EQUALITY ACTION'S

Annual Public Lecture 2022

TACKLING HEALTH INEQUALITIES

How long can we wait and what are we waiting for?

Toby Lewis

equality action

Loughborough University

Charnwood

vita health group

Chair's Introduction

“Healthy citizens are the greatest asset any country can have” is a quote by Winston Churchill. That being the case, the question is why are there such inequalities in health in our country today ? Health inequality along with other inequalities have a huge impact on social cohesion in our societies.

Systematic differences in the health status of our different population groups have a significant social and economic costs both to individuals and societies. Equality Action takes great pride in shining a light on all forms of inequality and challenging the status quo.

In keeping with that ethos, Equality Action is privileged to host its annual public lecture focussing on Health Inequalities.
Our guest speaker this year is Toby Lewis, Senior Fellow, Health Inequalities- The King’s Fund. In his lecture on health inequalities, he asks the question : What are we waiting for and why are we waiting ? Indeed !!

Geetha Bala

Our Guest Speaker

Toby Lewis, Senior Fellow, Health Inequalities – The King's Fund

Toby grew up in Loughborough.

He undertakes research at The King's Fund, focused on health inequalities and poverty. He contributes to their ground-breaking work on integrated care and health system reform, and has a particular interest in how the NHS can contribute to local regeneration and to changing disparities of outcome.

Before joining The King's Fund, Toby worked in the health services for more than 25 years in mental health, primary care and hospital services. He has held director roles since 2005 across University College London Hospital, Mid Yorkshire Hospitals, Bart's Health, and was Chief Executive of Sandwell and West Birmingham Hospitals for eight years. He worked in the Prime Minister's Delivery Unit from 2003, holds degrees from the University of Oxford and the University of London, and is studying for a third in public health medicine with Edinburgh University.

HEALTH INEQUALITIES

What are we waiting for and why are we waiting?

Toby Lewis, Senior Fellow at The King's Fund

Health inequalities

What are we waiting for and why are we waiting?

I was born and went to school in Loughborough fifty years ago. So, it is a particular pleasure to return to talk with you. I am, of course, talking about something all too familiar; health inequalities. Familiar enough to seem inevitable. That familiarity can create a patience with inaction or recurrent failure that is gives rise to the title for my remarks.

And yet health inequalities are avoidable, preventable, treatable. So, we should explore how that could happen and a little of why it seems not to too. Whilst I am not going to tilt every comment towards Charnwood, I am sure that in communities like yours, lies the capability to do something to bend the curve of inequality. And I believe your chair allows time for questions and discussion.

I am going to try and take us through what health inequalities are, why they arise, whether we can fix or tackle them, why we don't do that, and how we might address them.

Health inequalities mean that some will die younger: premature avoidable mortality. But before that you will spend more of your life in poor health: this is healthy life expectancy, the term used to describe the period of your life before that happens to you. That of course then drives down your productivity and wealth, your contribution to our community, at least in certain senses. That cuts you off from aspects of community life, and so a fairly vicious spiral exists, of isolation and exclusion. And crucially these effects are inter-generational.

Health inequalities are avoidable, preventable, treatable.

In other words, they pass through households, through families, with my health being affected by that of my parents and how I grow up. I die sooner, I live less well, I can contribute less, and I pass those impediments on. In sum:

"health inequalities are avoidable, unfair and systemic differences in health"[1]

Let's add some numbers to the pallet of the picture I am trying to paint:

Men living in more deprived areas will die 10.3 years younger than those in better off areas, for women that gap is 8.3 years, but during the period of austerity that gap widened for women quite significantly. Michael Marmot[2] would argue that that gradient continues, it is not a simple a difference between the poorest and rest, but it continues really until very close to the top strata of wealth in the UK.

Maintaining that idea of differentiating the poorest areas from the wealthiest, that Healthy Life Expectancy difference is about 19 years. So roughly a third of someone's life spent in poor health. Ironically, for men, your neighbourhood of Rutland has the best Healthy Life Expectancy in England.

Part of this story then is preventable mortality. In other words, causes of death amenable typically to either treatment or prevention. Here again, we see huge differences by the wealth of where someone lives and works. With cancer, cardiovascular disease, respiratory illness and drug misuse all considered preventable, we see poor to wealth differences that are more four-fold between local authorities.

