Public Health Dorset

An overview of health inequalities in BCP

CONTENTS:

1. Executive summary

- Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups.
- In the BCP area people are generally healthier and live for longer than England overall; 0.9 years longer for men, and 0.6 years longer for women. However, there is a social gradient to people's health in BCP, and the length of time people live is closely related to the extent of disadvantage and deprivation they experience. Males living in the least deprived areas live on average 8.6 years longer and females 6 years longer, than those living in the most deprived areas.
- There are also significant health differences between different ethnic minorities, between people with and without different forms of disability and between other discriminated against groups and the majority.
- Covid-19 has caused a decrease in life expectancy overall in 2020 but has also exacerbated these longstanding inequalities.
- People's life chances and their prospects of living a long and healthy life are established in their very early years and accumulate throughout life. The link between disadvantage and poor health outcomes can only be broken by influencing for the better the conditions in which people are born, grow, live, work and age. It is important to understand factors that influence health are wide ranging and cover income, employment, education, housing and the natural and built environment, often referred to as the 'social determinants of health'.
- The Marmot Review reflects this and states that addressing health inequalities will require action on 6 policy objectives:
    1. Give every child the best start in life
    2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives
    3. Create fair employment and good work for all
    4. Ensure healthy standard of living for all
    5. Create and develop healthy and sustainable places and communities
    6. Strengthen the role and impact of ill-health prevention

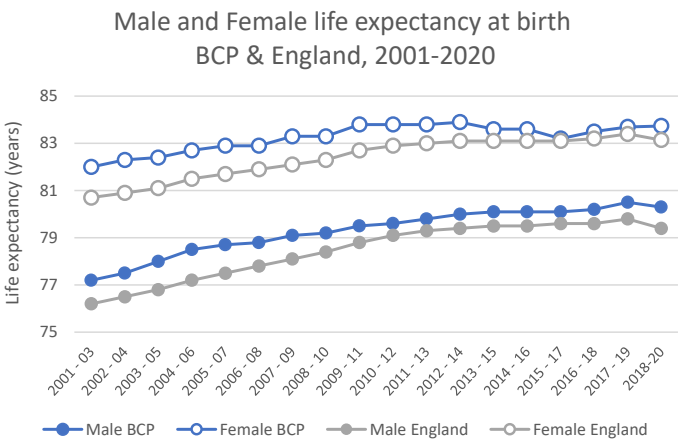
  These objectives are also reflected in the government's latest flagship 'Levelling up' policy which aims to improve living standards, reduce inequalities, and increase opportunities where there are geographical disparities.
- Addressing health inequalities will therefore require commitment at a strategic level and action across all sectors and a wide range of public policy areas.
- Local authorities will have a key role to play through their work on early years, health visiting, employment and the local economy, healthy workplaces, leisure and environmental services, housing, and services for older and disabled people. However, no single agency can implement these objectives alone, and collaboration and partnership working are essential components to addressing health inequalities.
- Action must be based on evidence of need, and an understanding of the extent and nature of health inequalities in BCP's population. This report aims to develop a shared understanding of where health inequalities exist between communities and population groups within the BCP area, and how the wider determinants impact on health.

2. Inequalities in overall health status

2.1 Life expectancy

Life expectancy at birth in BCP remains higher than for England, but this gap has been narrowing over time. Improvements in life expectancy have slowed since 2011, and in 2020 there has been a drop in life expectancy due to Covid, especially for males.

- Life expectancy at birth for men is 80.3 years, and for women 83.7 years in BCP for 2018-20[1].
- BCP has higher life expectancy at birth than the England average, 0.9 years higher for men, and 0.6 years higher for women for 2018-20[4].
- This gap has been narrowing over time. While life expectancy has been increasing, the rate of improvement has been slower in BCP than for England, especially for females.

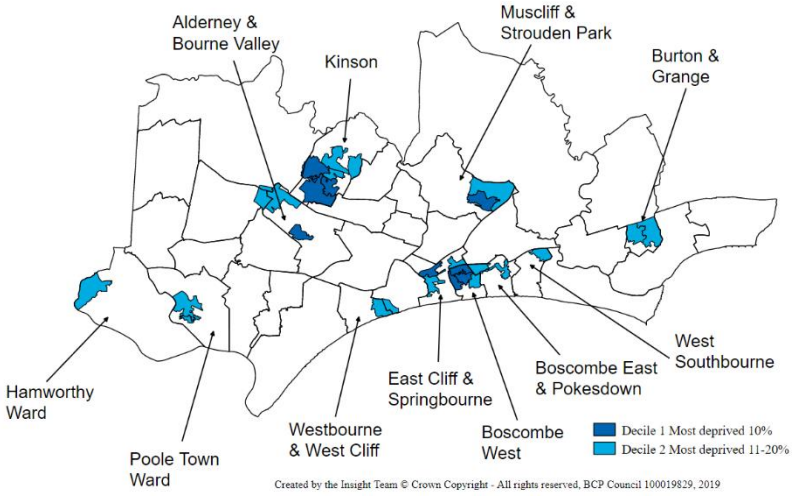


2.2 The significance of deprivation

Levels of deprivation play a significant role in health inequalities. Deprivation is a measure that assesses areas based on how they fare on multiple fields, including income, employment, quality of environment, health, education, and housing.

- BCP is an area of significant disparity with neighbouring areas among the most and least deprived within England.
- According to the Indices of Multiple Deprivation (IMD 2019) [2] 45,400 people (12% of the population) in BCP live in areas that are among the most deprived 20% nationally, including 8,900 0-16 year olds and 6,200 over 65s. 9 of 233 areas (LSOAs[3]) in BCP fall within the most deprived 10% nationally, 17 LSOAs are in the 11-20% most deprived areas.
- 56 LSOAs in BCP fall within the least deprived 20% nationally. 82,800 people (21% of the population) live in these areas, including 12,700 0–16 year olds and 26,000 over 65s.

LSOAs in BCP within the most deprived 20% of areas nationally, IMD 2019 (including ward boundaries)



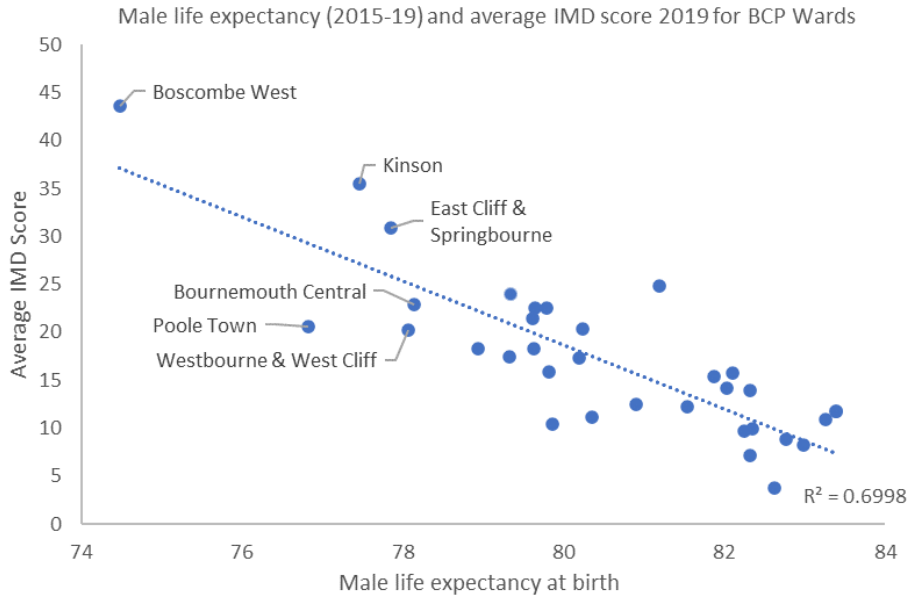
[1] PHE Health Inequalities Dashboard

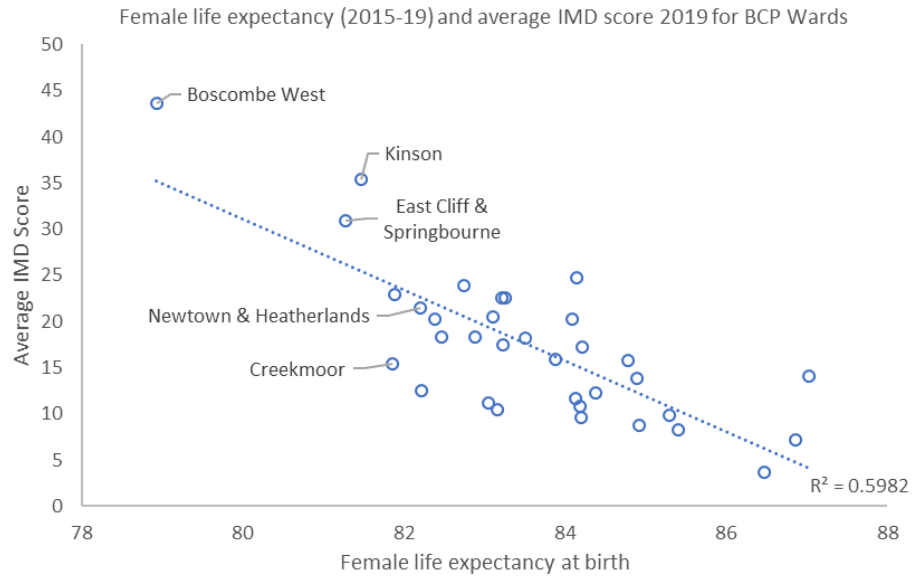
[2] Further detail on the Index of Multiple Derivation 2019 in BCP can be found here

[3] Lower Super Output Areas (LSOAs) are small areas or neighbourhoods with an average of around 1,500 residents each. There are 32,844 LSOAs in England, of which 233 are in the BCP area.

There is a social gradient to people's health, and the length of time people live is closely related to the extent of disadvantage and deprivation they experience[4].

- When life expectancy is mapped against the average IMD scores for each ward in BCP, the correlation between deprivation and male and female life expectancy is strong. Life expectancy is lower in the more deprived areas (with a higher IMD score). There is a clear social gradient in life expectancy for men and women in BCP, as there is across England.
- Boscombe West, Kinson, East Cliff & Springbourne, Bournemouth Central, Poole Town and Westbourne & Westcliffe Wards have significantly lower life expectancy for males than BCP overall and high levels of deprivation. Poole Town has especially low life expectancy for males given its relative IMD score.
- Boscombe West, Kinson, East Cliff & Springbourne,, Newtown & Heatherland, and Creekmoor have significantly lower life expectancy for females than BCP overall. Creekmoor has especially low life expectancy for females given its relative IMD score.
- Action is needed to tackle the social gradient in health, but this must be universal at a scale that is proportionate to the need. Focusing only on the most disadvantaged will not reduce the social gradient and will only tackle a small part of the problem. Marmot called this approach 'proportionate universalism'[7].





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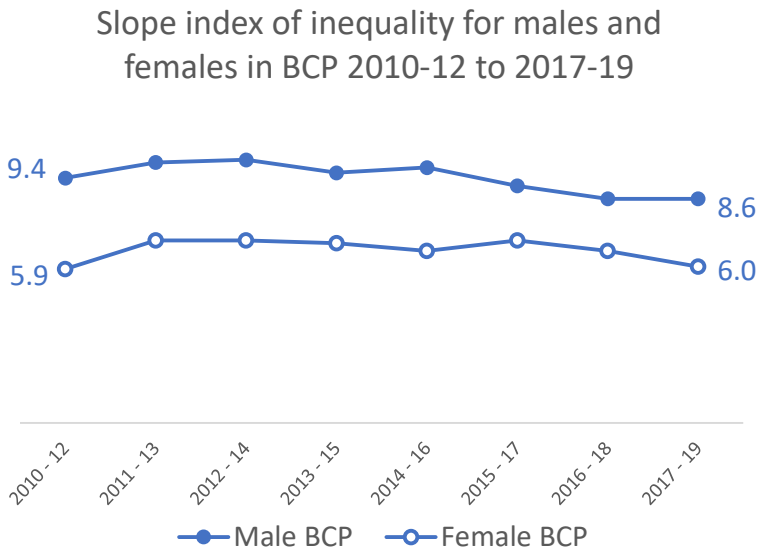
[4] Michael Marmot et al (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.
[5] PHE Local Health

There is a sizable gap in life expectancy between the most and least deprived parts BCP. This gap is larger for males than for females.

- The range in years of life expectancy between the most and least deprived quintiles in BCP (according to the Slope Index of Inequality[6]) was 8.6 years for males and 6 years for females in 2017-19[7].
- This gap in life expectancy has improved over time for males but remained similar for females.
- Covid-19 is likely to reverse this trend in the short-term at least, as men experienced greater losses in life expectancy, and higher death rates than women at all ages over the pandemic, particularly in more deprived areas.

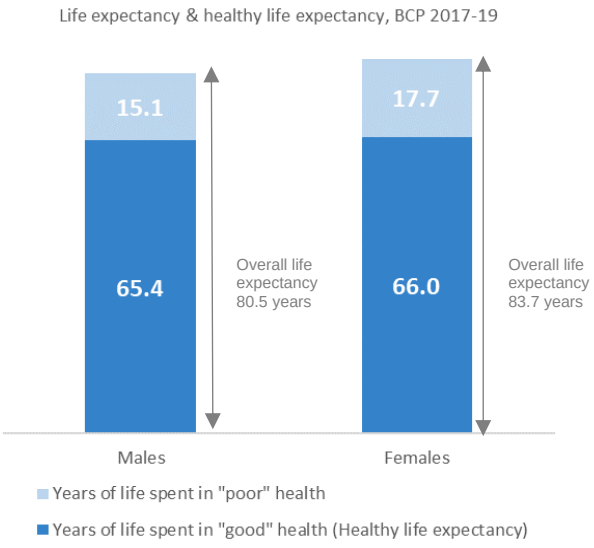


2.3 Healthy life expectancy

Healthy life expectancy at birth is a measure of the length of time spent in good health. The difference between overall life expectancy and healthy life expectancy gives an indication of years lived in poor health. People living in deprived areas spend fewer years in good health and a larger proportion of life in poor health.

- Healthy life expectancy in BCP was similar for men (65.4 years) and women (66.0 years) in 2017-19. Higher than England for males 63.2 and similar for females 65.5[10].

  Women in BCP spend more years in poor health than men, around 18 years compared to 15 years for men, as although women have higher overall life expectancy, both live similar years in good health.



- Years spent in poor health is increasing for both men and women as improvements in life expectancy have not been matched by improvements in healthy life expectancy. As a result, the population is growing older, and a higher proportion are living with L-T conditions and disability.
- Inequalities in healthy life expectancy are larger than in overall life expectancy. The difference in healthy life expectancy between the most and least deprived areas in England (as measured by the SII) was 19 years for both females and males. People in deprived areas have shorter life expectancy, spend fewer years in good health, and spend a larger proportion of life in poor health: 35% for females and 29% for males, compared with 18% and 15% in the least deprived decile[10,8].

[6] The Slope Index of Inequality (SII) is a measure of the difference in life expectancy between the most and least deprived sections of the local population. The measure assumes a linear relationship between the indicator and deprivation. A higher SII = greater inequality within an area.
[7] PHE Health Inequalities Dashboard
[8] Data only available at national level.

3. A life-course approach

Disadvantage starts before birth and accumulates throughout life, and the life course perspective provides a framework to consider how exposure to social determinants and risks can accumulate over time. It recognises there are stages of the life course where exposure to risks may be especially detrimental or beneficial for health and development, and that the relative importance of the wider social determinants can shift with age.

The importance of the early years is undeniable and actions to tackle inequalities must start before conception and continue throughout childhood. This way the links between early disadvantage and poor outcomes throughout life can be broken. Action is also needed to improve the lives and health of people who have already reached adolescence, working and older age[9].

Public Health Dorset has been developing a common understanding of health inequalities across partners through workshops to inform system-wide approaches to addressing health inequalities. The 'Health Inequalities Story Map' developed as part of this process can be accessed here. It highlights a life course ladder of drivers of health inequalities and shows how they impact health at different life stages, as well as 'whole life' wider determinants such as housing and environment.

Subsequent sections of this report examine the leading causes of death and poor health, and inequalities in health and the underlying social determinants through the life course: from infant and child, through working age to older age.

3.1 Leading causes of death and disability across the life-course

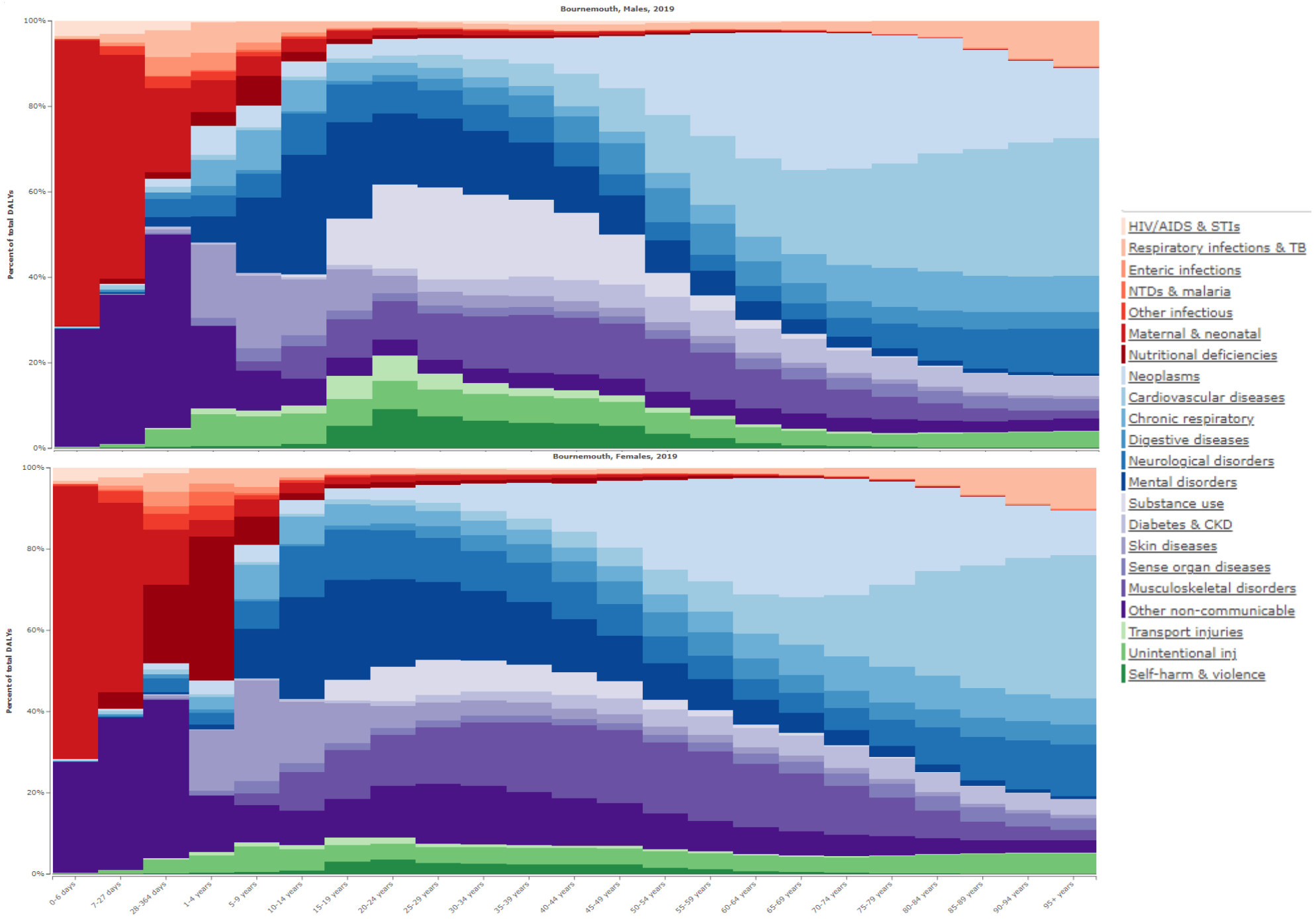
Across all ages, the leading causes of death and disability in Bournemouth and Poole in 2019 were cancer and cardio-vascular disease, followed by musculoskeletal disorders, mental disorders, and neurological disorders[10].

