Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 November 2021
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Reducing Health Inequalities and Promoting Health Equity
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Ros Jervis, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne McCarthy, Consultant in Public Health

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

My focus in this report is on our widening 'health inequalities.' Enduring health inequalities have always been present across society, however the impact of the COVID-19 pandemic has brought these to the forefront of the health and social policy agenda. The pandemic has exposed and exacerbated the systematic inequalities that exist as a result of deprivation and poverty as well as those that exist between and within population groups.

While this year's report focuses on health inequalities it reiterates the ambitions set out in my previous report in 2018/19 by highlighting the need for movement towards a joint whole system approach to health and well-being with our partners and communities.

Cefndir / Background

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. They arise from the conditions in which we are born, grow, live, work and age. These conditions influence our opportunity for good health and how we think, feel and act, and this shapes our physical health, mental health and wellbeing.

The causes of health inequality are complex, but they do not arise by chance. There is widespread agreement that the fundamental causes of health inequalities are an unequal distribution of income, power and wealth and reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are.

COVID-19, along with BREXIT, climate change and other political shifts in the last five years, has meant that there is a need for greater vigilance now as the end of the furlough scheme, a rising cost of living, access to affordable food and heating and the waiting list pressures on health and social care systems present a formidable challenge.

Asesiad / Assessment

Chapter 1 provides an overview of health inequalities in Hywel Dda and describes what they are, who experiences them and why they are a priority. The Welsh Index of Multiple Deprivation (WIMD) is used to illustrate the geographical distribution of deprivation across key domains. Data on life expectancy and healthy life expectancy are used in this chapter to illustrate the social gradient in health.

The direct effect of COVID-19 is described in chapter 2 using Public Health Wales COVID-19 Recovery Profile data and COVID-19 virology data to describe local morbidity and mortality and the effect on health and social care. The indirect impact of COVID-19, both negative and positive, is described in Chapter 3.

Chapter 4 considers what we as a Health Board, in partnership with other statutory and voluntary organisations, are already doing to deliver an organisational and community response to the COVID-19 pandemic and how these approaches have at their core an intention to reduce inequalities and promote health equity. This chapter focuses on the following priorities and uses stories to highlight existing activity and future plans:

- Community Participation and Resilience
- Promoting Health Equity in COVID-19 vaccine uptake
- Healthy weight, Healthy Hywel Dda
- Promoting Mental Health and Wellbeing
- Prioritising the Early Years

The final chapter highlights the steps we need to take to address health inequalities by taking a systems approach using known assets to promote healthy lives and identify areas where we need to do more.

I have also included, in Appendix 1, an overview of some of the key wellbeing and health equity measures for Hywel Dda. These show how Hywel Dda is doing compared to the rest of Wales and forms a baseline from which change and progress can be monitored.

Argymhelliad / Recommendation

The Board is asked to discuss the report, note the content and join the Director of Public Health in recognising the actions required to reduce health inequalities. Some of these actions include developing health equality and health equity targets which are integrated into the Health Board's planning cycle, increasing the capacity of the health system to better serve the needs of vulnerable and minority groups and to continuously monitor and measure the organisation's impact on health inequalities.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 1.1 Health Promotion, Protection and Improvement

Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 4. The best health and wellbeing for our individuals, families and communities
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included in this report
Rhestr Termau: Glossary of Terms:	Included in this report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	N/A
Risg: Risk:	N/A
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	Statutory requirement to publish annually
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	The Annual Report highlights inequalities in health that exist across the health board area, recognises the importance of protected characteristics highlighted in the Equality Act 2010 and describes how the COVID-19 pandemic has exacerbated existing inequalities in health.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2020-21
HYWEL DDA UNIVERSITY HEALTH BOARD

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FOREWORD

ROS JERVIS
Executive Director of Public Health, Hywel Dda University Health Board

I am very pleased to be publishing my Annual Report as Director of Public Health for Hywel Dda University Health Board. The past eighteen months has presented some previously unimaginable challenges to all aspects of life, and no one has been left untouched by the COVID-19 pandemic. In my last annual report I reflected on the progress the Health Board had made to agree a process for transforming the way it delivers healthcare services through a commitment to shift from a system focused on treatment and diagnosis to one where preventing ill health is a core activity and that embraces consideration of people's wellbeing.

I also reflected on how the Health Board had recognised its important role in working with local authorities, community organisations, businesses and communities themselves to improve not only the services we deliver, but the conditions we grow up, live, work, play and age in. The last eighteen months has clearly demonstrated the importance of these relationships. Out of adversity there has been an evolution of these connections as existing partnerships have been strengthened and new ones forged across sectors to manage the short and longer term impact of the pandemic. From establishing multi-agency teams to deliver the Test, Trace, Protect strategy including the largest vaccination programme seen in the NHS to the rapid response of third sector organisations, communities and countless individuals to help others in their neighbourhoods during lockdown, our response has helped many people who would otherwise have been left isolated and without support.

My focus in this report is on our widening 'health inequalities.' Enduring health inequalities have always been present across society, however the impact of the COVID-19 pandemic has brought these to the forefront of the health and social policy agenda. The pandemic has exposed and exacerbated the systematic inequalities that exit as a result of deprivation and poverty as well as those that exist between and within population groups. COVID-19 along with BREXIT, climate change and other political shifts in the last five years, means there is a need for greater vigilance now as the end of the furlough scheme, a rising cost of living, access to affordable food and heating and the waiting list pressures on health and social care systems present a formidable challenge.[1] Health inequalities and the conditions that lead to them are not inevitable.

The pandemic has highlighted the need to take action to address these inequalities as the health and socioeconomic fallout from the pandemic will continue to widen the health gap and make people more vulnerable to poor health. We need to do something now to address this unfairness. This report does not attempt to solve the problems but tries to focus on the opportunities we have to direct our efforts to address and reduce inequalities through meaningful action across all domains of public health practice.

Last but not least, I would like to acknowledge the tremendous efforts of the whole health and care workforce throughout the pandemic response. It has been a difficult and exhausting year. However, the response across all parts of the organisation has been astonishing, from those working on the clinical front line in very difficult circumstances to those doing the planning, recruitment and delivery of the vaccination programme. We are acutely aware that the next stage will be no less demanding, and we must ensure that we have reasonable expectations of the pace of recovery to ensure the negative effects on staff are not further exacerbated.

I hope you enjoy reading this report. Our strengthened relationships and the vision I set out in the previous Annual Report are a solid foundation on which to build recovery in Hywel Dda.

Acknowledgements:

I would like to thank Dawn Esther-Davies, Jan Batty and Asha Boyce for co-ordinating, writing and editing this report.

I would also like to thank Anna Bird, Helen Sullivan, Llyr Lloyd, Rebecca Evans, Beth Cossins, Rhys Sinnett, Kelly Davies, Liz Western, Dr Joanne McCarthy, Dr Michael Thomas and Megan Harris for their contributions and Wendy Roberts for the administrative support given to the team.

Finally, I would like to thank our Local Authority partners, Noeline Thomas, Caryl Alban and Tina Taylor for their contribution to the “Early Years” narrative.

EXECUTIVE SUMMARY

This year's Annual Report focuses on health inequalities in Hywel Dda and highlights the way in which organisations and communities have been working together to reduce the gap. It also highlights the way in which the COVID-19 pandemic has worked synergistically to exacerbate the inequalities across the health board footprint.

Chapter 1 provides an overview of health inequalities in Hywel Dda and describes what they are, who experiences them and why they are a priority. The Welsh Index of Multiple Deprivation (WIMD) is used to illustrate the geographical distribution of deprivation across key domains. Data on life expectancy and healthy life expectancy are used in this chapter to illustrate the social gradient in health.

The direct effect of COVID-19 is described in chapter 2 using Public Health Wales COVID-19 Recovery Profile data and COVID-19 virology data to describe local morbidity and mortality and the effect on health and social care. The indirect impact of COVID-19, both negative and positive, is described in Chapter 3.

Chapter 4 considers what we as a health board, in partnership with other statutory and voluntary organisations are already doing to deliver an organisational and community response to the COVID-19 pandemic and how these approaches have at their core an intention to reduce inequalities and promote health equity. This chapter focuses on the following priorities and uses stories to highlight existing activity and future plans:

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CHAPTER 1. HEALTH INEQUALITIES IN HYWEL DDA

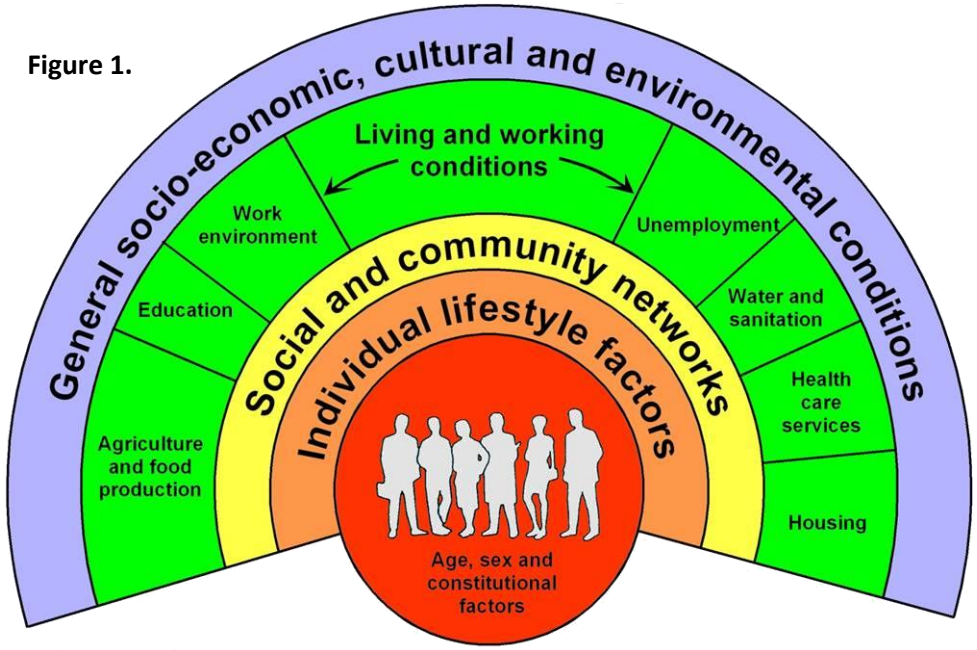
'Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society." Sir Michael Marmot, Fair Society Healthy Lives, 2010

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. They arise from the conditions in which we are born, grow, live, work and age. These conditions influence our opportunity for good health, and how we think, feel and act, and this shapes our physical health, mental health and wellbeing. The causes of health inequality are complex, but they do not arise by chance. There is widespread agreement that the fundamental causes of health inequalities are an unequal distribution of income, power and wealth and reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are.

Health inequalities are caused by a range of factors that interact in a dynamic way across the life course and persist through generations. These factors are described as the 'determinants of health.' Addressing the wider determinants of health will help address health inequalities and improve health equity.[2]

Figure 1 provides an overview of the main health determinants. It places the individual and their 'constitutional factors' such as age and genetics in the centre, surrounded by lifestyle factors. Outside these individual factors are the wider determinants: the conditions of people's daily lives and then the broader contextual socioeconomic, cultural and environmental conditions

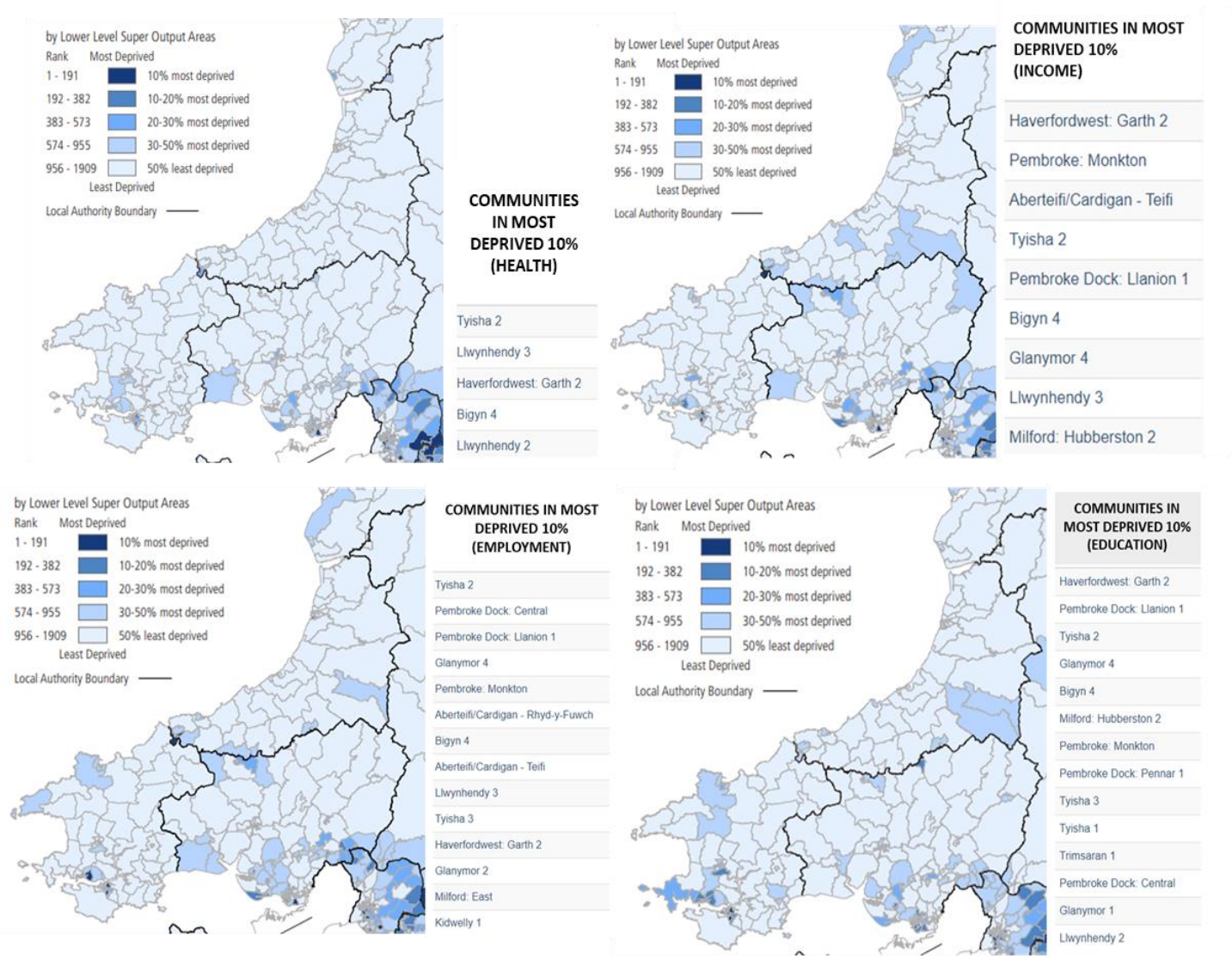
Figure 1.



