ANNUAL REPORT
of the Director of Public Health
2014/15

Health and Social Inequalities in Somerset

SOMERSET
County Council

Contents

Executive Summary

There are many inequalities throughout society and in Somerset some are even more pronounced, even more difficult to address. We face inequalities in our rural communities, in our school and college results, in employment prospects, in health issues experienced by different groups of the population, all these and many more can have a significant impact on people's lives – especially vulnerable children and adults.

Public sector organisations in Somerset do great work and make a huge difference to people's lives, experiences and prospects – but there is always more to be done. This report makes recommendations about what we can do to refocus some of our work. Some of the obvious priorities include:

- Invest in tackling and preventing inequalities, aiming to improve the health, wellbeing and life chances of those in greatest need first and fastest.
- Solutions lie across the entire public sector and policies should take account of and be designed to narrow the inequalities that exist.
- Focus on early years, aiming to reduce child poverty, increase breastfeeding and ensure every child is ready to start school. To do this we need to provide better information, advice and support for parents, especially young mums.
- Increase focus on adult education to give people the best chance to support their child's education and improve their own prospects.
- Make the most of huge opportunities like the Hinkley C development to boost the local economy and community and transport networks.
- Enable individuals to help themselves. In particular health services need to get the right messages to the people, in an accessible way.
- Good quality affordable housing is an imperative and provision needs to reflect both our ageing population, the needs of young families and the rural nature of the county.
- Infrastructure, in the form of roads, rail, transport, digital and mobile provision needs to help tackle the inequalities throughout the county.

Throughout the public sector there is no doubt that much can be done to reduce inequalities.
Tacking this is a big job. Many inequalities are deep-rooted and need a long term approach. It requires a change of thinking across the sector, focussing foremost on prevention and the needs of the most vulnerable and disadvantaged throughout our county.

Foreword

In Somerset, some people have poorer health and live shorter lives. Some children do not fulfil their potential. Some people live in poor housing. Some people have low paid, unstable jobs. Some people struggle to afford to feed their families…others don't.

We have many inequalities in this county – such as our rural communities and the challenges they face, the differences in educational attainment seen in young people and the multiple health issues experienced by different groups of the population.

Health and social inequalities have a major impact on the lives of vulnerable people in our society. They impact on all areas of life, from social and economic to cultural and political.

This is also where many of the solutions lie – in social, economic and cultural change. We know that inequalities in health arise from inequalities throughout society.

Inequality in access to high-quality healthcare is thought to contribute only 20% of the inequalities in health that we see. The rest of the burden of inequality is due to influences such as education, employment, finance, housing and transport: what are called the 'wider determinants of health'.

It's a tough job and it takes time, but we can influence and change the things that cause inequalities. We have already had some success locally. The gap between male and female life expectancy is closing, locally we have reduced the association between deprivation and teenage pregnancy and notably, over the past couple of years we have also made huge strides in reducing smoking in pregnancy. This is complex work as inequalities are often deep rooted, but the key to any solution is for agencies to work together.

This report aims to:

- ⊡ Increase knowledge and awareness of health and social inequalities in Somerset;
- ⊡ Stimulate and influence activity across organisations to narrow the inequality gaps;
- ⊡ Make recommendations for the coming years.

The issue of inequalities is broad and very complex. This report does not cover everything related to inequalities; it looks at what health and social inequalities are, some of the causes and where we could focus our efforts to narrow the gap. There is also a technical appendix[1] to this report that presents the supporting data on the health status of Somerset residents.

I have written this report to help and encourage partner organisations to meet our combined duties in reducing inequalities and so improve the lives of everyone in Somerset, but especially the most vulnerable people.

Trudi Grant

Only together we can make a difference; only together we can bring about change; only together we can move to a fairer and more equal society.

Introduction

What is inequality?

'Health and social inequalities' is a way of describing differences in life chances between people from different groups. For example, these groups could include those from less advantaged backgrounds, different ethnic groups or different age groups. There will always be variations in life, but some inequalities have a pattern to them and are unjust. In this report we will look at some of the inequalities that exist in Somerset.

What is the relationship between equality and equity?

'Equality' and 'equity' are related but not interchangeable. 'Equity' involves fairness of provision and opportunities, which may mean there needs to be different provision for different groups depending on their needs.

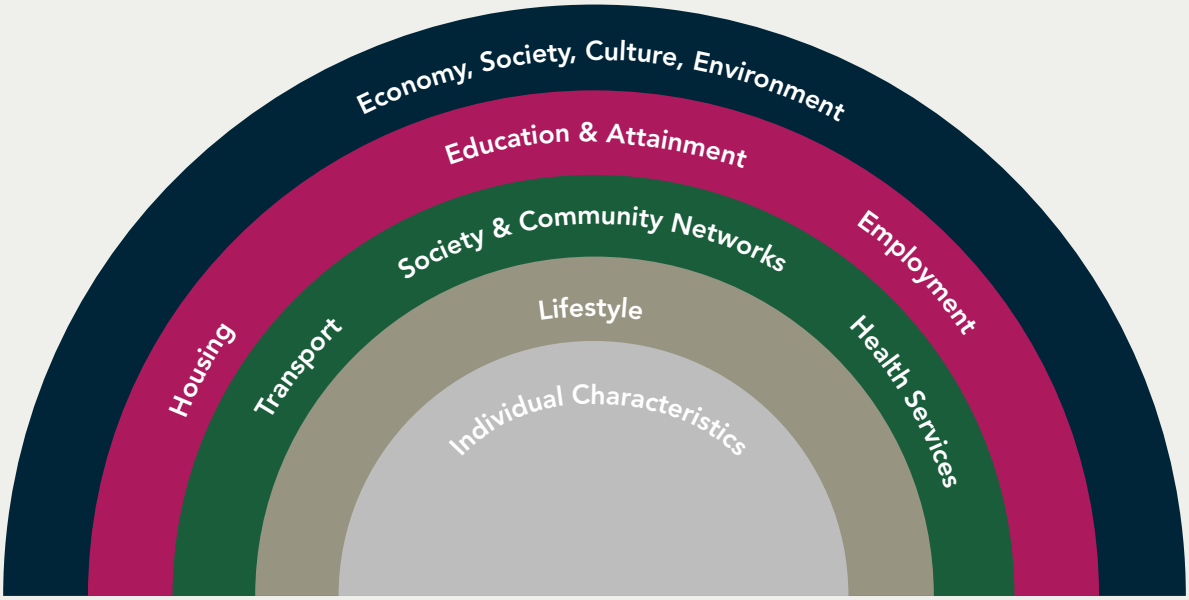
'Equality', in contrast, means that everyone gets the same things. Equal provision may result in inequalities as different groups have different needs and opportunities. The Equality Act (2010)[2] , places specific duties on public bodies to consider how different people who have protected characteristics will be affected by their activities. In addition to the nine protected characteristics[3] covered under the Act, Somerset County Council has adopted a further four locally: rurality, low income, military status and caring.

This report highlights that health and social inequality exists in Somerset and some people experience poorer health and life chances than others. To combat inequalities it may not be enough to just provide equal treatment for all. This is where equity comes in; it may be that a different solution is required for different groups according to their needs.

What causes health and social inequalities?

Our health and social circumstances are influenced by many things; some are more obvious than others. **Figure 1** shows the determinants of health and wellbeing in many layers, much like an onion. At the centre are factors such as age and genetics, which are difficult to influence. Next are individual behaviours such as smoking and physical activity. Third are our wider social networks and the influence of the people around us. Further out are influences such as

Figure 1 **Determinants of health and wellbeing[4]**



healthcare and the wider determinants of health such as housing, education and employment and finally are the wider socioeconomic, cultural and environmental conditions within which we live. The outer layer of the diagram is usually influenced at a national level and therefore will not be considered as part of this report. The inner four layers will, however, be considered in turn and will form the structure of this report.

How do all these influences in health and wellbeing interact?

Often these influences on health and wellbeing on their own will not cause significant inequality. When several of them are experienced at once, however, they can lead to inequalities in outcomes, depending on how resilient people are and the degree of support they have around them. For example, the effects of losing a job, experiencing financial hardship and housing problems may be far more problematic for someone with low self-esteem.

These influences can also cause deprivation for a whole neighbourhood, and the effects are often multiplied if they are combined. This is commonly measured by the 'Index of Multiple Deprivation' (IMD) (Communities and Local Government 2010[5]), which looks at seven domains:

- Income
- Work
- Health
- Crime
- Education
- Housing
- Living Environment

Neighbourhood deprivation is often grouped into five bands or quintiles, allowing comparisons to be made between different levels. Analysis based on the IMD appears later in this report.

