APPENDIX

Leicestershire County Council

2024 Annual Report of the Director of Public Health, Leicestershire

Leicestershire's Health
Inequalities in health

PEOPLE PROMOTE PROTECT PROVIDE PARTNERSHIP

1 Foreword

Welcome to my annual report for 2024.

When presenting last year's report on the health status of people in Leicestershire I found that, overall, the health of the Leicestershire population was pretty good compared to the rest of the country and our comparator authorities. However, I made recommendations relating to a number of areas, in particular the need to focus on physical activity and diet as important areas where Leicestershire's performance wasn't as good as it can be.

I said at the time I wanted this year's report to look beneath the bonnet of that overall picture and examine how health is experienced by different groups and communities in Leicestershire.

I am sure people are used to seeing reports where people in such and such an area live for more or fewer years than those in another area. I'd agree that where a person lives is an important part of the data on health inequality, but I want to look beyond geography and consider the characteristics of different people, the experience of their lives and how that shapes their health too.

This report takes the chapter on Health Inequalities that was published last year as part of the Leicestershire Joint Strategic Needs Assessment (JSNA), condenses that chapter and updates data where refreshed data is available. It has enabled me to reflect on the existing recommendations in the JSNA and tweak them to guide departmental work in the next year. As always, I give an update on the recommendations in last year's report. That update has given me pause to reflect on the tremendous work done by the department this year, as they do every year. Thank you all.

I would like to thank my colleagues that have helped in producing this report, particularly Sally Vallance for producing the original JSNA chapter, Victoria Rice for refreshing some of the data in this report, Alex Clark, Anuj Patel, Jenna Parton and Liz Orton, along with Jo Spokes from Active Together, for their updates and the whole team for their work in tackling inequalities.

Mike Sandys
Director of Public Health

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2 Introduction and summary

Directors of Public Health have a statutory duty to write an Annual Public Health Report that describes the state of health within their communities.

It is a major opportunity for advocacy on behalf of the population and, as such, can be used to help talk to the community and support fellow professionals, providing added value over and above intelligence and information routinely available.

It is intended to inform local strategies, policy and practice across a range of organisations and interests and to highlight opportunities to improve the health and wellbeing of people in Leicestershire. The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and thereby serve their local populations. It is also a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities they serve.

Within this report, data is presented on health inequalities in Leicestershire. The content should be used by commissioners and providers of services to respond to the inequalities in health that are faced by people in Leicestershire.

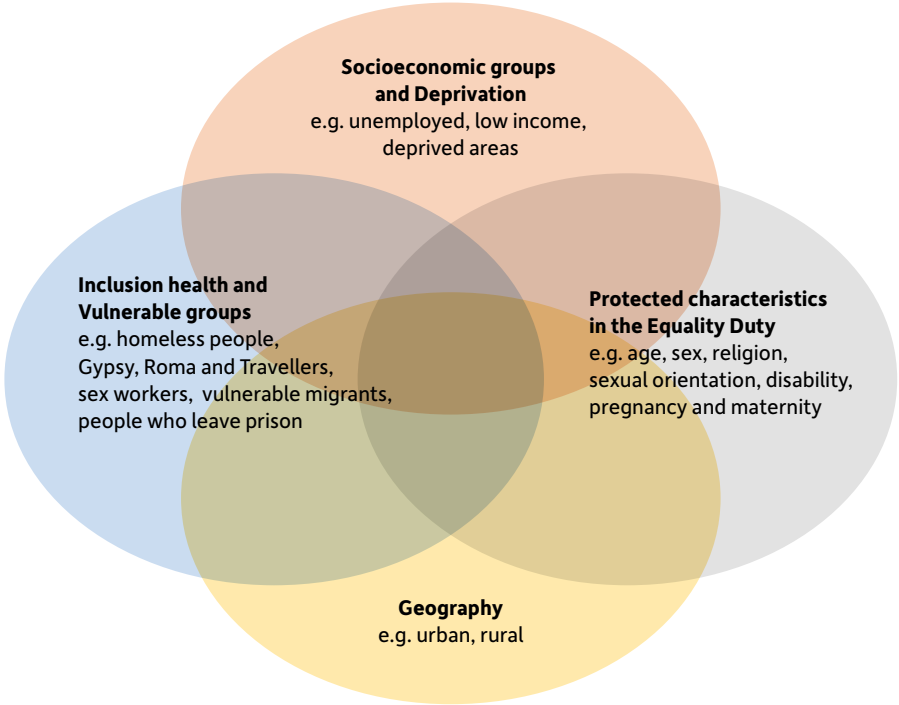
Health inequalities are avoidable, unfair, and systemic differences in health between different groups of people. Health inequalities are everywhere, people experience them because of their life experiences, the risks they're exposed to and the environments they live in as well as their access to services and to community, family, and friends[1].

Health inequalities have a huge impact on people's lives. In the worst examples, using national data, people are dying significantly earlier than the general population because of health inequalities. This includes people with a learning disability dying 20.7 years before the general population in England[2] and people who are homeless dying around 30 years earlier than the general population[3]. Health inequalities also impact on whether we live in good health. Carers in England report a 60% rate of long term conditions[4] (the rate is 50% in the general population) and disability-free life expectancy is estimated to be lower among several ethnic minority groups[5].

Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2012[6], socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group. People who share protected characteristics, as defined in the Equality Act 2010, may experience poorer health outcomes as a direct result of discrimination or due to different experiences of the factors described above[7].

Where the dimensions of health inequality overlap, people can often face greater risk of poor outcomes. This is often referred to as intersectionality. Figure 1 below shows how these dimensions overlap.

Figure 1 – Dimensions of health inequalities



Source: HEAT (Health Equity Assessment) tool, Public Health England, 2021

Health inequalities may be driven by:

- Different experiences of the wider determinants of health, such as the environment, income or housing
- Differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- Psychosocial factors, such as social networks and self-esteem
- Unequal access to or experience of health services

These conditions influence our opportunities for good health and how we think, feel and act, and this shapes our mental health, physical health and wellbeing[7].

The recent pandemic has served to highlight the impact of health inequalities. Coronavirus (COVID-19) has not only replicated existing health inequalities, but in some cases, has increased them, through its disproportionate impact on certain population groups. Analyses have shown that older age, ethnicity, male sex and geographical area are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death[7].

Some groups of people experience worse outcomes because of health inequalities than others. To reduce the inequality in the population overall, there needs to be a focus on those with the worst outcomes. In doing this, we start to reduce the gap between the most and least healthy in Leicestershire.

This report reviews the evidence base for health inequalities in different populations. It looks at the local evidence of inequalities using key measures such as life expectancy. It also examines the different measures of poverty and deprivation and who experiences these in Leicestershire. Whilst the local evidence shows that living in an area of high deprivation can reduce life expectancy by up to nine years, national studies into health inequalities for other at-risk population groups almost always reference the impact that poverty has in compounding the inequality experienced by that group already. For this reason, it may be wise to consider poverty as a way of identifying those at higher risk within each of the population groups below.

The groups at risk of facing health inequalities in Leicestershire are:

- **Looked after children and care experienced adults**
- **People living in poverty/deprivation**
- People who identify as Lesbian, Gay, Bisexual or Transgender (LGBT)
- People with a disability, **including people with a learning disability**
- **People who are homeless**
- Victims of modern slavery
- Sex workers
- Vulnerable migrants
- Carers
- **People with severe mental illness**
- **Prisoners**
- People who have experienced trauma
- A complex picture was identified around race and ethnicity but evidence of health inequalities being most common for people who are Bangladeshi, Pakistani or **Gypsy or Irish Travellers**

Those groups with a particularly high risk (from evidence of years of life lost from their lives as a result) are identified in bold text in the above list.

When looking at health inequalities in Leicestershire, it is vital to examine differences that exist in neighbourhoods. On a whole County scale, Leicestershire is a relatively healthy place. However, this masks wide variation at a neighbourhood level with some communities experiencing the best health outcomes and others the worst. Through examining available data at a neighbourhood level, we can start to identify neighbourhoods at higher risk of health inequalities. Identifying these neighbourhoods is important as it helps to focus resource and efforts on prevention in order to reduce risk.

Whilst these population groups represent areas of focus for health inequalities, it is important to remember that the risk increases when someone belongs to more than one of these groups. This intersectionality of populations is where we see the greatest risk.

The 15 neighbourhoods, measured by analysis at middle super output area (MSOA) level, identified as high risk in terms of potential health inequalities are:

- **Charnwood**: Loughborough Lemyngton & Hastings, Storer and Queens Park, University, Shelthorpe & Woodthorpe, Syston West and Shepshed East
- **Harborough**: Market Harborough Central
- **Hinckley and Bosworth**: Barwell, Hinckley Central and Hinckley Clarendon Park
- **Melton**: Melton Mowbray West
- **North West Leicestershire**: Agar Nook, Coalville
- **Oadby and Wigston**: Wigston Town, South Wigston

Whilst these neighbourhoods have been selected due to at least one indicator of socioeconomic need, under 75 mortality or life expectancy performing significantly worse than England, it is important to note that these communities also hold a huge amount of resilience, support and determination and it is these characteristics alongside positive action from agencies working alongside them that can reduce the risks that they face.

3 Update on recommendations from 2023

The overview of health in last year's annual report made several recommendations for the public health department to lead.

Looking at the 'big' public health issues, where national and comparative performance leaves room for concern, the two big issues the department needed to give more focus to were:

- Physical Activity, where both the percentage of physically active adults and the percentage of adults walking for travel need improvement and,
- Diet, where the percentage of adults aged 16 and over meeting the 'five-a-day' recommendations requires improvement

Additionally, working with partners to improve air quality was highlighted as a focus for the public health department and performance against the 'winter mortality index' data shows tackling excess winter deaths should receive more priority. Lastly, the report said 'we will work with partners to improve the uptake of vaccination, immunisation and screening'.

In the last year the department has responded to these challenges by:

Physical activity

Over the last 12 months we have used the public health grant to prioritise physical activity programmes for those most likely to be inactive. We have continued to fund highly specialised, evidence-based programmes for people with specific health needs (e.g. cancer or cardio-pulmonary conditions – these are level 4 programmes), programmes aimed at inactive people with one or more stable health conditions (level 3 programmes, previously referred to as the exercise referral scheme) and level 0/1 programmes aimed at providing population-level interventions, brief advice and sign posting for self-help.

