NHS Leicester, Leicestershire and Rutland

Rutland County Council

Leicester City Council

Leicestershire County Council

Women's Health in Leicester, Leicestershire and Rutland 2026

A Health Needs Assessment based on The Women's Health Strategy for England, 2025



Acknowledgements

We would like to express our sincere gratitude to everyone who contributed to this Women's Health Needs Assessment. Your insights, expertise, and dedication have been invaluable in shaping this comprehensive overview of women's health across Leicester, Leicestershire and Rutland.

Special thanks go to the Women's System Partnership, whose collaborative efforts and commitment to improving outcomes for women have provided a strong foundation for this work. Your ongoing support and leadership are crucial in driving positive change throughout our communities.

We are deeply appreciative of all those who will carry this important work forwards. It is only through shared responsibility, continued collaboration, and a unified vision that we can build a system which truly meets the needs of women at every stage of life. Thank you for your passion, perseverance, and dedication to making a difference.

Produced by:

Leicestershire County Council

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WHNA - Words for our women

This Women's Health Needs Assessment is about the women and girls of Leicester, Leicestershire and Rutland: their lives, their experiences, their health, and the inequalities that continue to shape their opportunities and outcomes. It brings together evidence and insight to help partners across the system understand what needs to change and where collective action can make the greatest difference. The following words from senior leaders reflect a shared commitment to listening, learning and working together so that women and girls are better heard, supported and served at every stage of life.

Roz Young NHS England

On behalf of NHS England Midlands, I welcome this comprehensive Women's Health Needs Assessment. This HNA strongly aligns with the ambitions set out in the NHS Long Term Plan and the Women's Health Strategy for England, reinforcing the importance of prevention, early intervention, and personalised, joined-up care. It provides a shared foundation for Integrated Care Boards, local authorities, providers, voluntary and community sector partners, and wider system leaders to plan and prioritise services that respond to what matters most to women in LLR.

Crucially, this document is not an end in itself. Its value lies in how it is used to inform how services are planned and redesigned, support targeted improvement programmes, and strengthen accountability for outcomes. NHS England Midlands will continue to work alongside system partners to ensure that the insights from this HNA translate into meaningful action, measurable improvement, and better experiences of care for women and girls across Leicester, Leicestershire and Rutland.

By working collectively, with women's voices at the centre, we can deliver more equitable, responsive, and high-quality services that support women to live healthier lives at every stage.

Mike Sandys, Director of Public Health, Leicestershire County and Rutland County Councils

To the girls and women of Leicester, Leicestershire and Rutland: your health, safety, opportunities and voices matter. We recognise that too many women and girls continue to face gender-based violence, educational disparities and health inequalities, and that these experiences can shape wellbeing across the whole life course.

At every stage of your life, your health is important to us. Through prevention, early action and strong partnership across our health, care and community system, we are committed to supporting you to live longer and healthier lives and reducing the inequalities you face. This means working together to address the wider factors that influence health and ensuring that services and support are shaped around what women and girls tell us they need.

Rob Howard, Director of Public Health, Leicester City Council

Women's health is at the heart of everything we do in Leicester City. Women in Leicester have significantly lower healthy life expectancy than the England average, and those facing the multiple issues of deprivation and ethnicity experience the worst outcomes of all. We know that Black women are four times more likely to die during pregnancy and childbirth, that women experiencing homelessness in Leicester die on average at just 42 years of age, and that too many women across our communities still face barriers to accessing the care they need and deserve. Through our commitment to prevention and our work across the system — from Women's Health Hubs to improving cervical screening uptake in underserved communities — we are determined to change this. To every girl and woman in Leicester I would say: your health matters, your voice matters, and we are working together to build a system that truly serves you.

Simon Pizzey, Associate Director, University Hospitals Leicester NHS Trust

Across Leicester, Leicestershire and Rutland, we are proud of the strength of our system and our shared commitment to improving Women's health at every stage of life. Through collaboration between health, care, and community partners, we are working to ensure that services are not only clinically excellent, but accessible, inclusive and shaped around the real experiences of Women and girls.

At University Hospitals of Leicester, this commitment is reflected in the care we provide every day—from Maternity and Gynaecology services through to specialist treatment and support for complex conditions. As a key partner in our system, UHL continues to play a vital role in improving outcomes, reducing inequalities, and listening to Women's voices to ensure services evolve in line with what matters most to those we serve.

To every girl and woman across our communities: you matter, and you deserve to be heard and supported. Whether it's accessing care, seeking advice, or making choices about your wellbeing, we are here to stand with you—today and for the future.

Executive Summary

How to Use This Document

This Women's Health Needs Assessment (WHNA) represents Phase 1 of the LLR Women's Health Programme. It provides a comprehensive synthesis of quantitative evidence, local intelligence, and existing assessments across the life course. It is deliberately expansive in scope, reflecting the breadth and complexity of women's health. It is important to acknowledge that, at this stage, data limitations have constrained the depth of our analysis. Addressing this issue through improved data sharing provisions should be a priority moving forward.

It is not intended to be read cover-to-cover.

Readers are encouraged to focus on the chapters that are most relevant to their roles, alongside the cross-cutting recommendations, which apply system-wide.

Phase 2 will centre on the voices and lived experiences of women across Leicester, Leicestershire and Rutland. Only by combining the hard data of this HNA with women's narratives, realities and priorities can we develop an equitable, coherent, and actionable system plan.

Women's health cannot be the responsibility of any single service or sector. To improve outcomes for women, every part of the system must apply a women's lens to their work, from maternity to mental health, from leisure to licensing, from primary care to planning.

And critically, supporting women's health benefits everyone. Women are disproportionately primary carers for children, older adults, partners, and wider families. When we improve the health of women, we improve the health, wellbeing, stability and prosperity of households and communities, with positive reverberations across social care, mental health services, and the wider economy.

Why Women's Health Matters in LLR

Across England, women live longer but spend many years in poor health. Locally, this pattern is intensified by pronounced inequalities shaped by ethnicity, deprivation, disability, age and geography. Leicester's diversity and concentrated deprivation, Leicestershire's rurality and ageing population, and Rutland's distinct demographic profile mean that women's health needs are stratified and heterogeneous.

National evidence shows that women's health has historically been under-researched, under-recognised and, at times, trivialised. Conditions such as menstrual disorders, pelvic pain, menopause symptoms, or perinatal mental health needs are often normalised or dismissed, resulting in delays in diagnosis, fragmented pathways, and avoidable health and economic burden.

LLR now has the opportunity to reshape this landscape, aligning the Women's Health Strategy for England with local priorities, assets, and population needs.

Headline Findings Across the Priority Areas

Menstrual Health & Gynaecological Conditions

- Menstrual disorders, gynaecological conditions and pelvic pain are common, often normalised and under-diagnosed, leading to avoidable pain, distress and daily disruption.
- Long diagnostic delays, especially for endometriosis, persist, with access strongly shaped by deprivation, ethnicity and health literacy.
- Women in areas of deprivation, particularly Leicester City, face greater barriers to accessing timely diagnosis, menstrual health literacy and gynaecology services.
- Conditions such as fibroids, PCOS and pelvic floor dysfunction have wide-ranging impacts on quality of life, fertility, mental health and work participation. True prevalence in LLR is masked by stigma and likely under-reporting.

Sexual & Reproductive Health

- STI testing, diagnoses and outcomes vary significantly across LLR, with inequalities patterned by deprivation, ethnicity, age and geography.
- Contraception access, particularly long-acting methods, is inconsistent, with variation in service capacity and waiting times.
- Women are under-represented in HIV prevention pathways, including PrEP, despite unmet need.
- Patterns in abortion and conception reflect broader socio-economic inequalities, particularly in Leicester.
- Leicester shows higher chlamydia and gonorrhoea diagnoses in young women, while parts of the county have persistently low screening rates.

Menopause

- Menopause symptoms have major impacts on physical health, mental wellbeing, relationships and employment.
- LLR shows stark variation in HRT prescribing, with women in Leicester's most deprived areas far less likely to receive treatment than those in more affluent Leicestershire districts, mirroring national trends.
- Menopause is a key life-course transition intersecting with cardiovascular risk, musculoskeletal health, cognitive function and mental health, amplifying inequalities.
- The burden of symptoms intersects with high levels of midlife obesity, inactivity and mental health need in LLR.

Mental Health

- Women experience higher rates of depression, anxiety and self-harm, with midlife women particularly affected.
- Depression in LLR is highest among women aged 35–64, especially in areas of deprivation across Leicester City.
- Suicide in women aged 40–59 is rising locally, mirroring national patterns but with added local risk factors (e.g., deprivation, VAWG, perimenopause, caring burden).
- Women with serious mental illness face substantial physical health inequalities and lower screening uptake.

Lifestyle & Wellbeing

- Lifestyle-related factors, including smoking, substance use, physical inactivity and obesity, significantly shape women's health across the life course.
- These factors are strongly driven by deprivation, trauma, caring responsibilities, cultural norms and the built environment rather than individual choice alone.
- Combined, they contribute to preventable long-term conditions, poorer pregnancy outcomes, reduced healthy life expectancy and widening health inequalities for women.
- Women in LLR's more deprived wards face cumulative barriers to healthy behaviours - financial strain, time poverty, safety concerns, cultural norms, trauma and caring responsibilities.
- LLR shows clear deprivation-related patterns: higher smoking rates in Leicester, lower physical activity in the city (particularly among women) and rising obesity across all three areas.

Cancer

- Outcomes for breast and cervical cancers vary by ethnicity, deprivation and access to screening.
- Screening uptake varies significantly, with Leicester City consistently below national averages for cervical and breast screening.
- Women from Black, Asian and other minority communities in Leicester are less likely to participate in screening and more likely to present later, driving poorer outcomes.
- Rural women in Rutland and Leicestershire face different access barriers (travel distance, appointment availability).

Violence Against Women and Girls (VAWG)

- VAWG is a pervasive driver of physical, mental, and sexual ill-health, with impacts across the entire life course.
- Domestic abuse, sexual violence and coercive control significantly increase risk of mental illness, substance use, reproductive complications, chronic pain and suicide.
- Marginalised women, including those who are younger, disabled, migrant or from minority ethnic backgrounds, face the highest burden and greatest barriers to accessing help.

Healthy Ageing

- Ageing-related conditions, cardiovascular disease, osteoporosis, falls, frailty and cognitive decline, disproportionately affect women.
- Outcomes in later life reflect earlier inequalities in deprivation, ethnicity, health behaviours, hormonal transitions and caring responsibilities.
- Women are more likely to live longer with disability or dementia and often bear the emotional and financial burden of caring for others with these conditions.
- Cardiovascular disease risk is highest among women in deprived urban areas, while rural Rutland shows a rapidly ageing female population with increasing frailty.
- Osteoporosis, hip fractures and falls affect women disproportionately across all three areas, with Leicester women more affected by multimorbidity and Leicestershire/Rutland women more affected by age-related decline.

Women's Health Hubs

- Women's Health Hubs offer an opportunity to reduce fragmentation, improve access and deliver joined-up, life-course-oriented care.

Cross-Cutting Themes Emerging from the Evidence

1. Inequalities are cumulative and intersectional
Women from Black, Asian, migrant, disabled, LGBTQ+ and lower-income backgrounds experience poorer outcomes across multiple domains, often simultaneously.

2. Women's health pathways are fragmented
Many women must navigate multiple services to address interconnected issues (e.g., menstrual health, fertility, pelvic pain, and mental health), resulting in delays, duplication and distress.

3. Stigma, taboos and cultural norms create pervasive barriers
Across menstrual health, sexual health, menopause, pelvic health, pregnancy loss and mental health, stigma reduces help-seeking and contributes to unmet need.

4. Prevention opportunities could be better utilised
From smoking to physical activity to menopause to menstrual health literacy, prevention efforts require far greater system coherence and visibility. The system needs to work together to prevent the issue from occurring, as well as treating the issues as they present themselves.

5. Data gaps hinder understanding
Lack of granularity in ethnicity, gender identity, disability, neurodiversity and lived experience data restricts the ability to design targeted, equitable interventions. Data sharing between organisations to understanding need, demand and supply is lacking.

6. Improving women's health improves population health
Healthy women support healthier children, partners, older relatives, workplaces and communities. The societal return on investment is substantial.

Cross-Cutting Recommendations (System-Level)

- **Women's Health is Everyone's Responsibility**
  All partners and teams should consider how their work can better address women's diverse health needs.

- **Neighbourhood Health**
  Neighbourhoods and primary care should adopt a women-centred approach, tailoring services to local needs.

- **Recognising and Responding to Women's Distinct Needs**
  Services must move beyond male defaults and be designed to reflect women's real-life experiences and requirements.

- **Strengthening Data Foundations for Collaboration**
  Better data sharing is vital for transparency and effective collaboration to understand and meet women's health needs.

- **Making Every Contact Count (MECC) for Women's Health**
  Each interaction should be used to support women's health through open, supportive, and informed conversations.

- **Prioritising Health Literacy**
  Improved health literacy enables women to advocate for themselves and helps reduce health inequalities.

- **Place-Based Sensitivity**
  Approaches should be shaped by the unique needs and experiences of women in each local area.

- **Workplace Wellbeing for Women**
  Employers should address the specific challenges women face and create supportive, equitable workplaces.

Next Steps: Phase 2 & Beyond

Phase 2 will conduct extensive engagement with women across LLR, ensuring representation from diverse communities, life stages and experiences. This will include targeted engagement with groups at higher risk of poor outcomes or exclusion from services.

Phase 3 will synthesise the evidence from this HNA with women's lived experiences to form a LLR Women's Health System Plan, setting priority areas, outcomes, and actions for the entire system.

Improving women's health requires shared responsibility across partners, sectors, and communities. By placing women's needs, realities and strengths at the centre of system thinking, LLR can accelerate progress towards a fairer, healthier and more equitable future, not only for women, but for the families and communities who rely on them every day.

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Introduction

Why this Health Needs Assessment (HNA) and Why Now?

Although women on average live longer than men, it is known that they spend a greater proportion of their lives in ill health or suffering disability when compared to men. Although they represent just over half of the population, they are often under-represented in clinical trials and other scientific evidence as well as the ways in which research and education of medical professionals is done. This 'male as default' approach has led to systematic inequalities in the way that women-specific health issues are dealt with, including fragmented and inefficient systems that means people must attend multiple appointments to adequately address one area of their health, for example, reproductive health. We also know that this inequality extends past healthcare and into the wider determinants. For example, women on average do around 60% more unpaid work in a week than their male counterparts and this often includes the bulk of caring responsibilities for children or older relatives. This lack of time leads to them having more difficulty accessing healthcare in the first place and often leads to them neglecting their own needs in favour of the needs of others.

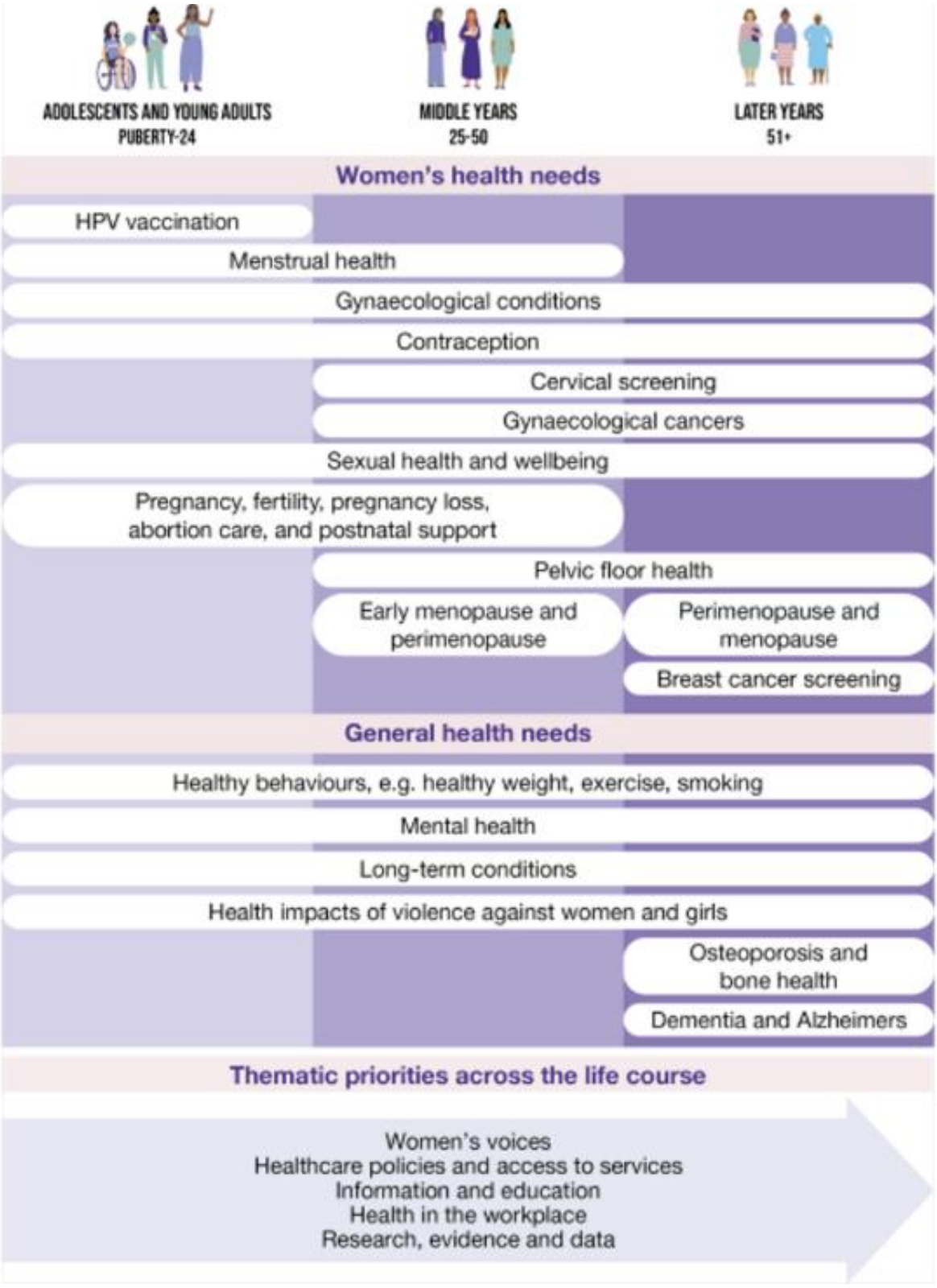
As well as disparities in health between men and women, it is also true that data can often mask significant variation in outcomes between groups of women. Those experiencing intersectionality of, for example, being from a background other than white British, and living in an area of severe deprivation will experience significantly worse outcomes than their more affluent, white counterparts. Recognising all of this, the government commissioned the writing of the Women's Health Strategy for England, published in 2022.[1] A public call for evidence elicited over 100,000 responses from members of the public as well as more than 400 written submissions from experts and organisations working in health and care. This was used to shape the document and set out a ten-year strategy for improvement. The main ambitions of the strategy are that in 10 years, they will have:

- Boosted health outcomes for women and girls
- Radically improved the way in which the health and care system engages with and listens to all women and girls

Although the disparities in health for women and girls become more pronounced and start to widen at adolescence, it is clear that the foundations are laid before that and as with all thorough approaches to tackling health inequalities, the strategy takes a life course approach to looking at the problem. The following diagram taken from the strategy document illustrates what a life-course approach might include:

[1] Women's Health Strategy for England. Department of Health and Social Care. 2022.

Figure 1: Women's Health Across the Life Course



Source: Women's Health Strategy for England, 2022, UK Government Policy Paper.

Research that has been done consistently demonstrates that women's health issues are often normalised, trivialised or dismissed, leading many women to delay seeking help or feeling unheard.[2] This pattern can be found across various conditions from menstrual disorders to chronic pelvic pain, with issues being cited as rooted in systemic biases, cultural stigma and underinvestment in women's health.[3,4] We want to change this for women living in LLR, as well as celebrating the successes we do have.

Scope, Aims and Objectives

A health needs assessment is a systematic method of reviewing the health issues facing a particular population and should lead to agreed priorities and actions that improve health and reduce health inequalities. Clearly, a review of all the health issues affecting nearly 51% of the population is neither feasible, nor advisable since it would produce a vast (and likely non-specific) set of recommendations to be enacted. Consequently, the scope for the LLR Women's Health Needs Assessment will take as its initial framework the priority areas outlined in the 2022 Women's Health Strategy for England (henceforth referred to as Women's Health Strategy or WHS). It is worth noting however, that the second priority area in the strategy covers 'fertility, pregnancy, pregnancy loss and postnatal support'. Although many of these areas are considered within the scope of this HNA, topics directly related to later pregnancy, maternity and the puerperium are not considered here as they are within scope of other work streams already. This will, of course, feed into and inform this needs assessment. The scope of this HNA will include women aged 18 years and over in LLR and will explore the causes of morbidity and mortality. It is important to note that some health issues can impact young girls during their teenage years, therefore where relevant, these will be included.

There also exists specific Joint Strategic/Specific Needs Assessments on several of the topic areas covered by the WHS. In this instance, these will be referred to in the relevant chapters within this HNA. This HNA will aim to avoid duplication of existing work but will take the most pertinent aspects and put them into the context of women within Leicester, Leicestershire and Rutland (LLR).

As well as a defined population, the first stage of any health needs assessment requires the careful definition of aims and/or objectives of the project. The aims of this document are as follows:

Aims:

- to produce a systematic overview of the current situation in LLR with regard to the priority areas as set out in the WHS
- to identify key areas where information is currently lacking and make recommendations on addressing this
- to describe current services in relation to need and to make recommendations on addressing any gaps

[2] Jouanny, C., Abhyankar, P. & Maxwell, M. A mixed methods systematic literature review of barriers and facilitators to help-seeking among women with stigmatised pelvic health symptoms. BMC Women's Health 24, 217 (2024). https://doi.org/10.1186/s12905-024-03063-6

[3] House of Commons (2024). Women's Reproductive Health Conditions. Available at: https://committees.parliament.uk/publications/45909/documents/228040/default/

[4] Genevieve Jeffrey (2025). Barriers to Women in Accessing Healthcare in the UK – A Review. Available at: https://ppr.lse.ac.uk/articles/10.31389/lseppr.122

Traditional health needs assessment methodology dictates that a simple descriptive health profile alone is not a true HNA, and that it must also involve an analysis of felt or perceived needs of the population and those of the providing or managing organisations and those of commissioners and planners.

Consequently, this needs assessment process will take place in three stages, of which this document represents the first stage. This document will primarily serve to pull together what is already known about these areas, sourcing data and intelligence from existing needs assessments and other relevant documents, and information from local stakeholders. It will provide a starting point from which to commence our work on implementation of the strategy in LLR, and signpost to other sources of important intelligence.

The WHS has an overarching aim of ensuring that women feel listened to and empowered to make decisions about their own care. The second stage of this process will involve a detailed programme of engagement with LLR residents and stakeholders to ask and to understand their views on the topics addressed in the needs assessment document and strategy.

The third stage of the process will involve the synthesis of these two sources of information, plus the addition of any further important intelligence that comes to light during the process in order to inform the continuing strategic approach to women's health across the system and achieve the overall objective of the health needs assessment which is to describe and critically appraise the current status of women's health overall in LLR and make actionable recommendations for change.

A brief note on language:

The Women's Health Strategy for England uses the terms 'women' or 'woman' and 'girls' throughout to refer to its target population. In the interests of brevity, this document will often do similarly, however it also recognises that not everyone will recognise themselves in or identify with that terminology. For the purposes of clarity, this needs assessment therefore addresses the health needs of anyone assigned female or intersex at birth regardless of how the subsequently choose to identify. It is also important to note that those who were assigned differently at birth but later identify as female also may recognise some of the issues and problems raised as being important and relevant to them. The authors also recognise that it is a limitation of current data that for many of the included topics, we are unable to accurately define or quantify how many of the affected population may choose to identify differently from their birth-assigned gender.

The data presented is the latest that was available at the time of producing the document. Data has been presented at LLR ICB level where possible or by each individual local authority area. It is important to note that where data is presented at a combined LLR level, variation will exist within the three individual areas. Where local data is not available, national and academic sources have been used.

Since completing this HNA, the National Women's Health Dashboard has been launched. This will help to develop and shape future work, and deeper dives, into specific areas of women's health locally.

Demographics of Women in LLR

Context

This section offers a concise overview of the female adult population across LLR, setting the scene with a high-level summary to provide context for understanding women's health needs in the region. LLR is distinctive in its demographic makeup, encompassing highly diverse communities and a broad spectrum of challenges – from the complexities of urban living in Leicester, to the unique health access and service delivery issues faced by those in rural parts of Leicestershire and Rutland.

Full chapters on demography in LLR are available via the following links:

- Leicestershire
- Rutland
- Leicester City

LLR has a total population of 1,175,364, with 50.3% females and 49.7% males. A breakdown for each local authority is provided in the table below:

Table 1: Population by gender in LLR

Sex	Leicester		Leicestershire		Rutland		LLR	
	number	%	number	%	number	%	number	%
All persons	388,348	100.0	745,573	100.0	41,443	100.0	1,175,364	100.0
Female	193,725	49.9	377,127	50.5	20,206	48.8	591,058	50.3
Male	194,623	50.1	368,446	49.4	21,237	51.2	584,306	49.7

Source: Mid Year Population Estimates, ONS, 2024

Age Structure

The 2024 population pyramid for Leicester, Leicestershire, and Rutland (LLR) provides a comprehensive overview of the region's demographic structure by age and gender. The chart is split into green bars for males on the left and purple bars for females on the right, with each horizontal bar representing a five-year age group from 0–4 years up to 90+ years.

The LLR combined population has a balanced distribution across most age groups, with a slight female predominance in older age brackets, reflecting national longevity patterns. A strong representation in younger age groups (0–19), indicating ongoing demand for education, youth services, and family support. The working-age population (20–64) is well distributed, supporting economic activity and service delivery.

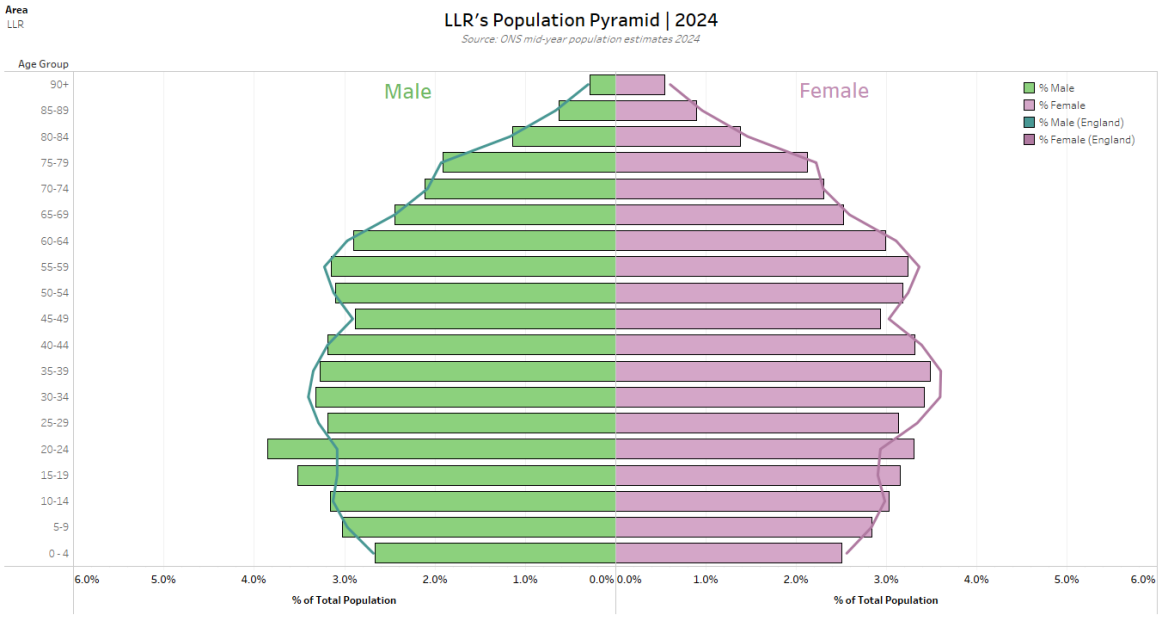
Compared to England, LLR shows similar demographic proportions, though subtle differences may reflect local migration, birth rates, or ageing trends. The age structure in LLR varies between each area.

Leicester has a younger population in comparison to England. The large proportion of younger people in Leicester reflects the student population attending Leicester's two universities and inward migration to the city. The proportion of females aged 15-24 in Leicester (8.5%) is higher compared to England (5.8%). A gradual tapering can be seen in older age groups, with females outnumbering males in the 80+ age brackets, consistent with national patterns of longevity.

Leicestershire's age structure has a fairly balanced distribution across most age groups, with slight female predominance in older age brackets (70+), reflecting national longevity trends. Compared to England (6.2%) Leicestershire (5.9%) shows lower proportions in the 20–29 age range and higher proportions in the 50-64 age range.

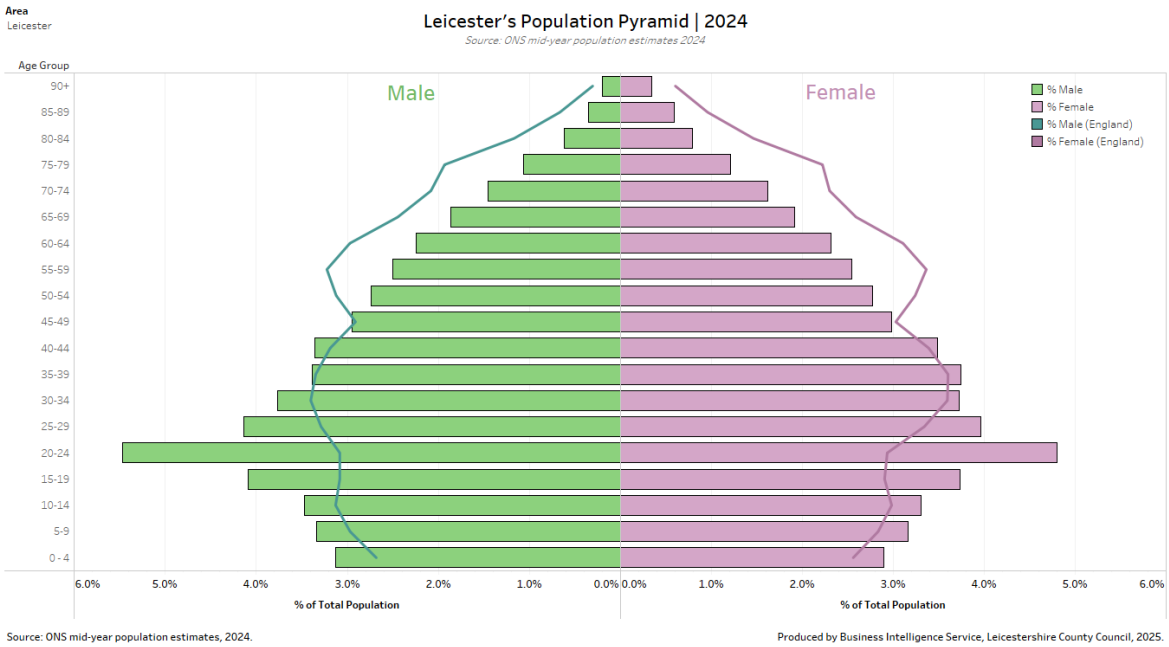
Rutland has a smaller proportion of young people compared to national averages. A larger representation in older age groups, particularly in the 65 and over categories, suggesting an ageing population. The female population outnumbers males in the oldest age brackets (80+), consistent with national longevity trends. Compared to England, Rutland shows higher proportions in older age groups and lower proportions in younger and working-age groups (20-49).

Figure 2: Age structure of LLR population, 2024



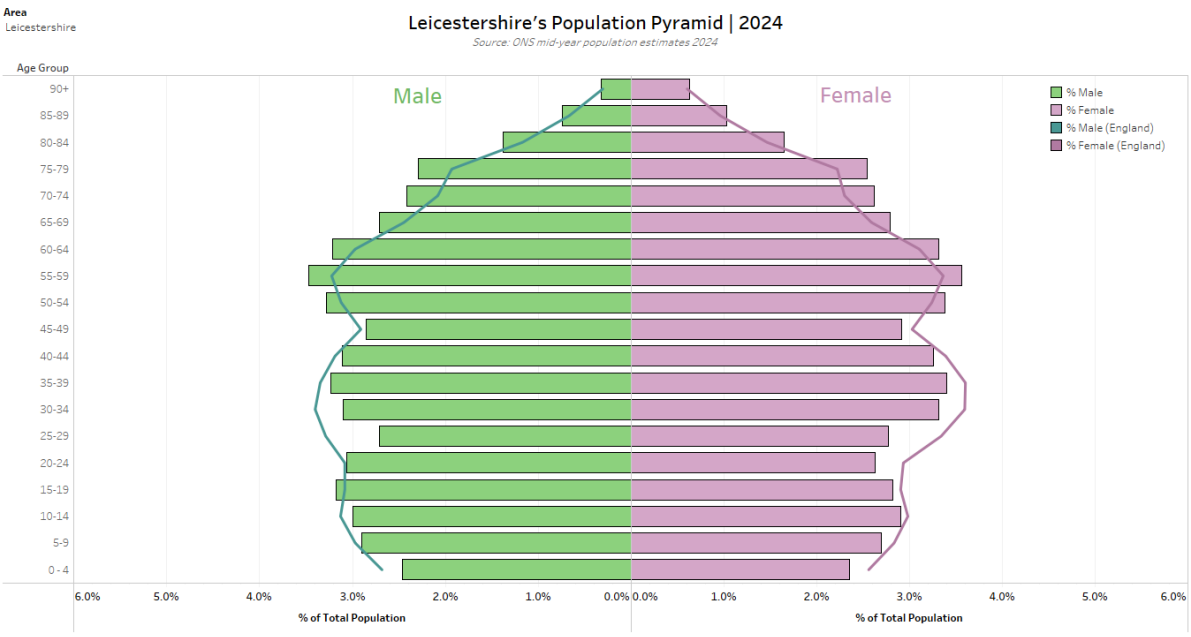
Source: ONS mid-year population estimates, 2024.

Produced by Business Intelligence Service, Leicestershire County Council, 2025.



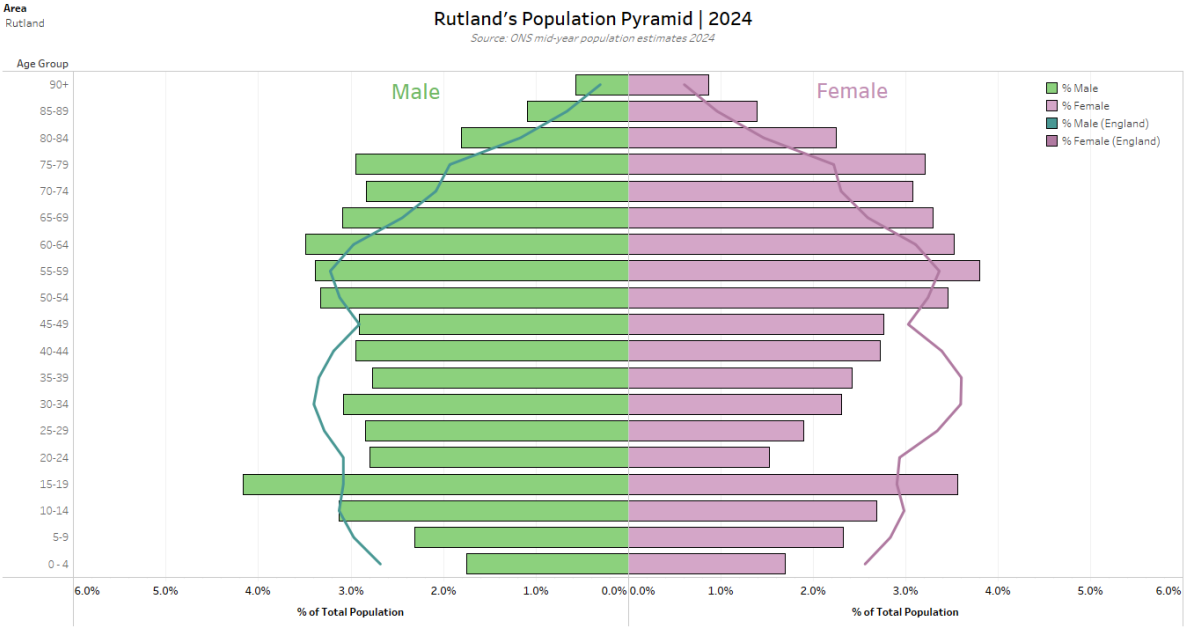
Source: ONS mid-year population estimates, 2024.

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Source: ONS mid-year population estimates, 2024.

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Source: ONS mid-year population estimates, 2024.

Produced by Business Intelligence Service, Leicestershire County Council, 2025.

Ethnicity

Figure 3 below provides a comparative overview of the ethnic composition of the female population across Leicester, Leicestershire, Rutland, and England as a whole. It highlights the variation in ethnic diversity between these areas using Census 2021 data.

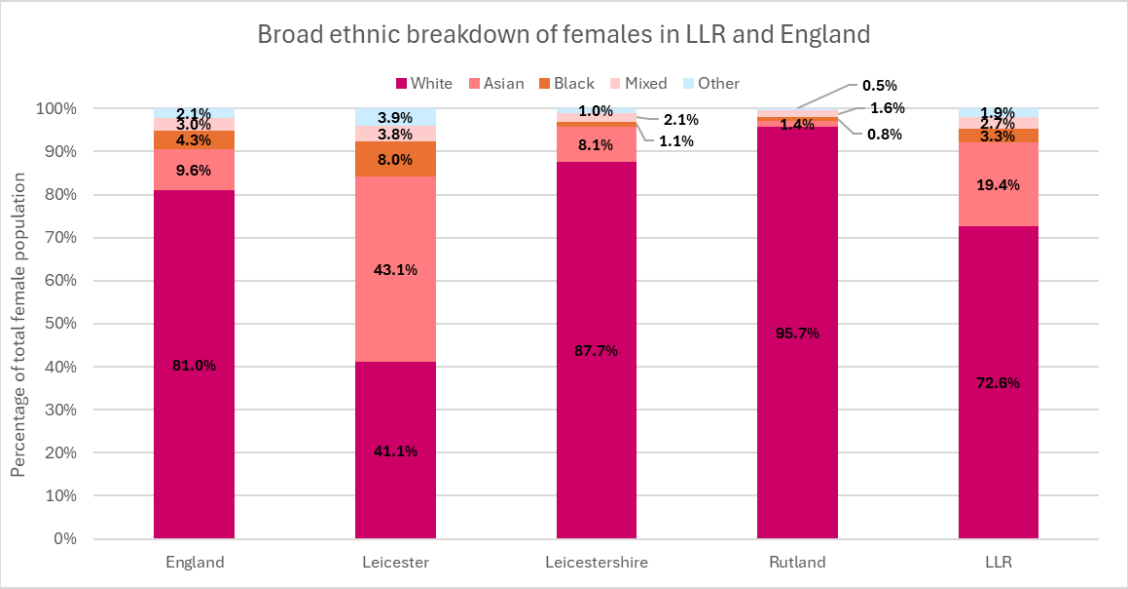
Leicester stands out as the most ethnically diverse area, with Asian females comprising the largest group (43.1%), slightly surpassing the White female population (41.1%). This is in stark contrast to the national average, where White females make up 81.0% of the population. Leicestershire and Rutland show a markedly different profile, with White females representing 87.7% and 95.7% of their respective populations. Ethnic minority groups in these areas are present in much smaller proportions.

The LLR aggregate reflects the combined diversity of its constituent areas, with White females making up approximately 72% of the population. This figure is lower than the national average but higher than Leicester's, indicating the influence of the less diverse surrounding counties.

Nationally, Asian (9.6%), Black (4.3%), Mixed (3.0%), and Other (2.1%) ethnic groups form a smaller proportion of the female population compared to Leicester, where these groups are more prominently represented.

This breakdown is crucial for understanding local population needs, informing culturally sensitive public health strategies, and ensuring equitable service provision across the LLR region.

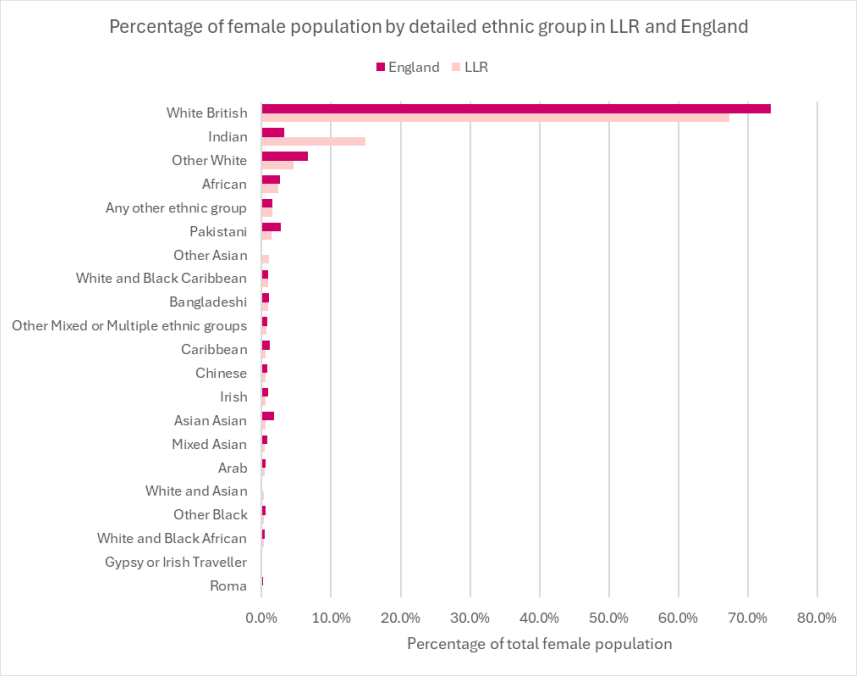
Figure 3: Broad ethnic profile of females in LLR and England, 2021.



Source: Census 2021, ONS.

The detailed ethnic breakdown of the female population in LLR and England shows the most prominent group in both regions is White British, though the proportion is notably lower in LLR than the national average. Indian females represent a significantly larger share in LLR (15%) compared to England (3.2%), reflecting the area's unique demographic profile. Other ethnic groups such as African, Pakistani, and Other White also show varying levels of representation, highlighting the diversity within LLR compared to national trends.

Figure 4: Detailed ethnic profile of females in LLR and England, 2021



Source: Census 2021, ONS.

Languages

The table below provides an overview of the top ten various languages that are spoken by females in Leicester and Leicestershire according to the Census 2021. English is the most prominent language spoken by female residents in Leicester and Leicestershire. In Leicester a higher proportion of females speak Gujarati, other European language, Punjabi and Polish compared to Leicestershire where the proportions are below 1% for these categories.

Table 2: Language profile for females in Leicester and Leicestershire, 2021

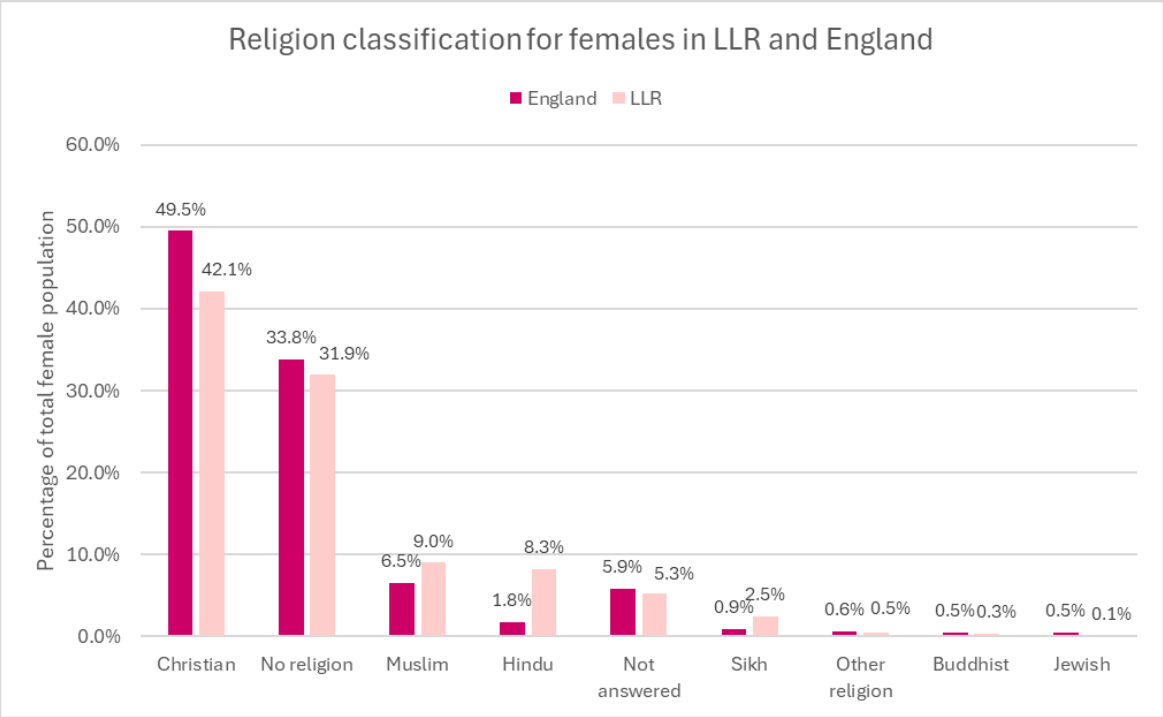
Language Spoken	Leicester Percentage		Language Spoken	Leicestershire Percentage
English	66.9%		English	92.4%
Gujarati	12.8%		Any other European languages	0.9%
Any other European languages	3.0%		Gujarati	0.9%
Panjabi	2.6%		Polish	0.8%
Polish	2.2%		Panjabi	0.6%
Any other South Asian languages	1.7%		Mandarin, Cantonese and other Chinese languages	0.2%
African languages	1.4%		Any other South Asian languages	0.2%
Urdu	1.0%		Any other East Asian languages	0.2%
Bengali	0.8%		Bengali	0.1%
West or Central Asian languages	0.7%		Portuguese	0.1%

Source: Census 2021, ONS.

Religion

According to Census (2021) data, Christianity remains the largest religion in both England and LLR, its representation is lower in LLR (42.1%) compared to England (49.5%). LLR has notably higher proportions of Muslim (9.0%) and Hindu (8.3%) females, reflecting the area's diverse cultural makeup. The percentage of females reporting no religion is similar across both regions. Smaller religious groups such as Sikh, Buddhist, and Jewish are present in lower proportions, with LLR showing higher Sikh representation.

Figure 5: Religion profile for females in LLR and England, 2021

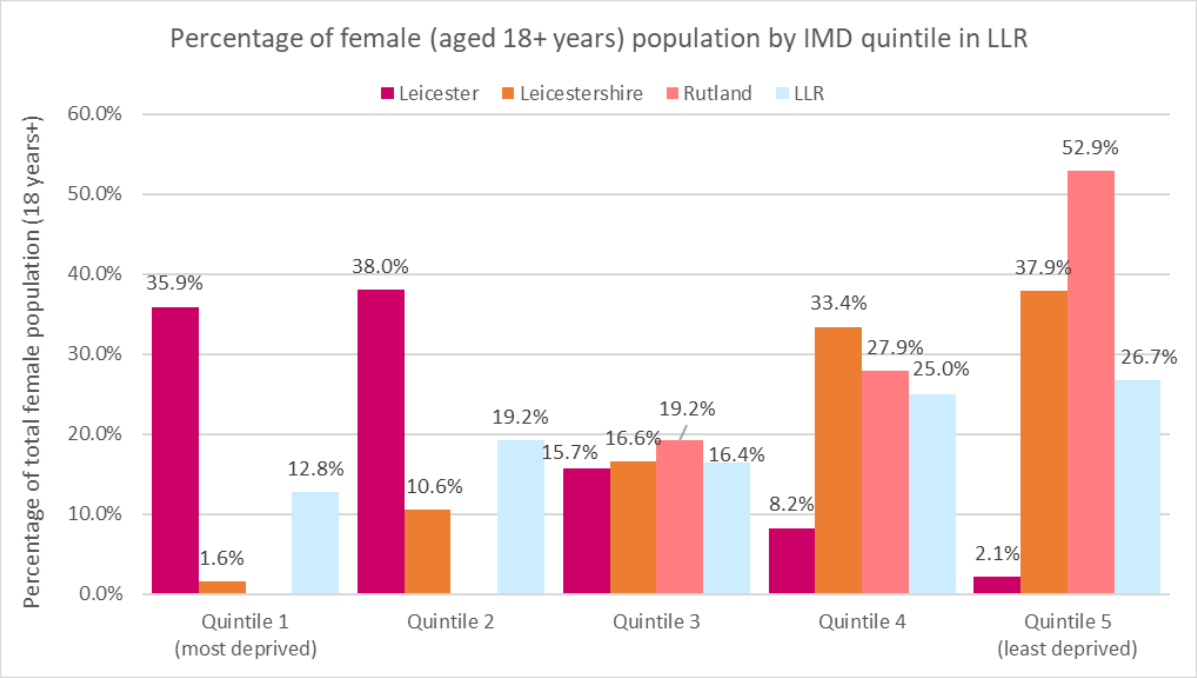


Source: Census 2021, ONS.

Deprivation

Figure 6 illustrates the distribution of adult females across deprivation levels in Leicester, Leicestershire, Rutland, and the combined LLR area. Leicester has a significantly higher proportion of females living in the most deprived quintiles (35.9% in Quintile 1) highlighting concentrated deprivation. In contrast, Leicestershire and Rutland show much lower proportions in these categories, with Leicestershire having only 1.6% in Quintile 1. The data highlights the stark inequalities across the region and the need for targeted public health interventions in Leicester. In Rutland over half (52.9%) of the female population aged 18 years and over are resident in quintile 5 (least deprived).

Figure 6: Proportion of female population by IMD quintile in LLR

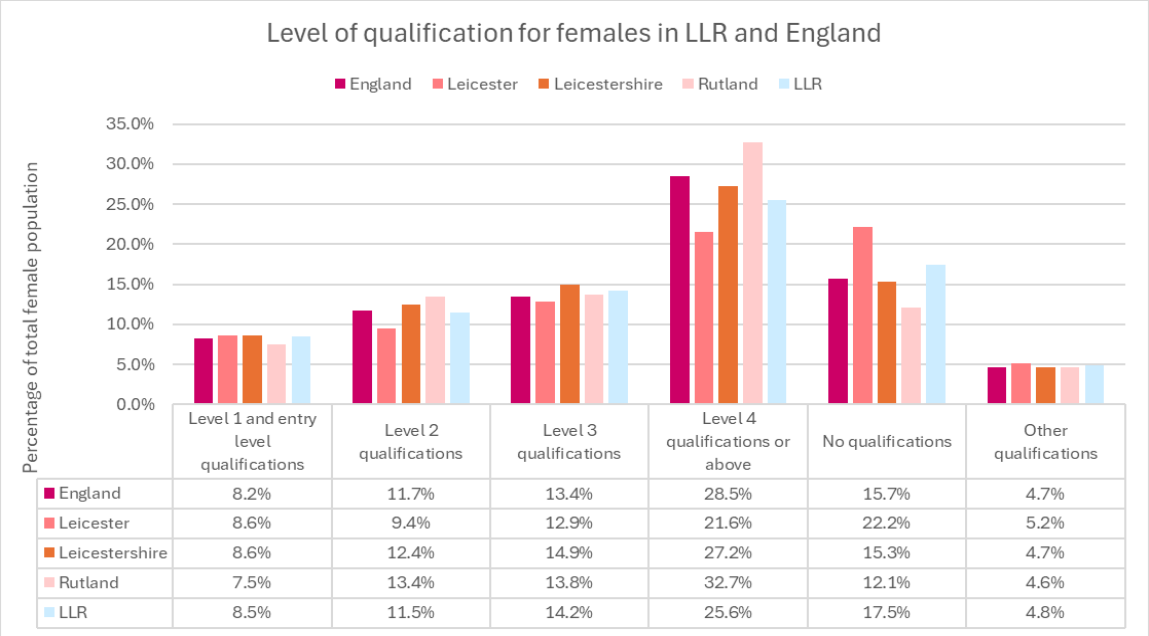


Source: ONS LSOA population estimates, 2021/22 and IMD 2019.

Education

Figure 7 compares the educational attainment of females across Leicester, Leicestershire, Rutland, and England. LLR shows a slightly lower proportion of females with Level 4 qualifications or above (25%) compared to the national average (28%), with Rutland having the highest at 32%. Leicester has the highest percentage of females with no qualifications (22%), significantly above the national figure of 15%, highlighting potential inequalities in access to education. The distribution across other qualification levels is broadly similar, though Leicestershire and Rutland show slightly higher attainment at Level 2 and Level 3.

Figure 7: Education qualification profile on females in LLR and England, 2021



	Level 1 and entry level qualifications	Level 2 qualifications	Level 3 qualifications	Level 4 qualifications or above	No qualifications	Other qualifications
England	8.2%	11.7%	13.4%	28.5%	15.7%	4.7%
Leicester	8.6%	9.4%	12.9%	21.6%	22.2%	5.2%
Leicestershire	8.6%	12.4%	14.9%	27.2%	15.3%	4.7%
Rutland	7.5%	13.4%	13.8%	32.7%	12.1%	4.6%
LLR	8.5%	11.5%	14.2%	25.6%	17.5%	4.8%

Source: Census 2021, ONS.

Life Expectancy at Birth and Healthy Life Expectancy at Birth

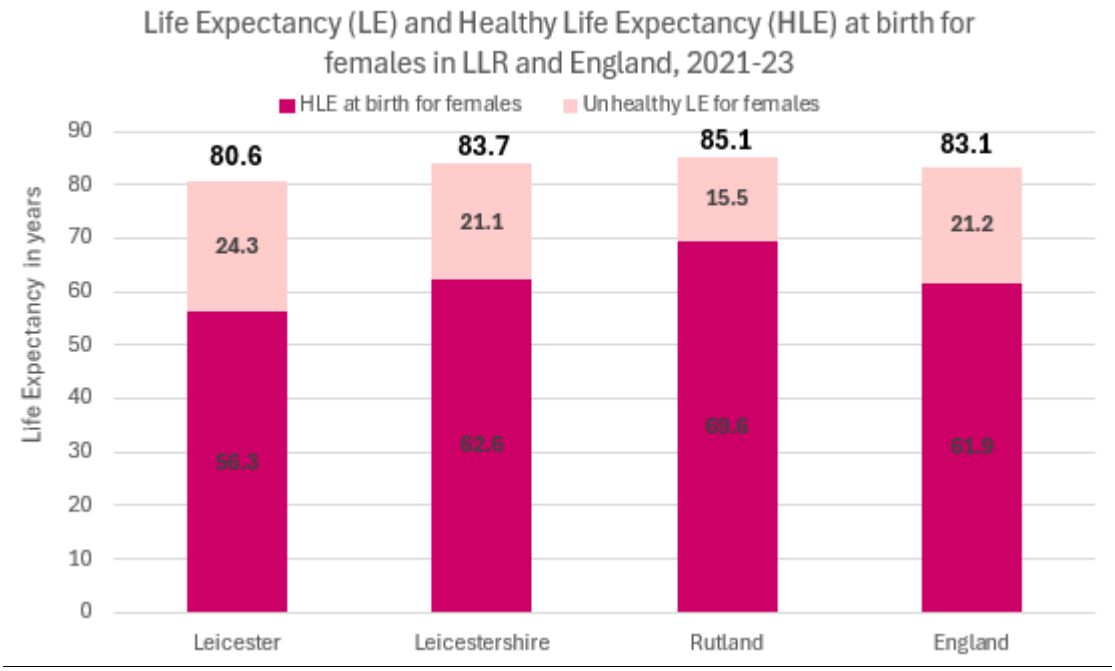
Life expectancy (LE) data gives context to healthy life expectancy (HLE) figures by providing information on the estimated length of life. The two indicators are extremely important summary measures of mortality and morbidity.

Life expectancy at birth data provides the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age specific mortality rates for that area and time period throughout his or her life. Whilst healthy life expectancy shows the years a person can expect to live in good health (rather than in poor health).

Life expectancy at birth for females in Leicestershire and Rutland has remained significantly better (higher) in comparison to the national average since 2001-03 and 2010-12, respectively. For Leicester, the life expectancy at birth for females has remained significantly worse (lower) in comparison to the national average since 2001-03. Healthy life expectancy at birth for females in Leicester has remained significantly worse (lower) and for Rutland, significantly better (higher) than the national averages since 2011-13. Healthy life expectancy at birth for females in Leicestershire has remained statistically similar to the national average since 2015-17.

Figure 8 compares female life expectancy and healthy life expectancy at birth across Leicester, Leicestershire, Rutland, and England. Rutland leads with the highest life expectancy (85.1 years) and the longest healthy life expectancy (69.6 years), while Leicester has the lowest figures (LE: 80.6 years, HLE: 56.3 years). The data highlights significant disparities in health outcomes across the region, with females in Leicester spending a larger portion of their lives in poor health compared to those in neighbouring areas.

Figure 8: Life expectancy and healthy life expectancy at birth for females in LLR and England, 2021/23



Source: Public Health Outcomes Framework Profile, OHID, 2025.

Mortality

All-cause mortality is a fundamental measure of the health status of a population. It represents the cumulative effect of the prevalence of risk factors, the prevalence and severity of disease, and the effectiveness of interventions and treatment. Differences in levels of all-cause mortality reflect health inequalities between different population groups, e.g. between genders, social classes and ethnic groups.

In LLR, there was a total of 15,295 deaths in females from all ages and all causes. The mortality rate (DSR per 100,000 female population) for all causes, all ages for females in Leicestershire (802) and Rutland (698) are significantly better (lower) in comparison to the national rate of 840. The mortality rate for Leicester (1,031) is significantly worse (higher) in comparison to the national rate. The trend for mortality from all causes, all ages in females for Leicester has remained significantly worse (higher) than England since 2011-03, whereas for Leicestershire and Rutland the trend has remained significantly better (lower) compared to England for the same time period (except 2004-07 for Leicestershire).

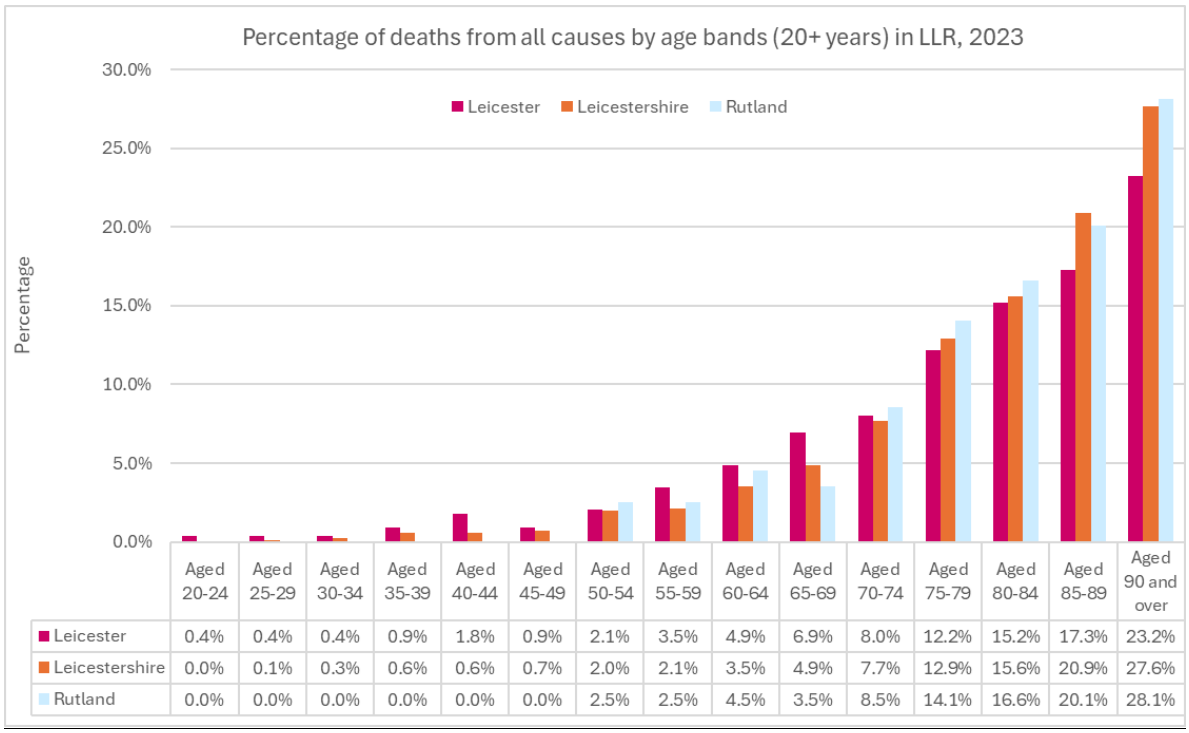
Figure 9: Mortality rate from all causes, all ages (females) - Directly age-standardised rate per 100,000, 2021-23, LLR.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	804,732	840	838	841
East Midlands region (statistical)	–	73,717	877	870	883
Leicester	–	4,098	1,031	1,000	1,064
Leicestershire	–	10,546	802	787	817
Rutland	–	651	698	644	755

Source: Mortality Profile, OHID, 2025

Figure 10 illustrates the distribution of female deaths by age group across Leicester, Leicestershire, and Rutland in 2023, focusing on individuals aged 20 and over. The proportion of deaths increase sharply with age across all three areas, with the highest percentages observed in the 90+ age group. Leicester consistently shows slightly higher percentages in younger age groups (e.g. 20–49), which may reflect underlying health inequalities or population structure differences. Female deaths in Leicestershire show a steady increase in the 50+ age groups. The older age bands (75+) dominate the mortality profile, with all three areas showing significant proportions of deaths, peaking in the 90+ group

Figure 10: Percentage of deaths from all causes for females aged 20 years and over in LLR, 2023.

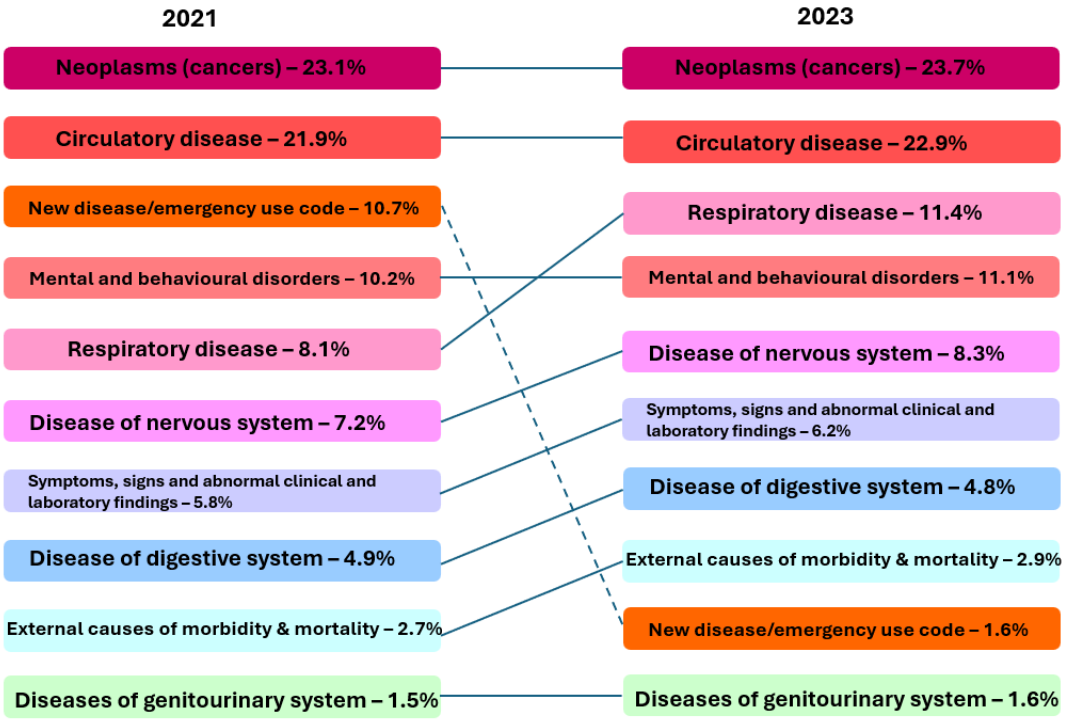


	Aged 20-24	Aged 25-29	Aged 30-34	Aged 35-39	Aged 40-44	Aged 45-49	Aged 50-54	Aged 55-59	Aged 60-64	Aged 65-69	Aged 70-74	Aged 75-79	Aged 80-84	Aged 85-89	Aged 90 and over
Leicester	0.4%	0.4%	0.4%	0.9%	1.8%	0.9%	2.1%	3.5%	4.9%	6.9%	8.0%	12.2%	15.2%	17.3%	23.2%
Leicestershire	0.0%	0.1%	0.3%	0.6%	0.6%	0.7%	2.0%	2.1%	3.5%	4.9%	7.7%	12.9%	15.6%	20.9%	27.6%
Rutland	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.5%	2.5%	4.5%	3.5%	8.5%	14.1%	16.6%	20.1%	28.1%

Source: ONS Mortality Statistics, NOMIS, 2023.

The top ten broad causes of death for females aged 20 years and over are presented below for 2021 and 2023, which account for over 90% of total female deaths. Deaths due to cancer, followed by circulatory diseases have remained the same in 2021 and 2023. Covid-19 (10.7%) would have been classed as 'new disease' and was ranked 3rd highest in 2021, but has since dropped to 9th highest in 2023, with respiratory diseases ranking 3rd highest in 2023.

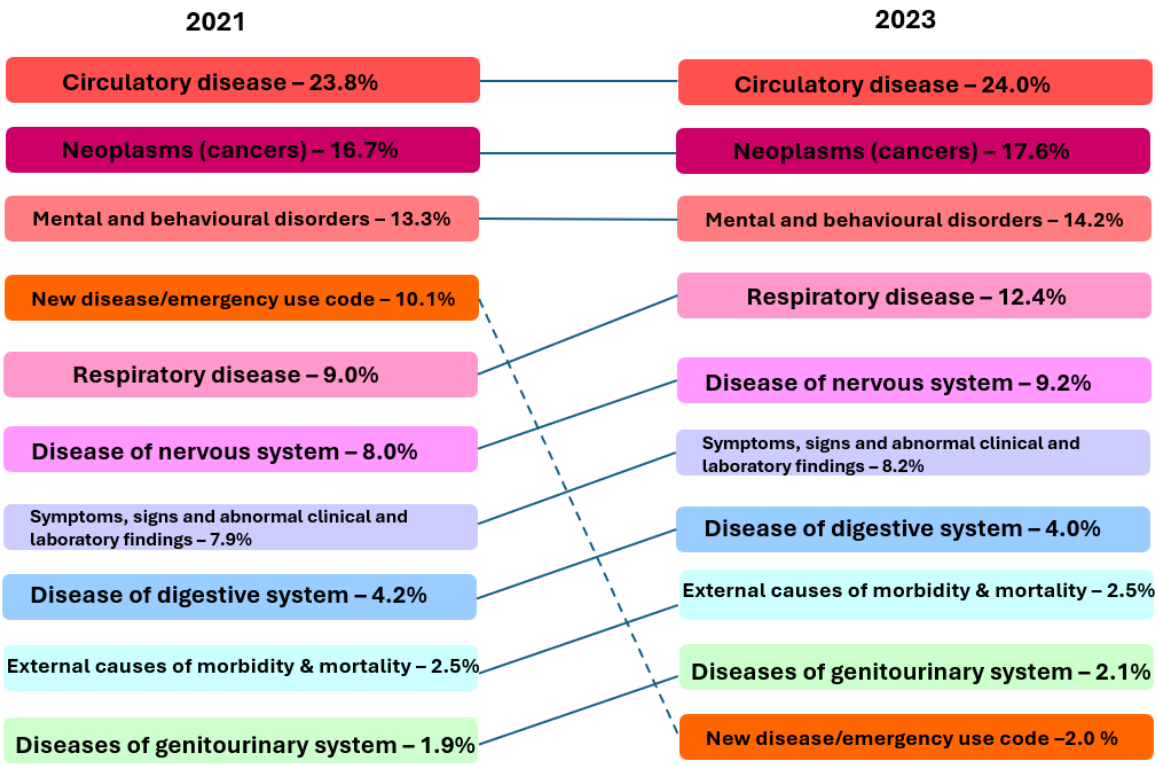
Figure 11: Top ten broad causes of deaths for females aged 20 years and over in LLR



Source: ONS Mortality Statistics, NOMIS, 2023.

The top ten broad causes of death for females aged 75 years and over are presented below for 2021 and 2023. Circulatory diseases remain the leading cause of death, increasing slightly from 23.8% in 2021 to 24.0% in 2023, indicating continued prevalence of heart-related conditions. Mental and behavioural disorders also increased from 13.3% to 14.2%, reflecting growing recognition or burden of these conditions and are ranked third highest cause after cancer. The proportion of deaths due to respiratory diseases has increased from 9.0% in 2021 to 12.4% in 2023, possibly influenced by post-pandemic effects or seasonal factors.

Figure 12: Top ten broad causes of deaths for females aged 75 years and over in LLR



Source: ONS Mortality Statistics, NOMIS, 2023.

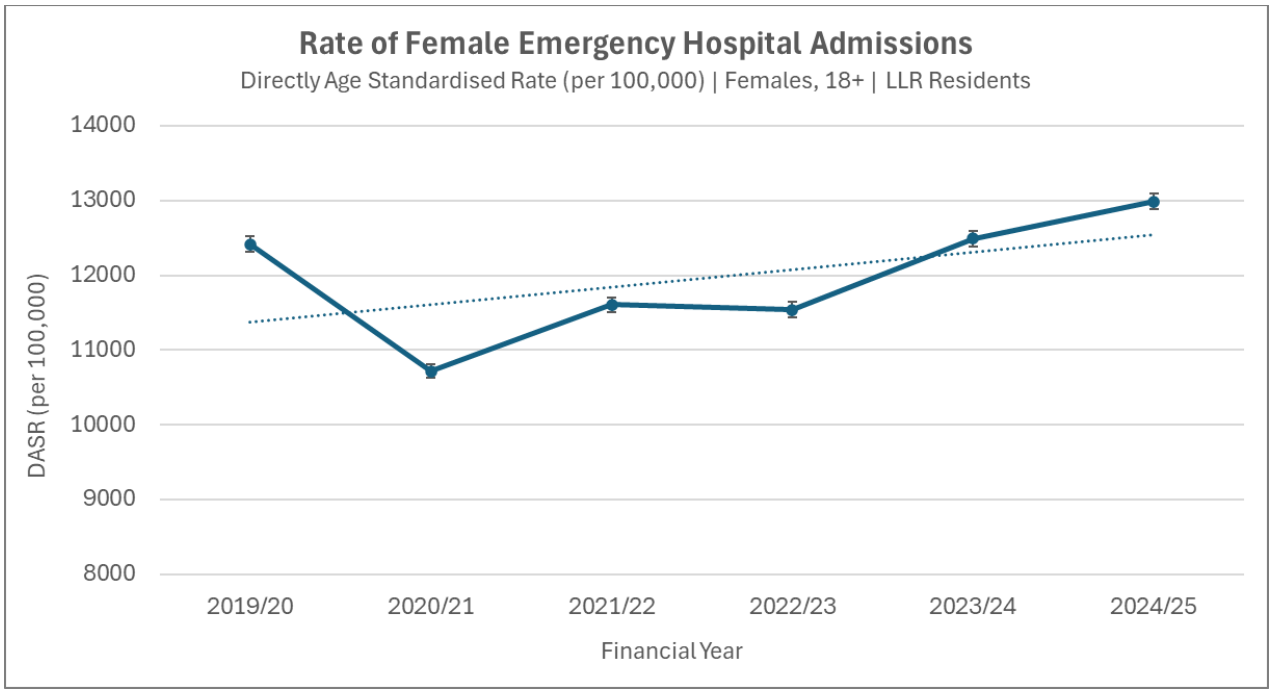
Morbidity

Morbidity refers to the presence of illness, disease or health conditions within the population. Morbidity data is important because it is an indicator of population health, it helps provide an understanding of what health conditions people are living with. High morbidity rates signal increased demand for healthcare services, medications and support systems. Morbidity data can also identify health inequalities which can often reveal disparities between different groups, therefore guiding targeted interventions.

Emergency Admissions:

This section presents emergency hospital admissions data to explore what health conditions, women in LLR are living with. In 2024/25, there were a total of just over 62,200 emergency admissions for females aged 18 and over in LLR. This equates to a rate of 12,986.5 per 100,000 female population (aged 18+), which is significantly higher in comparison to the previous years presented. The trend observed for this cohort over the last six years, shows the rate of emergency admissions has continued to rise significantly in LLR since 2022/23.

Figure 13: Emergency hospital admissions for females aged 18+ in LLR, 2019/20 to 2024/25



Source: HES, Admitted Patient Care Data

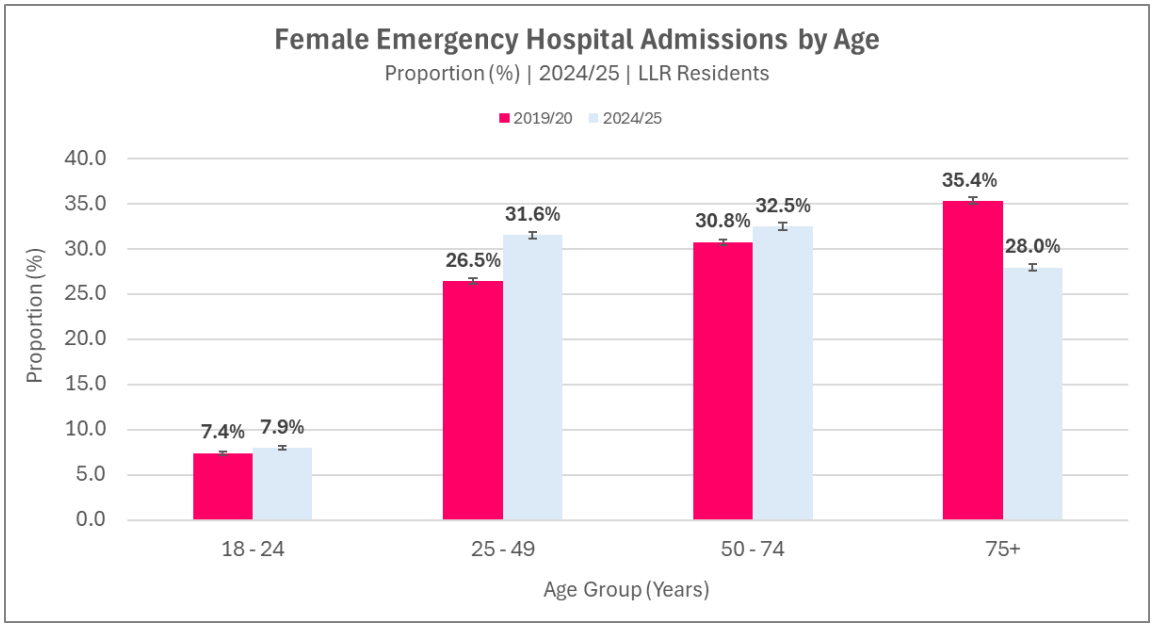
Emergency admissions by age:

Figure 14 compares the proportion of female emergency hospital admissions by age group for two time periods: 2019/20 and 2024/25 for LLR residents.

The highest number of emergency admissions in 2019/20 was in the 75+ age group (19,910), accounting for 35.4% of all emergency admissions. This changed to the 50-74 age group (20,245) in 2024/25 which accounted for 32.5% of all emergency admissions.

The largest increase in emergency admissions can be witnessed within the 25-49 group (31.8%), whilst a percentage decrease of 12.6% can be witnessed in the 75+ age group.

Figure 14: Emergency hospital admissions for females aged 18+ in LLR by age bands, 2019/20 and 2024/25



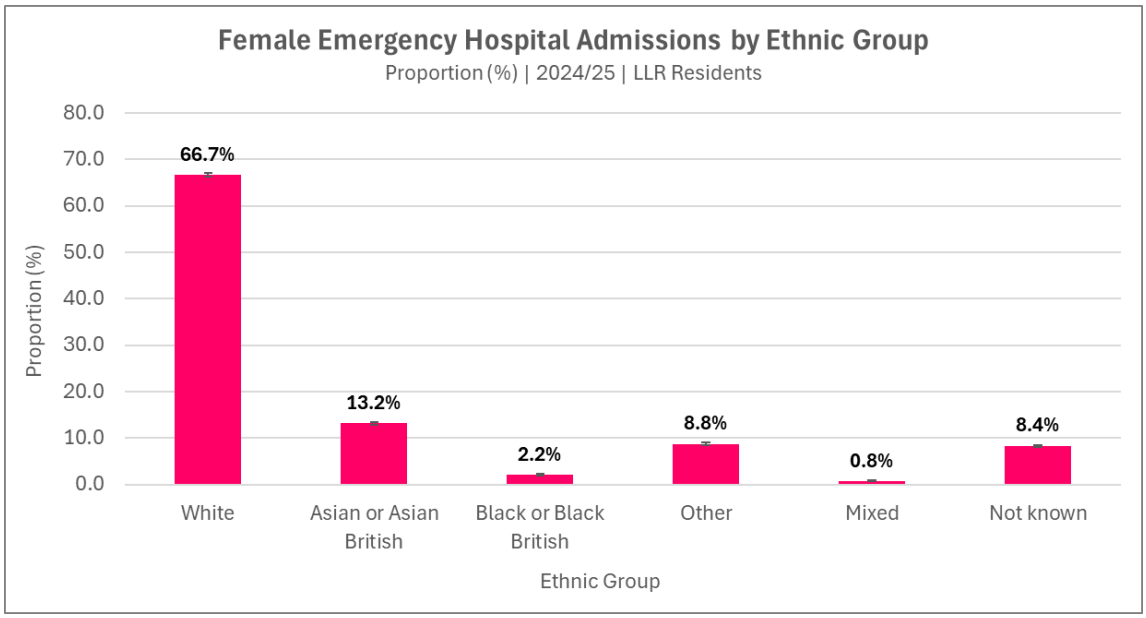
Source: HES, Admitted Patient Care Data

Emergency admissions by ethnicity:

Figure 15 shows the proportion of female emergency hospital admissions by ethnic group for LLR residents in 2024/25.

Over 65% of all emergency admissions were in females from the White ethnic group, followed by 13.2% from the Asian and Asian British ethic group which represents the second highest proportion of emergency admissions. Smaller proportions are within the remaining ethnic groups.

Figure 15: Emergency hospital admissions for females aged 18+ in LLR by ethnicity, 2024/25



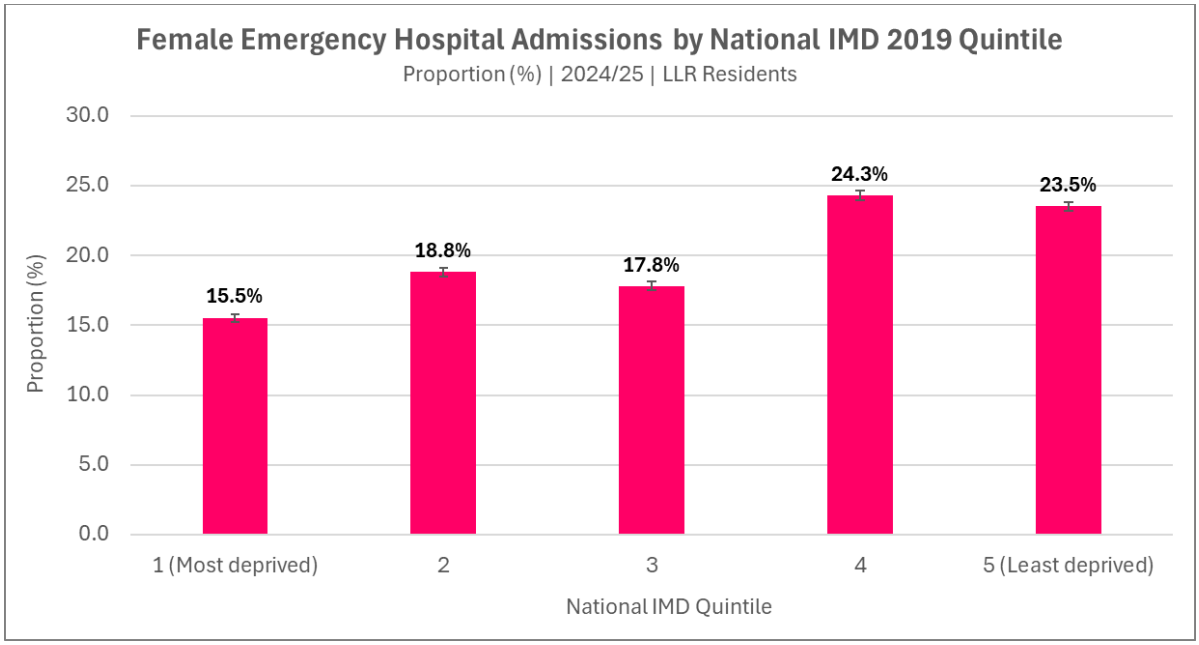
Source: HES, Admitted Patient Care Data

Emergency admissions by deprivation quintiles:

Figure 16 shows the proportion of female emergency hospital admissions by deprivation quintile (IMD 2019) for LLR residents in 2024/25.

The proportion of emergency admissions are higher among women in less deprived areas (Quintiles 4 and 5) compared to the most deprived group. This pattern contrasts with typical health inequalities, suggesting that factors other than deprivation—such as age distribution or health conditions—may influence admission rates.

Figure 16: Emergency hospital admissions for females aged 18+ in LLR by deprivation quintile, 2024/25



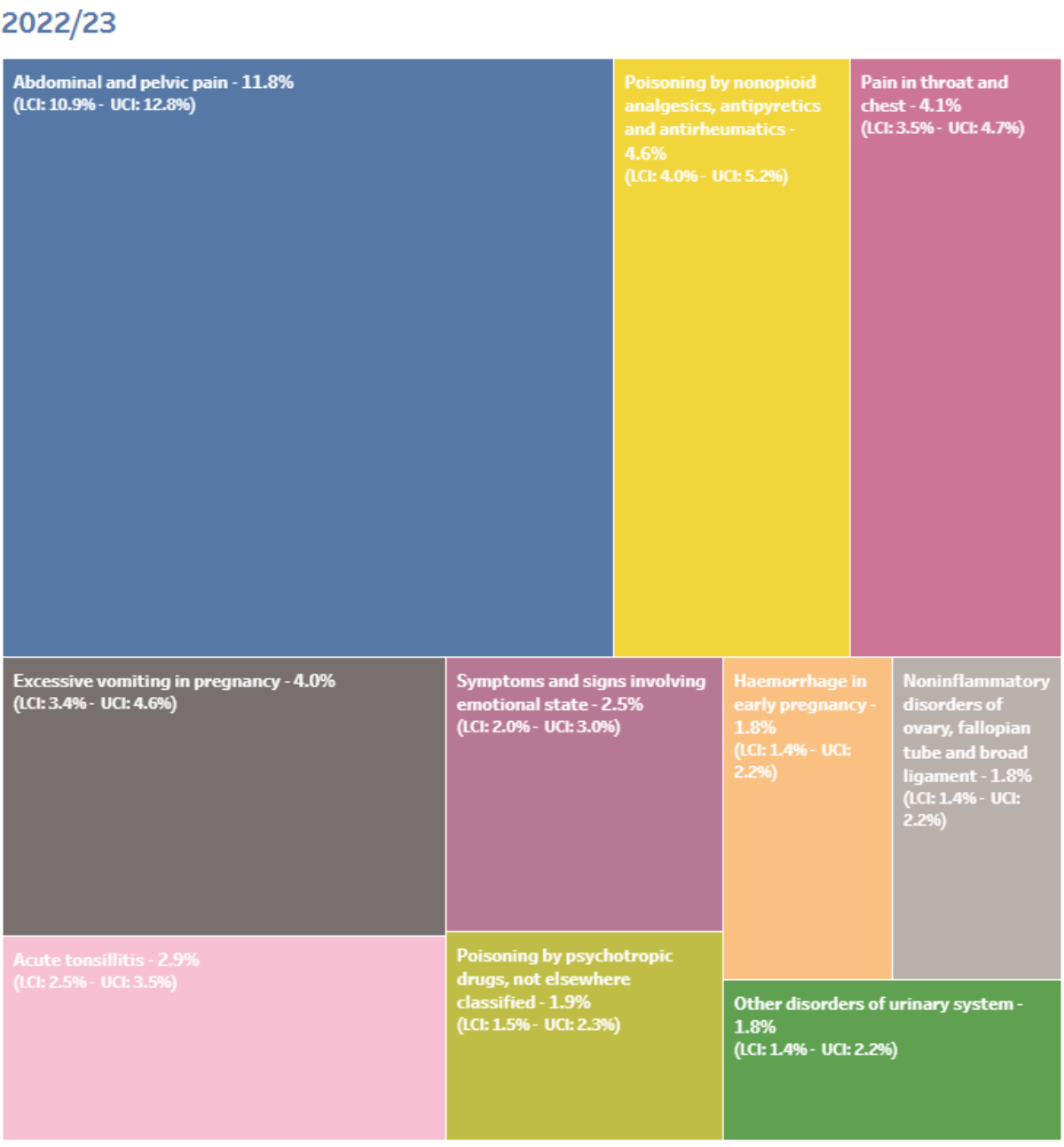
Source: HES, Admitted Patient Care Data and IMD 2019

Emergency admissions by health condition and age group:

The next few tree maps represent the proportion of emergency admissions categorised by the top ten reasons for admission by age group for 2022/23 and 2024/25.

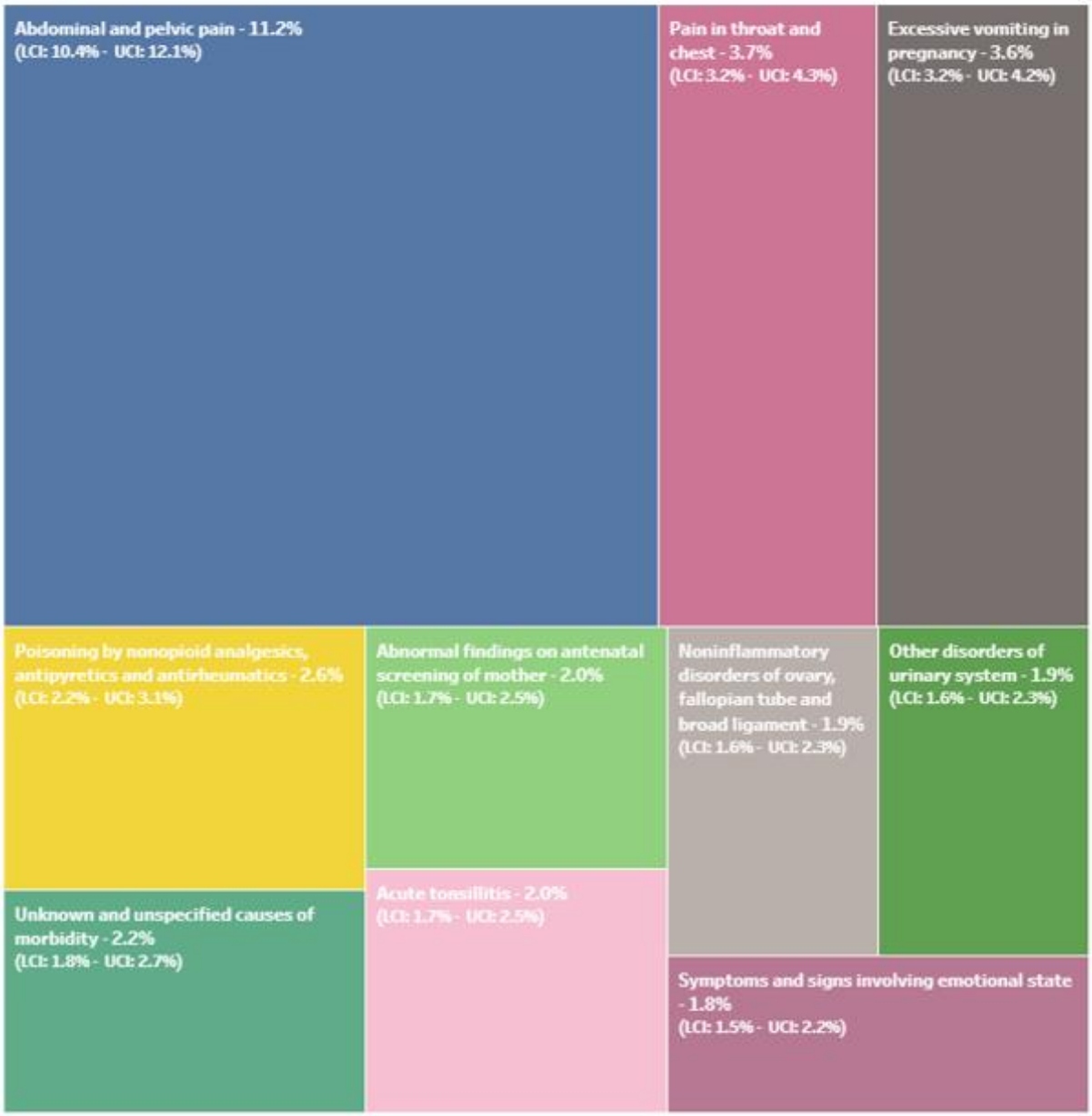
Emergency admissions in females in the 18-24 age group, account for about 8.0% of total admissions during both time periods. The most common reason for emergency admissions across both time periods within the 18-24 age group was Abdominal and pelvic pain, accounting for just over 11.0% of all admissions. The following conditions were within the top three highest across both years; poisoning from common painkillers and fever-reducing medicines, pain in throat and chest and excessive vomiting in pregnancy.