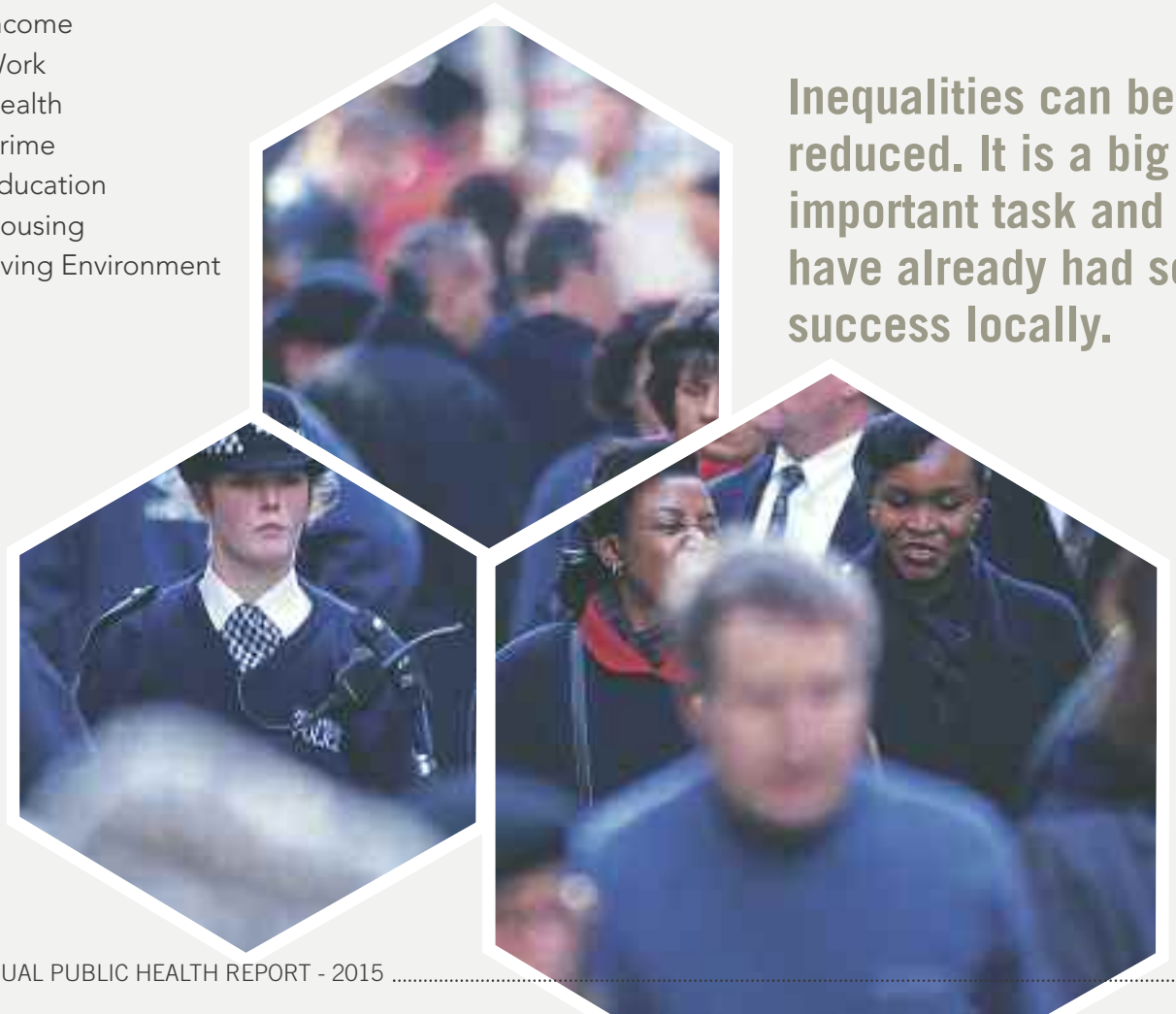
IMD scores measure deprivation in communities. It should be noted that not every person who lives in a deprived area is deprived, and the least deprived neighbourhood may not be the most prosperous.

Can inequalities be narrowed?

Inequalities can be reduced. It is a big but important task and we have already had some success locally. Overall life expectancy at birth has been improving year on year in Somerset, and currently stands at 80 for a man and 84 for a woman, but the gap between males and females has narrowed. Since 2006-8 life expectancy has increased by 12 months for women, and 18 months for men.

Why should we narrow inequalities?

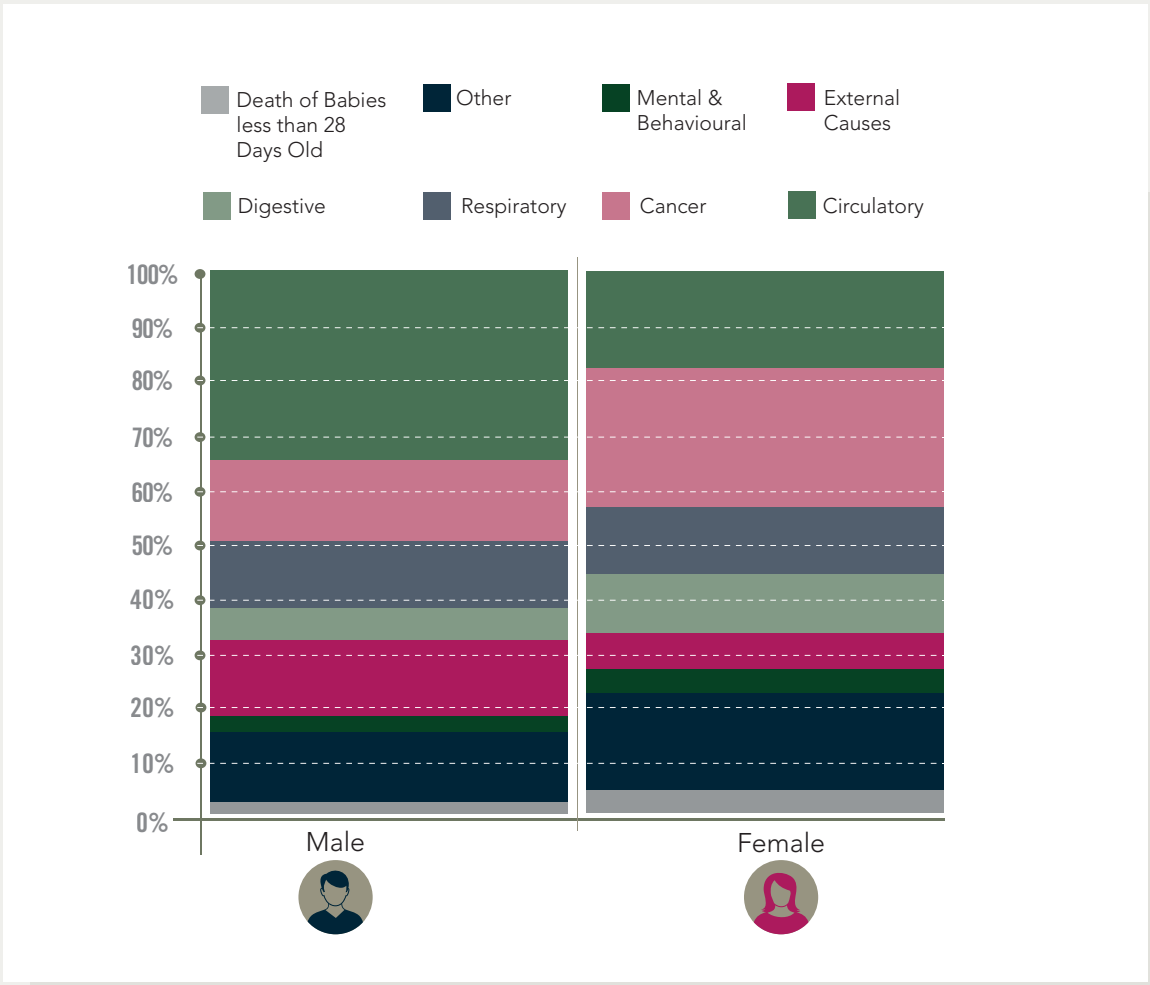
Social inequalities often lead to manifest health inequalities, including lower life expectancy and poorer quality of life. In financial terms, inequalities in health alone cost the English taxpayer between £56 and £60.5 billion a year[6]. This includes the NHS and social care costs; however, most cost is in reduced productivity and higher welfare payments.



Inequalities can be reduced. It is a big but important task and we have already had some success locally.

Figure 2 shows the health conditions that are driving the inequality in life expectancy in Somerset. Premature deaths from coronary heart disease, chronic obstructive pulmonary disease and diabetes, for example, are more than two or three times higher in individuals living in our most deprived communities than in our least deprived. Fortunately, these conditions can, for the most part, be prevented – offering a real opportunity to reduce health inequalities.

Figure 2 **'Scarf Chart' showing the breakdown of the life expectancy gap between Somerset's most and least deprived quintile by broad cause of death 2010-12[7]**



Section 1

Individual characteristics

Genetics and personal characteristics

Genetics can have a huge impact on those with an inherited disease but for most the impact of genetics on inequalities is more subtle. The personal characteristics an individual has are partly determined by genetics and partly by their environment. The extent to which the environment may override genetics is hotly debated. Personal characteristics contribute significantly to health and wellbeing and influence our ability to 'bounce back' from stress and have more control over our behaviours and lifestyle.

We all have setbacks, but our ability to cope determines how big an impact these setbacks have on us, often called our 'personal resilience'. For example, people with mental health problems or a learning or physical disability can experience lower personal resilience; often issues that arise in their lives can have a more significant impact[8].

Some examples of the inequalities that are experienced by people at increased risk of low personal resilience are:

- Approximately 70% of people with psychotic disorders are economically inactive
- People with depression experience higher work absences, premature retirement and long-term unemployment[9]
- People with learning disabilities die younger than the general population. Based on the 2008-11 period, the median age of death for people with learning disabilities in Somerset is 61
- The Somerset economic activity rate for people with a disability (2015) was 65.6%, compared to 82.4% for the general population
- LGB and Transgender young people are more likely to experience adverse mental health and emotional wellbeing outcomes than their peers in the general population
- Somerset County Council has estimated that about 400 benefit claimants in receipt of Employment Support Allowance (ESA), Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) have a primary disabling condition of alcohol misuse[10]