- The leading causes of death and disability change over the life-course. Appendix A gives the top 10 causes of death and disability by age group for BCP.
- For children and younger working age adults' (aged 15-49) mental disorders are the leading cause. And substance use and unintentional injuries are more prominent, especially for males. Through working age musculoskeletal disorders are the second most common cause of death and disability for those aged 15-49, and rank third for the 50-64 age group.
- From age 50 onwards cancer and cardio-vascular diseases grow more dominant. From age 50-69 cancer is the leading cause, and from age 70 onwards cardio-vascular disease takes over as the leading cause of death and disability.

[9] Michael Marmot et al (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.

[10] Global Burden of Disease Study 2019 Leading causes of death and disease are ranked according to the number of DALYs (Disability Adjusted Life Years). More info on DALYs can be found here

Causes of death and disability combined (measured using % of total DALYs) by age groups for males and females, Global Burden of Disease Study 2019



4. Infant and child health inequalities

'Giving every child the best start in life' is viewed as the foundation for the future health and wellbeing of England's population.[11,12] Yet inequalities are pervasive across a wide range of child health and development indicators.

Children living in poverty are more likely to: die in the first year of life; be bottle fed; breathe second-hand smoke; become overweight; suffer from chronic diseases; and die in an accident[13]. Poor health associated with poverty in childhood reduces their potential and development across a range of areas which has a knock-on effect to poor health and life chances in adulthood.

4.1 Infant mortality

Infant mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. It is a key marker of maternal and infant health and the clearest indicator of health inequalities at birth.

- Between 2017-19 43 babies did not live to see their first birthday in BCP. The infant mortality rate (IMR) in BCP (3.8 per 1,000 live births) was similar to England 3.9, but among the higher levels for the South West 3.2.[14]

Infant Mortality Rate 2017-19, BCP compared to England & South West[17]

Area	Value	Lower CI	Upper CI
England	3.9	3.9	4.0
South West region	3.2	2.9	3.5
Plymouth	4.2	2.9	5.9
Bournemouth, Christchurch and Poole	3.8	2.7	5.1
Cornwall	3.7*	2.8	4.8
Swindon	3.3	2.2	4.9
Devon	3.3	2.5	4.2
Somerset	3.2	2.4	4.2
South Gloucestershire	3.2	2.1	4.5
Gloucestershire	3.1	2.4	4.0
Wiltshire	3.1	2.2	4.1
Bristol	3.0	2.2	3.9
Torbay	2.9	1.5	5.2
North Somerset	2.8	1.6	4.4
Dorset	2.4	1.5	3.7
Bath and North East Somerset	2.0	0.9	3.6
Isles of Scilly	*	-	-

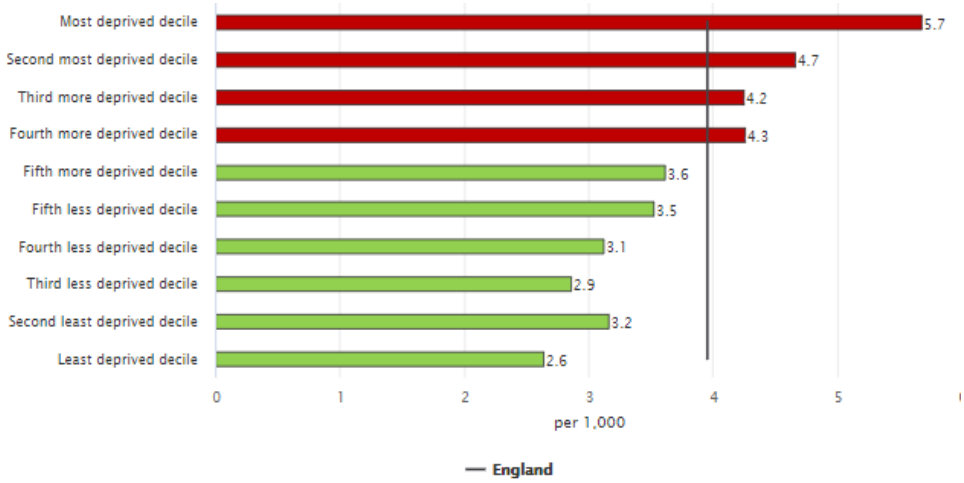
- The IMR fell in BCP to 2.4 per 1000 in 2014-16, but rates have stalled since. Due to the small number of deaths, however, rates can be prone to fluctuations making year on year comparisons difficult[17].
- Most deaths during childhood occur during the first year of life, particularly the first month of life (the neonatal period). Neonatal mortality accounts for around three quarters of infant mortality in BCP.

[11] Michael Marmot et al (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.
[12] PHE Health Profile for England 2021
[13] Wickham S, Anwar E, Barr B, et al. Arch Dis Child 2016;101: 759–766.
[14] PHE Fingertips – Child & Maternal Health Profiles

Social inequalities have a marked impact on infant mortality and its underlying risks.

- The risk of infant death increases with greater levels of maternal deprivation, reflecting the social gradient that exists across underlying risk factors, such as preterm delivery, low birth weight, maternal health during pregnancy and uptake of recommended practices such as breastfeeding and safe infant sleeping positions.

Infant Mortality Rate 2017-19 by IMD 2019 decile, England[20]



Other maternal characteristics shown to increase risk of infant mortality include mothers age, ethnicity, and occupation.

- The IMR for teenage mothers is 35% higher than the overall rate in England. In BCP, 73 young women aged under 18 years conceived in 2018, which is a rate of 13.1 per 1,000 population: 15% of these were to girls aged under 16 years. The national rate of under 18 conceptions was 16.7.[15]
- The IMR for Black African (6.4), Black Caribbean (6.5), and Bangladeshi (6.1) minority ethnic groups are significantly higher than the England average[19]. In BCP 7.5% of deliveries were to women from BME groups in 2019/20.
- The IMR for mothers in routine & manual occupations is 27% higher than the overall rate for England[16].

4.2 Maternal lifestyle risks and behaviours

Modifiable risk factors in pregnancy can have health impacts on both mother and child. Smoking, alcohol and substance misuse, poor nutrition, and obesity, both before and during pregnancy, are all associated with adverse child health outcomes, and are more common in deprived areas. Breastfeeding is a protective factor for infant survival, particularly for infants born preterm.

- While rates of obesity and smoking in pregnancy and smoking at delivery in BCP are similar or better than for England overall, significant social inequalities exist. National data suggest women living within the three most deprived deciles experience significantly higher rates[17].
- The rate of alcohol related admissions for females aged <40 in BCP is significantly worse than the national average, and the highest in the South West. Rates have been rising since 2015/16. Social inequalities are also evident with IMD deciles 1, 2 & 4 having significantly worse rates nationally[20].

[15] ONS Conceptions in England and Wales: 2019
[16] ONS Child and infant mortality in England and Wales: 2019
[17] PHE Fingertips – Child & Maternal Health Profiles

Maternal lifestyle risks and behaviour PIs and inequalities, BCP 2018-19[21]

	BCP	England	South West	Inequalities maternal deprivation	Inequalties ethnicity	Inequalities age of mother
Folic acid supplements before pregnancy (2018/19)	34.7%	27.3%	32.0%	IMD deciles 1-4 sig worse	Mixed, Asian & Black sig worse	Age <40 sig worse
Obesity in early pregnancy (2018/19)	19.6%	22.1%	21.0%	IMD deciles 1-3 sig worse	White & Black sig worse	-
Smoking in early pregnancy (208/19)	12.4%	12.8%	13.3%	IMD deciles 1-3 sig worse	White sig worse	-
Smoking status at time of delivery (2018/19)	10.5%	10.4%	11.0%	NA	NA	NA
Alcohol-related admissions for females <40 rate per 100,000 (2018/19)	435.4	261.7	323.4	IMD deciles 1, 2, 4 sig worse		
Babies first feed breastmilk (2018/19)	79.7%	67.4%	75.3%	IMD deciles 1-3 sig worse	White sig worse	Age <30 sig worse

Compared with England	Better	Similar	Worse

Admission episodes for alcohol related conditions (Females <40) 2018/19, BCP compared to England & South West[21]

Area	Value	Lower CI	Upper CI
England	262	259	264
South West region	323	313	334
Bournemouth, Christchurch and Poole	435	393	481
Swindon	426	371	486
North Somerset	416	357	483
Somerset	400	363	439
South Gloucestershire	373	328	422
Cornwall	365*	330	402
Torbay	342	274	422
Bristol	331	301	364
Wiltshire	306	272	343
Dorset	265	227	308
Gloucestershire	260	234	289
Devon	258	233	284
Plymouth	244	207	286
Bath and North East Somerset	239	196	289

4.3 Access to antenatal care

Late booking and poor attendance at antenatal care are associated with poor outcomes for mothers and babies. NICE recommends antenatal booking by 10 weeks of pregnancy, but significant inequalities exist in timely access to care.

- The proportion of women who access antenatal care within 10 weeks of pregnancy in BCP is significantly below the national and South West average: 55.4% compared to 57.8% for England and 63.5% for the South West[18].

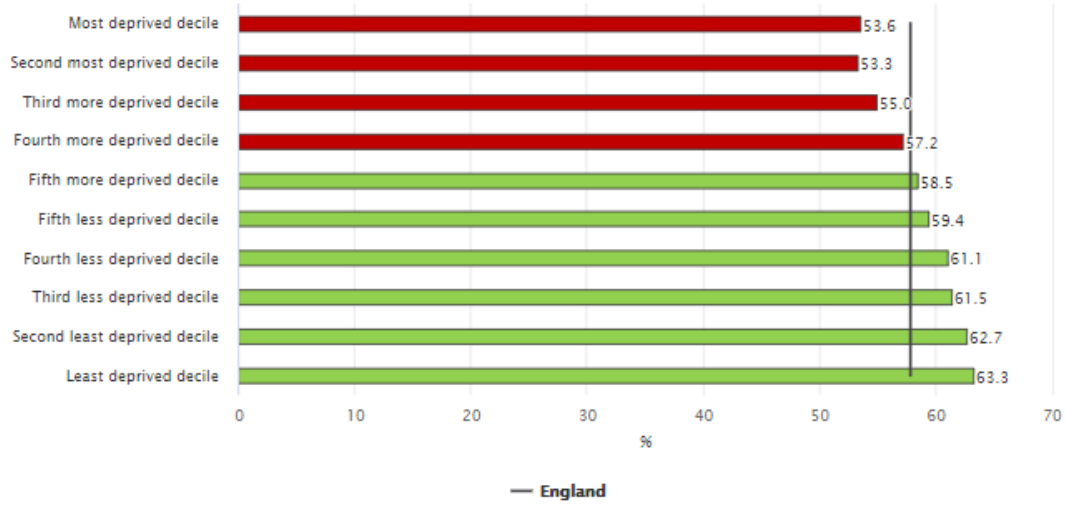
[18] PHE Fingertips – Child & Maternal Health Profiles

Early access to maternity services 2018-19, BCP compared to England & South West[21]

Area	Value	Lower CI	Upper CI
England	57.8	57.7	57.9
South West region	63.5	63.1	63.9
Wiltshire	75.0	73.7	76.1
South Gloucestershire	72.1	70.6	73.6
Cornwall	71.6*	70.4	72.8
Plymouth	68.5	66.8	70.1
Bath and North East Somerset	67.5	65.4	69.8
Swindon	65.5	63.7	67.2
Somerset	64.5	63.2	65.7
Devon	62.1	61.0	63.2
Gloucestershire	61.3	60.1	62.6
Torbay	60.9	58.1	63.6
North Somerset	60.8	58.9	62.9
Bournemouth, Christchurch and Poole	55.4	53.9	57.0
Dorset	54.2	52.4	56.0
Bristol	52.0	50.8	53.2
Isles of Scilly	*	-	-

- Risk factors for late initiation of antenatal care include mothers living in the more deprived areas, ethnic minority groups (Mixed, Asian and Black ethnic groups in particular), high parity, age of mother especially <20, and living in temporary accommodation[19].

Early access to maternity services 2018-19, by IMD deprivation decile, England[21]



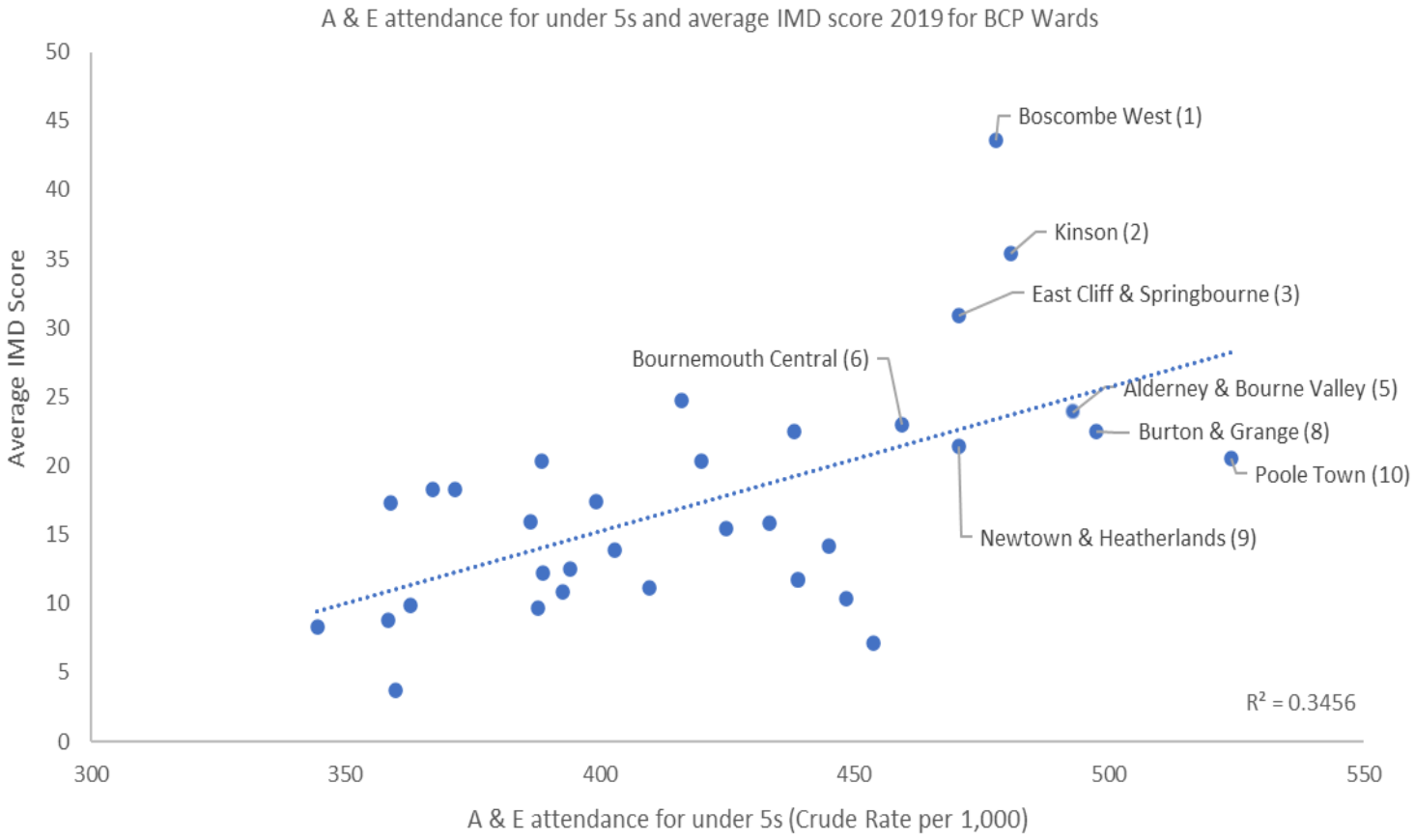
4.4 A&E attendance and hospital admissions for injuries for under 5s

Unintentional injury is among the top 5 causes of death in the under 5s, and a source of long-term health issues. A&E attendance in children aged under five is often preventable, and commonly caused by accidental injury or minor illnesses which could have been treated in primary care. Children from the most deprived areas are consistently more likely both to go to A&E and to need emergency hospital treatment.

- The rate of A&E attendance for children under 5 in BCP (434.3 per 1000 in 2018-19) is significantly lower than for England (655.3 per 1,000) and the South West (522.1 per 1,000)[21].

[19] PHE Reducing infant mortality in London: An evidence based resource

- BCP wards with significantly higher rates of A&E attendance than for BCP overall are highlighted below, with their IMD 2019 Rank in (). Wards with higher levels of deprivation also have significantly higher rates of A&E attendance than the BCP average[20].



