Life in Maryport:

Access to Resources and Services

CENTRE FOR RESEARCH IN HEALTH & SOCIETY

November 2021

University of Cumbria

NIHR | Applied Research Collaboration North East and North Cumbria

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1. Introduction

Maryport is a small, coastal, ex-industrial town in West Cumbria within the Allerdale District area, population circa 12,000 (2019)[1]. Across England, many coastal and ex-industrial towns face significant challenges from 'economic decline, social isolation, a lack of investment, under-employment and a lack of social Wellbeing'; coastal towns are also argued to be the most isolated wherein residents frequently struggle to access healthcare and services (Centre for Towns[2], 2020:4).

The most recent Chief Medical Officer (CMO) for England's annual report focusses on health in coastal communities (Department of Health and Social Care (DHSC), 2021[3]). The report shows that 'the worst health and wellbeing outcomes in England are concentrated in coastal communities' (DHSC, 2021:19). It refers to a 'coastal effect' that 'suggests that living on the coastal fringe is associated with an increased risk of ill-health, over and above that which can be explained by demography, ethnicity and socioeconomic deprivation (based on IMD2019 and ONS residential categories)' (Gibson and Ashana, 2021:193[4]). Reasons cited include poor educational attainment and low aspiration (particularly in progression to higher education); poor employment prospects (including high unemployment, higher levels of part-time and seasonal jobs, and lower pay from full-time employment); a deficit in health services together with poor transport connectivity and higher proportions of older people; a high burden of unhealthy behaviours and mental health problems (including high rates of self-harm, and depression).

Many of the attributes above apply in Maryport. In May 2021, the University of Cumbria undertook a 'deep dive' analysis of publicly available health and social data for the town of Maryport[5] based on work undertaken by Oxford Consultants for Social Inclusion (OCSI, 2019[6]), commissioned by Local Trust[7]. OCSI argued that 'left behind areas' have additional characteristics beyond those of other deprived areas in general, and that they compare very poorly to the rest of the country. Whilst no Maryport wards were identified as 'left behind' by OCSI, this was largely due to the configuration of wards in the town. Notwithstanding, the data dive revealed Maryport to share many of the characteristics of left behind areas and to face numerous socio-economic challenges relating to Income, employment, health, education and training. An analysis of key facilities also revealed poor connectedness to key services and civic, educational and cultural assets. The Index of Multiple Deprivation[8] placed six of the seven Maryport Lower Super Output Areas (LSOAs) within the 40% most deprived in England; this indicated that Maryport residents generally lack access to the resources required to meet their needs; resources that are perceived as customary to the rest of society.

Notwithstanding, such indicators do not enable understanding of what limited access to resources and services means for people living in Maryport. Consequently, there was a need for local voices to give more detail and context; enabling greater understanding of the issues faced. As such, qualitative research was needed.

This report presents findings from a qualitative case study which gathered information from a small sample of stakeholders and residents of Maryport. The research was undertaken from November 2020 to May 2021 and so was unavoidably limited in scope due to the Covid-19 restrictions in place at that time.

2. Methods

2.1 Stakeholders

Seven stakeholders took part in one-to-one semi-structured interviews. They were invited to participate because they either represented (e.g., councillor) or worked with the Maryport community; four stakeholders were also residents of Maryport. A further five stakeholders were invited to participate but did not respond. As the country was in lockdown at the time of the interviews they were conducted via telephone (3) or videoconferencing (4). Interviews lasted between 40 and 90 minutes. Six interviews were audio recorded and fully transcribed, notes were taken for the seventh. In the findings, stakeholders' contributions will be indicated but, to protect the identity and confidentiality of participants, no attempt will be made to distinguish between them (e.g., labelling them as councillor, voluntary sector etc.) and the pronoun 'they' will be used.

2.2 Residents

In addition to the above, two focus groups were held in May 2021, one with adults (five residents, most aged 50 years plus) and one with young people (three, aged 17-18). The focus groups were organised by Ewanrigg Local Trust, who also recruited the participants, as such the participants were relatively engaged in community matters. The focus group with adults (FG1) was held at a community centre following the relaxing of Covid-19 restrictions and lasted 90 minutes. The focus group with young people (FG2) was held via videoconferencing and lasted 75 minutes.

2.3 Ethics

Ethics approval for the research was given by the University of Cumbria Ethics panel. All participants were given an information sheet and opportunity to ask questions about the research, and all consented to participate in the research and for the information they gave to be analysed and reported.

2.4 Limitations

As this research was undertaken whilst Covid restrictions were in place it is unavoidably limited in scope. The sample and spread of participants are not as great as we would have wished. Consequently, the findings presented here may not be representative of the whole Maryport community and associated stakeholders. In addition, it was not possible to undertake face-to-face interviews with residents and it may be that the 'focus group' method inhibited them from talking openly about personal difficulties and experiences. Consequently, there may have been issues which have remained 'unsaid'. Similarly with stakeholders, we were unable to access people in the health, teaching and social work professions, mostly because of Covid pressures; their input may have brought different perspectives on the issues discussed.

3. Findings

> "Some of the highest levels of deprivation have the lowest levels of services and it just like sums it up really" (FG2).

In this section, we report informants' perceptions on access to a range of services and resources that are perceived as customary to the rest of society. Focus group participants and stakeholders reported poor access to a range of facilities and services in Maryport, which they believed was exacerbated by poor public transport infrastructure and poverty. Informants were concerned that access had been further restricted due to the rapid switch to telephone or online contact only during the Covid-19 pandemic, which was thought unsuitable for many Maryport residents.

3.1 Access – Connectivity

3.1.1 Digital connectivity

Our previous report[5] indicated broadband availability was good in Maryport, although broadband speeds were substantially lower than the in rest of the UK, and Gigabit availability was very low. Nevertheless, FG2 highlighted digital poverty in relation to home schooling during the pandemic; they were acutely aware that some families simply could not afford to go digital:

> "Nobody has £300 just sat there waiting to buy a new laptop and everything that comes with it, so even though it sounds a brilliant idea like 'oh we can get a laptop', actually the financial side, people just can't do it" (FG2).

FG1 also talked about digital access, especially in relation to accessing statutory services because "*everybody's hasn't got a computer, a smart phone*". FG1 described how the community centre had a project where people "*could come in and use the computer for your Universal Credit and things like that*". However, funding for the project was lost – although "*We still let them on a Friday, if we're here*". One participant mentioned that people can use the computers in Maryport library.

Four stakeholders also perceived digital exclusion to be a challenge for Maryport; again, this was an issue that had been brought into focus during the Covid-19 lockdowns. Stakeholders believed digital exclusion was the result of lack of digital access, digital poverty (low incomes, unaffordable equipment, Wi-Fi costs), and low skills and confidence in using technology. Stakeholders also highlighted the hard choices to be made in low-income households. One stakeholder pointed to inequities in home schooling, whilst another described some of the efforts that had gone into providing computers to children, with Sellafield and the County Council having donated many re-cycled machines. Two stakeholders pointed to the potential loneliness and isolation of young people without digital access, especially during the Covid-19 lockdowns:

> "For those kids growing up, without that engagement with digital, not only are they going to be more isolated than their friends or their contemporaries, they're going to need to catch up because everything's going digital" (Stakeholder).

Another stakeholder was concerned over how digitally excluded residents would access council services when "*it's all being done online now*". Indeed, the rapid switch to digital services, especially since Covid-19, means digital access is increasingly important in accessing a range of services – including online banking, shopping, health advice and medical appointments.

3.1.2 Transport connectivity

Transport was reported to be a significant challenge in Maryport. Car ownership was said to be low, as a result, large sections of the community are reliant on public transport to get around. Focus group participants reported several bus routes through Maryport and one bus that circles the town, but which stops at 14:15. Journeys to neighbouring towns were said to be time consuming. Bus services were also said to be expensive – "*about £4 return to Workington; £9 or £10 to Carlisle*" (FG1). FG1 identified transport as a significant challenge when trying to access hospitals (discussed further at 3.5 Access to Health services). FG2 believed poor transport infrastructure to contribute towards inequalities in Maryport:

> "A lot of people don't have a car just to jump in and go to the nearest town for support or help and that's a big inequality I feel like is there and you can use public transport but it's really expensive and it's not regular enough as well" (FG2).

Stakeholders also identified problems with public transport:

> "Public transport, well you know, I don't even know if I need to say it do I? It's appalling; there is no public transport in some parts" (Stakeholder).

One stakeholder believed all of West Cumbria to experience problems with public transport, including Maryport (over an hour from Maryport to Carlisle and the bus does not stop at the hospital); they also commented on the financial considerations for a population of working people on low incomes; several others agreed. One stakeholder also mentioned the local bus that stops mid-afternoon; they believed this caused problems for residents in getting to GP appointments, food shops, and contributed to the social isolation of older people.

Another stakeholder highlighted the problems in using public transport to get to "employment hubs":

> "The poor quality of public transport which then means you've got to be able to drive; you've got to be able to afford to buy a car and run a car which was I know a difficulty for a number of people … I think it's about, it's about a combination of improving transport links so if people are taking work, you know, in the other kind of work hubs of Cumbria, if you like, they can actually get there. […] I think we do have huge challenges with the distance we are from other centres, particularly in West Cumbria ... I think if we could improve that railway line down the West Coast that would help places like Maryport a lot […] you need much better public transport services, regular transport services, that get people where they need to be … when they want to be there, not just to suit the bus companies" (Stakeholder).

A further stakeholder commented on the West Coast Rail Line, which they thought "*appalling*". FG1 also mentioned the rail line but reported travel by train to be less convenient than bus travel due to having to catch a bus to the train station.

Only one stakeholder commented on the roads linking Maryport to other towns and the motorway, "*Roads, oh my god, roads, it's a level of underinvestment*". However, poor road connectivity, road quality and road safety are usually the subject of much debate on the west coast of Cumbria – especially with regards access to health services.

3.2 Access to Education

3.2.1 Schools

There are several primary schools and one secondary school within Maryport.

FG2 believed the secondary school to have a poor reputation, and to have "*a stigma attached to it*", especially in comparison to other schools nearby; they reported that some families opt to travel elsewhere for secondary education as a result. The school was thought to be under pressure financially; this resulted in a lack of resources generally but also impacted the support that could be given to pupils with learning or mental health needs:

> "I think the school itself has quite a negative reputation as a Secondary School. I think that puts a lot of people off. A few years ago, they didn't have resources at all, like even when I was there, there was no paper, spare paper, to write on at one point, so I feel like that a lot of people are like 'oh you have to go' - so Keswick is a Boarding School and schools like that have a really good reputation, and Cockermouth. I feel like when you do go to Netherhall you're a bit overlooked as such, but at the end of the day you're still getting the results, but the school does still have a stigma attached to it" (FG2).

> "I do feel like schools do lack funding for individual support. I didn't get diagnosed with [disorder name] until I came to the University … so I worry how many other children are in the same situation who will never receive their full support because there's not the money to give children diagnoses for anything really" (FG2).

> "Especially due to funding; they didn't have a therapist in school; no mental health support at all because they couldn't afford it, but to us that's a priority in school, because without good mental health well how are you meant to get good grades? So, it just creates that inequality as well for children that are struggling" (FG2).

Participants in FG1 did not comment on quality or satisfaction with local education services when asked, this was likely due to most being older adults, although they believed Maryport to be well served by primary schools and that the secondary school was well located.

Alternatively, several stakeholders highly regarded both the secondary and primary schools in Maryport, and it was reported that "*a lot of the schools have good Ofsted reports*". The secondary school has "*a great Headmaster*" and the school does "*as much as they possibly can for all the youngsters there and families that are struggling*". One stakeholder reported that the secondary school has a "*really good record*" in relation to job preparation, the school was reported to collaborate with different industries in West Cumbria to raise confidence and awareness of opportunities and to undertake mentoring "*particularly around interview techniques*"; there are around 40 employers offering work experience to the school.

3.2.2 Further Education and Training

Maryport residents wanting to do further education can do A-levels at the secondary school but for anything else they must go out of the area, usually to the college in Workington - ~9 miles away, a journey which takes 19 minutes by car and 50 minutes by bus.

FG1 discussed the distance to the nearest College in Workington but they did not comment on the services offered there and they did not appear to feel that distance was a significant issue, as "*Every bus goes to the College*" and students "*normally get a pass*". One participant had attended the college and commented "*It was alright, the journey*". No others commented on further education provision for Maryport.

In terms of training, one stakeholder reported that much employment training had now been taken over by private training providers and that many local employers send new starters to them. However, some young people can go through that system numerous times which can be disheartening:

> "When they come out after the first time, and they don't get a job then they'll go to a different employer who's applying for people and they say, 'well you've got to go back to the training employer' and they say, 'I've been there once'. 'Well, our process now is that you have to go them, and you get trained up' and I know some people were very disheartened with that process because they'd been there three times and they still haven't got any employment" (Stakeholder).

3.2.3 Adult education

Our previous analysis of key services and facilities in Maryport suggested there is a limited adult education offer available through Cumbria County Council Adult Learning, the local secondary school and 'The Settlement', a third sector organisation in the town. Only one Stakeholder mentioned adult education however, their feeling was that it needed to be expanded:

> "I'd like to see Adult Education being introduced fast so that, if you know, they didn't get the chance in their teens, there are routes back into education later on … I'd want to remove all of the financial barriers that are perceived about moving on. I'd probably want to see even courses being ran within the community as well and I think you can do that for heaven's sake"

3.2.4 Factors impacting education

One stakeholder identified a lack of aspiration in young people which they believed due to a lack of knowledge and experience of what is possible for them; they argued that young people in Maryport were "*not any thicker*" than elsewhere but that "*they just don't have the same opportunities*":

> "You've got a lack of aspiration, not necessarily because people don't want their kids to do well; it's that they just have no knowledge of [what's possible] … kids don't ask for things they've never had, they only ask for the stuff they've seen, or they can see other people having, or that they've had before themselves".

This stakeholder believed that young people in Maryport do not possess the "*social capital*" that would enable them to access the things they needed or to progress in the ways they deserved. For example, they said educated young people were not getting "*the jobs that they should be getting because they don't have the social capital to go with it … they just don't have the experiences*" such as having read the right books, gone to the right school, having had certain cultural experiences. They believed that as a result, many residents are accepting of the inequities they face; they do not demand better services because they "*were brought up to take what they're given*". In a similar vein, another stakeholder proposed that few residents had experienced other ways of being, for example, they are unaware of the lifestyles lived in wealthier areas and as such "*it is something they can't imagine in some ways, so they don't*".

Alternatively, a further stakeholder believed that young people were more aspirational now than in the past, with "*Many of them now hav[ing] ambitions to go to universities and Netherhall School does really well now; [in getting] young people to go to university for a variety of careers*". Nonetheless, this was balanced with a recognition that such aspiration would probably result in young people leaving Maryport: "*If they decide to go on, get some kind of higher-level qualification … then they are more likely to move out of Maryport*" (Stakeholder).