[1] Williams E, Buck, D, Babalolo G (2020) "What are health inequalities?" The King's Fund
[2] Marmot M, Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010.

As you will appreciate there many more differences and examples to give. But the point to focus on is that the scale of difference is huge.And that the picture of difference is remarkably consistent.

I have spoken of differences expressed by deprivation and by spatial area. I am very aware that these are not the only markers of inequality we see.And I will return to that later in this talk. But I do want to be clear that differences based on gender, orientation, ethnicity, age, and so on, tend to reflect these base differences of socio-economic circumstance and setting. In plain terms, inequality is deprivation plus, rather than any one of a list of antecedents, from which very often poverty is omitted. Part of my argument tonight is that that reality is part of why health systems struggle to grapple with this issue. Part of why health inequalities seem so intractable.

Of course, Covid-19 has given inequality a salience. I worked as a hospital chief executive during the first wave of the pandemic, in inner city Birmingham. And even before we had enough data, it was all too apparent that different communities were bearing the brunt of the virus in different ways. You can now spend an evening googling your way through pieces articulating those differences[3]. The causation is less clear, because we understand something - but not everything - of Covid-19. So initially there was a sense that this was a respiratory disease, and so COPD was likely to be a key co-indication. Then that seemed to not manifest itself, but hypertension, well treated, or less controlled, seemed to predict admission pretty associatively. Progression to intensive care certainly had some association with obesity, and of course we know that initially male death rates were much higher than those for women.

[3] E.g. Covid-19 pandemic: impact on people with disabilities (ONS), Health inequalities: Learning disabilities and COVID-19 (LGA),

Now, for the first time in many years, we see life expectancy differences by ethnicity which show lower life expectancy among the Asian and black British communities[4]. It is often assumed that that was previously the case, but it was not. It is a pattern drawn from 2020 and 2021 ONS data, and as the virus recedes, we will see how things change. Differences in cancer prevalence, lower in some minority ethnic communities, was held to explain the pre Covid state, and of course the pattern of cancer care is among many gravely disrupted by the pandemic's effect on hospital capacity and patient presentation.

As it is clear that the condition impacts those in greatest poverty in far higher numbers, as the ethnicity effect by the second wave seems to map to houses of multiple occupancy in the Pakistani and Bangladeshi origin communities, so we again I would suggest see the pattern I began this talk described to you.

My point though was about the impact of a single shared disease on public perception. It has created an opportunity for discussion. Much is made of the moment. The shared experience of the living through this once in a century event. The Health Foundation of course challenge our thinking on public perception of inequality[5]. On the one hand, IPSOS MORI polling might make us think that this is not high on the list of public concerns when it comes to health. On the other, understanding of difference, variation, and risk is ill developed and so how one frames the question, as ever with survey work, makes a huge difference to the response one gets. Many minimise the variations – so the scale of difference – four-fold or twenty odd years – that I talked about would not be in the imagination of many among us.

[4] Raleigh V, (2021) Ethnic differences in life expectancy in England and Wales: the unexpected? BMJ
[5] The Health Foundation (2022) Building public understanding of health and health inequalities

The health service colludes in that of course by being opaque about outcomes, about variation and about causation. Even among those who do accept the scale of difference, there is a legitimate discussion about the ill-understood role of genetics (we can find fifty markers for obesity for example) and a less legitimate discussion about individual fault and error. Before we turn to discussing lifestyle and drift, let's recognise that however the pandemic brought us here, there is indeed some greater discussion of the ills of inequality than perhaps a decade ago. Now of course the virus can happen to any of us. The same belief in my own susceptibility does not typically get associated with poverty. The covid-19 effect is fear based. That same fear does not have the same reach into every part of the country in terms of scarcity. The cost-of-living crisis, grave though it is, will not hit everyone and not hit everyone with the same valance. The sense of whether it could be me if crucial to this discussion in my view.

How does poverty impact our health? There is as you might expect a range of views about this. Psychologists would tell us that this poverty effect is what is labelled scarcity theory[6]. In essence my choices are made differently if I have very little. My sense of urgency, rush and time are changed. We know too that communities of deprivation do not have a market offering the same choices my parents or I might enjoy. Lending is different. Food shopping more constrained. Even if supply existed, the simple reality of funds if often unrecognised – so classically NHS healthy eating guidance would consume three quarters of the disposable income of someone in the poorest quintile in this country. We know that relative poverty matters very much. So, the trope that contrasts the child in the horn of Africa living through the worst drought in forty years, in contrast to a kid on the Garendon estate has limited relevance.

