Detailed Analysis of Health Deprivation Divide using the 2011 Census

Coverage: England
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Geographical Area: Country
Theme: Health and Social Care

Key points

- Men and Women (aged 40 to 44) living in the most deprived areas are around four times more likely to have ‘Not Good’ health compared to their equivalent in the least deprived areas.
- Inequalities in health remain large, even at older ages; in the least deprived areas people aged 80 to 84 reported better rates of health than those 20 years their junior in the most deprived areas.
- The inequality in health between the most and least deprived areas peaks at ages 55 to 59 for women and 60 to 64 for men.
- Future fitness to enjoy retirement is likely to be more favourable for the least deprived population than the most deprived; at ages 60 to 64 disabling health problems are much less common among the least deprived.
- The disability prevalence divide between the most and least deprived areas is large across the working ages of 30 to 64, where adults are expected to participate in the labour market.
- The fact that both men and women in the least deprived areas aged 65 to 69 have similar percentages disabled as those aged 40 to 44 in the most deprived areas suggests fitness to extend working careers post the traditional state pension age for men (65) is more likely among the least deprived area residents.

Introduction

This new analysis focuses on the extent of inequality in health and disability between more and less disadvantaged populations in England using Census 2011 and area deprivation data. The distribution of health and disabling health conditions across the population of England has been shown to follow a sizeable, persistent and incremental pattern; health outcomes generally worsen in line with greater levels of socioeconomic disadvantage. Health organisations now have a statutory duty[^4] to have regard to the need to reduce health inequalities, and therefore health improvement is no longer the only success criterion: reducing differences in health between populations is also a policy objective for [NHS England](https://www.nhs.england.nhs.uk) and [Public Health England](https://www.gov.uk/phe).

Background

In the 2011 Census, residents were asked to self-assess their general health (see Box 1). This provides a measure of health based on a subjective response. They were also asked whether their daily activities were limited because of a health problem or disability lasting or expected to last 12 months or more (see Box 2). This response was based on measuring our functional health status, which includes mental and physical limitations. For the purpose of this analysis, an individual responding to Question 13 (Box 1) is categorised as having ‘Not Good’ health if they assessed it as Fair, Bad or Very bad, and can be categorised as disabled if they responded to question 23 (Box 2) as either ‘Yes, limited a lot’ or ‘Yes, limited a little’.

Box 1: The general health question included in the 2011 Census

Box 2: The disability question in the 2011 Census
Activity limitation is an important measure for assessing health and social care need, fitness for work (for certain types of occupations) and access to the labour market generally. It can also indicate how well health care controls the disabling effects of health conditions such as diabetes through effective treatment and management.

It is important to note that figures for children, aged 0 to 15, will include the assessment of parents or carers completing the census form on their behalf.

Notes

1. Functional health status relates to mobility, dexterity, self-care and performing general tasks such as shopping, cooking, paying bills amongst others and encompasses mental as well as physical limitations. The categories limited a lot and limited a little indicate the extent of dependency on others to perform general daily activities people usually do.

How do we measure area disadvantage to compare health status?

Where we live in England (which can be categorised and grouped according to a scale of deprivation) is linked directly to the responses to both the subjective and functional health questions.

The analysis in this short story uses the English Indices of Deprivation 2010 Index of Multiple Deprivation (IMD 2010), the scores of which have been adjusted to reflect Lower Layer Super Output Area (LSOA) boundary changes in 2011. This Index encompasses seven domains of deprivation for small areas of England. They are:

- Income
- Employment
- Health and disability
- Education skills and training
- Barriers to housing and services
- Living environment
- Crime

Each area’s exposure to these aspects of deprivation is measured on the basis of available data, and an area’s residents' relative exposure is ranked against other areas. Using this index the least deprived LSOA in England is located in Three Rivers in the county of Hertfordshire, while the most deprived is located in Tendring in the county of Essex.

However, it is not the area itself which is deprived but the circumstances and lifestyles of those residing in the area that affects the areas deprivation score relative to another area. This means that not all residents of a deprived area are deprived, and conversely, not all deprived people live in deprived areas.

