#healthyplym

Oversight and Governance
Chief Executive's Department
Plymouth City Council
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Published 04 March 2020

HEALTH AND WELLBEING BOARD

Thursday 12 March 2020
10.00 am
Warspite Room, Council House

Members:
Councillor McDonald, Chair

Dr Shelagh McCormick, Vice Chair

Councillors Mrs Bowyer, Laing and Kate Taylor.

Statutory Co-opted Members: Strategic Director for People, Director of Children's Services, NHS Devon Clinical Commissioning Group, Director for Public Health and Healthwatch.

Non-statutory Members: Plymouth Community Homes, Livewell SW, University Hospitals Plymouth NHS Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By entering the Warspite Room, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

For further information on attending Council meetings and how to engage in the democratic process please follow this link - http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Apologies

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. Declarations of Interest

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. Chairs urgent business

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. Minutes **(Pages 1 - 8)**

To confirm the minutes of the meeting held on 9 January 2020.

5. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

6. Children and Young People's System **(Pages 9 - 16)**

7. PAUSE Plymouth **(Pages 17 - 24)**

8. Together for Childhood **(Pages 25 - 30)**

9. Marmot Report Update **(Pages 31 - 64)**

10. COVID-19 Verbal Update

11. Work Programme **(Pages 65 - 66)**

The Board are invited to add items to the work programme.

Health and Wellbeing Board

Thursday 9 January 2020

PRESENT:

Councillor McDonald, in the Chair.
Dr Shelagh McCormick, Vice Chair.
Councillors James (for Councillor Mrs Bowyer), Laing and Kate Taylor.

Apologies for absence: Councillor Mrs Bowyer and David Bearman

Also in attendance: Professor Sub Banerjee (University of Plymouth), John Clark (Plymouth Community Homes), Ruth Harrell (Director of Public Health), Ch Supt Tamasine Matthews (Devon and Cornwall Police), Craig McArdle (Strategic Director for People), Dr Adam Morris (Livewell SW), Nick Pennell (Healthwatch), Rob Nelder (Plymouth City Council), Zoe Allen (University of Plymouth and Public Health England), Sarah McFarlane (NHS England), Carol Harman (Plymouth City Council) and Rob Witton ((PDSE) - Peninsula Dental Social Enterprise, University of Plymouth and Public Health England), Steve Statham (Chief Executive) and Abenaa Gyamfuah-Assibey (Community Development Worker) from St Luke's Hospice, Lin Walton (NHS Devon Clinical Commissioning Group) Anna Moss and Jackie Kings (Plymouth City Council) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 1.02 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

20. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

21. **Chairs urgent business**

There were no items of Chair's urgent business.

22. **Minutes**

Agreed that the minutes of 3 October 2019 were confirmed.

An update was provided on the following minutes:

Minute 14 (1). It was reported that the sign off of the NHS Long Term Plan which was delegated to the Director of Public Health for sign off on behalf of the Health and Wellbeing Board had been delayed. The NHS Plan was still under review with the regulators.

Minute 16. It was reported that a workshop on how to tackle deprivation in the city would be taking place on 12 February 2020. An agenda would be circulated shortly. It was also highlighted that a 10 year review of the Marmot Report would be launched on 25 February 2020.

23. **Questions from the public**

There were no questions from members of the public.

24. **Oral Health Needs Assessment**

Rob Nelder (Plymouth City Council), Zoe Allen (University of Plymouth and Public Health England), Sarah McFarlane (NHS England), Carol Harman (Plymouth City Council) and Rob Witton ((PDSE) - Peninsula Dental Social Enterprise, University of Plymouth and Public Health England) were present for this item and referred to the report in the agenda. The presentation highlighted that:

(a) there was a recognition for the need for an Oral Health Needs Assessment (OHNA) to evidence the issues within Plymouth;

(b) Public Health and Peninsula Dental Social Enterprise (PDSE) worked collaboratively to produce and deliver the OHNA;

(c) the OHNA has been used to support the bid submitted to NHS England for a new City Centre dental practice and to inform conversation between dental leads in Plymouth the Chief Dental Officer;

(d) oral health was an integral part of health and wellbeing and oral diseases were largely preventable;

(e) oral diseases impact negatively on quality of life and imposes a significant social and economic burden on the city;

(f) over 14,000 people in Plymouth on the waiting list for routine NHS dental and 3,000 children in Plymouth on the waiting list;

(g) in conclusion:

- a partnership approach was required to address the wider determinants of health, to prioritise particular groups at higher risk of disease and to develop oral health programmes and services which reduce health inequalities;
- Plymouth would benefit from additional health improvement activity and from increased access to urgent and routine NHS dental care.

In response to questions raised, it was reported that:

(h) they would welcome working with social housing providers such as Plymouth Community Homes to help spread the word within the

communities and reaching the more vulnerable groups within the city;

(i) NHS England reported that the Oral Health Needs Assessment was in place and would inform the commissioning plans and procurement. They were also looking at providing more urgent care to help more patients to receive treatment and improve access whilst trying to provide a more sustainable approach;

(j) with regard to the 623 children having teeth extracted under general anaesthetic, it was reported that Plymouth was 4 times higher than the rest of the peninsula. This was a challenge, however, the key was giving young people the best start in life, first dental steps and were in the process of training midwives, health visitors, school nurses to give the key oral messages to parents and better access to dental care would help address this serious issue;

(k) that with regard to community water fluoridation in Plymouth, it was reported that this was not a straight forward solution. The main water pipe which supplies Plymouth also supplies neighbouring areas which meant that negotiating water fluoridation was made more difficult;

(l) the number of students that have remained in the city following graduation had changed over the years, many factors such as students having to undertake a foundation year in another part of the country as well as students coming to the city to undertake their studies move back to their hometown when qualified had impacted on the number of dentists retained in the city;

(m) also qualified dentists were not choosing to work in NHS Dental services because of the current NHS contracts leading to a shortage of dentist in this field. Currently in Plymouth there were 17 vacancies. The national contract needed to be revised to encourage more dentists to take the NHS route otherwise recruitment issues would persist;

(n) NHS England reported that Plymouth remained a priority area and the current waiting list supports and evidences what was needed to commission and working with our partners to address the issues. There were plans to be part of the primary care networks and would need to be looked at across the patch;

(o) it was highlighted to the Board that Plymouth has the smallest dental school in the country and there was no good reason for this inequity. Plymouth could accommodate more students and we could accommodate more students we would be able to undertake more work within the community and help with retention in the city;

(p) it was reported to the Board that the Child Poverty Action Plan since its inception five years ago included the issues within the city around poor dental health and access to dental care. The Oral Health Needs Assessment helps with the visibility and member's need to consider how to move this great work forward so that we are not sat here in a year's time saying how shocking were children's teeth;

(q) this was such a fundamental issue but what we really need to focus on was poverty and that we're not addressing by picking off single issues and to have the serious conversations around this with communities, with charities, with social enterprises, with people out there trying to address this;

(r) there were established care pathways for looked after children and Livewell SW was one of the service providers within the city, however it was clear that the demand exceeds capacity. The Dental School were also happy to accept children in care but there was a need to have proper structure in place with sustainable services to address all of the needs and looked after children were an important part of the Oral Health Needs assessment;

(s) the Dental School and (PDSE) provide a service to homeless people with an 84 percent re-attendance rate. They started with a pilot to provide ½ day session per week which was increased to 2 days a week and were now at the limit on what they could provide. They put forward a proposal to NHS England 12 months ago based on the oral health needs analysis and were hoping that there would be some progress on commissioning a proper service for this particular group otherwise these individuals would continue to suffer significant health inequality as a result of a lack of dental access;

(t) that the Dental School and the University have two excellent clinical facilities located at the Cumberland Centre and Plymouth Science Park. However these facilities do not provide students with real life experience of working in a general dental practice so they were keen to develop a dental practice for students to rotate through in their final years. A proposal for a city centre practice for students have been made formally with a business case to NHS England seeking ongoing costs of treating the patients and that proposal was with NHS England for the last 12 months;

(u) PCC working closely with PDSE to put the proposal together for the City centre dental practice and can only take the idea so far but need NHS England to take forward this contact, 14,000 on the waiting list which includes 3,000 children and this practice would reduce this number.

The Board agreed:

1. That a letter is sent from Plymouth's Health and Wellbeing Board to the relevant lead person within NHS England to express the Board's support for the initiatives outlined in the presentation and to be kept up to date with progress. The letter to include:

    - lobbying NHS England and Health Education England to increase the capacity at the Dental School in line with other Dental Schools in the country;
    - definitive timeline around the proposals for the city centre dental practice and homeless dental service.

2. To request the Health and Adult Social Care Overview and Scrutiny Committee to undertake a select committee to further scrutinise dental health in Plymouth and to include how to recruit students from Plymouth and support students living in the city to choose dentistry as a career option.

25. **Plymouth as a Compassionate City**

Steve Statham (Chief Executive) and Abenaa Gyamfuah-Assibey (Community Development Worker) from St Luke's Hospice were present for this item and referred to the report in the agenda. The presentation highlighted that:

(a) that Plymouth had been recognised by Public Health Palliative Care International as being the first Compassionate City in England which was a great achievement for the city;

(b) that despite some real progress made around death and dying it still remained a real taboo subject within our society and one that affects every aspect of people's lives;

(c) that there was a real challenge on how we meet those needs around palliative care and that no one in our community should die alone, in distress or in pain. However it was reported that many patients if not supported by St Luke's would have died alone;

(d) it was known that no organisation has the resource or capability to ensure that no one dies alone and feel that it needs a real joined-up approach based on individual organisations working together recognising that loss and bereavement was simply not solely for health and social services but was everybody's responsibility;

(e) the impact of bereavement on young people in terms of their school life and building the resilience in our younger communities so they can transition through life I'm being able to cope with the impacts that death and loss;

(f) have been working on developing compassionate workplaces and asking workplaces and businesses to review their compassionate

policies and to think about their employee's health and well-being at a time when they're caring for someone that might be dying or have been bereaved;

(g) they have developed compassionate cafes and compassionate friends have gone into hubs and social spaces that already exist in Plymouth to help provide a friendly ear to people that might be experiencing bereavement;

(h) more people were dying within a care home setting and how to recognise the good work taking place in care homes supporting people towards the end of their life;

(i) about how we encourage more organisations and workplaces to sign up to the End of Life Compassionate City Charter.

Board members welcomed the presentation and the opportunity to engage with the network and support this work.

In response to questions raised, it was reported that they have limited resources and rely on the support of the community, however if they could get more support at a senior level within organisations would help drive this agenda forward.

1. Note the progress that has already been made against the Compassionate City Charter.

2. Commit to considering what each partner organisation could contribute to the Charter.

26. **Plymouth Mental Health Programme Board**

Lin Walton (NHS Devon Clinical Commissioning Group) was present for this item and referred to the report in the agenda pack. It was highlighted that:

(a) the Plymouth Mental Health Programme Board is a multi-agency board which meets bi-monthly and was established to cover all age groups and to develop plans to meet the needs of the Plymouth population;

(b) sixteen priority areas were identified and the prioritisation reflects the status of service or pathways in the city alongside the importance to people's mental health and wellbeing;

(c) nationally there was a recognition that mental health funding was behind physical health funding and that despite investment were not at the same level of equity.

In response to questions raised, it was reported that:

(c) Plymouth would be involved in the work and input into the

workstreams;

(d) there was a separate workstream addressing autism and the Autism Partnership Board would pick up this area of work. However it was reported that the waiting time for the autism diagnosis in Devon was longer than Plymouth;

(e) there was a challenge around the workforce to support people with mental health, however this was a national problem and not unique to Plymouth. There was a need to think more broadly about what the workforce would look like and the skill mixes rather than just thinking about the specialists roles;

(f) some of the work we need to do in terms of what that third sector capacity needs to needs to look like and the acknowledgement that the third sector need both support and capacity in order to deliver and was something that would need to be addressed for moving forward.

The Board to note Plymouth Mental Health Programme Board Report.

27. **Safer Plymouth Briefing Paper**

Chief Superintendent Tamasine Mathews (Chair of the Safer Plymouth Board), Anna Moss and Jackie Kings (Plymouth City Council) were present for this item and referred to the agenda in the pack. The attached presentation was shared with the board.

Safer Presentation H&WB board.pptx

In response to questions raised, it was reported that:

(a) there was a challenge supporting the workforce with rolling out the trauma informed approach. However, it was reported that training would be freely accessible to anyone but they could only currently train 30 people each month. Since the roll out of the training they have had well over 600 applicants and were looking at other avenues to deliver this training;

(b) the Livewell Training Academy might be able to help and support with rolling the trauma informed approach training.

The Board agreed:

1. To bring greater clarity to the functions of the Safer Board and Safer Executive Group.
2. To reduce the eleven current delivery priorities sub-groups of Safer Plymouth into the following thematic partnerships:

- Safer Families
- Safer Communities
- Safer People

3. That Safer Plymouth activity should significantly increase focus on effective communication and workforce development. This was the overwhelming feedback from our consultation events and will be reflected in the refreshed communication plans and a workforce development plan.

28. **Work Programme**

The Board noted the work programme and delegated to the Chair and the Lead Officer to prioritise the work programme.

Health and Wellbeing Board

Date of meeting:	12 March 2020
Title of Report:	**Children and Young People's System**
Lead Member:	Councillor Jemima Laing (Cabinet Member for Children and Young People)
Lead Strategic Director:	Alison Botham (Director for Childrens Services)
Author:	Alison Botham
Contact Email:	Alison.botham@plymouth.gov.uk
Your Reference:	
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of this report is to provide a briefing to the Health and Wellbeing Board.

Recommendations and Reasons
None.

Alternative options considered and rejected
Not applicable.

Relevance to the Corporate Plan and/or the Plymouth Plan
This contributes to both key aspects of delivery our priorities as set out in the caring and growing city.

Implications for the Medium Term Financial Plan and Resource Implications:
Not applicable.

Carbon Footprint (Environmental) Implications:
Not applicable.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
Not applicable.

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Briefing report title							
B	Equalities Impact Assessment (if applicable)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

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Sign off:

Fin	Click here to enter text.	Leg	Click here to enter text.	Mon Off	Click here to enter text.	HR	Click here to enter text.	Asset s	Click here to enter text.	Strat Proc	Click here to enter text.

Originating Senior Leadership Team member: Click here to enter text.

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: Date.

Cabinet Member approval: *[electronic signature (or typed name and statement of 'approved by email/verbally')]*

Date approved: 02/03/2020

PARTNERSHIPS AND GROUPS

To support the children's system and programmes of work we use a range of partnership groups. The Children and Young People's Partnership is held quarterly and attended by a wide range of key senior stakeholders, including commissioned and non-commissioned providers, schools and the voluntary and community sector.

The Partnership considers the vision for the city, the needs of children and young people and how we can work together to challenge ourselves to redesign the system and make change happen.

The Partnership is underpinned by some jointly owned documents:

- A shared system narrative
- A plan on a page

Three main steering groups report into the Partnership:

- SEND Strategy Steering Group – with a focus on children with additional needs
- Vulnerable Children and Young People Steering Group – with a focus on children with complexity and risk
- Maternity and Early Years Steering Group – with a focus on pre-birth provision and services for families with children aged 0-5

In addition, there are a number of other key governance groups, such as the Plymouth Education Board, the Safeguarding Partnership and the Early Help Strategic Group, which have oversight of issues relating to the lives of children and young people in Plymouth.

Our vision for children and young people in Plymouth:

We are currently in the process of developing a vision document and plan for our Council programmes of work for children and young people for 2020-22. This document is provisionally titled "A Bright Future", and aims to:

- Be ambitious and aspirational for all our children in Plymouth
- Describe the needs of the children and young people in the city
- Identify the priority areas for the next three years
- Set out the plans and actions to be taken to drive change
- Provide reassurance that programmes of work are being well managed and monitored

This document will sit alongside "Caring for Plymouth", the equivalent approach for adult services in the city.

