
Bath & North East
Somerset Council

Improving People's Lives

Working Towards a Fairer B&NES

Reducing Health Inequalities in Bath and North East Somerset

Director of Public Health Annual Report 2024/25



Contents

Director of Public Health (DPH) Introduction and Acknowledgments	3
Chapter 1 – What Are Health Inequalities	4
Chapter 2 – What Are The Causes of Health Inequalities	9
Chapter 3 – Action on Health Inequalities in B&NES	26
Chapter 4 – Looking Forward – Report Recommendations	37
Chapter 5 – Reflecting on 2023/24 Recommendations	40
Indicators	45
Glossary	49
References	51
Appendix	55



Director of Public Health (DPH) Introduction and Acknowledgments

Introduction

I am pleased to present the 2024/25 Director of Public Health Annual Report for Bath and North East Somerset (B&NES). This report focuses on health inequalities. At its heart, tackling health inequalities is about fairness and making sure that everyone has the best chance of a long and healthy life. While the population of B&NES generally has good health compared with that of the population in England as a whole, some groups of people have poorer health than others and die earlier, and that's not right.

When that poorer health happens because of preventable unfairness or barriers to opportunities, then we need to tackle that inequality through coordinated action, building on the strengths of communities and voluntary sector, and working across our services and other system partners. B&NES has many excellent partnerships, programmes and community-led initiatives which are making a difference and some of these are highlighted in Chapter 3 of this report. However, there is more to do.

This report cannot do justice to the whole subject of health inequalities, so instead aims to raise issues as important prompts for urgent further discussion and action. Chapter 4 sets out five clear recommendations for the year ahead, ensuring we stay focused on those who need more support first and fastest. If I was to have one overall recommendation, it would be that we make reducing inequalities a collective strategic priority across organisations and partnerships, working closely with local communities. There's great strength in coordinated endeavour.

Acknowledgements

My grateful thanks to Ryan Doherty (Public Health Registrar) who led the research and production of this excellent report, supported by Sarah Heathcote (Health Inequalities Manager), Paul Scott (Associate Director and Consultant in Public Health), and Katy Wilkins for the design work.

I am especially grateful to colleagues in the voluntary and community sector, B&NES Council, the NHS, and other partners for your valuable contributions to this report through your sharing of case studies and insights.

Finally, thank you to our elected members in Cabinet and in the B&NES Policy Development and Scrutiny panels for your ongoing commitment to improving the conditions for good health and fairness through the council's activities.

Becky Reynolds
Director of Public Health and Prevention



Chapter 1 – What Are Health Inequalities



Health inequalities are avoidable, unfair and systematic differences in health between groups of people. These inequalities may include differences in:

1. How long people live
2. The health conditions they may have
3. How they use health and care services and their experiences of this care
4. Behavioural risks to health, for example smoking or diet
5. The building blocks of health, for example housing or education¹

Communities that may face inequalities are often described by the following 4 key groups, as shown in Figure 1:

The groups referenced in Figure 1 include^{2,3}:

1. **Socio-economic deprived populations** - for example the impact of income, living in deprived areas or other determinants of health such as education or employment
2. **Inclusion health groups** - for example people who are homeless, migrants or people who are part of Gypsy, Roma, Traveller and Boater communities
3. **Protected characteristics** - including those protected in law, such as sex, ethnicity or disability
4. **Geography** - for example whether living in an urban or rural area, or the impact of the built and natural environment

Sometimes a person belongs to more than one of these groups. When this happens, the effects can add up and make health inequalities even worse. This is called intersectionality. For example, the combined inequalities faced by a woman from a Black Caribbean background who is living with a long-term disability.

The following pages will look more closely at the following groups and how inequalities affect them: **Socio-economic deprived populations**, **Inclusion health groups** and **Protected characteristics**. Geography, and specifically the impact of rurality and service access, will be explored within later sections of this report.

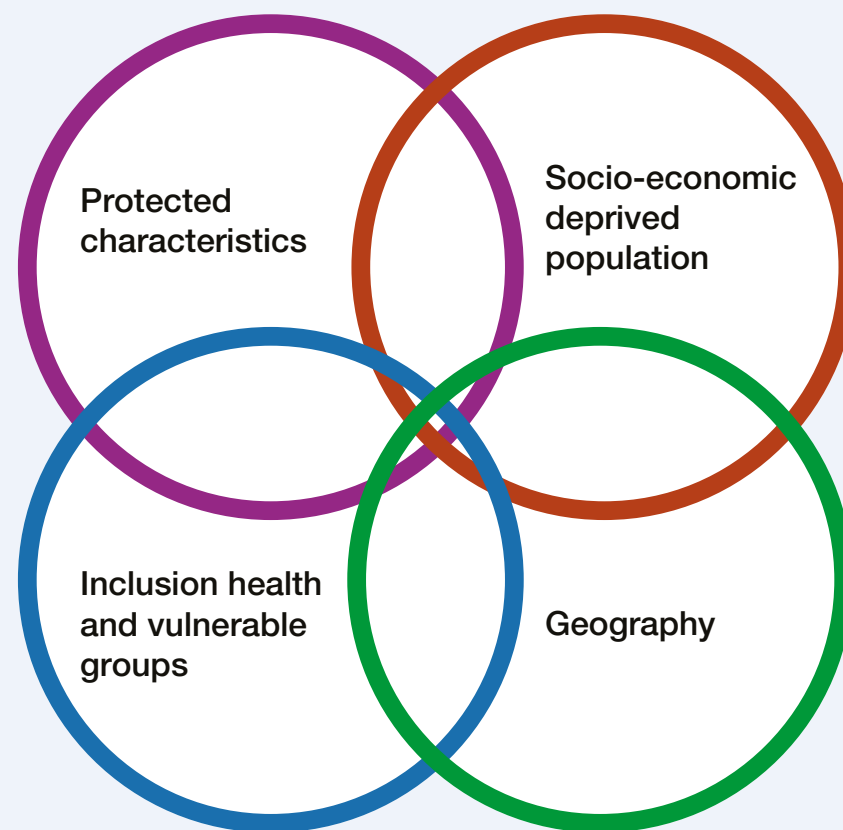


Figure 1 – Health Inequalities Population Dimensions Source: Local Government Association

Socio-economic deprived populations

Deprivation is more than not having enough money and refers more broadly to a lack of resources and opportunities in life³. The [Index of Multiple Deprivation](#) (IMD) is a way of measuring how deprived an area is in England. It combines seven domains (Income, Education, Employment, Health, Crime, Barriers to Housing and Services, and Living Environment) to create a ranking of small areas (around 1,500 people) from 1 (most deprived area) to 33,755 (least deprived area)⁴.

In his seminal 2010 [Marmot Review](#)⁵, Sir Michael Marmot explored the impact of deprivation on health. The review found that people living in poorer areas tend to die younger and spend more of their lives in poorer health. This is called the social gradient in health. In a [10 year update](#)⁶ of the original Marmot Review, the report highlighted that people can expect to spend even more of their lives in poor health and that the health gap between the most and least deprived areas had grown during the period. Figure 2 outlines the national life expectancy gap between the most deprived and least deprived areas in England.

Within B&NES the most recent IMD release (2025) showed that whilst it remains among the least deprived local authorities nationally, it has become relatively more deprived since 2019, with 3 areas in the 10% most deprived in 2025 compared to 2 in 2019 and 1 in 2015. Approximately 4,500 people now live in the 10% most deprived areas in B&NES compared to 1,500 in 2015. Figure 3 shows a map of B&NES by IMD deprivation levels.

As is seen nationally, the impact of deprivation is pronounced in B&NES with men in the most deprived areas living on average 8 years less than men in the least deprived areas, and women in the most deprived areas living on average 5.1 years less than women in the least deprived areas in 2021-23. This means that people from more deprived areas in B&NES are unfairly dying sooner than those from the least deprived areas.

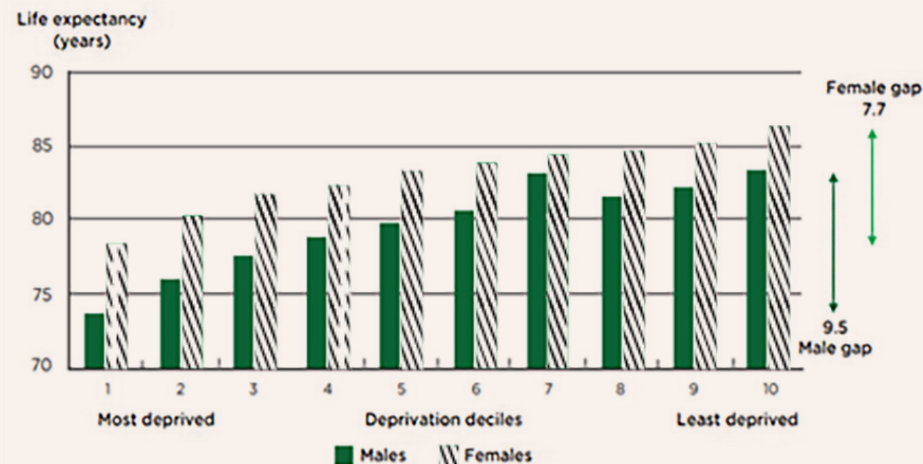


Figure 2 – Life expectancy at birth by area of deprivation deciles and sex, England, 2016-18. Source – Marmot Review – 10 Year Update (2020). For further explanation go to [Figure 2 in the Appendix](#)

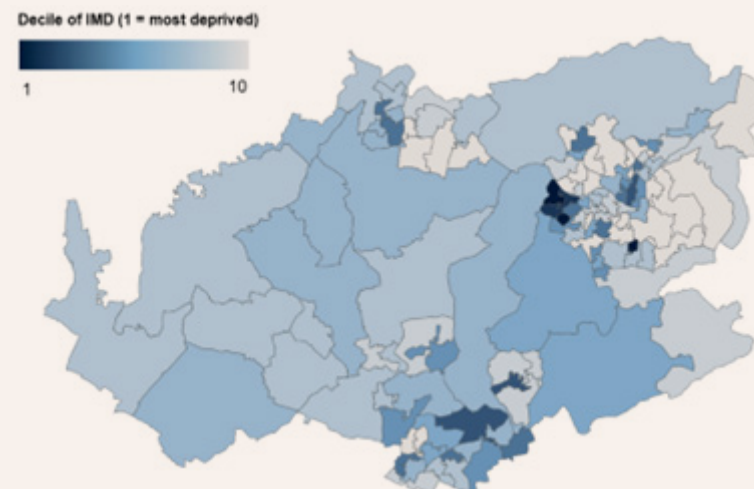


Figure 3 – Map showing areas of B&NES by the decile of IMD (1 = most deprived). Source – B&NES Strategic Evidence Base

Inclusion Health Groups

“Inclusion health” is an umbrella term used for people/groups who are left out or excluded from society. They often face many challenges that harm their health, like stigma, discrimination, poverty, violence, and difficult life experiences⁷.

These groups include people who are homeless, refugees and vulnerable migrants, and Gypsy, Roma, and Traveller communities. People in these groups often have much worse health outcomes. In fact, they can be 8 to 12 times more likely to die early compared to the general population⁸. Their death rates are even far higher than those in the most deprived communities in England (see Figure 4), showing just how big these health gaps and inequalities are.

For people who are homeless the average age of death in 2021 was about 45 years for men and 43 years for women in England and Wales⁹. That’s around 33–39 years less than the average life expectancy at that time¹⁰.

Asylum seekers and refugees also face big health challenges such as poorly controlled chronic conditions, such as high blood pressure or diabetes, or by having untreated infectious diseases, such as tuberculosis or Hepatitis B. Additionally, they are 10–20 times more likely to have post-traumatic stress disorder (PTSD) than most people, because of experiences like war, violence, and living in fear⁷.

Gypsy, Roma, and Traveller communities face severe inequalities. They have the lowest levels of educational attainment and economic activity of any ethnic group in England and Wales¹¹. Their life expectancy is 10–12 years shorter than other groups. They are also more likely to have long-term health problems (42% compared to 18% in the general population), and Gypsy Traveller mothers are 20 times more likely to suffer child loss than mothers in other communities¹¹.

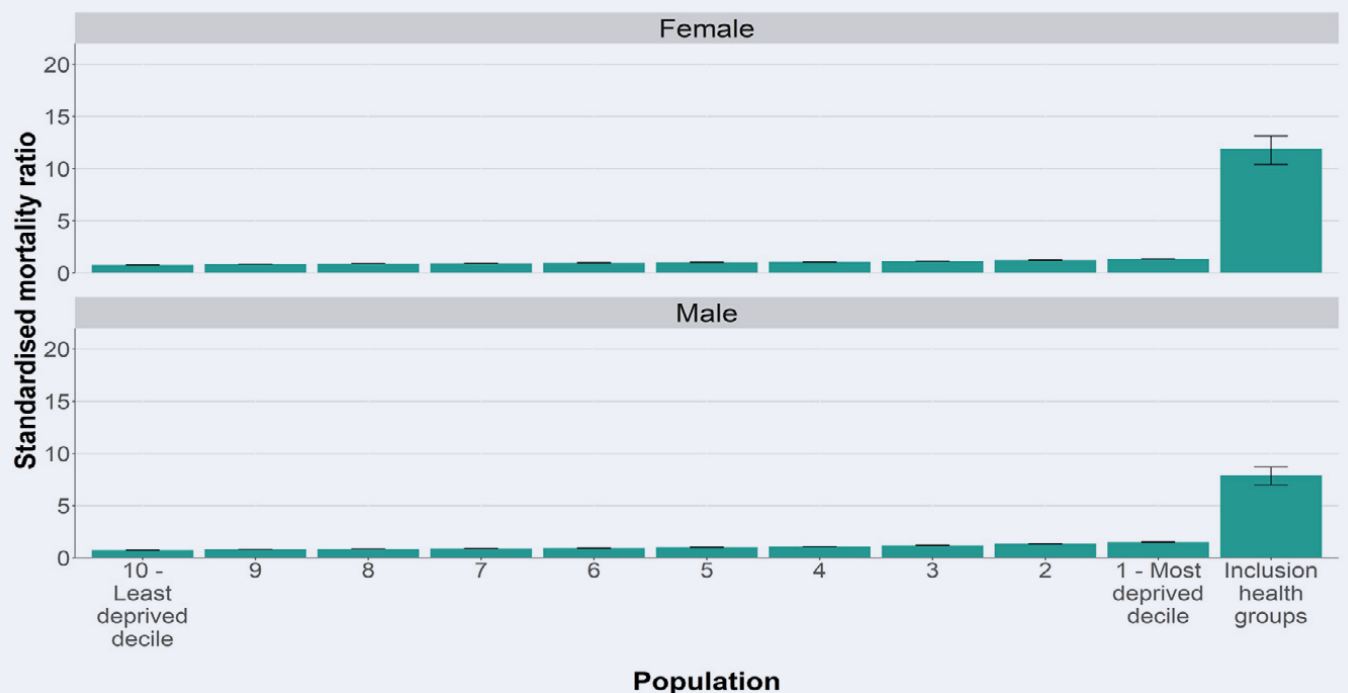


Figure 4 – Standardised all-cause mortality ratio for inclusion health groups, compared to the general population by deprivation decile. Source: Office for Health Improvement and Disparities (OHID). For further explanation go to [Figure 4 in the Appendix](#).

