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Health and Wellbeing Board

Thursday, 28th January, 2021 at 9.30 am

This meeting will be held in a virtual format in accordance with The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panels Meetings) (England and Wales) Regulations 2020 ("the Regulations").

The Council will be live streaming its meetings.

This meeting can be viewed online from 9.30am on the 28 January 2021 at:
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Date of despatch of Agenda: Wednesday, 20 January 2021

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Gordon Oliver / James Townsend on (01635) 519486 / 01635 503605
e-mail: gordon.oliver1@westberks.gov.uk / james.townsend1@westberks.gov.uk

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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

To: Zahid Aziz (Thames Valley Police), Dr Bal Bahia (Berkshire West CCG), Councillor Dominic Boeck (Executive Portfolio: Children, Young People and Education), Councillor Graham Bridgman (Executive Portfolio: Deputy Leader and Adult Social Care), Councillor Lynne Doherty (WBC Leader of Council), Charlotte Hall (Corn Exchange Newbury), Dom Hardy (Royal Berkshire NHS Foundation Trust), Matthew Hensby (Sovereign Housing Association), Tessa Lindfield (Strategic Director for Public Health Berkshire), Councillor Steve Masters (Shadow Portfolio Holder (Green Party) for Health and Wellbeing), Gail Muirhead (RBFRS), Sean Murphy (Public Protection Manager), Meradin Peachey (Director of Public Health Berkshire West), Matthew Pearce (Service Director-Communities & Wellbeing), Garry Poulson (Volunteer Centre West Berkshire), Andrew Sharp (Healthwatch West Berkshire), Andy Sharp (Executive Director (People)), Reva Stewart (Berkshire Healthcare NHS Foundation Trust), Sarah Rayfield (Public Health Registrar, Public Health and Wellbeing), Councillor Martha Vickers (Shadow spokesperson for H&WB) and Councillor Howard Woollaston (Executive Portfolio: Public Health and Community Wellbeing)

Also to: Paul James, Tess Ethelston (Group Executive (Cons)), Christine Elsasser (Group Executive (Lib Dem)), Gordon Oliver (Corporate Policy Support), James Townsend (Policy Officer- Executive Support), John Underwood (Communications and Engagement Lead), Nicky Lloyd (Chief Executive- RBFT), Andrew Stratham (Director of Strategy and Transformation- RBFT), Sally Moore (Head of Communications- RBFT) and Laura Vicinanza (Alzheimer's Society)

Agenda

Part I

		Page No.
1	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	
2	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 24 September 2020.	7 - 18
3	**Health and Wellbeing Board Forward Plan** An opportunity for Board Members to suggest items to go on to the Forward Plan.	19 - 20
4	**Actions arising from previous meeting(s)** To consider outstanding actions from previous meeting(s).	21 - 22

5 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

The following are considered to be standing declarations applicable to all Health & Wellbeing Board meetings:

- Dr Bal Bahia – General Practitioner at Burdwood Surgery, Non-Executive Director of Royal Berkshire Hospital NHS Foundation Trust
- Councillor Graham Bridgman – Governor of Royal Berkshire Hospital NHS Foundation Trust, and Governor of Berkshire Healthcare NHS Foundation Trust
- Andrew Sharp – Chair of Trustees for West Berks Rapid Response Cars

6 **Public Questions** 23 - 24
Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.

The list of public questions is shown under item 6 in the agenda pack.

7 **Petitions**
Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

Items for Discussion

Strategic Matters

8 **Royal Berkshire Hospital Redevelopment** 25 - 26
To receive an update from Royal Berkshire NHS Foundation Trust on development of its proposals for a major modernisation of its services and buildings.

9 **Alzheimer's Society Report - From Diagnosis to End of Life** 27 - 46

To receive a presentation looking at what local authorities can do to enable people with dementia to live well with the condition at each stage of the dementia pathway.

10 **Cultural Heritage Strategy** 47 - 106
To present the adopted Strategy and invite the Board to support the delivery of its aims and objectives and oversee its implementation in line with the governance arrangements agreed by Executive.

11 **Joint Health and Wellbeing Strategy** 107 - 148
To receive an update on progress in developing the draft Joint Health and Wellbeing Strategy.

Operational Matters

12 **Local Outbreak Control Plan (Verbal Report)** Verbal Report

To receive an update on the COVID situation in West Berkshire and measures put in place to manage local outbreaks.

13 **Tackling Health Inequalities** 149 - 234
To provide a summary of the Institute of Health Equity report: "Build Back Fairer: The COVID-19 Marmot Review" and consider how this could be applied in West Berkshire

14 **Integrated Care Partnership Update (Verbal Report)** Verbal Report

To provide an update on the work of the ICP and its Transformation Programme.

Other Information not for discussion

15 **Members' Question(s)** 235 - 236
Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.

The list of Member questions is shown under item 15 in the agenda pack.

16 **Future meeting dates**

From 2021/22, the Health and Wellbeing Board will move to five public meetings per year. The dates are shown below:

- 20 May 2021
- 22 July 2021
- 30 September 2021
- 09 December 2021
- 17 February 2021

All meetings will start at 09:30.

Sarah Clarke
Service Director: Strategy and Governance

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

WestBerkshire
COUNCIL

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 24 SEPTEMBER 2020

Present: Dr Bal Bahia (Berkshire West CCG), Councillor Graham Bridgman (Executive Portfolio: Deputy Leadeer and Adult Social Care), Sam Burrows (Berkshire West CCG), Councillor Lynne Doherty (WBC Leader of Council), Matthew Hensby (Sovereign Housing Association), Councillor Steve Masters (Shadow Portfolio Holder (Green Party) for Health and Wellbeing), Matthew Pearce (Head of Public Health and Wellbeing), Garry Poulson (Volunteer Centre West Berkshire), Andrew Sharp (Healthwatch West Berkshire), Andy Sharp (Executive Director (People)), Reva Stewart (Berkshire Healthcare NHS Foundation Trust), Councillor Martha Vickers (Shadow spokesperson for H&WB) and Councillor Howard Woollaston (Executive Portfolio: Public Health and Community Wellbeing)

Also Present: Kamal Bahia (Patient and Public Engagement Group), Paul Coe (WBC- Service Director Adult Social Care), Gordon Oliver (Principal Policy Officer), Sarah Rayfield (Public Health Trainee) and James Townsend

Apologies for inability to attend the meeting: Councillor Dominic Boeck, Charlotte Hall, Dom Hardy and Gary Lugg

PART I

103 Apologies for Absence

Apologies were received from Councillor Dominic Boeck, Dom Hardy, Charlotte Hall and Gary Lugg.

104 Minutes

The Minutes of the meeting held on 21 May 2020 were approved as a true and correct record and signed by the Chairman.

105 Health and Wellbeing Board Forward Plan

Councillor Vickers asked for an update on work being done around health inequalities and the BAMER community.

Matt Pearce stated that tackling health inequalities was a priority, with immediate health inequalities from the pandemic being addressed by working with community groups / champions. He indicated that discussions with communities would inform the long-term strategy to tackle inequalities. He noted that tackling inequalities was a theme running through all activities and could not be tackled in isolation.

Councillor Doherty stated she was concerned there were no standing items on the forward plan relating to KPIs.

Action: Gordon Oliver to update the KPIs and circulate these to the board.

106 Actions Arising from Previous Meeting(s)

The actions arising from previous meetings were noted and updated as appropriate.

107 Declarations of Interest

Dr Bal Bahia, Councillor Graham Bridgman, Andrew Sharp and Councillor Martha Vickers declared an interest in Agenda Item 10 and Councillor Masters declared an interest in Item 11, but since their interests were personal or an other registrable interest, but not a disclosable pecuniary interest, they determined to remain to take part in the debate and vote on these matters.

108 Public Questions

A full transcription of the public and Member question and answer sessions are available from the following link: Transcription of Q&As.

(a) **Questions submitted to the Berkshire Healthcare NHS Foundation Trust by Mrs Paula Saunderson.**

Six questions standing in the name of Mrs Paula Saunderson on the subject of services for dementia patients would receive a written response from the Berkshire Healthcare NHS Foundation Trust.

(b) **Questions submitted to the Portfolio Holder for Public Health and Community Wellbeing by Mrs Lucy Brown**

A question standing in the name of Mrs Lucy Brown on the subject of the local response to the Covid-19 pandemic would receive a written response from the Executive Member for Public Health and Community Wellbeing.

(c) **Question submitted by Zoe Teather and Heather Wild to the Berkshire Healthcare NHS Foundation Trust**

A question standing in the name of Ms Zoe Teather and Ms Heather Wild on the subject of health services for new parents would receive a written response from the Berkshire Healthcare NHS Foundation Trust.

(d) **Question submitted by Zoe Teather and Heather Wild to the Berkshire West Clinical Commissioning Group**

A question standing in the name of Ms Zoe Teather and Ms Heather Wild on the subject of maternity mental health services would receive a written response from the Berkshire West Clinical Commissioning Group.

(e) **Question submitted by Mrs Carol Jackson-Doerge to the Berkshire Healthcare NHS Foundation Trust**

A question standing in the name of Mrs Carol Jackson-Doerge on the subject of improving outcomes for pregnant women from ethnic minority backgrounds during the Covid pandemic would receive a written response from the Berkshire Healthcare NHS Foundation Trust.

109 Petitions

There were no petitions presented to the Board.

110 Health and Wellbeing Sub-Group Activities

Councillor Woollaston asked the Board to note the updates of the sub-groups. He suggested that it was an opportunity to note the achievements of the sub-groups.

Dr Bal Bahia indicated that the Steering Group had thought this approach to be more useful than the usual dashboard, since the new strategy was not yet prepared.

Councillor Doherty stated she would like to see KPIs alongside the narrative.

Dr Bal Bahia stated that there had been no dramatic changes in the KPIs from the sub-groups.

111 Joint Health and Wellbeing Strategy

Sarah Rayfield introduced a report updating the Board on progress with the development of a Joint Health and Wellbeing Strategy for Berkshire West.

She noted that Phase 1 (Defining the Current State) was complete and they were currently nearing the end of Phase 2 (Prioritisation).

She explained that wide-ranging stakeholder engagement had been undertaken to identify potential priorities. A data exercise had also been completed to identify areas of population need that had not been highlighted through stakeholder engagement. Also, an online survey had been used to engage hard-to-reach / vulnerable groups.

She stated that a long-list of potential priorities had been identified and a series of workshops had been held to assess these with the intention of reducing them to three to five priorities for the final strategy. She confirmed that the next step was to look at inter-dependencies between potential priorities and ways to tackle more than one area at a time, as well as mapping out specific areas in more detail. She highlighted four emerging themes of:

- Empowerment and self-care
- Digital enablement
- Prevention
- Covid-19 recovery

She noted that there would be a comprehensive public engagement exercise taking place in October that would make use of a variety of media and techniques to gather feedback.

She stated that the development of the strategy had faced a number of challenges:

- Limited capacity within the team and the wider system.
- There were many new people in roles across the three local authorities, which had reduced corporate memory.
- The impact of the coronavirus pandemic.
- Difficulties in undertaking early public engagement as planned, but a wider piece of public engagement was being co-produced for later in the process.
- Difficulties with developing a ten year strategy which is fit for purpose in a post-Covid world, when the full impacts of the pandemic are not yet fully known. However, she noted that an early review after 1-2 years would ensure the strategy remained fit for purpose.

Given these challenges, it was recommended to extend the completion date for producing the strategy by a month to allow time for further public engagement.

Councillor Vickers asked if there were any figures on the numbers of people who had been engaged. She highlighted Berkshire Youth, and asked if the community hubs were being utilised, and if town and parish councils had been engaged. She also asked about the age profile of respondents and which groups had not been reached.

Sarah Rayfield stated that engagement was due to start in October. She confirmed that they would be engaging through the community hubs and town and parish / town councils to discuss priorities and get their insights into their local communities. She stated that responses would be closely monitored and profiled to inform changes to the engagement process.

Councillor Doherty noted that previous surveys had attracted a low response from young people. She suggested contacting Nikki Davies about the Peer Mentoring Network and how to engage young people in different ways.

Andrew Sharp commended the work that had been done in such challenging circumstances, but suggested that the strategy should be given more time if necessary. He stressed the need for the Board to get all of its partners involved. He suggested that the long-term implications of Covid were not yet understood and so more time would be useful.

Garry Poulson agreed with Andrew Sharp that the strategy needed more time to allow voluntary groups to properly engage with the process. He also stressed the importance of a 'call to action'.

RESOLVED that the report be noted.

112 Healthwatch Maternity Report

Michelle Paice, Alice Kunjappy-Clifton and Andrew Sharp introduced the Healthwatch report about Maternity Services in West Berkshire

They explained that their work followed on from the BOB STP maternity survey undertaken by the five local Healthwatch services, which highlighted the need for improvement in a number of key areas.

Healthwatch wanted to find out more about what women thought about their whole maternity experience. Their survey attracted around 200 responses.

Their report highlighted that West Berkshire mothers used three hospitals:

- Royal Berkshire Hospital in Reading (40%)
- Basingstoke Hospital (24%)
- Great Western Hospital in Swindon (28%)

Healthwatch recommended that future data on maternity services should come from all three hospitals.

They highlighted that only 35% of ante-natal care was provided by GP practices and that data from the three hospitals must be included to get a more representative picture.

They suggested that more work was required to explore if women wanted an alternative to giving birth in a hospital delivery suite.

They highlighted issues and variances between hospitals and across various aspects of maternity services. Particular issues were identified with women being able to make their own decision, and the quality of post-natal care.

Between 12 and 15% described their birth experience as 'poor' or 'traumatic'. Also, 34% of mothers said that they did not get the opportunity to speak to a health professional about their experience.

They explained that a West Berkshire Maternity Forum had been set up to enable women to share their childbirth experiences. The forum highlighted issues during Covid lockdown when many new mothers lost support from their families and friends, and lacked information about where to get help.

They highlighted inconsistencies between the hospital trusts around partners being allowed to visit and attend scans and births.

They also expressed concerns about the impact of Covid on health visitors, who were unable to perform their role normally and highlighted the mental and physical impacts of the pandemic on new mothers.

They summarised maternity care for West Berkshire women as being disjointed and inconsistent and stressed the need for continuity of care from ante-natal to post-natal care, and the need to work across NHS and local authority boundaries. They noted that women wanting home births could only book with Royal Berkshire Hospital.

They suggested that more work was needed to understand the birth experiences of minority groups, since they experienced additional risks and had been disproportionately affected by Covid.

They also suggested that maternity provision should be given greater priority in the District Needs Assessment, and pointed out that it was a priority of the NHS Long-Term Plan.

Healthwatch encouraged the Board to engage more with new mothers, learn from the report findings, and improve monitoring processes for all of the maternity hospitals.

Councillor Woollaston asked about the John Radcliffe Hospital. Michelle Paice indicated that only a very small number of respondents had used this hospital.

Action: Healthwatch to confirm John Radcliffe Hospital maternity figures for Councillor Woollaston.

Councillor Woollaston also asked about the number of survey responses.

Michelle Paice stated that there had been around 200 responses. Andrew Sharp stated this represented just over 10% of the births in West Berkshire.

Councillor Doherty agreed with the recommendation to look at all hospitals used by West Berkshire women. She stated that comments about emotional and physical support after birth focused solely on health professionals and did not take account of support in the wider community. She questioned a couple of the report findings. For example, during Covid-19 lockdown, she had been informed that every new mother was still getting new birth visits, which was in contrast to the report’s findings. Also she had talked to one new mother whose partner had been permitted to attend the birth and they had felt ‘safe and cocooned’ in the hospital, which again was at odds with the report’s findings.

Alice Kunjappy-Clifton stated that the information she had received was from the new mums’ Facebook group, and this had highlighted variations in the approaches adopted by individual hospitals. She also stated that changes had been made since the start of the pandemic, but there was a clear pattern both locally and nationally of more women birthing alone.

Councillor Masters thanked Healthwatch for the report and hoped that the Board would act on the recommendations. In relation to the inconsistencies raised, he suggested that this was inevitable. He noted that whilst there were a number of areas that were working well, some issues needed looking at.

Councillor Vickers also expressed her thanks for the report. She highlighted the addendum on health visiting. She noted that one new birth visit was provided, but suggested that this was not enough, and the traumatic post-natal period was when additional support was needed. She also noted that while peer support was good, a professional viewpoint was of paramount importance. She pointed to the priority of the first 1001 days as a key driver in this and noted that post-natal depression could have long-term impacts.

Councillor Doherty agreed and stated that the first visit was a screening visit to assess needs and determine if additional help was needed. She had been informed that additional visits were being made as necessary.

Michelle Paice commented that if could take up to 6 weeks for post-natal depression to appear.

Alice Kunjappy-Clifton indicated that there was still a communication gap and mums needed to be told how and where to access information.

Sam Burrows commended the report. He stated that he had experienced excellent post-natal care with all three of his children. He explained that his second child had been stillborn and they had experienced outstanding bereavement care, but he recognised that this was not always the case. He noted that the CCG too often looked solely within its boundaries and acknowledged that it should look beyond these for residents who use other hospitals. He indicated that there were some recommendations in the report that could be tackled quickly and stated that he had been working with Hampshire Hospital to improve continuity of care for West Berkshire residents. He concluded by highlighting the need to focus on fathers as well as mothers in post-natal care.

Dr Bal Bahia agreed with Sam Burrows on the need for a cross-boundary approach, given West Berkshire's proximity to a number of hospitals. He noted that some patients chose to switch hospitals if a previous birth experience was poor. He noted that his practice had always worked closely with midwives and health visitors and recognised the need for continuity of care that was flagged in the report. He welcomed the feedback provided by the report, but suggested that it was important to note that the report only reflected a small proportion of the overall number of births in West Berkshire. He also noted that at the start of the pandemic, hospitals were instructed to minimise visitors and partners being present, but this quickly changed to allow more flexibility. He also noted changes in primary care – midwives visited within 10 days, followed by a health visitor check, and an 8 week check to coincide with immunisations. However, he recognised that there may be cases where this did not happen as planned and welcomed the feedback highlighted in the report. In terms of cross-boundary working, he confirmed that a midwife from Basingstoke Hospital now held regular clinics at his surgery in Thatcham. He stated that previously it had been agreed that the Board should discuss exceptions (issues that were not being resolved), but this approach could change.

Matt Pearce thanked Healthwatch for the report and agreed the need to focus on the first 1000 days. He stated that 97% of mums had a new birth visit in Q1 and during Covid a feeding call was introduced. He also stated that Berkshire West were looking to recommission the 0-19 service and he undertook to incorporate the report's recommendations in the new contract.

Action: Public Health to consider the Healthwatch Maternity Report findings when recommissioning 0-19 services.

Councillor Bridgman asked for clarification on the time period of the births in the report. He asked if the 75 births at the Royal Berkshire Hospital took place over the 3 year period of the BOB survey. He also noted differences between the Healthwatch survey results and hospitals' own surveys and asked how these could be reconciled.

Andrew Sharp stated that 3 out of 10 mothers were not asked about their experiences, which was a problem, and he suggested that some of these would have responded to the Healthwatch survey, so there was not necessarily parity between the surveys.

Michelle Paice stated that the Healthwatch surveys covered births between January 2016 and December 2019.

Alice Kunjappy-Clifton noted that the Reading Maternity Voices survey results focused on patients in Reading and Wokingham with limited feedback from West Berkshire women.

Councillor Bridgman suggested that the survey responses did not account for 10% of births if taken over a three year period.

Andrew Sharp stressed that the important thing was to note the 500 women on the Facebook group who had provided feedback. He suggested that too much focus was placed on Royal Berkshire Hospital, with Reading Maternity Voices failing to talk to Basingstoke, Great Western or John Radcliffe Hospitals. He stated that the qualitative feedback in the report raised issues that needed urgent attention.

RESOLVED that:

- All future reports and data on maternity services presented to the West Berkshire Health and Wellbeing Board to include data on West Berkshire births at the Great Western Hospital and Basingstoke and North Hampshire Hospital in addition to Royal Berkshire Hospital.
- Any tracking data sets and data dashboards developed and used to evaluate quality of maternity services by West Berkshire Health and Wellbeing Board should include data on West Berkshire births at the Great Western Hospital and Basingstoke and North Hampshire Hospital, in addition to Royal Berkshire Hospital
- Data on all maternity services including during pregnancy, during birth and 10 days following birth are presented to the West Berkshire Health and Wellbeing Board on an annual basis including national and comparative area benchmarking.
- Postnatal care in particular is scrutinised and improved in whatever way possible, including setting up of postnatal classes to help women learn from each other and the involvement of voluntary and community groups, supported by health professionals, and that all discussions include Health Visitors, Midwives and Family Hubs.

113 Prevention Concordat for Better Mental Health

Rachel Johnson introduced a report that sought the Board's approval to sign up to the national Prevention Concordat for Better Mental Health.

She noted that this would demonstrate the Board's and its partners' shared commitment to prevent mental health problems and promote good mental health, which was important, since this should not just be the responsibility of Public Health.

Councillor Vickers stressed this was an important step in the current circumstances. She also highlighted the importance of childhood experiences and commented that health visitors used to do a 6-8 week questionnaire with new mothers about their mental health, which often highlighted issues that had not previously been detected. She asked if this could be reinstated.

Rachel Johnson commented that the action plan would address all different age groups to develop a life course approach to preventing mental health problems.

Councillor Doherty agreed the need for a cradle to grave solution, and asked if the National Concordat could incorporate some points that are more specific to West Berkshire, with a particular focus on young people.

Rachel Johnson suggested that this was something that could be woven through the work of all the Board's sub-groups and highlighted work already underway with young people.

Councillor Masters supported the Concordat, but wanted it to be more than a badge, and for it to be supported by action and adequate resources. He thanked Rachel Johnson for her work.

Matt Pearce agreed with Councillor Masters and noted that it was about securing a shared commitment. He also agreed with Councillor Doherty about the need for a cradle

to grave approach in tackling mental health issues. He emphasised that all of the Board's partners had a role to play in tackling mental health issues.

Dr Bal Bahia supported the report, and agreed the need for a cradle to grave solution. He asked who would lead on delivering the Concordat and over what footprint would it be delivered.

Matt Pearce confirmed that he was happy to continue as Chair of the Mental Health Action Group. He confirmed that the Concordat applied just to West Berkshire, but recognised that it needed to interface with work done at the Berkshire West level and understand what partners' roles would be.

RESOLVED that the Board formally adopt the Prevention Concordat for Better Mental Health.

114 Health and Wellbeing Board Membership

Gordon Oliver introduced a report that sought to confirm the current membership of the West Berkshire Health and Wellbeing Board and whether any changes to membership were required.

He invited the Board to consider the proposal to appoint Sean Murphy to the Health and Wellbeing Board as a Public Protection Partnership representative.

He asked the board to note the recent changes in the individuals attending Board meeting and highlighted the current vacant employer position. He also encouraged members to nominate substitutes to attend Board meetings where they were unable to do so.

Councillor Woollaston noted that it was good practice to keep membership under review and suggested that this be done annually or in between as needed.

Garry Poulson noted that the Corn Exchange represented the arts on the Board, but due to current circumstances, their attendance had been limited. He suggested that the Watermill Theatre could potentially share the role to represent the arts sector and attend when the other could not.

Councillor Bridgman suggested that members should be representative of a body or sector and suggested that membership should apply to the role rather than the person. He suggested that West Berkshire Council members should be the Portfolio Holders for Adult Social Care, Children Young People and Education, Health and Wellbeing, and the Leader, with opposition and minority group representatives and substitutes nominated.

Andrew Sharp agreed and suggested that Thatcham Research could be approached about being an employer representative.

Dr Bal Bahia stated that an employer member should represent the whole of West Berkshire. He stated that Vodafone had been approached previously, but the Board's activity was not particularly relevant to them. He suggested that it would be good to have a post for people to come into to talk about particular issues as required rather than attending every meeting.

Resolved that:

- Changes to the individuals attending Health and Wellbeing Board meetings be noted;
- The Watermill Theatre and the Corn Exchange be approached regarding sharing arts representation on the Board;
- Thatcham Research be approached about employer representation on the Board;

- Sean Murphy be appointed to Health and Wellbeing Board as a Public Protection Partnership representative;
- Members should nominate substitutes to attend Health and Wellbeing Board meetings where they are unable to do so.

115 Review of Health and Wellbeing Board Meetings

Gordon Oliver introduced a proposal to revise the meeting schedule for Health and Wellbeing Board, which would increase the annual number of public meetings from three to five, with no regular meetings to be held in private.

It was proposed that Board meetings would still be preceded by Steering Group meetings, to be held in private as they are now. The Steering Group meetings would be used to agree the agendas for Board meetings and to discuss operational issues.

It was also proposed to have two or three themed workshops each year and an annual conference, which would be opened up to members of the public.

He suggested that the proposed changes would make the board more effective and efficient, while making agendas more manageable and increasing opportunities for public engagement.

It was suggested that the changes come into force from 1 April 2021 so they could be integrated with other council meetings when meeting dates are agreed for the coming municipal year.

Councillor Doherty stated that private board meetings allowed for open and frank conversations with one another and it was perhaps wise to bring the LGA peer review back to review this. She suggested that there needed to be time between meetings for work to happen.

Dr Bahia stated that when the Board was formed, the private meetings were vital in order to facilitate frank and honest conversations. However, the Board had reached a stage of maturity and development that permitted meetings to be held in public. He noted that there was a greater emphasis on public involvement and co-production and applauded the Council for its ways of working. He acknowledged that he had the benefit of attending Steering Group meetings, so was more aware of work being delivered between meetings. He concluded by noting that the LGA Review had steered the Board towards more transparency in due course.

Nick Carter agreed with Dr Bahia. He suggested that if there was a need to have a conversation not in the public domain, this could be done via the Steering Group, but that he thought the board had reached a point where it could be confident about holding all of its meetings in public. He suggested that development work could be taken off-line if necessary.

Councillor Doherty stated that it may be wise to have a review in 6 to 9 months.

Nick Carter agreed with Councillor Doherty, but suggested that structural changes in the NHS needed to take place first.

Action: West Berkshire Council to arrange another Peer Review once structural change in the NHS are complete.

Councillor Vickers welcomed the proposal and suggested that meetings should be public unless there was a specific reason to have them in public. She noted that Part II items

would allow for matters to be discussed in private. She also suggested that the Board could be scrutinised by the Council's Overview and Scrutiny Management Commission.

Councillor Masters stated that he believed more regular and public meetings would be good for public accountability and transparency.

Andrew Sharp expressed his support for the proposed changes and suggested that it was good for public engagement. He noted the Homelessness Strategy Group was also moving to more public meetings.

Matt Pearce stated that a rapid review had been done previously against the Peer Review recommendations.

Councillor Woollaston noted that items taken to private meetings were being brought back to public meetings, which was inefficient.

RESOLVED that:

- The number of public meetings be increased from three to five per year with no regular meetings to be held in private;
- The revised meeting schedule be referred to the Council meeting on 3 December so the meetings can be integrated into West Berkshire Council's municipal calendar for 2021/22.

116 Recovery Strategy

Nick Carter introduced a report that set out the Recovery Strategy for West Berkshire, which was approved by the council's Executive in July. He stated that there was an action plan that was regular updated.

He explained that the council had a Recovery Group and there was also a Berkshire Recovery Group and a Thames Valley Recovery Group. In addition, he noted that recovery was being discussed by health partners.

He indicated that with the second wave of Covid recovery was progressing alongside response and that response activity could dominate in the coming months.

He noted that the ICP had been overseeing a health-focused recovery plan.

In terms of the economic impacts, he indicated that 21% of the workforce had been furloughed. He explained that work was progressing with the LEP on short and medium term economic recovery.

He highlighted the fact that schools were open again which was positive, but the long-term impacts of Covid on children and young people were not yet understood.

He suggested that there may be positive environmental impacts, particularly around promotion of active travel.

He noted that the Communications and Engagement Strategy would go to Executive for approval in October, which needed to be delivered in partnership with the Board.

He indicated that the council was looking at how it would work differently in future (e.g. increased home working).

Councillor Vickers asked if the Council were considering employing Covid-19 marshals to provide a visible presence, inform residents and challenge businesses where they do not follow safety requirements.

Nick Carter stated that Government's view was that local authorities should enforce regulations that applied to businesses, and the Police should carry out enforcement with

residents. He stated that no decision had been made about Covid marshals yet. He indicated that the army could be used to support the police, but not on the streets.

Matt Pearce stated that the Government was still considering what Covid marshals should do. He suggested that these would be prioritised in high-risk areas. He also highlighted Appendix 1 of the Strategy, which featured a life-course infographic which had been recognised nationally and cited as best practice by the LGA.

RESOLVED that the strategy be noted.

117 Housing Strategy

Gary Lugg was unable to attend the meeting so Councillor Woollaston asked members to note the report and the fact that the draft strategy had been published on 18 September. He highlighted that the public consultation would run until 1 November and encouraged members to provide feedback.

RESOLVED that the report be noted.

118 Health and Wellbeing Conference

Kamal Bahia introduced a report on the Health and Wellbeing Conference held on 11 September 2020.

She noted that there had been a good turnout, with a mix of member of the public and other stakeholders. She indicated that there had been good presentations from Garry Poulson, Matt Pearce and Nick Carter. These were followed by three workshops on Young People, Working Together and Volunteering. She stated that the presentation slides would be made publicly available.

She explained that feedback was being collected from delegates and that the Health and Wellbeing Engagement Group would be reviewing this to understand what had gone well and what should be done differently in future. She stated that there had been positive feedback about the conference being open to the public.

She asked if the Board was happy for the conference to remain as a public event and for the report to be shared with delegates.

Councillor Woollaston congratulated Kamal Bahia for organising such a successful event.

Councillor Vickers agreed that it had been a success and suggested that the strong attendance reflected public interest in health and wellbeing issues. She noted that the event had encouraged many new people to attend. She also indicated that she welcomed the informal atmosphere of the event.

RESOLVED that:

- the report be noted and
- future conferences should be held as public events.

119 Exclusion of Press and Public

RESOLVED that members of the press and public be excluded from the meeting for the under-mentioned item of business on the grounds that it involves the likely disclosure of exempt information as contained in Paragraphs(s) * of Part 1 of Schedule 12A of the Local Government Act 1972, as amended by the Local Government (Access to Information)(Variation) Order 2006. Rule 8.10.4 of the Constitution also refers.

120 Future meeting dates

The next public meetings of the Health and Wellbeing board would take place on 28 January 2021.

(The meeting commenced at 9.30 am and closed at 12.01 pm)

CHAIRMAN …………………………………………….

Date of Signature …………………………………………….

Health and Wellbeing Board Forward Plan 2020/21 (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

There is a fire alarm and lockdown alarm in the Council Chamber at 10am on Thursdays.

Item	Purpose	Action required by the H&WB	Date Agenda Published	Lead Officer/s	Those consulted
30 January 2020 - Board meeting					
11 February 2021 - Health and Wellbeing Workshop (Cancelled)					
25 March 2021 - Informal meeting					
Programme Management					
Delivery of Health & Wellbeing Strategy Q3	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	17/03/2020	Gordon Oliver	Health and Wellbeing Steering Group
Strategic Matters					
West of Berkshire Safeguarding Adults Partnership Board	Presentation of Annual Report for 2019/20	For information	17/03/2020	Councillor Teresa Bell	Health and Wellbeing Steering Group
Tier 4 support arrangements for young people	To present proposed changes involving the closure of the Willows House unit (9 bed service) which currently operates on an in-patient basis to be replaced by a community model.	For information and discussion	17/03/2020	Karen Cridland – Director of Children and Young People Services Berkshire Healthcare	Health and Wellbeing Steering Group
Domestic Abuse and Safe Accommodation Duty	To consider a report outlining proposals for how new duties around domestic abuse and provision of safe accommodation will be implemented	For information and discussion	17/03/2020	Jade Wilder, Community Coordinator, Prevention	Health and Wellbeing Steering Group
Joint Health and Wellbeing Strategy	Presentation of the draft Joint Health and Wellbeing Strategy	For information and discussion	17/03/2020	Sarah Rayfield	Health and Wellbeing Steering Group
Leisure Strategy	To present the adopted Leisure Strategy	For information and discussion	17/03/2020	Paul Anstey	Health and Wellbeing Steering Group
Housing Strategy	To present the Housing Strategy, which is due to be adopted in February 2021.	For information and discussion	17/03/2020	Gary Lugg	Health and Wellbeing Steering Group
Operational Matters					
Local Outbreak Control Plan	Updates on COVID in West Berkshire and measures put in place to manage local outbreaks	For information and discussion	17/03/2020	Matt Pearce	Health and Wellbeing Steering Group
COVID Recovery	Update on development and implementation of the Recovery Strategy	For information and discussion	17/03/2020	Nick Carter / Joseph Holmes	Health and Wellbeing Steering Group
ICP Transformation Programme	To provide an update on current activity	For information	17/03/2020	Andy Sharpe	Health and Wellbeing Steering Group
01 April 2021 - Health & Wellbeing Conference (To be rescheduled)					
20 May 2021 - Board meeting					
Programme Management					
Delivery of Health & Wellbeing Strategy - Q4	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	12/05/2020	Gordon Oliver	Health and Wellbeing Steering Group
Strategic Matters					
Joint Health and Wellbeing Strategy	Presentation of final document(?)	For decision	12/05/2020	Matt Pearce / Sarah Rayfield	Health and Wellbeing Steering Group
Voice of Disability	Report back on the recommendations made in relation to the Healthwatch VoD report	For information and discussion	12/05/2020	Andrew Sharp	Health and Wellbeing Steering Group
Operational Matters					
Local Outbreak Control Plan	Updates on COVID in West Berkshire and measures put in place to manage local outbreaks	For information and discussion	12/05/2020	Matt Pearce	Health and Wellbeing Steering Group
COVID Recovery	Update on development and implementation of the Recovery Strategy	For information and discussion	12/05/2020	Nick Carter / Joseph Holmes	Health and Wellbeing Steering Group

Tackling Health Inequalities	Update on work to tackle health inequalities in West Berkshire particularly for diverse communities	For information and discussion	12/05/2020	Matt Pearce	Health and Wellbeing Steering Group
ICP Transformation Programme	To provide an update on current activity	For information	12/05/2020	Andy Sharpe	Health and Wellbeing Steering Group
Review of Health and Wellbeing Board Sub-Groups	To consider options for the structure of the Health and Wellbeing Board Sub-Groups to reflect the priorities identified in the Joint Health & Wellbeing Strategy.	For decision	12/05/2020	Gordon Oliver	Health and Wellbeing Steering Group
Review of Terms of Reference	To consider how the terms of reference for the Health and Wellbeing Board and Steering Group should change to reflect the new Strategy.	For decision	12/05/2020	Gordon Oliver	Health and Wellbeing Steering Group

Actions arising from Previous Meetings of the Health and Wellbeing Board

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
140	30/01/2020	Future HWB agenda item - consider how to make better use of the resources available to improve the health and wellbeing of our communities and what more could be done in the future	Charlotte Hall	Corn Exchange Newbury	Health and Wellbeing Board Forward Plan	**Complete.** Integrated into the Cultural Heritage Strategy and will be delivered as part of the associated Delivery Plan.
143	30/01/2020	Contact Royal Berkshire Fire and Rescue Service regarding Steady steps referrals	Matt Pearce	WBC	Delivering the Health and Wellbeing Strategy Q2 2019/20	**Complete.** Public Health Team is in ongoing dialogue with RBFRS. Steady Steps classes are not being delivered during lockdown. The focus of the Ageing Well Task Group is currently on tackling wider issues such as social isolation. However, resources on falls prevention are still being circulated within information packs, and online exercise classes are being delivered to help keep older people active.
147	21/05/2020	Matt Pearce to liaise with Kamal Bahia regarding engaging communities and identifying priorities	Matt Pearce	WBC	COVID-19 Review	**Complete.** The Health and Wellbeing Conference was held on 11 September, with public and local stakeholders invited. Work is ongoing with Community United to engage with BAMER communities to identify issues and potential solutions. A comprehensive community engagement programme is being delivered to inform the Joint Health and Wellbeing Strategy, including events to engage with seldom heard groups. Kamal and Matt have briefly discussed how the work of the Health and Wellbeing Engagement Group and the Council's new Enabling and Engaging Communities will align. Further conversations will take place over the coming months
148	24/09/2020	Circulate KPI data to HWB members	Gordon Oliver	WBC	Health and Wellbeing Board Forward Plan	**Complete.** Included within papers for 26 November informal meeting.
149	24/09/2020	Healthwatch to send maternity statistics for John Radcliffe Hospital to Councillor Woollaston.	Andrew Sharp	Healthwatch West Berkshire	Healthwatch Maternity Report	**Complete.**
150	24/09/2020	Public Health to incorporate the recommendations from the Healthwatch Maternity Report when recommissioning 0-19 services.	Matt Pearce	WBC	Healthwatch Maternity Report	**Complete.** The report has been shared with the public health commissioners and they will consider the recommendations as part of the development of the new service specification.
151	24/09/2020	Contact Thatcham Research about becoming an employer representative on the Health and Wellbeing Board	Andrew Sharp	Healthwatch West Berkshire	Health and Wellbeing Board Membership	**Complete.** Initial approach made. Gordon Oliver to follow up.
152	24/09/2020	Liaise with Watermill Theatre and Corn Exchange over potential for shared membership of Health and Wellbeing Board.	Howard Woollaston	WBC	Health and Wellbeing Board Membership	
153	24/09/2020	Seek another peer review of Health and Wellbeing Board.	Howard Woollaston	WBC	Health and Wellbeing Board Meetings	**Deferred.** To be undertaken post-Covid.
154	24/09/2020	Move to five public meetings of Health and Wellbeing Board from April 2021	Gordon Oliver	WBC	Health and Wellbeing Board Meetings	**Complete.** The meeting schedule for 2020/21 was agreed at Full Council in December.
155	24/09/2020	Bring Communications Strategy to Health and Wellbeing Board	Nick Carter	WBC	Recovery Strategy	**Complete.** Taken to 26 November informal meeting.
156	26/11/2021	Make use of social media to undertake focused promotion to target groups	Sarah Rayfield	WBC	Joint Health and Wellbeing Strategy Update	**Complete**. Social media has been used to promote the survey and engage with key groups as part of developing the Joint Health and Wellbeing Strategy.

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Item 6:

Public Questions to be answered at the Health and Wellbeing Board meeting on 28 January 2021.

Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.

(a) Questions submitted to the Berkshire West Clinical Commissioning Group by Mrs Paula Saunderson:

1. *"How many patients* ***over 65*** *have a Diagnosis of Dementia (or Memory & Cognition)?"*
2. *"How many of these are deemed to now have Long-Term Care Needs?"*
3. *"How many of these are receiving funding for Long-Term Care from the NHS in the form of CHC (both types) and FNC – a figure for each type would be helpful and % if possible?"*
4. *"How many patients over 65 with a diagnosis of Dementia (or Memory & Cognition) are still resident in their own accommodation?"*
5. *"How many Family Carers are there looking after a Dementia Patient without the use of ASC or NHS funding?"*
6. *"Why is Long Term Dementia Care not considered as a Medical Condition like other Terminal Regressive Diseases (Cancer/Tumour etc) and badged as a Social Care need which is self-funded?"*
7. *"How many Dementia patients does Berks West CCG assist with End of Life funding (outside of hospital) and what amount of funding is this as a % of end of life care in total."*
8. *"Who within the NHS Governing bodies has a Duty of Care towards Family Dementia Carers?"*

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Royal Berkshire Hospital Redevelopment

Report being considered by:	Health and Wellbeing Board
On:	28 January 2021
Report Author:	John Underwood
Item for:	Information

1. Purpose of the Report

To provide an update from the Royal Berkshire Hospital on the Health Infrastructure Plan.

2. Recommendation(s)

For the presentation made by the Trust to be noted by Health and Wellbeing Board members.

3. How the Health and Wellbeing Board can help

The Trust will be providing a courtesy presentation to members regarding the redevelopment of the Royal Berkshire Hospital. We seek an ongoing, engaged relationship with the Health and Wellbeing Board, and wish to keep members updated throughout the process.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

Royal Berkshire NHS Foundation Trust is beginning a major modernisation of its services and its buildings. We have been developing this programme for some time and we can progress work now because the Department of Health & Social Care has allocated seed funding to the Royal Berkshire NHS Foundation Trust to develop a Strategic Outline Case for improved hospital facilities. Our dual objective is to develop and deliver outstanding NHS services that are fit for the future, and to play a greater part in the growth and development of our local economy.

5. Supporting Information

A presentation will be provided at the meeting. Information on the redevelopment project can be found at https://thefutureroyalberkshire.uk.engagementhq.com/

6. Options for Consideration

The Trust is in the process of developing an Outline Business Case (OBC) which will explore and assess our options for change at the hospital.

7. Proposal(s)

There are no proposals at this stage.

8. Conclusion(s)

We seek the views of the Health and Wellbeing Board today and on an ongoing basis.

9. Consultation and Engagement

We have engaged with over 5000 individuals and the following organisations:

Age Concern Newbury, Age UK – Berkshire, Area PPG Patient Panel, Berkshire Guide Dogs, Berkshire Vision, Boyes Turners Solicitors, CLASP – Wokingham Adult Learning Disability Group, Coffee Companion Close, Communities in Action, Communities United, Eight Bells Mental Health Charity, Ethics & Engagement Advisory Group for Thames Valley & Surrey, Healthwatch West Berkshire, Jacobs Jewellers, Learning Together, Medical Centre PPC, Newbury Soup Kitchen, Open for Hope, Oxford AHSN, Parenting Special Children, Patient Experience Oversight Group for Thames Valley and Milton Keynes,Reading Healthwatch, Reading Voluntary Association, Reading UK, ResPECT Steering Group, Sue Ryder Hospice, Suicide Prevention Forum, Toka labs, Vector, West Berkshire Council, West Berks Independent Living, West Berks Patient Panel, Wokingham and Bracknell Cancer Champions, Wokingham Cancer Support, Wokingham Borough Healthwatch, Wokingham Carers Service

10. Appendices

None

Background Papers:

None

Health and Wellbeing Priorities 2019/20 Supported:

☒ Give every child the best start in life
☒ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☒ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☒ Build a thriving and sustainable environment in which communities can flourish
☒ Help older people maintain a healthy, independent life for as long as possible

Officer details:

Name: *
Job Title: *
Tel No: *
E-mail Address: *

From diagnosis to end-of-life: the lived experiences of dementia care and support

Report being considered by:	Health and Wellbeing Board
On:	28 January 2021
Report Author:	Ella Robinson, Senior Policy Officer, Alzheimer's Society Kielan Arblaster, Policy Officer, Alzheimer's Society
Item for:	Discussion

1. Purpose of the Report

1.1 The report, from Alzheimer's Society, aims to shine a light on the inconsistent provision of high-quality, integrated care and support for people affected by dementia across England, from diagnosis to end of life.

1.2 It also has the objective to provide a roadmap for action to improve dementia care from pre-diagnosis to end of life, offering insight from people affected by dementia about what makes a good pathway and how meaningful change can be implemented by local decision-makers.

2. Recommendations

2.1 Alzheimer's Society recommends that the Health and Wellbeing Board notes the findings of the report and implements its recommendations to address the current care and support needs of people living with dementia and their carers in West Berkshire;

2.2 Alzheimer's Society also recommends that the Board considers how the Council can work with care homes and the NHS to improve care for people with dementia, including making provision for meaningful visits by key family and friends carers for patients in care homes.

3. How the Health and Wellbeing Board can help

In line with the current Joint Health and Wellbeing Strategy's priority aimed at ensuring early assessment of and good provision of care for those with dementia, the Health and Wellbeing Board can help address the issues raised by committing in its new Joint Health and Wellbeing Strategy to develop a dementia strategy that includes the recommendations for dementia care and support set out in the report.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

The report looks at the four stages of NHS England's Well Pathway for Dementia. It explores in detail what NICE and the Government say people in England should be receiving at each stage and benchmarks it against the experiences of people affected by dementia. The four stages of the NHS England's Well Pathway were used as a framework for structuring the report – Diagnosing Well, Supporting Well, Living Well and Dying Well. The aim was to show the discrepancy between what people living

with dementia are entitled to in terms of care and support at each stage of the pathway, and what people are actually receiving based on their own experiences.

5. Supporting Information

The report has highlighted that:

- People are struggling to access a timely and high-quality diagnosis, as well as get a subtype diagnosis.
- Access to post-diagnostic care and support, as well as access to dementia advisers and care coordinators is variable across the country.
- Access to coordinated, proactive and ongoing care and support is limited. There is variation in the provision of follow-up care and people with dementia reported inconsistent care plan reviews, which were not meaningful.
- Many people with dementia receive most of their support from their primary informal carer, but carers are struggling to access support services for their own wellbeing. This is a result of inconsistent needs assessments, as well as the quality of formal care acting as a deterrent to them seeking help.
- Many people living with dementia are struggling to access the appropriate care for their level of need within hospitals and care homes.
- Many people living with the condition struggle to access appropriate palliative and end of life support, which often exacerbates unnecessary hospital admissions.

6. Options for Consideration

The Health and Wellbeing Board can choose to implement the Alzheimer's Society report's recommendations in full or in part, or it can choose to continue with current provision of services. Alzheimer's Society's preferred option is to implement the recommendations in full as per the proposal below.

7. Proposals

7.1 Alzheimer's Society proposes that the Health and Wellbeing Board implements the following recommendations as set out in the report:

- To facilitate dementia diagnosis, formalise arrangements that enable multidisciplinary team meetings between memory service clinicians, neurology and neuroradiology.
- Memory services should have clear referral pathways to enable access to psychiatrists, psychologists, occupational therapists, social workers, dementia advisers, as well as linguists and interpreters during the diagnostic process.
- Memory services should all include dementia adviser services, with people automatically referred to the service unless they opt out. There must also be integration of dementia adviser services within primary care.

- All people with a dementia diagnosis should have a named care coordinator to support them to navigate the complexity of the health and care system and access the right professionals at the right time.

- Each Clinical Commissioning Group (CCG) should have a dedicated dementia lead with dedicated time to fulfil this role – this should ensure the roll-out of training to GPs on referral criteria and diagnosis, as well as personalised care and support planning

- Evidence-based, post-diagnostic support interventions should be provided for people with dementia and their carers. These must be appropriate and tailored, considering age, ethnicity, religion, gender and sexual orientation and should consider projected future population trends and needs.

- High quality support for carers should be provided, which includes straightforward methods of booking overnight care in advance, and accessible lists of recommended local respite care services identified by local authorities.

- Care homes should have enhanced access to professionals through local multidisciplinary teams, and all professionals should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework.

- Access to end of life care should be ensured by reviewing capacity and access to palliative care in care home settings, including an audit of training for care home staff as well as access to out-of-hours support.

8. Conclusion

Alzheimer's Society research concludes that people aren't consistently receiving support that enables them to live well. A recurring theme across all stages of the pathway is a sense of disjointed and fragmented care. This means that people are falling off the pathway after diagnosis, are unable to receive appropriate, proactive and ongoing post-diagnostic support, and they struggle to access early and effective palliative and end of life care.

9. Consultation and Engagement

9.1 The Health and Wellbeing Steering Group has been consulted on the report.

9.2 Alzheimer's Society gathered evidence for this report by:

- identifying and analysing national guidance and legislation relevant to the dementia pathway and using this as a benchmark against what people affected by dementia had told Alzheimer's Society about their own pathway.

- undertaking a thorough literature review of existing pathways, standards and datasets for people with dementia.

- running a series of focus groups with people affected by dementia from November 2018 to April 2019 to explore their experiences of care and support in England. In total, Alzheimer's Society engaged with nine focus groups, and spoke to over 75 people with dementia and carers of people with dementia.

- contacting a range of health and care professionals, including General Practitioners, geriatricians, nurse practitioners, occupational therapists, neurologists, psychiatrists and dementia advisers.

10. Appendices

Appendix A:
From diagnosis to end of life: The lived experiences of dementia care and support (Executive Summary) (The full version of the report is available online at: https://www.alzheimers.org.uk/sites/default/files/2020-10/pathway_report_full_final.pdf)

Background Papers:

None

Health and Wellbeing Priorities 2019/20 Supported:

☐ Give every child the best start in life
☐ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☐ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☐ Reduce premature mortality by helping people lead healthier lives
☐ Build a thriving and sustainable environment in which communities can flourish
☒ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by ensuring an early assessment of and good provision of care for those with dementia.

Officer details:

Name:	Ella Robinson
Job Title:	Senior Policy Officer, Alzheimer's Society
Tel No:	
E-mail Address:	ella.robinson@alzheimers.org.uk

From diagnosis to end of life:

The lived experiences of dementia care and support

Introduction

This is a short summary of Alzheimer's Society's report on the lived experiences of dementia care and support from diagnosis to end of life.

The report found that people with dementia are not consistently receiving good quality, integrated care and support that enables them to live well. While there is good practice happening in parts of the country, we heard many accounts of places where care is failing to provide what's needed.

We spoke with 75 people affected by dementia to understand their experiences of care and support from pre-diagnosis to end of life. We also spoke with a range of health and care professionals to identify the barriers to providing effective care. This evidence was benchmarked against what the National Institute for Health and Care Excellence (NICE) and the Government say people in England should receive, as well as the Dementia Statements, which reflect the things people with dementia have said are essential to their quality of life.

Our research revealed a range of issues facing people across the dementia pathway. It also identified actions that would create positive change, both locally and nationally, to improve care and support.

Key findings

The results of this research are presented according to four stages of NHS England's Well Pathway for Dementia:

- **Diagnosing Well**
- **Supporting Well**
- **Living Well**
- **Dying Well.**

While prevention is a critical part of the pathway, this report doesn't focus on Preventing Well.

'For us, there was no dementia pathway. Everywhere I turned for help, I felt like I was walking through candy floss – everywhere I turned I met a sticky end.'

Carer for a person with dementia

Diagnosing well

‘Because he didn’t have a formal diagnosis, they treated him like he didn’t have dementia at all.’

Carer for a person with dementia

Our research found that opportunities to identify dementia early are being missed. Due to difficulties identifying symptoms – for professionals as well as non-professionals – people are being misdiagnosed or facing unnecessary delays. GP training on referral criteria and diagnosis can also be a barrier to facilitating an early diagnosis, as can the short consultation time GPs can offer to patients. Success will require new ways of working within primary care to improve assessment of a person's cognitive, mental, physical and emotional wellbeing.

