"I have a dream that my four little children will one day live in a nation where they will not be judged by the colour of their skin but by the content of their character".

Martin Luther King Jnr

"Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has."

Margaret Mead, Social Anthropologist

"The true measure of any society can be found in how its treats its most vulnerable members"

Mahatma Gandhi

VOLUNTARY, COMMUNITY, FAITH AND SOCIAL ENTERPRISE (VCFSE) POPULATION HEALTH MANAGEMENT PROGRAMME IN BLACKBURN WITH DARWEN

GUIDANCE DOCUMENT TOTHE BWD VCFSE EQUITY TASK FORCE TO BUILD A BETTER, FAIRER, MORE EQUITABLE BLACKBURN WITH DARWEN

"It is the little things that citizens do that make the difference. My little thing is planting trees."

Wangari Maathai Founder Green Belt Movement in Kenya, Noble Peace Prize (2004)

"Poverty is not just the lack of money, it is not having the capability to realise one's full potential as a human being."

Amatyra Sen, Nobel Prize for Economics (1998)

"Cities have the capability of providing something for everybody, only because, and only when, they are created by everybody."

Jane Jacobs, US activist

"The test of our progress is not whether we add more to the abundance of those who have much, it is whether we provide enough for those who have too little."

Franklin Roosevelt, US President (1882-1945)

"The outstanding faults of the economic society in which we live are its failure to provide for full employment and its' arbitrary and inequitable distribution of wealth and incomes"

John Maynard Keynes, Economist (1883-1946)

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INTRODUCTION AND BACKGROUND

The purpose of this document is to provide information and guidance to voluntary, community, faith and social enterprise organisations operating within Blackburn with Darwen and public sector partners about the VCFSE Population Health Management programme that is being developed within Blackburn with Darwen. It is a resource tool that will develop and grow over time as our collective understanding develops and grows and will hopefully become a tool that members of the Equity Task Force can use as a point of reference when taking forward the collaborative working..

The programme is a partnership between Community CVS, Blackburn with Darwen Borough Council, the NHS and the wider VCFSE Sector. It will develop and change over time as we develop and change in response to the COVID 19 Pandemic and hopefully start to move from the Protection Phase of the COVID 19 Time Horizons (January to June 2021) into the Recovery Phase (Summer 2021 onwards). Appendix A - provides background information to the population health management programme and relevant COVID information.

We actively want VCFSE involvement to co-design the programme as it develops and grows. There is a potential grant available to help your organisation participate in the programme (if you need funds), but we want as many VCFSE organisations as possible to participate so even if you are unsuccessful in securing a grant or do not need a grant we would still like you to be involved if you have the capacity to participate and to join the Blackburn with Darwen VCFSE Equity Task Force. The terms of reference for the task force and its ambitions are outlined in Appendix D.

There are two grant forms.

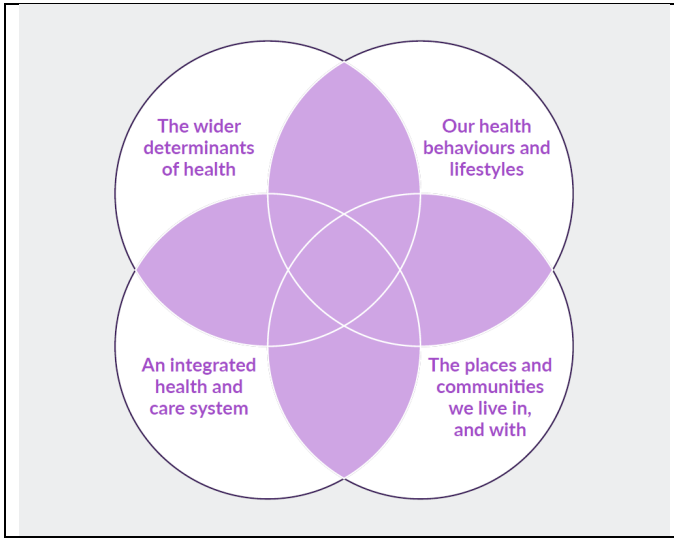
Volunteer Only for Grants up to £1000: One for volunteer only organisations that want grants of up to £1000. We have tried to keep the form as simple and 'light touch' as possible to make it easier to complete and allow as many grassroots organisations as possible to get involved in helping make our community more equal, less impoverished and help more people, who have been disadvantaged in some way to get back on their feet.

Any VCFSE Organisations Grant up to £10,000: The more detailed one is for VCFSE organisations that employ people or volunteer only organisations that want more than £1,000 and can bid or grants of up to £10,000.

Over time we will look to bring other potential investment into the programme and the BwD VCFSE Equity Task Force will develop to be a collaborative a strategically co-ordinated response to the growing inequity that is emerging within Blackburn with Darwen as a result of the COVID 19 pandemic, the impact of ten years of austerity and structural social and economic inequalities that have existed within the Borough for generations.

The Me Too movement, the Black Lives Matter movement, the disproportionate impact of austerity on some parts of our community, the disproportionate impact of COVID 19 on some parts of our community - all point to the need to take equalities and equity seriously in terms of health inequalities, in term of social inequalities, in terms of economic inequalities, in terms of environmental inequalities or inequalities of place. Appendix B provides information on what the Equality and Human Rights Commission monitor in terms of equality. Appendix C analyses the areas within BwD that fall within the most deprived 10% nationally. We need to look at all aspects of inequality, deprivation and poverty and disadvantage.

WHAT IS POPULATION HEALTH?



"Population Health (and system) is an approach aimed at improving health of an entire population. It is about improving the physical and mental health outcomes and well-being of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies. How all these contributions connect and work together defines a population health system."

[Source Noble et al (2014) in the The King's Fund (2018) A Vision for Population Health - Towards a Healthier Future page 17.

The King's Fund identify the four pillars on the left as being crucial for any population health system.

WHAT IS POPULATION HEALTH MANAGEMENT?

The description below is taken from the NHS website: https://www.england.nhs.uk/integratedcare/phm/

"Population Health - is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

This includes focusing on the wider determinants of health – which have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality health care – and the crucial role of communities and local people.

Population Health Management is an emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.

What is Population Health Management?

Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap is increasing.

A new approach – called Population Health Management (PHM) – is helping us understand our current, and predict our future, health and care needs so we can take action in tailoring better care and support with individuals, design more joined up and sustainable health and care services, and make better use of public resources.

It is how we use historical and current data to understand what factors are driving poor outcomes in different population groups. It is how we then design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time. This could be by stopping people becoming unwell in the first place, or, where this isn't possible, improving the way the system works together to support them.

PHM is a partnership approach across the NHS and other public services including: councils, the public, schools, fire service, voluntary sector, housing associations, social services and police. All have a role to play in in addressing the interdependent issues that affect people's health and wellbeing.

For example, adults and children who live in cold, damp housing may be more likely to develop respiratory problems over the next 20 years because their lungs are affected by the mold spores in their home. If we improved their housing now by working with partners such as local councils and housing associations, they may not end up with various health conditions in the future which can result in poor quality of life (conditions like asthma, chest infections, and other respiratory problems) and could avoid the need for multiple health and care services.

In some areas PHM is already working well and we are currently spreading learning and development across the country in a Development Programme, run by NHS England. In Lancashire and South Cumbria for example, they linked data on people living with long term conditions and mobility issues, who have high numbers of GP and A&E appointments and are living in households with assisted bin collections. This enabled the team to find people living with frailty who were in need of more proactive personalised care to keep them living well at home. The team arranged visits, home adaptations were made and social prescribers connected people into support groups in the community to reduce social isolation.

In Berkshire West, analysis pinpointed poorer outcomes in their Nepalese community with diabetes and a lack of uptake in the standard NHS offer. Primary Care Networks in the area are now offering longer consultations including group consultations in the evening, with more information about diet and nutrition, and social prescribers are connecting people into community health coaching. This is providing this population group with better personalised care to stay well, active and independent."

So what are the key ingredients:

- Empowering Our Vulnerable Communities: engaging and supporting people facing inequalities, deprivation & poverty and other forms of disadvantage with a Shared Leadership Model co-designing new ways of working with everyone facing inequalities, deprivation or poverty or other form of disadvantage to prevent or reduce the chances of people falling ill in the first place or

- Digitally Empowered: better use of data both historical and current live data and better use of technology to support us achieve our goals.

- 'systems thinking' rather than 'silo thinking' - collaborating working across organisations and sectors for the benefit of the populations we are here to serve. Systems thinking also means taking holistic approaches to meet every need and promote everyone's development across all aspects of the social determinants of health and tackling inequalities in all its forms.

- Asset and Place Based: understanding the communities we are working with and maximising the use of all the assets, talents, skills and resources we can muster and lever to our use to achieve our aims (taking an assets based approach).

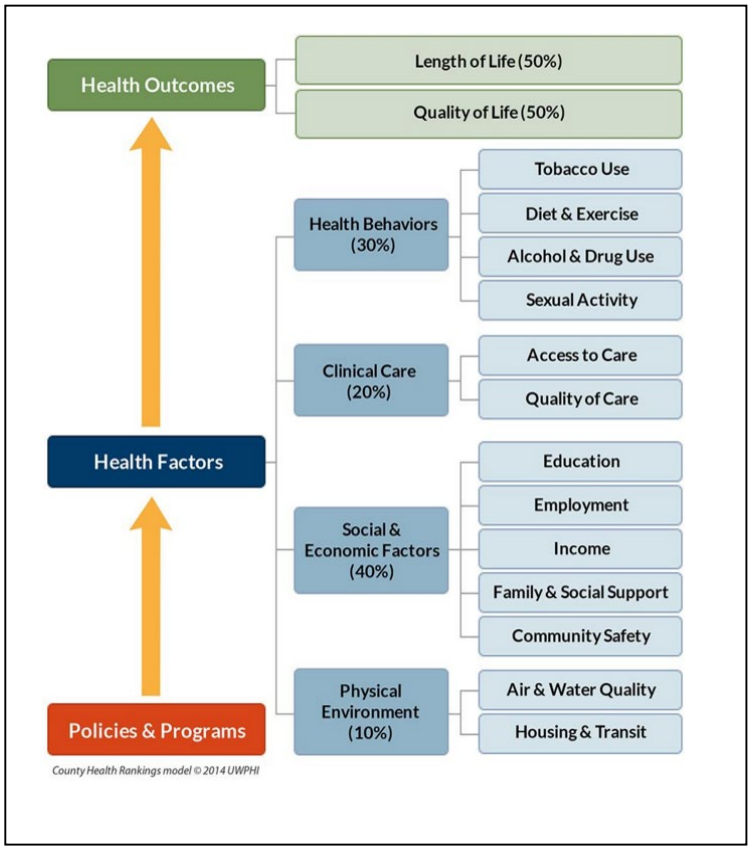
- To become a Learning System, where everyone, every organisation is committed to reflecting on our collective practice, evaluating and refining what we do as we go, learning through practice - sharing what we do well and what goes wrong so we can learn and improve.

FACTORS IMPACTING ON A PERSON'S HEALTH OUTCOMES

As the illustration to the right indicates 80% of the contributing factors that influence people's health outcomes **do not** relate to clinical care or what happens within the GP surgery or hospital. **The NHS, in terms of the clinical interventions it performs, only contributes 20% towards someone's health**.

The main factors (80%) that influence our health outcomes are social and economic, physical or relate to choices we make in terms of our health behaviours.

The Voluntary, Community, Faith and Social Enterprise Sector (VCFSE for short), already makes a significant contribution to the 80% of non-clinical factors. However, we need to raise our game, innovating, collaborating and working together as a team alongside our public sector partners to maximise the difference we can make within our communities.

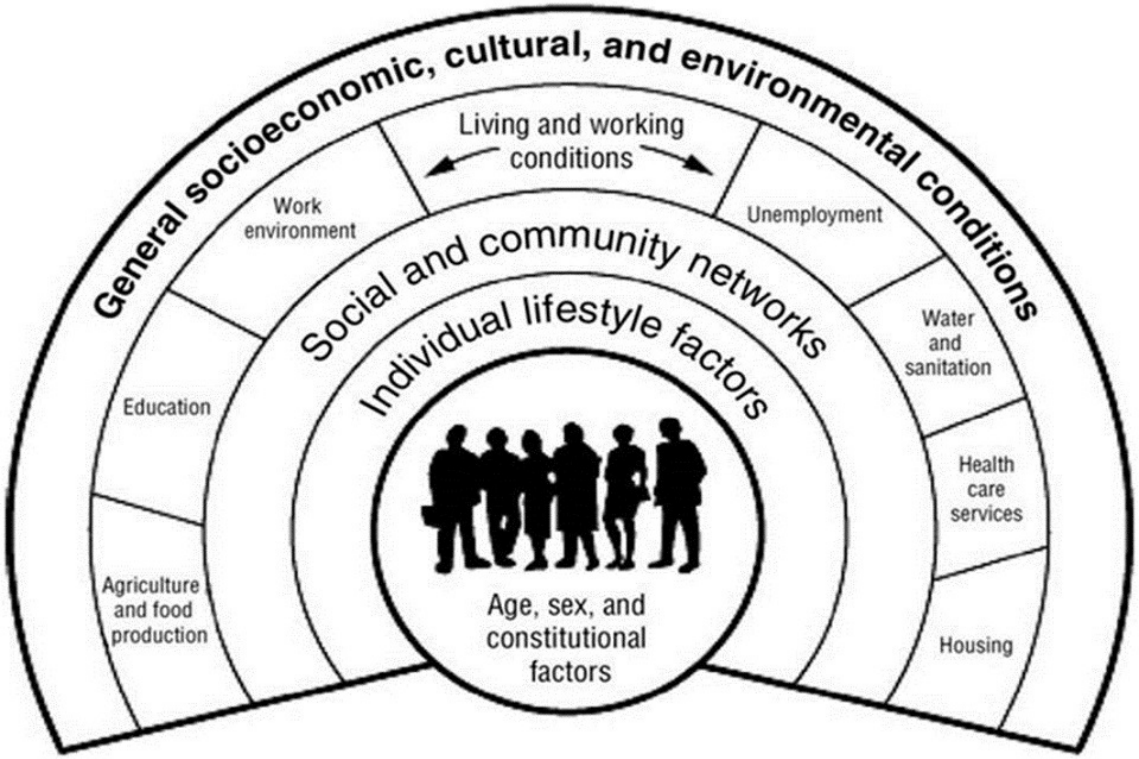


HEALTH INEQUALITIES AND THE SOCIAL DETERMINANTS OF HEALTH

Our focus is to use population health management approaches to tackle health inequalities and wider socio-economic inequalities that impact on people's health and wealth.

SOCIAL DETERMINANTS OF HEALTH

Public Health England use Dahlgren and Whiteheads model of health determinants to explain the broad social and economic circumstances that together determine the quality of the health of the population are known as the 'social determinants of health. The illustration



[Source: Dahlgren and Whitehead Model downloaded from https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health on 03rd March 2021 - Public Health England (2017) Health Profile or England, Chapter 6, Figure 1 - published on 13th July 2017].

AGE, SEX AND CONSTITUTIONAL FACTORS

This relates to

- Age
- Biological Sex of having a man or woman's body
- Genetic inheritance

INDIVIDUAL LIFESTYLE FACTORS AND HEALTH BEHAVIOURS

This relates to health behaviours such as:

- Alcohol or drug use
- Diet and Food Consumption
- Levels of physical activity
- Safe sexual activity
- Smoking

But it also relates to lifestyle factors such as

- Offending and other risk taking behaviours
- Exposure to the sun

SOCIAL AND COMMUNITY NETWORKS

This relates to:

- the level of positive social connections you have and how active you are in terms of volunteering, working, engaging in arts, leisure, social activities
- the level of support that you can tap into from family, friends, colleagues, neighbours, etc

WHAT DO WE MEAN BY 'EQUALITY'?

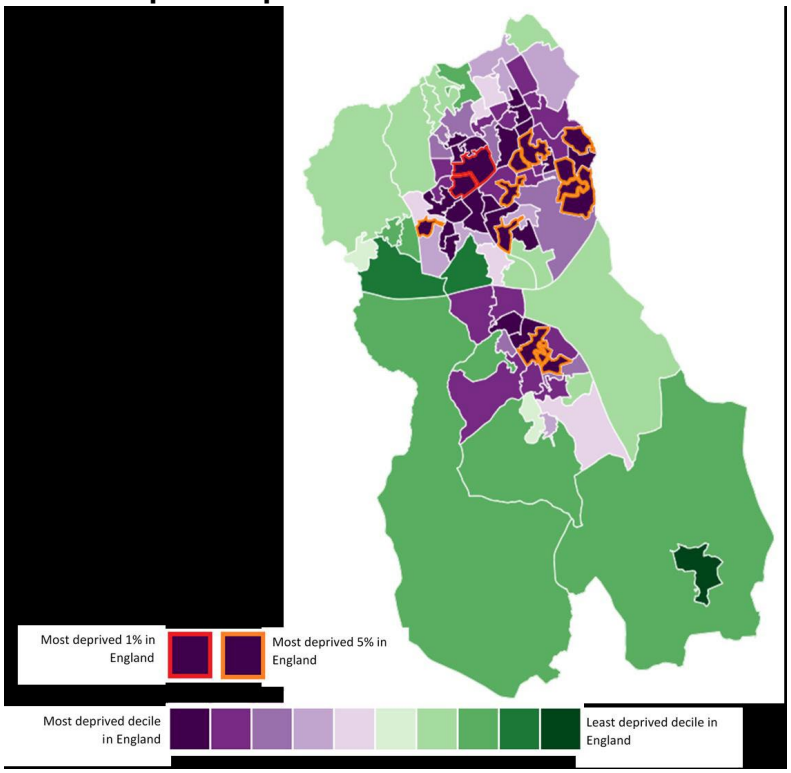
The Equalities and Human Rights Commission understand four categories for measuring equalities: Source: Adapted from Figure 4.1 of the Equality and Human Rights Commission (2017) Measurement Framework for Equality and Human Rights, page 54]

Detailed explanations of the various categories and the groups within those categories are contained within the ~EHRC definitions which are contained in Appendix B.

The protected characteristics grouping is very much defined by the Equalities Act 2010. The socio-economic group generally related to unemployed or economically inactive people. The geographical analysis we have taken to be the Lower Super Output Areas in the most deprived 10% nationally on the Index of Multiple Deprivation 2019. The people at higher risk of harm we describe as people facing disadvantage due to their personal circumstance.

Index of Multiple Deprivation 2019 -

Lower Super Output Areas in BwD



Geographical Analysis (see map opposite)

Of the 91 Lower Super Output Areas within Blackburn with Darwen:

- 33 are within the most deprived 10% of LSOAs in the country (over a third of the total number)
- 12 are within the most deprived 5% of LSOAs in the country (with the orange boundary)
    - 8 are largely within the Blackburn East PCN area concentrating in Audley, Shadsworth,
    - 3 are within the Darwen PCN area concentrated around Sudellside / Darwen East.

- 1 is within Blackburn West PCN area in the Green Lane estate
- 2 are within the most deprived 1% of the LSOAs in the country (with the red boundary). These are located within Blackburn West Primary Care Network and contain the Galligreaves Estate, Montague Street and Ashworth Estates and surrounding terraced housing.

We have grouped the 33 LSOAs into 14 'local neighbourhoods' - the detail is explained in Appendix C.

WHAT DO WE MEAN BY BLACKBURN WITH DARWEN VCFSE SECTOR (or Voluntary, Community, Faith and Social Enterprise)?

Blackburn with Darwen

Your organisation needs to be established operating and delivering activities and services to residents of Blackburn with Darwen from venues within Blackburn with Darwen. So national or sub-regional organisations can be involved in the programme, but you need to have an established local presence and be actively working with local people.

Voluntary Organisations

Normally including registered charities with the Charity Commission, which are those organisations who have charitable purposes and incomes of £10,000 and above. On some interpretations, can also include exempt charities such as schools, colleges and Universities and some faith institutions.

