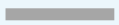
Health Inequalities Legal Duties Performance Report

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