Dementia assessment tools may also have an impact on the timeliness of a diagnosis, as they can identify who needs referral for specialist assessment. It's important that appropriate tests are used to avoid misclassification due to biases, such as age, education and ethnicity. Professionals told us that diagnosing people from ethnic minorities can be challenging, due to people being concerned about shame and stigma and not viewing dementia as an illness. During assessments, challenges included language and a lack of familiarity with the concept of cognitive functions.

For people needing referral, processes can be confusing. People told us they felt daunted about 'what comes next' due to a lack of information. There must be a clear referral pathway between different providers, and written information to help address questions and concerns. Another issue is variation in the number of people being diagnosed and starting treatment within six weeks of referral. However, there's limited data on memory service performance, so assessment of variation currently relies on ad hoc audits. Regular audits of memory service data and performance would support the initiation of service improvement projects.

Key to facilitating a high quality and timely diagnosis are the appropriate staffing of memory services and good referral pathways. This must include occupational therapists to conduct functional assessments, which are important for non-English speaking communities. It must also include multidisciplinary meetings between memory service clinicians, neurology and neuroradiology to facilitate clinical case discussions.

'It's so daunting when you get that diagnosis and think "what's life going to be like now?"... It's getting that message across, to get out there – your life isn't over.'

Person living with dementia

The way a diagnosis is given has an impact on people's experiences. But we heard about diagnoses being given insensitively, focusing on what people can no longer do rather than what they can. People should also receive a subtype diagnosis (a diagnosis of which type of dementia they have). This should be accompanied by appropriate, tailored information to support the person to understand symptoms. A subtype diagnosis can affect future medication, care plans, interventions and opportunities to engage in, or benefit from, research. However, not all memory services can view brain scans, which is a barrier to diagnosing a subtype.

Hospitals and care homes also present opportunities to identify dementia. Systems must therefore be put in place within these settings to facilitate a diagnosis. People with advanced dementia living in care homes, as well as their families and staff, still benefit from a formal diagnosis. It enables them to access the appropriate care for their needs, and prompts staff to consider Mental Capacity Act issues where relevant.

Supporting well

This chapter looks at a person's immediate support needs, up to about a year after diagnosis.

Our research found that people can feel overwhelmed with information after receiving a diagnosis. To manage this, opportunities for follow-up discussions should be an integral part of the diagnostic process. Consideration must be given to how this support can be delivered, as often memory services are commissioned to provide a diagnostic service only.

Following a diagnosis, access to a care coordinator could significantly help people navigate the complexity of the health and social care system to get the right care and support. However, there's a lack of clarity around the role of a care coordinator – specifically who does it and what it involves. This means people may not know who their care coordinator is, and professionals may not know they are someone's named care coordinator. National guidance on this role is essential.

People told us that access to a dementia adviser-type service is also beneficial. It gives them a single identifiable point of contact with knowledge of, and direct access to, a range of available local services. However, more work needs to be done to consider availability. To support access, the service should be integrated within memory services and primary care.

Uncertainty over who should do what in dementia care is a key barrier preventing people from accessing the consistent care they need. This is clear when people with dementia who need medication follow a different pathway to those who don't need medication. The distinction between care plans that fall under the remit of a GP and care plans that fall under the remit of the local council can also be confusing. People with dementia will need to access a range of services and professionals, who will need to access the same care plan. However, people told us they have to explain their story multiple times to different professionals. Professionals told us they have to try to piece together disjointed information, which can lead to 'scattergun' referrals. There must be more integration of care and support plans between different services involved in a person's care.

Advance care planning is an integral part of the pathway. But there are mixed views on when these conversations should happen, and on whether professionals are trained and comfortable to have these conversations. As dementia is a progressive condition that affects mental capacity, there must be a more prominent role for advance care planning within post-diagnostic support. This should be accompanied by clear levels of responsibility outlined at a local level. These measures should ensure early, necessary and repeated conversations.

After a diagnosis, people should be offered post-diagnostic support interventions to help them maintain cognitive function, independence and wellbeing. However, immediate and ongoing access to this support can be variable. We also heard accounts of inappropriate interventions that weren't tailored to individual preferences. The provision of interventions must be reviewed and made more appropriate and tailored. They must consider age, ethnicity, gender and sexual orientation, and reflect the diversity of our society.

People should also have access to occupational therapists, who support functional ability and independent living. We heard positive stories of people feeling supported to improve their ability to carry out daily living tasks and other meaningful activities after accessing an occupational therapist. Other Allied Health Professionals (AHPs) can also offer rehabilitation, such as physiotherapists, dieticians, speech and language therapists and podiatrists. AHP leadership on dementia, and enhanced dementia awareness for AHPs, are critical to ensure people can access these therapeutic services but also realise the contribution they can make in developing supportive self-management strategies.

'Occupational therapists saved my life when I would have been happy to drink and eat myself to death.'

Person living with dementia

Living well

This chapter looks at the period following initial post-diagnostic support – we refer to this as around a year after diagnosis until end of life.

Our research found that people receive limited access to coordinated, proactive and ongoing care and support. Follow-up care, particularly from GPs, is not the same for everyone living with dementia, meaning some people are left to manage their own condition. Because dementia is a complex condition, people encounter a range of different services and professionals that can provide support for different symptoms. But the route of access to these services is also complex. A lack of ownership means that people are falling through the gaps and aren't receiving the support they need from the professionals they need it from. There must be more consistent support throughout the dementia pathway.

Annual care plan reviews are important. They assess whether people's needs have changed and what support is required. But these reviews aren't happening consistently, and they're not matching people's expectations of understanding how their dementia is progressing. Future service design should consider how primary care can be enabled to provide more appropriate and integrated care. Or it should consider where responsibility for dementia lies in terms of primary or secondary care.

Inconsistency of follow-up is shown by therapeutic interventions coming to an end. Within a dementia pathway, few non-pharmacological interventions are provided after the initial diagnosis, or they're harder for people to access once they've been discharged from the memory service. Initiating more opportunities within the pathway to access post-diagnostic support interventions, both for people with dementia and for carers, would help ensure that people who declined the initial offer, or are in crisis, can access these. People who are in crisis also need access to timely specialist input.

Many people receive most of their support from their primary informal carer. But carers are struggling to access support services due to inconsistent assessments of their needs. We also heard that many carers are left to research local respite care services themselves, and an accessible list of recommended places would be preferable. Formal support for people with dementia can also help non-professional carers to continue in their role. But having to pay for care and endure financial assessments can deter people from seeking support. Another deterrent is the lack of culturally appropriate care, which must be addressed by local authorities.

'I am constantly having to search for culturally appropriate carers, speak to the council, and get different healthcare professionals and services to speak to each other. It all became too much and I had what I would describe as a nervous breakdown.'

Carer for a person with dementia

While a person can live well with dementia, there will come a time where decisions about more advanced care need to be agreed. However, dementia care in hospitals and care homes can be variable. Within hospitals, there are issues with discharge processes and NHS Continuing Healthcare assessments. Within care homes, there must be access to clinical input to reduce unnecessary hospital admissions. This includes access to Allied Health Professionals who can transform health, care and wellbeing. All health and social care professionals involved in dementia care should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework.

Dying Well

Because there is much focus on living well, end of life care for people with dementia is often overlooked.

This is made worse by a lack of awareness that dementia is a terminal condition. People told us they struggled to access palliative care, including end of life care, because professionals told them that:

- the person isn't nearing the end of their life, they just have 'good days and bad days'
- Alzheimer's disease is a mental illness, not a physical condition (this is incorrect)
- it isn't their responsibility
- the person already has carers coming to the home
- there isn't enough funding.

‘In the 13 months from December 2017, when she was first identified for palliative needs, right up until her death, absolutely nothing was done to provide mum with the palliative care and support she required.’

Daughter of a person with dementia

People with advanced dementia who are nearing the end of life will have complex needs. They typically have a high level of symptoms, leading to frequent hospital admissions and in turn high health and social care costs. Some people with dementia are unable to communicate their symptoms, which can affect how far they are managed. Action should be taken to manage hospitalisations, such as better integration of services and the upskilling of care home staff. This should help ensure that people can access the right services for their needs.

To date, there’s been a strong policy focus on place of death. Preferred place of death is a commonly used quality marker. Care homes are key to reducing the number of people with dementia who die in hospital, so more must be done to improve comfort and quality at end of life within care homes. The number of people dying at home and in care homes is set to increase. There must be an expansion of capacity, and end of life care training for staff in care homes and in home care services, to sustain deaths outside of hospital.

Advance care planning enables people to plan ahead and can support healthcare professionals and families to carry out the wishes of a person at the end of their life. It’s essential that healthcare professionals providing care to dementia patients in the last stages of life have access to a person’s advance decisions. They must adhere to the wishes of the attorney with authority to act, if the person has one.

Conclusion and recommendations

Dementia causes complex cognitive and behavioural symptoms and is unpredictable by nature.

This means that the provision of appropriate care and support, across the entire dementia pathway, is also complex. This has led to significant variation in practice and a debilitating lack of ownership.

This report showcases the need to drive change, and builds the case for a streamlined dementia pathway. Local decision-makers, services and professionals are best placed to take ownership of developing dementia pathways. But these must be underpinned by clear roles and responsibilities at each stage. Consideration and implementation of the local recommendations should be coordinated through Integrated Care Systems where they're already in place.

The recommendations below provide a roadmap for action to improve dementia care, from pre-diagnosis to end of life. They offer insight from people affected by dementia about what makes a good pathway and how meaningful change can be implemented.

National recommendations

The Department of Health and Social Care should:

- work with NHS England and NHS Improvement to produce clear guidance on care coordination. This should include who can do it, what it involves and transition requirements if the care coordinator changes along the pathway. This should be supported by regular data collection and publication.
- review the NHS Continuing Healthcare process to ensure it is fit for purpose for people with dementia.
- clearly identify dementia as a terminal condition, and conduct a national review of capacity and access to palliative care in care home settings. This must include an audit of training for care home staff, as well as access to out-of-hours support.
- establish a National Dementia Observatory that brings together new and existing data. This must inform wider policy, research and implementation of high quality, effective and evidence-based care and support.

The Care Quality Commission should:

- include end of life as a separate entity for inspection within care homes. Evidence of access to palliative care and personalised care and support planning should be reviewed.

NHS England and NHS Improvement should:

- further recognise the growing challenge of dementia, which requires solutions from health and care. The revised NHS Long Term Plan must make further progress on dementia care quality and outcomes.
- develop and publish good practice guidance for the commissioning of dementia assessment, diagnosis and ongoing post-diagnostic support.
- ensure that all memory services have access to picture archiving and communication systems, so that memory services can view brain scans.
- ensure that people with dementia have a single digital health and care record that is accessible to all health and care professionals involved in their care. This must include advance care planning.
- publish regular, accurate memory service data, including memory service waiting times. It should also commission an annual national memory service audit to measure performance and initiate service improvement projects.
- add further indicators for dementia on the Quality and Outcomes Framework to include:
  - identification of a main carer and the number of carers offered annual access to relevant NICE-recommended carer interventions
  - the number of patients diagnosed with dementia given opportunities to participate in advance care planning discussions
  - the number of people with dementia added to the palliative care register, and who have been offered a personalised care planning discussion as a result.
- ensure that named clinical leads for care homes:
  - facilitate dementia assessment and diagnosis to ensure access to appropriate care within care home settings
  - identify people who need advance care planning.
- monitor and publish data on the implementation of the Enhanced Health in Care Homes model.

Local recommendations

While it's recognised that local pathways need some flexibility, there are considerations that must be factored into their development. These include:

- Each Clinical Commissioning Group (CCG) should have a dedicated dementia lead. They should be responsible for ensuring the delivery of training to GPs on referral criteria, diagnosis and personalised care and support planning. Leads must have dedicated time to fulfil this role.
- To facilitate dementia diagnosis, particularly complex cases, there must be formalised arrangements that enable multidisciplinary team meetings between memory service clinicians, neurology and neuroradiology.
- Memory services should have clear referral pathways to enable access to psychiatrists, psychologists, occupational therapists, social workers, dementia advisers, as well as linguists and interpreters during the diagnostic process.
- Memory services should all include dementia adviser services, with people automatically referred to the service unless they opt out. There must also be integration of dementia adviser services within primary care.
- All people with a dementia diagnosis should have a named care coordinator. For example, this could be allocated during the initial post-diagnostic support meeting with the memory service but could be reviewed within primary care.
- Evidence-based, post-diagnostic support interventions should be provided for people with dementia and their carers. These must be appropriate and tailored, considering age, ethnicity, religion, gender and sexual orientation.
- There should be clarity on where responsibility sits for the initiation of medicines and follow-up appointments for people with all types of dementia.
- People diagnosed with dementia should have access to follow-up opportunities to discuss their diagnosis and this should be embedded within the local pathway. For example, this could be delivered through follow-up within primary care by a GP, specialist nurse, dementia adviser, or through memory services. There must be opportunities to step up care when more support is needed.
- Memory services should consider accepting referrals from sources other than primary care, including social services and patients and carers themselves. This would support access to timely specialist input, especially in urgent or crisis situations.
- There should be support for carers, which includes providing straightforward methods of booking overnight care in advance, and accessible lists of recommended local respite care services identified by local authorities.
- Appropriate post-diagnostic support interventions and social care services should be provided to ensure language, communication or cultural needs are met. This should consider projected future population trends and needs.
- There should be ongoing opportunities for people with dementia and carers to access support following diagnosis.
- Local multidisciplinary teams should be formed to assist local care homes. These teams should include (but not be limited to) palliative care teams, Allied Health Professionals and wider support services such as dentistry.
- Every health and social care professional involved in dementia care should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework. This must be accompanied by protected training time, targets for numbers of staff trained and training standards being a part of inspections by regulators.

The report also highlights many examples of good practice from across the country, so that these can be learned from and adapted to local contexts. For these examples, and the evidence underpinning this summary, see the full report at **alzheimers.org.uk/diagnosis-end-of-life**

For more information contact Ella Robinson, Senior Policy Officer at Alzheimer's Society by emailing **policy@alzheimers.org.uk**

People affected by dementia need our support more than ever. With your help we can continue to provide the vital services, information and advice they need.

To make a regular donation please call us on **0330 333 0804** or go to alzheimers.org.uk/donate

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Cultural Heritage Strategy 2020-30

Report being considered by:	Health and Wellbeing Board
On:	28 January 2021
Report Author:	Paul James
Item for:	Discussion

1. Purpose of the Report

1.1 The Council's Executive approved the Cultural Heritage Strategy 2020-30 on 14th January 2021 with the recommendation:

- To set up the Cultural Heritage Strategy Delivery Group with key stakeholders and:
  - Develop the Delivery/Action Plan with specific actions, outcomes, measures and resources to deliver the vision and strategic themes - and seek approval of the Executive for the Plan within 6 months of the Group's inception.
  - To report on progress to the Health & Wellbeing Board and the Culture & Leisure Programme Board as required.
  - Review / refresh the strategy every 2 years to reflect progress and any changes required to deliver on the vision and objectives.

1.2 To present the strategy which has a strategic theme *to contribute to the improvement in the health and wellbeing of all our residents.*

2. Recommendation(s)

To support the Cultural Heritage Strategy 2020-30 and the delivery plan with particular regard to the strategic theme *to contribute to the improvement in the health and wellbeing of all our residents.*

3. How the Health and Wellbeing Board can help

3.1 To approve the plan to satisfy the governance arrangements agreed by the council's Executive.

3.2 To participate in the Delivery Group which will develop actions that require the allocation of resources.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

4.1 The purpose of the Cultural Heritage Strategy 2020-30 is to set out a strategic vision for West Berkshire - the council and key stakeholder organisations working together.

4.2 For the purposes of this strategy, we use the term **cultural heritage** to describe **t**he combined definitions that are used by, for example, Arts Council England, DCMS and Historic England. These encompass arts (performing arts, visual arts, digital arts, crafts), architecture, libraries, museums, galleries, broadcasting, film, the music industry and also the historic environment (landscapes, historic places, sites and built environments, as well as biodiversity, collections, past and continuing cultural practices).

4.3 Our Vision:

By 2030

- We will have a sustainable, resilient and thriving cultural heritage sector that supports creativity and innovation, continuing to make a significant contribution to the economy.
- The cultural heritage sector will have increased its contribution to the health and wellbeing of residents, and there will be improved access to cultural heritage and activities.
- We will have supported an increase in cultural education learning, training and career progression.
- Our unique cultural heritage and historic environment will have been protected and its significance promoted.

4.4 Strategic themes:

The strategy includes six strategic themes, each leading to associated high-level objectives. These have been arrived at through consultation with the public and stakeholders and take into consideration other key strategic documents including the West Berkshire Vision 2036, West Berkshire Council strategies for Leisure, Environment, Economic Development, Health and Wellbeing, and the Core Strategy Development Plan Document (Policy CS19: Historic Environment and Landscape Character), in conjunction with regional and national strategies and plans including Arts Council England, Historic England, NHS, and Visit Britain/Visit England.

6 Strategic themes	Objectives
Sustainability	Ensure our cultural and heritage organisations are sustainable and thrive. This is linked to Economic Development.
Health and Wellbeing	Contribute to the improvement in the health and wellbeing of all our residents.
Education, Training and Employment	Improve access to cultural education, training and employment opportunities.
Access	Improve access to cultural heritage and activities for all. Across all consultations there were many comments about the importance of access to culture and the heritage for all and this is now a strategic theme.

Historic Environment	Protect and promote our unique cultural history, heritage and historic environment.
Economic Development	Increase domestic and international tourism to generate income, investment and increase economic resilience. This is linked to sustainability.

4.5 The strategy is a key document alongside strategies for health and wellbeing, the environment, leisure and economic development.

4.6 The strategy draws on a wide range of information sources (local, regional and national data, policies, strategies and reports) which have been referenced, with the consultation responses, as the evidence base for the strategy.

4.7 In October/November 2019 the draft objectives were developed through consultation with stakeholders. A draft strategy was agreed by Operations Board in February 2020 for stakeholder and public consultations in April 2020. This was postponed to September/October 2020 due to the Covid-19 pandemic. This presented an opportunity to reflect on the impacts of Covid-19 on cultural heritage – organisations, practitioners – as well as communities. The consultation – with the public and a more detailed consultation with stakeholders – included questions about those impacts.

4.8 The consultations with the public and stakeholders (see list on Page 5) on the draft strategy showed strong support for the strategic themes and objectives.

4.9 Their responses to the impacts of Covid-19 highlight the existential threat to many cultural and heritage organisations of all sizes. Therefore, the strategic theme of 'Sustainability' is a higher priority than it was before the pandemic.

4.10 The need for access to culture and the heritage for all came across very strongly in the consultations and 'Access' has been added as a strategic theme in its own right, whereas previously it was included under Health and Wellbeing.

4.11 When the strategy is adopted by the council a Delivery Group with key stakeholders who have the relevant expertise will be formed to develop the Delivery/Action Plan for approval by the Council's Executive and oversee its delivery.

5. Supporting Information

5.1 **Stakeholder consultation results**. The stakeholder consultation was sent to 160 organisations, groups, individuals and businesses (see page 5). There were 71 responses. The survey asked 28 questions about them and/or their organisation, sought feedback on the proposed objectives and actions and included questions about the impacts of COVID-19 and their ability to secure funding support during the pandemic.

Stakeholder responses to the proposed objectives	Agree / Strongly Agree
Ensure our cultural and heritage organisations thrive and are as sustainable as possible	94.4%
Contribute to the improvement of the health and wellbeing of all our residents	93%
Improve access to cultural education, learning and employment	95.7%

<table>
<tr><td>Protect and promote our unique cultural history, heritage and environment</td><td>95.8%</td></tr>
<tr><td>Increase domestic and international tourism to generate income, investment and increase economic resilience</td><td>77.1%</td></tr>
<tr><td colspan="2">Across all consultations there were many comments about the importance of Access to culture and the heritage for all and this has been added as a new objective in its own right.</td></tr>
</table>

We also collected information about the possible actions required to deliver the strategy. The responses were positive about the actions we proposed and we collected information and proposals that will benefit the Delivery Plan.

93% of stakeholder respondents said they had been negatively affected by COVID-19. 75% of respondents said they were not eligible for financial support. Of those who were eligible 78.6% applied for financial support. We collected information about the negative effects and what funding sources they had applied for. One conclusion is that more could be done to co-ordinate grant funding advice, support and inward investment.

5.2 **Public consultation results.** There were 235 responses. The survey asked 26 questions designed to understand their attitudes/what they felt was important about culture and heritage (these link to the strategic themes and objectives); whether they participate in events/activities and what they participate in; how they find out about events activities and the impacts of COVID-19, including whether they participated in online activities during lockdown.

Public responses to questions linked to the strategic themes and objectives in the strategy	**Agree / Strongly Agree**
The arts and heritage makes a significant contribution to West Berkshire's economy; providing jobs and attracting people to the area to go to the theatre, museums and for holidays, spending money in West Berkshire.	76.5%
The arts are an important part of children and young people's education. Subjects such as English and Drama help children and young people to gain confidence, and skills such as improved communication and team working.	93.4%
Access to training, apprenticeships and higher education in the arts and heritage sector is important for improving the local economy and people's life chances.	82.9%
Everyone should have the opportunity to access the arts and heritage across West Berkshire regardless of where they live, age, income, health, and education.	95.9%
The arts and heritage make a contribution to the health and wellbeing of its residents, e.g. arts activities for people who would otherwise be socially isolated, music groups for people with dementia, arts groups for people with mental health and/or physical difficulties.	91.9%
A strong arts and heritage offer, e.g. theatre, museums, countryside, festivals, historic buildings, brings visitors and tourists to the area, which encourages spending.	88.6%

Statement	%
There should be more arts and heritage events to bring tourists and visitors to West Berkshire and help to increase people spending money in the area and help the local economy.	74.7%
We need more publicity and marketing to bring tourists and visitors to West Berkshire to enjoy its arts and heritage.	73.4%
It's easy to find out what is going on in terms of arts and heritage events, activities and opportunities in West Berkshire.	33.8%
Rural communities in West Berkshire have reasonable access to arts and heritage compared to urban communities.	16.9%
West Berkshire already has a strong arts and heritage offer, e.g. arts venues, festivals, events, activities, museums and places of historical interest to visit.	60.5%
A strong arts and heritage offer is an important part of why I choose to live and/or work in West Berkshire.	22%
Do you think there are enough organised arts and heritage activities in West Berkshire for people...	
With physical health conditions	15.8%
With mental health conditions	14.1%
Who are socially isolated	9.3%
Of all age groups	32.7%
31% of respondents participated in events/activities online during the Covid-19 Lockdown.	

Governance / Reporting / Delivery

5.3 A Delivery Group shall be set up with key stakeholders.

5.4 The Delivery Group to report to the Culture & Leisure Programme Board and the Health & Wellbeing Board.

5.5 The stakeholder survey asked respondents to provide information if they would like to be considered as a member of the board. 18 responded positively.

5.6 The Cultural Heritage Strategy Project Board propose that the membership of the Delivery Group shall be as follows:

- Chair: West Berkshire Council Executive Portfolio Holder: Public Health and Wellbeing, Leisure and Culture.
- West Berkshire Council elected member / Heritage Champion.
- 1 representative for arts venues/organisations.
- 1 representative for heritage organisations. Propose: the Chair of the West Berkshire Heritage Forum.
- 1 representative for the economy/tourism.
- 1 representative for community organisations. Propose: the Director of West Berkshire Volunteer Centre.
- 1 representative Town Councils. Possibly on an annual rotation.
- 1 representative Parish Councils. Possibly on an annual rotation. OR the senior WBC officer responsible for liaison with parish councils.
- The senior WBC officer responsible for Culture & Libraries.

The external representatives/stakeholders to have a deputy to cover in their absence.
The group shall invite council officers (for example, Health & Wellbeing, Education, Adult Social Care, Countryside, Leisure) and other stakeholders as required.

5.7 Terms of reference

- Develop the Delivery/Action Plan with specific actions, outcomes, measures and resources to deliver the vision and strategic themes - and seek approval of the Executive for the Plan within 6 months of its inception.
- To report on progress to the Health & Wellbeing Board and the Culture & Leisure Programme Board as required.
- Review / refresh the strategy every 2 years to reflect progress and any changes required to deliver on the vision and strategic themes.
- To report progress to residents via the media.

5.8 Selection of representatives of external organisations.

- The sectors represented by external organisations should be asked to propose their representative and deputy.
- To assist them we will provide the terms of reference and an outline person specification.

6. Options for Consideration

To not develop a Cultural Heritage Strategy for the district. This would mean that the many benefits of developing and delivering a strategy in partnership with key stakeholders would not be realised, leading to possible negative outcomes (for example, lack of inward investment) and missed opportunities to improve the cultural heritage offer for all in the district.

7. Proposal(s)

7.1 That the strategy be noted by the Health and Wellbeing Board.

7.2 To note that the Cultural Heritage Strategy Delivery Group with be set up with key stakeholders and they will report to the Health and Wellbeing Board and the Culture and Leisure Programme Board.

7.3 To note that the detailed Delivery/Action Plan will come to the Health and Wellbeing Board and the Council's Executive for agreement within 6 months of the inception of the Delivery Group.

8. Conclusion(s)

8.1 Culture and heritage touch everybody's lives and we are fortunate to have an abundance of arts, crafts, heritage and community organisations, tourism providers, events and activities and a wealth of beautiful and historic places and landscapes to enjoy in West Berkshire.

8.2 The strategy sets out strategic themes and objectives for the next ten years to make this cultural and heritage "offer" even better for residents and visitors and these can be delivered through strong partnership working with key stakeholder organisations. The Delivery Plan and actions shall be developed by the Delivery Group which

includes key stakeholders with the specialist knowledge, experience and networks to assist in driving this forwards.

8.3 We wish to thank the members of the public and stakeholders who participated in the consultations to develop the strategy. They clearly supported the vision and strategic themes. They also stressed the importance of 'access for all' to the cultural heritage. As a result 'Access' has been added as a strategic theme in its own right as well as being included in the objectives of other strategic themes. It was also clear that the Covid-19 pandemic has had a significant negative impact on our cultural and heritage organisations, and on the livelihoods of those working in the sector. Therefore, working together to increase inward investment in our cultural heritage is key to recovery.

9. Consultation and Engagement

9.1 The strategic objectives were developed in consultation with stakeholders in October/November 2019. The public and stakeholder consultations on the draft strategy were postponed due to Covid-19. This gave an opportunity to consider the impacts on the sector and the public. The draft strategy went out for consultation with the public and for more detailed consultation with stakeholders in September/October 2020.

9.2 This included the public, WBC members, WBC Heads of Service, WBC managers (Public Health, Education, Adult Social Care, Countryside, Planning, Libraries, Culture services, leisure, Economic Development), performing and visual arts organisations, arts centres, theatres, arts festivals, community arts groups, digital arts, film and video production, web and digital creatives; heritage, history and archaeology clubs, groups and societies, West Berks Heritage Forum; community groups and organisations (Volunteering, BAMER, stroke care, dementia, hearing impaired, sight impaired, physical and learning disabilities, Parkinson's disease, carers support, dementia, autism/aspergers, Healthwatch, Phoenix Resource Centre); Greenham Common Trust; Environment (Countryside Agency, Natural England, BBOWT, North Wessex Downs, Thatcham Nature Discovery Centre); Health & Well-Being Strategy Group; Housing Strategy Group; Economy and tourism (Tourism SE, Thames Valley LEP, Newbury Racecourse, Newbury Showground, Newbury BID, Hungerford Chamber of Commerce, Thames Valley Chamber of Commerce, Newbury West Berks EDC, Great West Way); Headteachers; Parish and town councils.

10. Appendices

Appendix A – The West Berkshire Cultural Heritage Strategy 2020-30

Background Papers:
None

Please put a cross in the appropriate box(es) by double-clicking on the box and selecting 'Checked':
Health and Wellbeing Priorities 2019/20 Supported:
☒ Give every child the best start in life
☐ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:
The proposals will help achieve the following Health and Wellbeing Strategy aim(s):
☒ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☒ Build a thriving and sustainable environment in which communities can flourish
☒ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by including a strategic theme to *Contribute to the improvement in the health and wellbeing of all our residents.*

Officer details:
Name: Paul James
Job Title: Culture and Libraries Manager, Communities and Wellbeing.
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Appendix A

Data Protection Impact Assessment – Stage One

The General Data Protection Regulations require a Data Protection Impact Assessment (DPIA) for certain projects that have a significant impact on the rights of data subjects.

Should you require additional guidance in completing this assessment, please refer to the Information Management Officer via dp@westberks.gov.uk

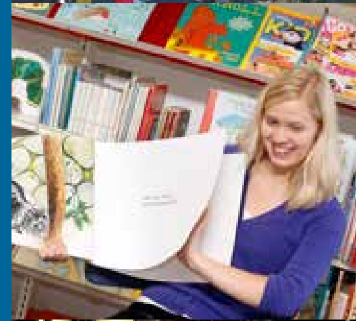
Directorate:	People
Service:	Communities and Wellbeing
Team:	Culture and Libraries
Lead Officer:	Paul James
Title of Project/System:	Cultural Heritage Strategy 2020-30
Date of Assessment:	15/01/2021

Do you need to do a Data Protection Impact Assessment (DPIA)?

	Yes	No
Will you be processing SENSITIVE or "special category" personal data? Note – sensitive personal data is described as "*data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation*"	☐	☒
Will you be processing data on a large scale? Note – Large scale might apply to the number of individuals affected OR the volume of data you are processing OR both	☐	☒
Will your project or system have a "social media" dimension? Note – will it have an interactive element which allows users to communicate directly with one another?	☒	☐
Will any decisions be automated? Note – does your system or process involve circumstances where an individual's input is "scored" or assessed without intervention/review/checking by a human being? Will there be any "profiling" of data subjects?	☐	☒
Will your project/system involve CCTV or monitoring of an area accessible to the public?	☐	☒
Will you be using the data you collect to match or cross-reference against another existing set of data?	☐	☒
Will you be using any novel, or technologically advanced systems or processes? Note – this could include biometrics, "internet of things" connectivity or anything that is currently not widely utilised	☐	☒

If you answer "Yes" to any of the above, you will probably need to complete Data Protection Impact Assessment - Stage Two. If you are unsure, please consult with the Information Management Officer before proceeding.

West Berkshire Cultural Heritage Strategy 2020-2030



West Berkshire
COUNCIL

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Cover images (top to bottom): The Corn Exchange | Shaw House outdoor theatre | Storytime at Newbury Library | Festival of Light, The Corn Exchange, photo Alex Harvey-Brown | The Hound of the Baskervilles in the Watermill Theatre Garden. photo Pamela Raith Photography| Interactive app at West Berkshire Museum

Foreword

Foreword by Councillor Howard Woollaston

Culture and heritage touch everybody's lives and we are fortunate to have an abundance of arts, heritage and community organisations, events and activities and a wealth of beautiful and historic places and landscapes to enjoy in West Berkshire.

Our vision is that by 2030 we will have a sustainable, resilient and thriving cultural heritage sector which continues to contribute to the local economy, increases its contribution to the health and wellbeing of residents (through improved access to cultural heritage and cultural education and learning) and that our precious historic environment is protected and better understood for the enjoyment of all.

Many thanks to the individuals and organisations who helped in the development of this strategy by taking the time to consider what is important and unique about the cultural heritage in West Berkshire, and what we can do together to make it even better.

The strategy will be delivered by The West Berkshire Cultural Heritage Strategy Delivery Group – a partnership between the council and key partners who have the knowledge, experience and networks to develop the right actions and ensure that progress is maintained to succeed in our vision.

Cllr Howard Woollaston,
Executive Portfolio Holder: Public Health & Community Wellbeing, Leisure and Culture

"Culture and heritage touch everybody's lives and we are fortunate to have an abundance of arts, heritage and community organisations, events and activities and a wealth of beautiful and historic places and landscapes to enjoy in West Berkshire."

“The strategy recognises the uniqueness of the area – its rural and urban communities, its heritage, historic buildings and landscape, the richness of the arts in all its forms”

Festival of Light 2019 presented by the Corn Exchange Newbury - Adam Hillier

Vision

By 2030 we will have a **sustainable, resilient and thriving** cultural heritage sector that **supports creativity and innovation, continuing to** make **a significant contribution to the economy.**

The cultural heritage sector will have **increased its contribution to the health and wellbeing of residents,** and there will be **improved access to cultural heritage and activities.**

We will have supported an **increase in cultural education learning, training and career progression.**

Our **unique cultural heritage and historic environment will have been protected** and its **significance promoted.**

This document contains six strategic themes, each leading to an associated high-level objective. These have been arrived at through consultation with the public and partners and take into consideration a number of key strategic documents including the West Berkshire Vision 2036[1], West Berkshire Council strategies for Leisure[2], Environment[3], Economic Development[4], Health and Wellbeing[5], and the Core Strategy Development Plan Document (Policy CS19: Historic Environment and Landscape Character)[6] in conjunction with regional and national strategies and plans including Arts Council England, Historic England, NHS, and Visit Britain/ Visit England.

These are:

- **Sustainability:** Ensure our cultural and heritage organisations are sustainable and thrive.
- **Economic Development:** Increase domestic and international tourism to generate income, investment and increase economic resilience.
- **Health and Wellbeing:** Contribute to the improvement in the health and wellbeing of all our residents.
- **Access:** Improve access to cultural heritage and activities.
- **Education, Training and Employment:** Improve access to cultural education, training and employment opportunities.
- **Heritage and the Historic Environment:** Protect and promote our unique cultural history, heritage and historic environment.

[1] https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0
[2] Draft Leisure Strategy – no link available
[3] https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0
[4] https://info.westberks.gov.uk/drafteds
[5] https://info.westberks.gov.uk/CHttpHandler.ashx?id=33954&p=0
[6] https://info.westberks.gov.uk/CHttpHandler.ashx?id=36373&p=0

Introduction

‘Each community has its own culture – its own history, museums and traditions. In this global, interconnected economy, what is local and unique has a special value and should be supported and encouraged’[7]

The term ‘Cultural Heritage’ means something different to all of us. It is a term which includes a broad and diverse range of creative, cultural and heritage professions, activities, buildings and landscapes.

For the purposes of this strategy and the accompanying Delivery Plan, when we refer to **cultural heritage**, we are using the combined definitions below (a. b. and c.) which are widely used when describing cultural heritage.

Where we use the term **arts and culture**, we are referring to the definitions a. and b. below*

a. In May 2007 the Department for Digital, Culture, Media & Sport (DCMS)[8] defined **arts and culture** as: Arts, Libraries, Museums, Galleries, Broadcasting, Film and the Music Industry, Architecture and the Historic Environment (landscape and built heritage).

b. The DCMS mapping document for the Creative Industries produced in 1998[9] defined the creative industries as: Advertising, Architecture, Crafts, Design, Fashion, Film, Music, Performing Arts, Publishing, TV, and Radio.

Where we use the term **heritage,** we are referring to the definition used by Historic England[10]

c. **Heritage** includes the natural as well as the cultural environment. It encompasses landscapes, historic places, sites and built environments, as well as biodiversity, collections, past and continuing cultural practices, knowledge and living experiences. It records and expresses the long processes of historic development, forming the essence of diverse national, regional, indigenous and local identities and is an integral part of modern life. It is a social dynamic reference point and positive instrument for growth and change. The particular heritage and collective memory of each locality or community is irreplaceable and an important foundation for development, both now and into the future.

Note: The National Endowment for Science and the Arts[11] has undertaken research into the inadequacy and ‘incompleteness’ of the DCMS definition and made recommendations for a more inclusive and accurate definition. As yet this has not been widely adopted, so for the purposes of this strategy we are using the DCMS 1998 listing.

[7]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/510798/DCMS_The_Culture_White_Paper__3_.pdf
[8]https://www.gov.uk/government/organisations/department-for-digital-culture-media-sport
[9]DCMS (1998) ‘Creative Industries Mapping Document 1998.’ D
[10]https://historicengland.org.uk/advice/hpg/hpr-definitions/#cat_H
[11]https://media.nesta.org.uk/documents/a_dynamic_mapping_of_the_creative_industries.pdf

Whilst individual understanding will vary according to personal perception and engagement with cultural heritage, the benefits to individuals, including wellbeing, the economy, personal and academic development are recognised and evidenced.

This strategy links with and delivers on the collective aims in the West Berkshire Vision 2036[12], and is therefore not a stand-alone document. This strategy outlines the high-level themes, objectives, aims and actions we have as a council for the district's cultural heritage sector through to 2030.

Covid-19 Pandemic

The Covid-19 pandemic has had a significant negative impact on the cultural heritage sector with 93% of responders to the stakeholder consultation stating they had been impacted.

Throughout 2020, many organisations and individuals, particularly freelancers, are struggling to survive economically. The resulting economic downturn presents challenges on a scale not encountered for decades. It is clear from the public and stakeholder consultation responses conducted for this strategy- and the previously unprecedented steps taken by for example, Arts Council England[13] and the National Lottery Heritage Fund[14] - that the cultural heritage sector is at a critical point.

This strategy aims to support the sector, and in so doing, the significant contribution it makes to people's health and wellbeing, the economy, education and training, improving people's access to cultural heritage and activities, whilst protecting what is one of West Berkshire's most valued assets- its historic environment.

There is evidence to show that cultural participation can contribute to social relationships, community cohesion, and/or make communities feel safer and stronger. Research has found positive links between cultural participation and improved social skills and engagement with the wider community, and evidence that culture can play a role in tackling crime[15].

Much of this strategy focusses on participation, whether that is for health and wellbeing, education, training, volunteering, for example: to help protect our scheduled monuments, or for pure enjoyment. The consultation feedback confirms that while there are a large number and range of events and activities in the district, some residents are unable to access these.

This strategy aims to improve access, creating more inclusive provision, so that as many residents as possible who wish to engage with our cultural heritage can do so.

[12]https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0
[13]https://www.artscouncil.org.uk/
[14]http://www.heritagefund.org.uk/
[15]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/416279/A_review_of_the_Social_Impacts_of_Culture_and_Sport.pdf

Strategy Delivery – A Phased Approach

The strategy will be delivered in phases. The Covid-19 pandemic had had a considerable negative impact and has shifted the focus of the earlier stages of its delivery. Support and economic recovery is a priority to continue to provide residents and visitors with a strong cultural heritage offer. Working across services within the council and with partners in all sectors- such as economic development, tourism, health and wellbeing, education and training, planning and the environment- is very important to encourage inward investment, fully utilise what we already have and protect and support the cultural heritage sector to ensure benefits are delivered to communities.

Partners: we will be looking to work collaboratively with public, private and community sector services and providers including extending our reach to include those not previously worked with. This will be alongside local organisations, charities and volunteers to deliver this strategy. This is key, as we want to engage with those with an interest in the cultural heritage of this district, and complement existing provision, adding value and opportunities.

Over the next 10 years this strategy will need to be adapted to reflect changes to local need, regional and national cultural heritage policies, strategies, and the wider context such as the impact of Covid-19 on health and wellbeing and the economy.

Now more than ever, it is crucial that we work closely and cooperatively partners to deliver focussed and targeted support, projects/programmes for the sector and communities of West Berkshire.

In developing this strategy it has become clear that we require more data regarding the cultural heritage sectors. This is important as we are reliant upon this to measure the current state of cultural heritage across the district, and to set meaningful targets to indicate progress. A method for regular data gathering and processing will be one of the actions in the first phase of the Delivery Plan.

Craft and Chat group at Newbury Library

Delivery Plan

Through consultation with partners it was apparent that the Delivery Plan will be more effective and deliverable if developed with a range of partners. This is due to the delivery of this strategy:

- covering a breadth of specialisms and they should be part of planning.
- being reliant on partnership working.
- requiring input from organisations/individuals who represent the diversity of the population of West Berkshire.
- requiring grassroots and strategic knowledge and thinking.
- so that it delivers the requirements of the sector.

We will form a Delivery Group to develop a Delivery Plan. This is a document which outlines the actions, projects/programmes to deliver this strategy, specifying timescale, partners and resources required. It will indicate links to other West Berkshire Council Strategies and Plans (i.e. Leisure, Economic Development, Health & Wellbeing, Environment), Key Performance Indicators and measures will be set accordingly.

"Over the next 10 years this strategy will need to be adapted to reflect changes to local need, regional and national cultural heritage policies, strategies, and the wider context such as the impact of Covid-19 on health and wellbeing and the economy."

Context and Strategy Themes

West Berkshire has a significant cultural heritage offer, with theatres, museums, festivals, visual arts, music, historic buildings and a beautiful landscape. This is combined with individual artists, makers, and creative professionals, small and medium enterprises (SME's), particularly film production and a developing digital/gaming sector. It is difficult to quantify exactly the number of community groups, societies and clubs, and those who give up their time to volunteer in the cultural heritage sector. However, through consultation with the public, and the development of this strategy, we can say with confidence that West Berkshire has a vibrant cultural heritage sector.

This is not to say that there are parts of West Berkshire which are not well served, a fact which has been supported through the results of the public consultation. Many have cited a lack of provision in rural areas and access to activities/performances in urban locations to be a barrier. Improving access for all is an important theme in this strategy and the accompanying delivery Plan.

In April 2019, Arts Council England with research conducted by Centre for Economics and Business Research (CEBR)[16] estimated the arts and culture (cultural heritage) industry contributed £10.8 billion a year to the UK economy (based on data from the Office of National Statistics), a growth of £390 million in a year.

Productivity in the arts and culture industry between 2009 and 2016 was greater than that of the economy, with gross value added per worker at £62,000 for arts and culture, compared to £46,800 for the wider UK economy.

Although we do not hold detailed accurate figures specifically for our district, given the profile of the arts, culture and heritage in West Berkshire we can reasonably state this district benefits economically from cultural heritage. Therefore, it is crucial we continue to support our organisations, small and medium enterprises (SME's), and individuals in the cultural heritage sectors. Given the impact of the Covid-19 pandemic this has never been more important.

The Hound of the Baskervilles in the Watermill Theatre Garden.
Pamela Raith Photography

[16]https://www.artscouncil.org.uk/sites/default/files/downloadfile/Economic%20impact%20of%20arts%20and%20culture%20on%20the%20national%20economy%20FINAL_0_0.PDF

Cultural heritage is not just about income generation. There is strong, growing evidence which indicates its importance to peoples' health and wellbeing. Through this strategy, we aim to strengthen partnership working, and continue to develop and increase the arts and heritage projects/programmes which provide a range of benefits to all. We will increase initiatives which specifically deliver on health and wellbeing, led and delivered by the district cultural heritage sector, with a specific focus on those identified in the West Berkshire Vision 2036[17].

West Berkshire has a range of heritage settings such as museums, historic houses, archives, heritage landscapes, residential areas and towns with historic buildings. There is strong evidence to suggest that creative and heritage related activity in a heritage environment, healthcare setting, day to day exposure to one or more of these settings, or volunteering in a heritage setting, have a range of benefits to people's health and wellbeing[18].

People across our district value our heritage. A recent report regarding public perceptions of heritage[19] published by the National Heritage Lottery Fund found the most important aspects of heritage with the highest levels of support are:

- museums/libraries/archives (83%).
- historic buildings/monuments (82%).
- land/natural heritage (81%).

Although these figures are for the UK, they echo those on a regional level and present a clear indication that residents consider our heritage to be of value.

[17]https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0
[18]https://www.whatworkswellbeing.org/theimpactofhistoricplacesandassetsoncommunitywellbeing
[19]https://www.heritagefund.org.uk/publications/public-perceptions-heritage

Strategic Themes

There are six strategic themes.

Sustainability and Economic Development should be considered as a joint priority and given their importance in terms of economic recovery from the Covid-19 pandemic are likely to require more urgent attention.

Without sustaining (Sustainability) our cultural heritage sector through, increased partnership working resulting in greater access to external funding, and generating new income streams through initiatives such as tourism, increasing visitor numbers and spend (Economic Development), we will be unable to deliver on other themes identified through consultation and outlined in this strategy. Much of West Berkshire's rich and diverse cultural heritage sector, a highly valuable asset, will diminish resulting in a loss of expertise, venues, and talent, all of which are central to the objectives and aims in this strategy, and those identified in other West Berkshire strategies such as West Berkshire Vision 2036.

The themes are interlinked with the need for residents to be able to access cultural heritage for the purposes of health and wellbeing, education and enjoyment. For example, our historic environment is a unique part of West Berkshire from listed buildings to the character of the landscape. Conserving and raising awareness of it for now and future generations is important.

"Our historic environment is a unique part of West Berkshire from listed buildings to the character of the landscape. Conserving and raising awareness of it for now and future generations is important."

Donnington Castle, photo courtesy of English Heritage.

Sustainability

The Covid-19 pandemic has shown that, for many, cultural heritage is key to their health and wellbeing. It provides a creative way of connecting with others, reducing social isolation, providing creative activities and new skills (either for the first time or rediscovery). More people are accessing local green spaces and going for walks in their towns and villages, therefore the historic environment has never been more important as a way of reducing the negative impacts of the virus on health and wellbeing.

Whilst this is a positive result, there has and continues to be a significant cost to the cultural heritage sector starting with the national lockdown, and the subsequent restrictions on public gatherings, performances, screenings and tourism of which the districts cultural heritage sector plays a role. With the roll-out of vaccines it is hoped that this will improve throughout 2021.

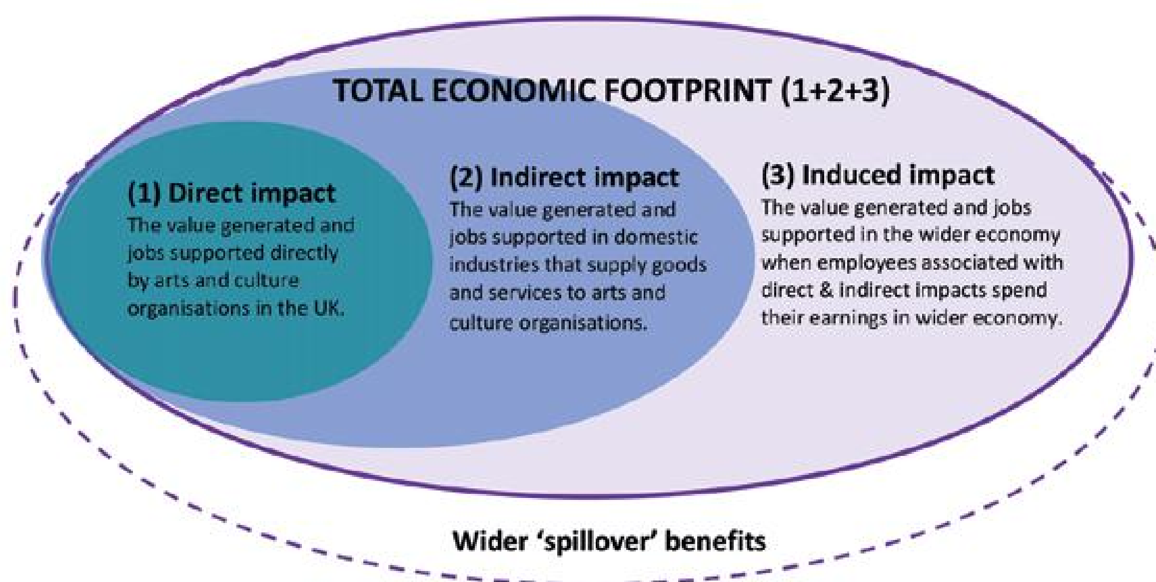
As already noted, a priority must be the survival of our cultural heritage sector. Whilst organisations such as the Corn Exchange (Newbury) Trust, Zippo Circus, Cirque Berserk Ltd have been successful in gaining a grant through the Arts Council England Cultural Recovery Fund[20], this only goes part way in supporting them and there is still much to be done. It should be taken into consideration that many organisations, small and medium enterprises (SME's) and individuals have been unable to access financial support. This was evidenced through the results of the stakeholder consultation with only 24.1% reporting they were eligible to apply for financial support, with the Coronavirus Job Retention Scheme being the second most applied for scheme (23.1 %); 'other' was cited as the first with responders choosing not to specify the source of support.

Economic Development and Sustainability are linked, and the promotion of the district's cultural heritage specifically in relation to tourism and income generation is one element of the strategic approach to supporting and increasing the economic resilience of the sector. Tourism requires a phased approach, with short, medium, and longer-term planning and delivery. This inward investment represents an opportunity for the cultural heritage sector, working with local businesses, tourism providers, and partners to develop and increase resilience over the course of this strategy.

One aspect of the economic development theme of this strategy, which was supported by results from the consultation with residents and partners, and is related to increasing visitor numbers to the district, is increasing public awareness of 'the wealth and diversity of cultural heritage activities, events and places across the district'. The extent and form this takes will be identified through partnership working in the development of the Delivery Plan. There are examples of how local authorities have successfully undertaken the branding and marketing of their districts/counties. These will be reviewed as part of the project planning process should this action be ratified.

[20]https://www.artscouncil.org.uk/funding/culture-recovery-fund-grants

The cultural heritage sector has a far-reaching impact on the economy, and to protect and support it, is to protect and support the wider economic ecology of the district.



Wider multiplier impacts of the arts and culture industry[21]:

Gross Value Added (GVA) measures the contribution to the economy of each individual producer, industry or sector. When indirect (supply chain) and induced (wider spending) effects are considered, it is estimated that the arts and culture industry (including both market and non-market elements) supported £48bn in turnover, £23bn in GVA, 363,713 jobs and £13.4bn in employee compensation in 2016.

This implies:

- For every £1 in turnover directly generated by the arts and culture industry, an additional £1.24 in output is supported in the wider economy through indirect and induced multipliers.
- For every £1 of GVA generated by the arts and culture industry, an additional £1.14 of GVA is supported in the wider economy through indirect and induced multipliers.
- For every 1 job directly created by the arts and culture industry, an additional 1.65 jobs are supported in the wider economy through indirect and induced multipliers.
- For every £1 in employee compensation paid to workers directly employed in the arts and culture industry, an additional £1.21 in employee compensation is supported in the wider economy through indirect and induced multipliers.

[21]https://www.artscouncil.org.uk/sites/default/files/download-file/Economic%20impact%20of%20arts%20and%20culture%20on%20the%20national%20economy%20FINAL_0_0.PDF

Source: ONS, Cebr analysis

The cultural heritage sector has a strong track record in partnership working. West Berkshire has the breadth and diversity of organisations, individuals and businesses to develop joint initiatives, and to undertake, where appropriate, increased cross sector strategic schemes. By doing so there is scope to attract inward investment and access external funding from a range of sources.

