# A HOPEFUL FUTURE: EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN LANCASHIRE AND CUMBRIA

INSTITUTE of HEALTH EQUITY

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**Submissions to the Health Equity Commission can be found here**

https://www.healthierlsc.co.uk/hec/hec-presentations-evidence

# GLOSSARY

### HEALTH INEQUALITIES

The systematic differences in health between groups of people. These differences, which are avoidable and unfair, are the differences in the care that people receive, and the quality of care and the opportunities they have to lead healthy lives. Inequalities in life expectancy – people living in the poorest neighbourhoods die earlier than those in wealthier areas – are one of the key measures of health inequality.

### HEALTHY LIFE EXPECTANCY

This measures the duration people spend in 'good' or 'very good' health, based on how people perceive their general health, and is another key measure of health inequality.

### INDIVIDUAL HEALTH BEHAVIOURS AND PREVENTION

Individual health behaviours include those around smoking, physical exercise, diet/nutrition, alcohol and drugs and they are often the focus of prevention programmes and initiatives. These factors affect health inequalities but do not address the drivers of these behaviours – the causes of the causes. The NHS has a role in supporting people to improve their health and wellbeing but addressing the causes of the causes requires partnerships with wider systems, supporting people with good education and employment, fair pay and incomes, and good quality homes and neighbourhoods.

### INDEX OF MULTIPLE DEPRIVATION (IMD)

This is the most common measure of the socioeconomic circumstances of the places in which people live. The IMD summarises how 'deprived' an area is based on a set of factors that includes: levels of income, employment, education and local levels of crime. The IMD is mapped on lower-layer super output areas (LSOAs), which, though small, may include areas of high and low deprivation. Quintiles of deprivation are calculated by ranking the LSOAs from 'most deprived' to 'least deprived' and dividing them into five equal groups. These range from the most deprived 20 percent (quintile 1) of small areas in England to the least deprived 20 percent (quintile 5) of small areas in England.

### MINIMUM INCOME STANDARD

standard, developed to measure the income needed to live a healthy life. The minimum income standard is higher than the living wage; in 2021 it was calculated that an individual needed to earn £20,400 a year to reach a minimum acceptable standard of living, while the living wage paid around £17,400 for an individual working full-time.

### PROPORTIONATE UNIVERSALISM

The aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher.

### REAL LIVING WAGE

Set by the Resolution Foundation, the real living wage was created to better estimate the wage rate needed to ensure that every household earns enough to reach a minimum acceptable living standard, this standard is defined by the public. In 2021/22 the living wage was £9.90 per hour for areas outside of London.

### SOCIAL DETERMINANTS OF HEALTH

These are the social and environmental conditions in which people are born, grow, live, work, and age, which shape and drive health and wellbeing. Access to good quality care is a determinant of health but most of the social determinants of health lie outside the healthcare system. The social determinants include: education in early and later childhood and adolescence, as well as lifelong learning; employment conditions and quality of work; income; housing, and built and natural environments. All of these are the building blocks to healthy and equitable societies – good jobs with fair pay; good quality housing and education, and so on.

### SOCIAL GRADIENT IN HEALTH

The relationship between social circumstances and health is graded, health is progressively better the higher the socioeconomic position of people and communities. The social gradient shows health inequalities are experienced by all of society, everyone below the top has greater risk of worse health than those at the top. It is important to design policies that are universal but are implemented at a level and intensity of action that is proportionate to need – proportionate universalism.

### SOCIAL VALUE

The Social Value Act 2012 requires the public sector to ensure that the money it spends on services creates the greatest economic, social and environmental value for local communities. A social value approach involves looking beyond the price of each individual contract and at what the collective benefit to a community is when a public body chooses to award a contract.

### VCFSE SECTOR

Voluntary, community, faith and social enterprise sector and partnership organisations that support the sector.

# CHAPTER 1
# INTRODUCTION

*The basic need is to instil a sense of hope in people's future chances of a better job, better house, better education, better life. This needs a total approach to investment in jobs, good social housing, better transport and the built environment.*

**Central Lancashire Partnership**[1]

[1]Quotes come from the submissions made to the Health Equity Commission in Lancashire and Cumbria.

**Lancashire and Cumbria are both counties that contain many contrasts, with wealthy areas with good health alongside areas of poor health and deprivation. This region of two neighbouring counties in the North West of England with a combined population of approximately 2 million, does not have a single major city conurbation and can go 'under the radar' in national discussions about poverty, deprivation and exclusion. However Lancashire and Cumbria includes coastal areas with high levels of deprivation, with high levels of persistent poverty and small rural communities with high levels of deprivation as well as areas of urban deprivation, all of which contribute to unfair and wide inequalities in health and poor health compared with other regions in England.**

There are national parks, a lengthy coastline and flourishing towns and cities. There are also areas still feeling the effects of industries that have long closed down, from tourism to fishing and textiles – where poverty, health inequalities and low levels of aspiration continue to leave their mark on communities. Despite the decline, manufacturing continues to be a large contributor to Lancashire's economy. In Cumbria, agriculture is similarly important. Economic inactivity due to long-term illness is higher in the region than in England and the North West. Some of the challenges faced in rural areas concern access to services including education and healthcare, lack of public transport and high and rising levels of fuel poverty. Blackpool is the most deprived (lower-tier) local authority in the country, Blackburn with Darwen is among the most deprived 10 percent in England, and Lancaster, Wyre, Pendle and Preston are among the 20 percent most deprived lower-tier local authorities.

The UCL Institute of Health Equity's (IHE) report *Health Equity in England: The Marmot Review 10 Years On*, published in 2020, showed life expectancy in England was stalling and the impacts of austerity policies had likely damaged health and increased health inequalities (1). The 2021 report *Build Back Fairer: The COVID-19 Marmot Review* demonstrated that these inequalities had worsened the impact of the COVID-19 pandemic for those on the lowest incomes and would widen health inequalities in the longer term as a result of deepening inequalities in key social determinants of health (2).

Lancashire and South Cumbria Health and Care Partnership (HCP), prompted by concerns about the high and highly unequal COVID-19 impacts and the longstanding wide health inequalities within the region, commissioned IHE to assess the extent of health inequalities and the reasons for those and to propose how to best respond. North East and North Cumbria ICS joined the project soon afterwards. IHE began working in Lancashire and Cumbria in the summer of 2021. The counties have had some of the highest rates of COVID-19 infections and deaths in England.

Continuing as before is not an option – it has led to poor health and high levels of inequality. Many times during our work in Lancashire and Cumbria we were told 'we can't keep doing the same thing and expecting different results'. From discussion within the region – in the NHS, local government, public health and in the voluntary, community, faith and social enterprise (VCFSE) sector – we heard that partners across the system need to take a more effective, coordinated approach to tackle inequalities. They also spoke with a sense of urgency: that now is the time for Lancashire and Cumbria to improve health equity. North Cumbria's Director of Public Health stated: 'For the last 30 years we have been seeking to tackle smoking, inactivity and healthy eating as a means to improve health equality – with limited success.' In 2016, the Blackburn with Darwen annual report from the Director of Public Health reported:

> ***The current health and care service models are failing to address the wider determinants of health and wellbeing and it is clear that big institutions – like the NHS – are not able to tackle today's health challenges on their own. When the NHS was conceived, the most pressing health issues were infectious diseases, and most hospitals' work was around managing short periods of acute illness. The main health issues now facing [...] the wider population are [...] very different, being predominantly long term conditions: diabetes, heart and lung disease, cancer and mental illness (3).***
>
> *Director of Public Health,*
> *Blackburn with Darwen annual report*

Reducing health inequalities is essential for social justice; but it is also vital for the economic vitality of the region and to reduce demand on NHS and public services. Poor health reduces productivity and harms employers. Inequality drives up cost and demand for local government and public services, placing unnecessary demands on the public purse, as well as unnecessarily harming and shortening the lives of so many. Put simply, prevention is better – and cheaper – than a cure.

This report will show significant problems in Lancashire and Cumbria but also highlight many examples of best practice – some of which are recognised nationally and internationally. These examples show how to work differently, to better meet the needs of the people living in the most deprived areas in Lancashire and Cumbria, and provide proof that when systems work together to serve these populations, it is possible to offer a better quality of life and reduce inequalities. However, all too often these actions are funded in the short term, or are too small in scale, and change is momentary as funders move on to find more examples of 'innovation'. Too frequently these actions rely only on spending for healthcare but without action on the social determinants, this will not improve population health nor reduce health inequalities.