A Bright Future will initially be a Council focused document, with the intention of sharing it with partners and embedding a wider approach as plans develop.

Next steps:

In March 2020 the Children and Young People's Partnership is meeting to review the strategic narrative and plan on a page and to consider together what the key priorities for 2020/21 need to be.

This meeting will also consider the most appropriate governance groups needed to drive the priorities forward, and this may involve some changes to existing groups to make the best use of our shared time.

CHILDREN AND YOUNG PEOPLE IN PLYMOUTH – OUR SHARED NARRATIVE 2019

Plymouth's children and young people are the future of our city – it is our shared responsibility to give them the best possible start to life, and be the place where they can develop, aspire, and have fun and new experiences.

To achieve this everyone will need to play their part in their communities; in voluntary services and statutory agencies; from families to schools, from children's centres to GPs and from Children's Social Care to services for parents.

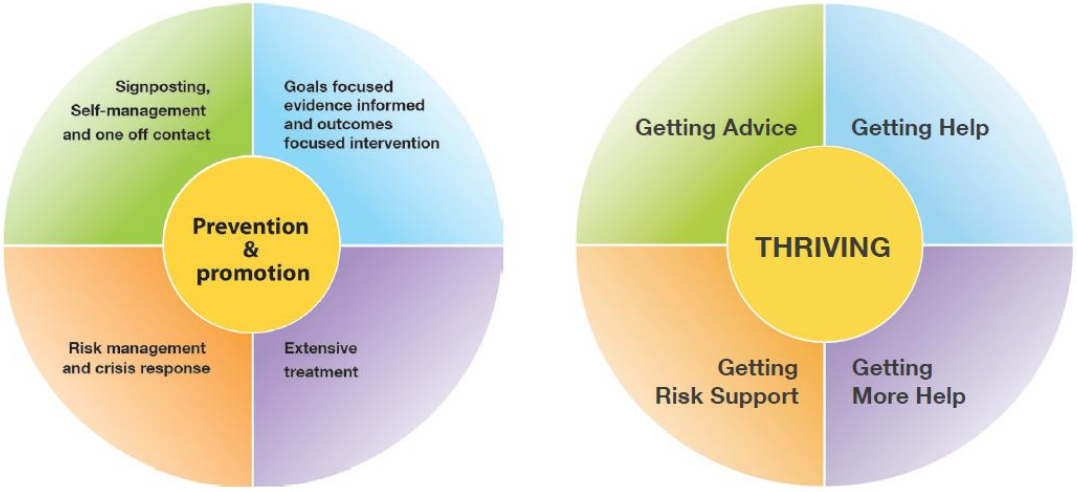
All of us working with children, young people and their families will:

- **listen**, and champion the voice of our children and young people in all that we do;
- **co-create** to support and enable partners and communities to work together to design the services they need;
- be **fair and equitable**, ensuring our children and young people feel included and can access opportunities that make a difference to them;
- have **high aspirations**, celebrating strength and success and being optimistic about the futures of all our children;
- make sure that what we do is **sustainable**, having a real impact on the lives of children, young people and their families for this generation and those that follow.

In Plymouth, children, young people and their families will be supported to stay healthy, achieve and aspire and services will seek to prevent needs arising. Our children young people and families will be able to access what they need at the right time and in the right place, whether what is needed is some advice on the internet or by phone, an assessment or a longer-term intervention or support.

We want to identify any challenges that our families are experiencing early, so that they can be enabled and supported at the earliest opportunity, to both address their needs and prevent any issues getting worse.

In Plymouth we have adopted the principles behind the **iThrive model** shown below, which was designed for CAMHS but is relevant across wider children's services. It operates a graduated approach to meeting need, with a focus on intervening early with the most appropriate intervention to prevent escalation.



We will take into account national plans and initiatives such as the NHS long term plan, which seek to achieve 'a strong start to life for children and young people', through greater collaboration, which moves beyond service boundaries. We will also factor regional approaches and opportunities into our thinking, such as the Devon Sustainability and Transformation Plan.

However, we will ensure we don't lose sight of what we need to do locally, to meet the needs of Plymouth children and young people in their everyday lives in the city.

Professionals will work together in ways that mean that:

- we base our approaches on trauma informed practice and behaviours;
- we can sustain change by building resilience in our families and communities;
- children and young people, and their families don't have to tell their story over and over again;
- transitions between services or teams happen at the right time, and are well managed and seamless.

We will **never stop learning**; what works, what doesn't work and how we can continue to improve.

OUR KEY SYSTEM ACHIEVEMENTS:

There is much to celebrate in Plymouth in relation to the way we work together to prioritise meeting the needs of our children and young people. These are some examples from the last couple of years:

- Integrated commissioning of community health, wellbeing and SEND support services, driving a city-wide approach based on the principles of iThrive and involving the voices of children, young people and families throughout;
- Driving forward integrated working across agencies to improve the experiences of children, young people and families when they approach services for help, through the creation of Access;
- Development of a Children's System Improvement Board, to scrutinise the performance of children's services in Plymouth City Council, Livewell South West and University Hospitals Plymouth;
- Partnership working to improve our responses when children and young people experience crisis, to ensure we remain focused on the child and their pressures and concerns;
- Significantly reducing waiting times for assessments for autism.

Plymouth's Children and Young People's Partnership Plan 2019 – 2020

Our vision

Britain's Ocean City: A great place to grow up where children and young people have the best start to life and are happy, healthy and aspiring

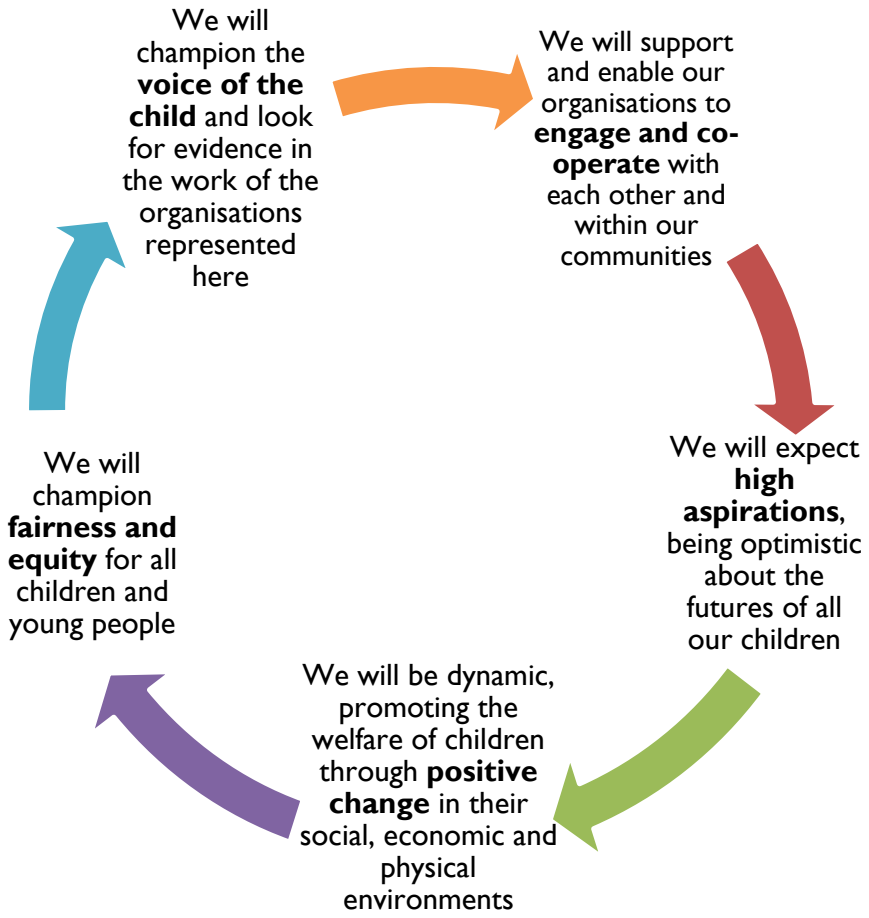
The role of the Children and Young People's Partnership System Design Group

We will carry out the following three functions:

- To bring stakeholders together to have oversight of the needs of children and young people in Plymouth
- To drive and monitor the progress of a programme of change for services for children and young people in the city
- To cascade key messages and requirements to organisations and partners in Plymouth.

We will also scrutinise the strategies, plans and initiatives surrounding the children and young people's agenda in the city and hold the delivery of these to account in order to ensure we are collectively meeting their needs. We will report our progress to the Health and Wellbeing Board.

Our partnership values



Our aims and priority actions:

RAISE ASPIRATIONS	DELIVER PREVENTION AND EARLY HELP	DELIVER AN INTEGRATED EDUCATION, HEALTH AND CARE OFFER	KEEP OUR CHILDREN AND YOUNG PEOPLE SAFE
Ensure that all children and young people are provided with opportunities that	Intervene early to meet the needs of children, young people and their families	Ensure the delivery of integrated assessment and care planning for our	

Ensure effective safeguarding and provide excellent services for children in care

The Children and Young People's Commissioning Plan is the main vehicle for ensuring the outcomes for all children, young people and their families in our city are delivered. Each of the aims is threaded throughout the Plymouth Plan. The Plymouth Plan sets a shared direction of travel for the long-term future of the city. It is the mechanism which enables the city to work together to create the conditions where children, young people and their families can thrive.

Plymouth's Health and Wellbeing Strategy along with the Child Poverty Strategy are also firmly embedded within the Plan. There are a number of subsequent delivery plans and initiatives which will ensure the outcomes of the Plymouth Plan are realised. These include;

- Delivery Plans for Education

- Early Help and Targeted Support Business Case
- Families with a Future Programme
- Child Poverty Action Plan
- Maternity Transformation Plan

- SEND Strategic Plan 2018-2021
- Transition to Adulthood Plan
- NHS Long Term Plan

- Strategic Safeguarding Children's Partnership Business Plan
- Ofsted Improvement Action Plan
- Safer Plymouth Partnership Plan

Health and Wellbeing Board

Date of meeting:	12 March 2020
Title of Report:	**Pause Plymouth**
Lead Member:	Councillor Jemima Laing (Cabinet Member for Children and Young People)
Lead Strategic Director:	Alison Botham (Director for Childrens Services)
Author:	Andrea Langman (Commissioning Officer)
Contact Email:	Andrea.langman@plymouth.gov.uk
Your Reference:	AL/Pause/HWB2020
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
This report provides an update on progress of the Pause Plymouth service, implemented in April 2019.

Recommendations and Reasons
To note the report.

Alternative options considered and rejected
Not applicable.

Relevance to the Corporate Plan and/or the Plymouth Plan

The Pause service supports delivery of Corporate Plan priorities, including:

- Keep children, young people and adults protected
- People feel safe
- Reduced health inequalities

The Pause service also supports Plymouth's aim to become a trauma informed city.

Implications for the Medium Term Financial Plan and Resource Implications:
No implications directly arising from this report.

Carbon Footprint (Environmental) Implications:
No implications directly arising from this report.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
No other implications.

Appendices

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A	Pause Plymouth							

Background papers:

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Sign off:

Fin	djn.19.20.242	Leg	MS/24.02.20	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A

Originating Senior Leadership Team member: Jean Kelly

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 25/02/2020

Cabinet Member approval: Cllr Laing, approved verbally

Date approved: 26/02/2020

PAUSE PLYMOUTH

PART I Briefing Paper

12 March 2020

PLYMOUTH CITY COUNCIL

Background

The Pause service model

Pause is a trauma informed model of therapeutic, practical and behavioural support offered to women who have experienced (or are at risk of experiencing) a cycle of recurrent care proceedings leading to removal of their children into local authority care.

Interim outcomes sought from the Pause service:

- Women experience a 'pause' from pregnancy (so they are able to focus on own needs and goals)
- Improved stability and employability
- Improved wellbeing and sense of self
- Better engagement with services

Longer term outcomes sought from the Pause service:

- Women gain greater control over their lives, including their reproductive health;
- Women create the foundations on which to move forward to a more positive future;
- More integrated and responsive services which are better able to support women at risk of experiencing a cycle of repeated care proceedings;
- Fewer children are taken into care.

Whilst Pause does not seek to reunify mothers with children already removed from their care, many women are able to recommence or improve the quality of contact with their children; the service therefore has the potential to improve lifelong outcomes not just for the women themselves and any future children they may have, but also for their existing children.

The key elements of the Pause model are set out in Appendix 1.

Plymouth's implementation approach

The first Pause service was piloted in Hackney in 2013. When Plymouth implemented Pause in April 2019, there were approximately 20 Pause practices operating in other areas, however Plymouth was the first local authority in the country to commission an external provider (Trevi House) to deliver a Pause practice via a 'social outcomes contract' approach.

Within this approach (previously known as a 'social impact bond'), commissioners successfully secured circa £1m of social investment to implement the service. In addition, a circa £0.5m grant was secured from the Department for Culture, Media and Sport (DCMS) Life Chances Fund. Upon successful achievement of specified social outcomes, this grant will contribute towards repayment of the social investment, helping to support sustainability of Plymouth's integrated system of services.

Commissioners and our social investment partner (Bridges Outcome Partnerships) have shared learning from developing our social outcomes contract with a number of other local authorities, some of whom are now exploring implementation of Pause via a similar approach, thereby helping to increase the number of women who will potentially benefit from this service nationally.

Overview of local need

Analysis of children's social care case files revealed that (as at January 2019), there were 122 women in Plymouth who had experienced more than one episode of care proceedings leading to

removal of a child from their care, and who were therefore potentially eligible to participate in the voluntary Pause programme. In total, 408 children had been removed from those mothers, an average of 3.3 children each. The highest number of children removed, from one mother, was 10.

Age profiling showed that 68% of the women had become mothers before they were 20, and 97% by the age of 25.

The prevalence of presenting issues amongst the 122 women was as follows:

- Domestic Abuse – **89%***
- Mental Health – **79%***
- History of social care involvement (as a child) – 54%
- Experience of local authority care (as a child) – 29%
- Drugs – 54%
- Alcohol – 45%
- Criminal Justice – 25%
- Learning Difficulty – 13%
- Physical Health – 8%
- Sex work – 7%

*issues with significantly higher prevalence than Pause national had seen in other local authority areas which had completed similar 'scoping' exercises.

Pause national also confirmed the likelihood that further issues would be discovered/disclosed once women started receiving intensive relationship-based support from a Pause practitioner.

Hackney's 2013 feasibility study highlighted a range of further risk factors impacting women vulnerable to recurrent proceedings:

- 'Chaotic' lives and/or the influence of a controlling partner and/or concern over the impact of contraceptives on their body leads to contraception not being prioritised or well managed;
- Women experience a desire for the nurturing experience of pregnancy, for a child to love - and to be loved – and a belief that their next pregnancy may result in them keeping the child.

Progress to date

Engaging eligible women

In April 2019, the new Pause Plymouth practice began outreach activity to make contact with women identified as potentially eligible for the service. Many of the women are clearly living with significant trauma and 'chaos', and are mistrustful and sometimes hostile towards 'services'. Despite this context, and through the skill and tenacity of the practitioners, 23 women have so far agreed to participate in the voluntary programme and are currently engaging well with the support offered. To date, none of the 23 women have left the programme, there have been no further pregnancies amongst them (and therefore they are able to focus on their own needs and goals), and no further care proceedings have been instigated by the local authority involving those mothers.

Partnership working

This level of engagement has also been enabled by partner agencies - initially through their assistance in locating the women where current addresses where not known to children's social care, and then through their timely and flexible responses to requests for support/services, which has helped the Pause team establish credibility and build trust with the women. Those partner agencies include Police, Community Sexual Health, Community Dentistry, First Light, Plymouth

Domestic Abuse Service, Adult Mental Health Services, Plymouth Hospitals NHS Trust, Psychiatric Liaison Service, Job Centre Plus, Harbour Drug & Alcohol Service, Housing (NB: This may not be an exhaustive list).