Protected Characteristics

“Protected characteristics” are things like age, disability, ethnicity, and sexual orientation, as set out in the [Equality Act 2010](#). These characteristics are often linked to differences in health outcomes and experiences³.

Health inequalities exist between ethnic groups. Analysis by [The King's Fund](#) showed that before COVID-19, some ethnic minority groups had a higher life expectancy than White and mixed groups. But during the pandemic, this reversed with death rates higher among ethnic minority groups¹². These overall figures hide big differences - people from Gypsy or Irish Traveller, Bangladeshi, and Pakistani communities often have the poorest health outcomes across many measures¹².

Looking beyond life expectancy, the King's Fund found some ethnic minority groups are more likely to say they have poorer health or a long-term health condition than White British people¹². Additionally, South Asian and Black mothers have higher proportions of premature, stillbirth and low birthweight babies than white mothers¹².

Beyond ethnicity, people who identify as lesbian, gay, bisexual or transgender (LGBT) often have worse mental health and lower wellbeing than those who do not identify as LGBT¹³. Additionally, people with a severe mental illness (SMI) also face big health inequalities - they are almost four times more likely to die before age 75 than the general population¹⁴. Young adults with SMI are also 5 times more likely to have 3 or more physical health conditions¹⁴.

Within B&NES, people with SMI are at much higher risk of dying early. The rate of deaths for people with SMI under age 75 is worse than the England average - 504% compared to 384 % (2021–23) and has been consistently poorer than England since 2015-17 as shown in Figure 5¹⁵. B&NES ranks among the worst areas in England for this measure (13th out of all local authorities).

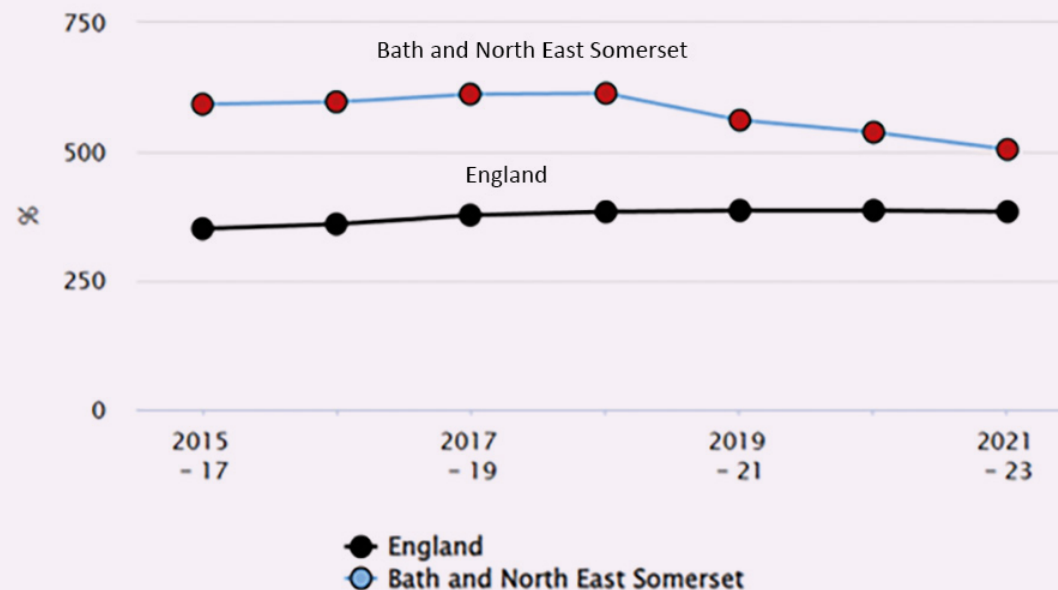


Figure 5 – Excess under 75 mortality rate in adults with SMI (2015-2023). Source – OHID Fingertips. For further explanation go to [Figure 5 in the Appendix](#).

Chapter 2 – What Are The Causes of Health Inequalities



Health inequalities stem from a complex range of factors, including the building blocks of health such as housing, employment and education, the services available to us, and lifestyle risks that shape how we live. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing¹⁶.

These factors affect us throughout life. This idea is called the “life course” model. It helps explain how health inequalities start, continue, and even pass from one generation to the next. Our health is shaped by the experiences we have over our whole life¹⁷.

The life course model recognises that specific times in life may matter more than others. For example, difficult experiences in childhood can affect our opportunities, health and wellbeing for the rest of our lives. We can also have both good and bad experiences at different points in life, and these all add up to shape our health.

The Dahlgren and Whitehead rainbow model¹⁸ (Figure 6), shows how health is shaped by many layers – from our personal factors and choices, through to our education, the services we have access to and the environment in which we live. This model helps show that our health and in turn health inequalities are shaped by many factors, rather than our personal choices alone.

Studies have looked at how much each factor affects our health¹⁹. They all show that while things like healthy habits and healthcare matter, they are only part of the picture. Other factors, like housing and income, play a big role too as shown by Figure 7²⁰. The following pages will now explore these different factors in more detail.

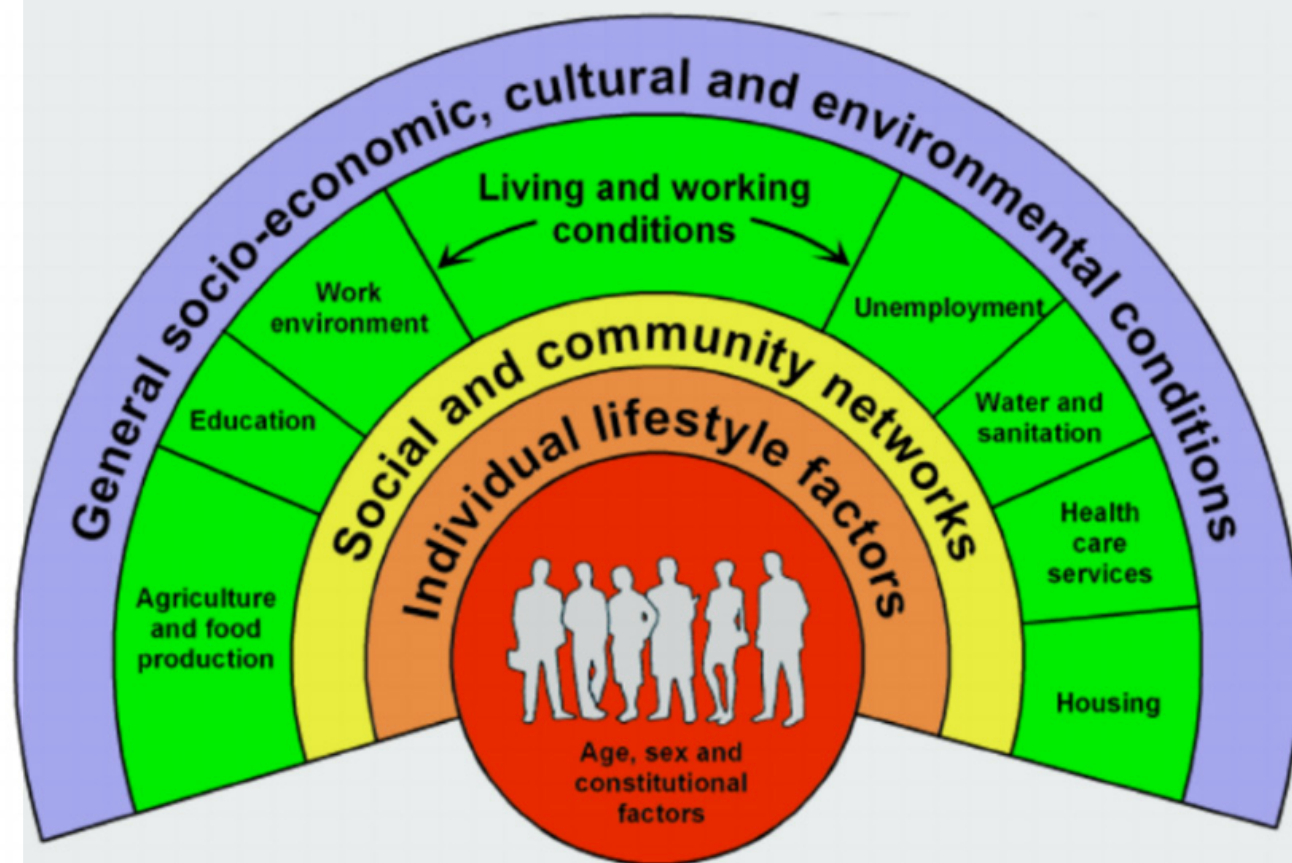


Figure 6 – The Dahlgren and Whitehead Rainbow Model. Source: Dahlgren, Göran & Whitehead (1991). For further explanation go to [Figure 6 in the Appendix](#).

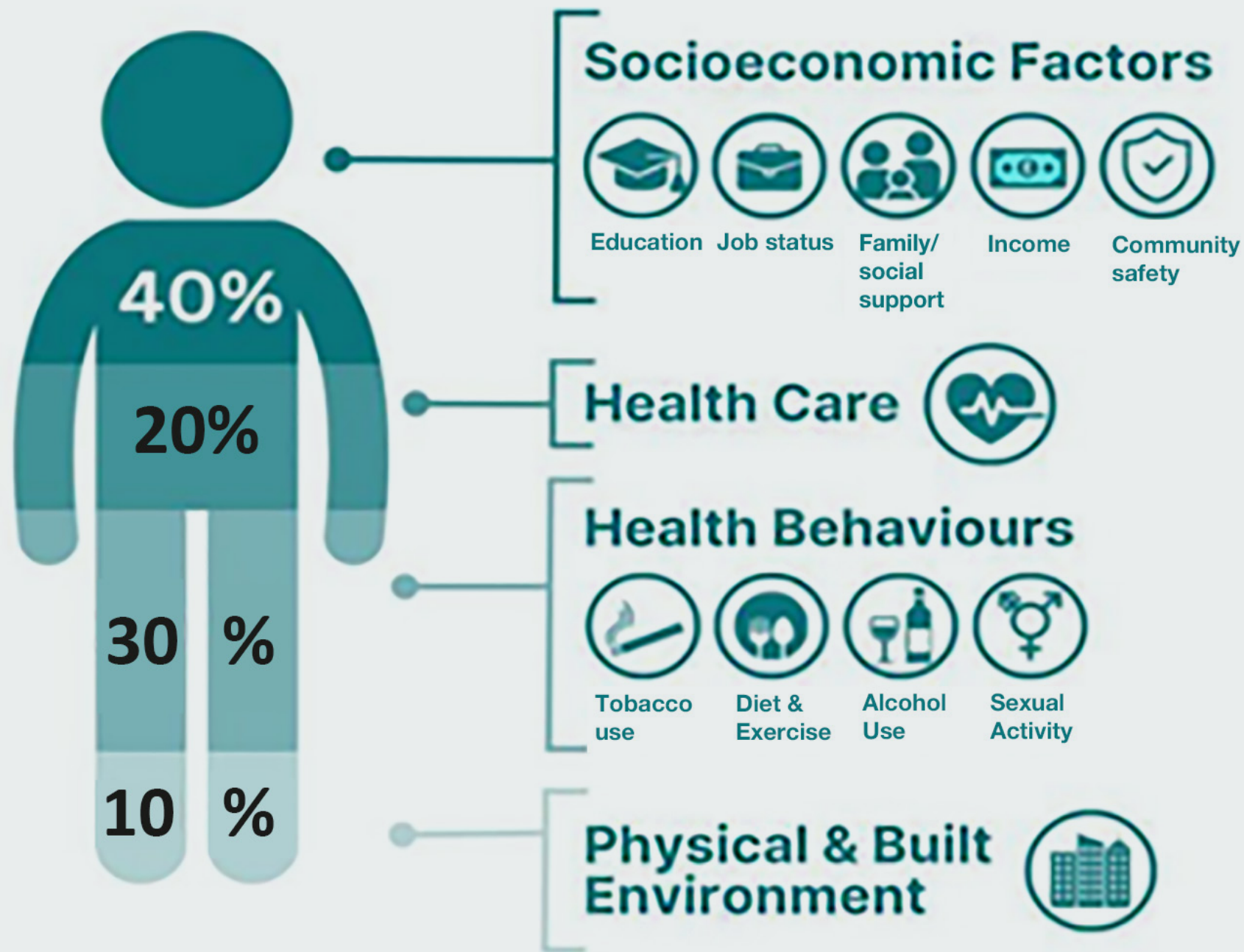


Figure 7 – Factors Affecting Health. Source – Milton Keynes Local Authority. For further explanation go to [Figure 7 in the Appendix](#).

The Building Blocks of Health

The socio-economic and environmental factors shown previously in Figure 7 have an important influence on our health and are present where we are born, grow, learn, work and age²¹.

These factors are the building blocks of our health (see Figure 8), as not only are they themselves vital to our health, but they are also the foundations on which other factors are built upon, such as the services we use and the lives we live. The building blocks of our health include:

- Education and skills
- Housing
- Money and resources
- Work
- The food we eat
- Transport
- Family, friends and communities
- Our surroundings

These building blocks are connected. For example, if someone doesn't do well at school, they may struggle to get a good job later. That can lead to low income and poor housing, which might expose them to damp and mould - harming their health.

Next, we will look at some of these building blocks in more detail, how they each contribute to our health and what they look like in B&NES.

(The following descriptions and narrative have been taken and adapted from [The Health Foundation](#)²²)

“Why treat people and send them back to the conditions that make them sick?”

Sir Michael Marmot, The Health Gap



Figure 8 – Infographic of the building blocks of health.
Source: The Health Foundation

Education and Skills

A good education is a strong foundation for a decent quality of life. Along with the skills we learn and develop, it influences our prospects for where we live and work, and for our health.

Children from disadvantaged households tend to do worse at school which in turn influences their life chances. Eligibility for free school meals (FSM) is one sign of disadvantage, and children who get FSM are less likely to reach expected education levels at every stage, from preschool to entry to higher education, compared to those who don't²².

In B&NES, whilst overall school performance is good compared to national figures, and including for pupils with special educational needs (SEN), inequalities in educational attainment exist. The gap in attainment between pupils who receive FSM and those who don't is wider in B&NES than the national gap at every stage of education, and this has been the case for several years²³.

At Key Stage 4 (KS4) (GCSE level), whilst pupils receiving FSM in B&NES still do worse than the national average, their performance is stronger than at earlier stages - B&NES sits in the bottom third of Local Authorities (LAs) for KS4 results, which is noticeably better than its rankings for Early Years Foundation Stage (EYFS) and Key Stage 2 (KS2)²³.

Attainment in the B&NES FSM cohort is amongst the lowest in England - second lowest of all LAs at the EYFS, and joint third lowest of all LAs at KS2, with trends in KS2 attainment in B&NES shown at Figure 9²³.

