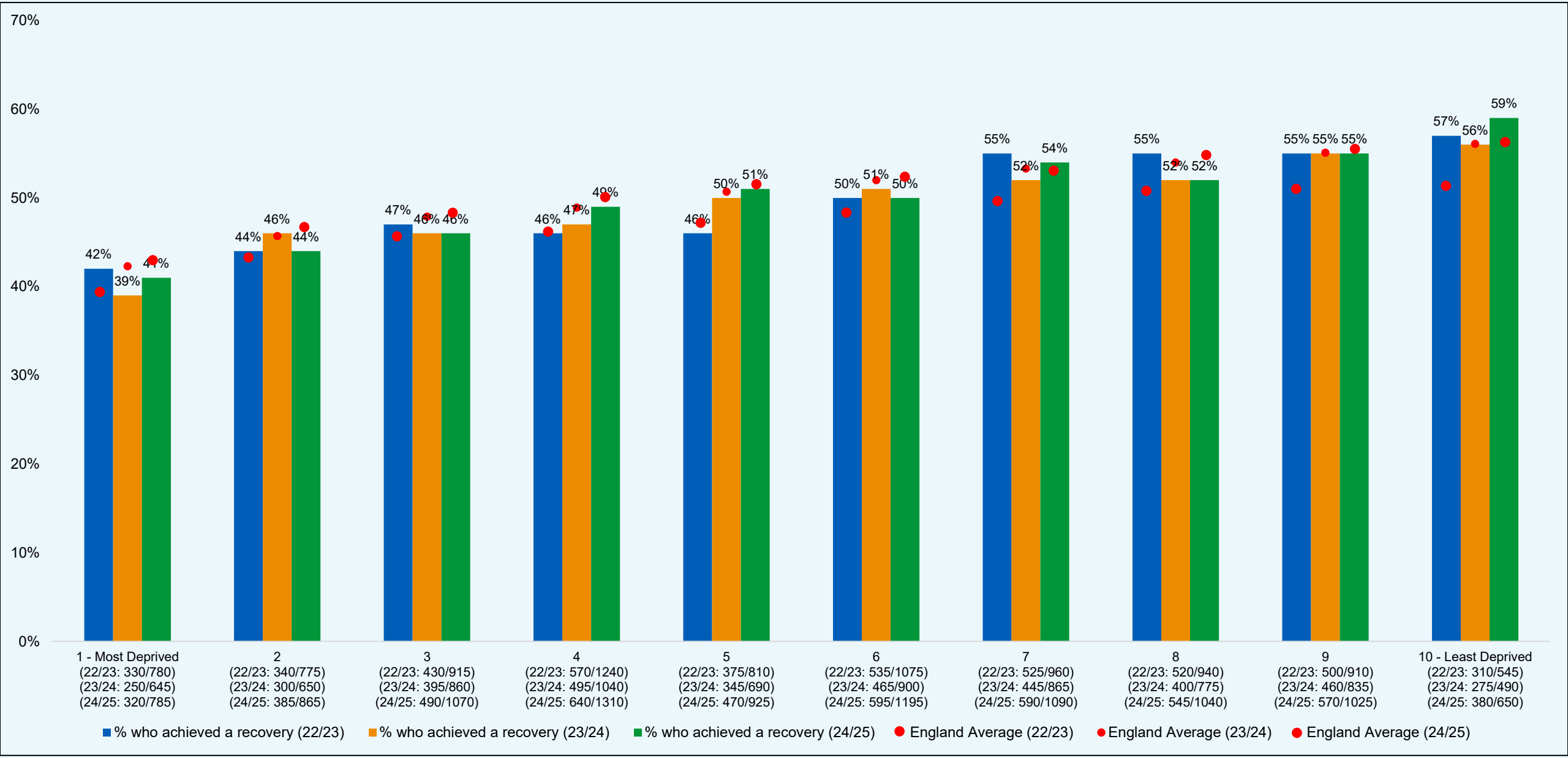
% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Ethnicity

Between April 2023 and March 2024, 49% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This increased to 50% in 23/24.

The proportion of individuals achieving recovery varies across ethnicities. Considering many of the ethnic minority groups have very low counts compared to the White British population (both in terms of the numerator and the denominator), this makes it difficult to determine whether there are genuine health inequalities in achieving a recovery by ethnicity. The small counts also make a year on year comparison difficult.

Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Deprivation Quintile



Sources: NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23; NHS Talking Therapies, for anxiety and depression, Annual reports, 2023-24; NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25

% of people at caseness who had a ‘Recovery’ outcome once they accessed NHS talking therapies by Deprivation Quintile

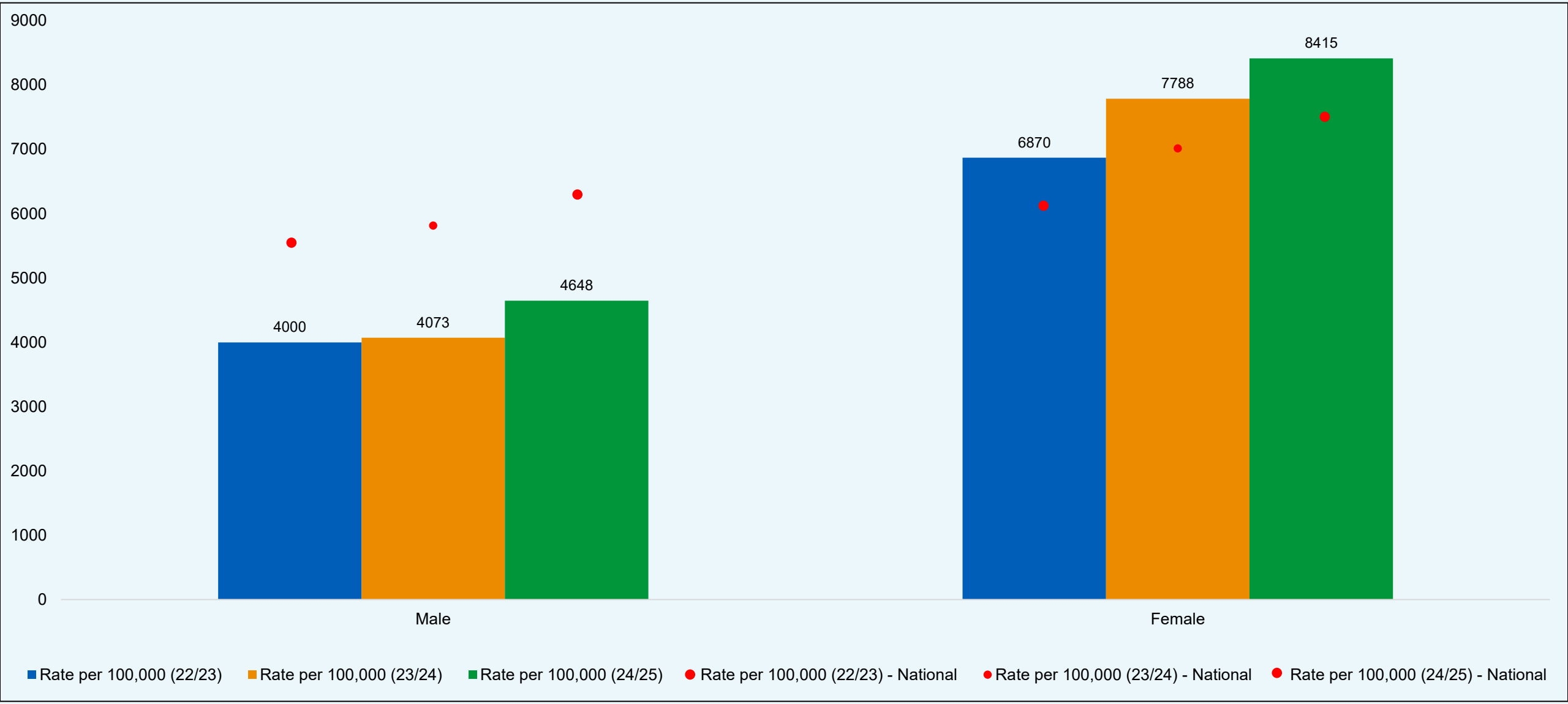
Between April 2023 and March 2024, 49% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of ‘recovery’ - meaning a person who is deemed to be a clinical case at the start of their treatment (‘at caseness’) and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This increased to 50% in 23/24.

The proportion of individuals achieving recovery varies across deprivation deciles. The main conclusion from this chart is that the difference in those achieving a recovery is worse in those in the most deprived parts of the county, and better in the least deprived parts of the county. The gap between the most deprived and the least deprived increases from 17 percentage points in 23/24 (most deprived decile had 39% who achieved a recovery; least deprived decile had 56% who achieved a recovery) to 18 percentage points in 24/25.

For 23/24, the Slope Index of Inequality (SII) is 14.57%; this means those who live in the least deprived parts of the county have, on average, a 14.57% higher probability of achieving a recovery outcome compared to those living in the most deprived parts. The Relative Index of Inequality is 1.35; this means that, on average, people who live in less deprived areas are approximately 35% more likely to achieve a recovery than those in the most deprived parts of the county. This suggests that deprived is associated with poorer outcomes following therapy, and those living in more affluent areas have better recovery rates. There may be other factors driving this observation, such as the severity of anxiety or depression with which those in more deprived areas present.

For 24/25, the Slope Index of Inequality (SII) was 15.64%; this means those who live in the least deprived parts of the county have, on average, a 15.64% higher probability of achieving a recovery outcome compared to those living in the most deprived parts. The Relative Index of Inequality is 1.37; this means that, on average, people who live in less deprived areas are approximately 37% more likely to achieve a recovery than those in the most deprived parts of the county. This suggests that deprived is associated with poorer outcomes following therapy, and those living in more affluent areas have better recovery rates. There may be other factors driving this observation, such as the severity of anxiety or depression with which those in more deprived areas present.

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Sex



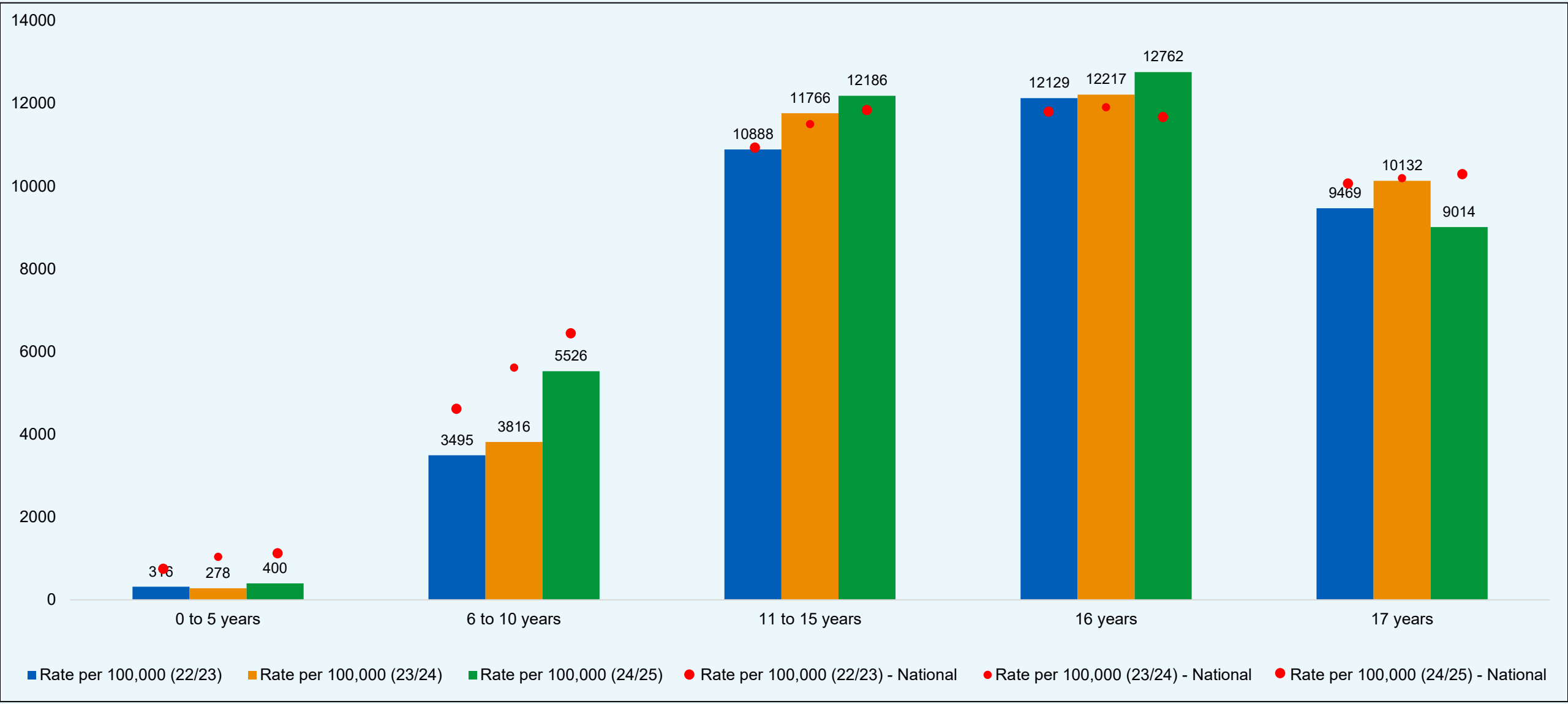
Sources: Mental Health Bulletin (22/23) - Indicators 17a and 17b; Mental Health Bulletin (23/24) - Indicators 17a and 17b; Mental Health Bulletin (24/25) - Indicators 17a and 17b

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Sex

Between April 2024 and March 2025, there were 6617 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made. This was slightly lower than the England rate of 6895 per 100,000. The Lincolnshire rate increased from 5893 CYP mental health pathways opened per 100,000, which was also lower than the England average of 6568 per 100,000.

The rate of children and young people accessing at least one mental health service in the area has increased for both males and females over the three-year period from 2022/23 to 2024/25. Among males, the local rate rose from 4,000 per 100,000 in 2022/23 to 4,648 per 100,000 in 2024/25, which remains consistently below the national rate, increasing from 5,547 to 6,225 per 100,000 over the same period. For females, access rates are notably higher than for males locally, rising from 6,870 per 100,000 in 2022/23 to 8,415 per 100,000 in 2024/25. Although female rates locally have increased at a similar pace to the national trend, they have remained slightly above the national averages each year (6,187 to 7,378 per 100,000 nationally). This pattern suggests both an overall increase in service access locally and nationally, but with persistent sex-based differences—females are more likely to access mental health services than males, and the gap between local and national rates is narrowing slightly for females while remaining wider for males.

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Age Group



Sources: Mental Health Bulletin (22/23) - Indicators 17a and 17b; Mental Health Bulletin (23/24) - Indicators 17a and 17b; Mental Health Bulletin (24/25) - Indicators 17a and 17b

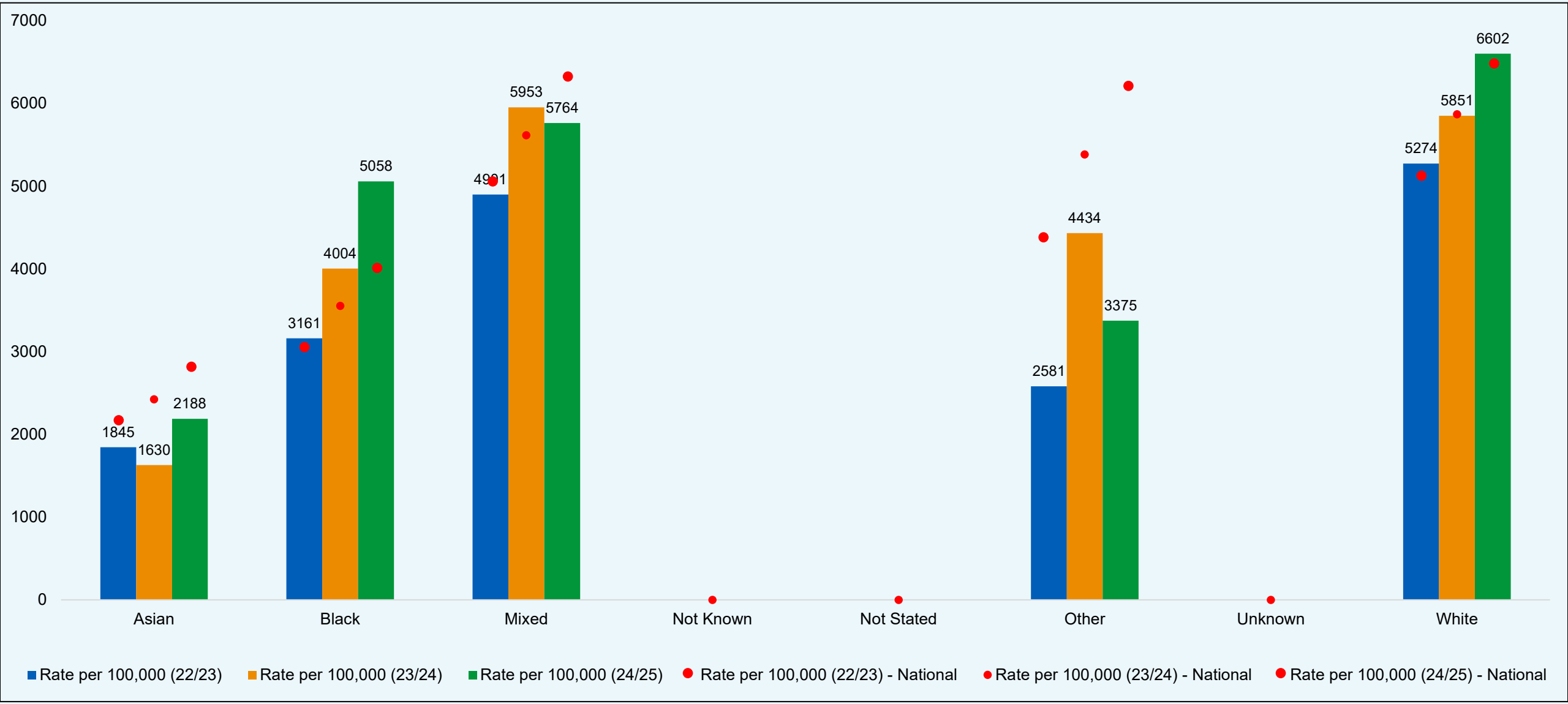
Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Age Group

Between April 2024 and March 2025, there were 6617 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made. This was slightly lower than the England rate of 6895 per 100,000. The Lincolnshire rate increased from 5893 CYP mental health pathways opened per 100,000, which was also lower than the England average of 6568 per 100,000. However, the pattern varies by age.

The lowest rates are consistently seen among children aged 0 to 5 years, where there has been a notable increase in children between the ages of 6 and 10 years (especially between 23/24 and 24/25), where the Lincolnshire rate increased from 3,816 per 100,000 to 5,526 per 100,000. The Lincolnshire rate for each reporting period (for 6- to 10-year-olds, and to a lesser extent in 0- to 5-year-olds) is still lower than the national average which may be worth exploring.

The rate in 11- to 15-year-olds, and 16-year-olds, appears to have plateaued (although it is much higher compared to other age groups) – and there has been a slight decrease in the rate of 17-year-olds. When comparing to the national rate, it's interesting to note the rate in 16-year-olds in Lincolnshire having at least one contact with NHS funded mental health services is higher than it was in the previous two reporting periods. In contrast, the 17-year-old group rate has slightly decline while the national rate appears to stay fairly consistent across the three reporting periods.

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Ethnicity



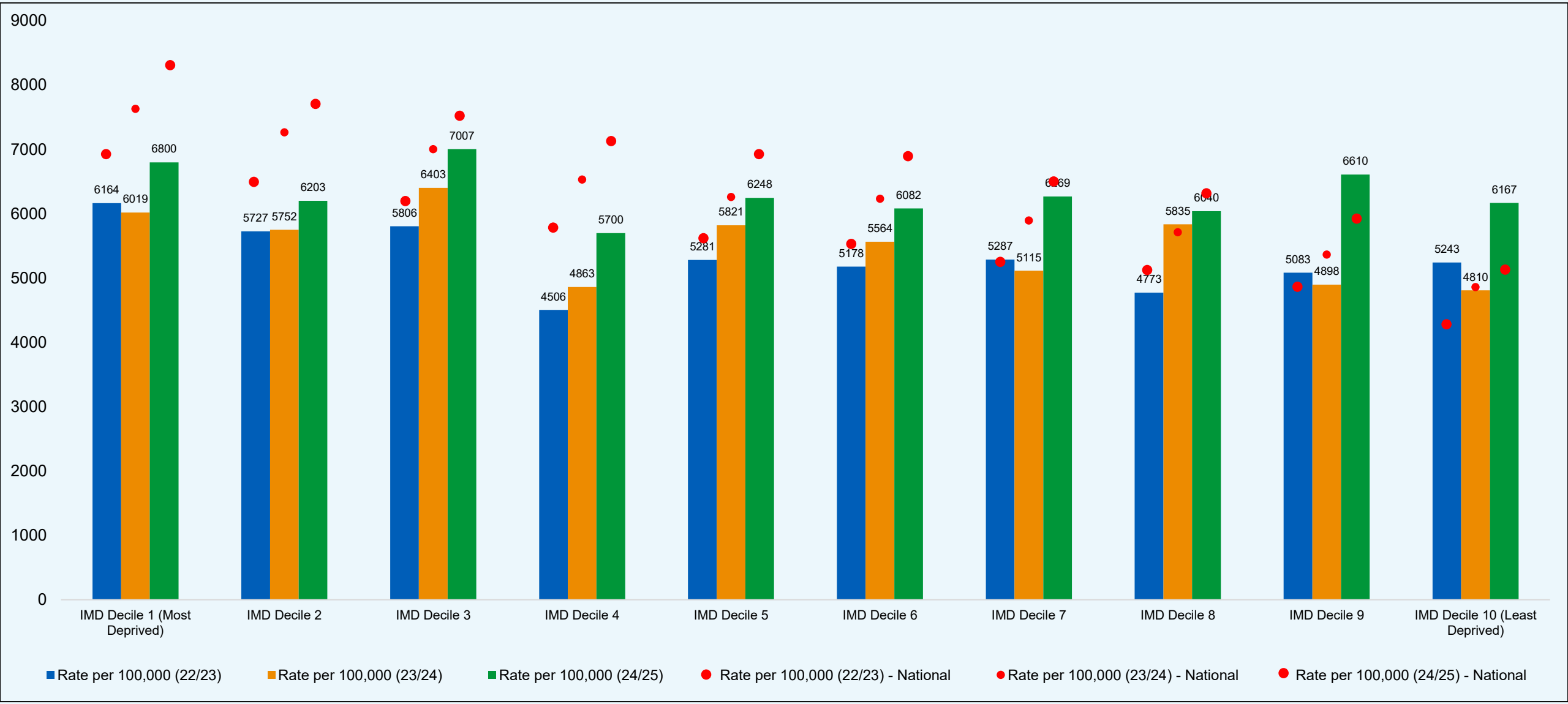
Sources: Mental Health Bulletin (22/23) - Indicators 17a and 17b; Mental Health Bulletin (23/24) - Indicators 17a and 17b; Mental Health Bulletin (24/25) - Indicators 17a and 17b

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Ethnicity

Between April 2024 and March 2025, there were 6617 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made. This was slightly lower than the England rate of 6895 per 100,000. The Lincolnshire rate increased from 5893 CYP mental health pathways opened per 100,000, which was also lower than the England average of 6568 per 100,000.

Considering the low counts associated with ethnic minorities in Lincolnshire, it is difficult to determine whether there are genuine disparities in children and young people from different ethnic backgrounds who having at least one contact with an NHS funded mental health service.

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Deprivation Decile



Sources: Mental Health Bulletin (22/23) - Indicators 17a and 17b; Mental Health Bulletin (23/24) - Indicators 17a and 17b; Mental Health Bulletin (24/25) - Indicators 17a and 17b

Crude Rate (per 100,000) of CYP aged <18 years supported through NHS funded mental health services with at least one contact by Deprivation Decile

Between April 2024 and March 2025, there were 6617 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made. This was slightly lower than the England rate of 6895 per 100,000. The Lincolnshire rate increased from 5893 CYP mental health pathways opened per 100,000, which was also lower than the England average of 6568 per 100,000.

The rate of children and young people accessing at least one mental health service has increased across all deprivation deciles between 2022/23 and 2024/25, indicating a general upward trend in service access. The highest rates continue to be seen among the most deprived groups, with the rate IMD Decile 1 rising from 6,019 per 100,000 in 23/24 to to 6,800 per 100,000. The gap between children living in the most and least deprived decile between 23/24 and 24/25 has closed – this appears to be driven by a steeper increase in the rate of children from the two most deprived deciles compared to those in the two least deprived areas. Children living in the least deprived deciles experienced a lower rate in the two previous reporting period, whereas the children living in the most deprived deciles experienced a consistently higher rate of accessing mental health services. The reasons for this increased rate in children from less deprived areas will need exploring, but broadly speaking the gap between the most and least deprived appears to have narrowed.

It should be noted that, compared to the national average, children living in the more deprived areas have a lower rate of accessing mental health services. This may need to be explored further to understand what is driving this relatively lower rate in children from more deprived areas in Lincolnshire.

Mental Health – Domain Summary

Age: Younger people, particularly those under the age of 25, experience poorer mental health outcomes. They are less likely to receive all six recommended physical health checks if they have a severe mental illness, more likely to be detained under the Mental Health Act, and experience higher rates of restrictive interventions. Additionally, those under 25 have lower recovery rates from NHS Talking Therapies. While secondary school-aged children make up the majority accessing CYP mental health services, this likely reflects rising need rather than improved outcomes.

Sex: Females appear to experience poorer mental health outcomes overall, based on these indicators. They are more likely to be detained under the Mental Health Act and to undergo restrictive interventions (both markers of more acute mental health crises) and have a lower recovery rate from NHS Talking Therapies compared to males. Although they are more likely to access CYP mental health services, this may reflect greater need or help-seeking rather than better outcomes. The only area where females perform better is in receiving all six physical health checks for severe mental illness, though the gap with males is narrowing.

