Appendix A

Medway Marmot Place Partnership: Together for a fairer, healthier future

INSTITUTE of HEALTH EQUITY

Medway MARMOT PLACE Partnership
Together for a fairer, healthier future

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AUTHORS

Report writing team:

Lauren Blum, Owen Callaghan, Benjamin Viles, April Whitworth

Team support:

Dr Jessica Allen, Dr Angela Donkin, Professor Sir Michael Marmot

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Nucleus Arts
Regeneration Culture Environment and Transformation
Rivermead Inclusive Trust
Voluntary Sector Leaders Network

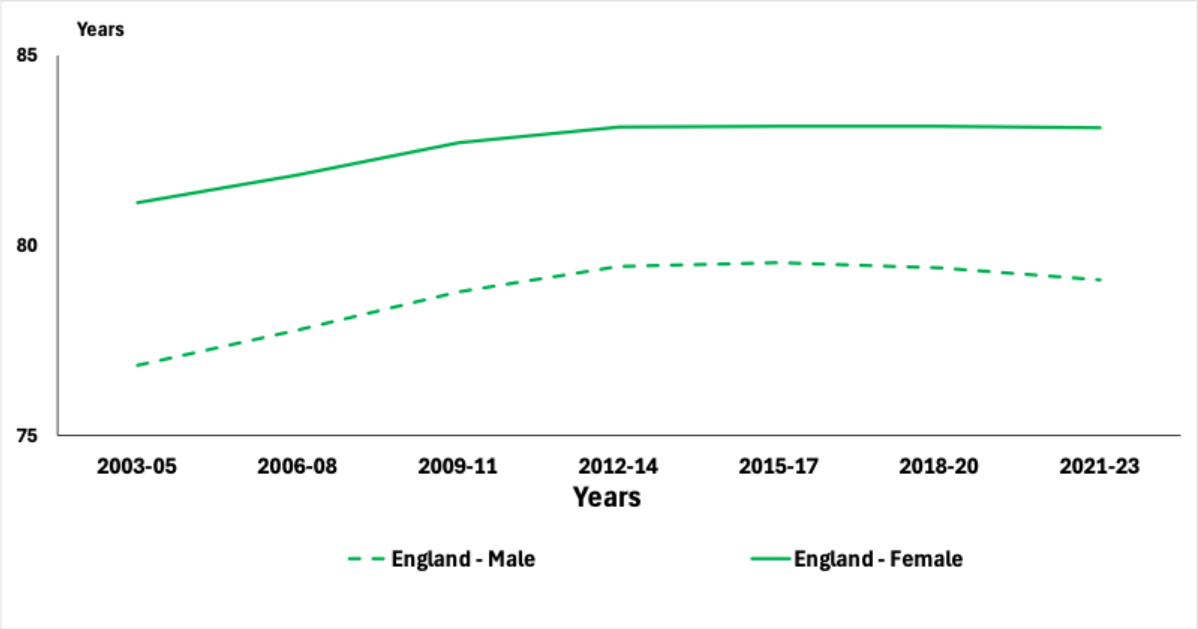
GLOSSARY

CIPFA - Chartered Institute of Public Finance and Accountancy
CNE – Children North East
EPC – Energy Performance Ratings
HEN - Health Equity Network
ICS – Integrated Care System
IHE – Institute of Health Equity
IMD – Index of Multiple Deprivation
LEAP – Lambeth Early Action Partnership
ME – Marmot Envoy
MFF – Making Manchester Fairer
MSOA - Middle Layer Super Output Areas
FSM – Free School Meals
MVA - Medway Voluntary Action
NEET – Not in Education, Employment or Training
SEN – Special Educational Needs
SEND - Special Educational Needs and Disabilities
UCL – University College London
VCFSE - Voluntary, Community, Faith, and Social Enterprise
WSO - Whole Systems Obesity

1A HEALTH INEQUALITIES: THE NATIONAL PICTURE

Across England, health is deteriorating, and health inequalities are widening. This is reflected most starkly through data on how long people are expected to live, their **life expectancy**, and how long people are expected to live in good health, their **healthy life expectancy**. In terms of life expectancy, Figure 1 shows a national decline for both males and females following 2010 and the policies of austerity and continuing declines after the Covid 19 pandemic. The decline is particularly pronounced among males.

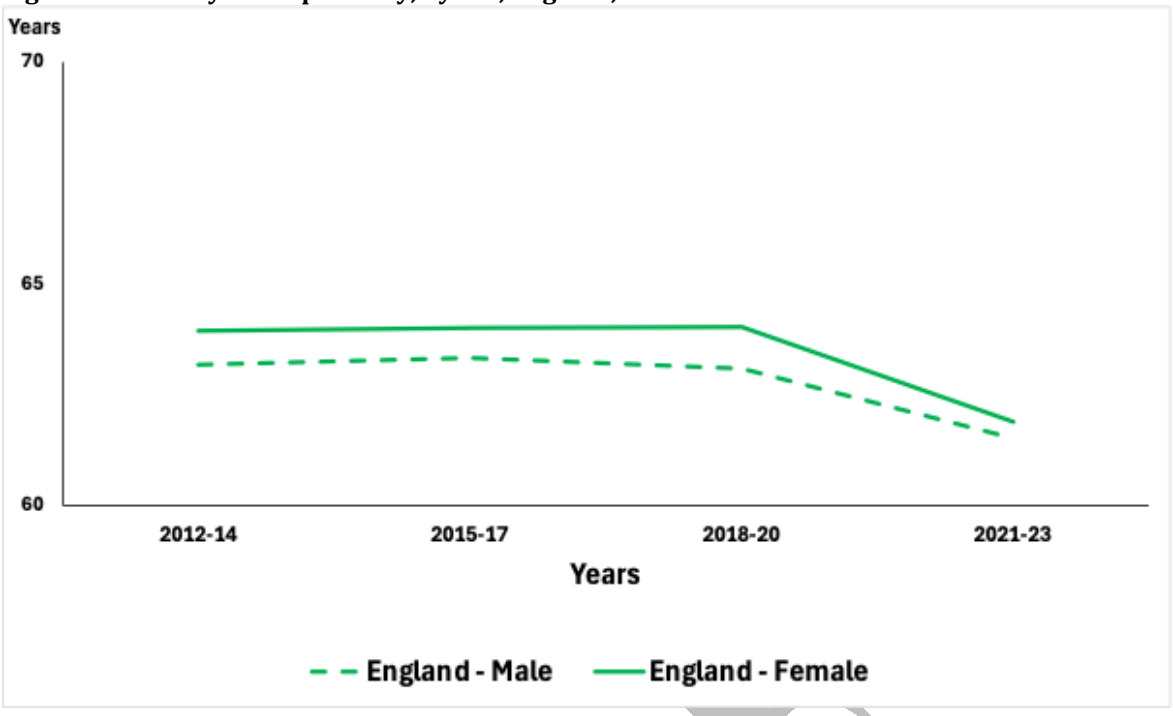
Figure 1. Life expectancy at birth, England, 2003-05 to 2021-23



Source: ONS (2024) [1]

Meanwhile, looking to trends in healthy life expectancy in England (Figure 2), there has been a stagnation along a similar timeline, with the Covid-19 pandemic marking the turning point to a decline in the expected years of healthy life for males and females.

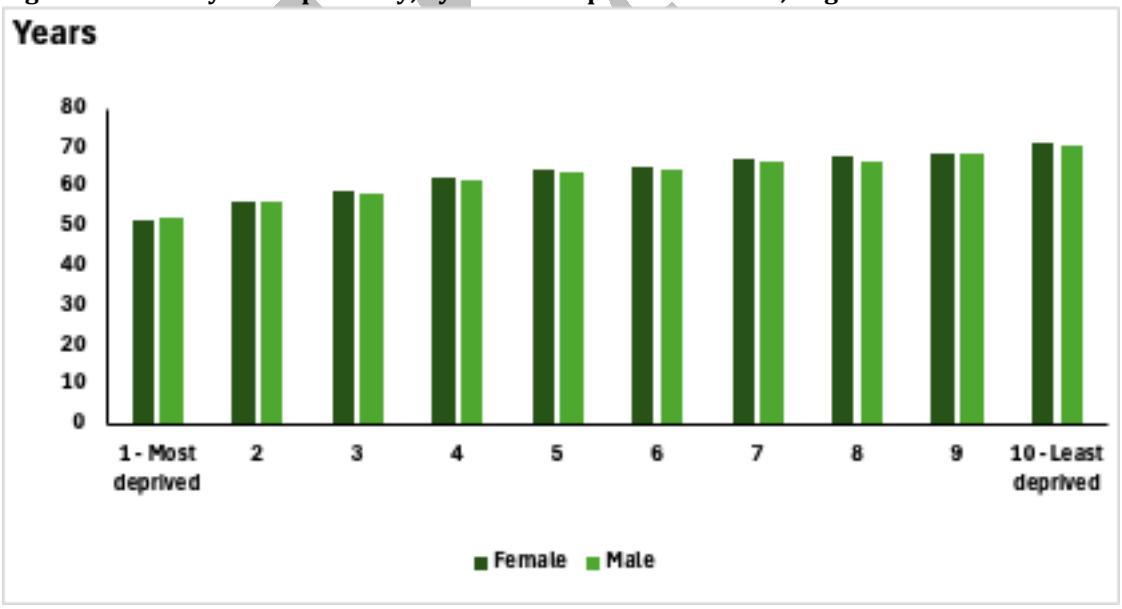
Figure 2. Healthy life expectancy, by sex, England, 2012-14 to 2021-23



Source: ONS (2024) [2]

Figure 3 shows wide inequalities in healthy life expectancy related to level of deprivation of areas in England. Of note is the clear gradient in health, among both males and females and the close relationship between health and area deprivation. This gradient is a feature of health in every area in England and globally. The Institute of Health Equity (IHE) 2010 and 2020 reports showed how the social gradient in health runs from the top of the socioeconomic spectrum to the bottom, that people below the top income deciles is likely to live shorter lives and develop a disability earlier than those at the top [3, 4].

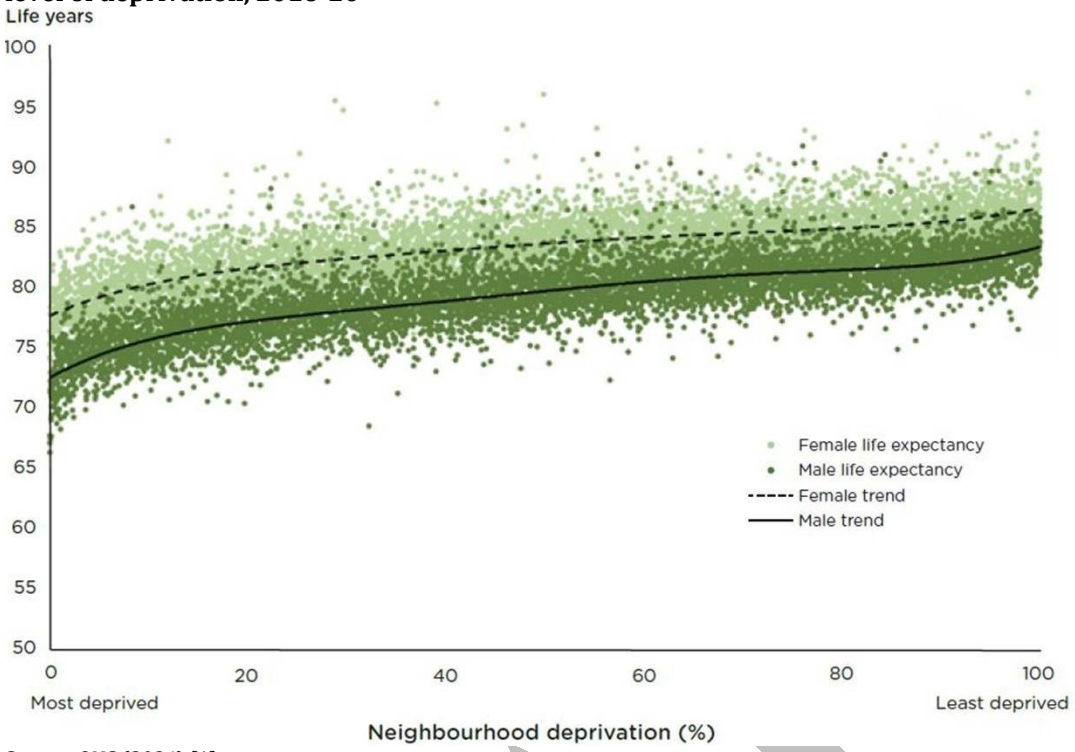
Figure 3. Healthy life expectancy, by sex and deprivation decile, England 2017-19



Source: ONS (2024) [2]

Figure 4 shows the social gradient in female and male life expectancy by neighbourhoods in England. The lines show that broadly, as neighbourhood income increases, life expectancy increases. The IHE is clear that this is preventable and unjust, and that health inequalities can and should be reduced across the gradient.

Figure 4. Life expectancy at birth for neighbourhoods in England, by sex and level of deprivation, 2016-20



Source: ONS (2024) [1]

Despite widening health inequalities and widespread recognition of the extent of health inequalities in England, there is currently **no national health inequalities strategy** to support action on tackling health inequalities. However, there are **various relevant strategies** that will contribute towards this ambition including the Fit for the Future: 10 Year Health Plan [5] which aims to shift provision of some health and care services into community settings focussing on prevention and the development of a Neighbourhood Health Service; The Best Start in Life strategy [6] and Best Start Family Hubs [7] to be available in every local authority; the Child Poverty Strategy [5, 8, 9]; the Pride in Place Programme [10] focused on long term investment in deprived neighbourhoods; the Make Work Pay and Get Britain Working White Paper which, in part, aim to reduce economic inequalities [3, 6, 7]; and the Pride in Place Programme [8] focused on long term investment in deprived neighbourhoods. These strategies and their overarching commitment to focus on prevention of ill health offer potential for reducing health inequalities.

Within this national context, over 60 **local places** across the UK and beyond are working with the University College London (UCL) IHE to identify where and how they can make positive difference in reducing health inequalities through action on the social determinants of health and to develop a system that prioritises health equity in the long-term.

1B The Marmot approach

Most **health is shaped by factors outside of the healthcare system** through the conditions in which people are born, grow, live, work and age. These are known as the **social determinants of health**. The UCL IHE has developed 8 key principles covering these determinants to reduce health inequalities.

The **Marmot 8 principles** are as follows:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.

5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

These evidence-based principles were developed in the 2010 and 2020 Marmot Reviews [3, 4] and have been utilised by places which have taken on the Marmot approach, by national governments and international and national organisations and sectors.

The 2010 and 2020 Marmot reports also proposed adopting **proportionate universalism** to reduce inequalities in health. This is the approach that universal policies and interventions should be implemented in proportion to need. The aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher. For example, cuts to local government funding over the past decade have disproportionately affected more deprived areas [3] and contributed to widening inequalities in health within and between areas. For these to be reversed, funding should be greater where loss has been most substantial.

In developing approaches to support greater health equity, many local areas, including Medway, have taken up the approach. Although every place has different priorities, common features of the 'Marmot' approach includes places:

- Recognising that health and health inequalities are mostly shaped by the social determinants of health
- Assessing inequalities in health and the social determinants of health and actions that are already happening
- Identifying gaps in existing approaches and action to go further to reduce inequalities
- Evaluating how partners within a place can work together more effectively
- Strengthening the health equity system in a place and collaborations with the national system
- Developing and delivering approaches to tackle health inequalities.

From work in other Marmot places, the IHE have identified areas where the Marmot approach has had positive impacts and where to make changes to progress towards health equity.

These aspects can be described by this three-part cycle, shown in figure 5: acting on the Marmot principles, developing system change, and culture shifts and transformational processes.

Figure 5. The Marmot approach – securing change to reduce inequalities in the social determinants of health.

The Marmot principles acts on the list of principles set out above.

Meanwhile, the systems change and culture shift comes from various operational elements. These include governance, leadership and advocacy, partnerships with a breadth of organisations including local government, public services, the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector, healthcare, education, community organisations and business and the private sector, training and capacity building and prioritising health equity in all policies.

The third element - transformational processes, - refers to types of approaches taken. These include proportionately universal and equitable resource allocation, directed towards prevention, commissioning shaped for greater health equity and the social determinants of health, and the use of appropriate data, monitoring and indicators.

1C Marmot activity in Medway

In April 2024 Medway commissioned the UCL IHE to support them to develop as a Marmot place. This programme also enables Medway to be part of the wider IHE Health Equity Network (HEN) and learn from and share with colleagues across the UK. Work in Medway is termed the **Medway Marmot Place Partnership** and has set out the following ambition:

> *In ten years' time, Medway will halve the gap in life expectancy between Medway and England; halve the gap in life expectancy between the best and worst-off areas in Medway; and halve the gap in healthy life expectancy between Medway and England*

The ambition is challenging but will help to prioritise action and ensure that health equity is embedded in all decisions and approaches. The Marmot programme is just the start of meeting this ambition, and work must continue at pace and at scale across Medway over the next ten years.

This report begins to explore a range of local datasets relating to health equity in Medway and seeks to collate and build existing insights to inform local stakeholders of the landscape. In turn, the report functions as an introduction to Medway's Marmot Place Partnership and acts as an opportunity for involved stakeholders to see the bigger picture in which they are working. Meanwhile, local stakeholders can learn about the work, understand how they can engage with health equity across the system and join the collective effort to shift the culture in Medway towards one which embeds equity sustainably and consistently. This programme seeks to strengthen a health equity system in Medway, consolidate work so far and in turn, build momentum and engagement for work going forward.

Activity in Medway focused on this aim can be broken down as follows:

Strengthened Governance for health equity

At a senior level, Medway's Marmot Place Partnership is overseen by an **Advisory Board**, chaired by Professor Sir Michael Marmot. The group have met quarterly since March 2025, and report into the Medway Health and Wellbeing Board. The Advisory Board aims to provide expertise, advice and representation that enables the progression of the Marmot priorities. The Board seeks to empower Medway colleagues and communities to develop and strengthen accountability and activity to reduce health inequalities in Medway. The group includes a variety of stakeholders from the IHE, Council, NHS, education, voluntary, community, faith and social enterprise (VCFSE) sectors, all of which shape health in Medway. The membership of this group can be found in Annex A.

A **Steering Group** meets every two months and reports into the Advisory Board. The purpose of this group is to identify priorities for the programme, set up and act as the liaison with the working groups and implement the Marmot approach on the ground. The Steering Group oversee the activity of its working groups (described below). Membership of this group includes an array of stakeholders from the IHE, public sector, VCFSE and will expand its membership where appropriate to ensure adequate and diverse representation. The membership of the Steering Group can be found in Annex B.

Working groups

The Steering Group reflected on the outputs of the launch event (described below: Marmot Launch event) and based on the input from attendees identified priority areas for focused working groups to drive progress on the ambition to halve health inequalities.

The working groups consist of partners involved in the oversight and delivery of local services across Medway and work together. The groups are well placed to prioritise collaboration with, and activation of, local organisations and evolve as new stakeholders are identified to participate. In each of the groups the IHE participates as a critical friend: to challenge, hold to account, support and collaborate with cross-sector partners and bring expertise, including that from other Marmot Places across the country.

1. The **resident engagement group** oversees the gathering and analysis of resident insights to ensure lived experience is central. The first priority of the group was for one of Medway's VCFSE partners, EK360 [11], to produce a report collating existing residents' thoughts on health inequalities. This process included the collation of all insights gathered in Medway over the previous five years and was developed through partnerships across Medway to ensure as much breadth of reach and representation as possible. A summary of the findings from this is included in Chapter 3. The group will use this report to strategically shape future activity and respond to gaps in terms of resident engagement for this programme and beyond. The group includes representatives from Medway Council, EK360, Medway Diversity Forum, MidKent College, IHE, Maritime Children's Foundation Trust, Medway HDRC and Medway Community Healthcare.

2. The **asset mapping group** are focused on identifying, analysing, and compiling existing local interventions, services, and programmes that contribute to building a healthy and fair Medway. The ambition is to build an interactive map that collates this information to enable local stakeholders to identify and participate in a range of initiatives working to reduce health inequalities. Medway are the first Marmot Place to take on this ambitious task of comprehensive mapping. The work on this to date is summarised in Chapter 4. The group includes representatives from Medway Council, IHE, Medway Voluntary Action, Maritime Academy, MidKent College, Department for Work and Pensions, and Medway HDRC.

3. The **communications group** lead the development and implementation of the Marmot communications strategy. They are focused on building clear, consistent and culturally sensitive messaging and promotional material that builds awareness and outlines Medway's approach to the public and wider stakeholders. Part of this work is focused on developing the Medway Marmot Website [12]: this will be a central hub for people to learn about what is happening locally, an access point for local partners to get involved in the work and hold the various outputs and milestones of the work. This group has representatives from Medway Council, Medway Voluntary Action, K&M ICB, IHE and Rivermead Inclusive Trust.