Measuring differences in health states between populations exposed to different levels of deprivation allows health organisations to make intuitive decisions about the level of intensity with which preventive actions designed to improve health should be focused, and the likely savings to the
health care system that would accrue from better health states, and for the wider economy in terms of fitness for work and extending the working lifespan.

Notes

1. These adjusted scores were used to assign 2011 LSOAs to deprivation deciles (tenths) on the basis of ranking within England for analysis of health inequalities. The responsibility for producing these adjusted deprivation scores lies purely with Public Health England - the figures have neither been quality assured nor endorsed by Department for Communities and Local Government, but have been used in Public Health Outcomes Framework indicators. Further details on how the scores were adjusted can be found here.

2. LSOAs have an average of roughly 1,500 residents and 650 households, and are built up from adjacent output areas.

Why age standardise percentages of health and disability?

For any deprivation analysis, age standardisation is also applied as it enables different populations to be compared on an equal footing in terms of age structure. Age standardisation adjusts percentages or rates to take into account how many old or young people are in the population being looked at. Analysis based purely on a crude percentage or rate of the total population can mask other important differences between populations such as area deprivation. The European Standard Population (ESP) 2013 has been used in this short story (please see the background notes section for more detail).

Age-specific health comparisons

National level

Figure 1 demonstrates the strong relationship between self-assessed health status and age. While those aged under 20 have the best health status, after the age of 20 health status deteriorates more quickly for both men and women; but the greatest change generally occurs between the ages of 65 and 85 and over (Figure 1).
Among males aged 0 to 20, self-assessed ‘Not Good’ health was 3.6 per cent, with percentages remaining below 10 per cent up to those aged 30 to 34 inclusive. From ages 35 to 39 to ages 60 to 64, percentages increase more acutely from 10.9 per cent to 33.6 per cent, a percentage difference of 22.7 per cent, showing those aged 60 to 64 are more than 3.1 times more likely to assess their health as ‘Not Good’ than those aged 35 to 39. From ages 65 to 69 to 85 and over, equivalent percentages increase from 37.7 per cent to 69.1 per cent, a 31.4 percentage point difference.

Source: Census - Office for National Statistics

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Among females a similar pattern is observed, although the increase in ‘Not Good’ health between ages 65 to 69 and 85 and over is sharper than that for males; a percentage difference between these ages of 38.1 per cent.

Health across levels of deprivation

One way to assess how the pattern above varies in populations exposed to different levels of deprivation is to compare the difference in health status by age. All figures described in the text below (percentages of males and females assessing their health as ‘Not Good’ by age and level of deprivation in England 2011) are included in the accompanying reference tables. Generally, health worsens as deprivation exposure increases for both genders. At younger ages, those below age 20, differences are smaller, but divergence becomes more noticeable between ages 20 to 24 and 30 to 34, where even the difference between the most and second most deprived residents is marked. Beyond ages 35, those in decile 1 have the most pronounced health declines and remain clearly distinct even from those in the adjacent decile 2. The difference in health status remains sizeable even at the oldest ages 85 and over.

An interesting feature in these findings is an absence of any cross-over in health status where health is more favourable in a more deprived decile compared to a less deprived, even between adjacent deciles. This means a consistent pattern of health deteriorating in line with increasing levels of deprivation. At both ends of the deprivation decile spectrum (most and least deprived) the differences between deciles 1 and 2 and 9 and 10 exceeds that of all the intervening decile comparisons. This may point to falling beneath or rising above a given deprivation threshold affects health disproportionately at the extremes; beneficially in the case of the least deprived areas and harmfully in the case of the most deprived.

Analyses of more objective measures of health status such as health and social care usage, premature mortality from certain causes of death, life expectancy (398.4 Kb Pdf) and health expectancy (398.4 Kb Pdf) are also worse among the more deprived residents of local administrations. This independent assessment adds weight to the usefulness of these subjective self-assessments of health collected at the 2011 Census in understanding the differences in the underlying health of populations exposed to different levels of deprivation. Figures 2 and 3 isolates the information to the least and most deprived tenth of areas.
Figure 2: Percentage of males with ‘Not Good’ health by age and level of deprivation(1), England 2011

Source: Census - Office for National Statistics

Notes:
1. Decile 1 is most deprived and decile 10 is least deprived.