4.5 Managing long term conditions and complex health needs

Just over 2,000 children aged 0-14 in BCP (3.5%) had a long-term health problem or disability that limited their daily activities[21]. Children living in more deprived areas are more likely to suffer from chronic diseases such as asthma, epilepsy and diabetes. Also, children's ability to manage long-term conditions varies considerably depending on their home environment[22].

- Hospital admissions for children and young people for asthma, epilepsy and mental health conditions in BCP are significantly worse than for England as a whole, and for asthma and epilepsy are among the highest rates in the South West[23].
- Asthma is currently one of the most prevalent chronic childhood diseases. It is more prevalent within more deprived areas, and children living in these areas are more likely to go to hospital for their asthma. This largely reflects the social gradient in the underlying risks such as air pollution, along with poor quality housing (through mould exposure), second-hand smoke, poor diet and obesity.

[20] PHE Local Health
[21] 2011 Census
[22] Children's Commissioner's Briefing: Health Inequalities in Childhood
[23] PHE Fingertips – Child & Maternal Health Profiles

Indicators on admissions for long term conditions and complex health needs 2019-20, BCP compared to England and the South West[26]

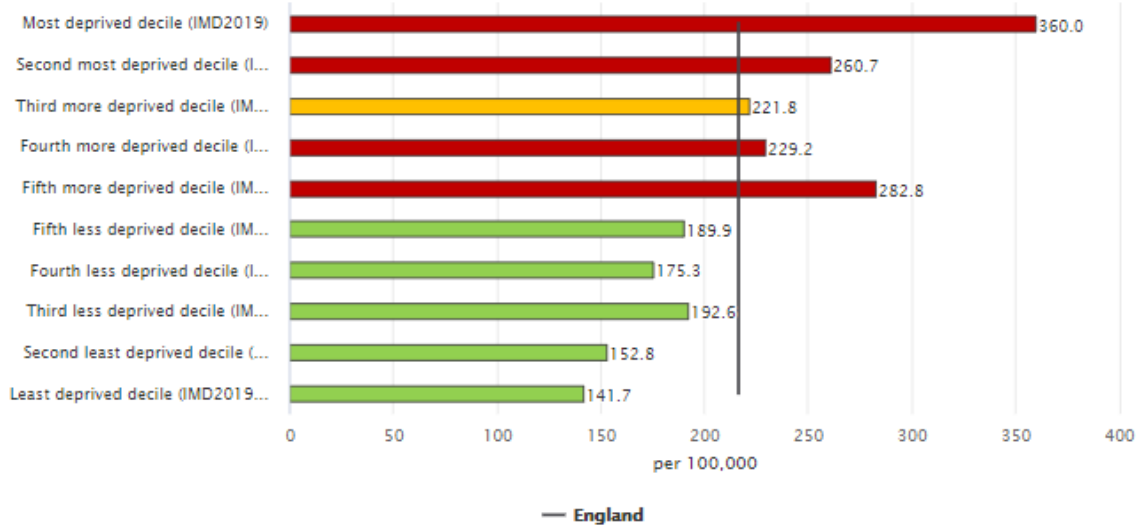
Compared with England: Better 95% | Similar | Worse 95% | Not applicable | a note is attached to the value, hover over to see more details

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

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Bournem., Christch. and Poole		Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Hospital admissions for asthma (under 19 years)	2019/20	→	155	194.4	138.8	160.7	405.2		68
Admissions for asthma for children aged 0 to 9	2019/20	→	100	233	172	192	521		
Admissions for asthma for young people aged 10 to 18	2019/20	→	55	149.2	102.7	123.4	367.2		53
Admissions for diabetes for children and young people aged under 19 years	2019/20	→	35	43.9	58.7	51.9	148.9		19
Admissions for diabetes for children aged 0 to 9	2019/20	–	15	35.0	30.0	27.6	69.4		0
Admissions for diabetes for young people aged 10 to 18	2019/20	→	20	54.3	91.8	80.6	282.4		30
Admissions for epilepsy for children and young people aged under 19 years	2019/20	↑	125	156.8	89.9	78.2	175.7		25
Admissions for epilepsy for children aged 0 to 9	2019/20	→	90	209.9	112.5	94.6	261.2		29
Admissions for epilepsy for young people aged 10 to 18	2019/20	↑	35	95.0	64.6	58.8	161.6		0
Percentage with a long-term illness, disability or medical condition diagnosed by a doctor at age 15	2014/15	–	-	-	14.5%	14.1%	18.6%		9.2
Hospital admissions for mental health conditions (<18 yrs)	2019/20	→	90	119.1	114.7	89.5	249.7		26

Hospital admissions for asthma in - under 19 years (Crude rate per 100,000) 2018-19, by IMD deprivation decile, England[26]



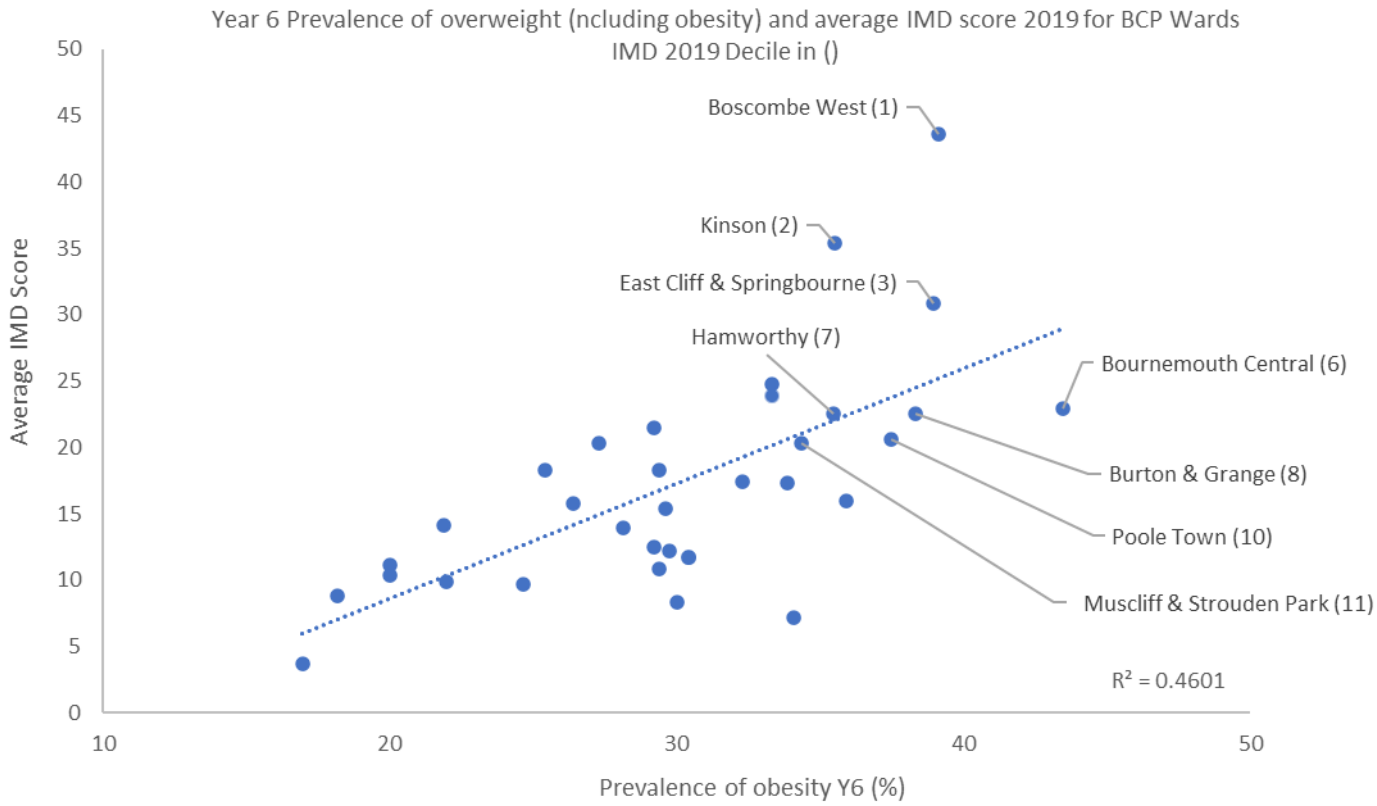
4.6 Obesity

Having excess weight or being obese has significant implications for both physical and mental health. As well as increasing risk of disease, obesity in childhood is linked to poor mental health and sleep. Children who are obese are more likely to be obese in adulthood, with the associated risk of disease and premature mortality.

- Although local rates for BCP are better than rates nationally, the figures are still of great concern. 20.2% of children in Reception and 30.7% of children in Year 6 were overweight in BCP (2017/18 to 2019/20)[24].

[24] Public Health Dorset JSNA

- Significant inequalities exist in childhood obesity. In both age categories, children in the most deprived areas were more than twice as likely as children in the least deprived areas to be obese. There are also inequalities by ethnic group[25]. Ward level data for BCP show areas with significantly higher rates in Year 6 (shown below) are also areas with higher levels of deprivation[26].



- The causes of obesity are complex, from individual's unhealthy lifestyle and eating choices through to wider issues such as the local environment and food availability.

4.7 Mental health and wellbeing in children

Mental disorders are the leading cause of death and disability among children and young people[27]. Variations in a broad range of social, economic, and environmental determinants contribute to inequalities in the distribution of mental health problems among young people. Existing inequalities have widened due to Covid, as increases in mental health problems have not affected all groups equally[28].

- Nationally, the incidence of probable mental health problems increased in 5-16 year olds from 10.8% in 2017 to 16.0% in July 2020. As a guide this proportion equates to potentially 8,300 5-16 year olds with a 'probable mental health problem' in BCP in 2020[31].
- National data suggests some groups of children and young people are more vulnerable to mental health problems including those from poor and disadvantaged backgrounds and refugee and asylum-seeking families, young carers, disabled, LGBT and looked-after children[29].

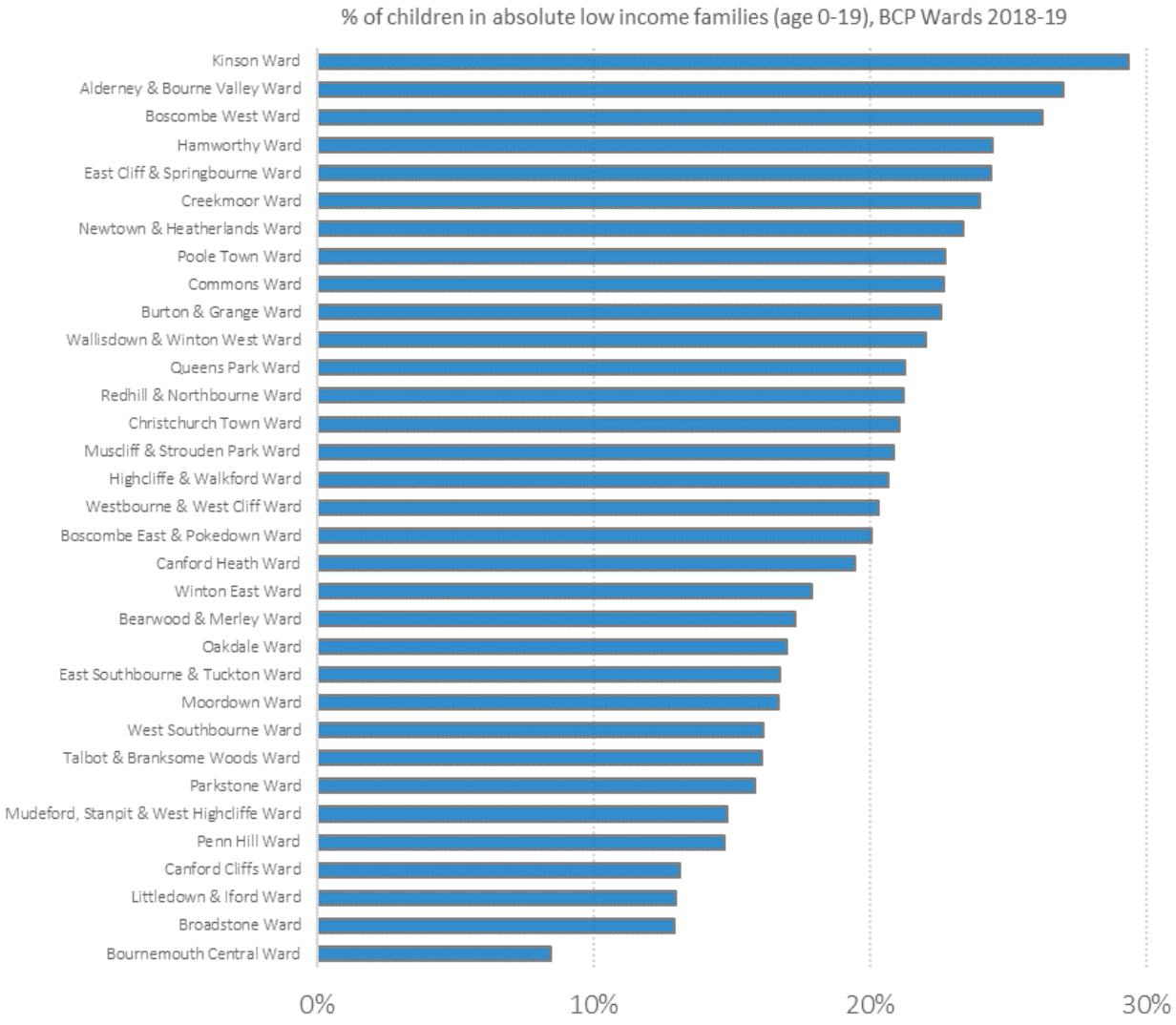
[25] PHE Health Profile for England 2021
[26] PHE Local Health
[27] Global Burden of Disease Study 2019
[28] COVID-19 impact on children and young people in BCP
[29] The Kings Fund (2017) Reducing inequalities in children and young people's mental health.

- Research conducted locally by the BCP Youth Parliament identified factors such as increased exam stress, catching up with work and returning to school as factors that have impacted negatively on young people's mental health since the Covid-19 pandemic[30].
- In BCP the rate of hospital admissions (per 100,000) related to mental health among those aged <18 is 119, significantly higher than the rate for England (89.5). Compared with England, BCP also has a significantly higher rate of young people admitted to hospital for substance misuse and for self-harm[31].

4.8 Child poverty and other wider determinants

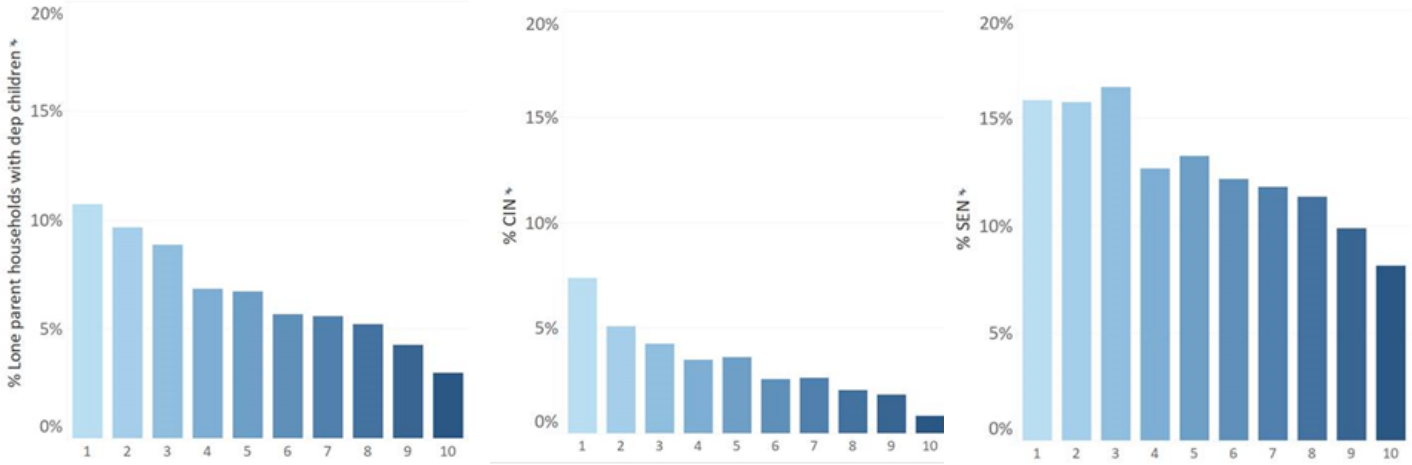
The main driver of child health inequalities is child poverty and the resulting unequal distribution of resources and opportunities to enjoy nurturing environments. Children living in poverty are also more likely to experience other associated risks that exacerbate their vulnerability to poorer health outcomes.

- Latest figures suggest around 8,800 children are living in absolute poverty in BCP. This is 20% of those aged 0-19. Child poverty is highly polarised, with rates at ward level ranging from 8% in Bournemouth Central to 29% in Kinson[32].



[30] COVID-19 impact on children and young people in BCP
[31] PHE Fingertips – Child & Maternal Health Profiles
[32] DWP 2020 Children in low-income families

- Child poverty in BCP is exacerbated by its relatively low wage economy, where median household income is lower than the national average. BCP also has less affordable housing, as median house prices have increased at a faster rate than the median wage. Housing costs are currently 25% higher than the national average.
- Covid-19 has meant, meeting basic needs has become even more challenging for some families and young people, with growing financial stress & poverty, housing issues brewing with increasing arrears, and rising food insecurity.
- In BCP the increasing financial hardship is reflected by the 52% rise in families with dependent children on Universal credit to almost 11 thousand households, between Feb - Nov 2020, the 23% increase in children eligible for free school meals, and food bank use in BCP has also more than doubled[33].
- Other risks associated with living in poverty can further exacerbate children's vulnerability, such as having a disability or SEN, being a young carer, in social care (CIN, LAC, or CPP), or being part of a lone-parent or large family. For example, 11% of households in the most deprived decile of areas in BCP were lone parent households, compared to 3% in the least deprived decile[34]. A combination of factors including lack of flexible working options, low wages, and high childcare costs can affect single parents' ability to work.
- The charts below show the degree of inequality, by IMD 2019 decile (where 1=most deprived), for children living in BCP across a range of vulnerabilities[35].



