INTERIM REPORT

Building Back Fairer in Cheshire and Merseyside: Evidence for action and key approaches

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CONTENTS

1 INTRODUCTION

In 2021 the Institute of Health Equity (IHE) was commissioned by the Population Health Board of the Cheshire and Merseyside Health and Care Partnership (HCP) to support work to reduce health inequalities through action on the social determinants of health and to Build Back Fairer from COVID-19. IHE will provide added focus and priority to existing work on health inequalities in the Region and develop new momentum and recommendations for effective action in the context of the COVID-19 pandemic.

Specifically, the ambition is to:

- Provide an overview of inequalities in health and the social determinants of health including the impacts of COVID-19 infection, mortality and impacts of containment measures.
- Develop tools and strategies to place health inequalities and the social determinants of health at the centre of the Health and Care Partnership (HCP).
- Make recommendations for mechanisms to facilitate strong partnerships with stakeholders on the social determinants of health
- Develop an indicator set for monitoring inequalities in health and the social determinants of health.
- Ensure that health inequalities are prioritised by the Population Health Board, Local Authorities, and the HCP.

This report is the first output of IHE's work in Cheshire and Merseyside and sets out inequalities in health and the social determinants of health and the impacts of the COVID-19 pandemic on health inequalities and in the social determinants. It assesses the role of austerity policies between 2010-20 in driving these inequalities and the impacts of the COVID-19 pandemic. The report highlights existing and developing actions and partnerships currently addressing health inequalities. There are proposed further actions for consideration by various stakeholders and between October to December 2021 we will consult with local areas and other stakeholders in the Region on these developing approaches, and in subsequent months we will refine and redevelop recommendations and activities to prioritise the approaches outlined.

The actions for consideration are not the sole responsibility of the NHS and will have resonance for a wide range of stakeholders across Cheshire and Merseyside. Effective action on health inequalities and inequalities in the social determinants requires concerted action between the NHS, local authorities, businesses, public services, the voluntary, community, and faith (VCF) sector and communities themselves. Aligning different sectors and organisations' priorities, budgets, levers, and incentives is an essential next step for Cheshire and Merseyside's HCP and there is great ambition to achieve this. The development of the Integrated Care System in Cheshire and Merseyside provides an opportunity to forge a system which generates greater health equity in the Region based on partnerships with other sectors.

The Population Health Board, the Cheshire and Merseyside Health and Care Partnership and each of Cheshire and Merseyside's nine boroughs are involved in the work. Each area is refining their Place Based Plan to address inequalities and indicators to monitor health inequalities and the key social determinants of health. Each plan will involve the Local Authority, local NHS Trusts and Clinical Commissioning Groups (currently amalgamating into one place NHS), the VCF sector, public services, businesses, academic institutions, and citizens.

In addition to the nine place plans, there will be a Cheshire and Merseyside Strategy, which will be developed by Champs Public Health Collaborative from the recommendations made in the final IHE report for strategic action to improve population health and address inequalities in the social determinants of health across Cheshire and Merseyside.

2 CHESHIRE AND MERSEYSIDE PRE-PANDEMIC

The Cheshire and Merseyside region is home to over two and a half million people across nine boroughs. There are nine 'Places' coterminous with individual local authority boundaries, 19 NHS Provider Trusts and 51 Primary Care Networks, Figure 1.

Figure 1. Cheshire and Merseyside HCP

Local Council leaders and Health and Wellbeing Chairs have stated structural reforms during the public health emergency 'were a distraction' but nonetheless they all agree that "Addressing health inequality at place should be a central guiding principle of the ICS, and all its decisions should be measured against that principle" (1).

2A EMPLOYMENT AND FUNDING

Austerity policies during the decade 2010-2020 in England are associated with worse health and widening health inequalities. Across England, life expectancy stopped increasing and for those outside London and in more deprived areas, life expectancy actually declined and regional inequalities widened. This was the context in which the COVID-19 pandemic arrived which further damaged health and has led to declining life expectancy across England, set out in section 3.

The Marmot report *Ten Years On* showed health inequalities widened between 2010 and 2020, that improvements in life expectancy had stopped. We showed this likely related to policies of austerity, including deteriorating quality of work, stagnating wages, public service and benefit cuts, cuts to local authority funding and declining investments in deprived communities (2). The cumulative effects of national policy and funding decisions in the decade 2010-20 harmed health and widened health inequalities.

SHORT AND LONG-TERM EFFECTS OF CUTS

Funding cuts reduce costs in the short term, but evidence is showing these cuts to local authorities are increasing demand on the NHS. As adult social care budgets decreased the average number of annual accident and emergency visits for a person aged 65 and above increased by almost a third between 2009–10 and 2017–18 and researchers state public spending cuts to social care explain between a quarter and a half of this growth. The increased pressures on A&E departments were most pronounced among older people and those living in the most deprived areas (3).

Researchers have also examined how funding reductions in more deprived areas have affected life expectancy. The estimate funding cuts increased the gap in life expectancy between the most and least deprived areas by 3% for men and 4% for women between 2013 and 2017. They estimate an additional 9600 deaths in people younger than 75 years old occurred and suggest the causes could be attributed to decreased spending in adult social care, housing and homelessness prevention, and environmental and regulatory services (4). Analysis of funding cuts in health and social between 2010-11 and 2014-15 estimate these cuts will have caused 57,500 additional deaths in England (5). In addition to life expectancy falling, healthy life expectancy is falling, between 2014/2016 and 2017/19 in England, men lost 1.6 months in healthy life expectancy and women lost 3.5 months (6).

A systematic review of the effects of social security policies in high-income countries found reducing eligibility/generosity, policies associated with austerity, were related to worse mental health, and tended to increase health inequalities (7). The closure of Sure Start centres has been found to affect levels of obesity and hospital admissions. Between 2010/2011–2017/2018 in England, the prevalence of childhood obesity increased more in areas that experienced greater cuts to spending on Sure Start. For each 10% spending cut, a 0.34% relative increase in obesity prevalence was associated in the following year, with an estimated additional 4,575 children who were obese and 9,174 children who were overweight or obese (8). The Institute for Fiscal Studies found more than 13,000 hospital admissions of children a year were prevented by Sure Start centres and that children in the most deprived neighbourhoods had the highest effects (9).

In October 2021 the budget and spending review committed 1.25% of National Insurance Contributions to the new Health and Social Care Levy which will fund increases to the budget of the Department of Health and Social Care. Whilst this is welcome, the increase in funding is inadequate to breadth of cuts and combat the continuing rise of inequality and damage done by a decade of austerity.

CUTS TO LOCAL AUTHORITY FUNDING

A marked feature of the decade 2010-20 was steep and inequitable cuts to local authorities. The Local Government Association estimate a £5 billion shortfall in funding by 2024 for councils to maintain current services in England (10). IHE's 2020 report '*Ten Years On*' showed local authority expenditure per person was lower in the most deprived local authorities and in the North of England (2). In England the North West region had the highest level of funding shortfall for councils in 2020– 21 at £227.8 million, compared to £20.1 million in the West Midlands (11). Prior to the pandemic, due to the reductions in core funding, local governments in England were estimated to face a funding gap of £6.5 billion by 2024/25 (12). Central government funding to help local authorities manage the increased pressures has not been adequate and instead most local authorities in England are further in debt than before the pandemic. Local authorities are being forced to make further cuts in 2021/22 and even with these cuts, local authorities predict a £3bn shortfall in their budgets by 2023-24 (13).

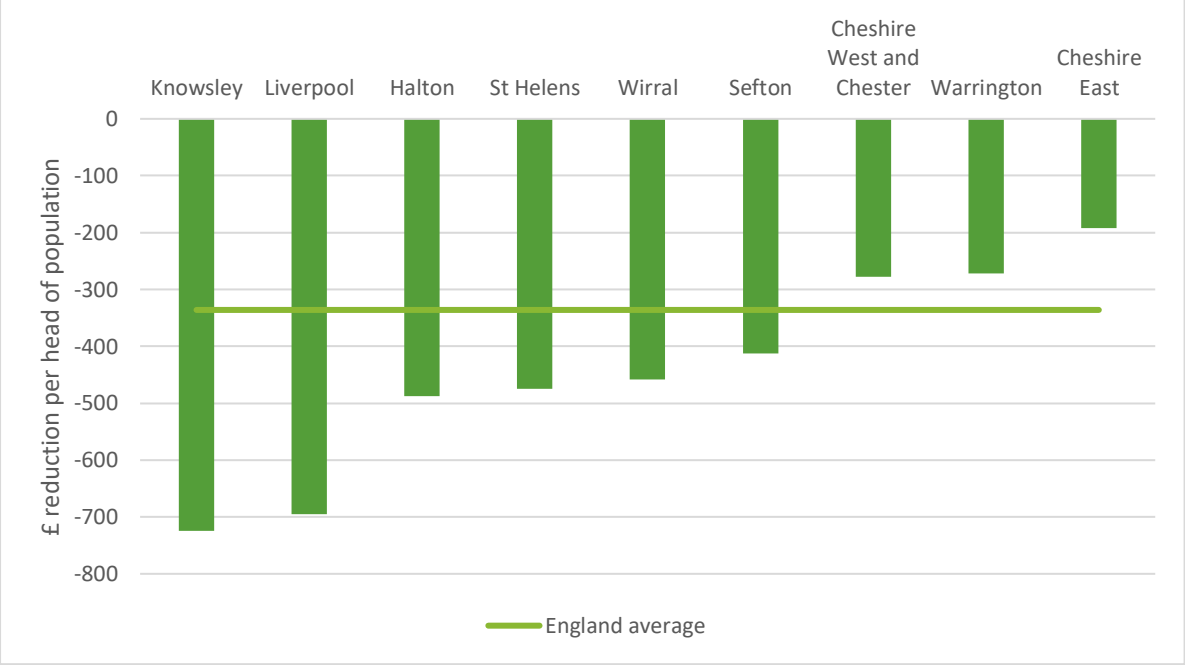
Figure 2 shows local authority cuts between 2010 and 2020, reduced spending in every aspect of council services, except child social care, though increased demands eliminated the increased funding.

Figure 2. Net spending per person by local authority service 2009/10 and 2019/20, England

*Note: * Services such as council tax administration and corporate services*
Source: IFS calculations of Ministry of Housing, Communities and Local Government data (14)

On a per capita basis, between 2010 and 2018, Liverpool had the largest cut of any city with a population over 250,000, equating to a fall in funding of £816 for every resident in the city (15)[1]. Examining the nine boroughs within Cheshire and Merseyside shows Knowsley, the most deprived local authority in the HCP, had the highest spending cuts, £725 per head of population, Figure 3.

Figure 3. Change in local authority spending power (real terms), 2010-2018, Cheshire and Merseyside and England, per head of population



Source: Ministry of Housing, Communities & Local Government (16)

[1] This figure is from the Centre for Cities report which uses 'Primary Urban Areas' – the built-up areas of cities, not individual local authority districts or combined authorities.

Cheshire West and Chester has lost more than £330 million in funding from central government; Warrington has lost £173 million since 2010 (17), (18). Since 2010 the Revenue grant to Cheshire East reduced by 36% and Sefton Borough Council has had cuts to its budget of £115 million (real terms).

LOCAL AUTHORITIES AND FUNDING FROM OTHER SOURCES

In areas such as Knowsley, and in other Northern cities, there are high levels of deprivation, more homes in lower Council Tax bands and as a result, less income from residents. Prior to 2010 the funding formula for local areas reflected this inequality, however in 2010 this protection was changed, leading to decreased incomes for these areas and increased dependence on central government funding.

With all local authorities affected by reduced incomes as a result of the pandemic, from, for example, reduced income from business rates, leisure facilities and car parking, those in the most deprived areas will be affected more, as their funding was lower, per capita, before the pandemic. Additionally, central government has shifted from providing longer term funding to one-off (and often ring-fenced) grants. One quarter of all grants available to local governments are worth less than £1 million, and one-third last a year (19). Spending on prevention is a long-term commitment, short-term, one-off grants are the antithesis of the type of longer-term funding needed to address prevention and reduce health inequalities. The Chartered Institute of Public Finance and Accountancy stated these short-term grants 'has reduced the ability for joined-up planning' (20).

VOLUNTARY, COMMUNITY AND FAITH SECTOR

Community, voluntary and faith groups, and organisations play a vital role in supporting community resources and health and wellbeing at the local level. The *10 Years On* report showed the cuts to local authorities have resulted in significant cuts to the community and voluntary sector (21). In the UK around 10% of charities state they may not survive beyond 2021 (22). In January 2021 Cheshire and Warrington community and voluntary groups reported a 16% drop in income and one in four charities in the area were uncertain that they will survive beyond 2021

Pro Bono Economics predicted in 2021 one in ten UK charities will face bankruptcy with smaller charities, the vast majority of charities in the North West, expected to fare worse (23) (24). Merseyside has 807 'micro' charities, with a turnover of less than £10,000, and 919 'small' charities with a turnover of between £10,000 and £100,000. Micro and small charities make up 66% of all charities in the area. 51% of charities polled in Liverpool in October stated they would no longer be sustainable within a year. 70% of charity chief executives said they had seen a serious drop in income as a result of the pandemic and 68% said demand for their services had increased (25).

Nottingham Trent and Sheffield Hallam Universities with the National Council for Voluntary Organisations have measured the impact of COVID-19 in ten waves of surveys since September 2020. In September 2020 56% of voluntary organisations reported an increasing demand for services, rising to 69% in August 2021 (26).

FUNDING CUTS: EDUCATION AND YOUTH SERVICES

In addition to cuts to local government spending, there were cuts to a range of public services - all of which affect health outcomes and harm more deprived and excluded communities the most. Between 2009/10 and 2019/20, school spending per pupil fell by 9% in real terms in England, with schools in deprived areas experiencing the deepest cuts per pupil. Announcements of funding increases in 2020 are estimated to return spending to 2009/10 levels (27).

Cuts between 2010 and 2020 also reduced the number and capacity of children and youth services, police services and the voluntary sector and spending on prevention (28). Between 2009/10 and 20019/20, funding for youth services in the UK fell by 66%, and between 2012 and 2016, more than 600 youth centres and nearly 139,000 youth service places closed (29) (30). In 2009 Liverpool City Council employed 110 youth workers and in 2019, they employed 26 and the budget reduced by more than two-

thirds (31). Warrington's budget for youth services fell from £3.4 million in 2010/11 to £668,000 in 2019/20 (32).

FUNDING CUTS: POLICING AND LEGAL SERVICES

Across England and Wales spending on police services fell by 16% between 2009/10 and 2018/19 (24). In 2019 Cheshire's Police and Crime Commissioner and chief constable stated that cuts to public services, including policing were impacting on the number of violent crimes in Cheshire and stated 135 police officers were lost between 2010 and 2019 (25). In Merseyside, the Police and Crime Commissioner stated between 2010 and 2021 they have 1,110 fewer police officers (26). These cuts affect community safety and sense of belonging in local areas. Similarly, cuts to legal aid also influence feelings of community safety and a sense of social justice and fairness.

In Merseyside, the Violence Reduction Partnership is adopting a public health approach to address the roots causes of violence, Box 1.

Box 1. Merseyside Violence Reduction Partnership (MVRP)

The Merseyside Violence Reduction Partnership (MVRP) has a public health approach to violence reduction. The MVRP strategy has a strong emphasis on addressing the root causes of serious violence and endorsing factors that promote against and mitigate the impacts of violence. Preventing adverse childhood experiences (ACEs) and developing trauma-informed approaches are key aspects of the MVRP strategy. In 2020/21 over 22,000 young people benefitted from MVRP interventions and over 3000 of these were potential high risk.

The MVRP support and deliver a wide range of interventions around prevention, early, therapeutic and desistence, whilst also focusing on primary, secondary, and tertiary. MVRP aims are divided into key areas including: early help; early years; speech and language therapy and readiness for school; targeted interventions (with at risk young people); youth diversion and mentoring and local education initiatives.

The MVRP believe that violence is preventable. By understanding the drivers behind crime, the risk of offending can be reduced and therefore the number of victims will be reduced. To achieve this the MVRP believe multiagency public health approach is essential and this underpins MVRP activities.

A newly formed Evidence Hub will ensure that all MVRP activities are targeted and with appropriate monitoring and evaluation processes in place for all activities, both for internal performance monitoring and external evaluation of MVRP funded interventions. This includes the use of the MVRP commissioned Data Hub, developed by the Trauma and Injury Intelligence Group (TIIG) based at the Public Health Institute, Liverpool John Moores University (LJMU).

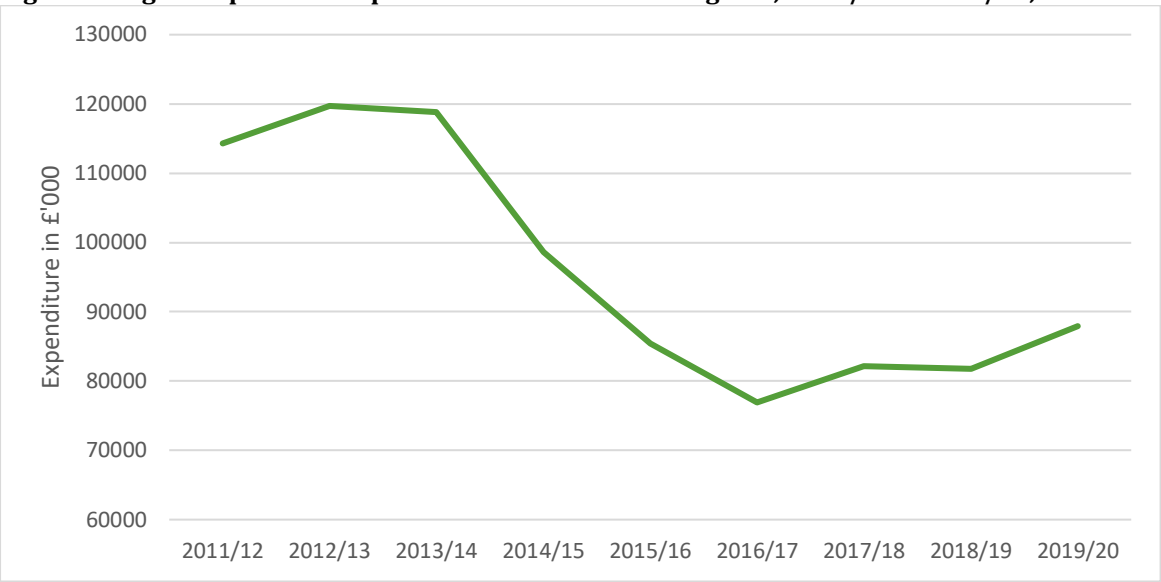
One of MVRP's programmes is the **Mentors in Violence Prevention Program** which incorporates five core components (explore violence through a gendered lens, developing leadership, adopting a bystander approach, recognising the scope of violent behaviour and challenge victim blaming). It supports a whole school approach to early intervention and prevention of bullying, harassment, and risky behaviours, empowers pupils to identify and communicate concerns with peers and school staff alike.

MVRP developed additional guidance for schools to when considering **permanent exclusion** and making this crucial decision about the direction of a child's life can take when considering permanent exclusion. By highlighting the principles, consequences and identifying local level support, MVRP sees this guidance as a valuable tool to assist schools when undertaking the difficult decision of considering exclusion.

The **VRP 'Destinations Directory'** targets young people aged 16-25 years looking for training, education, and employment opportunities. It also connects them with housing providers for any accommodation needs. The Department for Work and Pensions have promoted the directory to all staff in job centres across Merseyside. The County Football Association have also publicised the VRP Destinations Directory within their social media platforms and the Combined Authority have also utilised this directory to support the establishment of Youth Employment Hubs.

Between 2010/11 and 2017/18 there was a 37% decrease in legal aid spending and between 2009 and 2019 there was a 40% decrease in funding for Law Centres (36). Figure 4 shows there was a 23% decline in legal aid provider offices, reflecting the decline in legal aid providers across England and Wales. These cuts affect a number of social determinants of health, importantly, income. The Department of Work and Pensions face a number of legal cases appealing decisions to deny various benefits, most of these cases are funded by legal aid and many have proved to be successful (37). In September 2021 a freedom of information request revealed seven in 10 cases arguing decisions to deny disability benefits were successful (38)

Figure 4. Legal aid provider expenditure in North West England, 2011/12 – 2019/20, £'000

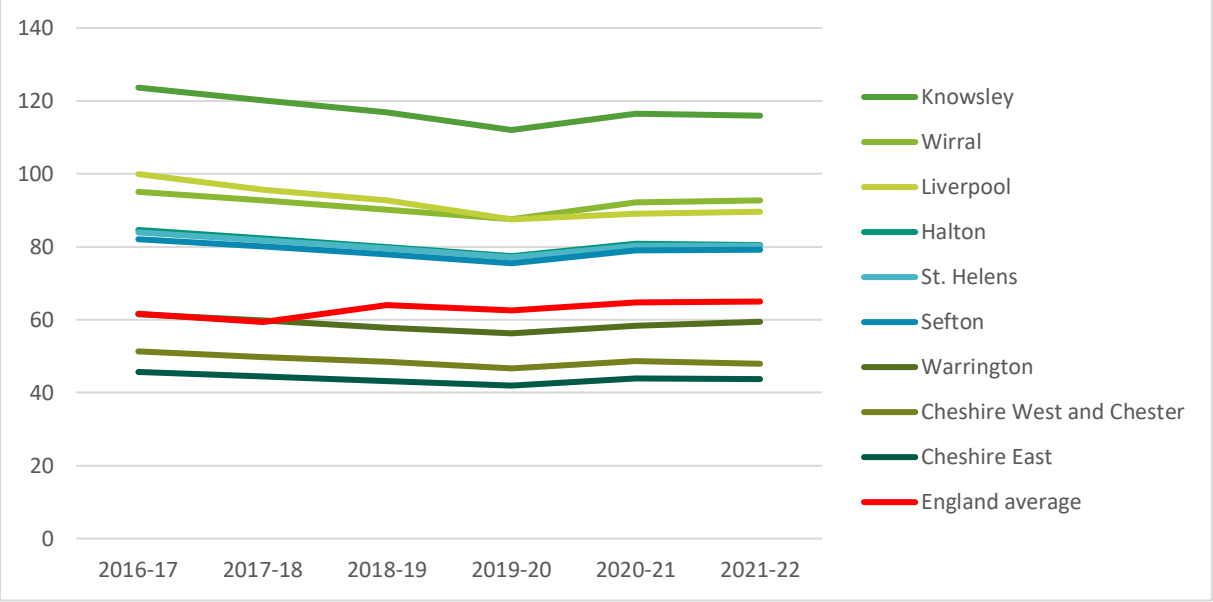


Source: Bolt Burdon Kemp (39)

THE PUBLIC HEALTH GRANT

The public health grant had already declined significantly before the pandemic. Nationally, in 2015/16 the grant was £4.2bn and had fallen to £3.3 bn in 2021/22. Figure 5 shows that whilst the England spending per head of population increased slightly, from £62 in 2016/17 rising to £65 in 2021/22, in all areas of Cheshire and Merseyside, spending per head declined.

Figure 5. Public health local authority allocations (£/person), Cheshire and Merseyside, 2016/17-2021–22



Source: Department of Health and Social Care (40)

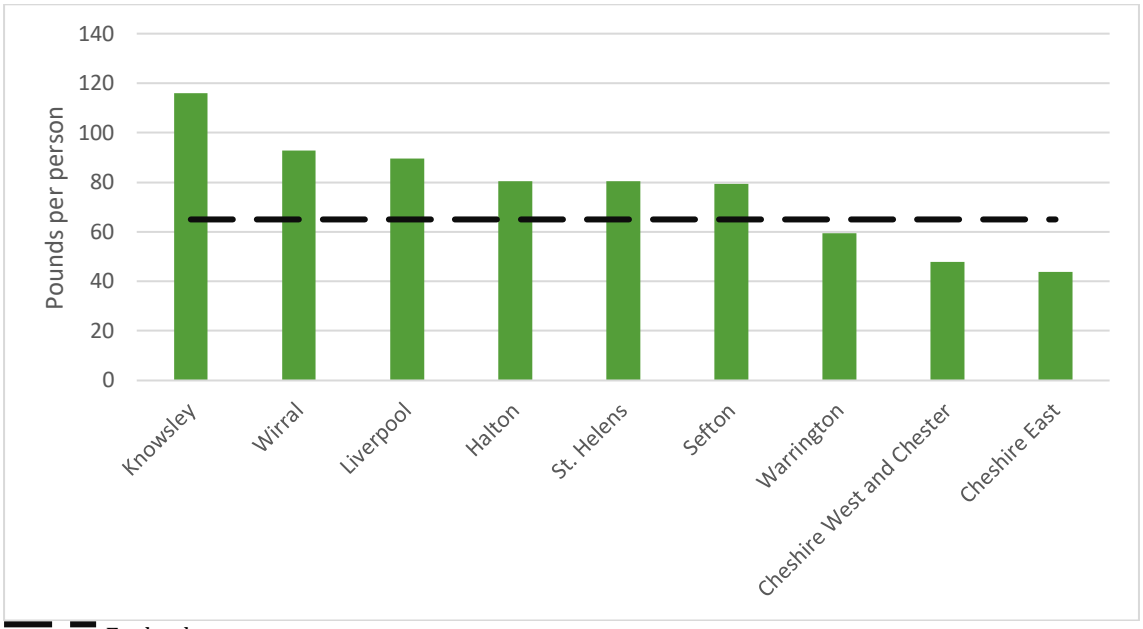
In 2016 the British Medical Association warned cuts to public health would have significant effects:

> *"cuts to the public health grant will inevitably lead to service reduction and will, in the longer term, result in greater costs for both the NHS and the taxpayer. While it is too early to assess the impact of these cuts, there is evidence that local authorities are disinvesting in areas such as prevention, addiction services, sexual health, and weight management"* (41).

These predictions have come to fruition. Public health funding is not sufficient in light of the extensive cuts to local authority budgets and the 24 percent decrease in real terms public health funding that has been experienced since 2015/16 (42) (43).

Despite the increased workloads and responsibilities for more than a year due to COVID-19 pandemic, the grant increased by only £45 million in 2020/21 (43). Figure 6 outlines the allocations for 2021/22 in Cheshire and Merseyside. Due to high levels of deprivation, Liverpool City Region local authorities receive a higher per head allocation compared to the England average.

Figure 6. Public health local authority allocations (£/person), Cheshire and Merseyside, 2021–2022



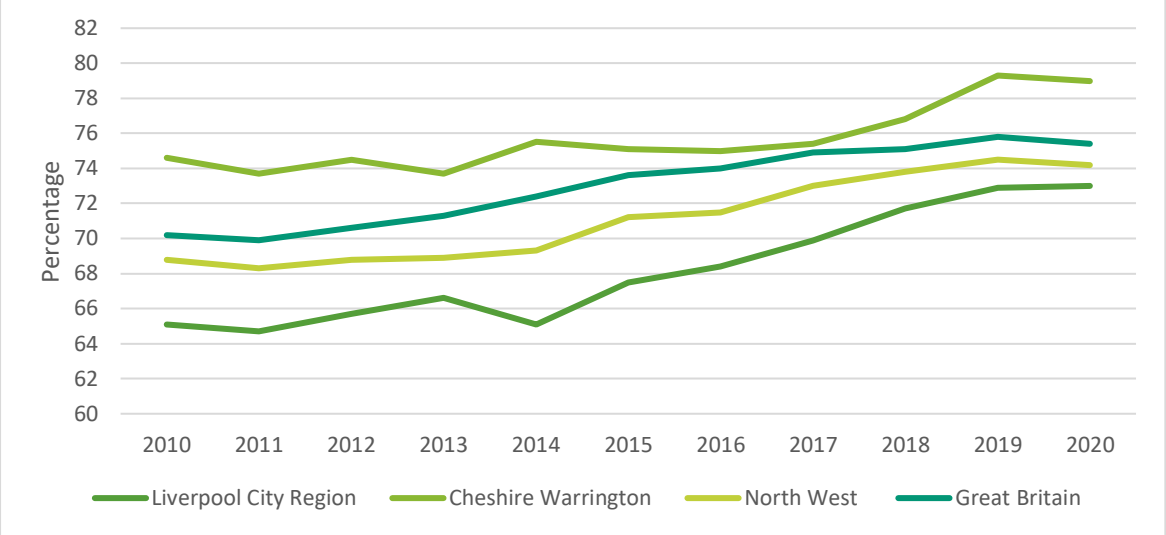
Source: Department of Health and Social Care (44)

In October 2021 the budget and spending review committed 1.25% of National Insurance Contributions to the new Health and Social Care Levy which will fund increases to the budget of the Department of Health and Social Care. Whilst this is welcome, the increase in funding is inadequate to breadth of cuts and combat the continuing rise of inequality and damage done by a decade of austerity. It is also important to ensure that the increase is committed to prevention and reducing inequality.

EMPLOYMENT

Whilst official unemployment figures show declining unemployment in the Region, research shows these figures underestimate the reality of unemployment. In 2017 OECD estimated if Liverpool's figures included those who are economically inactive its unemployment rate was 19.8%, as opposed to the official rate, which was just below 6% (4). Figure 7 shows that in the last decade, the percentage of the population who are economically active has increased in Liverpool City Region, but they are still below the regional and England averages. In Cheshire and Warrington a higher percentage of the population are economically active than average for Great Britain and the North West, but this masks significant inequalities within those areas.

