NHS
Lincolnshire
Integrated Care Board

Statement of Information on Health Inequalities

Lincolnshire Integrated Care Board

About this document

This report demonstrates how as Lincolnshire Integrated Care Board (ICB) we are meeting our duties to understand the health inequalities in Lincolnshire and how to reduce them.

This requires us to collect, analyse and publish information in relation to the Statement on Information on Health Inequalities as given by NHS England (NHSE) further to its duty under section 13SA of the National Health Service (NHS) Act 2006.

This Statement provides the opportunity:

- To help the Integrated Care System identify disparities in access to services and patient outcomes, highlighting where change is needed.
- To improve data collection and recording, for example ethnicity recording which will support action on reducing health inequalities
- To distill key messages and explain what the data is saying – leading to more detailed and robust analysis to further reduce inequalities.

About us in Lincolnshire

The Integrated Care System (ICS) was established on the 1st July 2022 to arrange the provision of services for the purposes of the health service in Lincolnshire in accordance with the Health and Care Act 2022. It is a statutory organisation bringing the local NHS together to improve Lincolnshire's health and wellbeing.

The ICB and Lincolnshire County Council have established a joint committee known as an Integrated Care Partnership. This Partnership has developed an Integrated Care Strategy which sets out how the needs identified in Lincolnshire are being met by the NHS and Lincolnshire County Council.

Our Integrated Care System is are a partnership of organisations that come together to plan and deliver joined up health and care services, and aim to improve the lives of people who live and work in their area. In Lincolnshire, our ICS is known as Better Lives Lincolnshire – for more information click here.

About our county

- Lincolnshire is the fourth largest county in England with an area of 5,921 sq. km.
- It has 778,000 residents (2021) and there are 819,837 registered patients dispersed across city, market towns, rural and coastal areas. The nature of our geography and communities make up alone is incredibly diverse and varied.
- Lincolnshire is predominately rural, being the fourth most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which which presents a number of challenges in terms of service provision.
- The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
- The combination of an ageing population, a rural geography and areas of high socio-economic deprivation defines the specific challenges of delivering high-quality and effective treatment and preventative services in Lincolnshire.

This is the first Statement on Information on Health Inequalities produced by Lincolnshire ICB. Addressing inequalities in health and healthcare is a core duty of ICBs and is a key priority of the ICS. The document details how we are performing against a set of indicators for the period 1st April 2023 to 31st March 2024 unless otherwise stated, alongside a narrative on how we are working to tackle healthcare inequalities in these areas and ensure improvements against these indicators.

As set out in the ICB Annual Report 2023/24, we have a system wide approach to reducing inequalities. Underpinning all our approaches is the need to ensure we are collecting accurate and complete information.

How the Statement on Information on Health Inequalities has been used by Lincolnshire ICB

We recognise the differences in our communities from their health needs, ability to access services (both digitally and in person), and the ways they want to get involved.

It is intended that the information within this report should be used by services and decision makers to inform service improvement and reductions in healthcare inequalities. This lets us tailor services to the needs of people in each area, improve people's health, prevent illnesses, and make better use of public resources.

This includes, but is not limited to, using the information to inform:

Understanding general healthcare needs

- Adopt a population health management approach, which helps us understand people's health and care needs and how they are likely to change in the future, underpinned by hearing from our people and communities.
- Build from Joint Strategic Needs Assessments (JSNA) to support strategy development.

