The Health Foundation

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INSTITUTE of HEALTH EQUITY

VOLUNTARY SECTOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

ACKNOWLEDGEMENTS

About the UCL Institute of Health Equity (IHE)

The Institute is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health. The Institute continues to build on previous work to tackle inequalities in health, led by Professor Sir Michael Marmot and his team, including the 'Commission on Social Determinants of Health', 'Fair Society, Healthy Lives' (The Marmot Review) and the Review of Social Determinants of Health and the Health Divide for the WHO European Region'. www.instituteofhealthequity.org

About this report

This report was commissioned by the Health Foundation and developed in collaboration with New Philanthropy Capital. It provides a wide range of evidence demonstrating the impact of social determinants on health and identifies clear system levers that can be utilised by the voluntary sector to highlight the need for action, to approach potential new partners, and to work collaboratively across sectors.

This report was written for IHE by Sorcha Daly and Jessica Allen.

IHE would like to thank all those who contributed to the development of this report, including New Philanthropy Capital, in particular, Charlotte Lamb, Iona Joy, and Katy Boswell. We would also like to thank Jo Bibby and Natalie Lovell from the Health Foundation. Further thanks go to Patricia Hallam (IHE) and to UCL Health Creatives and to the voluntary sector organisations that contributed to the report.

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VOLUNTARY SECTOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

Good health and wellbeing can be seen as an asset. It is one of the main factors that shapes quality of life and can promote the health and wellbeing of the wider community.

Social, economic, environmental, political and cultural factors influence people's health at every stage of life, and inequalities in these factors lead to widespread and persistent inequalities in life expectancy and time spent in good health.

Many charities pursue social and economic outcomes that impact on health outcomes, but relatively few articulate their work in terms of its relevance to health and health inequalities.

This report aims to provide the most relevant evidence to enable the voluntary sector to expand and develop its action on the social determinants of health. It has been developed with small- to medium-sized charities, who may only just be starting to engage with the issue.

The report is the start of a knowledge-sharing and activation process to ensure charities can appreciate the impact their work has on the wider determinants of health. It begins a process that will:

- Raise awareness among non-health charities that their work on the determinants of health influences health outcomes.
- Provide easily accessible evidence that demonstrates the likely health outcomes achieved by charities taking action on the social determinants of health.
- Provide evidence to shape strategy and service design in order to promote improved health.
- Enable charities to engage with policy-makers and the public about the impact of the social determinants of health in order to further build the movement around the social determinants agenda.
- Demonstrate charities' wider impact to their funders and supporters and potentially leverage a more diverse range of funding for their activities.
- Enable charities to communicate the health benefits of their work to beneficiaries.
- Enable charities to contribute to the body of evidence by identifying and measuring their own impact on health, if appropriate.

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NAVIGATING THIS DOCUMENT

Throughout this document boxes are used to highlight specific information.

Key messages:

In the Executive Summary and at the beginning of each section on the social determinants of health these boxes are used to highlight key points from the research.

Strength of evidence:

At the beginning of Sections 2–9 these boxes are used to highlight the most recent research that examines the strength of evidence relating to links between the specific social determinants and health outcomes.

Example interventions:

A variety of case studies demonstrating action on the social determinants of health are presented in these boxes at the end of each section.

Key terms are identified and explained in these boxes throughout the document

Each section is followed by a number of evaluations and evidence reviews of interventions that address specific determinants of health.

EXECUTIVE SUMMARY

The role of social determinants in the nation's health

Good health and wellbeing is an asset. It is one of the main factors that shapes our quality of life and can promote the health and wellbeing of the wider community.

However there are clear and persistent health inequalities across England. People who have lower socioeconomic status have worse health and live shorter lives in comparison with those who have higher socioeconomic status. This social gradient in health (shown in Figure S1 and Figure S2 on the right) affects everyone; inequalities in life expectancy and healthy life expectancy impact on everyone below the very highest socioeconomic status, not just the most deprived.

Health inequalities are a result of the social, economic, political, cultural and environmental conditions in which people are born, grow, live, work and age. This means that the majority of health inequalities are avoidable and that the social gradient in health is unfair and unjust. People are living shorter lives with longer periods of ill health unnecessarily, as a result of socioeconomic factors.

Action taken to address the social determinants of health is possible and effective and results in people living longer, healthier, lives.

Figure S1. Life expectancy and disability-free life expectancy (DFLE) at birth, males by neighborhood deprivation, England, 1999–2003 and 2009-2013

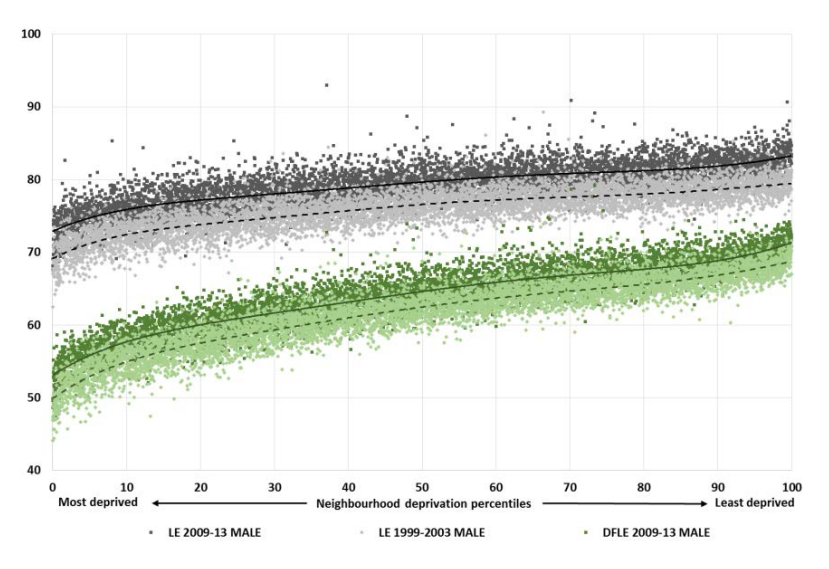
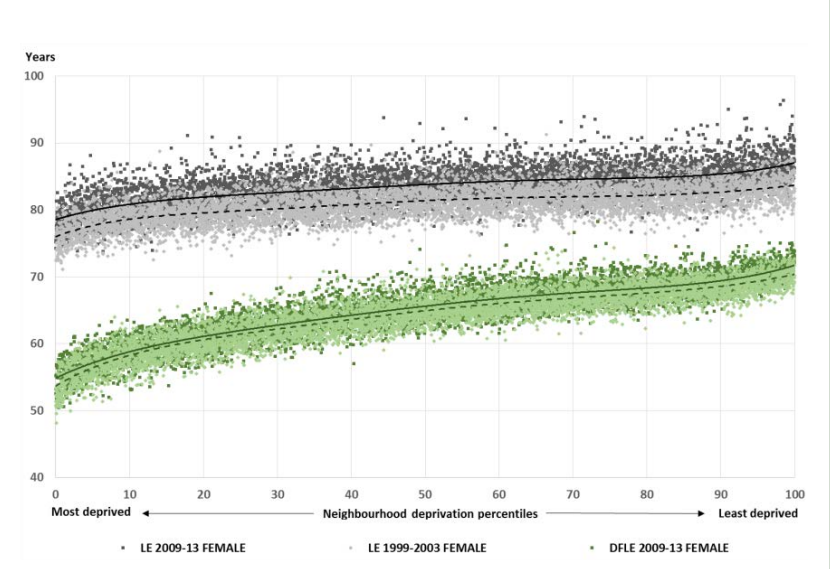


Figure S2. Life expectancy and disability-free life expectancy (DFLE) at birth, females by neighborhood deprivation, England, 1999–2003 and 2009-2013



The role of charities in taking action on social determinants of health

Many charities take action on the social determinants of health which directly and indirectly impact on health outcomes, but relatively few articulate their work in terms of its relevance to health and health inequalities. This includes charities that already work in areas that directly influence health, but do not recognise their work as relevant to health. Meanwhile, charities that address specific health conditions and needs do not work to address the social determinants of those conditions. Their work could become more effective by influencing social determinants, fostering prevention of ill health and disease, as well as influencing and offering treatment and care. These charities may want to consider what role they could have in highlighting the impact of social determinants on their specific health condition.

Charities are often well situated to influence social determinants because of the kind of services they deliver and the proximity to the communities they engage with. Excluded communities that have a history of non-engagement with statutory or mainstream services and that often have poor health outcomes may choose to engage with charities. National policies will have only limited effectiveness in health improvement without local delivery systems that are focused on health equity and that can work effectively within communities. Charities are well placed to support this work.

Of course, charities are not homogenous – their activities span a range of actions, including:

- **Service delivery:** Charities deliver direct services to communities, including information, advice, emotional/psychological support, including social or clinical services such as nursing, social care, and specialist health workers.
- **Influencing policy, and lobbying:** Charities' policy and campaigning teams may aim to improve services to the people they serve, or to improve policies affecting people. The services/policies charities want to improve are often provided by government, although increasingly the commercial sector is an object of influence. For instance, charities have successfully campaigned for increases to basic wages through the Living Wage campaign, which was directed at both government and employers. Many charities work closely with government at all levels to improve health and social services.
- **Public awareness and campaigns:** Charities regularly raise public awareness of issues; for example, the recent high-profile Heads Together campaign about mental health stigma, spearheaded by the young Royals, was conceived and implemented by a group of charities.
- **Research:** The medical research area of the voluntary sector commands a high proportion of voluntary donations. Non-medical research by charities is also valued.

Any of these activities could be relevant to addressing social determinants of health. A housing charity may well provide people with temporary accommodation, or direct and support them into permanent accommodation, while campaigning for improvements in housing policy. They may also be active in raising public awareness of housing issues through media campaigns.

Why this report?

Many actors – funders, charities, academics, health professionals, government – are concerned with the UK's health and especially the relatively poor health of the most disadvantaged. The amount of expert and local authority attention given to the role of social determinants and inequality in causing poor health is also increasing. Groups of concerned organisations and individuals are keen to develop a social movement to address the problem and to engage further with a wider group of stakeholders and the public. There are many national and local actions, from a range of stakeholders, which can reduce inequalities. The important next step is ensuring that the most appropriate actors prioritise the issue and take effective action.

Three organisations – Health Foundation, NPC, and Institute of Health Equity – have formed a partnership to address part of the jigsaw: evidence.

This report is an initial step in supporting greater work and emphasis on social determinants of health by identifying the evidence of links between inequalities in health and social determinants of health and exploring relevance for the charity sector. This will help to make the case for the movement, and we hope will be a resource to draw upon. The report has

been developed with small- to medium-sized charities in mind, who may only just be starting to engage with the issue. A range of such organisations input into the report, and we also sought the views of some larger organisations.

The report will:

- Raise awareness among non-health charities that their work on the determinants of health influences health outcomes.
- Provide easily accessible evidence that demonstrates the likely health outcomes achieved by charities taking action on the social determinants of health.
- Provide evidence to shape strategy and service design in order to promote improved health.
- Enable charities to engage with policy-makers and the public about the impact of the social determinants of health in order to further build the movement around the social determinants agenda.
- Demonstrate charities' wider impact to their funders and supporters and potentially leverage a more diverse range of funding for their activities.
- Enable charities to communicate the health benefits of their work to beneficiaries.
- Enable charities to contribute to the body of evidence by identifying and measuring their own impact on health, if appropriate.

Explaining the issue of health inequity

Current healthcare systems focus almost exclusively on healthcare and treatment and most preventive action is focused on screening, immunisations and changing the behaviours of individuals and communities. Access to healthcare, although important, has a limited influence on health outcomes in England, and in particular a limited impact on the drivers of ill health across the social gradient. Social, political, environmental, cultural and economic determinants, however, are significant influencing factors on the patterns and prevalence of ill health in populations. People's health is worse as a result of disadvantage not only in absolute terms, but it also seems that poor health is exacerbated by being towards the bottom of the social scale.

Social determinants can have both direct and indirect impacts on health through three main pathways:

1. Material deprivation, linked to poor living standards has a direct effect on physical health: cold, damp housing, or poor nutrition as a result of poverty, for instance.
2. Material factors also act through the mind (the psychosocial pathway): poor living conditions can be associated with feelings such as stress, lack of control, misery, despair and hopelessness that inhibit self-efficacy and reduce wellbeing and directly impact physical and mental health.
3. Health behaviours (behaviour that has an impact on physical or mental health) are significantly influenced by social determinants: levels of physical exercise are influenced by the quality of the local environment, such as levels of crime, crossings of busy roads, and available green space. Quitting smoking is more difficult in adverse financial circumstances, stressful situations, poor-quality housing and unemployment.

The response

To address inequalities in health a greater focus is needed on social, political, cultural, economic and environmental circumstances, as these are the 'causes of the causes' that drive ill health. For example, although it is well known that a lack of physical exercise can cause obesity and related health conditions, there are multiple reasons why people are physically inactive. Local levels of crime and fear of crime, poorly maintained and busy roads and walkways, a lack of access to good quality green space – factors common to deprived areas – can significantly inhibit physical activity.

People who are lower down the socioeconomic scale live shorter lives and spend more time in poor health than those who are higher up the socioeconomic scale. To address the social class gradient in health, universal action across the whole social gradient is needed, but with a scale and intensity proportionate to need, so that those in greater need with higher risk of ill health and premature mortality receive proportionately greater intensity of action and support. This approach is called 'proportionate universalism'.

The evidence

The evidence relating to the impact of social determinants on health across the life course is strong, meaning that there is a wide range of evidence demonstrating either robust associations, correlations, causal links, or significant relationships between social determinants and health outcomes. Most of the evidence is centred on negative links – for instance poor housing is clearly linked to poor health.

Evidence relating to the efficacy of interventions that address the social determinants of health and the social gradient in health is less prevalent, and often considered less strong. This is partly because public health evaluations of interventions are based on a medical model of research. This medical model assumes, or hypothesises and assesses, that the relationship between an intervention and health outcome is linear. In other words, public health evaluations try to assess whether an intervention has worked, or not, related to whether it has caused a specific outcome. However, this approach is problematic. Social inequalities in health are shaped by multiple factors within complex systems and any evaluation that seeks to identify a causal relationship between a specific, isolated intervention and a specific health outcome will not take account of the dynamic, inter-related contexts of the drivers of poor health. There is now a growing acknowledgement of the need for a new approach to assessing interventions on the social determinants of health and building a stronger evidence base in this area.

Key messages

Inequalities in the social, political, environmental, cultural and economic conditions in which people are born, grow, live, work and age impact on health across the life course and result in differences in health status between different groups. These social determinants of health operate through the following pathways:

Material pathways link social conditions to health outcomes: for example, cold housing has a direct effect on physical health.

Psychosocial pathways connect the social and physical environment to psychological states, including feelings of stress, lack of control and anxiety and depression that can inhibit self-efficacy and reduce wellbeing.

Health behaviours – any behaviour that has an impact on physical or mental health – are significantly influenced by social determinants and improving local environments and reducing day-to-day stress can increase the likelihood of improved health behaviours.

This report examines a number of areas that can impact on health across the life course and that influence the social gradient in health. These include:

- Family
- Friends and communities
- Education and skills
- Good work
- Money and resources
- Housing
- Our surroundings

Family – key messages:

Family life is important for health. The wellbeing of mothers can positively impact on the health of foetuses and infants, on children's physical and mental health, and a range of other outcomes, such as education. Families can provide support throughout life, particularly during adverse experiences.

Social and economic inequalities impact on the level of resources available to support family life and increase the risk of poor health and developmental outcomes for children, and educational and employment outcomes.

For example, higher infant mortality rates are associated with lower socioeconomic status and there is also an increased risk of adverse childhood experiences (ACEs) for children who experience disadvantage and deprivation. Experience of ACEs can have long-term negative impacts on health and a range of other desirable outcomes: ACEs are associated with ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease, stroke, cancer, hypertension, diabetes, asthma, arthritis, angina pectoris and osteoporosis.

Adult family life can also be a determinant of health and factors such as caring responsibilities, family debt and marital conflict can have a detrimental effect on health, often mediated through poorer health behaviours and poor mental health.

Marital strain can cause chronic social stress with negative long-term consequences for health. Conversely, good quality relationships have been shown to lower levels of depression, stress and blood pressure.

Friends and communities – key messages:

Strong friendship networks and participation in community, political, religious and social groups have a positive impact on physical and mental health.

A lack of good quality social relationships and resulting social isolation affect physiological and psychological functioning, health behaviours, and the risk of ill health and mortality.[2]

Stress is the main mechanism through which social isolation impacts on health. Prolonged exposure to stress damages the biological systems of the body and has a clear impact on life expectancy and physical and mental health.

Social isolation and loneliness also increase the risk of poor health outcomes, mediated through poorer health behaviours.

A range of factors increase the risk of social isolation and loneliness including low income, poor-quality built and natural environments, cold housing and inadequate transport links, which can prevent people from developing and maintaining social ties.

Older people, people with disabilities, parents with young children and carers are more likely to encounter barriers to developing and maintaining social networks and relationships and as such have a higher risk than others of associated health outcomes.

Research has found that a sense of community can boost immune systems, lower blood pressure and guard against cognitive decline, while joining a community group can reduce the risk of dying.

Conversely, links have been found between civic distrust and poor social support and coronary heart disease and mortality.

Education and skills – key messages:

Education and skills are important for health. Participation in higher levels of education and higher education attainment are associated with healthier lifestyles, better mental health, greater levels of health literacy, and a reduced risk of a range of conditions, including cognitive decline and dementia.

Children from disadvantaged backgrounds are more likely to start school with lower levels of social, emotional, language and literacy development than their better-off peers.

Poor housing, adverse childhood experiences, poor living standards and nutrition, inadequate parental support, family conflict and poor interactions with children can negatively influence childhood educational outcomes.

These issues can impact on future life chances, including increasing the risk of a young person becoming NEET (not in education, employment or training), affecting future employment opportunities and future income.

Poorer educational attainment is linked to multiple adverse health outcomes, including an increased risk of obesity and dementia, decreased levels of health literacy, poor mental health, and poorer health behaviours.

Good work – key messages:

There are strong relationships between good quality employment and health. Good work enables enough economic resources for material wellbeing and participating in community life and contributes to psychosocial needs, including individual identity, social role and status.

Unemployment and poor-quality employment are strongly linked to poor physical and mental health outcomes.

Poor-quality work can lead to ill health including poor mental health and musculoskeletal problems and can increase the risk of prolonged absenteeism and future unemployment.

Unemployment increases the risk of limiting long-term illness, poor mental health and cardiovascular disease and is associated with an increased risk of mortality and suicide.

Unemployment also lowers living standards, increases psychosocial stressors and increases the likelihood of poorer heath behaviours including excessive alcohol consumption, smoking and decreased physical exercise.

Money and resources – key messages:

People on higher incomes live longer, healthier lives than those on lower incomes.

Low income and deprivation impact on health across the life course through various mechanisms, including material deprivation, psychosocial pathways, and health behaviours.

Research has demonstrated an increased likelihood of smoking during pregnancy, poorer foetal development, low birthweight, feelings of stress and lack of control, and an increased risk of cardiovascular disease and all-cause mortality, all linked to low income.

Particular groups are more at risk of low income and these include people with mental health illness, people with disabilities, young people, carers and lone parents and some ethnic minorities.

The relationship between low income and poor health is cyclical: low income causes poor physical and mental health outcomes, and poor health increases the likelihood of low income.

There are multiple social determinants that influence the amount and adequacy of people's money and resources. These include inadequate levels of benefits to meet the minimum income for healthy living (MIHL), in-work poverty due to high costs of living and low wages, and high levels of debt. These issues are influenced by the unequal distribution of taxes, and the clustering of payday loan and gambling outlets in areas of deprivation.

Payday lenders and betting shops, which can cluster in areas of deprivation, increase the risks of financial difficulties and debt and associated poor health outcomes, including intimate partner violence, emotional and psychological distress, and feelings of lack of control, insecurity, lack of safety, shame and stigma.

Income deprivation increases the risk of debt with at least a quarter of UK households experiencing income deprivation unable to pay specific bills, including mortgage and rent bills.

Strong relationships have been found between debt and: depression and anxiety; poor self-rated physical health, including obesity; suicide; and drug and alcohol abuse.

Housing – key messages:

Good quality, secure homes are beneficial to their occupiers, the wider community and to society. They can reduce the risk of poor physical and mental health and mortality, reduce the number of trips and falls, reduce lost school days and improve educational attainment, and reduce visits to the GP and other health and social care services.

There are clear inequalities in exposure to poor housing. Approximately three in 10 people in England live in poor-quality housing. This includes 3.6 million children, 9.2 million working-age adults and 2 million pensioners.

Poor housing and homelessness pose significant risks to health, including poor mental health, respiratory disease, long-term health and disability and the delayed physical and cognitive development of children.

Cold housing is particularly damaging for health and caused an estimated 20 per cent of the 24,300 extra winter deaths that happen during the cold winter months in 2015/16.

Poor-quality housing such as damp, cold, overcrowded, insecure and short-term tenure housing, is damaging for physical and mental health. Most of the poor-quality housing in England is in the private rental sector.

Emerging evidence shows that exposure to multiple poor housing conditions is particularly damaging, comparable to the health risks posed by smoking, and greater than the health risk posed by excessive alcohol consumption.

Our surroundings – key messages:

Our surroundings operate through a number of pathways and impact on health. Economic, geographical and social factors influence these pathways and the health outcomes of local populations.

Health-promoting surroundings are important for retaining people, place attachment, encouraging community engagement, and for thriving communities with improved health outcomes.

People who have inadequate economic resources are more likely to live in areas that have health-damaging characteristics. This can include poor-quality housing, obesogenic environments (encouraging people to eat unhealthily and do insufficient exercise), lack of good quality green and natural spaces, poor air quality and affordable transport availability, high levels of crime, or fear of crime and a lack of recreational and community facilities and opportunities for community participation. However, multiple interventions can be used to encourage good place-making and place attachment that promotes improved health outcomes, including:

Green infrastructure: Good quality green infrastructure (including parks, gardens and street planting) increases the likelihood of physical exercise, lowers the risk of obesity, and offers a restorative environment for mental fatigue. It can also create a sense of place and civic pride, and be used for social activities that promote social cohesion. It also combats climate change, which has associated health impacts.

Walkability and cycle-ability: Streets that are safe and easy to navigate increase the likelihood of using environmentally sustainable modes of transport, such as walking and cycling. This can also promote the spontaneous social interaction needed for social cohesion and improved mental health.