Community Organisations

Normally described as being 'under the radar' because they do not have to report to any of the regulators such as the Charity Commission, Companies House, the CIC regulator or the Financial Conduct Authority, community organisations normally have the following features:

- Incomes of less than £10,000 per annum
- Not reporting to any regulator (although sports clubs are an exception to this and may be registered as Community Amateur Sports Clubs with HM Treasury and can have incomes over £10,000)

- Basic constitution, with a committee running the affairs of the organisation and a bank account requiring two signatories

Faith Based Organisations

Normally described as those organisations who promote a particular faith, but may also do valuable community work to the whole of the community. Some faith based organisations are registered charities and many are exempt charities.

Churches, Mosques, Buddhist, Sikh or Hindu Temples or Jewish Synagogues or any other faith based organisation can apply for funds to support activities that combat inequalities, poverty and disadvantage by addressing social, economic or environmental barriers and support people across the community who are experiencing inequalities, poverty or disadvantage.

Social Enterprises

Normally used to describe organisations who derive the majority of their income from trading or delivering contracts. They usually take the form of a Community Interest Company (regulated by the CIC Regulator and Companies House) or a Company Limited By Guarantee (regulated by Companies House) or a Community Benefit Society (regulated by the Financial Conduct Authority through the Mutual Public Register. The Financial Conduct Authority also regulates Credit Unions, Co-Operative Societies, Friendly Societies and Building Societies - which on some definitions could also be included as social enterprises.

GOVERNANCE, CO-ORDINATION AND LINKAGES

Governance

For the programme, reporting will be simple and as follows:

Integrated Care System

Pennine Lancashire Integrated Care Partnership

(exact sub group to be determined)

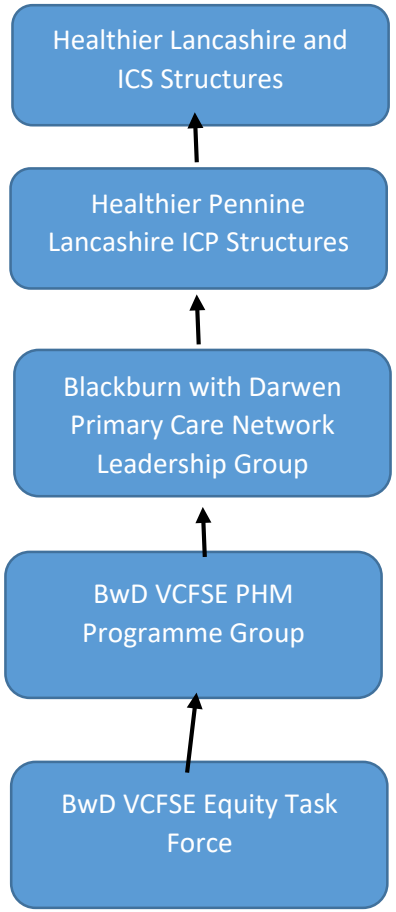
Primary Care Network

VCFSE Population Health Management Group

(Council staff, NHS staff, PCN Clinical Lead,

BwD Help Hub, CVS and Care Network)

BwD VCFSE Equity Task Force



Co-ordination, Collaboration and Linkages

We definitely do not want to re-invent the wheel and plan to use existing partnerships or groupings wherever possible in terms of building the collaborations and also in terms of reporting and sharing what we are doing with our public and private sector partners in multi-sector partnerships. Below is an illustrative example, as the programme becomes live - many more partnerships and collaboration will emerge. The BwD

Strategic Partnership Linkages

Pennine Lancashire ICP Structures

BwD Health Board

- Start Well
- Live Well
- Age Well

BwD Help Hub & Primary Care Networks

BwD Employment & Skills Board

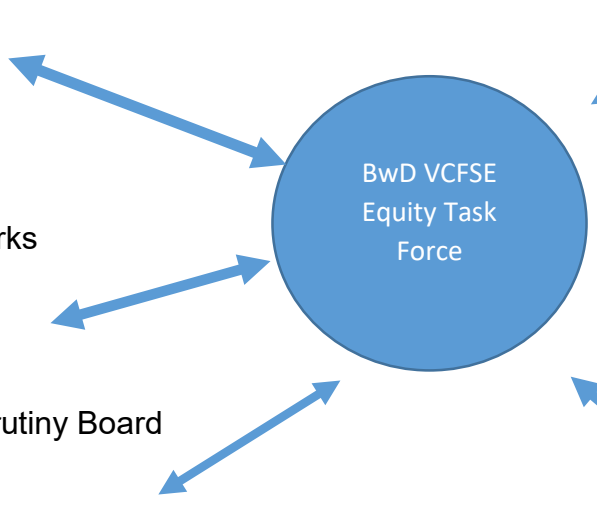
- Social Inclusion Group

BwD Adult Learning Partnership & Scrutiny Board

BwD Food Alliance

BwD Learning Disability & Autism Partnership

Our Community, Our Future Board



VCFSE Linkages

Pennine Lancashire VCFSE Leadership Group

BwD VCFSE Prevention Partnership

Lancashire Social Prescribing Collaborative

VCFSE Emergencies Partnership

Disability Inclusion Network

COVID 19 Community Champions

Enterprise & Employment Group

Nourish Group

Lancashire Racial and Equality Panel

Public Sector / Strategic Linkages

a) Neighbourhood Level: Primary Care Network

It is really important that this programme sits alongside developments within Primary Care Networks and links successfully with

- Social Prescribing and the role of Link Workers
- The Neighbourhood Accelerator

b) Borough Level

It is really important that this programme sits alongside developments within:

- Help Hub and any emerging developments in terms of moving from response to recovery
- Blackburn with Darwen Food Resilience Alliance and the East Well, Move More, Shape Up Strategy
- Start Well Board and its work around child poverty
- Live Well Board and its work to implement the Vulnerable People's Strategy
- Age Well Board and its work around the inequalities connected with old age.

c) Pennine Lancashire Level and the Integrated Care System

It is really important that this programme supports the emerging plans of the Pennine Lancashire Integrated Care Partnership around developments in terms of population health management, tackling health inequalities and social prescribing and any preventative work that focus on the social determinants of health. Through the Pennine Lancashire Integrated Care Partnership we can link into the Lancashire and South Cumbria Integrated Care System.

Blackburn with Darwen Eat Well Move More Shape Up Strategy 2017 – 2020:

Our Vision:
Success for us is when everyone in Blackburn with Darwen is able to move more, eat well and maintain a healthy weight

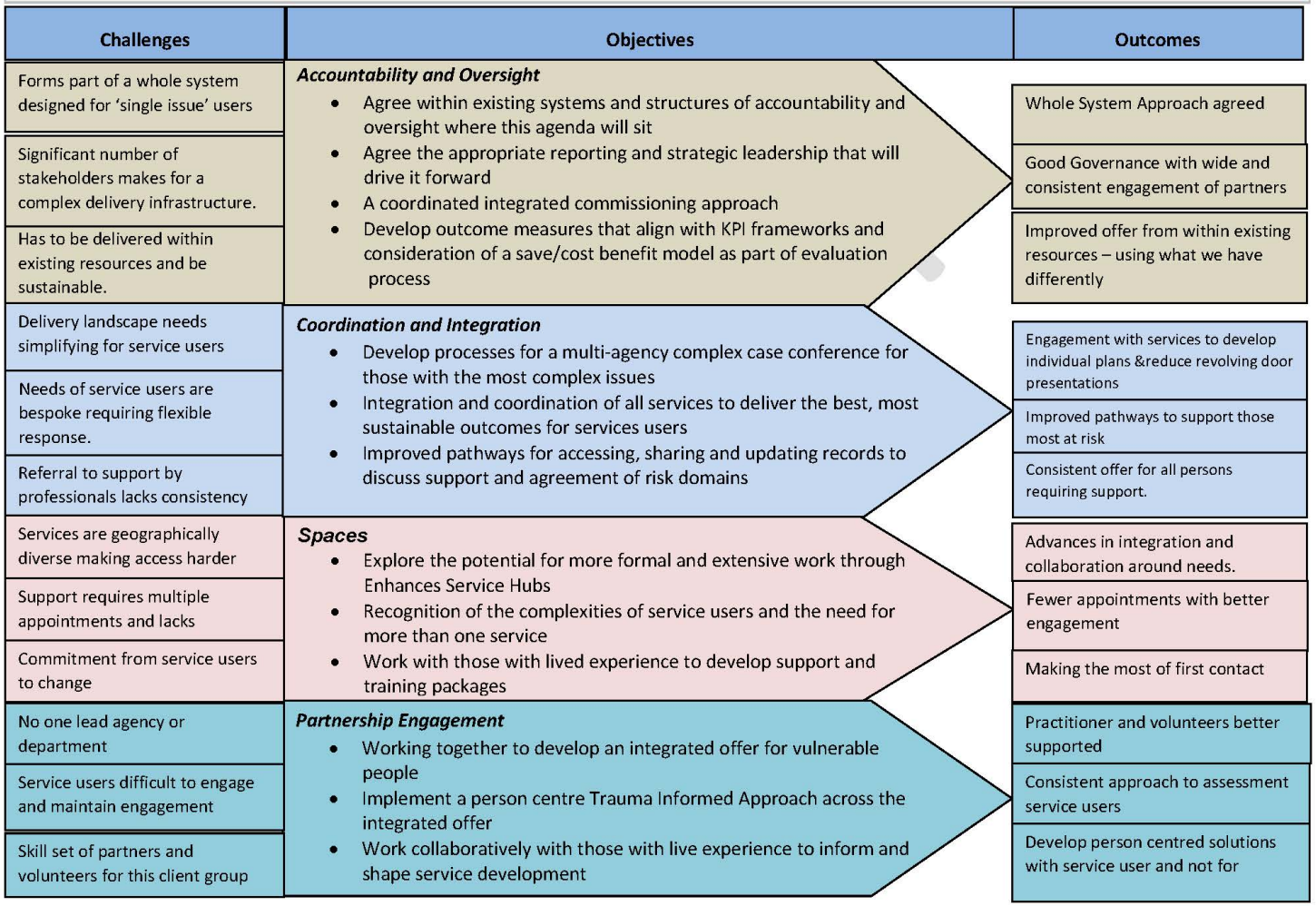
We will do this by:

- Supporting an environment that empowers people to make physical activity and healthy eating the easy choice for everyone throughout the course of their lives
- Encouraging positive lifestyle changes that enables everyone to improve their health and wellbeing and to be a healthy weight
- Empowering the most vulnerable and at risk of poor health in our community to make positive behaviour changes
- Building community capacity and mobilising the workforce in our Borough to make every contact count

Challenges	Opportunities	Cross cutting themes	Priorities	
High levels of physical inactivity and obesity in children, young people and adults Poor healthy life expectancy and disability from largely preventable long term conditions High levels of diabetes and cardiovascular disease High levels of dental decay in children Continuing poverty, deprivation and disadvantage Increasing levels of food poverty Varied food knowledge and cooking skills Reducing budgets for service provision	• Wide range of key partners engaged • Parks & Open Spaces • Network of volunteers • Strong community spirit • Healthy settings approach • Workforce development	Local Authority Declaration on Healthy Weight Positive mental health & wellbeing Communications & marketing	**Eat Well:** 1. Promote healthy and sustainable food choices for all 2. Tackle food poverty and diet related ill health 3. Build community food knowledge, skills and resources 4. Promote a vibrant, diverse local food economy 5. Transform catering and food procurement 6. Reduce waste and the ecological footprint of the food system **Move More:** 1. Active Society: creating a social movement where physical activity is a priority for everyone 2. Moving Professionals: activating networks of expertise to create healthy workplaces and make every contact count to promote physical activity 3. Active Environments: creating the right spaces for safe and enjoyable physical activity 4. Moving at scale: maximising the potential of the existing assets and partnerships **Shape Up:** 1. Transforming the environment we live in 2. Making healthier choices easier by educating and empowering individuals and communities 3. Giving all children the best start and tackling the generational issue of healthy weight in families 4. Ensuring holistic and integrated evidence based support for individuals with weight related conditions – either under or overweight	KEY OUTCOMES
OPPORTUNITIES/DRIVERS /ENABLERS		Every Body Active Every Day, Childhood Obesity: A Plan for Action, UK Active Blueprint for an Active Nation, Sport England's Towards an Active Nation, Lancashire Walking & Cycling Strategy, NHS 5 Year Forward View, Locality Working, Healthy Child Programme, Digitalisation		

Our

Vulnerable People Strategy Overview



Blackburn with Darwen Employment and Skills Strategy 2017-2040

By 2040, the vision is to achieve full employment and have a learning system that caters or everybody. The strategy has six objectives, but the two most relevant ones for our work are:-

5. Social Inclusion. What does this mean?

- All age groups will be able to access support to re-engage with the labour market –
- All age groups will be able to access enterprise and self-employment support –
- Pathways into employment, training, volunteering schemes will be clearly signposted and promoted –
- Employers will be diverse and inclusive in their recruitment practices to promote social justice –
- Digital learning will be promoted and encouraged –
- Accessible examination centres –
- Intensive support for troubled families
- Access to paid work for those with a special educational need and/or disability.

6 Full Employment What does this mean?

- Creating more jobs and self-employment
- Targeted employment programmes
- Meaningful employment, less reliance on benefits
- Healthcare and employers collaborating
- Increased number of apprenticeships including higher level and degrees
- Promoting volunteering opportunities as an entry into employment
- Encouraging employers to allow flexible working practices

Our Community Our Future Integration Strategy

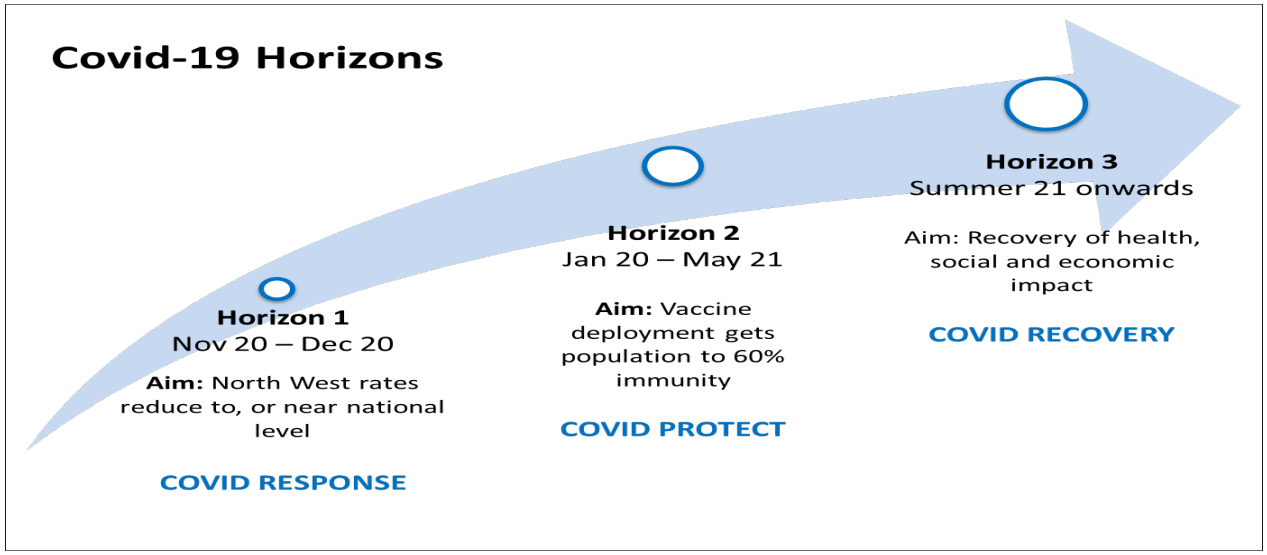
The strategy has four priorities for making our borough stronger:

1. To increase economic prosperity for all the borough's communities as an essential prerequisite for social integration
2. To strengthen relationships between the borough's diverse communities
3. To build connections and strengthen relationships between young people who live in the borough's diverse communities
4. To connect the borough's disadvantaged communities to shared spaces – linking people and neighbourhoods to zones of employment, physical assets, community shared spaces and social action.

APPENDIX A: BACKGROUND TO THE POPULATION HEALTH MANAGEMENT PROGRAMME AND POTENTIAL OTHER SOURCES OF FUNDING AND SUPPORT

Background:
The novel Coronavirus pandemic has had a significant impact across Pennine Lancashire (PL). It has caused delays in diagnosis and treatment, interrupted care of long term condition management and critically it exposed and exacerbated existing health inequalities.

Pennine Lancashire was well on with restoration and recovery plans to address the aforementioned impacts, however; the current situation of exponentially rising rates of infection and in-patient numbers of COVID positive patients far exceeding the peak of wave 1 requires our system to refocus efforts on the most vulnerable groups within the current context – those with a positive diagnosis of COVID-19. This view is driven by medical expertise and aligned to the 3 horizon COVID exit strategy assessment of likely timescales and scenarios as set out by Public Health Directors across Lancashire and South Cumbria (figure 1 below):



The PL system response to wave 2 has seen the rapid mobilisation of:

- **COVID Virtual Ward** – Risk stratification and clinical assessment of COVID positive patients and management of moderate risk patients through a virtual platform that includes digital monitoring at home.
- **Community Help Hubs** – Continued offer of support to communities including wellbeing and loneliness, access to food and essentials, mental health support, finance and debt management and learning, training and employment.
- **Neighbourhood Accelerator** – An integrated approach to delivering wrap around, holistic health and care needs to those with post-acute ongoing COVID needs and learning disabilities.

The Population Health Management Cell has secured £1.5m of non-recurrent funding for LSC to deliver community led responses to help address inequalities with a focus on COVID-19 impacts. Pennine Lancashire's allocation is £399k (based on normalised population split) for use up to and including March 2021. Blackburn with Darwen's share of the

The investment is for grass roots and community led interventions taking an asset based approach to population health to support:

- COVID positive patients.
- COVID vulnerable groups and addressing health inequalities.

COVID 19 AND THE ROADMAP STEPS

A quick overview of the 4 steps on the Road Map to move out of lockdown. Further information is available at https://www.gov.uk/government/publications/covid-19-response-spring-2021

Step One:

08th March 2021

- **Education:** Schools and Colleges re-open and practical higher education courses.
- **Social Contact:**
  - Recreation or exercise outdoors with household or one other person.
  - No household mixing indoors
- **Business and Activities:**
  - Wraparound childcare within guidelines.
- **Events:** Funerals (maximum 30 people), wakes and weddings (maximum 6 people).
- **Travel:** Stay at Home still the key message. No holidays.

29th March 2021

- **Social Contact**:
  - Rule of 6 or two households outdoors.
  - No household mixing indoors.
- **Business and Activities:**
  - **Outdoor sport and leisure facilities can open.**
  - **Organised outdoor sport allowed (children and adults).**
  - **Outdoor parent and child groups (up to 15 parents)**
- **Travel:** Minimise travel. No holidays.

Step Two:-

12th April 2021 (at the earliest):

- **Social Contact:**
  - Rule of 6 or two households outdoors.
  - No household mixing indoors.
- **Business and Activities**
  - Indoor Leisure (including gyms) open for use individually or within household groups
  - **Public buildings, Libraries and Community Centres**
  - **All children's activities, indoor parent and child groups (up to 15 parents).**
  - Personal Care premises.
  - All retail.
  - Outdoor hospitality.
  - Outdoor attractions such as zoos, theme parks and drive-in cinemas
- **Travel**
  - Domestic overnight stays (household only)
  - Self-contained accommodation (household only)
  - Minimise travel. No international holidays.
- **Events**
  - Funerals (Maximum 30);
  - wakes, weddings and receptions (maximum 15)
  - Event pilots begin

Step 3:-

No earlier than 17th May 2021.

- **Social Contact**
  - Maximum 30 person limit outdoors.
  - Rule of 6 or two households indoors (subject to review)
- **Business & Activities**
  - Indoor hospitality
  - Indoor entertainments and attractions.
  - **Organised indoor adult sport or exercise**
  - Remaining accommodation.
  - Remaining outdoor entertainment (including performances).
- **Travel**
  - Domestic overnight stays
- **Events**
  - Most significant life events (30 maximum people)
  - Some large events (except for pilots) capacity limits apply.
    - Indoor events 1,000 or 50% capacity whichever is lower
    - Outdoor other events: 4,000 or 50% capacity whichever is lower
    - Outdoor seated events: 10,000 or 25 % capacity, whichever is lower.