Examples include:

- Cultural heritage organisations working more collaboratively with Clinical Commissioning Groups, to lead, create and deliver targeted health and wellbeing programmes (i.e. Mental health, dementia) and the potential to trial arts and health initiatives to assist in recovery from Covid-19.

- Covid-19 has created an increased need for social prescribing as evidenced by The National Academy for Social Prescribing (NASP) being awarded £5 million in funding to support people to stay connected and maintain their health and wellbeing. The NASP will be working with, amongst others, Arts Council England and Natural England, to develop and deliver 'Covid-19 specific' initiatives.

- Cultural heritage organisations working with Leisure, and healthcare providers to develop and deliver creative health walks, facilitating access to our Area of Outstanding Natural Beauty and the historic environment combined with participation in creative activities (for example, painting and photography).

- Increased collaboration with higher education institutions (HEI's) provides opportunities for accessing funds both directing through universities and through grants (for example, the Arts and Humanities Research Council) and associated inward investment through business partnerships. HEI's can access funding often not available directly to the cultural heritage sector for 'non-academic' activities. However, through partnership working there is scope to create, trial and develop innovative cultural heritage projects.

In so doing we not only have the potential to develop high quality initiatives, maximise existing resources, we sustain the areas of cultural heritage sector, providing employment opportunities.

- Use of Community Infrastructure Levy (CIL)[22] is one way in which we can work with partners to raise funds from developers. Although, much of this capital is used to support new facilities it is possibl to bid for cultural heritage work and, or create opportunities for the inclusion of for example, public art within new developments as part of placemaking schemes. Whilst the forthcoming review of the planning system may impact on this it is worth including it in this strategy.

Summary of Sustainability Objectives, Aims and Actions

OBJECTIVES	**AIMS**	**ACTIONS** **To be developed by the Delivery Group**
Ensure our cultural and heritage organisations are as sustainable as possible and can thrive.	Provide support and increased economic resilience for organisations, small and medium enterprises (SME's) and individuals in the cultural heritage sector.	• Increase inward investment through joint initiatives and external funding. • Increase and develop joined up working between organisations and effective strategic partnership working.

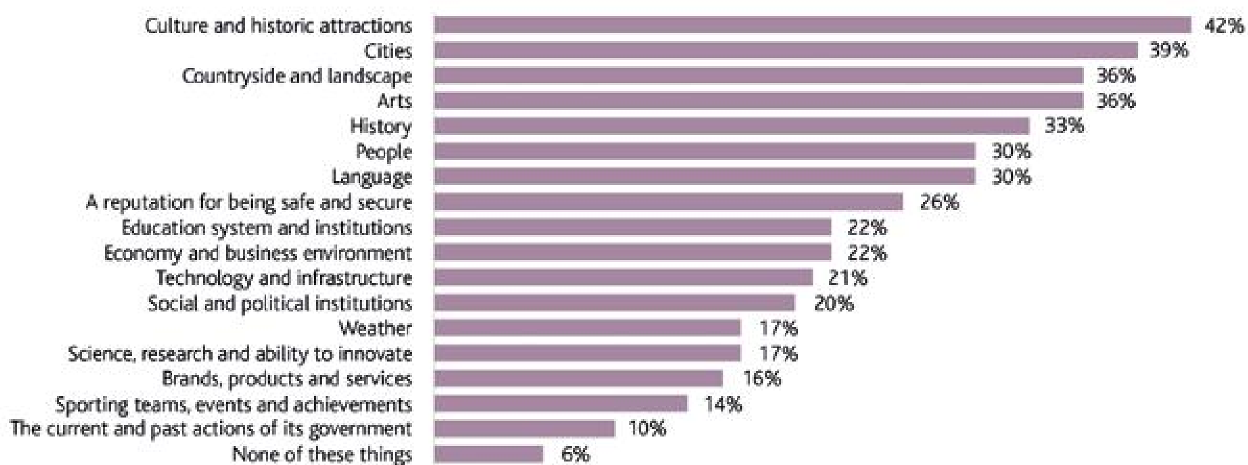
The Pheonix Rescource Centre

[22]https://historicengland.org.uk/research/heritage-counts/heritage-and-economy/

Economic Development

'Visitors don't make a culture and heritage distinction – they don't think "Oh I'm visiting a castle now which is heritage and a contemporary gallery now which is cultural". They just want to visit and be immersed in both the contemporary and historical culture of a place to feel that they understand and know it better[23].'

Research by the British Council shows that cultural attractions are the most commonly mentioned factor in terms of what makes the UK an attractive place to visit while the arts were the fourth most commonly mentioned reason[24].



Source: Department for Culture, Media & Sport The Culture White Paper

Heritage tourism accounts £2.0 billion per year[25] (2019) in the South East, with £7.6 billion being attributed to the arts and culture tourism across the UK (2011)[26].

Developing our tourism offer in relation to cultural heritage has the potential to generate income into the sector as a whole through visits to museums, historic houses, galleries, theatres, performances, festivals, and increasing secondary spend via for example, retail (for example, merchandise, work created by artists/ craftspersons), and food and drink.

44% of visitors to Britain are motivated by cultural attractions and the economic impact of cultural tourism is substantial – in 2016 alone, overseas visitors spent £889m on Museums and galleries in the UK[27].

There has been an increase in the demand for experiential tourism (engaging with local history and culture). The local cultural and heritage sector is well placed to offer a range of interesting, exciting and attractive experiences which generate income and raise the profile of what West Berkshire has to offer.

[23]https://englandscreativecoast.org/2017/12/01/cultural-tourism-why-bother/
[24]British Council https://www.britishcouncil.org/sites/default/files/as-others-see-us-report.pdf
[25]https://historicengland.org.uk/research/heritage-counts/heritage-and-economy/
[26]https://www.artscouncil.org.uk/sites/default/files/download-file/Value_arts_culture_evidence_review.pdf
[27]https://visitenglanddiscoverengland/summaryinsightsonoverseasvisitorstoenglandsregions/august2016

Whilst there is a need to protect our natural environment and control numbers which could negatively impact on the landscape, ecology and visitor experience (through crowded paths and increase noise levels, there is potential to attract visitors whilst managing numbers.

Cultural Heritage tourism not only generates income to the sector itself but has a positive impact on the economy through supporting local pubs, restaurants, hotels, B&B's, and retail. A strong economy is advantageous to the cultural heritage sector directly and indirectly. An example of this is Sussex Modern[28] which promotes the landscape, arts, culture, and vineyards of Sussex, providing visitors (both domestic and international) with information, trails, and 'packages' with visits to for example winemakers and/or galleries for an experiential trip including i.e. creative sessions, wine tasting and or dinner.

The Local Government Association refer to the 'pulling power' of arts and culture: visitors to a theatre, museum, or festival spend money on their ticket or entrance fee, meals in local restaurants, spending in local shops, or perhaps hotel bookings as part of their visit. The 500,000 visitors to the Hepworth Wakefield Museum during its first year contributed an estimated £10 million to the local economy in Wakefield and a recent economic impact of the Yorkshire Sculpture Park estimated its annual contribution to the local economy to be £5 million[29] (LGA, 2013).

Whilst international tourism is currently (2020) on the downturn due to the pandemic, it is hoped that during the life of this strategy the situation will improve. The pandemic has led to an increase in domestic tourism and West Berkshire is well placed to take advantage of this.

There is an increase in what is termed 'microgapping'[30] – experiential holidays for domestic holiday makers. Supported and marketed by Visit Britain. This is due to a number of factors including: Redundancies and reduced wages mean that people are no longer looking for long or expensive holidays, and the UK offers a more financially safe option[31].

Holidays within the UK are not only a financially safer option for most, but many people will find staying with the UK to be a less stressful option as there are less concerns about local health advice differing from home.

46% of trips within the UK in 2019 were to large towns and cities. This has now changed and it is likely that travel habits will change significantly in the short term due to people avoiding crowded spaces where you need to be in close quarters with other people, even when new vaccines are available for all[32].

Another consideration is climate change and the environmental impact of long-distance travel.

In the 25-49 age group, 30% say they would consider swapping a holiday abroad for one in the UK to reduce the impact of travel on the environment, a 2% increase over just 6 months[33].

[28]https://www.sussexmodern.org.uk
[29]https://www.artscouncil.org.uk/sites/default/files/download-file/Value_arts_culture_evidence_review.pdf
[30]https://trade.visitbritain.com/destination-uk/microgapping-uk/#page-2
[30]https://www.schofields.ltd.uk/staycations-uk-travel-2020-21/
[32]https://www.schofields.ltd.uk/staycations-uk-travel-2020-21/
[33]https://yougov.co.uk/

Visit Britain/Visit England[34] (a non-departmental body funded by the Department of Digital, Culture, Media and Sport) has, and continues to invest in tourism, with initiatives such as Discover England. Funding[35] worth £40m has been made available to develop new bookable English tourism products. Bookable products are something that can be booked by a visitor. Examples include, a vineyard tour, a visit to a castle, a behind the scenes experience. These 'products/experiences' are open to anyone wishing to book and are therefore available to domestic and international travellers. Cultural heritage organisations (and others such as breweries, wildlife and nature conservation, sporting) have benefitted from this funding and the wider opportunities it presents to generate income.

Examples of successful projects specifically relating to the cultural heritage sector, leading to increased footfall resulting in income generation, including those delivered across districts/counties include. England's Creative Coast[36] (funded by Visit England, Arts Council England Cultural Destinations Fund, South East LEP, and local authorities) builds on the success of Margate's Turner Contemporary Gallery which in its first year of trading was responsible for generating £13.9m across the Kent economy[37]. England's Creative Coast aims to grow the South East visitor economy by 3% by 2020[38] with a range of visitor 'attractions' and experiences, marketed in a coherent and targeted manner.

'When it comes to selecting a holiday destination culture and heritage was found to be an important element'
Source: HPI research, Leveraging Britain's Culture & Heritage.

In 2019 Reading was the 20th most visited destination by domestic tourists, with 237,000 visitors
Oxford was 9th with 581,000, with London ranked highest with 21,713,000[39].

Given West Berkshire's proximity, its cultural heritage and wider offer. It is feasible to suggest that through this strategy, this district can benefit from tourism, supported by inward investment through Visit Britain/Visit England, and related schemes, to generate income and increase resilience by expanding revenue streams.

'Visitors should be encouraged to take advantage of the brilliant things that West Berkshire has to offer.'
Local resident responding to public consultation.

Thatcham Festival

[34]https://www.visitbritain.org
[35]https://trade.visitbritain.com/destination-uk/discover-england-fund/
[36]https://www.englandscreativecoast.com
[37]https://www.artscouncil.org.uk/sites/default/files/infographics/Evidence_review_Infographic_March_2014.jpg
[38]https://englandscreativecoast.org/about/
[39]https://www.visitbritain.org/town-data

Source: Cebr, 2019b

Summary of Economic Development Objectives, Aims and Actions

OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group
Increase domestic and international tourism to generate income, investment and increase economic resilience.	Promote and raise awareness to potential visitors, of the wealth and diversity of culture and heritage. For example: historic buildings and landscapes, events and creative industries in the district.	• Develop partnerships and programmes across cultural, heritage, landscape and tourism sectors to create experiential tourism opportunities. • Increase public awareness of the wealth and diversity of cultural and heritage activities, events and places across the district. • Develop partnerships including with Destination Management Organisations, to create and promote experiential tourism opportunities and promote these to tourism providers. • Research and seek financial support from external funders / investors to develop tourism.

Health & Wellbeing

Cultural heritage has an important role to play in the health and wellbeing of people of all ages. Those who had attended a cultural place or event in the previous 12 months (pre-Corvid-19) were almost 60 per cent more likely to report good health compared to those who had not, and theatre-goers were almost 25 per cent more likely to report good health[40].

There is evidence which supports this both in terms of 'the prevention of mental and physical illness [and] enhancing quality of life from engagement with the arts[41].

There is also strong evidence on the benefits of arts engagement for cognition in older age, including memory, executive function, and that the arts can reduce physical decline in older adults, including improving gait, strength and balance[42].

Museums and heritage settings have an equally important part in creating and delivery initiatives for which there is strong evidence regarding the benefits to health and wellbeing. There are many examples. National Museums Liverpool run dementia friendly Memory Walks which not only increase physical exercise but elicit group reminiscence that becomes part of a shared cultural heritage with important implications for collective wellbeing[43].

Such sharing plays a vital role in place making and there are examples of where reminiscences have then formed part of a wider project to create plays, performed at local venues and aired on radio as is the case with a project in Oxford[44].

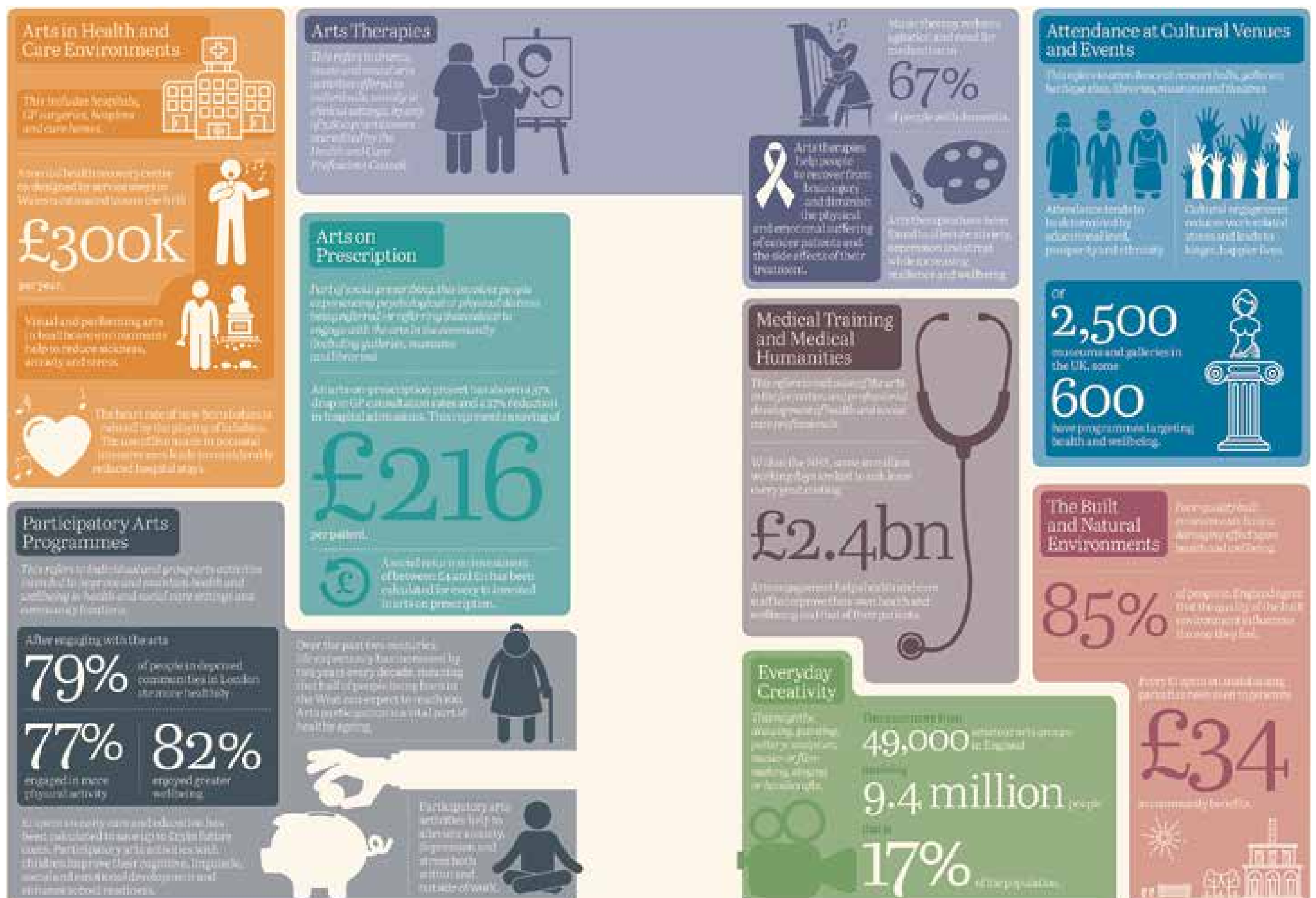
'I think the current pandemic has taught us all the importance of the arts in providing people with an outlet for their concerns. I am aware that, for example, music can be a great help for people with dementia.'
Local resident responding to public consultation.

Nationally, it has been estimated that there are approximately 255,000 young carers and 110,000 carers themselves over the age of 85. As noted in the 2014 NHS Five Year Forward View, 'the five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself[45].

[40]https://www.artscouncil.org.uk/exploring-value-arts-and-culture/value-arts-and-culture-people-and-society
[41]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918253/The_role_of_arts_in_improving_health_and_wellbeing.pdf
[42]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918253/The_role_of_arts_in_improving_health_and_wellbeing.pdf
[43]http://www.houseofmemories.co.uk/things-to-do/memorywalks
[44]http://www.artshealthandwellbeing.org.uk/case-studies/museum-oxford-morris-motors-centenary-reminiscence-project
[45]www.england.nhs.uk/wp-content/ uploads/2014/10/5yfv-web.pdf

‘Ongoing research is demonstrating that access to programmes which incorporate arts- and healthbased interventions leads to increased independence, improved self-esteem, confidence and resilience and allows individuals to build a peer support network.’[46]
Rebecca Johnson, Occupational Therapist and Clinical Lead, Breathe Arts Health Research (originally part of Guy’s and St Thomas’ Charity; now a social enterprise that designs and delivers arts-in-healthcare programmes).

Carers are often struggling financially, restricted as to where and when they can go out, and have limited time or energy to spend on themselves away from their caring duties. As a result their health is poor (87% of carers report poor mental health, 83% poor physical health), 91% report suffering from depression and anxiety, and they are often socially isolated[47]. Poor wellbeing in carers also has a knock-on effect on the people they care for, so there are real benefits in supporting carers. Museums, galleries and theatres are all well placed to support them through a range of activities designed specifically for target groups, or as is sometimes the case (for example: Birmingham Museums Creative Carers Programme) schemes to support carers and those they care for.



Source: Creative Health:The Arts for Health and Wellbeing.

[46]https://culturallearningalliance.org.uk/wp-content/uploads/2018/04/Arts-Health-and-Wellbeing-Briefing.pdf
[47]https://museumsandwellbeingalliance.files.wordpress.com/2018/04/museums-as-spaces-for-wellbeing-a-second-report.pdf

Social prescribing- the prescription of creative and cultural activities by health care professionals, and other referral services, to people experiencing anxiety, stress-related symptoms, depression or other mental and physical health problems[48] is now an established initiative with seven social prescribers working across the district.

This structured and targeted approach is proven to be an effective means of tackling a range of health and wellbeing difficulties. The cultural heritage sector is constantly creating and delivering programmes, successfully supporting patients, and alleviating pressure on other healthcare services. Our communities across the district, benefit from this provision and the pandemic has generated an increased need for social prescribing initiatives with a particular focus on for example, singing, movement and physical exercise and access to green spaces. Our cultural heritage sector is well placed to work in partnership with Berkshire West Clinical Commissioning Group (CCG) to respond.

When I first heard about the Social Prescribing Service, I immediately felt it would play an important part in delivering holistic care to my patients, and indeed it has[49]'
Dr Doon Lovett, who is based at Tilehurst Surgery.

Volunteers are a valuable asset to our cultural heritage organisations, many of whom could not function without them. However, there is also evidence that volunteering in cultural heritage settings has a range of positive effects on people's health and wellbeing. This includes reducing social isolation, improved cognitive function (i.e. learning new skills), with many experiencing a greater sense of safety in their day to day lives as they feel part of their community.

This feeds into the importance of our cultural heritage sector and the need to protect and support it, as outlined in the Sustainability strand of this strategy.

Culture and Connections' at Ripon Museum Trust is a supported volunteering programme organised on social prescribing lines with people of all ages with mental health issues such as social isolation, anxiety and lack of confidence. This is an example of how volunteer schemes can be developed in partnership with healthcare providers to increase positive health and wellbeing outcomes[50].

We know that our natural landscape is of great importance to the local community. West Berkshire benefits from having a range of open spaces including historic parks and gardens, and Areas of Outstanding Natural Beauty and Sites of Specific Scientific Interest. These are an important asset for local people to enjoy as a leisure activity, bringing benefits to health and wellbeing.

Accessible outdoor space is often referred to as 'Green Infrastructure' or 'GI'. Natural England, provides helpful information on the multiple benefits of effectively using and protecting the landscape/open spaces and we will seek to employ this as part of our Cultural Heritage Strategy and Delivery Plan, linking in with West Berkshire Leisure[51], and Environment[52] Strategies.

[48]https://www.artscouncil.org.uk/letscreate
[49]https://www.berkshirewestccg.nhs.uk/newsroom/news/posts/2019/2019/march/social-prescribing/
[50]www.riponmuseums.co.uk/events/special_projects/culture_and_connections_at_ripon_museums
[51]NOT CURRENTLY ON WBC WEBSITE SO NO LINK AVAILABLE
[52]https://info.westberks.gov.uk/CHttpHandler.ashx?id=49068&p=0

National surveys that monitor engagement in the natural environment[53] show that between 2009 and 2019 the majority of people are motivated to visit the natural environment for health and exercise, with the age group 16-34 the smallest (23.7%), over 55's (32.06%) and the largest participating age group being 35-54 (44.24%). Local residents who do spend time in the natural outdoors do so regularly, reporting either 'once a week' (21.94%), 'several times a week' (24.2%) or every day' (12.72%).

Greater numbers of people across different sectors of the population are now visiting the natural outdoors than ever before. With the pandemic and resulting 'lockdown' the desire to access the natural environment increased. Therefore, the need to work with colleagues in Leisure, and Countryside Service to increase access to our Areas of Outstanding Natural Beauty and historic landscapes, parks and gardens is important, as is appropriately maintaining and protecting these important areas.

Exposure to cultural heritage (for example landscape, historic buildings, performing, visual arts, museums) and, or participation in cultural heritage activities is beneficial to people's health and wellbeing.

For others, a more structured approach is required, and through this strategy we aim to work with partners to increase and develop existing provision, and create new initiatives with a particular focus on those identified in the West Berkshire Vision 2036[54].

Over 60% of respondents to the public consultation felt that the arts and heritage are important to health and wellbeing.

'It would be good to have more (cultural heritage activities) especially for people with dementia.'
Local resident responding to public consultation.

Summary of Health and Wellbeing Objectives, Aims and Actions

OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group.
Contribute to the improvement of the health and wellbeing of all our residents.	Develop the cultural and heritage sector to meet short, medium, and long-term needs of residents, taking a lifespan approach.	• Develop strategic partnerships. • Develop and deliver effective projects and programmes which meet health and wellbeing priorities as identified in council and health service strategic plans. • Increase access to culture and heritage for our rural and urban communities including children and young people.

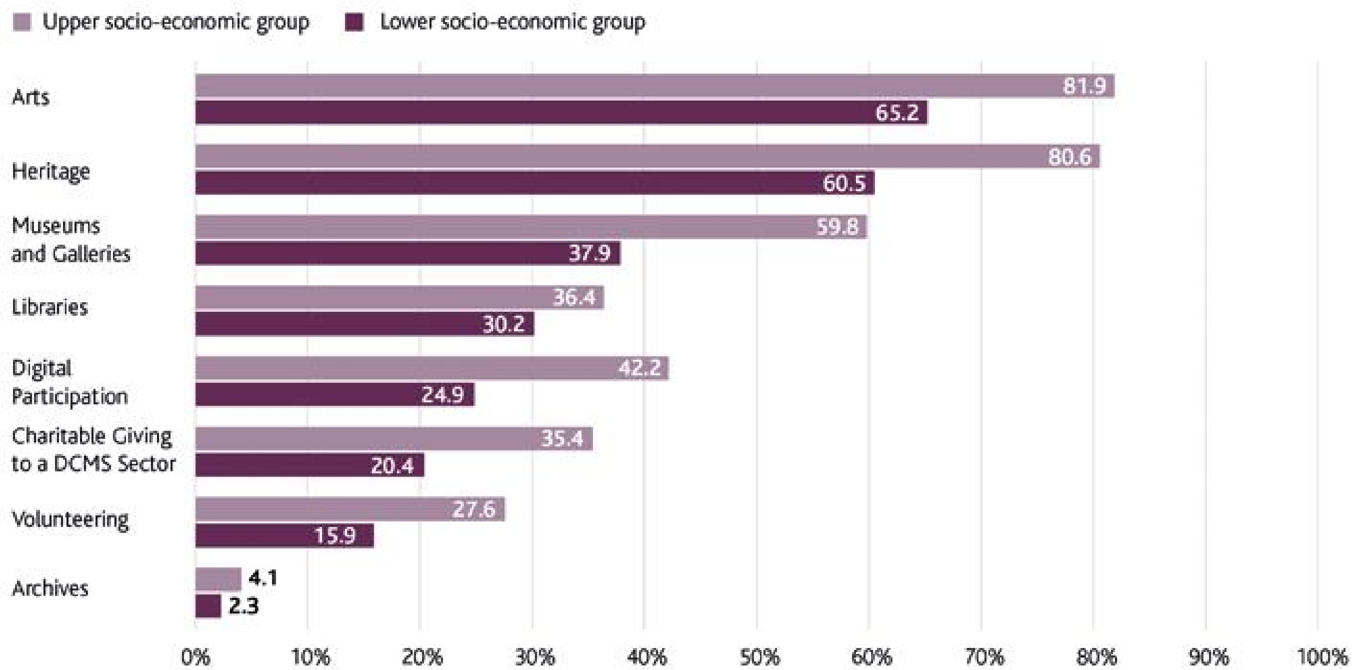
[53]https://defra.maps.arcgis.com/apps/MapSeries/index.html?appid=2f24d6c942d44e81821c3ed2d4ab2ada
[54]REFERENCE VISION 2036

Access

Access to cultural heritage activities varies across the district, with some residents having fewer opportunities to participate than others.

'Everyone should have the chance to experience culture, participate in it, create it, and see their lives transformed by it[55]'

Participation in culture is often significantly lower among those from a lower socio-economic background (as defined by the Index of Multiple Deprivation[56]. Disability, age, limited/no access to public transport are also factors which can create barriers to participation.)



Source: Department for Culture, Media & Sport The Culture White Paper

[55]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/510798/DCMS_The_Culture_White_Paper__3_.pdf
[56]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/510798/DCMS_The_Culture_White_Paper__3_.pdf

Ace Space music festival hosted by Shaw House, Newbury

Those living in rural communities (Defra, ONS classifications and local authority classifications[57]) face difficulties, particularly if combined with one or more of the above. Factors identified by the Arts Council England Rural Evidence and Data Review 2019[58]. This has been echoed by responders to the public and stakeholder consultation undertaken as part of the development of this strategy.

'It would be good to be able to access these things (cultural heritage activities), particularly in rural areas' Local resident responding to public consultation.

We know there are a range of benefits to participation in cultural heritage activities. It is therefore important that through this strategy we seek to improve access for those who want to enjoy such activities. This is not necessarily straightforward or easy to resolve, however, we aim to improve access. One of the first steps the Delivery Group will take will be to better understand what residents (particularly those from rural areas) would like to access/participate in, and then find solutions to barriers. Through the Delivery Plan we will take a phased and focussed approach.

Taking into consideration the current restrictions in place due to Covid-19 we need to work in a more imaginative way, this means taking a varied approach working with local specialists in digital, gaming and publishing creating safe online activity, combined with other participatory programmes which are accessible for those without the internet. If we do not take this route, we will not deliver on the objective to reduce inequality of access.

Summary of Access Objectives, Aims and Actions

OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group
To strive to create equality of opportunity for residents to access the district's cultural heritage and activities.	Improve access to the district's cultural heritage and activities through a variety of measures, responding to need.	• Increase access to existing cultural heritage activities. • Create new accessible activities responding to demand . • Develop the above with a specific focus initially for those in rural locations with limited/no access to transport with restricted mobility (for example, disability) and, or health considerations.

[57]https://www.gov.uk/government/statistics/the-rural-urban-definition
[58]https://www.artscouncil.org.uk/community-and-place/rural-evidence-and-data-review

Education, Training and Employment

The inclusion of arts and culture in education from pre-school onwards is important. It provides those who have strengths in these subjects equivalent opportunities for learning, academic achievement, and the option to pursue a career in this diverse and varied sector (for example. design, architecture, publishing, digital, gaming, artists, performers, makers, arts administrators, senior managers, and chief executives), and for all pupils to gain a range of skills.

Evidence shows that engaging in culture can increase the likelihood of a young person going on to further and higher education[59]. One study showed that 16-18 year olds who participated in the arts and those who visited heritage sites or libraries were more likely to go on to further education in subsequent years[60]. There is a range of data showing a clear relationship between culture and educational attainment.

Inclusion of arts and culture in education has been proven to enable pupils to gain for example, strong communication skills, confidence, increased team working; and for some a route to re-engage with education.

Despite this we know that, as with general access to cultural heritage, not all children and young people have equality of opportunity when it comes to arts and culture in school/education settings. This is particularly the case for those from deprived backgrounds.

'We know that there is startling evidence that those from the most educationally deprived backgrounds are least likely to engage with cultural activities, perpetuating the cycle of exclusion'.
Darren Henley, CEO of Arts Council England.

Initiatives such as Arts Awards[61] and Artsmark[62] (managed by Trinity College London in association with Arts Council England), led in West Berkshire, by Artswork[63] (Arts Council England Bridge Organisation), can provide schools, Pupil Referral Units, and alternative education provision with a structured programme to deliver arts initiatives with support and guidance.

Arts Awards not only benefit pupils/participants but provide opportunities for informal Continued Professional Development, for example teachers and employment for professionals within the cultural heritage sector. Successful completion of a Gold Level Arts Award can assist with application for higher education courses and in some instances relate to UCAS points. This is one example of how the cultural heritage can be supported in schools and other settings with children and young people. It should be noted that Arts Awards can be offered by other organisations providing access and a range of options for children and young people. The settings include: Museums, libraries, galleries, arts centres, theatres, heritage organisations, performing groups, youth centres, in addition to youth justice settings, and healthcare services.

[59]https://www.gov.uk/government/uploads/system/uploads/attachment_data/ file/304896/Quantifying_the_Social_Impacts_of_Culture_and_Sport.pdf.
[60]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/446273/Health_and_educa tional_benefits_of_sport_and_culture.pdf
[61]www.artsaward.org.uk
[62]www.artsmark.org.uk
[63]www.artswork.org.uk

The Artsmark Award is the only creative quality standard for schools and education settings, accredited by Arts Council England. This programme supports settings to develop and celebrate their commitment to arts and cultural education.

In 2015, the programme was refreshed to align with School Improvement Plans and support core EBacc (English Baccalaureate) and STEM (science, technology, engineering and mathematics) priorities, giving the curriculum breadth and balance.

There are a number of advantages for schools and other education settings in undertaking and gaining an Artsmark Award:

- Build young people's confidence, character and resilience through arts and cultural education.
- Support the health and wellbeing of pupils through arts and culture.
- Strengthen pupil voice and develop young people's leadership skills through Artsmark.
- Settings can use Artsmark's clear and flexible framework to embed creativity across the whole curriculum and use it to address school improvement priorities.
- Celebrate schools and education settings long-term commitment to cultural education with pupils, parents and your local community.
- Access professional support, advice and resources to strengthen your arts provision.

Artsmark and Ofsted:

- Meet Ofsted's requirements for Quality of Education by using the Artsmark framework to maintain a broad and ambitious curriculum that connects learning across all subjects.
- Equip pupils with the cultural capital they need to succeed in life and nurture their imagination and creativity through a high-quality arts and cultural education.
- Artsmark clearly demonstrates how you support personal development and provides evidence to Ofsted on how you meet its spiritual, moral, social, cultural requirements.

Artsmark is open to primary, secondary and special schools, pupil referral units, youth offending teams and sixth form colleges.

Through this strategy we will seek to support schools and education settings in gaining an Artsmark Award. The Delivery Plan Board will be tasked with considering and planning this aspect of the strategy, taking into consideration challenges faced by the education and associated sector's as a result of Covid-19.

Code Club at West Berkshire Libraries.

It is important to recognise that schools, Pupil Referral Units and alternative education settings currently employ artists, cultural heritage organisations, and/or artists to design and deliver extracurricular activities, however, there is no data available. Arts Awards are just one way in which children and young people can and should be able to access cultural heritage, and a 'one size fits all' approach is not the answer.

The Local Cultural Education Partnership[64] model piloted by Arts Council England and now adopted by over 90 cities/counties/districts in England is an effective mechanism to create a meaningful partnership approach, delivering initiatives and projects which respond to the needs of children and young people in that specific area. West Berkshire currently has no such partnership in place. This strategy, through the delivery plan, will explore options for the formation of this or a similar body.

Source: ACE Cultural Education Portal for West Berkshire:[65]

Number of Children & Young People

West Berkshire **39,063**

South East **2,132,480**

Multiple Index of Deprivation Ranking

West Berkshire
Very Low Deprivation

291st out of 353 in the UK

289 Harrogate
290 Ribble Valley
291 West Berkshire
292 Reigate and Banstead
293 Wycombe

Number of National Portfolio Organisations

West Berkshire **2**

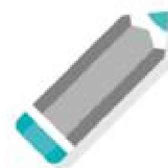
Local Authority investment in Arts & Culture

West Berkshire **£2,885**

Grants for the Arts for Young People

West Berkshire **1** grants worth **£14,870**

Number of educational establishments



99 West Berkshire

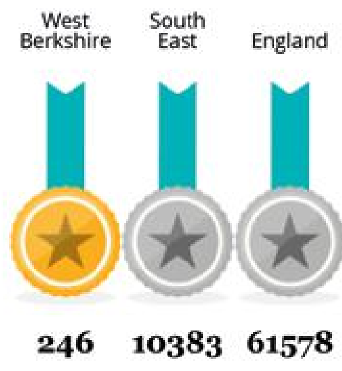
[64]https://www.artscouncil.org.uk/children-and-young-people/working-partnership

[65]https://www.artscouncil.org.uk/research-and-data/children-and-young-people

% of Schools with Artsmark Awards

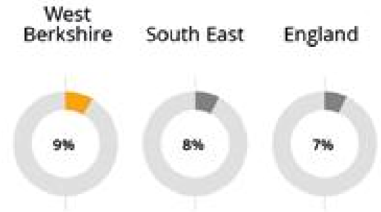
West Berkshire	11%
South East	12%
England	15%

Number of Children & Young People with Arts Award

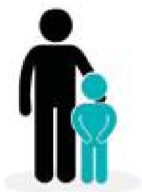


West Berkshire	South East	England
246	10383	61578

GCSE entries in Arts Subjects



% of Children in Poverty



West Berkshire	10%
South East	15%
England	20%

'The arts and culture may not be the main economic driver within West Berkshire, but it still has a vital role to play in providing jobs and opportunity for all.'
Local resident responding to public consultation.

Through the provision and equality of access to high quality and varied cultural heritage activities and learning opportunities, we aim to support and nurture their talents, skills, and provide them with the choice to pursue cultural heritage studies. There are barriers to higher and further education which this strategy alone is unable to tackle. However, through this strategy we aim to link with the council's Vision 2036[66] and Economic Development Strategy[67] to support local businesses and colleges in offering apprenticeships including the new T Level pathway, and the development of the cultural heritage sector with particular reference to small and medium enterprises (SME's) and new business development.

The cultural heritage sector is often thought of as not offering many opportunities for employment; however, this perception is dependent on which field being considered. For example, it is estimated that 11% of firms in the heritage sector have a skill gap in their workforce, and that 6% operate with at least one skill shortage. As a result, £140 million of potential GVA were lost in 2016.

This will in turn provide a strong economic environment for work-based training and employment.
Whilst this strategy recognises there are particular challenges at present (2020) due to Covid-19, and a shrinking economy, over the life of this strategy the objectives and aims reading education, training and employment remain pertinent. Industries such as digital, gaming and publishing are considered likely to continue to grow. This combined with the objectives and aims under the economic development strand of this strategy, will provide employment opportunities across the wider cultural heritage sector.

'I personally have done an apprenticeship within West Berkshire (at a library), and it was incredibly valuable, leading to the career I now have. To have apprenticeships, higher education and training opportunities within arts and heritage help establish not only skills for individuals, but a sense of community belonging and engagement.'
Local resident responding to public consultation.

Summary of Education, Employment and Training Objectives, Aims and Actions

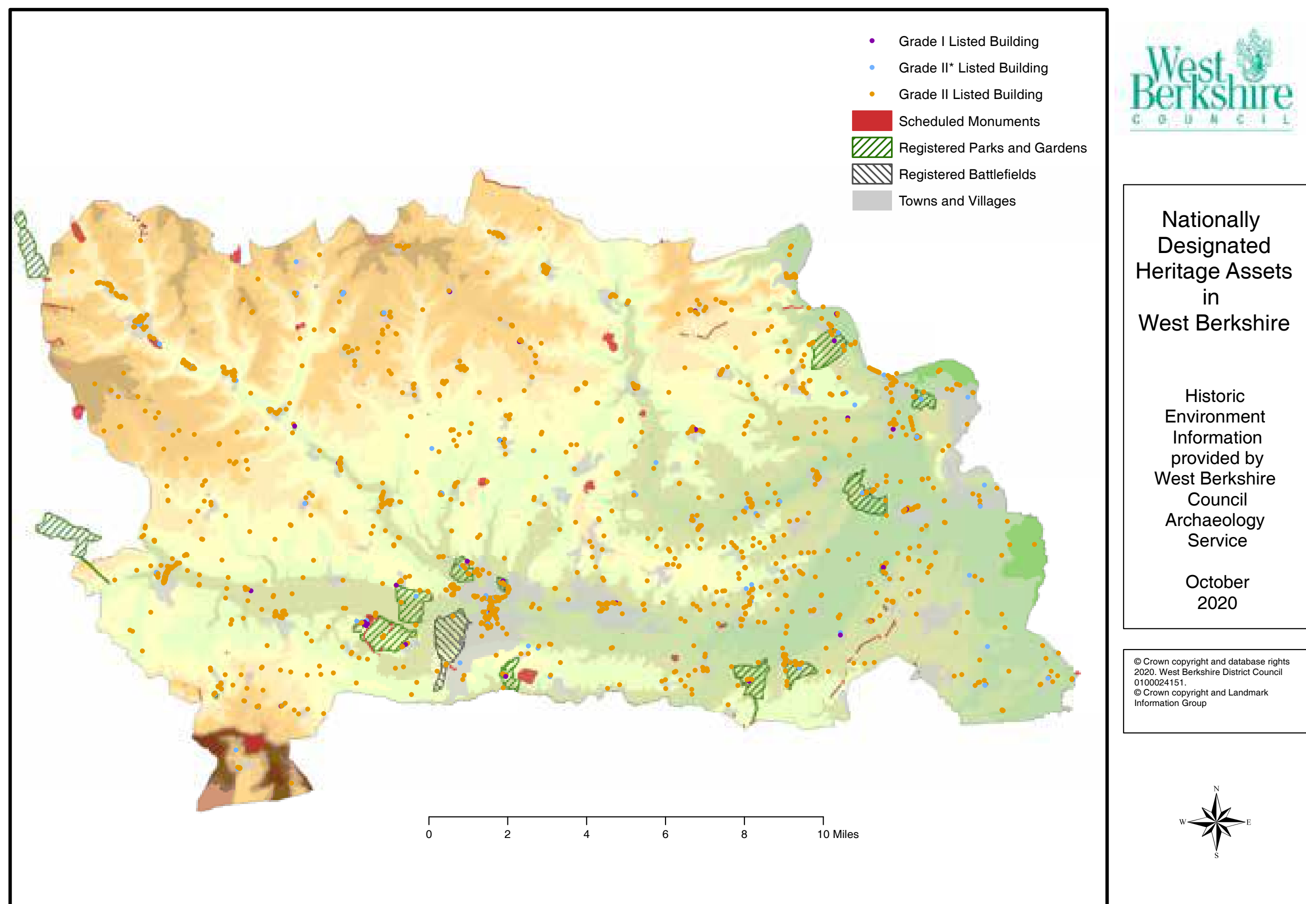
OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group
Improve access to cultural education, learning and employment.	Support the education and cultural heritage sector to develop and deliver arts and creative learning opportunities, training, and career progression.	• Support and promote opportunities for apprenticeships and paid internships, through partnerships with local cultural and heritage organisations and businesses.

[66]https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0
[67]https://www.westberks.gov.uk

Heritage and the Historic Environment

Through the consultation conducted as part of the development of this strategy we have evidence of the significance of the district's heritage and historic environment to communities and partners.

West Berkshire has a wealth of heritage assets with nearly a hundred Scheduled Monuments and just under two thousand Listed Buildings as well as several Registered Parks and Gardens and one Registered Battlefield[68]. Much of the district is within an Area of Outstanding Natural Beauty (AONB)[69].



It is important these heritage assets are monitored and conserved. Through this strategy we aim to ensure they are protected for current and future generations. This provides an opportunity to work in partnership with local organisations and engage more widely with communities to promote the understanding and appreciation of the historic environment.

Historic England employs a designation / classification system for heritage assets. For example, historic buildings of significant importance to the national heritage are designated in a listing system – Grade I or Grade II Listed. Many features that make up West Berkshire's historic environment are important to the local heritage but do not meet the criteria for designation under Historic England's scheme. There are opportunities for local groups and residents to help record these as part of a "local listing" initiative to increase our appreciation of the richness of the local heritage.

For example, West Berkshire Council has been working in partnership with the West Berkshire Heritage Forum and local communities to compile a 'West Berkshire Local List of Heritage Assets[70]. This initiative has enabled communities to identify and raise awareness of heritage assets that do not meet the criteria for national designation and raise awareness of them.

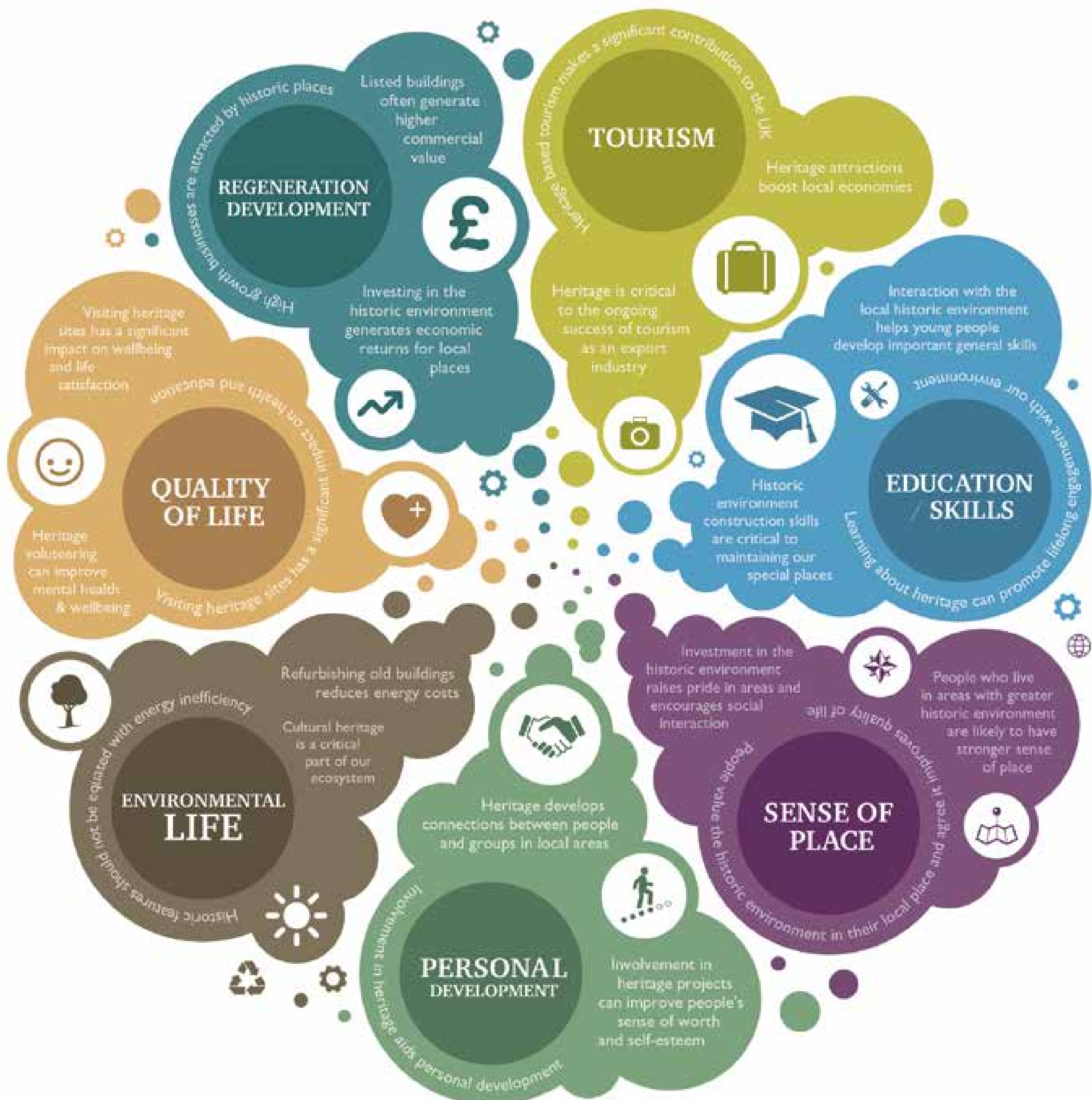
[68]https://www.northwessexdowns.org.uk/
[69]https://historicengland.org.uk/listing/the-list/
[70]https://info.westberks.gov.uk/locallist

In addition to the physical cultural heritage in our landscape, towns and villages, there are objects held in collections of West Berkshire Museum[71]. Through display and interpretation, schools and public engagement programmes, residents and visitors of all ages have the opportunity to gain an increased understanding of the historic environment. It is important to enable as many people as possible, from a wide range of backgrounds, to able to have access to these artefacts.

'The protection and preservation of our culture and heritage is a singular opportunity to educate and provide enjoyment for our and future generations.'
Response to consultation.

Protecting and conserving our historic environment and heritage has proven wide ranging benefits which are interconnected with the other 'themes' included in this strategy and other West Berkshire strategies which seek to promote and improve health and wellbeing, economic development, leisure, and education. For example, studies have shown that visiting heritage sites is strongly associated with life satisfaction[72].

The value and Impact of Heritage and the Historic Environment[73]



[71]https://www.westberkshireheritage.org/west-berkshire-museum
[72]https://historicengland.org.uk/content/heritage-counts/pub/2014/heritage-and-wellbeing-pdf/
[73]https://historicengland.org.uk/content/heritage-counts/pub/2014/heritage-infographic2-pdf/

Volunteering on heritage projects and programmes has evidenced benefits to participants. A study by the National Lottery Heritage Fund found[74]:

- Over 75% reported a significant increase in wellbeing after a year.
- Almost 60% reported long term sustained wellbeing improvements over two to three years.
- More than 30% of people gained employment or other new opportunities for getting into work.
- Participants also reported improvements in cognitive ability and an enhanced sense of belonging.

‘I can see life in a different way now, I don’t want to stay home, lonely and depressed any more. I want to get out there and get a job so that I can become more independent financially[75]’

Through this strategy we aim to work in partnership with existing groups and organisations to increase the number and diversity of those undertaking volunteering in relation to the district’s historic environment.

There are examples of good practice which engage with young people and those from more diverse backgrounds in monitoring the condition of listed buildings. Winchester City Council Historic Environment Team gained funding and worked in partnership with Historic England, and community organisations to train young people to photograph and record designated and non-designated local historic assets. This information was then used to draw up a new listing and formed the basis for further assessment and future works according to condition and ‘risk’.

This scheme not only assisted in the monitoring and reporting of historic assets, it provided skills-based training for those young people involved, some of whom were not in education, employment or training.

Such schemes can attract external funding (for example, Historic England, and Natural England). Similar schemes, along with Historic Environment apprenticeships (funded via the Apprenticeship Levy) have been undertaken by for example, National Parks, and have created new partnerships, and increased the diversity of those volunteering and training in historic environment programmes.

The Heritage at Risk Register[76] produced by Historic England, is a record of heritage assets which are in decline. However, the majority of West Berkshire’s historic buildings are Listed as Grade II and are therefore not included in the national register.

As part of our aim to increase volunteering schemes, we will develop a programme with partners to undertake the recording and monitoring of Grade II listed buildings. This will provide West Berkshire Council with important data, create an opportunity to work with historic environment groups who have never previously volunteered in heritage activities, or would like to reconnect. For example, this could be a pilot “social prescribing” initiative, or an intergenerational scheme with young people mentored by older people with the relevant knowledge and experience.

‘Historic places matter – they help remind us of our past, bring communities together in the present with a shared sense of history, and can inspire our future through their beauty, interest, and potential for new uses. Creativity and heritage go hand in hand and can help engage people through new creative experiences and opportunities to connect with each other.’
Hilary McGrady, (former) Director-General, National Trust.

[74]https://www.heritagefund.org.uk/news/heritage-volunteering-boosts-wellbeing
[75]https://www.heritagefund.org.uk/news/heritage-volunteering-boosts-wellbeing
[76]https://historicengland.org.uk/advice/heritage-at-risk/

Through this strategy we aim to develop more joined-up working with a range of organisations to engage a wider range of people, and enhance their understanding, appreciation and enjoyment of West Berkshire's historic and cultural assets and landscape.

There are numerous examples of how this is being done imaginatively and successfully:

- Researchers, developers and heritage producers are interested in the way video games allow millions of players around the world to play with and within the past and using games to engage students with history. This is known as archaeogaming[77] is just an example of a new approach to exploring archaeology through a digital game.

- Developers are also looking at new methods for conducting real archaeology in gaming environments. Augmented and virtual reality experiences are being developed by historic houses across the country, with a view to enhancing the visitor experience and diversity- Weston Park's augmented reality app 'The Enchanted Glen' and Castle Howard's hugely popular Christmas experience being a few examples. The Historic Royal Palaces and the National Trust have both invested in this new approach and have seen visitor numbers and diversity increase. West Berkshire is home to game developers and film production companies, and this provides an opportunity for us to not only present our historic environment in an engaging way, but to economically support the cultural heritage sector.

