COMMUNITY LEADERSHIP SCRUTINY COMMITTEE

Tuesday, 30 August 2016  6.00 pm  Committee Room 1, City Hall

Membership:  Councillors Karen Lee (Chair), Bob Bushell (Vice-Chair), Sue Burke, Chris Burke, Gill Clayton-Hewson, Thomas Dyer, Paul Gowen, Helena Mair, Liz Maxwell, Edmund Strengiel and Naomi Tweddle

Substitute member(s):  Councillor(s) Kathleen Brothwell

Also in attendance:  Shabana Edinboro and Charles Shine

Officers attending:  Simon Colburn, James Wilkinson and Democratic Services

AGENDA

SECTION A

Welcome and Introductions
1. Confirmation of Minutes - 21 June 2016  3 - 10

2. Declarations of Interest

 Please note that, in accordance with the Members' Code of Conduct, when declaring interests members must disclose the existence and nature of the interest, and whether it is a disclosable pecuniary interest (DPI) or personal and/or pecuniary.

3. Review on Suicide Rates in Lincoln - Data, Trends and Risk Factors  11 - 74

External Representatives Views

Working Groups Session

Feedback from Working Groups

Question and Answer Clarification Session

Summary - Review on Suicide in Lincoln - Data, Trends and Risk Factors
4. Lincoln City Profile 2016  75 - 164

5. Work Programme for 2016-17  165 - 168
Community Leadership Scrutiny Committee
21 June 2016

Present: Councillor Karen Lee *(in the Chair)*, Councillor Bob Bushell, Councillor Sue Burke, Councillor Edmund Strengiel, Councillor Gill Clayton-Hewson, Councillor Helena Mair, Councillor Liz Maxwell, Councillor Chris Burke, Councillor Paul Gowen and Councillor Thomas Dyer

Apologies for Absence: Councillor Naomi Tweddle

8. **Confirmation of Minutes - 12 May 2016**

RESOLVED that the minutes of the meeting held on 12 May 2016 be confirmed.

9. **Declarations of Interest**

No declarations of interest were received.

10. **Lincoln Anti-Poverty Strategy**

The Portfolio Holder for Social Inclusion and Community Cohesion and the Principal Policy Officer:

a. presented the report ‘Lincoln Anti-Poverty Strategy’.

b. advised that the aim of the report was for the committee to make comments on the extension of the Anti-Poverty Strategy from 2014-2016 to 2014-2020 with no change to the ambition, objectives or programmes involved within the strategy.

c. informed the committee of the background of the poverty review which spanned two years. The review resulted in the Anti-Poverty Strategy which was practically delivered through the Anti-Poverty Action Plan.

d. reported that through the monitoring of the Anti-Poverty Action Plan and the annual Anti-Poverty Conference it became apparent that poverty remained a key issue in the city and therefore it was considered appropriate to extend the Strategy to 2020.

e. highlighted that other than the extension to the Anti-Poverty Action Plan the objectives remained the same, these were:

   - Objective one: Helping people maximise their income
   - Objective two: Making the move into work easier
   - Objective three: Helping with the cost of raising a child
   - Objective four: Breaking the link between poor health and poverty
   - Objective five: Making sure older people get the services they need.
   - Objective six: Improving the condition of people’s homes
   - Objective seven: Working in a joined up way

f. invited members’ questions and comments.
Members made the following comments, asked the following questions and received the relevant responses.

**Comment** The chair inquired whether results could be seen in Lincoln through the work of the Anti-Poverty Strategy.

**Answer** It appeared that things were improving in the city. This was not just down to the anti-poverty work however, a new challenge that was being addressed through the extended plan was an increase in the number of ‘working poor’ residents.

**Comment** Concerns were raised over the actual impact of the strategy, and a potential discrepancy in the figures over the impact of the living wage.

**Response** The figures were explained, although it was noted that not every organisation in the city that pays the Living Wage will be accredited and therefore feature in the statistics. Officers agreed that progress was steady as it was a ‘slow burn’ campaign. The number of employers that were paying the Living Wage was a small increase however, it must be viewed as a success as the Council had no direct control over the businesses that paid it.

The Principal Policy Officer explained how Lincoln businesses were persuaded to pay the Lincoln Living Wage. Though it was also noted that some had responded to say they would not be able to, partly due to other financial circumstances e.g. pension contributions.

**Comment** Councillors thought that positive work had taken place in aid to reducing poverty in Lincoln and the Anti-Poverty Strategy had contributed to this. Though pockets of severe poverty and deprivation remained, especially in areas of the city such as Park and Abbey Wards. In these areas of the city it was felt there was still a presence of high interest money lenders.

**Comment** Councillor Kirk described the difficulties that were encountered with some people confused between the National Living Wage (which was the uprated minimum wage), and the Living Wage we were campaigning for. However, in relation to the High Interest Money Lenders commented on the success of the Say No To High Cost Borrowing campaign and the Helping Hand campaign, which deterred residents and staff from using high interest money lenders, and encouraged them to access money and benefits advice.

The difference between the Living Wage and Lincoln Living Wage was explained. The Living Wage stood at £8.25 per hour outside London, whereas the National Living Wage which stood at £7.20 per hour, though this was planned to increase to £9 per hour by 2020.

Members present enquired whether it would be possible for the Leader of the Council to discuss the Living Wage campaign with the committee from a Councillor perspective.

**RESOLVED** that:

1. the extension to the Anti-Poverty Strategy be approved.
2. Community Leadership Scrutiny Committee’s comments be forwarded to Executive for their consideration.
3. Councillor Ric Metcalfe be invited to a future meeting of the Community Leadership Scrutiny Committee to discuss the Living Wage.

11. **Summary Of City Centre Environment Work**

The Strategic Director (Housing and Regeneration) and the Public Protection and Anti-Social Behaviour Service Manager:

a. presented the report ‘Summary of City Centre Environment Work’.

b. informed that the committee had decided to examine issues affecting the city centre environment and began by scrutinising a report on 23 June 2015, and discovered there were three main issues, these were:

   - The Evening Economy (drunkenness, feeling of safety in the city centre).
   - Cleanliness (street cleansing and the enforcement of environmental offences).
   - Anti-Social Behaviour issues linked to substance misuse.

c. highlighted that following the identification of the issues that were in the city centre the committee investigated partnership responses, the committee heard evidence from two key partners at this stage Lincolnshire Police and Public Health.

d. reported that at the meeting on 18 August 2015 committee agreed to run a consultation exercise which ran throughout November 2015. The outcome of this consultation was reported to committee on 14 December 2016.

e. summarised that through a visit to the CCTV control room and walk round of the city centre area at night members identified that there was a small number of individuals that represented a number of complex challenges to a number of agencies.

f. further summarised that following the identification of these issues members of the committee invited representatives from Public Health and Lincolnshire Police, the chair summarised the key findings of these briefings:

   **Public Health**

   - Public Health was previously within the NHS and transferred to Local Government in 2012.
   - Public Health’s role was to prioritise services for the NHS and manage contract requirements.
   - Substance misuse and mental health was provided by separate services and more work needed to be done for those with dual diagnosis.
   - Public Health offered to work with the Council and other agencies to provide a targeted multi-agency approach to address those individuals that were difficult to engage with.

   **Lincolnshire Police**
• The review had identified complex issues relating to begging.
• Agreed the multi-agency partnership group would meet the needs identified during the review together with enforcement when necessary to address the issues.
• Public Health would engage with the process.
• The partnership group had made a commitment to try to engage with clients that were ‘traditionally’ difficult to engage with.

  g. advised that following the review of the city centre environment members had raised the outcome of these issues and encouraged communication, that enabled better partnership working to be achieved which was essential to deal with these complex problems.

  h. invited members questions and comments.

Members made the following comments, asked the following questions and received the relevant responses.

**Question** The Chair asked whether this work had a lasting positive effect on the city centre?

**Answer** This was an ongoing area of work but there had been improvements. The creation of the partnership group and joined up working through the multi-agency response had allowed work to take place to begin solving the majority of anti-social behaviour problems in the city centre.

**Question** Councillors raised concern that there appeared to be a lot of Charity Street Collection Agents in the city centre and at times these could appear intimidating, was there anything that could be done?

**Response** The Licensing team gave the street collection agents their licence, it needed to be carefully considered and was about finding a balance as ultimately they were there to carry out charity work for a good cause, but they should not make the Highstreet an unwelcoming place.

Members discussed the implications of the number of Charity Collection Agents within the city centre and both the positive and negative impacts they had, members requested more information to be circulated to members of the committee.

**Question** Councillors queried whether the enforcements against those committing anti-social behaviour in town were harsh enough?

**Answer** The PP&ASB manager thought that as an authority we had a reasonable enforcement approach, he explained that the problem with enforcement was that it often did not lead to sustainable results, it was a way of protecting ‘average’ people in the short term. However, often the answer to resolving the issues with individuals was a multi-agency response combined with support work.

**Comment** The Strategic Director (Housing and Regeneration) explained that often the people that appeared homeless in the city centre were not in many cases but led very complex lives and often suffered from alcohol and substance misuse.

RESOLVED that:

1. The report and members comments be noted.
2. Further information be sought on behalf of the committee regarding the licensing of street collection agents.

12. **Scope For Review On Suicide Rates In Lincoln**

The Leisure, Sport and City Services Manager

a. presented the report ‘Scope for Review on Suicide Rates in Lincoln’.

b. advised that the suicide rates in Lincoln had been above the regional and national rates for a number of years and were often cited as the worst in the country.

c. further advised that the annual report from the Director of Public Health for Lincolnshire identified suicide and undetermined causes as the third biggest loss of life in Lincolnshire with a rate of 12.8 across 100,000 population against the national rate of 8.8 across 100,000 population between 2011 and 2013.

d. informed that Lincolnshire Public Health had produced a number of documents relating to suicide and undetermined injury in Lincolnshire the key points of this report were:

   - during the 2014 calendar year in Lincolnshire, there were 67 deaths recorded as due to suicide and undetermined injury, an increase from the previous year, when there were 59 deaths. Three year rolling averages were calculated and suggested that annual changes in numbers were likely to be due to random variation.
   - rates of suicide in the Lincolnshire population appeared stable over time, with the directly age standardised rate of suicide in Lincolnshire remaining slightly above the national average.
   - the highest rate was seen in the 40-44 age group.
   - suicide was more commonly seen amongst males than females; in the calendar year 2014, 74.6% of suicides in Lincolnshire were completed by males.
   - rates of suicide were highest in the Lincoln, North Kesteven and Boston districts.
   - since 2006, hanging/strangulation had consistently been the most common method of suicide followed by poisoning.
   - an association was observed between rates of suicide and levels of multiple deprivation.

e. highlighted that a number of documents had been written regarding suicide rates in Lincolnshire that the committee would find useful whilst carrying out the review these were:

   - Preventing Suicide in England: Two Years on. Second Annual report on the cross government outcomes strategy to save lives, Department of Health 2015.
   - Preventing suicide in England - A cross-government outcomes strategy to save lives, Department of Health 2012
• No health without mental health: A cross-government mental health outcomes strategy for people of all ages, Department of Health 2011.
• closing the Gap: Priorities for essential change in mental health, Department of Health 2014.
• Lincolnshire Strategic Local Action Plan for Suicide Prevention 2016 (Draft), Lincolnshire County Council 2016.
• The Strategic Local Action Plan for Suicide Prevention (which was currently in draft form).

f. suggested an outline programme for the review over the next municipal year, these were:

• 30 August 2016 - Data, trends and risk factors;
• 25 October 2016 - Support and care – statutory mental health services;
• 20 December 2016 - Support and care – voluntary and community sectors, training and care;
• 31 January 2017 - Improving practice – are there any gaps in provision and is enough being done?

g. invited members’ questions and comments.

Members made the following comments, asked the following questions and received the relevant responses.

Members discussed the various reports, documents, and evidence and agreed that the first meeting should discuss these to ascertain what work had taken place and what the committee could do.

Comment Councillors raised concern that the national figures took into account the major cities and Lincoln’s suicide rate was still high.

Comment Councillors discussed that population density may be an issue when compared with other areas of Lincolnshire. Though agreed that often alcohol and substance abuse were contributing factors.

The Strategic Director (Housing and Regeneration) highlighted to members the importance of properly scrutinising the evidence provided in the documentation from Public Health England and Lincolnshire County Council in order to ascertain where the gaps were and why Lincoln had consistently been considered nationally as one of the worst suicide rates in the country.

RESOLVED that:

1. the report and members comments be noted.

2. The extent of the work programme be agreed and the Community Leadership Scrutiny Committee work programme be updated to reflect the topics of the meeting for the suicide review.

The Democratic Services Officer:

a. presented the Community Leadership Scrutiny Committee work programme for 2016/17.

b. asked members to agree the work programme and meetings for the suicide rate review 2016/17

Members suggested the following issues for a future review:

- Supported Housing.
- Bullying with a focus on cyber bullying.

RESOLVED that the work programme be updated to reflect the topics of the meeting for the Suicide review.
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1. Purpose of Report

1.1 To present to Members documents for information and discussion on suicide rates in Lincoln.

2. Executive Summary

2.1 Suicide rates in Lincoln have been above the regional rates for several years and has been anecdotally referred to as having the worst rate in the region and one of the worst in the country.

2.2 This report presents information on data, trends and risk factors as part of the Community Leadership Scrutiny Committee work programme examining suicide rates in Lincoln.

3. Main Body of Report

3.1 On 21 June 2016 Community Leadership Scrutiny Committee agreed a scope for reviewing Suicide Rates in Lincoln.

3.2 The scope set out that next over the course of the review, Community Leadership Scrutiny Committee would look at the following areas -

1) Data, trends and risk factors (30 August 2016);
2) Support and care – statutory mental health services (25 October 2016);
3) Support and care – voluntary and community sectors, training and care (20 December 2016);
4) Improving practice – are there any gaps in provision and is enough being done? (31 January 2017)

3.3 This report presents some information on Data, trends and risk factors –

Appendix A - Suicide in Lincoln. A City of Lincoln Council produced summary of the statistics relating to suicide in Lincoln City.

Appendix B – Suicide Risk Factors in Lincolnshire. City of Lincoln Council summary of the risk factors highlighted in the Lincolnshire County Council’s report in appendix D and E.
Appendix C – A mental health case study. A real life case study of a City resident produced for the 2015 Lincoln Poverty Conference. The case study highlights the complex links between mental health, poverty and services. Fortunately this situation did not result in suicide.

3.4 In the Community Leadership Scrutiny Committee agenda of 21 June 2016 the following documents were also included. These have been included again as they provide a comprehensive overview of the data, factors and challenges relating to suicide in Lincolnshire.

Appendix D - Lincolnshire County Council – Suicide and undetermined injury review 2015

Appendix E – Lincolnshire Suicide Prevention Local Action Plan 2016

4. Strategic Priorities

4.1 Protecting the poorest people in Lincoln
There appears to be a link between deprivation and increased risk of suicide in the recent data evaluated by the County Council.

5. Organisational Impacts

5.1 Finance (including whole life costs where applicable)
None

5.2 Legal Implications including Procurement Rules
None

5.3 Land, property and accommodation
None

5.4 Human Resources
None

5.5 Equality, Diversity & Human Rights (including the outcome of the EA attached, if required)
None required.

5.6 Significant Community Impact
Suicide has significant community impacts but there are no community impacts directly arising from this report.

6. Risk Implications

6.1 (i) Options Explored
None – information reports presented as appendices

6.2 (ii) Key risks associated with the preferred approach
None
### Recommendation

#### 7.1 For members to make comments and consider the attached information.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
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<td>No</td>
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<td>Do the exempt information categories apply?</td>
<td>No</td>
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<td>Does Rule 15 of the Scrutiny Procedure Rules (call-in and urgency) apply?</td>
<td>Yes/No&lt;br&gt;<em>Rule 15 will only apply in exceptional circumstances and requires the Monitoring Officer’s permission.</em></td>
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<td>How many appendices does the report contain?</td>
<td>5&lt;br&gt;- Appendix A - Suicide in Lincoln&lt;br&gt;- Appendix B – Suicide Risk Factors in Lincolnshire.&lt;br&gt;- Appendix C – A mental health case study.&lt;br&gt;- Appendix D - Lincolnshire County Council – Suicide and undetermined injury review 2015&lt;br&gt;- Appendix E – Lincolnshire Suicide Prevention Local Action Plan 2016</td>
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**List of Background Papers:**

*Please note that any background papers must be provided to Democratic Services with your report for publication. If in doubt as to the definition of a background paper, please contact Democratic Services.*

**Lead Officer:** Simon Colburn Assistant Director (Health and Environment)<br>Telephone (01522) 873241
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Suicide in Lincoln

What the key statistics tell us

The suicide rate in Lincoln increased from 12.6 per 100,000 in 2011-13, to 13.2 per 100,000 in 2012-14. Lincoln continued to have a higher rate than England.

Lincoln had the fourth highest rate of suicides when compared its nearest neighbours for 2012-14.

The three graphs below highlight three key findings:

1 DoH (2016) Local Authority Profile 2015
• The majority of deaths due to suicide and undetermined injury in Lincolnshire have been amongst those aged 30-54, with a particularly peaks amongst people aged in their early 40s. In comparison, rates were lowest amongst those aged 15-19.
• The proportion of male deaths is higher than female deaths in Lincolnshire, which reflects the national picture.
• There appears to be a link between death by suicide, and deprivation. Within Lincolnshire, suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

Source: HSCIC Indicator Portal, November 2015..(1)

Source: HSCIC Primary Care Mortality Database, November 2015.
Risk Factors

The JSNA 2016 Suicide Theme Report highlights the following risk factors that could make a person more vulnerable.