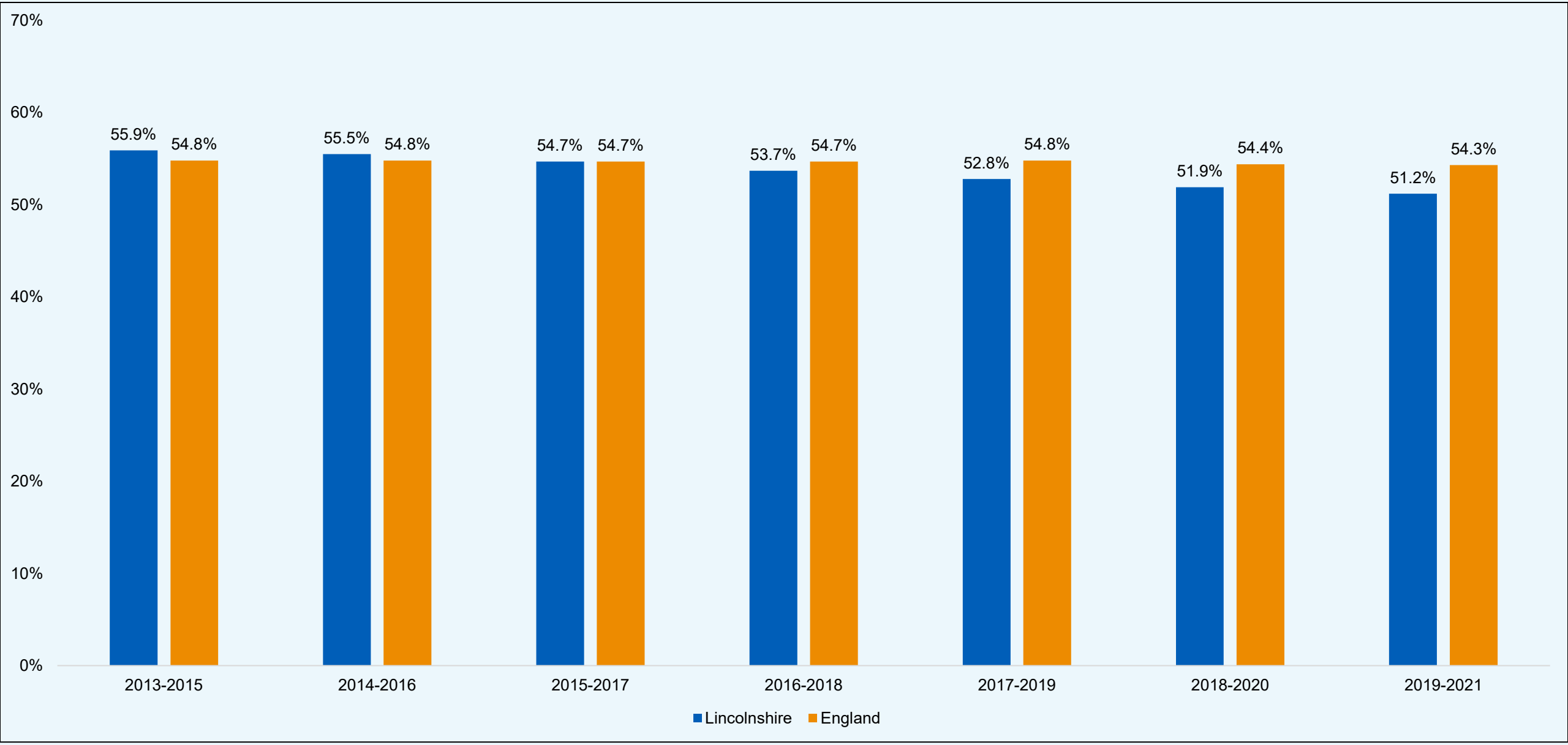
Deprivation: Those living in more deprived parts of the county consistently experience poorer mental health outcomes based on these indicators. They are significantly less likely to receive all six physical health checks if they have a severe mental illness, and more likely to be detained under the Mental Health Act or experience restrictive interventions. Additionally, recovery rates from NHS Talking Therapies are lower for this group. While the evidence is less clear for children and young people's access to services, the overall picture suggests a strong association between deprivation and worse mental health outcomes across multiple indicators.

Ethnicity: Given the low counts (sometimes a count can't be displayed due to data suppression rules), and the variation observed in mental health outcomes, it is difficult to state with any certainty whether people from ethnic minority backgrounds experience poorer mental health outcomes compared to the White British/Irish population.

Cancer Indicators – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex		—	—	—	—

Cancers diagnosed at stage 1 or 2 (case mix adjusted for cancer site, age at diagnosis, and sex)



Source: Cancer Registry Staging Data

Cancers diagnosed at stage 1 or 2 (case mix adjusted for cancer site, age at diagnosis, and sex)

This chart shows the proportion of cancers diagnosed at stage 1 or 2 in the past 7 reporting periods (using 3-year pooled data). Unfortunately, there is no breakdown by the various health inequality characteristics of age, sex, ethnicity, and deprivation. What this chart shows is that since the 2013-2015 period, the proportion of cancers diagnosed at stage 1 or 2 in Lincolnshire has gradually decreased to a point where it is worse than the national average. These figures have been case mix adjusted, accounting for differences in cancer site, age at diagnosis, and sex. However, several factors must be considered when interpreting these findings.

Firstly, cancer staging is inherently complex, and data quality issues are well documented. The inclusion criteria for this analysis are unclear, particularly regarding whether basal cell carcinomas have been included. Given that basal cell carcinoma is typically excluded from staging statistics, its potential inclusion could distort the overall proportion of early-stage diagnoses.

Secondly, patient pathways present a significant data limitation. Approximately one-quarter of all cancer patients from Lincolnshire receive their diagnosis and treatment in a different NHS trusts such as Cambridgeshire, Nottinghamshire, or Norfolk (depending on where the patient lives in the county). This means their data may not be captured within our local figures, potentially skewing the results. If these patients systematically differ in their stage at diagnosis compared to those receiving care locally, this could impact the observed trend.

The latest data is still somewhat outdated. Given the rapid developments in cancer screening, diagnostics, and treatment pathways, reliance on older data may not accurately reflect the current situation. More recent datasets would provide a clearer picture of whether the observed decline is a genuine deterioration in early-stage diagnosis or a reflection of data limitations.

While the case mix-adjusted data suggests a worsening trend in early-stage cancer diagnosis for Lincolnshire, several caveats must be considered. Data quality concerns, incomplete patient coverage, and the use of older datasets mean that caution is needed when interpreting these findings. Further investigation is required to establish the true scale of the issue and identify appropriate actions.

Source: Cancer Registry Staging Data

Cancer – Domain Summary

Age: The data source does not stratify the outcome by age groups.

Sex: The data source does not stratify the outcome by sex.

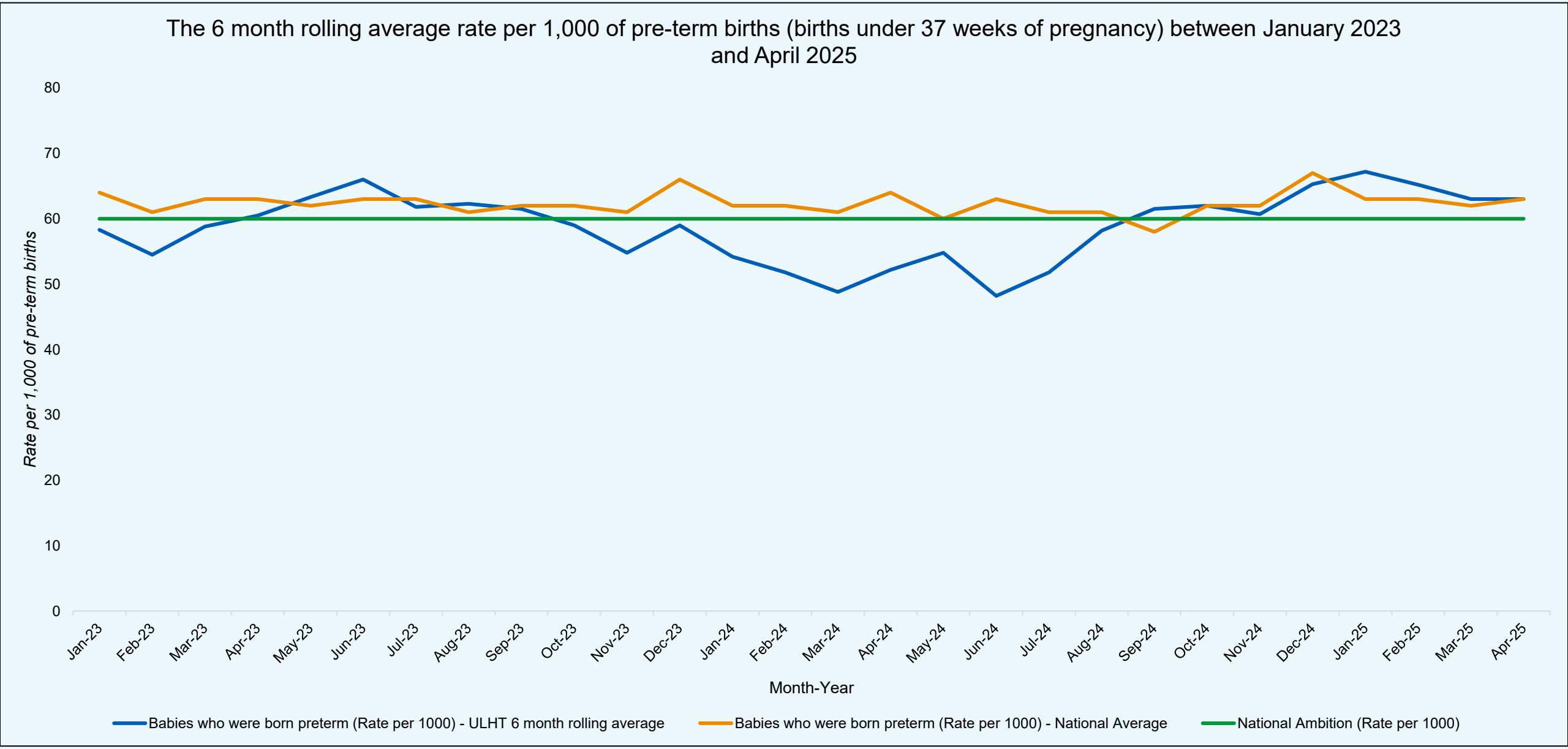
Deprivation: The data source does not stratify the outcome by deprivation decile/quintile.

Ethnicity: The data source does not stratify the outcome by different ethnic groups.

Maternity and neonatal – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Pre-term births under 37 weeks		—	—	—	—

Babies who were born preterm (Rate per 1000)



Source: [Maternity Services Dataset Dashboard]

Babies who were born preterm (Rate per 1000)

This chart shows data from the past 2.5 years (January 2023 to April 2025) on the rate of preterm babies (defined as babies born alive before 37 weeks of pregnancy are completed). The national target is 60 preterm births per 1000 births. In 30 of the 38 months from November 2021 to November 2024 inclusive, Lincolnshire has achieved a lower rate (calculated as a 6-month rolling average) compared to the national rate. The lowest 6 month rolling rate was reported in the six months from January 2024 to June 2024, where a rate of 48.2 preterm births per 1000 births was recorded. The highest 6 month rolling rate was reported in the six months from January 2023 to June 2023.

A potential note of concern can be seen in the gradual rise in the six-month rolling average rate of babies born pre-term. This increase in rate started around the middle of 2024 and has reached a peak of 67.2 pre-term births per 1000 for the six-month period from August 2024 to January 2025.

Maternity and neonatal – Domain Summary

Age: The data source does not stratify the outcome by age groups.

Sex: The data source does not stratify the outcome by sex.

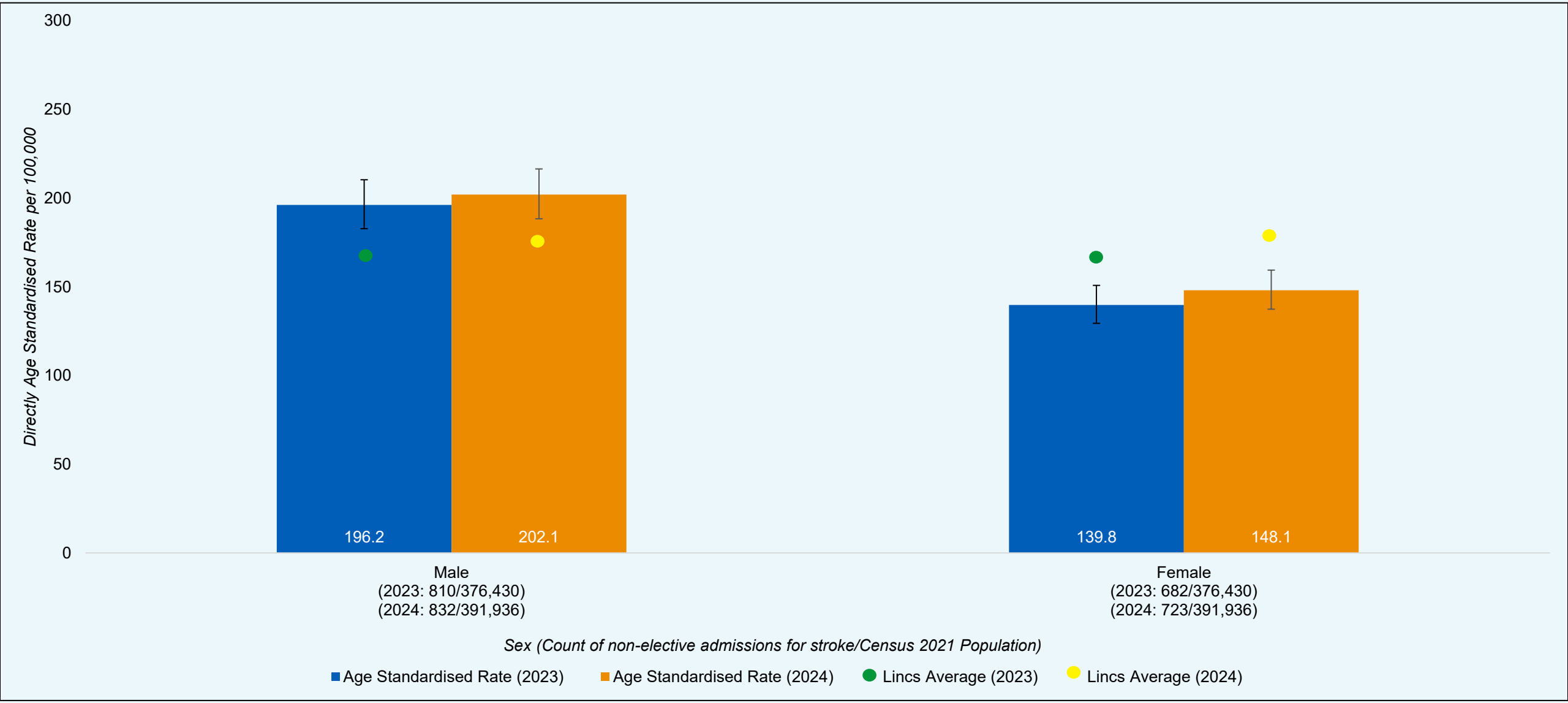
Deprivation: The data source does not stratify the outcome by deprivation decile/quintile.

Ethnicity: The data source does not stratify the outcome by different ethnic groups.

Cardiovascular Disease – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Stroke rate of non-elective admissions (per 100,000, age-sex standardised)	↑	↓	↑	↑	↑
Myocardial infarction - rate of non-elective admissions (per 100,000, age-sex standardised)	↓	↑	↓	↓	↓
% 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	↓	↑	↑	↓	↑
% 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	↑	↑	↔	↑	↔
% 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	↔	↔	↑	↓	–

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Sex



Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

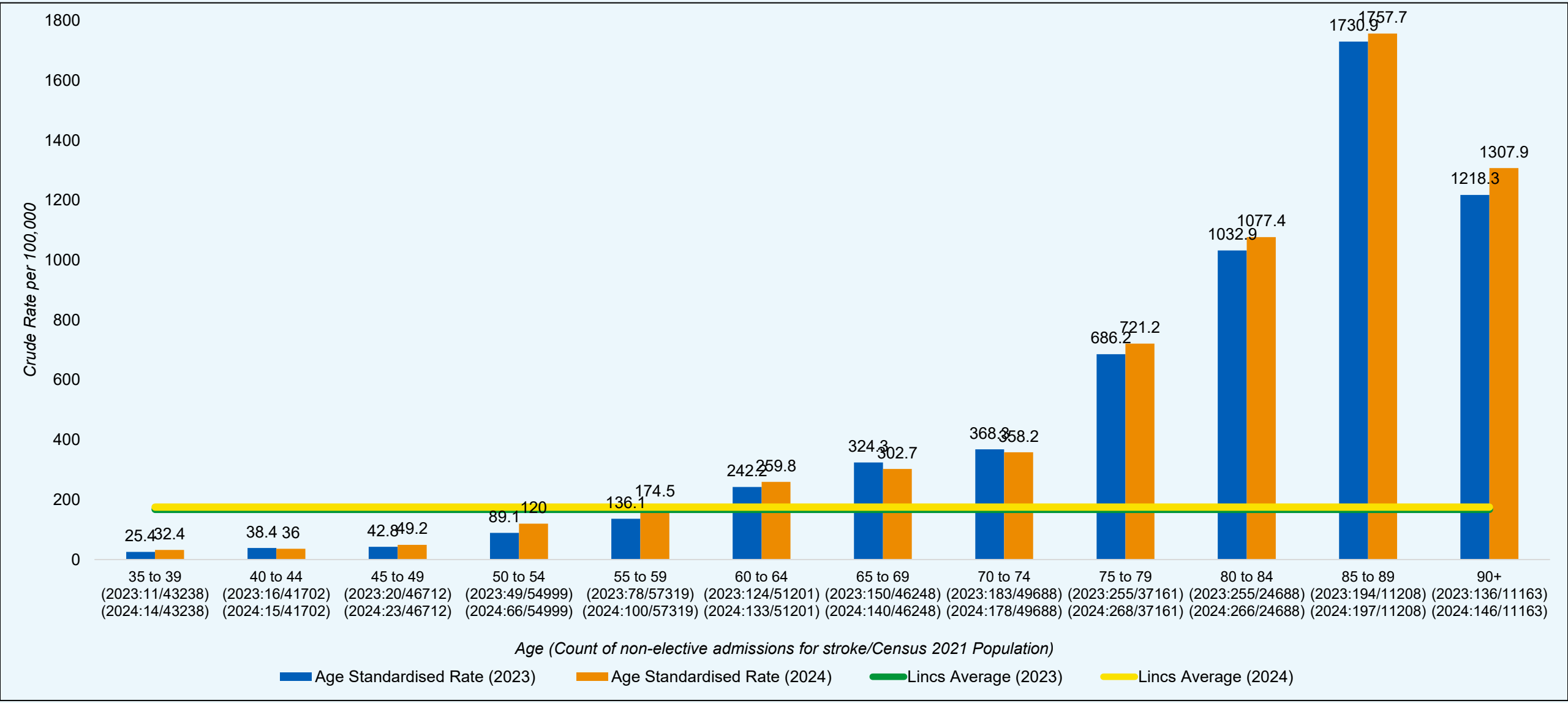
Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Sex

This bar chart presents the age-standardised rates of non-elective hospital admissions due to stroke in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 166.9 per 100,000 (there were 1492 strokes that required non-elective admission from a population of 768,366). Males experienced a significantly higher age standardised rate of non-elective stroke admissions compared to the Lincolnshire average, and compared to females who had a non-elective admission for stroke. The gap in the rate between males and females was 56.4 per 100,000. This indicates something is happening whereby males have a higher rate of non-elective stroke admissions. A deeper dive in to the reasons for this will need to be conducted to understand the drivers of this inequality.

In 2024, the Lincolnshire DASR per 100,000 was 174.8 per 100,000 (there were 1559 strokes that required non-elective admission from a population of 768,366). Males experienced a significantly higher age standardised rate of non-elective stroke admissions compared to the Lincolnshire average, and compared to females who had a non-elective admissions for stroke. The gap in the rate between males and females was 54.0 per 100,000, a minimal reduction compared to the gap in 2023, but it should be noted that the rate for both sexes increased slightly in 2024 (which could be due to the denominator used to calculate the age standardised rates).

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Age Group



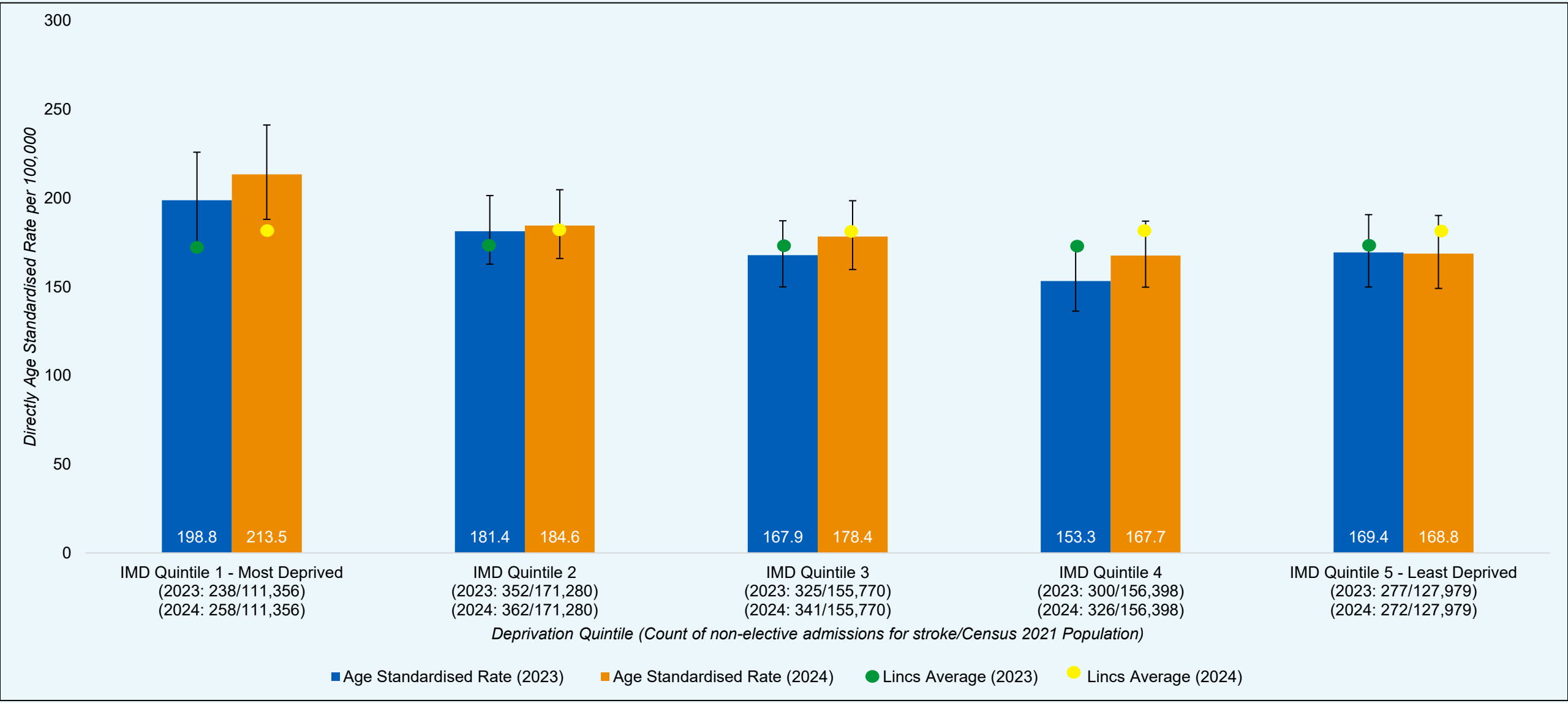
Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Age Group

This bar chart presents the age-standardised rates of non-elective hospital admissions due to stroke in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023 and 2024, there was a noticeable trend in that non-elective admissions for stroke were eminently more prevalent in older age groups compared to those in younger age groups. Those under 35 have not been presented in this chart due to low counts. Older age groups are more likely to be admitted to hospital due to a stroke because the risk of stroke increases significantly with age. As people get older, the cumulative effects of long-term exposure to vascular risk factors—such as hypertension, diabetes, high cholesterol, and atrial fibrillation—become more pronounced. These conditions are strongly associated with the development of stroke and are more prevalent in older populations.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Deprivation Quintile



Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Deprivation Quintile

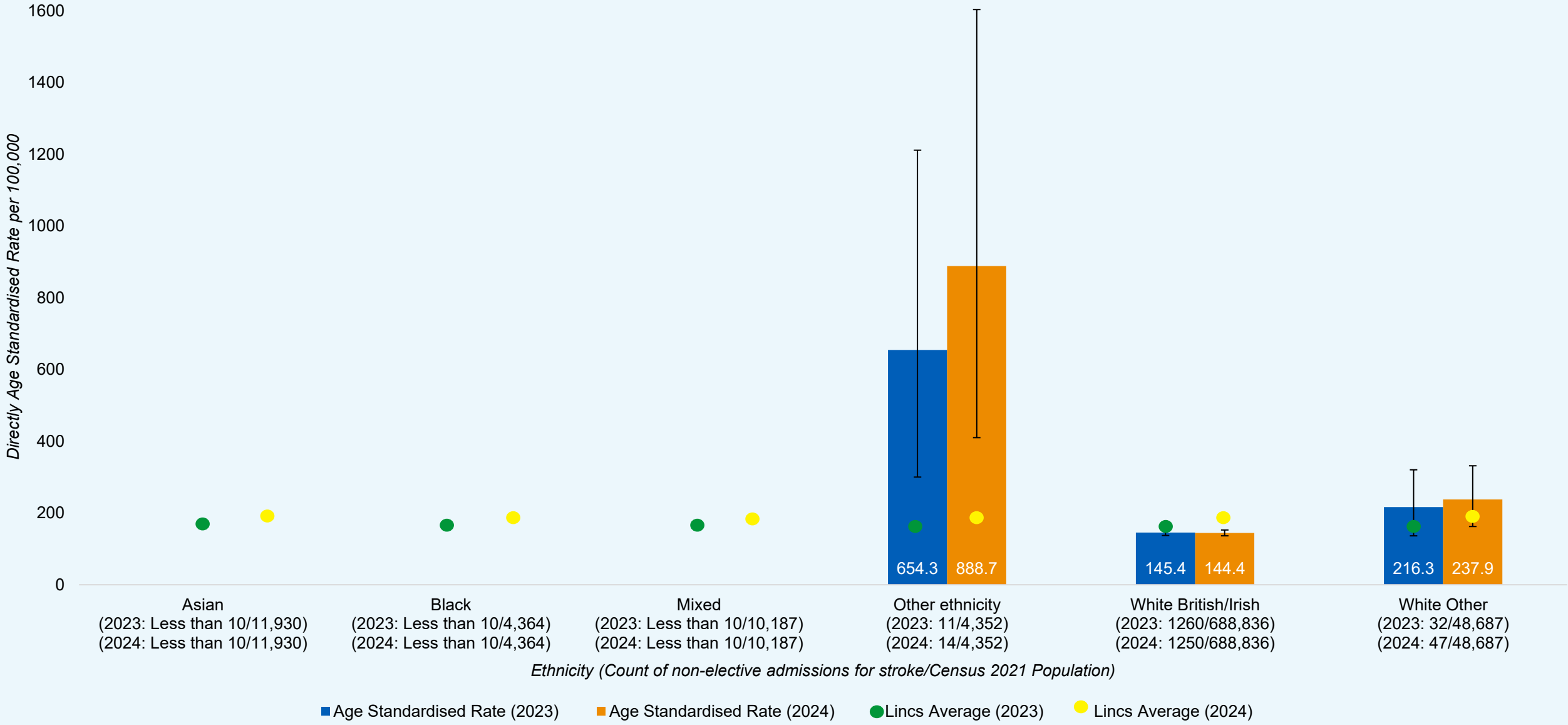
This bar chart presents the age-standardised rates of non-elective hospital admissions due to stroke in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 173.1 per 100,000 (there were 1492 strokes that required non-elective admission from a population of 722,783). Those who lived in the most deprived quintile experienced a direct age standardised rate of 198.8 non-elective stroke admissions per 100,000 (95% CI: 174.2 to 225.9). Those who lived in the second least deprived quintile (IMD 4) experienced the lowest DASR of 153.3 non-elective stroke admissions per 100,000 (95% CI: 136.3 to 171.8). Those who lived in IMD quintile 4 experienced a statistically significantly lower rate of non-elective stroke admissions per 100,000 compared to those living in the least deprived quintile, although this difference was only just statistically significant. No quintiles that had a statistically better or worse directly age standardised rate than the Lincolnshire average, those who lived in the least deprived quintile had a marginally higher and statistically significantly higher rate of non-elective stroke admissions in 2023.