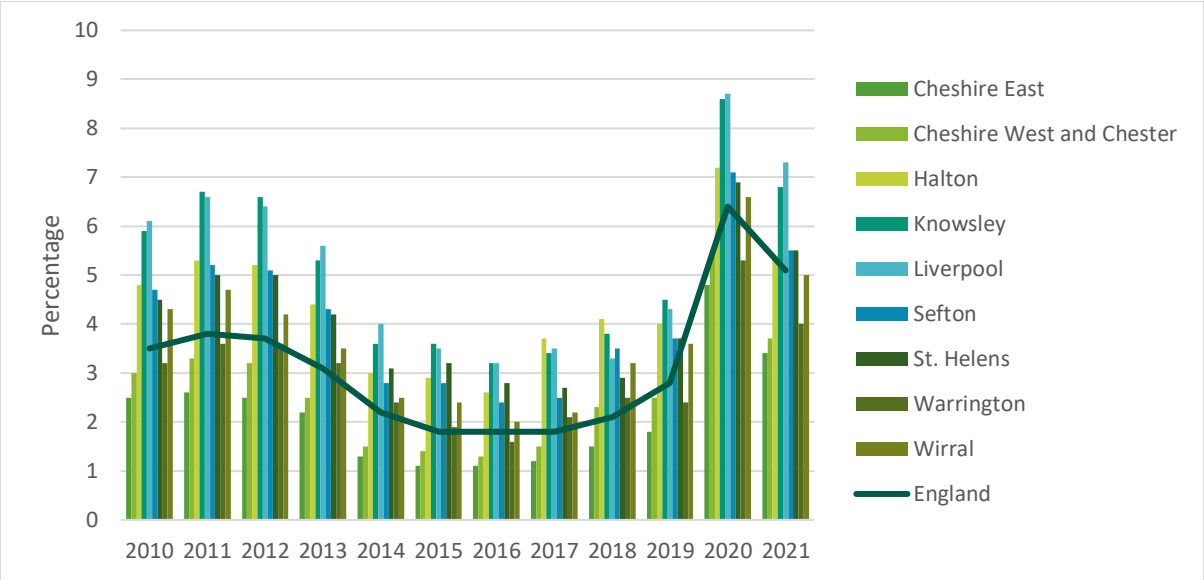
Figure 7. Economically active population,16-64 yrs, percentage 2010-2020, Liverpool City Region, Cheshire Warrington, North West, and England



Source: ONS (46)

On the whole, Cheshire and Warrington have faired better than the Liverpool City Region, with lower unemployment rates compared to the Great Britain average. Nonetheless, the claimant count, though low compared to Merseyside, more than doubled between 2004 and 2008/9, due to the financial crisis in 2008/9 (47). The effects of the financial crisis continued until 2013 as the percentage of claimants remained high, however the numbers declined slightly between 2013-2018, then began to rise again in 2019, before the pandemic, Figure 8.

Figure 8. Claimants as a proportion of residents aged 16-64, 2010-2021 (September), Cheshire and Merseyside and England, percentage



Source: ONS (48)

LEVELLING UP?

The 'Levelling Up agenda' needs to be oriented around reducing regional inequalities in health and the social determinants and focussed on levelling up between those more deprived and those least deprived – raising and flattening the social class gradient in health. As well as the unequal impacts of COVID-19, we

have set out how policies of austerity harmed the health and lives of those living in regions outside London and those in more deprived communities the most (2), (49).

Recent government declarations have stated 'austerity is over' (50), (51) however, as we stated in our *10 Years On* report:

> *'It is not enough for the Government simply to declare that austerity is over. Actions are needed in the social determinants to improve the lives people are able to lead and hence achieve a greater degree of health equity and better health and wellbeing for all.'* (21)

The government's 'Levelling Up' strategy still lacks clarity. In July 2021 MPs concluded 'it has yet to be defined beyond its aim of 'improving everyday life and life chances' (52). In May 2021 the Public Services Committee criticised the government for its Levelling up plans, warning "'left behind' places will be "short-changed" and inequality will grow if money for the NHS, schools and councils is not protected and 'levelling up' plans are not better targeted" (53). There are also concerns that the lack of transparency in the Levelling Up fund may contribute to rural areas of poverty missing out on funding (54). The Health Foundation state the role of local government and the NHS is unclear and 'underplayed' in helping to level up (55).

In September 2021 49% of poll respondents in the North West stated they were 'not confident at all' that their area will be levelled up, compared to 42% in the UK (56). Cuts continue in local governments, in October 2020 Cheshire West and Chester Council stated it faced a budget shortfall of between £34 million and £43 million, depending on what national funding becomes available (57).

In March 2021 the Liverpool City Region Combined Authority reported it had received an initial £4 billion from the Levelling Up Fund for England for the years 2024-25 (58). Academics from the University of Liverpool have shown that the UK Shared Prosperity Fund', does not match the EU funding previously available to these areas and the lack of transparency in awarding Ministry of Housing Communities and Local Government funding (59).

3 INEQUALITIES IN HEALTH AND THE SOCIAL DETERMINANTS IN CHESHIRE AND MERSEYSIDE

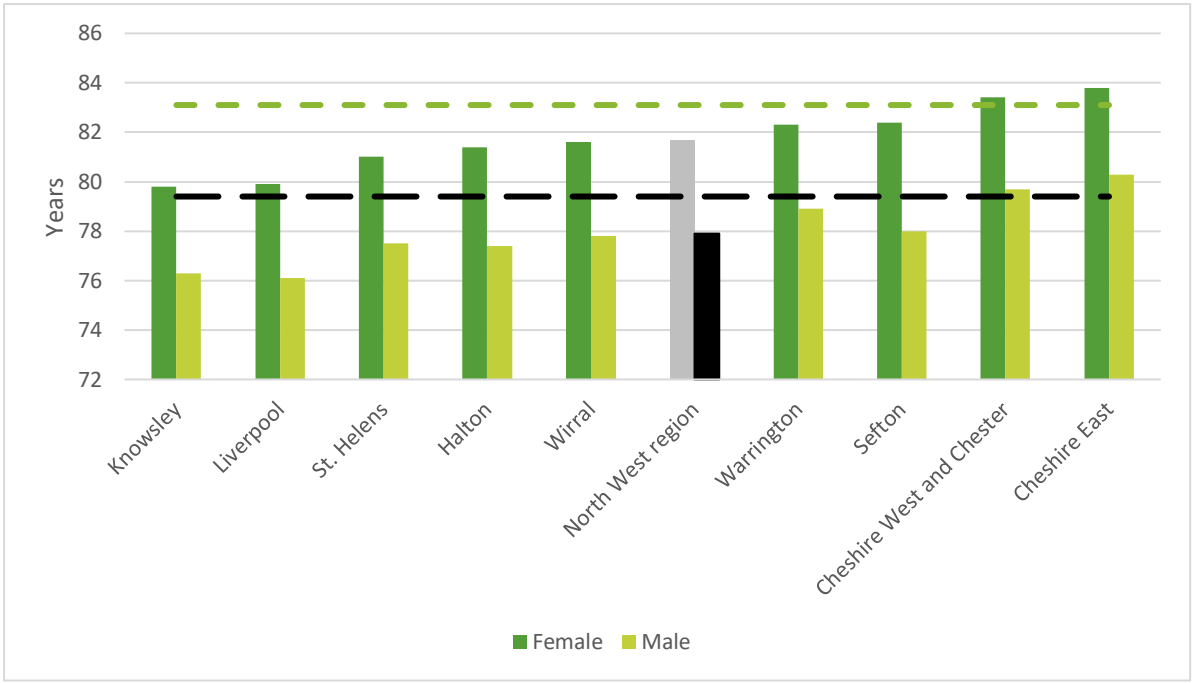
There are longstanding inequalities in health in Cheshire and Merseyside, as in the rest of England, although health outcomes are lower in this Region than the national average and health inequalities are wider. Within each of the nine boroughs of Cheshire and Merseyside, there are pockets of deprivation.

3A LIFE EXPECTANCY

Within Cheshire and Merseyside the health inequalities are stark; women living in the least deprived areas live 12 years longer than those in the most deprived areas, for men, the difference is 13 years. Life expectancy for women in Cheshire and Merseyside was 82.7 in 2018-20 , lower than the average for England, 83.1 years. For men in Cheshire and Merseyside, the average life expectancy of 78 years was also lower than the England average 79.4 years. Figure 9 shows Cheshire East and Cheshire West and Chester are the only boroughs with longer life expectancy than the national average for women. In men, Cheshire East and Cheshire West and Chester have longer life expectancy than the national average.

In the North West region, life expectancy at birth for men is 78.4 years and for women, 82.1 years, again, Cheshire East, Cheshire West and Chester and Sefton perform better than the North West average, as well as Warrington and Wirral.

Figure 9. Estimated male and female life expectancy at birth, 2018–2020, Cheshire and Merseyside boroughs, North West, and England



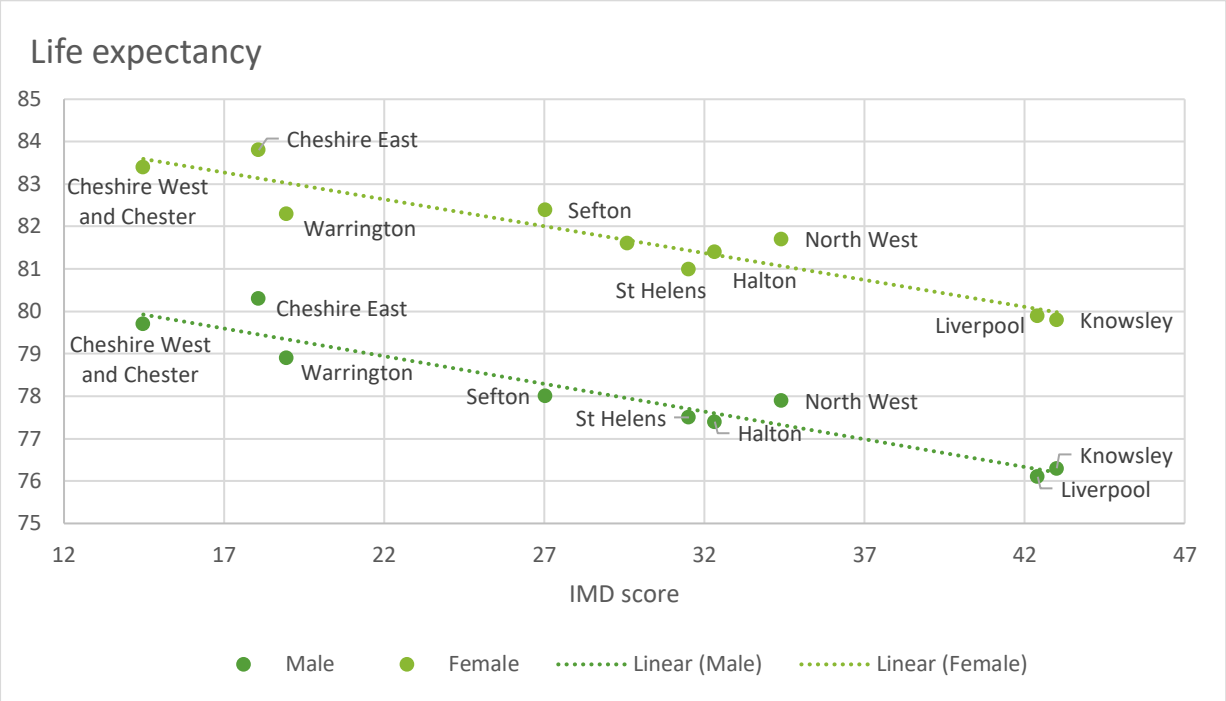
Female England average
Male England average

Source: Office for National Statistics (ONS). Life expectancy estimates by sex, age and area, 2017-19 (60).

Our *Ten Years On* review showed increases in life expectancy had slowed since 2010 and the slowdown was greatest in more deprived areas of England (2). Publishable life expectancy data for local areas is not yet available. National data shows life expectancy in England had its largest single year drop since records were first collected in 1981. In England, life expectancy in 2020 fell by 1.3 years for men and 0.9 years for women and inequalities in life expectancy also widened considerably. The gap in male life expectancy between the most and least deprived areas in England increased by a year between 2019 and 2020, rising to 10.3 years, for women, the gap increased by 0.6 years, rising to 8.3 years in 2020 (61).

In Cheshire and Merseyside, as elsewhere, average life expectancy is related to level of deprivation, as shown in Figure 10. The graded relationship with deprivation is remarkably similar to that seen in England as a whole, the higher the level of deprivation the lower life expectancy.

Figure 10. Male and female life expectancy at birth (2018–20) and average score in the Index for Multiple Deprivation (IMD) (2019), Cheshire and Merseyside boroughs

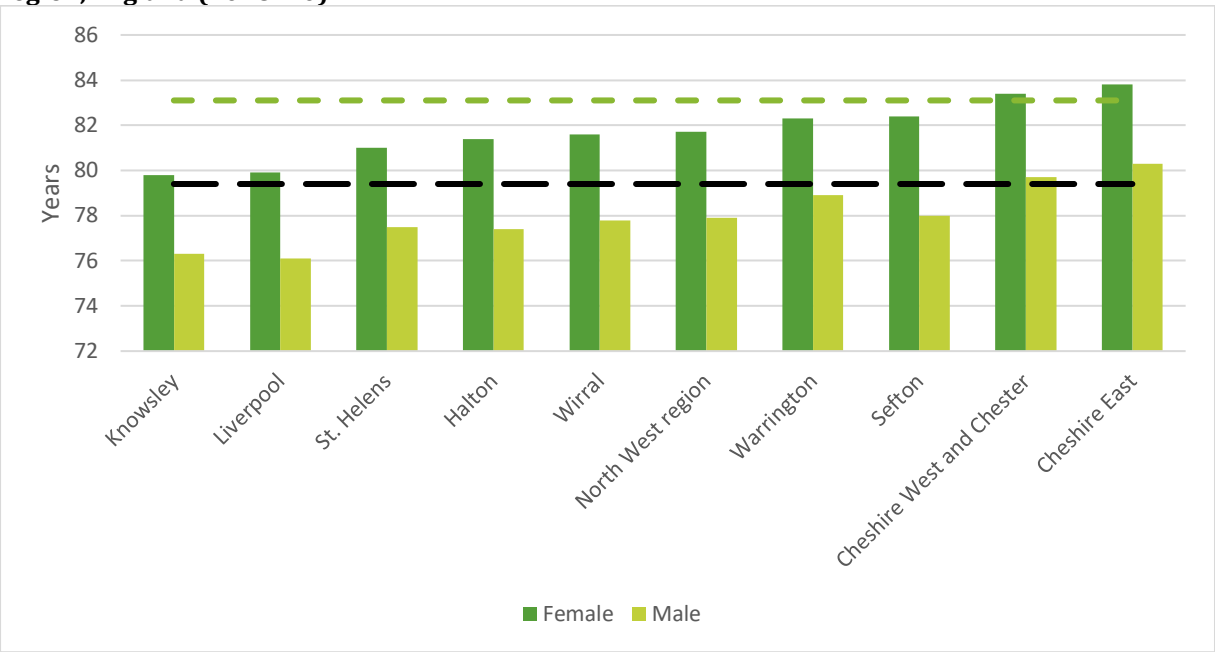


Source: ONS. Life expectancy estimates by sex, age and area, 2018-20 (60)

HEALTHY LIFE EXPECTANCY

Healthy life expectancy is the average number of years an individual is expected to live in a state of self-assessed good or very good health and provides evidence of the increased impact of inequalities on health and social care systems. Figure 11 shows women in Halton and Liverpool boroughs are six years below the national healthy life expectancy average, in St. Helens and Knowsley they are five years below. Men in St Helens, Halton, Knowsley, Liverpool, and Wirral boroughs are also below the healthy life expectancy national average.

Figure 11. Female and male healthy life expectancy at birth, Cheshire and Merseyside, North West region, England (2018–20)

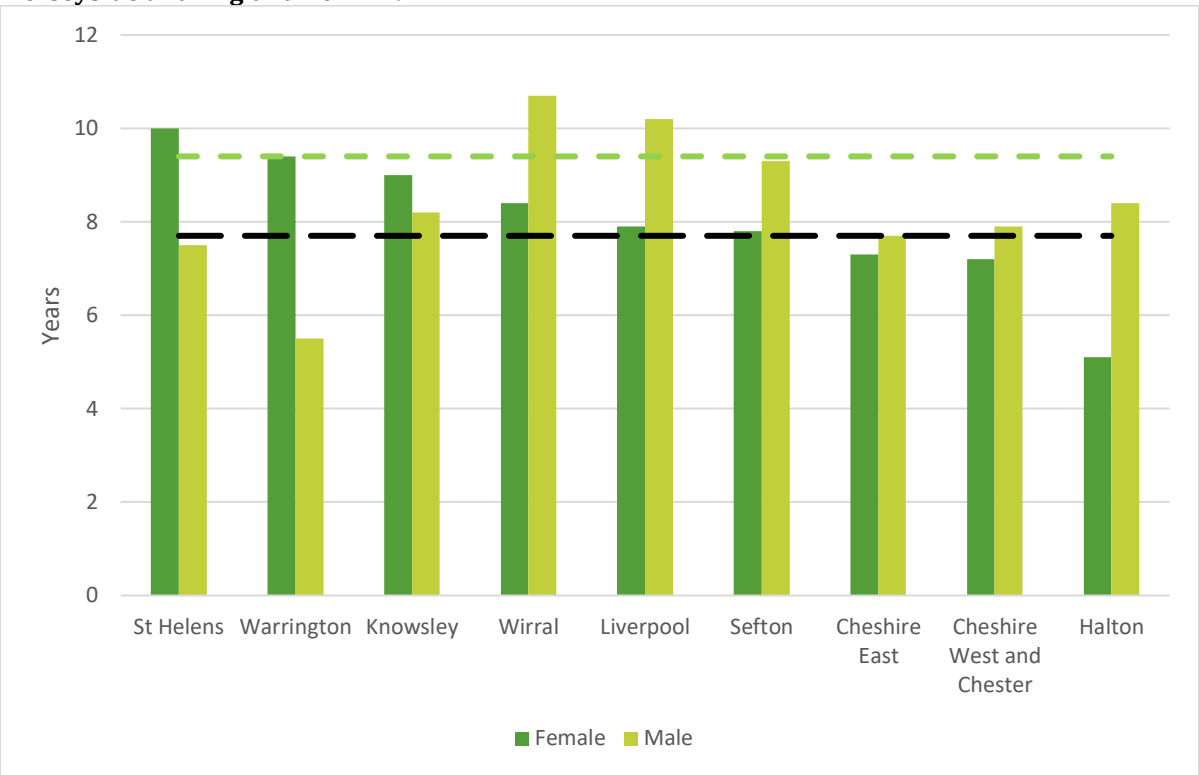


Female England average
Male England average

Source: ONS (6)

The system wide inequalities mask the steep inequalities within each borough, there is a ten-year gap in life expectancy within some local authorities, meaning the most deprived are living more than 10 years less than those in the least deprived areas. In the Wirral, with a population under 350,000 and measuring 60 square miles, men in the most deprived quintiles live 10.7 years less than men in the least deprived quintiles. In St. Helens, 53 square miles and a population of just over 180,000, women in the most deprived quintiles live 10 years less than women in the least deprived quintiles. Figure 12 shows six of the nine boroughs in Cheshire and Merseyside (St Helens, Warrington, Knowsley, Wirral, Liverpool, Sefton) there are wider gaps in life expectancy for women whilst three areas (Wirral, Liverpool, and Sefton) have larger internal gaps in life expectancy in males than the England average. Overall, inequalities in life expectancy are wider in Cheshire and Merseyside than they are in England. Women living in the least deprived areas live 12 years longer than those in the most deprived areas, for men, the difference is 13 years.

Figure 12. Gap in life expectancy between most and least deprived quintile (years), Cheshire and Merseyside and England 2017-19



Source: ONS (6)

Within the Region there are inequalities related specifically to place. The most recent Chief Medical Officer's report analysed health in coastal communities, such as Sefton, with its 22 miles of coastline. The report describes a 'coastal effect' on health, mainly caused by preventable diseases and higher levels of deprivation compared to non-coastal areas (62).

To better understand the pressures on Cheshire and Merseyside's population health, they have commissioned data experts to analyse their existing population, Box 2.

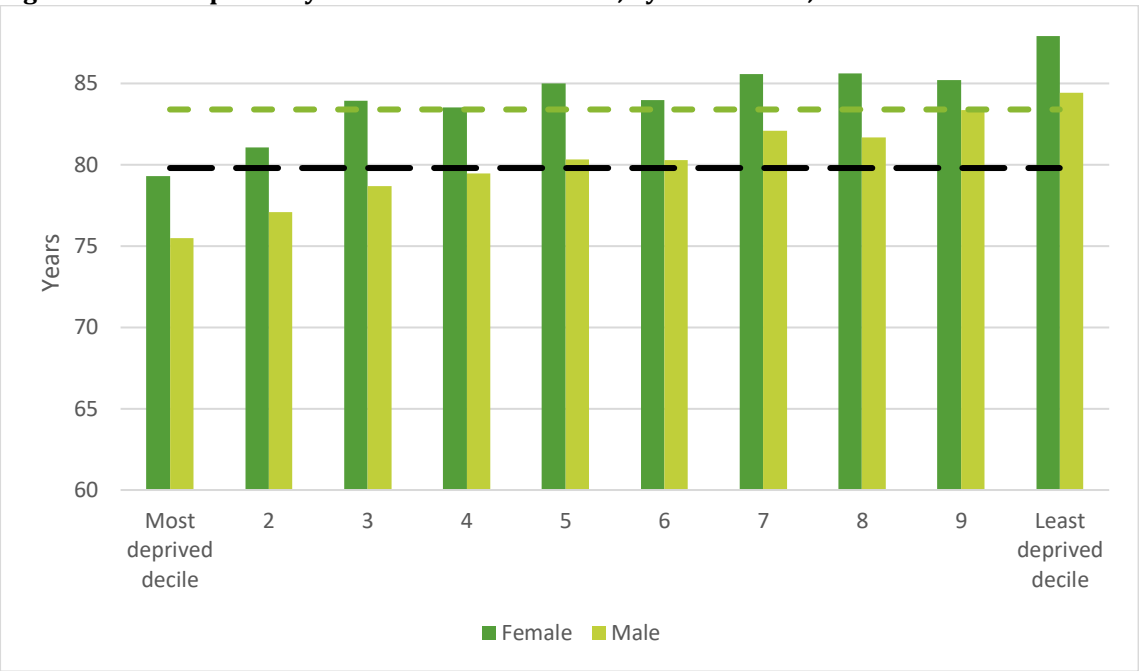
Box 2. "System P"

Cheshire and Merseyside are developing the System P programme to facilitate population health management at place level. System P is currently in pilot stage and aims to provide places with additional analytical capacity to segment the population and identify how to redesign services to shift from a treatment to prevention model. Data and analytics will aim to provide insight and inform future plans to influence change in care and payment models at both place and ICS level. The System P programme will aim to foster collaborative relationships between the NHS and, local authority partners to support integrated healthcare delivery and investment of NHS resources in primary and secondary prevention.

Cheshire East

With a population of 386,000, in 2018-20 life expectancy at birth for women in Cheshire East was 83.8 years, 0.7 years above the England average. For men it was 80.3 years, 0.9 years above the England average. Inequalities in life expectancy in Cheshire East are evident, Figure 13 shows in 2017-2019 there was an 8.6 year gap for women in life expectancy between the most and least deprived deciles in Cheshire East, 9 years for men.

Figure 13. Life expectancy at birth in Cheshire East, by IMD deciles, 2017-2019

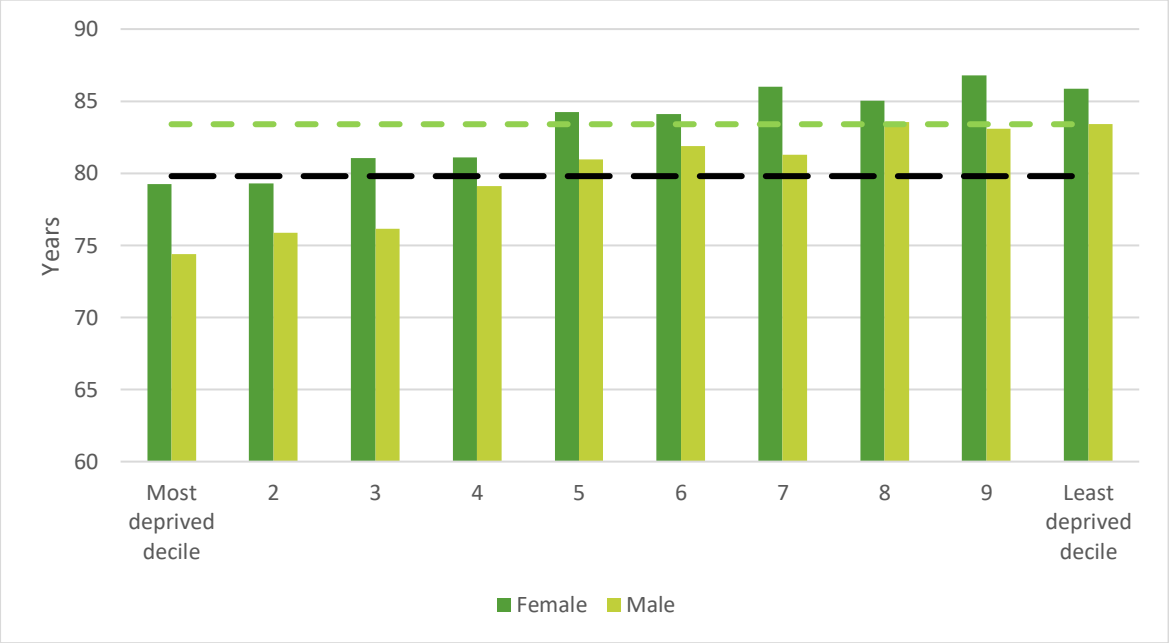


Female England average
Male England average
Source: PHE Fingertips (63)

Cheshire West and Chester

With a population of 343,000, in 2018-20 life expectancy at birth for women in Cheshire West and Chester was 83.4 years, 0.3 years above the England average. For men it was 79.7 years, 0.3 years above the England average. Inequalities in life expectancy in Cheshire West and Chester are evident, Figure 14 shows in 2017-2019 there was a 6.6 year gap for women in life expectancy between the most and least deprived deciles in Cheshire West and Chester, 9 years for men.

Figure 14. Life expectancy at birth in Cheshire West, by IMD deciles, 2017-2019

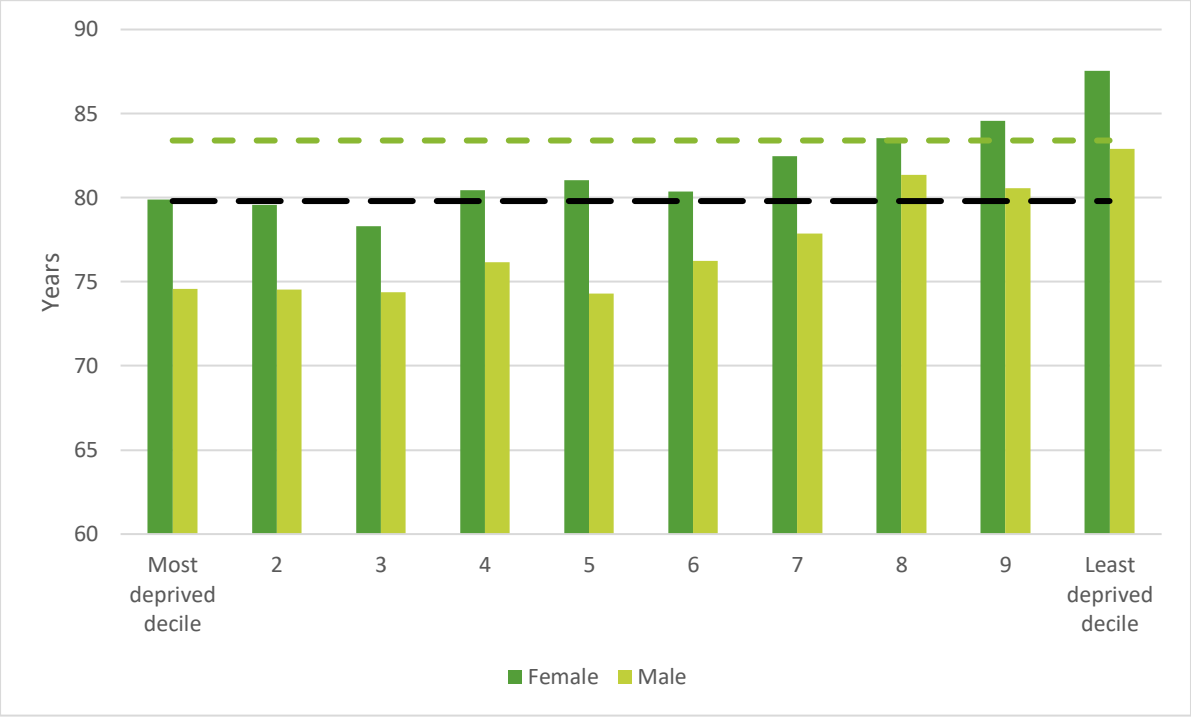


Female England average
Male England average
Source: PHE Fingertips (63)

Halton

With a population of 129,000, in 2018-20 life expectancy at birth for women in Halton was 81.4 years, 1.7 years below the England average. For men it was 77.4 years, 2 years below the England average. In addition, inequalities in life expectancy in Halton are evident, Figure 15 shows in 2017-2019 there was a 7.7 year gap for women in life expectancy between the most and least deprived deciles in Halton, 8.3 years for men. The life expectancy gap between the most deprived and least deprived ward is: 13.7 years for men and 9.3 years for women: Halton Lea vs Birchfield. Half of Halton's residents live in areas among the 20% most deprived in England.