- **Health**
  - History of mental health problems
  - History of depression
  - History of self-harm
  - Physical ill-health
  - Alcohol misuse
  - Drug misuse
  - Special educational needs

- **Social**
  - Financial issues
  - Bereavement
  - Living alone
  - Unemployed

- **Demographic**
  - Male (accounts for 75% in Lincs)

- **Geographic**
  - Living in a deprived area

Source: HSCIC Primary Care Mortality Database, November 2015.
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Suicide Risk Factors

Summary produced for Community Leadership Scrutiny Committee
30 August 2016

(Excerpts from Lincolnshire County Council– Suicide and undetermined injury review 2015)

National Picture

The main risk factors for suicide, which are known from national research, are being male, living alone, living in a deprived area, being unemployed, alcohol and drug misuse, and mental illness. It is important to note that not all people exposed to these risk factors take their own life, as over the life course a level of resilience and protective factors are developed. However, these factors are likely to contribute to an individual's vulnerability to suicide.

The report, 'Two Years On' (Department of Health: Preventing Suicide in England: two years on. Second Annual Report on Suicide Prevention) notes that middle-aged males’ rates of suicide completion have risen most since 2008. It suggests that this group is traditionally least likely to seek help. So this presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group.

Coroner Office Information

In addition to mortality data for suicides and injury undetermined in Lincolnshire, recent data was also provided by the Coroner’s office for deaths in Lincolnshire where the inquest conclusion was suicide. From this data for the period June 2014–May 2015 we can identify the following:

- Mental health issues were identified as a risk factor in 65% of suicides occurring in a one year period.
- Issues around relationships were identified in 38% of suicides.
- Chronic or terminal illness was identified in 35% of deaths.
- Drugs and alcohol, financial issues and previous suicide attempts were also identified as common risk factors.

It is unclear from the data relating to mental health issues whether this has a correlation to an increase in the number of cases that are in contact with mental health services. Detailed information regarding relationships is more difficult to analyse due to the complex nature of the subject.

It is envisaged that a partnership protocol, currently being developed with the Lincolnshire Coroner’s Offices will give better evidence of contributing factors for future reports.

Risk factors

The latest data regarding risk factors are from those deaths registered in 2011. Therefore it is this data that has been used to draw out contributing risk factors for deaths.
Risk Factors for Mental Ill Health and Suicide

Certain population subgroups are more likely to experience mental ill health or attempt to complete suicide. Risk factors or vulnerabilities may operate in isolation or interact within individuals to further increase risk (e.g., unemployment and deprivation). The Mental Illness Health Needs Assessment identified key risk factors for mental ill health including:

- **Deprivation:** people from the most deprived areas are at higher risk poor mental health and of developing mental health problems, as are their children.

![Figure](https://example.com/suicide-prevention-graph.png)

**Figure.** Mortality from suicide by quintile of deprivation of residence, 3-year pooled data, crude rate per 100,000 population, calendar years 2011-2013. Source: HSCIC Primary Care Mortality Database.

The figure illustrates the link between death by suicide and deprivation, and shows that within Lincolnshire suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

- **Homelessness:** the prevalence of common mental health problems among people who are homeless is more than twice that in the general population. Serious mental illness is often accompanied by alcohol and/or substance misuse problems, with most studies suggesting that around 10-20% of the
homeless population fulfil the criteria for dual diagnosis

- **Financial exclusion:** Financial exclusion can lead to social exclusion, debt and poverty. People with five or more separate debts have a 6-fold increased risk of mental ill health. Difficulty repaying debt is a risk factor for suicide

- **Unemployment:** Unemployment in Lincolnshire is lower than the national average. Between April 2014 and March 2015, 4.9% of the population of Lincolnshire was unemployed, compared with 5.3% in the East Midlands and 6.0% in England. However, across the county there are pockets of long-term unemployment and seasonal employment. Unemployment among younger adults (aged 18-24 years) is higher than the national average (12-month job seekers allowance 0.5% in Lincolnshire, 0.3% in the East Midlands and England). Further, a higher proportion of those people who are economically inactive in Lincolnshire, are inactive due to long-term sick leave (25.7%) compared with the East Midlands (23.0%) and England (21.6%)

- **Substance misuse:** substance use and mental health problems often co-occur, with a complex relationship existing between substance misuse and mental health. Substance use can exacerbate the symptoms of mental ill health and may interact with medications used to treat conditions such as mood stabilisers and anti-depressants.

- **Loneliness and social isolation:** it is estimated that between 5% and 16% of over 65 year olds nationally have reported loneliness, while 12% report social isolation. There is no current data to identify loneliness or social isolation in Lincolnshire, we can provide an approximate estimate using national rates. Of the 159,953 over 65 year old residents living in Lincolnshire, we can estimate that between 8,000 (5%) and 25,500 (16%) are lonely, with a further 19,200 who feel isolated.

- **Mental ill health** is a risk factor for suicide. In addition, a number of population subgroups that are at increased risk of completing suicide have been identified in the Lincolnshire Mental Illness Health Needs Assessment 2015.

- **Minority ethnic groups:** risk of suicide in minority ethnic groups is difficult to measure as place of birth, rather than ethnicity is recorded on death certificates. At the 2011 census, 2.4% of the population of Lincolnshire was non-White, an increase from 1.4% at the 2001 census. This is much lower than the proportion of the population of England that is non-White (14%) nationally. The majority of recently arrived international migrants come from Eastern and Central Europe, and tend to be younger and more economically active than the UK-born residents of Lincolnshire.

- **People in institutional care or custody:** the national rate of self-inflicted deaths in prisoners in the period ending September 2014 was 1.0/1,000 prisoners (n=87). This was a 38% increase on the same period in 2013 and is the highest annual number of deaths since 2007. The rate of suicide and...
self-harm is much greater in the prison population that the general population (7.9/100,000 people). There are two prisons in Lincolnshire: HMP North Sea Camp (NSC) and HMP Lincoln.

- **Asylum seekers** - Data on rates of suicide and self-harm among asylum seekers in the UK is scant. However, using data that is available from Immigration Removal Centres, coroner’s records and the Prison Ombudsman’s reports, there are high levels of self-harm and suicide among detained asylum seekers compared with the UK prison population.

- **People with post-natal depression:** suicide is the leading cause of maternal death in England. Key risk factors for maternal suicide included severe onset of mental illness soon after childbirth, older age and being free from social adversity (22).

- **People of sexual minorities:** lesbian, gay, bisexual and trans (LGBT) self-identified people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. If estimates of 5-7% are accurate for Lincolnshire, this suggests that between 36,575 and 51,205 people self-identify as LGBT.

- **Veterans:** Young men who leave the armed forces (particularly those with a short length or services and of lower rank) are 2-3 times more likely to complete suicide than members of the general population. For ex-servicemen aged 30-49 years the risk of suicide is lower than in the general population. Lincolnshire has a large number of ex-armed forces personnel. However, data on this cohort is currently very limited, so it is difficult to provide accurate estimates.

- **People bereaved by suicide:** research supports an increased risk of suicide in mothers bereaved by the suicide of an adult child and partners bereaved by suicide, as well as an increased risk of a range of other mental health outcomes for people bereaved by suicide. Ensuring mental health services are able to support those people who are bereaved by suicide may help to reduce future burden of mental ill health and suicide mortality.

- **People who have self-harmed:** there is an increased in risk of suicide following self-harm episodes. Among a national cohort of almost 8,000 emergency department self-harm attendees followed up over a four-year period, there was a 30-fold increased risk of suicide compared with the general population. Suicide rates were especially high in the 6 months after the index self-harm episode suggesting that early intervention after an episode of self-harm may be important to reduce suicide risk.

In Lincolnshire, between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm. This is a population in which timely intervention might reduce future suicide risk.
Person A is in her 50s, and worked in a retail store part-time in Lincoln. Her partner also worked part-time for a separate employer. Both earned just above minimum wage, and relied on over-time work to cover expenses for their household of five people.

Person A was diagnosed with stress and signed off work. After a period on sick leave, she returned to work, but unable to cope, she was diagnosed with depression and psychosis, and signed off work for several months.

Her family kept trying to get her support in hospital, but staff kept sending her home because “her family were at home to care for her”. Person A required 24-hour supervision for her own wellbeing, which was provided by her partner and family members. She was eventually admitted to hospital in December 2012 following a suicide attempt. Person A was discharged in May 2013. She attempted to return to her job in retail, but was unable to cope, and was eventually let go.

She became entirely dependent on her family, who felt increasing financial strain due to the loss of her income, and her partners’ inability to take on over-time due to his caring duties.

Person A relied on support provided at Lincoln Mental Health Day Care Ward, and was devastated when this closed, as she relied on it for independence, drive, and social skills. Following the closure, Person A spent most of her time at home in isolation.

In August 2013, Person A was re-admitted into hospital, and remained there for four months.

Person A has recently had her PIP (Personal Independence Payment) refused due to having support at home with laundry, housework and meals – all provided by the partner who is struggling to find time to work to bring in money.

Person A has been waiting 2 years and 3 months to receive talking therapy from a Psychotherapist, and recently received a letter advising she would need to wait a further 8 months, bringing the total waiting time to 3 years.

During Person A’s second stint of sick leave she was moved on to benefits which significantly reduced her household’s income.

Person A was sent home from hospital on more than one occasion because her partner was there to care for her. However, this meant her partner was unable to take on overtime (which the household were previously reliant on), and the household’s income reduced further.

The closure of the Mental Health Day Care Ward further worsened Person A’s isolation, and inability to socialise, affecting recovery. By spending more time at
home, the families’ heating bills also increased substantially, adding further to their financial strain.

The amount of time Person A spent in hospital added more financial pressure on household finances, with the partner still struggling to take on more hours due to hospital visits, and the cost of parking at the hospital becoming a real struggle.

Person A’s partner struggled with day-to-day costs such as mortgage repayments, food, fuel and other necessities.

The 3 year waiting list for talking therapy with a Psychotherapist has greatly affected Person A’s recovery process. The family now rely solely on Employment and Support Allowance, and income from the partner who is working part-time, in addition to substantial unpaid caring duties.
Suicide and Undetermined Injury Review
Lincolnshire 2015
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>p3</td>
</tr>
<tr>
<td>1 Aims and objectives</td>
<td>P4</td>
</tr>
<tr>
<td>2 Introduction</td>
<td>P4</td>
</tr>
<tr>
<td>3 Methodology</td>
<td>p4</td>
</tr>
<tr>
<td>4 National picture</td>
<td>p5</td>
</tr>
<tr>
<td>5 Findings</td>
<td>p9</td>
</tr>
<tr>
<td>6 Discussion and conclusions</td>
<td>p20</td>
</tr>
<tr>
<td>7 Recommendations</td>
<td>p21</td>
</tr>
<tr>
<td>Bibliography</td>
<td>p22</td>
</tr>
</tbody>
</table>
Executive Summary

This report provides a review of suicide and self-harm in Lincolnshire, with the purpose of demonstrating findings from the audit and to inform future suicide intervention. The most up to date information has been accessed from Health and Social Care Information Centre (1) (HSCIC) and Public Health Mortality Files (2) on suicides registered during the period 2012-2014:

- During the 2014 calendar year in Lincolnshire, there were 67 deaths recorded as due to suicide and injury undetermined. This was an increase from the previous year, when there were 59 deaths. Three year rolling averages were calculated and suggest that these annual changes in numbers are likely to be due to random variation (Figure 1.1).
- Rates of suicide in the Lincolnshire population appear stable over time, with the directly age standardised rate of suicide in Lincolnshire remaining slightly above the national average (Figure 1.1).
- The highest age specific mortality rate due to suicide in the pooled calendar years 2012 to 2014 was seen in the 40-44 age group (Figure 1.3).
- Suicide is more commonly seen amongst males than females; in the calendar year 2014, 74.6% of suicides in Lincolnshire were completed by males (Figure 1.6).
- Rates of suicide in the pooled calendar years 2011 to 2013 were highest in the Lincoln, North Kesteven and Boston districts. An association was observed between rates of suicide and levels of multiple deprivation (Figure 1.7).
- In the pooled calendar years 2011 to 2013, there were no significant differences between the age standardised rates of mortality across the 4 four Lincolnshire CCGs and Lincolnshire itself.
- Since 2006, hanging/strangulation has consistently been the most common method of suicide followed by poisoning (Figure 1.8).
1. Aims and Objectives

This review aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

The objective of this report is to begin to use this information to inform the process of implementing a suicide prevention plan for Lincolnshire, and reduce the number of completed suicides in Lincolnshire.

This information will be used in conjunction with the Mental Illness Health Needs Assessment for Lincolnshire (3) in order to give an understanding of the wider picture.

2. Introduction

This review aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention. The findings are presented in terms of the national strategy recommendations for suicide prevention and the Mental Illness Health Needs Assessment for Lincolnshire, (3) as these will inform the development of a Lincolnshire Local Action Plan.

Middle-aged male rates have risen most since 2008. This group are traditionally least likely to seek help, so that presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group.

3. Methodology

Four approaches were used to collate evidence for this Suicide Review

- Desk based research used to develop an overview of the current picture across Lincolnshire, and nationally for both suicide completion and suicide risk factors.
- Epidemiological, using a range of data to build a picture of the scale of those people in Lincolnshire who complete suicide, with comparison to the national picture
- Coroner Office information
- National and best practise evidence

Work was carried out by staff from the Public Health Directorate of Lincolnshire County Council during November and December 2015.
4. National Picture

4.1 Risk Factors

The main risk factors for suicide, which are known from national research, are being male, living alone, living in a deprived area, being unemployed, alcohol and drug misuse, and mental illness. It is important to note that not all people exposed to these risk factors take their own life, as over the life course a level of resilience and protective factors are developed. However, these factors are likely to contribute to an individual’s vulnerability to suicide.

The report, ‘Two Years On’ (4) notes that middle-aged males’ rates of suicide completion have risen most since 2008. It suggests that this group is traditionally least likely to seek help. So this presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rate among younger men has stalled, and suicide remains a leading cause of death for this group. There is a considerable amount of literature nationally. Three of the key national guidance are:

1) The All Party Parliamentary Group on Suicide and Self Harm Prevention
3) Preventing Suicide in England: Two Years On: Second Annual Report on the Cross government outcomes strategy to save lives

4.2. National Guidance

The All Party Parliamentary Group on Suicide and Self Harm Prevention 2015(5) asked for information on whether local authorities were actively implementing local suicide prevention plans, operating multi-agency suicide prevention groups to oversee these plans, and whether regular suicide audits were carried out. Local authorities were also asked to provide details of what resources were specifically allocated to support suicide prevention, and what, if any, joint strategies were in place with neighbouring local authorities. This information was then compared with the local suicide rate and, in some cases, with rates of deprivation.

4.2.1 All Party Parliamentary Group on Suicide and Self Harm Prevention

The All Party Parliamentary Group (APPG) 2015 identified three main elements that are considered essential to successful local implementation of the national strategy for the prevention of suicide:

- Carrying out a “suicide audit” which involves the collection of data about suicides that have occurred locally from sources such as coroners and health records in order to build an understanding of local factors such as high risk demographic groups.
The development of a **suicide prevention action plan** setting out the specific actions that will be taken based on the national strategy and the local data, to reduce suicide risk in the local community.

The establishment of a **multi-agency suicide prevention group** involving all key statutory agencies and voluntary organisations whose support is required to effectively implement the plan throughout the local community.

The APPG recognised that the collection of local data can be a time-consuming and often difficult task for local authorities, but APPG recommends that:

- a long-term aim should be for Coroners to collect and digitalise a wider range of suicide data which is automatically made available to public health teams.
- in the short-term, PHE should issue guidance on what data should be collected locally and how it can be used. This should include the provision of an updated suicide audit tool/template.
- the Chief Coroner should issue guidelines to Senior Coroners on enabling free access to public health teams to all necessary records and data
- PHE should also consider how suicide data could be pooled over wider geographical areas in order to better identify trends.

### 4.2.2 Public Health England (6) 'Prompts for local leaders on suicide prevention’

In October 2014, PHE published a new guidance document entitled *Guidance for Developing a Local Suicide Prevention Action Plan: Information for public health staff in local authorities* (7) The publication of this guidance document therefore represents a significant step forward as it directs local authorities towards practical steps that they ought to take in a clearer way than the national strategy. This document provides advice for local authorities on how to:

- Develop a suicide prevention action plan.
- Monitor data, trends and hot spots.
- Engage with local media.
- Work with transport to map hotspots.
- Work on local priorities to improve mental health.

### 4.2.3 Suicide rate in England

The suicide rate used by PHE is based on Office for National Statistics (ONS)(8) figures, which display the number of deaths by suicide per 100,000 of the population. These are calculated as an average annual rate across a three-year period because three-year
averages are considered to be a more reliable indicator of trends than single-year figures.

The suicide rate in England was in steady decline for most of the last decade until around 2008, but since then there has been a small increase. Given the extensive evidence base linking difficult economic circumstances and higher unemployment to higher rates of suicide, some researchers attribute this rise in recent years to the economic downturn.

4.2.4 Preventing Suicide in England: Two Years On: Second Annual Report on the Cross government outcomes strategy to save lives (4)

Current trends in suicide – the national picture
ONS (8) figures show 4,727 suicide deaths in 2013, an increase of 214 compared to the 4,513 deaths in 2012. The latest statistics show that:

- The rate of deaths from suicide and undetermined intent was 8.8 per 100,000 population in 2011-13. After 1998-2000 the general trend was a decrease in the overall rate of suicide. However, this tailed off in recent years, with small rises in rates in the last five years. The figure for 2011-2013 is the same as for 2004-06.
- Suicide continues to be more than three times as common in males than in females (13.8 per 100,000 for males in 2011-13, compared to 4.0 for females). The numbers and rates of suicide and undetermined deaths vary between age groups with rates among males highest for those aged 40-44, and in females highest for those aged 45-49 years.
- Hanging, strangulation and suffocation accounts for the largest number of suicides in males and females, 57% and 41% respectively. The second most common method is drug related poisoning, accounting for 19% and 37% of suicides for males and females respectively.
- While the number of suicides in patients has been higher in recent years, there is an overall downward trend in the suicide rate. From 2002-2011, there was a 50% fall in the number of in-patients dying by suicide. The number of suicides under crisis resolution home treatment has also fallen since 2009.3
- Self-inflicted deaths in prisons in England and Wales increased to 84 in 2014 from 75 in 2013; the second calendar year there has been a year-on-year increase. Suicides in women prisoners remain very few. In the 12 months to September 2014 there were 24,748 reported incidents of self-harm, up by 1,508 incidents (6%) on the same period in 2013.4
- Helium suicide remains a concern. ONS reported 59 deaths mentioning helium in 2013, over five times higher than the 11 deaths recorded in 2008 and an increase of 16% compared with 2012. Almost all of these deaths were suicide. Due to the sensitive nature of reporting of suicide methods, particularly unusual ones,
journalists are advised to follow the Samaritans’ media guidelines on the reporting of suicide.