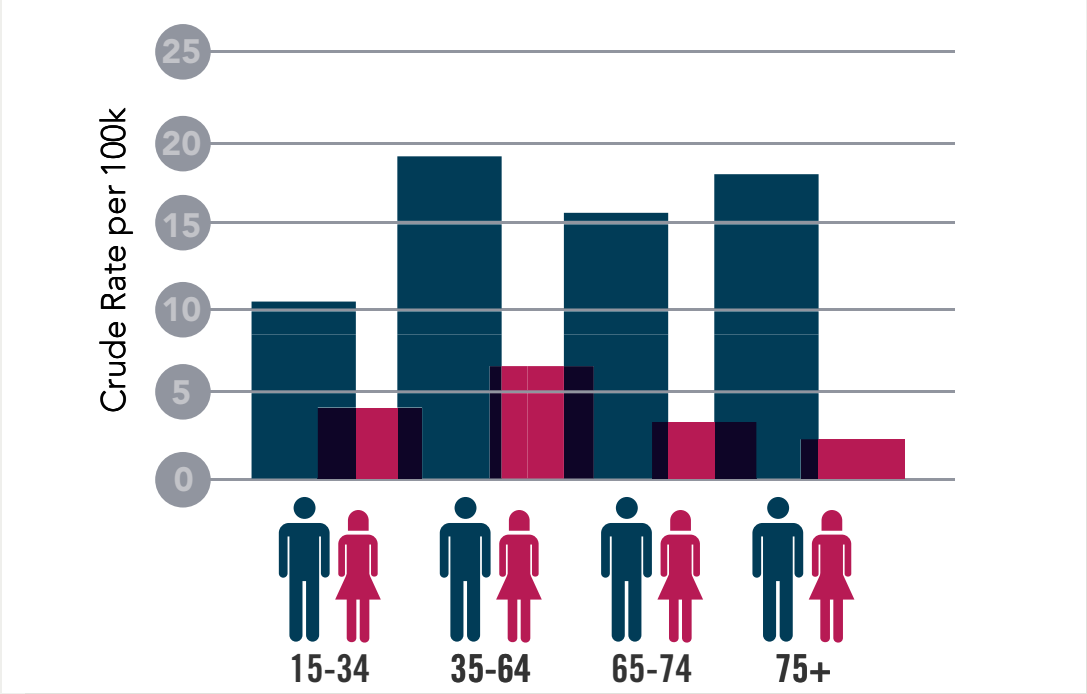
Gender

Many of the gaps between life chances for males and females still exist in our society, but they are narrowing. The significant difference in life expectancy in Somerset between males and females has already been mentioned. Some other examples of gender inequalities that exist in Somerset include:

- As nationally, there is a considerable disparity between average male weekly earnings (£536) and female earnings (£398), only partly explained by a greater likelihood of women working part-time
- Most homeless people are single men[11]
- Suicide is significantly higher in males than females in Somerset across all ages (**see Figure 3**)

Figure 3

Rates of mortality from suicide and undetermined death in Somerset for males and females aged 15 and over by age band, per 100,000 for the period 2010 - 2012[12]



Age

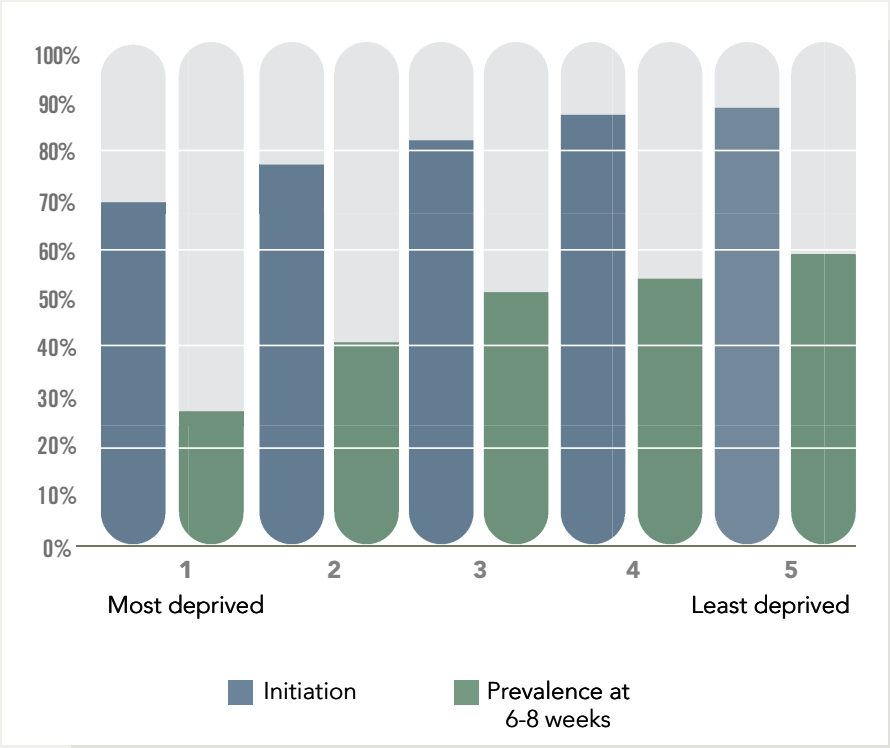
Early life strongly affects later health and wellbeing. Babies are affected by the circumstances of their conception and birth; low birth weight babies (<2500g/5lb 8oz) tend to have poorer health in later life. Low birth weight is more common in people living in more deprived conditions. In Somerset, 7.3% of babies in the most deprived areas had low birth weight, compared to only 5.1% in the least deprived.

Birth to two years of age is a time of rapid development, influenced by relationships and experiences. High quality stimulation between the ages of one and two can have a significant impact[13]. For some, development is hindered by parental difficulties. Parents living with poverty, substance misuse, domestic violence and mental health problems may not be in a position to respond as well to the needs of their children[14].

Breastfeeding helps babies and mothers both physically and mentally. **Figure 4** shows that mothers in more deprived areas of Somerset are less likely to start breastfeeding. This pattern is even more pronounced when looking at those continuing to breastfeed at 6-8 weeks following birth. Support networks and education are especially important; mothers with good support are more likely to breastfeed, and for longer (UNICEF, 2013).

Figure 4

Breastfeeding (exclusive or partial) status by deprivation quintile in Somerset



Somerset is a predominately rural county and one which is experiencing significant change in the age profile of its residents. In 2012, 22% of the population was over the age of 65 years; by 2037 this is expected to rise to 32%. The most recent Somerset Joint Strategic Needs Assessment (JSNA)[15] identified that the age profile is not distributed evenly; there are far more people over the age of 65 years living in rural Somerset. This has implications for inequalities in access to services for older people, particularly those without access to a car.

Breastfeeding helps babies and mothers both physically and mentally.

Section 2

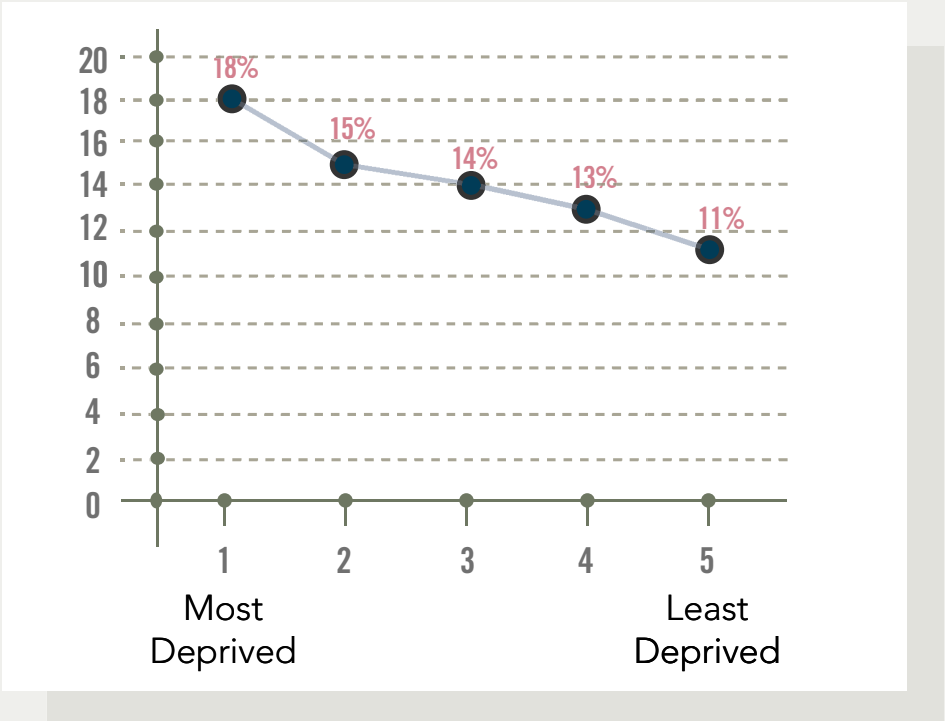
Lifestyle

The way we live our lives has changed over the last century and this has contributed significantly to the increase in major diseases such as heart disease, stroke and cancer. However, the patterns of behaviour are not consistent throughout the population. The lifestyle choices we make are often related to how we have been brought up through childhood, the behaviours of other people around us, the environment we live in and the control we feel we have over our lives. This section highlights some of the main lifestyle choices we make and some of the inequalities relating to them.

Smoking

Smoking rates have reduced significantly in Somerset but it still remains the largest cause of preventable premature death in Somerset, killing about 875 people a year and being the main cause of long-term health problems for many more. One in two smokers dies on average 10 years earlier than the general population. **Figure 5** shows a strong relationship between deprivation and smoking.

Figure 5 **Smoking prevalence by deprivation (GP practices in Somerset 2014)**



Those in routine and manual households are more likely to have started smoking before they were 16 than those in professional households (45% compared to 31%) and unemployed people (39%) are nearly twice as likely to smoke as those in employment (21%). For almost all social classes, smoking rates are higher in men than women.

Smoking is thought to cause about half the health inequality seen between our least and most deprived communities. Life expectancy of a 'never smoker' living in a more deprived area is higher than a 'lifelong smoker' from the wealthiest area. Cohabiters are most likely to smoke (33%) and the married least likely (14%)[16].

Services to provide support to people wishing to stop smoking are available to everyone but have been focused on areas and groups of the population with highest rates of smoking.

Alcohol

Regularly drinking more than the recommended levels of alcohol increases the risk of liver problems, reduced fertility, high blood pressure, various cancers[17] and heart attacks. Even three units a day (the amount in a pint of premium lager) can increase the risk. People who both smoke and drink alcohol to excess are much more likely to get cancer, because the substances act together to multiply damage to cells.