Source: Dahlgren and Whitehead, 1991

within which our lives take place. Crucially, the different layers of the model are shown as interlinked, highlighting the complex processes which determine people's health.

Figure 2.



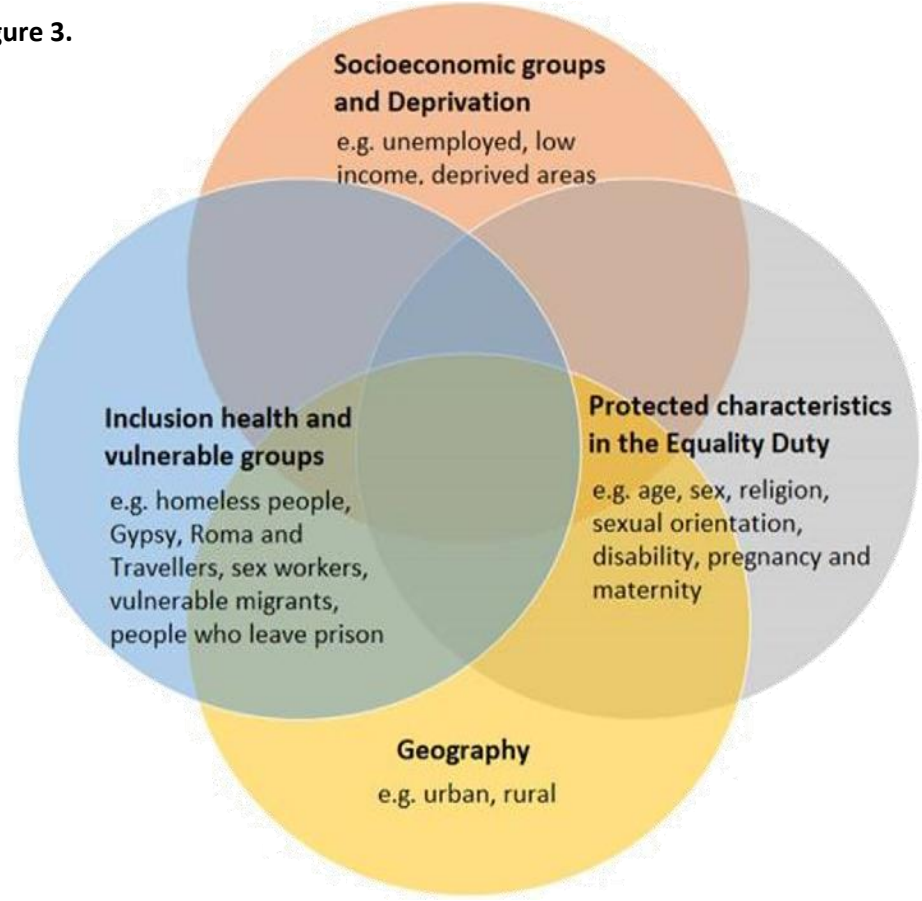
Within Hywel Dda, as within the rest of Wales and the United Kingdom, differences in health inequalities can be observed across the population. There are many kinds of health inequality and many ways in which the term is used. This means that when we talk about 'health inequality' it is useful to be clear on which measure is unequally distributed and between which people. For example, the relationship between income and health is well established. In Hywel Dda people living in the poorest neighbourhoods die on average 4.5 years earlier than people living in the more affluent neighbourhoods.

The Welsh Index of Multiple Deprivation[3] provides the official measure of relative deprivation for small areas in Wales. It identifies areas with the highest concentrations of several types of deprivation including overall deprivation, health, education, income, employment,

community safety, housing, access to services and the physical environment. As far as overall deprivation is concerned there are ten communities in Hywel Dda in the most deprived 10% in Wales. There are five communities in Carmarthenshire - specifically Llanelli (Tyisha 2 & 3, Glanymor 4, Bigyn 4 and Llwynhwndy 3); four communities in Pembrokeshire (Pembroke Dock Central and Llanon 1, Garth 2, Monkton); and one community in Ceredigion (Aberteifi/Cardigan – Teifi). Figure 2, above, provides an overview of the geographical distribution of deprivation for the health domain, income domain, employment domain and the education domain and identifies those communities in Hywel Dda in the most deprived 10% of the population.

Other health inequalities in Hywel Dda are aligned to certain geographical areas, key economic groups and key population groups. These population groups include the nine protected characteristics in the Equality Act[4] along with socioeconomic position, occupation, geographic deprivation (as shown above) and membership of a vulnerable group. As illustrated in Figure 3[5], these dimensions often overlap compounding the unfairness with those in lower socio-economic groups being exposed to risks across all health determinants. As a result poor social and economic circumstances will affect health and well-being throughout life. For example, people in the most deprived areas have higher levels of mental illness and long-term health problems, particularly chronic respiratory conditions, cardiovascular disease, arthritis, higher smoking prevalence and obesity.[6]

Figure 3.



While the overall health status of the population of Hywel Dda is good, health is not evenly distributed. For example, life expectancy is a measure of overall population health, an estimate of the average number of years new-born babies could expect to live, assuming that the current mortality rates for the area in which they are born apply throughout their lives.

It is also important to consider quality of life which is calculated using the Healthy Life Expectancy measure. Healthy Life Expectancy at birth represents the number of years a person can expect to live in good health. It is perhaps a better indicator of overall health since it looks at the period lived in good health and excludes the period when quality of life may be poor. In Hywel Dda the inequality gap in life expectancy for males and female in Hywel Dda is 4.8 and 4.5 years respectively. The inequality gap in healthy life expectancy is considerably larger at 12.2 years for both males and females, though this is below the Welsh average of just over 18 years for both males and females.

In recent years life expectancy across the population in Wales, along with the rest of the UK, has been stalling and is a marked change to the steady increases seen since the end of the Second World War. A Public Health Wales report (2020) found that male and female life expectancy in Wales has only increased by 0.2 years and 0.1 years, respectively, since 2010-12.[7] Prior to this, between 2001-03 and 2010-12, the increases had been 2.6 years and 2 years respectively and the gaps in mortality rate and healthy life expectancy between deprivation quintiles have continued to widen.

The study also found that premature death (under the age of 75) was also substantially more common in deprived communities, particularly in males who have a 33 per cent excess death rate compared with affluent communities. Deprived area mortality rates were high for a variety of causes of death including cancers (especially lung cancer), heart disease, respiratory disorders (especially chronic obstructive pulmonary disease), injuries and suicide.

It is also in the context of health inequalities that COVID-19 has been described as a 'syndemic'.[8] A synergistic pandemic interacts with and exacerbates existing inequalities in social conditions to reveal and extend any existing health gap. The disease itself affects those already vulnerable to ill health. Then the social measures brought in to prevent the spread of infection and the resulting impact on the economy, including, the disruption to children's education, unemployment, food poverty and mental ill-health and has had the greatest effect on those that are already struggling. Research by Public Health England has found the following disparities in the risk and outcomes of COVID-19:[9]

- Age - those 80 years of age or older being seventy times more likely to die than those under the age of 40
- Sex – risk of dying amongst those diagnosed is also higher in males
- Deprivation - people living in deprived areas have higher diagnosis and death rates than those living in affluent areas
- Ethnicity – death rates are higher among people of Black and Asian ethnic groups
- Learning disabilities - a Public Health England report found that people with a learning disability were between 4 and 6 times more likely to die from COVID than the general population and this disparity was greater for younger age groups[10]

- Disability - data published in September 2020 by the ONS shows that in the period March to July 2020, almost 7 in every 10 COVID related deaths in Wales were disabled people. Evidence also suggests that this death rate was not the inevitable consequence of impairment, as many deaths were rooted in socio-economic factors
- Increases in mental ill health
- Increases in child poverty.

The pandemic has brought health inequalities to the fore and has escalated the need for a wholly different approach to recovery and health improvement. Marmot's COVID-19 Review concluded that inequalities in social and economic conditions before the pandemic contributed to the UK's high and unequal death toll from COVID-19. Health inequalities such as deprivation, low income and poor housing have meant poorer health, reduced quality of life and early death for many people. Rather than create new inequalities the pandemic has exposed these existing inequalities causing further hardship to those who were already suffering.[11]

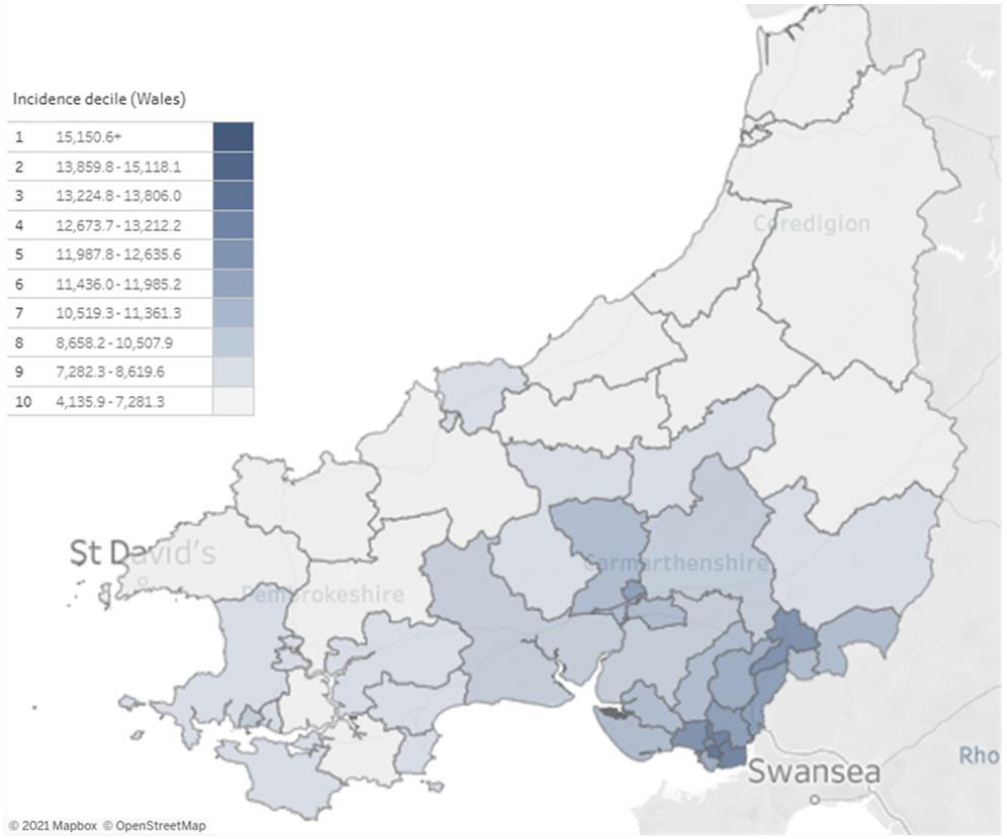
2.1 THE DIRECT IMPACT OF COVID-19 0N HEALTH INEQUALITIES

Data and the descriptive overview in this section are adapted from the Public Health Wales Observatory Recovery Profile, 2021.
https://publichealthwales.shinyapps.io/COVID19_Recovery_Profile_PHWO

When reflecting on the early part of 2020 it is hard to imagine how it was possible to mobilise all sectors of society in an effort to contain and then control the spread of the newly emerged Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). At this stage it was also hard to imagine how the pandemic would not only further reveal the extent of the pre-existing 'health gap,' but would also increase this gap through direct and indirect mechanisms. These include increased morbidity and mortality in the vulnerable and at risk groups mentioned above along with the prolonged disruption to children's education, unemployment, food poverty, reduced access to health care services and mental ill-health which have all become more evident.

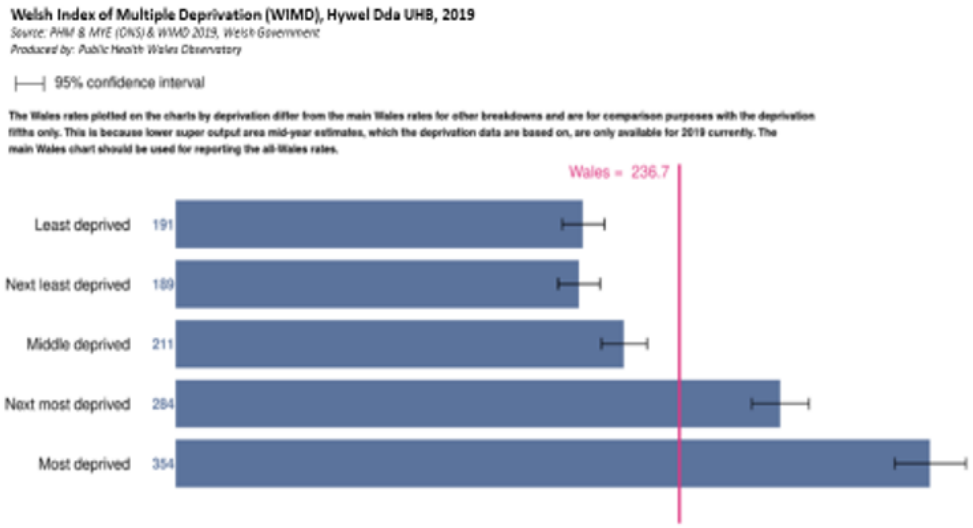
Population density is a factor in the distribution of confirmed cases with the more rural parts of the health board area in North Ceredigion and North Pembrokeshire having the lowest incidence rates (15.9/100,000 population). Figure 4 illustrates the variability in the number of cases across the health board area with the highest rates along the county border in areas with higher rates of deprivation.