Understanding healthcare access, experience and outcomes

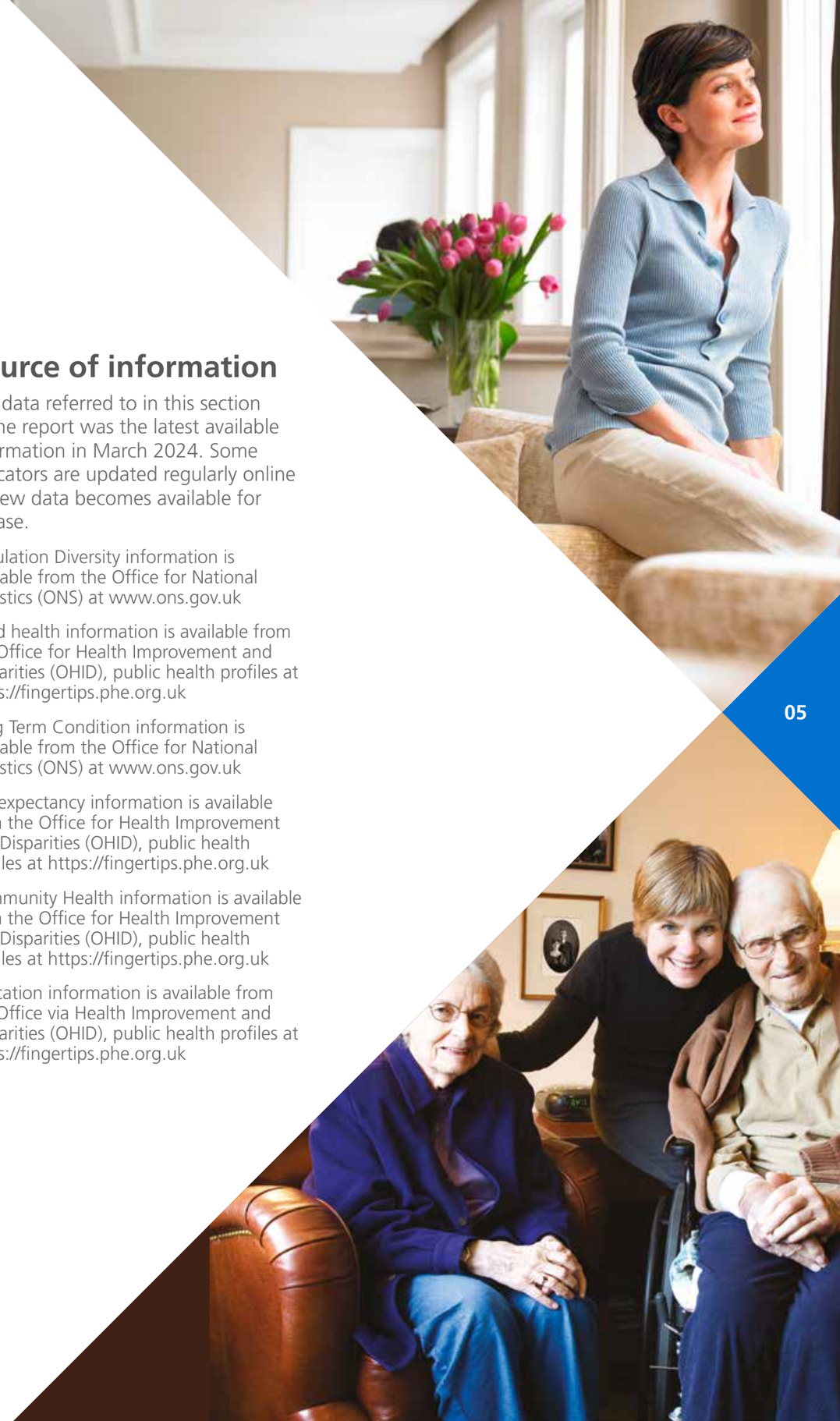
- Collate, analyse and publish performance information disaggregated by a limited number of variables where available (mainly age, sex, ethnicity, deprivation).
- Access to healthcare refers to the availability of services and can be measured by monitoring uptake of services and referrals. Some factors may be more likely to negatively impact those in the most deprived areas and people from minority ethnic groups. Other barriers such as location of services, transport, and work commitments may also affect ability to access healthcare.
- Experience data alongside other insights such as patient feedback and listening to those with lived experience are key in helping healthcare drive forward positive, patient centred change and embedding personalised care approaches which will help reduce health inequalities.

Informing service improvements and reductions in healthcare inequalities

- Enabling preventative healthcare, equitable access to health services and co-producing services with people with lived experience to support improvement in outcomes and reducing inequalities.
- Use data to inform service improvements, e.g. through changes to resource allocation.
- Encouraged to collect, analyse (and publish) other information.
- Support service evaluations and commissioning and delivery decisions.

Health Inequalities Lincolnshire

1.Population Diversity
2.Child Health
3.Long Term Conditions
4.Life Expectancy
5.Community Health
6.Education
7.Deprivation



Source of information

The data referred to in this section of the report was the latest available information in March 2024. Some indicators are updated regularly online as new data becomes available for release.

Population Diversity information is available from the Office for National Statistics (ONS) at www.ons.gov.uk

Child health information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Long Term Condition information is available from the Office for National Statistics (ONS) at www.ons.gov.uk

Life expectancy information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Community Health information is available from the Office for Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Education information is available from the Office via Health Improvement and Disparities (OHID), public health profiles at https://fingertips.phe.org.uk

Domains covered by the Statement

This report covers eleven domains and where possible focuses on variables by: sex/gender, age, deprivation and ethnicity. The indicators align to the five priority areas for addressing healthcare inequalities set out in the NHSE planning guidance and the Core20PLUS5 approach.

Data has either been sourced from existing anonymised data sources, Lincolnshire Joint data set or tools/dashboards that have been made available by NHSE.

Indicators related to inclusive recovery of services

1. Elective care

Indicators include:

- Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks.
- Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances.
- Elective activity versus pre-pandemic levels for under 18s and over 18s.

2. Urgent and emergency care

Indicators include:

- Emergency admissions for under 18s.

Indicators related to Core20PLUS5 for adults or children and young people

3. Uptake of Covid-19 and flu by socio-demographic group

Indicators include:

- Available to an ICB level only.

4. Mental health

Indicators include:

- Overall number of Severe Mental Illness (SMI) physical health checks
- NHS Talking Therapies (formerly IAPT) recovery.
- Rates of total Mental Health Act detentions.
- Rates of restrictive interventions.
- Children and young people's mental health access.

5. Cancer

Indicators include:

- Percentage of cancers diagnosed at stage one and two, case mix adjusted for cancer site, age at diagnosis, sex.

6. Cardiovascular Disease (CVD)

Indicators include:

- 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).
- Percentage of patients aged 18 and over with GP recorded hypertension in whom last blood pressure reading is below age-appropriate treatment threshold.
- Percentage 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.
- Percentage of patients aged 18 and over with GP recorded atrial fibrillation and record of a CHAD2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy.

7. Diabetes

Indicators include:

- Variation between % of referrals from the most deprived quintile and % of Type Two diabetes population from the most deprived quintile.
- Variation between % of people with Type One and Type Two diabetes receiving all eight care processes.

Key: ICB and Trust level

ICB level only

8. Smoking cessation

Indicators include:

- Proportion of adult acute and mental health inpatient settings offering tobacco dependency treatment services.
- Proportion of maternity settings offering tobacco dependence treatment services.

9. Oral health

Indicators include:

- Number of admissions for tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under.

10. People with a learning disability and/or autism

Indicators include:

- Learning Disability Annual Health Checks.
- Adult mental health inpatient rates for people with a learning disability and/or autism.