At least 13,000 of Somerset's working age people are dependent drinkers, which has an impact, not only on their health, but also many aspects of their lives, including their family relationships, finances and ability to undertake and retain employment.

The relationship between deprivation and alcohol is complex. Alcohol does not show the simple association with deprivation evident in other harmful behaviours[18]. Nationally, non-drinking is highest in deprived groups and lowest in the least deprived and there are high rates of harmful drinking amongst students and professionals. The impact of harmful drinking levels in Somerset is seen in hospital admissions related to alcohol, where figures show the highest rates in people living in more deprived areas.

Diet

Diet accounts for nearly 10% of all cancers, through a lack of fruit, vegetables and fibre and too much red or processed meat and salt. Eating at least five portions of fruit and vegetables a day reduces the risk of some cancers and helps to maintain a healthy body weight. The last Somerset Lifestyle Survey (2009) showed that 53% of people living in the most deprived communities consumed 'five a day', compared to 60% or more elsewhere in the county (it should be noted that these are self-reported figures). The survey also found inequality in the use of salt during cooking or being added to meals, with salt usage being 41% for people living in the least deprived areas and 49% in the most.

In Somerset, 23% of children in reception year were overweight or obese (England average of 22.5%). In Year 6 the proportion was 31%, (England average 33.5%). Being overweight can lead to low self-esteem and depression, as well as Type 2 diabetes, heart disease, stroke and some cancers. Levels of these diseases show a consistent inequality, being worse for those living in the most deprived area[19] .

Food poverty is the inability to afford, or to have access to, a healthy diet. It is about the quality of food as well as the quantity. People most likely to experience food poverty are those who are on low incomes, unemployed, households with dependent children, older people, people with disabilities and members of ethnic minority communities[20].

Food banks across Somerset have seen increased use in the year to 2014/15. The Trussell Trust had a 24% increase, to an annual figure of 6,638 food parcels; the West Somerset Food Cupboard reported a 31% increase in parcels to 1,504; Wells Storehouse distributed 113 food parcels compared to 93 in the previous year. The Lord's Larder in South Somerset saw a rise in the number of families receiving food from 636 to 708[10].

Food choice is strongly related to cost. Cost encourages people to consume cheaper, energy-dense food (such as fast food). Research has also found a link between obesity levels and availability of fast food outlets in deprived communities, as well as a lack of confidence and poor cooking skills which contribute to lower fruit and vegetable intake[21].

Physical activity

Our bodies are designed to move and stay active. Regular exercise helps protect against many conditions such as cancers and heart disease, but importantly it helps maintain our ability to function in everyday life and maintain our independence. It also helps to maintain our mental health; inactive people are approximately three times more likely to experience moderate to severe depression than active people.

Like many of the other lifestyle behaviours, there are inequalities in physical activity participation. People living in the most affluent areas are more likely to take regular activity but this becomes progressively less for those living in the more deprived areas[6].
There are also gender and age inequalities relating to physical activity levels, with men and younger people being far more likely to be active.

Overall in Somerset, 76% of adults do not do 30 minutes of physical activity three times a week[22]. Given the importance of activity for our physical, mental and social health and wellbeing, this is a significant lifestyle risk for the vast majority of our population.

Clusters of behaviours

Few people have just one lifestyle risk. Men living in deprived areas with lower levels of education are more likely to show multiple lifestyle risks than other groups[23]. Research has found that nationally, the proportion of people with at least three lifestyle risks fell from 33% in 2003 to 25% in 2008[24]. However, reductions were seen mainly among those with higher education; those with no qualifications were five times more likely to engage in multiple unhealthy behaviours, thereby suggesting that the inequalities gap is increasing rather than reducing.

The NHS Health Checks programme offers people a chance to discuss their health and lifestyles with a trained professional. To date, 14% of people who have had a health check through this programme have been identified as having a high risk of developing cardiovascular disease in the next 10 years. Those with the highest lifestyle risks benefit the most from the NHS Health Checks programme. Unfortunately, they are less likely to take up the offer, making it an example of the 'inverse care law'[25] - underuse of health services by those in greatest need. The availability of where and when health checks are offered is being increased, which will make them more accessible to those groups who are currently underusing the service.

The impact of our lifestyles on our health and wellbeing is clear, but so are the inequalities. People experiencing multiple problems such as poverty, poor housing, unemployment, mental health issues and so on, are less likely to feel that they have enough control in their lives to make healthier choices. Making healthier choices the easier choices by influencing the environment around us, as well as ensuring people have the knowledge and skills to live a healthier life on a low budget, is key.

The final point to note here is that there is strong evidence that the lifestyles we lead as children and the behaviours of the adults around us influence our lifestyles in adult life. We need to focus our efforts on children but remember the influences that adults have.

Food banks across Somerset have seen increased use in the year to 2014/15.

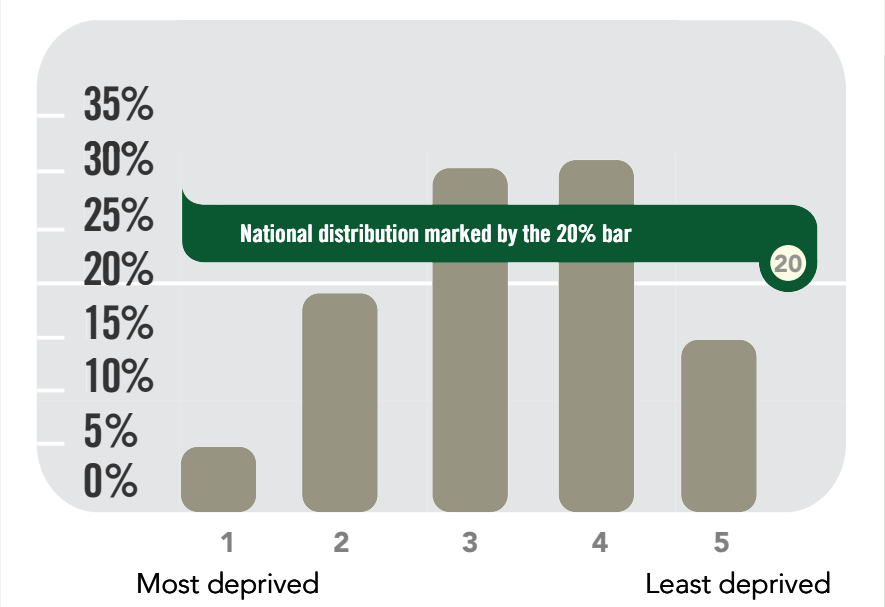
Section 3

Society and community networks

Community level inequalities are usually measured by the Index of Multiple Deprivation. Many deprived areas (often measured in Lower Super Output Areas (LSOAs) which contain approximately 1,500 people) are in towns, where income and employment levels are relatively low. However, rural areas such as Exmoor also show high deprivation, driven by high scores for the 'Barriers to Housing and Services' domain, the part of the Index that considers physical distances to schools, shops and GP practices, distinguishing urban and rural deprivation.

The comparison between deprivation in Somerset and nationally can be seen in **Figure 6**. Somerset shows low levels of deprivation overall compared to the national picture. It has fewer of the most affluent LSOAs but also fewer of the most deprived LSOAs. Somerset has 13 LSOAs amongst the most deprived 20% in the country.

Figure 6 **Distribution of Somerset LSOAs according to national quintiles[5]. (National distribution marked by the 20% bar)**



Social connections

Being lonely is harmful to health. Poor social connections are thought to be as damaging to health and wellbeing as smoking 15 cigarettes a day. Lack of social support produces long term physiological damage through the impact of stress hormones, poorer immune function and poorer cardiovascular health. Positive social networks also help individuals recover when they do fall ill[26].

'Connectedness' can take many forms - being in a group, taking part in activities, the people we meet day to day or online connections. Having friends who matter to us is more important in warding off loneliness than frequent contact[27]. We know that older people are more likely to be lonely and evidence from the JSNA[15] suggests this is worse for women in rural areas. Also at greater risk are those with poor health or disability, from a minority group, on a low income, living alone, in high crime areas or with high levels of material deprivation.

Social *support* is about having people we feel we can turn to for practical or emotional help. Nationally, people in more deprived areas report 50% less social support than those in the less deprived. The Somerset Lifestyle Survey in 2009 found that 22% of people reported having a severe lack of social support, but it did not show any significant relationship with deprivation.

Violence and feeling unsafe can constrain people's day to day activities and abuse can lead to withdrawal from social contact. Community safety and sexual and domestic violence programmes help create a safe environment where communities can flourish; they provide a lifeline to people at risk of falling into depression, ill health and isolation.

Volunteering

The degree to which a community is joined up and resilient depends on the strength of connections between people in the community. High levels of volunteering are key to joining up the community, often termed 'community cohesion'. The real fabric of communities lies within the informal networks between people and the degree to which people know each other sufficiently well to provide support and help to each other when it's needed.

Volunteering offers a good social return; every £1 spent on volunteering programmes is thought to result in a £4 - £10 return of social benefit[28]. A range of studies show how volunteering can reduce depression and lead to healthier lifestyles, including helping the unemployed back into work[29].

Unfortunately, even volunteering demonstrates inequality; research has shown that managers and professional groups are far more likely to volunteer, compared to people in more manual and routine occupations (37% compared to 21%)[30].

Digital connectivity

We are living in a digital age and more and more of our connections and services are online. Somerset has suffered from relatively poor broadband speeds in the past, especially in rural areas. In 2013, only 21% of premises had superfast broadband compared to 65% across the UK[31].

Connecting Devon and Somerset (CDS) aims to deliver superfast fibre broadband to at least 90% of premises by the end of 2016. The JSNA[15] highlighted that poor internet connectivity was a source of dissatisfaction for people of all ages in rural areas and young people were very dependent on the mobile phone signal, which is often poor in the countryside. To date, the CDS programme has delivered fibre broadband access to over 140,000 properties, through the deployment of over 600 new fibre broadband cabinets and the county continues to strive towards still greater coverage.