In 2024, the Lincolnshire DASR per 100,000 was 181.0 per 100,000 (there were 1559 strokes that required non-elective admission from a population of 722,783). Those who lived in the most deprived quintile experienced a direct age standardised rate of 213.5 non-elective stroke admissions per 100,000 (95% CI: 188.1 to 241.3). This was an increase of 14.7 non-elective stroke admissions per 100,000 compared to 2023 (for those living in the least deprived quintile), but this was not a statistically significant increase compared to 2023. Those who lived in the second least deprived quintile (IMD 4) again experienced the lowest DASR of 167.7 non-elective admissions per 100,000 (95% CI: 149.8 to 187.1). Those who lived in IMD quintile 4 experienced a statistically significantly lower rate of non-elective stroke admissions per 100,000 compared to those living in the least deprived quintile, although this difference was only just statistically significant. No quintiles that had a statistically better or worse directly age standardised rate than the Lincolnshire average, those who lived in the least deprived quintile had a marginally higher and statistically significantly higher rate of non-elective stroke admissions in 2023.

The rate per 100,000 increased in each deprivation quintile between 2023 and 2024, with the exception of those living in the least deprived quintile, where the rate dropped from 169.4 in 2023 to 168.8 in 2024.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Ethnicity



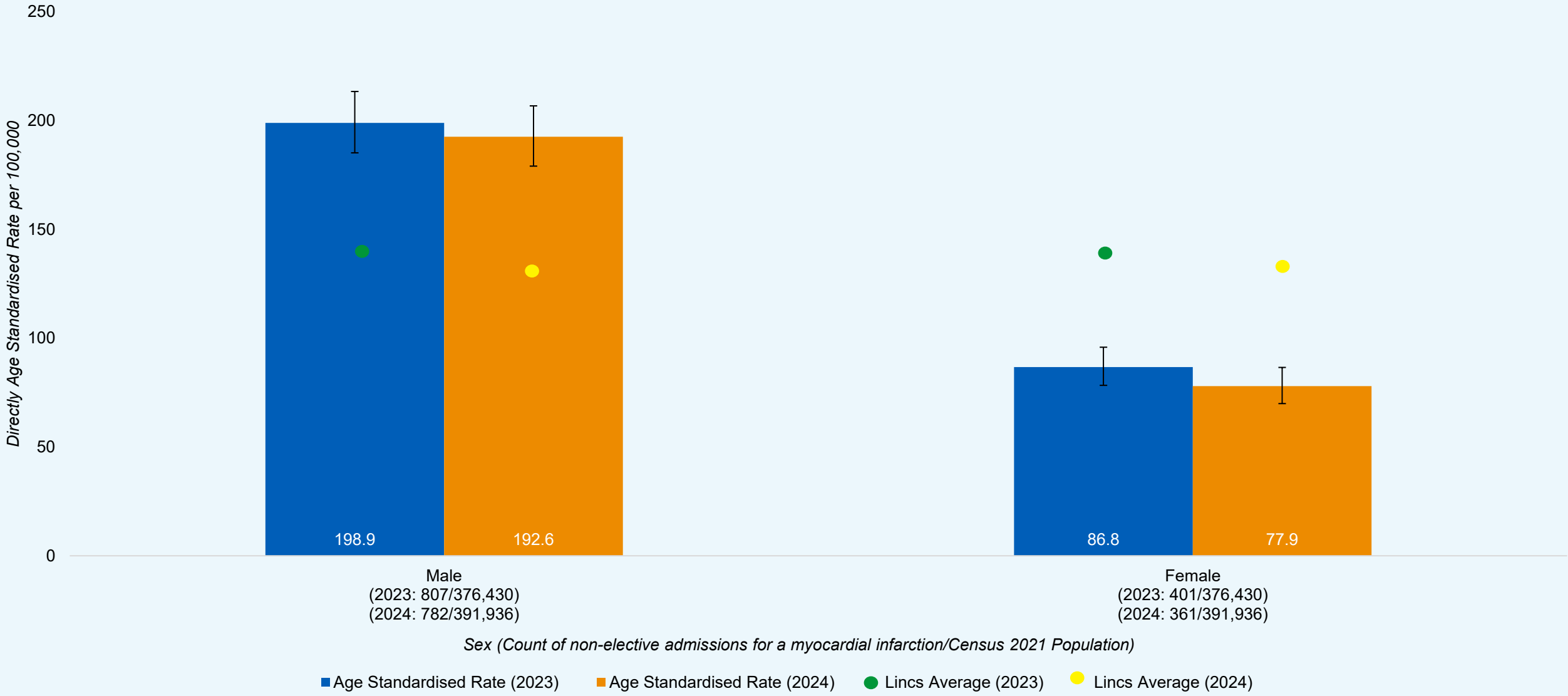
Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a stroke by Ethnicity

This bar chart presents the age-standardised rates of non-elective hospital admissions due to stroke in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 166.8 per 100,000 (there were 1492 strokes that required non-elective admission from a population of 768,356). The counts for those from an Asian, Black, and Mixed background were below 10, therefore an age standardised rate has not been calculated. Those from an Other ethnic group had a statistically significantly higher rate of non-elective admissions than the Lincolnshire average – however, caution should be used when interpreting this for two reasons. First, there were only 11 recorded non-elective admissions for a stroke in 2023 attributed to those from an Other ethnicity. While the confidence intervals around this rate do not overlap with the Lincolnshire rate, this does not necessarily mean those from an Other ethnicity experienced a worse rate of non-elective stroke admissions. Those from a White British/Irish background had the lowest age standardised rate of non-elective stroke admissions of 145.4 per 100,000 (95% CI 137.4 to 153.7). This is statistically lower than the 2023 Lincolnshire average – but only marginally. Those from a White Other background experienced 216.3 non-elective stroke admissions per 100,000. While this is higher than the Lincolnshire average, it is not significantly worse than the Lincolnshire average. Reader should note the relatively small count of those from a White background who had a non-elective stroke admission in 2023.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Sex



Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

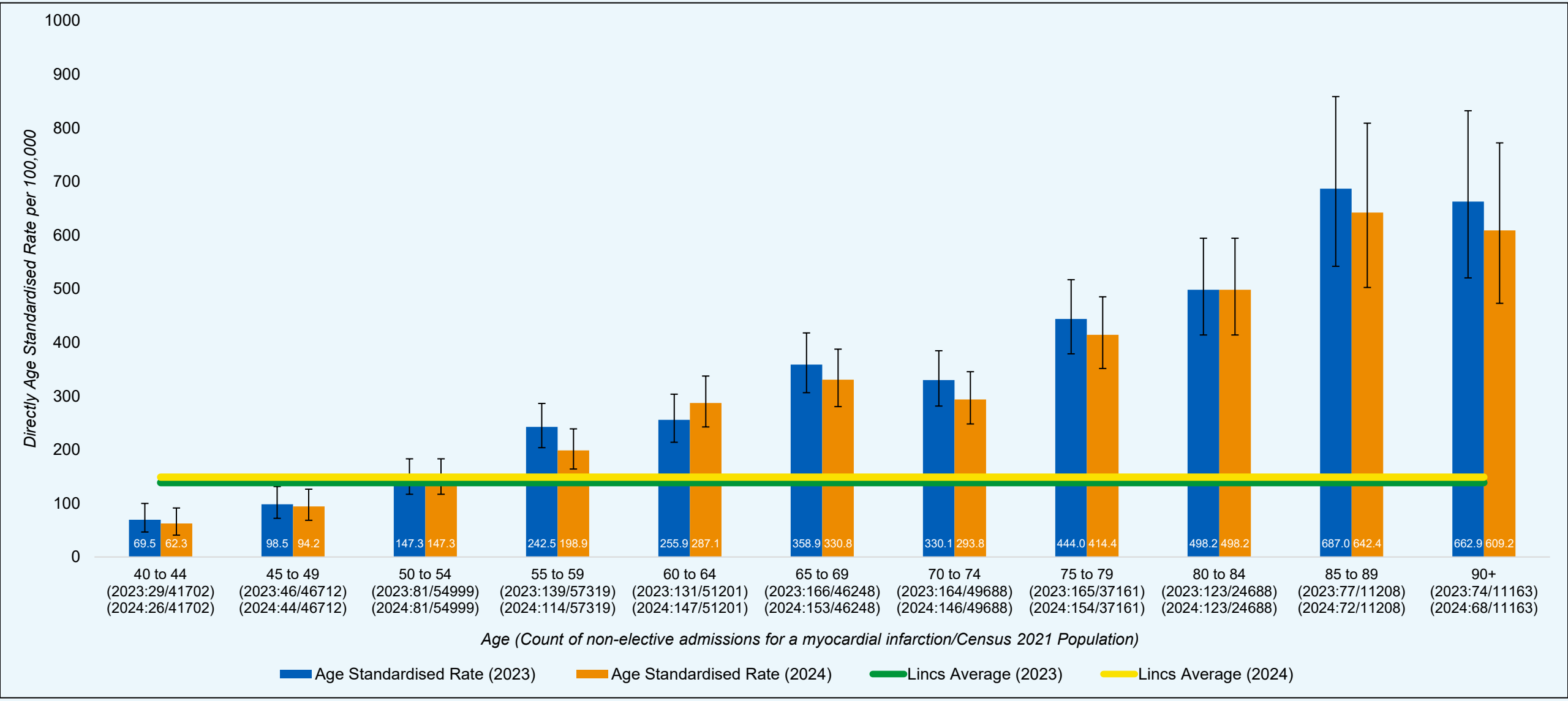
Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Sex

This bar chart presents the age-standardised rates of non-elective hospital admissions due to myocardial infarction in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 138.7 per 100,000 (there were 1209 myocardial infarctions that required non-elective admission from a population of 768,366). Males experienced a significantly higher age standardised rate of non-elective myocardial infarction admissions compared to the Lincolnshire average, and compared to females who had a non-elective admission for myocardial infarction. The gap in the rate between males and females was 112.1 per 100,000. This indicates something is happening whereby males have a higher rate of non-elective myocardial infarction admissions. A deeper dive in to the reasons for this will need to be conducted to understand the drivers of this inequality.

In 2024, the Lincolnshire DASR per 100,000 was 131.5 per 100,000 (there were 1144 myocardial infarctions that required non-elective admission from a population of 768,366). Males experienced a significantly higher age standardised rate of non-elective myocardial infarction admissions compared to the Lincolnshire average, and compared to females who had a non-elective admissions for myocardial infarction. The gap in the rate between males and females was 114.7 per 100,000, a minimal increase compared to the gap in 2023, but it should be noted that the rate for both sexes increased slightly in 2024 (which could be due to the denominator used to calculate the age standardised rates).

Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Age



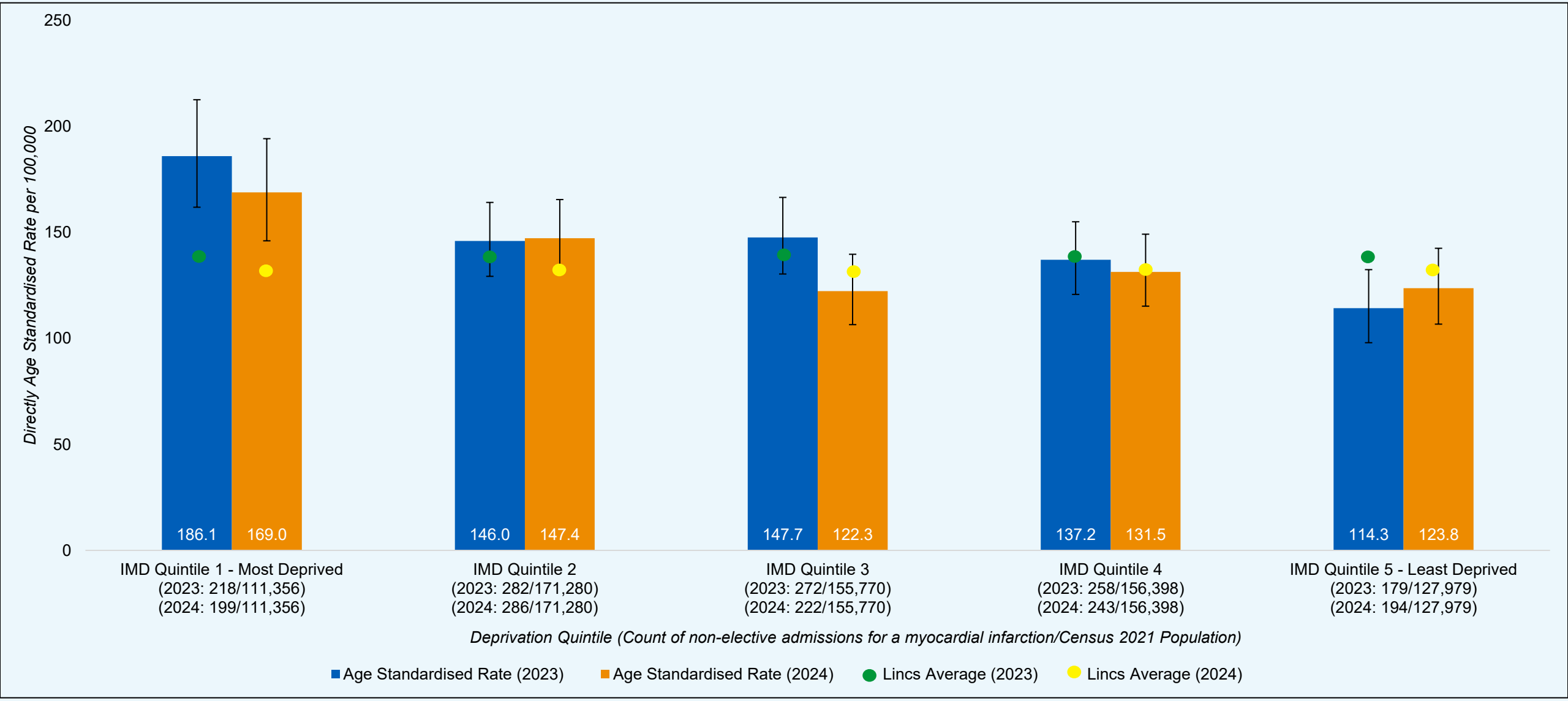
Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Age

This bar chart presents the age-standardised rates of non-elective hospital admissions due to myocardial infarction in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023 and 2024, there was a noticeable trend in that non-elective admissions for myocardial infarction were eminently more prevalent in older age groups compared to those in younger age groups. Those under 40 have not been presented in this chart due to low counts. Older age groups are more likely to be admitted to hospital due to a myocardial infarction because the risk of myocardial infarction increases significantly with age. As people get older, the cumulative effects of long-term exposure to vascular risk factors—such as hypertension, diabetes, high cholesterol, and atrial fibrillation—become more pronounced. These conditions are strongly associated with the development of myocardial infarction and are more prevalent in older populations.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Deprivation Quintile



Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

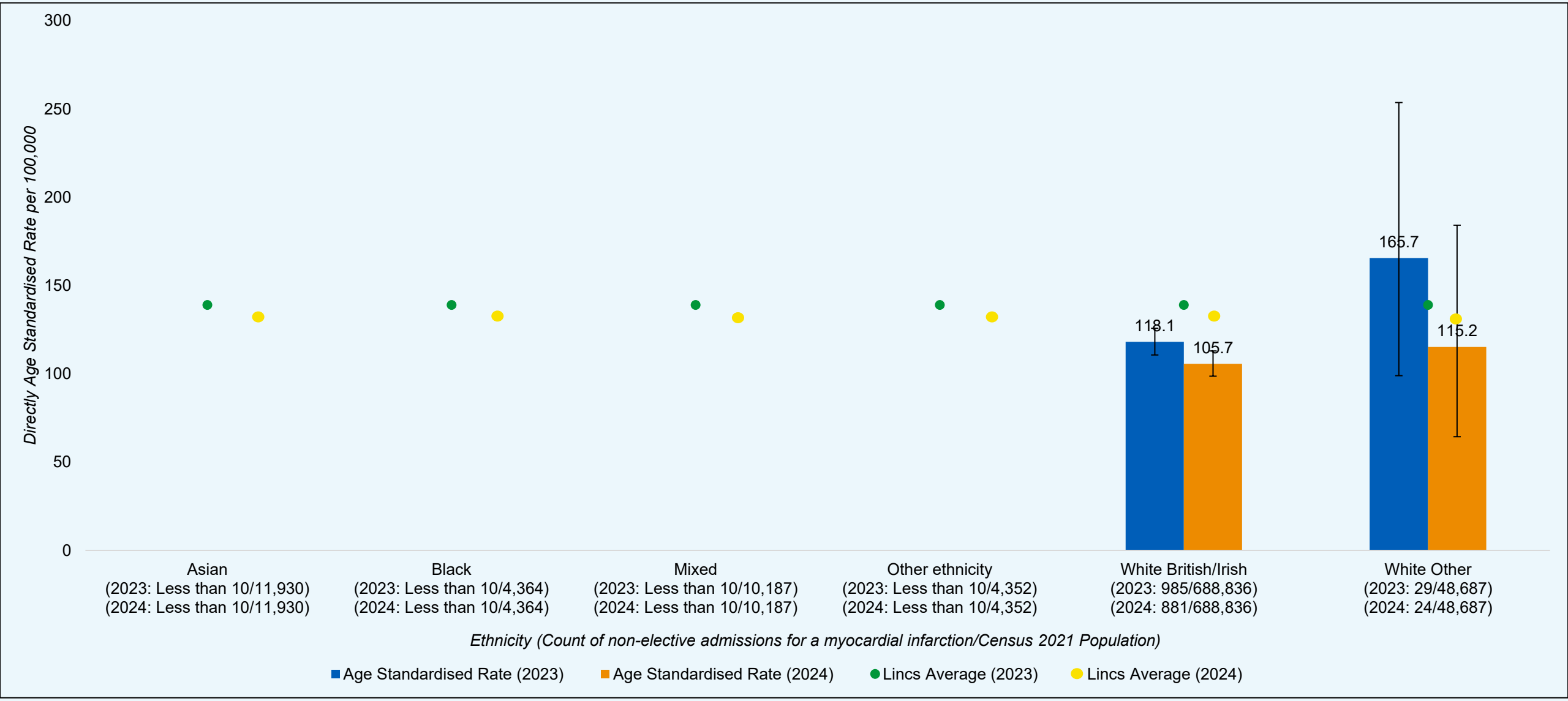
Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Deprivation Quintile

This bar chart presents the age-standardised rates of non-elective hospital admissions due to a myocardial infarction in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 138.7 per 100,000 (there were 1209 myocardial infarctions that required non-elective admission from a population of 722,783). Those who lived in the most deprived quintile experienced a direct age standardised rate of 186.1 non-elective myocardial infarction admissions per 100,000 (95% CI: 162.0 to 212.7). Those who lived in the least deprived quintile experienced the lowest DASR of 114.3 non-elective myocardial infarction admissions per 100,000 (95% CI: 98.0 to 132.5). Those who lived in the least quintile experienced a statistically significantly lower rate of non-elective myocardial infarction admissions per 100,000 compared to those living in the most deprived quintile. Those who lived in the most deprived quintile experienced a statistically significant higher rate of non-elective admissions for a myocardial infarction, and those living in the least deprived quintile experienced a statistically significantly lower rate of non-elective admissions for a myocardial infarction. This suggests there is a relationship between living in one of the most deprived areas of Lincolnshire and having a non-elective admission for a heart attack, which may require further exploration to understand the reasons driving this phenomenon.

In 2024, the Lincolnshire DASR per 100,000 was 131.5 per 100,000 (there were 1144 myocardial infarctions that required non-elective admission from a population of 722,783). Those who lives in the most deprived quintile experienced a DASR of 169.0 non-elective myocardial infarction admissions per 100,000 (95% CI: 146.1 to 194.4). Those who lived in least deprived quintile experienced the second lowest DASR of 123.8 non-elective myocardial infarction admissions per 100,000 (95% CI: 106.8 to 142.6). It should be noted that the lowest rate was experienced in those living in IMD quintile 3, where the rate was 122.3 per 100,000. Those who lived in the most deprived quintile experienced a statistically significant higher rate of non-elective admissions for a myocardial infarction, and those living in the least deprived quintile experienced a statistically significantly lower rate of non-elective admissions for a myocardial infarction. This suggests there is a relationship between living in one of the most deprived areas of Lincolnshire and having a non-elective admission for a heart attack, which may require further exploration to understand the reasons driving this phenomenon.

Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Ethnicity



Source: Secondary Use Services (SUS) Admitted Patient Care dataset. 2023 and 2024.

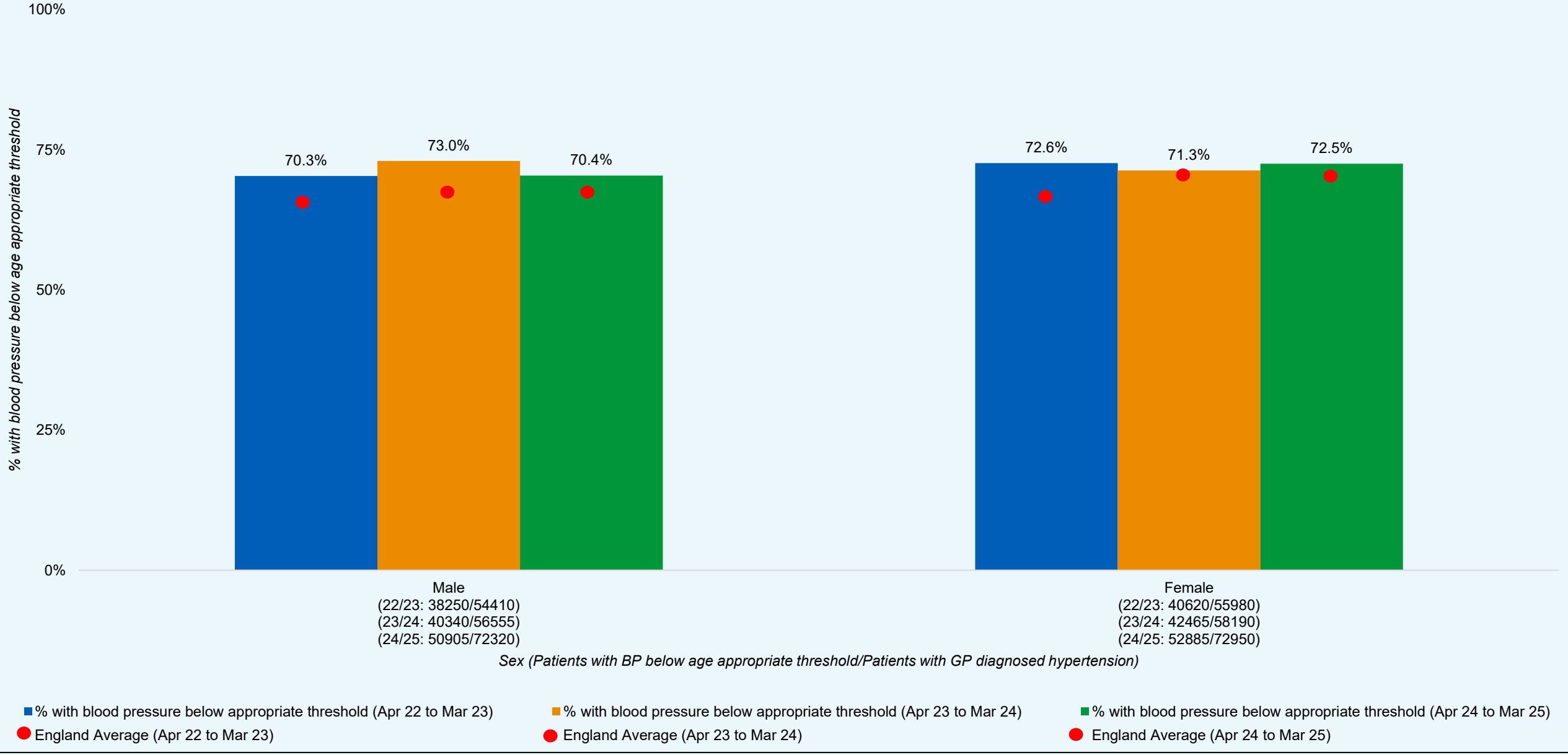
Directly Age Standardised Rate per 100,000 of non-elective admissions for a myocardial infarction by Ethnicity

This bar chart presents the age-standardised rates of non-elective hospital admissions due to a myocardial infarction in 2023 and 2024. Please note that 2021 Census population data has been used as the denominator because it is one of the few data sources which can stratify deprivation quintile by age bands needed to calculate directly age standardised rates per 100,000. A similar calculation was conducted using the latest data from the Lincolnshire Joined Intelligence Dataset (updated in March 2025) and while the rates were different due to the larger population in the LJID 2025 population, the overall trend was the same.