4.9 Early years and educational outcomes

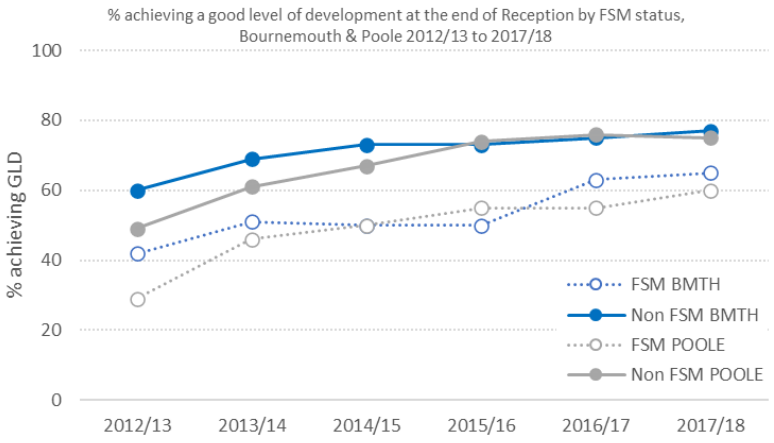
Inequalities in educational outcomes have significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health[36]. Factors associated with educational inequality and attainment gaps include economic disadvantage, ethnicity, disability, gender, and whether a child has been in care or has special educational needs and disability (SEND).

So, reducing inequalities in early years development, is a priority objective of the Marmot Review.

- BCP has seen improved attainment in the early years. In 2018/19 73.8% of children in BCP achieved a good level of development (GLD) at the end of Reception, compared to 57% and 46% in Bournemouth and Poole respectively in 2012/13. BCP also has higher levels of attainment than England with 71.8%[37].

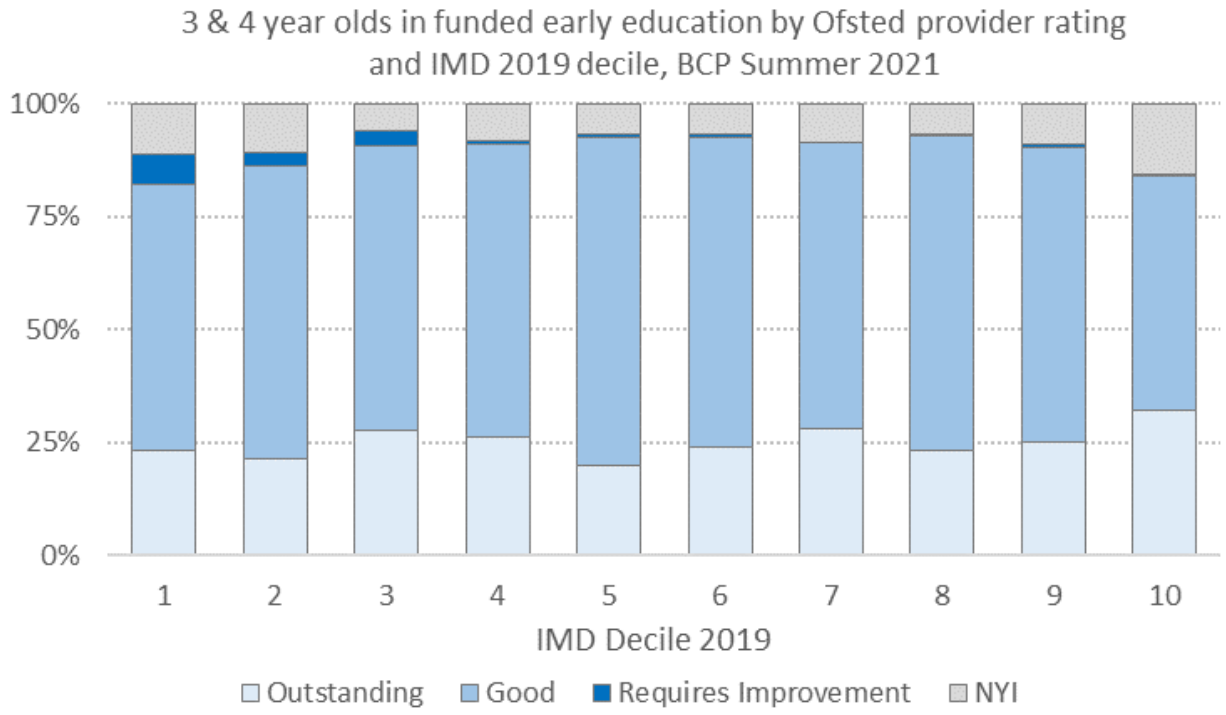
[33] BCP 2021 COVID-19 impact on children and young people in BCP
[34] 2011 Census
[35] BCP Children & Families data
[36] Michael Marmot et al (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.
[37] DfE data tables

- Improvements have been made for BCP children from disadvantaged backgrounds. The proportion of children eligible for free school meals (FSM) who achieved a GLD improved by 23% in Bournemouth and 31% in Poole from 2012/13 to 2017/18[40].
- However, inequalities remain in BCP with a 16% gap in attainment in 2018/19, where 58% of children eligible for FSM achieve a GLD, compare to 76% of those not eligible[40].



Access to high quality early education is a key component to reducing inequalities in early education outcomes.

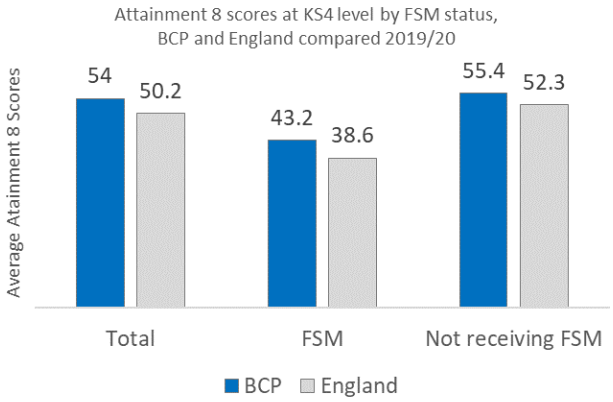
- Eligible 2-year-olds are entitled to 15 hours funded early education, and eligible 3-and 4-year-olds 30 hours funded early education per week for 38 weeks of the year. 77% of children aged 2 and 90% of children aged 3 and 4 in BCP benefitted from funded early education in 2021. This compares to an England average of 62% and 88% respectively[38].
- 98.5% of private, voluntary, and independent settings have a quality rating of 'good' or 'outstanding' in BCP. 97% of childminders are rated 'good' or 'outstanding'[39].
- While BCP Ofsted ratings are above the national and South West averages for both PVI settings and childminders, inequalities remain in access to quality early years provision. 7% of 3 & 4 year olds in funded early education from the most deprived areas attended settings with an Ofsted rating of 'requires improvement', compared to 0.3% in the least deprived areas[40].



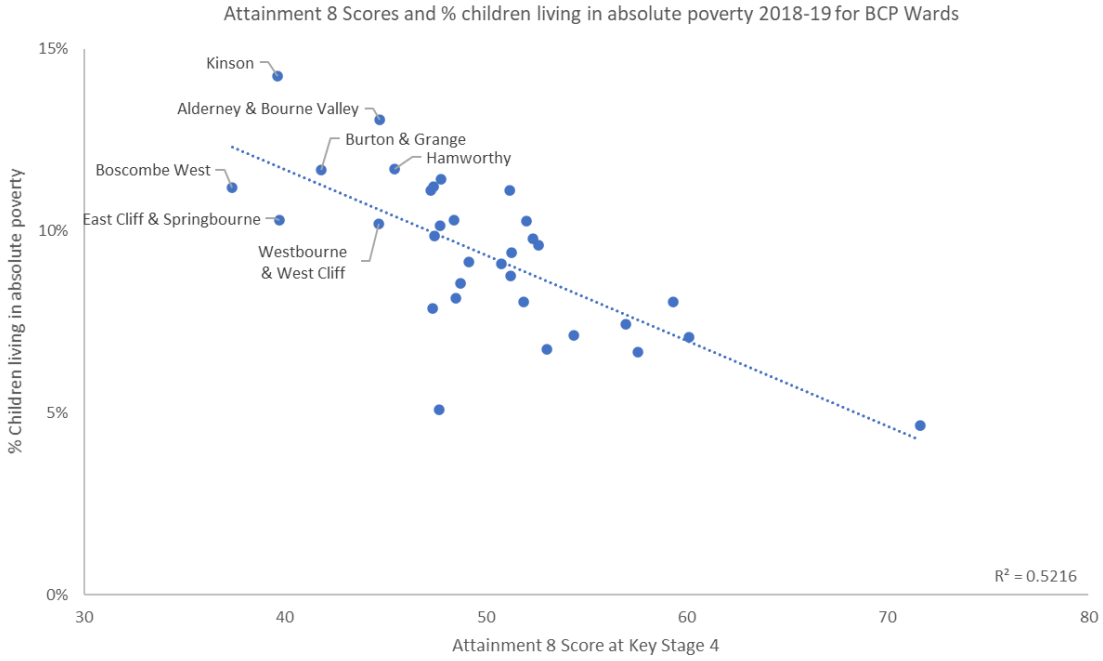
[38] LGA Inform Reports, Health and Wellbeing in Bournemouth, Christchurch and Poole: A Focus on Children
[39] BCP Childcare Sufficiency Assessment 2020
[40] Early Years Census Summer 2021

Maintaining a reduction in inequalities in educational outcomes requires a sustained commitment to children and young people through the years of education. It involves understanding the social determinants of educational outcomes, including family background, neighbourhoods, as well as what goes on in schools[41].

- Educational attainment in BCP is generally higher than it is nationally, though this is not the case for all children. At KS4 (15-16 years old), pupils eligible for free school meals (FSM) and pupils with SEN (SEN Support or EHCP) perform worse than BCP overall[42].



- There is a clear social gradient in KS4 outcomes in BCP, shown by the relationship between child poverty and Attainment 8 scores at ward level. Wards with scores significantly below the BCP average are highlighted below[43].



- Inequalities in attainment are also evident at age 19. The attainment gap between those eligible for free school meals and those who are not is more significant for level 3 (2 or more A levels) than it is level 2 (5 or more GCSEs) and is a lot larger than the gap nationally; 31% in BCP compared with 24.8% nationally[45].

The attainment gap has been closing, albeit slowly. But this progress could be halted or reversed by the Covid-19 pandemic. Factors such as access to equipment and home/learning environment have been key factors in a child's learning over the last 18 months and the experience of both is unlikely to have been consistent for all children / young adults.

[41] Michael Marmot et al (2010) Fair Society, Healthy Lives: The Marmot Review. London: Institute of Health Equity.
[42] DfE data tables
[43] BCP Children & Families data

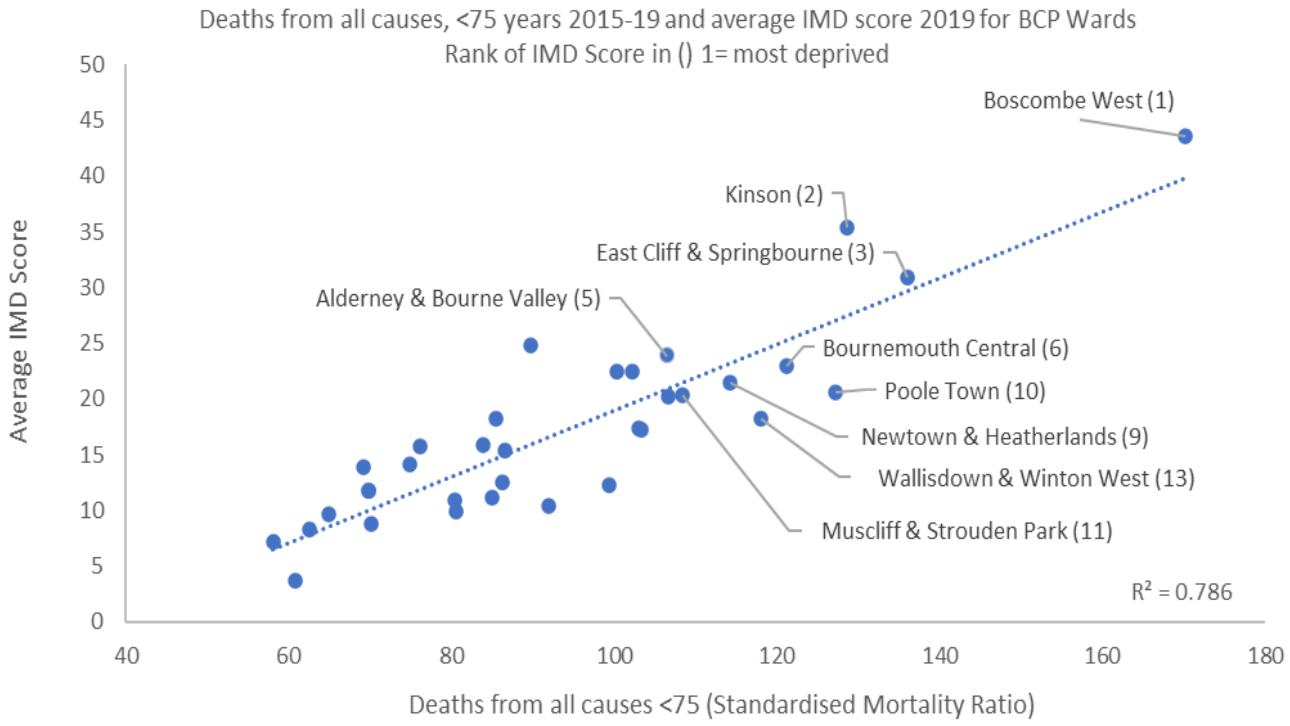
5. Health inequalities in working age

Good health is vital for maintaining quality of life in adults, with wide ranging benefits from remaining in employment, to maintaining relationships and being involved in activities that provide meaning and purpose[44]. However, Section 2 has shown significant inequalities exist in overall health status in BCP, both for life expectancy and healthy life expectancy. This section provides more detail on the main causes of premature deaths and disability in the adult population and any significant differences that exist between areas and population groups.

5.1 Premature deaths

Premature mortality is a good indicator of the overall health of a population, and there are significant differences in premature death rates between areas in BCP, reflecting a wide range of underlying differences between these populations.

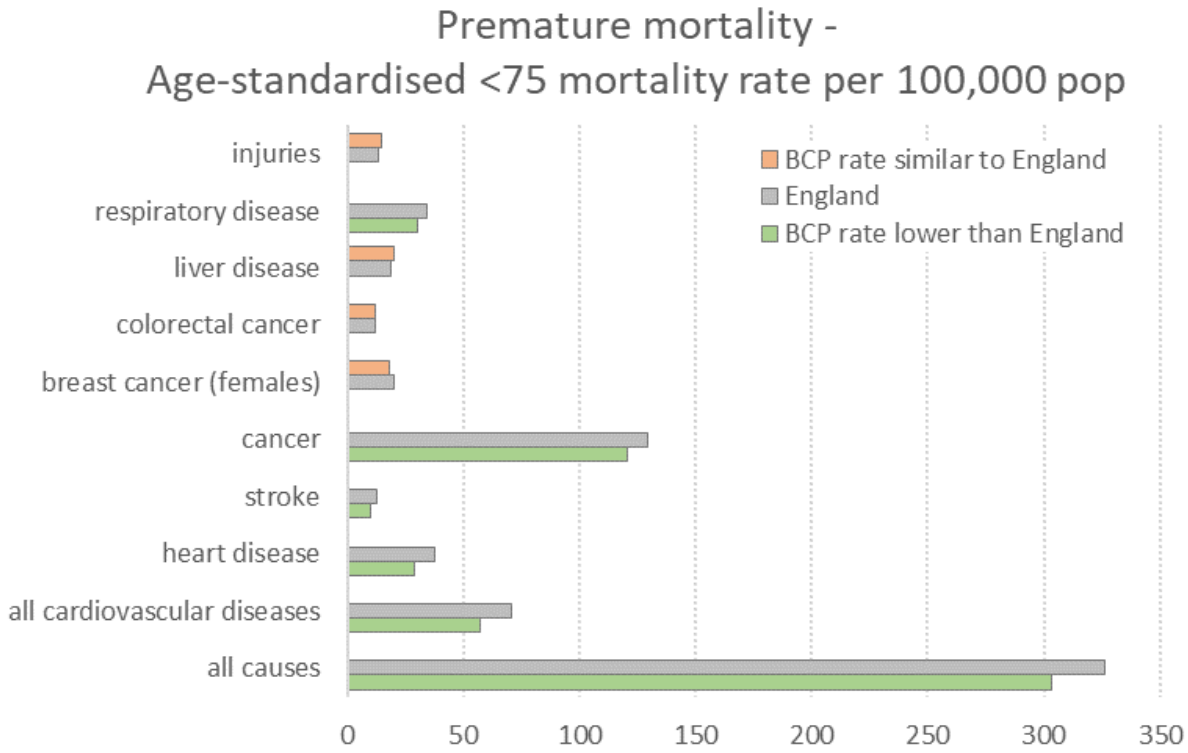
- Premature mortality (deaths of those aged under 75) in BCP from all causes are lower or similar, to those for England as a whole[45]. But as with life expectancy there is a clear social gradient in premature deaths in BCP, with the most deprived areas having higher rates than the least deprived.
- 9 wards in BCP have significantly Higher Standardised Mortality Ratios (SMRs)[46] for premature deaths than BCP overall. These are highlighted below[47].



- The Covid-19 pandemic has widened these inequalities. Among the under 75s excess mortality for the period March 2020 to February 2021 show a stark increase in already established inequalities in premature mortality by deprivation (deprived areas had 1.25 times as many deaths as expected, the least deprived 1.14)[48].

[44] PHE Health Profile for England 2021
[45] PHE Mortality Profile
[46] The Standardised Mortality Ratio (SMR) describes whether a specific population are more, less or equally likely to die than a standard/ reference population (e.g. England). >100 indicates there are excess deaths in the specific population.
[47] PHE Local Health
[48] Barnard et al, 2021. Effect of Covid-19 on inequalities in premature mortality in England: an analysis of excess mortality by deprivation and ethnicity medRxiv 2021.05.18.21256717

- Data pre-dating Covid, show there were just over 3,300 premature deaths in BCP from all causes in 2017-19 (amounting to just over a thousand deaths per annum). Cancer accounted for 40% of all premature deaths during the period 2017-19, Cardiovascular diseases (including heart disease and stroke) accounted for a further 20% of deaths, and Respiratory disease accounted for 10%[48].

