Health and Wellbeing Board **7th May 2025**

Report of the Director of Public Health

Goal #1 in the York Joint Local Health and Wellbeing Strategy 2022-2032: 'Reduce the gap in healthy life expectancy between the richest and poorest communities in York'

Summary

1. From 2022-2032, the York Joint Local Health and Wellbeing Strategy sets out our ambition to reduce the gap in healthy life expectancy between the richest and poorest communities in our city.

2. The Strategy made clear that this was an 'overarching goal', one that can't be approached through single actions but will instead be the result of a whole-system shift to greater health equity and to a health-generating city. The 10 goals in the strategy are the evidence-based route map to reduce inequalities, as they are based on where we know the gap comes from in terms of the causes of early disease and death.

3. As the Board has now approved Action Plan 2 for the strategy, we will continue to report on all the Goals in turn, and this paper is intended to present to the Board the current data on Goal 1 around inequalities in life expectancy and healthy life expectancy in York, following a similar paper at the same stage in Action Plan 1. This is also in fulfilment of a Council Plan 2023-2027 objective to 'Increase council-wide action to reduce health inequalities' and report on this annually.

4. This paper also updates on some key schemes in the city which aim to tackle health inequalities.

Recommendations

5. The Board are asked to:

   - Note and comment on the current data on inequalities in life expectancy and healthy life expectancy in York

   - Discuss where and how the inequalities arise, and 'where to look' for solutions

What is Life Expectancy and Healthy Life Expectancy?

6. The life expectancy of any given area is

   'the average number of years a person would expect to live based on contemporary mortality rates, if he or she experienced the age specific mortality rates for that area and time period throughout his or her life' (OHID, 2023)

7. Life expectancy can be measured at birth, and at age 65. The first measurement will reflect the impact of infant mortality on life expectancy to a higher degree than the second. Both will reflect the determinants of health across the life course.

8. The healthy life expectancy of any given area is:

   'a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.' (OHID 2023)

9. This essentially means that healthy life expectancy (henceforth HLE) is a composite measure, combining a local area's life expectancy (henceforth LE) with the proportion of people reporting 'good' or 'very good health' from the Annual Population Survey (ONS).

Measuring and understanding the gap

10. Whilst the definitions of LE and HLE are clear, measuring the gap in these statistics (i.e. the *inequalities*) between local areas is more complex. This may explain why there are sometimes several 'versions of the truth' for York's health inequality gaps.

11. Firstly, because of the sample size of the Annual Population Survey, data on HLE is actually not available for small areas, such as council wards. The only comparisons which can be made are between York and another local authority (or with regional/national data)

12. Secondly, LE data is available at a small area level (down to areas with populations of a few thousand people). This presents another challenge: whether to highlight the LE difference between one council ward and another council ward, or between the most deprived small areas in a local authority (which could be located across a number of different council wards) and the least deprived.

13. Thirdly, sometimes data on inequalities in HLE / LE is presented as the difference between the lowest and highest areas, but also sometimes as the gradient of the line between them.

14. Locally, we have decided that as part of the Health and Wellbeing Strategy Population Health Monitor which will come regularly to the board we will take this last approach and measure the Slope index of inequality in life expectancy at birth (3-year average), which is:

    'a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within each area and summarises this in a single number.' (OHID 2023)

Trends in York's Life Expectancy and Healthy Life Expectancy

15. The table below presents the current LE and HLE data for York, comparing it with national / regional data and breaking down LE into ward and deprivation decile.

HEALTHY LIFE EXPECTANCY				
	Male Healthy Life Expectancy at birth (years)	**Female Healthy Life Expectancy at birth (years)**	**Time period**	**Trend**
York	62.0	62.7	2021-3	Worsening
Y+H	58.8	59.3	2021-3	Worsening
England	61.5	61.9	2021-3	Worsening

LIFE EXPECTANCY				
	Male Life Expectancy at birth (years)	**Female Life Expectancy at birth (years)**	**Time period**	**Trend**
York	79.8	83.6	2021-3	Static
Y+H	78.1	82.1	2021-3	Static
England	79.1	83.1	2021-3	Static