Step 4:-

No earlier than 21st June 2021.

- **Social Contact**
  - **No legal limits on social contact**
- **Business and Activities**

    - Remaining businesses, including Nightclubs
- **Travel**
    - Domestic overnight stays
    - International travel
- **Events**
    - Larger events
    - No legal limit on all life events.

Vaccination Programme

The Vaccination Programme is being delivered in two phases:

Phase One: Priority Groups

In order of priority

1. Residents in a care home for older adults and carers working in the care homes.
2. Everyone aged 80 and over, and frontline health and social care workers.
3. Everyone aged 75 and over.
4. Everyone aged 70 and over, and the Clinically Extremely Vulnerable Group
5. Everyone aged 65 and over.
6. Everyone aged 16 to 64 years old with an underlying health condition at higher risk.
7. Everyone aged 60 and over.
8. Everyone aged 55 and over.
9. Everyone aged 50 and over.

Up until the 15th February 2021, vaccination sites and prioritised the first 4 groups above. At the beginning of March 2021, vaccination sites are currently working with priority groups 1 to 7. It is expected that later in March 2021 Priority Groups 8 and 9 will join the programme.

Phase Two

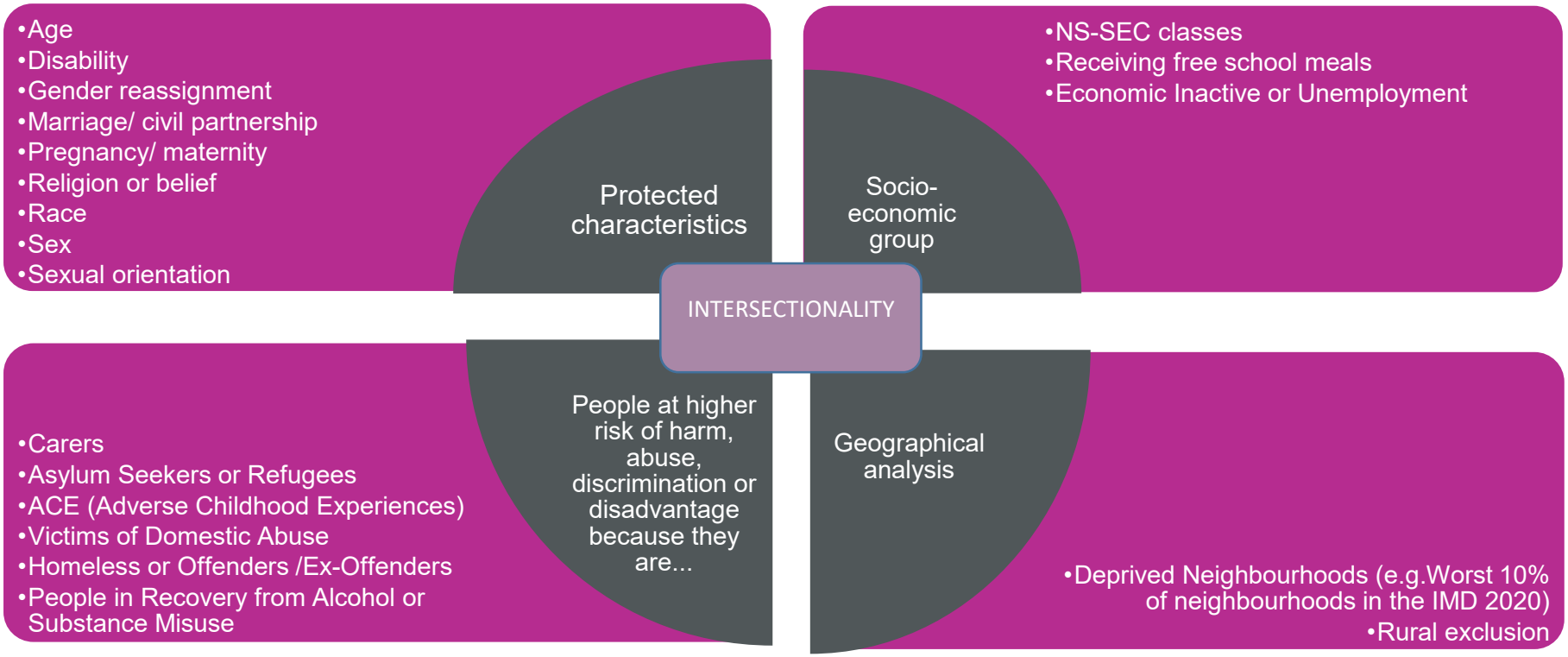
The Joint Committee on Vaccination and Immunisation (JCVI)'s Interim Statement published on the 26th February 2021 would suggest that continuing with age priority list is likely to be the way forward in phase two, which would see the following age groups being vaccinated in order:

- All those aged 40 to 49 years
- All those aged 30 to 39 years
- All those aged 18 to 29 years

There has been no indication at this moment above children and young people aged under 18 being vaccinated.

APPENDIX B: WHAT DO WE MEAN BY 'EQUALITY'?

The Equalities and Human Rights Commission understand four categories for measuring equalities:



[Source: Adapted from Figure 4.1 of the Equality and Human Rights Commission (2017) Measurement Framework for Equality and Human Rights, page 54]

Protected characteristics

One of the five components the EHRC use for evidence collection and analysis relates to the protected characteristics, as defined in the Equality Act 2010, and including the specific subgroups that are contained within them:

- **Age:** refers to a person of a particular age (for example 32-year-olds) or belonging to a particular age group, for example 16–24-year-olds. In our own statistical data analysis, we would usually report on age groups (for example 16–24 years, 25–34 years and so on up to 65–74 and 75 or over for adults).
- **Disability:** a person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities. For our own evidence collection and analysis, we disaggregate the population into disabled and non-disabled people, and then further into disabled people with specific impairments. Where data allows, we use ONS harmonised categories to report separately on the following impairment categories: Vision, Hearing, Mobility, Dexterity, Learning or understanding or concentrating, Memory, Mental health condition, Stamina or breathing or fatigue, Social or behavioural and Other impairment. Disabled people with more than one type of impairment will be counted within each relevant category.
- **Gender reassignment:** a person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. Due to the fact that survey and administrative data collected by government departments do not capture gender reassignment, for our own evidence collection we use other qualitative and quantitative evidence to shed light on the experiences of transgender people in Britain.
- **Marriage and civil partnership:** refers to the legal status of being married or being a civil partner. For our own statistical analysis, we try to use data where the population is disaggregated into those who are single (that is never married or in a civil partnership), currently married or in a civil partnership, or previously married or in a civil partnership. Since this characteristic

refers to legal status, the data we use would not usually include cohabiting couples who are not married or in a civil partnership with each other.

- **Pregnancy and maternity:** Pregnancy is the condition of being pregnant. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding. In our evidence collection, we often note that only few sources provide data on whether women are pregnant or have a young baby and this information is not routinely collected in official surveys.
- **Race:** refers to a group of people defined by their race, colour, nationality (including citizenship) or ethnic or national origins. Data used in monitoring is preferably based on ONS harmonised questions for ethnicity and in our own statistical analysis this characteristic will be referred to as 'Ethnicity'. Wherever possible, comparisons should be made between a White British group (including white people from England, Wales, Scotland, and/ or Britain) and ethnic minorities. The latter should ideally include as many as possible of the following: White minorities, such as Irish, Gypsy and Traveller; Asian, such as Indian, Pakistani, Bangladeshi and Chinese people; Black, such as African and Caribbean people; and other people not separately identified.
- **Religion or belief:** religion has the meaning usually given to it and includes lack of religion, and belief includes religious and philosophical beliefs (such as humanism) and includes lack of belief. Generally, a belief should affect one's life choices or the way that one lives for it to be included in the definition. Data used in monitoring cover affiliation to specified religions or to no religion, and should be disaggregated where possible to include: No religion, Christian, Buddhist, Hindu, Jewish, Muslim, Sikh and Other religion. Since data are not routinely collected on non-religious beliefs which would fall within this protected characteristic, in the statistical analysis this characteristic will be referred to as 'Religion'.
- **Sex:** refers to a man or a woman. In the survey data we use for our own statistical analysis, this characteristic is self-defined and allows transgender people to self-identify according to their gender and not their biological sex. Therefore, this characteristic is referred to as 'Gender' in our data tables.

- **Sexual orientation:** whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. Data used in monitoring allows people to self-define as belonging to one of the following categories: Heterosexual or straight; Gay or Lesbian; Bisexual; Other.

Within Blackburn with Darwen, the BwD VCFSE Equity Task Force will take anyone who has one of the above protected characteristics as potentially experiencing inequality, which may require support.

Socio-economic group

Another important component of evidence collection and analysis involves monitoring the position of people from different socio-economic groups. For adults, socio-economic group is based on the National Statistician's Socio-Economic Classification (NS-SEC). This is based on current or former occupation, plus those who have never worked or are long-term unemployed. Ideally, eight categories are identified:

1. Higher managerial and professional occupations
2. Lower managerial and professional occupations
3. Intermediate occupations (clerical, sales, service)
4. Small employers and own account workers
5. Lower supervisory and technical occupations
6. Semi-routine occupations
7. Routine occupations
8. Never worked or long-term unemployed

Where necessary, these may be combined into fewer categories, usually either six or four as appropriate. Alternative, proxy classifications may also be used where NS-SEC is not available. For children, socio-economic group can be identified from adults in the family, where such data are available. In an educational context, free school meals may be taken as a proxy to identify those children coming from families with low-paid or no employment. Children Living in Poverty could be another proxy indicator to use.

Within Blackburn with Darwen, the BwD VCFSE Equity Task Force will take any adult who is unemployed or economically Inactive, or any family, which has working adults but qualifies for Free School Meals or support through Universal Credit as being an individual or family experiencing inequality, deprivation or poverty or another form of disadvantage which deserves our support.

Geographical analysis

Geographical analysis is also an important component of evidence collection and analysis. A key element of the analysis within Blackburn with Darwen will be either:

a) The 4 Primary Care Network geographies;
b) Ward level geographies; or
c) Lower Super Output Area geographies.

Within Blackburn with Darwen, the BwD VCFSE Equity Task Force will take the following 14 clusters of Lower Super Output Area neighbourhoods as a starting point for exploring our deprived neighbourhoods and explore the equality of place:

Blackburn East Primary Care Network	Blackburn West Primary Care Network
• Blackburn Town Centre East • Audley and North Road • Whitebirk and Intack • Shadsworth Estate • Higher Croft	• Blackburn Town Centre West • Green Lane Estate • Mill Hill • Moorgate • Hollins Bank and Infirmary • Lower Preston New Road
Blackburn North Primary Care Network	**Darwen Primary Care Network**
• Bastwell and Daisyfield	• Hollins Grove • Sudell

Further details and maps are provided in Appendix C. These are the most deprived neighbourhood areas. The geographies may grow as the BwD VCFSE Equity Task Force develops and partners explore the communities of place in more detail.

People at higher risk of harm, abuse, discrimination or disadvantage because of personal circumstance

The EHRC definition of people at higher risk is:

> An individual can be at **higher risk** of harm, abuse, discrimination or disadvantage if they face **adverse external conditions** *and/or* have difficulty coping due to **individual circumstances**.

Within Blackburn with Darwen, an initial list of individuals the can be at higher risk of harm, abuse, discrimination or disadvantage due to individual circumstances including

- ***Asylum seeker and refugees***
- ***Carers (both adult carers and young carers)***
- ***Residents with multiple and complex needs, including***
    - ***Addiction backgrounds either still using alcohol or substance misuse or in recovery from alcohol or substance misuse***
    - ***Homelessness***
    - ***Mental health conditions***
    - ***Offending backgrounds***
- ***Victims of adverse childhood experiences***
- ***Victims of domestic abuse or violence***

This list is not exhaustive. Other groups may be added as the BwD VCFSE Equity Task Force begins it collaborative activity.

Intersectional analysis

The Equality and Human Rights Commission has developed the following definition of intersectionality which allows us to apply the concept practically to equality and human rights monitoring. The definition of intersectionality is:

> **Intersectionality** is an **analytical tool** that we use for the purpose of equality and human rights monitoring to show **distinct forms of harm, abuse, discrimination and disadvantage** experienced by people when multiple categories of social identity interact with each other.

Examples of distinct forms of harm, abuse, discrimination and disadvantage that we may detect with this approach are:

- Low rate of employment for Black, Bangladeshi, and Mixed ethnicity women.
- Social exclusion of older lesbians and gay men in care homes
- High rate of suicide among white, middle-aged men

Within Blackburn with Darwen, the BwD VCFSE Equity Task Force will public health specialist analytical support to better understand the multi-dimensional or intersectional forms of harm, abuse, discrimination and disadvantage within local area.

This will help to build our understanding and what collaborations we need to develop to design more integrated solutions that can support the whole person or whole family.

APPENDIX C: WHAT DO WE MEAN BY DEPRIVED COMMUNITIES OR EQUALITIES OF PLACE

Introduction

The purpose of this appendix is to help you, if your organisation takes placed based approaches and focuses on the equalities of place, you can determine if you are predominantly serving residents from a particular deprived neighbourhood or a cluster of deprived neighbourhoods. What is contained within this appendix are all the deprived neighbourhoods that feature in the most deprived 10% of the neighbourhoods (which are defined as lower super output areas by the Office for National Statistics and the Electoral Commission) on the 2019 Index of Multiple Deprivation. Lower Super Output Areas are geographical units - from which the Census statistics and other statistics are captured. They also make up wards.

Over time, the Equity Task Force will want to take a deep dive into each of the neighbourhoods to map what community assets exist within the neighbourhood and what needs to be developed to build on those assets.

There are **33 Super Output Areas that feature in the most deprived 10% of LSOAs nationally on the 2019 Index of Multiple Deprivation.** We have formed these into 14 reasonably cohesive neighbourhood communities - which are as follows:-

Blackburn East Primary Care Network	**Blackburn West Primary Care Network**
• Blackburn Town Centre East • Audley and North Road • Whitebirk and Intack • Shadsworth Estate • Higher Croft	• Blackburn Town Centre West • Green Lane Estate • Mill Hill • Moorgate • Hollins Bank and Infirmary • Lower Preston New Road
Blackburn North Primary Care Network	**Darwen Primary Care Network**
• Bastwell and Daisyfield	• Hollins Grove • Sudell

Blackburn East Primary Care Network Area

Blackburn East Primary Care Network contains **thirteen Deprived Lower Super Output Areas** (LSOAs) with 8 being in the most deprive 5% national and the other 5 being in the most deprived 10% nationally. Blackburn East has the largest number of deprived lower super output areas and collectively these form 5 reasonably cohesive neighbourhood areas, which are described below:-

a) Blackburn Town Centre East

Three Lower Super Output Areas (LSOAs), which we have termed Larkhill (006c), Higher Audley (007b) and Grimshaw Park (006b) form Blackburn Town Centre East. All three LSOAs are located within the Blackburn Central Ward. Higher Audley (007b) and Grimshaw Park (006b) are within the most deprived 5% of LSOAs nationally and Larkhill (006c) is within the most deprived 10%.

The boundaries for the area are:-

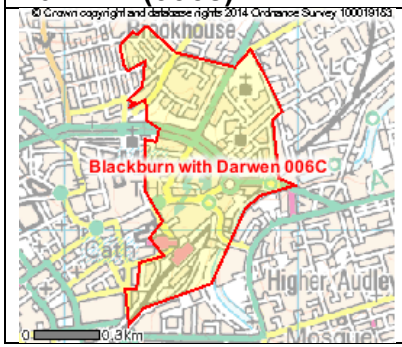
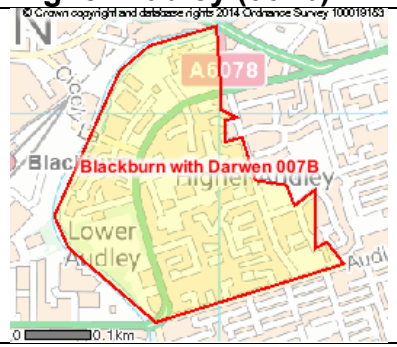
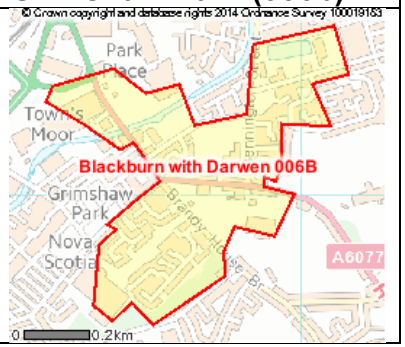
- The Northern boundary (from west to east) is London Road (from the junction with Charlotte Street), Earl Street, Brookhouse Lane, Whalley New Road, Whalley Old Road, Birley Street,

- The eastern boundary (from north to south) is Birley Street (from the junction with Whalley Old Road), Cleaver Street, Manner Sutton Street, Higher Eanam, Higher Barn Street, Chester Street, Audley Range (westwards), Dombey Street (southwards), Pringle Street (westwards), Whitendale Crescent and Kempton Rise to Haslingden Road, across to the entrance where Blackburn Yarn Dyers are located and the new road for Meadowbrook Rise.

- The southern boundary (east to west) is from the Blackburn Yarn Dyers entrance on Haslingden Road across their site to Brandyhouse Brow, then half way down Park Lee Road.

- The western boundary (from south to north) is north from Park Lee Road across wasteland to Cosmtec manufacturing site to join Rockliffe Street and Highfield Road. Eastwards along Rockcliffe Street to the mini roundabout, northwards along

Grimshaw Park, around Towns Moor and to Darwen Street Bridge (for ease). Down Darwen Steet and along Railway Road, Ainsworth Street, Victoria Street (crossing Barbara Castle Way) and straight up Charlotte Street to London Road.

Larkhill (006c)	Higher Audley (007b)	Grimshaw Park (006b)
		

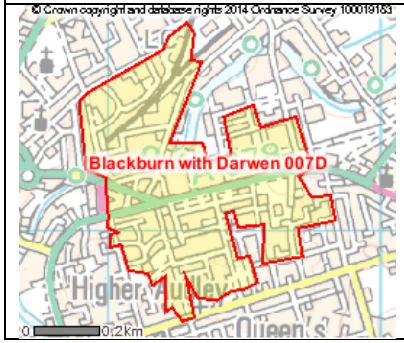
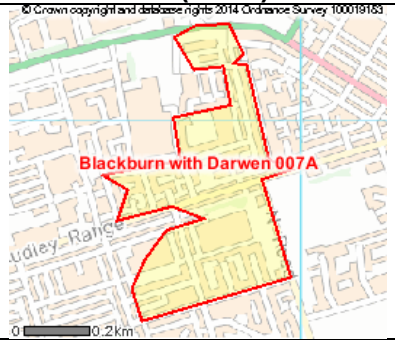
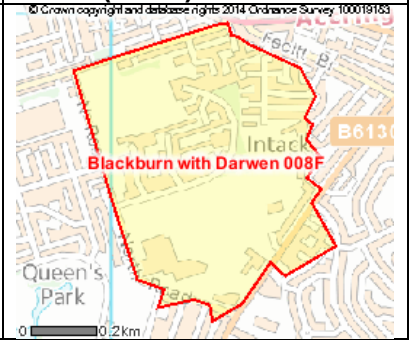
b) Audley and North Road Neighbourhood Area

Three Lower Super Output Areas form Audley and North Road Residential Area. The area contains several neighbourhoods including St Thomas's, Temple Drive, Cherry Street, the new estate where Lincoln Road Flats used to be, Romney Walk, Delph Lane and Hillside Avenue. The majority of the Neighbourhood area lies within the Audley and Queen's Park ward with a small element overlapping into the Blackburn Central Ward. Audley (007d) and Romney Walk and Delph Lane (008F) are within the 5% most deprived LSOAs nationally and Cherry Street and North Road (007a) is within the 10% most deprived nationally.