# 1A THE LANCASHIRE AND CUMBRIA HEALTH EQUITY COMMISSION

**The Institute of Health Equity was initially commissioned by the Lancashire and South Cumbria Health and Care Partnership, the local ICS. The scope of our work was subsequently widened to include all of Cumbria, incorporating part of the North East and North Cumbria ICS. The Health Equity Commission was established and included an advisory panel and a steering group. The panel is chaired by Professor Sir Michael Marmot and consists of leaders and representatives of partner organisations from across the Lancashire and Cumbria Region including from local government, the NHS, the VCFSE sector, universities and the local economic partnership (see Annex).**

The HEC panel launched in September 2021 and met five times between November 2021 and March 2022, hearing evidence from all integrated care partnerships, clinical commissioning groups, and health and wellbeing boards. They provided input and advice into the analysis, formulation of recommendations and the final report. Workshops were also held, with local stakeholders, covering housing, children and young people, mental health, the economy, leadership and older populations. Other meetings and conversations continued after the workshops and HEC meetings. The evidence from these meetings and workshops was then collated and analysed alongside our own research and incorporated in this report and described as 'submissions to the HEC'. The draft recommendations were presented to the HEC panel, steering group and system partners in 2022, and were revised following feedback.

A consistent theme in the feedback to the HEC is that there are many people in the NHS and local government who do not understand the social determinants of health and related health inequalities, nor, in particular, the role their institutions can play in reducing them. Often it is felt that local areas and services are relatively powerless to influence action on the social determinants, as policy and resources are driven by central government. However, evidence from across local areas in England shows the difference that can be made locally by a range of local organisations and sectors working together. In this report we highlight examples of good practice in key social determinants of health locally, which can be replicated and/or scaled up across the region. We also propose a number of important changes to the partnerships and systems across the region, to develop as a strong health equity system. This includes action to strengthen local partnerships, reallocate and increase resources, involve communities and the VCFSE sector, develop the role and impact of businesses and the economic sector and embed health equity (set out in Section 4).

The recommendations in this report present an opportunity to move to reduce health inequalities through action on their social and economic drivers. To achieve this requires a move from a reactive approach – responding to need and with funding for short-term projects with limited impacts – to implementing system-wide approaches and consistently working with partners beyond the NHS to achieve long-term reductions in health inequalities through action on the wider determinants of health.

# 1B THE SOCIAL DETERMINANTS OF HEALTH APPROACH

**The social determinants of health describe the social and environmental conditions in which people are born, grow, live, work and age, which shape and drive health outcomes. Factors that determine how the social determinants of health conditions are experienced across societies include the distribution of power, money and resources. Unfair distribution of these resources creates avoidable health inequalities, known as 'health inequities'.**

Good quality, equitable and accessible healthcare is a determinant of health but most of the social determinants of health lie outside of the healthcare system. These include good-quality experiences and services during early childhood, and education in later childhood and adolescence, as well as lifelong learning, all of which help create the conditions that enable people to have control over their lives. Working conditions, and contractual conditions of employment, are also key determinants of health, as is having sufficient income for healthy living and living in adequate housing, and living in a built and natural environment that protects from harm and enables healthy living (4). Focussing only on behaviour change and making individuals responsible for it, e.g. eating less or exercising more, fails to address the root causes of these behaviours. Understanding and improving the social determinants of health is needed in addition to working with people to better support these choices and behaviours (5).

The 2010 Marmot Review, *Fair Society, Healthy Lives,* showed that health inequalities are not limited to poor health in those who are the worst off or the most socially disadvantaged. There is a social gradient in health, running from the top to the bottom of society (6). Addressing the social determinants of health is addressing the causes *of the causes* of ill health and wellbeing; the approach requires time and partnerships, upstream investment and radical shifts in approaches.

## THE EIGHT MARMOT PRINCIPLES AND PROPORTIONATE UNIVERSALISM

Reducing health inequalities requires action on the six policy objectives outlined in *Fair Society, Healthy Lives* and in the follow-up report, *Health Equity in England: The Marmot Review 10 Years On*. The six Marmot principles are:

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

To this list of six, we now add another two principles:

7. Tackle discrimination, racism and their outcomes.
8. Pursue environmental sustainability and health equity together.

The first additional principle is to reflect the substantial impact of racism on inequalities highlighted in our Build Back Fairer report on tackling the aftermath of the COVID-19 pandemic. The second is to emphasise that climate change adaptation and mitigation actions should not worsen health inequalities, and that it is imperative that environmental and health actions work in conjunction to address the climate crisis.

The 2010 and 2020 Marmot reports proposed adopting a **proportionate universal approach**: universal policies and interventions developed to be more intense where need is higher – to be proportionate to need. The aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher – levelling up. Coventry, a 'Marmot City' since 2013, which adopted the approaches advocated in the original 2010 Marmot Report, outlined their experience of addressing the social determinants of health:

> ***A Marmot approach demands that we resource and deliver services at a scale and intensity proportionate to the degree of need; just focusing on one group of disadvantaged individuals or one geographical area won't deliver change (7).***

Our 2020 *Ten Years On* report showed funding allocations, including the public health grant, and cuts to benefits have disproportionately affected poorer areas and communities and have been greatest in the North of England (1). Reversing these losses requires universal funding and funding and actions to be greater in those areas which have lost most, areas that have had higher cuts and, as a result, widening inequalities.

# 1C THE CONTEXT FOR LANCASHIRE AND CUMBRIA

**In this report, we refer to the two neighbouring counties of Lancashire and Cumbria as a 'region' but they do not together make up a natural geographical or administrative region: there is currently one upper tier local authority in Cumbria with six district/borough councils (which is changing in 2022/23) and three upper tier authorities covering Lancashire county - Blackburn with Darwen, Blackpool and Lancashire and its 12 districts.**

The local authorities cover very different sized populations and geographies and the physical geography means there are coasts, valleys, towns and rural areas all with their own contexts and identities. The complexity of the governance arrangements create barriers to partnership working, and there is often a focus on the workings of the system itself rather than the priority issues for communities. A submission to the HEC stated:

> ***The organisational and geographical complexity of Morecambe Bay can lead to large amounts of time spent attending duplicate meetings and can be challenging in terms of achieving consensus to drive work forward. This can lead to a perception that the systems and processes are built for institutions rather than the people that they serve.***
>
> *Submission to the HEC*