Figure 15. Life expectancy at birth in Halton, by IMD deciles, 2017-2019

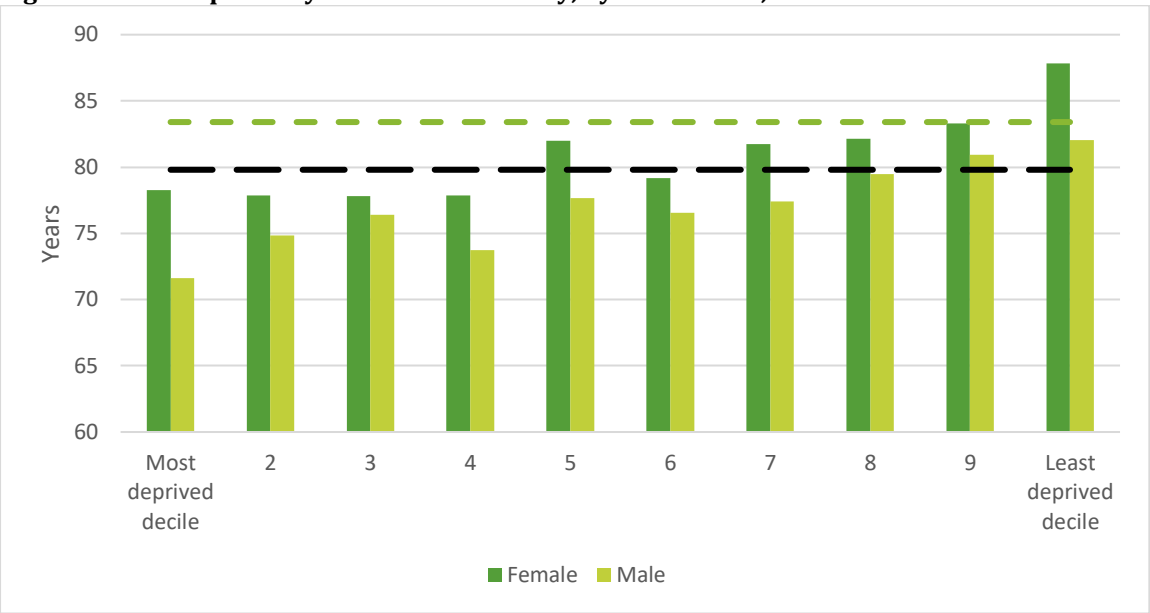


Source: PHE Fingertips (63)

Knowsley

With a population of 152,000, in 2018-20 life expectancy at birth for women in Knowsley was 79.8 years, 3.3 years below the England average. For men it was 76.3 years, 3.1 years below the England average. In addition, inequalities in life expectancy in Knowsley are evident and Figure 16 shows in 2017-2019 there was a 9.6 year gap for women in life expectancy between the most and least deprived deciles in Knowsley, 10.4 years for men.

Figure 16. Life expectancy at birth in Knowsley, by IMD deciles, 2017-2019



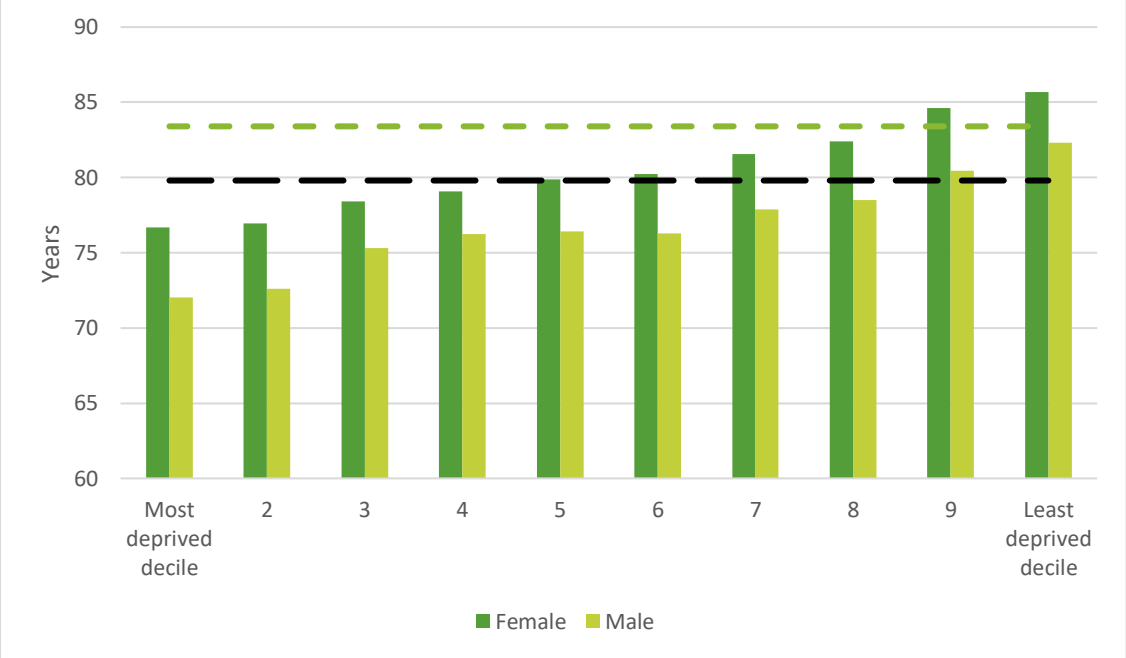
Female England average
Male England average

Source: PHE Fingertips (63)

Liverpool

With a population of 500,000, in 2018-20 in life expectancy at birth for women in Liverpool was 79.9 years, 3.2 years below the England average. For men it was 76.1 years, 3.3 years below the England average. In addition, inequalities in life expectancy in Liverpool are evident and Figure 17 shows in 2017-2019 there was a 9 year gap for women in life expectancy between the most and least deprived deciles in Liverpool, 10.3 years for men.

Figure 17. Life expectancy at birth in Liverpool, by IMD deciles, 2017-2019



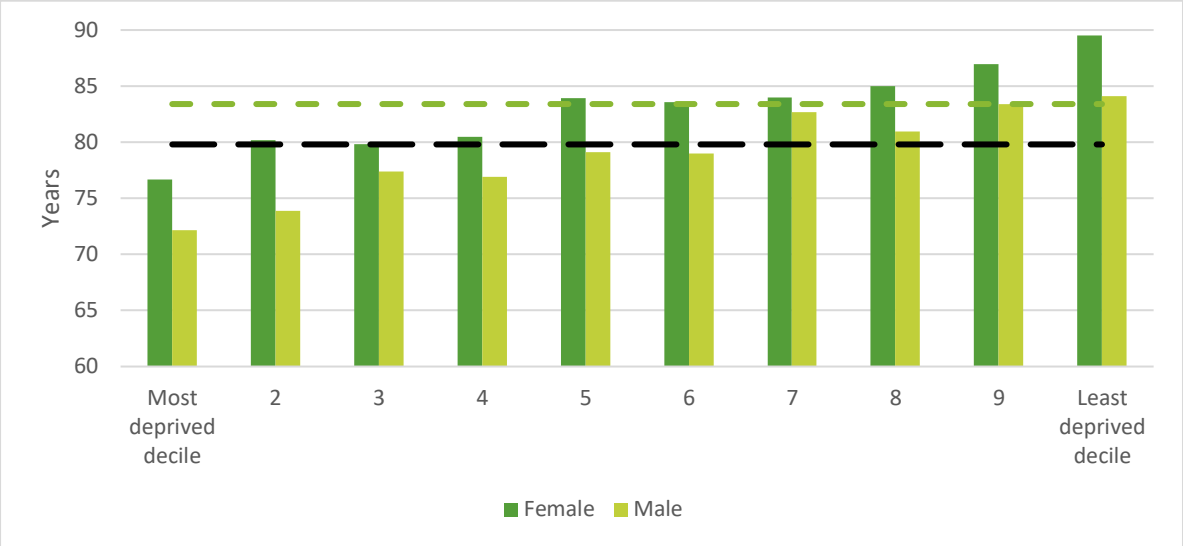
Female England average
Male England average

Source: PHE Fingertips (63)

Sefton

With a population of 275,000, in 2018-20 in life expectancy at birth for women in Sefton was 82.4 years, 0.7 years below the England average. For men it was 78 years, 1.4 years below the England average. In addition, inequalities in life expectancy in Sefton are evident and Figure 18 shows in 2017-2019 there was a 12.8 year gap for women in life expectancy between the most and least deprived deciles in Sefton,11.9 years for men.

Figure 18. Life expectancy at birth in Sefton, by IMD deciles, 2017-2019



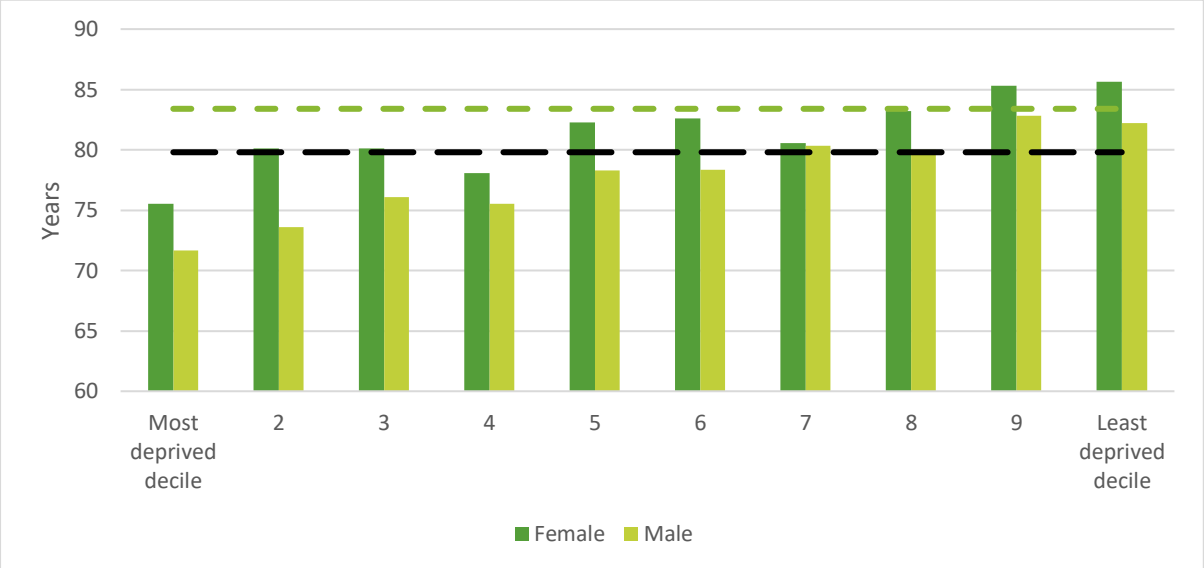
Female England average
Male England average

Source: PHE Fingertips (63)

St Helens

With a population of 181,000, in 2018-20 in life expectancy at birth for women in St Helens was 81.0 years, 2.1 years below the England average. For men it was 77.5 years, 1.9 years below the England average. In addition, inequalities in life expectancy in St Helens are evident and Figure 19 shows in 2017-2019 there was a 10.1 year gap for women in life expectancy between the most and least deprived deciles in St Helens,10.5 years for men.

Figure 19. Life expectancy at birth in St Helens, by IMD deciles, 2017-2019



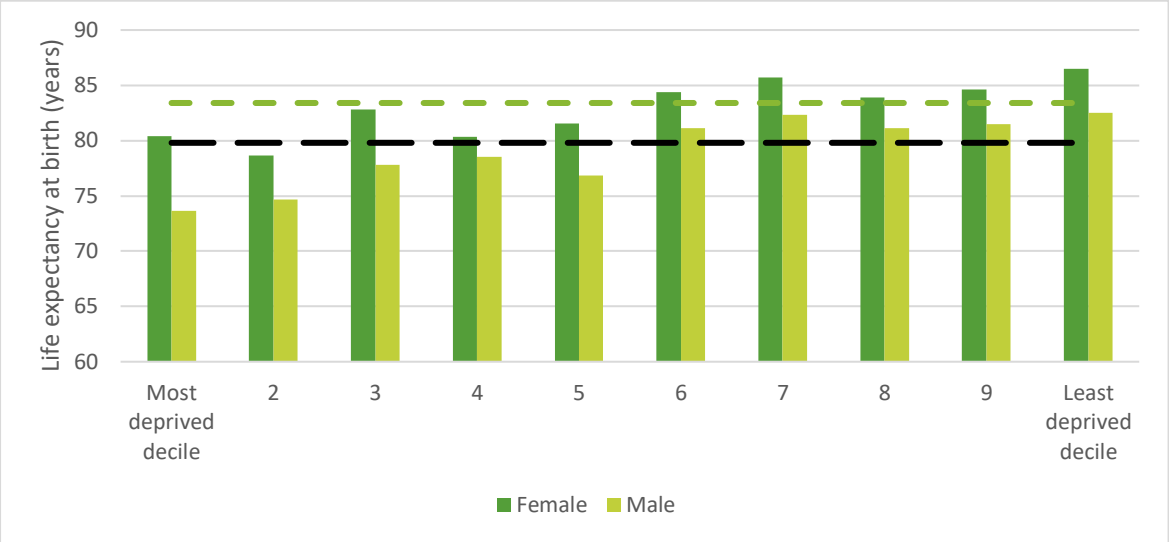
Female England average
Male England average

Source: PHE Fingertips (63)

Warrington

With a population of 209,000, in 2018-20 in life expectancy at birth for women in Warrington was 82.3 years, 0.8 years below the England average. For men it was 78.9 years, 0.5 years below the England average. In addition, inequalities in life expectancy in Warrington are evident and Figure 20 shows in 2017-2019 there was a 6.1 year gap for women in life expectancy between the most and least deprived deciles in Warrington, 8.9 years for men.

Figure 20. Life expectancy at birth in Warrington, by IMD deciles, 2017-2019



Female England average

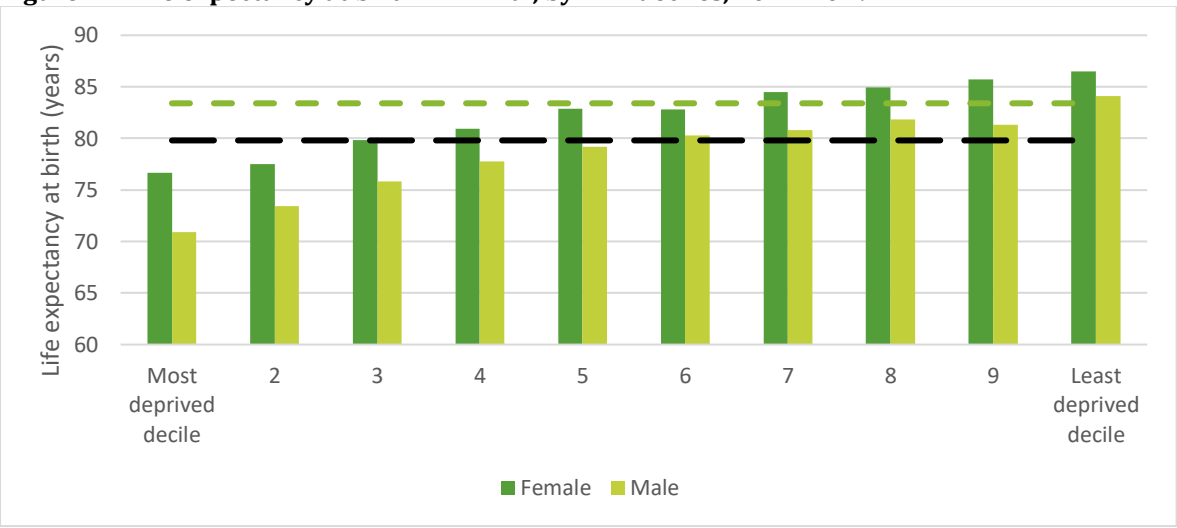
Male England average

Source: PHE Fingertips (63)

Wirral

With a population of 324,000, in 2018-20 in life expectancy at birth for women in Wirral was 8.16 years, 1.5 years below the England average. For men it was 77.8 years, 1.6 years below the England average. In addition, inequalities in life expectancy in Wirral are evident and Figure 21 shows in 2017-2019 there was a 9.8 year gap for women in life expectancy between the most and least deprived deciles in the Wirral,13.2 years for men.

Figure 21. Life expectancy at birth in Wirral, by IMD deciles, 2017-2019



Female England average

Male England average

Source: PHE Fingertips (63)

3B SOCIAL DETERMINANTS OF HEALTH

Health inequalities are largely the result of inequalities in the social determinants of health; the social, economic, and environmental conditions which shape everyone's health. There is global evidence showing that the social determinants have more of a bearing on our health than health care; and that is certainly the case in England. There remain some inequalities in access to healthcare services and in outcomes from treatment, but these are not the focus of this report, because *they do not drive the wide health inequalities we see in England and across Cheshire and Merseyside*. Box 3 shows the social determinants of health domains which drive health and are the areas in which we call for interventions.

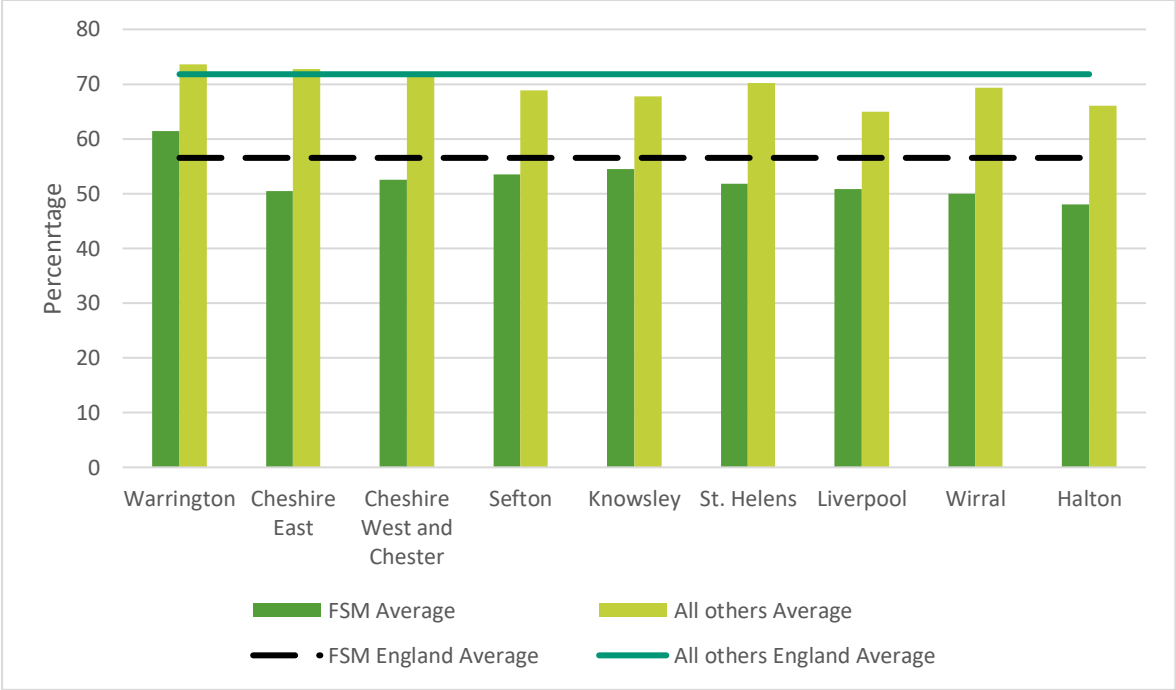
Box 3. Taking action on the social determinants of health (64)
A: Give every child the best start in life
B: Enable all children, young people, and adults to maximise their capabilities and have control over their lives
C: Create fair employment and good work for all
D: Ensure healthy standard of living for all
E: Create and develop healthy and sustainable places and communities
F: Strengthen the role and impact of ill health prevention

GIVING EVERY CHILD THE BEST START IN LIFE

Experiences during the early years and in education are particularly important for immediate and longer term health and outcomes in other social determinants of health such as education and income (2), (64).

Figure 22 shows Cheshire and Merseyside all but one boroughs has lower levels of school readiness compared to the England average for children eligible for Free School Meals at the end of reception. These marked inequalities between children eligible for free school meals and those who are not eligible are already visible at the age of five years.

Figure 22. Children achieving a good level of development at the end of Reception, Cheshire and Merseyside and England, 2018/19, percentage



Source: Department for Education (63)

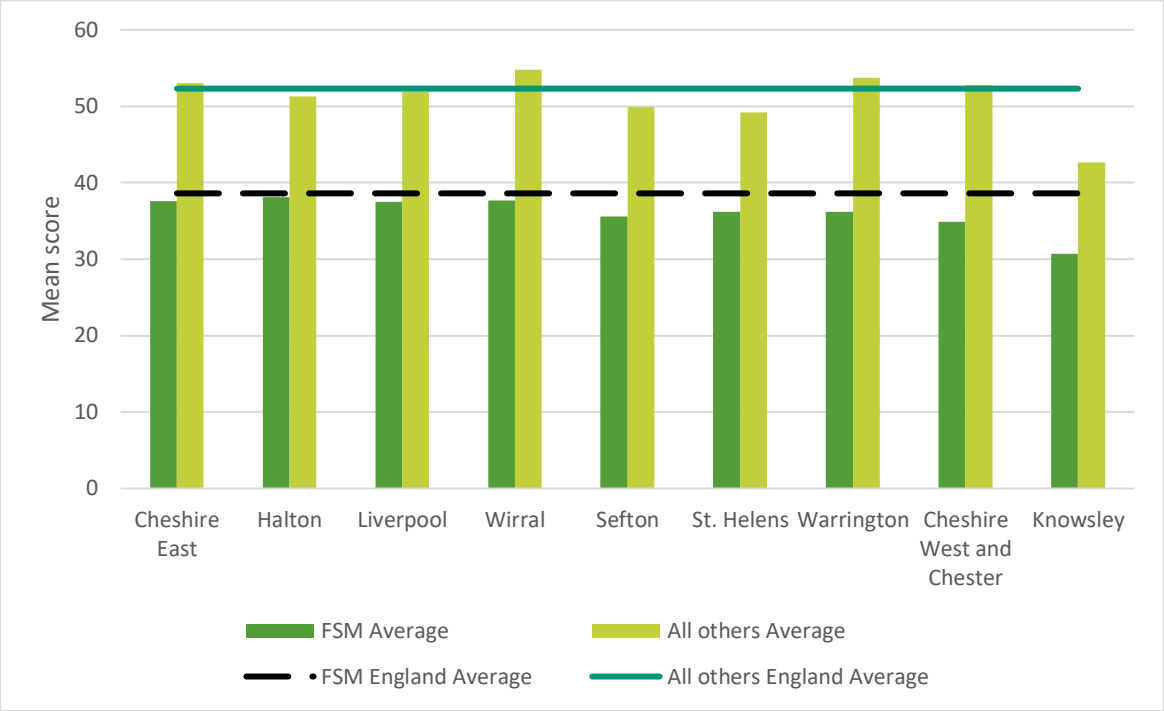
These educational attainment inequalities continue into secondary school. Inequalities in expected standards at the end of Key Stage 2 show, all but one borough have levels below the average for pupils eligible for free school meals, yet seven of the nine boroughs meet or better the England average for students not eligible for Free School Meals, Figure 23.

Figure 23. Pupils reaching expected standard at the end of Key Stage 2 in reading, writing and maths by free school meal eligibility and Local Authority, Cheshire and Merseyside and England, 2018, percentage

Source: Department for Education (63)

Inequalities in Attainment 8 are slightly wider than the English average and all boroughs have levels below the England average for pupils eligible for free school meals, Figure 24.

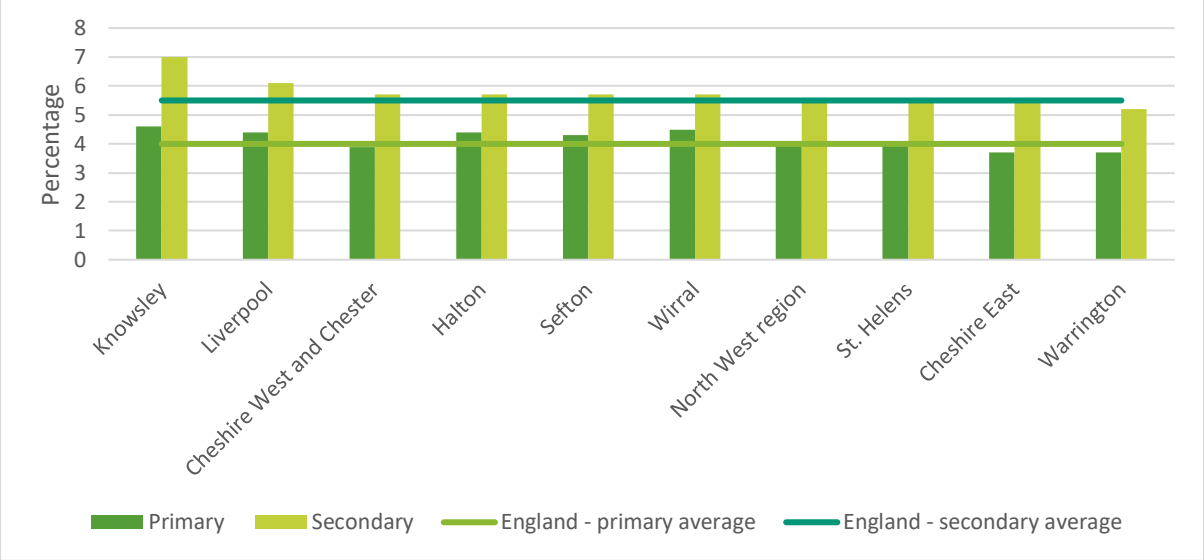
Figure 24. Average Attainment 8 Score mean score, Free School Meal eligibility, in Cheshire and Merseyside and England, 2019/20



Source: Department for Education (63)

In a normal school year, pupil absences can lead to a small decline in academic achievement and pupils from low-income households experience more substantial effects from each day of school absence (65). In Cheshire and Merseyside, only Cheshire East and Warrington are below the England average for both primary and secondary absences, Figure 25.

Figure 25. Pupil absences, primary and secondary, 2018/19, Cheshire and Merseyside and England, percentage



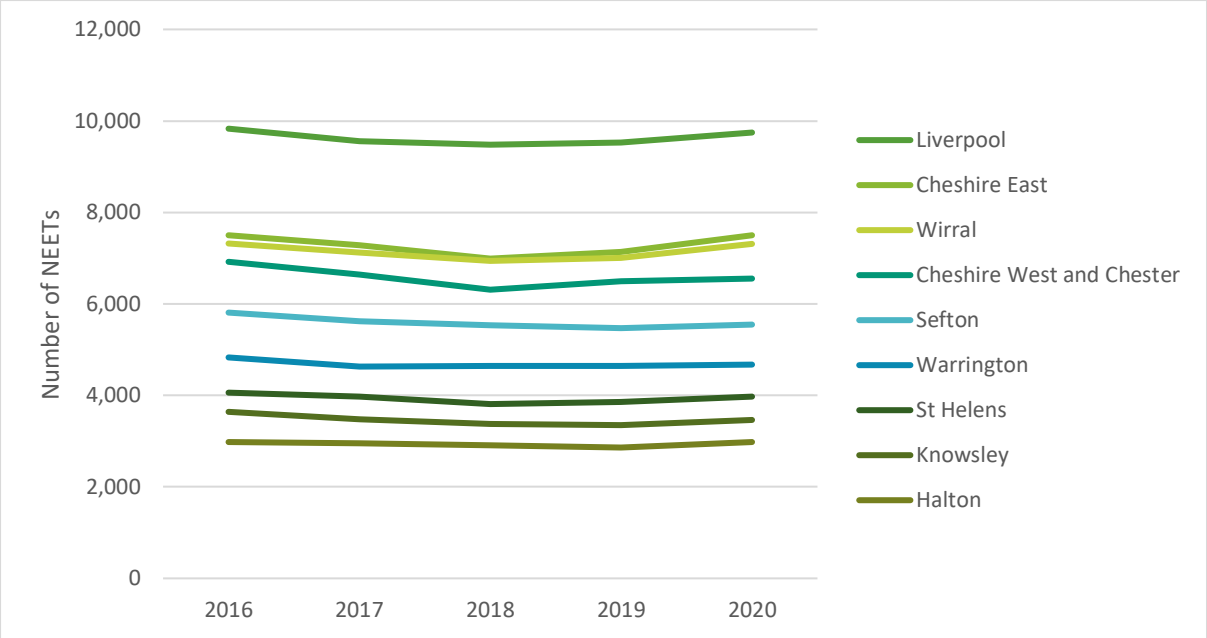
Source: Department for Education (63)

Prior to the pandemic, education inequalities were widening with pupils eligible for free school meals for more than 80% of their school life are 18 months behind their peers in learning by the time they finish their GCSEs, a gap that has not changed in the last five years (66). It was quickly anticipated pandemic-

related lockdown would further widen inequalities in education in England. In July 2020 educational attainment inequalities were already identified, 53% of teachers in the most deprived schools reported pupils were 4 months or more behind on average, and in contrast, only 15% of teachers in the least deprived schools stated pupils were 4 months or more behind (83). Six months later, in January 2021, 84% of teachers felt the pandemic would cause the attainment gap between the most and least disadvantaged to widen in their school, an increase from 76% in November 2020 (84).