Boundaries to be used are:

- For ease, the northern boundary (from west to east) is the Leeds-Liverpool Canal from Eanam Bridge until it reaches the bridge at Harwood Street (near Graham and Brown), then follow Harwood Street (in a southernly direction) until reaching Furthergate and follow Furthergate until it reached Cherry Street. Then follow the rear of the houses on Cherry Street southwards until you reach Audley Range and then follow Audley Range until it reaches Accrington Road.

- For ease, the western boundary (form north to south) is the Eanam Bridge, south along Higher Barn Street (crossing Higher Audley) and along Chester Street until you reach Audley Range. Along Audley Range until you reach Lincoln Road. Down Lincoln Road until the junction with Pringle Street.
- For ease, the Southern boundary (from west to east) is Pringle Street (from Lincoln Road junction) to North Road, along North Road to Shadsworth Road and down Shadsworth Road (in a north easterly direction) until you reach Farmhouse Close.
- The Eastern boundary (north to south) starts just behind the houses on Fecitt Brow, continues behind the rear of the houses on Hillside Avenue until you reach Farmhouse Close and join Shadsworth Road. This boundary is co-terminus with the Whitebirk and Accrington Road Neighbourhood Area.

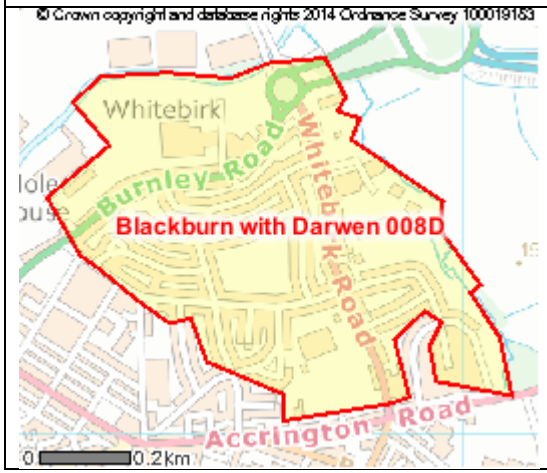
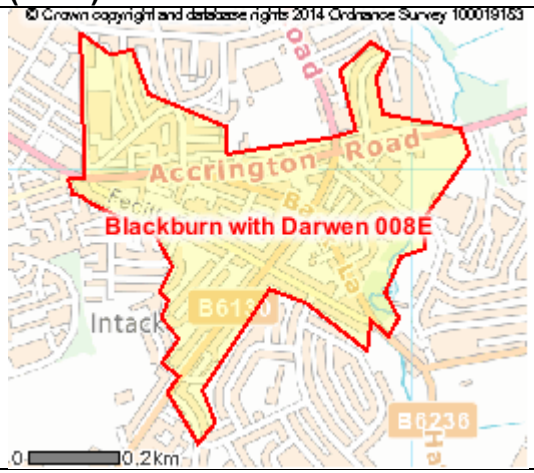
Audley (007D)	Cherry Street and North Road Area (007a)	Romney Walk and Delph Lane (008F)
		

c) Whitebirk and Intack Neighbourhood Area

Two Lower Super Output Areas - which we have termed Whitebirk and Intack estate (008d) and Accrington Road and Fecitt Brow (008e). Whitebirk and Intack Estate is within the most deprived 5% of LSOAs and Accrington and Fecitt Brow is within the most deprived 10%. In ward terms - the area is part of 3 different wards - the majority being within Little Harwood and Whitebirk, but there are also small parts on Blackburn South East and Audley and Queen's Park.

Boundaries:

- Northern boundary -Leeds-Liverpool Canal
- Eastern boundary - the Borough boundary which follows the water course of Knuzen Brook
- Southern boundary is the rear of the houses on Fecitt Brow and Shadsworth Road until you reach Farmhouse Close.
- Western boundary is the rear of the houses on Hillside Avenue and Fecitt Brow until it joins Accrington Road and then crosses Accrington Road and down Carluke Street until it reaches Hereford Road. At Hereford Road go down Hereford Road to Burnley Road, across Hole House Street and continue in a straight line until reaching the Leeds Liverpool Canal.

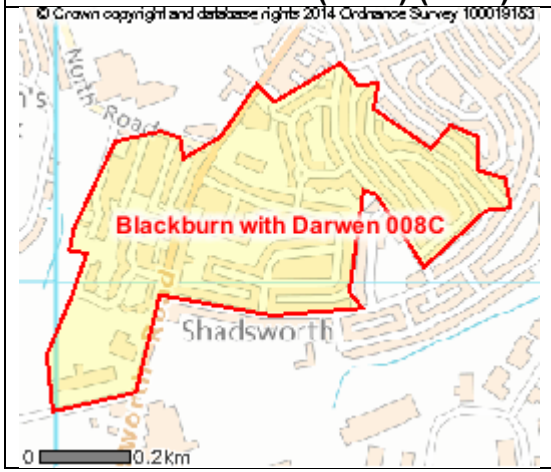
Whitebirk and Intack Estate (008d)	Accrington Road and Fecitt Brow (008e)
	

d) Shadsworth Estate

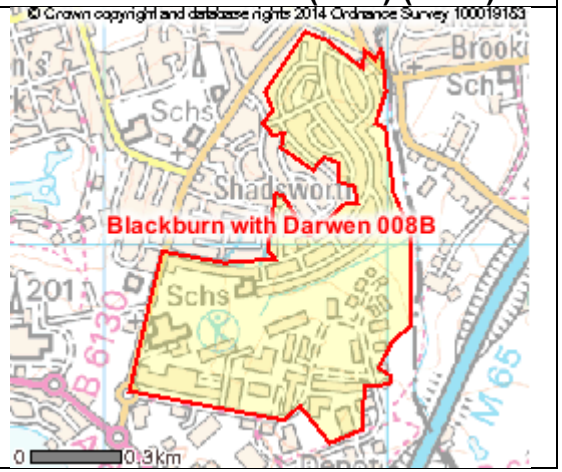
There are **two Lower Super Output Areas** - which we have termed Shadsworth Estate (west) (008c) and Shadsworth Estate (east) (008b), which forms Shadsworth Estate. Both LSOAs are within the 5% most deprived nationally and both are located within the Blackburn South East ward. The boundaries to the area are:

- Northern boundary (east to west) is North Road to the junction with Shadsworth Road, south along Shadsworth Road to the junction with Fecitt Brow and eastwards along Fecitt Brow to the Borough boundary with Knuzden. This boundary is co-terminus with the Audley and North Road boundary and with the Whitebirk and Intack boundary.
- Eastern boundary (north to south) is the Borough boundary and follows the Knuzen Brook water course.
- Southern boundary (east to west) is Knuzden Brook to Duttons Way (on Shadsworth Business Park) to Lions Drive and round to Sett End Road West until reaching the roundabout on Shadsworth Road.
- The Western boundary (south to north) is Shadsworth Road in northernly direction until reaching Old Bank Lane (westwards), going across country around the back of the Newfield School site and behind Borrowdale Avenue until reaching North Road.

Shadsworth Estate (west) (008c)



Shadsworth Estate (east) (008b)

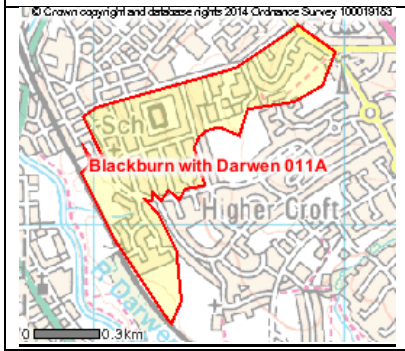
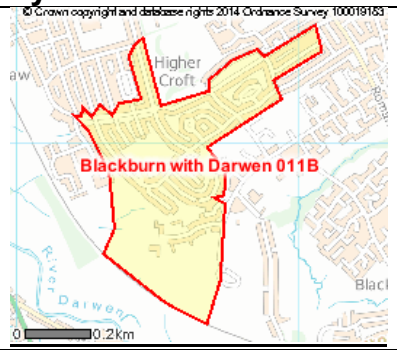
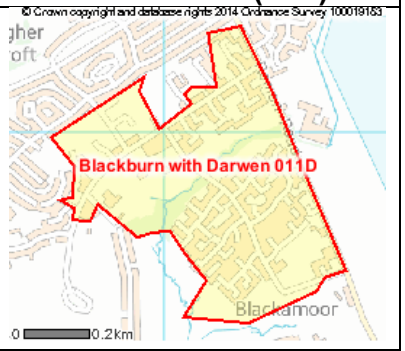


e) Higher Croft

Highercroft consists of **three lower super output areas**, one which is in the most deprived 5% (LSOA 11b - which we have termed Roman Road Estate) and the other two which are in the most deprived 10% (Longshaw 11a and Newfield Drive 11d). Longshaw and Roman Road estate are within the Blackburn South East ward, but Newfield Drive is within the Blackburn South and Lower Darwen ward.

The boundaries are as follows:-

- Northern boundary is Park Lee Road
- Western boundary is the Railway Line (Blackburn to Manchester)
- Eastern boundary is Roman Road (from the junction at Park Lee Road to the cemetery)
- Southern boundary (from west to east) is the railway line, cutting across fields to Fishmoor Drive (around and excluding Higher Croft Road), across Higher Croft Woods around Newfield Drive estate to St James cemetery next to Roman Road.

Longshaw (11a)	**Roman Road estate (11b) - Manxman and Lytham Roads**	**Newfield Drive & part of Roman Road estate - Fishmoor Drive (11d)**
		

Blackburn West Primary Care Network

Blackburn West Primary Care Network contains **twelve deprived Lower Super Output Areas** (LSOAs) with 2 being in the most deprived 1% nationally (Blackburn Town Centre West); 1 being in the most deprive 5% nationally (Green Lane) and 9 being in the most deprived 10% nationally (making up Lower Preston New Road, Mill Hill, Moorgate, and Hollins Bank /infirmary). The 12 deprived LSOAs make up 6 reasonably cohesive neighbourhood areas - which are:-

- Blackburn Town Centre West
- Green Lane Estate
- Mill Hill
- Moorgate
- Lower Preston New Road
- Hollins Bank and Infirmary

. Each of these areas are described below:

a) Blackburn Town Centre West

Blackburn Town Centre West contains the **only two Lower Super Output Areas within the most 1% deprived in the country that are in Blackburn with Darwen** at 13th and 62nd most LSOAs in the country. The area covers the residential areas around **Bank Top, Galligreaves estate, Whalley Banks, King Street, the lower parts of Montague Street and Ashworth Street estate.**

The LSOAs are located within the Blackburn Central Ward.

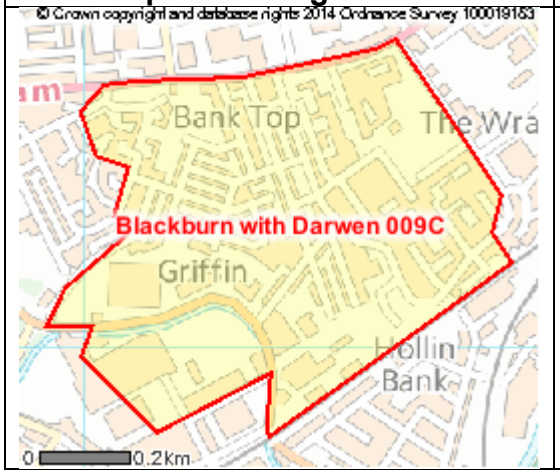
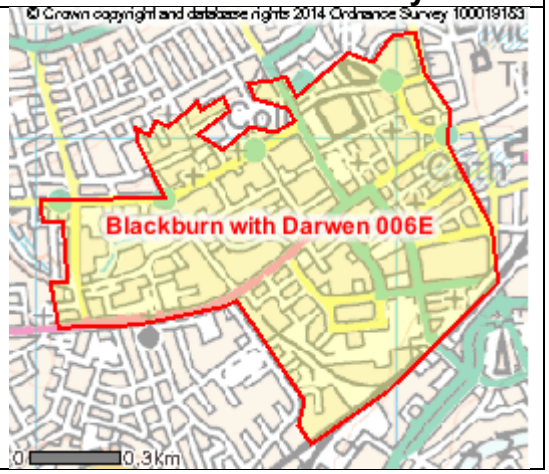
The boundaries are:

- The northern boundary (from west to east), includes King Georges Hall, the majority of the College Campus, Ashworth Street estate and Oakenhurst Road/Wensley Road to the junction with Saunders Road/Garden Street. This boundary is co-terminus with the Lower Preston New Road Neigbourhood Area mentioned later on.

- The eastern boundary (from north to south) is Northgate going down to Astley Gate and Mincing Lane, down to Darwen Street at Darwen Street Bridge.

- The southern boundary (from west to east) is the Railway line from Darwen Street bridge to the Hollin Street Bridge near the Havelock Public House on Standliffe Street.

- For ease, the western boundary (from South to North) runs along Stancliffe Street, up Griffin Street, along Portland Street and around the back of properties on Curzon Place and Belgrave Close so as not to include them, but to join St Philips Street and Redlam. From Redlam (eastwards) to the miniroundabout on Garden Street. North along Garden Street to Wensley Road.

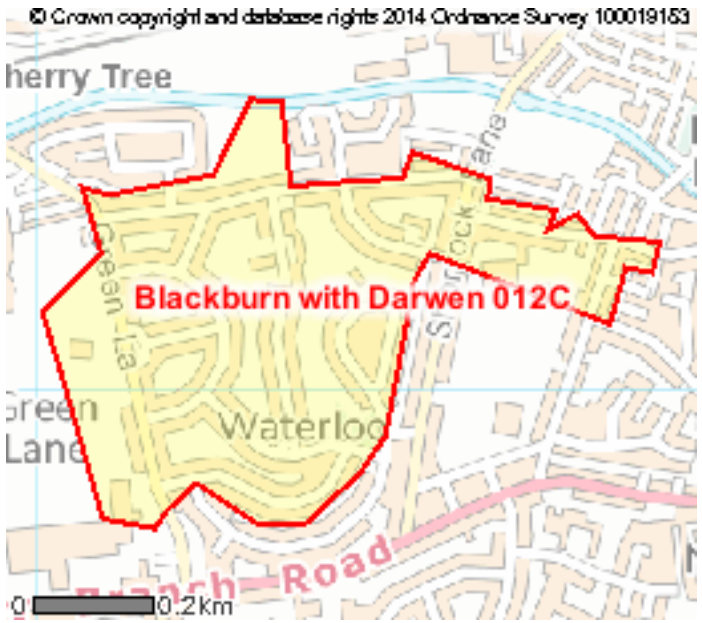
Bank Top and Galligreaves Estate	Blackburn Town Centre/Whalley Banks
	

b) Green Lane Estate

There is one lower super output area within the 5% most deprived - which almost entirely consists of the Green Lane Housing estate between Shorrock Lane and Green Lane. The LSOA is located within the Mill Hill and Moorgate Ward.

For ease, the boundary consists of:

- Northern boundary - the Leeds-Liverpool Canal
- Western boundary - Green Lane (from Livesey Branch Road to the Leeds-Liverpool Canal)
- Eastern boundary - Shorrock Lane (from Livesey Branch Road to the Leeds-Liverpool Canal) including houses on Bentham Road
- Southern boundary - Livesey Branch Road from Green Lane to Shorrock Lane.



c) Lower Preston New Road Area

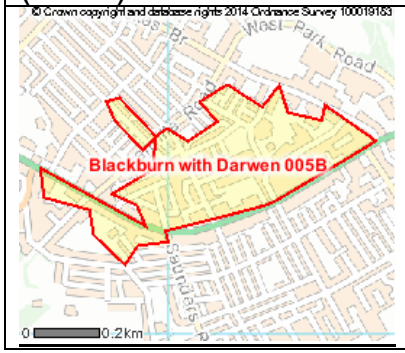
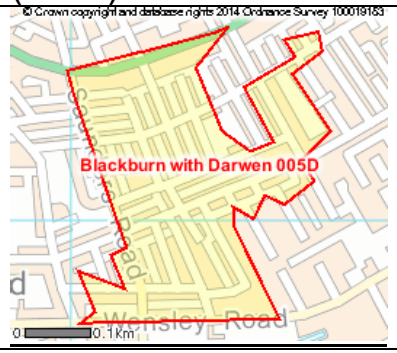
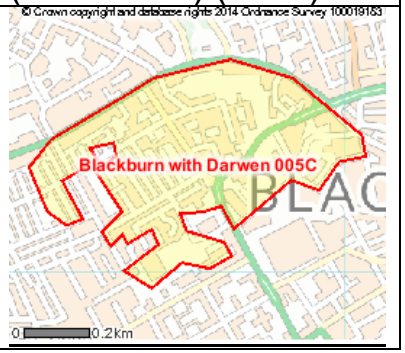
There are **three lower super output areas** around Leamington Road north of Preston New Road, and the Johnston Street / Montague Street / Park Road area south of Preston New Road. Preston New Road is the main road going through the area so we have called the area the 'Lower Preston New Road Area' to describe the area closer to the Town Centre rather than the bit around Beardwood and Billinge.

The **three lower super output areas** are within the most deprived 10% of LSOAs nationally and they are largely located within the Wensley Fold Ward with a very small element being located in the Corporation Park and Shear Brow ward.

The geographical boundaries are:

- The northern and eastern boundary is Granville Road, Dukes Brow and Preston New Road until it reaches Northgate at Sudell Cross.

- The western boundary is Saunders Road.
- The southern boundary is Wensley Road. Oakenhurst Road and Barbara Castle Way. This boundary is co-terminus with the northern boundary of the Blackburn Town Centre West area.

Leamington Road (005b)	Johnston Street area (005d)	Montague Street (north area) (005c)
		

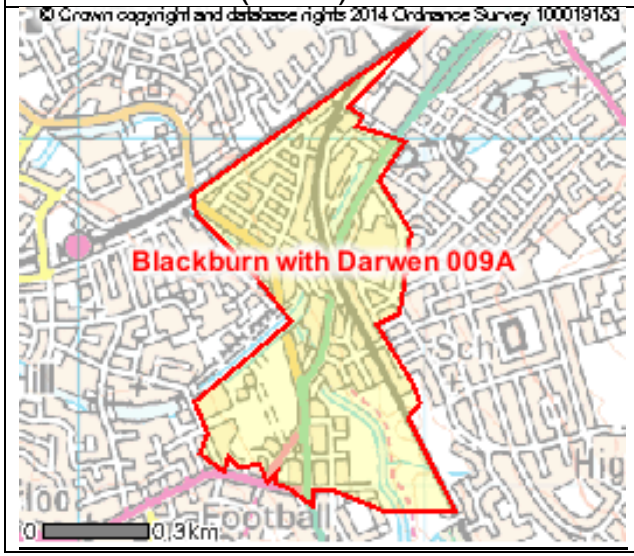
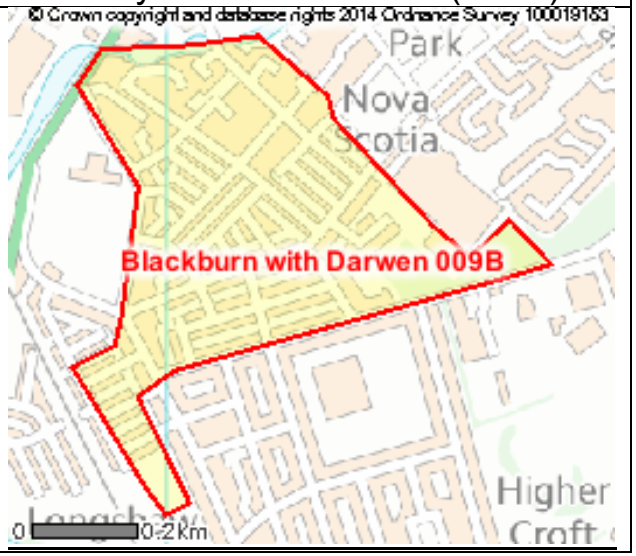
d) Hollins Bank and Infirmary Area

There are **two Lower Super Output Areas (LSOAs)** located within the Ewood Ward that are within the most deprived 10% of LSOAs nationally - which we have termed Hollins Bank and Infirmary Neighbourhood Area.