Community safety: Crime and fear of crime have direct and indirect impacts on health and can limit social behaviour and physical activity.

Feelings of safety are critical for community wellbeing and economic vibrancy. 'Crime prevention through environmental design' is an intervention that uses a number of approaches to reduce crime and fear of crime and focuses on territoriality, encouraging ownership and community cohesion and improving the physical fabric of communities, encouraging natural surveillance.

There is consistent and strong evidence demonstrating that the maintenance and upkeep of local areas decreases crime and the fear of crime (the broken window theory). Neglected spaces that have been repurposed have been shown to improve perceptions of safety and create economic and job opportunities.

Food outlets: Areas of high deprivation can experience a proliferation of fast food outlets, and this can have direct and indirect impacts on health.

'Food deserts' areas that have little access to healthy food, increase the risk of food poverty, obesity and malnutrition, in turn increasing the risk of cancer, diabetes and coronary heart disease.

Initiatives that promote independent food and other retail outlets, featuring locally-sourced food for example, and that limit the number of fast food, payday lender and gambling outlets, will support the local economy and promote improved health outcomes.

Accessible, affordable and sustainable public transport: This type of transport can provide access to education, employment and essential goods and services, including health and social care. Transport systems, including well maintained roads and pavements, encourage active travel and help reduce pollution and climate change.

1. INTRODUCTION

The social determinants of health – key messages:

Inequalities in the social, political, environmental, cultural and economic conditions in which people are born, grow, live, work and age impact on health across the life course and result in differences in health status between different groups.

Material pathways link social conditions to health outcomes: for example, cold housing has a direct effect on physical health.

Psychosocial pathways connect the social and physical environment to psychological states, including feelings of stress, lack of control, and anxiety and depression that can inhibit self-efficacy and reduce wellbeing. Chronic low-level stress impacts on physical health, including higher cholesterol levels, blood pressure and heart disease.

Health behaviours are significantly influenced by social determinants and poor or negative health behaviours cluster further down the social gradient. This clustering is increasing and means that health inequalities experienced between those at the bottom and the top of the social gradient will grow.

Improving local environments and reducing day-to-day stress can increase the likelihood of improved health behaviours, including increased physical activity, improved diet, and increased success with smoking cessation attempts.

1.1 Health inequalities in England

There are clear and persistent health inequalities across England, meaning that there are 'differences in health status or in the distribution of health determinants between different populations groups.'[2] Some health inequalities are caused by biological variations or lifestyle choices. However, there is now much wider recognition that the majority of health inequalities are caused by inequalities in the external environment and conditions in which people are born, grow, live, work and age. As such, health inequalities are unjust and unfair, and lead to inequity in health outcomes across populations.[2]

The Marmot Review, *Fair Society, Healthy Lives*, published in 2010, provided a review of health inequalities in England and made proposals and recommendations for action from government and other organisations. It clearly demonstrated that people in England who have lower socioeconomic status have worse health and shorter lives in comparison with those who are better off and have a higher socioeconomic status. The social gradient in health affects us all. Inequalities in life expectancy and healthy life expectancy impact on everyone below the very highest socioeconomic status, not just the most deprived. The social gradient in health is described in Figure 1 and Figure 2 on page 15.

Inequalities in health arise because of inequalities in the social, political, cultural, environmental and economic conditions in which people live. These social determinants, the conditions in which people are born, grow, work and age, affect life expectancy, and profoundly influence how long people live in good health (healthy life expectancy). The latest Marmot Indicators[A] (2015) demonstrate that there is a clear difference in both total life expectancy and also healthy life expectancy between men and women from the poorest and most well off areas.

[A]The Marmot Indicators provide information to local authorities annually about health inequalities and social determinants of health. There are a range of indicators at local authority level and at smaller area level within local authorities. The data is related to socioeconomic status and other social and economic domains to describe how health relates to area deprivation and social status.

Figure 1. Life expectancy and disability-free life expectancy (DFLE) at birth, males by neighborhood deprivation, England, 1999–2003 and 2009-2013

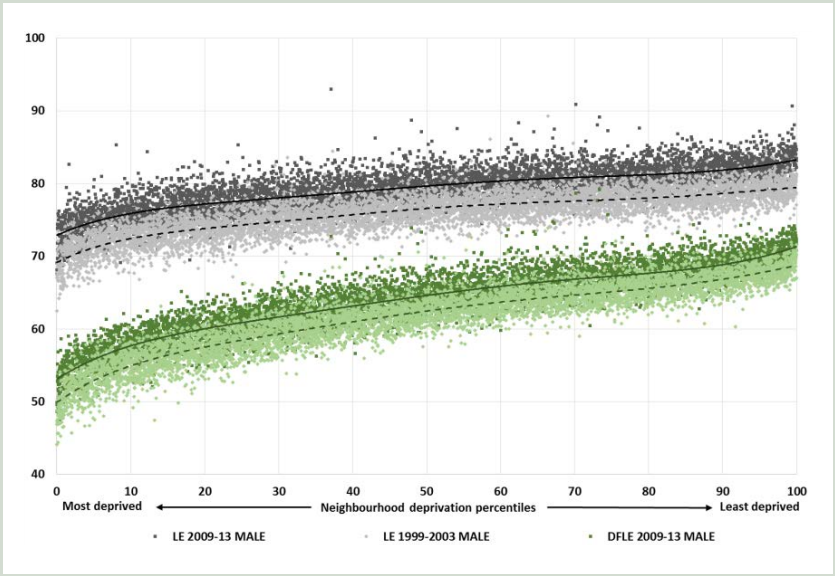
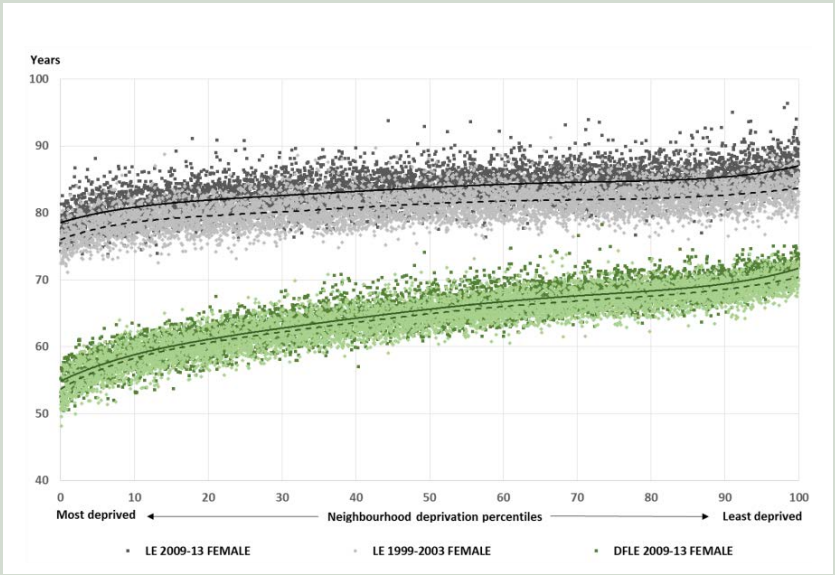


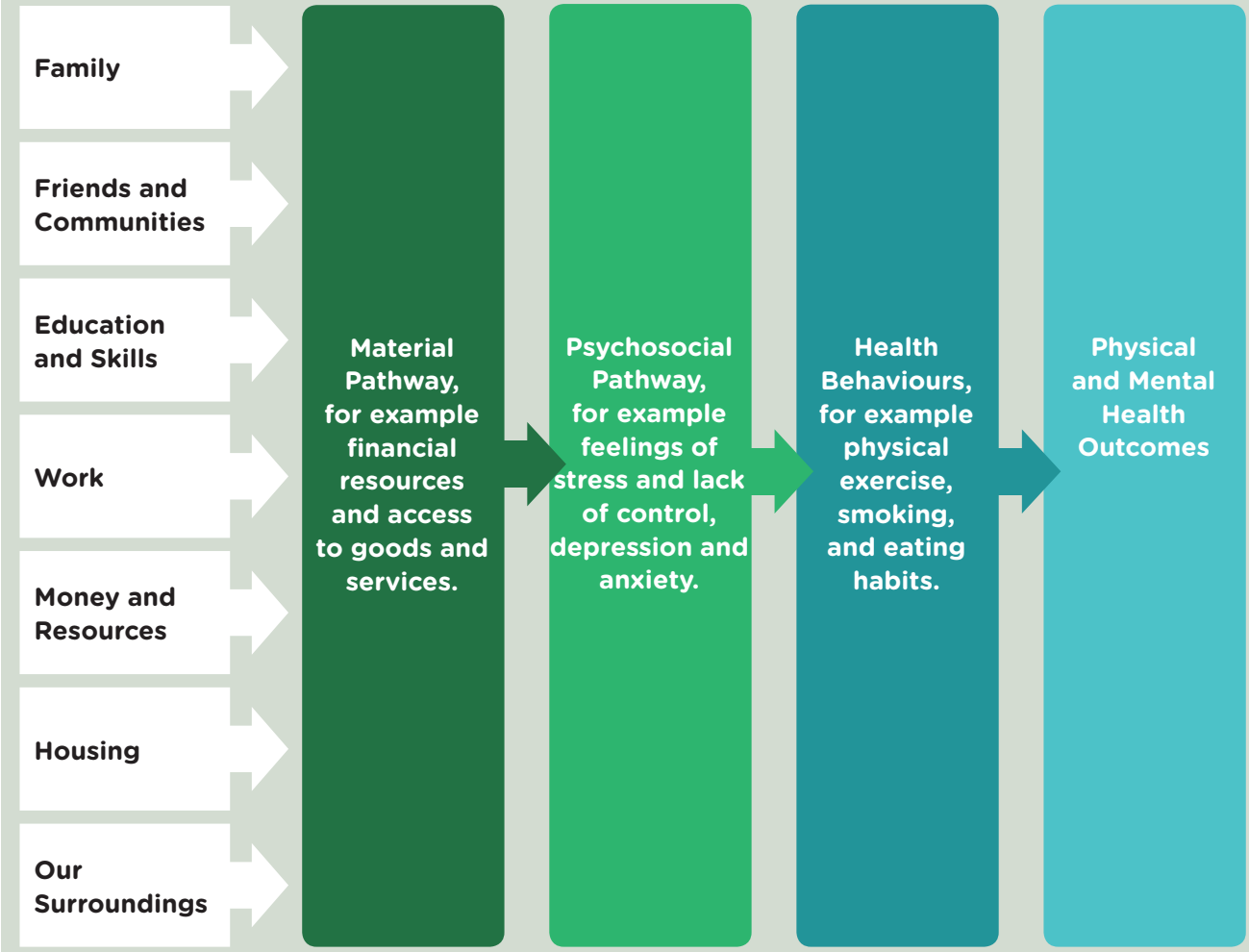
Figure 2. Life expectancy and disability-free life expectancy (DFLE) at birth, females by neighborhood deprivation, England, 1999–2003 and 2009-2013



These differences are related to area deprivation. Men in Blackpool (in the Northwest) can expect to live around 74.3 years, while men in Wokingham (in the Southeast) can expect to live 81.7 years – a difference of 7.4 years in life expectancy. For women, the difference in life expectancy between the least and most deprived areas is 4.6 years. There are also clear differences in healthy life expectancy, or expected years lived without disability. In terms of living without a limiting long-term illness, men in Blackpool can expect to live to 54.9 in this condition while men in Wokingham can expect to live to 71.4, a 16.5 year difference. For women, the difference in healthy life expectancy is 11.6 years.

Figure 3 below provides a simplified model of how social determinants can impact on health through psychosocial or material pathways. How social determinants influence pathways to health and health behaviours is explained in more detail below.

Figure 3. The social determinants of health



The material pathway

Material pathways directly link social conditions to health outcomes. Material deprivation, linked to poor living standards (for example, cold housing) has a direct effect on physical health. Material factors also act through the mind (the psychosocial pathway): poor living conditions can be associated with feelings such as misery, despair and hopelessness, which inhibit self-efficacy and reduce wellbeing.

The psychosocial pathway

Social determinants can have both direct and indirect impacts on health. One way in which social determinants have an indirect impact is through psychosocial pathways.

Stress

Psychosocial pathways connect the social environment to psychological states, often inducing a state of stress, which can lead to anxiety or depression. The use of the term 'stress' incorporates both the feelings generated by stressors such as poor housing, poverty or discrimination, and the ability of a person to cope with both the stressors and the feelings generated. Lazarus emphasises when stress can arise when:

'a person appraises a situation as threatening or otherwise demanding, perceives that it is important to respond, and does not have an appropriate coping response immediately available.'[3] People under stress typically

experience 'negative emotions (e.g. anxiety, depression), changes in physiology, and changes in behaviour patterns that increase risk for disease and mortality.'[4]

Ongoing challenges experienced through living with deprivation can cause chronic low-level stress, which can also impact on physical health, including higher cholesterol levels, blood pressure and heart disease.[5]

Control

Feelings of control, or lack of control, are further important psychosocial factors that influence mental and physical health and are determined by both macro- and micro-level conditions. For example, the nature and extent of social stratification in a society, and a person's position within that stratification, has psychological effects. Hierarchical societies attribute status according to, among other things, gender, sexuality, ethnicity, education, employment and income. Occupying what is considered to be a low status position is associated with experience of subordination that causes a sense of lack of control and low authority in decision-making.[6, 8] This can be played out in multiple micro arenas. For example, adverse psychosocial working conditions that are characterised by high demand and low control[7] can cause job strain, associated with increased risk of coronary heart disease, poor health behaviours and common mental health disorders.[8,9]

Health behaviours

Any individual or group behaviour that has an impact on physical or mental health is known as a health behaviour. Health behaviours can be categorised as positive, for example taking regular exercise, or as negative, poor, or risky, the latter including smoking, drinking excessively, and not taking regular exercise.[10]

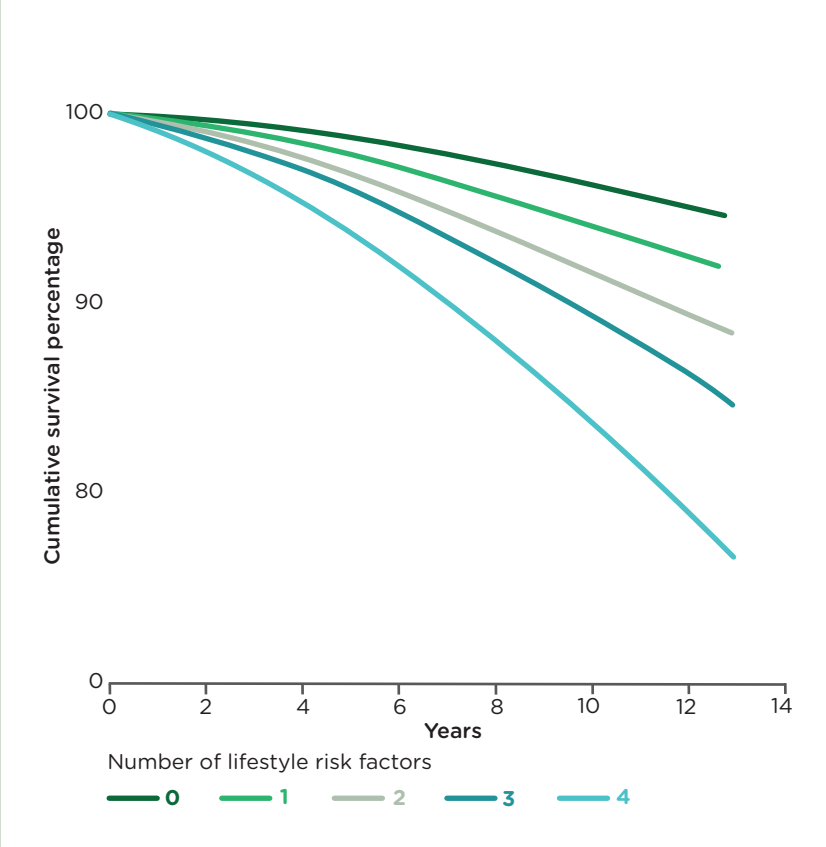
Health behaviours are significantly influenced by social determinants. For example, levels of physical exercise are influenced by the quality of the local environment, including levels of crime and perceived safety, pavements, crossings and available green space. A healthy diet is influenced by the availability and affordability of healthy produce, knowledge of nutrition and healthy food preparation. Smoking, or the inability to stop smoking, is associated with seeking relief from stress,[11] often caused by the day-to-day difficulties faced when living with deprivation.[5]

Poor or negative health behaviours cluster further down the social gradient. The latest evidence demonstrates that the strongest predictor for engaging in multiple risky behaviours is socioeconomic status.[12] People with no educational or training qualifications are more than five times more likely to smoke, drink and have a poor diet as those with qualifications.[13]

This concentration of unhealthy or poor health behaviours further down the social gradient is deepening[13] Although the overall proportion of people in England engaging in three or more unhealthy behaviours reduced by 8 per cent between 2003 and 2008, most of these reductions were experienced by higher socioeconomic and educational groups.[14]

This means that although the health of the population may improve overall due to a reduction in poor health behaviours, the health inequalities experienced between those at the bottom and top of the social gradient will increase. [14]

Figure 4. Clusters of lifestyles matter for health



Reproduced from the Kings Fund: Clustering of unhealthy behaviours over time. Implications for policy and practice. 2012. Adapted from source: Khaw et al 2008.

Health as an asset

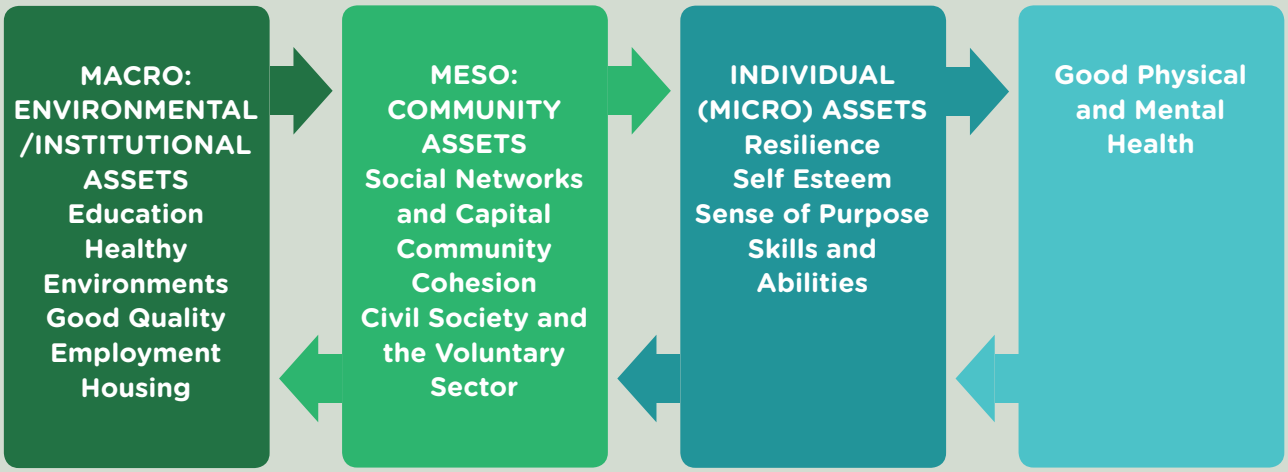
Approaches to health often focus on identifying problems and needs within populations and then targeting healthcare resources to address specific issues. These 'deficit models' are important for calculating level of need, and for prioritising services and care, but can result in high levels of dependence on hospital and welfare services.[15]

However, an asset-based approach to health focuses on positively activating assets and resources to promote health. This can be done at three levels:

- Macro, for example environments, institutions, organisations
- Meso, for example communities and neighbourhoods
- Micro, for example individual resilience, self esteem

An asset-based approach to health is helpful as it enables a focus on factors that promote health and enable communities and individuals to gain more control over their lives and circumstances.[16,17] It also enables a focus on health as an asset in itself, one that feeds back into the health and wellbeing of wider communities and reduces dependence on hospital and welfare services. Figure 5 below shows how an asset-based approach to health can help identify positive social determinants of health that contribute to ill health prevention, stronger communities and a reduction on reliance on healthcare and welfare services.

Figure 5. An asset-based approach to health

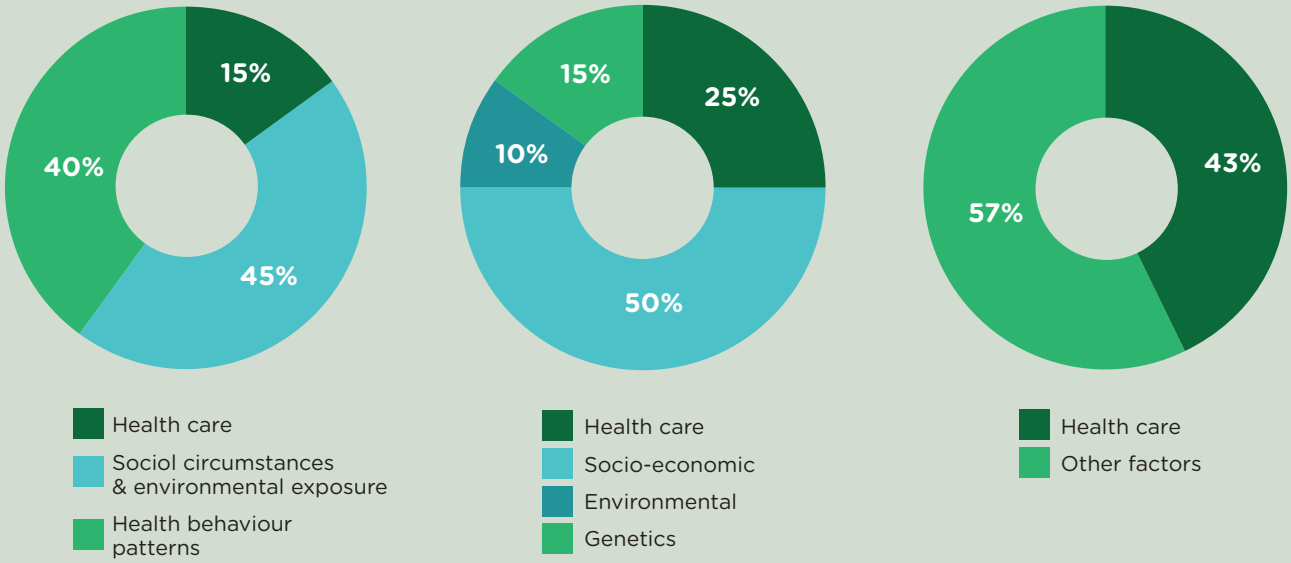


Given the social gradient in England, and the potential for health to enable communities and individuals to gain more control over their lives and circumstances, universal action across the whole social gradient is needed, but with a scale and intensity proportionate to need. The Marmot Review defined this approach as 'proportionate universalism' and, to reduce health inequalities, action was advocated across six policy objectives:

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

None of the areas prioritised for action on health inequalities related directly to the healthcare service. Indeed, it has been estimated that healthcare is only responsible for between 15 and 43 per cent of health outcomes, as detailed in Figure 6 below. Although there is much debate around the actual percentage, which is impossible to calculate definitively, it is clear that access to healthcare, although important, has a relatively limited influence on health outcomes, and in particular on what drives ill health across the social gradient. Social and economic determinants are the most significant influencing factors on the patterns and prevalence of ill health in populations.