- Data from the Multicentre Study of Self-harm in England(10) show that rates of self-harm declined in both genders from 2003 until 2008 and then started rising in males until 2012. The decline in rates in females levelled off after 2008. This pattern is similar to that seen for national suicide rates over the same period. The Multicentre Study data showed a rise in self-harm in girls (but not boys) under the age of 16 years in 2010-12 compared to 2007-9. This rise was seen for both the number of self-harm episodes involving girls under 16 years (increased by 16%) as well as the number of girls under 16 years presenting with self-harm (increased by 10%), but was much smaller than the increase reported based on Hospital Episode Statistics (HES). (11) Data on self-harm trends using HES data may be somewhat misleading and the large rise they suggest probably reflects improved data collection.

4.2.5. Areas of Review for future national consideration

The report, ‘Two Years On’ (4) highlights a number of areas that raise concern across many Local Authority areas:

- Suicide among primary care patients is linked to frequent GP attendance, increasing attendance, and also non-attendance, the latter being associated with young and middle-aged men.
- There is a need to re-focus efforts to reduce post-discharge suicide deaths. The first three months post discharge remains a period of high risk - particularly in the first two weeks. This has been linked to short last admission of less than seven days. Although there have been improvements over the last 15 years since this issue was first highlighted and the introduction of early follow-up recommended, progress has stalled in recent years.
- Self-harm in prisons is associated with subsequent suicide in this setting, suggesting that prevention and treatment of self-harm is an essential component

4.2.6. National picture on Alcohol and suicide

Alcohol-related death was more frequent than expected among both males and females who presented at emergency departments with self-harm. Hospital-presenting patients should receive assessment following self-harm in line with NICE guidelines, to enable early identification and treatment of alcohol problems. Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm. (12)

Men are at greater risk for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant
to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death.

4.2.7. Best Practise

The report 'Two Years on' (4) cites a number of Local Authorities that have successfully undertaken or commissioned specific programmes of work that have shown a reduction in the rates of suicide or self-harm. All of these have demonstrated exemplary partnerships across all sectors. A number of these demonstrate the importance and success of partnership working across all sectors.

5 Findings

5.1. Lincolnshire compared to the national picture

Figure 1 Three years' rolling directly age standardised rate of suicide in Lincolnshire between 2008-10 and 2012-14

The graph in figure 1 shows that Lincolnshire has a higher rate of male suicide than England. The rate for females shows the trend as being the same as the rate for England.
5.2. Number of deaths in Lincolnshire between 1995 and 2014

The report has identified levels in line with those of the Office of National Statistics (8) but in addition provides greater depth of understanding of themes around suicide locally, as shown in figure 2. Overall figures have not changed greatly compared to previous audits which emphasises the need for further work to address entrenched patterns.

Figure 2 Number of deaths due to suicide (ICD10 X60-X84) in Lincolnshire, calendar years 1995 to 2014. Source: Public Health Outcomes Framework, November 2015 (9)

Source: HSCIC Indicator Portal, November 2015 (1)

The graph in figure 2 shows the number of deaths due to suicide in Lincolnshire 1995-2014. The single year trend shows an overall increase with noticeable variation during the time period however the three-year rolling average shows a smoother increase which has slowed down since 2009.

5.3 Age Profile

In Lincolnshire, the majority of deaths were of those aged 40–44 years, which is a consistent pattern observed over time. This is shown in figure 3.
Figure 3 Mortality due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34), three year pooled data, age-specific crude rate per 100,000 population, calendar years 2012-14

Source: HSCIC Indicator Portal, November 2015. (1)

Figure 3 shows that the majority of deaths in Lincolnshire due to suicide and undetermined injury were amongst those aged 40-44, while in comparison, rates were lowest amongst those aged 15-19.

5.4 District & CCG Data

Data for the seven districts shows that all the Districts in Lincolnshire, except South Kesteven have a higher rate of completed suicides than the East Midlands rate. Five of the Districts have a higher rate than the England rate.

Figure 4 Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) by district of residence, three-year pooled data, directly age standardised rate per 100,000 population, calendar years 2011-13.

<table>
<thead>
<tr>
<th>Area</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>12.6</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>10.3</td>
</tr>
<tr>
<td>Lincoln</td>
<td>14.5</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>13.5</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.7</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>8.1</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>11.4</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>11.1</td>
</tr>
<tr>
<td>East Midlands</td>
<td>9.9</td>
</tr>
<tr>
<td>England</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Source: HSCIC Indicator Portal, November 2015. (1)
Figure 4 indicates that in the three-year pooled data period, the highest rate of suicide was in the City of Lincoln District (at 14.5/100,000), which is higher than the rates seen regionally (9.9/100,000) and nationally (10.4/100,000). Within Lincolnshire, South Kesteven District has the lowest rate of suicide, at 8.1/100,000.

The pooled data indicates that Lincolnshire West CCG had the highest rate of completed suicide in the period 2011-2013 (Figure 5).

Figure 5 Mortality from suicide (ICD10 X60-X84) by CCG of registration, three-year pooled data, directly age standardised rate per 100,000 population, financial years 2011-2013

![Bar chart showing suicide rates by CCG]

Source: HSCIC Indicator Portal, November 2015 (1)

Figure 5 shows the rates of suicide completion within each CCG area. It shows that Lincolnshire West CCG has the highest rate of suicide completion, however there is statistically no significant difference between the suicide mortality rates in Lincolnshire, by CCG.

5.5 Gender

Figure 7 illustrates that the trend of male deaths from suicide is higher than female deaths.
Figure 7 Proportion of suicides by sex, Lincolnshire, calendar years 2006 to 2014

![Bar chart showing the proportion of male and female suicides by year]

Source: HSCIC Primary Care Mortality Database, November 2015.

**Figure 7** shows that the proportion of male deaths is higher than female deaths, in Lincolnshire. This reflects a national picture.

### 5.6 Suicide and Deprivation

National research confirms link between suicide and deprivation, although there are many complex reasons that contribute to the completion of suicide.

**Figure 8** Mortality from suicide by quintile of deprivation of residence, three-year pooled data, crude rate per 100,000 population, calendar years 2011-2013

![Bar chart showing mortality rates by deprivation quintile]

Source: HSCIC Primary Care Mortality Database, November 2015.
Figure 8 illustrates the link between death by suicide and deprivation, and shows that within Lincolnshire, suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

5.7 Method of suicide

The Coroner's data confirms findings from the Primary Care Mortality Database (the data shown in Figure 9) where hanging/strangulation was identified as the most common method of suicide. The figures provided by the Coroner's office state that in a one year period, 68% of suicides were completed by hanging. Hanging, strangulation and suffocation continue to be the most common method of suicide, accounting for 70% of deaths in the period 2012–2014. Along with drug-related poisoning, hanging is also becoming a more common method amongst women.

The Coroner's data illustrates that 27% of those who completed suicide in the period June 2014–June 2015 had previously attempted suicide. The reasons for the unsuccessful conclusion of these attempts are unknown. The time length between previous attempts and the completion of suicide is also unknown.

Figure 9 Proportion of suicides by method, Lincolnshire, three-year pooled data, calendar years 2006-2014

Source: HSCIC Primary Care Mortality Database, November 2015.

Figure 9 shows the method of suicide. It shows that the most used methods are hanging and strangulation.
5.8 Contributing Factors that may lead to suicide

There are a number of known risk factors and it is often a combination of these that lead to suicide. Many of these factors are known from national research – being male, living alone, living in a deprived area, being unemployed, alcohol and drug misuse, and mental illness. It is important to note that not all people exposed to these risk factors take their own life as over the life course a level of resilience and protective factors are developed. Rather, these factors contribute to an individual’s vulnerability to suicide.

Local data that details the correlation between these varied and complex factors and suicide is not currently available. The Mental Illness Health Needs Assessment (3) discusses these factors in more detail. There is however detailed information currently available that shows the correlation between self-harm and suicide.

5.9 Self-harm

People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm himself or herself. Risk is particularly increased in those repeating self-harm and in those who have used violent or dangerous methods of self-harm.

The rate of hospital admissions due to self-harm, whilst remaining fairly stable, saw a small but significant increase in the financial year 2013/14 compared with 2012/13. There was no significant difference in the number of admissions related to self-harm in any of the age groups between these time periods. In 2013/14, the highest age specific hospital admissions rates for self-harm were seen in the 15-19 age group (Figures 10 and 11). (11)

The District with the highest rate of self-harm, in the period 2011-2014, leading to hospital admission was City of Lincoln (25%), with East Lindsey at 19.9%. 
Figure 10 Hospital admissions due to self-harm in Lincolnshire, directly age standardised rate per 100,000 population, financial years 2010/11-2013/14

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved. (11)

Figure 10 shows a net increase in the number of hospital admissions in Lincolnshire due to injury by self-harm between 2010/11 and 2013/14. There has been a statistically significant increase in hospital admission between 2012/13 and 2013/14 due to self-harm.
Figure 11 Hospital admissions due to self-harm in Lincolnshire, age specific crude rate per 100,000 population, pooled financial years 2012/13-2013/14

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.

Rates of hospital admissions due to self-harm are highest amongst 15-19 year olds in Lincolnshire with rates increasing between 2012/13 and 2013/14. Interestingly, there has been a significant increase in the number of admissions amongst 10-14 year olds over the same period, which could lead to a higher rates in subsequent years.

Figure 12 Proportion of hospital admissions due to self-harm by district of residence, Lincolnshire, pooled financial years 2011/12–2013/14

<table>
<thead>
<tr>
<th>District</th>
<th>2011/12 - 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>8.8%</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>19.9%</td>
</tr>
<tr>
<td>Lincoln</td>
<td>25.0%</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>10.3%</td>
</tr>
<tr>
<td>South Holland</td>
<td>9.2%</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>16.1%</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Source: HSCIC Hospital Episode Statistics.
Figure 12 shows that City of Lincoln has the highest rate of hospital admission due to self-harm.

Figure 13 Hospital admissions due to self-harm by CCG of registration, three-year pooled data, directly age standardised rate per 100,000 population, pooled financial years 2011/12 -2013/14


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Hospital admissions due to self-harm show that rates are significantly higher in Lincolnshire East and Lincolnshire West CCG areas, compared to South Lincolnshire and South West Lincolnshire CCG’s.

Figure 14 Proportion of hospital admissions due to self-harm by sex, pooled financial years 2010/11 to 2013/14

<table>
<thead>
<tr>
<th>Year</th>
<th>Lincolnshire</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>2010/11</td>
<td>42.8%</td>
<td>57.2%</td>
<td></td>
</tr>
<tr>
<td>2011/12</td>
<td>43.5%</td>
<td>56.5%</td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>41.3%</td>
<td>58.7%</td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>39.5%</td>
<td>60.5%</td>
<td></td>
</tr>
</tbody>
</table>

Source: HSCIC Hospital Episode Statistics, November 2015. Copyright © 2015, reused with the permission of The Health & Social Care Information Centre. All rights reserved.
The admissions for self-harm were higher for females; 60.5% of admissions were female in the financial year 2013/14 (Figure 14).

Figure 14 shows that females consistently have a higher rate of hospital admission than males, due to injury from self-harm.

Figure 15 shows that rates of hospital admissions due to self-harm are highest among the most deprived quintile in Lincolnshire compared to the least deprived quintiles.

5.10 Coroner Office Information

In addition to mortality data for suicides and injury undetermined in Lincolnshire, recent data was also provided by the Coroner's office for deaths in Lincolnshire where the inquest conclusion was suicide. From this data for the period June 2014–May 2015 we can identify the following: (14)

- Mental health issues were identified as a risk factor in 65% of suicides occurring in a one year period.
- Issues around relationships were identified in 38% of suicides
- Chronic or terminal illness was identified in 35% of deaths.
• Drugs and alcohol, financial issues and previous suicide attempts were also identified as common risk factors.

It is unclear from the data relating to mental health issues whether this has a correlation to an increase in the number of cases that are in contact with mental health services. Detailed information regarding relationships is more difficult to analyse due to the complex nature of the subject.

It is envisaged that a partnership protocol, currently being developed with the Lincolnshire Coroner’s Offices will give better evidence of contributing factors for future reports.

5.11 Risk factors

The latest data regarding risk factors are from those deaths registered in 2011. Therefore it is this data that has been used to draw out contributing risk factors for deaths

• history of mental health problems and depression
• history of self-harm
• physical ill-health
• alcohol misuse
• financial issues
• bereavement
• special educational needs.

6. Discussion and conclusions

This report gives an overview of the current picture in relation to suicides in Lincolnshire and should be reviewed in conjunction with the Mental Illness Health Needs Assessment (3) and Local Action Plan for Suicide Prevention. (13)

This report is limited to some extent by lack of access to source records, but it does provide an overview of the picture of suicide in Lincolnshire today. It highlights that overall, rates of suicide have remained stable over time and that certain key risk factors (e.g. rates of suicide being higher in males) have remained consistent in recent years. This report will support the development and implementation of a local suicide prevention plan. (13)

The key challenges faced in compiling this report were lack of access to individual level information. Until 2013, access to patient records was available, enabling us to identify possible risk factors for Lincolnshire patients. However, since Public Health transferred from the NHS to the local authority, permission to access patient records has not been
granted. As a result of the difficulties encountered in accessing information no scrutiny of the data was possible.

Many individuals are in contact with a range of organisations and members of their local community leading up to their death, all of which potentially have a role in suicide prevention. The challenge is ensuring that individuals know what signs to recognise. There is therefore, a need to raise awareness for suicide prevention training and awareness, targeting specifically community and front line services. There may be an opportunity to develop a ‘Suicide Champion’ Scheme.

7. Recommendations

1. Self-harm is a known risk factor and one of the strongest known predictors of suicide. Hospital admissions rose in the period 2012-2013, emphasising the importance of engaging with and supporting individuals who self-harm. Emergency departments and primary care have an important role in the care of people who self-harm, specifically for those who present with repeated self-harm injuries.

2. Since the transfer of Public Health to Local Authority, access to data and specifically to GP patient records, which had previously informed suicide and self-harm prevention, has been restricted. There is a need to develop information sharing agreements with partner organisations and explore alternative data sources, as collating numbers alone does not provide the quality of data to inform and target suicide prevention effectively. Partnership work is developing to better use the intelligence from the Coroner. It is envisaged that in future this will allow for a clearer picture relating to risk factors. The intention is to use this information in order to gain more understanding of the issues that increase the risk of the completion of suicide, in order to reduce the number of suicides in Lincolnshire. The annual suicide rate in Lincolnshire shows a stable trend, however it is still above the England average, therefore further learning is essential.

3. There are a number of contributory factors towards the risk of suicide and self-harm, including deprivation and depression. Further investigation is required into the risk factors of those living within the most deprived quintiles to help define the local action plan, with particular reference to self-harm. Greater understanding is required of the journey and triggers that result in suicide.

4. One of the most effective ways to prevent suicide is to reduce access to means and one of the suicide methods most open to intervention is self-poisoning. Further work in this area is identified in the Local Suicide Prevention Action Plan.

5. Improving the mental health of the population as a whole can also reduce suicide, particularly those already known to mental health services. Reference should be
made to findings in the Mental Illness Health Needs Assessment and recommendations within the Local Suicide Prevention Action Plan.

6. It is clear that repeated audits with this level of detail are not going to improve our understanding. Consideration needs to be given to a more detailed audit methodology, perhaps using a confidential inquiry approach as is currently in place for maternal deaths and for child deaths.

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Suicide Prevention
Lincolnshire Local Action Plan
2016
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>p3</td>
</tr>
<tr>
<td>1 Aims and objectives</td>
<td>P3</td>
</tr>
<tr>
<td>2 National Context</td>
<td>P4</td>
</tr>
<tr>
<td>3 Lincolnshire Context</td>
<td>p4</td>
</tr>
<tr>
<td>4 Impact of Suicide</td>
<td>p6</td>
</tr>
<tr>
<td>5 Risk Factors</td>
<td>p8</td>
</tr>
<tr>
<td>6 Suicide and Self Harm</td>
<td>p11</td>
</tr>
<tr>
<td>7 Local Action Plan</td>
<td>p12</td>
</tr>
<tr>
<td>8 Developing a local Plan for Lincolnshire</td>
<td>p12</td>
</tr>
<tr>
<td>9 Bibliography</td>
<td>p13</td>
</tr>
</tbody>
</table>
Executive Summary

The national strategy, Preventing Suicide in England 2012,[1] identifies six key areas for action:

- Reduce the risk of suicide in key high risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The multi-agency Lincolnshire Suicide Prevention Steering Group (LSPSG) was formed in September 2015, building on previous work of the multi agency 'Choosing Life' group and the 2012 national strategy.[1] Lincolnshire’s Suicide Prevention Steering Group was established to develop a whole system approach to suicide prevention by providing a process for key stakeholders to create and own a Lincolnshire wide evidence based suicide prevention action plan that is both meaningful and achievable. Members are drawn from across all sectors, including representation from users of mental health services. It is a strategic group, tasked with formulating a Lincolnshire Local Action Plan, with an agreed aim of reducing levels of suicide in Lincolnshire. The LSPSG is chaired by a Consultant in Public Health, and coordinated and supported by Public Health staff. However, its progress to date is as a result of the collaboration and hard work of many stakeholders.

We know that the reasons that lead someone to take their own life may be extremely complex. No organisation or single programme can address all the factors that may contribute towards a suicide, hence the need to develop further a model of collaborative working.