11. Maternity and neonatal care

Indicators include:

- Preterm births under 37 weeks.

Health Inequalities Legal Duties – Lincolnshire ICB Results Summary

This table summarises the differences seen across the data broken down by health inequalities dimensions (age, sex, deprivation and ethnicity). It highlights where we have a significant difference where available and also describes any variation between groups for each metric.

Elective Recovery				
Indicator	Sex	Age	Deprivation	Ethnicity
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				
Age Standardised activity rates with 95% CI for elective inpatient admissions				
Age Standardised activity rates with 95% CI for non-elective inpatient admissions				
Age Standardised activity rates with 95% CI for outpatient attendances				
Age Standardised activity rates with 95% CI for virtual outpatient attendances				
Elective activity vs. pre-pandemic levels for CYP and adults				
Urgent and Emergency Care				
Indicator	Sex	Age	Deprivation	Ethnicity
Emergency admissions for under 18s (under 19s)				
Respiratory				
Indicator	Sex	Age	Deprivation	Ethnicity
Uptake of Covid-19 vaccines by socio-demographic groups				
Uptake of flu vaccines by socio-demographic groups				
Mental Health				
Indicator	Sex	Age	Deprivation	Ethnicity
Overall number of Severe Mental Illness (SMI) physical health checks				
Rates of total Mental Health Act detentions				
Rates of restrictive interventions				
NHS Talking therapies (formerly IAPT) recovery				
CYP Mental Health access				
Cancer				
Indicator	Sex	Age	Deprivation	Ethnicity
Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex				

- No Health Inequalities identified by statistical tests
- No Health Inequalities identified (but not statisticaly tested)
- Health Inequalities identified (but not statistically tested)
- Health Inequalities identified by statistical tests
- Data not stratified by this characteristic

Cardiovascular Disease				
Indicator	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				
Diabetes				
Indicator	Sex	Age	Deprivation	Ethnicity
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				
Smoking Cessation				
Indicator	Sex	Age	Deprivation	Ethnicity
Proportion of adult acute inpatient settings offering smoking cessation services				
Proportion of maternity inpatient settings offering smoking cessation services				
Oral Health				
Indicator	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)				
Learning disability and autistic people				
Indicator	Sex	Age	Deprivation	Ethnicity
Learning Disability Annual Health Checks				
Adult Mental Health inpatient rates for people with a learning disability and autistic people				
Maternity and neonatal				
Indicator	Sex	Age	Deprivation	Ethnicity
Pre-term births under 37 weeks				

Elective Recovery

Indicators

Size and shape of the waiting list.
Rates of hospital activity.
Elective activity in under 18s and over.

Age

Waiting Lists: Almost half of those on waiting lists are of working age (18-64). A greater proportion of the working age population are waiting longer than those in older age groups, which may be explained by the fact those of working age may not be able to take time off work to attend appointments. This may lead to poorer outcomes.

Under 18 year olds accounts for 15% of the waiting list volume and are waiting longer on average than the rest of the population.

The greatest level of activity in under 18 year olds is observed in Ear, Nose & Throat (ENT) and Paediatric appointments.

Ethnicity

Waiting Lists: 19% of those on a waiting list (waiting 18-51 weeks) have no recorded ethnicity.

Small numbers in ethnic minority groups, especially compared to White British population, although we can't see this clearly in the data, these groups are known to experience inequalities and we would expect this in Lincolnshire.

Inpatient admission rate per 100,000 people is statistically higher in the ethnic minority groups when compared to the White British this is compared to the Lincolnshire average.

Deprivation

Hospital activity: Significantly higher rates in the most deprived quintile for non-elective admissions may be caused by acute admissions which could have been prevented by better access to preventative care.

A decrease in the proportion of those from most deprived deciles (for adults and Children & Young People (CYP)) may indicate poorer access to healthcare for those in more deprived areas as part of the Covid-19 recovery.

CYP living in the most deprived decile, who are on an ENT or a paediatrics waiting list, had longer average waits than those in less deprived areas.

Other supporting narrative

More than half of those on a waiting list have been waiting longer than 18 weeks.

Geographic hotspots of longer waiting times for dermatology appointments noticed in southeast of the county, potentially due to no hospitals offering dermatology clinics (even out of county), but this does not necessarily correlate with the most deprived areas.

As a proportion of the population, there are almost twice as many missed appointments in the most deprived areas than in the least deprived areas.

Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted work to reduce long waiting times in Ear, Nose & Throat (ENT) appointments, particularly in children/young people.
- Targeted work on reducing the number of missed appointments in ULHT. Missed appointments are almost twice as prevalent in the most deprived population. Various reasons including poor administration, digital exclusion, unstable accommodation (amongst others) contribute to missed appointments, which in turn may lead to missed opportunities for medical intervention.

Urgent and Emergency Care

Indicators

Emergency Admissions for under 18s.

Age

Most activity seen in the 0-1 age group. Babies/infants are most vulnerable to a range of health conditions, and parents/caregivers are more likely to seek medical attention when their child develops symptoms.

Ethnicity

High proportion (9.1%) of activity from those without a stated/known ethnicity.

Activity not reflective of the ethnic breakdown of Lincolnshire, raising questions about equality of access. This is particularly noticeable in the 'Other' 0-19 population, which accounts for 8.6% of the population; but only accounts for 1.3% of the non-elective activity.

Deprivation

Despite accounting for about 15% of the 0-19-year-old population, children in the most deprived quintile account for just over 20% of the activity. Conversely, 0-19 year olds in the least deprived quintile account for 18.5% of the population, but only account for about 10% of the non-elective activity. This raises questions about those in the most deprived quintile seeking care when they are at a crisis point, rather than taking preventative measures.