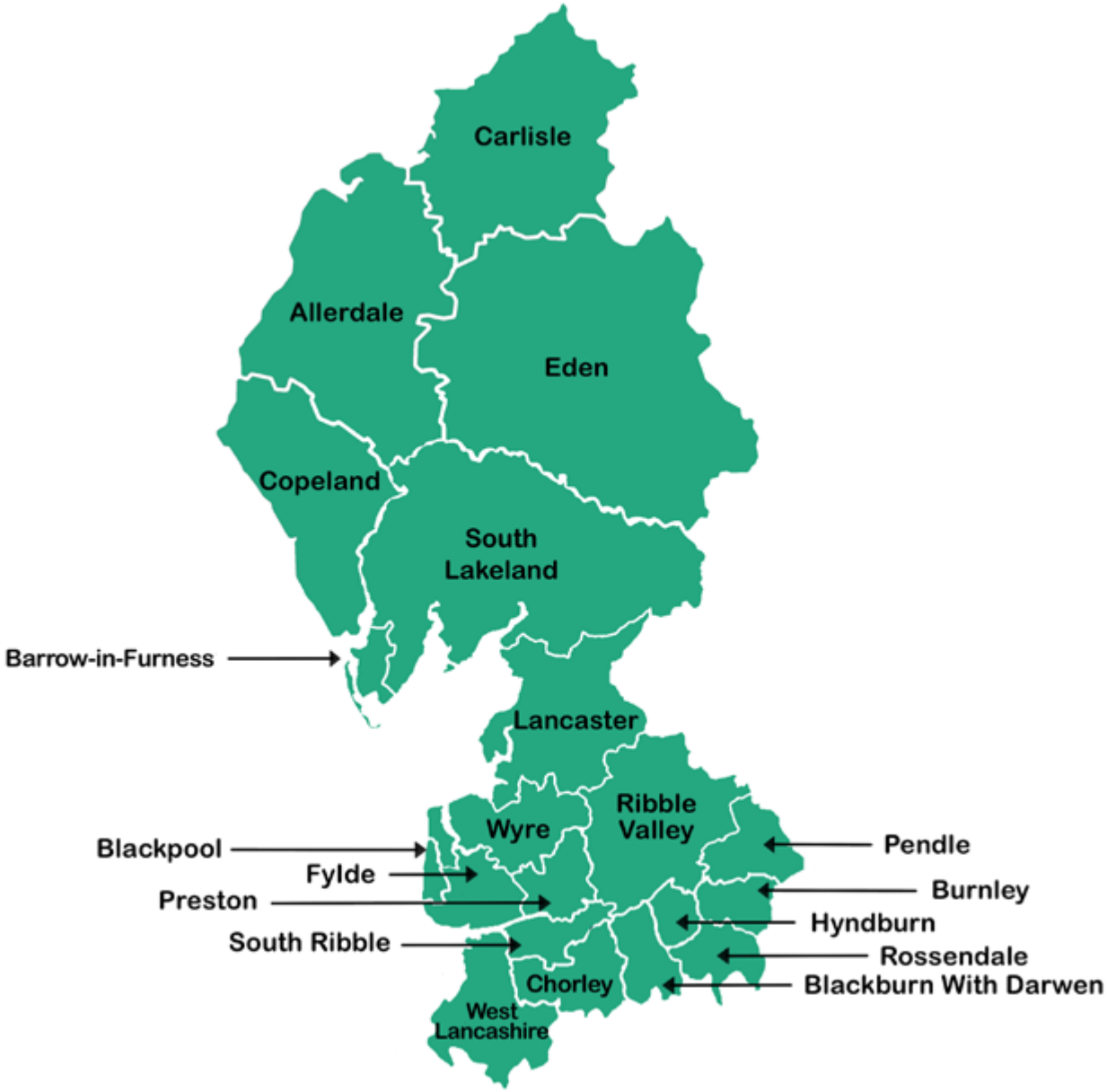
## THE NHS AND LOCAL GOVERNMENT STRUCTURE

The 2019 NHS Long Term Plan stated the aim to better integrate health and care services. Integrated care systems (ICSs) are seen as key tools to deliver this integration and develop partnerships between NHS providers and commissioners, local authorities and local partners to better plan health and care services to meet the needs of all of their local populations.

Two NHS ICSs, North East and North Cumbria ICS and Lancashire and South Cumbria HCP, administer across Lancashire and Cumbria. ICSs comprise integrated care boards and integrated care partnerships (ICPs). ICBs will focus on NHS core services and the commissioning and management responsibilities of clinical commissioning groups – which will cease to exist. ICPs will have a broader focus, and address public health, including health inequalities, social care and wider issues (8). It is anticipated that as a result of ICSs better coordinating services and improving population health, health inequalities will be reduced (9). To achieve this reduction, ICSs need to develop strong relationships with partners outside the NHS – such as with the VCFSE sector, local authorities, public services, housing associations and schools – those sectors which influence the social determinants of health.

Many of the decisions that have been devolved in other regions in the North of England remain in the hands of central government. In addition, in 2022 and 2023 local government reorganisation will see Cumbria divided into East and West Cumbria, with some of the smallest council areas in England. The system will spend the next year, at least, adapting to this administrative change while continuing to deliver services as well as planning for its future. The current six district councils in Cumbria will cease to exist but retain current provision until March 2023.

Figure 1.1. Map of Lancashire and Cumbria




In many areas within the region, the place-based partnerships have to respond to multiple stakeholders. The two ICSs have responsibilities to 11 local authorities (this report only covers part of the North East and North Cumbria ICS) , two local enterprise partnerships (Cumbria LEP and Lancashire LEP – business-led partnerships that bring together the private sector, local authorities and academic and voluntary institutions), and many NHS, VCFSE sector and local government organisations.

## AUSTERITY AND CUTS

Our *Ten Years On* report outlined how policies of austerity since 2010 have taken their toll on health and the social determinants of health. Government spending as a percentage of GDP declined by seven percentage points between 2009/10 and 2018/19, from 42 percent to 35 percent (1). There were widespread cuts to public services and local government allocations from the Ministry of Housing, Communities and Local Government declined by 77 percent between 2009/10 and 2018/19 (10). Connected to these cuts, since 2010, health has deteriorated, improvements in life expectancy have slowed down, and inequalities in health have widened.

Since 2010 there have been freezes and changes to the benefit system. The introduction of Universal Credit and changes to tax credits have negatively affected low- and middle-income households and children, and widened income inequalities – penalising the poorest the most. The Institute for Fiscal Studies found Universal Credit reduced the income for those in the lowest decile by 1.9 percent, equivalent to £150 per year per adult (11). Overall, the areas with the worst levels of deprivation in England have had the greatest reductions in per person spending: the areas where need is highest and conditions are generally worse (1).

Child poverty has increased and children's centres and services for young people experienced significant cuts. Funding for local authority children and young people's services fell by £3 billion between 2010/11 and 2017/18 – a 29 percent reduction (12). Spending per pupil in secondary and tertiary education has decreased since 2010, and for primary children there have been decreases since 2015–16 (13). There have been increases in precarious work and zero hours contracts, pay has not increased and in-work poverty for working-age families after housing costs rose from 16 percent in 2010 to 18 percent in 2018, as a result of higher cost of living, low levels of benefits and low pay (14). Housing has become increasingly unaffordable. All of these factors have led to increasing rates of poverty, homelessness, food and fuel poverty and a decrease in social mobility.

Funding for public health grants declined substantially – the Institute for Public Policy Research (IPPR) estimated there was an £850 million decline in net expenditure on public health in England between 2014 and the end of 2019, with absolute cuts in the most deprived areas six times larger than in the least deprived (15).

These cuts have had direct and indirect impacts on health, inequalities and the social determinants of health. Between 2013 and 2017, it is estimated that male life expectancy at birth could have been 2.2 months higher and female life expectancy 2.0 months higher if the cuts had not occurred. In the most deprived areas, as local government cuts were worse, male life expectancy at birth could have been 3 months higher and female life expectancy 2.8 months higher (16).

The cuts across Lancashire and Cumbria have harmed health and widened health inequalities. It is in this context that our proposals for more resources and more equitably allocated resources are made. Also important to note that while many services are forced to increasingly focus on interventions to support people in crisis it is much more beneficial and cheaper in the long run to prevent people from being forced into crisis situations in the first place.

We call for spending on prevention and investment in the social determinants of health; spending that will yield multiple beneficial outcomes and in the long run reduce demand on services and boost economic productivity.

The economic case, as well as the social justice case, is clear.

## THE LEVELLING UP AGENDA

The 2022 Levelling Up white paper was presented by the government as a response to widening regional inequalities across the UK and it highlighted geographical inequalities including differences in life expectancy, pay and productivity (17). The white paper extended devolution beyond metropolitan areas to every area of England that wants a devolution deal. The paper set out four areas of action with 12 missions to be achieved by 2030, with actions across the UK.

The four areas of action are:

**A.** To boost productivity and living standards by growing the private sector, especially in those places where they are lagging.

**B.** To spread opportunities and improve public services, especially in those areas where they are weakest.

**C.** To restore a sense of community, local pride and belonging, especially in those places where they have been lost.

**D.** To empower local leaders and communities, especially in those places lacking local agency.

The four missions under the second area are particularly relevant to addressing the social determinants of health, with the following stated targets:

- By 2030, the number of primary school children achieving the expected standard in reading, writing and maths will have significantly increased. In England, this will mean 90 percent of children will achieve the expected standard, and the percentage of children meeting the expected standard in the worst performing areas will have increased by over a third.
- By 2030, the number of people successfully completing high-quality skills training will have significantly increased in every area of the UK. In England, this will lead to 200,000 more people successfully completing high-quality skills training annually, driven by 80,000 more people completing courses in the lowest skilled areas.
- By 2030, the gap in Healthy Life Expectancy between local areas where it is highest and lowest will have narrowed, and by 2035 Healthy Life Expectancy will rise by 5 years.
- By 2030, wellbeing will have improved in every area of the UK, with the gap between top performing and other areas closing.

There is a welcome shift from individual funding offers to longer term funding. However, overall, the funding commitments in the white paper do not 'level up' funding to 2010 levels and do not match the scale of ambition set out in the white paper. The Levelling Up Fund introduced in November 2020 was to fund capital spending on local transport, urban regeneration and cultural asset projects. All areas in the UK are able to bid for this funding, so it is unclear how this could 'level up' if funding was available to all. Much of this funding is also included in projects in the Levelling Up white paper, and there are examples of funding announcements that have been repeated yet are presented in the white paper as 'new money' (18). Analysis from IPPR North has shown that the Levelling Up Fund will provide £32/head for people in northern England yet the fall in annual local council service spending since 2010 in northern England was £413/head (19). Despite consistent announcements that the Levelling Up fund is

working, further research from IPPR North in July 2022 found total public spending in 2021 in the North was £16,223 per person, lower than the England wide average of £16,309 per person and far below London's public spending per person, at £19,231 per person.

In addition, the white paper focuses on infrastructure projects rather than on sustainable investments in the social determinants or health – the type of investments which would level up health and other outcomes.

Box 1 briefly overviews the inconsistent and modest resources available in Lancashire and Cumbria to level up.

## Box 1. Levelling up in Lancashire and Cumbria?

Funding analysis of the four key levelling up funds, the Levelling Up Fund itself, and three funds already fully allocated: the Towns Fund, the Future High Streets Fund and the Community Renewal Fund showed that some of the most deprived areas have received less funding than the wealthiest areas. In Lancashire and Cumbria this has led to Copeland and Barrow-in-Furness to receive more than £600 a head, the largest per capita awards, yet Hyndburn, with comparable levels of deprivation, will receive only £2.85 a head (20).