1. Aims and Objectives

This strategic plan aims to confirm our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

The objective of the Local Action Plan is to implement a suicide prevention plan for Lincolnshire, and reduce the number of completed suicides in Lincolnshire.

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1 See Appendix 1 for a full membership list of the LSPSG.
2. The National Context

A wide range of national policies and strategies to improve mental health in the UK have been implemented in recent decades. Some are specific to mental health:

- No health without mental health: A cross-government mental health outcomes strategy for people of all ages;[2]
- Closing the Gap: Priorities for essential change in mental health;[3].

Others are broader health policies and strategies that include objectives specific to improving mental health, for example:

- Public Health Outcomes Framework for England;[13]

Together, these documents provide a ‘way-forward’ for improving the nation’s mental health and wellbeing, identifying good practice and key indicators that can be used to measure progress. An overarching aim is to give mental health the same importance as physical health and improve the health care experience of people with mental ill health. Through mental health promotion (starting early to promote mental wellbeing and prevent problems from developing) and ensuring access to effective services for people with mild and severe mental illness, the Government’s strategy aims to ensure fewer people will suffer avoidable harm, stigma and discrimination, and more people will recover from mental health problems. These policies aim to reduce premature mortality in people with serious mental illness and improve the quality of life for people with mental health problems.

The Government has developed a separate policy specific to preventing suicide. Suicide is a leading cause of years of life lost and the 2012 Suicide Prevention Strategy for England [5] aims to reduce the suicide rate in the general population in England and better support those who are bereaved or affected by suicide.

3. The Lincolnshire Context

The effects of suicide can be devastating. Many people – friends, family, professionals, colleagues and wider society will feel the impact. There are also significant financial costs associated with a suicide. The average cost of a completed suicide of a working age adult in the UK is estimated to be £1.67m. The 2014 Annual Report from the Director of Public Health for Lincolnshire [6] identified that death from suicide or undetermined causes is the third biggest cause of years of life lost in Lincolnshire. Recommendations arising from the report include:

- Continued monitoring of suicide and death by undetermined causes to enable the identification of causes and delivery interventions that could save lives. Development of a suicide surveillance system, incorporating appropriate information sharing and reporting.
- More people trained to raise awareness of how to talk to someone that might be at risk of completing suicide.
- Create an action plan for suicide prevention, working together to help people and making sure frontline staff have the skills and information to help people at risk.

Improving mental health and reducing mortality from suicide have been identified as public health priorities in Lincolnshire. Mental health is embedded as a cross-cutting theme in the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018 [7]

Deaths due to Suicide in Lincolnshire

Figure 1.1. 2 Number of deaths due to suicide (ICD10 X60-X84) in Lincolnshire, calendar years 1995 to 2014. Source: Public Health Outcomes Framework, November 2015 (9)

Source: HSCIC Indicator Portal [8]
Figure 1.2. Mortality due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) in Lincolnshire, 3-year pooled data, directly age standardised rate per 100,000 population, calendar years 2008-2014.

Source: HSCIC Primary Care Mortality Database [9]

Figure 1.2 shows that Lincolnshire has a higher rate of male suicide than England. The rate for females shows the trend as being the same as the rate for England

The Mental Illness Health Needs Assessment [10] identifies that between 2011 and 2013, 184 people aged 15 years and older died from suicide and injury undetermined in Lincolnshire. The age-standardised suicide and undetermined injury mortality rate (per 100,000) in Lincolnshire is 7.0, comparable to the East Midlands rate of 6.8 and lower than the England rate of 7.9 mortality rate is lowest in Lincolnshire East and South Lincolnshire at 7.5 and 7.6 respectively and highest in Lincolnshire West at 10.4.

4. The Impact of Suicide in Lincolnshire

The mental illness health needs assessment (2015)[10] was developed to inform the development of a suicide action plan for Lincolnshire. However, it is important to remember that not all people who complete suicide are in contact with mental health services; indeed on average it is estimated that fewer than half of adults and a quarter of children and young people who complete suicide had previous contact with mental health services. As such, it is important to consider the mental health needs assessment alongside other key evidence on suicide and risk factors for suicide in Lincolnshire.

Over the last 10 years, the death rate for suicide has decreased from 9.13 per 100,000 people in 2000 to 8.13 in 2010, but in Lincolnshire this equates to 60-70 people every year who take their own life.
The majority of suicides continue to occur in middle aged men. The mortality rate for suicide and injury undetermined in Lincolnshire PCT area 2008-2010 is 9.69 per 100,000 people. During this 3 year period, 151 males and 57 females died. The death rate of 25.82 per 100,000 population for male suicide in Lincoln City and 12.41 for females in East Lindsey is significantly higher.

Nationally and locally, the most common method of suicide for men and women is hanging, strangulation and suffocation with self-poisoning as the second most common method.

In Lincolnshire, the ratio of deaths at Home: Elsewhere is 2:1.

Although a higher number and rate of suicides occurred in the most deprived areas of Lincolnshire, they were not statistically significantly different compared to the county as a whole. The majority of deaths by suicides were people living within an urban area; however analysis found that this is not statistically significant.

Suicide is the leading cause of death in young people. Risk factors include male gender; up to three times as many men than women complete suicide, and mental health problems. (18) Young people who complete suicide are less likely to be in contact with mental health services compared with adults (14% vs 26%). Young men, who are more likely to complete suicide, are less likely to be in contact with mental health services than young women.

In Lincolnshire between September 2011 and January 2014 there were 4 confirmed cases of suicide and 2 suspected cases of suicide among young people aged under 18 years of age.

Figure 1.3. Mortality due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34), 3 year pooled data, age-specific crude rate per 100,000 population, calendar years 2012-14.

Source: HSCIC Indicator Portal.[8]
Figure 1.3 shows that the majority of deaths in Lincolnshire due to suicide and undetermined injury, were amongst those aged 40-44, while in comparison, rates were lowest amongst those aged 15 - 19.

**Figure 1.4.** Mortality from suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) by district of residence, 3-year pooled data, directly age standardised rate per 100,000 population, calendar years 2011-3.

<table>
<thead>
<tr>
<th>Area</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>12.6</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>10.3</td>
</tr>
<tr>
<td>Lincoln</td>
<td>14.5</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>13.5</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.7</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>8.1</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>11.4</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>11.1</td>
</tr>
<tr>
<td>East Midlands</td>
<td>9.9</td>
</tr>
<tr>
<td>England</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Source: HSCIC Indicator Portal, November 2015 [8]

Figure 1.4 indicates that in the three year pooled data period, the highest rate of suicide was in the City of Lincoln District (at 14.5/100,000). Within Lincolnshire, South Kesteven District has the lowest rate of suicide at 8.1/100,000.

5. Risk Factors for Mental Ill Health and Suicide

Certain population subgroups are more likely to experience mental ill health or attempt to complete suicide. Risk factors or vulnerabilities may operate in isolation or interact within individuals to further increase risk (e.g. unemployment and deprivation). The Mental Illness Health Needs Assessment[10] identified key risk factors for mental ill health including:

- **Deprivation**: people from the most deprived areas are at higher risk poor mental health and of developing mental health problems, as are their children

**Figure 1.5.** Mortality from suicide by quintile of deprivation of residence, 3-year pooled data, crude rate per 100,000 population, calendar years 2011-2013.
Figure 1.5 illustrates the link between death by suicide and deprivation, and shows that within Lincolnshire suicide rates are higher in the most deprived quintile of deprivation, than in the least deprived quintiles.

- **Homelessness:** the prevalence of common mental health problems among people who are homeless is more than twice that in the general population. Serious mental illness is often accompanied by alcohol and/or substance misuse problems, with most studies suggesting that around 10-20% of the homeless population fulfil the criteria for dual diagnosis.

- **Financial exclusion:** Financial exclusion can lead to social exclusion, debt and poverty. People with five or more separate debts have a 6-fold increased risk of mental ill health. Difficulty repaying debt is a risk factor for suicide.

- **Unemployment:** Unemployment in Lincolnshire is lower than the national average. Between April 2014 and March 2015, 4.9% of the population of Lincolnshire was unemployed, compared with 5.3% in the East Midlands and 6.0% in England. However, across the county there are pockets of long-term unemployment and seasonal employment. Unemployment among younger adults (aged 18-24 years) is higher than the national average (12-month job seekers allowance 0.5% in Lincolnshire, 0.3% in the East Midlands and England). Further, a higher proportion of those people who are economically inactive in Lincolnshire, are inactive due to long-term sick leave (25.7%) compared with the East Midlands (23.0%) and England (21.6%).

- **Substance misuse:** substance use and mental health problems often co-occur, with a complex relationship existing between substance misuse and mental health. Substance use can exacerbate the symptoms of mental ill health and may interact with medications used to treat conditions such as mood stabilisers and anti-depressants.

- **Loneliness and social isolation:** it is estimated that between 5% and 16% of over 65 year olds nationally have reported loneliness, while 12% report social isolation. There is no current data to identify loneliness or social isolation in Lincolnshire, we can provide an approximate estimate using national rates. Of the 159,953 over 65 year old residents living in Lincolnshire, we can estimate that between 8,000 (5%) and 25,500 (16%) are lonely, with a further 19,200 who feel isolated.

- **Mental ill health** is a risk factor for suicide. In addition, a number of population subgroups that are at increased risk of completing suicide have been identified in the Lincolnshire Mental Illness Health Needs Assessment 2015.[10]

- **Minority ethnic groups:** risk of suicide in minority ethnic groups is difficult to measure as place of birth, rather than ethnicity is recorded on death certificates. At the 2011 census,
2.4% of the population of Lincolnshire was non-White, an increase from 1.4% at the 2001 census. This is much lower than the proportion of the population of England that is non-White (14%) nationally. The majority of recently arrived international migrants come from Eastern and Central Europe, and tend to be younger and more economically active than the UK-born residents of Lincolnshire.

- **People in institutional care or custody:** the national rate of self-inflicted deaths in prisoners in the period ending September 2014 was 1.0/1,000 prisoners (n=87). This was a 38% increase on the same period in 2013 and is the highest annual number of deaths since 2007. The rate of suicide and self-harm is much greater in the prison population that the general population (7.9/100,000 people). There are two prisons in Lincolnshire: HMP North Sea Camp (NSC) and HMP Lincoln.

- **Data** on rates of suicide and self-harm among asylum seekers in the UK is scant. However, using data that is available from Immigration Removal Centres, coroner’s records and the Prison Ombudsman’s reports, there are high levels of self-harm and suicide among detained asylum seekers compared with the UK prison population.

- **People with post-natal depression:** suicide is the leading cause of maternal death in England. Key risk factors for maternal suicide included severe onset of mental illness soon after childbirth, older age and being free from social adversity (22).

- **People of sexual minorities:** lesbian, gay, bisexual and trans (LGBT) self-identified people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. If estimates of 5-7% are accurate for Lincolnshire, this suggests that between 36,575 and 51,205 people self-identify as LGBT.

- **Veterans:** Young men who leave the armed forces (particularly those with a short length or services and of lower rank) are 2-3 times more likely to complete suicide than members of the general population. For ex-servicemen aged 30-49 years the risk of suicide is lower than in the general population. Lincolnshire has a large number of ex-armed forces personnel. However, data on this cohort is currently very limited, so it is difficult to provide accurate estimates.

- **People bereaved by suicide:** research supports an increased risk of suicide in mothers bereaved by the suicide of an adult child and partners bereaved by suicide, as well as an increased risk of a range of other mental health outcomes for people bereaved by suicide. Ensuring mental health services are able to support those people who are bereaved by suicide may help to reduce future burden of mental ill health and suicide mortality.
6. Suicide and self-harm

**Figure 1.6.** Hospital admissions due to self-harm in Lincolnshire, directly age standardised rate per 100,000 population, financial years 2010/11 - 2013/14.


Figure 1.6 shows a net increase in the number of hospital admissions in Lincolnshire due to injury by self-harm between 2010/11 and 2013/14. There has been a statistically significant increase in hospital admission between 2012/13 and 2013/14 due to self-harm.

**Figure 1.7.** Hospital admissions due to self-harm in Lincolnshire, age specific crude rate per 100,000 population, pooled financial years 2012/13 - 2013/14.

<table>
<thead>
<tr>
<th>District</th>
<th>2011/12 - 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>8.8%</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>19.9%</td>
</tr>
<tr>
<td>Lincoln</td>
<td>25.0%</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>10.3%</td>
</tr>
<tr>
<td>South Holland</td>
<td>9.2%</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>16.1%</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>10.8%</td>
</tr>
</tbody>
</table>


Figure 1.7 shows that the City of Lincoln has the highest rate of hospital admission due to self-harm.

Self-harm is a key risk factor for suicide. In the UK, a 30-fold increase in risk of suicide, compared with the general population, was observed for a cohort of people aged 10-92 years of age who had attended an emergency department following deliberate self-harm. Suicide rates were highest in the first 6 months after presentation for the self-harm episode. In Lincolnshire, hospital admissions as a result of self-harm in people ages 10-24 years in 2013/14 were significantly higher than the national average.

A healthwatch [12] survey of 1,251 young people in Lincolnshire identified that 20.5% (n=257) have self-harmed. Reasons for self-harm included being bullied (40.2%), anxiety/hopelessness (46.7%),
difficulties at school/college (52.1%), family problems (58.7%), depression (61.8%) and loneliness/isolation (38.2%). Almost two-fifths of young carers stated that they self-harm.

People who have self-harmed: there is an increased in risk of suicide following self-harm episodes. Among a national cohort of almost 8,000 emergency department self-harm attendees followed up over a four-year period, there was a 30-fold increased risk of suicide compared with the general population.(26) Suicide rates were especially high in the 6 months after the index self-harm episode suggesting that early intervention after an episode of self-harm may be important to reduce suicide risk.

In Lincolnshire, between 2011 and 2013 there were 2,448 emergency admissions for intentional self-harm. This is a population in which timely intervention might reduce future suicide risk.

7. LOCAL ACTION PLAN FOR SUICIDE PREVENTION IN LINCOLNSHIRE

The HM Government 'Preventing Suicide in England' report 2014,[1] and the 'Preventing Suicide in England' Strategy 2012 [5] cite that 'much of the planning and work to prevent suicides will be carried out locally'. From April 2013, local responsibility for coordinating and implementing a local suicide prevention action plan, became an integral part of local authorities' public health responsibilities

8. Developing the Lincolnshire Local Action Plan

The effectiveness of a programme to support the reduction of completed suicides is dependent on exemplary partnership working. We formed a strategic group, the Lincolnshire Suicide Prevention Strategic Group, in order for organisations to work together across Lincolnshire to achieve our vision. This plan sets out our approach to achieving this goal.

The process to date

- Formed a Lincolnshire wide cross sector multi agency Strategic Suicide Prevention Group. Some organisations had experience and expertise from the 'Choosing Life' group, which had previously extended awareness of suicide and suicide prevention in Lincolnshire by sharing information and enabling organisations to work together on agreed actions to meet priority areas of highest risk.

- Reviewed the National Strategic Plan [5] and the six key areas contained within it. We used these as a basis for developing a Lincolnshire plan. We also searched for local action plans in other areas in England to understand what best practice was being implemented elsewhere.
- Developed an initial draft of the Local Action Plan for Suicide Prevention in Lincolnshire which was based on the six national objectives, but also included an additional objective identified within a recent Mental Illness Health Needs Assessment for Lincolnshire.[10]

- Convened a wider stakeholder day, in order to refine the draft Local Action Plan. This included additional representation from wider stakeholders, including Voluntary & Faith sector providers and District Councils.

**Suicide Prevention Stakeholder Event Recommendations**

The suicide action plan detailed below, has been shaped through an iterative, multi-agency and cross-sectoral process. The core development took place at a stakeholder event on 22nd January 2016, in which 45 representatives from over 25 organisations across the community and voluntary sectors, private sector, CCGs, the local authority and district councils, came together to:

- **Discuss key actions that could be included in the action plan.** This included considerations across a range of domains: preventing access to the means of suicide; reducing the risk of suicide in high risk groups; timely support based on needs; tailoring approaches to improve mental health in specific groups; providing better information and support to those bereaved or affected by suicide; research and data collection. This group exercise generated approximately 35 separate activities that were perceived could reduce suicide locally.

- **Prioritise actions identified during those discussions.** We created an interactive task that enabled people to prioritise the individual actions that they perceived to be most important within a Lincolnshire Suicide Prevention Action Plan. Each individual was enabled to prioritise up to 14 activities.

- **Cluster prioritised activities into themes based on the stakeholder prioritisation exercise.** From the interactive exercise above, similar actions were clustered into themes. Six themes were identified:
  - raising community awareness of self-harm and suicide, and how to spot vulnerabilities;
  - suicide prevention training (e.g. increase awareness and understanding, including what to do when);
  - crisis care, including a broad range of crisis services in the community, a listening service, and timely access to mental health crisis care;
  - conduct risk assessments for people diagnosed with long-term conditions to identify people who may be at risk of poor mental health;
  - coordination of resources (e.g. trained people and organisation which provide services);
  - data collection and sharing, including recording data on attempted suicide, data of key risk groups, and protocols for sharing data across organisations.

- **Discuss key themes identified.** Stakeholders subsequently discussed each of these themes in turn, identifying key activities within each theme as well as who should lead on coordinating the delivery of each theme. However, during this process it became clear that:
some themes, although well supported in the prioritisation exercise, were either not
aligned to the groups vision for a suicide action plan in Lincolnshire; or
we risked overcomplicating the plan with too many themes.

- **Reframe the key themes.** Following a lively discussion between stakeholders from across a
range of organisations and sectors, the following key themes (which are a simplified version
of the six themes identified earlier in the day) were agreed:
  o Awareness*
  o Prevention*
  o Crisis Care
  o Data & Monitoring

- **Identify key actions and lead organisations for each theme.** A set of key actions were
identified from each theme, and we agreed to identify lead organisations to take ownership
of driving forward each theme at the next Suicide Prevention Board Meeting, where all of
the key stakeholders would be represented.