Other supporting narrative

Children & Young People (CYP): Poor asthma management due to lack of annual asthma reviews, amongst other reasons, may be contributing to an increase in the rate of A&E attendances for asthma exacerbations in CYP.

Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Analyse GP practice data to identify trends, prioritising deprived areas for interventions (especially annual asthma reviews), ensuring personalised asthma action plans for all CYP, monitoring prescribing practices, addressing the challenges of passive smoking, and disparities in A&E attendances.
- System-wide efforts aim to reduce high A&E attendance among 0-4 year olds, and utilise National Child Measurement Programme (NCMP) data for better tracking of CYP weight and height. Implementing post A&E/admission reviews, and the development of a local asthma dashboard to monitor the effectiveness or interventions.

Mental Health

Indicators

Overall numbers of Severe Mental Illness (SMI) physical health checks.
Rates of total Mental Health Act (MHA) detentions.
Rates of restrictive interventions.
NHS Talking Therapies (formally IAPT) recovery.
Children and Young Peoples mental health access

Age

SMI: Younger ages have the lowest achievement for all six health checks at 21.7% which may be explained by various factors including personal, societal, and psychological changes during a critical part of young people's development.

Talking therapies: Younger ages have the lowest achievement of recovery outcome at 27% (18 year olds) and 18-25 at 41%. A possible explanation for poorer outcomes in the younger population may be the lack of life experience and coping strategies younger people have when engaging with therapeutic interventions.

Ethnicity

SMI health checks: 11.4% of those eligible for all six SMI health checks had no ethnic recording. Low counts in ethnic minorities raise questions about access to SMI diagnosis.

MHA detentions: Low counts in ethnic minority groups may account for the variation and higher than average rate of MHA detentions.

Talking therapies: Low counts in ethnic minorities raise questions on access to the service – with 95% White and 2% of those accessing had no ethnic recording.

Deprivation

SMI: Despite nearly a quarter of the SMI population living in the most deprived quintile, achievement of all six health checks is the lowest in this cohort.

Talking therapies: 42% of those living in the most deprived decile had a 'recovery' outcome, compared to 57% of those living in the least deprived decile.

MHA Detentions: 15% of the population consists of those who live in the most deprived 20%, but this cohort accounts overwhelmingly for the dominant rates of detentions made under the Mental Health Act.

Other supporting narrative

SMI health checks: on average 51.5% of those with SMI achieving all six health checks, with notable disparity between the most and least deprived population. Noticeable difference in female achieving better outcomes compared to male.

Talking therapies: On average 50% of people who accessed had an outcome of recovery. Those aged 65 plus have a better outcome exceeding 50%.

More than twice as many females than males engage in talking therapies. This may point to higher levels of anxiety and depression in females compared to males, or reluctance for males to seek psychological interventions to deal with their mental health.

Areas of focus 2024/25:

- The highest rates of MHA detentions are represented by the PLUSS5 CORE20 population. Further deep dive is planned to understand the data and potential additional metrics which would help inform the targeted support on future preventative measures and to ensure more effective primary and secondary care approach in meeting the needs of the population.
- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Further work required to understand gender differences and ethnicity uptake and access for both SMI health checks and Talking Therapies.

Mental Health Areas of focus 2024/25 (continued):

- **SMI**
  - Validation of SMI registers with primary care including improving the recording of ethnicity data.
  - Stakeholder engagement with Inclusion Health groups such as people experiencing homelessness and Gypsy, Roma, Travellers is priority for 2024/25 to better understand how we can support all communities to engage with health services.
  - This information, alongside the results of our extensive stakeholder engagement will be used to inform our next steps in service development.

We will work with our stakeholder and co-production network to develop a range of options for delivery. Ambition to pilot options during 2024/25.

- **Talking Therapies**
  - LPFT to review service offer to target more deprived areas and ethnic communities.
  - Exploring interventions linked to participation in community activities (for example Wellbeing Hub/ Community Connector contact/Night Light Café attendance).
  - Through the work of the Adult Community Mental Health Transformation, Primary Care Networks (PCNs) all have dedicated primary care mental health professionals in place which is strengthening the link between primary and secondary care and improving quality of referrals and uptake to services.

Oral Health

Indicators

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

Age & Ethnicity

Number of under 10-year-olds with tooth extraction due to decay too low to derive any meaningful narrative.

Deprivation

Decay-related hospital extraction rates for children were nearly three times higher for those living in the most deprived communities than those in the most affluent (national data).

Other supporting narrative

- The National Dental Epidemiology Programme (NDEP) Surveys amongst children identify that children in the most deprived areas of the country are more likely to experience tooth decay than those living in the least deprived areas.
- Nationally, tooth decay was the most common reason for hospital admission in children aged between 5-9 years (2022-23). From the children examined in Lincolnshire as part of the latest NDEP surveys, 21.2% of 5 year old, and 16.8% of Year 6 children (10/11 year olds) had dentinal decay.

Areas of focus 2024/25:

To continue to deliver the Prevention Theme of the Lincolnshire Dental Strategy. This includes a wide range of actions to support the oral health amongst children, in relation to improving the population knowledge and understanding of good oral health, creating healthy places and supporting behaviour change. Targeted work will take place with for example, nurseries and schools, Family Hubs, Holiday and Food Programmes.

Indicators

Stroke rate of non-elective admissions.

Myocardial infarction – rate of non-elective admissions.

% of patients aged 18 and over, with GP recorded hypertension whose blood pressure reading s 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.