Figure 17: Emergency hospital admissions for females aged 18-24 in LLR by health condition, 2022/23 and 2024/25



Source: HES, Admitted Patient Care

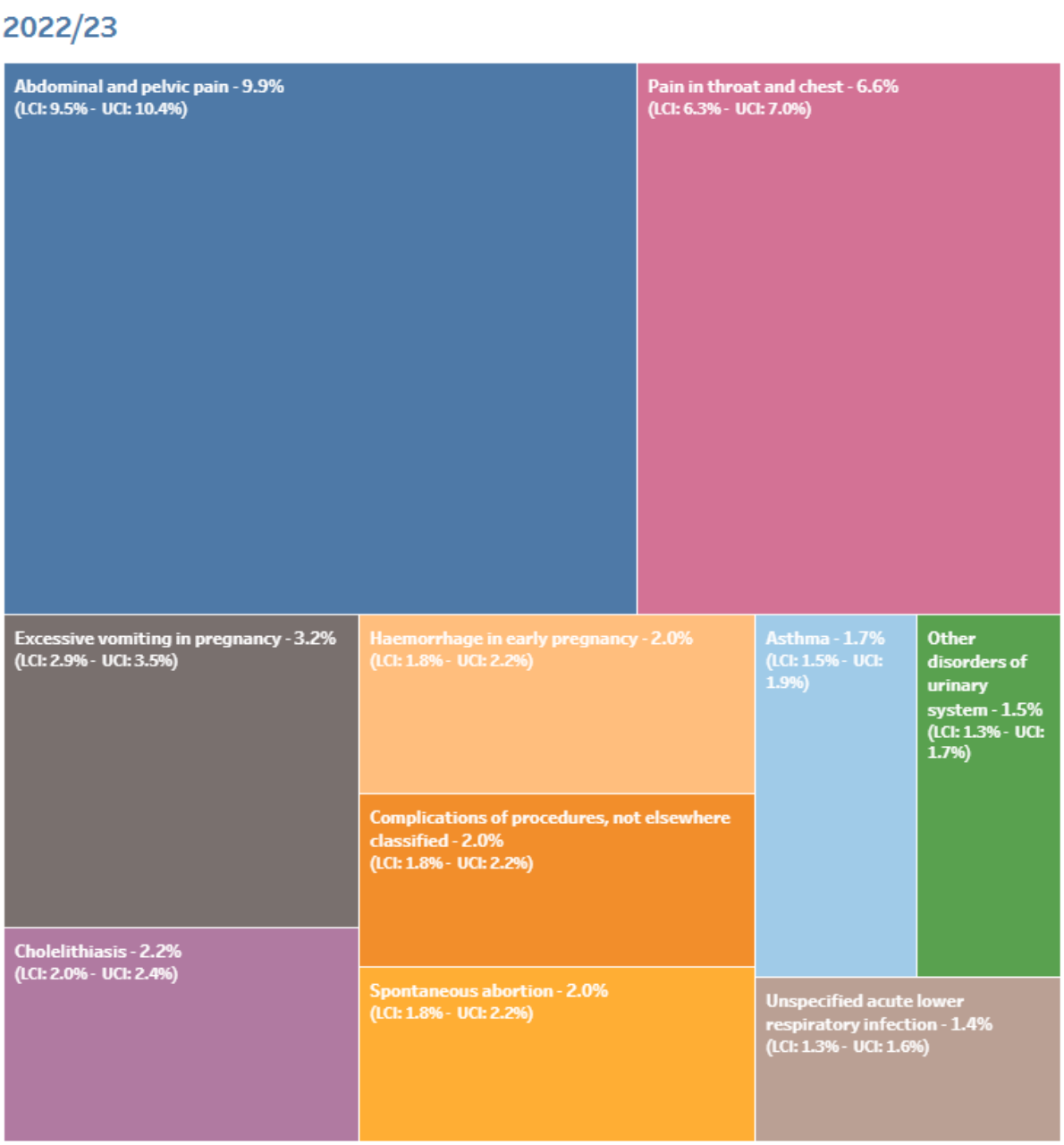
2024/25



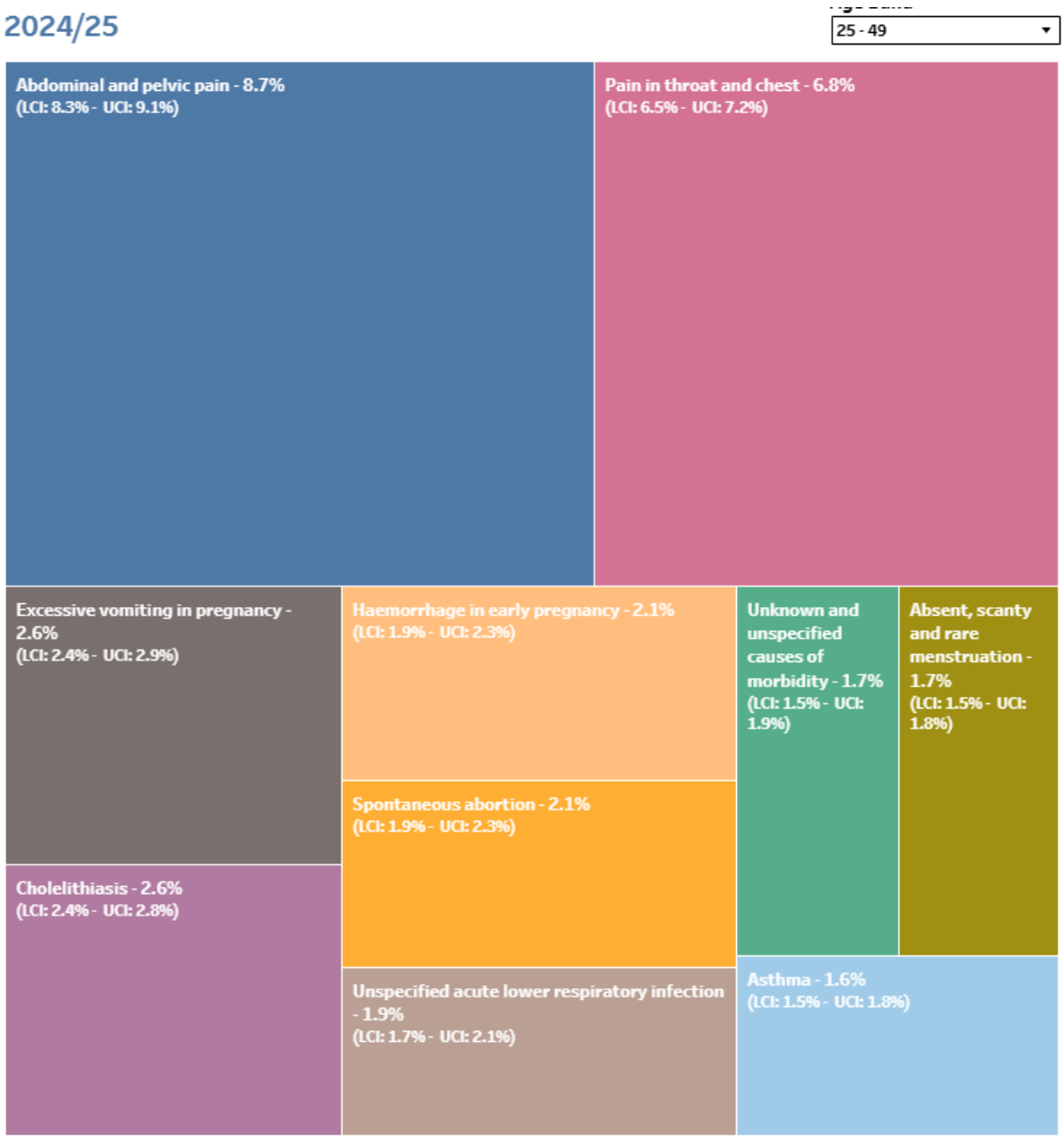
Source: HES, Admitted Patient Care

Emergency admissions in females in the 25-49 age group, account for just over 30.0% of total admissions during both time periods. The most common reason for emergency admissions across both time periods within the 25-49 age group was Abdominal and pelvic pain, accounting for 9.9% (2022/23) and 8.7% (2024/25) of all admissions. This was followed by pain in throat and chest and excessive vomiting in pregnancy across both time periods.

Figure 18: Emergency hospital admissions for females aged 25-49 in LLR by health condition, 2022/23 and 2024/25



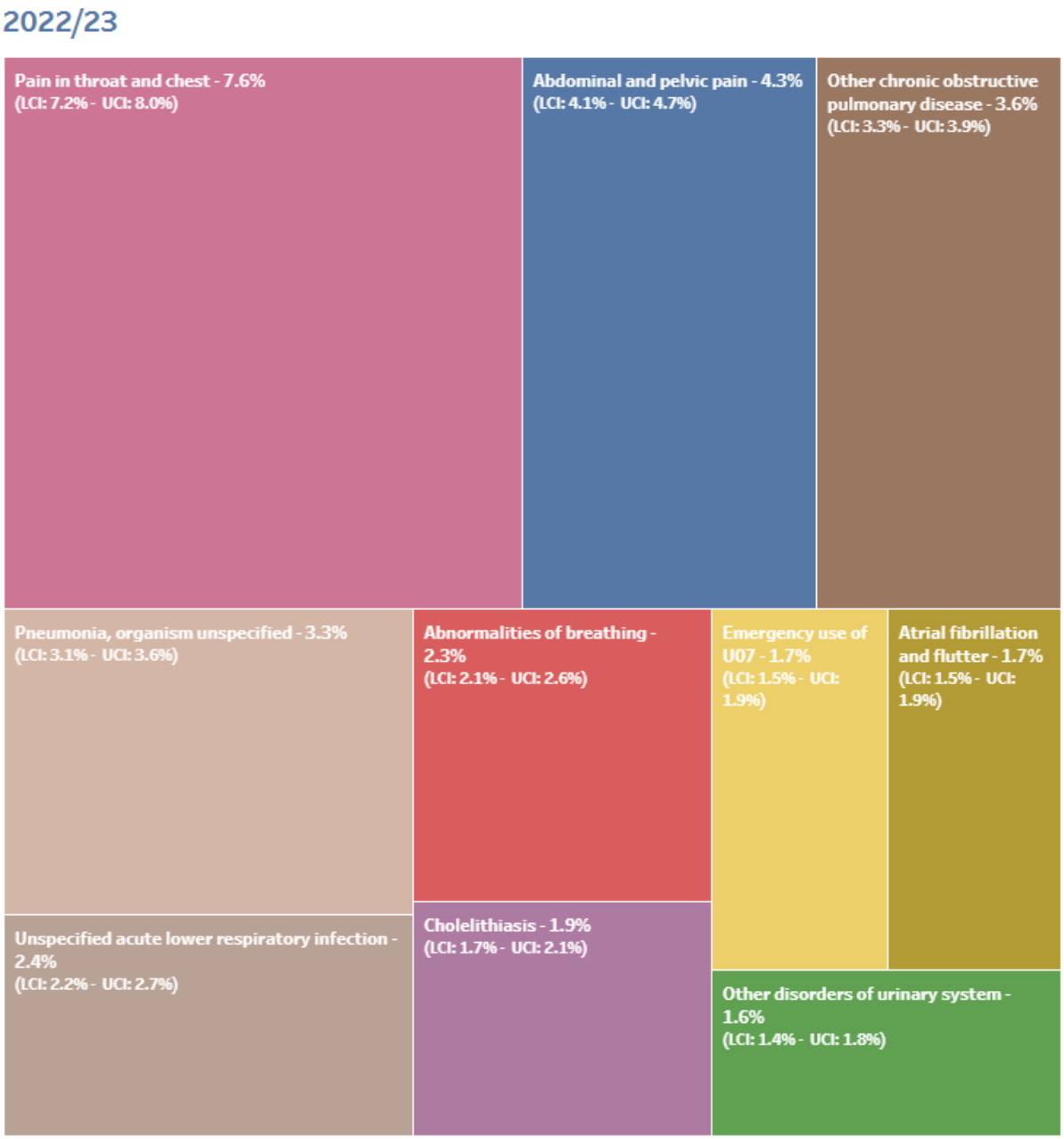
Source: HES, Admitted Patient Care



Source: HES, Admitted Patient Care

Emergency admissions in females in the 50-74 age group, account for 32.0% of total admissions during both time periods. The most common reason for emergency admissions across both time periods within the 50-74 age group was pain in throat and chest, accounting for 7.6% (2022/23) and 9.3% (2024/25) of all admissions. This was followed by abdominal and pelvic pain and other chronic obstructive pulmonary disease (2022/23) and pneumonia (2024/25).

Figure 19: Emergency hospital admissions for females aged 50-74 in LLR by health condition, 2022/23 and 2024/25



Source: HES, Admitted Patient Care

Emergency admissions in females in the 75+ age group, account for just over 28.0% of total admissions during both time periods. The most common reason for emergency admissions across both time periods within the 75+ age group was pneumonia, accounting for just over 5% of all admissions during both time periods. This was followed by fracture of femur and heart failure (2022/23) and pain in throat and chest (2024/25).

Figure 20: Emergency hospital admissions for females aged 75+ in LLR by health condition, 2022/23 and 2024/25



Source: HES, Admitted Patient Care



Source: HES, Admitted Patient Care

Women's Health Chapters

1 Menstrual Health and Gynaecological Conditions

This chapter covers endometriosis, dysmenorrhoea, menorrhagia and other menstrual disorders, period poverty, pelvis pain, ovarian pathology (non-cancerous), pelvic organ prolapse and continence and fibroids.

Key Epidemiology & Context

- Menstrual disorders are common, affecting a substantial proportion of women, with conditions such as heavy menstrual bleeding affecting up to 1 in 4 women.
- Endometriosis affects ~1 in 10 women, with long diagnostic delays (average ~8 years).
- Pelvic pain impacts up to 1 in 6 women and is a frequent cause of GP consultation, with local data showing rising trends in inpatient admissions for PID.

Inequalities & At-Risk Groups

- Women in deprived areas report worse symptoms and poorer quality of life
- Ethnic minority women may under-report symptoms due to stigma and health literacy differences
- Younger women disproportionately affected by menstrual disorders and period poverty

Gaps & Unmet Need

- Significant diagnostic delays (especially endometriosis)
- Underreporting means prevalence is likely underestimated
- Limited focus on quality of life impacts (social, economic, emotional)
- Data gaps across ethnicity and underserved groups

Implications for LLR

- High burden on primary and secondary care pathways
- Missed opportunities for early diagnosis and prevention
- Economic impact through reduced work participation

Priority Action Themes

- Improve diagnostic pathways and reduce delays
- Strengthen menstrual health literacy and stigma reduction
- Expand research and data on local prevalence and experience
- Enhance holistic support beyond clinical treatment

1.1 Endometriosis

1.1.1 Background

Endometriosis is the second most common gynaecological condition in the UK.[5] Endometriosis is a 'disease which tissue similar to the lining of the uterus grows outside the uterus. This leads to inflammation and scar tissue forming in the pelvic region and (rarely) elsewhere in the body'.[6] It is a chronic disease associated with severe, life-impacting pain during periods, sexual intercourse, bowel movements and/or urination, chronic pelvic pain, abdominal bloating, nausea, fatigue, and sometimes depression, anxiety, and infertility.[6]

The cause of Endometriosis is unknown and there is not yet a cure for this disease. Tests such as ultrasound scans, MRI scans and a laparoscopy procedure are used to diagnose Endometriosis.[8] Endometriosis costs the UK economy around £8.2 billion every year in healthcare costs, loss of work and treatments.[7]

Treatment options are available to manage symptoms, such as medicines (painkillers and hormones) in the first instance, followed by surgery if medicines are not working.[8]

1.1.2 Who's at risk for Endometriosis

Studies have shown there are several risk factors that can increase a women's chance of developing endometriosis, these include:[9, 10, 11, 12]

- Low birth weight.
- Early menarche (menstruation).
- Short menstrual cycles.
- Increased menstrual flow.
- Nulliparity (female who has never given birth to a live baby).
- Family history.
- Vaginal outflow obstruction.
- White ethnicity.
- Low body mass index (BMI).
- Autoimmune disease (an increased prevalence of autoimmune diseases has been noted in women with surgically confirmed endometriosis).

[5] Endometriosis UK (2025). Endometriosis facts and figures. Available at: https://www.endometriosis-uk.org/endometriosis-facts-and-figures#:~:text=1%20in%2010%20women%20and,5

[6] World Health Organisation (2023). Endometriosis. Available at: https://www.who.int/news-room/fact-sheets/detail/endometriosis

[7] Endometriosis UK (2024). The long road to endometriosis diagnosis in the UK. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.endometriosis-uk.org/sites/default/files/2024-03/Endometriosis%20UK%20diagnosis%20survey%202023%20report%20March.pdf

[8] NHS (2024). Endometriosis. Available at: https://www.nhs.uk/conditions/endometriosis/

[9] Zondervan, K.T., Becker, C.M. and Missmer, S.A. (2020) Endometriosis. *New England Journal of Medicine* **382**(13), 1244-1256

[10] Horne, A.W. and Missmer, S.A. (2022) Pathophysiology, diagnosis, and management of endometriosis. *British Medical Journal* **379**(e70750), e70750

[11] Allaire, C., Bedaiwy, M.A. and Yong, P.J. (2023) Diagnosis and management of endometriosis. *Canadian Medical Association Journal* **195**(10), E363-E371

[12] BMJ Best Practice (2023) *Endometriosis*. BMJ Publishing Group. Available at: https://bestpractice.bmj.com

1.1.3 Level of Need

In the UK, around 1 in 10 females of reproductive age suffer from Endometriosis (this equates to over 1.5 billion people), this increases to 30-50% in females experiencing infertility.[13]

A survey carried out by Endometriosis UK aimed to determine the average length of time to secure a diagnosis of endometriosis and found that in England this was on average 8 years and 10 months, with 72% of participants diagnosed by laparoscopy and 18% by scan (MRI or ultrasound).[7]

ONS (Office for National Statistics) published findings on a population level study that explored the characteristics of women with endometriosis in England between 2011 to 2021. There was a total study population of 24,560,795, with a count of 262,065 females with endometriosis. A summary of the findings is stated below:[14]

- women living in the most and least deprived areas were least likely to have an endometriosis diagnosis, possibly reflecting lower access to healthcare services in the most deprived group and more use of private healthcare in the least deprived group.
- The likelihood of receiving and endometriosis diagnosis was highest in the 'White British', 'Black Caribbean' and 'Mixed White' ethnic groups.
- Women reporting being in bad health or disabled, were more likely to have an endometriosis diagnosis compared to those in very good health or non-disabled women, respectively.
- LLR Local Authority estimates were based on a total study population of 473,720, with 4,830 (1.0%) females diagnosed with endometriosis. The table below provides a breakdown of age standardised rates by LA area. Leicestershire and Rutland have statistically similar rates to England, whilst Leicester had significantly lower rates of females diagnosed with endometriosis.

Table 3: Age standardised rates for Endometriosis in LLR, 2011-2021

Area	Count, with an endometriosis diagnosis	Count, total	Age-standardised rate	Age-standardised rate, 95% lower confidence limit	Age-standardised rate, 95% upper confidence limit
Leicester	1,495	147,310	938.51	889.80	987.21
Leicestershire	3,200	309,260	1,069.92	1,032.65	1,107.18
Rutland	135	17,150	956.04	790.72	1,121.35
England	262,065	24,560,795	1,067.01	1,062.92	1,071.09

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

Source: ONS, 2024

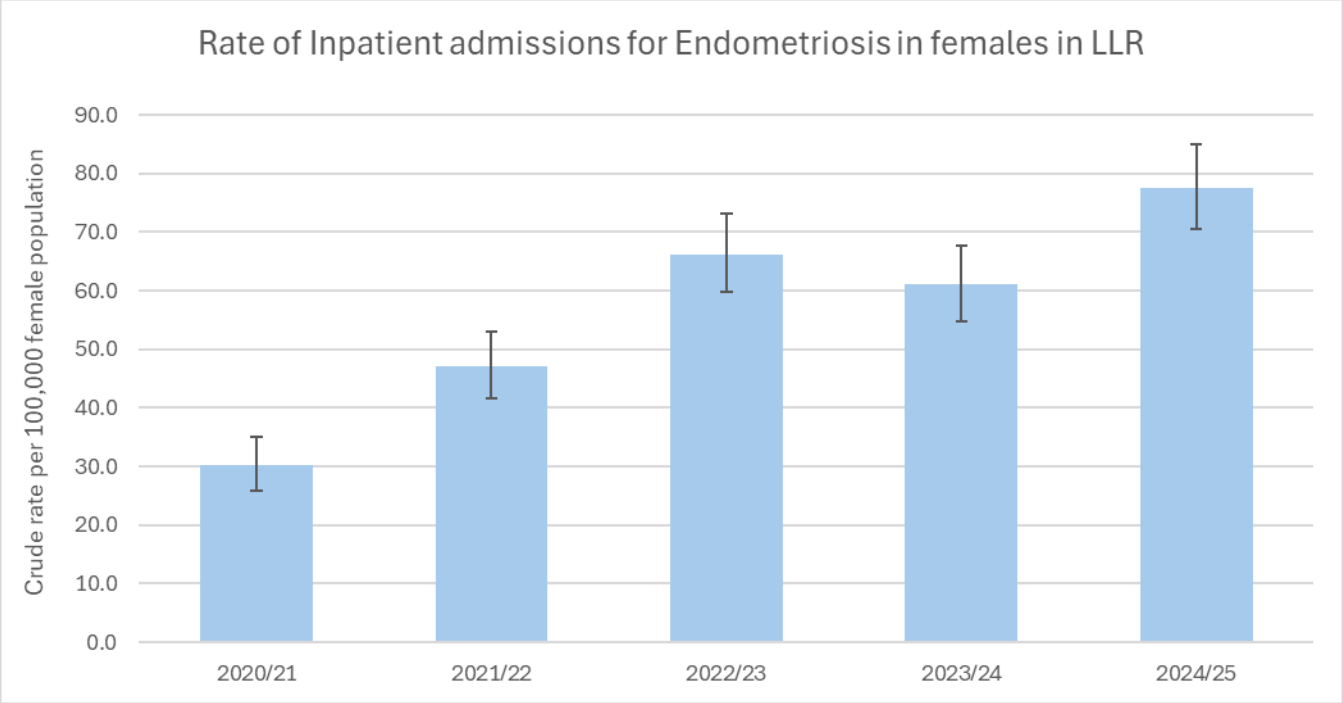
Figure 21 below shows a five year trend in inpatients admissions for Endometriosis in females' resident in LLR. The rate in 2024/25 (77.5 per 100,000 female population) is significantly higher

[13] Rogers PA, D'Hooghe TM, Fazleabas A, Gargett CE, Giudice LC, Montgomery GW, Rombauts L, Salamonsen LA, Zondervan KT. Priorities for endometriosis research: recommendations from an international consensus workshop. Reprod Sci. 2009 Apr;16(4):335-46. doi: 10.1177/1933719108330568. Epub 2009 Feb 5. PMID: 19196878; PMCID: PMC3682634.

[14] ONS (2024). A better understanding of endometriosis in England. Available at: https://blog.ons.gov.uk/2024/12/10/a-better-understanding-of-endometriosis-in-england/

in comparison to the rate in 2020/21 (30.2 per 100,000 female population), 2021/22 (47.1 per 100,000 female population) and 2023/24 (61.0 per 100,000 female population). It is important to note that lower admissions in 2020 and 2021 could have been due to the covid pandemic.

Figure 21: Trend in inpatient admissions for Endometriosis in females in LLR



Data Source: MLCSU SUS Inpatient Data, 2025

Note: ICD Diagnosis code used – N800 to N809.

1.1.4 What evidence-based management is recommended?

In terms of primary care management, NICE guidance recommends painkillers (paracetamol/NSAIDs (non-steroidal anti-inflammatory drugs)) and hormonal treatments (combined oral contraceptive pill/progesterone-only pill/implant/injections or IUS) for managing pain and symptoms. In addition to the above, transvaginal ultrasound should also be offered to patients with suspected endometriosis in order to rule out other causes, detect endometriosis and guide treatment.[15]

Secondary care investigations and treatment involve ultrasounds (Transvaginal or Transabdominal) and laparoscopy (keyhole surgery, used to examine and treat conditions with the abdomen and pelvis). If needed a hysterectomy is also an option.[15]

1.1.5 Current Services in LLR

Women are able to visit their GP for support, investigation and treatment, this is also the pathway for accessing secondary care. There are a total of 172 GP practices (including branch

[15] NICE (2024). Management of endometriosis. Available at: https://cks.nice.org.uk/topics/endometriosis/management/management-of-endometriosis/#secondary-care-assessment-investigations

surgeries) serving the population of LLR. The University Hospitals of Leicester NHS Trust have a department of Gynaecology that hosts gynaecology clinics for women with Endometriosis.

1.1.6 Unmet needs or gaps

The published average diagnosis time (average of 8 years) remains long, and unacceptable, further work needs to be carried out to understand what the diagnosis times are locally.

ONS research suggests women living in deprived areas were less likely to have an endometriosis diagnosis. This requires further exploration locally to establish what barriers females living in deprived areas within Leicester City and Leicestershire County face in accessing healthcare for endometriosis, therefore this could indicate that the rates of endometriosis could potentially be higher within the local population.

Endometriosis affects women during their working and reproductive years, which amplifies its social and economic impact.

Endometriosis significantly affects physical, mental, sexual and social well-being, this can all have a significant impact on quality of life, therefore, engaging with women in LLR about their health needs will provide valuable intelligence around any unmet needs and gaps in current services.

1.1.7 Recommendations

Every female with endometriosis in LLR should have the appropriate, high quality treatment regardless of background, identity, location or circumstance.

- Undertake work to establish what the diagnosis times are locally and pending findings, look at ways to reducing the time it takes for a diagnosis. The women's health hubs could also be an option to help improve the diagnostic process. Endometriosis UK have set a target to reduce the average time of diagnosis of eight years to four years by 2025 and under one years by 2030.[16]
- Use a PHM (Population Health Management) approach to exploring enablers and barriers to healthcare for those with diagnosed/undiagnosed endometriosis living in most deprived areas within LLR and also hard to reach communities.
- Explore ways in how best to support women who are impacted by Endometriosis to improve their quality of life.

1.2 Dysmenorrhoea, Menorrhagia and other Menstrual Disorders

1.2.1 Background

Menorrhagia, or heavy menstrual bleeding, is defined by NICE (National Institute for Health and Care Excellence) as "excessive menstrual blood loss which interferes with a woman's physical, social, emotional, and/or material quality of life, and which can occur alone or in combination with other symptoms".[17] Heavy menstrual bleeding is considered to be a loss of 80ml or more

[16] Endometriosis UK (2022). Women's Health Strategy England. Available at: https://www.endometriosis-uk.org/womens-health-strategy-england-much-be-welcomed-many-questions

[17] NICE (2024). Menorrhagia (heavy menstrual bleeding). Available at: https://cks.nice.org.uk/topics/menorrhagia-heavy-menstrual-bleeding/

of blood during a period, compared to 30-40ml for a 'normal' period.[18] As measuring menstrual blood loss is difficult, the NHS uses the following indicators for defining heavy periods:

- needing to change pads/tampons every 1 to 2 hours, or empty menstrual cups more often than the recommended frequency
- needing to use period products together – e.g., pad and tampon
- periods lasting more than 7 days
- passing blood clots larger than about 2.5cm width
- bleeding through clothes or bedding
- avoiding daily activities (exercise, work, school) due to bleeding.[19]

Menorrhagia can occur alone or in combination with other symptoms, including dysmenorrhea, which is defined by NICE as "painful cramping, usually in the lower abdomen, which occurs shortly before and/or during menstruation". Dysmenorrhoea falls into two types: primary, where there is no identifiable underlying cause, and secondary, which is linked to pathology such as endometriosis or fibroids or the insertion of an intrauterine device (IUD).[20]

Possible causes of menorrhagia include uterine fibroid, uterine cancer, endometriosis, systemic disorders (such as coagulation disorders and hypothyroidism), and medications (such as anticoagulants), but for nearly half of women diagnosed with menorrhagia, no underlying cause is found.

1.2.2 Who's at risk of menorrhagia/dysmenorrhea

Research into epidemiological risk markers for menorrhagia, published in medical journal Maturitas, found that "only age could be indicated as a risk marker for menorrhagia [and} parity, body mass index, and smoking habits appear to have no significant effect" on menstrual blood loss.[21] Risk factors for primary dysmenorrhea (no underlying pathology) include having a first period at an early age, heavy bleeding, never having given birth, and having a family history of dysmenorrhoea.

1.2.3 Level of need

According to NICE, about 1 in 20 women aged between 30–49 years consult their GP each year about menstrual disorders, constituting around 12% of all referrals to gynaecology services. A cohort study from the National Heavy Menstrual Bleeding Audit, published in the BMJ, states that heavy menstrual bleeding (HMB) affects 1 in 4 women of reproductive age and leads to 50,000 referrals to NHS secondary care gynaecology services per year.[22] The same study found approximately 20% of referrals to specialist gynaecology services are the result of menstrual disorders, and more than a third of women with heavy bleeding report severe pain. This ties in with information from NICE stating that dysmenorrhoea is reported to be common, with prevalence rates in studies ranging 16% to 91% in women of reproductive age. There is a higher risk of anaemia in women who eat less/ no red meat and this disproportionately affects the

[18] Patient (2024). Heavy Periods – Menorrhagia. Available at: https://patient.info/womens-health/periods-and-period-problems/heavy-periods-menorrhagia
[19] NHS (2024). Heavy Periods. Available at: https://www.nhs.uk/conditions/heavy-periods/
[20] NICE (2023). Dysmenorrhoea. Available at: https://cks.nice.org.uk/topics/dysmenorrhoea/
[21] Janssen CA, Scholten PC, Heintz AP. Menorrhagia--a search for epidemiological risk markers. Maturitas. 1997 Sep;28(1):19-25. doi: 10.1016/s0378-5122(97)00065-0. PMID: 9391991.
[22] Kiran A, Geary RS, Gurol-Urganci I*, et al* Sociodemographic differences in symptom severity and duration among women referred to secondary care for menorrhagia in England and Wales: a cohort study from the National Heavy Menstrual Bleeding Audit *BMJ Open* 2018;**8:**e018444. doi: 10.1136/bmjopen-2017-018444

Asian community, this is a further factor in women's health inequalities disproportionately impacting on women from BAME backgrounds.

The aforementioned National Heavy Menstrual Bleeding Audit cohort study found, "Women living in more socioeconomically deprived areas reported more severe HMB symptoms and poorer QoL [(Quality of Life)] at their first gynaecology outpatient visit. Older women reported less severe symptoms and better QoL than younger women. Reported symptom severity also varied by ethnicity with black and Asian women reporting less severe symptoms than women from white ethnic backgrounds." They propose this disparity could be because women from minority and deprived backgrounds are less likely to report symptoms and seek help, citing research that found people from these groups might be more tolerant of poorer health.[23] Applying this to Leicester with its ethnic makeup and levels of deprivation, it suggests the prevalence of menstrual disorders could be higher in the city than in the national picture.

As suggested by NICE's definition of menorrhagia, menstrual disorders can have a significant impact on the quality of life for women and girls. The Leicester Children's Health and Wellbeing Survey 2021/22 found that around two in five (37%) female secondary aged children could not access menstrual products all of the time. This was made up of almost one quarter (23%) who were able to access products for their periods most of the time, 12% able to access sanitary products some of the time, and 3% none of the time.[24] The survey did not include information on number of pupils missing school due to not being able to access menstrual products. However, a pupil survey conducted in Bristol in 2019 found that "10% of secondary school age girls had missed school in the last month due to their period and it was the third highest reason for absence".[25] As well as quality of life impacts, menorrhagia can affect physical health, with complications including iron deficiency anaemia.

1.2.4 What evidence-based management is recommended?

Addressing menstrual disorders centres around diagnosis and management. Definitive diagnosis for some conditions such as endometriosis (which requires a diagnostic laparoscopy) can be challenging to achieve and contributes to waiting lists for secondary care gynae and the lengthy time periods some women spend waiting for a diagnosis. Treatment options for menstrual disorders depends on nature, severity, and presence or absence of underlying pathology. For the management of dysmenorrhea, the NHS recommends non-medical options such as hot water bottles, massage, and gentle exercise, as well as medical interventions such as painkillers, anti-inflammatory medication, and contraception.[26] For menorrhagia, NICE outlines various pharmacological treatment options, such as anti-inflammatory medication and contraception, and surgical interventions, including hysterectomy for more severe cases.[27]

Treatment of dysmenorrhoea includes treatment for endometriosis which is often an underlying issue and treatment for menorrhagia often includes treatment for fibroids which may be an underlying cause. Medical interventions such as painkillers, anti-inflammatory medication, radiographic imaging, and hormonal treatment options such as oral contraceptive pill,

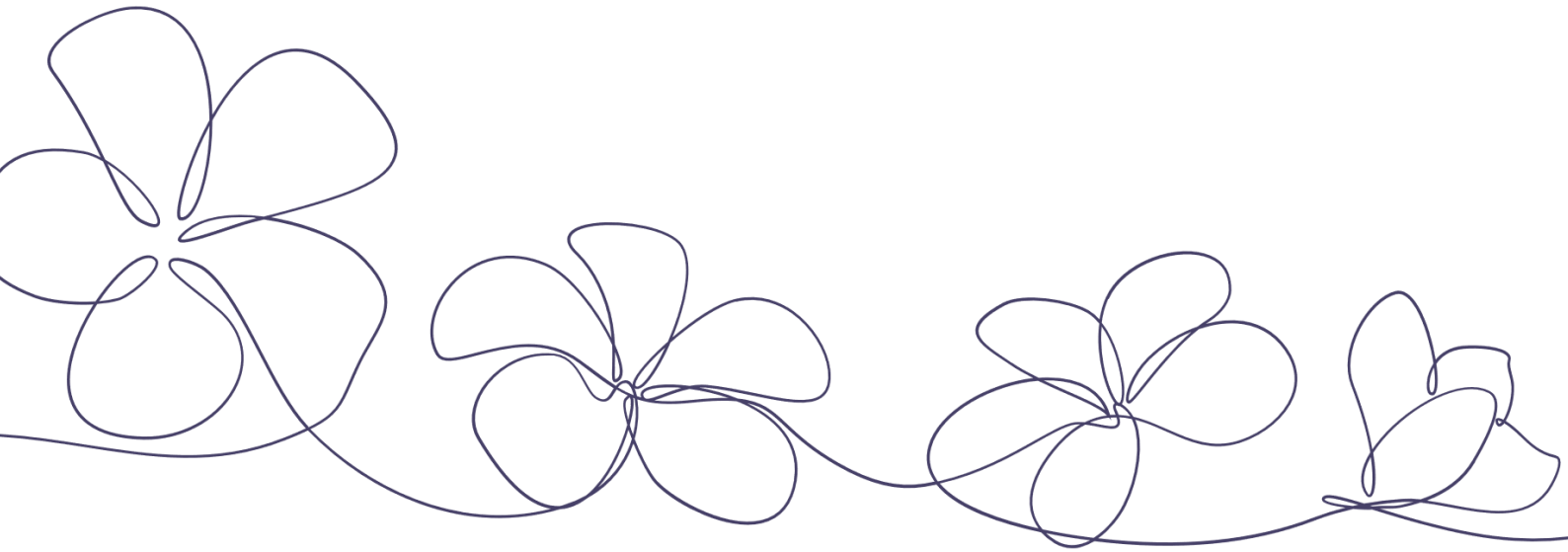
[23] Delpierre C, Lauwers-Cances V, Datta GD, *et al* Using self-rated health for analysing social inequalities in health: a risk for underestimating the gap between socioeconomic groups? *Journal of Epidemiology & Community Health* 2009;**63:**426-432.
[24] Leicester City Council (2024). Leicester Health and Wellbeing Survey. Available at: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-and-strategies/leicester-health-and-wellbeing-surveys/
[25] Bristol city Council (2019). Pupils' Voice Survey. Available at: https://www.bristol.gov.uk/bristol-healthy-schools
[26] NHS (2022). Period Pain. Available at: https://www.nhs.uk/symptoms/period-pain/
[27] NICE (2021). Heavy menstrual bleeding: assessment and management. Available at: https://www.nice.org.uk/guidance/ng88/chapter/Recommendations#management-of-hmb

contraceptive injections or hormonal intrauterine contraceptive devices which require specialist medical training; in severe cases women may undergo a 'medical menopause' to completely override natural hormonal cycles or require exploratory, day case, or inpatient surgery including hysterectomy or even pelvic clearance surgery.

1.2.5 Current services in LLR

University Hospitals of Leicester NHS Trust provides specialist secondary care gynaecology services at Leicester Royal Infirmary and General Hospital. Women and girls experiencing menstrual disorders can access over-the-counter medications at pharmacies and other retail outlets for lower-level pain or visit their GP for support, investigation, and treatment, which is also the pathway for accessing secondary care. The average waiting time (as of 13.12.24) for a first outpatient appointment at one of the hospital gynaecology clinics in Leicester is 16 weeks, and the average waiting time for treatment is 20 weeks. Private hospitals in Leicester also offer services.

Some GP surgeries have undergone additional staff training and can offer a coil fitting service but this offer is variable and community sexual health services offer coil fits for contraception purposes only and not for treatment of menstrual disorders. This means that women may have to wait to see a gynaecologist before they can access hormonal coil treatment.



1.2.6 Unmet needs or gaps

Support and guidance for menstrual disorders focus on diagnosis and management of the conditions. However, as the NICE definition of menorrhagia acknowledges, menstrual disorders affect the "physical, social, emotional, and/or material quality of life" for significant numbers of women and girls. Therefore, greater consideration could be given to measures that can be taken and services that can be provided to support women and girls experiencing menstrual disorders and minimise the impact of the conditions on their day-to-day lives. It is also the case that due to the widespread nature of menstrual disorder and the fact that often people will not seek medical care for them, or not receive a definitive diagnosis, means that prevalence data are likely an underestimate, particularly in groups who are less likely to seek care anyway. Engaging with women in LLR about their health needs will provide valuable intelligence around any unmet needs and gaps in services.

1.2.7 Recommendations

Heavy and painful periods are commonly experienced in the population, however, this does not mean they should be accepted as 'normal'. The size of the problem is currently likely underestimated. This brief review of the evidence suggests that the following would be beneficial:

- Establish the detailed local prevalence of menstrual disorders across different population groups and undertake research to understand whether factors such as ethnicity and deprivation affect the experiences of women and girls when it comes to recognising symptoms, seeking help, getting primary and secondary care support, treatment options, etc.
- Undertake local research to understand the impact of menstrual disorders on the physical, social, emotional, and/or material quality of life for women and girls, establish current provision for supporting these wider needs, and explore other measures that could help minimise the impact of menstrual disorders on day-to-day life (e.g., workplace policies). The forthcoming programme of engagement will be a valuable addition to the knowledge base.

1.3 Period Poverty

1.3.1 Background

Period poverty is about people being unable to afford essential menstrual products, and being unable to access hygiene facilities, waste management, and education.[28] Period poverty leads to mental, emotional and physical challenges.

Beyond the financial aspect, period poverty involves lack of support, societal stigma and the broader challenges associated with menstruation.[4] It often remains hidden as menstruation is frequently considered a taboo subject, further limiting the opportunity for support to those in need. Period poverty magnifies existing inequalities, disproportionately affecting women and girls in already disadvantaged neighbourhoods.[29]

[28] What is period poverty? September 16, 2021. Accessed November 10, 2021. https:/ / www.medicalnewstoday.com/ articles/ period-poverty

[29] Michel J, Mettler A, Schönenberger S, Gunz D. Period poverty: why it should be everybody's business. Journal of Global Health Reports. 2022;6:e2022009. doi:10.29392/001c.32436

Unsurprisingly, women and girls worry about potential embarrassment from bleeding through clothes, feel distracted by the ongoing challenge of accessing period products, and report discomfort from bleeding into underwear. During menstruation they may try to avoid leaving their home – a pathway to social exclusion. Period poverty also has wider impacts including increased absenteeism, lower educational attainment, and an impact on people's work.[30]

1.3.2 Who's at risk of period poverty

- According to a poll in 2023 by ActionAid, those aged 18-24 were most likely to struggle to afford period products, more than a quarter (27%) of people surveyed in this age group were affected.[33]
- Homeless women are also known to be at risk of experiencing period poverty and the challenges around this.[31]

Research carried out by Kind Direct and Irise International on period equity in the UK found: [32]

- Those living in low income households or receiving universal credit are more likely to experience period poverty.
- Those who may have experienced period poverty during childhood can also experience this into adulthood.
- Black and Black British people were significantly more likely to have gone without period products at some point in childhood or adolescence when compared with white people (25% v 18%).
- Almost half (47%) of those with a disability have gone without period products, with 13% going without in the last 12 months.
- Asylum seekers in the UK are significantly affected by hygiene and period poverty due to a lack of recourse to public funds.

1.3.3 Level of need

A 2019 report from University of Leeds Nuffield Centre for International Health and Development suggests that it is difficult to use the qualitative studies to determine the extent of the impacts of period poverty, or how influential period poverty contrasts with other challenges facing women and girls in the contexts studied.

Nationally, period poverty data is published by a range of organisations advocating for the tackling of period poverty. Reports from these various organisations all highlight the extent of period poverty in the UK, suggesting that around 21% of people who menstruate experience period poverty, and that the numbers of people affected is increasing somewhat rapidly – up to 21% from 12% during 2023.[33] Period poverty magnifies existing inequalities, disproportionately affecting women and girls in already disadvantaged neighbourhoods. More research is required to ascertain need at a local level.

[30] Period poverty impact on the economic empowerment of women (2019) period.pdf
[31] Orsini, G. D., Tarabay, J., Hardy-Johnson, P. L., Barker, S. L., & Greenway, F. T. (2024). The homeless period: a qualitative evidence synthesis. Women & Health, 64(3), 250–260. https://doi.org/10.1080/03630242.2024.2310716
[32] Kind Direct and Irise International (2024). Period Equity in the UK: Breaking Cycles of Exclusion. Available at: https://www.inkinddirect.org/wp-content/uploads/2024/02/The-State-of-Period-Equity-in-the-UK-Feb-2024.pdf
[33] ActionAid UK (2023) Cost of living: UK period poverty has risen from 12% to 21% in a year UK Period poverty rises from 12 to 21% | ActionAid UK

1.3.4 What evidence-based management is recommended?

The causes of period poverty are strongly linked to broader levels of deprivation, and, more recently, to the cost-of-living crisis. Organisations campaigning against period poverty work at policy level within the UK and globally seeking to end period poverty.

In January 2021, the 'tampon tax' was abolished in the UK, meaning that VAT added to sanitary pads and menstrual cups was removed. Furthermore, January 2024 brought the abolishment of VAT on period pants.[34] This has been seen as a positive move in the UK because tax on period products has been shown to exacerbate period poverty and access to menstrual products.[35]

All of the organisations campaigning against period poverty, as well as institutions such as universities and the NHS, and the UK Government, have programmes for the provision of free menstruation products.

1.3.5 Current services in LLR

The UK Government provides the period product scheme for schools and colleges, providing free period products to girls and women in their place of study. It is available to state-maintained schools and Department for Education (DfE) funded 16 to 19 education organisations in England. Since January 2020, data shows that Leicester (85%) and Leicestershire (88%) have schools and colleges making at least one order.[36]

All women and girls being cared for by the NHS will be given appropriate sanitary products free of charge on request.[37]

Both universities in Leicester (De Montfort University - 95 toilets and Leicester University – all toilets) provide free period products across campus.[38, 39]

TESCO runs a scheme which allows shoppers in need to discreetly access free sanitary products.[40]

In 2022 Public Health in Leicester City ran a pilot providing free period products in Leicester's Children's Centres. The pilot was successful, showing that there is a need for this type of support, and that accessing the support through our public buildings is a pathway that can be embraced.[41] At the conclusion of the pilot, Children's Centres opted to self-fund the continuing provision of free period products within their buildings. Leicester City Council obtained some further pilot funding and are providing free period products within 16 front-facing Leicester City Council buildings and an online portal from December 2024.

Freedom4girls is an organisation operating in LLR, that aims to tackle period poverty by providing disposable products to sections of the community where needed, advocating and campaigning for equality and equity for Women and People who Menstruate from all

[34] Gov.uk (2024) VAT on period pants scrapped VAT on period pants scrapped - GOV.UK
[35] J Jaafar H, Ismail SY, Azzeri A. Period Poverty: A Neglected Public Health Issue. Korean J Fam Med. 2023 Jul;44(4):183-188. doi: 10.4082/kjfm.22.0206. Epub 2023 May 16. PMID: 37189262; PMCID: PMC10372806.
[36] Gov.uk (2022) 94% of secondary schools provide free period products to students https://www.gov.uk/government/news/94-of-secondary-schools-provide-free-period-products-to-students
[37] NHS (2019) The NHS in England will offer free tampons and other sanitary products to every hospital patient who needs them NHS England » The NHS in England will offer free tampons and other sanitary products to every hospital patient who needs them
[38] De Montfort University (2021) Tackling Period Poverty Tackling Period Poverty
[39] University of Leicester (2024) Embracing diversity: Support for women Residence Life :: University of Leicester
[40] Independent (2023) Tesco praised for two-word 'white envelope' code Tesco praised for two-word 'white envelope' offer | The Independent
[41] Leicester City Council (2024) Period Poverty Evaluation

communities and raising awareness via pop ups, social media and public talks to tackle stigma.[42]

1.3.6 Unmet needs or gaps

A gap in the existing offer of free period products in LLR is that they are not available universally in all reasonable locations. In Scotland, for example, local authorities have been required by law since 2020 to provide free period products within all public buildings.

There are recognised gaps in data to what extent period poverty is at local level.

The support offered through private enterprise is not universal but rather limited to the endeavours of individual organisations.

The 2022 Leicester City Council Pilot suggests that there may be cultural difference in approaches to menstruation, and the preferred period products. These cultural differences may not be particularly well understood.[40]

The pilot also carried out a series of focus groups and surveys which highlighted the following gaps/limitations:

- There were concerns from survey responders about not knowing how to talk to daughters or other young girls about periods, or where information could be accessed. It was felt that more education and information is required alongside an understanding of who to talk to about periods, with GPs not being seen as an appropriate professional to turn to.
- Menstrual products are predominantly purchased from supermarkets, and availability of menstrual products as alternatives to menstrual towels and tampons in those supermarkets is limited.
- More help is needed particularly for children with Special Educational Needs and Disabilities (SEND), such as those with autism and those who have sensory needs.
- Fathers were also mentioned as desiring more information to support their daughters and partners, underlining the importance and need for inclusivity and support for all groups.

1.3.7 Recommendations

Although everyone who needs them should have access to period products, the reality is that many cannot afford these basic provisions for their needs. The cost-of-living crisis has only exacerbated this problem, with more people and households falling into poverty, but the issue compounds existing inequalities because it is likely to disproportionately affect those who are already vulnerable, such as those experiencing homelessness, those living in poverty or those fleeing domestic violence. Period poverty is therefore not just an economic issue, but an important issue of health equity that must be addressed.

The following recommendations are adapted from those made by the Leicester City period poverty pilot evaluation:[41]

[42] NHS Leicester, Leicestershire and Rutland (2025). Freedom4girls. https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/vcse-introduction/vcse-alliance/vcse-directory/freedom4girls/

- To promote provision of free period products more widely across the communities, teams and organisations so that more people know about free products and where to get them
- Providing free period products is the obvious and most effective way to tackle period poverty, however the environmental impact of single use period products is significant and therefore reusable products should be considered in any pilot/scheme which offers products
- It is important to work with communities to understand how to best deliver education programmes and dissemination of information and support on menstrual health over the life course, including understanding norms of menstruation in faith practices and cultures, product options and availability, where free products can be accessed and reducing stigma.
- It could be helpful to develop a menstrual health page on the 'Healthy Conversation Skills' website with appropriate signposting for more information and tips for talking about the topic
- Further research is needed to better understand needs and support required for different groups e.g., faith groups, SEND, fathers or male guardians
- It is important to recognise and support voluntary sector organisations in the work they are currently delivering. (e.g. Community shops offering low-cost products, awareness raising of periods and educating young girls in schools, and HeyGirls projects) and to work with them to ensure work is joined up across system

1.4 Pelvic Pain

1.4.1 Background

Intermittent pelvic pain, often with no identified cause, is a common experience for many women. However, in some cases this can be severe, persistent and life-limiting for patients. Pelvic pain is defined as pain that starts from one of several organs located in the pelvis, from the pelvic bones besides those organs, or from muscles, nerves, blood vessels or joints located nearby.[43] There are two types of pelvic pain: acute and chronic. Acute pelvic pain is 'sudden and sharp'[44] and is commonly related to pregnancy (including miscarriage and ectopic pregnancy) or gynaecological causes (e.g., ovulation, dysmenorrhea, pelvic inflammatory disease). Chronic pelvic pain is defined by Royal College of Obstetricians & Gynaecologists (RCOG) as "intermittent or constant pain in the lower abdomen or pelvis of a woman of at least 6 months in duration, not occurring exclusively with menstruation or intercourse and not associated with pregnancy."[45] RCOG states that chronic pelvic pain is a symptom rather than a diagnosis and identifies a number of potential causes/interrelated conditions:

- Central and peripheral nervous system
- Endometriosis and adenomyosis
- Adhesions
- Irritable bowel syndrome or interstitial cystitis
- Musculoskeletal pain/damage

[43] Patient Health Topics (2023). Pelvic Pain in women. Available at: https://patient.info/womens-health/pelvic-pain-in-women
[44] Johns Hopkins Medicine (2025). Pelvic Pain. Available at: https://www.hopkinsmedicine.org/health/conditions-and-diseases/pelvic-pain#:~:text=Pelvic%20pain%20can%20be%20categorized,known%20as%20chronic%20pelvic%20pain.
[45] Royal College of Obstetricians & Gynaecologists (2012). The Initial Management of Chronic Pelvic Pain (Green-top Guideline No. 41). Available at: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/the-initial-management-of-chronic-pelvic-pain-green-top-guideline-no-41/

- Nerve entrapment
- Psychological and social issues

1.4.2 Who's at risk of pelvic pain

A study evaluated factors pre-disposing women to chronic and recurrent pelvic pain and found the following risk factors:[46]

- Drug or alcohol abuse
- Miscarriage
- Heavy menstrual flow
- Pelvic inflammatory disease
- Previous caesarean section
- Pelvic pathology
- Abuse
- Psychological comorbidity

1.4.3 Level of need

Pelvic pain is a common experience for women, with most experiencing some degree of pain due to menstruation, ovulation, or sexual intercourse. Chronic pelvic pain can affect as many as 1 in 6 women and its prevalence in general practice has been estimated to range between 5.7% and 26.6%. According to RCOG, "Chronic pelvic pain presents in primary care as frequently as migraine or low-back pain".

Pelvic Inflammatory Disease (PID) is a clinical syndrome referring to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy, tubal factor infertility and chronic pelvic pain. Both PID and ectopic pregnancy have a multi-factorial aetiology although chlamydial infection and other sexually transmitted infections are considered to be major causes of both conditions.[47]

In 2023/24, there were 600 admissions for PID in LLR. Leicestershire (251.9) and Rutland (169.7) had a statistically similar rate (per 100,000 females aged 15-44) in comparison to the national rate (247.5), whilst Leicester (289.0) had a significantly worse (higher) rate. The recent five year trend shows no significant change for each local authority.

[46] Latthe P, Mignini L, Gray R, Hills R, Khan K. Factors predisposing women to chronic pelvic pain: systematic review BMJ 2006; 332 :749 doi:10.1136/bmj.38748.697465.55

[47] NHS (2022). Pelvic Inflammatory Disease. Available at: https://www.nhs.uk/conditions/pelvic-inflammatory-disease-pid/

Figure 22: Pelvic Inflammatory Disease (PID) admissions rate / 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	➡	27,974	247.5	244.6	250.4
East Midlands region (statistical)	➡	2,170	230.8	221.2	240.8
Leicester	➡	255	289.0	253.5	325.5
Leicestershire	➡	335	251.9	225.6	280.3
Rutland	–	10	169.7	69.8	289.9

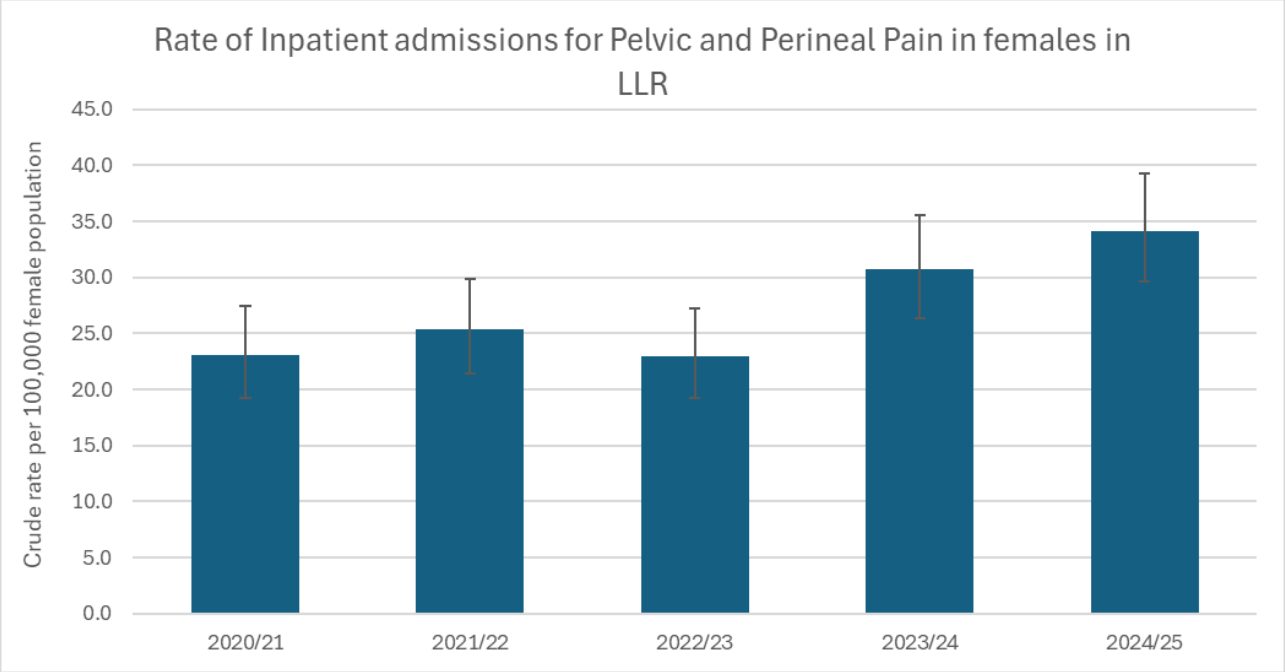
Source: Sexual and Reproductive Health Profile, OHID, 2025

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

Recent trends: – Could not be calculated | ➡ No significant change | ⬆ Increasing & getting worse | ⬆ Increasing & getting better | ⬇ Decreasing & getting worse | ⬇ Decreasing & getting better

Figure 23 shows a five-year trend in inpatients admissions for pelvic and perineal pain in females' resident in LLR. The rate in 2024/25 (34.2 per 100,000 female population) is significantly higher in comparison to the rate in 2020/21 (23.1 per 100,000 female population) and 2022/23 (25.4 per 100,000 female population). It is important to note that lower admissions around 2020/21 could have been due to the covid pandemic.

Figure 23: Trend in inpatient admissions for Pelvic pain in females in LLR



Data Source: MLCSU SUS Inpatient Data, 2025

Note: ICD Diagnosis code used – R102.

1.4.4 What evidence-based management is recommended?

Managing pelvic pain, both acute and chronic, requires identifying and treating the underlying cause, although some women can remain without a clear diagnosis even after extensive investigation. Treatment options, depending on cause, can include medication, physiotherapy, hormone treatment, surgical intervention, and psychological support. There doesn't appear to be any evidence/guidance for prevention of pelvic pain.

1.4.5 Current Services in LLR

Services available to women and girls experiencing pelvic pain depend on the nature, degree, and underlying cause of their condition. The standard pathway is to visit their GP in the first instance, from which they will be referred into secondary care specialist services for investigation and treatment.

There is a national support organisation called the Pelvic Pain Support Network, who provide support, information, and advocacy for those with pelvic pain.[48] They are undertaking research into how women experiencing pelvic pain without a diagnosed/specific cause are managed and supported within primary care.

1.4.6 Unmet needs or gaps

Although management of pelvic pain depends on cause, for many sufferers, no specific cause can be identified which makes management difficult but also takes a psychological toll on those experiencing symptoms.

1.4.7 Recommendations

Pelvic pain is a somewhat diffuse constellation of symptoms and causes and therefore it can often be difficult to adequately gauge the true disease burden in the community.
It would therefore be of benefit to:

- Undertake work locally to understand the prevalence of pelvic pain and how women and girls from different backgrounds experience the condition itself along with access to services and support. The planned engagement work will be an important part of understanding women's experience of pelvic pain in LLR.
- Look at what learning can be applied locally from the Pelvic Pain Support Network's research into primary care management of pelvic pain when a specific cause has not been found.

1.5 Ovarian Pathology (non-cancerous) – including Polycystic Ovary Syndrome (PCOS)

1.5.1 Background

Ovarian pathology refers to disease originating in women's ovaries.

Benign ovarian conditions include ovarian cysts and polycystic ovary syndrome (PCOS). Ovarian cysts are of two kinds: functional, which develop during the menstrual cycle and tend to be harmless, and pathological, which result from abnormal cell growth. The former are more common and don't last long, whereas the latter are rarer but potentially more serious, as in the case of ovarian cancer. Symptoms usually only present when cysts rupture, are large in size, or

[48] Pelvic Pain Support Network (2025). Available at: https://www.pelvicpain.org.uk/

twist and affect the blood supply to the ovaries, and include pelvic pain, pain during sex, period problems, and difficulty getting pregnant. Ovarian cysts can link to other conditions such as endometriosis and fibroids.[49]

PCOS is defined by NICE as a "heterogeneous endocrine disorder"[50] – that is, an imbalance in the production of hormones by the ovaries. PCOS creates multiple fluid-filled sacs in the ovaries, causing them to grow larger, and can cause women with the condition to experience irregular periods and hirsutism (hairiness) due to the presence of excess androgen, a 'male' hormone. Complications of PCSO can include infertility, cardiovascular disease, metabolic disorders, obstructive sleep apnoea syndrome, psychological disorders, complications in pregnancy, cancer, and non-alcoholic fatty liver disease. The causes of PCOS are unknown, although there may be a link to insulin resistance for some women.

1.5.2 Risk factors for PCOS/Ovarian Cysts

The risk factors for developing PCOS are higher in women with:[51]

- a family history of PCOS
- Type 2 diabetes
- Obesity

The risks factors for developing Ovarian cysts are higher in women who are:[52]

- From a pre-menopausal age group
- In the first trimester of pregnancy
- Have a personal history of infertility or polycystic ovary syndrome

1.5.3 Level of Need

Ovarian cysts are reported to be very common in girls and women of menstruating age, with one source stating "it is estimated that virtually all women who still have a period, and 1 in 5 women who have been through the menopause, will have one or more ovarian cysts".[53] Most of these are estimated to be symptomless cases, with 1 in 25 women experiencing ovarian cysts with symptoms.

PCOS is thought to affect 1 in 10 women in the UK, with half of women not having any symptoms. Evidence suggests Black women are most affected by the condition compared to women from other ethnic groups. At the time of producing this needs assessment, there was no local data available on the prevalence of ovarian cysts.

1.5.4 What evidence-based management is recommended?

Guidance on what works for addressing ovarian cysts and PCOS centres around diagnosis and management in cases where symptoms are present and problematic. For ovarian cysts, as most cysts resolve themselves, a policy of 'watchful waiting' is recommended by the NHS, whereby

[49] NHS (2025). Ovarian cyst. Available at: https://www.nhs.uk/conditions/ovarian-cyst/
[50] NICE (2025). PCOS: what is it? Available at: https://cks.nice.org.uk/topics/polycystic-ovary-syndrome/background-information/definition/
[51] John Hopkins Medicine (2025). Polycystic Ovary Syndrome. Available at: https://www.hopkinsmedicine.org/health/conditions-and-diseases/polycystic-ovary-syndrome-pcos#:~:text=Who%20is%20at%20risk%20for,insulin%20resistance%20or%20are%20obese.
[52] BMJ Best Practice (2025). Ovarian Cysts. Available at: https://bestpractice.bmj.com/topics/en-gb/660

[53] Central Manchester University Hospitals, NHS Foundation Trust (2012). Ovarian Cysts. Available at: https://mft.nhs.uk/app/uploads/sites/4/2018/04/12-103-Ovarian-Cysts-September-2012.pdf

treatment is delayed until a sufficient period of monitoring has determined that the cyst requires intervention.[54] Surgery can then be used to remove cysts that are persistent and causing symptoms. PCOS is considered incurable[55] and guidance looks instead at management and treatment of the problems caused by PCOS (hirsutism, menstrual irregularity, fertility, etc.).[56]

1.5.5 Current Services in LLR

Women presenting with symptoms are examined by their GP in the first instance. Referrals can be made for further investigation to University Hospitals of Leicester NHS Trust, which provides specialist secondary care gynaecology services at Leicester Royal Infirmary and General Hospital.

Pharmacies can provide over-the-counter medications for management of lower-level symptoms, and GPs can prescribe medication for more severe symptoms and refer to secondary care. The average waiting time (as of 13.12.24) for a first outpatient appointment at one of the hospital gynaecology clinics in Leicester is 16 weeks, and the average waiting time for treatment is 20 weeks.[57]

Private hospitals in Leicester also offer services. The Leicester, Leicestershire, and Rutland Integrated Care Board 'policy for hair depilation for excessive growth' does not cover hirsutism caused by PCOS.

1.5.6 Unmet needs or gaps

As with menstrual disorders, there appears to be little consideration of the non-physical/clinical impacts of ovarian cysts and PCOS on women. For example, complications resulting from PCOS, such as fertility issues and hirsutism, could cause women to experience social, mental, and emotional struggles as well as physical challenges, but these impacts are not covered in guidance on ovarian pathology and conditions. Therefore, greater consideration could be given to measures that can be taken to support women and girls experiencing ovarian cysts and PCSO and minimise the impact of those conditions on their day-to-day lives.

There is a recognised gap in terms of data to what extent ovarian pathology is at local level.

1.5.7 Recommendations

- Establish the local prevalence of ovarian cysts and PCOS across different population groups and undertake research to understand whether factors such as ethnicity and deprivation affect the experiences of women and girls when it comes to recognising symptoms, seeking help, getting primary and secondary care support, treatment options, etc.
- Undertake local research to understand the impact of ovarian cysts and PCOS on the physical, social, emotional, and/or material quality of life for women and girls, establish

[54] NHS (2023). Ovarian Cyst – Treatment. Available at: https://www.nhs.uk/conditions/ovarian-cyst/treatment/
[55] NHS (2023). Polycystic Ovary Syndrome – Treatment. Available at: https://www.nhs.uk/conditions/polycystic-ovary-syndrome-pcos/treatment/
[56] NICE (2025). Management of polycystic ovary syndrome in adults. Available at: https://cks.nice.org.uk/topics/polycystic-ovary-syndrome/management/management-adults/

[57] NHS – My Planned Care. Gynaecology (2024). University Hospitals of Leicester. Available at: https://www.myplannedcare.nhs.uk/mids/leicester/specialty/?sname=Gynaecology

current provision for supporting these wider needs, and explore other measures that could help minimise the impact of fibroids on day-to-day life (e.g., workplace policies).

1.6 Pelvic Organ Prolapse and Continence

1.6.1 Background

Pelvic organ prolapse is defined by NICE as the "symptomatic descent of 1 or more of: the anterior vaginal wall, the posterior vaginal wall, the cervix or uterus, or the apex of the vagina (vault or cuff). Symptoms include a vaginal bulge or sensation of something coming down, urinary, bowel and sexual symptoms, and pelvic and back pain".[58] The NHS identifies four main types of prolapse: anterior prolapse (cystocele), prolapse of the womb and / or cervix (the opening between the vagina and the womb), 'vault' prolapse, and posterior wall prolapse (rectocoele or enterocoele). These affect different areas of the vagina and more than one can be present at the same time.[59]

Urinary incontinence is unintentional passing of urine. It can result from pelvic organ prolapse but is also attributable to a wide range of other causes. The NHS identifies several types and causes of urinary incontinence, including:

- Stress incontinence, which happens when the bladder is under pressure (e.g., due to coughing) – usually caused by the muscles that prevent urination being weakened or damaged.
- Urge incontinence, relating to the need to urinate – often caused by the muscles that control the bladder being overactive.
- Overflow incontinence (chronic urinary retention), where the bladder leaks due to not being fully emptied – usually caused by an obstruction or blockage in the bladder.
- Total incontinence, where the bladder cannot store urine at all – causes can include bladder problems from birth, spinal injury, or fistulas.[60]

1.6.2 Risk factors for pelvic organ prolapse/urinary incontinence

Risk factors for urinary incontinence include family history, pregnancy and vaginal birth, obesity, and ageing.[60] The latter three are also risk factors for pelvic organ prolapse, along with long-term constipation or other conditions that cause stain in the body, having a hysterectomy, and doing a lot of heavy lifting. Some health conditions (e.g., joint hypermobility syndrome, Marfan syndrome, and Ehlers-Danlos syndromes) also identified risk factors.[61] Women are affected more urinary incontinence than men, and the condition increases in severity as well as prevalence with age, although there is a plateauing or reduction of incontinence in women between 50 and 70 years of age before increasing again in later age.[62]

1.6.3 Level of Need

National data presented by NICE indicates that the prevalence of pelvic organ prolapse is high amongst UK women, with:

[58] NICE (2019). Urinary incontinence and pelvic organ prolapse in women. Available at: https://www.nice.org.uk/guidance/ng123/chapter/Context

[59] NHS Inform (2024). Pelvic Organ Prolapse. Available at: https://www.nhsinform.scot/illnesses-and-conditions/sexual-and-reproductive/pelvic-organ-prolapse/

[60] NHS (2023). Urinary Incontinence. Available at: https://www.nhs.uk/conditions/urinary-incontinence/

[61] NHS (2021). Pelvic Organ Prolapse. Available at: https://www.nhs.uk/conditions/pelvic-organ-prolapse/

62 NICE (2025). Incontinence – Urinary in women: How common is it? Available at: https://cks.nice.org.uk/topics/incontinence-urinary-in-women/background-information/prevalence/

- 8.4% of women reporting a vaginal bulge or lump at primary care level.
- 50% of women examined showing the presence of prolapse.
- 1 in 10 women needing at least one surgical procedure, with re-operation being required in up to 19% of cases.

Urinary incontinence is common, although NICE states that "The reported prevalence of urinary incontinence varies widely (5–69%) in women because of differences among the populations studied, definitions, and measurements used." One study found a rate of 40% prevalence amongst women in one UK medical practice, with urinary incontinence causing significant problems for 8.5% of sufferers and 17% of the study participants seeking professional help.[63]

Studies suggest there may be disparities along ethnic lines with help-seeking behaviours and referrals to specialist care. A qualitative study among South Asian Indian women in Leicester found "women commonly normalized symptoms of urinary incontinence" and were reluctant to seek help due to embarrassment, suggesting there may be underreporting.[64] A national cohort study using primary care data from the UK found lower rates of referral to specialist care for women from Asian/Asian British and Black/Black British backgrounds in the 45% of cases where ethnicity data was available.[65]

At the time of producing this needs assessment, there was no local data available on the prevalence of pelvic organ prolapse and urinary incontinence.

1.6.4 What evidence-based management is recommended?

Pelvic organ prolapse and urinary incontinence are generally not considered preventable, although general healthy lifestyle behaviours (e.g., exercise, weight management) are recommended, as well as pelvic floor muscle exercises. For pelvic organ prolapse, these are also recommended as treatment options, along with vaginal hormone treatment, vaginal support pessaries, and/or surgery depending on severity.[66]

For urinary incontinence, surgery is also a treatment option, but medication and other non-surgical interventions such as bladder training are recommended first.[67]

1.6.5 Current Services in LLR

University Hospitals of Leicester NHS Trust provides a specialist Pelvic Health Physiotherapy Service for inpatients and outpatients. Leicester, Leicestershire, and Rutland Integrated Care Board policy for Uterovaginal Prolapse is that treatment will be funded if conservative

[63] Cooper J, Annappa M, Quigley A, Dracocardos D, Bondili A, Mallen C. Prevalence of female urinary incontinence and its impact on quality of life in a cluster population in the United Kingdom (UK): a community survey. Prim Health Care Res Dev. 2015 Jul;16(4):377-82. doi: 10.1017/S1463423614000371. Epub 2014 Oct 2. PMID: 25273552.
[64] Anjum Doshani, Emma Pitchforth, Christopher J Mayne, Douglas G Tincello, Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester, *Family Practice*, Volume 24, Issue 6, December 2007, Pages 585–593, https://doi.org/10.1093/fampra/cmm058
[65] Gurol-Urganci et al. BMC Family Practice (2020) Determinants of referral of women with urinary incontinence to specialist services: a national cohort study using primary care data from the UK21:211 https://doi.org/10.1186/s12875-020-01282-y
[66] Royal College of Obstetricians & Gynaecologists (2013). Pelvic organ prolapse. Available at: https://www.rcog.org.uk/for-the-public/browse-our-patient-information/pelvic-organ-prolapse/
[67] NHS (2023). Non-surgical treatment. Urinary incontinence. Available at: https://www.nhs.uk/conditions/urinary-incontinence/treatment/

management as per guidance (e.g., supervised pelvic floor exercises and pessary device treatment) has failed and there is moderate or severe symptomatic prolapse.[68]

Leicestershire Partnership NHS Trust runs a service for adults over the age of 18 with continence needs.[69] The service offers advice and education, treatment management plans, and appropriate follow up interventions to people with urinary and bowel conditions in the community. The service is accessed via referrals from GPs and health care professionals, although previous patients can refer themselves back to the Continence Team.

There are a number of national support groups and campaigning organisations: for example, Association for Pelvic Organ Prolapse Support (APOPS)[70] and Bladder & Bowel Community.[71]

1.6.6 Unmet needs or gaps

Due to lack of local level of need data and service access data, it is difficult to determine any gaps or limitations in services locally. However, NICE have indicated that due to the ageing population, the need for surgery for pelvic organ prolapse and support for urinary incontinence is likely to increase in the future.

1.6.7 Recommendations

- To obtain local data on need to fully understand the actual prevalence of pelvic organ prolapse and urinary incontinence.
- The community study cited earlier, which found embarrassment hindered South Asian women in Leicester getting help for urinary incontinence suggests more work around raising awareness of the condition and reducing stigma could be beneficial.
- The national cohort study which found lower referral rates to specialist pelvic organ prolapse services for women from ethnic minority backgrounds suggests further research is needed to establish whether there are disparities for local women in LLR.

1.7 Fibroids

1.7.1 Background

Fibroids (also known as uterine fibroids, uterine myomas, or leiomyomas) are non-cancerous growths made of muscles and fibrous tissue that develop in/around the uterus.[72] They can vary in size and number and can be symptomless, but around 1 in 3 women with fibroids will experience heavy and/or painful periods, abdominal pain, lower back pain, a frequent need to urinate, constipation, and pain/discomfort during sex. Fibroid-related complications can affect pregnancy and fertility[73] and heavy/abnormal uterine bleeding linked to fibroids could also lead to iron deficiency anaemia.[74]

[68] NHS Leicester, Leicestershire and Rutland (2023). LLR policy for uterovaginal prolapse. Available at: https://leicesterleicestershireandrutland.icb.nhs.uk/llr-arp-98-policy-for-uterovaginal-prolapse/
[69] NHS Leicestershire Partnership Trust (2025). Continence Service. Available at: https://www.leicspart.nhs.uk/service/continence/
[70] Association for Pelvic Organ and Prolapse Support (APOPS) (2025). Available at: https://www.pelvicorganprolapsesupport.org/
[71] Bladder and Bowel Community (B&B) (2025). Available at: https://www.bladderandbowel.org/
[72] NICE (2023). Fibroids. Available at: https://cks.nice.org.uk/topics/fibroids/
[73] NHS (2022). Overview – Fibroids. Available at: https://www.nhs.uk/conditions/fibroids/
[74] NICE (2023). Fibroids – what are the complications? Available at: https://cks.nice.org.uk/topics/fibroids/background-information/complications/

1.7.2 Risk factors for Fibroids

Fibroids are believed to be linked to oestrogen levels, and therefore tend to typically affect women between the ages of puberty and menopause. Risk factors associated with fibroids include being of reproductive age, early onset of menstruation (before the age of 11), never having given birth, being of an older age at first pregnancy, obesity (which increases oestrogen levels), having Black or Asian ethnicity, and family history.[75]

1.7.3 Level of Need

The absence of symptoms for many women means there is a significant degree of underreporting, with many cases being diagnosed by chance when other conditions are being investigated. However, with underreporting taken into consideration, an international survey reported prevalence (self-reported) of 4.5% for fibroids in the UK in women aged 40-49 years.[76]

At the time of producing this needs assessment, there was no local data available on the prevalence of fibroids, indicating a need for further work to understand the true local picture.

1.7.4 What evidence-based management is recommended?

Guidance on what works for addressing fibroids centres around diagnosis and management. As fibroids are linked to oestrogen levels, they can shrink in/after menopause when levels reduce and not require intervention. However, those that do require intervention can be managed by treating the symptoms (e.g., as for menorrhagia in cases of heavy bleeding) and treatment options for more problematic cases can include medication to shrink the fibroid, radiology, or surgery.[77]

1.7.5 Current Services in LLR

In the first instance, women reporting symptoms of fibroids are examined by their GP. Referrals can be made for further investigation to University Hospitals of Leicester NHS Trust, which provides specialist secondary care gynaecology services at Leicester Royal Infirmary and General Hospital. Pharmacies can provide over-the-counter medications for management of lower-level symptoms, and GPs can prescribe medication for more severe symptoms and refer to secondary care. The average waiting time (as of 13.12.24) for a first outpatient appointment at one of the hospital gynaecology clinics in Leicester is 16 weeks, and the average waiting time for treatment is 20 weeks. Private hospitals in Leicester also offer services.

1.7.6 Unmet needs or gaps

Fibroids are a common condition affecting significant numbers of women and girls. For those who are symptomatic, their needs could go beyond the need for physical treatment to requiring social, mental, and emotional care as well. Therefore, greater consideration could be given to measures that can be taken and services that can be provided to support women and girls experiencing fibroids and associated conditions and minimise the impact of those conditions on their day-to-day lives.

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[75] NICE (2023). Fibroids – what are the risk factors? Available at: https://cks.nice.org.uk/topics/fibroids/background-information/risk-factors/

[76] Zimmermann A, Bernuit D, Gerlinger C, Schaefers M, Geppert K. Prevalence, symptoms and management of uterine fibroids: an international internet-based survey of 21,746 women. BMC Womens Health. 2012 Mar 26;12:6. doi: 10.1186/1472-6874-12-6. PMID: 22448610; PMCID: PMC3342149.

[77] NICE (2023). Fibroids – Management of Fibroids. Available at: https://cks.nice.org.uk/topics/fibroids/management/management/

1.7.7 Recommendations

- Establish the local prevalence of fibroids across different population groups and undertake research to understand whether factors such as ethnicity and deprivation affect the experiences of women and girls when it comes to recognising symptoms, seeking help, getting primary and secondary care support, treatment options, etc.
- Undertake local research to understand the impact of fibroids on the physical, social, emotional, and/or material quality of life for women and girls, establish current provision for supporting these wider needs, and explore other measures that could help minimise the impact of fibroids on day-to-day life (e.g., workplace policies).



2 Sexual and Reproductive Health

Key Epidemiology & Context

- STI testing rates in LLR remain below national averages
- Leicester shows higher chlamydia and gonorrhoea diagnoses in young women, while parts of the county have persistently low screening rates.
- Contraceptive access and uptake varies significantly across the system
- Abortion rates reflect broader inequalities, particularly in Leicester

Inequalities & At-Risk Groups

- Higher STI burden in younger women and those in deprived areas
- Ethnic disparities in diagnosis rates and contraceptive use
- Barriers for migrants, vulnerable groups, and those with learning disabilities

Gaps & Unmet Need

- Fragmented pathways across contraception, sexual health, and reproductive services
- Low PrEP awareness and uptake among women
- Variation in LARC access and prescribing

Implications for LLR

- Risk of worsening inequalities in reproductive outcomes
- Opportunity to improve service efficiency through more integrated system design

Priority Action Themes

- Increase STI testing and PrEP uptake in women
- Expand access to LARC and contraceptive choice, through exploration of different delivery models and support
- Strengthen targeted interventions for high-risk groups

2.1 Sexual Health

2.1.1 Background

The World Health Organisation (WHO) describes sexual health as "...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity".[78]

Maintaining good physical health – having healthy genitals and reproductive organs. To support this detecting, preventing and treating Sexually Transmitted Infections (STIs) is important. In women, complications from undetected STI's can lead to Pelvic Inflammatory Disease (PID) which can harm the reproductive system causing ectopic pregnancies and infertility. STIs can also be transmitted from mother to child during pregnancy and childbirth posing health risks to the child. Since 2021, progress has slowed in reducing HIV transmission among heterosexual women in England, with cases rising by 26% from 447 to 564 in 2022. Women were also less likely to start or continue PrEP (Pre-exposure prophylaxis), according to the UKHSA's latest monitoring and evaluation framework, which focuses on the interim ambitions of England's HIV Action Plan.[79]

2.1.2 Risk factors for poor sexual health

Any sexually active individual is at risk of unintended conception and STIs, including HIV. There are certain groups within the population who are known to be at greater risk of poor sexual health which can also be linked to other poor health outcomes.

- **Deprivation** – Multiple studies have indicated a correlation between deprivation and sexual and reproductive health outcomes, with outcomes being worst among those living in more deprived areas.[80]
- **Ethnicity** – a study examining the disparities within sexual and reproductive outcomes in racially minoritised population found that women from the black ethnic group had significantly higher positivity rates for gonorrhoea and chlamydia compared to women who identified as of white ethnicity, whereas women of Asian ethnicity reported significantly lower positivity rates compared to women who identified as white.[79]
- **Age** - Among heterosexuals aged 15 to 24 years, women are seven times more likely to be diagnosed with an STI (Sexually Transmitted Infection), than their counterparts aged 25 to 64 years.[81]
- **Sex workers** - Sex work or prostitution carries a high risk of STIs for both the sex worker and their customers. The people involved in sex work often face challenges such as substance use, limited access to services, violence and exploitation.[82]
- **Learning disabilities** - People with learning disabilities are amongst the most vulnerable in our society and have greater health needs than the rest of the population.

[78] World Health Organization. Sexual health [Internet]. World Health Organisation. 2006. Available from: https://www.who.int/health-topics/sexual-health#tab=tab_2
[79] UK Health Security Agency. Further HIV progress needed among heterosexual women [Internet]. GOV.UK. 2024. Available from: https://www.gov.uk/government/news/further-hiv-progress-needed-among-heterosexual-women
[80] Solomon D, Gibbs J, Burns F, et al Inequalities in sexual and reproductive outcomes among women aged 16–24 in England (2012–2019)J Epidemiol Community Health 2024;78:451-457.
[81] Public Health England. Variation in Outcomes in Sexual and Reproductive Health in England a Toolkit to Explore Inequalities at a Local Level [Internet]. GOV.UK. 2021. Available from: https://assets.publishing.service.gov.uk/media/60955c3de90e073573036703/SRH_variation_in_outcomes_toolkit_May_2021.pdf
[82] Jean, N; Salisbury, C. Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: a cross-sectional survey. BJOG An Int. J. Obstet. Gynaecol. 114, 875–81 (2007).

Research has found that young people with learning disabilities do not have good access to sex and relationship education or information.[83]

- **Looked after young people** - Young people who are looked after or in care are recognised as being vulnerable to risk taking behaviour, including early and unprotected sexual activity.[84] Young people in and leaving care are more likely than their peers to be teenage parents. One study found almost half of young women leaving care became pregnant within 18-24 months and another reported that a quarter were pregnant or young parents within a year of leaving care.[85]

2.1.3 Level of need

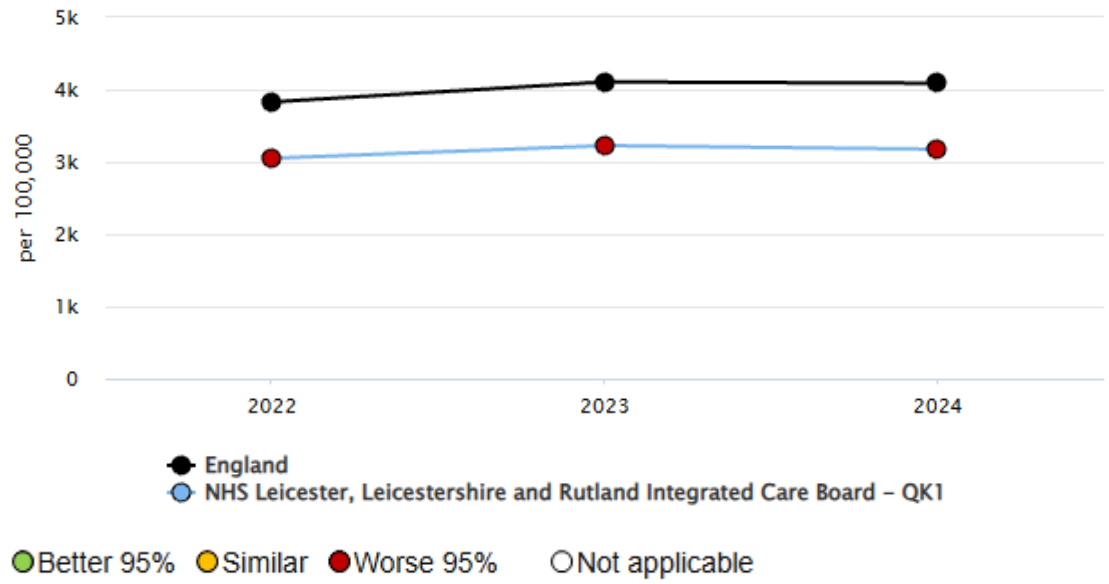
Sexual Health Screening and Diagnosis

STI Testing

STI testing rates and diagnosis rates are closely linked. The figure for STI testing rate is complementary to the 'New STI diagnoses (excluding chlamydia aged 24 and under)' and 'STI testing positivity (excluding chlamydia aged 24 and under)' indicators. STI testing rates include tests for syphilis, HIV, gonorrhoea and chlamydia (aged over 25) among people accessing sexual health services in England.

In LLR, Sexual Health Screens dropped from 36,659 in 2023 to 36,096 in 2024. STI testing rates in LLR remain well below the national average, with heterosexual women accounting for most screens, similar to England overall.

Figure 24: STI testing rate (exclude chlamydia aged 24 and under) per 100,000 in LLR



Source: Sexual and Reproductive Health Profiles, OHID, 2025.

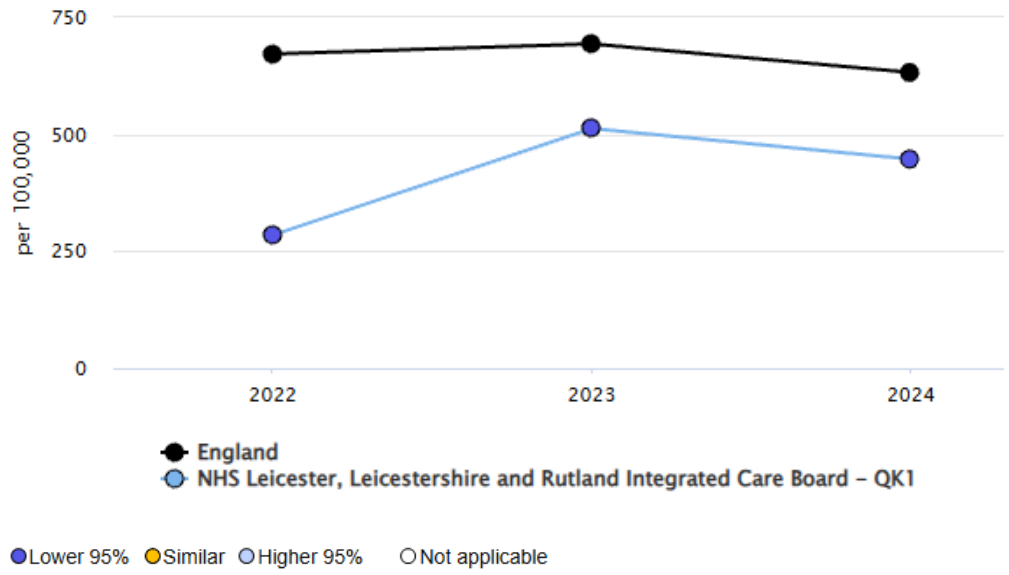
[83] CHANGE. Talking about sex and relationships: the views of young people with learning disabilities. (2010).
[84] DFES. Teenage Pregnancy Next Steps. (2006).
[85] Department of Health; Department for Children Schools and Families. Statutory Guidance on Promoting the Health and Well-being of Looked After Children. (2009).

All new STI diagnoses

All new STI diagnoses (excluding chlamydia aged 24 and under) among people accessing sexual health services in LLR. It is important to note, a high diagnosis rate is indicative of a high burden of infection however, a low diagnosis rate may be explained by other factors, such as, lack of awareness of risk, lack of education contributing to low testing rates.

In LLR the STI diagnoses rate has remained significantly lower in comparison to the national rate since 2022. It is important to note that variation in rates will exist between each local authority area.

Figure 25: All new STI diagnosis rate per 100,000 in LLR



Source: Sexual and Reproductive Health Profiles, OHID, 2025.

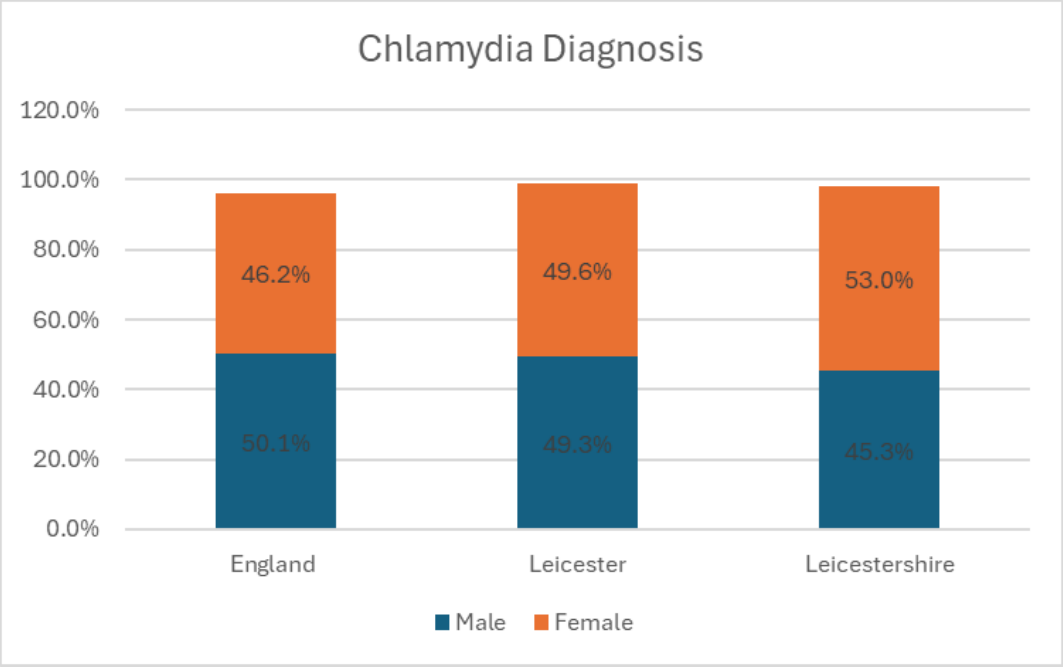
Chlamydia

Chlamydia is England's most common bacterial STI, especially among young adults.[86] It often shows no symptoms but can cause serious health issues in women if untreated. Early diagnosis and treatment of chlamydia reduce an individual's chance of developing chlamydia associated complications and also reduce the amount of time someone is at risk of passing the infection on. The overall Chlamydia diagnosis rate for LLR was 243 (per 100,000 population) in 2024, this is significantly lower in comparison to the national rate of 293 (per 100,000 population). The overall rate for LLR has remained significantly lower than England since 2022. Leicestershire and Rutland have had significantly lower Chlamydia diagnosis rates compared to England since 2012, whilst Leicester has had significantly higher rates for the same time period.

There was a total of 627 people diagnosed with Chlamydia in LLR, out of these, 322 were females (51.4%). The proportion of women diagnosed with Chlamydia are higher in Leicestershire compared to males, whilst in England males tend to have a higher proportion diagnosed with Chlamydia compared to females. Data for Rutland has not been presented due to small numbers for females.