We have continued to invest in fundamental movement skills training for young children, provide physical activity support for children who are overweight or obese as part of the children's weight management programme HE-HA, and support schools to deliver active travel programmes thought the input from a Safe and Sustainable Travel Officer.

Our hosted partner Active Together continue to deliver communications and marketing campaigns across the county, promote physical activity through advocacy and training with the NHS (e.g. Active Practices) and monitor delivery of the public health grant for physical activity through the district councils.

Within this work, the Medium-Term Financial Strategy 2023/24 – 2026/27 included a requirement for savings via a review of physical activity commissioning. Following a review of the current delivery model, a revised delivery model was proposed which would achieve the required savings. Following consultation and approval by cabinet, the approach adopted from April 2024 was to retain programmes with the following outcomes:

- High risk prevention strategy – retain specialised programmes for children and adults with the highest levels of ill-health as defined by existing health conditions and who are inactive and therefore with the greatest capacity to benefit.
- Left shift prevention strategy – retain population-level and large-group programmes aimed at supporting inactive people to be active as a primary prevention approach, including mass participation events, campaigns and group-based programmes such as walking and beginner running (e.g. couch to 5k) programmes.

The review led to the removal of public health funding to support:

- Contribution to leisure centre-based exercise referral programmes
- School based programmes
- Locally specified programmes based in the community
- Physical Activity Graduate Trainee Programme

Diet

- We have achieved Sustainable Food Places Silver Award, recognising our joined up approach to food and sustainability.
- We are in the process of reinvigorating our Whole System's Approach to Healthy Weight, Food and Nutrition, by bringing workstreams together to ensure a wide reaching, impactful and holistic approach is adopted across the system.
- We have taken action on pre and post-natal physical activity, furthering the reach of the Active Mum's Club and supporting pregnant women and new mums to maintain or begin to be active.
- We have worked successfully with Family Hubs to implement the evidence based HENRY programme to support healthy eating and physical activity in the early years.

Wider Determinants

Over the past year much of the focus within the wider determinants portfolio has been on influencing healthy placemaking. Work has continued with Local Planning Authorities to embed health considerations within Local Plans, with a number of strategic Health Impact Assessments carried out on these plans. We have also worked in partnership to draft strategic health policies within these plans, and where appropriate, Health Impact Assessment requirements for certain planning applications. Public Health also contributed to the Local Authority response to Hinckley National Rail Freight Interchange, embedding health considerations and evidence on the local population need. The team have worked closely with our Environment and Transport team to embed 'Enabling Health and Wellbeing' as a key theme within Local Transport Plan 4 and carried out Health Impact Assessment on our Local Highway Design Guide. An updated Health Needs Assessment was carried out on the area of outdoor Air Quality and Health, giving a number of recommendations for action from key stakeholders, and close work has begun with the Environment and Transport team to re-align work on active travel to the areas of most need. The team supported the successful bid for the LLR WorkWell vanguard and its early development and are key stakeholders within the Leicestershire Health Determinants Research Collaboration, which focuses on the wider determinants of health.

A Health in All Policies approach to decision making has been embedded within Leicestershire County Council, with a set of key processes and training packages launched to support this. This programme has received national interest and recognition and will be rolled out throughout the county using learning from its initial pilot.

Excess winter deaths – the winter mortality index

The Warm Homes service has received 1,102 referrals in the year April 2023 to March 2024. This is in addition to direct applications to partners delivering grant funded projects.

The Home Upgrade Grant scheme has received to date 186 eligible applications for energy efficiency measures targeting non mains gas heated homes with installations underway and continuing to March 2025.

Since the introduction of the Home Energy Retrofit Offer demonstrator project in May 2024, 162 households have received home visits and 249 have received face to face advice via community-based events.

A county wide Flexible Eligibility mechanism widening access to Energy Company Obligation funding for Leicestershire residents was implemented in August 2024. 43 households have accessed improvements via this mechanism in the first two months.

150 Winter Wellness Packs were distributed to households experiencing a heating or financial crisis resulting in significant risk of cold during the Winter of 2023/24. Distribution has been coordinated alongside Local Area Coordination.

A revised advice guide to keeping warm at home has been made available digitally and physical copies have been circulated via Community Delivery teams in public spaces including libraries.

The Warm Homes service has received **1,102** referrals in the year April 2023 to March 2024

Vaccination and Immunisation

Seasonal programmes (COVID-19 and Flu)

- Community transport offer, delivered by the Marlene Reid Centre, enables anyone to access vaccination who otherwise would not be able to attend a vaccination clinic. Feedback given highlights that the service reduces isolation as well as improving vaccination coverage.
- Mobile vaccination unit, making vaccinations accessible in local areas and working with groups where eligible people congregate (e.g. golf club, steady steps groups).
- Specialist Learning Disability (LD) clinics in Loughborough open to anyone aged 5+ who is eligible. This is arranged either by invite, or eligible individuals/ carers can phone to book an appointment. A drive through option is available for anyone who prefers not to leave the car. Several dates have been scheduled throughout the winter at the Emmanuel Church Hall.
- Large number of community pharmacies delivering seasonal vaccines around the county- the most pharmacies on board delivering COVID-19 vaccines since the campaign began.
- Focus on eligible cohorts where uptake has been lower (e.g. approaching weight management to offer flu to those with a BMI meeting vaccination criteria, charities that may support eligible people).
- Local booking system highlighting walk-in options as well

MMR

In response to the measles cases identified in the county, onsite clinics were set up in areas where cases were detected. No outbreaks of measles were reported in Leicestershire. This included schools as well as other community settings. Whilst uptake at these clinics was low, it is worth noting that uptake for 2 doses is >90% in Leicestershire.

Webinars held by ICB clinical leads to parents in schools (and the wider public) where measles cases emerged, to highlight the importance of vaccination to avoid measles transmission.

Engagement with primary care to alert them to increase in cases and promote vaccination in those who may have missed one or both doses, as well as timely recall for eligible cohorts.

Pertussis

Working with practices that have lower uptake and groups that engage with pregnant women to discuss the importance of vaccination.

Maternity offer to remain consistent. Working with UHL to message eligible mothers to advise on opportunities to be vaccinated. Pertussis vaccination is also available on the roving health unit.

Respiratory Syncytial Virus (RSV)

Community hospital clinics for all eligible cohorts, including pregnant women: Coalville, Melton, Hinckley, Loughborough and Harborough.

School programmes: HPV (+ seasonal flu and MMR catch up)

Streamline consent process, though this still requires some refinement.

Working with schools to advocate for self-consent, with a view to an equitable offer across the county.

Care home staff: Agenda slot on regular calls with care home staff to discuss vaccinations throughout the year, hosted by adult social care. Content varies throughout the year but an opportunity for care home managers to ask any questions as well. This is also an opportunity to promote resident vaccinations too.

4 Groups at higher risk of health inequalities

Health inequalities occur across many population groups and across protected characteristics. For each protected characteristic group, health behaviour, condition, and neighbourhood in Leicestershire we have been able to identify inequalities in outcomes, access, and experience.

Whilst the data and research reviewed here provides helpful insight into where health inequalities may exist in Leicestershire, these can only provide a guide and need to be viewed alongside local knowledge and lived experiences to build a robust picture of need. It should also be remembered that populations and need changes over time and any approaches to identifying populations most at risk needs to build flexibility in approach to accommodate this change.

Whilst some population groups are at greater risk of experiencing health inequality, not everyone belonging to that group will have the same experience or outcome. Taking a population level view on which people may experience poorer outcomes is important to shape policy and action but an individual approach is always required when looking at service delivery. The groups detailed below are those where research, evidence or data helps to identify them as facing a greater risk of poor health outcomes.

4.1 Socio economic groups and deprivation

The impact of deprivation and poverty

The Marmot Review[8] published in 2010, set out an analysis of the causes of health inequalities in England and what needed to be done about them.

There is a strong relationship between deprivation measured at the small areas level and healthy life expectancy at birth (the years someone is expected to live in good health). The poorer the area, the worse the health. There is a social gradient in the proportion of life spent in ill health with those in poorer areas spending more of their shorter lives in ill health. There are also clear socioeconomic gradients in preventable mortality. The poorest areas have the highest preventable mortality rates, and the richest areas have the lowest[9].

Further research into health inequalities in 2022 found that a 60-year-old woman in England's poorest areas typically has the same level of illness as a woman 16 years older in the richest areas[10]. One in three children in the UK lives in relative poverty. There are clear and consistent links between child poverty and paediatric morbidity and mortality[11].

Groups at higher risk of poverty

Disabled people are more likely to experience poverty than non-disabled people[12] and disabled adults in Great Britain were more likely to report it was difficult (very or somewhat) to afford energy, rent or mortgage payments than non-disabled adults in the period June to September 2022 according to data from the Opinions and Lifestyle Survey (OPN)[13].

Larger families and single-parent families have particularly high poverty rates at almost half for both single-parent families and for families containing three or more children. Households headed by someone of Bangladeshi, Pakistani or Black ethnicity have higher poverty rates (over 40% are in poverty)[12]. Whilst being in a working family reduces the risk of poverty, it is not a guarantee, especially if that work is part-time or in self-employment in a low paying sector or if there is a single earner in the household. Almost a quarter of people working in the administrative and support sector are in poverty[12].

Socio economic need in Leicestershire

The Index of Multiple Deprivation[14] commonly known as the IMD, is the official measure of relative deprivation for small areas in England. The IMD combines information from seven domains to produce an overall relative measure of deprivation. The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area).

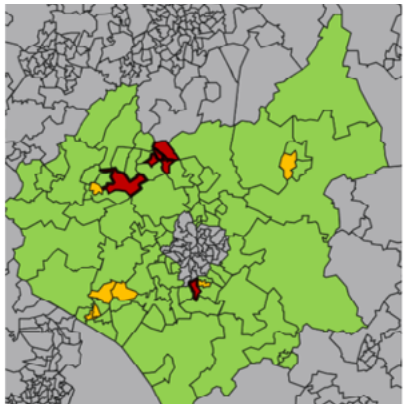
Leicestershire is overall one of the least deprived upper tier local authorities in England, being in the top decile when ranked using the Index of Multiple Deprivation 2019[15]. All seven Leicestershire districts fall within the least deprived half of all local authority districts within England. North West Leicestershire is the most deprived district in the county (ranked 216th out of 326) while Harborough is the least deprived (ranked 308th out of 326)[16].