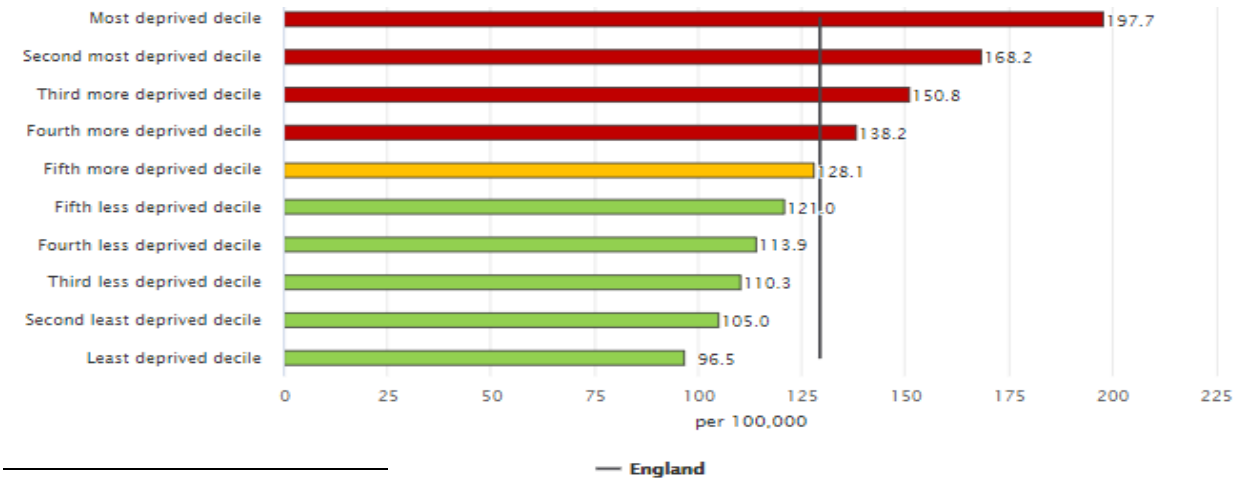


5.2 Cancer

People living in more deprived areas are more likely to get certain cancer types, but also to be diagnosed at a later stage and to die from the disease. They are more often diagnosed through emergency routes like A&E, as data suggests people from the most deprived communities are less aware of cancer symptoms and report additional barriers to seeking help. With so many differences in prevention, diagnosis, care and treatment, people in more deprived areas have worse cancer survival[49].

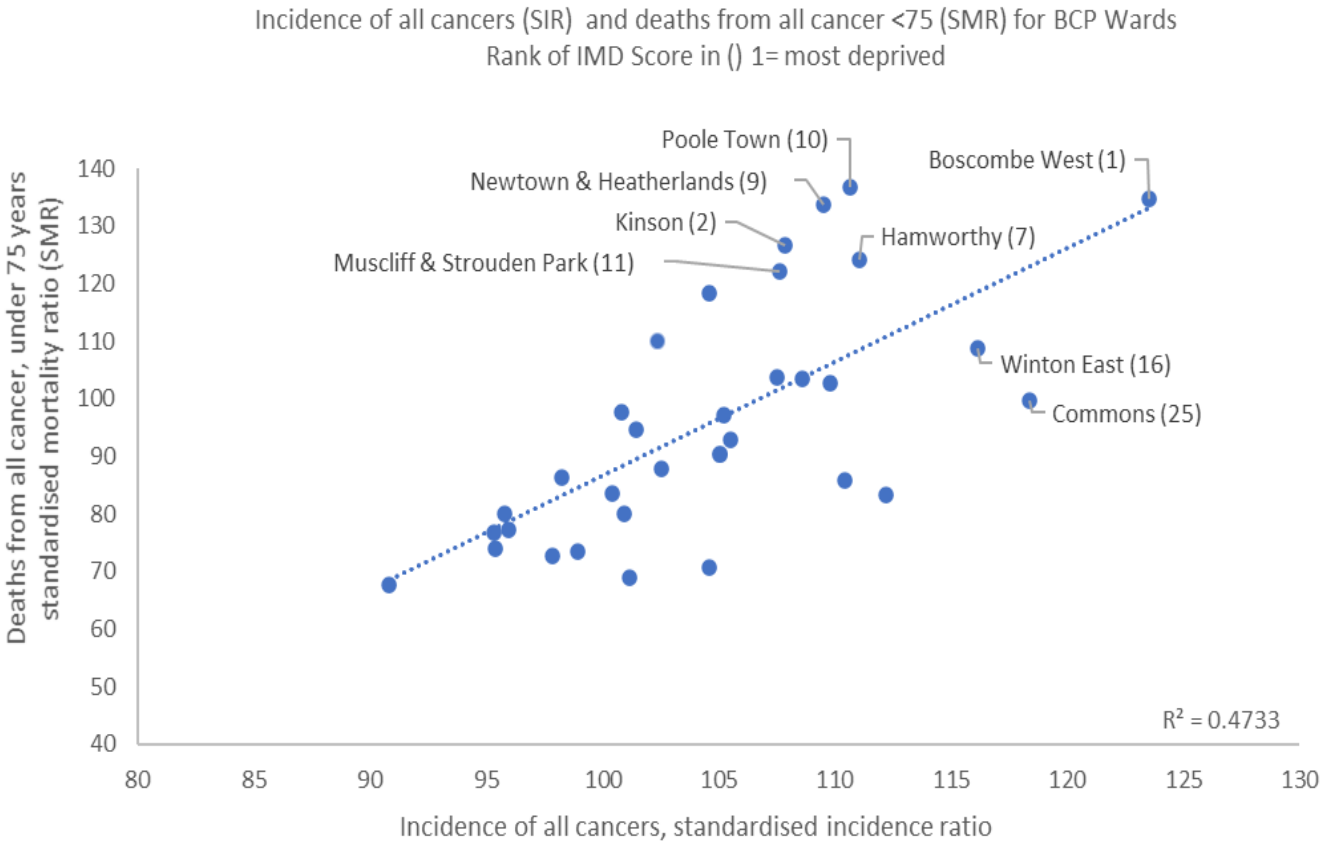
- National data for England shows a steep social gradient for premature mortality (age <75) for cancers overall, with rates more than double in the most deprived decile, compared to the least deprived[50].

Under 75 mortality rate from cancer (Directly Standardised Rate per 100,000) 2017-19, by IMD deprivation decile, England[53]



[49] Cancer UK. UK health inequalities: 20,000 more cancer cases a year in the most deprived areas
[50] PHE Public Health Profiles

- Men are also significantly more likely to die from cancer compared to women, with mortality rates over 20% higher[51].
- Over the period 2017-19 there were 1313 cancer deaths in BCP, a rate of 147.1 per 100,000, not significantly different to 125.1 per 100,000 for England. Over 40% of these deaths were considered preventable[54].
- The incidence of cancers overall in BCP 2014-18 was significantly higher than for England as a whole[52], largely driven by a higher incidence of breast and prostate cancers. Cancer incidence refers to the number of new cancers occurring in a specified population during a year. Note cancer incidence can be influenced by many factors including screening and diagnosis, risks and behaviours, and socio-economic factors.
- Wide variations exist in both cancer incidence and death rates between areas in BCP. The chart below shows the relationship between cancer incidence and deaths rates, together with IMD 2019 rank at ward level for BCP.
- BCP Wards with significantly higher premature death rates from all cancers than the BCP average are Poole Town, Boscombe West, Newtown & Healtherlands, Kinson, Hamworthy and Muscliff & Strouden Park. These wards generally have higher levels of deprivation, and a higher incidence of lung and/or bowel cancers, which have lower cancer survival rates. Boscombe West, Hamworthy, Poole Town and Newtown & Heatherlands also have significantly higher incidence of cancers overall[53].
- Two additional wards Commons and Winton East have cancer incidence rates significantly above the BCP average, although their mortality rates are lower. These wards have lower levels of deprivation and a higher incidence of breast and prostate cancer, which tend to have a higher incidence in less deprived areas and higher survival rates[56].

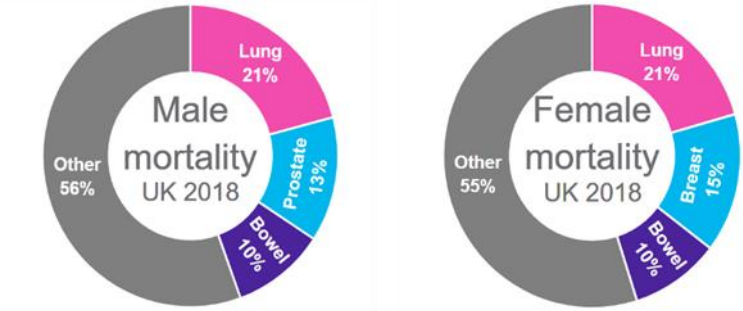


[51] PHE Public Health Profiles

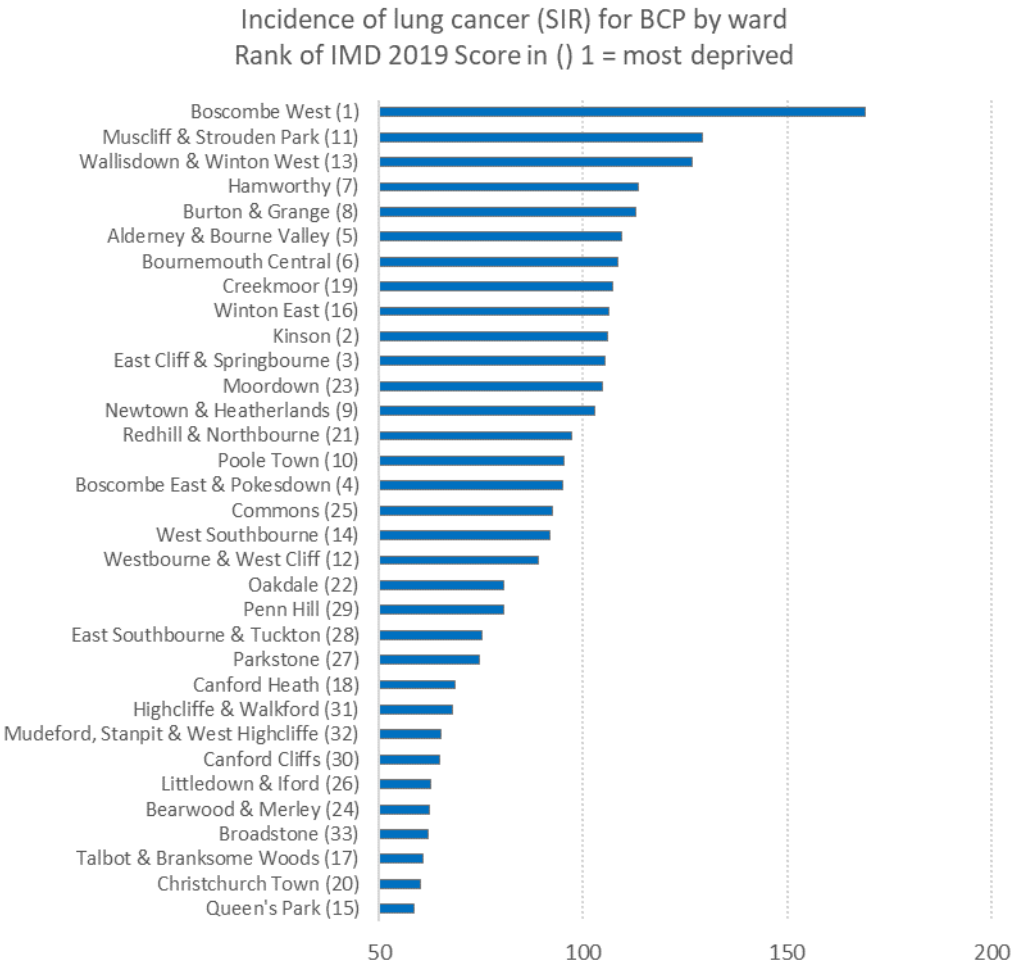
[52] As measure by Indirectly age-sex-year standardised ratios - SIRs (number of new cases as a percentage of expected new cases), calculated relative to England.

[53] PHE Local Health

- The three most common causes of cancer deaths are lung, prostate and bowel for males, and lung, breast, and bowel for females[54].



- Lung cancer shows the biggest differences between the most and least deprived areas, both in terms of incidence and deaths. Bowel cancer incidence is higher only for males in more deprived areas, but inequalities in deaths effect both males and females. Breast and prostate cancer conversely have higher incidence in less deprived areas, although breast cancer deaths remain higher in more deprived areas[55].
- The were 1,433 new lung cancer cases in BCP between 2014-18, and the standardised incidence ratio (SIR) was below the England average (88.5). Boscombe West and Muscliff & Strouden Park wards had SIRs significantly above the BCP average[56].



[54] Cancer Research UK. Cancer mortality from common cancers
[55] Cancer Research UK, Statistics by cancer type
[56] PHE Local Health

- Smoking is a major cause of inequalities in cancer incidence and mortality and accounts for much of the inequalities in the most deprived populations. Smoking prevalence is also highest in males, people in routine and manual occupations, and other white, mixed, black Caribbean ethnic groups[57,58].
- Lung cancer death rates are also highest in males and Bangladeshi, Mixed and White ethnic groups which reflect populations with higher smoking prevalence[59].

Measures to control the spread of COVID-19 in England have had a significant impact on the number of new cancer diagnoses. This may result in more people being diagnosed at later stages when curative treatments are less likely to be effective. It is possible that we may see the impact of these reductions in new diagnoses through an increase in deaths in future years[60].

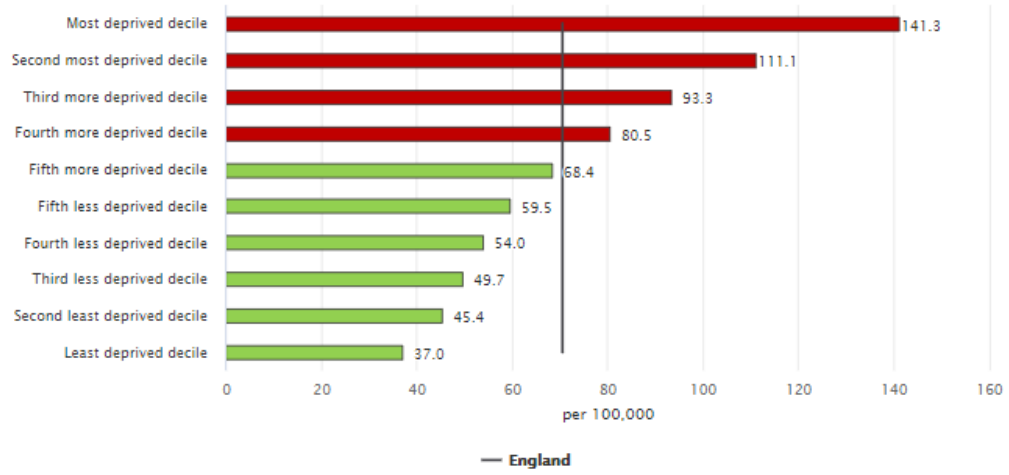
- There were smaller reductions for cancer diagnoses at a later stage than at earlier stages, and there were similar reductions across sex, deprivation, and ethnicity groups. However, people aged 0 to 49 had a smaller reduction than other age groups.

5.3 Cardio-vascular disease

Cardiovascular disease (including heart disease and stroke) accounts for a fifth of premature deaths in BCP. v

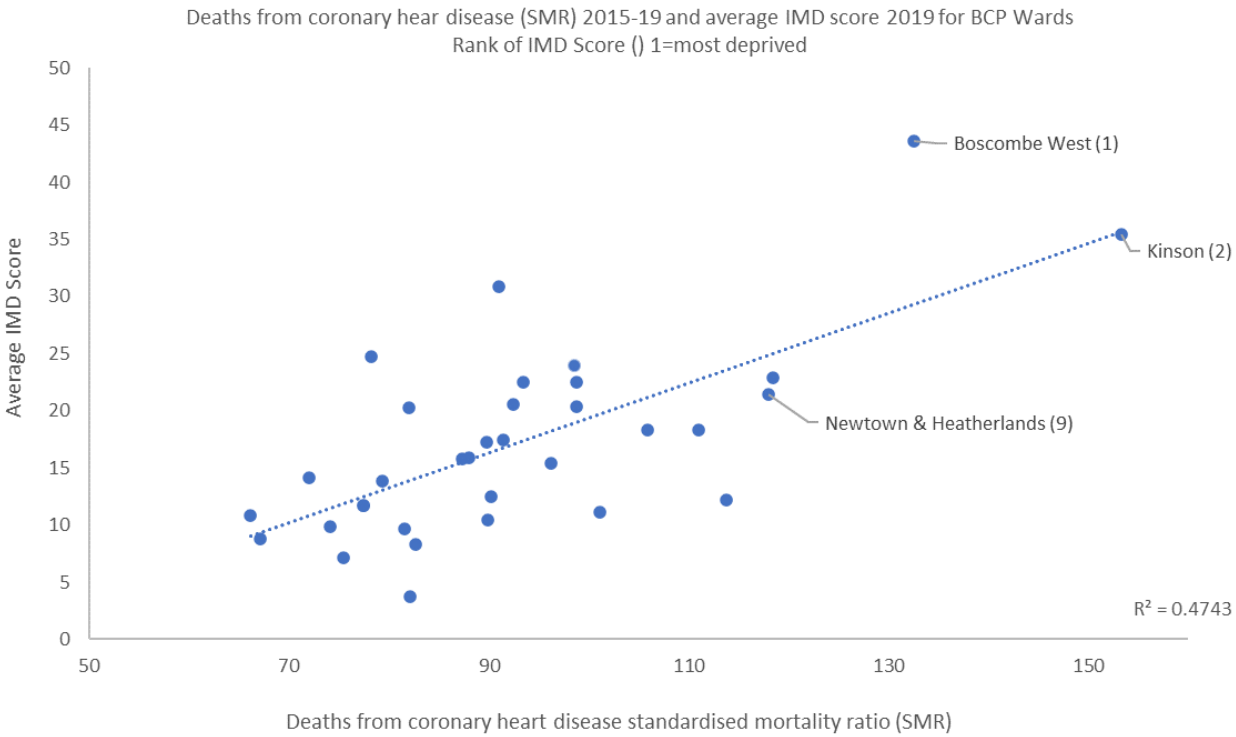
- Since 2001-03 the under 75 mortality rate for CVD has reduced by 47%. During 2017-19 there were 626 deaths, a rate of 57.2 per 100,000, significantly lower than 70.4 per 100,000 for England. Over a third of these deaths were considered preventable[61].
- National data for England show a steep social gradient for premature mortality (age <75) for cardio-vascular disease, with rates almost 4x higher in the most deprived decile, compared to the least deprived[62].