'Once lost these areas are hard, if impossible, to regenerate. In a time of difficulty the option to visit, learn about and experience culture, heritage and landscape can prove a lifeline to many and the economic benefits of such opportunities could be a major element in regeneration of our economy.'
Response to consultation.

The National Endowment for Science, Technology and the Arts (Nesta), Arts Council England, The National Heritage Lottery Fund, UK Research and Innovation Fund (Audience of the Future) continue to fund the research, trial, and delivery of such schemes, with Historic England supporting (through funding and training) the use of augmented reality (XR technology) to map and record the structures which are unsafe to enter, thus allowing for monitoring and for people to experience them as if at first hand.

Such initiatives provide opportunities to partner with the higher education sector, providing skills, expertise and access to funding (for example Arts and Humanities Research Council).

The digital route is not the only path and there are many examples of where artists, musicians, writers and so on have collaborated with the heritage sector to bring to life and engage a wider demographic, increase understanding, appreciate and enjoyment of the historic environment. Many of these projects/programmes have included 'residencies' or outreach work in community, healthcare, and/or education settings, increasing access.

Images L-R: © Cath Rawas/Hecate Arts

[77]https://www.theheritagealliance.org.uk/wp-content/uploads/2019/09/InspiringCreativity_THAreport.pdf

A good example is a schools and community project which explored Cromford Mills, the home of Sir Richard Arkwright's first mill complex, birthplace of the modern factory system.

- A Creative Residency was established with workshops taking place at the mill, in schools and in the community. The project was based on the history of the mill, buildings created by Arkwright, stories connected with these sites, and of how the mill and Cromford families were affected by the War. Locally the path between the church and mill (both built by Arkwright) and is known as 'The Poppy Path' and 150 banners were created to line the pathway. Textiles and pigment were used to reflect and teach people about the mill's heritage and that of the village. A wide range of local people and visitors to the mill attended the workshops, and were encouraged to explore the site and local area inspired by the information available.

- Stories from the project were used to inspire The Tinderbox Theatre Company and Peak Ballet to develop processional performance pieces. For their commemoration event held on 11 November, the public were invited to follow the performance along a poppy path lined with the banners.

- Community archaeology projects provide opportunities to teach and engage people not usually engaged in the historic environment. Through the development of this strategy we know that young people, and particularly those from disadvantaged backgrounds are less likely to participate in activities relating to heritage in general and archaeology. This reflects the national trend and is why for example Historic England launched their successful 'Kick the Dust' programme (funded by the National Lottery Heritage Fund).[78]

- Unloved Heritage? Falling in Love with Archaeology[79] is the name given to a programme of community archaeology activities designed to engage, enthuse and inspire young people throughout Wales to get involved with their local heritage. Each of the projects was developed with partners and young people to make them relevant, and to meet the requirements of the region's archaeology and communities. Using activities ranging from traditional archaeology, recording music, recording buildings, and making public art, creating an app and heritage trail, young people have enthusiastically engaged with the projects.

- One of these projects was run by Gwynedd Archaeological Trust (GAT) which focused on the heritage of Dyffryn Nantlle's once lucrative slate quarrying industry. Over the course of the project GAT, along with the community group Dyffryn Nantlle 2020, have worked with local young people whilst they explore, learn and interpret their heritage, making this an intergenerational project.

'East Ilsley itself is steeped in History and Heritage from the old Sheep Sale days and we have a very active local history society as well. It is important that these historical events and facts thrive into the future and help educate the children so they can learn more about the area they live. Anything that promotes this all over West Berkshire is a great thing.'
Response to consultation.

[78]https://www.heritagefund.org.uk/blogs/what-kick-dust
[79]https://www.theheritagealliance.org.uk/wp-content/uploads/2019/09/InspiringCreativity_THAreport.pdf

Summary of Heritage and the Historic Environment Objectives, Aims and Actions

OBJECTIVES	AIMS	ACTIONS **To be developed by the Delivery Group**
Protect and promote our unique cultural history, heritage and environment.	Protect and promote cultural assets across West Berkshire – historic buildings and landscapes, Areas of Outstanding Natural Beauty, Sites of Special Scientific Interest, museum and archaeology.	• Increase investment through strategic partnership applications to external funding bodies. For example: The National Lottery Heritage Fund. • Increase volunteering schemes. For example: monitoring of Scheduled Monuments and Listed Buildings. • Increase and develop joined up working and partnerships, including with non-arts arts/heritage organisations, to engage a wider demographic, and enhance their understanding, appreciation and enjoyment of West Berkshire's historic and cultural assets and landscape.

Former Cruise missile shelter complex, Greenham Common airbase. Historic England: Scheduled Monument number 1021040.

Outdoor Theatre at Shaw House, Newbury

Our Vision for Cultural Heritage in West Berkshire 2030

By 2030 we will have a **sustainable, resilient and thriving** cultural heritage sector that **supports creativity and innovation, continuing to** make **a significant contribution to the economy.**

The cultural heritage sector will have **increased its contribution to the health and wellbeing of residents,** and there will be **improved access to cultural heritage and activities.**

We will have supported an **increase in cultural education learning, training and career progression.**

Our **unique cultural heritage and historic environment will have been protected** and its **significance promoted.**

Cultural Heritage Strategy Themes, Objectives, Aims and Actions to be delivered by 2031

The table below outlines the Cultural Heritage Strategy Themes, Objectives, Aims and Actions to be delivered by 2031. These have been arrived at through a process of consultation with partners and public, with consideration given to West Berkshire Council strategies, relevant national and regional policies and strategies, and in response to external factors such as the significant impact of the Covid-19 pandemic.

THEMES	OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group
Sustainability	Ensure our cultural and heritage organisations are as sustainable as possible and can thrive.	Provide support and increased economic resilience for organisations, small and medium enterprises (SME's) and individuals in the cultural heritage sector.	• Increase inward investment through joint initiatives and external funding. • Increase and develop joined up working between organisations and effective strategic partnership working.
Economic Development	Increase domestic and international tourism to generate income, investment and increase economic resilience.	Promote and raise awareness to potential visitors, of the wealth and diversity of culture and heritage. For example: historic buildings and landscapes, events and creative industries in the district.	• Develop partnerships and programmes across cultural, heritage, landscape and tourism sectors to create experiential tourism opportunities. • Increase public awareness of the wealth and diversity of cultural and heritage activities, events and places across the district. • Develop partnerships including with Destination Management Organisations, to create and promote experiential tourism opportunities and promote these to tourism providers. • Research and seek financial support from external funders / investors to develop tourism.
Access	To strive to create equality of opportunity for residents to access the district's cultural heritage and activities.	Improve access to the district's cultural heritage and activities through a variety of measures, responding to need.	• Increase access to existing cultural heritage activities. • Create new accessible activities responding to demand.

THEMES	OBJECTIVES	AIMS	ACTIONS To be developed by the Delivery Group
			• in rural locations with limited/no access to transport. • with restricted mobility (for example, disability) and, or health considerations.
Health and Wellbeing	Contribute to the improvement of the health and wellbeing of all our residents.	Develop the cultural and heritage sector to meet short, medium, and long-term needs of residents, taking a lifespan approach.	• Develop strategic partnerships. • Develop and deliver effective projects and programmes which meet health and wellbeing priorities as identified in council and health service strategic plans. • Increase access to culture and heritage for our rural and urban communities including children and young people.
Education, Training and Employment	Improve access to cultural education, learning and employment.	Support the education and cultural heritage sector to develop and deliver arts and creative learning opportunities, training, and career progression.	• Support and promote opportunities for apprenticeships and paid internships, through partnerships with local cultural and heritage organisations and businesses.
Heritage and the Historic Environment	Protect and promote our unique cultural history, heritage and environment.	Protect and promote cultural assets across West Berkshire – historic buildings and landscapes, Areas of Outstanding Natural Beauty, Sites of Special Scientific Interest, museum and archaeology.	• Increase investment through strategic partnership applications to external funding bodies. For example: The National Lottery Heritage Fund. • Increase volunteering schemes. For example: monitoring of Scheduled Monuments and Listed Buildings. • Increase and develop joined up working and partnerships, including with non-arts arts/heritage organisations, to engage a wider demographic, and enhance their understanding, appreciation and enjoyment of West Berkshire's historic and cultural assets and landscape.

Actions to Deliver the Vision

Actions will be delivered through the Delivery Plan which will be developed following the ratification of this strategy.

The Delivery Plan, with targets and measures, will accompany this strategy. and be used to track progress, and for monitoring and evaluation purposes.

For reference, the Delivery Plan template is included in the appendices (appendix 2).

Projects/programmes will be selected for inclusion in the Delivery Plan according to a set criteria and 'score sheet'. This allows for the council, partners to take a considered, targeted approach, selecting and prioritising projects/programmes in line with this strategy, and allows for transparency in decision making. It should be noted that over the life of this strategy this method for selection will be reviewed and is subject to change according to changing demands and external factors.

The Delivery Plan Project/Programme Selection Sheet is included in the appendices (appendix 3)

Ace Space music festival hosted by Shaw House, Newbury

Appendices

Appendix: 1

Governance, reporting and communication

The Cultural Heritage Delivery Group

The Cultural Heritage Delivery Group will be tasked with the development of the Delivery Plan. This includes assessing the viability and prioritisation of new projects/programmes, taking into consideration resources required. Setting targets, measures and Key Performance Indicators to assess and maintain progress.

The Cultural Heritage Delivery Group will report to the West Berkshire Health and Wellbeing Board who will have oversight of the work of the Delivery Group and how the strategy contributes to other major strategies in the district.

There will be an annual West Berkshire Cultural Heritage Forum event for community, voluntary, arts, heritage, environment, education, business and tourism organisations to communicate and feedback on progress.

BODY	PURPOSE	PARTNERS / MEMBERS
Manages the delivery of the strategy (objectives and actions). Develops the Delivery Plan to ensure it can deliver on the vision and objectives.	Develops the Delivery/Action Plan. Manages the delivery of the strategy (objectives and actions). Develops the Delivery Plan to ensure it can deliver on the vision and objectives. Listens to / communicates with partners. Reports to the Council's Health and Wellbeing Board. Liaison with national bodies including: Arts Council England, Historic England, Public Health England,	Chair: West Berkshire Council Executive Portfolio Holder: Public Health and Wellbeing, Leisure and Culture. West Berkshire Council elected member / Heritage Champion. 1 representative for arts venues/ organisations. 1 representative for heritage organisations. 1 representative for the economy/ tourism. 1 representative for community organisations. 1 representative Town Councils. 1 representative Parish Councils. The senior West Berkshire Council officer responsible for Culture & Libraries.

Appendix: 2

Supporting Information and Reference Material

Baseline: data and research

Alignment with key council strategies

In developing this strategy we have conducted a review of West Berkshire Council and Public Health strategies to ensure the objectives align with the longer-term and wider strategic view of the challenges facing residents in terms of health, the economy, the environment and demographic change. These are:

- **West Berkshire Vision 2036.**

An exploration into what makes West Berkshire a fantastic place to live, work and learn now and in the future.

- **Joint Health and Wellbeing Strategy 2017-2020.**

The framework for joint working with colleagues in the health sector, looking at health inequalities and producing assessments of local need.

- **Economic Development Strategy 2019-2036.**

Considers how the council and its partners might meet the economic challenges likely to emerge in the coming years.

- **Local Transport Plan 2011-2026.**

The framework for the delivery of all aspects of transport and travel for West Berkshire.

- **Core Strategy Development Plan 2006-2026.**

Sets out a long-term vision for West Berkshire to 2026 and translates this into spatial terms, setting out proposals for where development will go, and how this development will be built. The Core Strategy aims to make the different settlements within West Berkshire even more attractive places within which to live, work and enjoy leisure time.

- **Environment Strategy 2019-2023.**

Sets the Councils ambition and vision towards our response to the Climate Emergency.

- **The Natural Environment in Berkshire Biodiversity Strategy 2014-2020.**

Sets out objectives to enhance across habitats and ecosystems on land, species, people and some more general targets.

- **Leisure Strategy 2021 -2031.**

The following is a summary of objectives in these key strategies which are considered of particular relevance to this strategy:

- To improve health, safety and wellbeing and reduce inequalities
- A West Berkshire with beautiful and diverse natural landscapes and a strong cultural offering
- To ensure that the character and distinctiveness of the natural, built and historic environment is conserved and where possible, enhanced
- To improve accessibility to community infrastructure / promote and maximise opportunities for sustainable travel
- To support a strong, diverse and sustainable economic base which meets identified needs
- To support the protection of the natural environment and reduce carbon emissions

Appendix: 3

External Reports, Research Papers, Plans, and Strategies

Source	Document
NHS	10 Year Long Term Plan
Arts Council England	Arts and Older People Survey, 2015 Cultural Activities, Artform and Wellbeing, 2015 The Value of Arts & Culture to People and Society Evidence review of the economic contribution of Libraries Cultural and Creative Spill overs The Economic Impact of Museums in England, 2018 Active Lives Survey, Mid November 2015- Mid May 2017 Funding data: All organisations in receipt of funding from Arts Council England, and sums received (available per financial year) Education Data Portal Rural Evidence and Data Review 2019 The Value of Arts and Culture to People and Society Arts Council England Lets Create Strategy 2020- 2030 Case: The Culture and Sport Evidence Programme- A review of the Social Impacts of Culture and Sport 2015 Research to understand the resilience, and challenges to this, of Local Authority Museums, 2015 Children and Young People
The National Lottery Heritage Fund	Heritage Volunteering Boosts Wellbeing, 2017
The Heritage Alliance	Inspiring Creativity, 2019
Centre for Economics and Business Research (CEBR)	Contribution of the arts and culture industry to the UK economy, April 2019

What Works - Heritage and Wellbeing	Visual Arts and Mental Health Heritage and Wellbeing Music, Singing and Healthy Adults Music, Singing and Wellbeing The Impact of Historic Places and Assets on Community Wellbeing
Crafts Council	Can Culture do Healthcare
All Party Parliamentary Group on Arts, Health and Wellbeing	Inquiry Report- Creative Health: The Arts for Health & Wellbeing, 2017
Department of Health and Social Care	The National Academy of Social Prescribing and Covid-19
Ministry of Housing, Communities & Local Government	National Planning Policy Framework, 2019
Historic England	Heritage Counts: The Value of Heritage, 2014 Heritage and Wellbeing, 2014 (Daniel Fujiwara Thomas Cornwall Paul Dolan) Kick the Dust, 2017 Conservation Principles, Policies and Guidance, 2008 Neighbourhood Planning and the Historic Environment, Historic England Advice Note 11, 2018
Hey, G and Hind, J	*Solent-Thames Research Framework for the Historic Environment Resource Assessments and Research Agendas.* Project Report. Oxford Wessex, 2014
North Wessex Downs AONB	North Wessex Downs Area of Outstanding Natural Beauty Management Plan 2019-2024, 2019
West Berkshire Heritage Forum	The West Berkshire Historic Environment Action Plan, 2011

www.westberks.gov.uk

WBC/PPC/PJ/1120

Development of the Berkshire West Joint Health and Wellbeing Strategy

Report being considered by:	Health and Wellbeing Board
On:	28th January 2021
Report Author:	Sarah Rayfield
Item for:	Information

1. Purpose of the Report

To provide the board with an update on the development of a Joint Health and Wellbeing Strategy for Berkshire West.

2. Recommendation(s)

2.1 To continue with the strategy development initial write up stage and public engagement as planned.

2.2 To extend the period allowed for public engagement until the end of February 2021. This will allow us to complete sufficient public engagement, in view of the impact of the current national lockdown.

3. How the Health and Wellbeing Board can help

For the board to continue to support the current public engagement and initial write up of findings.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

4.1 In April 2019, Health and Wellbeing Board chairs from West Berkshire, Reading and Wokingham agreed to propose development of a shared Joint Health and Wellbeing Strategy across the three Local Authorities. This was supported by the CCG and ICS leadership.

4.2 Integration and the promotion of whole system health and social care integration is central both to the delivery and outcomes of this strategy. The strategy is intended to focus on area where partnership action adds value and will have a shared direction with local priorities which may vary from locality to locality.

4.3 The four stages of the development of the strategy, with current timeframe are as follows:

Phase	Timeframe
Defining the current state	March – July 2020
Prioritisation Process	August – September 2020
Public engagement and further engagement with stakeholders	October 2020 – January 2021
Production of the Joint Health and Wellbeing Strategy	February – March 2021

5. Supporting Information

5.1 The first two phases of the strategy development (Defining the current state and the prioritisation process) have led to a short list of 11 potential priorities. These are as follows:

(1) Reduce the differences in health between different groups of people

(2) Support vulnerable people to live healthy lives

(3) Help families and young children in the early years

(4) Reduce the harm caused by addiction to substances (smoking, alcohol or drugs)

(5) Good health and wellbeing at work

(6) Physically active communities

(7) Help households with significant health needs

(8) Extra support for anyone who has been affected by mental or physical trauma in childhood

(9) Build strong, resilient and socially connected communities

(10) Good mental health and wellbeing for all children and young people

(11) Good mental health and wellbeing for all adults

5.2 Engagement with the public is now intended to help refine the short list of 11 priorities into the final 3 priorities of the JHBWS.

5.3 The following have been identified as themes running throughout the strategy: Empowerment and self-care; Digital enablement, Prevention and Recovery from COVID-19.

5.4 The public engagement has been co-produced by an Engagement task and finish group. The group has around twenty members, meeting weekly since the end of July to ensure oversight and support our consultation process. The membership of the Group is made up of equal representatives from each Local Authority Area and includes members of the Programme Steering Group, HealthWatch Chief Officers and members of grass roots community groups that have strong links and experience with community consultations.

5.5 The Engagement Task and Finish Group have developed an Engagement Plan and a supporting Social Media Plan in partnership to support a robust and smooth and successful consultation process. The Plans are reviewed weekly and includes individual ownership and responsibilities for the members to action in their own areas and communities to support the best possible outcomes from the consultation process.

5.6 The consultation is currently taking place from November 2020 to the end of January 2020. It is proposed that this period of engagement is extended to the end of February, to take account for the current challenges of the national lockdown.

5.7 The consultation and public engagement includes:

(1) An online survey

(2) General public focus groups and targeting specific groups as well as in collaboration with Healthwatch

(3) Call to action to chairs of voluntary organisations across the 3 LA's with an invitation to all organisations to engage with our consultation.

(4) Social media promotion of public events and the survey via two need pages developed for the JHWBS:

Twitter Page - @HHBerks

Facebook Page - @AHappierandHealthierBerkshire

(5) Focus on young people including Young Carers, Children in care and the peer mentoring network

(6) Virtual engagement sessions for staff members at each of the three local authorities and CCG (to be confirmed)

(7) Three public meetings to be held in January 2021

5.8 A narrative behind each of the priorities has been developed to support this public engagement and ensure that discussions are consistent (see attached document). This has also been produced in an easy read version along with a British Sign language translation of the strategy engagement.

5.9 Early findings from the survey show that 1175 people had responded by 13th January 2021 (556 from West Berkshire). Please note, these are very early findings and subject to change.

(1) Initial responses indicate that the following were the top three ranked priorities

(a) Supporting vulnerable people to live healthy lives

(b) Help families and young children in the early years

(c) Good mental health and wellbeing for all children and young people

(2) When asked what had been missed by the listed potential priorities the following answers were given: Dementia, Transport, Access to services, Suicide prevention

(3) The following table shows the percentage of people who ranked each priority as “Extremely important”

Good mental health and wellbeing for all children and young people	60%
Good mental health and wellbeing for all adults	56%
Support vulnerable people to live healthy lives	50%
Extra support for anyone who has been affected by mental or physical trauma in childhood	50%
Help families and young children in early years	47%
Help households with significant health needs	42%
Reduce the harm caused by addiction to substances (smoking, alcohol or drugs)	39%
Build strong, resilient and socially connected communities	39%
Reduce the differences in health between different groups of people	36%
Physically active communities	35%
Good health and wellbeing at work	34%

5.10 Organisations from West Berkshire that have responded to the survey so far include: Burghfield and Mortimer Volunteer bureau, National Autistic Society (West Berkshire), Dementia Friendly West Berks, Newbury Samaritans, PALS (West Berkshire, Loose Ends Newbury, Lambourn RDA, Interakt community charity, Dog’s trust, Oxfordshire Crossroads West Berkshire, Re-engage, West Berkshire Therapy Centre, FlagDV, Newbury Family Counselling Service. A number of parish councils have also been in contact to request the toolkit as well.

5.11 Focus groups that have run so far include:

(1) Healthwatch Reading - one group with diverse ethnic communities – identified adequate mental health services, isolation and loneliness and health inequalities as their main priorities

(2) Healthwatch Wokingham – one group with adults with learning disabilities: identified mental health, strong healthy communities and transport as their main priorities, along with protecting communities from future pandemics

(3) Healthwatch West Berkshire – one maternity focus group (feedback in progress)

(4) Healthwatch West Berkshire – older people focus group: identified issues around importance of SureStart centres, people with multi-morbidities falling through the gap if their individual conditions do not meet thresholds for support

5.12 In West Berkshire, there are also plans to attend Youth groups facilitated by Swings and Smiles and discussions regarding a virtual group with 6th formers at one of the schools in Newbury.

5.13 January will include another round of promotion of the survey, along with further focus groups supported by the three Healthwatch organisations and other members of the Engagement Task and Finish group.

5.14 The final draft strategy will be submitted to each of the three Health and Wellbeing boards and then it will go out for public consultation. The sign off and governance process for the final strategy will be drafted and agreed with the 3 Health and Wellbeing boards over the next month.

5.15 The development of the strategy has faced several challenges

(1) Limited capacity within the core group but also the wider system to be able to engage with the process of developing the strategy

(2) The impact of the coronavirus pandemic on both capacity and methods of engagement with stakeholders and the public. In particular, this has impacted our methods of engagement with the public and at present is preventing us from holding any face to face engagement sessions.

(3) We have had limited support from each of the communication teams at the three local authorities although this has improved recently

(4) Developing a ten-year strategy which is fit for purpose in a post-Covid world when we may not fully realise the impacts of Covid, is a challenge and potential risk.

6. Options for Consideration

For members of the board to continue to support the development of the strategy and in particular the current public engagement and planned early stages of the strategy write up.

7. Proposal(s)

This paper provides an update on progress of development of the strategy.

8. Conclusion(s)

8.1 The development of the Joint Health and Wellbeing Strategy for Berkshire West is ongoing and currently in the middle of an extensive piece of public engagement

8.2 This will inform the refinement of the final 3 priorities of the strategy

8.3 The current deadline for the first draft of the final strategy is March 2021. However, it is proposed that the public engagement is extended by a period of one month. This would delay the completion of the first draft of the strategy to April 2021

9. Consultation and Engagement

This report is a summary of work undertaken so far on the development of the Joint Health and Wellbeing Strategy for Berkshire West.

10. Appendices

Appendix A - What do the priorities mean (narrative to support engagement)

Appendix B - JHWBS Task and Finish Engagement plan

Appendix C - Social Media Plan

Background Papers:

None

Health and Wellbeing Priorities 2019/20 Supported:

- [ ] First 1001 days – give every child the best start in life
- [ ] Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

- [ ] Give every child the best start in life
- [ ] Support mental health and wellbeing throughout life
- [ ] Reduce premature mortality by helping people lead healthier lives
- [ ] Build a thriving and sustainable environment in which communities can flourish
- [ ] Help older people maintain a healthy, independent life for as long as possible

The new strategy will include an updated set of aims and objectives.

Officer details:

Name: Sarah Rayfield
Job Title: Public Health Registrar
Tel No: *
E-mail Address: Sarah.rayfield1@westberks.gov.uk

A Happier and Healthier Berkshire

Reading West Berkshire Wokingham

The Joint Health and Wellbeing Strategy for Berkshire West will describe what we will do during the next 10 years, to improve the health and wellbeing of everyone living in Reading, West Berkshire and Wokingham

We have a number of possible areas we could include in the strategy. Read on to find out more about each of them

Reduce the differences in health between different groups of people

- Differences in health can be caused by living in poverty, by not having good education or childcare available, by not being able to get a good job or through having problems getting health care
- In England, people living in poorer areas live shorter lives than those living in richer areas and often spend more of their life in poor health
- We want to make sure that everyone has the same chance to live a healthy life, no matter where they live or who they are

Support vulnerable people to live healthy lives

- People can be vulnerable for many different reasons: ethnicity, disabilities, being a migrant, due to age or sexuality; it also includes people with complex needs, unpaid carers, homeless people, travellers and offenders

- Vulnerable people often need extra help to improve their health and wellbeing, for example finding ways to stop isolation, help to manage their conditions, help with education and employment and help to get the information they need to stay healthy

- By supporting the most vulnerable in our society we can make it fairer for everyone

Help families and young children in early years

- What happens during pregnancy and during the first 2 years of a child's life will affect how a child will grow, learn and how they will cope with challenges in the future

- Supporting parents wellbeing is essential: to be able to parent well, people need good relationships, and to be emotionally and financially secure. We want parents to have the support they need during the early years, whatever that support may be

- Valuing and supporting families and our youngest children will help us to create a strong economy and a society where everyone can be happier and healthier

Reduce the harm caused by addiction to substances (smoking, alcohol or drugs)

- Using these substances causes a lot of poor health and affects some people and communities more than others

- We want to create environments where people do not start using these substances; but also provide support and good quality services to help anyone stop when they choose to do so

- There is no safe level of smoking, alcohol or drug use but we want to reduce the harm caused to those using them and the people around them

Good Health and Wellbeing at work

- Ensuring everyone has the same chance to be in good employment and helping people at risk of poor health to stay in employment

- Having a good job, that pays a reasonable wage, helps to protect people against poor health. A healthy workforce is also good for business

- Helping employers to support a healthy inclusive workforce, being aware of the physical, mental and cultural needs of all workers

Physically Active Communities

- Not being active enough is one of the leading risk factors for death worldwide. Physical activity can reduce your risk of many diseases and also help emotional and mental wellbeing

- Supportive communities and being able to use green spaces can make it easier for people to walk, cycle or be physically active

- Communities and organisations can work together to overcome problems that people may face in becoming more physically active. This may be through developing new policies or by environmental change

Help households with significant health needs

- Having significant health needs is one of the major cases of poor quality of life in England. People with several medical conditions often have longer stays in hospital

- We want to inform, educate and empower people with significant health needs to have a better quality of life and also support those caring for people with these needs, as this can affect their own health.

- This may be through helping to prevent medical problems, supporting people to be diagnosed earlier, providing them with the information they need and by ensuring they are looked after by high quality services

Extra support for anyone who has been affected by mental or physical trauma in childhood

- Children who have stress in childhood can be affected in the long term. Stresses may include: being abused, not being cared for properly, living in poverty, having parents who argued constantly, or had anxiety or depression, losing a parent to prison or the death of someone close to them

- Having the right support can protect children and help them to cope with the events they experience

- Organisations that recognise the signs and symptoms of trauma in children, can make sure their service is designed in a way to prevent any further negative experience

Build strong, resilient and socially connected communities

- Feeling isolated or lonely can affect both emotional and physical health. It can lead to depression, poor sleep, a weaker immune system and heart problems

- When people live in supportive communities, they are better able to help each other cope with challenges such as pressures at school or work, or changes in life like becoming a new parent

- We want to help our residents to live, work and play in places that support and promote health and reduce isolation

Good mental health and wellbeing for all children and young people

- More children and young people than ever are reaching out for help with their mental health. We want to support every child to be resilient.

- By developing positive parenting and good attachment, we can help families support the health and emotional wellbeing of their children and young people.

- We want to promote positive mental health for all and to ensure that, when needed, children and young people can get the best possible mental health support to help overcome life's difficulties

Good mental health and wellbeing for all adults

- Having good mental health affects both the quality of your life and how long you will live for. But 1 in every 4 people will experience a mental health problem of some kind each year in England.

- Our emotional wellbeing is affected by many things such as housing, poverty, education, employment and our physical health. Having poor mental health can affect someone's ability to get a good education or to get a job

- By promoting good mental health as a priority for everyone, we can ensure people get the right help and support at the right time and also help those with poor mental health and wellbeing to remain in work

Berkshire West Joint Health and Wellbeing Strategy
Public Engagement plan

Introduction

In 2019, the Chairs of the Health and Wellbeing Boards for Reading, West Berkshire and Wokingham decided to come together to produce a Joint Health and Wellbeing Strategy for Berkshire West. It was agreed that public engagement and consultation would be key to the process of developing the final priorities to be included in the strategy.

Aim

The aim of this public engagement is to actively listen to people's views and to work in partnership with the public to discuss and find consensus on the final priorities for inclusion in the Berkshire West Joint Health and Wellbeing strategy. The Group strongly believes in sharing to reduce duplication. Input will be obtained via a series of focus groups and events to provide a platform for the public to share their views and respond to draft priorities, before reaching consensus.

Goals

Following the engagement and once input has been collected from the public and consensus reached, the final Health & Wellbeing Strategy will be in place for 5-10 years. The goal is to support the community to drive a robust programme of health and well-being priorities and a realistic Covid-19 recovery process. The success of the final Strategy relies on commitment and input from the Local Authorities, CCGs and community members.

Methods

- Public facing webpage hosted by a variety of stakeholders – including background information on the strategy and promoting the engagement events
- Generic inbox inviting comments
- Call to action to Chairs of voluntary organisations and an invitation to engage
- Online public survey: to be promoted by all stakeholders using all methods of dissemination
- Social media – to create a Facebook and Twitter pages for the strategy (as well as considering other social media) and to use to promote public events. To consider sponsored posts with targeted advertising such as eliciting feedback via local press, radio and possibly television.
- Specific focus group events for Town and Parish councils' representatives
- Engaging with children and young people
    - Peer mentoring networks

    - Engagement with Youth Councils across Reading, West Berkshire and Wokingham (where active)
    - Young carers across Berkshire West
    - Children in care
- Virtual engagement sessions for staff members at each of the three local authorities and CCG (Aiming for 1 per organisation)
- Virtual public engagement focus groups (Healthwatch) – 2 per local authority
- To join existing focus groups for community organisations
- Virtual Public meetings – open to everyone

In order to support the public engagement through focus groups and other face to face sessions, we have developed a background narrative to each priority. This enables consistent discussions to be had and ensures that the engagement is robust.

Partners and Roles

A Consultation & Engagement Task and Finish Group has been established to help develop and deliver robust consultation and engagement around the development of the new Joint Health and Well-being Strategy for Berkshire West. The membership of the group spans across the 3 local authority areas, Healthwatch, Voluntary Sector Umbrella organisations as well representatives from local communities, in particular diverse ethnic communities and those who traditionally are marginalised in these types of engagement.

We would like to formally acknowledge the help, support and hard work undertaken by the Task and Finish Group in co-producing the consultation and engagement work within this programme. This has been rich, robust and inclusive.

Partner	Role in public engagement
Programme lead and programme manager for the JHWBS	Establish a Consultation and Engagement Task and Finish (T&F) Group with representatives from across the 3 LAs. Co-chair, facilitate and support the T&F Group to co-produce and deliver a robust and inclusive programme of engagement and consultation. Overall co-ordination of the programme of engagement and consultation. Development of the engagement plan. Formulation of survey questions (co-produced with other stakeholders) and development of the overall survey. Facilitation of virtual engagement events. Production of background information pack on potential priorities to aid engagement events.
Local Authority Comms teams	Update local authority websites (public and staff facing) with details of the strategy development. Promotion of virtual public engagement events. Promotion of public survey.

	Promotion of staff events. Press releases to media to promote strategy and public engagement.
Healthwatch	Hosting information about the strategy on public facing website. Running of public engagement events (2 per local authority), focusing on harder to reach communities. Promotion of online survey.
Voluntary sector	Support the Call to action of voluntary sector organisations to engage with the public consultation. Hosting of JHWS development webpage with opportunities to collate comments and feedback. Dissemination of public survey via existing networks.
Local Authority engagement leads	Ensure that all 3 LA engagement leads support and drive the programme and have information to share around engagement and consultation Identify existing communication channels and ways to engage residents – particularly, hard to reach groups.
Community United	Dissemination of public survey and promotion of public events through networks Identify Specific focus groups within community and engage to facilitate their views on the draft priorities and survey
Community Engagement Champions	Disseminate public survey among networks Raise awareness of public events and encourage communities to attend
CCG engagement leads	Dissemination of public survey and promotion of public events through networks.
Community Support hubs	Dissemination of public survey and promotion of public events through networks.

Timeline of events

Week Commencing	Event	Responsible person
28th September	Background narrative on strategy to be published on all stakeholder websites	Sarah

	Contact Youth Councils to initiate engagement and brief them about the programme and the opportunity to get involved and have their say Start to contact organisations to raise awareness	
5th October	Create Social Media pages Develop Framework for focus groups	Chris
12th October	Qualitative discussion on public survey questions	Sarah/Chris/ Task & Finish group
2nd November	Develop supporting documents for public engagement	Sarah/Chris
9th November	Public survey questions finalised Information on CCG website finalised	Sarah/Chris Sarah/Chris
23rd November	Attend LDPB (West Berks) Care2listen group (Reading Children in Care) – postponed Engagement Toolkit finalised Call to action to be sent to chairs of community organisations	Sarah/Chris Sarah Rachel/Phil/Garry
30th November	Public survey opens Care Leavers focus group (Reading) – postponed Domestic Abuse Steering group BME Focus Group hosted by HealthWatch (4th December)	 Sarah Sarah Mandeep
7th December	Ensure wide dissemination of the survey using contact lists below Finalise social media engagement plan Young Carers (Wokingham) Maternity Focus Groups x 2 hosted by HealthWatch (dates to be confirmed) Learning Disability Focus Group hosted by HealthWatch (dates to be confirmed)	Sarah/Chris Chris Nina Andrew Nick
14th December	Young Peoples Focus Group hosted by HealthWatch (15th December)	Mandeep
21st December	(Christmas)	
28th December	(Christmas)	
4th January	Social media sponsored promotion of the survey Virtual Staff event CCG (tbc)	Chris Sarah/Chris

13th January	Zoom Public Focus Group – open event Virtual Staff event Wokingham	Sarah/Chris/Janette/Nina Sarah/Chris
20th January	Zoom Public Focus Group – open event Virtual Staff event West Berkshire (TBC)	Sarah/Chris/Janette/Nina Sarah/Chris
27th January	Zoom Public Focus Group – open event Virtual Staff event Reading (TBC)	Sarah/Chris/Janette/Nina Sarah/Chris

Engagement Toolkit

An engagement toolkit has been developed to support the public engagement and to facilitate the possibility of organisations running their own discussions or focus groups with their members. This consists of the following documents

- Facilitators guide to the potential priorities
- Public guide to the potential priorities
- Feedback template

Evaluation of the engagement

Qualitative and quantitative data will be collected throughout the engagement process.
Interpretation will include analysing, comparing and contrasting themes and patterns as well as the production of key themes and trends

Appendix 1: Stakeholders & Engagement Task and Finish Group

Name	**Position/Organisation**
Sarah Rayfield	Programme lead
Chris Barrett	Programme manager
Sally Moore	Engagement lead, Berkshire West CCG
Andrew Sharp	Health Watch West Berkshire
Mandeep	Health Watch Reading
Nicholas Durman	Health Watch Wokingham
Kamal Bahia	West Berkshire HWB engagement lead
Adrian Barker	Chair of Patient Panel West Berkshire
Garry Poulson	Voluntary sector
Rachel Spencer	Reading Voluntary Action
Nina Crispin	Reading Borough Council Engagement lead
Alice Kunjappy-Clifton	Community United
Cecily Mwaniki	Berkshire West Community Engagement champion
Rhys Lewis	West Berkshire Community support hub
Phil Cooke	Involve Wokingham
Suzie Watts	Wokingham BC
Carol-Anne Bidwell	Wokingham BC

Appendix 2: Key contact details

Name	Contact details
Children and young people	
Reading Youth Council	Brighter Futures for children Tel: 0118 937 3641 RYC Reading (Twitter)
Reading Young Carers Manager Catie Blundell	cspoa@brighterfuturesforchildren.org Catie.Blundell@brighterfuturesforchildren.org
Newbury Youth Council	Elisa Adams (elisa.adams@newbury.gov.uk)
West Berkshire Youth Hub	admin@berkshireyouth.co.uk
Berkshire Youth David Seward)	David.seward@berkshireyouth.co.uk
West Berkshire Young Carers	Joe Sutton Joe.Sutton@westberks.gov.uk
The Greenhams Youth Group	Tina@greenham.org
Wokingham Young Carers Hub – provided by TuVida Manager Sam Smith	berkshire@tuvida.org samsmith@tuvida.org
Groups for younger people with dementia and carers	contact@ypwd.info
Reading University Student Engagement Team	john.ellul@reading.ac.uk
Reading University Student Well-being Service	s.patankar-owens@reading.ac.uk
Schools	sal.thirlway@wokingham.gov.uk Gillian.Cole@wokingham.gov.uk
Early Years (Wokingham)	Stuart.milne@wokingham.gov.uk
Early Years (West Berkshire)	Avril.allenby@westberks.gov.uk
Deborah Mitchell: Participation officer, children in care	Deborah.Mitchell@westberks.gov.uk

Swings and Smiles (Laura Lewis)	Laura Lewis <laura@swingsandsmiles.co.uk>
Early Help and Safeguarding	Estelle.kellaway@wokingham.gov.uk
Children with Disabilities team	cwdadmin@wokingham.gov.uk
Children's Centres	Beccy.Franklin@wokingham.gov.uk Rupa.Joshi@wokingham.gov.uk Melanie.Duck@wokingham.gov.uk
School Nursing	Beverley.wheeler@berkshire.nhs.uk
Fiona Howell	Fiona.howell@wokingham.gov.uk Fiona.howell@berkshire.nhs.uk
Immunisations	Charlotte.church@berkshire.nhs.uk
Bridges Centre	CSBridgesResource@wokingham.gov.uk
HomeStart	admin@home-Startwd.org.uk
HomeStart (West Berkshire)	Grace.green@home-startwb.org.uk
Midwifery	jean.sangha@royalberkshire.nhs.uk
Facebook support and meetings for parents of children with special needs and disability.	admin@sendcarersunited.co.uk
ASSIST	assist@wokingham.gov.uk
Group run by parents for parents in Berkshire and Hampshire	enquiries@steppingstonesds.co.uk
Training and support for parents and carers	pburton@parentingspecialchildren.co.uk admin@parentingspecialchildren.co.uk
SEN parent carer forum	info@sendvoiceswokingham.org.uk
Sports and leisure	
Reading FC Community Trust	rwitt@readingfc.co.uk

The Greenhams Youth Group	tina@greenham.org
Get Berkshire Active	chelsea.piggott@getberkshireactive.org
Sports and Leisure	Susan.Bentley@wokingham.gov.uk Beverley.Thompson@wokingham.gov.uk
Reading FC Premier league Kicks Coordinator Paul Brown	Pbrown@readingfc.co.uk
Vulnerable groups	
West Berkshire Learning Disability Partnership Board	Alex.Osterritter@theadvocacypeople.org.uk
Wokingham Learning Disability Partnership Board	anna.overd@claspwokingham.org.uk
Reading Mencap	office@readingmencap.org.uk
Reading Deaf Centre	info@readingdeafcentre.co.uk
Reading Association for the Blind	adelebw@rabsightloss.org
Berkshire Vision	info@berkshirevision.org.uk
Autism Berkshire	contact@autismberkshire.org.uk
Reading Community Learning Centre	rclcinfo@yahoo.co.uk
Age Concern Twyford and District	http://www.ageconcerntwyford.org.uk/ac_about_us.php
Weekly singing group for people with dementia and their carers	Berkshire@alzheimers.org.uk
Carers group once a month lead by Berkshire Carers hub	Ian.Cunningham@stroke.org.uk ReadingWokingham@stroke.org.uk
Support for parent/carers through drop-in sessions and family workers	contact@asdfamilyhelp.org
Weekly group for people with dementia and carers	claire@wokinghammethodist.org.uk
Deaf Positives Action CiC Wokingham	admin@deafpositivesaction.org

Link	marjiewalker@googlemail.com
Respite care and breaks	contact@wokinghamcrossroads.org
Monthly meetings for people living with cancer	vickie.randall@involve.community
Dementia Carers Support Group	val@misthos.com
Wokingham Mencap	admin@wokinghammencap.org
Learning Disabilities	Sarah.salter@wokingham.gov.uk admin@partnershipboard.org.uk
Commissioning Specialist – Services involving Carers	Lesley.buckland2@wokingham.gov.uk
Social Inclusion Officer (Strategy and Partnerships)	Ashwani.gupta@wokingham.gov.uk
Support for disabled children	Parvaazinfo@taha.org.uk
Support for families with drug and alcohol issues	office@drugfam.co.uk
Yvonne Mhlanga Head of mental health commissioning (Berkshire West CCG)	'y.mhlanga@nhs.net'
Faith groups	
Faith Groups	Deana.humphries@wokingham.gov.uk Sikh Centre RSR gujaratsamajreading@googlemail.com Indian Community Centre info@indiancc.co.uk Islamic Centre info@aishaislamiccentre.org.uk Bangladeshi Community Centre bcsreading@gmail.com Pakistan Community Centre pcc-admin@btconnect.com

Wokingham Churches Together	www.wokinghamchurches.org.uk/
Richard Littleslade	minister@newburybaptistchurch.org
Adult social care	
WISH (Wokingham Integrated Social Care & Health)	Helen.spokes@wokingham.gov.uk; Anita.balmer@wokingham.gov.uk
Community Care Services/Adult Services team	Victoria.scotford@wokingham.gov.uk
Wokingham Older People's Mental Health Team	Michelle.gilbert@wokingham.gov.uk
Health and Safety – Public Organisations	healthandsafety@wokingham.gov.uk
Care Homes / Nursing Homes / Domiciliary Care	ASCMailboxAdminQuality&Contracts@wokingham.gov.uk CommissioningSupportTeam@wokingham.gov.uk
Berkshire Carers Hub	janineoakley@berkshirecarershub.org
Libraries	
Libraries	libraries@wokingham.gov.uk heather.dyson@wokingham.gov.uk
Community engagement	
Community Support Hub (West Berkshire council)	Susan.powell@westberks.gov.uk
Community Engagement	Deana.Humphries@wokingham.gov.uk
Involve	clarissa.webb@involve.community
Our Community First	Lisa.hookway@wokingham.gov.uk
Jade Wilder Community co-ordinator (prevention)	Jade.wilder@westberks.gov.uk
Council services	
Safer Neighbourhoods Initiatives	joanne.anderson@reading.gov.uk
Licencing	Licencing@wokingham.gov.uk

Tenant Services	housing@wokingham.gov.uk kim.jakubiszyn@wokingham.gov.uk
Housing Needs	Housing.needs@wokingham.gov.uk
Citizens Advice	admin@citizensadvicewokingham.org.uk
Transform Housing	wokingham@transformhousing.org.uk
Other	
Salvation Army	Jan.howlin@salvationarmy.org.uk
Tobacco Control Alliance & Community Alcohol Partnership	Caroline.Stevenson@westberks.gov.uk
Reading Pride Committee	enquiries@readingpride.co.uk
Newbury Gay Pride Committee	hello@newburypride.co.uk
Ethnic diverse communities	
Wokingham BME Forum	Deanna Humphries – deanna. humphries @wokingham.gov.uk
Gypsy, Roma and Traveller Community	Nicky.mears@wokingham.gov.uk
Pamela Voss	Pamela.voss@westberks.gov.uk
Community United	Alice Kunjappy-Clifton alice@communityunited.uk
Vulnerable & Diverse communities and groups Reading	Contact these groups via Nina.crispin@reading.gov.uk Age UK Berkshire Age UK Reading Africa 4U Alliance for Cohesion & Racial Equality (ACRE) Apollo Youth club Association of Reading Malayalees Bangladesh Association Greater Reading Barbados & Friends Association Berkshire Filipino-British Association (BFBA) Berkshire MS Therapy Centre Berkshire West for Mental Health British Red Cross Christian Community Action Ministries Churches in Reading Drop in Centre Citizens Advice Reading Community Mission Project (The Globe) Enrych Berkshire FAITH/Readifood

	Forgotten Gurkha Globe Church and social club Goan Association- President Mr Matthias (Luis) Dias Greater Reading Nepalese Association Gujarat Samaj Reading Imaad Indian Community Centre Jamaican Society Multiple Sclerosis Society (CIO) Reading, Wokingham and Districts Branch Nepali Community Groups Pakistani Community Centre Reading Association of Mothers Reading Caribbean Cultural Group Reading Chinese Association Reading Community Learning College Reading Community Welfare Rights Reading Dusseldorf Association Reading Ex British Gurkha Association Reading Islamic Trustees of the Environment (RITE) Reading Refocus Reading Refugee Support Group Reading Sudanese Community Reading Swahili Speakers Community Reading Ukrainian Community Centre Sadaka Sangam Lunch Club (Indian) Shahjalal Bangladesh Islamic Cultural Association South Africans in Reading St Vincent and the Grenadines Sudanese / Rwanda Community groups Talkback-UK Ltd Thames Valley Positive Support The Hibernian Society (Irish) The Jamaica Society Reading The Communicare Trust (reading) The Mustard Tree Foundation (Reading) Utulivu Women’s Group (Kenyan) West Indian Women’s Circle

Appendix 3: Town and Parish Council contact details

Town & Parish Councils	
Aldermaston Parish Council- Christine McGarvey - clerk Chairman Dave Shirt	parishclerk@aldermaston.co.uk dave.shirt@btinternet.com
Aldworth Parish Council – June Ives Chairman Philp Chapman	admin@aldworthpc.co.uk philiptimothychapman@gmail.com
Arborfield and Newland Parish Council	parishclerk@arborfield.org.uk
Ashampton Parish Council – Paul Thompson – clerk	clerk.ashampstead@gmail.com
Barkham Parish Council – Ellen Timms – clerk	clerk@barkham-parishcouncil.org.uk
Basildon Parish Council – Robert Greasley Chairman	parishcouncil@basildon-berks.net idparsons_bpc@btinternet.com
Beech Hill Parish Council (contact via Aldworth June Ives)	admin@aldworthpc.co.uk
Benham Parish Council Chairman	clerk@beenham-pc.gov.uk graham.bowsher1@btinternet.com
Boxford Parish Council Chairman Peter Thompson	parishcouncil@boxford.org.uk
Bradfield Parish Council – Helen Pratt Chairman	admin@bradfieldpc.org ajhouse147@outlook.com
Brightwalton Parish Council – Sarah Youlden Chairman Shaun Orpen	brightwaltonpc@btinternet.com shaun@orpenonline.co.uk
Brimpton Parish Council Chairman John Hicks	clerk@brimptonparish.org.uk jhicks@brimptonparish.org.uk
Bucklebury Parish Council Chairman Barry Dickens	clerk@buckleburyparish.org barry.dickens20@gmail.com
Burghfield Parish Council Chairman Tim Ansell	enquiries@burghfieldparishcouncil.gov.uk t.ansell@burghfieldparishcouncil.gov.uk
Charvil Parish Council – Miranda Parker	clerk@charvil.com
Catmore Parish Chairman – David Gardener	davidgardiner@waitrose.com
Chaddleworth Parish Council – Kim Lloyd Chairman Mr G Murphy	chaddleworth.pc@outlook.com
Chieveley Parish clerk – Kim Lloyd Chairman Rob Crispin	chieveley.pc@outlook.com
Cold Ash Parish Council Linda Randall Chairman Richard Marsh	coldash.pc@btinternet.com

Combe Parish Meeting – Mrs K Astor c/o Endborne Rectory Newbury RG20 OHD	
Compton Parish Council Dr Sarah Marshman – clerk Chairman - David Aldis	comptonparish@gmail.com
Early Town Council Jo Friend – clerk	townclerk@earley-tc.gov.uk
East Garston Parish Council Chairman David Ruse	eastgarstonpc@gmail.com
East Illsley Parish Council – Fenella Woods Chairman Andrew Sharp	clerk@eastilsley-pc.gov.uk
Enborne Parish Council – Kim Lloyd Chairman Christopher Garrett	clerk@enborne.org.uk
Englefield Parish Council Chairman – Edward Crookes	clerk.englefieldpc@outlook.com
Farnborough Parish Meeting Chairman Lesley Chandler	chandlermanor@yahoo.co.uk
Fawley Parish Meeting – no contact details	
Finchampstead Parish Council Katy Dagnall – clerk	clerk@finchampstead-pc.gov.uk
Frilsham Parish Council - Helen Pratt Chairman Marcus Allum	clerk@frilshamparish.org.uk
Great Shefford Parish Council - Kim Lloyd Chairman Steve Ackrill	greatsheffordpc@hotmail.com
Greenham Parish Council – Lisa Blake Chairman Steve Jones	clerk@greenham.gov.uk
Hamsptead Norreys Parish Council Dr Sarah Marshman – clerk Chairman David Barlow	clerk@hampsteadnorreysparishcouncil.org
Hampstead Marshall Parish Council Sarah Bosley – clerk Chairman John Handy	parish_clerk@hotmail.co.uk
Hermitage Parish Council Nicky Pierce – clerk Chairman Ruth Cottingham	hermitagepc@outlook.com
Holybrook Parish Council Pam Kilpatrick – clerk Chairman Mary Bedwell	clerk@holybrook-pc.gov.uk
Hungerford Town Council Claire Barnes – clerk Chairman - Cllr Helen Simpson (Town Mayor)	claire.barnes@hungerford-tc.gov.uk
Hurst Parish Council Maria Bradshaw – clerk	clerk@hurstpc.org.uk