Despite the low average deprivation in Leicestershire, pockets of significant deprivation do exist, with four Lower Super Output Areas (LSOAs) in the county falling within the most deprived decile in England. These areas can be found in Loughborough (within the Loughborough Lemyngton and Hastings and Storer and Queens Park MSOAs) and two in Coalville (within the Agar Nook MSOA)[17].

When expanded to the two most deprived deciles nationally (or the 20% most deprived neighbourhoods in England), there are 11,642 Leicestershire residents living in these deciles out of a total population of just over 713,000[17]. The districts with populations living in the 20% most deprived areas are Charnwood (7,006 people), Hinckley and Bosworth (1,269 people) and North West Leicestershire (3,367 people)[17].

The Child Poverty, Income Deprivation affecting Children Index (IDACI) shows there are 12,681 children in Leicestershire living in poverty in 2019. Populations are significantly worse (higher) in six Middle layer Super Output Areas (MSOAs) of Leicestershire (Figure 2)[18].

Figure 2 – IDACI by MSOAs in Leicestershire



MSOAs significantly worse than England (17.1%)		
MSOA name	Count	Value
Agar Nook (NWL)	408	31.5%
Loughborough Lemyngton & Hastings (Charn)	604	25.1%
Loughborough Storer & Queen's Park (Charn)	245	23.0%
Loughborough – University (Charn)	229	21.7%
South Wigston (O&W)	296	20.9%
Loughborough - Shelthorpe & Woodthorpe (Charn)	371	20.3%

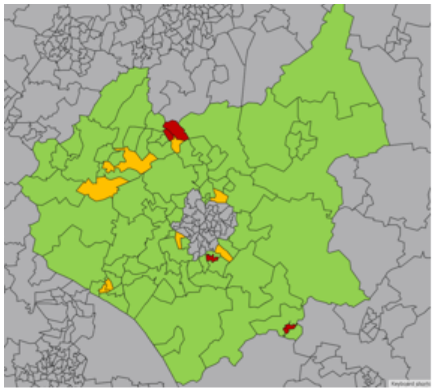
Better 95% | Similar | Worse 95% | Not compared

Source: Office for Health Improvement and Disparities, Fingertips, 2023

The Income Deprivation Affecting Older People Index (IDAOPI) identifies Leicestershire overall as having significantly better (lower) rates of older people in poverty compared to England, but this is significantly worse (higher) in four MSOAs sitting within the districts of Charnwood, Oadby and Wigston and Harborough

Figure 3)[19].

Figure 3 – IDAOPI, by MSOAs in Leicestershire



MSOAs significantly worse than England (14.2%)		
MSOA name	Count	Value
Loughborough Lemyngton & Hastings (Charn)	500	28.8%
Loughborough Storer & Queen's Park (Charn)	241	17.4%
Wigston Town (O&W)	368	16.4%
Market Harborough Central (Harb)	283	15.8%

Better 95% | Similar | Worse 95% | Not compared

Source: Office for Health Improvement and Disparities, Fingertips, 2023

Modelling estimates of the proportion of households in fuel poverty look at the number of households whose fuel poverty energy efficiency rating is band D or below and their disposable income (after housing and fuel costs) is below the poverty line. Leicestershire has the lowest rate of fuel poverty in the East Midlands[20] but this still results in 38241 people meeting these criteria in 2022.

Across the districts, North West Leicestershire has the highest rate of fuel poverty (14.1%), followed by Melton (14.0%) and Charnwood (12.8%). Blaby has the lowest rate (10.9%).

Unemployment rates across Leicestershire (2.9%) in 2021/22 are significantly better (lower) than England (5.0%). All districts across Leicestershire were also significantly better (lower) in comparison to the England rate and only one MSOA (Loughborough Lemyngton & Hastings) had a rate that was significantly worse (higher) than England at 6.5%[21].

Long term unemployment (claimants of Jobseeker's Allowance for more than a year) in 2023 was also significantly better (lower) than England at 0.3 per 1,000 working age population in Leicestershire compared to 0.9 in England. All district areas were also significantly better (lower) than England except Melton which was statistically similar to England[22].

Rates of economic inactivity (people that are neither employed or unemployed) in Leicestershire (16,5%) are statistically significantly better (lower) than the England average (21.2%) as a proportion of the population in 2023/24. The districts are also classed as statistically similar to England with the exception of Blaby which is significantly better (lower) (13.5%) and Oadby and Wigston where significance is not calculated[23].

Rates of economic inactivity (people that are neither employed or unemployed) in Leicestershire (16,5%) are statistically significantly better (lower) than the England average (21.2%) as a proportion of the population in 2023/24.

Leicestershire performs significantly better or statistically similar to England on a range of other employment related measures. The exceptions to this are the percentage of the population who are in contact with secondary mental health services that are in paid employment at 3.0% for Leicestershire compared to 6.0% for England, the gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate people at 78.1 percentage points for Leicestershire and 69.4 percentage points for England[24,25], the percentage of the population in contact with secondary mental health services and on the care plan approach in paid employment (aged 18 to 69) at 6.0% for Leicestershire in 2020/21 compared to 9.0% for England, and the gap in employment rate for this same population and the overall employment rate in 2020/21 at 70.9 percentage points for Leicestershire and 66.1 percentage points for England[26,27]. These four are significantly worse than England.

4.2 Inclusion health and vulnerable groups

People experiencing homelessness

People experiencing homelessness have far worse health and social care outcomes than the general population. The average age of death for the homeless population is around 30 years lower than for the general population[3]. Homeless people aged 16-24 have twice the chance of dying as the general population; those aged 25-34 four times; those aged 35-44 five times; those aged 45-54 three times; and those aged 55-64 one and a half times the national risk[28].

People experiencing homelessness often experience severe and multiple disadvantage and unmet health and social care needs that may be contributing factors for becoming homeless as well as consequences of homelessness. As well as the experience of homelessness, other disadvantages that are likely to be present include harmful drug or alcohol use, criminal justice involvement, poor mental health, and domestic violence and abuse. People experiencing severe and multiple disadvantages have often experienced underlying adverse childhood experiences, poverty, psychological trauma, stigma and discrimination. People with these experiences may have had sporadic and inconsistent contact with services or been serially excluded from services. People who experience severe and multiple disadvantages tend to have much poorer physical and mental health, have higher social care needs, and die at a much younger age than people without severe and multiple disadvantage[3]. A report by the Centre for Homelessness Impact found more than a quarter of people experiencing homelessness in England had been in care at some point in their lives[29].

The rate of homelessness in 2022/23 in Leicestershire (6.8 per 1,000 population) was significantly better (lower) than the England rate (12.4 per 1,000 population) The rate in 2022/23 has decreased from 2019/20 when the rate was 7.7 per 1,000 population. There were 2105 people owed a duty under the Homeless Reduction Act in Leicestershire in 2022/23[30]. Melton had the highest rate out of all the districts in the same period (14.6 per 1,000 population) and Harborough had the lowest (6.3 per 1,000 population)[31].

Victims of modern slavery

Modern slavery is a term that includes any form of human trafficking, slavery, servitude or forced labour, as set out in the Modern Slavery Act 2015. Although the evidence base on the health consequences of modern slavery is not substantial or comprehensive, a range of serious physical and mental health consequences of modern slavery were documented across a range of settings. Health implications depended on the nature, duration and severity of abuse. An updated systematic review reported trafficked men, women and children had high exposure to violence and significant physical health symptoms such as headaches, stomach pain and back pain and mental health problems such as depression, anxiety and post-traumatic stress disorder (PTSD). Sex trafficking resulted in high prevalence of sexually transmitted infections and PTSD associated with sexual violence. Modern slavery victims experienced high levels of unmet health needs and poor access to health services. Studies suggested mistrust in health services because of stigma, fear of law enforcement and experiences of discrimination[32].

Research in 2019 looking at health inequalities and equity challenges for victims of modern slavery found that survivors experienced repeated challenges accessing healthcare, for themselves and their children, and initially could not access GP services. This improved when accompanied by an advocate[33].

In 2021, 154 referrals for investigation into potential modern slavery offences were made to Leicester, Leicestershire and Rutland Constabulary.

Nationally, the number of victims referred to the National Referral Mechanism in 2021 was 12,727. Of those referred, 75% were male and 25% female. The most common nationality for those referred was UK nationals (31%) followed by Albanian (20%) and Vietnamese (8%)[34]. In 2021, 154 referrals for investigation into potential modern slavery offences were made to Leicester, Leicestershire and Rutland Constabulary. Of these referrals, 93 were for adults over 18, 49 for children 17 years or under and 12 were of an unspecified or unknown age[35].

Sex workers

Street sex workers are a highly marginalised and stigmatised group who carry an extremely high burden of unmet health need. They experience multiple and interdependent health and social problems and extreme health and social inequality. They frequently experience poor mental health, particularly anxiety, depression, isolation, post-traumatic stress disorder, self-harm, and suicide[36]. Research with both street and off-street sex workers found violence, anxiety and depression linked to poverty, unstable housing and police enforcement. Street based sex workers experienced greater inequalities compared with off street for violence, homelessness and law enforcement[37, 38].

There are 40,800 estimated sex workers outside of London[38]. Figures for Leicestershire are unknown.

Vulnerable migrants

The Race Equality Council found some barriers to health care arising from restricted entitlement for some vulnerable migrants[39]. Research into the health needs of asylum seekers and refugees show they have differing experiences of health and of health care. One in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression. Symptoms of psychological distress are common in this population, but do not necessarily signify a mental illness[40].

There have been 156 asylum resettlements between 2014 and the end of 2023 in Leicestershire[41] and, as of June 2024, there were 215 people seeking asylum living in the County[42].

Looked after children and care experienced people

A longitudinal study tracking adults who spent time in care as children between 1971 and 2001 in England and Wales found that care experienced people were 70% more likely to die prematurely than those who did not. The extra risk of premature death rose for care leavers from 40% in 1971 to 360% in 2011. Care leavers are also more likely to experience an unnatural death (suicide, violent death, accident). The same study found that adults who lived in residential care during childhood were between 3 and 4 times more likely to report their health as 'not good' compared with 'good'[43].

Care experienced children and young people have consistently been found to have much higher rates of mental health difficulties than the general population, including a significant proportion who have more than one condition. They are approximately four times more likely to have a mental disorder than children living in their birth families. Almost half (rising to three quarters in residential homes) meet the criteria for a psychiatric compared to 10% of general population[44].

