
ROYAL VOLUNTARY SERVICE
VOLUNTEERING FOR A HEALTHIER BRITAIN
KICKSTARTING A NEW VOLUNTEER REVOLUTION
ROYAL VOLUNTARY SERVICE

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FOREWORD

The pandemic has revealed significant regional health disparities and has exacerbated poor health. The longevity of this pandemic, the numerous lockdown and social distancing measures have taken their toll on the nation.

According to the Office of National Statistics, the pandemic triggered the greatest annual declines in personal wellbeing (i.e. happiness, anxiety) since they started measuring wellbeing in 2012[1] and over half of adults (55%) are still avoiding physical contact with others (Oct 2021[2]). Our urgent need to reverse these trends should be at the heart of the government's 'building back better' agenda given the link between our happiness, social relationships/trust, and economic productivity[3].

Part of the solution in reversing these trends is capitalising on the resurgence of civic participation during the pandemic; we need to play forward the 12.4 million who stepped forward to support their neighbours, communities, and the NHS. We know from the London School of Economics' analysis of the NHS Volunteer Responders programme (April 2021) that volunteering was a driver for significantly higher wellbeing scores, as well as greater feelings of social connectedness and belonging to neighbourhood compared to those who did not volunteer. The findings on wellbeing and greater social connectedness brought about by volunteering are in stark contrast to what we know about wider population experience during the pandemic - which has charted declines in wellbeing and under-socialisation[4].

In this report we review the breadth of medical research on social connections and the link to physical, cognitive, and mental health. The report also presents new data collected on the impact of health and social relationships across a range of deprived neighbourhoods during the pandemic and how volunteering might play a protective factor. What is clear from this evidence is that our *social environment* is not just a 'nice thing to have' but appears critical for our overall health outcomes.

In a similar way to how the pandemic has highlighted regional health disparities, it has also highlighted areas which lack social and community infrastructure necessary to foster social capital; the findings in this report and the All-Party Parliamentary Group on Left Behind neighbourhoods[5] shows us we need to do more in these communities as we look towards recovery - as they appear hardest hit by the pandemic in terms of their health, wellbeing and social relationships. Going forward, Royal Voluntary Service, in partnership with others, want to prioritise those communities. We must work with them to build up their social infrastructure to help reduce regional disparities in health and in the words of Professor Michael Marmot, 'build back fairer'. Volunteering can play a key part in delivering the social connections that make that goal achievable.

Catherine Johnstone, CBE,
CEO Royal Voluntary Service

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EXECUTIVE SUMMARY

There is a compelling body of medical research that finds that our social relationships have an impact on our long-term health; those people who feel lonelier, are isolated and have less support are more likely to develop issues like cardiovascular disease, dementia, depression, and even have a higher risk of death.

It appears that poor social relationships are detrimental to our health because it increases levels of bodily inflammation (our immune system can't switch off), causes higher blood pressure, blood sugars and stress hormones. There are added behavioural risk factors associated with poor quality sleep and reduction in physical activity.

This is concerning given the longevity of the pandemic - with various lockdowns and social distancing measures – which have undoubtedly impacted on people's social relationships and connections. In a similar way to how COVID-19 has highlighted regional health disparities, it has also brought to light areas which lack essential social and community infrastructure to create social capital and build resilience – as set out in the All-Party Parliamentary Group on Left Behind Neighbourhoods (Dec 2020).

The survey conducted as part of this report appears to confirm this. A sample of 2500 (Sept 2021, UK wide) were surveyed to understand the impact of the pandemic on people's social relationships, volunteering activity, health and wellbeing. The survey found a stark difference in findings between the 10% least deprived communities versus the 10% most deprived. Those living in the 10% most deprived areas reported that they:

- **had fewer 'people to call when they want company'**
- **were less likely to talk with neighbours**
- **were 'often/always/sometimes' lonely**
- **had 'much worse' mental and physical health compared to a year ago.**

However, those who volunteered (n=408) compared to those who did not volunteer had statistically significant higher scores on:

- **talking with neighbours**
- **socialising with others**
- **gaining confidence in socialising with others since the start of the pandemic**
- **and had better mental and physical health, and general wellbeing.**

These results can't be explained by these volunteers being in better health and/or living in the least deprived areas; this sample had equal numbers of volunteers across deprived areas and over one in three surveyed (33%) stated they had an underlying health condition.