3.3 Access to Employment

Stakeholders referred to a historical lack of employment opportunities in Maryport dating back to at least the 1980s; "*The job situation still isn't good; there are no sort of major employers left in Maryport*" (Stakeholder). This situation was said to have resulted in high levels of worklessness, some of which is long-term and multi-generational. The main prospects locally are with Sellafield or the public sector and if "*you don't work at Sellafield or, … or you're not with the Council or you're not at the hospital, then the chances are you're in a low paid job*" (Stakeholder).

Covid-19 was reported to have increased job insecurity, bringing in individuals and families into poverty that might never have expected to be there.

> "One of the big noticeable differences in our work coming in now is families that we never thought would be anywhere near the need of [assistance]. The poorer families if you like, the ones we normally deal with, they haven't been so bad because they've been given a few pounds more and they understand the value of money, but where people have been employed on between 5 and 800 pound a week wages and now there's a massive reduction in that through furlough and their bills … are still exactly the same, they are having to come now and knock on the door and it's breaking their hearts ... Some people are now very distressed about the fact that they're facing some financial difficulties that they thought they were never going to have to face, and I think that will have an effect, both mentally and physically on them going forwards" (Stakeholder).

Another stakeholder reported that within Maryport, there are few professional and/or skilled jobs and so residents with higher qualifications who are working in Maryport are often employed in jobs for which they are over-qualified. Stakeholders believed "*There are job prospects, but you've got to travel to find them*", which means leaving Maryport, either by commuting daily, which is problematic due to transport poverty, or by moving away. However, some stakeholders reported many people "*don't want to leave their homes, they don't want to leave their families*" and, for those without a car, public transport will not necessarily get people to where they need to be at the right time.

Furthermore, as much available employment in Maryport is low paid and insecure, the result is that "*across Allerdale and Copeland … low income is the main crisis, that's not unemployment but low income*" (Stakeholder). This stakeholder commented that Maryport can no longer provide employment for all its residents, and knowing this is very challenging to people's sense of identity and mental health:

> "That makes the mental health side of things even worse for them because [they] belong there, that's the place they identify with but now that place can't support them [financially]; all the sorts of feelings that bubble up from that" (Stakeholder).

FG2 were aware that jobs had once been plentiful in the town - usually having heard this from older relatives. However, they reported that persistent unemployment made competition for vacancies high: "*so when there's like a rare job that's available a lot of people try to go for that*" (FG2).

Further, the group were aware that employment opportunities for young people were limited in Maryport and that many need to travel long distances to access work. Nevertheless, the young people in FG2 had achieved in school and they aspired to careers, they felt there were opportunities locally depending on one's chosen career path, for example: "*it depends on what you're doing as well. I feel like with healthcare you can get a lot more opportunities in general*", compared to:

> "I feel like it's a lot harder, both personally, like I want to be in [type of employment] and like my friends from Manchester and Preston they have a really big head start compared to me because I'm from Maryport and there's barely any opportunities there. You really have to go out of your way if you want to do something like that" (FG2).

Stakeholders believed employment opportunities for young people to be particularly bleak, a situation thought to have worsened during the pandemic. One believed young people who have not achieved in education will struggle to find the unskilled jobs they are looking for: "*any young person who has a learning disability or does not reach those levels [GCSEs], they're not likely to get any form of employment, there just isn't that kind of employment around for them*". And those that have achieved tend to leave Maryport for college, university or work; with many unlikely to return due to the lack of employment and lifestyle opportunities, resulting in a 'Brain Drain' for Maryport:

> "This has always been a problem for education in Cumbria … because once they get on into Manchester or Liverpool or over to Sheffield, even further afield, they see a different lifestyle … they get into that community down there and they see where the opportunities are. But quite a lot of them don't come back; they really don't come back up into Cumbria and that's a great shame because we're losing their talents" (Stakeholder).

Young people leaving Maryport has additional knock-on effects for the wider community, ageing residents without family support for example, or mental health and dependency issues for those young people remaining but unable to find work:

> "So that has an impact on young people, it has an impact on their mental health; that's about anxiety, worry, sense of hopelessness and it then moves onto 'well I'm not good enough; I didn't get the grades that are needed', that sense of I'm not good enough or clever enough and sadly that's when they start to turn to drink or drugs" (Stakeholder).

3.4 Access to Healthy Lifestyles

FG2 recognised the high levels of poor physical health in Maryport. One participant believed "*the reason why the life expectancy of people here is low is purely because of peoples' like lifestyle*". They commented that whilst "*there's some people that maintain a really healthy lifestyle*" such people tend to be younger; they felt "*people above 40 tend to be in that sort of situation where they just like live to work and just, you know care about the income and just trying to make ends meet*" (FG2). Both FG1 and FG2 highlighted the easy availability of fast food in Maryport. One participant in FG2 believed healthier food options too expensive for some residents, another felt there was a lack of knowledge of how to cook healthier meals:

> "The majority of the food shops in Maryport are takeaways. If there were more healthy food available … there is healthier options, but they are a lot more expensive and because of the poverty in Maryport, we can't afford that more healthier food" (FG2).

> "It is all fast food takeaways which are easy, you know, people have been at work all day and they think 'oh you know what we've got a little bit of extra money tonight, we'll have a takeaway', things like that, where actually it's not the healthiest option and I think that's the problem, people aren't taught to cook; we aren't taught to cook properly and full meals, in schools, so when people have money they're not sure how to balance it to make food and meals, and go food shopping so takeaways are the quickest, easiest option" (FG2).

FG2 believed 'poverty' to restrict people's ability to lead healthy lifestyles.

Two stakeholders ventured explanations for poor physical health in Maryport; these again related to poor lifestyle behaviours, but also to occupational hazards, lack of exercise facilities and "*cases of people with obesity*", for example:

> "I think that is all down to lifestyle choices, drug taking, alcohol, lack of exercise. There is no facilities for sport in Maryport, swimming and stuff like that" (Stakeholder)

> "You've got this ageing population that have come through smoking, you know, a high section of the population smokes … Alcohol … going to the pub, drinking alcohol, is the biggest cultural kind of activity […] And you've got poor diet […] you've also got people who have worked in highly manual jobs all their lives so yeah, you're going to see arthritis in the hips; you're going to see, you know, people who've worn out their bodies because they've been in manual labour jobs their entire lives and there is a large population that have done that" (Stakeholder).

Low income was also an issue and the increased use of Foodbanks and FareShare was noted by several stakeholders. One stakeholder shared the numbers:

> "The kinds of things that are an issue are the numbers of people using the food banks, particularly, and we're talking about 1,020 using it in the past year, that's November to the end of October [2019-2020], 670 adults; 441 children and that's obviously a referral type of service … Holiday food parcels for families whose children would normally have free school meals has been a big issue, 189 children fed over the summer period [2020], 104 in primary and 85 in secondary and 107 families had access to that scheme […] An increasing number of families are using FareShare … And those are what we would call the newly poor, those families where the parents or parent if it's a one-parent family, just can afford, they can afford to pay the rent or the mortgage, but they can't afford the food or vice versa. If they can't afford to pay the rent or the mortgage, then there's all those additional mental health issues" (Stakeholder).

In addition, three stakeholders identified alcohol consumption as a problem, whilst one felt alcohol consumption was an "*issue*" but not "*a massive issue*" they reported that "*People are tending to get in more with alcohol perhaps younger than they should be*". Another felt "*having a drink, going to the pub, drinking alcohol, is the biggest cultural kind of activity*" in Maryport. The third stakeholder believed alcohol consumption was a "*complex problem*" for which more support could be offered.

In terms of physical exercise, it appeared that provision of opportunities for physical activity came mainly through the voluntary and community sector. Participants in FG1 reported several sports clubs run by the community: "*There's loads of clubs for them to do isn't there? There's football, rugby, boxing*"; there were also a "*few gyms*".

One stakeholder also reported an abundance of sporting opportunities for children and young people, again these were mostly organised by the community sector:

> "Lots of sports; there are lots of football clubs, rugby clubs, tennis clubs; there's cricket, there's the golf course at Maryport so there's some opportunities there for young people to be involved and from a very early age" (Stakeholder).

Others believed there was a huge lack of investment in sporting facilities which meant there was not a culture of exercise in Maryport. Participants in both focus groups reported their disappointment that the swimming pool in the local school had closed; people in Maryport "*live too near the sea for kids not to have swimming lessons*". They were pleased to learn that a new pool is proposed at 'The Wave' centre, although concerned about cost: "*How much will that cost?*" (FG2). Further, the clubs mentioned above are oriented towards traditional male sports, whilst girls can now participate in spots such as boxing, football, and Rugby, some will not want to, and there are many adult women for whom this was not an option when they were young. Consequently, there are fewer options available to women and girls and so it will be hard for them to develop sporting habits.

3.5 Access to Health Services

3.5.1 Addiction Services

FG1 perceived drug and alcohol misuse/addiction to be a problem in Maryport; they reported having witnessed people dealing drugs on their estate and people under the influence of drugs and/or alcohol. One stakeholder reported that "*drugs have been a big issue in Maryport over a number of years*" and that 'County Lines' activity was impacting in the area.

However, a participant in FG1 reported a lack of addiction services for residents of Maryport: "*for that kind of thing it's pathetic around here, there is nothing, absolutely nothing*" (FG1). The participant believed those in need of support can access limited support at the GP surgery, but for greater support they must travel to the North East.

Nonetheless, most focus group participants were unaware of the availability of addiction services, for example "*I've not heard of anything in Maryport with Drugs and Alcohol*" and "*I'm pretty sure if you go to the hospital, you might get signposted for some kind of programme*" (FG2). As stated previously, one stakeholder believed more support could be offered locally for alcohol problems.

3.5.2 Dental Care

Most participants in FG1 were registered with a dentist and were satisfied with the service received, but one reported difficulty in accessing an NHS dentist with space to take them on:

> "No for dentists … there's hardly any dentists that take you on … if you're on Universal Credit you can't afford to pay but you can't get in … They take people on but only at a certain time so if you're in agony and you phone and they're not taking people on you've got to wait … There's an emergency one; you've to ring Carlisle and they'll sort you an appointment out" (FG1).

3.5.3 Cottage Hospital

Several stakeholders commented on the loss of inpatient care at Victoria Cottage hospital, it was reported that the hospital now contains facilities for ambulatory care (e.g., transfusions of various kinds); there is also a space for multi-disciplinary teams and "*that seems to work very well*" (Stakeholder). Nonetheless, it was reported that the loss of inpatient care at the hospital was still being felt in the community, largely because there are "*no hospital beds available now in a 30-mile stretch*" that can be used for end-of-life care or rehabilitation:

> "You probably know the saga of … the leader to try to save all beds in Maryport. He had huge support from all of Maryport, that was a campaign and they all pulled together, but it was a campaign they couldn't win, and you die in a ditch" (Stakeholder).

> "So a lot of upset about that when we lost the beds because the nearest hospital then is Cockermouth or Keswick or Whitehaven because there's nothing now going north; Wigton closed down … there's no hospital beds available now in a 30-mile stretch which is very disappointing because the community built the hospital; the community extended the hospital and they built the Physiotherapy Centre on the back of it for injuries and people getting physio; there was a real public ownership of the Community Hospital so a lot of people got disheartened" (Stakeholder).

The loss of overnight beds at Victoria Cottage Hospital was felt keenly by focus group participants. Many had been involved in the 'Save Our Beds Campaign' and so perhaps their disappointment was heightened. One participant stressed how important it had been for patients' relatives and friends to be within easy access; another highlighted that there is now nowhere to go locally for patients who are ready to be discharged from hospital but not ready to go home:

> "Victoria Cottage Hospital was paid for by the residents years ago, people bought a brick and that's how it was built and then just to take it away" (FG1).

> "When they took the beds out, it was devastating for the town, absolutely. It wasn't just the bit of overnight care; it was the bit of the next-door neighbour could pop and see them, so mentally it just got them better so much quicker, didn't it? Your grandkids could pop in and see you; do you know what I mean? If they're in visiting one they're usually in visiting the lot, because they knew them" (FG1).

Other stakeholders were more accepting of the outcome; at least there were still some services being offered there:

> "At one point it looked as if it was going to be done away with altogether [and] patients were so, so grateful that they could get this treatment in Maryport instead of Carlisle, that's because of cost and time and everything else" (Stakeholder).

> "Such huge importance to keep the hospital at Maryport with all the services to support the local people. Now the beds went but at least we've got, you know, actually more services locally available […] It's a shame that there aren't any End-of-Life Care beds in it but hey, you know, they've got the hospital now and a good GP surgery" (Stakeholder).

3.5.4 GP Surgery

Participants in FG1 praised and valued Maryport Health Services; they described the practice as a "*Super Surgery*" because it serves such a large catchment and provides a range of services such as "*child nurses*" and a "*mental health nurse*". FG1 also reported that GPs are trusted by patients; it is a place where patients feel "safe".

> "The trust when you walk through a doctor's surgery, well Maryport surgery, I trust – if [name] says to me you need to stand on your head in a corner for 10 minutes every night, I'd stand on my head in a corner; it's just because you trust them" (FG1).

Participants in FG2 did not comment upon the quality of, or their satisfaction with GP services, but did comment on the difficulty of getting appointments, which they thought due to high demand. This issue is not unique to Maryport; surgeries up and down the country are struggling to meet demand, especially those is deprived communities, and it is a situation that has been exacerbated by the Covid-19 pandemic. Nonetheless, FG2 were concerned that the situation may result in patients not trying for appointments:

> "I think at the Dr's Surgery they're so busy, if you do not ring up at 8 o'clock in the morning that day you're not getting an appointment and you can get through and 'oh we've got an appointment in two weeks' but you're like two weeks isn't really any benefit at all. They're just so overwhelmed I don't think they know where to turn and it does impact people because if they're ill they're like 'oh do I really need to phone the doctors? Oh, I'll live a little bit without'" (FG2).

Three stakeholders commented on the GP practice in Maryport. One reported that it "*seems to be pretty good, they're very good at making sure things run through, Flu vaccines, that sort of thing*". However, others commented on some patients' "*frustration*" at trying to contact the surgery: "*Every week on social media I just see people ranting that it's a disgrace, that they can't get in touch with the doctors*". A dislike of the triage system was also reported; people do not appreciate being asked personal questions by receptionists.

3.5.5 Maternity Provision

One stakeholder expressed dissatisfaction that women with labour complications must be transferred to Cumberland Infirmary in Carlisle: "*families shouldn't have to be having to deal with that, you know, because it's a hell of a journey if somebody wants to come and visit you*" (Stakeholder).

3.5.6 Mental Health

FG1 perceived poor mental health to be a "*massive*" problem in Maryport wherein antidepressants are "*probably dished out like jelly tots*" (FG1). One participant attributed poor mental health to financial worries.