Measures of the emotional and behavioural health of looked after children using the Strengths and Difficulties Questionnaire (SDQ) found that 37% had scores considered a cause for concern, compared to 12% of children in the general population. A survey of care leavers found that 46% identified as having mental health needs, with 65% not receiving any form of statutory support and further research identifies care leaves as between four and five times more likely than their peers to attempt suicide[44].

On 31st March 2023 there were 681 looked after children in Leicestershire[45]. It is not known how many care experienced adults live within Leicestershire.

Carers

The Census 2021 provides some data on the rates of caring in England and Wales and in Leicestershire. The rates of caring have been age standardised to take into account some areas having larger older populations that may require more care.

Across England and Wales, the age-standardised proportion of usual residents aged 5 years and over who provided any amount of unpaid care decreased from 11.4% in 2011 to 9.0% in 2021. It should be noted that there were some changes to the wording between the 2011 Census and 2021 Census which may have had an impact on the number of people who self-reported as unpaid carers.

Table 1 – Age adjusted rates of carers by district

District	50 or more hours unpaid care a week	20-49 hours unpaid care a week	19 or less hours unpaid care a week
Blaby	2.5%	1.8%	5.0%
Charnwood	2.5%	1.6%	4.8%
Harborough	2.0%	1.4%	4.9%
Hinckley and Bosworth	2.6%	1.6 %	5.0%
Melton	2.4%	1.5%	4.7%
North West Leicestershire	2.7%	1.7%	4.7%
Oadby and Wigston	2.7%	2.0%	5.1%

Source: Office for National Statistics, Unpaid care, England and Wales: Census 2021

A report by Carers UK[4] using data from the 2021 GP Patient Survey looked closer at the health of carers compared to non-carers. The key findings from the survey relating to inequality are presented below (Figure 6). 18% of the 850,000 respondents have some unpaid care responsibilities.

Figure 4 – Summary of health inequalities experienced by carers

Long-term conditions disability and illness	Mental Health	Social Isolation
• **60% of carers stated they had a long-term condition,** disability or illness compared to **50% of those who weren't caring.** The most likely were arthritis, back or joint problems and high blood pressure. • **69% of those providing 50 hours or more** reported having a long-term condition compared to **58% providing less than 35 hours** • **Older and retired carers were also most likely to report having a long-term condition,** 79% and 76% respectively	• **27% of carers not in work** declared they had a mental health condition compared to **12% of working carers and 5% of retired carers** • **26% of carers under the age of 25** had a mental health condition, compared to **5% of carers over 65** • **36% of lesbian, gay and bisexual carers** had a mental health condition compared to **13% of heterosexual carers**	• **18% of carers reported feeling isolated** compared to 14% of those who weren't caring • **Feeling isolated increased during COVID-10,** from 8% in 2019, 9% in 2020 qne 18% in 2021 • **32% of carrs aged under 25** reported feeling isolated over the last 12 months, **compared to 12% over 65**

Source: Carers UK, Carer's health and experiences of primary care. Data from the 2021 GP Patient Survey

Carers over the age of 55 in England have significantly lower levels of physical activity (14%) than all adults (54%). 46% of Carers are inactive, compared to 30% of all adults. The greatest barriers were limited time, lack of motivation, affordability and not having anyone to go with. 76% of Carers do not feel that they can do as much physical activity as they'd like to do and this is highest in Carers who are disabled, lonely or struggling financially[46].

76% of Carers do not feel that they can do as much physical activity as they'd like to do and this is highest in Carers who are disabled, lonely or struggling financially

A review of evidence by the National Institute for Health and Care Research found that caring can have a serious financial impact with many needing to give up or reduce their employment, rely on charities for basic necessities and pay for expensive services or equipment to support their loved one with 1 in 5 carers worried about being able to cope financially. The review suggests online resources (due to difficulties in people attending in person), support for daily tasks such as managing medication, supporting carers into work through initiatives such as flexible working hours for example and active engagement with carers (e.g. when they attend clinical appointments, often with the person they care for) can all help to improve the health of carers[47].

People in or leaving prison

Evidence from the Revolving Doors Agency, the Home Office and Public Health England identifies the mortality rate for prisoners is 50% higher than the rest of the population. People in and out of the criminal justice system are four times more likely to be smokers. 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population. 42% of men and women in prison and 17.3% on probation suffered from depression, compared to just over 10% of the rest of the population. Further, it is broadly recognised that many prisoners have the biological characteristics of those who are 10 years older than them[48].

People who have experienced trauma

Adverse childhood experiences (ACEs) are stressful or traumatic events that occur during childhood or adolescence. In England, a household survey found that nearly half of adults (aged 18 to 69) had experienced at least one ACE, including childhood sexual, physical, or verbal abuse, as well as household domestic violence and abuse (DVA) with 9% experiencing four or more ACEs. DVA is considered to be a chronic and cumulative cause of complex trauma. Up to 29% of women and 13% of men have experienced DVA in their lifetime, at a cost of £14 billion a year to the UK economy[49].

A study on trauma informed care in the UK finds that patients with four or more ACEs were at higher risk of a range of poorer health outcomes including cardiovascular disease and mental ill health, versus those with no ACEs history. Adults who had experienced four ACEs were twice as likely to attend their GP repeatedly compared to those with no ACEs history and incidence of health service use rose as the ACEs experiences increased. 47% of patients in mental health services had experienced physical abuse and 37% had experienced sexual abuse[49].

Leicestershire Police recorded a rate of 23.1 per 1,000 for domestic abuse related incidents and crimes in 2020/21 in Leicestershire. This was below the England value of 30.3[50]. Estimates for the number of survivors of sexual abuse in Leicestershire suggest 14,728 male survivors and 34,048 female survivors aged 18-64 in 2020[51]. If the rate of 9% found in the UK survey were applied to the Leicestershire population aged 18 to 69, this would equate to 51,330 people.

People experiencing Severe Mental Illness (SMI)

The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI.

Public Health England carried out research and analysis into severe mental illness and physical health inequalities in 2018[52]. The results summarised in a briefing, highlight some important aspects of health inequalities faced by this population.

People with SMI are at a greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI in England:

- die on average 15 to 20 years earlier than the general population
- have 3.7 times higher death rate for ages under 75 than the general population
- experience a widening gap in death rates over time

It is estimated that for people with SMI, two in three deaths are from physical illnesses that can be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.

Compared to the general population, people aged under-75 in contact with mental health services in England have death rates that are:

- 5 times higher for liver disease
- 4.7 times higher for respiratory disease
- 3.3 times higher for cardiovascular disease
- 2 times higher for cancer

It is estimated that for people with SMI, two in three deaths are from physical illnesses that can be prevented.

At the same time, the difference between the death rate in people under 75 years of age in contact with mental health services and the general population is:

- 84 more deaths per 100,000 population in adults with SMI for liver disease
- 147 more deaths per 100,000 population in adults with SMI for respiratory disease
- 198 more deaths per 100,000 population in adults with SMI for cardiovascular disease
- 142 more deaths per 100,000 population in adults with SMI for cancer

Reducing the difference in the premature death rate from each of the conditions will address health inequality experienced by the population with SMI. However, action to address cardiovascular disease mortality has the potential to impact on most people.

In addition to chronic physical health conditions, suicide is also an important cause of death in the SMI population. Suicide risk in people with SMI is high following acute psychotic episodes and psychiatric hospitalisation. It peaks during psychiatric hospital admission and shortly after discharge. Other causes of death include substance abuse, Parkinson's disease, accidents, dementia (including Alzheimer's disease), and infections and respiratory acute conditions (particularly pneumonia).

Using analysis of GP data, the Health Improvement Network (THIN) was able to demonstrate that patients living in more deprived areas had a higher prevalence SMI and that SMI patients living in more deprived areas have a higher prevalence of physical health conditions. The analysis also found differences in age groups with the highest health inequality in ages 15 to 34 for asthma, diabetes, hypertension and obesity[52].

4.3 Protected characteristics in the Equality Duty

It should be noted that marriage and civil partnerships and religion or belief are not covered in this report due to the lack of evidence of health inequalities resulting from these protected characteristics.

Age

Most studies on health inequalities for different age groups focus on many of the issues covered by this report chapter including socio economic factors, health behaviours, vulnerable groups and protected characteristics and how these affect people of different ages.

Case studies explored by the Local Government Association focussing on health inequalities for children provide some key statistics including one in four children living with obesity by the end of primary school, up from 1 in 5 before the pandemic and one in six young people having a diagnosable mental health disorder, up from 1 in 9 in 2017[53]. A further report specifically focussing on mental health identifies that emotional disorders, particularly anxiety and depression are on the rise for young people[54].

The Association for Young People's Health (AYPH) has drawn together publicly available data on inequalities in health outcomes for 10 to 24 year-olds. It identifies data and groups to display drivers of inequalities, levers for action and inequalities in health outcomes. Headline issues include one in five secondary school children being eligible for free school meals, England's richest areas having twice as many youth services than the poorest and, for 2021, there being a 16.6% gap between obesity rates in 10–11-year-olds in the most and least deprived areas[55].

When it comes to older age, the Centre for Ageing Better report into inequalities in later life highlights inequalities can be the produce of cumulative advantage or disadvantage over time. People born at a similar point in time may have very different outcomes in later life due to experiences over the life course[56]. The State of Ageing report 2022 highlights a sharp increase in pensioner poverty, meaning that almost 1 in 5 pensioners were living in poverty in the 2019/20 period. There has also been a decline in employment rates among people approaching retirement age and the number of older people renting rather than owning their own homes has reached an all-time high. There is a steady increase in the number of people in mid and later life who live alone[57].

Office for National Statistics population estimates for mid-2020 show that, compared with England, the population of Leicestershire is older, with higher proportions of the population aged 40-64 (32.9% in the county compared with 31.7% in England) and 65 and over (20.6% compared with 18.5% for England). There were 119,567 children under the age of 15 in Leicestershire in 2020 (16.8% of the population)[58].

Race

In England, there are health inequalities between ethnic minority and white groups, and between different ethnic minority groups. The picture is complex, both between different ethnic groups and across different conditions.

Access to primary care health services is generally equitable for ethnic minority groups, but this is less consistently so across other health services. However, people from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts.