Violence and feeling unsafe can constrain people's day to day activities and abuse can lead to withdrawal from social contact.

Section 4

Education and attainment

School readiness

Children's physical, social, and cognitive development during their early years strongly influences their school-readiness, educational attainment, work and health. Good birth weight, being read to every day and having a regular bed time at age three all help a child to do well in school. These interventions have been found to be strongly associated with parental income and education and account for much of the difference in attainment between higher and lower achievers. Health visitors' checks at about two and a half years of age are an opportunity to monitor such factors and provide additional support and information to parents who need it. Inequalities in development emerge in early childhood and tend to increase as children get older[32].

Poverty has also been found to shape child development. Before reaching his or her second birthday, a child from a poorer family is already more likely to show lower attainment than a better-off child. High quality early years provision helps all children, but particularly those from more disadvantaged backgrounds. Under the current national definition, it is thought that 3,105 children in Somerset currently live in poverty[33]. A focus on addressing child poverty is key to breaking the cycle of deprivation and raising educational attainment.

The proportion of pupils achieving a good level of development at the Early Years Foundation Stage increased in Somerset from 57% in 2011 to 63% in 2012, but lags behind the national average of 64% and similar counties (64%). The most deprived areas in Somerset have only 54% of pupils achieving a good level of development at Foundation Stage[34] .

School education

This pattern of poorer educational attainment can be seen throughout school life. By GCSE stage the link between poorer educational outcomes and living in a more deprived area is even more pronounced, perhaps due also to other factors such as exclusion and teenage pregnancy, which are higher in the most deprived areas.

Figure 7 **Percentage of Somerset children not achieving five good GCSEs 2014**

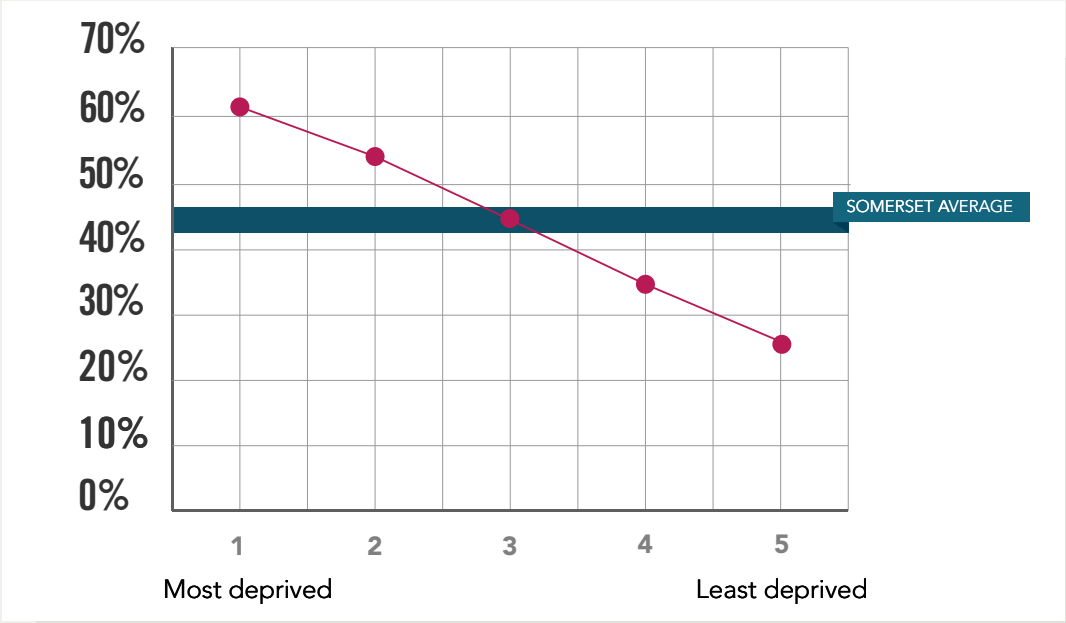


Figure 7 shows that children living in the most deprived areas in Somerset are more than twice as likely not to achieve five good GCSE grades as the least deprived, even three years after the introduction of the 'pupil premium', intended to reduce such disparity. Importantly, looked-after children do even less well, with only 19% achieving five good GCSE grades compared to 37% nationally (2012). Pupils from more deprived areas, or the 11% who received free school meals, showed:

- Lower than average attainment at the end of the Early Years Foundation Stage and Key Stages 1, 2 and 4
- The highest early achievers from more deprived areas are overtaken by lower achieving children from advantaged backgrounds by the age of 7
- Pupils from a more affluent area are more than twice as likely to go to university than the children from more disadvantaged areas
- 53% of children from Gypsy and Traveller backgrounds achieved Key Stage 2 English and maths, compared to 80% overall
- 47% of children with Special Educational Needs (SEN) achieved five or more good GCSEs, compared to 88% of non-SEN pupils[34]

The gap in educational attainment is a complex problem which requires a sustained and concerted effort. Central to reducing the gap is starting early; supporting children's skills when very young will mean they are ready to learn when they enter school and are not already playing catch up.

Just as we cannot hope to reduce health and social inequalities through health services, we cannot radically reduce educational inequalities just by intervening in schools. It is thought that schools explain only a minority of the variation highlighted above; family, community and social factors are key to both education and health[35].

Education brings many advantages and can help reduce social and health inequalities. **Education is not just about attainment of qualifications; it should also enable children to fulfil their aspirations and develop their personalities, talents and abilities, to build resilience, self-esteem and to live a full and satisfying life.**

'Family focus' is the Somerset part of the national 'troubled families' programme which has been in place since 2012. The 2,970 families in Somerset who are eligible for targeted support show high unemployment, anti-social or offending behaviour and children who have a high number of exclusions and/or unauthorised absences from school. This scheme seeks to encourage the many services such as police, health, schools and housing to work together from the families' perspective to improve outcomes for children and young people. In doing so, a broad range of harmful influences on children's health and attainment is addressed. This programme is now showing real results, helping members of households into continuous employment, supporting young people away from crime and anti-social behaviour and gaining positive outcomes in education. Family focus now sits within the GetSet early help programme, preventing 'low level' domestic problems becoming more serious.

Adult education

Adult learning has direct and indirect links with health and wellbeing; for example, by increasing employability. The most deprived people benefit most from adult learning, but are also the least likely to participate. This can be because of high cost or lack of confidence, availability or access.

In the UK, those with a low level of educational attainment are almost five times as likely to be in poverty as those with a high level of education. The 2011 Census suggests that the Somerset proportion of the population without qualifications is almost equal to the national average (22.4% compared to 22.5% respectively). Within Somerset there is an inequality between the urban and rural areas, with a higher proportion of people without qualifications in urban areas at 24%, compared to 20% in villages and hamlets[36]. People with limited English or poor literacy have been found to have a higher prevalence of diabetes and particular difficulties of access to treatment services[37].

Section 5

Employment

Work is generally good for both physical and mental health and wellbeing[38], but a distinction is made between the quality of work with 'good work' being healthy, safe and importantly offering the individual influence on how it is undertaken.

Poor health can result from work when:

- Employment is insecure
- The work is monotonous
- Workers have little autonomy
- Workers feel 'taken for granted'
- There are few supportive social networks
- Workers do not feel sure their employer will treat them fairly

Unsurprisingly, unemployment has been linked with worse health and wellbeing, including higher risks of cardiovascular disease, poor mental health, suicide and higher levels of smoking. People who are unemployed show a 20-25% higher death rate over a ten year period than employed people with equivalent occupations[39].

Age and disability can reduce the opportunity to work. Older people in disadvantaged groups face particular difficulties finding and keeping jobs as they are less likely to have built up skills and are more likely to be experiencing health problems. Changes to benefits and pensions will, however, mean we will have to work for longer. Somerset has an older and ageing population structure, so good quality employment for older people will be even more essential in the future to help maintain independence and health and wellbeing.

Disadvantaged groups are at higher risk of unemployment. People with a disability have far lower employment rates than other groups, exacerbating inequalities and contributing to further deterioration in health. People with mental health issues were found to have employment rates over 10 percentage points lower than the general population[40] .

Somerset unemployment rates are, at 4.4%, lower than the national rate of 6.0%. The county has lower average earnings than the England figure of £26,500. Mendip has the highest median earnings in the county (£26,506) and West Somerset the lowest (£20,629). Rural jobs often have low wages and can be insecure, with higher seasonal employment.

Town dwellers are more likely to be in administration or elementary occupations (jobs which involve mostly routine tasks and a degree of physical effort) and rural areas have a greater proportion in professional or managerial or technical roles. This apparent contradiction is explained by higher earners in rural areas commuting to towns or working remotely. Self-employment in rural areas is substantially higher than urban areas (33% compared to 19% respectively)[31].

Significant numbers of Somerset residents (25,000) are thought to be 'underemployed', wanting to work longer hours[31]. Unstable employment includes 'zero hours contracts'. The average weekly earnings for zero-hours workers are £188, compared to £479 for permanent contracts[41]. Zero-hours workers are five times more likely not to qualify for statutory sick pay.

Hinkley C Development

The largest current inward investment programme in Somerset is Hinkley C nuclear power station. **During the peak construction phase it is estimated that 5,600 jobs will be generated, with the aim that 30% - 40% of workers will currently living in the area and recruited locally.** Achieving this presents challenges and opportunities for raising local skill levels and providing the right type of quality local employment. This will include targeted 'back to work' support for disadvantaged communities in local community centres, together with action for young people to promote training and development opportunities to maintain social cohesion. It is predicted that there will be 900 direct full time equivalent (FTE) jobs from the on-going activities once the plant becomes operational from 2019, 700 of which would be permanent and 200 of which would be contract staff.