[6] Shafir E, Mullainathan S (2013) Scarcity: Why Having Too Little Means So Much

The population level explanations follow the gradient of social construction that is local to where you are:

"it is the inequalities of income within these countries that are most strongly related to life expectancy and levels of morbidity, mortality and wellbeing, with average income level having a much weaker relationship to ill-health"[7]

Contrastingly, to live in a mixed neighbourhood, in other words one with wealth and disadvantage, seems to ameliorate some of those effects – perhaps because of the impact on supply, perhaps the neighbourhood is safer (violence and the fear of violence being a major public health issue rarely labelled in those terms), perhaps because of some psycho-social factors around aspiration – status syndrome in the language of these things.

In summary poverty drives health outcomes in perhaps four ways: it creates stress and a loss of control which we know exacerbates ill health, it means a focus on chasing resources, it drives different lifestyle choices, and that lack of safety net alters how we think of ourselves.

And before I move from poverty to a wider landscape, let's just scale what I am describing. Fourteen million people living in relative poverty, including 4.6 million children. Half of those in poverty being in work, and the principal reason that pensioner poverty fell in the last twenty years is deeply definitional. Half of all in poverty are themselves disabled or care for someone who is, so a key intersectionality of exclusion sits there, with all the health implications of being an informal carer or living with a disability. That's my deprivation+ point once again.

[7] Wilkinson RG and Pickett K (2009) The Spirit Level: Why More Equal Societies Almost Always Do Better

Half of all in poverty are themselves disabled or care for someone who is.

Poverty is bad for your health. We should think of it as a disease. Curable, chronic, and significant to the ill health we have and the outcomes we get.

This is not a new story for the NHS. If Nye Bevan were here, he would be articulating the case for a universalist health service precisely in the terms I have described and putting forward the notion that a free at the point of use service is a part of the remedy. And in trying to create to access to care he would have a point. It is difficult to argue that the removal of the worry of the cost of some care (clearly not dentistry) is something that may disinhibit access and let people get treatment sooner.

And yet, here again, with access we see very different patterns of use. We know that the longest waiting lists for surgery seem to be in areas of greatest deprivation, though we don't know why[8]. We know that GP ratios to population are greatest in areas of greatest exclusion[9], I think we do know why – the formula for GP remuneration is fairly inadequate when it weights deprivation. I am not aware of similar analysis for mental health provision, ironically given parity of esteem, but I suspect a fair hypothesis would be that, whilst access generally is very poor, it is likely to be poorest where poverty is greatest.

Levelling up then is but the latest response to the pattern I have outlined. The focus is on that healthy life expectancy that I mentioned at the start. Life to years rather than pointing everything at being alive for longer. That seems morally decent and is probably a good acknowledgement of the economic consequences of exclusion too.

[8] Holmes J, Jeffries D (2021) Tackling the elective backlog – exploring the relationship between deprivation and waiting times

[9] Nussbaum C, Massou E, Fisher R, Morciano M, Harmer R, Ford J (2021) Inequalities in the distribution of the general practice workforce in England: a practice-level longitudinal analysis BJ GP Open 5

Narrowing the gap in healthy life expectancy is the declared 2030 aim – albeit the Health Foundation tells us that on current trajectory it will take 192 years to get to that aim. So we need to speed up! We have been here before.

Four, perhaps five times, since the 1980s we have seen August reports outline the challenge, as I have done. This is the moment in my talk where I move from pessimism to realism and a measure of optimism, so bear with me. I view the past effort as prototypes not failures. But of course, they are only prototypes if we learn from them.

Douglas Black bravely told Margaret Thatcher that the welfare state has helped tackle poor health but had not reduced health inequality as Bevan had hoped. The report went largely unimplemented.

Then in 1998 Donald Acheson picked up the theme and made thirty-nine specific recommendations, which were implemented, about the role of public health. It gave rise to a green and white paper[10], much as we know a white paper is coming soon on health disparities.

Blair then pitched an OECD level of health expenditure, and asked Derek Wanless [11] to provide a context for those changes. His fully engaged scenario for population health talks exactly to the more preventative, self-care orientated health model that we see now championed again twenty years on.