  *Awareness defined as ‘educating communities on the issue of suicide, including key risk
factors, signs and symptoms, how to respond and where to go for help’
  *Prevention defined as ‘upskilling members of the community and healthcare professionals
to respond appropriately to individuals believed to be at risk of suicide, for example through
basic and advanced training programmes to support people identified as at risk’

**The Way Forward**

In order to progress the Local Action Plan, a number of actions are required:

- Finalise the specific actions within each key area in collaboration with key stakeholders
- Identification of a number of lead partners who will lead/develop a specific Action Plan
  Work Programme for that particular area of work
- Development of a number of key task & finish groups
- Identify/allocate partners to join/own appropriate task and finish groups. Some of these
  may be selected from the wider stakeholder group who attended the event
- Prioritisation of each area of work programme action plans within each task & finish group
- Agree timescales and objectives and outcomes for implementation
- Initial coordination by Public Health

The Suicide Prevention Stakeholder event identified that the key area of priority was to develop a
'Suicide Awareness Tool Kit'.

This will:

- Increase factual knowledge of the symptoms of mental ill health
- Increase factual knowledge of the complex issues that lead to suicide
- Increase skills in order to recognise the warning signs of suicidal ideation
• Increase skills/knowledge of how to respond
• Increase skills/knowledge of intervention pathways for crisis support

Many of the other actions identified during the stakeholder event are dependent on this first step.

Figure 1.8 below illustrates the broader vision for the Lincolnshire Suicide Prevention Action Plan.

**Figure 1.8: A vision of Lincolnshire’s Suicide Prevention Action Plan**

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**Implementation of the Lincolnshire Local Action Plan**

The Lincolnshire Suicide Prevention Local Action Plan was agreed at the Strategic Suicide Prevention Steering Group in May 2016. It will be offered for approval at a number of executive level Boards during May and June 2016.

The Local Action Plan incorporates the recommendations both from the Mental Illness Health Needs Assessment (10) and from the Annual Suicide and Undetermined Injury Review 2015(16).
It sets out the key priorities and key tasks for both adults and children and young people in the four identified areas: prevention, awareness, crisis care and data, monitoring and research. It also notes a number of proposed actions for implementation.
Recommendations from the Mental Illness Health Needs Assessment (November 2015)

Six broad recommendations for Lincolnshire have been identified from this work.

1. **Identification and recording of mental ill health**
   Work should be undertaken to ensure that health professionals can correctly and consistently identify and record the signs and symptoms of all forms of mental ill health. Consistent data collection across services is required in order to gain common understanding of issues and characteristics, and therefore this also includes the recording of common demographic and characteristic data. Work should also be carried out to ensure that the mental health register is fully populated in a consistent manner, and recording should not be limited to the specific illnesses referred to in the Quality and Outcomes Framework (QOF).

2. **Timely access to mental health services based on needs**
   People in Lincolnshire should have timely access to mental health services based on their needs. Whilst most adult outpatients are initially seen within the 18 week target, timely access to specific services such as IAPT and dynamic psychotherapy could be improved.

3. **Data Sharing between different organisations**
   In order to provide a better experience for patients, particularly if they need to access a variety of services, or consult a number of professionals, the sharing of data between different organisations needs to be improved. This should also ensure that essential data is available for analysis of risks and associations, understanding various need, service review purposes and investigating health equity. This includes improved data sharing between local providers but also between national data controllers and local intelligence teams of data such as the Mental Health Minimum Dataset, Hospital Episodes Data, GP patient demographic data and, eventually, data from the Care Data programme. The effective sharing of information is vital during the transition of patients between children’s and adult services, and this is also an area of concern.

4. **Awareness of Services and Support**
   More should be done to comprehensively bring together information on mental health services and support networks in one place, so that both the public and professionals are clear on what is available and how it can be accessed. This should then be promoted as the primary source of information to, and by, all agencies. This would help to raise awareness, signpost to the most appropriate services and manage expectations for children and adults services.

Further, whilst a number of crisis care services are currently available (e.g. specialist mental health crisis resolution and home treatment services), developing a clear, comprehensive network of information on the support available for people in crisis will enable the better signposting of people in crisis to the appropriate support.

5. **Service User Consultation**
   Service user feedback is important for understanding and improving the experience of service users. Providers should seek feedback from those who contact or use all mental health services and support networks. Although the nature and scale of this may vary, for example between commissioned services and community support networks, feedback is essential in order to review and improve. Service evaluation processes, reporting and monitoring should form a standard
requirement of contracts with a commitment from providers and commissioners to act upon findings. Standard frameworks should be developed to aid organisations in engaging service users and collecting feedback, along with provision of appropriate advice.

6. Professional Skills
Training provided for front-line staff working in mental health services should be improved and made more consistent. It should cover topics such as listening skills, empathy, respect and building of trust, and should adopt a holistic approach in their treatment of those suffering from mental illness, rather than attempting to treat the mental illness in isolation. Opportunities for joint local training should be considered (potentially linked to the LHAC programme) alongside in-house awareness training, with advice from commissioning and exemplar organisations and extension of existing mental health awareness training to include wider aspects of attitudes and communication styles.
BIBLIOGRAPHY


[8] Health & Social Care Information Centre

[9] HSCIC Primary Care Mortality Database


[12] Healthwatch Lincolnshire; 'Service Users, patients and Carers Views on Mental Health Services; Interim report 2014


[14] Department of Health; 'A mandate from Government to NHSE'. April 2014


Suicide prevention action plan

1. PREVENTION

Strategic Aim: 'Reduce Suicide in Lincolnshire, by timely and appropriate intervention'

PRIORITIES:

- Identify clear pathways of support, in relation to suicide prevention awareness for dissemination to all professionals.
- Identify systems/networks of support for those at risk of self harm and suicide, to promote wellbeing resilience
- Develop coordinated training packages for suicide prevention awareness

KEY TASKS:

- Establish systems that ensure knowledge of common pathways and goals
- Develop resources that identify networks of support for wellbeing resilience
- Identify resources to undertake a complex mapping process in respect of prevention and crisis care

Proposed Actions for Implementation

<table>
<thead>
<tr>
<th>Identify/Develop clear pathways of support for dissemination to all professionals.</th>
<th>Use reporting systems to develop a share and learn approach, particularly relating to users experiences of response and access.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop coordinated Training packages to include provision of training/guidance for staff/individuals in bereavement support.</td>
<td>Coordinate current pathways/resources. Liaise with stakeholders to better understand pathways</td>
</tr>
<tr>
<td></td>
<td>Share skills of all Suicide Intervention trained people initially to SPSG e.g.: negotiators. Coordinated training packages aimed at reducing stigma &amp; raising awareness in the general public and front line staff develop MECC model. Develop info/ training models in order that those who encounter a distressed person will make that contact</td>
</tr>
</tbody>
</table>
CHILDREN & YOUNG PEOPLE

PREVENTION

Strategic Aim: 'Reduce Suicide in Lincolnshire, by timely and appropriate intervention'

PRIORITIES:

- Develop processes and systems that ensure knowledge of the pathways to support
- Develop processes for implementation of a common language to help remove stigma
- Develop coordinated training packages
- Develop a programme of evidence based interventions

KEY TASKS:

- Commission an emotional wellbeing service to support children and young people who require supportive interventions
- Interpret the evidence base to understand successful interventions that prevent children and young people completing suicide
2. Awareness

Strategic Aim: 'To raise awareness of suicide prevention in Lincolnshire, including causes, symptoms and how to help'

PRIORITIES:

- Develop a Task & Finish Awareness Group
- Develop a county wide Suicide Prevention Charter
- Develop a communications strategy for suicide prevention in Lincolnshire

KEY TASKS:

- Develop consistent messages and use them in suicide prevention awareness campaigns
- Develop a targeted Suicide Awareness Campaign using a best practice model

**Proposed Actions for Implementation**

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop consistent messages and use them in awareness raising campaigns.</td>
<td>Develop effective use of social media including websites to disseminate core messages. Use opportunities such as ‘World Suicide Day’/‘World Mental Health Day’/ ‘Time to Change’ e.g. for coffee mornings (community, etc.) Add suicide awareness strapline to email signatures.</td>
</tr>
<tr>
<td>Establish Countywide Suicide Prevention Protocol</td>
<td>Encourage organisations include suicide prevention in their training plans. Develop materials for organisational use for local training to include risk assessment knowledge</td>
</tr>
<tr>
<td>Develop Communications Strategy charter.</td>
<td>Develop social media campaign targeted to workers and users. Develop/agree to use a common language/help remove stigma</td>
</tr>
</tbody>
</table>

CHILDREN & YOUNG PEOPLE

Awareness

Strategic Aim: 'To raise awareness of suicide prevention in Lincolnshire, including causes, symptoms and how to help'

PRIORITIES:

- Develop targeted suicide awareness campaign
- Deliver effective intervention to reduce the risk of suicide amongst women experiencing post-natal depression

KEY TASKS:

- Commission services that improve the early identification of post-natal depression
- Research interventions and tools that have a strong evidence base and specify their use in commissioned services
- Ensure funding available as part of commissioned services to train staff to deliver interventions
- Ensure requirement is part of service specification for children's health services 0-19
3. CRISIS CARE

Strategic Aim: 'Recognising risk for those who present in crisis, ensuring robust and timely support and clear pathways to professional care.'

**PRIORITY:**

- Develop pathways for coordinated collaboration with the Lincolnshire Mental Health Crisis Concordat Board

**KEY TASKS:**

- Establish systems to transfer the Strategic Suicide Prevention Group priorities to the Mental Health Crisis Concordat work programme
- Establish systems that ensure joint representatives & effective reporting mechanisms to each Board

---

**CHILDREN & YOUNG PEOPLE**

**CRISIS CARE**

Strategic Aim: 'Recognising risk for those who present in crisis, ensuring robust and timely support and clear pathways to professional care.'

**PRIORITY:**

- Ensure access to a range of appropriate crisis services

**KEY TASKS:**
• Identify existing range of Crisis services

4. Data, Monitoring & Research

Strategic Aim: 'Develop efficient systems to access & use data to understand strategy and improve service provision'

PRIORITIES:

• Develop an Adult Suicide Overview Panel
• Develop a Suicide Prevention Data Review sub group

KEY TASKS:

• Develop information sharing protocols between organisations
• Developing reporting systems to develop a share & learn approach

Proposed Actions for Implementation

<p>| Establish a Data Review Task and Finish Group to learn from Para Suicides or near misses. Establish systems of collation. | Identify risk triggers from this data. |
| Develop detailed audit methodology using a confidential enquiry approach. | Develop information sharing agreements with partner organisations. |
| Develop Data Sharing Protocols. Extend existing partner data sharing protocols to other partners, to improve speedy access to crucial information. | Using a confidential inquiry approach as is currently in place for maternal deaths and for child deaths. National developments relating to Peer Reviews may be useful. Gather learning from established system in Derbyshire and elsewhere |
| Develop triangulation system with health/education/prison/ etc. in order that a complete story is available in Lincolnshire | Analyse and interpret data to understand trigger points for suicide |</p>
<table>
<thead>
<tr>
<th>Including deprivation and depression.</th>
<th>attempts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Sharing Protocols between Police, Acute Services and Police Negotiators</td>
<td>Ensure ISA’s are in place to allow information exchange between services to allow better pathway for service users. Develop 4 monthly reporting mechanisms and establish Adult Suicide Overview Panel. Establish Data review Task and Finish Group</td>
</tr>
<tr>
<td>Engage with East Midlands Suicide Prevention network</td>
<td>Invite leads from other areas to SPSG. Keith Waters – Regional Adviser on Suicide would be helpful in supporting us to develop actions – a number of other LA’s have successful elements of their plans already in place. Keep abreast of research to understand better the reasons for self-harming</td>
</tr>
</tbody>
</table>

**CHILDREN & YOUNG PEOPLE**

Data, Monitoring & Research

Strategic Aim: 'Develop efficient systems to access & use data to understand strategy and improve service provision'

**PRIORITIES:**

- Develop systems to enable the sharing of learning from other areas
- Establish systems and protocols to enable regular information sharing and updates from the Coroners Service

**KEY TASKS:**

- Invite leads from other areas to SPSG
- Provide Coroner with all necessary equipment including PPE and cameras
1. Purpose of Report

1.1 The Lincoln City Profile (2016) is the updated version of the previous years “Lincoln Drivers Report (2015)”, which encompasses a breadth of information, and focuses on key demographic and socioeconomic characteristics of, and challenges to, Lincoln. In doing this, it acts as the evidence base behind the City of Lincoln Council’s strategic priorities. It also provides information to help the council continue to target resources where they are needed most.

2. Executive Summary

2.1 The Lincoln City Profile highlights a number of key opportunities for the city. These include an increasing population (page 8); an improving male life expectancy rate (page 16); and a reducing rate of total reported crime (page 28) - despite having the sixth highest rate of crime when compared to its Police audit family (page 38).

2.2 However, there are also a number of key challenges highlighted in the report. In particular, these concern the relatively high premature mortality rate for cancer and cardiovascular disease. Additionally, Lincoln has a relatively high rate of hospital stays for self-harm, and admissions for alcohol-related conditions. The city also has a relatively high rate of teenage conceptions (pages 19-27).

A key challenge for Lincoln as we move forwards is the median annual salary in the city, which has decreased by 6.7% in 2015, when compared to the year before (page 60).

2.3 Feedback from CMT indicates that whilst this is an excellent report for policy making and partners funding bid applications (etc.) – the current version could lead potential new external businesses to develop an incomplete view of the progress of most of the city.

So they have asked that we include the (slightly adapted) forward section that will be in the new Strategic Plan, directly after the introduction – to set the positive Lincoln scene and demonstrate the vision for the city. This section will be completed during September, so will be added as soon as possible after that.
3. **Main Body of Report**

3.1 The population of Lincoln for 2015 was 97,065 which is an increase of 0.9% when compared to the previous year (page 8).

3.2 The number of migrant workers who are registering for their NI number in Lincoln increased from 1,164 in 2014/15 to 1,514 in 2015/16 (page 13). Note that whilst migrants have to register somewhere for their NI number, this does not mean that they stay in that town/city for life.

3.3 The male life expectancy for Lincoln increased from 77.5 years in 2011-13 to 78.2 years old in 2012-14. However, over the same period the female life expectancy decreased slightly from 82.1 to 82 in 2012-14 (page 16).

3.4 Lincoln continued to have a higher rate than England for, ‘Under 75 Mortality Rate for Cancer’, ‘Under 75 Mortality Rate for Cardiovascular Disease’, ‘Hospital Stays for Self-Harm’, ‘Admission episodes for alcohol-related conditions (Narrow*)’ and ‘Under 18 Conception Rates in Females Aged 15-17’ despite the rates improving (page 19 – 27).

* Note that the term ‘narrow’ in this context indicates that the main reason for the admission was alcohol as opposed to ‘broad’ when there could be multiple reasons.

3.5 The total number of reported crimes in Lincoln decreased by 2.1% in 2015/16 when compared to the previous year (page 28). Despite the crime rate in Lincoln decreasing for the fourth year in a row, Lincoln had the sixth highest total crime rate per 1,000 population when compared to the Police audit family (page 39).

Note that for the crime section (only) data has been compared to the Police audit family as opposed to its nearest neighbour family and England as for all other comparisons. This was following a recommendation by the Police at the Crime & Disorder Committee (July 27 2016)

3.6 The percentage of Foundation Stage students achieving a good level of development rose from 64% in 2013/14 to 65% in 2014/15 (page 41). The percentage of Key Stage 4 students in Lincoln who are achieving 5 or more GCSEs graded A* - C (incl. English and Maths) remains the same as the previous year at 49% (page 42).

3.7 Lincoln’s median total salary has decreased from £19,358 in 2014 to £18,054 in 2015, this is a decrease of 6.7% (page 61). Lincoln had the third lowest median total salary when compared to its nearest neighbours (page 62).

3.8 The Claimant Count for Lincoln in April 2016 was 1,595 residents (page 70). Lincoln had the fourth highest claimant rate when compared to its nearest neighbours and the rate continues to be higher than the England and the East Midlands rates (page 72).

3.9 The IMD 2015 showed 10 areas in Lincoln within the most 10% of deprived areas nationally. This is an increase from seven areas in the IMD 2010, and five areas in the IMD 2007. Within these 10 areas of Lincoln, there are an estimated 16,014 residents (or 16.6% of the total city of Lincoln population) (page 73 – 80).
4. Organisational Impacts

4.1 Finance (including whole life costs where applicable) – This report in itself does not have any financial implications, other than signposting to potential financial issues.

4.2 Legal Implications including Procurement Rules – This report in itself does not have any legal implications.

4.3 Equality, Diversity & Human Rights
A full EA is not required. The Lincoln City Profile brings together important information that helps inform decisions from an Equality and Diversity perspective.