OTHER ACTIVITIES

The Medway Marmot Place Partnership works closely with IHE colleagues to build and evolve a clear workplan. The IHE have developed a data pack that provides data on health, the social determinants of health, and the 8 Marmot principles in Medway to inform the approach. This is due to be renewed in early 2026 and shared with key stakeholders. This pack will be used for monitoring and informing priorities.

The IHE have also supported with communication and discussion papers around the ambition of the Marmot work and data relevant to various audiences to encourage involvement. Medway colleagues have been involved with the IHE through attendance of the HEN Conference in October 2025 and engagement with the HEN forum. This has been an opportunity for learning and evolving thinking with likeminded colleagues across the UK.

Medway partners have an appetite to focus on young people who are 'not in education, employment or training' (NEET). Reducing NEETs among young people will help reduce inequalities in health and inequalities in key social determinants of health, such as employment and income throughout life. Multiple stakeholders are collaborating to plan the 'NEET Summit' scheduled for 30th April 2026. This

event will seek to explore the lived experience of young people prior to being NEET and how to prevent NEET. The IHE are supporting the Summit and will produce a data pack to inform and share at the event.

A key outcome from the event will be an action plan for local partners on what they can do next to reduce the number of young people who are NEET in Medway. This event will also mark one year from the Medway Marmot launch event (described below) and will be an opportunity to share recommendations (see chapter 8) to build a sustainable health equity system in Medway. For this reason, exploration and recommendations for preventing the current and future rate of young people NEET remains high-level in this report, and more detailed analysis will be published following the Summit.

In 2026, all stakeholders who have been involved so far, will continue to engage broader partners and present the Medway Marmot Place Partnership to new groups and seek to expand the horizon of the approach. There is also the possibility of Medway Council adopting an 'Integrated Impact Assessment' model which is currently being explored as a means of ensuring a health inequalities lens is used in all decision making at the council.

Colleagues are also exploring the novel concept of 'Marmot Envoys' (MEs) as a championing model for the programme of work. MEs will be local stakeholders and residents who get involved in the Marmot Partnership as leaders, community representatives and local experts to embrace and push forward the Partnership and ensure it meets the needs of locals.

Marmot Launch event

In April 2025, over 100 stakeholders, from health, education, housing, local businesses, academia and the VCFSE in Medway came together for the Medway Marmot Place Partnership launch event [13]. This event formally launched Medway's intention to embed a health inequalities lens across decision making and activity in the Medway area.

The event also sought to strengthen partnerships across Medway to tackle health inequalities collaboratively as well as draw in new partners and showcase the Marmot approach as a long-term, sustainable commitment to health equity and social justice. The event included presentations from the leader of Medway Council, Vince Maple, Professor Sir Michael Marmot, Coventry as the first Marmot place, the Director of Public Health in Medway, Professor David Whiting, Councillor Teresa Murray, and an interactive workshop involving all attendees.

Following the launch event, Medway's Advisory Group agreed its Marmot ambition (as stated above):

> *In ten years' time, Medway will halve the gap in life expectancy between Medway and England; halve the gap in life expectancy between the best and worst-off areas in Medway; and halve the gap in healthy life expectancy between Medway and England.*

1D Stakeholder findings from the launch event

The workshop session highlighted key themes through a Lego discussion where the toy blocks were used to represent the concept of the 'building blocks' or social determinants of health, post-it note contributions and online interactive audience polling tool (Mentimeter) input. Overall, key discussion themes covered barriers, opportunities and potential actions.

In terms of barriers, colleagues highlighted a lack of trust among some communities towards statutory services. They also highlighted inefficiencies within these services which are often siloed, and residents are at times marginalised in terms of access due to identity, geography, stigma or language. Another key obstacle is the short-termism and funding which often limits or avoids entirely a focus on prevention. These barriers are frequently cited in other Marmot places.

However, numerous opportunities for improvement were also identified among Medway stakeholders. The Marmot programme was viewed as an opportunity to prioritise joined up working between services and sectors, build networks among different organisations and shift the culture towards long-term

planning and prevention from the earliest stages in life. Excitement was built around reimagining a Medway 'healthy high street', the potential to co-locate services in existing safe places including schools and VCFSE venues, and reinstating Medway's celebration of equality, diversity and inclusion principles, in particular amongst young people through social media.

In terms of next steps, stakeholders saw value in one-stop-shop style care that holistically supports the community in neutral spaces. These encompass collaborative working across statutory and VCFSE sectors to support residents with wellbeing, social care or healthcare needs and could be developed in an empty shop on the high street or co-located with another service, such as a school. The potential for collaborative, multi-sector and family-based approaches was also highlighted as a means of providing wraparound support through a community. Other priorities identified were the need to strengthen pathways from education into careers, the desire for true codesign, coproduction and codelivery with residents, and the need to prioritise and value creativity throughout all initiatives.

Lastly, there was importance placed on a unified service directory to support Medway residents, with the Joy platform - while collates social prescribing services (see section The Joy database in Medway) - recognised as something that should continue to build momentum in terms of awareness and use.

Overall, these ambitions require gradual and long-term change with a focus on equity and value-based leadership and consistency. These system changes can be enabled by the Marmot approach.

CHAPTER 2. LOCAL DATA SUMMARY

This chapter provides a brief overview of the demographics of Medway and health and health equity among Medway residents. It begins to illustrate the health impacts of various dimensions of deprivation in Medway and how this compares to the national picture. This data analysis informs the recommendations which follow in

2A DEMOGRAPHICS IN MEDWAY

The size, age and ethnicity of the population provide important context to understanding and tackling inequalities in health and the social determinants of health. Changes in the size, age and ethnic composition of residents can mean services and support may be inappropriate for the changing populations.

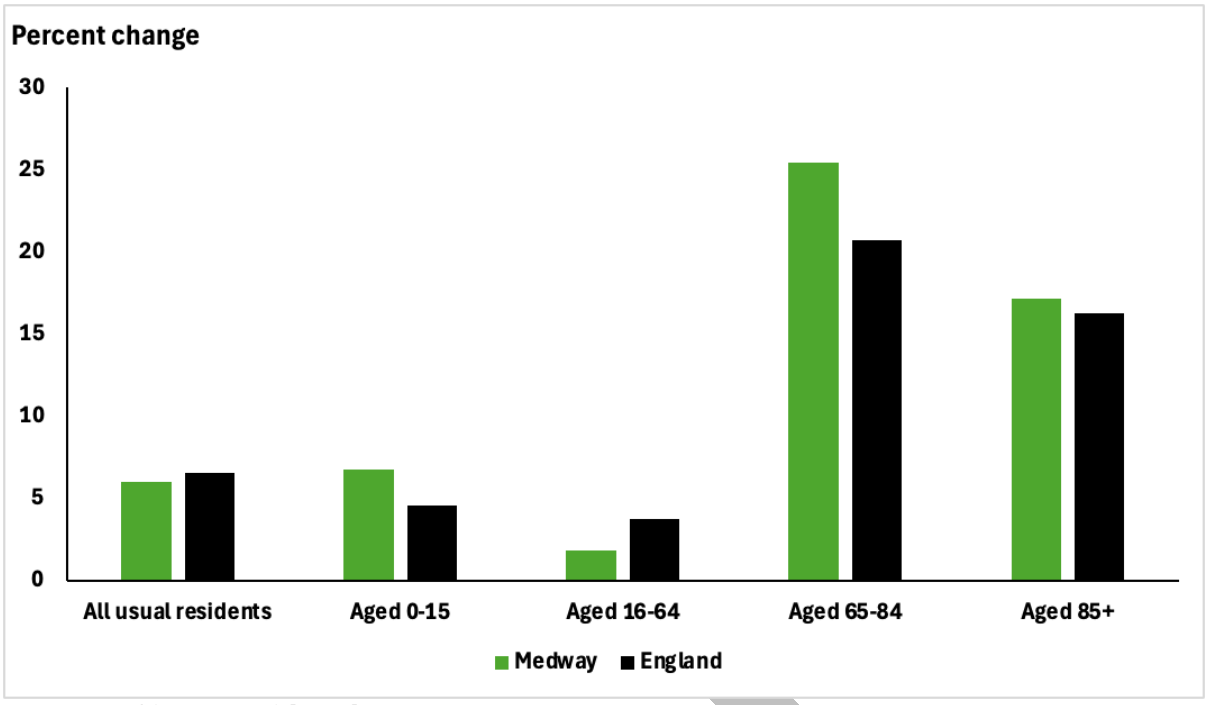
For example, areas with an increasing proportion of older residents require higher levels of health and social care provision and additional support. However, there are fewer people of working age in Medway to deliver these essential services, and the costs can be high [14]. In England more broadly, evidence suggests that ethnic minority groups are particularly isolated or experience discrimination in areas which are ethnically homogenous and appropriate services and support may not as readily available as they are in areas with larger ethnic minority populations [15]. Further evidence is required to unpick whether this trend is present in Medway.

POPULATION SIZE AND AGE STRUCTURE

The population of Medway was 279,773 in 2021, and had increased by 6 percent between 2011 and 2021, 0.6 percent less than that the increase across England. The median age of Medway increased by one year between 2011 and 2021, from 37 to 38 (two years below that of the England average at both time points). As shown in Figure 6, all but one age group in Medway experienced a greater percentage increase than the England average. This contrasted with the 16 – 64 "working" age group where the population increased by 1.8 percent in Medway compared with 3.7 percent across England. Meanwhile, the cohorts that have seen substantial increases in size are those which often require more resource and support. The under 16 population has increased by 6.7 percent (compared to 4.6 percent in England), the 65 to 85 population has increased by 25.4 percent (compared to 20.7 percent in England) and the over 85 population has increased by 17.2 percent (compared to 16.3 percent in England).

Medway is not solely ageing but is simultaneously seeing growth among the 0-15 aged population. Services and programmes to support whole families, build joint ambitions and shared outcomes among multiple age groups will be important to sustain, support and best utilise local resources.

Figure 6. Percent change in population by age group, Medway, and England, 2011 to 2021

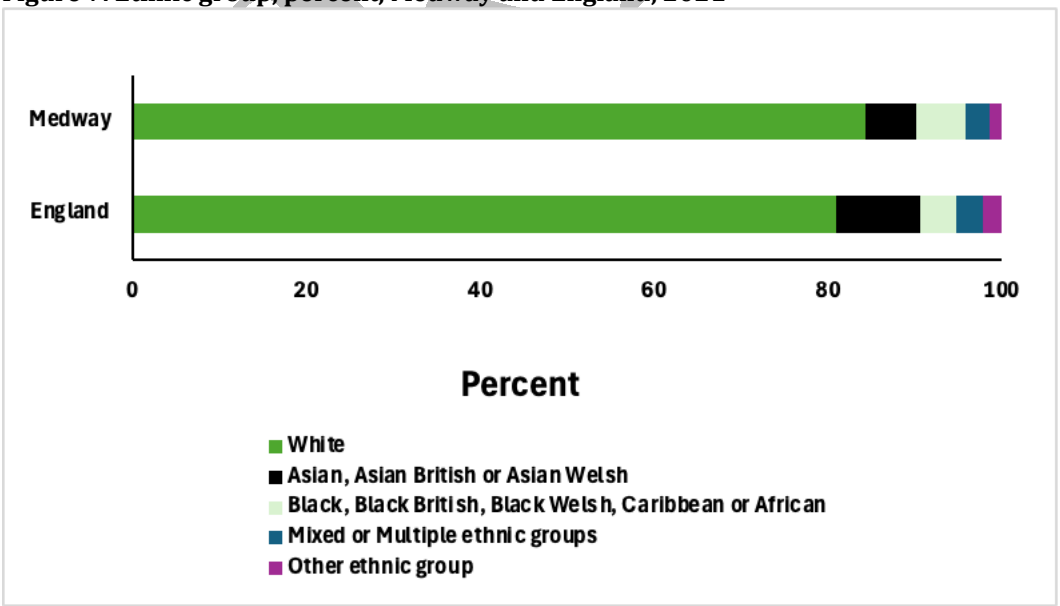


Source: Census' (2011 & 2021) [16, 17]

ETHNICITY

The population of Medway is 84.3 percent 'White', slightly higher than the England average of 81 percent. Of those who are not 'White', the next largest groups are 'Asian, Asian British or Asian Welsh' at 5.9 percent closely followed by Black, Black British, Black Welsh, Caribbean or African at 5.6 percent.

Figure 7. Ethnic group, percent, Medway and England, 2021

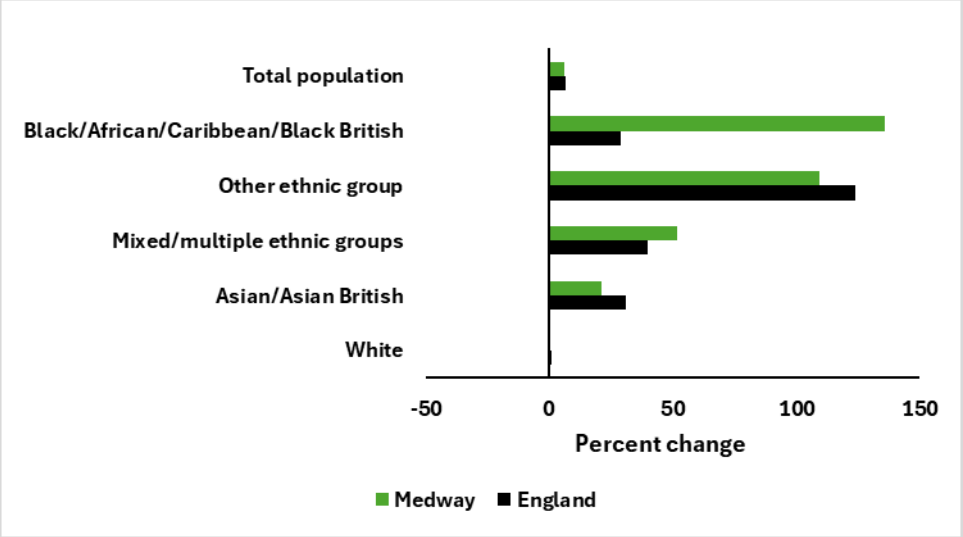


Source: Census (2021) [16]

While Medway is diversifying at a slower rate than England as a whole, the population of Medway is more ethnically diverse than it was in 2011. The most significant change is amongst the 'Black/African/Caribbean/Black British' group, which increased by 136 percent across the 2011 to 2021

decade. This equates to a jump from 6,663 residents in 2011 to 15,723 residents in 2021, a more than two-fold increase. Meanwhile, all other non-White ethnic groups have also seen a percentage change increase, though these are closer aligned with the England-wide shifts.

Figure 8. Percent change of population by ethnic group, Medway and England, 2011 to 2021



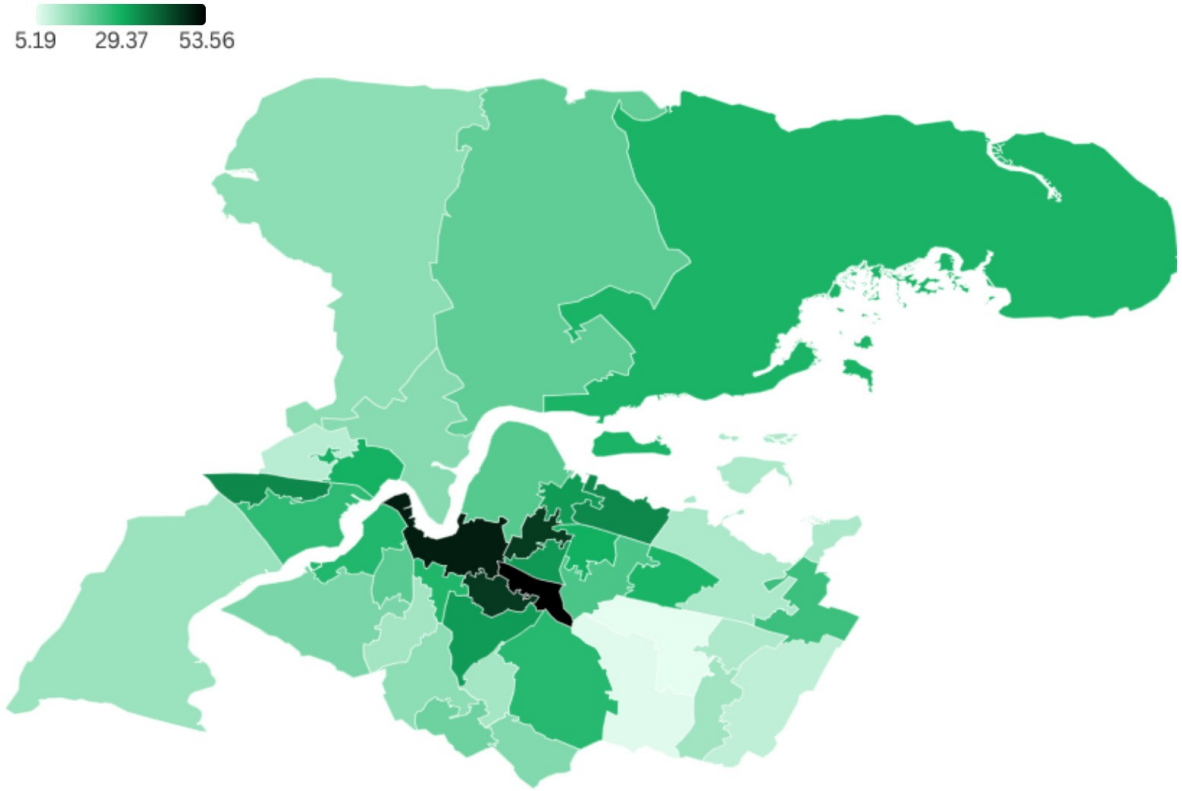
Source: Census (2021) [16]

The reason behind these changes needs to be further explored. There is evidence, though, that 'Black/African/Caribbean/Black British' groups experience lower income and worse housing conditions in London (associated with both deprivation and racial discrimination) [18] and that there has been movement among these ethnic groups from London to neighbouring areas, such as Medway. In the context of health inequalities, it is important to recognise the implications for the suitability of interventions and ensuring culturally appropriate services and efforts to tackle racism and discrimination.

Deprivation

On average, Medway is more deprived than England as a whole, indicated by the index of multiple deprivation (IMD) 2025 scores. England's average score is 20.08 whilst Medway's shows greater levels of deprivation at 24.35. Figure 9 shows the IMD scores of all Middle Layer Super Output Areas (MSOA) areas in Medway which cover between 2,000 and 6,000 households and usually have a resident population between 5,000 and 15,000 persons. [19]. In this report where we discuss MSOA data we have referred to it as "local areas".