And Michael Marmot, a member of the Acheson commission, produced reports in 2010 and in 2020[12]. They provide a contrast. The first in 2010 recognises that there were green shoots of health inequality improvement towards the end of the noughties.

[10] Green paper: Our Healthier Nation: A Contract for Health (1998) & White paper: Saving Lives: Our Healthier Nation (1999)
[11] Wanless D (2002) - Securing our Future Health: Taking a Long-Term View
[12] Marmot M, (2020) Health Equity in England: The Marmot Review 10 Years On

The relationship between income inequalities and health inequalities got weaker over the period and there was a reduction in amenable mortality in deprived areas, inequalities in life expectancy between deprived and non-deprived local authorities narrowed[13], and there were reductions in inequalities in infant mortality[14].

By 2020, having abandoned the approach being taken to targeting health inequalities in favour of an incentives model, we see the following retrenchment – improvements in life expectancy have stalled, and among women in most deprived communities life expectancy had fallen.

So, what are some lessons we might draw from this? First the obvious, that good intentions and policy direction are woefully insufficient to sustain this effort. Once-a-decade restatements of aim seem a poor return for such a huge subject. A second was laid out by something called the Health Devolution commission just before the pandemic when it said:

> "...a clear view about the central importance of the wider determinants of health. This is not new news to many of us – but the reality is that the knowledge of this has not translated into thinking about how government approaches public service delivery and economic growth... health in all policies is easy to say but takes real political commitment (at all levels) to see it through in a meaningful way."[15]

To put that in less convoluted language – we know what works. We need to focus on implementation.

[13] Barr B, James Higgerson J, Whitehead M (2017) Investigating the impact of the English health inequalities strategy: time trend analysis British Medical Journal 358
[14] Robinson T, Brown H, Norman PD, et al (2019) The impact of New Labour's English health inequalities strategy on geographical inequalities in infant mortality: a time-trend analysis Journal of Epidemiology and Community Health 73
[15] Warren S (2021) Improving the nation's health: striking the right balance between national and local

And I would suggest that that is a subtly important insight. The problem of health inequalities is relatively well understood. Many of the actions needed are too. What is not typically focused on is the science, or maybe its an art, of implementation. Seeing through the change and incrementally, experimentally, improving it.

Colleagues and I published a brief review of this notion a few months ago[16].

We found that the health service struggles with the topic of inequality because it contains characteristics which challenge the way that the NHS organises and sees itself. And we found that health policy struggles too.After all, here is a topic that is a long-term endeavour. There are short term things that you can do, and should do, sorting out primary prevention for heart disease for example, but if you want to address the real issues that are implied, in particular the issues of income and housing, and the stability that flows from that, you need to chart a medium-term course. We are faced with a political cycle of maybe four years, often shorter, and a leadership cycle of three years, which the service considers long term – because that is the limit of leaders' tenure.So, there is an intrinsic problem, which we labelled the endurance problem.

If you involved with or worry about the health service you will know that presently, a few days ago in fact, the Bill[17] passed to change NHS structures yet again.The initiating logic of these changes was to establish partnerships between health and others. Deeper and more purposive partnerships than we have had in past. You will appreciate that the legal basis for health and local government is very different, certainly in England, and that historically relationships have been at times challenging.

[16] Lewis T, Buck D, Wentzel L – Equity and endurance: how can we tackle health inequalities this time?
[17] The King's Fund briefing (2021) 'The health and care bill – six key questions'

Integrated Care Systems, or ICSs in the inevitable acronym, are intended to fuse together local public services. And this is helpful to us, because the second of three key characteristics to tackling health inequalities is that it demands a partnership approach. Of course, I would argue it requires a partnership that is much broader than health and local government, that pivots around community enterprises, and forms a partnership with communities, very much in the mode that Hillary Cottam wrote about in her incredibly important work Radical Help[18].

And then there is the final issue. Tackling inequalities is a conversation about power. Whose interests are privileged, whose voices are heard, how we weight different issues and priorities, and who gets to weigh them. We labelled this disruption, because we wanted to denote both that issue of power and the reality that finding the right path in a given community to change the status quo will feel disruptive to some. You cannot graft health inequalities as an extra onto the side of what is already done, it necessarily reframes what work is done and with who. That preparedness to see the existing approach to health disrupted lies at the heart of the challenge of inequalities. The NHS is deep down a fairly traditional model of healthcare.It is predominantly a sickness model, and it is certainly a disease specific model. It is not designed, nor are its workforce trained, to think on a multi-morbid basis, nor certainly to consider social circumstance as itself a basis for diagnosis. So, health inequalities must surmount this design feature or design fault.