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The deterioration in health as age rises is starkly different among the least and most deprived populations for males. Among the most deprived populations, the decline in health occurs at younger ages and the change with increasing age is steepest from early middle-age (ages 30 to 34) to later middle age (60 to 64) with a difference in rates of 'Not Good' health between these ages of 36.4 percent. When combining all deciles to obtain the England estimate, the comparative difference between these ages is only 20 per cent; in the least deprived areas it is only 11 per cent.

In contrast, males living in the least deprived areas have a shallower increase up to ages 40 to 44, where 'Not Good' health remains below 10 per cent; the sharp increase occurring between
ages 65 to 69 and 85 and over. This means that males living in the most deprived areas experience worsening general health much earlier in life than those in the least deprived areas. At ages 35 to 39, those in the most deprived areas have comparable percentages of 'Not Good' health (20.5%) to those aged 60-64 in the least deprived areas, 25 years their senior, and even compared to the average for all deciles those aged 60 to 64 in England generally have a similar percentage of 'Not Good' health (33.6%) to those aged 45 to 49 (33.2%) in the most deprived areas.

The earlier worsening in general health among the most deprived has consequences for health and social care use and fitness for work. There are clear productivity gains through reductions in health and social care expenditure and dependency on benefits, likely to accrue through improving the health of the neediest sections of society to levels found in less deprived areas.

The age-specific pattern shows a marked divergence between the most and least deprived starting to become noticeable at ages 30 to 34 (Figures 2 and 3) with the gap widening to ages 60 to 64. So for males, it is in early adulthood where the health status starts to diverge between the most and least deprived, with the scale of the health divide intensifying during the working ages of 30 to 64.

Females living in the least deprived areas also show a much shallower increase up to ages 45 to 49, where 'Not Good' health remains below 10%; the sharp increase also occurs between ages 65 to 69 and 85 and over, but it is more accentuated than that of men. Again the age contrast is stark with females aged 55 to 59 in the least deprived areas having better health than females aged 30 to 34 in the most deprived areas. At the post retirement ages, up to ages 80 to 84, females in the least deprived areas assessed their health as, or more, favourably than females who were twenty to twenty-five years younger than them in the most deprived areas.

The age-specific pattern for males and females shown here demonstrates the divergence between the most and least deprived areas: it is estimated from 2011 Census data that to achieve the levels of good health existing in the least deprived areas of England, around 1.7 million more men and 1.8 million more women would have had to assess their health as either very good or good.

**Age-standardised health comparisons**

The use of age standardised rates provides a weighted average of percentages of 'Not Good' health which takes account of the age structure of each population decile. As age and health are closely linked, with health worse at older ages, if one decile had proportionately more older people than another, this could bias the overall percentage of residents assessing their health as 'Not Good' compared with a decile which had proportionately less older people.

In the context of current health legislation in England, a duty is placed on health organisations to have regard to reducing health inequalities when formulating policies and making decisions about funding health services. There is also an understanding that actions to reduce inequalities are relevant across all levels of disadvantage and not simply focused on the most disadvantaged.

A measure that is designed to capture the inequality across all levels of disadvantage is the Slope Index of Inequality (SII). In this analysis the SII represents the absolute difference in 'Not Good' health and disability (see next section) percentages between the most and least advantaged tenth of areas (deciles 1 and 10), taking account of the age standardised percentages in all the other area.
tenths (deciles 2 to 9). When the outcome analysed is unfavourable, such as ‘Not Good’ health, the SII will be negative if percentages are highest in the most deprived areas compared with the least deprived.

Figures 4 and 5 plot age-standardised percentages of ‘Not Good’ health for each decile (shown as squares) for males and females separately, together with the SII line running from 0 to 100, (that is the cumulative population percentage of each IMD 2010 decile). The reference table accompanying this release tabulates the age-standardised percentages.

As is evident from Figures 4 and 5, a steady decline in the percentage of the population assessing their health as ‘Not Good’ is present for both males and females; percentages fall with each reduction in level of deprivation experienced. For males it falls from 31.5 per cent in decile 1 to 13.0 per cent in decile 10 and for females from 32.3 per cent in decile 1 to 13.5 per cent in decile 10. The SII for males is -19.1 percentage points, while for females it is -19.6 percentage points, demonstrating a pronounced inequality across the whole population.