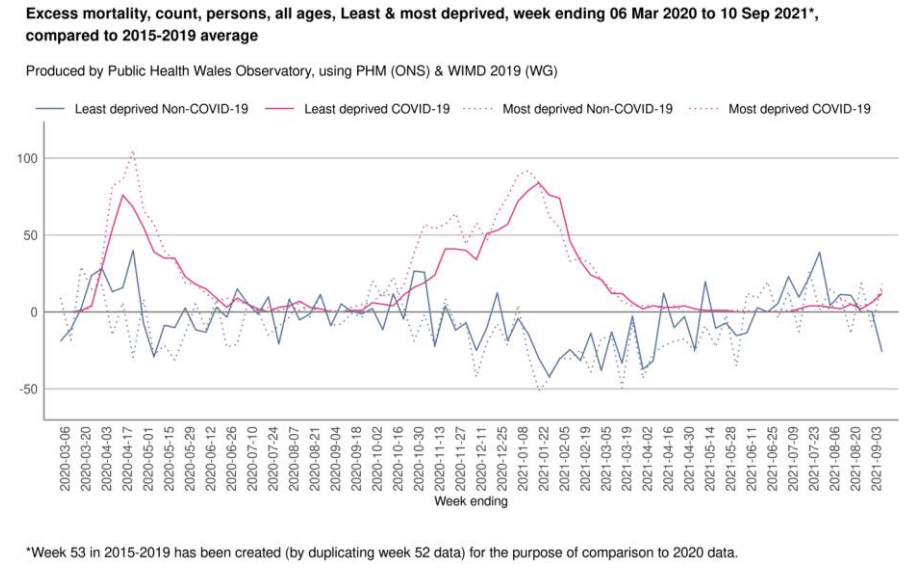
Figure 4. Confirmed cases, by Middle Super Output Area of residence, cumulative rate per 100,000 population, Hywel Dda, as at October 11 2021

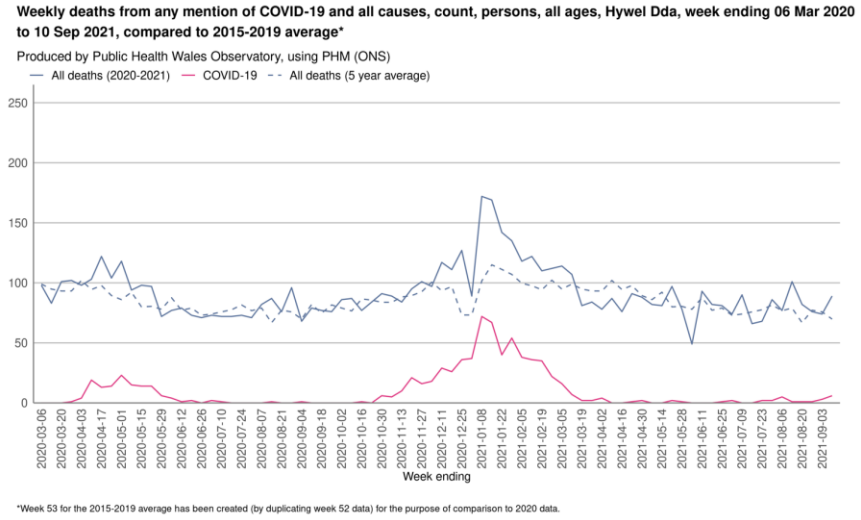


This map uses the Office for National Statistics' (ONS) middle layer super output areas (MSOAs) as defined by their 2011 boundaries. The case numbers are suppressed for any MSOA where there were fewer than three cases. The colours are defined by the decile an area falls under when ranked by their incidence per 100,000; with the highest 10% of MSOAs in Wales categorised as 1 and the lowest as 10.

Deaths from COVID-19, age-standardised rate per 100,000 persons, by deprivation quintile

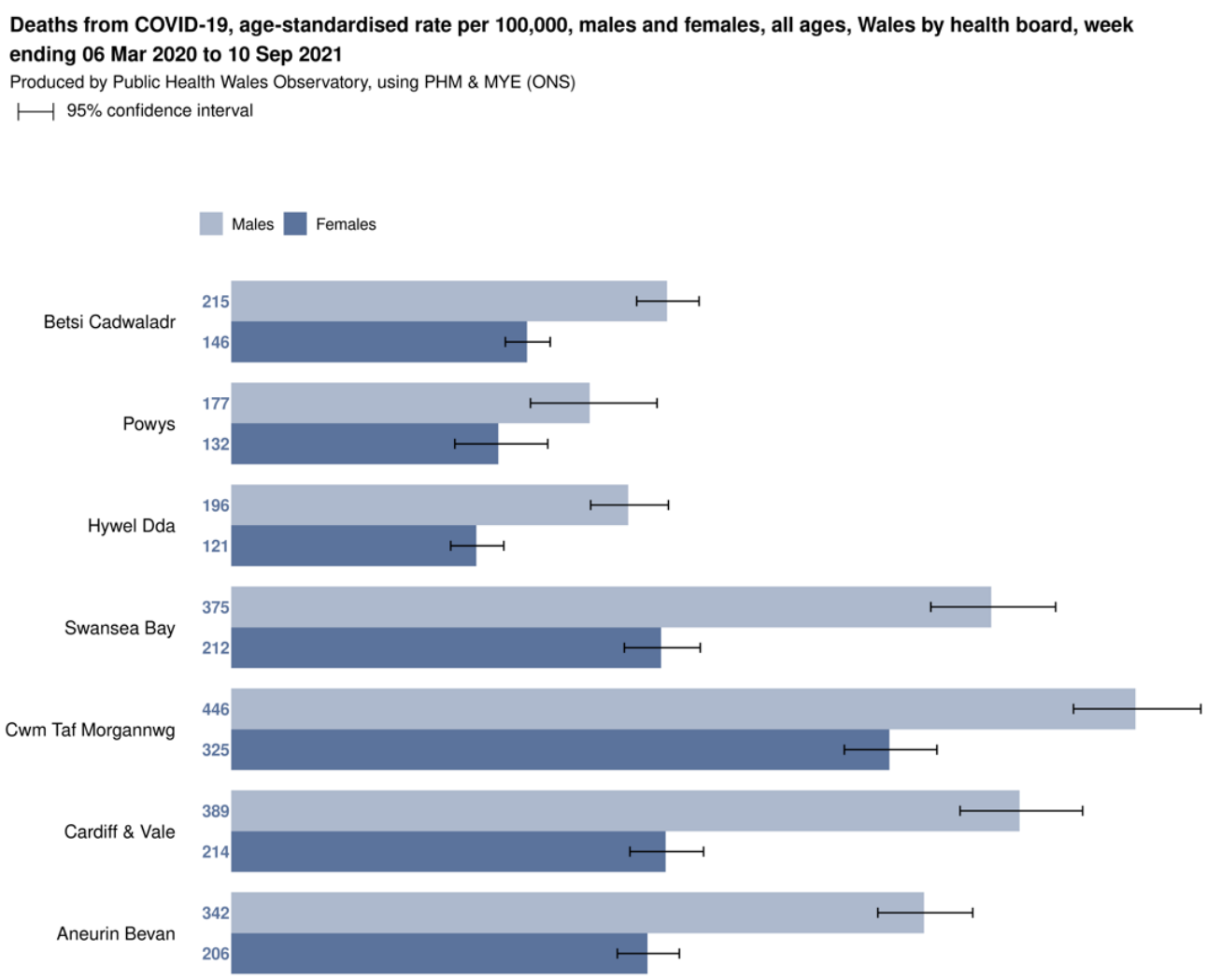






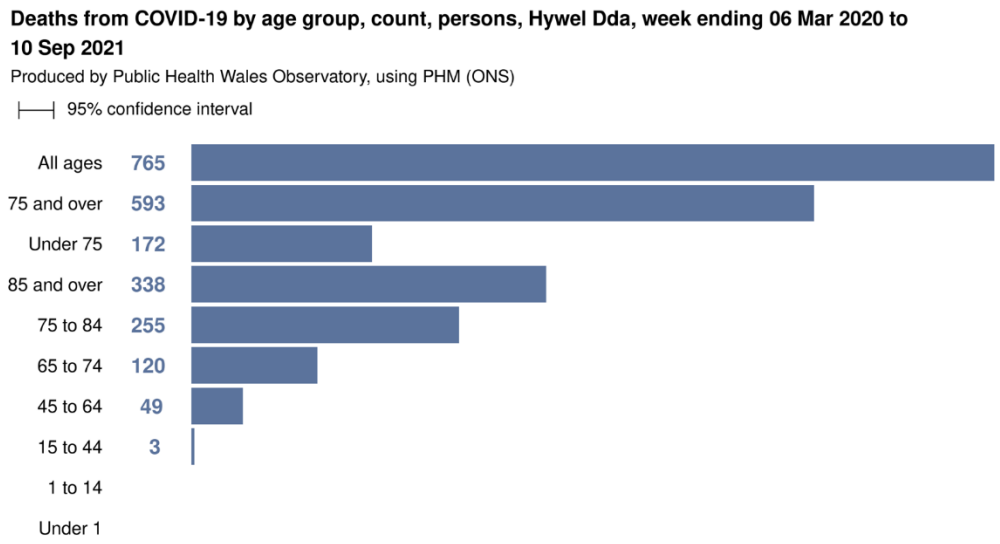
In Hywel Dda, deaths which mentioned COVID-19 on the death certificate rose sharply between the week ending 20 March 2020 and week ending 1 May 2020 (week 16). This was followed by a decline and levelling off due to the first lockdown period. This trend started to reverse during mid-October 2020 with COVID-19 deaths more than tripling. The sharp increase in deaths during December 2020 triggered the second lockdown with COVID-19 deaths falling consistently after this point (falling to 0 deaths by mid-June 2021). Since then COVID-19 deaths remained under 4 until week ending 23 July 2021 when rates increased once again to 16, the highest count since week ending 9 April 2021.

In Hywel Dda, the highest number of COVID-19 deaths occurred in the week ending 08 Jan 2021 with 72 deaths. As of the week ending September 10th 2021, all cause deaths were higher than the 2015-2019 5-year average (by 19.2 deaths).



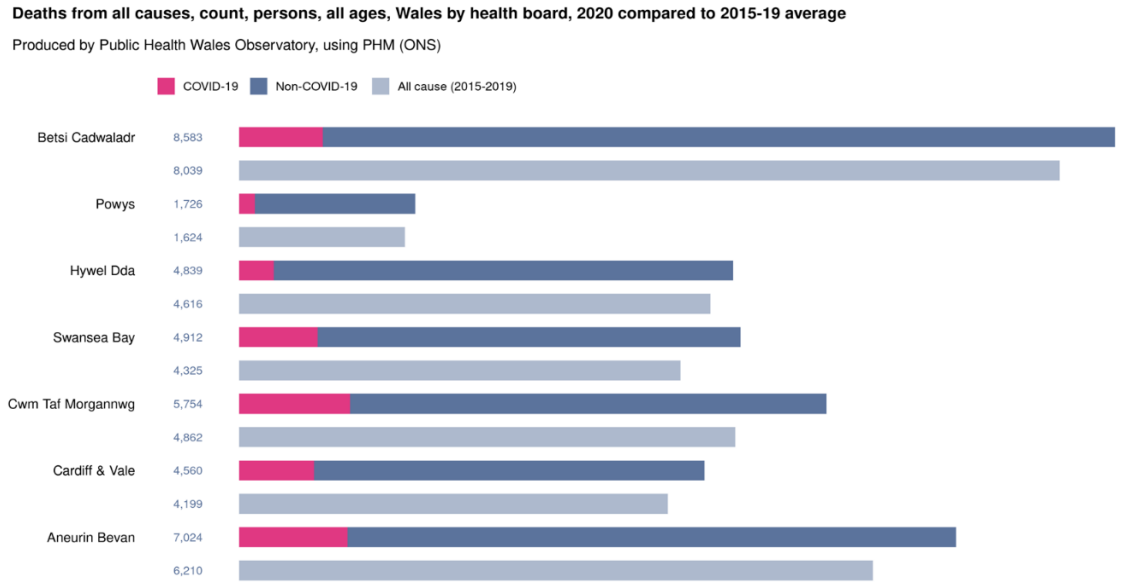
Deaths for males and females with any mention of COVID-19 registered between 29 February 2020 up to and including 30 July 2021. In Hywel Dda there were 411 deaths in males and 337 deaths in females with any mention of COVID-19 in the reported period. This translates as an age-standardised rate of 191 per 100,000 and a crude rate of 215 per 100,000 in males, and an age-standardised rate of 119 per 100,000 and a crude rate of 170 per 100,000 in females.

In Hywel Dda the age-standardised rate for deaths in males was statistically significantly higher than the rate for females during this period. This suggests that males are disproportionately affected by COVID-19 mortality, after adjusting for age. Hywel Dda had the lowest age-standardised death rated for females when compared to the rest of Wales.



Age and specifically old age is a significant risk factor for COVID-19 mortality. Deaths mentioning COVID-19 on the death certificate significantly increased with age for the period 29 February 2020 to 30 July 2021.

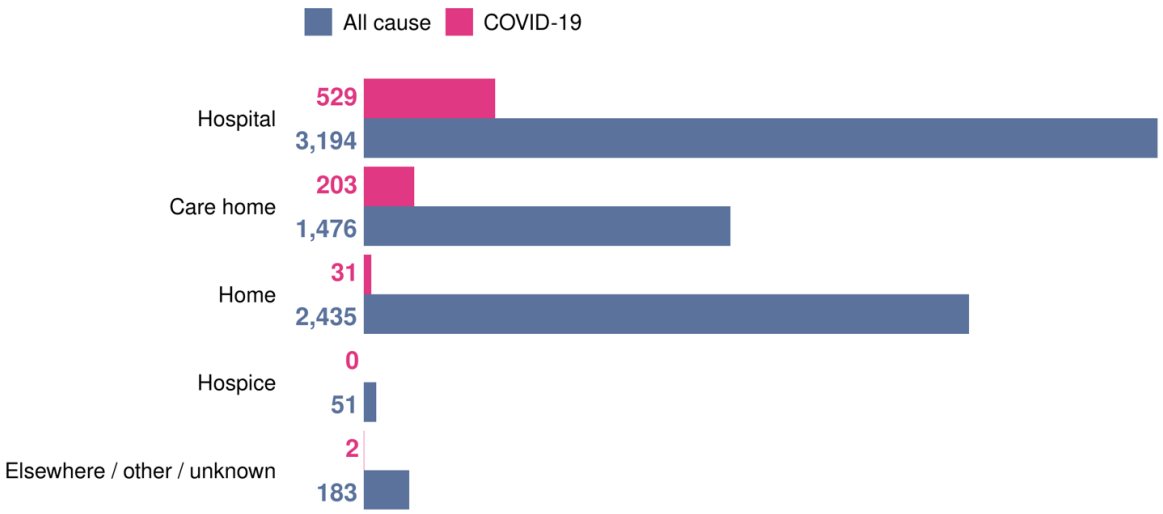
44% (338) of the total deaths from COVID-19 in Hywel Dda occurred in persons aged 85 and over. The age-specific mortality rate was over three times higher in this age group than for persons aged 75 to 84, with 2,632 per 100,000 persons aged 85 and over dying from COVID-19 compared to 795 per 100,000 persons aged 75 to 84. Of the 748 deaths in Hywel Dda UHB mentioning COVID-19 172 deaths were in persons aged under 75.



In 2020 there were 37,392 deaths in Wales from all causes which is around 3,500 more than the annual average for 2015-19. This translates as a crude rate of 1,180 deaths per 100,000 compared to 1,084 deaths per 100,000 on average in 2015-19. Hywel Dda recorded 4,837 deaths from all causes which is 218 more than the annual average for 2015-19. This translates as a crude rate of 1,242 per 100,000 in 2020 compared to 1,200 in 2015-19. According to Public Health Wales all health board areas had higher counts of all cause deaths for persons in 2020 compared to their 2015-2019 averages.

Place of death, deaths from COVID-19 and all causes, count, persons, all ages, Hywel Dda, 29 February 2020 to 10 September 2021

Produced by Public Health Wales Observatory, using PHM (ONS)



In Wales, of the 8,108 COVID-19 related deaths, 5,874 (72.4%) occurred in hospital. In all health boards and local authorities in Wales, hospitals report the highest number of COVID-19 related deaths.

In Hywel Dda, 69.2% of all deaths from COVID-19 occurred in hospital, while 26.5% occurred in care homes.