The number of Young People Not in Education, Employment or Training in Cheshire and Merseyside has remained stable since 2016, Figure 26.

Figure 26. Not in education or training, NEETS (16 and 17 yrs known to the local authority), 2016 - 2020), Cheshire and Merseyside, total number

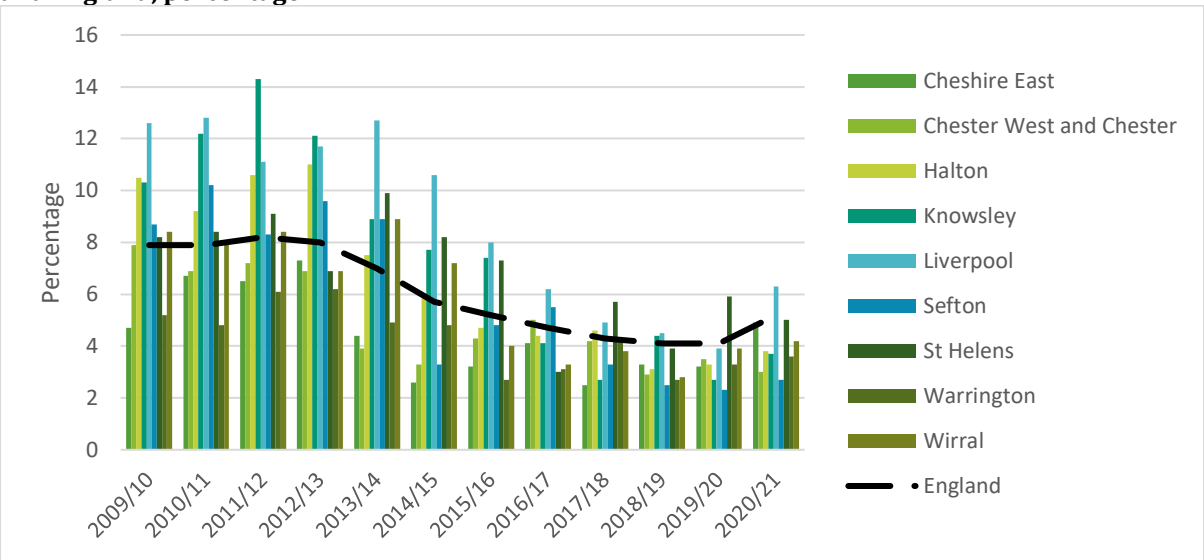


Source: Department for Education (69)

FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Evidence shows unemployment, particularly long-term unemployment, contributes significantly to poor physical and mental health and early mortality (2), (64), (70). As discussed earlier, the economic recession in 2008/09 had significant effects in Liverpool, Figure 27 shows the recession also had longer term effects on unemployment in Knowsley, Halton, and St Helens.

Figure 27. Unemployment rate, 16-64 yrs, Jul-June 2009/10 - 2020/21, Cheshire and Merseyside and England, percentage

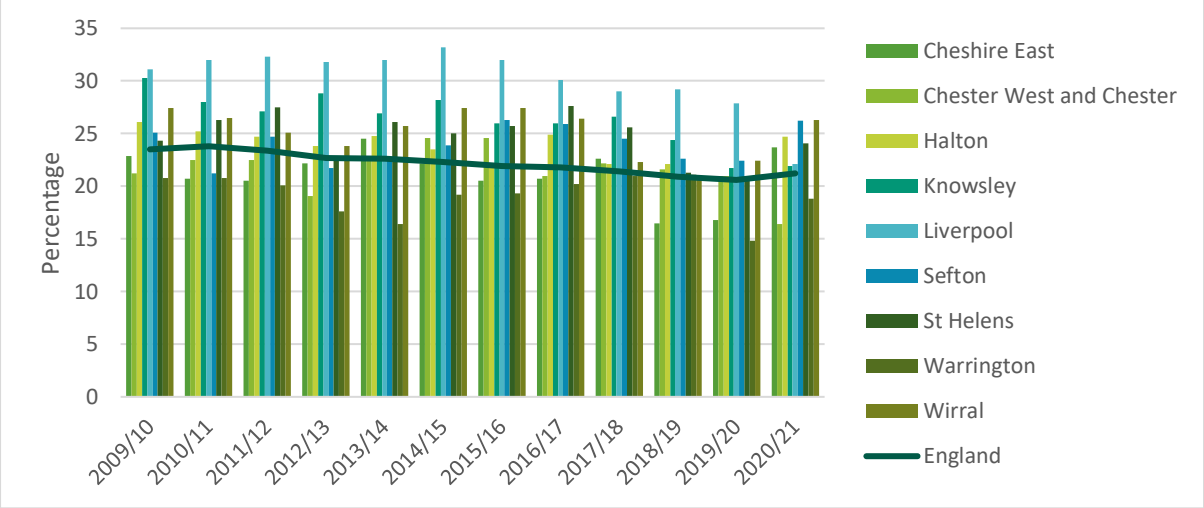


England Average

Source: Annual Population Survey (71)

Many of those unemployed have given up on looking for work and are classified as 'economically inactive', when this figure is used, it reveals much higher rates of unemployment, as Figure 28 shows.

Figure 28. Economically inactive population, 16-64 yrs, 2009/10-2020/21, Cheshire and Merseyside and England, percentage

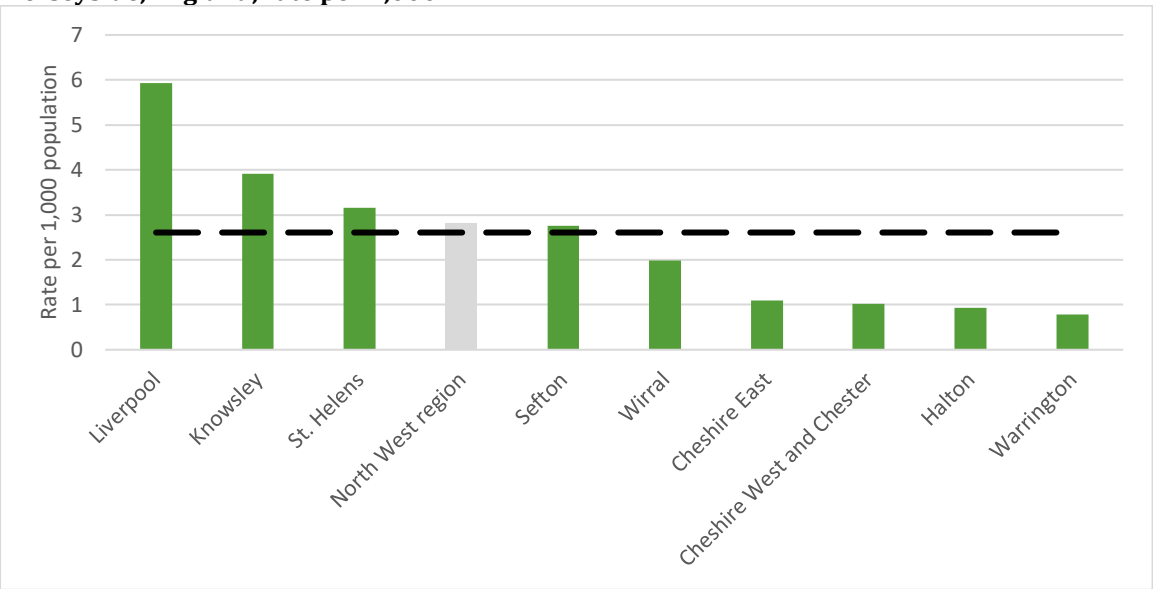


England Average

Source: Annual Population Survey (71)

Being in long-term unemployment leads to higher risks of poor health and wellbeing compared to those who are unemployed for shorter periods of time (72). Figure 29 shows the high levels of long-term claimants of Jobseeker's Allowance, notably in Liverpool the rate is more than double the England average.

Figure 29. Long term claimants of Jobseeker's Allowance, 16-64 yrs, 2020, Cheshire and Merseyside, England, rate per 1,000



Source: NOMIS (73)

Box 4 outlines Sew Halton, a locally developed project that works with a range of partners, including the Department of Work and Pensions, to improve wellbeing and employment skills in those who are long-term unemployed.

Box 4. Improving health, wellbeing, and employment skills in Halton

Sew Halton is a not-for-profit community interest company that utilises machine sewing, garment creation and upcycling as a platform to positively impact the wider determinates of health.

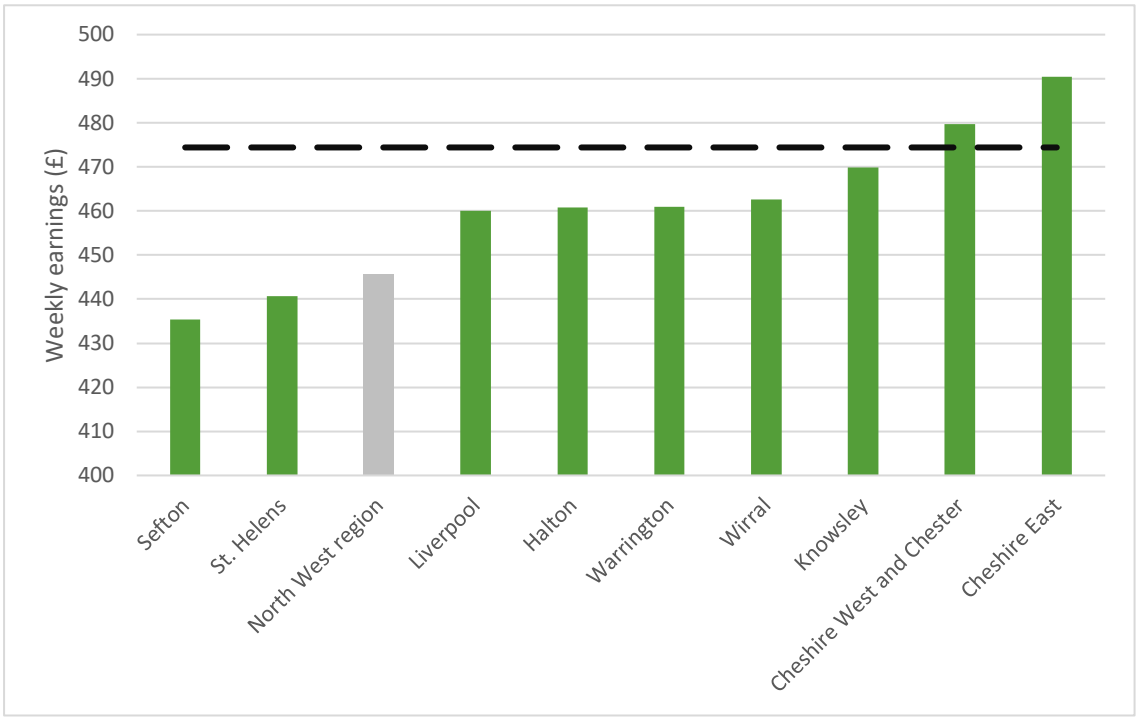
In 2018. Sew Halton ran a number of 'Confidence Sewing Courses' funded by local housing associations. The aim of the courses was to improve the wellbeing of isolated residents. Sew Halton approached the Department of Work and Pension to work together to bring residents closer to work-readiness and a strong partnership developed. Sew Halton was awarded a Flexible Support Fund Grant, to run a pilot project for 40 people who were long-term unemployed. The participants were identified by DWP Work Coaches and was aimed at those with 'low mood', mild mental health challenges, or physical disabilities. Participation was completely voluntary and there was no expectation that participants must find work at the end of the course.

The courses were popular and proved highly successful, of the 39 long-term unemployed people that participated, 7 went into employment upon completing the course. 13 participants took up voluntary positions. 37 of the 39 showed increased wellbeing scores.

Sew Halton also acted as a sign poster, directing participants to a variety of partners including Citizens Advice, Halton Carers Centre, Urgent Care Centre, Domestic Abuse Services, local councillors, and many others.

There are a number of opportunities to improve employment conditions in Cheshire and Merseyside, particularly related to wages. Figure 30 shows only in Cheshire East and Cheshire West have average earnings above the England average.

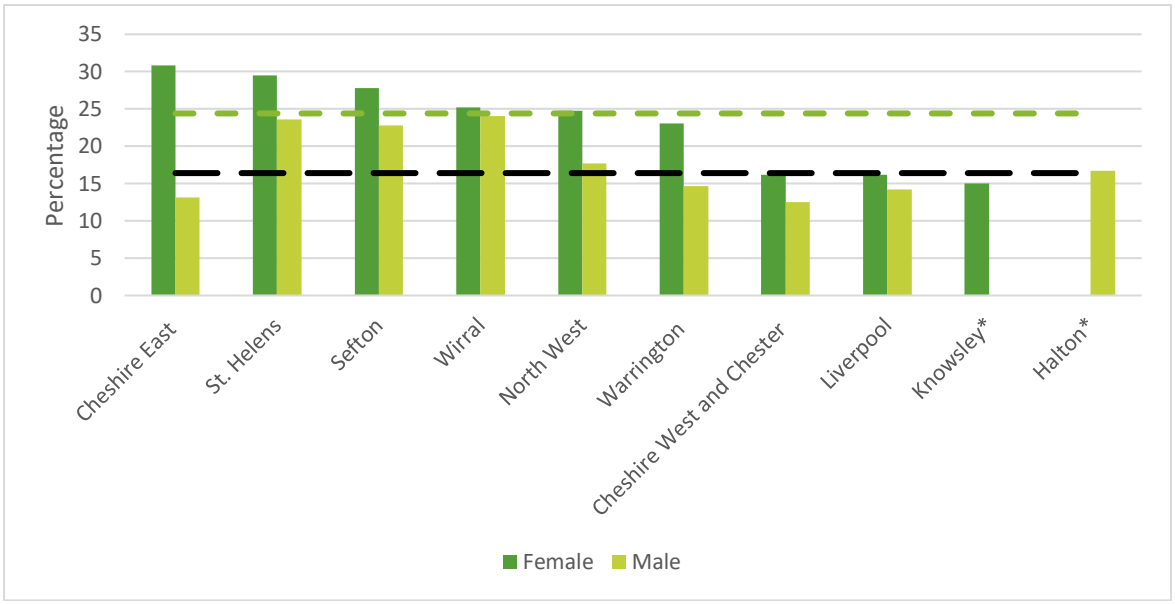
Figure 30. Average weekly earnings, aged 16+ yrs, 2020, Cheshire and Merseyside boroughs, North West and England, pounds



Source: PHE Fingertips (63)

Having high average weekly earnings, such as in Cheshire East, can hide problems, Figure 31 shows Cheshire East also has the highest percentage of women earning below the living wage, £9.50 in 2021 (£9.30 in 2020). Sefton, St Helens, and Wirral also have average earnings below the England average for both women and men.

Figure 31. Earning below Living Wage Foundation rates, 2020, Cheshire and Merseyside boroughs, North West and England, percentage



Source: Annual Survey of Hours and Earnings (74)

Liverpool City Region has sought to improve the conditions for its local workforce by introducing the Fair Employment Charter, Box 5.

Box 5. Promoting fair employment in Liverpool
The Liverpool City Region has established a Fair Employment Charter in consultation with employees and employers from across the public, private, community and voluntary sectors and other stakeholders including Trades Unions, the Chartered Institute of Personnel and Development, Acas (92). The Charter commits to:

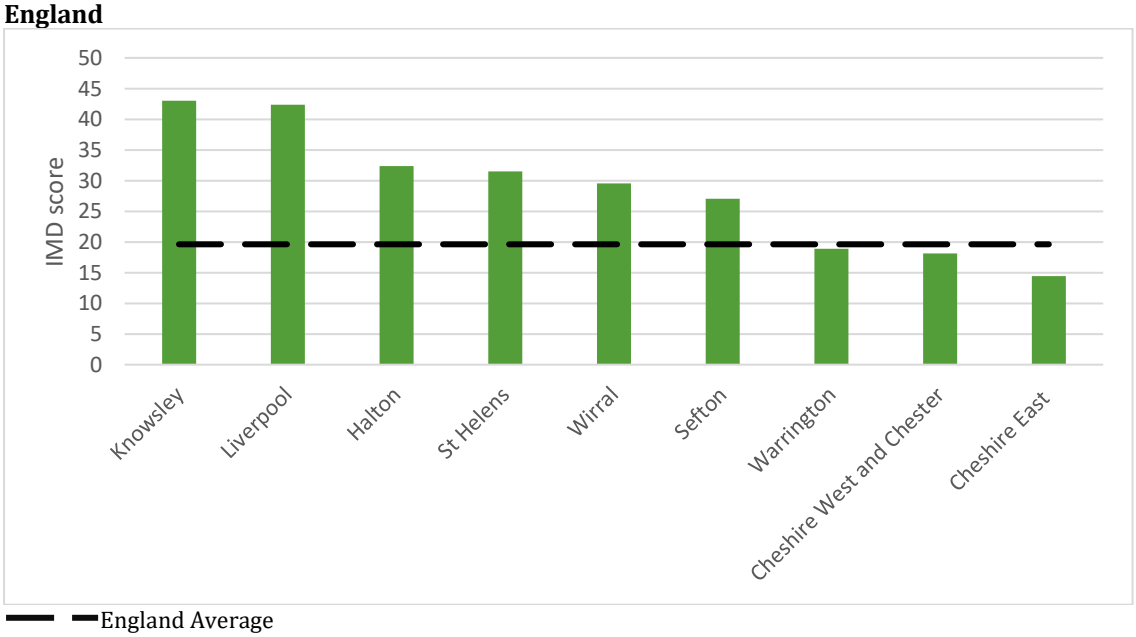
- safe workplaces supporting a healthy workforce
- fair pay and fair hours
- inclusive workplaces that support staff to grow and develop
- a voice for staff to help deliver justice in the workplace with opportunities available for young people.

HEALTHY STANDARD OF LIVING FOR ALL

33% of Cheshire and Merseyside's residents live in the most deprived 20 percent of neighbourhoods in England, rising to 44 percent in Liverpool City Region (76). Most of Merseyside and Liverpool are described as income-deprived areas, Knowsley is the (joint) most deprived local authority in England.

All boroughs in Cheshire and Merseyside have high levels of poverty, including in rural and urban areas. Figure 32 shows in Cheshire and Warrington's boroughs income-deprivation is less common compared to Liverpool, however there are areas of poverty within these boroughs. In Cheshire West & Chester, 10.8% of the population is income deprived. In Cheshire East, it is 8.3%, 10.9% in Warrington and rising to 18.5% in Halton. Throughout Cheshire there are pockets of deprivation. In the least deprived neighbourhood in Cheshire East, 1.2% of people are estimated to be income-deprived whereas in the most deprived neighbourhood, 35.8% of people are estimated to be income-deprived. Similarly, in the least deprived neighbourhood in Cheshire West and Chester, 1.5% of people are estimated to be income-deprived and in the most deprived neighbourhood, 41.0% of people are estimated to be income-deprived (77).

Figure 32. Index Multiple Deprivation score, 2019, Cheshire and Merseyside boroughs and England

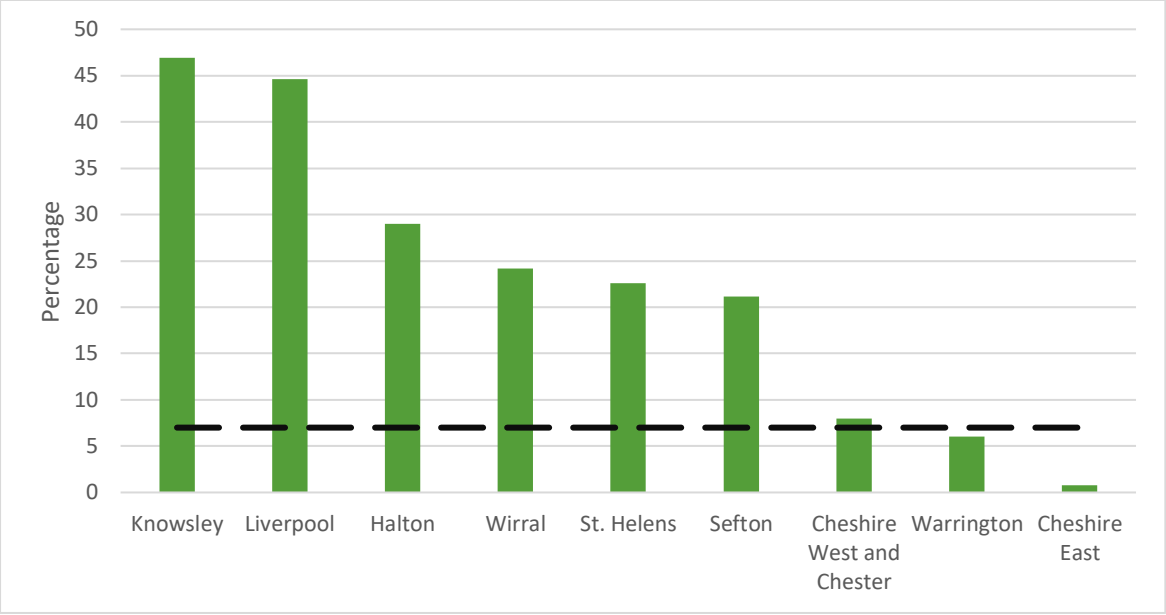


Source: Ministry of Housing, Communities and Local Government (78)

Cheshire and Merseyside contains some of the poorest local authorities in England. Knowsley has the highest proportion of its population living in income deprived households in England, equating to one in four of all households or 25.1 percent. Liverpool is fourth, with 23.5 percent of its population living in

income deprived households. Figure 33 shows the level of deprivation within Cheshire and Merseyside and that seven of nine boroughs have a higher proportion of most deprived LSOAs compared to the England average.

Figure 33. Proportion of LSOAs in most deprived 10%, 2019, Cheshire and Merseyside boroughs and England

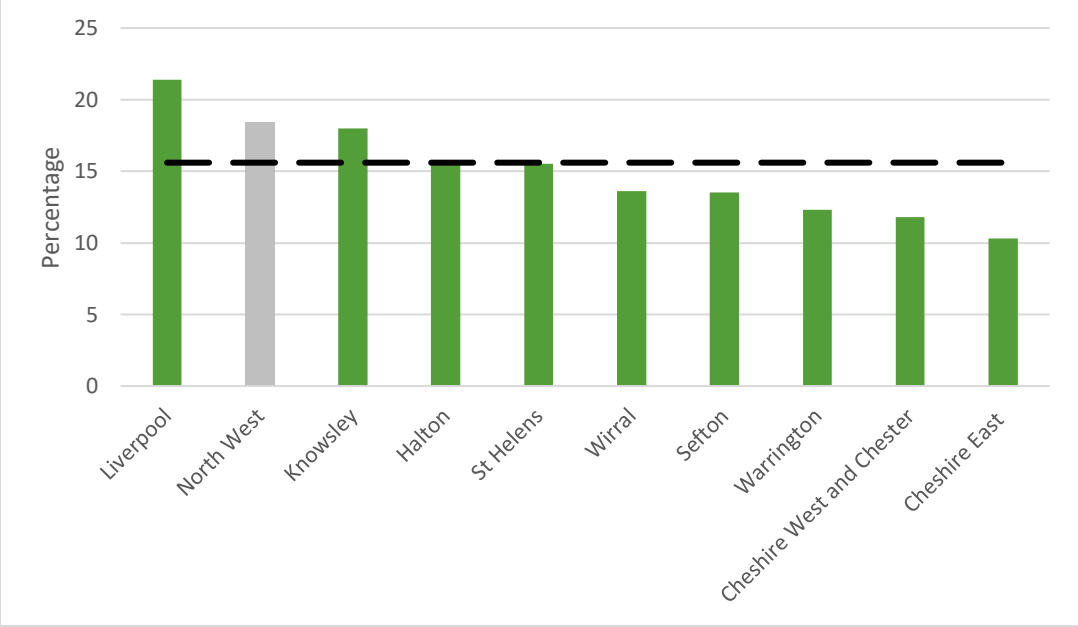


Source: Ministry of Housing, Communities and Local Government (78)

CHILD POVERTY

In Cheshire and Merseyside 14.7 percent of children live in absolute poverty households, compared to 15.6 percent in England, Figure 34. Absolute low income is measured if equivalised income is below 60% of the 2010 to 2011 median income adjusted for inflation.

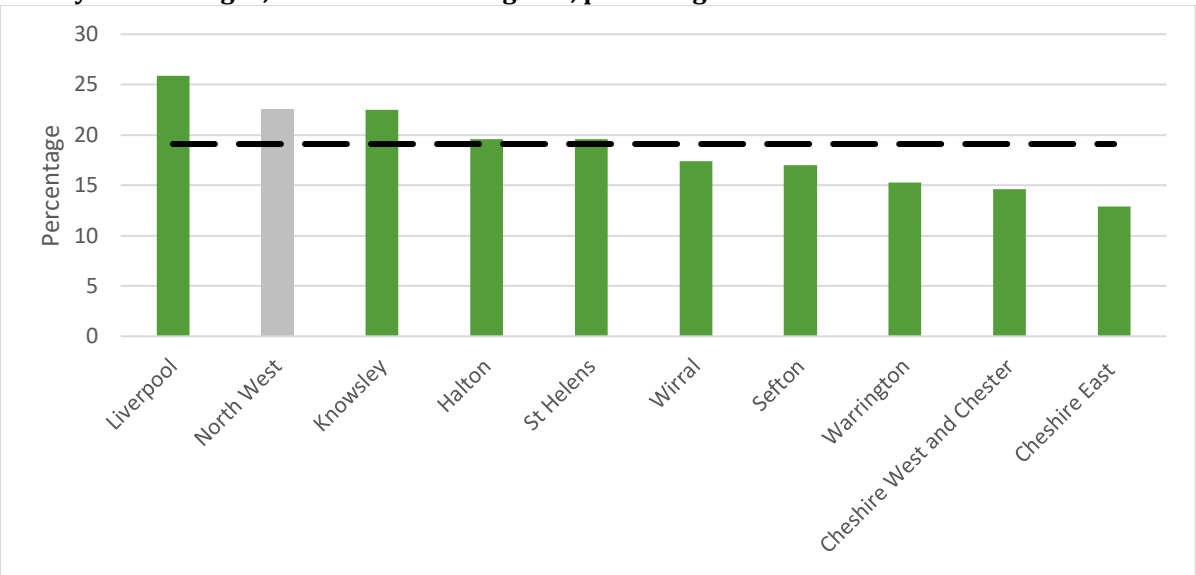
Figure 34. Children living in absolute poverty households (under 16s), 2019/20, Cheshire and Merseyside boroughs, North West and England, percentage



Source: Households Below Average Income (79)

In Cheshire and Merseyside HCP 18.3 percent of children live in relative poverty households, compared to 19.1 percent in England, Figure 35. Liverpool, Knowsley, Halton, and St. Helens have higher numbers of children in relative poverty households compared to the England average. Relative poverty is understood if a household's equivalised income is below 60% of median income.