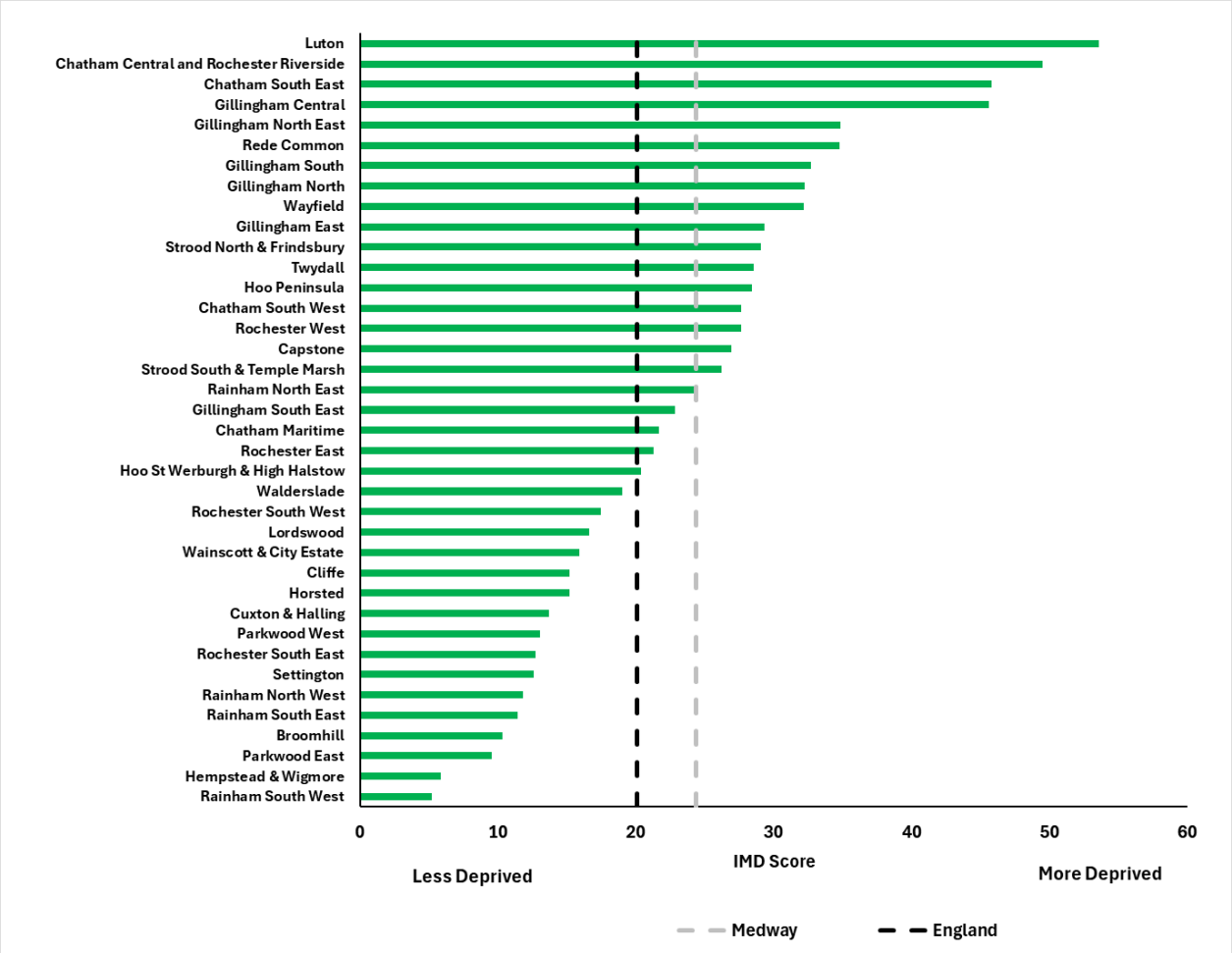
Figure 9. IMD scores, Medway MSOAs, 2025



Source: Ministry of Housing, Communities & Local Government (2025) [20]

The map illustrates the close proximity of more and less deprived areas within Medway. Geographically, there are some areas of Medway where deprivation is driven by remoteness, including the Isle of Grain (the east most part of the Hoo Peninsula) likely driven by low interconnectivity and travel options and low levels of opportunity for education and education. This means deprivation is more likely deprivation of opportunity.

Figure 10. IMD Score, Medway MSOA's, Medway and England, 2025



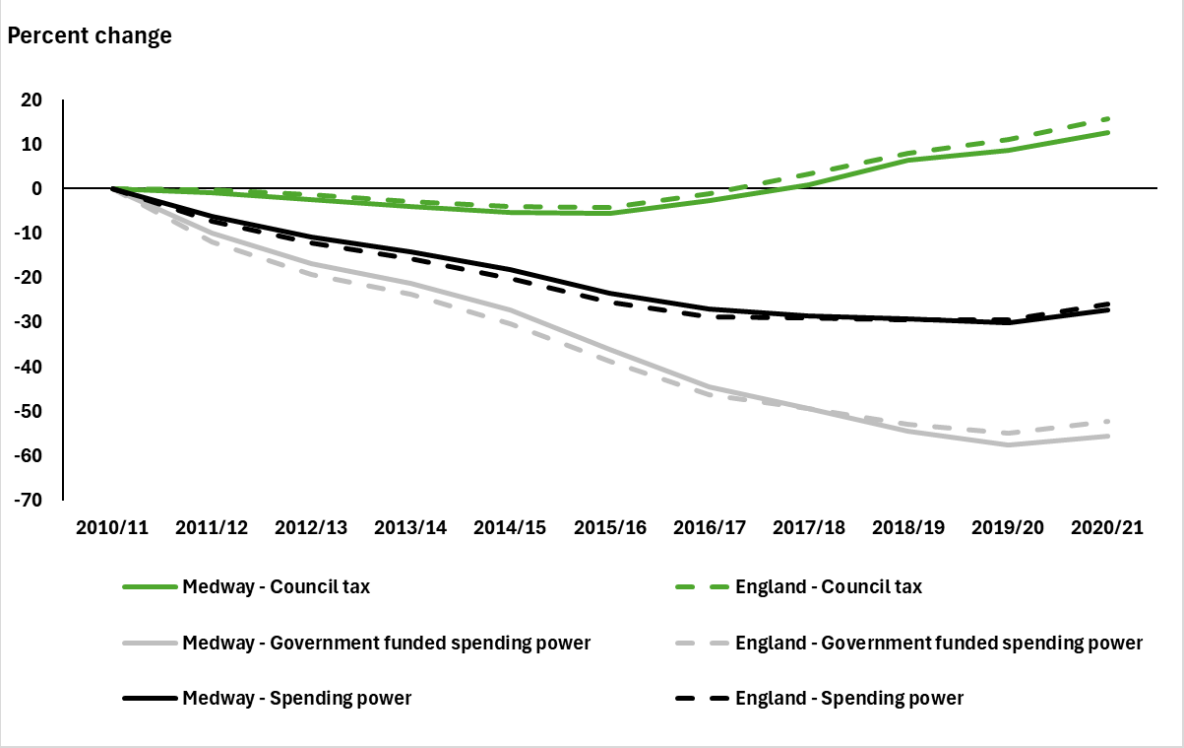
Source: Ministry of Housing, Communities & Local Government (2025) [20]

There are significant differences in levels of deprivation within Medway. Luton is the most deprived area in Medway with an IMD score of 53.56 and the least deprived area in Medway is Rainham South West with an IMD score of 5.19. Chatham Central and Rochester Riverside, Chatham South East and Gillingham Central all also have an IMD score above 45, considerably higher than the England and Medway average. Meanwhile, Hempstead and Wigmore and Parkwood East both have an IMD score below 10. While there are clearly areas with higher levels of deprivation, it should be noted that some residents experience deprivation in every area. As such, even the least deprived areas need support.

CHANGES IN LOCAL GOVERNMENT FUNDING

The rapidly changing financial situation across Medway is important context to understand and mitigate existing inequalities. There have been reductions in per-head spending on public services across England since 2010 and related rapidly increasing need and widening inequalities. One important tranche of funding to local areas is through national Government funding to the Council. Medway has experienced marginally greater reductions in government funded spending power than the average for England. Between 2010/11 and 2020/21 funding from Central Government to Medway decreased by 55.5 percent. These reductions have been partially offset by increases in Council Tax which has increased by 15.6 percent in the same period. Although this will reduce spending power among affected residents which in turn has knock on effects for the local economy. Taking increased income from Council Tax into account, Medway's overall spending power reduced by 27.2 percent between 2010/11 and 2020/21.

Figure 11. Spending power and its components indexed to 2010/11, Medway and England, 2010/11 to 2020/21



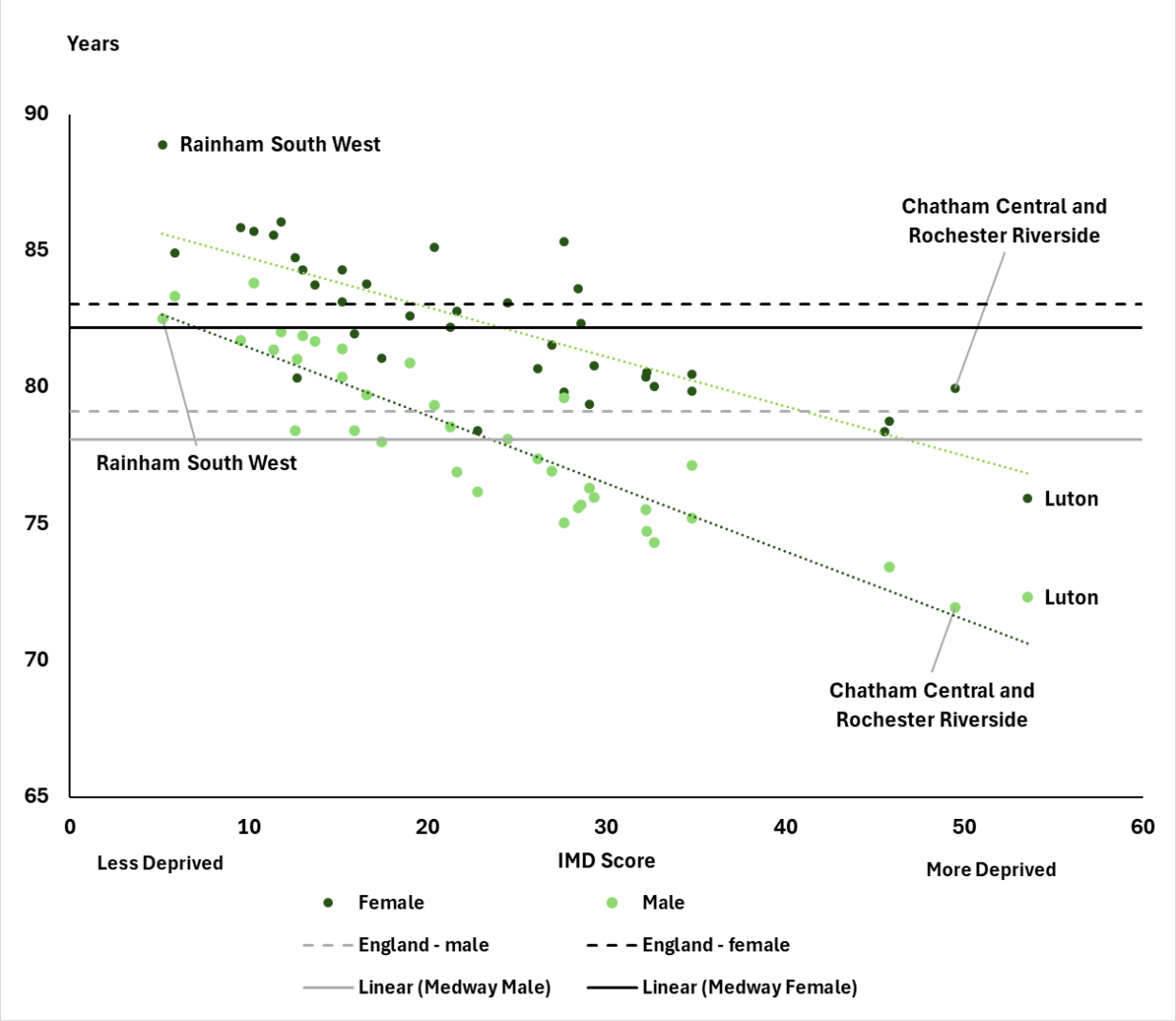
Source: National Audit Office (2021) [21]

2B LIFE EXPECTANCY

As is the case across England, life expectancy in Medway has stagnated over the past decade. The trend shown in Figure 1 (1A Health inequalities: The national picture) for life expectancy in England is similar to trends in Medway, although, the life expectancy for both males and females in Medway is consistently slightly higher than the England average by approximately one year. Therefore, by 2021-23 the life expectancy for females in Medway was 82.08 years and for males was 78.04 years having shown a relative stagnation since 2012. There is a gender gap of 4 years between women and men in Medway, like that seen at an England level.

There are stark inequalities in life expectancy in Medway associated with the level of deprivation in the local area. The difference in life expectancy for residents of Luton, the most deprived area in Medway, compared to those from Rainham South West, the least deprived area in Medway, is 10.21 years for men and 12.99 years for women. The gap between male and female average life expectancy widens (light and dark green dotted lines, respectively) as the IMD score increases. This shows that, across Medway, greater deprivation is associated with greater differences in life expectancy by gender (Figure 12).

Figure 12. Estimated female and male life expectancy at birth by deprivation (IMD 2025), Medway MSOA's, 2019-23

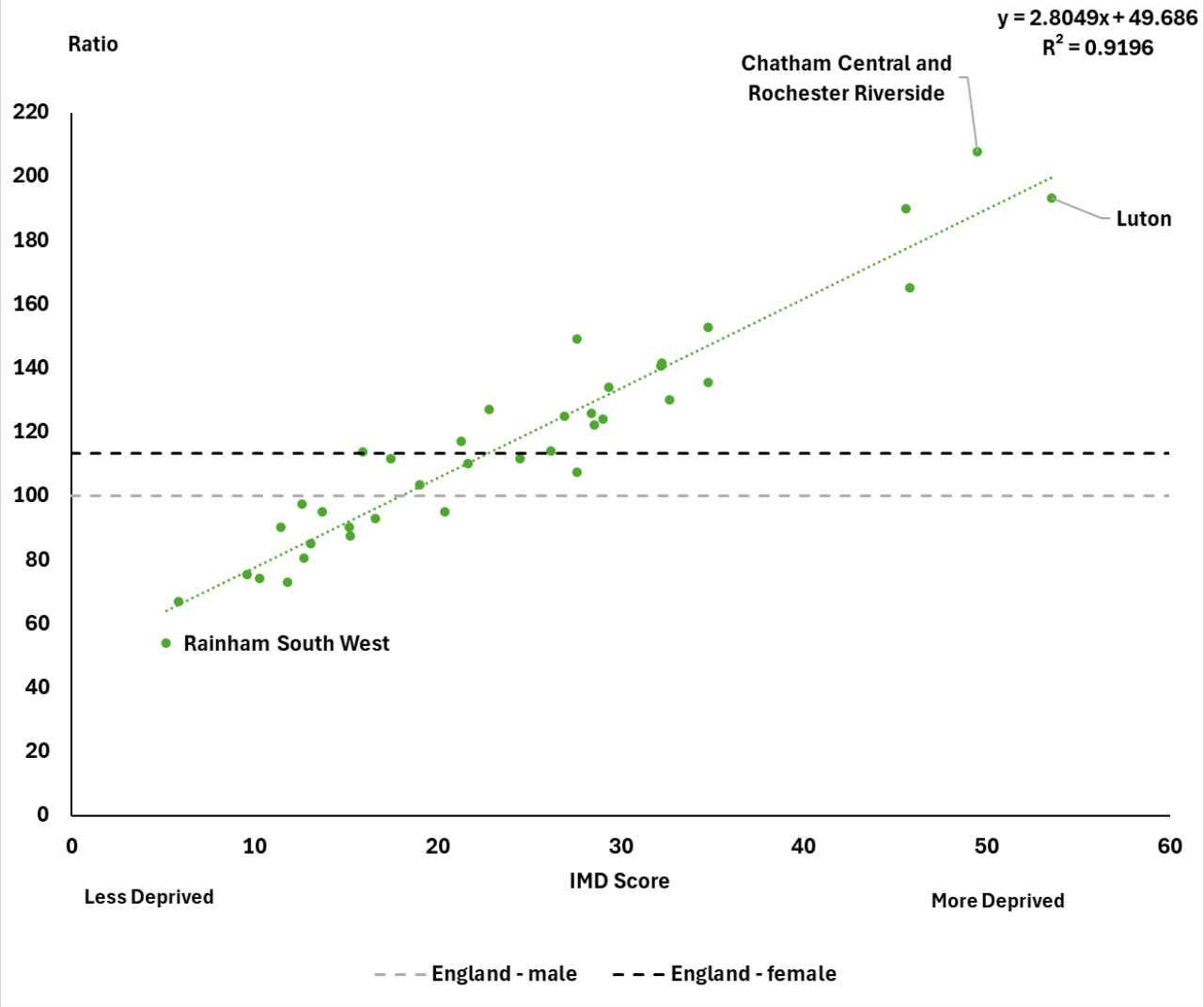


Source: ONS (2024) [1]

Gradients in life expectancy and health are clearly evident in Medway (Figure 13) as across England; this means that action is needed to flatten this gradient, so that everyone can enjoy the good health experienced by those living in the least deprived areas. The way to do this is to ensure that services, support and resource allocations are offered in a way which is proportionate to the scale of the problem but universally available to reach the whole gradient – proportionate universalism.

All-cause premature mortality (death rates for under 75s) outlines deaths which are often considered preventable. Figure 13 shows that in Medway's most deprived areas, the premature mortality rates are nearly double the England average. This also shows significant health inequalities within Medway, where deprivation is strongly associated with a notably higher risk of dying prematurely from preventable diseases.

Figure 13. All-cause mortality ratio under 75, by deprivation (IMD score 2025), Medway MSOA's, 2019-23



Source: OHID (2025) [22]

2C The social determinants of health

As reflected by the Marmot principles, inequalities in the social determinants drive health inequalities across the life course. This section takes a preliminary look at data relevant to different social determinants of health in Medway. This overview helps to establish a base for future monitoring of health inequalities and inequalities in the social determinants of health and assists with prioritising potential focus for intervention in Medway.

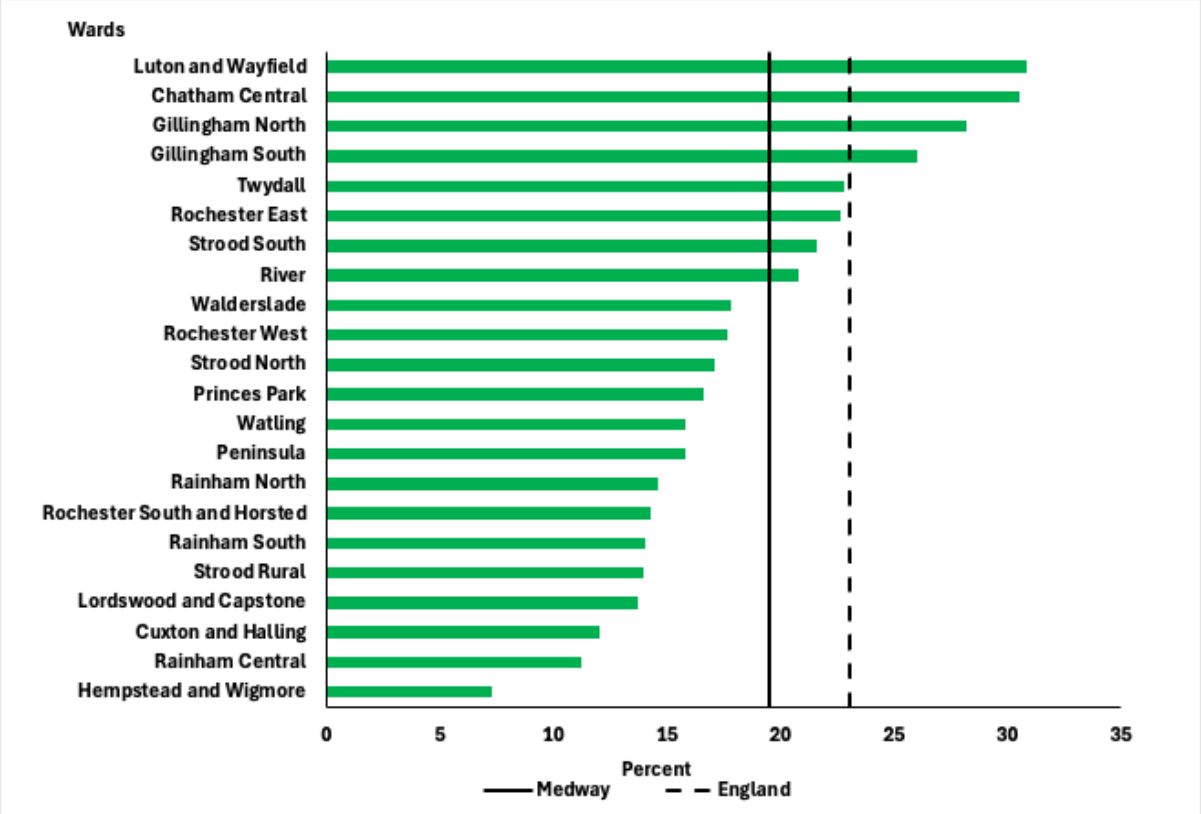
Whilst these data do not reflect the full picture in Medway, they highlight areas for further exploration and start to inform

Chapter 6. Recommendations. The data points have been chosen due to interest in what they reflect. Therefore, they disproportionately show themes where Medway is below average nationally as opposed to a complete, more balanced picture. Consequently, drivers where Medway are performing better than the England average, such as lower rates of economic inactivity and fuel poverty, are omitted but are available in an accompanying Medway Marmot data pack.

CHILDREN AND YOUNG PEOPLE

Programmes to prevent and reduce child poverty must be proportionate to the scale of the issue but also sensitively targeted so that poorer families in wealthier areas also have access. In Hempstead and Wigmore, only seven percent of children are living in poverty however, they still must be offered appropriate support. Moreover, children living in poverty and deprivation in wealthier areas often have worse educational and other outcomes than those living in poverty in more deprived areas. There are several explanations for this including stigma and discrimination and appropriate services and support not being so widely available. Meanwhile, areas such as Luton and Wayfield, Chatham Central, Gillingham North and South all have a greater proportion of children in relative low-income families compared to the England average (between 26 and 31 percent) and require appropriate levels of support aligned with the greater need.