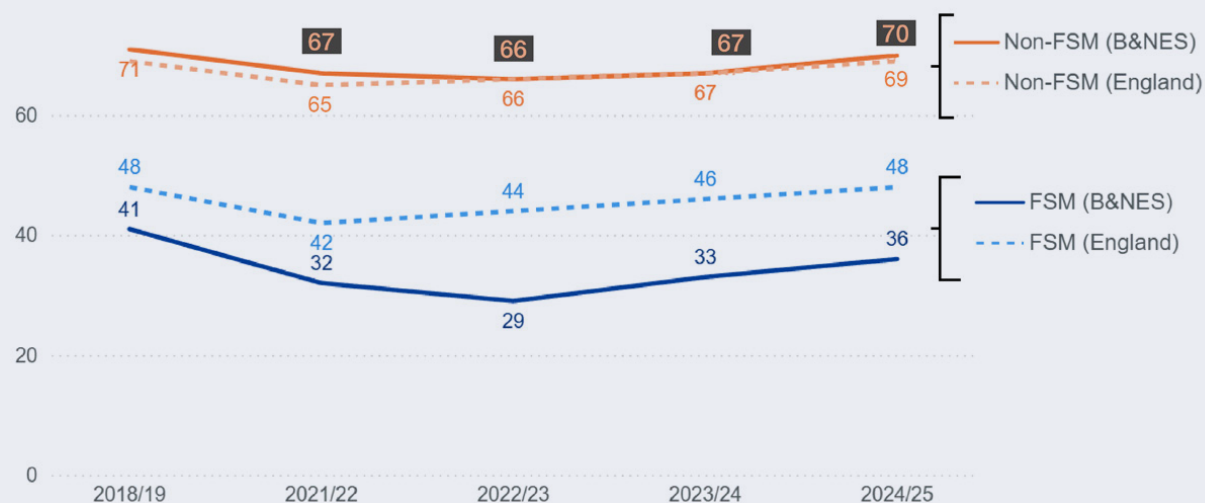


Figure 9 – Percentage of pupils meeting expected standard at KS2 in reading, writing & maths by FSM status. Source: B&NES Strategic Evidence Base (SEB). For further explanation go to [Figure 9 in the Appendix](#).

Housing

Our homes affect both our physical and mental health. Things such as whether our housing is affordable, safe, and of good quality all make a difference. Nationally, more than one in four families spend over a third of their income on housing, making it unaffordable for many²⁴.

In 2022, over 3.1 million homes in England (14%) did not meet the Decent Homes Standard²⁵. Poor-quality housing was most common in private rentals and low-income households. This includes homes that were exposed to damp and mould, which can seriously harm people's physical and mental health, especially for children and older adults²⁶.

Affordability of housing within B&NES is a significant challenge, with the ratio of house prices to earnings above both national and West of England figures as shown in Figure 10. Additionally, the average monthly private rent is much higher in B&NES (£1,734) compared to England (£1,386)²³.

Finally, around 10.5% of households within B&NES were estimated to be in fuel poverty in 2023, which is where households must spend a high proportion of their income to keep their houses warm. This compares to around 11.4% of households in fuel poverty within England²⁷.

House Price to Earnings Ratio (Workplace-based)

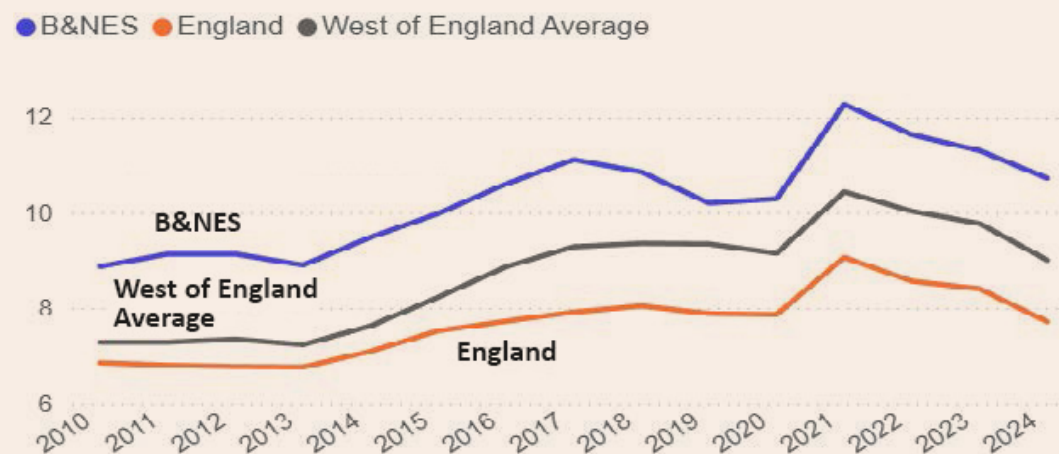


Figure 10 – House Price to Earnings Ratio (Of people working in B&NES).
Source: B&NES SEB. For further explanation go to [Figure 10 in the Appendix](#).

Money and Resources

Money and resources are essential for good health as they unlock access to other building blocks of health, such as good-quality housing and participation in society. Not having enough money and resources can cause poor health by making it hard to save, feel in control of our circumstances and keep healthy.

In the UK 11.6 million people (17%) were in relative poverty before housing costs and 14.2 million after housing costs (21%) in 2023/24²⁸. This includes 3.4 million children (23%) before housing costs and 4.5 million after housing costs (31%)²⁸, with children consistently the most affected by poverty as shown in Figure 11²⁹. When considering the deepest form of poverty, destitution, where people cannot afford to meet their most basic physical needs to stay warm, dry, clean and fed, around 3.8 million people experience destitution in 2022, including 1 million children²⁹.

Within B&NES, whilst levels of poverty are below average rates within the UK, 1 in 5 (21.1%) children and young people in B&NES in 2023/24 were estimated to be living in relative poverty (after housing costs), which equates to some 8,100 children and young people³⁰.

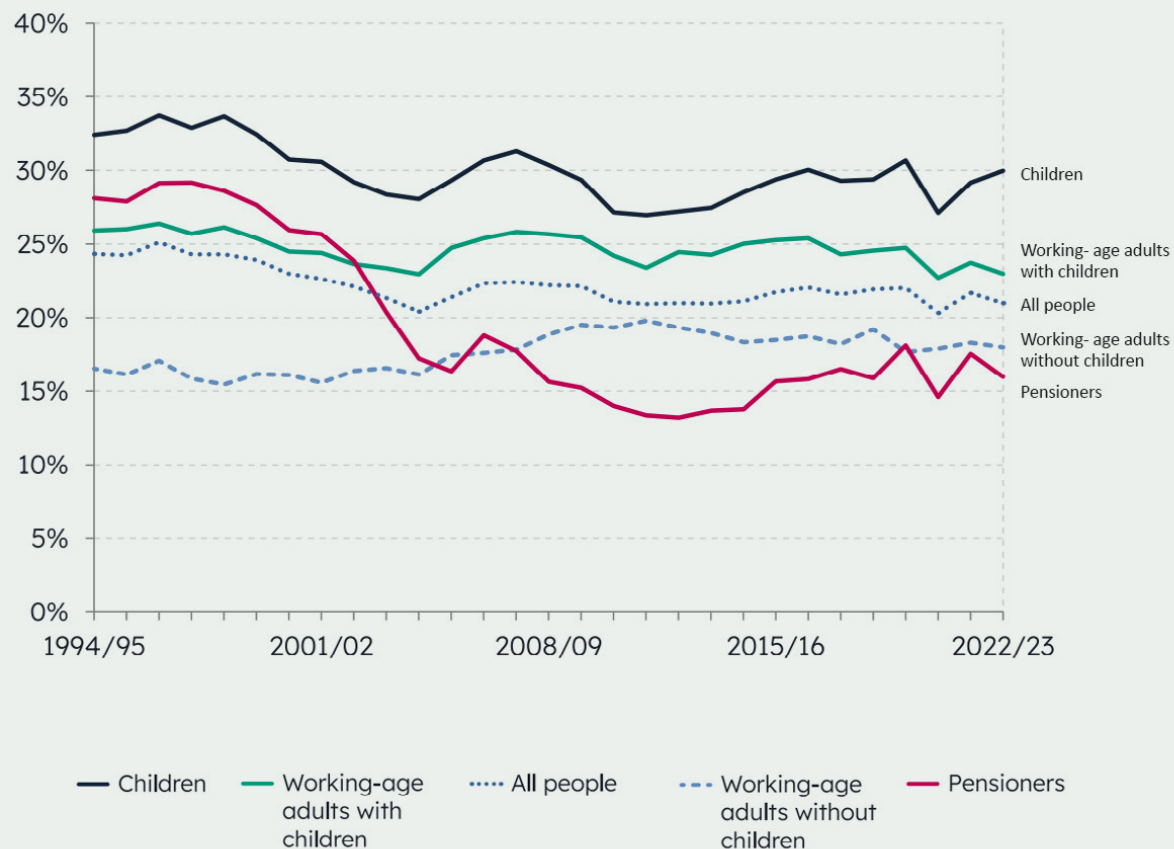


Figure 11 - % poverty rate in the UK by population group, 1994/95 to 2022/23. Source: Joseph Rountree Foundation. For further explanation go to [Figure 11 in the Appendix](#).

Work

Access to good-quality jobs is one of the building blocks of a healthy life and a healthy society. It's not just about being paid enough and having enough money to meet basic needs – a good-quality job benefits our health in other ways too.

People who are unemployed are more than five times more likely to have poor health than those who are employed³¹. Unemployment can lead to poor health, but poor health can also make it harder to find work. Disabled people are more than twice as likely to be unemployed compared to non-disabled people³².

Other employment inequalities that exist are that younger people are the most likely to be unemployed³³, as shown in Figure 12. Being out of work at a young age can affect health, wellbeing, and lifelong opportunities.

The quality of work also matters, with employees with insecure jobs or low job satisfaction are more than twice as likely to report poor health as the average employee³⁴.

In B&NES, unemployment was at 3.7% between July 2024 and June 2025, better than the national average (4.2%) but slightly worse than the South West (3.5%)³⁵. This equates to around 3,900 people in B&NES able and looking for work. When considering inequalities, in B&NES, people with a long-term health condition or illness are over 20% less likely to be employed compared to those without²³.

Finally, in 2025 4.6% of 16 to 17 year-olds in B&NES were not in education, employment or training or whose activity is not known (NEET), this compares with a national figure of 5.6%³⁶.

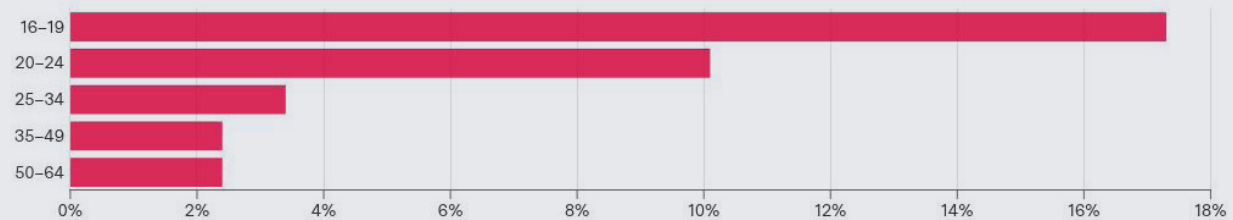


Figure 12 – Unemployment rates for ages 16-64 years by group, UK, 2024. Source: Health Foundation analysis of Office for National Statistics, Annual Population Survey, UK, 2024. For further explanation go to [Figure 12 in the Appendix](#).

The Services We Use

Beyond the building blocks of health, the services we use are also another important determinant of our health. However, not everyone has the same access to services, experiences of these services or outcomes from these services.

Groups that face health inequalities often have differences in their access, experience or outcomes of services because of things like where they live, holding protected characteristics, or being part of inclusion health groups. We'll now look at these issues in more detail.

“The availability of good medical care tends to vary inversely with the need for it in the population served.”

Tudor Hart, The Inverse Care Law



Service Access

More than 50 years ago, Tudor Hart described the “inverse care law” - which described how people who need healthcare the most often get the least³⁷. This need is often driven by deprivation, with those in the most deprived areas having higher need but less access than those in the least deprived areas. Evidence shows that people living within deprived areas have fewer GP's³⁷, longer waits for elective treatment³⁸ and later entry to the social care system³⁹, despite having a greater need for such services.

People who have protected characteristics and/or are from inclusion health groups also face access barriers. For example, breast and cervical cancer screening rates are lower among women from ethnic minority groups, especially South Asians¹². Additionally, children of mothers from some ethnic minority groups are less likely to get childhood vaccinations than those of White mothers⁴⁰. Finally, sex workers often report barriers to accessing cervical screening and antenatal appointments⁷. The barriers these groups face include stigma, language difficulties, lack of internet access, cultural misunderstandings, and structural racism³; with these often combined or made worse by higher levels of deprivation.

When considering geography, people living within rural communities often report barriers in accessing specialist healthcare settings, driven by long and costly travel for appointments^{41, 42}. They also travel further for GP access and have poorer internet access^{41, 42}, which may make it harder to access online health services and clinics.

Within B&NES, Swindon and Wiltshire (BSW), persistent inequities in access to mental health, elective care, and emergency services exist - especially among deprived communities and marginalised groups.



Service Experiences

People with protected characteristics, who are from inclusion health groups, or who live in more deprived areas often have different experiences with services. For example, in mental health care, people from the most deprived areas or from Black or Black British backgrounds are much more likely to be detained under the Mental Health Act⁴³.

Additionally, Gypsy, Roma, and Traveller communities often face problems registering with GP practices. They are also less satisfied with GP access and the care they receive compared to White British people^{44, 45}.

Finally, a [Stonewall](#) study found that one in eight LGBT people (13%) report having experienced some form of unequal treatment from healthcare staff because they're LGBT⁴⁶.

Service Outcomes

Some of the differences in health outcomes between groups are directly linked to the services people get. For example, [Cancer Research UK](#) found that people in deprived areas wait longer for cancer diagnosis and treatment, which leads to poorer survival outcomes⁴⁷.

Additionally, people from some ethnic minority groups, people who are Lesbian, Gay or Bisexual or people living in deprived communities are less likely to recover well after mental health treatment compared to others⁴⁸.

Finally, in social care, people living within more deprived areas, where more residents rely on state funding, are more likely to receive worse quality care than those from less deprived areas, which have a higher proportion of self-funded residents⁴⁹.

Health outcomes in BSW remain unequal across gender, age, ethnicity, deprivation and inclusion health groups, with such populations repeatedly experiencing poorer outcomes across different conditions and services. Key issues include longer waiting times for patients in deprived areas, lower uptake of vaccinations, such as the flu vaccine, and higher risk of serious illness, including stroke and heart attack.



NHS Action on Healthcare Inequalities

To respond to the inequalities different groups may face when accessing healthcare services and to reduce healthcare inequalities, NHS England (NHSE) developed the Core20PLUS5 programme. It identifies key population groups and clinical areas that need faster improvement to reduce healthcare inequalities⁵⁰. The key focus areas for children are shown in Figure 13. There are also key focus areas for [adults](#).