In 2023, the Lincolnshire DASR per 100,000 was 139.1 per 100,000 (there were 1209 myocardial infarctions that required non-elective admission from a population of 768,356). The counts of myocardial infarctions requiring a non-elective admission were less than 10 in those from an Asian, Black, Mixed, and Other ethnic background. Those from a White British/Irish ethnicity had a statistically significantly lower rate of myocardial infarctions compare to the Lincolnshire average (118.1 per 100,000; 95% CI: 110.7 to 125.8).

In 2024, the Lincolnshire DASR per 100,000 dropped slightly to 131.8 per 100,000 (there were 1144 myocardial infarctions that required non-elective admission from a population of 768,356). The counts of myocardial infarctions requiring a non-elective admission were less than 10 in those from an Asian, Black, Mixed, and Other ethnic background. Those from a White British/Irish ethnicity had a statistically significantly lower rate of myocardial infarctions compare to the Lincolnshire average (105.7 per 100,000; 95% CI: 98.7 to 113.0).

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months, by Sex



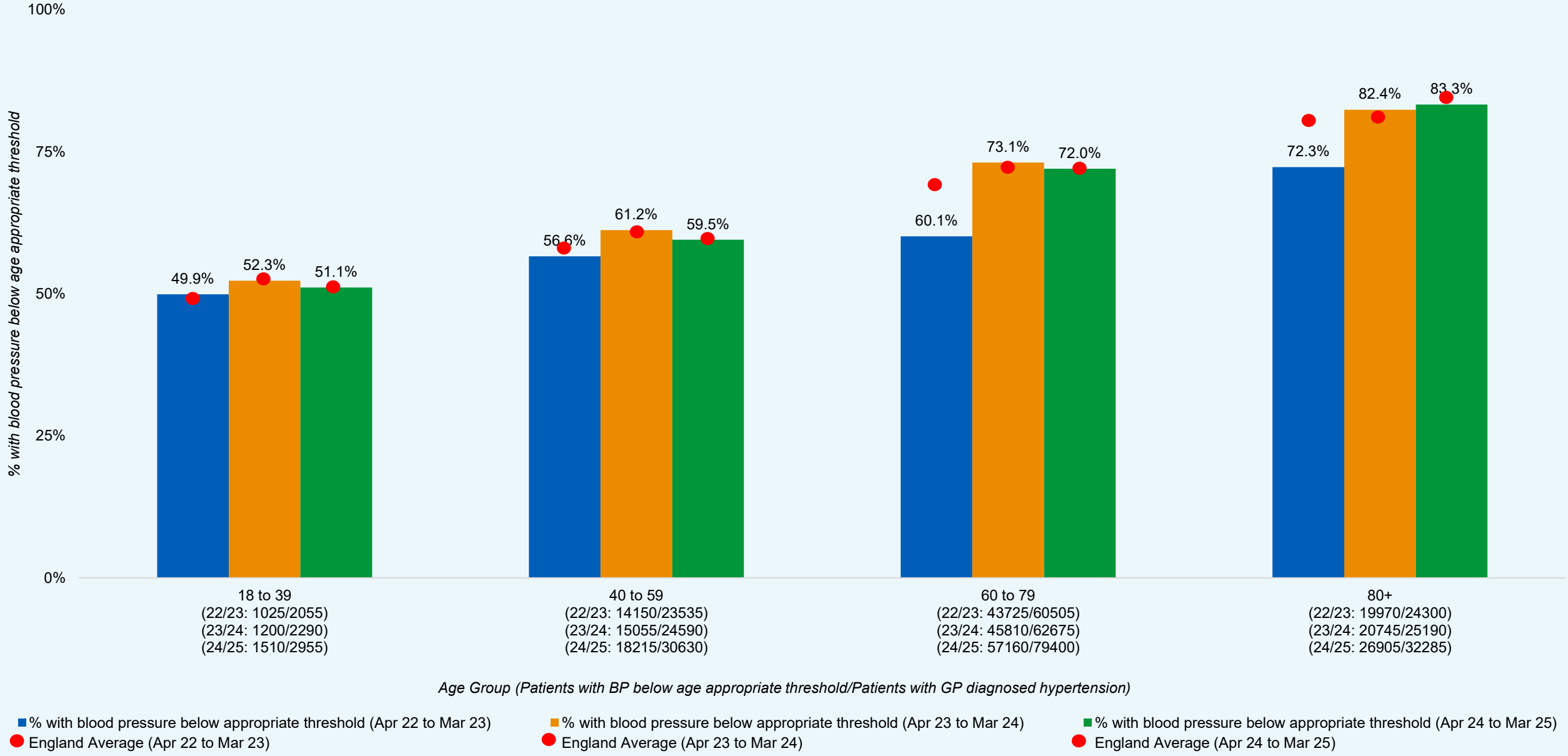
Source: CVD Prevent Data Explorer (Indicator CVDP007HYP)

Between April 2023 and March 2024, 72.2% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. 73.0% of males had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than the female population, where 71.3% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

Between April 2024 and March 2025, 71.5% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold – a 0.7 percentage point decreased compared to the previous 12 months. 70.4% of males had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than the female population, where 72.5% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

The difference between males and females having their hypertension optimally managed has switched between 23/24 and 24/25, the size of the gap has increased (from 1.7 percentage points in the favour of males to a 2.1 percentage point change in the favour of females) and is still significant. This indicates males with GP recorded hypertension have slightly poorer hypertension management than females in Lincolnshire.

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months, by Age Group



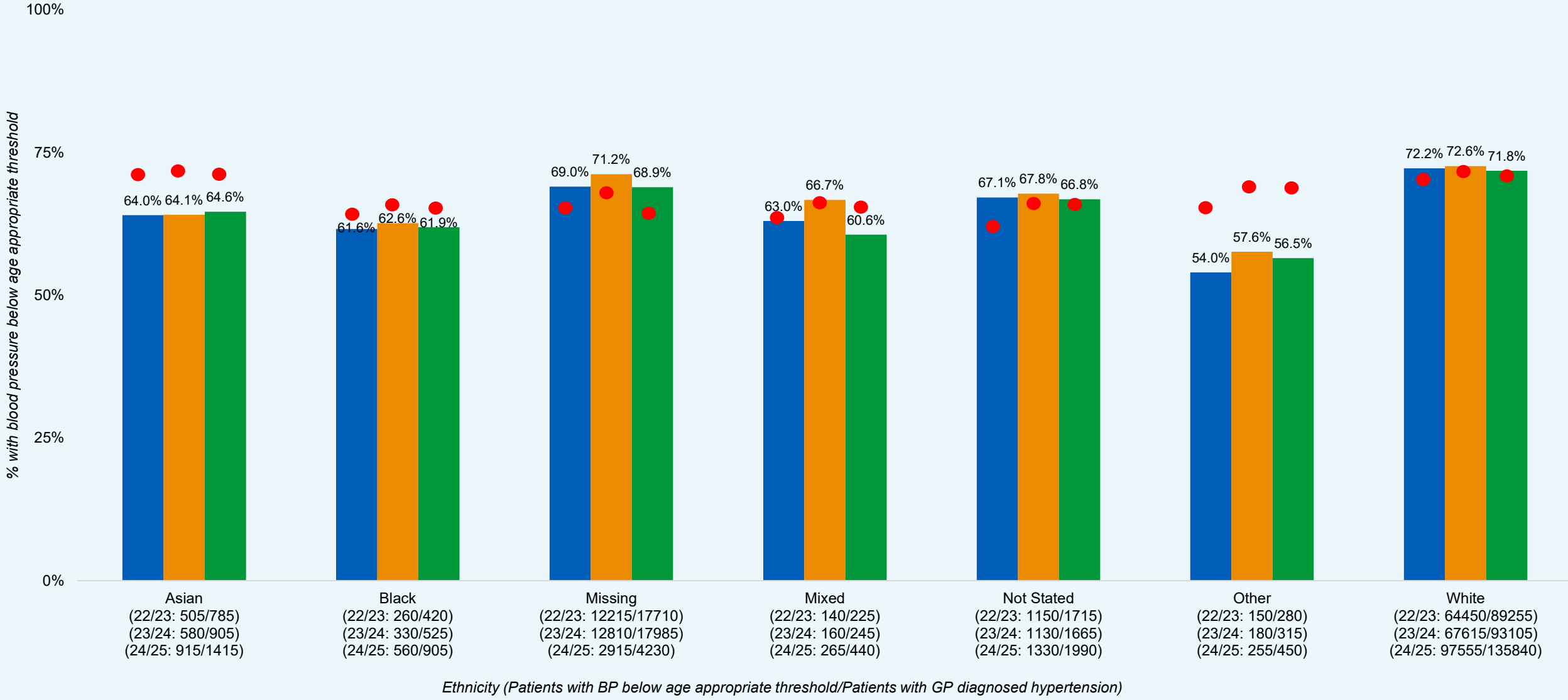
Source: [CVD Prevent Data Explorer (Indicator CVDP007HYP)]

Between April 2023 and March 2024, 72.2% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. 52.3% of 18-to-39-year-olds had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than the 80+ population, where 82.4% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

Between April 2024 and March 2025, 71.5% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold – a 0.7 percentage point decreased compared to the previous 12 months. 51.1% of 18-to-39-year-olds had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than the 80+ population, where 83.3% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

Those with GP recorded hypertension under the age of 60 had a significantly lower proportion who had their hypertension optimally managed. The gap between 18- to 39-year-olds and 80+ year olds increased from 30.1% point difference to 32.2% point difference between 23/24 and 24/25, indicating there may be a growing inequality in hypertension management observed between working age adults and older adults.

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months, by Ethnicity

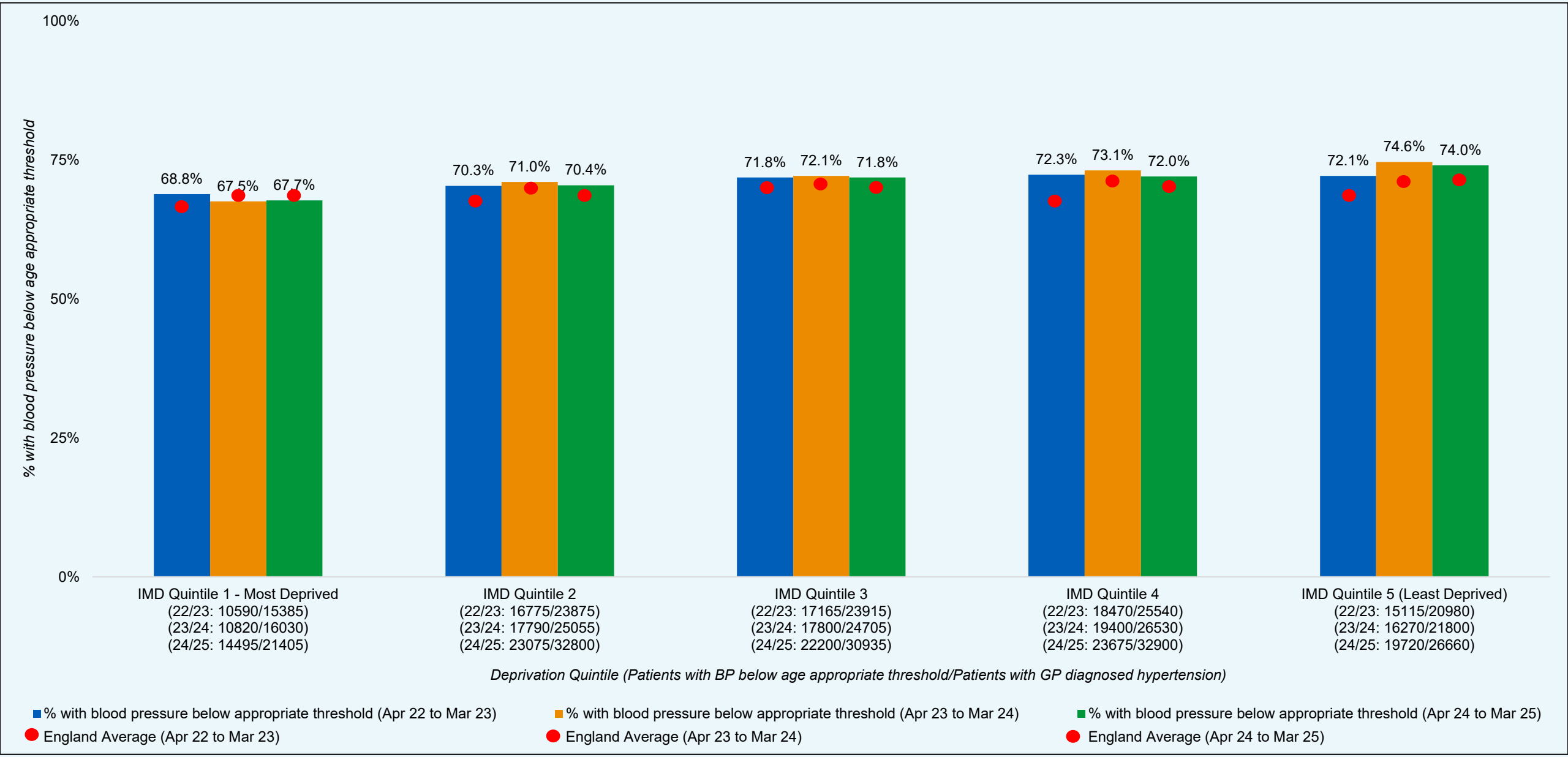


Source: [CVD Prevent Data Explorer (Indicator CVDP007HYP)]

Between April 2023 and March 2024, 72.2% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in hypertension management based on ethnicity between 2023 and 2024. The data suggests those from an Asian, Black, Mixed, or Other ethnic background have poorer hypertension management compared to the White population but given the data quality issues concerning ethnicity, readers should interpret this finding with caution.

Between April 2024 and March 2025, 71.5% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold – a 0.7 percentage point decreased compared to the previous 12 months. Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in hypertension management based on ethnicity between 2023 and 2024. The data suggests those from an Asian, Black, Mixed, or Other ethnic background have poorer hypertension management compared to the White population but given the data quality issues concerning ethnicity, readers should interpret this finding with caution.

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months, by Deprivation Quintile



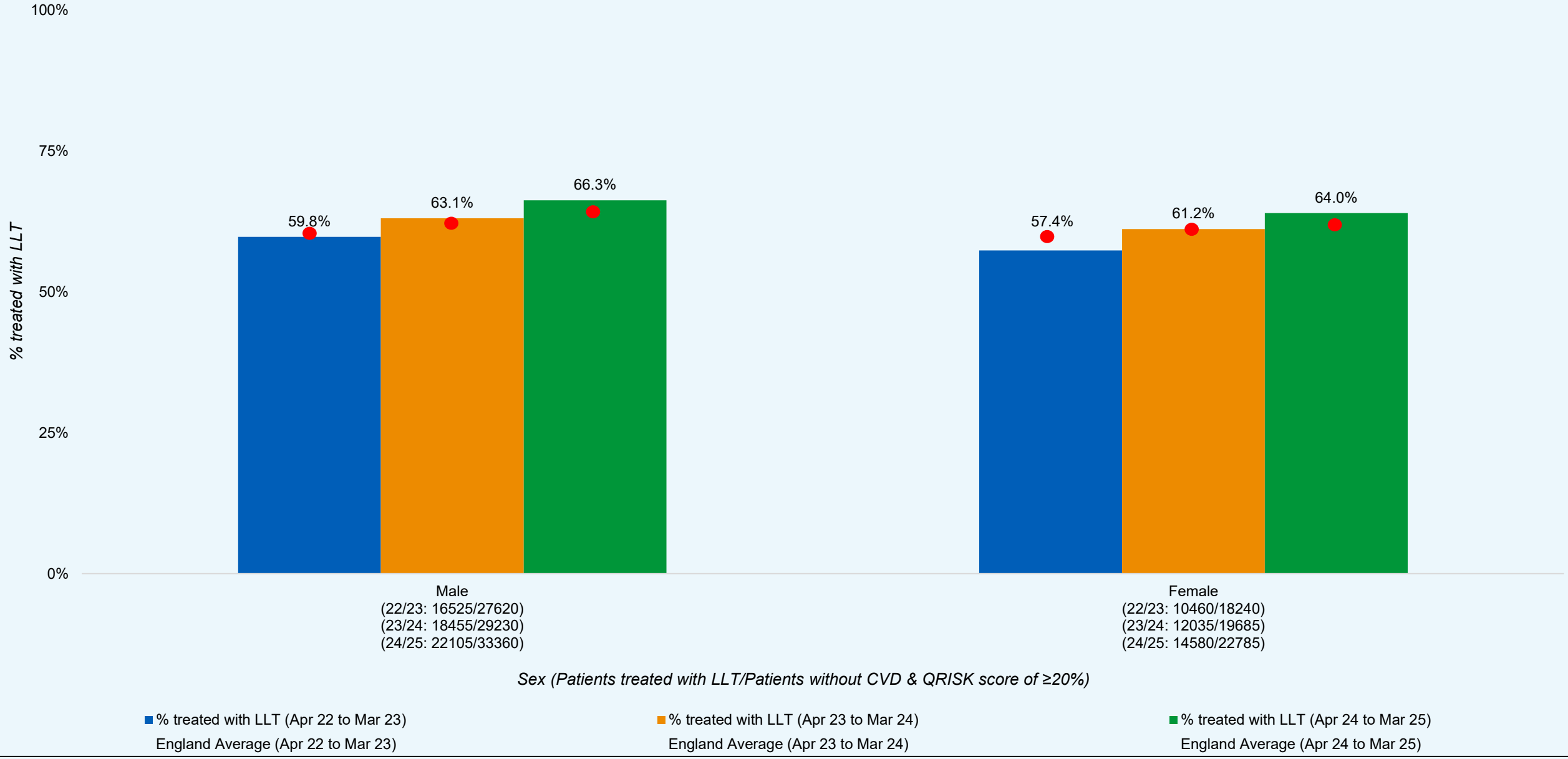
Source: [CVD Prevent Data Explorer (Indicator CVDP007HYP)]

Between April 2023 and March 2024, 72.2% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. 67.5% of those living in the most deprived quintile had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than those living in the least deprived quintile, where 74.6% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

Between April 2024 and March 2025, 71.5% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold – a 0.7 percentage point decreased compared to the previous 12 months. 67.7% of those living in the most deprived quintile had their blood pressure below the age-appropriate treatment threshold, which was significantly lower than those living in the least deprived quintile, where 74.0% of the hypertensive population had their latest blood pressure reading below the age-appropriate threshold.

Those with GP recorded hypertension living in the most deprived quintile had a significantly lower proportion who had their hypertension optimally managed than those living in the least deprived quintile. The gap between those living in the most deprived and least deprived parts of the county decreased from a 7.1 percentage point difference in 23/24 to a 6.3 percentage point gap in 24/25, indicating there is a potential improving picture of health inequalities related to hypertension management.

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy, by Sex



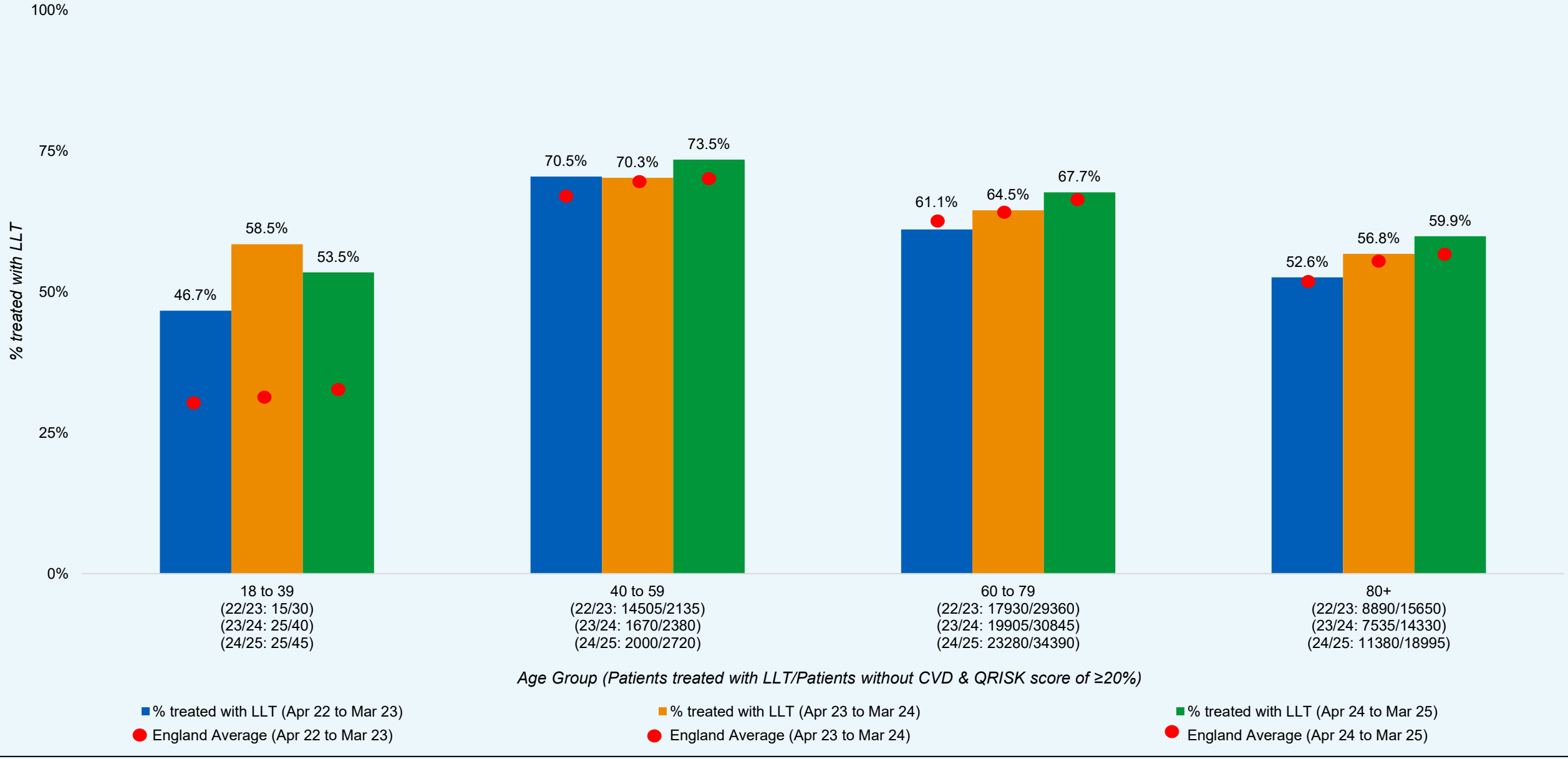
Source: CVD Prevent Data Explorer (Indicator CVDP003CHOL)

Between April 2023 and March 2024, 62.3% of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. 63.1% of eligible males were being treated with LLT, which was significantly higher than the female population where 61.2% were being treated with LLT.

Between April 2024 and March 2025, 65.3 % of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy – an increase of 3.0 percentage points. 66.3% of eligible males were being treated with LLT, which was significantly higher than the female population where 64.0% were being treated with LLT.

The difference between eligible males and females being treated with LLT increased from 1.9 percentage points in 23/24 to 2.3 percentage points in 24/25. This indicates are potentially eligible females are receiving a lower uptake of LLT compared to males.