EXECUTIVE SUMMARY (CONTINUED)

The data leads us to the central question in this report - ***"Could volunteering be mobilised as a way to help reduce health and social inequalities seen in deprived communities in the post-pandemic period?"***

Given the evidence, we believe volunteering could have a fundamental role to play in these communities and the government's "levelling up" agenda by increasing social capital, connecting communities and helping to reduce some of the inequalities exacerbated by the pandemic.

We put forward a number of recommendations based on the evidence from this report:

1

Recognise volunteering as a public health intervention

The evidence linking good quality social relationships and volunteering to disease and longevity is compelling. It can no longer be ignored or considered 'a nice to have' but appears critical to individual and community health outcomes.

2

Develop partnerships between the business, public and voluntary sectors

Maximising the benefits of volunteering will require not only volunteer-involving organisations but businesses and public sector bodies working together. Supporting volunteering (and hence a thriving civil society) is not just the remit of the voluntary sector – it is critical to a well-functioning public and corporate sector; as the evidence demonstrates the benefits are played forward in terms of better population health and wellbeing, and hence economic productivity.

3

Focus on those areas with an underdeveloped volunteering infrastructure

As the research in this report has highlighted, in a similar way to how health inequalities were exposed during the pandemic, so too were differences in geographical areas in terms of their social infrastructure and resilience. These areas should be prioritised as we look towards recovery. The difference in charity funding, and hence charitable activity are all issues which can be addressed if we work together.

4

Build volunteering into the levelling up agenda

The evidence we presented makes a very compelling case for the power of social relationships (and hence volunteering) to address health disparities. However, health disparities are complex and multifaceted. As the government looks to develop the levelling up agenda and ahead to the publication of the Levelling Up White Paper, we need to ensure the focus of this agenda goes beyond a single focus on economic productivity. A cross-government and cross-sector strategy and approach on levelling up is needed, if we truly want to build back better and ultimately fairer.

1.0 THE POWER OF STRONG SOCIAL CONNECTIONS AND COMMUNITIES

The relationships that we have with others, our family, friends and people in the community are hugely important for our wellbeing. Having the support of people around helps us to cope with difficulties in our life and feeling loved and cared for helps us to feel happy and improves our wellbeing. In fact, when we ask people what things are most important for their happiness and wellbeing, having good social relationships is always near the top of the list.

However, there is also an increasing amount of research showing us that having good social relationships not only makes us happier, but it could also help make us healthier. There is evidence showing that when we have poor social relationships, this could potentially increase our risk of developing both physical and mental health problems. We have set out the existing medical evidence in a supplementary paper to this report – see *The link between social relationships with health and wellbeing – a review of the literature.*

The importance that social relationships have for keeping us healthy and happy seems to have become magnified during the pandemic – more people in the UK have reported feeling lonely and socially isolated during the pandemic than ever before; and rates of loneliness continue to be higher than pre-pandemic levels (ONS, 22nd Sept to 3rd Oct survey, 2021).

The pandemic has also emphasised existing differences in health – there are some groups in society for whom we see persistently poorer physical and mental health, commonly referred to as "health inequalities" or "health disparities" – and some of these same groups seem to have also been disproportionately impacted by the pandemic in terms of their social relationships – as you will see in the survey we conducted in section 3.0.

The government has urged us to "build back better" but they focus mostly on financial aspects of building back. Like Marmot's (2020) report, we feel we also need to 'build back fairer'. We believe that the post-pandemic recovery period represents an important time for us to think about addressing the issues that the pandemic has highlighted in terms of health inequalities and social relationships. Therefore, we ask the question, ***"Could volunteering be mobilised as a way to help reduce health and social inequalities seen in deprived communities in the post-pandemic period?"***

2.0 EXPLORING WHY RESEARCHERS THINK SOCIAL RELATIONSHIPS INFLUENCE OUR HEALTH – A SUMMARY

The literature review attached to this report collates the academic and medical evidence – from the past 10 years – related to social relationships and physical and mental health. The review explores **what** the medical research tells us about social relationships and the link to health outcomes and critically, **why** social connections are having this impact on our health outcomes. This section provides a very short summary of this literature.