Alongside Core20PLUS5, NHS England published a [national framework](#) in October 2023 to improve services for inclusion health groups⁷. The key principles and actions outlined to make real improvements for these groups include:

1. Commit to action on inclusion health
2. Understand the characteristics and needs of people in inclusion health groups
3. Develop the workforce for inclusion health
4. Deliver integrated and accessible services for inclusion health
5. Demonstrate impact and improvement through action on inclusion health

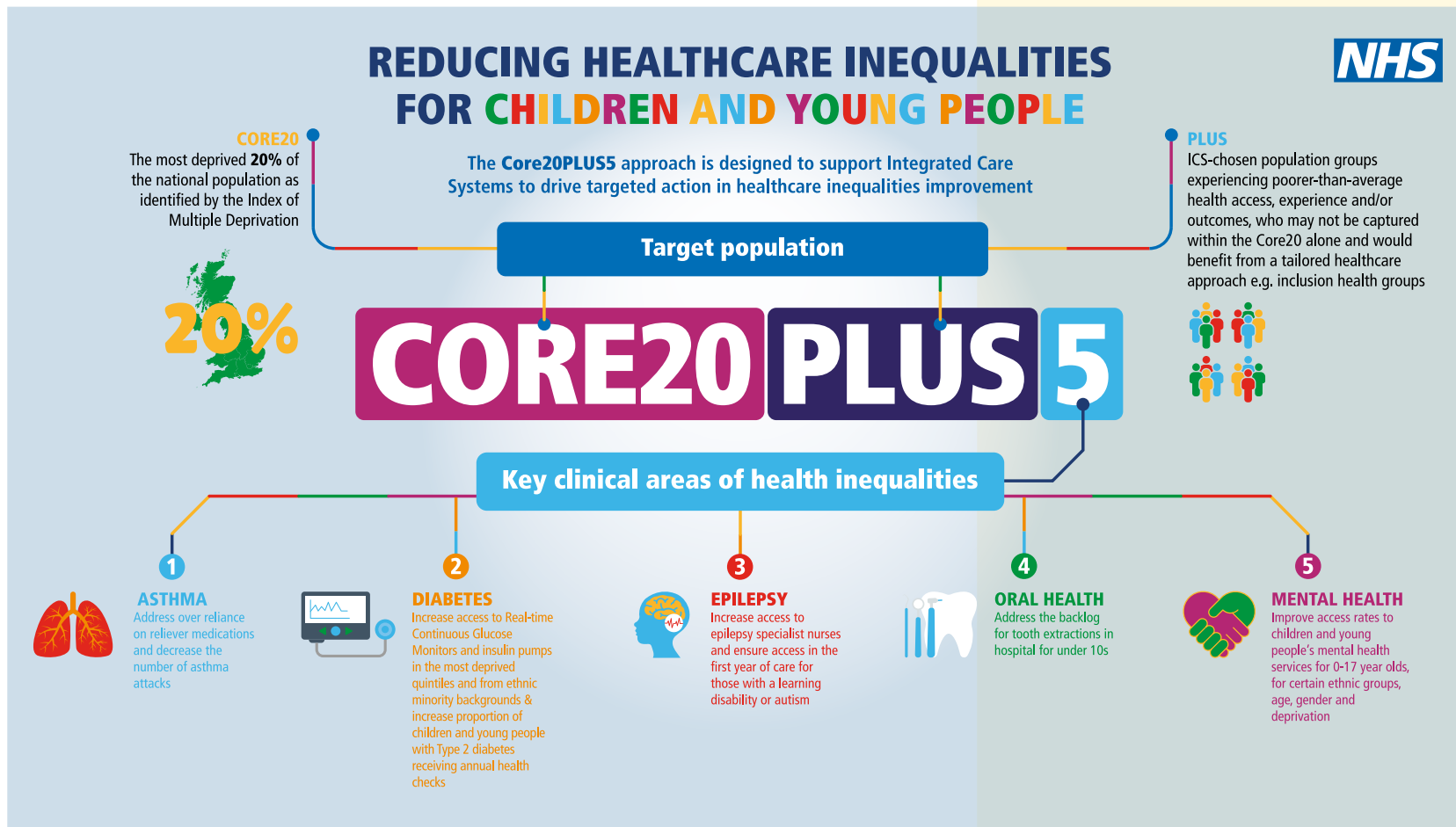


Figure 13 – Infographic of Core20PLUS5, Children and Young People. Source – NHSE. For further explanation go [Figure 13 in the Appendix](#).

Lifestyle Risk Factors (The Lives We Lead)

The ability of people to lead healthy lives is influenced by both their individual health behaviours (which is in turn associated with their opportunities and experiences) and by the building blocks of health³. The main behavioural risk factors for health are smoking, having excess weight, physical inactivity and drinking too much alcohol³.

These risk factors are not spread evenly. People's chances of smoking, eating well, staying active, and drinking moderately are linked to their social, economic, and environmental conditions³. Next, we'll look at these risk factors in more detail.



Smoking

Smoking is the biggest preventable cause of illness and early death. It caused 74,000 deaths in 2019 and over 400,000 hospital admissions in 2022/23⁵¹. Smoking harms both smokers and those around them and is the biggest contributor to health inequalities in England, especially in disadvantaged communities^{51, 52}.

People with lower incomes are much more likely to smoke. The more disadvantaged someone is, the higher their risk of smoking-related illness and early death⁵². Smoking rates are also higher among people with mental health conditions, those involved with the criminal justice system, and LGBT people⁵².

In B&NES, overall adult smoking rates are lower than England (9.4% vs 10.9% in 2022–24). But there are big differences within the area. Among people in routine and manual jobs, smoking is much higher, 24.5% compared to 19.2% nationally, and this rate has been rising in recent years in B&NES while falling in England (see Figure 14). Smoking is also much more common among adults in B&NES with long-term mental health conditions, with a figure of 22.3% in B&NES compared to 24% nationally⁵³.

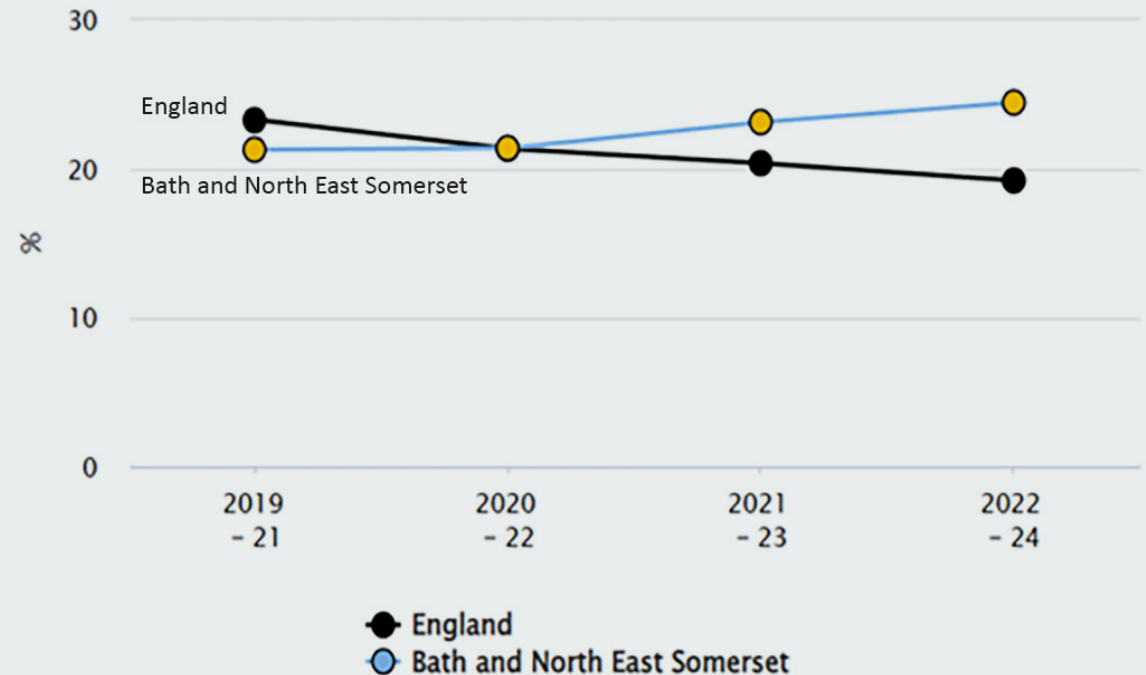


Figure 14 – Smoking prevalence in adults in routine and manual occupations (aged 18 to 64) – current smokers – 2019 - 2024. Source: OHID Fingertips. For further explanation go [Figure 14 in the Appendix](#).

Having Excess Weight

Excess weight means being either overweight or obese as calculated by Body Mass Index (BMI)⁵⁴. Having excess weight can cause many harms including increased risks of disease, disability and death, lower employment, and experiencing discrimination and stigmatisation, with these impacts noted throughout life^{55, 56}.

There are many reasons why people become overweight or obese, including biology, psycho-social reasons, lifestyle, the environment (such as having lots of fast-food outlets nearby) and commercial (through unhealthy food advertisement)⁵⁵. People in more deprived areas are more likely to have excess weight⁵⁷.

In B&NES, while fewer children have excess weight compared to the national average, it is still a significant concern. In 2024/25, 22% of reception-age children were overweight or obese, rising to 28.7% by Year 6⁵⁸. Obesity amongst children was highest in children from the most deprived areas, as show in Figure 15. Among adults, 51.6% had excess weight in 2023/24⁵⁸, again rates are higher among lower-income households.

Finally, as the last [DPH Report](#) noted, around 8,000 B&NES residents experienced food insecurity in 2023 with 4,200 people per week receiving food from affordable food projects. A challenge that has emerged in recent years is the cost of eating a healthy diet, with those on lowest incomes needing to spend 43% of their disposable income on food to comply with the Government's recommended [Eatwell Guide](#) (pdf)⁵⁹.

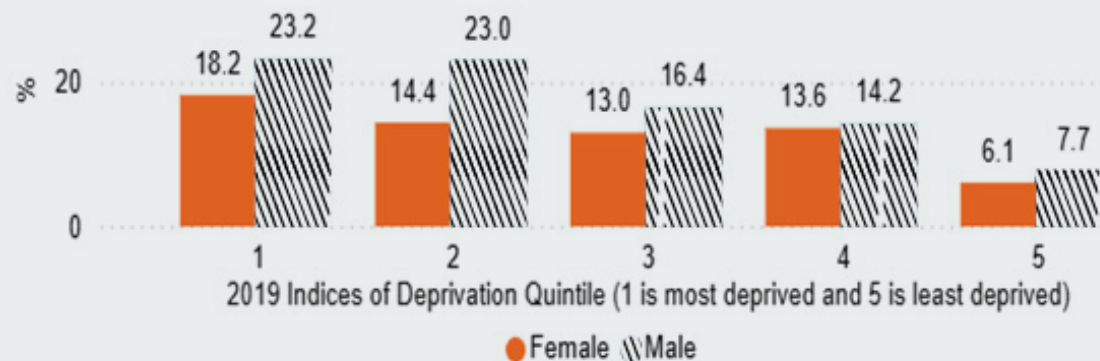


Figure 15 – percentage of Year 6 children classified as Obese (inc. Severely Obese) by Deprivation Quintile, B&NES 2017/18 – 2023/24. Source: B&NES SEB. For further explanation go to [Figure 15 in the Appendix](#).

Physical Inactivity

Being physically active is key to staying healthy, lowering the risk of long-term illnesses, and improving overall wellbeing. Regular physical activity brings many health benefits including reducing the risk of death (by 30%), risk of dementia (by up to 30%), reducing hip fractures (by up to 68%) and reducing type 2 diabetes (by up to 40%)⁶⁰.

In B&NES, in 2023/24 about 72.8% of adults were active for the recommended 150+ minutes of physical activity per week, compared with 67.4% in England⁶¹. The proportion of people considered physically inactive was 14.9% in B&NES compared with 22.0% in England⁶¹. This is positive news; B&NES is more active and less inactive than England as a whole. However, there are still 24,287 inactive adults, which represents significant potential to improve health and wellbeing across the area.

There is potential to improve activity in specific groups. Children's positive views on physical activity decline with age, and lower levels of activity are observed among girls.

Additionally, according to the Active Lives survey (2022/23), only 52.4% of those with disabilities in B&NES met the recommended 150+ minutes of physical activity per week, with rates consistently lower than people in B&NES who do not have a disability as indicated at Figure 16⁶².

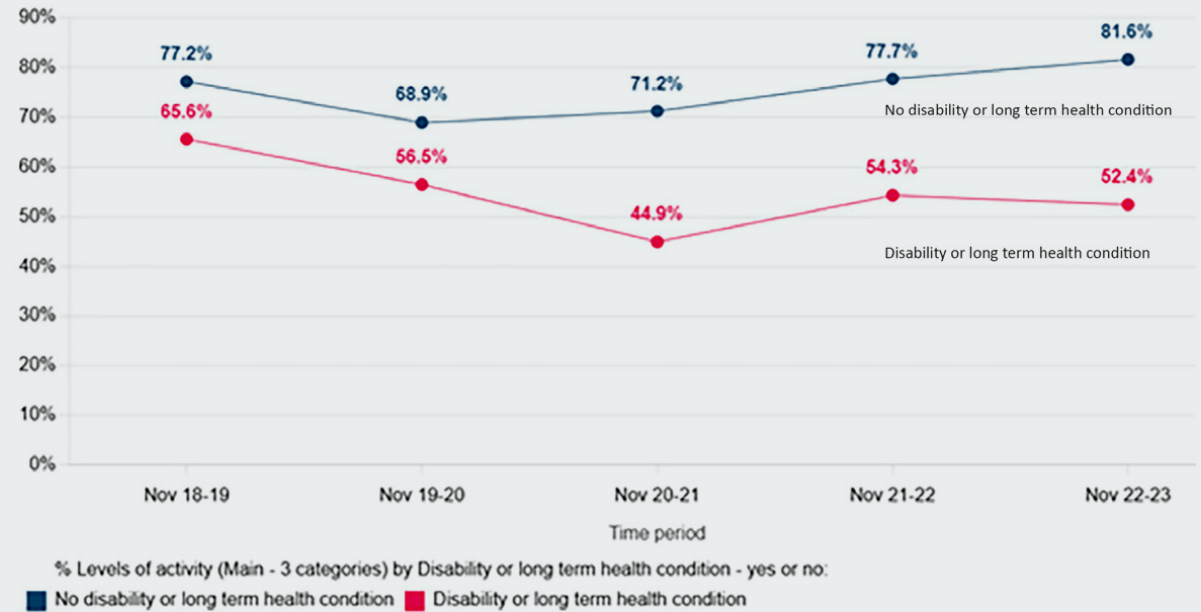


Figure 16 – % of physical activity (150 mins+ per week) by disability in B&NES, 2018/19 – 2023/24. Source: Active Lives. For further explanation go to [Figure 16 in the Appendix](#).

Alcohol Consumption

Alcohol is one of the main causes of ill health and death in the UK. It harms health and wellbeing both in the short and long-term, as well as having significant effects on society. While its use is often seen as a normal part of social life, it carries serious risks to health as outlined in Figure 17.

While alcohol consumption rates have fallen since their peak in 2008, rates of binge drinking in men have remained steady and have increased in women^{63, 64}. Additionally, alcohol related deaths have been increasing, with 22,644 deaths in England in 2023 which was a 23% higher than 2016 (start of data collection)⁶⁵. In B&NES, figures suggest around 28% of adults are at increased risk of health harms from their drinking patterns⁶⁶.