Before the COVID-19 pandemic, life expectancy at birth was higher among ethnic minority groups than the White and Mixed groups. The headline figures conceal significant differences between ethnic groups, for example:

- people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators
- compared with the white population, disability-free life expectancy is estimated to be lower among several ethnic minority groups
- rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups
- mortality from cancer, and dementia and Alzheimer's disease, is highest among white groups

The COVID-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population. Unpicking the causes of ethnic inequalities in health is difficult. Available evidence suggests a complex interplay of deprivation, environmental, physiological, health-related behaviours and the 'healthy migrant effect'. Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status in all communities, but it is not clear if the relationship applies equally across all ethnic groups[5].

An Equality and Human Rights Commission report focussing on Gypsy and Travellers identifies life expectancy for Gypsy and Travellers as 10 years lower than the national average. The report also found that Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child[59]. In 2011, 14.1% of Gypsy and Irish Traveller people in England and Wales rated their health as bad or very bad, compared with 5.6% on average for all ethnic groups[60]. Further research evidences 14% of Gypsy and Traveller people describing their health as 'bad' or 'very bad', more than twice as high as the White British group. 42% of Gypsy and Traveller people are affected by a long term condition, as opposed to 18% of the general population[61]. A Parliamentary report[62] into the inequalities faced by Gypsy, Roma and Traveller communities reports 42% of this population affected by a long-term condition, as opposed to 18% of the general population. It also reports that one in five Gypsy or Traveller mothers will experience the loss of a child, compared to one in a hundred in the non-Traveller community.

In Leicester, Leicestershire and Rutland, analysis of data across a range of clinical areas at University Hospitals of Leicester looking at rates of people not attending arranged appointments, discharged after the first appointment and on waiting lists for treatment show higher rates across all of these measures for non-white ethnic groups and particularly high rates across many areas for people of Black ethnicity.

In Leicestershire, the majority of the population is White (91%) which is slightly higher than the figure for the East Midlands (89%) and England (85%). The next largest group in Leicestershire is Asian (6.3%) followed by Mixed or Multiple Ethnic Group (1.7%) and Black ethnic group (0.6%)[63,64].

The Kings Fund long read examining the health of people from ethnic minority groups in England (as summarised above) presents a number of key messages, summarising overall that the picture is complex both between different ethnic groups and across different conditions. However, the report does state that people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators. When we look at where people from these ethnic groups live in higher numbers in Leicestershire, we can see that:

- The Census 2021[64] identifies Lutterworth MSOA has the highest proportion of people identifying as Gypsy or Irish Travellers (1.4%) in Harborough district. This is followed by Stoney Stanton, Sapcote & Sharnford MSOA (0.4%) in Hinckley and Bosworth district. However, it should be noted that the Multi Agency Travellers Unit (MATU) locally reports concerns with the census data which doesn't compare to local data on the number of travellers living on local sites. The MATU estimate the local traveller population to be between 0.2 and 0.4% of the local population, resulting in a range of 1,425 to 2,850 people (higher than the 0.1% identified in the census). The MATU reports larger traveller sites being situated in the districts of Blaby, Harborough, Hinckley and Bosworth and North West Leicestershire. Larger populations in housing in Leicestershire are located in Charnwood district.
- Loughborough Lemyngton and Hastings MSOA has the highest proportion of Bangladeshi people in Leicestershire (13.7%). This is followed by Loughborough Shelthorpe and Woodthorpe (2.2%). Both of these MSOAs are in the Charnwood district.
- Oadby East MSOA has the highest proportion of Pakistani people in Leicestershire (8%) of the population. This is followed by Oadby South and West (6.7%), Oadby North (6.6%) and Wigston North (4%). All of these MSOAs are in Oadby and Wigston district[64].

Data released in 2023 from the Office for National Statistics[65] shows Asian Pakistani and Asian Bangladeshi people have the lowest median income of all ethnic groups in England (although the Gypsy Irish Traveller population are not specifically identified).

Sex

Much of the research into health inequalities by sex focusses on inequalities experienced by women. Many also highlight the intersectionality of factors such as poverty or ethnicity alongside sex. A study on behalf of the British Medical Association into health inequalities experienced by women highlights that although women live longer than men on average, women are estimated to spend a lesser proportion (76.0%) of their lives free from disability compared with males (79.5%). There is evidence that poorer, migrant women suffer the worst health of all and there are differences in health outcomes between ethnic groups for women[66].

The Women's Health Strategy for England was put before Parliament in August 2022 by the then Secretary of State for Health and Social Care[67]. This identified priority areas of:

- Menstrual health and gynaecological conditions
- Fertility, pregnancy, pregnancy loss and postnatal support
- Menopause
- Mental health and Wellbeing
- Cancers
- Health impacts of violence against women and girls
- Healthy ageing and long-term conditions

Sexual orientation and gender reassignment

The evidence that LGBT people have disproportionally worse health outcomes and experiences of healthcare is both compelling and consistent. With pretty much every measure we look at LGBT individuals fare worse than others[68].

A national survey of LGBT people by the Government in 2017 found that at least 16% who accessed or tried to access public health services had a negative experience because of their sexual orientation, and that at least 38% had a negative experience because of their gender identity[69]. Discrimination is not always overt but can instead exist in more subtle forms such as a heteronormative bias and a lack of LGBT representation in service promotion leaflets or assumptions that patients are heterosexual unless stated otherwise[70].

International studies have found the life expectancy of gay men to be up to 20 years less than their heterosexual counterparts, but most of this was attributable to HIV and subsequent work has suggested that the gap in life expectancy due to HIV is reduced substantially by treatment. However, more recent work in Denmark found that, despite the positive impact of same-sex marriage, individuals in same-sex relationships had a significantly higher mortality rate than the general population[71].

Based on the experiences of more than 800 trans and non-binary people, a 2018 study by Stonewall looked at the discrimination trans people face on a daily basis in the UK. When accessing general healthcare services in the last year, two in five trans people (41%) said healthcare staff lacked understanding of specific trans health needs. 7% of this cohort said they have been refused care because they are LGBT[72].

The census 2021 showed 89.4% of the population aged 16 years and above in England identified as straight or heterosexual, 1.5% identified as gay or lesbian. A further 1.3% identified as bisexual and 0.3% as any other sexual orientation[73].

In Leicestershire, the MSOAs with the highest proportion of people aged 16 year and over who identify as lesbian, gay, bisexual or other are:

- Loughborough Storer and Queens Park (5.55%)
- Loughborough University (5.55%)
- Loughborough Lemyngton and Hastings (4.81%)

The census 2021[74] showed 0.55% of the population aged 16 years and over reported their gender identify was different from their sex at birth. In Leicestershire, the MSOAs with the highest proportion of people identifying with a different gender from birth are:

- Coalville (0.81%)
- Hinckley Central (0.80%)
- Loughborough Lemyngton & Hastings (0.72%)
- Loughborough Storer & Queens Park (0.62%)

When accessing general healthcare services in the last year, two in five trans people (41%) said healthcare staff lacked understanding of specific trans health needs.

Disability

The census 2021 provides an insight into the outcomes for disabled people in the UK[75]. The impact of inequality experienced by people with a disability are clear to see from the insight this provides. Key points include:

- One-quarter (24.9%) of disabled people aged 21 to 64 years in the UK had a degree as their highest qualification compared with 42.7% of non-disabled people; 13.3% of disabled people had no qualifications compared with 4.6% of non-disabled people.
- Around half of disabled people aged 16 to 64 years (53.5%) in the UK were in employment compared with around 8 in 10 (81.6%) for non-disabled people (July to September 2021); disabled people with severe or specific learning difficulties, autism and mental illness had the lowest employment rates.
- Nearly 1 in 4 (24.9%) disabled people aged 16 to 64 years in the UK rented social housing compared with fewer than 1 in 10 (7.9%) non-disabled people; they were also less likely to own their own home (39.7%) and less likely to live with parents (16.4%) than non-disabled people (53.3% and 19.2% respectively).
- Disabled people aged 16 to 64 years had poorer ratings than non-disabled people on all four personal well-being measures; average anxiety levels were higher for disabled people at 4.6 out of 10, compared with 3.0 out of 10 for non-disabled people.
- The proportion of disabled people (15.1%) aged 16 years and over in England who reported feeling lonely "often or always" was over four times that of non-disabled people (3.6%).

Census data for Leicestershire districts show disability rates for each of the districts as displayed in the table below:

Table 2 – Age adjusted rates of people with a disability by district

District	Disabled under the Equality Act: day to day activities limited a lot	Disabled under the Equality Act: Day to day activities limited a little
Blaby	6.1%	9.6%
Charnwood	6.4%	10.2%
Harborough	5.1%	9.3%
Hinckley and Bosworth	6.5%	10.5%
Melton	5.7%	10.3%
North West Leicestershire	6.8%	10.6%
Oadby and Wigston	6.5%	10.1%

Source: Office for National Statistics, Census 2021, Census maps

It is worth noting that whilst Severe Mental Illness (SMI) is detailed as a specific population group above, people with an SMI are often considered to have a disability.

Learning disability and autism

The Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR programme) nationally reports that the median age of death for people with a learning disability in 2021 was 62. The median age of death for the general population in England in 2018-20 was 82.7[2]. The Local LeDeR programme in Leicester, Leicestershire and Rutland in 2022 reports a similarly poor life expectancy of 64 years[76]. This compares to a Leicestershire 2020 one year range for the general population of 79.9 years for men and 83.7 years for women[77].

The national LeDeR programme also identifies that 6 out of 10 people with a learning disability died before they were 65. This compares to around 1 in 10 of the general population. 49% of deaths were classified as avoidable for people with a learning disability, compared to 22% for the general population. The greatest causes of avoidable deaths in those with a learning disability were cancer (8%), hypertension (14%), diabetes (17%) and respiratory (17%) conditions.

The report highlights that over 50% of people with a learning disability died in areas rated as some of the most deprived (25% fell into the 20% most deprived, rising to 50% of people living in the 40% most deprived areas). People of Black, Black British, African or Caribbean, mixed ethnic group and Asian or Asian British ethnicity died at a younger age in comparison to people of White ethnicity[2].

The National Institute for Health and Care Excellence (NICE) identify that people with a learning disability are 3 to 4 times more likely to die from an avoidable medical cause of death. Most of the avoidable deaths in people with a learning disability were because timely and effective treatment was not given[78]. The report highlights the importance of annual health checks, cancer screening and advice and health action plans for people with a learning disability in order to reduce health inequalities and the impact these are having.