[86] UKHSA - NCSP: patient information leaflet (text version) Updated 1 November 2024

Figure 26: Proportion of people diagnosed with Chlamydia in LLR by gender, 2024

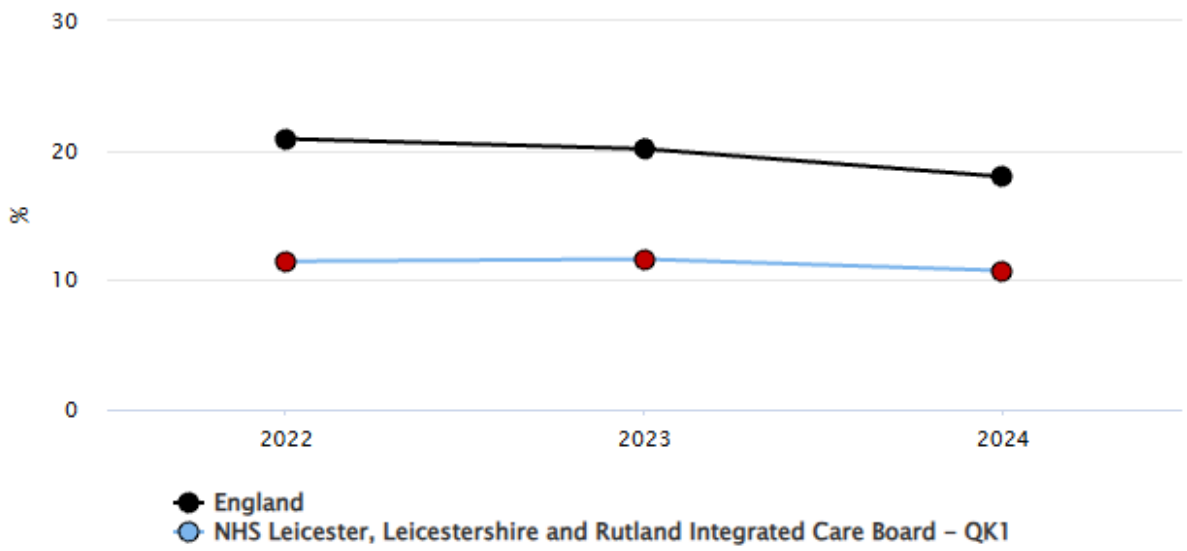


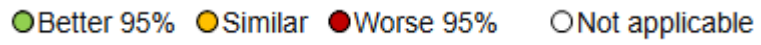
Source: GUMCAD, STI Diagnoses Data

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young women aged under 25 years, with guidance that all sexually active women under the age of 25 accessing a sexual and reproductive health service (including online), any service offering contraception, termination of pregnancy service, GP or pharmacy should be offered a chlamydia test.

Monitoring of the NCSP screening indicates that the screening rates in LLR are significantly worse (lower) than the England average since 2022.

Figure 27: Chlamydia proportion of females aged 15-24 years screened in LLR





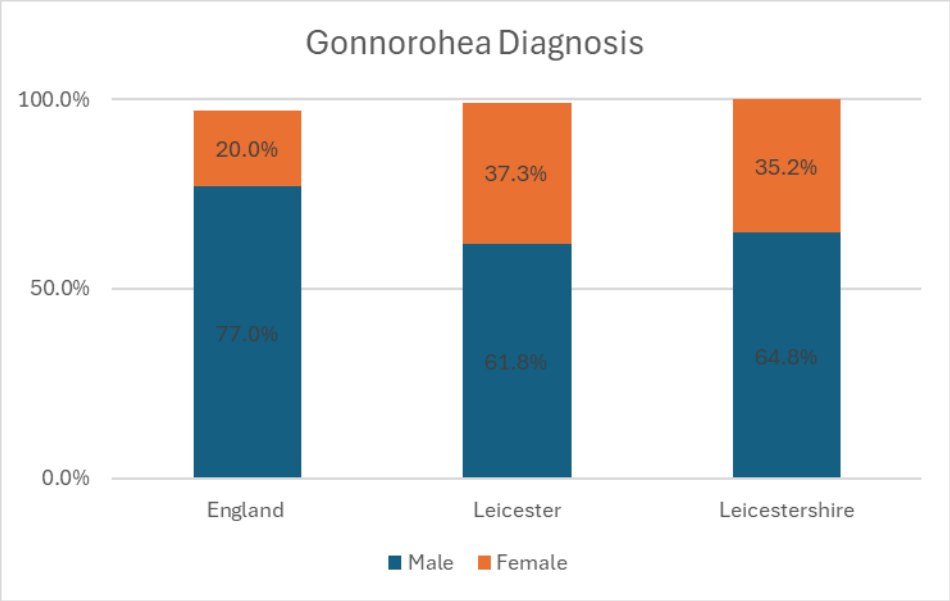
Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Gonorrhoea

Gonorrhoea causes avoidable sexual and reproductive ill-health. Gonorrhoea is used as a marker for rates of unsafe sexual activity. This is because the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to sexually transmitted infection (STI) treatment.[87]

Overall Gonorrhoea rates in LLR have remained significantly better (lower) in comparison to the England average since 2022. There was a total of 196 people diagnosed with Gonorrhoea in LLR, out of these, 71 were females (36.2%). The graph below shows a breakdown by gender which indicates females tend to have a lower percentage of gonorrhoea diagnoses in comparison to males in Leicester and Leicestershire, this is also mirrored nationally for 2024. Data for Rutland has not been presented due to small numbers.

Figure 28: Proportion of people diagnosed with Gonorrhoea in LLR by gender, 2024



Source: GUMCAD, STI Diagnoses Data

HIV (Human Immunodeficiency Virus)

HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates and reduces the risk of onward transmission through aiding early diagnoses and treatment.[88]

[87] OHID, (2025). Sexual Health Profiles. Available at: https://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/8000035/pat/15/par/E92000001/ati/221/are/nE54000015/iid/90759/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

[88] OHID (2025). Sexual and Reproductive Health Profiles. Available at: https://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/1938133286/pat/15/par/E92000001/ati/502/are/E10000018/iid/94106/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

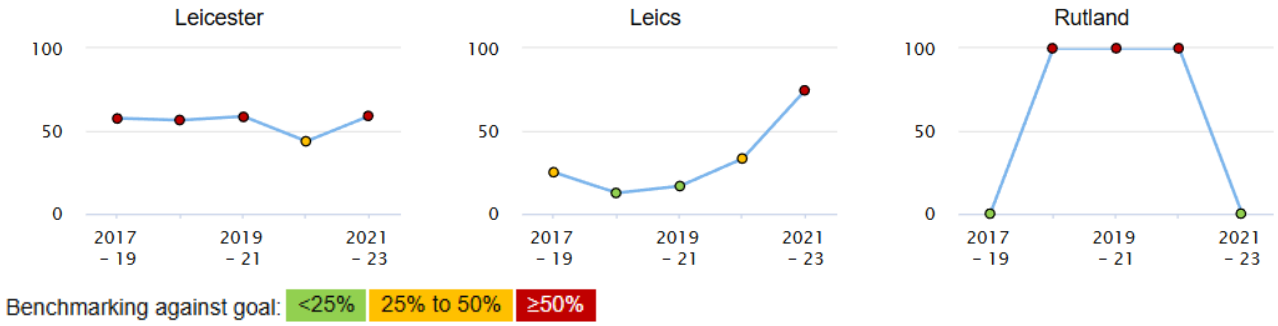
HIV testing rates have been significantly increasing and getting better across LLR since 2019, with Leicester having significantly better (higher) testing rates than national since 2020, however testing rates in Leicestershire and Rutland remain significantly below the national average since 2013. As gender breakdown of HIV testing is unavailable, it is not possible to determine, how many tests are carried out on females.

New HIV diagnosis is not synonymous with incidence; however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission. In terms of HIV diagnoses among people newly diagnosed in the UK with no previous diagnoses abroad reported, the rates (per 100,000 population) in Leicester (6.6) and Rutland (2.5) are statistically similar to the national average (4.9) for 2023, whilst Leicestershire (2.2) has a significantly lower rate. As gender breakdown of new HIV diagnoses in the UK is unavailable, it is not possible to determine, how many of these cases were in females.

A key HIV strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection. Late diagnosis is defined as newly diagnosed with a CD4 count less than 350 cells per mm3, within 91 days of diagnosis. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Among those diagnosed in England, those diagnosed late in 2019 had more than a 7-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly.[89]

Between 2021-23, there were a total of 19 heterosexual or bisexual women who received a late diagnosis of HIV. (These include all reports of HIV diagnoses made in the UK, regardless of country of first HIV positive test (that is including people who were previously diagnosed with HIV abroad). The percentage of HIV late diagnosis in heterosexual and bisexual women first diagnosed in the UK, is above the benchmark goal of 50% in Leicester (59.1%) and Leicestershire (75%).

Figure 29: HIV late diagnosis (%) in heterosexual and bisexual women first diagnosed with HIV in the UK



Source: Sexual and Reproductive Health Profiles, OHID, 2025.

PrEP

Pre-exposure prophylaxis, or PrEP, is a medication taken by individuals who aren't living with HIV to significantly reduce their risk of acquiring HIV. Since pre-exposure prophylaxis (PrEP) was

[89] UK Health Security Agency (UKHSA). HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report. 2020.

commissioned by the NHS in autumn 2020, the number of people taking PrEP has increased annually.

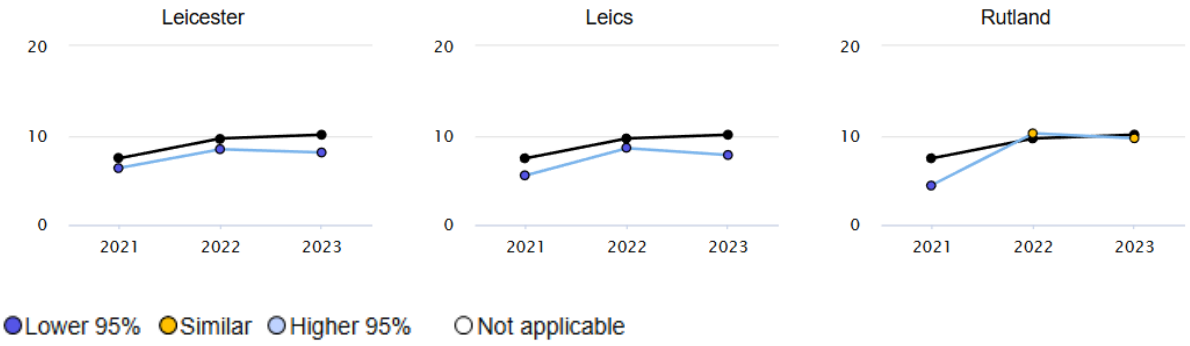
There are significant differences in PrEP need and uptake by population group - for example, heterosexual women are much less likely to have their need identified at a clinical consultation at a specialist SHS and to start and continue using HIV PrEP than gay, bisexual and other men who have sex with men (GBMSM).[90]

2025 PrEP guidelines include new sections on equity and risk assessment, shifting away from clinical trial-based eligibility criteria, where representation was predominantly MSM.

Determining PrEP need, measures the portion of all HIV negative individuals accessing specialist services who have a high HIV risk and could benefit from receiving PrEP. This indicator is not used to determine better or worse performance nationally as is dependent on local clinical practice and population demography. However, an increasing trend would be preferable.

In LLR, a total of 1,218 people tested negative for HIV who accesses specialist services and would benefit from receiving PrEP. The percentage for Leicester (8.1%) and Leicestershire (7.8%) is significantly below the national average (10.1%).

Figure 30: Determining PrEP (%) need in LLR



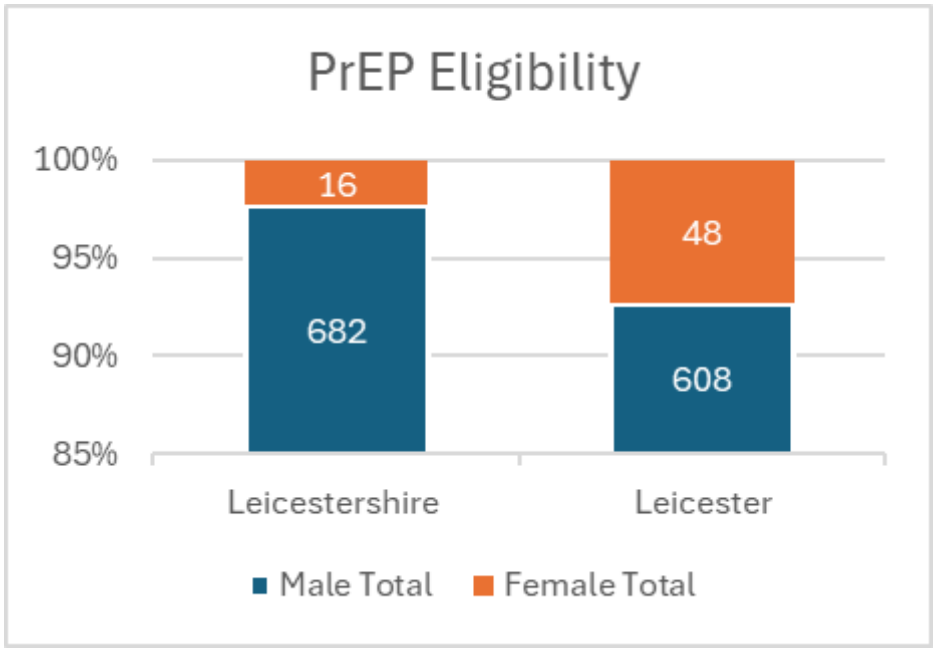
Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Data provided by UKHSA (UK Health Security Agency), showed there were a total of 1,401 people eligible for PrEP in LLR. Out of these, 69 were females (4.9%). The proportion of women in Leicester and Leicestershire who were eligible for PrEP was much lower in comparison to males. Data for Rutland has not been presented due to small numbers. Reasons for the disparity could be due to difficulty identifying women at highest HIV risk, low self-perception of HIV risk, low PrEP knowledge, as well as structural and individual barriers to PrEP initiation.[91] Also previously PrEP was targeted at GBMSM so awareness is higher in those groups.

Figure 31: PreP Eligibility by gender in LLR, 2024

[90] Department of Health & Social Care. Roadmap for Meeting the PrEP Needs of Those at Significant Risk of HIV [Internet]. GOV.UK. 2024. Available from: https://www.gov.uk/government/publications/roadmap-for-meeting-the-prep-needs-of-those-at-significant-risk-of-hiv/roadmap-for-meeting-the-prep-needs-of-those-at-significant-risk-of-hiv

[91] Saving Lives (2025). PrEP – what is it, and why aren't more women on it? Available at: https://www.savinglivesuk.com/women-and-prep/



Source: GUMCAD, STI Diagnoses Data

2.2 Contraception

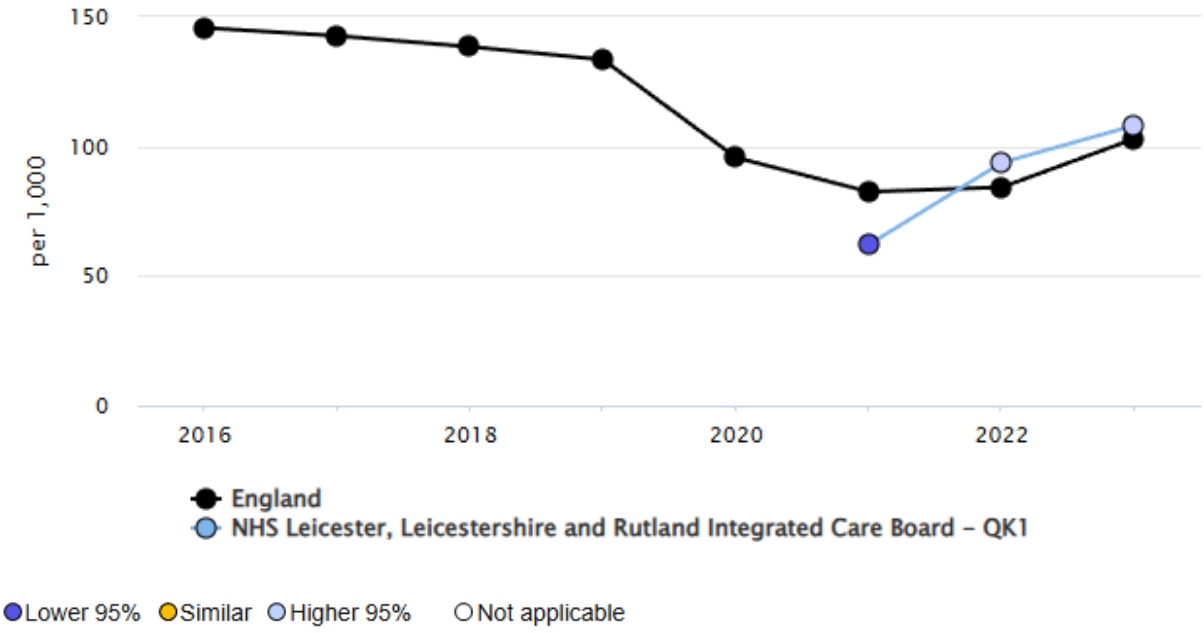
Nationally in 2023-24, within dedicated Sexual and Reproductive Health (SRH) services there were 1.06 million contacts for reasons of contraception, a decrease of 0.6% compared to 2022-23 (1.07 million). Overall contacts (includes those for non-contraception reasons) increased by 16% over the same period.[92]

There is an aim for all young people to have rapid and easy access to high quality SRH services. This is measured via an attendance indicator of young people's access to specialist contraceptive services. Females access services more than males and make more repeated visits in a year. The unique individuals view helps identify the degree of success regarding targeting this age group.

The rate of under 25 females in LLR attending specialist contraceptive services in 2023 was 108.1 (per 1,000 females), this is significantly higher in comparison to the national rate of 103.0.

Figure 32: Under 25s individuals attend specialist contraceptive services rate / 1000 – Females in LLR

[92] NHS England . Sexual and Reproductive Health Services, England (Contraception), 2023-24 (Part 1) [Internet]. NHS Digital. 2024. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2023-24/contacts-with-sexual-and-reproductive-health-services



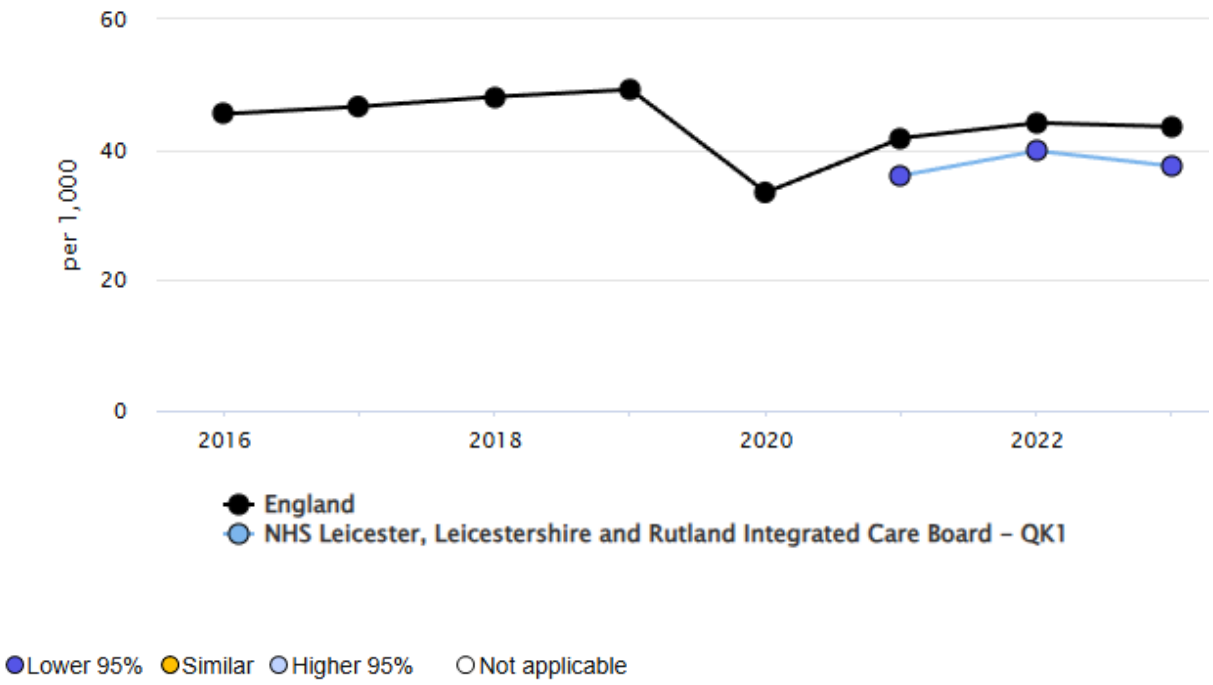
Source: Sexual and Reproductive Health Profiles, OHID, 2025.

NICE Clinical Guideline advises that LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years depending on the type of product.[93]

The rate of long acting reversible contraception (LARC) excluding injections prescribed by GP and Sexual and Reproductive Health Services in LLR was 37.5 (per 1,000 resident female population aged 15-44 years), this is significantly lower in comparison to the nation rate of 43.5.

Figure 33: Total prescribed LARC excluding injections rate /1,000

[93] NICE (2019). Long Acting Reversible Contraception. Available at: https://www.nice.org.uk/guidance/cg30



Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Women in LLR are able to access contraception such as LARCs, prescribed progesterone only pill and prescribed short acting combined hormonal contraception via sexual and reproductive health services and GP settings see **Table *4*** and **Table *5*** for data presented for 2021 to 2023.

Overall in LLR, rates for the prescribed contraception presented below are much higher in GP setting compared to SRH services and also significantly higher in comparison to the national rates across the different types of contraception.

In LLR, the rates of prescribed LARCs are significantly lower in comparison to the national rates across both settings. For prescribed short acting combined hormonal contraception, the rate in 2023 has increased to 10.5 from 3.5 in 2021 in SRH services and is now significantly higher compared to the national rate. There is a similar pattern witnessed for prescribed progesterone only pill and prescribed injectable contraception.

Table 4: LLR Sexual and Reproductive Health Services Activity

LLR Sexual and Reproductive Health Services Activity (rate per 1,000 population aged 15-44)				
	Prescribed LARC (excluding injections)	Prescribed short acting combined hormonal contraception	Prescribed progesterone only pill	Prescribed injectable contraception
2021	11.9 (16.1)	3.5 (7.6)	4.7 (9.6)	1.3 (3.6)
2022	14.3 (17.7)	8.2 (8.1)	12.1 (9.9)	1.7 (3.7)
2023	12.5 (18.0)	10.5 (9.1)	15.5 (11.6)	2.1 (5.0)

Note: National rates are presented in brackets ()

●Lower 95% ●Similar ○Higher 95% ○Not applicable

Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Table 5: LLR GP Practices Contraception Prescribed Activity

LLR GP Practices Activity (rate per 1,000 population aged 15-44)				
	Prescribed LARC (excluding injections)	Prescribed short acting combined hormonal contraception	Prescribed progesterone only pill	Prescribed injectable contraception
2021	24.1 (25.7)	122.1 (128.3)	119.4 (137.1)	24.5 (26.5)
2022	25.5 (26.5)	108.3 (116.9)	113.2 (130.7)	23.7 (25.8)
2023	24.5 (25.6)	97.3 (106.7)	106.6 (125.5)	23.8 (25.1)

Note: National rates are presented in brackets ()

●Lower 95% ●Similar ○Higher 95% ○Not applicable

Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Compared with women from the White British group, rates of contraceptive use are lower among women from ethnic minority groups, and use of emergency contraception is higher in women from the Black Caribbean group.[94]

Emergency Contraception

Nationally, 94,429 items of Emergency Contraception were provided by SRH services in 2023-24, an increase of 13% on 2022-23. There has been a steady fall in the number of emergency contraception items provided in the community (pharmacists and GPs) 65,623 items were dispensed in 2023, a fall of 11% compared to 2022 (74,002), and 69% lower than the 215,000

[94] UK Health Security Agency. SPLASH Leicestershire 2025-02-21 [Internet]. Phe.org.uk. 2025 [cited 2025 Aug 7]. Available from: https://fingertips.phe.org.uk/static-reports/sexualhealth-reports/2025/E10000018.html?area-name=Leicestershire

items provided in 2013.[95] Changes in this decline are expected as NHSE launch their expansion of the community pharmacy contraception service to include Emergency Hormonal Contraception (EHC) (expected October 2025).

In LLR, rates of females provided emergency contraception by SRH services locally are 1 per 1,000 for women aged 13-15, however for women aged 16-54 rates provided in Leicester City is 11 per 1,000 compared to 6 per 1,000 in Leicestershire (data for Rutland has been combined with Leicestershire), both above the England rate of 4 per 1,000.[96] Data from online Sexual Health Service delivered in Leicestershire and Rutland indicates in Leicestershire there are a higher proportion of BME women accessing EHC than accessing all other online service types.

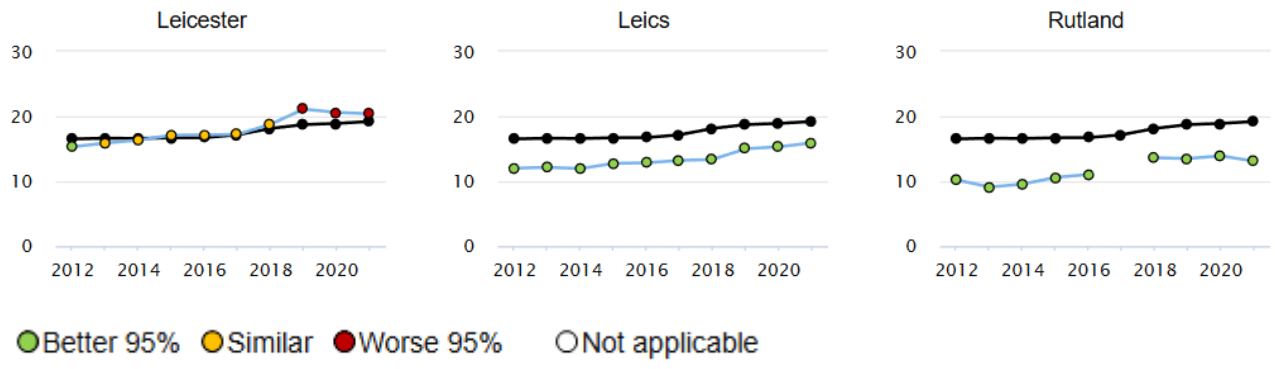
2.3 Abortions

An abortion is a way of ending a pregnancy, also know as termination of a pregnancy (TOP). Abortions can be carried out under the care of an NHS Hospital or a licenced clinic and are usually free of charge on the NHS. Abortions can be done using medicine or surgery. Most abortions in the UK are carried out before 24 weeks of pregnancy, however under special circumstances, they can be carried out after 24 weeks if there is a serious health risk.[97]

The total abortion rate (per 1,000 female aged 15-44 years) in 2021, in Leicestershire (15.9) and Rutland (13.1) was significantly better (lower) in comparison to the national average (19.2) and has remained below the national rate since recording. For the same time period for Leicester (20.4) the rate was significantly worse (higher) in comparison to the national average. For Leicester and Leicestershire, the five year trend indicates that the rates are significantly increasing and getting worse.

Compared with women from the White British group (20 per 1,000 women aged 15–44), the age-standardised abortion rate in 2022 was highest in women from Black and Mixed White-Black groups and lowest in women from Chinese, Bangladeshi and Pakistani groups.[98]

Figure 34: Total abortion rate in LLR



[95] NHS England . Sexual and Reproductive Health Services, England (Contraception), 2023-24 [Internet]. NHS Digital. 2024. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2023-24/emergency-contraception

[96] NHS England . Sexual and Reproductive Health Services, England (Contraception), 2023-24 Table 18a [Internet]. NHS Digital. 2024. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2023-24/data-tables

[97] NHS (2024). Abortions. Available at: https://www.nhs.uk/tests-and-treatments/abortion/what-is/

[98] Raleigh V. The Health Of Women From Ethnic Minority Groups In England | The King's Fund [Internet]. The King's Fund. 2025. Available from: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/the-health-of-women-from-ethnic-minority-groups-england#what-are-the-differences-in-health-outcomes

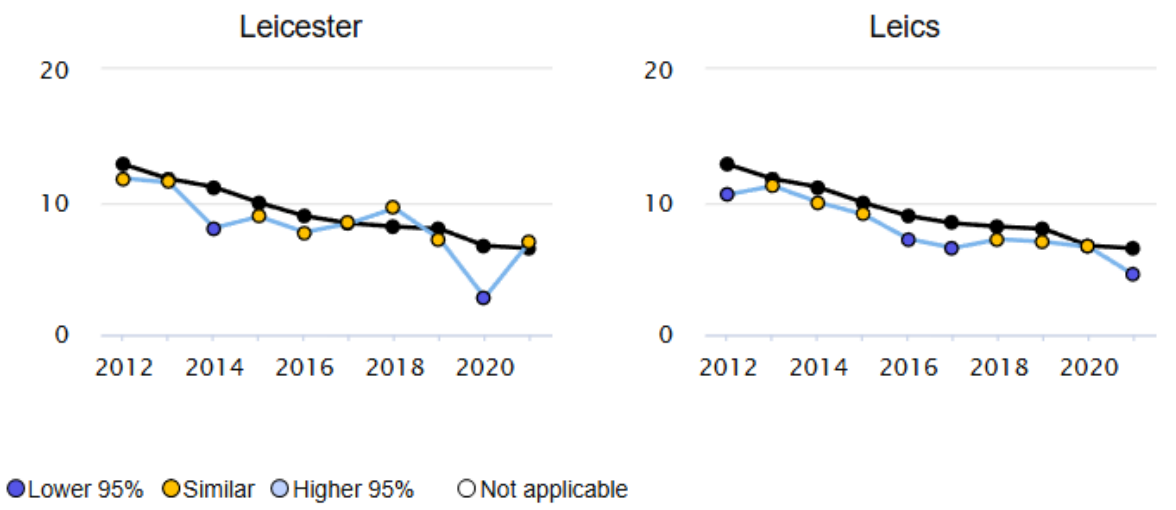
Source: Sexual and Reproductive Health Profiles, OHID, 2025.

Nationally abortion rates are higher amongst some BAME groups, which may indicate either higher rates of total unplanned pregnancies or greater proportions that culminate in abortion. Unplanned pregnancy is also an issue for women who are over the age of 35, and right through to menopause. This group are the least likely to be using adequate contraception, despite being sexually active and not wanting to conceive. Rising rates of abortion in this age group support this finding.[99]

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS.[100]

Under 18 abortion rates (per 1,000 females aged under 18 years) in Leicester (7.0) in 2021 were statistically similar to the national rate of (6.5), whereas in Leicestershire (4.5) the rate was significantly lower. The five year trend in Leicester indicates that rates are significantly decreasing. Rutland data is suppressed due to low numbers in these groups.

Figure 35: Under 18s abortion rates in LLR



Source: Sexual and Reproductive Health Profiles, OHID, 2025.

The percentage of under 18 conceptions leading to abortion in Leicester (42.5%) was significantly lower in comparison to the national average (53.4%), whilst in Leicestershire (54.5%), the proportion was statistically similar to the national rate. Rutland data is suppressed due to low numbers.

[99] Public Health England. Health matters: Reproductive Health and Pregnancy Planning [Internet]. GOV.UK. 2018 [cited 2025 Jun]. Available from: https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning

[100] OHID (2025). Sexual and Reproductive Health Profiles. Available at: https://fingertips.phe.org.uk/search/abortions#page/6/gid/8000036/pat/15/par/E92000001/ati/502/are/E06000016/iid/91456/age/173/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

2.3.1 What evidence-based management is recommended?

In recent years, there has been a decrease in condom use, likely a consequence of the success of interventions such as HIV combination prevention (including PrEP) and use of long-acting reversible contraception to prevent pregnancy. Increasing trends in testing and better diagnostic

Providing open access to non-judgmental and confidential services, where the majority of sexual health and contraceptive needs can be met enables residents to effectively maintain optimal sexual health. Offering a mixture of face-to-face and online services is required to meet the needs of different population groups. Services and modes of delivery should be designed to meet the needs of local populations and work to reduce inequalities in both access and health outcomes.

PrEP has been successful in impacting on HIV rates in the UK, with Public Health England clear that PrEP, alongside other HIV combination prevention interventions, has played a part in reducing HIV transmission – particularly amongst gay, bisexual and other men who have sex with men (GBMSM) – Equitable PrEP access is now a key focus in supporting the work of the Towards Zero action plan.

An National Institute for Health and Care Research NIHR funded study documents the positive effect good sex education programmes can have for young people, within the study programme adolescent boys and girls who were already sexually active, were significantly more likely to use contraception than those who didn't receive the programme.[101]

Unplanned pregnancies contribute to rising abortion rates. Enabling access to contraception reduces the risk of unplanned pregnancies. A planned pregnancy is likely to be a healthier one, as unplanned pregnancies represent a missed opportunity to optimise pre-pregnancy health with preconception care leading to better outcomes for both mother and child.[102]

2.3.2 Current Services in LLR

LLR has dedicated Integrated Sexual Health Services ISHS, providing walk in and appointment based face to face clinics, provision of online sexual health services offering digital access to a range of testing and contraception (including PrEP for the county and Rutland), there are good rates of GP LARC provision with over 70 registered LARC fitters and 3 women's health hubs. There are a number of pharmacies also providing access to EHC however this number has reduced year on year since 2020. It is hoped the recent decision to add provision of oral EHC to the national Pharmacy Contraception Service will increase the number of pharmacies offering the service, making it easier to access in local populations.

Specialist ISHS is only part of a range of the provision that is provided to meet the sexual health needs of the local population. Services delivered by primary care, third sector and community-based organisations form an essential part of any local sexual health system.

Termination of pregnancy services are provided via University Hospitals of Leicester UHL and British Pregnancy Advisory Service BPAS.

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[101] Lohan M, Brennan-Wilson A, Hunter R, Gabrio A, McDaid L, Young H, et al. Effects of gender-transformative relationships and sexuality education to reduce adolescent pregnancy (the JACK trial): a cluster-randomised trial. The Lancet Public Health [Internet]. 2022 Jul 1;7(7):e626–37. Available from: https://www.sciencedirect.com/science/article/pii/S2468266722001177

[102] Public Health England . Making the Case for Preconception Care Planning and preparation for pregnancy to improve maternal and child health outcomes [Internet]. 2018 Jul. Available from: https://assets.publishing.service.gov.uk/media/5b585b3a40f0b6338218d6f1/Making_the_case_for_preconception_care.pdf

2.3.3 Unmet needs or gaps

The APPG report Fixing the System: Reducing Women's Reproductive Inequalities summarises some of the challenges faced by women.[103]

"Care pathways are disjointed, difficult to navigate and create artificial divisions between contraception, sexual and reproductive health. This means women must attend multiple consultations or examinations and experience lengthy waiting times to access appropriate services. Fragmented and disjointed services deepen inequalities between women, with certain groups facing disproportionate additional barriers to accessing care. Women from higher socio-economic backgrounds are often able to navigate the system more easily than those from under-served communities, who more often have additional caring responsibilities, are without the financial ability to travel to multiple appointments or have language barriers or learning difficulties. There are systemic biases and cultural and religious beliefs that present specific challenges for women trying to access vital services. For example, women being denied access to, or dissuaded from accessing, emergency contraception because of family or community ties to pharmacists who hold specific beliefs about sex before marriage and pregnancy termination."

Commissioning responsibilities Sexual Health, Reproductive Health & HIV sit within the local authorities ICB's and NHSE, joined up working across the system of commissioners and services provided is a key element to achieving good sexual health.

2.3.4 Recommendations

- Ensure women's health work is linked into the LLR HIV action plan and local strategic plans.
- To increase HIV testing and address PrEP inequalities through improved access and targeted work to identify service user need across LLR and the wider healthcare system.
- Increase STI testing rates, – particularly in Leicestershire and Rutland
- Chlamydia – Data above shows that we have differences in rates of infections in women locally compared to England averages.
- Leicester city and Leicestershire (despite Leicestershire having better rates than England) have higher rate of chlamydia diagnosis in women than England.
- Deep dive into Gonorrhoea diagnosis rates of women locally
- Women are disproportionately affected by Gonorrhoea across LLR
- Deep dive into Leicestershire syphilis in women
- Leicestershire has higher syphilis diagnoses in women compared to men than both locally and in comparison, to England.
- Further work to be undertaken on promoting PrEP to women. Within Leicester Sexual Health, there is a Diverse Communities service, which aims to improve access and break barriers for Leicester's diverse communities, when it comes to sexual health.
- Across LLR need to do better at NSCP - more promotion to increase uptake – focus on county areas with lower rates - LARC providers etc
- Increase STI testing and treatment to reduce rates of PID in women
- Improve contraception use and reduce reliance on EHC

[103] All Party Parliamentary Group APPG. Fixing the System: Reducing Women's Reproductive Inequalities a Report by the APPG on Sexual and Reproductive Health [Internet]. Available from: https://fsrh.org/Common/Uploaded%20files/documents/APPG%20Abridged%20Report%202025_FINAL.pdf

- Improve rates of attendance at specialist contraception service in Rutland (and Leicestershire possibly)
- Work with providers to look at targeted interventions and messaging for specific groups highlighted as higher risk.
- Encourage community contraception provision
- Utilise teen health and school nurses to encourage contraception uptake
- Ensure contraception is offered post birth and post abortion
- Increase LARC uptake in Leicester City and within Leicestershire districts of Blaby, Melton, and O&W
- Support GPs to increase LARC prescription rates.
- Support practices in areas with low LARC prescribing rates with funding and training* opportunities to enable them to increase access to LARCs in their area.
- Consider a PCN-based hub and spoke model for LARCs with one or more GP practices in each PCN acting as a hub and enable inter-practice referrals from spoke practices to ensure patients have easy local access to LARCs.
- Encourage nurse-led models for LARCs.
- Develop a (SPA) single point of access model to improve patient journey/experience and to help streamline LARC pathway in Leicester.
- Undertake a deep dive into abortion, improve knowledge and data collections on wait times referral pathways and post abortion contraception support.
- It is recommended that there be more accessible information and support for young people with learning disabilities and for their parents. This needs to include information about sexuality, abuse and consent and practical information about contraception and safer sex where appropriate.

2.4 Fertility and Pregnancy

2.4.1 Background

Fertility, pregnancy, pregnancy loss, and postnatal support impacts the lives of the majority of women at some point in their lives, and are key, important aspects to consider when addressing the health needs of women in LLR. Nationally NHS England has committed to improve maternity and neo-natal services with a three-year plan, aiming to make these services more equitable for women, pregnant people, babies and their families.[104] The government have also announced a maternity review to take place with UHL being one of the sites to be reviewed.[105]

Fertility

Fertility refers to the natural capability of individuals to conceive and produce children. It is a fundamental aspect of women's health that influences not only reproductive outcomes, but can also impact the wider physical, mental, and emotional health and wellbeing of women.[106] The impact of women's fertility can affect quality of life at any age. It is of significant importance when looking at not only women's health needs, but wide-ranging factors influencing population health as a whole.

[104] NHS England » Three year delivery plan for maternity and neonatal services
[105] GOV.UK (2025). 14 NHS trusts the focus of national maternity investigation. Available at: https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation
[106] Introduction - Fertility - NCBI Bookshelf

Infertility rates in the UK estimate that around 1 in 7 couples have difficulty in conceiving, with rates steadily increasing in recent decades.[107] There are two types of infertility:

Primary infertility – where someone who has never conceived a child in the past has difficult conceiving.

Secondary infertility – where someone has had one or more pregnancies in the past but is having difficult conceiving again.[108]

Pregnancy

Pregnancy significantly shapes women's health needs and is a substantial part of many women's lives. Due to this pregnancy requires holistic, comprehensive approaches to care to ensure women's physical, mental and emotional health and wellbeing needs are being met throughout their pregnancy.[109] During pregnancy women often experience a range of physical and mental changes that can lead to specific health needs including specialised care, it is therefore of vital importance that antenatal care in LLR provides women with the support they need during this period.

Pregnancy Loss

Miscarriage is the loss of a pregnancy before the fetus reaches viability, often taken as 24 weeks of gestation.[110] Miscarriages are the most common cause of pregnancy loss, and accounts for one of the most common pregnancy complications. 80% of miscarriages occur in the first trimester, resulting in a large portion of women who do miscarry, not knowing they are pregnant before this happens. Approximately 25% of women will experience a miscarriage in their life, and recurrent miscarriages, when a woman experiences three or more early miscarriages[111], are experienced by approximately 1% of women trying to conceive.[112] If a baby is born dead after 24 completed weeks of pregnancy, it is defined as a stillbirth.[113]

Providing care and support for women who experience miscarriage, stillbirth, or other forms of baby loss is essential for supporting their physical, emotional and mental wellbeing. Miscarriage and pregnancy loss is common but many communities and populations in the UK consider it a taboo subject, resulting in the potential for significant negative impacts on women's mental wellbeing.

Postnatal Support

Postnatal care is essential for supporting the physical, mental and emotional wellbeing of women following childbirth. By providing postnatal care to mothers, it provides healthcare services such as the 0-19 Healthy Child Programme, the opportunity to monitor the mother's recovery and how she is adapting to life with a new child, provides the opportunity to share knowledge around any emerging issues, and provide support, guidance and signposting for the emergence of mental health issues such as postnatal depression. Postnatal care is key, not only to ensure a mother's wellbeing, but that of the safeguarding of babies in LLR.

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[107] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU
[108] Infertility - NHS
[109] More than a third of women experience lasting health problems after childbirth, new research shows
110 Definition | Background information | Miscarriage | CKS | NICE
[111] Recurrent Miscarriage: Definition, Causes & Care Plan
[112] Prevalence | Background information | Miscarriage | CKS | NICE
[113] Stillbirth - NHS

2.4.2 Risk factors for infertility, pregnancy and inequalities

Infertility

There are numerous risk factors associated with infertility including:[114]

- The impact of increasing cost of living on couples choosing to delay attempts to conceive,
- Poor diet,
- Smoking,
- Stress
- Sexually transmitted infections (STI's).

Common causes of infertility in women include, but are not limited to:[114]

- Lack of regular ovulation,
- Blocked or damaged fallopian tubes,
- Endometriosis
- Uterine or cervical abnormalities
- Age– lower and poorer quality of eggs remaining as women age
- Immunological factors – where antibodies attack eggs interfering with fertilisation
- Genetic conditions

In some cases, there is no clear cause for infertility, despite thorough testing.

Pregnancy Loss

Miscarriages in early pregnancy can be caused by a range of factors including:

- Abnormal chromosomes
- Blood clotting disorders
- Hormonal imbalances and diseases including problems with the thyroid and diabetes
- Polycystic Ovarian Syndrome (PCOS)
- Having an unusually shaped womb/uterine problems
- Cervical weakness

A pregnancy may also be more likely to end in miscarriage if the pregnant person is obese, smokes, use drugs, drinks lots of caffeine, or drinks alcohol.[115] In many instances of miscarriage and recurrent miscarriage, however, the cause remains unknown. Women experiencing recurrent miscarriages may be experiencing each loss for different reason, and therefore tests may not provide conclusive answers to these women as to why they are experiencing repeated lost pregnancies. It is therefore of key importance to ensure these women have access to information, support and resources to support their emotional and mental wellbeing.

Inequalities

There are groups of women in LLR who are more likely to experience health inequalities during their pregnancy, and this is often due to a combination of factors, rather than single stand-alone

[114] Risk factors | Background information | Infertility | CKS | NICE
[115] Miscarriage - Causes - NHS

factors. These inequalities can lead to poorer maternal and neonatal health outcomes and higher mortality rates in both mothers and their babies and so it is essential services in LLR consider these factors and deliver targeted interventions and support for these populations and groups of mothers. Those at risk of experiencing poorer maternal outcomes include:

- **Ethnic minority women** – women from ethnic minority backgrounds are disproportionately affected by health inequalities during pregnancy. Reports and studies such as MBRRACE-UK[107] have shown that Black women are more likely to experience complications such as pre-eclampsia, stillbirth, and maternal mortality compared to White women. Asian women also face higher risk of gestational diabetes, stillbirth, low birth weight babies, and preterm babies. These disparities may be in part due to factors including genetic predispositions, socioeconomic inequalities, cultural differences in accessing healthcare, and systematic biases within healthcare systems. It is of vital importance that all offers in LLR are free from bias and all pregnant women are offered the same options in accessing support when they need it.
- **Women from deprived areas/backgrounds** – women living in deprivation are more likely to experience poor pregnancy and maternal outcomes. Lower socioeconomic status is associated with factors such as poor nutrition, higher stress levels, and being less likely to access antenatal education. Women from this group may feel unable to access antenatal education or attend key appointments, even when antenatal offers are free, due to the need to travel to sessions or feeling like they cannot have time off from work.[116]
- **Teen parents** – Teenage pregnancies are associated with a higher risk of maternal health complications, including pre-eclampsia, anaemia and postnatal depression. This can be due to a number of factors including the challenges faced by teenage mothers when accessing antenatal support, including the role of stigma, which lead to poorer pregnancy outcomes.[117]
- **Migrants, refugees and asylum seekers** – this is a particularly vulnerable group of women, especially for those who have recently arrived in the UK/LLR. These groups may face multiple barriers and challenges related to their pregnancy included limited access to healthcare, language barriers, lack of knowledge about healthcare systems and the offer available to them in the UK, traumatic experiences in their country of origin, lack of resources, social isolation and inadequate housing.[118] Immigration policies can undermine NHS care principles and therefore create distrust amongst these populations when accessing pregnancy care.[119]
- **LGBT+ Women** – pregnant women identifying as part of the LGBT+ community may experience discrimination, lack of understanding from healthcare professionals, or mental health needs specifically linked to their experiences being LGBT+. LGBT individuals who are pregnant or want to become pregnancy face worse pregnancy outcomes than their heterosexual peers including the ability to achieve a successful pregnancy, higher rates of pregnancy loss and miscarriage and higher rates of preterm births.[120]

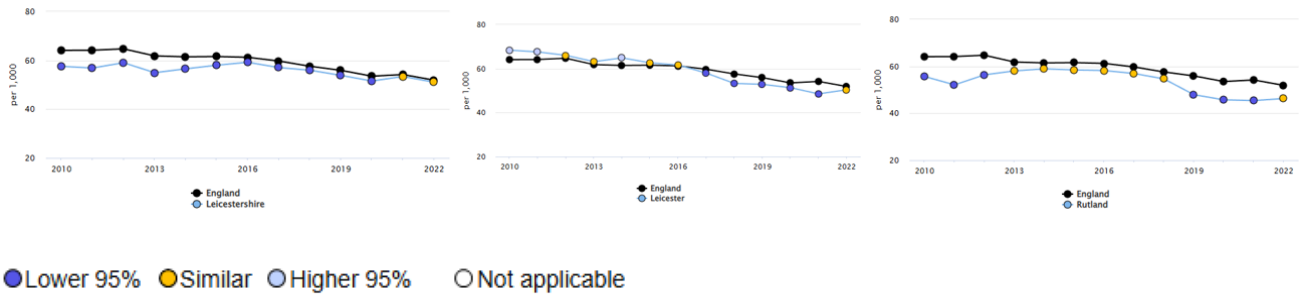
[116] RCOG position statement: Poverty, deprivation and women's health | RCOG
[117] Adolescent pregnancy
[118] RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women | RCOG
[119] Effects of UK hostile environment policies on maternity care for refugees, asylum seekers, and undocumented migrants in Camden: Examining the experiences of healthcare professionals and community organisations - ScienceDirect
[120] LGBTQ+ individuals and pregnancy outcomes: A commentary - PMC

2.4.3 Level of need

Fertility

Fertility rates are generally monitored nationally by measuring the number of live births per woman of childbearing age (15-44 years). Fertility rates are closely tied to growth rates for an area and can be an excellent indicator of future population growth or decline in that area. Over the last five-year period (2018-2022), the trend in general fertility rates (per 1,000 females aged 15-44 years) in Leicester and Leicestershire are significantly decreasing which mirrors the national trend. The latest data in 2022 indicates that general fertility rates in Leicester (50.4), Leicestershire (51.1) and Rutland (46.3) are statistically similar to the national rate (51.9).

Figure 36: General Fertility Rates in LLR

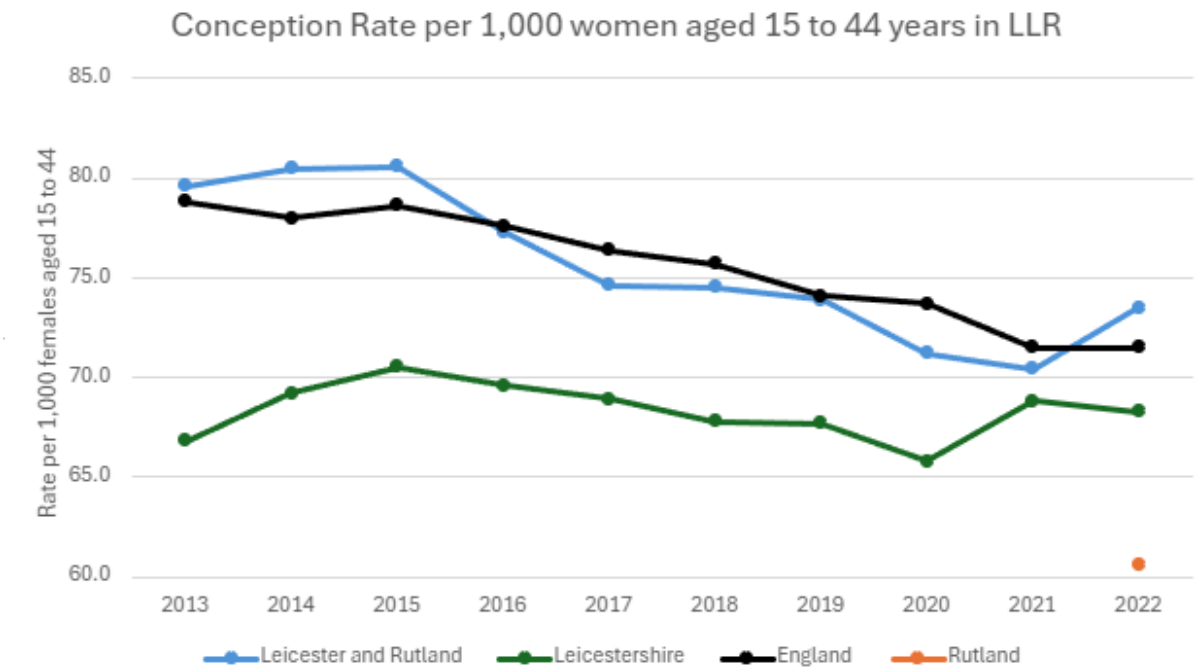


Source: Sexual and Reproductive Health Profiles, OHID, 2025

Conceptions

Conception statistics are provided by ONS (Office for National Statistics) and include pregnancies that result in one or more live or stillbirths (a maternity), and legal abortions. They do not include miscarriages or illegal abortions. The trend in conception rate for Leicester and Rutland (combined) has fluctuated over the past decade, with an increase witnessed in 2022 for Leicester, whereas nationally, a declining trend can be seen. The trend in conception rates for Leicestershire has remained below the national rates. In 2022, there were a total of 15,576 conceptions in LLR. The rates (per 1,000 females aged 15-44) for Leicestershire (68.3) and Rutland (60.6) are significantly lower in comparison to the national rate of 71.5, whereas for Leicester (73.5), the rate is statistically similar.

Figure 37: Conception rates in LLR



Source: ONS, 2025

Note: data up to 2021 for Rutland has been combined with Leicester.

Teenage Pregnancy

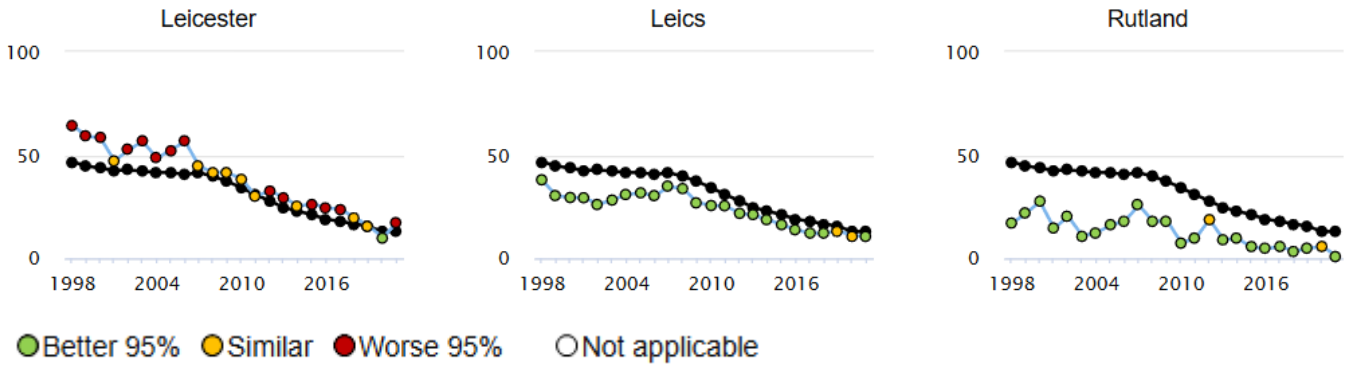
Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes. Over 50% of under-18 conceptions end in abortion and inequalities remain between and within local authorities.[121]

Babies born to mothers under 20-years have a 24% higher rate of stillbirth than average, 75% higher rate of infant mortality and 30% higher rate of low birth weight. Mothers under 20- years old have a higher risk of poor mental health up to 3 years after giving birth. This affects their own wellbeing, and their ability to form a secure attachment with their baby, recognised as a key foundation stone for positive child outcomes.[122]

Teenage pregnancy rates in Leicester City have been significantly decreasing and getting better, however, in 2021, the rate significantly increased to 17.3 (per 1,000 females aged under 18 years) from 10.1 in 2020, this equates to an additional 50 pregnancies to teenage mothers and is significantly worse (higher) in comparison to the national rate of 13.1. The rates in Leicestershire (10.7) and Rutland (1.1) are significantly better (lower) in comparison to the national average during the same period.

[121] Public Health England. LASER (Local Authority Sexual Health, Reproductive Health and HIV Epidemiology Report). (2018). Available at: https://hivstiwebportal.phe.org.uk/login.aspx?ReturnUrl=%2f
[122] Teenage Pregnancy Prevention Framework PHE (2018). Available at: https://assets.publishing.service.gov.uk/media/5d9604dee5274a70cbf535ec/Teenage_Pregnancy_Prevention_Framework.pdf

Figure 38: Under 18's conception rate in LLR



Source: Sexual and Reproductive Health Profiles, OHID, 2025

Pregnancy Loss

Pregnancy loss is an often controversial and stigmatised topic, and as such data is not as robust or readily available as other health topics, relying often on national level data from research carried out by academics and charities.

Many women who have experienced a miscarriage often do not wish to discuss their experience and may not seek medical care as a result of miscarriage. Miscarriages can also occur before a person knows they are pregnant, resulting in a lack of data from these people. Due to this, miscarriages are not officially recorded in the UK, therefore research is relied upon to estimate this number. The charities Sands and Tommy's estimate that 15 in every 100 pregnancies (15%) end in miscarriage, with around 100,000 miscarriages in England in 2021-22.[123] Approximately 25% of women will experience a miscarriage in her life.[124] No causes or associations are found in about 50% of those experiencing recurrent miscarriages, however 75% of this population are able to achieve a successful pregnancy and live birth in future pregnancies, dependant on them receiving support and care in dedicated early pregnancy assessment units.[125] Over 50,000 hospital admissions per year in the UK relate to early pregnancy loss.[126]

Postnatal Care

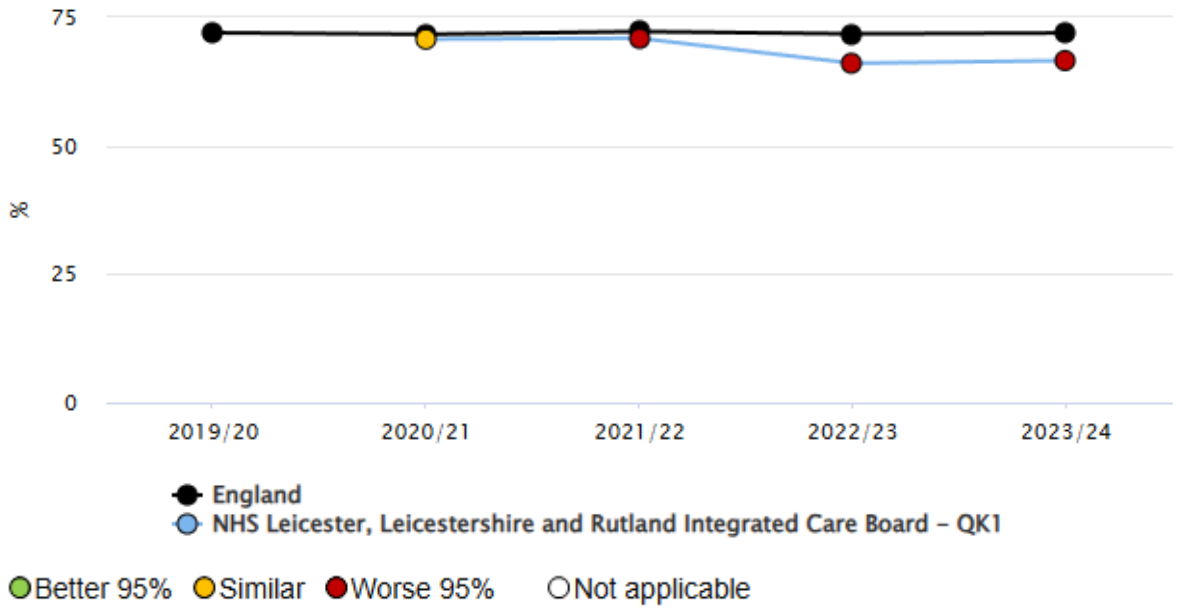
Postnatal care is essential for the physical recovery and mental well-being of the mother, as well as the health and development of the newborn. This care provides monitoring for complications, support for wound healing, guidance on newborn feeding and care, and crucial emotional support to help parents navigate the challenges of early parenthood and build new family relationships.[127]

Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants,[128] therefore it is important to provide ongoing breastfeeding support to all mothers. In terms of breastfeeding, data on

[123] Miscarriage statistics | Sands - Saving babies' lives. Supporting bereaved families.
[124] Prevalence | Background information | Miscarriage | CKS | NICE
[125] Causes | Background information | Miscarriage | CKS | NICE
[126] Prevalence | Background information | Miscarriage | CKS | NICE
[127] WHO (2020). What matters to women in the postnatal period? Available at: https://www.who.int/news/item/22-04-2020-what-matters-to-women-in-the-postnatal-period
[128] Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom Millennium Cohort Study. Pediatrics. 2007 Apr;119(4):e837-42. doi: 10.1542/peds.2006-2256. PMID: 17403827.

initiation (babies whose first feed is breastmilk) and uptake at 6-8 weeks is published. In 2023/24, there were a total of 6,065 babies in LLR who's first feed was breastmilk, this equates to 66.6% and is significantly worse (lower) in comparison to the national average of 71.9%. Breastfeeding initiation rates within LLR have remained significantly worse (lower) in comparison to the national average since 2021/22.

Figure 39: Breastfeeding Initiation in LLR



Source: Child and Maternal Health Profiles, OHID, 2025

The proportion of infants being totally/partially breastfed at 6-8 weeks varies within LLR. Whilst the prevalence of breastfeeding in Leicester (66.2%) and Rutland (63.6%) are significantly better (higher) in comparison to the national average (52.7%), the prevalence in Leicestershire (51.9%) is statistically similar to the national rate.

There is a lack of general data around postnatal care, perceived usefulness and reach of the current offer available to women in LLR. It would be of use to carry out evaluation work to understand the efficacy of the current provision to enable gaps to be identified, and good work to be praised.

2.4.4 What evidence-based management is recommended?

The topics of fertility, pregnancy, pregnancy loss and postnatal care are large and wide ranging and require their own individual research projects in order to understand the evidence base fully and the impact this may have on service provision in LLR.

Here it is important to note the role of guidance from the NHS and NICE in the provision of services regarding fertility, pregnancy, pregnancy loss, and postnatal care. Such guidelines include:[129]

- NICE Clinical Guideline CG156: Fertility: Assessment and Treatment
- NICE Clinical Guideline CG183: Donor Insemination

[129] NICE Guidance (2025). Available at: https://www.nice.org.uk/

- NICE Guidelines on the Preservation of Fertility
- NICE Clinical Guideline CG62: Antenatal Care
- NICE Clinical Guideline CG37: Intrapartum Care for Healthy Women and Babies
- NICE Clinical Guideline CG118: Caesarean Section
- NICE Clinical Guideline CG123: Postnatal Care
- NICE Clinical Guideline CG154: Miscarriage (Early Pregnancy Loss)
- NICE Clinical Guideline CG127: Antenatal Care (including stillbirth prevention)
- NICE Quality Standard QS72: Pregnancy Loss (Miscarriage and Stillbirth)
- NICE Guideline on Emotional and Psychological Support for those experiencing pregnancy loss.
- NICE Guidance on Recurrent Miscarriage

Antenatal care – A recent study by Larkai et al[130] indicates that women in the UK favour NHS antenatal classes as trusted source of antenatal information, support and education. It is key that a provision of such antenatal education should be informed by and provided by, or in combination with the local NHS maternity services. Also important to women when looking at antenatal education is the ability for the model to be flexible, with tailored content to suit different population needs. This is especially important for Leicester, with such a diverse population requiring differing messages, with the ability for these to be made available in community languages.

2.4.5 Current Services in LLR

Due to the nature of the fertility, pregnancy, and pregnancy loss healthcare landscape, much of the available services are the same or similar across LLR, with the University Hospitals of Leicester NHS Trust providing major services to the LLR population.

Services, activities, and projects are offered by a range of organisations in LLR during pregnancy. Due to the nature of the funding for some of these projects, information regarding them is subject to change, and some are only available for selected geographical areas or populations. All information is correct at the time of producing this needs assessment.

Below is a summary of the services available in LLR that support women through fertility, pregnancy, pregnancy loss, and postnatal care.

Fertility / Pregnancy

- University Hospitals of Leicester Maternity Services – including specialist infant feeding midwives.
- **Leicester Fertility Centre** – NHS and privately funded fertility care through a wide range of treatments, using the latest and most cutting edges advances in IVF as standard, regardless of funding, based at the LRI.
- **LPT Healthy Together** – providing the 0-11 Healthy Child Programme including Public Health Nurses (Health Visitors).
- **Leicester Mammas** – VCSE organisation providing support for mothers and babies to breastfeed.

[130] Larkai E, Davies A, Toolan M, Lynch M, Plachcinski R, Larkin M, Fraser A, Burden C, Merriel A. *What Do Antenatal Women Want From Their Antenatal Education?* A National Survey. Matern Child Health J. 2025 Mar;29(3):324-337. doi: 10.1007/s10995-025-04048-z. Epub 2025 Feb 3. PMID: 39900851; PMCID: PMC11926007.

- **Mammas Antenatal Course** – this is an online free antenatal course run on Zoom monthly, including four sessions with a focus on preparing for breastfeeding. Parents must book onto these sessions. Provided by Leicester Mammas.
- **Booking appointments** – early booking for antenatal care enables health promotion at the earliest possible opportunity and late booking is associated with poorer birth outcomes. Ensuring women know they need a booking appointment is key, with recent promotional materials developed in combination with the local ICB, Leicester City Council and Leicestershire County Council to encourage women to book their appointment with a midwife before they are 12 weeks pregnant.
- **Heads Up Leicester** – providing the Teen Parent Pathway, Universal Antenatal Education Classes known locally as Bumps to Babies, and Wellbeing in Pregnancy (support for pregnant people with low level mental health needs).
- **Bumps to Babies** – a four-week, free antenatal course available to all pregnant people and their families in Leicester. The course covers a range of topics including birth, labour and pain relief, infant feeding, and parental wellbeing. Sessions are designed and delivered by midwives, public health nurses (health visitors, infant feeding specialists and early years professionals. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester. This offer is for Leicester residents only.
- **Bumps to Babies for Teen Parents** – a five-week free antenatal course for teen parents to be, covering topics including wellbeing in pregnancy, labour and pain relief, feeding babies, and becoming a parent. Those who attend receive a free 'baby box' full of essentials. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester. This offer is for Leicester residents only.
- **Wellbeing in Pregnancy** – an antenatal group for parents-to-be in Leicester. Sessions cover everything that pregnant parents want to know about how to have a healthy pregnancy emotionally. The sessions look at ways to cope with worry, stress and anxiety during pregnancy, and how to bond and communicate with their baby both before and after birth. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester. This offer is Leicester residents only.
- **Bumps to Babies Online** – An online version of Bumps to Babies antenatal sessions, comprising of four short videos, is available on the Health for Under 5s website for prospective parents living in Leicestershire and Rutland. The four videos offer advice and information on: becoming a parent, labour and pain relief, breastfeeding and baby care.
- **Blossom and Bloom** – Group by Wesley Hall Community Centre and Leicester Mammas providing new parents with a space to improve their mental and physical wellbeing.
- **Maternity CURE Team** – The CURE Team gives specialist support to pregnant women and their partners to quit smoking for good. Their advisors can meet service users in locations that are suitable for them and provided personalised one-to-one support throughout pregnancy. The support is free, including free nicotine replacement therapy and e-cigarettes, shopping voucher incentive scheme to support their quit journey, and on-going behavioural support to help women stay smoke-free, even after their pregnancy. Families can self-refer or be referred into this project by a professional. Provided by The Maternity CURE project at UHL
- **Best Start For Life Workforce Pilot** – this pilot offers specific help to parents with vulnerabilities, offering them face to face contacts, and offers such as one to one bumps to babies delivered at home during the antenatal period.
- **Leicester Maternity Matters Podcast** – A brand-new educational podcast recorded by healthcare professionals from UHL is now available to listen to on Spotify. This allows

prospective or new parents to listen to trusted, accessible information at a time convenient to them.

- **Chat Health** – LPT runs a confidential secure, weekday text messaging service for parents of children aged 0-19. Messages will be responded to by a Public Health Nurse within 24 hours (within working hours). There are two numbers available one for Leicester and one for Leicestershire and Rutland.
- **Healthy Together Helpline** – LPT runs the Healthy Together Helpline for parents and carers in LLR. Calls are answered 9am-4:30pm on weekdays. There is one universal number for LLR.
- **Leicester Children, Young People, and Families Centres (CYPFCs) aka Family Hubs** – 12 centres located around the city that offer support, activities and information for babies, children and their families. Clinics for contacts organised by the health visiting team may be held in these locations.
- **Family Hubs Leicestershire** – There are 37 Family Hubs located around Leicestershire and Rutland that offer support, advice, activities and information for children, young people and families.

Pregnancy Loss

Losing a pregnancy can be extremely traumatic for mothers, being able to provide support for these parents when they need it is essential. Services and support available in LLR include:

- **Maternity Bereavement Service** – a specialist service from UHL to support families through the death of their baby which aims to ensure each family feels supported and guided through their journey, help navigate practical and emotional challenges and provide practical telephone or face to face support once parents are discharged. Midwives or doctors can make referrals to this service, or parents can self-refer.
- **Neonatal Bereavement Team** – similar to the maternity bereavement service, however this team offers specialist support to families whose babies have died in a hospital neonatal unit.
- **Rainbow Clinic** – run by consultants and specialist midwives this clinic supports parents who have had a stillbirth, late miscarriage, or early neonatal death in a previous pregnancy. The clinic aims to improve the emotional and psychological wellbeing of families.
- **Babyloss Support** – this is a peer support group offering support to families affected by the death of a baby in LLR Rutland. They also work with local professionals and charities to provide training to enable them to care sensitively for families experiencing baby loss.
- **The Laura Centre** – helps to provide a confidential space where bereaved families can explore their grief and find a way to move forward through a range of person-centred support options.

Postnatal Care

Postnatal care in LLR is delivered in a number of ways, with the key support listed below:

- **Maternity services at UHL**: The University Hospitals of Leicester have maternity wards at two of the Leicester Hospitals – Leicester Royal Infirmary and Leicester General Hospital. These units provide support to women throughout their pregnancy and provide some postnatal care including:
- **Information and resources** – Upon discharge from hospital women who have given birth are provided with a number of resources including the 'red book' (personal child health record) which documents their child's health and development, logging their weight, height, vaccination history and other important information such as medicines

or illnesses. Mothers are also given information sheets with links to websites such as Health for Under 5's, information about registering baby's birth and leaflets regarding some local services.

- **Community Midwives** – Community midwives will aim to visit new mothers in their home the day after they go home from hospital. During this visit midwives will arrange any further visits, these may be at home or at a clinic. During this visit midwives will weight babies and organise a newborn blood spot test on day 5.
- **Online resources** – Midwifery at UHL has worked with LPT to develop a substantial offer regarding care, support and information for new parents and babies that is available for families to access on the Health for Under 5s websites. This information includes videos about what to expect post-birth and information tailored to LLR.
- **Health Visiting Service (Healthy Together)**: This is a commissioned service provided by Leicestershire Partnership NHS Trust (LPT). There are two programmes commissioned, one for those living in Leicester and one for those living in Leicestershire and Rutland. The service, known locally as Healthy Together, provides all mandated contacts for babies via the Public Health Nurse (Health Visiting) Team. Whilst all of these mandated contacts are essential for ensuring the wellbeing and growth of babies, the first sessions are also an essential aspect of postnatal care for new mothers. Currently the offer in Leicester, Leicestershire and Rutland is as follows:
- **New Birth Review** - Mothers are contacted by their Public Health Nursing Team to arrange a contact when their baby is between 10 and 14 days old. During this contact the emotional wellbeing of mothers, the support they have available, their family and their environment are all discussed.
- **6-8 Week Review** - Mothers are contacted by their Public Health Nursing Team to arrange a contact when their baby is between 6 and 8 weeks old. During this contact there are discussions again around the emotional health and wellbeing of mother, bonding with baby, and coping with crying (ICON messaging).
- **3–4 month review** – Mothers are contacted by the Public Health Nursing Team when their child is between 3 and 4 months old and will be directed to the Health for Under 5s website to view information on a wide range of topics, including information on help available for parents.
- **10-12 month review** - Mothers are contacted by their Public Health Nursing Team to arrange a contact when their baby is between 10 and 12 months old. During this contact the emotional wellbeing of mothers, the support networks they have available, and how they are coping.
- **2 – 2.5 year review -** Mothers are contacted by their Public Health Nursing Team to arrange a contact when their baby is between 2 and 2.5 years old. During this contact the emotional wellbeing of mothers, the support networks they have available, and how they are coping.
- **GP Services**: GP surgeries should offer and provide new mothers with a postnatal check six to eight weeks after their baby is born. This check covers a range of topics including:
- Mental health and wellbeing
- Vaginal discharge and whether the mother has had a period since giving birth
- Blood pressure check
- Examination of stitches
- Offer of booking a cervical screening appointment if this was due during pregnancy
- Contraception
- Vitamin D supplements if breastfeeding
- Guidance on healthy eating, exercise and maintaining a healthy weight

- **VCSE Organisations**: LLR has a wealth of local VCSE organisations that provide support, activities, and information for new parents and their babies to attend. Some of these services are listed below. Due to the nature of funding for some of these projects, information regarding them is subject to change. Some projects are only available to specific populations. All information is correct at the time of producing this needs assessment.
- **Blossom and Bloom** – this is a project offering a range of activities and support to parents to help improve their physical and mental wellbeing. The project provides access to activities such as dance fit sessions, coffee mornings, breathful moments sessions, Dadventures outdoor activities, and one to one support. Families can self-refer or be referred into this project by a professional or other VCSE organisation. Provided by Wesley Hall community Centre and Leicester Mammas. Available to those living in Leicester only.
- **Babies and Toddler improving communication skills group –** this is a weekly group for families wanting to help their child to learn to communicate. This offer is particularly for those whose first language is not English and aims to provide parents with the confidence to communicate with their baby effectively. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester. Available to those living in Leicester only.
- **Mammas Baby Cafes –** these groups where mums can meet and get support with a range of topics such as sleep, feeding and weaning. These sessions also offer one to one support with breastfeeding. These sessions are drop in and do not require booking or referral. Provided by Leicester Mammas.
- **Babies Learning Together –** this programme helps parents and carers to extend learning opportunities where possible, improve the quality of home learning, and develop secure attachment relationships with their babies. The programme aims to improve babies' health and physical development, communication and language skills and personal, social and emotional development. These are invite only programmes delivered by Family Hubs.
- **Mammas Baby Project –** a project helping families in crisis situations including those living with or fleeing domestic violence, in insecure housing, facing financial hardship, and those struggling with their mental health and social isolation. The project provides support, signposting and information around infant feeding and welfare. Where appropriate this project can provide emergency supplies of essentials including vouchers for formula milk. Provided by Leicester Mammas. Available to those living in Leicester only.
- **Understanding Your Baby –** a seven-week course covering a range of topics new parents may be worried about. It provides practical information, a chance to play, and time to share experiences with other parents. Parents must book onto these sessions. Provided by Leicester Mammas.
- **Best Start Baby Groups –** weekly groups for families living in Leicester to help support baby development and to meet other parents in a fun and friendly group. Support with transport is available for this offer. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester.
- **Babies Learning Together for Teen Parents –** weekly group for teen parents and their babies to meet others and support babies learning and development. Activities include swimming, walks in the park, farm trips, first aid courses, and craft activities. Families can self-refer or be referred into this project by a professional. Provided by Heads Up Leicester.

2.4.6 Unmet needs or gaps

There are significant inequalities when looking at the way in which fertility treatments can be accessed by certain groups – of which there is significant representation in the LLR population. Two key groups affected by access to NHS-funded fertility treatment can be found below;

Firstly, couples who have one or both members who were not born in the United Kingdom, and or do not have indefinite right to remain in the UK are not eligible to access fertility treatment through the NHS. This remains the case if the person requiring the treatment does have right to remain, but their partner does not. For example, if a woman born in the UK required fertility treatment due to Polycystic Ovary Syndrome (PCOS), and her partner born in India with no right to remain had no fertility issues, they would still be ineligible to access fertility. This would result in the couple needing to access private fertility treatment at a significant financial, and potentially emotional cost. This is unequal access to these couples, which requires action from HM Government and or the NHS to change.

Secondly, same-sex female couples accessing fertility treatment face significant inequalities when compared to heterosexual couples. 90% of integrated care board in England, with LLR being one of these, require LGBTQ+ couples to self-fund at least six cycles of artificial insemination before they are eligible for NHS IVF treatment. This incurs a massive financial cost to same-sex couples, a burden that is not borne the same of heterosexual couples wishing to access fertility treatment through the NHS. This is not only a financial strain for these couples, but also both a physical, mental, and emotionally straining process, that is an inequality for these couples. Guidelines have now been changed nationally to allow ICB's to alter these rules to help same-sex couples access fertility treatment should they require it – this was a focus of the East Midlands Fertility Policy Listening Exercise in January 2025 which may address this issue for these couples. This outcome is being awaited, and LA's in LLR should note the outcomes of this policy review for access to fertility treatment provisions not just for same-sex couples but individuals wanting children, older individuals and the number of NHS funded treatment cycles available to all couples.

As previously discussed, LLR and specifically Leicester has a significantly diverse population – in order to ensure that all pregnant women in Leicester have access to the same information and resources during their pregnancy, work needs to continuously be undertaken and reviewed into the needs of the population. This includes the reviewing of the languages in which information is provided, and antenatal classes are delivered. Currently, the offer provided is not equitable for all pregnant women in LLR, and therefore this will be a contributing factor to health inequalities for pregnant women.

Gaps in maternal health care often go unnoticed due to it not being clear what is missing without doing extensive evaluation and engagement work with the pregnant population of LLR. Maternal health is influenced by many different factors as previously discussed and so identifying areas to focus on can be both difficult and controversial, with services not wanting to seem to favour particular demographics or groups. Whilst LLR seemingly has a substantial range of services to support women throughout fertility, pregnancy, contraceptive, and postnatal journeys, disparities and health inequalities in these services, projects or offers may go unnoticed or underreported. To truly address and minimise health inequalities, a deep and more nuanced exploration is needed, involving detailed data collection, patient feedback and targeted studies to understand where and how care and services are lacking, to information

future policies in the NHS, Public Health and wider, and ensure interventions are based on clear understand of evidence based needs for the population.

2.4.7 Recommendations

- Review the recommendations and outcomes from the East Midlands Fertility Policy Listening Exercise and note how this impacts on residents from LLR.
- Ensure that there are easy and accessible ways for pregnant women and those trying to get pregnant, to continuously feedback to services.
- Promote through all possible avenues the services and provisions available to women when looking to support their sexual and reproductive health and wellbeing.
- Ensure that fertility, pregnancy, and postnatal support is, where possible, provided by or in conjunction with NHS services.
- Offer early, ongoing support and clear information about antenatal care, labour and infant care to mothers with learning disabilities.
- Embed cultural competence training - discrimination and a feeling of not being listened to is a recurrent theme for ethnic minority populations in particular in maternity services.
- Further exploration into areas where no data is available to fully understand need and impact around fertility, pregnancy and postnatal support.
- Reduce health inequalities and improve healthy equity for mothers.

3 Menopause

Key Epidemiology & Context

- Around 75% of women experience symptoms, with 1 in 4 reporting debilitating impacts
- ~13 million women in the UK are peri- or post-menopausal
- HRT prescribing varies significantly by deprivation - with women in Leicester's most deprived areas far less likely to receive treatment than those in more affluent Leicestershire districts, mirroring national trends.

Inequalities & At-Risk Groups

- Lower HRT prescribing in deprived areas
- Poorer access for ethnic minority, disabled, and neurodiverse women
- Workforce impacts significant for midlife women

Gaps & Unmet Need

- Low awareness and health literacy (many women not seeking support)
- Primary care confidence and training gaps
- Lack of routine data on prevalence and symptom burden

Implications for LLR

- Increasing demand due to ageing population
- Links to cardiovascular risk, mental health, and workforce participation

Priority Action Themes

- Improve primary care capability and reduce unnecessary referrals
- Address prescribing inequalities
- Strengthen menopause support in workplaces
- Improve local intelligence and data systems

3.1.1 Background

Menopause is a natural part of aging that all women go through, typically around the age of 51 in the UK. However, about 1 in 100 experience it before age 40. It is defined as the permanent cessation of menstruation for 12 consecutive months, resulting from the decline in ovarian follicular activity and a subsequent reduction in oestrogen and progesterone production. It usually affects women between the ages of 45 and 55. Menopause can happen naturally, or prematurely due to surgery (removal of ovaries or uterus), cancer treatments or genetics.[131]

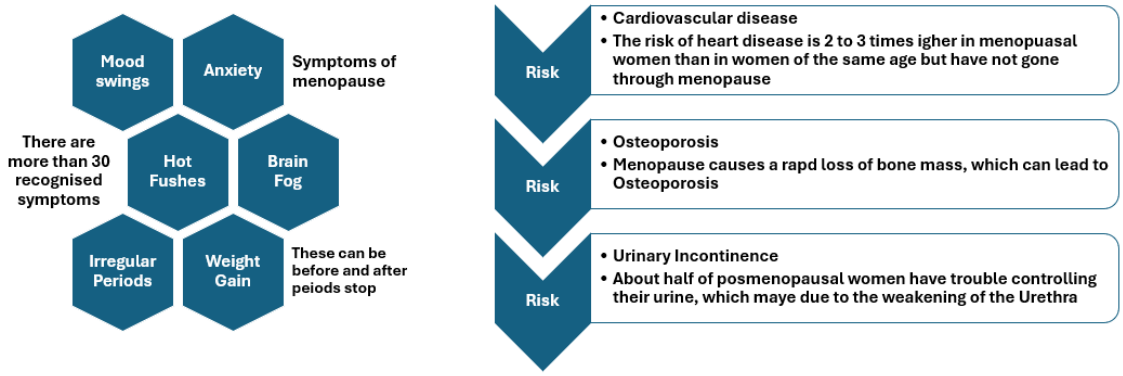
The period leading up to menopause, known as "perimenopause," is when hormonal changes begin. This phase can start as early as someone's twenties or as late as their forties. Perimenopause is when someone has symptoms of menopause, but periods have not stopped. Currently, an estimated 13 million people in the UK are in either the peri-menopausal or menopausal stage, which represents about one-third of the UK's female population. Black women typically start menopause around 49.6 years old, which is about two years earlier than the UK average.[131]

3.1.2 Symptoms and health risks for menopause

3.1.2.1 Symptoms

The following diagram depicts some of the symptoms experienced during perimenopause/menopause and some of the associated health risks.

Figure 40: Symptoms and Health Risks for Menopause



Source: Office of Women's Health, August 2023

The symptoms can last for months or years and can change with time. Symptoms range from cognitive, physical and psychological and it is important to note, that even women who do not experience obvious symptoms still undergo physiological changes that will have an impact on their health. Other symptoms can include:

- **Vasomotor symptoms**: Hot flushes, night sweats
- **Sleep disturbances**: Insomnia, disrupted sleep
- **Mood changes:** Anxiety, depression, irritability, low self-esteem
- **Cognitive difficulties:** "Brain fog", memory lapses, difficulty concentrating
- **Musculoskeletal pain:** Joint and muscle aches

[131] NHS (2022). Menopause. Available at: https://www.nhs.uk/conditions/menopause/

- **Urogenital symptoms:** Vaginal dryness, urinary frequency or urgency, sexual dysfunction
- **Other:** Palpitations, headaches, changes in skin and hair, weight gain, reduced libido, recurrent urinary tract infections

However, and concerningly, a large proportion of women are not aware of the breadth of symptoms, or that there is support available, as well as self-help. A recent study found that 49% of women did not feel informed about the menopause, 62.7% found it either difficult or very difficult, and 94.1% of women had never been taught about the menopause at school.[132]

Barriers to seeking help for symptoms include:

- Lack of knowledge of the full range of symptoms
- Stigma and embarrassment
- The belief that it is a natural part of aging
- Previous negative experiences in accessing advice or previously having treatment discouraged[133]

According to menopause Support UK, symptoms last on average between 4 to 8 years, with:[134]

- 1 in 4 experiencing very few symptoms
- 3 in 4 experiencing symptoms
- 1 in 4 experiencing debilitating symptoms.

3.1.2.2 Health Impacts of menopause

Menopause represents a significant physiological transition that affects women both mentally and physically due to the decline in oestrogen and other hormonal changes. These shifts not only trigger a spectrum of symptoms, ranging from vasomotor disturbances to cognitive and emotional fluctuations, but also increase vulnerability to long-term health risks such as osteoporosis, cardiovascular disease, dementia, and metabolic disorders. Importantly, many of these risks are modifiable through timely clinical interventions and lifestyle strategies, highlighting the need for awareness, education, and proactive management during this life stage.

Weight Gain and Associated Risk

Academic evidence shows an increase in women's weight during the perimenopause and menopause. Most of this weight is concentrated in the abdomen and upper body. As oestrogen levels decline, visceral fat proportion rises from 5–8% of total body weight to 10–15%, while lean muscle mass decreases, contributing to a slower metabolic rate.[135] [136]

[132] Aljumah R, Phillips S, Harper JC. An online survey of postmenopausal women to determine their attitudes and knowledge of the menopause. Post Reproductive Health. 2023;29(2):67-84. doi:10.1177/20533691231166543
[133] Barber K, Charles A. Barriers to Accessing Effective Treatment and Support for Menopausal Symptoms: A Qualitative Study Capturing the Behaviours, Beliefs and Experiences of Key Stakeholders. Patient Prefer Adherence. 2023;17:2971-2980. Published 2023 Nov 15. doi:10.2147/PPA.S430203
[134] Menopause Support UK (2024). Available at: https://menopausesupport.co.uk/?page_id=2
[135] Karvonen-Gutierrez, C., & Kim, C. (2016). Association of Mid-Life Changes in Body Size, Body Composition and Obesity Status with the Menopausal Transition. Healthcare, 4(3), 42. https://doi.org/10.3390/healthcare4030042
[136] British Menopause Society. Nutrition and Weight Gain at Menopause. June 2023. Available from: https://thebms.org.uk/wp-content/uploads/2023/06/19-BMS-TfC-Menopause-Nutrition-and-Weight-Gain-JUNE2023-A.pdf

Central adiposity heightens the risk of cardiovascular disease, type 2 diabetes, sleep apnoea, and hormone-sensitive cancers.[137] Menopausal hormone therapy has been shown to attenuate increases in visceral fat and improve insulin sensitivity.[138] [139]

Alongside changes in fat distribution and reductions in lean muscle mass, as women age, they also tend to loss bone mass. Therefore, even if a menopausal/post-menopausal woman weighs the same as she did when she was younger, her body composition will be different, with more weight being accountable for within fat stores. This makes usage of BMI less accurate for older women, and something that should be taken into account by clinicians.[140]

Cardiovascular Risk

The decline in oestrogen during the menopausal transition accelerates several cardiometabolic changes that increase women's risk of cardiovascular disease. As visceral fat accumulates, a hallmark of menopause-related body composition change, metabolic risk rises. Evidence shows that the shift from peripheral to central fat is directly linked to insulin resistance, dyslipidaemia and adverse vascular changes, all of which heighten cardiovascular risk in midlife and beyond.[137, 143]

Alongside this, menopause drives a rise in LDL-cholesterol, greater vascular stiffness and endothelial dysfunction, changes recognised as part of a broader "cardiometabolic transition" that is biologically distinct from chronological ageing alone. Women with more pronounced vasomotor symptoms may face particularly elevated risk.[141]

These risks are further shaped by structural factors, with socioeconomic disadvantage compounding women's vulnerability to cardiovascular disease during and after the menopausal years.[142]

Overall, the combination of hormonal decline and visceral fat gain makes menopause a critical period for cardiovascular risk assessment, prevention and early intervention.

Bone Health & Osteoporosis

Hormonal changes during and after menopause accelerate bone resorption, results in losses of bone mineral density for several years post-menopause. This substantially increases the risk of osteoporosis and fragility fractures, particularly of the hip, spine, and wrist.[143] The Women's Health Initiative and other large studies confirm that hormone replacement therapy (HRT) can prevent bone loss and reduce fracture risk but should be tailored to individual risk profiles.

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[137] Powell-Wiley TM, Poirier P, Burke LE, et al. Obesity and Cardiovascular Disease: A Scientific Statement From the American Heart Association. Circulation. 2021;143(21):e984-e1010. doi:10.1161/CIR.0000000000000973

[138] Papadakis G, Hans D, Rodriguez EG, Vollenweider P, Waeber G, Marques-Vidal P, Lamy O. Menopausal Hormone Therapy Is Associated With Reduced Total and Visceral Adiposity: The OsteoLaus Cohort, The Journal of Clinical Endocrinology & Metabolism, Volume 103, Issue 5, May 2018, Pages 1948–1957, https://doi.org/10.1210/jc.2017-02449

[139] Lovre D, Lindsey SH, Mauvais-Jarvis F. Effect of menopausal hormone therapy on components of the metabolic syndrome. Therapeutic Advances in Cardiovascular Disease. 2016;11(1):33-43. doi:10.1177/1753944716649358

[140] Rubin R. Postmenopausal Women With a "Normal" BMI Might Be Overweight or Even Obese. JAMA. 2018;319(12):1185–1187. doi:10.1001/jama.2018.0423

[141] Nappi RE, Chedraui P, Lambrinoudaki I, Simoncini T. Menopause: a cardiometabolic transition. Lancet Diabetes Endocrinol. 2022;10(6):442–56. doi:10.1016/S2213-8587(22)00076-6

[142] W Glen Pyle, Tackling change: menopause as a cardiovascular disease risk factor and the path to health equity, Cardiovascular Research, Volume 120, Issue 16, November 2024, Pages e63–e64, https://doi.org/10.1093/cvr/cvae232

[143] Nappi, R.E., Cucinella, L. (2020). Long-Term Consequences of Menopause. In: Petraglia, F., Fauser, B. (eds) Female Reproductive Dysfunction . Endocrinology. Springer, Cham. https://doi.org/10.1007/978-3-030-03594-5_17-1

Mental Health & Cognitive Decline

Although explored in full within the Mental Health and Cognitive Health chapters, it is important to acknowledge the implications of menopause on mental health and cognitive functioning.

The hormonal changes of perimenopause and menopause can significantly affect mental health, mood regulation, and cognitive functioning. Many women experience anxiety, low mood, irritability, sleep disturbance, and "brain fog" during the menopausal transition.[144, 145] These symptoms can overlap with, or be mistaken for, primary mental health disorders, meaning that perimenopausal symptoms are sometimes misdiagnosed as depression or anxiety, resulting in inappropriate treatment such as antidepressants rather than menopause-specific support, something which is not supported by NICE.[146]

Menopause is also associated with short-term cognitive changes, including memory lapses and reduced concentration, which typically improve over time.[145] However, post-menopausal hormone changes contribute to longer-term risk of dementia, including Alzheimer's disease, the most common dementia type among women. Women account for around two-thirds of people living with Alzheimer's, in part due to longer life expectancy, but also due to biological factors such as loss of oestrogen's neuroprotective effects.[147, 148]

Although the mechanisms remain under investigation, large cohort studies suggest that earlier menopause, whether natural or surgically induced, may be linked with increased dementia risk later in life.[148] These associations highlight the importance of recognising menopausal cognitive symptoms and distinguishing them from primary mental health conditions, ensuring women receive appropriate and targeted support rather than a one-size-fits-all approach that may result in antidepressants being offered when depression is not present.

3.1.3 Level of need

Understanding the true level of need relating to perimenopause and menopause is challenging, as neither local systems nor national data collections routinely capture menopausal symptoms, severity, duration, or help-seeking behaviours. This absence of structured surveillance means that the burden of need is likely significantly underestimated, particularly among those less likely to seek care due to stigma, cultural expectations, language barriers, or prior negative healthcare experiences.

Nevertheless, the evidence base, from academia, NHS datasets, and UK-wide surveys, demonstrates clearly that the scale of need is both large and systemically important.