Figure 6. Estimates of the contribution of the main drivers of health status.



Source: [18]

However, current healthcare systems focus almost exclusively on healthcare and treatment and most preventive action is focused on screening, immunisations and changing the behaviours of individuals and communities. To address the social gradient in health a greater focus is needed on social, economic and environmental circumstances, the 'causes of the causes' that drive ill health. The underlying root causes of poor health, such as poor housing, unemployment and local area deprivation, need to be addressed if the gap between the least and most healthy is to narrow.

Delivering the policy objectives of the Marmot Review requires action across a variety of sectors and different types of organisations. These organisations include a wide range of local and national government departments, the community and voluntary sector, the NHS and other public services, and the private sector.

1.2 The role of charities in addressing the social determinants of health

The voluntary sector makes significant impacts on the social determinants of health, improving health and reducing health inequalities – even those charities whose primary purpose and remit may not be directly health-related.

Many charities pursue social outcomes that directly and indirectly impact on health outcomes but relatively few articulate their work in terms of relevance to health and health inequalities. This includes charities that already work on the social determinants of health, but do not recognise their work as relevant to health, and condition-specific charities that address health needs, but do not work to address the social determinants of those conditions. All the while, charities are often better situated, both in the services they deliver and proximity and engagement with communities, to work closely with communities, particularly those that have a history of non-engagement with statutory or mainstream services.

National policies will have limited effectiveness if local delivery systems that are focused on health equity are lacking. It is clear that charities are organisations that are close to some of the most deprived and excluded communities and play a role in advocating for communities and addressing gaps in statutory service provision; thus they have a significant and hitherto under-recognised role to play in relation to health. Charities frequently address the inequalities that result from the social determinants of health and also often have a direct role in influencing inequalities in the social determinants of health. Charities working in these areas are more likely to have a social rather than a health lens. Those that are focused on inequalities have developed services working with the most disadvantaged to address complex needs. Other charities offer activities that benefit people and society more generally, but may be interested in ensuring activities can be accessed by all, including those from disadvantaged backgrounds. We talk about these charities in more detail later in Table1.

Health charities could join the social determinants of health movement

Many charities also work to achieve better health outcomes for people who have specific health conditions, or are at risk of developing health conditions. These conditions range from mental distress, addiction issues and eating disorders to complex neurological conditions such as motor neurone disease, Parkinson's and multiple sclerosis. Other charities support people with chronic conditions such as asthma, Crohn's disease and arthritis. Some focus on conditions often associated with later life, such as dementia and osteoporosis. Cancer and cardiovascular conditions, rare conditions and those affecting young children are also priority areas.

The work of health charities is usually focused on the following areas:

- Representing patient voice and advancing patient involvement, as well as involving families and carers
- Direct treatment and support, ranging from nursing to emotional/social support, and helping people with material aspects of their condition, e.g. employment, benefits, assistive technology
- Supported self-management: helping individuals to understand their condition, take control of its management, and navigate the system
- Engaging people in keeping healthy: prevention and early intervention are important here, as well as helping people to stay well once diagnosed
- Integrating and coordinating care
- System redesign: working with public services to improve the system and design of services delivered by others; may include lobbying and policy work
- Support for health and care professionals: specialist training as well as help with service design and implementation
- Raising awareness of conditions, to increase early identification and also improve awareness in others of the effect of conditions
- Medical and social research (adapted from Untapped Potential[19])

Health charities are increasingly connecting individuals' circumstances to recovery of health. For example, many mental health charities focus heavily on employment and its potential mental health benefits; cancer charities similarly support people to maintain or find employment. Many charities' helplines cover not only information about the condition, but also access to benefits, housing and other services. Some charities, especially those working in mental health, see the causes of distress as being rooted in unemployment, poor housing or debt.

Some health charities talk about inequality, and worry if they are or are not reaching the most disadvantaged individuals. Other health charities working in prevention talk about social determinants of health, although prevention strategies are usually based on changing behaviour, e.g. promoting healthy eating and exercise. But these are prone to failure unless underlying social determinants are addressed.

However, health charities have limited resources, many unequal to dealing with social determinants at scale – the problems appear too big to grapple with. Others may conclude that tackling social determinants is not the best use of their limited resources – and that they should be addressed by the state/government policy/ organisations with the scale to make a difference.

Yet there is a strong case for health charities to become more involved in the debate, so that the level of impact that social determinants have on health is more widely recognised. In addition, charities are well placed to influence the social determinants for people

and communities they work with. Action at a local community and individual level can address multiple issues, such as debt or poor housing for instance.

1.3 Implications for charities

Recognising and raising awareness around the significant role that non-health charities already play in taking action on the social determinants of health and reducing health inequalities will:

- Raise awareness among non-health charities that their work on the determinants of health influences health outcomes.
- Provide easily accessible evidence that demonstrates the likely health outcomes achieved by charities taking action on the social determinants of health.
- Support non-health charities to use this evidence to engage with the health system, broadening the scope for identifying and securing new funding opportunities.
- Support non health charities to develop and use monitoring systems that capture impacts on health and wider determinants.
- Engage with condition-specific health charities to enable a greater focus on the wider determinants of health, and to develop and embed more preventive work that addresses the social determinants of specific health outcomes.

Therefore, this report aims to provide information to:

- Enable charities to recognise that their work has relevance to the social determinants of health and to health outcomes and to potentially expand their work to better address the social determinants of health.
- Enable charities to access data that will help them to demonstrate that their work addresses the social determinants of health, or to identify and address the social determinants of their condition focus.
- Enable charities to measure and demonstrate the difference they make in a more systematic and convincing way, and to use this information to potentially expand their role to focus more on health outcomes and assist in advocacy at a local and national policy level.
- Enable charities to contribute to the body of evidence by measuring their own impact on health, if appropriate

Table 1 on page 22 provides an 'at a glance' view of the inequalities in social determinants of health and health outcomes, as evidenced in the Marmot and subsequent reviews. [20-27] Column 2 in table links to sections 2 to 9 of this report, which provide a wide range of evidence demonstrating the impact of social determinants on health and links to the latest evidence on effective interventions, many of which are already implemented by the voluntary sector. Column 3 provides examples of action that the voluntary sector either already does, or could do, to develop and expand its work, and to better identify charities' work as health related.

The following themes are applicable to all areas across the table:

Tailored services to meet the needs of the most vulnerable groups: Charities are generally alert to the needs of excluded people – this is a strength of the sector. The external environment constantly evolves, so charities may need to be vigilant in identifying groups.

Collaboration: We would encourage charities to share lessons, best practice and collaborate wherever they can – especially with organisations providing services to the same people, even if their services are different. It also makes sense to collaborate with similar service providers to avoid duplication and reduce costs. We see many opportunities for cross-referral with statutory services.

Evidence: We would urge charities to monitor, evaluate and assess their outcomes, and where appropriate and reasonable, to monitor any progress in health behaviours, or improvements in short-term health and wellbeing outcomes.

Table 1. Inequalities in social determinants of health and health outcomes, and where charities can respond

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
FAMILY Social, economic, and environmental inequalities impact on family life, including intimate and broader family relationships and the home environment, and these affect child health, life course health and life chances. Family disadvantage in early years leads to disadvantage in multiple domains throughout life and therefore interventions to improve the quality of family life are a priority. Adverse childhood experiences (e.g. bereavement, abuse, trauma) can have an adverse effect on future health.	**Section 2** provides evidence demonstrating the impact of social determinants on family life, and life course health outcomes, in addition to evidence relating to effective interventions and case studies.	Many charities support children and families, from pregnancy and infancy through childhood, adolescence and onto later life. Charities are well placed to: • Reach the most excluded and identify entry points for engagement • Develop trust and work holistically with excluded families • Pilot and share best practice in supporting families, children and young people, nurturing healthy relationships, developing skills, and promoting healthy routines/diets • 'Step in' when there is a crisis • Liaise with multiple agencies and services, ranging from GPs to nurseries and libraries • Support young people in the state care system • Monitor and evaluate the effectiveness of programmes A focus on the early years is especially valuable, although many would argue charities should not ignore the whole course of family life.
FRIENDS AND COMMUNITIES The quality and quantity of social networks affect health behaviours and physical and mental health. The social, economic and environmental determinants of poor-quality social networks and a lack of social connectedness are not distributed evenly and so particular individuals and groups will be disproportionately at risk of social isolation throughout the life course.	**Section 3** provides evidence demonstrating the social determinants of social networks, and the impact of social isolation on health behaviours, physical and mental health, in addition to evidence relating to effective interventions and case studies.	Many charities foster social networks and friendship for a range of disadvantaged and excluded groups, ranging from people with mental health issues to refugees. Activities include: • Community and social groups and activities • [befriending schemes] Social interactions and support • Identifying the most isolated and addressing their needs • Creating neighbourhoods, towns and cities that are 'friendly' towards, autism, dementia, disability and other disadvantage • Campaigns to promote neighbourly action

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
EDUCATION AND SKILLS Multiple determinants, including family and community-based factors and material inequalities, influence the educational outcomes of children, young people and adults. Lower educational achievement increases the risk of a range of poor health outcomes, including a clustering of unhealthy behaviours such as smoking, excessive alcohol consumption or substance misuse, and obesity, cognitive impairment and dementia, diabetes, heart disease, stroke and some cancers. It also increases the risk of poor health literacy. Inequalities in educational outcomes and experiences as a child and young person lead to inequalities in a range of domains throughout life. Addressing inequalities requires action in schools, work and in the community.	**Section 4** provides evidence demonstrating the determinants of poor educational outcomes and impact on health, evidence of effective interventions and case studies.	Many charities work within or outside the education system and can: • Work directly in schools to support staff and students • Work across school/home boundaries to provide support • Provide after-school and extra-curricular activities • Provide alternative learning environments for students with special needs, including social, emotional and behavioural difficulties. These may be provided within the school or outside • Support transition between schools • Support the transition from school into further education, employment and adulthood, e,g. by facilitating work experience • provide lifelong support, training and education to adults to address education/skills gaps • Life and employability skills • Basic educational attainment e.g. literacy and numeracy • Building social networks • Healthy lifestyles, including diet, nutrition, physical activity, mindfulness • Raising aspirations The avenues of work referred to above can address these themes: social and emotional skills, including confidence, resilience and so on. Charities are often able to link with, and gain the trust of, those who are most disadvantaged, and struggle most to engage with formal education. Charities benefit from being outside the formal education system as this enables much greater flexibility in developing and testing imaginative programmes. Charities can also, less directly, raise awareness and take action on the social determinants that impact on educational achievement such as poor housing, family stress, poor-quality housing and fuel poverty, access to green space and adequate green infrastructure.

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
GOOD WORK There is inequality in access to the labour market and good quality employment. Poor-quality work, such as temporary, inflexible, routine work that is badly paid, leads to ill health and psychosocial stress. Unemployment increases the risk of mental ill health, cardiovascular disease and overall mortality through a range of mechanisms including material deprivation and psychosocial stressors. Long periods of unemployment are particularly harmful to health and a range of other factors throughout life.	**Section 5** provides evidence demonstrating the links between unemployment and poor-quality employment and poor health outcomes, in addition to effective interventions and case studies.	Many charities work to improve employment: • Preparing people for work, including lifelong learning • Placing people in work/brokering work placements and supporting vulnerable people in placements • Supporting people to engage with active labour programmes • Working with employers to employ the vulnerable and disadvantaged, e.g. carers, lone parents, people with disabilities or health/mental health problems • Working with employers to support healthy lifestyles, e.g. diet, active travel • Campaigning for better working practices, e.g. living wage, flexible working, job security, inclusive recruitment • Supporting workers to negotiate
MONEY AND RESOURCES Income and debt significantly influence health through direct and indirect pathways. Low levels of income and debt can influence health directly by preventing access to health-promoting goods and services. Low income and debt can also increase the likelihood of social isolation and can impact on mental and physical health and health behaviours through psychosocial pathways, including feelings of stress and lack of control.	**Section 6** provides evidence demonstrating the impact of poverty and low standards of living on health, in addition to evidence relating to interventions and case studies.	There are many charities: • Offering debt advice and referrals to debt management and other support services • Offering information on money issues, such as changes in status resulting in economic hardship, benefits, guidance on pensions • Building the capacity of people to manage their money better and build financial resilience, including schemes promoting savings, insurance • Campaigning on issues that result in people being financially excluded. Charities are often able to reach the most excluded and disadvantaged, for instance mental health charities are very alert to the needs of people in mental distress, and recognise financial difficulties as the cause of distress. Collaborating with statutory services such as health, criminal justice, adult learning and housing services would be valuable in identifying those at risk and would help to serve those people from accessible venues.

1. Inequalities in health outcomes and their determinants	2. Evidence of inequalities – location in report	3. Role of the charitable sector
HOUSING Living in poor-quality and insecure housing has as significant impact on physical and mental health. Poor housing conditions including damp, mould and cold homes, is linked to poor mental health and respiratory illness. Insanitary conditions can lead to the spread of infectious diseases and cold, energy-inefficient housing contributes to excess winter deaths every year. Poor housing also influences levels of social isolation and loneliness.	**Section 7** provides evidence demonstrating health inequalities resulting from poor housing, in addition to evidence relating to effective interventions.	Charities work at several levels on housing: dealing with individuals but also campaigning on issues that affect the housing of vulnerable people. Charities work to: • Provide individual advocacy and advice to people needing housing, enduring poor-quality housing • Provide individual support to those who need help maintaining tenancies or are housed in tailored accommodation • Provide specialist housing • Provide specific programmes addressing issues such as fuel poverty • Campaign on housing issues, such as private rental sector market regulation • Campaign on the severe shortage of affordable housing • Gather information on the housing status of clients and impact on health
OUR SURROUNDINGS The local built and retail environments and green and blue space are significant determinants for physical and mental health, influencing health behaviours including levels of physical exercise, diet and social connectedness. However, good quality local environments are not evenly distributed and contribute to health inequalities across the social gradient. Poor local environments also increasing pollution and energy consumption, contributing to climate change, which also has a detrimental effect on the	**Section 8** provides evidence demonstrating health inequalities resulting from poor-quality local environments and climate change.	There are many charities that: • Support communities to engage with the planning process regarding public space, transport and local neighbourhoods and high streets • Highlight and help to address accessibility for vulnerable groups in local regeneration plans • Provide support to influence local decision-making • Design and deliver interventions that promote, encourage and facilitate active travel and increase levels of walking and cycling, in particular walking groups for older people more vulnerable to busy roads and high levels of traffic • Highlight and support '20 is plenty' campaigns (to limit traffic speed to 20mph) • Improve and maintain local green areas in ways that engage local residents and promote ownership and social cohesion. This can include gardening groups, allotments, city farms, and green space interest groups • Advocate for an improved local food environment and provide interventions that promote cooking skills and healthy eating. • Campaign for improvements to the high street environment including the retail offer, and better, inclusive street design. • Promote and support volunteering and community engagement.

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2. FAMILY

Family – key messages:

Family life is important for health. The wellbeing of mothers can positively impact on the health of foetuses and infants, on children's physical and mental health and on a range of other outcomes, such as education. Families can provide support throughout life, particularly during adverse experiences.

Social and economic inequalities impact on the level of resources available to support family life and increase the risk of poor health and developmental outcomes for children, and educational and employment outcomes.

For example, higher infant mortality rates are associated with lower socioeconomic status and there is also an increased risk of adverse childhood experiences (ACEs) for children who experience disadvantage and deprivation. Experience of ACEs can have long-term negative impacts on health and a range of other desirable outcomes: ACEs are associated with ischemic heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, stroke, cancer, hypertension, diabetes, asthma, arthritis, angina pectoris and osteoporosis, .

Adult family life can also be a determinant of health and factors such as caring responsibilities, family debt and marital conflict can have a detrimental effect on health, often mediated through poorer health behaviours and mental health.

Marital strain can cause chronic social stress with negative long-term consequences for health. Conversely, good quality relationships have been shown to lower levels of depression, stress and blood pressure.

Strength of evidence: strong

Socioeconomic status and child health outcomes

A systematic review published in 2010, and giving specific attention to the strength and consistency of evidence relating to the effects of socioeconomic measures on child health outcomes, found that socioeconomic disadvantage was consistently associated with an increased risk of adverse birth outcomes, such as still or pre-term birth.[1]

Adverse childhood experiences (ACEs)

Robust associations have been found between physical and emotional abuse, neglect and sexual abuse for the following health outcomes:

- Depressive disorders
- Anxiety disorders
- Suicide attempts
- Drug use
- STIs/risky sexual behaviour

Robust associations have been found between physical abuse and:

- Eating disorders and childhood conduct disorders

Robust associations have been found between sexual abuse and:

- Eating disorders
- Self harm
- Personality disorders [2]

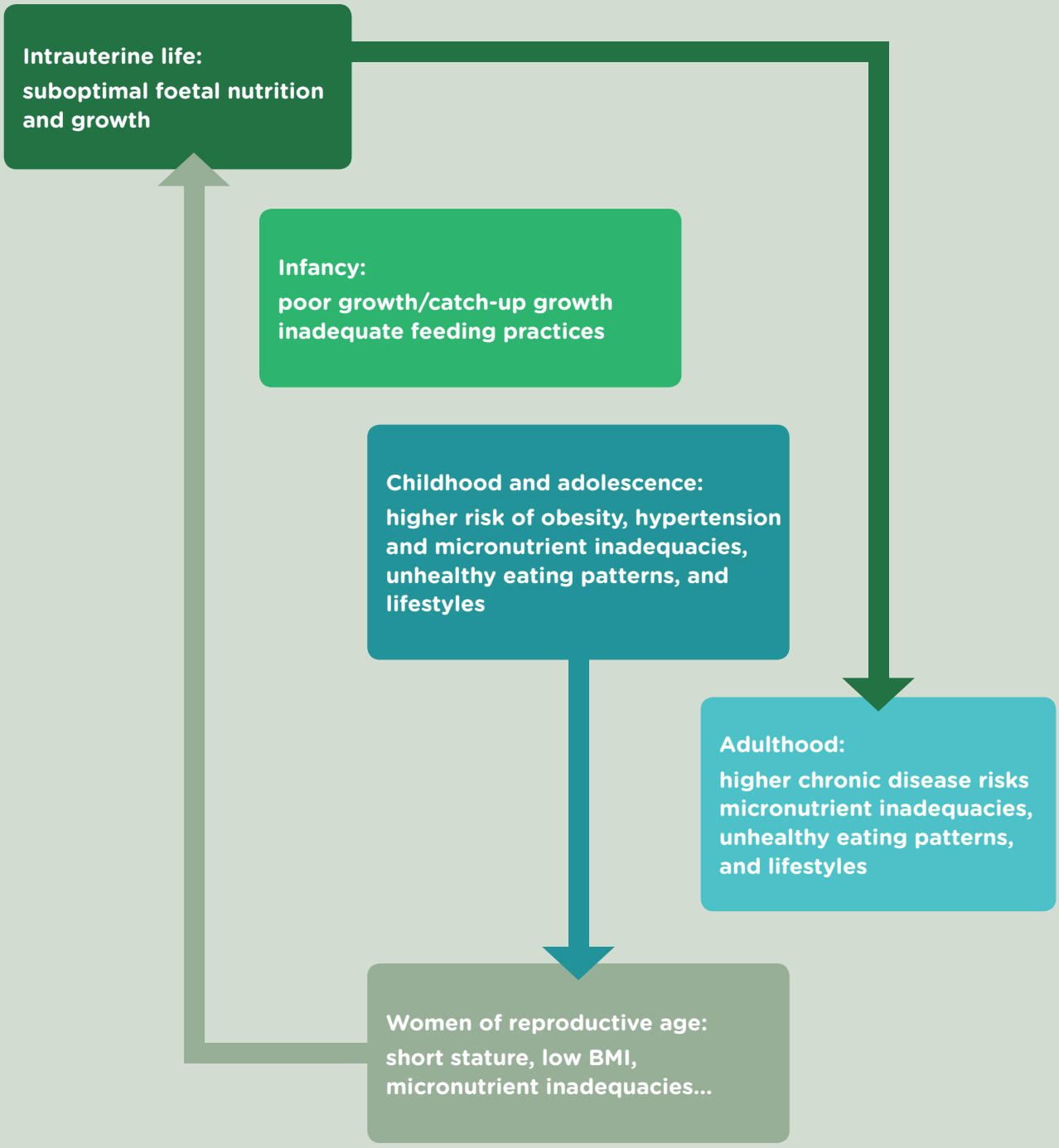
Family life is important for health. The wellbeing of mothers can positively influence the health and development of foetuses and infants. Family life can be protective for health in later life too. In times of hardship or during adverse life experiences, such as the loss of employment or bereavement, family life can provide much needed support. However, the social and physical environments into which we are born, grow and live can profoundly affect the quality of family life. The resources needed to promote maternal health and build and maintain healthy family relationships are not evenly distributed across communities.

2.1 Maternal and infant health

Social inequalities affecting the wellbeing and socioeconomic status of mothers can significantly affect health and a range of other outcomes for mothers, babies and children, during the early years and across the life course. Inequalities in housing conditions, income and wealth, education levels, levels of family and community support, environments, and quality of work and employment opportunities, are associated with a range of poorer developmental outcomes for children.

For example, low availability of nutrients during pregnancy can permanently change the structure and metabolism of the foetus, and this can increase the risk of a range of poor health outcomes including coronary heart disease, stroke, diabetes and hypertension in later life.[3,4] The World Health Organisation's depiction of the lifecycle of diet-related chronic conditions is shown in Figure 7 below.