The young people in FG2 were also very mindful of poor mental health; they highlighted amongst adults a 'tradition' of reluctance to talk about mental health: for example:

> "They just don't want to speak about it because they grew up to just get on with it"

> "It is still really difficult to convince elderly people that times have changed and that we are more accepting of peoples' mental health"

> "[Mental health is] a very stigmatised topic and you can't have conversations with like a lot of the older generation without them saying 'oh just get on with it'. Like 'we just got on with it; why can't you?'" (FG2).

Three stakeholders also identified poor mental health as a challenge. Poor mental health was said to be more of an issue than physical health and to be on the increase. Limited employment prospects, unemployment and poverty were cited as causes: "*If they can't afford to pay the rent or the mortgage then there's all those additional mental health issues*". One stakeholder again expressed concern for young people who had not achieved in school and believed many internalised their lack of success which then can create further problems:

> "They don't tend to make a lot of it. They don't talk about it. But certainly … others pick up the signs that they're beginning to struggle mentally; that they're beginning to feel it's not worth it, 'why do we bother?' The problem then is they're in this cycle, 'why do I bother? Can't get a job, why do I bother?' it just goes on, it perpetuates it" (Stakeholder).

Both focus groups were concerned about access to mental health services. Participants in FG1 perceived an absence of Mental Health Services for residents of Maryport, "*There isn't any help; there isn't*". One participant in FG1 recalled the experience of a young person who "*had just had a breakdown*" who had to wait "*14 months*" to be seen "*unless he was in crisis*". Another participant asked "*But then where do you go for help? You know what I mean? If you're sitting there, in a dark place … that's it, where do you go? Where do you actually go?*", to which further participant responded: "*I would just ring Hug A Mug*[1]".

FG2 also reported a lack of mental health services in Maryport:

> "We have some of the poorest services, especially for Mental Health and a lot of them are in Whitehaven and places you have to travel and it's not as easy".

> "There's a Mental Health Community Team in Maryport but I'm pretty sure it's aimed towards adults and then there's Hug A Mug which is mental health, well where they signpost people to different mental health services, but … things that is in groups rather than [individual] support is out of Maryport I believe".

FG2's primary concern was waiting times. They talked about an incident "*two Christmases ago*" where staffing at Child and Adolescent Mental Health Services (CAHMS) was under pressure and waiting time for the Crisis Team was "*48 hours when it's supposed to be 4 hours*". The following excerpt from FG2 illustrates:

> "It's like CAHMS, the waiting list is so long. Like the other Christmas they had no staff; two Christmases ago there was no staff available so even if you called there was nobody there at all to get support from".

> "48 hours, I always think that's such a long time for somebody on their own that is crying out for help and then it kind of feels like you're not wanted; 'oh we'll get back to you in 48 hours'; well, there's no point then. You just feel like you're a bit like lost with support".

[1] Hug A Mug is a drop-in support and signposting service developed by Ewanrigg Local Trust and based in the local GP practice.

FG1 discussed where one would go to access hospital mental health services, they were aware of a ward in Whitehaven but "*That's only got two beds hasn't it now? Yewdale Ward?*", and the 'Carleton Clinic' but "*The Carleton Clinic's at Carlisle anyway*" and after that "*You have to go miles away; you have to*", "*so you'd be talking Newcastle*" (FG1).

One stakeholder reported similarly, they highlighted a lack of provision for young people's mental health and the distances they were required to travel to receive 'inpatient' support, with some young people "*being sent as far away as Middlesbrough and Aberdeen because we didn't have the facilities in Cumbria*". They relayed the experience of one family whose child was an inpatient in Middlesbrough, they were "*desperate*" to get them home and their "*whole life was travelling to and from Middlesbrough; it was ridiculous*".

3.5.7 Hospital Services

For residents of Maryport in need of hospital care "*It's Whitehaven or Carlisle*", for more specialist care, it is further still (Stakeholder).

Unsurprisingly then, focus group participants reported significant challenges to accessing hospital services. Participants in FG1 acknowledged that Maryport was "*way too small*" to justify a hospital, nonetheless, they reported difficulties in accessing hospital services and in visiting relatives in hospital; transport was a main barrier:

> "If you haven't got a car, you can't get there" (FG1).
>
> "The nearest place is like Whitehaven which is like two towns over and a half an hour drive and obviously like more people can't go there than people that can" (FG2).

FG1 reported that there is a bus that stops outside West Cumberland Hospital but "*It just takes that long to get there because the bus goes round the estates*"; it takes "*Over an hour because you're stopping at every stop*", consequently "*if you want to get there for 2:00 or 3:00 you've got to get a bus at 12:00*". Travel to Cumberland Infirmary in Carlisle was more problematic as the bus does not stop at the hospital and the nearest bus stop is a long walk away and then there is a steep hill. Consequently, FG1 reported they "*would have to go to Carlisle, wait in the bus station in Carlisle and get a bus from Carlisle to the hospital*". FG1 acknowledged that "*If you're disabled or elderly you can get transport which is free, but you've got to be prepared to be out of your house for ten hours*".

For more specialist secondary care, residents of Maryport must travel further still:

> "If there's anything out of the usual or more severe, we're Newcastle. I mean if you've got to go for treatment, like sometimes two days a week, you've got to drive; you'd never ever do that on a bus or – you just couldn't get there. So, it's travelling to Newcastle, there and back, it's a long way" (FG1).

Participants shared experiences of relatives travelling to Newcastle for care, whilst they understood why this was required, they nonetheless felt that some appointments had been unnecessary:

> "… going every week and … 'Oh, come back next week' (FG1).

> "Any nurse can do an infusion but they're the only ones that had the specialist knowledge, I suppose, to figure out what you want, but even then, I always thought 'well why can't they [do it locally]'" (FG1).

Distance to hospital services was also stakeholders' main concern.

> "The idea that all the people, that everybody has to be shipped up to Carlisle from West Cumbria for treatment is shocking. It wouldn't be tolerated in the South East of England. It's the equivalent to telling somebody in south London they have to go to Brighton for a service" (Stakeholder).

One stakeholder described people *"having to travel far and wide to get the medical attention that they want*", for example:

> "Most of our links are now with the North East, over to Middlesbrough, over to Newcastle, some into Lancashire and even some into Cheshire and again that means you've got to be able to travel; you've got to have the physical means of getting to these places" (Stakeholder).

Cancellations of surgery in North Cumbria due to Covid-19 were reported to have increased hospital appointments and surgical procedures in hospitals outside of North Cumbria. One stakeholder described having to drive "*to a hospital 20 miles north of Newcastle; it was over a 3-hour drive to get an appointment with a specialist*". Another described a journey to Middlesbrough for surgery, "*but we can do that*"; it is not easy for those without a car, and it appeared an inability to travel can result in treatment delays:

> "If you haven't got a vehicle or you haven't got the means to do that; you haven't got the means of catching buses and trains to do that, then you'll have to sit and wait […] it'll take us two hours by car to Middlesbrough so it's not too bad, but yeah you'll probably go to Newcastle by train from Carlisle and then catch a bus from Newcastle or a train from Newcastle to Middlesbrough but it would take you the best part of three hours so if you had a 10 o'clock in the morning appointment you'd need to leave home at 6 o'clock[2] in the morning and then you'd have to try and catch a train all the way back down again and that would be probably the best part of £40" (Stakeholder).

Stakeholders also acknowledged that transport would be provided to those in most need, but the problem is then that "*relatives found it almost impossible to visit and that's no good for your health. You need your family; you need that support*". And some patients will need relatives to advocate for them.

One stakeholder identified access to health services as the biggest issue in North Cumbria, but this was not just about the distance to services, it was also about understanding how to access and navigate the health system. This stakeholder argued that services are never described in a way that makes sense to the people who need them; services are designed by educated, white, middle-class people in their own image, the systems make sense to them and are situated in places that also make sense to them.

One participant in FG1 suggested that video consultations could be used more frequently, as did one stakeholder:

[2] In fact, for those relying on public transport a 10:00am appointment in Middlesbrough would require an overnight stay as the earliest one can arrive is 10:22; a return journey will cost at least £43.70.

> "I mean technology now is really good, particularly within the Health Service, now, you know, you can get an X-ray taken in Whitehaven and a Specialist in Newcastle can look at it in 10 minutes on his screen and give you a diagnosis … saves a lot of time, a lot of travel and a lot of expense" (Stakeholder).

3.5.8 Health and Social Care Recruitment problems

During conversations about healthcare stakeholders also talked about a recruitment and retention crisis in the health and care sectors; of getting "*good people to come and work in West Cumbria*" and then "*keeping them in the West of Cumbria, that's the big challenge*" (Stakeholder). One stakeholder spoke of the need to recruit and train local people to work in the NHS because "*at least*" they may stay.

3.6 Access to Housing

In 2011 38% of Maryport residents lived in rented housing, three quarters of whom lived in social housing. Participants in FG1 were social housing tenants and generally satisfied with their homes. Nonetheless, problems with repairs were reported and it appeared that there were long waiting times which was said to be due to the pandemic: "*They're blaming everything on Covid now*". One participant commented they had not "*bothered reporting*" a problem because they knew "*it's going to take a long time for them to come out*".

A further participant of FG1 raised concerns over the process of moving into social housing for the first time, especially the requirement to "*pay a month's rent upfront, which is very difficult if you're on Universal Credit*" (FG1). They were also concerned that there is not time to make the home fit for purpose before moving in:

> "You haven't got very long to move in and some of them's disgraceful inside so they've got to be decorated, so you can't pay the rent for your new place and the rent for your old place before you can get in. Once over they used to give you two weeks rent-free to get you in; they don't now" (FG1).

Nevertheless, FG1's perception was that they were more fortunate with housing than people living in other towns and cities

> "I mean we're spoilt here; we really are spoilt [compared to other places], you'd be like 4 years on the list waiting for a house … and then you get the shitty little tier number 119 … flat" (FG1).

Three stakeholders talked about housing in Maryport. One stakeholder reported that some social housing was of a poor standard due to damp and other environmental hazards. Another stakeholder talked about the introduction of "*choice-based letting*" which means that people from outside of the area can apply for and get housing in Maryport; they reported this had caused resentment from local people needing a home. They also reported problems with some of the new arrivals to Maryport; some have "*difficult backgrounds*" and then are causing disruption for other residents, and others cause serious damage to the properties they have rented, at great expense to the housing association.

In addition, two stakeholders highlighted the lack of a local housing office which meant that tenants can only access housing services remotely, by telephone or internet, once again raising the problem of digital access:

> "Housing is particularly remote. If you are a Home Housing tenant, then your contact with them is in a Call Centre in Newcastle and that alienates you because that is not rooted within their own communities anymore. You're just another faceless Call Centre customer, particularly for the older residents, I think that's probably quite difficult" (Stakeholder).

Nonetheless, FG1 reported that the local tenants' association had good relationships with social housing providers and that housing providers attended tenants' association meetings:

> "We're quite lucky because … we used to have monthly meetings, a representative would come down to the monthly meetings so any issues that anybody relayed to us, could be brought up there, minuted, so they kind of had to do something about it, but they always turned up" (FG1).

3.7 Access to Leisure

> Interviewer: "What is there to do in Maryport?"
>
> Participant: "Well there's nowt to do really, in Maryport"
>
> Participant: "Nothing" (FG1).

Both focus groups reported a lack of access to cultural and leisure activities in Maryport; pubs and takeaways appeared to be the main options, "*There's a couple of restaurants in town*" and "*there's about 800 takeaways*" (FG1); "*Maryport's full of pubs and takeaways, so there's not much more*" (FG2).

It appeared that lack of money was prohibitive of participation in the few leisure activities available. Both focus groups mentioned 'The Wave' centre and the aquarium in Maryport, however, it appeared that cost was a barrier and therefore not somewhere one would visit regularly:

> "[The Wave Centre]'s never really taken off because of the financial cost to go. It's like one of those places you go once and you're like 'oh well I've been so I'm not going to go again for a few months'. So, it's quite hard to find things that are affordable" (FG2).

Moreover, participants in FG2 highlighted that there is "*nothing, really, for teens*", as a result teenagers congregate in the town, and this is perceived negatively by other residents, which the young people thought unfair:

> "You see a lot of young children just hanging around town in groups because there is nowhere for them to go, so they do just like go into town and [person] was like 'there was loads of young people and I had to cross the road', because she was scared of them. So, I think they have that reputation, even though they're not doing anything, they're literally just stood there with a portion of chips"
>
> "I feel as if you get shouted at for not going out and then you get shouted at for going out because you're in a group and like there's just no winning".
>
> "My grandparents say, 'oh back in my day you couldn't stop us going out and now all young people all want to stay inside' and I'm like 'well going outside now, like where is there to go?' Like everything's gone".

> "I remember before I turned the legal age to go into pubs, I used to knock on my neighbour's door and ask her if I can walk the dog just so I can do something".
>
> "I think it's split into two categories: you have the playgrounds for the children and then you have the pubs for the older generation. I feel like for like growing up, [names of friends] and I would go out all the time and we would always say 'oh there's nothing to do' because there's no like theatres; there's no like clubs and stuff".
>
> "It's all very much travelling again to places like Workington and Whitehaven, Carlisle, but again when you're 13/14 you don't always have that money to go to them places so you're always just walking around Maryport, going to see what you can find in Maryport" (FG2).

The impression given was that young people roam the streets together until they turn eighteen at which point, they can enter the adult world of drinking in pubs: "*that's where we go to the Friday night when you're of age*" (FG2).

Participants in FG1 were regular attenders at the community centre, so when asked where they go for leisure they answered "*here*"; "*Some weeks we live here*"; "*they might as well get a bed up*"; "*I never see my Mam no more; she's always in here*".

Two stakeholders also reported an absence of entertainment and leisure facilities in Maryport, other than pubs. One reported that "*there are some really nice pubs*" but "*some of those meeting places in the centre of the town are not there anymore and that's a great shame*". The other believed the lack of amenities to be a cause of alcohol problems within the town:

> "My explanation for that [alcohol problems] would be that there are not a lot of amenities in Maryport, as one councillor put it the other week, it's becoming a ghost town really. All the shops are closed; there's hardly any leisure facilities or entertainment facilities, people have to travel to Workington or Carlisle" (Stakeholder).

3.8 Access to Shops

> "Charity shops"
>
> "Hairdressers"
>
> "Aye you're right there; charity shops and hairdressers". (FG1).

Access to shops is limited in Maryport. FG1 reported an absence of "*shoe shops*" and "*clothes shops*". Stakeholders agreed, they reported a massive decline in the town centre, Maryport "*wasn't the town it used to be, we didn't have many shops to start with but now we've got practically nothing*". One stakeholder commented "*One of my colleagues will say to me 'you can't buy a pair of knickers in Maryport' you know, and that's probably true*". Consequently, residents must travel outside of Maryport to buy many things. The newly arrived Lidl and B&M, which are on the outskirts of the town centre, were very welcome additions because residents "*actually get a good range of products in the town itself but that just saves them the bus fare and it just saves them the time that they've got to take*" (Stakeholder). FG1 agreed: "*it's the likes of Lidl and B & M have kind of like; they've done really well for the town*".