Figure 35. Children living in relative poverty households (under 16s), 2019/20, Cheshire and Merseyside boroughs, North West and England, percentage

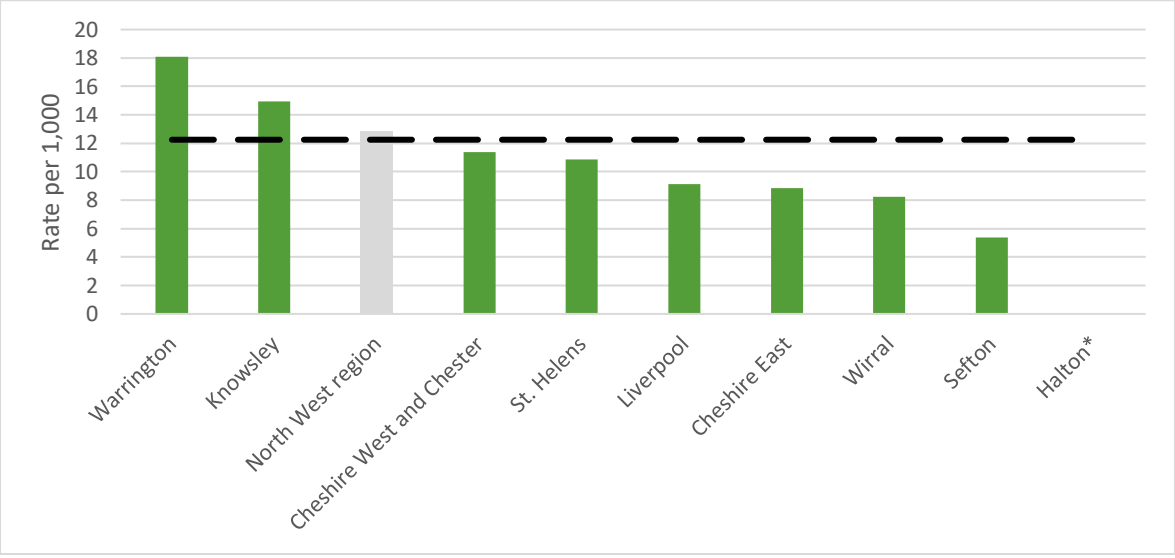


Source: Households Below Average Income (79)

HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

Poor-quality and overcrowded housing is harmful to health, widens health inequalities and inequalities in key social determinants of health (2), (49).
Liverpool has the highest levels of households owed a duty by local authorities to prevent homelessness in the Region and both Liverpool and Knowsley have a higher average compared to the England average, Figure 36.

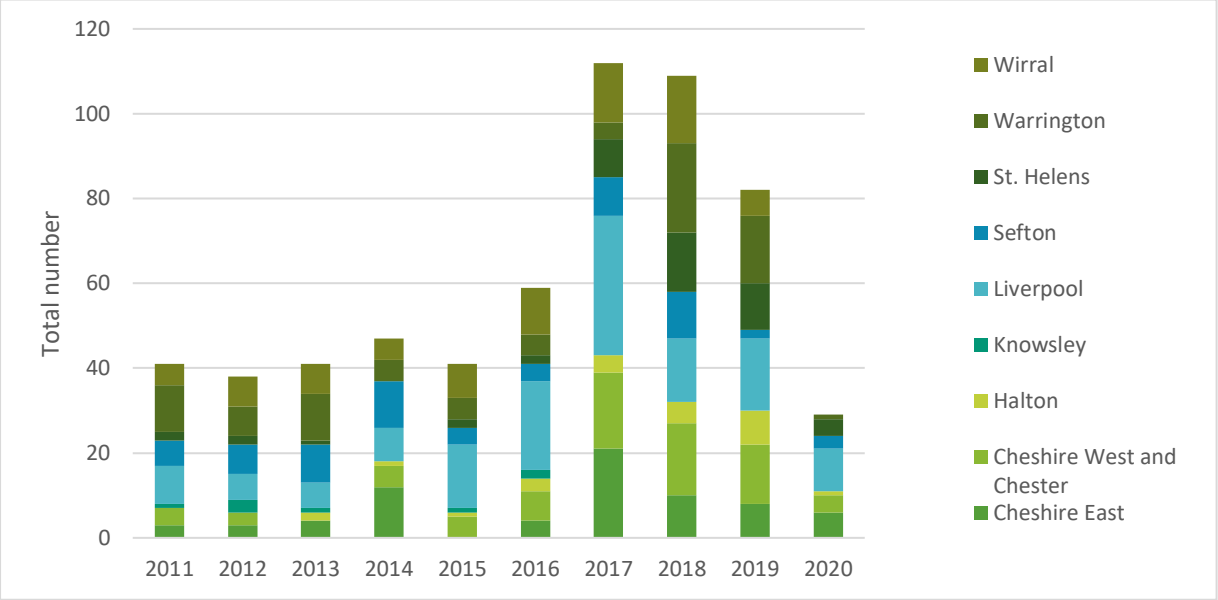
Figure 36. Households owed duty under Homeless Reduction Act, 2019/20, rate per 1,000



Source: Ministry of Housing, Communities & Local Government (80)

In the Region rough sleeping reached a peak in 2017 and 2018 and since then has fallen significantly, Figure 37.

Figure 37. Number of people estimated to be sleeping rough, 2011-2020, Cheshire and Merseyside boroughs.



Source: Department for Communities and Local Government (81)

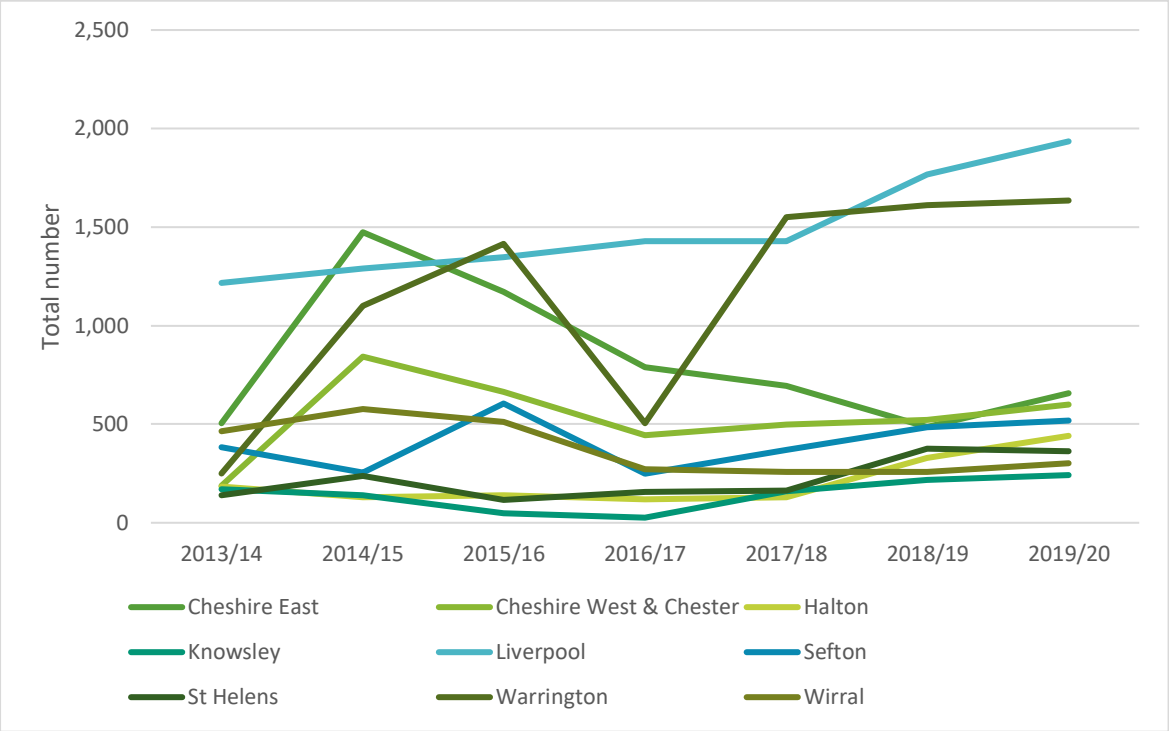
In the first weeks of the COVID-19 pandemic the government's 'Everyone In' programme funded local councils to provide additional support to those sleeping rough, Box 6 outlines how Warrington used this funding.

Box 6. Reducing people sleeping rough in Warrington

In Warrington, prior to COVID, various resources were available to address the needs within the homeless population, including; two designated homeless hotels, properties utilised as temporary accommodation, and Women's Refuge supported accommodation.
However during COVID, the accommodation offer to the homeless population had to change almost overnight to meet social distancing guidelines. Warrington Council commissioned the local Travelodge as part of the Government's "Everyone In" programme and 75 individuals were supported.
There was limited Government guidance on how to manage people with complex addictions, especially in the first part of lockdown. Some of the national guidance such as "social distancing" and "hands, face, space" were difficult to translate to this group whose primary focus was to manage their addiction and complexity with the lockdown period, adding further stress and anxiety.
As most mental health support was only available remotely during lockdown this left many people in the homeless population with limited to no access to support due to the lack of technology or access to telecommunication. During lockdown there was the potential for vulnerable people, including homeless people, to be discharged from a range of services as they were identified as 'no show' or 'refusal of services' which Warrington Borough Council had to unpick and give dedicated support to vulnerable people to re-engage with these services. In spite of these challenges the hotel accommodation program was, for example, able to identify and refer 5 individuals to detox programs and 3 people were referred to residential rehabilitation programs.
The Council was able to use government funding to develop a further accommodation setting at Museum Street to ensure single room space was available to all homeless residents. Warrington Council currently has 101 bed spaces for homeless people alongside its temporary accommodation stock.

Concerningly for health, the number of people living in insanitary, overcrowded, unsatisfactory housing conditions almost doubled between 2013/14 and 2019/20. The highest number are in Liverpool and Warrington, Figure 38.

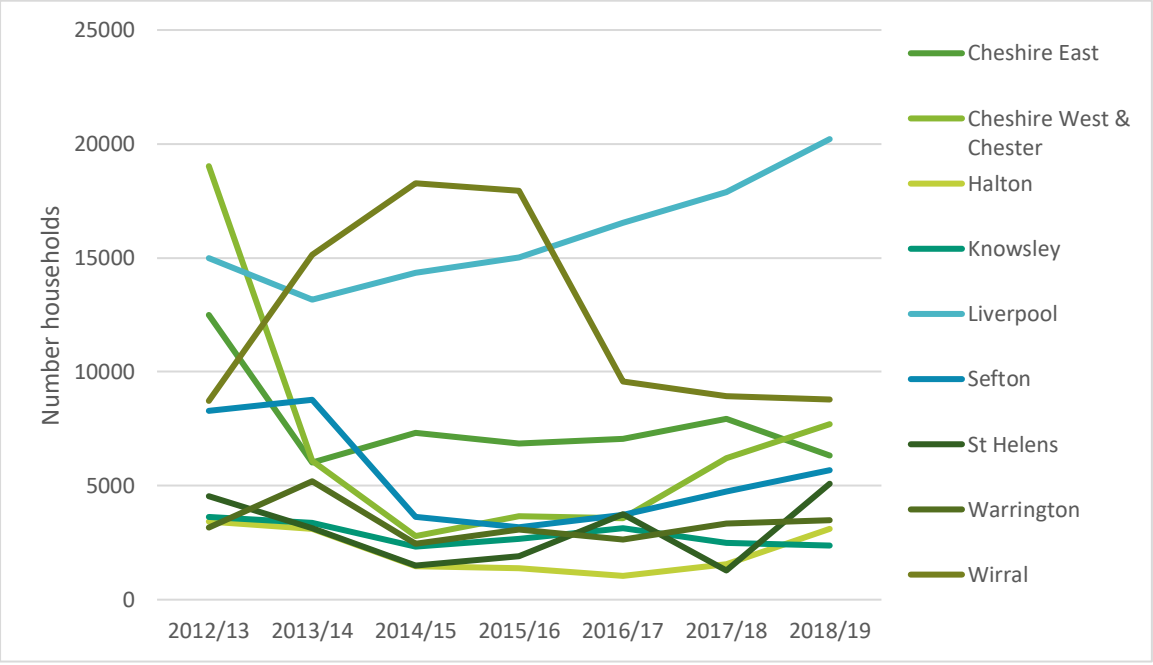
Figure 38. Households occupying insanitary or overcrowded housing or otherwise living in unsatisfactory housing conditions, 2013/14-2019/20, Cheshire and Merseyside, total number



Source: Ministry of Housing, Communities & Local Government (82)

Local authorities control the allocation of council housing, Liverpool has the largest waiting list in Cheshire and Merseyside, and rates have increased each year since 2013/14, Figure 39.

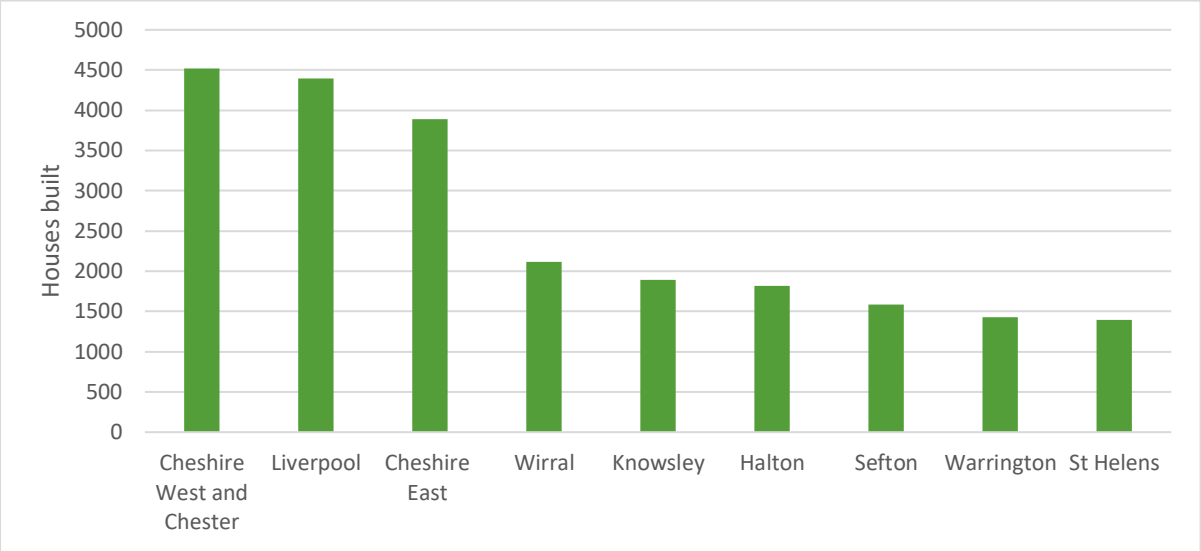
Figure 39. Households on housing waiting List, 2012/12-2018/19, Cheshire and Merseyside, total number



Source: Ministry of Housing, Communities & Local Government (83)

The affordable homes budget available to local authorities has declined since 2010. Data from the Ministry of Housing, Communities and Local Government highlighted a decrease of nearly 70 percent between 2010–11 and 2016–17, though it rose slightly in 2019/20 (2). Whilst the waiting lists for council housing are highest in Liverpool, Cheshire West and Chester has built the most affordable homes between 2010/11 and 2019/20, Figure 40.

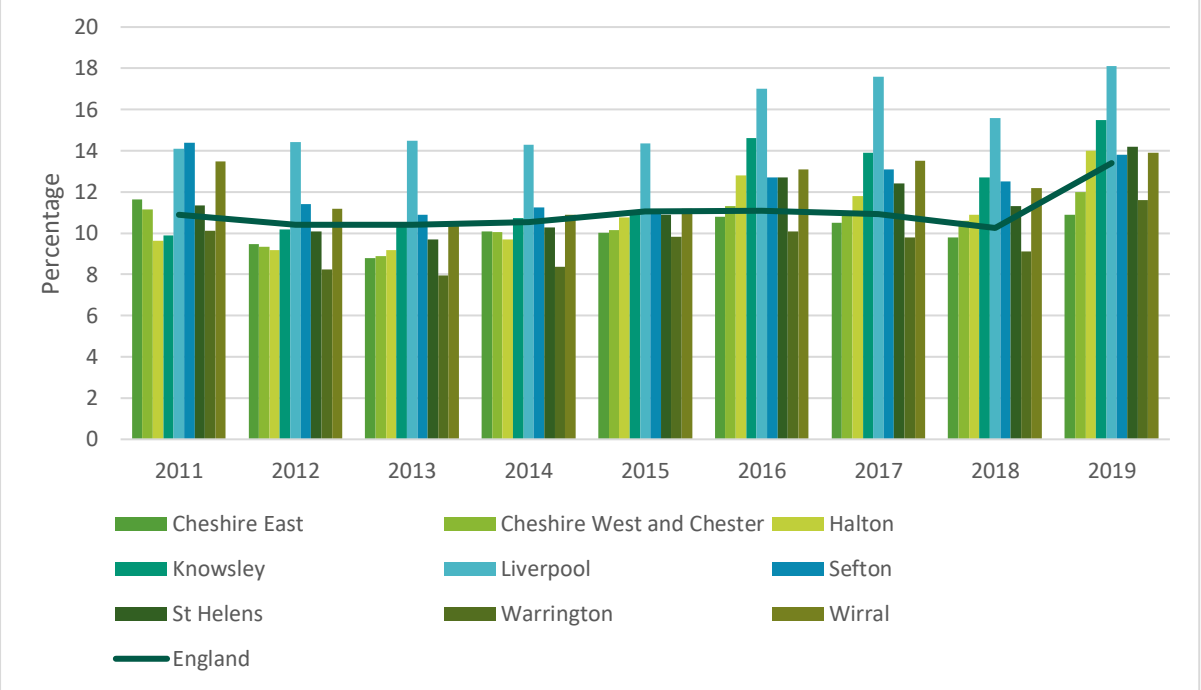
Figure 40. Affordable homes built, 2010/11-2019/20, Cheshire and Merseyside boroughs, total number



Source: Ministry of Housing, Communities & Local Government (84)

Since 2016 levels of fuel poverty in Cheshire and Merseyside have been above the England average, worst in Liverpool, Figure 41. These levels are likely to increase rapidly in the winter of 2021/22 due to rising fuel costs, higher cost of living and the removal of the £20 uplift in Universal Credit.

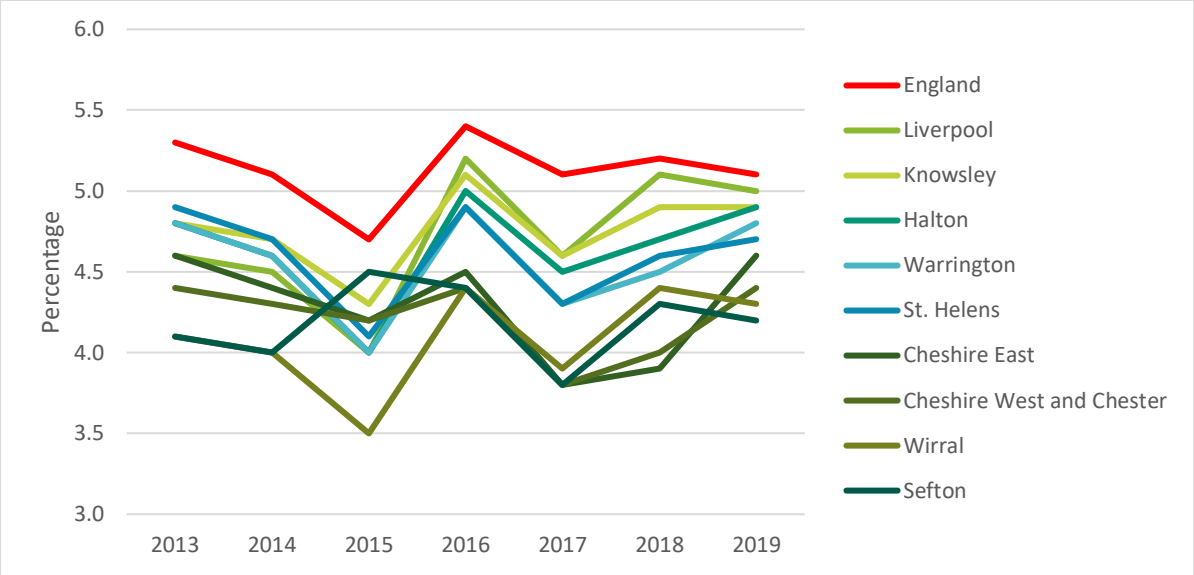
Figure 41. Homes in Fuel Poverty, 2011-2018, Cheshire and Merseyside, North West and England, percentage



Source: Department for Business, Energy, and Industrial strategy (85)

On average, pollution levels are worse in areas of highest deprivation compared with areas of lowest deprivation, however in Cheshire and Merseyside, mortality attributable to exposure to poor air quality is lower than the England average, Figure 42.

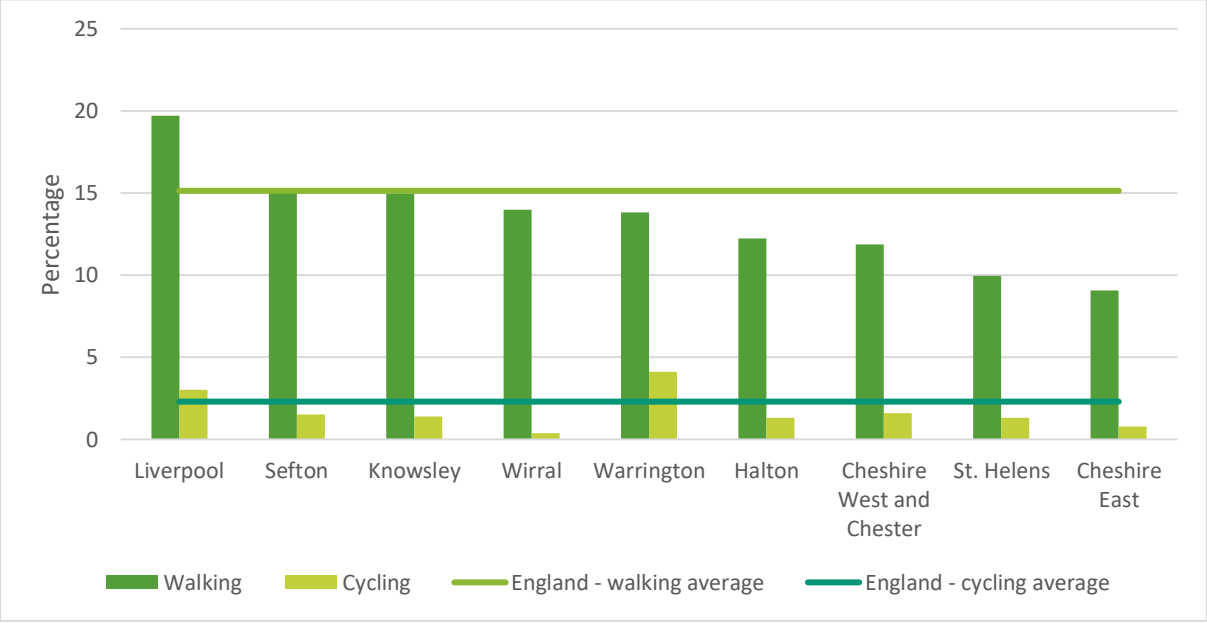
Figure 42. Fraction of mortality attributable to particulate air pollution, 2013-2019, Cheshire and Merseyside boroughs, percentage



Source: Department for Environment, Food & Rural Affairs (86)

Domestic transport is the largest contributor to greenhouse gas emissions in the UK, emitting , 27% of the UK's total emissions in 2019 (87). Active travel is central to reducing these emissions. In Liverpool more adults walk and cycle for travel compared to the England average, Figure 43.

Figure 43. Adults that walk or cycle, three times per week for travel, 2019/20, Cheshire Merseyside boroughs and England, percentage



Source: Department for Transport (88)

Healthy high streets are supportive of good health, and unhealthy high streets undermine health – there are clear socioeconomic inequalities in access to healthy high streets (21). Direct influences on physical

and mental health arise from a lack of diversity in products and services on high streets, litter, high levels of traffic, crime and fear of crime, and inaccessible design. High streets can also affect health and worsen inequalities indirectly through rundown or inadequate communal areas, shelters, seating, and focal points, deterring people from visiting or spending time in high streets, potentially preventing community activities, and increasing the risk of social isolation and reducing the likelihood of community cohesion (89). Increasing the number of takeaway food outlets, maybe regarded as a quick win for economies, but high takeaway food outlet concentrations can increase litter, anti-social behaviour, and the quality of their food, often energy dense and nutrient poor, makes them a public health concern. Increased exposure to takeaway food outlets is associated with greater odds of being overweight or obese (90).

A number of areas in the Region have taken action to improve their high streets, including Sefton's Public Health team have been involved with the regeneration of the Strand and Bootle High Street, Box 7.

Box 7. Planning healthier and more equitable spaces in Sefton

In 2017 Sefton Council purchased the Strand shopping centre as part of its long-term plans to regenerate the Strand and Bootle town centre. Pre-pandemic, the public health team were involved in scoping out the breadth of pro-health and pro-equity opportunities presented by the project and its potential to influence a range of locally relevant health determinants. For example, using health promoting models to guide improvements in the built environment, including spaces that support community bridging and bonding and creating opportunities for inclusive economic development.

People living in this part of Sefton are more likely to have multiple long-term physical and mental health conditions, and to experience the impact of these earlier in life - health inequalities rooted in the higher proportion of low income households and high rates of child poverty. Indicators from ward profiles highlighted other local issues - a higher number of people living alone, and most households without access to their own vehicle. Whilst this part of Bootle has substantial green and blue space assets, it is also situated close to Sefton's Air Quality Management Areas and air pollution is a health concern for many in these communities. Applying a health determinants perspective helps to ensure that improvement schemes work for the needs of local people and create enriching environments for everyone to enjoy.

In 2021 work to identify options to revitalise the Strand and surrounding area continues and has been complemented through more recent input from Public Health into the Bootle Area Action Plan**.** This includes a pilot initiative launched when Sefton Council was selected as one of 14 areas to test out the multi-disciplinary approach behind the Government's new National Model Design Code, which aims to help Planners and Communities work more collaboratively to design good quality built environments. Work to date has gathered in a broad range of health considerations spanning from active travel barriers, to housing needs of people with long-term health conditions, the socio-economic determinants of obesity, options for maximising social value returns, policies that could bring more focus to local income inequality, and the importance of respecting the distinctive qualities of place that foster a sense of belonging and community. The first stage of community consultation on the Our Future, Our Bootle Area Action Plan is live until January 2022 (91).

3C COVID-19 PANDEMIC AND HEALTH INEQUALITIES

The pandemic has revealed the entrenched health inequalities and our *Build Back Fairer* report stated:

> *"There is an urgent need to do things differently, to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a wellbeing economy that puts achievement of health and wellbeing, rather than narrow economic goals, at the heart of government strategy; to build a society that responds to the climate crisis at the same time as achieving greater health equity."* (49).

The stark evidence of inequalities in COVID-19 cases and mortality have strengthened awareness and appetite for the NHS to take action. A survey of healthcare leaders in 2021 found 81 percent either 'agreed' or 'strongly agreed' tackling health inequalities should be a key measure when reviewing the

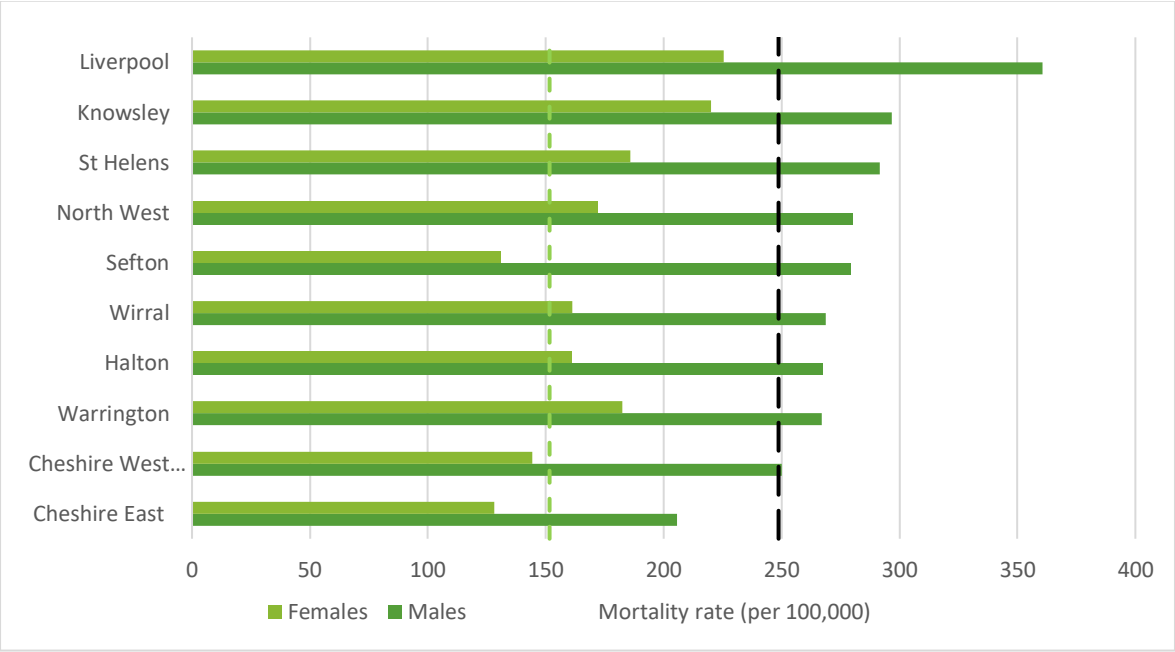
performance of senior NHS leaders and their organisations and 91 percent stated addressing health inequalities should be a priority as the NHS moves forward from the COVID-19 pandemic (92).

The pandemic has shown that NHS place-based approaches can address inequalities. There are numerous examples in Cheshire and Merseyside and across England which show the NHS working in partnership (with local authorities, the VCF sector) to reduce inequalities in COVID-19 vaccination uptake. In Cheshire and Merseyside the NHS can build on these successes to implement new actions to reduce inequalities but there are also other examples of partnerships developed by Clinical Commissioning Groups (CCGs), set out in Joint Strategic needs assessments (JSNAs) – where previous actions have sought to reduce inequalities but have not been scaled up to achieve more substantial impacts.