Figure 7. Lifecycle of diet-related chronic conditions[5]



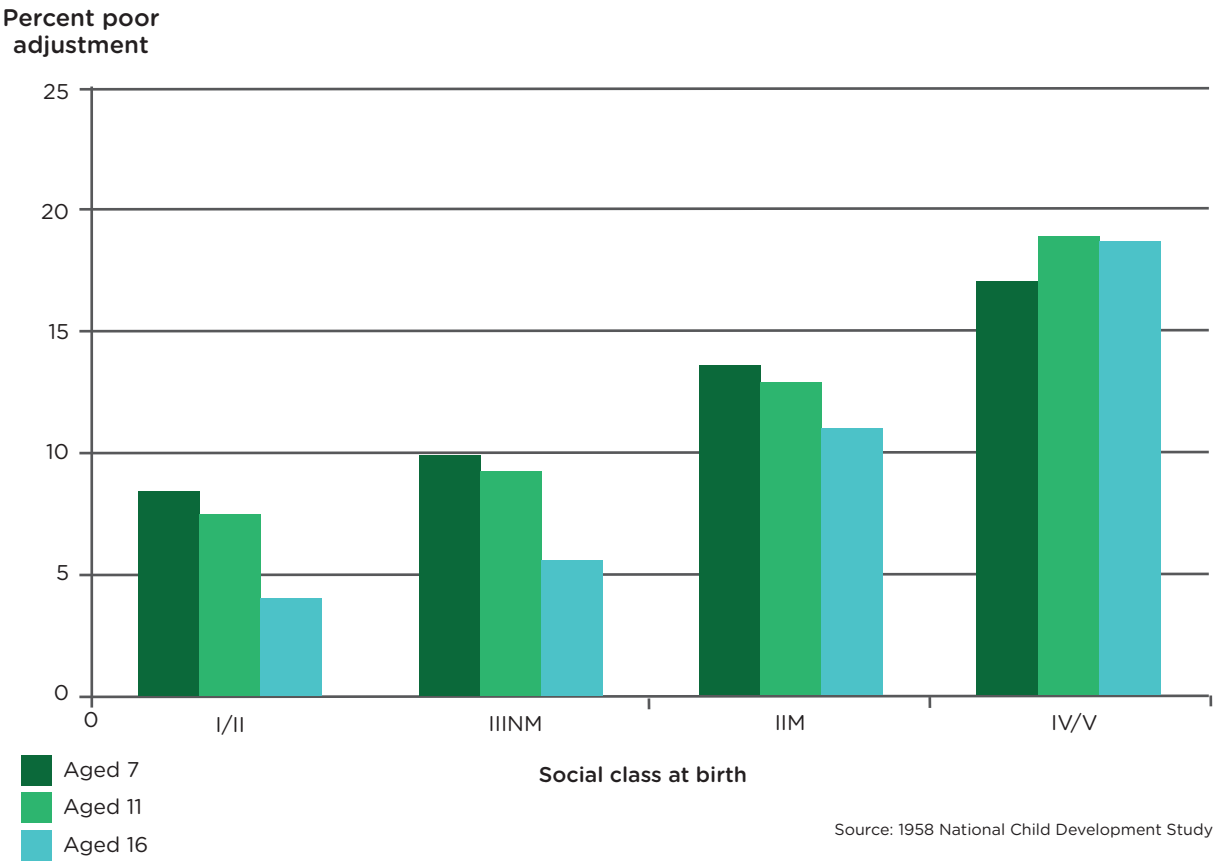
Disadvantaged mothers also have a greater risk of having low-birth-weight babies, and poor maternal health, including levels of stress, which has a significant influence on the development of the foetus and the baby's future life chances.[5,6]

2.2 The first year of life

During the first year of life children go through important neuro-developmental stages for ongoing cognitive capacities[7] and capabilities such as self-regulation and emotional and social development.[8] These factors influence later educational success, income and health outcomes.[9]

Inequalities in these cognitive and non-cognitive developments are related to inequalities in socioeconomic factors. Studies have shown lower social and emotional development in children aged 7, 11 and 16 who are further down the socioeconomic scale, as shown in Figure 8 below.

Figure 8. Rates of poor social/emotional adjustment at ages 7, 11 and 16, by father's social class at birth, 1958 National Child Development Study



Source: 1958 National Child Development Study

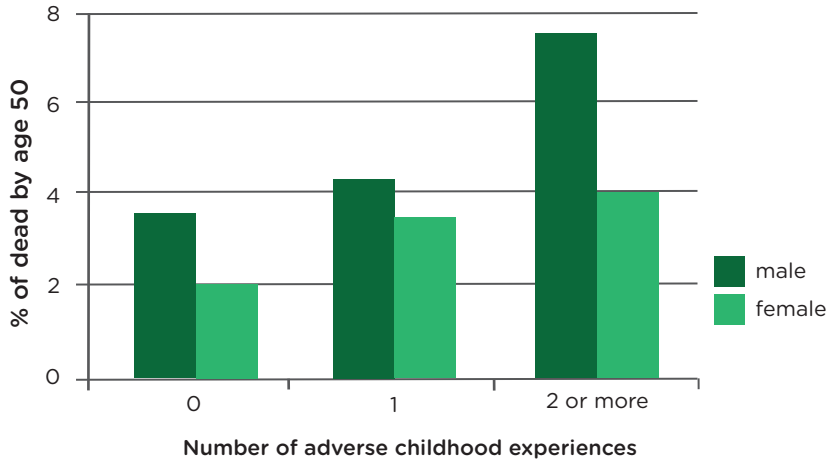
2.3 Adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) can include maltreatment (physical, sexual or emotional abuse, or neglect) and household adversity (domestic violence, criminality, mental ill health, substance misuse, parental separation or death, and living in care).[2, 11-13] The relationships between maltreatment, household adversity and ACEs are complex and not all children who experience household adversity experience ACEs.[2, 14]

However, disadvantage and deprivation do increase the risk of ACEs and the clustering of multiple ACEs. Children experiencing economic and material deprivation are more likely to experience four or more ACEs during childhood and this can be particularly damaging to lifetime health outcomes.[15, 16]

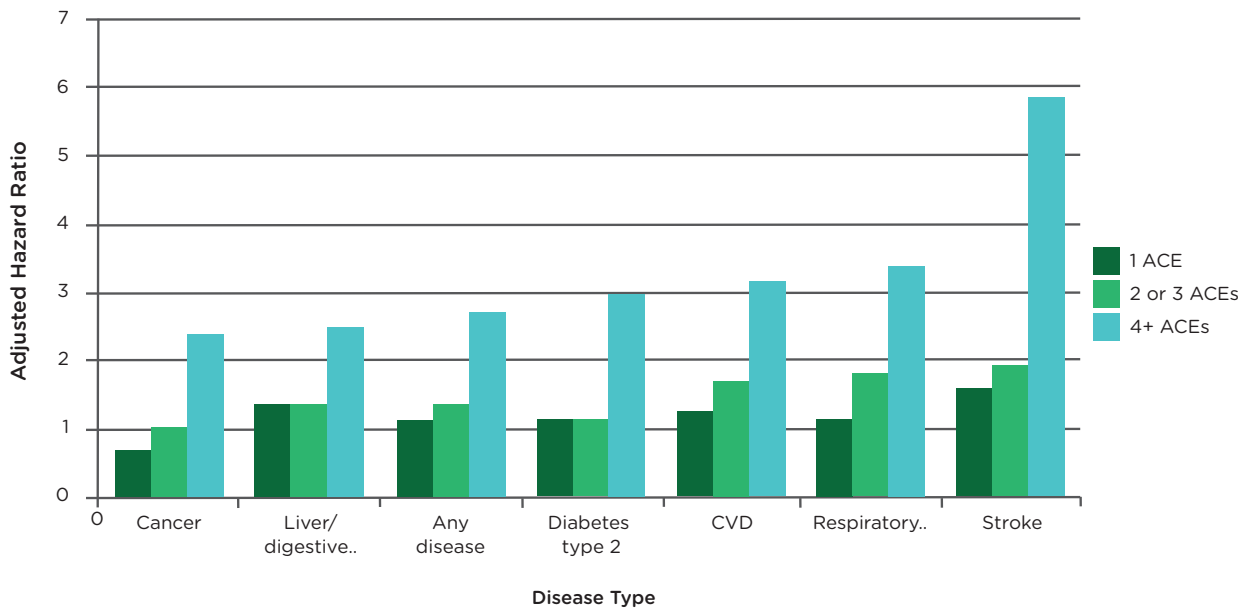
British research published in 2013 found that 'in men the risk of death was 57 per cent higher among those who had experienced two or more ACEs compared to those with none. Women with one ACE had a 66 per cent increased risk of death and those with two or more ACEs had an 80 per cent risk versus those with no ACE.'[13]

Figure 9. All-cause mortality rate by age 50 according to prevalence of adverse childhood experiences, British men and women, 2008. Source data from: [18]



Multiple American studies have found a relationship between the number of ACEs and the presence of diseases in adulthood, including ischemic heart disease, chronic lung disease, skeletal fractures and liver disease[17] stroke,[18] cancer,[19] hypertension, diabetes, asthma,[20] arthritis, angina pectoris and osteoporosis,[18] including a three-fold increased risk of lung cancer for those with six or more ACEs.[21]

Figure 10. Changes in risk of disease development with increased history of ACEs, English survey data, 2013. Source: [18]



A lack of good quality social relationships and social interaction can also increase the risk of maltreatment and there is also some evidence that younger parents are at an increased risk of maltreating their children, although this risk may be mediated through other factors such as unemployment and low income.[19-24]

2.4 Adult family life

Adult family life can act as a source of either stress or support. For example, adult children can continue to access advice and financial and emotional support from parents. However, young and adult children can, for example, have caring responsibilities for ill or disabled parents that exceed their financial, emotional and physical resources.[25-27] Carers are more likely than non-carers to report high levels of psychological distress, including anxiety and depression, in addition to loss of confidence and self-esteem.[28] Additionally, issues such as marital and family conflict can have an impact on health that is mediated through depression, and poorer health behaviours such as excessive alcohol intake, increasing the risk of poor health outcomes.[29] Financial concerns have been cited as one of the biggest pressures experienced by families.[30]

2.5 Marriage

Marriage is a significant relationship experienced by just over half of all adults [31] and can have beneficial effects on health.[32] For example, happily married individuals have been shown to have greater satisfaction with life and lower levels of stress and depression, and lower levels of ambulatory blood pressure. Conversely, those who were unhappily married, and experiencing marital strain, have been shown to be experiencing repeated, and at times chronic, social stress which may have long-term negative consequences for health. Poor-quality relationships have been shown to have a strong association with poor health outcomes, including responses to infectious disease and wound healing.[33-34] There are clear social determinants that influence the quality of marital relationships. For example, in a survey of 6,000 couples, the relationship charity Relate found that concerns about money and financial security were identified as a 'top strain' for 61 per cent of couples with children, and 47 per cent of couples without children.[34]

2.6 Family – interventions

Incredible Years [36]

The Incredible Years is a parenting group programme for children aged 3–4 years who are already exhibiting challenging behaviour. It is designed to help parents improve their child's behaviour. The majority of programmes are delivered via local authorities and children's centres in collaboration with parents. The Incredible Years programme originated in the USA. Evidence indicates that children's outcomes will significantly improve as a result of the programme. A large number of evaluations have been carried out in various countries, including randomised control trials. Findings consistently demonstrate positive outcomes in terms of reducing disruptive and aggressive behaviour, and improvements in pro-social behaviour and in interaction with parents, teachers and peers. Parents develop parenting skills, learn new techniques in how to communicate effectively with their children, improve relationships, establish rules and routines and manage anger and conflict. Further evidence of the impact of the Incredible Years programmes is available at www.incredibleyears.com/for-researchers/evaluation/

Triple P [37]

The Positive Parenting Program (Triple P) is an evidence-based, flexible, parenting programme accessed in over 25 countries, supported by over 30 years of ongoing research, designed to take a population-based health approach to parenting. The programme has been shown to work across cultures, socioeconomic groups and different family structures and provides a multi-level system that delivers different levels of support and intervention intensity depending on need. The programme provides parents with simple and practical strategies to help build strong, healthy relationships, manage children's behaviour with confidence and prevent problems from developing. All interventions are supported via a suite of resources that have been translated into 19 languages. Triple P has built in evaluation tools to monitor results.[1]

The NSPCC implemented two programmes designed to work with families where there was evidence of severe neglect, children were between the ages of 2 and 12 and the child or children had not yet met the threshold for child protection interventions. One programme implemented the Triple P programme through its Pathways Triple P service; the other utilised an historical NSPCC programme for comparison. Evaluation demonstrated that while almost three quarters (74 per cent) of children experienced severe problems at the start of their engagement on the Pathways Triple P programme, by the end of engagement this figure had dropped to 45 per cent. Significant improvements were noted in children's emotional symptoms, behaviour problems, hyperactivity and pro-social behaviour. Similar levels of impact were noted in the service that utilised the historical NSPCC programme, although there was a different 'patterning' of outcomes. Triple P saw impact in conduct problems, hyperactivity and pro-social strengths, while the historical programme saw impact for emotional symptoms and peer problems.

2.7 Family interventions – further reading and resources

A range of evidence reviews and evaluations are available that demonstrate the value of early intervention in children's lives and best practices in delivering services and achieving positive outcomes.

The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects (2015), written by the Institute of Health Equity, demonstrates the links between adverse experiences in the home experienced before the age of 18 and poorer health outcomes across the life course. It provides an analysis of the strength of evidence relating to causal links, associations and relationships between adverse experiences and poor health outcomes, the impact of interventions and local and national practice, both current and historically implemented.

What works to enhance inter-parental relationships and improve outcomes for children (2016), written by the Early Intervention Foundation and the University of Sussex, provides evidence of the role and impact of parental relationships on the development and outcomes for children and of the effectiveness of interventions, and presents successful case study examples.

Early years literature review (2014), conducted by the Centre for Research in Early Childhood, examined the evidence base for the impact of early years initiatives in the UK and internationally. The paper summarises and evaluates research relating to good practice in social care, health and education, provides a review of key interventions and their evaluations, identifies different strategies to measure effectiveness and value for money, and provides recommendations for further action.

Grasping the nettle: early intervention for children, families and communities (2010) provides evidence that spending should be prioritised on early years interventions including speech, language and communication needs, parenting programmes, targeted family support, and young people at risk of going into care. It also points to the need for better evaluation and development of an evidence base for effective interventions.

Early interventions. The next steps (2011), a report by Graham Allen MP, looks at how intervention in children's earliest years can prevent or reduce costly and damaging social problems. It sets out the role of the voluntary sector in the provision of early intervention and highlights the difficulties experienced through ad hoc funding, lack of a diverse funding base, and poor evaluations of interventions.

The best start in life: what do we know about the impact of early interventions on children's life chances? (2013), a review published by WISERD at Cardiff University, examines some of the most prevalent early years interventions currently used in 'Westernised' countries and focuses mostly on longitudinal research to assess the efficacy of programmes. It provides evidence for a range of interventions, including paid paternal leave, parental support during pregnancy, home visits and targeted support for disadvantaged parents.

Inter-parental relationship support services available in the UK. Rapid review of the evidence (2016), produced by the Early Years Foundation, has a particular focus on families in or at risk of 'poverty', and details the nature and extent of relationship support in the UK, the profile of service users and barriers to service implementation.

There are a number of publications that are aimed at local statutory services but contain useful information about the need for early intervention programmes, their effectiveness and cost effectiveness, and illustrative case studies and example programmes. These include: ***Early years interventions to address health inequalities in London – the economic case (2011)*** and ***Early intervention: informing local practice (2012).***

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3. FRIENDS AND COMMUNITIES

Friends and communities – key messages:

Strong friendship networks and participation in community, political, religious and social groups have a positive impact on physical and mental health.

A lack of good quality social relationships and resulting social isolation affect physiological and psychological functioning, health behaviours, and the risk of ill health and mortality.

Stress is the main mechanism through which social isolation impacts on health. Prolonged exposure to stress damages the biological systems of the body and has a clear impact on life expectancy and physical and mental health.

Social isolation and loneliness also increase the risk of poor health outcomes, mediated through poorer health behaviours.

A range of factors increase the risk of social isolation and loneliness including low income, poor-quality built and natural environments, cold housing and inadequate transport links, which can prevent people from developing and maintaining social ties.

Older people, people with disabilities, parents with young children and carers are more likely to encounter barriers to developing and maintaining social networks and relationships and as such have a higher risk than others of associated health outcomes.

Research has found that a sense of community can boost immune systems, lower blood pressure and guard against cognitive decline, while joining a community group can reduce a person's risk of dying.

Conversely, links have been found between civic distrust and poor social support and coronary heart disease and mortality.

Strength of evidence: strong

In 2010 a meta-analytic review was conducted to determine the extent to which social relationships influence the risk of mortality. Drawing on the results of 148 studies (308,849 participants) the review found that 'people with stronger social relationships had a 50 per cent increased likelihood of survival than those with weaker social relationships.[2]

In 2016 the Institute of Health Equity published a report that reviewed the evidence relating to the association between social isolation and loneliness and cognitive decline, impairment and dementia. The review found that there are strong links between social isolation and loneliness and the increased risk of cognitive decline, cognitive impairment and dementia.[3]

3.1 Friendship and health

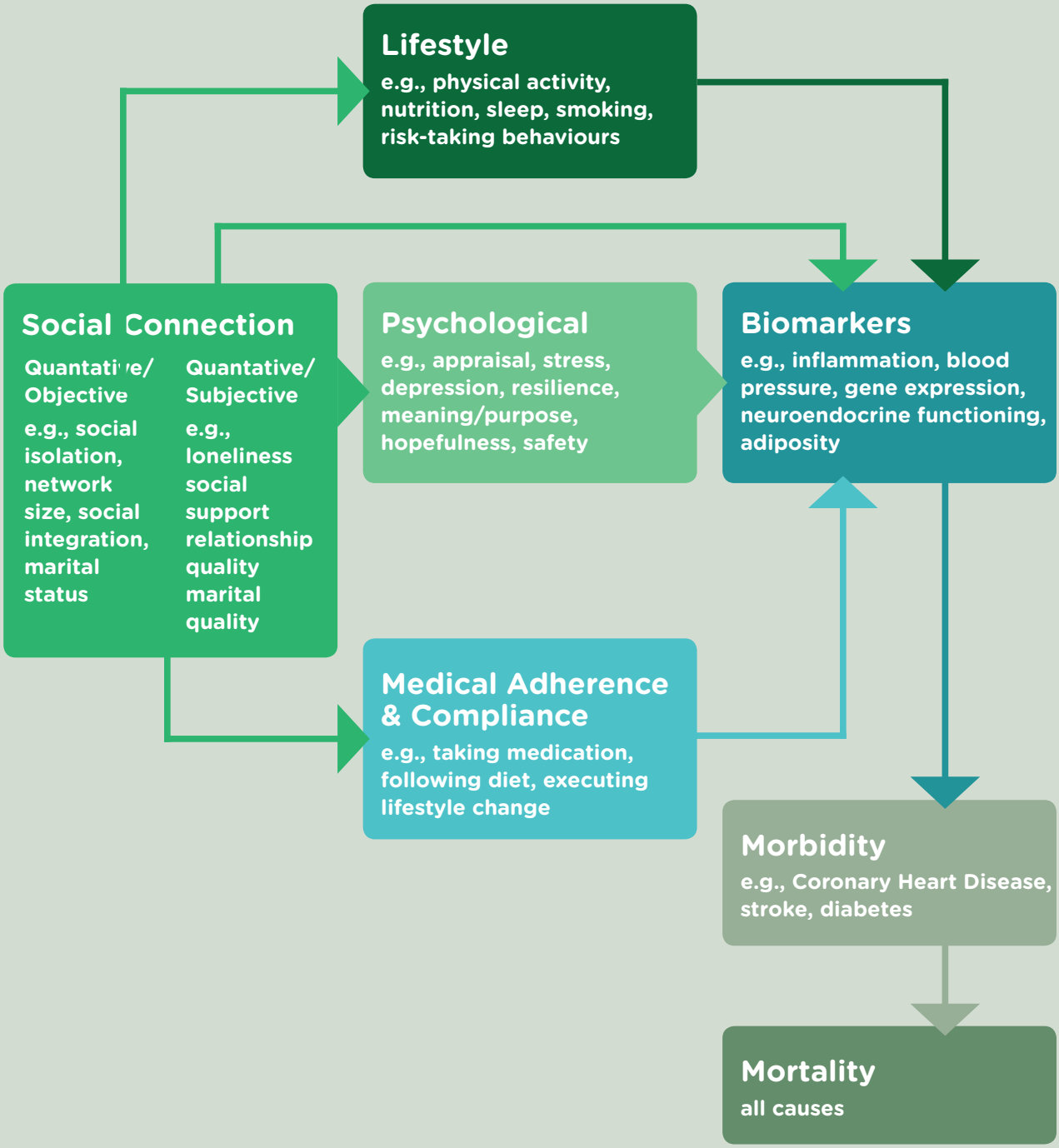
Strong friendship networks and participation in community, political, religious and social groups have a positive impact on physical and mental health.[4,5] This is because social relationships affect the physiological and psychological functioning of the body[6,7] and can also increase or decrease the likelihood of poor health behaviours.

Large-scale studies have found that social isolation and loneliness are associated with a 50 per cent excess risk of coronary heart disease, similar to the excess risk associated with work-related stress.[8] Holt, Lundstad and Smith demonstrate the links between loneliness and isolation and morbidity in Figure 11 on page 38.

Social isolation: The inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place. [2]

Loneliness: An emotional perception that can be experienced by individuals regardless of the breadth of their social networks. [1]

Figure 11. Simplified model of possible direct and indirect pathways by which social connections influence disease morbidity and mortality[10]



Stress is the main mechanism through which social isolation impacts on health and prolonged exposure to stress damages the biological systems of the body.[7, 10] Social isolation, and in particular, loneliness, can also increase the risk of smoking and lack of physical exercise, in addition to increasing the risk for cognitive decline, mild cognitive impairment and dementia.[11-14]

Although social isolation is often thought of as attributable to later life circumstances, anyone can experience social isolation and loneliness across the life course. Specific groups can be more vulnerable to social isolation and this is influenced by physical and mental health, level of education, employment status, wealth, income, ethnicity, gender and age or life stage[15]

3.2 Communities and health

Participation in community, political, religious and wider social groups also has a positive impact on physical and mental health[4, 5] and can affect the physiological and psychological functioning of the body[6, 7] in the same way that closer friendship networks can. Research has found that a sense of community can boost immune systems, lower blood pressure and guard against ageing.[17] Other research has found that joining a community group can reduce the risk of dying in the next year to the same extent that giving up smoking will.[17-20]

Strong communities can enable local populations to maintain or enhance positive local outcomes, to be resilient against shocks and provide support to community members. Strong communities value collaboration and participation, trust and responsibility and have adequate levels of social and civic participation, social networks, support and reciprocity.[21] Importantly, strong communities enable groups and individuals to feel part of and have influence over decisions that affect them.[22] All of these factors have an impact on physical and mental health.