Apart from Lidl and B&M, shops are mainly small and privately owned, or are charity shops: "*There's no money now – look at the start-up shops, like many places now the second-hand shop business, you know, the charity shops, are very much the place to be at the moment*". One stakeholder commented that the closure of charity shops during lockdowns had impacted people's ability to purchase clothes for children.

FG1 and stakeholders reminisced about how busy the high street had once been

> "It never used to be like that in Maryport; there was always something for everybody. I mean the shops was full. … I used to bring my mother into Maryport because there was everything" (FG1).
>
> "Maryport in the '70s, the late '60s, the main street on a Friday afternoon, when everybody got paid on Friday teatime, there was 100s on the main street, you know, buying whatever they could afford to buy. There was, you know you could buy furniture; there was the Co-operative; there was all sorts going on. There were shoe shops, dozens of shoe shops and I think now there's probably only one shoe shop in Maryport" (Stakeholder).

The significance of poor digital connectivity is again relevant here. Those without digital access are disadvantaged in relation to online shopping and in being able to shop around to get the best prices or accessing sites selling used items such as eBay. In effect then, the people with less resources end up paying more. The same issue applies with utilities, people without digital access are unable to shop around for the best deals with energy and communications providers. A similar problem can be associated with banking in Maryport, one stakeholder reported that Maryport once had four banks; now it has one so "*The banking services have pretty much gone*".

3.9 Access to Green and Outdoor Spaces

Residents valued the coastal location of Maryport, the seafront, coastal walks, and views; both focus groups shared happy memories of times on the beach - although residents bemoaned the state of the harbour and promenade area and believed "*It's asset to the town that could be done up and toilets and things like that*".

Several stakeholders also commented on Maryport's location with its "*marina … wonderful views across Scotland and of course you've got all the Roman history … It's much more attractive than a lot of the other smaller towns along the coast*" (Stakeholder).

3.9.1 Green spaces and Parks

Whilst participants in FG1 reported they were "*not bad off for green*" they were despairing over the state of their local park which they reported to be a "*disgrace*":

> "I walk that way nearly every day, bottles, rubbish, empty boxes, they take maybe twenty-four cans"
>
> "That blackthorn cider?"
>
> "All sorts. Amaretto! Empty bottle!
>
> "I wouldn't walk onto there at night"
>
> "It's full of glass" (FG1).

Adult residents reported that they and the children in their families were afraid to use the local park because of the behaviours of others: "*I was on that park one day with a couple of the grand kids and I come off traumatised … the abuse I took*". They also reported having witnessed people under the influence of drugs and/or alcohol "*staggering*" around, "*smashing bottles*" and "*cooking up*". The presence of people consuming alcohol and drugs in playparks was said to scare younger children, as did some older children:

> "The drug and alcohol's terrible at the moment, there was somebody staggering up there and he didn't have a clue where he was" (FG1).
>
> "They're always over there. I've been on there with [name] before and there's two druggies sitting watching you, on that old bench, it makes you scared (FG1).
>
> "When you do stuff for the kids the older ones wreck it … [name] was on there on Sunday and the cops came because they'd been lighting fires up there … he's scared to go on the park now because there's too many big ones" (FG1).

A participant in FG2 reported similarly:

> "There's like a park near me, about a 10-minute walk, and it would be so unsafe to take a child or anybody down there; it's just full of needles, full of drugs, everything – just drink, glass bottles, like you can't walk down there safely and that is one place I wouldn't feel safe walking alone which is a beautiful place because there's a lovely river that goes right through it and everything and a nice forest, but it's just because of the drugs and the needles, it's not safe at all" (FG2).

Three stakeholders also mentioned challenges arising from anti-social behaviour, which often involved damage to social assets such as play parks and public spaces, although no one reported any serious criminality:

> "We have a lot of anti-social behaviour, and you get people that go and damage the play parks, they set fire to them, they've smashed them up. There was one on [estate name] but due to damage that got removed so there's practically nothing for the children" (Stakeholder).

Participants in FG1 talked about how a local football pitch, which had been well used by residents, had been upgraded by Lidl supermarket as a corporate social responsibility gesture. Once upgraded the park was fenced off, locked and only available to hire. Unsurprisingly, this upset a lot of residents who had been used to using the area. It seems that some residents have a strategy of breaking down the fences "*and as fast as they put it on, they kick it off*" again.

3.10 Access to Council Services

FG1 reported that accessing council services was "*just a minefield*". The nearest office was reported to be in Workington, a forty-minute bus ride away, although they were aware of a council office in Maryport, they commented "*it's shut, and it's not going to open now because they're doing it up with them grants; they're saying they're probably not going to open it*". FG1 were not impressed by the offices in Workington, "*Perry's Palace is what they spent thousands on, millions I would say – the Town Hall, the new build*". One participant reported that council staff "*are just rude, absolutely rude. It's like a power trip with them*".

Stakeholders mentioned a range of issues in relation to council services. One stakeholder also mentioned a Council office in Maryport but noted it was closed at the time of interview and that there was "*no news that it will ever open again because it's all being done online now*"; they thought this problematic for those "*without online access*". This stakeholder had valued the local office: "*it worked pretty well, even though it wasn't heavily staffed at least they could get information there*". Another stakeholder was also concerned at the lack of local access to council services; they were keen to see a "*one-stop shop situation where you can go in, and you can pick up six or seven services within the same building in Maryport*".

A further stakeholder highlighted "*a real lack of communication*" between local authorities and residents which had resulted in a lack of knowledge in the community as to the roles of the different tiers of local government:

> "nobody really understands what the different councils do to be honest because you've got County, and I know it's coming up to change, you've got County, Borough Councils and Town Councils; nobody has the slightest idea what any of them do really because we're just so completely disenfranchised by them and that's all about communication; it's about those councils communicating what they're doing – they're not doing it; they're terrible at communicating. No commercial business would ever do that" (Stakeholder).

This stakeholder believed that many people employed in council services were too detached from the realities of life in the communities they serve:

> "There's a real privileged blindness from the people that are offering the services. So, people that are working in the public sector are earning a comfortable wage or living in a particularly affluent area of Cumbria are completely blind to the issues that people that are living in those on the edge communities actually face … I think that's a real problem and I think it's a real problem with our working-class school communities and it's a real problem within our local authorities, is that they really all need to be doing training to open their eyes up a bit" (Stakeholder).

3.10.1 Children's Services

One participant in FG2 commented on the local children's centre, originally a Sure Start. It had been run by Barnado's, but the contract had recently been given to 'Family Action'. This participant felt the new service had taken a long time to reopen – probably due to covid – so families had struggled as a result and continued to struggle because they did not know what the centre now offers:

> "There was the Barnardo's Centre and then Bernardo's lost the contact and Family Action came in and when Family Action came in it was so confusing. Nobody knew what services were available. I really felt like families who were struggling have really struggled extra for the past year because they're really not sure what services are available now Bernardo's isn't there. It's taken quite a long time to get up and running and then, because of Covid, it has really impacted on that […] I think people just don't know what services are available because a lot of them are online as well, like you can fill in the forms online for things, but people don't know that".

Another stakeholder talked about the poor inspection reports for Cumbria County Council's Children's Services. Although this was some years ago, they believed that the service has never really recovered, and that Cumbria still has too many looked after children; this was especially the case in West Cumbria. This stakeholder also mentioned difficulties in recruiting social work professionals to work in West Cumbria.

3.10.2 Libraries

Focus group participants were very positive about the library in Maryport "*It's a good library*" (FG1). They mentioned Wi-Fi availability, the facility to order books from libraries across the district, and the "*activities in the six-week holidays … which are really good for the children*" (FG2). One stakeholder also mentioned the services provided via the town library, including access to IT facilities. However, it was noted that the library has been operating on reduced hours and has been under threat of closure for several years.

3.10.3 Social Services

Only one focus group participant had experience of Social Services and they chose not to comment on their experience: "*I'm not going to comment on social services, you wouldn't like what I had to say*" (FG1). Participants in FG2 believed those needing assistance from social services often did not feel supported and some felt stigmatised:

> "I feel like there is a big stigma around Social Services, like 'oh God I don't want Social Services knocking on my door' or 'Social Services did this and they took my child off me for this reason'. I've heard a lot of that, like people don't feel supported with that at all" (FG2).

> "I think a lot of people also don't want that label of I'm involved with Social Services, especially in Maryport because word gets around very easy because everyone knows everyone so as soon as one person finds out, the entire town knows" (FG2).

The stigma connected to needing social services is perhaps why participants did not want to comment in a group situation. Nonetheless, no stakeholders commented on Social Services either.

3.11 Access to State Services

Participants in FG1 reported no local access to employment and social security services, even in normal, non-covid times; all such services are based in Workington. However, it was reported that claimants for jobseekers' allowance no longer need to 'sign on' in person and that everything is done online, again raising questions about how this works for those without digital access:

> "You had to have your own email address; how you're going to do that when you haven't got a computer is beyond me, but you have to have your own email address, and then everything is online" (FG1).

Online access was reported to be particularly frustrating when dealing with problems:

> "You can never get to speak to somebody because there's a couple of times, I could have thrown my computer through the window … So, you've to type because you can't get to talk to anybody … I could have put my fist through the computer … It's an awful thing to be on because you can't physically shout at anybody or speak to anybody. Everything is computer" (FG1).

3.11.1 Policing

Two stakeholders commented on policing, one reported there used to be "*a dedicated Police Station in Maryport and therefore the Policeman was always out and about. We don't have that anymore*", although they did not believe this had led to "*crime or disorder rising greatly*". Alternatively, another felt the closure of the station had resulted in the police appearing remote from the community:

> "Criminal justice in Maryport, they closed the Police Station; it's gone so you very rarely see the Police except, you know if you call them out, they're coming out from Workington. I sat on the phone for non-emergency service stuff with the Police and again I was sat waiting for 45 minutes on hold because you're talking to a Call Centre, God knows where. A computerised system that's you know, they're just remote I think – by taking themselves out of the community they've made themselves remote from the community" (Stakeholder).

Focus group participants did not talk about the absence of a police station, although participants in FG1 felt disempowered to do anything about the anti-social behaviour they experienced; their perception was that the people causing the problems knew this: "*They know there isn't really much we can do and then if you phone the police, by the time they've come, they've gone*".

3.12 Access to Voluntary, Community, Faith and Social Enterprise Services

Focus group participants and stakeholders identified a small number of VCSE service providers in Maryport including Ewanrigg and Netherton Community Centre, Hug A Mug run by Ewanrigg Local Trust, The Settlement run by Castle Hill Trust, North Lakes Foodbank, and Signpost run by the Methodist Church in Maryport. Mention was also made to some third sector organisations visiting Maryport to offer 'clinics'. As we saw under 3.4 Access to Healthy Lifestyles, there are also a number of 'grassroots' organisations, mostly offering sport but some with health and social groups as well. Nonetheless, this is a surprisingly short list for a town of ~12,000 residents; there are few incorporated third sector organisations/charities with a base in Maryport.

3.12.1 Ewanrigg and Netherton Community Centre and Ewanrigg Local Trust

This is the only community centre in Maryport. FG1 and FG2 talked positively about Ewanrigg and Netherton community centre. FG2 described centre activities; "*it's just lovely to see everyone get along … 60/70 people just sitting around having dinner together*". One participant commented on the person running the centre, who was said to be "*really good. I think she recognised … people that don't get out much and she kind of set up a place for them to go which is like really amazing*". FG1 reported that volunteers work hard to promote intergenerational activities but that it has proved difficult to engage with all residents:

> "Coffee and crack does integrate both ends because we've got toddlers running round and then you've got maybe somebody in their eighties … Saying that though we've been door to door. We've put Fun Days on and it's the same people that come … a lot of people, you can't get them in whatever you do" (FG1).

Those stakeholders that commented were very supportive of the work undertaken within Ewanrigg and Netherton Community Centre, although they did not appear to distinguish between the work of the Community Centre and that of Ewanrigg Local Trust, rather, they saw it as one thing.

> "I will certainly be blowing the horn for the community centre and all the work they're doing there. I haven't come across an organisation that are so supportive and generate so much good work ever before" (Stakeholder).

One stakeholder commented on how the funding received had been used to enormous effect:

> I think the Community Centre and the work that [name] and staff and getting the erm, the money to set up the work that [name] is doing, has made an enormous difference to what they've been able to deliver to the community and the support for the community and looking at what the community genuinely needs […] I'd say that it has come along in leaps and bounds over the last five years and you know whenever you go into the Community Centre it's always really busy; any event they're having there's lots of people there and I think it's done an enormous amount to support the local community … and also, they're aware, because they all meet and they talk about other people, they're much more aware of people who need that extra support as well (Stakeholder).

Another stakeholder talked warmly about the community activism and the way in which activists look to identify needs and then strive to meet them, they saw this as a very responsive and positive way of working, that others could learn from:

> I think you'll find when you talk to them there are people there that want the best for Ewanrigg and for Ewanrigg youngsters and it's finding ways of doing that […] At Ewanrigg, certainly, they listen to the people and then think what are we going to do about this need […] I think that the places where things happen, that have succeeded, they see a need and aim to meet it and as that need disappears or is met, they're continually looking to say 'what do we do next?' And they look for it and that seems to be to me how Ewanrigg works, and other places don't (Stakeholder).

A further stakeholder described the range of activities available at the centre and reported there is "*a group of ladies there that are very, very committed to young people … they bring them in three or four nights a week*". They also reported that centre volunteers had become aware of people feeling isolated in the community and so they reacted by organising a lunch club.

3.12.2 Hug A Mug

Hug A Mug was highly praised and valued by all focus group participants and, those stakeholders aware of Hug A Mug were also very positive about it.

> "I think everywhere should have a Hug A Mug"
>
> "Definitely … It's just a success from day one" (FG1).

One stakeholder had experience of Hug A Mug and was able to describe the work undertaken there, for example, "*visits from DWP and citizen's advice and various other services*", "*a cabinet full of contacts*" and helping people "*fill in forms*". They explained how the people visiting Hug A Mug are listened to and how relationships are built over time which enables people to gradually feel safe to "*open up*" and share problems. This stakeholder also spoke about how volunteers at Hug A Mug "*learnt a lot*" and that some people "*who had been helped … then became helpers … it was an education and helping with self-worth*". They felt that "*without [Hug A Mug] and the community centre things would be far, far worse in Maryport*". As such:

> "People come A. for a warm, B. for a cup of tea or coffee, C. for company and D. for private information, and hopefully by chatting … just feeling a little bit more confident in where their future lies" (Stakeholder).

One young person also summed up Hug A Mug and stressed the importance of easy access:

> "The main values of Hug A Mug is that it's a cosy, warm place to go. Like it's in the title really 'Hug A Mug'; it's like not really like 'hug a mug two weeks in advance' do you know what I mean?"

3.13 Access to Investment

Several stakeholders commented on the lack of investment in Maryport. One felt money coming to Allerdale district was always spent in Workington:

> "There's never any investment into Maryport and I've noticed that even with Allerdale Borough council … everything seems to get put into Workington; there's never any investment for Maryport" (Stakeholder).