Age

Optimal management of hypertension, cholesterol, and atrial fibrillation (AF) is worse in under 40 year olds. Which may be explained by the fact those of working age may not be able to take time off work to attend appointments. This may lead to poorer outcomes.

For cholesterol, in addition to the above we can also see an observed drop in outcomes for the age 60-79 cohort.

Generally, there are fewer people under 40 with a diagnosis of these cardiovascular conditions despite lifestyle factors such as stress and poorer diet which contribute to the onset of cardiovascular conditions.

Ethnicity

Hypertension management is poorer in ethnic minority groups. Potential undiagnosed hypertension and AF in ethnic minorities also a concern, particularly in the Black population.

Variation across different ethnic groups may be explained by low counts in ethnic minority population.

Deprivation

Higher rates of strokes and myocardial infarctions in the most deprived quintile suggest poorer preventative practice which increases likelihood of acute admissions.

Hypertension management in the most deprived quintile is worse in comparison to the least deprived population; noticeable slope of inequality observed.

Lower levels of adherence to treatment regiments for cardiovascular conditions, especially in younger and more deprived populations, may explain the observation of higher levels non-elective admissions for stroke and myocardial infarctions.

Other supporting narrative

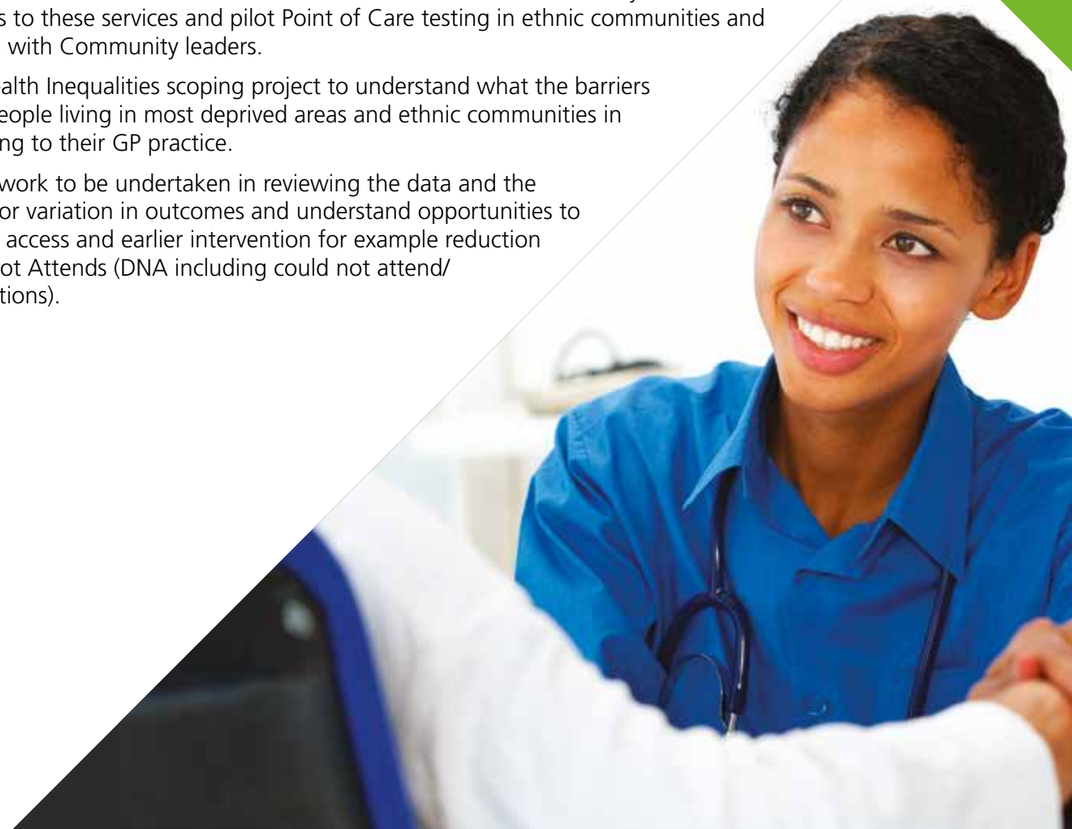
Current focus on secondary prevention in cholesterol with introduction of lipid specialist nursing to review the highest risk patients and support management with active caseloads.

Hypertension: on average 70.2% of patients over 18 with GP recorded blood pressure reading in the last 12 months, with notable disparity between the most and least deprived population and 18-59 years ranging from 51.7% and 59% . Note Lincolnshire is 3rd highest performing ICB in the country for blood pressure control.

AF: on average 93.5% of patients over 18 with GP recorded atrial fibrillation who are currently treated with drug therapy, with notable disparity between the 40-59 years at 89.9% identified inequalities for patients with learning difficulties and patients who are carers.

Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted communication and Public Health awareness campaigns in relation to healthy lifestyles, and review with Public Health on opportunities for targeted support to specific population groups (ethnicity, age, IMD).
- Assess the feasibility of weekend/out of hours clinics/ outreach to support improvement in uptake for targeted population cohorts.
- Ethnicity: Further work to be undertaken in 2024/25 to understand any cultural barriers in access to these services and pilot Point of Care testing in ethnic communities and working with Community leaders.
- IMD: Health Inequalities scoping project to understand what the barriers are to people living in most deprived areas and ethnic communities in presenting to their GP practice.
- Further work to be undertaken in reviewing the data and the drivers for variation in outcomes and understand opportunities to improve access and earlier intervention for example reduction in Did Not Attends (DNA including could not attend/ cancellations).