[144] Greendale GA, Derby CA, Maki PM. Perimenopause and cognition. Obstet Gynecol Clin North Am. 2011 Sep;38(3):519-35. doi: 10.1016/j.ogc.2011.05.007.
[145] Weber MT, Mapstone M, Staskiewicz J, Maki PM. Reconciling subjective memory complaints with objective memory performance in the menopausal transition. Menopause. 2012 Jul;19(7):735-41. doi: 10.1097/gme.0b013e318241fd22.
[146] National Institute for Health and Care Excellence. Menopause: diagnosis and management. NG23. London: NICE; 2015. Available from: https://www.nice.org.uk/guidance/ng23
[147] Alzheimer's Society. Women and Dementia Factsheet. 2024. Available from https://www.alz.org/getmedia/76e51bb6-c003-4d84-8019-e0779d8c4e8d/alzheimers-facts-and-figures.pdf
[148] Georgakis MK et al. Age at menopause and duration of reproductive period in association with dementia and cognitive impairment. JAMA Psychiatry. 2016;73(5):531–9.

High Prevalence and Long Duration of Symptoms:

Findings from a survey on perimenopause and menopause conducted by the Fawcett Society in 2022 found the following:[149]

- 77% found at least one menopause symptom 'very difficult'
- 84% experienced trouble sleeping
- 73% experienced brain fog
- 69% of women experience difficulties with anxiety and depression
- 44% of women experienced three or more severe symptoms
- Almost half (45%) of women hadn't spoken to their GP about their symptoms.

Despite gaps in routine data, the scale of need is undeniably substantial. More than half of the population will experience perimenopause or menopause. The demographic profile of Leicestershire and Rutland indicates a rapidly ageing population, with a higher proportion of women in midlife and older age compared to national averages. Rutland, in particular, has one of the highest proportions of residents aged 65+ in the region, and Leicestershire has seen steady growth in women aged 45–64, the core perimenopausal and post-menopausal population.

As these cohorts continue to grow, the local prevalence of menopausal need, associated long-term conditions (e.g., osteoporosis, cardiovascular disease), and age-related cognitive decline will inevitably increase. This demographic trend means that the already-substantial need will intensify over the coming decade, placing additional demands on primary care, women's health hubs, mental health services and community-based support.[150, 151]

Given the trajectory of population ageing in Leicestershire and Rutland, addressing menopause effectively is therefore not only a clinical necessity but also a key strategy for healthy ageing, prevention of long-term morbidity and reducing future pressure on health and care services.

In the Workplace:

The Fawcett Society Study found 44% menopausal women in employment not able to meet their work demands due to menopausal symptoms and 8 in 10 women highlighted no basic workplace support such as absence policies (81%) and support networks (79%).

The menopause fact file published by the Local Government Association (LGA) states that menopausal women are the fastest growing demographic in the workforce and almost 8 out of 10 menopausal women are in work.[152] According to NOMIS (ONS), LLR has approximately 152,100 women aged 35-64 in employment (including self-employed) between 2024/25, so this would equate to an estimated 121,680 women who could potentially be experiencing symptoms of peri-menopause/menopause in the workplace.[153] However, it is important to note that not all women will experience negative symptoms.

[149] Fawcett Society (2022). Landmark Study: Menopausal women let down by employers and healthcare providers. Available at: https://www.fawcettsociety.org.uk/news/landmark-study-menopausal-women-let-down-by-employers-and-healthcare-providers

[150] Leicestershire County Council. Demography of Leicestershire 2024. Leicestershire: LCC; 2024. Available from: https://www.lsr-online.org/uploads/demography-2024.pdf?v=1727078295

[151] Rutland County Council. Demography and Growth: Rutland Overview. Rutland: RCC; 2024. Available from: https://www.lsr-online.org/uploads/demography-and-growth.pdf?v=1729673835

[152] Local Govermenmet Association (2025). Menopause Factfile. Available at: https://www.local.gov.uk/our-support/workforce-and-hr-support/wellbeing/menopause/menopause-and-perimenopause-legal

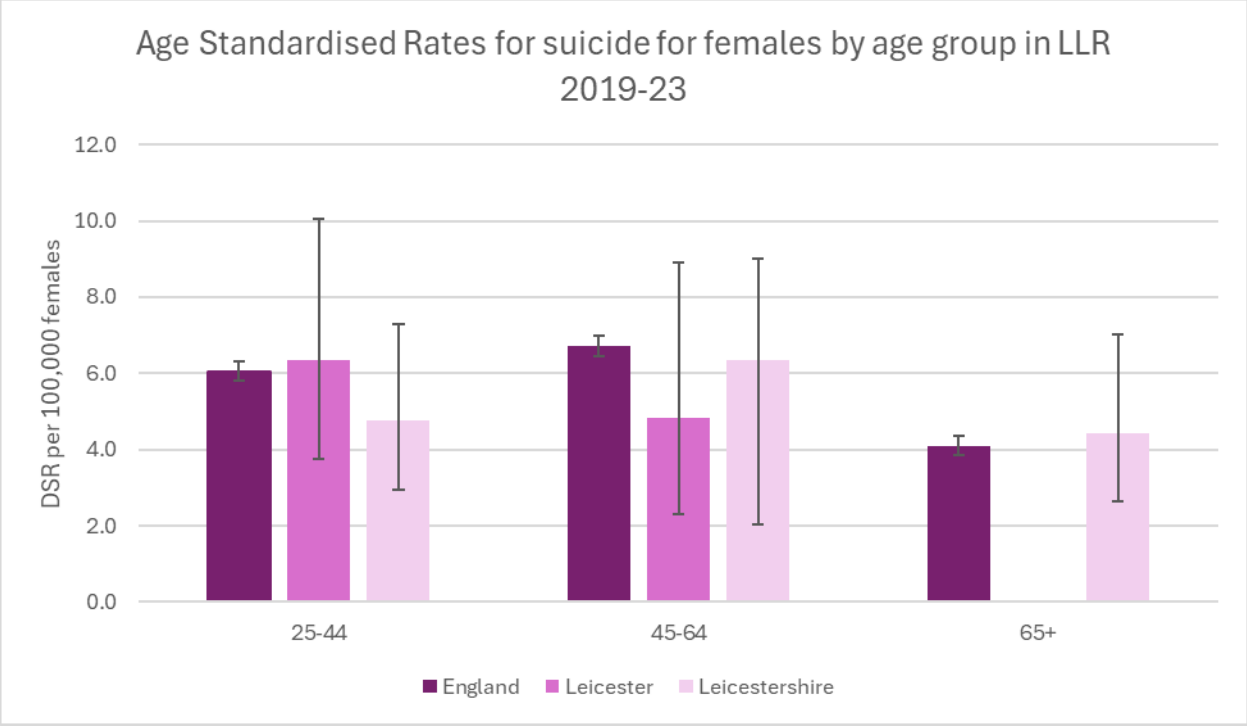
[153] NOMIS, ONS (2025). Labour Market Profiles. Available at: https://www.nomisweb.co.uk/

Mental Health and Suicide:

The menopause has mental health impacts, owing to the change of hormone levels, but these are distinct from depression and NICE guidance states that antidepressants should not be the first line of treatment. Within the Mental Health chapter, Figure 43 shows the increased rates of depression in women aged 35-64. It is often unclear whether women diagnosed with depression around menopause are actually experiencing depression or mood shifts due to hormonal changes, as they are frequently prescribed antidepressants instead of HRT.[154] Overlooking the connection between hormone imbalance and mental health could lead to unnecessary suffering and strains NHS resources[155], especially when depression associated with menopause can be effectively treated with HRT.[156]

There are also links between mental health and perimenopause, with research suggesting this could be a factor in an increase suicide rate in perimenopausal women.[157] The Office of National Statistics data on suicide highlights that women aged 45-64 have significantly higher suicide rates in England compared to the other age bands presented, this is also mirrored for Leicestershire although not significantly higher. Data for Rutland was not available due to small counts.

Figure 41: Age standardised rates for suicide in females by age groups in LLR



Source, OHID Mental Health and wellbeing profiles, 2025

[154] All-Party Parliamentary Group on Menopause. APPG Menopause Inquiry: Concluding Report. London: APPG Menopause; 2022. Available from: https://thebms.org.uk/wp-content/uploads/2022/10/APPG-Menopause-Inquiry-Concluding-Report-12.10.22.pdf
[155] Newson L, Lewis R. Delayed diagnosis and treatment of menopause is wasting NHS appointments and resources. BMS 30th Annual Scientific Conference 2021. Post Reprod Health2021;27:226-31doi:10.1177/20533691211036953
[156] Nelson-Piercy C. Curb antidepressant use: perimenopausal women may benefit from HRT. BMJ. 2024;384:q220. Available from: https://www.bmj.com/content/384/bmj.q220
[157] Newson Health Menopause Society (2022). Available at: https://www.nhmenopausesociety.org/

Local Insight:

Anecdotal evidence shows that a significant number of women are referred from primary care to secondary care to deal with 'complex menopause', however a large proportion of these could be dealt with in primary care if the correct knowledge and confidence was present. This is also demonstrated in academic research "*There are substantial differences in the beliefs and attitudes towards the menopause amongst GPs and often a lack of confidence in prescribing HRT. Secondary care services can consequently be overwhelmed by an explosion in uncomplicated referrals which could be effectively managed in primary care*."[133]

Equity and hidden need:

Evidence suggests women from minoritised ethnic groups, those living in deprivation, people with disabilities, LGBTQ+ people, and those with English as an additional language face greater diagnostic delays, lower awareness of available support, and reduced access to specialist care.[1]Because these groups are least likely to be captured in surveys, the true burden of unmet need is likely higher than estimates indicate.

Studies show that menopausal need is consistently under-recognised among women with learning disabilities and neurodivergence. Studies report low recognition and under-treatment (e.g., very low HRT use) in women with learning disabilities, despite elevated risks; diagnostic overshadowing and variable staff confidence are recurrent barriers.[158, 159]

3.1.4 What evidence-based management is recommended?

Effective management of perimenopause and menopause is grounded in national guidance (NICE NG23) and a strong evidence base demonstrating clear benefit from individualised, risk-stratified care. The overarching recommendation is that management should be symptom-driven, person-centred, and based on shared decision-making, with particular attention to mental health, urogenital health, bone health, and cardiovascular risk.[146]

HRT

Hormone Replacement Therapy (HRT) which replaces the hormones that are at low levels, is the main medicine treatment, and most effective treatment for menopause and perimenopause symptoms as recommended by NICE, such as vasomotor symptoms and sleep disturbances.[146] There are different types of HRT e.g. combined oestrogen and progestogen, with different modes of delivery e.g. transdermal routes. Different management is recommended for those with a history of oestrogen-receptor-positive breast cancer.

HRT delivers benefits beyond symptom control by actively protecting long-term health. Randomised trial evidence shows that HRT increases bone mineral density and substantially reduces osteoporotic fractures, including hip and vertebral fractures, across a wide range of women. These are not marginal gains: fracture reductions have been demonstrated consistently and represent a major prevention opportunity, particularly when HRT is commenced in the early post-menopausal years, when bone loss accelerates most rapidly.[160] In addition, NICE

[158] Avery K, et al. Management of the perimenopause and menopause in women with learning disability. Post Reprod Health. 2023;29(3):154-155.
[159] Wilson J, et al. Health and social care staff awareness of menopausal symptoms in adults with intellectual disability: survey. BJPsych Open. 2024;10(Suppl 1):S177.
[160] Cauley JA, Robbins J, Chen Z, Cummings SR, Jackson RD, LaCroix AZ, et al. Women's Health Initiative Investigators. Effects of estrogen plus progestin on risk of fracture and bone mineral density: the Women's Health Initiative randomized trial. JAMA. 2003 Oct 1;290(13):1729-38.

evidence summaries collate the broader health picture so women can make informed choices: they set out how different HRT regimens may positively influence cardiovascular outcomes, cancer risks (by cancer type and regimen), cognitive outcomes (including dementia), and overall mortality.[161]

Other, if HRT is contraindicated or declined

Other drugs may be prescribed where HRT is contraindicated or declined. Several non-hormonal drugs can reduce vasomotor symptoms, but often with smaller effect than HRT.

Non-Pharmacological Options

Other recommendations for management of symptoms include, menopause specific cognitive behavioural therapy (CBT), guiding patients through information and support that is available and referral to psychology services for psychological support. NICE also provides guidance on managing symptoms associated with menopause, such as vasomotor, genitourinary and depressive.[146]

Core lifestyle interventions include promoting healthy weight, physical activity, smoking cessation and alcohol moderation, all of which contribute to symptom improvement and reduce long-term disease risks.[146]

Anti-Depressants

NICE guidelines state that antidepressants should not be used for menopause or perimenopause symptoms, as there is no clear evidence they relieve mental health symptoms during menopause.[146, 162]

3.1.5 Local HRT Prescribing

Nationally, there were 13 million HRT items prescribed in 23/24 (22% increase since 22/23), with the most common age group to be prescribed HRT being 50-54. The least deprived areas had more than twice as many identified patients receiving HRT prescriptions compared to the most deprived areas, demonstrating a clear inequity in HRT prescribing.[163]

Between Aug'23 to Sept'24 116,771 HRT prescriptions were written with a total cost of £2,558,352 across LLR.[164]

[161] NICE. Menopause: identification and management. NG 23. Evidence Summaries. 2024. Available from https://www.nice.org.uk/guidance/ng23/evidence

[162] Glynne S, Newson L. Curb antidepressant use: perimenopausal women may benefit from HRT. BMJ. 2024;384:q220.

[163] NHS Business Services Authority (2024) Available at: https://cms.nhsbsa.nhs.uk/statistical-collections/hormone-replacement-therapy-england/hormone-replacement-therapy-england-april-2015-june-2024

[164] NHS Prescribing data (2025). Midlands and Lancashire Commissioning Support Unit (MLCSU)/

The table below indicates the top 3 prescribing surgeries**. These are all in some of the least deprived deciles and within Leicestershire** (Loughborough and Melton).

Practice name	Female practice population >45	items	Net cost	Rate per 1000 population	IMD Decile
Manor House Surgery	1,433	1,863	17,346	1300.1	8
Campus View Medical Centre	202	252	3,116	1247.5	10
Long Clawson Medical Practice	2,040	2,422	31,968	1187.3	10

Source: Prescribing data, MLCSU

The table below indicates the bottom 3 prescribing surgeries. **These are all in deciles 2 and 3 based within Leicester City.**

Practice name	Female practice population >45	Items	Net cost	Rate per 1,000 population	IMD Decile
Dr R Kapur and partners	450	18	139	40.0	2
Leicester City Assist Practice	62	2	32	32.3	3
Brandon Surgery	1,239	38	441	30.7	3

Source: Prescribing data, MLCSU

This highlights a potential local prescribing inequity, which requires further work to understand fully.

3.1.6 Current Services in LLR

Locally, primary care is the main source of support for menopause (including the women's health hubs), with a specialist menopause clinic operating out of UHL. There are several private clinics, as well as charity organisations such as Henpecked and Loughborough wellbeing hub, who offer support.[165]

The LLR Health and Wellbeing Partnership online page offers information and access to services linked to menopause such as embrace your change – menopause webinar (a six week group course provided by Talking Therapies), menopause services within the community and active menopause with Active Together (how physical activity can help women manage and cope better with symptoms).[166]

[165] Local Government Association, Leicestershire, Leicester and Rutland Girls Can: Social Prescribing and Active Menopause. August 2024. Available at: https://www.local.gov.uk/case-studies/leicestershire-leicester-and-rutland-girls-can-social-prescribing-and-active-menopause
[166]Leicester, Leicestershire and Rutland Health and Wellbeing Partnership (2025). LLR Menopause Hub. Available at: https://leicesterleicestershireandrutlandhwp.uk/staff-room/llr-academy/llr-menopause-hub/

Currently, there is a national Menopause Workplace Pledge organised to recognise support and training required in workplaces for the menopause, with over 2,600 employers signed up.[167] This pledge supports listening to staff needs, provides materials for open conversation of the menopause and encourages accommodation of the general needs within the workplace.[141] Leicestershire County Council is a menopause friendly council.

Healthy Workplaces is a workplace health programme delivered by Leicestershire County Council Public Health team which offers workplaces a chance to understand the needs of those they employ though a health needs assessment which includes questions around menopause.[168]

NHS Health Checks

During 2025 it was announced that menopause questions would be introduced in the NHS Health Check programme for women aged 40-74. This presents a major opportunity to raise awareness, identify symptoms earlier, and connect women to appropriate support, particularly those who may not proactively seek help.[169]

However, this change also brings significant risks if not carefully implemented. Asking about menopause without providing clear onward pathways may raise expectations without offering support, widening inequalities. There is also a risk that symptoms are dismissed or mismanaged if staff lack training, leading to women being incorrectly reassured or offered non-recommended treatments, such as antidepressants for menopause-related low mood in the absence of clinical depression. Without sufficient capacity, training and system readiness, the intervention could cause more harm than good.

North West Leicestershire Menopause Model

The North-West Leicestershire Primary Care Network's Women's Health Hub delivers specialist menopause care via a pharmacy and nurse-led model across 12 GP practices. BMS-accredited pharmacists provide structured 20-minute consultations following NICE and BMS guidance. Weekend clinics increase accessibility, while pre-consultation educational videos and digital follow-up support safe, consistent care. This approach improves access, reduces GP workload, and offers a scalable, equitable solution for women's health in primary care.

Aims of this service is to:

1. To improve patient access to timely, evidence-based menopause care in a primary care setting.
2. To reduce GP workload by offering structured consultations led by a BMS-accredited pharmacist, supported by digital triage tools.
3. To reduce secondary care referrals by managing menopause presentations safely and effectively within primary care, minimising unnecessary hospital demand.

The conclusion of this model so far shows that the pharmacist-led menopause clinic improved access to evidence-based care, reduced GP workload, and avoided over 900 appointments,

[167] The menopause is a workplace issue: guidance and model policy. Available at: https://www.unison.org.uk/content/uploads/2019/10/25831.pdf
[168] Healthy Workplaces, Leicestershire (2025). Avaialbel at: https://www.healthyworkplacesleicestershire.co.uk/
[169] Department of Health and Social Care. Major NHS update brings menopause into routine health checks. GOV.UK; 2024 Oct 8. Available from: https://www.gov.uk/government/news/major-nhs-update-brings-menopause-into-routine-health-checks

saving approximately 150 clinical hours. Supported by pre-visit education and AI follow-up, the model enhanced patient understanding and prescribing safety. It also reduced unnecessary secondary care referrals, showing this approach is scalable, cost-effective, and impactful for NHS primary care.

3.1.7 Unmet needs or gaps

Despite high prevalence and clear guidance, multiple gaps persist across awareness, access, quality and equity. These gaps are amplified by demographic ageing in LLR and the imminent expansion of menopause questions within the NHS Health Check, which will surface need faster than current services can meet it unless mitigations are in place.

Knowledge Gaps

There are currently 13 million perimenopausal or post-menopausal women in the UK, however 41% of the UK's 33 medical schools do not have a mandatory menopause education program for their students. Almost 60% of doctors leave university with no education on menopause despite half of the population experiencing these at some time in their lives.[170] A large proportion of unmet menopause need could be ameliorated through better clinician education and confidence in primary care. The local anecdotal evidence shows a tendency to refer menopause patients from primary care to secondary care unnecessarily. Also highlighting a gap in knowledge, skills and confidence.

Gaps in knowledge may also account for the higher rates of anti-depressant prescribing in middle aged women.

Workplaces

While the Menopause Workplace Pledge addresses some of the unmet needs of women experience menopause in the workplace, it is important to recognise that it remains a pledge. Without specific policies to enforce support, guidance remains inconsistent and results in workplaces providing inadequate, uniform support for its employees.

NHS Health Check – limited capacity

If implemented correctly, NHS Health Checks could support timely care for the majority of women within LLR. However, there should be careful consideration for those not eligible for an NHS Health Check. There is also a risk of raised expectations without capacity to satisfy. The workforce (via primary care appointments) may not exist to meet demand created through new menopause questions. Although it should be noted that at the time of writing, the questions have not yet been released.

Data

More data on prevalence of perimenopause and menopause is required to understand the need locally.

Equity

Locally, HRT prescribing is lower in those living in areas of deprivation, compared to those living in areas of higher affluence. This suggests an unmet needs for those living in areas of

[170] Diane Danzebrink (2021): Make Menopause Matter. Available at: https://menopausesupport.co.uk/wp-content/uploads/2021/05/Web-info-Shocking-Disparity-in-Menopause-Training-in-Medical-Schools-1.pdf

deprivation. There are likely multiple factors at play e.g. unawareness of symptoms, health literacy issues etc. which warrants further investigation.

3.1.8 Recommendations

- **Engage with women across diverse communities**: understand lived experiences of perimenopause and menopause, including barriers to accessing timely support, medication, and information. This will help contextualise service gaps and inform inclusive commissioning.
- **Strengthen the local evidence base** by collecting granular data on prevalence, symptom burden, and service utilisation, with attention to intersectionality and stratified population groups, including those with learning disabilities and neurodiversity.
- **Broaden the scope of inquiry to include non-HRT interventions**: such as lifestyle, complementary therapies, and digital health tools—alongside a behavioural analysis of HRT prescribing patterns across primary and secondary care (e.g. using the COM-B model).
- **Investigate antidepressant prescribing trends** in perimenopausal and menopausal women to explore potential misdiagnosis, treatment substitution, or unmet mental health needs.
- **Explore the intersection between menopause and suicide risk**: look to identify potential causal pathways and opportunities for early intervention.
- **Conduct a targeted review of HRT access and prescribing disparities**, with a focus on deprivation, ethnicity, and other social determinants, to uncover inequities and inform targeted outreach.
- **Undertake a deep dive into diagnostic timelines and treatment pathways**, examining how long it typically takes for women to receive a diagnosis and what treatment options are offered across care settings.
- **Review menopause-related training provision across the system**: from health promotion and frontline advice to clinical guidance and prescribing practice, to assess coverage, consistency, and fidelity.
- **System support for the roll-out of menopause questions in the NHS Health check**: To maximise benefit, the rollout must ensure that questions are paired with workforce education, clear referral pathways, and consistent and equitable access to evidence-based treatments including HRT.

4 Mental Health

This chapter covers general mental health, suicide, serious mental illness, eating disorders and perinatal mental health.

Key Epidemiology & Context

- Women experience higher rates of common mental disorders than men, with young women (16–24) particularly affected; rates of self-harm, PTSD and eating disorders have risen significantly in this group
- Local need in LLR aligns with national patterns, with an estimated 15.8% of adults experiencing common mental disorders and higher numbers of diagnosed depression in women aged 35–64, many potentially linked to peri menopause/menopause
- Increasing rates of self-harm and suicide in some groups

Inequalities & At-Risk Groups

- Multiple gendered risk factors contribute to poorer mental health in women, including caring responsibilities, poverty, abuse, sexual violence, long term physical conditions, and inequalities affecting ethnic minority, disabled, and LGBTIQ+ women.
- Ethnic minority women face additional risk and barriers
- LGBTQ+ and disabled women disproportionately impacted

Gaps & Unmet Need

- Overlap with menopause often poorly recognised
- Data gaps on women-specific mental health pathways
- The contribution of menopause, domestic and sexual abuse, caring responsibilities, chronic illness and socioeconomic strain to women's suicidal distress is not always systematically recognised or understood.

Implications for LLR

- Significant demand on services across life course
- With an ageing population, there is a need to better understand local menopause implications on mental health and ensure appropriate services are in place.
- Links with wider determinants and social inequalities

Priority Action Themes

- Strengthen early identification and prevention
- Improve understanding of gender-specific drivers
- Integrate mental health with women's health pathways

4.1 Mental Health

4.1.1 Background

Mental Health is defined as "a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well and contribute to their community".[171] Mental ill health/disorder involves significant disturbances in thinking, emotional regulation or behaviour. It is usually associated with distress or impairment in important areas of functioning.[171]

Mental health problems affect both men and women, but not in equal measure. Nationally, 1 in 5 women have a common mental disorder, compared with 1 in 8 men Between the ages of 16 and 24, women are almost 3 times as likely to experience a common mental health issue as men - 26% and 9% respectively.[172] Moreover, young women and girls are reporting increasing levels of mental disorders. Rates are likely worse since the Covid pandemic, and research shows an increased prevalence of clinically significant levels of mental distress during lockdown (18.9% 2018/19 to 27.3% in April 2020). Crucially, increases were the greatest in women and young people.[173]

The Adult Psychiatric Morbidity Survey (APMS) is a population survey of mental health disorders in adults, carried out every 7 years in England. The most recent report highlights a number of key issues concerning women. Rates of common mental health disorders (CMHD) across England have remained relatively stable over last 10 years, however, proportional rates of moderate/severe CMHD have increased – this is driven by the deteriorating mental health of women. Young women (aged 16 – 24 years) were identified in the APMS as a group particularly 'at risk' of a range of mental health problems. Rates of self-harm amongst young women have tripled since 1993, and today's young women are three times more likely than young men to experience post-traumatic stress disorder and eating disorders.

4.1.2 Risk factors for ill mental health

The Mental Health foundation suggests there can be many reasons why women develop common mental health problems, however there are some risk factors which affect women more than men.[174]

- Women are more likely to be carers, which can lead to stress, anxiety and isolation
- Women are more likely to live in poverty which, along with concerns about personal safety and working mainly in the home, can lead to social isolation
- Women are more likely to experience physical and sexual abuse, which can have a long-term impact on their mental health.
- Women are more likely to experience sexual violence, which can cause PTSD

Physical Health

[171] Mental Health (2022). World Health Organisation (WHO). Available at : https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[172] McManus, S., Bebbington, P., Jenkins, R. and Brugha, T. (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20171010183932tf_/http:/content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

[173] Pierce, M., Hope., H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S. and Abel, K.M. (2020) 'Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population', The Lancet Psychiatry. Available at: https://www.sciencedirect.com/science/article/pii/S2215036620303084

[174] Women and mental health (2021). Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/women-and-mental-health

People with a physical health condition are more likely to experience a mental health problem. Thirty-percent (over 15 million people) of the UK population live with one or more long term condition, out of these, over 4 million people will also have a mental health condition.[175]

Ethnicity

Black, Asian and Minority Ethnic women face additional inequalities and challenges to their mental health, such as racism and stigma, and are at particular risk of experiencing Common Mental Disorders. The Adult Psychiatric Morbidity Survey (2014)[176] showed that Black and Black British women (29%), Asian women (24%) and Mixed race women (29%) are more likely to experience a common mental health problem compared to White British women (21%) and non-British White women (16%).

Disability

Rates of mental health problems are higher among people with learning disabilities than among other people. For people with learning disabilities, being female is associated with mental health problems in general, and possibly depression.[177]

Sexual Orientation

Although mental health problems can affect anyone, they are more common among people who are lesbian, gay, bisexual, trans, intersex, queer (LGBTIQ+). A study by Stonewall found that half of LGBTIQ+ people had experienced depression and 60% had experienced anxiety. Almost 50% of trans people had thought about taking their life.[178]

Sex Workers

Sex workers have often experienced trauma including child abuse, domestic and sexual violence.[179] They frequently experience poor mental health, particularly anxiety, depression, isolation, post traumatic stress disorder, self harm and suicide.[180]

4.1.3 Level of need

Estimated prevalence of common mental disorders (CMD)

Common mental health conditions include a variety of, often overlapping, disorders such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD) and panic disorder. Although they do not affect cognition, they may cause a significant level of distress and disability. They are relatively common and often undiagnosed, hence the importance of population-based estimates.[181]

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[175] Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossy, M., & Galea, A. (2012). Long-term conditions and mental health – The cost of co-morbidities. London: The King's Fund, & Centre for Mental Health.

[176] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. NHS Digital. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748

[177] OHID Fingertips (2025). Health Inequalities: Mental Health problems. Available at: Health inequalities: Mental health problems - Fingertips

[178] LGBTIQ+ people: statistics (2025). Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/explore-mental-health/statistics/lgbtiq-people-statistics

[179] Jeal N, Salisbury C. A health needs assessment of street-based prostitutes: cross-sectional survey. J Public Health. 2004;26(2):147–51.

[180] otter, L. C., Horwood, J., & Feder, G. S. (2022). Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers. BMC Health Services Research, 22(1), Article 178. https://doi.org/10.1186/s12913-022-07581-7

[181] Kendrick T, Pilling S. Common mental health disorders — identification and pathways to care: NICE clinical guideline British Journal of General Practice 2012; 62 (594): 47-49.

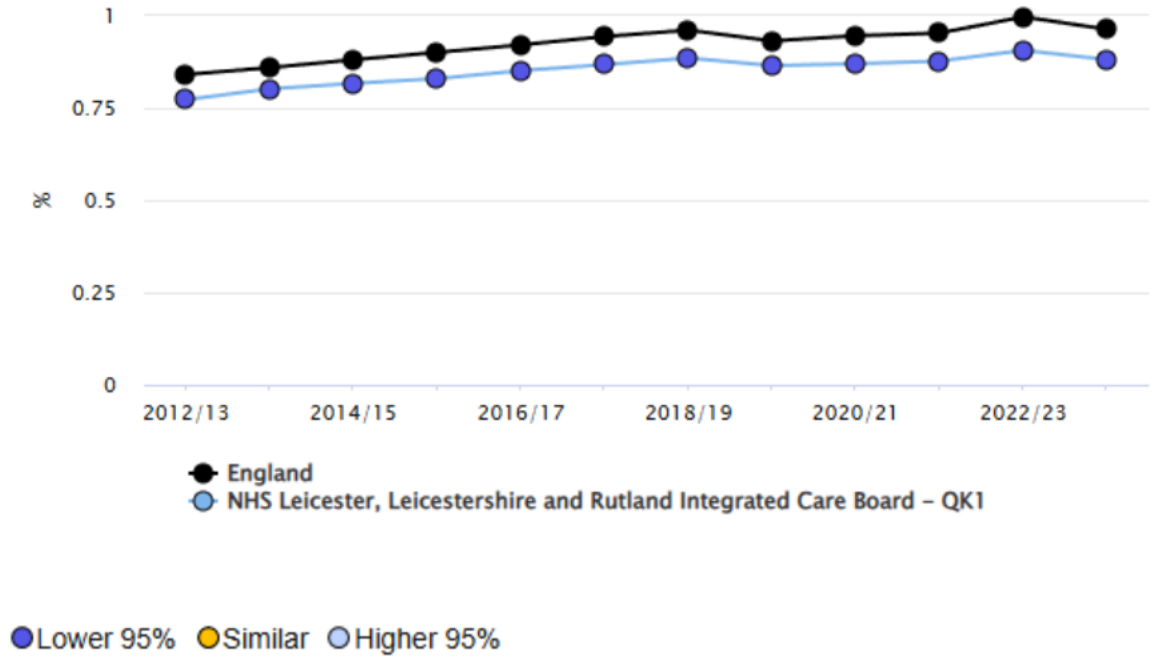
The estimated prevalence of common mental disorder can support action to improve the mental health and life opportunities of those living with CMD by enabling local policy makers, service providers and commissioners to understand the numbers of people with CMD. In LLR the estimated prevalence for CMD in those aged 16 and over was 15.8% (138,840), this was statistically similar to the national average of 16.9%.

Mental Health (QOF) Prevalence

The following data shows the percentage of patients on a GP register with a diagnoses of schizophrenia, bipolar affective disorder and other psychoses.

In 2023/24, there were 0.9% (10,818) of patients registered on GP lists with mental health in LLR, this was significantly lower in comparison to the national average (1.0%).

Figure 42: Trend in Mental Health (QOF) Prevalence in LLR

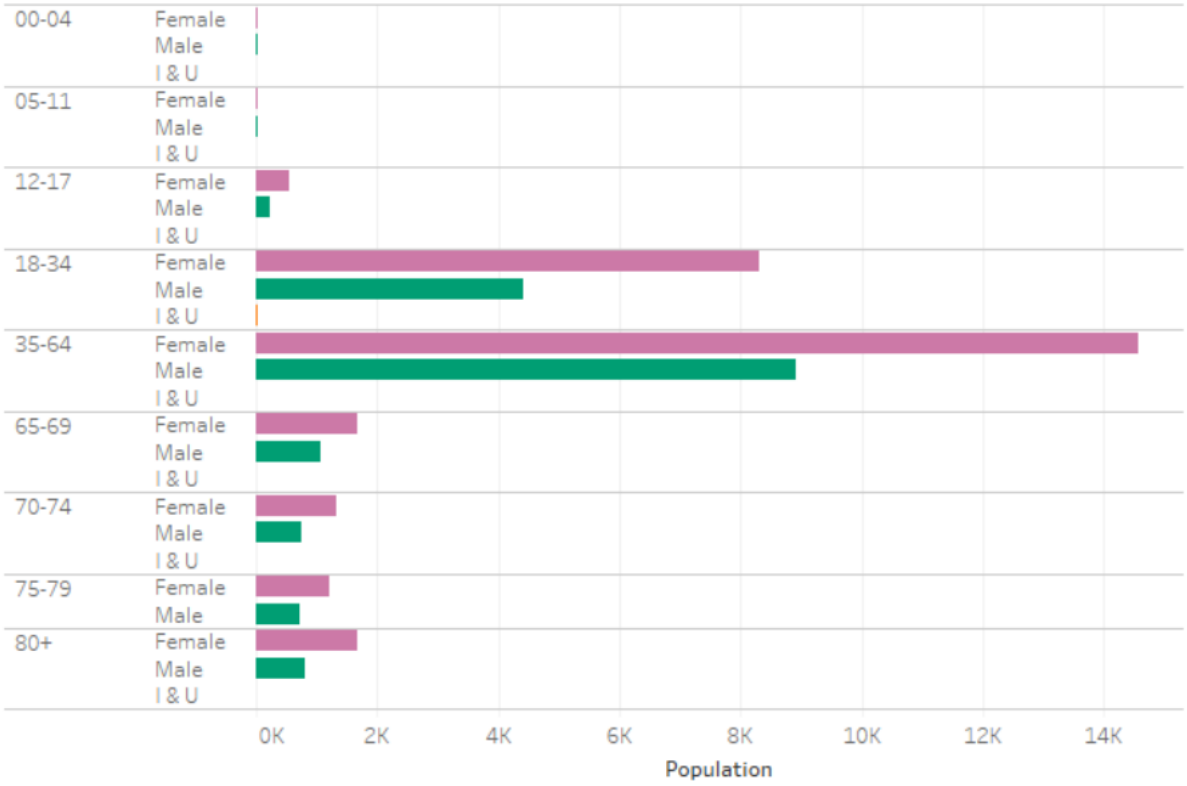


Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

Depression

Using the Population Health Management Risk Segmentation Tool, there are a total of 46,340 patients registered on GP lists with depression in LLR. Out of these, 28,798 (62.1%) are females, with the majority belonging to the 35-64 age group (14,566), followed by the 18-34 age group (8,323). It should be noted that the numbers diagnosed within the 35-64 age group will include women who are going through peri menopause and menopause.

Figure 43: Number of patients with Depression on GP list in LLR as at January 2025



Source: PHM Risk Segmentation Tool, Aristotle, Jan 2025

Bipolar

Using the Population Health Management Risk Segmentation Tool, there are a total of 3,945 patients registered on GP lists with bipolar disorder in LLR. Out of these, 2,427 (61.5%) are females, with the majority belonging to the 35-64 age group (1,394), followed by the 18-34 age group (478).

4.1.4 What evidence based management is recommended?

NICE provides guidance which covers identifying, treating and manging common mental health problems, which includes depression, anxiety (inc social anxiety), obsessive compulsive disorders and body dysmorphic disorders.[182]

The guidance covers identifying, assessing, diagnosing, treating and managing common mental health conditions, see some examples in table below:

Depression	General anxiety disorder (GAD)	Obsessive compulsive disorder (OCD) & body dysmorphic disorders (BDD)
Principles of care: • ensure steps are taken to reduce stigma, discrimination and barriers for	Principles of care: • For people with GAD who have a mild learning disability or mild acquired cognitive impairment,	Principles of care: • Understanding • Continuity of care • Religion and culture • Families and carers

182 NICE (2024). Mental Health guidelines. Available at: https://www.nice.org.uk/guidance/indevelopment/gid-hub10005

individuals seeking help for depression. • Provide people with depression with up-to-date and evidence-based verbal and written information about depression and its treatment, appropriate to their language, cultural and communication needs.	offer the same interventions as for other people with GAD, adjusting the method of delivery or duration of the intervention if necessary to take account of the disability or impairment	
Recognition and assessment: • Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment). • Conduct a comprehensive assessment that does not rely simply on a symptom count when assessing a person who may have depression, but also takes into account severity of symptoms, previous history, duration and course of illness.	Stepped care for people with GAD: • Step 1 - dentification and assessment; education about GAD and treatment options; active monitoring • • Step 2 - Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups • Step 3 - Choice of a high-intensity psychological intervention (cognitive behavioural therapy [CBT]/applied relaxation) or a drug treatment.	Stepped care for people with OCD and BDD: Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person's needs. It assumes that the course of the disorder is monitored and referral to the appropriate level of care is made depending on the person's difficulties. Each step introduces additional interventions; the higher steps normally assume interventions in the previous step have been offered and/or attempted, but there are situations where an individual may be referred to any appropriate level. • Step 1 – awareness and recognition. • • Step 2 – recognition and assessment. • Step 3 to 5 – treatment options fir people with OCD or BDD.
Choice and delivery of treatments: • Match the choice of treatment to meet the needs and preferences of the person with depression. Use the least intrusive and most resource		

efficient treatment that is appropriate for their clinical needs, or one that has worked for them in the past. Pharmacological treatments: • Antidepressant medication • Use of lithium as augmentation • Use of oral antipsychotics as augmentation	• Step 4 - Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from • multi-agency teams, crisis services, day hospitals or inpatient care.	• Step 6 - intensive treatment and inpatient services for people with OCD or BDD. •

4.1.5 Current Services - see section 4.5

4.1.6 Unmet needs or gaps

- Further data is required specifically on women and mental health both nationally and locally.
- Explore and obtain data to fully understand the specific reasons that cause depression in women.
- Local depression data indicates high numbers in the 35-64 age range, more needs to be understood around how many women are diagnosed with depression due to peri menopause/menopause.

4.1.7 Recommendations

- Seek opportunities for prevention and early detection of mental health conditions in women, particularly for those in high risk groups such as carers of people with mental health difficulties to provide support before that person reaches a crisis.
- Explore depression data in terms of how many women diagnosed with depression are peri-menopausal / menopausal.
- Continue raising awareness of the risk factors of dementia in women and prevention measures for these.
- Work with Active Together to promote physical activity in terms of Active medicine programme and Clinical Champions to support prevention and management of mental health conditions.

4.2 Suicide

4.2.1 Background

Suicide is a significant cause of death in young adults and is seen as an indicator of underlying rates of mental ill health. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.

Suicide is very complex and can often be a culmination of risk factors that have built up over time. In 2021-23, nationally, the rate of suicides in females (5.4 per 100,000 population) was just over three time lower than the rate of suicides in males (16.4 per 100,000 population). There are a number of key factors around mental health issues and social factors which increase the risk of a woman taking her life.[183]

4.2.2 Risk factors for Suicide

There are a range of factors at different levels, for example, individual, relationship, community and societal that can increase the risk of suicide. Below are some risk factors identified for suicide.

- **Mental illness** - Mental illness is a risk factor for suicidal thinking and behaviour among all genders,[184] however, depression is more common among women.[185]
- **Domestic violence** - Intimate partner abuse, which disproportionately affects women, may also be a risk factor for increased suicidal ideation and behaviour.[186]
- **Perinatal** - Deaths from suicide are a leading cause of death for individuals in the first year after childbirth, with up to 20% of global post-partum deaths occurring because of suicide.[187]
- **Childhood abuse** – women who may have experienced childhood maltreatment or even sexual abuse were more at risk of engaging in 'self-injurious' thoughts and behaviours.[188]
- **Eating disorders** - Eating disorders are psychiatric disorders and involve emotional distress that can lead to severe mood imbalances resulting in self-harm, feeling out of control or suicidal thoughts or attempts.[189]
- **Cancer** – evidence suggests that a cancer diagnosis with or without previous mental health conditions is a risk factor for suicide along with increases in anxiety and depression.[190]

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[183] Suicide Prevention Profile (2025). OHID fingertips. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

[184] Brådvik L. Suicide Risk and Mental Disorders. Int J Environ Res Public Health. 2018 Sep 17;15(9):2028. doi: 10.3390/ijerph15092028. PMID: 30227658; PMCID: PMC6165520

[185] Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: a meta-analysis. BMC Psychiatry. 2004 Nov 4;4:37. doi: 10.1186/1471-244X-4-37. PMID: 15527502; PMCID: PMC534107.

[186] Pirkis, Jane et al. Addressing key risk factors for suicide at a societal level. The Lancet Public Health, Volume 9, Issue 10, e816 - e824

[187] Kobylski, Lauren A et al. Preventing perinatal suicide: an unmet public health need. The Lancet Public Health, Volume 8, Issue 6, e402

[188] Serafini, G., Canepa, G., Adavastro, G., Nebbia, J., Murri, M. B., Erbuto, D., Pocai, B., Fiorillo, A., Pompili, M., Flouri, E., & Amore, M. (2017). The Relationship between Childhood Maltreatment and Non-Suicidal Self-injury: A Systematic Review. Frontiers in Psychiatry, 8.

[189] Koutek, J., Kocourková, J., & Dudova, I. (2016). Suicidal behavior and self-harm in girls with eating disorders. Neuropsychiatric Disease and Treatment, 787. https://doi.org/10.2147/ndt.s103015

[190] Miiligan F (2022). Suicide and women living with and beyond a breast cancer diagnosis. British journal of Nursing, Volume 31, Issue18, 0966-0461

- **Sexual Orientation** - Suicide is major concern among trans and non-binary people too who experience a set of specific risk factors for suicide, and whose experiences challenge many assumptions in our understanding of the role of gender as factor influencing suicide risk, and suicidal behaviours.[191]
- **Menopause/Perimenopause -** There are also links between mental health and perimenopause, with research suggesting this could be a factor in an increase suicide rate in perimenopausal women.[192]

4.2.3 Level of need

The Adult Psychiatric Morbidity Survey (APMS) in 2014 assessed the prevalence of suicidal thoughts, attempted suicide and self-harm through both the face to face and the self-completion survey. Younger women (16-24) were more likely to self-harm (26%) than men of the same age (10%), or older women; the gap between young men and young women has grown over time.[193]

Between 2021-2023 there were 80 female suicides within LLR highlighting a pattern of increased numbers of female suicides over every 3-year cumulative data set since 2018. The suicide rate in females (10+ yrs) in Leicester has remained statistically similar to the national rate since 2009/11. The suicide rate has increased over the last 5 time periods from 3.1 (per 100,000 population age 10+) in 2017/19 to 6.0 (per 100,000 population age 10+) in 2021/23. In Leicestershire, the suicide rate in females (10+ yrs) has remained statistically similar to the national rate since 2017/19. The suicide rate was the highest since recording (2001/03) in 2019/21 at 5.2 (per 100,000 population age 10+), since the rate has decreased to 4.8 (per 100,000 population age 10+). Although the suicide rate for females in Rutland has been suppressed due to small counts, the data shows the actual counts of suicide has remained under five since 2005/07.

Years of life lost is a measure of premature mortality and gives an estimate of the length of time a person would have lived had they not died prematurely. In 2020/22, the rate for years of life lost due to suicide for females (aged 15-74 yrs) in Leicester was 14.3 (per 10,000 population aged 15-74) and 14.5 (per 10,000 population aged 15-74) for Leicestershire, both rates were statistically similar to the national rate of 17.2 (per 10,000 population aged 15-74).

Table 6: Suicide rate and years of life lost to suicide in LLR

Indicator	Time Period	Leicester	Leicestershire	Rutland
Suicide rate – females (10+ yrs)	2021/23	6.0	4.8	*
Years of life lost to suicide (females (15-74)	2020/22	14.3	14.5	*

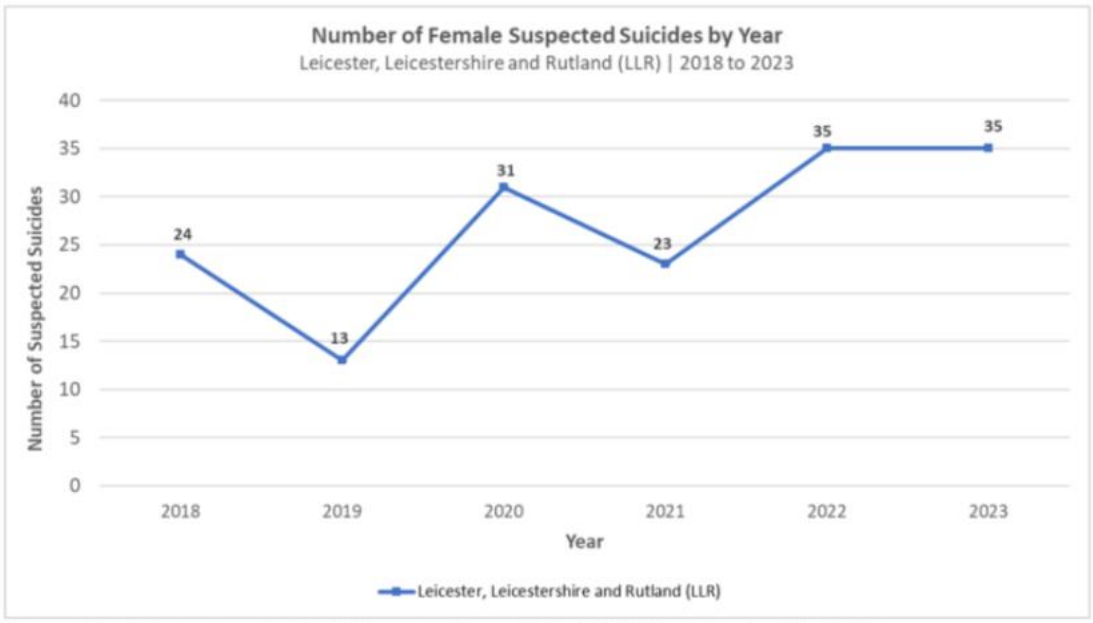
Better 95% | Similar | Worse 95% | Not compared

Source: Suicide Prevention Profile, OHID.

[191] Bachmann, C. L., & Gooch, B. (2018). LGBT in Britain: Health Report. https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf
[192] Newson Health Menopause Society (2022) https://www.nhmenopausesociety.org/
[193] NHS England (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

The following data has been provided by Leicestershire Constabulary on suspected suicides, which mean the deaths are still subject to a Coroner's Inquest and therefore the deaths have not been officially registered as deaths by suicide at the time the data was received. the data. Between 2018 and 2023, a total of 587 deaths by suspected suicide were recorded across LLR, which includes both LLR residents as well as residents that live outside of LLR. Of these 587 deaths, 27.4% (n = 161) occurred in females. Figure 36 below shows the number of female suspected suicides recorded across LLR for each year between 2018 and 2023.

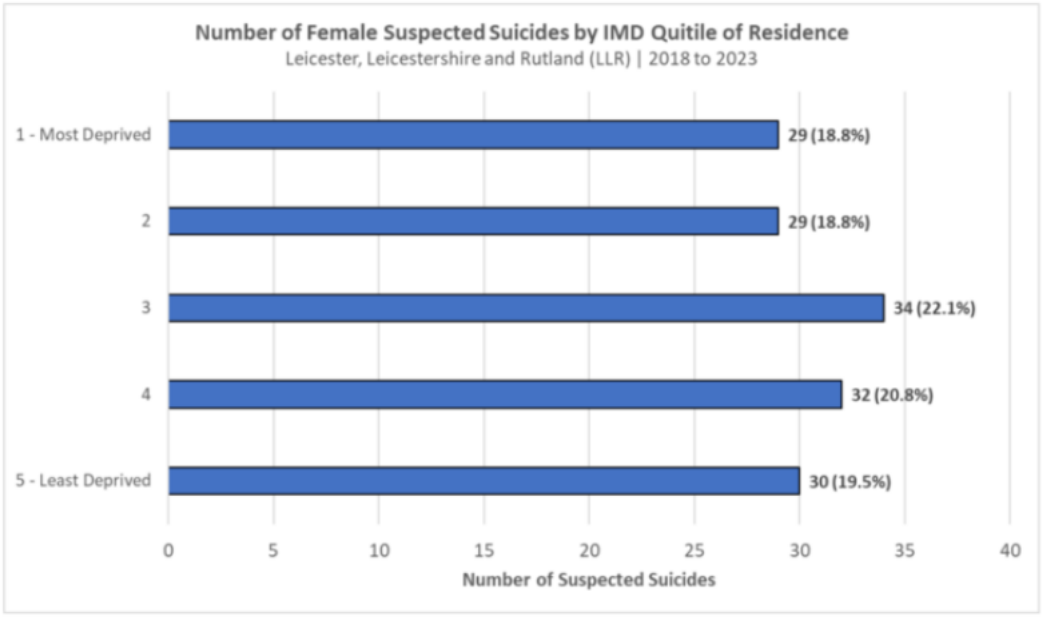
Figure 44: Number of female suspected suicided in LLR, 2018 to 2023



Source: Real-time suspected suicide surveillance data (RTSSSD), Leicestershire Police

The number and proportion of suspected suicides in females across LLR was evenly distributed across the five IMD quintiles of residence between 2018 and 2023, with each quintile accounting for approximately 20% of all female suspected suicides.

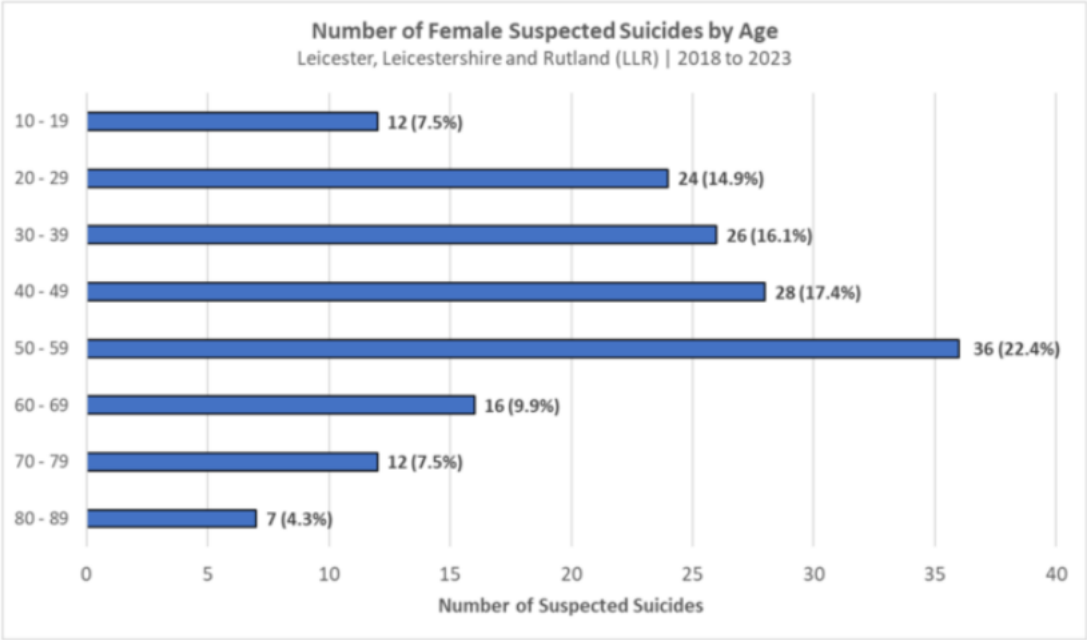
Figure 45: Number and proportion of female suspected suicides in LLR, by IMD quintile, 2018 to 2023



Source: Real-time suspected suicide surveillance data (RTSSSD), Leicestershire Police

Using the median as an average, the average age of the 587 persons that died by suspected suicide across LLR was 46 years for females. The 50-59 age group had the highest proportion (22.4%) of female suicides in LLR, followed by the 40-49 age group (17.4%)

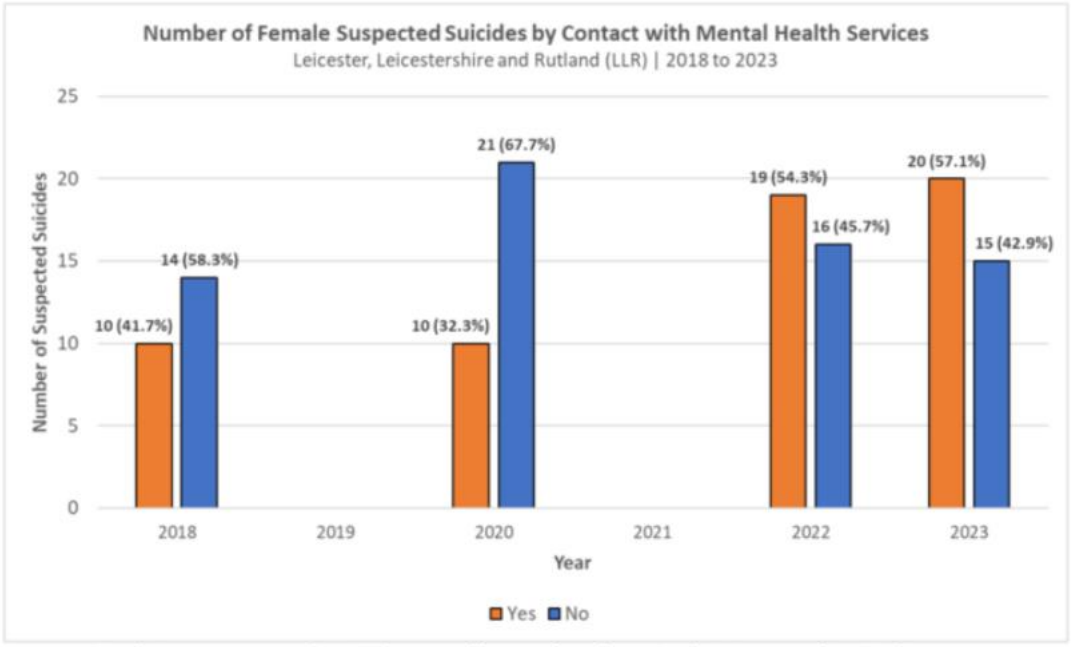
Figure 46: Number and proportion of female suspected suicides in LLR by age in 2018 to 2023



Source: Real-time suspected suicide surveillance data (RTSSSD), Leicestershire Police

Of the 161 females that died by suspected suicide across LLR between 2018 and 2023, 53.4% (n = 86) were found to be in contact with mental health services. Figure 47 below shows the number and proportion of females that died by suspected suicide across LLR by contact with mental health services, for the years of 2018 to 2023. Note that the figures for 2019 and 2021 have been suppressed due to disclosure control purposes.

Figure 47: Number and proportion of female suspected suicides in LLR by contact with mental health services, 2018 to 2023.



Source: Real-time suspected suicide surveillance data (RTSSSD), Leicestershire Police

4.2.4 What evidence management is recommended?

The recommendations stated by NICE apply to staff from all sectors that work with people who have self-harmed. Some of these includes:[194]

- Providing information and support (on all aspects of self harm) for people who have self-harmed as well as share the information with family members or carers.
- Asking about safeguarding concerns, for example, domestic abuse, violence or exploitation at the earliest opportunity and, if appropriate, when the person is alone.
- Involving family members and carers, even if the person has not consented to involving them as they can still provide valuable information.
- Assessment and care by:
- Healthcare professionals and social care practitioners
- Professionals from other sectors
- Admission to and discharge from hospital.
- Initial aftercare after an episode of self-harm.
- Interventions for self-harm.

[194] NICE (2022). Self-harm: assessment, management and preventing recurrence. Available at: https://www.nice.org.uk/guidance/ng225/chapter/Recommendations

4.2.5 Current services – see section 4.5

4.2.6 Unmet needs or gaps

- Women-specific risk factors are not fully understood
- The influence of menopause, domestic and sexual abuse, caring responsibilities, chronic illness, and socioeconomic strain on suicidal distress in women is not always systematically identified or understood.
- Missed intervention opportunities in mental health services
- Over half of women dying by suspected suicide had recent mental health service contact, suggesting gaps in proactive follow-up, safety planning, continuity of care, and recognition of escalating risk.
- Gaps within early support around self-harm
- High emergency admissions for self-harm among women highlight gaps in earlier psychosocial intervention, crisis follow-up, and the consistency of community-based support. There is a service available, therefore the gaps could cover a range of issues including; communications and awareness, or services not designed to be flexible towards women's need. Further work is needed to understand.
- Further data, especially on females who self-harm is needed to understand the condition more. Service data also need to be analysed to look at who is, and who is not engaging in services to address inequalities in access.

4.2.7 Recommendations

- Ensure self-harm is considered within the context of suicide prevention, acknowledging it as a high-risk factor, especially within women.
- Work to understand self-harm more by accessing further data and service data.
- To continue monitoring data and emerging evidence on suicide among trans and non-binary people, especially in relation to intersectionality, and put measures in place to address need as it's becomes available.
- To work to ensure that suicide is everyone's business, and raise awareness on the risk factors specific to women.
- Ensure the Women's System Partnership is joined up with the Suicide Audit and Prevention group, to support efforts and avoid duplication.

4.3 Serious Mental Illness (SMI)

4.3.1 Background

Serious Mental Illnesses are usually defined as Psychotic Disorders (including schizophrenia, schizoaffective disorder, and affective psychosis) and Bipolar Disorder and are often so debilitating that a person's ability to engage in functional and occupational activities is severely impaired.[195]

People with SMI are at greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI often have one or more physical health conditions at the same time as their mental illness. These conditions can include obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD) stroke, heart failure and liver disease.[196]

4.3.2 Risk factors

- The onset of psychotic disorders in women tends to be later in life than in men, with a peak post menopause. Reasons for this are unclear, although there is developing consensus that decreasing levels of oestrogen (which operate protectively on the brain) around the time of the menopause increase the risk of psychosis.[197, 198]
- Young women in particular have been shown to be more susceptible to comorbid substance use and mental illness rates.
- In comparison with men, women with co-occurring substance use/misuse and mental health disorders are more likely to stay in treatment for longer.[199]

4.3.3 Level of need

Premature mortality in adults with SMI

Although people with SMI die prematurely from physical conditions, their SMI may still have been a significant feature in their lives, influencing their lifestyle, risk of developing chronic health conditions, their access to health services, and their ability to self-manage physical health conditions.[200]

The following table provides a breakdown by gender for premature mortality indicators for a range of conditions for adults with SMI in LLR. The premature mortality rate in females with SMI in Leicester and Leicestershire were significantly better (lower) in comparison to males and the overall local authority average. The same pattern is witnessed for premature mortality due to cardiovascular diseases in adults with SMI in Leicestershire, whereas in Leicester, the rate for females were significantly better (lower) even though they are similar when compared against

[195] Heller T and others 'Benefits of support groups for families of adults with severe mental illness' American Journal of Orthopsychiatry 1997: volume 67, issue 2, pages 187 to 198
[196] DE Hert M and others. 'Physical illness in patients with severe mental disorders' World Psychiatry 2011: volume 10, issue 1, pages 52 to 77
[197] Ochoa S, Usall J, Cobo J, et al (2012) Gender Differences in Schizophrenia and First-Episode Psychosis: A Comprehensive Literature Review. Schizophr Res Treatment 2012:1–9. doi: 10.1155/2012/916198
[198] Falkenburg J, Tracy DK (2014) Sex and schizophrenia: A review of gender differences. Psychos Psychol Soc Integr Approaches 6:61–69. doi: 10.1080/17522439.2012.733405
[199] Choi S, Adams SM, Morse SA, Macmaster S (2015) Gender differences in treatment retention among individuals with co-occurring substance abuse and mental health disorders. Subst Use Misuse 50:653–663.
[200] Premature mortality in adults with severe mental illness (SMI)
Updated 19 April 2023. OHID https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi#introduction

the local authority average. The rates between males and females across all other indicators are statistically similar.

Table 7:Premature mortality rates (DSR per 100,000 population) in adults with SMI by gender in LLR, 2021/23

2021/23	Leicester		Leicestershire		Rutland	
	Male	Female	Male	Female	Male	Female
Premature mortality in adults with SMI	216.0	133.5	109.1	83.5	97.6	64.0
Premature mortality due to cardiovascular diseases in adults with SMI	45.5	25.6	22.6	11.9	21.1	*
Premature mortality due to cancer in adults with SMI	37.0	28.1	19.9	21.2	24.6	*
Premature mortality due to liver disease in adults with SMI	14.1	9.2	7.5	5.0	*	*
Premature mortality due to respiratory disease in adults with SMI	23.8	16.9	6.2	7.6	*	*

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

comparison against local authority average

**data suppressed due to small counts*

Source: Severe Mental Illness Profile, OHID, 2025

SMI Health Checks

People living with SMI face one of the greatest health equality gaps in England. Their life expectancy is 15–20 years shorter than that for the general population, and this disparity is largely due to preventable physical illnesses. Work to address this inequality is part of Core20PLUS5, NHS England's flagship approach for tackling health inequalities.[201]

Annual physical health checks are offered to those aged 18+ who have been diagnosed with SMI, this provides an opportunity for patients to discuss any health issues along with any discussions around treatment. It also provides an opportunity for any health professionals to identify any physical health issues.

In LLR, between the period July 2023 to June 2024, there were a total of 8,885 patients listed on the SMI GP register, out of these 5,775 (65.0%) received a SMI health check.

In LLR (as at June 2024), there are very low coverage rates for breast cancer screening - less than a quarter of eligible women with SMI are screened, compared to 70% of those in the general population.[202]

[201] Office for Health Improvement & Disparities (2023). Premature mortality in adults with severe mental illness (SMI)
[202] Leicestershire Partnership Trust (August 2024).

4.3.4 What evidence based management is recommended?

NICE provides guidance which covers recognising and managing psychosis and schizophrenia in adults. It aims to improve care through early recognition and treatment, and by focusing on long-term recovery. The guidance also covers recognising, assessing and treating bipolar disorder (formerly known as manic depression) in children, young people and adults. It aims to improve access to treatment and quality of life in people with bipolar disorder.[182] This includes the following:

Bipolar disorder[182]

- Recognising and managing bipolar disorder in primary care.
- Monitoring the physical health and mental health of people with bipolar disorder in primary care.
- Assessing suspected bipolar disorder in adults in secondary care.
- Managing crisis, risk and behaviour that challenges in adults with bipolar disorder in secondary care
- Managing bipolar depression in adults in secondary care.
- Discussing long term treatment.

Psychosis and Schizophrenia in adults[182]

- Preventing psychosis
- Monitoring and follow up
- First episode psychosis
- Subsequent acute episodes of psychosis or schizophrenia and referral in crisis
- Promoting recovery and possible future care.

4.3.5 Current services – see section 4.5

4.3.6 Unmet needs or gaps

- The rates of premature cancer mortality among people with SMI are higher than average, of note are very low coverage rates for breast cancer screening and low uptake of physical health checks for people with SMI.

4.3.7 Recommendations

- To explore opportunities to further understand and address, as appropriate, premature cancer mortality among people with severe mental illness (SMI) which may be linked to low breast screening coverage.
- To improve the uptake of breast screening for women with SMI and to monitor and improve uptake of physical health checks, particularly among those with SMI.
- Monitor and improve uptake of physical health checks, particularly among those with SMI.

4.4 Eating Disorders

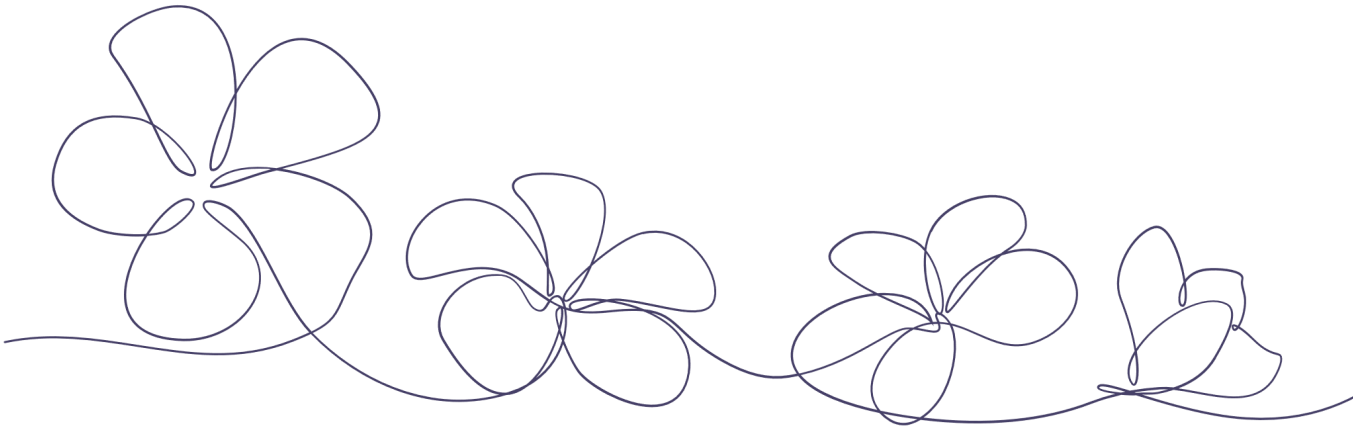
4.4.1 Background

Eating disorders are relatively common mental health conditions, with estimates suggesting that they affect millions of individuals worldwide. The most prevalent eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Eating disorders disproportionately affect females compared to males, with rates typically higher among women and girls. However, it's important to recognise that males also experience eating disorders, though they may be less likely to seek treatment or receive a diagnosis. They can develop at any age, but they often emerge during adolescence or young adulthood. However, they can also occur in childhood or later in life.

Various risk factors contribute to the development of eating disorders, including genetic predisposition, psychological factors (e.g., low self-esteem, perfectionism), sociocultural influences (e.g., media portrayals of body image), interpersonal factors (e.g., history of trauma or abuse), and biological factors (e.g., alterations in brain chemistry).

Eating disorders frequently co-occur with other mental health conditions, such as mood disorders (e.g., depression, anxiety), substance use disorders, and personality disorders. Individuals with eating disorders may also experience medical complications related to their disordered eating behaviours. They can have serious consequences for physical health, including nutritional deficiencies, electrolyte imbalances, gastrointestinal problems, cardiovascular complications, and bone density loss. They also significantly impact psychological well-being and quality of life. Due to stigma surrounding eating disorders and barriers to accessing care, many individuals may not seek treatment or receive a formal diagnosis. As a result, the true prevalence of eating disorders may be underestimated. While eating disorders are recognized as a global health concern, prevalence rates may vary between countries and cultures due to differences in sociocultural norms, access to healthcare, and awareness of eating disorders.[203]



[203] LSE and Centre for Mental Health, The cost of perinatal mental health problems, 2014

4.4.2 Risk Factors

Researchers have identified a range of risk factors for eating disorders that are classified as either biological, psychological and sociocultural, see table below: [204]

Table 8: Risk factors for eating disorders

Biological	Psychological	Social
Having a close relative with an eating disorder	Perfectionism	Weight stigma
Having a close relative with a mental health condition	Cognitive inflexibility	Teasing or bullying
History of dieting	Body image dissatisfaction	Limited social networks
	Personal history of mental health condition	Personal experiences of trauma
	Personal history of substance use disorder	

Source: National Eating Disorder Association (NEDA)

4.4.3 Level of Need

The 2007 national Adult Psychiatric Morbidity survey (APMS) highlighted the likely gap in epidemiological data due to under-reporting and under-diagnosis of eating disorders. In the 2007 study the 'SCOFF' survey tool22 was therefore used in order to detect attitudes and behaviours associated with possible eating disorders in a large population sample. [205] Twenty-three percent of young women (6.1% of men) aged 16 – 24 years scored two or more (the clinical threshold for diagnosis of an eating disorder) on the SCOFF scale within this survey. The APMS reports that the prevalence derived from this tool likely to be an overestimation. Applying this percentage to the female LLR resident population aged15 – 24 years suggests there may be more than 14,000 young women with a possible eating disorder in the combined areas.

4.4.4 What evidence based management is recommended?

NICE guidance on eating disorders includes the following (full details are available on the NICE website):[182]

General Principles of care:

- Improving access to services – be aware that people with an eating disorder may find it difficult or distressing to discuss issues with healthcare professionals.
- Communication and information – when assessing a person with suspected eating disorders, find out about what family members knowledge is on eating disorders and address any misconceptions.
- Support for people with an eating disorder - Assess the impact of the home, education, work and wider social environment on each person's eating disorder. Address their emotional, education, employment and social needs throughout treatment.

Identification and Assessment:

[204] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/

[205] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. E. & Jenkins, R. (2009). Adult psychiatric morbidity in England: results of a household survey. Leeds, UK: Health and Social Care Information Centre.

- Initial assessments in primary and secondary mental healthcare - be aware that eating disorders present in a range of settings such as primary/secondary care, social care, education and work.

Treating the following eating disorders:

- Bulimia nervosa
- Binge eating disorder
- Anorexia nervosa

4.4.5 Current services – see section 4.5

4.4.6 Unmet need or gaps

- More data is needed around eating disorders amongst women in LLR in order to be able to properly assess health needs in this area.

4.4.7 Recommendations

- To explore existing eating disorder pathways and consider ways to provide early intervention.

4.5 Mental Health Services

Mental health services for adults in England are provided mainly by the National Health Service (NHS) and a variety of Voluntary, Community and Social Enterprises (VCSE). Most of the local commissioned mental health services for adults operate across Leicester, Leicestershire and Rutland (LLR). See table below for a brief summary of some services offered by NHS and locally.

NHS Services	
Service	Service Description
General Practitioners (GPs)	GPs are often the first point of contact for individuals seeking mental health support. They can provide assessments, referrals to specialist services, and prescribe medication.
Talking Therapies	This program offers therapies like cognitive behavioural therapy (CBT) for common mental health issues such as depression and anxiety. It aims to provide timely and evidence-based interventions.
Community Mental Health Teams	This team consists of various professionals, including psychiatrists, psychologists, social workers, and community psychiatric nurses. They provide comprehensive support to individuals with severe and enduring mental health problems.
Crisis Resolution and Home Treatment Teams	This team offers intensive support to individuals experiencing a mental health crisis, aiming to prevent hospital admissions and support individuals in their homes.
Inpatient Services	This service is offered to individuals requiring more intensive support, there are psychiatric hospitals and units available across England. These provide care and treatment for acute mental health conditions.

Local Mental Health Services for Adults	
Mental Health Central Access Point	The phone line is staffed by recovery workers from Turning Point, who, after an assessment, can transfer callers to an appropriate staff member at Leicester Partnership NHS Trust (LPT).
Neighbourhood Mental Health Cafes	The cafes are drop-in centres operated by supportive, trained staff.
Talking Therapies	Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. The service is provided by Vita Health Group (previously VitaMinds) for all adults who live and are registered with a GP in Leicester, Leicestershire and Rutland
LLR Self Harm Service	The national voluntary organisation Harmless has been commissioned to deliver an all-age LLR wide service for people who self-harm, their friends, families and professionals, through face to face support and counselling, email and online support.
JOY Platform	An online service provided by LPT. Joy helps you to find local community activities, groups and support, including instant referrals.

Leicestershire Partnership Trust (LPT) also provides a wide range of inpatient, outpatient and community services. The following Joint Strategic Needs Assessments (JSNAs) on mental health (adults) provide a full list and further details of local mental health services for residents within LLR.

Leicester City Council: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-and-strategies/jsna/adults-joint-strategic-needs-assessments/mental-health-and-wellbeing/

Leicestershire County Council: https://www.lsr-online.org/uploads/adult-mental-health-chapter.pdf?v=1716543234

Rutland County Council: https://www.lsr-online.org/mental-health-and-dementia-adult

4.5.1 Service Use Data

Referrals to secondary mental health services

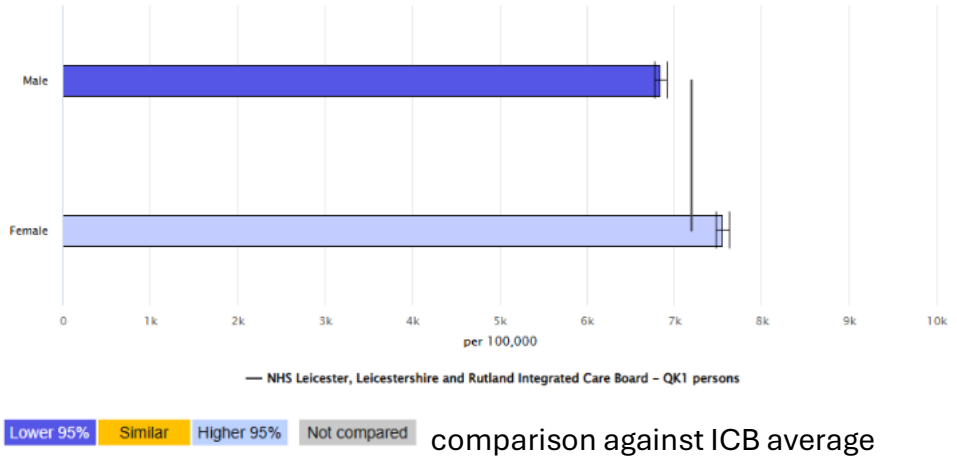
The rate of new referrals provides local health and care systems with an important measure of demand. It will help to assess how the demand reflects the mental health needs of the local population and if the demand can be met by current service provisions. It is a measure of the number of referrals made to mental health services in the time period which will reflect factors such as the prevalence of mental ill health in the community, the capacity of primary care services to manage this need, local secondary mental health services and the expectation that the secondary services are able to accept referrals.

In 2019/20, there were a total of 78,735 new referrals to secondary mental health services in LLR. Out of these, 42,350 were for females in LLR, this equates to a rate of 7,551 (per 100,000 female population), this is significantly higher than the overall LLR ICB rate (7,192 per 100,000 population). The rates for females in Leicestershire (7,346 per 100,000 female population) and

Rutland (6,232 per 100,000 female population) are significantly higher in comparison to the rate for males (6,137 and 4,859 per 100,000 male population, respectively). Whereas in Leicester, the rate for females (8,586 per 100,000 female population) is lower in comparison to males (8,869 per 100,000 male population), however there is no significant difference.

Note: where male and female breakdowns are provided, the statistical significance is compared to the local authority/ICB average not the England average.

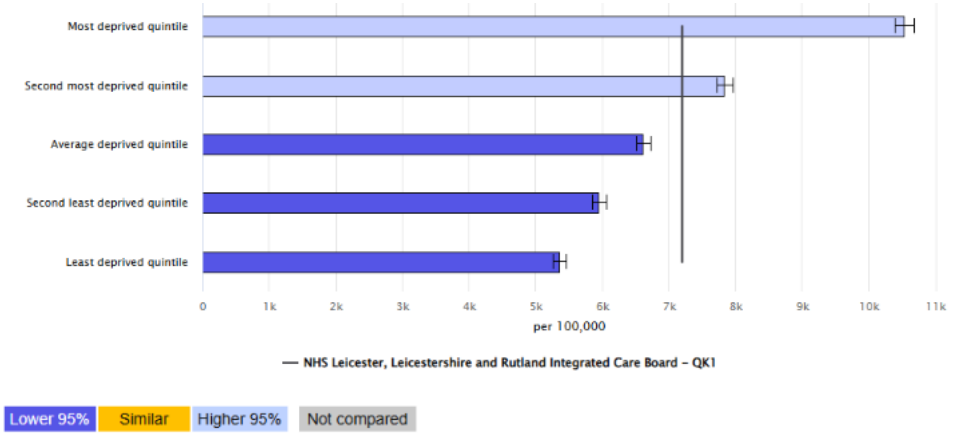
Figure 48: New referrals to secondary mental health services (DSR per 100,000 population), by gender, 2019/20 in LLR



Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

Figure 49 below, shows that in 2019/20, the rate for new referrals to secondary mental health services in LLR were significantly higher for those living in the most deprived quintile (10,553 per 100,000 population) compared to those living in the least deprived quintile (5,357 per 100,000 population).

Figure 49: New referrals to secondary mental health services (DSR per 100,000 population), by deprivation quintiles, 2019/20 in LLR



Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

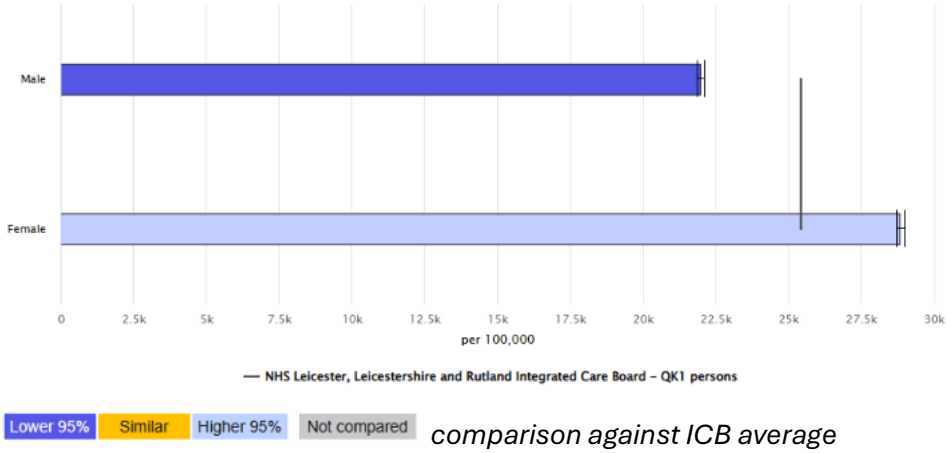
Attended contacts with community and outpatient mental health services

The rate of attended contacts provides local health and care systems with an important measure of demand. It will help to assess how the demand reflects the mental health needs of the local population and if the demand can be met by current service provisions. It is a measure

of the number of attended contacts with mental health services that are happening in the community in the time period. This will be influenced by the prevalence of mental ill health in the community, the capacity of primary care services to manage this need, and how much activity local secondary mental health services are delivering.

In 2019/20, there were a total of 276,795 attended contacts with community and outpatient mental health services in LLR. Out of these, 159,350 were for females in LLR, this equates to a rate of 28,849 (per 100,000 female population), this is significantly higher than the overall LLR ICB rate (25,416 per 100,000 population). The rates for females in Leicestershire (27,596 per 100,000 female population), Rutland (23,641 per 100,000 female population) and Leicester (34,248 per 100,000 female population) are significantly higher in comparison to the rate for males (18,838, 15,500 and 31,121 per 100,000 male population, respectively).

Figure 50: Attended contacts with community and outpatient mental health services (DSR per 100,000 population), by gender, 2019/20 in LLR



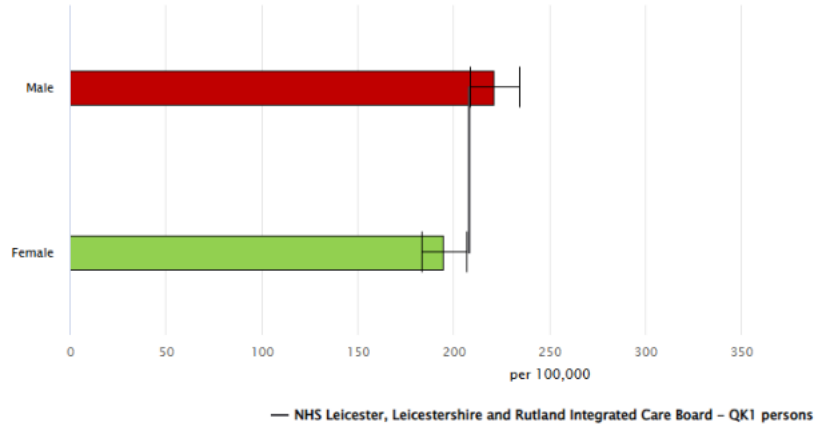
Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

Inpatient stays on secondary mental health services

The rate of inpatient stays provides local health and care systems with an important measure of this aspect of demand. It will help to assess how the demand reflects the mental health needs of the local population and if the demand can be met by current service provisions. It is a measure of the all inpatient stays where the patient was in hospital for all or part of the time period. This will reflect factors such as the prevalence, and possibly severity, of mental ill health in the community, the capacity of primary care and community mental health services to manage this need, local secondary mental health service structures and how inpatient capacity is used locally.

In 2019/20, there were a total of 2,215 inpatient stays in secondary mental health services in LLR. Out of these, 1,065 were for females in LLR, this equates to a rate of 195 (per 100,000 female population), this is significantly better (lower) than the overall LLR ICB rate (208 per 100,000 population). The rates for females in Leicestershire (159 per 100,000 female population) and Rutland (126 per 100,000 female population) are statistically similar to the rate for males (163 and 83 per 100,000 male population, respectively). The rate for females in Leicester (291 per 100,000 female population) is significantly better (lower) in comparison to the rate for males (362 per 100,000 male population).

Figure 51: Inpatient stays in secondary mental health services (DSR per 100,000 population), by gender, 2019/20 in LLR





comparison against local authority average

Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

Emergency hospital admissions for self harm

This indicator is a measure of intentional self harm as it has not been possible to include a suitable indicator representing all aspects of mental health and well being. Self harm results in approximately 110,000 inpatient admissions to hospital each year in England, 99 percent are emergency admissions. Self harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. Self harm is defined as an intentional act of self poisoning or self injury irrespective of the type of motivation or degree of suicidal intent. However, following an episode of self harm, there is a significant and persistent risk of suicide which varies markedly between genders and age groups.

In 2022/23, there were a total of 2,135 emergency admissions for self harm in LLR. Out of these, 1,355 were for females in LLR. The rates for females in Leicestershire (211.5 per 100,000 female population) and Leicester (268.7 per 100,000 female population) are significantly worse (higher) in comparison to the rate for males (130.1 and 162.7 per 100,000 male population, respectively). There was no significant difference between males and females in Rutland for this indicator.

Table 9: Emergency admissions for intentional self-harm (DSR per 100,000 population), by gender, 2022/23 in LLR

	Leicester	Leicestershire	Rutland
Males	162.7	130.1	69.9
Females	268.7	211.5	98.2
All persons	214.5	169.5	83.2



comparison against local authority average

Source: Mental Health and Wellbeing JSNA Profile, OHID, 2025

Admission episodes for mental and behavioural disorder due to the use of alcohol

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population.

4.5.2 Unmet needs or gaps

- Potential gap in provision of services; disparity between estimated prevalence and demand for services such as Talking Therapies. Less than a half of people estimated to have a severe mental illness are registered with GPs or accessing community mental health services.
- The rates of access to secondary NHS mental health services are increasing, albeit remaining lower than the national average.
- The employment gap between those in contact with mental health services and general population is wider than expected, while the proportion of those in contact in stable and appropriate accommodation is lower than expected.
- Potentially less than a third of children with a mental health condition have an appropriate intervention at a sufficiently early age.

4.5.3 Recommendations

- Continue to support and develop interventions to enable people in contact with mental health services to engage in employment and have access to stable and appropriate accommodation.
- To enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women.
- Continue to support and develop interventions to enable people in contact with mental health services to engage in employment and have access to stable and appropriate accommodation.
- Improve access to mental health services particularly in communities where there may be a stigma attached to living with a mental health problem.
- Improve the transition from children's services such as CAMHS into adult services, with a focus on prevention. The ICB is leading on this piece of work and the system plays a key part in shifting the focus from separate children and adult services into considering children's mental health as part of the preventative offer across the whole life course.

4.6 Perinatal Mental Health

4.6.1 Background

The physical and mental health of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to mental health. Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 27% of new and expectant mums and covers a wide range of conditions. Perinatal mental health conditions can include depression, post traumatic stress disorder (PTSD), panic disorder and obsessive compulsive disorder (OCD).[206] If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. It is estimated that perinatal mental health problems cost the NHS and social services around £1.2 billion annually. A significant proportion of this cost relates to impact on the child.[207]

[206] NHS (2024). Mental Health in Pregnancy. Available at: https://www.nhs.uk/pregnancy/keeping-well/mental-health/
[207] Centre for Mental Health, LSE Personal Social Services Research Unit. The costs of perinatal mental health problems – report summary (2015)

4.6.2 Risk Factors

Any woman may develop mental health problems during pregnancy and in the first year after giving birth. However, certain risk factors as listed below are recognised as increasing risk for specific disorders:[208]

- poverty,
- migration,
- extreme stress,
- exposure to violence (domestic, sexual and gender-based),
- emergency and conflict situations
- natural disasters,
- trauma,
- low social support.
- Bereavement by miscarriage, stillbirth or neonatal death[209]

Risk Factors for postpartum depression include:[210]

- History of mental health problems
- Childhood abuse and neglect
- Domestic violence
- Interpersonal conflict
- Inadequate social support
- Alcohol or drug abuse
- Unplanned or unwanted pregnancy
- Migration status

Risk factor for postpartum psychosis[211]

- Family or personal history of bipolar disorder

Partners/carers of women experiencing severe mental illness during the perinatal period may be at an increased risk of developing mental ill-health.[212]

4.6.3 Level of need

Suicide is a leading cause of maternal death in the first twelve months after birth.[213] In LLR, between 2021-2023 there were 80 female suicides within LLR highlighting a pattern of increased numbers of female suicides over every 3-year cumulative period since 2018.

[208] Royal College of GPs. Position statement about Perinatal Mental Health (2016) https://www.rcgp.org.uk/policy/rcgp-policy-areas/perinatal-mental-health

[209] Howard LM, Molyneaux E, Dennis C-L, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. The Lancet (2014) 384(9956):1775-88 Available at: https://www.sciencedirect.com/science/article/abs/pii/S0140673614612769?via%3Dihub

[210] World Health Organisation. Maternal mental health (2017)

[211] Pearlstein T, Howard, M., Salisbury, A., & Zlotnick, C. Postpartum depression. American Journal of Obstetrics and Gynecology (2009) 200(4):357-6 Available at: https://www.sciencedirect.com/science/article/abs/pii/S0002937808022710?via%3Dihub

[212] Ruffell, B., D.M. Smith, and A. Wittkowski, The experiences of male partners of women with postnatal mental health problems: A systematic review and thematic synthesis. Journal of Reproductive & Infant Psychology, 2019: p. 1-17

[213] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (EMBRRACE -UK), Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17

Women with a history of mental health illness are at significant risk of relapse during pregnancy and the first twelve months after birth.[214] Depression and anxiety are the most common mental health problems during the perinatal period. Depression and anxiety affect 15-20% of women in the first year after childbirth as well as during pregnancy in some cases.[215]

Estimates suggest that 12% of pregnant women experience depression and 13% anxiety, rising, respectively, to 15% and 20% postpartum. Often both. 1-2 per 1,000 women may develop psychosis postpartum. Mental health of mothers in perinatal period affects foetal well-being, obstetric outcomes and the development of the child, and there are risks to using psychotropic medication.

Estimates presented in the two tables below have serious potential caveats and were derived in 2019 from 2017 data by applying national estimates to local birth data; also data are only available down to UA (Unitary Authority) level (data for Leicester city was unavailable). The number of women with post-partum psychosis or chronic SMI are estimated at less than 20 for Leicestershire, with under 190 cases of severe depression or PTSD in perinatal period. However, there could be around 800 women with mid-moderate depression and anxiety and twice as many with adjustment disorders and distress in perinatal period.

Table 10: Estimated prevalence of mental health disorders in post partum period in Leicestershire

	Number/Range	Lower CI	Upper CI
Postpartum psychosis	11	5	19
Chronic SMI	11	5	19
Severe depressive illness	159	136	186
Mid-moderate depression and anxiety	531-797	487	854
PTSD	159	136	186
Adjustment disorders and distress	797-1,593	742	1,674

(Source: OHID 2024)

In 2017/18 in Rutland, less than 10 women were estimated to have severe depression or PTSD in the perinatal period. Estimates suggest that in 2017/18 in Rutland there were up to 40 women with mild-moderate depression and anxiety and twice as many with adjustment disorders and distress in the perinatal period.

[214] The British Psychological Society and The Royal College of Psychiatrists, Antenatal and postnatal mental health, the NICE guideline- Clinical management and service guidance, updated edition, 2007.
[215] LSE and Centre for Mental Health, The cost of perinatal mental health problems, 2014

Table 11: Estimated prevalence of mental health disorders in post-partum period in Rutland

Indicator	Time Period	Rutland Value	CIPFA range*
Severe depressive illness in perinatal period: Estimated number of women	2017/18	8	8-118
Mild-moderate depressive illness and anxiety in perinatal period (lower and upper estimate): Estimated number of women	2017/18	27 – 40	Lower estimate: 27-393 Upper estimate: 40-589
PTSD in perinatal period: Estimated number of women	2017/18	8	8-118
Adjustment disorders and distress in perinatal period (lower and upper estimate): Estimated number of women	2017/18	40– 80	Lower estimate: 40-589 Upper estimate: 80-1,178

*Range of values for Rutland's CIPFA comparators

(Source: Office for Health Improvement and Disparities, Fingertips)

4.6.4 What evidence- based management is recommended?

In terms of antenatal and postnatal mental health, NICE provides recommendations for identifying, and managing mental health conditions in women who are planning a pregnancy, currently pregnant, or have been pregnant within the past year. It addresses a range of conditions including depression, anxiety, eating disorders, substance use disorders, and severe mental illnesses such as psychosis, bipolar disorder, and schizophrenia. The focus is on early identification and effective treatment to enhance the mental well-being and overall quality of life for women during pregnancy and the postnatal period.[216]

The guidance includes recommendations on the following:

- Principles of care
- Treatment decisions, advice and monitoring
- Recognising mental health problems
- Assessment and care planning
- Providing interventions
- Treating specific mental health problems

4.6.5 Current services

Perinatal Mental Health Services

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. Maternity, general practice and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified.[217]

[216] NICE (2020). Antenatal and postnatal mental health: clinical management and service guidance. Available at: https://www.nice.org.uk/guidance/cg192

[217] NICE. Antenatal and postnatal mental health Quality Standard QS115 (2016)

Early access to maternity care

A booking appointment (by week 10 of pregnancy) allows the healthcare provider (midwife) to discuss all aspects of pregnancy with women, this can include scheduling of an ultrasound, identification of risk factors such as smoking and offering support, discussion of mood and mental health. It also ensures the mother's details can be shared in good time with the health visiting service, who visit the mother at home during the last three months of her pregnancy for promotion of health and wellbeing and planning for parenthood, and to arrange for more intense support following the birth, where needed.