Figure 14. Children in relative low-income families, percent, Medway wards, Medway, and England, 2024

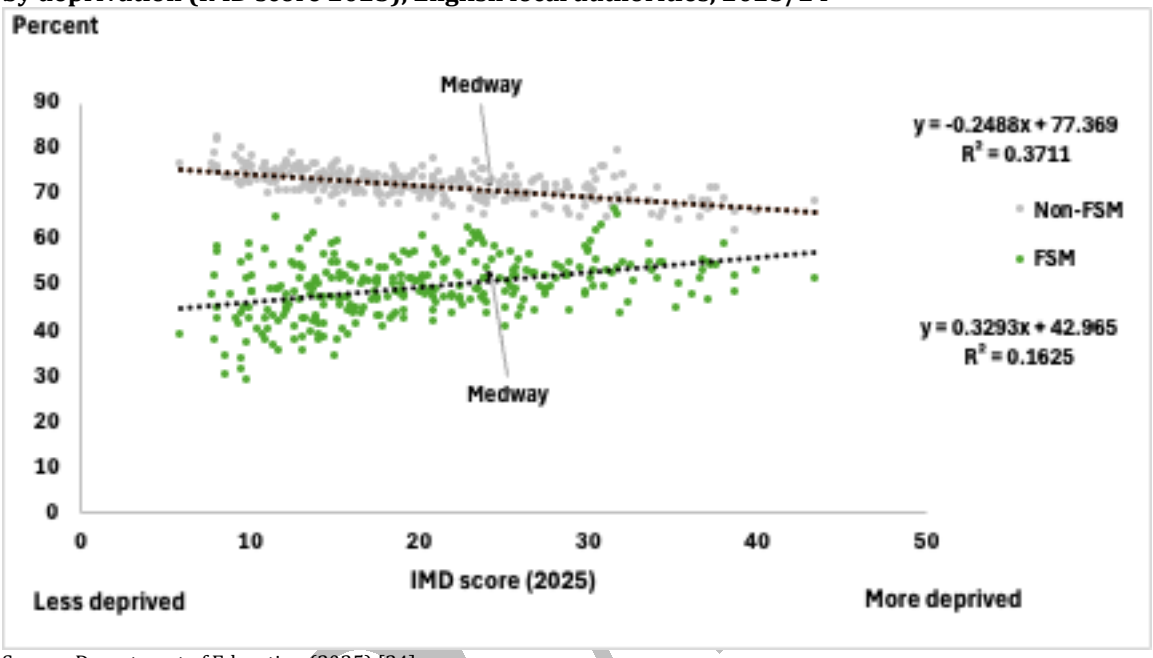


Source: UK Government Department for Work and Pensions (2025) [23]

Across England, there are wide gaps in levels of development between those eligible for free school meals (FSM) and those not with children eligible for free school meals much less likely to reach a good level of development by the end of reception. Figure 15 sets out the size of the gap in each local authority or district council area in England. Children eligible for FSM are more likely to achieve a good level of development in more deprived areas than in less deprived areas of England. Plausible explanations may include he feelings of shame and stigma experienced amongst those growing up in poverty in more less deprived areas and a lack of appropriate services and support for poorer families in wealthier areas. In Medway, 52.1 percent of children who are eligible for FSM achieved a good level of development at the

end of reception in 2023/24, 20.1 percentage points lower than pupils not eligible for FSM. The gap between levels of development related to FSM is slightly lower than the England average where the difference is 20.5 percentage points between those eligible for FSM (51.5 percent) and those ineligible (72 percent).

Figure 15. Pupils achieving a good level of development at the end of reception, by FSM eligibility, by deprivation (IMD score 2025), English local authorities, 2023/24

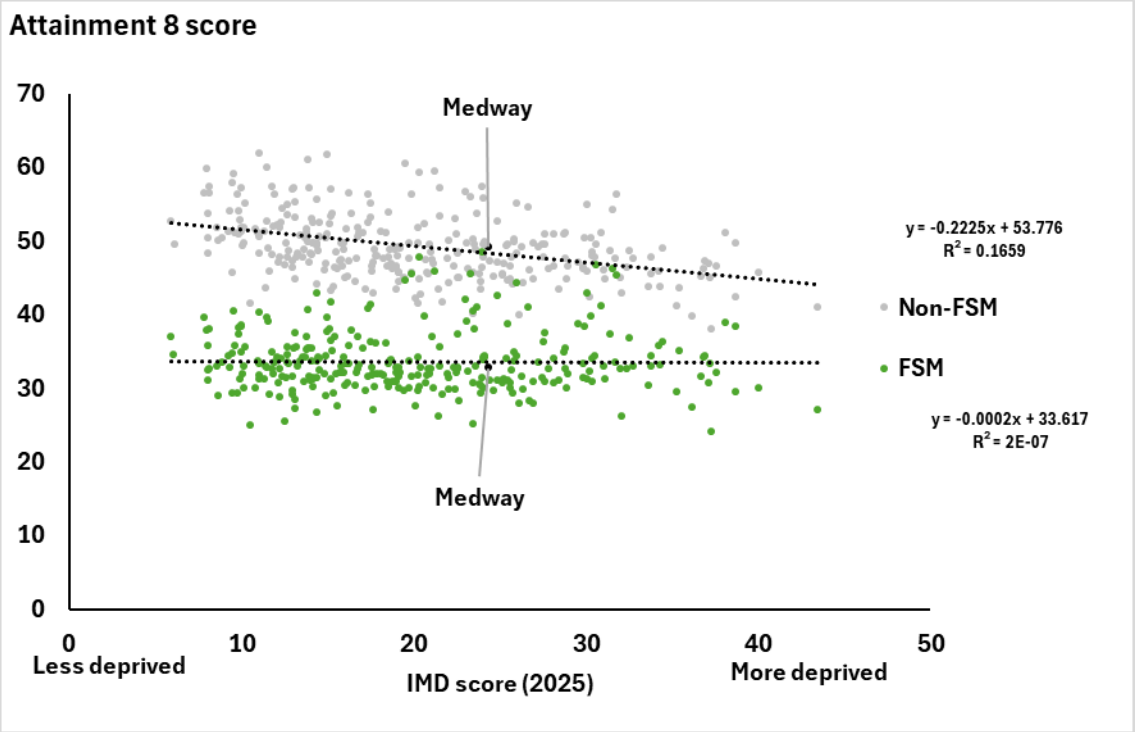


Source: Department of Education (2025) [24]

SECONDARY SCHOOL AGE POPULATION

Across England, there are notable differences between and within local areas in levels of educational attainment related to household income, similar to levels of early years development in the previous figure. In less deprived councils or districts, the inequality between pupils eligible for FSM and those not eligible is much wider than it is in more deprived areas and some of the wealthiest areas in England have the widest differences in educational attainment, even though overall rates of attainment may be higher on average. Figure 16 shows Attainment 8 scores at age 16 for pupils eligible for free school meals and those who are ineligible in every Unitary and District in England including Medway. Less deprived places have higher levels of attainment for those ineligible for FSM but not among those pupils who are eligible for FSM than in less deprived areas – hence wider gaps.

Figure 16. Attainment 8 score, FSM and Non-FSM pupils, by deprivation (IMD score 2025), English local authorities, 2023/24

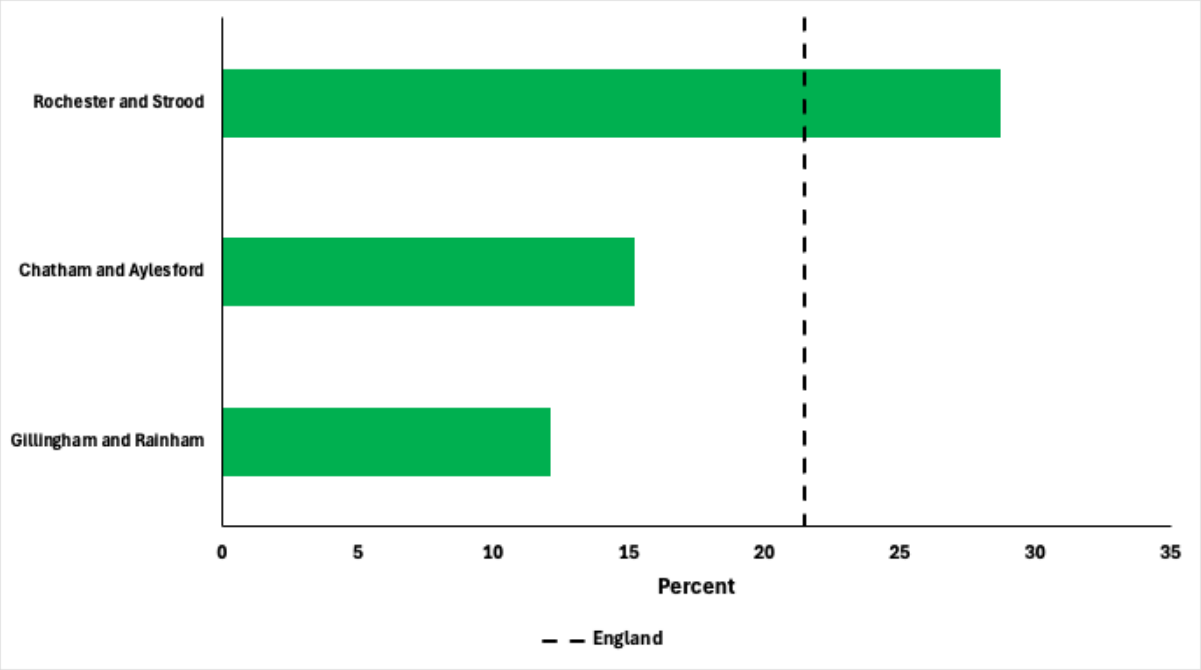


Source: Department of Education (2025) [25]

Reasons for these differences in the size of the attainment gaps may relate to how well set up schools are for children experiencing deprivation: schools with more children from more deprived households may be well attuned with how to support those children to have higher attainment. Schools also receive higher levels of funding for pupils who are eligible for FSM and for children with special educational needs (SEN) diagnoses which gives them more capacity to support pupils. In large urban areas, with high levels of ethnic diversity, pupils from ethnic minority groups tend to have relatively high levels of attainment, including those pupils from low-income households. As mentioned, there may be a sense of shame and stigma attached to being eligible for FSM. This can lead to bullying and disengagement from school and schoolwork. The sense of shame and stigma also means that some households do not access support or benefits, including FSM eligibility, to which they are entitled.

Additionally, Figure 17 shows a clear difference across Medway constituencies in the proportion of FSM pupils achieving a pass in English and Maths GCSE, although figures are low across Medway and across England. Gillingham and Rainham and Chatham and Aylesford are both well below the national average, with Rochester and Strood as the only constituency above the national average.

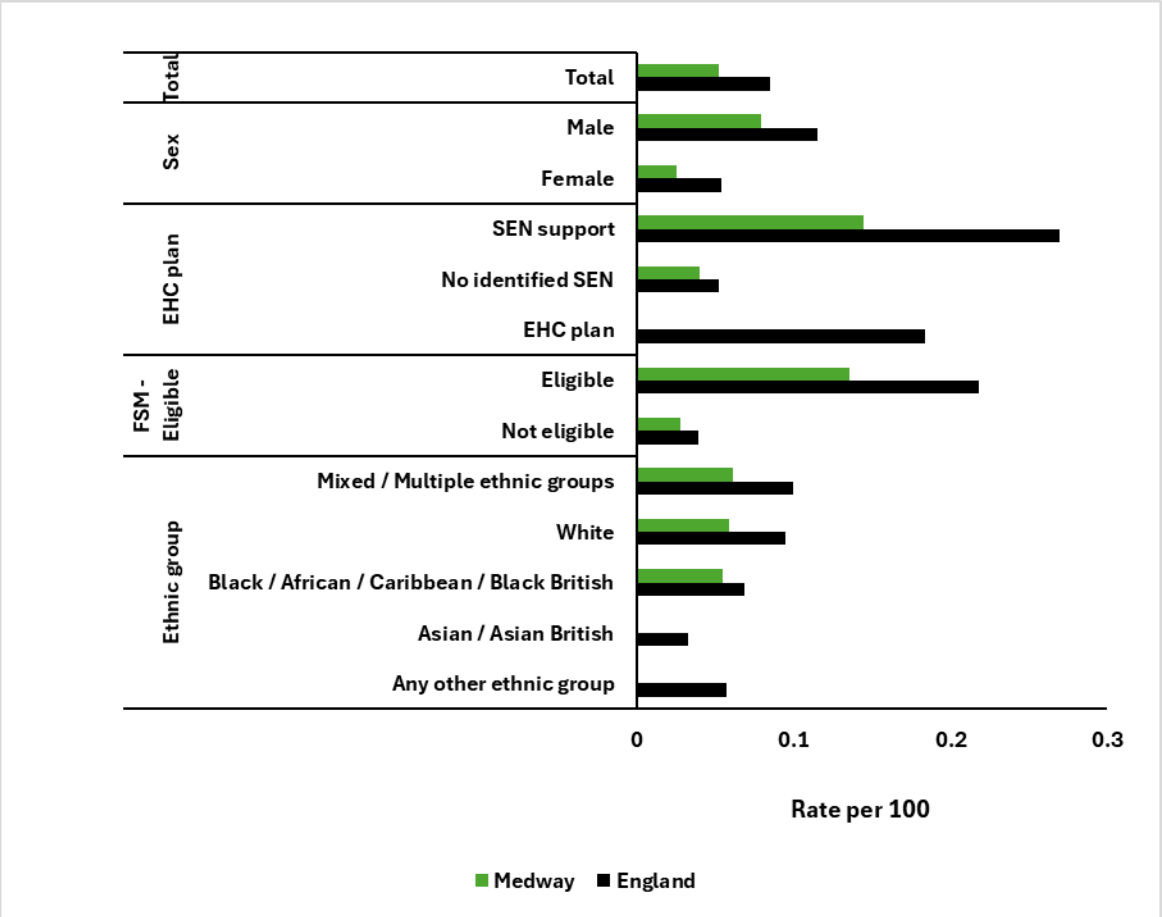
Figure 17. FSM Pupils achieving a pass in English and Maths, Percent, Constituencies within Medway, 2025



Source: Sutton Trust (2025) [26]

School exclusions and absentees impact pupil attainment and are associated with a range of negative outcomes throughout life, including fewer opportunities, worse job prospects and worse mental and physical wellbeing [27-29]. In many areas, rates of exclusion and absenteeism have risen since the pandemic, with clear inequalities emerging related to eligibility for FSM. Permanent exclusions, as per Figure 18, are higher amongst FSM eligible pupils than non-eligible pupils in Medway. In Medway, this difference is 0.11 percent which is smaller than the difference seen across England (0.18). Whilst the rates themselves in Medway are lower than the England averages, in the context of the South East they are slightly higher (0.14 percent compared with 0.12 percent for FSM eligible pupils and 0.03 percent compared to 0.02 percent for non-FSM eligible pupils). However, it is of note that for every category with data, Medway have a lesser difference in permanent exclusion rates than the England average. However, whilst less exacerbated than England, there is still a clear weight towards those with SEN support and those eligible for FSM being permanently excluded.

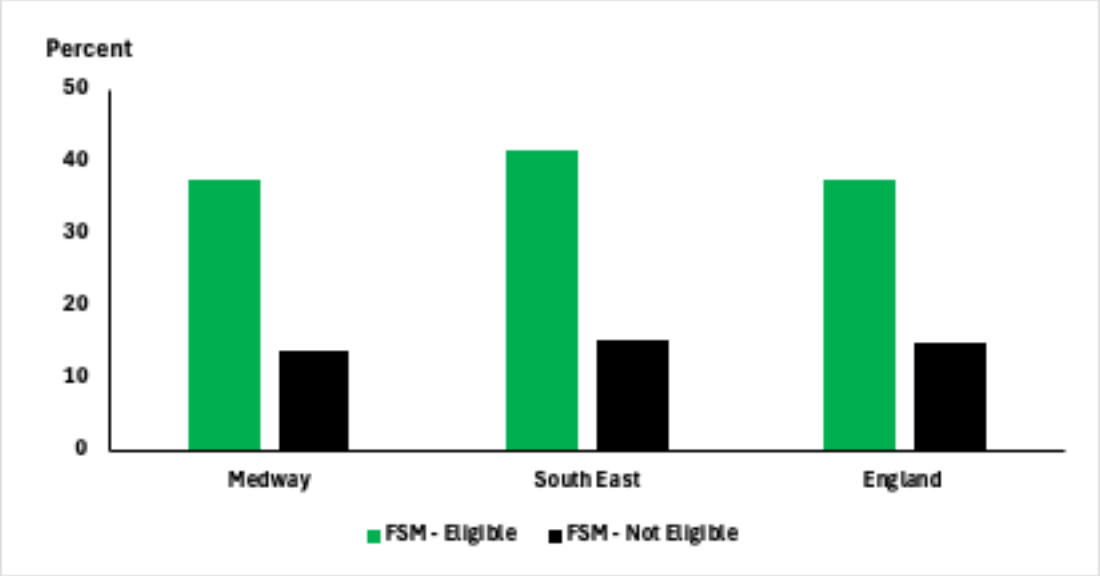
Figure 18. Permanent exclusions, by characteristic, state funded secondary schools, Medway and England, 2024/25 Autumn Term



Source: Department of Education (2025) [28]

Persistent absence is when a pupil enrolment's overall absence equates to missing 10 percent or more of possible sessions. This is particularly harmful for educational attainment, employment and income prospects and health in the immediate and longer terms. There are many programmes set up by schools to try and reduce persistent absence, but there have been increases since the pandemic and there are clear inequalities related to household income. Medway show a similar picture to that seen across England in levels of persistent absenteeism with a difference of 23.83 percentage points between FSM eligible and non-eligible pupils compared to a South East difference of 26.36 percentage points and an England difference of 22.38 percentage points. This again highlights the inequalities between FSM eligible and non-eligible pupils in Medway and the particularly disadvantageous position of lower income pupils.

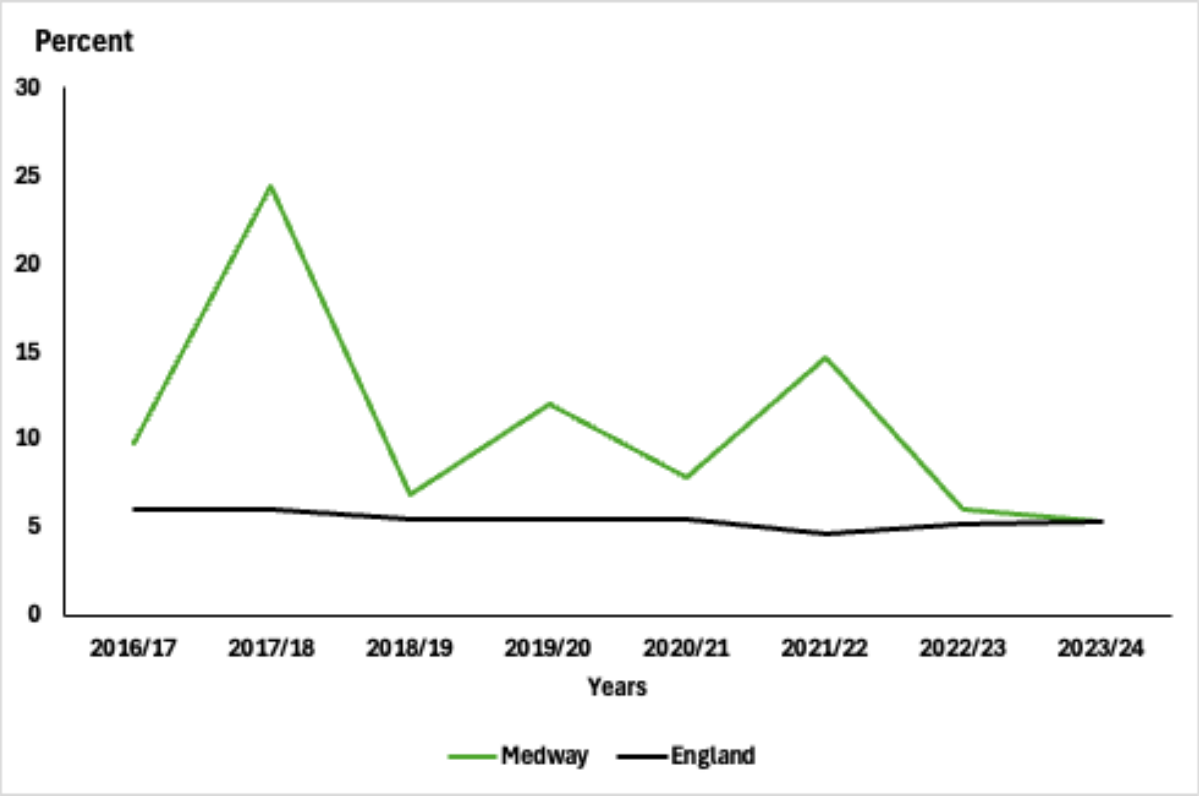
Figure 19. Pupils that are persistent absentees, percent, authorised or unauthorised, secondary schools, by FSM eligibility, Medway, South East, and England, 2024/25 Autumn and Spring term



Source: Department of Education (2025) [30]

NEET is an important indicator of future health outcomes, as well as often being a symptom of deprivation and inequalities in the early years. 5.4 per cent of 16–17-year-olds in Medway were known to be NEET which is the same as the England average. However, over time, as seen in Figure 20, Medway has been above the England average by varying degrees since 2016/17. It is helpful to contextualise Medway using the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Statistical Neighbours model. This model selects a place's 'nearest neighbours' by those who rank similar on a range of measures, such as demography and economy. Using this model, Medway is middling in terms of NEET (eighth of 16 areas). However, this data should be treated with caution due to the low level of confidence in reliability of the data.