Inkpen Parish Council Mrs G Keene Clerk & Dr David Thomas Chairman c/o 2 Robins Hill, Inkpen, Hungerford RG17 9QD	
Kintbury Parish Council Chris Trigwell – clerk Chairman Stephen Cook	chris@trigwell.net cookta69@googlemail.com
Lambourne Parish Council Karen Wilson – clerk Chairman Michael Billinge-Jones	lambournpc@btconnect.com
Leckhampsted Parish Council Sarah Youlding – clerk Chairman Mr E Knight	Leckhampsteadpc@gmail.com parishcouncil@xxiv.co.uk
Midgham Parish Council Christine Heath – clerk Chairman Anthony Markham	clerk@midghamparish.co.uk tony@midghamparish.co.uk
Newbury Town Council Mr Hugh Peacocke (CEO) – clerk Chairman Elizabeth O' Keeffe	towncouncil@newbury.gov.uk elisa.adams@newbury.gov.uk
Padworth Parish Council Christine Heath – clerk Chairman mike Warner	clerk@padworthparishcouncil.gov.uk mike.warner@live.co.uk
Pangbourne Parish Council Rebecca Elkin – clerk Chairman Peter MacIver	clerk@pangbourne-pc.gov.uk Peterpangbourne@gmail.com
Peasemore Parish Council Sarah Cameron – clerk Chairman – Mr A Cameron	parishcouncil@peasemore.org.uk LizPrest@KBIS.CO.UK
Purley-on-Thames Parish Council Claire Thompson – clerk Chairman Sue Briscoe	clerk@purleyonthames-pc.gov.uk sue.briscoe@purleyonthames-pc.gov.uk
Remenham Parish Council Paul Sermon – clerk	clerk@remenhamparish.org.uk
Rushcolmbe Parish Council Ruth Reid – clerk	clerk@ruscombepc.org.uk
Shaw-cum-Donnington Parish Council Mr J Austin – clerk Chairman Mr B Graham	scdclerk@jayay.co.uk beefast@btopenworld.com
Sonning Parish Council Lesley Bates – clerk	clerk@sonning-pc.gov.uk
Shinfield Parish Council Mike Balbini - clerk Chairman Andrew Grimes	clerk@shinfieldparish.gov.uk andrew.grimes@shinfieldparish.gov.uk
Speen Parish Council Jean Lindsell – clerk Chairman Antony Amirtharaj	clerk@speenpc.org.uk chair@speenpc.org.uk

Standford Dingley Parish Council Mrs H Pratt – clerk no con details Chairman Cllr. Harry Fullerton	Cllr Harry Fullerton c/o West Berks Council
Stratfield Mortimer Parish Council Lynn Hannawin – clerk Chairman Michael David Dennett	the.clerk@stratfield-mortimer.gov.uk
Streatley Parish Council Hazel Preston-Barnes – clerk Chairman Jeremey Spring	clerk@streatley.org jeremy.spring@streatley.org
Sulhampstead Parish Council Elle Gibbons – clerk Chairman Margaret Baxter	sulhamsteadparishclerk@hotmail.co.uk margaret.baxter@sulhamstead.org.uk
Swallowfield Parish Council Liz Halson – clerk	clerk@swallowfieldpc.gov.uk
Thatcham Town Council Mel Alexander – clerk Chairman Cllr Jan Cover (Town Mayor)	enquiries@thatchamtowncouncil.gov.uk
Theale Parish Council Paul Manley – clerk Chairman Becky Williams	enquiries@thealeparishcouncil.gov.uk
Tidmarsh with Sulham Parish Council Jennie Currie – clerk Chairman Cllr Jonathan Pearson	tidmarshwithsulham@gmail.com
Tilehurst Parish Council Miss J Major – clerk Chairman Kevin Page	clerk@tilehurstpc.co.uk kevin@qualitykev.com
Twyford Parish Council Lucy Moffatt – clerk	clerk@twyfordparishcouncil.gov.uk
Ufton Nervet Parish Council Fiona Jones – clerk Chairman D Hannington c/o Glebe Land, Sulhampstead Road Ufton Nervet, Reading RG7 4DH	
Wargrave Parish Council Stephen Hedges – clerk	office@wargrave.org.uk
Wasing Parish Meeting Nick Corp – clerk Chairman Mr P Woodley	nick@wasing.co.uk
Welford Parish Council Karen Griffiths – clerk Chairman Mr D Hunt	welfordparish@yahoo.com
Winnersh Parish Council Clerk – vacant post	clerk@winnersh.gov.uk
Wisley Parish Council No clerk (vacant) Chairman Mr Rollo Duckworth	clerk@westilsley.org
West Woodhay Parish Meeting Robert Macdonald – clerk	Robert.mac55@hotmail.com

Winterbourne Parish Council Jen Telford – clerk Chairman – Jill Hoblin	Winterbourneparishcomms@gmail.com jillhoblin@me.com
Wokefield Parish Council Sandra Faulkner – clerk Chairman Mr R Thorne	wokefield.parishclerk@hotmail.co.uk richard-thorne@rtcc.co.uk
Wokingham Town Council	info@wokingham-tc.gov.uk
Wokingham Without Parish Council Katy Huges – clerk	admin@wokinghamwithout-pc.gov.uk
Woodley Town Council Deborah Mander – clerk	townclerk@woodley.gov.uk
Woolhampton Parish Council Mrs S Brady – clerk Chairman Tony Renouf	 tony@renouf.me.uk
Yattendon Parish Council Dr Sarah Marsham – clerk Chairman Dr Gordon Robertson	yattendonparish@gmail.com gordonallanrobertson@gmail.com

A Happier and Healthier Berkshire

Reading West Berkshire Wokingham

JHWBS Berkshire West Social Media Weekly Comms Plan
December 2020

Date	Type	Topic	Post	Links
Friday 4 Dec	Facebook	Launch	The Consultation Launch	Survey CCG page
Friday 4 Dec	Twitter	Launch	The Consultation Launch	Survey CCG page
Tues 8 Dec	Facebook	Survey Focus Gps	Focus on Survey and focus groups	Survey CCG page
Tues 8 Dec	Twitter	Survey Focus Gps	Focus on Survey and focus groups	Survey CCG page
Thurs 10 Dec	Facebook	What can we do to help improve your health and wellbeing?	We want to make life happier and healthier for everyone. Please let us know your thoughts and complete the Health and Wellbeing Survey. Covid-19 has had a huge impact on everyone's lives, and (tag) Reading Borough Council, NHS, Wokingham Borough Council and West Berkshire need to hear from you to understand what you need and where we should focus our work to improve your health and wellbeing - more crucial now than ever. https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Thurs 10 Dec	Twitter	We want to make life happier and healthier for everyone.	Covid-19 has had a huge impact on everyone's lives. Where should we focus our work to improve your health & wellbeing? Let us know: https://www.surveymonkey.co.uk/r/jhwbstrategy @NHSuk @Reading @WestBerkshire @WokinghamBC	Survey CCG page
Tues 15 Dec	Facebook	This is how we got here	Our Journey (Roadmap Visual) Check out our journey to date with our great new visual roadmap	Survey CCG page Roadmap
Tues 15	Twitter	This is how we got here	Our Journey (Roadmap Visual) Check out our journey to date with our great new visual roadmap	Survey CCG page Roadmap
Friday 18 Dec	Facebook	How can we improve your health and well-being?	Over the next ten years, the Berkshire West Joint health and wellbeing strategy will aim to make life happier and healthier for everyone. We want to hear from as many people as possible	Survey CCG page

			about what is important, to improve health and wellbeing. Please let us know your thoughts and share the survey with your communities and any local groups you belong to. The survey is open until 29th January. https://www.surveymonkey.co.uk/r/jhwbstrategy	
Fri 18 Dec	Twitter	How can we improve your health and well-being?	Over the next ten years, the Berkshire West Joint health and wellbeing strategy will aim to make life happier and healthier for everyone. Please let us know your thoughts and share the survey with your communities and any local groups you belong to. The survey is open until 29th January. https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Wed 23 Dec	Facebook	We wish you a happier and healthier Xmas	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Wed 23 Dec	Twitter	We wish you a happier and healthier Xmas	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tues 29 Dec	Facebook	Win £100 of vouchers by telling us how we can improve your health and wellbeing!	For everyone who completes the survey, there is the chance to enter a draw to win £100 of shopping vouchers. We need to hear from you to understand what you need and where we should focus our work to improve your health and wellbeing. https://www.surveymonkey.co.uk/r/jhwbstrategy @NHSuk @WokinghamBC @WestBerkshire	Survey CCG page

Tues 29 Dec	Twitter	Win £100 of vouchers by telling us how we can improve your health and wellbeing!	For everyone who completes the survey, there is the chance to enter a draw to win £100 of shopping vouchers. We need to hear from you to understand what you need and where we should focus our work to improve your health and wellbeing. https://www.surveymonkey.co.uk/r/jhwbstrategy @NHSuk @WokinghamBC @WestBerkshire	Survey CCG page
Tues 5 Jan	Facebook	Make this New Year happier and healthier	Where should we focus our work to improve health and wellbeing? Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tues 5 Jan	Twitter	Make this New Year happier and healthier	Where should we focus our work to improve health and wellbeing? Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy @NHSuk @Reading Council @WokinghamBC @WestBerkshire	Survey CCG page
Friday 8 Jan	Facebook	Join our online focus groups and tell us what you think	Join one of our Public Focus Groups on Zoom 13 Jan @ 2pm 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details	Survey CCG page
Friday 8 Jan	Twitter	Join our online focus groups and tell us what you think	Join one of our Public Focus Groups on Zoom 13 Jan @ 2pm 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details	Survey CCG page
Tues 12 Jan	Facebook	Join our online focus groups and tell us what you think	Join one of our Public Focus Groups on Zoom 13 Jan @ 2pm 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details	Survey CCG page

Tues 12 Jan	Twitter	Join our online focus groups and tell us what you think	Join one of our Public Focus Groups on Zoom 13 Jan @ 2pm 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details	Survey CCG page
Fri 15 Jan	Facebook	Have you completed the health and wellbeing survey? You could win £100 of shopping vouchers	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey and enter a draw to win £100 of shopping vouchers https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Fri 15 Jan	Twitter	Have you completed the health and wellbeing survey? You could win £100 of shopping vouchers	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey and enter a draw to win £100 of shopping vouchers. @NHSuk @WokinghamBC @WestBerkshire https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tue 19 Jan	Facebook	Join our online focus groups and tell us what you think	Join one of our final Public Focus Groups on Zoom 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tue 19 Jan	Twitter	Join our online focus groups and tell us what you think	Join one of our final Public Focus Groups on Zoom 20 Jan @ 6.30pm 27 Jan @ 10am Contact us on our email for joining details https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Fri 22 Jan	Facebook	Only a week left to tell us how we can make your life happier	Our Health and Wellbeing Survey closes at 5pm Friday 29th January. We need to hear from you https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page

		and healthier		
Fri 22 Jan	Twitter	Only a week left to tell us how we can make your life happier and healthier	Our Health and Wellbeing Survey closes at 5pm Friday 29th January. We need to hear from you https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tue 26 Jan	Facebook	How can we improve your health and well-being?	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Tue 26 Jan	Twitter	How can we improve your health and well-being?	We want to understand what people living in our communities need and where we should focus our work to improve health and wellbeing. Please share your thoughts with us in our Health and Wellbeing Survey https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Fri 29 Jan	Facebook	Last day to tell us how we can make your life happier and healthier	Our Health and Wellbeing Survey closes at 5pm today. We want to hear from you and don't forget by completing our survey you can enter the draw to win £100 shopping vouchers https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page
Fri 29 Jan	Twitter	Last day to tell us how we can make your life happier and healthier	Our Health and Wellbeing Survey closes at 5pm today. We want to hear from you and don't forget by completing our survey you can enter the draw to win £100 shopping vouchers https://www.surveymonkey.co.uk/r/jhwbstrategy	Survey CCG page

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Build Back Fairer: The COVID-19 Marmot Review

Report being considered by:	Health and Wellbeing Board
On:	28 January 2021
Report Author:	Sarah Rayfield
Item for:	Discussion

1. Purpose of the Report

1.1 To provide a summary to the Board on the report by the Institute of health Equity: "Build Back Fairer: The COVID-19 Marmot Review".

2. Recommendation(s)

2.1 This paper is to inform the Board of the report and provide a basis for a discussion on how it should be applied to the work of the Health and Wellbeing Board in West Berkshire.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

3. Introduction/Background

3.1 Immediately prior to the COVID-19 pandemic, The Marmot Review 10 years on reported that the increase in life expectancy had stalled in the UK, with social and economic inequalities increasing. In addition, life expectancy for the poorest people was falling.

3.2 Health is closely linked to social determinants: the conditions in which people are born, grow and live, work and age, and inequities in power, money and resources.

3.3 The gradient in healthy life expectancy is even steeper than that of life expectancy. People living in more deprived areas are living shorter lives, and are spending more of their life in ill-health compared to those living in less deprived areas.

3.4 COVID-19 has highlighted and amplified the inequalities that were already present in our society.

3.5 Age standardised mortality rates from COVID-19 follow the same social gradient as death rates from all causes. The causes of inequality in death in general, overlap with causes of death from COVID-19.

3.6 Mortality rates from COVID-19 are particularly high amongst British people who self-identify as Black, Bangladeshi, Pakistani and Indian. Most of this is linked to deprivation rather than explained by pre-existing health conditions. It is impacted by

crowded housing and being more exposed to the virus at work and at home. These conditions are the result of longstanding inequalities and structural racism.

3.7 The relative cumulative age standardised all-cause mortality rate in 2020 has been highest in the UK compared to all other European countries. The report describes 4 potential reasons why the pandemic toll is so high in England:

(1) The governance and political culture has reduced social cohesion and inclusiveness and failed to recognise health and wellbeing as a priority for the population;

(2) Widening inequities in power, money and resources have generated inequalities in health general and in COVID-19 specifically;

(3) Government policies of austerity have reduced public expenditure in the decades prior to the pandemic. Public services have been depleted with lower income groups particularly disadvantaged;

(4) Health had stopped improving with a high prevalence of the health conditions that increase mortality from COVID-19.

3.8 The economic impact of the pandemic is significant. The youngest age group (16-24 years) has the highest unemployment cumulative growth. Low income workers are most likely to be in sectors that have been shut down. Employment recovery from COVID-19 is likely to be hardest in areas of greater deprivation.

4. Supporting Information

4.1 There are a number of factors associated with higher mortality from COVID-19. Many people have experienced more than one of these factors and these risks are cumulative, often resulting in a much higher mortality rate. This should be considered in the roll-out of treatments and vaccinations and in efforts to prevent spread.

(1) England has had higher mortality rates from COVID-19 compared to other European countries;

(2) Certain underlying health conditions significantly raise the mortality from COVID-19. This includes diabetes, cardiovascular disease and chronic obstructive pulmonary disease;

(3) The more deprived a local authority, the higher the COVID-19 mortality rate has been;

(4) The pandemic has shown a close association between underlying health, deprivation, occupation and ethnicity. Mortality has been particularly high in the North West and North East of England;

(5) Living conditions: overcrowded living conditions and poor-quality housing are associated with higher risks of mortality from COVID-19;

(6) Occupation: being a key worker, unable to work from home and being in close proximity to others has put individuals at higher risk. This has

particularly been the case for those in health and social care, as well as other key workers such as taxi and bus drivers.;

(7) It is now well recognised that individuals from ethnically diverse communities have much higher mortality risks compared to white people in England. This is in part due to living in more deprived areas and being in high risk occupations but there is also evidence that individuals may not have been sufficiently protected by PPE and other safety measures.

4.2 Even before the pandemic, the UK ranked poorly in child wellbeing – ranking 27th out of 38 in the UNICEF report card. Clear and persistent socioeconomic inequalities in educational attainment have persisted since 2010.

4.3 COVID-19 has had a particular impact on early years and school-age education. More disadvantaged children have been harmed by closures of early years settings and levels of development have been lower than expected among poorer children. Parents with lower incomes have experienced significant stress when young children have been at home. More disadvantaged children have had less access to online learning and educational resources and have been impacted by inequalities in the exam grading systems. Children with special educational needs have been particularly disadvantaged by the school closures.

4.4 COVID-19 has had a significant impact of children's learning and their personal, social and emotional wellbeing. This has particularly been the case for parents who have continued to work outside of the home, with stress related to reducing family finances, poverty, larger family size and overcrowded households. These have impacted parents' capacity to support their young children during lockdowns.

4.5 Inequalities in education are widening. Schools from deprived areas have been less able to provide online learning with more deprived children less likely to have a suitable space at home to study. Wealthier parents have been more able to compensate for loss of learning through additional tutoring and educational resources as well as having more time to support their children's education.

4.6 COVID-19 has had wider impacts on inequalities for children and young people. Indications are that child poverty will increase further with food poverty among children and young people already increasing significantly. The mental health of young people has deteriorated during the pandemic with lack of access to appropriate services. Exposure to abuse at home has risen. Unemployment among young people is rising more rapidly than among other age groups with declining availability of apprenticeships and training schemes.

4.7 Countries that controlled the pandemic better than England have seen less impact on employment and wages. Rising unemployment and low wages will lead to worse health and increasing health inequalities. Unemployment has been protected by the Coronavirus Job Retention Scheme (furlough), but is expected to rise considerably when the scheme ends in April 2021.

4.8 Low income workers are most likely to have been furloughed, resulting in a 20 percent pay cut. This is likely to have pushed many into poverty, without the buffer of savings. One third of people in the bottom decile for earnings were employed in shuttered sectors, compared with less than 10 percent in the top three income

deciles. Self-employed workers have been hit particularly badly, with many having to stop working, but being ineligible for the furlough scheme. The crisis has also highlighted the pre-existing difficulties and low pay in the social care sector – one in 10 care workers is on a zero hours contract and 70 percent earn less than £10 per hour.

4.9 While the measures put in place for COVID-19 have had a negative economic impact on much of the population, the level of impact has varied according to prior socioeconomic position, religion, occupation, age, ethnicity and disability. This is resulting in further widening of income inequalities in the UK. Young people and those from Black and Minority Ethnic groups have been most impacted by decreases in income. Disabled people have also been disproportionately harmed by the economic impacts of containment.

4.10 Even before the pandemic, food insecurity was a significant concern in the UK with the Trussell Trust estimating 8-10 percent of households had experienced either moderate or severe food insecurity between 2016 and 2018. During March to August 2020, four million people in households with children experienced food insecurity (14 percent of households).

4.11 The physical, economic and social characteristics of housing, places and communities play an important role in people's mental health and wellbeing. However, inequalities between places have been widening since 2010 with regressive cuts to public services negatively impacting more deprived areas the most. Places that were already deprived will find recovery from COVID-19 more difficult and are likely to experience even greater deprivation and ill-health after the pandemic.

4.12 Housing is a key determinant of health and overcrowded housing has emerged as a high risk factor for COVID-19 infection, as well as being associated with poor mental and physical health. Over the lockdowns, people have spent much of their time in their own homes, which in some cases has increased exposure to unhealthy and overcrowded conditions. Inequalities related to access to outdoor space have increased and housing costs have become an even greater burden for many. The economic impact of COVID-19 will lead to an escalation of homelessness. In March 2020, funding was provided to local authorities to provide accommodation for those sleeping rough. However, since then there have been increases in rough sleeping and homelessness, along with reduced access to support services as many have had to move online.

4.13 The original Marmot review in 2010, found that many unhealthy behaviours are driven by the conditions in which people are born, grow, live, work and age (the social determinants of health). Inequalities in health behaviours and health have contributed to inequalities for COVID-19 mortality. The longer term health impacts of containment measures are creating a new public health crisis, increasing inequalities. The public health system needs a strengthened focus on the social determinants of health in order to address this and to ensure full and equitable recovery from COVID-19.

5. Options for Consideration

5.1 The recommendations within the report are divided into a number of sections which are summarised below.

5.2 Recommendations to reduce the inequalities in mortality from COVID-19 include:

(1) Consider proportionate allocation of measures to prevent COVID-19. For example focusing vaccination efforts on people in particularly high risk occupations and geographical areas;

(2) Ensure that Personal Protective Equipment is available and its use is enforced;

(3) Provide adequate financial support for workers who are unable to work due to COVID-19 and the requirement to self-isolate.

5.3 Recommendations to reduce the impact on early years and reduce the inequalities in education include:

(1) For Early Years In the short term: improve access to parenting support programmes, increase funding rates for free childcare places to support providers and to allocate additional governmental support to early years settings in more deprived settings;

(2) For Education in the short term: to address inequalities in laptops – particularly for more disadvantaged students; to increase the focus on equity in assessments for exam grading; to roll out catch-up tuition for children in more deprived areas; to provide additional support for families and students with SEND and to urgently give excluded students additional support and enrol those who need it into Pupil Referral Units;

(3) For Early Years in the medium term: increase levels of spending on the early years, ensuring allocation of funding is proportionately higher for more deprived areas; improve the availability and quality of early years services (including children's centres); increase pay and qualification requirements for the childcare workforce;

(4) For Education in the medium term: restore the per-student funding for secondary schools at least in line with 2010 levels;

(5) For Early Years in the long term: Government should prioritise reducing inequalities in early years development;

(6) For Education in the long term: to put equity at the heart of national decisions about education policy and funding; to increase attainment to match the best in Europe by reducing inequalities.

5.4 Recommendations to improve outcomes for children and young people include:

(1) In the short term: to take measures towards reducing child poverty (for example, increasing child benefit for lower income families and extending free school meal provision); urgently address children and young people's mental health, including training more teachers in mental health first aid; increase resources for preventing abuse and identifying and supporting children; develop and fund additional training schemes for school leavers; further support young people's training, education and employment schemes to reduce the numbers who are

NEET; raise minimum wage for apprentices and further incentivise employers to offer these schemes; prioritise funding for youth services;

(2) In the medium term: to reduce levels of child poverty to 10 percent; to increase the number of post-school apprenticeships and support in work training; improve prevention and treatment of mental health problems among young people;

(3) In the long term: to reverse the decline in mental health of children and young people and improve levels of wellbeing from the present low rankings nationally; ensure that all young people are engaged in education, employment or training up to the age of 21.

5.5 Recommendations to create fairer employment and good work for all include:

(1) In the short term: provide subsidies or tax relief for firms that recall previously dismissed workers; extend the Coronavirus Job Retention Scheme to cover 100 percent of wages for low income workers and self-employed workers; enforce living wages;

(2) In the medium term: reduce the high levels of poor quality work and precarious employment; invest in good quality active labour market policies; increase the national living wage to meet the standard of minimum income for healthy living;

(3) In the long term: establish a national goal for everyone in full-time work to receive a wage that prevents poverty and enables a healthy life; ensure the social safety net is sufficient for people not in full time work to receive a minimum income for healthy living; engage in a national discussion on work-life balance.

5.6 Recommendations on ensuring a healthy standard of living for all are as follows:

(1) In the short term: increase the scope of the furlough scheme to cover 100 percent of low income workers; eradicate benefit caps and lift the two child limits; provide tapering levels of benefits to avoid cliff edges; end the five-week wait for Universal Credit and provide cash grants for low-income households; give sufficient Governmental support to food aid providers and charities;

(2) In the medium term: Make permanent the £1000 a year increase in the standard allowance for Universal Credit; ensure that all workers receive at least the national living wage; eradicate food poverty permanently and remove reliance on food charity; remove sanctions and reduce conditionalities in benefit payments;

(3) In the long term: put healthy 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 benefits system to ensure that they achieve greater equity and are not regressive.

5.7 Recommendations to create and develop healthy and sustainable places and communities include:

(1) In the short term: increase grants for local government to deal with the COVID-19 crisis; increase government allocations of funding to the voluntary and community sector; increase support for those who live in the private rented sector; remove the cap on council tax; urgently reduce homelessness;

(2) In the medium term: increase deprivation weighting in the local government funding formula; strengthen resilience of areas; reduce sources of air pollution from road traffic in more deprived areas; build more good quality homes that are affordable and environmentally sustainable.

(3) Long term: invest in the development of economic, social and cultural resources in the most deprived communities; ensure 100 percent of new housing is carbon neutral by 2030; aim for net-zero greenhouse gas emissions by 2030, ensuring that inequalities do not widen.

5.8 Recommendations to strengthen the role and impact of ill health prevention include:

(1) In the short term: Funding for Public Health to be increased with spending focused proportionately across the social gradient; Public Health to develop capacity and expand focus on social determinants of health;

(2) In the medium term: To develop social determinants of health interventions to improve health behaviours and reduce inequalities; Public Health to inform the development of a government health inequalities strategy;

(3) In the long term: A National Strategy on Health Inequalities; build a public health system that is based on taking action on the social determinants of health and reducing health inequalities.

6. Proposal(s)

6.1 Although the containment response to the COVID-19 pandemic continues, it is also necessary to start to look towards how we will recover. The pandemic is an opportunity to build a fairer society and address the widening health inequalities that have been highlighted by COVID-19.

6.2 It is proposed that this will require both a commitment to social justice and putting equity at the heart of local decisions, along with specific actions taken to create healthier lives for all.

6.3 Many of the recommendations within the report can likely only be fulfilled through national policy making, however there are still opportunities for local decision makers to put in place measures to mitigate the impact of widening health equalities.

6.4 The report aligns with the recently published 2020 Annual Public Health Report for Berkshire and how we can tackle inequalities to build a renewed, more inclusive, healthy and prosperous district.

6.5 It is proposed that the Health and Wellbeing Board considers the recommendations as outlined in the report and to use these to inform recovery planning locally.

7. Conclusion(s)

7.1 The purpose of this paper is to provide a summary of the Report on the Pandemic, Socioeconomic and health inequalities in England and to provide an opportunity for discussion of how the recommendations could be implemented locally.

8. Consultation and Engagement

Matt Pearce (Service Director – Communities and Wellbeing)

8.1 Not applicable

9. Appendices

9.1 Appendix A - Executive Summary - Build Back Fairer: The COVID-19 Marmot Review

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Background Papers:

Build Back Fairer: The COVID-19 Marmot Review (The Pandemic, Socioeconomic and Health Inequalities in England)

Health and Wellbeing Priorities 2019/20 Supported:

☒ First 1001 days – give every child the best start in life
☐ Primary Care Networks

Health and Wellbeing Strategic Aims Supported:

The proposals will help achieve the following Health and Wellbeing Strategy aim(s):

☒ Give every child the best start in life
☒ Support mental health and wellbeing throughout life
☒ Reduce premature mortality by helping people lead healthier lives
☒ Build a thriving and sustainable environment in which communities can flourish
☐ Help older people maintain a healthy, independent life for as long as possible

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by

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BUILD BACK FAIRER: THE COVID-19 MARMOT REVIEW

The Pandemic, Socioeconomic and Health Inequalities in England

Executive summary

The Health Foundation

INSTITUTE of HEALTH EQUITY

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CHAPTER 1
INTRODUCTION

‘Build Back Better’ has become the mantra. Important, but we need to Build Back *Fairer*. The levels of social, environmental and economic inequality in society are damaging health and wellbeing. As the UK emerges from the COVID-19 pandemic it would be a tragic mistake to attempt to re-establish the status quo that existed before – a status quo marked in England, over the past decade, by a stagnation of health improvement that was the second worst in Europe, and by widening health inequalities. That stagnation, those social and regional health inequalities, the deterioration in health for the most deprived people, are markers of a society that is not functioning to meet the needs of its members. There is an urgent need to do things differently, to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a wellbeing economy that puts achievement of health and wellbeing, rather than narrow economic goals, at the heart of government strategy; to build a society that responds to the climate crisis at the same time as achieving greater health equity.

It was precisely those principles of fairness and the need to do things differently that animated the concrete recommendations we set out in Health Equity in England: *The Marmot Review 10 Years On*, published in February 2020, just before the pandemic hit with such devastating intensity (1). The COVID-19 crisis, the pandemic and associated social and economic response, have made such action even more important. The UK has fared badly. Not only does England vie with Spain for the dubious distinction of having the highest excess mortality rate from COVID-19 in Europe, but the economic hit is among the most damaging in Europe too. The mismanagement during the pandemic, and the unequal way the pandemic has struck, is of a piece with what happened in England in the decade from 2010.

The recommendations we make in this report are, in large measure, built upon those we made in our *10 Years On* report. We offer them, along with an over-riding commitment to equity, as a way to Build Back Fairer.

The main features of health before the pandemic are summarised in Box 1.

BOX 1. HEALTH IN ENGLAND BEFORE THE PANDEMIC (FROM THE *TEN YEARS ON* REPORT)

- Since 2010 improvements in life expectancy in England have 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 its 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, resulted 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 North East England 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 increased across England in the decade from 2010. Inequalities in poor health harm individuals, families and 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 than wealthier areas and their capacity to improve social determinants of health has been particularly undermined.

As we set out in this report, COVID-19 has exposed and amplified the inequalities we observed in our *10 Years On* report and the economic harm caused by containment measures – lockdowns, tier systems, social isolation measures - will further damage health and widen health inequalities. Inequalities in COVID-19 mortality rates follow a similar social gradient to that seen for all causes of death and the causes of inequalities in COVID-19 are similar to the causes of inequalities in health more generally. While health behaviours contribute to the causes of non-communicable diseases (NCDs), it is the social determinants of health that cause inequalities in these health behaviours – the causes of the causes.

The links between ill health, including COVID-19, and deprivation are all too familiar. Less so have been the findings of shockingly high COVID-19 mortality rates among British people who self-identify as Black, Bangladeshi, Pakistani and Indian. Much, but not all, of this excess can be attributed to living in deprived areas, crowded housing and being more exposed to the virus at work and at home – these conditions are themselves the result of longstanding inequalities and structural racism. There is also evidence that many people from Black, Asian and Minority Ethnic (BAME) groups have not been well protected at work, and less well protected than their White colleagues.

As this report will document, the economic and social effects of containment measures will worsen physical and mental health in the long term and make health inequalities worse. Without urgent action, inequalities in health and other social and economic domains will rise considerably, from an already very concerning starting point. We set out ways to Build Back Fairer – to protect England from the inequitable health impacts of the pandemic and containment measures.

The aim of this report is three-fold:

- To examine inequalities in COVID-19 mortality. Focus is on inequalities in mortality among members of BAME groups and among certain occupations, alongside continued attention to the socioeconomic gradient in health – the more deprived the area, the worse COVID-19 mortality tends to be.
- To show the effects that the pandemic, and the societal response to contain the pandemic, have had on social and economic inequalities, their effects on mental and physical health, and their likely effects on health inequalities in the future.
- To make recommendations on what needs to be done.

In the first part of the report we set out the inequities in risk of mortality from COVID-19 – which include those related to underlying health conditions and disability, levels of deprivation, housing conditions, occupation, income and being from BAME groups; further, these risks accumulate. Conversely, the likelihood of mortality from COVID-19 is lower among people who are wealthy, working from home, living in good quality housing, White and have no underlying health conditions.

We then examine the impact of the COVID-19 crisis – the pandemic and associated economic and social inequalities – on key social determinants of health. It is important to state that there is a false opposition between health and the economy. It is not the case that enacting early containment measures harms economic progress. In fact, the reverse is true: countries that have managed the pandemic more effectively have also had less economic impact from COVID-19 containment measures and in the longer run will also have less damaging impacts on health.

The message of our *10 Years On* report was that the status quo in England was not desirable. As judged by the health situation, society was failing its population in important ways. If, as we argue, health is a measure of how well society is meeting the needs of its members, then the UK's poor management of the pandemic may similarly be a marker of a society that is not functioning in a socially cohesive and supportive fashion. In Box 2 we set out how this might operate to lead to health inequalities before, during and post-pandemic.

BOX 2. WHY IS ENGLAND'S TOLL FROM COVID-19 SO HIGH?

There are potentially four ways that the pre-pandemic situation in England relates to the high and unequal toll on health during and likely after the pandemic:

1. The governance and political culture both before and during the pandemic have damaged social cohesion and inclusiveness, undermined trust, de-emphasised the importance of the common good, and failed to take the political decisions that would have recognised health and well-being of the population as priority.

2. Widening inequities in power, money and resources between individuals, communities and regions have generated inequalities in the conditions of life, which in turn, generate inequalities in health generally, and COVID-19 specifically. They augur badly for health inequalities as we emerge from the pandemic.

3. Government policies of austerity succeeded in reducing public expenditure in the decade before the pandemic. Among the effects were regressive cuts in spending by local government including in adult social care, failure of health care spending to rise in accord with demographic and historical patterns, and cuts in public health funding. These were in addition to cuts in welfare to families with children, cuts in education spending per school student, and closure of Children's Centres. England entered the pandemic with its public services in a depleted state and its tax and benefit system regeared to the disadvantage of lower income groups.

4. Health had stopped improving, and there was a high prevalence of the health conditions that increase case fatality ratios of COVID-19.

Relevant to Building Back Fairer, a number of highly significant insights come out of the pandemic, with the potential to alter public and government priorities, as summarised in Box 3.

BOX 3. SUMMARY OF LESSONS LEARNT FOR BUILDING BACK FAIRER

Health matters: Good health is recognised as of the utmost importance for the whole population and ensuring good health should be the highest priority for government.

Good governance is critical: Good governance will increase trust, social cohesion and effective responses to the pandemic and will support Building Back Fairer.

Commitment to the common good: A socially cohesive society with concern for the common good is likely to be a healthier society. Government has both a clear enabling role and is a crucial source of accurate information and advice.

There should be no trade-off between the economy and health: Managing the pandemic well allows the economy to flourish in the longer term, which is supportive of health.

Long-term policies: Reducing health inequalities requires long-term strategic policies with equity as the focus.

Multi-sector action: Action is needed from national, regional and local governments, in collaboration with civil society.

Inequalities in social and economic conditions damage health: The unequal conditions into which COVID-19 arrived contributed to the high and unequal death toll from COVID-19 in England.

Containment measures will damage health: Containment measures have been essential but a failure to control the pandemic promptly means that containment measures have lasted longer and damaged economic and social domains, which will worsen health and health inequalities.

Austerity harmed health: Policies that prioritised repaying the debt over the needs of the population have harmed health and laid the ground for a more prolonged pandemic with high mortality and great inequality. Here the lesson for the future is do not reimpose austerity when the economy is struggling.

Societal change: The enormous societal changes in patterns of working and living during the pandemic must lead to considerations of societal functioning post-pandemic. Considerations must be given to changing patterns of work, such as a four-day week, provision of universal basic income and universal basic services.

Investment – whatever it takes: The pandemic needs to be controlled and economic and social infrastructure need to be supported. Governments can spend, and they must, if we are to Build Back Fairer. The spending announcements from the Government in November 2020 will not be sufficient to mitigate the unequal impacts of containment.

Investment in public health: This investment needs to be increased and must go hand-in-hand with economic and social progress.

Key workers: During the pandemic there has been a high correlation between low pay and having to continue to work in frontline occupations. We need to recognise the value of these contributions to society. Building Back Fairer has to value people who play such a vital role in society.

Green economy: The temporary reductions in air pollution, and in the rate of greenhouse gas emissions, needs to be sustained and will have benefits for health equity as well as employment and the economy.

Overall, we urge that the Government learns the lessons of the pandemic, prioritises greater equity and health, and works urgently to reduce the severity of the health crisis caused by the economic and social impacts of the pandemic and the societal response. We build on recommendations in the 10 Years On and Marmot 2010 reports, which were to:

- 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 each of the sections that follow – on inequalities in the risk of mortality from COVID-19, inequalities as a result of containment measures for children in the early years and for young people, during working lives, and impacts on income, living conditions, communities and public health – we include recommendations to Build Back Fairer in the short, medium and long term.

Most important are our **recommendations for the long term**. We must ask ourselves, as we emerge from the pandemic, what sort of society do we want to build? The message of our *10 Years On* report was that the status quo – before the pandemic hit – was not desirable. Building Back Fairer will require fundamental thinking about the nature of society in light of two major challenges facing the global community in general and England in particular: the climate crisis and inequality – both of which have profound implications for health equity (2).

Our second set of recommendations deal with **overcoming the medium-term** deterioration in social and economic conditions caused by the pandemic and associated societal response and decreased economic activity.

The third set of recommendations looks at **what we must do right now** given the inequalities exposed and amplified by the pandemic.

The early signs from the Government's spending review in autumn 2020 present a mixed picture. There will be a permanent scarring effect on the economy, an estimated 3 percent smaller than expected by 2025, meaning it will take longer for the average family to recoup their losses (3). Amid welcome dedicated spending made necessary by the pandemic, there will be a reduction of £10 billion in 'normal public sector spending' next year (4). Public sector pay outside the NHS will be frozen, and the temporary boost of £20 a week to Universal Credit is not set to continue beyond March 2021. The measures will be insufficient to reduce the inequitable impacts of the containment measures – from widening inequalities in early years development, educational attainment and prospects for young people, to rising unemployment and low pay and increasing poverty, to deepening deprivations in certain communities and regions and deteriorating public health. All of these are harbingers of a long-term health and healthy equity crisis in England.

Our recommendations to Build Back Fairer recognise the challenges and realities of public finance but prioritise a more equitable, socially cohesive and healthy society. We make recommendations relevant to the management of the pandemic and in each of the key social determinants of health we cover. The Government must start by aiming for significant reductions in societal, economic and health inequalities. A vital first step is an Inequalities Strategy for England that lays out the ambition and provides practical steps to achieve it. The recommendations in this report could lay the foundations for such a strategy. This and other priorities are outlined in Box 4.

BOX 4. SUMMARY OF POLICY APPROACHES TO BUILDING BACK FAIRER

Inequalities strategy: Based on national and international evidence, in the *10 Years On* report we recommended development of a national strategy for action on the social determinants of health with the aim of reducing inequalities in health. This should now be extended to become a national strategy on inequalities, led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments.

Proportionate universalism: To deal with inequalities in health, particularly the social gradient, we need universal solutions but with effort proportionate to need.

Regional inequalities: In *10 Years On* we documented widening health inequalities between regions, largely a result of widening social and economic inequalities. The COVID-19 crisis is adding to these. If levelling up is to be achieved, reducing these regional inequalities must have high priority.

CHAPTER 2

INEQUALITIES IN RISK OF MORTALITY FROM COVID-19

There will be reports, much needed, that examine the Government's pandemic containment responses, the speed and clarity of decision-making, the failure to set up a properly functioning test, trace and isolate system, the stop/start approach to restricting the public's activities, the lack of communication between central government and cities and regions, the fatal delays in supplying personal protective equipment (PPE) to health and social care staff, and the mistakes that put people in care homes at such high risk. All of these will have played a part in the UK's high mortality rate from COVID-19. These factors are notable too in countries such as the USA and Brazil that also have had a high toll in the pandemic. It is not our purpose here to examine these aspects of the pandemic. Rather, we make the case that conditions and inequalities in key areas of life prior to the pandemic – including education, occupation and working conditions, income, housing communities and health itself – relate to England's high and unequal mortality rate from COVID-19. We point out that deteriorating conditions and widening regional and socioeconomic inequalities in all these areas exposed many groups to particularly high risk for COVID-19.

Ideally, we would examine rates of infection, severity of disease and mortality. Because of the lack of widespread testing for COVID-19, much of the analyses on which we draw is limited to mortality rates. Although all three, infection, severity and mortality, are important for controlling the pandemic, there is much to be learned from an examination of the social determinants of mortality rates.

The risk factors for higher COVID-19 mortality are summarised in Box 5. These risks accumulate. Many people are experiencing all of these conditions, making them particularly vulnerable to infection and mortality. These cumulative high risks should be considered in the roll-out of vaccinations and treatments and in efforts to prevent spread. Key workers and those living in deprived areas may be considered to be priority recipients of vaccinations and any other preventive treatments.

BOX 5. SUMMARY OF FACTORS IN INEQUALITIES IN COVID-19 MORTALITY IN ENGLAND

International comparison: England had higher mortality from COVID-19 and higher excess deaths in the first half of 2020 than other European countries for which comparable data are available. In addition to specific failures to control the pandemic, this may relate to the policy decisions and socioeconomic conditions prior to the pandemic (see Box 2 above).

Health conditions: Some underlying health conditions significantly raise the risk of mortality from COVID-19. In England, prior to the pandemic, health was deteriorating, life expectancy stalling and health inequalities widening. Socioeconomic inequalities played a big part in these adverse health conditions in the decade before 2020.

Deprivation and inequality: The more deprived a local authority, the higher the COVID-19 mortality rate has been. Mortality rates from other causes follow a similar trajectory.

Regional inequalities: While the pandemic has affected different regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation and ethnicity and COVID-19 have made living in more deprived areas in some regions particularly hazardous. Mortality has been particularly high in the North West and North East since the end of the first wave.

Living conditions: Overcrowded living conditions and poor-quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and experienced by people with lower incomes. Evidence from analysis in *10 Years On* showed that housing conditions deteriorated for many in the last decade.

Occupation: There are clear differences in risks of mortality related to occupation. Being in a key worker role, unable to work from home and being in close proximity to others put people at higher risk. Occupations at particularly high risk include those in the health and social care, as well as those requiring elementary skills such as security guards and bus and taxi drivers. While mortality risks are closely linked to occupation, area of residence has an important bearing on the extent of occupational risk. Managers living in deprived areas have above-average risk for their occupation and workers in the elementary occupational group living in the least deprived areas have a lower risk of COVID-19 mortality.

BAME identity: Mortality risks from COVID-19 are much higher among many BAME groups than White people in England. BAME groups are disproportionately represented in more deprived areas and high-risk occupations, and these risks are the result of longstanding inequalities and structural racism. This does not fully explain COVID-19 risk; there is also evidence that much of the BAME workforce in highly exposed occupations have not been sufficiently protected with PPE and safety measures.

Cumulative risks: Risks of mortality are cumulative – being male, older, and BAME with an underlying health condition, working in a higher risk occupation and living in a deprived area in overcrowded housing leads to much higher rates of mortality.

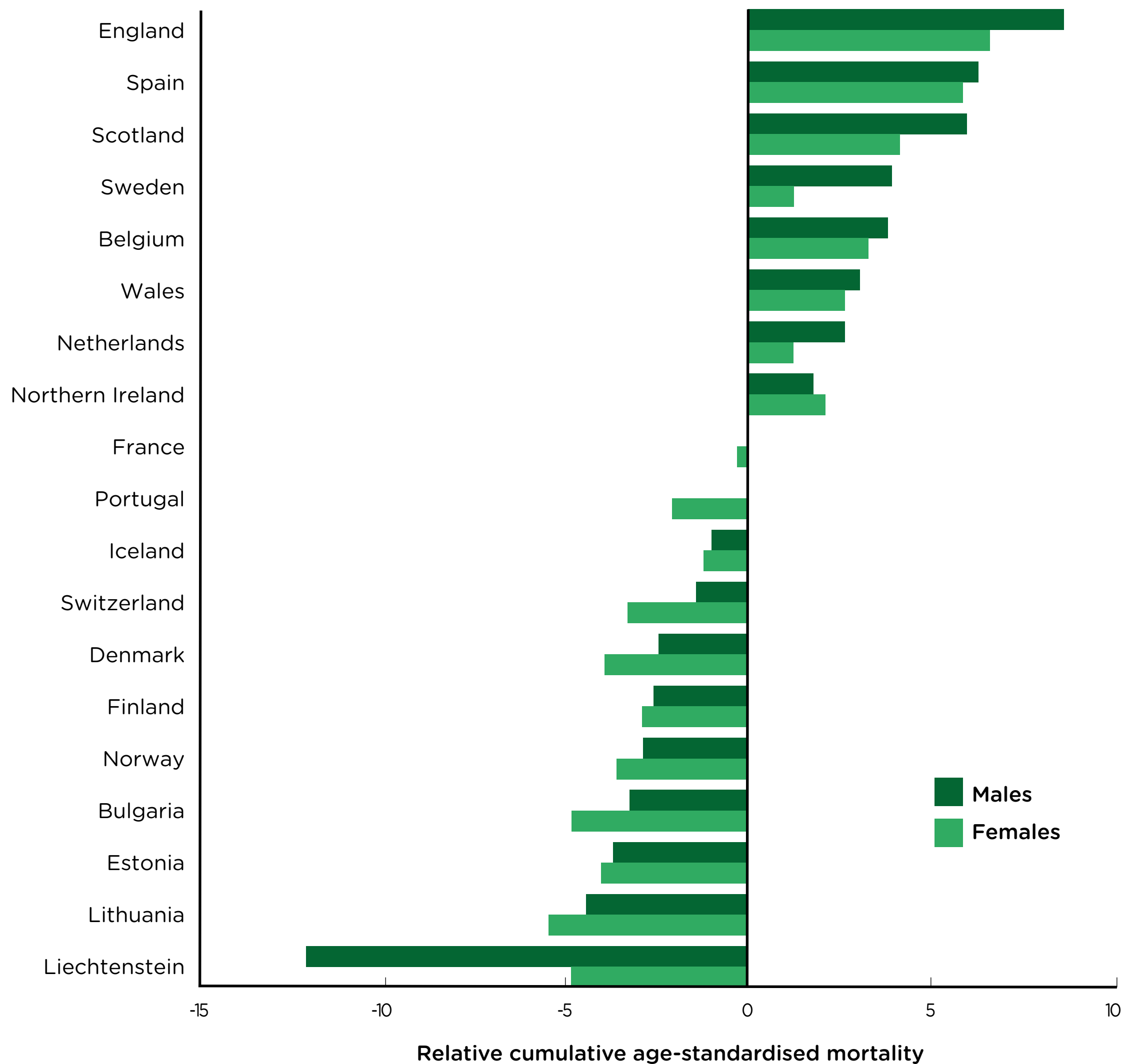
ENGLAND COVID-19 MORTALITY RATE: INTERNATIONAL COMPARISON

Excess mortality during the pandemic included deaths where COVID-19 appeared on the death certificate but also others where it did not. Excess 'non-COVID' deaths include those where COVID-19 went undiagnosed, particularly where testing was not being carried out routinely, as well as deaths from other conditions caused by reduced access to health care (e.g. the suspension of some cancer treatments), and resulting from a reluctance among some to visit GPs and hospitals for serious conditions (e.g. suspected heart attacks) (5) (6). Further analysis is needed to understand which of these factors has predominated in producing high levels of excess deaths (7). On average over the period March to November 2020, both the ratio of deaths registered to those expected and the number of excess deaths where COVID-19 did not appear on the death certificate were highest at ages 45-64 – although both were higher in older age groups during the peak of the epidemic in April. Similarly, on average over the period, both these figures were highest in the most deprived area quintile.

England has had higher mortality from COVID-19 and a greater number of excess deaths in the first half of 2020 than other European countries for which comparable data are available. This is not just a factor of population age structure, or of high rates of employment in particular sectors, nor is it solely to do with the management of the pandemic, although that is important. It relates to conditions prior to the pandemic, which we set out in *10 Years On*. England's poor position in relation to excess mortality in other countries is not unexpected, given that the UK's life expectancy improvement between 2011 and 2018 was the lowest among OECD countries apart from Iceland and the USA.

International comparisons of excess mortality rates between January and June 2020, compared with each country's average excess mortality over the previous five years, are shown in Figure 1.

Figure 1. Relative cumulative age-standardised all-cause mortality rates by sex, selected European countries, week ending 3 January to week ending 12 June 2020



Note: *Relative cumulative age-standardised mortality rates (rcASMRs) were developed by the Continuous Mortality Investigation (CMI) and described in working paper 111 (8). Rather than absolute values of death counts, rcASMRs sum all age-standardised mortality rates between two time points. In this figure, rcASMRs are calculated cumulatively from week 1, 2020 until week 24, 2020 and are relative to the 2015-2019 average cumulative age-standardised mortality rate for that time period in each country.*

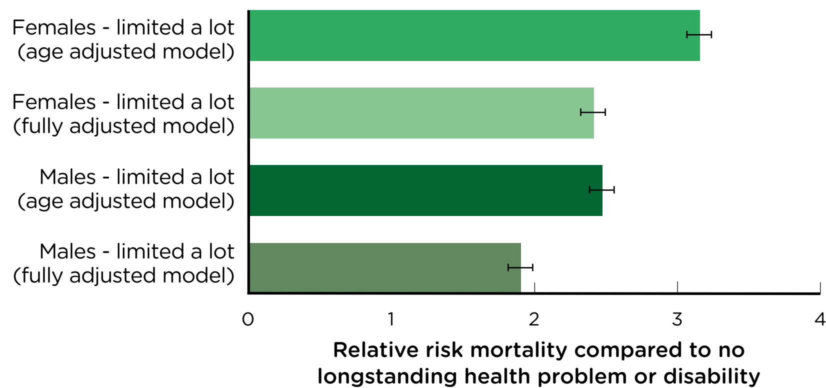
Source: *January to June 2020 (8).*

PREVIOUS HEALTH CONDITIONS AND RISK OF MORTALITY FROM COVID-19

Many people who have experienced severe COVID-19 disease, and who have died with COVID-19, have pre-existing conditions such as dementia, Alzheimer's disease, diabetes, cardiovascular disease and other chronic diseases such as chronic obstructive pulmonary disease and kidney disease. Some of these, such as dementia, reflect the ages at which COVID-19 deaths occur, while others such as diabetes, have been identified as risk factors for adverse outcomes of COVID-19 infection. Many of the underlying health risk factors for COVID-19 are the result of poor conditions associated with the social determinants of health.

Figure 2 shows "fully adjusted" mortality ratios, adjusted for age, region, population density, socio-demographic, household characteristics and occupational exposure. Based on these, the relative difference in mortality rates in England and Wales between those whose day-to-day activities were limited a lot because of a longstanding health problem or disability and those whose were not was 2.4 times higher for females and 1.9 times higher for males (from 2 March to 15 May 2020) for all those living in private households in 2011 (9). The 'fully adjusted' ratios are intended to show the relevance only of health problems and disability to mortality from COVID-19.