Another stakeholder felt that much of the available funding in West Cumbria has frequently gone to "*the more middle-class institutions*". They highlighted a lack of knowledge in the area of how to access and apply for funding:

> "There's a real lack of knowledge about how much money is available; they don't know which is available, much less speaking the right language to access it … You've got to speak a particular kind of language in a particular kind of way and if communities don't know about it, they don't access it" (Stakeholder).

Consequently, they believed the money goes to communities that do not need it:

> "The Cultural sector will come and suck up funding meant for working-class people in West Cumbria … they will suck up the funding but then just deliver what they want to deliver, and back-end jobs … in middle-class areas, with it, because they know how to apply for the money" (Stakeholder).

A further stakeholder believed that the Maryport community had to ensure they "*don't get forgotten*" when (and if) new, levelling up money becomes available and that it is not "*just dished out regionally*" as has happened previously:

> "The problem that Cumbria has, is when money was given out regionally it went to Manchester, and it went to Newcastle to dish out and Cumbria doesn't really sit with either of them so again it gets forgotten […] We get tagged onto other things, this is the problem, which means that we're never ever the centre of the universe" (Stakeholder).

One stakeholder described the closure of a locally based government office that employed 250 skilled workers, the workers were eligible to transfer their employment to their local regional office but the nearest was Liverpool, "*Well it's a fat lot of good, isn't it?*". This stakeholder believed that decisions are made in London without due consideration of the impacts "*on places that are, as I was told once, peripheral*". This stakeholder believed Maryport needed a "*sense of ambition*" and investment "*or something to lift it and give people hope for the future*".

Moreover, Allerdale District Council had recently been successful in bidding for money for investment in Maryport Town centre. The High Street Heritage Action Zone (HAZ) will bring investment of £1.2m and the plan is to spend this on a shopfront improvement scheme that will enhance Maryport's historical architecture. The Future High Streets Fund is giving £11.5 million which will be used to improve the route between Maryport railway station, main street and the harbour and promenade; to re-purpose vacant units in the town centre into office, shopping, cultural and residential spaces; and construction of a new swimming pool at the Wave (see https://www.allerdale.gov.uk/en/maryport/).

Participants in FG1 discussed the funding coming to Maryport; they did not feel they had been consulted about it: "*We didn't know anything about it until we had a meeting about six weeks ago; didn't know a thing*". Their perception was that "*all the money is going into Council property*":

> "So, it's the Church, which the Council own now; it's the Town Hall which the Council own and the Maritime Museum, which the Council own and then there was talks of doing something with … did it used to be the Picture House? … I did ask the question of 'how come it's all going the Council's way?' and he just said, 'Well they put it out there and that seems to be what the people want', but I never saw it" (FG1).

Several stakeholders also commented on this funding. Whilst one acknowledged the money would "*tidy up*" the appearance of the town they doubted it would "*create massive employment*". Another reported that "*the idea is that we're going to take Maryport down this Arts and Cultural route towards more visitors*" but added that there had been "*promises of cultural and tourism regeneration in Maryport since the '30s*" none of which ever happened. They asserted that the residents of Maryport had experienced a succession of broken promises over decades; they also doubted Allerdale District Council's ability to manage the regeneration:

> "So what you've got in Maryport is the culture of being promised regeneration and promised jobs but not necessarily having them delivered, you know, the ideas down at the docks and the whole development there in the late '80s; they built the houses but the supermarket, hotel and attractions that they promised at the time, when they were built, they just made the money on the houses and buggered off […] So you're in a situation now where there's a shed load of money being thrown at Maryport with not many questions being asked … I don't think there's plans being submitted for how the buildings will be run afterwards. It's all catapult, throw the money at it but they've nobody within the Council with any kind of experience or understanding of how that sector works. So, they're making assumptions and decisions that are just, I find, eye-watering" (Stakeholder).

This stakeholder also questioned the appropriateness of focussing on tourism jobs for Maryport, not least because "*tourism jobs are low-paid anyway*", but also because tourism is not a suitable match with the skills of residents:

> "An ex-industrial culture where actually people that have been in education would be very industrial, very, you know, manufacturing, and yet you're wanting them all to convert into excellent customer service, front-facing service industry. It's just an oddity to me … I don't think there's anybody in Maryport actually believes that it's going to do anything in terms of good jobs and security for their families" (Stakeholder).

Another stakeholder feared that the money would not be invested in long term solutions and could potentially become "*a sticking plaster and the town's bright for a few years but actually nothing actually gets any better*". They highlighted the need to invest in things in Maryport that would make people want to visit and to stay, including a hotel.

> "I think there are two particular things that strike me. One is it's a beautiful old marina, you know, seaside town and has it got a decent hotel? No. It's got nothing like that. Nothing to encourage you to stay there. You might go and visit for a day, but you wouldn't go and stay there for a holiday, would you? … and you've also got, as I said before, the Roman history and the need to be linking it into Hadrian's Wall. Now the little museum – great – but you could make so much more of that. So, to me it's getting all of those pieces in together because if people want to come and people want to stay and people want to come and see Maryport, it gives everything a boost" (Stakeholder).

Moreover, during data collection both residents and stakeholders talked fondly about Maryport in the past, about what a great place it had once been to live. So instead of examples of investment the transcripts are littered with sentences that portray loss, for example:

> "We had everything here, in Maryport, everything" (FG1).
>
> "It never used to be like that in Maryport; there was always something for everybody" (FG1).
>
> "Where is there to go? Like everything's gone" (FG2).
>
> "Maryport in the '70s, the late '60s, the main street on a Friday afternoon, when everybody got paid on Friday teatime, there was 100s on the main street" (Stakeholder).
>
> "… it's becoming a ghost town really. All the shops are closed; there's hardly any leisure facilities or entertainment facilities" (Stakeholder).
>
> "We have a swimming pool here and we really enjoyed that, now it's gone'" (FG2).
>
> "Victoria Cottage Hospital was paid for by the residents years ago … and then just to take it away" (FG1).
>
> "My grandma would say that back in the day it was so easy to get a job" (FG2)
>
> "… the late '60s and there was probably nearly a 1,000 people working on the factory estate then and they were good jobs" (Stakeholder).
>
> "Maryport seems to be the town that was forgotten" (Stakeholder).
>
> "There's never any investment into Maryport" (Stakeholder).
>
> "We get tagged onto other things, this is the problem, which means that we're never ever the centre of the universe" (Stakeholder).
>
> "So, what you've got in Maryport is the culture of being promised regeneration and promised jobs but not necessarily having them delivered" (Stakeholder).
>
> "I think people in Maryport just think they've been forgotten about" (Stakeholder)

Such sentiments could be seen to portray a left behind community.

4. Discussion

The findings above have demonstrated the difficulties for residents in accessing services and resources in Maryport. Many of the points raised by informants resonate with the findings in the CMO's annual report (DHSC, 2021[3]) and the OCSI's work on 'Left behind communities' (2019[6]). Indeed, Maryport could be seen as a typical, left behind, coastal town. Furthermore, the difficulties faced by Maryport residents can be conceptualised as the wider determinants of their health.

Educational achievement, for example, is associated with increased employability, wages and standards of living and thus increased access to the positive determinants of health such as 'nutritious food, safe housing, a good working environment and social participation' (Dahlgren and Whitehead, 2006:58[9]). Education can also be seen to increase self-efficacy in health. However, quality educational services are unequally distributed and therefore, educational attainment is too (Dahlgren and Whitehead, 2006:58). Our previous report (2021[5]) highlighted the presence of deprivation in education, training, and skills in Maryport, with four of the seven LSOAs being ranked in the 20% most deprived in England – and one LSOA being ranked 607th most deprived. Ward level census data (2011) showed a high proportion of residents to have no qualifications (r. 35.7%-42.2% compared to 22.5% in England) and few to have qualifications at level four or above (r.10.0%-15.6%, compared to 27.4% in England). This matters because 'Poor educational attainment is linked to worse health outcomes over a lifetime' (DHSC, 2021:17[3]).

Gibson and Asthana (2021:199[4]) highlight that whilst children in coastal communities perform 'only slightly less well than elsewhere' at key stage 4, this is accompanied by 'a marked difference in terms of both the educational capital supporting children and the proportion progressing onto higher education'. Similarly, a Social Mobility Commission report (SMC, 2020:41[10]) discusses how young people from deprived backgrounds lack 'family connections that help them to learn about and gain good jobs' and 'knowledge of the differentials in income and life quality between different jobs or industries'; this leaves them with 'a smaller frame of reference from which to develop and make choices'. This SMC report (2020) shows how the influence of family background 'persists beyond education into the labour market' resulting in intergenerational disadvantage. In a similar vein, Gibson and Asthana (2021:200[4]), imply a 'coastal effect' on educational outcomes:

> 'Educational capital is known to play an important role in determining academic outcomes but, along with exposure to social, economic and cultural opportunities, will also have a broader impact on the aspirations, expectations and attitudes of young people, including those which foster harmful behaviours. The much lower participation of coastal children in higher education is perhaps indicative of the fact that, for many, the full spectrum of career opportunities and the role educational success plays in seizing those opportunities is a rather abstract concept. More generally, this may point to a degree of socio-psychological as well as economic dislocation in many coastal communities' (Gibson and Asthana, 2021:200[4]).

Moreover, another SMC report (2017[11]) identified areas in England that are social mobility 'cold spots', places where people from disadvantaged backgrounds are 'least likely to make social progress'. It ranked Allerdale District as the sixth worst cold spot out of 324 local authority areas – just behind Carlisle which was ranked fifth worse, but higher than places such as Blackpool (12th), Northumberland (37th) and Barrow (45th). The report highlights that 'disadvantage has become entrenched' in areas that are predominantly 'Isolated rural and coastal towns and former industrial areas' and in which poor educational achievement amongst disadvantaged young people is combined with weak labour markets (SMC, 2017:12).

Consequently, the young people living in these areas have less chance of social mobility due to being trapped by limited employment opportunities, and poor transport connectivity restricts their opportunities further (2017:2). As a result, the only option for 'aspiring' young people is to leave coastal communities, and they rarely return (DHSC, 2021:18[3]).

Notwithstanding, the SMC (2020:4[10]) suggest that the pay gap in adult earnings between those from affluent and disadvantaged backgrounds 'is not a problem that equalising education alone can fix'. The authors argue that in areas of low social mobility the gap in educational attainment 'explains only two-thirds of the adult pay gap' (SMC, 2020:7). So, whilst improving education might reduce gaps in wages it may not impact social mobility. It may even contribute to increased inequalities between those able to take advantage of improved educational opportunities and those who cannot, as the following paragraph illustrates:

> 'Clacton shares some common drivers in the decline of coastal communities. These in large measure are around the poor and declining employment prospects and opportunities in the town. These result in low aspiration and academic achievement. Where young people do achieve their potential, there is a need for outward migration in order to optimise prospects. Improving educational attainment is important but will be challenging without improved local job prospects and may only improve the lot of those who use education as their opportunity to live elsewhere' (Gogarty, M, 2021:48[12])

Therefore, 'To 'level up' between areas, we need to look beyond education' (SMC, 2020:7[10]). The unequal distribution of employment may be a good place to start.

Maryport has a weak labour market. Informants' remarks in relation to employment are supported by the data in our previous report[5]; the observation that in Maryport "*low income is the main crisis*" may be correct. Whilst the unemployment rate was close to the GB average (r. 5.6%-6.7% compared to 6.4% nationally) the rate for universal credit was substantially higher (r. 18%-25.6% compared to 14.9% nationally) and 39% of universal credit claims were made by those in employment. Income estimates showed average household income to be £11,907 lower than the England/Wales average. Occupation data showed few people to be employed in professional occupations and higher proportions employed in low-skilled occupations. Population data showed a decline in younger age groups between 2013-2018 (age 16-29 -6.6%, age 30-44 -10.9%).

The SMC's 2020[10] report identifies a lack of high skilled jobs as a main reason for young people moving for work, whilst many want to remain in their home towns the 'lack of opportunities and infrastructure' push people out (SMC, 2020:74). The authors argue that, given the geographical differences in employment opportunities 'the importance of location as a determinant of intergenerational social mobility is obvious' (SMC, 2020:14).

Moreover, 'Poor employment prospects underpin many drivers of poor health outcomes' (DHSC, 2021:16[3]). Unemployment causes physical ill health; deterioration in mental health and increases the risk of suicide and premature death (Dahlgren and Whitehead, 2006[9]). Low paid, low status, and insecure employment restricts access to decent housing and healthy food; increases exposure to occupational hazards; and is associated with 'chronic psychological distress and the development of a wide range of non-communicable diseases' (Gibson and Asthana, 2021:199[4]). And there are further effects on the young:

> 'The adverse socio-psychological factors associated with a limited range of employment opportunities are likely to particularly affect the development of children and young people and may help explain the worrying disparity between coastal and non-coastal areas in terms of hospital admissions due to health risking behaviour' (Gibson and Asthana, 2021:199).

Informants in this study commented upon the health risks and unhealthy lifestyles apparent in Maryport, these included lack of exercise, poor diet, excessive alcohol consumption, and smoking; such behaviours are not uncommon in disadvantaged areas, however. The CMO's report (DHSC, 2021[3]) highlights higher prevalence of 'smoking, substance misuse and excess alcohol use in coastal communities' as well as higher levels of obesity in deprived communities. Such behaviours are undoubtedly related to poor health outcomes. These unhealthy behaviours can often be understood as 'freely chosen', hence interventions and campaigns to educate people to exercise, eat more healthily and quit smoking, alcohol and so on. But, as Dahlgren and Whitehead (2007:84[9]) point out, the assumption that such behaviours are freely chosen is 'flawed, as the social and economic environments in which people live are of critical importance for shaping their lifestyles'. The CMO (DHSC, 2021[3]) highlights deprived areas are more likely to have 'obesogenic environments' than those less deprived, characterised by, for example, an abundance of 'take-aways' and fewer opportunities for exercise, as was reported in Maryport. Further, 'Whether we can be active or eat healthily is impacted by a number of socio-economic factors, such as income, housing, education, access to space and sale of unhealthy foods' (DHSC, 2021:10). Consequently, living in areas with a deficit in opportunities for healthy living impacts people's choices and can make change difficult.

Moreover, our previous report demonstrated a high burden of ill health in Maryport, yet findings here show access to health services in Maryport to be problematic, especially so with access to mental health services and emergency and secondary care. The nearest hospital for secondary care and accident and emergency is West Cumberland Hospital in Whitehaven (~16 miles), but for many treatments, and major emergencies, residents must travel to Cumberland Infirmary in Carlisle (~27 miles). For specialist care, Maryport residents may be required to travel to a host of northern hospitals (ranging from ~70 miles to Hexham to ~140 miles to Manchester). Problems of access are exacerbated by poor transport connectivity and poor road infrastructure. With regards access to mental health services, informants reported limited access locally, confusion over how to access help, long waiting times for some services, and long journeys out of the area for specialist support. Stakeholder informants also commented on problems with the recruitment and retention of the health and care workforce in West Cumbria.