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy, by Age Group



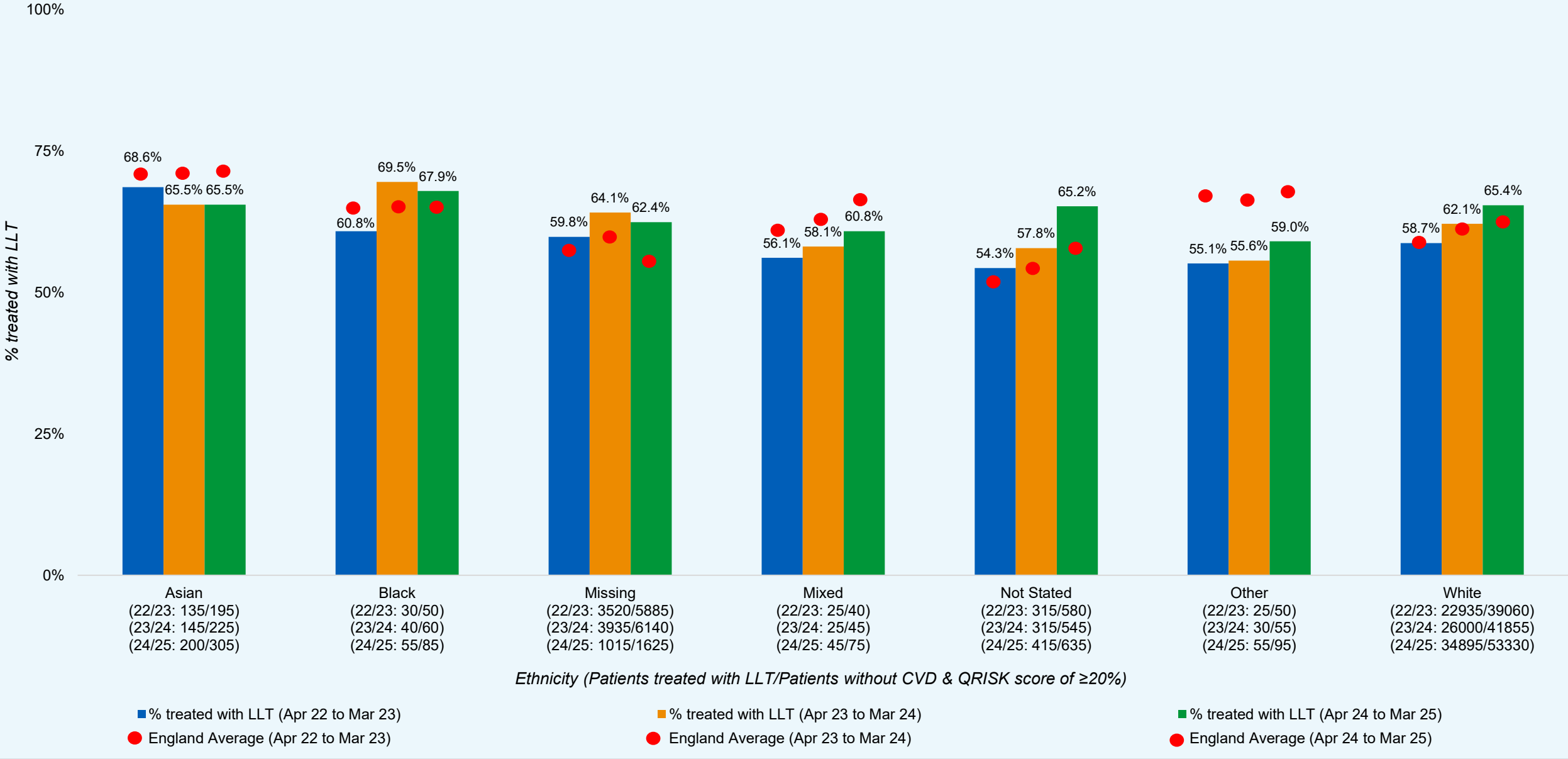
Source: CVD Prevent Data Explorer (Indicator CVDP003CHOL)

Between April 2023 and March 2024, 62.3% of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. 70.3% of eligible 40-to-59-year-olds were being treated with LLT, which was significantly higher than the eligible 80+ population, where 56.8% of the eligible population were being treated with LLT.

Between April 2024 and March 2025, 65.3 % of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy – an increase of 3.0 percentage points. 73.5% of eligible 40-to-59-year-olds were being treated with LLT, which was significantly higher than the eligible 80+ population, where 59.9% of the eligible population were being treated with LLT.

The difference between 40-to-59-year-olds and 80+ year olds eligible to be treated with LLT effectively stayed the same between 23/24 and 24/25 (a 13.5 percentage points difference between the two age groups in 23/24, and a 13.6 percentage point difference between the same two age groups in 24/25). This is perhaps an unsurprising finding given this is primary prevention, which working age adults are more likely to be subject to than older adults. This trend is reflected nationally.

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy, by Ethnicity



Source: CVD Prevent Data Explorer (Indicator CVDP003CHOL)

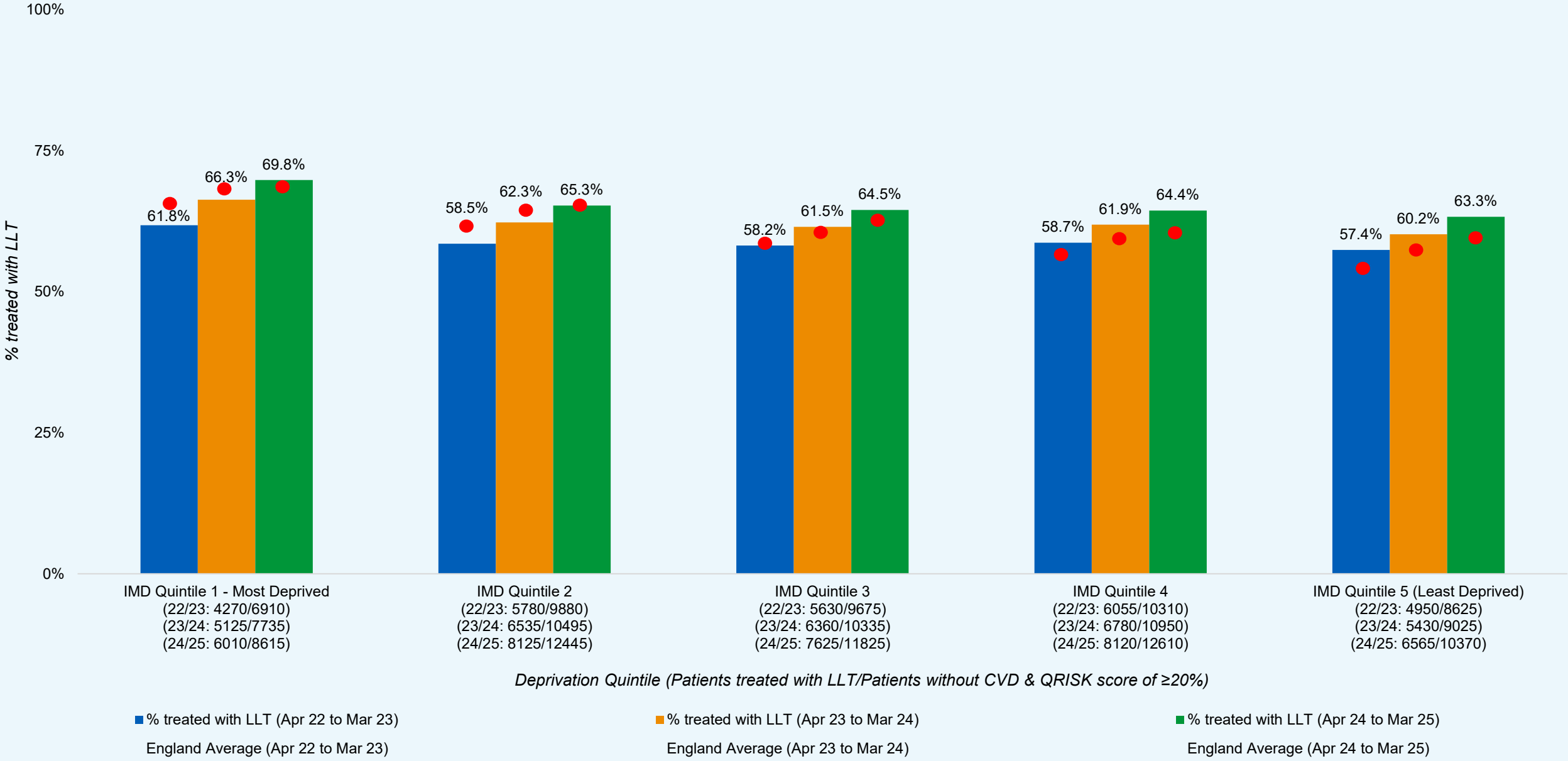
Between April 2023 and March 2024, 62.3% of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. 62.1% of eligible people from a White background were being treated with LLT, which was significantly higher than those from an Other ethnicity, where 55.6% of the eligible population were being treated with LLT.

Between April 2024 and March 2025, 65.3 % of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy – an increase of 3.0 percentage points. 65.4% of eligible people from a White background were being treated with LLT, which was significantly higher than those from an Other ethnicity, where 59.0% of the eligible population were being treated with LLT.

The difference between those from a White background and those from an Other ethnic background effectively stayed the same between 23/24 and 24/25 (a 6.5 percentage point difference in 23/24 to a 6.4 percentage point difference in 24/25). It's difficult to determine whether there are genuine health inequalities in being treated with LLT (where there is no GP recorded CVD and a QRISK score of 20% or more) based on ethnicity given the lower count in the ethnic minority groups. The Other ethnicity group was selected to compare against the White population as it had the lowest uptake.

Source: CVD Prevent Data Explorer (Indicator CVDP003CHOL)

Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy, by Deprivation Quintile



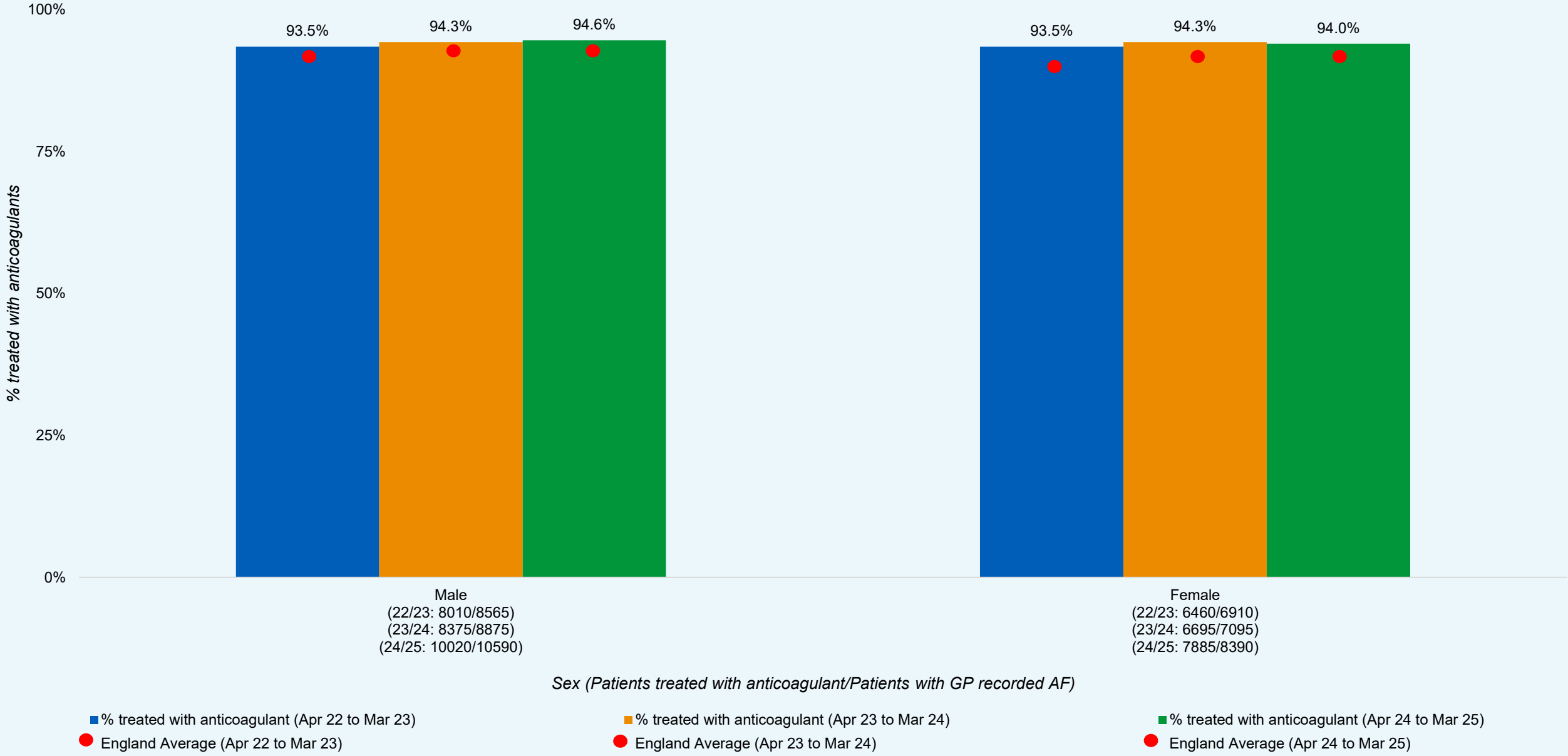
Source: CVD Prevent Data Explorer (Indicator CVDP003CHOL)

Between April 2023 and March 2024, 62.3% of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. 66.3% of eligible people from the most deprived quintile were being treated with LLT, which was significantly higher than those from the least deprived quintile, where 60.2% of the eligible population were being treated with LLT.

Between April 2024 and March 2025, 65.3 % of those no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy – an increase of 3.0 percentage points. 69.8% of eligible people from the most deprived quintile were being treated with LLT, which was significantly higher than those from the least deprived quintile, where 63.3% of the eligible population were being treated with LLT.

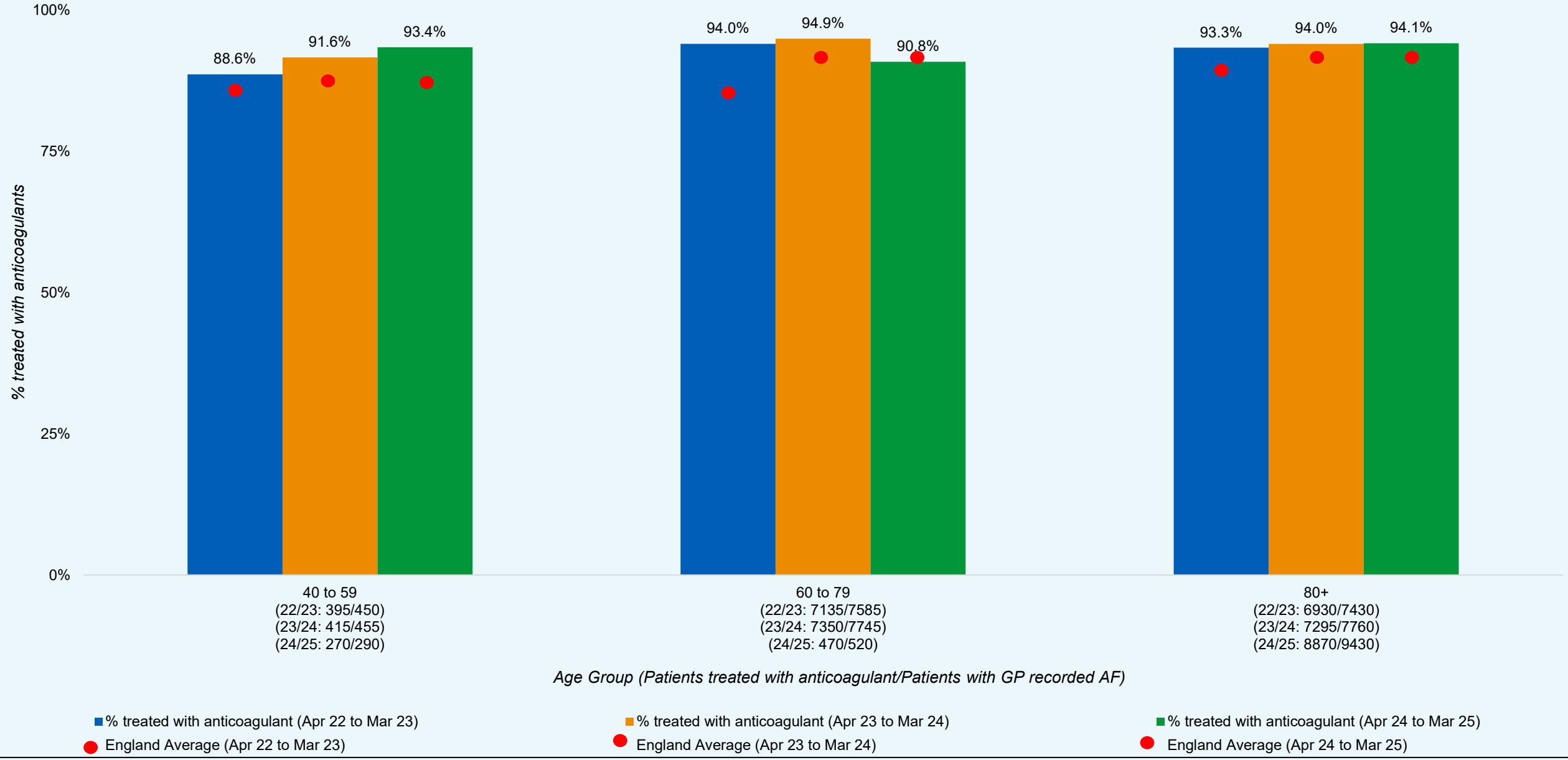
The difference between those from the most deprived quintile and least deprived quintile between 23/24 and 24/25 slightly widened between from 6.1 percentage points to 6.5 percentage points. It's difficult to determine whether there are genuine health inequalities in being treated with LLT (where there is no GP recorded CVD and a QRISK score of 20% or more) based on deprivation quintile as there may be greater need for primary prevention in those living in more deprived parts of the county.

Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant, by Sex



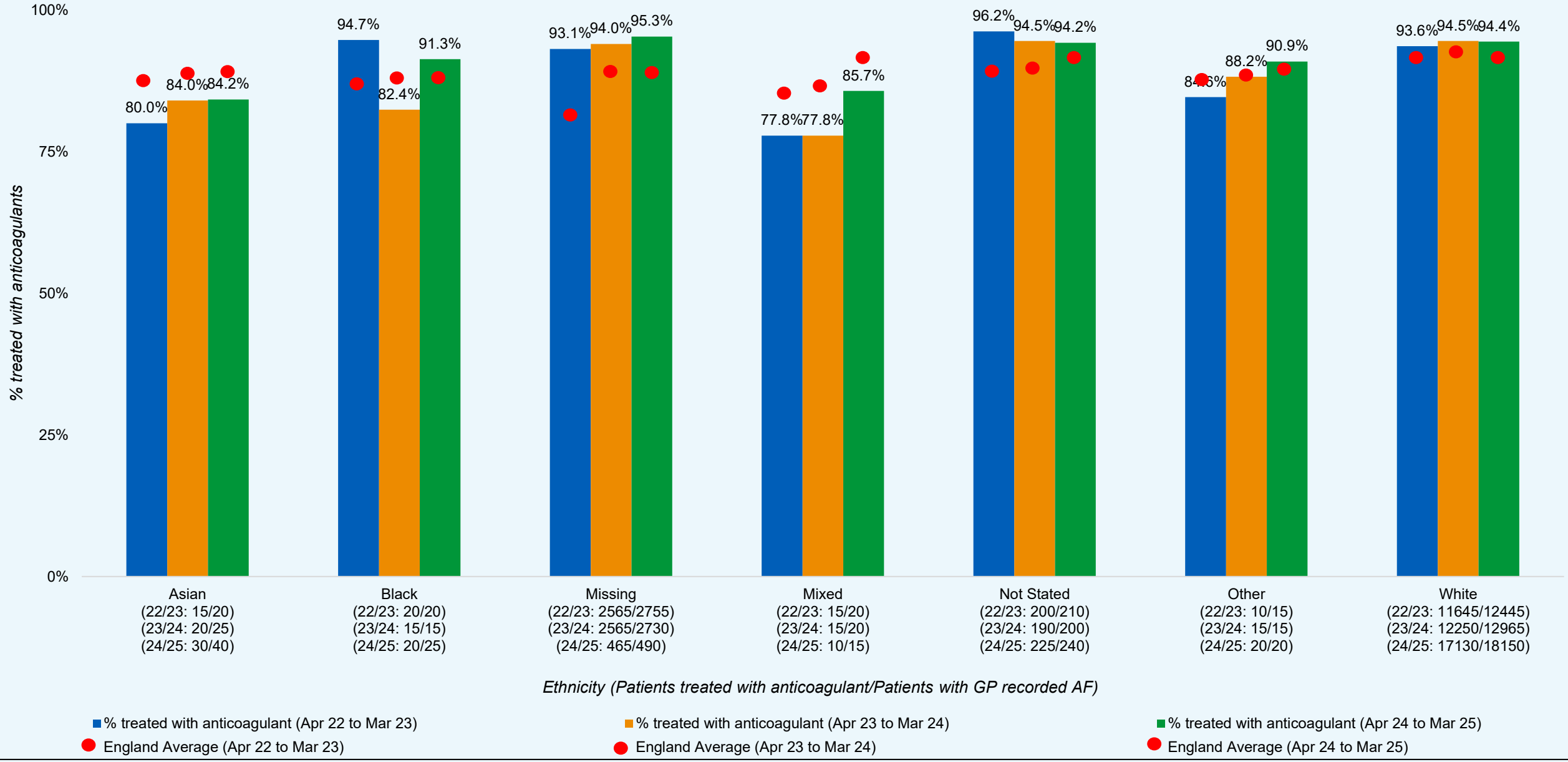
Source: CVD Prevent Data Explorer (Indicator CVDP002AF)

Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant, by Age Group



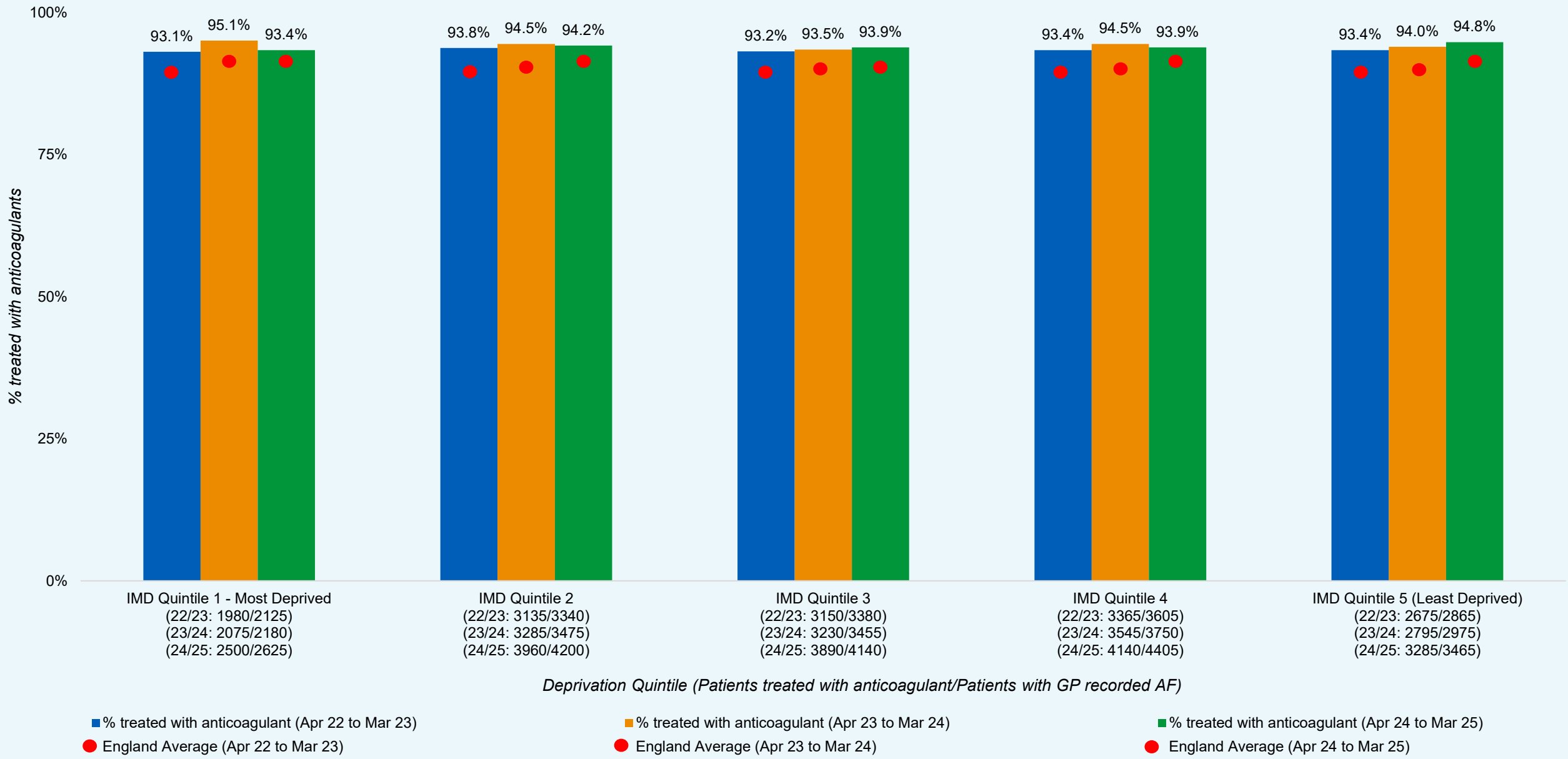
Source: CVD Prevent Data Explorer (Indicator CVDP002AF)

Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant, by Ethnicity



Source: CVD Prevent Data Explorer (Indicator CVDP002AF)

Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant, by Deprivation Quintile



Source: CVD Prevent Data Explorer (Indicator CVDP002AF)

Cardiovascular Diseases – Domain Summary

Age: There is a clear age gradient in both acute cardiovascular outcomes and the effectiveness or uptake of preventive care interventions. While older adults bear the greatest burden of disease, there are emerging concerns about preventive management in younger age groups, suggesting potential missed opportunities to mitigate long-term risk.

Sex: Males are more likely to suffer acute cardiovascular events (stroke and MI), which may be linked to poorer hypertension control we have observed in males. Females are less likely to receive lipid-lowering therapy when clinically indicated, yet still show better outcomes, evidenced by a significantly lower rate of acute cardiovascular events.

Deprivation: There is a consistent pattern of poorer cardiovascular outcomes among those living in more deprived parts of the county, potentially driven by the observed poorer uptake of hypertension management but higher uptake in primary cholesterol management (lipid lowering therapy). These results suggest more effective preventative care efforts are needed to reduce the disparities between those living in the most and least deprived parts of the county.

Ethnicity: The ethnic breakdown of cardiovascular data in Lincolnshire highlights potential disparities, primarily in preventive care indicators and outcomes for non-White populations. However, small counts in these indicators, coupled with well documented data limitations around accurate ethnicity coding, prevent firm conclusions and may underestimate or overestimate the true scale of inequality.

What is encouraging when looking at the hypertension, cholesterol, and AF measures is a significant reduction in the proportion of the respective populations where the ethnicity is missing or unknown.
4.3% of those in the hypertension indicator had a missing or unknown ethnicity in 24/25, compared to 17.1% in 23/24.
4.0% of those in the cholesterol indicator had a missing or unknown ethnicity in 24/25, compared to 13.7% in 23/24.
4.0% of those in the AF indictor had a missing or unknown ethnicity in 24/25, compared to 18.3% in 23/24.