This report aims to provide additional impetus and practical actions for consideration about the NHS in Cheshire and Merseyside, through the HCP and ICPs, how they can scale up their efforts to reduce inequalities and implement approaches throughout the system which can improve outcomes in the social determinants of health to improve health and reduce health inequalities. These should be done in concert with reducing inequalities in diagnosis, access to services and in outcomes from treatment. These social determinants of health approaches will require strong partnerships with local authorities, public services, businesses, the VCF sector and communities.

Compared to most other countries, England has reported high COVID-19 mortality rates (93). The age-standardised COVID-19 mortality rate in Cheshire and Merseyside has been higher than the national average. Between March 2020 and April 2021, the COVID-19 mortality rate in Cheshire and Merseyside was 276.7 per 100,000 population for men and 171.1 for women compared with 248.7 for men and 151.6 for women for England (94). Figure 44 shows that Cheshire and Merseyside as a whole, and all but one of its boroughs for men (Cheshire East) and three areas for women (Cheshire East, Cheshire West and Chester, Sefton), had higher mortality rates from COVID-19 than England, over the period March 2020 to April 2021 (95).

Figure 44. Age standardised COVID-19 mortality per 100,000, England, the North West, Cheshire, and Merseyside boroughs, 14 month total (March 2020 to April 2021)



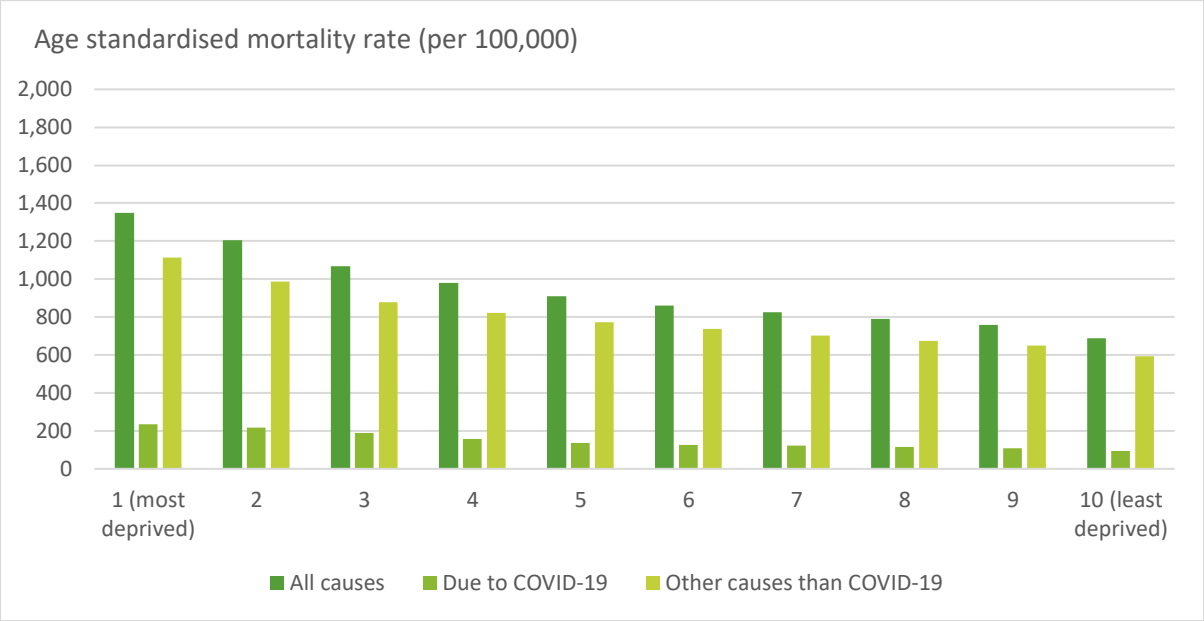
Female England average
Male England average

Note: Deaths 'due to COVID-19' only include deaths where coronavirus (COVID-19) was the underlying (main) cause.
Source: ONS. Age-standardised rates from COVID-19, People, Local Authorities and Regions in England and Wales, deaths registered between March 2020 and March 2021 (95).

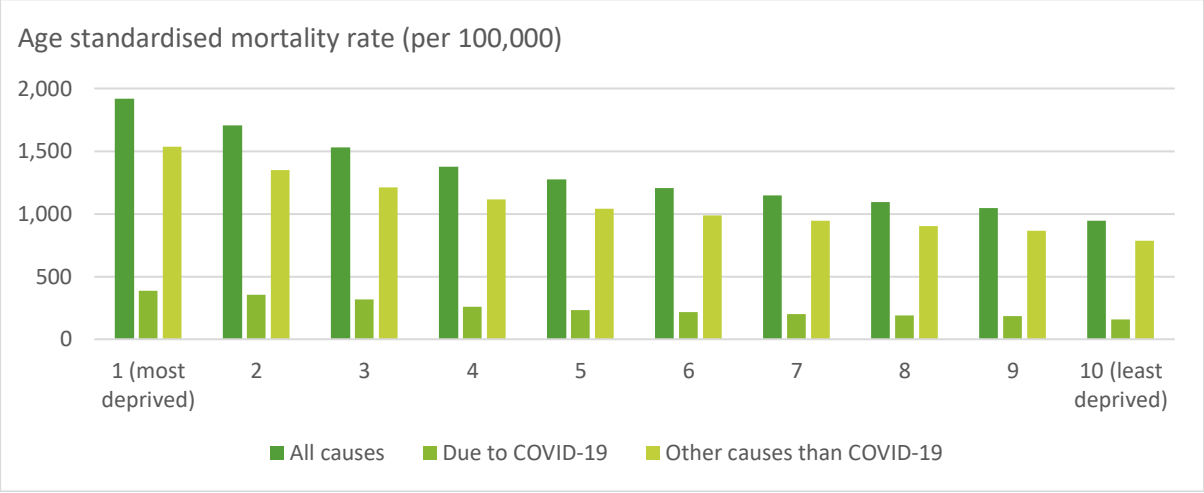
The relationship between all causes of mortality and deprivation in England reflects the relationship between deprivation and mortality from COVID-19, Figure 45. The more deprived the area, the greater the mortality rate from COVID-19. The gradient was slightly steeper for COVID-19 than for all-cause mortality.

Figure 45. Age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by sex and deprivation deciles in England, March 2020 to April 2021

a) Female



b) Male



Source: ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2021 (94)

The close associations between deprivation and mortality rates from all causes of death and COVID-19 helps areas understanding how COVID-19 has affected inequalities in mortality and how to develop appropriate and effective remedial interventions.

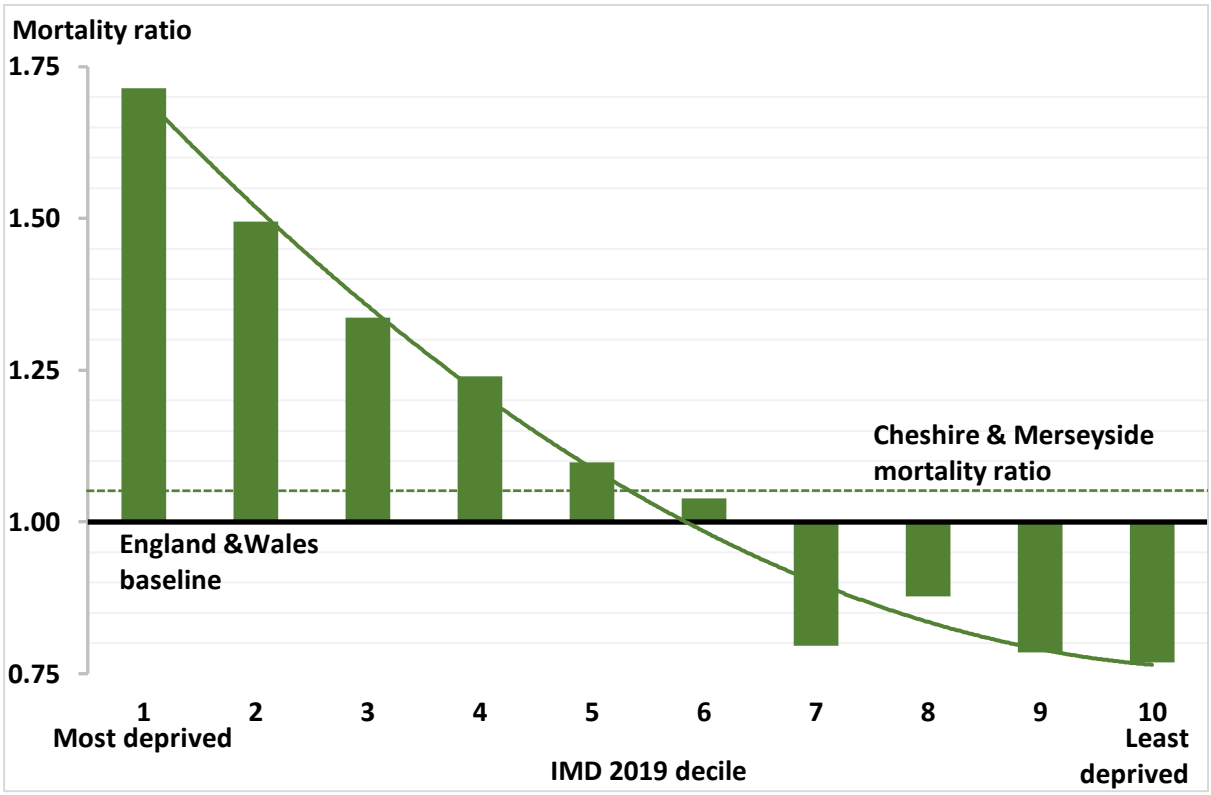
Overall, COVID-19 mortality in Cheshire and Merseyside was 5 percent higher than the England and Wales average between March 2020 and April 2021, with wide inequalities in mortality. In the *four least deprived areas* (measured by the Index of multiple deprivation), mortality from COVID-19 *was lower* than the England and Wales average over the same period, but in the other six deciles COVID-19 mortality in Cheshire and Merseyside *was greater* than the England and Wales average. For the most deprived decile

in Cheshire and Merseyside, the mortality ratio was 2.23 times higher than that of the least deprived decile.

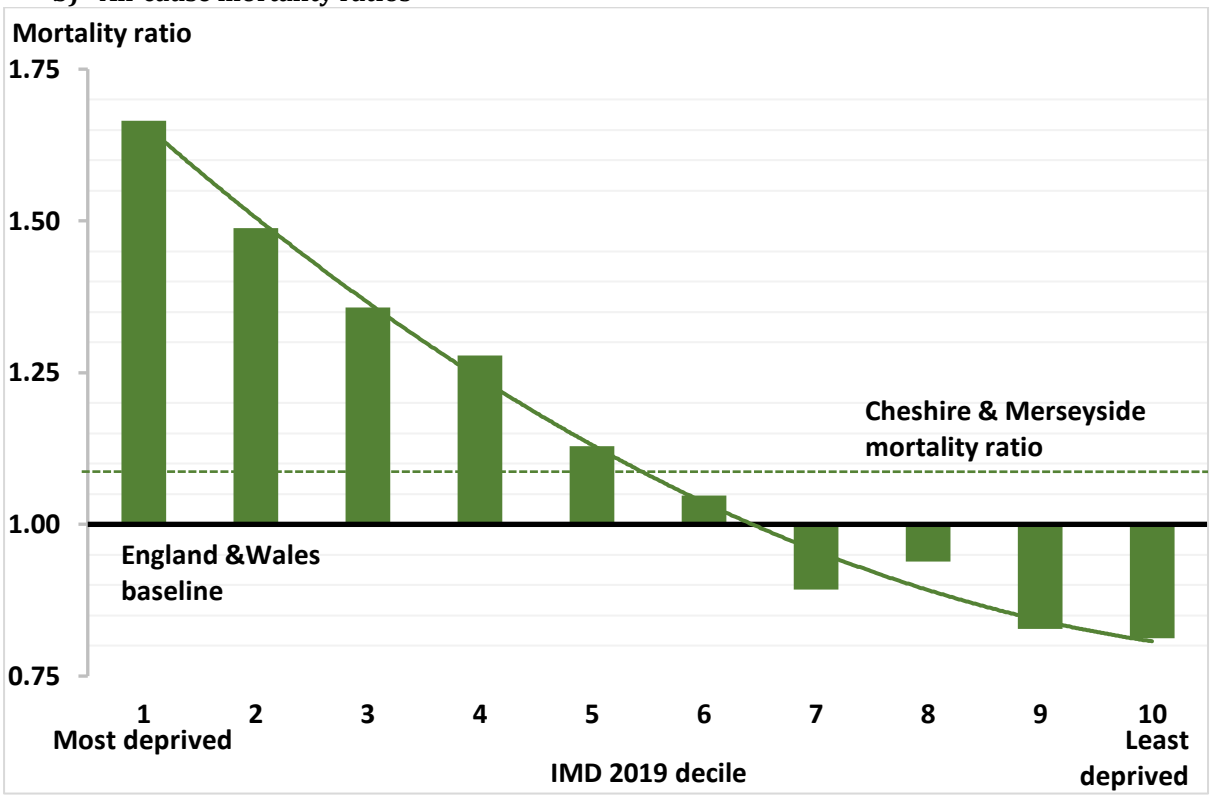
Figure 46 shows the ratio of COVID-19 mortality by deprivation using deciles in the Index for Multiple Deprivation (IMD) within Cheshire and Merseyside compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. Overall, COVID-19 mortality in Cheshire and Merseyside was 5 percent higher than the England and Wales average between March 2020 and April 2021, with wide inequalities in mortality across deprivation deciles. In the four least deprived areas, mortality from COVID-19 was lower than the England and Wales average over the same period, but in all other deciles COVID-19 mortality in Cheshire and Merseyside was greater than the England and Wales average. In Cheshire and Merseyside the COVID-19 mortality ratio in the most deprived decile was 2.23 times that in the least deprived decile. In the Region, as for England as a whole, inequalities in COVID-19 mortality are slightly wider than for all-cause mortality, Figure 46.

Figure 46. Age and sex standardised mortality ratios by IMD 2019 deciles of MSOAs* in Cheshire and Merseyside, March 2020 to April 2021

a) COVID-19 mortality ratios



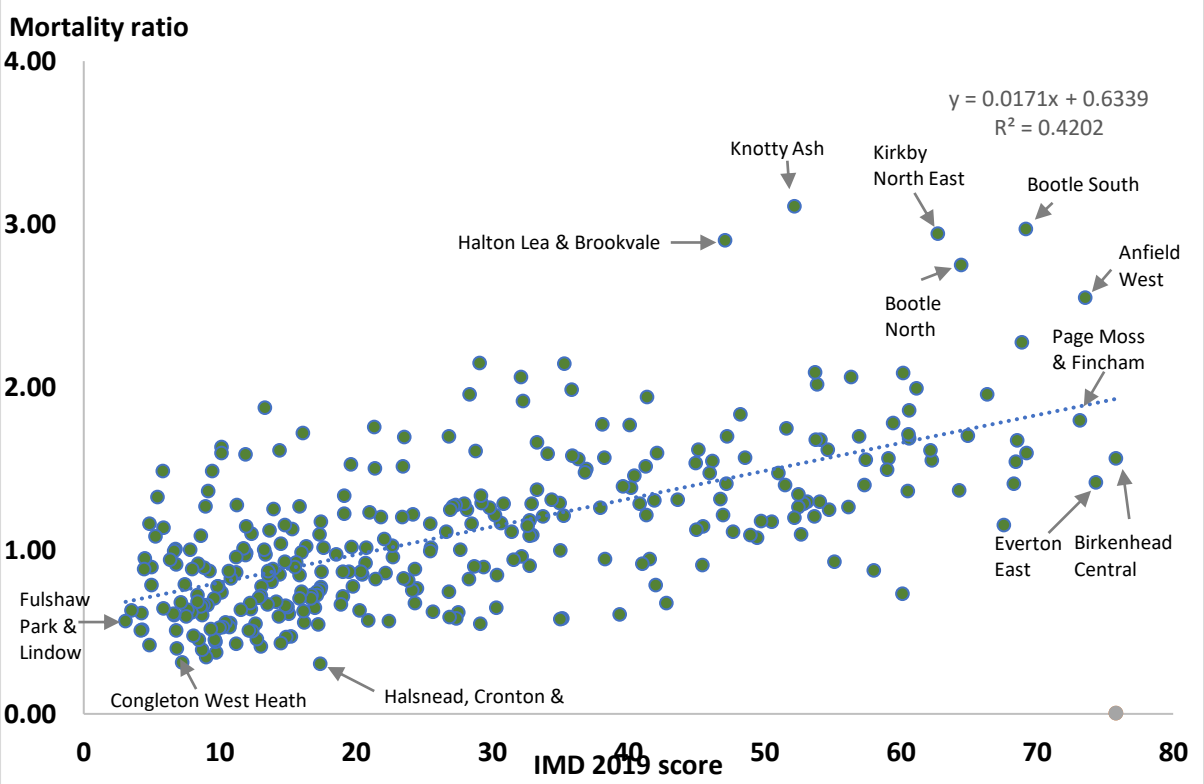
b) All-cause mortality ratios



*Notes: *MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these domains for each MSOA, as set out in the Technical Report on The English Indices of Deprivation 2019* (96). *Deciles were obtained by ranking each MSOA within Cheshire and Merseyside and then population weighting these ranks to split all MSOAs into 10 groups with equal sized populations, ordered according to the IMD scores of the MSOAs in each group. Mortality ratios were obtained by applying England and Wales COVID-19 mortality rates to the age and sex specific populations of each decile to obtain an expected number of deaths and then dividing the observed number in each decile by this figure. The horizontal black line shows a ratio equal to one, representing the England and Wales average. Deciles above this line have more deaths than expected based on this average, those below the line fewer deaths. The ratio of COVID-19 mortality for Cheshire and Merseyside as a whole is shown by the horizontal green dotted line.*
Source: ONS. Deaths due to COVID-19 by local area and deprivation, March 2020 to April 2021 (94)

Figure 47 shows the mortality ratios for each neighbourhood (middle layer super output area) to explore how mortality from COVID-19 varied between neighbourhoods in Cheshire and Merseyside. Each dot represents the mortality of a neighbourhood and its association with deprivation. There is considerable variation around the trendline, suggesting that factors other than deprivation (as measured by the IMD) may have influenced the size and effect of local disease outbreaks during 2020. These include the outbreaks in care homes, particularly in the period March to July 2020.

Figure 47. Age-adjusted COVID-19 mortality ratio of observed to expected deaths by level of deprivation, March 2020 to April 2021, neighbourhoods (MSOAs) in Cheshire and Merseyside



*Notes: *MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these domains for each MSOA, as set out in the Technical Report on The English Indices of Deprivation 2019* (96). *Mortality ratios were obtained by applying England and Wales COVID-19 mortality rates to the age and sex specific populations of each decile to obtain an expected number of deaths and then dividing the observed number in each MSOA by this figure.*
Source: ONS. Deaths due to COVID-19 by local area and deprivation, March 2020 to April 2021 (97)

IMPACT OF SOCIETAL RESPONSES AND CONTAINMENT MEASURES ON INEQUALITIES

The accumulated risks for higher COVID-19 mortality - deprivation, underlying health conditions, occupation, living conditions, black and ethnic minority ethnicity – were created prior to the pandemic, and are the reason for England's high and unequal morality rate from COVID-19 (2).

Our Build Back Fairer analyses in England outlined how the pandemic has widened inequalities in children and young people, education, employment, housing, income, communities and place and public health. These worse outcomes in the social determinants of health will affect health and worsen inequalities, Box 8.

Box 8. Summary of COVID-19 containment impacts on inequalities
EARLY YEARS AND DURING SCHOOL-AGE EDUCATION
• More disadvantaged children have been disproportionately harmed by closures of early years settings and levels of development have been lower than expected among poorer children.
• Parents with lower incomes, particularly those who continued working outside the home, have experienced greater stress when young children have been at home.
• Many early years settings in more deprived areas are at risk of closure and of having to make staff redundant as a result of containment measures.
EDUCATION
• Compared with children from wealthier backgrounds, more disadvantaged children were disproportionately harmed by closures in the following ways:

- Greater loss of learning time
- Less access to online learning and educational resources
- Less access to private tutoring and additional educational materials
- Inequalities in the exam grading systems

• Children with special educational needs and their families were particularly disadvantaged through school closures.
• School funding continues to benefit schools in the least disadvantaged areas the most, widening educational outcomes.

CHILDREN AND YOUNG PEOPLE

• Indications are that child poverty will increase further.
• Food poverty among children and young people has increased significantly over the pandemic.
• The mental health of young people, already hugely concerning before the pandemic, has deteriorated further and there is widespread lack of access to appropriate services.
• Exposure to abuse at home has risen through the pandemic, from already high levels beforehand.
• Unemployment among young people is rising more rapidly than among other age groups and availability of apprenticeships and training schemes has declined.

EMPLOYMENT AND GOOD WORK

• Countries that controlled the pandemic better than England have had a less adverse impact on employment and wages.
• Rising unemployment and low wages will lead to worse health and increasing health inequalities.
• Rising regional inequalities in employment in England relate to pre-pandemic labour market conditions.
• Overall, unemployment has risen slowly so far, protected by the Coronavirus Job Retention Scheme (furlough), but will rise considerably now the scheme has ended.
• Low-income groups and part-time workers are most likely to have been furloughed and furloughed staff have experienced 20 percent wage cuts from their already low wages.
• Older Pakistani and Bangladeshi people were more likely to be working in shutdown sectors, compared with other groups.
• There were over 2 million jobs where employees were paid below the legal minimum in April 2020, more than four times the 409,000 jobs a year earlier.

STANDARDS OF LIVING AND INCOME

• Young people and BAME groups have been most affected by decreases in income.
• Poverty is increasing for children, young people and adults of working age.
• Increases to benefit payments have protected the lowest income quintile (the poorest) from the effect of decreases in wages but have not benefitted the second quintile to the same extent.
• The two-child limit and the benefit cap are harming families and pushing people into greater poverty.

PLACES AND COMMUNITIES

• The same communities and regions that were struggling before the pandemic – more deprived areas and ignored places – are struggling during the pandemic and this will likely continue in its aftermath. Their resilience has been undermined by the effects of regressive reductions in government spending over the last decade.
• Pre-pandemic cuts to local authorities were higher in more deprived areas, leading to greater losses in services there.
• Local authorities are now under even more intense pressure and extra government funding will not make up the shortfall.
• Continuing high costs of housing are pushing even more people into poverty as incomes fall.
• Rough sleeping was eliminated early on in the pandemic, showing what is possible. However, it is already increasing again.
• The number of families in temporary accommodation has increased.
• Private and social renters live in unhealthier conditions and have struggled more with lockdown

PUBLIC HEALTH

• The priority and importance of public health has increased during the pandemic and public health is now a central concern of the public and Government, with a new focus on the importance of protecting and improving health in England.
• The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
• Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
• There have been some significant changes in behaviours during lockdown – including potentially increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.

• We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of Build Back Fairer.
• Inequalities in health behaviours should also be a priority area for action.
• The Public Health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
• The Public Health system needs higher levels of investment and resourcing from central government – sustained cuts of 22% in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
• Underfunding and planned reorganisation of Public Health organisations and workforce has undermined capacity to contain the pandemic and improve health through the containment measures (49), (98).

DEPRIVATION, POVERTY AND DEBT

Official data on poverty levels during the 2020 COVID-19 pandemic will be available in 2022. The most recently published child poverty rates were published in March 2021 and showed the rates of children living in relative and absolute low-income households increased in 2019/2020, a number that has increased since 2012 in the absence of a strategy to reduce child poverty (99). In the interim, there are numerous indications that poverty will increase (100).

The removal of the £20 uplift in Universal Credit, the end of the furlough scheme, and the eviction ban ending are all affecting the incomes of those in the lowest income brackets. Estimates range from between 500,000 to 1.2 million extra people living in poverty in 2021 (101) (102). Citizens Advice has identified that people are one and a half times more likely to claim Universal Credit in places the Government has prioritised for levelling up investment. They also found for every £1 that could be invested from the Levelling Up Fund in England, £1.80 would be taken from these local economies following the Government stopping the uplift (103).

The average cost of living is increasing in the UK, in October 2021 prices had risen by an average of 3.1% in the previous 12 months, with estimates it could rise to 4% by December 2021 (104). Resolution Foundation analysis of family spending in May and September 2020 found families on a low income, especially those with children, were the most likely to report they were spending more during the pandemic compared to those on higher incomes, who saw their savings rise (105). A *Financial Times* analysis of ONS data found those in the poorest decile spent, on average, 21% of their expenditure on to food, gas and electricity whilst the richest decile spend 9.5% of their expenditure and estimate due to increasing prices, the poorest decile will spend 23% of the income on food, gas and electricity by the spring of 2022 (106).

The Centre for Cities found high levels of debt in Liverpool as a result of the pandemic, estimating half of Liverpool's neighbourhoods have been pushed into debt because of the pandemic (107). The Child Poverty Action Group survey also found around half of all families responding stated they had a new or worse debt problem (100).

Out of 151 upper tier local authority districts in England, Knowsley is the third most deprived district, Liverpool the fourth and Halton is the 31st most deprived district in England (55). In October 2020 Cheshire West and Chester Council declared a poverty emergency, in response to the pandemic but also reflecting the work of the two Poverty Truth Commissions, held in the borough since 2017, and Cheshire East have also recently initiated an Increasing Equality Commission, Box 9.

Box 9. Cheshire West and Chester Poverty Truth Commission and Cheshire East's Increasing Equality Commission

Cheshire West and Chester Council established its first Poverty Truth Commission in 2017, with the aim of tackling the root causes of poverty and address the gaps in services across the borough. The local public health team and the Health and Wellbeing Board supported the Commission.

Community Inspirers shared their lived experience of poverty, the effect it had had on them and that of their families and the time and strength it takes to recover from it. Through true listening and collaboration, members of the Commission were able to reflect on how borough systems and process could better support local people. Based on these listening exercises, three priorities were identified for the Commission to work on in its first year: the relationship between mental health and wellbeing (the impact poverty has on people's mental health and vice versa); developing a person-centred approach (focusing on how people's experiences make them feel and what effect that has on their dignity); and benefit systems (supporting people to navigate current systems).

The second Poverty Truth Commission was launched in 2019 and ran until 2020 (50). Its main outcomes include:

- Creating a voice and empowering inspirers to contribute to a range of Council and partner agency work.
- Inspirers feel listened and able to influence change, by sharing their lived experience of poverty. Community Inspirers consistently reported a stronger sense of confidence, enabling them to have voice, secure employment, develop their learning, become more independent.
- Increased partnership working across a number of agencies.
- New models of working across the Council, the voluntary sector, businesses, and the wider community.
- New support for front line staff to understand the story of the person in front of them (their challenges, stresses and often complex problems) and the need for compassion, empathy, and making any difference they can, no matter how small.

As a result, one social housing provider moved from a process-driven approach to offering a person-centred, wellbeing service which focuses on early intervention and supporting people to sustain tenancies and they are now reporting a 75 per cent reduction in evictions.

Its work continues to have an impact, in July 2020 a report to the Council's Cabinet proposed the Council declare a poverty emergency for the borough and this was adopted by elected members in October 2020. The declaration sets poverty, alongside climate, in providing the framework for a fairer, greener recovery. As part of the declaration a number of commitments were set out, along with key principles to underpin its approach. The Council has committed to:

- Treat the issue of poverty as an equalities and fairness issue.
- Work collectively to gather better quality evidence on the impacts of poverty, including the full range of disproportionate impacts of the crisis on those struggling on low incomes.
- Put quality lived experience alongside quality evidence and partnership, including cross-council and cross-party partnership, at the heart of our approach.
- Provide the spaces and opportunity for those affected by low income to gather, learn, strengthen and support one another in raising their democratic voice on the poverty-related issues that directly affect them, locally and nationally.
- Explore routes to incorporate Community Wealth-Building and Collective Ownership approaches that address low income and environmental concerns within the Council's own provision and across the borough, with a focus on the communities most harshly economically impacted by the crisis.
- Collaborate, work collectively and celebrate one another's successes.
- Put working together to solve the root causes of poverty at the heart of our agenda, recognising that poverty is not a lifestyle choice.

The Council are currently working with the Poverty Truth Commission and a wide range of stakeholders to develop a Fairer Future Strategy (51).

In **Cheshire East** the Increasing Equality Commission, a subgroup of the Health and Wellbeing Board, was established in December 2020. The Commission will adopt a co-ordinated and comprehensive approach

to address issues related to where people live – the environment, green spaces, crime and anti-social behaviour, access to services – and factors affecting their individual circumstances - education and skills, employment, income, poverty, housing conditions, health and wellbeing. Their terms of reference endorses 'courageous and honest' approaches that are evidenced-based and that promote dignity and respect.

The Commission supports strategies that invest in prevention and sustainable and inclusive growth when addressing the increasing demand on public services. Its aim is to identify areas for local action and interventions to increase equality and opportunity within the population of Cheshire East and during their first year, the Commission will focus on Crewe.