Mencap provide a summary of research findings into health inequalities for people with a learning disability, highlighting 38% of people with a learning disability died from an avoidable cause, compared to 9% in the general population[79].

The Office for Health Improvement and Disparities (OHID) have produced a set of summaries[80] of specific health inequalities experienced by people with learning disabilities covering a range of issues from physical activity to cardiovascular disease and cancer screening. The summaries provide evidence on prevalence and risk factors, the impact on people with a learning disability, healthcare and treatment, social determinants and signposting to resources.

GP records in April 2023 show 2,680 people registered with a learning disability with practices that are based in Leicestershire. These records also show that 5.5% of patients on the learning disability register lived in IMD 20% most deprived areas of Leicestershire which compares to 3.2% of the non-learning disability population. Across Leicester, Leicestershire and Rutland, people with a learning disability are four times more likely to have 5 or more chronic conditions (39.2%) than people without a learning disability (9.7%)[81].

A report into the determinants of health inequalities experienced by children with learning disabilities concluded these children were more likely to live in households characterised by low socio-economic position and poverty, more likely to be exposed to a wide range of material and psychosocial hazards (e.g. inadequate nutrition, poor housing, family, peer and community violence and poor parenting and family instability). They were also less likely to have access to the resources necessary to build resilience in the face of adversity[82].

In the academic year 2023/24, there were 13,983 children with Special Educational Need (SEN) support and 5,170 children with an Education, Health and Care Plan (EHCP) or statement in Leicestershire[83].

Research[84] using self-reported data from people with autism identified lower quality healthcare for people with autism than non-autistic adults, including poorer access to healthcare and poorer communication amongst other factors. Autistic adults were also more likely to have chronic health conditions than non-autistic adults.

The National Strategy for Autistic Children, Young People and Adults[815] states that autistic people die on average 16 years earlier than the general population[86] Reasons for this include poor professional understanding of autism amongst health and care staff, and a lack of adjustments needed for autistic people to engage in medical appointments, leading to avoidance of seeking medical attention or losing out of support.

The National Strategy[85] estimates there are 700,000 autistic adults in the UK with the National Autistic Society estimating the proportion of the UK population that have autism at 1.1%[87]. Applying this 1.1% rate to the population of Leicestershire would result in 7,836 autistic people.

Pregnancy and maternity

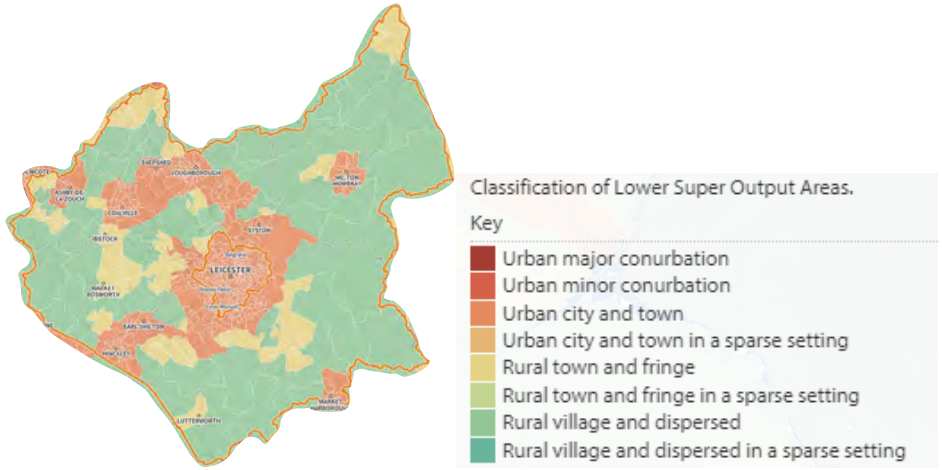
Inequalities in pregnancy and maternity are often linked to deprivation and ethnicity. The lowest rates of neonatal deaths occur for White British babies in the least deprived areas, the highest rates are for Pakistani babies in areas of higher deprivation[88]. There is a gap between the mortality rates for women from Black, Asian, Mixed and White ethnic groups, with women from Black ethnic groups four times more likely to die than women from White groups. Women from Asian ethnic backgrounds are almost twice as likely to die in pregnancy compared to White women. Women living in the most deprived areas are twice as likely to die than those in the most affluent areas[89]. Gypsy and Traveller mothers are 20 times more likely than the rest of the population to have experienced the death of a child[59].

4.4 Geography

Health inequalities can also occur across different geographies and be influenced or driven by the issues presented by both rural and urban areas. Living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London for example, to the extent that life expectancy is nearly five years or less[5].

While the county is rural in terms of area, the population is concentrated within urban areas. Overall, 69 percent of the population of Leicestershire live in areas classed as Urban City and Town, while 19 percent live in area classed as Rural Town and Fringe and the remaining 12 percent live in areas classed as Rural Village and Dispersed (Figure 5)[15].

Figure 5 – Rural/urban classification of LSOAs in Leicestershire



Source: Office for Health Improvement and Disparities, SHAPE Atlas. 2011

Urban risk

Eight out of ten people in the UK currently live in cities or towns. Where we grow up, live and work hugely influences our health. In urban areas, we see the best and worst health outcomes, often just roads away from each other[90].

In Leicestershire, the work on mapping neighbourhood level areas at greater risk of health inequalities has identified these as urban areas. It is also urban areas that come up in mapping of deprivation, a key risk factor in health inequalities.

Rural risk

Nineteen per cent of the population of England live in rural areas which make up 85 per cent of the land. Overall, health outcomes are more favourable in rural areas than in urban areas. But broad brush indicators can mask small pockets of significant deprivation and poor health outcomes. Rural communities are increasingly older and issues of access to health and care services, travelling and transport uses and lack of community support in some areas contribute to pressures on local government and the NHS[91].

In Leicestershire, 18 LSOAs fall into the most deprived 10% in England for the Index of Multiple Deprivation Domain of Barriers to Housing and Services which may help to highlight areas of higher risk in terms of access in particular. However, it is worth noting that 14 of these LSOAs fall into the 20% least deprived in England and 4 of them in the 40% least deprived for income, suggesting they may have the means to pay for travel to access services as needed[92].

4.5 Intersectionality

Intersectionality is a way of thinking about how multiple identities together shape how a person experiences oppression or privilege[3]. It means that if someone falls into more than one at risk group, their risk increases e.g. someone who is a carer and who lives in an area of high deprivation would have a higher risk of experiencing health inequalities than someone who fell into only one of these groups.

Ideally this report would build a picture of where people in Leicestershire fall into more than one at risk group. However, much of the data on population groups in particular is not available at a neighbourhood level and a national or Leicestershire level is too broad to map where intersectionality may be occurring.

5 Level of need in Leicestershire

Life expectancy and healthy life expectancy are two key measures that help to identify where health inequalities exist. Indicators on inequality in life expectancy and healthy life expectancy identify the difference in the results for people in areas of highest deprivation and those in the areas of least deprivation using a national approach to grading known as the slope index of inequality[93].

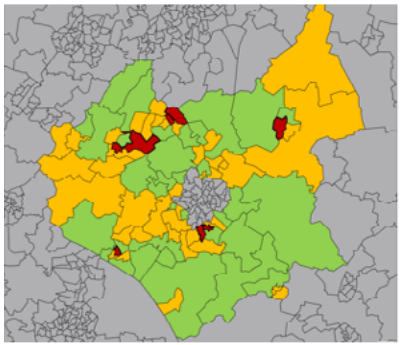
5.1 Life expectancy

Life expectancy at birth is significantly better (higher) than England for both men and women in Leicestershire at 80.5 and 84.1 years respectively when looking at the 3 year range data 2018 to 2020. Life expectancy at age 65 is also significantly better (higher) for women in Leicestershire and is similar to England for men in the 1 year data range in 2020[94].

Across the districts, life expectancy is either significantly better (higher) than or similar to England on all indicators[94].

However, when life expectancy data is viewed at MSOA level for 2016-20, we can see there are 11 areas where life expectancy is significantly worse (lower) than England for males and/or females. These areas cover parts of Charnwood, Hinckley and Bosworth, Melton, North West Leicestershire and Oadby and Wigston[94] (Figure 6 & Figure 7).

Figure 6 – Life expectancy at birth (upper age band 90 and over) (male, 3 year range) 2016-20 by MSOAs in Leicestershire

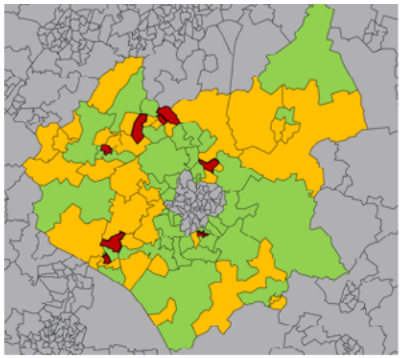


MSOAs significantly worse than England (79.4)		
MSOA name	Count	Value
Melton Mowbray West	-	77.7
Hinckley Central	-	77.0
South Wigston	-	76.9
Coalville	-	76.4
Agar Nook (NW)	-	76.1
Loughborough Lemyngton & Hastings	-	75.4
Wigston Town	-	75.4
Loughborough Storer & Queen's Park	-	74.9

Better 95% | Similar | Worse 95% | Not compared

Source: Office for Health Improvement and Disparities, Fingertips, 2016 - 2020

Figure 7 – Life expectancy at birth (upper age band 90 and over) (female, 3 year range) 2016-20 by MSOAs in Leicestershire



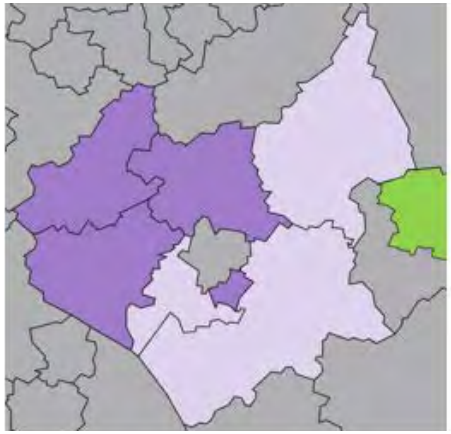
MSOAs significantly worse than England (83.1)		
MSOA name	Count	Value
Barwell	-	81.2
Syston West	-	80.9
Loughborough Storer & Queen's Park	-	80.7
Shepshed East	-	80.1
Wigston Town	-	79.5
Hinckley Central	-	79.3
Loughborough Lemyngton & Hastings	-	79.1
Coalville	-	77.6

Better 95% | Similar | Worse 95% | Not compared

Source: Office for Health Improvement and Disparities, Fingertips, 2016 - 2020

Life expectancy at birth is calculated for each deprivation decile of lower layer super output areas for each area. This allows for a slope index of inequality to be calculated which represents the range in years of life expectancy from the most to least deprived area, allowing for a calculation of the difference (or inequality) in life expectancy. Inequality in life expectancy is felt to a lesser extent on the East of the county (dark purple) than on the West (light purple), except for Oadby and Wigston in the South. Inequality in life expectancy at birth is noticeably wider for women in Charnwood[95] (Figure 8 & Figure 9).