In our literature review we outline how different social relationships are linked to some different physical and mental health issues. To summarise **what** we found in the literature:

- Poor social relationships are linked to a higher risk of developing **cardiovascular disease**.
- Poor social relationships are linked to greater levels of **cognitive decline** and a greater risk of **dementia**, whereas having good social relationships is linked to a lower risk of cognitive decline and dementia.
- Poor social relationships are linked to a greater risk of experiencing future **common mental illnesses** (particularly depression), whereas good social relationships can lower people's risk of developing common mental illnesses.
- Poorer social relationships are linked to a greater risk of **suicide** and **mortality**.

But, **why** are social connections having this impact on our health outcomes? This is explained in the text and diagram below.

While it is possible that social relationships could directly impact health, a lot of theories propose that this is probably an indirect relationship (i.e. social relationships influence something which then goes on to impact health). There are a variety of reasons that we think poor social relationships could indirectly impact health and these can be broadly thought of as biological, behavioural, psychological, and stress-related.

Biological explanations propose that poor social relationships might influence our biology. There is evidence to show that poor social relationships are linked to **increased bodily inflammation, increased blood pressure and increased blood sugar levels**. These are all biological issues that put us at a higher risk of developing a lot of physical (and sometimes mental) health issues.

Behavioural explanations suggest that poor social relationships are linked to health behaviours. People with poor social relationships have been shown to have **poorer quality sleep** and **to be more physically inactive**. It has also been suggested that we might be drawn to and

influenced by the health behaviours of others. So if other people we have relationships with also have poor health behaviours, we are more likely to also have those same health behaviours. When we have poorer sleep and are less physically active we have a higher risk of both physical (and sometimes mental) health issues.

Psychological explanations suggest that our social relationships impact how we feel. People with poorer social relationships can have poorer psychological wellbeing, have lower life satisfaction and a greater likelihood of experiencing common mental illness. There is a lot of evidence that shows us that when we are unhappy or experiencing mental illness, this can affect us biologically, behaviourally and can also affect our long-term health (for example, people who have depression have a greater risk of many of the physical health issues that we see are linked to poor social relationships).

Stress-related explanations propose that having poor social relationships could be a source of stress for us. **Stress is also linked to poorer psychological wellbeing and worsened health behaviours and it changes our bodies' biology in a way that is harmful for our long-term physical and mental health**. Interestingly, when we have good social relationships, this has been proposed to help buffer the effect of stress on us – such that our friends and family help us to cope with stressful life events. When we lack those relationships we don't have people who can help us cope with difficulties in our life.

It is also worth considering why people with good social relationships might have a lower risk of developing health issues. We can link into many of the same pathways. For example, good social relationships can help maintain our health by:

- Making us feel happy and improve our life satisfaction.
- Helping us to cope with the impact of stressful life events, so that the biological-psychological-behavioural response to stress is dampened.
- Having a direct biological impact so that we have lower levels of bodily inflammation and stress hormones.