Conversely, social exclusion, defined as not having the means, materials or other factors needed to participate in social, economic and cultural life,[23] has been found to have a negative effect on health. Relationships have been found between civic distrust and poor social support, and coronary heart disease and mortality.[24, 25]

3.3 Social determinants of social isolation and social exclusion

A wide range of evidence demonstrates clear links between social determinants and social isolation.[15, 26-33] A number of factors increase the risk of becoming socially isolated, particularly for older people, parents, women, people with disabilities, and people on a low income. These risk factors are depicted in Figure 12 below.

Figure 12. Factors increasing the risk of social isolation

3.4 Friends and communities – interventions

Metal Culture, Southend-on-Sea, Essex

The arts organisation Metal creates large-scale participatory projects that involve people of all ages and from all sectors of the local community. Founded in London in 2002 and active in Southend since 2007, Metal works through a wide range of partnerships, including Arts Council England, Southend local authority, local economic partnerships, Cycle Southend, and a wide range of other arts organisations, community groups, schools and higher and further education institutions.

Metal and Southend Borough Council public health team collaborated to create an 18-month project based at the Metal Art School. The project was developed as part of Southend Council's mental health strategy, which aimed to build community resilience and improve self-management and prevention, thus diverting people from hospitals and secondary care.

Working with people with dementia, young carers, and people with learning disabilities, the project aimed to provide opportunities for people at risk of isolation, or who experience common mental health conditions such as anxiety, loneliness or depression, to become more socially connected while experiencing art and learning new digital skills. The project is free and open to individuals or groups and aims to challenge traditional interventions, bringing about system efficiencies, and growing the infrastructure of local groups.

To date, the following outcomes have been achieved:

- 64 volunteers have taken part in the programme to date
- 38 of the 64 volunteers (59%) have a disclosed mental health condition
- 33 volunteers (51.6%) have gone on to higher education or employment after volunteering
- 25 participants (17%) have returned as volunteers

Participants were also asked to score their mental health and wellbeing on the Warwick Edinburgh Mental Health Scale and results demonstrated that mental health had been meaningfully improved:

- 84% stated their self-confidence had improved
- 50% said their use of the GP and crisis team had reduced
- 75% increased their physical exercise since undertaking project
- 81% stated that their symptoms of social isolation had improved
- 76% said they enjoyed meeting new people
- 72% said symptoms of anxiety, depression and stress had improved
- 85% said their confidence in using technology had improved
- 76% said they enjoyed learning something new

Springboard, Cheshire [26]

Springboard is a partnership between Age UK Cheshire and Cheshire Fire and Rescue Services (CFRS). The partnership uses advanced data-sharing to target home visits to older people by CFRS staff. These staff act as a gateway to a range of early intervention and support activities.

In 2005 CFRS, Age UK Cheshire, the local authority and NHS started to seek data sets that could identify older people most in need of support, due to a range of risk factors for poor wellbeing. A data-sharing protocol was established that allowed CFRS to use 'personal' NHS data. This was used in conjunction with information from the Index of Multiple Deprivation and other open data sets, such as details of households receiving assisted bin collections.

Using this data Springboard delivers around 30,000 'smart' home visits per year. As the CFRS and Age UK are trusted community brands, they have a 98 per cent success rate of being invited into people's homes. The approach focuses on older people's capacity, rather than deficits. Older people are connected with local resources, signposted to befriending services, tea/coffee clubs, social and leisure networks and Men's Sheds schemes. The work has resulted in more people who do not reach eligibility criteria for social care receiving help and support at home and becoming more involved with their local community.

Website: www.cheshirefire.gov.uk/partnerships/springboard

3.5 Friends and community interventions – further reading and resources

There is a range of evaluations and evidence reviews that examine interventions targeting social isolation in later life, and across the life course, in addition to reviews of local action implemented to improve social integration.

Interventions targeting social isolation in older people: a systematic review (2011), a study published in BMC Public Health, examined 32 studies for efficacy and provides evidence relating to participatory and non-participatory, targeted and non-targeted interventions, home visits, and internet training to address social isolation in older people.

Loneliness and isolation. Evidence review, by Age UK, provides evidence on the prevalence and effects of loneliness and isolation in later life, and evaluation of recent one-to-one, group and community involvement interventions.

Interventions to reduce social isolation and loneliness among older people: an integrative review (2016), a study by Gardiner et al., conducted an integrative review of interventions that target social isolation and loneliness for older people and examines why specific interventions are successful. Adaptability, community development approaches and productive engagement were factors associated with the most effective interventions. The review also argues for better research to provide more robust data in this area.

Reducing social isolation across the life course (2015), produced by the Institute of Health Equity on behalf of Public Health England, is a practice resource providing evidence of the risks of social isolation during pregnancy, in children and young people, throughout working life, and in retirement and later life. It provides evidence of effective interventions for each life stage.

Immigration and social cohesion in the UK. The rhythms and realities of everyday life (2008), published by the Joseph Rowntree Foundation, set out to improve the understanding of the relationship between new immigrants and social cohesion. The research explored the relationships between long-term residents and new arrivals and the impact of social and economic transformations in six sites across the UK.

If you could do one thing... Local actions to improve social integration is a British Academy policy project on interventions for local authority bodies, businesses and voluntary sector organisations to improve social integration.

Wellbeing and social cohesion (2008), published by the Economic and Social Research Council, is a policy briefing that analyses data from the European Social Survey and explores how policy can support wellbeing for all. The research demonstrates that there are significant differences in the wellbeing and levels of trust in government between different regions, ages and socioeconomic groups.

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4. EDUCATION AND SKILLS

Education and skills – key messages:

Education and skills are important for health. Participation in higher levels of education and higher education attainment is associated with healthier lifestyles, better mental health, greater levels of health literacy, and a reduced risk of a range of conditions, including cognitive decline and dementia.

Children from disadvantaged backgrounds are more likely to start school with lower social, emotional, language and literacy development than their better-off peers.

Poor housing, adverse childhood experiences, poor living standards and nutrition, inadequate parental support, family conflict and poor interactions with children can negatively influence childhood educational outcomes.

These issues can impact on future life chances, including increasing the risk of a young person becoming NEET (not in education, employment or training), affecting future employment opportunities and future income.

Poorer educational attainment is linked to multiple adverse health outcomes, including an increased risk of obesity and dementia, decreased levels of health literacy, poor mental health, and poorer health behaviours.

Strength of evidence: strong

In 2006 a review of the evidence found 'considerable international evidence that education is strongly linked to health and to determinants of health such as health behaviours, risky contexts and preventive service use.' Further, it was found that 'there are substantial and important causal effects of education on health.'[1]

4.1 Education and skills and health

Education and skills are important for health throughout the life course. Higher cognitive scores are associated with healthier lifestyles,[2] and reduce the likelihood of obesity and major diseases, including diabetes, heart disease, stroke and some cancers.[3] Cognitive development in early life also affects mental health throughout the life course, with good development reducing the risk of poor mental health in later life.[4] Higher cognitive functioning is linked to higher socioeconomic position, which protects against psychological distress in later life.[5]

Higher levels of education also reduce the risk of poor health behaviours such as smoking.[6] Educational attainment also strongly predicts for good health literacy, the skills, knowledge and confidence to access and use health and social care services.[7]

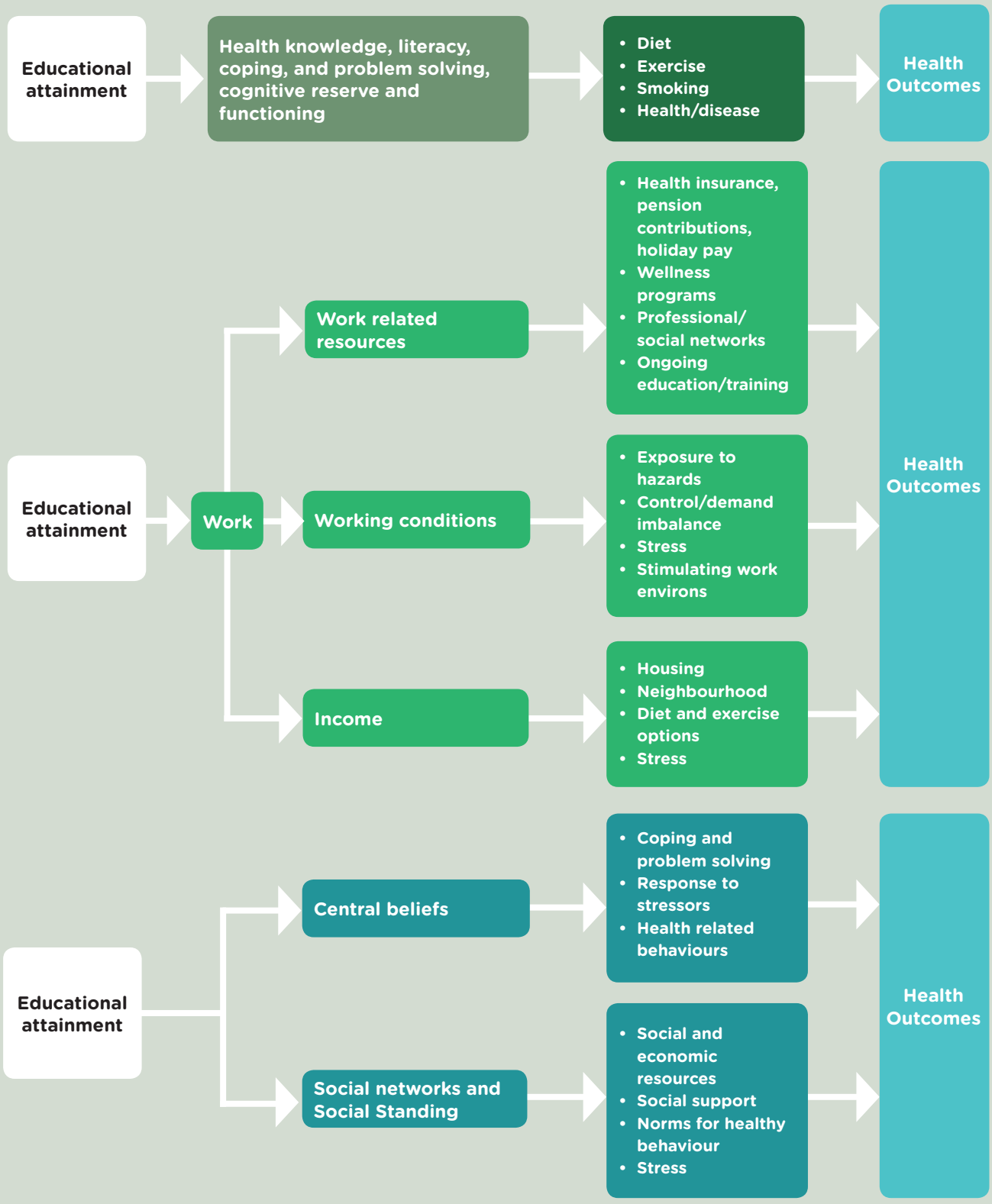
Education and a broad range of skills and abilities can protect against the onset and symptoms of cognitive impairment and dementia in later life.[8-10] 'Cognitive reserve', the skills, abilities and knowledge gained throughout the life course, is higher for those with greater levels of education and experience of stimulating employment and environments, and strong cognitive reserve enables people to cope better with the onset of cognitive impairment and dementia in later life.[11-13] It can also delay the onset of dementia symptoms.[11]

Cognitive reserve: The skills, abilities and knowledge built throughout life that decrease the risk and delay the onset of cognitive impairment and symptoms of dementia in later life.

Education in later life is also important. Mentally stimulating experiences have been found to have a physiological effect on the brain and can be clinically effective in replacing lost cognitive function caused by dementia, in particular Alzheimer's disease.[12]

The multiple pathways through which poor educational attainment can impact on health are depicted in Figure 13 on page 45.

Figure 13. Education: Pathways to health outcomes (adapted from Egerter S, et al).[13]



4.2 Social determinants of education and skills

The following sections provide information on the various factors that determine access to education and the unequal distribution of education outcomes.

4.3 Childhood education

A range of interacting factors impact on educational outcomes for children, including parental support and relationships with children, and school and peer factors such as the nature of the school and its pupils. However, there is a particularly strong relationship between disadvantage and educational achievement. Specific factors that are linked to the likelihood of a child achieving well at school, such as levels of stress and maternal mental health, weight at birth, and cognitive stimulation, are all influenced by the socioeconomic status of parents. [15]

Children from disadvantaged backgrounds are more likely to start school with less social, emotional, language and literacy development and skills and have an increased risk of behavioural problems that can impact on educational attainment.[15] These factors are not linked to children's differential abilities or to innate cognitive functioning, but to the circumstances and environments that they are born into and live.

Poor housing conditions are also linked to slower cognitive development and limited educational attainment,[16] while access to green space and adequate green infrastructure is known to impact on the cognitive development and educational outcomes of children.[17]

ACEs have also been shown in a wide range of evidence reviews to have a significant impact on educational attainment including lowering grades and reducing school attendance, and increasing levels of placement in special education programmes.[18-24]

Gender and ethnicity also influence levels of education. Poorer white girls and boys (those eligible for free school meals from year 3 onwards) achieve some of the lowest rates of GCSE A–C grades in England.[25] Irish Traveller, Gypsy and Roma children also achieve significantly lower educational outcomes than the national average and are four times more likely to be excluded from school.[26]

4.4 Not in education, employment or training (NEET)

There is strong evidence that poor educational achievement in childhood increases the risk of not being in education, employment or training (NEET) between the ages of 16 and 24. Young people who are NEET are not evenly distributed: greater numbers are found in areas of deprivation and disadvantage.[27]

The long-term impacts of becoming NEET include 'wage scarring' or lower levels of earnings in later life, future unemployment, poorer physical and mental health, increased risk of teenage and early parenthood, insecure housing, homelessness and involvement in crime.[28, 29]

4.5 Education in later life

There is a social gradient in terms of access to, and the ability to utilise, stimulating educational resources for older people. A large proportion of older people are not engaged in learning and only 7 per cent of people over the age of 75 participating in a 2012 study stated that they had any plans to take up some form of learning in the future.[30]

There are multiple barriers to learning in later life, experienced particularly by disadvantaged groups. Funding can be skewed towards higher educated groups, and there is unequal access to meaningful training and professional development between professional, manual and low-paid groups of workers.[31]

4.6 Education and skills: interventions

Example: Building emotional resilience in schools in Denny, Scotland [32]

This pilot, funded by the Scottish Government, Falkirk Council and HeadsUpScotland, was delivered by YoungMinds in 2007–08, with the aim of building emotional resilience and wellbeing in school. The programme had a specific focus on supporting the transition from primary to secondary school, including through training teachers and working with parents.

YoungMinds is a charitable organisation in Scotland and offers advice and information about bullying, divorce and separation, and children's behaviour.

The pilot programme included four initiatives:

- Building confidence and self-esteem among pupils, including through peer support, use of the Creating Confident Kids programme, and the Aiming for High programme, which is specifically designed to increase resilience in young people during times of transition.
- Promoting confidence and understanding among teachers and other staff, including through training on resilience and emotional wellbeing.
- Raising awareness of resilience and wellbeing among parents through workshops designed to increase support across the transition between schools.
- Enhancing the leadership skills of head teachers in the areas of resilience and wellbeing.

An evaluation revealed the following key findings:

- Pupils' self-esteem and resilient attitudes were enhanced, and worries about transition were reduced.
- Staff's own confidence in their ability to promote and facilitate discussion about resilience and emotional wellbeing increased.
- Parents felt more confident in their ability to support their child, and there were improvements in the parent–child relationship.
- Schools reported a greater focus on, and prioritisation of, resilience and emotional wellbeing.

Example: Open Age [35]

Open Age is a charity led by users, supporting older people to develop and maintain physical and mental health through pursuing their interests. Over 200 mentally, physically and socially stimulating activities are delivered from Open Age hubs across London each week, run from a range of settings including community centres, sheltered housing, libraries, church halls and residential settings. Open Age runs the Link Up Project and is funded by the NHS and local councils. Project workers aim to identify and support older people who are most vulnerable to social isolation and non-engagement in activities. Open Age workers offer a range of support including one-to-one confidence-building, accompaniment to first sessions, home visits and meetings in the community, advice, and links to transport options designed for older people with physical mobility issues. Activities have also been facilitated over the phone for those unable to leave their home, for example a telephone book club.[33]

4.7 Education and skills – further reading and resources

Improving school transitions for health equity (2016), a paper by the Institute of Health Equity, summarises the latest evidence on school transitions to determine the nature and extent of their impact on health outcomes. It also considers whether or not school transition interventions and strategies can help to reduce health inequalities. The paper includes example interventions and a review of programme evaluations.

Local action on health inequalities: Building children and young people's resilience in schools (2014), published by the Institute of Health Equity, demonstrates inequalities in the clustering of adverse circumstances and experiences that lower resilience in children and young people and argues that action to build resilience in children and young people should be taken by a wide range of organisations, including in the voluntary sector. It recommends a number of actions including extra-curricular activities that build social networks, inter-personal relationships, confidence and self-esteem.

Approaches to supporting young people not in education, employment or training – a review (2012), written by the National Foundation for Educational Research, examines preventive and reintegration approaches and research about successful approaches supporting those not in education, employment or training (NEET). It examines the evidence at a general level as well as evidence pertinent for those in identifiable sub-groups, including those 'open to learning', those with sustained absence from education, employment or training, and those who are undecided and dissatisfied with their choices.

Are we failing young people not in employment, education or training (NEETs)? A systematic review and meta-analysis of re-engagement interventions (2017), research compiled by the universities of Newcastle, Durham, Lincoln and Leeds Trinity, demonstrates a 'small but significant 4 per cent increase in employment' achieved by interventions supporting NEETs and estimates a saving of £469 million to the public purse. Successful interventions had high levels of contact with service users and targeted deprivation.

The early bird... Preventing young people from becoming a NEET statistic (2011), research published by the University of Bristol, focuses on identifying a set of characteristics that helps to identify those young people who are most at risk of becoming NEET, and provides a review of interventions from the UK and internationally that have addressed issues that increase the risk of becoming NEET. Interventions that demonstrated the most success were those that offered financial incentives for engagement and part-time work experience during school hours. Young people who are most vulnerable to becoming NEET are those that lack basic numeracy and literacy skills. The research also found that programmes that force individuals to stay in formal education, without providing alternatives, can do more harm than good. The study reports: 'Formal apprenticeships with key on the job training and a proper connection to the world of work could play a fundamental role on increasing engagement.'

Evaluation of the ESF [European Social Fund] support to lifelong learning: final report (2012), a study written by European research and consulting company Ecorys, focused on three target groups: young job seekers (up to the age of 24), low-skilled workers (those with qualifications up to ISCED [International Standard Classification of Education] level 2) and older workers (age 55 plus). The focus of the study has been on the economically active – European Social Fund participants in work or actively seeking work. The report provides a list of critical success factors for young, low-skilled and older workers, and details how the design and operation of ESF processes and delivery systems can influence impact.

Higher education access: Evidence of effectiveness of university access strategies and approaches (2014), research written by Durham University, uses various methodologies, including systematic review, meta-analysis, experimental, regression discontinuity and other quasi-experimental designs and was undertaken mainly in the United States. The research demonstrates that widening participation programmes with specific interventions including financial incentives, advice and academic mentoring were most successful at increasing participation in higher education.

Impacts of lifelong learning upon emotional resilience, psychological and mental health: fieldwork evidence (2004), qualitative research published in the Oxford Review of Education, uses 145 in-depth biographical interviews with learners and 12 group interviews with learning practitioners regarding the impact of lifelong learning on their health and wellbeing. A range of health outcomes were recorded including wellbeing, protection and recovery from mental health difficulties, ability to cope with potentially stressful circumstances, including the onset and progression of chronic illness and disability. These health outcomes were mediated through a number of psychosocial qualities including self-esteem and self-efficacy, a sense of purpose and hope, competences, and social integration. The research also found that learning had to match the interests, strengths and needs of the learner if it was to have a positive impact on health.

Intervening to improve outcomes for vulnerable young people: A review of the evidence (2010), published by the Department for Education, identifies common barriers to implementation of new initiatives for vulnerable young people and their families and elements of effective practice in the delivery of multi-agency services and their associated costs and outcomes.

Lifelong learning and crime: A life-course perspective (2014), a review written by the Institute of Education, examines the financial and other social benefits that are gained from utilising lifelong learning to address crime. It provides a review of the policy environment that has linked education and desistance from crime and the ways in which education for people involved in the criminal justice system has been delivered. The paper provides evidence on the returns to be expected from educational interventions with offenders and argues for a 'more broadly based methodological stance in relation to this kind of research'. It reviews how education, social exclusion and offending are linked.

Literature review of research on the impact of careers and guidance-related interventions (2009), written by the CfBT Education Trust, found that, although it is difficult to quantify in hard terms the impact of careers and guidance-related interventions on intermediate or longer-term learning, social and economic outcomes, there is 'reasonably' strong evidence that careers advice and guidance interventions can have an impact on delivering softer outcomes, such as increased self-confidence and enhanced decision-making skills that can be viewed as 'precursors' or proxy indicators that make a significant contribution to longer-term socioeconomic outcomes.

Getting older people involved in learning (2010) is a best practice guidance report written by the Institute of Lifelong Learning, to support older people into learning throughout the EU.

Older people, learning and education: what do we know? (2011), produced by NIACE, provides evidence from the English Longitudinal Study of Ageing that shows a strong correlation between older people's participation in music, arts and evening classes and wellbeing outcomes, particularly for women and those still in work. It also demonstrated that for older people, more formal, exam-based education was not related to wellbeing outcomes.