Figure 8 – Inequality in life expectancy at birth (male) 2018-20, by districts in Leicestershire

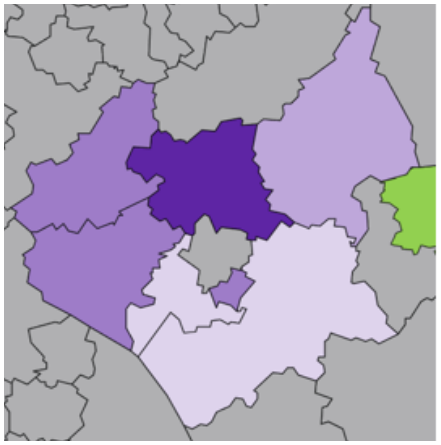


Area	Count	Value	Lower CI	Upper CI
North West Leicestershire	-	8.3	6.1	10.4
Oadby and Wigston	-	8.3	4.5	12.0
Charnwood	-	7.1	5.4	8.8
Hinckley and Bosworth	-	7.0	4.9	9.2
Melton	-	4.0	0.4	7.7
Harborough	-	2.3	-0.2	4.8
Blaby	-	1.7	-0.5	3.9

Quintiles: Best ○ ○ ○ ○ ● Worst ○ Not applicable

Source: Office for Health Improvement and Disparities, Fingertips, 2018 - 2020

Figure 9 – Inequality in life expectancy at birth (female) 2018-20, by districts in Leicestershire



Area	Count	Value	Lower CI	Upper CI
Charnwood	-	9.2	7.3	11.1
Hinckley and Bosworth	-	7.0	4.2	9.9
North West Leicestershire	-	5.9	3.7	8.2
Oadby and Wigston	-	5.8	2.2	9.4
Melton	-	4.1	0.8	7.4
Harborough	-	-1.4	-4.1	1.3
Blaby	-	-1.4	-3.3	0.6

Quintiles: Best ○ ○ ○ ○ ● Worst ○ Not applicable

Source: Office for Health Improvement and Disparities, Fingertips, 2018 – 2020

5.2 Under 75 mortality (Premature Mortality)

Leicestershire performs significantly better (lower) than England on under 75 mortality ratios from all causes. There are many indicators available to show the causes of under 75 death and Leicestershire performs either significantly better (lower) or similar to all measures with the exception of excess under 75 mortality rate in adults with severe mental illness (SMI) and excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) which are both significantly worse (higher) than England[96].

At a district level, again, performance is similar to or better (lower) than England on the indicators available with three exceptions:

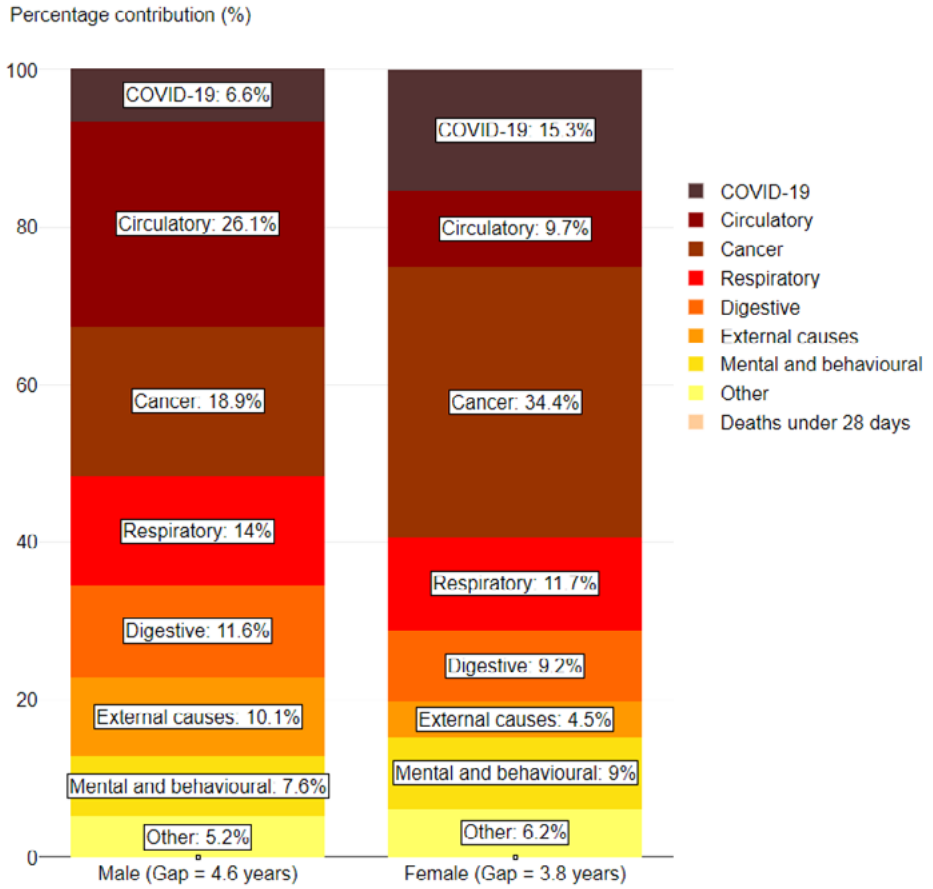
- Under 75 mortality rate from colorectal cancer (persons, 3 year range) 2017-19 for Blaby and Oadby and Wigston,
- Under 75 mortality rate from colorectal cancer (male, 3 year range) 2017-19 for Blaby and Oadby and Wigston
- Under 75 mortality rate from cancer considered preventable (2019 definition) (female, 3 year range) 2020 in Blaby[96].

At an MSOA level there is more variation in performance with 7 MSOA's having significantly worse (higher) under 75 mortality ratios than England[96].

5.3 Health conditions

The Segment tool[97] provides an overview of the causes of death and the leading difference in cause between the most and least deprived quintiles in Leicestershire (Figure 10). This identifies circulatory in men (26.1%) and cancer in women (34.4%) as the biggest difference in cause of death between the most and least deprived quintiles in Leicestershire.

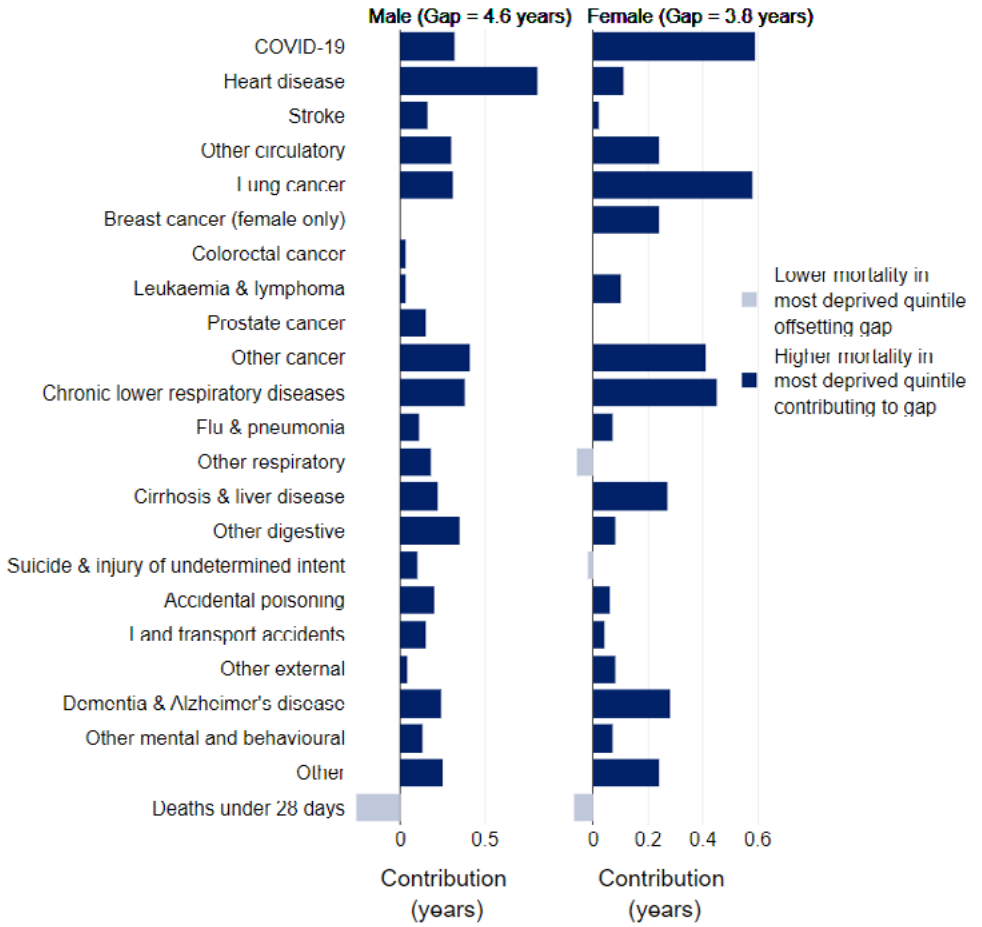
Figure 10 – Life expectancy gap between the most and least deprived quintiles of Leicestershire by cause of death 2020 to 2021



Source: Office for Health Improvement and Disparities, Segment tool, 2020 - 2021

It is possible to drill down into more detail behind these headlines (Figure 11) revealing heart disease as particularly high for men followed by other circulatory and stroke as circulatory causes and lung cancer as a particularly high cancer rate for women, followed by other cancers, breast and leukaemia and lymphoma. When cancers aren't grouped, COVID 19 becomes the biggest difference for women.