2.2 LONG COVID-19

Long COVID is the collective term used to represent the persistent symptoms in those who have recovered from SARS-CoV-2 infection. It is commonly used to describe the signs and symptoms of the disease that continue or develop after the acute phase. It includes both on-going symptomatic COVID-19 (from 4 to 12 weeks) and post-COVID-19 syndrome (12 weeks or more). As of 5th September 2021 it is estimated that 1.7% of people living in private households in the UK are experiencing self-reported long COVID. [12]

Long COVID is a new and emerging condition that can have a significant effect on people's quality of life and presents many challenges to the individual in terms of managing the condition. Ongoing symptoms - often including fatigue, shortness of breath and difficulty concentrating - can affect all systems of the body which can hamper treatment, recovery and mental health and wellbeing. Findings suggest that the following groups are more likely to be effected by long COVID:[13]

- Women (6.6%) appeared to be more likely than men (5.8%) to report they may have experienced long COVID
- Those aged between 30 and 49 years (8.0%) were the most likely to report they may have experienced long COVID of any age group
- Disabled adults (8.0%) were more likely to report they may have experienced long COVID than non-disabled adults (5.4%)
- Those living in the most deprived areas - 8.4% of adults reported they may have experienced long COVID compared with 5.2% in the least deprived areas
- Those with certain lifestyle related risk factors such as smoking, physical inactivity and obesity.[14] (See Story 1)

Developing a better understanding of these symptoms will help with long-term management, but this is a considerable extra burden on the NHS and affects people's ability to return to work and life.

STORY 1 OBESITY, INEQUALITIES AND COVID-19 RISK

One example of how risk factors for COVID have widened health inequalities is obesity.

Evidence gathered during the course of the pandemic has shown that patients living with overweight and obesity are more likely to:[15]

- Test positive for COVID-19, particularly among BAME groups
- Be hospitalised if infected with COVID-19
- Be admitted to intensive/critical care and require advanced treatment for severe COVID-19 symptoms[16]
- Have a higher risk of COVID-19 related death with increasing Body Mass Index (BMI) but more evidence is needed to establish this.[17]

Overweight and obesity is a good example of the interaction between individuals and social determinants and the link between deprivation and obesity has been well established. A myriad of socio-economic factors – including income, housing, education, access to space, exposure to advertising and sale of unhealthy foods – impact upon whether we can be active or eat healthily and thus ultimately our risk of developing obesity. Several of the elements that make up the Welsh Index of Multiple Deprivation (WIMD), such as employment and educational attainment, have been individually linked to obesity.

There is also recognition that the socioeconomic impact of the pandemic alongside the mental health impact of lock-downs and social distancing measures, have affected people's ability to eat healthily and to be physically active, both behaviours that help people maintain a healthy weight. The PHW survey 'How are we doing in Wales?' found that forty-three percent said their physical fitness was worse now than before the pandemic.[18]

Individuals from more deprived communities, females and those aged 35-54 are more likely to report worse physical fitness. Forty percent of adults said their weight had increased since the pandemic. Females and younger adults are more likely to have gained weight though differences by deprivation level were not significant.

CHAPTER 3. ASSESSING THE INDIRECT IMPACT OF COVID-19 ON HEALTH INEQUALITIES

As highlighted in Chapter 1, health and wellbeing is largely determined by the interaction of individual characteristics, health behaviours and the social, economic and physical environment. The direct impact of COVID-19 is described in chapter 3 and describes the effect of the disease on morbidity and mortality in Hywel Dda. This section will focus on the indirect impact of COVID-19, both positive and negative, and will consider some of the longer term planning that will be required to ensure pre-existing inequalites are not made worse. Reduced access to routine health care, alongside the social and economic fallout from the measures taken to control the spread of coronavirus, will have an impact on the population's health. The term 'long COVID' could be applied as a metaphor for the impact of COVID-19 on the determinants of health as the symptoms of our social, economic and psychological condition are likely to be persistent and recovery slow.

The harms of lockdown did not fall equally on all groups. Those in areas of deprivation, with disabilities and chronic illnesses, are more vulnerable to harms from lockdown which isolated people, affecting their mental health and, due to the pressures on the health and social care system, their physical health. In addition, COVID-19 has highlighted how risk factors such as obesity can increase the risk of diabetes and hypertension - comorbidities that are associated with poor outcomes - and reinforced the need to develop a 'systems' approach to address the wider determinants of health.

While coronavirus infection has not affected children as badly as adults for the most part, it has had a severe impact on their lives in a different way. The most devastating long term costs of the pandemic are likely to fall on today's children as they grow and develop.[19] Child poverty is already the biggest threat to child health and development in the UK.[20] A combination of worsening financial strain within families and stay-at-home pandemic policies has caused immediate harm to the development and mental health of children, with some younger children regressing in basic skills. Currently one in six children and young people have mental health problems as their lives are "put on hold," with clear implications for their long term health and earnings.[21],[22]

Almost 1 in 3 children are currently living in poverty in Wales which has the highest rate of child poverty among the four U.K. nations.[23] In an effort to mitigate the impact of the pandemic on child poverty the Welsh Government has led the development of the 'Child Poverty: Income Maximisation Action Plan.[24] This plan supports financial resilience by ensuring families claim all the financial support they are entitled to, reducing the cost of sending children to school and promoting access to and reducing the cost of public transport, especially for young people requiring access to education, training and employment.

Young people have experienced the largest deterioration in their mental health due to COVID.[25] They have been affected by the closure of schools and higher education facilities and by the wider restrictions on their freedom to meet with their peers. Young workers are bearing the brunt of the economic disruption with employees under 25 almost three times as likely to have been working in shut-down sections of the economy.[26]

Whilst the direct and indirect harms caused by the COVID-19 pandemic might seem overwhelming it is also important to recognise that the pandemic has facilitated some significant social and economic shifts.

- During the initial stages of the pandemic there was an increase in community cohesion and resilience
- There was a significant increase in the use of digital technology across society and a renewed focus on how to make access to technology more equitable[27]
- Local communities have become more important than ever during the pandemic. Local charitable and voluntary organisations have been critical to the response to COVID-19, but there are inequalities between communities based on the strength of community infrastructures or assets. The stories in chapter 4 provide examples of some of the activity taking place locally
- There was a reduction in noise, air pollution and CO_2 emissions, temporarily[28]

- Health and hygiene became a priority to minimise the spread of infection resulting in a decline in the spread of influenza and other respiratory viruses
- Increased flexibility in regulatory controls for medicines and medical devices to support the healthcare products supply chain and the wider response to the pandemic. This allowed for the rapid development of COVID-19 vaccines as well as technologies to support telehealth and the management of chronic conditions though medical devices and interactive Apps[29]
- Greater partnership working across statutory and voluntary sectors to develop a regional response to Test, Trace, Protect Legislation.

STORY 2 PARTNERSHIP WORKING TO TEST TRACE PROTECT

The Health Board, Public Heath Wales and the three local authorities in the Hywel Dda area have developed a range of shared responses to maximise information sharing, plan for incidents or outbreaks in identified settings and provide shared learning opportunities for staff working in this field to improve their knowledge and skills.

These response mechanism is co-ordinated through a Regional Response Cell which includes a Consultant Lead, health board Operation Managers, the public health team and a Nursing team who manage positive cases in secondary care settings. Specific activity includes:

- A daily 9.00am meeting to discuss specific cases by county that require additional investigation, a review of the latest surveillance data, a discussion of any outbreaks that may require additions management, a review of testing capacity and infection control issues
- A weekly meeting is held to discuss all issues relating to the management of care homes, including whole home testing, review national guidance, compliance with guidance and implementing or lifting restrictions.
- During term time the lead Public Health Consultant meets with the Directors of Education, health protection leads for each county, healthy schools leads and school nursing leads to discuss guidance and management pathways to ensure outbreaks are controlled to reduce any disruption to children's education.

The systems and relationships that have been developed through this pandemic will provide further opportunities in the future to enhance not only any response to communicable disease management but also to strategically plan for other civil contingencies as they emerge.

CHAPTER 4. COVID-19 RECOVERY AND OPPORTUNITIES TO PROMOTE HEALTH EQUITY

"We need to move from death to health; from disaster to reconstruction; from despair to hope; from business as usual to transformation. Now is the time to secure the well-being of people, economies, societies and our planet."

António Guterres, United Nations Secretary-General 28th January 2021

Although COVID-19 remains a steady threat to everyday activities, the advent and subsequent rollout of the vaccination programme, more robust mechanisms for testing and behaviourally-informed guidance has led to an ease in restrictions and a kick start towards recovery. COVID recovery has brought a variety of opportunities to do things differently helping us to adapt and apply lessons learnt. It also provides a chance to transform thinking, change the ways we work and to build back differently. We know that the pandemic, has created the 'perfect storm', exacerbating health inequalities and highlighting the interplay between the factors that determine our individual and population health.

Understanding the impact of COVID-19 is still an emerging area of research. Understanding the full impact of the direct costs of COVID-19 on health in its broadest sense and the indirect costs to the social and economic structures of society have yet to be quantified. In this section we will consider what we as a health board, in partnership with other statutory and voluntary organisations, are already doing to deliver an organisational and community response to the COVID-19 pandemic and how these approaches have at their core an intention to reduce inequalities and promote health equity.[30] We will focus on the following public health priorities and use stories to highlight existing activity and future plans:

- Community participation and resilience
- Promoting health equity in COVID-19 vaccine uptake
- Healthy weight, Healthy Hywel Dda
- Promoting mental health and wellbeing
- Prioritising the early years

4.1 COMMUNITY PARTICIPATION & RESILIENCE

The COVID-19 pandemic has had both positive and negative impacts on social and community networks. There is evidence of increased participation in response to the pandemic and a positive impact on social cohesion. This is evident in the number of voluntary organisations that have been established in communities across Hywel Dda. However, social isolation and loneliness have impacted on wellbeing for many. There are also serious concerns about how the combination of greater stress and reduced access to services for vulnerable children and their families may increase the risk of family violence and abuse. Compounding this, safeguarding issues have been largely hidden from view during lockdown.[31]

It has been well documented that the health and wellbeing of the population is influenced by the role of citizenship and communities. One of the most heartening responses to the pandemic was the number of people who came together to provide social and physical support to neighbours and communities suddenly in need.[32] In Hywel Dda, there has been a marked increase in people wanting to engage in volunteering. The types of activity undertaken were:

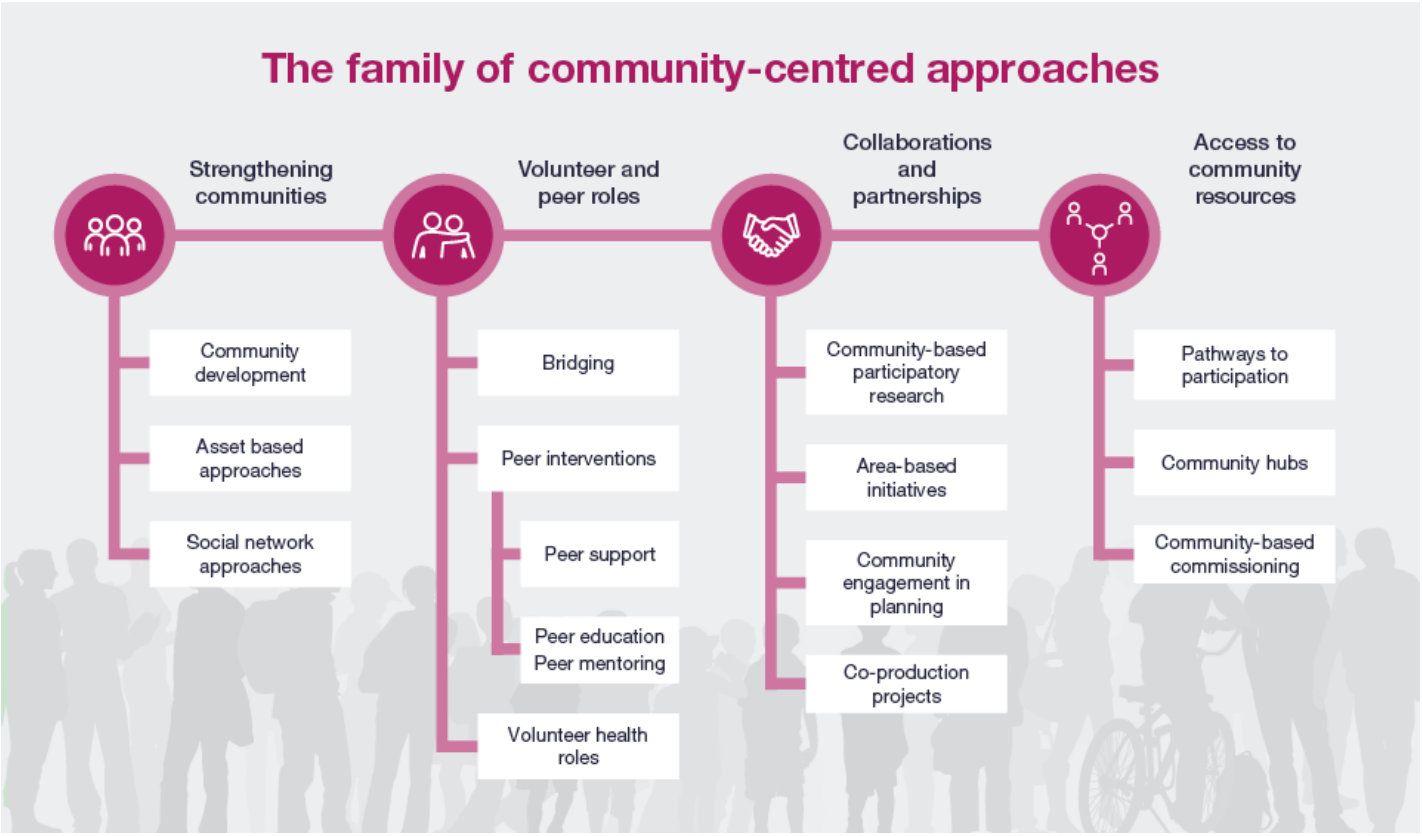
Transporting equipment/staff

- Check and chat volunteers
- Gardeners
- Community response drivers Wave 2 [33]

The voluntary sector have played a key role in providing support to communities during COVID and continue to provide a bridge between service provision and access in particular for those who are vulnerable. [34] [35] During the pandemic, vulnerability (i.e. unmet need) rapidly arose and was often exacerbated when individuals were unable to access support from particular resources, services and local infrastructure. Research by Public Health Wales found that vulnerabilities were typically found to cluster together and were often patterned along pre-existing lines of social inequality so that those who were suffering hardship before the pandemic were worst affected.[36] The key emergent needs they identified were:

- Worsening mental health due to anxiety and loneliness
- Economic insecurity due to strained household finances and job loss
- Digital exclusion
- Loss of face-to-face services and limitations in the statutory response.