People on the lowest incomes suffer more harm from alcohol, even though they drink less than wealthier groups. Those in the most deprived areas are twice as likely to die from alcohol-related causes compared to those in the least deprived areas^{65,67}. This is thought to be due to differences in diet, fitness, smoking, alcohol consumption patterns, more shops selling very cheap alcohol and psychosocial stresses.

In B&NES, there were 1,273 alcohol-specific condition admissions in 2023/24, which is equivalent to a rate of 687 per 100,000 population. This is the highest rate seen in B&NES since currently available data started in 2016/17⁶⁸.

Additionally, there were an estimated 70 alcohol-related deaths in B&NES in 2024, which is equivalent to a rate of 35.7 per 100,000 population. This compares to a rate of 38.9 deaths per 100,000 in England⁶⁸.

Harmful use of alcohol causes

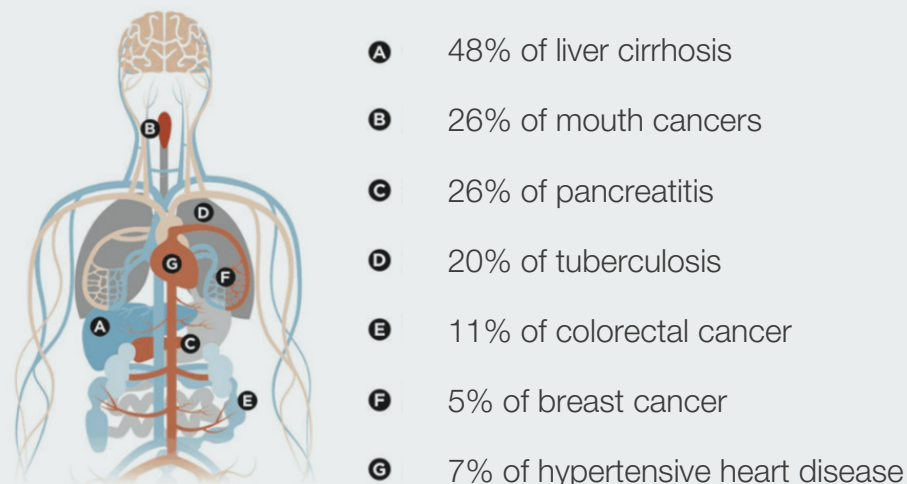


Figure 17 – Infographic showing health harms of alcohol use. Source: WHO.

Chapter 3 – Action on Health Inequalities in B&NES



Although B&NES is a relatively wealthy area and does well on many health measures, there are still big differences in how long people live, their health and wellbeing, and how they access and experience health and care services.

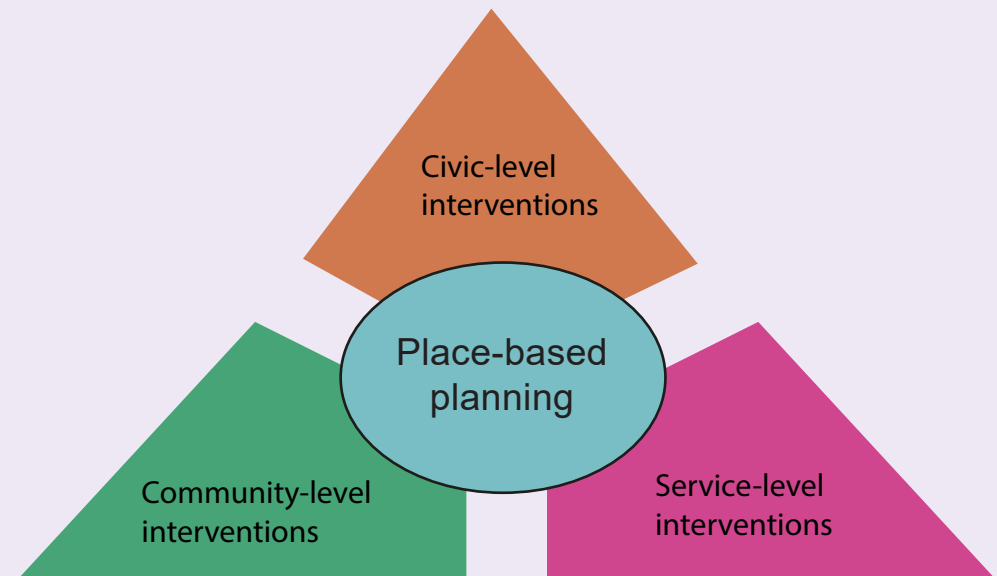
Whilst these inequalities can be stark and may appear complicated, we can and must act to reduce them. People from disadvantaged communities should not continue to die earlier than they should or live with poorer health during these shorter lives.

Within B&NES, many activities and actions are underway to reduce health inequalities within the area. These range from work led by the Local Authority through its plans and strategies to grassroots projects happening within local communities.

To make a real difference, action must collectively happen at three levels: civic, service, and community. The Health Inequalities National Support Team created the [Population Intervention Triangle¹⁶](#) to explain this approach.

The Population Intervention Triangle recognises that the causes of health inequalities are complex and connected and thus require a joined-up approach that treats the 'place' and not just individual problems or issues¹⁶. The key components of the Triangle are outlined in Figure 18.

Next, we'll look at examples of work in B&NES to reduce health inequalities using the Population Intervention Triangle framework. It is recognised this will only ever be a snapshot of the huge amount of work taking place to reduce health inequalities within organisations and communities across B&NES every single day.



Civic-level Interventions – Includes policy and strategies, economic development and environmental planning

Service-level Interventions – Includes targeting of services to meet the needs of disadvantaged groups for example through tailored service access and choice

Community-level Interventions – Includes promoting health and wellbeing using non-clinical methods and building upon assets already within communities

Figure 18 – Infographic showing the Population Intervention Triangle

Civic Level Interventions

Bath and North East Somerset Council, along with other statutory partners such as the B&NES, Swindon and Wiltshire Integrated Care Board (BSW ICB), have a range of civic-level responsibilities and functions. Activities happening at this level include:

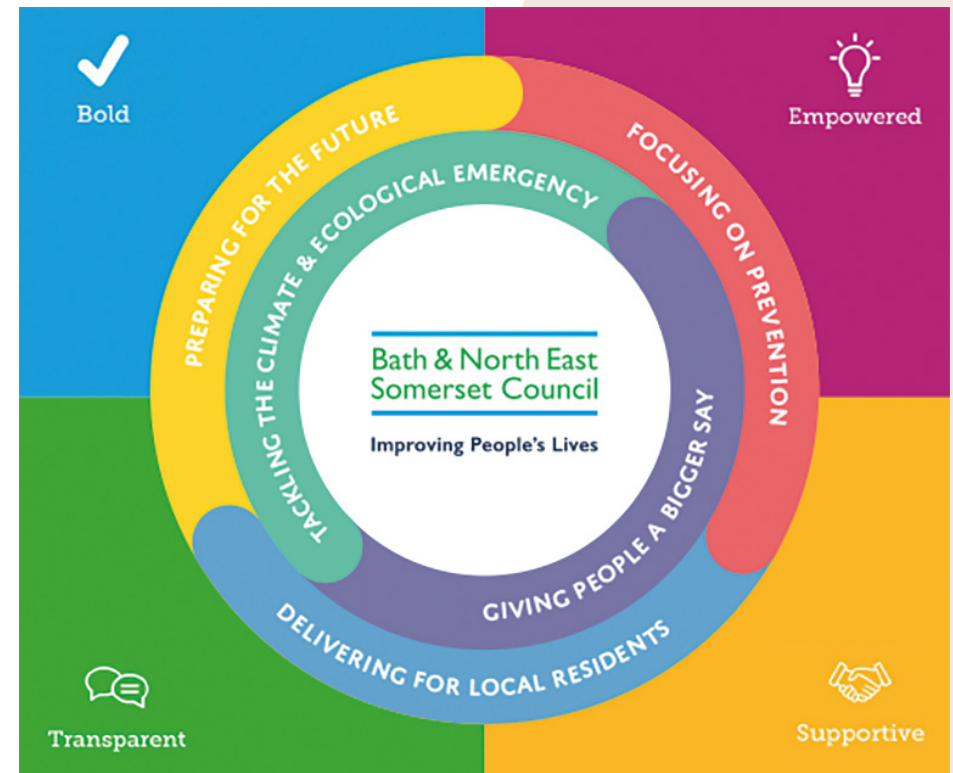
Council's Strategic Priorities

The [B&NES Corporate Strategy](#) sets out the Council's overarching principle which is to improve people's lives alongside two key policies which are tackling the climate and nature emergency and giving people a bigger say. These are then underpinned by three principles – Preparing for the Future, Delivering for Local Residents and Focusing on Prevention, with the latter having a key focus on tackling inequalities.

The Council is currently consulting on its Local Plan, which will outline how places may change over the next 20 years to 2043. A key focus of this consultation is engagement with, and outreach, to young people, renters and other underrepresented groups, including via a roving engagement bus.

When considering the building blocks of health including employment and money and resources, the [B&NES Economic Strategy](#) sets out the economic vision for B&NES between 2024-2034. This strategy has 6 pillars which are a Greener Economy, Good Work, Resilient Businesses, Creativity & Innovation, Housing Affordability and Stronger Places.

Specific examples of how this will help to reduce inequalities in B&NES include increasing inclusive pathways in to work, for example through [We Work for Everyone](#), which supports people with a learning disability, learning difficulty or who are autistic in to paid work. Additionally, there will be a focus on increasing sustainable transport options and digital connectivity for residents living within rural communities.



Health and Wellbeing Strategy

B&NES [Joint Health and Wellbeing Strategy](#) (JHWS) (2023-2030) has addressing inequality at the heart of its vision.

“Together we will address inequalities in Bath and North East Somerset, so people have the best start in life, live well and age well in caring, compassionate communities, and in places that make it easier to live physically and emotionally healthy lives.”

The commitment to tackling inequalities is one of the core principles underpinning action focused on four priority areas:

- Ensure that children and young people are healthy and ready for learning and education
- Improve skills, good work and employment
- Strengthen compassionate and healthy communities
- Create health promoting places

These actions which are owned by a key partnership, team, or subgroup of the Health and Wellbeing Board are detailed in an [Implementation Plan](#). The plan has been reviewed and refreshed in 2024-25 ensuring that bridging the gap and addressing inequality are central to all actions.

There is a well-established process for monitoring implementation of the JHWS which provides the Health and Wellbeing Board with assurance that addressing inequalities is addressed through delivery.

B&NES Health Inequalities Network

NHSE health inequalities funding allocated to B&NES has supported implementation of the BSW Inequalities Strategy objectives through creation of dedicated posts in different parts of the local system, including at the Royal United Hospitals Bath and within primary care via B&NES Enhanced Medical Services.

This core network of posts has fostered relationships across organisations and sectors to tackle health inequalities. Some of the B&NES Health Inequalities Funding (BHIF) has been directly allocated to work to address healthcare inequality through the Core20Plus5 approach for adults and children since 2024/25.

The network has developed and overseen a robust process for allocation of the BHIF. This process has been in line with the Core20PLUS5 priority criteria as set out by BSW ICB. Creation of the B&NES Health Inequalities Group (BHIG) and Dynamic Core20PLUS5 Delivery Plan has broad engagement across partners and has been a vehicle for understanding and acting on healthcare inequality over the past two years.

BSW Integrated Care Board

Embedding prevention and addressing inequalities are golden threads through various plans, strategies and governance activities within the BSW ICB. Achieving fairer health and wellbeing outcomes by reducing inequalities are strategic priorities in the [BSW Integrated Care System \(ICS\) Strategy](#) and within the [BSW ICS Implementation Plan](#). The [BSW Inequalities Strategy](#) aims to address inequalities across the life course, with a current focus on healthcare inequalities via Core20PLUS5. The Inequality Strategy is currently in the process of being refreshed, capturing strategic intentions and setting a foundation for future system-wide engagement. Finally, the BSW Outcomes Framework, which focuses on measuring outcomes rather than activity, and the BSW Population Health Board Outcome Deep Dives, ensure system oversight of activities to reduce inequalities.

B&NES Educational Attainment Gap Workstream

In B&NES children and young people that are eligible for FSM and/or are care experienced are experiencing lower educational attainment than their peers in most other areas in England. Poor educational attainment affects children and young people in their childhood (lower confidence, self-esteem and aspirations for example) and reverberates into lifelong disparities across health, employment, and income.

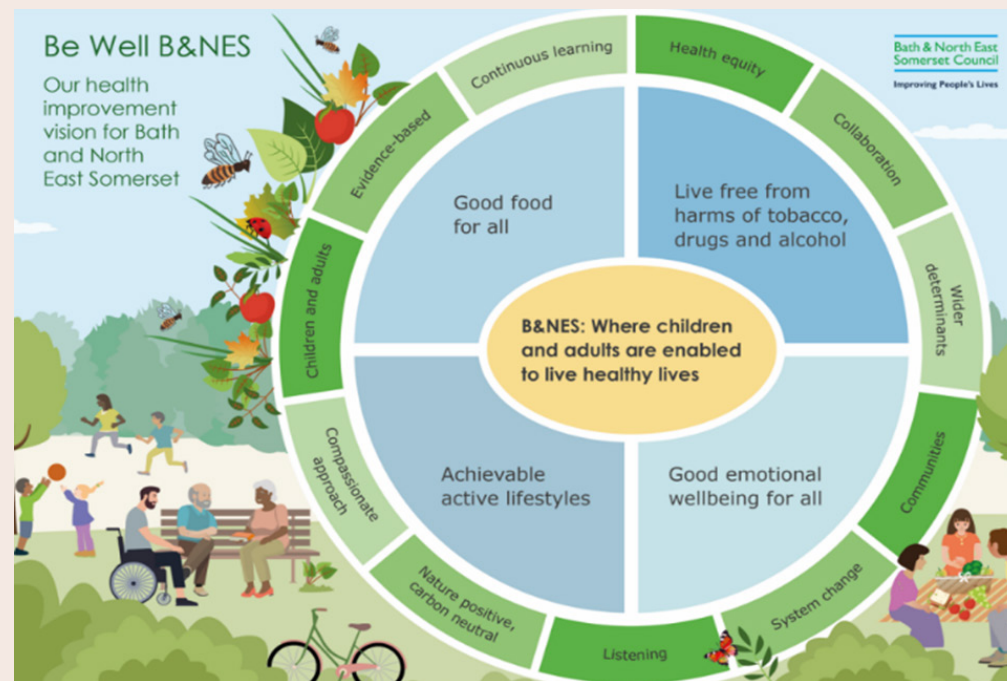
Addressing the attainment gap is a shared responsibility. B&NES Council has an important role in leading a whole-systems approach to addressing the attainment gap by addressing the root causes across Council services, coordinating place-based action with partners, and aligning capacity and resources. To date research has been undertaken to better understand the reasons for B&NES educational attainment gap and how best to address it and a Council action plan has been developed to utilise key Council levers.

Be Well B&NES

[Be Well B&NES](#) is our whole system health improvement framework for B&NES. The framework has four main health improvement aims as outlined in the blue segments above.

Tackling inequalities is one of the key underpinning principles of Be Well B&NES and promoting health equity is one of the core values. By this we mean prioritising the needs of underserved populations to ensure that health improvements benefit everyone, regardless of socio-economic status, age, ethnicity, or geography.