Figure 2. Ratios of death involving COVID-19 comparing those who were limited a lot because of a longstanding health problem or disability to those with no such problems by sex, England and Wales, 2nd March to 15th May 2020



Notes:

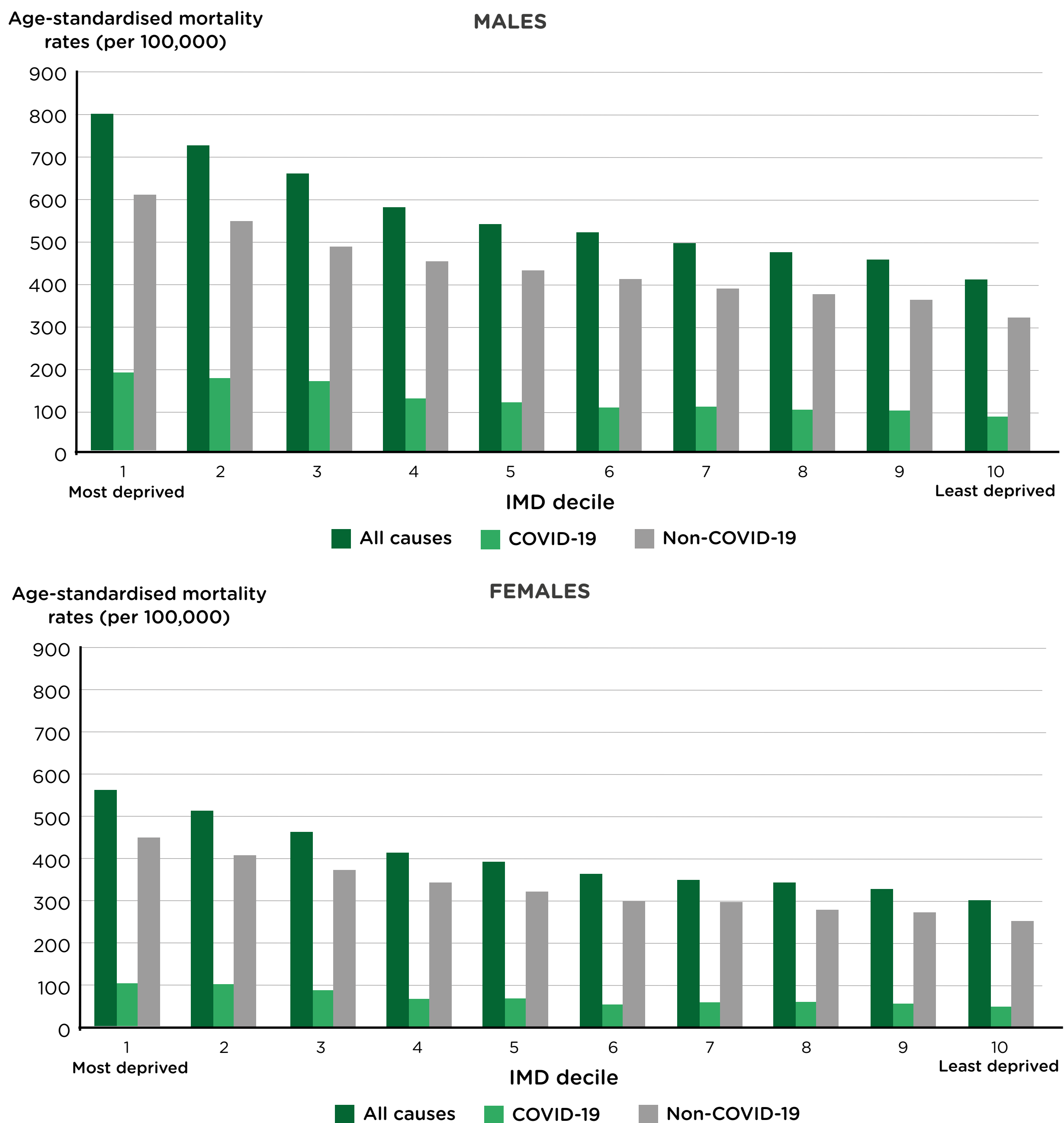
1. *Cox proportional hazards models adjusting for age and the square of age. Fully adjusted models also include region, population density, area deprivation, household composition, socio-economic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators (including key workers and exposure to others) in 2011.*
2. *Office for National Statistics (ONS) figures based on death registrations up to 29 May 2020 that occurred between 2 March and 15 May 2020 that could be linked to the 2011 Census for the coronavirus (COVID-19) rate of death.*
3. *Deaths were defined using the International Classification of Diseases, 10th Revision (ICD -10). Deaths involving COVID-19 include those with an underlying cause, or any mention, of ICD-10 codes U07.1 (COVID-19, virus identified) or U07.2 (COVID-19, virus not identified).*
4. *Hazard ratios are compared to the reference category of no longstanding health problem or disability. "Whiskers" on each bar are 95 percent confidence intervals.*
5. *Health status was defined using the self-reported answers to the 2011 Census question: "Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? - Include problems related to old age" (Yes, limited a lot; Yes, limited a little; and No).*

Source: *ONS, Coronavirus (COVID-19) related deaths by disability status, England and Wales, 2020 (19).*

AREA DEPRIVATION AND COVID-19

In England, as across the world, mortality rates from all causes are higher in more deprived areas, and prior to the pandemic health inequalities related to deprivation had been increasing. COVID-19 follows a similar trajectory to inequalities in mortality from other causes – the more deprived the area of residence, the greater the mortality from COVID-19. Figure 3 shows that rates of mortality from COVID-19 in England between March and July 2020 were double in the most deprived areas compared with the least and there is a clear gradient in mortality rates related to deprivation. These relative differences in COVID-19 are marginally greater than those for non-COVID-19 deaths, although absolute numbers of non-COVID-19 deaths are substantially greater.

Figure 3. Age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by sex, deprivation deciles in England, between March and July 2020



Note: *IMD = Index of Multiple Deprivation*

Source: *ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2020 (10).*

Clearly, levels of deprivation and health within an area have an enormous impact on mortality rates from COVID-19.

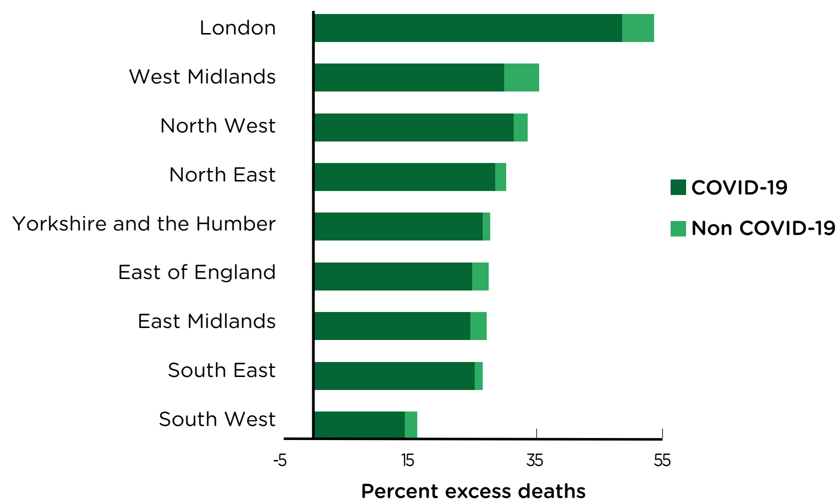
REGIONAL INEQUALITIES AND COVID-19

In *10 Years On* we showed that inequalities in health between regions were large and increased from 2010–20. This widening related to growing inequalities in wealth, income, employment and unequal government funding cuts between regions (1).

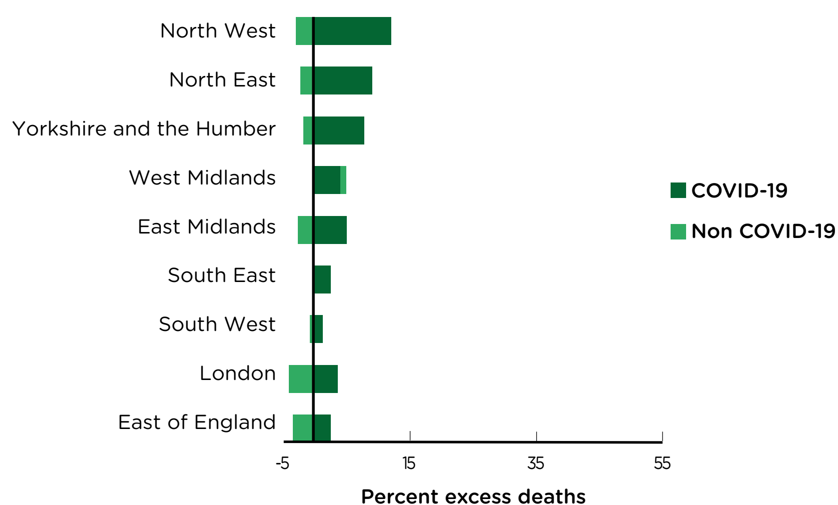
There are regional differences in rates of mortality from COVID-19, which relate to levels of poverty, occupational structure, ethnicity, age and housing conditions. In the first wave, London experienced the highest mortality rate, and in the second wave Northern regions have experienced higher mortality than the England average. The South East and South West had lower than average mortality during both waves, although overall rates in both Regions were slightly above their expected values in November 2020 compared to the low levels seen in August to October.

Figure 4. Percentage excess mortality compared with the trend in each region of England in the previous five years, by region and time period, 20 March to 6 November 2020

A) PERIOD 20 MARCH TO 31 JULY 2020



B) PERIOD 1 AUGUST TO 6 NOVEMBER 2020

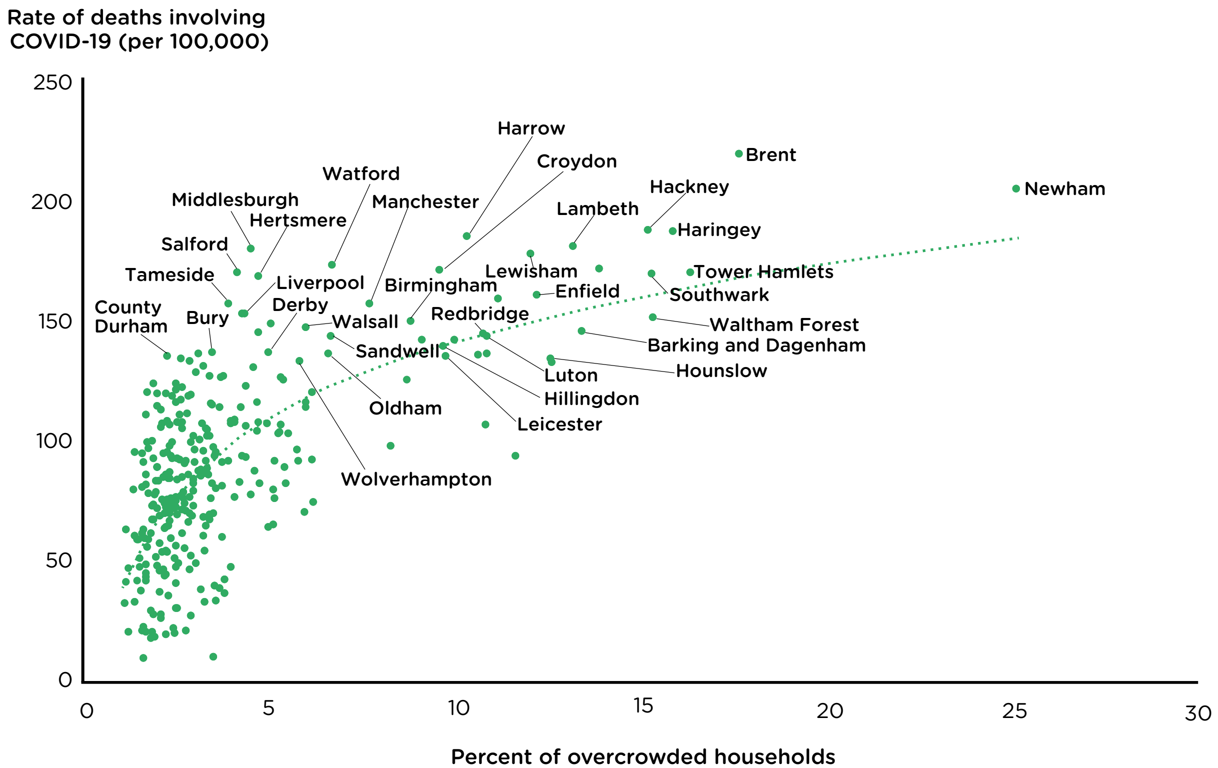


Source: *PHE Excess mortality in English regions - 20 March 2020 to 06 November 2020 (11).*

INEQUALITIES IN LIVING CONDITIONS AND MORTALITY FROM COVID-19

Overcrowded living conditions and poor-quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and inhabited by people with lower incomes. Evidence from the *10 Years On* analysis showed that housing conditions had deteriorated for many in the decade from 2010 and overcrowding had increased in the rented sectors. It remained at the highest rate it has been in the social rented sector since this information was first collected in the 1990s (13). Figure 5 shows the close association between COVID-19 mortality rates and overcrowding by local authority in England (10) (14).

Figure 5. Age-standardised COVID-19 mortality rates and percent of overcrowded households, local authorities in England, deaths occurring between March and July 2020

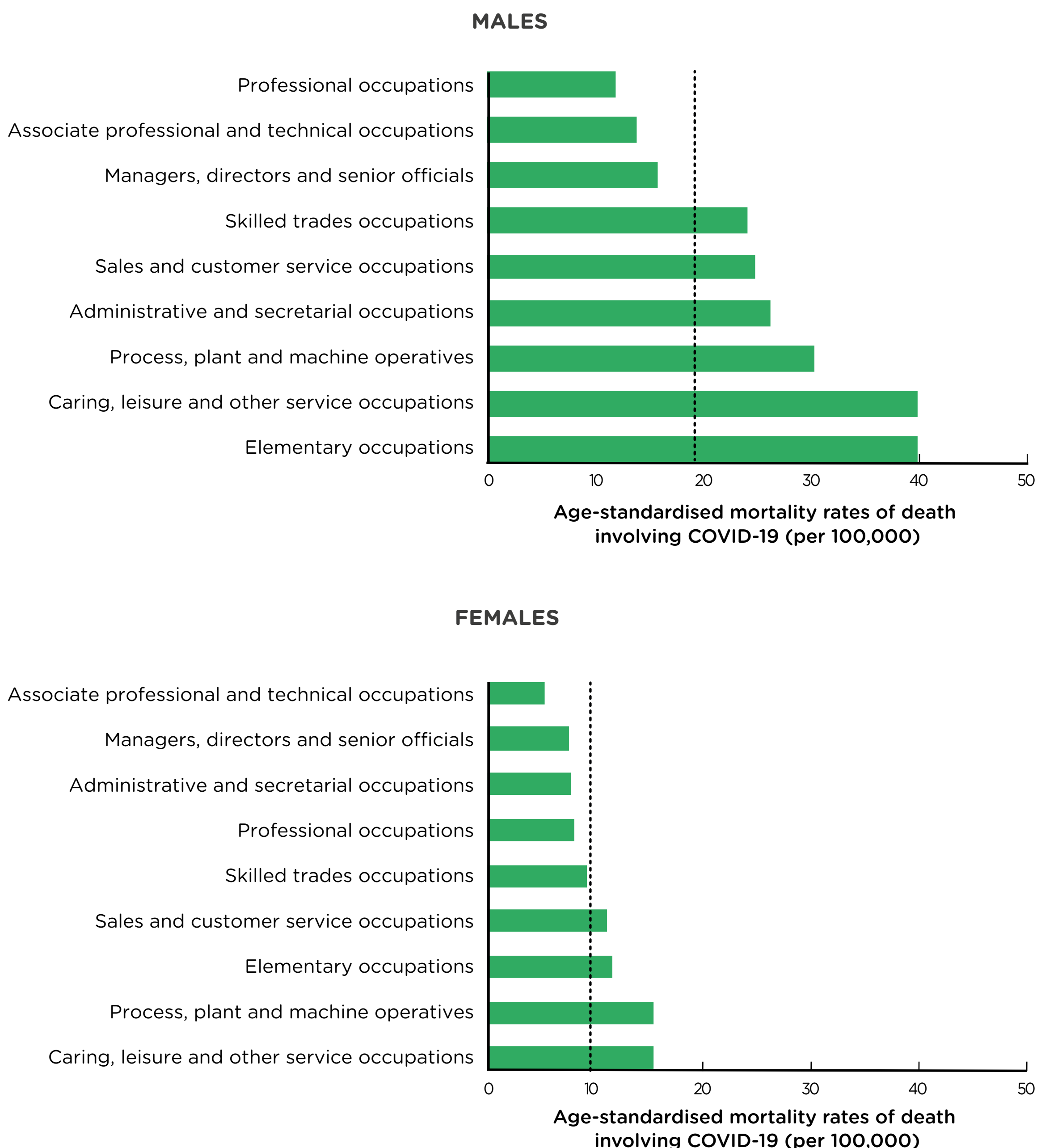


Source: *ONS. COVID-19 age-standardised mortality rates by local authority and percent of overcrowding, 2020 (10) (14).*

OCCUPATION AND MORTALITY FROM COVID-19

Some occupations have particularly high rates of mortality from COVID-19. These include jobs that cannot be done from home, those that require being in close proximity to others, lower grade occupations, jobs with a higher-than-average percent of older workers, and jobs more likely than others to be occupied by those from a BAME group.

Figure 6. Age-standardised mortality rates at ages 20 to 64, by sex, and major occupational group, deaths involving COVID-19 registered in England and Wales, between 9 March and 25 May 2020



Notes: *Elementary occupations are those that require the knowledge and experience necessary to perform mostly routine tasks. Most occupations in this major group do not require formal educational qualifications but will usually have an associated short period of formal experience-related training.*

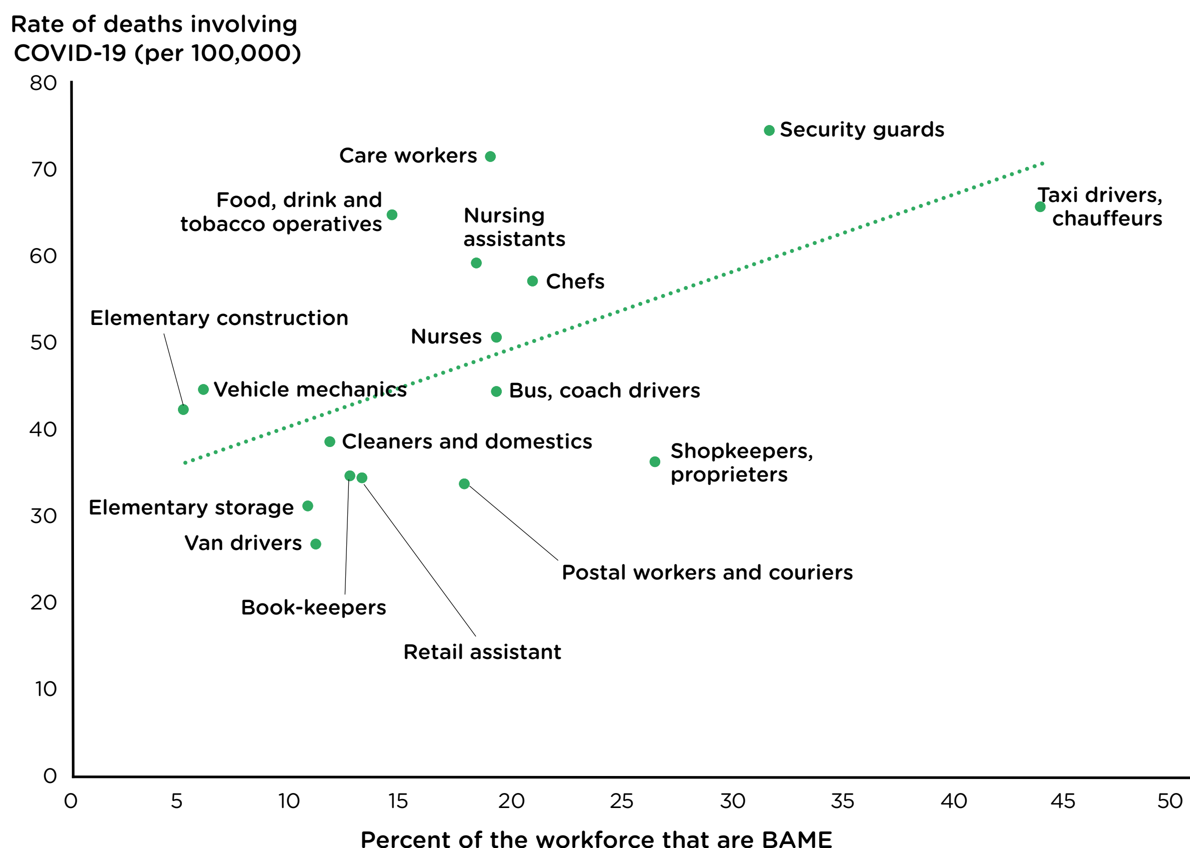
The vertical line represents the average death rate at ages 20 to 64 in England and Wales, for men and women with an occupation, respectively.

Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (15).*

The Office for National Statistics (ONS) assessed 17 occupations as being particularly high-risk for COVID-19 mortality. Security guards and related occupations, care workers and home carers, and taxi and cab drivers and chauffeurs had the highest mortality rates. Most of the occupations considered high risk had double the COVID-19 mortality rates expected based on mortality rates during the four previous years and all were occupations that necessitate being within close physical proximity to other people (15).

Figure 7 shows that some of the occupations with the highest mortality rates from COVID-19 – taxi drivers, chauffeurs and security guards – comprised a high proportion of BAME workers (15). Many BAME groups tend to work in occupations with high levels of proximity to others and this partly accounts for higher rates of mortality among these groups.

Figure 7. Percent of the workforce in 17 occupations with significantly raised risk of COVID-19 mortality that come from BAME groups, by age-standardised COVID-19 mortality rates at ages 20 to 64, England and Wales, 9 March to 25 May 2020

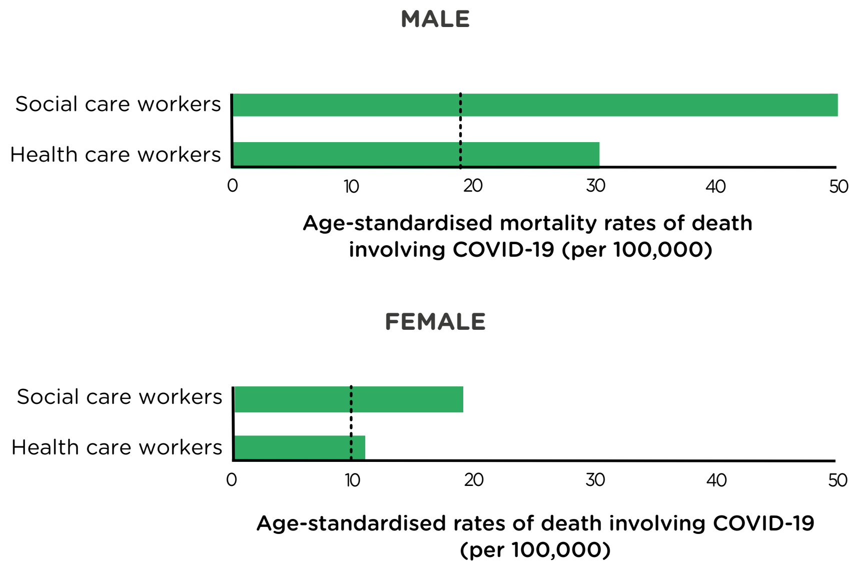


Source: *ONS 2020 (15).*

Workers from BAME groups have had more negative experiences related to discrimination and safety in the workplace during COVID-19 than White British workers. Specifically, those who identify as Black African, Bangladeshi and Pakistani have been less likely than White British workers to have been given adequate PPE. Higher proportions of Pakistani (20 percent) and Indian (20 percent) key workers, reported having had safety complaints ignored during the first lockdown (16). Poor treatment in the workplace has been highlighted as a key problem and described as a longstanding issue prior to COVID-19. Many BAME respondents to a survey about these issues said that they were concerned about raising them because of past experiences and fear of the consequences of speaking up (17). This issue has been particularly highlighted among health care workers during the pandemic.

Social care and health care workers had particularly high rates of deaths involving COVID-19 between 9 March and 25 May 2020 compared with those in other professions. For both men and women, the rates were higher for social care workers than health care workers and higher than average COVID-19 mortality rates in England and Wales at 19.1 deaths per 100,000 for men and 9.7 for women.

Figure 8. Age-standardised mortality rates at ages 20 to 64 for social care and health care workers by sex, deaths involving COVID-19 registered in England and Wales between 9 March and 25 May 2020



Notes: *The vertical line represents the average death rate at ages 20 to 64 in England and Wales for men and women with an occupation, respectively.*
Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (15).*

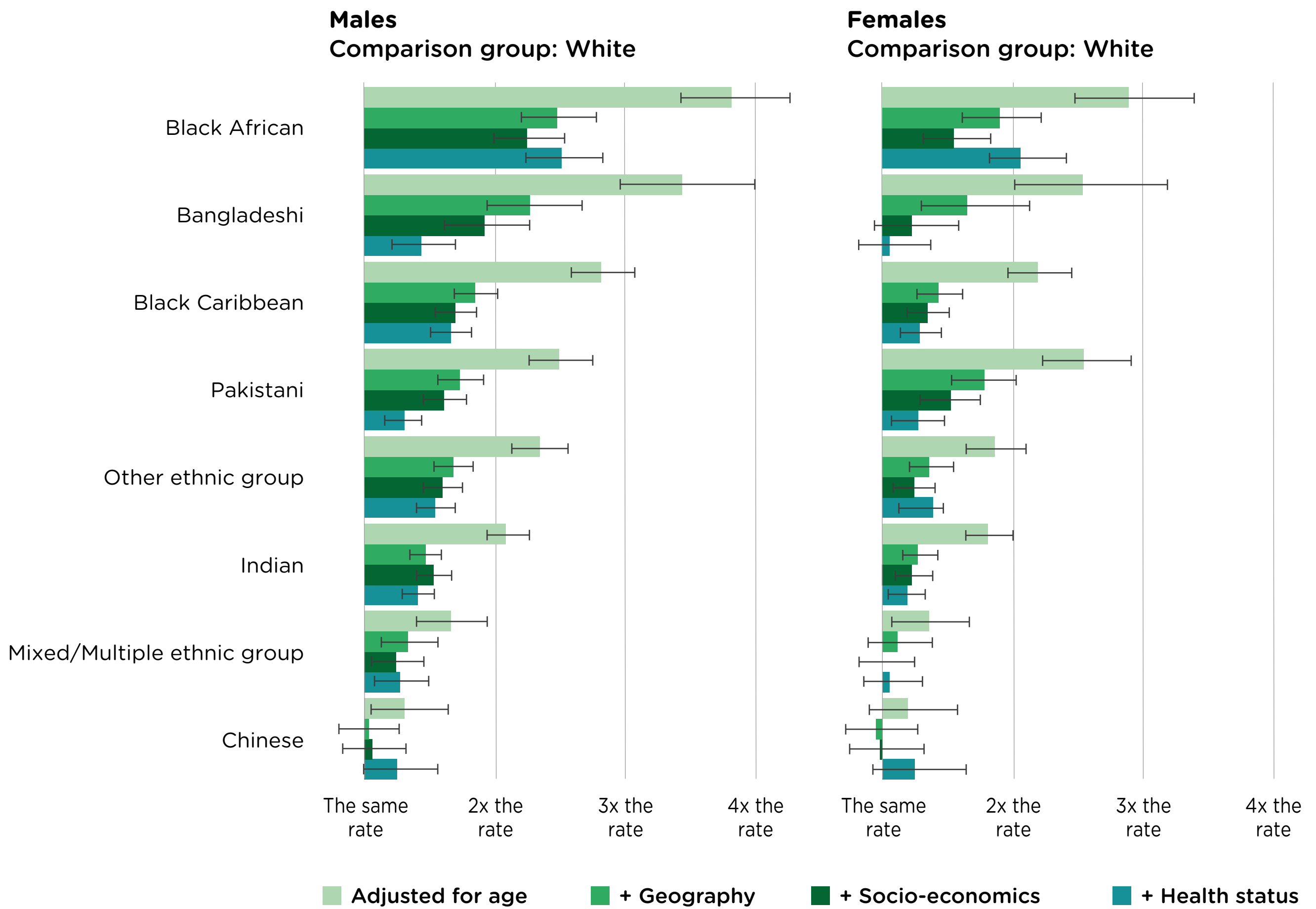
While different occupations have markedly different rates of mortality, there are additional differences within occupation groups related to age, underlying health conditions and area of residence. Those working as managers and in professional occupations have an above-average risk of mortality if they live in a deprived area, whereas those in elementary occupations have a much lower risk if they live in a wealthier area. This points to the significance of level of deprivation of area of residence for the risk of mortality for COVID-19 (15).

BAME GROUPS AND RISK OF MORTALITY

Mortality risks from COVID-19 are much higher among many BAME groups in England than they are for the White population. The reasons for this relate to these groups being disproportionately represented in high-risk occupations and more likely to be living in deprived areas and with more underlying health conditions that increase the risk from COVID-19, such as diabetes. All these conditions are the result of longstanding inequalities and structural racism. However, even these unequal conditions do not fully account for the higher mortality rates of non-White ethnic groups.

Figure 9 shows that even after accounting for age, geography, socioeconomic factors and health, mortality rates are highest for males and females with Black African ethnicity, and all ethnic groups described have higher rates than White people.

Figure 9. Death rates at ages 9 and over involving COVID-19 by ethnic group and sex relative to the White population, taking account of demographic, socioeconomic and health-related factors, England, 2 March to 28 July 2020



Notes:

1. *Cox proportional hazards models adjusting for age, geography (local authority and population density), socioeconomic factors (area deprivation, household composition, socioeconomic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators – including keyworkers and exposure to others), and health (self-reported health and disability status in March 2011, and hospital-based co-morbidities since April 2017).*
2. *Figures relate to persons enumerated living in private households as indicated by the 2011 Census, for whom deaths that occurred between 2 March and 28 July could be linked to ethnic group data from the 2011 Census.*
3. *'Other ethnic group' encompasses Asian other, Black other, Arab, and other ethnic group categories in the classification.*
4. *Error bars not crossing the x axis at value 1.0 denote a statistically significant difference in relative rates of death.*

Source: *ONS, COVID-19 related deaths by ethnic group, England and Wales, 2020 (18).*

SUMMARY

Analysis of risk factors for COVID-19 mortality clearly show that risks are much higher for those living in more deprived areas, in overcrowded housing, in key worker roles with close proximity to others, being from BAME groups, having underlying health conditions, as well as being older and male. Living outside the South of England is also a higher risk. And the risks are cumulative.

In *10 Years On* we made clear that the Government had not prioritised equity over the previous decade. We laid out evidence that inequalities in health and in key social determinants of health had widened, and that this was related to the policies of the decade from 2010 and the unequal cuts that had been made – affecting more deprived areas the most. Tragically, the results of these inequalities can now be seen again.

The recommendations from *10 Years On* will be even more critical after the pandemic. Given all the evidence for the inequalities in risks of mortality from COVID-19, it is essential that all efforts at rebuilding have the goal of greater equity at their heart – so that we can Build Back Fairer and ensure that unfair and unnecessary health inequalities are reduced. We make recommendations throughout the report for how to reduce the longer-term health inequality impacts that will arise as a result of containment measures.

Given that the risk of infection and mortality are so unequal, efforts to reduce risk and mortality must be proportionate to that risk and be particularly focused on the high-risk groups, areas and occupations.

The approach of proportionate universalism implies action to make whole communities safer with extra focus on higher risk areas, for example urban areas with overcrowded and multiple-occupation housing. Without these kind of proportionate responses, high risk groups and places will continue to experience high rates of mortality.

As COVID-19 treatments and vaccinations are rolled out, it is essential to take into account the differential risks facing people. The Government has signaled its intention to prioritise older people, care home residents and health and care staff for early receipt of the vaccine, but working age people in particular occupations could also be prioritised.

RECOMMENDATIONS

BOX 6. BUILD BACK FAIRER: REDUCING INEQUALITIES IN MORTALITY FROM COVID-19

- Consider **proportionate allocation of measures** to prevent COVID-19, including vaccinations and support to people in particularly high-risk occupations and geographical areas.
- Ensure that **personal protective equipment is available** and its use enforced.
- Provide **adequate financial support** for workers who cannot work because of COVID-19 risk and those who have to self-isolate.

CHAPTER 3

GIVE EVERY CHILD THE BEST START IN LIFE: COVID-19 CONTAINMENT AND INEQUALITIES

In the *10 Years On* report we showed that from 2010, in a number of critical drivers of children's early years development and education, trends were going in the wrong direction: in particular, regressive changes to taxes and benefits and a rise in child poverty. There was widespread closure of Children's Centres and early years services, with greatest impact in more deprived areas, where they are most needed. Inequalities in early childhood development and in attainment at school were persisting, closely related to deprivation and socioeconomic position of households. We also pointed to positive outcomes in places where there was a particular focus on improving equity in the early years, including London and Greater Manchester.

BOX 7. SUMMARY OF INEQUALITIES IN EARLY YEARS AND IN EDUCATION (FROM *10 YEARS ON* REPORT)

- Since 2010, progress has been made in early years development, as measured by children's readiness for school. However, 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, providing encouragement that it is quite possible to break the link between deprivation and poor early child development.
- Funding for Sure Start and Children's Centres, and other children's services, has been cut significantly, particularly in more deprived areas.
- There are still low rates of pay and a low level of qualification required in the childcare workforce.
- 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. The gap in achievement between poorer children and the average is less in London than in the rest of the country. This may result from higher levels of funding in London.
- School student numbers have risen while funding has decreased, by 8 percent per student, with particularly steep declines in funding for sixth form (post-16) and further education.
- Since 2010 the number of exclusions from school has significantly increased in both primary and secondary schools.

The persistent inequalities in attainment and severe cuts to school funding in England did not provide a sound footing to support early years development and educational attainment through the COVID-19 lockdowns in an equitable way. Furthermore, containment measures have led to widening inequalities in early years development and in educational attainment. Children with special needs and children with poor mental health have been especially vulnerable to damage from containment school closures.

Even prior to the pandemic and the first lockdown, the UK ranked poorly in child wellbeing. UNICEF Report Card 16 ranks children in 38 rich (OECD and EU) countries using three measures: mental wellbeing, physical health and academic and social skills. The UK ranks 27th out of 38. The five best-performing countries are the Netherlands, Denmark, Norway, Switzerland and Finland. Without even accounting for wide inequalities in the UK, it was doing poorly in child wellbeing. The COVID-19 lockdowns and school closures will have damaged children's wellbeing and it will be instructive to learn if the international rankings change as a result of the COVID-19 crisis.

BOX 8. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN THE EARLY YEARS AND DURING SCHOOL-AGE EDUCATION

EARLY YEARS

- More disadvantaged children have been disproportionately harmed by closures of early years settings and levels of development have been lower than expected among poorer children.
- Parents with lower incomes, particularly those who continued working outside the home, have experienced greater stress when young children have been at home.
- Many early years settings in more deprived areas are at risk of closure and of having to make staff redundant as a result of containment measures.

EDUCATION

- Compared with children from wealthier backgrounds, more disadvantaged children were disproportionately harmed by closures in the following ways:
  - Greater loss of learning time
  - Less access to online learning and educational resources
  - Less access to private tutoring and additional educational materials
  - Inequalities in the exam grading systems
- Children with special educational needs and their families were particularly disadvantaged through school closures.
- School funding continues to benefit schools in the least disadvantaged areas the most, widening educational outcomes.

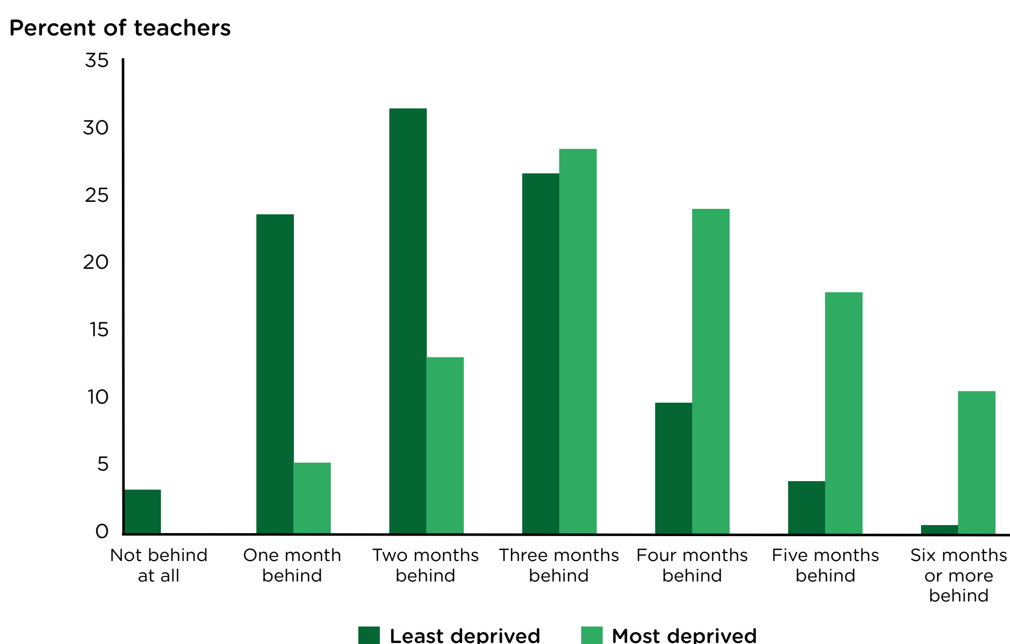
As abundant evidence over many years has shown, early years settings are particularly beneficial for more disadvantaged children, helping to close inequalities in development levels at this early and critical stage.

Ofsted reported that almost all early years providers said the COVID-19 crisis had had a significant impact on children's learning and their personal, social and emotional development. However, providers reported that children who continued to attend their setting or who were well supported at home had made good progress in their learning (19). Parents who continued to work outside the home, and who had lesser financial resources, were unable to offer their young children the same levels of support as wealthier parents and those working from home. Stresses related to deteriorating family finances, poverty, larger family size and overcrowded households have impacted on parents' capacity to support their young children during lockdowns.

Despite the support measures introduced by the Government, a quarter of early childhood settings reported that it is unlikely they would be operating in spring 2021 (20). Early years settings in deprived areas are most concerned about their futures and most likely to have to close and make staff redundant; their financial security needs to be further supported. As we pointed out in *10 Years On*, the closures of early years settings in more deprived areas are leading to even greater inequality in early childhood development and for a range of outcomes, including educational attainment, later in life (1).

The closure of schools during the first lockdown has also harmed the educational attainment of more deprived students in particular. Teachers in more deprived schools were significantly more likely than teachers in schools in less deprived areas to report that their students were further behind compared to where they would normally expect them to be at the same time of year (Figure 10).

Figure 10. Percent of teachers reporting loss of learning in the least and most deprived schools, England, September 2020

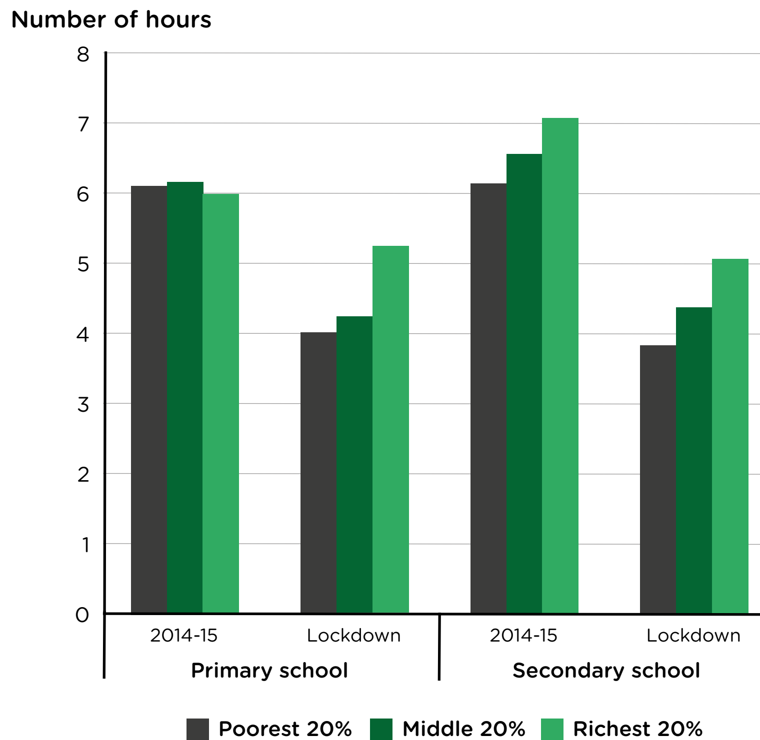


Source: *The National Foundation for Educational Research. The challenges facing schools and pupils in September 2020 (21).*

Among the reasons for widening inequalities in learning and attainment during lockdowns and social distancing are unequal access to laptops and technology, with schools in deprived areas less able to provide online learning and more deprived students having much less suitable space at home to study. Some schools, including most private schools, have the resources to provide a full timetable of online lessons and one-to-one support and wealthier parents can compensate for loss of learning through additional tutoring and educational resources, as well as through having more time to devote to supporting their children's education.

Inequalities in education are widening. Figure 11 shows changes in student learning time by three family earning groups. Learning time for primary school students had been equitable for all three groups before the pandemic, but COVID-19 containment measures have introduced new inequalities, and inequalities during secondary school have widened even as total learning time has reduced for everybody.

Figure 11. Number of hours spent learning during 2014/15 and lockdown in 2020, by family earnings



Note: *Poorest, middle and richest groups are based on equivalised family earnings (based on pre-pandemic earnings for lockdown data).*

Source: *Institute for Fiscal Studies (IFS) calculations using data from the 2014–15 UK Time Use Survey and the IFS–IOE survey of time use during COVID (22).*

Containment measures clearly harm more deprived students the most, but the funding allocations for schools mean they have no opportunity to reduce these damaging inequalities. More deprived schools have received lower real-terms increases in funding per student since 2017–18 for each year up to 2021–22: funding per student will increase by 4 percent less among the most deprived primary schools when compared with the least deprived ones. More deprived secondary schools are similarly affected. Further, special needs provision in England was reduced by £1.2 billion between 2015 and 2019 and urgent additional support for students with SEND is now required.

Problems with the grading of public exams in summer 2020 have further exacerbated disadvantaged students' capacity to demonstrate their capabilities, even after grading was handed to teachers. On average, independent and selective school students benefitted more from changes to the grading systems, while students in state schools were more likely to lose grades, magnifying existing grade systems inequalities (23).

SUMMARY

In *10 Years On* we set out proposals to reduce the widescale development and attainment inequalities that occur during the early years and throughout education. These proposals are even more urgent now following the widening of inequalities for young and school-age children during the pandemic. Child poverty has increased since 2010 and containment measures are leading to further increases, discussed in the next section. Poverty harms early years development and education.

Shortfalls in funding for early years settings and schools mean that the intensity and resources required to reduce widening inequalities are not available. The 2.2 percent increase in funding for schools announced in November 2020 is insufficient to meet the task and does not compensate for cuts to funding in the pre-pandemic decade, which harmed more disadvantaged areas the most. It is essential we learn the lessons from the pandemic and from the previous 10 years and invest proportionately more in early child development and education in more deprived areas in order to Build Back Fairer and for the long term. In the shorter term, investments in laptops and online infrastructure in more disadvantaged areas will help reverse some of the inequitable impacts arising from the pandemic.

RECOMMENDATIONS

BOX 9. BUILD BACK FAIRER: GIVE EVERY CHILD THE BEST START IN LIFE

LONG TERM	Government should prioritise reducing inequalities in early years development.
MEDIUM TERM	• Increase levels of spending on the early years, as a minimum meeting the OECD average, and ensure allocation of funding is proportionately higher for more deprived areas. • 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.
SHORT TERM	• Allocate additional government support to early years settings in more deprived areas, to prevent their closure and staff redundancies. • Improve access to availability of parenting support programmes. • Increase funding rates for free childcare places to support providers.

BOX 10. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM	• Put equity at the heart of national decisions about education policy and funding. • Increase attainment to match the best in Europe by reducing inequalities.
MEDIUM TERM	Restore the per-student 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).
SHORT TERM	• Address inequalities in access to laptops and expand and adequately resource the programme designed to enable provision of laptops to more deprived students. • Significantly increase the focus on achieving equity in assessments for exam grading. • Urgently roll-out catch-up tuition for children in more deprived areas, in full. • Provide additional support for families and students with SEND. • Urgently give excluded students additional support and enrol those who need it into Pupil Referral Units.

CHAPTER 4

CHILDREN AND YOUNG PEOPLE: INEQUALITIES AND COVID-19 CONTAINMENT

Children and young people have a much lower risk than adults of experiencing adverse physical health impacts from contracting COVID-19. However, the containment measures and the resulting social and economic impacts are having significant negative impacts on children and young people's mental health and on the long-term prospects for young people. Factors include reductions in family income, increases in child poverty, food poverty and hunger, damage to employment and training prospects as well as educational attainment. In each of these areas there are widening inequalities, which will blight the lives of many more disadvantaged young people and in turn translate into widening health inequalities in the longer term.

In *10 Years On* we assessed how the previous decade had been particularly scarring for many children and young people and for those from more disadvantaged households and areas, as summarised in Box 11.

BOX 11. SUMMARY OF INEQUALITIES IN CHILDREN AND YOUNG PEOPLE'S DEVELOPMENT (FROM *10 YEARS ON*)

- Rates of child poverty increased in the decade from 2010, with over 4 million children affected.
- Rates of child poverty are highest for children living in workless families, at an excess of 70 percent.
- More deprived areas have lost more funding for children and youth services than less deprived areas, even as need has increased.
- Violent youth crime increased greatly over the period.

BOX 12. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN CHILDREN AND YOUNG PEOPLE

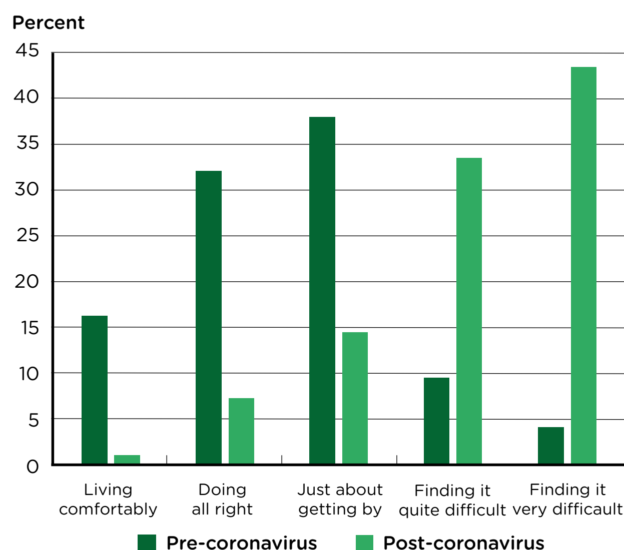
- Indications are that child poverty will increase further.
- Food poverty among children and young people has increased significantly over the pandemic.
- The mental health of young people, already hugely concerning before the pandemic, has deteriorated further and there is widespread lack of access to appropriate services.
- Exposure to abuse at home has risen through the pandemic, from already high levels beforehand.
- Unemployment among young people is rising more rapidly than among other age groups and availability of apprenticeships and training schemes has declined.

Child poverty is a critical determinant of early child development and educational attainment and has a negative impact on other outcomes throughout life, including employment, income and health. Rates of child poverty increased between 2010 and 2020, with greatest increases for families with an adult in work. Even before the pandemic, increasing numbers of children were living in temporary accommodation, and this is set to increase as poverty rises and housing costs remain high.

While poverty data will not be available until March 2021, there are likely to be significantly more families in poverty, including those with a working adult, compared with before the pandemic. Working parents made up the highest number of furloughed workers; the furlough scheme is paying only 80 percent of wages, pushing many families into poverty.

Eight in 10 respondents to on an online survey of 285 low-income families by the Child Poverty Action Group reported a significant deterioration in their living standards due to a combination of falling income and rising expenditure. As shown in Figure 12, in July to August 2020 low-income families were doing substantially worse than they were before the COVID-19 crisis and the financial situation of families who responded to the survey had worsened since an earlier survey carried out in May to June.

Figure 12. Low-income families' responses to how they were coping financially, July–August 2020, England

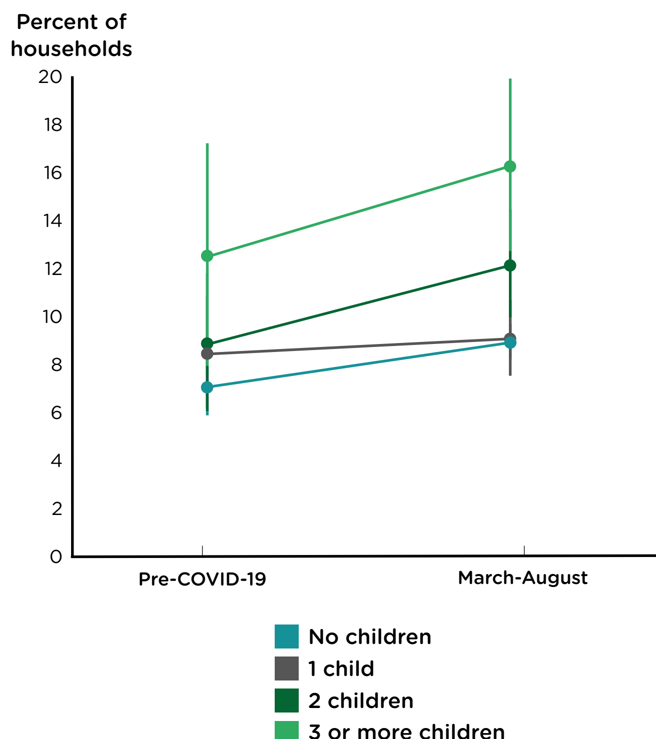


Note: *Online survey of 285 low-income families by the Child Poverty Action Group.*

Source: *Child Poverty Action Group. Poverty in the pandemic, 2020 (24).*

School closures led to greater strain on family finances as free school meals were taken away from 1.3 million children. The substituting food voucher scheme mitigated hunger, but did not eliminate it and there have been reported increases in hunger and food poverty among young people; for example, the Food Foundation found that food poverty rose from 12 pre-COVID-19 to 16 percent in March to August 2020 in homes with three or more children (25).

Figure 13. Food insecurity in homes by number of children, before lockdown and in March–August 2020

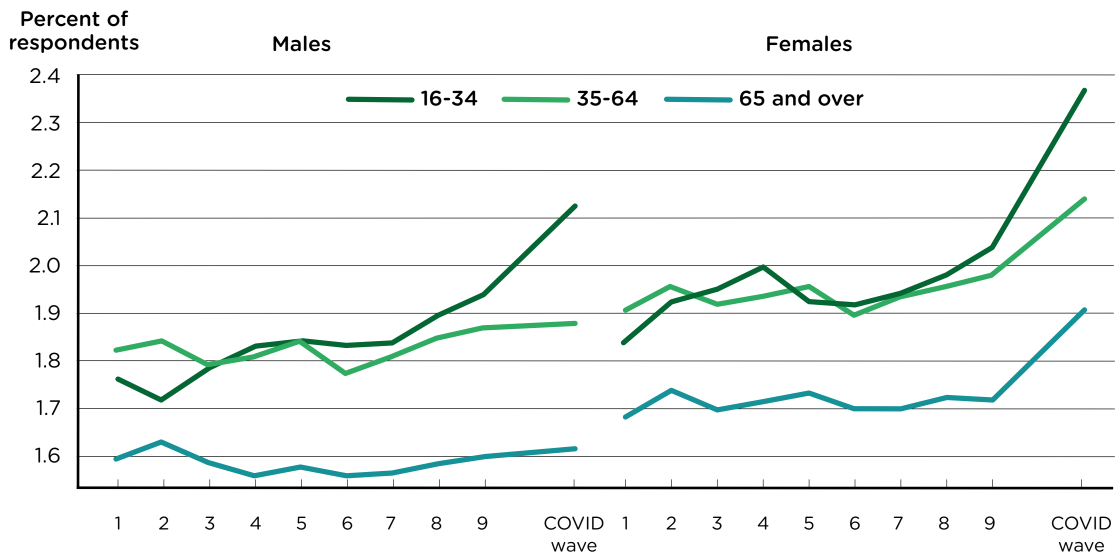


__Notes:__ Analysis by Loopstra R comparing 12 month food insecurity data for 2016 to 2018 to 6 month food insecurity data from YouPoll collected at the end of August, 2020. Analyses are adjusted for age, gender, ethnicity, marital status, region, and employment status.