The research highlights the critical role that the voluntary and community sector played in addressing these needs and the fact that they were uniquely positioned to respond rapidly and effectively. These assets included local knowledge and understanding, an ability to innovate quickly, their ability to collaborate with other third sector organisations and statutory services and a holistic focus on a person's needs. Barriers including 'top-down' decision making and poor citizen engagement were lowered in the pandemic allowing swifter decision-making and more co-production. During COVID recovery it will be important to maintain and sustain community and voluntary action to mitigate against these vulnerabilities. A number of Welsh reports strongly agree that building upon community resilience, investing in prevention and promoting social connectedness will reduce the negative impact of COVID-19. [37,38,39] Health Matters - Public Health England have attempted to describe the many ways in which communities can build resilience through a 'family of community-centred approaches'. [40]



To understand the interplay between these factors Public Health Wales and the University of Bristol have developed a Community Response to Covid-19 Interactive Map to explore the need and support that exist in the community and to help plan for the future. This planning tool can be accessed via the highlighted hyperlink above.

The next section provides examples of local action that has taken place to support individuals and communities.

STORY 3 COMMUNITY ACTION

Through the Public Service Boards, the Transformation Fund and our Health and Wellbeing Framework Hywel Dda is making this shift towards working *with* and *by* communities through using asset-based approaches, creating connected communities, volunteering and community hubs.

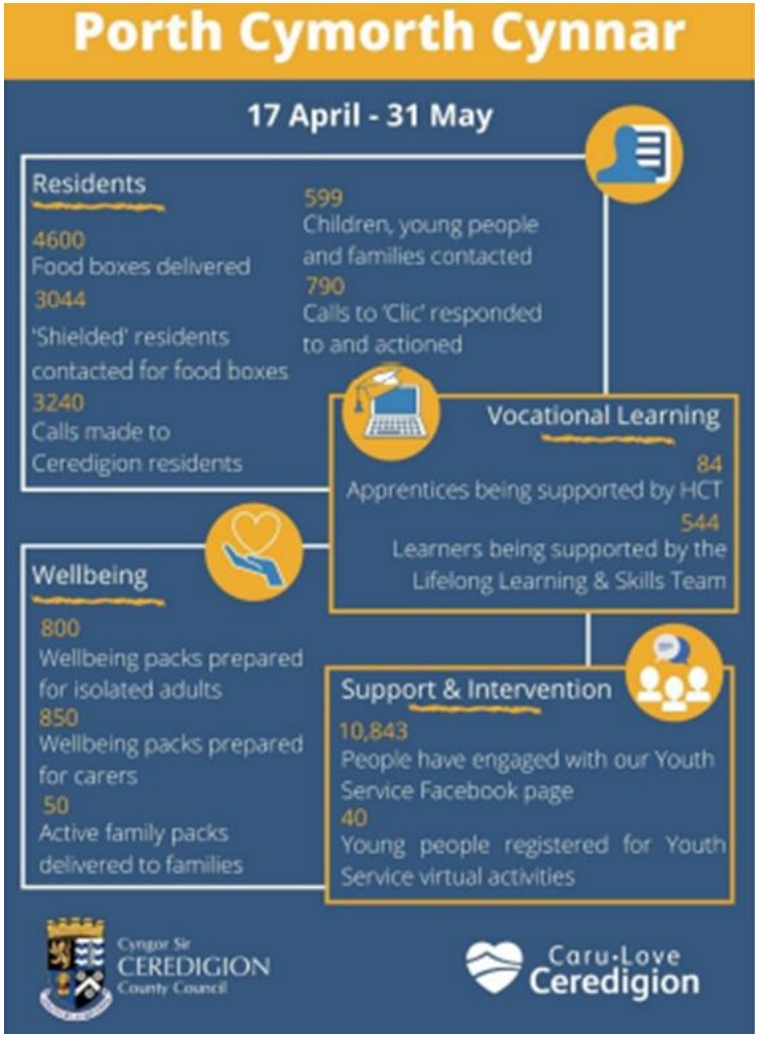
One example of this is the development of the Community Hub in Pembrokeshire which brings together statutory and voluntary agencies to work alongside individuals and emerging community groups across the county. Support to the community was provided by redeployed call centre workers, Delta Wellbeing officers and Pembrokeshire Association Voluntary Service, but the action needed was identified by communities and groups within them. The hub coordinated community action to support shielding people in the county and has supported 96 new groups of community volunteers formed during the lockdown in Spring 2020 to continue to evolve their role.

Whilst there are challenges for the voluntary and community sector including the lack of secure funding, the impact of digital exclusion on service coverage and the impacts of the pandemic on the wellbeing of the workforce, there are also opportunities. These include the time and cost savings from digital working, increased collaboration with statutory services and greater recognition and appreciation for the sector as a whole.[41]

STORY 4 DIGITAL TRANSFORMATION

A Healthier Mid and West Wales strategy already outlined the need for transformation of health and care system.[42] Due to the pandemic many health and social care services were forced to deliver differently. Face to face appointments were substituted for virtual ones facilitated by a digital transformation across all sectors. Digital transformation has been accelerated and has revolutionised health and social care enabling cross sector partnerships and facilitating the delivery of services to the population via digital platforms, technology enabled care and devices.[43, 44,45] Organisations across Hywel Dda are keen to continue to use the insight and learning from the pandemic, to help other parts of the health and social care system rethink and redesign services.

Despite the benefits of digital transformation a scoping review into the relationship between digital technology and health inequalities indicates that there is a digital divide stemming from a lack of access, skills and motivation for using technology for health. It found that digital exclusion can lead to worse health outcomes through direct (i.e. access to digital health and social care services) and in-direct routes (i.e. impact on the wider determinants such as access to better housing, social networks and work).[46]



Due to the geography and level of inequality in Hywel Dda, there may be barriers to digital access including the cost of hardware and connectivity. From our Public Service Boards we understand that as many as 12% of people in Hywel Dda may be digitally excluded, and many more may not be using digital services for a variety of reasons. Locally the voluntary sector and Delta Connect have been providing support to increase access and skills, but further work will be needed to identify the barriers and reduce the digital divide. [47]

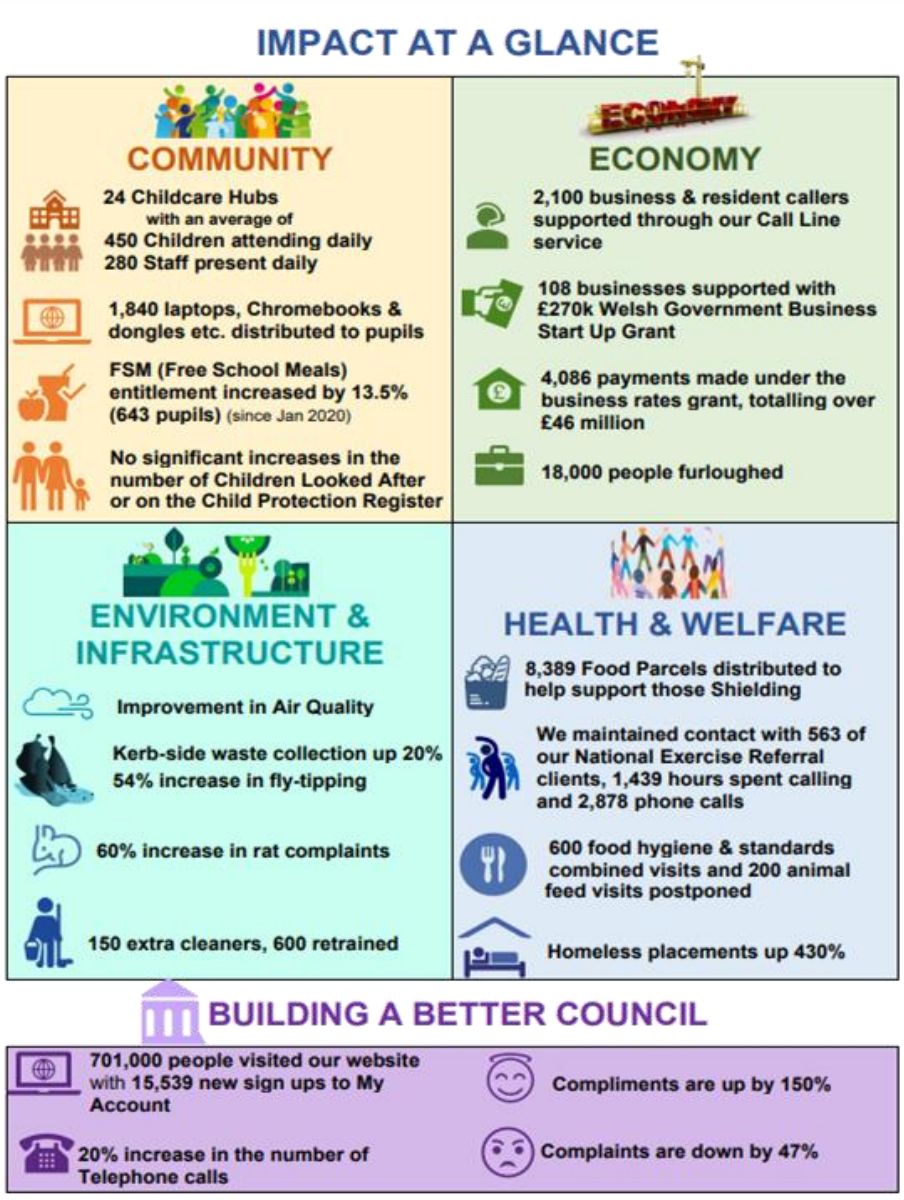
STORY 5 STATUTORY RESPONSE

LOCAL AUTHORITIES:

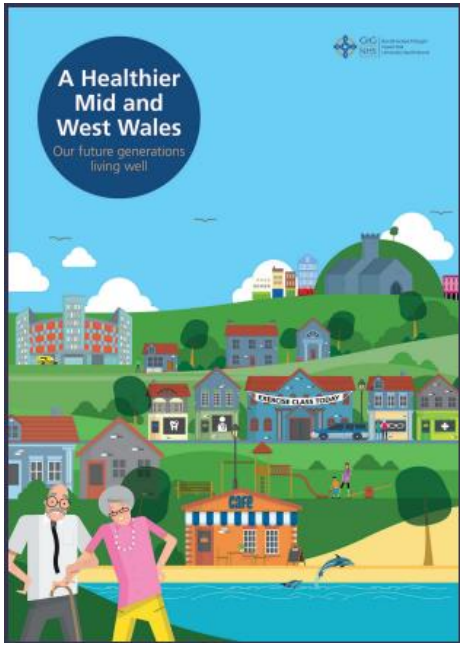
All statutory organisations have responded well to the pandemic by mobilising staff, resources and funds. In Ceredigion, Porth Cymorth Cynnar kept in touch with individuals and families already known to council services as vulnerable. The service offered regular contact, advice and support during the pandemic.

In Carmarthenshire, an impact assessment highlighted the re-orientation of services and outlines a reset for work going forward. This includes

- Learning from the pandemic at an organisational level
- Revisit Wellbeing Objectives and Corporate Strategies
- Reconsider business plans
- Opportunity to lead the way with visionary ideas and transformative investment to a future based on well-being.
- Respond to recommendations from the Future Generations Commissioner's report to:
  - Develop an economic stimulus package that leads to job creation and supports the decarbonisation of homes
  - Invest in better ways to connect and move people through improving digital connectivity, active travel and public transport
  - Invest in skills and training to support the transition to a better future, creating new greener jobs
  - Invest in nature and prioritise funding and support for large-scale habitat and wildlife restoration, creation and connectivity throughout Wales



- Invest in the industries and technologies of the future, and support for businesses that will help Wales to lead the low carbon revolution and lock wealth and jobs into local areas with investment in the foundational economy.
- Recognition that digital solutions will play an ever-increasing role in shaping services.[48]



HEALTH SERVICE RESPONSE TO COVID

The cornerstone of the Healthier Mid and West Wales Strategy is the improvement of health and wellbeing moving away from a reactive to a proactive system. [49] This transformation of clinical services in Hywel Dda is underway and a need for further change is recognised. During the pandemic the acceleration of new pathways created to support those at most clinical need and more streamlined governance structures meant swift decision making with less bureaucracy.[50]

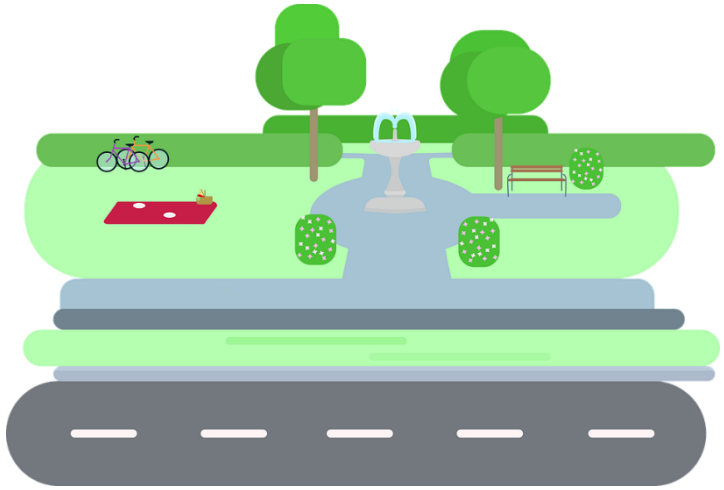
Health service transformation has been facilitated and accelerated by new ways of working.[51] These include

- On-line interpreter service for health service staff to use with those whose first language is not English or Welsh.
- Expanding the use of digital platforms, for example providing telephone and video consultations, as well as face-to-face consultations when required
- Linking with secondary care hospital teams virtually using new digital platforms
- Establishing hubs for urgent and emergency care
- Supporting the field hospitals, the test and trace and COVID-19 vaccination programmes
- Pharmacies providing support for a range of services without appointments, particularly when GP services were seen to be under greater pressure
- Practices adapting ways of working to ensure appropriate infection control to keep patients safe. remotely and expanding the use of digital platforms

To maintain and sustain health service transformation, further work to engage and assess the impact of the changes to services on vulnerable populations has been planned. This work will be led by the Strategic Enabling Group: 'Better ways to connect: Continuous engagement, diversity and inclusion' and will consider many of the valuable lessons learnt from the rapid transformation that occurred in response to the pandemic.