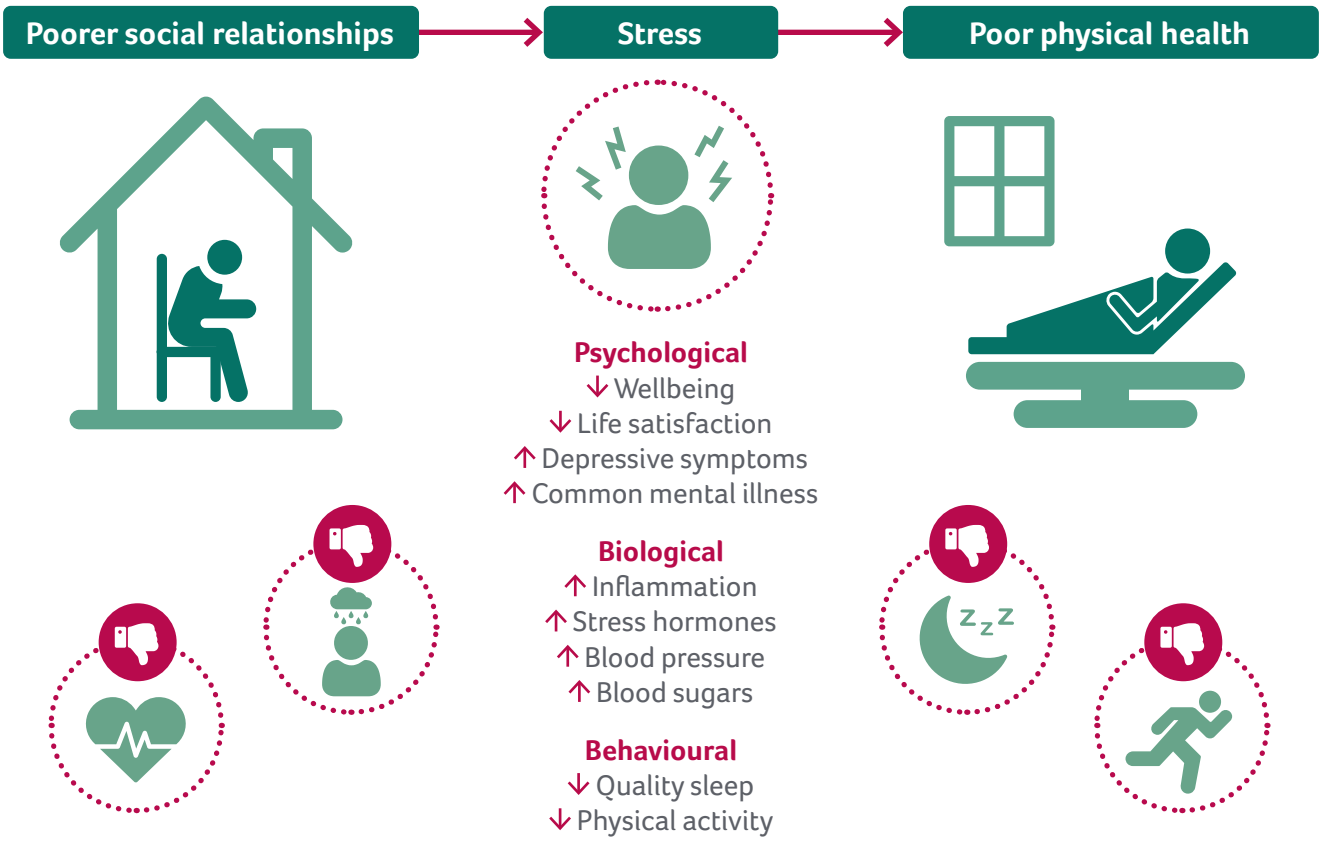


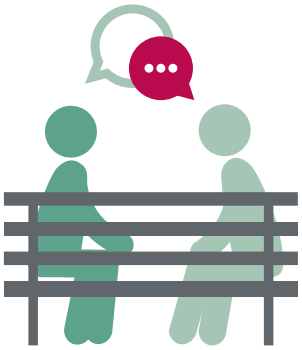
Diagram A: Why people with poorer social relationships may have worsened health

3.0 LOOKING AT HOW THE PANDEMIC HAS IMPACTED OUR SOCIAL RELATIONSHIPS AND HEALTH

The past 20 months has undoubtedly taken its toll on our health given the restrictions on our ability to connect with others. Research from the Office of National Statistics – Social Impacts of Covid surveys (April 2020-ongoing) - suggests that personal reported wellbeing and loneliness remain worse than pre-pandemic levels (15th Oct 2021 publication).

But, research has also shown that those people who connected more with others during the pandemic – for example through volunteering – weathered the pandemic much better. The London School of Economics' report *'Happy to Help: The Welfare effects of nationwide micro-volunteering programme'* (April 2021, n~9000) found that volunteering was a driver for statistically significantly higher wellbeing scores, as well as greater feelings of social connectedness and belonging to a neighbourhood compared to those who did not volunteer and that this 'wellbeing effect' lasted for a minimum of three months (see Dolan et al 2021). In addition, the analysis found that tasks that had a greater social component – e.g. Check In and Chat welfare calls – had much higher impact on wellbeing scores.

To better understand how the pandemic has impacted our social relationships, volunteering activity, health and wellbeing, Royal Voluntary Service (Sept 2021) undertook a survey of individuals living across a range of deprived neighbourhoods in England, Scotland, Wales and Northern Ireland. Through an online survey of 2500 individuals (18 years and over) we wanted to look at differences in experience of those living in more affluent neighbourhoods compared to those living in the most deprived. The survey aimed to understand levels of socialisation and perceived health and wellbeing across a range of deprived areas – from least to most deprived; the data presented below is predominantly the findings from the **10% most deprived** areas to **10% least deprived** because these appeared to provide the starkest contrast. (To note: those in bold are statistically significant.)