Section 6

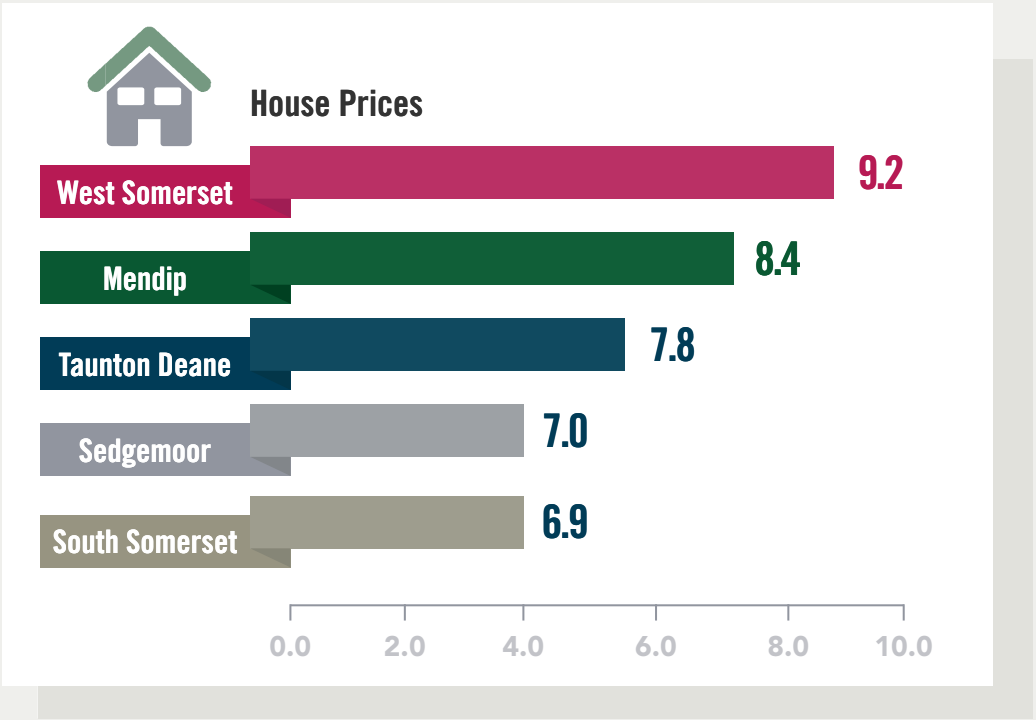
Housing

Housing and health are intrinsically linked. Poor, unsuitable and unaffordable housing and precarious living circumstances affect our physical and mental health as well as our ability to function in normal everyday activities. Older people, children, disabled people and those with long-term illnesses are at particular risk.

Affordable housing is one of Somerset's biggest challenges. The county is one of the less affordable areas in England and Wales, with homes costing up to nine times an individual's salary. **Figure 8** shows the relationship between the average of the lowest quarter of wages and the lowest quarter house prices. These high ratios make it very difficult for people on a low income to buy a property or move into the area for employment. Reassuringly, all Somerset districts have met or exceeded their targets for affordable housing in the last five years[42]. The targets may not be high enough, though, to meet demand on the ground.

Figure 8

Ratio of lower quartile house prices to lower quartile earnings, Somerset districts, 2013[42]



In Somerset from 2012/13 to 2013/14 there was an almost three-fold increase in households receiving extra help with housing costs through Discretionary Housing Payments (DHP). These are grants that district councils can make to people who are already receiving housing benefit for some of their rent but still find it difficult to keep up payments, perhaps because of policy changes such as the withdrawal of the spare room subsidy.

Housing quality and fuel poverty

Cold housing harms health in various ways. Children living in cold homes are more than twice as likely to suffer from respiratory problems, including asthma, than those in warm homes. In Somerset, around 31,000 dwellings (16%) have particularly poor energy efficiency (Category 1 under the Housing Health and Safety Rating System) – this is well above the England average of 12%.

More than one in four adolescents in cold housing are at risk of multiple mental health problems, compared to one in twenty of those who have always lived in warm housing. Cold housing increases minor illnesses such as colds and flu and exacerbates conditions such as arthritis and rheumatism, with a greater impact on older people[43].

Housing quality is measured by the Decent Homes Standard. Research by Building Research Establishment in 2007 suggested that around 40% of private sector stock in Somerset would fail to meet the standard. The number of non-decent homes in the private sector has grown for three reasons. Housing stock is ageing; so is the population, meaning that dwellings may become less appropriate, and landlords have not invested because of poor economic conditions.

Homeless people have particularly poor health. Somerset has approximately 50 rough sleepers, overwhelmingly in Taunton Deane and Mendip. Whilst small in number, they are especially vulnerable[44], with life expectancy estimated as being 30 years shorter than that of someone in housing, because of the associated risks including accidents, infection, substance abuse and suicide[45].

Homeless people have particularly poor health. Somerset has approximately 50 rough sleepers.

Section 7

Transport

Around two-thirds of car journeys in towns like Taunton and Bridgwater start and end within the town. More than half of car journeys are under two miles. The vast majority of journeys in Somerset are by car and the travel system has largely been designed over the years for car travel. Unfortunately, high car usage hampers the reliability and viability of public transport. For those without a car, especially in rural areas, this restricts access to services, entertainment and social life, a key aspect of rural deprivation.

High car usage has also been found to lead to congestion, loss of community freedom for children as parents fear traffic, pollution, increased death and serious injuries on the roads. This disproportionately affects children and young people, older people and those with a disability. Children in the 10% most deprived wards in England are 4 times more likely to be involved in a road accident than children in the 10 % least deprived wards[46]. Active transport such as walking or cycling can benefit individuals' health, finance and satisfaction with the environment.

The Somerset population is very inactive: only a quarter are active enough to benefit their health. A quarter of us are obese and two-thirds overweight or obese. In Somerset, very few children cycle to school, but around a third say they would like to. The Dutch have shown that people of all ages and abilities will choose to walk and cycle if provided with the right infrastructure. Cycling also reduces congestion, air pollution, road damage and the pressure on health services.

Figure 9 **Travel to work (selected modes and occupations)[36]**

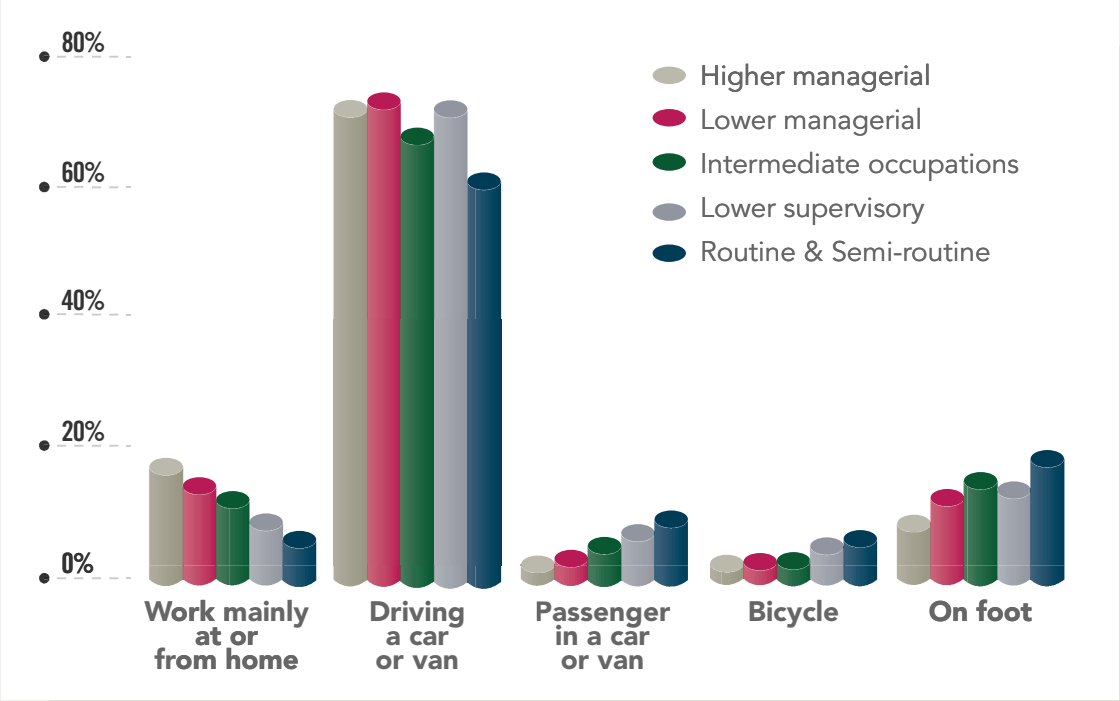


Figure 9 shows that more than half of people in all groups drive to work, but on a positive note, active travel was highest in routine and semi routine occupations, partly offsetting other health risks. No children died on Somerset's roads in 2012 or 2013, but 75% of the young people killed or seriously injured were in rural areas, reflecting the dangers of rural roads. Somerset's rurality also leads to difficulties in access to services and increased financial pressures. In parts of Exmoor, households can be 40 minutes by public transport (where available) from their nearest food store and 50 minutes from a GP surgery. Travel is not only an expense in itself, but makes 'shopping around' harder and can make complying with benefit claim conditions, such as signing on, difficult.