The Levelling Up Funding funding categories do not necessarily follow need and Table 1.1 shows the inconsistency in these categories in Lancashire and Cumbria. The districts of Lancaster and Wyre are deemed lower priority than Allerdale and Chorley, yet have higher levels of income deprivation. Eden has been labelled as priority 2 yet it has similar levels of deprivation to Ribble Valley and South Lakeland, which are both priority 3 in the Levelling Up index.

**Table 1.1 Levelling Up priority categories and levels of income deprivation in Lancashire and Cumbria**

| | Ranking of income deprivation in England's 316 local authorities | Levelling Up Priority Category | Percent population income deprived |
|---|---|---|---|
| **Blackpool** | 3 | 1 | 25 |
| **Blackburn with Darwen** | 10 | 1 | 21 |
| **Burnley** | 13 | 1 | 20 |
| **Hyndburn** | 34 | 1 | 18 |
| **Pendle** | 46 | 1 | 17 |
| **Barrow-in-Furness** | 58 | 1 | 16 |
| **Preston** | 55 | 1 | 16 |
| **Rossendale** | 81 | 1 | 15 |
| **Copeland** | 109 | 1 | 13 |
| **Lancaster** | 110 | 2 | 13 |
| **Wyre** | 121 | 3 | 13 |
| **Allerdale** | 132 | 1 | 12 |
| **Carlisle** | 139 | 2 | 12 |
| **West Lancashire** | 124 | 2 | 12 |
| **Chorley** | 177 | 1 | 10 |
| **Fylde** | 193 | 2 | 10 |
| **South Ribble** | 205 | 3 | 9 |
| **Eden** | 266 | 2 | 7 |
| **Ribble Valley** | 298 | 3 | 6 |
| **South Lakeland** | 286 | 3 | 6 |

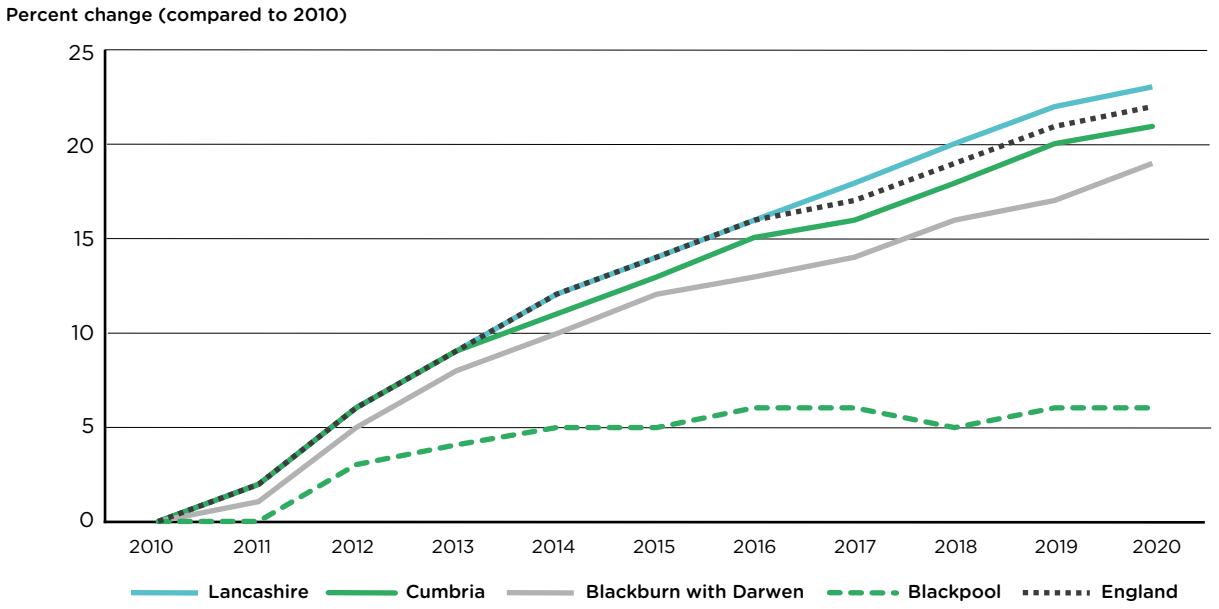
***Source:*** *Office for National Statistics, Department for Levelling Up, Housing and Communities (21) (22)*

## AGEING POPULATION

In addition to the COVID-19 pandemic and funding cuts, another major factor affecting Lancashire and Cumbria is the region's population age structure. By 2043 Cumbria's proportion of people aged 65-plus is estimated to increase to 31 percent, the sixth greatest proportion among all counties (23). For comparison globally, the countries with the largest ageing populations are Italy, where in 2020, 23 percent of the population was aged 65 and above, and in Japan, where 28 percent are in this age group (24). In the UK population in 2019 19 percent of the population were aged 65 years and over, and this population is projected to increase to 24 percent of the population by 2043 (25).

Cuts to local government funding affect the ability of councils to support their ageing populations and to meet the increased demands on social care. It is estimated that total public spending, assuming the same relative allocations and excluding interest payments, will increase from 34 percent to 38 percent of GDP between 2019/20 and 2064/65 due mainly to the UK's ageing population (26). Figure 1.2 shows in Lancashire and Cumbria as a whole, the population aged 65–84 has increased since 2010, although much less rapidly in Blackpool.

**Figure 1.2. Population change, (age 65–84), indexed to 2010, percentage change, Lancashire and Cumbria upper tier Local Authorities and England, 2010–2020**




***Source:*** *Office for National Statistics (27)*

## THE ECONOMIC IMPACTS OF POOR HEALTH

In 2018 the Northern Health Science Alliance reported that rates of ill health were 5–15 percent higher in the government's designated 'Northern Powerhouse' regions (covering 11 Northern England Local Enterprise Partnerships including Cumbria and Lancashire). They argued that 34 percent of the employment gap between the Northern Powerhouse and the rest of England could be attributed to poorer levels of health in the North and an estimated 30 percent gap in gross value added between the Northern Powerhouse and the rest of England can also be attributed to poorer health in the North (28). However, it is not only ill health or worse levels of health that contribute to lost productivity; so too do poor working conditions and the social determinants of health (e.g. quality and cost of housing) (29) (1). The Northern Health Science Alliance's 2021 COVID-19 report continued to analyse the costs of lost productivity in the North, and conservatively estimated the increased COVID-19 related mortality in this part of England could cost the national economy up to £7.3 billion in lost productivity (30).

In recognition of the damaging economic effects of poor health, local economic partnerships in Lancashire and Cumbria are embracing the principles of working together to improve health, economic development, the early years, environment and climate and housing in each county, and to increase productivity, providing good quality employment. The Cumbria LEP (CLEP) focuses on creating the economic conditions that reduce health inequalities through supporting the creation of high-quality employment opportunities and promoting inclusive growth. The CLEP will encourage businesses to engage in the health-related issues on which they can have an impact, such as supporting good mental health and wellbeing.

In Lancashire, the LEP established the Health Sector Group which takes a holistic view of health and prosperity, rooted in the belief that *health is wealth* and *wealth is health*. The Health Sector Group includes members from the public and private sectors and will work to improve opportunities for businesses to provide solutions to address some of Lancashire's health inequalities and increase productivity. The Health Sector Group will work with healthcare providers and anchor institutions and employers, and like the CLEP will explore how better health and wellbeing provision can boost performance and drive more local economic growth.

The Lancashire 2050 strategic plan, published in 2022, revised the New Deal for a Greater Lancashire and included additional policy areas related to the social determinants of health: inequalities, improvement and wellbeing, and community building (including crime and public safety).

## DEPRIVATION IN LANCASHIRE AND CUMBRIA

Deprivation is a result of the social structures, not the result of the behaviours of individuals. We consider health behaviours – actions individuals take that affect their health – to be profoundly related to the underlying social, economic and environmental conditions. In many areas in Lancashire and Cumbria, people live in areas of high deprivation, affecting the social, economic and environmental conditions that influence these health behaviours.

The Index of Multiple Deprivation is one of the best measures in helping to understand deprivation (see Box 2). It is a measure of relative deprivation. Within our study region, Blackpool unitary authority is the most deprived lower-tier local authority in England on the IMD rank of average rank measures, as well as the individual measures on income, health, local concentration and the percentage of people in employment who are deprived. Blackburn with Darwen, Burnley, Hyndburn and Barrow-in-Furness are in the most deprived 10 percent of lower-tier local authorities in England and Lancaster, Wyre, Pendle and Preston are in the most deprived 20 percent (31). In Cumbria 26 lower super output areas, 8 percent of all of Cumbria's LSOAs, rank within the most deprived 10 percent of LSOAs in England, all in the districts of Allerdale, Barrow-in-Furness, Carlisle and Copeland (31). Analysis of North Cumbria's IMD shows high levels of health deprivation and disability, and deprivation in education, training and skills across North Cumbria and deprivation in relation to housing, services and living environment is concentrated in Eden District Council and the more rural Lower Super Output Areas (LSOAs) (31).