In 2023/24, 73.8% (7,935) of women had their booking appointment with a midwife within 10 completed weeks of their pregnancy in LLR. Each local authority area within LLR had a significantly better (higher) rate in comparison to the national rate (63.5%). Although the recent five year trend shows no significant change for each local authority, Leicestershire and Rutland have had significantly better (higher) rates than England since recording in 2019/20 and for Leicester since, 2022/23.

Figure 52: Early access to maternity care (%), Leicester, Leicestershire and Rutland, 2023/24

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	397,575	63.5	63.4	63.7
East Midlands region (statistical)	→	34,955	70.2	69.8	70.6
Rutland	→	255	82.3	76.4	85.0
Leicestershire	→	5,065	76.5	75.4	77.5
Leicester	→	2,615	68.5	67.0	69.9

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

Source: Perinatal Mental Health Profile, OHID, 2025

New birth visits (NBV)

Carrying out the new birth visit within 14 days means that any problems can be identified early, and interventions may be more successful the earlier they are put in place. This visit from the midwife is important for identifying any development issues with the infant (including early referral to a specialist team where needed), to promote sensitive parenting, to provide safe sleeping advice, to support feeding and to discuss concerns and worries, including maternal mental health.

In 2023/24, 93.4% (10,501) of new birth visits were completed within 14 days in LLR. Leicester (95.4%) and Leicestershire (92.3%) had a significantly better (higher) rate in comparison to the national rate (83.0%), whilst Rutland (86.7%) had a statistically similar rate to the national average. Since recording started in 2017/18, the rate in Rutland has fluctuated, whereas in Leicester and Leicestershire the rate has remained above 90% (except for the year 2020/21).

Figure 53: Proportion of New Birth Visits (NBV) completed within 14 days in LLR, 2023/24

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	443,753	83.0*	82.9	83.1
East Midlands region (statistical)	↓	40,152	89.8	89.5	90.1
Leicester	→	4,328	95.4	94.7	95.9
Leicestershire	→	5,939	92.3	91.7	93.0
Rutland	→	234	86.7	82.1	90.2



Source: Perinatal Mental Health Profile, OHID, 2025

The 6 to 8 week review

The 6 to 8 week review is an opportunity for support with breastfeeding if required, and allows an assessment of the mother's mental health, as well as reinforcing the discussions and messages from the new birth visit. It is an opportunity to ensure the mother has had a six-week postnatal check, and that the infant has received the infant physical examination, as well as a reminder of the importance of the vaccinations that take place in the first few months.

In 2023/24, 93.3% (10,387) of infants received a 6 to 8 week review in LLR. Leicester (94.2%), Leicestershire (92.7%) and Rutland (95.0%) had a significantly better (higher) rate in comparison to the national rate (81.8%). The recent five year trend indicates that there has been a significant increase in the rate for Rutland and Leicester.

Figure 54: Proportion of infants receiving a 6 to 8 week review in LLR, 2023/24

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	436,402	81.8*	81.7	81.9
East Midlands region (statistical)	→	40,714	90.7	90.5	91.0
Rutland	↑	248	95.0	91.7	97.1
Leicester	↑	4,188	94.2	93.4	94.8
Leicestershire	→	5,951	92.7	92.0	93.3

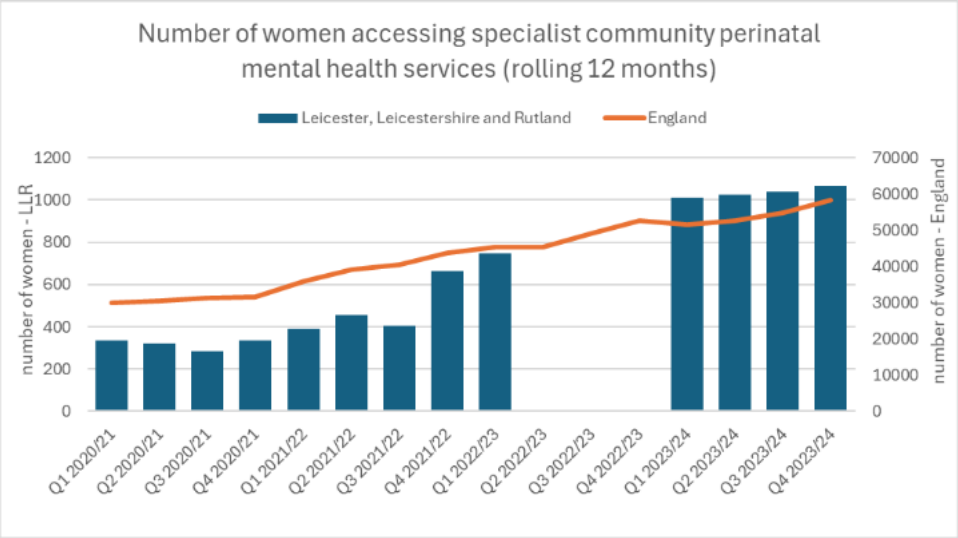


Source: Perinatal Mental Health Profile, OHID, 2025

The trends in the numbers of women accessing community perinatal mental health services have been increasing since 2020/21 in both LLR ICB and nationally, with 1,065 women across Leicester, Leicestershire and Rutland recorded in quarter 4 of 2023/24 financial year. This equates to a proportion of 8.5% of total live births in LLR and 8.8% nationally. There is a national target to increase access by 10% each year.

In 2023/24 the spend on this service across Leicester, Leicestershire and Rutland was £3.1 million, with over £2.7 million planned for 2023/24 across LLR.

Figure 55: Number of women accessing specialist community perinatal mental health services



Source: NHS Mental Health Dashboard (January 2025)

The national data for 2022/23 show that the rates for contact with specialist perinatal mental health community services correlated to social deprivation with 4.4/1,000 women in contact in the most deprived quintile of population, compared to 2.9/1,000. This would indicate a 50% increased risk, although these are crude rates and need to be treated with caution.[218]

4.6.6 Unmet need or gaps

- An increasing number of women are accessing community perinatal mental health services, therefore services in this area need to meet rising demands.
- Continue to increase the number of women attending their booking appointment with a midwife within 10 completed weeks of their pregnancy.

4.6.7 Recommendations

- An increasing number of women are accessing community perinatal mental health services, therefore services in this area need to meet rising demands.
- Continue to increase the number of women attending their booking appointment with a midwife within 10 completed weeks of their pregnancy.

[218] Leicestershire JSNA, Adults Mental Health. Available at: https://www.lsr-online.org/leicestershire-2022-2025-jsna

5 Lifestyle and Wellbeing

This chapter covers substance use, smoking, physical activity, obesity and healthy weight.

Key Epidemiology & Context

- Smoking, inactivity, and obesity significantly impact women's health across the life course
- Patterns strongly linked to deprivation and wider determinants
- Combined, they contribute to preventable long-term conditions, poorer pregnancy outcomes, reduced healthy life expectancy and widening health inequalities for women
- LLR shows clear deprivation related patterns: higher smoking rates in Leicester, lower physical activity in the city (particularly among women) and rising obesity across all three areas.
- National research shows that excessive alcohol intake is increasing in women, yet the number of women in alcohol treatment has remained relatively stable over recent years

Inequalities & At-Risk Groups

- Higher risk behaviours concentrated in deprived communities
- Cultural and structural barriers influence behaviour
- LGBTQ+ individuals are more likely than the general population to use alcohol and other drugs, however, less likely to access treatment services

Gaps & Unmet Need

- Interventions often focus on individual choice rather than system drivers
- Limited integration with wider services
- Systems and interventions do not always consider women's unique and different needs e.g. caring responsibilities, thus making it difficult for women to engage, and stay engaged longer term.

Implications for LLR

- Major contributors to long-term conditions and inequalities, especially with an ageing population

Priority Action Themes

- Shift towards system-wide prevention approaches, focussed on women's issues
- Address structural determinants of health behaviours
- Use a MECC approach

5.1 Substance Use

5.1.1 Background

Substance use (including drugs and alcohol) remains a significant public health concern across Leicester, Leicestershire, and Rutland (LLR), with profound implications for physical, mental, and social wellbeing. While national and local strategies have historically addressed substance use in general populations, there is increasing recognition of the gendered dimensions of substance use, particularly among women.

Traditionally, approaches to substance use primarily considered men's experiences, while women's substance use was often only acknowledged if it impacted their caregiving roles.[219] Feminist theorists have brought attention to the specific ways women interact with substances and the particular types of support they need. Continued research is necessary to reduce bias and enhance services for women.

Women who misuse substances often face unique vulnerabilities, including higher rates of trauma, domestic abuse, mental health comorbidities, and social stigma.[220] These factors can influence patterns of use, access to services, and treatment outcomes. Although the prevalence has been reported higher in men, those women with addictive disorders present a more vulnerable profile and are less likely to enter treatment than men.[221]

It is estimated that there are approximately 3 million drug users in England, with one in ten individuals using the most harmful substances, such as opiates and/or crack cocaine. National statistics indicate that drug-related deaths are rising, with nearly 4,860 fatalities due to drug poisoning registered in England and Wales in 2021—a six percent increase compared to 2020. There is also a strong correlation between drug misuse, particularly involving opiates and crack cocaine, and areas of social deprivation or poverty.[222]

For further information please consult:

Leicestershire JSNA (drug misuse update 2023)

Leicestershire JSNA (alcohol misuse 2023)

Rutland JSNA Drug and Alcohol Misuse 2023

Drug Use in Leicester Adults JSNA 2023

Drug Use in Leicester Adults JSNA 2023

[219] Mutatayi C, Morton S, Robles Soto N, Pálsdóttir K, Vale Pires C. Implementing a Gender Approach in Drug Policies: Prevention, Treatment Criminal Justice. A Handbook for Practitioners Decision Makers. (2022). Available online at: https://rm.coe.int/2022-ppg-implementing-a-gender-approach-in-drug-policies-a-pg-handbook/1680a66835

[220] Hecksher D, Hesse M. Women and substance use disorders. Mens Sana Monogr. 2009;7(1):50-62. doi:10.4103/0973-1229.42585

[221] Fonseca, F., Robles-Martínez, M., Tirado-Muñoz, J. et al. A Gender Perspective of Addictive Disorders. Curr Addict Rep 8, 89–99 (2021). https://doi.org/10.1007/s40429-021-00357-9

[222] Rutland JSNA. Substance use. 2020 Available from https://www.lsr-online.org/uploads/substance-misuse-(drugs-and-alcohol).pdf?v=1729680053

5.1.2 Risk factors for Substance use

Women's substance use is often shaped by complex and intersecting risk factors:

- **Adverse Childhood Experiences (ACEs)**: Abuse, neglect, and household substance use are strongly associated with later substance use.[223]
- **Mental Health**: Depression, anxiety, and PTSD are prevalent among women who misuse substances, often co-occurring with substance use disorders.[224]
- **Domestic Abuse**: Women experiencing domestic violence are more likely to use substances as a coping mechanism.[170] Women are also more likely to be victims of domestic abuse when their male partners misuse drugs of alcohol.[225]
- **Socioeconomic Factors**: Deprivation, unemployment, and housing insecurity disproportionately affect women and are linked to increased substance use.[226]
- **Pregnancy and Parenthood**: Substance use during pregnancy poses risks to maternal and infant health. It can result in foetal harm such as foetal alcohol syndrome, premature birth, and developmental issues in children.[227] Women often conceal substance use due to fear of child removal, which delays help-seeking and increases harm.[228, 229]
- **Hormonal influences**: Fluctuations in oestrogen and progesterone across the menstrual cycle can affect drug sensitivity and craving. For example, higher oestrogen levels are linked to increased dopamine release in reward pathways, which may heighten vulnerability to substances like cocaine and nicotine.
- **Sex-specific pharmacokinetics**: Women often experience stronger physiological effects from substances at lower doses due to differences in body composition (e.g. lower total body water) and enzyme activity (e.g. reduced gastric alcohol dehydrogenase), leading to higher blood concentrations and increased risk of harm.

5.1.3 Level of need

5.1.3.1 Substance Use

The prevalence of problematic substance use among women is rising. Global data indicate that 46 million women experience alcohol use disorders, with the highest rates observed in the European region. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), women constitute approximately one quarter of individuals engaged in problematic

[223] Public Health Wales Observatory. What are the risk and protective factors for drug misuse? [Internet]. 2020 Dec. Available from: https://phw.nhs.wales/services-and-teams/observatory/evidence/evidence-documents/what-are-the-risk-and-protective-factors-for-drug-misuse-pdf/

[224] SAMHSA. Co-Occurring disorders and other health conditions [Internet]. www.samhsa.gov. 2023. Available from: https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders

[225] David Gadd, Juliet Henderson, Polly Radcliffe, Danielle Stephens-Lewis, Amy Johnson, Gail Gilchrist, The Dynamics of Domestic Abuse and Drug and Alcohol Dependency, The British Journal of Criminology, Volume 59, Issue 5, September 2019, Pages 1035–1053, https://doi.org/10.1093/bjc/azz011

[226] Shaw A, Egan J. Drugs and poverty: A literature review A report produced by the Scottish Drugs Forum (SDF) on behalf of the Scottish Association of Alcohol and Drug Action Teams by [Internet]. 2007. Available from: https://sdf.org.uk/wp-content/uploads/2024/05/Drugs-Poverty-Literature-Review-2007-written-by-SDF-in-association-with-the-Scottish-Association-of-Alcohol-and-Drug-Action-Teams.pdf

[227] NHS. Illegal drugs in pregnancy [Internet]. nhs.uk. 2020. Available from: https://www.nhs.uk/pregnancy/keeping-well/illegal-drugs/

[228] Wolfson L, Schmidt RA, Stinson J, Poole N. Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. Health Soc Care Community. 2021;29(3):589-601. doi:10.1111/hsc.13335

[229] Stone R. Pregnant women and substance use: fear, stigma, and barriers to care. Health Justice. 2015;3:2. Published 2015 Feb 12. doi:10.1186/s40352-015-0015-5

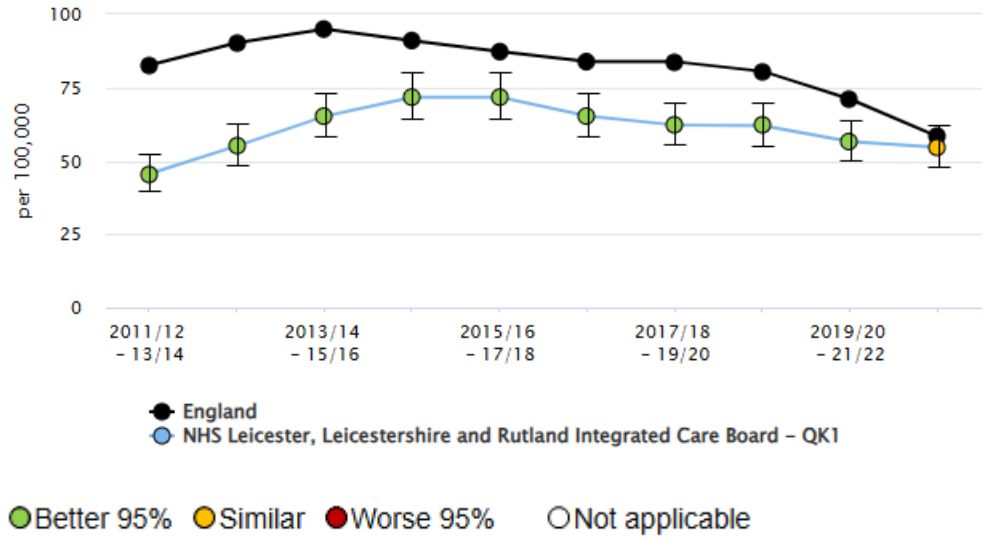
illicit drug use in Europe. Worldwide, women account for roughly one third of all drug users and represent one fifth of injecting drug users.[230]

Traditionally, men have had higher rates of substance use and dependence than women, but recent studies show this gap is shrinking. Women now have higher use rates for some drugs, such as sedatives and weight loss pills. Although men still tend to drink more alcohol and do so more often, these differences are less pronounced, particularly among younger people, with women beginning to drink at earlier ages.[231]

Although women generally start using substances later than men, they tend to escalate their use of alcohol, cannabis, cocaine, and opioids more quickly—a pattern called "telescoping." This rapid progression often results in women entering treatment with more severe medical, behavioural, psychological, and social issues.[232,]

Across LLR, hospital admissions due to substance use in 15-24 year have been on a declining trend since 2025/16 (*Figure*). However, although still declining, at the last time point the rate became similar to the England average, rather than significantly better as it had been since 2011/12. It should also be noted that although rates appear higher than in 2011/12, this difference is not statistically significant.

Figure 56: Hospital admissions due to substance use (15 to 24 years)

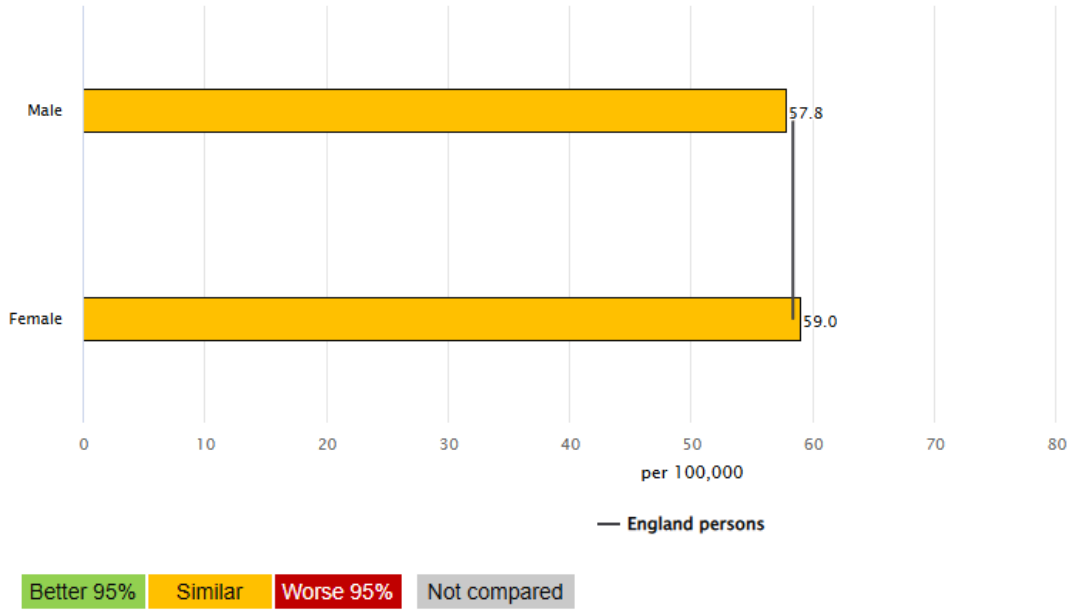


Source: OHID, Fingertips

Rates between males and females are similar (**Figure 57**).

[230] Webb L, Fox S, Skårner A and Messas G (2022) Editorial: Women and substance use: Specific needs and experiences of use, others' use and transitions towards recovery. Front. Psychiatry 13:1078605. doi: 10.3389/fpsyt.2022.1078605
[231] Fonseca, F., Robles-Martínez, M., Tirado-Muñoz, J. et al. A Gender Perspective of Addictive Disorders. Curr Addict Rep 8, 89–99 (2021). https://doi.org/10.1007/s40429-021-00357-9
[232] Greenfield SF, Back SE, Lawson K, Brady KT. Substance abuse in women. Psychiatry Clin North Am. 2010a;33:339–55. https://doi.org/10.1016/j.psc.2010.01.004.

Figure 57: Hospital admissions due to substance use (15 to 24 years) by gender



Source: OHID, Fingertips

Nationally, there were 310,863 adults in contact with drug and alcohol treatment services between 1 April 2023 and 31 March 2024. Women made up smaller proportions of service users across all four categories. In the opiate group, men accounted for about 73%, and similar trends were observed in the non-opiate only (68%) and non-opiate with alcohol (71%) groups. By comparison, the divide in the alcohol-only group was less, comprising of 60% men and 40% women.

Figure 58:Numbers in contact with treatment services nationally 2023/2024

Substance group	Men	Women	Total
Opiate	100,359 (72.7%)	37,606 (27.3%)	137,965 (44%)
Non-opiate only	24,982 (68.4%)	11,545 (31.6%)	36,527 (12%)
Non-opiate and alcohol	30,101 (71.3%)	12,097 (28.7%)	42,198 (14%)
Alcohol only	56,429 (59.9%)	37,744 (40.1%)	94,173 (30%)
Total	211,871 (68.2%)	98,992 (31.8%)	310,863 (100%)

Source: OHID (NDTMS data)

In 2023/24, National Drug Treatment Monitoring System (NDTMS) data indicates the majority of women newly presenting at substance use treatment services in Leicester were White British. In

Leicestershire, White British individuals represent the largest ethnic group receiving treatment.[233]

Nationally, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals are more likely than the general population to use alcohol and other drugs, however, less likely to access treatment services.[234]

Nearly three-quarters (72%, or 115,229) of adults beginning treatment reported a mental health need. Among substance groups, this need was reported by 69% (opiate), 72% (non-opiate only), 78% (non-opiate and alcohol), and 72% (alcohol only). Over one-fifth (22%) with a mental health need were not receiving treatment. Of those treated, 64% received care in primary care settings, 21% through community mental health services, 2% via NHS talking therapies, and 2% through NICE-recommended psychosocial interventions in drug or alcohol services.[235] This data is not broken down by gender.

5.1.3.2 Alcohol

In terms of alcohol specific needs, on the LLR ICB footprint, successful completion of alcohol treatment in 2023/24 is similar to the England average. This data is not broken down by gender.

Admission episodes for females in 2022/23 was on a downwards trends and significantly better than the England average.

Figure 59: LLR ICB Alcohol Profile

Indicator	Period	Leicester, Leics and Rutland ICB - QK1			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Successful completion of alcohol treatment	2023/24	–	648	34.3%	34.2%	24.2%		43.5%
Admission episodes for alcohol-related conditions (Narrow) (Persons)	2022/23	↓	4,979	460	475	680		327
Admission episodes for alcohol-related conditions (Narrow) (Male)	2022/23	→	3,281	625	639	883		461
Admission episodes for alcohol-related conditions (Narrow) (Female)	2022/23	↓	1,698	308	326	553		177

Better 95% Similar Worse 95% Not applicable

Source: OHID, Alcohol Profile

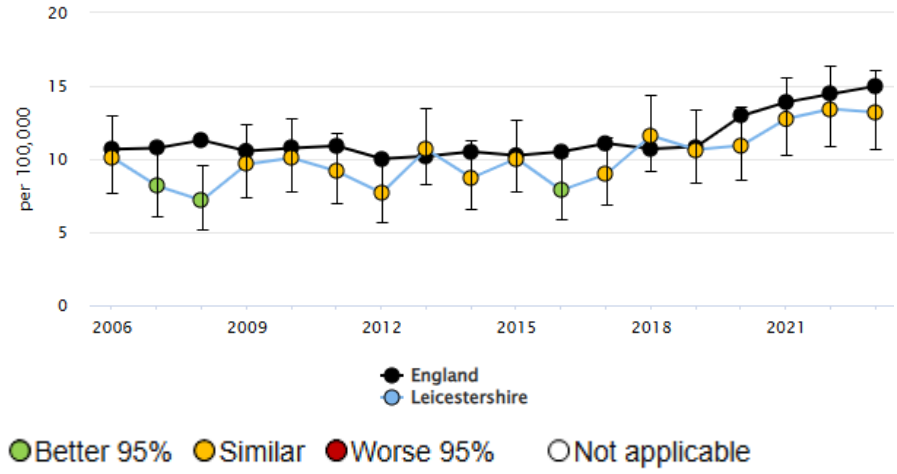
Rates of alcohol-specific mortality have fluctuated since 2006, recent years, there has been a national incline, which is reflected in Leicestershire (**Figure 60**), however this is not statistically significant, largely due to the lower numbers. In Leicester rates have also fluctuated, but are often significantly worse than the England average, likely linked to increased deprivation. Rutland data is suppressed.

[233] Turning Point. 2024.

[234] Bradley R. What the Research says about LGBTQ+ People and Substance Use [Internet]. SFAD. 2020. Available from: https://www.sfad.org.uk/what-the-research-says-about-lgbtq-people-and-substance-use

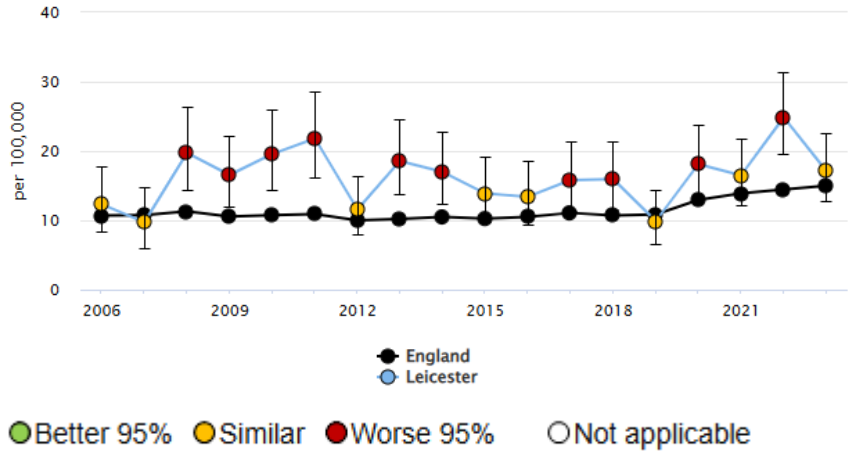
[235] OHID. Adult substance use treatment statistics 2023 to 2024: report. 2024. Available from https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report

Figure 60: Alcohol Specific Mortality – Leicestershire (2006 – 2023)



Source: OHID, Alcohol profile

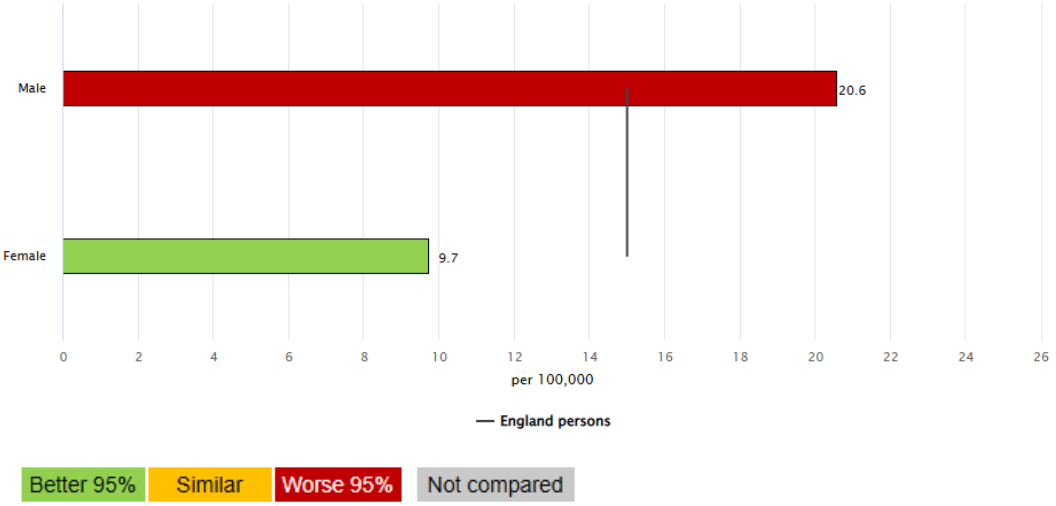
Figure 61: Alcohol Specific Mortality – Leicester (2006 – 2023)



Source: OHID, Alcohol profile

When broken down by gender, rates of alcohol specific mortality are significantly higher in men. This data is national, not local.

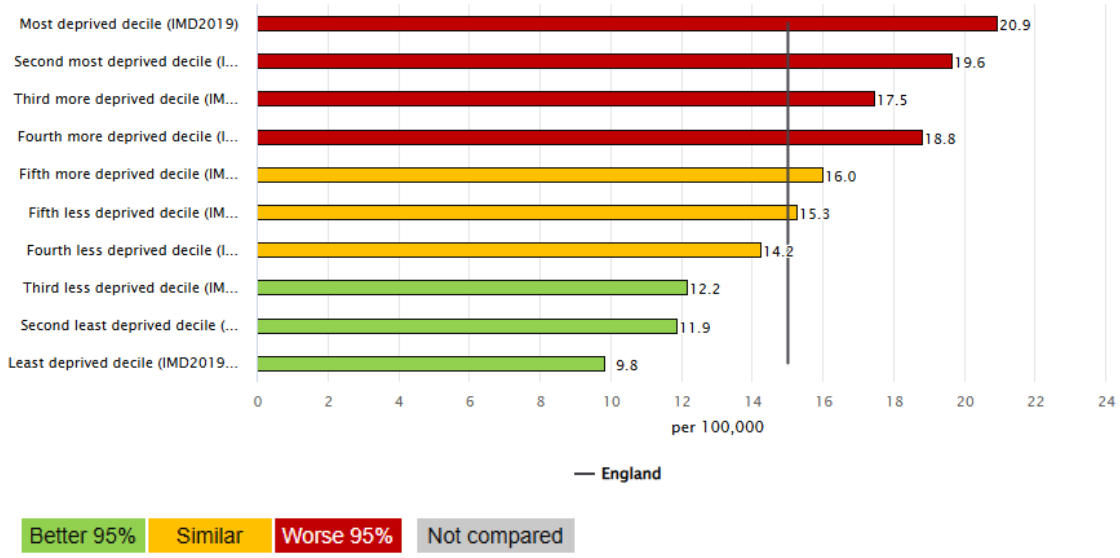
Figure 62: Alcohol Specific Mortality – by gender 2023



Source: OHID, Alcohol profile

Alcohol specific mortality is also strongly correlated with deprivation. Alcohol specific mortality rates are more than double in those living in the most deprived areas compared to the least deprived.

Figure 63: Alcohol Specific Mortality – by deprivation 2023



Source: OHID, Alcohol profile

As demonstrated, alcohol related harm correlates with deprivation, which is likely related to higher alcohol mortality rates in Leicester City as compared to the County. Leicester faces high deprivation, with a notable concentration of alcohol outlets that may contribute to social and health challenges. The city's Alcohol Harm Reduction Strategy (2022-2027) aims to address these issues.[236]

[236] Leicester City Council. Leicester City Alcohol Harm Reduction Strategy 2022-2027 [Internet]. Available from: https://www.leicester.gov.uk/media/2xtnzl2j/alcohol-harm-reduction-strategy-2022.pdf

A Leicester Health and Wellbeing Survey was conducted in 2018 and showed[237]:

- Highest levels of non-drinkers: Asian ethnic groups (73%) and Black ethnic groups (72%).
- Lowest levels of non-drinkers: White (32%) and Mixed ethnic groups (32%).
- Highest levels of drinking above the recommended weekly limits: White groups (7%), compared to Asian, Black and Mixed ethnic groups (2%).

For Leicestershire, the estimate of adult alcohol dependent population, potentially in need of specialist alcohol treatment is just under 5,370 (or 9.6 per 1,000), while the number in treatment (including alcohol only and alcohol/non-opiate) was 1,377 in 2021/22. This results in an overall estimate of need at 74% (95% CI: 65-81%) or around 4,000 adults. This is not statistically different to the national unmet need estimate of 80%.[238] In Rutland, the gap in treatment is estimated at 79%, however due to low numbers, there is a high degree of uncertainty on prevalence estimates, therefore this should be viewed with caution.[239]

Leicester's 2023 JSNA reports that the proportion of dependent drinkers not in treatment in Leicester for 2019/20 was 85.0% (3,649 individuals) and for 2020/21 was 81.7% (3,509 individuals), figures comparable to those for England (82.3% and 81.9%, respectively). During 2018/19, 2019/20, and 2020/21, Leicester had the third lowest proportion of dependent drinkers not in treatment among its five comparator areas. No significant differences were observed between Leicester and its comparators across these three years.

This data is not broken down by gender, however it is recognised that women are less likely to enter treatment. National research shows that excessive alcohol intake is increasing in women, yet the number of women in alcohol treatment has remained relatively stable over recent years.[240]

More women than men in substance use treatment reported living with a child or being a parent at intake (58% vs 48%).[241] This highlights the need to consider gender equity when designing treatment services, which have often focused on male users and rarely address women's needs, such as childcare or women-only spaces.

5.1.3.3 Drugs

Drug misuse is a growing public health problem in England, with around 3 million users – 10% using the most harmful substances like opiates or crack cocaine. Drug-related deaths are rising, reaching nearly 5,448 in 2023 in England and Wales, higher than subsequent years, and are strongly linked to social deprivation, especially for opiate and crack cocaine use. Among males, there were 127.6 drug-poisoning deaths registered per million in 2023 (3,645 deaths), compared with 59.8 deaths per million among females (1,803 deaths). [242]

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[237] Leicester City Council. Contents [Internet]. 2022. Available from: https://www.leicester.gov.uk/media/jqip0wkx/drug-and-alcohol-needs-assessment-jsna-2022.pdf

[238] Leicestershire County Council, Alcohol JSNA, 2023. Available from: https://www.lsr-online.org/uploads/alcohol-misuse.pdf?v=1708331521

[239] Rutland County Council, Alcohol JSNA, 2023. Available from: https://www.lsr-online.org/uploads/substance-misuse-(drugs-and-alcohol).pdf?v=1729680053

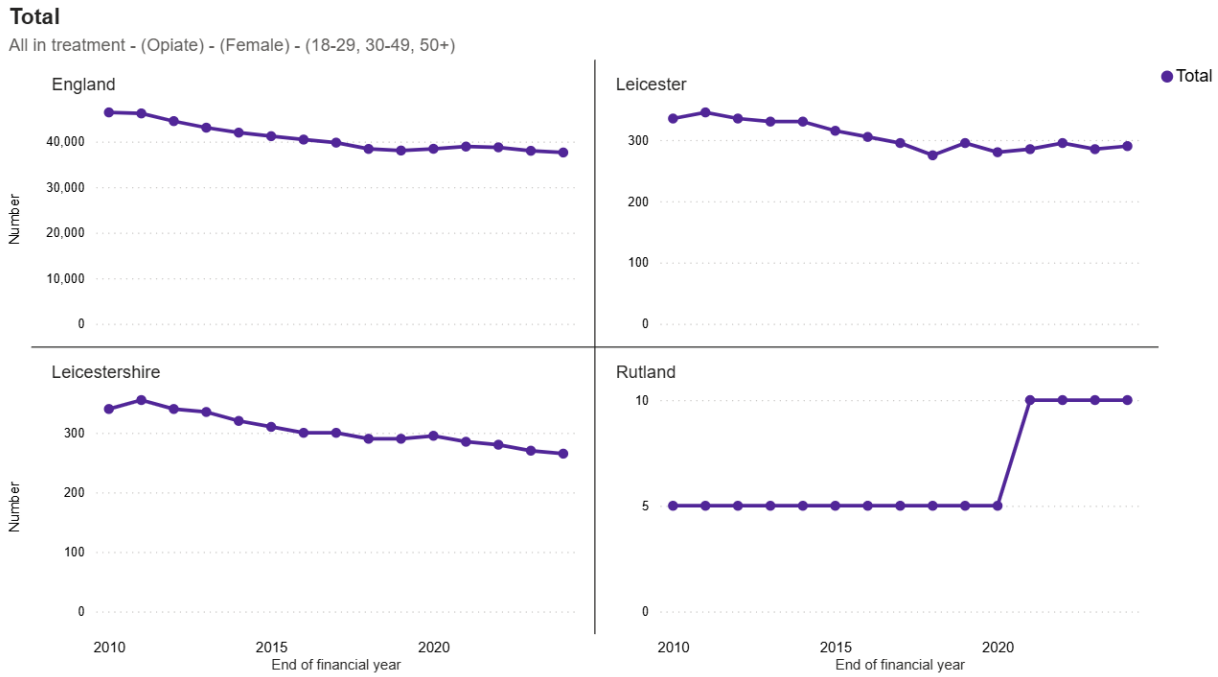
[240] Institute of Alcohol Studies, Women in Alcohol. Available from: https://www.ias.org.uk/report/women-and-alcohol/#:~:text=The%20number%20of%20women%20in,women%20over%20this%20time%20period.

[241] PHE, Substance use treatment for adults: statistics 2018 to 2019. Available from: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2018-to-2019

[242] ONS, Deaths related to drug poisoning in England and Wales: 2023 registrations, 2024. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations

Nationally, numbers of both males and females in treatment for opiate use is declining.

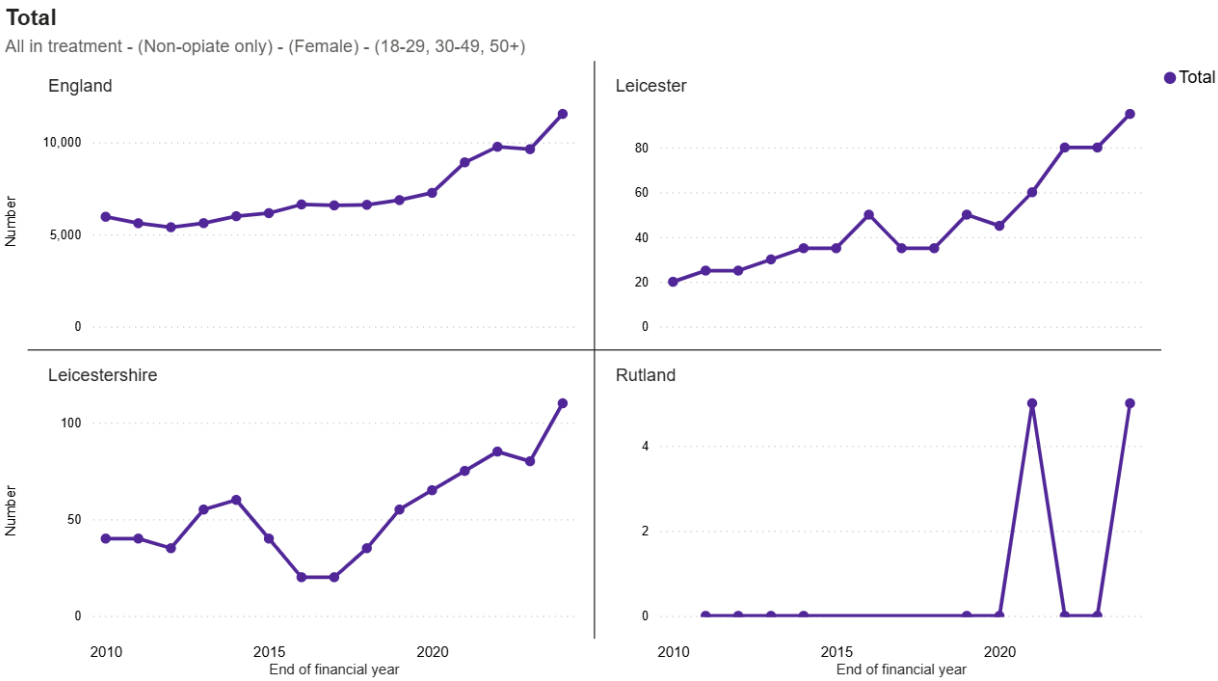
Figure 64: All in treatment (opiates) – females over 18



Source: NDTMS

Conversely, those in treatment for non-opiates only is on a national incline.

Figure 65: All in treatment (non opiates only) – females over 18



Source: NDTMS

This shift in treatments trends can be attributed to several interrelated factors.

Opiate treatment numbers may be decreasing due to:

- **Stabilisation and Ageing of the Opiate-Using Population**: Many individuals with long-term opiate use have already been in treatment for years. This cohort is ageing, and some are either stabilised, disengaging from services, or experiencing mortality. As a result, fewer new opiate users are entering treatment compared to previous decades.
- **Treatment Complexity and Retention Challenges**: Opiate users often require longer, more intensive treatment episodes. Services are cautious about closing cases too early to avoid re-presentations, which may reduce the number of new entries into treatment at any given time, which could result in an unmet need.
- **Unmet Need and Hidden Populations**: For example, an estimated 53% of opiate users in Leicestershire are not currently in treatment—around 1,300 individuals.[243] This suggests a significant hidden population that may not be engaging with services due to stigma, service accessibility, or personal choice.

Non-opiate treatment numbers may be increasing due to:

- **Changing Patterns of Drug Use**: Nationally, there has been a rise in the use of substances like cocaine, cannabis, and prescription drugs. The proportion of adults entering treatment for powder cocaine, for example, has reached its highest level since reporting began.[244]
- **Improved Identification and Referral Pathways**: Increased awareness and screening in primary care, mental health services, and criminal justice settings has led to more referrals for non-opiate users, particularly those with co-occurring alcohol or mental health issues.
- **Post-COVID Shifts in Behaviour**: The pandemic disrupted traditional engagement methods and may have altered substance use behaviours. Some individuals turned to non-opiate substances during lockdowns, and services adapted to reach these groups through digital and community-based models.
- **Younger and More Diverse Service Users**: Non-opiate users tend to be younger and more likely to be in employment or education. These groups may be more willing to engage with brief interventions or harm reduction services, contributing to the rise in treatment numbers.

5.1.3.4 Comorbidities and Socio-economic impacts

Although covered elsewhere within the HNA and other HNAs/JSNAs, it would be remiss not to mention the comorbidities and socio-economic impacts of substance use. Women who misuse alcohol and drugs often experience a complex interplay of physical and mental health conditions, with consequences far reaching.

[243] Leicestershire County Council. Drug use JSNA, 2023. Available from: https://www.lsr-online.org/uploads/substance-misuse.pdf?v=1708331200
[244] OHID. Adult substance use treatment statistics 2023 to 2024: report. 2024. Available from: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report

Comorbidities:

- **Mental health disorders**: High rates of depression, anxiety, PTSD, and eating disorders are common among women with substance use disorders (SUDs). These conditions are often both antecedents and consequences of substance use.[245]
- **Reproductive and sexual health issues**: Substance use is associated with menstrual irregularities, fertility problems, increased risk of STIs, and complications during pregnancy, including foetal alcohol spectrum disorders (FASD).[246]
- **Chronic physical conditions**: Long-term alcohol and drug use increases the risk of liver disease, cardiovascular problems, gastrointestinal disorders, and certain cancers (e.g. breast cancer in alcohol-using women).[247]

Socioeconomic Impacts:

- **Employment and income**: Women with SUDs are more likely to be unemployed or in precarious work and may face discrimination in the workplace or during job-seeking. Substance use can both result from and contribute to economic instability.
- **Housing insecurity**: Substance use is both a cause and consequence of unstable housing, with women often facing additional risks of exploitation or abuse in insecure living situations.[248]
- **Parenting and child safeguarding**: Women who misuse substances may face child protection interventions, which can deter them from seeking help due to fear of losing custody.[249] In Leicestershire in 2019 to 2020, 15.3% (586) of children in needs assessments identified alcohol misuse by a parent or other adult living with the child as an issue. Drug misuse was a factor in 13.6% (519) of assessments. In Rutland, drug misuse was a factor in 16% of assessments, while alcohol misuse contributed to 7% of assessments.
- **Criminal justice involvement**: Although women are less likely than men to be involved in drug-related crime, those who are often have histories of trauma, coercion, and survival-based offending linked to substance use.[250]
- **Stigma and social exclusion**: Women face heightened stigma related to substance use, particularly during pregnancy or motherhood, which can exacerbate isolation and reduce engagement with services.[251]
- **Sex workers**: Women engaged in sex work often experience a range of significant and complex challenges, including substance misuse, mental ill health, homelessness, and histories of violence. These intersecting adversities compound barriers to accessing services. Many sex workers use substances to cope with trauma or to manage the demands of their work, while others engage in sex work to fund addiction. Mainstream

[245] PHE. Better care for people with co-occurring mental health and alcohol/drug use conditions. 2017. Available from: https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[246] National Institute for Health and Care Excellence (NICE). Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110). 2010. Available from: https://www.nice.org.uk/guidance/cg110

[247] World Health Organization. Alcohol and cancer in the WHO European Region. 2021. Available from: https://iris.who.int/bitstream/handle/10665/336595/WHO-EURO-2020-1435-41185-56004-eng.pdf

[248] PHE. Substance use treatment for adults: statistics 2017 to 2018. 2018. Available from: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2017-to-2018/alcohol-and-drug-treatment-for-adults-statistics-summary-2017-to-2018

[249] NSPCC. Parents with substance use problems: learning from case reviews. 2023. Available from: https://learning.nspcc.org.uk/media/w2eh34r1/learning-from-case-reviews-parents-substance-use.pdf

[250] Prison Reform Trust. There's a reason we're in trouble: Domestic abuse as a driver to women's offending. 2017. Available from: https://prisonreformtrust.org.uk/wp-content/uploads/old_files/Documents/Domestic_abuse_report_final_lo.pdf

[251] EMCDDA (European Monitoring Centre for Drugs and Drug Addiction). Women and drugs: health and social responses. 2021. Available from: https://www.euda.europa.eu/publications/mini-guides/women-and-drugs-health-and-social-responses_en

services are frequently ill-equipped to meet their complex needs, and fear of criminalisation or stigmatisation further deters engagement with health and support services.[252, 253]

Women experiencing multiple and severe disadvantage, such as poverty, trauma, insecure housing, and discrimination, face compounded barriers to accessing support. These intersecting disadvantages not only increase vulnerability to substance misuse but also reduce the likelihood of engaging with health and social care services. Cultural, financial, and structural barriers, including fear of judgement, language barriers, and lack of trauma-informed care, further marginalise these women and limit their ability to self-manage health conditions or seek help safely.

5.1.4 What evidence- based management is recommended

Substance use interventions include pharmacological, psychosocial, and recovery support approaches, usually provided in community, inpatient, primary, or residential care settings. The JSNAs previously cited provide more in-depth information on evidence-based substance use management.

Evidence-based management of substance use in women requires a holistic, trauma-informed, and gender-responsive approach. NICE provides a suite of guidelines that underpin best practice in prevention, treatment, and recovery.

NICE Recommendations

NICE outlines a range of evidence-based interventions that form the foundation of effective substance use treatment including:

- Psychosocial Interventions for drug misuse (CG51)[254]
    - Motivational interviewing and brief interventions for individuals in the early stages of use or not yet engaged in treatment.
    - Structured psychological therapies such as cognitive behavioural therapy (CBT) and contingency management, particularly effective for stimulant and cannabis misuse.
    - Key working to coordinate care and build therapeutic relationships—especially important for women with complex needs, including those with co-occurring mental health issues or safeguarding concerns.
- Targeted Prevention (NG64)[255]
    - NICE advocates for proactive, targeted interventions for individuals at higher risk of drug misuse, including women with histories of trauma, domestic abuse, or mental health conditions. Recommendations include:
        - Delivering prevention activities through existing services such as sexual health, maternity, and mental health services.
        - Providing tailored information and skills training to vulnerable adults and young people.

[252] Mellor R, Lovell A. The lived experience of UK street-based sex workers and the health consequences: an exploratory study. Health Promot Int. Available from: https://academic.oup.com/heapro/article-abstract/27/3/311/750002
[253] Patel R, Redmond NM, Kesten JM, et alDrug Use in Street Sex worKers (DUSSK) study: results of a mixed methods feasibility study of a complex intervention to reduce illicit drug use in drug dependent female sex workersBMJ Open 2020;10:e036491. doi: 10.1136/bmjopen-2019-036491
[254] NICE. Drug misuse in over 16s: psychosocial interventions. CG51. 2026. Available from: https://www.nice.org.uk/guidance/cg51
[255] NICE. Drug misuse prevention: targeted interventions. NG 64. 2017. Available from https://www.nice.org.uk/guidance/ng64

- Alcohol-Use Disorders – Prevention (PH24)[256]
    - Availability: limit the number of alcohol outlets and restrict hours of sale to reduce harm.
    - Marketing: strengthen regulations to reduce exposure to alcohol advertising
    - Screening and brief interventions aimed at those identified at higher risk
    - As with NG64, use existing services to deliver prevention activities.
- Integrated, Person-Centred Care
    - NICE emphasises the importance of culturally appropriate, accessible care that considers the individual's preferences, safeguarding needs, and social context. This is particularly relevant for women who may face:
        - Stigma related to substance use and motherhood.
        - Barriers to accessing services due to childcare responsibilities.
        - Fear of child removal or involvement with social services.

Gender-specific evidence highlights the importance of designing substance use services that reflect women's lived experiences. Trauma-informed, women-only, and family-inclusive approaches are particularly effective in improving engagement and outcomes. Public health guidance from the World Health Organization (WHO) and NICE supports the following:

- **Trauma-informed and women-only services**: These address co-occurring mental health issues, reproductive health needs, and experiences of violence, which are disproportionately common among women with substance use disorders.[257]
- **Family-inclusive approaches**: Involving family members in care planning can reduce isolation and support recovery, especially for women in caregiving roles.
- **Support for carers**: Recognising that many women are both service users and caregivers, services should offer flexible, accessible support that considers these dual roles.[258]

5.1.5 Current services in LLR

At the time of production, Turning Point is the local authority provider of substance use services. Services include:

- Turning Point provide drug and alcohol substance use treatment services in Leicester and Leicestershire and Rutland. The service also offers:
- Domestic abuse support via trained recovery workers
- Family support
- Sex worker specific support
- An improved non-opiate pathway to support the rise in non-opiate cases, allowing a bespoke for service users and training for staff
- Turning Point has a specific team that is in place to support those within the service that have substance use needs as well as mental health support requirements (dual diagnosis) – the Substance Use and Mental Health Team.
- The Substance use Clinic (SMC) at Leicester Royal Infirmary (LRI).
- There is a substance use maternity offer, which includes trained staff and a drop-in service to allow informal substance conversations, and direct referrals when required.

[256] NICE. Alcohol-Use Disorders – Prevention. PH24. Available from: https://www.nice.org.uk/guidance/ph24
[257] WHO. Violence against women. 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women
[258] WHO. Mental health, brain health, substance use. Available from: https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention

- Turning Point and commissioned pharmacies via the provider in LLR play a key role in harm reduction, offering needle exchange programmes and supervised drug use programmes. They also distribute naloxone.
- Detoxification bed days are offered to those who require the clinical intervention; there is a specific women's only offer with privacy away from other residents.
- Rehabilitation placements are in place with specific rehab spaces offered via a framework where women are supported to choose the rehab placement that is best for them. This can range from women only, domestic abuse specialists, family units or dual with mental health support.
- Dear Albert: Offers peer-led recovery support and mutual aid groups.

5.1.6 Unmet needs or gaps

- There is insufficient information on the extent of substance use during pregnancy in LLR, including how many women are receiving appropriate support during this critical period.
- There is limited data available around LGBTQ+ substance usage which may or may not impact on access to services.
- All available evidence indicates that services are specifically tailored to support women's adherence and enhance accessibility. Service providers report, anecdotally, that they address women's needs effectively, and commissioners have expressed satisfaction with these provisions. However, further unbiased engagement with women is necessary to gain a deeper understanding of their experiences and requirements.
- With growing rates of non-opiate use, services need to ensure provision is available to deal with rising demands.
- There is limited information around pain medication that is prescribed and illicit for women.
- Although services are operating well, women are still less likely to access service provision, and women do not progress as well as others through the service.

5.1.7 Recommendations

- Further explore the data around substance use and potential barriers to access of LGBTQ+ individuals. Continue to offer services specific to need such as Chemsex.
- Examine the relationship between substance use and domestic abuse, as well as children being taken into care across LLR.
- Explore women's successful completions in services and determine any changes which could improve completion rates.
- Ensure all services continue to consistently adopt a trauma informed approach.
- Conduct a deeper dive into the mental health needs of substance use service users to understand the local picture and any barriers to service access and adherence.
- Ensure that all services adopt a gender informed approach, fully understanding the different and diverse needs of women experiencing substance use. This should also be considered for future service commissioning.
- Work locally and advocate nationally to reduce alcohol marketing.
- Support for Mothers: Provide wraparound care for pregnant women and mothers, including safeguarding-sensitive pathways.
- Training for Professionals: Review and expand training on gendered substance use for frontline staff - for services and staff to understand and recognise the impact on women experiencing multiple and severe disadvantage and how this affects capability to access and use services.

5.2 Smoking

5.2.1 Background

Tobacco is the only legal consumer product that kills up to half of its users when used as intended by the manufacturer – now read that again.[259]

Smoking is the main cause of premature death and preventable illness in the UK. In England in 2022 to 2023, there were an estimated 408,700 smoking-related admissions to hospital. One in 4 patients in a hospital bed is a smoker. Smokers also see their GP 35% more than non-smokers.[260]

The impact of smoking on women's health is multifaceted, contributing to cardiovascular disease, respiratory illness, reproductive complications, and increased cancer risk. Smoking during pregnancy remains a significant concern, with implications for maternal and infant outcomes.

Women who smoke face elevated risks of cardiovascular disease, respiratory illness, reproductive complications, and cancers such as cervical and breast cancer. The impact is particularly severe during pregnancy, where smoking can double the risk of stillbirth and triples the risk of sudden infant death syndrome (SIDS).[261] Smoking also exacerbates mental health conditions.[262]

Stopping smoking at any time has considerable health benefits, including for people with a pre-existing smoking-related disease. For people using secondary care services, there are other advantages. These include:

- shorter hospital stays
- lower drug doses
- fewer health complications
- higher survival rates
- better wound healing
- decreased infections
- fewer re-admissions after surgery[260]

5.2.2 Policy Context

5.2.2.1 Fit for the Future: 10 Year Health Plan

The 10-Year Health Plan for England prioritises smoking cessation with measures such as the Tobacco and Vapes Bill, which will prohibit tobacco sales to anyone born on or after 1 January 2009 to create a Smoke-Free Generation. The plan also restricts youth vaping through controls on packaging, flavours, and retail display. These actions are part of a shift to community-based preventative care, integrating smoking cessation into neighbourhood health services to reduce

[259] UK Government. Fit for the Future. 10 Year Plan for England. 2025. Available from https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf
[260] OHID. Smoking and tobacco: applying All Our Health. 2025. Available from: https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health
[261] NHS England. Tobacco dependency programme [Internet]. London: NHS England; [cited 2025]. Available from: https://www.england.nhs.uk/ourwork/prevention/tobacco-dependency-programme/
[262] Action on Smoking and Health. Causal effect of smoking on mental health: A summary of the evidence. London: ASH; 2022. Available from: https://ash.org.uk/uploads/Causal-effect-smoking-and-mental-health.pdf

health inequalities and preventable illness. Smoking is addressed as a modifiable risk factor, targeted by both policy and service redesign to enhance population health.[259]

5.2.2.2 Pregnancy

The UK government set an ambition to reduce smoking at the time of delivery (SATOD) to 6% or less by the end of 2022, as part of its broader maternity safety goals.[263]

The Saving Babies' Lives Care Bundle Version 3 (SBLCBv3), published by NHS England, reinforces this target through its first element: reducing smoking in pregnancy. SBLCBv3 mandates carbon monoxide testing at antenatal booking and throughout pregnancy, alongside opt-out referrals to NHS-funded tobacco dependency treatment services. These services offer personalised care plans delivered by trained advisers, in line with NICE guidance and the NHS Long Term Plan. The NHS also promotes the use of nicotine replacement therapy (NRT) during pregnancy as a safer alternative to smoking, while not recommending use of stop smoking medications varenicline, cytisine or bupropion".[264]

5.2.3 Risk factors for Smoking

- **Socio-economic status**: Women in lower socio-economic groups are more likely to smoke, with smoking often linked to stress and mental health conditions.[265] Women from the most socio-economically deprived 10% of the population are six times more likely to smoke than those from the most affluent 10%.[261]
- **Mental health**: Women with mental health conditions, including depression and anxiety, are more likely to smoke and less likely to quit.[266]
- **Pregnancy**: Smoking during pregnancy is the primary modifiable risk factor associated with adverse birth outcomes, such as stillbirth, miscarriage, and preterm birth.[267]
- **Age**: Smoking initiation typically occurs during adolescence or early adulthood, with young women more likely to take up smoking during periods of stress or social pressure.[268]
- **Disability**: Adults with disabilities are more likely to smoke than those without disabilities.[269]
- **Sexual Orientation**: Lesbian, gay, bisexual and transgender people were more likely to be current cigarette smokers, when compared to heterosexual/straight people. The gap is more pronounced for women.[270, 271]

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[263] Department of Health. Towards a smoke-free generation: a tobacco control plan for England 2017–2022. London: GOV.UK; 2017 Jul. Available from: https://assets.publishing.service.gov.uk/media/5a822dc740f0b6230269b419/Towards_a_Smoke_free_Generation_-A_Tobacco_Control_Plan_for_England_2017-2022__2.pdf

[264] NHS England. Saving Babies' Lives Care Bundle Version 3 [Internet]. London: NHS England; 2023 Mar. Available from: https://www.england.nhs.uk/long-read/saving-babies-lives-version-3/

[265] Action on Smoking and Health. UK Smoking Statistics. Thorax [Internet]. 2023 Oct 1;43(10):801–1. Available from: https://ash.org.uk/uploads/Smoking-Statistics-Fact-Sheet.pdf?v=1697728811

[266] Public Health England. Health matters: smoking and mental health. London. 2020 Available from: https://www.gov.uk/government/publications/health-matters-smoking-and-mental-health/health-matters-smoking-and-mental-health

[267] Tobacco Advisory Group of the Royal College of Physicians. Hiding in plain sight Treating tobacco dependency in the NHS A report by the Tobacco Advisory Group of the Royal College of Physicians. 2018. Available from: https://www.rcp.ac.uk/media/bdnj2ykk/hiding-in-plain-sight.pdf

[268] Action on Smoking and Health. Young People and Smoking [Internet]. ASH. 2024. Available from: https://ash.org.uk/resources/view/young-people-and-smoking

[269] Emerson E. Smoking among adults with and without disabilities in the UK. J Public Health (Oxf). 2018 Dec 1;40(4):e502-e509. doi: 10.1093/pubmed/fdy062. PMID: 29617853.

[270] Action on Smoking and Health. Smoking: LGBT [Internet]. London: ASH; [cited 2025 Sep 27]. Available from: https://ash.org.uk/uploads/HIRP-LGBT-community.pdf?v=1652365376

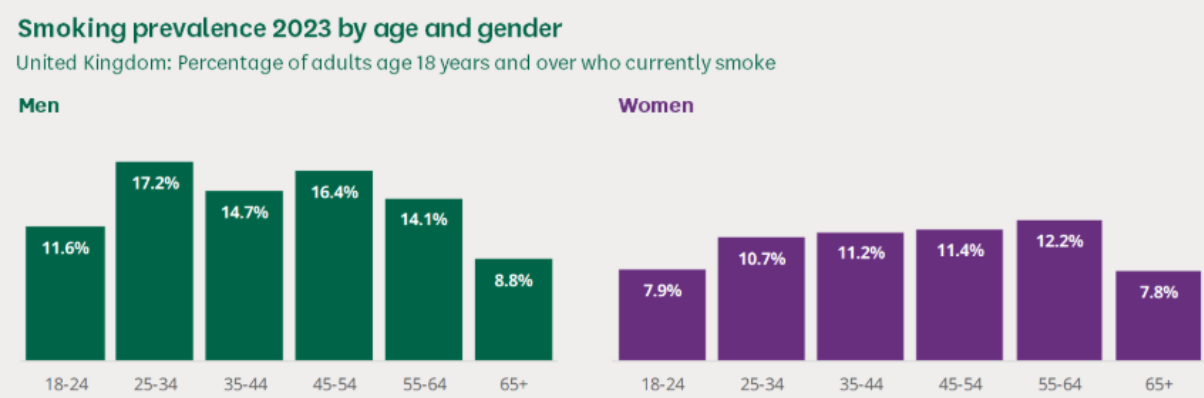
[271] Hagger-Johnson G, Taibjee R, Semlyen J, et alSexual orientation identity in relation to smoking history and alcohol use at age 18/19: cross-sectional associations from the Longitudinal Study of Young People in England (LSYPE)BMJ Open 2013;3:e002810. doi: 10.1136/bmjopen-2013-002810

5.2.4 Level of Need

5.2.4.1 National

- In 2023, around 11.9% of people aged 18 years and over in the UK were current smokers, equating to around 6 million people.
- Men were significantly more likely to smoke than women in the UK, with 13.7% of men and 10.1% of women reporting that they were current smokers in 2023.
- Smoking prevalence for women was highest among those aged 55-64 years, and lowest among those aged 65 year and over.[272]

Figure 66: Smoking Prevalence 2023 by age and gender



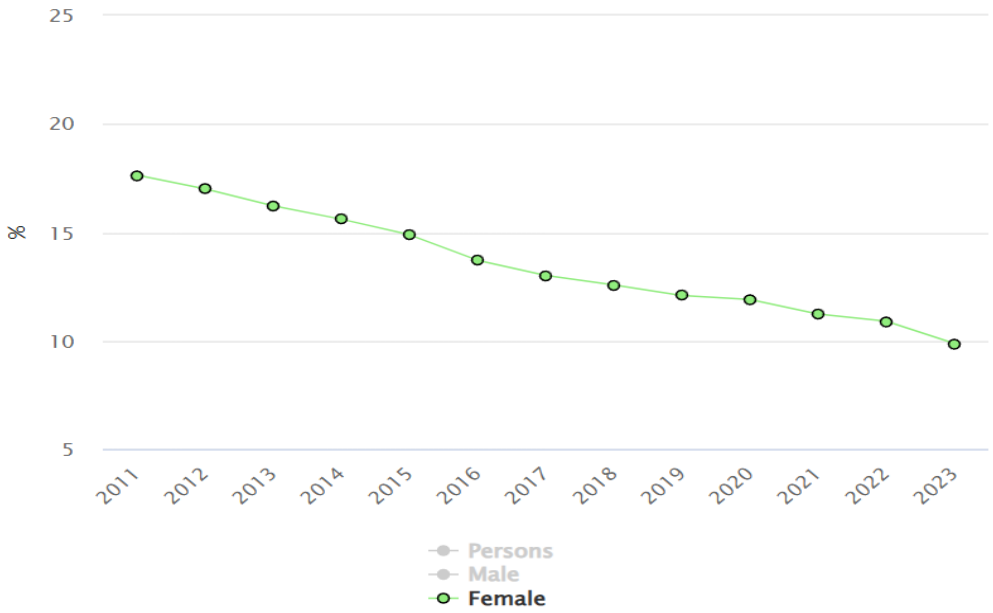
Source: UK Parliament

- Smoking prevalence among women has been steadily declining over the past few decades.[273]
- Smoking prevalence is highest for men and women in Mixed and White ethnic groups and lowest for Asian and Chinese women.

[272] UK Parliament. Statistics on Smoking. 2025. Available from: https://commonslibrary.parliament.uk/research-briefings/cbp-7648/

[273] Smoking Profile - Data | Fingertips | Department of Health and Social Care [Internet]. Phe.org.uk. 2025 [cited 2025 Jan 8]. Available from: https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132885/pat/159/par/K02000001/ati/15/are/E92000001/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-pt-1_ine-yo-1:2023:-1:-1_ine-ct-4

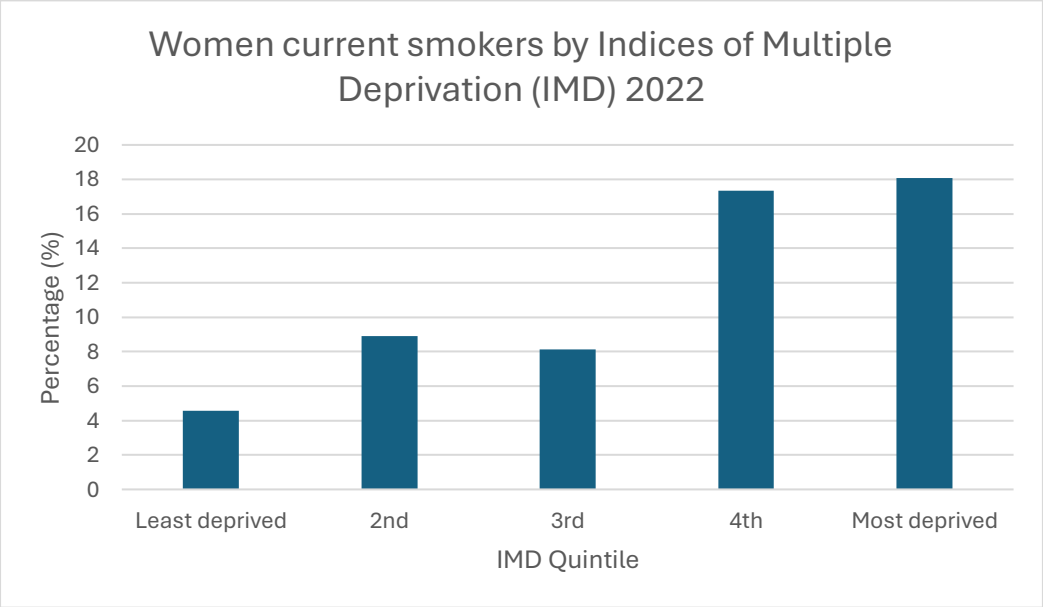
Figure 67: Smoking Prevalence in Females Aged 18 and over in England.



Source: OHID. Smoking Prevalence

- Smoking prevalence is correlated with deprivation status, with those living the most deprived areas, more likely to smoke.

Figure 68:Cigarette smoking status in women, by Index of Multiple Deprivation (IMD), 2022

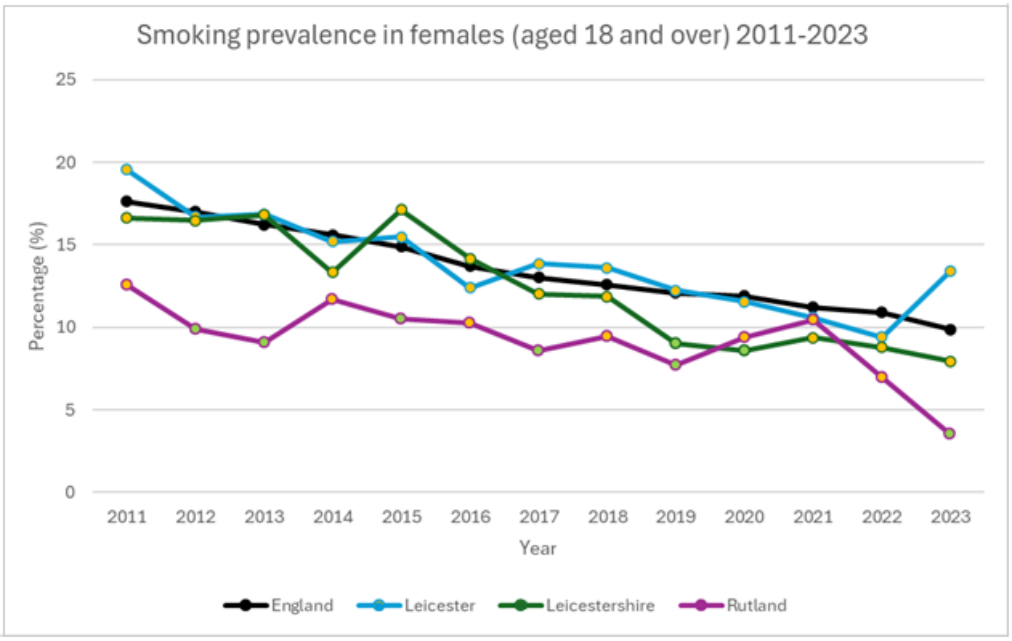


Source: Health Survey for England 2022

5.2.4.2 Leicester, Leicestershire and Rutland

Over the past decade smoking prevalence has declined significantly across LLR. Even Rutland, who are consistently lower than the England average, has significantly reduced smoking prevalence, from 13.4% (women 12.5%) in 2011 to 4.6% (women 3.5%) in 2023. Currents rates in Leicestershire are 9.5% (7.9%) and within Leicester City are 14.6% (13.3%).

Figure 69: Smoking prevalence in females between 2011 and 2023



Source: OHID, Smoking Profile

While men generally have higher smoking rates nationally, this pattern does not appear locally, where both male and female rates are similar when compared to area averages. The absence of a clear trend may be due to limited sample sizes and thus broader confidence intervals.

Across the districts and boroughs of Leicestershire, prevalence rates vary, with Charnwood being significantly better than the England average, however all areas are statistically similar to each other, as denoted by the overlapping confidence intervals.

Figure 70: Smoking prevalence in adults (aged 18 and over) – current smokers (1 year range)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	11.6	11.3	12.0
Leicestershire	–	-	9.5	6.7	12.2
Oadby and Wigston	–	-	17.4	4.6	30.1
Blaby	–	-	11.2	3.8	18.5
North West Leicestershire	–	-	9.9	1.3	18.5
Harborough	–	-	9.9	4.5	15.2
Melton	–	-	9.6	0.0	19.2
Hinckley and Bosworth	–	-	8.9	1.4	16.3
Charnwood	–	-	6.2	2.1	10.3

Source: OHID, based on Office for National Statistics data

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

When disaggregated by gender, female prevalence is varied by area.

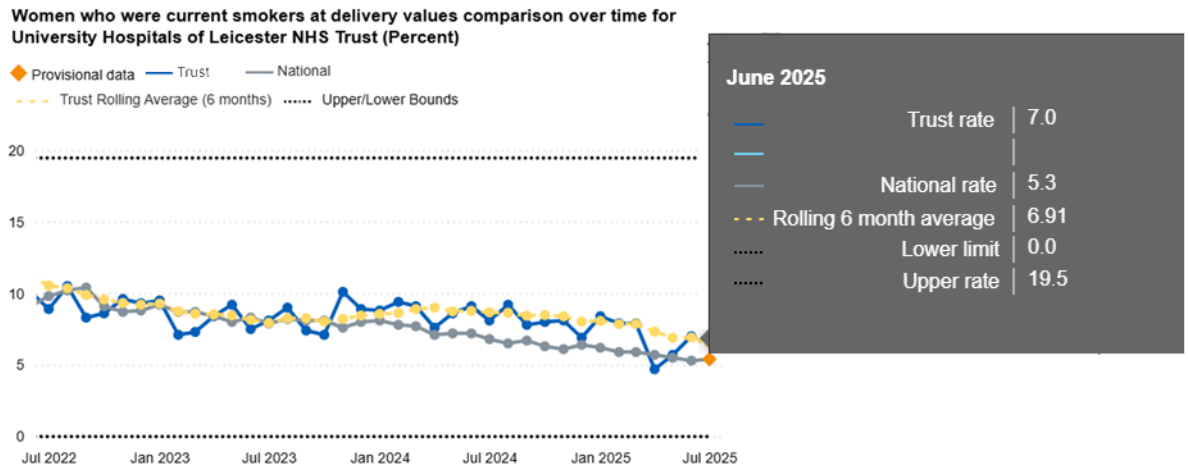
Table 12: Smoking prevalence in female adults 2023

District	Smoking prevalence (%)	Females (%)
Oadby & Wigston	17.4%	23.1%
Harborough	9.9%	8.3%
Hinckley & Bosworth	8.9%	11.4%
Blaby	11.2%	7.6%
Melton (2022 data)	10.8%	11.1%
North West Leicestershire	9.9%	10.6%
Charnwood	6.2%	2.4%

5.2.4.3 Smoking at time of Delivery

Smoking at the time of delivery (SATOD) remains a key indicator of maternal health and health inequalities across England. In quarter 1, 2025-26, 4.7% of pregnant women were known to be smokers at the time of delivery in England.[274] For the same time period locally, Leicester was 7.3%, Leicestershire and Rutland combined were 5.3%. Maternity Services Data Set (MSDS) shows the rate within UHL as of June 2025 to be 7%, higher than the national rate of 5.3%, with a rolling 6-month average of 6.91%.

Figure 71: SATOD within University Hospital's of Leicester July 2022 – July 2025



Source: Maternity Services Data Set

5.2.5 What evidence- based management is recommended

Effective smoking cessation interventions for women should combine behavioural support with pharmacotherapy, as recommended by NICE guideline NG209.[275] Behavioural support includes one-to-one counselling, group therapy, motivational interviewing, and digital interventions such as SMS and app-based support. According to a Cochrane Review, counselling increases quit success by 44%, and financial incentives by 46%, compared to no support. These findings are particularly relevant for women, who may benefit from tailored

[274] NHS England. Statistics on women's smoking status at time of delivery: England, Q1 2025/26 [Internet]. Leeds: NHS England; 2025 Sep 18. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england-q1-2025-26

[275] National Institute for Health and Care Excellence. Tobacco: preventing uptake, promoting quitting and treating dependence. NG209.London: NICE; 2021. Available from: https://www.nice.org.uk/guidance/ng209

support that addresses gender-specific stressors, mental health comorbidities, and pregnancy-related challenges.[276]

Pharmacotherapy options include nicotine replacement therapy (NRT), varenicline, e-cigarettes, cytisine and bupropion. Combining pharmacotherapy with behavioural support significantly improves quit rates compared to either approach alone. For pregnant women, NRT is recommended as the safest option, while varenicline, cytisine and bupropion are generally avoided due to limited safety data in pregnancy.[275]

Stop Smoking Services offer free, personalised support through trained advisers. These services provide access to NRT, behavioural counselling, and relapse prevention strategies. Smokers are up to three times more likely to quit successfully when using both treatment and support from stop smoking services.[277]

5.2.6 Current Services in LLR

Across Leicester, Leicestershire and Rutland (LLR), a range of smoking cessation services are available to support women. In Leicester City, the Live Well Leicester service offers a 12 week programme of free behavioural support, nicotine replacement therapy (NRT), and access to e-cigarettes. In Leicestershire and Rutland, Quit Ready delivers a 12-week stop smoking programme that includes behavioural support, NRT, and e-cigarettes.

The CURE Project, operating within University Hospitals Leicester (UHL), provides immediate nicotine replacement and the option of smoking cessation support to hospitalised patients.[278]

Support for pregnant women is systematised across LLR. Women are asked whether they smoke at their booking appointment and have a carbon monoxide reading. Those with a reading of 4ppm+ should have an opt-out referral to the Maternity CURE team. Referrals are picked up by an advisor from the women's corresponding local authority stop smoking service (Live Well or Quit Ready). Women are supported to quit using behavioural support and are offered free nicotine replacement therapy as a first line treatment option as per NICE recommendations or e-cigarettes if at their request. Pregnant women are offered home visits by an advisor and where possible will be supported by the same advisor throughout their pregnancy. The advisor will update the UHL maternity electronic system to update midwives of progress towards a quit attempt . All women have access to a financial incentive scheme funded by the Department of Health which offers them up to £400 of vouchers if they stay quit throughout their pregnancy and for 3 months postnatal.

CURE Maternity advisors see women who are admitted to hospital maternity wards and support them with nicotine replacement therapy during their stay and support them to start a quit

QuitReady provides enhanced support for smokers living with serious mental illness, recognising their higher levels of tobacco dependence and the complex challenges they face in quitting. Support is delivered collaboratively with community psychiatric nurses (CPN) and GPs, ensuring quit plans are safe and personalised with wider mental health care. The service

[276] Hartmann-Boyce J, Livingstone-Banks J, Ordóñez-Mena JM, Fanshawe TR, Lindson N, Freeman SC, Sutton AJ, Theodoulou A, Aveyard P. Behavioural interventions for smoking cessation: an overview and network meta-analysis. Cochrane Database of Systematic Reviews 2021, Issue 1. Art. No.: CD013229. DOI: 10.1002/14651858.CD013229.pub2.
[277] NHS. NHS stop smoking services help you quit. London: NHS. Available from: https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/
[278] Leicester City Council. The CURE Project [Internet]. Leicester: Leicester City Council. Available from: https://www.leicester.gov.uk/health-and-social-care/public-health/get-help-to-stop-smoking/the-cure-project/

offers extended behavioural support if needed and careful prescribing of nicotine containing products in line with NICE guidance. This targeted approach seeks to reduce health inequalities and premature mortality for women with SMI who remain disproportionately affected by tobacco use.

5.2.7 Unmet needs or gaps

This chapter focuses on tobacco smoking and does not include detailed analysis of vaping, e-cigarette, nicotine pouches or waterpipe use. While vaping is increasingly common, especially among younger women, current local and national data collection prioritises smoking due to its well-established health risks and policy relevance. Future assessments may explore vaping in more depth as evidence and guidance evolve.

Although smoking at time of delivery rates are decreasing across LLR, the referral rate for pregnant smokers at the time of booking with maternity services is 60%. This is significantly below the national target of 90%.

Within LLR ICB it is estimated that 36% of people with SMI smoke. While there are strong indications that people with SMI smoke at much higher rates locally, data that specifically isolates women with SMI in LLR is currently not available.

Current data on vaping among women, intersectional smoking patterns (including ethnicity, disability, and LGBTQ+ status), and long-term quit outcomes remains limited. This could present challenges for service planning and evaluation.

5.2.8 Recommendations

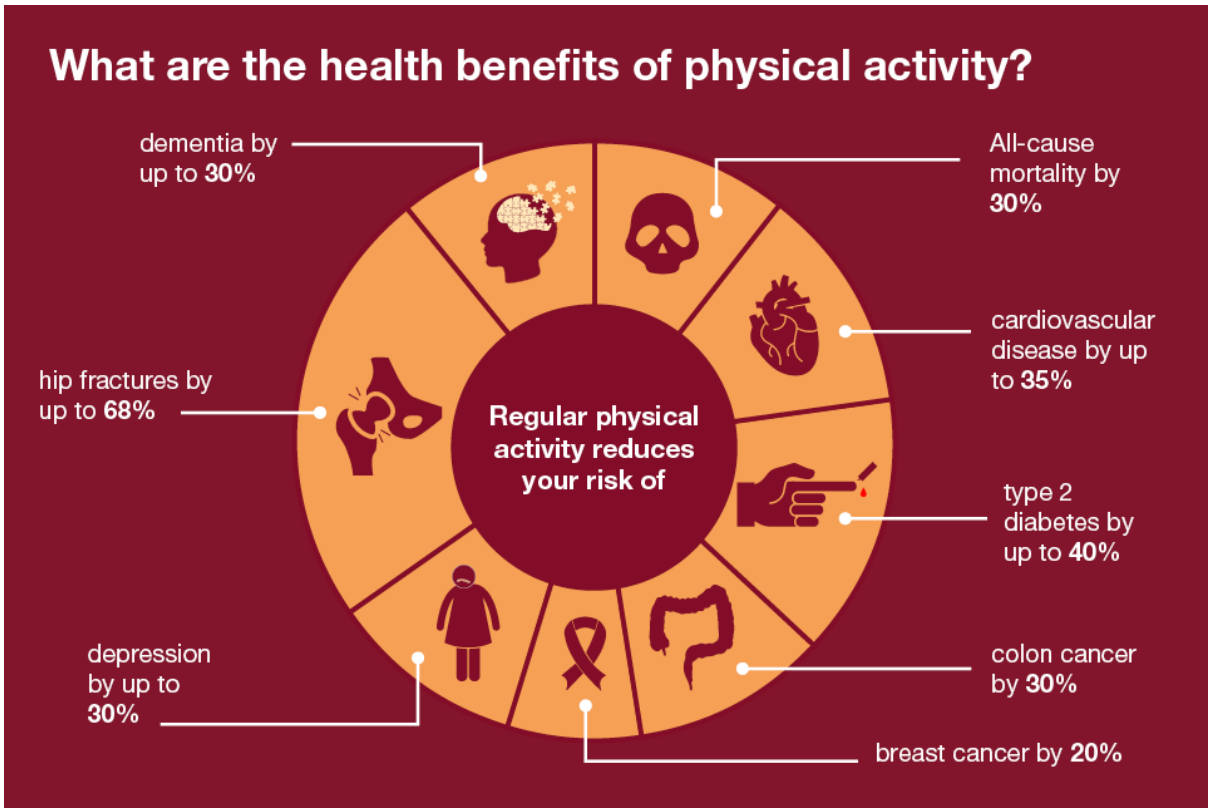
- Explore why local smoking prevalence is similar between men and women, unlike national trends. Use this insight to refine service targeting and messaging.
- Continue tracking service engagement across gender and intersecting characteristics to identify gaps and tailor outreach accordingly.
- Ensure strong partnership working between NHS services and local stop smoking services, supporting patients to stop smoking in the best way possible for them e.g. to further reduce SATOD rates.
- Ensure true opt out system fully implemented for pregnant women who have a carbon monoxide reading over 4 at their booking appointment and they are referred to an advisor.
- Strengthen primary care engagement to encourage rapid electronic referral to community stop smoking services.
- Ensure consistent availability of all NICE recommended pharmacotherapies across LLR stop smoking services and NHS Tobacco Dependence Services.
- Continue and strengthen the enhanced stop smoking service for people with serious mental illness, working in partnership with community psychiatric nurses and GP's to improve quit outcomes across Leicestershire & Rutland. Work with partners to obtain smoking prevalence data for SMI smokers gender disaggregated
- Strengthen routine data sharing on quit outcomes with primary care to track long term quit rates and relapse.

5.3 Physical Activity

5.3.1 Background

World Health Organisation refers to physical activity as 'all movement'. Walking, cycling, wheeling sports and active recreation/play can be participated by and enjoyed by the majority of people.[279] Physical activity is a foundational determinant of health, with benefits spanning cardiovascular, musculoskeletal, metabolic, and mental health domains.[280] The UK Chief Medical Officers' Guidelines recommend adults engage in at least 150 minutes of moderate intensity activity weekly, alongside muscle-strengthening activities on two days per week. There are also specific guidelines aimed at disabled adults, and during pregnancy and after childbirth.[281] Despite this, over a quarter of adults in England are classified as inactive, with women disproportionately affected. **This issue accounts for one in six UK deaths** and costs £7.4 billion each year, including £0.9 billion to the NHS. The population is now about 20% less active than in the 1960s, with a projected decrease to 35% by 2030 if trends persist.[280]

Figure 72: Health benefits of physical activity



Source: OHID, Applying All Our Health

[279] World Health Organisation. Physical Activity [Internet]. World Health Organization. 2024. Available from: https://www.who.int/health-topics/physical-activity#tab=tab_1

[280] Office for Health Improvement and Disparities. Physical activity: applying All Our Health. London: Department of Health and Social Care; 2022 Mar 10. Available from: https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health

[281] Department of Health and Social Care. UK Chief Medical Officers' Physical Activity Guidelines. London: DHSC; 2019. Available from: https://www.gov.uk/government/publications/physical-activity-guidelines-infographics

During pregnancy, physical activity can lower the risks of gestational diabetes,[282] back and pelvic pain,[283] mental health conditions[284] and preeclampsia.[285] Women reporting higher levels of physical activity also have higher quality of life measures[286] and the odds of having a caesarean section can be lowered.[287]

The Active Together Partnership Framework (2022–2031) sets out a bold vision for Leicestershire, Leicester and Rutland (LLR): "A place where physical activity is part of daily life, leading to people living healthier and happier lives.". It recognises physical activity as a tool to reduce health inequalities, improve mental wellbeing, and foster community cohesion.[288]

5.3.2 Risk factors for Physical Inactivity

- **Age**: Physical activity levels generally decline with age.
- **Socio-economic status**: Women from lower socio-economic backgrounds often face greater barriers to engaging in physical activity, such as financial constraints, lack of time, and limited access to facilities.
- **Health conditions**: Chronic conditions such as arthritis, obesity, and mental health issues may limit the ability or motivation to engage in physical activity. Inactivity correlates with lower life satisfaction and higher anxiety.
- **Disability and long-term conditions**: Women with disabilities are less likely to meet activity guidelines.
- **Cultural and social norms**: Longstanding inequalities mean that those from black and ethnic minority backgrounds are less likely to engage in physical activity than others.[280, 289, 290]

Women's experiences of physical activity are shaped by a complex interplay of biological, social, cultural, and structural factors. Unlike men, women often navigate additional layers of responsibility, expectation, and constraint that influence their ability to engage in regular movement. These include disproportionate caregiving roles, societal norms around femininity and exertion, and systemic barriers in service design and accessibility. Understanding these gendered dimensions is essential to designing equitable and effective physical activity interventions, as well as being able to communicate and encourage women to be active in their daily lives.

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[282] Russo LM, Nobles C, Ertel KA, Chasan-Taber L, Whitcomb BW. Physical Activity Interventions in Pregnancy and Risk of Gestational Diabetes Mellitus: A Systematic Review and Meta-analysis. Obstet & Gynecol. 2015;125(3):576-582. doi:10.1097/AOG.0000000000000691

[283] Liddle SD, Pennick V. Interventions for preventing and treating low-back and pelvic pain during pregnancy. Cochrane Database Syst Rev 2015; Issue 9. Art. No.: CD001139. DOI: 10.1002/14651858.CD001139.pub4

[284] Morres ID, Tzouma N-A, Hatzigeorgiadis A, Krommidas C, Kotronis KV, Dafopoulos K, et al. Exercise for perinatal depressive symptoms: A systematic review and meta-analysis of randomized controlled trials in perinatal health services. J Affect Disord. 2022; 298(Part A):26-42. https://doi.org/10.1016/j.jad.2021.10.124

[285] Aune D, Saugstad OD, Henriksen T, Tonstad S. Physical Activity and the Risk of Preeclampsia: A Systematic Review and Meta-Analysis. Epidemiology 2014;25(3):331-43. doi: 10.1097/EDE.0000000000000036

[286] Krzepota J, Sadowska D, Biernat E. Relationships between Physical Activity and Quality of Life in Pregnant Women in the Second and Third Trimester. Int J Environ Res Public Health. 2018 [cited 2022 May 5];15(12):2745. doi: 10.3390/ijerph15122745.

[287] International Weight Management in Pregnancy (i-WIP) Collaborative Group. Effect of diet and physical activity based interventions in pregnancy on gestational weight gain and pregnancy outcomes: meta-analysis of individual participant data from randomised trials. BMJ 2017 [cited 2022 May 4]; 358:j3119. https://doi.org/10.1136/bmj.j3119

[288] Active Together. Active Together Partnership Physical Activity Framework 2022–2031. Active Together; 2022. Available from: https://www.active-together.org/framework

[289] World Health Organisation. Physical Activity Key Facts [Internet]. World Health Organization. 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/physical-activity

[290] Sport England. Active Lives Adult Survey November 2022-23 Report sportengland.org [Internet]. 2024 Apr. Available from: https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2024-04/Active%20Lives%20Adult%20Survey%20November%202022-23%20Report.pdf?VersionId=veYJTP_2n55UdOmX3PAXH7dJr1GA24vs

- Caring and Childcare Responsibilities
    - Women are disproportionately affected by unpaid caregiving roles, including childcare, eldercare, and domestic responsibilities. These roles often limit time, energy, and opportunity for physical activity. The Royal Society for Public Health (RSPH) identifies "competing factors on time" and "family organisation and roles" as key barriers. This is particularly acute for single mothers and women in low-income households, where access to childcare and flexible services is limited.[291, 292, 293]
- Stigma and Cultural Norms
    - Stigma around women being physically active, especially during pregnancy, remains pervasive. Studies show that pregnant women often fear judgement or harm to the baby, leading to reduced activity levels. Some report being told to "sit down" or avoid exertion, despite evidence supporting safe exercise during pregnancy. This stigma is compounded by societal expectations of passivity and fragility in pregnancy.[294, 295]
- Ethnicity and Cultural Barriers
    - Women from minority communities can face additional barriers to being active:
        - Cultural norms may discourage certain types of physical activity, especially in mixed-gender environments.[296]
        - Modesty requirements can limit participation in activities like swimming or gym classes.[296]
- Accessibility and Infrastructure
    - Access to safe, affordable, and culturally appropriate facilities is uneven:
        - Swimming pools may lack women-only sessions or appropriate changing facilities.
        - Transport costs and location are significant barriers, especially in rural areas.
        - Safety concerns (e.g., poorly lit parks or lack of surveillance) disproportionately affect women's willingness to engage in outdoor activity.[297, 298]
- Mental Health and Stigma
    - Low self-esteem, anxiety, and depression are both causes and consequences of inactivity.[299]

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[291] Peng B, Ng JYY, Ha AS. Barriers and facilitators to physical activity for young adult women: a systematic review and thematic synthesis of qualitative literature. Int J Behav Nutr Phys Act. 2023;20(1):23. Published 2023 Feb 27. doi:10.1186/s12966-023-01411-7

[292] Sparks JR, Flanagan EW, Kebbe M, Redman LM. Understanding Barriers and Facilitators to Physical Activity Engagement to Inform a Precision Prescription Approach during Pregnancy. Am J Lifestyle Med. 2022;17(1):108-122. Published 2022 Jul 19. doi:10.1177/15598276221108669

[293] Royal Society for Public Health. Level 2 Award in Encouraging Physical Activity. London: RSPH; 2020. Available from: https://www.rsph.org.uk/media/filer_public/61/0b/610ba5a7-85f1-4be6-8512-0f093b4d2b84/level_2_award_in_encouraging_physical_activity.pdf

[294] McKeough R, Blanchard C, Piccinini-Vallis H. Pregnant and Postpartum Women's Perceptions of Barriers to and Enablers of Physical Activity During Pregnancy: A Qualitative Systematic Review. J Midwifery Womens Health. 2022;67(4):448-462. doi: 10.1111/jmwh.13375

[295] Harrison AL, Taylor NF, Shields N, Frawley HC. Attitudes, barriers and enablers to physical activity in pregnant women: a systematic review. J Physiother. 2018 ; 64(1):24-32. https://doi.org/10.1016/j.jphys.2017.11.012

[296] Liverpool John Moores University. Cultural influences on physical activity and diet. Liverpool: LJMU; 2023. Available from: https://www.ljmu.ac.uk/microsites/promoting-healthy-weight-in-pre-school-children/modules/cultural-considerations/cultural-influences-on-physical-activity-and-diet

[297] Mbabazi J, Kanmodi KK, Kunonga E, Tolchard B, Nnyanzi L. Barriers and facilitators of physical activity: a systematic review of reviews. J Health Allied Sci NU. 2022;12(3):1–12. Available from: https://research.tees.ac.uk/en/publications/barriers-and-facilitators-of-physical-activity

[298] Women's Sport and Fitness Foundation. Barriers to sports participation for women and girls. London: WSFF; 2024. Available from: https://www.wsff.org.uk/resources/how-women-experience-sport-and-fitness/barriers-to-sports-participation-for-wom

[299] Mental Health Foundation. Physical activity and mental health [Internet]. London: Mental Health Foundation; 2023. Available from: https://www.mentalhealth.org.uk/cy/explore-mental-health/a-z-topics/physical-activity-and-mental-health

- Women report feeling embarrassed, judged, or regarded as “not fit enough” to participate in physical activities, or undergo ‘social identity threat’ when they undertake an activity stereotyped ‘masculine’. This stigma can be particularly acute for women with learning disabilities or mental health conditions.[300, 301]

- Pelvic Health
  - Pelvic health issues including urinary incontinence, pelvic organ prolapse, and pelvic pain are significant barriers to physical activity for many women. Research shows that up to one in three women may experience pelvic floor symptoms, which can lead to embarrassment, fear of leakage, or discomfort during exercise.[302] These concerns often result in women avoiding certain activities, reducing exercise intensity, or withdrawing from group and high-impact exercise altogether. The stigma and lack of awareness around pelvic health, uncertainty about safe exercises, and limited access to specialist support further compound these barriers. Addressing pelvic health openly and providing access to women’s health physiotherapy and tailored exercise guidance are essential to enable more women to participate confidently and safely in physical activity.[303]

5.3.3 Level of Need

5.3.3.1 Physical activity and inactivity

- Nationally, females are significantly less physically active than males.
- Over the past decade, the percentage of women classed as physically active has risen significantly, however this only equates to an additional 1.4% of women being physically active from 63.5% in 2015/16 to 64.9% in 2023/24. For all years, there are significantly higher proportions of men reporting being physically active.