Employment

The pandemic has hit the local economies in Cheshire and Merseyside. 28% of all those in employment in the Liverpool City Region were furloughed at some point during the pandemic and the claimant count rose by 54%, from 41,505 in March 2020 to more than 63,110 in August 2021. In the Cheshire and Warrington Local Economic Partnership recovery has been quicker, claimants numbered 29,615 in March 2020 and dropped to 21,780 in August 2021, a 26% decrease (110). The National Audit Office estimated there was a £600m funding gap arising from the COVID-19 pandemic (111).

Since 2010 changes to the welfare benefit system, the freezing of benefits since 2015-16, and changes to tax credits, have significantly and negatively affected low- and middle-income households and children and widened income inequalities, with the poorest penalised the most (112). Research from the Resolution Foundation shows benefit support for those out of work in 2019-20 was £73 a week lower than in 1991-92 and child benefit in 2019-20 was worth less than when it was fully introduced in 1979 (113).

Education

Educational losses as a result of the pandemic were more significant in deprived students (49). The Social Mobility Commission show that at the start of the new academic year in 2020, disadvantaged pupils in primary school were seven months behind more wealthy peers (114).

4 ROUTES FOR ACTION IN CHESHIRE AND MERSEYSIDE

Reducing health inequalities requires effective national prioritisation, policies, resources and action (64), (49), (21). As we have assessed in other reports, there are serious limitations in national approaches to reducing health inequalities in the 11 years since the original Marmot Review (21), (49), (98). We have also described how many local authorities have developed effective action to reducing health inequalities, even in the context of austerity, highly limited resources and the COVID-19 pandemic. However, local authorities cannot take on the required action alone – they do not have sufficient resources, capacity and levers to achieve that. Other stakeholders, particularly the NHS and business have a lot of potential, mostly underdeveloped, to initiate and implement actions on the social determinants of health to reduce health inequalities.

Addressing health inequalities requires addressing the social determinants of health and shifting the NHS's priorities from treating inequalities to preventing inequalities. Focussing solely on reducing inequalities in access to care is not sufficient: reducing health inequalities requires implementing actions to prevent inequalities, addressing the causes of the causes. For example, inequalities in deaths from cancer will not be addressed by improving access to cancer services alone. Reducing these inequalities requires the NHS to take actions to reduce the upstream causes of inequalities. Indeed, the NHS Long Term Plan states the NHS cannot simply 'treat' inequalities:

> *"While we cannot treat our way out of inequalities, the NHS can ensure that action to drive down health inequalities is central to everything we do"* (115).

THE NHS AND THE SOCIAL DETERIMINANTS OF HEALTH

IHE have previously set out potential routes for the NHS and healthcare staff to take action on the social determinants, Box 10. These opportunities have become more important as health inequalities widen and as the development of Place Based health care systems provides further opportunities for the NHS to act on the social determinants of health.

Box 10. The NHS, health inequalities and the social determinants of health

The NHS and health care staff has many routes to improving the social determinants of health – including through:

- **Workforce education and training:** Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and referring patients to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses. Student placements in a range of health and non-health organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students' knowledge and skills related to the social determinants of health.
- **Working with Individuals and Communities:** Gathering information health professionals should be taking a social history of their patients as well as medical information. This should then be used in two ways: to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care. Providing information health professionals should refer their patients to a range of services – medical, social services, other welfare agencies and organisations, so that the root causes of ill health are tackled as well as the symptoms being medicated.
- **NHS Organisations:** Health professionals should utilise their roles as managers and employers to ensure that:
  - Staff have good quality work, which increases control, respects and rewards effort, and provides services such as occupational health.
  - Their purchasing power, in employment and commissioning, is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.
  - Strategies on health inequalities are given status at all levels of the organisation, so the culture of the institution is one of equality and fairness, and the strategies outlined elsewhere in this document are introduced and supported

- **Working in partnership:** In order to take effective action to reduce inequalities, working in partnership is essential. Evidence shows that effective action often depends on how things are delivered, as much as what is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector or draws on information and expertise from other sectors. Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of stakeholders that have the potential to affect social and economic conditions, including local government, business and the VCF sector (116).

There are also important and underdeveloped ways for large businesses and other stakeholders to support local businesses and the economic sector more broadly to use the many opportunities they have to reduce health inequalities. Communities, should be the focus of the action and all the sectors noted above, can work to support and build community resourcefulness in areas which they have influence.

This report also overviews the opportunities for health and care organisations and the economic sector, particularly businesses to support health and reduce health inequalities in local areas, leading to an approach for both sectors to collaborate with other sectors to build community resourcefulness. Initially we set out current health inequality priorities in the Region, and overview approaches to reduce inequalities in the social determinants of health in the Region.

3A CURRENT HEALTH INEQUALITY PRIORITIES IN CHESHIRE AND MERSEYSIDE

In the absence of a national England-wide health inequalities strategy since 2010, local and regional organisations, such as Health and Wellbeing Boards, CCGs and individual staff, have taken their own actions and developed their own strategies. While these are helpful in supporting local action, given the reduced funding, they are necessarily limited in the impact that they can have. Nonetheless, there are some helpful actions and approaches which can be fostered locally and as we point out, there is underdeveloped opportunity and capacity for greater impact on the social determinants of health from the business and economic sector and the NHS.

THE NHS

While NHSE have placed a great deal of emphasis on reducing health inequalities in recent years, this mostly relates to the task of reducing inequalities in access to care and outcomes from treatment. IHE, and others, have argued that the NHS should take a much broader view of their role in supporting population health than just access to health care – important though that is.

In Cheshire and Merseyside the aim of each ICP is to 'ensure local services (primary care, social care, community & mental health) are joined up and supporting people to manage their own wellbeing' (120). Each ICP should challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place-and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers (121).

Knowsley and Liverpool have created posts to specifically address the wider determinants of health, Box 11.

Box 11. Unique posts to address the wider determinants of health

Knowsley created the role of Public Health Programme Officer in March 2020 to support the core Public Health team to deliver its functions around influencing the wider determinants of health, reducing health inequalities and health improvement. They work across different parts of the council, wider partners and the community to embed health equity into policies, strategies and practice.
They develop projects, programmes and initiatives aimed at improving the wider determinants of health and contribute to policy and strategy decision-making. In 2021 they influenced Knowsley's new Housing Strategy and Gambling Policy; contributed to local planning decisions and planning processes; studied the

impact of COVID-19 on health inequalities in the borough to inform policy and the Joint Strategic Needs Assessment and are piloting a health impact assessment document for use within Knowsley council.

Liverpool City Council have also recently employed a Senior Public Health Practitioner – Wider Determinants who is leading multi-agency projects across the city to improve health and reduce health inequalities.

LOCAL GOVERNMENT

All nine boroughs within the Cheshire and Merseyside region have existing priorities for improving the health and wellbeing of their residents and to reduce health inequalities. Each of the boroughs have identified health inequalities and the social determinants of health as areas for action. Similarly, there is a consistent theme that integrated working, across partnerships within and without the health and social care sector, using existing assets and resources, guided by local communities, with a focus on prevention and early intervention, has the potential to be more effective and more cost-efficient than ever before.

Health and Wellbeing Boards have been central to leading place-based partnerships and bringing together the key NHS, public health and social care stakeholders in local areas to work together to commission services (119). Learning from the successes and challenges from local Health and Wellbeing Boards is a useful for local health leaders. In July 2021 Cheshire and Merseyside Council Leaders and Health and Wellbeing Chairs stated what is needed to achieve success in addressing health inequalities in Cheshire and Merseyside, Table 1 features the key factors.

Table 1. Actions identified by HWBs and council leaders to achieve health equity in Cheshire and Merseyside

Addressing health inequality at place should be a central guiding principle of the HCP, and all its decisions should be measured against that principle.
Statutory Health and Wellbeing Boards should continue to be recognised as the appropriate basis for effective governance and accountability for place-based partnership; bringing together local government leadership, with leaders of the local NHS, the voluntary and community sector, and other stakeholders
Local commissioners, including councils and the NHS, to work alongside providers to deliver improved health and social care and wider population health management outcome and should play a lead role in place-based partnerships, under the leadership of Health and Wellbeing Boards, with specific arrangements determined through local discretion. HCP place-lead roles should be jointly appointed with councils, including the option of joint HCP-council senior officer appointments.
NHS spending in each place should be determined in partnership with local government, working to deliver integrated care to their communities, including through effective arrangements for joint commissioning of services.
The HCP should develop effective mechanisms for public engagement in co-production and decision-making, in particular communities with direct experience of health care, poverty, and poor health outcomes.
Partnerships between councils (including elected councillors) and multidisciplinary teams working with primary care networks should be strengthened, to form care communities, addressing the diverse health needs of different communities across Cheshire and Merseyside.
Funding allocations to places and providers should be transparent, fair, and subject to local democratic challenge, with an emphasis on community-based and preventative services. They should invest in local place-based plans and ensure the long-term financial sustainability of NHS and social care provision across all our communities **(1)**.

PUBLIC HEALTH - CHAMPS PUBLIC HEALTH COLLABORATIVE

Champs, the Cheshire and Merseyside Public Health Collaborative led by the nine Directors of Public Health in Cheshire and Merseyside, leads local systems, and seeks to influence strategic partnerships to focus on prevention, health inequalities based on the best data and evidence.

The Population Health Board is made up of partners from across the public sector and leads a series of programmes to improve health and increase life expectancy. Specific actions to address inequalities and the social determinants of health are needed in the five main Champs Public Health Collaborative programmes: the Cardiovascular Disease Programme; Reducing Harm from Alcohol Programme; Cancer Screening Programme; Physical Activity Programme and the Suicide Prevention and Bereavement Programme. A deliberate and specific plan to address health inequalities is needed in the Population Health Board's plan otherwise there is a risk that health inequalities will be featured, but not addressed.

All nine boroughs have already identified their health inequalities priorities within their local plans and are undertaking actions.

Two of the key policies Champs Public Health Collaborative are supporting to improve population health are the NHS Prevention Pledge and 'Making Every Contact Count'. The NHS Prevention Pledge aims to ensure prevention is embedded across all NHS providers across Cheshire and Merseyside. This work also involves helping NHS providers to become anchor institutions and system leaders in prevention. Making Every Contact Count (MECC) seeks to embed a prevention approach in the NHS. Support is needed to reinvigorate this programme after the pandemic and to ensure it is equity aware. This can involve work with a range of NHS staff and non-NHS partners to deliver services or signpost to services and embedding this work in ICP contracts and plans.

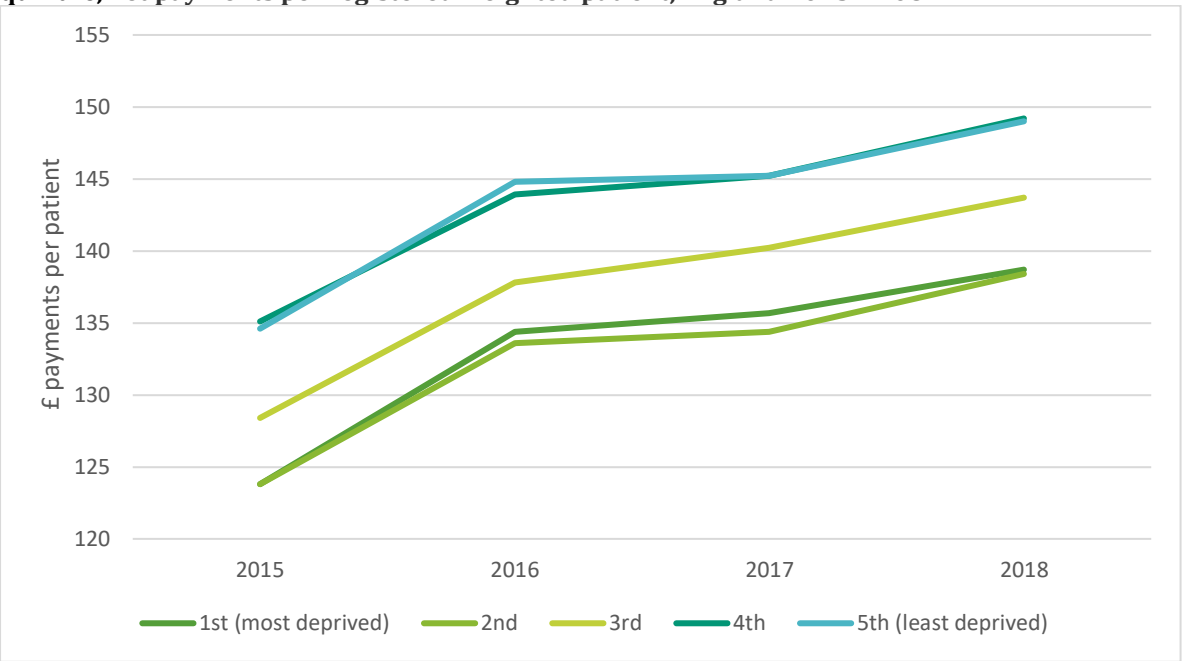
The lack of a specific actions related to prevention or health inequalities reflects a review of 44 sustainability and transformation partnership (STP) plans (the precursors to ICSs). The review, from 2016, found that whilst prevention was included in all plans, the plans 'often lacked detail and had little on population-level interventions affecting the social determinants of health… fewer than half of plans included detail on how they will work with their local government public health team' (120). Instead, STP prevention strategies more commonly concentrated on individual-level behaviour change interventions. A Cochrane review of the wider determinants in childhood obesity research, which also found most interventions targeted individual and family behaviours and not the wider, upstream causes (such as policies, infrastructure and local environments) (121).

One of the actions for the Cheshire and Merseyside Health and Care Partnership is to ensure primary care provision is not worsening health inequalities in Cheshire and Merseyside. Shortages in general practice are higher in practices in deprived areas. GPs working in practices in the most deprived neighbourhoods have, on average, almost 10 percent more patients than a GP serving patients in less deprived (122).

PRIMARY CARE NETWORKS

The aim of Primary Care Networks is to improve access to primary care and expand the range of services available. Cheshire and Merseyside HCP can work with PCNs to improve access and specifically target areas where general practice is either under greatest pressure and of poor quality, where the inverse care law is occurring and health inequalities widening. General practice should be funded using proportionate universalism whereby all universal services are adequately resourced, and additional funding is provided to areas where the degree of need is higher. Analysis from The Health Foundation showed after weighting for need, practices serving more deprived populations receive around 7% less funding per patient than those serving more affluent populations, Figure 48.

Figure 48. Trends in general practice payments per patient by neighbourhood deprivation quintile, net payments per registered weighted patient, England 2015-2108



Source: NHS Digital, ONS, and MHCLG quintiles aggregated from LSOA 2011 neighbourhoods (122)

Working with Primary Care Networks and leading effective partnerships between primary care and other NHS and non-NHS partners are actions to be taken to reduce inequalities. A survey of primary care leaders and managers by NHS Confederation found 50 percent said they were 'unclear' or 'very unclear' about the role of primary care networks (PCN) within integrated care systems. PCN members stated they wanted the following seen in ICS structures:

- collective voice and representation for primary care at system level
- processes and structures for primary care at place level
- system priorities that reflect local neighbourhood needs
- systems that promote collaboration and enablers that equip primary care for system working.

The NHS Confederation argue 'the duty to collaborate on improving health inequalities could create a shared vision for each system' (123).

Actions for Cheshire and Merseyside HCP to reduce inequalities:

- Analyse primary care provision to ensure the same quality of service is offered in every area Cheshire and Merseyside.
- Analyse commissioning in the NHS to understand which areas are commissioning to reduce inequalities and which areas can do more.
- Bring local population, third sector, academics and health workforce together to develop ways for the NHS to identify people experiencing poverty or at risk of poverty. To help NHS staff identify whether patients are experiencing poverty and how primary, acute, and other services can develop a more effective anti-poverty pathways in the NHS.

5 A HEALTHY AND EQUITABLE CHESHIRE AND MERSEYSIDE REGION

Given the importance of local social and economic conditions in shaping health in Cheshire and Merseyside and the damaging and inequitable impacts of austerity and the pandemic in the Region, there is an urgent need for all local stakeholders to continue work in partnership to reduce inequalities and improve conditions in local areas and develop new partnerships where needed. As set out in this and other reports essential partners in this local system include local government, businesses, the VCF sector, health and social care and communities. Getting the requisite focus and investment is challenging. The actions for consideration are intended to overcome specific barriers and to support greater prioritisation and investment in health inequality. National government must take a much stronger approach to reducing health inequalities across England if they are to meet the challenge of levelling up – but that is not the focus of this report.

Following an initial assessment of the extent of health inequalities in the Region and the actions and responsibilities of a variety of stakeholders, IHE has proposed a number of areas for action across the system. These will be adjusted following input from stakeholders in the Region and are summarised in Box 12.

IHE will the develop a detailed set of draft recommendations which will include immediate and next step actions in order to achieve progress on health inequalities. These will also be provided for each sector - local authorities, HCP and the ICS, public services, businesses, the voluntary and community sector, and communities and include recommendations that the Region must take to national government, including greater resources for levelling up.

In the months after the Interim Report is published IHE will continue to refine the recommendations and develop a detailed action plan for specific sectors and for the system as a whole.

Box 12. Draft areas for taking action on health inequalities

1. Embed a systemwide social determinants of health approach
2. Improve leadership for health inequalities
3. Strengthen local partnerships
4. Co-create solutions with communities
5. Develop social value and anchor organisations
6. Develop shared local indicators
7. Strengthen the role and resources of local government and the NHS in reducing health inequalities
8. Strengthen the role of business in reducing health inequalities
9. Implement health equity in all policy approaches
10. Strengthen community resourcefulness

1 A SOCIAL DETERMINANTS OF HEALTH APPROACH

All partners in the system need to move towards a social determinants approach to reducing health inequalities, including the health care sector. This will be explored in the Place Based workshops.

While recent moves from NHSE and the establishment of integrated care systems do offer opportunities for greater focus on prevention; the prevention agenda must be more than prevention of unhealthy behaviours but focus far more on the causes of those behaviours – the social determinants of health. Examples of social determinants of health programmes already established in Cheshire and Merseyside are set out in Boxes 13 and 14.

Box 13. Supporting Households Into Work

Liverpool City Region Households into Work (HIW) works with long-term unemployed people, providing tailored approaches to help them back to work. They provide 12 months of support, with mental health needs the main support identified in HIW participants. The programme provides a wide range of support services such as addiction, domestic abuse, debt issues or they have low self-confidence and/or low self-

esteem. 72% of their participants live on incomes below £13,000 / year, 40% state they live on less than £6,000 / year (124).

In addition to the innovative and important work done by the Households into Work programme, the Life Rooms project in Liverpool adopts a social determinants approach to address the causes of poor mental health, Box 14. It is a preventative, flexible, socially focused model that encourages the health system shift its focus to the wider determinants of health. They address social determinants of health and, more specifically, address problems related to: social exclusion, poverty, unemployment, lack of education and opportunities, poor housing conditions and fuel poverty, digital exclusion, poor mental health and difficulties engaging with health care services.

Box 14. Life Rooms: addressing the social determinants, the NHS and local partners

Mersey Care NHS Foundation Trust launched its Life Rooms Social Model of Health in May 2016.
The Life Rooms is an innovative community centred service, and its main aim is to improve population health and is based on a social and preventative non-clinical approach that integrates public, private, voluntary and community sector services through the facilitation of existing and developing community-based assets.

Life Rooms works 'side by side' with its users, communities and stakeholders to design, develop and evaluate its services. Services are shaped by everyone in the Life Rooms community; people who access, work and volunteer within the service, as well as partners and the wider community. Working in this way means The Life Rooms is continuously changing in response to the needs and experiences of these stakeholders - the fundamentals of the model do not shift but the approach is flexible, according to place-based need.

The initial evaluations of the impact of this model indicate potential cost-savings, saving 41,000 hours of GP time each year and saving costs equivalent to £13m if expanded across the Liverpool City Region.
The Life Rooms aim to offer a seamless pathway of advice, support and care where people are not required to navigate multiple complex systems based in different places.

Collaborative and cross-sector partnerships are central to The Life Rooms model and they work with more than 120 community organisations, the main collaborations are: voluntary and community sector organisations supporting people with practical and social issues (for example, housing or benefits); clinical and statutory services (for example, Primary Care Teams, Integrated Care Teams, Community Mental Health Teams, Social Care Practitioners); and local people and communities themselves to deliver what is needed and wanted.

They adopt a three-pillar model to support the prevention and population health agendas and to support each person to become motivated to improve their own health:

- **Learning:** A wide range of courses offering support in relation to mental and physical health as well as cultural and creative opportunities. Courses promote social inclusion and focus on lived experience as a key part of learning.
- **Social Prescribing:** Practical and social one to one support in areas such as employment, housing, debt. Individuals are connected to a wider system of community assets, including the voluntary and community sector, and clinical or social care services.
- **Community:** Building an accessible infrastructure within local communities offering welcoming environments and opportunities for collaborative working with the community to inform service

Each Life Rooms' venue offers a range of services, decided on by service users:

- Pathways advisor support (social prescribing support) - practical and social support in areas such as employment, housing or debt.
- Learning - Courses offering support in relation to mental and physical health as well as cultural and creative opportunities. Life Rooms offer learning opportunities that support people with their mental health needs including courses that focus on understanding and managing conditions like depression and anxiety delivered in non-clinical setting.
- Social activities - Informal groups promoting social inclusion and relationship building.

- Employment support - Clear routes to employment, including training and work placement opportunities, support with job searches, CV building and all areas of seeking and gaining meaningful employment.
- Volunteering - Opportunities to build confidence and responsibility through volunteering opportunities within The Life Rooms or in the wider community

From April 2019 to March 2020 Life Rooms had 53,866 visits to their services, delivered 2,562 learning opportunities and 65% of users stated they had improved wellbeing as a result of visiting Life Rooms. In March 2020 Life Rooms moved online and was delivered by telephone and 6,575 telephone contacts took place between April 2020 and March 2021. Re-opening of all face to face activity has commenced. The commitment to remaining physically present within communities is a key feature of the efforts to tackle health inequality but the lessons of COVID-19 means that a remote offer will remain part of how they seek to extend their reach.

Actions for consideration:
2022-2027

- **Ensure social determinants (Marmot 6) are at the heart of interventions and policies in Cheshire and Merseyside including in the healthcare system**
- **Develop and extend proportionate universal approaches** – interventions to reduce inequalities are universal, but with a scale and an intensity that is proportionate to the level of disadvantage. Adopting a proportionate universalist approach in Cheshire and Merseyside requires actions that do not focus only on the most disadvantaged. To reduce the health gradient requires actions across the population, with additional efforts and actions in the most deprived communities.
- Cheshire and Merseyside Clinical Networks to work in harmony with the ICS and Population Health Board to coordinate prevention activity across the system to improve population health, supported by dedicated resources and a Health Inequalities Team.

2 IMPROVING INEQUALITIES LEADERSHIP

Taking action on the social determinants of health and forging the partnerships and collaborations needed to do this requires strong, effective leadership which is focussed on health equity. Where social determinants of health approaches have been successfully implemented they are usually driven by committed leaders (125).

Within Cheshire and Merseyside there is clear demand for approaches on the social determinants of health and a willingness to take action – the leadership is there, but it tends to be diffused between public health, health care and within local authorities and all have to manage with high demand, repeated crises and lack of short and long term investment. Notwithstanding all these demands, there remains and appetite for action and leadership commitment.

There are specific ways leaders can embed and sustain action on the social determinants of health and health inequalities. We recommend that the Population Health Board takes a strong lead in developing partnerships for health, assessing health equity impacts of all activity, strengthening the social and economic impacts of commissioning and all expenditure with a greater focus on equity and ensuring that all staff understand and seek to improve the social and economic contexts of their patients and the areas in which they live. The approaches we advocate are compatible with the NHS Long Term Plan (115). The NHS Long Term Plan requires every local area across England to create specific measurable goals and mechanisms to narrow health inequalities over the next five and ten years.

Immediate opportunities for leaders to request action, map service provision, identify actions to address the social determinants of health including:

- Food insecurity – who are the service providers locally? How can primary and secondary care best refer to these services? How can these services be more preventative and not based on emergency provision?
- Environments and social cohesion

- Fuel poverty - who are the service providers locally? How can primary and secondary care best refer to these services and support people to keep warm especially in the face of escalating fuel costs?

The current membership of the Cheshire and Merseyside HCP Board is made up of 36 members, including the chair and chief officer. Eight local councillors sit on the Board, along with one member representing the voluntary sector. The remaining 27 members, three-quarters of the Board work for the NHS, most trained doctors or in executive positions. Public Health is not included in the Board nor are Primary Care Networks. Including Public Health and PCN input or representation within the evolving ICS Board will be essential if the proposed changes are to achieve their goal of enabling better integration between primary care, acute hospitals, mental health, community and social care services' (126). Whilst PCNs 'are expected to play a central role in 'places' and integrated care systems… these networks are nascent and small-scale, and redefining their functions risks derailing early progress' (127).

Actions for consideration:
2022-23

- Immediate opportunities for leaders to request action, map service provision, identify actions to address the social determinants of health including:
  - Food insecurity – who are the service providers locally? How can primary and secondary care best refer to these services? How can these services be more preventative and not based on emergency provision?
  - Environments and social cohesion
  - Fuel poverty - who are the service providers locally? How can primary and secondary care best refer to these services and support people to keep warm especially in the face of escalating fuel costs?
- Develop a deliberate and specific action plan, with a timeline, to address health inequalities in the Population Health Board's plan to ensure that inequalities will not just feature but be addressed.
- ICS – a Consultant in Public Health Medicine and supporting team to work in partnership with the medical director and nursing director and the DsPH to lead on health inequalities.
- Health inequalities should be integrated within all HCP strategies to support a system-wide approach, coordinated by a health inequalities committee.
- Begin conversations with non-NHS partners on how they can adopt Cheshire and Merseyside's Marmot indicators in their own organisations (e.g. Local authorities, businesses, VCF sector).
- Develop a network of chief executives, in the NHS and beyond, who are committed to reducing inequalities.
- Work with leaders throughout the NHS to adopt equity principles and actions, public health cannot do this alone.
- Ensure the Prevention Pledge and Making Every Contact Count incorporate equity and the social determinants of health, embed this in ICP contracts and plans.

2023-2027

- **Embedding practice.** Consistently share local best practice to reduce inequalities and update regularly. Work with ICPs to facilitate the roll-out for local best practice, enable ICPs to know where best practice is happening and how they can adopt.
- Collect and monitor social determinants data from patients in primary and secondary care, use data to influence services offered and how delivered
- Integrate health equity in all policies in all work commissioned
- Learn from Health and Wellbeing Boards and what has/not worked to address inequalities since they were established. What has enabled partnership working, what are the barriers

3 STRENGTHENING PARTNERSHIPS FOR HEALTH EQUITY

Strong partnerships between all the different regional stakeholders which impact health inequalities is essential to reducing health inequalities. These stakeholders include the VCF sector, health and social care, business and local governments and communities. Forging partnerships, the required partnerships for action on health inequalities, requires shifting priorities and culture. Collaborations do not work

without sustained efforts and actions. Sustainability and Transformation Plans (STPs) in England were expected to increase local governments involvement however they were ultimately 'criticised by council leaders for not involving local government closely enough' (120). It is up to Cheshire and Merseyside to identify and outline the role of the local authority in the HCP's and ICP's work, as it is not outlined in guidance from central government.

Budgets, incentives, work cultures and political, financial and delivery pressures are very different for each stakeholder -however there is an appetite to change and to collaboratively work towards greater health equity. Budgets, incentives, working cultures need to be further aligned. Coventry has made considerable progress in developing joint action on health inequalities among a disparate set of stakeholders, with a "Marmot' working and delivery group (98), (125).

The responsibility to forge strong cross sector partnerships should not fall to a single person or post, such as link workers or social prescribers. For collaborations to succeed, partnerships need to occur at different levels, including at the highest level, strategically, at middle management as well as partnerships for those directly delivering services.

As causes of health inequalities, the social determinants of health are found outside of health systems, it is essential that the HCP and ICPs embed partnerships to influence these wider conditions – the homes where people live, the work they do or apply to do; the schools they attend; the places where they spend time outside; the financial support they do or do not receive; the bus/train/metro/cycling/walking systems they access – all of these factors affect their health, wellbeing and quality of life. Local authorities and the voluntary and social enterprise sector are indispensable partners in providing, supporting and improving these wider conditions.

Whilst there are warnings from, for example, the Health Foundation, that ICSs may not have capacity to deliver effective collaborations (127), the Director of Partnerships in Cheshire and Merseyside has shown innovation and leadership in tackling the social determinants of health. Actions include a memorandum of understanding has been signed with local housing associations, a review of health justice partnerships and the Social Value Award.

Cheshire and Merseyside HCP should be aware of the make-up of its local VCF sector. The vast majority of the VCF sector are small organisations. 83 percent of voluntary organisations had an income of less than £100,000 in 2019 (128). The pandemic has had significant impacts on the VCF sector. A survey of 216 charitable organisations found they received, on average, 29 percent less income during the first lockdown (March-May 2020) and 84 percent of charities reported a decrease or a significant decrease in their total income. Over half of charities, 55 percent stated they were likely they would have to make redundancies as a result of losing funds (129). These decreases in funding are on top of cuts to the VCF since 2010. In addition, the number of volunteers has dropped. Despite large numbers of first-time and more diverse volunteers coming forward during the pandemic, just 24% of charities reported an increase in volunteer numbers since March 2020, compared with 36% who saw a decline (130).