GAP IN LIFE EXPECTANCY				
	Male Life Expectancy at birth (years)	**Female Life Expectancy at birth (years)**	**Time period**	**Trend**
Lowest Ward (Westfield)	76.1	80.6	2016-20	Not available
Highest (Copmanthorpe)	87.1	91.8	2016-20	Not available
Gap between wards	11.0	11.2	2016-20	Not available

SLOPE INDEX OF INEQUALITY IN LIFE EXPECTANCY				
	Slope index of inequality in Male LE at birth (years)	**Slope index of inequality in Female LE at birth (years)**	**Time period**	**Trend**
York	8.4	5.7	2018-20	Static
Y+H	10.7	8.8	2018-20	Static
England	9.7	7.9	2018-20	Static

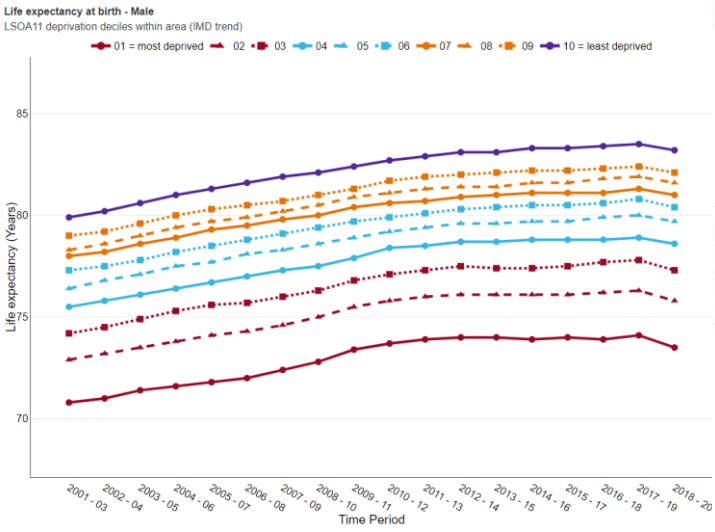
Source: OHID fingertips tool

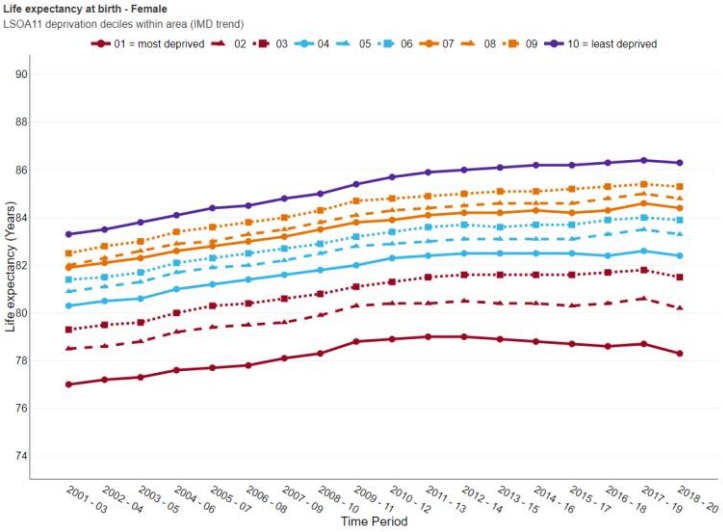
16. This table also illustrates that between 2021-23 men could expect to live in ‘bad or very bad’ health for, on average, 17.8 years, and women 21.9 years. Over the decade since 2011-13, this is an increase of 2.4 years of extra male ill health and 3.6 years of extra female ill health.

17. It should be noted data for LE and HLE is timely, whereas data for the gap in life expectancy is now increasingly out of date.

18. Recently, data has been released breaking down 2016-20 LE for all persons at Parliamentary Constituency level. LE at birth for York Outer is 83.5 years, which places it 61st in the UK out of 650 constituencies (with 1 being the highest LE). LE at birth for York Central is 78.89 years, which places it 541st in the UK out of 650 constituencies (with 1 being the highest LE). This puts the constituency in the bottom 20% of constituencies nationally in terms of LE, and shows that lower life expectancy in York is mainly concentrated in a ‘ring’ of residential suburbs around the city centre.

19. Trends in LE over two decades in our city are shown below, with each line of the graph representing 10% of York’s population according to deprivation levels. Three long-term shifts can be seen: first the gap in LE has grown between the most and least deprived deciles, from 9.1 to 9.7 years in males, and from 6.3 to 8 years in females. Secondly, improvements in LE were made in the first decade of the century and stalled in the second. Thirdly, the gap between the most deprived decile and second most deprived decile is large that all other decile gaps (the ‘cliff edge’ effect).