### Box 2. The language and measurement of 'deprivation'

The language of deprivation can be stigmatising but the Index of Multiple Deprivation (IMD) is a powerful tool to identify the impacts of living on low incomes, and in some cases, very low incomes. The IMD has been labelled as an index of social justice and our work is rooted in this concept. As the World Health Organisation's Commission on Social Determinants of Health states: 'Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.' While we support the idea of the IMD being an index of social justice, for simplicity, we continue to use the term deprivation throughout this report.

Since 2000, the IMD has produced relative measures of deprivation for small local areas (lower-layer super output areas/LSOAs) based on seven domains of deprivation (Income; Employment; Health Deprivation and Disability; Education, Skills Training; Crime; Barriers to Housing and Services; and Living Environment). Neighbourhoods are ranked from most deprived to least and then divided into 10 equal groups, and this helps to understand where a neighbourhood is among the most or least deprived in England. As such, when we refer to people living in areas of deprivation, this is our measure.

CHAPTER 2

# HEALTH INEQUALITIES IN LANCASHIRE AND CUMBRIA

## KEY MESSAGES

- Physical and mental health is closely related to levels of deprivation and there is relatively poor health and wide inequalities in health and life expectancy across Lancashire and Cumbria.
- Inequalities in health are unfair and cause unnecessary harm to individuals, families and communities and can be reduced through action on the social determinants of health.
- Roughly 40 percent of the healthcare provision is being used to manage preventable ill health and it costs the NHS acute sector nearly approximately £5 billion per year in England.

## LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY

- Life expectancy is below the English average in all 4 local authorities in Lancashire and Cumbria and healthy life expectancy is below the English average in each local authority except Cumbria and healthy life expectancy is well below the English average in Blackburn with Darwen.
- There are large inequalities in health in each of the four main areas and across the region there is nearly an eight year difference in life expectancy between districts for men and nearly seven years for women, closely related to level of deprivation of the area.
- Life expectancy declined across England in 2020 due to the pandemic but declines were greater in the North West and more deprived areas had a greater decline.
- All but four of the 20 local authority districts in Lancashire and Cumbria have higher rates of preventable mortality than the average for England; closely related to levels of deprivation.

## COVID-19

- The COVID-19 pandemic has exposed and amplified socioeconomic and ethnic inequalities and deepened regional inequalities in England. Mortality from COVID-19 is nearly 20 percent higher in the North West than the national average.
- By February 2022 Blackburn with Darwen had the third highest COVID-19 mortality rate in the UK, Blackpool had the fifth highest mortality rate among local authorities.
- Across Lancashire and Cumbria, the COVID-19 mortality in the most deprived decile was 2.3 times greater than in the least deprived decile.

## MENTAL HEALTH

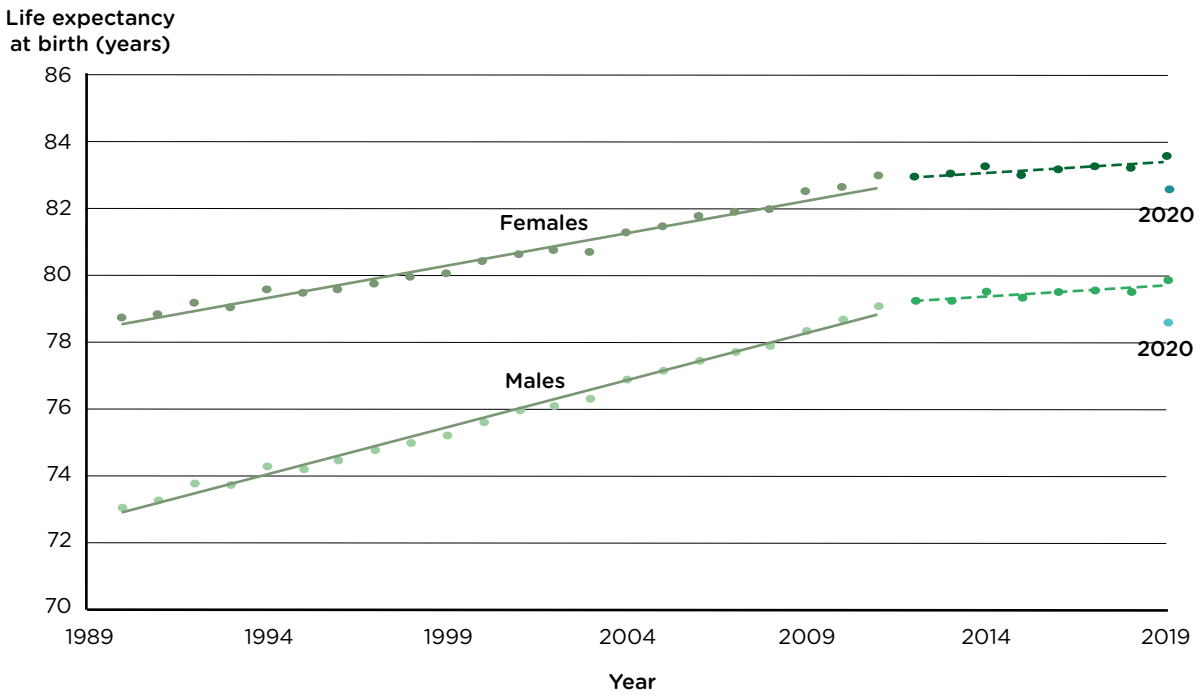
- Poor mental health is related to deprivation and is a major contributor to inequalities in health.
- There is a relationship between deprivation and loneliness and areas with higher levels of deprivation have higher rates of loneliness.
- Over the last five years Lancashire and Cumbria reported higher levels of depression than the England average and levels of depression are increasing.
- There is a close relationship between levels of deprivation and hospitalisation for self-harm in Lancashire and Cumbria.
- Rates of suicide are higher than the average for England in all but five of the 20 local authority districts in Lancashire and Cumbria, closely related to levels of deprivation.

# 2A LIFE EXPECTANCY IN ENGLAND

## In 2020 the IHE Ten Years On report showed life expectancy in England had stalled and for the most deprived areas outside of London had actually declined.

Figure 2.1 shows life expectancy has declined for everyone since 2020, related to the COVID-19 pandemic.

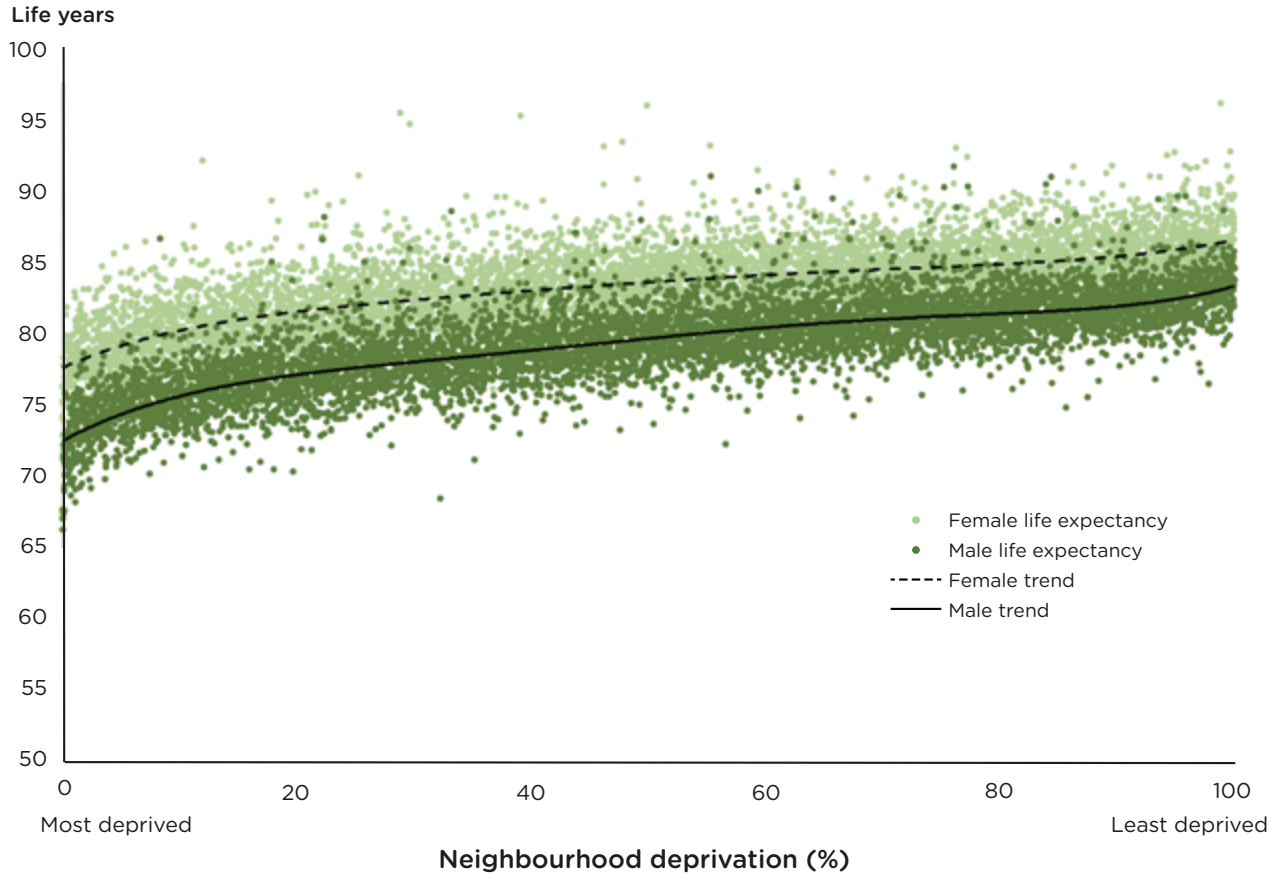
**Figure 2.1. Life expectancy at birth for males and females, England and Wales, 1989–2020**