5. Risk Implications

5.1 (i) Options Explored – n/a

5.2 (ii) Key risks associated with the preferred approach – n/a

6. Recommendation

6.1 Community Leadership members are asked to comment on the Lincoln City Profile 2016.

Is this a key decision? No

Do the exempt information categories apply? No

Does Rule 15 of the Scrutiny Procedure Rules (call-in and urgency) apply? No

How many appendices does the report contain? 1 – The Lincoln City Profile 2016 (report)

List of Background Papers: n/a

Lead Officer: Matt Nash, Corporate Performance and Engagement Officer

Telephone (01522) 873315
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The Lincoln City Profile – 2016

A collection of themed factsheets
Contents
Introduction.................................................................................................................. 4
Executive Summary ........................................................................................................ 5
Ward Boundaries and CIPFA nearest neighbours ........................................................... 6
Population ......................................................................................................................... 7
  Population Summary ...................................................................................................... 7
  Total estimated population of Lincoln .......................................................................... 7
  Population of Lincoln by ward ...................................................................................... 8
  Population of Lincoln by age ....................................................................................... 9
Migration ........................................................................................................................... 12
  Migration Summary ....................................................................................................... 12
    The Number of National Insurance registrations to adult overseas nationals entering
    Lincoln ...................................................................................................................... 12
    World Area of Origin .................................................................................................. 13
    Country of Origin ....................................................................................................... 14
Health ............................................................................................................................... 15
  Health Summary .......................................................................................................... 15
  Life Expectancy ............................................................................................................ 15
  Male Life Expectancy .................................................................................................. 16
  Female life Expectancy ............................................................................................... 17
  Under 75 Mortality Rate for Cancer .......................................................................... 18
  Under 75 Mortality Rate: Cardiovascular Disease ................................................... 19
  Hospital Stays for Self-Harm ..................................................................................... 20
  Admission episodes for alcohol-related conditions (Narrow) ..................................... 21
  Alcohol Related Mortality ......................................................................................... 22
  Under 18 Conception Rates in Females Aged 15-17 .................................................. 23
  Suicide ......................................................................................................................... 24
Crime ............................................................................................................................... 27
  Crime Summary .......................................................................................................... 27
  Total Reported Crime in Lincoln between 2002/03 and 2014/15 .............................. 27
  Total Reported Crime for Lincoln, East Midlands and England ............................... 28
  Decrease and Increases in the Types of Crime in Lincoln ........................................ 28
    All other theft offences .......................................................................................... 31
    Bicycle theft ............................................................................................................ 31
    Public order offences .............................................................................................. 34
    Sexual offences ...................................................................................................... 35
  Antisocial Behaviour Heat Map ................................................................................ 39
Education ........................................................................................................................................... 40
Education Summary .............................................................................................................................. 40
Foundation Attainment .......................................................................................................................... 40
GCSE Attainment .................................................................................................................................. 41
Educational Attainment at ward level (2007 Boundary) ........................................................................ 45
Percentage of children eligible for Free School Meals achieving 5 good GCSEs including English and maths ................................................................................................................................. 53
Lincoln residents aged 16-64 with no qualifications ........................................................................... 55
Lincoln residents aged 16-64 with NVQ Level 1 ................................................................................. 56
Lincoln residents aged 16-64 with NVQ Level 2 ................................................................................. 57
Lincoln residents aged 16-64 with Level 3 ......................................................................................... 58
Lincoln residents aged 16-64 with an NVQ Level 4 and above ......................................................... 59
Economy .................................................................................................................................................. 60
Economy Summary ............................................................................................................................... 60
Median Annual Total Salary ................................................................................................................. 60
Median Annual Total Salary ................................................................................................................. 61
Male and Female Total Salary .............................................................................................................. 62
Types of Occupations in Lincoln ......................................................................................................... 64
Professional occupations ...................................................................................................................... 65
Unemployment ........................................................................................................................................ 69
Unemployment Summary ...................................................................................................................... 69
The rate of out of work benefit claimants in Lincoln compared to the East Midlands and England ............................................................................................................................................................................. 70
Rate of out of work claimants in Lincoln compared to its nearest neighbours ................................. 71
Poverty and Deprivation .......................................................................................................................... 72
Poverty Summary .................................................................................................................................. 72
Income Deprivation ............................................................................................................................... 73
Employment .......................................................................................................................................... 74
Education, Skills and Training ............................................................................................................... 75
Crime ..................................................................................................................................................... 77
Barriers to housing and services .......................................................................................................... 78
Living Environment .............................................................................................................................. 79
Appendix .................................................................................................................................................. 80
Countries ............................................................................................................................................... 80
Miscellaneous Crimes Against Society – Crime List ............................................................................ 84
Educational Attainment - NVQ Qualification Definitions ...................................................................... 85

81
Introduction

The Lincoln City Profile encompasses a breadth of information, and focuses on key demographic and socioeconomic characteristics of, and challenges to, Lincoln. In doing this, it acts as the evidence base behind the City of Lincoln Council's strategic plan.

It uses information sourced from the City of Lincoln Council, as well as other organisations. This enables the city council, along with all its partners, to use this information when developing strategic direction, creating and implementing policy, and ensuring resources continue to be targeted where needed most.

The Lincoln City Profile uses England, the East Midlands and the CIPFA nearest neighbours as comparators to Lincoln. The nearest neighbours are 15 other districts within England with similar statistical characteristics in terms of social and economic landscapes.

It is a valuable source of summary information, all contained in one document. It draws and collates information from across the full range of quality of life indicators, and so paints a unique picture of what it is like to live, and work, in Lincoln. The report is therefore a vital tool to use when planning the delivery of services across the public sector.

Further information

If you have any questions or comments concerning this report, or require further information, please use the contact details below:

Write to: The Policy Team, Room 321 City Hall Lincoln Beaumont Fee Lincoln LN1 1DD

Email: policy@lincoln.gov.uk
Executive Summary

The population of Lincoln for 2015 was 97,065 which is an increase of 0.9% when compared to the previous year (page 8).

The number of migrant workers entering Lincoln increased from 1,164 in 2014/15 to 1,514 in 2015/16 (page 13). 25.8% of migrants entering Lincoln in 2015/16 came from Romania (page 15).

The male life expectancy for Lincoln increased from 77.5 years in 2011-13 to 78.2 years old in 2012-14. However, over the same period the female life expectancy decreased marginally from 82.1 to 82 in 2012-14 (page 16).

Lincoln continued to have a higher rate than England for, ‘Under 75 Mortality Rate for Cancer’, ‘Under 75 Mortality Rate for Cardiovascular Disease’, ‘Hospital Stays for Self-Harm’, ‘Admission episodes for alcohol-related conditions (Narrow)’ and ‘Under 18 Conception Rates in Females Aged 15-17’ despite the rates decreasing (page 19 – 27).

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The IMD 2015 showed 10 areas in Lincoln within the most 10% of deprived areas nationally. This is an increase from seven areas in the IMD 2010, and five areas in the IMD 2007. Within these 10 areas of Lincoln, there is an estimated 16,014 residents (or 16.6% of the total city of Lincoln population) (page 73 – 80).
Ward Boundaries and CIPFA nearest neighbours

Ward Boundaries

Despite the ward boundaries changing in May 2016, the information in this report remains based on the 2007 ward boundaries to maintain consistency across data. (Some of which is only in old boundaries). Where the changes have shown an effect this will be noted.

CIPFA nearest neighbours

Nearest neighbours are a group of local authorities that are similar to Lincoln for a range of demographic and socioeconomic measures.
Population Summary

Lincoln's population has grown considerably over the last decade, from 88,603 residents in 2005 to 97,065 residents in 2015. This represents an increase of 9.6%. 13.2% of Lincoln’s estimated population in 2015 was between 20 – 24 years old. This is considerably higher than the England percentage.

Total estimated population of Lincoln

The population of Lincoln has continued to increase, rising from 96,202 in 2014 to 97,065 in 2015.

1 ONS (2016)
Total estimated population of Lincoln by gender

The estimated female population in Lincoln continues to be marginally higher than the male population, with 51% of Lincoln’s estimated population being female in 2015.

There was an estimated 47,835 males in Lincoln in 2015.

This was an increase of 431 when compared to 2014.

There was an estimated 49,230 females in Lincoln in 2015.

This was an increase of 432 when compared to 2014.

² ONS (2016)

Population of Lincoln by ward

Below is the population of each ward according to the mid-2014 population estimates.

² ONS (2016) Mid 2015 population estimates
³ ONS (2016) Mid 2014 population estimates
Population of Lincoln by age

The most common age range in Lincoln continues to be 20-24, accounting for 13.2% of the population. We know that much of the increase in population since 2001 was due to the growth in residents aged in their 20s, and that part of the reason for this was the expansion of the University of Lincoln over the same period.

The age breakdown of Lincoln's and England's population from the mid 2015 population estimates

4 ONS (2016)

4 ONS (2016) Mid 2015 population estimates
Ethnicity of Lincoln – 2011 Census

The below graphic shows the ethnic make up of Lincoln from the 2011 Census.

ONS (2016)

ONS (2016) : Census – Ethnic Groups
Internal Migration – 2015 Estimate

The below map and graphs show where people have come from to live in Lincoln and where people from Lincoln have moved to within England for the year ending June 2015.

↓ People from this location migrating to Lincoln
↑ People from Lincoln migrating to this location

ONS (2016)

ONS (2016) Moves within the UK

6 ONS (2016)
Migration Summary

The number of migrant workers entering Lincoln increased from 1,164 in 2014/15 to 1,514 in 2015/16. Lincoln continued to follow the same direction of travel as the East Midlands and England.

The vast majority of migrant workers entering Lincoln continued to come from European Union countries. 25.8% of the migrants entering Lincoln in 2015/16 came from Romania.

The Number of National Insurance registrations to adult overseas nationals entering Lincoln, The East Midlands and England between 2002 - 2014

The inflow of migrant workers has fluctuated year on year with 1,514 migrants entering Lincoln in 2015/16. It should be noted that not all migrant workers remain in the area, with some returning home and others moving elsewhere in the country or world. This indicator is used to measure of inflow.

7 DWP (2016)

7 DWP (2016) NiNo Registrations To Adult Overseas Nationals Entering The UK
Lincoln followed a similar trend to England and the East Midlands for National Insurance registrations to overseas nationals.

89% of the adult overseas nationals who registered in Lincoln came from EU countries. This is an increase of 405 when compared to the previous year. (See definitions of countries in these groupings in Appendix 1)

8 DWP (2016)

World Area of Origin

89% came from the European Union
4% came from the Rest of the world
7% came from the Asian countries
1% came from the Non-European Union countries

9 DWP (2016)

8 DWP (2016) NINo Registrations To Adult Overseas Nationals Entering The UK
9 DWP (2016) NINo Registrations To Adult Overseas Nationals Entering The UK
Country of Origin

This fact sheet highlights the percentage of the country of origins for migrant workers for 2015/16. Please note that “Other Countries” section has been populated together. They have been broken down below the pie chart.

- 25.8% came from Romania
- 17.9% came from Poland
- 12.6% came from other countries
- 11.9% came from Lithuania
- 1.8% came from India
- 3.9% came from Spain
- 5.9% came from Latvia
- 7.5% came from Bulgaria
- 9.3% came from Portugal
- 1.7% came from China
- 1.7% came from Italy
- 1.4% came from Hungary
- 1.3% came from Greece
- 1% came from Nigeria
- 0.9% came from Germany
- 0.7% came from France
- 0.7% came from Slovakia
- 0.6% came from Estonia
- 0.5% came from Malaysia
- 0.5% came from Canada
- 0.5% came from United States
- 0.5% came from Australia
- 0.5% came from Russia
- 0.4% came from Pakistan
- 0.4% came from Bangladesh
- 0.4% came from Czech Republic
- 0.4% came from Sweden
- 0.4% came from Finland
- 0.3% came from Vietnam
- 0.3% came from Indonesia
- 0.3% came from Iran
- 0.3% came from Norway

10 DWP (2016)

10 DWP (2016) NI No Registrations To Adult Overseas Nationals Entering The UK
Health Summary

Male life expectancy for Lincoln increased from 77.5 years in 2011-13 to 78.2 years old in 2012-14. However, over the same period the female life expectancy decreased marginally from 82.1 to 82 in 2012-14.

Lincoln continued to have a higher rate than England for, ‘Under 75 Mortality Rate for Cancer’, ‘Under 75 Mortality Rate for Cardiovascular Disease’, ‘Hospital Stays for Self-Harm’, ‘Admission episodes for alcohol-related conditions (Narrow)’ and ‘Under 18 Conception Rates in Females Aged 15-17’ despite the rates decreasing.

Life Expectancy

In 2012 – 2014 the male life expectancy in Lincoln was 78.2 years.

Which was an increase of 0.7 years when compared to the 2011-13.

In 2011 – 2013 the male life expectancy in England was 77.5 years.

In 2012 – 2014 the female life expectancy in Lincoln was 82 years.

Which was a decrease of 0.1 years when compared to the 2011-13.

In 2011 – 2013 the female life expectancy in England was 82.1 years.

DoH (2016)
Male Life Expectancy

Despite the male life expectancy rate in Lincoln increasing, it still remained lower than England.

Lincoln had the 8th lowest male life expectancy when compared to its nearest neighbours.

12 DoH (2016) Local Authority Profile
Female life Expectancy

The female life expectancy rate in Lincoln continues to follow a similar trend to England, but it decreased from 82.1 years in 2011-13 to 82 years in 2012-14.

Lincoln had the 7\textsuperscript{th} lowest female life expectancy when compared to its nearest neighbours.

\textsuperscript{13}DoH (2015) Local Authority Profile
Lincoln continues to have a higher “Under 75” mortality rate for cancer than England in 2012-2014, despite this the rate is continuing to decrease.

Lincoln had the 8th highest “Under 75” mortality rate for cancer in 2012-2014 when compared to its nearest neighbours.
Despite the Under 75 Mortality Rate for cardiovascular disease in Lincoln very slightly decreasing from a rate of 184 in 2002/04 to 183 in 2012/14, it was still significantly higher than the England rate.

Whilst Lincoln had the fifth highest rate of under 75 mortality for cardiovascular disease in 2012/14 amongst Lincoln’s nearest neighbours, Lincoln’s rate was still substantially lower than the highest rates of Preston, Hyndburn and Burnley.
Hospital Stays for Self-Harm

Despite the decreasing rate of hospital stays for self-harm in Lincoln from 287.9 in 2013/14 to 248.9 in 2014/15, Lincoln continued to have a higher rate than England.

Lincoln had the eighth lowest rate of hospital stays for self-harm amongst our nearest neighbours in 2014/15.

16 DoH (2016)
The rate of admission episodes for alcohol-related conditions (Narrow) continues to decrease from 734 in 2011/12 to a rate of 678 in 2014/15. The term, “narrow” is important as it indicates hospital admissions in adults where the main reason for admission was alcohol as opposed to the “broad” definition which are admissions based on all reasons for admission (primary and secondary diagnosis fields).

Lincoln had the third lowest rate of hospital stays for rate of admission episodes for alcohol-related conditions (Narrow) amongst its nearest neighbours for 2014/15.

17 DoH (2016)

17 DoH (2016) Local Authority Profile
Alcohol Related Mortality

The estimated rate of alcohol related mortality in Lincoln decreased for the second year in a row, but still continued to have a higher rate than England.

Lincoln had the fifth lowest rate per 100,000 for the estimated number of alcohol related mortality when compared to its nearest neighbours in 2014.

18 DoH (2015) Local Authority Profile
The under 18 conception rate in Lincoln continued to decrease since the peak in 2007, from 36.6 in 2013 to 36 in 2014, which is the lowest rate since 1998.

Even though the under 18 conception rate in Lincoln continued to decrease, it had the third highest rate when compared to its nearest neighbours.

19 DoH (2016)
Suicide

The suicide rate in Lincoln increased from 12.6 per 100,000 in 2011-13, to 13.2 per 100,000 in 2012-14. Lincoln continued to have a higher rate than England.

Lincoln had the fourth highest rate of suicides when compared its nearest neighbours for 2012-14.

---

20 DoH (2016)

20 DoH (2016) Local Authority Profile
**Adult Obesity (2012-2014)**

Between 2012 and 2014, 50.6% of Lincoln’s adult population (16+) had excess weight. This figure combined overweight figures and obesity figures. This percentage was higher than the England percentage of 49.3%, but slightly lower than the East Midlands percentage of 51.2%.

2.4% of the adult population in Lincoln were underweight in 2012 - 14. This was lower than the England percentage of 2.8% and the East Midlands percentage of 2.8%.

**Percentage of adult population who are underweight**

In 2012 -14, 2.4% of Lincoln’s adult population were underweight. Lincoln had the lowest percentage of underweight people when compared to the East Midlands (2.8%) and England (2.8%).

When compared to its nearest neighbours, Lincoln had the 4th lowest percentage of underweight people.

**Percentage of adult population that are a healthy weight**

In 2012-14, 47% of Lincoln’s adult population were a healthy weight. Lincoln had the 2\textsuperscript{nd} highest percentage of people that were a healthy weight when compared to the East Midlands (46%) and England (47.9%).

When compared to its nearest neighbours, Lincoln had the 5\textsuperscript{th} highest percentage of people who are at a healthy weight.

**Percentage of population adult that have excess weight (overweight and obese)**

In 2012-14, 50.6% of Lincoln’s adult population had excess weight (overweight and obese). Lincoln had the 2\textsuperscript{nd} highest percentage of people who have excess weight when compared to the East Midlands (51.2%) and England (49.3%).

When compared to its nearest neighbours, Lincoln had the 6\textsuperscript{th} lowest percentage of adults who were at a healthy weight.

---

\textsuperscript{22} PHE (2016): Prevalence of underweight, healthy weight, overweight, and obesity among adults in England, 2012-2014
Crime Summary

The total number of reported crimes in Lincoln decreased from 9,080 in 2014/15 to 8,886 in 2015/16. This was a decrease of 2.1%, and followed the same direction of travel as seen for the East Midlands and England.

Despite the crime rate in Lincoln decreasing for the fourth year in a row, it remains relatively high when compared to the Police audit families (the local authorities the Police use to compare Lincoln). Lincoln had the 6th highest total crime rate per 1,000 population when compared to its Police compactor neighbours.

The number of criminal damage and arson offences; drug offences; possession of weapons offences; public order offences; robbery offences; sexual offences; violence with injury; and violence without injury continued to increase in Lincoln from the 31st March 2015 to the 31st March 2016.

Total Reported Crime in Lincoln between 2002/03 and 2015/16

The total number of reported crimes in Lincoln continued to decrease for the fourth year in a row.

\[
\begin{array}{c c c c c c c c c c c c}
\hline
\text{Number of reported offences} & 16000 & 14000 & 12000 & 10000 & 8000 & 6000 & 4000 & 2000 & 0 & 0 & 0 & 0 & 0 & 8,886 \\
\end{array}
\]

23 ONS (2016) Offences
Total reported crime for Lincoln, East Midlands and England

The diagram below shows the total number of reported crimes for England, the East Midlands; and Lincoln since 2002/03 as a rate per 1,000 population.

Lincoln followed the same direction of travel as both England and the East Midlands, but still has a higher reported crime rate.