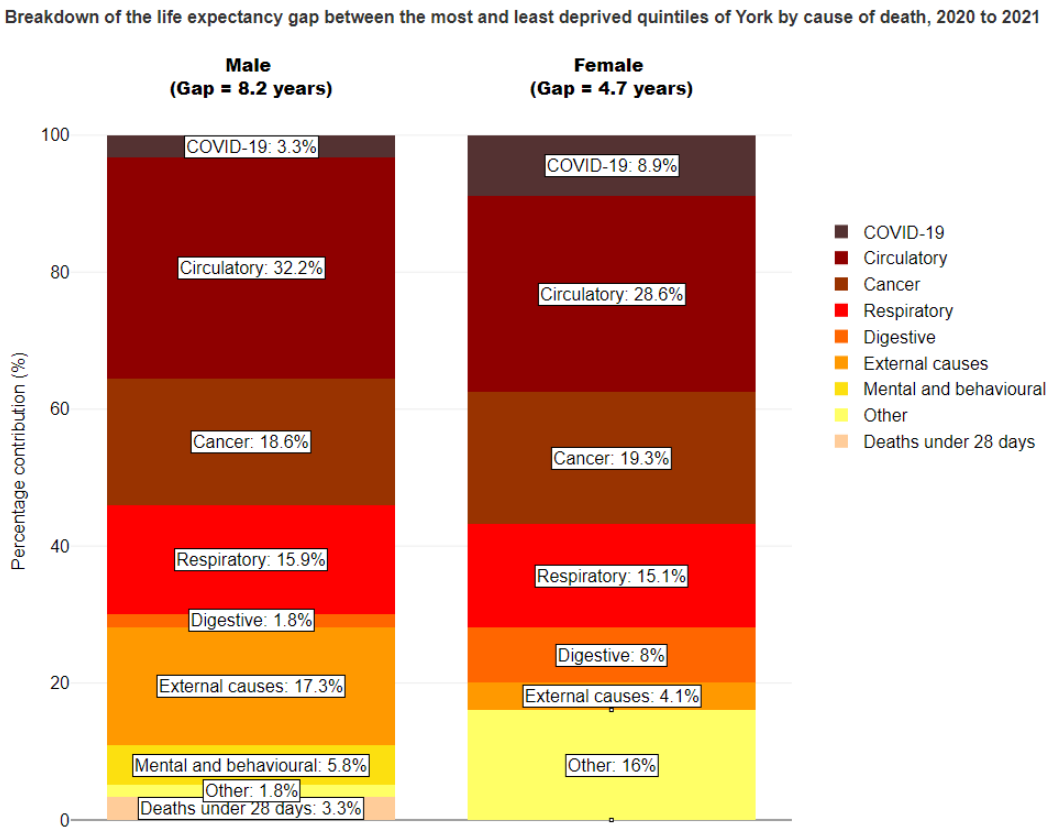




Source: OHID Health Inequalities tool

Explaining the gap

20. It is important to understand the drivers of these gaps so that action can be targeted to tackle them. One way of doing so is by breaking down the clinical reasons for the LE gap between richest and poorest areas:



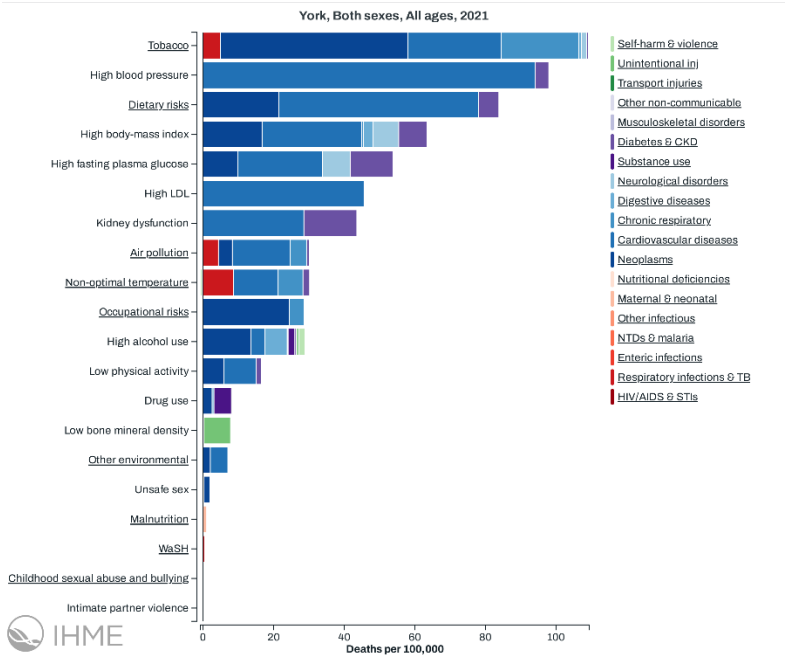
Source: OHID Segment tool

21. As the chart shows COVID-19 contributed within this year, following a pattern seen in other areas where higher death rates were seen in poorer communities from the virus. But in keeping with other years where COVID was not a factor, around two thirds of the LE gap in both females and males comes from three areas: cardiovascular diseases, cancer and respiratory diseases.

22. An estimated 80% of CVDs are considered preventable (WHF), 30% of cancers are considered preventable (WHO) and around 60% of respiratory diseases are considered preventable (ONS).

23. Preventing these three diseases is, therefore, highly achievable, and likely to be the highest impact thing we can do to reduce health inequalities.

24. Lying behind these diseases areas there is a set of ‘risk factors’, as the following chart from the Global Burden of Disease study shows:



25. Unsurprisingly, the trio of tobacco use (20%), high blood pressure (15%) and poor diet (14%) are responsible for a large proportion of the diseases noted above which contribute the most to the LE gap.

26. Underlying the clinical areas and their risk factors are, of course, the wider determinants of health, and again significant variation is seen in these:

	Variation between wards in York	
Households in fuel poverty	25.9% (Hull Road)	8.1% (Copmanthorpe)
Child Poverty (IDAC)	19.8% (Hull Road)	2.2% (Bishopthorpe)
Older people in poverty (IDAOP)	16.6% (Clifton)	4.0% (Heworth Without)
Unemployment	5% (Westfield)	1.3% (Wheldrake)
Overcrowded housing	21.3% (Guildhall)	0.9% (Copmanthorpe)
Prevalence of overweight and obesity in Reception	27.9% (Heworth)	12.5% (Bishopthorpe)

Source: Local Health (OHID)

CORE20PLUS5

27. NHS work to tackle health inequalities uses the CORE20PLUS5 framework.

28. CORE20 populations are those who live in the most deprived 20% of areas according to the Index of Multiple Deprivation. In York this is 9,343 people, this represents 4.6% of the whole population but

more children live in the most deprived 20% of areas (6.1% of the 0-19 population).

29. PLUS populations are identified at local level based on what are referred to as 'inclusion health' groups. These people experience poorer access or outcomes from healthcare, and as researchers from UCL have demonstrated, experience mortality rates 11.9x higher (women) and 7.9x higher (men) and are 'denied legal protection from the extreme health harms of poverty and systemic discrimination'.

30. Local PLUS groups identified in York are:

Adults	Children and Young People
Minoritised Ethnic Communities	Minoritised Ethnic Communities
People experiencing homelessness	Vulnerable Housing (Homeless & Risk of homelessness)
Drug and alcohol dependence	Young Carers
Gypsy, Roma, and Traveller communities	Transgender & Non-Binary CYP
Recent migrants, Asylum seekers and Refugees	CYP who are Gypsy or Travellers
Sex workers	Children and Young People's Mental Health
Transgender and non-binary people	Special Educational Needs and Disabilities (SEND)
People with Learning Disabilities	CYP transitioning out of care (care leavers)
People Leaving Care	Children who are looked after
	Children and Young People Experiencing Parental Substance use

31. The 5 refers to the clinicals areas (eg oral health, CVD, mental health) where the highest levels of health inequalities are seen.

32. The Population Health Hub has produced profiles on our Adult and Children and Young People CORE20PLUS5 population.

Conclusions

33. This data shows that:

- Trends in our key Health and Wellbeing Strategy indicator are hearing in the wrong direction, and the direction of travel will need to be reversed first before a reduction in the inequalities gap is seen.