Figure 20. Percent of 16–17-year-olds Not in Education Employment of Training (NEET), Medway, and England, 2016/17 to 2023/24

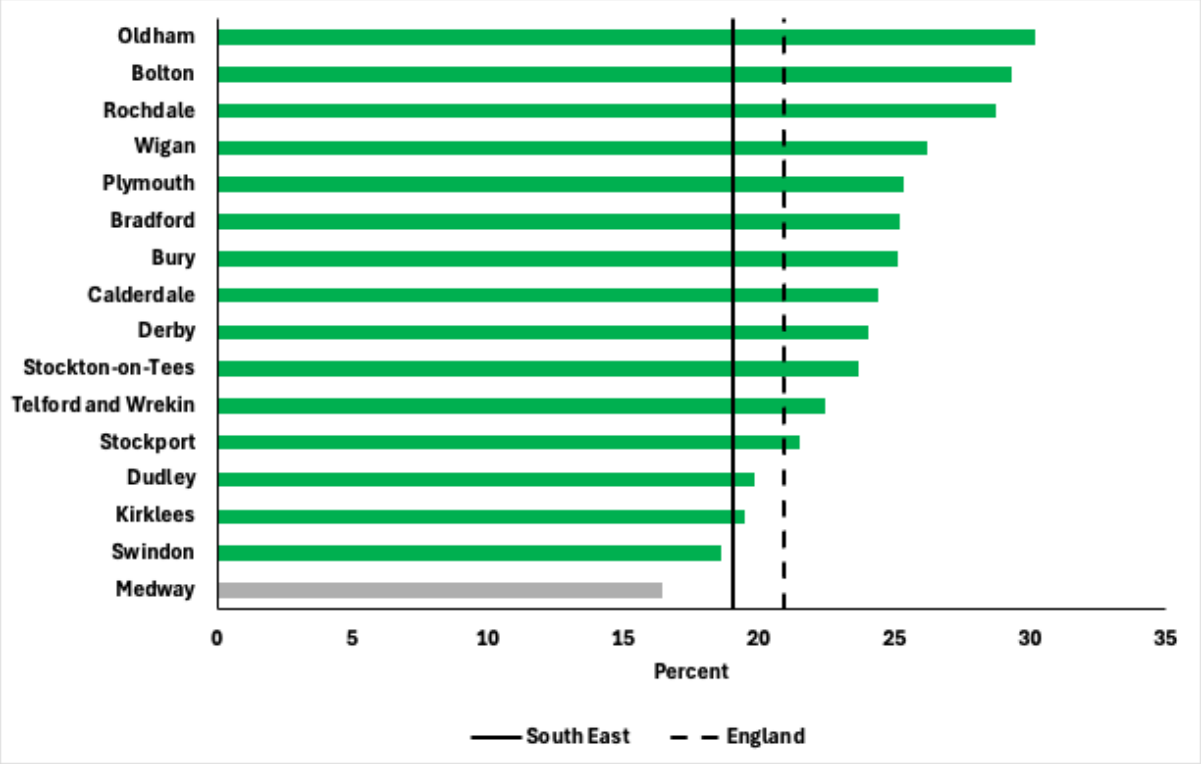


Source: UK Government (2025) [31]

WORKING AGE POPULATION

Being in good employment is protective of health and so ensuring as much of the population as possible are in good quality employment is essential for reducing inequalities. Using the CIPFA model, Medway has the lowest levels of economic inactivity for its 16–64-year-old population at 16.4 percent. This is 4.5 percent lower than the England average and 2.6 percent lower than the South East average, as seen in Figure 21.

Figure 21. Economic inactivity, 16-64, Medway and CIPFA Nearest Statistical Neighbours, South East, and England, Jul 2024-Jun 2025

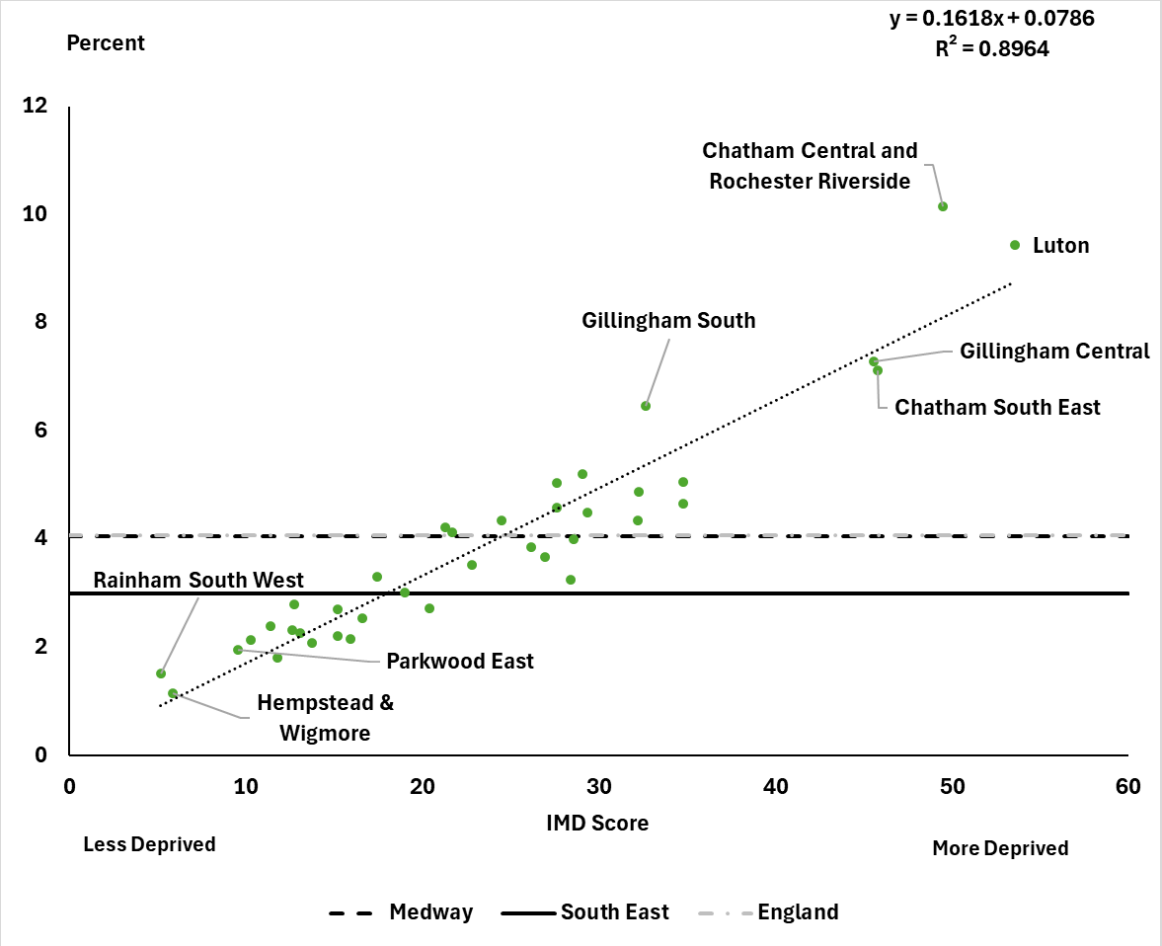


Source: NOMIS (2025) [32]

Considering those claiming out of work benefit highlights the cyclical relationship between deprivation and employment. Figure 22 shows that Medway, and England have the same average proportion of the working age population claiming out of work benefits (4.1 percent in 2024/25). However, Medway has a higher proportion of people out of work compared with the South East region as a whole (by 1.1 percent).

Unsurprisingly, it is the most deprived areas of Luton and Chatham Central and Rochester Riverside that have the highest levels of out of work benefit claimants (9.4 percent and 10.2 percent respectively) and in these areas one in 10 working age adults are claiming out of work benefits. Meanwhile, the least deprived areas such as Rainham South West and Hempstead and Wigmore have much lower proportions at only (1.5 and 1.1 percent respectively). This difference of 9.1 percent indicates that, to reduce inequities, support should be sensitive to geographic and household differences in Medway.

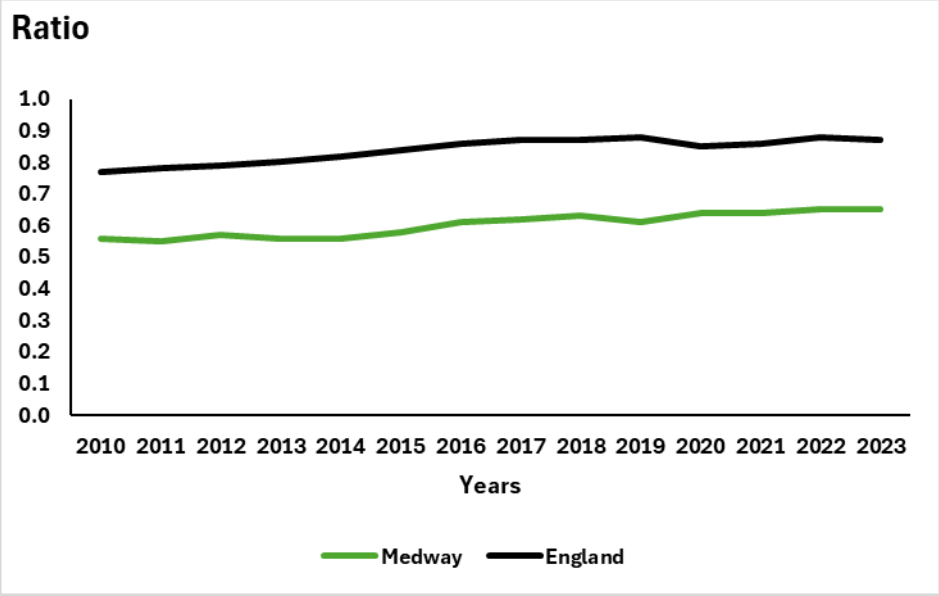
Figure 22. Working age (16-64) population claiming out of work benefit, by deprivation (IMD Score 2025), percent, Medway MSOA's, Medway, and England, 2024/25



Source: Office for National Statistics (2025) [32]

Consideration of the number of jobs available per resident (or job density) also raises interesting questions for Medway. Between 2010 and 2023, the jobs available per working-age resident in Medway has ranged between 0.55 and 0.66, whilst nationally, this has ranged between 0.77 and 0.88. This is in the context that Medway has had a bigger increase than England in the population older than working age. As seen in Figure 23, the trend in Medway has remained broadly in line but at a lower level than for England. Of note is that the working age population in Medway has not increased at the same rate as that across England, as shown in Figure 6.

Figure 23. Jobs per resident, aged 16-64, ratio, Medway and England, 2010-23



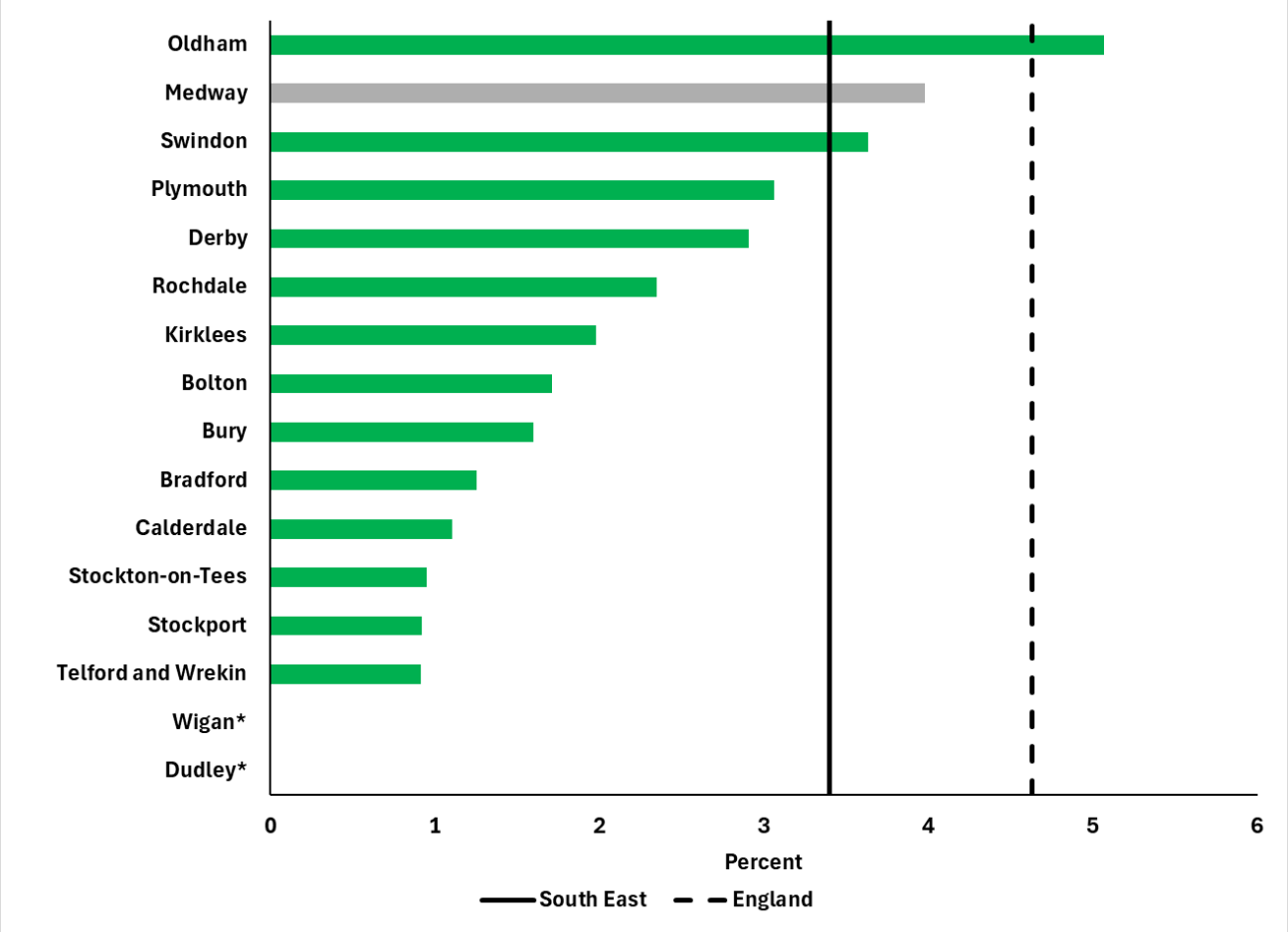
Source: NOMIS (2024) [32]

Whilst at first glance it may appear that Medway have a job deficit, it is relevant to note that Medway is a commuter area to the City of London and other areas of Kent. From the data, it is not clear how much of the Medway population work outside of Medway, and therefore how this interacts with the Medway job density. Given the power of employment as a social determinant of health, it will be essential to understand further how Medway residents access job opportunities and travel to work where appropriate. For example, travel may need to be subsidised if local jobs are not available.

HOUSING AND ACCOMMODATION

Nationally, there has been increasing demand for social housing accommodation in recent years [33] due to a lack of affordable and appropriate housing. As a result, local authorities have faced huge financial pressure. Temporary accommodation is intended as short-term housing for vulnerable households experiencing homelessness. However, families are often housed in such accommodation for extended periods of time. These homes are often unsuitable for families placed in them, with hazards such as damp, mould, cold, and pests, sometimes present in the property. Accommodation is also often too small for families, leading to overcrowding. These conditions undermine physical and mental health in the short and long term and inhibit children's cognitive and physical development [34]. Figure 24 shows that Medway places second worst among its statistical neighbours for households in temporary accommodation at a rate of 3.98 households per thousand and higher than the regional, but not national average.

Figure 24. Households in temporary accommodation, rate per 1,000, Medway and CIPFA Nearest Statistical Neighbours, South East, and England, 2023/24



Source: Ministry of Housing, Communities, and Local Government (2025) [35]
*Data not available

When exploring heat insulation, Medway ranks lowest compared with its statistical neighbours for Energy Performance Certificate (EPC) ratings. The percentage of dwellings with a rating of EPC C or above, stands in Medway at 52 percent, compared with 53.3 percent nationally and 55.6 regionally. This suggests that housing insulation in Medway is worse and there is space for improvement.

Similarly, in terms of fuel poverty, Medway places as the fourth lowest estimated percentage for fuel poverty against its CIPFA neighbours at 11.1 percent. Whilst it places it slightly below the England average (11.4 percent), it is higher than the South East average of 9.7 percent.

CHAPTER 3. RESIDENT ENGAGEMENT

A key activity for the resident engagement group was a scoping exercise to gather existing information on how residents of Medway are experiencing health inequalities. This was led by the local engagement group, EK360, to map existing resident feedback, identify gaps and where to focus future engagement as well, as to support prioritisation of issues.

Community groups, organisations, and key system partners were asked to submit insights that detailed people's views on health inequalities from the previous five years. These insights were thematically analysed and categorised against each of the 8 Marmot principles. For inclusion, submissions had to relate to at least one of these principles, be specific to Medway, and include some supporting demographic data.

This resulted in a total of 90 submissions from which a total of 450 insights were extracted. While the demographic element of the dataset is incomplete and therefore it is not possible to comment on the representativeness of the data, the exercise begins to build an understanding of the issues that face people in Medway and in what circumstances.

3A OVERVIEW AND EARLY ANALYSIS OF findings

FINDINGS BY THE 8 MARMOT PRINCIPLES

The analysis was conducted through the lens of the 8 Marmot principles with thematic analysis identifying the following key themes. The full report includes visual maps for each Marmot principle and identifies the complex, interlinking drivers that are resulting in health inequalities.

1. Give every child the best start in life

Across the 36 insights mentioned here, poor availability and accessibility of early family support came out as a significant issue. This was higher among parents facing additional pressures including a lack of peer support for single parents, and unmet needs for parents with neurodiverse children.

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

Across 69 insights provided, young people in Medway felt that they lacked agency in decision-making. Several responses voiced feeling excluded from decisions about their own lives and not being taken seriously in discussions about issues like their mental health. Limited access to services such as mental health support and community and leisure activities were highlighted as undermining young people's sense of agency and control over their lives.

> *'Young people felt they knew themselves best with regards to what worked for them (and) the timing of interventions, but their influence over their care was limited'*

3. Create fair employment and good work for all

From 42 responses, it emerged that working hours and workplace stress were restricting opportunity for healthy behaviours such as time for physical activity and with families. For those not in work, there were more significant barriers such as limited access to work due to disabilities, and a perceived lack of good employment opportunities in Medway.

4. Ensure a healthy standard of living for all

Across 68 contributions, strain on finances was the most significant factor limiting access to the essentials needed for healthy living. This encompassed issues like the rising costs of living, food, housing, and ability to participate in community and social activities. There were particular challenges associated with accessing welfare benefits and being able to afford to pay for dental appointments.

'The rising cost of living including fuel, food, mortgage/rent, energy and clothes is making life hard'

5. Create and develop healthy and sustainable places and communities

From 81 comments from residents, there were a wide range of issues raised which were identified as contributing to residents feeling unsafe, including crime, antisocial behaviour, littering, and drug and alcohol use. Green spaces were considered to be protective of health, but factors like transport, time, and safety were seen as restricting access to these.

'Rural communities are losing transport links. Transport links may not be able to break even in these areas. Someone who was once independent and self-sufficient may then be a victim of isolation'

6. Strengthen the role and impact of ill-health prevention

With 87 contributions, this principle had the highest response rate. It was felt that one's ability to engage in prevention of ill health was unequal, and dependent on a range of factors including life experience, language, confidence, level of knowledge, and existing health conditions. Residents also referred to healthcare and constraining factors in accessing referral and assessment routes for this.