Diabetes – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Variation between % of people with type 1 diabetes receiving all 8 care processes	N/A*	⇩	⇧	⇧	–
Variation between % of people with type 2 diabetes receiving all 8 care processes	N/A*	⇧	⇔	⇧	⇧
Variation between % of referrals from the most deprived quintile and % of type 2 diabetes population from the most deprived quintile	⇔	⇔	⇔	⇔	–

% of patients with type 1 diabetes who received all 8 care processes by PCN

PCN	01/01/23 to 31/03/24	01/04/24 to 31/03/25
Apex	53.8% (140/260)	53.8% (140/260)
Boston	36.4% (120/330)	25.7% (90/350)
East Lindsey	47.1% (120/255)	41.8% (115/275)
First Coastal	41.2% (140/340)	29.2% (105/360)
Four Counties	48.6% (90/185)	47.4% (90/190)
Grantham and Rural	48.1% (185/385)	39.2% (155/395)
Imp	55.1% (190/345)	46.5% (165/355)
K2 Healthcare Sleaford	42.6% (115/270)	38.6% (110/285)
Lincoln Health Partnership	48.4% (75/155)	38.2% (65/170)
Meridian Medical	55.3% (105/190)	42.5% (85/200)
South Lincoln	34.0% (80/235)	38.3% (90/235)
South Lincolnshire Rural	45.0% (225/500)	41.1% (220/535)
Spalding	30.0% (60/200)	45.0% (90/200)
Trent Care	42.2% (95/225)	38.6% (85/220)
Lincolnshire ICB Average	***45.0% (1,745/3,875)***	***39.5% (1,600/4,030)***
England Average	***44.3% (120,590/272,400)***	***39.5% (109,795/278,210)***

Source: National Diabetes Audit (Jan 2023 to March 2024); National Diabetes Audit (April 2024 to March 2025)

% of patients with type 2 diabetes who received all 8 care processes by PCN

PCN	01/01/23 to 31/03/24	01/04/24 to 31/03/25
Apex	72.8% (2,030/2,790)	69.9% (2,010/2,875)
Boston	52.8% (2,455/4,650)	49.1% (2,350/4,790)
East Lindsey	62.3% (2,495/4,005)	52.9% (2,195/4,150)
First Coastal	53.9% (4,110/7,625)	44.0% (3,485/7,925)
Four Counties	64.8% (1,425/2,200)	58.1% (1,310/2,255)
Grantham and Rural	64.8% (2,940/4,540)	56.7% (2,660/4,695)
Imp	66.2% (2,640/3,990)	57.3% (2,380/4,155)
K2 Healthcare Sleaford	52.2% (2,040/3,910)	47.7% (1,945/4,075)
Lincoln Health Partnership	58.6% (855/1,460)	50.0% (770/1,540)
Meridian Medical	66.6% (1,775/2,665)	56.6% (1,565/2,765)
South Lincoln	57.4% (1,630/2,840)	53.4% (1,575/2,950)
South Lincolnshire Rural	57.3% (4,150/7,245)	56.5% (4,285/7,585)
Spalding	33.7% (880/2,610)	51.7% (1,410/2,725)
Trent Care	51.9% (1,460/2,815)	46.0% (1,330/2,890)
Lincolnshire ICB Average	***57.9% (30,885/53,350)***	***52.8% (29,260/55,385)***
England Average	***62.3% (2,231,875/3,583,440)***	***57.6% (2,159,900/3,753,010)***

Source: National Diabetes Audit (Jan 2023 to March 2024); National Diabetes Audit (April 2024 to March 2025)

% of patients with type 1 diabetes who received all 8 care processes by Sex

Sex	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
Female	**32.1%** (557/1734)	**31.5%** (551/1746)	**32.5%** (573/1762)	**35.2%** (627/1781)
Male	**33.2%** (690/2079)	**32.7%** (688/2099)	**32.8%** (697/2127)	**35.7%** (767/2148)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 1 diabetes who received all 8 care processes by Deprivation Decile

Between 01/07/23-30/06/24 and 01/04/24-31/03/25, there was a decrease between the proportion of males and females who achieved all 8 care processes (1.1% points to 0.5% points).

% of patients with type 1 diabetes who received all 8 care processes by Age Group

Age Group	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
0 to 9	**0.00%** (Small count suppression)	**0.0%** (Small count suppression)	**0.0%** (Small count suppression)	**0.00%** (Small count suppression)
10 to 19	**3.5%** (14/396)	**3.5%** (14/401)	**4.4%** (18/411)	**4.0%** (17/422)
20 to 29	**27.8%** (129/464)	**26.9%** (126/468)	**27.5%** (126/458)	**27.8%** (127/457)
30 to 39	**27.9%** (150/538)	**28.4%** (153/538)	**29.0%** (160/552)	**33.2%** (185/557)
40 to 49	**28.0%** (139/496)	**28.5%** (143/501)	**31.2%** (159/509)	**33.3%** (170/511)
50 to 59	**37.8%** (250/662)	**35.3%** (229/648)	**36.5%** (239/654)	**38.5%** (251/652)
60 to 69	**46.9%** (266/567)	**48.8%** (286/585)	**46.5%** (278/598)	**51.4%** (314/611)
70 to 79	**52.8%** (214/405)	**49.8%** (203/408)	**52.5%** (213/406)	**56.7%** (233/411)
80 to 89	**44.4%** (80/180)	**44.1%** (79/179)	**38.1%** (69/181)	**50.0%** (91/182)
90 to 99	**20.0%** (5/25)	**21.4%** (6/28)	**28.6%** (8/28)	**18.2%** (6/33)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 1 diabetes who received all 8 care processes by Age Group

Between 01/07/23-30/06/24 and 01/04/24-31/03/25, there was an increase between the proportion of under 60s who received all 8 care processes and the proportion of over 60s who received all 8 care processes (17.1% points to 18.4% points).

% of patients with type 1 diabetes who received all 8 care processes by Deprivation Decile

Deprivation Decile	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
IMD Decile 1 (Most Deprived)	**24.7%** (60/243)	**27.0%** (67/248)	**21.2%** (55/259)	**22.7%** (58/255)
IMD Decile 2	**28.7%** (82/286)	**28.4%** (83/292)	**28.4%** (85/299)	**27.9%** (85/305)
IMD Decile 3	**36.1%** (162/449)	**32.0%** (149/465)	**33.7%** (160/475)	**34.0%** (161/474)
IMD Decile 4	**28.7%** (146/509)	**25.5%** (132/518)	**27.6%** (140/507)	**29.9%** (156/521)
IMD Decile 5	**32.9%** (111/337)	**32.0%** (106/331)	**32.1%** (108/337)	**37.8%** (126/333)
IMD Decile 6	**35.5%** (171/482)	**33.7%** (167/495)	**34.3%** (172/501)	**38.1%** (186/488)
IMD Decile 7	**29.4%** (131/445)	**32.4%** (149/460)	**30.0%** (137/456)	**37.1%** (174/469)
IMD Decile 8	**32.0%** (116/363)	**33.2%** (121/365)	**35.6%** (131/368)	**36.9%** (137/371)
IMD Decile 9	**37.6%** (151/402)	**39.0%** (157/403)	**41.8%** (173/414)	**46.5%** (201/432)
IMD Decile 10 (Least Deprived)	**41.8%** (102/244)	**41.9%** (104/248)	**40.7%** (105/258)	**40.5%** (104/257)
Slope/Relative Index of Inequality	**SII: 8.99%** **RII: 1.32**	**SII: 12.62%** **RII: 1.49**	**SII: 14.79%** **RII: 1.59**	**SII: 18.13%** **RII: 1.69**

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 1 diabetes who received all 8 care processes by Deprivation Decile

Between 01/07/23-30/06/24 and 01/04/24-31/03/25, the SII and RII increased from 12.88% and 1.32 to 13.91% and 1.31 respectively.

This means the gap between those living in the most and least deprived parts of Lincolnshire who have type 1 diabetes who receive all 8 care processes is growing, indicating a potential inequality in diabetes management.

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 1 diabetes who received all 8 care processes by Ethnicity

Ethnicity	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
Asian	**22.2%** (Small count suppression)	**32.0%** (Small count suppression)	**39.3%** (11/28)	**50.0%** (14/28)
Black	**27.8%** (Small count suppression)	**19.1%** (Small count suppression)	**26.9%** (Small count suppression)	**22.2%** (Small count suppression)
Mixed	**27.3%** (Small count suppression)	**32.4%** (11/34)	**38.2%** (13/34)	**37.5%** (12/32)
Other Ethnic Groups	**34.4%** (62/180)	**31.1%** (61/196)	**29.4%** (52/177)	**33.0%** (57/173)
Unknown	**28.3%** (17/60)	**25.5%** (12/47)	**34.1%** (15/44)	**34.1%** (15/44)
White - British & Irish	**33.2%** (1114/3360)	**32.8%** (1111/3383)	**33.0%** (1131/3432)	**35.8%** (1246/3484)
White - Other	**25.2%** (34/135)	**22.9%** (32/140)	**27.8%** (42/151)	**31.4%** (48/153)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 1 diabetes who received all 8 care processes by Ethnicity

Given the relatively low counts of those from different ethnic minority backgrounds compared to the White British/Irish population, it is difficult to state with certainty whether there is a genuine inequality who receive all 8 care processes.

% of patients with type 2 diabetes who received all 8 care processes by Sex

Sex	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
Female	**45.6%** (10229/22424)	**45.2%** (10311/22790)	**47.1%** (10820/22988)	**50.4%** (11720/23250)
Male	**48.0%** (13946/29067)	**48.1%** (14175/29462)	**49.6%** (14739/29724)	**53.3%** (16022/30083)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 2 diabetes who received all 8 care processes by Sex

Between 01/07/23-30/06/24 and 01/04/24-31/03/25, there was an increase between the proportion of males and females who achieved all 8 care processes (2.4% points to 2.9% points).

% of patients with type 2 diabetes who received all 8 care processes by Age Group

Age Group	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
0 to 9	**0.0%** (Small count suppression)	**0.0%** (Small count suppression)	**0.0%** (Small count suppression)	**0.0%** (Small count suppression)
10 to 19	**6.7%** (Small count suppression)	**6.9%** (Small count suppression)	**11.5%** (Small count suppression)	**11.1%** (Small count suppression)
20 to 29	**26.2%** (65/248)	**26.2%** (66/252)	**28.7%** (75/261)	**30.7%** (81/264)
30 to 39	**30.3%** (360/1190)	**31.4%** (386/1228)	**33.6%** (421/1253)	**34.6%** (442/1278)
40 to 49	**33.5%** (1086/3243)	**33.9%** (1129/3326)	**35.5%** (1206/3398)	**38.2%** (1324/3466)
50 to 59	**40.0%** (3480/8694)	**40.6%** (3577/8809)	**42.2%** (3742/8871)	**45.5%** (4058/8928)
60 to 69	**48.9%** (6640/13587)	**48.5%** (6711/13836)	**50.2%** (7024/14006)	**53.4%** (7605/14241)
70 to 79	**53.6%** (7843/14621)	**53.6%** (7920/14773)	**55.4%** (8218/14831)	**59.3%** (8889/14995)
80 to 89	**49.9%** (4178/8370)	**49.5%** (4189/8460)	**50.6%** (4299/8497)	**55.0%** (4713/8564)
90 to 99	**35.0%** (520/1488)	**33.3%** (504/1514)	**37.0%** (570/1542)	**40.5%** (624/1541)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 2 diabetes who received all 8 care processes by Age Group

This table illustrates the proportion of individuals with type 2 diabetes who received all eight care processes, stratified by age group in 10-year bands. A clear pattern emerges, showing that the uptake of all eight care processes increases with age up to a peak in the 70 to 79 age group, before declining in the older age bands. For instance, during the most recent reporting period (01/12/23 to 30/11/24), only 27.2% of individuals aged 20 to 29 completed all eight care processes, whereas this rises to 54.4% for those aged 70 to 79. The proportion then drops to 50.2% for the 80 to 89 age group and further to 35.4% in the 90 to 99 age group. Uptake in the youngest age groups, particularly 0 to 9 and 10 to19, but this is likely explained by the younger population who receive their diabetes management processes under the care of a consultant in secondary care. These observations are similar to other population level programmes such as screening or health checks.

% of patients with type 2 diabetes who received all 8 care processes by Deprivation Decile

Deprivation Decile	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
IMD Decile 1 (Most Deprived)	**40.0%** (1727/4320)	**39.6%** (1732/4369)	**40.2%** (1781/4428)	**44.6%** (1989/4458)
IMD Decile 2	**39.6%** (1895/4783)	**39.7%** (1921/4836)	**41.9%** (2033/4850)	**44.4%** (2174/4894)
IMD Decile 3	**47.7%** (2862/5998)	**46.7%** (2846/6090)	**47.7%** (2938/6154)	**51.2%** (3177/6204)
IMD Decile 4	**44.2%** (3020/6830)	**45.4%** (3151/6934)	**47.1%** (3314/7041)	**49.8%** (3552/7133)
IMD Decile 5	**47.2%** (2111/4475)	**46.3%** (2099/4534)	**48.6%** (2221/4574)	**52.6%** (2434/4628)
IMD Decile 6	**48.8%** (3000/6151)	**48.1%** (3018/6281)	**49.8%** (3145/6320)	**55.0%** (3528/6414)
IMD Decile 7	**49.1%** (2703/5510)	**48.4%** (2720/5619)	**49.4%** (2816/5702)	**53.4%** (3068/5747)
IMD Decile 8	**48.7%** (2403/4930)	**48.8%** (2453/5019)	**50.9%** (2621/5151)	**54.6%** (2830/5181)
IMD Decile 9	**51.3%** (2697/5262)	**52.0%** (2799/5383)	**53.8%** (2907/5402)	**57.1%** (3115/5460)
IMD Decile 10 (Least Deprived)	**55.6%** (1571/2824)	**56.2%** (1618/2880)	**58.5%** (1683/2875)	**59.8%** (1730/2891)
Slope/Relative Index of Inequality	**SII: 12.88% RII: 1.32**	**SII: 13.45% RII: 1.34**	**SII: 14.18% RII: 1.34**	**SII: 13.91% RII: 1.31**

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 2 diabetes who received all 8 care processes by Deprivation Decile

The table highlights a clear gradient in care process uptake, with lower percentages observed in the more deprived deciles and higher percentages in the less deprived ones. For example, in the most recent reporting period (01/12/23 to 30/11/24), only 39.5% of individuals in IMD Decile 1 received all eight care processes, compared to 57.1% in IMD Decile 10.

This inequality in uptake of all 8 care processes is summarised in the Slope Index of Inequality (SII) and Relative Index of Inequality (RII). The SII values suggest a consistent and notable absolute inequality in uptake. The RII, which reflects relative inequality, hovers around 1.3 to 1.34, indicating that individuals in the least deprived decile are roughly 30% more likely to receive all 8 care processes compared to those in the most deprived decile. This suggests a consistent disparity in receiving all 8 diabetes care processes.

% of patients with type 2 diabetes who received all 8 care processes by Ethnicity

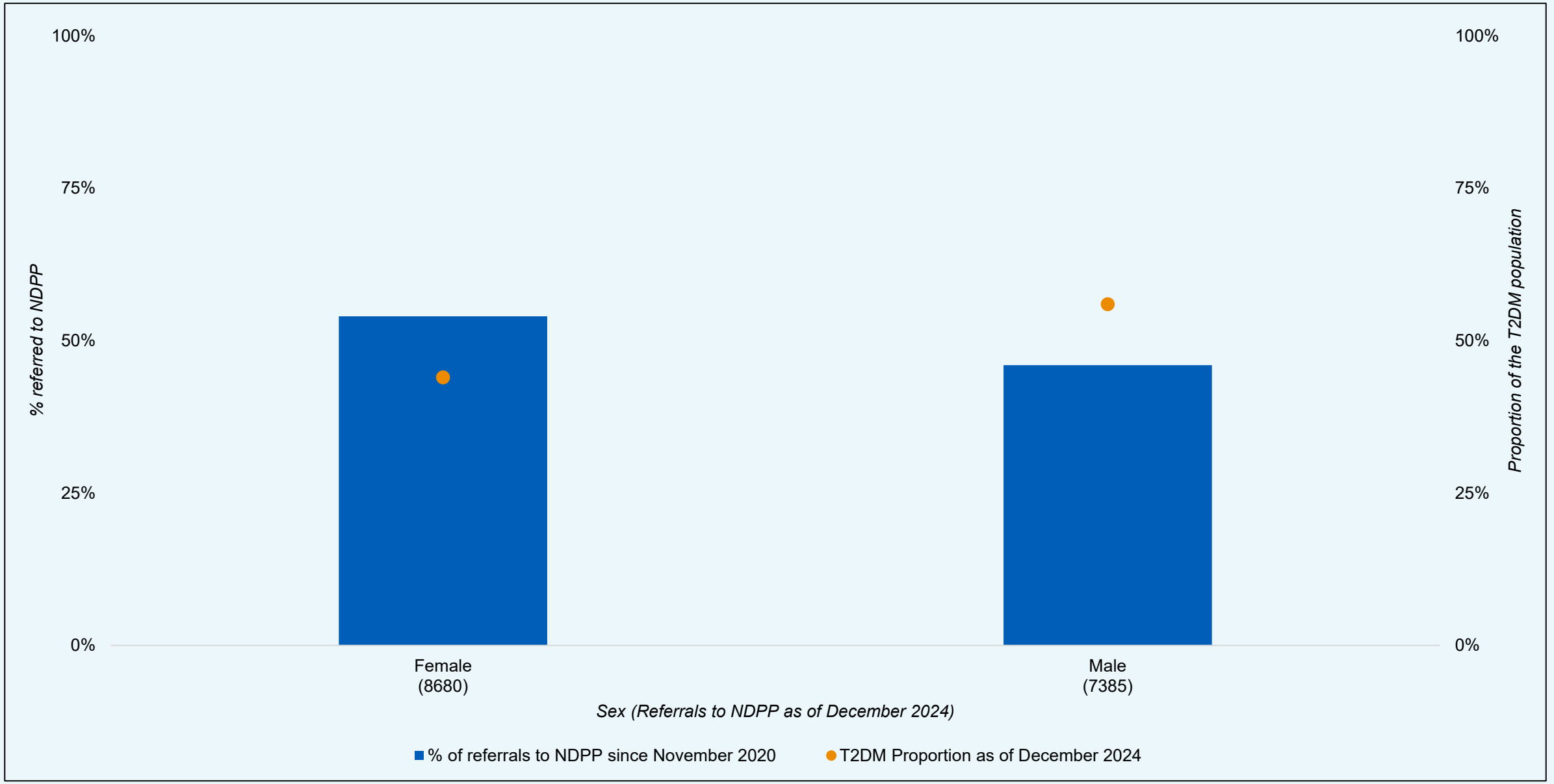
Ethnicity	01/07/23 to 30/06/24	01/10/23 to 30/09/24	01/01/24 to 31/12/24	01/04/24 to 31/03/25
Asian	**43.3%** (311/719)	**42.6%** (316/742)	**43.1%** (339/786)	**45.7%** (359/785)
Black	**44.9%** (170/379)	**42.9%** (169/394)	**43.3%** (191/441)	**46.6%** (180/386)
Mixed	**45.0%** (294/653)	**42.3%** (266/629)	**47.1%** (280/594)	**47.7%** (275/577)
Other Ethnic Groups	**44.8%** (1584/3536)	**43.1%** (1543/3579)	**45.9%** (1665/3626)	**49.2%** (1749/3553)
Unknown	**44.4%** (506/1141)	**43.4%** (496/1144)	**47.4%** (469/990)	**48.1%** (461/960)
White - British & Irish	**47.4%** (20813/43876)	**47.5%** (21192/44593)	**49.0%** (22082/45061)	**52.6%** (24103/45798)
White - Other	**41.6%** (500/1202)	**42.5%** (517/1216)	**44.3%** (564/1273)	**48.7%** (650/1336)

Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2025.

% of patients with type 2 diabetes who received all 8 care processes by Ethnicity

Between 01/07/23 to 30/06/24 and 01/04/24 to 31/03/25, all ethnicities experienced an increase in the uptake of all 8 care processes for patients with type 2 diabetes. The biggest increase was observed in the White Other population (41.6% to 48.7%), although the only ethnic group who had more than 50% of the population who received all 8 care processes.

National Diabetes Prevention Programme (NDPP) referrals by Sex



Source: National Diabetes Prevention Programme. November 2020 to December 2024.

National Diabetes Prevention Programme (NDPP) referrals by Sex

Between November 2020 and December 2024, approximately 16,065 people in Lincolnshire were referred to the National Diabetes Prevention Programme (NDPP). There are approximately 51,725 people in Lincolnshire who have a diagnosis of Type 2 Diabetes (T2DM).

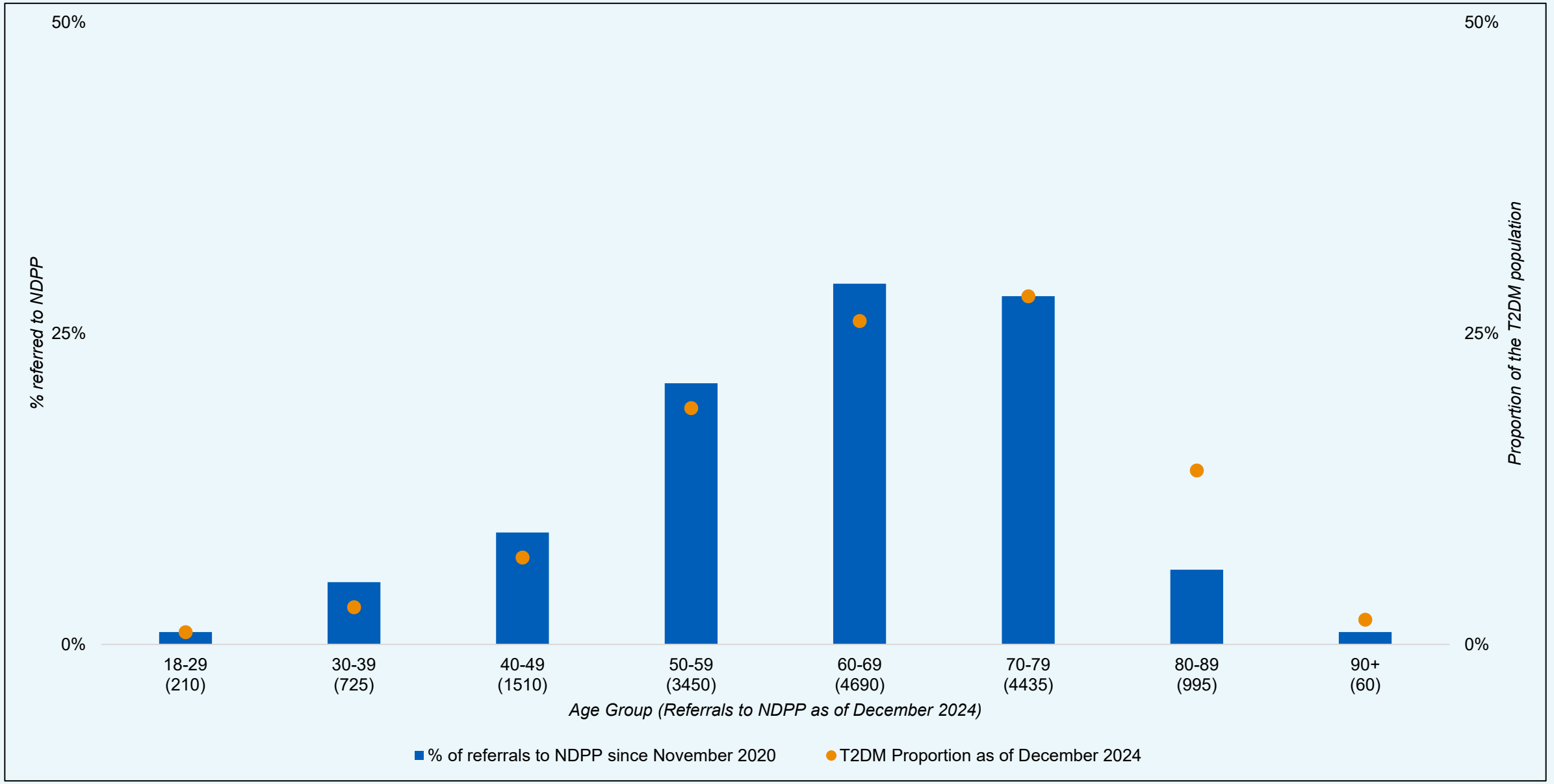
Approximately 44% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM are females. However, since November 2020, females account for 54% of referrals to the NDPP.

Approximately 56% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM are males. However, since November 2020, males account for 46% of referrals to the NDPP.

This suggests there is an inequity in referrals to the NDPP. As females account for 44% of people with T2DM in Lincolnshire, we would expect 44% of the referrals made to the NDPP to be females.

This suggests that, proportionately, there are more females being referred to the NDPP than males. This trend has been fairly consistent since November 2020.

National Diabetes Prevention Programme (NDPP) referrals by Age Group



Source: National Diabetes Prevention Programme. November 2020 to December 2024.

National Diabetes Prevention Programme (NDPP) referrals by Age Group

Between November 2020 and December 2024, approximately 16,065 people in Lincolnshire were referred to the National Diabetes Prevention Programme (NDPP). There are approximately 51,725 people in Lincolnshire who have a diagnosis of Type 2 Diabetes (T2DM).

There is variation in referrals between the different age groups. For example, 19% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM are between 50-59 years of age. However, 50–59-year-olds account for 21% of referrals to the NDPP.