The largest between decile inequality for males and females occurs between deciles 1 and 2 (Figures 4 and 5) with a more than 4 percentage point gap: This presents the possibility that the additional deprivation experienced among decile 1 residents compared with decile 2 residents affects health more than say the change in level of deprivation experienced among people in decile 9 compared to decile 10. This may be pointing to a threshold effect where the risk to health is greater once a certain level of deprivation is reached.
Figure 4: Age-standardised percentage of males with ‘Not Good’ health by IMD 2010 deprivation deciles, England 2011: includes Slope Index of Inequality

Source: Census - Office for National Statistics

Notes:
1. Decile 1 is most deprived and Decile 10 least deprived.

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Figure 5: Age-standardised percentage of females with ‘Not Good’ health by IMD 2010 deprivation deciles, England 2011: includes Slope Index of Inequality

Source: Census - Office for National Statistics

Notes:
1. Decile 1 is most deprived and Decile 10 least deprived.

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Notes
1. The SII is calculated using population-weighted linear regression and it represents the hypothetical absolute difference in ‘Not Good’ health prevalence between the extremes of deprivation in England. The SII measures the health gap by accounting for the inequality existing between the other deciles (classes 2 to 9) and also accounting for the varying population sizes across all deciles. In this analysis the SII represents the absolute difference in health rates between the least and most deprived small area groupings, taking account of the
health status in all the other deciles. Smaller SII values represent narrower health inequality and vice versa. As the outcome measure in this analysis is unwanted (i.e. 'Not Good' health and disability), the SII will be negative if the magnitude of the unwanted outcome is higher in more deprived areas.

**Age-specific disability comparisons**

**National level**

Disability prevalence is also strongly related to age with those aged under 40 generally having the lowest levels of disability (less than 10%); however, prevalence increases more sharply between the ages of 40 and 64, and sizeably after age 60 to 64, with the greatest transition from non-disabled to disabled occurring between the ages of 65 and 85 and over (Figure 6).

**Figure 6: Percentage of males and females with disability by age, England 2011**

Source: Census - Office for National Statistics
Slightly higher levels of disability occur in males at ages 5 to 14 and in females at ages 45 and above. At ages 85 and over more than four-fifths of men and women in England have some level of disability carrying out normal daily activities.

Disability across levels of deprivation

Again we can assess how the pattern varies in populations exposed to different levels of deprivation by comparing the difference in disability prevalence by age. All figures described in the text below (percentages of males and females with a disability by age and level of deprivation in England 2011) are included in the accompanying reference tables.

Across levels of deprivation, the prevalence of disability consistently falls in line with a lessening exposure to deprivation across all ages. At younger ages, those below age 30, absolute differences in disability prevalence are smaller, but divergence grows markedly after ages 30 to 34, where even the difference between the most and second most deprived decile residents is noticeable.

Between ages 35 and 74, those in decile 1 have the most pronounced increases in disability prevalence and remain clearly distinct even from those in the adjacent decile 2. However, a contrasting picture is observed in the least deprived areas where the prevalence of disability remains below 10 per cent for males and below 11 per cent for females even at ages 50 to 54; for males this is equivalent to the disability prevalence of 25 to 29 year olds in the most deprived areas. Even at ages 65 to 69, under a fifth of men and just under a quarter of women in the least deprived areas are disabled, compared with more than half of those in the most deprived areas, suggesting fitness to enjoy retirement is clearly contrasting for these populations.

Figures 7 and 8 isolate the information to the least and most deprived deciles. The increase in disability as age rises is starkly different in deciles 1 and 10.

In the most deprived populations, disability among males is higher than the average for all deciles combined at all ages; but the expansion in disability prevalence occurs at younger ages and the change with increasing age is steepest from early middle-age (ages 30-34) to later middle age (55 to 59) with a difference of 30 percentage points between these ages. In England the comparative increase is half this magnitude at 15.3 per cent; in the least deprived areas it is only 7.4 per cent.