The boundaries for this area are:-

- Northern boundary is the railway line and Lower Hollins Bank Street / Chadwick Street and the Leeds-Liverpool Canal
- Eastern boundary is Highfield Road
- Western boundary is the River Darwen, Leeds Liverpool Canal and Albion Street

- Southern boundary is Livesey Branch Road, the Blackburn side of Ewood Park and Park Lee Road.

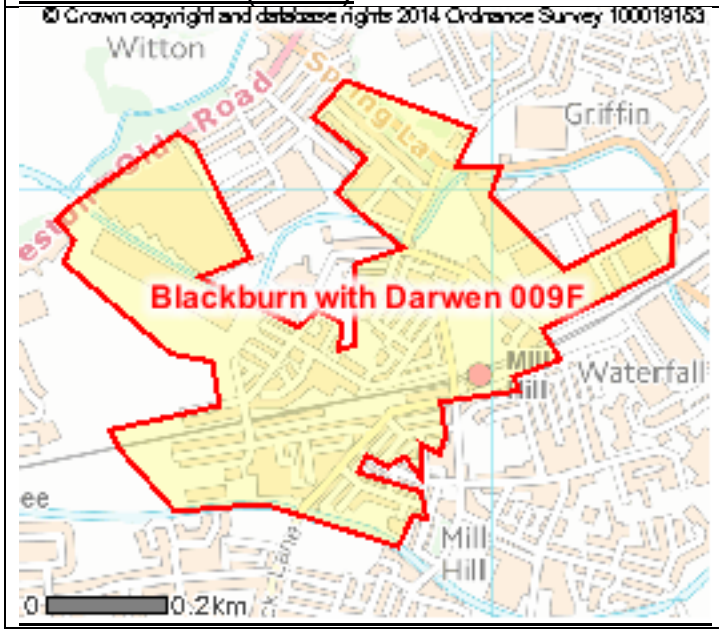
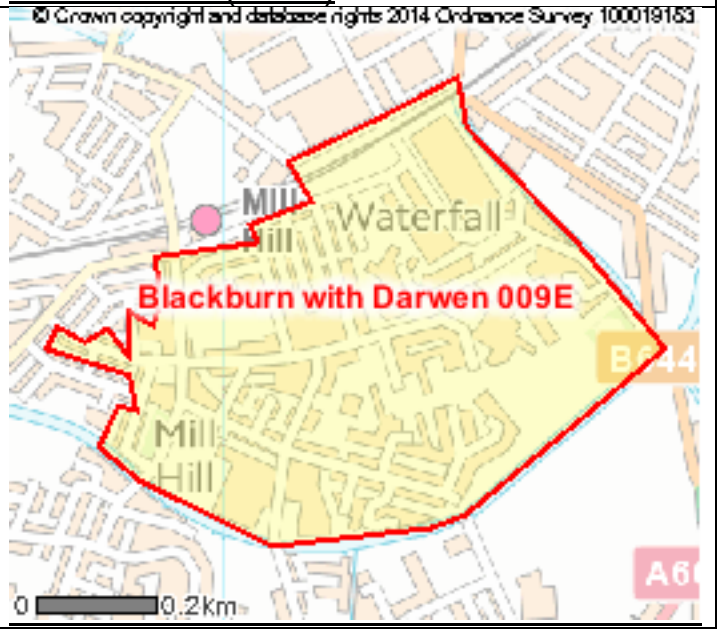
Hollins Bank (009A)	Infirmary Residential Area (009B)
	

e) Mill Hill

There are **two lower super output areas** [which we have described as Mill Hill West 009F and Mill Hill East 009E] within the most deprived 10% nationally, which form Mill Hill. They are located within the Mill and Moorgate Ward.

The boundaries for the Mill Hill area are:-

- The northern boundary is Preston Old Road, and Spring Lane
- The eastern boundary is the River Darwen and Stanscliffe Street.
- The western boundary is the playing fields at St Francis.
- The southern boundary is the Leeds-Liverpool Canal.

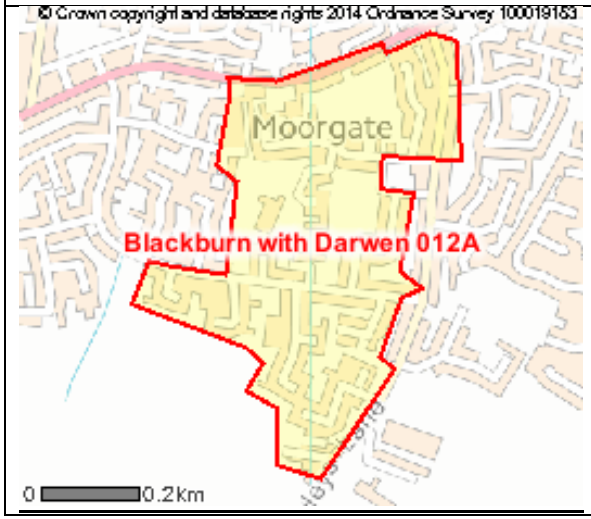
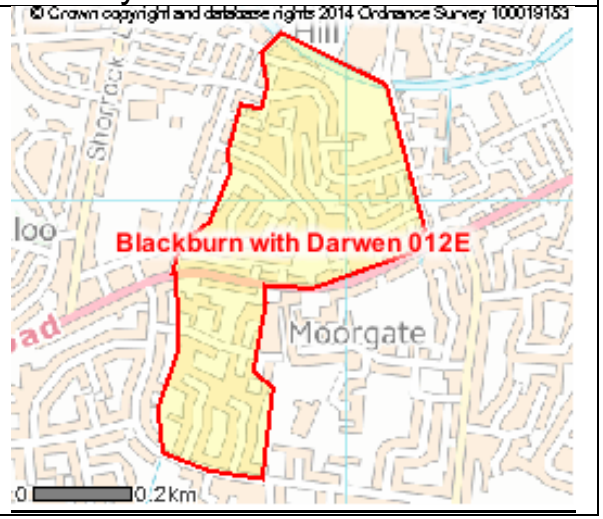
Mill Hill West (009F)	Mill Hill East (009E)
	

f) Moorgate Neighbourhood

There are **two lower super output areas** within the most deprived 10% nationally which span Livesey Branch Road and the Mill Hill and Moorgate and Ewood Wards. We have described them as:Livesey estate (012a) and Old Moorgate (12e) - although old Moorgate contains part of the Livesey estate. Together they form the Moorgate Neighbourhood area.

The boundaries are:

- Northern boundary is the Leeds-Liverpool Canal. This is co-terminus with the Mill Hill Neighbourhood Area.
- The eastern boundary is Moorgate Street and Heys Lane
- The western boundary is the rear of the houses on Parklands Way and Kings Road / Kings Bridge Street.
- The southern boundary is the Livesey housing estate.

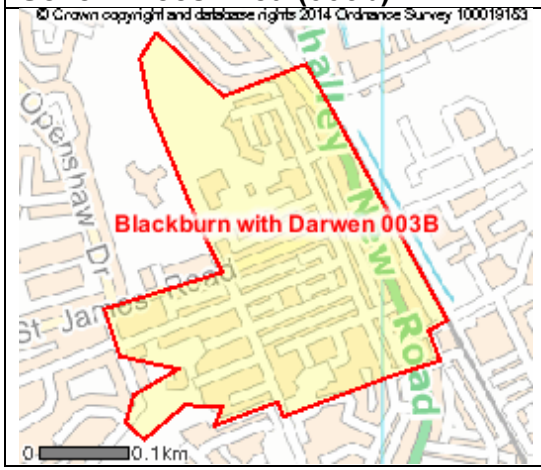
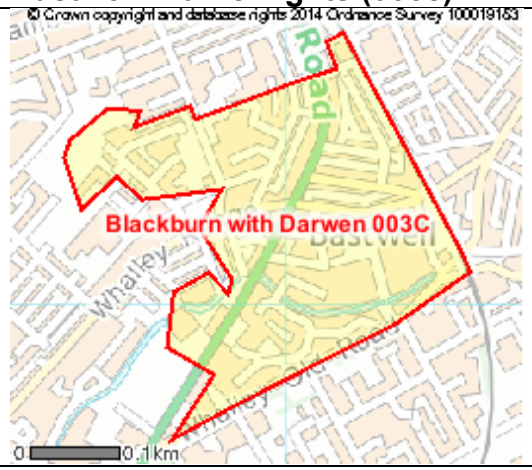
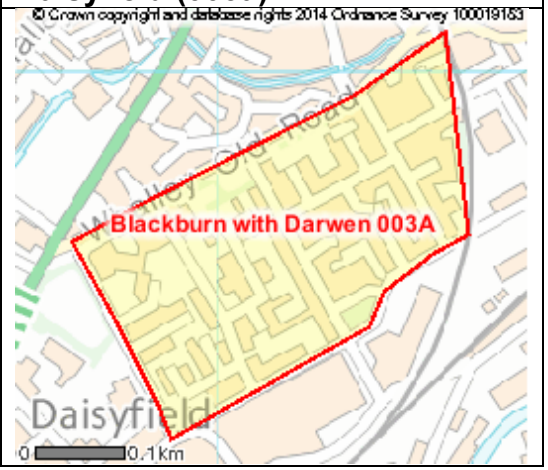
Livesey Estate (012a)	Old Moorgate (12E) and part of Livesey Estate
	

Blackburn North

Blackburn North Primary Care Network contains **three** Lower Super Output Areas (LSOAs) within the most deprived 10% nationally. These LSOAs are located within the Bastwell and Daisyfield ward. Whalley New Road is the main road that runs through the area and the three:LSOAs form a cohesive area, which reflects the name of the ward.

The boundaries are:

- The northern boundary is Skew Bridge, Teak Street allotments and land of Cedars Primary Schools, which are behind Rosewood Avenue (which is not part of the area).
- The eastern boundary is the Blackburn to Clitheroe railway line to Skew Bridge
- The western boundary is Darwen Street, Railway Road, Ainsworth Street, Victoria Street, Whalley Range,and Troy Street.
- The southern boundary is the Blackburn to Leeds Railway Line.

Seven Trees Area (003b)	Bastwell Traffic Lights (003c)	Daisyfield (003a)
		

Darwen

Darwen Primary Care Network contains **five Deprived Lower Super Output Areas** with 3 of those being in the most deprived 5% nationally and the other 2 being in the most deprived 10% nationally. These form two cohesive neighbourhood areas, namely **Hollins Grove** and **Sudell**.

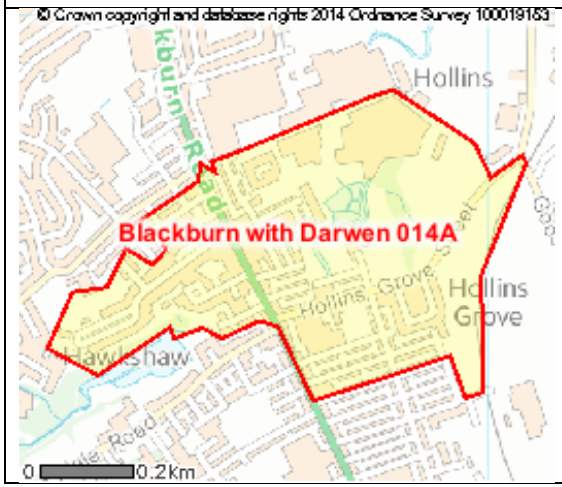
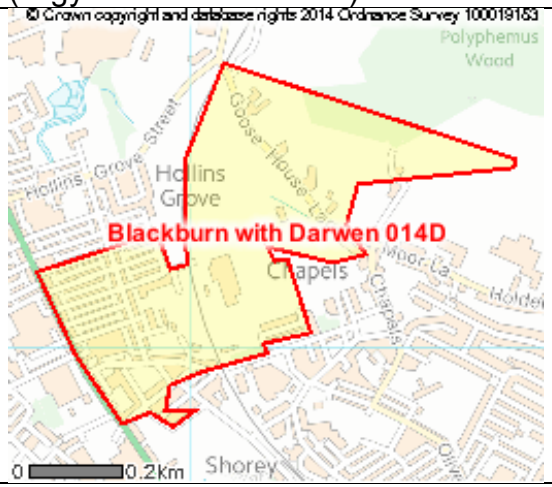
These areas are described below:

Hollins Grove (10% most deprived)

There are two lower super output areas in the most deprived 10% of LSOAs nationally, which are located within the Hollins Grove area of Darwen and are largely located within the Darwen East ward.

The boundaries for the area are:-

- Northern boundary (West to East)- Hollins Road to Hollins Grove Street and Lower Eccleshill Road
- Eastern boundary (north to south) - across fields in an easternly direction before coming back west of Knowle Lane to join Goose House Lane at Chapels
- Western boundary - Blackburn Road / A666 - but including properties along Hawshaw Avenue across to St Cuthberts School and down St Albans Road.
- Southern boundary (east to west)- for ease, from the Punch Public House, Exchange Street, Dove Lane and Heys Lane to the A666 - Blackburn Road.

Hollins Grove North (14 a)	(14d) Hollins Grove South (Argyle St to Dove Lane)
	

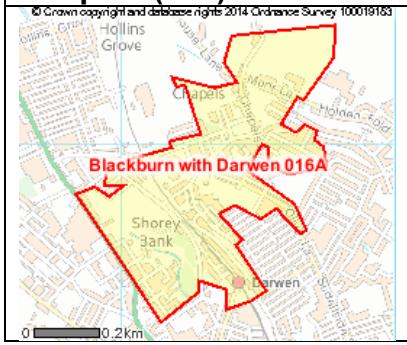
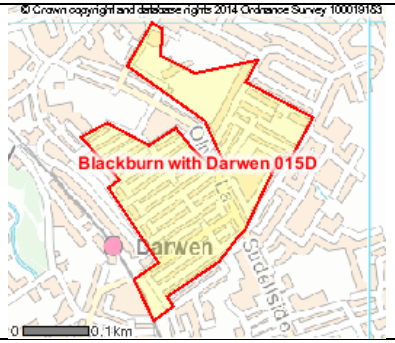
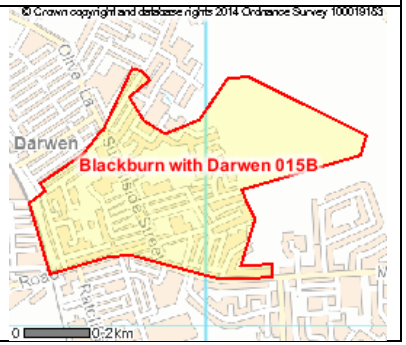
Sudell (5% most deprived)

There are three lower super output areas in the most deprived 5% of LSOAs nationally, which are located within the Sudell area of Darwen- which is forms the central part of Darwen East ward. This includes the Shorey Bank and Chapels LSOA; the Olive Lane LSOA (which has Sarah Street and Anyon Street as its southern edge); and Sudellside LSOA (which contains the area from Sarah Street /Anyon Street to Sudell Road).

Boundaries for this area are:

- Northern boundary (west to east) from the A666 (Duckworth Street), Heys Lane, Dove Lane, then Exchange Street in a straight line to the Punch. Along Chapels and Moor Lane to Holden Fold.
- Western boundary (north to south) - along A666-Duckworth Street to the junction with Union Street

- Eastern boundary (north to south) - at Holden Fold go south to Ivinson Road, down Elm Grove, along Hazel Avenue, down Higher Perry Street, along Laurel Avenue, up Anyon Street to Ellison Fold Way and along Ellison Fold Way to the mini-roundabout with Marsh House Lane.
- Southern boundary (west to east) - along Union Street, Knott Street, Railway Road and Atlas Street, south along the railway line to the Sudell Road Bridge and along Sudell Road, Marsh House Lane to Ellison Fold Way.

Shorey Bank and Chapels (16a)	Olive Lane area (15d)	Sudellside (15b)
		

APPENDIX D: BLACKBURN WITH DARWEN VCFSE EQUITY TASK FORCE TERMS OF REFERENCE AND AMBITIONS

Terms of Reference

Aim: to create a 'BwD VCFSE Equity Task Force' of VCFSE organisations that will work collaboratively to engage and empower our communities, which are experiencing health and wider socio-economic inequalities and to create pathways to improve their health and social, economic and personal well-being. We need to change how we approach the structural inequalities within our communities and tailor what we do to help particular parts of our community to achieve lasting change.

Ambitions:

1. **Empowering Our Communities by developing a Shared Leadership Model** where we work alongside people facing inequalities, deprivation & poverty and other forms of disadvantage to work together to create a vision and common purpose for a new future for everyone and support them to achieve the vision.

2. **Becoming Digitally Empowered**: improving how we use data and technology to support how we achieve our goals

3. **Becoming 'systems thinkers'** rather than 'silo working' putting the needs of the population first. We also need to be **holistic in our approach** where we work together to support all aspects of the person or family's life and make progress on all fronts (e.g. access to care; changing behaviours and lifestyles; tackling social, economic and environmental conditions or factors). Silo working is not having the necessary impact on changing people's lives.

4. **Becoming Asset and Placed Based** in our approach understanding the assets, talents, skills, capabilities and resources within our communities, maximising their use and development and working together to overcome the social, economic and environmental conditions and challenges that exist within the area to remove barriers to help everyone to achieve their potential. Our approach has to be asset and place based and look to the sustainable development of our communities.

5. **To become a Learning System**, where everyone, every organisation and every communities is committed to reflective practice, evaluating, learning through practice, refining what we do as we go - sharing what we do well and sharing what goes wrong so we can collectively learn, develop and improve as we embark on our journey.

Membership

Membership is open to any VCFSE organisation, who delivers activities or services within Blackburn with Darwen that support anyone who is facing inequality, deprivation, poverty or other form of disadvantage because of their protected characteristics, economic status, living in a deprived neighbourhood or due to personal circumstance. Members need to fill in a membership form and their membership approved by Community CVS until such time as the Executive Group is established. Membership will only be declined if the organisation is found not to be a VCFSE organisation, not to operate within Blackburn with Darwen or where there is evidence that the activities of the organisation does not support the aims and ambitions of the Task Force, may bring into disrepute the reputation of the Task Force or where it is questionable whether the organisation does in fact support goals of reducing inequalities, deprivation & poverty and other forms of disadvantage.

The membership can agree to set up action learning sets or task groups to explore any aspect of inequalities, deprivation & poverty, or disadvantage. A simple terms of reference setting out the remit of the group, the tasks to be completed and the timetable for completing and reporting back on what they have done.

Accountable Body and Secretariat

Community CVS will act as the accountable body and secretariat for the Blackburn with Darwen VCFSE Equity Task Force co-ordinating activity, seeking resources for the task force; managing and monitoring the distribution of those resources.

In some circumstances, it will make more sense for a member of a task group or action learning set to lead a grant application and manage a grant for that task group and action learning set. This will be agreed in advance through an open and transparent process.

Executive Group

An Executive Group to oversee the work of the Equity Task Force will be set up. The exact details to be co-designed and agreed by the membership and added to these terms of reference. Rules around frequency or meetings, quoracy for meetings, establishment of sub groups, development of action plans, etc. may be developed by the Executive Group and presented to the Membership for approval.