The Local Sustainable Transport Fund 'Smart Rural Travel' is designed to test innovative solutions to the twin challenges of decreasing public sector funding and the unsustainable current model of rural public transport provision by:

1. **Improving** knowledge of the potential passenger transport market
2. **Improving** public transport offer and choice to customers
3. **Stimulating** additional demand for passenger transport
4. **Achieving** commercial viability for currently subsidised services
5. **Improving** access to and information on transport services
6. **Improving** coordination between transport providers

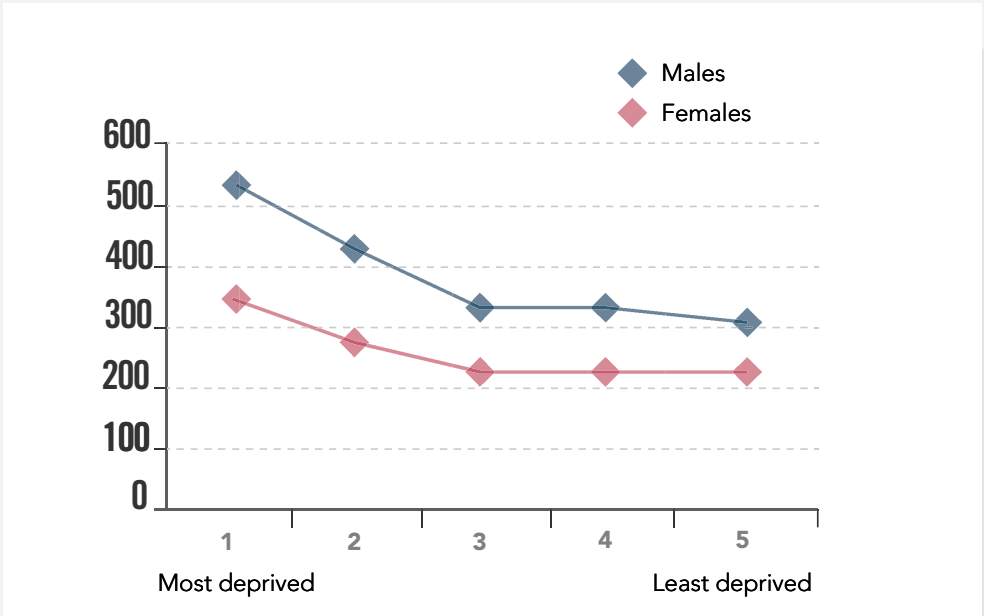
Travel is not only an expense in itself, but makes 'shopping around' harder.

Section 8

Health and care services

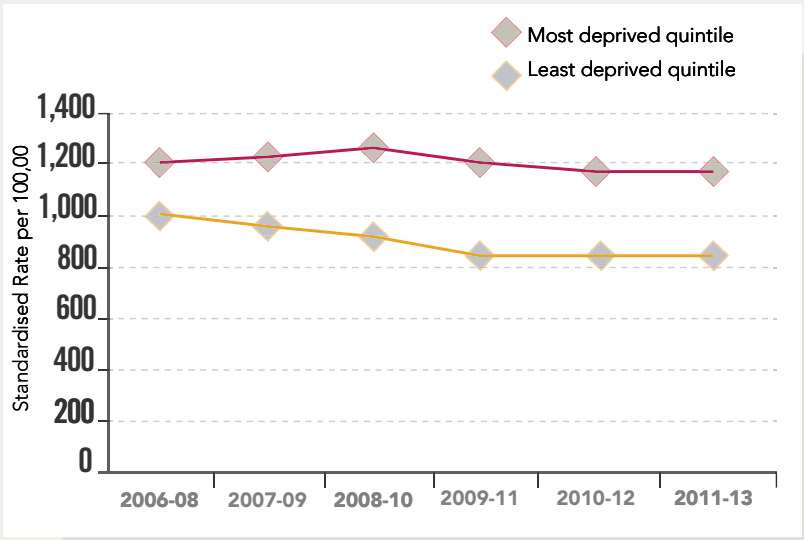
Health inequalities account for £5.5 billion of national NHS spend[6] but only 10% of inequality is thought to be due to clinical care[47]. This section considers the inequalities in health, health and social care service use and patterns that could contribute to inequalities in Somerset. It uses the IMD[5] to assign people to quintiles of deprivation based on the communities in which they live. Understanding the patterns better, for instance through clinical audit, can help make the services more effective and focus attention on improving access and take up for the groups that need them most. The life expectancy gap between the most deprived fifth of Somerset's communities and the least deprived is five years for men and three years for women. Just over 80% of life was in 'good health'. **Figure 10** shows the rate of premature deaths (under the age of 75 years) in Somerset for men and women. There is a statistically significant difference between males and females. Men and women have a similar pattern of premature deaths across the five quintiles; however, the rate is significantly higher in men - in the most deprived quintile it is almost 60% higher than for women. Men in the most deprived areas are 1.8 times more likely to die before the age of 75 than men in the least deprived. Overall, there are 70% more premature deaths in the most deprived quintile compared to the least deprived, after taking into account differences in age and gender.

Figure 10 **Somerset premature deaths by deprivation quintile – All Causes 2006-13[48]**



As seen in **Figure 11**, however, the gap in death rates between the most and least deprived parts of Somerset has widened in recent years, not narrowed. This is cause for significant concern as both local authorities and NHS organisations have a statutory duty to reduce inequalities. As can be seen from **Figure 11,** the widening is due to a faster lowering of death rates in the more affluent areas, whilst death rates in more deprived areas have remained relatively constant. This data would suggest that the health and wellbeing of people living in more deprived areas is getting relatively poorer than the more affluent areas. More needs to be done to focus the efforts of all organisations on improving the lives of people most in need.

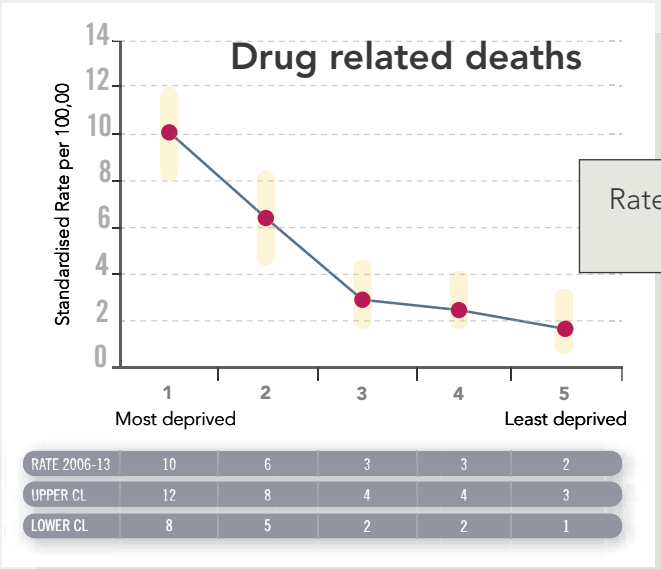
Figure 11 **Standardised Death Rates (all ages)**[48]



Higher rates of ill health in people living in Somerset's more deprived areas can be seen for most health conditions; it is not due to chance. **Figure 12** shows a series of graphs illustrating similar patterns for a number of the major disease areas. (There are a few notable exceptions, such as prostate and breast cancer which do not show a significant trend).

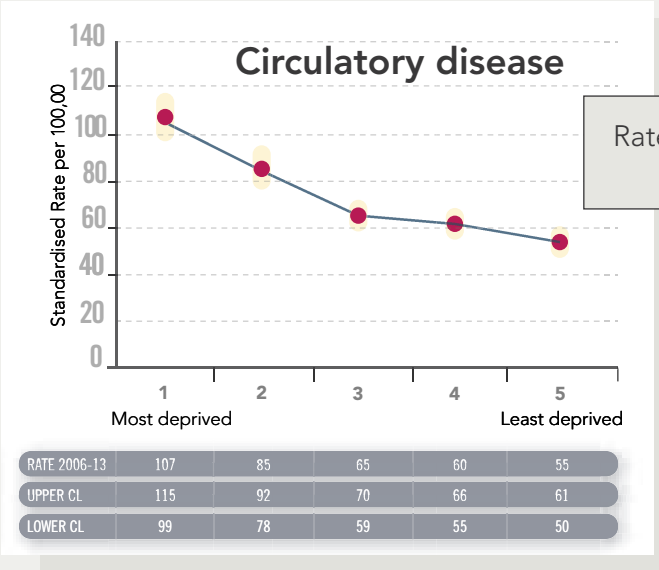
Figure 12

Somerset premature deaths by deprivation quintile: Deaths 2006-13[48]



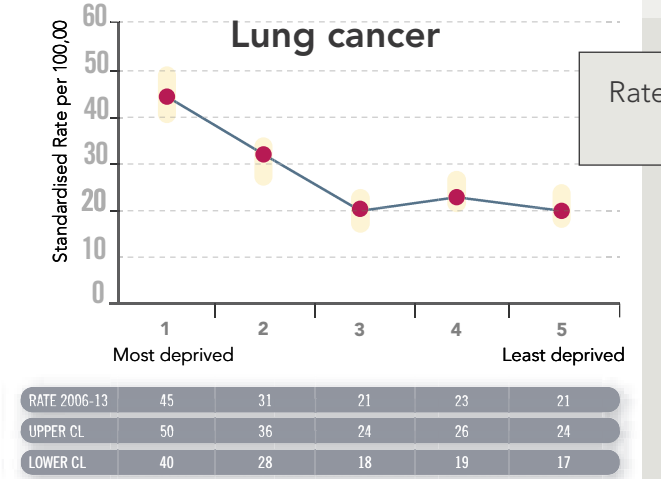
RATE 2006-13	10	6	3	3	2
UPPER CL	12	8	4	4	3
LOWER CL	8	5	2	2	1