STORY 6 ACCESS TO GREEN SPACE

The restrictions on movement at the beginning of the pandemic meant that many people re-evaluated their usual habits and their relationship with their local area. People exercised more during lockdown which may be partly due to the number of people working from home. Homeworkers were more likely to leave the home than those with a daily commute.[52]

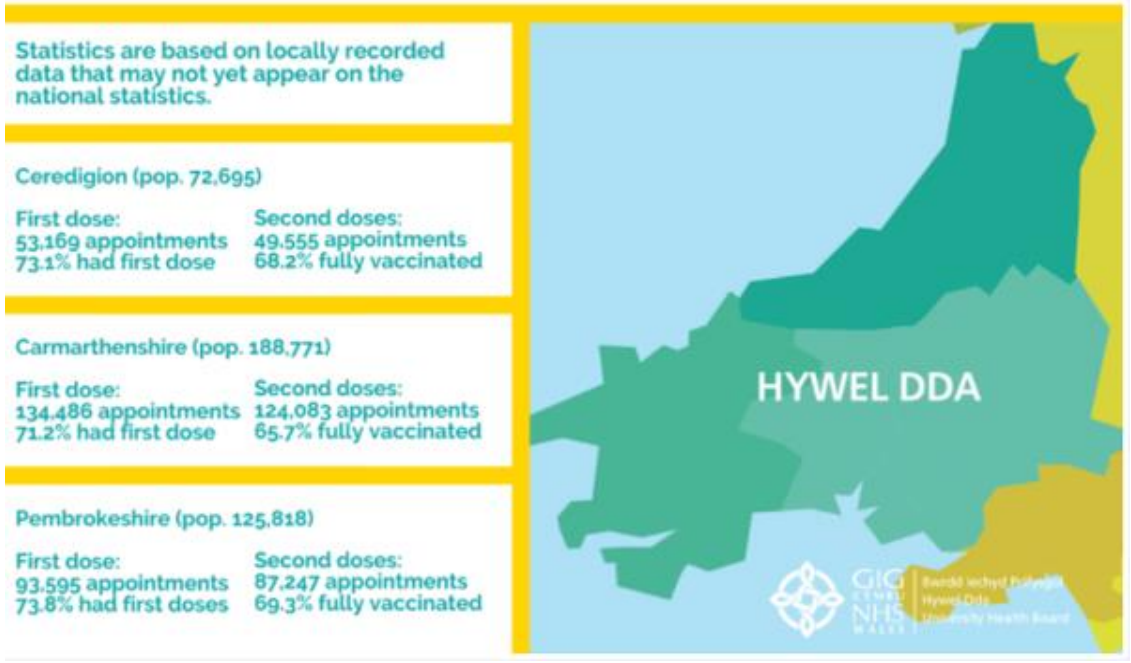


Along with this rise in outdoor exercise people's interest in nature surged. A report by the four UK nations' environment agencies found that engaging with nature played a key role in maintaining people's physical and mental health and overall wellbeing during the COVID-19 pandemic and associated lockdowns. The importance of these green and blue spaces to people's wellbeing has increasingly been recognised, but access to them is unequally distributed. Being poor, less educated, living in a deprived area, being unemployed and also being from an ethnic minority all negatively impact people's access to the benefits nature can provide.[53] 'Green health' has been a strong aspect of our work locally for health and wellbeing. This is happening within Health Board estates and there are excellent community projects creating green space and improving people's access to it across the area.

Without travel and traffic CO_2 emissions dropped (though not by much), air quality improved and noise pollution plummeted. We had a glimpse of how different the world could be. This proved temporary - CO_2 emissions are back to pre-Covid levels and the climate emergency is as present a danger as before. The health impacts of climate change will also not be felt equally. Old age, having pre-existing medical conditions and social deprivation are key attributes that make some people more vulnerable and likely to experience more adverse health outcomes than others.[54] If we are to 'build back fairer' then addressing the climate and biodiversity crises have to be part of the solution. Natural Resources Wales and the Public Service Boards, through the Wellbeing of Future Generations Act, are working hard to create 'A Resilient Wales'. Key recommendations identified in the Health Board's Local Needs Analysis focus on reducing carbon emissions through promoting renewable energy; safeguarding, sustaining and enhancing natural and built spaces to encourage healthy living for residents and visitors; and supporting resilience within our rural and urban communities.[55]

4.2 PROMOTING HEALTH EQUITY IN COVID-19 VACCINE UPTAKE

The development of effective vaccines for COVID-19 and their distribution to people across the UK has been one of the success stories of the pandemic. In Hywel Dda University Health Board area a total of 281,250 first doses and 260,885 second doses have been administered (as of 1st September 2021). In Hywel Dda 84% of care home residents have received their second vaccine dose. Nearly 97% of all those aged over 80 years have received their second dose as have 85% of adults under the age of 70 years who are clinically extremely vulnerable. While nearly 70% of the population in Hywel Dda have received their second dose, inequities in uptake still exist.



[From Wales COVID-19 Vaccination Enhanced Surveillance Equality Report 8: 23 September 2021 This report summarises surveillance of equality in coverage of COVID-19 vaccination in Wales, from 8th December 2020 up to 10 September 2021, by sex, socioeconomic deprivation and ethnic group.]

The largest inequality in coverage in Wales (?) between ethnic groups is currently in adults aged 30 to 39 years. Coverage for the combined Black, Asian, Mixed and Other ethnic groups in this age-group was 64.0% compared to 80.7% in the combined White ethnic groups.

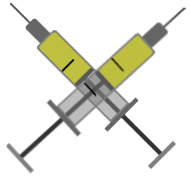
Inequities in vaccine uptake have also been identified between adults living in the most and least deprived areas of Wales. The inequality gap is greatest amongst the younger population groups though it continues to narrow as more people take up the offer of the vaccine.

The Welsh Government identified at the outset that the 'vaccination programme for COVID-19 must work towards an equal and fair NHS by ensuring equitable access to vaccination across population groups so that 'no-one is left behind'. In March 2021 they published their Vaccine Equity Strategy for

Wales. Acknowledging the unfair impact that Covid had already had on certain population groups, the strategy recognised that targeted action would be needed to make sure that everyone had a 'fair and meaningful opportunity' to access vaccination.[56]

These priority groups mirror those identified as already disproportionately affected by Covid – people with protected characteristics under the Equality Act 2010 including people from ethnic minority backgrounds and people with disabilities; those at socio-economic disadvantage living in communities with high deprivation or social exclusion and those within marginalised or under-served groups such as asylum or sanctuary seekers, people experiencing homelessness, people involved in the justice system, mental health clients and people from Traveller communities who do not regularly access traditional healthcare services.

STORY 7 VACCINE EQUITY GROUP



Local Health Boards delivering the vaccination programme, including Hywel Dda University Health Board, were already working hard to make their Covid-19 vaccination programmes as accessible as possible, including mass vaccination centres. At the start of the COVID-19 vaccine roll out a homelessness and vaccination group had been set up with partners from the vaccination team, the Public Health Team and local authority colleagues as we were concerned about this group. In response to the publication of the strategy we extended this to become the Vaccine Equity group and invited other local authority and third sector colleagues who served as links between the Health Board vaccination programme and the services they commissioned or represented.

Alongside this the Welsh Government funded Community Outreach workers in each Health Board area to engage with BAME communities on health and social issues. The team of three, who joined the Health Board in April 2021, have been a crucial part of reaching out and building trust with people who may not have full confidence in health services.

Perhaps unexpectedly, the necessity to meet virtually during the pandemic and the IT solutions that were put in place, helped us to connect with these groups. In the past we would have struggled to get people from across our large geographical area to come to a 'live' meeting and would have resorted to email and phone conversations. On-line meetings meant people were able to join us for an hour on a regular basis meaning better representation from across different target groups. This in turn benefited us all – we were able to share and discuss problems, compare experiences and solutions and adopt a

unified approach. Those in the group gained confidence in talking to others about the vaccine and dispelling misinformation. Data on uptake between different groups, particularly at a local level, was hard to come by, so the intelligence that the group members could bring through their contacts on the ground was invaluable.

The overall aim of the Vaccine Equity Group was to make sure people had good information about the vaccine to make an informed decision about whether to have it, and then to make sure it was as easy as possible for them to access it. Some of the solutions we put in place were:

- Sharing links to FAQs and information on the vaccine in Easy-Read, languages other than Welsh or English, BSL videos and information produced by homeless and learning disability groups, for example
- The HDUHB vaccination team put on bespoke clinics at accommodation for the homeless and they were offered drop-in slots at mass vaccination centres
- The vaccination team worked with workplaces where there were a large number of migrant workers to offer on-site vaccination
- Clinics at Mass Vaccination clinics with a Mental Health nurse present for those with mental health diagnoses
- Bespoke arrangements for people with a learning disability through the Learning Disability Nurses
- Bespoke arrangements for pregnant women with a Midwife or Health Visitor at the Mass Vaccination Centres.

THE MOBILE VACCINATION VEHICLE

Through the Mobile Vaccination Vehicle the Health Board has so far (24/10/21) delivered 2591 Covid-19 vaccinations – 1083 first doses and 1508 second doses – at 144 pop-up clinics.

The Fire Service generously offered one of their vehicles with driver for the use of the vaccination team as a Mobile Vaccination Vehicle. It delivered pop-up vaccination clinics

- At Travellers' sites
- In areas of socio-economic deprivation
- In other geographical areas where low uptake of the vaccine was identified
- in places geographically distant from the Mass Vaccination Centres
- for students at colleges and universities across Hywel Dda

The MVV also attended local events to provide advice and a pop-up vaccination clinic including The Garth Engagement Day in Haverfordwest and the Pembrokeshire County Show.

The relationships built within the Vaccine Equity group will have benefits in other areas too establishing a process and pathway for future collaboration. This group will be used to ensure equitable access to the Covid booster and influenza vaccination programmes this winter. It has the potential to be a very useful forum for discussing and improving access to other health care services in future.

STORY 8 ACCESS TO VACCINE FOR UNPAID CARERS

One of the priority groups in Phase 1 of the vaccination programme was unpaid carers (Priority Group 6) recognising the vital role that they play. These family members and friends, who may be adults or children, provide crucial care to a person who, due to a lifelong condition, be it to their physical and/or mental health, disability, or serious injury, simply cannot cope without their support.

Whilst the Health Board, GP practices, local authorities and third sector carers' organisations were already in contact with many unpaid carers through existing support programmes, there was now a renewed drive to identify those who had yet to come forward. This offer of protection through the vaccine was communicated widely, along with the criteria for eligibility and information about how to apply. A simple on-line form was developed. It worked – 3,000 unpaid carers across the Hywel Dda Area, previously unknown to us, came forward. Those unpaid carers and those they support will now benefit from other offers of support and information, should they need it now or in the future.

4.3 OBESITY AND HEALTH INEQUALITIES

In Hywel Dda, as in the rest of Wales, the proportion of adults and children not maintaining a healthy body weight is increasing. Data from the National Survey for Wales (2020) shows that 61 % of adults in Hywel Dda are overweight or obese. This is above the Welsh average of 59%. Unhealthy weight in children is also increasing with 29% of children in Hywel Dda being overweight or obese this is above the Welsh average of 27%. [57]

The proportion of children who are overweight or obese is significantly lower in the least deprived area for children ages 4-5 (21%) when compared to the most deprived areas in Wales (30%). Wales has a higher proportion of adolescents self-reporting as overweight or obese (boys – 27%, girls – 13%) compared to all other UK nations. [58] For adults the prevalence of overweight or obese increases with deprivation and there is a 12% difference in the prevalence between the most and least deprived areas in Wales. The difference between the least and most deprived fifths has increased over time, widening the gap from 6.9% in 2008 to 9.2% in 2015.[59]

Preventing and reducing overweight and obesity is a complex challenge because of the number of inter-related factors that can contribute to it, including our individual biology and behaviours as well as the environment and circumstances in which we live. This complexity means that to be effective in

reducing and preventing overweight and obesity requires action by government, business and the public sector in areas as diverse as legislation, food production, retail and catering, transport, the media and more to make the healthy choice the easier choice. Fundamental to the approach is a shared vision and collective action that is led by many partners and which involves local communities.

STORY 9 HEALTHY WEIGHT HEALTHY HYWEL DDA

Welsh Government has recognised that a 'systems' approach is needed and this is reflected in their 2019 'Healthy Weight: Healthy Wales' Strategy.[60] The strategy sets out action to be taken over the next ten years to help prevent and reduce overweight and obesity in Wales. It will be achieved through a series of two year plans, the first of which for 2020-2022 had a focus on children and families. This has recently been updated to reflect actions that should now be prioritised in light of what has been learnt in the COVID-19 pandemic thus far.

Hywel Dda is taking a systems approach to try and reduce any further rise in the levels of overweight and obesity and associated inequities and is also using funding made available by Welsh Government to provide better weight management support and services. Whilst the pandemic has highlighted the risks of overweight and obesity to COVID-19 it has also magnified those inequities that existed pre-pandemic, renewing the need to focus efforts on those that have been most adversely affected. It has underlined its importance to the health of the population, especially those on low income or living in areas where healthy food choices are unavailable.

Supporting people who are overweight or living with obesity to lose weight, together with interventions to prevent or slow weight gain across the population, is likely to reduce future population risks of COVID-19. Moreover, there is robust evidence that these interventions will bring wider health benefits to individuals and reduce pressures on the NHS and to society as a whole. Addressing our current unhealthy food and physical activity environment has potential benefits, not only to individuals, but for the climate emergency, air pollution and sustainability.

4.4 PROMOTING MENTAL WELLBEING:

Mental health and many common mental disorders are shaped by the socioeconomic and physical environments in which people live and inequalities are associated with an increased risk of poor mental health. [61] Some groups are at higher risk of mental disorders due to exposure to unfavourable and harmful social, economic and environment circumstances. These disadvantages usually start before birth and become reinforced throughout every stage of life.

COVID-19 and the associated social restrictions have taken an enormous toll on people's mental health and wellbeing. Cases of anxiety and depression around the world increased dramatically during 2020 with an estimated 76m extra cases of anxiety and 53m extra cases of major depressive disorders than would have been expected had COVID not struck.[62] Mental health is a key determinant for educational success, productivity, future earnings and life expectancy and can exacerbate and cause physical illness, so understanding the impact of COVID and who has been affected most is crucial.

During the period immediately before the pandemic, 11.7% of Welsh people suffered severe mental health issues. This share climbed to 28.1% in April 2020. This means mental health conditions in Wales during the first lockdown almost tripled compared to the period before the onset of the pandemic. The deterioration in average mental health was equivalent to that associated with an individual moving from being employed to unemployed during the pre-COVID-19 period[63]]

A study from Cardiff University looking at the impact of COVID-19 on the mental health of Wales concluded that "COVID-19 seems to have exacerbated inequalities in mental health among age groups and worsened pre-existing inequalities." [64] Across all three of the measures they looked at groups that had poor mental health before the pandemic suffered the largest deterioration in mental health, both in absolute and percentage terms. Women and young people were the most negatively affected. On average women exhibited lower levels of mental health of 1.04 points, or 9.9%, relative to men over the period 2009-2019. This gap widened to 1.59 points or 14.1% after the onset of the pandemic.

Some of the reasons for the gender difference in emotional and mental wellbeing are correlated with the social and economic consequences of COVID. For example, women are more likely to have lost their jobs and are less likely to be able to work from home. Women have also been at the forefront of responding to the COVID-19 pandemic working in health, social care and education. Women are also more likely to take on additional caring or household responsibilities than men due to children being at home or family members being unwell, even if they are still working.

Recent modelling for Wales suggests that for 2021 the potential increase in demand for primary care mental health services could be up to 40%, which could translate into 31,000 referrals. A similar increase in demand is predicted for acute mental health services with an increase of up to 25%, translating into 10,000 referrals.[65]

The other group suffering a stark drop in mental wellbeing are those who lost their jobs or suffered income shocks. Those with insecure or low-paid work were the most likely to experience this along with other adversities during this time, including having an existing health condition. The result is that Covid has disproportionately affected the mental wellbeing of the lowest income quintile and the mental health gap between them and the highest income quintile has increased significantly.