In terms of Ambition 1 and the **Shared Leadership Model** it is useful to consider **the Community Engagement Continuum** below

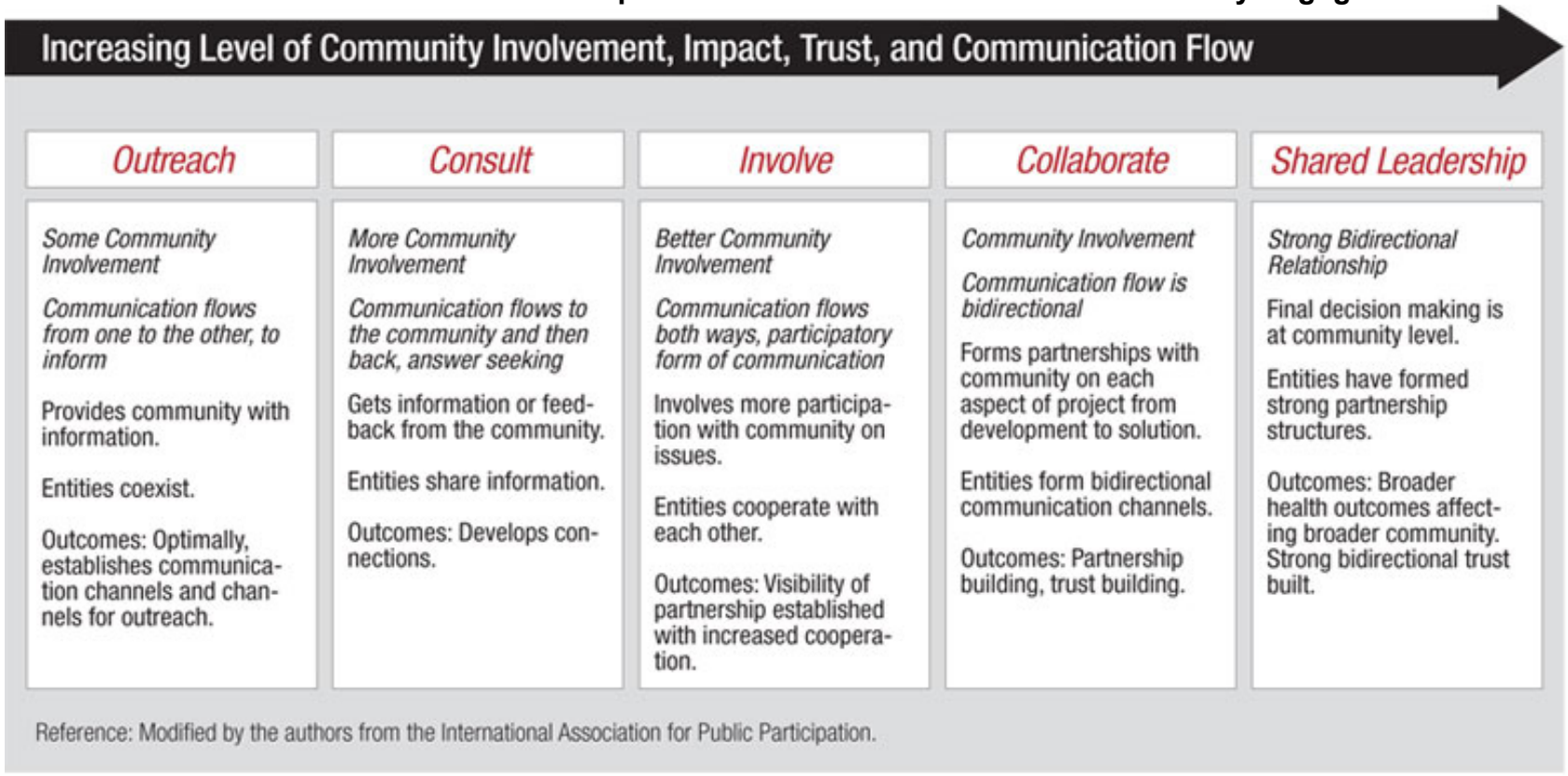


Figure 1.1. Community Engagement Continuum

[Source: Community Engagement Continuum, developed by the Clinical and Translational Science Awards Consortium (2011) Principles of Community Engagement, 2nd edition, page 8]

We need to work together to develop our relationships, understanding and trust and move along the continuum.

APPENDIX E: NATIONAL RESEARCH INTO THE COVID 19 PANDEMIC AND HEALTH INEQUALITIES

Introduction and Background

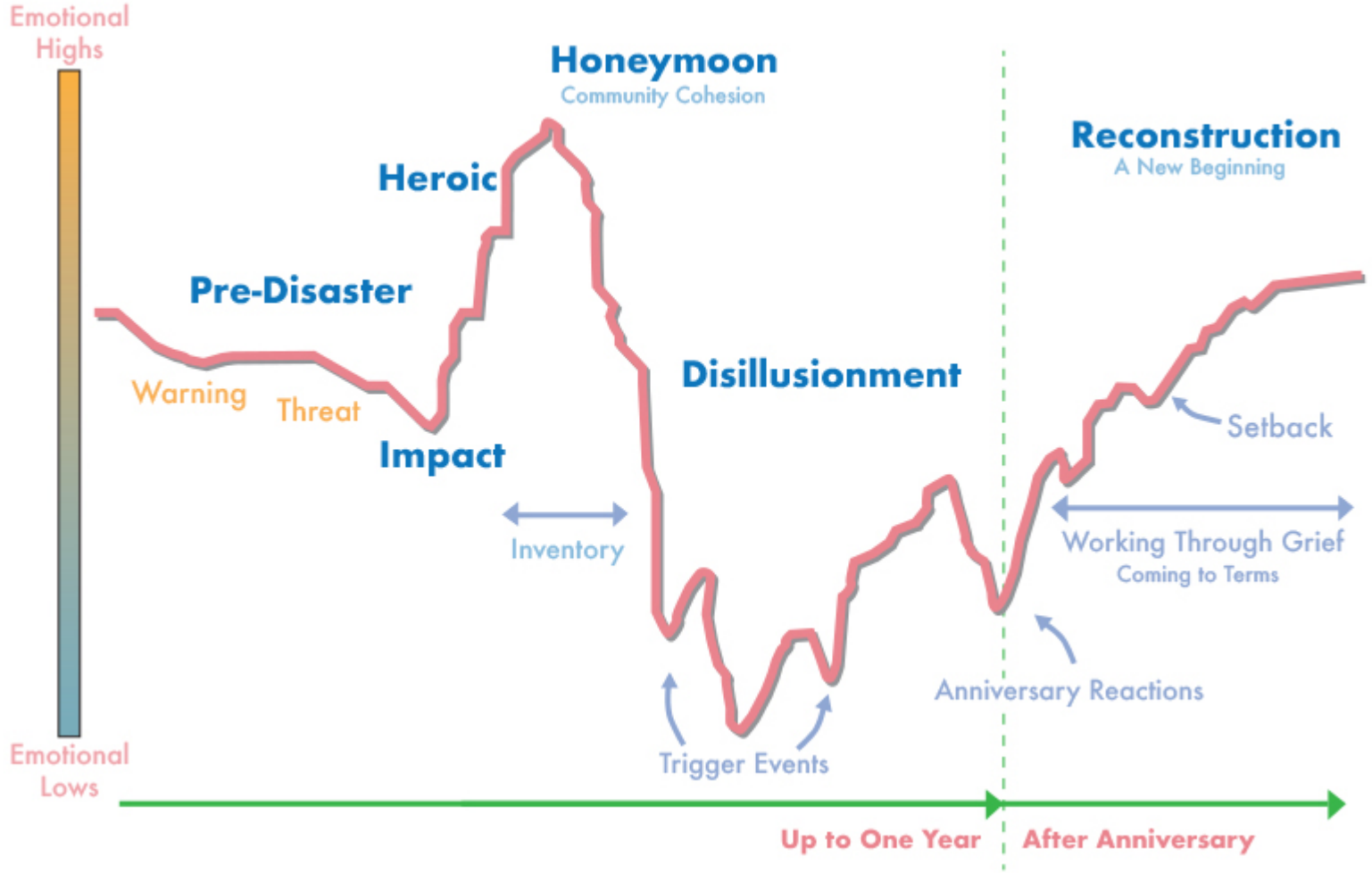
There is a growing body of evidence nationally into the COVID 19 Pandemic and health inequalities. We will provide a snapshot summary of some of those findings in due course together with evidence provided by many national charities are providing further evidence.

Locally we will have the support of public health specialists that can help us build our local understanding and as part of the collaborative work we undertake to improve our understanding of the target populations and start to develop our population health management approach to supporting those populations to take an asset based approach to improving their social, economic and health status within our community. The snapshot will include as a minimum the following:-

- Covid Recovery Commission (2020) Levelling Up Communities
- Health Foundation (2020) Infographic on unequal impact of COVID 19.
- Institute of Health Equity (2020) Build Back Fairer: The COVID 19 Marmot Review - The Pandemic, Socio-Economic and Health Inequalities in England
- Institute of Fiscal Studies (2021) The IFS Deaton Review of Inequalities - a New Year's Message
- Institute for Public Policy Research (2020) Levelling Up Health for Prosperity
- King's Fund (2021) Covid 19 Recovery and Resilience
- Public Health England (2020) Disparities in the risk and outcomes of COVID 19
- National Institute for Social and Economic Research (2021) (February 2021 - research for Channel 4 Dispatches **Britain's £400bn Covid Bill Who will Pay?**, broadcasted on 22nd February 2021)
- NCVO, ACEVO & Lloyds Bank Foundation (2021) Rebalancing the Relationship
- Resolution Foundation (2021) The Living Standards Outlook 2021: Resolution Foundation

If anyone has come across any research that is particularly illuminating and will support our collective understanding, please let Garth Hogkinson know about it by sending a link to the research or a copy of the research at garth.hodgkinson@communitycvs.org.uk

APPENDIX F: PSYCHOLOGICAL PHASES OF DISASTERS



- Phase 1, the pre-disaster phase, is characterized by fear and uncertainty. The specific reactions a community experiences depend on the type of disaster. Disasters with no warning can cause feelings of vulnerability and lack of security; fears of future, unpredicted tragedies; and a sense of loss of control or the loss of the ability to protect yourself and your family. On the other hand, disasters with warning can cause guilt or self-blame for failure to heed the warnings. The pre-disaster phase may be as short as hours, or even minutes, such as during a terrorist attack, or it may be as long as several months, such as during a hurricane season.
- Phase 2, the impact phase, is characterized by a range of intense emotional reactions. As with the pre-disaster phase, the specific reactions also dangerous disasters. As a result, these reactions can range from shock to overt panic. Initial confusion and disbelief typically are followed by a focus on self-preservation and family protection. The impact phase is usually the shortest of the six phases of disaster.
- Phase 3, the heroic phase, is characterized by a high level of activity with a low level of productivity. During this phase, there is a sense of altruism, and many community members exhibit adrenaline-induced rescue behaviour. As a result, risk assessment may be impaired. The heroic phase often passes quickly into phase 4.
- Phase 4, the honeymoon phase, is characterized by a dramatic shift in emotion. During the honeymoon phase, disaster assistance is readily available. Community bonding occurs. Optimism exists that everything will return to normal quickly. As a result, numerous opportunities are available for providers and organizations to establish and build rapport with affected people and groups, and for them to build relationships with stakeholders. The honeymoon phase typically lasts only a few weeks.
- Phase 5, the disillusionment phase, is a stark contrast to the honeymoon phase. During the disillusionment phase, communities and individuals realize the limits of disaster assistance. As optimism turns to discouragement and stress continues to take a toll, negative reactions, such as physical exhaustion or substance use, may begin to surface. The increasing gap between need and assistance leads to feelings of abandonment. Especially as the larger community returns to business as usual, there may be an increased demand for services, as individuals and communities become ready to accept support. The disillusionment phase can last months and even years. It is often extended by one or more trigger events, usually including the anniversary of the disaster.
- Phase 6, the reconstruction phase, is characterized by an overall feeling of recovery. Individuals and communities begin to assume responsibility for rebuilding their lives, and people adjust to a new “normal” while continuing to grieve losses. The

reconstruction phase often begins around the anniversary of the disaster and may continue for some time beyond that. Following catastrophic events, the reconstruction phase may last for years

Source: downloaded from **https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster** on 04th February 2021 using information from the Training manual for mental health and human service workers in major disasters (2nd ed., HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Implications for the BwD VCFSE Equity Task Force, Commissioners and Funders

- we need to support people and communities to move from wherever they are (whichever phase they are in) and it will be different for different people and communities and help them move through the phases into the reconstruction phase and the start of rebuilding their lives
- we need to recognise that the reconstruction phase may be open ended and take a long time. Dealing with grief, trauma, as well as their current circumstance, existing barriers and external conditions can be considerable.
- Commissioners and Funders need to be aware that support may be time intensive and support may need to be long term.

APPENDIX G: KING'S FUND - THE HEALTH OF PEOPLE FROM ETHNIC MINORITY GROUPS

[Downloaded from https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england on 21st February 2021]

Originally published 17 February 2021

Authors: Veena Raleigh and Jonathon Holmes.

This explainer examines the differences in health outcomes for ethnic minority groups, highlighting the variation across groups and conditions, and considers what's needed to reduce health inequalities.

Key messages

- In England, there are health inequalities between ethnic minority and white groups, and between different ethnic minority groups. The picture is complex, both between different ethnic groups and across different conditions, and understanding is limited by a lack of good quality data.
- Access to primary care health services is generally equitable for ethnic minority groups, but this is less consistently so across other health services. However, people from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts.
- Despite this, before the Covid-19 pandemic, life expectancy at birth was higher among most ethnic minority groups than the white population. This underlines the complexity of the picture and the importance of distinguishing between the inequalities experienced by different ethnic groups.
    - People from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators.
    - Compared with the white population, disability-free life expectancy is estimated to be lower among several ethnic minority groups.
    - While the incidence of cancer is highest in the white population, rates of infant mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups. CVD and diabetes cause significant

morbidity among these groups, much of which can be prevented by public health measures aimed at tackling risk factors such as obesity, poor diet, inadequate physical activity and smoking.

- The Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population. The reasons for this are multi-factorial and not fully understood, but there is overwhelming evidence that existing socio-economic inequalities and co-morbidities such as CVD and diabetes have played a key role. The impact of Covid-19 has been so significant that it has reversed the previous picture and many ethnic minority groups now have higher overall mortality than the white population.
- Unpicking the causes of ethnic inequalities in health is difficult. Available evidence suggests a complex interplay of deprivation, environmental, physiological, behavioural and cultural factors.
- Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism can reinforce inequalities among ethnic groups, for example in housing, employment and the criminal justice system, which in turn can have a negative impact on their health. Evidence shows that racism and discrimination can also have a negative impact on the physical and mental health of people from ethnic minority groups.
- Covid-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in ethnic minority communities. A cross-government strategy for reducing health inequalities, and the wider socio-economic and structural inequalities that drive them, should be an urgent priority.
- Comprehensive, good-quality data is essential for enabling policy-makers and health care professionals to identify the specific needs of different ethnic minority communities, respond with tailored strategies for addressing inequalities, and track the impact of these strategies.

The references providing the evidence to support the contents of each section of this explainer are listed in drop-downs at the end of each section on the website version of this paper. CVS can also supply the references if required.

Introduction

In the 2011 census, 15 per cent of people in England identified themselves as belonging to an ethnic minority group (*see* Table 1)[1]. Office for National Statistics (ONS) estimates of population by ethnic group show the per cent non-White in England in 2018 was 16

per cent. Ethnicity is a complex, multidimensional concept, defined by features such as a shared history, origins, language, and cultural traditions. Although it is a social construct often used to describe distinct populations, it is a subjective identity based on how individuals define themselves.

Health patterns differ significantly between ethnic minority groups and the white population, and between minority groups, reflecting the diversity of demographic, socio-economic, behavioural, cultural and other characteristics between ethnic groups.

This explainer provides an overview of health outcomes and their determinants among ethnic minority groups. It focuses on selected topics where ethnic differences are significant and affect large numbers.

This explainer describes ethnic differences in:

- overall health
- maternal and infant mortality, and child health
- cardiovascular disease (CVD)
- diabetes
- cancer
- Covid-19
- determinants of health.

This is not a comprehensive review of all aspects of ethnic minority health. In particular, it does not cover mental health because of the challenges in summarising ethnic differences across diverse forms of mental illness in a short report.

Data on the health of ethnic minority groups

This explainer focuses on the health of ethnic minorities in England. Where articles and data sources refer to different geographies, e.g. England and Wales or the UK, this is stated in the text.

The 2011 census ethnic categories are used, although sometimes data sources refer to aggregated ethnic groups when numbers are small. The categories used here are those used in the original data sources. The South Asian group refers to people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan. The Asian group generally also includes people from South East Asia. The Black group includes people of African and/or Caribbean origin.

Much of the data for examining ethnic differences in health comes from health records. However, its coverage and quality are imperfect. National data on mortality by ethnic group has not been available routinely because ethnicity is not recorded at death registration (although Scotland introduced this in 2012). Earlier analyses of mortality therefore used country of birth of migrants as a proxy for ethnicity, but this excludes second-generation migrants. Ad hoc analyses of mortality have been undertaken, for example by the ONS and Public Health England, by linking death records to secondary sources from which ethnicity is derived, eg, the 2011 Census and hospital records. These data limitations present barriers to understanding health issues among ethnic minority groups.

Following the Covid-19 pandemic, national agencies are moving to improve ethnicity recording in health records and the government has said it will introduce ethnicity recording in death certificates. These data developments should facilitate a better understanding of ethnic differences in health.

Overall health

General health can be measured by self-reported outcomes, such as how people perceive their health, and observed outcomes such as mortality. There are differences in health between ethnic minority groups, and between ethnic minority groups and the white group; the patterns vary depending on the aspect of health being measured.

People from ethnic minority groups (especially Pakistani and Bangladeshi groups) are more likely than those from the White British group to report limiting long-term illness and poor health, with those identifying as White Gypsy and Irish Traveller reporting the poorest health. Health-related quality of life scores at older ages, based on responses to the GP patient survey, are lower than average among most ethnic minority groups, especially the White Gypsy and Irish Traveller, Bangladeshi and Pakistani groups, but not among some others (Black Caribbean, Black African and Mixed groups). Ethnic minority groups also have an increased prevalence of some long-term conditions (e.g. diabetes), but not of some other common conditions (e.g. arthritis).

Compared with the White British group, disability-free life expectancy is estimated to be higher among the Other White, Chinese and Black African groups, lower among Black Caribbean, Other Black, Indian, Other Asian and some Mixed groups, and lowest among the Pakistani and Bangladeshi groups.

Analyses show most ethnic minority groups in England and Scotland have lower overall mortality than white counterparts but also that this mortality advantage is reduced in their UK-born descendants – possibly because cultural assimilation over time leads to lifestyle changes, eg, in diet and smoking. Public Health England's analysis showed that in 2014–18 all-cause mortality rates in England were up to 20 per cent lower among Asian and Black groups than the national average. Analyses by country of birth for years back to 1971, when data by ethnicity was unavailable, also showed a general pattern of lower overall mortality rates among migrants born in South and East Asia, Africa, the Caribbean and the Middle East compared with the national average.

However, the Covid-19 pandemic has reversed the mortality advantage in some ethnic minority groups. Between March and July 2020 overall mortality was higher in Black Caribbean males and females, and Black African and Bangladeshi males, than in the white group; it was lower in Chinese, Indian and Other ethnic groups.

The ONS is due to publish a comprehensive analysis of ethnic differences in overall and cause-specific mortality in spring 2021.

Maternal and infant mortality, and child health

Maternal mortality

More than one-quarter of the 600,000 babies born annually in England and Wales are to mothers of ethnic minority origin (*see* Table 2). Compared with the white group, the rate of women dying in the UK in 2016–18 during or up to one year after pregnancy is more than four times higher in the Black group, and almost double in the Asian group (although the number of such deaths is relatively low – under 10 a year in both the Black group and also the Asian group).

Infant mortality

Infant mortality rates are generally higher among ethnic minority groups. Infant mortality in 2015 –17 was highest among babies of Pakistani origin, followed by Black African and Black Caribbean groups (*see* Table 2).

The causes of infant mortality differ between ethnic groups. South Asian and Black mothers have higher proportions of premature and low birthweight babies than white mothers (*see* Table 2). Although immaturity-related conditions, such as respiratory and cardiovascular disorders, contribute most to infant mortality in most ethnic groups, in the Pakistani and Bangladeshi groups more infant deaths are caused by congenital anomalies. However, ethnic minority women are less likely to smoke and the risk of sudden infant death syndrome is lower in South Asian babies. Explanations for variations in infant mortality between ethnic groups are complex, involving the interplay of deprivation, environmental, physiological, behavioural and cultural factors. Research suggests quality of care is equitable.