Matin et al. (2021[14]) consider the need for health care services in coastal communities against the actual health care workforce present. They highlight that coastal communities have higher levels of deprivation, worse health indicators, and older age profiles - in Maryport 23.5% are aged 65 and over compared to 18.4% in England (ONS Population estimates 2019[1]). Yet coastal communities are looked after by fewer NHS staff. Matin et al. (2021:208) show that coastal communities have '14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient' compared to nationally. For specific diseases the disparities are greater, for example:

> Per patient with COPD, there are 22.1% fewer GP trainees, 10.5% fewer respiratory medicine trainees, 17.1% fewer respiratory medicine consultants, and 9.4% fewer nurses;
>
> Per patient with chronic kidney disease, there are 21.3% fewer GP trainees, 8% fewer renal medicine trainees, 14% fewer consultants and 8.4% fewer nurses;

> Per patient with learning disabilities (LD), there are 16.1% fewer GP trainees, 64% fewer LD psychiatry trainees, 60.4% fewer LD psychiatry consultants and 29.7% fewer LD nurses.
>
> Source: Matin et al, 2021:209.

Informants in this study commented upon the difficulties in getting a GP appointment. This issue has received significant media attention in recent months as GP surgeries up and down the country come under pressure from the ongoing effects of the Covid-19 pandemic. Nevertheless, there are some surgeries that will be feeling this pressure more than others. Gibson and Asthana (2021:199[4]) demonstrate a 'coastal excess' in patient numbers on GP registers for a range of diseases, as shown in table 1 below for cardiovascular disease. They also highlight differences between coastal and non-coastal areas in service standards, including in use of recommended treatments, investigative procedures, referrals, presentations and cancer conversion rates. In attempting to explain these differences, Gibson and Asthana (2021:198-200) point to the wider determinants of health including employment (low skilled, low paid, low status work contributing to material deprivation and psychological distress) and educational attainment (which is impacted by the employment status of families).

Table 1. Actual, expected & additional patients with Cardio Vascular Disease in coastal areas 2014/15 – 2018/19

QOF CVD Condition	National Prevalence Rate	Actual Patients (5yr average)	Expected patients	'Additional' Patients	Coastal Excess
Coronary Heart Disease	3.16%	377,048	320,067	56,968	17.80%
Peripheral artery Disease	0.60%	76,688	61,795	14,893	24.10%
Stroke/TIA	1.75%	209,176	177,337	31,839	18.00%
Heart Failure	0.81%	96,981	81,925	15,056	18.40%
COPD	1.87%	242,297	212,203	30,094	14.18%
Atrial Fibrillation	1.82%	219,073	198,711	20,362	10.25%

Source: Gibson and Asthana, 2021:188

Fisher et al (2020[15]) highlight the persistence of the 'inverse care law' in funding for GP services, this refers to the fact that 'General practice in areas of high socioeconomic deprivation – where health need will be greatest – is relatively underfunded and under-doctored'. Fisher et al (2021) warn that unless the inverse care law is tackled then health inequalities will widen.

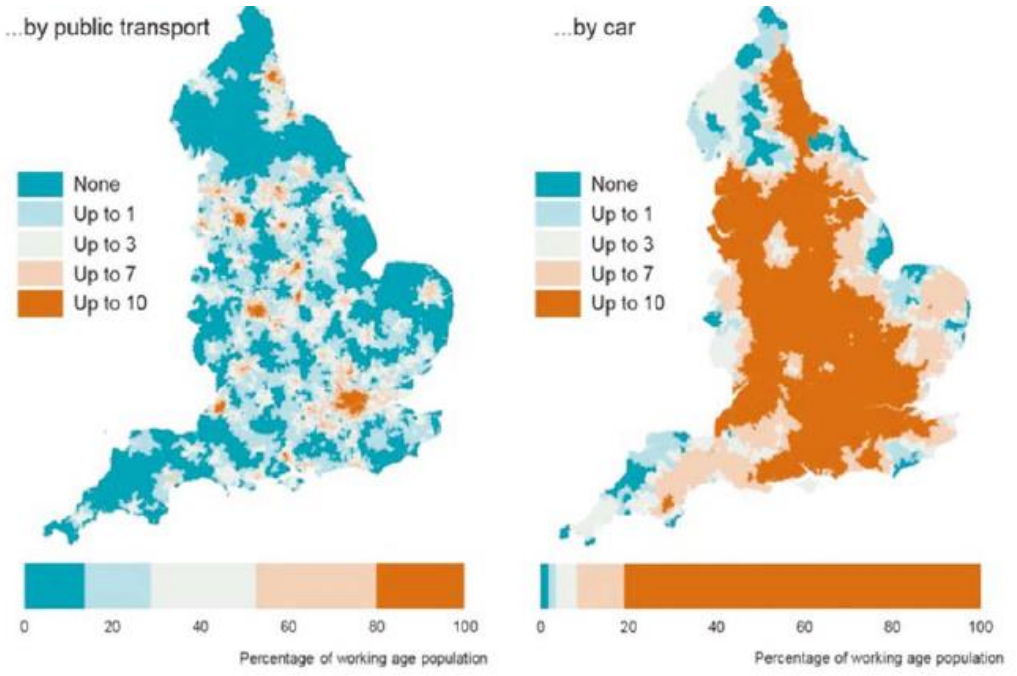
Furthermore, the health service situation in Maryport undermines the core principles of the NHS. Services may be 'free at the point of delivery' but when the point of delivery is many miles away being able to afford access to healthcare becomes paramount. For those without access to a car this becomes challenging. Travelling to appointments is a significant issue in terms of cost and travel time. Some working people will lose up to a day's wages to attend hospital appointments for themselves or family members.

On top of this, digital and transport 'connectivity' is clearly a significant problem for Maryport residents. Poor connectivity creates further problems in underserved communities and such associated problems were discussed at various points throughout the findings.

With regards digital connectivity, a recent report for the Good Things Foundation (Stone et al, 2021[17]) emphasised the importance of digital access to facilitate contact with a host of services including education, employment, and income, as well as access to information, and social participation, in effect, the wider determinants of health. Informants here emphasised in Maryport a lack of digital access, digital poverty (low incomes, unaffordable equipment, Wi-Fi costs), and low skills and confidence in using technology. In December 2020, the UK Parliament published a 'Rapid Response' on 'Covid-19 and the digital divide' (Baker et al, 2020[16]) in which they highlighted the exact same reasons for digital exclusion as above. They also highlighted the challenges during lockdown for digitally excluded people, including unequal access to services, medical appointments, welfare activities and opportunities to socialise with others. They stressed the negative impacts on children and young people, highlighting that during the pandemic '9% of households containing children did not have home access to a laptop, desktop PC or tablet' and that, as a result, 'children from disadvantaged backgrounds have experienced the greatest disruption to their education'.

Transport connectivity was also reported to be a significant challenge in Maryport. The SMC (2017:80[11]) has highlighted the detrimental impact of geographical isolation combined with low car ownership on people's 'ability to get on in life' due to restricted access to employment and services. Having a car can more than halve travel-to-work time, but only '52 per cent of people in the lowest household income group have access to a car, compared with nearly 90 per cent in the highest household income group' (SMC 2017:80). Maps produced by the SMC (Figure 1) illustrate the disconnection to employment hubs experienced by people living in Maryport – as well as the rest of north Cumbria, and many other coastal communities.

Figure 1. Average number of large employment centres accessible within 45 minutes by public transport or car



Source: Department for Transport (2016) *Road Use Statistics Great Britain 2016*, statistical release.
www.licencebureau.co.uk/wp-content/uploads/road-use-statistics.pdf

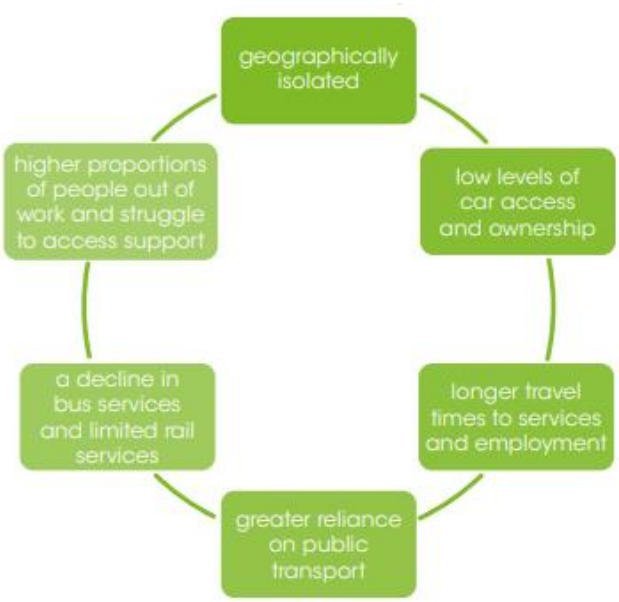
Source: SMC (2017:80).

An All-Party Parliamentary Group for 'left behind' neighbourhoods report (APPGLBN, 2021:12[18]) has argued that 'Poor levels of connectivity, both physical and digital, are a key defining characteristic and an underlying determinant of what constitutes a 'left behind' neighbourhood'. Their analysis shows that residents of left behind wards travel further to access accident and emergency services than other deprived wards and that 34% of wards have longer travel time to hospitals. They argue:

> 'Reliable connectivity is essential for people to access opportunities such as employment and education, as well as essential services such as healthcare. Where this physical connectivity is missing, it has a serious negative impact on people's quality of life and exacerbates social disadvantage. The result is already deprived communities becoming further 'left behind'

The paucity of services in Maryport, which is elaborated above, means that local connectivity, both digital and transport, needs to be improved in Maryport. Figure 2 illustrates the factors which reinforce disconnection.

Figure 2. Factors reinforcing community disconnection: correlation, cause and effects of poor connectivity in 'left behind' neighbourhoods



Source: All-Party Parliamentary Group for 'left behind' neighbourhoods report (2021:10)

Moreover, informants' opinions of local transport suggest that 'transport poverty' is common in Maryport. Lucas et al's (2016[19]) definition of transport poverty has resonance here:

> 'An individual is transport poor if, in order to satisfy their daily basic activity needs, at least one of the following conditions apply.
> - There is no transport option available that is suited to the individual's physical condition and capabilities.
> - The existing transport options do not reach destinations where the individual can fulfil his/her daily activity needs, in order to maintain a reasonable quality of life.
> - The necessary weekly amount spent on transport leaves the household with a residual income below the official poverty line.

- The individual needs to spend an excessive amount of time travelling, leading to time poverty or social isolation.
- The prevailing travel conditions are dangerous, unsafe or unhealthy for the individual'.

Lucas et al (2016) note that it is 'the poorest and most vulnerable' that are most affected by transport poverty.

Furthermore, OCSI (2019[6]) have identified three domains which contribute towards the residents of neighbourhoods feeling left behind or not, these are:

- **Civic assets** - Does the area offer access or provide close proximity to key community, civic, educational and cultural assets, including pubs, libraries, green space, community centres, swimming pools etc. – facilities that provide things to do often, at no or little cost, which are important to how positive a community feels about its area?
- **Connectedness** - Do residents have access to key services, such as health services, within a reasonable travel distance? Are public transport and digital infrastructure good? And how strong is the local job market?
- **An engaged community** - Are charities active in the area, and do people appear to be engaged in the broader civic life of their community?

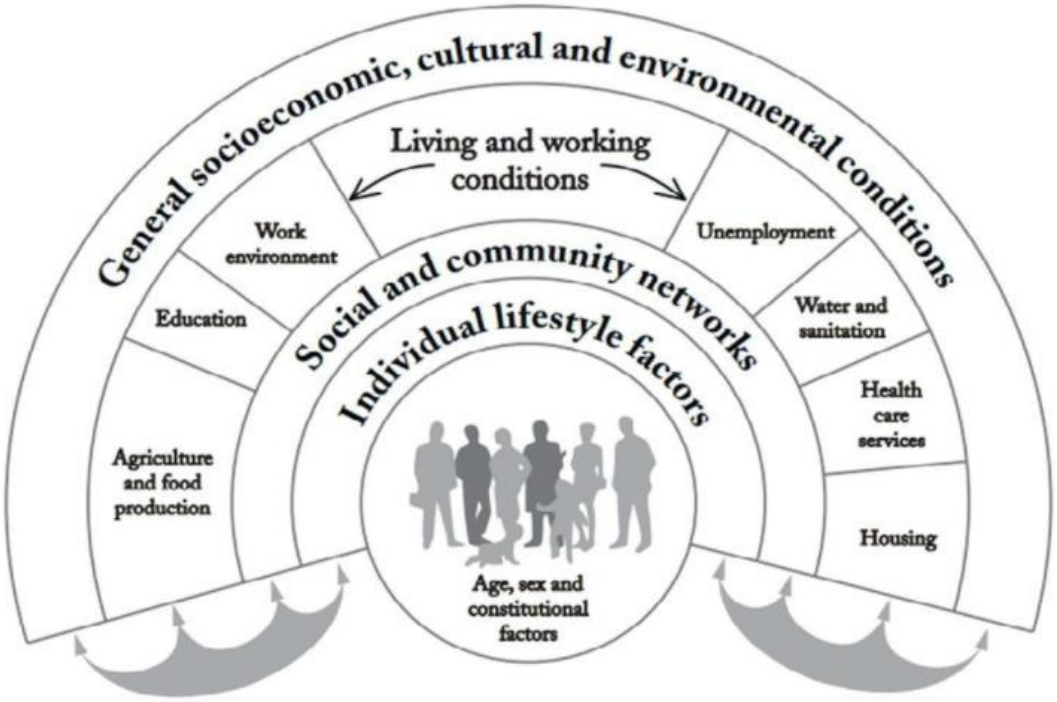
The findings presented here suggest that Maryport is lacking in all three domains, residents have limited access to civic assets; poor connectedness to key services and employment opportunities; few VCFSE providers, and there is low community engagement. There also appeared to be a dearth of cultural and leisure facilities in Maryport which provide 'things to do often, at no or little cost'; this seemed especially the case for children and young people, who have little to keep them occupied outside of school. OCSI (2019) found that communities that 'suffer from this combination of factors' have 'notably worse outcomes', and that such circumstances 'may contribute significantly to how people feel about wider issues and, in particular, their satisfaction and engagement with the political process'. Figure 3 demonstrates the importance of social infrastructure:

Figure 3. The importance of social infrastructure to local communities

Source: All-Party Parliamentary Group for 'left behind' neighbourhoods report (2021:8)

The discussion above illustrates how residents of Maryport are impacted by a range of interconnected challenges, all of which impact negatively on health and can be understood as wider determinants. Dahlgren and Whitehead's (2006) model (figure 4) conceptualises wider determinants as 'rainbow-like layers of influence'. In the middle are characteristics that are fixed, these are biological factors, however, the layers surrounding these 'are influences that are theoretically modifiable by policy'.