***Source:*** *Office for National Statistics (32)*

Our 2010 and 2020 reports showed how the social gradient in health runs from the top of the socioeconomic spectrum to the bottom, and that everyone below the top is likely to live shorter lives and develop a disability earlier than those at the top. Figure 2.2 shows the social gradient in female and male life expectancy by neighbourhoods in England. For each increase in the level of neighbourhood deprivation, life expectancy decreases. Our reports repeatedly state that this is unnecessary and that health inequalities that are remediable by reasonable means are unjust.

**Figure 2.2. Life expectancy at birth for neighbourhoods (MSOAs) by sex and deprivation percentiles, (IMD 2019), England, 2016–20**

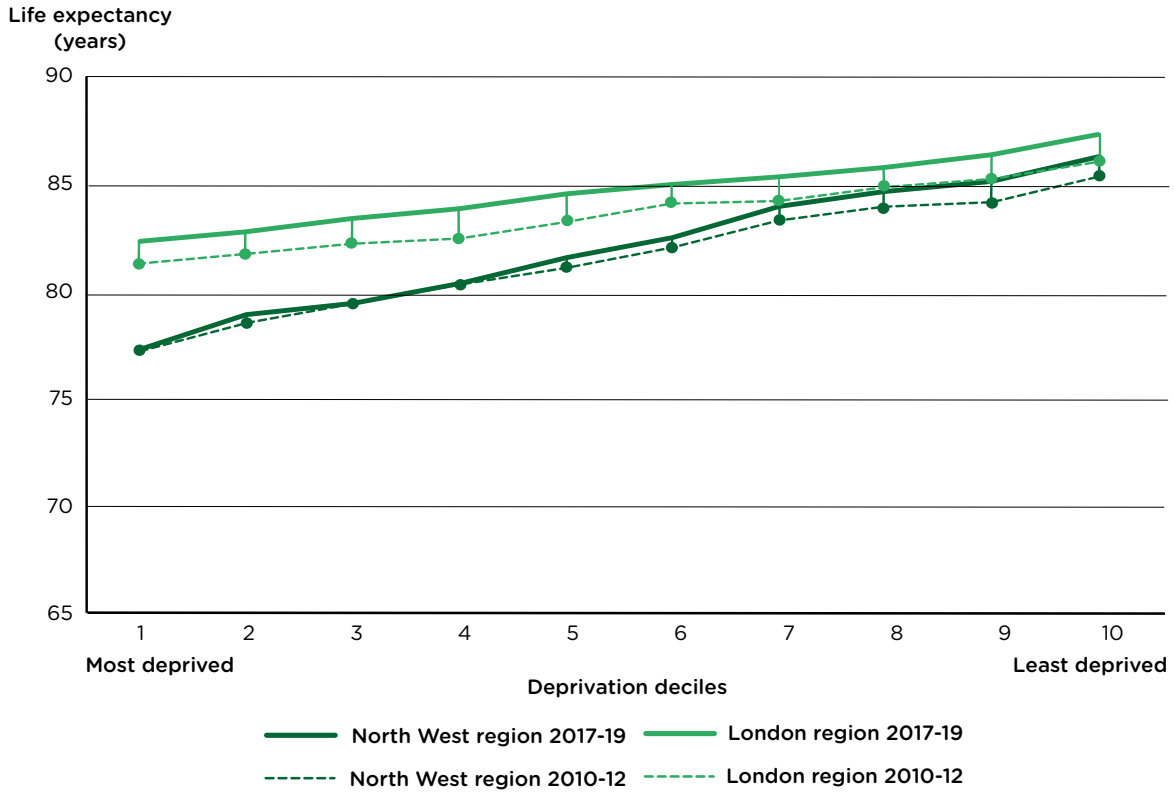



***Note:*** *Each dot represents life expectancy (LE) or disability-free life expectancy (DFLE) of a neighbourhood (middle level super output area/MSOA).*
***Source:*** *Office for National Statistics and Department for Work and Pensions (33) (34)*

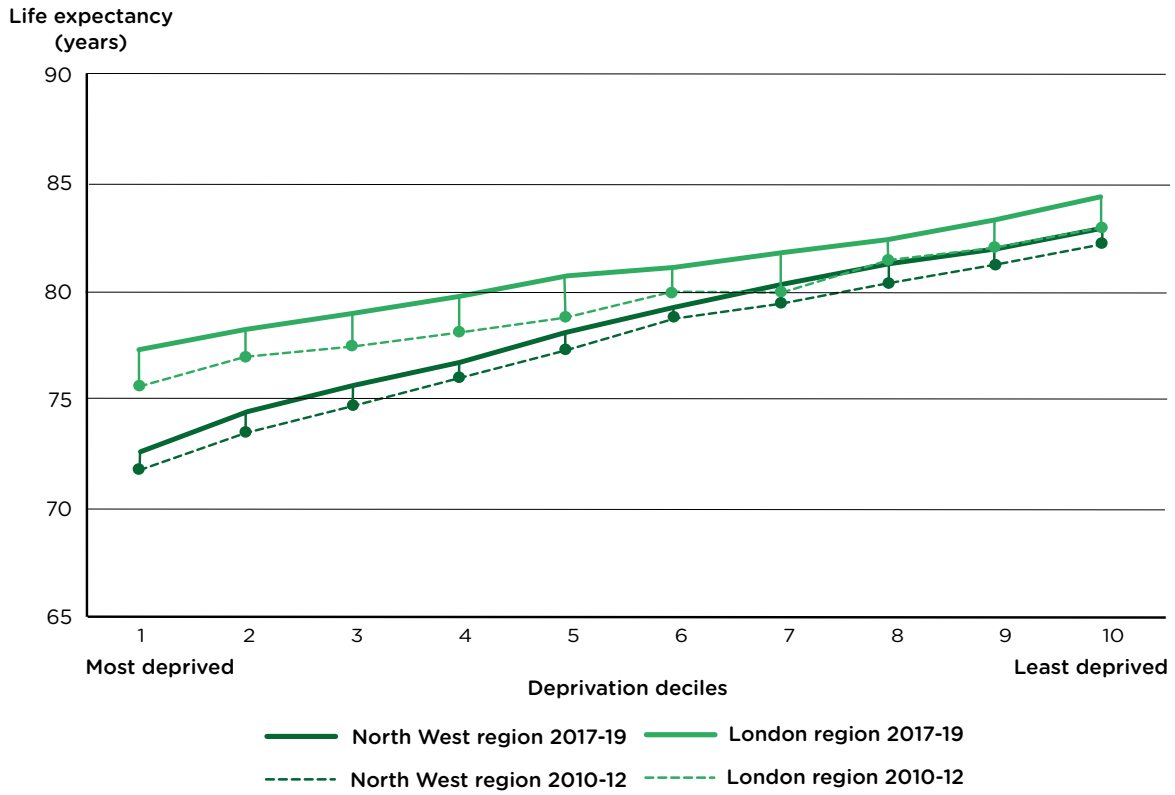
Our 2020 *Ten Years On* report showed the differences in life expectancy across England's regions. From 2010, London's life expectancy increased more rapidly than other regions. Figures 2.3A and 2.3B show life expectancy in the North West region is lower than in London, and that there is a steeper gradient for both men and women in the North West. For those who are wealthy in London and the North West there is not much difference in life expectancy, however, for those who are less wealthy, the differences are large – being poor in the North West is much more damaging to health than being poor in London. There is an 8.8 year difference in life expectancy between women living in the most and least deprived areas in the North West, compared with a 4.9 year difference in London. For men, there is a 10.4 year difference in the North West and 7 years in London.