Decrease and increases in the types of crime in Lincoln

24 ONS (2016) Offences
The table below shows the differences in each category of crime between the year ending March 2014/15 and March 2015/16.

<table>
<thead>
<tr>
<th>Category</th>
<th>31 March 2015</th>
<th>31 March 2016</th>
<th>Percentage Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other theft offences</td>
<td>938</td>
<td>857</td>
<td>-8.6%</td>
</tr>
<tr>
<td>Bicycle theft</td>
<td>541</td>
<td>354</td>
<td>-34.6%</td>
</tr>
<tr>
<td>Criminal damage and arson</td>
<td>1207</td>
<td>1309</td>
<td>8.5%</td>
</tr>
<tr>
<td>Domestic burglary</td>
<td>529</td>
<td>427</td>
<td>-19.3%</td>
</tr>
<tr>
<td>Drug offences</td>
<td>346</td>
<td>370</td>
<td>6.9%</td>
</tr>
<tr>
<td>Homicide</td>
<td>3</td>
<td>3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Miscellaneous crimes against society</td>
<td>225</td>
<td>148</td>
<td>-34.2%</td>
</tr>
<tr>
<td>Non-domestic burglary</td>
<td>629</td>
<td>584</td>
<td>-7.2%</td>
</tr>
<tr>
<td>Possession of weapons offences</td>
<td>63</td>
<td>76</td>
<td>20.6%</td>
</tr>
<tr>
<td>Public order offences</td>
<td>440</td>
<td>490</td>
<td>11.4%</td>
</tr>
<tr>
<td>Robbery</td>
<td>48</td>
<td>64</td>
<td>33.3%</td>
</tr>
<tr>
<td>Sexual offences</td>
<td>179</td>
<td>229</td>
<td>27.9%</td>
</tr>
<tr>
<td>Shoplifting</td>
<td>1509</td>
<td>1387</td>
<td>-8.1%</td>
</tr>
<tr>
<td>Theft from the person</td>
<td>122</td>
<td>116</td>
<td>-4.9%</td>
</tr>
<tr>
<td>Vehicle offences</td>
<td>901</td>
<td>709</td>
<td>-21.3%</td>
</tr>
<tr>
<td>Violence with injury</td>
<td>753</td>
<td>896</td>
<td>19.0%</td>
</tr>
<tr>
<td>Violence without injury</td>
<td>647</td>
<td>867</td>
<td>34.0%</td>
</tr>
<tr>
<td><strong>Total Crime</strong></td>
<td><strong>9080</strong></td>
<td><strong>8886</strong></td>
<td><strong>-2.1%</strong></td>
</tr>
</tbody>
</table>

*A definition of miscellaneous crimes against society has been provided in appendix 2.

25 ONS (2016)

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Crime categories compared to nearest neighbours per 1,000

25 ONS (2016) Offences
The sections below compare Lincoln to the Police audit family for each crime category, considered to be the most appropriate comparison by the Police. We use rates to compare two or more areas with different population sizes fairly.

**Criminal damage and arson**

Lincoln had the 8th highest arson and criminal damage crime rate when compared to its Police audit family, with a rate of 13.5 per 1,000 population.

**Drug offences**

Lincoln had the 2nd highest drug crime rate when compared to its Police audit family, with a rate of 3.8 per 1,000 population.

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26 ONS (2016)

All other theft offences

Lincoln had the joint 5th lowest of all other theft offences crime rate when compared to its Police audit family, with a rate of 8.8 per 1,000 population.

Bicycle theft

Lincoln had the 2nd highest bicycle theft crime rate when compared to its Police audit family, with a rate of 3.6 per 1,000 population.

Domestic burglary

Lincoln had the 7th highest domestic burglary crime rate when compared to its Police audit family, with a rate of 4.4 per 1,000 population.

![Rate per 1,000 population for domestic burglary for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16](chart)

Homicide

Lincoln had the highest homicide crime rate when compared to its Police audit family, with a rate of 0.031 per 1,000 population. It should be noted that numbers of homicides in real terms are numerically low.

![Rate per 1,000 population for homicide for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16](chart)

28 ONS (2016)

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Miscellaneous crimes against society

Lincoln had the 7th highest rate of miscellaneous crimes against society per 1,000 population, with a rate of 1.5 per 1,000 population.

The rate per 1,000 population for miscellaneous crimes against society for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16

Non-domestic burglary

Lincoln had the highest non-domestic burglary crime rate when compared to its Police audit family, with a rate of 6.0 per 1,000 population.

The rate per 1,000 population for Non-domestic burglary for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16

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29 ONS (2016)

Possession of weapons offences

Lincoln had the joint highest possession of a weapon crime rate when compared to its Police audit family, with a rate of 0.8 per 1,000 population.

Public order offences

Lincoln had the 4th highest public order offences crime rate when compared to its Police audit family, with a rate of 5.0 per 1,000 population.

30 ONS (2016)

Robbery

Lincoln had the 4\textsuperscript{th} lowest robbery crime rate when compared to its Police audit family, with a rate of 0.7 per 1,000 population.

Sexual offences

Lincoln had the 6\textsuperscript{th} highest sexual offences crime rate when compared to its Police audit family, with a rate of 2.4 per 1,000 population.

Shoplifting

Lincoln had the highest shoplifting crime rate when compared to its Police audit family, with a rate of 14.3 per 1,000 population.

![Chart showing shoplifting rates for Lincoln and other local authorities.]

Theft from the person

Lincoln had the 7th highest rate of theft from a person when compared to its Police audit family, with a rate of 1.2 per 1,000 population.

![Chart showing theft from person rates for Lincoln and other local authorities.]

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32 ONS (2016)

Vehicle offences
Lincoln had the 6th lowest vehicle crime rate when compared to its Police audit family, with a rate of 7.3 per 1,000 population.

Violence with injury
Lincoln had the 6th lowest crime rate of violence with injury when compared to its Police audit family, with a rate of 9.2 per 1,000 population.

33 ONS (2016)

Violence without injury

Lincoln had the 5th lowest violence without injury crime rate when compared to its Police audit family, with a rate of 8.9 per 1,000 population.

The rate per 1,000 population for violence without injury from the person for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16

Total Reported Crime

Lincoln had the 6th highest total crime rate per 1,000 population when compared to its Police audit family with a rate of 91.5 per 1,000 population.

The rate per 1,000 population for total crime for Lincoln and the local authorities the Police use to compare Lincoln for 2015/16

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ONS (2016)
Antisocial Behaviour Heat Map

The heat maps below highlight the number of reported antisocial behaviour incidents in Lincoln for April 2014 – March 2015 and April 2015 – March 2016 at LSOA level.

The city centre has the highest levels of reported antisocial behaviour incidents in Lincoln. There was a noticeable decrease in the number of reported antisocial behaviour incidents around suburban areas of Lincoln, such as Moorland ward, Castle ward and Minster ward.

There was a noticeable increase in the number of reported antisocial behaviour incidents around North Boultham ward, eastern Abbey ward, eastern Glebe ward and central Moorland ward.

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35 Police.uk (2016) Offences
Education Summary

The percentage of Foundation Stage students achieving a good level of development rose slightly from 64% in 2013/15 to 65% in 2014/15. The percentage of Key Stage 4 students in Lincoln who are achieving 5 or more GCSEs graded A*-C (incl. English and Maths) remains the same as the previous year at 49%.

A definition of a good level of development is defined as a child who is achieving or excelling at the expected level of learning. These levels consist of, communication and language; physical development; and personal, social and emotional development; literacy; and mathematics.

Castle ward had the lowest percentage of Key Stage 4 students achieving 5 or more GCSEs graded A*-C (Inc. English and Maths) in Lincoln when compared to the other wards.

Foundation Attainment

The percentage of Foundation Stage students in Lincoln who achieved a good level of development increased from 64% in 2013/14 to 66% in 2014/15. This was just below the England rate of 67%. This is the first time Lincoln has dropped below the England rate.

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36 LRO (2016)
GCSE Attainment

The percentage of Key Stage 4 students in Lincoln who achieved 5 or more GCSEs graded A* - C (incl. English and Maths) in 2014/15 remained the same as the previous year at 49%. Lincoln continued to lag behind the national rate.

For a definition of each qualification category according to NOMIS see Appendix 3 (page 85)

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37 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Abbey Ward (2007 Boundary)

Foundation Stage

66% of Foundation Stage students who live in Abbey ward achieved a good level of development in 2014/15. This was slightly higher than the Lincoln percentage of 65%.

Key Stage 4

46% of GCSE students who live in Abbey ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was slightly lower than the Lincoln percentage of 49%.

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38 LRO (2016)
39 LRO (2016)
Birchwood Ward (2007 Boundary)

Foundation Stage

60% of foundation students who live in Birchwood ward were achieving a good level of development in 2014/15. This was slightly lower than the Lincoln percentage of 65%.

![The percentage of foundation students who live in Birchwood ward achieving a good level of development](chart1)

Key Stage 4

39% of GCSE students who live in Birchwood ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was lower than the Lincoln percentage of 49%.

![The percentage of Key Stage 4 students who live in Birchwood ward achieving 5 GCSEs A*-C (inc. English and Maths)](chart2)

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40 LRO (2016)
41 LRO (2016)

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40 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address

41 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Foundation Stage

75% of Foundation Stage students who live in Boultham ward were achieving a good level of development in 2014/15. This was higher than the Lincoln percentage of 65%. There was a specific decrease in Boultham ward when compared to Lincoln in 2012/13.

Key Stage 4

55% of GCSE students who live in Abbey ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This is slightly higher than the Lincoln percentage of 49%.

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42 LRO (2016)
43 LRO (2016)
Bracebridge Ward (2007 Boundary)

Foundation Stage

67% of Foundation Stage students who live in Bracebridge ward were achieving a good level of development in 2014/15. This was slightly higher than the Lincoln percentage of 65%.

Key Stage 4

42% of GCSE students who live in Bracebridge ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was lower than the Lincoln percentage of 49%.

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44 LRO (2016)
45 LRO (2016)

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44 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address
45 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Carholme Ward (2007 Boundary)

Foundation Stage

61% of Foundation Students who live in Carholme ward were achieving a good level of development in 2014/15. This was slightly lower than the Lincoln percentage of 65%. There was a specific decrease in Carholme ward when compared to Lincoln in 2012/13

Key Stage 4

57% of GCSE students who live in Carholme ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was higher than the Lincoln percentage of 49%.

46 LRO (2016)
47 LRO (2016)
Castle Ward (2007 Boundary)

Foundation Stage

62% of Foundation Stage students who live in Castle ward were achieving a good level of development in 2014/15. This was slightly lower than the Lincoln percentage of 65%.

Key Stage 4

22% of GCSE students who live in Castle ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was significantly lower than the Lincoln percentage of 49%.

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48 LRO (2016)

49 LRO (2016)

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48 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address

49 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Foundation Stage

67% of Foundation Stage students who live in Glebe ward were achieving a good level of development in 2014/15. This is slightly higher than the Lincoln percentage of 65%.

Key Stage 4

37% of GCSE students who live in Glebe ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was significantly lower than the Lincoln percentage of 49%.

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50 LRO (2016)
51 LRO (2016)

50 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address
51 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Hartsholme Ward (2007 Boundary)

Foundation Stage

78% of Foundation Stage students who live in Hartsholme ward were achieving a good level of development in 2014/15. This was significantly higher than the Lincoln percentage of 65%.

Key Stage 4

63% of GCSE students who live in Hartsholme ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was significantly higher than the Lincoln percentage of 49%.

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52 LRO (2016)
53 LRO (2016)

52 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address
53 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Minster Ward (2007 Boundary)

**Foundation Stage**

71% of Foundation Stage students who live in Minster ward were achieving a good level of development in 2014/15. This was higher than the Lincoln percentage of 65%.

The percentage of foundation students who live in Minster ward achieving a good level of development

![Graph showing percentage of Foundation stage students achieving a good level of development in Minster ward compared to Lincoln from 2009/10 to 2014/15.]

**Key Stage 4**

49% of GCSE students who live in Minster ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was same percentage as Lincoln.

The percentage of Key Stage 4 students who live in Minster ward achieving 5 GCSEs A*-C (inc. English and Maths)

![Graph showing percentage of Key Stage 4 students achieving 5 GCSEs A*-C in Minster ward compared to Lincoln from 2008/09 to 2014/15.]

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54 LRO (2016)

55 LRO (2016)

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54 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address

55 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Moorland Ward (2007 Boundary)

Foundation Stage

60% of Foundation Stage students who live in Moorland ward were achieving a good level of development in 2014/15. This was slightly lower than the Lincoln percentage of 65%.

The percentage of foundation students who live in Moorland ward achieving a good level of development

Key Stage 4

50% of GCSE students who live in Moorland ward achived 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was slightly higher than the Lincoln percentage of 49%.

The percentage of Key Stage 4 students who live in Moorland ward achieving 5 GCSEs A*-C (inc. English and Maths)

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56 LRO (2016)
57 LRO (2016)

56 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address
57 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
Park Ward (2007 Boundary)

**Foundation Stage**

55% of Foundation Stage students who live in Park ward were achieving a good level of development in 2014/15. This was lower than the Lincoln percentage of 65%.

**Key Stage 4**

47% of GCSE students who live in Park ward achieved 5 GCSEs A*-C (inc. Maths and English) in 2014/15. This was slightly lower than the Lincoln percentage of 49%.

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58 LRO (2016)
59 LRO (2016)

58 LRO (2016) Percentage of Foundation stage students achieving a good level of development by home address

59 LRO (2016) Percentage of Key Stage 4 students achieving 5+ GCSEs A*-C (Inc. Maths and English) by home address
**Percentage of children eligible for Free School Meals achieving a 'good level of development' at the end of Early Years Foundation Stage**

In 2015 the percentage of children who were eligible for Free School Meals achieving a ‘good level of development’ at the end of Early Years Foundation in Lincoln was 53.2%. When compared to Lincoln’s nearest neighbours, Lincoln had the second highest percentage. This is lower than the overall percentage of Foundation stage students Lincoln achieving a good level of development in 2014/15, which was 66%.

**Percentage of children eligible for Free School Meals achieving 5 good GCSEs including English and maths**

In 2015 the percentage of children who are eligible for Free School Meals achieving at least 5 GCSEs A*-C including English and Maths in Lincoln was 22.7%. Lincoln had the fourth lowest percentage when compared to Lincoln’s nearest neighbours. This is significantly lower than the overall percentage of children achieving 5 good GCSEs including English and maths in 2014/15, which was 49%.
The Educational Attainment of Lincoln Residents

The graphic below highlights the educational attainment of the residents of Lincoln residents aged 16-65 from December 2015. Please see page 85 for the definition of each NVQ.

- **25.5%** of Lincoln’s working age population had an NVQ level 4 qualification.
- **15.1%** of Lincoln’s working age population had an NVQ level 3 qualification.
- **26.5%** of Lincoln’s working age population had an NVQ level 2 qualifications.
- **10.7%** of Lincoln’s working age population had no qualifications.
- **7.6%** of Lincoln’s working age population had other qualifications.
- **14.6%** of Lincoln’s working age population had a NVQ level 1 qualifications.

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ONS (2016)

ONS annual population survey (2016)
Lincoln residents aged 16-64 with no qualifications

This category is for the percentage of Lincoln residents aged 16-64 who hold no formal qualifications, compared to the East Midlands and England.

The percentage of Lincoln residents aged 16-64 with no qualifications continues to increase from 10% in 2014 to 10.7% in 2015.

Lincoln had the sixth highest percentage of residents aged 16-64 who had no qualifications when compared to its nearest neighbours.

ONS (2016)

ONS annual population survey (2016)
Lincoln residents aged 16-64 with NVQ Level 1

This category is for the percentage of Lincoln residents aged 16-64 who have an NVQ level 1 or equivalent qualification. These qualifications include and are not limited to, fewer than 5 GCSEs at grades A-C, foundation GNVQ, NVQ 1, intermediate 1 national qualification (Scotland) or equivalent.

The percentage of Lincoln residents aged 16-64 who have an NVQ level 1 or equivalent qualifications rose from 13.3% in 2014 to 14.6% in 2015.

Lincoln had the eighth highest percentage of residents aged 16-64 who have an NVQ level 1 or equivalent qualification when compared to its nearest neighbours.

ONS (2016)

ONS annual population survey (2016)
Lincoln residents aged 16-64 with NVQ Level 2

This category is for the percentage of Lincoln residents aged 16-64 who have who have an NVQ level 2 or equivalent qualification. These qualifications include and are not limited to, 5 or more GCSEs at grades A-C, intermediate GNVQ, NVQ 2, intermediate 2 national qualification (Scotland) or equivalent.

The percentage of Lincoln residents aged 16-64 who have an NVQ level 2 or equivalent qualifications rose from 17.4% in 2014 to 26.5% in 2015.

Lincoln had the highest percentage of residents aged 16-64 who have an NVQ level 2 or equivalent qualification when compared to its nearest neighbours.

\[\text{ONS (2016)}\]

\[\text{ONS annual population survey (2016)}\]
Lincoln residents aged 16-64 with Level 3

This category is for the percentage of Lincoln residents aged 16-64 who have who have an NVQ level 3 or equivalent qualification. These qualifications include and are not limited to, 2 or more A-levels, advanced GNVQ, NVQ 3, 2 or higher or advanced higher national qualifications (Scotland) or equivalent.

The percentage of Lincoln residents aged 16-64 who have an NVQ level 3 or equivalent qualifications decreased from 22.7% in 2014 to 15.1% in 2015.

Lincoln had the second lowest percentage of residents aged 16-64 who have an NVQ level 3 or equivalent qualification when compared to its nearest neighbours.

ONS (2016)

ONS annual population survey (2016)
Lincoln residents aged 16-64 with an NVQ Level 4 and above

This category is for the percentage of Lincoln residents aged 16-64 who have who have an NVQ level 4 and above equivalent qualifications. These qualifications include and are not limited to, HND, Degree and Higher Degree level qualifications or equivalent.

The percentage of Lincoln residents aged 16-64 who have an NVQ level 4 or equivalent qualifications decreased from 32.8% in 2014 to 25.5% in 2015.