Early impact

The women working with Pause are extremely vulnerable and many do not ask for help easily for a variety of reasons, including feelings of shame, stigma and fear of judgement. However, 9 of the women are attending the Sunflower Women's Centre (some for groups and courses, some for twice-weekly drop-ins and some for both). The Sunflower Centre is also run by Trevi House, and the Pause team report that being based there has been very helpful in terms of being able to link women to this wider support.

At the initial stage of the programme, there is a focus on providing practical support to enable stability:

- One woman has moved into full time employment (a first for her);
- Following practical help from the Pause team enabling her to return to her own flat, one woman ended her relationship with an abusive partner and has since had the courage to ask for support to speak to the police about him. This is a significant step forward for the woman;
- Pause have supported a third of the women to engage with the Community Dentistry service – including hand holding during dental extractions. This has proved to be a vital element of the relationship-based support Pause practitioners are providing and is making a big difference to the women, some of whom have been living with chronic pain prior to treatment. A number of women report that they had adopted a 'strategy' of deliberate neglect of their personal hygiene, including oral hygiene, in order to avoid the sexual advances of violent male partners. This further evidences the prevalence of domestic abuse and sexual violence experienced by many of the women. Following dental treatment, some women are reporting that they feel able to smile in public without embarrassment for the first time in years. One women is so pleased with the service she received, she is keen to participate in a future journalistic feature to raise awareness of the Community Dentistry service.

What women say about Pause

A couple of examples of feedback the Pause team have received so far:

"I have had support from the Pause team from early September 2019; though it's been a short time I've benefited so much from their support. Most people would find doing fun things easy, I can struggle. Pause team have given me the confidence to achieve this! I'm grateful to the team for picking me up and helping me take a Pause in my life and have made me find self-worth."

"When I first met Pause I was desperate to change my life. One of the first things I asked for help with was to get a safe contraceptive; I was too chaotic to sort it myself. Pause has been the support that my family wasn't."

Early system learning

Seven women shared their experiences during the Pause practice launch event in October 2019, which has opened a dialogue about how their experiences could inform training of social work students and newly qualified social workers.

Next steps

The current capacity of the Pause practice will enable up to 48 women to work with the programme over a 3 year period. The Life Chances Fund has indicated that there may potentially be an opportunity to apply for additional grant funding during 2020; if this opportunity materializes and Plymouth is subsequently successful in securing an additional grant award, this would create scope for increasing the capacity of the practice to work with a larger number of women.

Meanwhile, and whilst the multi-agency partnership response to the Pause practice has been very positive to date, the Pause Practice Lead will continue activity to raise and maintain awareness of the aims of the programme, to ensure that local pathways of support for the women working with Pause are developed and maintained, and to sustain the momentum the practice has successfully achieved so far.

Appendix 1 – The Pause Model

The diagram below highlights the key elements of the systemic Pause model of therapeutic, practical and behavioural support:

The Pause model starts by looking at the woman's life as it is and the factors that may have led to her children being removed, makes a shared assessment of the woman's goals and the strategies that can help to improve things, motivates the woman and mobilises resources to help her address the identified issues.

The model recognises that factors such as domestic abuse, substance misuse, mental ill health and poverty are often interlinked with each other and with the woman's feelings of self-worth, making it difficult for her to deal with the complexity of issues she faces.

Pause practitioners use their professional judgement and skill to create an holistic bespoke programme tailored to meet the unique emotional, psychological, behavioural and practical needs of each individual women, enabling her to tackle the root causes of destructive patterns, develop new skills and avoid further trauma.

Pause practitioners work with women for a period of up to 18 months, after which they can choose to continue with a further period of lighter touch 'next steps' support, according to their needs and goals at that time.

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Health and Wellbeing Board

Date of meeting:	12 March 2020
Title of Report:	**Together for Childhood**
Lead Member:	Councillor Jemima Laing (Cabinet Member for Childlren and Young People)
Lead Strategic Director:	Alison Botham (Director for Childrens Services)
Author:	Siobhan Wallace, Head of Service for Referral, Assessment and Early Help, Children Young People and Families Service, Oliver Mackie, Strategic Service Manager, NSPCC
Contact Email:	siobhan.wallace@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
Provides updated information to elected members about the Together for Childhood Project- a 10-year partnership initiative co-led with the NSPCC, aimed at preventing child sexual abuse in Plymouth.

Recommendations and Reasons
No recommendations- report is for information only.

Alternative options considered and rejected
Not applicable- report is for information only

Relevance to the Corporate Plan and/or the Plymouth Plan
This project is relevant to the Caring Council priorities of keeping children, young people and adults protected, focus on prevention and early intervention and people feeling safe in Plymouth.

Implications for the Medium Term Financial Plan and Resource Implications:
No significant financial resource implications for PCC- resource is in kind in terms of commitment of staff time across a range of directorates but most significantly the Children, Young People and Families service.

Carbon Footprint (Environmental) Implications:
No direct carbon/environmental issues identified

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

This project is relevant to risk management and health and safety in that it aims to prevent the sexual abuse of children.

Together for Childhood fits into the agenda for a Trauma-Informed city, and relates to I-thrive principles.

Prevention of the harm caused by sexual abuse aims to have a long-term impact on prevention of offending, substance misuse and domestic abuse. This project is therefore relevant to the Safer Plymouth agenda.

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Together for Childhood							
B	Equalities Impact Assessment, contained within the PID document							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

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Originating Senior Leadership Team member: Jean Kelly, Service Director CYPFS

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 27/02/2020

Cabinet Member approval: Cllr Jemima Laing (by email)

Date approved: 02/03/2020

1.0 Introduction

Health and Wellbeing Board will be shown the 5 minute TFC film

Together for Childhood is an innovative, 10-year, place-based project, that was launched in Plymouth in January 2018 at a stake-holder event. It is co-led by PCC and the NSPCC with the support of the PSCB, a range of partner agencies and the community, and aims to target the prevention of child sexual abuse. The community of Ernesettle has been selected as a pilot site so the programme can engage with, learn from and develop new activities that are co-created. The evidence emerging from this work will inform future delivery across the wider city.

This is an exciting opportunity for Plymouth. We are one of only 4 sites nationwide chosen to work in this way. Plymouth was identified on the strength of our existing partnership arrangements and the multi-agency partnership are very much engaged in the project development.

There are 4 outcomes being sought

- More support is available to prevent harmful sexual behaviors and sexual offending.

- Increased confidence in preventing child sexual abuse, among people who work with children.

-Increased evidence base on 'what works' in preventing child sexual abuse.

- Increased public belief that child sexual abuse can be prevented.

We have just completed the first stage of our evaluation which focused on identifying baseline data around child sexual abuse in Plymouth and on levels of understanding and awareness amongst professionals and within the community in the pilot site. Ninety-eight community members from Ernesettle completed the Knowledge, Attitudes and Behaviour survey and the following 4 key messages have been identified;

- Community members think it is important to prevent sexual abuse and have a good knowledge of what abuse is, but don't always know what to do if they are worried or how to spot the signs of sexual abuse
- Community members aren't always clear about how agencies work to prevent sexual abuse or who to contact for advice and support
- Community members think the main responsibility to keep children safe lies with parents, schools and children themselves
- Most people had talked to their children about stranger danger, but we know that children are more likely to be abused by someone they know. People may not have these conversations because they think their children are too young or they are worried about scaring them.

A media and communications strand aims to ensure positive outcomes and stories are reported and publicised - for instance there is an active twitter feed and a regular set of articles in the local paper.

2.0 How Together for Childhood works

Together for Childhood follows a strengths-based, community-led model and is an innovative, evidence-informed approach. It brings local partners and families together to make our communities safer for children. Working collaboratively, we are starting to develop and test effective approaches for preventing child abuse, drawing on examples of best practice from around the world.

We are creating a wide range of local partnerships between social care, schools, health, voluntary and community groups, alongside the police, NSPCC and communities. There are currently 35 agencies / organisations actively involved in Together for Childhood.

We use three types of interventions to achieve our goals:

- primary (universal) interventions – stopping abuse before it occurs, such as campaigning to raise awareness of what sexual abuse is
- secondary (targeted) interventions – reducing the impact of an ongoing issue, such as delivering services that help families experiencing domestic abuse
- tertiary (specialist) interventions – helping children after abuse has occurred.

2.1 Evaluation of Together for Childhood

We are committed to evaluating Together for Childhood robustly, with the development of a multi-stranded evaluation for each area. Local evaluation teams are embedded and we aim to learn lessons from the implementation of Together for Childhood in other sites. The evaluation activity covers three strands.

Process evaluation

A process evaluation is exploring the planning and setting-up of Together for Childhood and examining how the initiative has been implemented in each of the sites.

Impact evaluation

This will help determine how Together for Childhood has helped prevent abuse and neglect, in the short, medium and long term.

Economic evaluation

This will investigate the costs of delivering Together for Childhood and how cost-effective it is.

At the heart of Together for Childhood is continuous learning and improvement. This is in contrast to more traditional models, where learning and development are seen as the final step and the end result of the evaluation.

2.2 Learning how to work with communities to prevent sexual abuse

If we really want to create lasting change we need to work with community members. We aim to provide a framework around which communities can build social change, so that our power to prevent abuse is multiplied exponentially. For communities to begin building something new, they need to be

empowered and inspired, which is why we put young people and their parents' voices first when setting up our site in Plymouth.

We decided upon Ernesettle as the pilot location, after hearing from local people that this is a community which recognises that everyone has a part to play preventing abuse from happening; it has a passion for keeping children safe, and there is already a thriving network of community groups carrying out vital work for children and families in the area.

By providing expert knowledge, project management and evaluation skills, we can enable this community to decide upon programmes which fit their context, wants and needs, and develop sustainable, locally-driven change.

We have made fantastic progress creating the partnerships with a wide range of agencies and groups who can support this. The more we build relationships, and a presence, within Ernesettle, the more we see conversations about preventing child sexual abuse become a normal part of life. From those conversations, we are able to identify what the community needs and wants to make itself safer.

The next stage of the work is for initiatives piloted successfully in Ernesettle to be rolled out more widely. This will be an organic process as each initiative comes online over the life of the whole project. Examples where this is starting to happen include the TALK PANTS Citywide campaign and the Empower Education resource pack which supports schools to quality assure their resources and approach to relationship and sex education.

3.0 Activity to Date

The work of Together for Childhood is delivered through 5 themed "Building Block" groups.

3.1 Relationship and Sex Education

- Young People (through EMPOWER) have been involved in co-production of an education resource pack to help schools start preparing for statutory RSE, leading a strategic piece of work for the city sets aspirations for all of us in our work with young people.

- Marine Academy Plymouth are working with the Together for Childhood partnership to help deliver "InCtrl", a secondary-age prevention group work offer for young people at risk of sexual abuse online, this service commenced in February 2020.

3.2 Community Engagement

- Asset based community engagement is continuing with staff regularly engaging with community members at "Tea and Toast" and other community events.
- A project with the Sports Hall has been completed which resulted in a contextual safeguarding plan, 10 parent pledges to keep children safe in sport and PANTS messages being shared.
- A National Lottery application has been submitted to continue community engagement work and delivery of the SUSTAIN programme (an Exeter University evidence-based programme to develop community cohesion).

3.3 Trauma Informed System

- Plymouth Cabinet and Health and Wellbeing Board endorsed the Plymouth Trauma Informed Approach Document. The Trauma Network is aligned with the Together for Childhood Building Block and this approach helps create the conditions for focused effort on prevention of adverse childhood experiences, including sexual abuse.

- Need, demand and gap analysis along with pathway mapping is underway for therapeutic (tertiary) support for children who experience sexual abuse. There is also the requirement to consider how CSA recovery services are quality assured and whether there is sufficiency. It is worthwhile referencing the Ofsted JTAI into CSA services (embedded)

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se_to_child_sexual_ab

3.4 Public Health Messaging

- A city-wide PANTS campaign has been co-designed (in Efford, Ernesettle and with all Children Centres) and launched with great success on Saturday 28th September 2019 for the public, followed with a professionals launch in October. Pantosaurus (the campaign mascot) is widely recognised and children write and ask for his attendance at schools in the City. The assemblies delivered more often than not result in child disclosures of abuse.
- Local people in Ernesettle have knitted over 200 pairs of pants for teddy bears to support the message and we have anecdotal information about how this has started conversations in the community about safe and unsafe touch, and talking to children about privacy and their bodies etc.
- Co-creation work is also underway for a healthy relationships campaign.

3.5 Preventing Offending and Harmful Sexual Behaviour

- In summer 2018, we partnered with the police in workshops with the National Citizen Service, participating in workshops on preventing child sexual exploitation with more than 800 young people across Plymouth. Young people said that they were unsure what unhealthy or healthy relationships were, and that they learned best through peer-to-peer networks. 3 year funding (£277K) was subsequently secured from The Samworth Foundation to develop a campaign focused on peer-to-peer relationships. Recruitment of youth workers now complement the multi-disciplinary team and campaign development is well underway with young people recently agreeing a partnership with Plymouth Music Zone to progress a creative approach to getting key messages out.
- Marine Academy Plymouth are working with us to baseline Harmful Sexual Behaviour and will start recording concerns on their IT system (CPOMS) as a category, initial analysis of this data is providing significant learning and opportunities for enhancing safeguarding in schools.
- The Harmful Sexual Behaviour Audit as a city-wide activity launched in February 2020, facilitated by the NSPCC, funded by Safer Plymouth.

3.6 Promote existing services that work alongside Together for Childhood

In addition, the project supports and promotes the delivery of existing work aimed at preventing child sexual abuse. For example, "Speak out- Stay Safe" has been delivered in 93% of Plymouth primary schools

HEALTH EQUITY IN ENGLAND:
THE MARMOT REVIEW 10 YEARS ON
EXECUTIVE SUMMARY

INSTITUTE of HEALTH EQUITY

Contents

AUTHORS

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The work of the Review was informed and guided by the Advisory Group and the Health Foundation.

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SOURCE MATERIALS FOR CASE STUDIES

Source materials used in the case studies presented in the report were collated by Jessica Allen, Tammy Boyce, Peter Goldblatt and Joana Morrison. Some case studies were provided by People's Health Trust.

We are grateful to the following organisations that represent the case studies: ACORN Ethical Lettings, Advice Nottingham, Aspire & Succeed, Beat the Cold, Bikes for All, Centre for Local Economic Strategies, Edberts House, English for Action (EFA), Eastern Savings and Loans Credit Union, Gateshead Public Health, Justice Prince, Magic Breakfasts, Malmo City Council, Northumbria Foundation Trust Welfare Rights Team, Nottingham City Council, Open Door Community Action Trust, Positive Youth Foundation, Redcar Athletic Football Club Limited, the Resurgam Trust, Stepping Stones for Families, Streetgames, Switchee, Surrey Minority Ethnic Forum (SMEF), Tower Hamlets Whole Systems Data Project, Wales Future Generation Commission, West Midlands Fire Service, Whitehawk GPs.

Key messages of this review

- Since 2010 life expectancy in England has stalled; this has not happened since at least 1900. If health has stopped improving it is a sign that society has stopped improving. When a society is flourishing health tends to flourish.

- The health of the population is not just a matter of how well the health service is funded and functions, important as that is. Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.

- The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.

- Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18.

- There are marked regional differences in life expectancy, particularly among people living in more deprived areas. Differences both within and between regions have tended to increase. For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.

- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.

- The gradient in healthy life expectancy is steeper than that of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas.

- The amount of time people spend in poor health has increased across England since 2010. As we reported in 2010, inequalities in poor health harm individuals, families, communities and are expensive to the public purse. They are also unnecessary and can be reduced with the right policies.

- Large funding cuts have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts; their capacity to improve social determinants of health has been undermined.