Table 2 Live births, low birthweight and infant mortality by ethnic group, England and Wales

Ethnic group	Total live births (term) 2018	Per cent of live births 2018	Low birthweight (term) 2018	Per cent of low birthweight 2018	Infant deaths per 1,000 live births 2015-17
White British	353,418	59.4	8,997	2.5	3.2
White other	71,383	12.0	1,541	2.2	2.6
Bangladeshi	8,696	1.5	561	6.5	4.8
Indian	18,132	3.0	1,066	5.9	4.1
Pakistani	24,503	4.1	1,172	4.8	6.8

Ethnic group	Total live births (term) 2018	Per cent of live births 2018	Low birthweight (term) 2018	Per cent of low birthweight 2018	Infant deaths per 1,000 live births 2015-17
Black African	19,661	3.3	612	3.1	6.3
Black Caribbean	4,946	0.8	215	4.3	5.6
Other	69,968	11.8	2,155	3.1	4.1
Not stated	24,267	4.1	697	2.9	-
Total	**594,974**	**100**	**17,286**	**2.9**	**3.8**

Source: Office for National Statistics (2020a, b)

Child health

Health and wellbeing in the early years have a significant bearing on future health. Childhood obesity rates are higher among Black and Asian children (*see* Table 3). Some of these differences may be associated with higher levels of deprivation among ethnic minority groups, as children in deprived areas are twice as likely to be obese than those in less-deprived areas. Children in Asian (37 per cent) and Black (37 per cent) households are twice as likely to live in persistent low-income households than children from White households (18 per cent).

South Asian children also have lower levels of physical fitness than children in white European and Black groups, and physical activity levels are lower among children from Bangladeshi and Pakistani groups.

Table 3 Prevalence of obesity by ethnic group, England, 2018/19

Ethnic group	Ages 4-5 years per cent	Ages 10-11 years per cent
White	9.3	18.4
Asian	9.8	25.2
Black	15.2	28.9
Chinese	6.4	18.7
Mixed	10.1	22.4
England	**9.7**	**20.2**

Source: [NHS Digital]

Cardiovascular disease

Cardiovascular disease[2] (CVD) is a leading cause of death nationally, and in ethnic minority groups, causing 24 per cent of all deaths in England and Wales in 2019. It is a significant contributor to inequalities in life expectancy and a risk factor for poor outcomes from Covid-19. Up to 80 per cent of premature deaths from CVD are preventable through better public health. Diabetes increases the risk of CVD almost two-fold.

Prevalence of CVD

Studies in the UK and across the Indian diaspora (eg, Europe, Fiji, Singapore, South Africa, the US and Canada) consistently show a higher incidence, prevalence and mortality from CVD in South Asian groups compared with the white group or national average. South Asian groups also develop heart disease at a younger age. As with heart disease, stroke incidence and mortality are also higher in the South Asian population. CVD mortality is high and rising in South Asia, in contrast to the declining trend elsewhere.

These patterns are associated with a higher clustering in South Asians of risk factors[3] that increase the risk of heart disease, stroke and diabetes. Although body mass index (BMI) levels are lower among South Asian groups compared with normal ranges, rates of excess abdominal fat and insulin resistance are higher. Hence National Institute for Health and Care Excellence (NICE) guidelines specify lower BMI thresholds for use by health care professionals for introducing preventive interventions in these groups. In terms of other risk factors, although smoking prevalence is lower among South Asian groups, they have low physical activity rates, especially among women. The causes of increased CVD risk among South Asian groups are multifactorial and include physiological susceptibility, environmental determinants such as deprivation, and adverse changes to lifestyle and diet following migration.

In contrast to South Asian groups, Black groups in the UK have a significantly lower risk of heart disease compared to the majority of the population, despite having a high prevalence of hypertension and diabetes (risk factors for heart disease and stroke). Lower cholesterol levels among people of African Caribbean heritage than white Europeans may protect them against heart disease. Heart disease rates are low in sub-Saharan Africa and the Caribbean.

However, Black groups have a higher than average incidence of and mortality from stroke, and they have strokes at a younger age. The prevalence of hypertension, a risk factor for stroke, is reported to be high in the West Indies. Obesity levels are also higher in Black groups, with NICE guidelines specifying lower BMI thresholds for them.

Care for CVD

Recent evidence suggests that greater awareness among health care providers of the CVD risk in South Asian populations, earlier diagnosis and improved management of diabetes and CVD, together with second-generation adopting healthier lifestyles than first-generation migrants, have reduced CVD mortality risks relative to white Europeans. Research also indicates that South Asian groups have equitable access to care for heart disease and better survival rates from it.

In contrast, Black groups have lower than expected rates of access to and use of cardiovascular care.

Diabetes

Diabetes[4] is a chronic condition that can cause serious secondary complications and premature death if it is not well managed. This explainer considers type-2 diabetes. Being overweight, abdominal obesity and physical inactivity are risk factors for diabetes. The prevalence of diabetes is higher among South Asian and Black groups than in the white population and people in these groups develop the condition at a younger age.

Prevalence of diabetes

The risk of developing diabetes is up to six times higher in South Asian than white groups. About 400,000 people of South Asian ethnicity in the UK have diabetes, one-fifth of the UK diabetes population. High diabetes prevalence is seen also in their countries of origin and across the South Asian diaspora worldwide, eg, in Europe, the US, Canada, the Caribbean, South Africa, Fiji. South Asians with diabetes have a higher risk of developing secondary complications of cardiovascular and end-stage renal disease. However, recent studies show that excess CVD mortality in South Asians with diabetes has reduced and overall mortality is lower than in the white group.

Explanations for the high prevalence of diabetes among South Asian groups include a mix of biological, lifestyle and socio-economic factors. As with CVD, these patterns are associated with a clustering in South Asians of risk factors (*see* footnote 3) that increase the risk of diabetes, exacerbated by socio-economic disadvantage and changing lifestyles after migration. Even though South Asians typically have a low BMI, excess abdominal fat increases the risk of diabetes and CVD. Accordingly, NICE, the World Health Organisation and several national diabetes associations recommend lower BMI thresholds for introducing preventive measures in South Asians with diabetes.

Diabetes prevalence in Black groups is up to three times higher than in the white population; they also have a higher risk of hypertension and stroke but, unlike South Asians, are less prone to heart disease. The physiological pathways and impacts of diabetes therefore differ between ethnic minority groups. Diabetes-related co-morbidities in Black groups are similar to or lower than those in white groups, except for higher rates of end-stage renal disease. Like South Asians, excess mortality associated with diabetes is lower in Blacks groups than in the white population.

Care for diabetes

A recent study found improved diabetes outcomes in South Asians are attributable in part to earlier diagnosis and risk factor management, indicating increased awareness among health care providers, equity of access and standardisation of care for chronic conditions incentivised in the Quality and Outcomes Framework for GPs. It also found little evidence of inequalities in the management of diabetes among Black patients at initial diagnosis, indicative of a wider trend of shrinking inequalities in diabetes care.

Cancer

Cancer incidence

The incidence of cancer overall is generally lower among ethnic minority groups in England. Asian, Chinese and Mixed groups have a significantly lower risk (of 20–60 per cent) of getting cancer than the white group; smoking rates are generally lower in these groups. Cancer incidence is also lower among Black women but similar in Black and white men.

In terms of specific cancers, Asians have a higher incidence than the white group of cancer of the liver and mouth (females only), and a lower risk of the four major cancers (breast, prostate, lung, colorectal) and several less common cancers.

Black groups have a significantly lower incidence of three major cancers (breast, lung and colorectal) and several less-common cancers. However, the incidence of and mortality from prostate cancer is significantly higher among Black males than white males. Black men in Africa, the Caribbean and the US are also at greater risk of prostate cancer for reasons that are unclear.

Although lower breast cancer incidence in Asian and Black women is associated with a lower risk profile (such as lower alcohol consumption, breastfeeding, childbearing), cultural assimilation over time can lead to changes in health behaviours. Some evidence suggests cancer rates in South Asian groups are converging towards those in the white population.

Cancer screening

Screening is an important part of efforts to reduce cancer mortality. Screening rates for breast and cervical cancer are lower among ethnic minority women, particularly South Asians. South Asians also have lower rates of bowel cancer screening.

Poorer awareness of risk factors for cancer and symptoms, and socio-cultural and practical barriers such as language, contribute to lower cancer screening rates among ethnic minority groups.

Stage at diagnosis

The stage at which cancer is diagnosed can have an impact on treatment outcomes and mortality. It may be related to a patient's route to diagnosis, including through screening. Although data for 2012–13 showed the Black Caribbean group was more likely than the White British group to be diagnosed late for some cancers, 2017 data shows the proportion of early-stage cancer diagnoses

among Asian and Black groups (55 per cent) was similar to the white group (52 per cent). Research has also found weak evidence of ethnic inequalities in times to cancer diagnosis and staging.

Cancer mortality

Cancer mortality rates measure cancer deaths in relation to population size, and reflect both cancer incidence (ie, the numbers who develop cancer) and the deaths from it. Overall cancer mortality rates by country of birth are lower than the national average among migrants born in Asia, Africa and the Caribbean. However, prostate cancer mortality is higher among male migrants born in West Africa or the West Indies.

Cancer survival measures the proportion of people with cancer who survive, and reflects many factors including deprivation, stage at diagnosis and quality of care. Cancer survival in minority ethnic groups is reported to be similar to the white population.

Covid-19

The Covid-19 pandemic is having a disproportionate effect on ethnic minority groups, with Black, Asian and most other minority groups more likely to be diagnosed with Covid-19, get severely ill and die compared to the white population. Several factors contribute to these patterns.

Outcomes of Covid-19

Exposure to infection is higher among ethnic minority groups because, for example, they are more likely to work in public-facing jobs such as transport and health and social care, use public transport, and live in high-density housing, multi-generation households and urban areas where transmission is higher.

Once infected, the risk of severe disease and death from Covid-19 is also higher in South Asian and Black groups, in part due to a higher prevalence of obesity and chronic conditions such as CVD, hypertension and diabetes, which increase the risk of adverse outcomes.

In the first Covid-19 wave[5], ethnic minority groups other than Chinese had higher Covid-19 mortality rates than the white group, rates being about double in Black groups. In the second wave, Pakistani and Bangladeshi groups continued to have higher Covid-19 mortality, but Black groups did not. Lockdown measures introduced in March 2020 were associated with significant reductions in ethnic inequalities in Covid-19 mortality. The findings suggest these inequalities are largely due to an increased risk of infection rather than a worse prognosis, and can be addressed.

Higher mortality is also reported for NHS and social care staff from Black, Asian and other ethnic minority groups.

Covid-19 and inequalities

Several reviews have examined the impact of Covid-19 on ethnic minority groups and the contributory factors, including the role of racism and discrimination, noting how Covid-19 has amplified health and socio-economic inequalities in UK and elsewhere. Demographic, geographical, socio-economic and household characteristics, and co-morbidities, contribute significantly to ethnic differences in Covid-19 outcomes, but they do not explain all the variation. The reasons for ethnic differences in Covid-19 outcomes are not yet fully understood, and the government has funded research on this

Determinants of health

Here we examine ethnic differences in some key determinants of health, namely behavioural risk factors, access to health care services, and socio-economic factors.

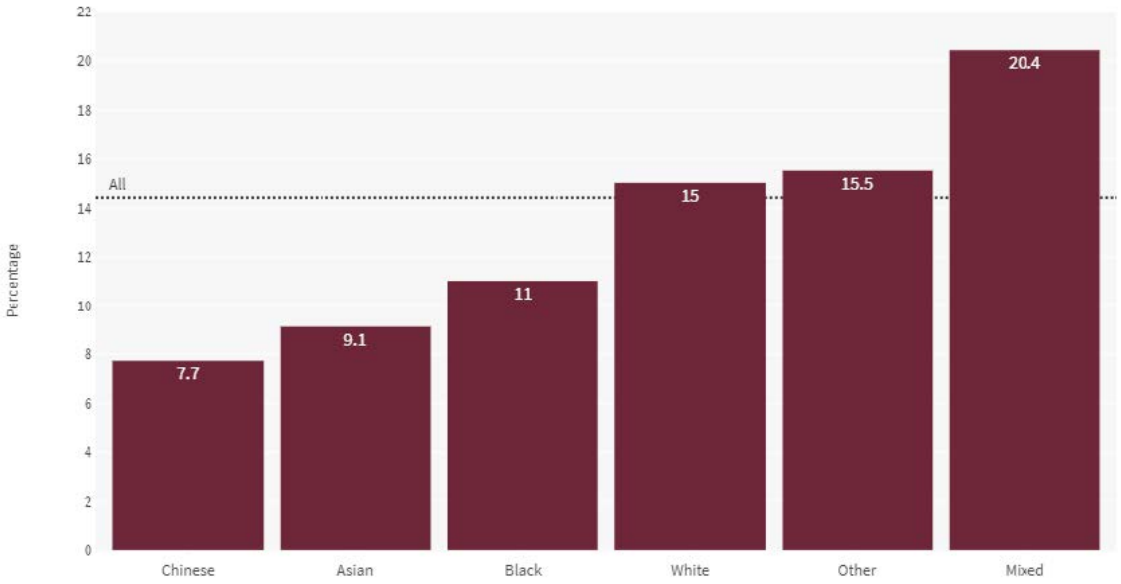
Selected behavioural risk factors

Smoking, high alcohol consumption, physical inactivity and a poor diet are four principal behavioural risks to health; the latter two also cause obesity. Their prevalence varies across the population, although they tend to cluster in more deprived communities.

Smoking

Smoking prevalence is lower in most ethnic minority groups than in the white group, and highest in the Mixed group (*see* Figure 1).

Figure 1 Per cent of people aged 18 years and over who smoke, England, 2018



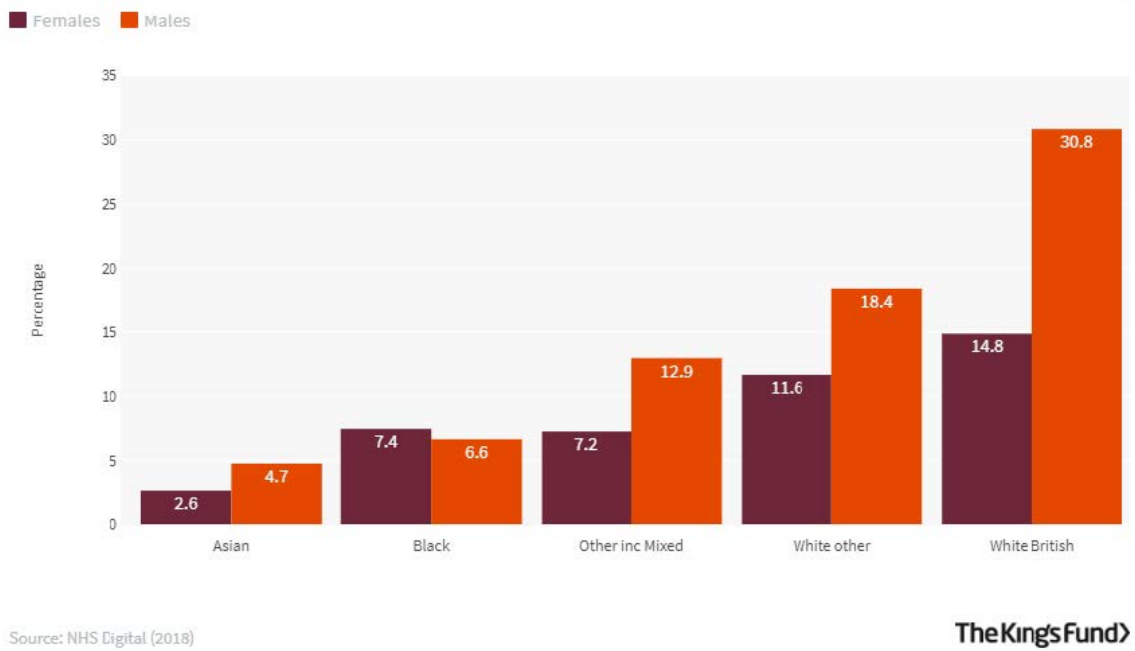
Source: Office for National Statistics (2019)

The King's Fund

Alcohol consumption

Adults in ethnic minority groups are less likely to drink alcohol at a hazardous, harmful or dependent level compared to white groups (*see* Figure 2).

Figure 2 Per cent of people aged 16 years and over who drink at hazardous, harmful or dependent levels: England, 2014



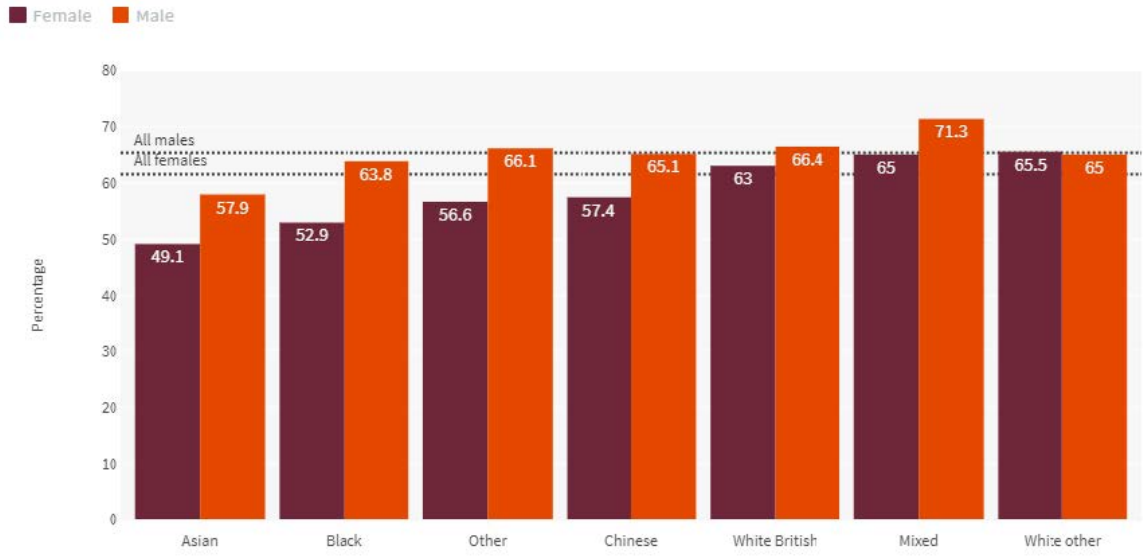
Source: NHS Digital (2018)

The King's Fund

Physical activity

Physical activity levels differ between ethnic groups and genders. People from Asian and Black groups, and women in particular, are most likely to report being physically inactive and least likely to report being active (*see* Figures 3a and b).