7. Tackle racism, discrimination and their outcomes

50 contributions from residents in Medway highlighted that discrimination is prevalent at both an individual level, illustrated in interpersonal racism, but also embedded in society and systems, including the health service. Discrimination was seen as based on many characteristics, including language, gender and sexual identity, race, personal history including drug addiction, and disability.

'My parents' face racism, and what they say to my parents really hurts me. They had it growing up, but it still happens'

8. Pursue environmental sustainability and health equity together

Only 17 residents highlighted this theme, among those who responded, the dominant theme was that poor quality environments which damaged health were more prevalent in the more deprived areas in Medway. This included air pollution and lower access to green space.

Comparing the opinions of residents with other Medway stakeholders

While perspectives may differ, it is clear there are overlapping priorities from residents of Medway and views expressed at the launch event from stakeholders (see section 1D Stakeholder findings from the launch event) where there was representation from a variety of sectors and organisation types across Medway.

Most notably, both residents and stakeholders highlighted lack of equitable access to services as a key issue. Residents tended to relate this to their individual circumstances and identified practical barriers in accessing services and community spaces, including cost and transport. Stakeholders at the launch event spoke to the same issue of poor accessibility, but approached it more systemically, speaking of services being siloed, a lack of partnership working between services and sectors and societal discrimination. The importance of community spaces for socialising and accessing services and support were emphasised in both groups.

3B Next steps for resident engagement

Acting as a helpful benchmark, future resident engagement should build on these findings and inform prioritisation of issues across Medway and the design and delivery of appropriate support. Further research should capture more demographic information to assess differences by population groups (such

as gender, ethnicity, age, deprivation, geography). This will allow for identification of who is being heard, and, crucially, not being heard.

Over time, this will allow the Medway Marmot Place Partnership to build a more comprehensive picture of the challenges facing residents relating to health inequalities.

CHAPTER 4. CURRENT ASSETS

A key priority identified by the Steering Group was to build an interactive map of existing assets in Medway that work towards addressing health inequalities. This approach to mapping of assets aims to reduce duplication, consolidate services and identify gaps in provision. Moreover, it will seek to build a network of service providers looking to build greater health equity. Medway are leading this work amongst Marmot Places nationally as one of the first to take on asset mapping of this manner.

Prior to the launch event of Medway as a Marmot Place, Medway Council developed a Prevention and Early Intervention Plan. The Council recognise that it faces increasing pressure from an ageing population, health inequalities, and a rising demand for crisis services. This Plan sets out a place-based and collaborative agenda to address the factors influencing health and wellbeing, with a primary focus on reducing health inequalities.

The Plan has six themed chapters that are aligned with the Joint Local Health and Wellbeing Strategy and the One Medway Council Plan. The plan complements the Medway Marmot ambitions as the intention is for it to be delivered with effective partnership working and collaboration with a wide range of stakeholders including private, public, voluntary, community, and education partners including close working with local residents. By embedding early action across health, housing, education, employment, and finance, Medway seeks to empower residents, reduce demand on crisis services, and build long-term wellbeing. Effective delivery depends on robust partnerships, co-production with communities, and investment in data, digital tools, and frontline capacity.

Alongside the plan, in January 2026, Medway Council Service Managers and Directors identified 147 prevention-led interventions and services already happening within their departments. Through a senior officer working group, these interventions are being reviewed for opportunities to work collaboratively across departments and gap areas.

Interventions range from focused services that already adopt a universal proportionalist approach such as Stop Smoking Services which are universally available but focus on people in more deprived areas, to interventions that are primarily targeting populations experiencing conditions which are particularly damaging to health, such as targeted sports clubs for people experiencing homelessness. There are core council functions listed that are in place to address the social determinants of health, such as services providing housing support, financial advice and employment support. A next step for this work will be to align these interventions with the 8 Marmot principles.

Beyond this Council work, four separate sources – corresponding with the headings below – have been used in the identification of the assets currently available in Medway. Even so, this is not a complete picture of all activities, programmes and services in Medway. However, the information does help understanding the landscape for strengthened action for health equity and provides a good baseline for this analysis. The Medway Marmot website will host and periodically update the map of existing activities. This will, in turn, enable further identification of gaps in provision relating to the social determinants of health.

This chapter analyses a range of sources that begin to build a picture of what activities and interventions exist in Medway and where, and the existing assets and gaps in service provision. The information is also important to enable more partnership working between and within different services and sectors, and to allow residents to identify what appropriate support is available to them in Medway.

4A ANALYSIS OF EXISTING RESOURCE COMPILATIONS

1. MAPPING ASSETS ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH IN MEDWAY

The asset mapping working group collected information (see Annex C for the Microsoft form) on services addressing the social determinants of health inequalities in Medway. As of January 2026, 25 organisations had responded, covering 36 different activities reaching almost 850,000 people. EK360 have then added other services from the Joy platform database (described below). Services that target Medway residents,

seek to reduce health inequalities, address one or more of the social determinants of health, are currently active, and are documented publicly have all been included. This means that the analysis considers 206 services however, the reach of these cannot be known as this information is not included in the Joy database.

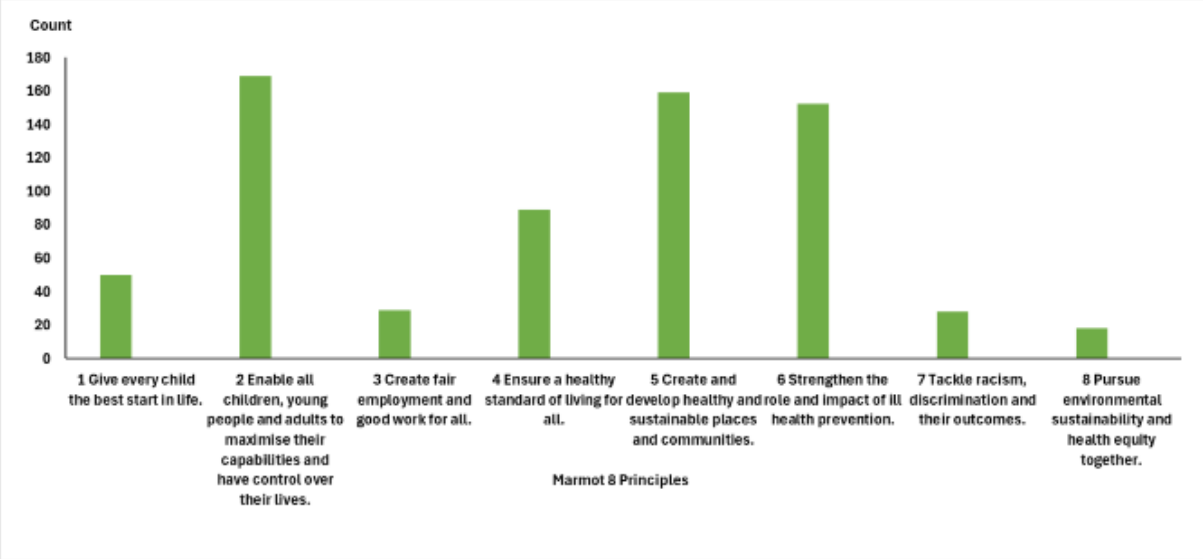
The services and programmes included span the 8 Marmot principles (see figure 25), such as public health, social care, community engagement, physical activity, mental health support and cultural inclusion. These are delivered by a range of charities, community interest companies, local authority teams, healthcare providers and community groups. Many of the services are available to 'all Medway residents' (60 counts) with some taking a more focused approach on children and young people (36 counts) and people with long-term conditions (33 counts). The groups identified from the Joy database transfer were much more limited than those inputted by organisations themselves. This is worth considering for future analysis.

When considering the geographic spread of services, all services transferred from the Joy database automatically said that they were 'Medway wide (open to all residents)' only. Therefore, they have been excluded from this count. Of the other 36 services, 28 of them are open to all Medway residents. Meanwhile, there is also activity specific to a combination of areas including Gillingham, Strood, Chatham, Rainham, Rochester, Hoo Peninsula, Lordswood and Walderslade, Twydall and Cuxton and Halling (in descending order between 10 and three).

The providers and EK360 selected which of the Marmot principles best describes the focus of their service, as represented in Figure 25. This begins to paint an interesting and varied picture of activity through a health inequalities lens. This highlights that, of the services mapped, there are fewer initiatives focused on environmental sustainability (18 counts, principle eight), tackling racism and discrimination (28 counts, principle seven), positive employment (29 counts, principle three) and early years (50 counts, principle one). Meanwhile, ensuring a healthy living standard (89 counts, principle four), ill health prevention (152 counts, principle six), developing sustainable places and communities (159 counts, principle five) and enabling all people to have control over their lives (169 counts, principle two) all have more services identified.

This provides an early indication as to the extent to which each principle is being supported. Further work will provide a more comprehensive picture, and support Medway Marmot leads to identify gaps in support for particular social determinants of health, any geographic gaps, and gaps for specific population groups. An important part of the next steps for this map will be ensuring that a breadth of relevant organisations respond to the survey, i.e. businesses, education providers, green spaces and leisure centres are currently not captured.

Figure 25. Number of services included in the asset mapping group database by Marmot principle, December 2025



Source: Medway data source (2026)

Among the outcomes of the services included, improved mental wellbeing is the most noted (180 counts), closely followed by increased social connection/reduced isolation (175 counts) and improved access to services or support (140 counts). Numerous initiatives meet multiple of these criteria, such as 'Nordic Walking' [31]. Meanwhile, improved housing stability, improved living conditions and environmental or sustainability benefits all have low counts from the current list (13, 14 and 15 counts respectively). The free text responses relating to improvements also flagged the role of reduced isolation and increased social connection linking to mental health, improving access to services and support and overall health improvement.

2. The Joy database in Medway

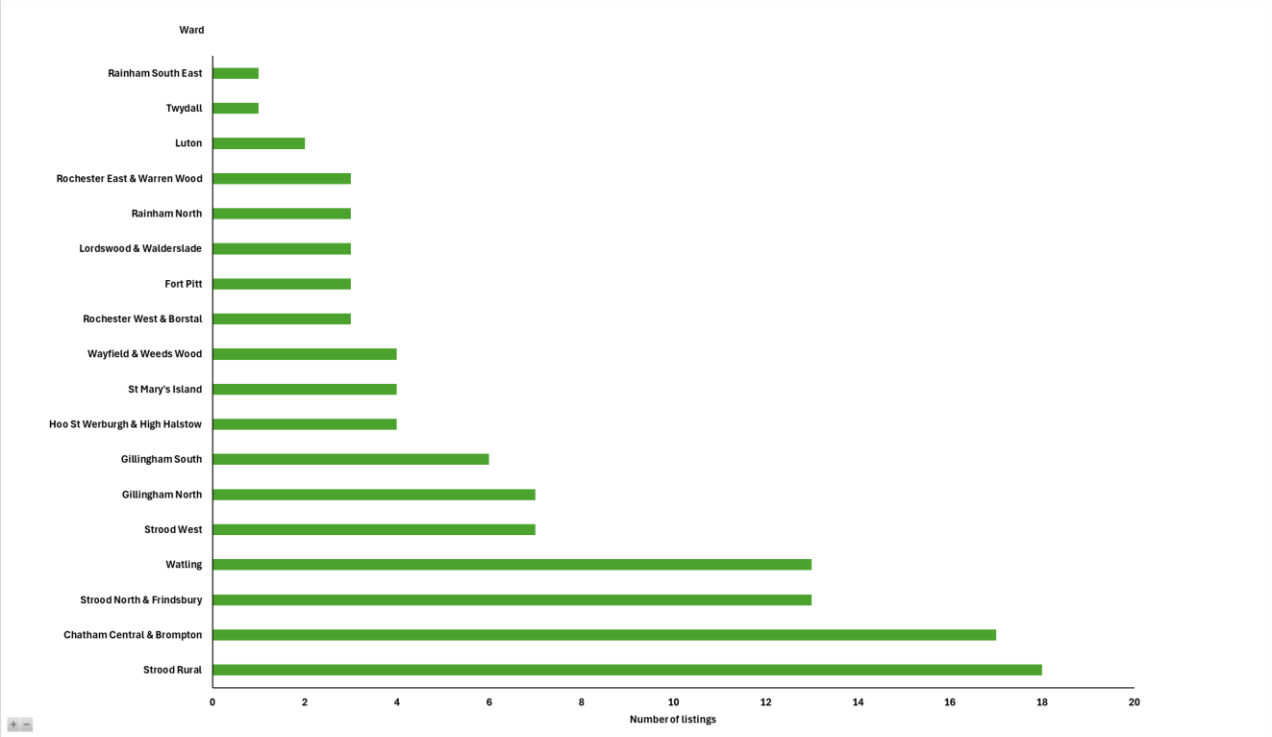
Joy is an online platform used to connect people with local services across the UK [32]. In Medway, the tool has been used by social prescribers in supporting residents. Through collaboration between Medway Voluntary Action (MVA), Medway Council and Medway and Swale Health and Care Partnership, the Joy platform was set up for use in Medway. As of October 2025, there were 112 programmes for Medway that are live and running from 75 different providers, spanning 18 different local admin wards. The Joy platform likely gives a comprehensive array of initiatives taking place in Medway however, as these are collated for use by social prescribers and so do not all take a health equity lens. Therefore, whilst the content is highly relevant to the Medway Marmot Place Partnership, the inclusion and exclusion criteria do not align entirely with the 8 principles.

Overall, Medway-based initiatives hosted on Joy have an emphasis on social connection paired with creativity or gentle physical activity to ensure accessibility. For example, services such as the chronic obstructive pulmonary disease singalong, the teens Saturday 'sew-cial' and community gardening. A common focus emerged on 'connecting with others' (41) and 'mental health' (36) as well as 'services for older people' (29) and 'managing long term health conditions' (29). Meanwhile, there were several category values with only one count. These included: consumer advice, drugs advice and support, mobile meals, hostels and emergency accommodation, asylum seekers and refugee support, end of life support, palliative care and stop smoking. Whilst the category count element of the platform could be better streamlined due to some duplication, and therefore may not give a completely accurate picture, these less represented elements highlight potential gaps in local service provision.

In terms of the geographical spread of interventions, there is relatively high variation between the number of listings in each admin ward. Areas such as Strood Rural (18 listings, 16 providers), Chatham Central & Brompton (17 listings, 8 providers), Watling (13 listings, 13 providers) and Strood North & Frindsbury (13 listings, 5 providers) are all on the higher end, in terms of numbers of activities. In Strood Rural and Watling, these high numbers of services are provided by a similarly high number of providers.

However, Chatham Central & Brompton and Strood North & Frindsbury both have less than half the number of providers to the number of activities being run. The respective strengths and weaknesses of these two contrasting models, where local providers deliver numerous services and are embedded in the hyper-local community compared to a wider range of providers existing within a local area, are worth understanding better to consider suitability in other locations. Meanwhile, Luton, Rainham South East and Twydall all have only one or two services provided in their admin wards but are among the most deprived areas and therefore likely missing essential support. Future research should map how the distribution of these services correlates to level of deprivation. Doing so will help to develop a plan for where to focus resources next in Medway.

Figure 26. Number of local service listings on the Joy platform database, Medway wards, October 2025



Source: Joy (2025) [35]

There are several learnings that can be taken from this analysis of the Joy platform, which should be built upon in future. Given that its application is relatively new in Medway and that not all services are onboarded onto Joy, there is a need to continue building momentum by expanding the services represented on the platform. This will build a more accurate picture of where service provision is good, and where there are gaps. Targeting onboarding through outreach or pop-up events and connecting in through local communities and community representatives are all avenues to explore for this work. Further analysis should also be done into the geographic and thematic coverage of services, with a mapping exercise required to match provision to local need. This exercise could be both qualitative and quantitative, looking at local data as well as speaking to residents and providers to understand their perspective and expertise on provision gaps, requirements, as well as success stories to be learned from.

3. Whole System Obesity (WSO) dashboard

Set up in 2020, the Whole Systems Obesity (WSO) Dashboard maps services that support residents to adopt a healthier lifestyle. While it is important to recognise the limitations of doing this solely for obesity interventions, this is a helpful exercise in mapping the services that exist in Medway to support healthy eating, physical activity, weight management and food growing. The most recent data-pull was in December 2025 [36], when there were a total of 863 active interventions and 253 inactive ones. The active services covered whole-school approaches, greenspace activities and learning specific skills (e.g. bike riding or line dancing). The inactive services were mostly cover time-limited events such as campaigns (e.g. 'walk to school month') or structured weight management cohorts that have ended. From

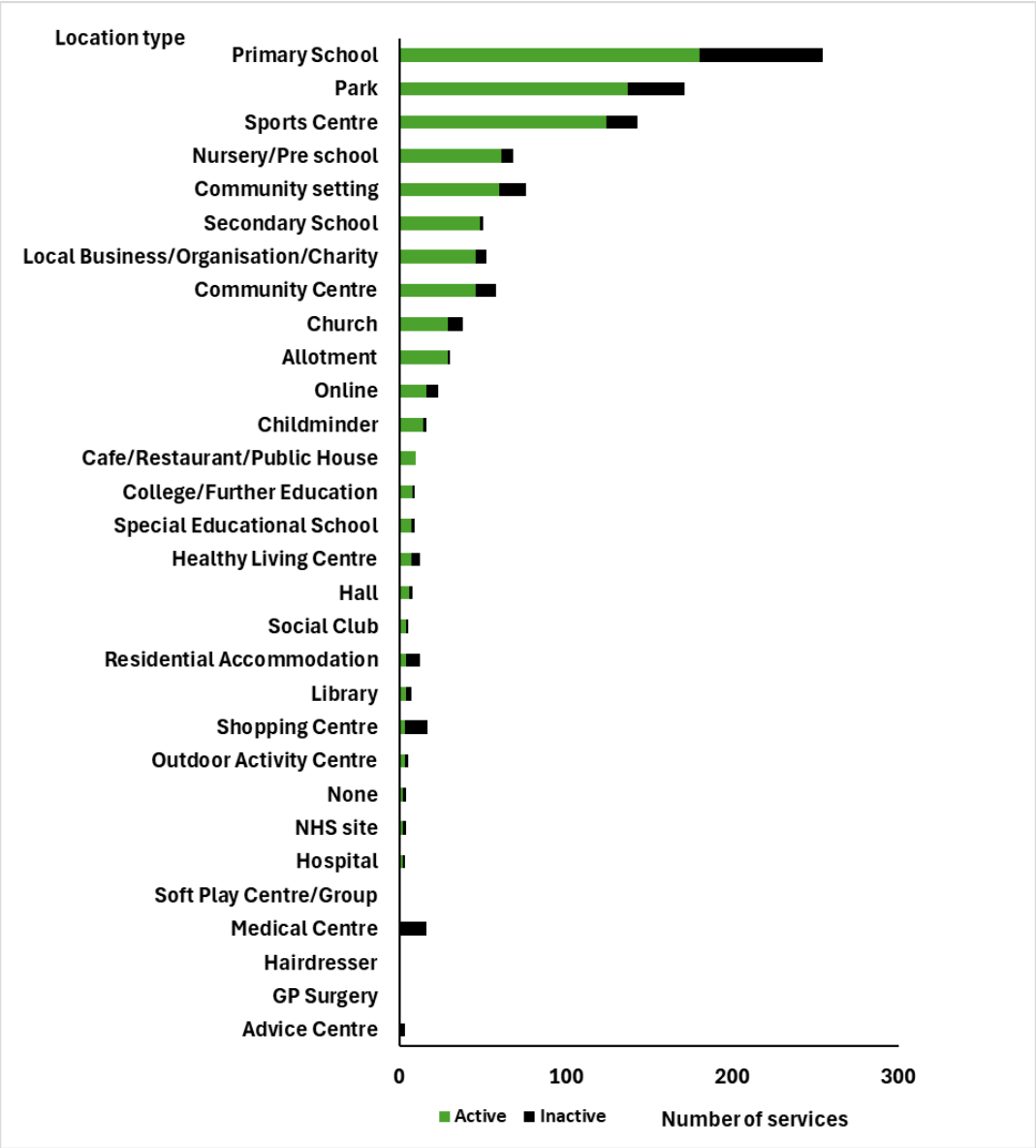
a health equity perspective, most of these interventions are relevant and particularly those which focus on prevention and engage with the social determinants of health and support wider partnership working.

Whilst the geographic reach of interventions is hard to establish due to the use of postcodes for service location, this is of interest from a health equity perspective, as with the Joy Platform. An ambition of developing the Marmot approach is to build and maintain system partnerships between public services, local authority and VCFSE and businesses and strengthening shared accountability for health equity. Given the large number of programmes and services identified in the asset mapping, it will also be important to identify duplication as well as gaps and consider simplifying provision and reimagining how local networks can be activated in working towards improved health equity.