- As in 2010 reducing health inequalities requires action on six policy objectives. In this report we review significant changes since 2010 in five of them.
  - Give every child the best start in life
  - Enable all children, young people and adults to maximise their capabilities and have control over their lives
  - Create fair employment and good work for all
  - Ensure a healthy standard of living for all
  - Create and develop healthy and sustainable places and communities

- For each objective we outline areas of progress and decline since 2010 and make clear the links with health and health inequalities.

- Despite the cuts and deteriorating outcomes in many social determinants some local authorities and communities have established effective approaches to tackling health inequalities. The practical evidence about how to reduce inequalities has built significantly since 2010.

- The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010. We see this as an essential first step in leading the necessary national endeavour to reduce health inequalities.

- We set out a clear agenda for national government to tackle health inequalities, building on evidence of experience in other countries and local areas since 2010. We establish how the Government must take action in England as a matter of urgency.

- The goal should be to bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South.

Introduction

Health is repeatedly shown to be the Nation's top priority. And so it should be – it is quite simply a matter of life or death of wellbeing or sickness. Good health is an indication that society is thriving and that economic and social and cultural features of society are working in the best interests of the population.

The last decade has been marked by deteriorating health and widening health inequalities. People living in more deprived areas outside London have seen their life expectancy stalling, even declining for some, while it has increased in more advantaged areas. For healthy life expectancy there has been little increase for men and a slight fall for women.

This damage to health has been largely unnecessary. There is no biological reason for stalling life expectancy and widening health inequalities. Other countries are doing better, even those with longer life expectancy than England. The slowdown in life expectancy is not down to exceptionally cold winters or virulent flu, and cannot be attributed solely to problems with the NHS or social care – although declining funding relative to need in each sector will undoubtedly have played a role. The increase in health inequalities in England points to social and economic conditions, many of which have shown increased inequalities, or deterioration since 2010.

In the 2010 Marmot Review, *Fair Society Healthy Lives,* we set out 6 areas, which covered stages of life, healthy standard of living, communities and places and ill health prevention. These formed the basis for our six priority objectives and areas of recommendations:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

In this 10 Years on Report, we assess what has happened since 2010 in all the areas except the sixth – ill health prevention. Our reason for not covering the sixth area is that it has been explored in detail by others since 2010 and there have been many programmes and interventions – led by Public Health England and NHS England and public health teams in local government. This area is vitally important for ill health prevention and our recommendations in 2010 still stand: we call for an increase in public health funding and increased focus on prevention from the NHS.

For the other five areas we examine outcomes over the last decade and include new areas for analysis which have risen in importance since the original report. We have a stronger focus on regional inequalities; areas outside London and the South have fared worse in health and the social determinants since 2010 and remedying this should be a major focus of government action. We make recommendation to this effect.

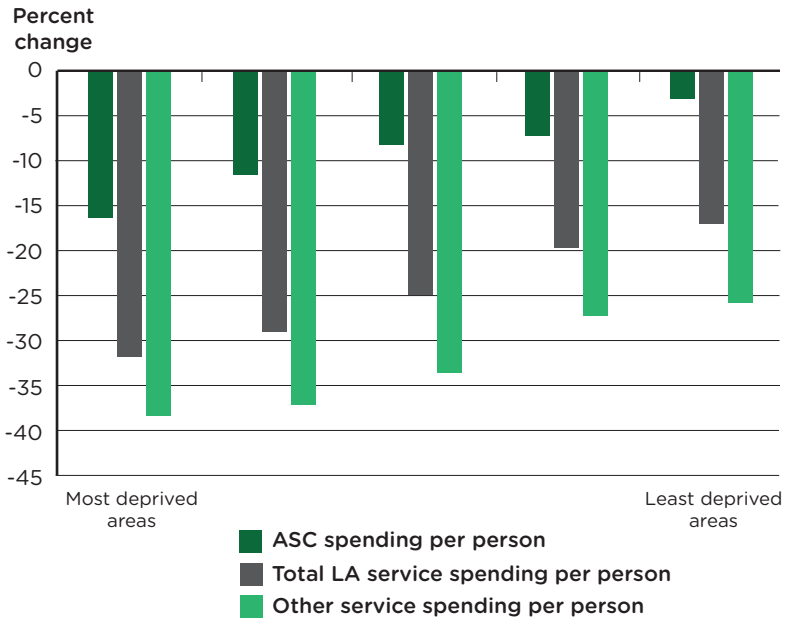
We also have a greater emphasis on poverty as well as the socioeconomic gradient, those towards the bottom of the socioeconomic gradient have suffered particularly over the decade and require proportionately more investment and support over the next decade even just to bring them back to where they were in 2010.

We have a somewhat stronger focus on ethnicity, recognising that ethnicity intersects with socioeconomic position to produce particularly poor outcomes for some minority ethnic groups. Lack of data though is a continuing limitation in understanding ethnic inequalities in health and we welcome efforts to make better use of data linkage to support analyses, and to inform policy and interventions to reduce ethnic inequalities and to strengthen accountability.

Since 2010 there have been widespread and deep cuts in most areas of public spending, a result of austerity and government responses to perceived financial pressures. Government spending as a percentage of GDP declined by 7 percentage points between 2009/10 and 2018/19, from 42 percent to 35 percent. Cuts to local authorities have been hugely significant; local government allocations from the Ministry of Housing, Communities and Local Government declined by 77 percent between 2009–10 and 2018–19. There have also been large cuts to most other Departments' expenditure. Spending on social protection and education, both vital for health, have declined the most – by 1.5 percent of GDP.

But it is not just the impact of overall cuts: it is how and where they have fallen which has impacted most on inequalities. The cuts over the period shown have been regressive and inequitable – they have been greatest in areas where need is highest and conditions are generally worse, as shown in Figure 1. It is likely that the cuts have harmed health and contributed to widening health inequalities in the short term and are likely to continue to do so over the longer term.

Figure 1. Average change in council service spending per person by quintile of Index of Multiple Deprivation average score, 2009–10 to 2017–18



Source: Institute for Fiscal Studies, 2018 (1)
Note: LA=local authority; ASC=adult social care Other services=all council services except adult social care

While outcomes and actions in England have been disappointing, there is some cause for optimism. Since 2010 there has been a marked change in awareness and prioritisation of health inequalities and social determinants of health. Many organisations in England now have social determinants of health strategies and have helped build evidence, providing practical tools for implementing approaches for a wide range of organisations and sectors; they have also provided support and funding to help communities to make the changes. Examples of these are highlighted throughout the report. There has been a welcome change in debate, at least by local governments, think tanks, health workforces, public health – and social determinants approaches are increasingly on the agenda.

Internationally too, governments have taken forward national approaches to health inequalities. Some governments in the UK have prioritised health inequalities and social determinants to a greater extent than in England. Throughout the main report we include brief descriptions of these and refer to others.

Local governments have played a vital role. Despite widespread cuts there has been positive action and some are leading the way, establishing whole system approaches to tackling health inequalities. Alongside this report we publish an evaluation assessing what Coventry City Council has achieved since becoming a Marmot City in 2013. We are also publishing a short case study of work in Greater Manchester to establish itself as a Marmot City Region. Other areas in England have similarly developed strong and effective ways of improving health and reducing inequalities. Some of these are described in the report. There is much evidence and ample precedent on which the national government in England can base future plans to improve the nation's health and reduce health inequalities.

Another reason for optimism is that the current Government has signalled an end to austerity and announced a programme of spending which could, if allocated in the right way, help reduce health inequalities and turn around some of the trajectories and poor outcomes experienced over the last ten years. This would require a significant prioritisation of equity – in relation to reducing regional inequalities and inequalities related to area deprivation and peoples' socioeconomic position.

We set out proposals for policies and actions which, taken together, would reduce inequalities in the social determinants of health and thus achieve greater health equity. There is a pressing need to do this, and lives are being lost and harmed unnecessarily. There is clear evidence of the way forward, practical experience from England and around the world about how to take action, and evidence that there are savings to be made; there are no technical reasons for inaction and the onus is clearly on politicians to take the lead.

Proposals to support action on health inequalities

Strong national government commitment and leadership is required to begin to turn around the deteriorating health situation in England. Improving the health and wellbeing of the population and reducing health inequalities is a whole of society endeavour. But the necessary prioritisation, focus and resources must come from national government with leadership from the Prime Minister. Within the context of overall improvement in health, there are twin challenges:

- To reduce socioeconomic inequalities in length of life and health;
- To reduce regional inequalities in health, improving the health of people living in deprived areas – particularly those outside affluent areas in London and the South.

The following components are essential to achieve that:

Implementation of action on health inequalities and their social determinants

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
2. Ensure proportionate universal allocation of resources and implementation of policies.
3. Early intervention to prevent health inequalities.
4. Develop the social determinants of health workforce.
5. Engage the public.
6. Develop whole systems monitoring and strengthen accountability for health inequalities.

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities.

A first priority for the Government is to establish a national strategy for health inequalities, led by the Prime Minister. There is evidence that the previous health inequality strategy which ended in 2010 reduced inequalities. Other national governments around the world have established effective national strategies. We propose:

- Development a of national strategy on health inequalities led by the Prime Minister.
- Ensuring a strong focus on social determinants of health in the new strategy and by Public Health England and NHS England.
- Establishing a Cabinet Level cross-departmental committee to lead implementation of the work on the health inequalities strategy.
- The cross departmental committee to lead prioritisation of equity considerations at the heart of policy formulation and implementation in all sectors.

2. Ensure proportionate universal allocation of resources and implementation of policies.

In the 2010 Marmot Review we proposed proportionate universal approaches, that is, policies and interventions which are universal but developed to be more intense where need is higher – to be proportionate to need. These approaches can raise overall levels of health and flatten the gradient in health and we have examples of them in the Report. As we describe in the report, over the last ten years, changes to funding allocations and cuts to benefits have disproportionately affected poorer areas and communities and have been greatest in the North. Reversing these losses requires funding and action to be greater in those areas which have lost most, but universal as all areas have suffered cuts and widening inequalities. Therefore, we propose:

- Health inequalities targets to reduce socioeconomic and area inequalities in health. Regional health inequalities should be reduced by achieving proportionately greater improvements in health inequalities in the North.
- Strengthen the deprivation components in the Revenue Support Grant to local authorities. The NHS Resource allocation formula should also be increased to better reflect social need.

- Fund and adopt a proportionate universalist approach to building community resources and involve communities in the design and implementation of programmes to reduce inequalities.

3. Early intervention to prevent health inequalities.

Take action on the five areas outlined in the report in the ways set out and summarised here and continue to take action in the sixth area of the 2010 Marmot Review:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention.

We also propose increasing spending on public health to seven percent of the NHS budget as set out in the 2010 Marmot Review

4. Develop the social determinants of health workforce.

Action on the social determinants of health requires action across multiple arenas and domains and that requires commitment and know-how from a range of workforces outside health. Since 2010, there have been many promising developments from non-healthcare workforces, which illustrate the possibility of health equity in all policies. Police, fire fighters, social care, housing and early years workforces have all developed approaches to tackling health inequalities, by extending and adapting their day-to-day practices and procurement.

Clearly the prime focus of the healthcare workforce will always be on health care and treatment, but there are many effective and promising practices developed by the health care workforce which can improve population health and reduce inequalities through actions on the social determinants. We recommend:

- Development of education programmes focusing on the social determinants for a range of workforces
- Development of anchor institution approaches
- Develop a health system approach to population health, with partnerships to improve population health among a range of sectors, locally and nationally.

5. Engage the public

While health is repeatedly at the top of the public's concerns, there is widespread lack of public understanding about what drives health. This is a major obstacle to further progress in reducing health inequalities and increasing population health. Even though the health system and national government know the evidence that social determinants are largely responsible for the nations' health and levels of health inequalities, they retain the focus on health care and continue to underfund and overlook actions on the social determinants of health.

A 2017 survey by the British Social Attitude Survey for the Health Foundation found almost all, 96 percent of respondents reflected the consistent political and media discourse, as they considered free health care to have a 'very large' or 'quite large' impact on health and 'individual behaviours' close behind, 93 percent. Assessments in England and internationally repeatedly show that social determinants account for most of health; health care a much lesser extent.

A 2019 report from WHO EURO concluded that only about 10 percent of self-reported health relates to health care, the rest in varying proportions to four other social, environmental and economic factors. The public and political debate on health needs to move towards the social determinants and away from the overwhelming focus on individual behaviours and health care; this will help shift political focus and lead to greater investment and action on social determinants. We therefore recommend:

- Government and Public Health England initiate a highly visible and accessible public debate highlighting widening health inequalities and addressing how the social determinants affect health.
- Development of appropriate public facing reporting mechanisms for inequalities in health.

6. Develop whole systems monitoring and strengthen accountability for health inequalities.

Accountability for health inequalities is weak. The Health and Social Care Act of 2012 did contain health inequalities duties and legal accountabilities for health inequalities, but these have been largely disregarded nationally, although NHS England has made some progress.

National Government needs to be accountable for health inequalities, and for the range of policies outside the health care sector that are necessary for addressing health inequalities. Reducing inequalities is a whole of society endeavour, involving many different parts of government and a range of different sectors and organisations as well as the public. National government must be responsible for regional and socioeconomic health inequalities and be held accountable for progress. Developing broad targets to strengthen accountability and galvanise action is one of number of ways of ensuring that action on health inequalities is prioritised.

Effective monitoring systems are an essential component of understanding the nature of health inequalities, understanding the impacts of policies and programmes and holding Government and other organisations to account for them. Since 2010, progress has been made in developing system-wide monitoring which incorporates health outcomes and social determinants at local level – these types of

monitoring offer opportunities for understanding the impacts of the social determinants on health at the local level – and for designing interventions to improve outcomes. Data showing regional and socioeconomic inequalities in health is routinely available. Government should demonstrate that it is accountable for progress on these inequalities by actively monitoring indicators based on these data and reporting to the public – much like current health care targets on waiting times for example.

We therefore propose development of targets to:

- Bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South.

In support of meeting those targets we propose to:

- Strengthen accountability mechanisms for health inequalities including through legislation

- Build more effective whole system data sets and improve data for ethnicity.

Inequalities in health since 2010

LIFE EXPECTANCY SINCE 2010

- Increases in life expectancy have slowed since 2010, with the slowdown greatest in more deprived areas of the country.
- The UK has seen low rates of life expectancy increases compared with most European and other high-income countries.
- Inequalities in life expectancy have increased since 2010, especially for women.
- Female life expectancy declined in the most deprived 10 percent of neighbourhoods between 2010-12 and 2016-18 and there were only negligible increases in male life expectancy in these areas.
- There are growing regional inequalities in life expectancy. Life expectancy is lower in the North and higher in the South. It is now lowest in the North East and highest in London.
- Within regions, life expectancy for men in the most deprived 10 percent of neighbourhoods decreased in the North East, Yorkshire and the Humber and the East of England.
- Life expectancy for women in the most deprived 10 percent of neighbourhoods decreased in every region except London, the West Midlands and the North West.
- For both men and women, the largest decreases were seen in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.
- In every region men and women in the least deprived 10 percent of neighbourhoods have seen increases in life expectancy and differences between regions for these neighbourhoods are much smaller than for more deprived neighbourhoods.

HEALTH SINCE 2010

- There is a strong relationship between deprivation measured at the small area level and healthy life expectancy at birth. The poorer the area, the worse the health.
- There is a social gradient in the proportion of life spent in ill health, with those in poorer areas spending more of their shorter lives in ill health.
- Healthy life expectancy has declined for women since 2010 and the percentage of life spent in ill health has increased for men and women.