Lincoln had the seventh lowest percentage of residents aged 16-64 who have an NVQ level 4 or equivalent qualification when compared to its nearest neighbours.

66 ONS (2016)

66 ONS annual population survey (2016)
Economy Summary

Lincoln’s median total salary has decreased from £19,358 in 2014 to £18,054 in 2015, this is a decrease of 6.7%. Lincoln had the third lowest median total salary when compared to its nearest neighbours.

Due to the 2015 total male median annual salary for Lincoln not being available during the time this report was written, the 2014 total male and female annual salary of Lincoln residents have been substituted.

The percentage of Lincoln residents who were employed in professional occupations had decreased from 16.3% in 2014 to 11.6% in 2015. The percentage of residents who were employed in caring, leisure and other service occupation jobs had decreased from, 15.6% in 2014 to 9.2% in 2015.

The percentage of Lincoln’s residents who were employed in administrative and secretarial occupations increased from 9.1% in 2014 to 13.8% in 2015. The process, plant and machine operative’s occupations increased as well from 6.8% in 2014 to 11.5% in 2015.

Median Annual Total Salary

When comparing Lincoln’s median total salary to England and the East Midlands, Lincoln’s salary had decreased in 2015 by 6.7% (£1,304) when compared to the previous year. This is unlike England and the East Midlands.


67 NOMIS (2016)
The diagram below highlights the median annual salary in Lincoln, East Midlands and England. Lincoln’s total annual salary decreased by 6.7% when compared to the East Midlands and England.

England’s median annual salary for full time workers in 2015 was £22,716. This was an increase of £366 when compared to 2014.

The East Midlands median annual salary in 2015 was £21,093. This was an increase of £193 when compared to 2014.

Lincoln’s median annual salary in 2015 was £18,054. This was a decrease of £1,304 when compared to 2014.

Note – The median reflects the mid-point of a range of numbers, as opposed to the mean (or average). The median is best used when the data is not symmetrical – as in the case of salaries.
Male and Female Total Salary

The information below highlights the difference in annual median earnings for male and female residents for Lincoln in 2014. Whilst 2015 data is available for females, it is unavailable for males due to this data being statistically unreliable. Therefore, 2014 data has been used to ensure comparability.

The annual total median earnings for male residents in Lincoln for 2014 was £23,620.

This was a reduction of £1,118 compared to previous year.

The total annual median earnings for male residents in England for 2014 was £27,575.

The total annual median earnings for male residents in the East Midlands for 2014 was £26,038.

The total annual median earnings for male residents in Lincoln for 2014 was £23,620.

The total annual median earnings for female residents in Lincoln for 2014 was £14,848.

This was an increase of £595 compared to previous year.

The total annual median earnings for female residents in England for 2014 was £17,226.

The total annual median earnings for female residents in the East Midlands for 2014 was £15,771.

The total annual median earnings for female residents in Lincoln for 2014 was £15,843.

The total annual median earnings for female residents in Lincoln and its nearest neighbours in 2014 was £15,843.

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NOMIS (2016) Annual Survey of Hours and Earnings - Resident Analysis
The percentage of jobs that are paid less than the Living Wage Foundation living voluntary rate

In 2015, 22.7% of jobs in Lincoln were estimated to be paid less than the Living Wage Foundation voluntary rate – the minimum someone needs to earn to afford basic standard of living. This is a lower rate than England (24.6%) and the East Midlands (27.3%).

27.3% of jobs in the East Midlands are paid less than the applicable Living Wage Foundation living wage

24.6% of jobs in England are paid less than the applicable Living Wage Foundation living wage

22.7% of jobs in Lincoln are paid less than the applicable Living Wage Foundation living wage

In 2015 Lincoln had the fourth lowest percentage of jobs that were paid less than the Living Wage Foundation voluntary rate.

Percentage of jobs that are paid less than the applicable Living Wage Foundation living wage

71 Social Mobility Index (2015)

72 Social Mobility Index (2015)
Types of Occupations in Lincoln

This section compares the different categories of occupations for Lincoln residents to Lincoln’s nearest neighbours in December 2015. It should be noted there is no “high/low is good” for this section, the comparison has been done to compare occupations for different areas. The categories that have been used in this report are the ONS Standard Occupational Classification (SOC). Brief examples of occupations have been provided for different categories listed.

Managers, directors and senior officials

6.3% of Lincoln residents were employed in managerial, director or senior official roles in December 2015.

% all in employment who were managers, directors and senior officials Dec 2015

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73 NOMIS (2015)

73 NOMIS (2015) Annual population survey - workplace analysis
Professional occupations

11.6% of Lincoln residents were employed in professional occupations in December 2015. This includes those working in the sciences, engineering, IT and research.

Associate Professional & tech occupations

7.9% of Lincoln residents were employed in associate paraprofessional and technical occupations in December 2015. Occupations within this category include technicians working in laboratories, electrical technicians, manufacturing engineers, amongst other technical professions.

74 NOMIS (2015) Annual population survey - workplace analysis
Administrative and secretarial occupations

Compared to our nearest neighbours, Lincoln had the highest percentage of residents who were employed in administrative and secretarial occupations, with 13.8% of Lincoln residents employed in this sector in December 2015. Occupations within this category include those working in administrative support, finance roles, and debt, benefits, and revenue officers.

Skilled trades occupations

9.9% of Lincoln residents were employed in professional occupations in December 2015. Occupations within this category include farmers, groundsmen, electricians, those working in construction, food preparation, and hospitality.

75 NOMIS (2015)

75 NOMIS (2015) Annual population survey - workplace analysis
Caring, leisure and other service occupations

9.2% of Lincoln residents were employed in professional occupations in December 2015. Occupations in this category include people working in nurseries, care workers, teaching assistants, veterinary nurses and housekeepers.

Sales and customer service occupations

12.7% of Lincoln residents were employed in professional occupations in December 2015. Occupations within this category include sales and retail assistants, telephone salespersons, market research interviewers, and those working in customer service roles.

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76 NOMIS (2015)

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76 NOMIS (2015) Annual population survey - workplace analysis
Process, plant and machine operatives

11.5% of Lincoln residents were employed in professional occupations in December 2015. Occupations within this category include those working in process roles such as plant operatives, scaffolders, assemblers, and road construction operatives.

Elementary occupations

16% of Lincoln residents were employed in professional occupations in December 2015. Occupations within this category include factory workers (e.g. packing), cleaners, street cleaners, farm workers and refuse operations.

NOMIS (2015) Annual population survey - workplace analysis
Unemployment Summary

The claimant count is the number of people claiming benefit principally for the reason of being unemployed. This is measured by combining the number of people claiming Jobseeker’s Allowance and National Insurance credits with the number of people receiving Universal Credit principally for the reason of being unemployed. Claimants declare that they are out of work, capable of, available for and actively seeking work during the week in which the claim is made.

The measure of the number of people receiving Universal Credit principally for the reason of being unemployed is still being developed by the Department for Work and Pensions. Consequently this component of the total claimant count does not yet correctly reflect the target population of unemployed claimants and is subject to revisions. For this reason the claimant count is currently designated as Experimental Statistics.

The claimant count for Lincoln in April 2016 was 1,595 residents. In April 2016 Lincoln had the fourth highest claimant rate when compared to its nearest neighbours and the rate continues to be higher than the England and the East Midlands rates.

The number of out of work claimants in Lincoln from January 2013 to April 2016

The graph below shows the claimant count in Lincoln from January 2013 to April 2016. The number of claimants in Lincoln continued to decrease, with 1,595 claimants in Lincoln at the end of April 2016.

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78 NOMIS (2015) Claimants as a proportion of residents aged 16-64
The rate of out of work benefit claimants in Lincoln compared to the East Midlands and England

Main out of work benefits include Jobseeker’s Allowance claimants, and claimants of other types such as Employment and Support Allowance; Incapacity benefits; Lone Parent benefits; and others in income-related benefits. It is therefore broader than the traditional unemployment claimant count.

Lincoln followed the same direction of travel as both the East Midlands and England for the rate of residents claiming out of work benefits. Nevertheless, Lincoln continued to have a higher rate of claimants when compared to the East Midlands and England.

79 NOMIS (2015)

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79 NOMIS (2015) Claimants as a proportion of residents aged 16-64
The rate of out of work claimants in Lincoln compared to its nearest neighbours for April 2016

Lincoln had the joint fourth highest out of work claimant rate when compared to its nearest neighbours in April 2016.

\[\text{Diagram showing the claimant rate of Lincoln compared to its nearest neighbours in April 2016.}\]

\[\text{NOMIS (2015)}\]

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\[\text{NOMIS (2015) People Claiming Benefit}\]
Poverty Summary

The Indices of Multiple Deprivation 2015 (IMD 2015) ranks all 32,844 Lower Super Output Areas (LSOAs) in England in order from most deprived area (given a rank of 1) to least deprived area (given a rank of 32,844). Previous IMD publications include the IMD 2010 and the IMD 2007 (where there were only 32,482 LSOAs).

It is important to note these statistics are a measure of relative deprivation, not affluence, and to recognise not every person in a deprived area will be deprived. Likewise, there will be some deprived people living in the least deprived areas.

It is a measure of long-term structural deprivation. For this reason, it is not an effective dataset to monitor the performance of an organisation or team, but is highly effective in identifying areas of deprivation to support strategy and resource allocation.

This chapter will highlight that the IMD 2015 showed 10 areas in Lincoln within the most 10% of deprived areas nationally. This is an increase from seven areas in the IMD 2010, and five areas in the IMD 2007.

Within these 10 areas of Lincoln there are an estimated 16,014 residents (or 16.6% of the total city of Lincoln population).

This information will be displayed at LSOA level (with the 2016 ward boundaries overlaid with the help to identify LSOA locations).

There are seven themes (domains) that contribute to the IMD 2015:

- Income
- Employment
- Education, skills and training
- Health deprivation and disability
- Crime
- Barriers to housing and services
- Living environment
Income deprivation

The areas highest for income deprivation are 010D in Moorland ward and 004E in western Birchwood. 004E in St. Giles along with 007A in central Birchwood feature as the next hotspots for income deprivation, which all feature within the top 5% of the most deprived areas for income deprivation. The indicators used to create this domain are income-related benefits data.

Whilst the map shows concentrated hotspots of income deprivation in the south of the city, there are also areas of relative income deprivation in the north and east of the city.

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81 CoLC (2016)
Employment

The area of Lincoln ranked highest for employment deprivation, that is also within the top 1% of most deprived areas for employment deprivation nationally, is 010D in Moorland ward. Other areas that feature highly include 007C in western Birchwood, 004E in St. Giles, 004D in Abbey ward, 001B in Ermine West, and 002C in north of St. Giles, which all feature within the top 5% of the most deprived areas in England for employment deprivation.

Whilst the indicators for this domain do include unemployment claimants, they also extend beyond unemployment data to include worklessness due to disability data, along with data on residents claiming carer’s allowance.

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\[\text{Lincoln 010D} \text{ Is ranked } 241\]

\[\text{Lincoln 007C} \text{ Is ranked } 2,314\]

\[\text{Lincoln 001B} \text{ Is ranked } 2,365\]

\[\text{Lincoln 004E} \text{ Is ranked } 1,687\]

\[\text{Lincoln 004D} \text{ Is ranked } 1,090\]

\[\text{Lincoln 002D} \text{ Is ranked } 1,237\]

\[\text{Lincoln 001A} \text{ Is ranked } 595\]

\[\text{Lincoln 002C} \text{ Is ranked } 711\]

\[\text{Lincoln 007A} \text{ Is ranked } 2,500\]

\[\text{Lincoln 006B} \text{ Is ranked } 1,090\]

\[\text{Lincoln 010A} \text{ Is ranked } 1,090\]
Education, skills and training

There are three areas in Lincoln within the top 1% of the most deprived areas in England for education, skills and training. These are 007C in western Birchwood, 010D in Moorland ward, and 004E in St. Giles. Other areas that feature particularly highly for this domain include 006B in southern Abbey ward (east of the city centre), and 007A in central Birchwood, which all feature amongst the top 5% of the most deprived areas in England.

The indicators in this domain include educational attainment at Key Stages 2 and 4, along with the secondary school absence rate, the proportion of young people in education post 16, and proficiency in English.

83 CoLC (2016)
Health deprivation and disability

There are no areas in Lincoln within the top 1% of the most deprived areas in England for health deprivation and disability, but 18 of Lincoln’s 57 LSOAs are amongst the top 10% of the most deprived areas in England. This is a substantially large number of areas in the city with high levels of health deprivation and disability, making it one of the standout domains for widespread impact in the city.

The most deprived areas of Lincoln for this domain are 004D in central Abbey ward (east of the city centre), 007C in western Birchwood, 001B in Ermine west, 004E in St. Giles, 010D in Moorland ward, 006B in southern Abbey ward (east of the city centre), and 002C north of St. Giles, which all feature amongst the top 5% of the most deprived areas nationally.

The indicators used in this domain look at premature death rates, levels of illness and disability, emergency admissions to hospital, and mood and anxiety disorders.
Crime

There is one area amongst the top 1% of the most deprived areas in England for crime. This is 004A in Abbey ward which includes an area of the city centre and the area around the western end of Monks Road. Other areas that feature within the top 5% of the most deprived areas in England for crime deprivation include 003G which also covers part of the city centre and is included in Minster ward, and 004D in central Abbey ward (just east of the city centre). It is likely the part coverage of the city centre influences the ranking of these LSOAs.

The indicators for this domain include crime relating to violence, burglary, theft and criminal damage.
Barriers to housing and services

There are no areas in Lincoln that feature within the top 1% of the most deprived areas in England, and only one area in the city that features within the top 5% of the most deprived areas in England for barriers to housing and services. This area is 005A, which lies predominantly southeast of the Ropewalk roundabout, and east of the most northern part of Tritton Road.

Many of the indicators for this domain relate to road distance to amenities including post offices, primary schools, shops and GPs which will tend to show lower deprivation in more compact urban areas. Other indicators contributing to this domain include household overcrowding, homelessness and housing affordability.

(Lincoln 005A) Is ranked 1,429
Living environment

There are no areas in Lincoln within the top 1% of the most deprived areas nationally for living environment, however there are seven areas that feature within the top 5% of the most deprived areas. From the map below, we can see these are largely focused in areas around the city centre, where there are clusters of high density, older properties and where there is a convergence of road networks and high levels of commuter and shopper traffic.

The indicators included in this domain are houses that are in poor condition, houses without central heating, areas with poor air quality, and areas with higher levels of road traffic accidents.
The tables below show which countries are in which world groupings according to the DWP, from where the migration information was sourced.

### EU Countries

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88 DWP (2016)
The below crimes are the definitions of “Miscellaneous crimes against society” which is one of the categories of crime covered in this report (page 30).

- Concealing an infant death close to birth
- Exploitation of prostitution
- Bigamy
- Soliciting for prostitution
- Going equipped for stealing etc.
- Making, supplying or possessing articles for use in fraud
- Profiting from or concealing proceeds of crime
- Handling stolen goods
- Threat or possession with intent to commit criminal damage
- Forgery or use of drug prescription
- Other forgery
- A possession of false documents
- Perjury
- Aiding suicide
- Perverting the course of justice
- Absconding from lawful custody
- Bail offences
- Obscene publications etc.
- Disclosure, obstruction, false or misleading statements etc.
- Wildlife crime
- Other notifiable offences
- Dangerous driving
- Fraud, forgery associated with driver records

89Gov.uk (2016)
Educational attainment - NVQ qualification definitions

APPENDIX 3

The list below highlights the definitions of each qualification category according to NOMIS.

No qualifications
No formal qualifications held

Other qualifications
This includes foreign qualifications and some professional qualifications

NVQ 1 equivalent
- fewer than 5 GCSEs at grades A-C
- foundation GNVQ, NVQ 1
- Intermediate 1 national qualification (Scotland) or equivalent

NVQ 2 equivalent
- 5 or more GCSEs at grades A-C
- intermediate GNVQ
- NVQ 2
- Intermediate 2 national qualification (Scotland) or equivalent

NVQ 3 equivalent
- 2 or more A-Levels
- advanced GNVQ
- NVQ 3
- 2 or more higher or advanced higher national qualifications (Scotland) or equivalent

NVQ 4 equivalent and above
- HND
- Degree and Higher Degree level qualifications or equivalent

NOMIS (2016) Definitions and Explanations
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COMMUNITY LEADERSHIP SCRUTINY COMMITTEE

SUBJECT: COMMUNITY LEADERSHIP SCRUTINY COMMITTEE WORK PROGRAMME 2016/2017

REPORT BY: CHIEF EXECUTIVE AND TOWN CLERK

LEAD OFFICER: BEN CULLING, DEMOCRATIC SERVICES OFFICER

1. Purpose of Report

1.1 To present the Community Leadership Scrutiny Committee Work Programme for 2016/2017.

2. Background

2.1 The 2016/17 work programme for the Committee is attached under Appendix A, for Members’ consideration.

3. Recommendation

3.1 That Members consider and comment on the work programme for 2016/2017.

Lead Officer: Ben Culling, Democratic Services Officer
Telephone 873387
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## Draft Community Leadership Scrutiny Committee Work Programme – Timetable for 2016/17

### 21 June 2016

<table>
<thead>
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<th>Item(s)</th>
<th>Responsible Person(s)</th>
<th>Strategic Priority/Comments</th>
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<tr>
<td>Final Report – City Centre Environment</td>
<td>Sam Barstow/ Bob Ledger</td>
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<tr>
<td>Suicide Rates in Lincoln - Scoping</td>
<td>Simon Colburn</td>
<td>Report</td>
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<td>Simon Colburn</td>
<td>Review</td>
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<td>Scrutiny Annual Report</td>
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<td>Review</td>
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<td>Simon Colburn</td>
<td>Review</td>
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<td>Democratic Services Officer</td>
<td>Regular Report</td>
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### Suggested topics

- Suicide Rates
- Street Surfaces
- Charity sellers and Street Traders