We aim to do this by addressing the building blocks of health and working with communities which have the greatest health improvement needs. When working with communities we will work in genuine partnership - listening, understanding community assets, and co-developing activities and plans.



Infographic showing the Be Well B&NES framework, which is the Council's health improvement vision for B&NES. Further explanation go to [Be Well B&NES in the Appendix](#).

Service Based Interventions

Community Wellbeing Hub

The [Community Wellbeing Hub](#) (CWH), established in March 2020 as a key part of B&NES Council's pandemic response, is a partnership between the Council, BSW ICB, HCRG Care Group and a wide range of commissioned organisations such as Bath Mind, Citizens Advice, Developing Health and Independence (DHI), and Everyone Health who are among a few. Whilst the original focus of the CWH was on the pandemic response, the CWH has steadily adapted to new crises: offering practical and emotional support for Ukrainian refugees settling in B&NES, supporting people on hospital discharge and tackling the cost-of-living crisis with solutions for housing, debt advice, mental health, and community support.

The CWH aims to support multi-agency collaboration among its 38 member organisations to respond to what are often complex problems, ensuring service users holistic needs are considered and managed. This is facilitated by using a shared IT system, RIVIAM, which provides a secure digital platform for referral and case management, ensuring service users only have to tell their story once. In April 2025, CWH marked its fifth anniversary, achieving over 32,000 referrals and providing support to more than 15,000 individuals.

When considering inequalities, the CWH facilitates early detection and swift referrals to services like housing, debt advice, mental health support, and community services - tackling the building blocks of health before they develop into clinical crises. By ensuring individuals do not fall through service gaps, the CWH helps reduce inequalities, foster healthier, more resilient communities and supports the prevention of the need for formal care in the longer term.

“The Community Wellbeing Hub is a remarkable legacy from the pandemic that is still supporting the most vulnerable residents in B&NES. There could be no better examples of what happens when a community comes together to help others and we are proud to be part of that journey.”

Becky Somerset, Director of the 3SG
(B&NES 3rd Sector Group)



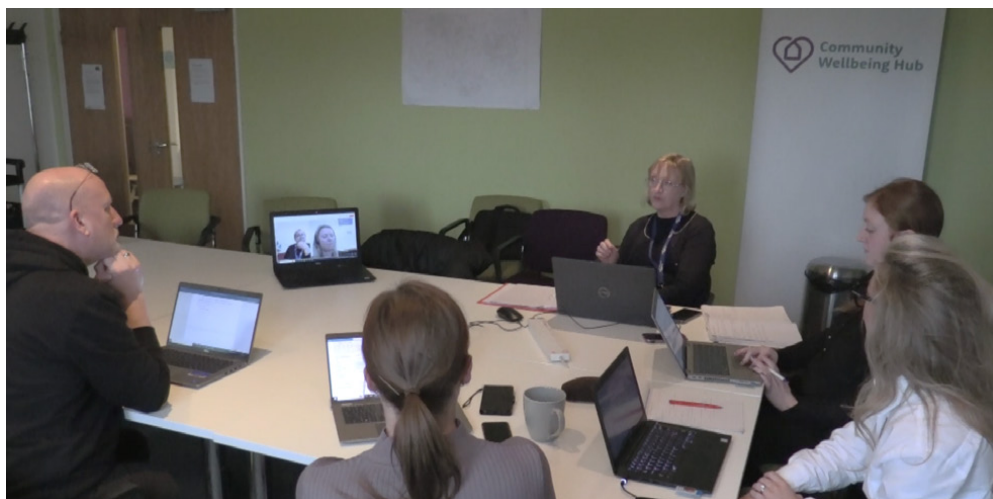
B&NES Multi-Disciplinary Team (MDT) Frailty Service

The B&NES MDT Frailty Service is a community-based service which aims to support the proactive, coordinated and person-centred management of clinically frail individuals. The MDT, which meets weekly, comprises of an Advanced Nurse Practitioner (ANP) along with health coaches and several third sector organisations.

The MDT aims to identify individuals who tend not to be on the radar of other health and care services but who have evidence of a deterioration, a history of falls or reaching a crisis point. The MDT provides a frailty review by the ANP with relevant referral, signposting and ongoing case management until needs are met.

Two of the many third sector organisations involved include [West of England Rural Network Village Agents](#) and the Bath Ethnic Minority Senior Citizens Association ([BEMSCA](#)). Their involvement helps to reduce inequalities in the access, uptake and experiences of services in population groups that may often face barriers due to rurality, language/cultural barriers or a lack of awareness or accessibility of services.

[Video of the Frailty MDT](#) in action.



Reducing Inequalities: Cold Homes, Damp and Mould

B&NES Council and partners deliver targeted interventions to reduce health risks from cold homes, damp and mould. This includes practical advice on our website and leaflets, a [Damp and Mould Charter](#) for landlords, and development of a frontline professional toolkit. Initiatives such as the [Bright Green Homes scheme](#) and [Community Energy Network](#) provide affordable warmth and energy efficiency support for vulnerable households, alongside signposting to grants and local services.

As cold, damp and mould disproportionately affect low-income households, renters, and those in poor-quality housing, by providing such resources and schemes, the programme targets those most at risk of fuel poverty and poor housing conditions. This approach aligns with the JHWS and supports equitable health outcomes by improving housing quality and reducing preventable illness.

One student at a Fresher's Fair who received information said, "Thank you so much for the leaflet, I have been really worried about the damp and mould in my student house, so it's helpful to know what I can do about it".

Damp, mouldy and cold home?

You can do something about it - live smarter



Find support and advice at:
www.bathnes.gov.uk/DampMouldCold



Keynsham Waste and Recycling Service – Improving Health

Working with Keynsham Waste and Recycling Centre in January and February 2025, the Council’s Public Health Team and B&NES Wellness Service, provided by Everyone Health, offered employees health checks, including blood pressure and cholesterol testing, and support to stop smoking for those wanting to quit.

We know those of working age, in manual occupations and men are less likely to take up the offer of health checks/wellbeing support. With the support of managers, employees were given time to have free health checks and talk to advisors about their health goals. Those wanting to quit smoking were offered free vape kits and free nicotine replacement therapy. 26 staff took up the offer of an NHS Health Check and 10 received vape kits to help their quit journey.

Laura, Operations Manager Keynsham Waste and Recycling Centre, said “As an ex-smoker myself, I have first-hand experience of the benefits of quitting, both physical and financial so was very keen for this to go ahead. As a manager, it is not uncommon to hear staff regretting that they smoke but acknowledging how difficult it is to stop. If we could provide some practical help with this, I thought it could only be a good thing.”



Reducing Inequalities in Immunisation & Screening Uptake

B&NES Council works with NHS England, BSW ICB, and local providers to improve vaccination and screening uptake among underserved groups. Initiatives include Family Health & Wellbeing Clinics in deprived areas, outreach vaccination in care homes, and targeted campaigns for flu, COVID-19, Measles Mumps & Rubella (MMR), and Human Papilloma Virus (HPV). Screening priorities focus on breast and cervical programmes, supported by local awareness campaigns and national strategies such as the HPV catch-up programme.

Lower uptake of immunisations and screening can be linked to many factors including deprivation, ethnicity, and access barriers. Recent outreach clinics in Twerton and Whiteway improved flu vaccination rates for children and adults, while care home engagement and outreach delivery provided nearly 900 vaccinations to staff who wouldn’t have ordinarily visited a GP or pharmacy to get their vaccinations, including internationally recruited workers.

As an example, one social care worker receiving outreach support said “I would not have been vaccinated if you had not made it accessible to me at my workplace.”



Community Based Interventions

Age UK B&NES - Befriending Service

Friendship and meaningful social connections are essential for good mental health and wellbeing, especially in later life. Loneliness is a recognised major determinant of health for older people in B&NES, especially for those living alone, with dementia, or without local family networks.

Our [Befriending Service](#) aims to reduce the impacts of loneliness, supporting older people in B&NES through regular visits or phone calls from trained volunteers. The service pairs individuals who feel lonely or isolated with a like-minded volunteer, helping to build confidence, foster community bonds, and create lasting, mutually rewarding friendships.

The family of Doreen (a service user) said “Doreen absolutely loves her weekly visits from George (befriender) and Winslow (George’s dog). Having always had dogs and being a huge animal lover, it improves her week greatly. She loves the company and the interesting chats they have...”

Nick Howdle, CEO, Age UK B&NES

“Doreen absolutely loves her weekly visits from George (befriender) and Winslow (George’s dog). Having always had dogs and being a huge animal lover, it improves her week greatly. She loves the company and the interesting chats they have...”

Family of Doreen, service user of the Age UK B&NES Befriending Service



St John's Foundation - Best Start in Life

In 2020, we launched our ambitious strategy to narrow the attainment gap at Key Stage 2 across B&NES. The vision for [Best Start in Life](#) is to ensure all children, regardless of their background, grow into healthy, happy, educated members of their communities.

Through investment in organisations, charities and direct school funding, interventions have been implemented with the aim of reducing the attainment gap, focusing on schools in the most deprived areas of B&NES. The programme has supported thousands of children, focusing on mental health and wellbeing; foundational literacy, numeracy and oracy; and nutritious food.

One specific example is that of the mathematics parents' workshops, which have specifically addressed generational mathematical anxiety, helping to break cycles of negative attitudes towards mathematics and ensure parents are better able to support their children at home.

Sam Gillett, Head of Delivery & Impact, St John's Foundation



Julian House - Gypsy, Roma, Boater & Traveller Outreach

Our [Support for travelling communities](#) aims to improve the lives of Gypsy, Roma, Boater and Traveller (GRBT) communities across B&NES. Without a fixed address, accessing services for health, housing support, education, or social care can be challenging. Members of our outreach team, all of whom have lived experience of life in a travelling community, work to support clients to overcome barriers and live safer, healthier lives wherever they call home.

Our crisis support work has fostered greater trust between the GRBT community and statutory services. We've found ourselves acting as a bridge between the community and external agencies. This has led to more effective collaboration and a noticeable increase in service uptake among individuals who had previously disengaged or been excluded. One client said:

"Thank you I haven't slept properly for 10 nights because of this. I'll sleep tonight". When asked how they had heard about the service they replied that a former client had recommended the service saying, "Julian House will sort you out, they helped me."

Fanny Tastic, Service Manager GRBT Services, Julian House

Orchestra of Everything Foundation (OOEF)

The [OOEF](#) is a Bath-based charity formed by local music teachers and volunteers. We provide free, high-quality music tuition to primary school children, including those in receipt of Pupil Premium funding, for whom educational attainment is amongst the lowest in England. With nearly 80% of participants receiving Pupil Premium, and 40% with Special Educational Needs or Disabilities (SEND), OOEF removes financial and access barriers to music.

Children benefit from the sheer joy of making music, and our impact goes beyond that too. Research shows that learning music fosters confidence and resilience. Our program has led to teachers reporting a noticeable improvement in attitude toward learning in around 86% of the children we support.

One parent emailed us: "Your music lessons and band workshop make such a difference to my nine-year-old's school experience. The fact that he's exposed to music is like a lifelong gift!"

[News report on the OOEF](#) (video).

Jon Gore, Founder, Orchestra of Everything Foundation



Bath City FC Foundation - “Beyond the Pitch” Initiative

As an anchor institution based within Twerton, Bath City FC Foundation run a wide variety of football and non-football related activities, one of which is Beyond the Pitch. Beyond the Pitch is a free weekly session which provides a space for individuals to exercise and socialise in an environment that encourages discussion and honesty about mental wellbeing, while promoting a healthy lifestyle to improve physical wellbeing.

The sessions, which started in April 2024, are a safe space which provide a mix of workshops, guest speakers, casual conversation and exercise, and additionally benefit from a clinical mental health professional attending the sessions.

Hayley, who started attending sessions in March 2025 and who has a diagnosis of Autism and trauma induced Schizophrenia, said “Opening up to the staff has been massive for me, I got ill six years ago and had to stop working”. Hayley went on to say, “The biggest change for me is I didn’t do anything on my own before attending, it has really helped me gain confidence.”

**Chris Gannon, Head of Wellbeing & Communications,
Bath City FC Foundation**



Bath City Farm - Roots to Work

The Roots to Work programme works holistically with people facing barriers to employment through poor mental health, learning disabilities or economic/educational disadvantage. It offers supported work placements in areas including Hospitality, Maintenance, Horticulture and Wildlife Conservation.

Trainees gain help with CVs, interviews, employment opportunities and can earn certification in AQA Awards and City and Guilds. People complete placements when they feel they have improved their self-confidence, learned and enhanced their skills and are ultimately ready to move on. Destinations trainees have moved on to in the past year include paid employment (11), volunteer roles (22), education (28) and traineeships/ apprenticeships (3).

One trainee said ‘It transformed my life. The placement equipped me with all the skills for re-entering employment after becoming ‘unfit for work’ due to mental health. I learnt to manage my time, ask for help, maintain friendships, practice new skills – enough to start work, which I didn’t think I could do again!’

**Amy Nelson, Adults Skills and Employability Lead, Bath
City Farm**



Chapter 4 – Looking Forward – Report Recommendations



Although a lot of work is being done across B&NES to reduce inequalities, we need to go further and act faster on this, as despite this action inequalities will remain. This is even more important as the B&NES population is becoming relatively more deprived and diverse, there needs to be further focus on the impacts of inequalities that different population groups may face.

Actions to reduce inequalities should make use of the strengths and resources that communities already have - this is called an asset-based approach. It means building on positive things already happening locally and working with communities as equal partners⁶⁹. For example, this approach could guide how the £20 million [Pride in Place](#) funding is used in Twerton.

These actions also need to reflect how complex inequalities are. This means using a whole-systems approach, bringing together organisations and communities to understand the issues and take coordinated action. This approach helps create long-term, sustainable change⁷⁰.

Finally, such actions should have an eye to the future and respond to national priorities, including considering the [Government's Missions](#) which have a focus on [Breaking Down Barriers to Opportunity](#) and [Building an NHS Fit For the Future](#). Specific areas of focus include priorities to giving every child the [Best Start in Life](#) and the [NHS 10 Year Plan](#) including its focus on shifting focus from sickness to prevention and the delivery of [Neighbourhood Health Services](#) within communities.

With this in mind, this report makes the following recommendations for the year ahead to further reduce inequalities within B&NES and ensure the residents of B&NES can live as happy, healthy and fulfilling lives as possible.



1. System partners to further strengthen the accurate collection and use of inequalities data to allow for better identification of disparities and development of targeted responses; with the ambition that efforts lead to improvements that benefit those with the poorest outcomes first and fastest.
2. Ensure that the emerging Neighbourhood Health Plan for B&NES has a focus on reducing inequalities, including considering how the building blocks of health (wider determinants) can further contribute.
3. Work with the West of England Combined Authority (WECA) to ensure its core levers around the building blocks of health (Transport, Housing, Employment and Skills & Economic Development) are used to reduce child poverty in B&NES as outlined in its [West of England Child Poverty Action Plan](#) (pdf).
4. Embed and deliver the updated Health and Wellbeing Strategy Implementation Plan with its focus on its key pillars to reduce inequalities.
5. In line with the recommendation of the Local Government Association (LGA) Peer Review of B&NES Council of ensuring inequalities features more prominently in the Council's thinking, planning, narrative and delivery; undertake a self-assessment on the current position and develop a Council wide plan.