Under 75 mortality rate from CVD (Directly Standardised Rate per 100,000)
2017-19



- Wide variations exist in cardio-vascular death rates between areas in BCP. Deaths from coronary heart disease are significantly higher than BCP overall in Kinson, Boscombe West, and Newtown Heatherlands wards, with the first two being outliers and the two most deprived wards in BCP[63].

[57] ONS Smoking inequalities in England 2016
[58] ONS Adult smoking habits in the UK 2019
[59] ONS Mortality from leading causes of death by ethnic group, England and Wales: 2012 to 2019
[60] PHE Health Profile for England 2021
[61] PHE Public Health Profiles
[62] PHE Public Health Profiles
[63] PHE Local Health



- Men are significantly more likely to die from CVD compared to women, with mortality rates over double those for women[64]. CVD deaths are also more common in Bangladeshi, Pakistani, Indian, White, and Mixed ethnic groups both for males and females[65].
- Most of the excess CVD mortality in lower socio-economic groups can be explained by known risk factors include smoking and alcohol, raised blood pressure, diabetes, obesity, and lack of physical activity.

5.4 Mental health and wellbeing in adults

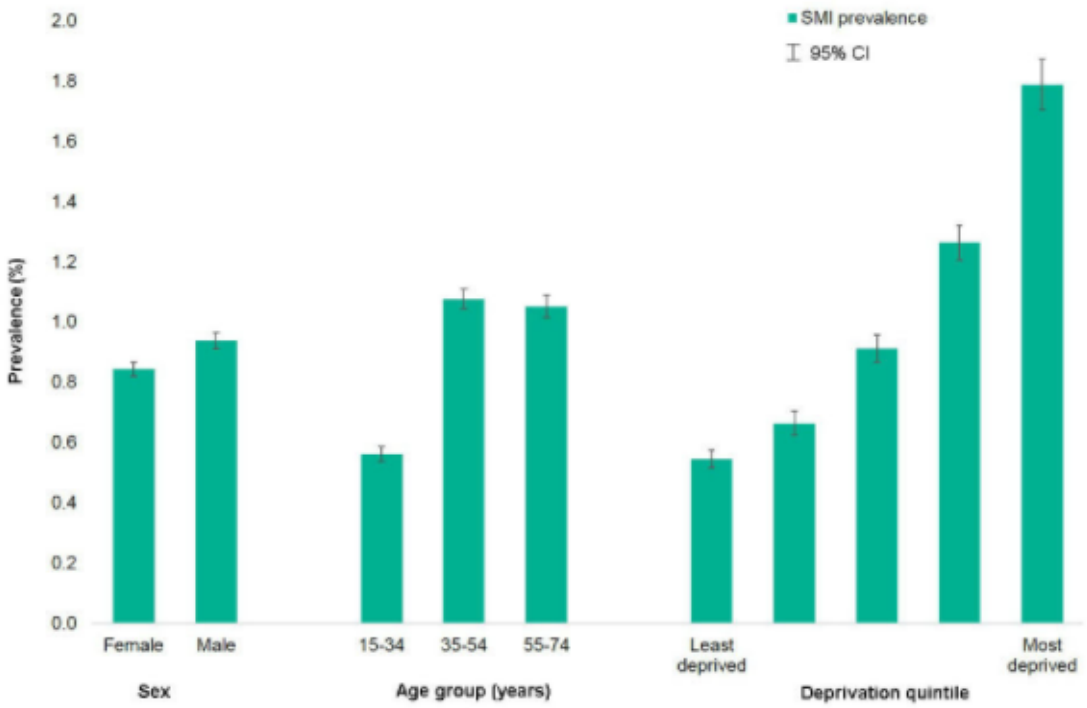
Mental health is both a cause and effect of physical ill-health and health inequalities. The life chances of people with mental health conditions are significantly impaired compared with the general population, and there are substantial differences in mental health and wellbeing between population groups.

- Mental health conditions such as depression and anxiety, were the leading cause of death and disability in those aged 15-49, accounting for a fifth of total death and disability in this age group in BCP. They accounted for 13% in the 50-69 age group[66], [67].
- Estimates suggest there were almost 54,000 people with a mental disorder aged 16+ in BCP in 2017. Rates in Bournemouth were significantly worse than both the South West and England average (18% compared to 15.6% and 16.9% respectively). Rates for Poole (15.3%) and Christchurch (13%) were lower[68].

People with Severe Mental Illness (SMI) are at greater risk of poor physical health and have a higher premature mortality than the general population. And there is a higher prevalence of SMI in more deprived areas[69].

[64] PHE Public Health Profiles
[65] ONS Mortality from leading causes of death by ethnic group, England and Wales: 2012 to 2019
[66] Measured as a % of Disability adjusted life years (DALYs)
[67] Global Burden of Dis3ease Study 2019
[68] PHE Public Health Profiles
[69] PHE Sept 2018. Severe mental illness (SMI) and physical health inequalities: briefing

Prevalence of severe mental illness (SMI) by sex, age group and deprivation[72]



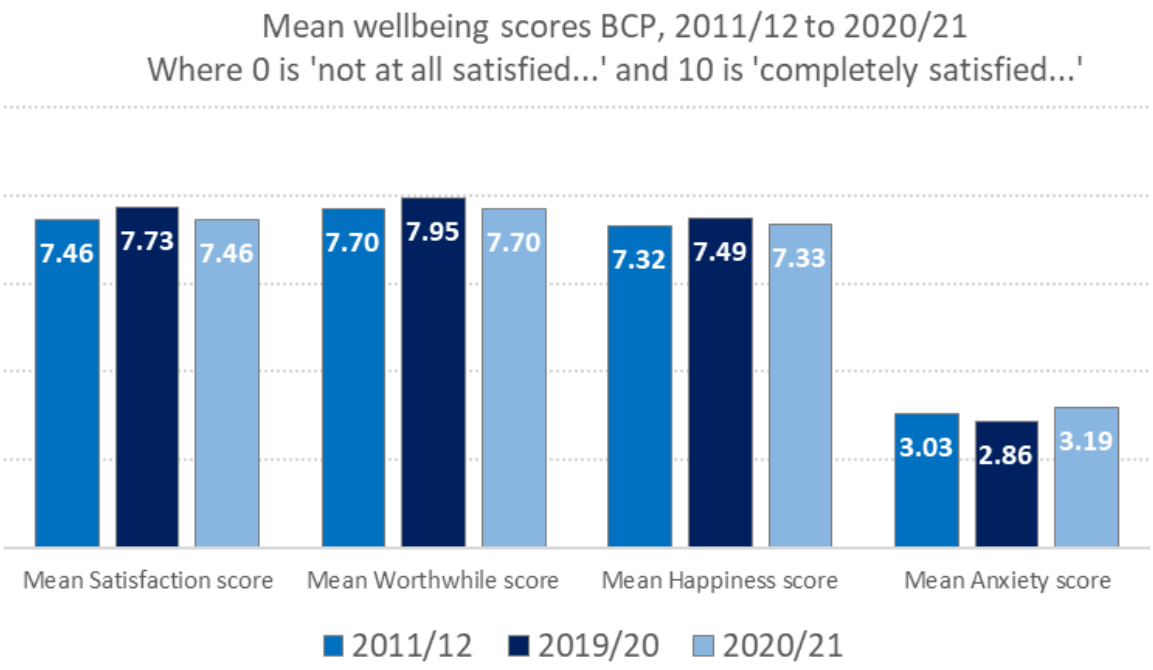
- People with SMI die on average 15 to 20 years earlier than the general population and have a 3.7 times higher death rate for ages under 75[72].
- SMI patients have a higher prevalence of obesity, asthma, diabetes, COPD, CHD, stroke, and heart failure. And health inequality between SMI and all other patients is almost double for multi-morbid (2 or more) physical health conditions[72].

In addition to poorer physical health, people with mental health problems are less able to secure employment, are more likely to be homeless, and have fewer qualifications. Outcomes in BCP are poorer than nationally.

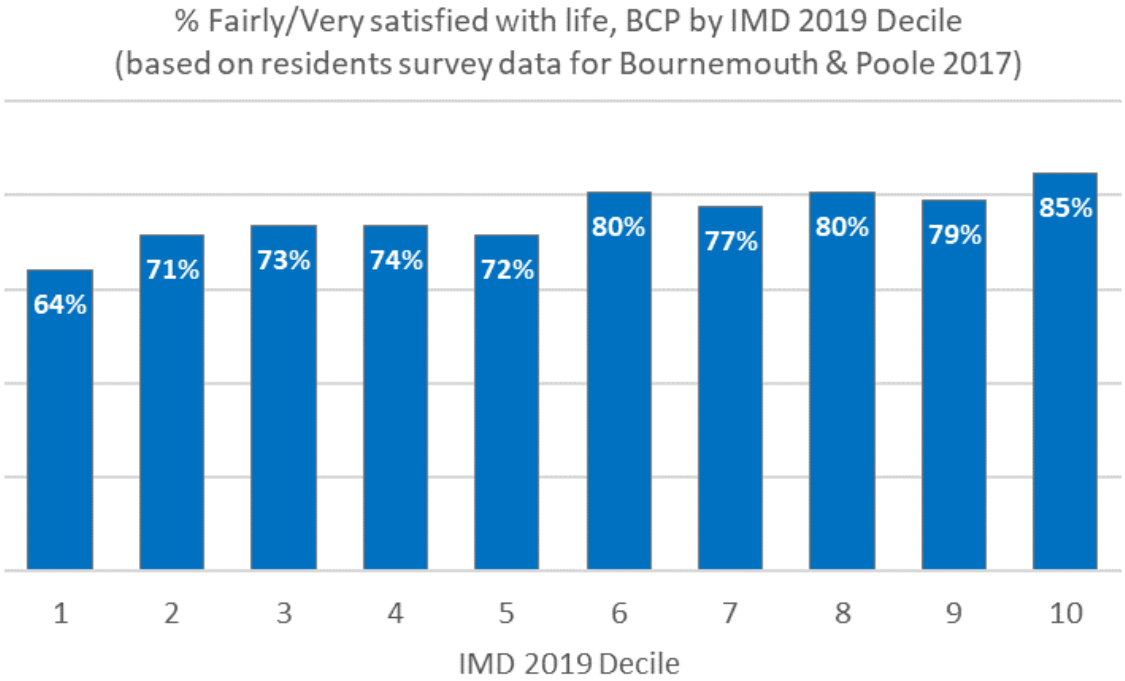
- The gap in employment rate for those in contact with secondary mental health services and the overall employment rate was 72.2% in BCP in 2019/20, significantly worse than the England (67.2%) and South West (68.2%) average[70].
- The proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation was 41% in BCP in 2019/20, significantly worse than the England (58%) and South West (56%) average[73].
- Mental health problems are common among those needing treatment for alcohol misuse and alcohol misuse is common among those with a mental health problem. Admission episodes for mental and behavioural disorders due to use of alcohol are significantly higher in BCP (485 per 100,000) than the England and South West average (412 and 392 per 100,000 respectively) [73]. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Differences in wellbeing between areas of deprivation and population groups exacerbates health inequalities.

[70] PHE Public Health Profiles

- Estimates of life satisfaction, worthwhile, happiness and anxiety, after a period of improvement to 2019/20, have seen rates deteriorate in 2020/21, both in BCP and nationally. BCP scores are similar or better than the national average[71].



- Low wellbeing scores are more common among people who were economically inactive and unemployed, those living with a disability, people from Black and Mixed ethnic groups, and people aged between 45 and 64 in 2019/20[72].
- Data from Bournemouth and Poole residents' surveys in 2017 suggest wellbeing in terms of life satisfaction is lower in the most deprived decile (64%), compared to the least deprived decile (85%).



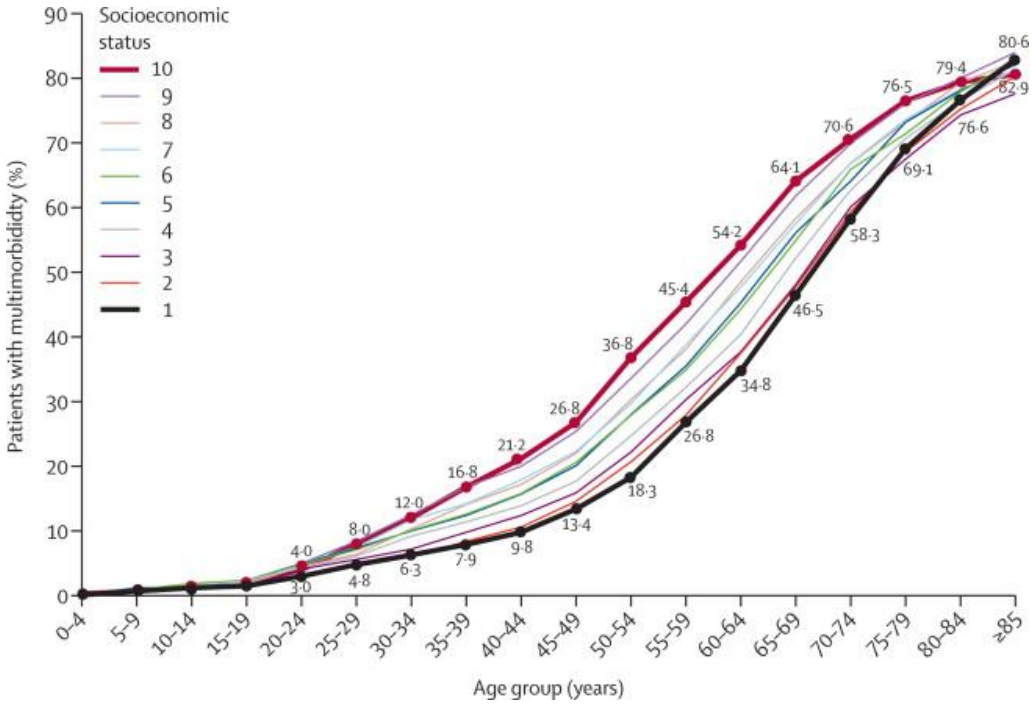
[71] ONS Annual personal wellbeing estimates
[72] PHE Health Profile for England 2021

6. Health inequalities in older age

The latest population estimates indicate 86,800 people aged 65 or over live in the BCP area. Over 65s currently represent 22% of the total population in BCP[73]. This is predicted to grow to 24% by 2028: an increase of 12,400 people or 15%[74]. In the context of population ageing, older age-related inequalities will take on greater urgency.

- Many older people retain overall good health well into old age, but as the older population increases, the number of people living with ill health and with multiple long-term conditions will increase too. This may be exacerbated as the length of time spent in poor health is increasing for both men and women, as recent improvements in life expectancy have not been matched by improvements in healthy life expectancy. As shown in Section 2 this disproportionately affects those living in more deprived areas as they are shown to spend a larger proportion of life in poor health.
- Long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40)[75]. And the number of conditions and the proportion of people with multiple conditions increases substantially with age. By age 65 years most have more than one condition. But again, multi-morbidity disproportionally effects those with lower socio-economic status at all ages, apart from those aged 85 years and older, and they have multiple conditions from a younger age. This is significant as people with multimorbidity have poorer functional status, quality of life, and health outcomes[76].

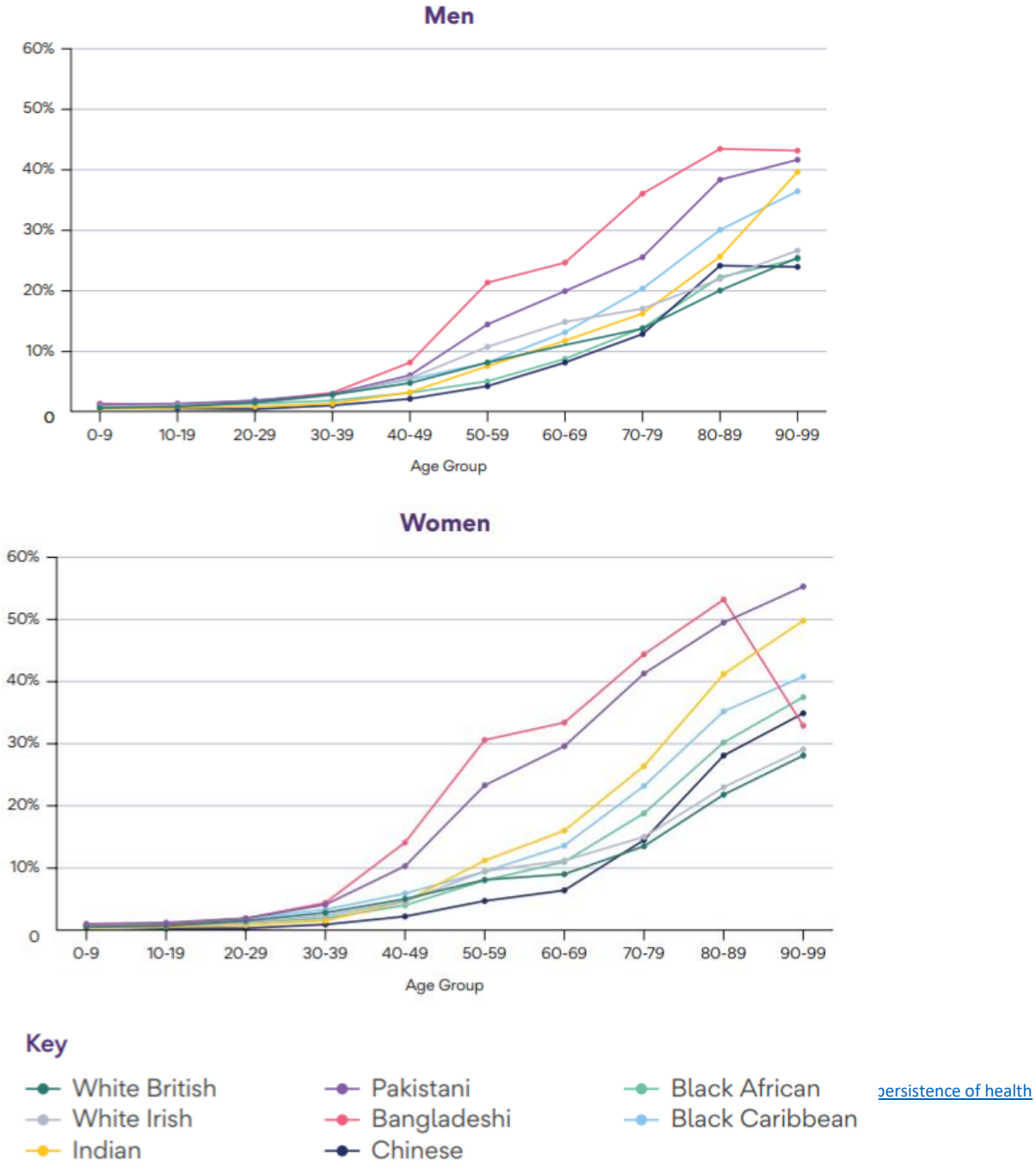
Prevalence of multi-morbidity by age and socio-economic status[79]



[73] ONS 2020 Mid-year population estimates for BCP
[74] ONS 2018 based sub-national population projections for BCP
[75] Kings Fund, Long term conditions and multi-morbidity
[76] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S and Guthrie B (2012). Research paper. Epidemiology of multi-morbidity and implications for health care, research and medical education: a cross-sectional study The Lancet online

- Therefore, just as there is a social gradient in health in the adult population, there is also a social gradient in healthy ageing that is rooted in inequality. Those who have been socio-economically disadvantaged throughout their lives carry this disadvantage through to old age. Therefore, older people living in more deprived areas are more likely to enter older age in poorer health and die younger.
- The increasing population of older ethnic minorities will be a key demographic change over the next decades. Recent research on ethnic inequalities in health in later life in the UK[77] has shown that the health status of different ethnic groups begins to diverge from around age 30 and accumulate over the life course. Inequalities in health between ethnic minority and white majority groups are significantly larger in older ages[78]. Older Black Caribbean, Indian, and particularly Pakistani and Bangladeshi minority groups are worst affected by ill-health in older age[80].
- There is clear evidence that some inequality in health status of ethnic groups can be accounted for by the socio-economic disadvantage in employment, earnings, housing, and neighbourhoods that most ethnic minority groups experience. But that experiences of racism and racial discrimination are also partly responsible for driving these health inequalities[81].