The special educational needs and disability review. A statement is not enough (2010), a report by Ofsted, evaluates how effective the legislative framework and arrangements are for serving disabled children and young people and those who have special educational needs. It examines the accuracy and appropriateness of identification and assessment, expectations about the potential of children with special educational needs, access to good educational provision and other services that meet needs, improvements in opportunities, and any progress that has been made in preparing children and young people with disabilities for the future.

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5. GOOD WORK

Good work – key messages:

There are strong relationships between good quality employment and health. Good work enables enough economic resources for material wellbeing and participating in community life and contributes to psychosocial needs, including individual identity, social role and status.

Unemployment and poor-quality employment are strongly linked to poor physical and mental health outcomes.

Poor-quality work can lead to ill health including poor mental health and musculoskeletal problems and can increase the risk of prolonged absenteeism and future unemployment.

Unemployment increases the risk of limiting long-term illness, poor mental health and cardiovascular disease and is associated with an increased risk of mortality and suicide.

Unemployment also lowers living standards and increases psychosocial stressors and the likelihood of poorer heath behaviours including excessive alcohol consumption, smoking and decreased physical exercise.

Strength of evidence: strong

In 2014 a systematic review of the evidence was completed to investigate the effect of employment on health. Thirty-three studies were reviewed, 23 of which were identified as high quality. Strong evidence was found for a protective effect of employment on health outcomes such as depression and general mental health.[1]

In 2015 a systematic review of the evidence relating to the health-related risks of both job insecurity and unemployment assessed 375 articles and included 13 studies for in-depth review. The review found that 'job insecurity and unemployment were strongly related to mental health, whereas job insecurity was more strongly associated with somatic, or physical, symptoms. Unemployment showed a strong relationship with worse general health and mortality.[2]

In 2015 a systematic review of longitudinal studies investigated the causal relationship between employment status and physical health through examining 22 longitudinal studies conducted in seven different countries and found that unemployment and job loss were associated with poorer physical health.[3]

5.1 Work and health

The relationship between work and health is close, long-lasting and multi-dimensional.[4] Good work is essential for obtaining the economic resources that are needed for material wellbeing and participating in community life. Good work also contributes to wellbeing and good mental health and can be central to an individual's identity, their social role and status. A wide range of evidence, as demonstrated in this report, notes the significant role that good employment and subsequent socioeconomic status has in driving the social gradient in mental and physical health across the life course.[5] However, not all work is good for health.

5.2 Poor-quality work

Poor-quality jobs include those that offer little stability or security, are intensive and entail long hours, have working conditions over which the employee has no control, and which are physically hazardous and demanding. They are unequally distributed within the labour market and affect the most deprived workers disproportionately. Poor-quality work can lead to illness including common mental health illness, musculoskeletal problems and diseases associated with stress. Ongoing ill health can result in prolonged absenteeism which, in turn, leads to unemployment.[6-15]

5.3 Unemployment

People who are unemployed have an increased risk of limiting long-term illness[16] including mental illness[17] and cardiovascular disease.[18, 19] Unemployment is also associated with an increase in overall mortality and suicide.[20] The adverse impact of unemployment on health increases over time, and influences health through lower standards of living, psychosocial stressors that also impact on the family of unemployed people, and through the increased likelihood of poor health behaviours such as smoking, excessive alcohol consumption and decreased physical exercise.[20-22]

5.4 Social determinants of unemployment and poor-quality work

There is inequality in access to the labour market and unemployment is higher than average among certain groups including disabled people, people with learning disabilities, lone parents, some ethnic minorities, people over the age of 50, people with low level or no qualifications and those living in deprived local authority wards.[23] Carers and those with criminal convictions also experience specific barriers to employment[24, 25] A number of social determinants impact on the ability of specific groups to access, maintain and progress in good quality employment, with adequate pay. These can include discrimination,[25] inadequate transport links,[26] lack of special features at employment premises,[27] high child care costs and lack of availability,[28] discrimination and stigma, and a lack of reliable work with adequate pay.[28, 29]

5.5 Good work – interventions

Example: Unison [30]

In Northern Ireland, the union UNISON has developed a partnership programme with health and social care trusts and the Open University. Staff from across disciplines in health and social care are eligible, including those working in direct care provision, administration, catering, cleaning, security and labs. The programme aims to support health and social care staff to improve their practice, develop knowledge and skills and to award them with a qualification that would support them to improve their skills and job possibilities. The academic course engages learners who may never have considered university study an option for them. Approximately 70 per cent of those entering the programme left school with fewer than five O'Levels/GCSEs.

UNISON developed a study skills course and an exam preparation day as part of the programme and negotiated release for staff to attend tutorials. Additional support was put in place for learners with dyslexia, and close contact between UNISON and the Open University during each course ensured that extra support could be provided for learners if needed. This has resulted in a much higher retention rate than the UK average.

Participants have used the course to enter pre-registration nurse training, gain job promotions (for example, a kitchen stores worker [band1] applied and succeeded in gaining a position as a rehab worker [band 3]) and to pursue further study with the Open University towards a full degree. The partnership has supported over 500 low-paid workers to access the level 4 Health & Social Care certificate, which awards 60 credits towards a degree.

For more information see www.ulearnni.org

Example: ThinkForward [30]

ThinkForward is a programme created in 2010 by Impetus – The Private Equity Foundation (Impetus-PEF) and delivered by Tomorrow's People, a national employment charity. The programme aims to act early to ensure young people make a successful move from education into employment. The programme places coaches in schools, where they work with those who are most at risk from the age of 14, providing one-to-one coaching. Support is provided long term for up to five years, and includes linking young people to existing services in the community and facilitating contact with local employers. The programme is based on a pilot delivered in Tower Hamlets, East London, which placed coaches in five schools for two years, helping 320 young people and achieving an 88 per cent reduction in those NEET at age 18. Currently, ThinkForward operates in 14 schools in East London, working with 1,100 young people, 88 per cent of whom have improved their behaviour or attendance at school and 95 per cent continued into further education, employment or training at age [16.32]

The intervention is funded in part by a three-year Social Impact Bond, which is commissioned by the Department for Work and Pensions' Innovation Fund, backed by the Private Equity Foundation and Big Social Capital.

5.6 Good work interventions – further reading and resources

A number of evidence reviews, evaluations and 'what works' publications have been published demonstrating local area initiatives aimed at helping people back to work, improving working conditions and addressing workforce wellbeing.

Local action on health inequalities. Promoting good quality jobs to reduce health inequalities (2015), an Institute of Health Equity and Public Health England publication, provides evidence of inequalities of access to good employment and the corresponding impact on health, the attributes of poor and good quality work, and examples of recommended local area action to improve working conditions for local populations.

Mental capital and wellbeing: Making the most of ourselves in the 21st century (2008), a resource produced by the Government Office for Science, aims to identify the opportunities and challenges for everyone's mental capital and wellbeing and provides evidence for action on how to better allocate current resources. It also provides a summary of interventions that address the mental wellbeing of the workforce.

A working life for people with severe mental illness (2003), published by the Oxford University Press, advocates for a new approach to the inclusion of people with mental illness in employment, advocating for job placements in meaningful jobs, supported by on-site trained coaches.

What works for whom in helping disabled people into work? (2013), written for the Department for Work and Pensions, is a rapid review of international evidence examining what works to help disabled people into employment and to remain and progress in work. The review found a lack of robust evaluation evidence on what works for whom. However, the review did find that supported employment programmes that involve intensive personalised support, early interventions, supportive and trusted relationships with advisers, and a balance between specialist and mainstream provision and access to other types of support if and when needed, were more successful than generic programmes. Training that occurs in the work place, rather than general training programmes, were also found to be more successful.

Work stress interventions and their effectiveness: A literature review (2003) provides an integrated review on the effectiveness of occupational stress interventions. The paper concludes that the majority of work stress interventions work with the individual rather than at an organisational level. However, many reviews promote the positive factors of organisational interventions, based on the premise that it is better to prevent than to cure and that causes can be best addressed at an organisational level.

50+ back to work evidence review and indicative guide for secondary data analysis (2010), written by the Policy Institute for the Department for Work and Pensions (DWP), reviews the scope, nature and effectiveness of DWP's back to work provision in supporting over-50s' return to work. It identifies the key factors associated with successful programme outcomes and assesses which strategies are most effective for older age groups.

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6. MONEY AND RESOURCES

Money and resources – key messages:

People with higher levels of income live longer, healthier lives than those on lower incomes.

Low income and deprivation impact on health across the life course through various mechanisms, including material deprivation, psychosocial pathways, and health behaviours.

Research has demonstrated an increased likelihood of smoking during pregnancy, poorer foetal development, low birthweight, feelings of stress and lack of control, and an increased risk of cardiovascular disease and all-cause mortality, all linked to low income.

Particular groups are more at risk of low income and these include people with mental health illness, people with disabilities, young people, carers and lone parents and some ethnic minorities.

The relationship between low income and poor health is cyclical: low income causes poor physical and mental health outcomes, and poor health increases the likelihood of low income.

There are multiple social determinants that influence the amount and adequacy of people's money and resources. These include inadequate levels of benefits to meet the minimum income for healthy living (MIHL), in-work poverty due to high costs of living and low wages, and high levels of debt. These issues are influenced by the unequal distribution of taxes paid on goods and services by lower and socio economic groups, and the clustering of payday loan and gambling outlets in areas of deprivation.

Payday lenders and betting shops, which can cluster in areas of deprivation, increase the risks of financial difficulties and debt and associated poor health outcomes, including intimate partner violence, emotional and psychological distress, and feelings of lack of control, insecurity, lack of safety, shame and stigma.

Income deprivation increases the risk of debt with at least a quarter of UK households experiencing income deprivation unable to pay specific bills, including mortgages and rent bills.

Strong relationships have been found between debt and: depression and anxiety; poor self-rated physical health, including obesity; suicide; and drug and alcohol abuse.

Strength of evidence: strong

In 2014 a systematic theoretical review was conducted by the Joseph Rowntree Foundation to develop a better understanding of how income and health are related over the life course. 5,795 papers were assessed and 272 papers were identified for in-depth review. The review found that health inequalities are a result of a combination of interdependent pathways, including material, psychosocial and behavioural, which formed a 'complex web of causal factors' that influenced health.[1]

A systematic review and meta-analysis conducted in 2013 reviewed 65 papers relating to the association of personal debt and health and found a significant relationship between debt and mental disorder, depression suicide completion or attempt, problem drinking, drug dependence, neurotic disorders and psychotic disorders.[2]

6.1 Low income, deprivation and health

There is a strong association between income and health, and many health outcomes improve incrementally as income increases.[3] A clear example of this is the impact of income on life expectancy and healthy life expectancy, demonstrated in the Marmot graphs included in the Introduction to this report (Figures 1 and 2 on page 15). Not only do people with higher levels of income live longer, but they live longer in better health.

Links have been found between income inequality and specific health outcomes. For example, levels of adult obesity tend to be lower in countries where there is less income inequality,[4] and rates of poor mental health are higher in countries with higher levels of inequality,[5] as are rates of infant mortality.

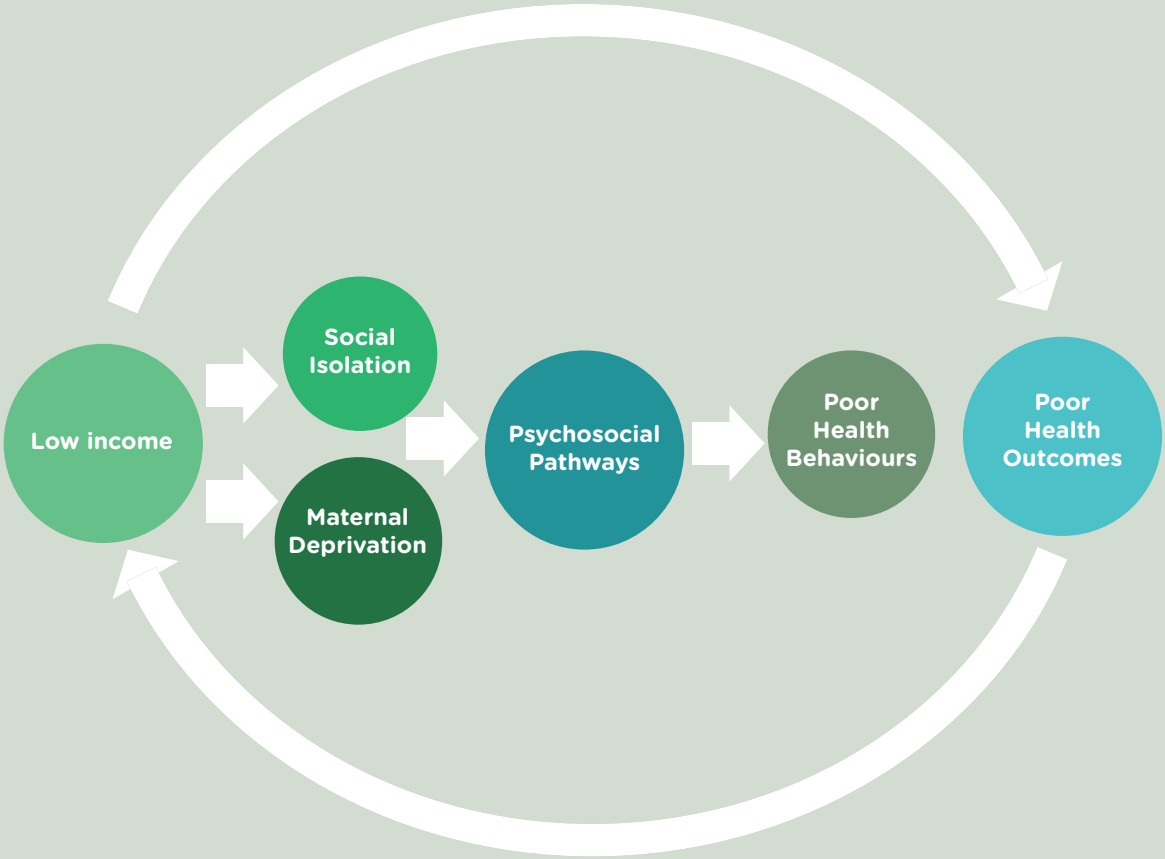
Low income and deprivation have been shown to impact on parental behaviour, child health and wellbeing, levels of social integration and crime rates.[6, 7] For example, women from low-income households are less likely than average to book and attend antenatal appointments and are more likely to smoke, consume alcohol and a have a poor diet, impacting on foetal development and increasing the likelihood of low birthweight.[8]

The relationship between income and health is non-linear, meaning that its impact on health is mediated through various mechanisms, including material deprivation preventing access to essential goods and services, psychosocial pathways mediated through feelings of stress and lack of control, depression and anxiety, and through increasing the risk of poor health behaviours such as excessive alcohol consumption and smoking. Low income can also prevent people from participating in social events and can leave people feeling less worthy or of a lower status than those who are better off.[9] Material deprivation can increase even when income levels stay the same if, for example, the cost of living increases.

Low income resulting in inadequate financial resources and debt is also linked to poorer physical health, including cardiovascular disease and all-cause mortality, with levels of harm mediated through several factors including age, gender, income, family structure and the type and size of debt.[10-12] Particular groups are more at risk of low income and these include people with mental health illness, people with disabilities, young people, carers and lone parents.[13-18] Other groups, such as Gypsy, Traveller and Roma groups and Bangladeshi communities, have low uptake of state benefits.[19]

Importantly, the relationship between low income and poor health is cyclical: low income can cause poor health, and poor health increases the likelihood of low income, as depicted in Figure 14 on page 59.

Figure 14. The cyclical nature of low income, deprivation and health



6.2 Social determinants of money and resources

In England there are gaps between a minimum income for healthy living (MIHL), including the income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene, and the level of state benefits received by a number of groups.[20] For people in work, high rents, low wages and cuts to working age benefits have resulted in 3.8 million working people now living with less than the minimum income for healthy living.[21] The number of people living in poverty in the private rental sector doubled in 10 years, from 2.2. million in 2004/5 to 4.5 million people in 2016.[21]

In the UK 3.7 million children live in poverty – that's over a quarter of all children, and 1.7 million of those are living in severe poverty. Over 63 per cent of the 3.7 million live in a household where someone works.[22]

Additionally, people on low income spend a larger proportion of their money on commodities that attract indirect taxes and pay a higher level of tax than those on higher incomes as a result. VAT is the largest component of indirect taxes and the proportion of disposable income that is spent on VAT is highest for the poorest fifth and lowest for the richest fifth.[23]

Payday loans are loans usually of small amounts of money, over a short term, with a high cost. Although fees and charges were capped in 2015 it is possible to pay up to 1,500 per cent annual percentage interest over a year, compared with an average of 18 per cent on a typical credit card. (Source: The Money Advice Service)

B2 gambling machines allow high stakes (up to £100) to be placed on a bet that takes 20 seconds to provide a result, enabling people to lose large amounts of money quickly

In addition to the broad health impacts of low income detailed above, there is a higher risk of gambling and debt. Areas of high deprivation can experience a proliferation of gambling and 'pay day' loan outlets, and this can have direct and indirect impacts on health.[24-29] People living in disadvantaged communities and in close proximity to areas with a high density of payday loan shops, are more likely to make use of their services. [25]

Betting shops also tend to cluster in some of the most deprived areas and the level of 'B2' gambling machines increased by 51 per cent between 2006 and 2011.[28] B2 gambling machines have a 'statistically significant' association with problem gambling.[29] Some groups are more vulnerable to gambling than others. These include young people, Asian and Black British communities, unemployed people, adult children of gamblers, smokers and those with poor self-rated health.[31]

The harm associated with gambling affects individuals, families and communities and includes:

- Financial harm
- Damage to family relationships (including intimate partner violence)
- Emotional and psychological distress
- Reduced performance at work or study
- Increased risk of criminal activity
- Feelings of lack of control around behaviour or circumstances
- Feelings of insecurity or lack of safety
- Feelings of shame and stigma

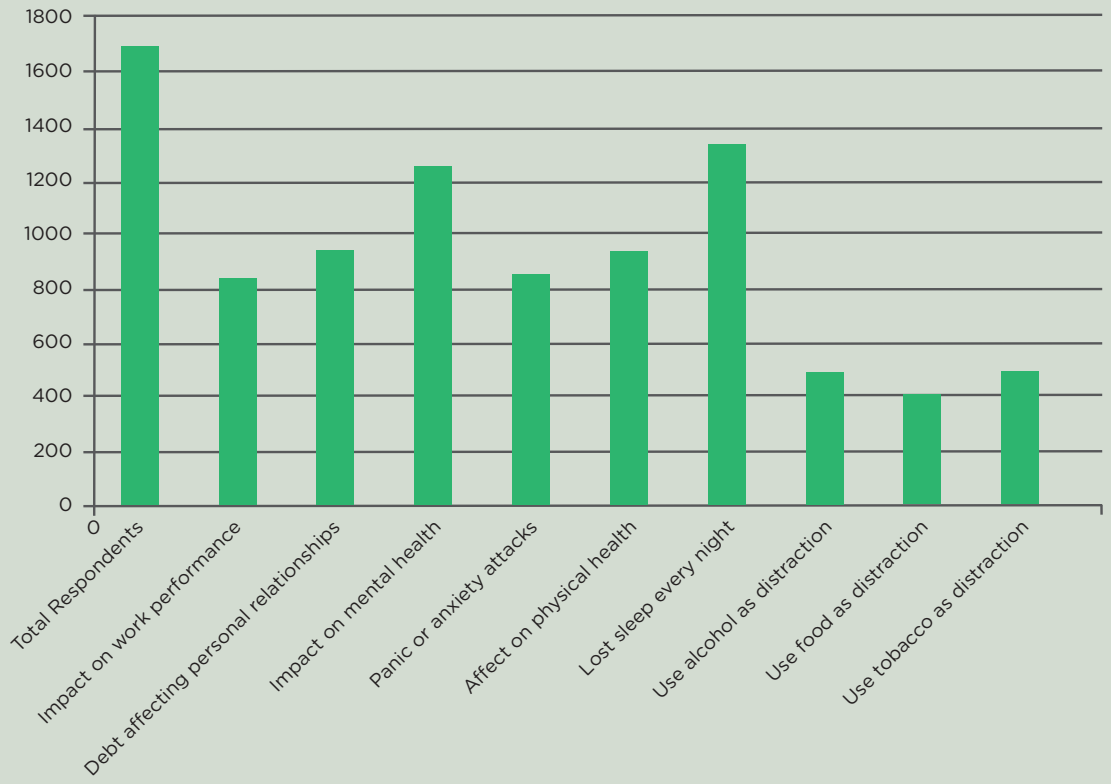
These issues can result in poor health behaviours including poor sleep practices, non-compliance with prescribed medication, more sedentary lifestyles, headaches from excessive screen time, increased blood pressure, diabetes and depression.[32, 33]

Debt

A quarter of UK households experiencing income deprivation are unable to pay at least one bill on time, including rent, mortgages or other loans.[34] A systematic review found that indebtedness may contribute to the development of mental health problems, and that this relationship appears to be bi-directional.[11]

Strong relationships have been found between debt and: depression; poor self-rated physical health, including obesity; suicide; and drug and alcohol abuse.[2] Financial difficulties, including personal debt, have been shown to independently predict an increased risk of depressive symptoms, including suicidal thoughts.[35] Qualitative research completed by Citizens Advice in 2012 confirms these findings, as shown in Figure 15 on page 61.

Figure 15. Impact of debt on health (adapted from figures based on qualitative research undertaken by Citizens Advice, 2012)



6.3 Example interventions – income and debt

Example: Citizens Advice [36]

Citizens Advice provides finance and benefits advice to people experiencing poverty and debt. 37 per cent of Citizens Advice's 2,030 regular outreach programmes take place in healthcare settings. In some areas there is comprehensive financial support delivered in these settings, but in other areas there is none. For example, more than half of Derbyshire Primary Care Trust's GP surgeries have regular Citizens Advice sessions and in 2008/9 it helped more than 2,050 clients to secure over £2 million in additional benefits. Derbyshire PCT estimates for every £1 invested, the project secured £6.50 in additional income.

Example: Macmillan Cancer Support [36]

Macmillan Cancer Support provides information to support people affected by cancer in the process of claiming the money they are entitled to, and so they can manage complex financial affairs. During periods following the diagnosis of a serious illness like cancer, income can become an unnecessary additional worry. A cancer diagnosis frequently results in a drop in income as jobs are lost and savings eroded. Ninety per cent of people affected by cancer in the UK experience a significant drop in income and an increase in daily living expenditure as a direct consequence of a diagnosis and financial concerns can be a significant source of additional stress.