Social relationships

Those living in the most deprived areas report more frequent social contact with family and friends, but are less likely to feel they have people to call on when they want company, less likely to talk with neighbours, have lost confidence in socialising with others, and also report higher levels of loneliness.

The survey asked participants: **how often do you meet up in person with family members or friends?** Those in the 10% most deprived areas reported having greater contact with people outside their household compared to people in the least deprived areas.

Meet up in person with family members or friends - at least once a day, 2-3 times a week, or once a week		
	10% most deprived	10% least deprived
Now	64%	53%

However, there is a marked difference in respect to the question: **To what extent do you or do you not have people to call on if you want company or to socialise?**

Those in the most deprived areas felt there were fewer people they could call on if they wanted company.

People to call on if I want company?		
	10% most deprived	10% least deprived
Lots / Some	61%	72%
Not many/none	36%	27%

Those living in the most deprived areas were more likely than people in less deprived areas to report that they **never chatted to neighbours or had no neighbours** – 16% stated that they never chat with their neighbour/had no neighbour compared to 8% in the least deprived areas.

When compared to people living in the least deprived areas, those people living in the most deprived areas are more likely to endorse the following reasons for not speaking to their neighbours:

- **Don't trust/get on with neighbours** (12% most deprived vs. 5% least deprived)
- **Being new to the area** (9% most deprived vs. 3% least deprived)
- **People just don't speak to one another** (18% most deprived vs. 10% least deprived)

The survey also asked participants: **To what extent have you lost or gained confidence socialising with others since the start of the pandemic?** Interestingly, there was no difference across the areas – in total 34% stated they had lost confidence versus 8% stating they had gained confidence. This indicates there might be some work to do across areas to boost confidence levels.

Those living in the 10% most deprived areas also reported higher rates of 'always or sometimes' feeling lonely; over 1 in 3 people in the most deprived areas of the country feel lonely versus 1 in 5 from the least deprived areas. By way of comparison the Office of National Statistics (Social Impacts of Covid-19 survey 10th Sept and 24th Sept) found approx. 1 in 4 (25%) report often/always/sometimes being lonely.

How often do you feel lonely?		
	10% most deprived	10% least deprived
Often/always/some of the time	**34%**	**21%**
Occasionally	**23%**	**26%**
Hardly ever/never	**42%**	**52%**

Health and Wellbeing

Those living in the most deprived areas also feel that their mental and physical health is 'much worse' compared to a year ago.

The survey asked a series of questions about health and wellbeing - **to what extent do you feel that each of the following aspects of your health is better or worse than it was 12 months ago?**

Those living in the most deprived areas report poorer physical and mental health than those living in the least deprived areas. The impact of general wellbeing is slightly poorer in the most deprived areas, however this is not statistically significant. This might reflect the wider wellbeing impacts of the pandemic across the population – as captured in the ONS Social Impacts of Covid survey series (April 2020-ongoing).

Better or worse than 12 months ago?		
	10% most deprived	10% least deprived
Mental		
Much worse	11%	5%
Much better	5%	5%
Physical		
Much worse	9%	4%
Much better	4%	6%
General wellbeing		
Much worse	6%	4%
Much better	4%	7%

The power of volunteering

For those that volunteered, this appeared to be linked to better wellbeing and health.

In total 408 of the 2500 sample stated that they had volunteered in the past 12 months. Those who volunteered had statistically significant higher scores on questions of socialisation with others, mental and physical health, and general wellbeing.

It should be noted that the findings are not the result of the sample being healthier or more affluent, and hence more positive findings; 33% - over one in three of those surveyed – of the sample stated they had an underlying health condition and there were equal numbers of volunteers across all areas – from most to least deprived areas. This suggests that volunteering might be a protective factor.