Figure 4. Model of the Wider Determinants of Health



Source: Dahlgren and Whitehead's (2006:20)

The 'individual lifestyle factors' layer includes things like diet, exercise, smoking and alcohol misuse. These lifestyle behaviours are in turn influenced by the social and community networks layer which represents an individual's interactions with peers and their immediate community. These first two layers can be conceptualised as 'downstream factors'. However, individuals (and their peers and community) will also be influenced by living and working conditions, for example the availability and types of employment in a given area, access to health services, decent housing, and shops selling affordable and healthy food; together, these 'will impact on their ability to maintain their health'. The outer layer refers to the general socioeconomic, cultural, and environmental conditions that prevail in society at a given time – the political ideologies and policies. These last two layers can be conceptualised as 'upstream factors' (Dahlgren and Whitehead, 2006:21).

The evidence reported here shows many of the challenges experienced in Maryport to be influenced by 'upstream factors', that is factors located in the 'living and working conditions' layer. As such policies to increase access to employment, education and health and wellbeing services are likely to result in health gains.

Several recent reports have made recommendations to tackle these 'upstream' determinants, including DHSC (2021[3]), Marmot et al. (2010[20], 2020[21], 2021[22]) and SMC (2017[11], 2020b[23]); and there is significant crossover between their recommendations - a summary of these can be found in the appendices.

The 2010 Marmot Review, set out six priority objectives with associated recommendations; these were reiterated in the Marmot Review: 10 years on (2020[21]):

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

Marmot et al. (2010:15)

DHSC (2021) highlighted a need for 'a national strategy to improve the health and wellbeing of coastal communities' and, because the report recognises the significance of wider determinants of health, it argues that this needs to be 'cross-government'. They also point to a need for the unequal distribution of the health and social care workforce to addressed so that deployment matches need.

The SMC (2017) recommends a range of strategies to increase social mobility targeted at the early years, schools, youth and working lives, and the SMC (2020b) forward a range of questions to be considered and reflected upon by local leaders, education providers and employers.

Notwithstanding, initiation of such 'upstream' recommendations is dependent on the general socioeconomic, cultural, and environmental conditions, that is, the prevailing ideologies in the outermost layer, and whilst there is much talk of 'levelling up' the country, what this means in practice remains elusive. Until this becomes clearer, tackling health inequalities will remain the responsibility of local authorities, health systems/providers, and organisations in the VCFSE sector. However, in attempts to tackle health inequalities at local level, individuals and their behaviour frequently become the focus and the wider determinants remain unchallenged.

Williams and Fullager (2018[24]) examine 'The challenge of ensuring socially-orientated rather than individually orientated framings' in area-based initiatives to promote health. They argue that 'the new public health agenda has lost sight of the need to build bridges to healthier lives and instead promotes individual responsibility' via an emphasis on behaviours; this emphasis 'tends to undermine the significance of structural factors, social processes and local settings that both impinge upon people's health and their capacity to adopt healthy lifestyles'. This process has been termed 'lifestyle drift', a process that starts with commitment to tackle wider determinants but ends with 'instigating narrow lifestyle interventions on individual behaviours', such as diet and exercise programmes. Such programmes tend 'to be paternalistic and to blame the victim', are frequently of more benefit to less disadvantaged people, and they 'generally have no or little effect on low-SES [socio-economic status] groups'.

Cottam (2018[25]) proposes that traditional welfare approaches build solutions to symptoms rather than the causes of these symptoms and that 'management tries to fix discrete and individual problems with no bigger developmental purpose in mind'. She argues for a reimagining of welfare so that it can 'create capability rather than manage dependence'; this will be achieved by focussing on the lives people want to lead and then helping and supporting them to reach their goals. This requires a shift from transaction to relationships.

Moreover, organisations and services can examine the ways in which they interact with disadvantaged communities to ensure they are not further disadvantaging them. Children North East (CNE)[26] have developed a process called 'Poverty Proofing©'[27] to counter and alleviate the routine, unintentional stigma experienced by people in poverty when accessing the services designed to support them. The process was initially designed to poverty proof the school day but has now been used successfully with a range of organisations nationally, including, for example, cultural institutions, early years providers and in health settings. CNE have developed a 'Community Poverty Proofing Model', which involves speaking to the community to gain a common understanding of the issues faced and to identify the main institutions with which the community interacts, for example schools, GP practices, hospitals, state and local authority services. Work is then undertaken with those institutions to change practices and to infiltrate them with a different ethos and approach. The process is reviewed by going back to the community to see what has changed. There is potential for such an endeavour to be undertaken in Maryport.

There are other actions that local organisations and services can take. The Eighth Global Conference on Health Promotion (2013) endorsed a definition of 'health in all policies' to encourage attention to the wider determinants of health:

> 'Health in all policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity' (in Greszczuk, 2019[28])

In attempting to tackle up stream determinants, local organisations and services can aim for a 'health in all policies' approach; the 'Health Inequalities Assessment Toolkit'[29] can be used to support this. The toolkit has been designed to assist organisations to consider the ways in which all of their activities have the potential to reduce or create inequalities in Health.

Furthermore, this report has highlighted poor connectivity in Maryport; this is exacerbated for residents without access to a car and those that are digitally excluded. The APPG for left behind neighbourhoods (2021[18]) details the effects on neighbourhoods from poor connectivity. It advocates for community engagement to increase confidence and capacity in local people so that they can 'work on the ground to identify and implement solutions that are tailored to meeting local needs'. They suggest a range of ways that communities can influence local transport, including, for example, working with local authorities to influence transport planning and developing community transport schemes to be run as social enterprises. In addition, the 'No Place Left Behind Commission' (2021[30]) argues for new community powers and neighbourhood improvement. Amongst its many recommendations it argues for out-dated 'predict and provide' transport planning models be replaced 'with those that support better place making and sustainable mobility throughout planning, development and regeneration processes'; a comprehensive national bus network, connecting every neighbourhood with regular and reliable services, at a flat £1 fare'; and 'freedom passes to jobseekers in all areas eligible for levelling up funding'.

With regards digital poverty, Stone et al (2021[17]) make the following recommendations to improve digital access for disadvantaged users:

1. Recognise digital access & skills as a social determinant of health
2. Co-design digital health services
3. Improve digital health literacy in the population
4. Develop 'digital health hubs' to improve inclusion
5. Build trust and relationships with poorly-served groups

6. Harness the benefits of digital for health and wellbeing
7. Improve digital skills in the health and care workforce
8. Embed digital inclusion in health, care and wellbeing strategies

A Local Trust report (Robinson et al, 2021) also considers data poverty; it highlights the extent to which this was exposed by the Covid-19 pandemic. Whilst the report recognises that there is no 'cure-all' for data poverty, it does make specific recommendations which are directed at Community Groups, Government and Industry, and Civil Society. It argues that community groups are well placed to 'listen to the lived experience of people experiencing data poverty'; to think about 'prioritising dimensions of data poverty'; 'consider where partners can add value'; and 'plan how to evaluate what works'. Nonetheless, they also argue that:

> 'Communities want to continue to lead action on data poverty and wider digital inclusion but recognise their limits. They do not think it is their role to solve the causes of data poverty, which requires system level change. Support and action from civil society, government and industry are urgently needed if communities continue playing a much-needed role in addressing the complex challenges of data poverty'.

There is much that can be achieved at local level through community engagement and empowerment, but the voices of local people need to be listened to. Community activism needs to be encouraged and supported by those working in the outer layers of Dahlgren and Whitehead's model (2006), in the 'living and working conditions' and 'general socioeconomic, cultural, and environmental conditions' layers. Moreover, there is a need to build bridges between services and communities.

5. Conclusion

This report has focussed on access to resources and services for people living in Maryport; it has shown Maryport to be an underserved community and revealed a range of interconnected challenges relating to education, employment, and connectivity. These findings begin to help explain the data presented in our previous report[5] which considered whether Maryport can be defined as a 'left behind area'.

As OCSI (2019:6) point out, the term 'left behind' is controversial and contentious and can be seen as patronising towards residents. However, they argue that some residents of deprived communities believe the term to aptly describe the way that their communities have missed out on investment and, consequently, services and facilities. During data collection both residents and stakeholders talked fondly about what Maryport was like in the past and referenced services lost or withdrawn. This may be nostalgia for a former way of life but there was a real sense of loss in these conversations. Further, young participants also talked about life in Maryport "back in the day", and so this loss is written in the collective memory of the town.

Moreover, this report highlights the complexity of issues that exist in Maryport and potential solutions to those issues. Various approaches to planning solutions might be adopted across three tensions of power, structure and depth.

Power

Decision makers may want to consider what are the 'priority issues' out of all of those identified in this report in order to decide what to do first. This raises questions of who assigns priorities and whose priorities come top of the list. The views of residents, service providers and policy makers may not align.

Structure

The level at which change planned is of great significance. Whilst front line changes may seem to address priority issues, they are rarely preventative, and instead tend to address the symptoms of the issues highlighted here. Working 'upstream' at a policy level is challenging however, and it may leave people in dire straits if resources are redirected upstream. A dual approach could be adopted if there are sufficient resources, campaigning for systemic change whilst meeting immediate needs in the community.

Depth

Spreading resources across a wide range of solutions might seem to bridge the first two tensions – allowing a wide range of issues, agendas and levels of work to run in parallel. However, diving in deep to make one change in a significant manner could have more positive impact.

Perhaps the first step is to agree a process for deciding what issues to tackle from the body of this report, then consider how to address them while reconciling the power base, structure and depth of that action. What is clear is that doing nothing is not an option, so rather than being paralysed by choice, know that every choice may lead to a better life for people in Maryport, no matter how small.

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Appendices: Recommendations

Appendix 1. Department of Health and Social Care (2021)

Department of Health and Social Care (2021) Chief medical officer's annual report 2021 health in coastal communities. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005216/cmo-annual_report-2021-health-in-coastal-communities-accessible.pdf (date last accessed 28/09/21).

Recommendations

This report has three key recommendations, and several more specific recommendations.

Lead government departments and organisations are listed where appropriate, but this is not exhaustive, and this work needs a whole of government response.

Key recommendations:

1. Given the health and wellbeing challenges of coastal communities have more in common with one another than inland neighbours, there should be a national strategy to improve the health and wellbeing of coastal communities. This must be cross-government as many of the key drivers and levers such as housing, environment, education, employment, economic drivers and transport are wider than health.
2. The current mismatch between health and social care worker deployment and disease prevalence in coastal areas needs to be addressed. This requires action by HEE and NHSE/I.
3. The paucity of granular data and actionable research into the health needs of coastal communities is striking. Improving this will assist the formulation of policies to improve the health of coastal communities. Local authorities, ONS and NHSE/I need to make access to more granular data available. Research funders, including NIHR and UKRI, need to provide incentives for research aimed specifically at improving coastal community health.

Detailed recommendations:

1. Develop a national cross-government strategy on health and wellbeing of coastal communities

The strategy should consider cross-government action on the following:

1.1	Planning for the ageing population in coastal and other peripheral areas, with consideration to migratory patterns, and the potential for a deficit of social care and healthcare workers relative to older populations	Cross-government
1.2	Opportunities for joint working from early years through to further education to improve both health and educational outcomes for children and young people in coastal communities	NHSE/I, DWP, DHSC, MHCLG
1.3	Opportunities for joint working to maximize economic opportunities for coastal communities including maintaining the current focus on the role of the NHS as an anchor institution	NHSE/I, DWP, DHSC, MHCLG

1.4	Review of incentives in the private rental sector in coastal communities, specifically HMOs which draw a transient vulnerable population to coastal communities	MHCLG, HMT
1.5	How to mitigate the transport links which make coastal communities more peripheral	DfT
1.6	Specific plans for major risk factors concentrated in coastal communities – especially high rates of smoking in pregnancy, alcohol and substance misuse	DHSC, NHSE/I
1.7	Looking at funding formulas which disadvantage coastal communities	MHCLG, DHSC, HMT
1.8	Making more of the potential health and wellbeing benefits of living in coastal communities	DEFRA, MHCLG

2. Maintain focus on the current and proposed future medical education reforms which includes the geographical redistribution programme

Additional work is required to:

2.1	Take account of the coastal deficit in the location of new medical schools, and actively recruit in coastal communities to existing medical schools	HEE, DHSC
2.2	Increase GP and specialty training placements (including public health) in coastal areas	HEE, NHSE/I
2.3	Increase access of coastal communities to specialist healthcare, including via digital methods	HEE, NHSE/I
2.4	Build upon learning from the COVID-19 pandemic and HEE's Future Doctor report to strengthen the focus on maintaining generalist skills, which are doubly useful in populations with multimorbidity in peripheral areas further from specialist care	HEE
2.5	Review whether current funding arrangements are a disincentive to GP, nursing and other NHS and social care workers moving to coastal areas	HEE, DHSC
2.6	Consider the wider workforce including social care and other NHS workforce in addition to the medical and nursing workforce	NHSE/I, DHSC

3. Improve data and research into coastal communities

This work should include the following actions:

3.1	Review the availability, access and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels. This includes the analytical capacity across the system to collate, analyse, interpret and disseminate the existing data. This needs consideration of data sharing arrangements	OHP, ONS
3.2	Further multi-disciplinary research is required to understand the multiple drivers of poor health outcomes in coastal communities and test effective interventions	NIHR, MRC, ESRC

	and solutions. This requires specific incentives to leading health academic groups by research funders	
3.3	Analysis suggests that there may be service level challenges in coastal communities. Further research is required to assess this including reviewing the actual, versus expected disease prevalence and service provision in coastal and non-coastal communities	Health inequalities team in NHSE and DHSC
3.4	Research on the health and wellbeing of coastal communities should be encouraged in coastal universities where appropriate, for example through civic agreements between universities and local authorities	NIHR, MRC
3.5	Review migration patterns at lower level geographies to improve understanding of their impact on local communities	ONS
3.6	Improve joint working between local authorities and academic institutions data sharing arrangements	Research funders, especially NIHR, MRC, ESRC
3.7	Given the commonality of interest between coastal areas, learning networks of those leading population health in these areas should be encouraged, linked to academic institutions with an interest in building the knowledge base on health improvements	ADPH

Further recommendations

4.1	Continue work to ensure Directors of Public Health in every Integrated Care System (ICS) are an integral part of the ICS Executive leadership team/ board	DHSC
4.2	The high rates of excess alcohol use in coastal communities, and specifically issues in resort towns, further strengthens the case that public health should be added as a licensing objective in the Licensing Act 2003	HO, DHSC

Appendix 2. Marmot et al. (2020)

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020) Health Equity in England: The Marmot Review 10 Years On – Executive Summary. Institute of Health Equity. Available at https://www.health.org.uk/sites/default/files/2020-03/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_executive%20summary_web.pdf (Date last accessed 26/10/2021)

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

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention (p4).

Recommendations for giving every child the best start in life (p20).

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

Recommendations for enabling all children, young people and adults to maximise their capabilities and have control over their lives (p23).