STORY 10 COVID-19 AND STAFF WELLBEING

COVID-19 has emphasized the tremendous pressures on the NHS workforce. Prior to the pandemic, staff were already experiencing high levels of anxiety and stress. It is known that those already experiencing mental health issues have seen an adverse effect due to the pandemic.

There is a recognition that ensuring the health and mental wellbeing of staff in the NHS is important for key aspects of recovery within NHS workforce and for population health.[66,67] These include:

- Benefit individual staff
- Support the drive to deliver high-quality healthcare services for all
- Reinforce the NHS brand image as a caring and committed employer
- Produce real benefits to the NHS bottom line
- Reinforce and support public health promotion and prevention initiatives

Hywel Dda Health Board employs 12,000 staff of which the workforce is predominantly female and the majority of staff work full time. The age profile generally indicates an ageing workforce with very few employees below the age of 20.[68] [69]

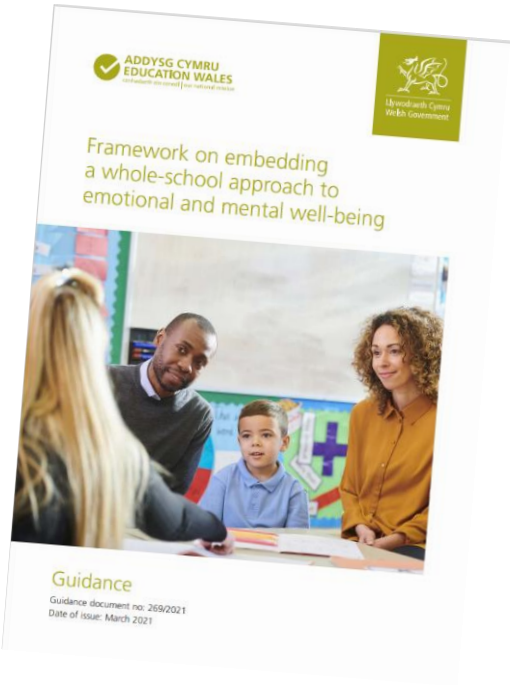
During the Pandemic, the health board's discovery reports captured insights into staff wellbeing. Staff were affected both personally and professionally. For some staff who were shielding, looking after loved ones due to lockdown and caring for those with COVID at home meant this altered their capacity to work. In some cases staff felt guilty working from home and equally some managers found it difficult managing staff remotely. For those staff still offering key services there were concerns about exposure to and catching COVID-19, however, staff felt engaged and a sense of camaraderie. Some of the other key messages from the staff wellbeing survey reflected the challenges all staff faced professionally and personally, including, managing change, delivering services differently and balancing home and working life.[70]

4

To help NHS staff working in Hywel Dda there are now multiple pathways of support. At an organisational level there is access to a dedicated intranet with wellbeing resources and additional support offered, specific guidance for staff shielding, additional bank staff and support from the voluntary sector and digital enablement of staff.

Additionally, psychological support services are being offered through a variety of opportunities such as an Employee Assistance Programme to provide 24/7 access, welsh language counselling provision and BAME ethnicity counsellors, virtual wellbeing webinars, bereavement support services for personal and professional grief and loss, a printed Wellbeing @ Work booklet distributed to all staff and spaces for Listening sessions. These services are supported by highly specialist clinical / Counselling psychologist leading the development and implementation of a Trauma Response Plan; an assistant psychologist to support training programmes, one to one support and access to resources; a Mental Health Practitioner / Trainer offering more workshops and courses. In addition, the health board have created new opportunities for staff wellbeing through positive experiences such as access too lifelong learning, provision of outdoor gyms, arts and wellbeing and flexible working. Engagement with staff has been enhanced by particularly including BAME groups and other initiatives such as 'Praise for Peers' and 'Valuing your Voice.'

STORY 11 WHOLE SCHOOL APPROACH TO MENTAL WELLBEING



The Framework on embedding a whole-school approach to emotional and mental wellbeing) is statutory guidance that aims to address the emotional and mental wellbeing needs of all children and young people as well as all school staff, governors and families as part of a whole school community. [71] This Framework also supports the Welsh Government's wellbeing approach to COVID-19 in an effort to mitigate the impact of the pandemic on all children, in particular those with additional learning needs and vulnerabilities. It recognises that the school alone cannot meet all the needs of what is a complex population of young people whose needs will vary as they progress through infancy to adolescence and early adulthood. The fundamental premise of the framework is not about medicalising well-being; rather it is about taking account of the continuum of need. Primarily it is about building resilience, ensuring preventative action and ensuring that specialist interventions are in place to support poor wellbeing when it arises. This approach also reflects the work that has taken place in the last decade to understand the impact of Adverse Childhood Experiences (ACEs) and ensure that teachers and other staff are equipped to identify and address their impact.

The Framework is based on the core values of belonging, efficacy and voice and these values apply equally across the school community to achieve the following:

- Embedding good well-being through teaching as well as all the other aspects of school life
- An ethos that values inclusion, where everybody works together, contributing their individual skills and resources to the collective good
- Creating a supporting environment where young people are encouraged to fulfil their personal and academic potential, where they thrive, learn and emotionally develop, supported by teachers who operate in a culture that also values teachers' own well-being
- Incorporating and building on existing good practice in the field such as the Welsh Network of Healthy Schools Schemes
- Incorporating the work of others such as Child and Adolescent Mental Health Services (CAMHS), which has traditionally offered assessment, treatment and interventions, and which should now be viewing the child and their needs more holistically

In Hywel Dda, 24 pilot schools are participating in the programme and a number of activities are taking place to support the local implementation of the Framework. These include:

- Establishing a regional partnership to support and oversee implementation
- Supporting schools to map current strengths/progress and scope needs
- Supporting schools to develop an implementation plan to address identified priorities
- Supporting schools to assess impact through monitoring and evaluation
- Supporting staff training
- Encouraging schools to provide peer support during the initial phase
- Developing a library of resources and services in preparation for post pilot.
- Supporting schools to overcome barriers to deliver meaningful well-being support including adequate time, teacher/staff well-being and staff training

In delivering the pilot in Hywel Dda we have had to adapt our approach to ensure that we acknowledge the challenging times schools have had and continue to have. The Implementation Coordinator is key to supporting schools directly and will ensure that learning and good practice is shared and wellbeing is promoted.

4.5 PRIORITISING THE EARLY YEARS

Over the last 18 months the Public Health and Wellbeing Directorate have been working with partners to realign our early years' services to move away from single institutions towards a place-based approach organised around networks of care. We agreed to support the creation of early years' integrated teams to work with families in specific communities using a strengths based community model in the anticipation that this approach would build trust and create strong relationships; improving community engagement and contributing to safe, secure and supportive environments for children to grow up in.

Part of the work that has taken place has been to examine place-based approaches in more detail with funding from Welsh Government to deliver two Pathfinder Programmes in Hywel Dda. These programmes focus on the period of life from pre-birth to the end of the Foundation Phase, or 0-7 years of age.

It is widely agreed that early childhood experiences are crucially important for children's long-term development and their achievements in later life. At these times children and their families have regular contact with a number of different services such as midwifery, health visiting, various family support workers, and childcare and early years' education provision. These services are currently accountable to different bodies and can work independently without sharing information or coordinating their support to families. Distinctions and boundaries in the ways of working that mean something to professionals can often appear complex, unequal, arbitrary and frustrating to the parent or child in need of help. In trying to overcome some of these barriers, and to promote health equity during the early years, the following broad aims are included as part of the local pathfinder approach:

1. Tackle child health inequalities through the transformation of early years services, support the ongoing delivery of the Healthy Child Wales Programme, Flying Start, Home Start, Healthy Pre-school Schemes and the Hywel Dda Pathfinder project to ensure that all children living in poverty have their needs assessed and have access to enhanced services when required.
2. Improve child health outcomes across Hywel Dda through focusing on prevention. This includes the delivery of programmes that promote health enhancing behaviours related to obesity, dependent behaviours (e.g. smoking, substance misuse), emotional and mental wellbeing and childhood immunisation and vaccination.
3. Address the wider determinants of health through the development of a systems approach to the early years which focuses on sustainable service development and alignment.

The story below provides an overview of the Pathfinder work taking place in Carmarthenshire.

STORY 12 THE EARLY YEARS INTEGRATION TEAM: GWENDRAETH VALLEY

First and foremost we support families with young children. We do this by working closely with the Health Visitors and Midwives within the team. As universal, home visiting providers they are ideally placed to make accurate assessments of the health and social needs of families with young children. Since October 2020, the Health Visitors have referred around 400 families for additional support. As part of our programme of work we have developed the following:

- Provided new opportunities for one to one and group support for families struggling with parenting issues such as sleep, infant feeding, behaviour management and toileting. This may be provided by the Early Years Integration Team exclusively or in partnership with other agencies
- We have created a local network meeting for family support services working, or wishing to work in the Gwendraeth Valley area. This facilitates the possibility of co-working between all agencies which may or may not include our project
- We actively seek out opportunities for co-working across health, local authority, third sector, and voluntary sector. We are currently working on joint projects with MIND, Mid and West Wales Fire Service, Tumble Family Centre, HDUHB Perinatal Mental Health Service, Carmarthenshire County Council, Team Camau Bach, The Child Disability Team and CCC safeguarding services. We also work in partnership with families and this includes supporting them to be proactive within their own community
- We are working with Perinatal Mental Health Service to bring a new clinic and group to the Gwendraeth Valley—facilitating a venue for them
- We have introduced our own rolling programme of Time to Shine in partnership with Tumble Family Centre and Carmarthenshire County Council
- We are working with local head teachers to create and pilot a county wide school transition document for school entry
- We are working with child disability services, health and education to create and test a county-wide one page profile for children with Additional Learning Needs (ALN) as well as supporting the development of a parent led group for children with ALN. Professionals working with children with ALN will be invited to come and speak to the group
- We are working with Mid and West Wales Fire and Rescue Service to facilitate home fire safety training. The home safety sessions are delivered in partnership with the Road Safety Team, Midwives and the Health Visitors. It includes a fun talk from the fire service, car seat safety buying and fitting advice and basic life support and choking advice. Participants receive a free home safety kit.

"The best thing I ever did was call, we were in a dark place before we saw the leaflet come through the door. You have been really helpful, and we are over the moon. Thank you" *(mum suffering with depression)*

"I think that you coming to the house has helped me realise that the boys are very small and that they don't know how to express themselves, so they do get angry and they do get frustrated because they're small. I don't let it get to me as much anymore and try better to understand what they're trying to say and that has made things much easier "(*struggling mother of*

SOME OF OUR PROJECTS:

The Summer of Fun is a Carmarthenshire County Council project. The Early Years Integration Team delivered eight sessions during the summer at various venues across the Gwendraeth Valley. There are a further two in September, but to date we have had 128 individual children attend. This project targets children with ALN, single parents, communication delay, ethnic minorities, and those isolated by Covid.

'It was lovely watching (child's name) play with other children as this has not been possible with the pandemic—Thank you'' (Summer of Fun)

Baby massage is a rolling programme currently delivered in two formats - face to face in small groups and a virtual group for parents that prefer that format. Since starting in October we have offered baby massage to all new parents and there is always a waiting list for the next cohort.

''My daughter loved it and was always happy and all the ladies were lovely. It was a bit strange at first with it being online but Sarah was always clear and showed us well how to do the massage. We always had a chat at the beginning and end, it was lovely just to see new mums'' (baby massage)

Time to Shine delivered in partnership with Menter Cwm Gwendraeth and Carmarthenshire County Council. For this project, we usually support other agencies to deliver the Time to Shine project, however, from October we will be delivering our own programme in partnership with Tumble Family Centre. The project targets children with social, physical and communication delays.

''Thank you so much for all the support that you have given me and (child's name). It has been lovely to have someone to talk to. I was very alone because of Covid and I couldn't see my family for help and advice but you came and helped me understand about his development and I am now more patient. Thank you (isolated young mum)

5. LOOKING FORWARD

In the previous Director of Public Health Annual Report I described the transformational shift that the Health Board is making away from a system just focused on diagnosing and treating illness towards one that supports people to live well by promoting wellbeing and preventing ill health. I talked about the steps we had already taken on that journey and set out the plans we had to take it forward. My report described how health is created largely in communities with access to healthcare being only a small part of what makes and keeps people healthy. Of course, health services have been absolutely critical for some people during the pandemic. Health Board staff have worked tirelessly and selflessly to save lives in unimaginably difficult conditions. But we have now seen the impact that an infectious disease and its consequences has on those already vulnerable or in poorer health. This is why we now have to redouble our efforts to improve those conditions in which we grow, live and work that make the biggest difference to our health.

In the 'Looking Forward' section of my report in 2019 I made a call to action for us to be 'big, bold and brave', for all of us to 'be the change' that we want to see. I set out a plan of work for the Public Health Directorate over the next three years to embed an asset based approach, to integrate meaningful continuous engagement mechanisms with our citizens and to see widespread use of the Wellbeing Lens - our tool for system change - and the Compendium - our evidence of what works to improve health.

Like the rest of Wales, the UK and the world, we have spent the last eighteen months working together to respond to the pandemic and to save lives. However, as highlighted in this annual report the pandemic has accelerated the pace of change through necessity. Partnerships have been strengthened and new relationships formed. Communities discovered assets and resources they did not know they had and organised themselves with support from the third sector.

With this in mind we need to 'Look Forward' again and continue to build on the wellbeing goals and commitments set out in the Health and Wellbeing Framework by recognising that we have an opportunity to adopt new approaches and solutions to reduce health inequalities and achieve a healthier and more resilient Hywel Dda. We should also recognise the shared responsibility we have to act on all determinants of health by supporting partners to create new and sustainable opportunities that will support the local economy and build on the positive impacts of current COVID-19 mitigation strategies such as promoting active travel, increasing digital inclusion and using and supporting community assets and other resources.[72]

As we now come through the curve of the pandemic, our challenge is to learn from the successful solutions that communities and local organisations have devised in the face of this disruption. To use this learning to find ways of working with and alongside communities to further build on and support this

community response in a respectful but not intrusive way. We have the opportunity to make this part of a longer-term strategy, beyond the current crisis, in order to help sustain a stronger set of social care supports and services within our communities. Most importantly, where we see good solutions working, that are clearly building community resilience, they should be nurtured and supported, building resilience for the long-term.

Address the health care need for individuals who have had cancelled operations or have not been able to access services in a timely manner for their initial consultation during the pandemic.

Promote a system wide recognition that family health and wellbeing and giving children the best start in life is central to reducing health inequalities

Continuously measure our impact on health inequalities.

Support and encourage staff to use behaviour change approaches to help address the broader context of peoples lives.

Continue to support the rollout of the COVID-19 vaccination programme and continue to work with partners to address vaccine equity.

Work with partners across sectors to increase social and green solutions for health

Adopting a shared language across the whole system to ensure that health inequalities are recognised and health equity is promoted.