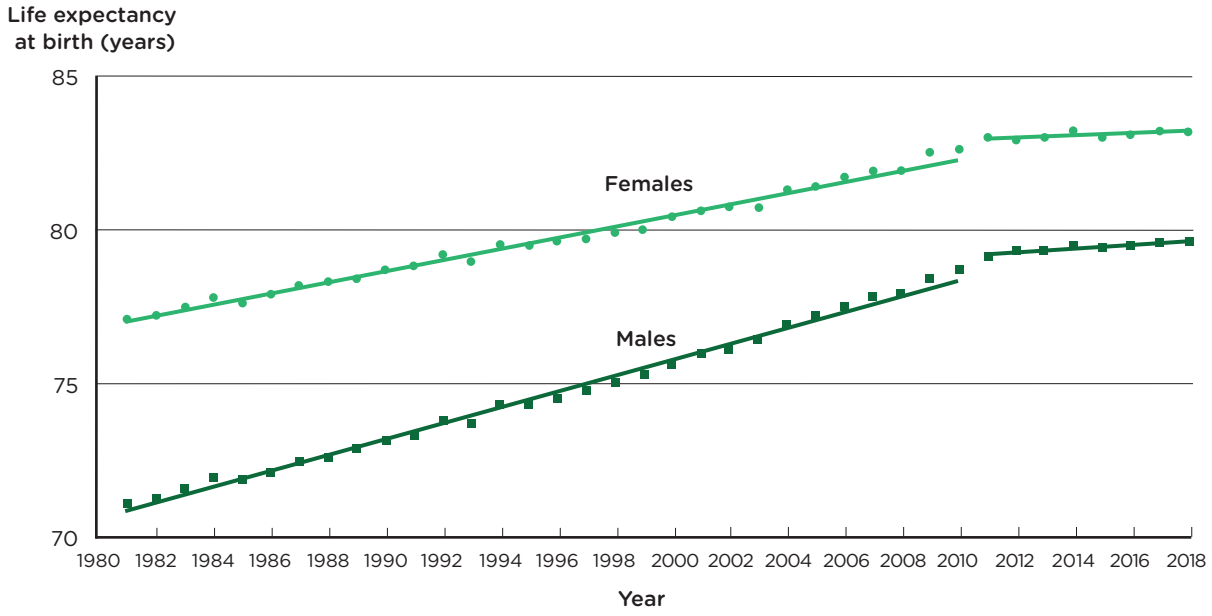
MORTALITY RATES SINCE 2010

- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.
- For people in their 70s mortality rates are continuing to decrease, but not for those at older ages.
- The slowdown in life expectancy increase cannot, for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.
- There are clear socioeconomic gradients in preventable mortality. The poorest areas have the highest preventable mortality rates and the richest areas have the lowest.

In the 2010 Marmot Review we labelled health inequalities as 'unjust' and 'unnecessary' and that is still the case. Since 2010 there have been worrying deteriorations in health and widening health inequalities in England and these are likely related to deteriorations in the social determinants.

Figure 2, shows stalling life expectancy in England since 2011, this stalling is unprecedented, at least since the turn of the last century. Life expectancy from 1980 is shown in Figure 2 and the stalling of life expectancy growth is clear for both men and women.

Figure 2 Life expectancy at birth for males and females, England, 1981–2018



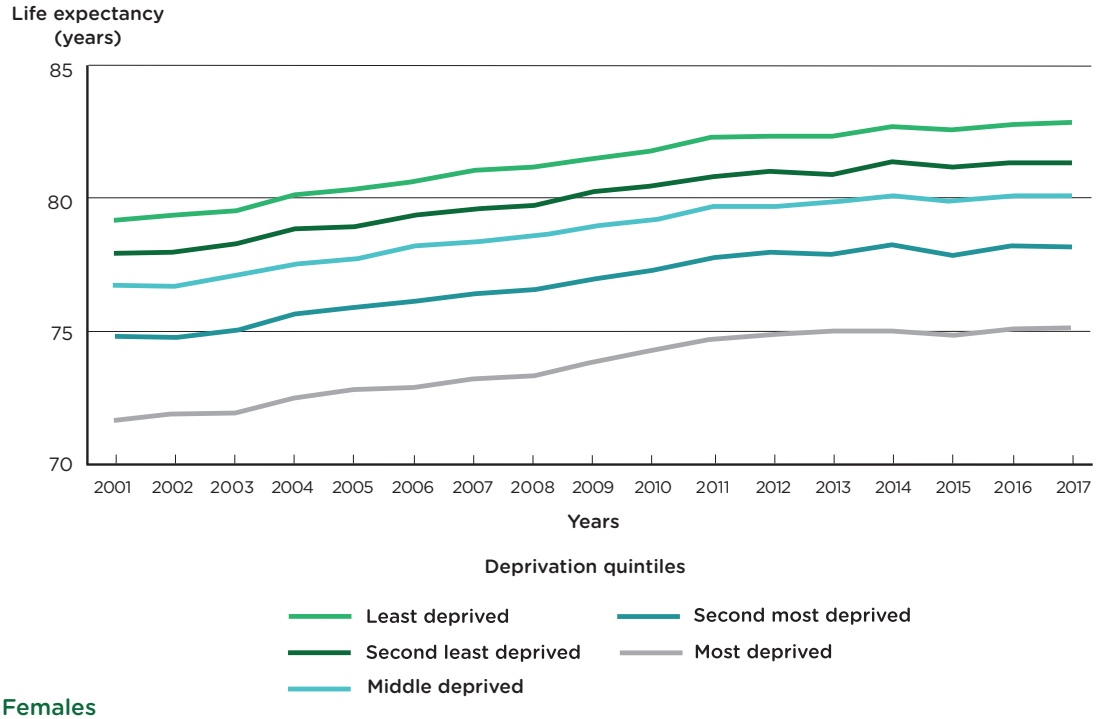
Source: Calculated by Bajekal M using ONS data (2019) (2)

Inequalities in life expectancy have widened since 2010. The difference in life expectancy at birth between the least and most deprived deciles was 9.5 years for males and 7.7 years for females in 2016–18. In 2010-12, the corresponding differences were smaller - 9.1 and 6.8 years, respectively. Life expectancy at birth for males living in the most deprived areas in England was 73.9 years in 2016-18, compared with 83.4 years in the least deprived areas; the corresponding figures for females were 78.6 and 86.3 years.

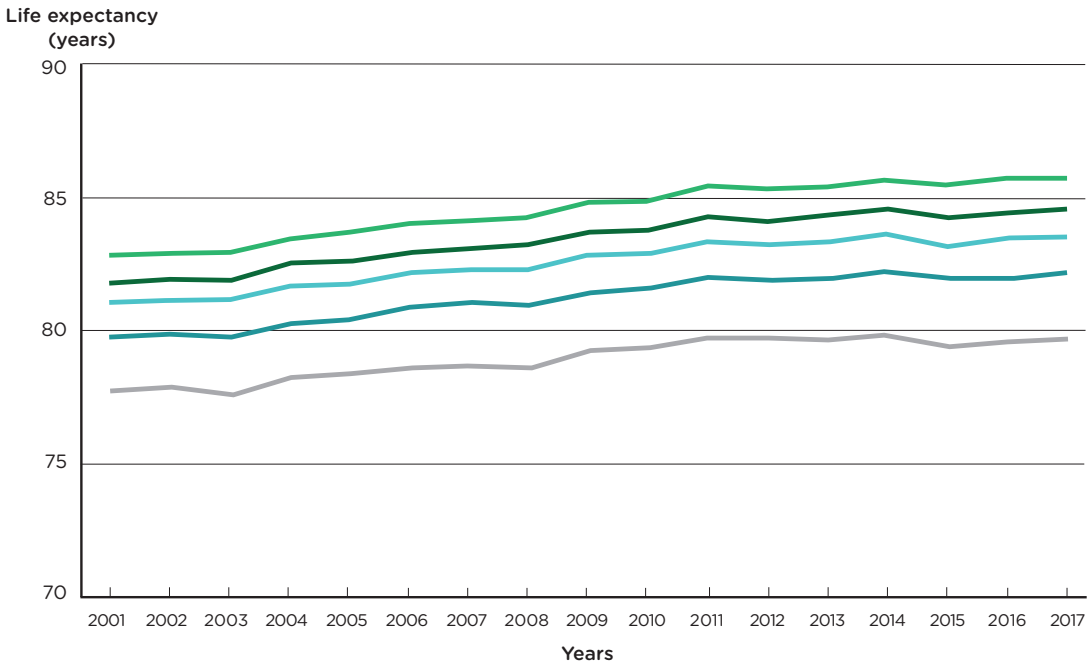
Trends in inequalities in life expectancy by quintile of area deprivation are shown in Figure 3. People in the most deprived area quintile experienced slower improvements in life expectancy than the rest of the population between 2001 and 2017. The differences between the least and most deprived area quintiles in 2001 were 7.4 for men and 5.0 for women. These differences increased to 7.5.and 5.4, respectively in 2010 and further increased to 7.7 and 6.1, respectively in 2017 – a substantially greater rate of increase in inequalities, especially for women, in the years since 2010 than in the previous decade.

Figure 3. Life expectancy at birth by area deprivation quintiles and sex, England, 2003–05 to 2015–17

a) Males



b) Females



Source: Calculated by Bajekal M using ONS data, 2019 (3)

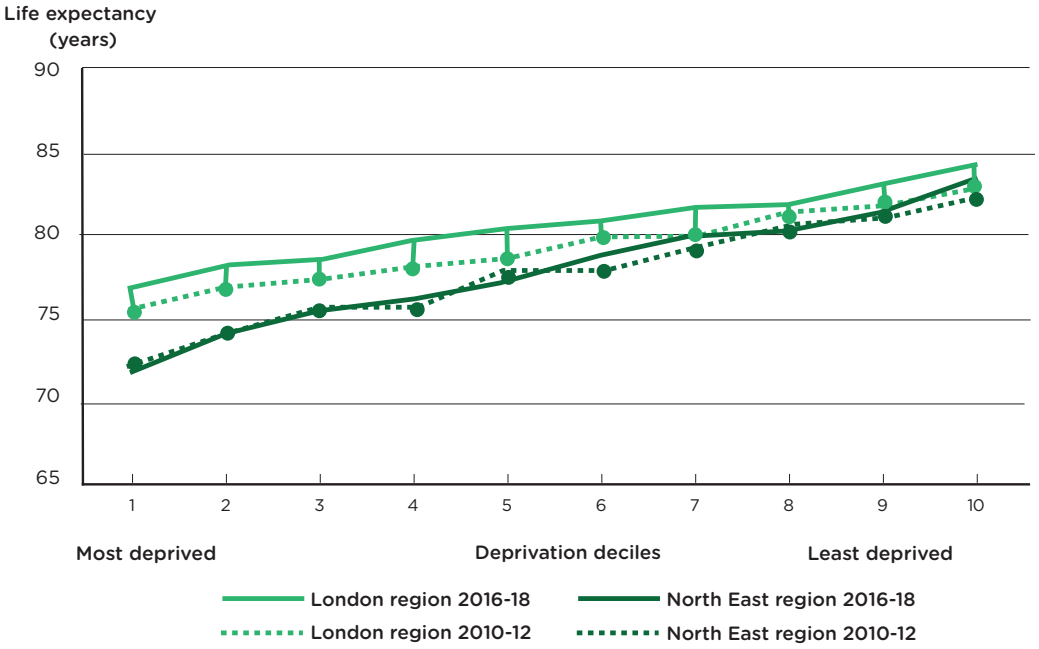
As in 2010, there are clear inequalities in life expectancy between regions in England and between area deprivation deciles within each region. Since 2010 there have been some significant changes in regional inequalities. Principally, life expectancy in London increased more rapidly than elsewhere from 2010, so that the region had improved from having the fourth highest life expectancy to the highest for males and females by 2016–18. By contrast, the North East, had the slowest rate of improvement to become the region with the lowest life expectancy in 2016–18.

Changes in relative positions in average regional life expectancy provide important information about how different regions are performing in health. Inequalities in life expectancy within regions point to possible reasons for these regional differences. Wealthier areas in the North and South have similar life expectancy to one another, while more deprived areas have lower life expectancy in the North. The life expectancy difference between regions can be accounted for by differences between more deprived areas (4).

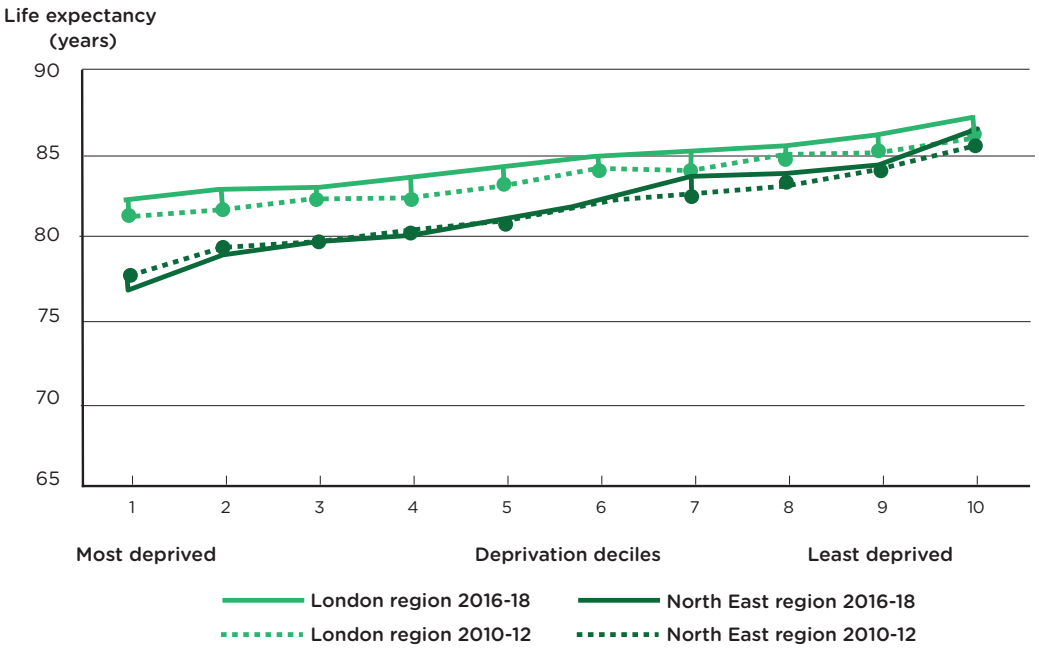
This can be illustrated by comparing London with the North East region (Figure 4). The gradient in life expectancy is steeper in the North East than in London. The health disadvantage of living in the North East increases with the level of deprivation of the area of residence. Figure 4, also shows that, in the North East, life expectancy stagnated between 2010-12 and 2016-18 for men living in more deprived areas, and actually declined for women. By contrast, it increased for both men and women in the least deprived area deciles. For those living in London, life expectancy increased in all deciles for both men and women.

Figure 4. Life expectancy at birth by sex and deprivation deciles in London and the North East regions, 2010–12 and 2016–18

a) Males



b) Females



Source: PHE, 2020 (5)

Ethnicity is not recorded at death registration, making routine analysis of ethnic inequalities in health difficult. Two research studies using area data pointed to those with Pakistani and Bangladeshi ethnicity having the lowest life expectancy and non-British Whites having the highest.

While life expectancy is one important measure of health, how long a person can expect to live in good health is an even more significant measure of quality of life. Certainly, recent debates have focused on adding 'life to years, rather than years to life'. Giving cause for concern on top of the stalling in life expectancy improvements, recent measures have shown that improvements in health have stalled too and have even declined for many. For women, healthy life expectancy has declined since 2009–11 and, for both men and women, years spent in poor health have increased.

In Table 1 ONS data show that healthy life expectancy at birth in England in 2015–17 was 63.4 years for males and 63.8 years for females, meaning that more than one-fifth of life will likely be spent in ill health. The figures in red in Table 1 indicate the deterioration since 2009–11.