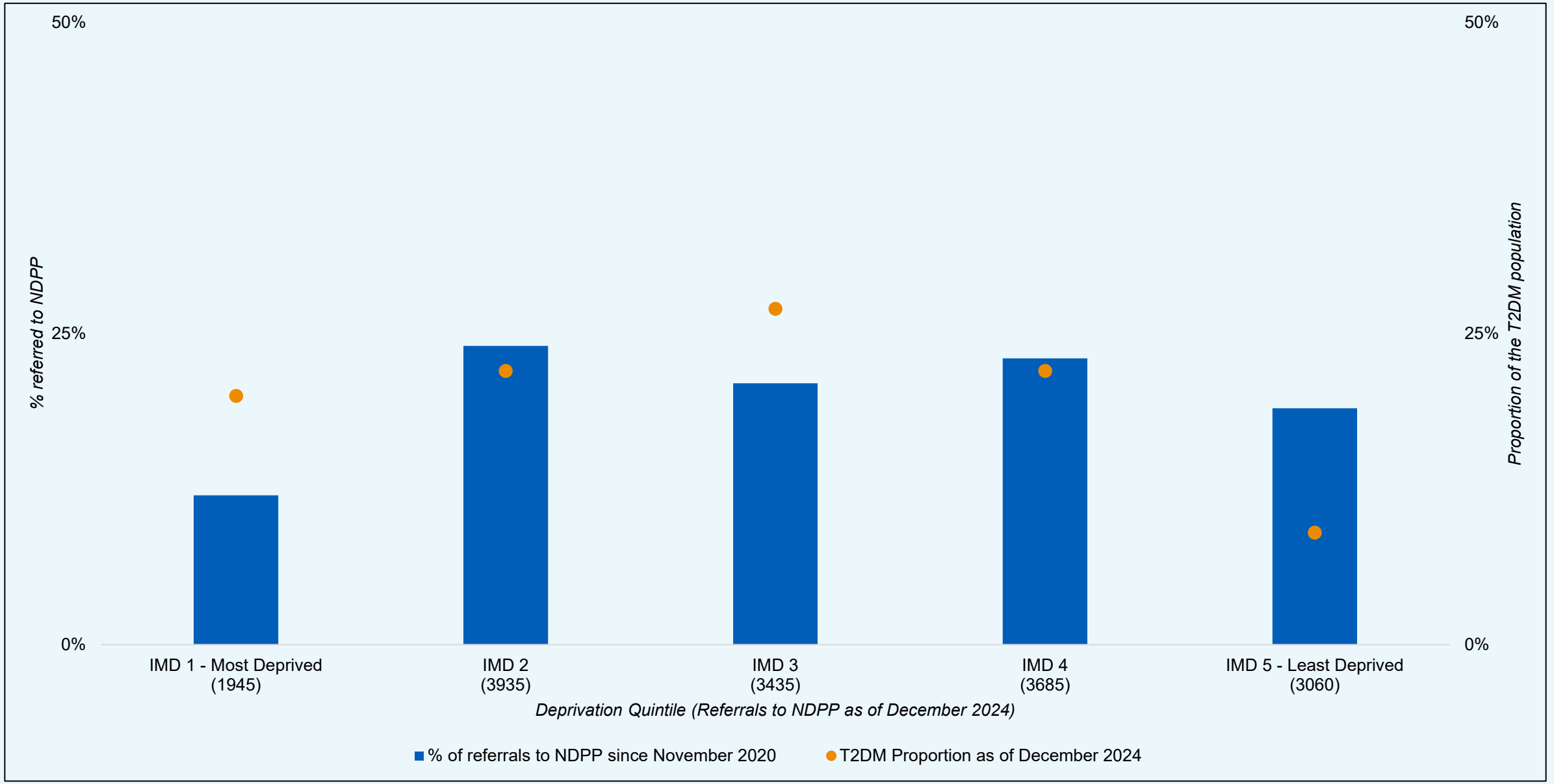
Whereas 14% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM are between 80-89 years of age. However, 80–89-year-olds account for 6% of referrals to the NDPP.

This suggests there is an inequity in referrals to the NDPP by age groups. As those aged 50-59 account for 19% of people with T2DM in Lincolnshire, we would expect 19% of the referrals made to the NDPP to be in the 50-59 age groups.

This suggests that, proportionately, there are more people in the 30-39, 40-49, 50-59, and 60-69 age groups being referred to the NDPP than those in the 18-29, 80-89, and 90+ age groups.

This trend has been fairly consistent since November 2020.

National Diabetes Prevention Programme (NDPP) referrals by IMD Quintile



Source: National Diabetes Prevention Programme. November 2020 to December 2024.

National Diabetes Prevention Programme (NDPP) referrals by IMD Quintile

Between November 2020 and December 2024, approximately 16,065 people in Lincolnshire were referred to the National Diabetes Prevention Programme (NDPP). There are approximately 51,725 people in Lincolnshire who have a diagnosis of Type 2 Diabetes (T2DM).

There is variation in referrals between the different deprivation quintiles. For example, 20% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM live in the most deprived quintile. However, those living in the most deprived quintile account for 12% of referrals to the NDPP.

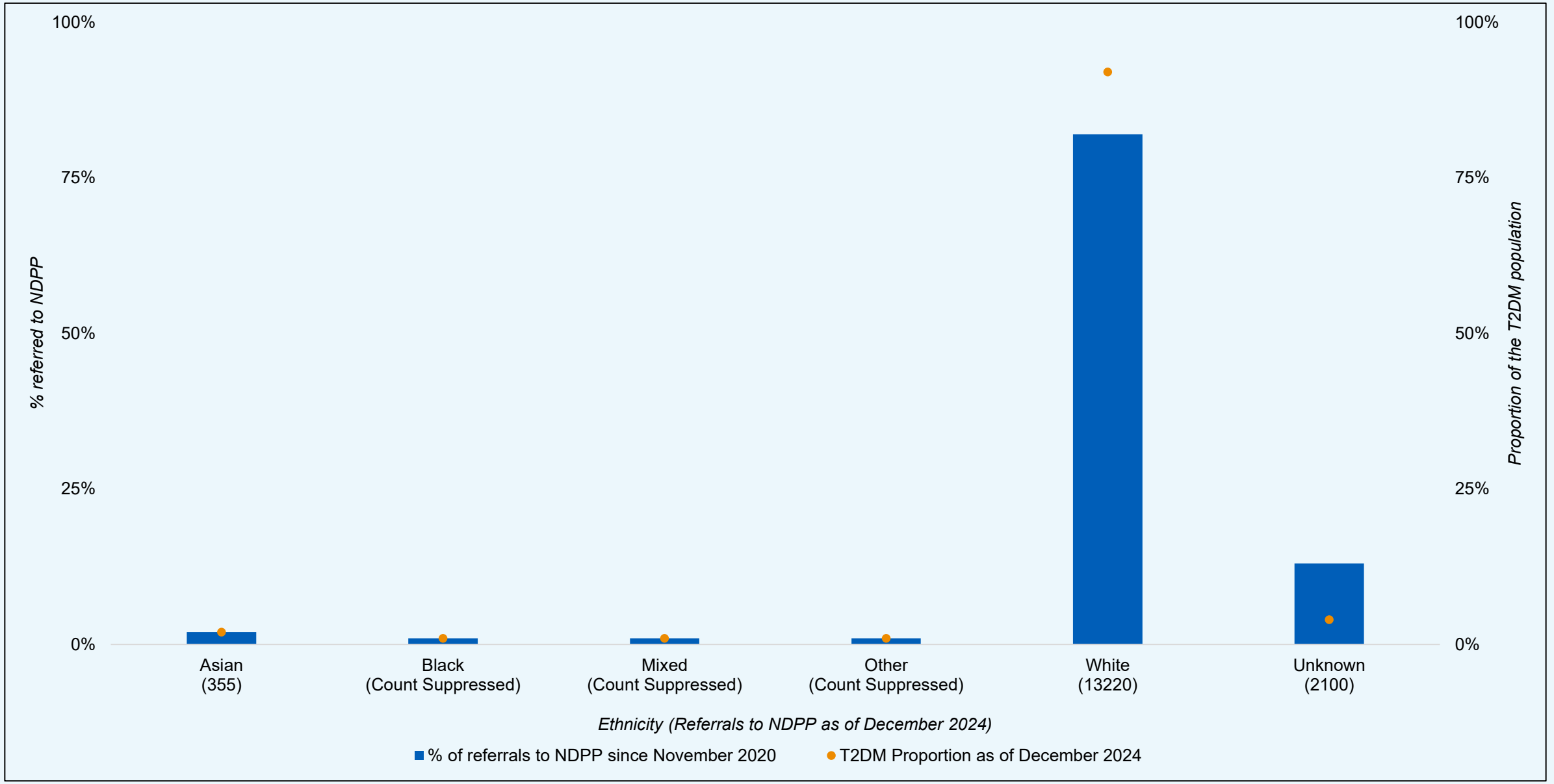
Whereas 9% of the 51,725 people in Lincolnshire who have been diagnosed with T2DM live in the least deprived quintile. However, those living in the least deprived quintile account for 19% of referrals to the NDPP.

This suggests there is an inequity in referrals to the NDPP by deprivation quintile. As those who live in the most deprived quintile account for 20% of people with T2DM in Lincolnshire, we would expect 20% of the referrals made to the NDPP to be from those living in the most deprived quintile.

This suggests that, proportionately, there are more people in least deprived quintile being referred to the NDPP than those living in the least deprived quintile.

There has been a slight widening in the proportion of those who have been referred to the NDPP between those living in the most deprived quintile and those living in the least deprived quintile since November 2020.

National Diabetes Prevention Programme (NDPP) referrals by Ethnicity



Source: National Diabetes Prevention Programme. November 2020 to December 2024.

National Diabetes Prevention Programme (NDPP) referrals by Ethnicity

Between November 2020 and December 2024, approximately 16,065 people in Lincolnshire were referred to the National Diabetes Prevention Programme (NDPP). There are approximately 51,725 people in Lincolnshire who have a diagnosis of Type 2 Diabetes (T2DM).

Given the low counts it can make it difficult to understand if there is a genuine health inequality in the referrals to NDPP.

Diabetes – Domain Summary

Age: A clear and consistent relationship shows better diabetes management in older adults, and a higher proportion of expected referrals to the NDPP. This age-related gradient may reflect several factors: younger people with diabetes, particularly those with type 1, are often managed in secondary care settings where structured primary care processes may not be systematically recorded or prioritised; in addition, younger adults may have lower engagement with routine health services, due to work or lifestyle pressures, or may not perceive themselves at high risk of complications.

Sex: While males appear to have higher rates of completing all 8 care processes (for both types of diabetes), the significantly higher rate of referrals to the NDPP in favour of females indicates a potential disconnect between routine diabetes care and prevention services. The reasons for this divergence may stem from differences in how men and women engage with healthcare services, are perceived by healthcare professionals, or are assessed for risk. It also raises questions about the targeting criteria and referral mechanisms used for NDPP, suggesting a need to evaluate whether males with Type 2 diabetes are being under-referred despite potentially greater clinical need.

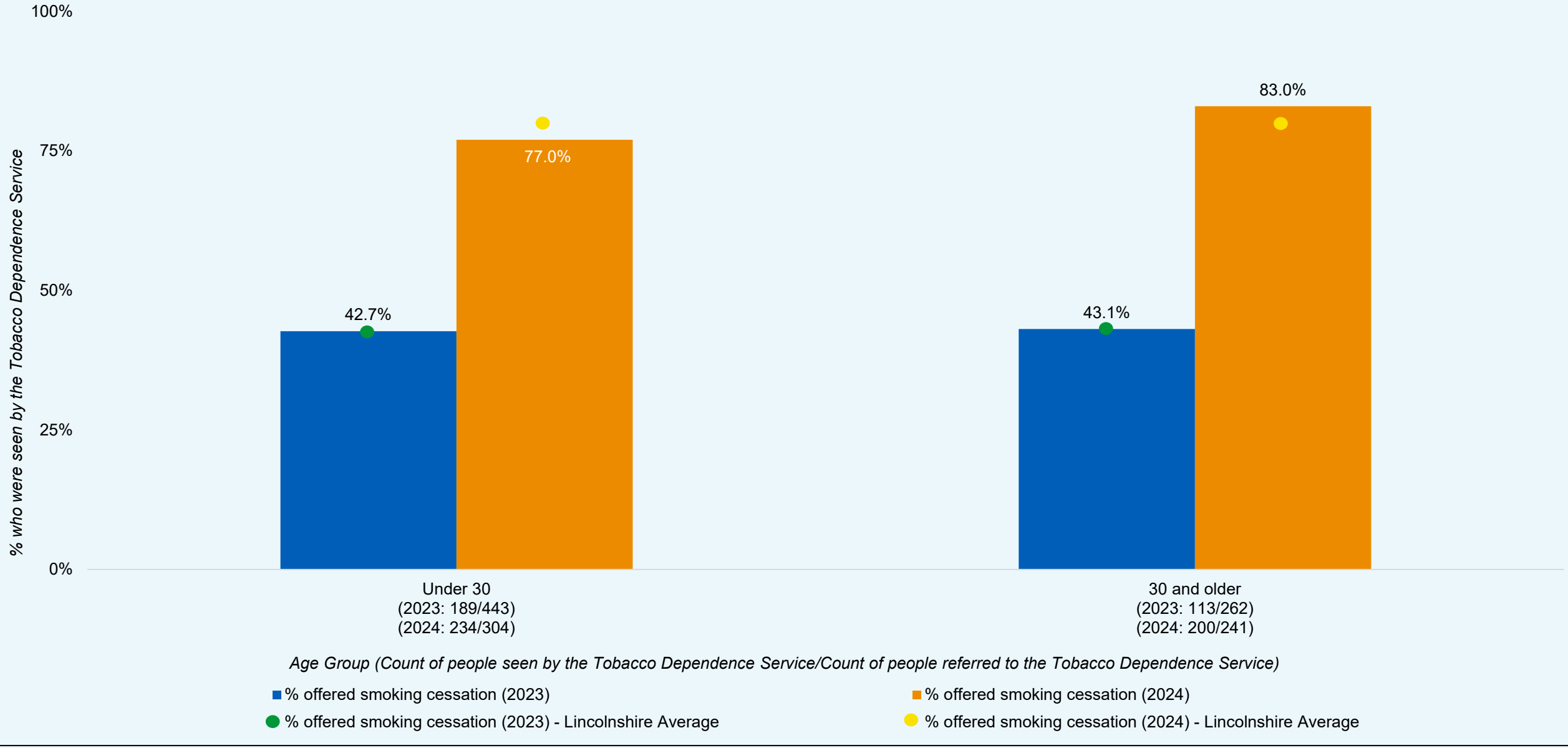
Deprivation: A clear and widening socioeconomic gradient exists in diabetes care across Lincolnshire, with individuals in more deprived areas consistently less likely to receive all eight care processes for both type 1 and type 2 diabetes. This inequality is mirrored in NDPP referrals, where those in the most deprived quintile are significantly under-represented despite their higher burden of disease.

Ethnicity: People from White British/Irish backgrounds have higher uptake of the eight diabetes care processes and appear more likely to be referred to the NDPP, particularly for type 2 diabetes. While this suggests potential inequalities affecting ethnic minority groups, low population counts limit the ability to draw firm conclusions. Improved ethnicity data capture is essential to better understand and address these possible disparities.

Smoking cessation – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Proportion of adults in acute inpatient settings who took up the smoking cessation service	↔	–	–	↑	–
Proportion of mothers in maternity inpatient settings who took up the smoking cessation services	↑	–	↑	↑	–

Smoking Cessation Services in Maternity Settings by Age Group

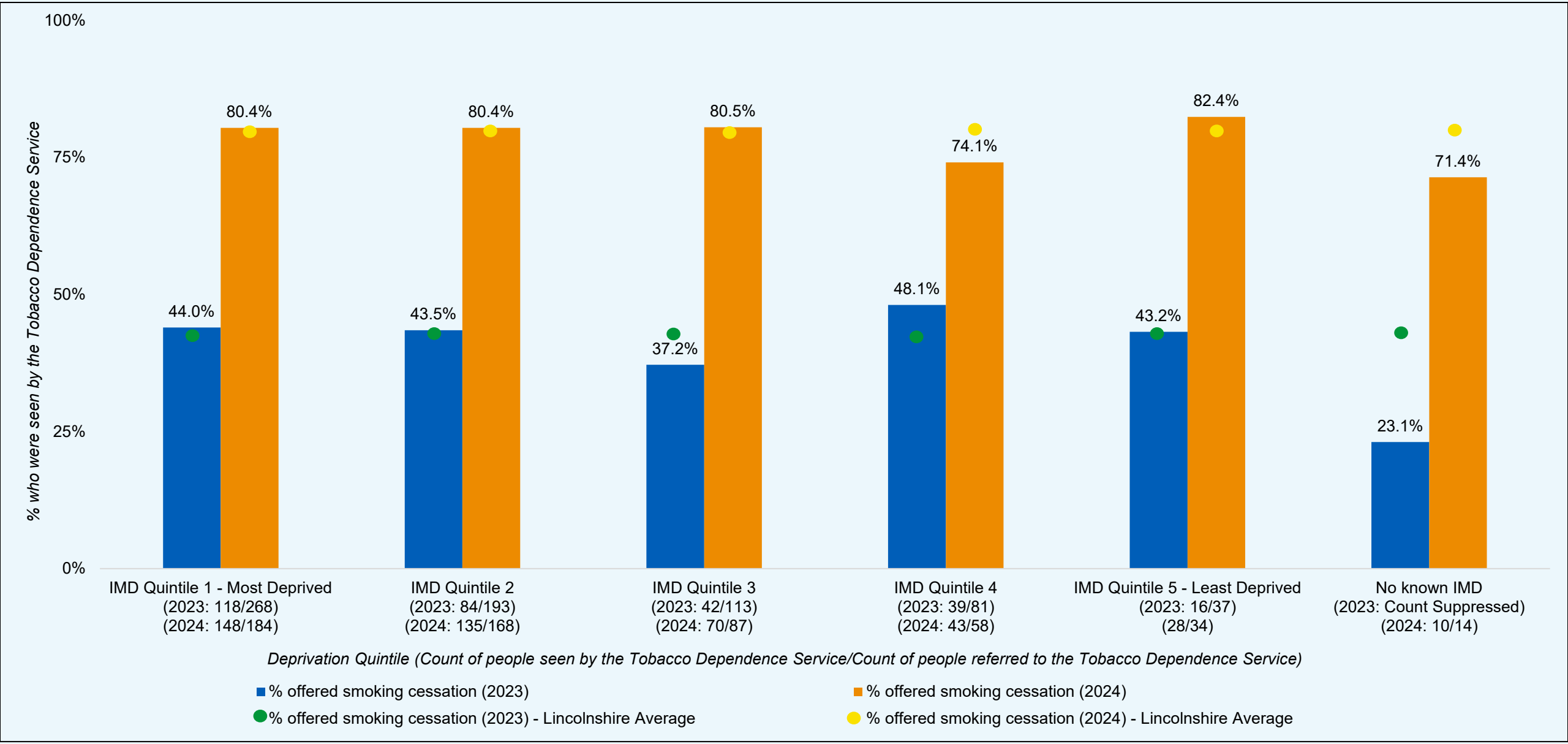


Sources: Tobacco Dependency Service Dataset (2023 and 2024)

Smoking Cessation Services in Maternity Settings by Age Group

The number and proportion of expectant mothers who were offered smoking cessation services in a maternity setting increased from 42.9% (302/705) in 2023 to 79.6% (434/545) in 2024. In 2023, the difference between mothers under 30 and those over 30 was only 0.4% (42.7% vs. 43.1%), but in 2024 the difference increased to 6.0% (77.0% vs. 83.0%). The Tobacco Dependency Service in Lincolnshire scaled up late in 2023 which explains this increase.

Smoking Cessation Services in Maternity Settings by Deprivation Quintile

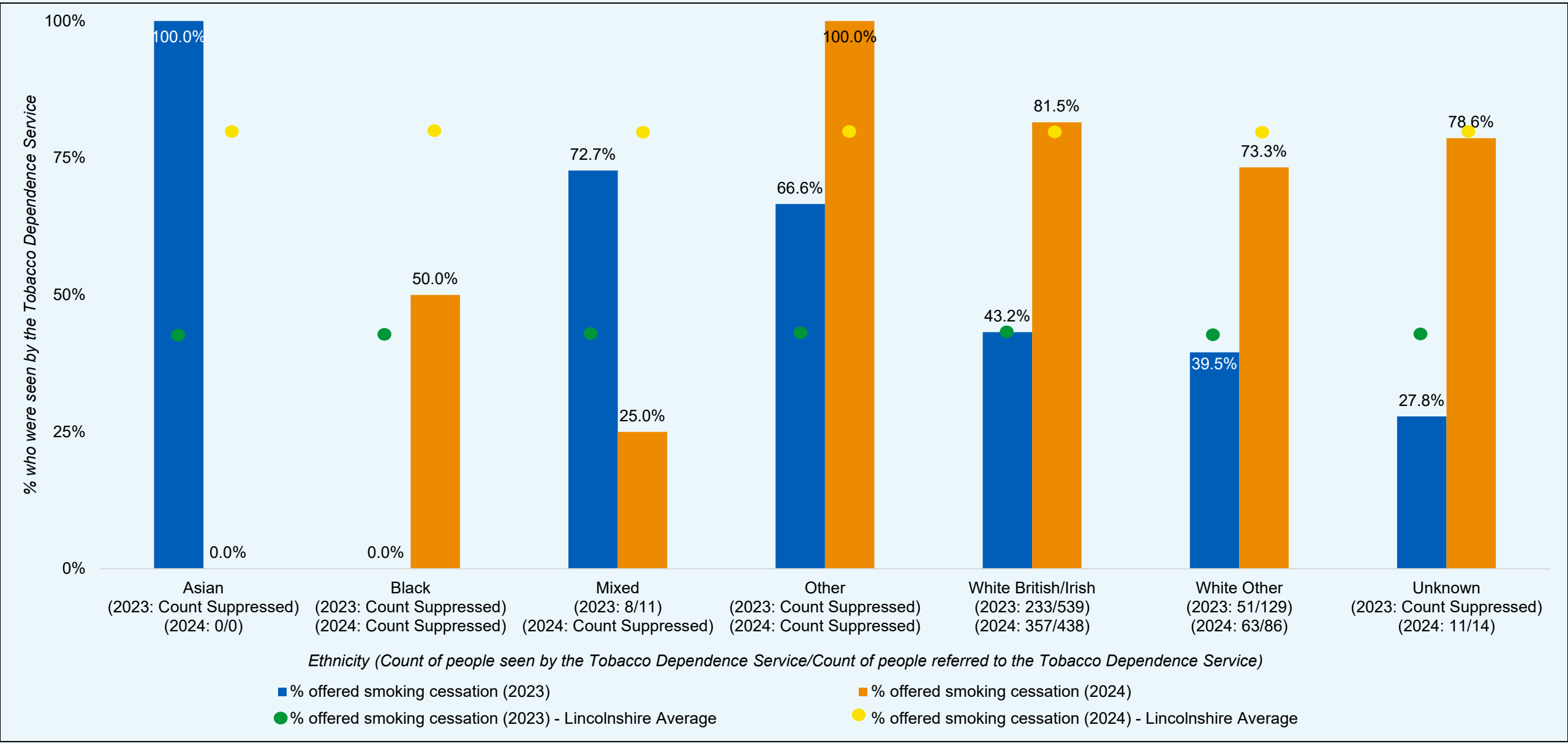


Sources: Tobacco Dependency Service Dataset (2023 and 2024)

Smoking Cessation Services in Maternity Settings by Deprivation Quintile

The number and proportion of expectant mothers who were offered smoking cessation services in a maternity setting increased from 42.9% (302/705) in 2023 to 79.6% (434/545) in 2024. The gap between the most and least deprived quintile between 2023 and 2024 increased from a 0.8% points to 2.0% points. Readers should interpret this results with caution due to the relatively low count of mothers in the least deprived quintile who smoked compared to mothers from the most deprived population.

Smoking Cessation Services in Maternity Settings by Ethnicity



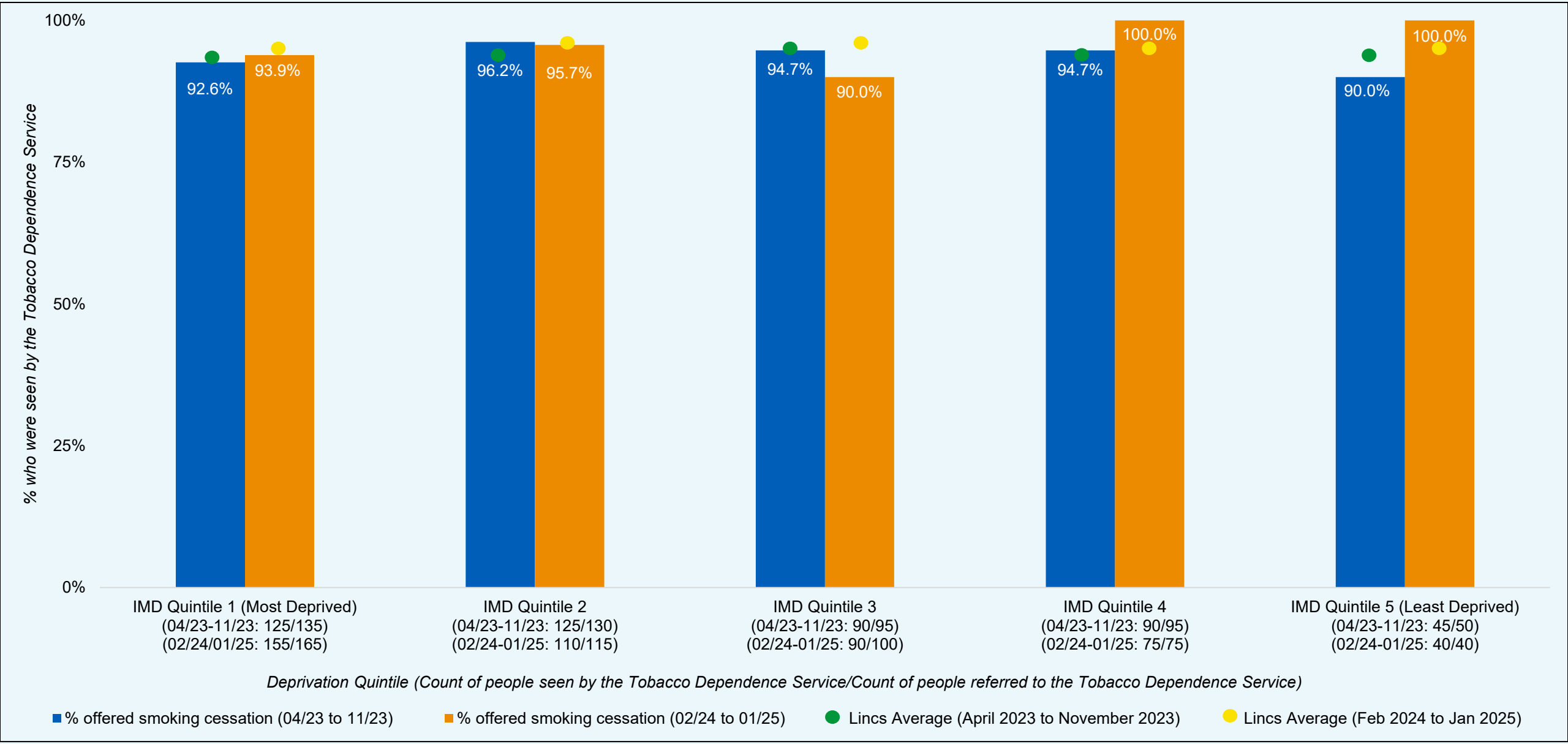
Sources: Tobacco Dependency Service Dataset (2023 and 2024)

Smoking Cessation Services in Maternity Settings by Ethnicity

The number and proportion of expectant mothers who were offered smoking cessation services in a maternity setting increased from 42.9% (302/705) in 2023 to 79.6% (434/545) in 2024.