In contrast, males living in the least deprived areas have a shallow increase up to ages 50 to 54, where disability prevalence remains below 10%; the sharp increase occurs after ages 65 to 69. The earlier increase in disability among the deprived has similar consequences for health care use and fitness for work as described above for self-assessed health.

The age-specific pattern demonstrates that the divergence between the most and least deprived populations intensifies after ages 25 to 29, with this gap growing steadily up to ages 65 to 69 when
the percentage difference reaches 33.9 per cent. So the disability divide is large across the working ages of 30 to 64, when adults are expected to participate in the labour market.

Females living in the least deprived areas also show a much shallower increase up to ages 60 to 64, at which point the percentage disabled remains below 20 per cent; the sharp increase also occurs after ages 65 to 69 as with males, but is slightly more accentuated. Again the age contrast is stark with women aged 65 to 69 in the least deprived areas having comparable disability prevalence to those aged 40 to 44 in the most deprived areas (figures 7 and 8).

The fact that both men and women in the least deprived areas aged 65 to 69 have similar percentages disabled as those aged 40 to 44 in the most deprived areas suggests fitness to extend working careers post the current or future state pension age is more viable among residents of areas exposed to less deprivation.

**Figure 7: Percentage of disabled males by age and level of deprivation, England 2011**

Source: Census - Office for National Statistics

**Notes:**
1. Decile 1 is most deprived and decile 10 is least deprived.
Figure 8: Percentage of disabled females by age and level of deprivation, England 2011

Source: Census - Office for National Statistics

Notes:
1. Decile 1 is most deprived and decile 10 is least deprived
Age-standardised disability comparisons

Figures 9 and 10 plot the age-standardised percentages of disability for each decile (shown as squares) for males and females separately, together with the SII line, the gradient of inequality running from 0 to 100 (that is the cumulative population percentage of each IMD 2010 decile). The reference table accompanying this release tabulates the age-standardised percentages.

Figure 9: Age-standardised percentage of disabled males by IMD 2010 deprivation decile, England 2011: includes Slope Index of Inequality

Source: Census - Office for National Statistics

Notes:
1. Decile 1 is most deprived and decile 10 is least deprived.

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Figure 10: Age-standardised percentage of disabled females by IMD 2010 deprivation decile, England 2011: includes Slope Index of Inequality

As is evident, a steady decline in the percentage of the population disabled is present with each fall in level of deprivation experienced, as was the case for self-assessed health above, although the scale of the difference is smaller. For males it falls from 28.9 per cent in decile 1 to 12.9 per cent in decile 10 and for females from 29.5 per cent in decile 1 to 14.0 per cent in decile 10. This suggests area deprivation and disabling health problems are strongly linked across the whole population as well as in age-specific rates shown above. The SII for males is -16.3 percentage points, while for females it is -15.9 percentage points, demonstrating a pronounced inequality.
The largest between decile inequality for males and females also occurs between decile 1 and decile 2 with just under a 4 percentage point gap, suggesting that the additional deprivation experienced among decile 1 people compared with decile 2 contributes more to differences in disabling health problems than a change in level of deprivation experienced among people in decile 9 compared to decile 10. This also suggests a threshold effect found for self-assessed health above.

**Background notes**

1. In England there were 32,844 LSOAs with enumerated populations in 2011, 362 more than there were in 2001; use of the ONS Census Geography lookup file enables the old LSOA geographies to be mapped to the 2011 Census geography. The Department for Communities and Local Government Indices of Deprivation 2010 used the old boundaries to assign a deprivation score to LSOAs, so an adjustment has been made to the published IMD2010 scores in areas affected by changes to LSOA boundaries in 2011 to enable their continued use with the latest LSOA boundaries. These adjusted scores were used to rank LSOAs from the most to least deprived, and aggregated into ten groups (deciles) of broadly similar population size based on their ranking. The most deprived tenth were allocated to decile 1 and the least deprived to decile 10. Those people residing in lower super output areas allocated to decile 1 have the highest exposure to the domains of deprivation shown above and those in decile 10 the lowest exposure, with the intervening deciles having levels of exposure between these extremes.