Percentage of men and women with poor self-rated health by age and ethnicity - 2011 Census [81]



persistence of health

- Cardio-vascular disease and cancer cause half of deaths and disability in the older population as shown in Section 3, accounting for 26% and 24% respectively[79]. Therefore, health inequalities relating to these conditions outlined in the previous section on working age health inequalities will also apply and are exacerbated in older age.
- But older age brings its own unique challenges. It is the single most important predictor for cognitive decline and dementia. And older adults are particularly at risk of social isolation, as they withdraw from the labour market and become more susceptible to chronic disease[80].

6.1 Dementia

Dementia is the most feared health condition for many older people aged over 65, according to the latest survey by Alzheimer's Research UK in July 2021[81].

- The proportion aged over 65 with a recorded diagnosis of dementia in the BCP area in 2020 was 4.43%, significantly higher than both England 3.97% and the South West 3.83%. However, the estimated dementia diagnosis rate of 60.5% in 2021, remains significantly below the 66.7% benchmark[82].
- In the UK, 62% of people with dementia are female and 38% are male. This is because women live longer than men and age is the biggest known risk factor for the condition[83].
- There is greater prevalence of dementia among black and South Asian ethnic groups. These groups are more prone to risk factors such as cardiovascular disease, hypertension, and diabetes, which increase the risk of dementia and contribute to increased prevalence.[86].
- There are several lifestyle factors that can increase the risk of dementia. The 2020 Lancet Commission Report found 40% of dementia cases might be attributable to potentially modifiable risk factors which could be prevented or delayed. These risks were: lower education, unmanaged hypertension, hearing impairment, smoking, obesity, depression, physical inactivity, diabetes, infrequent social contact, alcohol consumption, traumatic brain injury, and air pollution. Many of these risks cluster around inequalities, which occur particularly in lower socio-economic groups and in vulnerable populations[84].

6.2 Loneliness

Age UK identifies loneliness as one of the major factors older people worry about. And loneliness can undermine well-being and impact negatively on quality of life and health.

- National data suggest levels of loneliness have increased since spring 2020, because of lockdowns, social distancing, and restrictions on travel and gatherings. The proportion of the adult population who said they felt lonely "often" or "always" increased from 5% in May 2020, to 7.2% in February 2021.

[79] Global Burden of Disease Study 2019
[80] PHE Health Profile for England 2021
[81] Alzheimer's Research UK – Public Attitudes towards Dementia Survey 2021
[82] PHE Dementia Profiles
[83] PHE June 2021. Health matters: midlife approaches to reduce dementia risk
[84] Lancet 2020; 396: 413–46. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission

- The most recent data for the BCP area, which predates Covid, show 25.6% of adults feel lonely always/often or some of the time. This is not statistically higher than England 22.3% or the South West 21.7%.

- While data suggest younger adults reported feeling lonely more often than those in older age groups overall[85], especially during the Coronavirus pandemic[86], common risk factors show some groups of older people may be at higher risk of loneliness. Also, other analysis has shown people in the oldest age groups (aged 80 and over) are twice as likely to report feeling lonely than those of working age, and the 65 to 79 age group[87].

- Where you live, your health or disability, and education and wealth can influence the extent and quality of social connections and participation in leisure activities in later life[88]. Also, ONS analysis of the Community Life Survey highlights the following groups as at greater risk of feeling lonely more often[88]:
    - Women reported feeling lonely more often than men
    - Those single or widowed were at particular risk of experiencing loneliness
    - People in poor health or who have conditions they describe as "limiting"
    - Renters reported feeling lonely more often than homeowners
    - People who feel that they belong less strongly to their neighbourhood
    - People who have little trust of others in their local area, and
    - People living alone

[85] ONS 2018, Loneliness - What characteristics and circumstances are associated with feeling lonely?
[86] ONS April 2021, Mapping loneliness during the coronavirus pandemic.
[87] ONS 2015, Insights into Loneliness, Older People and Well-being
[88] Centre for Ageing Better Dec 2017, Inequalities in Later Life

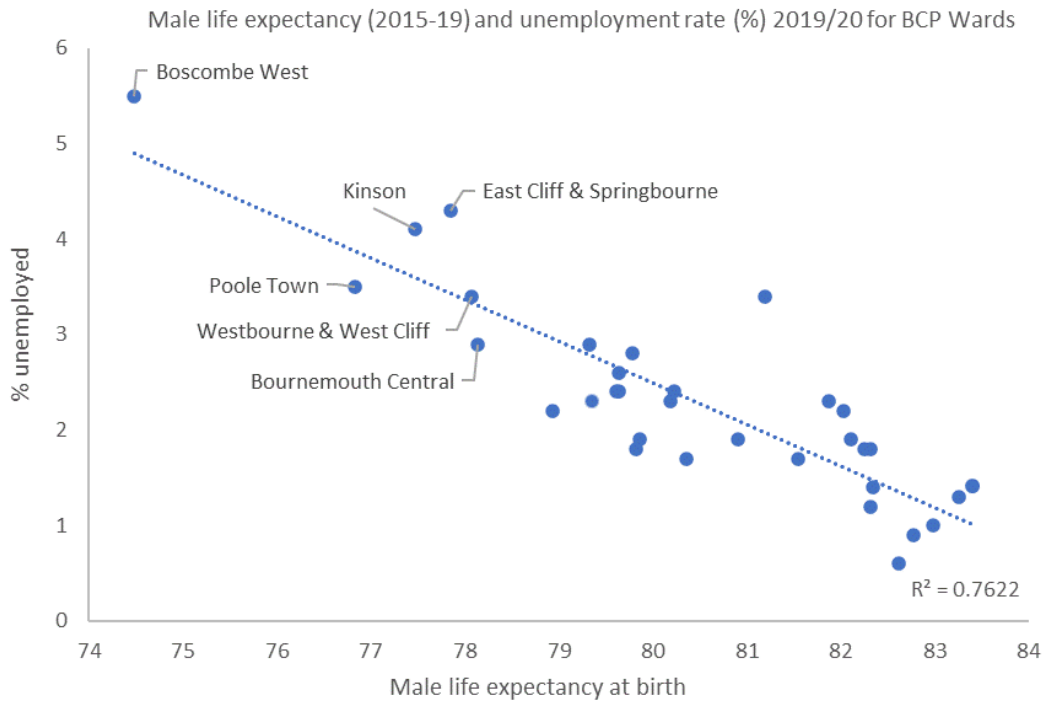
7. Inequalities in the wider determinants of health

'Wider determinants of health' are a diverse range of social, economic, and environmental factors which impact on people's health. Several studies have attempted to estimate the contribution of the wider determinants to population health, finding they have a greater influence on health than health care, behaviours, or genetics[89]. Inequalities in the wider determinants are important drivers of the inequalities in the health outcomes and risk factors presented earlier. This section briefly outlines these wider determinants, and their impact on health inequalities, in relation to BCP.

7.1 Employment and income

Patterns of employment reflect the social gradient in health, and closely mirror childhood deprivation and inequalities. Unemployed people, particularly long-term unemployed have a higher risk of poor physical and mental health.

- 77% of BCPs adult population were in employment, compared to 51% who have a health condition or illness lasting more than 12 months[90]. BCPs employment rate is above the national average (75%).
- The employment rate for ethnic minorities in BCP is 75%, compared to 67% for ethnic minorities in England overall[93].
- The latest modelled unemployment rate for BCP is 4.6%, 9,300 individuals (Jul 20-Jun21)[91]. Unemployment across the BCP area has trended downward since 2011/12. But the latest estimates from 2020/21 show an increase in the rate of unemployment, due to the Covid-19 pandemic.
- The relationship between unemployment and health status is clear at ward level for BCP. Wards where levels of unemployment are significantly above the BCP average (shown below) also have the lowest life expectancy[92].



[89] PHE Wider determinants of Health
[90] Annual Population Survey Jun 20- Jul 21
[91] Model-Based Estimates of Unemployment, ONS
[92] PHE Local Health

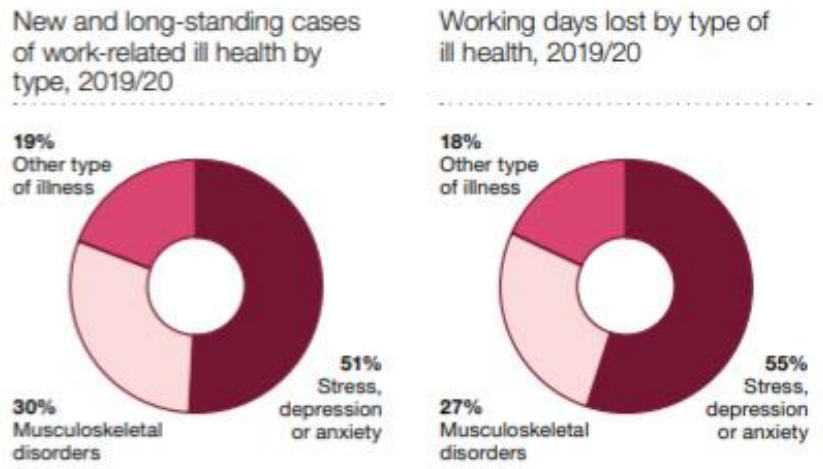
- These areas with the highest unemployment rates are significantly more likely to include residents that have no or few qualifications, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, some ethnic minorities, older workers and particularly young people[98].

There are risks associated with being unemployed at a young age. A report by Public Health England links spending time NEET to ongoing unemployment, low wages, and poor physical and mental health[93].

- The percentage of young people NEET and whose activities are unknown is higher in BCP than it is nationally. In BCP 3.8% of 16-17-year-olds are NEET, compared with 3% nationally, and the activities of 3.7% are unknown, compared with 2% nationally[94].
- Locally, as of July 2021, the percentage of young people classified as NEET or activities unknown is highest among the following groups: teenage mothers (78.3%), those who are pregnant (50%), those involved with the youth offending system (42.6%), care leavers (33.3%) and looked after children (27.9%)[97].

Insecure and poor-quality employment can also adversely affect health through poor physical or psychosocial conditions at work; poor pay or insufficient hours; and temporary work, insecurity, and the risk of redundancy or job loss[95].

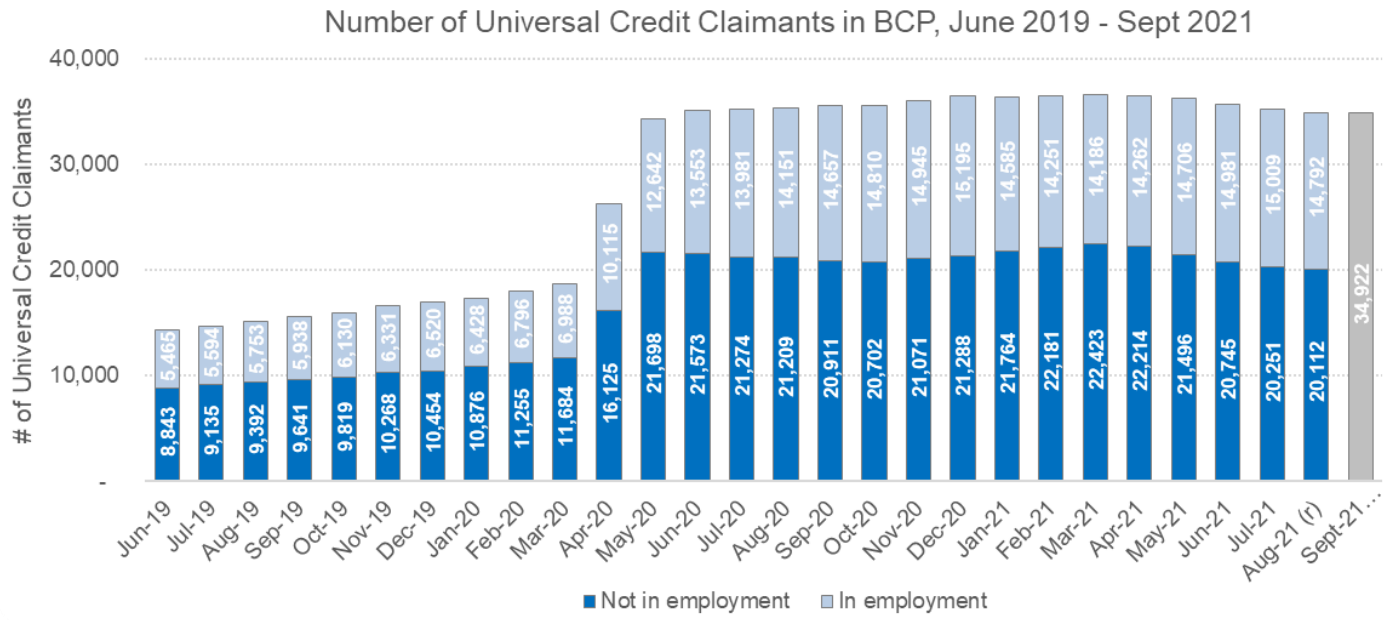
- Around a fifth of people in employment in Bournemouth and Poole in 2018 were not in quality employment, but lower than the national average of 30%[96], and 5% and 7% respectively were on low pay.[97]
- Work-related stress, depression or anxiety, and musculoskeletal disorders were the most common work-related illnesses and accounted for over 4 in 5 working days lost due to ill-health in England[98].



- BCP had among the highest rates of sickness absence in the South West and significantly worse than the national average. 2.8% of employees in BCP had at least one day off in the previous week due to sickness absence in 2017-19, compared to 2.1% for England[99].

[93] Public Health England (Sept 2014) Local action on health inequalities: Reducing the number of young people not in employment, education, or training (NEET)
[94] BCP Insight Briefing Paper Sept 2021, Young People (11-19) in BCP: Data Overview
[95] Public Health England (Sept 2015) Local action on health inequalities Promoting good quality jobs to reduce health inequalities
[96] Employees not in quality work had at least one of the following characteristics: receiving low pay, working more than 48 hours (including overtime) in a typical week, were underemployed, did not have a permanent contract because they could not find permanent employment. APS 2018
[97] Low pay is defined as those earning less than two-thirds of the median pay (HOURPAY) of the UK, APS 2018
[98] HSE. Health and safety at work Summary statistics for Great Britain 2020
[99] PHE Health Profiles

Financial insecurity is a significant cause of health inequalities. And Covid has increased levels of financial hardship and poverty, exacerbating existing socio-economic inequalities, as well as creating new ones.



- Between March and May 2019 Universal Credit Claimants almost doubled in BCP during the first Covid lockdown. In September 2021 almost 35 thousand individuals were claiming UC in BCP[100].
- These benefits are a lifeline for the many people in low paid jobs or unable to work for various reasons including disability and caring responsibilities. However, with the £20 temporary uplift introduced during Covid being removed in the 2021 Budget, and the removal of other Covid protections, many will find themselves worse off. This, along with other economic shocks such as the energy price rises, is likely to create a period of financial stress for those on lower incomes.

Housing affordability has a significant impact on the number of people defined as living in poverty, which in turn impacts health. In BCP where housing costs are higher, but incomes are lower than the national average it will inevitably lead to families having to make stark choices between essentials such as heat or food.

- The median housing affordability ratio[101] for BCP was 9.73 in 2020 which is above the England average of 8.55. A higher ratio indicates that on average, it is less affordable for a resident to purchase a house[102].

Weekly median earnings of Full-time workers resident in the area, 2020 ONS	Median monthly private rental sector rent 2020/21, ONS
BCP- £537 South West £558.40 England-£589.80	BCP -£850 South West-£750 England- £730

[100] DWP Universal Credit Statistics

[101] Median housing affordability ratio refers to the ratio of median price paid for residential property to the median workplace-based gross annual earnings for full-time workers.

[102] ONS Housing affordability in England and Wales 2020

The number of people with problem debt is rising. in 2019/20, the Family Resources Survey showed 11% of low-income households were behind on at least one household bill or credit commitment. New research suggests 33% could now be in arrears[103].

- Households are disproportionately more likely to be in arrears if they are young, BAME, have children in their household, have a disability, or are a Universal Credit recipient[106].

% of low-income households (LIH) in arrears by demographic[106]

There has been an increase in food insecurity because of the increase in redundancies, reduced hours, and enforced self-isolation caused by covid. This is likely to exacerbate diet-related health inequalities.

- In BCP food bank usage doubled in the first lockdown (2408 vouchers issued in March/April 2020, compared to 1273 in March/April 2019).