Figure 27 based on the WSO dashboard outlines which organisations are already activated in Medway (those with higher counts), which spaces are yet to be fully utilised (those with lower counts) and those which are yet to be mapped or considered (those not listed). Figure 27 highlights that from a WSO perspective, bigger organisations such as schools, sports centres, community centres and churches are relatively well used for community interventions. Meanwhile, the lower use of NHS spaces suggests that efforts to tackle obesity do encompass the social determinants of health and that obesity has not been over-medicalised. It is encouraging to see parks as second highest location of services to reduce obesity and encourage physical activity (137 of the active services) with allotments (29 active services) and outdoor activity centres (three active services), indicating recognition of the importance of outside spaces for physical activity as well as wellbeing. Looking at the list of location type, there are several spaces with potential for locating and providing more support programmes such as libraries, shopping centres and cafes. As neutral spaces that are often owned locally and likely viewed as safe and familiar by residents, there is scope to pursue further work in these locations. Additionally, there is an important task in assessing which types of spaces are not included on the list. Lastly, from a health equity perspective, there is scope to use these locations as a potential springboard for expanded services and a means of identifying engaged providers that may want to engage with the Marmot programme to evolve existing provision as well as develop new provision.

It is important to consider the structural drivers of obesity that exist. Food and other household costs are particularly important in inequalities in access to healthy food: analysis finds that healthy food costs over double that of less healthy food options, per calorie [37], leading to inequalities in nutrition at a national level.

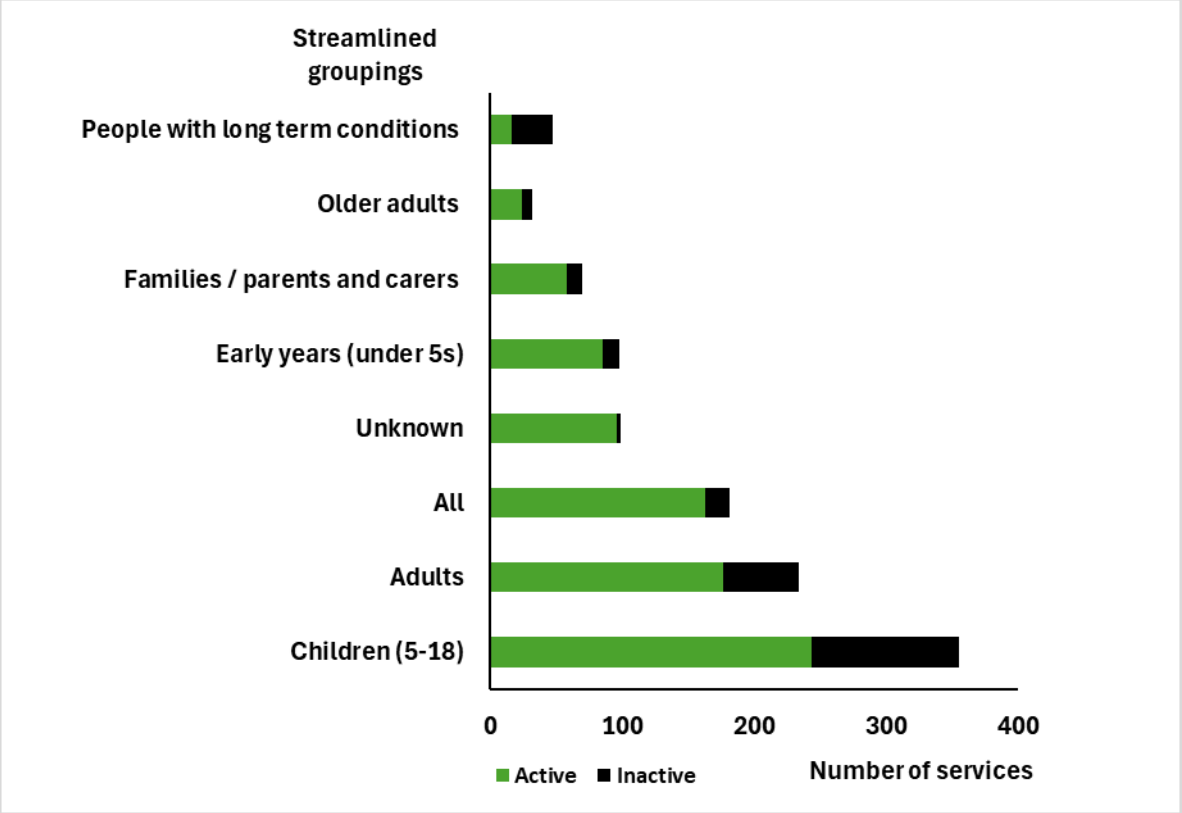
Figure 27. Whole system obesity map number of services by location type, December 2025



Source: Medway Council (2025) [36]

From a health equity perspective, the target audience of WSO map services is also important. As shown in Figure 28, children between 5-18 years are the target of the highest number of services preventing and reducing obesity in Medway with 244 active services followed by adults, young children and then older adults. This distribution indicates that there may be a need to strengthen efforts to reduce obesity and encourage physical activity among older adults. Assessing how this support aligns to the Marmot principles would help build an understanding of which social determinants are being addressed through these services, where gaps arise and the degree to which services are addressing social inequalities. The category 'families / parents and carers' group requires further assessment. Various Marmot programmes in other places focus on family-wide interventions, recognising the influence the household has on health and the social determinants of health and the benefit of supporting the family unit together as opposed to individuals within the family. Building on the assets to provide more family-based support may be a fruitful area of opportunity to progress on health equity and the social determinants of health.

Figure 28. Whole system obesity map service provision by targeted age group, December 2025



Source: Medway Council (2025) [36]

4. CHILDREN'S MENTAL HEALTH UNIVERSAL DIRECTORY

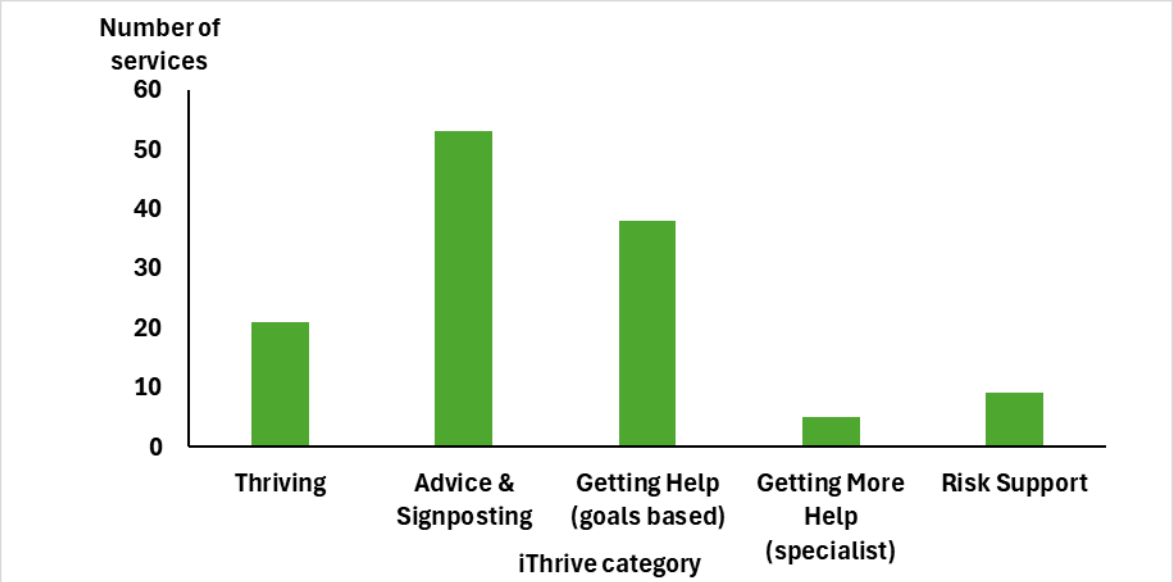
The Children's Mental Health Universal Directory was initially built in 2021 by the council to compile available services in Medway. Since 2023 it has been used as a directory for professionals and is reviewed for quality twice a year by a working group at the council, as well as being an updated online resource. As of November 2025, the full directory consisted of 289 services, 126 of which are specific to Medway (as filtered by the Senior Partner Commissioner for Positive Behaviour Support & Emotional Wellbeing at Medway Council). This Directory is highly relevant to the first and second Marmot principles (give every child the best start in life, and enable all children, young people and adults to maximise their capabilities and have control over their life). Whilst it is valuable to explore the contents of the directory, as with the other directories, it is important to recognise that its purpose is not to comprehensively cover mental health interventions for children and young people. Therefore, the data held within the platform should be considered as an interesting but incomplete picture.

Assessing only the services local to Medway, 28% are school services (35 services) and the remaining 72 percent are not (91 services). Overall, most provision is from the public health child health team (24), Medway Council (12), North East London Foundation Trust (10) and Medway Community Healthcare (10). In total, there are 10 different providers contributing towards the children's mental health provision in Medway. Overall, the services mentioned include wide-ranging interventions such as practical health and wellbeing education, family-based support and digital tools and platforms. There are also more targeted interventions including for children with special educational needs and disabilities (SEND), responses to incidents like bereavement, self-harm and suicide, and goal-based support for low to moderate mental health problems such as anxiety, sleep, exam stress and bullying. Two-thirds of these services are for all ages, with the remaining third being specific for under 5s (6), primary school age (12), secondary school age (10) and post 16 (13).

The directory breaks down services by categories from a national programme which aims to improve outcomes for children and young people's mental health and wellbeing. Known as iThrive, this programme works with integrated care systems (ICSs), the NHS, local authorities and charities to shift the

focus of interventions from diagnoses towards a framework focused on enabling young people to thrive. This THRIVE framework for systems change has five service categories – thriving, getting advice, getting help, getting more help, and getting risk support [38]. Figure 29 breaks down the 126 Medway services into these five categories and evidences the existence of those 'thriving' or preventative interventions. Reactive services are essential for young people in crisis or experiencing difficulty and therefore, for some individuals, are an essential part of achieving the second Marmot principle. However, the 'thriving' category is where building resilience and emotional wellbeing amongst young people occurs, as opposed to identifying incidents or diagnoses. This framing provides an interesting lens for other services to be considered through: support that enables local communities to blossom.

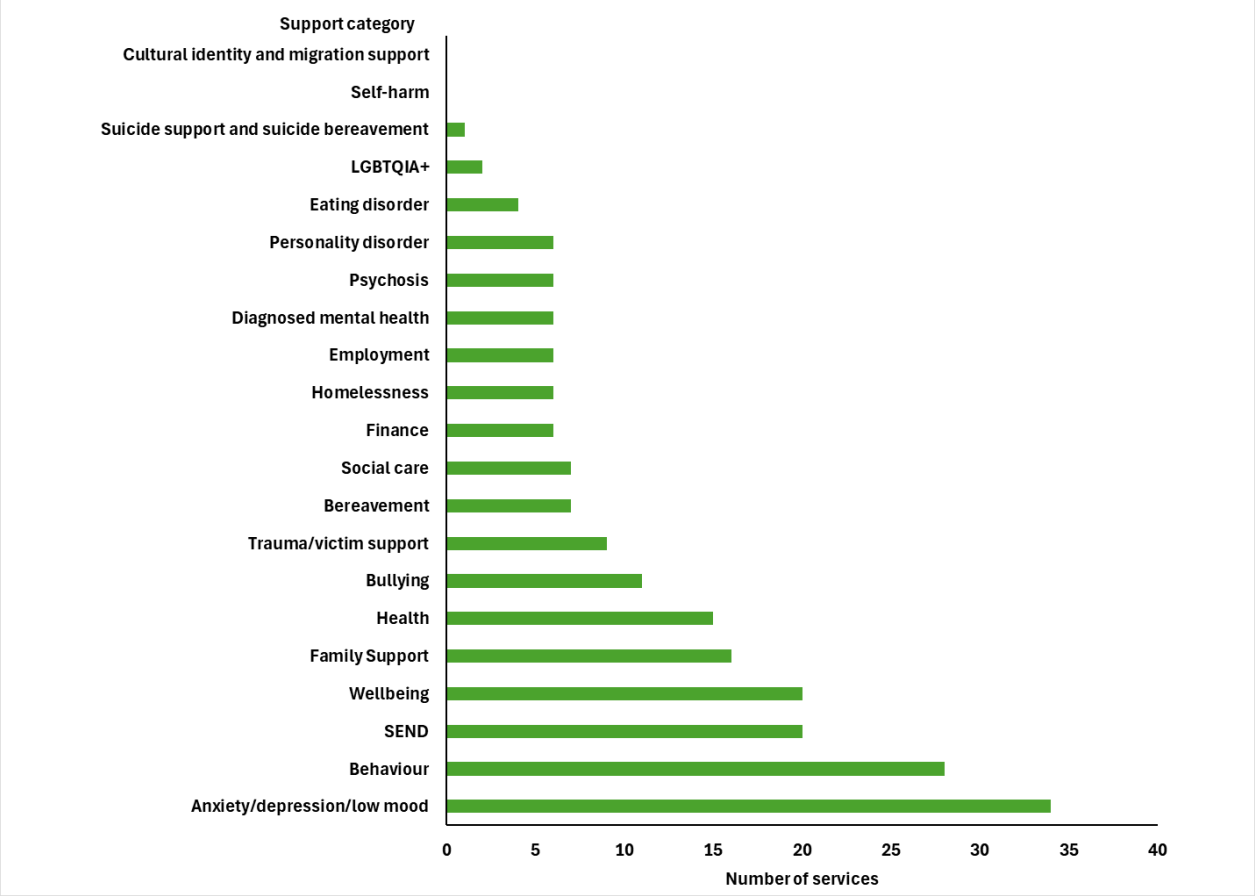
Figure 29. Number of services by iThrive category, November 2025



Source: Medway data source (2025)

Lastly, the categorisation of services in Figure 30 gives insight into the extent to which provision meets holistic needs of children and young people. Elements such as wellbeing, family support, health, bullying, social care, finance, homelessness, employment, LGBTQIA+ and cultural identity and migration all suggest a breadth of support that considers the whole person as opposed to simply their diagnosis. That is not to say specific diagnosis support is ineffective but to recognise the importance of wellbeing services as potentially prevention based and supporting in many facets of a person's life. As a next step, it is important to assess the geographic distribution of the services to begin to identify gaps and potential areas of need to support better mental health for children and young people in Medway. Crucially, whilst a focus on children and young people is essential in valuing the specific services available, it is also important to capture transition and support into adulthood services. These are all considerations for next steps in Marmot mapping activity in Medway and for understanding potential gaps and opportunities for further support.

Figure 30. Number of children's mental health services by support category in the Children's Mental Health Universal Directory, November 2025



Source: Medway data source (2025)

4B KEY LEARNINGS FROM EXISTING DATASET

Overall, analysis of these four asset mapping Directories highlights the presence of a high number of services in Medway designed to meet a range of resident and community needs and which support greater health equity through action on the social determinants of health. Given the purpose and structure of each database, these Directories do not give a full picture of services available in Medway, though they do give a preliminary indication of what is available.

For the whole Medway system to align and collaborate on halving health inequalities, the roll out of interactive maps based on the information provided in Directories and other sources must support the development of stronger partnerships and networks that react to local need and transform not only what exists but how it functions together. There is scope to consider how the maps could support and promote one another to enable cross-sector working as well as how different providers can collaborate. Moreover, there is a balance to be struck to avoid fragmentation of services, something more that must be explored. A high number of services may mean that a range of resident needs are being met however, without a strong network and community engagement, it may reflect fragmented delivery and engagement. Whilst enabling communication is the first step, there will also be a need to explore how joint working can be formalised from a contractual, employment, estates and other practical elements. Lastly, from the perspective of a local resident, the question of how to navigate services and how to voice opinions, feedback and codesign future services is probable. These questions must also be answered for the health equity lens that embraces shared ownership, local empowerment and activation as critical to a sustainable and better model of community care.

1B The Marmot approachAs set out in Chapter 1 Introduction, taking action to support greater health equity in Medway requires action on the social determinants of health, summarised in Figure 5.

There are further specific areas, for reducing health inequalities across Medway. Case studies of existing good practice are drawn on to inform the approach in Medway as the Medway Place Partnership continues to build. Interventions must be at a sufficient scale and involve collaborations across sectors and communities to make a sustained and tangible impact on health inequalities in the long term.

5A REDUCING INEQUALITIES FOR EARLY YEARS AND CHILDHOOD

Children's experiences during their early years impact opportunities and outcomes throughout the life course. Evidence has repeatedly shown that positive experiences and good development in the early years are closely associated with a range of beneficial long-term outcomes. For example, higher levels of attainment at school, better social and emotional development, improved employment outcomes, higher income and better lifelong health, including longer life expectancy [3]. Conversely, less positive experiences early in life, particularly experiences of poverty, adversity and trauma, are closely related to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health These inequalities have an impact by the time children enter school and persist and deepen during their school years and drive inequalities in health and inequalities in a range of other outcomes [3]. Socioeconomic inequalities in child development are already recognisable by the second year of life. These inequalities have an impact by the time children enter school and persist and deepen during their school years and drive inequalities in health and inequalities in a range of other outcomes [3]. Socioeconomic inequalities in child development are already recognisable by the second year of life. These inequalities have an impact by the time children enter school and persist and deepen during their school years and drive inequalities in health and inequalities in a range of other outcomes.

CULTURALLY SENSITIVE PROVISION FOR EARLY YEARS

Early childhood is the stage of life when interventions can have the greatest impact and be the most impactful and cost-effective. With regards to maternal and infant, there are striking inequalities in by ethnicity across the country. The 2024 *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* report found that Black women are three times more likely to die from pregnancy and childbearing-related complications than White women, while women from Asian ethnic backgrounds are two times more likely to die [39]. In 2023, rates of infant mortality were particularly high in England and Wales for many Black, Pakistani and Bangladeshi babies [40]. These ethnic inequalities indicate issues with living and working conditions for pregnant women, maternal health, access to maternity and obstetric services and the cultural appropriateness of those services. Given the diversifying ethnic makeup of Medway, it is essential that interventions take a culturally sensitive approach to care, as exemplified by the Early Action Partnership in Lambeth:

Case study 1: Lambeth Early Action Partnership [41]

The Lambeth Early Action Partnership (LEAP) caseload midwifery approach was implemented at Guys and St Thomas' NHS Foundation Trust, London. In LEAP, teams of six midwives care for 18 pregnant women per month. Individualised care pathways enable frequent and longer visits as required. Two midwives are involved from booking to postnatal care for each patient. Teams are on call for labour and provide extended postnatal care (up to 28 days). An evaluation of the approach showed that following the intervention, preterm births in non-white women were significantly reduced in those allocated to caseload midwifery compared with those allocated to traditional care, 7.3 percent compared with 14.4 percent, but the preterm birth rate remained higher overall in non-white women. For women who needed interpreters, there was a statistically significant reduction in the preterm (before 37 weeks) birth rate among those receiving caseload midwifery compared with the standard care. Long-term follow-up of these women would determine whether there are long-term clinical and economic benefits of caseload midwifery in this cohort.

PROPORTIONATE UNIVERSALISM AND A FAMILY APPROACH

Many places have recently been able to expand their early years services such as children's hubs, following years of cuts and been able to increase support for parents and young children who are at risk of poor outcomes. Family hubs [42] bring different forms of support for parents and carers into one location, making it easier to access all necessary services. They streamline the provision of services and recognise that support can be bespoke and effective for family groups as opposed to individuals. Sure Start – England's first large programme to provide support to families with children under 5 – led to improvements in the educational performance of children from low-income backgrounds. There was an improvement in GCSEs for FSM students living near a Sure Start centre compared to more financially deprived children who could not access Sure Start [43]. The Government's proposed expansion of Family Hubs into the new Better Start Family Hubs across all local authorities is a promising move towards reinitiating some elements of the early years approach previously provided by Sure Start centres and is essential for working towards narrowing inequalities in outcomes among babies, children and young people later in their education.

Having strict eligibility criteria for specific services means that many who need support miss out and for those who are eligible it can increase stigma, shame and disengagement from services. Eligibility, resource allocations and the design and delivery of services and interventions should follow the principle of proportionate universalism to raise awareness of, and flatten, gradients in health and the social determinants of health. Families and communities play a vital role in shaping health and wellbeing across all stages of life and family approaches need to be at the centre of the development and delivery of programmes and services. One example of this can be seen in Coventry where they have embedded the principle of proportionate universalism within their family hub provision:

Case study 2: Coventry - Family Hubs [44]

Whilst developing the model for family hubs [45], Coventry council chose to base the model on the principle of proportionate universalism: the services are universally available, but centres are located in the eight most deprived areas of the city. Family hubs are available to families with children from 0-19 years old and can be attended by any family in the city, as opposed to previous postcode restrictions. Also reflecting the Marmot best start in life objective, there is a written commitment to weight funding allocations towards those aged 0-2.