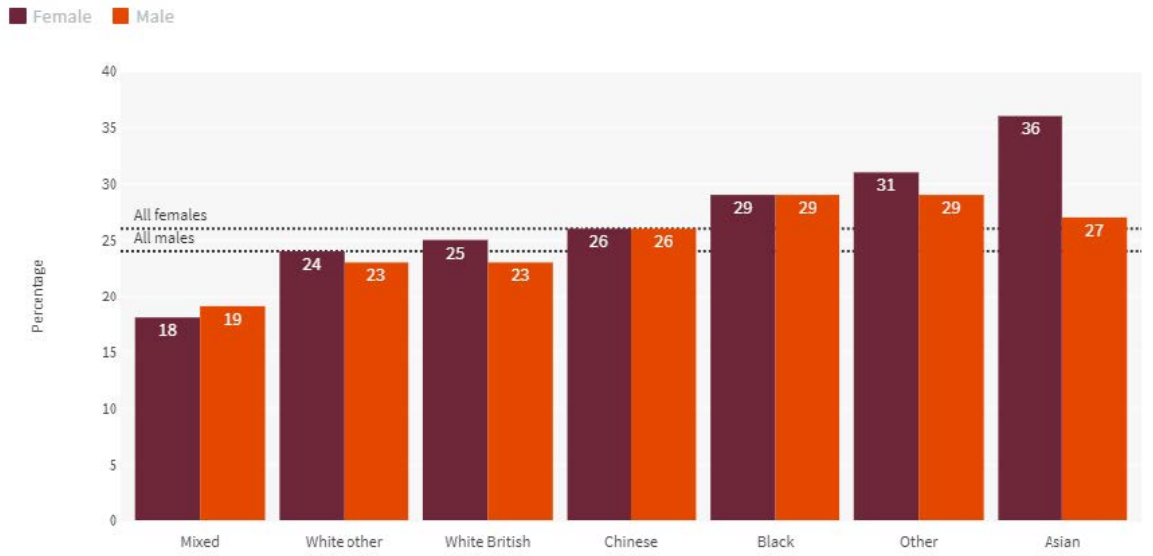
Figure 3a Per cent of people aged 16 years and over who were physically active: England, 2018/19



Source: Department for Digital, Culture, Media and Sport (2020)

The King's Fund

Figure 3b Per cent of people aged 16 years and over who were physically inactive: England, 2017/18



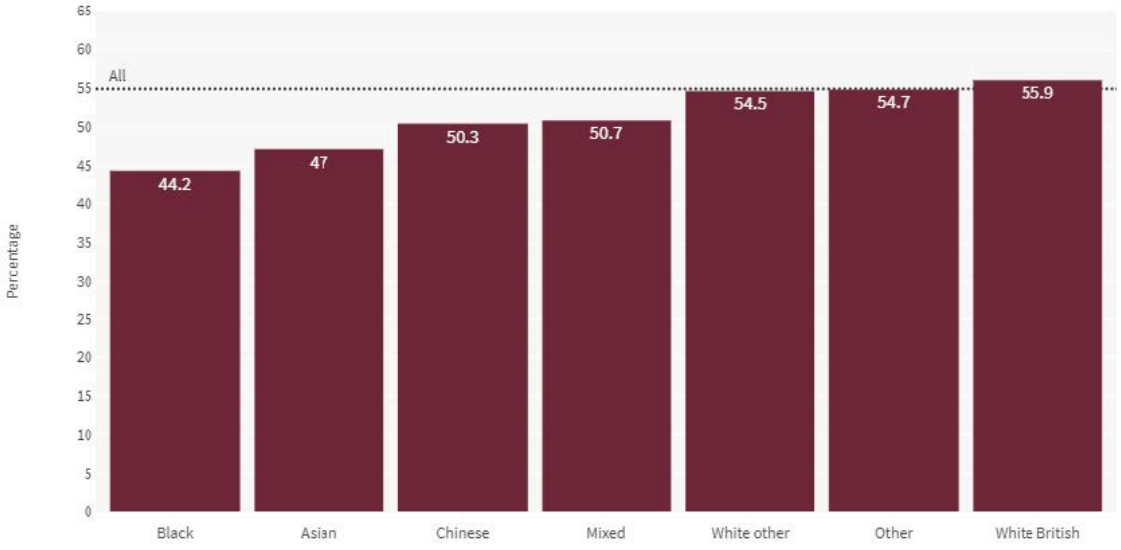
Source: Department for Digital, Culture, Media and Sport (2020)

The King's Fund

Healthy eating

The proportion of people eating recommended portions of fruit or vegetables per day is lower in ethnic minority groups than in white groups (*see* Figure 4).

Figure 4 Per cent of people aged 16 years and over who eat '5 a day', England, 2017/18



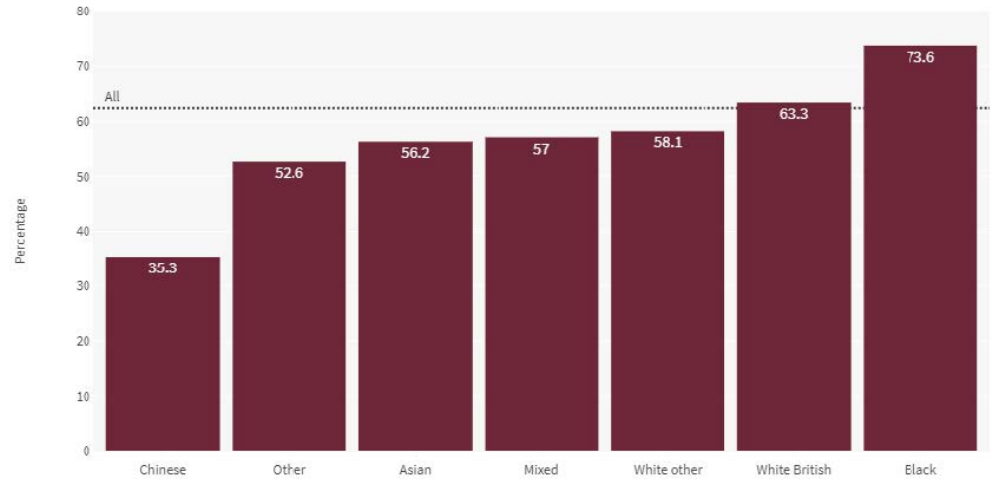
Source: Sport England (2019)

The King's Fund

Obesity

Compared with the White British group, obesity prevalence is higher in Black adults and lower among other minority groups (*see* Figure 5).

Figure 5 Per cent of people aged 18 years and over who were overweight or obese, England, 2018/19



Source: Sport England (2020)

The King's Fund

Access to services and patient experience

Free, universal access to health care and standardised treatment protocols have resulted in greater equality of access and outcomes across ethnic groups, especially in primary care, but less consistently across other health services. However, patients from ethnic minority groups report a poorer experience than the White British group of using a range of health care services, for example: GP, GP out-of-hours, inpatient, maternity, and cancer services. Patient-reported experiences differ between ethnic groups, with South Asian and Chinese groups generally responding more negatively than the white group, and Black groups less so or not at all.

As we have shown, there are different patterns of health across different ethnic groups. Moreover, ethnic minority communities experience a higher burden of some conditions that are potentially preventable. For example, much of the excess morbidity and mortality from CVD and diabetes among some ethnic minority groups is associated with modifiable risk factors. Prevention should therefore be a priority for public health and health care services.

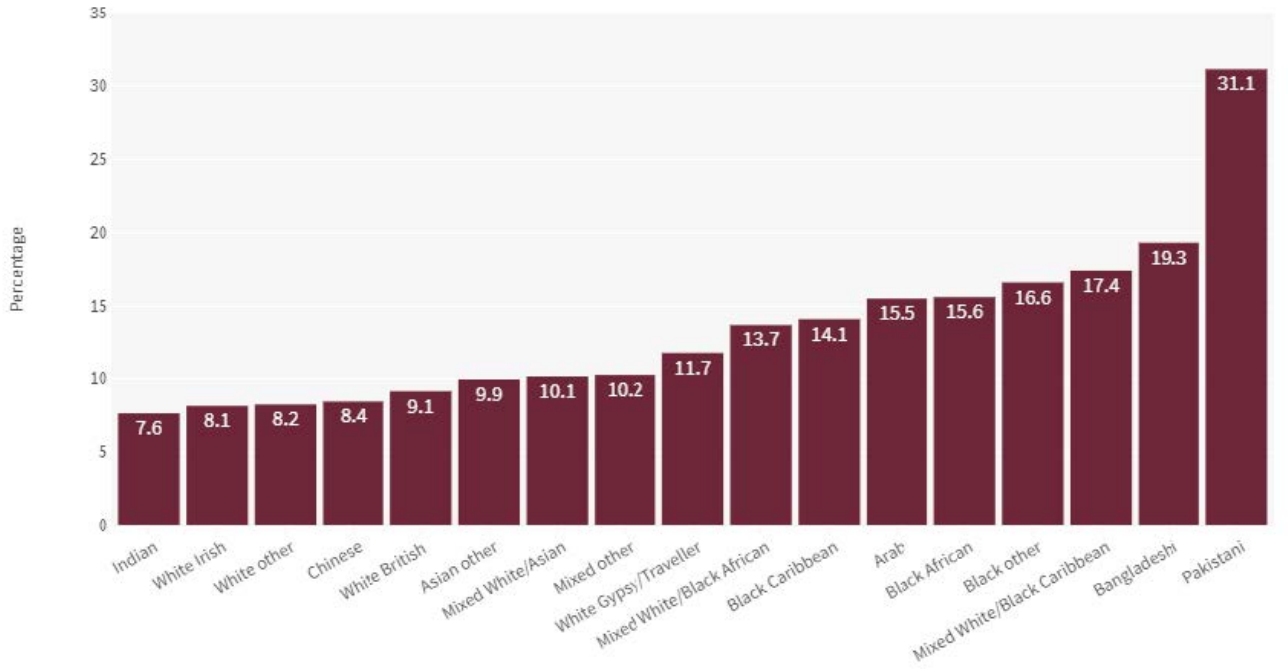
Low health literacy, potentially exacerbated by language barriers, can lead to unhealthy behaviours and poorer uptake of preventive services. Modes of disease presentation and therapeutic needs may also differ by ethnicity.

Health care services therefore need to be aware of the specific health care needs, risk factors and treatment requirements in different communities and ensure services are culturally tailored to promote adherence. For example, the incidence of diabetes among ethnic minority groups can be moderated through dietary and physical activity modifications, and culturally tailored diabetes programmes are effective at improving outcomes. Research shows that culturally adapted interventions can improve participation in cancer screening.

Socio-economic inequalities

There is a strong, systemic relationship between health and deprivation, with more deprived communities experiencing worse health and a shorter life-expectancy than more affluent groups. Deprivation levels are higher among ethnic minority groups and they are over-represented in deprived communities. People from minority ethnic groups make up 15 per cent of the total population, but account for 22 per cent of the population in the most deprived areas (*see* Figure 6).

Figure 6 Per cent of ethnic group populations living in the ten percent of most deprived neighbourhoods, England, 2019



Source: Ministry of Housing, Communities and Local Government (2020)

The King's Fund

Socio-economic inequalities experienced by ethnic minority groups also include the following examples.

- **Income:** Asian (26 per cent), Mixed (26 per cent) and Black (29 per cent) groups are more than twice as likely to live in households with persistent low income (after housing costs) than the white group (12 per cent).
- **Housing:** rates of overcrowding are higher in ethnic minority households than White British households (2 per cent), and highest in Bangladeshi (24 per cent), Pakistani (18 per cent), Black African (16 per cent) and Arab (15 per cent) households.
- **Unemployment:** unemployment rates in Black, Pakistani and Bangladeshi communities are approximately double the national average of 4 per cent.

However, on children's education the white group compares unfavourably:

- the White British group has the worst educational attainment rates at Key Stage 4 (ages 14–16 including GCSEs) and the biggest 'attainment gap' between children from low income families and others.

Structural racism and marginalisation

There is the wider social context that drives ethnic and other social inequalities. Evidence documents the prevalence of racism and discrimination in the UK, and the negative effects they can have on the physical and mental health of people from ethnic minority groups. They can also create barriers to accessing health information and health care services. Structural racism can also have an impact on health outcomes, operating via exclusionary frameworks that marginalise minority groups in, for example, the housing, employment and criminal justice systems.

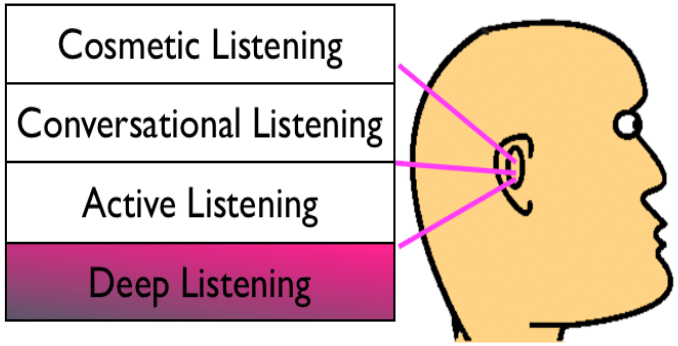
Conclusion

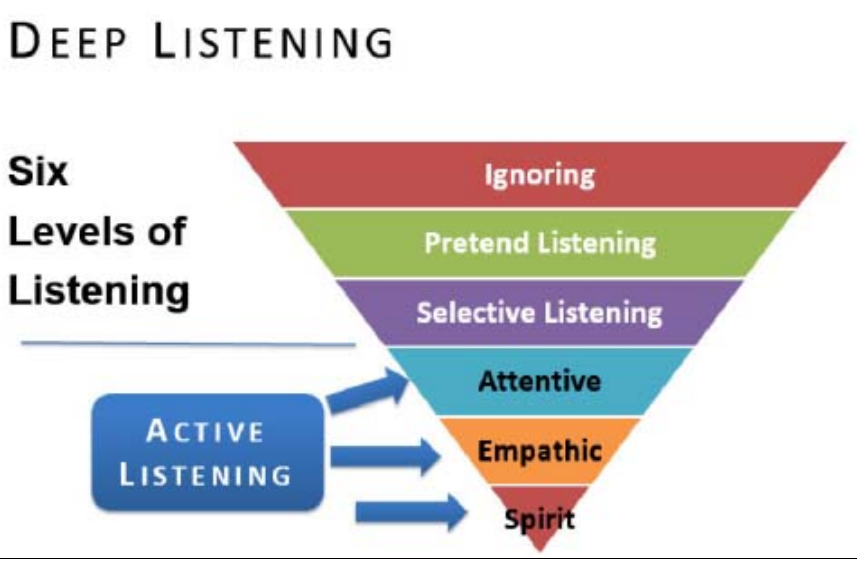
This explainer has highlighted inequalities in health among ethnic minority groups, such as higher mortality among infants and higher mortality from Covid-19, and a greater disease burden from diabetes and CVD. Strategies for improving the health of England's ethnic minority communities need to address the multiple factors that have an impact on their health.

- **The role of public health and NHS services:** The Covid-19 pandemic has highlighted the urgent need to strengthen action to prevent and manage ill health in ethnic minority communities, with their active engagement to ensure that the planning and delivery of services takes account of their needs, experiences and expectations.
- **Addressing the wider determinants of health:** The disproportionate impact of Covid-19 on deprived and ethnic minority groups has highlighted the urgent need for a cross-government strategy to address health inequalities and the wider socio-economic and structural inequalities that drive them. The government, NHS organisations and local authorities have a key role to play in implementing this agenda.
- **Tackling structural racism:** This requires action across national, local and societal levels. The NHS has a significant role to play in ensuring that health service provision is equitable and tailored to the needs of ethnic minority communities.
- **Data:** Comprehensive, good-quality data is essential for enabling policy-makers and health care professionals to identify the specific needs of different ethnic minority communities, respond with tailored strategies for addressing inequalities, and track their impact.

APPENDIX H: POTENTIAL TECHNIQUES TO IMPROVE ENGAGING WITH COMMUNITIES

Active and Deep Listening

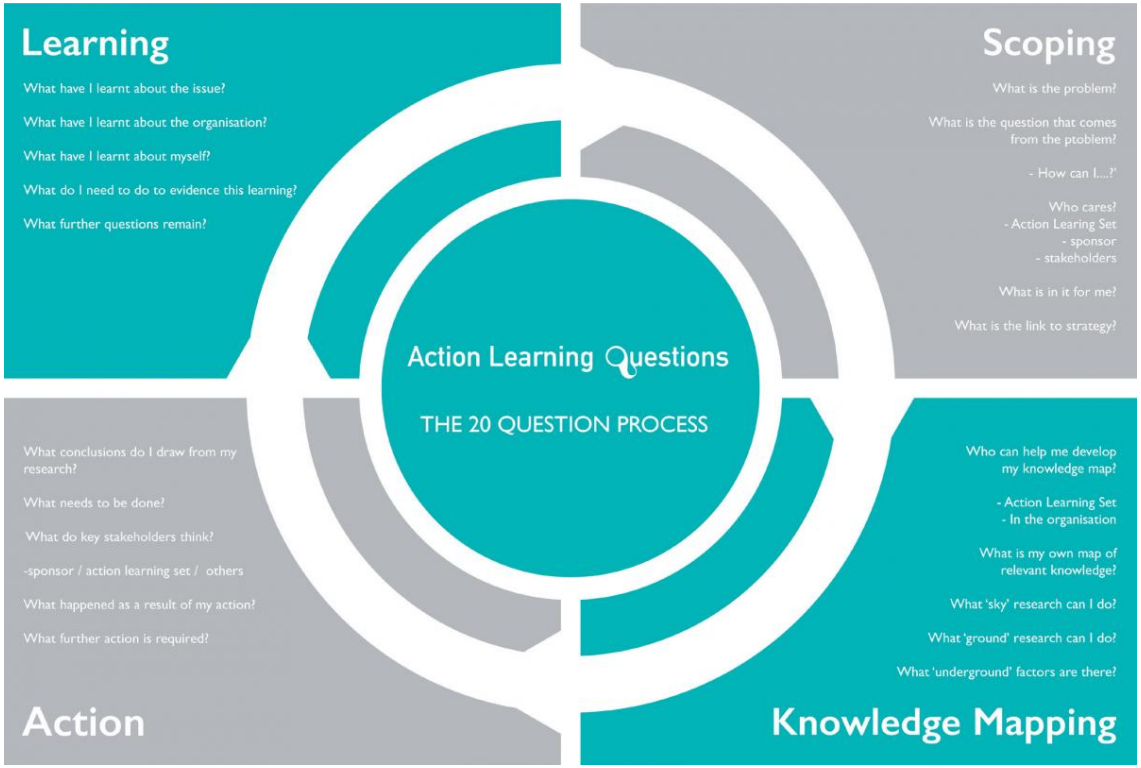




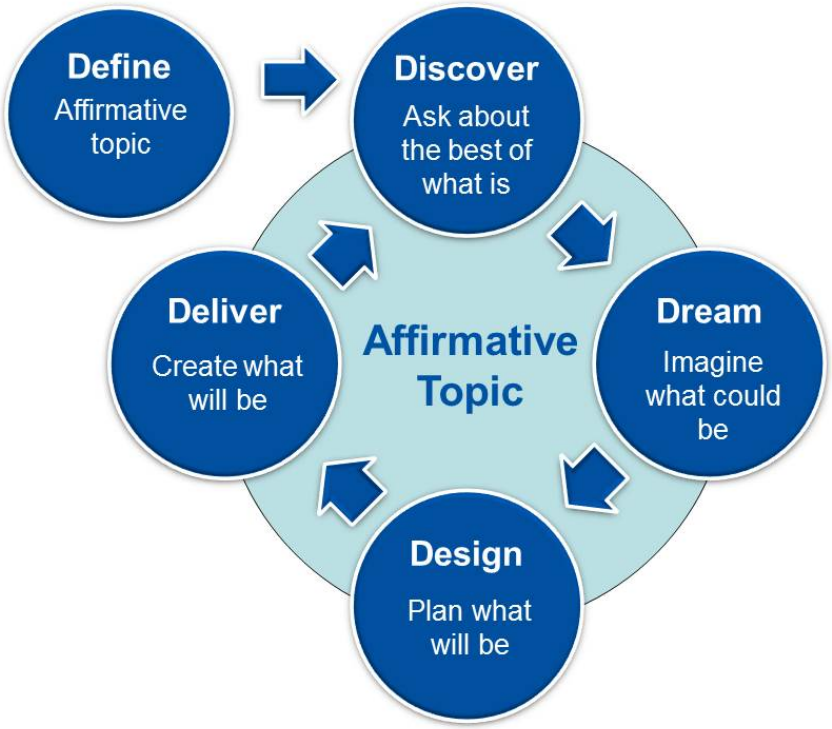
- Be attentive
- Be curious and ask deeper questions
- Do not interrupt, let the person tell their story
- Observe non-verbal cues from body language, facial expressions, etc.

Action Learning Questions - the 20 Question Process

If using an Action Learning approach, there is a 20 question process that can be used to scope the issue being presented, knowledge map what you already know about it, action what you are going to do to learn more and reflect on the learning.



Appreciative Enquiry 5 D Cycle



Asset Based Mapping