Figure 2.3A and 2.3B. Estimated female and male life expectancy at birth for the least and most deprived deciles (IMD 2019), North West and London regions, 2010–12 and 2017–19

**A. FEMALES**




**B. MALES**




***Source:*** *Based on PHE, 2020 (35)*

# 2B INEQUALITIES IN LIFE EXPECTANCY AND HEALTH IN LANCASHIRE AND CUMBRIA

## In many areas in Lancashire and Cumbria, life expectancy and healthy life expectancy are below the England average, and in some areas far below.

Tables 2.1 and 2.2 show that life expectancy and healthy life expectancy (2017–19) in Blackpool, Blackburn with Darwen and Lancashire as a whole are below the national average for men and women, while in Cumbria, life expectancy and healthy life expectancy are above the England average. For females in Blackpool, healthy life expectancy is 8.2 years less than the England average and for males it is 9.5 years less. These tables also show that less than three-quarters of women's life in Blackpool and Blackburn with Darwen is spent in good health. The same is true for men in Blackpool.

Table 2.1. Female life expectancy, healthy life expectancy and proportion of life spent in good health, Lancashire and Cumbria upper tier Local Authorities and England, 2017–2019

| Female | Life Expectancy | Healthy life expectancy | Proportion of life spent in 'good' health (%) |
|---|---|---|---|
| **Blackpool** | 79.5 | 55.3 | 69.5 |
| **Blackburn with Darwen** | 80.4 | 59.7 | 74.2 |
| **Lancashire** | 82.3 | 62.0 | 75.3 |
| **Cumbria** | 83.2 | 66.0 | 79.3 |
| **England** | 83.4 | 63.5 | 76.2 |

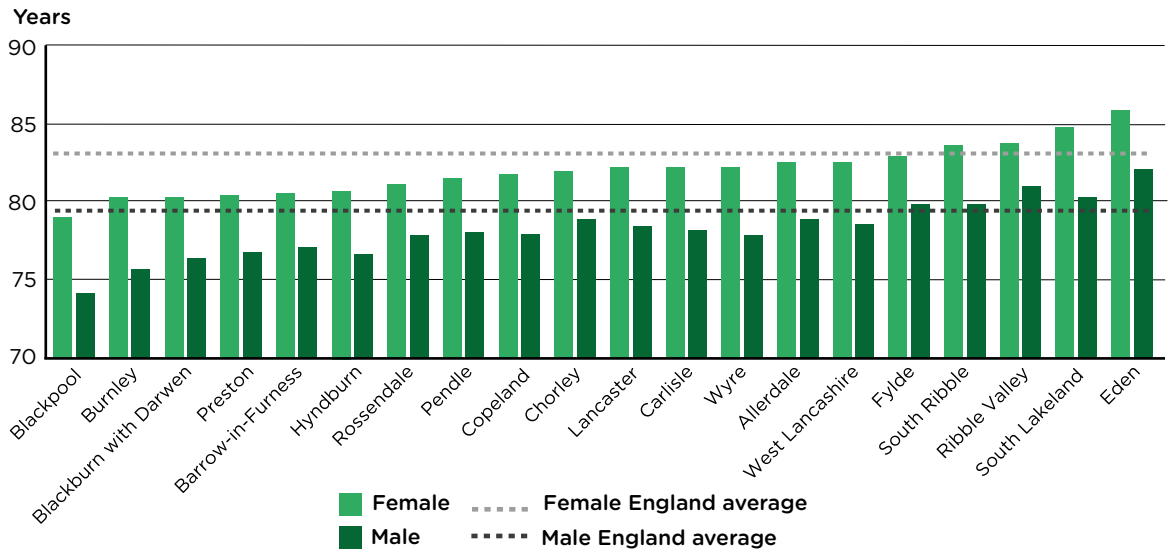
Table 2.2. Male life expectancy, healthy life expectancy and proportion of life spent in good health, Lancashire and Cumbria upper tier Local Authorities and England, 2017–2019

| Male | Life Expectancy | Healthy life expectancy | Proportion of life spent in 'good' health (%) |
|---|---|---|---|
| **Blackpool** | 74.4 | 53.7 | 72.2 |
| **Blackburn with Darwen** | 77.3 | 59.6 | 77.2 |
| **Lancashire** | 78.5 | 60.6 | 77.2 |
| **Cumbria** | 79.6 | 62.9 | 79.0 |
| **England** | 79.76 | 63.2 | 79.2 |

***Source:*** *Office for National Statistics (36)*

Between local authority districts in Lancashire and Cumbria there are wide inequalities. For example, women and men in Eden live on average 6.9 and 8 years longer, respectively, than women and men in Blackpool (Figure 2.4). In all areas life expectancy at birth is below the average for England except in South Ribble, Ribble Valley, South Lakeland and Eden.

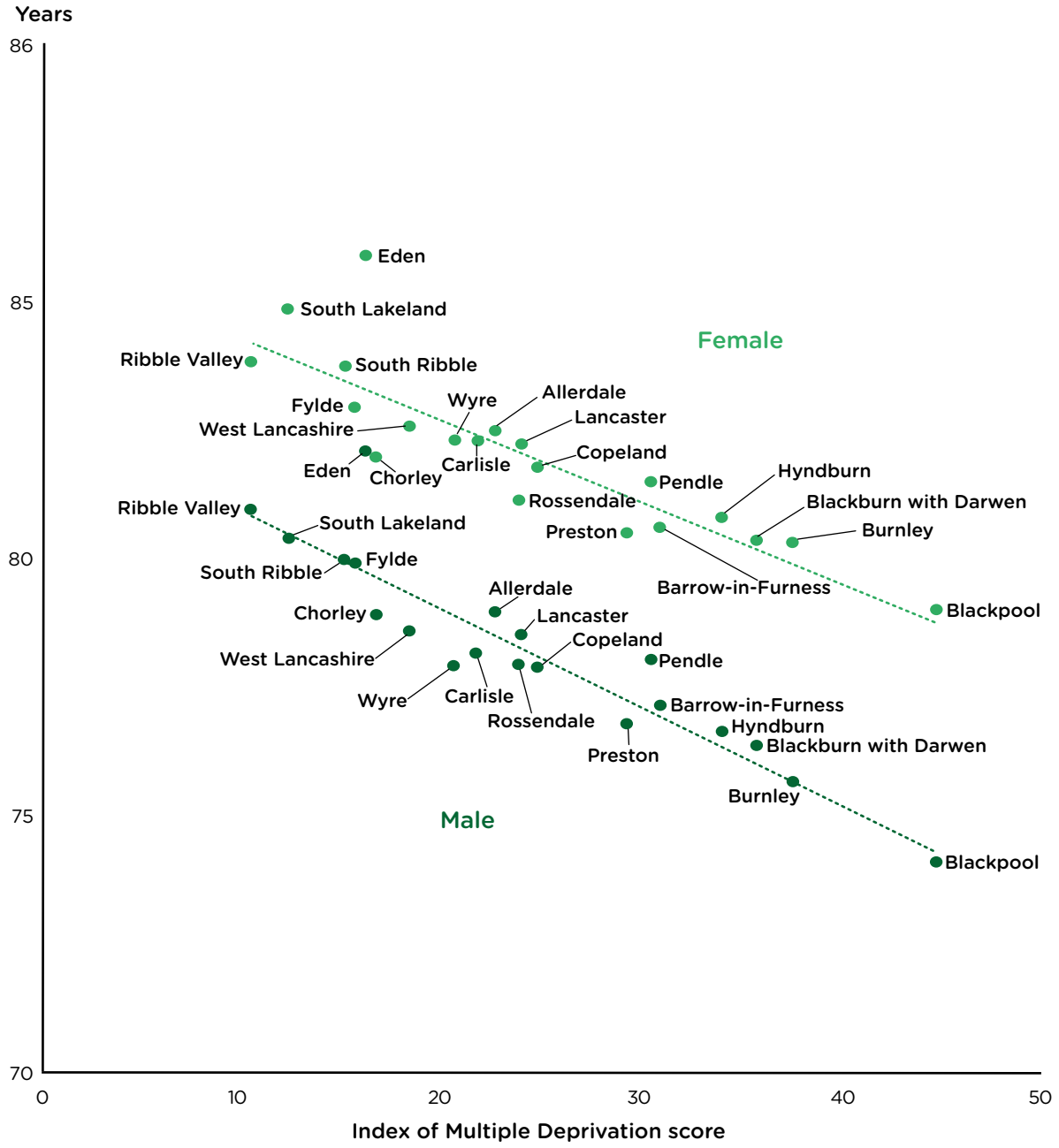
**Figure 2.4. Estimated male and female life expectancy at birth, Lancashire and Cumbria local authority districts and England, 2018–2020**




***Source:*** *Office for National Statistics (36)*

Life expectancy is closely related to level of deprivation. Figure 2.5 shows life expectancy in Lancashire and Cumbria local authority districts by IMD ranking. As deprivation increases, average life expectancy decreases, for both women and men.