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

Recommendations for creating fair employment and good work for all (p.24).

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

Recommendations for ensuring a healthy standard of living for all (p27).

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

Recommendations for creating and sustaining healthy and sustainable places and communities (p31).

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

Appendix 3. Marmot et al. (2021)

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2021) Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives (executive summary). Institute of Health Equity. Available at https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives/build-back-fairer-in-greater-manchester-executive-summary.pdf (date last accessed 27/10/21).

Build Back Fairer – Recommendations (pp12-13)

1 Build Back Fairer for future generations	**Prioritise children and young people** • Provide further support for early years settings in more deprived areas, including additional support for parents • Extend interventions to support young people's mental health and wellbeing at school and at work • Ambition for all young people, 18–25 years old, to be offered in-work training, employment or post-18 education • All policies assessed to consider impacts on health equity for future generations • Implement all recommendations and commitments in Greater Manchester's Young Person's Guarantee
2 Build Back Fairer resources	**Rebalance spending towards prevention** • Share expertise and evidence of prevention interventions across local authorities and public services, and continue to build capacity and partnerships • Double the budget for prevention in the total health care budget in Greater Manchester within five years and a system-wide prevention/health spending target for all of Greater Manchester to be developed by end of 2021, with incremental targeted increases over five years • Advocate for real terms percentage increase in the regional budget for public health Build Back Fairer opportunities for all • Ensure proportionate universal funding – increase funding in more deprived communities and particular areas of public services • Advocate for increases in local government funding and public service allocations and other regional shares of national budgets • Establish a Build Back Fairer Investment Fund in Greater Manchester to include contributions from businesses that support the Build Back Fairer agenda • Increase funding and support for training and apprenticeships in more deprived communities • Request that businesses invest in a regional Build Back Fairer Investment Fund or equivalent through social value approaches and corporate social responsibility Build Back Fairer commissioning • Extend social value commissioning to all public sector contracts and to businesses in Greater Manchester to enhance business contributions to Building Back Fairer
3 Build Back Fairer standards	**Standards for healthy living** • Identify the minimum income for healthy living in Greater Manchester and advocate for national resources to meet this in public sector pay and support business to pay the minimum income for healthy living • Guarantee offer of universal access to quality services including existing public services and public health services and universal access to training, support and employment for young people

	• Develop Greater Manchester minimum standards for quality of employment, environment and housing, and transport and clean air and advocate for enforcement powers and resources
4 Build Back Fairer institutions	**Extend anchor institution approaches** • Implement Greater Manchester's social value framework and extend anchor institutions approaches to VCSE sector and businesses • Extend the remit of anchor institutions to incorporate social value procurement and commissioning and contributions to the Build Back Fairer Investment Fund **Scale up social value contracting and extend business role** • Health and social care act as leaders in social value commissioning and work in partnership across local authorities to develop local supply chain across Greater Manchester • Embed widescale social value requirements in the Local Industrial Strategy and Good Employment Charter • Add provision of apprenticeships for all ages to the social value framework • Link Innovation Greater Manchester with social value framework
5 Build Back Fairer monitoring and accountability	**Develop Build Back Fairer equity targets for Greater Manchester** • Based on the Marmot Beacon Indicators develop publicly accessible targets to monitor progress towards Building Back Fairer • Report bi-annually on Marmot Beacon Indicators related to targets • Invest in routine data collection to support monitoring of reductions in inequalities in wellbeing, opportunity and community cohesion within local authorities
6 Build Back Fairer through greater local power and control	**Build Back Fairer devolution** • Advocate for increased local control of employment services, post-16 skills, labour market, social housing and early years policies and services • Build on success of devolved services and advocate for further powers and resources to deliver local health and wellbeing needs • Further involve communities in the design and delivery of interventions to support their health and wellbeing • Enhance public visibility of the Build Back Fairer approach in Greater Manchester including explicit commitments and offers to the public • Develop publicly accessible data on equity in health, wellbeing and the social determinants of health

COMMUNITIES AND PLACE (P28)	1. Advocate for increased deprivation weighting in funding by level of area deprivation. 2. Advocate for a greater share of resources for regions and local authorities hit particularly hard by COVID-19 and containment measures, and based on remedying shortfalls in funding over the last 10 years. 3. Develop publicly accessible data on equity in health, wellbeing and the social determinants of health within local authorities and strengthen monitoring by ethnicity at the local level.
HOUSING, TRANSPORT AND ENVIRONMENT (p34)	**1. Improve the quality and affordability of housing** • Fully implement the Good Landlord Scheme. • Strengthen and enforce decent housing regulation and advocate for resources to enforce housing regulations. • All new housing to be built to net-zero emissions standards, with an increased proportion being either affordable or in the social housing sector. • Continue to reduce rough sleeping and hidden homelessness and extend action to reduce risks for homelessness.

	2. Green spaces, air quality and quality high streets • Fully implement clean air zones and monitor for inequalities in exposure. • Improve quality of existing green spaces and prioritise provision of new green spaces in areas of higher deprivation. • Adopt city-wide strategies that put health equity and sustainability at the centre of planning. • Work with local communities to better include their needs when reviving local high streets. **3. Transport and active transport** • Extend incentives to encourage people back to public transport. • Improve road safety by implementing 20mph speed limit in all residential streets and implement other road safety initiatives in deprived areas first.
EARLY YEARS, CHILDREN AND YOUNG PEOPLE (p39)	**1. Reduce inequalities in early years development** • Increase the quality and availability of parenting support programmes run through early years centres and schools. • The regional budget to meet the OECD average for the proportion of spending on the early years and increase funding per child for early years settings in more deprived areas. • Develop a new measure of school readiness for Greater Manchester. • Ensure childcare workforce wages in public and private sector meet the Greater Manchester Minimum Income for Healthy Living. **2. Reduce inequalities in educational attainment** • Increase catch-up tuition for more deprived students, beyond the UK Government programme, and give additional support to families with children with special educational needs and disabilities (SEND). • Implement all recommendations and commitments in Greater Manchester's Young Person's Guarantee. **3. Prioritise and improve mental health and outcomes for young people** • Prioritise improving the mental health of young people including through providing further mental health support/first aid training in all schools in Greater Manchester. • Improve mental health treatment options for children and young people rapidly. • Work with primary care and local charities to provide a whole-system and early response to improve mental and physical health and wellbeing in children aged 0–5 years through the hub and spoke model and to address the social determinants of health in local communities. • Increase the provision of local youth services for young people, advocating for national resources. **4. Improve training and work prospects for young people** • Extend offers of apprenticeships and training for young people linked to requirements for social value employers to participate. • Achieve no NEETs in Greater Manchester by guaranteeing an employment or training offer for 18–25 years olds. • Advocate to raise the minimum wage for apprentices. • Increase mentoring opportunities (including in public services the voluntary, community and social enterprise sector and business) and add provision of mentoring to the social value framework and Good Employment Charter.

INCOME, POVERTY AND DEBT (p44)	**1. Reduce poverty** • Establish a goal for everyone in full-time work to receive a wage that prevents household poverty. • Develop a regional standard for minimum income for healthy living, to be used to establish the minimum wage for Greater Manchester. • Support food aid providers and charities, and advocate for better national funding. • Continue to advocate for additional £1,000 annual uplift to Universal Credit and explore other ways of providing this if it is cut. • Extend eligibility for free school meals. • Advocate for an end to the five-week wait for Universal Credit and extend cash grants for low-income households. **2. Reduce levels of harmful debt in Greater Manchester** • Increase financial management advice in schools and workplaces. • Further support community and voluntary sector provision of debt advice. • Work with Credit Unions to reduce the use of high interest loan businesses and further regulate loan agencies. • All local authorities in Greater Manchester to offer support for those who are in debt due to non-payment of council tax. **3. Monitoring for poverty and inequity** • Improve local data collection and collation of national and voluntary sector data to estimate inequalities in income and debt within local authorities.
PUBLIC HEALTH (p56)	**1. Allocate public health resources proportionately, with a focus on the social determinants** • Advocate for real terms percentage increase in the regional budget for public health. • Strengthen the public health focus on the social determinants of health. • Public health to provide a key leadership role post-COVID-19 in plans to Build Back Fairer. • Continue to support Greater Manchester's integrated health and care system to be a true population health system, working in partnership with the 10 local authorities and the GMCA. • Develop equity targets for local authorities and the City Region, with clear lines of accountability to reflect priorities for reducing health inequalities and inequalities in the social determinants in the longer term. **2. Prioritise inequalities in mental health** • Increase mental health provision in workplaces. • Continue and expand existing programmes which focus on preventing mental health problems, and strengthen monitoring and evaluation for equity. • Work with planners to develop mentally health high street and access to good quality green space within 15–20 minute walk for all in Greater Manchester, including specific actions to: reduce noise and air pollution, improve community safety and reduce anti-social behaviour. **3. Give prevention interventions time to succeed** • Invest for the long term, measure success over five and 10 years, and improve sharing of best practice between local authorities in Greater Manchester. • Identify and embed learning from the COVID-19 pandemic, including the value of place-based services and other 'bottom-up' approaches. • Place prevention and taking action on the social determinants at the centre of integrated care system in Greater Manchester

Appendix 4. Social Mobility Commission (2017)

Social Mobility Commission (2017) State of the Nation 2017: Social Mobility in Great Britain. London: OGL. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662744/State_of_the_Nation_2017_-_Social_Mobility_in_Great_Britain.pdf (date last accessed 07/10/21).

Early years:

- Every local authority should develop an integrated strategy for improving disadvantaged children's outcomes. This should include:
  - quality improvement support for early education settings, including collaborative working groups, tailored advice and comprehensive training for early years teachers
  - driving uptake of the early education offer for disadvantaged two-year-olds and ensuring that they do not lose places to children eligible for the 30-hour offer
  - ensuring that all parenting support programmes are evidence based and experimenting with ways to offer effective advice to more parents.
- Early education and childcare providers should invest pupil premium funds in evidence-based practice using the Early Education Foundation's toolkit.

Schools:

- Regional School Commissioners should be given responsibility for monitoring and managing the supply of teachers within their regions and should work with universities, schools and Teach First to develop sub-regional strategies with the right incentives to attract, recruit and keep teachers, offering region-wide opportunities for development and progression.
- The government should launch a fund for schools in rural and coastal areas to explore innovative approaches to partnerships with other schools in order to boost attainment.
- Regional School Commissioners should work with the combined authorities to ensure coherence between skill development and local industrial strategies.

Youth:

- Local Enterprise Partnerships should follow the approach of the North East Local Enterprise Partnership, which works to improve careers support for young people by facilitating collaboration between employers, schools and colleges via joint groups and websites.
- Universities should play a more active role in their local community by encouraging local employers to hire graduates and organising student volunteering in isolated areas nearby.
- Government should develop education and skill policies to better support disadvantaged young people in isolated areas; for example, by targeting any unused apprenticeship levy funds at regions that have fewer high-level apprenticeships.

Working lives:

- Central government should put social mobility and place at the heart of the industrial strategy, with a focus on rebalancing economic and work opportunities.
- Central government should rebalance the national transport budget to deliver a more equal share of investment per person and contribute towards a more regionally balanced economy.

- The Department for Education and the Department for Business, Energy & Industrial Strategy should collaborate on Opportunity Areas, aiming to improve educational attainment and labour market opportunity in coldspot areas.
- The Department for Business, Energy & Industrial Strategy should match the Department for Education's £72 million Opportunity Area fund to boost quality employment in coldspot areas.
- Local government should develop a new deal with employers and educators for inclusive employment, based on jointly agreed local social mobility action plans, using the Social Mobility Employer Index as a framework for employer action.
- Local government should support and incentivise accredited voluntary living wage employers and ensure that the local council is also accredited.

Appendix 5. Social Mobility Commission (2020)

Social Mobility Commission (2020) Moving out to move on: Understanding the link between migration, disadvantage and social mobility. London: Institute for employment studies. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/902943/Moving_out_to_move_on_report.pdf (date last accessed 07/10/21).

The Commission sees this report as the beginning of a conversation with leaders around the country about how they can contribute to an environment where the trade-offs between staying and moving are less severe than they are now. The suggestions below start to tease out the questions we think local leaders should be considering as they think about their role in improving choice for all people, regardless of where they live and where they call home.

Decision makers	Policy suggestions	Questions for consideration and reflection
College Principals and Vice-Chancellors	Education: Universities and colleges should work together to ensure each local area has a comprehensive, coherent and flexible local education offer for school leavers and adults.	How can collaboration trump competition to address local and regional gaps in educational provision? How can institutions tackle the social and financial barriers faced by those from less advantaged backgrounds who move to study?
Local authority leaders, community groups, metro mayors and large employers	Building place identity: Local authorities, metro mayors, community groups and bigger employers ought to join forces to strengthen the cultural sense of place identity in every local community.	What are the anchor institutions in each 'place' that can take the lead in harnessing the history, identity and prosperity of a place to foster a sense of identity? How can local leaders give enough strategic priority to building or re-building place identities? How might this approach differ in communities where populations might be more transient?
Local authority leaders, employers, education leaders, local enterprise partnerships	Local labour markets: Local authorities and employers should work with colleges and training providers to identify and correct any mismatch between local skills and local needs. This will enable effective and dynamic reskilling programmes where necessary, and provide the basis upon which public and private	What capacity do local authorities have to actively identify the skills needs in their areas, and do they have the relevant input from employers of different sizes, to do so? Do colleges, universities and other training providers have enough

	sector institutions will have the confidence to relocate.	dynamism to respond to the changing labour market in particular geographical areas? Is there enough deep and consistent engagement between colleges and employers to ensure there are smooth transitions between education and employment?[3]
Local authority leaders, metro mayors and combined authorities, local enterprise partnerships, housing associations, transport planning officials and the Ministry of Housing, Communities and Local Government	Local Infrastructure: After jobs and education, digital infrastructure and skills, transport connectivity and good quality housing are the three most essential ingredients to enable places to attract new people and retain others. These must be at the forefront of leaders' thinking in rebuilding after COVID-19.	How much do local leaders engage with their counterparts in neighbouring areas? How might metro mayors build strong towns, or city hub and spoke models, which consider social mobility and promote inclusive growth at the heart of planning in housing and transport? How might the skills for digital participation be delivered strategically across local areas for vulnerable groups?
Employers	Geographically diverse workforces: Many employers, where possible, have embraced remote working out of necessity during the pandemic. Now, as part of a commitment to social mobility, employers should think about recruiting and establishing progression pathways beyond their traditional physical headquarters and think about how flexible working arrangements can diversify the geography of their talent pipelines.[4]	How can more employers build workplace cultures which are not necessarily location-centric?

[3] Employers are encouraged to consider outreach carefully and to adopt best practice as found in the Commission's Toolkit for employers – accessible via www.socialmobilityworks.org

[4] According to the ONS, working from home is often more possible in occupations which "require higher qualifications and experience". Less than 30% of the workforce were able to work from home during the pandemic. ONS. Coronavirus and homeworking in the UK Labour Market.