Rate in most deprived quintile/rate in least deprived quintile = 5.9



RATE 2006-13	107	85	65	60	55
UPPER CL	115	92	70	66	61
LOWER CL	99	78	59	55	50

Rate in most deprived quintile/rate in least deprived quintile = 1.9

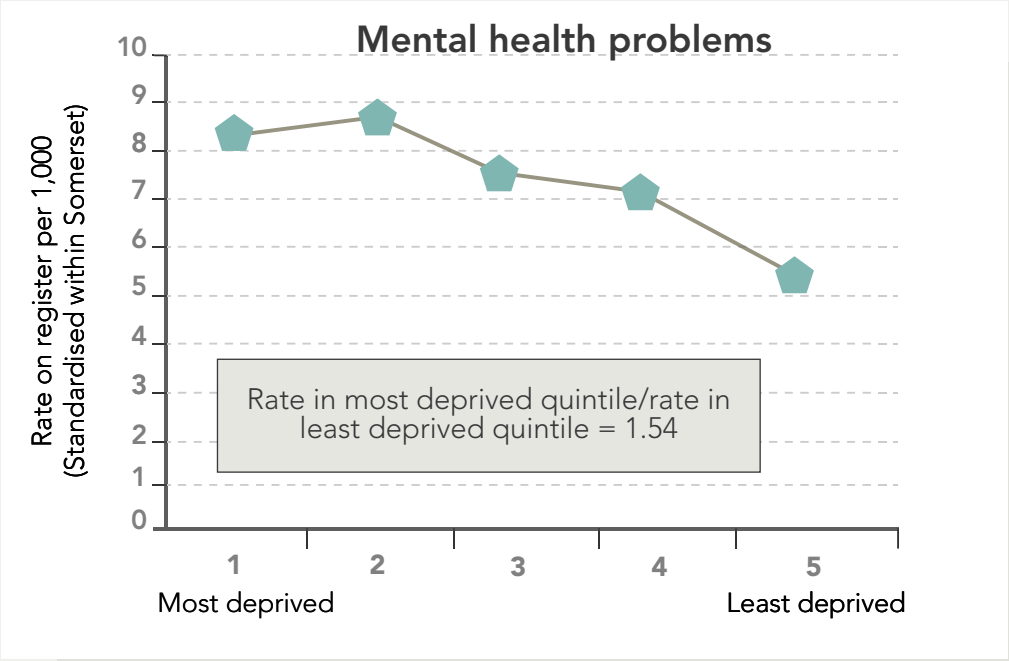


RATE 2006-13	45	31	21	23	21
UPPER CL	50	36	24	26	24
LOWER CL	40	28	18	19	17

Rate in most deprived quintile/rate in least deprived quintile = 2.2

There are also similar patterns in illnesses that people continue to live with, such as chronic kidney disease, where the rate is 35% higher for the most deprived communities than the least, and mental health problems where the rate is 54% higher (**see Figure 13**).

Figure 13 **Somerset prevalence of mental health problems by deprivation quintile: Recorded disease as at April 2014 in GP clinical systems.**



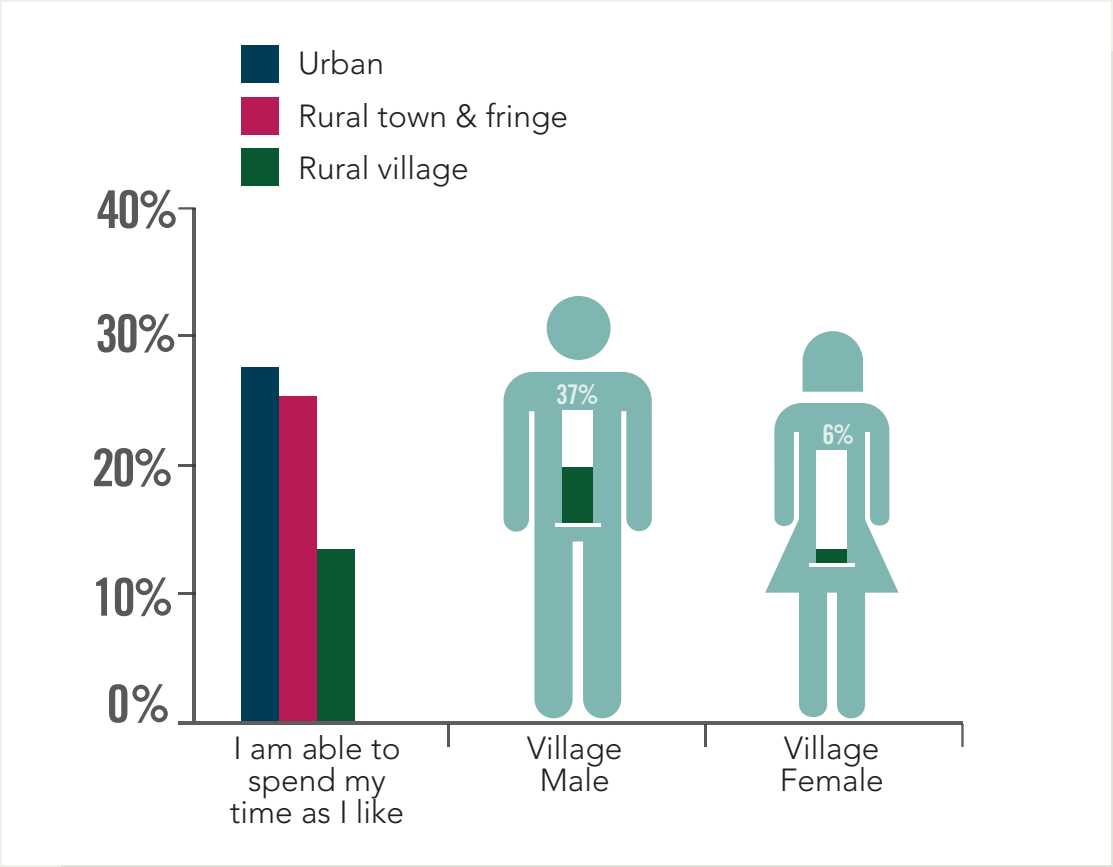
This report has shown there are systematic health inequalities in Somerset. We should therefore expect greater use of NHS services by people living in more deprived communities where the disease burden is greater, but this is not always the case.

Taking lung cancer as an example, **Figure 12** shows that individuals in the most deprived quintile are more than twice as likely to die from lung cancer than the most affluent communities. We should expect the same pattern in service use, such as hospital admissions. What we actually see is the rates being similar in the most and least deprived groups. This implies that people from more deprived communities are not detected as early, and so are harder to treat. Thus, 'equality' may mask 'inequity'. This is again an example of the inverse care law, where 'access to services' patterns do not reflect 'need' patterns. It should be noted that this can be due in part to people not presenting with symptoms or not presenting early enough. Ensuring that people living in more deprived areas of Somerset have good access to health services, particularly primary care services, have good understanding of key signs and symptoms to look out for and feel able to discuss their concerns with a health professional, are all ways in which we can improve early presentation.

Social care services are, necessarily, focused on those with the greatest need but inequalities are still present. The Adult Social Care Users' survey asked people who access social care services if they were able to spend their time as they liked. As shown in **Figure 14**, the proportion saying they could was 15% in villages compared to 28% in urban areas[15]. However, the gender inequality between men, at 33%, and women, at 7%, is striking. Put simply, women in receipt of social care services in more rural areas felt significantly less able to spend their time as they liked than men in rural areas. This is possibly because of transport problems faced by rural women without access to a car and less related to their social care services.

Figure 14

Social Care Users' 'ability to spend time as they like'[15]



Summary and recommendations

I have presented some examples of how inequality has an impact on people's lives across Somerset. It is not an exhaustive list; there are many more inequalities that exist which are not presented here. This section provides a summary of the report and makes recommendations about where we should focus our efforts going forward.

Taking a broad strategic approach:

- Improving the **overall** health of people in Somerset is best achieved by improving the health of those in the greatest need fastest
- Inequalities are linked to wider social and economic conditions, and exist by age, gender, location and specific vulnerabilities and characteristics. All public policies should take account of, and seek to address, inequalities that exist in our community
- People rarely suffer just one disadvantage, and problems multiply in their impact. This means a person-centred approach is often needed to overcome them. The Family Focus work provides an excellent example of this and shows real tangible results
- Health care and social services in Somerset are under pressure. Many people in disadvantaged groups have more than one condition and the costs of their care are high. There needs to be a focus on preventing poor health and wellbeing and maintaining independence throughout the services, but there needs to be far more focus given to prevention for specific groups and people living in our most deprived neighbourhoods. Investment to reduce inequalities will significantly reduce the future pressures in the public sector
- All scrutiny functions in the county should renew and strengthen their role as champions for addressing health and social inequalities. There should be specific challenge on inequalities to all new local policy and service redesign

More specifically:

- Early years are vital. Our priorities should be reducing child poverty and foetal and childhood exposure to smoking, increasing sustained breastfeeding, supporting early child development through high quality early years provision and increasing uptake of the two and a half year age check by health visitors
- Prosperity underlies much of the variation in health and wellbeing. Economic prosperity should continue to be a priority, focusing on secure, safe and satisfying work. Adults should have access to appropriate education, especially to improve their chances of finding or improving employment
- We should maximise the opportunities given to us through local development - notably Hinkley C - to increase wellbeing through employment, transport and community networks, amongst others
- Health services should focus greater attention on encouraging vulnerable people and those living in areas of higher deprivation to present to health services earlier. Clinical audit and a greater understanding by health services of who is not using services and why would help with this
- Housing is a fundamental determinant of health and wellbeing. We should continue to focus on providing affordable homes in rural and urban areas, developing the quality of the housing stock, notably in the private rented sector and continue to have a strong focus on addressing fuel poverty

- Housing provision should reflect demographic need to a greater extent – particularly in rural areas – focusing on affordable housing for young people wishing to stay in Somerset and a better mix of housing so older people are more able to change their housing as their needs change but without having to move out of their location

- Rural areas are often prosperous, but disadvantaged people in rural areas have particular challenges. There needs to be greater development of alternative transport. The Connecting Devon and Somerset programme, rolling out high speed broadband, offers an opportunity to help overcome some rural disadvantages and should continue to be developed still further. More could be done to use digital connectivity to help access to public services

Understanding and narrowing health and social inequalities is central to improving the overall prosperity of the county, achieving sustainable public services and ensuring everyone has chances to achieve and live prosperous and fulfilling lives to the best of their ability.

Tackling social and health inequalities which are deep rooted in our communities takes a long term approach. It needs a concerted effort over a long period of time and requires all partners in the county to work together to achieve it.

Acknowledgements

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