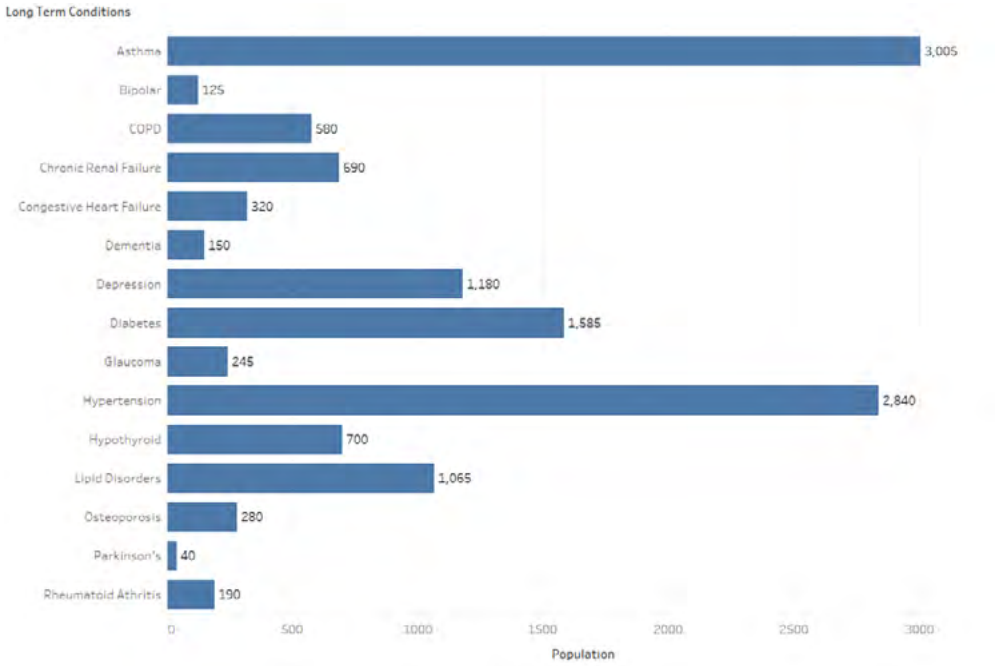
Figure 11 – Breakdown of the life expectancy gap between the most and least deprived quintiles of Leicestershire by cause of death, 2020 to 2021



Source: Office for Health Improvement and Disparities, Segment tool, 2020 - 2021

It is possible to view population level data about certain patient groups in Leicestershire held through GP records, accessed through the Aristotle system. For people living in the most deprived 20% LSOAs and registered with GPs based in Leicestershire, the most common long term conditions are Asthma (3,005 people) and hypertension (2,840 people) (Figure 12)[98].

Figure 12 – Long term conditions for the 20% most deprived in Leicestershire



Source: Midlands and Lancashire Commissioning Support Unit, Aristotle

When we consider the 15 MSOAs of higher risk we can look at other measures for those neighbourhoods using the OHID Local Health tool77. Whilst data is limited at this MSOA level, it does provide some early flags for further investigation. It should also be noted that these provide a snapshot at whichever date the measure relates to. A review of performance over a longer period should be carried out as part of any further work to see whether the issue is persistent. Data on emergency hospital admission rates99 for key conditions in the MSOAs identified as high risk. Whilst this doesn't mean that prevalence for that condition is necessarily high (it may be that it's poorly managed more frequently in those MSOAs, resulting in higher admission rates for example), it does help to provide some information on the conditions people are experiencing in those MSOAs. A summary is provided below:

- 9 MSOAs have significantly higher rates of emergency admissions for stroke than England, with the highest rate at 198.8 (almost twice the rate of England at 100)

- 12 MSOAs have significantly higher rates of emergency admissions for Chronic Obstructive Pulmonary Disease (COPD) than England, with the highest rate at 212.9 (over twice the rate of England at 100).
- 10 MSOAs have significantly higher rates of emergency admissions for hip fractures than England, with the highest rate at 224.1 (over twice the rate of England at 100).
- 2 MOSAs have significantly higher rates of emergency admissions for intentional self harm than England, with the highest rate at 131.8 (England is 100).
- 4 MSOAs have significantly higher rates of emergency admissions for alcohol attributable conditions (narrow definition), with the highest rate at 149.7 (England is 100).

5.4 Drivers of health inequality

Earlier in this report, we reviewed the Health Equity Assessment Tool (HEAT)[3] definitions of the drivers of health inequalities. These were:

- Different experiences of the wider determinants of health, such as the environment, income or housing
- Differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- Psychosocial factors, such as social networks and self-esteem
- Unequal access to or experience of health services

Understanding the drivers locally requires further work that we may wish to undertake a review of these drivers to contribute to our understanding and action to address.

Some early suggestions for further investigation resulting from significantly higher than England average rates at MSOA are set out below but this should not be viewed as a comprehensive list of drivers due to the absence of data for many drivers at MSOA level:

Wider determinants

- Overcrowded housing in Charnwood in Loughborough Lemyngton & Hastings and Loughborough Storer & Queen's Park
- Socio economic challenge e.g., deprivation, child poverty, fuel poverty etc in 9 of the MSOA's (note that these challenges are one of the reasons why the MSOA was selected as high risk so we would expect to see high rates).

Health behaviours

- Smoking as a lead cause of lung cancer (the leading cancer for women in Figure 15) although it should be noted that no MSOAs of risk had significantly higher than England rates of smoking which is the cause of lung cancer in more than 70% of cases
- Childhood obesity as significantly higher rates are occurring in several of the at risk MSOAs but particularly Loughborough Lemyngton & Hastings. The National Child Measurement Programme data for 21-22 in England shows obesity prevalence is over twice as high in reception (13.6%) and year six (31.3%) in the most deprived areas than the least deprived areas (6.2% and 13.5%)[100].
- 832 people living in the 20% most deprived LSOAs and registered with GPs based in Leicestershire are classed as obese on their records

Psychosocial

- Rates of excess under 75 mortality rates in adults with severe mental illness (SMI) and excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI)[97] are both significantly worse in Leicestershire than England.

Unequal access to or experience of health services

In Leicester, Leicestershire and Rutland, analysis of data across a range of clinical areas at University Hospitals of Leicester looking at rates of people not attending arranged appointments, discharged after the first appointment and on waiting lists for treatment show higher rates across all of these measures for non-white ethnic groups and particularly high rates across many areas for people of Black ethnicity. The data also shows higher rates for people living in higher levels of deprivation.

832 people living in the 20% most deprived LSOAs and registered with GPs based in Leicestershire are classed as obese on their records

5.5 Targeting action on health inequalities

Action to address health inequalities needs to be targeted at all of the population groups identified in this report. However, this is still a large cohort and there may be a need to target further.

We have seen that there are a number of groups at greater risk. From the available data or estimates, two populations are particularly large in Leicestershire:

- Carers (92,049 people).
- People with a disability (118,287 people).

In addition, some populations have a strong evidence base for substantial years of life lost:

- People with a learning disability (20.7 years lost).
- Looked after children or care experienced people (360% higher risk of premature death).
- People who are homeless (around 30 years lower).
- People living in poverty or deprivation (9.7 years for men and 7.9 years for women in England).
- Gypsy or Irish Travellers (life expectancy of 10 years lower).
- People who are in prison (mortality rate for prisoners is 50% higher).
- People with a Severe Mental Illness (on average 15-20 years earlier death than the general population).

Given the population of people with a learning disability is estimated to be both large in Leicestershire and the evidence base suggests a high number of years lost, this may be a useful population of priority focus. The significant estimated population of carers in Leicestershire may also present a reason for prioritising action for this population.

6 Recommendations

This report has identified the local needs and current gaps in service provision relating to health inequalities. The following recommendations have been produced on the basis of these findings, to support improved outcomes for the people in Leicestershire:

1

Raise awareness of our populations and neighbourhoods of concern

Identifying these populations enables partners to acknowledge the greater risk of them facing health inequalities and the additional barriers they may face in accessing services. All partners with investment in preventing health inequalities should acknowledge the populations at higher risk and consider how they will respond to the specific needs and barriers faced by these populations.

How

As part of business as usual, the department has presented the existing health inequalities JSNA chapter to a number of partnership meetings. The Public Health Department will continue this by raising awareness through the health and well being board, locality ICB groups/primary care networks and by working with the Health Equity committee of the Integrated Care Board (ICB).

2

Reflect the needs of our priority groups in our decision making and commissioning

As opportunities arise for new provision, or improvement of services, resource should be prioritised to ensure we consider those at greatest risk of health inequalities in our approach

How and who

The department will work with each locality at neighbourhood level, through the Health and Well Being Board and the emerging place based team, to consider these populations when looking at their own priority setting for health inequalities, e.g., through Community Health and Wellbeing Plans, especially those areas with MSOAs of concern.

3

Assess the equity of our services

Consider carrying out Health Equity Audits or other similar assessments, and/or Population Health Management analysis on take up for all preventative service areas (at all tiers), considering those priority population groups identified in chapters two and four.

How

Take up of Public Health delivery services to be analysed by the MSOAs of concern identified in this report wherever data allows for this. Where take up identifies underrepresentation, this should be followed up with positive action to address.

4

Understand the needs and barriers to priority populations accessing services

Consider engagement with priority populations to better understand the local issues and drivers of health inequalities and how we might collectively improve the experiences of these populations.

How

Building on work undertaken with Charnwood Primary Care Network (PCN) on engagement on barriers to accessing cancer screening for priority population groups we will promote this approach to other PCN's as part of the capcity building work.

5

Build capacity in partner organisations to assess health inequalities

Population Health Management support for primary care and the ICB in addressing health inequalities.

How

The department delivers a training offer with additional support to implement actions. This training is already delivered and one in-depth pilot has occurred with findings widely shared. The offer remains ongoing and fresh opportunities to deliver this through the broader NHS advice offer will be sought.

6

Ensure Leicestershire County Councils Health in all Policies approach considers the populations and areas most at risk of health inequalities to ensure this forms part of cross council decision making.

Ensure the health in all policies approach clearly communicates populations and neighbourhoods of concern across Leicestershire with LCC and partner organisations to acknowledge the greater risk and encourage action to address health inequalities.

How

Through the business as usual work of the department on Health in All Policies.

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