Other supporting narrative

Diabetes is highly prevalent in Lincolnshire (22/23 QOF estimates suggest 8.4% of the population aged 17 years and over have diabetes). Lack of resources to administer all eight care processes, especially in more deprived areas of the county and to those whose first language is not English (or who do not speak English), may introduce inequalities in provision of the care processes. Lack of awareness of optimal diabetes management in these cohorts may also explain poorer adherence to health checks.

There is a variation in T1 and T2 care process - a significant portion will be because ULHT are reviewing the patient and not informing GPs, or GPs receive letters but don't code the information onto system records.

Diabetes

Indicators

Variation between % of people with Type one and Type two diabetes receiving all eight care processes.

Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile.

Age

Lower uptake of all eight care processes in the under age 50 population for both Type One (T1) and Type Two (T2) diabetes. Much lower T2 Diabetes Management (T2DM) referrals in older age groups which may result in greater levels of undiagnosed T2DM, leading to poorer outcomes.

T1 Diabetes information (especially those in paediatrics/ transition where they are exclusively managed by secondary care) is not always recorded in primary care Quality Outcomes Framework (QOF).

Ethnicity

Receipt of all eight care processes in ethnic minorities is generally lower than the Lincolnshire average. It's possible there are greater levels of undiagnosed diabetes in ethnic minority populations as well. These phenomena combined make it likely those from ethnic minorities will have poorer diabetes related outcomes.

There are some cultural barriers to understand and how we can support / address improving uptake.

Deprivation

Those in most deprived areas achieving about 50% less completion of eight care processes compared to the least deprived population.

Much lower T2DM referrals in the most deprived areas, which may result in undiagnosed T2DM and poorer outcomes in those living in CORE20PLUS5 areas.

Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Targeted communication and Public Health awareness campaigns in relation to healthy lifestyles to specific population groups.
- Greater outreach and T2DM testing in more deprived communities.
- The T2 Remission programme and continue to target populations groups to access the National Diabetes Prevention Programme e.g. areas of deprivation. Further work to understand why people decline and how we can best support them.
- Data recording: Undertake sample audits across primary care and secondary care in Children and Younge People and Adults cohort to understand the actual % completion and what data is missing from the reported outcomes/ performance.
- Age: Targeted support for the under 40 cohort as part of the Type 2 day programme, which is funding for GP practices based on under 40 diabetic population to have an additional review/ care process completed if it is outstanding/ advice from a health and wellbeing coach/pre-pregnancy advice (such as stopping lipid lowering therapy).
- Transformation pilot – Piloting an Multidisciplinary Team (MDT) concept in one Primary Care Network (PCN) to learn from and then plans to roll out across Lincolnshire.
- Prevention focus - Improve coordination with diabetes and obesity/weight management programmes to ensure improving access to target population group for both weight management and access to the Diabetes prevention programme.
- Management of Diabetes in Pregnancy including gestational diabetes working with the local maternity and neonatal system (LMNS)

Cancer

Indicators

Percentage of cancers diagnosed at stage one and two.

Age

Older people are typically staged later, having lived with the condition for some time before becoming symptomatic.

Age inequalities in Lincolnshire is also linked to areas with higher deprivation, in particular East Lincolnshire and has a high proportion of disengaged patients.

Ethnicity

Ethnicity has not been identified as inequality due to small numbers.

Correspondence sent to patients whose first language isn't English, or who don't speak English, is likely to result in a lack of uptake in cancer screening.

Deprivation

This seems to be intrinsically linked to age with populations in our highest deprivation areas, typically having an older population.

Some of these areas seem to be disengaged with personal health and are being targeted for engagement and screening uptake.

Transport/distance has also been an issue for non-engagement after referral. The Bowel Screening inequality programme is currently in progress and findings will be shared across all screening programmes.

Other supporting narrative

Cancer Staging and reporting in Lincolnshire has historically been poor. An education programme was put in place in 2019/20 for clinicians, which has resulted in significantly improved reporting e.g. skin staging was also previously poor with only those staged at levels III & IV being reported, and the greater volume of Stage I and II's not being.

Initial findings from the Bowel Screening Inequality programme has potentially identified inequalities for patients with learning difficulties and patients who are carers.

Areas of focus 2024/25:

- Data: Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed. Future data sets are currently being scoped to include other health inequalities characteristics for future reporting e.g. Learning Disabilities.
- Targeted communication is being done in multiple languages, including leaflets, posters, videos and texts, to improve knowledge about general cancer warning signs and screening uptake.
- Improvement of clinical coding relating to cancer staging to determine if improvements are being made in early diagnosis.
- Continue bowel cancer screening health inequalities programme which includes engagement work with patients in most deprived areas and plus population groups.
- Improve education on warning signs and improve screening programme uptake to identify cancers earlier. Findings from the Bowel Screening Inequality programme will also be applied here.
- Staging: Reporting improvements continue to be a focus for ULHT in 2024/25.
- Targeted Lung Health Checks (TLHC) is a national priority and will contribute to the NHS Long Term Plan to improve early diagnosis and survival for those diagnosed with cancer, expected to be implemented 2025. The TLHC will target those most at risk of lung cancer. People over 55 years old but less than 75 years old that have ever smoked will be invited to a free lung check.

Respiratory

Indicators

Uptake of Covid-19 and Flu by sociodemographic group.

Age

The data that relates to Covid-19 vaccination uptake - the findings relate to a period when all adults were eligible for a Covid-19 vaccination (doses one to three), since then there has been a considerable change to the programme.