So, there is then this three-part challenge. In our view it is those design challenge which has not been faced in previous efforts to address health inequalities. Searching for the ingredients for the recipe for real change we came up with a list, which happened to have seven parts to it.

[18] Cottam H (2019) Radical Help

At this point you may be simply hoping that the NHS can operate on your sooner than 2024, or that your GP can fit you in the next few days. And that too is part of the issue here because inequalities are not an extra thing when systems are faced with those immediate so-called recovery issues. But I would argue is imperative we tackle inequality, not simply for the obvious moral injury, but notably for the economic waste that inequality represents.

The loss of productivity and contribution was something I spoke about at the start, but it also the case that we spend heavily tackling the effects of inequality in late-stage disease and multiple long-term conditions, which, if we addressed this upstream, we could forego some of. In adults the case is a more complex equation than in children. Our failure to focus on the needs of young child and complex family situations is a lifetime cost, and like many issues in healthcare we avoid it because we don't view the financial consequence across the public sector.

The siloed pound is in many ways more problematic than the siloed service. Avoiding the cost of a criminal justice system or child protection system involvement is a huge economic gain, but one that demands interventions by an NHS still chasing the weight of your baby to put into a red book on a universal basis. The risk is that doing the same for everyone is viewed as fairness, when in truth we need tailored related to need, what Marmot labelled proportionate universalism.

I mentioned there were seven elements to what we proposed. Let me explain what they were and why we chose them.

Part of the challenge of inequalities is our small country-ism that seeks to do most things from London. Following the logic of levelling up that seems ill-judged, but it is a very tricky habit and history to break.

There certainly is a national role. And if we look to countries like those in Scandinavia and the Netherlands that seem to have made a little progress with some underlying outcome issues, and clearly as more equitable societies by background, we can see that they seek to bring a constancy of purpose to their health prevention work. There is then a key step for government to put in place a comprehensive approach to policy around major harms, I am thinking of tobacco still, obesity of course, and misuse of alcohol.

Just to illustrate the changeability of policy in this area think how many obesity plan or strategies England has had since this century began. Yet we know that we have to tackle availability, supply, pricing, access, and provide in the case of many harms credible alternatives whether that is vaping or low alcohol alternatives. So, there is a grand challenge there that government distracts itself from if it seeps into other roles and remits.

That said, it must be right that it is government that creates a finish line, an ambition for the transformation required. Let's take Michael Gove at his word. So, turning that ambition into measures that are both transparent and accountable matters very much. Part of the late Blair/Brown period did see targets around inequalities[19], and it is difficult to see how one can cut through the competing priorities, needs and influences, without a simple regime that makes it clear what de-minimus must be done. You have guessed from this that I am, with some reservations, a fan of setting metrics by which we can be judged.

And that reflects the third, and arguably most important recommendation. Which was that we need to open the data. In other words, to make the variation, the inequity, absolutely obvious to all.

[19] HMG: Tackling health inequalities – a programme for action (2003)

I don't know how many of you have ever searched a website called Fingertips, which is run by the public health agency for the country. It is a great data resource, but one typically viewed by researchers and journalists. Of course, familiarity may dull the senses, but given the scale of what we are discussing, it is far more likely, I would suggest to fan outrage, and drive a righteous impatience for real change: Black Lives Matter or Extinction Rebellion style.

So, one of the great benefits of a nationalised industry ought to be standardisation and rapid spread of knowledge. Yet every data point we have suggests that whilst we have world leading research capability, not always pointed towards health inequalities, our deployment of the best of what we do more widely across the service is poor. And for health inequalities there is a further barrier. We need to share that learning across different traditions, health, local government and the third sector. When I said earlier that we know works, I was loose in not being clear that we remains a few, and that knowledge is not easily shared.

Anyone here from local government background will recognise that just as there are the reports I mentioned, Black through Marmot, there is also a venerable tradition of temporary NHS enthusiasm for health inequalities. Colleagues in public health and local government wonder how long it will last. There is a pressing need for inequalities to become part of how the NHS sees itself. It is lazy frankly, the put wider determinants of health at the door of others. In eight as an NHS Chief Executive, I was not regulated for equity in any way. Just as we were not regulated for outcomes. As that implies, I think that the regulatory regime has to decide that behaviours needed to address health inequalities are the behaviours that need to be assessed. And there is real work to be done to help staff in the NHS who want to open the Pandora’s box that is inequalities, not always sure they have the tools to hand to help.