2. The European Standard Population 2013 was published by Eurostat, the statistical institute of the European Commission, on 11 July 2013. The publication of the ESP 2013 provides an up-to-date standard population which reflects the average age structure of European countries from 2010-2030; this is important because of population ageing since the original ESP in 1976. ONS held a public consultation on the implementation of the ESP 2013 in UK official statistics which closed on 3 October 2013. Plans for future use of the ESP 2013 in UK official statistics will be published in the near future.

3. The percentage prevalence of ‘Not Good’ health and disability reported in the age-standardised section of this short story has been age standardised to the European Standard Population 2013. These age standardised estimates are calculated to allow comparison of populations with differing age structures. Age standardisation is a process where the age specific rates of ‘Not Good’ health and disability for a particular deprivation grouping are applied to a hypothetical European standard population (ESP) for the corresponding age group. The hypothetical number of people in the ESP with ‘Not Good’ health or disability in each age group is totalled and then divided by the total ESP for all ages studied, to give age standardised rates. There were 18 age groups in the census tables:<1; 1 to 4; 5 to 9; 10 to 14; 15 to 19; 20 to 24; 25 to 29; 30 to 34; 35 to 39; 40 to 44; 45 to 49; 50 to 54; 55 to 59; 60 to 64; 65 to 69; 70 to 74; 75 to 79; 80 to 84; 85+. The age specific groups in the census tables used in this analysis did not overlap perfectly with the ESP. The ESP has age groups 85 to 89 and 90 to 94 and 95+. Therefore, in order to create a population total for the age group 85 and over all age groups in the ESP above 84 were combined to give an ESP weight for those aged 85 and over.

4. A spreadsheet detailing the calculation of age standardised rates to the European Standard Population can be found on the ONS website.
5. The data in this short story are based on all usual residents using the commissioned tables CT0062 (Sex by age by general health; Geographical level: 2011 Deciles IMD2010 from LSOAs in England) and CT0063 (Sex by age by long-term health problem or disability; Geographical level: 2011 Deciles IMD2010 from LSOAs in England).

6. Census day was 27 March 2011.

7. Interactive data visualisations developed by ONS are also available to aid interpretation of the results.

8. Future releases from the 2011 Census will include cross tabulations by other census characteristics, and tabulations at other geographies. Further information on future releases is available online in the 2011 Census Prospectus.

9. ONS has ensured that the data collected meet users’ needs via an extensive 2011 Census outputs consultation process in order to ensure that the 2011 Census outputs will be of increased use in the planning of housing, education, health and transport services in future years.

10. Figures in this publication may not sum due to rounding.

11. The England and Wales census questionnaires asked the same questions with one exception; an additional question on Welsh language was included on the Wales questionnaire.

12. ONS is responsible for carrying out the census in England and Wales. Simultaneous but separate censuses took place in Scotland and Northern Ireland. These were run by the National Records of Scotland (NRS) and the Northern Ireland Statistics and Research Agency (NISRA) respectively.

13. ONS is responsible for the publication of UK statistics (compiling comparable statistics from the UK statistical agencies above) and these are available on the ONS website. These will be compiled as each of the three statistical agencies involved publish the relevant data. The Northern Ireland census prospectus and the Scotland census prospectus are available online.

14. A person’s place of usual residence is in most cases the address at which they stay the majority of the time. For many people this will be their permanent or family home. If a member of the services did not have a permanent or family address at which they are usually resident, they were recorded as usually resident at their base address.

15. All key terms used in this publication, such as usual resident are explained in the 2011 Census user guide.

16. All census population estimates were extensively quality assured, using other national and local sources of information for comparison and review by a series of quality assurance panels. An extensive range of quality assurance, evaluation and methodology papers were published alongside the first release in July 2012, including a Quality and Methodology Information (QMI) document (152.8 Kb Pdf) (177.6 Kb Pdf) (177.6 Kb Pdf).
17. The 2011 Census achieved its overall target response rate of 94% of the usually resident population of England and Wales, and over 80% in all local and unitary authorities. The population estimate for England and Wales of 56.1 million is estimated with 95 per cent confidence to be accurate to within +/- 85,000 (0.15 per cent).

18. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

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