Question	All Data: volunteers vs non-volunteers	Most deprived (50%) by those who volunteer (n~200) vs non-volunteers
On average, how often do you chat to your neighbours, more than to just say hello?	**65%** (volunteers) stated they had a chat with their neighbour most days or once or twice a week versus **45%** (non-volunteers)	**65%** (volunteers) stated they had a chat with their neighbour most days or once or twice a week versus **42%** (non-volunteers)
To what extent do you socialise now more or less than before the pandemic?	**17%** (volunteers) stated they socialise 'much more/a bit more' versus **8%** (non-volunteers)	**19%** (volunteers) stated they socialise 'much/a bit more' versus **7%** (non-volunteers)
To what extent have you lost or gained confidence socialising with others since the start of the pandemic?	**15%** (volunteers) stated that they had 'gained confidence socialising with others' since the start of the pandemic versus **6%** (non-volunteers).	**14%** (volunteers) stated that they had 'gained confidence socialising with others' since the start of the pandemic versus **7%** (non-volunteers)
To what extent do you feel that each of the following aspects of your health is better or worse than it was 12 months ago? • **Mental** • **Physical** • **General wellbeing**	**20%** (volunteers) felt their mental health was better versus **11%** (non-volunteers) **25%** (volunteers) felt their physical health was better versus **15%** (non-volunteers) **21%** (volunteers) felt their general wellbeing was better versus **13%** (non-volunteers)	**21%** (volunteers) felt their mental health was better versus **13%** (non-volunteers) **28%** (volunteers) felt their physical health was better versus **14%** (non-volunteers) **23%** (volunteers) felt their general wellbeing was better versus **13%** (non-volunteers)

The protective properties of volunteering have also been found in other research conducted during the pandemic. Findings from the interim report by Belong and University of Kent (2021) found that people who volunteered were protected from some of the worse effects of the pandemic compared to others (non-volunteers):

They reported greater connection with family and friends (10.5% higher on average), greater general political trust (10.6% higher), a greater sense of neighbourliness (16.5% higher) and were less likely to perceive their local area as deprived (6.5% lower). They also expressed greater trust in other people (to respect COVID-19 restrictions; 12.2% higher), higher subjective wellbeing (5.3% higher) and greater optimism for the future (5.6% higher). (p6)

Whilst this survey can't conclusively claim that volunteering is causally driving improved levels of socialisation, health and wellbeing, we know from the London School of Economics report (2021), cited above, that a causal relationship between volunteering as a driver for wellbeing has been found.

4.0 POST PANDEMIC RECOVERY – "BUILDING BACK FAIRER"

In 2010 Professor Sir Michael Marmot published *Fair Society Healthy Lives*, which was a forensic examination of the evidence around health inequalities and the social determinants of health in the UK.

Within Marmot's report a strong case is made for the importance of social and community capital, and health outcomes:

[Social capital] provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental wellbeing, and through the networks that help people find work, or get through economic and other material difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial wellbeing and, as a result, to other health outcomes. (Marmot, 2010, pg 34)

The importance of social and community capital became highly relevant in the pandemic – when our social movements and social contacts were restricted, our immediate communities became the epicentre of our daily lives. In the short-term the pandemic brought us together – irrespective of age, ethnicity, health and geographical area; however few of us anticipated the longevity of the pandemic and in a similar way that health inequalities were exposed so too were differences in geographical areas in terms of their 'community strength' and social infrastructure.

The Belong and University of Kent research (two year study from May 2020) is examining how the pandemic has affected social relationships and trust across six areas. Their interim report (Dec 2020) found that those areas that had strong levels of social cohesion (pre-pandemic) fared better (Blackburn with Darwen, Bradford, Calderdale, Peterborough, Walsall, and Waltham Forest); even as the pandemic persisted these areas still continued to show a strong sense of neighbourliness and active levels of social engagement/volunteering compared to others.

Similar analysis of the NHS Volunteer Responder programme (Dec 2020, unpublished) found that while all communities stepped forward at the start of the pandemic (March, April, May) the length of the pandemic appears to have disadvantaged some areas. Those communities with higher levels of deprivation had greater declines in volunteer activity starting from mid-May 2020 but the needs of the community increased (e.g. rise in requests/referrals for support).

This in part might reflect the lack of social investment and infrastructure in some areas as highlighted in the All-Party Parliamentary Group (APPG) on Left Behind neighbourhoods. The APPG Communities report (Dec 2020) highlighted 225 'left behind areas' – typically the 10% most deprived neighbourhoods according to the Index of Multiple Deprivation (IMD); in these areas charitable funding and access to charitable support was much lower than other areas. They found that left behind areas had some of the lowest levels of charitable funding - £21,182 per 100k population (left behind areas) compared with £50,054 (other deprived areas) and £60,312 (wider England). These areas also had lower levels of mutual aid activity during the pandemic – 3.5 groups per 100k population compared with 7.7 (other deprived areas) and 10.6 (wider England).