Covid-19 vaccines are no longer offered to everyone as standard. This means that unless you are eligible for a vaccination based on Joint Committee on Vaccination and Immunisation (JCVI) guidance you can no longer come forward for a vaccination even if you were eligible in a previous programme (e.g. a 25-year-old with no underlying health conditions who has not had a Covid-19 vaccination will be unlikely to now receive a vaccination until they fall into an age group that is recommended).

Ethnicity

Those whose first language is not English, or who do not speak English, will find it difficult to engage with health promotion campaigns in terms of vaccination uptake.

White-Other (within Lincolnshire is predominantly people from Eastern Europe) is the second largest ethnicity group in Lincolnshire and the population that we have struggled with the most in terms of coming forward for vaccinations.

Variation across different ethnic groups may be explained by low counts in ethnic minority populations.

Deprivation

Compared to national and regional uptake rates, Lincolnshire is performing well in addressing the variation between most affluent and most deprived areas with a variance of 14.6% (nationally 30.5% and regionally 29.4%).

Limited availability of places to receive vaccines, coupled with poor transport links for remote parts of Lincolnshire, are likely to have hindered uptake of Covid-19 vaccines in the most deprived areas.

Other supporting narrative

Mistrust in healthcare professionals and vaccinations are likely drivers of vaccine hesitancy in various population groups.

Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Uptake performance and areas of focus for Covid-19 and flu are reviewed at the Lincolnshire Immunisation Programme Board that currently meets monthly.
- Task and finish group that focuses on respiratory cohort for all immunisations and actions to improve uptake.
- Addressing variation across areas of deprivation – We will continue working with practices that fall in areas of high deprivation looking at how we can improve vaccination services that are provided. This will include putting on additional pop-up/outreach clinics, working with community pharmacies to provide additional access and supported by a detailed comms and engagement plan or the implementation of a detailed comms and engagement plan.
- Addressing variation across ethnicity - improving uptake in "White – Other" cohort.

Smoking Cessation

Indicators

Proportion of adult acute inpatient setting offering smoking cessation services.
Proportion of maternity inpatient settings offering smoking cessation services.

Age

Those aged 25 to 34 years continue to have the highest proportion of current smokers (15.8%, around 1.3 million people), when compared with any other age group, and those aged 65 years and over continue to have the lowest proportion of current smokers (8.0%, around 900,000 people).

Smoking prevalence data for young people in Lincolnshire is unavailable, however the smoking rate of 15-year-olds nationally is around 5%. Those under 25 years have a higher prevalence of smoking at time of delivery.

Ethnicity

Smoking prevalence is higher in ethnic minority populations, particularly from those from an Eastern European background where cultural norms around smoking are different.

Tobacco causes health problems across all ethnicities, but the way people from different ethnic backgrounds use tobacco varies considerably, leading to health disparities. Some ethnic minorities are more likely to use smokeless tobacco and shisha pipes.

Disparities in smoking rates in early pregnancy are also seen in some migrant communities within Lincolnshire. For example, migrants from countries in Eastern Europe, such as Bulgaria and Romania, where 'background' rates of smoking are higher than the UK.

Deprivation

Smoking is approximately twice as prevalent in those living in more deprived areas than those living in less deprived areas. This will have adverse health effects including cancer, further widening health outcomes between the most and least deprived.

In Lincolnshire, women in the most deprived decile have a higher prevalence of smoking in early pregnancy compared to those women living in the least deprived area. Younger women are also more likely to smoke.

Other supporting narrative

Rates of smoking during pregnancy, or at the time of delivery, in Lincolnshire are the worst in the East Midlands. Smoking during pregnancy increases the risk of low birth weight in babies, which in turn increases the risk of a child start life in poor health. Lincolnshire has one of the highest "smoking at time of delivery" (SATOD) rates, above the national and regional average and much higher than the national ambition – whilst rates remain high there are signs of more momentum in reduction. (Rate for 2023/24 12% compared to England average of 7.4%).

While smoking prevalence at England level continues to decline each year, In Lincolnshire we have a smoking prevalence rate of 16% which has seen an increase by 2.7% from 2021 data. Smoking rates are declining more slowly in the more deprived communities than they are in more affluent ones.

Areas of focus 2024/25:

- Smoking cessation services in acute inpatient settings going live in March 2024.
- Exploring expanded workforce offer in collaboration with Public Health and One You Lincolnshire (OYL).
- Development of Community Mental Health Services/ Outpatients offer for high-risk Mental Health population.
- Expansion of Community Hospital and Acute Hospital inpatient Tobacco Dependency Service (following commencement of services in March 2024).
- Exploring with Public Health – access to the Local Stop Smoking Services Grant and expanding the Lincolnshire.
- Development of smoke free pregnancy and smoke free homes action plan to support reduction of smoking during pregnancy and increase the number of smoke free homes.
- Tobacco Dependency Services and the continued development of integrated smoking cessation pathways with OYL.
- Development of Expression of Interest (EOI) with LMNS on the Pregnancy financial incentive scheme.
- Approval and implementation of e-cigarettes/vapes available to patients within the NHS Tobacco Dependency Service.
- Promotion of smoking cessation within the NHS – strengthening smoke free site polices, develop strategies to implement new staff offer.
- Review the opportunities for joint pathways – Targeted Lung Health checks, Emergency departments and outpatient pathways on pre assessment checks.

Learning Disability (LD) and/or Autism

Indicators

Learning Disabilities Annual Health Checks.
Adult mental health inpatient rates for people with learning disability and/or autism.

Age

LD is more prevalent in younger people, although the proportion of those who received all six health checks is lower than those over the age of 40.

This mirrors other health interventions where uptake is generally poorer in the younger population, meaning chances may be missed to identify health issues earlier. Note that LD health checks start at age 14.