High energy costs and energy inefficient properties effect people's disposable income and result in fuel poverty with resulting health implications.

- Pre-pandemic data for 2019 estimated around 10.3% of households in BCP (18,889) were in fuel poverty. This number is likely to have increased during the pandemic with the current record price increases in energy costs likely to put increased financial pressure for many households but particularly those on low incomes[104].

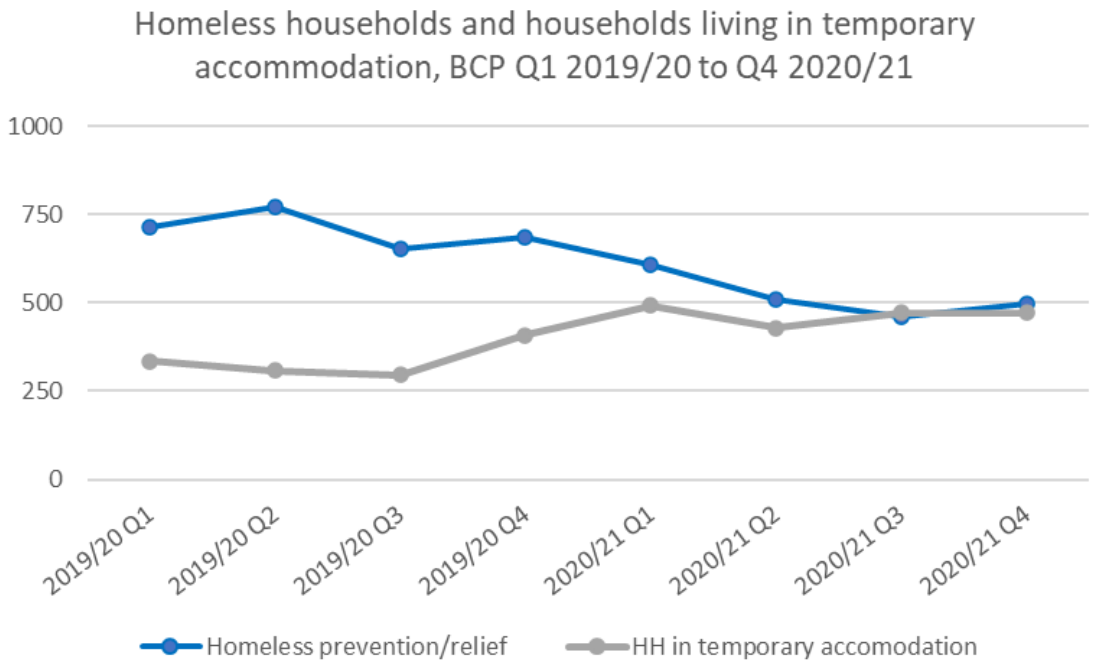
7.2 Housing

The quality of people's homes is a significant social determinant of health and a contributor to health inequalities. Housing conditions which constitute a risk to health include homelessness, overcrowding and poor physical condition.

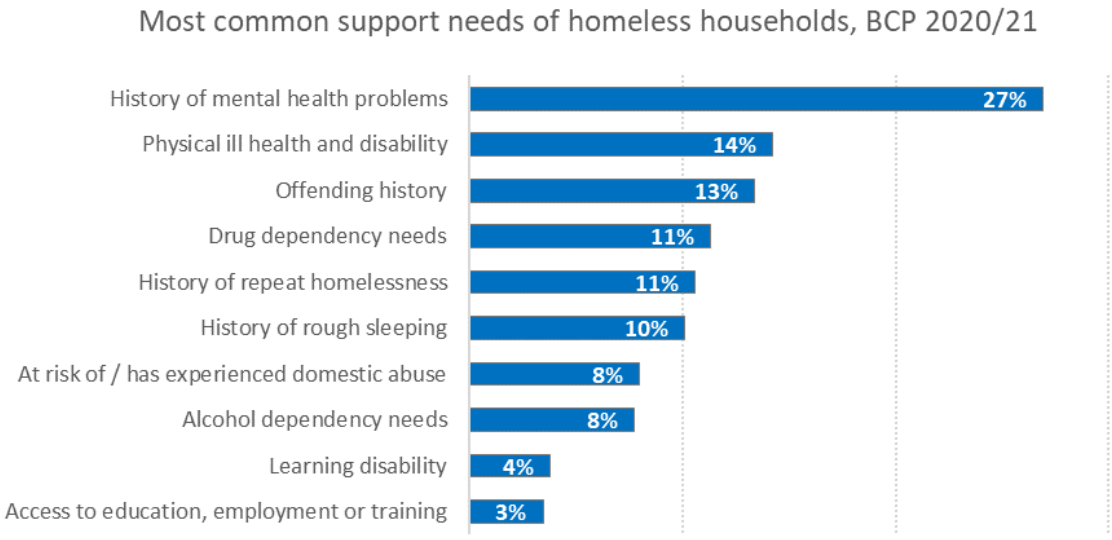
- During 2020/21, over 2,000 households were assisted by BCP Council to have their homelessness prevented or relieved, down 26% on 2019/20. This can be linked to Covid pandemic measures, to lengthen notice periods for landlords, and the restrictions on private rented sector evictions. The rate of households assessed as homeless remained higher in BCP (12.0 per 1000) than England (11.4 per 1000) [105].

[103] JRF Briefing (Oct 2021) Dragged down by debt: Millions of low-income households pulled under by arrears while living costs rise.
[104] State of Bournemouth Christchurch and Poole Report June 2021
[105] Department for Housing & Communities Homelessness Statistics

- In the same period 1,865 households were living in temporary accommodation, a 38% increase on 2019/20[108]. This is linked to the 'Everyone In' campaign whereby local authorities were asked to provide emergency accommodation to rough sleepers. However, temporary accommodation is no long-term solution and effects people's health. The uncertainty of their situation, often combined with poor living conditions, impacts both physically and mentally on homeless individuals and families.



- The projected growth in households facing homelessness, and growth in households living in temporary accommodation once the ban on evictions is lifted is a grave concern, and likely to exacerbate health inequalities[106].
- Single adult males comprised most homeless households in BCP in 2020/21 (44%), followed by single parents with dependent children (28%), and single females (18%)[107].
- A history of mental health problems, physical ill health and disability, offending history, drug and alcohol dependency and experience of domestic abuse were the most frequent support needs experienced by homeless households[110,108].



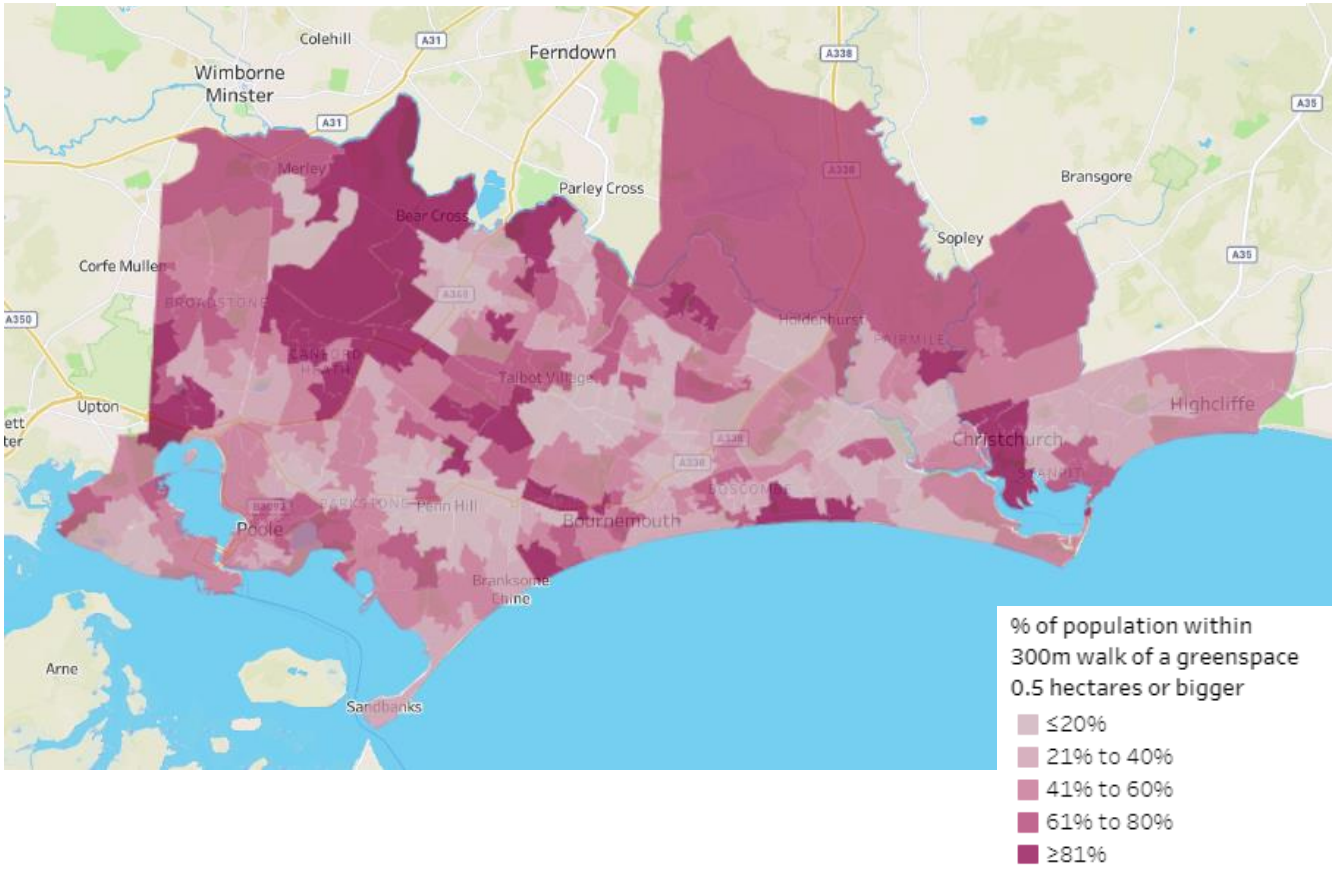
[106] LSE London. Homeless in the time of Covid 19
[107] Department for Housing & Communities Homelessness Statistics
[108] Note not all households have support needs and households can also have multiple needs

7.3 Healthy environments and sustainable communities

The quality of the environment such as air quality and quality of and access to green spaces also affect health. Evidence shows that living in a greener environment can promote and protect good health, and aid in recovery from illness and help with managing poor health. Disadvantaged groups appear to gain a larger health benefit and have reduced socioeconomic-related inequalities in health when living in greener communities[109].

- In the BCP area the proportion of mortality attributable to particulate air pollution was 4.3%. This compares to 5.1% for England and 4.1% for the South West[110].
- Not everyone across the BCP area enjoys equal access to green space, and the health and well-being benefits this brings. 56% of people living in the BCP area live more than 300m safe walk from a publicly accessible green-space 0.5 hectares or larger[111].
- National data suggest older people, those in poor health, with a physical disability, of lower socioeconomic status, ethnic minorities, and those who live in deprived areas face the greatest challenges with access and use greenspace less often[114].
- In 2018-19, 65% of adults spent time outdoors in the natural environment every week. This proportion was greater in the least deprived areas (70%) than the most deprived (57%). In addition, around 40% of people from Black and Asian ethnic groups spent time outdoors once a week compared with 69% of the White ethnic groups[112].

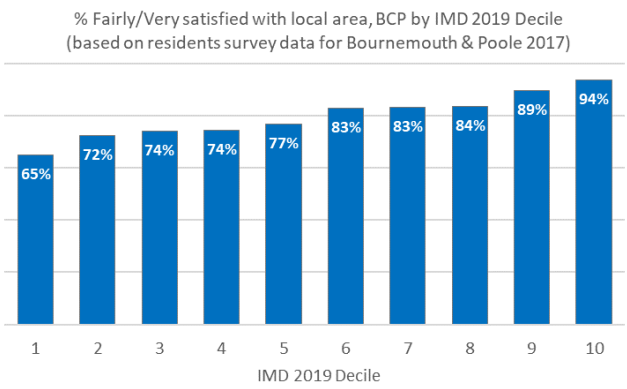
% of the population within 300m walk of a greenspace 0.5 hectares or bigger, BCP LSOAs[114]

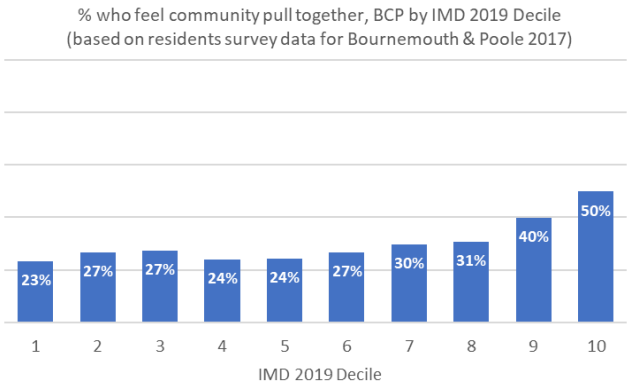


[109] PHE March 2020, Improving access to greenspace: A new review for 2020
[110] PHE Public Health Profiles
[111] Public Health Dorset 2019, Greenspace accessibility with deprivation
[112] Natural England 2019, Monitor of Engagement with the Natural Environment - The national survey on people and the natural environment. Headline report

Other aspects of communities such as community safety and social capital play an important role in maintaining and creating better health. Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing.

- Data from Bournemouth and Poole residents' surveys in 2017 suggest satisfaction with the local area is lower in the most deprived decile (65%), compared to the least deprived decile (94%). This is also the case for the proportion who feel the community pull together, with 23% agreeing for the most deprived areas compared to 50% for the least deprived areas[113].





[113] Bournemouth and Poole Residents Surveys 2017. Data from the latest Residents Survey for BCP 2021 with be available from Jan 2022.

8. The impact of COVID-19 on inequalities

Covid is having a significant impact on our communities, and the immediate and longer-term impacts have and will not be felt equally.

Covid-19 has exacerbated existing inequalities

There are inequalities in Covid-19 morbidity and mortality rates, that reflect the existing unequal experience of chronic diseases and the wider determinants of health[114].

- National analysis has highlighted several groups shown to be at greater risk of poorer health outcomes relating to Covid-19.[115,116] These include:
    - Older people
    - Males
    - Certain ethnic groups. In particular people of Chinese, Bangladeshi, Indian, Pakistani, Other Asian, Black Caribbean and other Black ethnicity.
    - Those with existing underlying health conditions. In particular, diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease, dementia, and obese or morbidly obese people.
    - People with learning disabilities
    - Those in public facing occupational roles and unable to work from home
    - Those living in more deprived areas.

The longer-term effects of COVID-19 on health inequalities

We must be mindful of the differential impact that any longer-term consequences of the disease may have on individual's health.

These should include:

- the unequal impact of COVID-19 across subgroups by age, sex, ethnicity and socioeconomic status and the longer-term health consequences such as Long-Covid.
- the implications of lockdown and other interventions on behaviours and mental health, as well as on the wider determinants such as education and employment.
- the consequences of treatment delays for other health conditions including cancer.

[114] Bambra C, Riordan R, Ford J, et al. The COVID-19 pandemic and health inequalities. J Epidemiol Community Health 2020;74:jech-2020-214401–8. https://jech.bmj.com/content/74/11/964

[115] PHE. Disparities in the risk and outcomes of COVID-19. Aug 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

[116] : Aburto JM, Kashyap R, Schöley J, et al. Estimating the burden of the Covid-19 pandemic on mortality, life expectancy and lifespan inequality in England and Wales. J Epidemiol Community Health Epub ahead of print: doi:10.1136/jech-2020-215505 https://jech.bmj.com/content/75/8/735

Appendix A: Top 10 causes of death and disability by age group[117]

Top 10 causes of death & disability by age group, for both sexes Bournemouth GBD 2019

Rank by number of Disability Adjusted Life Years - DALYs

	All ages	Age 5-14	Age 15-49	Age 50-69	Age 70+
1	Neoplasms	Mental disorders	Mental disorders	Neoplasms	Cardiovascular diseases
2	Cardiovascular diseases	Skin diseases	Musculoskeletal disorders	Cardiovascular diseases	Neoplasms
3	Musculoskeletal disorders	Neurological disorders	Substance use	Musculoskeletal disorders	Chronic respiratory
4	Mental disorders	Other non-communicable	Neurological disorders	Mental disorders	Neurological disorders
5	Neurological disorders	Chronic respiratory	Other non-communicable	Digestive diseases	Musculoskeletal disorders
6	Chronic respiratory	Unintentional injury	Neoplasms	Chronic respiratory	Diabetes & CKD
7	Other non-communicable	Musculoskeletal disorders	Unintentional injury	Diabetes & CKD	Respiratory infections
8	Digestive diseases	Nutritional deficiencies	Self-harm & violence	Other non-communicable	Digestive diseases
9	Diabetes & CKD	Neoplasms	Digestive diseases	Neurological disorders	Unintentional injury
10	Unintentional injury	Respiratory infections	Cardiovascular diseases	Unintentional injury	Other non-communicable

Top 10 causes of death & disability by age group, for both sexes Poole GBD 2019

Rank by number of Disability Adjusted Life Years - DALYs

	All ages	Age 5-14	Age 15-49	Age 50-69	Age 70+
1	Neoplasms	Mental disorders	Mental disorders	Neoplasms	Cardiovascular diseases
2	Cardiovascular diseases	Skin diseases	Musculoskeletal disorders	Musculoskeletal disorders	Neoplasms
3	Musculoskeletal disorders	Neurological disorders	Substance use	Cardiovascular diseases	Chronic respiratory
4	Neurological disorders	Other non-communicable	Other non-communicable	Mental disorders	Neurological disorders
5	Mental disorders	Chronic respiratory	Neurological disorders	Other non-communicable	Musculoskeletal disorders
6	Chronic respiratory	Musculoskeletal disorders	Neoplasms	Diabetes & CKD	Diabetes & CKD
7	Other non-communicable	Unintentional injury	Unintentional injury	Chronic respiratory	Respiratory infections
8	Unintentional injury	Nutritional deficiencies	Digestive diseases	Neurological disorders	Digestive diseases
9	Diabetes & CKD	Neoplasms	Cardiovascular diseases	Digestive diseases	Unintentional injury
10	Digestive diseases	Respiratory infections	Skin diseases	Unintentional injury	Other non-communicable

[117] Global Burden of disease Study 2019