- Female HLE is worsening in York, and females are living longer in poorer health. Male LE, both for the city as a whole and in terms of an inequality gap, is worse in absolute terms.

- The number of people living with multiple long terms conditions is a large driver in the downward trend in HLE in York.

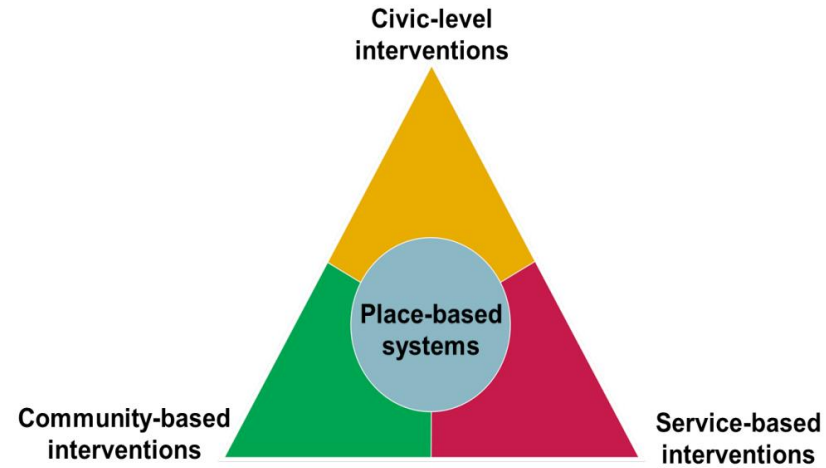
- There is variation across the city in the distribution of the physiological factors which lead to early disease and death, for instance high blood pressure, which could be tackled fairly swiftly (within a 3-5 year window)

- There is variation in the distribution of the risk factors which lead to early disease and death, for instance poor diet, which could be tackled within a reasonable time frame (within a 5-10 year window)

- Ward based outcomes in LE largely follow the pattern of the wider determinants of health in each ward. These will take longer to shift (within a 10-15 year window)

Examples of work across partners to tackle health inequalities

34. A great deal of work takes places in York which will positively impact the gap in healthy life expectancy between richest and poorest. One commonly used framework for such action was developed by Public Health England in 'Reducing health inequalities: system, scale and sustainability (2017):



Credit: PHE Public Health Data Science based on the original concept created by Chris Bentley.

35. Using this framework, several examples are given in the table below of work done by partners across primary, secondary and mental health care as well as the VCSE and council to reduce health inequalities. These are by no means exhaustive, but they illustrate a small number of local projects where a health inequality 'lens' has been taken.

Community-based interventions	The **Brain Health Café** project aims to enhance the experience of individuals with mild cognitive impairment who are awaiting a potential dementia diagnosis by providing personalised care. This support helps people navigate the dementia pathway while promoting healthy lifestyle choices. The project will increasingly focus on specific groups facing health inequalities, such as individuals living alone, those in deprived areas, people with learning disabilities who have a higher risk of developing dementia, and other high-risk groups, including younger individuals at risk of dementia
	Delivering **Citizens Advice services to York GP patients**, supports clients in York's most deprived wards, offering crucial advice on benefits, tax credits, and debt. Demand has risen due to the cost-of-living crisis and COVID-19 impacts, prompting an increase to 30 hours per week. A new vulnerable debtor service will fast-track clients to in-house debt specialists, offering support within four working days to address the link between debt and mental health.
	To address loneliness, isolation, and mental wellbeing among **Asylum seekers at the Staycity hotel**, which has limited communal space, work has been funded around regular social and wellbeing activities with additional female-targeted culturally sensitive health information sessions and a Wellbeing Fund for asylum seekers to apply for small grants, covering items like burkinis for swimming, travel costs for visiting family, and trainers for running clubs.
	The **Health Mela** event, which will run in May 2025 and previously saw 3000 attendees in September 2023, will promote Health Awareness, strengthen community ties, increase access to healthcare services including screenings, consultations, and health education, and celebrate York's **c**ultural Diversity.
	Supervised toothbrushing programmes are now funded in all special schools and targeted early years settings (8 settings). The main settings targeted are nursery or pre-school provision with some primary schools being targeted, all using IMD scores.
Civic-level interventions	A **Winter Warmth Grant** is now available to carry out quick win interventions to address cold, damp and mould in residents' homes. 50 homes per year have been supported through identification of residents most in need, assessment