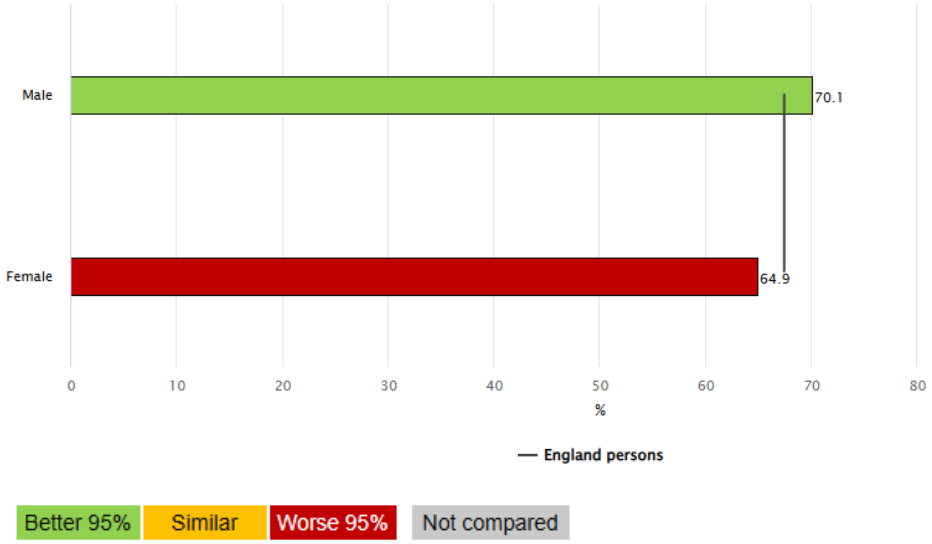
[300] White RL, Vea S, Bidde S, Sutcliffe J, Guagliano JM, Uddin R, et al.. Physical activity and mental health: a systematic review and best-evidence synthesis of mediation and moderation studies. Int J Behav Nutr Phys Act. 2024;21:134. doi:10.1186/s12966-024-01676-6

[301] Chalabaev A, Mazéas A, Forestier C, Sniehotta FF. “I am fatigued of being stigmatized”: On the need to investigate stigma-related barriers to physical activity. Movement & Sport Sciences - Science & Motricité. 2023;(120):33-40. Available from: https://hal.science/hal-04367276/file/Chalabaev%20et%20al_S%26M_AcceptedManuscript.pdf

[302] Royal College of Obstetricians and Gynaecologists. RCOG calling for action to reduce number of women living with poor pelvic floor health [Internet]. London: RCOG; 2023. Available from: https://www.rcog.org.uk/news/rcog-calling-for-action-to-reduce-number-of-women-living-with-poor-pelvic-floor-health/

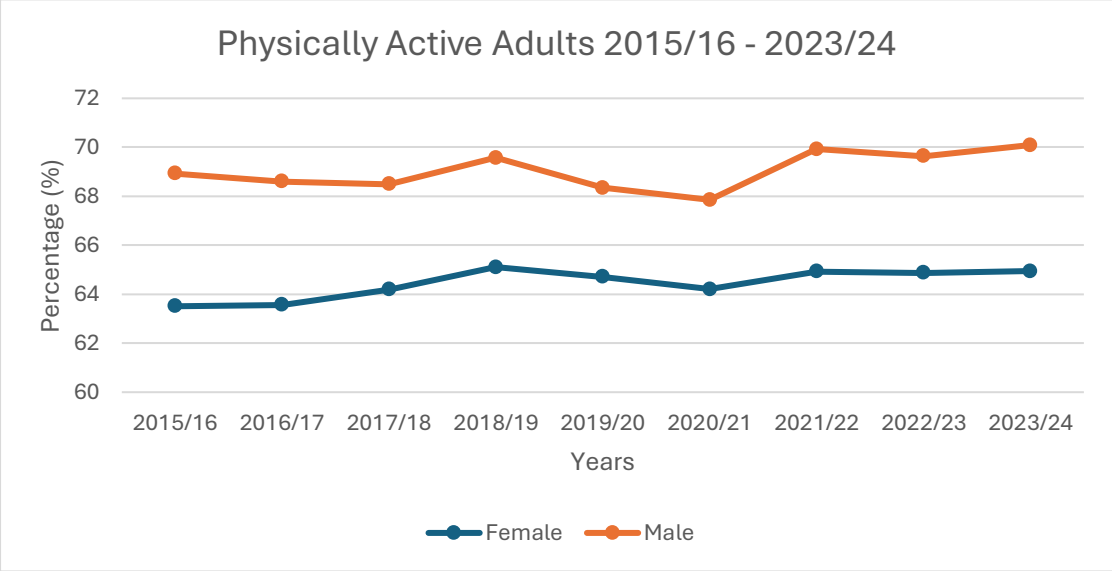
[303] Dakic JG, Hay-Smith J, Cook J, Lin KY, Calo M, Frawley H. Effect of Pelvic Floor Symptoms on Women's Participation in Exercise: A Mixed-Methods Systematic Review With Meta-analysis. J Orthop Sports Phys Ther. 2021 Jul;51(7):345-361. doi: 10.2519/jospt.2021.10200. Epub 2021 May 10. PMID: 33971737.

Figure 73: Physically active adults by gender 2023/24



Source: OHID, Obesity and Physical Activity Profile

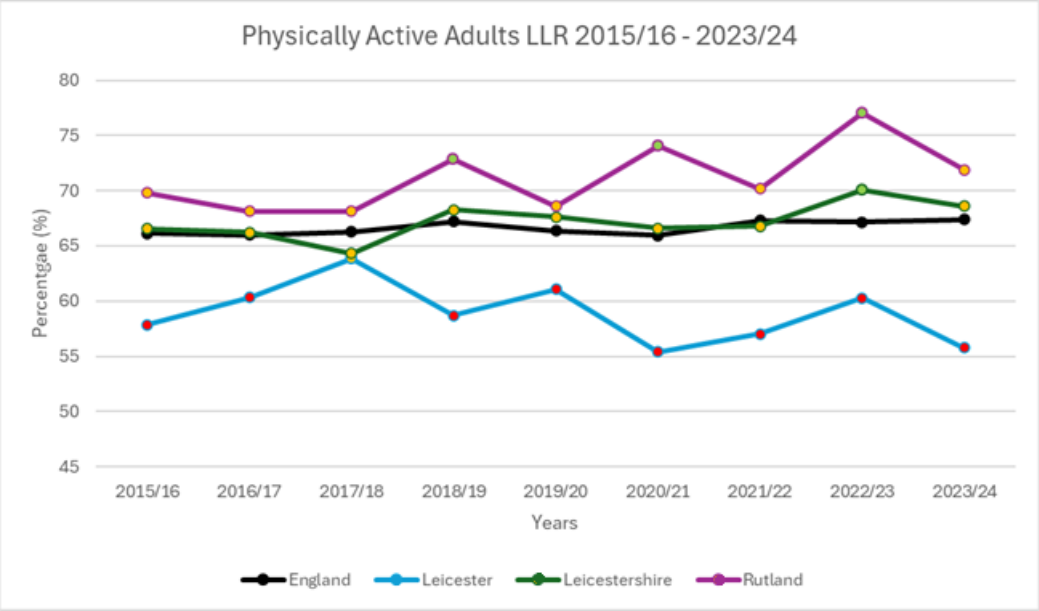
Figure 74: Percentage of physically active adults by gender 2015/16 – 2023/24



Source: OHID, Obesity and Physical Activity Profile

- Across LLR, percentages of physically active adults vary by upper tier local authority, as demonstrated in Figure 67. Leicester City has persistently seen significantly lower levels of physical activity.

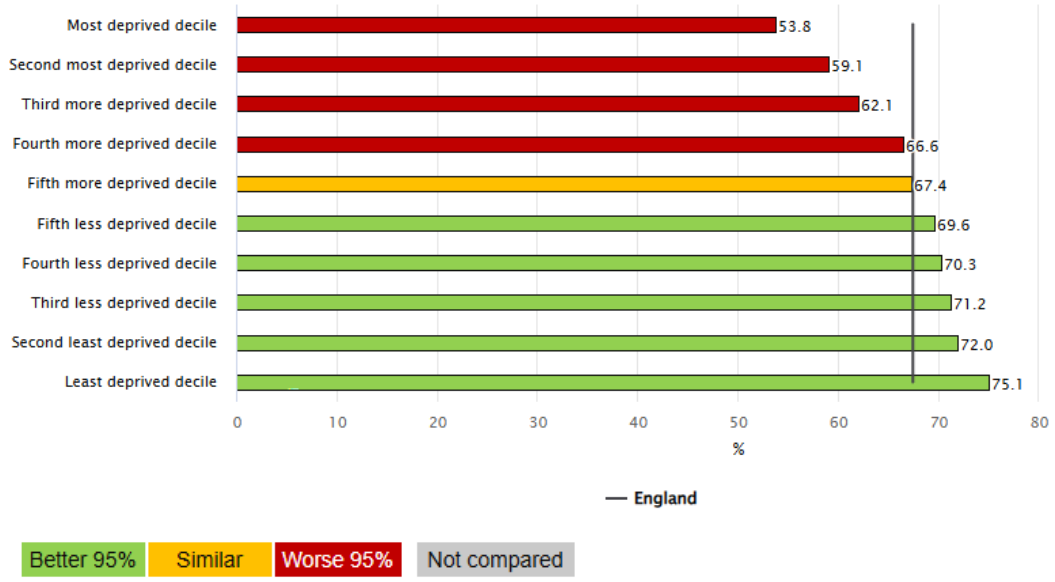
Figure 75: Percentage of physically active adults across LLR 2015/16-2023/24



Source: OHID, Obesity and Physical Activity Profile

- There is a social gradient in physical activity, with wealthier individuals typically being more active than those who are less affluent. Unfortunately, this data is not available at a local level.

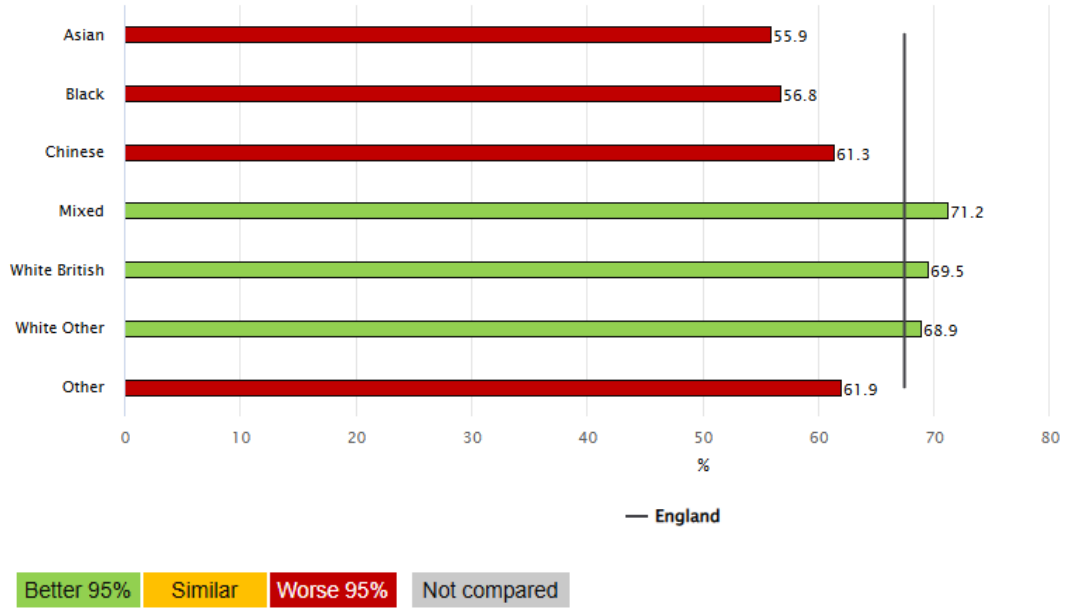
Figure 76: Percentage of physically active adults 2023/24 by deprivation decile



Source: OHID, Obesity and Physical Activity Profile

- Nationally, those of Mixed Ethnicity, White British, or White Other are significantly more active than other ethnic groups.

Figure 77: Percentage of physically active adults 2023/24 by ethnic group



Source: OHID, Obesity and Physical Activity Profile

Physical inactivity is defined as engaging in less than 30 minutes of physical activity per week. While increasing the activity levels of all adults who are not meeting the recommendations is important, targeting those adults who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease.[304]

Nationally, in 2023/24 22% of adults were classed a physically inactive. Across LLR, percentages of inactive adults varies. According to Fingertips data:

- Leicester City is significantly worse than the England average, with 30.8% of adults inactive.
- Leicestershire is similar to the England average, with 20.8% of adults inactive.
- Rutland is significantly better than the England average, with 16.4% of adults inactive.

5.3.3.2 Physical activity during pregnancy

Local data on physical activity prevalence during pregnancy is not available and is also not routinely collected nationally.

National and international evidence consistently shows that most pregnant women in the UK do not achieve the recommended levels of physical activity. The 2019 UK Chief Medical Officers' guidelines recommend at least 150 minutes of moderate-intensity activity per week during pregnancy,[304] yet national surveys and studies indicate that only a minority of women meet these guidelines.[305]

Inequalities in physical activity during pregnancy are well documented. Women from lower socioeconomic backgrounds, those living in areas of higher deprivation, and women from

[304] Department of Health and Social Care. UK Chief Medical Officers' Physical Activity Guidelines. London: DHSC; 2019. Available from: https://www.gov.uk/government/publications/physical-activity-guidelines-uk-chief-medical-officers-report
[305] Active Pregnancy Foundation. UK Physical Activity Guidelines for Pregnancy: Infographic and Evidence Summary. London: Active Pregnancy Foundation; 2022. Available from: https://www.activepregnancyfoundation.org/_files/ugd/4c66ce_b394d528788d4b9b85d9e9256972a0e2.pdf

Black, Asian and minority ethnic communities are less likely to be physically active during pregnancy. A systematic review by Coll et al. (2017) found that women with lower educational attainment, lower income, and those from minoritised ethnic groups were significantly less likely to meet physical activity recommendations in pregnancy. Barriers include lack of culturally appropriate services, limited access to safe spaces, and lower awareness of guidelines.[306]

5.3.4 What evidence- based management is recommended

The Chief Medical Officers' guidelines recommend:

- At least 150 minutes of moderate-intensity activity per week.
- Muscle-strengthening activities on two days per week.
- Reducing sedentary time and incorporating movement into daily routines.

These guidelines also apply to pregnant women and birthing people, however they should "listen to their body and adapt" and "don't bump the bump".

NICE has a range of guidance and quality standards on physical activity, largely covering ways in which to encourage and promote physical activity, such as walking or cycling, in the workplace and brief advice within primary care. A Sport England review found that physical activity, exercise or activity-related community rehabilitation is recommended in 98 NICE clinical, condition and setting-specific guidelines and quality standards.

This HNA will not go into these in detail, but the intention is to highlight the significant amount of guidance and standards available.

In terms of pelvic floor dysfunction, NICE guidance 210 recommends promotion of physical activity to aid prevention. For women with pelvic floor dysfunction, the guidance recommends that supervised exercise, such as yoga, may help with their symptoms.[307]

5.3.5 Current Services in LLR

Active Together

Active Together is the Active Partnership for LLR. Their vision is:

Leicestershire, Leicester and Rutland; a place where physical activity is part of daily life, leading to people living healthier and happier lives.

Their focus is to ensure that physical activity resources have a local reach. They run various campaigns to support LLR residents to move more and advocate for physical activity opportunities through various means such as accessing funding and developing interventions, translating national evidence and campaigns into local deliverable actions and working to create active spaces and places.

[306] Coll CVN, Domingues MR, Gonçalves H, Bertoldi AD. Perceived barriers to leisure-time physical activity during pregnancy: literature review. Rev Bras Ginecol Obstet. 2017;39(12):622-630. Available from: https://www.scielo.br/j/rbgo/a/6Qk8K7J8Q6k8K7J8Q6k8K7J8/?lang=en

[307] National Institute for Health and Care Excellence (NICE). Pelvic floor dysfunction: prevention and non-surgical management [Internet]. London: NICE; 2021 Dec 9. Available from: https://www.nice.org.uk/guidance/ng210/resources/pelvic-floor-dysfunction-prevention-and-nonsurgical-management-pdf-66143768482501

They currently coordinate the Active Mum's Club, aimed at promoting and supporting physical activity pre- and post-natally within Leicestershire. They are supporting the health system to integrate physical activity into prevention and treatment pathways through Active Medicine.

Active Together also oversee LLR Girls Can, Active Menopause and Women's Activity Search, as well as providing Physical Activity Clinical Champion training.

Local Authorities

There are also various services across LLR to promote physical activity. These include:

- **Leicester City Council**: Live Well provide a range of physical activity opportunities.
- **Rutland County Council**: Living Well Rutland provide physical activity opportunities in Rutland.
- **Leicestershire:** District and Borough councils provide universal and targeted provision, as well as leisure centres.

Provision may be targeted at women.

5.3.6 Unmet needs or gaps

Data shows women are less likely to engage in physical activity due to factors like caring duties, stigma, cultural barriers, and accessibility. Addressing these systemic issues requires ongoing attention and an understanding of women's specific needs.

Physical activity services should consider women's time limitations, perceptions of judgement, body image concerns, financial and structural accessibility, and cultural appropriateness. Many services overlook women's pelvic health needs, and the benefits of exercise in this area are not widely known.

More research is needed into local service use and leisure options to identify and address inequalities. It's unclear if antenatal care routinely provides physical activity guidance. While there is considerable formal and private sector provision, greater support for informal opportunities may help women increase their activity levels.

5.3.7 Recommendations

- **Making Every Contact Count**: ensure approaches are utilised to maximise opportunities to promote physical activity to women, including with midwives, women's services and primary care. Ensure MECC conversations are tailored to life stage (e.g. pregnancy, postnatal, menopause) and consider cultural, physical, and emotional barriers to participation.
- **Target the least active for greatest population impact**: Prioritise interventions for women who are sedentary or inactive, particularly those from marginalised groups (e.g. low-income households, ethnic minorities, disabled women), however adoption of proportionate universalism should also be considered to ensure there are physical and promotional opportunities for the wider population.
- **Co-production**: design services and offers with women, ensuring they reflect their preferences, cultural contexts and life pressures. Build on successful programmes that Active Together operate, such as Active Mum's Club.
- **Safety**: create safe and welcoming spaces for women to be active. This includes consideration of leisure provision, and working to ensure safety is a key consideration during planning processes for housing and infrastructure.

- **Pelvic health**: support women with pelvic health issues. This should begin with prevention, ensuring the benefits of physical activity are promoted at the earliest possible opportunities.
- **Pre and post-natal:** Continue to offer opportunities in the pre- and post-natal period. Undertake analysis of pregnancy pathways to establish the level of physical activity information being provided and address any gaps that may be discovered.
- **Promotion:** Support promotion of the This Girl Can Campaign across LLR, alongside sharing local Let's Get Moving Champion stories showing how being physically activity has supported local women.
- **Menopause:** Continue to promote the benefits of physical activity for managing and coping with symptoms
- **Space utilisation:** Embed physical activity into settings which are commonly used by women – e.g. early years settings, family hubs, GP practices, gynae waiting rooms.
- **Transition points:** The biggest drop off in physical activity is when women leave school, career changes and pregnancy. Focus should be on supporting women through these transition periods.
- **Active Medicine:** Healthcare professionals and GP Practices should aim to engage with Active Together on Active Medicine.

5.4 Obesity and Healthy Weight

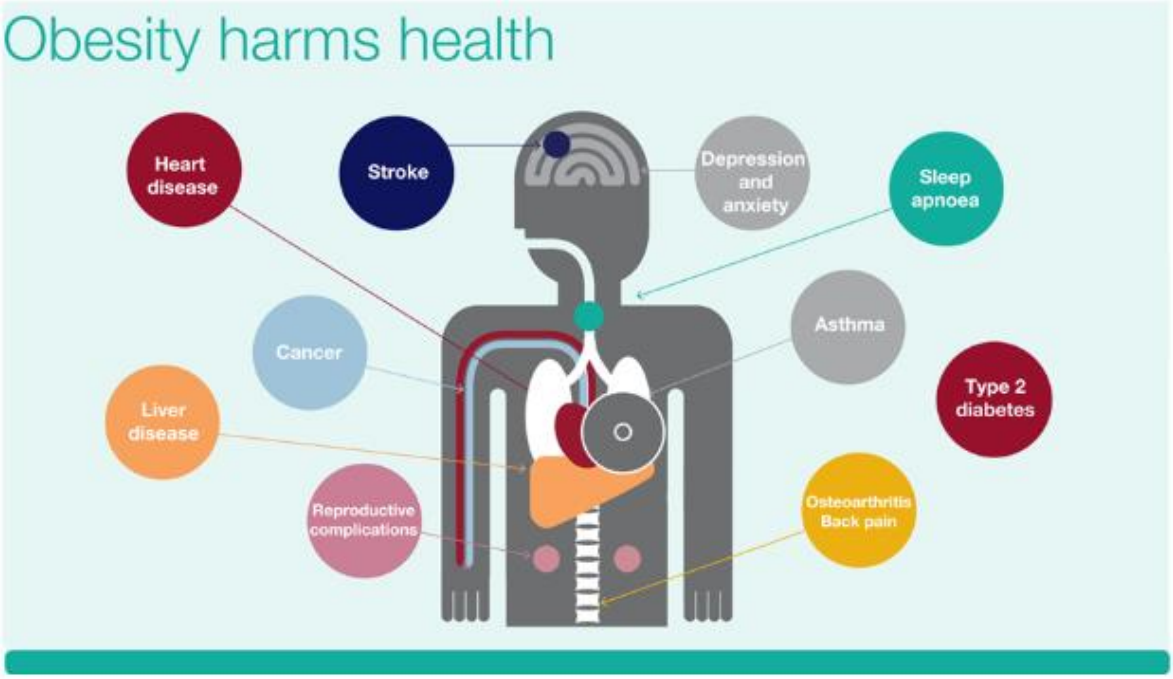
5.4.1 Background

Overweight, and especially obesity, are significant public health challenges with profound implications for women's health. Obesity is defined as a body mass index (BMI) of 30 or higher, with overweight defined as a BMI 25-29.9. However, due to a range of factors including varied adiposity distribution, health risk disparities and cultural and genetic factors, BMI ranges are different for Asian, Chinese, Middle Eastern, Black African and African-Caribbean background, with overweight being 23-27.4 and obesity being over 27.5.[308] Obesity affects physical, mental, and reproductive health outcomes in women. Worldwide, obesity rates among women are increasing, influenced by a range of biological, social, and environmental factors. [309]

[308] NHS. Obesity. 2023. Available from: https://www.nhs.uk/conditions/obesity/#:~:text=If%20you%20have%20an%20Asian,re%20in%20the%20obese%20range

[309] Phelps NH, Singleton RK, Zhou B, Heap RA, Mishra A, Bennett JE et al. Worldwide trends in underweight and obesity from 1990 to 2022: a pooled analysis of 3663 population-representative studies with 222 million children, adolescents, and adults. The Lancet. 2023;403(10431):1027-1050.doi: 10.1016/S0140-6736(23)02750-2

Figure 78: Health harms caused by obesity



Source: OHID, Adult Obesity: applying All Our Health[310]

Women face unique risks associated with obesity, including increased likelihood of polycystic ovary syndrome (PCOS), gestational diabetes, infertility, and pregnancy complications.[311, 312] Obesity also heightens the risk of chronic diseases such as cardiovascular disease, type 2 diabetes, and certain cancers, particularly breast and endometrial cancer. Furthermore, societal pressures and weight stigma disproportionately impact women, compounding mental health challenges like anxiety and depression.[313]

5.4.2 Risk factors Obesity

Obesity in women results from a mix of modifiable and non-modifiable risk factors, which are key to shaping successful prevention and intervention plans.

[310] OHID. Public Health England. Adult obesity: applying All Our Health [Internet]. London: Public Health England; 2022. Available from: https://www.gov.uk/government/publications/adult-obesity-applying-all-our-health/adult-obesity-applying-all-our-health
[311] Templeton A. Obesity and Women's Health. Facts Views Vis Obgyn. 2014;6(4):175-176. https://pmc.ncbi.nlm.nih.gov/articles/PMC4286855/
[312] Schon SB, Cabre HE and Redman LM. The impact of obesity on reproductive health and metabolism in reproductive-age females. Fertil Steril. 2024. 122(2);194-203. https://doi.org/10.1016/j.fertnstert.2024.04.036.
[313] Luppino FS, de Wit LM, Bouvy PF, Stijnen T, Cuijpers P, Penninx BW et al. Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Arch Gen Psychiatry. 2010;67(3):220-9. doi: 10.1001/archgenpsychiatry.2010.2.

Non-Modifiable Risk Factors

Non-modifiable risk factors include genetic, physiological, and demographic characteristics that affect an individual's weight status. Interventions addressing modifiable risk factors, such as diet and physical activity, are commonly used in weight management; however, considering nonmodifiable risk factors is also relevant when developing comprehensive approaches.

These are factors that cannot be changed but may increase a woman's susceptibility to obesity:

- **Genetics and Family History**: Genetic predisposition plays a significant role in obesity risk. Women with a family history of obesity are more likely to develop obesity themselves, due to inherited metabolic and behavioural traits.[310]
- **Ethnicity**: Certain ethnic groups, such as Black African and South Asian women, are at higher risk of obesity and related health complications at lower BMI thresholds.[314]
- **Age**: The prevalence of overweight and obesity increases with age, particularly after 45 years, peaking in later adulthood before declining in older age. This is partly due to metabolic changes and reduced physical activity with age.[315]
- **Life Stage and Hormonal Changes**: Key life stages such as puberty, pregnancy, and menopause are associated with hormonal fluctuations that can increase the risk of weight gain and fat redistribution.[316]
- **Early Life Factors**: Birth weight, early childhood nutrition, and exposure to obesogenic environments in early life can influence long-term obesity risk.[310]

Modifiable Risk Factors

These are factors that can be influenced by individual or societal action:

- **Dietary Habits**: High consumption of energy-dense, nutrient-poor foods, sugary drinks, and large portion sizes contribute to weight gain.[317]
- **Physical Inactivity**: Sedentary lifestyles, including low levels of physical activity and high screen time, are strongly associated with obesity. Women may face additional barriers to activity, such as caring responsibilities or safety concerns.[310,314]
- **Socio-Economic Status**: Deprivation is closely linked to higher obesity rates. Prevalence of overweight (including obesity) and obesity is highest in those living in the most deprived areas (71.2% and 37.4% respectively) and lowest in those living in the least deprived areas (59.4% and 19.8% respectively).[317]
- **Pregnancy and Postpartum Weight Retention**: Excessive weight gain during pregnancy and weight retention postpartum increases long-term obesity risk. Subsequent pregnancies often show higher rates of obesity, indicating cumulative weight retention, and adding additional risks such as perinatal mortality.[318]

[314] National Institute for Health and Care Excellence (NICE). Overweight and obesity: management [NG246]. London: NICE; 2024. Available from: https://www.nice.org.uk/guidance/ng246/resources/overweight-and-obesity-management-pdf-66143959958725

[315] NHS Digital. Health Survey for England 2022: Adult overweight and obesity [Internet]. NHS Digital; 2023. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-2/adult-overweight-and-obesity

[316] Poston L, Caleyachetty R, Cnattingius S, Corvalan C, Uauy R, Herring S, et al. Management of obesity across women's life course: FIGO Best Practice Advice. Int J Gynaecol Obstet [Internet]. 2023;163(Suppl 1):19–44. Available from: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.14549

[317] Office for Health Improvement and Disparities. Obesity profile: short statistical commentary, May 2025 [Internet]. London: OHID; 2025. Available from: https://www.gov.uk/government/statistics/obesity-profile-may-2025-update/obesity-profile-short-statistical-commentary-may-2025

[318] Oteng-Ntim E, Mononen S, Sawicki O, et alInterpregnancy weight change and adverse pregnancy outcomes: a systematic review and meta-analysisBMJ Open 2018;8:e018778. doi: 10.1136/bmjopen-2017-018778

- **Access to Healthy Food and the Built Environment**: Limited access to affordable, nutritious food and safe spaces for physical activity (e.g., due to food deserts or unsafe neighbourhoods) increases obesity risk, especially in deprived communities.[319]
- **Food Advertising and Purchasing Roles**: Women are disproportionately targeted by food advertising, particularly for products high in fat, salt, and sugar, as they are most likely to be the primary food purchasers for their households. UK government policy recognises that advertising of less healthy foods influences purchasing decisions and contributes to unhealthy diets, especially among families. Research by the Food Standards Agency highlights that food shopping is often habitual and that women, as main household shoppers, are especially exposed to marketing and labelling strategies designed to influence their choices. This exposure, combined with the responsibility for family food provision, means that women are both key decision-makers and key targets for food marketing, which can shape dietary patterns for the whole household.[320, 321, 322]

5.4.2.1 Food Access and the Build Environment

While this Women's HNA may focus on a narrower scope for obesity, it's important to note how access and the built environment affect obesity and healthy eating. Gender-specific data is limited, but these factors impact everyone, and without change, obesity rates will likely rise with serious health and economic consequences. Access to healthy food closely relates to poverty and deprivation, contributing to inequalities in cancer, diabetes, and heart disease. Nobles et al. (2019) found that most local authority obesity interventions focus on individual lifestyle changes rather than upstream determinants, despite evidence that 60% of causes are upstream, highlighting a mismatch between efforts and root causes.[323]

This begs the question of ***"Why treat people only to send them back to the conditions that made them sick in the first place?"***

[319] Office for Health Improvement and Disparities. Health matters: obesity and the food environment [Internet]. London: OHID; 2017. Available from: https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2

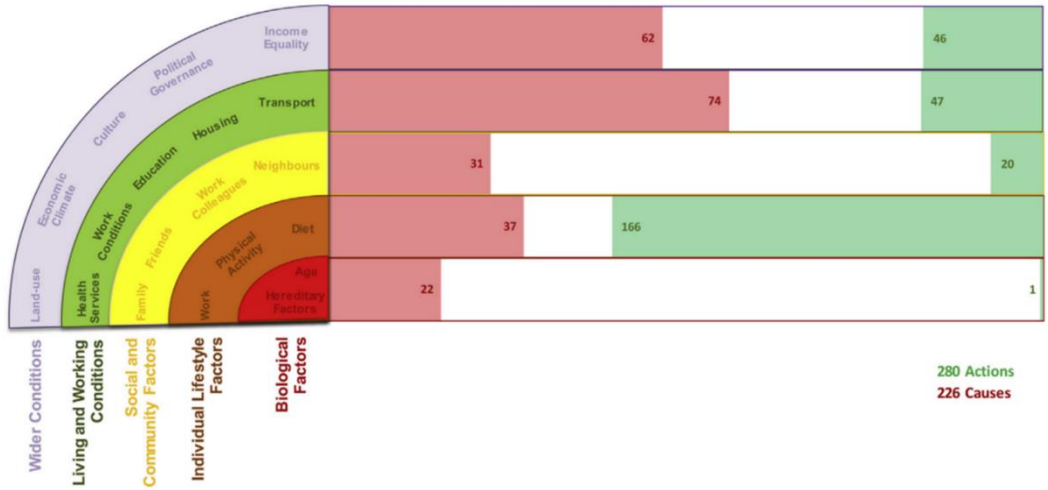
[320] Department of Health & Social Care. Response to brand advertising exemption from advertising restrictions for less healthy food or drink [Internet]. London: DHSC; 2025. Available from: https://www.gov.uk/government/consultations/brand-advertising-exemption-from-advertising-restrictions-for-less-healthy-food-or-drink/outcome/response-to-brand-advertising-exemption-from-advertising-restrictions-for-less-healthy-food-or-drink

[321] Food Standards Agency. Psychology of Consumer Behaviour and Behavioural Change [Internet]. London: FSA; 2021. Available from: https://www.food.gov.uk/node/10146

[322] Food Standards Agency. Food & You 2 trends: Chapter 7: Food shopping and labelling [Internet]. London: FSA; 2023. Available from: https://www.food.gov.uk/research/food-you-2-trends-chapter-7-food-shopping-and-labelling

[323] Nobles J, Christensen A, Butler M, Radley D, Pickering K, Saunders J, et al. Understanding how local authorities in England address obesity: A wider determinants of health perspective. Health Policy. 2019;123(10):998–1003. doi:10.1016/j.healthpol.2019.07.016.

Figure 79: LA actions to address obesity, mapped against the wider determinants of health



Source: Nobles et al 2019

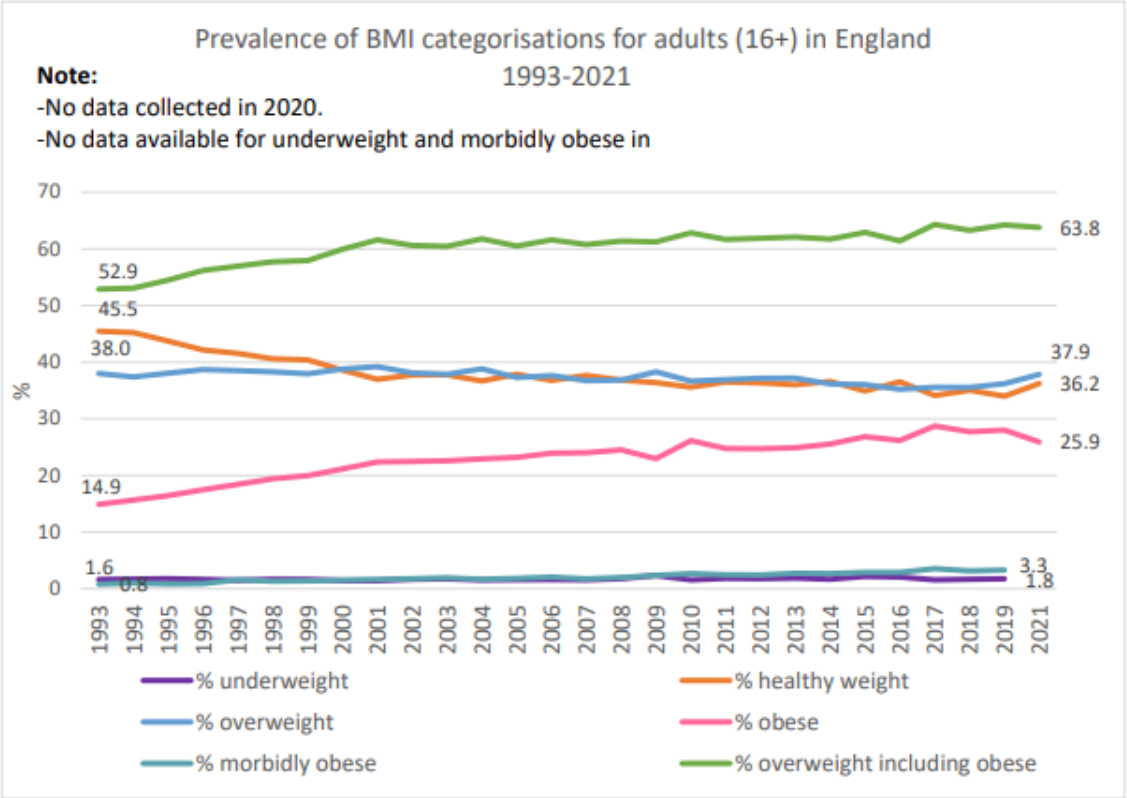
5.4.3 Level of Need

5.4.3.1 Overweight and Obesity

According to the 2021 Health Survey for England, approximately 60% of adults in England were classified as overweight or obese (with 38% identified as overweight and an additional 26% as obese or severely obese), representing a majority of the adult population. ***Figure 72*** indicates that, since 1993, the proportion of adults at a healthy weight has declined by 20%. In other weight categories, there has been a 13% rise in adults who are underweight, a 21% increase among those who are overweight or obese, and a notable 99% increase in adults classified as obese or severely obese.[324]

[324] Health Survey for England, 2021, Health Survey for England, 2021 part 1 - NDRS (digital.nhs.uk)

Figure 80: Prevalence of BMI categorisations for adults (16+) in England, 1993-2021



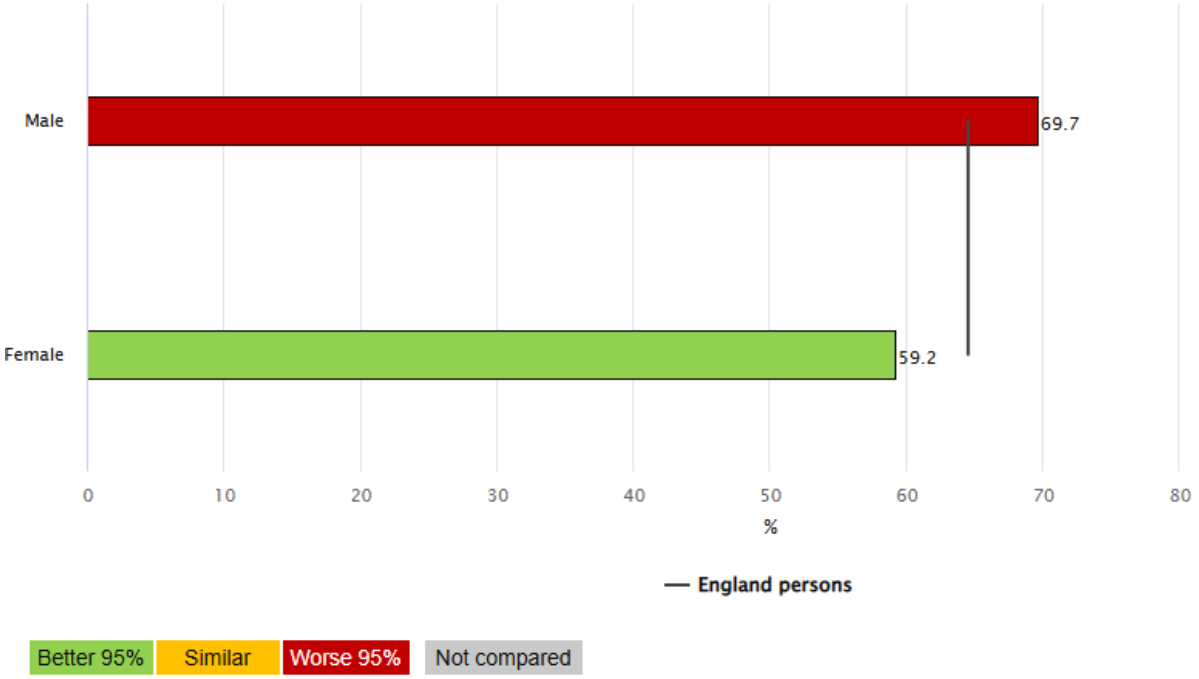
Source: Health Survey for England

In 2023 to 2024, nationally the prevalence of overweight (including obesity) in adults was higher among men (69.7%) than women (59.2%), while the prevalence of obesity in adults was higher among women (26.9%) than men (26.2%).

Within the East Midlands, 62% of women are classed as overweight, including obesity, with 29% being obese.[325]

[325] NHS Digital. Health Survey for England 2022. Published 2024. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england

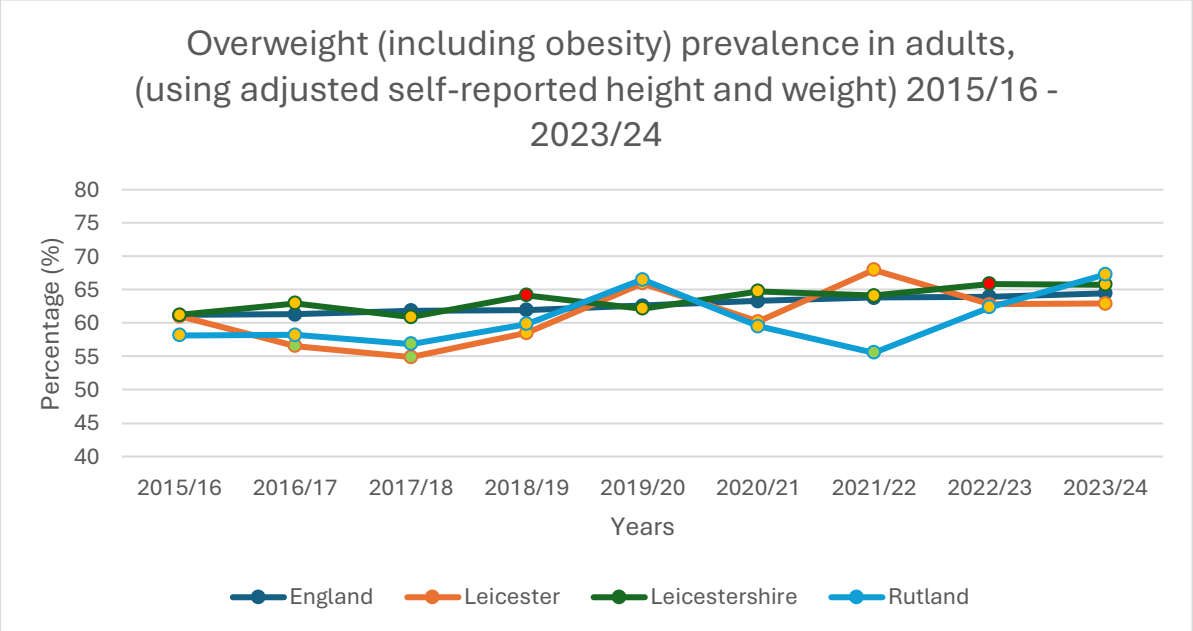
Figure 81: Adult obesity (including overweight) prevalence stratified by sex 2023/24



Source: OHID, Obesity Profile

Overweight and obesity rates across LLR have varied over time, as illustrated in ***Figure 74*** below. LLR generally aligns with the England average. Nevertheless, irrespective of this comparison, the prevalence of overweight and obesity within LLR remains substantial, affecting the majority of the adult population.

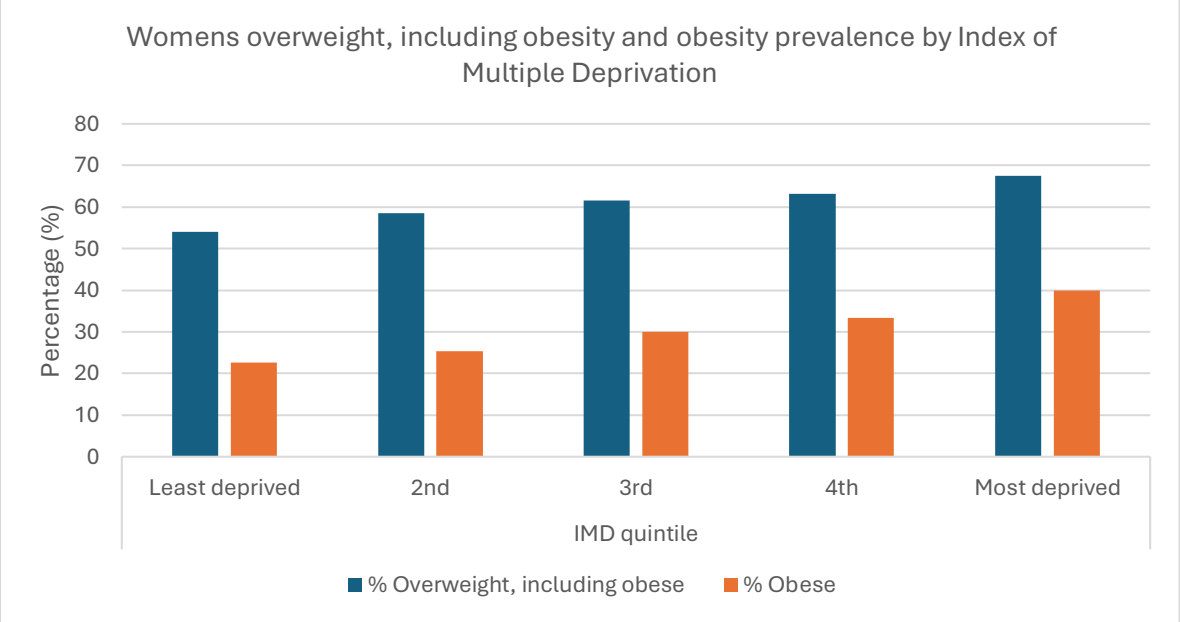
Figure 82: Adult obesity (including overweight) prevalence in LLR 2015/16 – 2023/24



Source: OHID, Obesity Profile

Overweight and obesity is also closely linked to deprivation, with rates being higher in the most deprived, which is more apparent in women. There is a 17% difference in obesity prevalence between the most deprived (40% obese) and least deprived quintiles (23% obese).[315]

Figure 83: Women's overweight, including obesity and obesity prevalence by IMD (HSE)



Source: Health Survey for England, 2022

Age also has an impact on prevalence, with those aged 45 and over having higher rates than the England average. The Health Survey for England shows a steady increase in the percentage of women being overweight (including obesity) from age 25 up to age 75, where it begins to decline.[325]

With regards to ethnicity, prevalence is significantly higher in Black (70.8%) and White British (65.2%) groups, however this data cannot be further broken down by gender.

5.4.3.2 5-A-Day

A person's weight is heavily linked to the food that they consume. Although narrow in its attention and focussed on only one aspect of a healthy diet, 5-a-day can (and is) used as a proxy measure of a healthy diet, and useful in the absence of other dietary intake data.[326] [327]

In England in 2023 to 2024, 31.3% of adults reported eating at least 5 portions of fruit and vegetables a day. This is similar to 2022 to 2023 when 31.0% of adults reported eating at least 5 portions, and lower than 2021 to 2022 (32.5%) and 2020 to 2021 (34.9%). Comparable data is not available prior to 2020 to 2021.

In England in 2023 to 2024 women were more likely than men to eat at least 5 portions of fruit and vegetables a day (34.8% compared with 27.6%). Adults aged 55 years and over were more

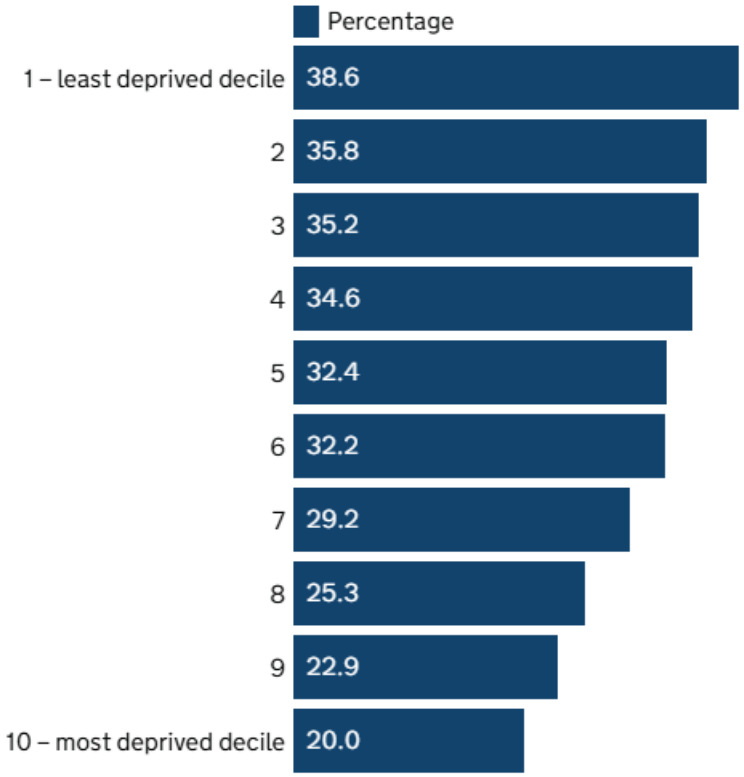
[326] Masterton S., Hardman CA, Boyland E, Robinson E, Makin HE, & Jones A. Are commonly used lab-based measures of food value and choice predictive of self-reported real-world snacking? An ecological momentary assessment study. Br J Health Psychol. 2023;28, 237–251. https://doi.org/10.1111/bjhp.12622

[327] van Rens T, Hanson P, Oyebode O, Walasek L, Barber TM, Al-Khudairy L. Healthy diets, lifestyle changes and well-being during and after lockdown: longitudinal evidence from the West Midlands. BMJ Nutr Prev Health. 2022;5(2):321-331. doi:10.1136/bmjnph-2022-000562

likely to eat at least 5 portions of fruit and vegetables (35.8% and higher) than those aged under 55 years.[317]

In the least deprived areas, 38.6% of adults reported eating at least 5 portions of fruit and vegetables a day compared with 20.0% of adults living in the most deprived areas.[317]

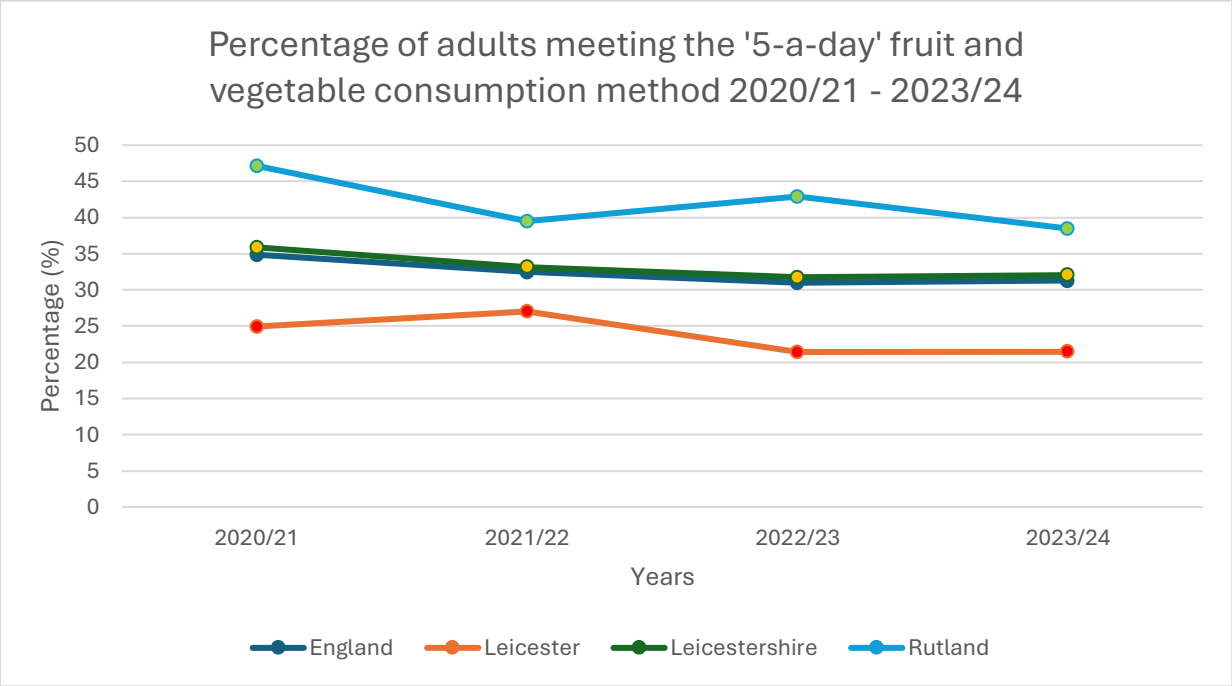
Figure 84: percentage of adults (aged 16 years and over) eating at least 5 portions of fruit and vegetables a day by LSOA deprivation decile 2023/24



Source: OHID, based on Sport England Active Lives Adult Survey data.

Locally, the 5-a-day picture is variable across LLR. Leicester is consistently significantly worse than the England average, with Rutland consistently significantly better, and Leicestershire being similar to the England average. This is likely linked to varying deprivation profiles, coupled with data demonstrating that White British adults are the most likely to eat 5-a-day. Local data is not available by gender.

Figure 85: Percentage of adults meeting the '5-a-day' fruit and vegetable consumption method 2020/21 - 2023/24



Source: OHID, Obesity Profile

5.4.3.3 Perinatal Obesity

Women with a pre-pregnancy body mass index (BMI) exceeding 25 kg/m^2 face a higher likelihood of conception difficulties compared to those whose BMI falls within the ideal range (20–24.99 kg/m^2). Additionally, they are at increased risk for miscarriage and stillbirth. Overweight, obesity, and excessive gestational weight gain are associated with a greater incidence of pregnancy complications, including those that may pose significant risks to both maternal and neonatal health. The occurrence of labour complications is also elevated in pregnancies affected by overweight or obesity.[328] Other risks include pre-eclampsia, gestational diabetes, foetal macrosomia, premature birth, emergency caesarean section and postpartum haemorrhage.[329]

2023/24 Fingertips data show early pregnancy obesity rates in Leicestershire are significantly higher than the England average (28.3% vs national average 26.2%), while Leicester City and Rutland align closely (26.3% and 26%). Obesity is more common in deprived areas, and rates increase with subsequent pregnancies, likely due to retained weight from previous pregnancies.[330, 331]

[328] Langley-Evans SC, Pearce J, Ellis S. Overweight, obesity and excessive weight gain in pregnancy as risk factors for adverse pregnancy outcomes: A narrative review. J Hum Nutr Diet. 2022;35(2):250-264. doi:10.1111/jhn.12999
[329] Marchi J, Berg M, Dencker A, Olander EK, Begley C. Risks associated with obesity in pregnancy, for the mother and baby: a systematic review of reviews. Obes Rev. 2015;16(8):621-38. doi: 10.1111/obr.12288.
[330] Abebe DS, Von Soest T, Von Holle A, Zerwas SC, Torgersen L, Bulik CM. Developmental trajectories of postpartum weight 3 years after birth: Norwegian Mother And Child Cohort study. Matern Child Health J. 2015;19(4):917-925. doi:10.1007/s10995-014-1593-x
[331] Endres LK, Straub H, McKinney C, et al. Postpartum weight retention risk factors and relationship to obesity at 1 year. Obstet Gynecol. 2015;125(1):144-152. doi:10.1097/AOG.0000000000000565

5.4.3.4 Healthy weight and fertility

Obesity can have a negative effect on a woman's fertility, culminating in longer-time-to-pregnancy and an increased risk of infertility.[332] NICE guidance (CG156) indicates that treatment with IVF is also more effective for women who have a BMI between 19 and 30.[333] Currently, fertility policies, which dictate the criteria for eligibility for fertility treatment, vary across the East Midlands. However, the majority do stipulate BMI criteria as guided by NICE. At the time of writing (September 2025), an East Midlands Fertility Policy review is underway to standardise policies across the East Midlands.

Within LLR, couples are currently advised that having a BMI of 30 or over (in either or both partners) is associated with reduction in fertility and chances of conceiving which may be reversed with weight loss.

5.4.4 What evidence- based management is recommended

Management of overweight and obesity requires a whole-systems approach, spanning prevention, early intervention, and specialist treatment. NICE guidance (NG246) provides a framework for evidence-based management, emphasising the importance of tailored, compassionate, and multi-component interventions across the life course.[314]

Adoption of Whole System Approaches to address obesity is recommended and evidence based.[334]

Prevention

Population-level prevention focuses on creating environments that support healthy eating and physical activity, addressing wider determinants such as deprivation, food access, and the built environment. Interventions include:

- Promoting healthy diets (e.g., increasing fruit and vegetable intake, reducing sugar and saturated fat)
- Promotion and policy changes (e.g. early years food standards)
- Encouraging regular physical activity and provision of opportunities for individuals and families to be active
- Supporting healthy weight before, during, and after pregnancy
- Reducing exposure to obesogenic environments (e.g., limiting fast food outlets near schools)
- Addressing weight stigma and promoting positive body image

Lifestyle and Behavioural Interventions

NICE recommends multi-component lifestyle interventions as the first-line management for overweight and obesity.[314] These should be:

[332] Schon SB, Cabre HE and Redman LM. The impact of obesity on reproductive health and metabolism in reproductive-age females. Fertil Steril. 2024. 122(2);194-203. https://doi.org/10.1016/j.fertnstert.2024.04.036.
[333] National Institute for Health and Care Excellence. Fertility problems: assessment and treatment. NICE clinical guideline CG156. London: NICE, 2013, updated 2017. Available from: https://www.nice.org.uk/guidance/cg156/resources/fertility-problems-assessment-and-treatment-pdf-35109634660549
[334] Public Health England. Whole systems approach to obesity: a guide to support local approaches to promoting a healthy weight [Internet]. London: Public Health England; 2019. Available from: https://www.gov.uk/government/publications/whole-systems-approach-to-obesity

- Delivered by trained professionals
- Include dietary advice, physical activity, and behaviour change techniques
- Be tailored to individual needs, preferences, and cultural backgrounds
- Provided in a compassionate, non-stigmatising manner

Pharmacotherapy

Pharmacological treatment may be considered for individuals with obesity who have not achieved sufficient weight loss with lifestyle interventions alone.[314] NICE recommends:

- Orlistat as a first-line medication, used alongside lifestyle support
- GLP-1 receptor agonists (e.g., liraglutide, semaglutide) for selected individuals, particularly those with type 2 diabetes or high cardiovascular risk
- Tirzepatide (Mounjaro®), a dual GIP/GLP-1 receptor agonist, is now approved for obesity management in the UK. Clinical trials show substantial efficacy in reducing body weight and improving metabolic health, but long-term safety and cost-effectiveness require ongoing evaluation. Access is subject to strict clinical criteria and local funding arrangements.

Specialist Services and Bariatric Surgery

For individuals with severe obesity, NICE recommends referral to specialist multidisciplinary teams (Tier 3 services) and consideration of bariatric surgery (Tier 4) when appropriate. Criteria include:

- Failure to achieve or maintain weight loss with non-surgical interventions
- Assessment and management of physical and psychological comorbidities
- Comprehensive pre-operative evaluation and post-operative support

Bariatric surgery options include gastric bypass, sleeve gastrectomy, and adjustable gastric banding. Surgery is associated with significant and sustained weight loss, improvement in obesity-related comorbidities, and enhanced quality of life, but requires lifelong follow-up.[314]

5.4.5 Current Services in LLR

5.4.5.1 Roles and Responsibilities

- **Local Authorities**: Lead on prevention, environmental and behavioural interventions, deliver community-based programmes, commission lower-tier services, provide public health advice, and promote healthy weight through frameworks like the Healthy Weight Declaration. District and Borough councils also provide services, including physical activity provision.
- **ICB**: Commission and fund clinical weight management services (Tier 3 and 4), coordinate clinical pathways (including pharmacotherapy), and lead strategic planning and integration across sectors.

5.4.5.2 Current Service Provision

Place-Based System Approaches

Each area within LLR has developed its own **whole-system approach**, tailored to local demographics, population size, and service needs. These approaches recognise the multifactorial nature of obesity and the need for coordinated action across sectors.

Collaboration and mutual accountability are emphasised. They are also broader than obesity; they focus on the broader holistic aspects concerned with healthy weight, food and nutrition.

Local Authority Provision

Service provision varies by area:

- Leicestershire and Rutland: Tier 2 services and specialist pre/post-pregnancy support are available.
- Leicester City: Tier 2 services were decommissioned in March 2024, but plans are underway to recommission targeted interventions for vulnerable populations.
- All areas: Broader services aim to prevent obesity and overweight, tailored to local priorities and needs.

Healthy Weight Declaration

Leicester City Council have signed up to the Healthy Weight Declaration. UHL and LPT are in the process of adopting the NHS Healthy Weight Declaration, aiming to leverage NHS institutions as anchor organisations to promote healthier environments. There is potential for further adoption by other system partners.

Tier 3 and Tier 4 Services

A pilot Tier 3 weight management service has been unable to accept new referrals for an extended period due to overwhelming demand, highlighting significant unmet need. The future of this, coupled with the introduction of Tirzepatide is currently being explored (as of October 2025). Tier 4 services are commissioned.

Tirzepatide Rollout

From October 2025, Tirzepatide (Mounjaro®) will be available across LLR following NICE guidance (TA1026).[335] It will be available within certain cohorts based on BMI and co-morbidities, in a rolling programme over the coming years. Its introduction presents both opportunities and challenges, including funding constraints due to under-recording of eligible patients and concerns about long-term sustainability and health inequalities. Evidence suggests weight regain after cessation, underscoring the need for integrated behavioural and lifestyle support alongside pharmacotherapy.[336]

National

The NHS Digital Weight Management Programme supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

It is a 12-week online behavioural and lifestyle programme that people can access via a smartphone or computer with internet access. It can be accessed via a referral from a G.P. or pharmacist: https://www.england.nhs.uk/digital-weight-management/

[335] National Institute for Health and Care Excellence (NICE). Tirzepatide for managing overweight and obesity [TA1026]. London: NICE; 2024. Available from: https://www.nice.org.uk/guidance/ta1026

[336] Wu, H., Yang, W., Guo, T. et al. Trajectory of the body weight after drug discontinuation in the treatment of anti-obesity medications. BMC Med 23, 398 (2025). https://doi.org/10.1186/s12916-025-04200-0

5.4.6 Unmet needs or gaps

Obesity is a complex, multifaceted condition, and there is no single approach to its prevention or treatment. In Leicester, Leicestershire, and Rutland (LLR), the current system lacks a fully coordinated approach to weight management. This fragmentation means risks services and interventions not being joined up, and opportunities for synergy and shared learning could be missed. However, work is underway to address this.

Women's weight is not static; it changes across the life course, with particular vulnerability at key stages such as puberty, pregnancy, and menopause. For example, menopause is associated with hormonal changes that can increase the risk of weight gain and fat redistribution, yet there doesn't appear to be awareness or promotion of this. Pregnancy represents a unique window of opportunity, as women are often more open to lifestyle messages and have increased contact with health professionals during this period. It is unknown if this is capitalised on this and used as a 'teachable' moment to educate on nutrition and physical activity and provide advice for post-partum.

Leicestershire reports higher levels of obesity despite lower deprivation, suggesting that other, as yet unidentified, factors are at play. Furthermore, obesity prevalence among females has now overtaken that of males, but the underlying reasons for this shift remain unclear and warrant further investigation. Due to lack of data, we also don't know if this national picture is also relevant for LLR.

Capacity issues are acute, particularly in specialist services. The Tier 3 weight management service has been unable to accept referrals for an extended period due to overwhelming demand, resulting in increased pressure on Tier 2 services and longer waiting times. This situation is exacerbated by the introduction of new pharmacotherapies, such as Tirzepatide, which, while promising, risk widening health inequalities if access is determined by the ability to pay privately or by under-recording of eligible patients in GP systems. Without robust prevention and early intervention, there is a real danger that all tiers of the system will be overwhelmed, and the cost of pharmacotherapy will become unsustainable.

There is a pressing need for improved data collection and sharing, evaluation, and collaborative learning to better understand need, service use, inequalities, and outcomes.

Within this HNA chapter, the focus has been on overweight and obesity, other weight-related issues, such as underweight have not been discussed and could be addressed in further work.

5.4.7 Recommendations

- **Adopt a Life-Course Approach**: Design weight management and prevention strategies that recognise women's changing needs at key life stages—such as adolescence, pregnancy, and menopause—ensuring support is relevant, timely, and accessible
- **Whole System Approaches**: Continue to develop place based WSA focussed on broader healthy weight, food and nutrition.
- **Services:**
    - A 'normal' HNA would recommend upscaling and continued delivery of tier 3, however it is clear that there are financial constraints in place that no recommendations will be able to overcome. Therefore, tier 3 services should continue to be evaluated and advocated for, as per NICE guidance. As pharmacotherapy is further rolled out, the two programmes should be looked at together to devise service provision to meet demand.

    - Focus provision of services relating to weight management on areas and population groups with higher experience of excess weight, particularly women in lower socio-economic areas.
- **Empower Women Through Food and Skills**: Promote food knowledge, cooking skills, and access to nutritious, sustainable food, celebrating the diversity of women's experiences and cultures across LLR. Support community initiatives that connect women and families around healthy eating.
- **Advertising**: Look at ways to promote healthier food advertising locally and on advertising spaces that system partners own and operate.
- **Integrate and Clarify Care Pathways**: Strengthen links between all tiers of weight management, from universal prevention to specialist and surgical services, so that women experience joined-up, seamless support throughout their lives.
- **Harness Opportunities for Prevention**: Make the most of key moments—such as pregnancy and menopause—when women are more open to health messages, by providing proactive, compassionate advice and support through trusted professionals. Ensure professionals are confident and competent to address weight conversations.
- **Champion Equity and Inclusion**: Ensure all services are inclusive, culturally sensitive, and address the needs of women from diverse backgrounds, with a focus on reducing inequalities in access and outcomes.
- **Work with local fertility services** to support weight and healthy eating discussions and ensure pathways to existing provision are easy to access.



6 Cancer

Due to data availability, this chapter focusses on breast and cervical cancer.

Key Epidemiology & Context

- Breast and cervical cancer outcomes vary by deprivation and ethnicity
- Screening uptake is lower in Leicester City
- Breast cancer is the most common cancer in UK women, with risk increasing with age, family history, hormones, obesity, alcohol use and smoking
- Screening saves lives, but LLR coverage (68.1%) remains below the national average
- Mortality rates are similar to England, but urgent suspected breast cancer referrals are rising in LLR
- Around 3,635 women in LLR are living with or beyond breast cancer
- HPV vaccination coverage in LLR is below national target of 90%.

Inequalities & At-Risk Groups

- Lower uptake among ethnic minority groups, as well as those with a learning disability
- Access barriers differ between urban and rural populations

Gaps & Unmet Need

- Low screening uptake in key populations
- Late presentation in some communities
- Routine cervical screening in LLR is typically conducted in GP surgeries, but uptake remains inconsistent. Barriers include embarrassment, lack of symptoms, cultural stigma, and previous negative experiences.

Implications for LLR

- Inequalities directly impacting survival outcomes
- Deprivation, ethnicity, language barriers and low health literacy may prevent some women from coming forward for screening or seeking help early

Priority Action Themes

- Improve screening and HPV uptake and access
- Target culturally appropriate engagement

While all cancers are important, the Women's Health Strategy has identified gynaecological, breast cancer screening and cervical cancer screening as priority areas. Local data for gynaecological cancers were unavailable at the time of producing this needs assessment, therefore only data for breast and cervical cancer are presented.

6.1 Breast Cancer

6.1.1 Background

Breast cancer is one of the most common type of cancer in women in the UK, which originates in the breast and can spread to another part of the body, which is known as secondary breast cancer. Breast cancer is when abnormal cells in the breast begin to grow and divide excessively and then form a growth (tumour). Breast cancer can also occur in men. Symptoms of breast cancer in women can include:[337]

- a new lump or thickening in your breast or armpit
- a change in size, shape or feel of your breast
- skin changes in the breast such as puckering, dimpling, a rash or redness of the skin
- fluid leaking from the nipple in a woman who isn't pregnant or breastfeeding
- changes in the position of the nipple

Women with symptoms can be referred by their GP to a breast clinic for further investigation, which can include examination/x-ray (mammogram/ultrasound/biopsy.[338]

The main treatments for breast cancer in women can include:[338]

- Surgery – removing only the area of the breast with cancer, removing the whole breast (mastectomy) or removing lymph nodes in your armpit.
- Chemotherapy – where medicine is used to destroy cancer cells.
- Radiotherapy – where radiation is used to destroy the cancer cells.
- Hormone Therapy – where medicine is used to lower the amount of certain hormones (that can increase and grow the cancer faster or block certain hormones from getting to breast cancer cells).
- Immunotherapy - Immunotherapy is where medicines are used to help your immune system destroy cancer

Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year.[339] The NHS provide breast cancer screening to all women aged between 50 up to their 71st birthday, every three years. Women can also self refer after the screening age.

[337] Cancer Research UK (2023). Breast Cancer. Available at: https://www.cancerresearchuk.org/about-cancer/breast-cancer
[338] NHS (2024). Breast Cancer in Women. Available at: https://www.nhs.uk/conditions/breast-cancer-in-women/treatment-for-breast-cancer-in-women/
[339] OHID (2025). Public Health Outcomes Framework – Breast Cancer Screening. Available at: https://fingertips.phe.org.uk/search/breast%20screening#page/3/gid/1/pat/15/par/E92000001/ati/502/are/E06000016/iid/22001/age/225/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Breast cancer is projected to cost the UK economy £3.2–£3.5 billion in 2025, rising to £4.2 billion by 2050. The wellbeing cost is even higher: £20.2 billion in 2025, rising to £24.5 billion by 2050.[340] Tackling health inequalities could save:[340]

- **2,000 lives annually** in ethnic minority communities
- **3,200 lives annually** in the most deprived areas

At least 30% of breast cancer cases are linked to modifiable risk factors. Breast Cancer UK's 2025–2028 strategy calls for a shift to prevention, focusing on modifiable risk factors such as:[341]

- Obesity
- Alcohol use
- Exposure to endocrine-disrupting chemicals (EDCs).

6.1.2 Risk factors for Breast Cancer

Anyone can get breast cancer, however women are at higher risk if they:[338]

- Are over the age of 50
- Have dense breast tissue
- Have a family member who has had breast or ovarian cancer
- Have certain breast conditions, such as benign breast disease, ductal of lobular carcinoma in situ
- Hormonal factors – hormones such as oestrogen and progesterone can affect breast cancer risk.
- Lifestyle factors such as:[342]
    - Being overweight – particularly after menopause (being overweight may change hormonal levels in the body).
    - Alcohol consumption – regularly drinking alcohol increases the risk of breast cancer, however the risk is lower in women who drink within the recommended guidelines.
    - Smoking - Smoking can slightly increase the risk of breast cancer. This seems to be linked with starting smoking at a young age and smoking for a long time.

6.1.3 Level of Need

Mortality from Breast Cancer

The under 75 mortality rate and the mortality rate for all ages from breast cancer in LLR has remained statistically similar to the England rate since 2011-13. The latest rates for 2020-22 are just above the rates for England, yet statistically similar.

[340] Breast Cancer Now (2025). The cost of breast cancer: 2025 update. Available at: https://breastcancernow.org/about-us/blogs/the-cost-of-breast-cancer-2025-update
[341] Breast Cancer UK (2025). Breast Cancer UK Strategy 2025-2028. Available at: https://cdn.breastcanceruk.org.uk/uploads/2025/05/Breast-Cancer-UK-Strategy-2025-2028-Summary.pdf
[342] Macmillan Cancer Support (2023). Risk factors for breast cancer. Available at: https://www.macmillan.org.uk/cancer-information-and-support/breast-cancer/risk-factors-for-breast-cancer?gclsrc=aw.ds&gad_source=1&gad_campaignid=19936005343&gbraid=0AAAAD1mVXFEFXS2P3ElBfhQXcngItY2V&gclid=EAIaIQobChMI4vPCwd3ijwMVNJNQBh1ZWgEFEAAYAyAAEgL0OPD_BwE

Table 13: Mortality Rates from breast cancer in LLR, 2020-22

DSR (Direct Standardised Rate – per 100,000 females)	LLR	England
Under 75 mortality rate	19.1	18.3
All ages mortality rate	31.9	31.3

Statistically Similar to England

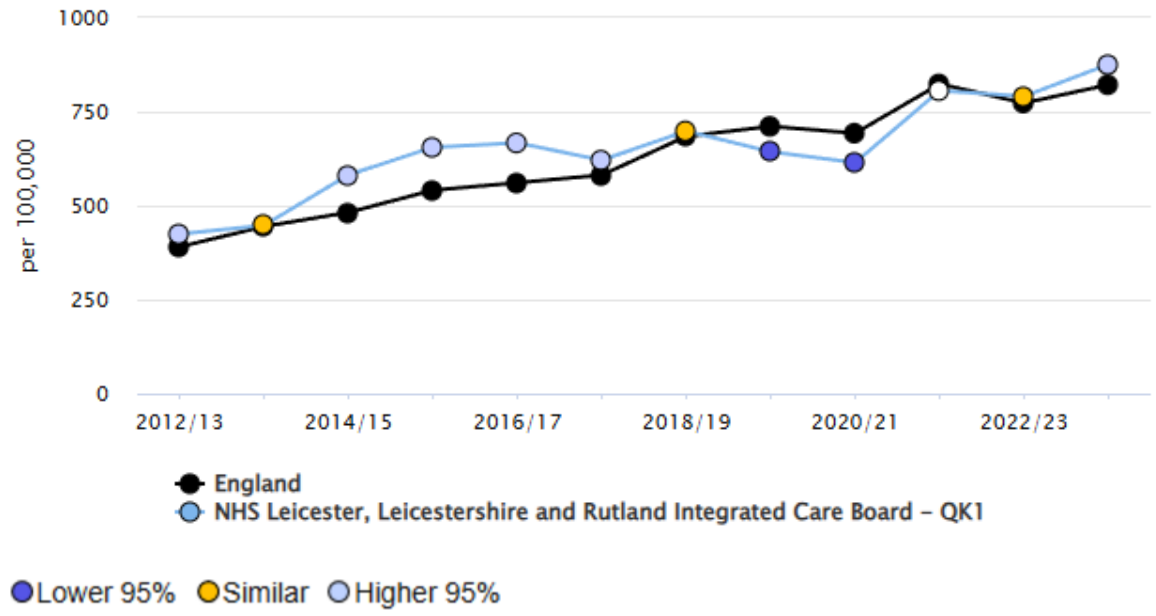
Source: Mortality Profiles, OHID, 2025

Urgent Suspected Breast Cancer Referrals

Urgent suspected cancer referrals are a managed route to secondary care, for investigation of possible cancer symptoms, with the intention to efficiently investigate the symptoms and, when a cancer is diagnosed, ensure the patient's cancer treatment and care is well managed within the system.

In LLR, the rate for urgent suspected breast cancer referrals over the last five years is significantly increasing in LLR. In 2023/24, the rate of urgent suspected breast cancer referrals in LLR was 876 (per 100,000 population), this is significantly higher in comparison to the national rate of 822.

Figure 86: Urgent suspected breast cancer referrals, LLR



Source: Mortality Profiles, OHID, 2025

Breast Cancer Screening

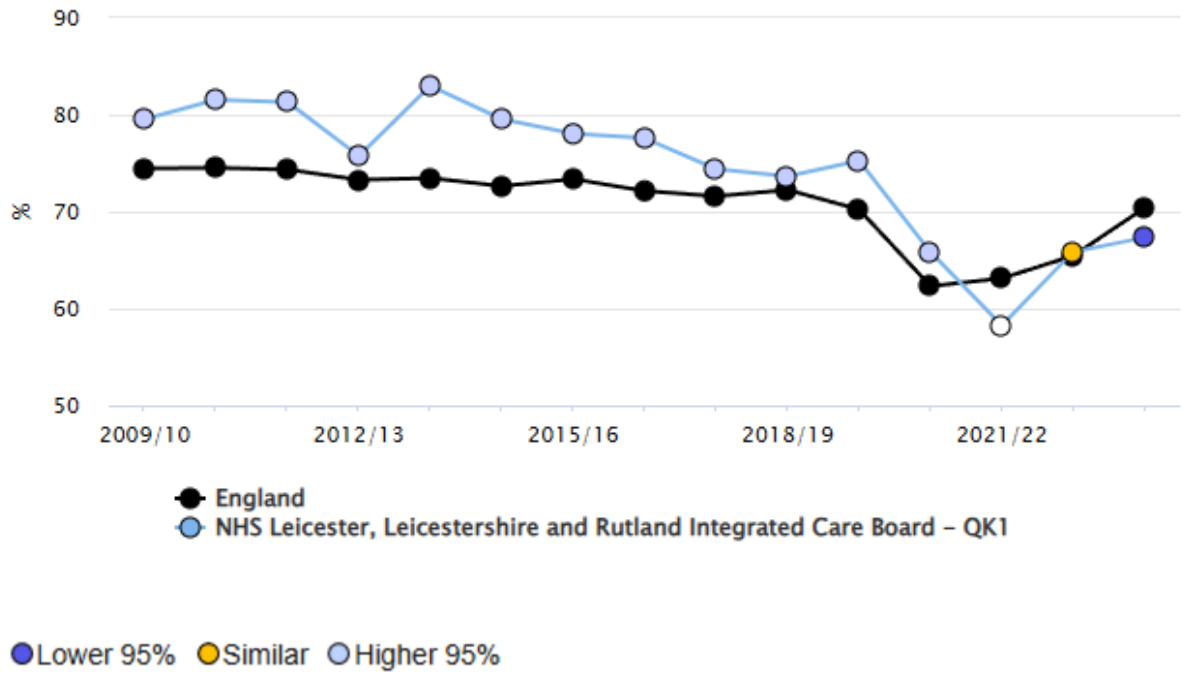
Breast cancer screening intends to detect breast cancer at an early stage when there is better chance of successful treatment. Women are eligible to be invited to screening when they reach the age of 50 until they reach their 71st birthday, on a 3 yearly cycle.

In 2023/24, 68.1% of the eligible population had a breast screening test result recorded (in the past 36 months) in LLR, this equates to 85,400 women aged 53 to 70 years old, over a 3 year

period, this is known as breast screening coverage. Breast screening coverage in LLR is significantly lower in comparison to the national average of 69.9% during the same time period.

Breast screening uptake measures how many women accept the offer of screening promptly and could reflect those more likely to take up offers of breast screening. Breast screening 1 year uptake in LLR has remained significantly higher than the national average from 2009/10 to 2020/21, when the covid pandemic was ongoing. Since 2021/22, breast screening uptake rates in LLR have increased, with 67.3% of women having a breast screening test recorded within 6 months of receiving a screening invitation, this is significantly lower in comparison to the national average of 70.4 in 2023/24.

Figure 87: Breast Screening uptake (females aged 50-70 years) in LLR



Source: Mortality Profile, OHID, 2025.

Breast Cancer Prevalence

The National Disease Registration Service (NDRS) published local cancer prevalence statistics in 2022, derived from cancer incidence and survival to provide counts on people living with and beyond a cancer diagnosis at a fixed point in time (between 2018 – 2022). In LLR, 3,635 women were living with and beyond with breast cancer during this period, this equates to a crude rate of 634.6 (per 100,000 female population), this is significantly lower in comparison to the national rate of 689.6. Further demographic breakdown is available but is combined for both males and females.

6.1.4 What evidence-based management is recommended

The primary goals of treatment are to reduce mortality, extend progression-free and disease-free survival, and enhance quality of life—each of which depends on the stage of the disease.

Surgery and radiotherapy are used to remove the tumour, while adjuvant drug therapy (administered after surgery) helps lower the risk of recurrence and the development of invasive

disease. Neoadjuvant drug therapy (given before surgery) aims to shrink the tumour to enable breast-conserving surgery and reduce involvement of the axillary lymph nodes.

In cases of advanced breast cancer, where a cure is not possible, treatment focuses on prolonging survival, alleviating symptoms, and improving quality of life.[343]

Breast cancer management typically involves surgery, radiotherapy, drug therapy, or a combination of these approaches. The treatment strategy and disease progression depend on the specific characteristics of the cancer.

Key factors such as the patient's age, menopausal status, tumour size and grade, involvement of axillary lymph nodes or skin, and the presence of hormone receptors within the tumour help determine the severity and aggressiveness of the disease.[343]

6.1.5 Current Services in LLR

Breast Cancer Screening – UHL provide breast cancer screening at the Glenfield Breast Care Centre within Glenfield hospital. The breast screening unit have mobile vans which visit and park up around LLR (i.e. local supermarkets) to deliver screening closer to home.

GPs – women with breast symptoms are able to contact their GP in the first instance. Once the GP has carried out an assessment, they may refer patients to the Breast Care Centre for further investigation. If GPs report any suspicion of breast cancer, the Breast Care Centre will aim to see patients within two weeks.

6.1.6 Unmet needs or gaps

- Incidence data, show LLR has a lower prevalence in the number of people living with and beyond breast cancer is significantly lower than England.
- Whilst breast screening rates are increasing after the covid pandemic, more data needs to be collected on demographics of those who are eligible, but not taking up the offer in order to increase breast screening rates.
- Urgent breast cancer referrals are on the rise. The rise in urgent breast cancer referrals is broadly positive—it suggests that more people are coming forward and being taken seriously. However, it also raises flags about system capacity, diagnostic delays, and the need for equitable access to timely care.

6.1.7 Recommendations

- Policy Shift to Prevention: Embed modifiable risk factor reduction in NHS and national cancer plans.
- More data needs to be collected on demographics of those who are eligible, but not taking up the offer in order to increase breast screening rates.
- Access to Screening: Women with learning disabilities are less likely to attend breast screenings — offer reminders, transport help, and accessible explanations or seeking support from LD Primary care liaison nurses.
- Promote cancer symptom awareness to encourage early presentation, especially for those groups most at risk and facing health inequalities.

[343] NICE BNF (2025). Breast Cancer. Available at: https://bnf.nice.org.uk/treatment-summaries/breast-cancer/

- Clarify referral and treatment pathways to reduce delays and improve patient experience.

6.2 Cervical Cancer

6.2.1 Background

The cervix is the opening between the vagina and the womb (uterus). Cervical cancer is found in the cervix and can occur at any age, however, is most common in women aged between 30 and 35. Nearly all cervical cancers are caused by an infection from certain types of human papillomarvirus (HPV).[344]

Symptoms of cervical cancer include:[344]

- Unusual vaginal bleeding (bleeding during/after sex, between periods, after menopause, or heavier periods than usual).
- Changes to vaginal discharge
- Pain during sex
- Pain in your lower back, between your hip bones, or in your lower tummy.

Women with symptoms are able to contact GPs for a physical examination. Once assessed, the GP may refer patients to a specialist in secondary care for further tests. The main test for cervical cancer is known as a colposcopy. Abnormal cells found in the cervix could indicate cervical cancer and can be removed during the colposcopy. If cancer cells are found, then further tests (blood tests/Scans (CT, MRI/PET/Xray)/internal examination) are required to assess the size and stage of the cancer.[344]

The main treatments for cervical cancer in women can include:[344]

- Surgery – this includes removal of different sections of the cervix depending on where the cancer cells are growing.
- Chemotherapy – where medicine is used to destroy cancer cells.
- Radiotherapy – where radiation is used to destroy the cancer cells.
- Immunotherapy - Immunotherapy is where medicines are used to help your immune system destroy cancer.
- If the cancer has advanced and cure is not an option, the aim of the treatment will be to limit the cancer and its symptoms, in order for a longer life span.

Cervical screening aims to check the health of the cervix and to prevent cervical cancer.[344] The NHS provide cervical cancer screening to all women and people with a cervix aged between 25 to 64, every five years until the age of 64.

Cervical cancer leads to approximately 685 deaths a year in England, with about 99.8% caused by HPV. NHS England have outlined its ambition to eliminate cervical cancer by 2040 by increasing equitable uptake of the HPV vaccination and cervical screening. This requires:

- 90% HPV vaccination coverage
- 70% screening coverage for women aged 30–49

[344] NHS (2024). Cervical Cancer. Available at: https://www.nhs.uk/conditions/cervical-cancer/what-is-cervical-cancer/

- 90% treatment of identified precancer or cancer cases[345]

The lifetime cost per cervical cancer case in the UK is estimated at **£210,000**, with a total preventable burden of **£406 million**.[346]

6.2.2 Risk factors for Cervical Cancer

Women are more at risk of cervical cancer if they:[344]

- Have a weakened immune system, for example those with HIV/AIDs.
- Have given birth to multiple children or had children at an early age (under 17 years of age).
- Have a mother who took hormonal medicine diethylstilbesterol (DES) whilst pregnant.
- Have previously had vaginal, vulval, kidney or bladder cancer.
- Smoke.
- Have taken the contraceptive pill for more than five years.

6.2.3 Level of Need

Cervical Cancer Screening

Cervical screening supports detection of cell abnormalities that may become cancer. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.

Cervical screening coverage in 2024 (the proportion of women in the eligible population who were screened within the previous 3.5 years) for those aged 25 to 49 years old in Leicestershire (72.6%) and Rutland (73.7%) were significantly better (higher) than the national average of 66.1% and have remained above the national average since 2010. For the same time period, in Leicester (53.7%), cervical screening coverage was significantly worse (lower) in comparison to the national rate and has remained below the national rate since 2010. However, the trend over the last five years indicates that cervical screening coverage rates are significantly decreasing and getting worse nationally and in LLR.

Figure 88: Cervical Cancer Screening Coverage (25-49 years old) in LLR

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	7,306,325	66.1*	66.1	66.1
East Midlands region (statistical)	↓	592,501	68.2*	68.1	68.3
Rutland	↓	3,739	73.7	72.5	74.9
Leicestershire	↓	86,483	72.6*	72.4	72.9
Leicester	↓	45,159	53.7	53.4	54.0

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

Source: Public Health Outcomes Framework Profile, OHID, 2025.

Cervical screening coverage in 2024 (the proportion of women in the eligible population who were screened within the previous 5.5 years) for those aged 50 to 60 years old in Leicestershire

[345] NHS England (2025). Cervical Cancer elimination by 2040 – plan for England. Available at: https://www.england.nhs.uk/long-read/cervical-cancer-elimination-by-2040-plan-for-england/

[346] OHE (2024). The Socioeconomic Burden Of Cervical Cancer in the UK: What are the benefits of achieving the WHO elimination target? Available at: https://www.ohe.org/publications/socioeconomic-burden-of-cervical-cancer/

(77.9%) and Rutland (78.8%) were significantly better (higher) than the national average of 74.3% and have remained above the national average since 2010. For the same time period, in Leicester (68.5%), cervical screening coverage was significantly worse (lower) in comparison to the national rate and has remained below the national rate since 2014. However, the trend over the last five years indicates that cervical screening coverage rates are significantly decreasing and getting worse nationally and in Leicester and Leicestershire.

Figure 89: Cervical Cancer Screening Coverage (50-60 years old) in LLR

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	4,071,683	74.3*	74.2	74.3
East Midlands region (statistical)	↓	360,106	75.8*	75.7	75.9
Rutland	→	3,252	78.8	77.5	80.0
Leicestershire	↓	54,247	77.9*	77.5	78.2
Leicester	↓	20,564	68.5	68.0	69.0

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

Source: Public Health Outcomes Framework Profile, OHID, 2025.

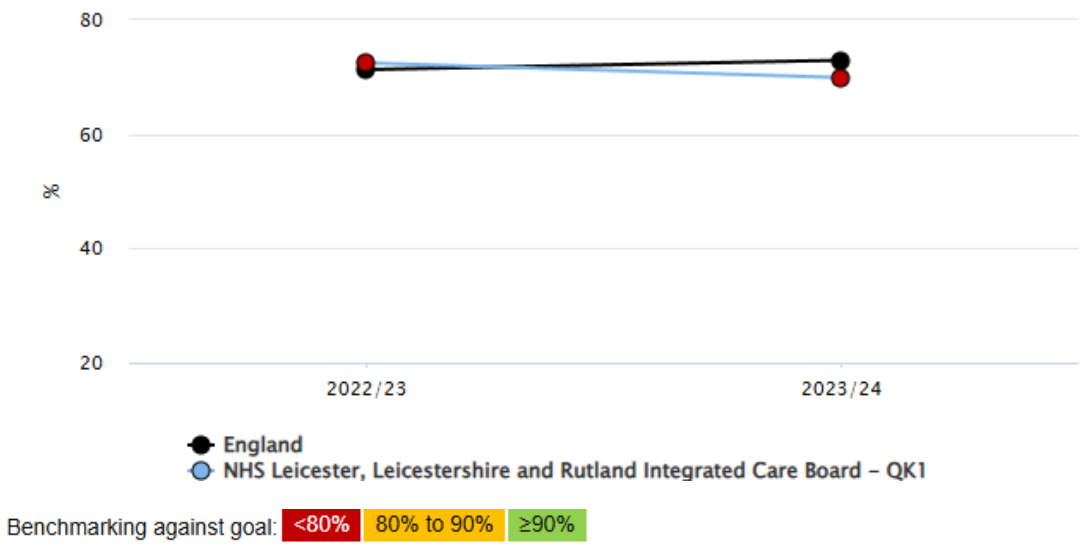
HPV Vaccination

The national HPV vaccination programme was introduced in 2008 on the advice of the Joint Committee on Vaccination and Immunisation (JCVI). The aim of the programme is to protect adolescents from HPV-related cancers.