Chapter 5 – Reflecting on 2023/24 Recommendations



1. Work effectively through the structure of the Fair Food Alliance to review and fulfil the ambitions of the Food Equity Action Plan and to broaden engagement

The [B&NES Food Equity Action Plan](#) sets out our goals, principles and strategies for reducing food inequality across B&NES, with key pillars focusing on Governance, Money, Food and Inclusion.

Food security and supporting local food supply is an objective in the stronger places pillar of the [B&NES Economic Strategy](#). Good Food has also been included as key focus of the [Be Well B&NES](#) Health Improvement Framework, and is a theme within the developing B&NES Climate and Nature Strategy. In addition, much work has taken place over the last year to develop a Food Strategy for B&NES. Addressing food insecurity is central to the healthy affordable food element of this work.

Integral wraparound financial support from [Citizens Advice](#) and [Clean Slate](#) continues in food banks, funded by the Trussell Trust, and further funding from [Feeding Britain](#) has allowed this service to be extended to food clubs and pantries. A priority going forward will be to map provision and explore ongoing funding for this income maximisation support.

There have been many examples of local community organisations continuing to offer opportunities for education and experience of food growing, preparation and cooking in the community. For example, [Bath City Farm](#) have set up a community fruit press, and partnership work between [Bath Community Kitchen](#), [One Big Local](#), [Radstock Town Council](#), [3SG](#) and the [National Trust](#) has meant the first community meal at the [Trinity Community Hub](#) has recently taken place.

In addition, work to better understand lived experience continues with a food and transport project focusing on ways in which local voices can influence transport planning and provision. This builds on previous research by B&NES Public Health and the [University of Bath](#) which highlighted how important affordable and accessible local and community transport is to reliably access healthy and affordable food.



2. Raise awareness, recognition and embed food security within the Children & Young People's Plan

The Children and Young People's (CYP) Plan reports as a subgroup of the B&NES Health and Wellbeing Board. Key actions to raise awareness and recognition and embed food security for CYP is as followed:

The B&NES Affordable School Programme is a collaborative movement helping schools create inclusive environments where all children can thrive, regardless of family financial circumstances. Alongside reducing hidden costs of education, the programme supports schools to address food access, such as barriers to school lunches, promotion of breakfast clubs, and signposting families to local food support and advice. Through network meetings and policy reviews, it raises awareness of the impact of food insecurity on learning and wellbeing. Currently, just over half of B&NES schools are engaged, supported by regular network meetings.

With funding from the Department for Education (DfE), [Holiday Activities and Food \(HAF\) Programme](#) provides access to nutritious food during school holidays for children and young people eligible for benefits-related free school meals, a time when food insecurity often increases because free school meals are not available. Alongside enriching activities such as physical activity, science, technology, engineering, and mathematics (STEM) building, and outdoor education, the programme connects families to local food banks, community resources, and advice services, helping to build a stronger support network for those experiencing food insecurity. In Winter 2024, HAF partnered with [FareShare South West](#) and [Feeding Bristol](#) to distribute 275 food hampers containing essential dried goods, recipe booklets, and creative resources, to support families after the Christmas period.

The Best Start in Life group, alongside the B&NES Affordable Food Network, prioritises tackling food insecurity as a core determinant of child health and wellbeing. It commits to creating supportive food environments, promoting breastfeeding and infant nutrition, and improving access to schemes like [Healthy Start](#) and advocating for automatic enrolment to reduce barriers. It also calls for tighter regulation of infant food marketing and an increase in Healthy Start allowances to strengthen the nutritional safety net. These actions aim to reduce inequalities and ensure every child thrives.



3. All partners to support progress on upstream determinants of food insecurity through advocating for action on the universal credit essentials offer, widening criteria for free school meals and opt-out for key benefits

The Welfare and Support Team have continued to work on auto-enrolment for free school meals over the past year. Around 570 families were contacted regarding free school meal eligibility based on Council Tax Support and an income lower than the threshold for free school meals. Some families weren't eligible due to other factors, but 138 families are now in receipt of free school meals who didn't previously have them. In addition, schools now receive extra funding for each of these children (approx. £1,400 a year). From September 2026, free school meals will apply to any household in receipt of Universal Credit. Officers are now confident that residents who are entitled to FSM within B&NES are receiving this support.

The team have also worked to increase the number of people in B&NES claiming pension credits. In total, 188 people that were identified as potentially being eligible for pension credit were contacted, and of these, 55 are now in receipt of pension credits.

The Council has made funding available from the Government's Household Support Fund to tackle the root causes of food insecurity most notably through Clean Slate's Financial Health Check scheme. This is in addition to providing immediate support to families who receive Free School Meals through supermarket vouchers for school holiday periods, and funding allocations to Citizens Advice and Bath and North East Somerset Carer's Centre, to help with living costs.



4. Take forward the conversation with system partners about the development of a local food strategy for B&NES that contributes to addressing household food insecurity, as committed to in the B&NES Economic Strategy 2024-2034

The B&NES Food Strategy has been in development since January 2025 following a commitment in the 2024 Economic Strategy. It sets out a whole system approach to make healthy, affordable, local, sustainable and culturally appropriate food accessible to all residents. The strategy has been co produced from the start, involving stakeholder workshops, resident surveys and resident engagement events with groups such as Age UK. It uses the Sustainable Food Places framework, organised around six themes:

- Food Governance
- A Good Food Movement
- Healthy Food for All
- A Sustainable Food Economy
- Catering and Procurement
- Food for the Planet

The strategy has been developed to align with the Climate and Nature strategy and the Local Plan, ensuring that food is embedded into decisions around neighbourhood design and other key policy decisions.

Addressing inequalities is central to any food strategy, particularly in B&NES. B&NES is a generally affluent area, however there are clear pockets of deprivation with limited access to healthy, nutritious, affordable, local and culturally appropriate food. Work continues to tackle food insecurity in the area.

Prioritising income maximisation - the Council has become a registered partner with the Money Guiders programme, a self-development programme that helps organisations to confidently talk about money with their service users and give safe, effective guidance. The programme is currently being piloted with the Council's Welfare and Support Team and with Food Bank volunteers. Feedback from the pilot will help to inform how the programme is rolled out to other partners and organisations in the future to help improve the knowledge, skills, and confidence of those working to support the financial wellbeing of B&NES residents.



Indicators

Public Health Outcomes Framework and other key indicators (as of Dec 2025)

General Key:

Better than national 95% (B)

Similar to national (S)

Worse than national 95% (W)

Recent trend Key:
Could not be calculated (CNC) No
significant change (NSC)
(IGB)

Increasing/Getting worse

Decreasing/Getting worse (DGW)

(IGW) Increasing/Getting better

Decreasing/Getting better (DGB)

Health Improvement

Period	Indicator Description	England	South West	B&NES	Trend
2022	Under 18 conceptions (crude rate per 1,000)	13.9	12.4	6.9 (B)	NSC
2024/25	Reception prevalence of overweight (including obesity) (4-5 yrs)	23.5%	23.5%	22.0% (S)	CNC
2023/24	Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (18+ yrs)	64.5%	62.7%	51.6% (B)	CNC
2023/24	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years), crude rate per 10,000	-	-	65.3*	DGB
2023/24	Hospital Admissions as a result of self-harm (10-24 years), DSR per 100,000	-	-	434.4*	NSC
2021-24	Admission episodes for alcohol-specific conditions (under 18 years), crude rate per 100,000	-	-	53.5*	CNC
2023/24	Percentage of physically active adults	67.4%	71.4%	72.8% (B)	CNC
2022-24	Loneliness: Percentage of adults who feel lonely often or always	7.0%	6.3%	6.1% (S)	CNC
2022-24	Smoking prevalence in adults in routine and manual occupations (aged 18 to 64) - current smokers (APS)	19.2%	19.1%	24.5% (S)	CNC
2022/23	Smoking status at time of delivery	8.8%	9.2%%	7.7%	NSC
2024/25	% showing substantial treatment progress (all substances)	46.8%	-	51.5%	CNC
2021-23	Deaths from drug misuse, DSR - per 100,000	5.5	6.2	6.3 (S)	CNC
2024	Cancer screening coverage - breast cancer	69.9%	72.6%	70.8% (B)	DGW
2024	Cancer screening coverage - cervical cancer (aged 25 to 49 years old)	66.1%	70.5%	71.0% (B)	DGW
2020-25	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health Check	29.6%	21.9%	41.2% (B)	CNC

Health Protection

Period	Indicator Description	England	South West	B&NES	Trend
2024/25	Population vaccination coverage - MMR for two doses (5 years old). Benchmarking against goal: <90%, 90 to 95%, ≥95%	83.7%**	89.6%	91.1% (S)	NSC
2024/25	Population vaccination coverage - Flu (aged 65 years and over). Benchmarking against goal: <75%, ≥75%	74.9%	79.4%	82.1% (B)	DGW
2022-24	HIV late diagnosis. Benchmarking against goal: <25%, 25 to 50%, ≥50%	43.3%	48.7%	50.0% (W)	CNC

Healthcare And Premature Mortality

Period	Indicator Description	England	South West	B&NES	Trend
2022-24	Under 75 mortality rate from cardiovascular disease (DSR per 100,000), 3 year range	76.5	66.3	52.3 (B)	CNC
2022-24	Under 75 mortality rate from cancer (DSR per 100,000), 3 year range	120.3	114.8	109.8 (B)	CNC
2022-24	Under 75 mortality rate from liver disease (DSR per 100,000), 3 year range	21.1	17.9	16.8 (B)	CNC
2022-24	Suicide rate (DSR per 100,000 population)	10.9	11.8	9.6 (S)	CNC
2023/24	Hip fractures in people aged 65 and over (DSR per 100,000 population)	547	530	513 (S)	NSC
2023/24	Percentage of 5 year olds with experience of visually obvious dental decay	22.4%	19.7%	16.7% (B)	CNC

Inequalities

Period	Indicator Description	England	South West	B&NES	Trend
2021-23	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	10.5***	8.0***	8.0***	CNC
2021-23	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	8.3***	5.9***	5.1***	CNC

Wider Factors that Shape Health (Wider Determinants of Health)

Period	Indicator Description	England	South West	B&NES	Trend
2024	Home ownership (ratio of median house price to median gross annual residence-based earnings, with a higher ratio indicating it is less affordable)	7.7	8.4	9.7	CNC
2024/25	Percentage of people in employment	75.7%	78.6%	79.3% (S)	NSC
2022/23	Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	10.4%	9.0%	12.0% (S)	CNC
2023/24	School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	51.5%	50.0%	44.6% (W)	CNC
2023/24	% of children living in poverty (after housing costs)	31.0%	27.0%	21.1%	CNC
2024/25	Attainment gap between disadvantaged and non-disadvantaged pupils reaching the expected standard in Reading, Writing, Maths (RWM) at KS2	22%	25%	33%	CNC
2024/25	% of disadvantaged pupils meeting the expected standard in RWM at KS2	48%	41%	37%	CNC
2024/25	% of non-disadvantaged pupils meeting the expected standard in RWM at KS2	70%	66%	70%	CNC

Glossary

Below is a glossary of terms not defined within the main report:

- Anchor institution: a large, stable organisation, such as a university, hospital, or local authority, that is firmly rooted in its community and uses its long-term presence and resources to support local economic and social wellbeing.
- B&NES (Bath and North East Somerset): Our geographical area (a unitary authority) with Bath and North East Somerset Council providing local government functions.
- B&NES, Swindon and Wiltshire Integrated Care Board (BSW ICB): A statutory body which brings together NHS organisations with local authorities and other partners to work to improve population health and establish shared strategic priorities. It oversees how money is spent and ensures that health services work well and are of high quality.
- BMI (Body Mass Index): A calculation which divides a person's weight in kilograms by their height in metres squared.
- Cardiovascular disease: A disease which affects the heart or blood vessels.
- Chronic condition: A health condition which is persistent or long lasting.
- Civic responsibilities: Responsibilities of the Council include its duties such as providing certain services, its engagement with communities, policy and strategy development, and community leadership.
- Disability: The experience of any condition which makes it more difficult for a person to do certain activities or have equitable access in society.
- Disadvantaged household: A household that faces social or economic barriers, such as low income, limited resources, or restricted opportunities, that reduce its ability to meet basic needs and thrive.
- Economic activity: Participation in work that contributes to the production of goods or services, including being employed or actively seeking employment.

- Educational attainment gap: A gap in educational achievement between groups of students.
- Elective Treatment: A planned, non emergency medical procedure that is scheduled in advance.
- Frailty: A condition in which a person's physical and sometimes cognitive reserves are reduced, making them more vulnerable to stressors and increasing the risk of poor health outcomes.
- Governance: System of rules, processes, and decision-making structures that guide how an organisation or society is directed, controlled, and held accountable.
- Health checks: Assessments of a person's overall health to identify if they are at higher risk of disease, usually referring to NHS health checks offered between 40 and 74 years.
- High Blood Pressure: Generally considered to be a blood pressure of higher than 140/90mmHg when taken in a healthcare setting, or higher than 135/85mmHg when taken at home.
- Life Expectancy: The average number of years a person can expect to live based on current patterns of mortality (deaths).
- Obesity: In adults it is defined as living with a body mass index (BMI) greater than or equal to 30kg/m². If you have an Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background it is defined as a BMI greater than or equal to 27.5kg/m². In children it is defined as a BMI greater than or equal to the 95th centile.
- Overweight: A condition in which a person has more body weight than is considered healthy for their height, usually defined by a BMI between 25 and 29.9kg/m². If you have an Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background it is defined as a BMI between 23 to 27.4kg/m².
- Policy: A set of ideas, a statement of intent or a plan for action adopted or proposed by an organisation.
- Poverty: Where people lack resources required to make it possible to meet their basic needs.
- Post Traumatic Stress Disorder: A mental health condition triggered by experiencing or witnessing a traumatic event, leading to persistent symptoms such as flashbacks, avoidance, and heightened alertness.
- Relative poverty: Individuals whose income is below 60% of median incomes.
- Refugee: A person who has been forced to flee their country because of persecution, conflict, violence, or a well-founded fear of harm.
- Self-Funded Residents: People who pay for their own social care costs.

- Stigma: A negative label or set of beliefs that leads people to judge, reject, or discriminate against someone based on a particular characteristic or circumstance.
- Strategy: A plan of action to achieve a long-term or overall aim.
- Third sector: Non-governmental, non-profit, values-based organisations.
- Universal Credit: UK government benefit that provides a single monthly payment to help with living costs for people who are on a low income, out of work, or unable to work.
- Wellbeing: A state in which a person feels healthy, happy, and able to cope with life's challenges, encompassing physical, mental, and social aspects.