Macmillan Cancer Support also provides other advice and support on a range of issues including employment rights, fuel poverty, prescription charges, hospital travel and insurance in addition to explaining how to access benefits to cover the extra costs experienced with a cancer diagnosis. Services are offered from over 60 benefits advisers in partnership with the NHS, local government, the Pension Service, Citizens Advice and other voluntary organisations across the UK.

For more information see www.macmillan.org.uk/HowWeCanHelp/FinancialSupport/BenefitsAdvisers/MacBenefitsAdvisers.aspx

6.4 Money and resources – further reading and resources

Reducing poverty in the UK: A collection of evidence reviews (2014), published by the Joseph Rowntree Foundation, provides evidence relating to the links between specific demographic and other individual, family and community characteristics and poverty. The review also examines evidence relating to links between poverty and wellbeing, and low levels of benefit take-up, and reviews interventions that are designed to tackle poverty.

Poverty, debt and credit: An expert-led review (2014), published by the Joseph Rowntree Foundation, provides an overview of the impact of problem debt and consumer debt on poverty, and the extent to which poverty results in problem debt and consumer credit use.

Income-related benefits: Estimates of take-up – financial year 2013/14, produced for the Department of Health, looks at the take-up of benefits in the UK, including pension credit, income support and jobseeker's allowance, and provides a summary of factors that may impact on take-up of benefits, including lack of awareness or lack of knowledge around eligibility.

Take-up of benefits and poverty: an evidence and policy review (2014) examines the non-take-up of income-related benefits and tax credits in the UK and how improvements to benefit uptake can contribute to reducing poverty. The report explores recent trends in the non-take-up of means-tested benefits and tax credits and the most significant factors associated with non-take-up. It also explores the impacts of take-up services and campaigns by government and intermediary organisations involved in the delivery of welfare rights and benefits information and advice, and how to support and encourage benefits take-up in new welfare landscapes.

What Works? A review of the evidence on financial capability interventions and older people in retirement (2016), by the International Longevity Centre, reviews the evidence in relation to what works for older people in terms of maximising their income, safeguarding them from fraud, financial planning, managing significant life events, and equity release schemes, and provision of access-to-money guidance tools and services online.

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7. HOUSING

Housing – key messages:

Good quality, secure homes are beneficial to their occupiers, the wider community and to society. They can reduce the risk of poor physical and mental health and mortality, reduce the number of trips and falls, reduce lost school days and improve educational attainment, and reduce visits to the GP and other health and social care services.

There are clear inequalities in exposure to poor housing. Approximately three in 10 people in England live in poor-quality housing. This includes 3.6 million children, 9.2 million working-age adults and 2 million pensioners.

Poor housing and homelessness pose significant risks to health, including poor mental health, respiratory disease, long-term health and disability and the delayed physical and cognitive development of children.

Cold housing is particularly damaging for health and caused an estimated 20 per cent of the 24,300 extra winter deaths that happen during the cold winter months in 2015/16.

Poor-quality housing such as damp, cold, overcrowded, insecure and short-term tenure housing, is damaging for physical and mental health. Most of the poor-quality housing in England is in the private rental sector.

Emerging evidence shows that exposure to multiple poor housing conditions is particularly damaging, comparable to the health risks posed by smoking, and greater than the health risk posed by excessive alcohol consumption.

Strength of evidence: strong

A report published by the Institute of Health Equity in 2011 examined the direct and indirect impacts of cold homes and fuel poverty on health. The report reviewed the latest evidence (77 papers identified for in-depth analysis) and found that:

- There is a strong relationship between cold temperatures and cardiovascular and respiratory disease.
- Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in adequately warm homes.
- There is a relationship between the number of excess winter deaths, low thermal efficiency of housing and low indoor temperature.
- The number of excess winter deaths is almost three times higher in the coldest quarter of housing than in the warmest quarter.[1]

A wide range of evidence has found strong associations between substandard housing and mental health, socio-emotional development, psychological distress, behavioural problems, and educational outcomes of children and young people. [2-7] Some evidence also suggests a greater impact on women and older people than on men and younger people.[8, 9]

7.1 Housing and health

'Decent homes' have been recognised as being beneficial to their occupiers, to the wider community and to society. Good-quality housing can reduce levels of physical injury associated with trips and falls, levels of depression associated with burglary, the amount of lost school days and visits to GPs, and the likelihood of developing circulatory conditions.[10]

7.2 Poor-quality housing and health

Poor housing conditions include issues such as damp and general poor physical conditions, overcrowding, insecure and short-term-tenure housing, homelessness, and temporary accommodation. Poor-quality housing poses significant risks to health and can increase the risk of contracting meningitis and TB, the transmission of infectious diseases, respiratory problems, long-term ill health, disability, and delayed physical growth and cognitive development in children.[11]

Emerging evidence shows that exposure to multiple poor housing conditions is particularly damaging.[12] comparable to the health risks posed by smoking and greater than the health risk posed by excessive alcohol consumption.[6] The longer the exposure to poor conditions, the greater the impact on mental and physical health.[13]

Mental health is also affected by poor-quality housing. It is estimated that 19 per cent of adults living in non-decent homes have poor mental health, including anxiety and depression.[9, 14, 15] Aspects of housing such as condensation, damp and mould, noise and pests, living in flats, draughts and the age of homes have all been shown to be connected to poor mental health.[16]

7.3 Cold housing and physical health

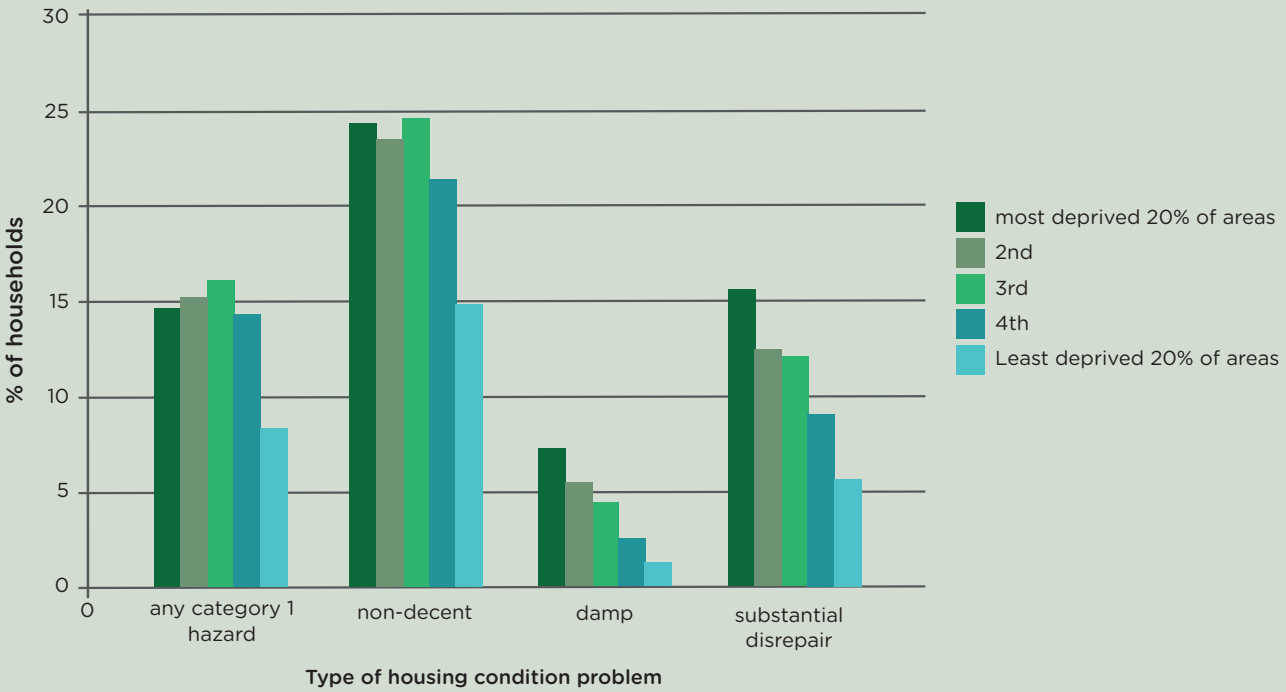
Cold housing in particular poses a significant risk to health, including contributing to the excess winter deaths that are experienced each year in the UK. 24,300 excess winter deaths were recorded for 2015/16 of which an estimated 6,000 deaths were the result of living in cold homes.[17] Indoor temperature is influenced by the energy efficiency of the home; in 2015 only 28 per cent of dwellings in England had an energy efficiency rating of A-C, with A being the most efficient.[18] This not only has a direct impact on physical and mental health, but also adversely influences health through impact on the environment and climate change.[19]

7.4 Inequalities in exposure to poor-quality housing

There are clear inequalities in exposure to poor housing. Approximately three in 10 people in England live in poor-quality housing – either non-decent or overcrowded. This includes 3.6 million children, 9.2 million working-age adults and 2 million pensioners.[9]

A higher proportion of the privately rented sector is in a poor condition than any other: 30 per cent of homes in the private rented sector failed to meet the decent homes standard in 2013. This is in comparison to 19 per cent of owner-occupied homes and 15 per cent in the social rented sector.[20] There is also evidence of worse energy efficiency, condensation, damp and mould in the private rented sector compared with the owner-occupied and socially-rented sectors.[20-22] In the most deprived areas 26 per cent of houses fail to meet the decent homes standard, compared with 17 per cent in the most affluent areas.[23] Figure 16 below demonstrates the increased risk of poor housing conditions for those living in deprived areas.

Figure 16. Housing condition problems by level of area deprivation, 2010



Source: [24]

Unsurprisingly, residents living in poverty are more likely than others to be exposed to poor housing conditions, particularly if they live in the private rented sector.[24-26] Poor residents may also have a lower likelihood of reporting a problem to a private sector landlord, due to fears of retaliatory eviction.[21]

Inequalities are also evident according to ethnicity – black and minority ethnic households are more likely to experience overcrowding and damp, for example, than the white majority.[9, 24, 27]

7.5 Housing – interventions

Case study: Islington – Seasonal Health Interventions Network (SHINE), 2010 – present[28]

In Islington, around 20 per cent of people living in private housing are unable to heat their homes adequately; within the private rented sector that rises to 31 per cent. The SHINE programme provides a single point of contact for referrals from frontline workers such as housing officers, children's services, local charities and health professionals. Once people are referred, they are offered a package of interventions in order to improve energy efficiency within the home and reduce fuel poverty. Interventions include free home visits, installation of energy-saving measures, benefits checks, financial advice, befriending services to combat social isolation and fire safety checks.

SHINE targets vulnerable households, 8,200 of which have been referred to date.

Citizens Advice – housing advice services[29]

In total 4.9 million homes in England failed to meet the Government's minimum decent home standard. Of those, the highest proportion are in the private rented sector, which constitute a third of total non-decent homes.30 Citizens Advice provides independent and confidential advice on housing. In 2013–14, 275,000 clients were provided with housing advice, 422,000 housing problems were dealt with, and the organisation's housing webpages received 2.6 million views. The services are free and offered either in person, or over the phone/online. The advice provided by Citizens Advice covers a broad range of housing topics, from buying and selling a home to helping clients understand their rights and responsibilities as tenants of both private and social housing. The advice helps to prevent homelessness, resolve disputes, secure accommodation and recover deposits and repair costs. Over 80,000 people with private rental problems went to Citizens Advice in 2016 and research and evaluations of its housing advice service shows that two-thirds of clients resolve their housing issues within three months of contacting the service. This outcome has an estimated worth of £750 million annually to society.

7.6 Housing – further reading and resources

There are a number of papers covering evidence reviews, recommendations for stabilising the private rental sector, and specific interventions for improving housing for older people.

The health impacts of cold homes and fuel poverty (2011), a review published by the Institute of Health Equity on behalf of Friends of the Earth, provides evidence of the direct and indirect health impacts of cold homes and fuel poverty, and the communities and individuals that are disproportionately affected. It also provides various case studies and example interventions that take action on fuel poverty and cold homes.

A better deal. Towards more stable private renting (2012), by Shelter, sets out the case for change in the private rental sector and practical recommendations to improve landlords' returns and give renters the chance of a real home.

Housing, prevention and early intervention at work: a summary of the evidence base (2011), a short overview from the Housing Learning and Improvement Network, provides evidence for the health and economic benefits of housing interventions to improve the safety and conditions of homes.

Housing and public health: a review of reviews of interventions for improving health. Evidence briefing (2011), by NICE, is aimed at policy- and decision-makers, housing officials and public health professionals and provides a systematic review, syntheses and meta-analyses of evidence relating to public health housing interventions. It includes cost-effectiveness data for housing-related interventions to promote health.

Living well in old age. The value of UK housing interventions in supporting mental health and wellbeing in later life (2016), a literature review by King's College London, examines what is known about UK housing interventions aimed at promoting mental health and wellbeing among older people. The paper identifies and evaluates such interventions in UK housing associations and explores issues of integration and how health, housing and social care agencies work together to support older people's mental health and independence at home. It also outlines some of the barriers to effective collaboration, and strategies to address barriers.

Off the radar: Housing disrepair and health impact in later life (2016), by Care and Repair England, provides information on the scale of poor housing conditions among older people in the UK, and the impact that poor housing conditions have on health and wellbeing. It sets out the scale of action needed to address housing disrepair for older households, and the benefits of taking action.

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8. OUR SURROUNDINGS

Our surroundings – key messages:

Our surroundings operate through a number of pathways and impact on health. Economic, geographical and social factors influence these pathways and the health outcomes of local populations.

Health-promoting surroundings are important for retaining people, place attachment, encouraging community engagement, and for thriving communities with improved health outcomes.

People who have inadequate economic resources are more likely to live in areas that have health-damaging characteristics. This can include poor-quality housing, obesogenic environments (encouraging people to eat unhealthily and do insufficient exercise), lack of good quality green and natural spaces, poor air quality and affordable transport availability, high levels of crime, or fear of crime and certain areas, and a lack of recreational and community facilities and opportunities for community participation. However, multiple interventions can be used to encourage good place-making and place attachment that promotes improved health outcomes, including:

Green infrastructure: Good quality green infrastructure (including parks, gardens and street planting) increases the likelihood of physical exercise, lowers the risk of obesity, and offers a restorative environment for mental fatigue. It can also create a sense of place and civic pride, and be used for social activities that promote social cohesion. It also combats climate change, which has associated health impacts.

Walkability and cycle-ability: Streets that are safe and easy to navigate increase the likelihood of using environmentally sustainable modes of transport, such as walking and cycling. This can also promote the spontaneous social interaction needed for social cohesion and improved mental health.

Community safety: Crime and fear of crime have direct and indirect impacts on health and can limit social behaviour and physical activity.

Feelings of safety are critical for community wellbeing and economic vibrancy. 'Crime prevention through environmental design' is an intervention that uses a number of approaches to reduce crime and fear of crime and focuses on territoriality, encouraging ownership and community cohesion and improving the physical fabric of communities, encouraging natural surveillance.

There is consistent and strong evidence demonstrating that the maintenance and upkeep of local areas decreases crime and the fear of crime (the broken window theory). Neglected spaces that have been repurposed have been shown to improve perceptions of safety and create economic and job opportunities.

Food outlets: Areas of high deprivation can experience a proliferation of fast food outlets, and this can have direct and indirect impacts on health.

'Food deserts' areas that have little access to healthy food, increase the risk of food poverty, obesity and malnutrition, in turn increasing the risk of cancer, diabetes and coronary heart disease.

Initiatives that promote independent food and other retail outlets, featuring locally-sourced food for example, and that limit the number of fast food, payday lender and gambling outlets, will support the local economy and promote improved health outcomes.

Accessible, affordable and sustainable public transport: This type of transport can provide access to education, employment and essential goods and services, including health and social care. Transport systems, including well maintained roads and pavements, encourage active travel and help reduce pollution and climate change.

Strength of evidence: strong

There is a wide range of evidence that demonstrates how our surroundings impact on health, including mortality, general health status, disability, birth outcomes, chronic conditions, health behaviours and other risk factors for chronic disease, as well as other indicators for health, including mental health, injuries, and violence.[1-5]

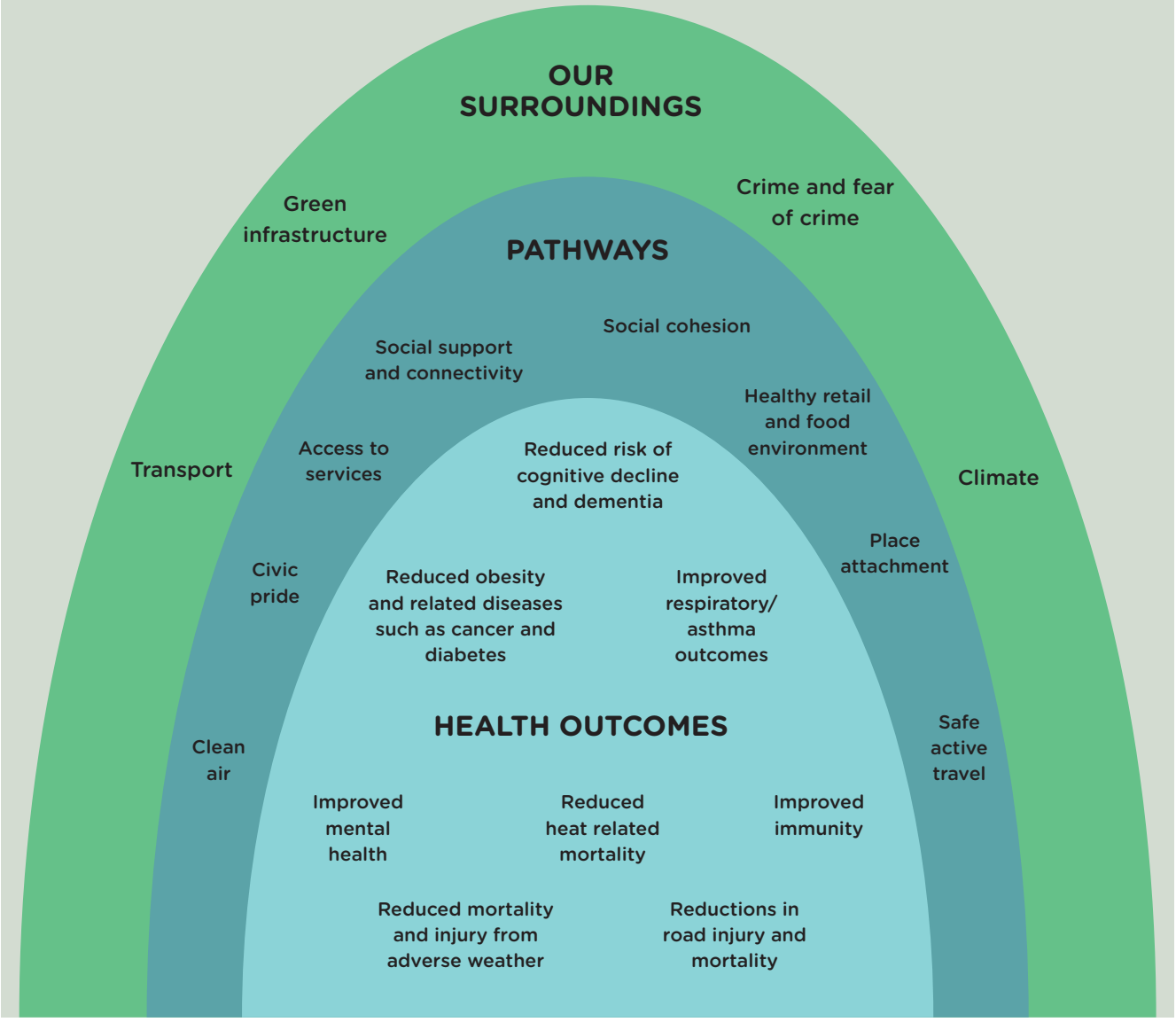
8.1 Our surroundings and health

Our surroundings are important for our health and operate through a number of pathways that have direct and indirect impacts. Factors such as adequate levels of green infrastructure, the local climate, levels of crime and fear of crime, and access to services and community resources all influence the health outcomes of local populations.

Local neighbourhood surroundings also influence the ability of local populations to develop a unique sense of place. Successful place-making is important for communities to thrive and can promote and maintain levels of place attachment, which is important for retaining people in a place and encouraging community engagement and participation,[6] particularly in areas of deprivation, and it is especially important for improving health outcomes, as shown in Figure 17 below.

Place attachment: The emotional or affective bonds that an individual feels to an area or place

Figure 17. Our surroundings and pathways to health



8.2 Green infrastructure and health

Green infrastructure helps to 'offset' the health impacts of income deprivation and decreases the risk of heat island effects (where the air temperature in urban areas is higher than in surrounding suburban and rural areas), intense microclimates and high concentrations of air pollution. Air pollution is damaging to health, contributing to cardio-respiratory mortality and morbidity[7, 8] being linked to diseases such as cancer, childhood and adult asthma, heart disease, obesity and diabetes[9] and an increased risk of dementia.[10]

Green infrastructure: Parks, gardens and street planting, green corridors including canals, river banks and cycle ways, and natural and semi-natural urban green spaces.

Communities living in the greenest environments have been shown to have the lowest health inequality related to income deprivation.[11-15] Green infrastructure is linked to multiple improved health outcomes including lower levels of obesity[16] and improved immunity in children, reducing the risk of premature mortality, and reducing the risk of and helping to manage long-term conditions including hypertension, asthma and coronary heart disease.[15, 17-20]

Proximity to green space can also offer a restorative environment to those who live or work in highly stressful or stimulating environments.[21] It offers opportunities for coping with stress, reducing hospital admissions for mental health conditions,[22, 23] and lowering blood pressure.[24-26]

Importantly, green infrastructure encourages active travel and civic pride, as environments become more attractive and less polluted. This encourages social interaction and cohesion, and reduces antisocial behaviour and other crime.[27]

Green open space also provides a platform for community activities, recreation and physical activity, reducing the risk of social isolation and loneliness and increasing social capital. Higher levels of social capital, including community volunteering, community trust and local safety, have been linked to improved health outcomes, including reducing the risk of dementia and cognitive decline[28-33]

8.3 Transport systems

Local transport systems are both significant determinants of health and also influencers of a number of other important determinants.