	of residents' homes, creation of Ventilation and Quick-Wins Strategy for each resident, and retrofitting properties.
	The **Homelessness Local Enhanced Service** increases access to healthcare of non-engaged members of society through a private space that can be fitted out as a consulting room, allowing a safe environment for residents to be seen in for both males and females. Collaboration with multi-agency partners, such as drug and alcohol services, community mental health teams, and Key Workers. Tailored healthcare assessments, including mental health, substance misuse, and preventive measures such as vaccinations.
	The new **Food Insecurity Pathway** will support families who are facing food insecurity and struggling to afford formula milk through the Healthy Child Service. Along with the vouchers, families will be connected to wrap around support services, including lactation support if needed.
	A **Reintegration Support Worker** has been employed to work directly with CYP, their families and schools to develop and implement reintegration plans through comprehensive holistic, outcome-based assessments, particularly for those children who's neurodivergence has led to barriers in access to education and other services.
	The **Asthma-Friendly Schools Programme** will deliver targeted training, advice & support to schools to ensure they are equipped to support CYP with this long-term condition, who are more likely to be from more deprived areas with worse air quality.
	A community-based intervention aims to improve outcomes for children and young people who are from the **Gypsy and Traveller community** by providing a bespoke health practitioner that is a child health nurse for these communities in York that will engage CYP and families through the York Travellers Trust and Raise York network and provide person-centred holistic care for vulnerable patient groups working in partnership with non-health professionals in a variety of settings reducing barriers to access.
Service-based interventions	**Targeting smoking cessation and NHS Healthchecks** work has been carried out for a number of years, including proactive invites made to both services through primary care systems using the IMD tool focussing on the most deprived 20%

	All adult **patients with a learning disability** diagnosis who are added to the elective / endoscopy waiting list in York and Scarborough Teaching Hospitals NHS Foundation Trust are now identified on booking and scheduling for procedure in an expedited time (within 8 weeks). There is also now a process for identification of Reasonable adjustments
	An onsite **GP service at Changing Lives Women's centre** for cases where women need to be seen urgently due to extreme situations e.g. domestic abuse. The benefits are anticipated that outreach model will help with building trust, a sense of security, stability and equal healthcare provision for a group that suffers negative health outcomes.
	The **Health Inequalities Education Programme** is a structured education programme for 30 professionals offering localised education sessions and workshops, where participants will take learning from the education sessions and apply this to real life practice. It will empower our leaders across primary and secondary care to reduce health inequalities with the skills, knowledge and sense of purpose that will enable them to achieve this goal.
	Inclusion health system searches have been created in primary care and as a result, in just three months at the start of 2025 the number of residents in York on a register has risen from 8287 to 10954.

36. It should also be acknowledged that work delivered by any partner in the health and care system has the potential to increase health inequalities if not delivered in the right way. An example of this is that, according to an NIHR evidence summary, 'people who are typically at higher risk of conditions for which screening programmes are available are less likely to participate in screening and receive benefit. This issue contributes to health inequalities'.

37. There are a number of tools available Health Equity Assessment Tool (HEAT) - GOV.UK

Consultation

38. This is a discussion document and thus the HWBB are being consulted on a variety of issues related to the Board's work.

Council Plan and other strategic plans

39. This paper reinforces some of the key aspirations of the Council Plan 2023-27 and the fulfils the Council Plan 2023-2027 objective to 'Increase council-wide action to reduce health inequalities' and report on this annually

Implications

40. The HWBB has no decision-making responsibilities for service provision or finance. There are no known implications in this report in relation to the following:

- Financial
- Human Resources (HR)
- Equalities
- Crime and Disorder
- Property
- Other
- Legal Implications

Recommendations

41. The Board are asked to:

- Note and comment on the current data on inequalities in life expectancy and healthy life expectancy in York
- Discuss where and how the inequalities arise, and 'where to look' for solutions

Author:	**Chief Officer Responsible for the report:**
Peter Roderick Director of Public Health	Peter Roderick Director of Public Health

Report Approved	√	**Date**	23/04/25

Specialist Implications Officers
Not applicable

Wards Affected: **All** ✔

For further information please contact the author of the report

Background Papers
Joint Local Health and Wellbeing Strategy