When Coventry commissioned their Family Health and Lifestyles 0-19 Service, MAMTA [46], a targeted and culturally sensitive service delivered by FWT - a centre for women (a community organisation) were included, as they work to identify and tackle inequality in outcomes for mothers and babies from ethnic minority groups. Using proportionate universalism as a model, MAMTA is a specific added on, targeted service, re-designing their core offer within existing resources to increase access. MAMTA now offer all pregnant women from a minority ethnic background in Coventry support and 'Parent Craft' run in conjunction with University Hospitals Coventry and Warwickshire NHS Trust maternity services.

SCHOOL-BASED APPROACHES

Many Marmot places have introduced programmes of work and interventions related to reducing inequalities among young people and aim to enable all children to maximise their capabilities and have greater control of their lives. Some of these programmes target educational inequalities, focusing on mitigating the impact of poverty on education and providing additional support for vulnerable young people at school. As data in Secondary school age population 2C (Secondary school age population) highlighted, there are wide inequalities in educational attainment, related to household income in Medway – as across England. Programmes to understand and reduce the impact that living in poverty has on children and young people's experience at schools as well as in their living environment can help improve outcomes for disadvantaged students, as exemplified through the poverty proofing approach taken in North Cumbria.

Case study 3: North Cumbria – Poverty proofing schools [47]

'Poverty proofing' provides schools with a toolkit to reduce stigma and remove barriers to learning. It was developed by Children North East (Children North East) in 2011 and continues to be delivered to schools in Cumbria and across the country. The poverty proofing process consists of an 'audit', a whole-school evaluation, written report, action plan and training for staff and governors. The process aims to uncover the institutional and cultural practices within a school that stigmatise pupils who are living in poverty. In 2016 Newcastle University evaluated poverty proofing and found the project to be successful in increasing attendance, FSM take-up, and attainment, with one school reporting a 5 percent rise in attendance and a 7 percent rise in FSM uptake [48]. The poverty proofing audit involves CNE practitioners visiting a school and living the school day through the eyes of a child living in poverty. This includes attending before- and after-school clubs, being in the playground during break and eating lunch with the children. The central component is that during lesson times CNE staff talk with all pupils in the school. Practitioners also engage with parents through questionnaires and face-to-face discussions in the playground before and after school. They talk to key staff, and all staff and governors have the opportunity to complete a survey to share their views. Once the audit is complete CNE provides detailed information to the school on the experiences that children who are living in poverty are having. CNE practitioners then work with the school to identify ways to overcome these challenges. The result is an action plan tailored to each individual school to address any stigmatising policies or practices. Poverty proofing uses this learning to make targeted recommendations and promote staff understanding, empathy and person-centred practice based on the social, health, psychological and behavioural impacts of poverty.

From the data in Chapter 2C Secondary school age population, the exclusion rate in Medway's state funded secondary schools also has room for improvement. Work in Salford to reduce all types of exclusions from schools through a holistic and inclusive approach helps to foster a sense of belonging among school-aged residents.

Case study 4: Salford – Reducing school exclusions [49]

Salford has adopted a holistic, multi-agency approach to reducing school exclusions through its 2020–2023 Education Inclusion Strategy. This strategy aims to reduce both fixed-term and permanent exclusions, improve attendance, and support schools in understanding why students may breach behaviour codes. It focuses on fostering a sense of belonging in students and supporting all at-risk children. Following research into Salford's high exclusion rates, the city found many permanently excluded students had special educational needs (SEN). This led to a review of SEN support thresholds and broader consultation with young people, parents, schools, social care, health services, and other stakeholders. Salford's approach has three key strands:

1) Team Around the School: Works with Early Help and other services to support children and families. Mental Health Support Teams and social workers are embedded in eight high schools. Staff receive training to identify and respond to needs. Support is available without needing to meet social care thresholds.
2) School Settings and Practices: Includes the Emotionally Friendly Schools Programme, developed by the Educational Psychology Service, offering tools and training. Efforts to reduce persistent absence, which affects over 3,000 students, are led by the Education Welfare Service and the Virtual School.
3) Processes, Provision, and Governance: Focuses on consistent evaluation, flexible service delivery, and transparency. The multi-agency Education on Track Panel supports entrenched non-attendance. Salford's Neglect Strategy recognizes Educational Neglect, improving school engagement with social care. The roles of Virtual Headteacher and Head of Education Inclusion are combined, allowing a comprehensive overview of all children needing support.

This inclusive strategy enables more effective intervention and collaboration to meet the diverse needs of Salford's young people.

Medway have a strong track-record in engaging with young people and amplifying their voices through the 'Medway school health and wellbeing survey'. In this same vein, Greater Manchester sought to work with young people and prioritise them, their priorities and their experiences through the Youth Task Force and the Young Person's Guarantee.

Case study 5: Greater Manchester – Youth Task Force and Young Person's Guarantee [50]

In June 2020 Greater Manchester's Mayor established a new Youth Task Force to examine the effect of the pandemic on young people. The report and recommendations were published in December 2020. In response to consultation with young people, Greater Manchester committed to reduce digital exclusion; improve travel support; improve mental health and specialist support for young people unemployed during the pandemic; and provide higher education grants, pre-employment training and mentoring and new apprenticeships and work placements. Greater Manchester has also committed to better engage and communicate with young people, a key factor identified as needed by many in this demographic.

5B Anchor organisations and partnerships

Reducing health inequalities requires strong partnerships between sectors and organisations that have an impact on health including local government, public services including healthcare, social care, education, housing, the police, the VCFSE sector, businesses, communities and households. Many places place a strong focus on equity delivered through partnership to build and strengthen the whole 'health equity system'. This requires a move away from siloed work patterns and tensions between sectors and organisations, proper activation of often overlooked services such as the VCFSE and collaboration on barriers such as information sharing and joint commissioning.

Education services and school buildings themselves have the potential to be developed as important anchor organisations, developing ways to improve the social determinants of health for communities in places where they are. The asset mapping exercise demonstrates that Medway has begun to make use of education facilities. Schools recruit and buy goods and services locally and their local procurement should be oriented towards supporting local economies. Schools have facilities, including sports facilities, meeting spaces which can be successfully utilised by local communities all year round.

Local businesses as key partners

Businesses have an important influence on the health and wellbeing of residents across Medway through their role as employers, suppliers of goods and services, by having an impact on the local economy and sometimes as donors to community programmes and households. However, businesses are not often considered to be a core partner for greater health equity, and it is important that they are involved in much closer partnerships with all the stakeholders, including public health. This regeneration initiative is a clear instance of activating local businesses, as part of a network of health equity partners in the local area:

Case study 6: Vision – King's Lynn [51]

Vision King's Lynn is a regeneration initiative focused on revitalising the town through investment in business, skills, infrastructure, and community wellbeing. A key element is the collaboration between local businesses, government, and community organisations to deliver social value alongside economic growth. This includes raising young people's aspirations and supporting business and skills growth. Businesses play a strategic role on the King's Lynn Neighbourhood Board, shaping priorities and directly supporting projects.

In addition to skills development, Vision King's Lynn invests in shared community infrastructure, such as the planned Community and Learning Hub, which will provide digital access, training, mental health support, and inclusive spaces for all residents. Through co-design and wide consultation, the initiative

ensures that regeneration efforts reflect local needs. Ultimately, Vision King's Lynn demonstrates how businesses can be key drivers of social good shaping strategy, offering opportunity, and contributing to a more inclusive and connected town.

PARTNERSHIP WORKING FOR GOOD QUALITY WORK

Good quality work is complex and multifaceted when defined comprehensively. It can be broken down to include safe working conditions for physical and mental health, decent pay; opportunities for learning, development and progression; job security; varied and interesting work; some autonomy; a balance of effort and reward; employee voice and representation; compatibility with a good work-life balance including flexible working where possible. Greater Manchester includes many of Medway's CIPFA Statistical Neighbours (Bolton, Bury, Oldham, Rochdale, Stockport, Wigan). So, it is interesting to consider the Manchester Work Well Model, a part of the 'Making Manchester Fairer' effort, in this context:

Case study 7: Manchester – Work Well Model [52]

Manchester's £1.3 million Work Well model has been designed to Making Manchester Fairer (MFF) principles and is aligned to the action plan to reduce health inequalities. The model comprises three strands:

1) £438k of Work Well funding will be allocated to scale up the MFF Employability Support Kickstarter from December 2024 until 31 March 2026 integrating the employability offer further into MSK clinical pathways including co-location. The Kickstarter has an evaluation approach informed by Making Manchester Fairer
2) The second Work Well strand of the Manchester model will enhance the city's Be Well (Social Prescribing) Service by adapting, improving and enabling earlier access to employability support and more co-ordinated support for racially minoritised communities
3) The third Work Well strand will provide employability support to racially minoritised communities by implementing a new service delivered by culturally competent VCSE organisations. This builds upon the learning from three small scale projects commissioned by Manchester City Council which initially focused on economically inactive Asian women in Cheetham and Longsight. A fourth project will go live in October targeted at Moss Side's Black African and Black Caribbean communities in Moss Side.

Statutory organisations, such as the NHS, have the potential to lead the way in improving health equity as a local employer. NHS organisations in Medway can engage with, support and enable a health equity approach as a community asset and an essential part of community health going forward. There are numerous opportunities for these as various initiatives, such as Neighbourhood Health, evolved and prioritised across the healthcare system. Programmes such as the ICS Education Collaborative in Birmingham and Solihull exemplify how local areas can go one step further in embedding good quality work, training and skills opportunities that meet employer and resident needs, within structures:

Case study 8: Birmingham & Solihull – Integrated Care System (ICS) Education Collaborative [53]

The Birmingham and Solihull ICS Education Collaborative was formed to ensure a diverse workforce that is well trained and provides high quality care to the local community. It works collaboratively with NHS Trusts, primary care, social care, councils, universities, further education colleges, and schools across Birmingham and Solihull with a shared vision and goals. This ties into the ICS's goal of embedding social value and corporate social responsibility into procurement, with the 20% of the procurement bid scoring based on social value. Since 2018, the education collaborative has supported the Birmingham and Solihull ICS) in delivering the deployment of 282 nursing students to support the NHS across the ICS system during covid, increased student recruitment to meet 25% target for nurse undergraduates, and increased overall student recruitment across Nursing, Midwifery & allied health professional by 18%.

5C HEALTHY AND SUSTAINABLE PLACES

Good physical and mental health are supported by healthy and sustainable places, which are characterised by good quality housing and safe environments. These require access to transport, services and shops, community facilities, leisure and entertainment, homes that are efficient to heat, and good quality green spaces. As we saw in Chapter 2C, Medway has scope to reduce its rate of households living in temporary accommodation. Work in both Greater Manchester and Liverpool has sought to tackle housing insecurity and enable residents to move away from housing insecurity and housing poverty.

Case study 9: Greater Manchester – The Bond Board – Supporting Homeless and Low-Income Families to Secure Deposits For housing [54]

The Bond Board, established in 1993 in Greater Manchester, provides bond guarantees for people who are homeless or on low incomes. These guarantees take the place of cash deposits and provide security for landlords. The Bond Board provides a specialist housing advice service to tackle eviction issues with funding from the Greater Manchester Mayoral Fund. Their services have provided advice to residents in Oldham, Wigan, Rochdale and Bolton and they have partnered with the National Housing Advice Service and Shelter to assist with any cases that demand additional specialist support for families at risk of eviction.

This section provides some examples of approaches in other places which may be relevant and helpful for the Medway context. Next steps will include expanding the analysis of relevant examples from other places and identifying what is already working well in Medway which can be scaled up. As identified earlier, to meet the challenging ambition to reduce health inequalities by half, effective programmes and support must be scaled up, designed and delivered in a way which supports greater equity, with investment for the longer term.

CHAPTER 6. RECOMMENDATIONS

These recommendations have been developed based on priorities indicated by the Medway data used to inform this report. This includes evidence from stakeholders including residents, the analysis of existing assets and services from available directories in Medway and examples from other places and approaches which have successfully supported action for greater health equity. The recommendations are not specific to a particular Marmot principle but are more general, aligned with the approach for this report. The recommendations set out here cover elements of the principles but also relate to how organisations work together, leadership and community involvement, resource allocation, commissioning, data and information and taking action to reduce stigma and inequalities everywhere.

At this stage, the recommendations are deliberately high-level. This allows for a consultation period with stakeholders across Medway to add specificity and amass buy-in. Insight gathered through this consultation will feed into the development and publication of an action plan later in 2026, that allocates responsibility for addressing health inequity across stakeholders in Medway.

Other next steps include a focus on young people who are NEET (see section 1C) as per the NEET Summit planned for April 2026.

1. TAKE ACTION ON THE MARMOT 8 PRINCIPLES IN MEDWAY

ALL PARTNERS IN MEDWAY TO FIRST PRIORITISE REDUCING INEQUALITIES IN THE EARLY YEARS, CHILDHOOD AND YOUNG PEOPLE

- Work in partnership (local government, early years settings, education, housing, police, children's services, businesses, VCFSE providers) to reduce inequalities in and experiences at school between children eligible and not eligible for Free School Meals and for those with SEND and looked after children.
- Prioritise reducing inequalities in children's early development, especially speech and language skills and greater support for parents in the early years to understand cognitive development.
- Profile the NEET population, prioritise reducing and prevent those NEET, engage partners through a 'NEET summit', and extend cross-sector provision of training opportunities, building on bringing in additional partners including businesses.
- Collaborate with young people to incorporate their views about what is needed in local areas to improve existing support for mental health and employment pathways.
- Strengthen partnerships to support looked-after children and care leavers alongside other groups at risk of exclusion and exploitation to build skills and enter employment, further education or training.
- Build career advice, local mentorship and apprenticeships and set out what is expected of local employers in collaboration with schools and young people.

FOSTER INCLUSIVE, CULTURALLY SENSITIVE AND ACCESSIBLE FAMILY SUPPORT

- Support family-empowerment (e.g. parenting programmes and support) and strengthen the role of community and voluntary sectors organisations in building trust and supporting families.
- Retain the idea for a community hub/one-stop-shop with co-located services (including onward referral) for families, such as at schools.
- Embed anti-racism and ensure support is culturally appropriate and bespoke to meet community needs.
- Develop routine collection of data by ethnicity to establish the extent of ethnic inequalities and build appropriate responses to identified need.

2. Strengthen cultures and systems for health equity in Medway

Strengthen partnerships in Medway for health equity

- Involve public services, council led services, the VCS, business and all stakeholders in Medway to be part of the Marmot place programme and in a Marmot Board
- Work with specific sectors to develop their contributions to early years, young people and those NEET and develop sector-specific actions and associated implementation plans for short and long term.
- Ensure meaningful engagement and involvement of communities is central to understanding needs and adapting and producing appropriate and effective services.
- Simplify grant giving and commissioning processes to be simplified particularly for VCS organisations and the reliance on short term funding reduced.
- Explore how joint working can be formalised from a contractual, employment, estates and other practical perspectives.

Identify, engage with and activate Medway's anchor organisations

- Identify, engage and activate Medway's anchor organisations as the vanguards of the Medway Marmot Place Partnership including the NHS, educational settings, the council, large charities, and key local employers.
- Anchor organisations and local economic partnerships to work closely with schools and colleges in areas with higher levels of deprivation to support apprentices, job training and employment shadowing with a guaranteed employment, apprenticeship or training offer for 18–25-year-olds.

Strengthen the role of businesses and the economic sector for health equity

- Develop in partnership a local good work charter for employers, which builds on the national Good Business Charter, and make becoming a signatory to this local charter a requirement for NHS and public sector contracts. This should include:
    - Wages to meet the minimum income for healthy living
    - Provision of in work benefits including sick pay, holiday and maternity/paternity pay
    - Provision of advice and support e.g. debt and financial management, housing support at work
    - Provision of education and training on the job
    - Strengthen equitable recruitment practices including provision of apprenticeships and in work training, recruitment from local communities and those underrepresented in the workforce.
- Support micro/small employers to follow in the footsteps of the anchor organisations in engaging with health equity work as specified through the above frameworks.

3. Transformational processes

Ensure health equity in all policies, programmes and services

- Embed equity and proportionate universalism into all decisions and services among all partners in Medway
    - Develop and implement an integrated equity impact assessment tool for decision making in Medway that incorporates existing assessment tools and is developed from the Marmot principles
    - Implement the streamlined tool in Medway Council as the leading statutory body to centre health equity in all decision making. Other statutory and non-statutory organisations follow suit and use the same tool as they are activated as partners in the Marmot work.

STRENGTHEN EVALUATION OF EXISTING PROGRAMMES

- A concerted effort to evaluate existing programmes is needed to build a clear evidence base to inform design and delivery of programmes and ensure that effective programmes are scaled up and ineffective programmes are decommissioned.
- Continue to frame initiatives through the lens of the Marmot principles and overlay this to geographic distribution, levels of deprivation and for excluded groups.

BUILD ON AND DEVELOP EXISTING PROGRAMMES

- Embed health equity and prevention in new national and local approaches for example, the NHS Neighbourhood Health programme, Family Hubs and the Pride in Place impact fund.
- Develop asset mapping to include physical assets and spaces (e.g. natural spaces or community facilities) where benefits could be further maximised to improve wellbeing and inclusivity of access to provision including leisure centres, libraries, education, and fire services.
- Celebrate, recognise and formalise the successes of existing initiatives and scale up to cover the whole of Medway, in a way which is proportionate to need across Medway.
- Use existing mapping to address gaps, inform procurement and commissioning, consolidate existing provision and reduce duplication to ensure effective use of the comprehensive picture.

DEVELOP HEALTH EQUITY MARMOT NETWORK ACROSS MEDWAY

- Build on the Marmot asset mapping and resident engagement exercises to map gaps in provision related to the 8 principles and excluded population groups. In turn, identify ways to reduce and monitor progress on the identified gaps.
- Transition the mapping of resources into the development of a local health equity network and partnership that functions as a collaborative system of commissioners, providers and residents.
- Make a clear commitment to continue funding and use of the Joy platform.
- Consider the positioning of residents within this active, health equity network and how they can navigate the system as a resident, as a potential Marmot envoy and in local work and volunteering opportunities.

Annex A: Membership of Advisory Board

Professor Sir Michael Marmot (Chair)	Director, UCL IHE
Councillor Teresa Murray	Medway Council, Deputy Leader of the Council; Portfolio holder for Adults' Services; Chair of the Health and Wellbeing Board
David Stokes	Chief Executive Nucleus Arts, Voluntary and Community Sector
Eithne Rynne	Chair of Voluntary Sector Leaders Network; CEO Kent Association for the Blind
Jacqui Moore	Senior Public Health Manager, Medway Council
Dr Jessica Allen	Deputy Director, UCL IHE
Lauren Blum	Senior Researcher, UCL IHE
Martin Riley	Chief Executive Officer, Medway Community Healthcare
Matthew Capper	Director of Strategy and Partnerships, Medway Foundation Trust
Professor David Whiting	Director of Public Health, Medway Council; Director of National Institute for Health and Care Research (NIHR); Health Determinants Research Collaborations (HDRC) Medway
Rachel Hewett	Acting Chief Strategy and Partnerships Officer NHS Kent and Medway Integrated Care Board (ICB)
Scott Elliott	Strategic Service Manager, Public Health, Medway Council
Sunny Ee	Assistant Director, Regeneration Culture Environment and Transformation
Tina Lovey	Chief Executive Officer, Rivermead Inclusive Trust
Ummi Bello	Public Health Programme Manager, Medway Council
Employer/business representative TBC	
Public representative TBC	

Annex B: Membership of Steering Group

Scott Elliott (Chair)	Strategic Service Manager, Public Health, Medway Council
Aeilish Geldenhuys	Strategic Service Manager, Medway Council
Amie Kemp	Senior Public Health Manager, Medway Council
Anne Trafford	Digital Communication Assistant, Medway Council
Debbie Amato	Trust Inclusion Improvement Lead, Rivermead Inclusive Trust
Eluned (Ellie) Broom	Senior Public Health Intelligence Team Manager, Medway Council
Lauren Blum	Senior Researcher, UCL IHE
Natalie Goldring	Head of Public Health Intelligence, Medway Council
Paul Cowell	Head of Culture Libraries and Heritage, Medway Council
Sue Alder	Managing Director, EK360
Susan Matheson	CEO, Maritime Children's Foundation
Ummi Bello	Public Health Programme Manager, Medway Council
Chris Giles	Acting Housing Strategy and Partnerships Manager, Medway Council
Rebecca Wilcox	Chief Housing Officer, Medway Council (Housing)
Primary care representative TBC	

Annex C: blank Microsoft Form

Mapping services

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