Ethnicity

Number of ethnic minorities with an LD diagnosis appears to be low, even as a proportion of the ethnic minority population. This may indicate under diagnosis of LD in ethnic minority population.

14.7% of those receiving LD health checks had no ethnic recording.

Deprivation

The prevalence of LD in 14+ year olds in the most deprived decile is three times that of those living in the least deprived decile. Despite this, LD health checks are lowest in most deprived decile (78.2%), with higher completion of health checks being observed in people living in less deprived parts of the county (85%). This indicates a widening of health inequalities related to health checks for people with learning disabilities.

Other supporting narrative

Generally, LD health checks are high (81.2% of the population), with males (particularly younger males) having the lowest proportion of health checks in the eligible population.

Lower rates of completing health checks in more deprived populations, who are more likely to have undiagnosed and/or diagnosed health issues, is likely to exacerbate inequalities in outcomes for those from a more deprived background.

Cancer was one of the four top causes of death for people diagnosed with a learning disability and/or autism in Lincolnshire in 2022/23 - where there was no screening, diagnosis and treatment plan.

Learning Disability (LD) and/or Autism Areas of focus 2024/25:

- Enhancing the accuracy and comprehensiveness of ethnicity recording is imperative to ensure genuine disparities in access, experience, and outcomes are identified and addressed.
- Ongoing work on annual health checks to understand the barriers to those health checks which are not completed. Support the work to ensure that annual health checks are completed.
- Support the work to develop LD friendly GP practices.
- The CYP Autism pathway is being finalised across the Lincolnshire system and we have just held workshop three of four.
- Local key priorities from learning taken from LeDeR and reviews are:
  - Inconsistencies in application and use of RESPECT/DNACPR across Lincolnshire identified from LeDeR Reviews. Working Group reaching out across residential, nursing home, community supported living providers, day care provisions, NHS Trust provider teams and primary care teams.
- The LD & Epilepsy Delivery Work Group is working in conjunction with the Lincolnshire LeDeR programme and the Lincolnshire ICS system partners with a focus on embedding SUDEP Checklist, promoting the use of SUDEP and the importance of the SUDEP Checklist.
- The Governance Panel has identified cancer as being a cause of death meeting local criteria for a focussed review in Lincolnshire. The LD & Epilepsy Delivery Work Group will hold a Webinar in April 2024 to promote equal access to screening to avoid missed opportunities and health inequalities for Lincolnshire citizens who have a learning disability and/or autism.

Maternity and neonatal

Indicators

Preterm births under 37 weeks.

Age, Ethnicity and Deprivation

Data collection is in early infancy and it is too soon to determine health inequalities in different age groups, ethnicity and areas of deprivation.

Other supporting narrative

Pre-term birth data not stratified. In past 2.5 years, pre-term births have generally been lower (better) than the national average of 60 pre-term births per 1000. This indicator is reviewed as part of the LMNS and East Midlands Neonatal Operational Delivery Network.

NHS
Lincolnshire
Integrated Care Board

Glossary

Word or Phrase	Definition
Direct Age Standardised Rate (DASR)	A statistical method used to compare disease rates among populations with different age structures.
Deprivation Decile/ Quintile	The way areas in England are categorised into different levels of deprivation. Areas in the decile or quintile 1 are the most deprived, and areas in decile 10 or quintile 5 are in the least deprived.
Elective Inpatient Admission	When a patient is admitted to a hospital for planned and scheduled medical treatment or surgery that requires an overnight stay.
Elective Care	Medical treatment or surgery that is pre-planned and scheduled in advance, rather than being done as an emergency.
A 95% Confidence Interval (CI)	A 95% confidence interval is a range of values that likely includes the true value we're trying to estimate, with a 95% chance of being correct. The range of values, or the margin of error, is linked to the sample size. A larger sample size makes the 95% confidence interval narrower, meaning we can be more precise about our estimate, while a smaller sample size results in a wider interval, indicating more uncertainty about the true value.çs
Non-elective admissions	Hospital admissions that are not planned or scheduled in advance, for example because of attending Accident and Emergency.
Outpatient attendances	When a patients visits a healthcare setting for treatment, but they are not admitted for an overnight stay. This can include day cases or follow-up appointments.
'Other' Ethnicity	Generally, someone is from an 'Other' ethnic background if they do not identify as Asian/Asian British, Black/Black British/Caribbean/African, Mixed/Multiple ethnic groups, or White. These are taken from the list of ethnic groups used in the 2021 Census.
Patient Pathways	The steps a patient goes through from referral with the NHS to the conclusion of their care. Note that one patient (an individual) who is on more than one waiting list will have a pathway for each waiting list they are on.
Pre-term births	When a mother gives birth to a baby before completing 37 weeks of pregnancy.
*	Counts between 1 and 5 have been replaced with a *, as well as other values within the data that cannot be used to recalculate the original small numbers. Suppressing these numbers is done to reduce the risk of identifying individuals.
Virtual Outpatient attendances	Medical appointments or consultations with a medical professiona l that takes place over the phone, by a video-call, or other online platforms.
8 care processes (for someone with Diabetes)	8 health checks which consist of an hbA1c blood test, blood pressure reading, cholesterol level reading, kidney function, urine albumin, foot surveillance, BMI (height and weight), and smoking status.
6 health checks (for someone with Severe Mental Illness, or SMI)	6 health checks which consist of checking someone's weight, heart rate, blood pressure, a urine test, a blood test, mental wellbeing, medicines, vaccinations, and any long term conditions such as asthma or diabetes.

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