Due to low counts in different ethnic categories, it can be difficult to determine if there are any genuine health inequalities experienced in uptake of smoking cessation services in Lincolnshire.

Smoking Cessation Services in Acute Inpatient Settings by Deprivation Quintile



Sources: Tobacco Dependence Services Dashboard

Smoking cessation – Domain Summary

Age: The number and proportion of mothers who were seen by the TDS once they were referred to the smoking cessation services in a maternity setting increased from 42.9% (302/705) in 2023 to 79.6% (434/545) in 2024. In 2023, the difference between mothers under 30 and those over 30 was only 0.4% (42.7% vs. 43.1%), but in 2024 the difference increased to 6.0% (77.0% vs. 83.0%). The Tobacco Dependency Service in Lincolnshire scaled up late in 2023 which explains this increase.

Sex: The indicators have not been stratified by sex.

Deprivation: While there appears to be a higher proportion of those from less deprived parts of the county being seen by the smoking cessation service in a maternity setting, this is potentially misleading as the numbers of those from more deprived backgrounds are much higher than those from less deprived backgrounds. This is a similar story in the maternity settings – where it should be noted that between 2023 and 2024, the overall proportion of smokers being seen by the smoking cessation services significantly increased, largely attributed to the Tobacco Dependency Service in Lincolnshire scaling up in late 2023.

Ethnicity: Due to the number of ethnic minorities where the low counts have had to be suppressed, this make it difficult to determine whether there are any inequalities in the uptake of smoking cessation services based on ethnic group.

Oral Health – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions, not number of teeth)	N/A (Small counts)	—	—	—	—

Tooth extractions due to decay for children admitted as inpatients, aged 10 years and under

Category	Number of children admitted as inpatients to hospital, aged 10 years and under, for a tooth extraction due to decay (2021 to 2024)
Persons	54
Male	32
Female	22
3 to 4 years	8
5 to 6 years	12
7 to 8 years	20
9 to 10 years	14
Mixed ethnicity	Count Suppressed
Not Known/Not Stated ethnicity	9
Other ethnicity	Count Suppressed
White ethnicity	39
IMD Quintile 1 – Most Deprived	17
IMD Quintile 2	Count Suppressed
IMD Quintile 3	Count Suppressed
IMD Quintile 4	14
IMD Quintile 5 – Least Deprived	Count Suppressed

Source: Secondary Use Services inpatient admissions. January 2021 to December 2024.

Oral Health – Domain Summary

Due to the very small counts, even when aggregated, it is not possible to determine whether there are any health inequalities between the different characteristics.

Learning Disabilities and Autism – One Page Summary (24/25)

Indicator	Lincs average compared to 23/24	Sex	Age	Deprivation	Ethnicity
Learning Disability Annual Health Checks	↔	↑	↑	↑	↔
Adult Mental Health inpatient rates for people with a learning disability and autistic people	↔	–	–	–	–

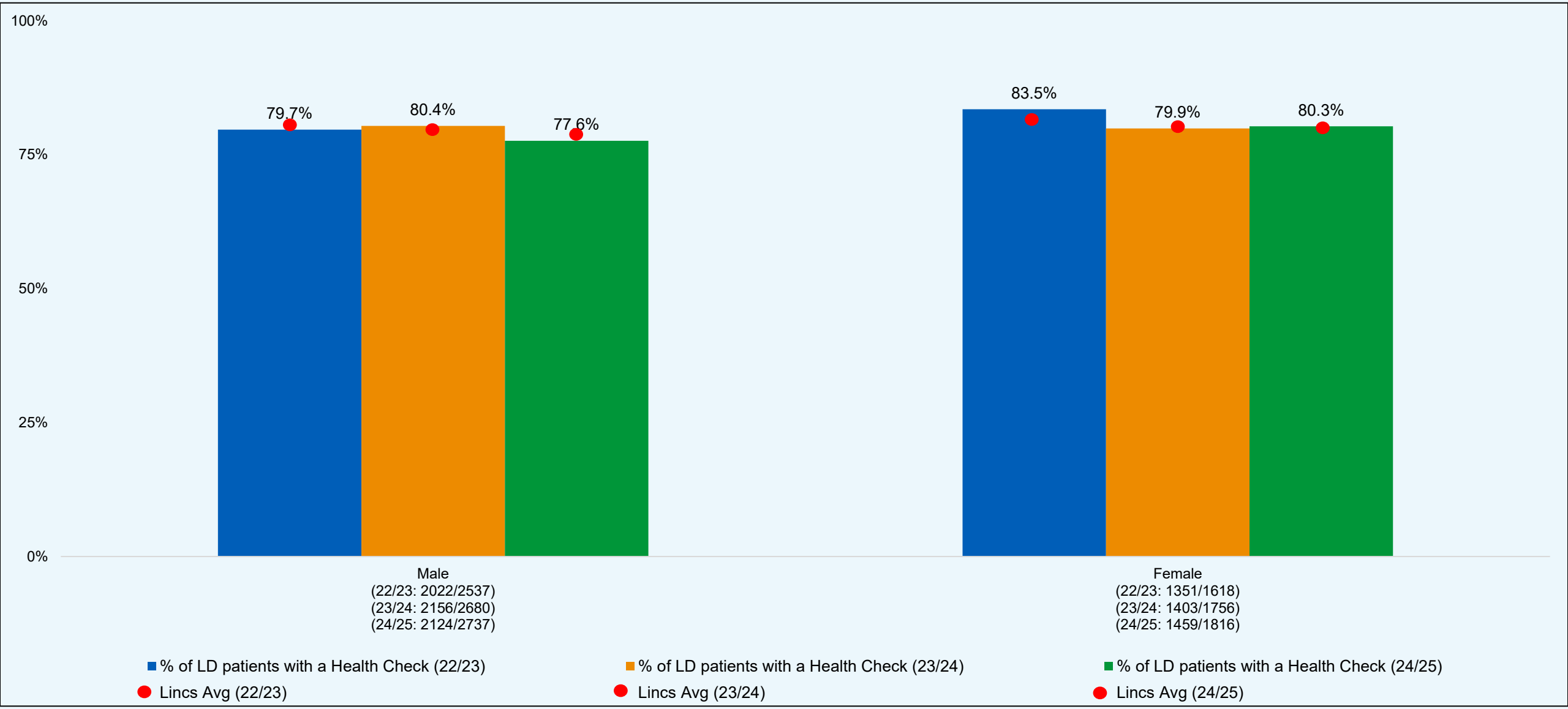
'Age' for Learning Disability Annual Health Checks compares those under the age of 30 to those aged 30 and older. A breakdown by 10 year age band is provided on slide 197.
'Ethnicity' for Learning Disability Annual Health Checks compares the White population with all other ethnic minorities combined (excluding those whose ethnicity is 'Not Stated').

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by PCN

PCN	22/23	23/24	24/25
Apex	92.9% (288/310)	87.1% (277/318)	84.9% (270/318)
Boston	80.0% (248/310)	73.0% (235/322)	88.2% (255/289)
East Lindsey	88.2% (231/262)	85.9% (214/249)	91.6% (241/263)
First Coastal	75.7% (519/686)	89.1% (589/661)	83.2% (561/674)
Four Counties	94.5% (104/110)	85.4% (105/123)	82.7% (91/110)
Grantham and Rural	84.0% (272/324)	84.8% (279/329)	86.5% (283/327)
Imp	83.9% (292/348)	80.7% (281/348)	76.2% (282/370)
K2 Healthcare Sleaford	90.8% (317/349)	88.2% (320/363)	93.2% (342/367)
Lincoln Health Partnership	92.1% (116/126)	90.7% (107/118)	90.4% (113/125)
Meridian Medical	84.8% (285/336)	87.3% (302/346)	83.0% (292/352)
South Lincoln	72.3% (170/235)	92.1% (198/215)	72.3% (162/224)
South Lincolnshire Rural	67.3% (290/431)	78.3% (331/423)	85.5% (371/434)
Spalding	81.4% (206/253)	81.5% (225/276)	83.6% (225/269)
Trent Care	84.9% (203/239)	80.4% (229/285)	92.8% (193/208)
Lincolnshire ICB Average	***82.0% (3541/4319)***	***84.4% (3692/4375)***	***85.0% (3681/4330)***
England Average	***82.3%***	***82.6%***	***79.9%***

Source: Learning Disabilities Health Check Scheme - NHS Digital

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Sex – Local analysis



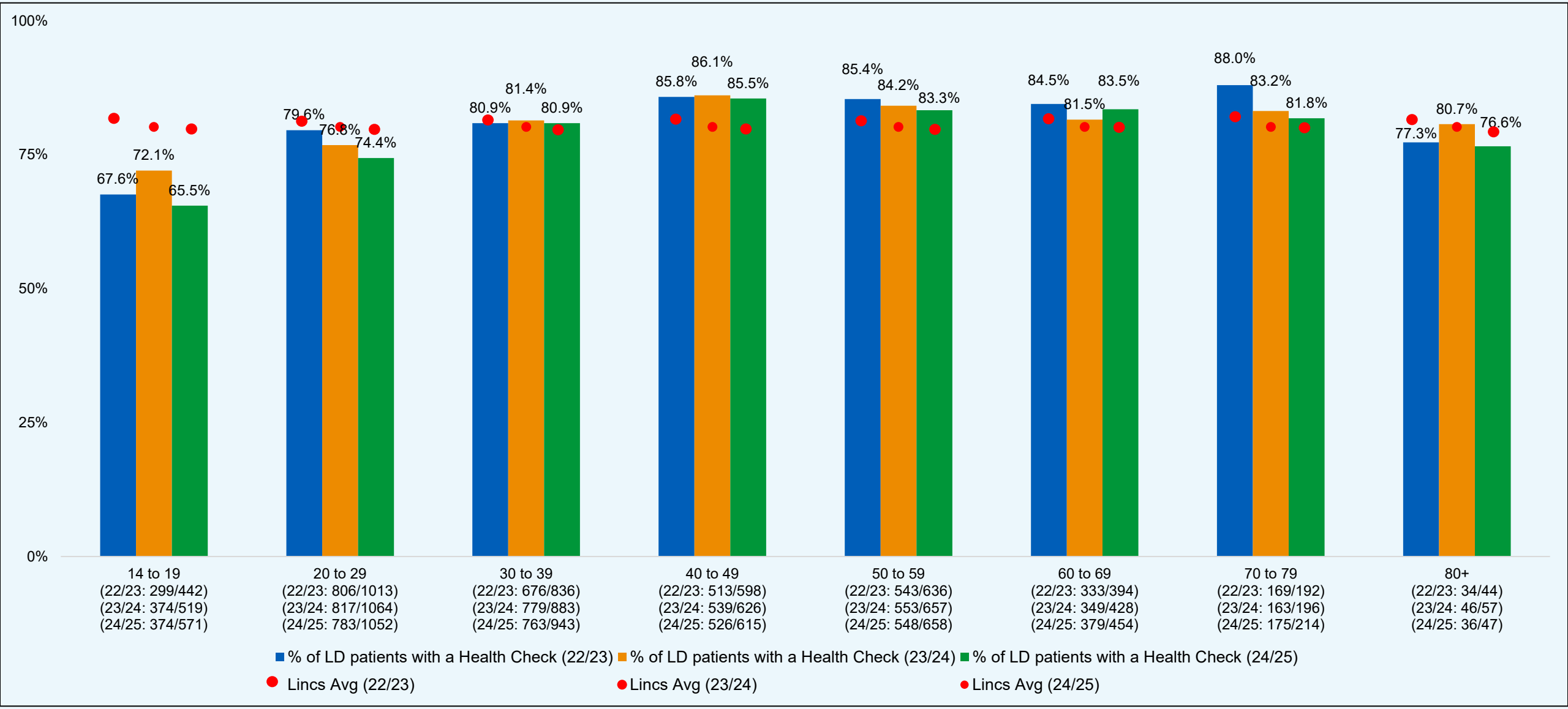
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Sex – Local analysis

In 23/24, males and females with a learning disability had a similar level of uptake of LD health checks. However, in 24/25, there appears to be a widening gap between females and males, with a greater proportion of females with a learning disability receiving an annual health check compared to their male counterparts (80.3% for females, vs. 77.6% for males). a significantly lower uptake of LD health checks compared to females. In 23/24, this inequality does not appear. It should be noted this analysis has been conducted using local data and therefore will not match exactly the nationally published data in the same timeframe.

Please note, while a similar methodology has been used to calculate these outcomes for 22/23, 23/24, and 24/25, differences in data reporting, clinical coding, patients declining a health check, and other phenomena may all contribute to this reduction observed in males. Therefore, readers should interpret these findings with caution before concluding something has substantial has happened to result in the decrease in males who received an LD health check in 24/25 compared to 23/24.

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Age Group – Local analysis



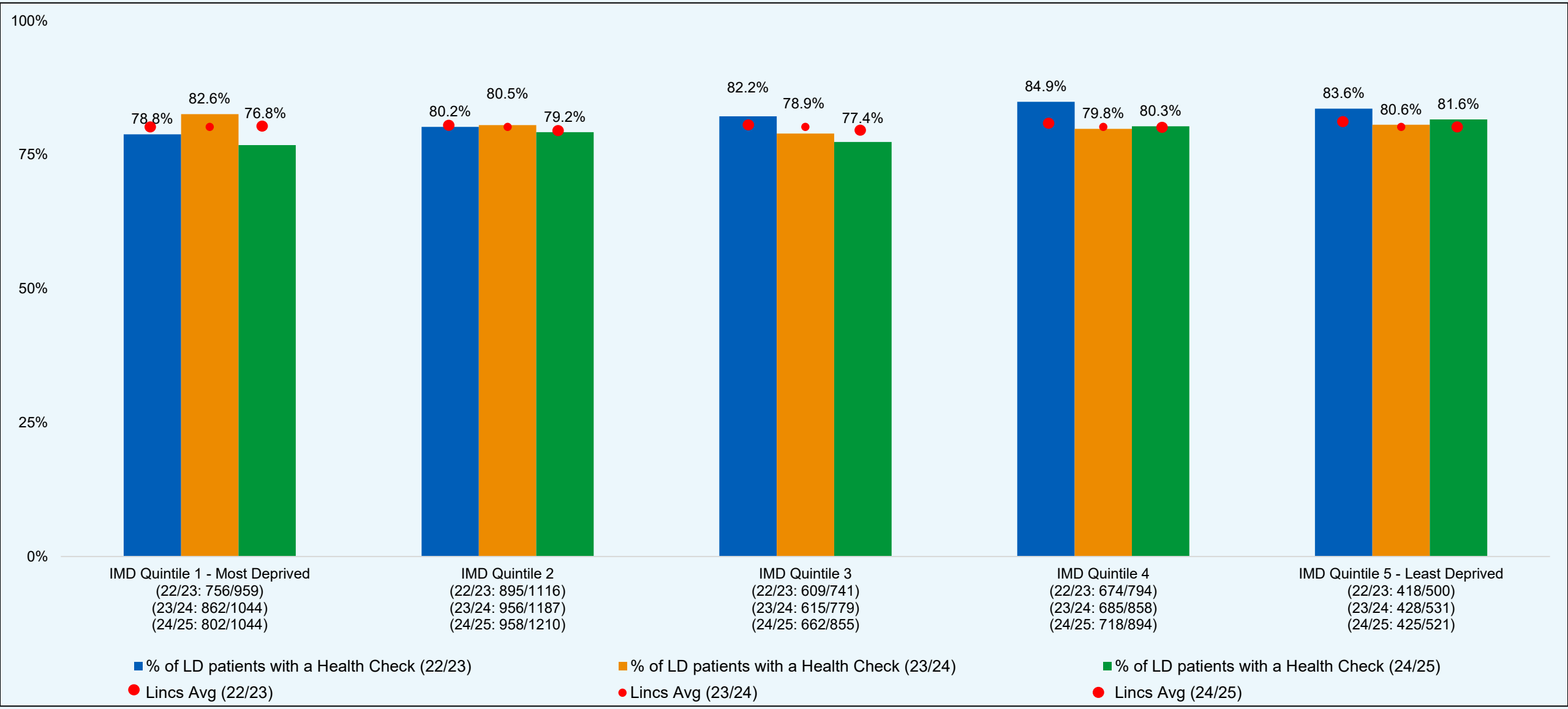
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Age Group – Local analysis

In general, those under the age of 30 have a lower uptake of LD health checks. This is particularly true for those under the age of 20, but there may be several reasons for this such as parental accompaniment to their health check. There is a 6.6% point decrease between 23/24 and 24/25 for those between the ages of 14 and 19 who received a health check (72.1% to 65.5%). This is a statistically significant decrease, although readers should be reminded that changes in data reporting, clinical coding, a subtle change in methodology (amongst other factors) may explain this perceived decrease.

With the exception of those in the 60 to 69 year olds age group, there has been a decrease (to a greater or lesser extent) in the uptake of all LD health checks for those with a learning disability. This change could be indicative of a genuine drop in uptake, or it could speak to potential changes in data reporting, clinical coding, change in methodology (amongst other factors). So readers should interpret this overall decrease with caution and be reminded that the uptake is still high overall – although this indicator cannot comment on the quality of health checks received.

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Deprivation Quintile – Local analysis



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Deprivation Quintile – Local analysis

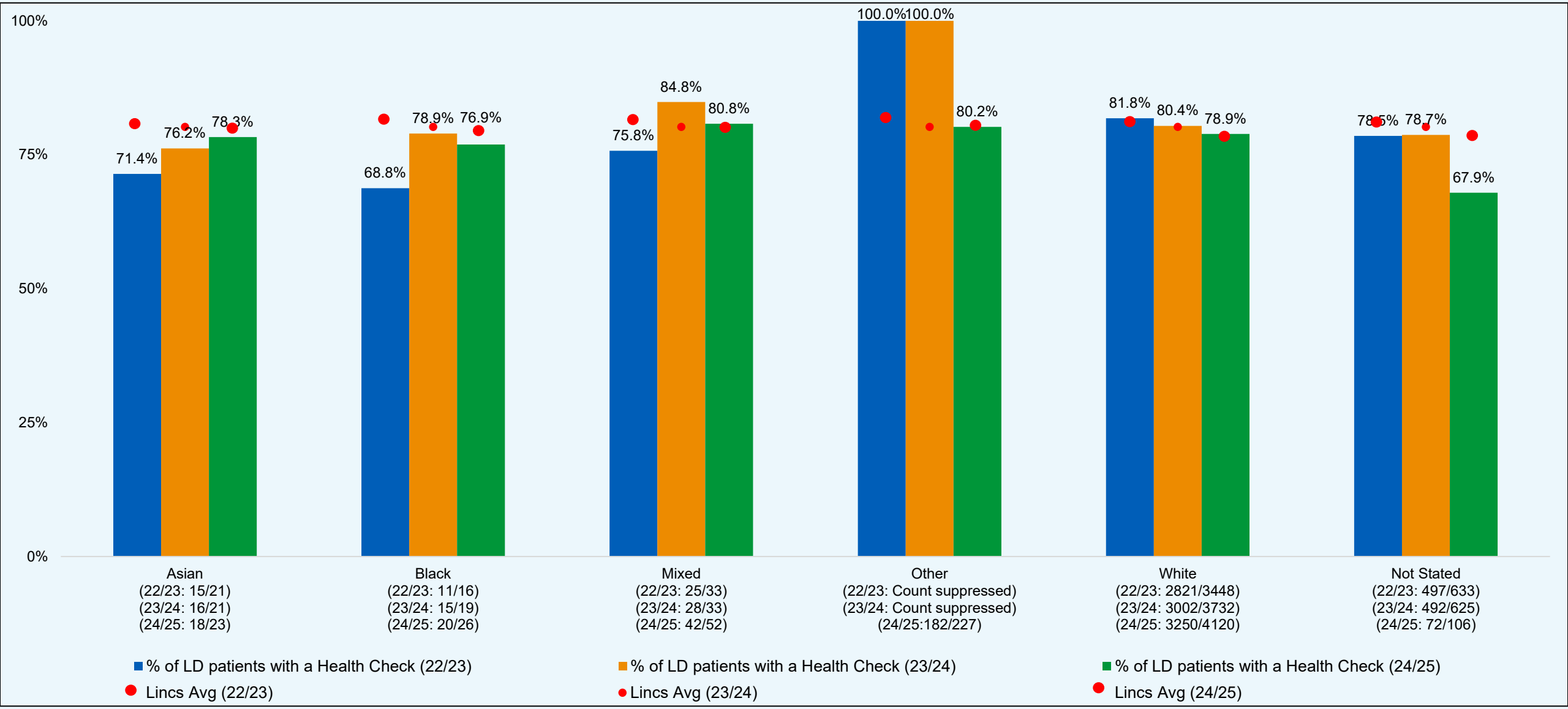
This chart provides insight into the uptake of health checks for patients with a learning disability who received a health check by deprivation quintile. The Relative Index of Inequality (RII) has been calculated at 1.09. This means the relative likelihood of those receiving an annual health check is about 9% more likely in those living in the least deprived areas than it is in those living in the most deprived areas.

Interestingly, in 23/24, the direction of the RII reversed; that is to say, those with a learning disability who lived in one of the most deprived parts of the county were more likely to receive an annual health check compared to those who live in one of the less deprived parts of the county. The RII has been calculated at 0.96. This means the relative likelihood of those receiving an annual health check is about 4% more likely in those living in the most deprived areas than it is in those living in the least deprived areas.

In 24/25, the RII reversed again and was calculated at 1.07. This means the relative likelihood of those receiving an annual health check is about 7% more likely in those living in the least deprived areas than it is in those living in the most deprived areas.

Readers should interpret these findings with caution, however, as a change in methodology, data collection, reporting, and clinical coding (amongst others) could explain these results.

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Ethnicity – Local analysis



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB

% of patients aged 14+ and on the QOF Learning Disability register who received a Learning Disability Annual Health Check by Ethnicity – Local analysis

It is difficult to provide any meaningful narrative concerning year on year improvements (or worsening) for LD health checks when stratifying the data by ethnicity. This is largely due to the very small sample sizes in ethnic minority groups, especially compared to the White population.

Readers will likely notice the reduction in the proportion of those who did not have an ethnicity stated in 24/25 compared to the two preceding reporting periods. Further exploration is needed to understand this, but a likely explanation is that the data used for the 24/25 analysis is the first that extracts data directly from the Lincolnshire Joined Intelligence Dataset – an indicator for LD Health Checks has been placed in the dataset which can refer to the patient's ethnicity directly.

Inpatient rates for people with a Learning Disability and/or Autism by Sex

Sex	LDA Patient count in Lincs		Lincs Rate per 1,000,000 adult patients		Regional rate per 1,000,000 adult inpatients		National rate per 1,000,000 adult patients	
	2023	2024	2023	2024	2023	2024	2023	2024
Persons	35	35	57.0	53.0	46.0	48.0	41.0	41.0
Male	20	19						
Female	Count Suppressed	Count Suppressed						
Non-Binary	Count Suppressed	Count Suppressed						

Source: Learning Disability Service Statistics (2023 and 2024)

Inpatient rates for people with a Learning Disability and/or Autism by Diagnosis

Diagnosis	LDA Patient count in Lincs		Lincs % of inpatients by diagnosis		National % of inpatients by diagnosis	
	2023	2024	2023	2024	2023	2024
Persons	35	35				
Learning Disability	Count Suppressed	Count Suppressed	Percentage Suppressed	Percentage Suppressed	34%	30%
Autism	18	20	51%	53%	44%	50%
Learning Disability and Autism	Count Suppressed	Count Suppressed	Percentage Suppressed	Percentage Suppressed	21%	20%

Source: Learning Disability Service Statistics (2023 and 2024)

Learning Disability and Autistic People – Domain Summary

Age: In general, those under the age of 30 have a lower uptake of LD health checks. This is particularly true for those under the age of 20, but there may be several reasons for this such as parental accompaniment to their health check. An interesting observation can be seen in the 6.6% point decrease between 23/24 and 24/25 for those between the ages of 14 and 19 who received a health check. This is a statistically significant increase, although readers should be reminded that changes in data reporting, clinical coding, a subtle change in methodology (amongst other factors) may explain this perceived decrease. There appears to be a slight decrease in most age groups, reflected by the overall drop. Readers should remember that uptake is generally very high in Lincolnshire.

Sex: In 23/24, the difference between females and males who received an annual LD health check was negligible. However, there was a decrease in the 24/25 period for males who received an LD annual health check, whereas the female LD population's uptake increased minimally. This difference is now statistically significant, although readers should be reminded that changes in data reporting, clinical coding, a subtle change in methodology (amongst other factors) may explain this perceived decrease. Readers should remember that uptake is generally very high in Lincolnshire.

Deprivation: The gap between the proportion of those with a learning disability who live in one of the most deprived parts of Lincolnshire compared to those from one of the least deprived parts of the county appears to have widened, according to the Relative Index of Inequality. The reasons for this will need fully understanding, but readers should remember the uptake is generally high, and changes in methodology, data reporting, coding (amongst other factors) could contribute to this observation.

Ethnicity: It is difficult to provide any meaningful narrative concerning year on year improvements (or worsening) for LD health checks when stratifying the data by ethnicity. This is largely due to the very small sample sizes in ethnic minority groups, especially compared to the White population. An interesting observation relates to the reduction in the number of people without a stated ethnicity dropping substantially – the reasons for this improvement will need further investigation.