__Source:__ The Food Foundation (25).

Another of the more immediate impacts of containment measures has been a deterioration in mental health, which is evident for all groups but particularly for young people. Traumatic experiences, social isolation, loss of education and routine, and a breakdown in formal and informal support and access to services and support from school have all been experienced during the COVID-19 crisis. Figure 14 shows that unhappiness and depression had been increasing slightly before the pandemic but then increased rapidly from the first lockdown, especially for women and all young people. Children and young people living in deprivation are likely to have experienced higher levels of mental distress than their better-off peers, given household conditions and pre-existing socioeconomic conditions (26).

Figure 14. Percent unhappy or depressed, UK household longitudinal survey waves 1-9 (January 2009 to May 2019) and April 2020 by gender and age group



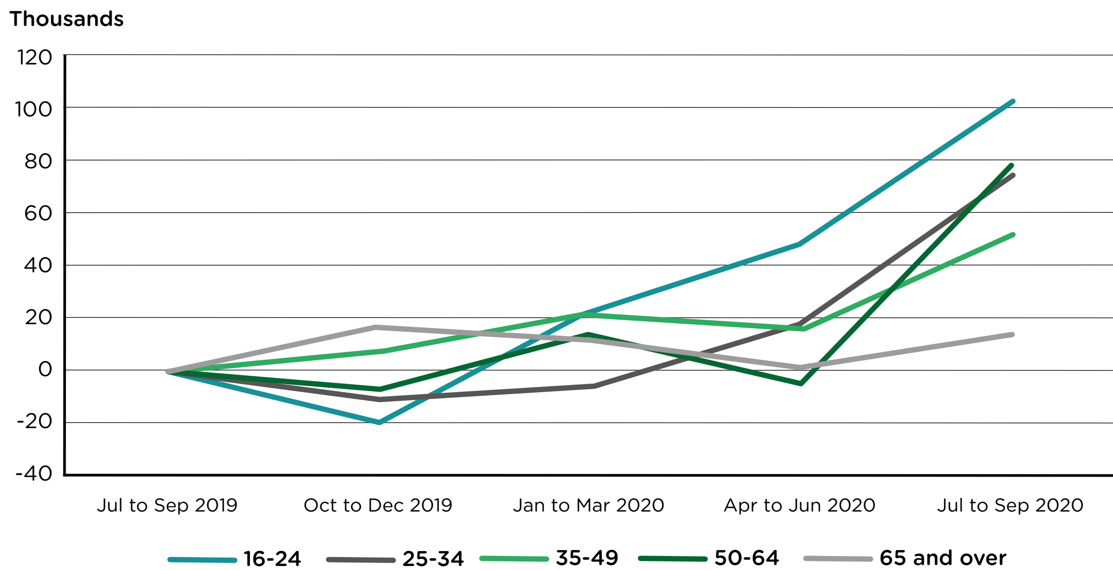
Note: *The waves ran as follows: wave 1 January 2009–March 2011, wave 2 January 2010–March 2012, wave 3 January 2011–July 2013, wave 4 January 2012–June 2013, wave 5 January 2013–June 2015, wave 6 January 2014–May 2016, wave 7 January 2015–May 2017, wave 8 January 2016–May 2018, wave 9 January 2017–May 2019. Higher values reflect poorer mental health.*

Source: *UKHLS waves 1–9 and April COVID-19 survey (27).*

Before the first lockdown, numbers of children exposed to violence in England were already high – with estimates that one in five children were exposed to domestic abuse (28). Children and young people who experience trauma and abuse at home are at high risk of immediate and long-term harm to their physical and mental harm. During the first lockdown it was estimated that there was at least a 25 percent increase in domestic abuse (29), with surveys indicating that the increases could be even higher. Women's Aid research on the impact of COVID-19 containment on domestic abuse showed that 53 percent of respondents stated that their children have witnessed more abuse towards them (30). Schools and a range of other services have a crucial role to play in identifying and supporting the young victims of abuse. Extra resources are required urgently to support them to do so.

While the increase in the unemployment rate has been relatively low so far (increasing by one percentage point for men and 0.5 percentage points for women between February - April 2020 and July to September 2020), it is projected to increase further. Young people are experiencing the greatest increases in unemployment compared with other age groups (Figure 15) because they tend to work in sectors that have been most affected by the containment measures, such as hospitality, leisure and tourism, and as students leave schools and colleges there are fewer jobs available to them than before the pandemic. As overall unemployment rises, youth unemployment will increase markedly. This is a scarring experience, reducing the future opportunities for young people and potentially leading to long-term loss of income and career progression, and adversely affecting mental and physical health.

Figure 15. UK unemployment by age group, seasonally adjusted, cumulative growth from July to September 2019, for each period up to July to September 2020



Source: *Based on ONS. Employment in the UK: November 2020 (31).*

The number of young people not in education, employment or training (NEET) had been stable before the pandemic. However, there was an increase of 1 percent in the NEET rate for young men between February/March 2020 and July/September 2020 and this rate will likely rise again as employment and training opportunities decline further.

Apprenticeships are particularly important for more disadvantaged groups and are important in reducing inequalities in work and income. They have been badly impacted by the crisis. The Sutton Trust shows that, by May 2020, fewer than 40 percent of apprenticeships were continuing as normal, more than a third of apprentices had been furloughed, one in 12 had been made redundant (32), and prospects for hiring apprentices in the future look bleak. Meanwhile youth services, which were cut severely in the decade to 2020, are struggling further as local government and charitable funding is reduced. It is likely that many of the remaining services that support young people and improve participation in schools and work, and reduce youth crime, will be forced to close.

SUMMARY

All children and young people have been affected by the pandemic and associated containment measures. Many young people are facing particularly bleak prospects as a result, and the impacts are being and will continue to be felt the most by the most disadvantaged (33). Reversing these impacts and reducing inequalities is a critical challenge; short-term interventions to reduce family poverty and food poverty and improve access to mental health services must be central to this. In the longer term, investments in employment and training for young people and more support for good mental health will be critical.

RECOMMENDATIONS

BOX 13. BUILD BACK FAIRER: IMPROVING OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

LONG TERM

- Reverse declines in the mental health of children and young people and improve levels of wellbeing from the present low rankings internationally, as a national aspiration.
- Ensure that all young people are engaged in education, employment or training up to the age of 21.

MEDIUM TERM

- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Improve prevention and treatment of mental health problems among young people.

SHORT TERM

- Reduce child poverty:
  - Remove the 'two-child' benefit restriction and benefit cap.
  - Increase child benefit for lower-income families to reduce child and food poverty.
  - Extend free school meal provision for all children in households in receipt of Universal Credit.
- Urgently address children and young people's mental health with a much strengthened focus in schools and training more teachers in mental first aid.
- Increase resources for preventing abuse and identifying and supporting children experiencing abuse.
- Develop and fund additional training schemes for school leavers and unemployed young people.
- Further support young people's training, education and employment schemes to reduce the numbers who are NEET, and urgently address gaps in access to apprenticeships.
- Raise minimum wage for apprentices and further incentivise employers to offer such schemes.
- Prioritise funding for youth services.

CHAPTER 5

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL: COVID-19 CONTAINMENT AND INEQUALITIES

In countries that have had good control of COVID-19 infection and relatively low rates of mortality, the economic damage has been less severe than in countries, such as England, where the infection and mortality rates have been high. There has been much discussion of the trade-offs between protecting health and protecting the economy but less remarked on is that economic impacts are also health impacts. The UK economy is expected to have shrunk by 11.3 percent in 2020. There is a robust evidence base showing that unemployment, poor quality work and low wages are hugely damaging for health and health equity. The COVID-19 economic crisis is therefore going to lead to another health crisis, and the people and geographical areas that are most likely to suffer these poor health effects are those that already had poor quality work and high levels of unemployment before the pandemic.

As we showed in *10 Years On*, in the decade from 2010 there were increases in employment in low-paid, unskilled, self-employed, short-term and zero-hours contract jobs. Rates of pay did not increase and, notably, more people in poverty by the end of the period were in work than out of work. This labour market context is critical for understanding the broad impact of COVID-19 and measures to contain it – the impact both on mortality in some occupations and on longer-term economic and social inequalities, with their knock-on effects on health inequalities.

BOX 14. SUMMARY OF INEQUALITIES IN WORKING LIVES (FROM *10 YEARS ON* REPORT)

- While 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 and this will particularly affect the North of England.

The COVID-19 containment measures are having hugely damaging impacts on the labour market in England, including declining employment rates and wages, despite the Coronavirus Job Retention Scheme (CJRS) (furlough) scheme. Unemployment is projected to rise to 7.5 percent in spring 2021, with 2.6 million people out of work. The impacts have not been experienced equally and wide inequalities are set to deepen when the furlough scheme ends. Young people are experiencing the greatest loss of employment but low-paid workers, BAME groups, disabled workers, women, part-time workers and the self-employed have all been disproportionately affected. Employment in hospitality, non-food retail, leisure, aviation, transport and tourism are all adversely affected.

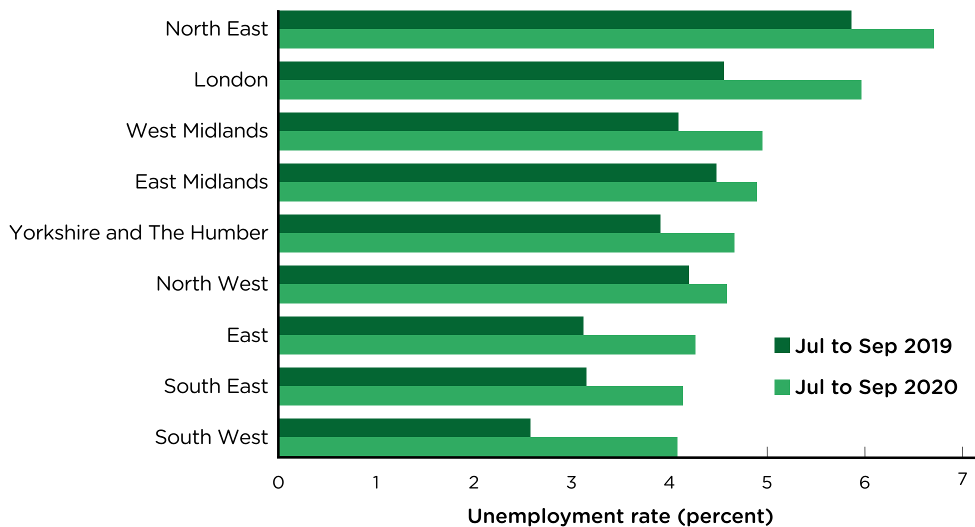
BOX 15. SUMMARY: BUILD BACK FAIRER: EMPLOYMENT AND GOOD WORK

- Countries that controlled the pandemic better than England have had a less adverse impact on employment and wages.
- Rising unemployment and low wages will lead to worse health and increasing health inequalities.
- Rising regional inequalities in employment in England relate to pre-pandemic labour market conditions.
- Overall, unemployment has risen slowly so far, protected by the Coronavirus Job Retention Scheme (furlough), but will rise considerably once the scheme ends, in March 2021.
- Low-income groups and part-time workers are most likely to have been furloughed and furloughed staff have experienced 20 percent wage cuts from their already low wages.
- Older Pakistani and Bangladeshi people were more likely to be working in shutdown sectors, compared with other groups.
- There were over 2 million jobs where employees were paid below the legal minimum in April 2020, more than four times the 409,000 jobs a year earlier.

IMPACTS OF COVID-19 CONTAINMENT ON UNEMPLOYMENT

One of the most immediate impacts of containment has been on unemployment, despite the Coronavirus Job Retention Scheme protecting many jobs. From March 2021, unemployment is projected to increase significantly, to over 11 percent, as furlough ends. Regional inequalities in unemployment were already wide before the pandemic, widened further to September 2020 and will increase again after March 2021. This will widen regional inequalities in health in the longer term. Figure 16 shows that the highest rates of unemployment in September 2020 were in North East England and the rates were lowest in areas in the South outside London. Although there have been increases everywhere over the year to July/September 2020, the largest increases were seen in the South West (1.5 percentage points), followed by London (1.4) and the East (1.2).

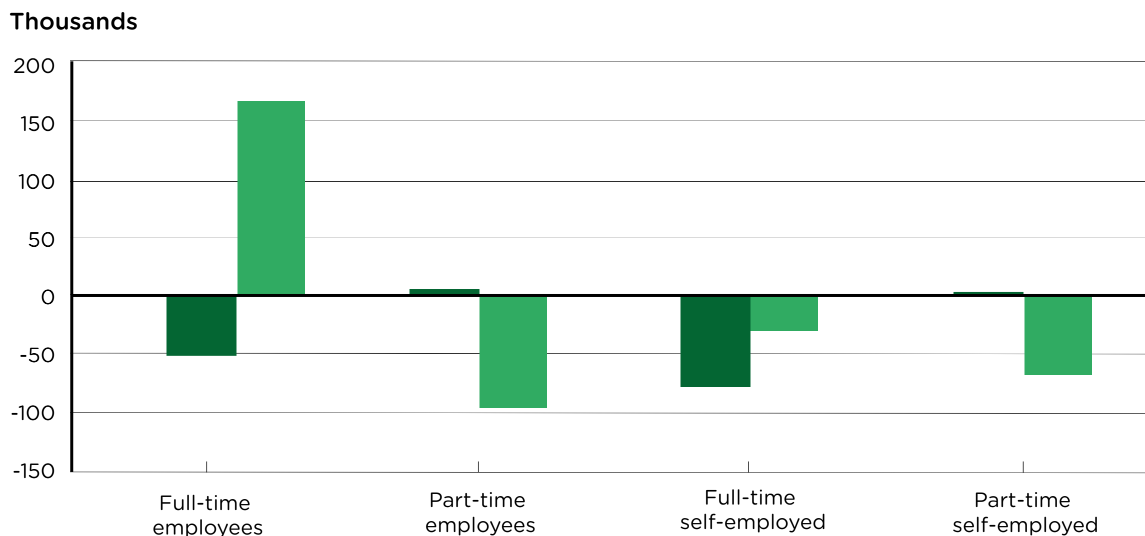
Figure 16. Unemployment rate estimates for people who are economically active, by English region, seasonally adjusted, between July–September 2019 and July–September 2020



Source: *Based on ONS. Employment in the UK: November 2020 (31).*

For the period until September 2020, part-time and self-employed workers were more likely than others to have lost their jobs, although much larger increases in unemployment for all workers are projected for the rest of 2020 and over the coming years.

Figure 17. UK quarterly changes for total in employment, full-time and part-time employees, and full-time and part-time self-employed by sex, seasonally adjusted, between April–June 2020 and July–September 2020

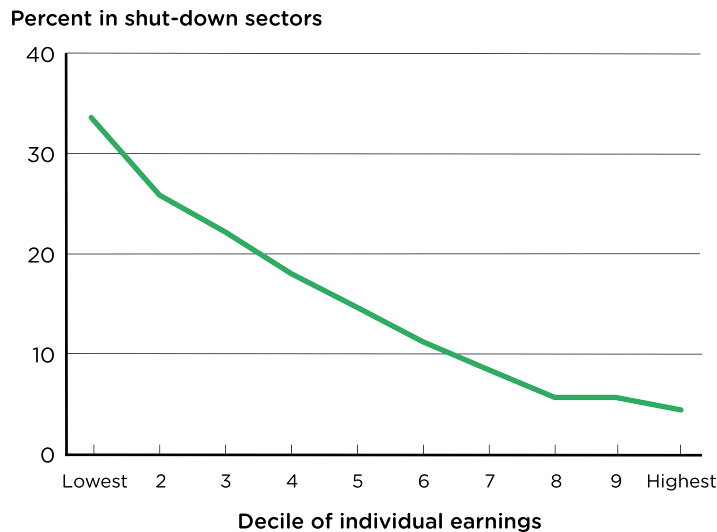


Source: *Based on ONS. Employment in the UK: November 2020 (31).*

SHUTDOWN AND FURLOUGHED SECTORS

Low-income workers are most likely than higher-paid people to have been furloughed, putting a further dent into their already low earnings as they take a 20 percent pay cut. This is likely to push many people into poverty as many do not have sufficient savings or other means to withstand the economic shock. One-third of people in the bottom decile for earnings were employed in shuttered sectors, compared with under 10 percent in the top three income deciles. Incomes in the bottom decile have been protected somewhat by increases in benefit payments, but for the second decile, the decrease in wages has not been compensated for and the loss of wages will be particularly acute. This shows the importance of benefit support that is proportionate across the income gradient.

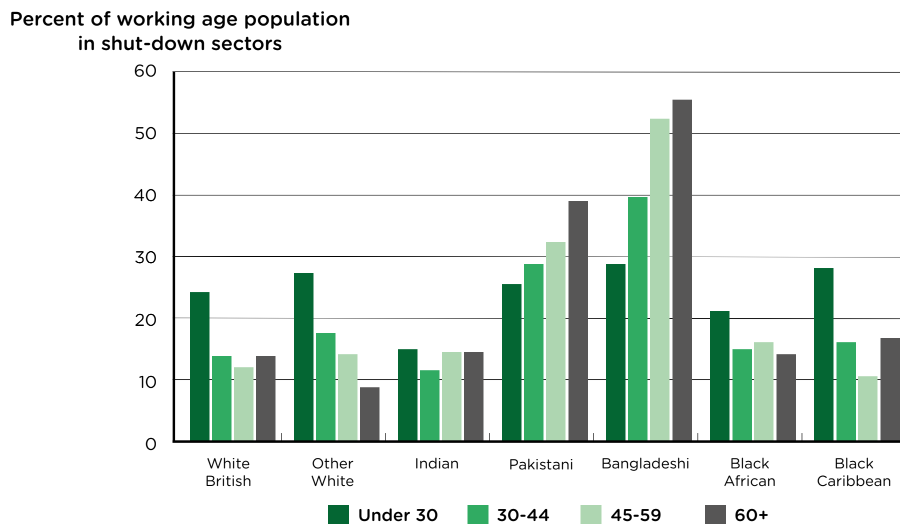
Figure 18. Percent of workers in shuttered sectors by earnings decile, (based on quarterly data for 2019), UK



Source: *IFS, analysis of Quarterly Labour Force Survey Q1-Q4 2019, Waves 1 and 5 only in: 'Sector shutdowns during the coronavirus crisis: which workers are most exposed?' 2020 (34).*

In terms of ethnic and age groups, older Pakistani and Bangladeshi workers have been the most likely to be in shutdown sectors and particularly affected by the reduction in wages. For other ethnicities it is largely younger people who have been most affected.

Figure 19. Percent of working-age population in each ethnic and age group in shutdown sectors in England and Wales, (based on quarterly data for 2016 - 2019)



Note: *Shares represent the percent of the working-age population (aged 16–64) (excluding students) of each group in shutdown sectors.*

Source: *Platt L, et al analysis of Quarterly Labour Force Survey Q1 2016 to Q4 2019 in: 'COVID-19 and Ethnic Inequalities in England and Wales,' 2020 (35).*

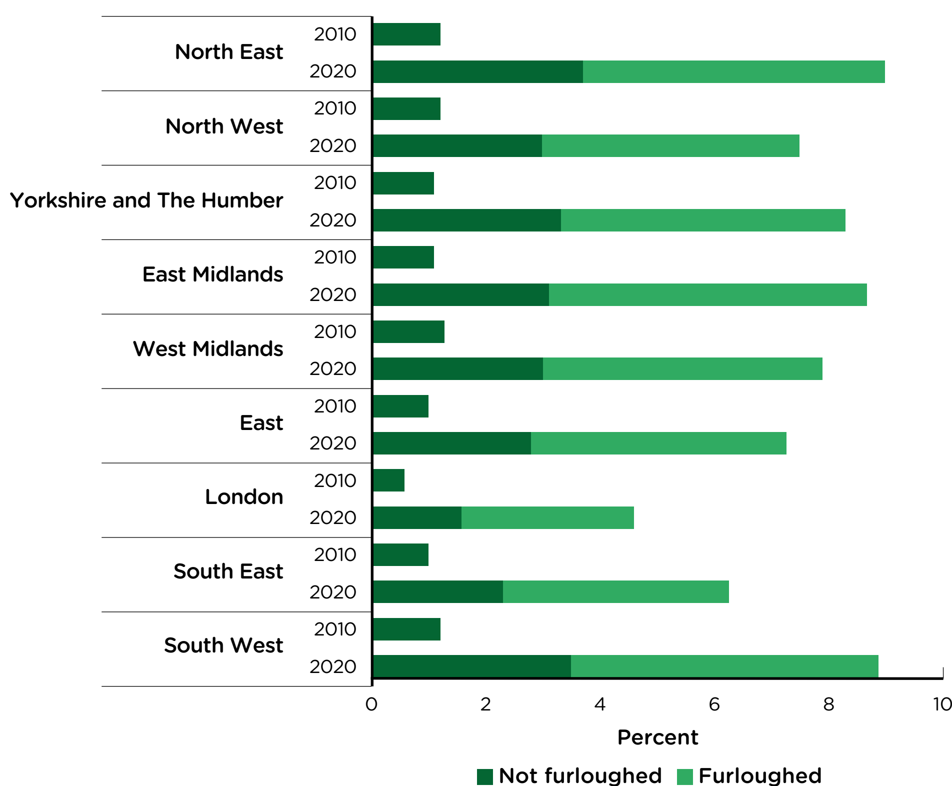
WAGES

While the furlough scheme and increases to benefit payments have helped mitigate the loss of wages for many, they do not do so sufficiently. Wages were already low before the pandemic and there had been substantial rises in in-work poverty over the preceding decade. There were 221,000 people in England earning below the national minimum wage in 2010. By 2019 this figure had risen to 354,000 people below either the national minimum wage (at ages under 25) or national living wage (at ages 25 and over) (36). However, in April 2020 the total number below these minimum wage rates rose to 1.7 million -comprising 649,000 who were not furloughed and just over one million who were furloughed. Some, but not all, of the increase due to furlough was a result of their pay being

frozen at rates that preceded the annual increase in the minimum wage level- indicating just how many people are on wages at or just above the minimum wage.

Figure 20 shows the large inequalities in the percentage of jobs paid below the national minimum wage between regions, with the North East having more than twice the rate in London for those who were not furloughed in 2020, and these inequalities increased between 2010 and 2020. The negative health impacts of low wages are clear, and the large increases in low-paid jobs will widen health inequalities, including regional inequalities, still further.

Figure 20. Percent of jobs paid below the national minimum wage/living wage by region in England, 2010 and 2020



Note: *Includes all furloughed employees.*

Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (37).*

Meanwhile, the highest paid have had faster hourly pay growth in 2020 than in 2019, which is further increasing wage inequality in England.

Self-employed workers have been particularly badly hit by the COVID-19 containment measures, with many having to stop working but being ineligible for the furlough scheme. This includes large numbers working in the gig economy on zero-hours contracts and low wages, who were already at risk of poverty and the associated health impacts. Many self-employed workers have reported considerable mental distress as well as reductions in wages. Prior to the introduction of the first lockdown measures in March 2020, workers on casual contracts were paid on average around £605 less per month than permanent employees. The difference has widened to £730 per month since the outbreak of the pandemic. In April 2020, 60 percent of self-employed workers were earning less than £1,000 per month, up from 30 percent a year earlier.

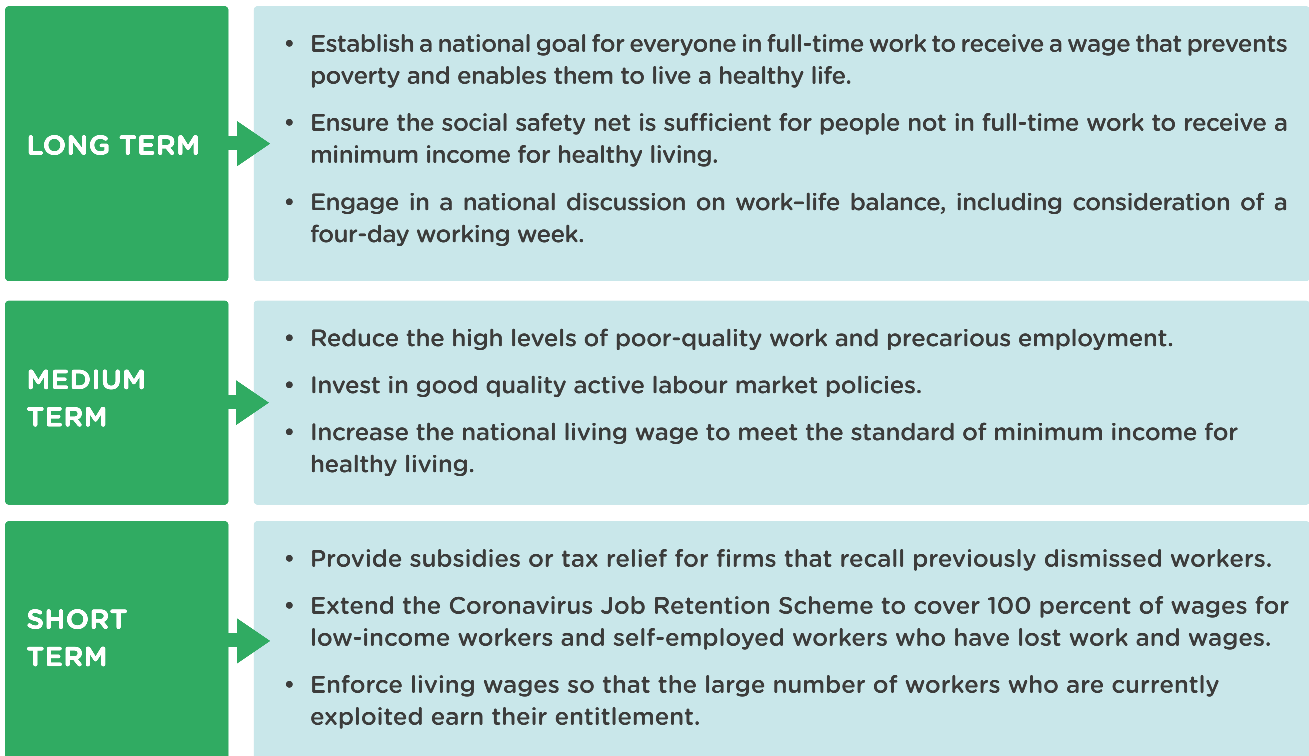
SOCIAL CARE WORKERS

As well as social care being one of the occupations with the highest rates of mortality from COVID-19, the crisis has exposed the pre-existing difficult conditions and low pay in this sector. In the UK there are more than 900,000 people working in frontline social care roles as their main job. A high proportion are women (83 percent) and 18 percent are BAME compared with 12 percent for all occupations. One in 10 care workers is on a zero-hours contract and 70 percent earn less than £10 an hour (38). The proportion of care workers on low wages is highest in the North of England, which is also the region whose care homes have been the most affected by COVID-19 (39). There are growing calls to reform social care pay to create parity with NHS pay (38) but the November 2020 spending review subjected care workers to a pay freeze.

SUMMARY

In practice there is no trade-off between protecting health and protecting the economy. Reducing the toll of the COVID-19 pandemic reduces the economic hit. It is critical that economic impacts are also understood as health impacts. Widening inequalities in wages and quality of work and growing unemployment will all widen economic inequalities in England, and health inequalities in turn. In many cases the geographical areas and groups of people who have experienced higher rates of infection and mortality from COVID-19 are now at risk from the health impacts of unemployment, poverty and low wages – the social care workforce being a case in point. Targeted support for wages and employment as part of a universal approach to fostering good quality and adequately paid employment will support health as well as livelihoods.

RECOMMENDATIONS



CHAPTER 6

ENSURE A HEALTHY STANDARD OF LIVING: COVID-19 CONTAINMENT AND INEQUALITIES

"Insufficient income is associated with poor long-term physical and mental health and low life expectancy" (1). The COVID-19 pandemic and associated containment measures have led to declining incomes and an increasingly precarious financial position for many, which has exacerbated already concerning levels of poverty, debt and financial insecurity in England. The last decade was marked by low and stagnating wage growth and increases in rates of poverty for people in work and for children. There were associated rapid increases in food poverty and homelessness. The introduction of the living wage did not prevent poverty among working people, while the new Universal Credit, limits to benefit entitlements and changes to the tax and benefit system were regressive and resulted in widening income and wealth inequalities. Incomes for wealthier people and regions increased markedly – buoyed by rising house prices and share values, and the relatively low levels of taxes.

BOX 17. SUMMARY OF INEQUALITIES IN STANDARDS OF LIVING AND INCOME (FROM 10 YEARS ON REPORT)

- Wage growth has been low since 2010 and wage inequality persists.
- Rates of in-work poverty have increased.
- Incomes have risen slowly and inequalities in income 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 households with children that 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.

While the COVID-19 containment measures have had significant negative economic impacts for much of the population, the level of impact has varied considerably between households, according to prior socioeconomic position, region, occupation, age, ethnicity and disability (40). The impacts will lead to further widening of income inequalities in the UK. Pre-pandemic levels of income and poverty are directly related to the hardship experienced by increasing numbers of households during the pandemic. By the end of July 2020, around one in three people reported that they were unable to save for the year ahead (40) and there is evidence of increasing debt, poverty and risks of homelessness. Food poverty has been one of the most visible and immediate effects and reliance on food charity has increased from already high levels (41).

BOX 18. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN STANDARDS OF LIVING AND INCOME

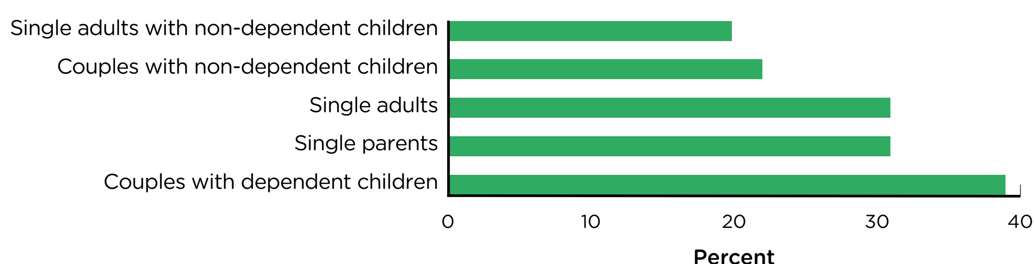
- Young people and BAME groups have been most affected by decreases in income.
- Poverty is increasing for children, young people and adults of working age.
- Increases to benefit payments have protected the lowest income quintile (the poorest) from the effect of decreases in wages, but have not benefitted the second quintile to the same extent.
- The two-child limit and the benefit cap are harming families and pushing people into greater poverty.

INCOME

Household income (from all sources, including wages, benefits, assets and savings) fell in the UK in April 2020, following the outbreak of the pandemic. Changes to the benefits system, introduced to support households, did reduce the impact on the lowest-income groups, but when these changes are reversed in March 2021 there will be great financial and health harm to those groups. People on a low income but who are not reliant solely on benefits have experienced large declines in their income.

The declines in income since March 2020 have been unequal, and lower-income groups have lost a greater proportion of their income from earnings than better-off groups (40). A higher proportion of people earning less than £20,000 reported receiving a reduced income than those in the higher income brackets (40). Families with children have been particularly affected, figure 21. and this is leading to increases in child poverty and food poverty.

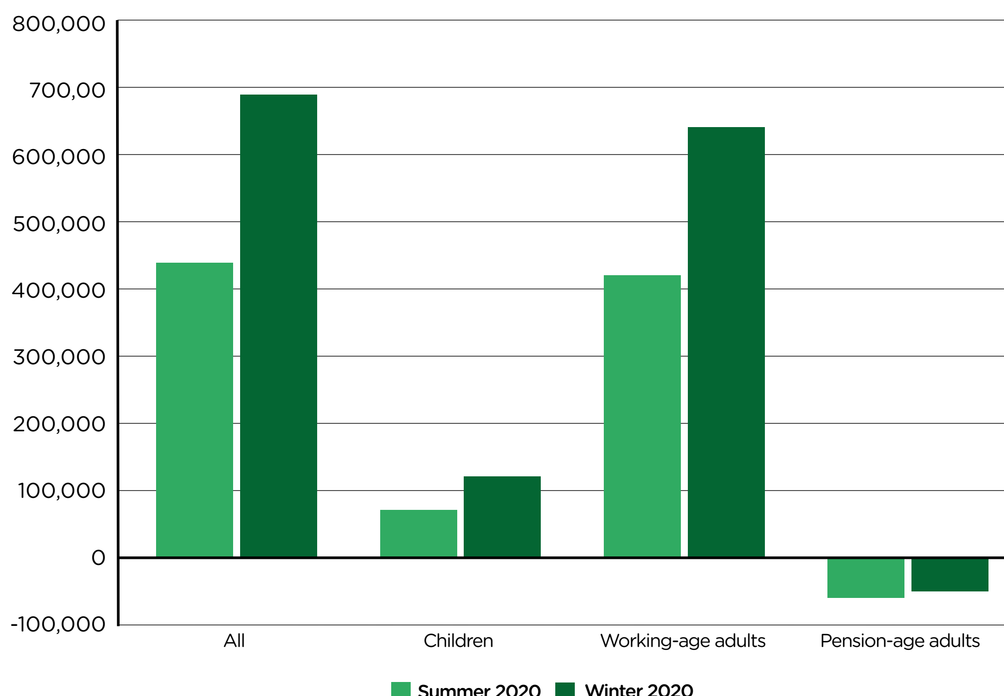
Figure 21. Proportion of those reporting their finances had been affected as a result of COVID-19 containment, by family household arrangement, Great Britain, May 2020



Note: *Finances that have been affected is defined as being furloughed, a fall in income, a reduction in hours worked, unemployment or redundancy.*
Source: *Based on data from StepChange poll (42).*

Data on poverty will not be published by the Department for Work and Pensions (DWP) until March 2021, but estimates show that there have been substantial increases in poverty rates this year. Estimates by the Legatum Institute indicate substantial increases from the start of the pandemic in the numbers of children and working households in poverty (43).

Figure 22. Changes in the number of people in poverty in summer and winter 2020, compared with 2018/19, UK



Notes: *The report presents the results of a 'nowcasting' exercise using the most up-to-date data on employment, earnings, and Government policy available, along with a range of assumptions in November 2020, to model the likely level and distribution of poverty in both Summer and Winter 2020. Summer 2020 scenario is the Legatum Institute 5.8 percent unemployment rate scenario. Winter 2020 is the Legatum Institute 7.5 percent unemployment rate scenario. Fall in poverty for pension-age adults is a result of a small reduction in the poverty line due to the median of Total Resources Available falling. Sum of elements may not match totals, due to rounding.*

Source: *Legatum Institute, Family Resources Survey and HBAI dataset (1998/99 – 2018/19), IPPR tax and benefit model (43).*

The level – or depth – of poverty has also increased compared with before COVID-19 containment. In the UK, 270,000 more people are in the deepest form of poverty (50 percent-plus below the poverty line) and the number of people that are 25–50 percent below the poverty line has increased by 160,000. The highest increase has been for those that are 0–25 percent below the poverty line, at 370,000 more than before the pandemic (43). The Institute for Public Policy Research (IPPR) estimates that it is plausible that by the end of 2020 over 1 million more people, including 200,000 children, will be in poverty compared with a situation where the pandemic had not occurred, and that unemployment will stand at 9.8 percent. Increases in the numbers of people on low incomes and living in poverty will harm health and lead to widening health inequalities.

As described in *10 Years On* (1), there are wide variations in poverty rates by ethnic group and all minority ethnic groups had higher rates of poverty than White groups over the decade from 2010. BAME and migrant groups have been particularly badly impacted by loss of income and employment during the pandemic and are 1.3 times more likely to have experienced income loss (44) than the White UK-born population. Disabled people also have been disproportionately harmed by the economic impacts of containment and have been much more likely than non-disabled people to think that the crisis would result in them being in debt and that they were likely to run out of money.

COVID-19 AND INCOME PROTECTION FROM BENEFITS

Prior to the pandemic, reforms to social security over the decade had damaged the income of low-income families. The introduction of Universal Credit (UC), the two-child limit – the restriction of the child element in UC and tax credits to the first two children, the benefit cap and changes to tax credits, have significantly and negatively affected low- and middle-income households and children and widened income inequalities. This has penalised the poorest the most and caused increasing hardship (45) (1). The disproportionate impacts on more deprived families and regions of cuts to local government and reduced support for babies, children and families over the past 10 years were well documented in the *10 Years On* report (1).

Since March 2020, temporary Government support schemes have protected incomes and jobs for many including through the Coronavirus Job Retention Scheme (CJRS) (furlough) and increases to UC and to the Employment and Support Allowance. The lowest income quintile, which has experienced the largest decreases in earnings as a result of the pandemic at nearly 20 percent, have had the losses reduced by 16 percent through increased benefits, including a temporary increase of £20 a week in the standard allowance of UC. In the short term, this is a real achievement. If the increase to UC were to be made permanent, it would be hugely beneficial for the health of out-of-work families in England. Currently, 75 percent of recipients find that UC is too low to meet basic living costs (46).

UC claims were nine times higher than the usual number of claims made per week in the first two weeks of the first lockdown and 5.7 million people were receiving UC by 8 October 2020. Of these, 3.6 million were new claims since March (47). Figures from the DWP show that the numbers affected by the benefit cap, which limits the financial support available to £20,000 a year outside London and £23,000 a year in London, increased by 93 percent between February and May 2020 to 154,000 households (48); 62 percent of those whose benefits were capped in May 2020 were single-parent families. Capping benefits during the pandemic is leading to much higher levels of poverty, including food poverty and inability to pay rent. Many low-income households are having to borrow money to cover housing and other costs, including from family, on credit cards and from loan companies. Other coping strategies have included selling possessions and spending available savings.

WEALTH INEQUALITIES

As a result of COVID-19, inequalities in wealth will widen even beyond their high level pre-pandemic (1). One-third of families in the top income quintile saved more than usual in the first two months of the pandemic, whereas lower-income families were more likely to have taken on additional debt and 50 percent of people with savings under £1,000 had used them to cover everyday expenses (49). In *10 Years On* we assessed the wide and increasing regional inequalities in income and wealth. Between 2006 and 2018, and particularly from 2010 onwards, households in London and the South East rapidly increased their wealth (1). Average household wealth in South East England was 2.6 times the wealth of households in North East England by 2017/18. These regional inequalities have significant long-term impacts on inequalities in health between regions and will be exacerbated by the different extent of containment measures in different regions.

FOOD POVERTY

Among the most immediate impacts of containment and school closures have been rapid increases in food poverty and hunger. Prior to the pandemic, food insecurity was already of significant concern in the UK and the Trussell Trust found that an estimated 8–10 percent of households had experienced either moderate or severe food insecurity between 2016 and 2018. These levels have risen considerably during the pandemic as a result of loss of income, school closures and the additional costs of having children at home. During March to August 2020, four million people in households with children experienced food insecurity – 14 percent of households - up from 12 percent before the pandemic (50). In September 2020 the prevalence of food insecurity in Black and mixed ethnicity households with children was nearly 50 percent higher than in White ethnicity households with children (50). Households with either an adult or child with a long-term health problem or disability were also at much higher risk, over 40 percent of such households.

Campaigns by the footballer Marcus Rashford succeeded in persuading the Government to provide food vouchers to families with children currently in receipt of free school meals during school holidays. However, many families living with food insecurity do not receive free school meals or holiday vouchers, so to reduce hunger and food insecurity free school meals should be provided to all children in households on UC.

SUMMARY

Prior to the pandemic, a decade of austerity and stagnating wages had resulted in many households, particularly those with children, being in poverty and suffering from ill health as a result. Regional inequalities in wealth had widened and many BAME and lower waged households were struggling to pay housing, food and fuel bills. Increases in in-work poverty, one of the clearest signs of a society that is not meeting the needs of its population, were damaging the health and prospects of working age adults and of children. Cuts to benefits had further increased rates of those living in poverty and persistent poverty. The increasing impoverishment of many workers and households in England before the pandemic is affecting the impacts of containment measures.

RECOMMENDATIONS

BOX 19. BUILD BACK FAIRER: ENSURING A HEALTHY STANDARD OF LIVING FOR ALL

LONG TERM

- Establish a national goal so that everyone in full-time work receives a wage that prevents poverty and enables them to live a healthy life without relying on benefits.
- Make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living.
- 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 benefits system to ensure they achieve greater equity and are not regressive.

MEDIUM TERM

- Make permanent the £1,000-a-year increase in the standard allowance for Universal Credit.
- Ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty.
- Eradicate food poverty permanently and remove reliance on food charity.
- Remove sanctions and reduce conditionalities in benefit payments.

SHORT TERM

- Increase the scope of the furlough scheme to cover 100 percent of low-income workers.
- Eradicate benefit caps and lift the two-child limits.
- Provide tapering levels of benefits to avoid cliff edges.
- End the five-week wait for Universal Credit and provide cash grants for low-income households.
- Give sufficient Government support to food aid providers and charities.

CHAPTER 7

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES: COVID-19 CONTAINMENT AND INEQUALITIES

The physical, economic and social characteristics of housing, places and communities have an important influence over people's physical and mental health and wellbeing, and inequalities in these are related to inequalities in health (1) (51). Pre-existing characteristics of communities shape their resilience to the social and economic impacts of COVID-19 containment measures. The levels and tiers of restriction will lead to further geographical variation. These differences will translate into wider inequalities in health between places.

Inequalities between places had been widening over the decade 2010–20. Cuts to local government over this period were regressive, with more deprived local authorities experiencing greater cuts than wealthier areas (1). From 2009 to 2020, net expenditure per person in local authorities in the 10 percent most deprived areas fell by 31 percent, compared with a 16 percent decrease in the least deprived areas. In North East England spending per person fell by 30 percent, compared with cuts of 15 percent in the South West. Cuts to public services were also regressive and negatively impacted more deprived areas the most. In some areas, which we call 'ignored places', by the start of 2020 deprivation was entrenched and deepening (1).

BOX 20. SUMMARY OF INEQUALITIES IN PLACES AND COMMUNITIES (FROM *10 YEARS ON* REPORT)

- There are more areas of intense deprivation in the North, Midlands and in southern coastal towns than in the rest of England. While other parts of England have thrived in the last 10 years, these areas have been ignored.
- Since 2010 government spending has decreased most in the most deprived places and cuts in services outside health and social care have hit more deprived communities the hardest.
- The costs of housing, including social housing, have increased, pushing many people into poverty and ill health.
- The number of non-decent homes has decreased, even in the private rental sector, but this sector still has high levels of cold, damp and poor conditions, and insecure tenures, which harm health.
- Homelessness and rough sleeping have risen significantly, by 165 percent between 2010 and 2017. In 2018 there were 69 percent more children in homeless families living in temporary accommodation than in 2010.
- Harm to health from climate change is increasing and will affect more deprived communities the most in future.
- In London 46 percent of the most deprived areas have concentrations of nitrogen dioxide above the EU limit, compared to 2 percent of the least deprived areas.

The impacts of COVID-19 are exacerbating already perilous conditions in more deprived areas, and these conditions will damage health and widen health inequalities. Without rapid remedial action and allocation of resources in a progressive manner, inequalities will widen further still.

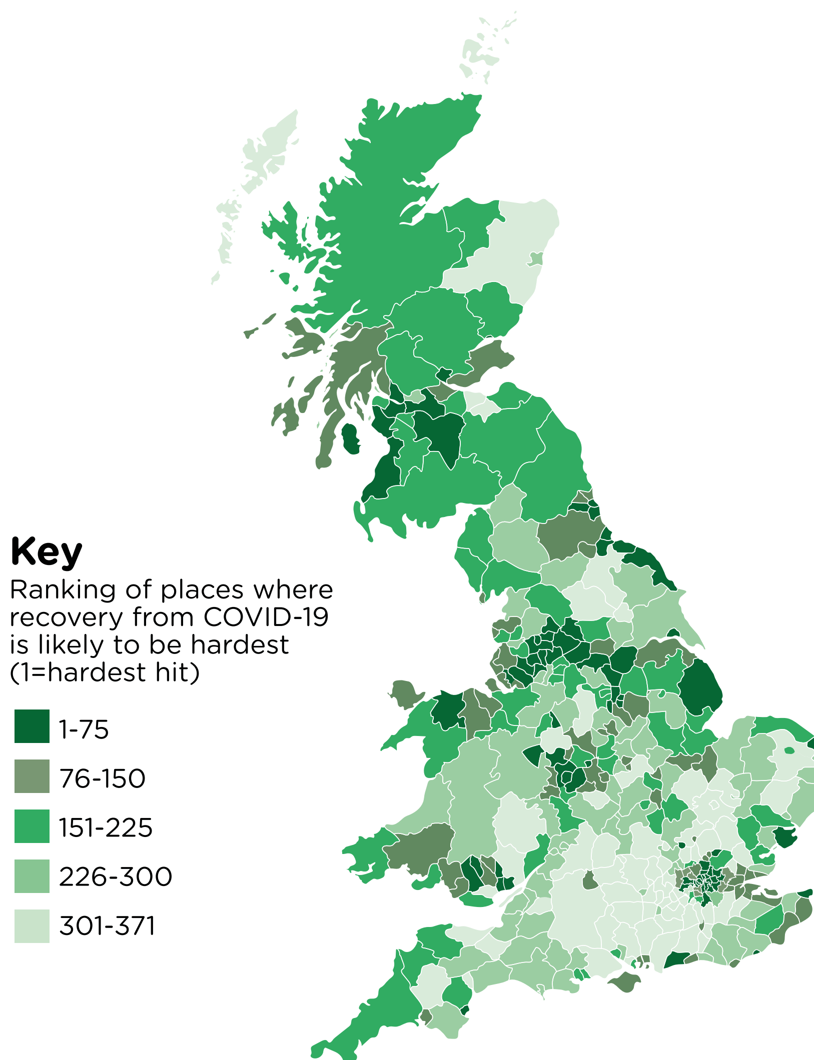
BOX 21. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PLACES AND COMMUNITIES

- The same communities and regions that were struggling before the pandemic – more deprived areas and ignored places – are struggling during the pandemic and this will likely continue in its aftermath. Their resilience has been undermined by the effects of regressive reductions in government spending over the last decade.
- Pre-pandemic cuts to local authorities were higher in more deprived areas, leading to greater losses in services there.
- Local authorities are now under even more intense pressure and extra government funding will not make up the shortfall.
- Continuing high costs of housing are pushing even more people into poverty as incomes fall.
- Rough sleeping was eliminated early on in the pandemic, showing what is possible. However, it is already increasing again.
- The number of families in temporary accommodation has increased.
- Private and social renters live in unhealthier conditions and have struggled more with lockdown.

Places have been affected differently in terms of both infection and mortality rates from COVID-19, and the containment measures. Places that were already deprived and struggling before the pandemic are those that will have been most negatively impacted by the containment measures and will find recovery from the COVID-19 crisis more difficult and experience even greater deprivation and ill health after the pandemic.

The Joseph Rowntree Foundation (JRF) has ranked places in England, Scotland and Wales on how difficult job recovery from COVID-19 is likely to be (Figure 23). The analysis shows that it will be difficult in areas with pre-existing deprivation and low employment and in places with high employment in retail and travel and leisure, which have been hit hard by containment measures. Some areas, such as Greater Manchester, are experiencing both types of impact.

Figure 23. Ranking of Local Authorities in Great Britain where employment recovery from COVID-19 is likely to be hardest, July 2020



__Note:__ The ranking uses a combined score based on: the claimant count, the share of local jobs in shut sectors pre-COVID-19, and the share of people currently supported by CJRS. This is combined with almost real-time information on the number of jobs currently being created.

__Source:__ JRF analysis of OBR Coronavirus analysis, Business Register and Employment Survey (via NOMIS), Institute for Employment Studies' Weekly vacancy analysis, and ONS claimant count and vacancies time series (52).

LOCAL GOVERNMENT FINANCES

Local authorities are central to efforts to Build Back Fairer from the pandemic. However, their capacity to manage during the pandemic, and to support recovery afterwards, has been hampered by the cuts over the last 10 years. The regressive nature of those cuts had weakened the resilience of more deprived areas before the pandemic, contributing to conditions that have led to high rates of infection and mortality during it and will affect how areas are able to recover. Inequalities between places will widen.