Table 1. Healthy life expectancy and proportion of life spent in good health, 2009–17, males and females, England

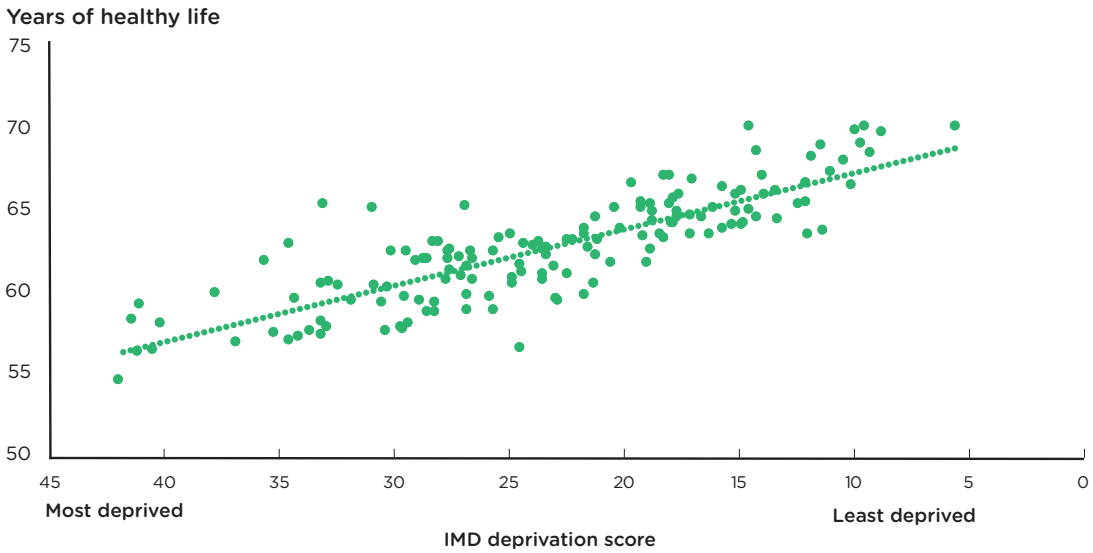
	Healthy life expectancy (HLE)	Years in poor health	Percentage life spent in poor health	Disability-free life expectancy (DFLE)	Years with disability	Percentage life spent with disability
Males						
2009–11	63.0	15.8	20.0	63.5	15.3	19.4
2012–14	63.4	16.1	20.2	63.1	16.3	20.5
2015–17	63.4	16.2	20.3	63.1	16.5	20.7
Females						
2009–11	64.0	18.7	22.6	63.9	18.8	22.7
2012–14	63.9	19.3	23.2	62.8	20.3	24.4
2015–17	63.8	19.4	23.3	62.2	21.0	25.2

Source: ONS (5)

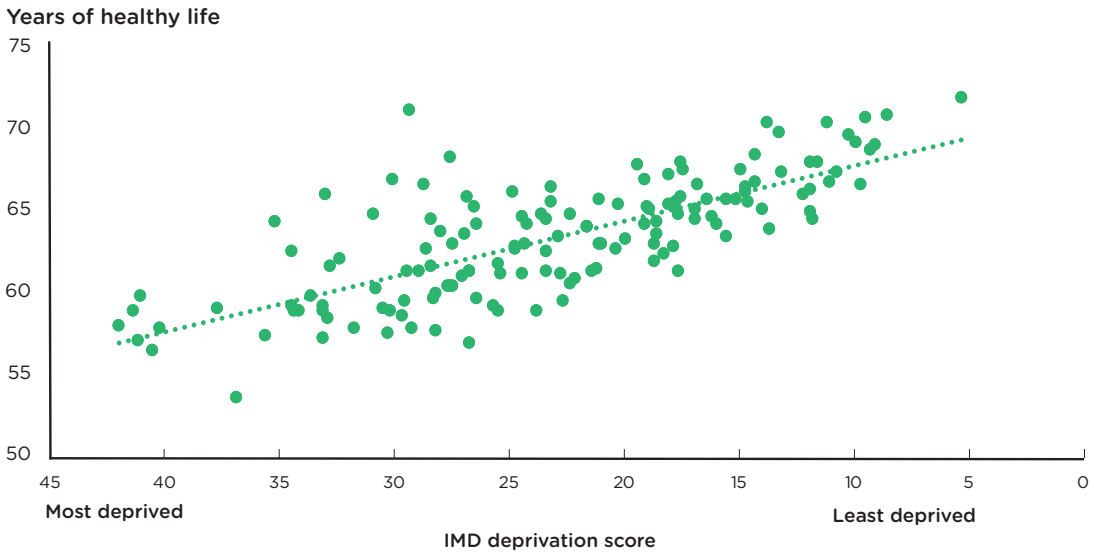
Figure 5 shows the relationship between local authority deprivation and healthy life expectancy at birth. On average, healthy life expectancy at birth differs by 12 years between the most and least deprived local authorities for men and women.

Figure 5. Healthy life expectancy at birth by Index of Multiple Deprivation score of upper tier local authorities, England, 2018

a) Males



b) Females



Source: Based on PHE, 2019 (5)

Public Health England's survey of quality life by different ethnic groups shows Pakistani, Bangladeshi and White Gypsy Travellers have much lower quality of life than other ethnic groups. For many groups in England, health and life expectancy are deteriorating and there are clear systematic inequalities in the groups for whom this is happening.

Broadly speaking, poorer communities, women and those living in the North have experienced little or no improvement since 2010. There has been a slowdown in life expectancy of a duration not witnessed in England for 120 years and that has not been seen to the same extent across the rest of Europe or in most other Organisation for Economic Co-operation and Development (OECD) countries. And health has deteriorated for the population as a whole.

While at this stage it is impossible to establish precisely why life expectancy has stalled and why health inequalities in England are widening, a change in winter-associated mortality and ill health is not the main factor and the reasons are most likely to lie in the social determinants of health.

Social determinants of health

Since the 2010 Marmot Review there have been important developments in the evidence about the social determinants of health and in the implementation of interventions and policies to address them. There have also been fundamental political, cultural, social, economic and policy changes that have profoundly affected all aspects of the social determinants in England. This section summarises important developments in five of the six areas set out in the 2010 Marmot Review, changes that may explain why health has deteriorated for many in England, and will likely continue to do so in the longer term.

The evidence base for the priority objectives in the 2010 Marmot Review was substantial at the time and has grown more so. Rather than repeat the evidence the report covers particular issues in each of the five areas that have increased in importance for equity, and that have also been a focus of policy since 2010.

Give every child the best start in life

SUMMARY

- Since 2010, progress has been made in early years development, as measured by children's readiness for school. Clear socioeconomic inequalities persist, with a graded relationship between these measures and level of deprivation.
- For low-income children, levels of good development are higher in more deprived areas than in less deprived areas.
- Rates of child poverty, a critical measure for early child development, have increased since 2010/11 with over four million children affected.
- Child poverty rates are highest for children living in workless families - in excess of 70 percent.
- Funding for Sure Start and Children's Centres, and other children's services, has been cut significantly, particularly in more deprived areas.
- More deprived areas have lost more funding for children and youth services than less deprived areas, even as need has increased.
- There are still low rates of pay and a low level of qualification required in the childcare workforce.

Early childhood is a critical time for development of later life outcomes, including health. Evidence shows that positive experiences early in life are closely associated with better performance at school, better social and emotional development, improved work outcomes, higher income and better lifelong health, including longer life expectancy. Conversely, less positive experiences early in life, particularly experiences of adversity, relate closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health. Since 2010 IHE and other organisations have continued to assess the growing body of evidence describing the associations between experiences in early years, education, and short- and long-term health outcomes. Such is the strength of evidence linking experiences in the early years to later health outcomes that this was the priority area for the 2010 Marmot Review.

ATTAINMENT

Since 2010 progress has been made on readiness for school and attainment during school and rates have risen. However, clear socioeconomic inequalities in these measures persist and there are wide inequalities in outcomes between regions. Gender inequalities remain and there are inequalities related to ethnic background that require much greater focus. Some areas, such as Greater Manchester, have rapidly improved outcomes for children in the early years, a result of concerted system-wide efforts and prioritisation of support for families and children during these years.

Since 2010 evidence has shown that children in families with low incomes do better at schools in more deprived areas than they do in wealthier areas. It seems clear that schools and communities in some more deprived areas are making a beneficial difference for the most deprived students and breaking the close association between deprivation and lower outcomes. A second possibility is that being a poorer child among more privileged children may lead to feelings of exclusion and lack of self-esteem.

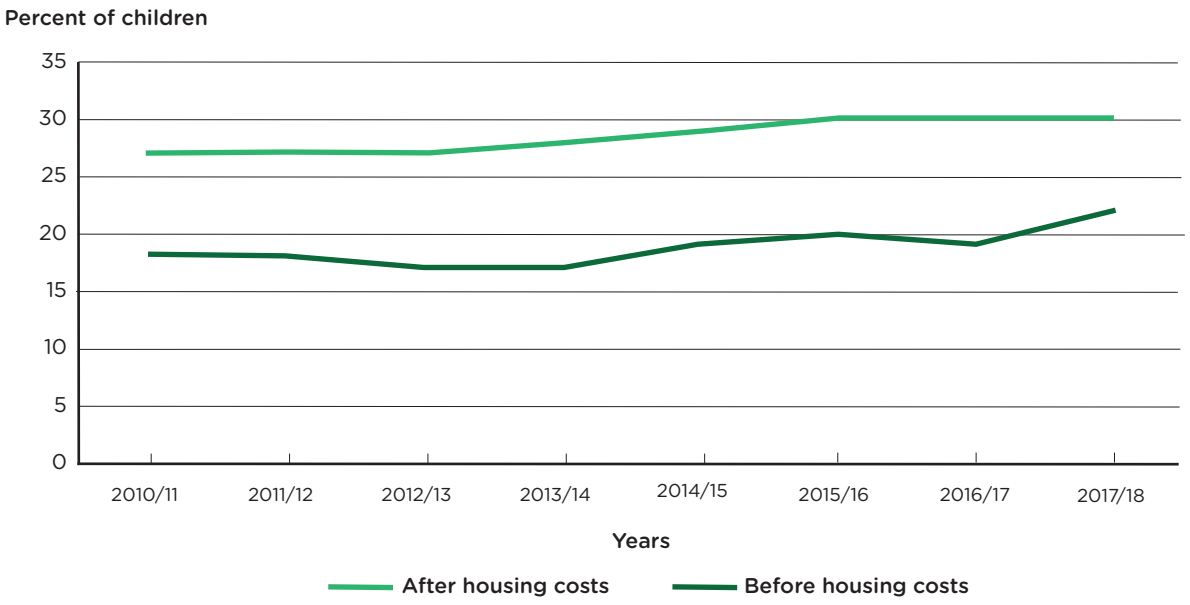
There are two types of influence on children's development – both of which follow the social gradient. The positive activities are associated with caring and nurturing which foster good early child development. By contrast, adverse child experiences, more frequent lower down the social hierarchy, have profound impact on children's lives and throughout their life course. Reduction of inequalities and relief of poverty will be important to both of these.

CHILD POVERTY

High rates of child poverty continue to blight the lives of too many children. Poverty experienced during childhood harms health at the time and throughout the rest of life. Since 2010 there have been increases in child poverty, particularly in families with parents in work. Child poverty is not an inevitability, but largely the result of political and policy choices in areas including social protection, taxation rates, housing and income and minimum wage policies. Many countries in the OECD have considerably lower rates of child poverty than England.

Figure 6 shows child poverty rates before and after housing costs, demonstrating the significant difference housing costs make to child poverty rates – an eight percent point increase in 2017/18. Numbers of children in poverty have increased to exceed four million after housing costs are taken into account. In England the proportion of children in poverty is projected to increase under present policies. The Institute for Fiscal Studies predicts relative child poverty, living in a household with less than 60 percent of median income, after housing costs will increase from 30 percent to 36.6 percent in 2021 in the UK.

Figure 6. Percent of children living in poverty measured before and after housing costs, England, 2010/11–2017/18



Source: Department for Work and Pensions, 2019 (7)
Note: Low-income families are those in receipt of out-of-work benefits or tax credits or whose reported income is less than 60 percent of median income

Some minority ethnic groups have particularly high rates of child poverty. In 2017/18, 45 percent of minority ethnic children lived in families in poverty after housing costs, compared with 20 percent of children in White British families in the UK. These children experience cumulative impacts of the intersections between poverty and exclusion and discrimination, which harms health and life chances even from the earliest age.

Child poverty is highest for children living in workless families - in excess of 70 percent of children in these families are in poverty, up from just over 60 percent in 2010, affecting 1.3 million children. Even for those in two parent families, where one of the parents is not working or working part time, there are 1.6 million children living in poverty.

FUNDING

At the same time that child poverty rates have been increasing, there have been significant cuts in funding for family support services. Funding for local authority children and young people's services fell by £3 billion between 2010/11 and 2017/18 – a 29 percent reduction, with the greatest cuts for more deprived areas. The North East has had the steepest decline in funding for children and young peoples' services, 34 percent between 2010–11 and 2017–18. The South East experienced the smallest decline, 22 percent.

Funding for free childcare for 3-4 year olds has been introduced, which is welcome, but this has been at the expense of Sure Start and Children's Centres, which evidence has shown has helped improve outcomes for the most disadvantaged children and families. It has been estimated that well over 500 Children's Centres have closed. Spending in England on the early years is currently 0.8 percent of GDP (latest available figures, 2015), compared with Iceland which spends 1.8 percent of GDP on children and families at this stage of life.

Recommendations for giving every child the best start in life

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Improve availability and quality of early years services, including Children's Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

SUMMARY

- Clear and persistent socioeconomic inequalities in educational attainment that were present in 2010 remain.
- Regionally, the North East, North West and East Midlands have the lowest levels of attainment at age 16 and London has the highest.
- Since 2010 the number of exclusions from school have significantly increased in both primary and secondary schools.
- Pupil numbers have risen while funding has decreased, by eight percent per pupil, with particularly steep declines in funding for sixth form (post-16) and further education.
- Youth services have been cut since 2010 and violent youth crime has increased greatly over the period.

Many of the changes to the education system and experiences of young people in England since 2010 have significant health equity impacts. Persisting socioeconomic inequalities in attainment during primary and secondary school have lifelong impacts on health and on a range of other outcomes throughout life. Since 2010 inequalities in attainment have persisted, although some schools and areas have shown promise in improving outcomes even in the most deprived circumstances, but at national level these approaches are not systematically applied and funding cuts are undermining the potential to do more. Exclusions from school have increased significantly, and violent youth crime has increased.

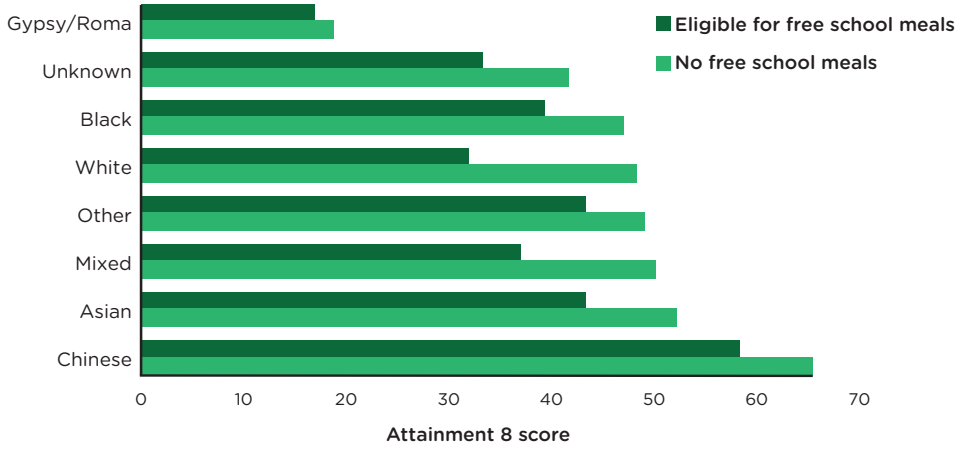
Funding has become an even greater concern in the decade since the 2010 Marmot Review as numbers of pupils have grown while secondary school funding, and particularly sixth form funding and funding for education post 16, has been reduced. This has limited the ability of schools, particularly in more deprived areas, to provide the intensive work and leadership required to reduce inequalities in attainment and experience.