References

1. [The King's Fund. What are health inequalities?](#)
2. [The Local Government Association. Place and health: Bridging the gap in health inequalities](#)
3. [Office for Health Improvement and Disparities \(OHID\). Health disparities and health inequalities: applying All Our Health](#)
4. [Ministry of Housing, Communities and Local Government. English indices of deprivation 2025: statistical release](#)
5. [The Marmot Review. Fair Society, Healthy Lives pdf](#)
6. [Health equity in England. The Marmot Review 10 years on pdf](#)
7. [NHS England. A national framework for NHS – action on inclusion health](#)
8. Aldridge, R W et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. [The Lancet, Volume 391, Issue 10117, 241 – 250](#)
9. [The Office for National Statistics. Deaths of homeless people in England and Wales: 2021 registrations](#)

10. [The Office for National Statistics. National life tables – life expectancy in the UK: 2020 to 2022](#)
11. [UK Parliament. Women and Equalities Committee. Tackling inequalities faced by Gypsy, Roma and Traveller communities](#)
12. [The King’s Fund. The Health of People from Ethnic Minority Groups in England](#)
13. [LGBT Foundation. Hidden figures: LGBT health inequalities in the UK pdf](#)
14. [Public Health England. Health matters: reducing health inequalities in mental illness](#)
15. [OHID Fingertips. Excess under 75 mortality rate in adults with severe mental illness \(SMI\)](#)
16. [Public Health England. Place-based approaches for reducing health inequalities: main report](#)
17. [Jones NL et al. Life Course Approaches to the Causes of Health Disparities. Am J Public Health. 2019 Jan;109\(S1\):S48-S55](#)
18. Dahlgren, Göran & Whitehead, Margaret. (1991).
[Policies and strategies to promote social equity in health. Background document to WHO - Strategy paper for Europe. Institute for Futures Studies, Arbetsrapport.](#)
19. [The King’s Fund. Broader Determinants of Health: trends](#)
20. [Milton Keynes Local Authority. People Friendly and Healthy Places pdf](#)
21. [Public Health England. Wider determinants of health](#)
22. [The Health Foundation. How to talk about the building blocks of health](#)
23. [B&NES Local Authority. Strategic Evidence Base](#)
24. [The Health Foundation. Analysis of Department for Work and Pensions, Households below average income](#)
25. [Ministry of Housing, Communities & Local Government. English Housing Survey 2022 to 2023: housing quality and condition](#)
26. [UK Health Security Agency. Understanding and addressing the health risks of damp and mould in the home](#)
27. [OHID Fingertips. Fuel poverty \(low income, low energy efficiency methodology\)](#)
28. [House of Commons Library. Poverty in the UK: Statistics pdf](#)
29. [Joseph Rowntree Foundation. UK Poverty 2025](#)

30. [End Child Poverty. Local Child Poverty Statistics](#)
31. [The Health Foundation. How employment status affects our health](#)
32. [The Health Foundation. Unemployment rates for disabled and non-disabled](#)
33. [The Health Foundation. Inequalities in unemployment](#)
34. [The Health Foundation. Relationship between low quality jobs and health](#)
35. [Office for National Statistics. Labour Market Profile – Bath and North East Somerset](#)
36. [Gov.UK. Create your own tables on participation in education, training and neet age 16 to 17 by local authority](#)
37. [The Health Foundation. Tackling the inverse care law pdf](#)
38. [British Medical Journal. “Shameful” inequalities leave patients in deprived areas waiting longer for hospital care](#)
39. [Care England. Bridging the Gap: Tackling inequalities in England Social Care sector and beyond pdf](#)
40. [Royal College of Paediatrics and Child Health. Vaccination in the UK: Access, uptake and equity pdf](#)
41. [House of Lords Library. Rural communities: Issues and support](#)
42. [Department for Environment, Food & Rural Affairs. Key findings, Statistical Digest of Rural England](#)
43. [The King’s Fund. Mental Health 360: inequalities](#)
44. [Friends, Families and Travellers. Health inequalities experienced by Gypsy, Roma and Traveller communities pdf](#)
45. [UK Parliament: Women and Equalities Committee. Tackling inequalities faced by Gypsy, Roma and Traveller communities](#)
46. [Stonewall. LGBT in Britain – Health](#)
47. [Cancer Research UK](#)
48. [Public Health England. Health matters: reducing health inequalities in mental illness](#)
49. [British Medical Journal. England’s two-tier care system deepens social care inequalities](#)
50. [NHS England. Core20PLUS5](#)

51. [OHID. Smoking and tobacco: applying All Our Health](#)
52. [Action on Smoking and Health. Health Inequalities and Smoking pdf](#)
53. [OHID Fingertips. Smoking Profile – Bath and North East Somerset](#)
54. [World Health Organization. Obesity and Overweight](#)
55. [OHID. Adult obesity: applying All Our Health](#)
56. [OHID. Childhood obesity: applying All Our Health](#)
57. [Candio et al. Socio-economic accounting of inequalities in excess weight: a population-based analysis. BMC Public Health. 2023 Apr 20;23:721](#)
58. [OHID Fingertips. Obesity, physical activity and nutrition: Area profile – Bath and North East Somerset](#)
59. [Bath and North East Somerset Council. Tackling Food Insecurity: Director of Public Health Report 2023/24 pdf](#)
60. [OHID. Physical activity: applying All Our Health](#)
61. [OHID Fingertips. Obesity, physical activity and nutrition: Area profile – Bath and North East Somerset](#)
62. [Sport England. Active Lives Online](#)
63. [OHID. Alcohol: applying All Our Health](#)
64. [Alcohol Change UK. Drinking trends in UK](#)
65. [OHID. Alcohol profile: short statistical commentary, Feb 2025](#)
66. [Public Health England, Local Alcohol Consumption Survey National Report pdf](#)
67. [Royal College of Physicians. Confronting alcohol harm and tackling inequalities: Guest Blog](#)
68. [OHID Fingertips. Alcohol Profile – Bath and North East Somerset](#)
69. [Local Government Association. Asset-based public health – shifting evidence and practice](#)
70. [Stansfield et al. What are the elements of a whole system approach to community-centred public health? A qualitative study with public health leaders in England’s local authority areas. BMJ Open 2020;10:e036044](#)

Appendix

Explanatory text of charts and images referenced in main report:

Figure 2. A bar chart which shows the life expectancy gap between the most deprived and least deprived deciles in England split by sex in years 2016-2018.

- Decile 1 (most deprived) life expectancy was around 74 for males and 78 for females
- Decile 2 it was around 76 for males and 80 for females
- Decile 3 it was around 77 for males and 81 for females
- Decile 4 it was around 78 for males and 82 for females
- Decile 5 was around 79 for males and 83 for females
- Decile 6 was around 80.5 for males and 84 for females
- Decile 7 was around 83 for males and 84.5 for females
- Decile 8 was around 81 for males and 85 for females
- Decile 9 was around 82 for males and 85 for females
- Decile 10 was around 84 for males and 86 for females

The overall gap between life expectancy of the most (1) and least (10) deprived deciles is 9.5 years for males and 7.7 years for females.

Figure 4. A graph showing the Standardised all-cause mortality ratio for inclusion health groups, compared to the general population by deprivation decile. There are two graphs one for females and another underneath for males split by bars for each deprivation decile. The graph shows for both males and females there is around double the mortality ratio for the most deprived decile, compared with the least deprived decile. However, for inclusion health groups, which are included as a separate bar, the mortality ratio is more than 10 times higher for females and more than 6 times higher for males. Confidence intervals are shown and are narrow.

Figure 5. A line graph showing the excess under 75 mortality rate in adults with severe mental illness (SMI) in B&NES compared to England from 2015 to 2023. The following key data points are shown:

- 2015 - 2017 – Excess mortality was 592% in B&NES and 351% in England
- 2017 - 2019 – It was 612% in B&NES and 377% in England
- 2019 - 2021 – It was 561% in B&NES and 385% in England
- 2021 - 2023 – It was 504.3% in B&NES and 384% in England

Figure 6. A semi-circular image with concentric circles showing the following influences on health:

- The outer ring (blue) represents the General socio-economic, cultural and environmental conditions.
- The next one is labelled the Living and working conditions (green) including things like housing, health services, water and sanitation, unemployment, work environment, education and agricultural/food production.
- The next ring is Social and community networks (yellow) and then Individual lifestyle factors (orange).
- Finally, age, sex and constitutional factors are in the centre (red).

Figure 7. The factors affecting health. On the left of the image is a simple human figure divided into sections with percentages representing the significance of each factor. On the right the description of the factor is given alongside the percentage. The image shows that the effects of each factor are as follows:

- Physical and built environment = 10% effect
- Health behaviours (including smoking, diet/exercise, sexual activity and alcohol use) = 30%
- Health care = 20%
- Socioeconomic factors (including education, job status, income, family support and community safety) = 40%

Figure 9. A line graph showing the percentage of pupils meeting expected standard at Key Stage 2 in reading, writing and maths by Free School Meals (FSM) eligibility status. The graph shows the following data points:

- 2018/19 – In B&NES 71% of Non-FSM students met expected standard compared with 69% in England. In FSM students, 41% met the expected standard in B&NES compared with 48% in England.
- 2021/22 – In B&NES 67% of Non-FSM students met expected standard compared with 65% in England. In FSM students, 32% met the expected standard in B&NES compared with 42% in England.
- 2022/23 – In B&NES 66% of Non-FSM students met expected standard compared with 66% in England. In FSM students, 29% met the expected standard in B&NES compared with 44% in England.
- 2023/24 – In B&NES 67% of Non-FSM students met expected standard compared with 67% in England. In FSM students, 33% met the expected standard in B&NES compared with 46% in England.
- 2024/25 – In B&NES 70% of Non-FSM students met expected standard compared with 69% in England. In FSM students, 36% met the expected standard in B&NES compared with 48% in England.

Figure 10. A line graph comparing house prices to earnings ratio (of working people) between B&NES, England and West of England (WoE) averages between years 2010 and 2024. This chart shows that B&NES has consistently had higher price to earning ratios than England and West of England.

In 2010 the price to earnings ratio was around 9 in B&NES, 7.5 in WoE and 7 in England. It steadily increased to 2017 reaching a ratio of 11 in B&NES, 9 in WoE and 8 in England. It then falls slightly between 2017 and 2020 before reaching its highest point in 2021. Here the ratio was 12 in B&NES, 10 in WoE and 9 in England. It then falls since this point reaching 11 in B&NES, 9 in WoE and 8 in England in 2024.

Figure 11. A line graph showing poverty rates for five population groups in the UK from 1994/95 to 2022/23. The following groups are represented:

- Children (Dark Navy) - Highest poverty rates across the entire period. Starts at around 32% in 1994/95. Fluctuates between 28% and 33% through the late 1990s and 2000s. Falls slightly in the early 2010s. Rises again towards around 30% by 2022/23. There is a sharp dip in 2020/21 from above 30% in the previous year to around 27%. It then sharply rises back to 30% in 2022/23.
- The pattern of a sharp decrease in 2020/21 with a rise back to the previous level in the subsequent year is seen across all population groups
- Working-age adults with children (Green) - Begins at just over 25% in the mid-1990s. Shows small variation through the 2000s. Ends just below 25% in 2022/23
- Pensioners (Red). Starts at around 27% in 1994/5. Experiences a sharp decline from 2000 to 2010, falling to around 14%. Stays between 14% and 18% afterward. Ends around 16% in 2022/23 and is the lowest poverty rate of all groups at this point.
- All people (Dark Blue Dotted Line). Starts at around 25% in 1994/95 and falls on a mostly downwards trajectory to around 21% in 2022/23.
- Working-age adults without children (Blue Dashed Line). Starts as the lowest poverty rate of all groups in 1994/95 at around 16% with small fluctuations until around 2007/08 where it starts a steady upwards trajectory before falling slightly, reaching around 18% in 2022/23.

Figure 12. A bar chart showing unemployment rates by age band during 2024 in the UK. The chart shows the following data points:

- Ages 16 – 19 is 17% unemployment rate
- Ages 20 – 24 is 10% unemployment rate
- Ages 25 – 34 is 3.5% unemployment rate
- Ages 35 – 49 is 2.5 % unemployment rate
- Ages 50 – 64 is 2.5 % unemployment rate

Figure 13. An infographic showing the NHS England Core20PLUS5 approach to support the reduction of health inequalities for Children and Young People (CYP).

It shows 2 target populations for this approach:

1. CORE20 = most deprived 20% of the national population as identified by the national Index of multiple deprivation
2. PLUS = Integrated care system chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the CORE20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

It then shows the following 5 key clinical areas of focus to reduce health inequalities:

3. Asthma - Address over reliance on reliever medications; and decrease the number of asthma attacks
4. Diabetes - Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase proportion of CYP with Type 2 Diabetes receiving annual health checks
5. Epilepsy - Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism
6. Oral Health - Address the backlog for tooth extractions in hospital for under 10s
7. Mental Health - Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Figure 14. A line graph showing the smoking prevalence in adults in routine and manual occupations (aged 18 to 64) who are current smokers in B&NES compared to England from 2019 to 2024. The graph shows how the England rate has fallen slightly in the period, whereas the B&NES rate has increased. It has the following key data points are shown:

- 2019 – 2021 – Smoking prevalence was 21.3% in B&NES and 23.3% in England
- 2020 – 2022 – It was 21.4% in B&NES and 21.4% in England
- 2021 – 2023 – It was 23.1% in B&NES and 20.4% in England
- 2022 – 2024 – It was 24.5% in B&NES and 19.2% in England

Figure 15. This bar chart shows the percentage of year 6 children classified as obese (including Severely Obese) split by IMD (2019) deprivation quintile and then further split by sex. It covers the years 2017/18 to 2023/24. It shows the following data points (bars):

- IMD Quintile 1 (most deprived) – 18.2% of females were obese (orange) and 23.2% of males (blue)
- IMD Quintile 2 – 14.4% of females were obese and 23% males
- IMD Quintile 3 – 13% of females were obese and 16.4% of males
- IMD Quintile 4 – 13.6% of females were obese and 14.2% of males
- IMD Quintile 5 (least deprived) – 6.1% of females were obese and 7.7% of males

Figure 16. This line graph shows percentage of physical activity in B&NES split by people who have no disability or long-term condition (LTC) (blue line) and those with a disability or LTC (red line). It covers the period Nov 2018 to Nov 2023 and has the following data points:

- Nov 2018/19 – Not disabled/LTC = 77.2% physically active and those with a disability/LTC = 65.6%
- Nov 2019/20 – Not disabled/LTC = 68.9% physically active and those with a disability/LTC = 56.5%
- Nov 2020/21 – Not disabled/LTC = 71.2% physically active and those with a disability/LTC = 44.9%
- Nov 2021/22 – Not disabled/LTC = 77.7% physically active and those with a disability/LTC = 54.3%
- Nov 2022/23 – Not disabled/LTC = 81.6% physically active and those with a disability/LTC = 52.4%

Be Well B&NES. An infographic showing the Be Well B&Nes framework – which is the Councils health improvement vision for B&NES.

Centre is statement saying B&NES: Where children and adults are enabled to live healthy lives.

Surrounded by a circle divided into four segments showing the 4 key principles

1. Good food for all
2. Live free from harms of tobacco, drugs and alcohol
3. Achievable active lifestyles
4. Good emotional wellbeing for all

This is then surrounded by an outer circle divided into segments showing the 11 other facilitators:

1. Health equity
2. Collaboration
3. Wider determinants
4. Communities
5. System-change
6. Listening
7. Nature positive, carbon neutral
8. Compassionate approach
9. Children and adults
10. Evidence-based
11. Continuous learning