There are many examples of good work between the VCF in the NHS in Cheshire and Merseyside, Box 15.

Box 15. The NHS and Voluntary Sector working together to prevent cancer
The Cheshire and Merseyside Cancer Alliance is currently scoping and mapping cancer data, building a picture of cancer outcomes and inequalities in the region. From this data, priorities will be agreed with key stakeholders. To address poorer cancer outcomes and inequalities, the Alliance plans to reserve a percentage of its project budget into which third and community sector organisations can bid. This reserved 'pot' will be hosted, and administered, by a third sector organisation such as a Community Voluntary Association. The Alliance will work with the VCF partner organisations to develop and agree key metrics against which improvements and inequalities can be monitored.

The National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care North West Coast has health inequalities as one of its main themes and is a valuable asset in Cheshire and Merseyside. There are a number of existing partnerships between the NHS and academics and opportunities for more joint research to address health inequalities.

Actions for consideration:
2022/23
- Strengthen the role of the Director of Partnerships at Board level
- Integrate partnership strategies in each ICP

2023-2027
- Identify leaders and organisations addressing the social determinants of health, such as education, employment and housing and work together to create short and long term strategies to improve the social determinants of health

4 WORKING WITH COMMUNITIES

The success of interventions and policies designed to improve health and the social determinants of health depends on the success of building relationships and coalitions with local communities. Co-creating with the public involves listening to a range of voices in local communities, not only those who have engaged with health systems in the past, or spoken the loudest, but with those in most need, who may need support to communicate their needs and opinions.

It is unclear how the Cheshire and Merseyside ICS will work with the public.

The King's Fund recommend the following priorities for co-created integrated care:
- Identify the issues and challenges that only people and communities can bring to light.
- Start with what matters to people rather than what the system thinks is important.
- Engage with people and communities to ensure systems, services, and programmes are meeting all of the public's needs, especially in the most deprived communities, work with these specific population groups to tackle inequalities.
- Listen to what is meaningful and what matters, and shape HCP work around these insights. Working closely with VCF organisations, patient leaders and user representatives to make sure that issues important to the communities served are being raised and fed into the IC system.
- Stay in regular communication with local communities and be realistic and honest about what will be done with the work and when (131).

Many local councils are well experienced in working with local communities to develop priorities. In Warrington the Central 6 masterplan was developed in partnerships with residents and as the project continues, the fundamental principle is to ensure the communities that live in the different areas are fully involved in decisions and projects that happen in their communities (132).

Community based approaches offer several clear benefits to the efficacy of interventions:
- they are appropriate to local conditions and contexts;
- they involve local people in the design and implementation of appropriate strategies;
- it is often easier to forge the required cross sector partnerships in local areas.

Disadvantages include:
- the often short term duration (and funding) of interventions;
- the lack of funds for local areas;
- pressure taken off larger, more visible political governance structures to take effective action;
- data on local areas is often not available;
- the dependence on active community leadership and involvement which may exclude many communities, particularly those which are already deprived and where communities are under enormous pressures and time constraints.

As part of their approach to reduce health inequalities, local areas are expected to make decisions in consultation with the communities whose health and wellbeing they are seeking to improve and to collaborate with local partners to create sustainable joined-up, efficient and effective services (133). NHS Confederation state the VCF are 'essential' in the shift towards prevention, they have knowledge and networks that are assets for the NHS to reduce health inequalities (134). STPs, many of which have similar footprints to ICS, have worked in close partnership with the VCF sector. The Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan's community services

contract ringfences 3 percent of the ten-year £100 million contract for VCF delivery, equating to £3 million per year (134).

Nottingham and Nottinghamshire ICS, one of the ICS accelerator sites established in 2017, have identified ten actions for success and the first action is to 'create a compelling common purpose with and for your local population'. They suggest actively communicating with the local public, and all those who 'involved in health and care (in the widest possible sense) who instinctively and emotionally want to support population health improvement and the provision of high-quality care' (135).

A key factor in working with local communities is how Cheshire and Merseyside will communicate with them and sharing how the NHS is working with local partners (councils, housing, VCF sector, employers, and others) and to create processes for the public to be able to communicate with their ideas on reducing inequalities.

Actions for consideration:
2022/23
- Involve people with lived experience in the development of health inequalities assessments and remedies at every level, e.g., through the creation of community engagement panels aligned to each ICP.

2023-2027
- Co-create solutions and involve communities in decisions about priorities and actions

5 DEVELOPING ANCHORS AND SOCIAL VALUE ORGANISATIONS

One of the important ways for all organisations, including ICS, NHS trusts, primary care, local authorities VCF and businesses to support health and social outcomes as well as economic value, is through changes to commissioning and procurement. The Social Value Act came into force in 2013 and requires all public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental effects in the procurement of services and contracts. Social value could become enhanced in NHS procurement. In August 2021 the Health Services Journal reported that a 10 percent social value weighting could become a mandatory in all NHS procurement (136). It is essential that NHS take actions now to understand the broader effects of their commissioning and wider elements of social value, beyond cost minimisation (137).

An early review of CCGs published in 2015, suggested CCGs 'have limited capacity and incentives to commission for equity' (138). A systematic review of CCGs found little evidence the reformed commissioning process had reduced health inequalities, most commonly commissioning did not focus on health inequalities; funding was uncertain and there were delays in resource allocation: low levels of trust and poor clarity of the roles and performance and poor relationships between local councils and CCGs in planning and decision-making and concluded 'there is very little evidence in the peer-reviewed literature of clinical commissioning policy having any noteworthy impact on reducing health inequalities' (139).

Cheshire and Merseyside HCP has shown leadership in its actions on social value, Boxes 16 and 17. They aim to have all 19 NHS trusts as well as wider public sector, voluntary sector and businesses sign up to become Anchor institutes, and state it is their 'duty' to ensure that they maximise Social Value opportunities, as a purchaser of goods and services, as an employer, and provider of services. In Cheshire and Merseyside, Anchor Institutions in the Social Value Accelerator site programme include:

- NHS Providers
- Local Authorities
- Clinical Commissioning Groups
- VCF Sector
- Blue Light Services
- Education: Schools, Colleges and Universities
- Business and Industry.

The Social Value Outcomes Framework aims to support local commissioners and is locally defined as:

- the good that we can achieve within our communities, related to environmental, economic and social factors;
- an enabler for the growth of 'Social Innovation' (SI) and helps to reduce avoidable inequalities – linked to the Marmot Principles;
- a requirement of the public sector as 'Anchor Organisations' to use their purchasing power to build capabilities, strengths and assets within our communities, ensuring that Cheshire and Merseyside is a great 'Place' to live and work – Corporate Social Responsibility (CSR) is the response from Suppliers, Business and Industry.

There are actions to take to increase local employment and recruitment in NHS Trusts and addressing current nursing, midwifery, and health visitor vacancies at the same time. NHS Trusts can provide incentives via student loan repayments in exchange for a bonded contract of NHS service (140).

Box 16. Economies for healthier lives

In 2021 Liverpool City Region Combined Authority was awarded three-year funding from the Health Foundation to transform the way labour market programmes and economic strategy are delivered within Liverpool City Region, ensuring they apply a public health-centred approach.

Labour market programmes will promote health and wellbeing, for example, through direct support for health conditions (e.g. early access to mental health support); through their employment effects; through community engagement, social connections and skills development (e.g. enabling the unemployed to remain socially connected and develop skills); and through material benefits (e,g. preventing income loss, debt, or decline in housing conditions that adversely affect health).

This will be achieved by integrating labour market programmes with health services. The project will fund a public health and employment post within the LCRCA Employment and Skills Team and practitioner training with the aim of act as a 'bridge' between health and economic development policy makers and commissioners. These efforts are aimed at ensuring there is greater overlap of activities and support between health and employment professionals.

The project also aims to integrate a wider social offer (e.g. welfare, housing, debt) with employment services. This work will be informed by the lived experience of residents of Liverpool scale to better understand the issues and circumstances they face so that these can be addressed in future service design.

The funding will also enhance data linkage systems. Liverpool City Region links health, social care and welfare data and the project will fund CIPHA (Combined Intelligence for Population Health Action) to link employment programme and health data to track health outcomes in employment services and employment outcomes in health services. This will ensure the project is able to identify and support groups at risk, monitor the health outcomes of labour market interventions and also apply methods to evaluate impact.

Box 17. Community Wealth Building in St Helens

St Helens is taking part in a project with the University of Liverpool to evaluate the health and wellbeing benefits of community wealth building. Liverpool University are working with Preston City Council, the Centre for Local Economic Strategies (CLES) and the Universities of Lancaster and Central Lancashire in this National Institute of Health Research (NIHR) to understand the extent to which the 'Preston model' has led to health and wellbeing benefits. The Preston Community Wealth Initiative involved all the anchor institutions, the large public and third sector organisations in Preston, and analysed their spent their budgets, to increase procurement from local suppliers and where local suppliers were not available, they helped establish new charities and cooperatives. The Preston Community Wealth Initiative also improved the conditions of their employees, increasing their wages and encouraged their suppliers to do the same.

The research will calculate the effect of the Community Wealth Initiative on mental health and will work with all the organisations and people involved in the Community Wealth Initiative to understand what has helped or hindered this change.

This research will involve a procurement analysis with Anchor Institutions in St Helens and a selected number of other local authority areas to estimate the percentage spend by these institutions in their local economy. The findings will be used in comparative analysis with Preston and will provide a baseline for assessing the development of future community wealth building in St Helens.

In addition, a Community Wealth Building Community of Practice will also be set up for participating areas to share findings from the research and develop a toolkit to support implementation of the findings. It is recommended that the findings of this research project are shared with other Cheshire and Merseyside places to support roll-out of community wealth building across the Region (141).

Anchor Institutions

The development of anchor institutions has become an increasingly important mechanism for the NHS, and other public sector organisations, to improve health and influence the social determinants of health in local areas. However, there is greater scope to further the role of anchor institutions in improving health in local areas, particularly the health of more disadvantaged communities. We also suggest that many of the principles of anchor institutions can be applied to universities and businesses.

In the Region many local authorities have already committed to being 'Anchor Institutions' and work is occurring in many NHS institutions to integrate the concept of 'Anchor Institutions' into future planning, Cheshire and Merseyside HCP will be running a focused consultation in January 2022 to bring together the relevant people and gain a clear understanding of what it means to be an anchor institution within Cheshire and Merseyside, with a particular focus on what are the social and moral responsibilities of organisations that wish to be an anchor institute. This will involve many elements, but it will be a requirement for all anchor institutions to have successfully been awarded the Cheshire and Merseyside Social Value Award and to have a clear understanding of the NHS Prevention Pledge, have fair and equitable policies and have a green outlook. The Memorandum of Understanding, signed between Cheshire and Merseyside and a number of housing associations is an example of embedding partnerships with the NHS in addition to helping the NHS become a stronger Anchor within the area, Box 18.

Box 18. Memorandum of Understanding between the NHS and housing associations in Cheshire and Merseyside

The Director of Partnerships in the HCP developed partnership with local housing associations through HACT. Their first task was worked together to identify what best the MOU could achieve and together they agreed to work together on workforce issues and to break down barriers between the NHS and housing associations. The result is a pilot that will encourage tenants in Housing Associations to work in the NHS. One Trust in the HCP will work with HACT. A representative from Human Resources will identify jobs in the NHS, connect with Learning Foundry, identify training needs and then work with local employment programmes and staff in housing associations to reduce vacancies in the NHS and provide jobs for tenants in housing associations.

Being good employers is part of being an anchor. The NHS should be offering the real living wage; all contracts with minimum hours and minimal use of zero hour contracts (i.e. unless in agreement with employees); all employees offered training and development opportunities. The Fair Employment Charter introduced by Liverpool City Region provides an excellent strategy on improving employment conditions, Box 5, above.

Actions for consideration:

2022/23

- Extend anchor organization approach within NHS and to all other stakeholders including businesses
- Extend anchor approaches to include investing in local communities
- Implement and enforce a 15 percent social value weighting mandatory in all NHS procurement

2023-27

- Anchor Institutions at Place to work collectively as an Anchor System to build community wealth, local training, and employment opportunities.

6 DEVELOPING SHARED LOCAL INDICATORS

Local relevant indicators provide information and evidence for local systems to priortise actions and have ownership over actions. Our 2020 report stated areas should focus on and measure what is important, not just what can be easily measured. Health inequality indicators need to include social determinants of health indicators, indicators that influence across the life course and include, for example, factors that affect the early years, children and young people in school, work, housing as well as health and wellbeing.

We are leading the creation of a local set of indicators for Cheshire and Merseyside, meeting with Directors of Public Health, health analysts as well as those holding data or interested in collecting data from outside of public health, including the VCF sector.

There are examples across England and more locally of the capacity of the systems to work collaboratively and provide good quality data (142). Liverpool CCG worked with the Citizens Advice and academics at the University of Liverpool to link NHS and non-NHS data which enabled the Advice on Prescription service. Launched in 2014, the service enables all Liverpool GP's to refer patients for assistance from Citizen's Advice advisors on a range of issues including: housing, homelessness, job loss, complex debt issues and benefits advice (143).

Deciding what actions to take to reduce health inequalities are best based on local data St Michael's hospital in Toronto Ontario has been collecting social determinants of health data, which has influenced the staff they hire and the services they provide, Box 19.

Box 19. Linking socio-economic patient data with actions.
St. Michael's Hospital in Ontario, Canada collects the following socio-demographic information from all of its patients: Language, Immigration status, Race/ethnicity, Disabilities, Income and Housing status. The hospital Social Determinants of Health Committee employs a team to address the social issues identified in this data. This team includes and 'Income Security Health Promoter', providing individual income interventions, education and advocacy; Medical-legal staff, working in individual legal services, patient rights education and systematic advocacy and a Community Engagement Specialist, ensuring the community's voice is heard during the planning of services.

A review of cancer screening rates in patients with data found housing status was also associated with colorectal, cervical and breast cancer screening, with screening less common among patients who rented their home (144).

The community resourcefulness approach set out below, could provide a useful way to monitor and measure social determinants of health and health inequality; an indicator set which is locally appropriate, relates to the communities themselves and is shared by all stakeholders in an area.

Actions for consideration:
2022/23
- Develop, alongside partners, a health inequality indicator set, based on the social determinants of health which is shared by all stakeholders.
- Communicate annual indicator outcomes to local places, public

2023-2027
- Review and renew health inequality indicators every five years

Table 3. Social value commissioning – areas for actions (116).

	Marmot Policy Objective				
Best start in life	**Maximise capabilities and control**	**Employment and good work**	**Standard of living (income)**	**Healthy and Sustainable places and communities**	**Public health and prevention**
Life course approach to planning services	Skill development programmes	Local residents employed (in local labour market)	Debt and welfare assistance advice	Environmental improvements, including recycling, carbon footprint reduction, energy efficiency and waste reduction	Health improvements
Family-friendly employment practices	Training and apprenticeships	Reduce unemployment through targeted recruitment	Living wage	Stimulating demand for environmentally-friendly goods, services and works	Health and social care schemes
	Volunteering	Employment of particular groups, for example ex-offenders and those with long-term health conditions	Increase in median wage of employees	Safety and antisocial behaviour projects	People supported to live independently (for example, older people)
	Working with schools and young people, including curriculum support, careers advice	Youth employment	Reducing gap between highest and lowest paid	Community centres	Reduce sick absence of employees through improved health and wellbeing support
	Building individual resilience and mental health protection	Local economic regeneration	Parity in income between employees	Social inclusion and integration, and tackling social isolation	Reduce avoidable hospital admissions
	Supporting people with a learning disability or service users into training or employment	Improvement in terms and conditions of employment, including security		Investment in the local area, for example via private sector through corporate social responsibility (CSR) strategies	
	Training for existing staff	Jobs with high level of control for employees		socially responsive governance, with fair and ethical trading	
				Encourage local supply chains	
				Investment in particular programmes, for example fuel poverty reduction	

7 ROLE OF LOCAL GOVERNMENTS

There are many opportunities for local governments to influence the health and wellbeing of their residents with a clear focus on reducing inequalities. Figure 49 shows some of these and in Cheshire and Merseyside, local governments have already taken many of these actions. They can also influence health inequalities indirectly, by leading partnerships, with other stakeholders including business (a role which is currently underdeveloped) and take action for extending and prioritising actions on the social determinants of health by implementing health equity in all policies assessments and working in partnerships with the NHS and local communities.

Figure 49. How local government can make a difference on the social determinants of health and wellbeing

Source: Local Government Association (145)

Since 2017 Liverpool City Region have made fairness and social justice central to its approach, Box 20 outlines the strategic leadership shown by its Fairness and Social Justice Board (FASJAB).

Box 20. FASJAB – the Fairness and Social Justice Board in Liverpool City Region.

The Mayor of Liverpool City Region Combined Authority created the Fairness and Social Justice Board (FASJAB) in 2017. The aim is to use the power of the Combined Authority as an employer, commissioner and procurer of services and goods to better address poverty and social justice brings together people from a cross section of our local communities, reflecting the diversity of the city region. It acts as an independent sounding board, ensuring that issues of fairness and social justice are considered in every strategy that they make as a Combined Authority. It is an advisory body to the Combined Authority to provide an independent fairness and social justice input from the perspective of people with relevant lived experience.

There are opportunities for the HCP to better collaborate and work in partnership with FASJAB, through the appointment of a Consultant in Public Health Medicine and the provision of work placements for future public health trainees (146).

Actions for consideration:

2022/23

- Identify how Councillors on Health and Wellbeing Boards can better communicate the social determinants of health to other councillors.
- Appoint public health consultant within LCRCA and register LCRCA as a training location to provide future opportunities for public health registrars . Equally, a public health consultant should be appointed to lead the health inequalities programme for Cheshire with links to Local Economic Partnership.

2023-2027

- Develop working groups for the social determinants of health with Chief Executive leadership
- Developed social determinants of health indicators across local authorities and NHS providers.
- Strengthen partnerships across local system with health care, local economic plans, and strategies.

8 STRENGTHENING THE ROLE OF BUSINESS IN REDUCING HEALTH INEQUALITIES

Collaborations between businesses and the public sector, working in places to improve conditions and support good health are fairly uncommon, and there is great potential for businesses in the UK, including SMEs to take further action to support health and advance positive social as well as economic impacts. This involves adapting what a successful economy looks like and shifting only valuing Gross Domestic Product (GDP), growth at no costs and the number of jobs, with no understanding of the impact on climate change – which can be in contrast to national government guidance. Cheshire and Merseyside can support economic indicators that emphasise sustainable growth, social value and wellbeing.
IHE have identified a number of ways businesses can build back fairer in Greater Manchester, Box 21 (98).

Box 21. Building Back Fairer by Business

Employers: Good working conditions, fair progression, decent pay and security of work are vital to good health. Developing within-work training and extending apprenticeships and other training schemes are important ways to skill-up the workforce at all ages, not to contribute to reducing the numbers of young people not in education, employment or training (NEET), and to reduce unemployment in Greater Manchester.

Services and products: Businesses procure and deliver services and products. These services and products and the related contracts offer potential routes to greater health equity. Healthier products are important, but supply chains also need to support healthy living and working conditions, and businesses have an important role to play in scrutinising suppliers and contracts to ensure they protect health and equity in the supply chain.

Social value: Businesses have a great potential to add social value through their usual business practices, including the addition of social value in tenders and in contract awards – contracting social value.

Investments and assets: Businesses invest in, own and manage assets that can benefit or undermine good health and equity in the social determinants of health. Divesting from assets that undermine health and equity is a powerful lever for supporting change. Thriving businesses have an opportunity to fund and support essential services and assets for local communities. We suggest a regional investment fund to facilitate coordinated investment in Building Back Fairer.

Business anchor institutions: Anchor institution approaches have mainly been developed in the health care sector with some additional developments in other public sector organisations such as universities. Businesses are also located in places and have an important place-shaping role. This includes but extends beyond their role as employers as they affect social, economic, cultural and environmental conditions within places and includes social value contracting and ensuring that assets and investments support, rather than undermine health equity.

Wider partnerships. Businesses should be closely involved with other organisations working to improve local conditions and foster healthier local areas. Hitherto, these collaborations have been weak or one-offs, and greater more sustained collaborations between business, the VCSE sector, local authorities and public services would be highly beneficial to building back fairly.

Workforce contributions. Many businesses support their staff to volunteer their time and expertise to support local communities. We suggest these roles and support are extended so that staff who wish to are able to support their local communities, including those employed in small and medium-sized enterprises (SMEs).

Advocacy. Businesses can also be powerful advocates for greater health equity and equity in the social determinants nationally and locally (98).

National economic strategies emphasise growth and improving the competitiveness of the UK economy. In contrast, the local economy in the Cheshire and Merseyside HCP has been dealing with changing industrial patterns, years of underinvestment in the North of England, all exacerbated by the COVID-19 pandemic. If economic recovery is be healthy, more equitable, inclusive and climate-sensitive, the HCP, should have a significant role.

The NHS Confederation states increasing participation in local economic partnerships can lead to several benefits, including:

- access to significant external funding sources
- greater influence in strategic local discussions
- tailored workforce supply and transformation planning
- more integrated service provision
- quicker access to innovative healthcare solutions (147).

Actions for consideration:

2022/23

- ICP to make contact with local large and SMEs to make the case for health equity and the social determinants of health.

2023-2027

- Work with local businesses to extend social value policies and focus on principles to reduce health inequalities.
- Take actions to be a better employer by the end of the 2022/23 financial year and embed Anchor values into financial plans from 2023/24.
- Communicate actions taken to local communities.

Adopting a health equity in all polices approach means all stakeholders are expected to explicitly consider the health equity implications of decisions they make including investments made and policies enacted.

A health equity in all policy approach identifies how processes can unknowingly exacerbate inequalities in policies, decision-making and resource allocation (148). Since the IHE's 2010 report, a number of organisations outside of the NHS, such as the police, fire fighters, social care, housing and early years workforces have developed approaches to tackling health inequalities, by extending and adapting their day-to-day practices and procurement. These examples illustrate the possibility of health equity in all policies, as does a health inequalities assessment toolkit, Box 22 (2).

Box 22. Health inequalities assessment toolkit
The Health Inequalities Assessment Toolkit (HIAT) developed at Lancaster University with the aim of increasing the potential for interventions to reduce health inequalities. The four steps in the toolkit are to:
1. Identify and clarify the inequalities associated with the health problem to be tackled and to identify the socio-economic causes of these inequalities.
2. Plan work to address some of the socio-economic causes of inequalities identified in the first step.
3. Monitor and evaluate the effect of the action on health inequalities and their socio-economic causes.
4.Analylse the actions will affect the social determinants of health that are not directly considered (152).

Actions for consideration:
2022/23
- Health equity assessment of Green Plan to reach Net Zero

2023-2027
- Develop and implement Health Equity in all Policies across all stakeholders and partners
- All local government, NHS strategies and decisions in the HCP, ICP, HWB and PCNs assessed for health equity impacts.

10 STRENGTHENING COMMUNITY RESOURCEFULNESS

Public Health England stated, 'community-centred approaches are increasingly used in public health practice to enhance individual and community capabilities, create healthier places and reduce health inequalities' (150). These community-centred strategies go alongside actively involving local populations in the design and implementation of programmes to support outcomes.

In order to support better health and better outcomes in the social determinants of health for communities, IHE proposes that Cheshire and Merseyside and regional partners take action to build and monitor *Community Resourcefulness*.

Community resourcefulness is an approach to community health which supports the social determinants of health in communities, creating and building sustainable community resources, encompassing social, economic, cultural and environmental resources in local areas. Community resourcefulness is a helpful way for Cheshire and Merseyside to conceive, design and organise their partnerships and activities to improve health. A number of places in Cheshire and Merseyside have implemented actions to empower local communities and improve community resilience, Boxes 23 and 24.

Box 23. St Helens People's Board
The St Helens People's Board carries out the statutory functions of the health and wellbeing board and the community safety, partnership. The board provides 'democratic stewardship' and its wide membership across public services and the voluntary and community sector includes housing associations, Merseyside, Police and Fire and Rescue, the NHS, adult and social care leaders, local government and the probation service.
In existence since 2017, its aims are to: promote greater health and social care integration; identify key actions needed to promote/improve health and wellbeing of local communities and to set the strategic direction for integrated health and care in the borough.
In 2018, the council's people's services department and the clinical commissioning group (CCG) came together to form St Helens Integrated People's Services (SHIPS). SHIPS covers CCG responsibilities,

including devolved commissioning for general practice, adult social care, children's social care, educational improvement and public health. Budgets are combined through a Section 75 agreement and there is close oversight of performance and finance.

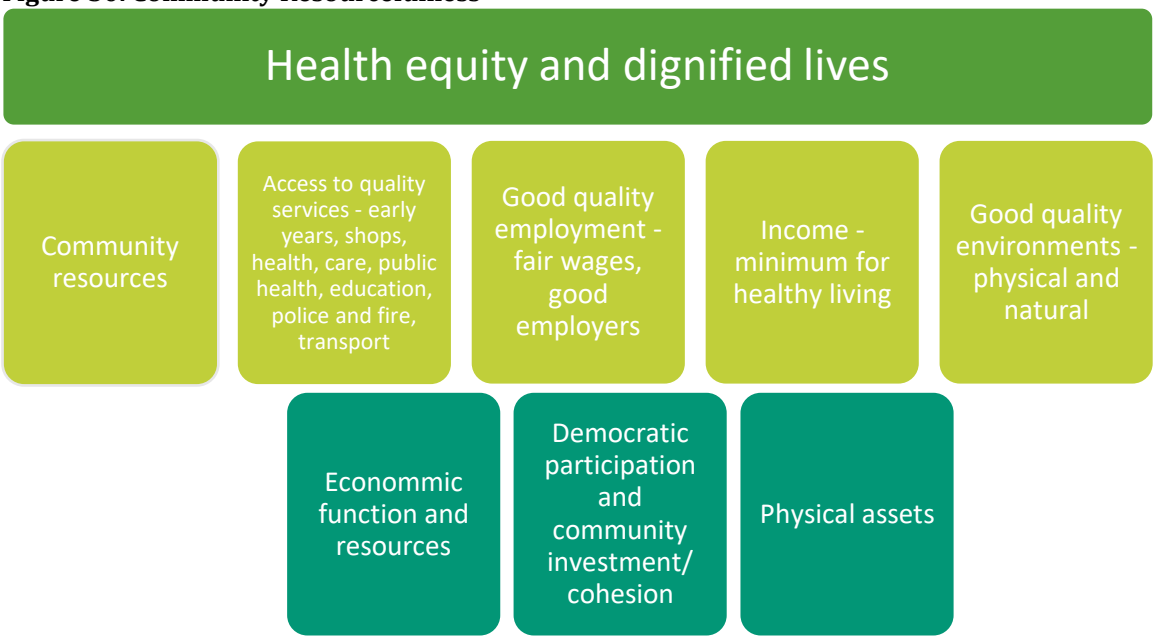
Box 24. Connect Us in Wirral

Public Health Wirral commissioned Connect Us in 2017, a project aimed at reaching the individuals and communities who face many barriers that stop them from accessing the services they need to improve their health and well-being, a sense of empowerment and reduce isolation. Connect Us was rolled out in January 2020 across Wirral and has a team of 44 Connectors.
Connectors work on what is 'strong and not what is wrong' and identifies how people may want to develop their potential. They visit people in their own home or in a place that is comfortable to them and together they explore the best ways to link in with local services and activities. The aim is to work in partnership with people to see just how they want to go about expanding networks, knowledge of their local area. Ultimately the goal is they feel part of and socially connected within their own community.
During the COVID-19 pandemic, Connect Us offered a wide range of support in Wirral, including: food deliveries; free school meal provision; delivering 30,000 Covid awareness leaflets; carried out a Safer Streets consultation; supporting discharge from hospital; made wellbeing calls; worked in partnership with Age UK to offer shopping/buddy service; prescription pick-ups and gas/electricity support.
Residents can be directly referred by GPs, Social Services, Housing Providers and other professionals and services, or self-refer and can access Connect Us through word of mouth, through advertisements in community venues and via Connectors, who knock on doors across Wirral.
Since 2017 *Connect Us* have knocked on 174,117 doors and of these, 45,605 doors have been answered and conversations had with community members on the doorstep. As a result, they have engaged with 130,000 individuals in Wirral, created 175 new groups in Wirral, signed up 450 people to move into volunteering; moved 360 people into further education or training and helped 220 find employment.

The most deprived areas tend to have worse outcomes and access to those resources and taking a regional/local approach to community resourcefulness means focussing proportionately more on more deprived areas.

We propose that each place within Cheshire and Merseyside take the lead in initiating partnerships for building community resourcefulness and use its role as community leaders to build on existing social and physical resources, and develop partnerships of multiple stakeholders including communities, businesses, local authorities and public services using the model outlined in Figure 50.

Figure 50. Community Resourcefulness



Actions for consideration
2022-2027

- HCP lead the development of concepts of community resourcefulness and bring the whole system together to build *community resourcefulness.*

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