We need to share that learning across different traditions, health, local government and the third sector.

Hand in hand with that then is shifting the way we spend health money from treatment to prevention, from hospital to district nursing, from adults to children, physical to mental health, and from health to housing, in particular. That is a huge shift and one the NHS has been trying to do all the days I have worked within it. It always finds a reason not to. The prize is too diffuse, the consequence too contested as everyone wants their hospital to hand. You make those hospital fairer and pretend that that tackles health inequalities.But the hard truth is that the disparity of who is not referred is far graver that the slight difference in waiting times.

Now an NHS audience would hear this and think I am saying, let's set up NHS services upstream.Which is why the anchor point, the crucial point perhaps, is about community capability. Everywhere that I have ever worked, communities are filled with small and tiny organisations able to fit into niches and needs that are hard to see from a statutory body. The NHS has the money, frankly a lot of it. It is the public service bank in all but name. And so it needs to find a role supporting and endorsing that community capability, because in that action at a local level, comes the sustainability and endurance to lift people up and away from the prevailing causes of inequality that we face.

Can those seven things happen?

We would say only if we commit to the endurance, the partnership and the disruption that I outlined. Why do they need to happen? Well let me end this talk where I began. These are preventable years of ill health which rob people of their wealth and contribution, and cede into their children the exclusion that we then expensively try and address.

Looking across the life course of individuals, households and communities, we can create safer and fairer models of care with better chance of a decent outcome. There is something familiar but nothing evitable about health inequalities.

As John Rawls[1] asked us, what system would we wish to see, if we did not know whether we could be at the top or the bottom of it. I would suggest to you a health system far more interested in the outcomes for whole communities. A system accountable for those local outcomes. One interested in the social fabric of those they care for. One able to see the inequalities up close.

That demands participation, involvement, and a willingness to hear the hurt, anger and exclusion people feel. And to help curate a different relationship with my own health and that of my neighbour. Perhaps the most powerful legacy of a pandemic is to reassert the idea that my health is in part a construct of the health of those around me.

That is certainly a starting point to taking health inequalities as seriously as we must.

[20] John Rawls (1971) A Theory of Justice

Equality Action

About us

Equality Action has been supporting the local communities across Charnwood for over 50 years! It started as Charnwood Community Relations Council, more familiarly known as 'The Garden – where good things grow'.

Our Mission is to:

"Promoting equality and diversity, dignity and respect through inclusion"

We aim to

- **Increase community cohesion**
- **Improve education and skills outcomes for people.**
- **Improve people's health and well-being.**
- **Ensure people have access to rights and entitlements.**

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Our Work and Projects

Advice Work

We help everyone through whatever they are facing and when we cannot support them directly we refer them to relevant partner agencies. We see clients on a wide range of topics from benefits and Immigration to mental and physical health and employment issues.

Positive Minds

Positive Minds is a 5-year project funded by the National Lottery Community Fund. The project's aims are to address issues on mental and physical health, raise awareness and build the capacity of women from Black, Asian and Ethnic Minority communities.
We run weekly groups including:

Vita Minds

We have started an exciting new 5-year project VitaMinds from April 2021. We are community partners for The Vita
Health Group in Improving Access to Psychological Therapies (IAPT) Service across Leicester, Leicestershire and Rutland (LLR) for people, particularly from BAME backgrounds.

VitaMinds aims to: -

Raise awareness of the IAPT services and refer people to the free service provided by Vita Health Group on behalf of the NHS

Build trust and confidence to reduce stigma and reluctance to engage with mental health services

Increase the number of people from BAME communities being treated using evidence based approaches to deal with anxiety and depression

Run a range of community support and engagement sessions throughout LLR to support physical and mental health.

To our supporters, funders and members for your support throughout this incredibly tough year.

Charnwood Borough Council
Leicestershire County Council
The Access to Justice Foundation
The National Lottery Community Fund
The Rank Foundation
Vita Health Group
Lloyds Foundation
Leicestershire Community Foundation

And everyone who has donated time, money, tech or goods to our work throughout the year. We are so very grateful.

We are open
Monday - Friday
9.30 - 5pm

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