The HPV immunisation programme is a school-based programme, with alternative provision for those not in mainstream schools. The vaccine is routinely offered to children in year 8 (aged 12-13) with an offer for any catch ups in year 9 and 10 depending on local need.

In LLR and England, vaccination rates for pupils in year 8, are significantly lower (below 80%) when compared against the benchmarking goal. The LLR HPV vaccination rate in 2023/24 was 69.9% which was below the England rate of 72.9%.

Figure 90: HPV vaccination coverage for one dose (12-13 year old) – females in LLR



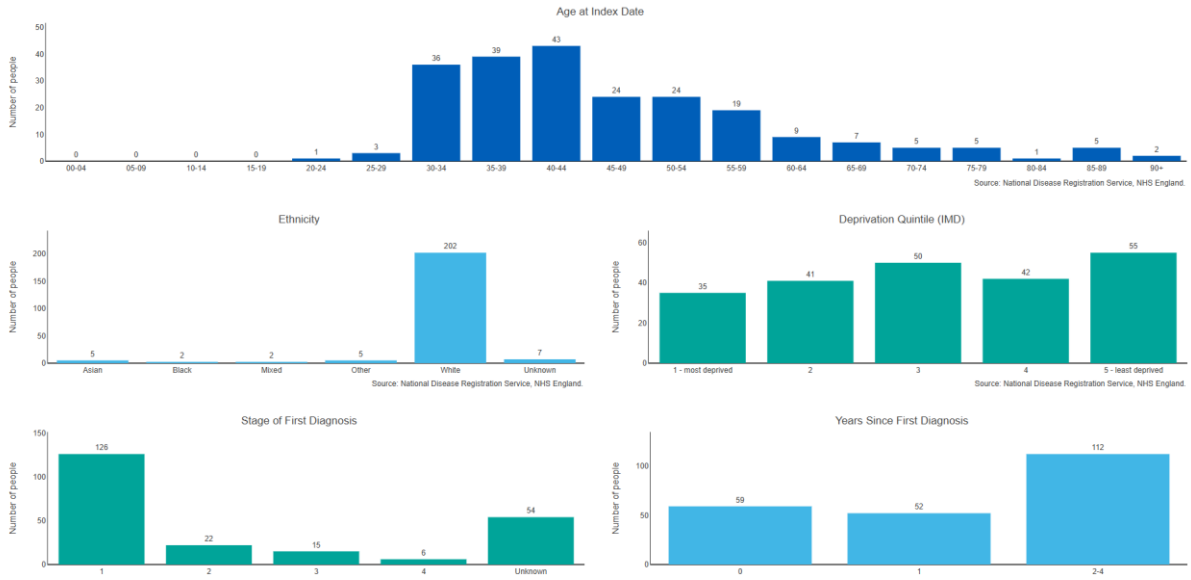
Source: Public Health Outcomes Framework, OHID, 2025.

Cervical Cancer Prevalence

The National Disease Registration Service (NDRS) published local cancer prevalence statistics in 2022, derived from cancer incidence and survival to provide counts on people living with and beyond a cancer diagnosis at a fixed point in time (between 2018 – 2022). In LLR, 223 women were living with and beyond with cervical cancer during this period, this equates to a crude rate of 38.9 (per 100,000 female population), this is significantly higher in comparison to the national rate of 36.2.

Figure 41 below shows the demographics of women living with and beyond with cervical cancer in LLR. In terms of age, the highest proportion living with and beyond cervical with cancer are from the 40-44 age group (19.3%), followed by 35-39 age group (17.5%) and 30-34 age group (16.1%). Out of all the ethnicities presented, 90.6% were from the White ethnic group. In terms of deprivation, 24.7% of women living with and beyond with cervical cancer were from the least deprived area, whilst 15.7% were from the most deprived area. Just over 55% of women who are living with and beyond with cervical cancer were diagnosed at stage 1 and for about 50% of women, it has been 2-4 years since their first diagnosis.

Figure 91: Characteristics of women living with and beyond cervical cancer in LLR, 2022.



Data Source: National Disease Registration Service (NDRS)

Cancer Mortality

Cervical cancer mortality rates in the UK have significantly declined, by 75% since the 1970s and around 18% in the last decade. Cervical cancer is the19th most common cause of cancer death in females in the UK. Each year more than a quarter of all cervical cancer deaths (28%) in the UK are in females aged 75 and over.[347]

In England, there are approximately just over 700 deaths per year from cervical cancer between 2021 and 2023. Over the five year period between 2019 and 2023, the number of deaths due to cervical cancer per year has been 10 or below in Leicester or Leicestershire. There have been no

[347] Cancer Research UK (2025). Cervical Cancer Statistics. Available at: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer#Cervicalcs2

deaths registered in Rutland due to cervical cancer during the same period. The cervical cancer mortality rates in Leicester and Leicestershire are statistically similar to the national rate.

Table 14: Number / Age Standardised Mortality Rates for Cervical Cancer, 2019 to 2023 in Leicester and Leicestershire

Number of Deaths			
Date	**Leicester**	**Leicestershire**	**England**
2019	0	9	681
2020	8	0	702
2021	5	5	703
2022	0	10	737
2023	5	9	702
Age Standardised Mortality Rates			
Date	**Leicester**	**Leicestershire**	**England**
2019	-	2.5	2.4
2020	5.2	-	2.5
2021	3.4	1.0	2.4
2022	-	2.4	2.5
2023	3.3	2.3	2.4

Statistically Similar to England

Note: ICD code C53 – Malignant neoplasm of cervix uteri

Source: ONS Mortality Statistics, NOMIS, 2025

6.2.4 What evidence- based management is recommended?

In terms of prevention, Cervical screening, HPV vaccinations and barrier methods of contraception are recommended.[348]

In terms of management, a specialist assessment of suspected cervical cancer is undertaken by a multidisciplinary team (including gynaecology oncologists, general gynaecologist, clinical oncologists, radiologists and clinical nurse specialists).

[348] NICE (2025). Cervical cancer and HPV Management. Available at: https://cks.nice.org.uk/topics/cervical-cancer-hpv/management/management/

If cervical cancer is confirmed, further investigations are done to determine disease extent. Imaging and diagnostic tools are used in staging and treatment planning. Staging is based on clinical, radiological, or pathological findings. Factors considered include:[348]

- Tumour size
- Lymph node status
- Vaginal or parametrial involvement
- Bladder/rectum extension
- Distant metastases

Women are also offered advice on sources of information and support such as Cancer Research and Macmillan Cancer support.

Management/treatment options depend on the stage of the disease, see summary below (full details are available on the NICE website):[348]

Stage	Example of treatment
Stage IA1 – microinvasive disease	• Loop electrosurgical excision and conization with the aim of achieving negative margins to both cancer and dysplasia or hysterectomy.
Stages IA2–IB2 - early stage disease	• Radical hysterectomy or radical trachelectomy • Chemotherapy/radiotherapy
Stage IB3–IVA - locally advanced disease	• Treatment with external beam radiotherapy, intracavity brachytherapy and concomitant chemotherapy
Stage IVB - spread to distant organs	• Systemic chemotherapy is usually offered first-line.

In terms of managing advanced cervical cancer, patients are offered management of general issues, complications (such as renal or haemorrhage) and bladder and bowel symptoms.

6.2.5 Current Services in LLR

Cervical Cancer Screening – Routine cervical testing is usually performed at GP surgeries in LLR.

Women with cervical symptoms are able to contact their GP in the first instance. Once the GP has carried out an assessment, they may refer patients to the department of Gynaecology based at UHL for further investigation.

Sexual Health Services will also undertake Cervical Screening.

HPV vaccine is offered free of charges as part of the NHS national vaccination programme, via:

- LPT School Age Immunisation Service (SAIS) to school aged children.

- Primary care can provide the vaccination to young people under the age of 25 years if the SAIS vaccination opportunity has been missed, or if they are home-schooled.
- Specialist sexual health services and the UHL HIV clinic provide the HPV vaccination to men who have sex with men (aged up to 45 years), and to other individuals who are considered at risk of HPV infection, eg to individuals diagnosed with HIV.

The vaccine is also available from private providers on a 'paid-for' basis.

6.2.6 Unmet needs or gaps

- Cervical cancer screening rates in LLR are significantly declining and worsening. Leicester City cervical screening rates are below national target of 70%.
- Routine cervical screening in LLR is typically conducted in GP surgeries, but uptake remains inconsistent. Barriers include embarrassment, lack of symptoms, cultural stigma, and previous negative experiences.
- Focus group data reveals that women from deprived areas and ethnic minority communities face additional challenges in accessing screening, including concerns about the process, transportation, and trust in services.
- Health equity audits for cervical screening programmes are either unavailable or incomplete, making it difficult to assess disparities.
- HPV vaccination coverage in LLR is below national target of 90%. While the HPV vaccine is widely available, uptake varies. There is a need for better education around HPV and its link to cervical cancer, especially in schools, colleges, and underserved communities.
- NDRS characteristics data for those living with and beyond with cervical cancer reveal, over 90% are of white ethnicity, and 24% are from least deprived quintile compared to 15% in the most deprived quintile. The data also shows that women diagnosed in stage 1 are living with and beyond with cervical cancer compared to the other stages.

6.2.7 Recommendations

- Targeted action to improve uptake of cervical screening by understanding local patterns of inequality in uptake and targeted action to increase coverage. This could be done by producing a health equity audit.
- Promote cancer symptom awareness to encourage early presentation, especially for those groups most at risk and facing health inequalities.
- Work with local partners to develop and deliver plans to increase uptake of HPV vaccination – including raising awareness of HPV to post 16-year-olds via further education routes, eg universities and colleges and other venues young people frequent.
- Apply a Core20PLUS5 focus to improve HPV knowledge/education and vaccination uptake – looking at deprivation, protected characteristics and inclusion health groups – to embed health inequalities approaches.
- Access to Screening: Women with learning disabilities are less likely to attend cervical screenings — offer reminders, transport help, and accessible explanations or seeking support from LD Primary care liaison nurses.
- Clarify referral and treatment pathways to reduce delays and improve patient experience.

7 Violence Against Women and Girls

This chapter covers domestic violence and female genital mutilation.

Key Epidemiology & Context

- VAWG is a serious and preventable public health issue, with pervasive impacts across physical, mental, sexual and reproductive health
- An estimated 3.8 million people experienced domestic abuse in England and Wales in the year ending 2025, including 2.2 million women
- Violence has both immediate and long-term health consequences, and in extreme cases results in homicide
- The true scale is substantially under-reported, with many incidents hidden and perpetrators unidentified

Inequalities & At-Risk Groups

- VAWG is both driven by and reinforces gender inequality, shaped by power imbalances and structural barriers
- Disproportionate impact on:
- Women in deprived communities
- Ethnic minority, migrant, and asylum-seeking women
- Disabled women and those with multiple vulnerabilities
- Younger women and girls
- Experiences are intersectional, often overlapping with poverty, poor mental health, substance use, and social exclusion
- Locally, nearly half of domestic abuse incidents occur in Leicester City, indicating place-based inequality

Gaps & Unmet Need

- Significant underreporting, hidden harm and stigma
- Fragmented pathways between health, justice, and community services
- Variable training, confidence, and response across healthcare settings
- Limited routine data linking health outcomes with VAWG experiences

Implications for LLR

- Significant cross-sector impact on health and social care
- Long-term health consequences can increase repeat service use and costs across the system
- Hidden needs, compounded by stigma, shame and fear, shows there are women living and suffering in silence
- Variation in recognition and response may lead to missed opportunities for early intervention and prevention

Priority Action Themes

- Strengthen identification and support pathways in health and care settings
- Improve multi-agency response
- Embed lived experience and improve data to drive service design across health and care settings
- Improve staff confidence and competence in addressing and enquiring

7.1 Background

Violence Against Women and Girls (VAWG) is a widespread and preventable public health issue with major implications for physical, mental, sexual and reproductive health. The World Health Organisation (WHO) identifies VAWG as a major global concern, with around 1 in 3 women worldwide experiencing physical and/or sexual violence.[349]

Under the Domestic Abuse Act 2021, local authorities must undertake domestic abuse needs assessments; however, these predominantly focus on accommodation-based provision, not the broader health needs and health-system responsibilities of victim-survivors. Consequently, gaps may exist in understanding the clinical, psychological and long-term health burden of VAWG across LLR.[350] VAWG includes domestic abuse, sexual violence, stalking, harassment, so-called honour-based abuse, forced marriage, and Female Genital Mutilation (FGM). Health services are often the first or only point of contact for many women experiencing abuse.

VAWG is not a marginal issue, nor an isolated series of incidents; it is a pervasive, entrenched and deeply systemic harm woven into the fabric of our society. It shapes the lives, opportunities, health, safety and wellbeing of women and girls across LLR in ways that are profound, far-reaching and often invisible. VAWG is upheld and perpetuated through longstanding social norms, gender inequality, power imbalances and structural barriers that continue to constrain women's autonomy, freedom and safety. Women affected by VAWG often experience more than one form of harm, with sexual violence and domestic abuse frequently co-occurring; such multiple victimisation disproportionately affects women already experiencing social and structural inequalities.[351]

This document therefore does not claim to do justice to the full reality of VAWG. Instead, it provides a high-level overview of the issues most relevant to women's health and the wider health and care system, including domestic abuse (DA) and female genital mutilation (FGM). It offers clarity on the evidence available, identifies critical gaps, and sets out recommendations for future work that must continue across the system if we are to meaningfully address VAWG.

This chapter should not be read in isolation. It does not duplicate detail already held in the Place-specific Domestic Abuse Needs Assessments or other statutory assessments; rather, it should be read in conjunction with them, and seen as part of a much wider, ongoing system effort. It will largely focus on domestic abuse and FGM.

Although the pages that follow cannot capture every experience, every injustice, or every barrier faced by women and girls in LLR, they serve as a call to action. They underline the urgent need for continued commitment, stronger partnership working, improved data, and sustained focus on prevention, early intervention and trauma-informed responses.

Together, as a system and as a community, we can reduce VAWG across LLR, and we must.

[349] World Health Organization. Violence against women: fact sheet. Geneva: WHO; 2024
[350] Legislation.gov.uk. Domestic Abuse Act 2021. London: The Stationery Office; 2021.
[351] Women's Aid (2025). Domestic abuse, the facts. Available at: https://womensaid.org.uk/what-we-do/research/domestic-abuse-the-facts/#:~:text=Domestic%20abuse%20is%20a%20gendered,members%2C%20often%20with%20multiple%20perpetrators.

7.1.1 Policy Context

7.1.1.1 Cross-Government Strategy

The Government's 2025 cross-government VAWG strategy, Freedom from Violence and Abuse, strengthens this landscape by setting an ambition to halve VAWG within a decade through a whole-of-government, whole-of-society approach[3]. The strategy's three pillars, Prevention and Early Intervention, Relentless Pursuit of Perpetrators, and Support for Victims and Survivors, align strongly with the public health approach taken in this WHNA. It emphasises early intervention, root-cause disruption, improving online and offline safety, whole-system accountability, and the importance of addressing the needs of marginalised women, including migrant and minoritised communities.[352]

7.1.1.2 LLR VAWG Strategy

Partners across LLR are committed to address the serious impact of VAWG by implementing the LLR Police and Crime Commissioner's VAWG 2024-2026 Strategy.[353] The strategy acknowledges the evidence that intervening early can prevent violence from escalating and further offending occurring, and there is some promising evidence from domestic violence perpetrator programmes. The strategy focuses on the following priorities:

- Priority 1 - Preventing violence against women and girls.
- Priority 2 - Responding to violence against women and girls.
- Priority 3 - Supporting victims and survivors.
- Priority 4 - Including people with lived experience in designing our services.
- Priority 5 - Strengthening the VAWG sector across all our communities.

Alongside the strategy's overarching priorities partners are working to Home Office expectations that local services will:

1. Put the victim/survivor at the centre of service design and delivery.
2. Have a clear focus on perpetrators in order to keep victims and survivors safe.
3. Take a strategic, system-wide approach to commissioning, acknowledging the gendered nature of VAWG.
4. Are locally led and safeguard individuals at every point.
5. Raise local awareness of the issues and involve, engage and empower communities to seek, design and deliver solutions to prevent VAWG.

An overview of local crimes statistics relating to VAWG can be found within this document. Locally is it understood that crimes remain hidden, and many perpetrators remain unknown.

7.1.1.3 Serious Violence Duty

Under the Serious Violence Duty, there is a requirement for specified authorities to collaborate on preventing and reducing serious violence. Domestic abuse is not mandated within the Duty's scope; however, authorities may include it locally where domestic abuse constitutes a significant form of violence.[354] In LLR, domestic abuse is recognised as a key driver of harm and

[352] Home Office. Freedom from violence and abuse: a cross-government strategy. London: Home Office; 2025.
[353] Police and Crime Commissioner for LLR. VAWG Strategy 2024-2026. Available from https://www.leics.pcc.police.uk/SysSiteAssets/documents/finance-and-transparency/public-information/publications/leicester-leicestershire-and-rutland-partnership-vawg-strategy-2024-2026.pdf
[354] UK Parliament. Victims and Prisoners Act 2024, Part 1: Duty to collaborate in exercise of victim support functions. 2024. Available from: https://www.legislation.gov.uk/ukpga/2024/21/part/1/crossheading/collaboration-in-exercise-of-victim-support-functions

is therefore incorporated into local strategic planning, enabling multi-agency collaboration and joint commissioning.

7.1.2 Risk factors and Consequences

VAWG does not occur in a vacuum: it is the product of entrenched structural inequality, harmful gender norms, discrimination, and power imbalances. These factors interact across individual, interpersonal, community and societal levels, increasing women's vulnerability to violence. Just as importantly, VAWG has far-reaching and often lifelong consequences, touching every dimension of a woman's life, from her physical health and mental wellbeing to her economic stability, relationships, parenting, education, and long-term life chances.

VAWG is not a single event. It is a continuum of harm that reverberates throughout women's lives.

7.2 Domestic Abuse

The statutory definition of domestic abuse (DA) is '*any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional.*'[350]

Forced marriage is a serious human rights abuse and a form of violence against women and girls, occurring when one or both parties do not freely consent and are pressured or abused. It can involve physical, emotional, psychological, sexual or financial coercion, affecting women and girls from diverse backgrounds. Forced marriage leads to poor mental health, sexual and reproductive health risks, domestic and sexual abuse, and social isolation. Barriers such as fear, stigma, language, immigration status or family control often hinder access to support. Health services are vital for early identification, safeguarding and referral, as forced marriage often overlaps with honour-based and domestic abuse.[355]

VAWG is shaped by gender inequality and structural disadvantage, but risk is amplified by multiple intersecting vulnerabilities. Not all women in LLR are at the same risk. Intersectional factors such as ethnicity, sexual orientation, disability and economic status can increase vulnerability. Information collated by Save Lives[356] identifies that:

- Domestic abuse is more prevalent amongst Black Caribbean than White British women
- Prevalence of DA may be higher among lesbian and bisexual females than heterosexual females
- Bisexual females experience more DVA than females belonging to other sexual identities
- Females in same-sex relationships reported a higher prevalence of physical assault, injuries, psychological aggression and the highest frequency of overall victimisation.
- Disabled people experience twice the rate of sexual assault, domestic abuse and stalking than non-disabled people.

[355] Home Office, Foreign, Commonwealth & Development Office. The right to choose: government guidance on forced marriage. London: GOV.UK; 2023. Available from: https://www.gov.uk/government/publications/the-right-to-choose-government-guidance-on-forced-marriage

[356] Women's Aid. The impact of domestic abuse [Internet]. Women's Aid. 2022. Available from: https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-impact-of-domestic-abuse

- Women in poverty are more likely to experience the most extensive violence and abuse. One research study found that 14% of women in poverty have faced extensive violence and abuse, compared to 6% of women not in living in poverty

7.2.1 Risk Factors

There are also individual, community and societal factors that can make someone more at risk. These can include:

Individual & Interpersonal Risk Factors

- **Young age (16–24)** is a key period of vulnerability.[357]
- **Pregnancy** is a recognised escalation point for abuse.[358]
- **Mental health conditions**, including depression, anxiety and PTSD, increase risk.[359]
- **Substance misuse** by perpetrators and/or victims is a well-established risk amplifier.[357]
- **Economic dependence**, reflecting structural gender inequality.[360]

Community & Structural Risk Factors[361, 358, 351]

- Living in areas of **high deprivation**, which correlates with elevated rates of domestic abuse and sexual violence.
- **Social exclusion**, insecure housing, and limited access to support.
- **Cultural norms and stigma**, particularly around sexual violence and FGM, affecting disclosure and help-seeking.
- **Racism and discrimination**, which reduces trust in services and increases barriers to access.

There are also **specific perpetrator risk factors:**[362] [363]

- Harmful gender norms and misogynistic attitudes.
- High levels of **alcohol and drug use**.
- Childhood exposure to violence.

7.2.2 Consequences of Domestic Abuse

Domestic abuse has broad and profound health impacts. Many consequences are invisible or misattributed by, yet evidence shows that IPV survivors face disproportionately high rates of

[357] Weir R, Adisa O, Blom N, et al. Adolescent domestic abuse and its consequences: a rapid systematic review. J Fam Violence. 2025. https://doi.org/10.1007/s10896-025-00813-4
[358] Schrubbe L, García-Moreno C, Sardinha L, Stöckl H. Intimate partner violence against women during pregnancy: a systematic review and meta-analysis protocol. Syst Rev. 2023;12:107. Available from: https://link.springer.com/article/10.1186/s13643-023-02232-2
[359] NICE Clinical Knowledge Summaries. Domestic abuse: risk factors. London: National Institute for Health and Care Excellence (NICE); 2024. Available from: https://cks.nice.org.uk/topics/domestic-abuse/background-information/risk-factors/
[360] Women's Aid. The Economics of Abuse: Report Summary 2019. Women's Aid Federation of England; 2019. Available from: https://womensaid.org.uk/wp-content/uploads/2019/03/Economics-of-Abuse-Report-Summary-2019.pdf#:~:text=Economic%20abuse%20is%20often%20misunderstood%20but%20it,to%20find%20out%20about%20survivors'%20experiences%20of.
[361] Hulley, J., Bailey, L., Kirkman, G., Gibbs, G. R., Gomersall, T., Latif, A., & Jones, A. (2022). Intimate Partner Violence and Barriers to Help-Seeking Among Black, Asian, Minority Ethnic and Immigrant Women: A Qualitative Metasynthesis of Global Research. Trauma, Violence, & Abuse, 24(2), 1001-1015. https://doi.org/10.1177/15248380211050590
[362] Ross JM, Davis J. Alcohol, gender, and violence: factors influencing blame for partner aggression. Behav Sci Law. 2023;41:41–54. Available from: https://onlinelibrary.wiley.com/doi/pdf/10.1002/bsl.2604
[363] Centers for Disease Control and Prevention. Risk and protective factors for IPV perpetration. CDC; 2024. Available from: https://www.cdc.gov/intimate-partner-violence/risk-factors/index.html

chronic disease, disability, and premature mortality including:[364, 365] (references refer to these, unless otherwise stated)

- Mental Health Consequences
    - Depression, anxiety, stress and PTSD
    - Suicide and suicidal ideation, and self-harm[366]
- Physical health consequences
    - Injuries, including traumatic brain injury
    - Chronic pain including back pain, migraines and MSK disorders
    - Gastrointestinal disorders
    - Hypertension stroke and heart disease
- Dental and oral health[367]
    - Dental and maxillofacial injuries due to physical trauma, as well as chronic pain.
    - Untreated disorders, where perpetrators restrict victims from healthcare access and finances.
- Reproductive and sexual health consequences
    - Sexually transmitted infections
    - Unintended pregnancy, infertility, chronic pelvic pain, and menstrual irregularity.
    - Adverse pregnancy outcomes, including miscarriage, preterm birth, low birthweight, and increased neonatal risk.
    - Long term gynaecological complications and persistent reproductive health issues.

There are also **intergenerational factors** and consequences. Herbert et al. succinctly describes how childhood exposure to intimate partner violence increases the likelihood that young people will experience such violence in their own relationships. Multiple systematic reviews over the past two decades consistently show that children who witness parental IPVA face elevated risks of IPVA in adulthood, including a dose–response pattern where greater severity and frequency of exposure correspond to higher future risk.[368]

7.2.2.1 Healthcare and Domestic Abuse

DA is a profound public health issue, and the healthcare system holds both an obligation and a unique opportunity to respond. The pervasive physical, psychological and social reverberations of DA create a pattern of harm that directly shapes women's health across the life course. As the data illustrates, DA is not peripheral to healthcare, it is interwoven into the daily milieu of clinical practice, with significant proportions of women presenting to primary care, maternity services and mental health settings while experiencing abuse.

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[364] Flor, Luisa S et al. Disease burden attributable to intimate partner violence against females and sexual violence against children in 204 countries and territories, 1990–2023: a systematic analysis for the Global Burden of Disease Study 2023. 2026. The Lancet, Volume 407, Issue 10523, 31 – 52. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)02503-6/fulltext

[365] García-Moreno C, Jansen HAFM, Ellsberg M, Heise L, Watts C. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet. 2006;368(9543):1260–9. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)08336-8/fulltext

[366] Broomfield H, Raphael-James H, Ranganathan M, Verma A, Pareek M. The impact of domestic abuse on suicide. Lancet Reg Health Eur. 2025;45:100780. Available from: https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(25)00168-1/fulltext

[367] Tripathy S, Kumar D, Mehta V, Neyazi A, Satapathy P, Rustagi S, et al. Bearing the marks: understanding how domestic violence affects oral health. 2023. Available from: https://journals.lww.com/ijsgh/fulltext/2024/01010/bearing_the_marks__understanding_how_domestic.5.aspx

[368] Herbert A, Barter C, Szilassy E, Heron J, Fraser A, Barnes M, et al. The impact of parental intimate partner violence and abuse (IPVA) on young adult relationships: a UK general population cohort study. Lancet Reg Health Eur. 2025;53:101278. Available from: https://www.thelancet.com/journals/lanepe/article/piiS2666-7762(25)00070-5/fulltext

Given this, healthcare professionals have a clear responsibility not only to understand the antecedents and impacts of DA, but also to recognise, enquire safely, and offer congruent, trauma-informed support. Early identification within health settings can ameliorate risk, improve wellbeing, and act as a critical gateway to specialist services. This infographic delineates why DA must be considered a salient and stratified component of women's health assessment and system-wide response.[369]

Figure 92: Why is domestic abuse a health issue?



Source: Safelives

7.3 Female Genital Mutilation

Female Genital Mutilation (FGM) refers to all procedures involving the partial or total removal of the external female genitalia, or any other injury to the female genital organs for non-medical reasons. It is a harmful traditional practice, carried out predominantly on girls between infancy and adolescence, with no health benefits and significant immediate and long-term consequences. FGM is recognised internationally as a violation of human rights and an extreme form of gender-based violence, reflecting deeply rooted inequalities and social norms that restrict the autonomy, bodily integrity and wellbeing of girls and women.[370]

FGM persists largely because of **powerful social and cultural norms** that link the practice to purity, marriageability, family honour and community identity. In many settings, FGM operates as a mechanism of social cohesion, reinforced through intergenerational expectations that

[369] SafeLives. Health Pathfinder project. SafeLives; 2026. Available from: https://safelives.org.uk/research-policy/health/pathfinder/
[370] World Health Organisation. Female genital mutilation: Fact sheet. Geneva: WHO; 2025. Available from: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

normalise the practice despite its well-documented harms.[358] Systematic reviews highlight that these social pressures are central to the continuation of FGM, with families often fearing stigma or exclusion if they do not conform to community expectations.[371] Broader structural gender inequality also plays a significant role: FGM functions as a means of regulating female sexuality and controlling girls' and women's bodies, reflecting wider patterns of discriminatory norms and unequal power relations. WHO evidence consistently emphasises that harmful practices affecting women's health are rooted in these unequal social structures.[369]

In addition, FGM is maintained through intergenerational transmission, with parents and extended family members reproducing established norms to avoid social sanctions or perceived dishonour. Risk can also be heightened in the context of migration, where girls may be taken abroad to countries of origin during school holidays or family visits, aligning with patterns of transnational harm.[372] Limited access to accurate health information further perpetuates FGM, as low awareness of long-term physical, psychological and reproductive consequences reduce motivation for change. Reports highlight that poor health literacy (not always termed healthy literacy, often termed health knowledge, information and awareness) amplifies the negative outcomes of harmful practices, underscoring the need for culturally competent education and community-led prevention efforts.[373] This may present a challenge within Leicester especially, because of the city's demographics, varying levels of health literacy, and language barriers.

7.3.1 Consequences of FGM

Girls who have undergone FGM frequently encounter hazardous and distressing outcomes. The repercussions of FGM often encompass both immediate and enduring health issues for many girls and women. These adverse effects, which can be physical, psychological, and social, typically result in challenges that persist from childhood through adolescence and into adulthood.

Short-term complications include:

- Severe pain, swelling and/or bleeding
- Fever, infection, wound healing issues
- Injury to surrounding genital tissue
- Urinary problems
- Shock
- Death

Long-term complications can include:

- Urinary, vaginal, sexual and menstrual problems
- Scarring and skin changes in the genital region
- Complications of childbirth
- Infertility

[371] Xu Z, Chen X, Yu J, Hu Y. Female genital mutilation/cutting: a systematic review of global patterns, sociocultural drivers, and health consequences. J Pediatr Adolesc Gynecol. 2025;38(1):101409. Available from: https://www.jpagonline.org/article/S1083-3188(25)00353-5/fulltext

[372] UNICEF. Female genital mutilation: a global concern. New York: United Nations Children's Fund; 2024. Available from: https://data.unicef.org/resources/female-genital-mutilation-a-global-concern-2024/

[373] UNFPA, UNICEF. 2024 Annual Report of the FGM Joint Programme: Accelerating Action. New York: United Nations Population Fund and UNICEF; 2025. Available from: https://www.unicef.org/documents/2024-annual-report-fgm-joint-programme-accelerating-action-strengthening-alliances-and.

- Need for surgeries
- Women's willingness or ability to engage with healthcare, due to pain, shame or fear
- Psychological problems[374]

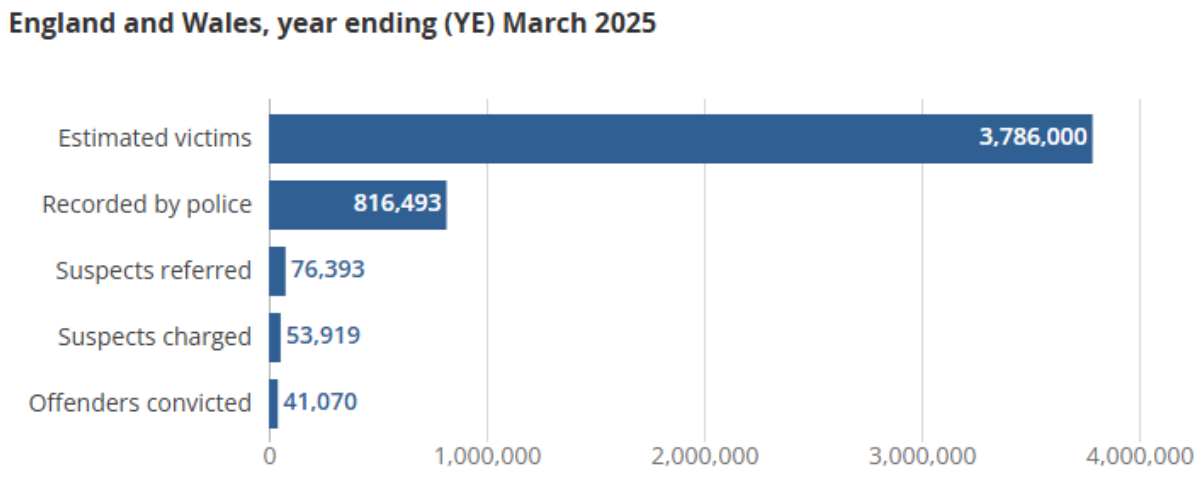
7.4 Level of need

This section will address prevalence, with an emphasis on the implications for healthcare services. To avoid duplicating other Health Needs Assessments and Strategies concerning VAWG/DA, service utilisation data regarding access to DA services has been excluded from this discussion. However, such data may be considered in future analyses or initiatives.

7.4.1 Domestic Abuse

Recorded prevalence of domestic abuse captures only a small fraction of the true scale of harm. National ONS data shows that an estimated 3.8 million people experienced domestic abuse in the year ending March 2025, yet only 816,493 cases were recorded by police. The accompanying diagram starkly highlights this disparity, making clear that official data reflects only the tip of the iceberg of victimisation.[375]

Figure 93: Domestic abuse data from incident to conviction



Source: Crime Survey for England and Wales from the Office for National Statistics, Police recorded crime data from the Home Office, and Crown Prosecution Service (CPS)

Domestic abuse also remains deeply gendered. 72.1% of domestic abuse related crime victims were female, demonstrating the disproportionate burden experienced by women. This aligns with wider VAWG evidence showing that women not only face higher rates of victimisation but also more severe, repeated, and long-term impacts.[351, 374]

Crucially, many women affected by domestic abuse will present to healthcare long before they ever seek support from police or specialist services. Health settings often represent the only safe or routine point of contact. This makes it essential that professionals are equipped to recognise the signs, both overt and subtle, and respond in ways that enable

[374] WHO (2023). Health risks of female genital mutilation (FGM). [online] www.who.int. Available at: https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation.
[375] Office for National Statistics. Domestic abuse in England and Wales overview: November 2025. Newport (UK): ONS; 2025. Available from: https://www.ons.gov.uk/releases/domesticabuseinenglandandwalesoverviewnovember2025

disclosure, provide immediate safety, and connect women with appropriate support pathways.[376] Local health services do carry out routine enquiry regarding domestic abuse at health contacts in line with NICE Quality Standard QS116.[377] This requirement has also been strengthened with the Domestic Abuse Act Statutory Guidance which promotes a Making Every Contact Count (MECC) approach as best practice.

National trends are also demonstrated locally, with women being disproportionately affected by Domestic Abuse across LLR.

- During 2023-24 there were 1167 known cases of high-risk domestic abuse discussed at the Multi Agency Risk Assessment Conference (MARAC). 1241 involved women as victims (94.9%).[378]
- Since 2011 there has been a combined total of 30 Domestic Homicide Reviews completed across LLR, with 23 (76.6%) victims being women.[379]
- There have been 19 DHRs commissioned by the Leicester Community Safety Partnership between 2011 and March 2023. 15 of these involved the death of a female (79 %).[380] In Leicestershire and Rutland there has been 11 DHR's commissioned between 2011 and March 2023 with 8 victims were female (73 %).

Since 2016, deaths by suicide of victims of DA have also been reviewed via the DHR process.[381] **In England and Wales domestic abuse related death by suicides are now exceeding those deaths by homicide.**[382] The LLR Suicide Prevention strategy acknowledges those experiencing intimate partner violence to be in a high-risk group.[383] Anecdotally, mental and physical health related needs and concerns are increasingly being seen in local authority commissioned DA service data, as well as being highlighted from those with lived experience.

Although there are no national reporting requirements for the health impacts of domestic abuse specifically, it's likely that women are underrepresented within data for hospital admission due to violence, which is the only national measure of health impacts of VAWG. This is because on average, where domestic abuse is a factor, women will be assaulted a total of 35 times before reporting to police.[384]

The Domestic Abuse Act 2021 brought in statutory duties to Tier 1 local authorities. Including development of a domestic abuse strategy encompassing the provision of support, informed by an updated needs assessment. Therefore, detailed data analysis of prevalence of domestic

[376] National Institute for Health and Care Excellence. Domestic violence and abuse: multi-agency working. London (UK): NICE; 2014. (Public health guideline PH50). Available from: https://www.nice.org.uk/guidance/ph50
[377] National Institute for Health and Care Excellence (NICE). Domestic violence and abuse: Quality standard (QS116). London (UK): NICE; 2016. Available from: https://www.nice.org.uk/guidance/qs116
[378] SafeLives. Our quarterly MARAC data [Internet]. SafeLives. 2024. Available from: https://safelives.org.uk/research-policy/practitioner-datasets/marac-data/
[379] Domestic homicide review [Internet]. GOV.UK. Available from: https://www.gov.uk/government/collections/domestic-homicide-review
[380] Leicester City Council. Domestic Homicide Reviews (DHRs). Leicester (UK): Leicester City Council; Available from: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-safety/leicester-community-safety-partnership/domestic-homicide-reviews-dhrs/
[381] Home Office. Domestic homicide review: statutory guidance. London (UK): Home Office; 2025. Available from: https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[382] Vulnerability Knowledge and Practice Programme (VKPP). Domestic Homicides and Suspected Victim Suicides: Year 4 Report (2020–2024). London (UK): VKPP; 2025. Available from: https://www.vkpp.org.uk/assets/Year-4-Report_publication.pdf
[383] Leicester, Leicestershire and Rutland Suicide Prevention Strategy Steering Group. LLR Suicide Prevention Strategy 2024–2029. Leicester (UK): LLR Partners; 2024. Available from: https://www.startaconversation.co.uk/uploads/llr-suicide-prevention-strategy-2024-2029.pdf?v=1756717068
[384] Living without abuse. Domestic Abuse Statistics | lwa.org.uk [Internet]. Living Without Abuse. 2021. Available from: https://lwa.org.uk/understanding-abuse/statistics/

abuse including inequalities and comparisons to statistical neighbours can be accessed via the respective local authority websites._[385], _[386], _[387]

Data could not be accessed on DA disclosures within healthcare, or local health care access due to DA. Future work should take a deeper dive into this to determine

Unfortunately, we were unable to obtain data regarding disclosures of domestic abuse within healthcare settings or local healthcare access related to domestic abuse. We recognise that this limitation is not a reflection of our valued healthcare partners, but rather highlights an important area for further exploration. Future work should focus on undertaking a more detailed analysis to understand how healthcare environments support domestic abuse disclosures, whether staff are adequately trained to respond, and the prevalence of domestic abuse-related healthcare access. Additionally, it would be beneficial to compare these findings with other areas to identify best practices and potential gaps.

Findings from the VRN Serious Violence Strategic Needs Assessment

Locally the LLR Violence Reduction Network produces a data driven annual strategic needs assessment. This has previously focused on public place violence. However, following the introduction of the Serious Violence Duty (2023) the network has reviewed the definition of serious violence and broadened it to include domestic abuse, sexual violence and violence in any setting. Therefore, this will provide a greater understanding of domestic abuse across LLR in the future.

In this section, we do not seek to reproduce the full Serious Violence Strategic Needs Assessment (SNA), nor replicate the breadth of analysis it contains. Instead, the intention is to distil the most salient domestic abuse findings that are directly relevant to women's health across Leicester, Leicestershire and Rutland.

Domestic abuse continues to constitute a major component of serious violence across Leicester, Leicestershire and Rutland (LLR), accounting for 31% of all serious violence. This reinforces the scale of the problem.

Although the latest data shows a 10% reduction in domestic abuse compared with the previous year, it remains a significant driver of harm locally. The most frequent offence types are Assault with Injury and Stalking and Harassment, behaviours that reflect both physical and psychological harm experienced by victims. Alcohol continues to play a notable role, with more than one-quarter of incidents flagged as alcohol-related, highlighting the need to understand and address intersecting risk factors such as substance use, stress, and family pressures.

Domestic abuse is unevenly distributed across LLR, with nearly half of all incidents occurring in Leicester City. High-priority areas include Hinckley & Blaby, East Leicester, and West Leicester, reflecting broader patterns of deprivation, population density and community-level risk. Notably, almost 90% of domestic abuse incidents occur within a dwelling, underscoring both

[385] LEICESTER DOMESTIC ABUSE NEEDS ASSESSMENT 2021 EXECUTIVE SUMMARY [Internet]. Available from: https://www.leicester.gov.uk/media/ypzflymu/domestic-sexual-violence-needs-assessment-executive-summary-2021.pdf
[386] Leicestershire County Council (LCC) - Domestic Abuse Act Statutory Duty 17 APPENDIX A. Available from: https://democracy.leics.gov.uk/documents/s165600/Appendix%20A%20Leicestershire%20DA%20Act%20Needs%20Assessment%20Final%20Report.pdf
[387] Rutland County Council. Rutland Domestic Abuse Strategy 2021–2024. Rutland (UK): Rutland County Council; 2022. Available from: https://www.rutland.gov.uk/sites/default/files/2022-12/Rutland%20Domestic%20Abuse%20Strategy%202021%20-%202024%20%28Nov%2022%29.pdf

the hidden nature of this harm and the importance of proactive, trauma-informed enquiry in health settings.

The SNA reports that's almost three quarters of victims are women, with the majority being recorded as white. Perpetrators are predominantly male, with the majority also being white.

7.5 FGM

Estimating the true prevalence of FGM in England and Wales remains challenging. FGM is a hidden practice, and national datasets reflect only the cases identified within health services. Evidence from academic modelling suggests no local authority area is likely to be entirely free from FGM, with prevalence patterns shaped by migration from countries where FGM is widely practiced. National prevalence estimates indicate that London has the highest concentration in the UK. Outside London, cities including Manchester, Slough, Bristol, Birmingham and Leicester show elevated prevalence, with modelled estimates in Leicester ranging from 1.2% to 1.6% of women.[388]

NHS Digital's FGM Enhanced Dataset records newly identified cases within the NHS, but the dataset captures only instances where FGM is disclosed or identified during clinical care. Many women may never disclose FGM, and opportunities for identification are concentrated in maternity, gynaecology, and sexual health settings. Consequently, recorded data is likely to represent only a small proportion of the true level of need.

In 2023-24 there were 55 reports of FGM either by self-report or examination across LLR reported via the NHS FGM data set.[389]

Table 15: Self-reported FGM reports in LLR, 2023/24

Area	Number of FGM Reports (%)
Leicester City	45 (81.8%)
Leicestershire	5 (9.1%)
Rutland	5 (9.1%)
LLR	55 (100%)

Source: NHS FGM Data

Professionals working within maternity and public health services acknowledge that mandatory reporting obligations may not always translate into complete or consistent identification, especially for historical FGM, which is frequently under-documented.

7.6 What evidence- based management is recommended

This section sets out evidence-based approaches that should guide local practice primarily across healthcare as well as public health, safeguarding, and local authority services. The intention is to highlight the national standards, clinical guidance and best-practice models that are relevant for all LLR partners involved in prevention, identification, support and system-level responses. This does not imply that certain practices are not already being implemented.

[388] Trust for London; City University London. Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates. London (UK): Trust for London; 2015. Available from: https://trustforlondon.org.uk/research/prevalence-female-genital-mutilation-england-and-wales-national-and-local-estimates/

[389] NHS Digital. Female Genital Mutilation (FGM) Enhanced Dataset: April 2023 to March 2024. Leeds (UK): NHS Digital; 2024. https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/april-2023-to-march-2024

Rather, this section outlines best practices to encourage local services to critically evaluate their current provisions in light of these recommendations.

7.6.1 Domestic Abuse

Healthcare plays a pivotal role in the early identification, risk assessment, and support of people experiencing domestic abuse. As the statutory guidance highlights, the health sector is often the first and sometimes only service to have routine contact with victims and perpetrators. This makes it a critical site for prevention, intervention, and safe enquiry.

7.6.1.1 Evidence and National Guidance – Healthcare Lens

The **Domestic Abuse Statutory Guidance** (2022)[390] identifies the Pathfinder: Enhancing the Response to Domestic Abuse Across Health Settings as a best-practice model for the NHS.[391] Evaluation demonstrated a 33% increase in identification of standard-risk cases and 11% rise in MARAC referrals in pilot areas.[392] This reinforces the critical role of healthcare as a universal point of contact, early identification, trauma-informed support, and safe enquiry. This model emphasises system-wide leadership, clear clinical pathways, improved staff training, and embedded specialist advocacy (e.g., IDVAs).

NICE PH50 (Domestic violence and abuse: multi-agency working) outlines the core responsibilities of healthcare systems[375]:

- Routinely enquire about DA in contexts where clinical indicators are present.
- Provide trauma-informed, culturally competent practice.
- Ensure referral pathways to specialist community-based support.
- Train staff across primary, acute, maternity and mental health services.
- Embed safeguarding and information-sharing frameworks.

NICE QS116 sets out essential actions for all frontline health and social care services.[3] This includes:[376]

- Ask safely: Conduct private, trauma informed enquiry/
- Recognise indicators: Such as depression, anxiety, PTSD, chronic pain, sexual health concerns, recurrent injury, self harm.
- Respond appropriately: Validate disclosures, consider immediate safety, document concerns clearly.
- Refer effectively: Ensure access to MARAC, IDVA support, safeguarding teams and specialist domestic abuse services.
- Collaborate: Share relevant information lawfully with safeguarding, health, police and local authority teams.

Local authorities, under the Domestic Abuse Act 2021, must assess need, commission support in safe accommodation, and coordinate partnerships.

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[390] Home Office. Domestic Abuse Statutory Guidance [Internet]. gov.uk. 2022 Jul. Available from: https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

[391] Pathfinder Toolkit June2020 [Internet]. Available from: https://communications.safelivesresearch.org.uk/Pathfinder%20Toolkit_Final.pdf

[392] Health Pathfinder: Technical report and profiles - SafeLives [Internet]. SafeLives. 2023. Available from: https://safelives.org.uk/research-policy-library/health-pathfinder-evaluation-reports/

Local government, housing, safeguarding, education and criminal justice partners all contribute to upstream prevention and multi-agency responses.

7.6.2 FGM

Effective management of FGM requires coordinated prevention, clinical care, safeguarding, community engagement and multi-agency information sharing. Evidence indicates that multi-level, culturally grounded interventions are most effective.[393]

Healthcare professionals in England must comply with the FGM Multi-agency Statutory Guidance (Home Office) and the Mandatory Reporting Duty for those under 18.[394]

A 2023 evaluation of interventions to prevent FGM found strongest effectiveness in community-led education, specialist FGM clinics, midwifery-based enquiry, and robust multi-agency safeguarding systems.[392]

Evidence and National Guidance – Healthcare Lens

Identification, Enquiry and Recording

NHS services must identify and document FGM type, complications, and safeguarding risks; and comply with reporting to the national FGM Enhanced Dataset.[393]

Safeguarding and Prevention

Safeguarding duties require assessing risk to female children in affected families and making timely referrals to the Multi-Agency Safeguarding Hub (MASH).

Locally, the LLR Safeguarding Children Partnership undertakes targeted summer-holiday FGM-risk campaigns to raise practitioner vigilance.[395]

Specialist Clinical Care

The RCOG Green-top Guideline No. 53 provides evidence-based clinical recommendations on:[396]

- Deinfibulation before or early in pregnancy
- Labour planning and surgical timing
- Management of sexual, urological and psychological sequelae

Specialist FGM clinics (urology, gynaecology, psychosexual therapy, midwifery) demonstrate improved outcomes and trauma-informed recovery.[397]

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[393] Berg RC, Denison E. A systematic review of the effectiveness of interventions to prevent and respond to female genital mutilation/cutting. Reprod Health. 2023;20(1):14.
[394] Home Office. Multi-agency Statutory Guidance on Female Genital Mutilation. 2020/2024.
Available from: https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation
[395] Leicester, Leicestershire & Rutland (LLR) Safeguarding Children Partnership. FGM Awareness Campaigns. Available from: https://lrsb.org.uk/fgm
[396] Royal College of Obstetricians and Gynaecologists (RCOG). Green-top Guideline No. 53: Female Genital Mutilation and Its Management. 2015.
Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/female-genital-mutilation-green-top-guideline-no-53/
[397] Topping A, Faraj M. Outcomes from UK specialist FGM clinics. BMC Women's Health. 2018.
Available from: https://bmcwomenshealth.biomedcentral.com/

Maternity and Reproductive Health Pathways

Early booking, risk assessment, birth planning, and coordinated multidisciplinary care are recommended in NICE antenatal standards and RCOG guidelines.[395, 396, 398]

Community Engagement and Education

Evidence shows that sustainable FGM abandonment requires:

- Community-owned prevention programmes
- Engagement with women, elders, religious leaders, and men
- School-based prevention
- Clear messaging on medical complications and legal protections[392, 399]

Healthcare can support by providing culturally competent education, translated materials, and referral pathways.

7.7 Current services in LLR

7.7.1 Domestic Abuse

Health organisations contribute to the LLR Partnership response to VAWG which utilises a public health approach and considers all levels of preventative interventions from perpetrator programs to delivering healthy relationship sessions in school. LLR also has a Trauma Informed Partnership with training being rolled out in many areas of the heath system.[400]

Within the three local authority areas domestic abuse support services are jointly commissioned in response to the needs of the local groups at risk. This includes 24-hour helpline, Independent Domestic Violence Advisors (IDVA), Children and young people workers and safe accommodation. Details of which can be found on the respective local authority website and needs assessments as previously mentioned. Specific services and support for specific groups are available, which include LGBTQ, Gypsy, Roma and Traveller people, and BAME. Services are generally delivered by VSCE organisations.

There are currently no clinical services commissioned locally to treat victims and survivors of domestic abuse. In line with the NHS key principle that care should be based on clinical priority, health services should ensure that all victims of domestic abuse and their children are not unduly disadvantaged in accessing physical and mental health services. University Hospitals of Leicester benefits from the co-location of two Independent Domestic Abuse Advisors (IDVA). For sexual assault within domestic abuse there is a local Sexual Assault Referral Centre for Adults as well as a regional paediatric centre.

Leicestershire County Council currently funds Project Echo which is a survivor-centred initiative led by SafeLives and delivered locally in Leicestershire. Project Echo is focused on embedding the lived experiences of victim-survivors of domestic abuse, including children and young people, into service design, commissioning and system improvement. The project creates safe,

[398] NICE. Antenatal care (NG201). 2021. Available from: https://www.nice.org.uk/guidance/ng201

[399] UNICEF. Female Genital Mutilation: A Global Review of Evidence. 2020. Available from: https://www.unicef.org/reports/female-genital-mutilation-global-review-evidence

[400] Violence Reduction Network. Trauma-Informed Partnership. Leicester, Leicestershire and Rutland Violence Reduction Network; 2024. Available from: https://www.violencereductionnetwork.co.uk/trauma-informed-partnership-home

trauma-informed opportunities for participants to share their views through surveys, workshops and co-production activities, ensuring choice, empowerment and inclusion.

Although not specific to DA or FGM, local Women's Health Hubs do provide extra support and help to women, and aim to break down inequalities in access to healthcare.

7.7.2 FGM

Opportunities to identify women who have undergone FGM mostly occur within maternity services. All women who are identified are offered appropriate clinical care in line with the International Well Women clinic at University Hospitals of Leicester NHS Trust.[401]

All health organisations across LLR follow the Multi-Agency Statutory Guidance and Safeguarding Risk assessment for those children who are deemed to be at risk of FGM. This is also embedded within the LLR Safeguarding Children procedures.[402] There is a statutory duty for health professionals to report all disclosure of FGM on under 18 to the police. Data reporting is also mandatory for all women identified as having FGM in accordance with the FGM Enhanced Dataset.

7.8 Unmet needs or gaps

Unmet needs persist within the VAWG landscape in LLR, despite national guidance, statutory obligations, and multi-agency frameworks. Additional research is required to accurately identify these unmet needs, as confirmation is not possible without access to relevant data.

- Outside of maternity services it is not clear how accessible the International Women's clinic is for those who may require clinical or psychological intervention for FGM.
- Significant data gaps to establish the health impact of Violence Against Women and Girls at a local level.
- Effective monitoring systems must routinely capture repeat and overlapping victimisation in local data to support early identification of complex risk and to inform commissioning and service planning that reflects the cumulative impact of these forms of violence on women's physical and mental health.
- Inequitable access to support: Women facing intersecting disadvantages (e.g. migrant, ethnic minority, disabled, LGBTQ+, or those with NRPF) face higher barriers to disclosure and help-seeking.
- Lack of perpetrator identification pathways: Healthcare lacks systematic processes for recognising, documenting and safely referring perpetrators, despite being one of the few universal touchpoints.
- There is not always consistent access to specialist support within health services.
- Under-identification and under-reporting of FGM.
- Barriers to help-seeking: Stigma, cultural norms, and fear of statutory consequences deter women from accessing healthcare or disclosing FGM-related harm.

[401] International Well Woman Clinic (FGM) [Internet]. UHL. 2024. Available from: https://www.leicestershospitals.nhs.uk/aboutus/departments-services/gynaecology/international-well-woman-clinic/
[402] Female Genital Mutilation [Internet]. llrscb.proceduresonline.com. Available from: https://llrscb.proceduresonline.com/p_fem_gen_mutil.html

7.9 Recommendations

- **Undertake further work to understand staff confidence and competence** in addressing and enquiring about Domestic Abuse (DA) and Female Genital Mutilation (FGM), recognising this as a key barrier to early identification and safe disclosure.
- **Embed core VAWG training** across all health settings — including primary care, maternity, mental health, urgent care, dentistry, and community services — to ensure practitioners feel equipped to undertake trauma-informed enquiry and make effective referrals, and adopt a Making Every Contact Count approach to VAWG.
- **Clarify and strengthen referral pathways** for both DA and FGM, ensuring staff know how and where to refer, and that bi-directional information flows exist between health, specialist VAWG providers, and safeguarding systems.
- **Continue embedding a Trauma Informed Approach** across all health and care services, ensuring organisational culture, environments and interactions reduce re-traumatisation and support safe disclosure.
- **Improve local data collection, coding, monitoring and sharing**, for DA and FGM to better understand prevalence, unmet need, repeat presentations, and access to specialist services.
- **Adopt health literacy-aligned communication** to address barriers for women with low literacy, English as an additional language, or communication needs.
- **Ensure bi-directional referral and data flows** between DA services and suicide-prevention partners, recognising the strong association between DA, trauma and self-harm.
- Undertake further work on related harms such as mental and physical health locally, through local DA service data.
- **Strengthen co-location and joint-working models**, particularly where multiple victimisation overlaps (e.g., DA and sexual violence).
- **Seek to understand the true prevalence of FGM locally**, including whether referrals to the FGM clinic reflect expected need.
- **Strengthen community-centred prevention** and culturally competent support for women and girls affected.
- Ensure **Women's Health Hubs** continue to enhance safeguarding through improved DA/FGM enquiry and strong, standardised pathways into specialist support, as well as through enhanced DA workforce training input.

8 Healthy Ageing

This chapter covers cardiovascular disease, bone health and cognitive health.

Key Epidemiology & Context

- Women more likely to live longer but with disability and chronic conditions
- High burden of cardiovascular disease, osteoporosis, and dementia in older women
- CVD can manifest and present differently in women, which is not always understood or known by women or healthcare staff
- Cardiovascular diseases are reported as the main cause of death in LLR (23% of all deaths in women), the percentage of deaths due to Hypertension, Stroke and Other CVD are higher in women compared to men.
- Bone health is significantly worse in women, with hip fractures and rates of osteoporosis higher in females, and mortality from accidental falls significantly worse in LLR than nationally.
- Bone health is strongly linked to changes during menopause

Inequalities & At-Risk Groups

- Deprivation and earlier life factors shape outcomes
- Ethnicity plays a role, with higher admission rates in the black ethnic group for CVD
- Rural vs urban differences in access and needs
- Higher risk among carers

Gaps & Unmet Need

- Limited prevention focus earlier in the life course
- Increasing demand due to ageing population
- There is a need to for greater understanding of how health conditions impact women specifically, and greater education of this for the general public, and healthcare professional to ensure that conditions are not missed or dismissed.
- Risk of social isolation and unmet need not being systematically identified

Implications for LLR

- Ageing population will drive increasing demand on health, social care, and community services
- Rising prevalence of multi-morbidity requiring coordinated, person-centred care
- Need to shift from treatment-focused models to prevention and independence
- Strong links to other chapters (e.g. menopause, mental health, VAWG, lifestyle), reinforcing a whole-life-course approach

Priority Action Themes

- Strengthen prevention across life course, not just in older age
- Improve management of long-term conditions
- Services need to understand the implications of the growing aging population and how they can ensure they will meet rising need

8.1 Cardiovascular Disease

8.1.1 Background

Cardiovascular disease (CVD) continues to be the leading cause of death worldwide and in England alone, it causes 1 in 4 deaths.[403] Cardiovascular diseases (CVDs) are a group of disorders of the circulatory system (heart and blood vessels)

They include:

- Coronary Heart Disease (CHD) – disease of the blood vessels supplying the heart muscle
- Cerebrovascular Disease - disease of the blood vessels supplying the brain, which can cause stroke and transient ischaemic attacks (sometimes referred to as mini strokes)
- Peripheral Arterial Disease (PAD) – disease of blood vessels supplying the arms and legs
- Rheumatic Heart Disease – damage to the heart muscle and heart valves from rheumatic fever, caused by streptococcal bacteria
- Congenital Heart Disease - malformations of heart structure existing at birth
- Deep Vein Thrombosis (DVT) and pulmonary embolism – blood clots in the leg veins, which can dislodge and move to the heart and lungs.

Heart attacks and strokes are usually acute events and are mainly caused by a blockage that prevents blood from flowing to the heart or brain. The most common reason for this is a build-up of fatty deposits on the inner walls of the blood vessels that supply the heart or brain. Strokes can also be caused by bleeding from a blood vessel in the brain or from blood clots.[404]

Overall, although females have a longer life expectancy than males, women make up the most significant percentage of CVD diagnoses in the elderly population, or in those greater than 80 years old.[405]

Men and women manifest CVDs differently, which can significantly affect the disease process. These can be categorised into structural, biological/hormonal differences, disease progression outcomes. Females tend to have smaller heart sizes and blood vessels, making them more prone to developing plaques. Hormonal differences in estrogen, progesterone, and testosterone also impact CVDs in each gender. Estrogen is protective for pre-menopausal women, and a drop in estrogen levels in menopausal women increases cardiovascular incidents.[406]

CVD is usually associated most with plaques of atheroma that form in the walls of blood vessels. There are many risk factors that increase the likelihood of forming atheroma, and its rate of development.[407]

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[403] Gov.uk (2019) Health matters: preventing cardiovascular disease available at: https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/health-matters-preventing-cardiovascular-disease

404 World Health Organisation (2021) Cardiovascular diseases (CVD). Available at: (Cardiovascular diseases (CVDs)

405 Rodgers JL, Jones J, Bolleddu SI, Vanthenapalli S, Rodgers LE, Shah K, Karia K, Panguluri SK. Cardiovascular Risks Associated with Gender and Aging. J Cardiovasc Dev Dis. 2019 Apr 27;6(2):19. doi: 10.3390/jcdd6020019. PMID: 31035613; PMCID: PMC6616540.

406 Betai D, Ahmed AS, Saxena P, Rashid H, Patel H, Shahzadi A, Mowo-Wale AG, Nazir Z. Gender Disparities in Cardiovascular Disease and Their Management: A Review. Cureus. 2024 May 5;16(5):e59663. doi: 10.7759/cureus.59663. PMID: 38836150; PMCID: PMC11148660.

[407] NHS.UK Cardiovascular disease (2022). Available at: Cardiovascular disease - NHS

Although hypertension is overall more common in males, females experience a much sharper incline in blood pressure from the third decade of life and consequently the prevalence of hypertension accelerates comparatively with age.[408]

8.1.2 Risk factors for CVD

Unmodifiable risk factors include:[406]

- with increasing age
- in younger men, rather than women
- in those with a family history, particularly when close relatives are affected
- in certain ethnic groups, such as South Asian, Black African or African Caribbean
- in populations with high socio-economic deprivation, in poor housing or with low educational attainment[402]

Modifiable risk factors include:[406]

- unhealthy diet
- physical inactivity
- overweight and obesity
- smoking
- excessive alcohol consumption

Pregnancy complications such as preeclampsia or gestational hypertension appear to serve as a key early indication of maternal cardiovascular disease.[407]

Young Women

Young women (<35 years of age) have the lowest awareness of risk factors for CVD and are the least likely to engage in dialog with their Health Care Professionals about heart disease. Moreover, young women, particularly those with adverse pregnancy outcomes, have limited awareness and understanding of the risks related to CVD.

Key risk factors are lifestyle choices, the effects of reproductive hormones and the increasing use of cigarettes. Studies suggest that factors related to reproductive hormones can also affect cardiovascular risk. Emerging risk factors such as early menarche, or abnormal menstrual cycle lengths, is associated with an increased risk in CVD development.[409, 410] Polycystic ovary syndrome (PCOS) is a heterogeneous endocrine disorder that appears to emerge at puberty. Complications of PCOS include also include CVD.[411]

Pregnancy and postpartum

Women with a history of maternal pregnancy complications such as gestational hypertension and gestational diabetes have a higher risk of developing CVD. Other pregnancy complications, such as foetal growth restriction, preterm delivery, and pregnancy loss are also associated with

[408] Connelly PJ, Currie G, Delles C. Sex Differences in the Prevalence, Outcomes and Management of Hypertension. Curr Hypertens Rep. 2022 Jun;24(6):185-192. doi: 10.1007/s11906-022-01183-8. Epub 2022 Mar 7. PMID: 35254589; PMCID: PMC9239955.
[409] Wang, L. Y., Chiang, G. S. H., Wee, C. F., Chan, S. W. K., Lau, J. X. X., & Taeihagh, A. (2024). Preventing ischemic heart disease in women: a systematic review of global directives and policies. Npj Women S Health, 2(1). https://doi.org/10.1038/s44294-024-00040-0
[410] Alshakarah A, Muriyah D, Alsaghir F, Alanzi R, Almalki S, Alsadan S, Alotaibi AB, Alshaalan R, Albrahim T. Awareness and Knowledge of Cardiovascular Diseases and Its Risk Factors Among Women of Reproductive Age: A Scoping Review. Cureus. 2023 Dec 2;15(12):e49839. doi: 10.7759/cureus.49839. PMID: 38164316; PMCID: PMC10758256.
[411] Nice.org.uk (2025) Polycystic ovary syndrome. Available at: Polycystic ovary syndrome | Health topics A to Z | CKS | NICE

an increased risk for CVD. When one of these problems exists, the risk of CVD events nearly doubles, and 20–30% of pregnant women may unknowingly carry a factor that predicts their future CVD risk. Even women who are unable to breastfeed or experience disrupted lactation may face a greater risk for heart disease and other metabolic disorders later in life.[408]

Table : Cardiovascular risk in women who have had a hypertensive disorder of pregnancy[412]

Risk of future cardiovascular disease	Any hypertension in current or previous pregnancy	Pre-eclampsia in current or previous pregnancy	Gestational hypertension in current or previous pregnancy	Chronic hypertension in current or previous pregnancy
Major adverse cardiovascular event	Risk increased (up to approximately 2 times)	Risk increased (approximately 1.5 to 3 times)	Risk increased (approximately 1.5 to 3 times)	Risk increased (approximately 1.7 times)
Cardiovascular mortality	Risk increased (up to approximately 2 times)	Risk increased (approximately 2 times)	(no data)	(no data)
Stroke	Risk increased (up to approximately 1.5 times)	Risk increased (approximately 2 to 3 times)	Risk may be increased	Risk increased (approximately 1.8 times)
Hypertension	Risk increased (approximately 2 to 4 times)	Risk increased (approximately 2 to 5 times)	Risk increased (approximately 2 to 4 times)	(not applicable)

Midlife and menopause

Key risk factors during this transitional stage of women's lives include bio-psycho-social changes such as hormonal changes, work-related issues and lifestyle choices.

Exposure to endogenous oestrogen during the reproductive years provides women with protection against cardiovascular disease, which is lost around 10 years after the onset of menopause. In particular, women with vasomotor symptoms during menopause seem to have an unfavourable cardiometabolic profile.[413]

Women in this age group typically experience multiple social, psychological and biological challenges such as family issues, health concerns, work-related issues, financial worries, and menopausal transition. Menopause, resulting in lower estragon levels, brings with it a host of changes. The hormonal changes associated with this phase can lead to an increased risk of

[412] Nice.org.uk (2019) Hypertension in pregnancy: diagnosis and management Recommendations | Hypertension in pregnancy: diagnosis and management | Guidance | NICE

[413] Nappi, Rossella E et al. Menopuse: a cardiometabolic transition. The Lancet Diabetes & Endocrinology, Volume 10, Issue 6, 442 - 456

cardiovascular disease, including higher blood pressure and cholesterol levels.[408] Early menopause is generally referred to the superior risk of CVD.[414]

Elderly women

Cardiovascular disease is a major health concern in the aging population. While age is an independent risk factor for CVD, other additional risk factors that are closely associated with advanced age, have been shown to compound these risks, including frailty, obesity, and diabetes. Overall, although females have a longer life expectancy than males, women make up the most significant percentage of CVD diagnoses in the elderly population, or in those greater than 80 years old. These comorbid risks, in combination, are shown to compound cardiovascular risk factors in older patients.[404] Lack of health literacy and psychosocial factors such as social isolation are considered risk factors for heart disease.[408]

Social Determinants

The social determinants of health are inextricably linked to biology and contribute to CVD outcomes. For instance, in many societies, women are traditionally viewed as primary caregivers who prioritise their family's needs above managing their own health. Increasing numbers of women are also taking on non-traditional roles such as being breadwinners and furthering their careers, which can make it challenging to set aside time to prepare healthy meals, exercise, attend health screenings or medical appointments.[408]

Some studies have shown stronger associations of low socioeconomic status with CHD and CVD in women compared with men. Substantial evidence has documented associations between socioeconomic disadvantage and poor cardiovascular health outcomes, and women may be more affected because they are overrepresented among low-income earners and underrepresented among higher-income earners.[415]

Psychosocial stress can affect cardiovascular health. Chronic stress can contribute to the progression of coronary atherosclerosis and other chronic risk pathways for cardiovascular disease. Reproductive events can also worsen stress responses favouring adverse cumulative effects of stressful exposures. Certain stressors, such as socioeconomic disadvantage, childhood adversity, intimate partner violence, and caregiving stress, are especially common among women. Financial adversity and limited access to education and employment opportunities are associated with an adverse psychosocial status.[416]

Overcoming gender-gaps in women's health is a huge challenge in many societies and requires a fundamental shift in community attitudes, including among healthcare professionals, for whom training in gender equity is lacking. A key example is the failure to properly diagnose the atypical clinical presentations of cardiac events in women, compounded by young women with heart-related chest pain being less likely to be admitted into hospital for observation, relative to young men. Lack of awareness of women's disease symptoms by healthcare workers,

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[414] Ryczkowska K, Adach W, Janikowski K, Banach M, Bielecka-Dabrowa A. Menopause and women's cardiovascular health: is it really an obvious relationship? Arch Med Sci. 2022 Dec 10;19(2):458-466. doi: 10.5114/aoms/157308. PMID: 37034510; PMCID: PMC10074318.

[415] Backholer K, Peters SAE, Bots SH, Peeters A, Huxley RR, Woodward M. Sex differences in the relationship between socioeconomic status and cardiovascular disease: a systematic review and meta-analysis. J Epidemiol Community Health. 2017 Jun;71(6):550-557. doi: 10.1136/jech-2016-207890. Epub 2016 Dec 14. PMID: 27974445.

[416] Ebong IA, Quesada O, Fonkoue IT, Mattina D, Sullivan S, Oliveira GMM, Spikes T, Sharma J, Commodore Y, Ogunniyi MO, Aggarwal NR, Vaccarino V; American College of Cardiology Cardiovascular Disease in Women Committee. The Role of Psychosocial Stress on Cardiovascular Disease in Women: JACC State-of-the-Art Review. J Am Coll Cardiol. 2024 Jul 16;84(3):298-314. doi: 10.1016/j.jacc.2024.05.016. PMID: 38986672; PMCID: PMC11328148.

compounded by implicit or explicit gender bias, can further impede women's access to timely diagnoses and their appropriate care. Women are more likely than men to experience a missed diagnosis of stroke or have their symptoms under-recognised in myocardial disease, thereby delaying management of life-saving treatment. There are differences in the way women clinically present with an acute coronary syndrome and stroke.[417]

8.1.3 Level of need

CVD Prevent is a national audit of GP records to support primary care in understanding how many people with cardiovascular disease (CVD), or conditions that lead to a higher risk of developing CVD, are potentially undiagnosed, under treated or over treated. Analysis and reporting of the audit is designed to support systematic quality improvement using the findings from annual audit reports and the associated Data & Improvement Tool, to reduce health inequalities and improve outcomes for individuals and populations.

CVD Morbidity:

CVD Prevent has prevalence estimates for CVD, Hypertension, Atrial Fibrillation and Heart Failure by age group and gender. The figures below provide CVD prevalence estimates for Leicester City and Leicestershire and Rutland ICB sub localities to March 2025 from CVD Prevent.

There were a total of 63,570 patients (6.4% of 18+ year olds) across LLR diagnosed with CVD (17,830 in Leicester and 45,740 across Leicestershire and Rutland). Of these around two thirds were male and one third female, giving a CVD prevalence of 7.9% of males and 4.9% of females. In Leicester, the prevalence for over 18s is 6.0% for males and 4.0% for females, in Leicestershire and Rutland, the prevalence is 9.1% for males and 5.4% for females. However, the younger population structure in Leicester will lower the overall prevalence.

Hypertension: Out of the total population aged 18+ years in LLR, there were around 188,200 patients (19%) diagnosed with hypertension, (57,325 In Leicester (16.2%) and 130,865 (20.7%) across Leicestershire and Rutland). Hypertension prevalence is similar in males and females at 19% in LLR, in Leicester City females have a higher prevalence (16.8%) than males (15.6%), whilst in Leicestershire and Rutland, males have a higher prevalence of (21.2%) than females (20.1%).

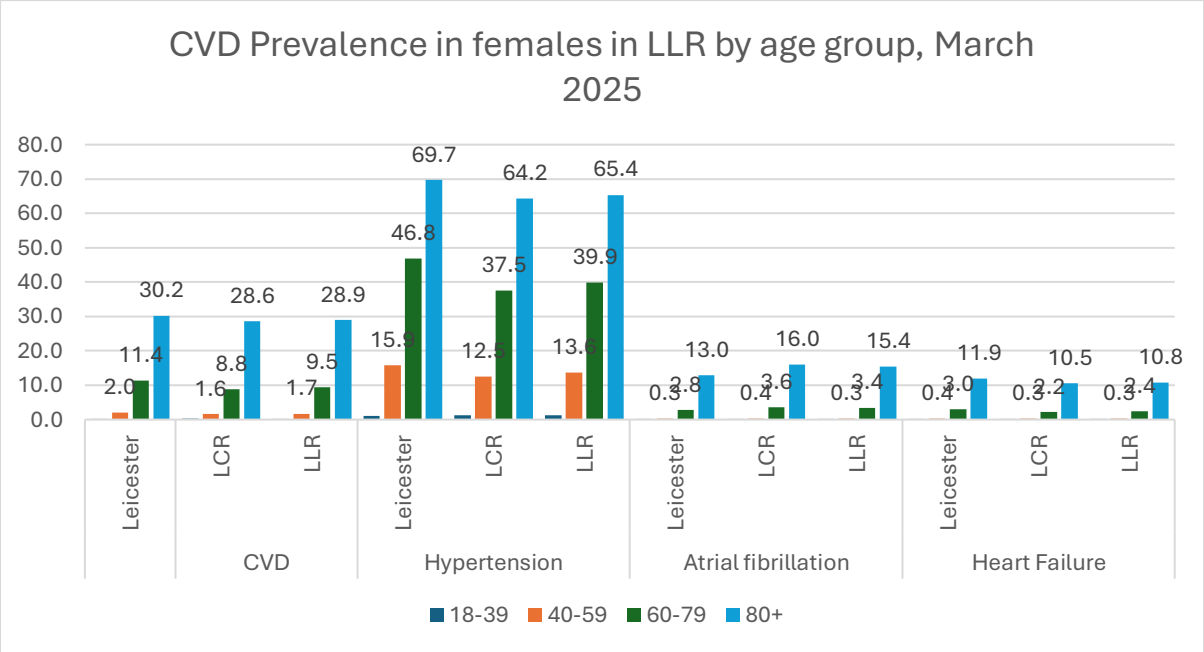
Atrial Fibrillation: Out of the total population aged 18+ years in LLR, there were 24,415 patients (2.5%) diagnosed with atrial fibrillation across LLR (Leicester 4,560 (1.3%) and 19,855 in Leicestershire and Rutland (3.1%). The prevalence in males (2.9%) is higher than females (2.0%) with lower prevalence in Leicester (males 1.4%, females 1.2%) and higher prevalence in Leicestershire and Rutland (males 3.8%, females 2.5%).

Heart failure: Out of the total population aged 18+ years in LLR, there were 16,345 patients (1.7%) registered with heart failure across LLR (Leicester (4,330 (1.2%), Leicestershire and Rutland (12,015 (1.9%). The prevalence of heart failure is higher in males (1.9%) than females (1.4%) in LLR.

[417] Carcel C, Haupt S, Arnott C, Yap ML, Henry A, Hirst JE, Woodward M, Norton R. A life-course approach to tackling noncommunicable diseases in women. Nat Med. 2024 Jan;30(1):51-60. doi: 10.1038/s41591-023-02738-1. Epub 2024 Jan 19. PMID: 38242981.

The figure below shows CVD prevalence for females across LLR by age group. The prevalence increases with age with the highest prevalence in the over 80s across all conditions. Hypertension prevalence starts to increase in those aged over 40 and rapidly increases in over 60 and 80 year olds. Leicester shows the highest prevalence in 60-79 and over 80 year olds for CVD, Hypertension and Heart failure.

Figure 94: CVD Prevalence in females in LLR by age group, March 2025



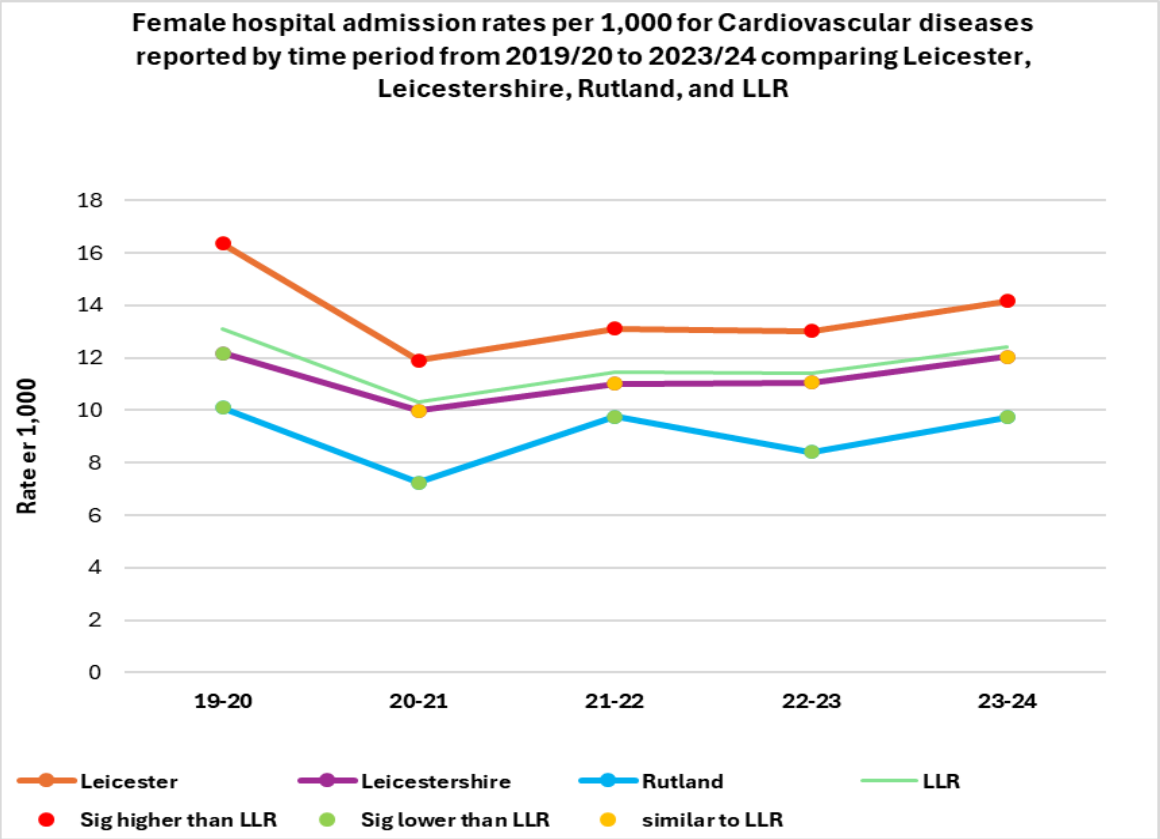
Source: CVD Prevent

CVD hospital admissions (females):

In 2023/24, there were a total of 17,280 hospital admissions for cardiovascular diseases across LLR. Around one third of these were elective and two thirds emergency hospital admissions**.** There are more admissions for males (57%) than females (23%). The rate for hospital admissions for CVD.

The observed trend for female CVD admissions in LLR, showed that the rates in Leicester are, consistently significantly higher compared to Leicestershire, Rutland, and overall LLR across all the years. In contrast, Leicestershire had statistically similar CVD admission rates in females compared to LLR. Rutland had significantly lower rates of female admissions compared to LLR.

Figure 95: Female hospital admission for CVD in LLR: age-standardised rate per 1,000 from 2019/20 to 2023/24



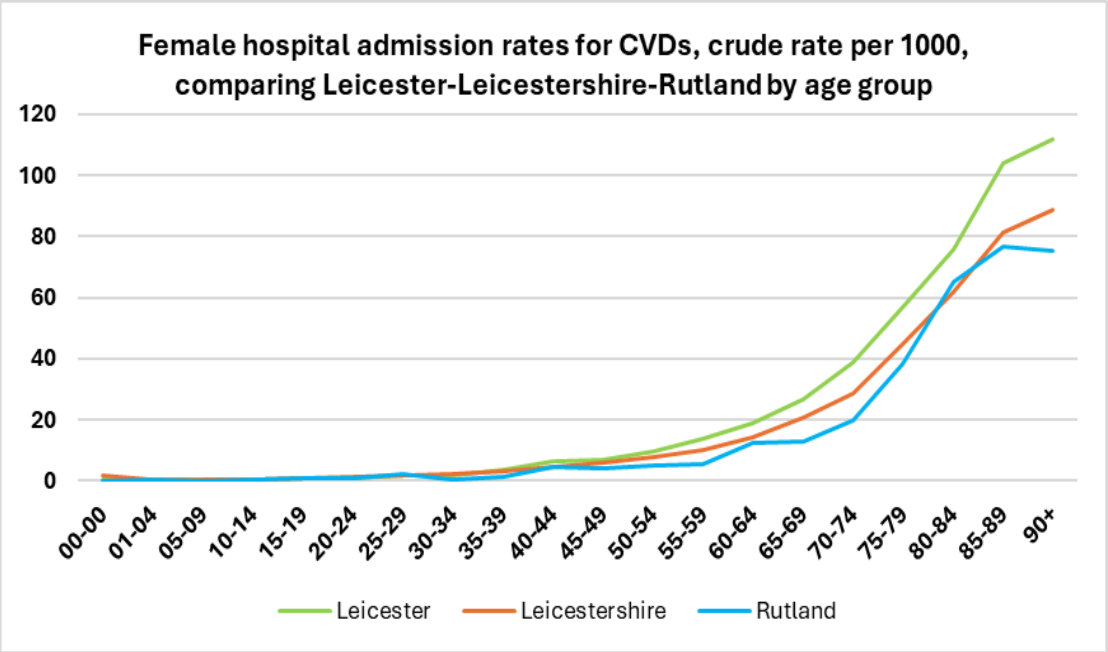
Source: HES Data

CVD hospital admission rates by age group (females):

Hospital admission rates increase with age in all three areas, which is expected for cardiovascular disease. The rates are very low in younger age groups (0–34) and rise sharply from age 50 onwards.

Overall, Leicester shows the highest CVD admission rates with increasing age groups, Rutland has the lowest rates across most age groups. All areas show a strong age-related increase in admissions.

Figure 96: Female hospital admissions for CVD in LLR: age-standardised rates per 1,000 between 2019/20 to 2023/24



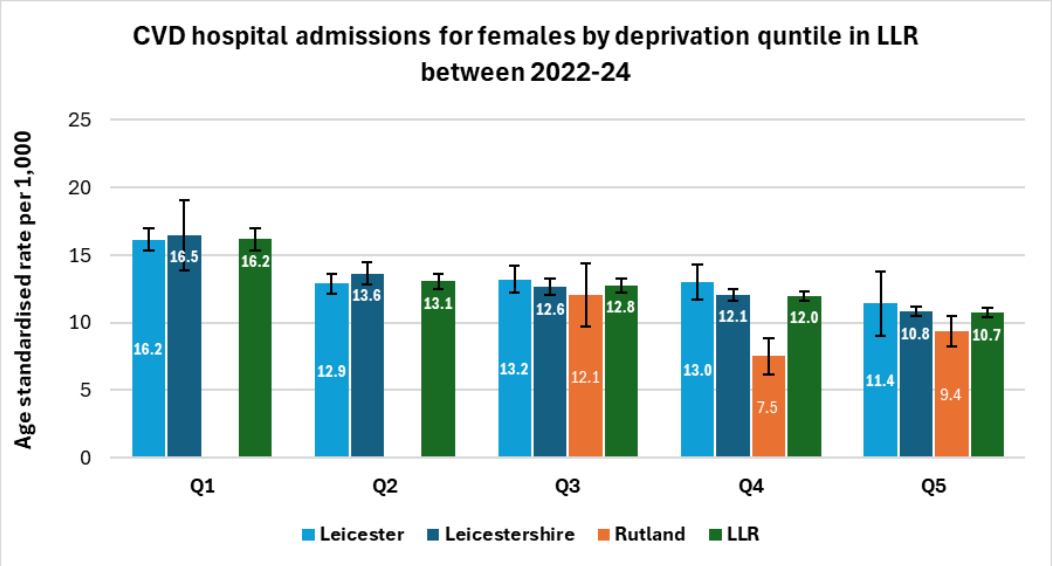
Source: HES Data

CVD hospital admission rates by deprivation (females):

The overall trend for CVD admission rates in LLR decrease as deprivation decreases (from Q1 most deprived to Q5 least deprived), indicating a clear social gradient.

The hospital admission rates for CVD in quintile 1 for Leicester, Leicestershire and overall LLR are significantly higher in comparison to quintile 5. There hospital admission rates for CVD are statistically similar between when comparing the three areas within each individual quintile.

Figure 97: Female hospital admission rates per 1,000 for CVDs in LLR by deprivation from 2022/23 to 2023/24



Source: HES Data

CVD hospital admission rates by ethnicity (females):

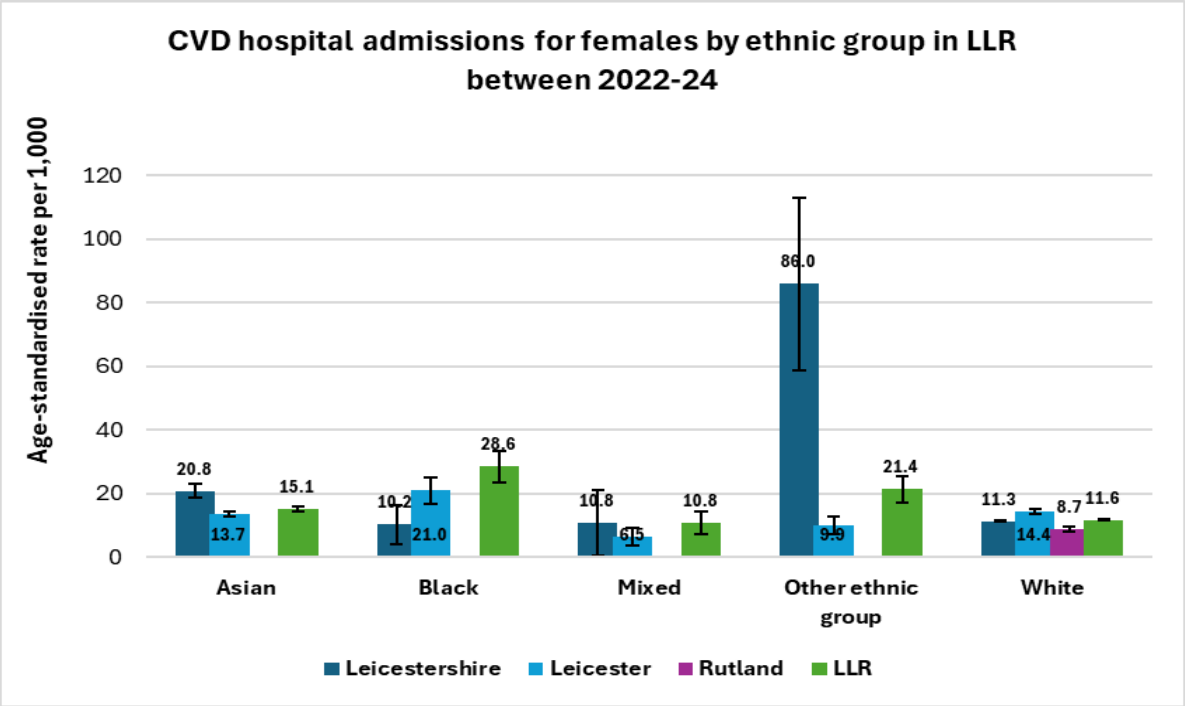
Overall in LLR, females from the black ethnic group (28.6 per 1,000 female population) had the highest rate of CVD admissions between 2022 and 2024.

CVD hospital admission rates are significantly higher in females from Leicestershire (20.8 per 1,000 population) in comparison to Leicester (13.7 per 1,000 female population). CVD hospital admission rates are significantly higher in the Black population in Leicester compared to Leicestershire where the rate is just over double.

Leicestershire shows a significantly higher rate for Other ethnic group, while Leicester and overall LLR rates are significantly lower. Note that numbers are smaller in this ethnic category.

CVD hospital admissions rates are significantly higher in females from White populations in Leicester compared to Leicestershire and Rutland.

Figure 98: Female hospital admissions for CVDs: age-standardised rates per 1,000 by ethnic groups from 2022/23 to 2023/24



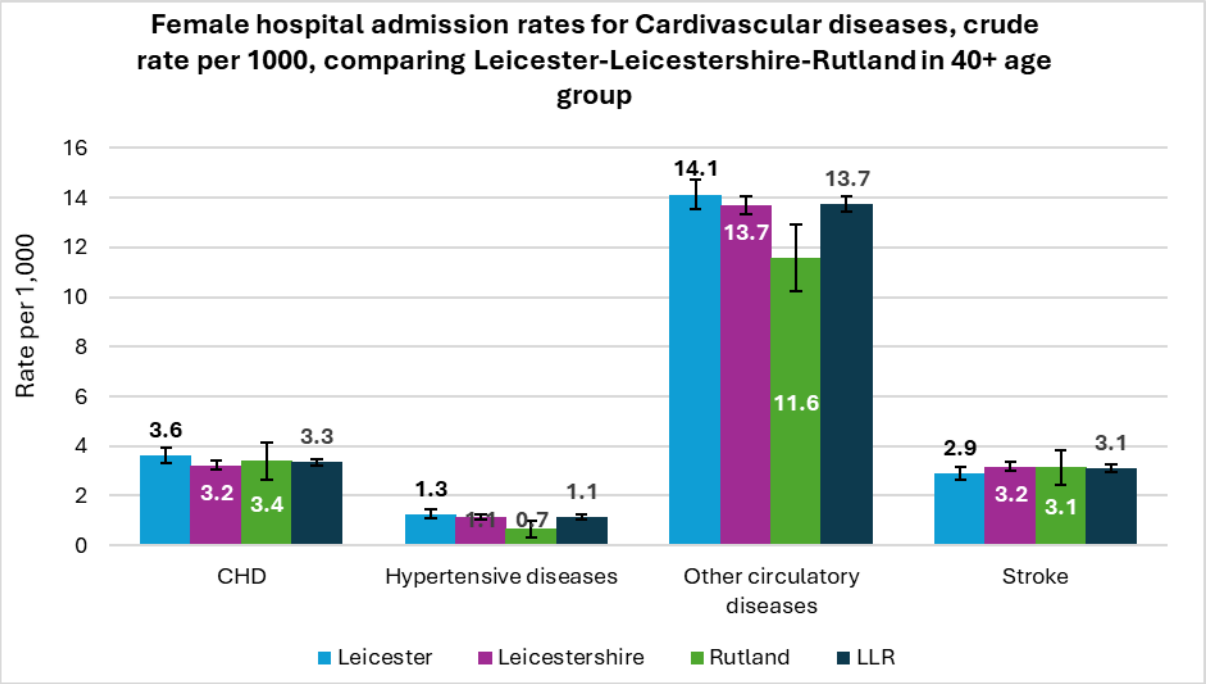
Source: HES Data

Female cardiovascular disease admissions in LLR

Within cardiovascular diseases, these can be sub-categorised into Coronary Heart Disease, Hypertension, Stroke and other circulatory diseases.

- Hospital admission rates for Hypertensive diseases are statistically similar in females in Leicester, Leicestershire, and LLR ranging between a rate of 0.7 to 1.3 per 1,000 population.
- Hospital admission rates for Other circulatory diseases in females are statistically similar for Leicester, Leicestershire, and for LLR, except for Rutland, which shows significantly lower rate compared to other local authorities.
- Hospital admission rates for Coronary Heart Disease (CHD) and Stroke are similar across all areas, ranging between 3.2 per 1,000 to 3.6 per 1,000 population.