As we look ahead to rebuilding, we must not forget about the important protective role communities have played during this pandemic. As the government looks to develop its levelling up agenda, those communities which lack critical community assets should be at the heart of their activities given the link to health outcomes, and hence economic productivity.

5.0 RECOMMENDATIONS

This leads us onto the main question for this report: "**Could volunteering be mobilised as a way to help reduce health and social inequalities seen in deprived communities in the post-pandemic period?**"

Given the evidence, we believe volunteering could have a fundamental role to play in these communities and the Government's Levelling Up agenda by increasing social capital, connecting communities and helping to reduce some of the inequalities exacerbated by the pandemic.

We put forward a number of recommendations based on the evidence from this report:

1

Recognise volunteering as a public health intervention

The evidence linking good quality social relationships and volunteering to disease prevention and longevity is compelling. It is can no longer be ignored or considered 'a nice to have' but appears critical to individual and community health outcomes. Primary Care Networks (PCNs) and social prescribing link workers could play a vital role here. These provide critical touch points for local residents and are trusted agents; volunteering could be used as a social prescription in its own right to drive better public health.

Also, we know from the 12.4 million that stepped forward in the pandemic (Together report 2020) – that the public has a significant appetite to support their neighbours and the local health & care system. At a strategic level, volunteering needs to be built into systems and plans (e.g. Integrated Care Systems (ICSs)) and the forthcoming social care white papers. Volunteering has double health benefits in that by helping others in need, we are also helping ourselves.

2

Develop partnerships between the business, public and voluntary sectors

Maximising the benefits of volunteering will require not only volunteer-involving organisations but businesses and public sector bodies working together. For example, the NHS Volunteer Responders programme demonstrated what could be achieved when different sector partners come together - government (NHS England), a charity (Royal Voluntary Service) and a tech social enterprise (GoodSAM) - to mobilise over 750,000 in support of the NHS at a time of greatest need. The public sector and businesses can play a bigger role in supporting their own employees to meaningfully participate in civic life. This will have health and wellbeing/morale benefits for their staff, but will also strengthen the communities they serve.

However, employee volunteering needs more ambition than it has currently. Supporting volunteering (and hence a thriving civil society) is not just the remit of the voluntary sector – it is critical to a well-functioning public and corporate sector; as the evidence demonstrates the benefits are played forward in terms of better population health and wellbeing, and hence economic productivity.

5.0 RECOMMENDATIONS (CONTINUED)

3

Focus on those areas with an underdeveloped volunteering infrastructure

As the research in this report has highlighted, in a similar way to how health inequalities were exposed during the pandemic, so too were differences in geographical areas in terms of their social infrastructure and resilience. Investing in the social and community infrastructure of these areas should be central to the Government's levelling up agenda and white paper and be a focus in the updated version of the National Resilience Strategy.

The difference in charity funding, and hence charitable activity, are all issues which can be addressed if we work together. A potential vehicle for some of this work is 'Shaping the Future with Volunteering' - launched in June 2021 – a group of 24 national volunteer involving charities. The group has a joint commitment around greater inclusion by working across all communities in the UK to ensure the benefits of volunteering are more equally enjoyed. In partnership with government, this group has the scale and reach to help create and transform the social fabric of these communities.

4

Building volunteering into the levelling up agenda

The evidence we presented makes a very compelling case for the power of social relationships (and hence volunteering) to address health disparities. However, we would be remiss if we didn't flag issues of *intersectionality;* this describes the intersection of multiple social determinants of health (e.g. the intersection of minority ethnic background, low paid jobs and living in a deprived neighbourhood is linked to poorer health). It is important to think about intersectionality because this is proposed to be one of the possible reasons why attempts to address health inequalities may not have worked (Holman et al., 2021).

Our focus should be on addressing single issues, rather than acknowledging that people often experience multiple and intersecting issues. As the government looks to develop the levelling up agenda and ahead to the publication of the Levelling Up White Paper, we need to ensure the focus of this agenda goes beyond a single focus on economic productivity. A cross-government and cross-sector strategy and approach on levelling up is needed, if we truly want to build back better and ultimately fairer.

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OUR VOLUNTEERS PROVIDE PRACTICAL SUPPORT AND VITAL COMPANIONSHIP TO HELP PEOPLE GET THE BEST OUT OF LIFE.

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