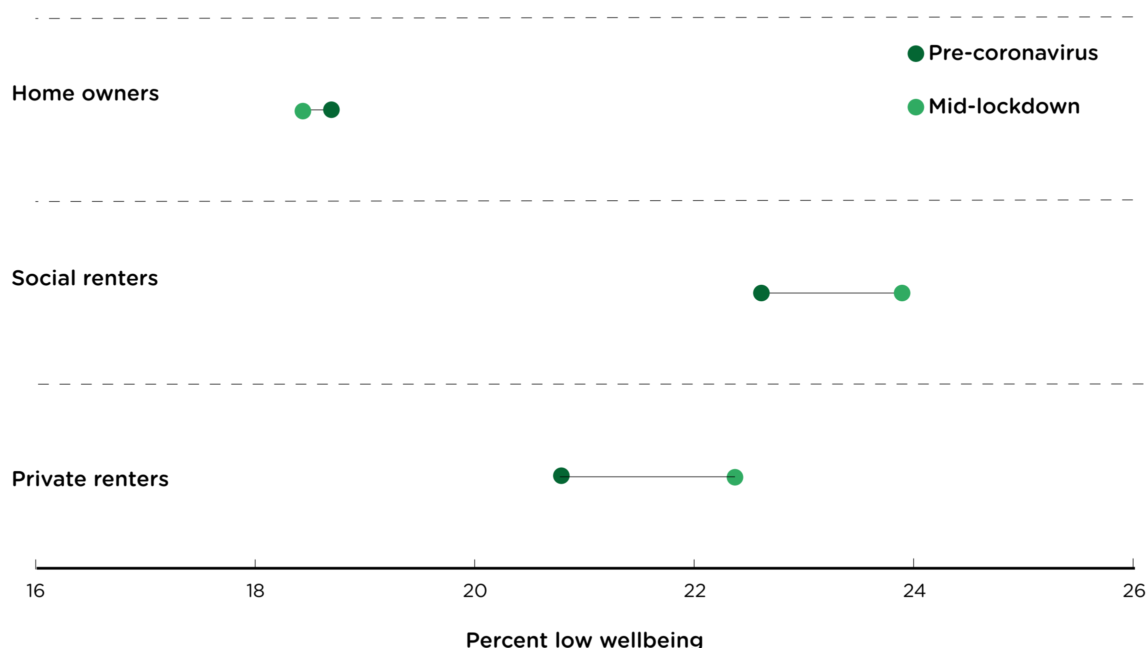
The Government has provided additional funding to local authorities to help them manage with additional pressures and funding shortfalls as a result of the pandemic. However, with reduced council and business tax revenue, the support from central government is insufficient and the outlook for local government revenues and spending in the coming years is bleak. Increased cost pressures and reduced revenues have left a shortfall of £2 billion in 2020–21. Without additional funding and/or flexibility over council tax rates, councils will have insufficient revenues to keep pace with rising spending needs. More deprived local authorities, which have a greater reliance on council tax revenues, and generate less revenue from business rates, are already underfunded and will experience even greater spending pressures in the coming years to deal with the impacts of COVID-19. Unless more funding is generated, local authorities in deprived areas will struggle to maintain basic services and meet statutory obligations, and inequalities in health and other outcomes will widen further still.

HOUSING

Housing is a critical determinant of health. Physical conditions of housing have direct and indirect impacts on health and poor conditions raise the risk of chronic diseases and infections and poor mental health. Overcrowded housing is associated with poor mental and physical health and is emerging as a high-risk factor for COVID-19 infection and mortality. Housing costs are also a key determinant of health as they push many households into poverty, causing both stress and mental health problems, while low incomes as a result of housing costs are associated with poor health.

During the COVID-19 pandemic, housing has become an even greater determinant of health and wellbeing. Over the lockdowns households have spent much of their time in their homes, and for some this has increased their exposure to unhealthy and overcrowded conditions and added to the stress of living in poor quality housing. Figure 24 shows that while all types of households have experienced declines in wellbeing during the lockdown, private renters experienced the largest declines in wellbeing. Inequalities in wellbeing related to housing have widened.

Figure 24. Percent of individuals reporting lower-than-usual levels of wellbeing on at least four of 12 General Health Questionnaire variables, controlling for personal characteristics, by tenure, UK, 2017–19 (pre-COVID-19) and April 2020 (mid-lockdown)

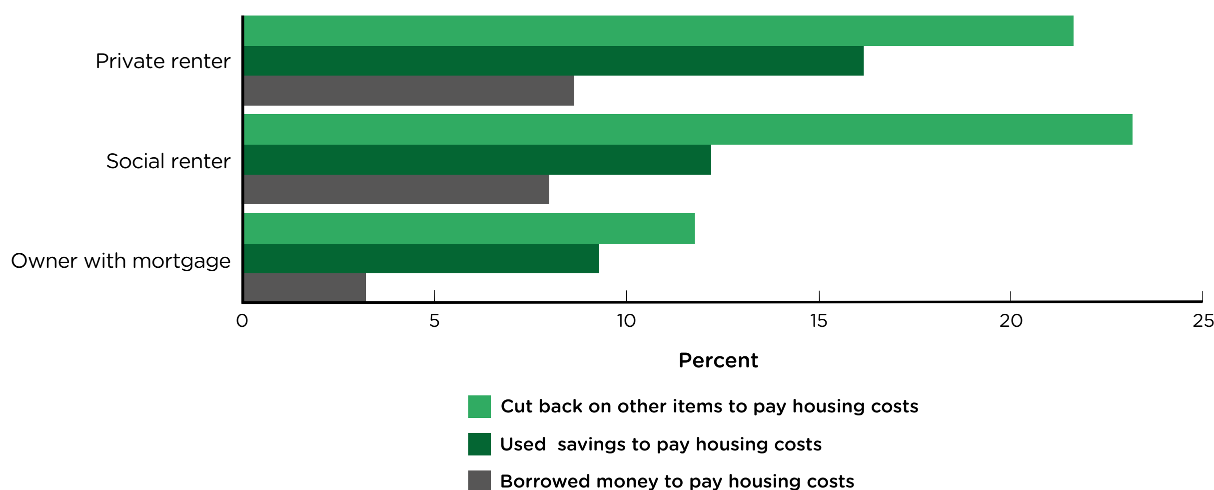


Source: *Judge L. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (53).*

There are regional differences in housing quality, which will have impacted on experiences during lockdown. In the West and East Midlands, and Yorkshire and the Humber, more than one in five homes failed to meet the decent homes standard in 2017, dropping to 16 percent in the South East and 11 percent in the North East. Lockdowns have exacerbated health inequalities related to housing conditions. During lockdowns people with gardens, who tend to be more affluent and include relatively more White people than BAME people, were able to benefit from the significant positive impacts on health and wellbeing from being outside, and inequalities in access to outdoor spaces were exacerbated. Income and ethnic inequalities related to quality of indoor spaces became more pronounced.

As unemployment has risen and wages have fallen due to furlough, housing costs have become an even greater burden. Housing costs have remained high in England in 2020, as house prices have increased related to stamp duty reductions. In order to meet housing costs nearly one-fifth of private and social renters have cut back on other items and 16 percent of private renters and 12 percent of social renters have had to use their savings to pay the rent and some have borrowed money. Some people with mortgages have also cut back and used savings, although to a lesser extent.

Figure 25. Percent of working age adults taking action to meet housing costs since COVID-19 by housing tenure and type of action taken, September 2020, UK



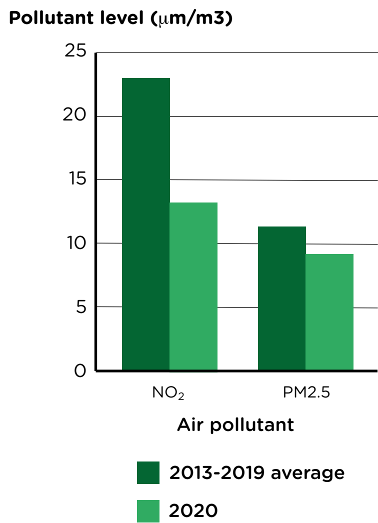
Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (54).*

The economic impact from COVID-19 and associated difficulties in paying rent will lead to an escalation in homelessness. Between 2010 and 2017 in England, homelessness and rough sleeping rates increased by 165 percent. For a short while, the extraordinary circumstances of the pandemic led to decisive action by the Government on homelessness: in March 2020, the Government instructed and provided funding to local authorities across the UK to provide accommodation for people sleeping rough during the pandemic and almost 15,000 people in England were moved into safe emergency accommodation such as hotels early on (55). Help with benefits applications and medical prescriptions was also provided to homeless people. However, there have since been increases in rough sleeping and large rises in homelessness, including people living in temporary accommodation and sofa surfing and people who have lost their housing during lockdowns. Many support services have had to stop face-to-face work and move online, which has reduced access.

AIR POLLUTION AND GREENHOUSE GAS EMISSIONS

Among the more positive outcomes of the COVID-19 crisis have been reductions in the global rate of increase of emissions of greenhouse gases, and a reduction in local air pollution. Carbon Brief reported that global CO2 emissions declined by 17 percent in early April 2020, and cleaner air was reported across the UK – Figure 26.

Figure 26. Average levels of fine particulate matter (PM2.5) and nitrogen dioxide (NO_2) levels in the UK in the 100 days following the start of the first lockdown, compared with the 2013–19 average



Source: *Higham et al. (56).*

Reductions in air pollution, if they had been sustained, would have gone on to provide enormous health and health equity benefits. However, people are currently understandably reluctant to use public transport if they have an alternative and since the first lockdown road traffic and its associated pollution have bounced back. The cleaner air during lockdown did afford an opportunity to experience cities and towns with much reduced air pollution and quieter roads with more people walking and cycling. Building Back Fairer requires a sizeable reduction in private car use and greater active travel and use of public transport – which would also help to reduce greenhouse gas emissions and lead to a more sustainable environment, contributing to our stated goal of reaching net-zero by 2030, ahead of the UK's legislative goal of net-zero by 2050. Efforts to support these changes are required urgently.

SUMMARY

The COVID-19 pandemic and containment measures are creating widening inequalities in local environments and prospects for communities there. The pandemic has also caused an even more bleak financial outlook for local authorities, especially those which are more deprived. To avoid further cuts to services and quality of environments, additional funding will be needed, a greater share of which should be for more deprived local authorities. The unaffordability of much of England's housing for lower income groups are compounded by rising poverty and unemployment. Services for homeless people, including rough sleepers need greater support.

The clean air during lockdown did afford an opportunity to experience cities and towns with much reduced air pollution and quieter roads with more people walking and cycling. Building Back Fairer requires a sizeable reduction in private car use and greater active travel and use of public transport. Efforts to support this are required urgently and would help to reduce Greenhouse Gas Emissions and lead to a more sustainable environment.

RECOMMENDATIONS

BOX 22. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM	• Invest in the development of economic, social and cultural resources in the most deprived communities. • Ensure 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 greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.
MEDIUM TERM	• Increase deprivation weighting in the local government funding formula. • Strengthen the resilience of areas that were damaged and weakened before and during the pandemic. • Reduce sources of air pollution from road traffic in more deprived areas. • Build more good-quality homes that are affordable and environmentally sustainable.
SHORT TERM	• Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls. • Increase government allocations of funding to the voluntary and community sector. • Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates. • Remove the cap on council tax. • Urgently reduce homelessness and extend and make watertight the protections against eviction.

CHAPTER 8

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION: INEQUALITIES AND COVID-19 CONTAINMENT

In the *10 Years On* report, we did not focus specifically on health behaviours, but on the causes of these health behaviours – the social determinants of health. We assessed how best to implement action on the social determinants of health to reduce health inequalities. These principles for governance for health equity and principles for implementing action on health and their social determinants (summarised in Boxes 23 and 24) are highly relevant to managing public health through the pandemic and in the aftermath.

BOX 23. PRINCIPLES FOR GOVERNANCE FOR HEALTH EQUITY – FROM *10 YEARS ON*

1. Health equity is an indicator of societal wellbeing.
2. The whole of government is responsible for prioritising health equity in all policies.
3. Development of strategies and interventions must involve a wide range of stakeholders.
4. Accountability must be transparent with effective mechanisms.
5. Communities must be involved in decisions about programmes and policies for achieving health equity.

BOX 24. PRINCIPLES FOR IMPLEMENTING ACTION ON HEALTH INEQUALITIES AND THEIR SOCIAL DETERMINANTS – FROM *10 YEARS ON*

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. Intervene early 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.

This report's remit is not to assess the Government's, the NHS's or Public Health organisations' efforts to manage and contain COVID-19 infections. We are, however, assessing how policies leading up to the pandemic laid the conditions for England's high, and geographically and socially unequal, mortality toll and set out how containment measures are leading to a deepening of health inequalities in England. We have made recommendations for immediate action to reduce widening inequities in the social determinants of health in order to mitigate the inequitable impacts of the pandemic.

In this section we assess how containment measures have affected the public's health and health inequalities and assess how Public Health organisations and their workforce need to be further focussed on reducing inequalities in the social determinants of health and strengthened in terms of capacity and funding. We make recommendations to refocus and strengthen public health in the wake of the pandemic to meet the challenge of reducing widening health inequalities and ensure that the new found prioritisation of public health is maintained.

The public's health and the public health workforce have been at the centre of the COVID-19 crisis in a number of ways, as summarised in Box 25.

BOX 25. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PUBLIC HEALTH

- The priority and importance of public health has increased during the pandemic and public health is now a central concern of the public and Government, with a new focus on the importance of protecting and improving health in England.
- The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
- Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
- There have been some significant changes in behaviours during lockdown – including potentially increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.
- We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of Build Back Fairer.
- Inequalities in health behaviours should also be a priority area for action.
- The Public Health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
- The Public Health system needs higher levels of investment and resourcing from central government – sustained cuts of 22% in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
- Underfunding and planned reorganisation of Public Health organisations and workforce has undermined capacity to contain the pandemic and improve health through the containment measures.

The Marmot Review in 2010 looked at inequalities in health behaviours, which we related to conditions in the social determinants: smoking, obesity, alcohol harm and drug misuse are all higher in more deprived communities and areas. In that report and several other subsequent reports, we showed that many unhealthy behaviours are driven by the conditions in which people are born, grow, live, work and age – the social determinants of health. These social determinants are the causes of the causes of poor health. Stress associated with poverty, for instance, makes changing behaviours much harder and the cost and availability of healthy food is a major constraint among more disadvantaged communities.

PUBLIC HEALTH AND INEQUALITIES DURING THE PANDEMIC

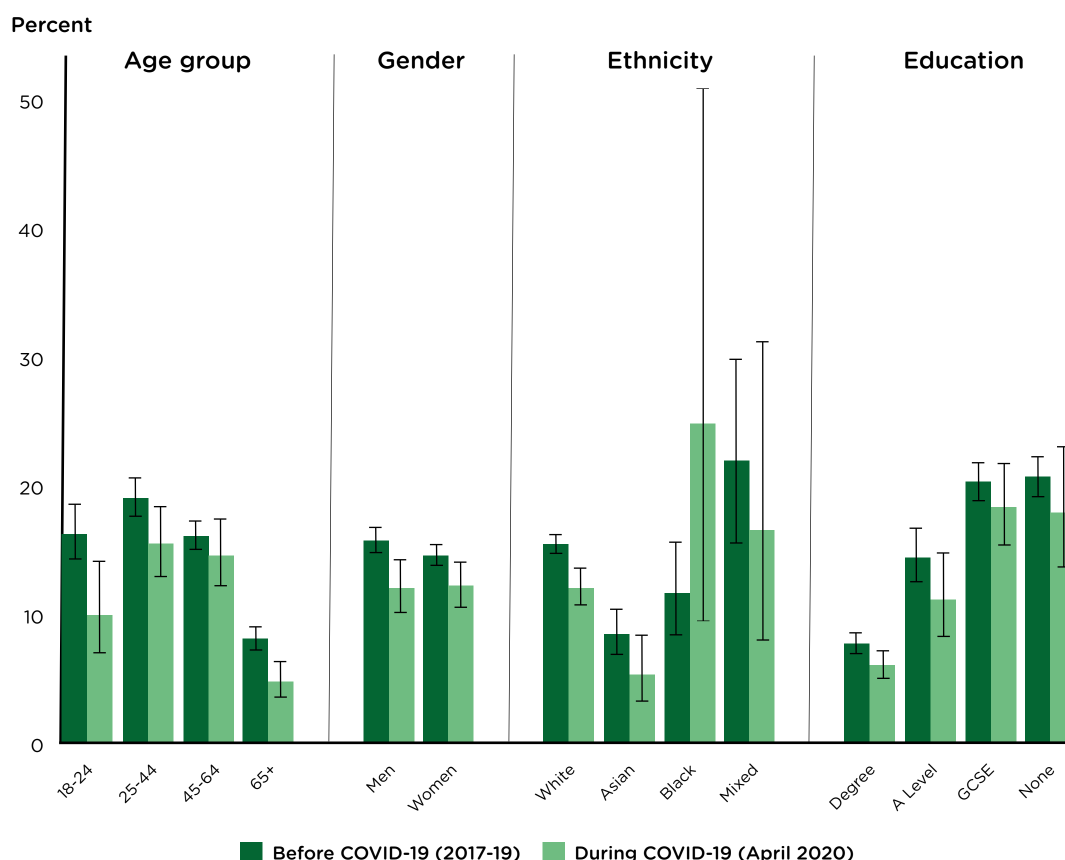
Public Health's overriding concerns during 2020 have been, quite rightly, about management and containment of the pandemic. While the challenges continue to be immense, there are also other concerns during this period and ongoing efforts by Public Health to improve health and reduce health inequalities.

Conditions in key social determinants of health have deteriorated and COVID-19 containment measures have resulted in some changes to health behaviours, increasing inequalities and concerning deteriorations in mental health.

SMOKING

Inequalities in smoking by social class have been well documented and reducing smoking rates in more disadvantaged communities continues to be a focus of Public Health efforts nationally and locally. Stress and anxiety have consistently been found to be risk factors associated with smoking (57; 58; 59), and stress and anxiety during the pandemic have been experienced disproportionately by more disadvantaged groups (60)(61). On the other hand, concerns about smoking and COVID-19 severity encouraged people to quit smoking. Although data is preliminary it suggests that cigarette smoking decreased during lockdown, except among those of Black ethnicity. The decrease in smoking was more apparent in younger age groups and men, shown in Figure 27 (62).

Figure 27. Percent smoking before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



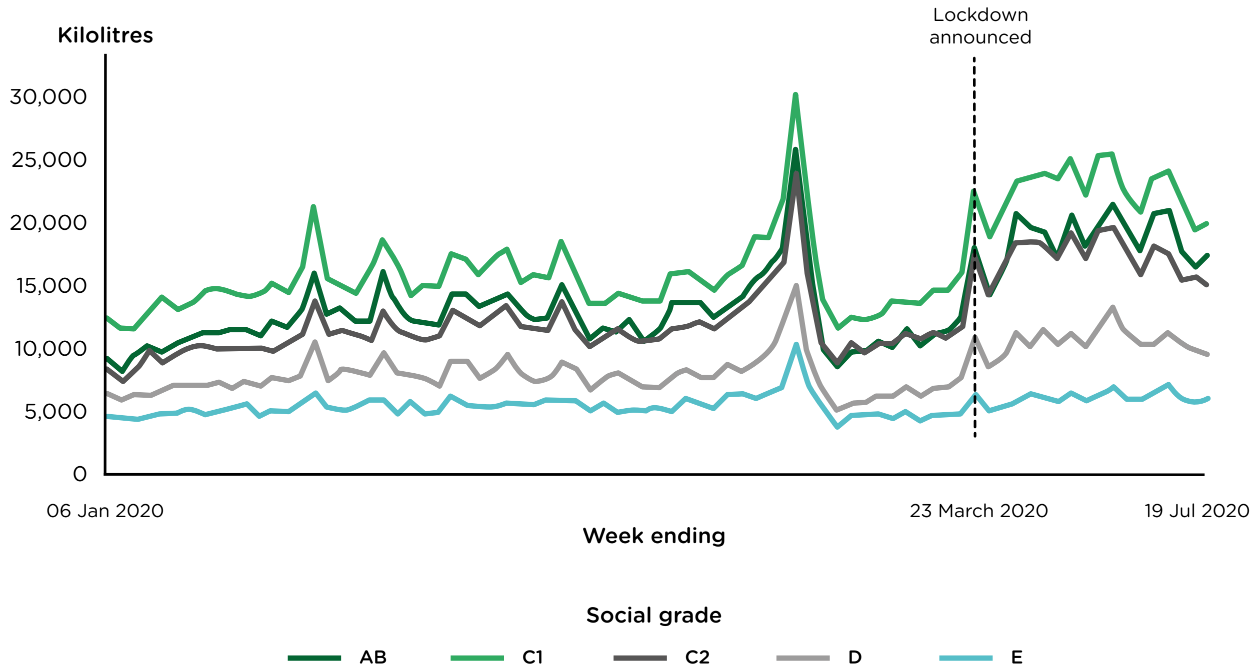
Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

When looking at smoking patterns across income groups, there was a decrease in the percent of respondents smoking in July 2020, when compared to the pre-COVID period for most income groups with the exception of those in the £10-20,000/year and £40,000-50,000/year income groups (63).

ALCOHOL

Alcohol consumption increased markedly in England during the lockdowns, particularly for those in social groups A, B and C1 (higher-income/-skilled). However, while alcohol consumption may be higher in those groups (Figure 8), harm from alcohol is disproportionately high among those in lower-income/-skilled groups – C2, D and E.

Figure 28. Trends in alcohol volume sales in Great Britain from 6 January to 19 July 2020, by occupational social grade

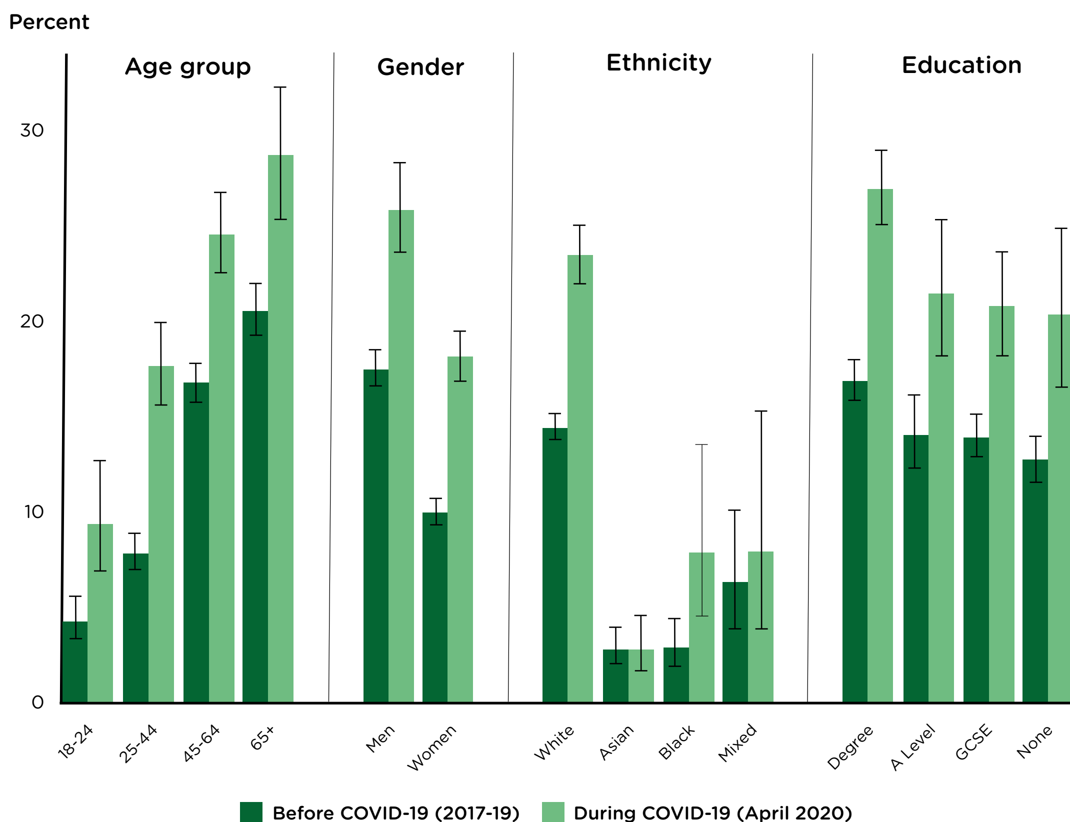


Notes: AB = higher and intermediate managerial, administrative and professional workers, C1 = supervisory, clerical and junior managerial, administrative and professional workers, C2 = skilled manual workers, D = semi-skilled and unskilled manual workers, E = people on long-term state benefits, casual and lowest grade workers, unemployed with state benefits (including pensions) only.

***Source:** Institute of Alcohol Studies (2020) (64) based on PHE analysis of Kantar Worldpanel Data.*

Frequent drinking defined as the percent of people reporting drinking four or more times a week increased during lockdown. Differences by age group and gender were apparent and increased more among women, White ethnic groups and those with degree-level education, Figure 29 (65).

Figure 29. Percent with alcohol intake 4+ times/week before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

OBESITY

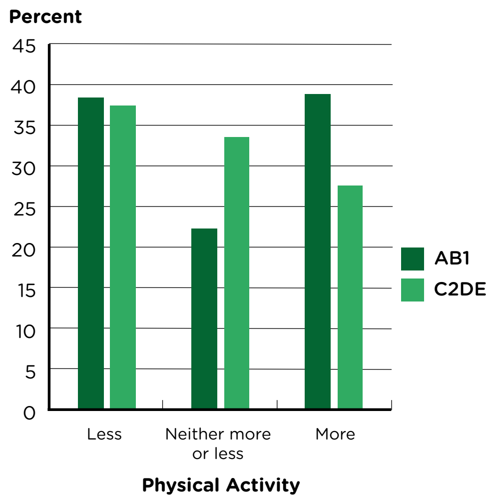
Obesity is a key health inequality issue and a risk factor for mortality from COVID-19. Obesity rates are higher among children and adults in more deprived groups compared with better-off groups, and analyses of 2018 data show that the prevalence of men and women who were obese increased with each level of deprivation (20).

While national data for levels of overweight and obesity during the period of COVID-19 containment are not yet available, there are studies and surveys showing inequalities may have risen and that those who are already obese gained relatively more weight (67). Data from a COVID-19 symptoms app show in every region users' weight had increased on average, but that increases in the South of England were lower than elsewhere (69).

A survey conducted during the first lockdown showed that being lower income, non-white, having a high-risk medical condition, a higher BMI and experiencing negative mental health symptoms were all associated with lower physical activity levels during lockdown (68).

Figure 30 shows differences in physical activity by social class during the first lockdown, showing adults in better-off social classes increasing their levels of physical exercise more than adults in lower-income classes.

Figure 30. Percent of adults doing more, less or the same amount of physical activity in England between 3 April and 11 May 2020, by social grade



Notes: ABC1 (higher and intermediate managerial, administrative and professional workers, supervisory, clerical and junior managerial administrative and professional workers) C2DE (skilled manual workers, semi-skilled and unskilled manual workers, people on long term state benefits, casual and lowest grade workers, unemployed with state benefits (including pension) only) (63).

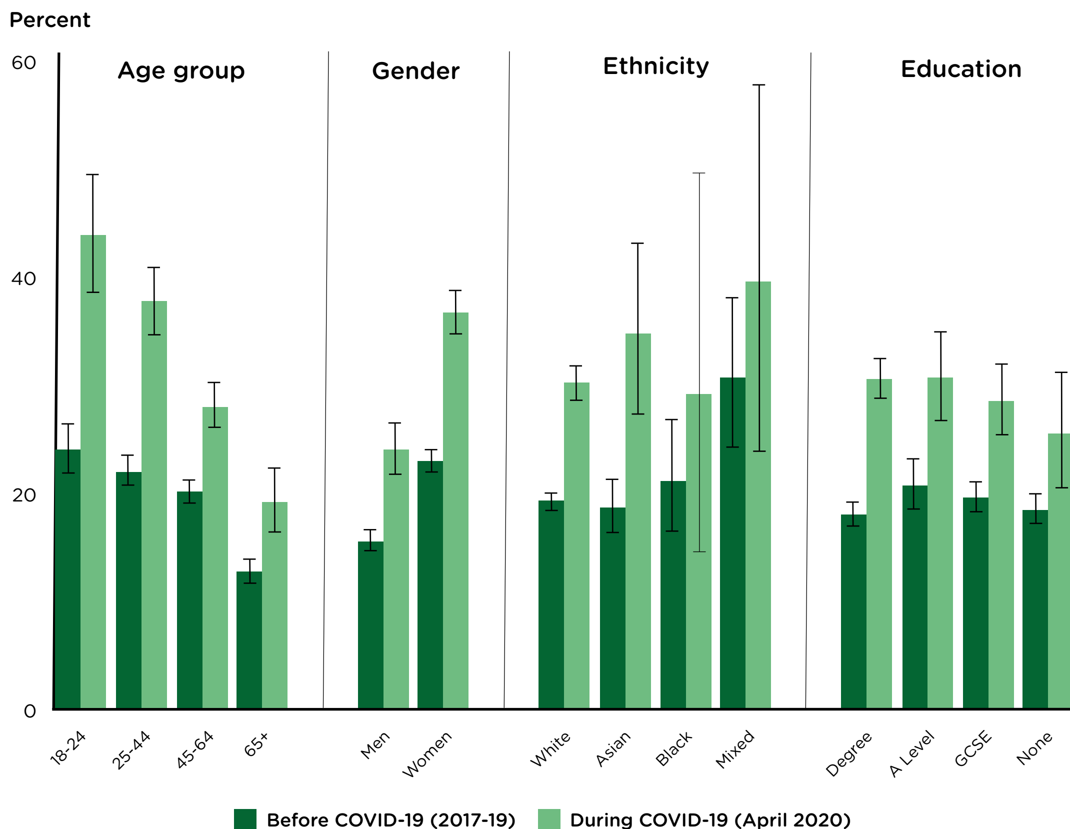
***Source:** based on survey data from Sport England by Savanta ComRes as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (63).*

MENTAL HEALTH

In the section on children and young people we outlined highly concerning increases in mental health problems and lack of access to appropriate services for young people since the start of the pandemic.

Levels of psychological distress worsened during the COVID-19 lockdown, according to the UK Household Longitudinal Study. Among the indicators measured, enjoyment of normal day-to-day activities showed the steepest decline. Worsening symptoms were also observed for concentration, sleep, feelings of unhappiness and loss of purpose (62). The overall increase in psychological distress was most pronounced among young people, as well as among those with higher educational attainment and among women. Among ethnic groups, those of Asian ethnic origin experienced the largest increase (Figure 31) (62).

Figure 31. Rates of psychological distress (GHQ-12) before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



***Source:** Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

Disabled people, many of whom have been self-isolating since the start of the pandemic and who are also experiencing increasing poverty and loss of employment, are reporting much higher levels of anxiety following the outbreak of the pandemic (70).

SOCIAL ISOLATION

The containment measures instigated in response to the virus exacerbated an existing problem to loneliness, 36 percent of survey respondents to wave 1 of Understanding Society COVID-19 Study stated feeling lonely (24-30 April 2020) (70).

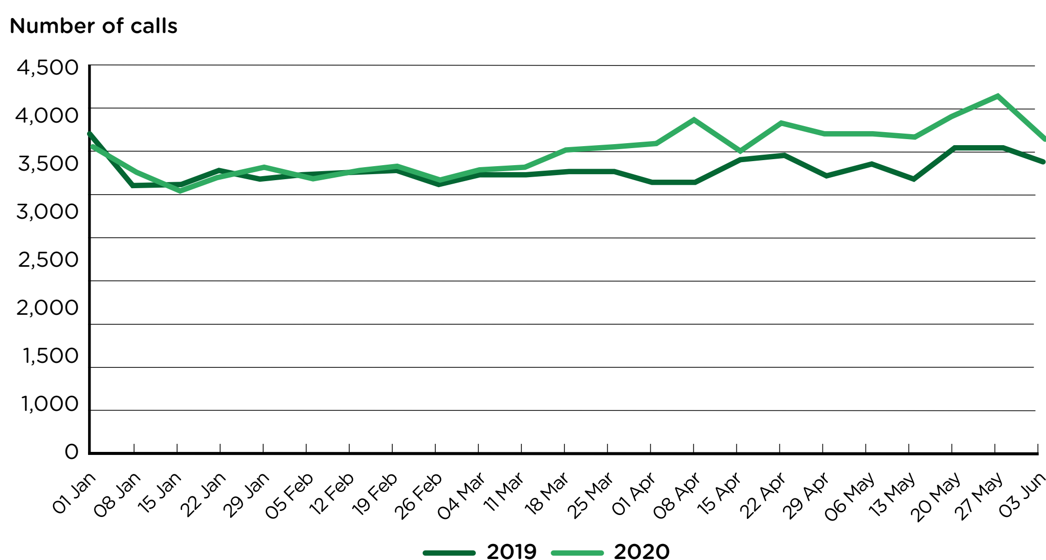
A study by Li et al investigated the prevalence of loneliness in the UK (in April 2020) by sociodemographic factors (70). Women had significantly higher odds of loneliness than men (Odds Ratio of 1.79), younger people had higher odds of loneliness compared to older people and those who do not live with a partner had higher odds of loneliness when compared to those who did live with a partner (Odds Ratio 3.22) (70). Fancourt et al. explored the risk factors for loneliness both before and during the pandemic and they found that the risk factors for loneliness were similar before and during the pandemic (71). Results showed similar groups at risk of loneliness to those in Li et al and their analyses found that those of lower education and on low income, were also at higher risks of being lonely (71). Students, who are usually not considered to be of high risk of loneliness, were identified as a new high risk group for loneliness during the pandemic (71).

VIOLENCE AND ABUSE

There have been many reports of increases in violence and abuse within households during lockdowns. Financial dependence and poverty are diminishing women's and children's resilience when experiencing domestic abuse and can prevent women from leaving an abusive partner (72).

Figure 33 shows that the London Metropolitan Police Service received a total of 41,158 calls-for-service for domestic incidents between 25 March (following the lockdown restrictions imposed on 23 March) and 10 June 2020 a 12% increase compared with calls over the same period in the previous year (73).

Figure 33. Weekly number of calls-for-service for domestic incidents, recorded by London Metropolitan Police Service, Greater London, 1 January to 10 June 2019 and 2020



Note: *Dates in the horizontal axis refer to date of when week commenced.*

Source: *Ivandic R. Changing patterns of domestic abuse during COVID-19 lockdown (73).*

COVID-19 containment measures such as lockdown and school closures increased the need for domestic violence support services. However, Women's Aid research showed that containment measures also restricted women's ability to access support services and support from friends, relatives and work colleagues (30).

PUBLIC HEALTH ORGANISATIONAL AND WORKFORCE CAPACITY AND FUNDING

Public health has been at the forefront of efforts to reduce infection and mortality from COVID-19 and trying to continue essential work to improve health and reduce inequalities in health in hugely difficult circumstances. In the decade before the pandemic, funding for public health declined and a series of major reorganisations took up organisational capacity, leaving public health systems and workforces without the necessary funding, resources and capacity.

The Public Health grant has been reduced substantially over the last decade, and despite an increase of £80 million in 2020/21, it is now 22 per cent lower in real terms compared with 2015/16. Restoring real-terms per capita spending to the same levels as 2015/16 would require the equivalent of an additional £0.9 billion a year (74). Meanwhile, the regressive cuts to public services and local authority grants over the last decade have undermined health and health equity and had a hugely negative impact on services that support health such as education, youth services, social care, housing, transport, leisure centres and green spaces (75). While spending on health care is projected to increase, public health funding is still woefully inadequate, with further cuts planned (3). As the president of the Association of Directors of Public Health stated in November 2020:

> "COVID-19 has shone a light on the knowledge, expertise, and skills of Directors of Public Health and their teams. In the current circumstances, and following years of cuts to local public health, it is completely incomprehensible that the Government is not increasing the public health grant. … During 2021–22, local public health teams will continue to have a key role in the management of COVID-19 – and being prepared for any future epidemics. In addition, if we are serious about learning the lessons of how existing health inequalities have driven and exacerbated the impact of COVID-19, we must address the socio-economic determinants of health and invest in local public health teams." (76)
>
> **President of the Association of Directors of Public Health**

The decision to reorganise public health at the national level in 2021 will undermine public health leadership focus and capacity at a time when it is needed more urgently than ever. Existing public health organisations need further support and a stronger focus on social determinants of health and health inequalities. As we said in *10 Years On*:

> "It is imperative that the Government, NHS England, PHE and other organisations charged with reducing health inequalities, work more effectively to improve the conditions in which people are living, and the structural drivers of these conditions, as well as positively influencing the choices that people make about health behaviours. The Government has the evidence about the overwhelming impacts of social determinants on health but it has largely not acted on it and certainly not at sufficient scale (1)."
>
> **10 Years On report**

These imperatives are even more critically important during, and following, the pandemic, as the country struggles with the health impacts of containment measures. Underfunding and undermining capacity of public health run completely counter to meeting these challenges.

SUMMARY

Public Health organisations and workforce must be at forefronts of efforts to contain the pandemic, while continuing efforts to improve health and reduce health inequalities. These efforts are undermined by insufficient government funding and planned reorganisations and weakening of public health leadership. As we have documented throughout the report, health in England was already in a poor state before the pandemic and the pandemic and associated containment measures are further damaging health and significantly increasing health inequalities. For these deteriorations to be reversed it is essential to have a better resourced, flourishing Public Health system. Without this it will be impossible for England to build back fairer.

Action on the social determinants of health is necessary to reduce health inequalities. Hence, we have set out the need for an Inequalities Strategy to be at the centre of recovery from the pandemic, which should involve the whole of Government, and be led by the Prime Minister. Public Health has a crucial role, centrally and locally in providing the expertise, helping shape policies, monitoring and evaluation. The pandemic has reemphasised the importance of Public Health experts' clear and effective communication with the public. While there has been a welcome focus on social determinants among Public Health systems in recent years, this still needs to be strengthened.

RECOMMENDATIONS

RECOMMENDATIONS – BOX 25. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM	• A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health. • Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities
MEDIUM TERM	• Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities. • Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.
SHORT TERM	• Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient • Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

CHAPTER 9

CONCLUSIONS

In 2017, Hurricane Maria hit Puerto Rico. Two months afterwards, mortality had risen – but far from uniformly: it shot up sharply for the lowest socioeconomic group, increased somewhat for the middle group, but the highest socioeconomic group saw far less impact (77). A huge external shock had thrust the underlying inequalities in society into sharp relief. So it has been with COVID-19 – a central message of this report. Documenting the pandemic's impact on inequalities in the social determinants of health, and in health, is a first step to achieving a more important goal: to Build Back Fairer. To do this, it is necessary to have the evidence of what has gone wrong and how to put it right.

In February 2020 we published Health Equity in England: The Marmot Review 10 Years On, a review of what had happened to health and health inequalities in the decade since the publication of the 2010 Marmot Review, Fair Society, Healthy Lives (78). The picture was bleak: stalling life expectancy, rising health inequalities between socioeconomic groups and regions, and life expectancy declining for people in the most deprived areas. We made a series of recommendations, addressing the social determinants of health, for how things could and should improve.

Since then, with the COVID-19 pandemic, the world has changed dramatically. But in England the changes have been entirely consistent with its existing state when the pandemic hit in February. We set out at the beginning of this report the proposition that England's comparatively poor management of the pandemic was of a piece with England's health improvement falling behind that of other rich countries in the decade since 2010. We offered four likely reasons why: the quality of governance and political culture which did not give priority to the conditions for good health; continuing increases in inequalities in economic and social conditions, including a rise in poverty among families with children; a policy of austerity and consequent cuts to funding of public services; and a poor state of the nation's health that would increase the lethality of COVID-19.

Addressing all of these needs to be at the heart of what needs to change if we are to build a fairer, healthier society as we emerge from the pandemic.

One striking feature of health in the time of COVID-19 is the high mortality rate of members of Black, Asian and minority ethnic groups. Much of this excess mortality can be attributed to living in more deprived areas, working in high-risk occupations, living in overcrowded conditions and, in the case of Bangladeshi and Pakistani groups, a greater prevalence of relevant pre-existing conditions. Structural racism means that some ethnic groups are more likely to be exposed to adverse social and economic conditions, in addition to the everyday experiences of discrimination – causing a "robbery of resilience", as Marvin Rees, the Mayor of Bristol, put it. The spreading of the Black Lives Matter protests to the UK has raised the visibility of these issues. Building Back Fairer will entail addressing this fundamental cause of social injustice, in addition to the social and economic inequalities that are so pervasive.

With vaccines coming on stream there is talk of getting back to 'normal'. As our *10 Years On* report made clear, 'normal' is not acceptable, if that means where we were in February 2020. The pandemic must be taken as an opportunity to build a fairer society. In Building Back Fairer we must accept the growing recognition, worldwide, that economic growth is a limited measure of societal success. We note the example of the New Zealand Treasury which in its 2019 policy statement put wellbeing at the heart of its government's mission.

Building a society that puts fairness at the heart of policy-making, from birth – equity from the start – through every stage of the life course, to flourishing later life, means building a society that no longer fares poorly by comparison with other rich countries. Whether it is ranking only 27th out of 38 countries on child wellbeing or having the slowest improvement in life expectancy of any rich country bar Iceland and the USA, or having the highest excess mortality in Europe during the COVID-19 pandemic, or having unacceptably high social and ethnic inequalities in health, we can do better.

But the problems we lay out here are not unique to England. In the USA, for example, both the widening economic inequalities and the high mortality associated with race and ethnicity are much in evidence. It was estimated that, from March to September 2020, the wealth of the United States' 643 billionaires increased by 29 percent. Over the same period the hourly pay of the bottom 80 percent of the workforce declined by 4 percent. The inequalities in the UK may be less dramatic than that, but how is that gross level of inequality compatible with a fair and healthy society? The answer is: it is not. In the UK, with the NHS, inequities in access to health care are not compounding the race/ethnicity disadvantage on anything like the scale that they are in the USA and elsewhere.

Fortunately, England, and the other countries of the UK, are blessed with having a strong scientific tradition and excellent high-quality data. We have drawn on these in this report. The scientific approach taken here has benefited from evidence from around the world. The insights could flow the other way, too. The evidence we have compiled here for England will have relevance more broadly.

We suggest that to Build Back Fairer we need commitment at two levels. First is the commitment to social justice and putting equity of health and wellbeing at the heart of all policy-making, nationally, regionally and locally. The pandemic has shown that when the health of the public is severely threatened, other considerations become secondary. The enduring social and economic inequalities in society mean that the health of the public was threatened before and during the pandemic and will be after. Just as we needed better management of the nation's health during the pandemic, so we need national attention to the causes of the causes of health inequalities.

The second level is to take the specific actions needed, as we lay out in this report, to create healthier lives for all.

This report has not dealt with the climate crisis. But as we stated at the outset, there is a companion report from the Institute of Health Equity, commissioned by the Government's independent advisory body, the Committee on Climate Change: Sustainable Health Equity: Achieving a Sustainable UK (2). The recommendations in that report are consistent with those contained here. To build back fairer, society needs to deal both with inequalities and with the climate crisis.

It is worth, perhaps, dealing with two objections. The first is money. Reversing the cuts to Children's Centres, to per-student funding in schools, to local governments, to the health service will take public spending. So, too, will paying care workers a living wage and having more generous safety nets that do not consign people and their families to dire poverty. At a time of huge national debt, can the country afford it? Britain has tried the austerity experiment, in the decade from 2010. It did not work, if health and wellbeing are the markers of success. Phrases like "maxing out the nation's credit card" are neither helpful nor based on sound economics. At a time of zero interest rates, with a tax rate that is at the low end among European countries and with control of its own currency, a nation can borrow for the purpose of building a better society. We should not be asking if we can afford for our children's wellbeing to rank better than 27th out of 38 countries, or to pay for free school meals during holidays so that eligible children do not go to bed hungry. Social justice requires it.

A second objection is that people make their own choices. Much of the ill health of the poor, it is argued, can be traced back to the poor choices they make. We have refuted this elsewhere (78). The evidence suggests that poverty leads to poor choices; not poor choices to poverty. For example, we have cited data from the Food Foundation that households in England in the bottom 10 percent of household income would need to spend 74 percent of household income on food were they to follow official healthy eating advice. We repeat: the problem is not poor 'choices'; the problem is poverty. During the pandemic this has become even more clear. Frontline workers were at high risk because they were doing essential work. People did not feed their children well not because they were spending money on the wrong things, or because they hadn't taken cooking classes, but because they lost their jobs. The rhetoric of the "undeserving poor" as justification for harmful social policies should have no place in Building Back Fairer.

We end this report on a hopeful note. The evidence is clear. There is so much that can be done to improve the quality of people's lives through the life course. Inequalities in health is a tractable problem. It is in all our interests to Build Back Fairer.

BOX 2.3. IN SUMMARY:

PREVIOUS HEALTH CONDITIONS	Specific health conditions suggest a worse prognosis and higher rates of mortality. These higher risk health conditions are associated with living in more deprived areas and being in a lower income group and are therefore exacerbating existing health inequalities. Evidence presented in our *10 Years On* report showed that there had been a deterioration in health in England, specifically in more deprived areas in some regions; COVID-19 has exacerbated this situation.
DEPRIVATION OF AREA OF RESIDENCE	Living in more deprived areas is associated with a greater risk of mortality from COVID-19. The reasons for this are associated with the other risk factors we describe: worse living conditions and type of employment. It is clear that in some areas conditions have.
REGION	While the pandemic is affecting different regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation, ethnicity and COVID-19 makes living in more deprived areas in certain regions particularly hazardous. Given the widening health and social determinants inequalities between regions in England prior to the pandemic, described in our *10 Years On* report, it is to be expected that mortality rates will be higher in regions outside London and the South – particularly in the North West and North East – and that has indeed been the case since the end of the first wave of the disease.
LIVING CONDITIONS	Overcrowded living conditions and poor quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and inhabited by people with lower incomes. Evidence from the *10 Years On* report showed that housing conditions had deteriorated for many and that regional inequalities in health and the social determinants had widened in the 10 years to 2020.
EMPLOYMENT	Some occupations have a higher risk of mortality than others – these include occupations that do not facilitate working from home or social distancing. Close proximity to other people is a clear risk factor for mortality from COVID-19. All the occupations with above-average mortality rates are lower paid and lower status. The health and care workforce are particularly at risk, especially nursing and care staff.
ETHNICITY	BAME groups are experiencing higher rates of mortality from COVID-19. This is related to their disproportionate experience of high-risk living and working conditions. These are partly the result of longstanding impacts of discrimination and exclusion associated with systemic racism. There is also evidence that the BAME workforce in highly exposed occupations are not being sufficiently protected with PPE and safety measures.
RELIGIOUS GROUP	Most major religious groups have higher rates of mortality from COVID-19 than people who do not follow a religious faith. Some of this is explained by high numbers of BAME groups following a faith, and by attendance at religious gatherings.

BOX 3.3. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EARLY YEARS

LONG TERM	Reduce inequalities in early years development as a priority for government
MEDIUM TERM	• 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. • 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.
SHORT TERM	• Early years settings in more deprived areas are allocated additional Government support to prevent their closure and staff redundancies. • Improve access to availability of parenting support programmes • Increase funding rates for free child childcare places to support providers

BOX 3.4. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM	• Put equity at the heart of national decisions about education policy and funding. • Increase attainment to match the best in Europe by reducing inequalities.
MEDIUM TERM	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).
SHORT TERM	• Inequalities in access to laptops, are addressed and the programme designed to enable provision of laptops to more deprived pupils is expanded and adequately resourced. • Significantly greater focus on achieving equity in assessments for exam grading. • Catch up tuition is fully rolled out for children in more deprived areas urgently • Additional support is provided for families and pupils with SEND • Excluded pupils are urgently given additional support and enrolled in Pupil Referral Units

BOX 4.3. RECOMMENDATIONS TO BUILD BACK FAIRER FOR CHILDREN AND YOUNG PEOPLE

LONG TERM

- Reverse declines in the mental health of children and young people and improve levels of well-being, from the present low rankings internationally, as a national aspiration.
- Ensure that all young people are engaged in education, employment or training up to the age of 21.

MEDIUM TERM

- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Improve prevention and treatment of mental health problems among young people.

SHORT TERM

- Reduce child poverty:
  - Remove the 'two-child' and benefit cap
  - Increase child benefit for lower income families to reduce child and food poverty
  - Extend free school meal provision for all children in households in receipt of Universal Credit.
- Urgently address children and young peoples mental health with a much strengthened focus in schools and teachers trained in mental first aid.
- Increase resources for preventing identifying and supporting children experiencing abuse.
- Develop and fund additional training schemes for school leavers and unemployed young people.
- Further support young people training and education and employment schemes to reduce NEET and urgently address gaps in access to apprenticeships.
- Raise minimum wage for apprentices and further incentivise employers to offer such schemes.
- Prioritise funding for youth services.

BOX 5.4. BUILD BACK FAIRER: RECOMMENDATIONS FOR CREATING FAIR EMPLOYMENT AND GOOD WORK FOR ALL

LONG TERM

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life.
- The social safety net must be sufficient such that people not in full time work receive a minimum income for healthy living
- Engage in a national discussion on the balance of the work-life balance including consideration of a four day week.

MEDIUM TERM

- Reduce the high levels of poor-quality work and precarious employment.
- Invest in good quality active labour market policies
- Increase the national living wage to meet the standard of minimum income for healthy living

SHORT TERM

- Provide subsidies or tax relief for firms that recall previously dismissed workers
- Coronavirus Job Retention Scheme to be extended to cover 100% of wages for low income workers
- Enforcement of minimum wages so that the large number of workers who are currently exploited earn their entitlement

BOX 6.3. BUILD BACK FAIRER: ENSURING A HEALTHY STANDARD OF LIVING FOR ALL

LONG TERM

- Establish a national goal so that everyone in full-time work receives a wage that prevents poverty and enables them to live a healthy life without relying on benefits.
- Make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living.
- 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 benefits system to ensure they achieve greater equity and are not regressive.

MEDIUM TERM

- Make permanent the £1,000-a-year increase in the standard allowance for Universal Credit.
- Ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty.
- Eradicate food poverty permanently and remove reliance on food charity.
- Remove sanctions and reduce conditionalities in benefit payments.

SHORT TERM

- Increase the scope of the furlough scheme to cover 100 percent of low-income workers.
- Eradicate benefit caps and lift the two-child limits.
- Provide tapering levels of benefits to avoid cliff edges.
- End the five-week wait for Universal Credit and provide cash grants for low-income households.
- Give sufficient Government support to food aid providers and charities.

BOX 7.3. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM	• Invest in the development of economic, social and cultural resources in the most deprived communities. • Ensure 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 greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.
MEDIUM TERM	• Increase deprivation weighting in the local government funding formula. • Strengthen the resilience of areas that were damaged and weakened before and during the pandemic. • Reduce sources of air pollution from road traffic in more deprived areas. • Build more good-quality homes that are affordable and environmentally sustainable.
SHORT TERM	• Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls. • Increase government allocations of funding to the voluntary and community sector. • Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates. • Remove the cap on council tax. • Urgently reduce homelessness and extend and make watertight the protections against eviction.

BOX 8.4. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM	• A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health. • Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities
MEDIUM TERM	• Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities. • Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.
SHORT TERM	• Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient • Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

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Item 15:

Member Questions to be answered at the Health and Wellbeing Board meeting on 28 January 2021.

Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.

(a) **Question submitted by Councillor Martha Vickers to the Service Director – Communities and Wellbeing:**
"In the light of the report of a significant rise in incidents of Non Accidental Injuries to children during the period of the pandemic could the Council create a Covid Dashboard Tracker in order to monitor the broader effects of the pandemic on our community?"

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