Figure 99: Female hospital admission rate per 1,000 for CVDs in LLR from 2022/23 to 2023/24



Source: HES Data

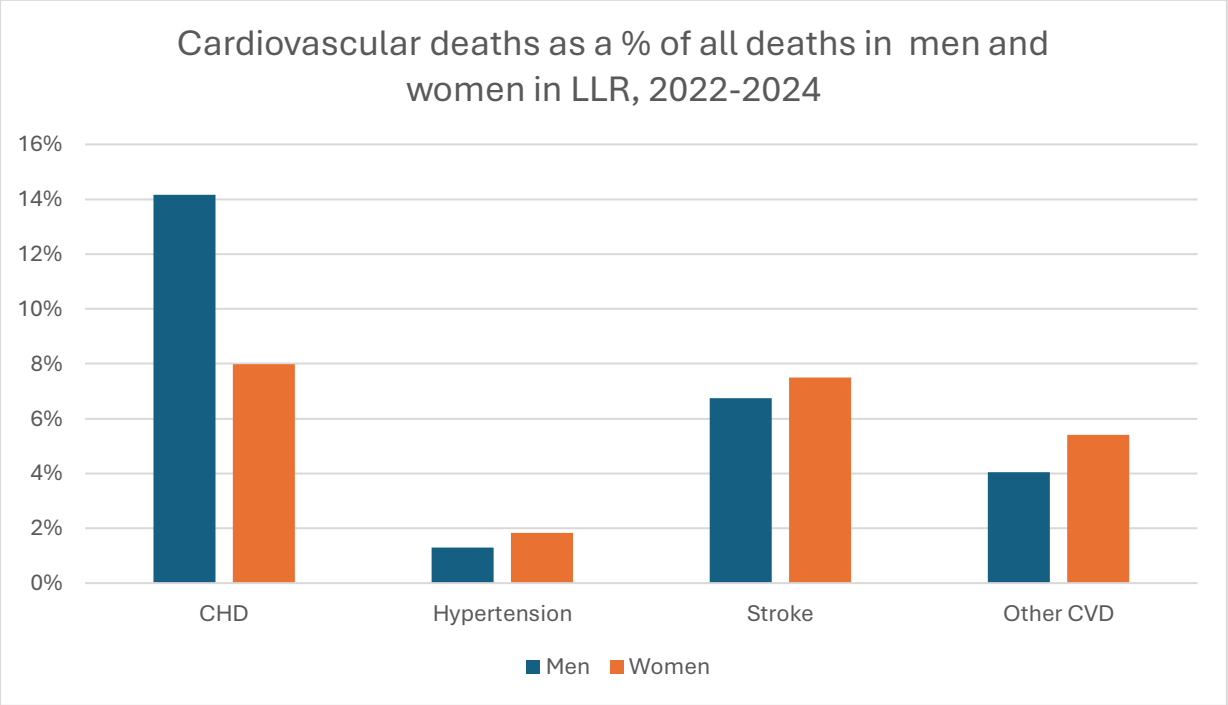
Based on the ONS 2018 population projections, if the current prevalence and detection of cardiovascular conditions remains the same, Leicester's growing population will increase the number of cases of each condition on Leicester GP registers over the next decade. By 2032 there will be an additional 3500 people with detected high blood pressure and 300 with atrial fibrillation. GP registers will also have a further 680 CHD, 350 stroke, and 240 heart failure patients.

The NHS Health Check offers advice to help prevent the onset of cardiovascular disease for eligible people - not currently on a cardiovascular disease register or being treated as at risk - aged between 40 and 74.

CVD mortality in females:

Cardiovascular diseases are reported as the main cause of death in LLR, with around 26% of all deaths in men and 23% of all deaths in women. In LLR, the percentage of deaths due to Hypertension, Stroke and Other CVD are higher in women compared to men.

Figure 100: CVD mortality by gender in LLR, 2022-2024

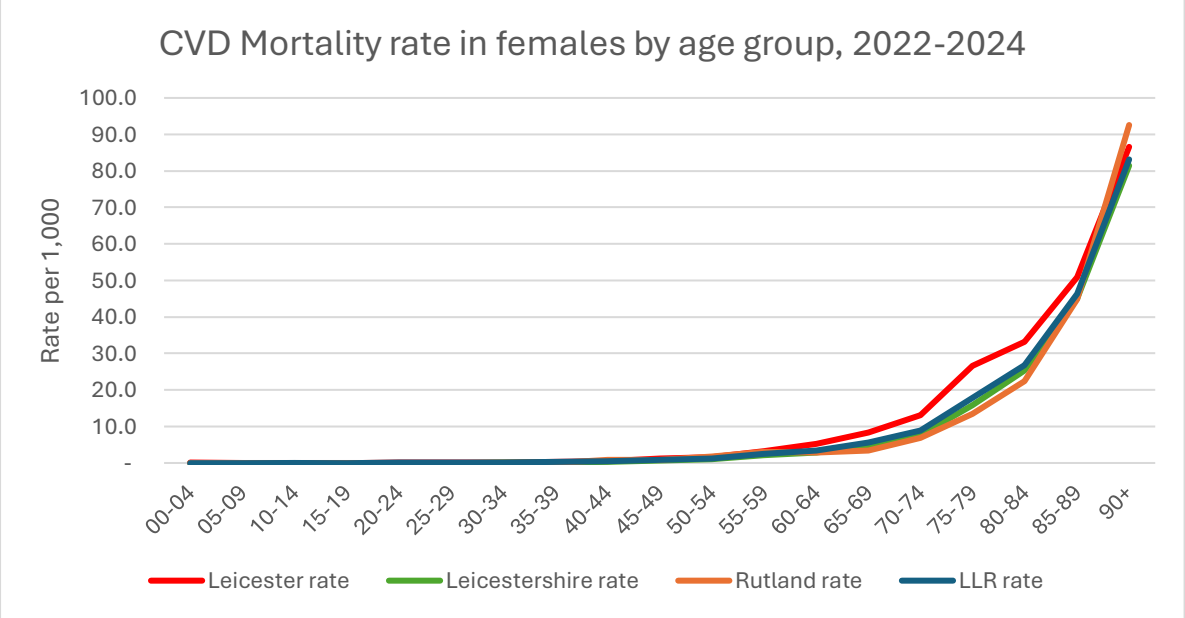


Source: ONS mortality data

CVD mortality by age group:

The chart below shows the CVD mortality rate in females starts to increase from around 60-64 years, rising sharply in the over 75s. Rates are similar for Leicestershire and Rutland whilst females in Leicester experience higher rates of CVD mortality between 60 and 85.

Figure 101: CVD mortality rate in females by age group, LLR, 2022-2024

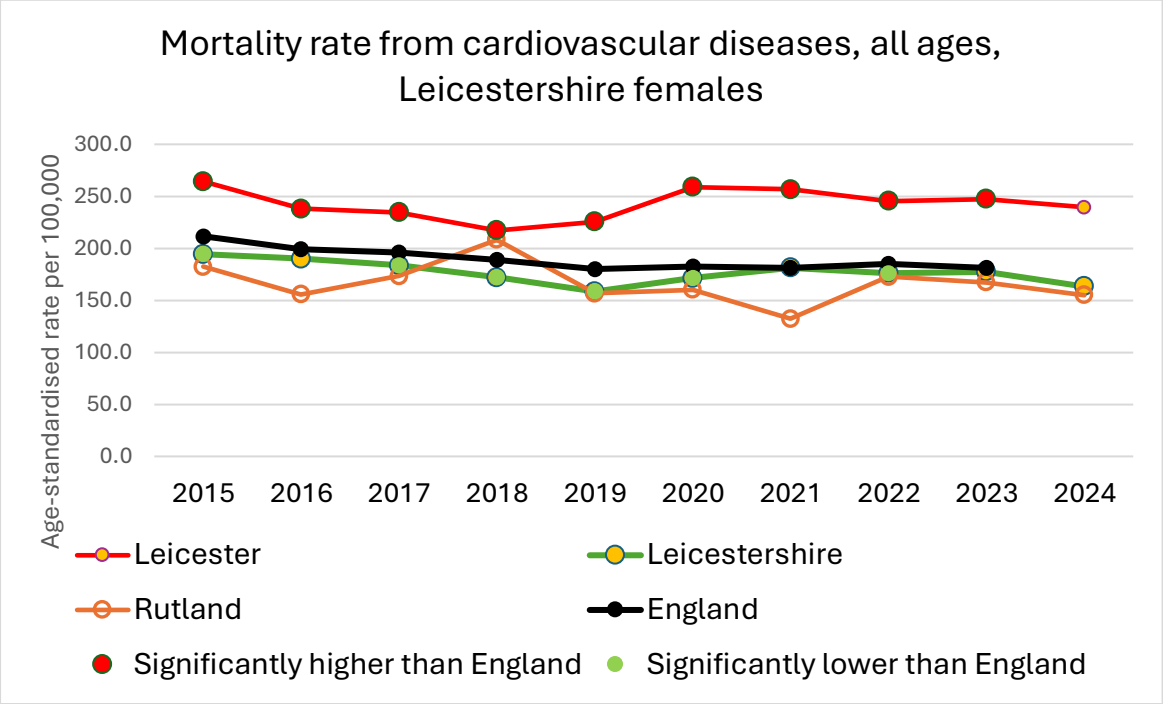


Source: ONS mortality data

Trend in CVD mortality:

Overall, the mortality rates for all ages for women in England show a general downward trend over the last 10 years. Within LLR, the CVD mortality rate is significantly higher in Leicester females, significantly lower in Leicestershire females, and (statistically) similar to England in Rutland females.

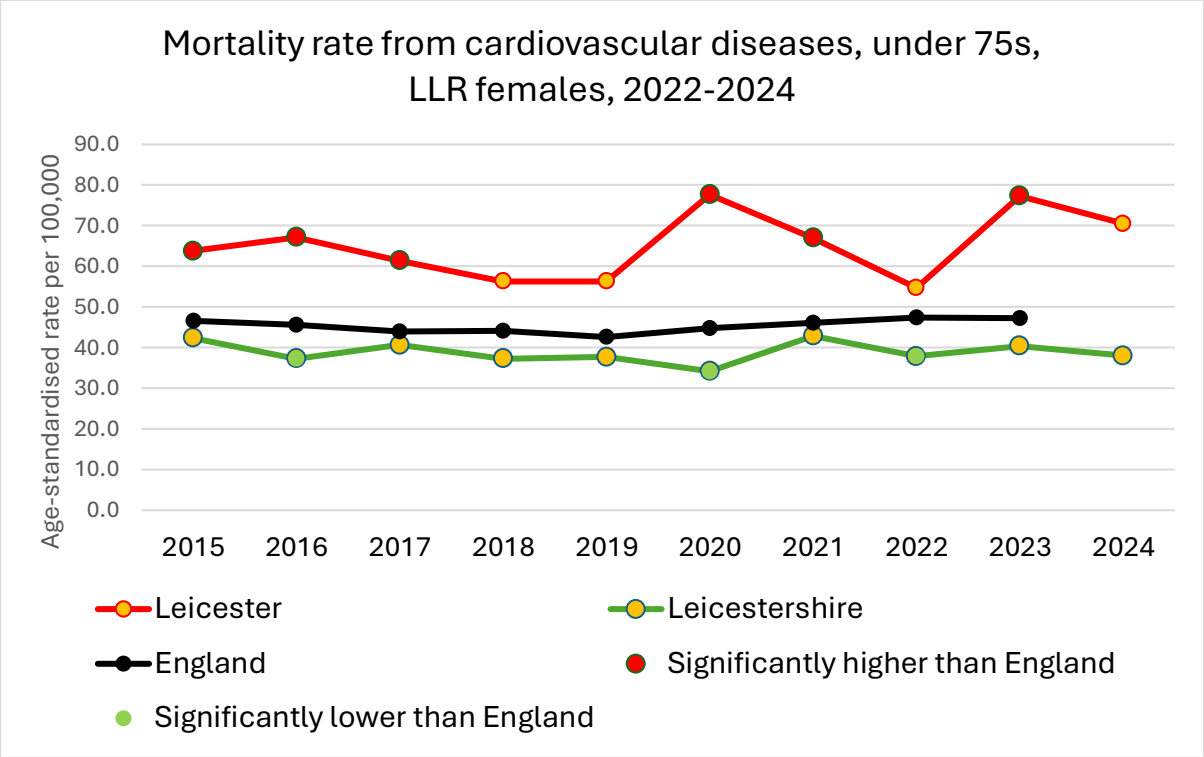
Figure 102: Trend in CVD mortality in females, in LLR, 2015-2024



Source: OHID, fingertips.

Premature mortality rates relate to deaths in those aged under 75 years. Premature mortality for CVD in Leicester females is significantly higher in comparison to England, whilst rates are significantly lower in Leicestershire. (Numbers are too small to show rates in under 75s in Rutland).

Figure 103: Premature mortality from CVD in females, in LLR, 2022-2024



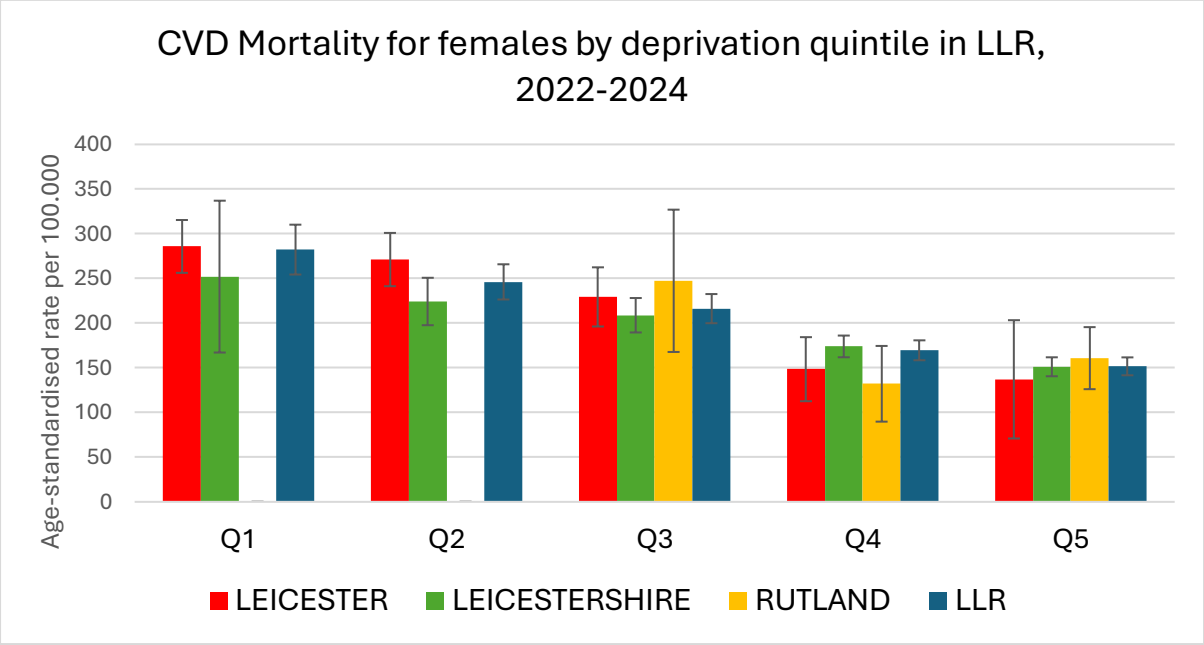
Source: ONS mortality data

CVD mortality by deprivation:

The chart shows the mortality rate for CVD in women across Leicester, Leicestershire and Rutland by deprivation quintile (quintile1is most deprived and quintile 5 is least deprived).

CVD Mortality rates in females in Leicester and Leicestershire are significantly higher in the most deprived areas (Quintile 1) in comparison to the least deprived areas (Quintile 5). The CVD mortality rates for females living in quintile 1 in Leicester are almost double compared to those living in quintile 5. For Leicestershire, the CVD mortality rates in females are 1.6 times higher for those living in quintile 1 compared to those living in quintile 5.

Figure 104: CVD mortality rates in females by deprivation in LLR, 2022-2024



Source: ONS mortality data and IMD 2019

8.1.4 What evidence- based management is recommended?

There are two main ways of reducing the risk factors associated with CVD:

1. Better management of risk factors such as weight, diet, smoking and exercise, and

2. Identifying people at risk early.

CVD is largely preventable, through lifestyle changes and a combination of public health and NHS action on smoking and tobacco addiction, obesity, tackling alcohol misuse and food reformulation. The NHS Long Term Plan recognises the early detection and treatment of CVD to help people live longer, healthier lives. Including an ambition for the NHS to work alongside local authorities and PHE (now UK Health Security Agency and Office for Health Improvements and Disparities) to improve the effectiveness of approaches such as the NHS Health Checks. Including, identified high risk individuals to be provided with preventative treatments in a timely manner.[418]

NICE guidance (NG238) recommendations include the identification and assessment of CVD risk for people without established CVD. This includes primary care to implement a systematic strategy to identify people likely to be high risk of CVD and prioritising people based on their estimated CVD risk using recorded CVD risk factors. For people over 40 to have an ongoing review estimates of CVD risk.[419]

NICE guidance also includes lifestyle changes for the primary and secondary prevention of CVD, including

[418] The NHS Long Term Plan (2019) NHS Long Term Plan v1.2 August 2019
[419] Nice.org.uk (2023) Cardiovascular disease: risk assessment and reduction, including lipid modification Recommendations | Cardiovascular disease: risk assessment and reduction, including lipid modification | Guidance | NICE

- Healthy eating – promotion of a cardioprotective diet appropriate to individual circumstances
- Physical activity – promotion of aerobic and muscle-strengthening activities whilst providing information of local opportunities
- Weight management – offering those who are overweight or obese appropriate interventions
- Alcohol consumption – reduction of alcohol consumption
- Smoking cessation – advise and support all who smoke to stop

It is noted that women remain underrepresented in CVD-related research studies and there are limited gender-specific studies conducted to study the prevention and treatment of CVD in women.[408]

Young Women

Due to emerging risk of risk factors such as early menarche, or abnormal menstrual cycle lengths. Menstrual history should not be taken lightly as it is a potentially useful tool to increase awareness about CVD and use for early counselling of future CV risk. Management of OCOS also includes screening for cardiovascular risk factors and advising on healthy lifestyle measures to reduce CVD risk. Where appropriate, weight loss should be advised.[410]

Pregnancy and postpartum

Recommendations for identification, advice and treatment for hypertension in pregnancy are published in[411], this includes,

- Reducing the risk of hypertensive disorders in pregnancy
  - Rasing awareness of pre-eclampsia symptoms
  - Aspirin prescription
  - Lifestyle advice
- Management of chronic hypertension in pregnancy
  - Specialist in hypertensive disorder of pregnancy referral
  - Medical advice
  - Treatment – including lifestyle advice, medicine
  - Increased antenatal appointments for poorly controlled hypertension
  - Postnatal investigation, monitoring and treatment

If statin treatment is indicated for women of childbearing age for secondary prevention of CVD, NICE advises that because of the potential for serious adverse effects,[420]

- Adequate contraception is required during statin treatment.
- Statins should be stopped 3 months before attempting to conceive and during pregnancy.
- Statins should not be restarted until breastfeeding is finished

Midlife and menopause

Screening for CV risk factors such as obesity and metabolic syndrome during this transition to menopause or when women present with hot flashes can aid in early detection and

[420] Nice.org.uk (2025) Lipid modification - CVD prevention:Scenario: Secondary Prevention of CVD Scenario: Secondary prevention of CVD | Management | Lipid modification - CVD prevention | CKS | NICE

management of CHD before it becomes established.[408] Including primary prevention of CHD in women, including,

- oestrogen may have a protective role in CHD prevention especially if initiated in women below age 60 years or within 10 years of onset of menopause
- women with a premature menopause should take oestrogen to reduce the risk of CHD
- lipid-lowering agents are probably beneficial in primary prevention
- aspirin cannot be recommended for primary prevention of CHD, but may protect against stroke
- treating hypertension reduces the risk of CHD
- in diabetics, prevention of CHD is based on management of established cardiovascular risk factors through both lifestyle measures and pharmacotherapy
- in metabolic syndrome, prevention of CHD is based on management of established cardiovascular risk factors through both lifestyle measures and pharmacotherapy
- stopping smoking, reducing obesity, improving diet and undertaking regular exercise are key lifestyle measures.[421]

Elderly Women

Primary prevention of CVD targets people who do not have established CVD but are at risk of a first cardiovascular event. This includes people who are aged 85 years and older.[419]

NICE recommends before offering statin treatment for the primary prevention of CVD,

- Discuss the benefits of lifestyle changes (such as physical activity and a cardioprotective diet).
- Recognize that the person may need support to change their lifestyle. To help with this, arrange referrals to programmes such as exercise referral schemes or weight management services.
- Where possible, optimize the management of all other modifiable CVD risk factors (such as hypertension and obesity).
- Where applicable, offer the person the opportunity to have their CVD risk assessed again after they have tried to change their lifestyle.
- People already taking medications to treat CVD risk factors.
- Recognize that CVD risk tools may underestimate CVD risk in certain groups of people, including;
  - people treated for HIV.
  - people already taking medications to treat CVD risk factors.
  - people taking medications that can cause dyslipidaemia (such as antipsychotics, corticosteroids, or immunosuppressant drugs)
  - people who have recently stopped smoking.
  - people with severe mental illness.
  - people with autoimmune disorders or other systemic inflammatory disorders.
- If lifestyle change alone is ineffective or inappropriate (for example, in people thought to be at higher risk of CVD based on comorbidities, risk scores, or clinical judgement):
  - Offer statin treatment for the primary prevention of CVD to people with a 10-year QRISK3 score of 10% or more, including those with type 2 diabetes.
  - Offer statin treatment for the primary prevention of CVD (without the need for a formal risk assessment) to:

[421] British Menopause Society (2022) Primary prevention of coronary heart disease in women - British Menopause Society

- people with type 1 diabetes who are aged over 40 years, have had diabetes for more than 10 years, have established nephropathy, or have other CVD risk factors.
- people aged 85 and older, especially if they smoke or have raised blood pressure. Consider the potential benefits from lifestyle changes, as well as the person's preferences, comorbidities, current medications, general frailty, and life expectancy.

Secondary prevention of CVD aims to reduce the risk of a recurrent cardiovascular event in people with established CVD, NICE recommends,

- Offer lipid-lowering treatment for the secondary prevention of CVD to adults with established CVD, regardless of their cholesterol level.
- Do not delay lipid-lowering treatment for secondary prevention of CVD, but discuss lifestyle changes at the same time if appropriate.

8.1.5 Current services in LLR

Leicester City Council Services:

- Live Well[422] – provides range of services intended to help women maintain a healthy weight, increase physical activity, reduce alcohol consumption, and stop smoking.
- Women's Cycle Confidence Rides[423] - is a programme offered by Leicester City Council to support women to boost their confidence to ride their bicycles within Leicester. Women have to opportunity to explore and learn cycle routes and provide an opportunity for social interaction.

Leicestershire County Council and Rutland County Council Services:

- A range of lifestyle services aimed to help women achieve their health goals, including the Leicestershire Weight Management Service, Active Together and Quit Ready and Turning Point.[424]
- Healthy Workplaces Leicestershire[425] is a programme which helps organisations of all sized across the county to become healthier workplaces. Health MOTs involve 30 minute individual appointments for staff at their workplace including, cholesterol, hBA1C (blood glucose levels), height, weight, BMI and blood pressure.

NHS:

- NHS Better Health is an NHS prevention programme aimed at supporting residents to make healthy changes. This includes apps to support individuals to lose weight, quit smoking, getting active and drinking less alcohol.[426]

Services specifically for pregnant women:

- Pregnant women are offered support to support quitting smoking, including the CURE project. The CURE project is a programme that specialises in supporting pregnant

[422] LiveWell Leicester (2025) Live Well Leicester – Helping to improve Leicester's Health and Wellbeing
[423] Choose How You Move (2025) Women's Cycling Women's Cycling < Choose How You Move
[424] Leicestershire.gov.uk (2025) A Healthier You A Healthier You | Leicestershire County Council

[425] Healthyworkplacesleicestershire.gov.uk (2025) Health MOTs Health MOTs | HealthyWorkplaces
[426] NHS.uk Better Health; Lets do this Better Health - NHS

women with quitting smoking. When seen by a hospital-based midwife, pregnant women are automatically referred to the Maternity CURE team for specialised treatments to help women quit during their pregnancy.
- Leicestershire County Council and Rutland County Council offer a programme of support for pregnant women to quit smoking including a financial incentive scheme.
- The Weight Management service within Leicestershire County Council offer weight management support for women who are pre-pregnancy, during pregnancy and post-pregnancy. This includes nutritional and physical activity related support.

NHS Health Checks:

- All three areas in LLR commissions the NHS Health Checks programme for their respective geographies, which aims to aims to prevent cardiovascular disease, and associated conditions, through the early assessment, awareness and management of individual behavioural and physiological risk factors. This programme invites all 40–74-year-olds without a current diagnosis of CVD or diabetes to be screened.[427, 428]

Pharmacies:

- NHS Community Pharmacy Blood Pressure Check service and Hypertension Case Findings enables community pharmacy staff to offer blood pressure services to individuals who are:
    - 40 years and over
    - Not previously been identified as having hypertension or a related condition; and
    - Has not had their blood pressure measured by a health professional within the previous six months.
- Pharmacies able to provide appropriate information including promotion of healthy behaviours and urgent referrals to their GP within 24 hours for very high blood pressures. All blood pressure readings are sent to their GP from the community pharmacy. In addition, GPs can also refer patients to a participating community pharmacy to a 24 hour ambulatory blood pressure monitoring.[429]

8.1.6 Unmet needs or gaps

While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. And while women make up 51% of the population, historically the health and care system has been designed by men for men.

This 'male as default' approach has been seen in:

- research and clinical trials
- education and training for healthcare professionals
- the design of healthcare policies and services

This has led to gaps in our data and evidence base that mean not enough is known about conditions that only affect women – for example, menopause or endometriosis. It has meant that not enough is known about how conditions that affect both men and women impact them in different ways – for example, cardiovascular disease, dementia or mental health conditions. It

[427] NHS.uk (2024) NHS Health Check Overview - Leicester City Council - NHS
[428] Leicestershire.gov.uk (2025) Get health advice Get health advice | Leicestershire County Council
[429] England.nhs.uk NHS Community Pharmacy Blood Pressure Check Service NHS England » NHS Community Pharmacy Blood Pressure Check Service

has also resulted in inefficiencies in how services are delivered – for example, we know that many women have to move from service to service to have their reproductive health needs met, and women can struggle to access basic services such as contraception.[430]

The Women's Health Toolkit, provided by the RCGP, aims to provide those working in primary care with a one-stop resource for all their women's health educational needs – it covers all stages of a woman's life. The toolkit signposts to educational materials and relevant guidelines in women's health, from a variety of organisations. However, CVD is not a specific health topic covered within this toolkit.[431]

There are significant gaps between estimated prevalence and rate of recorded diagnosis for hypertension and atrial fibrillation. Seeking to address this, services need a robust approach to earlier detection, diagnosis and treatment of both established disease and any modifiable risk factors.[410]

8.1.7 Recommendations

Manage core risk factors

- Specific work on detecting and managing major drivers for CVD such as hypertension, Atrial Fibrillation and high cholesterol through partnerships with PCNs and primary care services.
- Ensure women are regularly screened for hypertension, AF and raised cholesterol.
- Intensify early treatment for high BP and lipids.
- Further improvements in CVD care and prevention provided in the community.

Promote lifestyle changes with high preventative impact through public health services

- Ensure a Making Every Contact Count approach is adopted in clinical and community settings to reducing CVD amongst women.
- Encourage women to adopt a healthy diet, rich in vegetables, fruit, whole grains, legumes, nuts, and oily fish.
- Encourage women to be physically active – 150 minutes of moderate-intensity activity weekly.
- Support cessation through behavioural support and nicotine replacement.
- Support women to maintain a healthy weight.
- Ensuring lifestyle services continue to offer services to accommodate the needs of women in a culturally sensitive manner.

Pregnancy related factors

- Add adverse pregnancy outcomes to routine cvd risk assessments.
- Offer post-pregnancy cardiovascular follow-up to affected women.

Menopause

- Raising awareness locally of the links between menopause and CVD, especially in women experiencing vasomotor symptoms.
- Discuss menopausal symptoms, bone health, and CVD risk with women proactively.

[430] Department for Health and Social Care (2022) Policy paper Women's Health Strategy for England Women's Health Strategy for England - GOV.UK
[431] RCGP (2025) Women's health toolkit Women's health toolkit: Introduction | RCGP Learning

- Consider HRT within evidence-based parameters; avoid initiating beyond age 60 for primary CVD prevention.

Reduce Health Inequalities in women's heart health

- Target groups at higher risk such as south Asian, black African or Caribbean backgrounds.
- Improve culturally competent care and communication.
- Enhance screening uptake in underserved communities.
- Provide easier access to preventive services.
- Continue work to improve the coding of patient characteristics such as ethnicity. This will allow more in-depth analysis of health inequalities.

Improve early detection through population level interventions

- Expand NHS Health Checks to increase detection of high blood pressure, AF, diabetes, and high cholesterol in women.
- Further analysis of local NHS Health Check data in relation to women. Nationally published data is outdated.
- Seek opportunities to introduce opportunities to integrate CVD screening within existing programmes such as cervical screening, bowel cancer screening, breast cancer screening and contraception appointments etc.

Knowledge and awareness

- Improving the awareness and knowledge of CVD among women, particularly women in their reproductive age group. Additional efforts should be made to lessen socioeconomic and educational disparities. Lack of awareness regarding the symptoms and risk factors associated with CVD among women leads to delayed diagnosis and negative health outcomes.
- Educating health professionals on sex-specific symptoms and the need to avoid diagnostic bias. Including exploring opportunities to integrate QRISK and QRISK®3-lifetime cardiovascular risk calculator into appointments.
- Identifying those at higher risk of CVD and improving access to services such as NHS Health Checks and Hypertension Case Finding. Women felt it was difficult to access services – both GP appointments and more specific health services – outside of usual working hours, which made it very difficult for those who worked full time, especially in jobs where it is difficult to get time off at short notice.
- Improving the awareness and knowledge of CVD among women, particularly women in their reproductive age group. Additional efforts should be made to lessen socioeconomic and educational disparities. Lack of awareness regarding the symptoms and risk factors associated with CVD among women leads to delayed diagnosis and negative health outcomes.

8.2 Bone Health – Falls and Osteoporosis

8.2.1 Background

Falls and osteoporosis are significant public health concerns, particularly for older women. Osteoporosis, characterised by reduced bone density and increased fracture risk,

disproportionately affects women due to hormonal changes post-menopause.[432] Falls are a leading cause of injury-related hospital admissions among older adults, with women more likely to experience fall-related fractures due to underlying bone fragility.[433]

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS an estimated £4.4 billion per year.[434] Falls significantly impact on long term outcomes for older people. Hip fracture is a debilitating condition and has been demonstrated to have an immediate impact on an individual's independence. Both these causes of hospital admission can lead to people moving from their own home to long term nursing or residential care.

Short and long-term outlooks for patients are generally poor following a hip fracture, with an increased one-year mortality of between 18% and 33% and negative effects on daily living activities such as shopping and walking.70 Due to the impacts of falls on quality of life and cost to the NHS, NICE guidance on the assessment and prevention of falls in older people was updated in 2025 (NG249).[435]

The key issue of concern is not simply the high incidence of falls in older people, but the combination of a high incidence and a high susceptibility to injury. Osteoporosis increases bone fragility and susceptibility to fracture, particularly because of a fall.

Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture. Osteoporosis itself is asymptomatic and often remains undiagnosed until a fragility fracture occurs. Osteoporosis leads to over 300,000 patients presenting with fragility fractures to hospitals in the UK each year.[436]

Many individuals who suffer a fragility fracture are at increased risk of subsequently sustaining a hip fracture. Hip fractures are particularly severe, as they almost always necessitate hospital admission and result in permanent disability for half of those affected, whilst also being fatal in 20% of cases.[435]

8.2.2 Risk factors for Falls and Osteoporosis

Fear of falling can lead to social isolation, which not only diminishes the quality of life for many older people but also increases demand for care and support services. However, falling is not an inevitable consequence of ageing. The likelihood of falling, sustaining an injury, and requiring hospital admission as a result can all be significantly reduced.

The causes of having a fall are multifactorial – a fall is the result of the interplay of multiple risk factors. These can include:

- muscle weakness

[432] NHS (2022) Osteoporosis. Available at https://www.nhs.uk/conditions/osteoporosis/

[433] NICE (2025) New guideline will help cut falls and related hospital admissions for older and at-risk people. Available at https://www.nice.org.uk/news/articles/new-guideline-will-help-cut-falls-and-related-hospital-admissions-for-older-and-at-risk-people

[434] OHID (2022) Falls: applying All Our Health. Available at https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health

[435] NICE (2025) Falls: assessment and prevention in older people and in people 50 and over at higher risk. Available at https://www.nice.org.uk/guidance/ng249

[436] NICE (2017) Osteoporosis: assessing the risk of fragility fracture. CG146.Available at https://www.nice.org.uk/guidance/cg146

- poor balance
- visual impairment
- polypharmacy – and the use of certain medicines
- environmental hazards
- some specific medical conditions, which might make a person more likely to fall
- high blood pressure

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with a third of people older than 65 and half of people older than 80 falling at least once a year.

Women are at greater risk of osteoporosis due to the decrease in oestrogen production at the menopause, which accelerates bone loss,[435] particularly if the menopause begins early (before the age of 45) or they've had their ovaries removed.[437] The prevalence of osteoporosis increases markedly, from approximately 2% at 50 years of age to almost 50% at 80 years of age.[438]

Other risk factors for osteoporosis include low physical activity, poor nutrition, vitamin D deficiency, smoking and alcohol use. White and Asian women are at highest risk.[439]

NICE guidelines (CG146, NG249) highlight the importance of assessing fracture risk and implementing fall prevention strategies in individuals over 50 with risk factors.[435]

Frailty is a clinical syndrome characterised by a decline in physiological reserves and increased vulnerability to adverse health outcomes, particularly in older adults. It is closely linked to bone health, as frailty increases the risk of falls, fractures, and poor recovery following injury also increases. Risk factors for frailty include advancing age, chronic health conditions, reduced physical activity, poor nutrition, and social isolation. Women are at particular risk due to the higher prevalence of osteoporosis and longer life expectancy. Identifying and addressing frailty is essential for preventing further deterioration in bone health and reducing the risk of falls and fractures in later life.[440]

8.2.3 Level of need

Falls are the largest cause of emergency hospital admissions for older people with estimates that around 30% of people aged 65 and above – 2.5 million people – and around half of those aged 80 and above, will experience a fall at least once a year. These falls and fractures account for over 4 million bed days a year at an estimated cost of £2 billion.[441]

This commentary should consider LLR's varying demographics; Leicestershire and Rutland have older populations, so disease burden is likely to increase further.

[437] NHS (2022) Overview Osteoporosis. Available from https://www.nhs.uk/conditions/osteoporosis

[438] NICE (2025) Osteoporosis – prevention of fragility fractures: How common is it? Available at https://cks.nice.org.uk/topics/osteoporosis-prevention-of-fragility-fractures/background-information/prevalence/

[439] National Institute of Arthritis and Musculoskeletal and Skin Diseases (2022) Osteoporosis. Available at https://www.niams.nih.gov/health-topics/osteoporosis.

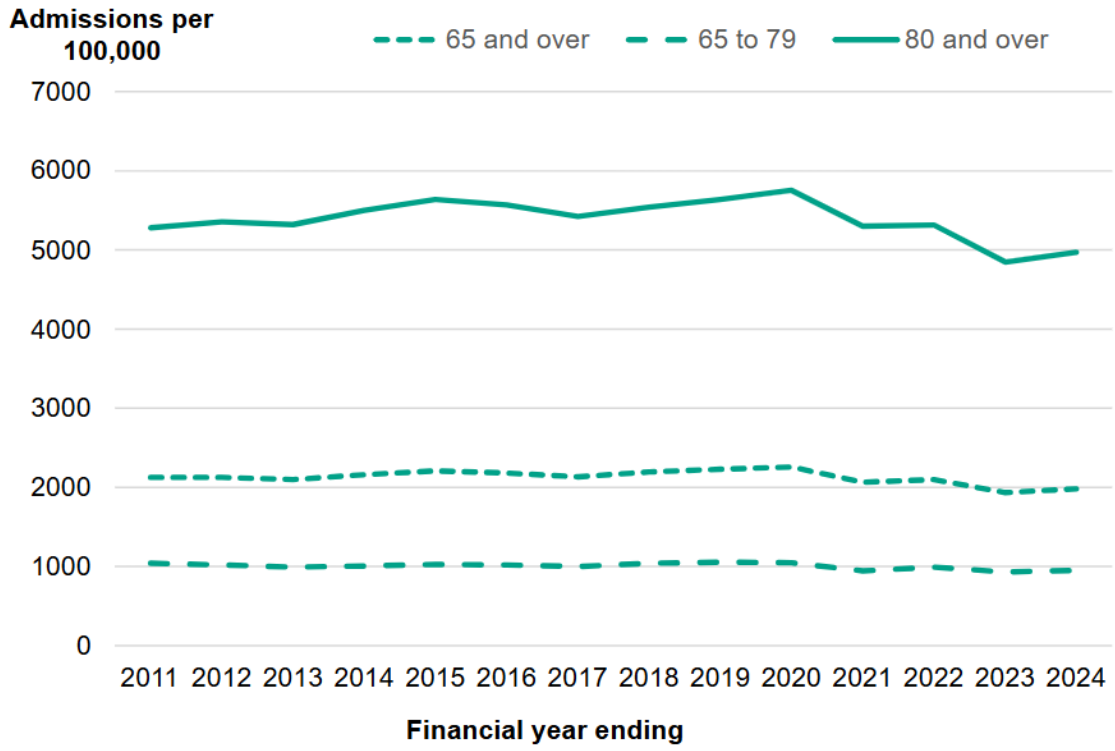
[440] British Medical Association (2025) Identification and management of patients with frailty. Available at https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/identification-and-management-of-patients-with-frailty

[441] NHSE (2025) National roll out of AI tool that predicts falls and viruses. Available at https://www.england.nhs.uk/2025/03/nationwide-roll-out-of-artificial-intelligence-tool-that-predicts-falls-and-viruses/

8.2.3.1 Falls

Nationally, between April 2010 and March 2024 emergency admissions for falls in people aged 65 years and over in England seen varying declines in recent time periods. However, all three indicators are significantly better now, compared to previous years.

Figure 105: Age-standardised emergency admission rate for falls in people aged 65 years and over, England, financial years, April 2010 to March 2024



Source OHID Fingertips

Across LLR, the picture is mixed. Leicester rates are statistically similar to the national average across the three age categories. Leicestershire is significantly better (lower) than the national average in the 65 and over and 65 to 79 age categories, with Rutland being significantly better (lower) than the England average across all three age categories. Rates are significantly worse in females than males.

Figure 106: Age-standardised emergency admission rate for falls in people aged 65 years and over, 65 to 79 and aged 80 plus for Leicester, Leicestershire and Rutland (respectively)

Leicester

Indicator	Period	Leicester			East Midlands	England	England	
		Recent Trend	Count	Value	Value	Value	Worst	Range
Emergency hospital admissions due to falls in people aged 65 and over	2023/24	→	870	2,001	1,908	1,984	3,311	
Emergency hospital admissions due to falls in people aged 65 to 79	2023/24	→	345	1,037	908	955	1,806	
Emergency hospital admissions due to falls in people aged 80 plus	2023/24	→	525	4,796	4,809	4,969	8,322	

Leicestershire

Indicator	Period	Leics			East Midlands	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range
Emergency hospital admissions due to falls in people aged 65 and over	2023/24	→	2,870	1,836	1,908	1,984	3,311	
Emergency hospital admissions due to falls in people aged 65 to 79	2023/24	→	965	824	908	955	1,806	
Emergency hospital admissions due to falls in people aged 80 plus	2023/24	→	1,905	4,771	4,809	4,969	8,322	

Rutland

Indicator	Period	Rutland			East Midlands	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range
Emergency hospital admissions due to falls in people aged 65 and over	2023/24	↓	155	1,330	1,908	1,984	3,311	
Emergency hospital admissions due to falls in people aged 65 to 79	2023/24	→	50	625	908	955	1,806	
Emergency hospital admissions due to falls in people aged 80 plus	2023/24	↓	105	3,374	4,809	4,969	8,322	

Source: OHID, Injuries due to fall

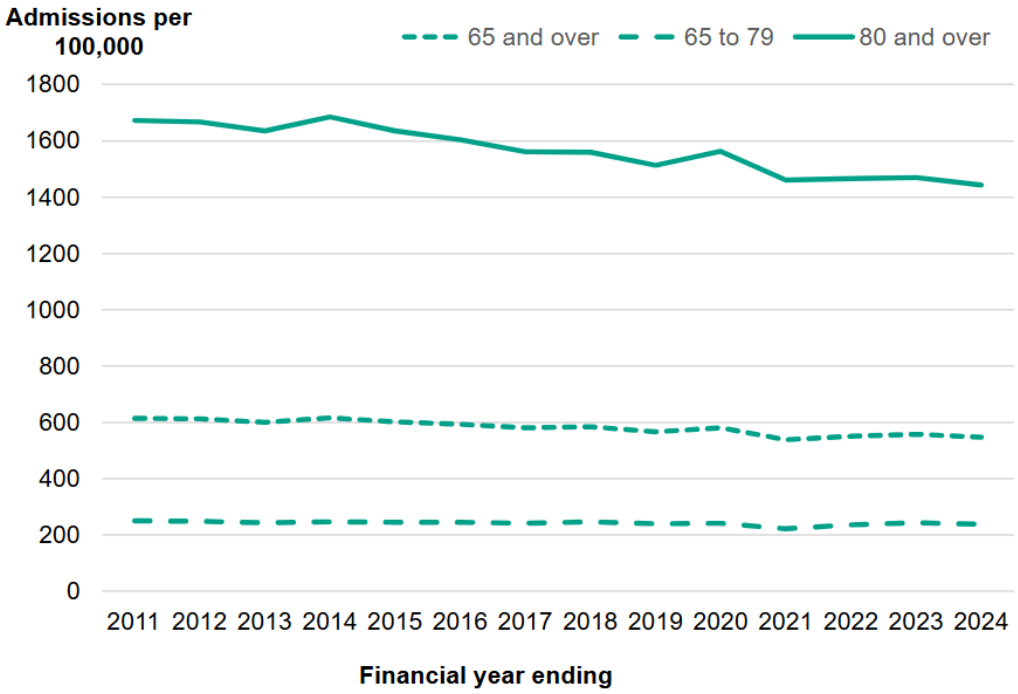
Better 95% Similar Worse 95% Not applicable

8.2.3.2 Hip Fractures

Nationally, emergency admissions for hip fractures have significantly decreased over the last decade. Locally, Leicester has seen declines in recent years and is now in line with the England average for all three age categories. Leicestershire and Rutland have seen declines in both people aged over 65 and aged over 80, however there is no significant change in those aged 65 to 79.[442]

[442] Office for Health Improvement & Disparities. Public Health Outcomes Framework: commentary, February 2025 [Internet]. GOV.UK. Available from: https://www.gov.uk/government/statistics/public-health-outcomes-framework-february-2025-data-update/public-health-outcomes-framework-commentary-february-2025

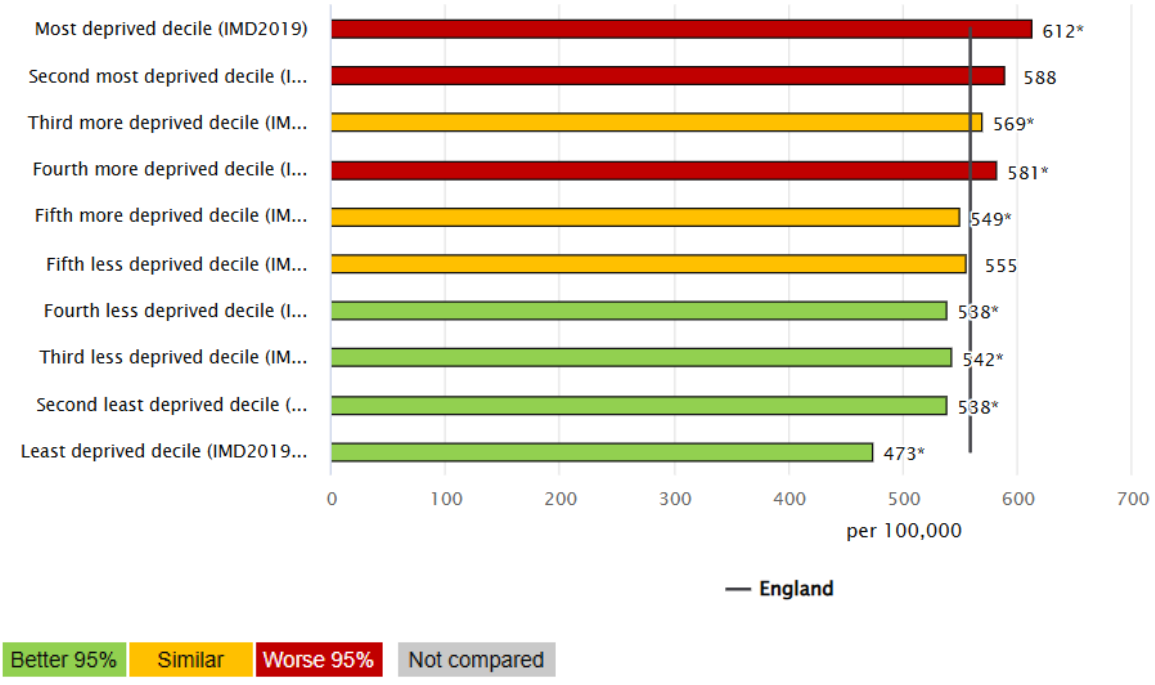
Figure 107: Age-standardised emergency admission rate for hip fractures in people aged 65 years and over, England, financial years, April 2010 to March 2024



Source OHID

When looking at differences in admissions due to deprivation, those in the most deprived deciles are more likely to experience hip fractures. This is less pronounced in those aged 80 and above. Unfortunately, this data cannot be broken down further by gender.

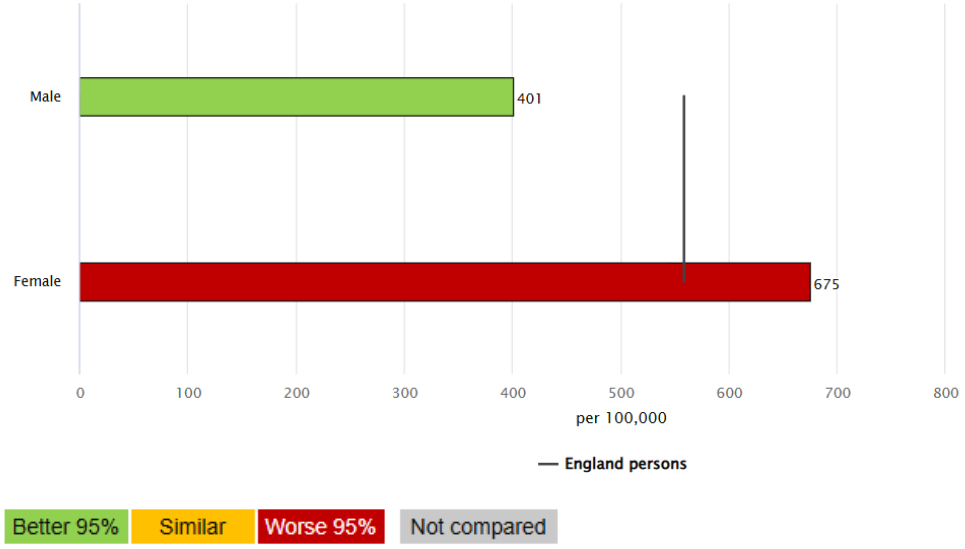
Figure 108: Hip fractures in people aged 65 and over, by deprivation decile 2022/23



Source: Hip fractures (OHID) 2025

However, nationally the rate of hip fractures is significantly worse (higher) in females than men. This is likely due to significantly higher rates of osteoporosis in women than in men.

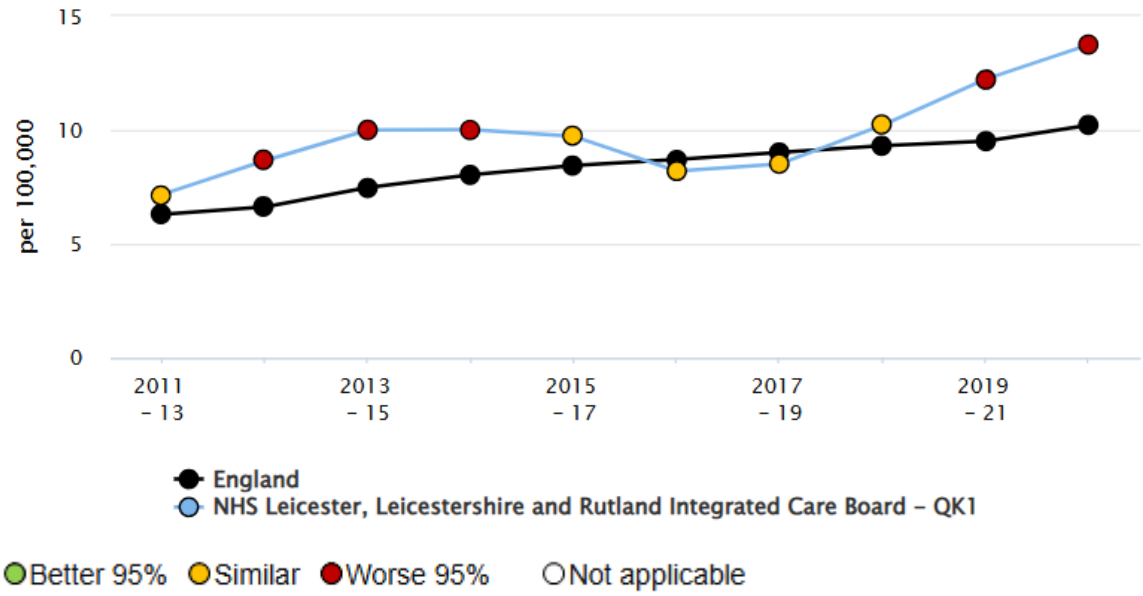
Figure 109: Hip fractures in people aged 65 and over, by gender 2022/23



8.2.3.3 Mortality from accidental falls

Mortality rates from falls in women across LLR is significantly worse (higher) than the England average and is on increasing trend, therefore more women are dying from accidental falls in LLR than in England as a whole. This trend has widened over time periods, demonstrating a faster rising local rate. Mortality is also significantly worse (higher) in those living in the most deprived deciles, as compared to the least deprived in LLR.

Figure 110: Mortality rates from accidental falls, all ages (Female)

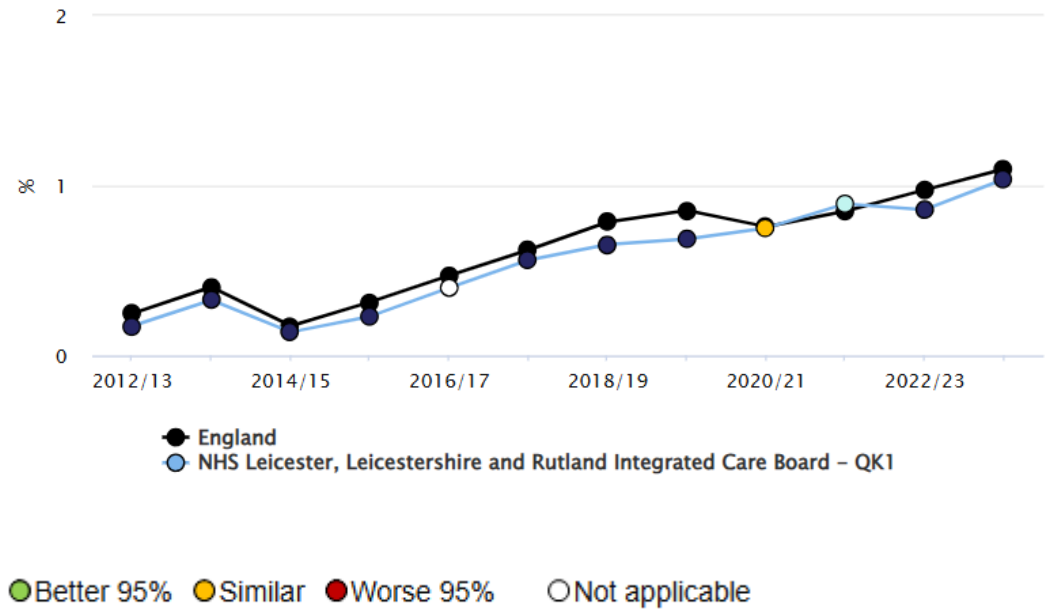


Source: OHID, Falls, 2025

8.2.3.4 Osteoporosis

Figure 90 shows the QOF prevalence of osteoporosis for LLR ICB. Recorded prevalence in Leicester City is significantly lower than the England average, with Leicestershire and Rutland generally being higher. An upward trend in QOF-recorded prevalence of osteoporosis may suggest improved case identification and data recording in primary care. However, this does not necessarily reflect the true burden of disease, as many individuals remain undiagnosed, largely due to the asymptomatic nature of the disease until a fracture occurs. The data is also limited to those engaged with services and may vary significantly across practices due to differences in coding and clinical behaviour. These factors should be considered when interpreting prevalence figures and planning service responses.

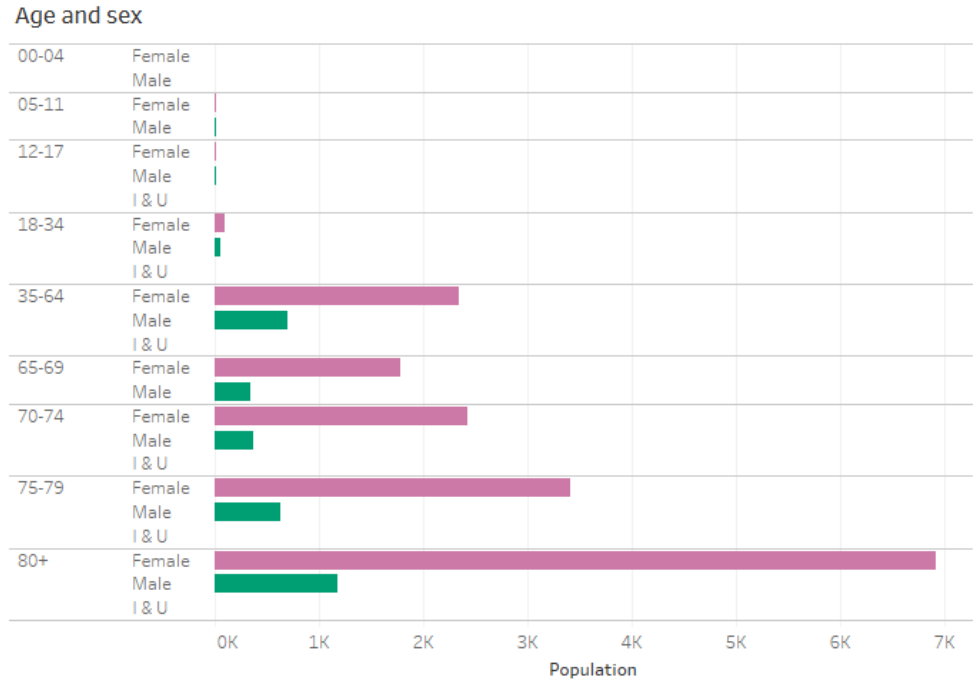
Figure 111: Osteoporosis: QOF prevalence (50+ years)



Source: OHID

Aristotle data below shows the burden of osteoporosis within LLR gender and age. In total, there are 20,271 patients with recorded osteoporosis. Prevalence is significantly higher in women, especially in those aged 75 and above. Those aged 80+ account for over 34% of osteoporosis cases.

Figure 112: Osteoporosis prevalence by gender in LLR



Source: Aristotle, August 2025

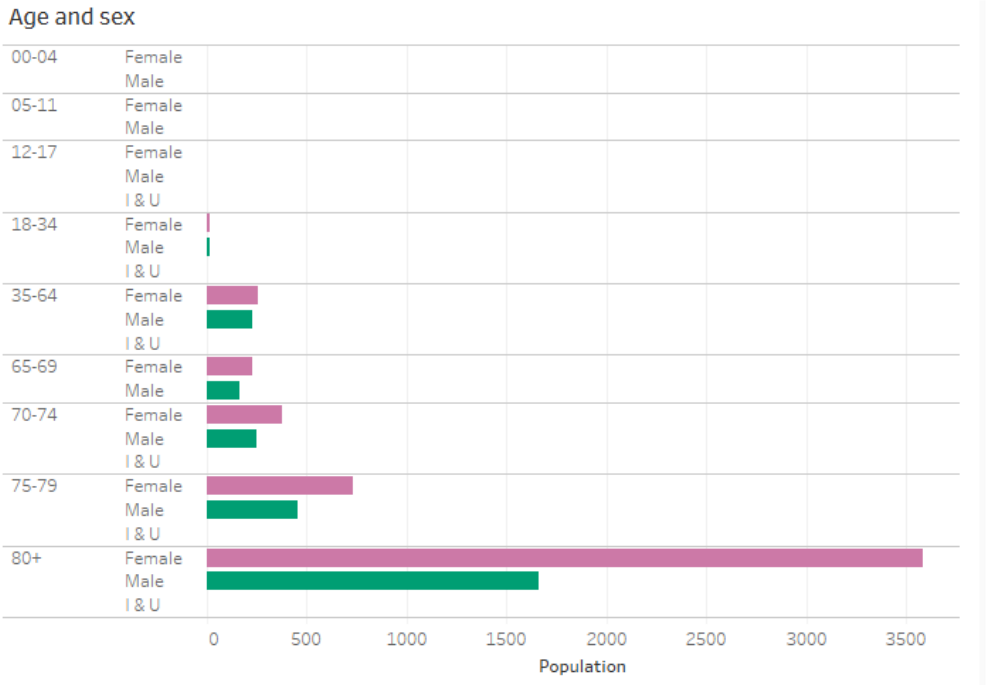
8.2.3.5 Frailty

Frailty can cause falls and falls can cause or accelerate the progression of frailty. NICE determines that 10% of patients with moderate or severe frailty are recorded as having a fall each year, but the true risk may be higher due to underreporting or differences in assessment. The risk is highest among those with severe frailty.[443]

Aristotle data on severe frailty across LLR shows the increase in numbers by age, and that women experience more severe frailty than men. Women do live longer, therefore higher numbers are expected within older age categories, however women experience higher numbers of severe frailty across all age brackets, showing other underlying issues, largely covered within 8.2.2.

[443] NICE (2018) NICE Impact Falls and Fragility Fractures. Available from https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-08-29/NICE-Impact-falls-and-fragility-fractures.pdf

Figure 113: Severe frailty across LLR by gender and age



8.2.4 What evidence- based management is recommended

The National Falls Prevention Coordination Group's Falls and fracture consensus statement advocates a whole system approach to prevention, which includes:

- risk factor reduction across the life-course
- case finding and risk assessment
- strength and balance exercise programmes
- healthy homes
- high-risk care environments
- fracture liaison services
- collaborative care for severe injury

Interventions can take place at population, community and individual levels. NICE NG249 recommends avoiding falls risk prediction tools and instead conducting opportunistic assessments. Comprehensive falls assessments should be offered to individuals with a history of falls or those at higher risk due to frailty or multimorbidity. Interventions should include strength and balance training, medication reviews, home hazard assessments, vision checks, and patient education. For osteoporosis, NICE CG146 advises fracture risk assessment in women aged 65+ and younger women with risk factors.[437] Academic evidence supports the effectiveness of tailored exercise programmes and multifactorial interventions in reducing falls and improving bone health. [444, 445]

[444] Sherrington C, Fairhall NJ, Wallbank GK, Tiedemann A, Michaleff ZA, Howard K, Clemson L, Hopewell S, Lamb SE. Exercise for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2019, Issue 1. Art. No.: CD012424. DOI: 10.1002/14651858.CD012424.pub2.

[445] Hopewell S, Adedire O, Copsey BJ, Boniface GJ, Sherrington C, Clemson L, Close JCT, Lamb SE. Multifactorial and multiple component interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2018, Issue 7. Art. No.: CD012221. DOI: 10.1002/14651858.CD012221.pub2.

Hormone Replacement Therapy (HRT) is recognised as a protective factor against osteoporosis, particularly for some women experiencing menopause. NICE guidelines (NG23 and QS143) recommend HRT for symptom management and bone health, especially in women with early menopause._[446, 447]

National guidance recommends that all patients aged 65 and over with moderate or severe frailty should be routinely asked about falls, as part of their care.[442]

Fracture Liaison Services (FLS) are a recommended model for secondary fracture prevention, providing coordinated identification, assessment, and treatment of adults aged 50+ following a fragility fracture. Guidance emphasises that FLS improves osteoporosis diagnosis, optimises treatment, and reduces recurrent fractures. Evidence demonstrates substantial impact: one study reported a 30% reduction in any re-fracture and a 40% reduction in major re-fracture in hospitals with an FLS compared with those without, equivalent to a number needed to treat (NNT) of 20 to prevent one re-fracture within three years. NICE quality standards and NHS improvement guidance consistently highlight FLS as the most effective and cost-efficient mechanism for reducing future fracture risk.[434, 437]

8.2.5 Current services in LLR

There are an array of services across LLR to address the associated risk factors for falls and osteoporosis, which have been discussed in other chapters within this needs assessment. These include stop smoking support, alcohol and substance use services, physical activity provision and weight management services.

At the time of writing this HNA, a falls review has commenced. The findings of this review will need to be considered alongside the recommendations within this HNA chapter.

Steady Steps

Across LLR, the Steady Steps Programme is offered; a 24-week programme aimed to improve balance and stability in those aged 65 and over. The programme is delivered by Level 4 specialised Postal Stability Instructors or Healthy Lifestyle Advisors. Eligibility of the programme includes people aged 65 and over, are at risk of falling or have fallen less than three times in the past twelve months. Individuals can self-refer or be referred by Health Professionals such as GPs._[448]

From discussions with the service, more participants were female than male. Outcome data shows improvements to participants in terms of reductions to falls risk, increases in physical activity and increases in confidence. Due to high service demand, there are often waiting lists.

Blood Pressure Checks

NHS Community Pharmacy Blood Pressure Check service enables community pharmacy staff to offer blood pressure services to individuals who are:

- 40 years and over
- Not previously been identified as having hypertension or a related condition; and

[446] NICE (2015, updated 2024) Menopause: identification and management. Available at https://www.nice.org.uk/guidance/ng23

[447] NICE (2017) Menopause. Available at https://www.nice.org.uk/guidance/qs143

[448] Active Together. Steady Steps. https://www.active-together.org/steadysteps

- Has not had their blood pressure measured by a health professional within the previous six months.

Pharmacies able to provide appropriate information including promotion of healthy behaviours and urgent referrals to their GP within 24 hours for very high blood pressures. All blood pressure readings are sent to their GP from the community pharmacy. In addition, GPs can also refer patients to a participating community pharmacy doe a 24-hour ambulatory blood pressure monitoring.[449]

Falls Prevention and Response Services

Leicestershire, Leicester and Rutland (LLR) offer a range of services aimed at preventing and responding to falls, which are closely linked to bone health and frailty in women. The LLR Urgent Falls Response Service, recently extended to March 2026, provides rapid support for individuals who have fallen and cannot get up, without suspected serious injury. It operates daily from 8am to 6pm and is accessible to a wide range of health and social care professionals1.

The Community Falls Prevention Service, delivered by LPT, includes initial assessments, therapy clinics, and a six-week exercise and management programme. Following completion, individuals are signposted to Steady Steps. Consultant-led outpatient clinics are available for those with medical needs. There is ongoing work to improve coordination between LPT therapy services and the falls prevention pathway.

8.2.6 Unmet needs or gaps

There is a lack of gender- and ethnicity-disaggregated data on falls and osteoporosis across LLR, and service capacity and waiting times for local falls services are not well documented or easily accessible. Without access to current service data, it is difficult to accurately assess local need. However, given the ageing population across LLR, demand for falls prevention and osteoporosis-related services is expected to rise significantly, and services must be equipped to respond.

Due to existing disparities in women's health, services should be tailored and targeted specifically towards women. It is essential that women are informed about the impact of menopause on bone health and the importance of early prevention. For women living in areas of deprivation and from certain ethnic backgrounds, particularly relevant in Leicester's culturally diverse population, these risks may be compounded. Targeted efforts are needed to reduce inequalities and promote health equity. Differences in HRT prescribing rates, as highlighted in subsequent chapters, point to disparities linked to deprivation and potentially ethnicity.

There is also a challenge in quantifying the number of people at risk of falling due to the wide range of contributing factors. Although frailty is often used as a proxy, recent evidence suggests it should not be the sole marker. Updated NICE guidance recommends considering all individuals aged 65 and over, and those aged 50–64 with health conditions that increase fall risk, as 'at risk'.[434]

[449] NHSE. NHS Community Pharmacy Blood Pressure Check Service. https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/nhs-community-pharmacy-blood-pressure-check-service/

Operationally, there are gaps in awareness among referrers about available services and when to use them, and communication between services—particularly at transition points such as hospital discharge or movement between community services—needs improvement.

8.2.7 Recommendations

- Undertake a deep dive into falls service data to determine if current services are meeting demand.
- Conduct a deep dive to understand why LLR mortality rates from falls are significantly worse than the England average.
- Ensure local services are equipped to deal with increases in future demand due to the ageing demographics within LLR.
- Conduct further research into osteoporosis and bone health in LLR to determine how it affects women differently to men, and whether (and likely where) there are differences between women at neighbourhood level and below.
- Conduct further research into mortality rates from falls to understand why LLR is significantly worse than England and implement measures for improvement if required.
- Scope further opportunities to have Healthy Conversations around bone health utilising Making Every Contact Count and future integration within NHS Health Checks.
- Prioritise outreach to ethnic minority women and those with limited-service access, particularly in Leicester City to address lower rates of osteoporosis prevalence.
- Continue to deliver Steady Steps, ensuring provision can be targeted towards women facing numerous risk factors and inequalities.
- Promote access to HRT for eligible postmenopausal women.
- Increase efforts to prevent individuals from becoming at risk of falling, with a particular focus on women at risk of osteoporosis.
- Develop and disseminate consistent falls prevention materials and resources. Educate referrers and the wider system workforce about available services and referral pathways.
- Undertake further analysis to determine why mortality rates from falls in Leicestershire might be higher than national average.
- A fracture liaison service could support patients, and ultimately reduce demand on health and social care, as well as reduce patient mortality due to falls. This should be looked into further to determine viability and feasibility.

8.3 Cognitive Health

8.3.1 Background

This section shall provide a brief overview of cognitive health. Across the system there are other workstreams addressing this area, and more in-depth analysis and assessments. Further reading can be found here:

LLR Joint Living Well with Dementia Strategy 2024-2028

Leicester City – Dementia in Leicester Adults: JSNA

Leicestershire Dementia JSNA 2022

Leicestershire End of Life Care and Support JSNA 2022

Leicestershire Adult Mental Health JSNA 2024

Rutland End of Life Care and Support JSNA 2022

Rutland Mental Health and Dementia – Adults 2024

Cognitive health refers to the ability to think, learn, and remember. It is essential for maintaining independence and wellbeing in later life. Dementia, a progressive condition affecting memory and reasoning, is not a normal part of ageing but results from accumulated brain damage. The illness mainly affects older people and gets worse over time. It is caused by many different diseases or injuries that directly and indirectly damage the brain. Alzheimer's disease is the most common form and may contribute to 60–70% of cases but other forms include vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to frontotemporal dementia. Dementia may also develop after a stroke or in the context of certain infections such as HIV, as a result of harmful use of alcohol, repetitive physical injuries to the brain (chronic traumatic encephalopathy) or nutritional deficiencies.[450]

Women are disproportionately affected:

- They account for 62% of dementia cases in the UK.[451]
- Dementia is the leading cause of death among women in the UK.
- Women are more likely to be unpaid carers, often experiencing isolation and depression—both risk factors for cognitive decline.[452]

The LLR Joint Living Well with Dementia Strategy 2024–2028 emphasises personalised, integrated care and aims to improve access to diagnosis and support, especially for underrepresented groups.[453] It uses the NHS England Well Pathway for Dementia to guide service development.[454]

8.3.2 Risk factors for cognitive impairment

There are various modifiable and non-modifiable risk factors for cognitive impairment. Around 40% of dementia cases could be attributable to modifiable risk factors.[450]

Non-Modifiable - These are characteristics that cannot be changed by the individual or through intervention (although deprivation does straddle modifiable and non-modifiable).

- **Age**: Risk roughly doubles every five years after 65. It is estimated that 2 in every 100 people between the ages of 65 and 69 have dementia compared to around 33 in every 100 people aged over 90.[455]

[450] Leicestershire County Council (2024) Adult Mental Health JSNA. Available at https://www.lsr-online.org/uploads/adult-mental-health-chapter.pdf?v=1716543234

[451] PHE (2021) Health matters: midlife approaches to reduce dementia risk. Available at https://www.gov.uk/government/publications/health-matters-midlife-approaches-to-reduce-dementia-risk/health-matters-midlife-approaches-to-reduce-dementia-risk.

[452] Alzheimer's Research UK (2022). The Impact of Dementia on Women. Available at: https://www.alzheimersresearchuk.org/wp-content/uploads/2022/05/The-Impact-of-Dementia-on-Women-ARUK-report.pdf

[453] LLR Joint Living Well with Dementia Strategy 2024–2028. Available at https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/social-care-and-education/leicester-leicestershire-and-rutland-joint-living-well-with-dementia-strategy-2024-2028/#local_picture

[454] NHSE Well Pathway for Dementia. Available at https://www.england.nhs.uk/mental-health/dementia/

[455] Corrada MM, Brookmeyer R, Paganini-Hill A, Berlau D, Kawas CH. Dementia incidence continues to increase with age in the oldest old: the 90+ study. Ann Neurol. 2010 Jan;67(1):114-21. doi: 10.1002/ana.21915.

- **Sex**: As described, women are more likely to get dementia and cognitive impairment. One reason is because women live longer than men, and age is the greatest risk factor for dementia. Other research also attributes the increased risk to changes during menopause as well as social and cultural factors.[456]
- **Ethnicity**: Minority ethnic groups may face higher risk and lower diagnosis rates.[457]
- **Socioeconomic deprivation**: Deprivation is inked to higher dementia mortality and poorer diagnosis quality, with more than 1 in 5 deaths from dementia thought to be related to socio-economic deprivation.[458]

Modifiable: These are behaviours, exposures, or conditions that individuals or communities can change or control to improve health outcomes.[450, 459]

- **Smoking:** Doubles the risk of dementia.
- **Obesity**: Associated with higher dementia rates.
- **Alcohol**: High consumption has been shown to raise risk.
- **Social isolation and depression**: Low levels of social activity and poor social networks, are significantly associated with poor cognitive function in later life.
- **Physical Inactivity**: Physical activity has been shown to be associated with reduced rates of dementia.

The Lancet Commission report 2020 on dementia prevention, intervention and care highlight 12 modifiable risk factors including (in addition to the above) hearing impairment, less education and air pollution.[460]

8.3.3 Level of Need

As of December 2024, there were 483,000 individuals in England with a recorded diagnosis of dementia aged 65 years and above.[461] However, this figure only reflects individuals who have received a formal diagnosis from a GP and is likely to be an underrepresentation. It may exclude people who are not registered with a GP, face language or health literacy barriers, or have limited access to primary care services. Consequently, the actual prevalence of dementia is believed to be considerably higher.

Estimates vary, but all sources indicate a substantial gap between recorded diagnoses and the true number of cases. According to NHS England, approximately 702,000 people aged 65 and over were estimated to be living with dementia in England as of August 2022, and as of May 2024 the Alzheimer's Society estimate this to be 982,000, set to rise to 1.4 million by 2040.[462]

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[456] Moutinho, S. Nature (2025). Women twice as likely to develop Alzeimer's disease as men – but scientists do not know why. Available at https://www.nature.com/articles/s41591-025-03564-3

[457] Mukadam N, Marston L, Lewis G, Mathur R, Rait G, Livingston G. Incidence, age at diagnosis and survival with dementia across ethnic groups in England: A longitudinal study using electronic health records. Alzheimer's Dement. 2023; 19: 1300–1307. https://doi.org/10.1002/alz.12774

[458] 7.Jitlal M, Amirthalingam GNK, Karania T, Parry E, Neligan A, Dobson R, Noyce AJ, Marshall CR. The Influence of Socioeconomic Deprivation on Dementia Mortality, Age at Death, and Quality of Diagnosis: A Nationwide Death Records Study in England and Wales 2001-2017. J Alzheimer's Dis. 2021;81(1):321-328. doi: 10.3233/JAD-210089.

[459] Leicestershire County Council (2022) Dementia JSNA. Available at https://www.lsr-online.org/uploads/dementia.pdf?v=1649162842

[460] Livingston, Gill et al. The Lancet (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission: 396, Issue 10248, 413 – 446. Available at https://www.thelancet.com/article/S0140-6736(20)30367-6/fulltext

[461] OHID (2025) Dementia profile: prevalence and supporting well topics statistical commentary. Available at https://www.gov.uk/government/statistics/dementia-profile-march-2025-update/dementia-profile-prevalence-and-supporting-well-topics-statistical-commentary-march-2025

[462] Alzheimer's Society (2024) How many people have dementia in the UK? Available at https://www.alzheimers.org.uk/blog/how-many-people-have-dementia-uk

This suggests a larger percentage of dementia cases in this age group remain undiagnosed or unrecorded, leaving many without the necessary care, support, and treatment.

While dementia predominantly affects older adults, it is important to note that young onset dementia does occur, with 15,300 individuals aged under 65 registered with a GP having a dementia diagnosis as of December 2024.[460]

Recorded prevalence aged 65 years and over in LLR in 2024 was 4.1% (N=9,002), which is similar to the England average.[463] As nationally, similar rates of males and females have a diagnosis of dementia across LLR, however this shifts with more females having a diagnosis of dementia in age categories above 80. Largest ethnic group to have a diagnosis of dementia across LLR is 'White', this is followed by 'Asian/Asian British', however there is significant gap in the rate of diagnosis between the two groups.[452]

The LLR Joint Living Well Dementia Strategy estimated that over 14,000 people were living with dementia across LLR in 2020. Projections suggest that by 2030, this number will rise to over 13,000 in Leicestershire County, 3,000 in Leicester City, and 900 in Rutland.

As of October 2023, it is estimated that more than 13,000 people aged 65 and over are living with dementia across the area. However, only around 8,000 of these individuals have a formal diagnosis recorded by NHS Digital, indicating a significant gap between estimated prevalence and diagnosed cases.

Approximately 1 in 14 people aged 65 and over in LLR are thought to be living with dementia, which aligns with national trends. While it is estimated that there are around 105,000 carers in the area, specific data on how many are supporting individuals with dementia is not currently available.[452]

Using the Population Health Management Risk Segmentation Tool, there are a total of 8,284 patients registered on GP lists with dementia in LLR. Out of these, 5,009 (60.5%) are females, with the majority belonging to the 80+ age group (3,483 compared to 1,869 males) which equates to 69.5%.

There was a total of 3,315 deaths in females in LLR involving dementia and Alzheimer's disease in 2021/23. The mortality rate for deaths involving dementia and Alzheimer's disease in Leicester (224.4 per 100,000 population) was significantly worse (higher) in comparison to the national rate of 166.5 (per 100,000 population). Leicestershire (164.7 per 100,000 population) and Rutland (167.2 per 100,000 population) had statistically similar rates to the national rate.

[463] DHSC (2025) Dementia Profile. Available at https://fingertips.phe.org.uk/profile/dementia

Figure 114: Mortality rate for deaths involving dementia and Alzheimer's disease (females – all ages) in LLR, 2021/23.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	168,585	166.5	165.7	167.3
East Midlands region (statistical)	–	16,174	184.4	181.5	187.2
Leicester	–	880	224.4	209.8	239.8
Rutland	–	168	167.2	142.8	194.6
Leicestershire	–	2,267	164.7	158.0	171.7



Source: Dementia Profile, OHID, 2025

Another factor for consideration is the ageing population of LLR (covered within the demography section), especially of those within Leicestershire and Rutland. With age being the biggest predictor of dementia, numbers will be expected to grow significantly over the coming years, and services should be carefully considering this in to forward planning. Women also live longer than men, therefore the need for women will grow in the future. Plans will need to take the projected growth into account to ensure that the capacity of dementia services is increased to meet this level of need in the future.

8.3.4 What evidence-based management is recommended?

There is substantial evidence that lifestyle choices can influence an individual's risk of developing dementia. The risk is lowest among those who adopt healthy behaviours during mid-life (ages 40 to 65).[464]

NICE Guidelines (NG16)[465] includes recommendations on promoting a healthy lifestyle to reduce the risk of or delay the onset of disability, dementia and frailty by individuals to:

- stop smoking
- be more active
- reduce their alcohol consumption
- improve their diet
- lose weight and maintain a healthy weight if necessary

Other guidance includes:

- keeping the mind engaged
- staying connected with social activities
- addressing physical and mental health problems

Evidence to support individuals to reduce the risk of or delay the onset of dementia for national and local organisations include:

- integrating dementia risk reduction prevention policies
- raising awareness of risk of dementia, disability and frailty

[464] Alzheimer's Society (2025) Reduce your risk of dementia. Available at https://www.alzheimers.org.uk/about-dementia/managing-the-risk-of-dementia/reduce-your-risk-of-dementia

[465] NICE (2015) Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset. Available at https://www.nice.org.uk/guidance/ng16

- producing information on reducing the risks of dementia, disability and frailty
- preventing tobacco use
- improving the environment to promote physical activity
- reducing alcohol-related risk
- supporting people to eat healthily

The Lancet Commission advocates for prevention strategies targeting modifiable risk factors.[459]

NICE guidelines[466] recommend a comprehensive approach to dementia care, including early diagnosis, person-centred care, and support for carers. Key recommendations include:

- Offering cognitive stimulation therapy to individuals with mild to moderate dementia.
- Providing access to memory assessment services.
- Ensuring coordinated care through multidisciplinary teams.
- Supporting advance care planning and end-of-life care.
- Supporting carers.

8.3.5 Current Services in LLR

The JSNA documents reference above provide information on the breadth of services available across LLR. In summary:

LLR offers a range of dementia services including memory clinics, community mental health teams, and voluntary sector support. Leicester City Council and Leicestershire County Council provide dementia care and support pathways. Rutland has integrated mental health and dementia services for adults. Despite these provisions, there can be service fragmentation and long waiting. The LLR Dementia Strategy aims to improve coordination and equity of access.

There are also different place plans and partnerships, with Rutland having a Dementia Delivery Plan and Partnership.

Age UK Leicester Shire & Rutland provide a Dementia Support Service, commissioned by the Councils and the NHS, which covers a wide breadth of community-based support, including carer learning programmes, assistive technology, and financial advice. These services are vital for women, who are more likely to be informal carers and may experience financial strain or reduced employment opportunities as a result.

There are also other services which address the modifiable risk factors, which could prevent or delay onset including substance use services, stop smoking services, physical activity and weight management. However, there is not a consistent offer across LLR and not all services meet varying needs such as accessibility, health literacy and language barriers. Services are generally not tailored towards women either.

8.3.6 Unmet needs or gaps

The LLR-wide dementia strategy emphasises a life-course approach to dementia care, structured around NHS England's "Preventing Well, Diagnosing Well, Supporting Well, Living Well, and Dying Well" framework. However, gaps remain in early diagnosis and culturally competent services, particularly for women from ethnic minority backgrounds. The strategy and

[466] NICE (2018 – reviewed 2023) NG97 Dementia: assessment, management and support for people living with dementia and their carers. Available at https://www.nice.org.uk/guidance/ng97

JSNAs recognise that women may face unique barriers to diagnosis, such as attributing symptoms to menopause or stress, and calls for improved awareness and gender-sensitive diagnostic pathways. There is also a need for more tailored support for women living with dementia, including those with younger onset, who often fall between service thresholds and experience social isolation.

Local evidence also emphasises the need for targeted outreach, improved data collection and investment in community-based support.

Awareness on the modifiable risk factors may also not be universally known; therefore, further targeted work may be necessary.

8.3.7 Recommendations

Work is already underway locally through the LLR Dementia Programme Board, to lead strategy implementation, addressing the gaps highlighted and continue to develop and deliver dementia care and provision. The JSNAs also highlight key recommendations. However, recommendations more specific to women and which the Women's System Partnership could facilitate and act on include:

- Improve local knowledge and awareness around dementia, including the modifiable risk factors and higher prevalence in women.
- Address inequalities in access for ethnic minority and socioeconomically disadvantaged women.
- Ensure primary prevention and early intervention related to services addressing risk factors such as smoking, alcohol, physical activity and isolation are targeted towards women at highest risk, raising awareness of the links between lifestyle behaviours and dementia.
- WSP to link in with existing groups focussed on cognitive impairment and dementia to ensure work is joined up.
- Support carers with tailored resources and services.

9 Women's Health Hubs

9.1 Background

In August 2022, the Department of Health and Social Care published the Women's Health Strategy for England, setting out a 10-year vision to transform how the health and care system engages with women and girls, and to improve their health outcomes. The strategy adopts a life course approach, recognising that health needs evolve from adolescence through to later life, and that services must reflect this continuum.

A key component of the strategy is the development of Women's Health Hubs (WHH); integrated service models that bring together healthcare professionals and existing provision to deliver holistic, community-based care. These hubs are designed to improve access, enhance care experiences, and reduce health inequalities by addressing physical, emotional, and social health needs across the life course. These hubs aim to:

- Improve access to and experiences of care
- Enhance health outcomes
- Reduce health inequalities
- Support self-management and informed decision-making

In March 2023, the government announced a £25 million investment to implement WHH in every Integrated Care Board (ICB) across England. Each ICB received £595,000 to support hub development, with expectations that hubs be operational by July 2024 (minimum core services) and fully functional by December 2024 (all core services). The national mandate emphasises the provision of comprehensive support, including sexual health, menopause care, social prescribing, and broader emotional wellbeing services.

9.2 National Evidence and Expectations

Early evaluations of WHH nationally suggest both qualitative and quantitative benefits, although the initiative remains in its early stages. NHS England's cost-benefit analysis[467] and highlights the following expected outcomes:

- Improved access to services such as menopause care, contraception, and sexual health
- Reduced secondary care referrals through better triaging and integrated care
- Enhanced workforce experience via multidisciplinary team (MDT) collaboration
- Efficient use of resources through collaborative commissioning and virtual/in-person service models

The national core specification[468] for hubs includes:

- Menstrual health
- Menopause care
- Contraceptive services
- Cervical screening

[467] DHSC (2024) Women's health hubs: cost benefit analysis. Available at: https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-cost-benefit-analysis
[468] DHSC (2024) Women's health hubs: core specification. Available at https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-core-specification

- STI and HIV screening
- Pessary fitting/removal

Hubs are also encouraged to incorporate holistic elements such as mental health support, social prescribing, and community engagement.

Prior to national implementation, a rapid mixed-methods evaluation was conducted on already established WHH.[469] Those accessing the hubs reported positive experiences, with many hubs adopting integrated approaches in order to meet the needs of their area. However, there were risks around the potential to widen inequalities if models were not accessible, especially to those experiencing higher levels of deprivation and disadvantage.

9.3 LLR Local Delivery Model

A structured and competitive expression of interest process was undertaken to identify suitable pilot sites for Women's Health Hubs across LLR. Due to the constraints of the available funding envelope, it was not feasible to achieve universal coverage at this stage. Instead, the LLR approach has been to implement the hubs as a proof of concept, with the intention of generating learning and evidence to inform future expansion, or adaptations to current and ongoing delivery mechanisms for women's health.

Three pilot hubs have been established across LLR:

North-West Leicestershire

- Locations: Longlane Surgery (Coalville) and Castle Medical Group (Ashby-de-la-Zouch)
- Core Services: Specialist menopause care, menstrual health, contraception (including LARC), cervical screening, STI/HIV screening
- Holistic Elements: Mental health checks, signposting to physical activity and parenting support, symptom management resources

The Willows (Leicester City)

- Locations: Springfield Road Medical Centre and Spinney Hill Medical Centre
- Core Services: Menstrual health, menopause care, contraception, cervical screening, STI/HIV screening
- Holistic Elements: Nutritional support, mother and toddler clubs, women's shelter, support for commercial sex workers and traveller communities, mental health services including Crisis Café

Rutland (also covering Melton)

- Location: Uppingham Surgery and mobile clinic
- Core Services: Menstrual health, menopause care, contraception, cervical screening, STI/HIV screening
- Holistic Elements: Virtual clinics, mental health groups for military spouses, weight management, signposting packs covering breast screening, domestic abuse, baby loss, and sexual health

[469] Daniel K, Bousfield J, Hocking L, Jackson L, Taylor B. Women's Health Hubs: a rapid mixed-methods evaluation. Health Soc Care Deliv Res 2024;12(30). https://doi.org/10.3310/JYFT5036

9.4 Data and Insights

While national data is emerging, local evaluation is limited due to the pilot status of LLR hubs. However, the following aims guide data collection and service design:

For Women and Girls

- Better access to preventative care and early intervention
- Improved patient experience and reduced unmet need
- Enhanced health outcomes and equity
- Accessible health information and support for self-management

For the Workforce

- MDT skill optimisation and joint training
- Improved retention and job satisfaction
- Strengthened communication across care settings

For the System

- Greater efficiency and reduced referrals
- Integrated commissioning and service design
- Improved data collection and use for planning

9.5 Service Gaps and Limitations

The LLR WHH are still in their pilot phase, and unfortunately there has not been a further funding commitment for continuation nationally. This in itself is a limitation. Due to the pilot nature of the WHH there are several other gaps and limitations:

- Current pilots only cover selected Primary Care Networks (PCNs)
- Limited data availability due to early implementation
- Variation in holistic service provision across sites

9.6 Recommendations

While the most straightforward recommendation would be to expand the coverage of WHH, this is currently neither feasible nor sustainable. External pressures—including Integrated ICB funding constraints, the ongoing clustering of ICBs, shifting strategic focus towards neighbourhood health models, and local government reorganisation, have created uncertainty around the long-term future of Women's Health Hubs in their current form. Nonetheless, the potential for future expansion should not be dismissed. Ongoing evaluation of the hubs' effectiveness may provide the evidence base needed to support further development and investment.

- Expand Coverage: Although the future of WHH is uncertain, if evaluation shows promising strengths a plan for sustainable and scalable rollout across all of LLR should be considered.
- Strengthen Evaluation: Ensure the local evaluation framework is aligned with national metrics and NIHR guidance.
- Enhance Data Use: Improve data collection and analysis to inform service design and monitor outcomes. This should also aid learning across the hubs sites and be shared with other PCNs and the wider system.

- Promote Equity: Ensure hubs address the needs of underserved groups, including ethnic minorities, LGBTQ+ communities, and those with disabilities. It is recommended that a Healthy Equity Audit is carried out towards the end of the pilot, and the findings are used to ensure that future work does not widen inequalities, a potential risk as highlighted by previous research.[470]
- Integrate Holistic Care: Continue to work with PCNs and provider to embed mental health, social support, and community engagement into core hub models.



[470] Daniel K, Bousfield J, Hocking L, Jackson L, Taylor B. Women's Health Hubs: a rapid mixed-methods evaluation. Health Soc Care Deliv Res 2024;12(30). https://doi.org/10.3310/JYFT5036

10 Cross Cutting Recommendations

Cross-Cutting Recommendations: A Shared Commitment to Women's Health

This HNA presents a comprehensive set of chapter-specific recommendations. In addition, the following cross-cutting recommendations offer a unifying foundation for all partners and stakeholders to build upon:

Women's Health is Everyone's Responsibility

- The advancement of women's health in LLR is not confined to the Women's System Partnership. Every collaborative, service, and team is encouraged to reflect on their own provision through a women-centred lens and consider how they can better meet the diverse needs of women.

Neighbourhood Health

- With the 10 Year Health Plan and the shift to Neighbourhood Models of Care, the system should look at ways to address women's health through Neighbourhoods, building on the good work of the Women's Health Hubs. It is recommended that Neighbourhoods and Primary Care use a Population Health Management approach to look at services through a women's lens and make alterations based on women's needs at a local level.

Recognising and Responding to Women's Distinct Needs

- Evidence from this HNA and national research highlights that many services have historically been designed with male defaults. Services should be intentionally shaped to reflect the realities of women's lives, ensuring they are targeted, tailored, and culturally responsive.

Strengthening Data Foundations for Collaboration

- Improved data sharing is essential to foster transparency, enable joint working, and support more nuanced understanding of women's health needs across systems.

Making Every Contact Count (MECC) for Women's Health

- Every interaction is an opportunity to support women's health. Organisations should embed MECC approaches that are sensitive to women-specific issues, such as menstrual health, to equip staff with the confidence and competence to engage in open, supportive conversations.

Prioritising Health Literacy

- Enhancing health literacy empowers women to advocate for themselves, make informed choices, and navigate services effectively. It also plays a vital role in addressing health inequalities, particularly those linked to deprivation and language barriers.

Place-Based Sensitivity

- Each locality has its own unique context and needs. Approaches should be locally informed and responsive to the lived experiences of women in different communities.

Workplace Wellbeing for Women

- Workplaces are central to many women's lives. Employers should recognise the specific challenges women may face and implement supportive measures that promote wellbeing, equity, and retention. Work should be undertaken to support employers to understand and address their women's workforce needs.