Continue to support systems approaches to address priority areas such as obesity, smoking, substance misuse and mental health

APPENDIX 1
BEST HEALTH & WELLBEING FOR INDIVIDUALS, FAMILIES & COMMUNITIES

PREPARED BY:
HYWEL DDA PUBLIC HEALTH TEAM

SEPTEMBER 2021 (BASELINE)

THEME: POPULATION **OUTCOME: OUR COMMUNITIES FEEL HAPPY, SAFE AND ARE ABLE TO LIVE LIFE TO THE FULL** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Percentage of adults agreeing that they belong to the area, that people from different backgrounds get on well together and treat each other with respect.	**57.8**	**62.0**	**51.6**	**56.0**	**52.2**	**45.5**		**60.0**
Percentage of adults who feel safe at home, walking the local area and when travelling	**89.4**	**82.0**	**76.1**	**80.0**	**71.0**	**67.0**		**81.0**
Percentage of adults who are satisfied with local area as a place to live	**94.0**	**89.8**	**88.4**	**90.7**	**85.3**	**79.0**		**90.0**
Percentage of adults who feel able to influence decisions affecting their local area	**18.3**	**15.8**	**18.8**	**18.0**	**18.7**	**17.0**		**21.0**
Percentage of adults who feel they can find and walk to local green space (2018-19)	**90.0**	**87.0**	**85.0**	**87.3**	**89.9**	**87.0**		**92.5**
Mental wellbeing (WEMWB Scale), adults 16+, 2018-19	**50.2**	**49.7**	**51.1**	**50.4**	**51.4**	**50.4**		**52.5**
Percentage of adults (16+) who are satisfied with their ability to get to/access facilities and services they need, 2018-19	**70.6**	**78.2**	**75.4**	**74.7**	**79.7**	**65.6**		**86.9**
Proximity to accessible natural green space (percent of households)	**55.4**	**67.8**	**60.5**	**61.9**	**77.0**	**61.9**		**87.8**

THEME: GENERAL HEALTH AND WELLBEING **OUTCOME: OUR COMMUNITIES HAVE AN OPPORTUNITY FROM BIRTH TO OLD AGE TO BE HEALTHY, HAPPY AND WELL INFORMED** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Percentage of adults who have fewer than two healthy behaviours *(2018-19 to 2019-20)*	**10.8**	**11.3**	**12.4**	**11.7**	**10.0**	**7.6**		**12.2**
Percentage of children who have fewer than two healthy behaviours *(2018-19 to 2019-20)*	**TBC at UA & UHB level**							

THEME: GENERAL HEALTH AND WELLBEING **OUTCOME: OUR COMMUNITIES HAVE AN OPPORTUNITY FROM BIRTH TO OLD AGE TO BE HEALTHY, HAPPY AND WELL INFORMED** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Percentage of adults who agree that they can get enough information to lead a healthy life (2019-20)				**29.0**	**42.0**	**29.0**		**49.0**
Parentage of adults (16+) who smoke (2018-19 to 2019-20)	**20.5**	**20.5**	**16.2**	**18.5**	**17.4**	**14.4**		**18.6**
Percentage of adults (16+) who use E-cigarettes (2018-19 to 2019-20)	**4.2**	**5.8**	**6.7**	**6.1**	**6.4**	**4.1**		**7.1**
Percent of adults (16+) drinking over guidelines – 14 units) (2018-19 to 2019-20)	**17.7**	**19.2**	**21.5**	**19.9**	**18.6**	**16.5**		**21.6**
Percentage of adults (16+) who were active for less than 30 minutes in the previous week (2018-19 to 2019-20)	**25.3**	**36.9**	**27.6**	**29.9**	**33.0**	**26.4**		**46.7**
Percentage of adults (16+) eating at least 5 portions of fruit & veg in the previous day (2018-19 to 2019-20)	**23.3**	**25.0**	**21.7**	**22.9**	**24.3**	**20.5**		**32.1**
Percentage of adults (16+) with a BMI ≥ 25 (overweight or obese)	**58.4**	**59.3**	**63.6**	**61.1**	**59.9**	**55.4**		**64.9**
Percentage of children (aged 3-7) eating fruit every day (2019)				**89.1**	**86.4**	**78.7**		**89.7**
Percentage of children (aged 3-7) who are active for one hour or more 7 days a week (2019)				**67.7**	**63.0**	**60.3**		**69.2**
Percentage of adults (16+) who are lonely (2019-20)	**16.0**	**13.0**	**16.0**	**16.0**	**15.0**	**13.0**		**17.0**
GENERAL HEALTH AND ILLNESS, Percentage of adults 16+, age-standardised 2019-20								
- Musculoskeletal complaints	**14.9**	**18.1**	**17.1**	**17.1**	**16.3**	**14.1**		**17.8**
- Heart and circulatory complaints	**11.6**	**13.3**	**16.6**	**14.5**	**12.6**	**10.3**		**14.8**
- Endocrine and metabolic complaints	**7.0**	**6.9**	**8.3**	**7.6**	**7.6**	**5.9**		**8.8**

THEME: GENERAL HEALTH AND WELLBEING **OUTCOME: OUR COMMUNITIES HAVE AN OPPORTUNITY FROM BIRTH TO OLD AGE TO BE HEALTHY, HAPPY AND WELL INFORMED** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
- Respiratory system complaints	**7.2**	**8.7**	**7.3**	**7.8**	**8.2**	**5.9**		**9.4**
- Mental disorders	**9.1**	**9.7**	**9.3**	**9.4**	**10.3**	**9.3**		**11.9**
- With 2 or more long standing illnesses	**16.4**	**20.5**	**23.5**	**21.2**	**19.7**	**16.1**		**23.9**
Flu immunisation uptake (adults aged 65+), *2019-20*				**64.8**	**69.4**	**64.8**		**71.4**
Flu immunisation uptake (vulnerable/at risk groups under age 65), *2019-20*				**40.2**	**44.1**	**40.2**		**46.9**
COVID-19 vaccine uptake (All Wales residents aged 18+) – 2 doses *(exact at 16/09/21)*	**78.8**	**84.2**	**83.1**	**82.6**	**83.0**	**79.2**		**88.3**
Teenage pregnancy rate per 1000 females aged under 18 years, (2018)	**17.8**	**14.9**	**19.5**	**17.6**	**20.2**	**17.4**		**24.2**
Low birth weight (% live births < 2500g), 2020	**5.5**	**4.7**	**4.9**	**4.9**	**6.1**	**4.9**		**7.1**
Smoking in pregnancy (a birth), 2020				**16.7**	**16.8**	**12.3**		**27.2**
Percentage of women who stopped smoking during pregnancy, (2020)				**27.7**	**18.1**	**9.5**		**27.7**
Percentage of pregnant women with a BMI ≥ 30, (2020)				**29.4**	**29.2**	**15.4**		**35.6**
Percentage of women at the initial antenatal assessment who had reported a mental health condition, (2020)				**25.4**	**27.1**	**5.5**		**37.4**
Percentage of women breast feeding at 10 days, (2020)				**54.9**	**51.7**	**40.9**		**66.1**
Percentage of women breast feeding at 6 months				**29.3**	**25.3**	**15.1**		**37.8**

THEME: GENERAL HEALTH AND WELLBEING **OUTCOME: OUR COMMUNITIES HAVE AN OPPORTUNITY FROM BIRTH TO OLD AGE TO BE HEALTHY, HAPPY AND WELL INFORMED** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Percentage of eligible children with recorded Healthy Child Wales contact at 10-14 days (2019-20)				**92.2**	**93.5**	**88.2**		**95.5**
Percentage of eligible children with recorded Healthy Child Wales contact at 6 months (2019-20)				**78.5**	**81.6**	**48.8**		**90.5**
Percentage of eligible children with recorded Healthy Child Wales contact at 3.5 years (2019-20)				**52.0**	**50.2**	**24.5**		**66.0**
Vaccination rates at age 4 (%) 2019-20				**86.7**	**88.0**	**86.6**		**90.3**
Percent of children aged 4-5 at a healthy weight or underweight (All) (2018-19)[1]	**78.1**	**69.2**	**69.6**	**70.9**	**73.1**	**70.7**		**78.1**
Bowel Screening uptake, percent eligible adults, (2018-19)	**56.4**	**57.5**	**58.6**	**57.8**	**57.3**	**56.4**		**58.3**
Breast screening uptake, percent eligible adults, 2019	**71.8**	**75.4**	**74.0**	**73.8**	**72.5**	**68.5**		**76.9**
Cervical screening coverage, percent eligible women, 2019	**69.9**	**71.8**	**70.6**	**70.9**	**73.2**	**70.9**		**76.1**

THEME: EQUITY **OUTCOME: OUR COMMUNITIES HAVE A VOICE AND ARE ABLE TO FULFIL THEIR POTENTIAL NO MATTER WHAT THEIR BACKGROUND OR CIRCUMSTANCES** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Inequality gap in life expectancy at birth (Slope Index of Inequality) in years, Males 2010-14	**3.1**	**4.3**	**5.3**	**4.8**	**8.8**	**4.8**		**10.3**

[1] MSOA wih highest rates of childhood obesity in HDda UHB = Llanelli West (19%)

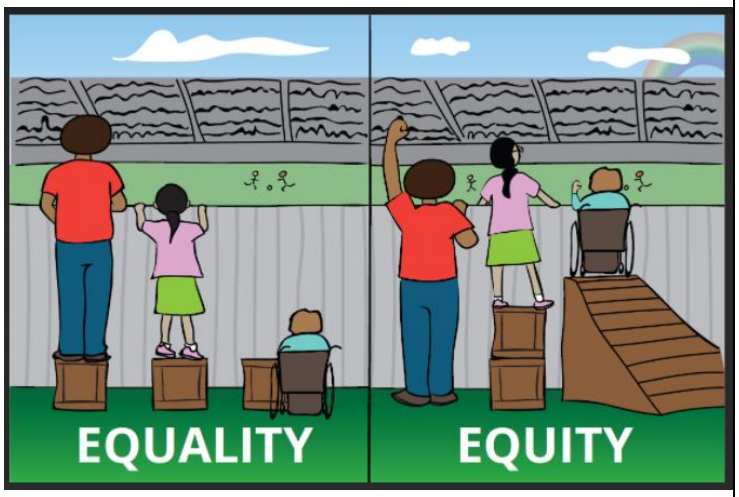
THEME: EQUITY **OUTCOME: OUR COMMUNITIES HAVE A VOICE AND ARE ABLE TO FULFIL THEIR POTENTIAL NO MATTER WHAT THEIR BACKGROUND OR CIRCUMSTANCES** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Inequality gap in life expectancy at birth (Slope Index of Inequality) in years, Females 2010-14	3.7	4.2	4.7	4.5	7.2	3.7		9.2
Inequality gap in healthy life expectancy at birth (Slope Index of Inequality) in years, Males 2010-14	9.3	11.9	10.6	12.2	18.7	10.4		23.2
Inequality gap in healthy life expectancy at birth (Slope Index of Inequality) in years, Females 2010-14	6.7	11.9	12.5	12.2	18.2	12.2		21.9
Life expectancy at birth, Males, years, 2010-2014	80.1	79.5	78.6	79.2	78.3	76.6		80.2
Life expectancy at birth, Females, years, 2010-2014	83.9	82.9	82.6	82.9	82.3	80.9		83.6
Healthy life expectancy at birth, years, Males, 2010-2014	67.9	66.9	65.0	66.2	65.3	61.2		68.2
Healthy life expectancy at birth, years, Females, 2010-2014	69.7	69.0	66.0	67.6	66.7	62.6		69.2
Premature death rate per 100,000 population, 2019	322.4	345.8	365.5	350.7	382.5	309.1		431.2
Percent of adults living in households in material deprivation, 2019-20	11.0	8.0	11.0	10.0	13.0	10.0		15.0
Percentage gap in employment rate for those with long term health conditions, 2018	9.8	16.3	14.9	14.3	14.0	8.5		17.7
Percent working age population in employment deprivation, 2019	8.0	10.0	11.0	10.0	10.0	7.0		13.0
Percent population in income deprivation, 2019	12.0	15.0	15.0	14.0	16.0	11.0		18.0
Percent of children aged 0-4 in income deprivation, 2019	23.0	26.0	26.0	25.0	28.0	17.0		31.0
Percent of adults aged 65+ in income deprivations, 2019	14.0	15.0	16.0	15.0	17.0	13.0		20.0

THEME: EQUITY **OUTCOME: OUR COMMUNITIES HAVE A VOICE AND ARE ABLE TO FULFIL THEIR POTENTIAL NO MATTER WHAT THEIR BACKGROUND OR CIRCUMSTANCES** **Proxy Measures (Purple text)**	**Ceredigion**	**Pembrokeshire**	**Carmarthenshire**	**Hywel Dda**	**Wales**	**Lowest UHB**	**Hywel Dda UHB RAG STATUS**	**Highest UHB**
Percent adults aged 25-64 with no qualifications, 2019	**14.4**	**16.7**	**18.6**	**17.2**	**19.4**	**16.2**		**24.5**
Percent population living in overcrowded households, 2019	**5.08**	**4.56**	**4.66**	**4.71**	**5.53**	**3.89**		**5.49**
Foundation Phase Education (FPE) Average Point Score[2]	**106**	**103**	**104**	**104**	**104**	**102**		**107**

[2] The score relates to the performance of children in language, literacy and communication (English or Welsh), maths, and personal and social development.. A maximum of 135 points per child is possible across the three areas of development, Most deprived MSOA for FPE in Hywel Dda is Llanelli South.

APPENDIX 2

GLOSSARY OF TERMS

<table>
<tr><td>Health inequalities</td><td>Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.</td><td rowspan="2"> 

The image above is often used to illustrate the difference between Health Inequalities and Health Equity</td></tr>
<tr><td>Health equity</td><td>Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

To achieve this, we must remove obstacles to health — reduce health inequalities such as poverty, discrimination, and deep power imbalances — and their consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.</td></tr>
<tr><td>Assets</td><td colspan="2">The many positive aspects of communities, including but not limited to its people, organisations, partnerships, facilities, and collective experiences.</td></tr>
<tr><td>Whole System approach</td><td colspan="2">A whole system approach involves applying systems thinking, methods and practice to better understand public health challenges and identify collective actions. Adopting a whole system approach to Hywel Dda’s Public Health Priorities is a long-term endeavour. The Wellbeing and Future Generations Act is a good example of systems thinking as it challenges organisations to put long-term thinking, integration, collaboration and prevention at the centre of planning and action.</td></tr>
<tr><td>Population Health</td><td colspan="2">The phrase ‘population health’ includes the whole range of determinants of health and wellbeing – many of which, such as town planning or education, are quite separate from health services. Referring to ‘population health’ rather than the more traditional phrase</td></tr>
</table>

	'public health' also helps avoid any perception that this is only the responsibility of public health professionals. Population health is about creating a collective sense of responsibility across many organisations and individuals, in addition to public health specialists. The king's Fund defines population health as "as an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.[73]

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