Walkability and cycle-ability

Levels of physical activity are influenced by the walkability and cycle-ability of the local environment. Improving the walkability or cycle-ability of roads and footpaths can reduce the risk of obesity and overweight, and cardiovascular and respiratory disease, and can strengthen bones, increase mental alertness and creativity. [27-29]

Improving the walkability of roads and pavements can also impact on health indirectly, as it increases opportunities for social interactions and improved mental health, as pedestrians tend to congregate in areas that have positive walking environments.[34-40]

Conversely, street environments with multiple barriers, including a lack of disabled access built into street design, street clutter, busy roads without safe crossing points, and poorly maintained pavements, make travel difficult and dangerous. In 2000 the Department for Transport highlighted that some UK highstreets are not safe for pedestrians.[34, 35] This is particularly true for older people, parents and children, carers and people with disabilities including wheelchair users and people who are blind or partially sighted.[36-39]

Traffic and pollution

With the prioritisation of motorised transport and car ownership over pedestrians, many roads are having a direct negative impact on health. Emissions from large numbers of cars add to a significant air quality problem.[40] Diesel car emissions are particularly harmful, and have been placed in the strongest class of carcinogenic groups, Group 1, the same class as tobacco. More than 40 per cent of new car sales in the UK are of diesel vehicles, and there are around 12 million diesel cars on UK roads.[41]

Access to employment, goods and services

Transport systems also impact on health through providing access to other determinants of health, such as employment, education, social and healthcare services. Accessible, affordable and sustainable transport systems can ensure that local populations, and particularly those who do not own a car and are vulnerable to social exclusion, can participate in cultural, social and leisure activities, and have access to essential goods, services, education and employment opportunities, all of which are important for improving health outcomes.

Inequalities in access to safe and sustainable transport systems

There are inequalities in access to safe, affordable and adequate transport systems. The social gradient in the risk of road casualties is a clear illustration of this.[12] Rates of fatal and serious injuries on the road involving children and young people are nine times higher for 5- to 9-year-olds and 3.7 times higher for 10- to 14-year-olds living in the 20 per cent most deprived areas. There are also inequalities in injuries and fatalities among cyclists and 10- to 14-year-olds. Ten out of every 100,000 cyclists killed or seriously injured come from the 20 per cent most deprived areas, compared with four out of 100,000 in the least deprived.[42] Inequalities also exist depending on the employment status of parents,[43] and family ethnicity.[44, 45]

Additionally, research demonstrates that the poorest and most disadvantaged communities experience transport disadvantage disproportionately.[46] This can contribute to and compound social exclusion. Issues such as poorly designed, non-inclusive public transport, remote or peripheral areas that are not serviced by public transport, the high cost of public transport, and fears for personal safety all exclude specific groups from using public transport and from essential goods and services.[46]

8.4 Climate change

Climate change represents a significant risk to health and wellbeing[47] and is predicted to increase the number of deaths, disability and injury resulting from extreme weather, floods and storms.[48, 49] Heat-related mortality is expected to increase steeply in the UK, from around a 70 per cent increase in the 2020s to around a 540 per cent increase in the 2080s, in the absence of any physiological or behavioural adaptation.[50] The increase in surface ozone levels is expected to result in an additional 1,500 deaths per year, and an increase in skin cancer and cataracts.[51, 52]

People who are already vulnerable due to the quality of their local environments, their homes, or their level of income are more likely to be vulnerable to the adverse impacts of climate change and its causes,[53-55] as they have fewer resources with which to prepare, respond or recover from adverse climatic conditions.[56]

8.5 Unhealthy retail environments

Areas of high deprivation can experience a proliferation of fast food outlets, and this can have direct and indirect impacts on health.[57-61]

Fast food restaurants that serve food high in fat and salt cluster in areas of deprivation.[60] 'Food deserts', where there is a lack of available healthy produce, impact disproportionately on low income, older or less mobile customers, increasing the risk of obesity and malnutrition.[15, 62,12,63] Food poverty, the lack of accessible healthy food can increase the prevalence of dental caries in children, the risks of trips and falls in older people, the risks and incidence of low birthweight, and childhood morbidity and mortality.[63] Over 2 million people in the UK are estimated to be malnourished, and 3 million are at risk of becoming malnourished.[64]

Malnutrition: A serious condition that occurs when a diet does not contain the right amount of nutrients; includes undernutrition, and overnutrition.

8.6 Crime and fear of crime

Crime, and fear of crime, negatively affects levels of footfall in local community spaces, the experience of visitors once they get there, and the likelihood of return visits. This reduces levels of physical activity, community cohesion and social interaction. For example, crime and fear of crime on local highstreets can lead to withdrawal from streets, contributing to highstreet degradation and increasing the number of vacant properties. These factors are known to increase the risk of antisocial behaviour and more serious crime.[65, 66] Therefore, feelings of safety are critical for community wellbeing, and for the economic vibrancy of local communities.[67]

Broken window theory: Degradation of the physical fabric of communities leads to people's withdrawal from streets, increasing their fear of crime, and increasing the opportunities for crime.

Crime and fear of crime have direct and indirect impacts on health outcomes. Direct impacts include mortality, lasting physical injury and disability, psychological distress and post-traumatic stress disorder, depression, anxiety, suicidal ideation and attempts, substance misuse, difficulties sleeping, and limited social behaviour and physical activity.[68, 69]

Neighbourhood crime also affects health through psychosocial pathways including increasing the risks of all-cause mortality,[70] coronary heart disease,[71] pre-term birth and low birth weight,[72] and reduced physical activity. There is clear evidence that this particularly impacts on black and minority ethnic communities, young people, older people and women.[73-77]

'Crime prevention through environmental design' (CPED) is an approach that has been proven to reduce levels of crime and fear of crime. It uses interventions such as improving a sense of ownership (territoriality) in local communities, through care and maintenance of the physical area, improving natural surveillance (eyes on the street) through glazing and well maintained green infrastructure, and through adequate lighting.[78-82]

8.7 Inequalities in access to good quality environments

People who have inadequate economic resources are more likely to live in areas that have health-damaging characteristics. This includes environments that have conditions that tend to make people obese (obesogenic environments), including inadequate access to quality green space, few places for children to play and be physically active, unhealthy food environments, inadequate walkable and accessible public spaces with poor public transport access, and a proliferation of major roads with poor road crossings. Other conditions such as poor air quality, high levels of crime and fear of crime, and high risk of road traffic injury all have direct impacts on health and are all more likely to occur in urban areas with high levels of deprivation than in other areas. Figure 18 below demonstrates some of the inequalities experienced in areas of deprivation:

Figure 18. Inequalities in access to health-promoting environments

8.8 Our surroundings – interventions

Example: Bristol Independents campaign .[83]

Bristol has around 180 specialist independent food shops that are owned by 140 businesses. Around 10 out of 35 of Bristol's wards have no greengrocer, and half of wards have no independent food retailers. In recent years many of the specialist small independent shops have disappeared.

In 2011, the Bristol Food Network, Bristol Food Policy Council, Bristol Green Capital and Destination Bristol launched a campaign highlighting the history of independent and diverse high street and shopping centres. This campaign built on initiatives developed by the Food Policy Council and acted on recommendations of the Who Feeds Bristol report, commissioned by Bristol Green Capital, NHS Bristol and Bristol City Council. A clear recommendation of the report was to safeguard the diversity of food retail in the city. A pilot project was launched in eight local shopping centres including recipe cards that could be purchased in local independent shops.

Businesses joining the campaign are locally owned and operated, are run from the individual shop, stall or farm and not from a centralised head office and must demonstrate that products are sourced locally[83]

Example: Tree Carers and Tree Champions, Hackney [84-87]

During November 2007 and March 2008 over 500 trees were planted across 28 roads in the London borough of Hackney.84 Embedded in the street tree planting programme were initiatives to encourage local communities to collaborate in the selection, management and care of street trees once planted. Programme aims also included reducing air pollution, transforming harsh urban landscapes (over 50 per cent of streets in Hackney had no trees), and increasing the biodiversity of the area through creating green chains for wildlife, habitats and food sources.

Tree Champions were recruited who engaged local residents. Turkish community members who became involved in the scheme opted to plant almond trees due to their 'long cultural and emotional connection with Turkey'.85 Tree Champions and Carers were encouraged to care for the trees after planting. In some areas it was found that additional planting was initiated by local residents in the newly available planted tree sites, and to date there has been minimal loss (less than 1 per cent) of trees due to damage and disease.[86 87]

8.9 Our surroundings – further reading and resources

Physical activity for children and young people (2009), published by NICE, offers guidance on promoting physical activity for children and young people under the age of 18. It includes awareness raising, listening to the views of children and young people and helping families to build physical exercise into their daily activities, and planning and providing spaces and facilities. The guidance is aimed at a range of statutory and non-statutory organisations and providers, including the voluntary and community sector.

Promoting and creating built or natural environments that encourage and support physical activity (2008), published by NICE, provides evidence-based recommendations on how to improve the physical environment to encourage and support greater levels of physical activity.

Design for Play (2008), developed by Play England, provides guidance around the design and implementation of play areas in both urban and rural settings.

Small area and individual level predictors of physical activity in urban communities: A multi-level study in Stoke on Trent, England (2009), by Cochrane et al., examines the links between individual and environmental characteristics and levels of physical activity in deprived urban areas. The study demonstrates that factors such as access to shops and green space, work, and fast food outlets, plus traffic, criminal damage, age and gender, impacted on levels of physical activity.

Crime prevention through environmental design (CPTED): A review and modern bibliography (2005), by Cozens et al., critically reviews the core findings from place-based crime prevention research. The paper found that there is a growing body of research that supports the premise that crime prevention through environmental design is effective in reducing crime and fear of crime in local neighbourhoods.

National Institute for Health and Care Excellence Review 4: Community engagement – approaches to improve health: map of the literature on current and emerging community engagement policy and practice in the UK (2015), published by Leeds Beckett University, provides a mapping review of the current evidence base for UK local and national policy and practice for community engagement and identifies current and emerging community engagement policy and practice in the UK.

At the heart of health. Realising the value of people and communities (2015), published by the Realising the Value programme, examines the value of people and communities in terms of health promotion and consolidates the evidence regarding a wide range of person- and community-centred approaches for health and wellbeing. It provides an overview of the existing evidence base with a particular focus on the potential benefits of adopting person- and community-centred approaches.

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9. THE ROLE OF THE VOLUNTARY SECTOR

There is a wide range of evidence available that demonstrates the significant and life course impact of social determinants on the health outcomes of individuals and local populations. In 2016, for men, there was a 7.4 year difference in life expectancy, and a 16.5 year difference in healthy life expectancy, between the least and most well off communities in the UK. It is clear that health inequalities, and their social determinants, result in significantly shorter lives for those individuals and communities lower down the social gradient. However, most of these health inequalities are avoidable through action on the social determinants of health and this means that the differences found in the life expectancy and healthy life expectancy between individuals and communities is unfair and unjust.

Charities are often well situated to influence social determinants, because of the kind of services they deliver and proximity to the communities they engage with. Excluded communities that have a history of non-engagement with statutory or main stream services and that often have poor health outcomes may choose to access charities.

Additionally, national policies will enhance their effectiveness in health improvement with local delivery systems that are focused on health equity and can work effectively within communities. Charities are well placed to support this work.

However, there are barriers to prioritising and developing further action on the social determinants of health. The health and care system does not always acknowledge or act on the social determinants of health. Neither does it always identify the scope of action taken by the charitable sector, or its impact on health outcomes. This can create obstacles to effective collaborative approaches that can ensure that the proportionate universal action needed to address health inequalities is realised. Action is needed across the social gradient, but with a greater intensity for those in greater need. Again, charities are well placed to support this work. Charities can take action on the social determinants of health by:

- Raising awareness that their work on the social determinants of health influences health outcomes
- Shaping their strategies and service design based on evidence on the social determinants of health and appropriate interventions
- Highlighting and prioritising the social determinants relevant to their local communities
- Activating communities and taking an asset based approach to health
- Influencing policy, leveraging a more diverse range of funding, and taking practical steps to address the social determinants of health
- contributing to the body of evidence by identifying and measuring their own impact on health, if appropriate.

The voluntary sector represents a strong and effective partner in preventing ill health and promoting stronger, healthier communities. There are clear system levers that can be utilised by the voluntary sector to highlight the need for action on the social determinants of health, to approach potential new partners, and to work collaboratively across sectors.

9.1 The NHS 5 Year Forward View

The NHS Five Year Forward View, published in October 2014, sets out the vision for the future of the NHS and identifies three major inequalities; the health and wellbeing gap, the care and quality gap and the funding and efficiency gap. Importantly, it encourages a focus on prevention and wellbeing and highlights the role of the voluntary sector in delivering services that promote wellbeing.

9.2 The General practice forward view (2016)

The General practice forward view (2016) also encourages stronger partnerships with the voluntary sector and emphasises the role of the voluntary sector in supporting the work of general practice. Social prescribing is identified as an effective method of accessing practical, community based support for patients in a number of areas including employment, housing and debt.

9.3 The Health and Social Care Act 2012

Section 14z5 of the NHS Act 2006, amended by the Health and Social Care Act 2012, gives Clinical Commissioning Groups (CCGs) the power to use grant funding to support VCS activities at national, regional and local levels. This enables CCGs to award grants to voluntary organisations providing a range of services which are similar to the functions of the CCG. This can include initiatives to address social isolation or unemployment for example. [1]
The Health and Social Care Act 2012 also introduced the first legal duties on health inequalities for NHS England, CCG's and the Secretary of State for Health. This means that health inequalities must be taken into account when making decisions or exercising functions.

9.4 The Equality Act, 2010

As part of the Equality Act, 2010, the public sector Equality Duty came into force across Great Britain on 5 April 2011. It requires public bodies to consider all individuals when carrying out their day-to-day work. This includes in shaping policy, delivering services and in relations to the people they employ. In line with the Equality Duty, public authorities must have 'due regard' to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share protected characteristics and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Protected characteristics covered by the Act include individuals and groups that can be more at risk of experiencing health inequalities due to having one or, more often, multiple protected characteristics. The characteristics covered by the act include:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex and
- sexual orientation

The Equality Act 2010, and the Public Sector Equality Duty will enable the voluntary sector to focus on the needs and health inequalities experienced by specific groups and will inform the planning of services, including engaging with different groups and providing tailored, more accessible services.

9.5 The Social Value Act, 2013.

The Social Value Act came into force in January 2013. The legislation requires all public sector commissioners to consider how they could improve the economic, environmental and social wellbeing of their population through their procurement activities. [2] As such, it presents an opportunity to use local and national commissioning to address the social determinants of health and reduce health inequalities.

One of the main aims of including social value in commissioning is to achieve increased value from public spending, including wider public benefits as a result of who receives the contract, how they deliver it and the impact the contract has on local communities. Improving the environmental, social and economic wellbeing of local communities is central to adding value to expenditure. [2]

A key aspect of the Social Value Act is that it encourages larger, national statutory and other voluntary sector organisations to seek out and engage with smaller, local voluntary organisations with a view to creating both financial and strategic partnerships.
It also provides smaller, local organisations with a clear lever to apply for funds and hold larger national bodies to account if smaller organisations are not facilitated to tender within large contracts. Smaller voluntary sector organisations often have a greater understanding and connection to local communities and also tend to have a social purpose as their central principle, making them well placed to improve the social circumstances of local communities and deliver social value. [2]

Social Enterprise UK provides the following examples of procurement activities that include social value:

- "a mental health service delivered by an organisation that actively employs people with a history of mental health problems to help deliver the service
- a housing association contracts a private sector company to undertake repair work, and the company states they will promote careers in construction and trade to local schools, and employ young people and long-term unemployed
- an NHS trust commissions a patient group to run a series of consultation events, and the group uses its profits to increase beneficial activities in the local area"

The World Health Organisation released a 2010 Statement on HiAP (Health In All Policies). HiAP and HEiAP (Health Equality in All Policies) have clear synergies with social value approaches, and those seeking to integrate health considerations into their policymaking could usefully use social value approaches and vice versa.

9.6 The role of the voluntary sector – further reading and resources

'The social determinants of health: Developing an evidence base for political action Final Report to World Health Organization Commission on the Social Determinants of Health' This report provides theory, principles and good practice guidance on monitoring and evaluating actions on the social determinants of health, and influencing local and national policy for action on health inequity. Found here: ***http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf?ua=1***

Public Health England's Public Health Outcomes Framework web page, listing data on the differences in healthy life expectancy and life expectancy between communities, and indicators for tracking the progress on action to improve the social determinants of health. Found here: ***http://www.phoutcomes.info/public-health-outcomesframework#page/0/gid/1000041/pat/6/par/E12000008/ati/102/are/E06000036***

'Health inequalities and population health': a publication by NICE summarising recommendations for local authorities and partner organisation on population and health and health inequalities. Found here: ***https://www.nice.org.uk/advice/lgb4/chapter/introduction***

An Equal Start, published by the UCL Institute of Health Equity, identifies the most important outcomes Children's Centres should be aiming for to ensure positive early years experiences. Found here: ***http://www.instituteofhealthequity.org/projects/an-equal-start-improving-outcomes-in-childrens-centres***

In 'Measuring what matters. A guide for children's centres', the UCL Institute of Health Equity proposes a set of measures to be used in evaluating children's outcomes. Found here: ***http://www.instituteofhealthequity.org/projects/measuring-what-matters-a-guide-for-childrens-centres***

The Marmot Review, 2010, Fair Society, Healthy Lives, includes sections on identifying outcomes, indicators and targets to address the social determinants of health, and the social gradient in health. Found here: ***http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review***

The IHE and PHE publication 'Understanding the economics of investments in the social determinants of health' gives examples of the cost, cost–benefit and social return on investment calculations for a range of programmes that act on the social determinants of health.

'Practical guide to engaging with clinical commissioning groups' is aimed at helping voluntary sector organisations to engage with CCGs and provides an overview of CCGs and practical tips to help voluntary organisations engage with and influence CCGs. Found here: ***http://www.compactvoice.org.uk/sites/default/files/engaging_with_clinical_commissioning_groups.pdf***

The Social Value Hub is a free resource hosted by Social Enterprise UK. It collaborates with NCVO, National Housing Federation, NHS Confederation, and NAVCA and provides links, statistics, articles, case studies, presentations, reports, guides, tweets and videos on social value in the UK. [3]

Social Enterprise West Midlands (SEWM) has a social value section on its website and provides news, case studies, resources (toolkits, impact, guides, procurement, business charters, social investment and social accounts) and information on champions.[4]

NAVCA (National Association for Voluntary and Community Action) devotes a section of its website to social value, which includes information about the Social Value Act, champions and e-network, blogs and articles, and a selection of frameworks, strategies and toolkits. The Local Government Association has done a range of work in this area, including providing links to further documentation on social value and how to measure it. [5]

The role of the voluntary sector – references

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3. Social Enterprise UK. Social Value Hub. Secondary Social Value Hub. . 2014; Available from: http://www.socialvaluehub.org.uk/.
4. Social Enterprise West Midlands. Social Value Champions. Secondary Social Value Champions. 2014; Available from: http://www.socialenterprisewm.org.uk/social-value/social-enterprise-west-midlands-social-value-champions/.
5. NAVCA. Social Value. Secondary Social Value. 2014; Available from: http://www.navca.org.uk/socialvalue.

APPENDIX 1 – A DISCUSSION OF TERMS

Area of deprivation

The English Indices of Deprivation 2015 are based on 37 separate indicators, organised across seven distinct domains of deprivation which are calculated for each area to produce the Index of Multiple Deprivation (IMD). The seven domains include:

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

For more information on the English Indices of Deprivation, including maps detailing areas of deprivation in the UK, visit: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf

Discrimination

Under the Equality Act 2010 everyone in Britain is protected from unlawful behaviour that discriminates, harasses or victimises someone because of their protected characteristic, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation. Direct discrimination means treating someone less fairly or favourably because of their protected characteristic, for example, not interviewing someone for a job because of their race. Direct discrimination by perception means treating someone less fairly or favourably because of a belief that they have a specific characteristic, for example, not providing services for someone because of a belief that they are gay. Indirect discrimination means implementing rules or policies or ways of doing things that have a disproportionately adverse impact on someone with a protected characteristic, if it cannot be objectively justified. Importantly, proposals to introduce legal requirements into the 2010 Act that could have forced companies to consider how they would reduce inequalities caused by class disadvantage were scrapped, and so while the 2010 Act can be used to challenge discrimination against the named characteristics, it cannot be used to challenge policies or practices that discriminate against people who are lower down the socioeconomic scale.[1]

Poverty

There are a number of definitions of poverty. Professor Peter Townsend has described it as when someone's 'resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities'.[2]

In the UK different definitions are given for relative and absolute poverty. Relative income poverty is measured by comparing income adjusted for family size to the median income in the UK. Households with less than 60 per cent of the median income are considered to be living in poverty. Absolute poverty is a term used to describe poverty that does not change over time and refers to a basic level of goods and services needed to achieve a minimum acceptable standard of living.

Low income is just one indicator of poverty. The Joseph Rowntree Foundation proposes a wider definition that is not based simply on income but also includes access to decent housing, community amenities, and social networks and assets, or what people own.3

Social class

Social classes are assigned according to the kind of work people do. Social classes were introduced in 1913 and are currently described as follows:

I Professional occupations

II Managerial and technical occupations

III N Skilled non-manual occupations

IV Partly-skilled occupations

V Unskilled occupations

Social exclusion

Social exclusion is an individual's or group's inability to participate socially, economically, politically and culturally in day-to-day life and their relationships with others. Poverty is a significant driver for social exclusion but there are other causal factors including age, disability, ethnicity, gender and employment status.[4]

Social isolation

Social isolation is conceptualised as being without social connections that provide positive feedback and are meaningful to the individual. Both quantity and quality of social connections are relevant to a definition of social isolation. Relationships of quality involve elements of emotional connectedness, support and reciprocity. Zavaleta et al. provide a useful working definition of social isolation as 'the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment)'.[5]

Appendix 1. References

1. The Equality and Human Rights Commission. The Equality Act: Guidance for small businesses. Understanding legal definitions of discrimination and unlawful behaviour in the Equality Act. No date provided. Available from: https://www.equalityhumanrights.com/sites/default/files/ea_legal_definitions_0.pdf.

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4. Mack, J. and PSE. Social Exclusion. 2016; Available from: http://www.poverty.ac.uk/definitions-poverty/social-exclusion.

5. Zavaleta, D. and K. Samuel, Social isolation: A conceptual and measurement proposal. 2014.