ATTAINMENT

As with inequalities in the early years, inequalities experienced during school years have lifelong impacts – in terms of income, quality of work and a range of other social and economic outcomes including physical and mental health. Socioeconomic inequalities in educational attainment have persisted since 2010 entrenching trajectories of inequality which begin in the early years. Young people living in more deprived areas continue to have significantly lower levels of attainment during secondary school, measured by GCSE results and attainment 8 scores, which measures pupils' performance in eight GCSE-level qualifications.

Figure 7 shows significant inequalities in attainment 8 scores related to eligibility for free school meals and ethnicity. For each ethnic group described, those eligible for free school meals do worse but there are different levels of attainment related to ethnicity. Chinese, Asian and mixed ethnic background children scored higher than average for Attainment 8.

Figure 7. Average Attainment 8 score, by ethnicity and free school meal eligibility, England and English regions, 2017/18



Source: Department for Education, 2019 (8)

SCHOOL EXCLUSIONS

Since 2010 there have been significant increases in the rate of school exclusions in both primary and secondary schools and official figures, while high, are likely to mask the scale of the problem, with pupils forced out of mainstream schools by informal methods that are not captured in national exclusions data. There are clear socioeconomic inequalities in the risk of being excluded. In 2012 the Department of Education found children eligible for free school meals were four times more likely to be punished by a permanent exclusion than children who were not eligible for free school meals. Outcomes for excluded children are poor and harm those children's prospects and health for the rest of their lives. There are also associations between exclusion and being a perpetrator or victim of crime.

YOUTH CRIME

Being a perpetrator or victim of crime is closely associated with deprivation and exclusion. It has impacts on health and a range of social and economic outcomes throughout life. Overall, youth crime rates have fallen since 2010, although the decrease has been more pronounced for White than Black children and in 2017/18 Black children were four times more likely than White children to be arrested.

Despite the welcome overall declines in youth crime, violent and particularly knife crimes have increased significantly among young people over the last decade. Between 2010/11 and 2018/19 there was a 31 percent increase in the total number of offences in England involving a knife or sharp instrument. Knife crime particularly affects young males from deprived communities. Household poverty and area deprivation are closely associated with youth violence.

FUNDING

There have been reductions in per pupil funding for secondary education since 2013/14 and the Institute for Fiscal Studies (IFS) reports that there were cuts of eight percent (by central and local government) per pupil. For many schools this has led to cutting subjects and reductions in the workforce. Post-16 education has been particularly hard hit, with spending per student in school sixth forms reported to have fallen by 23 percent in real terms between 2009/10 and 2018/19. The IFS estimate that reversing the cuts and bringing education spending back in line with 2009–10 would cost about £4.7 billion by 2022–23.

In the 2010 Marmot Review we set out how supporting young people to develop their capabilities was an essential component of supporting health equity and greater equity throughout life. Youth services have an essential role to play in that. However, since 2010, in addition to cuts in school funding, there have been significant cuts in funding for youth services following reductions in local authority funding from central government. Data from the Department of Education indicate that, from 2010–16, spending on youth services fell by 66 percent in real terms.

Recommendations for enabling all children, young people and adults to maximise their capabilities and have control over their lives

- Put equity at the heart of national decisions about education policy and funding.
- Increase attainment to match the best in Europe by reducing inequalities in attainment.
- Invest in preventative services to reduce exclusions and support schools to stop off-rolling pupils.
- Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

Create fair employment and good work for all

SUMMARY

- Employment rates have increased since 2010.
- There has been an increase in poor quality work, including part-time, insecure employment.
- The number of people on zero hours contracts has increased significantly since 2010.
- The incidence of stress caused by work has increased since 2010.
- Real pay is still below 2010 levels and there has been an increase in the proportion of people in poverty living in a working household.
- Automation is leading to job losses, particularly for low-paid, part-time workers; the North of England will be particularly affected.

Being in good employment is usually protective of health while unemployment, particularly long-term unemployment, contributes significantly to poor health. However, being in work is not an automatic step towards good health and wellbeing; employment can also be detrimental to health and wellbeing and a poor quality or stressful job can be more damaging to health than being unemployed. Unemployment and poor quality work are major drivers of inequalities in physical and mental health. Being in poverty and working in poor quality employment have marked effects on physical and mental health, including on children in the families concerned.

Since 2010 there have been profound shifts in many aspects of the labour market and employment practices in England. Rates of unemployment have decreased but increases in employment have often been in low-paid, unskilled, self-employed, short-term or zero hours contract jobs –which have seen a steady growth. Rates of pay have not increased and, notably, more people in poverty are now in work than out of work. The rise of automation in the labour market also has implications for health inequalities.

EMPLOYMENT RATES

Employment rates in England have risen since 2010, a welcome development. The risk of being unemployed and particularly long-term unemployed is still highly unequal between different groups. White people, married men, people with no disabilities and those with higher qualifications have higher employment rates than minority ethnic groups, women, lone parents and people with disabilities. The health risks associated with unemployment, and particularly long-term unemployment, are high and include higher mortality rates for those long-term unemployed.

As with so many factors overviewed in this report, there are significant inequalities between regions. The highest employment rates at the end of 2019 were found in the South West, followed closely by the South East and the East of England. The lowest employment rate was seen in the North East, followed by Yorkshire and the Humber which will impact on widening regional inequalities in health

The 2010 Marmot Review recommended an extension of active labour market programmes that were found to be effective in supporting unemployed people into work. However, these approaches have been scaled back. A major thrust of national policy since 2010 has been the extension of conditionalities and tougher sanctions for those who are unemployed or underemployed – requiring people to look for work for extended periods. A five-year study of welfare conditionality, conducted by the University of York from 2013 to 2018, which included analysis of Universal Credit, criticised the use of conditionality in England's employment support system. The study found that the provision of good quality and targeted support, rather than sanctions, is pivotal in triggering and sustaining paid employment.

WORK QUALITY

Employment has risen in England since 2010, however, the increases, while welcome, have not necessarily been beneficial for health as much of the growth in employment has been in low quality employment with risks to health. Rates of self-reported work-related stress, depression and anxiety have been increasing, at least partly as a result of poor-quality work. Notably, those with a lower socioeconomic position, younger people, those in lower paid jobs and non-White people are all more likely to experience poor quality work with attendant impacts on health and health inequalities.

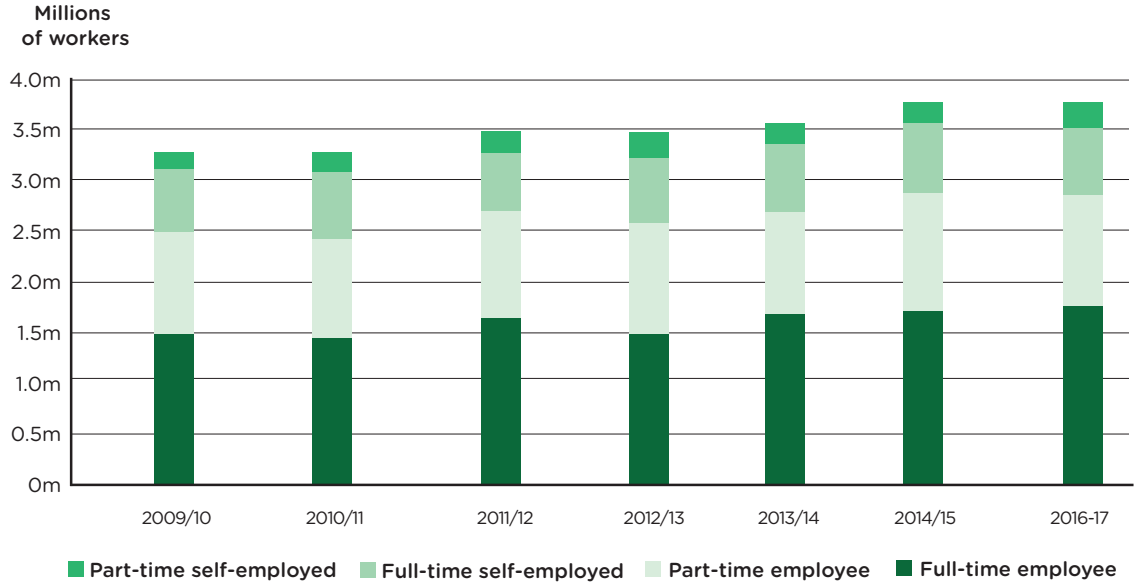
Zero hours contracts are contracts that do not guarantee a minimum number of paid hours: they are a highly insecure form of work – and this insecurity is often harmful to health, particularly for those on low pay and with low socioeconomic status. The number of people on zero hours contracts has risen significantly since 2010. In autumn 2018 there were nearly 900,000 people on zero hours contracts in the UK, compared with 168,000 in 2010. Most of the people on zero hours contracts are in lower skilled and manual occupations, and because of the impacts on health, this will have contributed to widening health inequalities.

LOW WAGES AND IN WORK POVERTY

While more people are in work now than in 2010, average weekly wages have not recovered to the levels of 2010: average weekly earnings were £502 in September 2019, only £5 higher than in 2008 (at 2015 prices). Data comparing OECD countries' wage growth found that the UK experienced negative wage growth between 2007 and 2018 and was third lowest along with Italy and Portugal and after Greece and Mexico.

Increasingly, work is not a way out of poverty and low wages, low level of benefits and the cost of living, particularly the high cost of housing mean that many working people are in poverty. The number of people in work and living in poverty increased from just over three million in 2010/11 to 3.7 million in 2015/16, with 2.4 million in full-time employment shown in Figure 8. A majority of people below the poverty line live in households where at least one adult is working.

Figure 8. Number of workers in poverty by employment type, UK, 2017



Source: Joseph Rowntree Foundation, 2019 (9)

AUTOMATION

Since 2010 concerns about the possible impacts of automation have risen. Unemployment and job insecurity are likely to follow automation both of which are associated with harm to health and rising mortality. Jobs with higher rates of female employment, part-time and low skill jobs are at particular risk of automation. The South East of England and London are relatively less likely to be impacted by automation than other regions.

Automation may also be an opportunity. Eliminating boring, repetitive jobs can be beneficial but only if the alternative is interesting, fulfilling work: achieving such a shift in the labour market entails investments in training as part of an overall approach to a changed economy. Labour market policy should be a key component of future automation strategy.

Recommendations for creating fair employment and good work for all

- Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.
- Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Reduce the high levels of poor quality work and precarious employment.

Ensure a healthy standard of living for all

SUMMARY

- Wage growth has been low since 2010 and wage inequality persists.
- Rates of in-work poverty have increased.
- Incomes have risen slowly and inequalities persist.
- Wealth inequalities have increased.
- Regional inequalities in wealth have increased: London and the South of England have increased their share of national wealth compared with the North.
- The number of families with children who do not reach the minimum income standard has increased.
- Food insecurity has increased significantly.
- Social mobility in England has declined.
- Tax and benefit reforms have widened income and wealth inequalities

The thrust of the 2010 Marmot Review and this report is that social disadvantage is not only a lack of money. Life is worse for people lower down the social hierarchy for each of the five domains covered in this report. Having control over one's life is critical to an individual's health and wellbeing. That said, position in the social hierarchy is, in part, defined by money and having resources to live a healthy life is central to reducing poverty in all its forms and to improving health.

Poverty is associated with poor long-term physical and mental health and low life expectancy. Living in poor quality housing, being exposed to poor quality environmental conditions, poor quality work and unemployment, not being able to afford nutritious food and sufficient heating for example all impact on health. Poverty is also stressful. Coping with day-to-day shortages, facing inconveniences and adversity and perceptions of loss of status all affect physical and mental health in negative ways.

Since 2010 rates of wage and income growth have been low and wage inequalities increased slightly and income inequality has persisted; wealth inequalities have increased and regional inequalities in wealth have widened a great deal. While wage growth has been low, benefits have been cut even while costs of living, particularly housing, have increased. As a result, rates of poverty have increased for many – particularly for children and for those in work.

WAGE, INCOME AND WEALTH INEQUALITIES

Since 2010 inequalities in weekly earnings have increased slightly, as those in the top 10 percent of earnings have seen their wages increase the most while those in the 40 percent of lower earnings have seen their wages increase at a lower rate, and barely increasing at all for the lowest 10 percent. Earnings in London remain the highest by some margin followed by the South East, while the North East has the lowest weekly earnings.

The National Living Wage introduced in 2016 has helped raise wages for those on low wages which is positive. However, it is still too low to meet the Minimum Income Standard, which sets out what is sufficient income as defined by the public for an acceptable standard of living.

Average incomes have barely increased since 2010, this is mainly the result of low wage growth and low levels of benefits. Inequalities in income have persisted since 2009/10 and there is a particularly large difference between the level of the top of the income distribution and the rest.

Wealth includes savings and also all financial assets, such as property, shares, private pensions and valuable goods. In 2016–18 the top three wealth deciles held 76 percent of all wealth, while the bottom three wealth deciles held 2 percent. Inequalities in wealth in England are higher than wage and income inequalities. For the lowest thirty percent wealth has hardly increased over the period. In the decade 2010–20, as in the decades that preceded it, the wealthy have become wealthier as capital growth has risen much faster than faltering wage growth. Put simply, the wealthy have got wealthier – and therefore healthier.

Regional inequalities in wealth have also risen markedly over the decade as London and the South East increased their wealth at a much faster rate than other regions. The North East, the region with the lowest average household wealth, has barely increased its wealth since 2010.

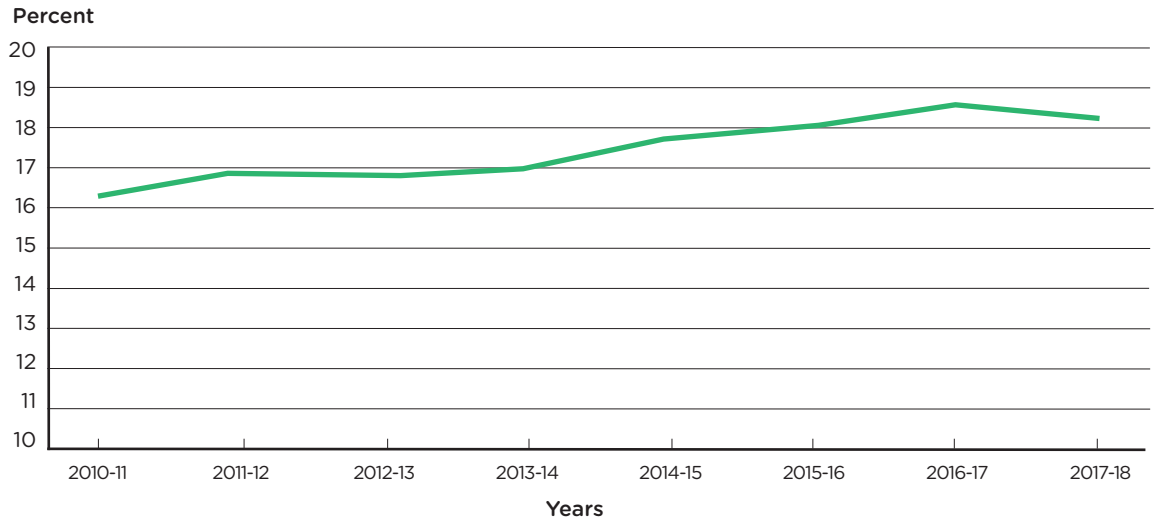
The UK is slightly more unequal in terms of wealth distribution than many other wealthy countries, but wealth inequality increased faster in the UK than in any other country OECD country except the USA between 2010 and 2016.

POVERTY

Since 2010 levels of benefits have been reduced, wages have stagnated and costs of living increased particularly, in housing. As a result, rates of poverty have increased for many. In 2017/18, 14 million people in the UK, 22 percent of the population, lived on incomes below the poverty line after housing costs are taken into consideration. Poverty rates (after housing costs) have increased for pensioners since 2010/11, and for children, poverty rates increased from 27 percent in 2010/11 to 30 percent in 2017/18.

Work is no longer a way out of poverty for many described in Figure 9. Poverty for families in work after housing costs rose from 16 percent in 2010 to 18 percent in 2018. Low pay, the cost of living, particularly housing, and low level of benefits contribute to in-work poverty. Most people in poverty are now working.

Figure 9. Relative poverty rate (after housing costs), working age adults in working families, UK, 2010/11 to 2017/18



Source: Based on IFS, 2019 (10)

Nearly half of those in poverty in the UK in 2018 – 6.9 million people – were from families in which someone had a disability. Some ethnic groups also face much higher rates of poverty than others, particularly those who are Black and Bangladeshi and Pakistani origin where rates of poverty after housing costs are as high as 50 percent. Persistent poverty refers to someone who has been in poverty in three of the past four years. People in persistent poverty are at particularly high risk of having poor physical or mental health. Rates have stayed roughly the same since 2010, at about 13 percent. Lone parents with children have the highest risk of being in persistent poverty

While poverty is harmful to health in many direct and indirect ways, not being able to pay rent, heat your home or eat a sufficient nutritious diet are perhaps the most obvious manifestations. In 2017, close to 11 per cent of households in England (2.5 million households) were classed as fuel-poor, while between eight and 10 percent of households in the UK were food insecure, rising from 28 percent to 46 percent of low-income adults between 2004 and 2016.

TAX AND BENEFIT SYSTEM

Since 2010 there have been widespread changes to the tax and benefit system, notably the introduction of Universal Credit. The implementation of Universal Credit has pushed many people further into poverty and debt, particularly through delays in being awarded credit. Overall the tax and benefit reforms in England between 2015 and 2017 were regressive. Analysis shows negative impacts of benefit reform for the poorest 50 percent in the UK with the poorest 20 percent experiencing the most negative impacts. Meanwhile, the benefit changes were positive for the top 40 percent, which, combined with tax reforms have been beneficial to the top 30 percent in particular.

Meanwhile the average effect of all forms of direct and indirect taxes on the bottom income decile is to take away 44 percent of gross income (which includes both earned income and direct cash benefits). The corresponding figure in the top decile is 34 percent. That is to say effective tax rates are higher in the bottom decile than in the top decile which means that the tax system is also regressive.

Tax revenues in the UK are below the OECD average. In 2018 the British Social Attitudes survey found 60 percent of the UK public were in favour of the Government increasing tax to spend more, an increase from 49 percent of the public who responded in this way in 2016 and 31 percent in 2010.

SOCIAL MOBILITY

Social mobility in England is stuck. This is partly a result of stagnating wages, increases in poverty for some and increasing inequalities in wealth, as we have described. It is also a result of the profound and persistent socioeconomic inequalities in experiences in early years, education and the labour market. The OECD stated in 2018 that social mobility in the UK was "so frozen that it would take five generations for a poorer family in the UK to reach the average income". It found just under one-fifth of the children of low-income families go on to become high earners. Social mobility is even less likely to occur in many Northern cities and coastal towns, due to higher rates of unemployment and poverty, low incomes, lower rates of home ownership, and lower levels of educational attainment in these places. Education, housing, income, taxation and social protection policies have undermined, not supported, social mobility.

Recommendations for ensuring a healthy standard of living for all

- Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.
- Remove sanctions and reduce conditionalities in welfare payments.
- Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
- Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
- Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.

Create and develop healthy and sustainable places and communities

SUMMARY

- There are more areas of intense deprivation in the North, Midlands and in southern coastal towns than the rest of England.
- Government spending has decreased most in the most deprived places and cuts in services outside health and social care have hit more deprived communities hardest.
- The costs of housing have increased significantly, including social housing, impacting on all the other social determinants of health and pushing many people into poverty, homelessness and ill health.
- The number of non-decent houses has decreased, including in the private rental sector, but this sector still has high levels of cold, damp and poor conditions, including insecure tenures.
- Homelessness has increased significantly including more children in homeless families living in temporary accommodation.
- Health harm from climate change is increasing, and will likely affect more deprived communities most.

Empowering and sustaining communities was central to the 2010 Marmot Review, an overarching theme was to 'create an enabling society that maximises individual and community potential.' The Review described the importance of communities and places in shaping physical and mental health and wellbeing and described how inequalities among communities are related to inequalities in health. Since 2010 these community inequalities have, in many ways, widened.

COMMUNITIES AND PLACES FACING PARTICULAR HARDSHIP AND ADVERSITY

Since 2010, in many places levels of deprivation and exclusion have intensified and accumulated. Throughout England there are communities and places, that have been labelled as 'left behind' we call it ignored, where multiple forms of deprivation intersect and where deprivation has persisted for many years with little prospect of alleviation.

Over the last ten years, these deprived communities and areas have seen vital physical and community assets lost, resources and funding reduced, community and voluntary sector services diminished and public services cut, all of which may have damaged health and widened inequalities. Since 2009, net expenditure per person in local authorities in the 10 percent most deprived areas fell by 31 percent, compared to a 16 decrease in the least deprived areas. In the North East spending per person fell by 30 percent, compared to cuts of 15 percent in the South West. Neighbourhoods in the North of England, the Midlands, the North West, Teesside and the East Midlands make up the majority of neighbourhoods dealing with the largest cuts.

AIR QUALITY

Air quality and related health risks have emerged as a major equity issue since 2010. Pollution levels are, on average, worse in areas of highest deprivation compared with areas of lowest deprivation. In 2016 the Chief Medical Officer's annual report was based on the risks of air pollution and described worse impacts for deprived communities and places, showing these places had 'a higher exposure to air pollution and a greater burden of poor health increasing susceptibility to the impact of pollution'.

BUILT ENVIRONMENT AND TRANSPORT

Many measures of environmental quality highlight that conditions are worse in more deprived areas, and these measures show a gradient – the more deprived the area the worse the conditions, including quality of high streets. The unhealthiest high streets are likely to be located in more deprived areas; and have the highest number of fast food outlets, betting shops, more littering and fouling, noise and air pollution, unhealthy retail outlets, crime and fear of crime and road traffic accidents.

The government's prioritisation of road and train travel over buses has widened inequalities in access to essential services, employment and social interactions. Current travel policies benefit those on higher incomes, as those on lower incomes tend to travel more on buses. Between 2010 and 2017 funding for bus travel reduced by 45 percent.

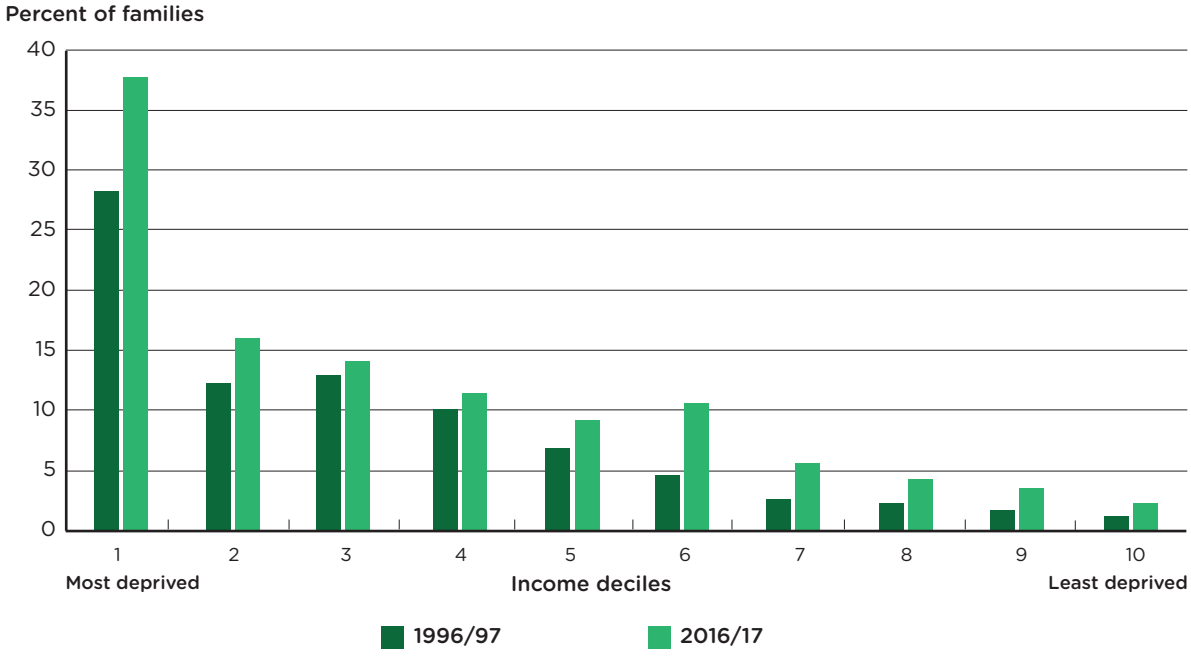
One quarter of the UK's greenhouse gas emissions come from transport and road transport is the largest contributor to poor air quality. In 2016 the Government set the target to double cycling rates and increase the number of children (aged 5-10) walking to school by six percent. However, between 2010 and 2018 the percentage of children in England (aged 5-16 years) who walked to school has not changed, while the number who cycle to school increased by one percent. More positively active travel for adults has increased but inequalities have widened. There was a 5 percent increase in walking trips per year for those on the lowest incomes and 14 percent increase for those on the highest incomes between 2010 and 2018.

HOUSING

Poor quality housing, particularly damp and cold homes, directly harm physical and mental health and poor housing conditions continue to harm health in England and widen health inequalities. Unaffordable housing also damages health, 21 percent of adults in England said a housing issue had negatively impacted their mental health, even when they had no previous mental health issues, and housing affordability was most frequently stated as the reason. The stress levels resulting from falling into arrears with housing payments are comparable to unemployment.

Housing costs have significantly increased in England since 2010 and the impacts are clearly higher for lower income families, described in Figure 10. The cost of social renting in England increased by 40 percent from 2008 to 2016 and one-third of households in the private rental sector fall into poverty as a result of their housing costs. As housing costs have increased, there is less to spend on other essentials such as food, clothing and transport; this, and the stress of trying to pay housing costs will have significantly worsened health for low income families.

Figure 10. Proportion of families spending more than a 1/3 of income on housing costs by income decile, 1996/97 and 2016/17



Source: Resolution Foundation (1)
Note: Housing costs and incomes net of housing benefit

The increasing costs of the private rental sector have not only led to increased arrears for renters, but also for record incomes for private landlords as a growing number of private renters receive Housing Benefit.

Housing conditions tend to be worst in the private rental sector, although there have been some improvements since 2010. Still in 2017/18 around 1.9 million private renters reported an issue with condensation, damp or mould in their home and many more keep silent about these condition as private landlords can evict tenants if they complain. In the West and East Midlands and Yorkshire and the Humber, more than one in five of homes fail to meet the decent homes standard.

Homelessness and rough sleeping rates have increased substantially since 2009-10. At the end of 2018, 83,700 households were homeless, including 124,490 children, a five percent increase on the end of 2017 and an increase of 74 percent since 2010. In 2016 the housing charity Shelter found one in three working families are a single paycheque away from homelessness. Rough sleeping has increased significantly since 2010, from approximately 1,700 to approximately 5,000 in 2017.

CLIMATE CHANGE

The 2010 Marmot Review labelled climate change as a fundamental threat to health and stated that mitigating climate change would also help mitigate health inequalities. The health risks arising from climate breakdown are now better understood. Climate change affects health and worsens inequalities; older people are at most risk of extremes of heat and cold; lower income groups are disproportionately impacted by extreme weather by virtue of living in poorer quality housing in vulnerable locations and conditions and tenants are more vulnerable than owner-occupiers as they have less ability to modify their homes and prepare for and to recover from climate events. In the UK close to 2 million people live in homes in areas of significant river, surface water or coastal flooding and people living in properties the UK's most deprived communities face higher increases in risk from flooding.

The UK has reduced its greenhouse gas emissions since 2010, and renewable energy now accounts for a higher proportion of energy generation. Measures to reduce greenhouse gas emissions must continue to be strengthened. Domestic emissions remain high – insulating housing has the twin benefits of reducing emissions and reducing cold and damp, improving health. However, programmes to insulate houses have been cut over the decade and active travel initiatives are not strong enough. In fact, budgets for cycling and walking have declined while road investment budgets increased

Recommendations for creating and sustaining healthy and sustainable places and communities.

- Invest in the development of economic, social and cultural resources in the most deprived communities
- 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector
- Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result

Conclusions

This '10 years on' report shows that, in England, health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining. The data that this report brings together also show that for almost of all the recommendations made in the original Marmot Review, the country has been moving in the wrong direction. In particular, lives for people towards the bottom of the social hierarchy have been made more difficult. Some of these difficulties have been the direct result of government policies, some have resulted from failure to counter adverse trends such as increased economic inequalities or market failures.

The purpose of the report is to show what can be done, in a spirit of social justice, to take action on the social determinants of health to reduce these avoidable health inequalities. It is not enough for the Government simply to declare that austerity is over. Actions are needed in all six domains set out in the 2010 Review to improve the lives people are able to lead and hence achieve a greater degree of health equity and better health and wellbeing for all; we set out new recommendations in five of these areas in this report, to account for profound changes in health and the social determinants since 2010.

The aim of all policies should be to level up, for everyone to enjoy the good health and wellbeing of those at the top of the social hierarchy – hence our reiteration of proportionate universalism: universalist policies with effort proportionate to need. We extend this to include investment – over the last decade government allocations of funding have declined most in poorer areas and this must be reversed. Funding should be allocated in a proportionate way – those areas that have lost the most and are more deprived must receive renewed investment first - and at higher levels.

We repeat: we neither desire nor can envisage a society without social and economic inequalities. The public thinks that inequalities have gone too far, and evidence suggests that the rising levels of health inequalities in England are avoidable. We welcome action from local and regional governments to tackle social determinants of health. More action of the type we have described here will be necessary. It is not, though, a matter of action by either central government or local government: we need both and we need leadership. If we leave this for another 10 years, we risk losing a generation.

Our main recommendation is to the Prime Minister – to initiate an ambitious and world-leading health inequalities strategy and lead a Cabinet-level cross-departmental committee charged with its development and implementation. We suggest that the new strategy is highly visible to the public and that clear targets are set.

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HEALTH EQUITY IN ENGLAND:
THE MARMOT REVIEW 10 YEARS ON

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HEALTH AND WELLBEING BOARD

Work Programme 2019 - 2020

Date of meeting	Agenda item	Responsible
11 July 2019	NHS Long Term Plan	Anna Coles/Ross Jago
	Plymouth Plan	Rob Nelder
	Trauma Informed approach/network	Julie Frier/Shelly Shaw
3 October 2019	Director of Public Health Annual Report	Ruth Harrell
	Green Paper on Prevention	Ruth Harrell
	Health and Wellbeing Hubs	Ruth Harrell/Rachel Silcock
	Safeguarding Adults Board Annual Report	Andy Bickley
9 January 2020	Update from Safer Plymouth Partnership	Matt Garrett
	Oral Health Needs Assessment	Rob Nelder
	Mental Health Programme Board	Lin Walton/Livewell SW/Primary Care
	Plymouth as a Compassionate City	St Luke's
12 March 2020	Children and Young People's System	Alison Botham
	PAUSE	Jean Kelly/Emma Crowther
	Together for Childhood Update	Siobhan Wallace, Shelly Shaw (NSPCC)
	Marmot Report Update	Ruth Harrell
	COVID-19 Update	Ruth Harrell
Items to be scheduled	Impacts of Poor Housing on Health Progress update	Ruth Harrell
	Substance Misuse and Impacts on the City	
	Local Care Partnership – Progress Report	Craig McArdle/Anna Coles
	SEND Access	Judith Harwood
	Barnado's Care Journey Partnership	Jean Kelly, Nick Cook (Barnado's)
	Working Together Update	Judith Harwood
	Health Protection Report	Julie Frier

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