**Figure 2.5. Estimated male and female life expectancy at birth and deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2018–2020**

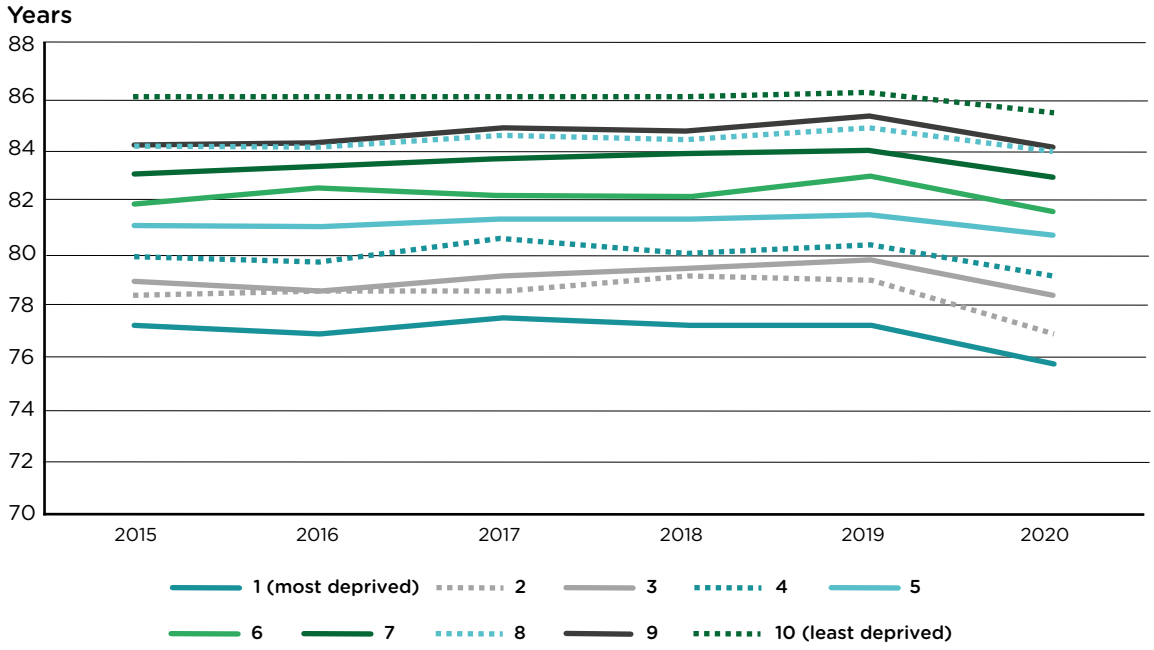



***Source:*** *Office for National Statistics (36)*

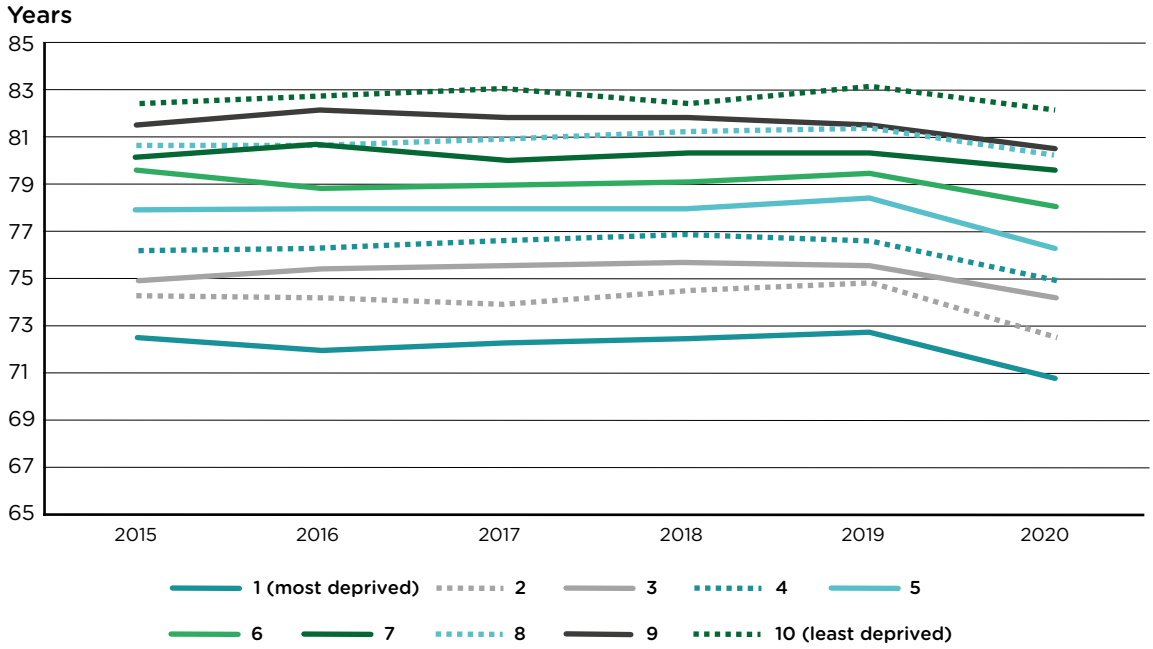
In 2020, life expectancy in the North West declined more than it did in England overall: for females in the North West by 1.2 years, compared with 1 year for females in England as a whole, and for males in the North West by 1.6 years, compared with 1.3 for males in England as a whole (37). The more deprived areas had a greater decline in life expectancy in 2020. Figures 2.6A and 2.6B show males in the second most deprived decile in North West England lost 2.2 years of life expectancy between 2019 and 2020, while men in the least deprived decile lost 1 year. For women, the highest decline was also in the second most deprived decile: 2.1 years lost between 2019 and 2020. In the least deprived areas in the North West, women lost only 0.8 months.

**Figure 2.6A and 2.6B. Trend in estimated life expectancy at birth by deprivation decile (IMD 2019), North West region, 2015–2020**

**A. FEMALES**



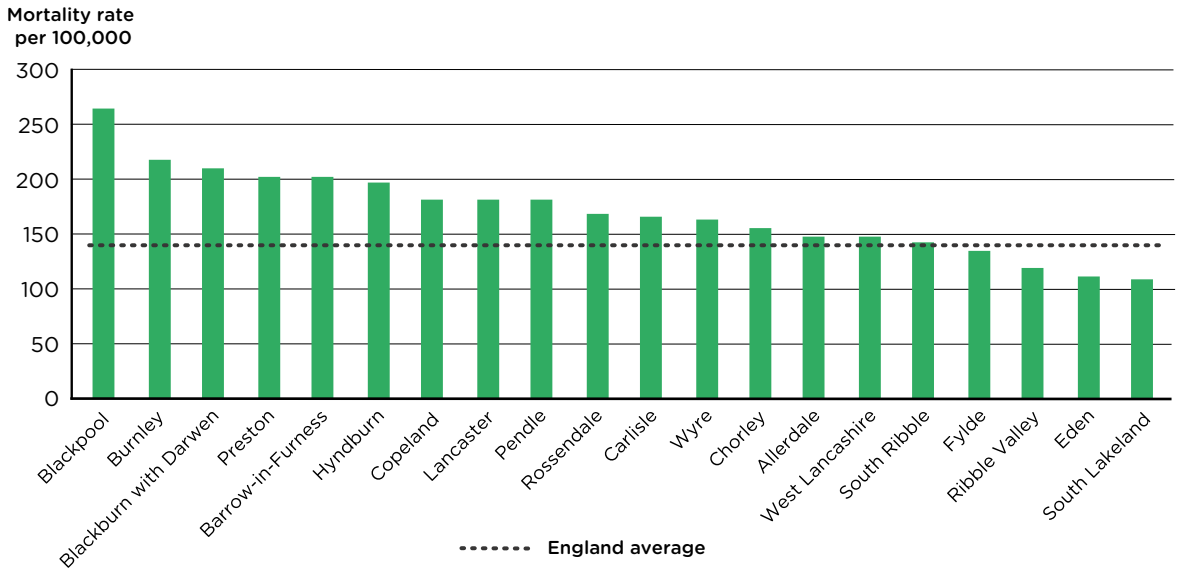

**B. MALES**




***Source:*** *Figures calculated by Public Health England using mortality data and population estimates from the Office for National Statistics. (38)*

There are high levels of mortality from causes considered preventable in many of the local authority districts in the region, shown in Figure 2.7. Most local authority districts in Lancashire and Cumbria have rates that are above the England average. Reducing mortality which is considered preventable would go a long way to improving health in the region and in reducing inequalities in health.

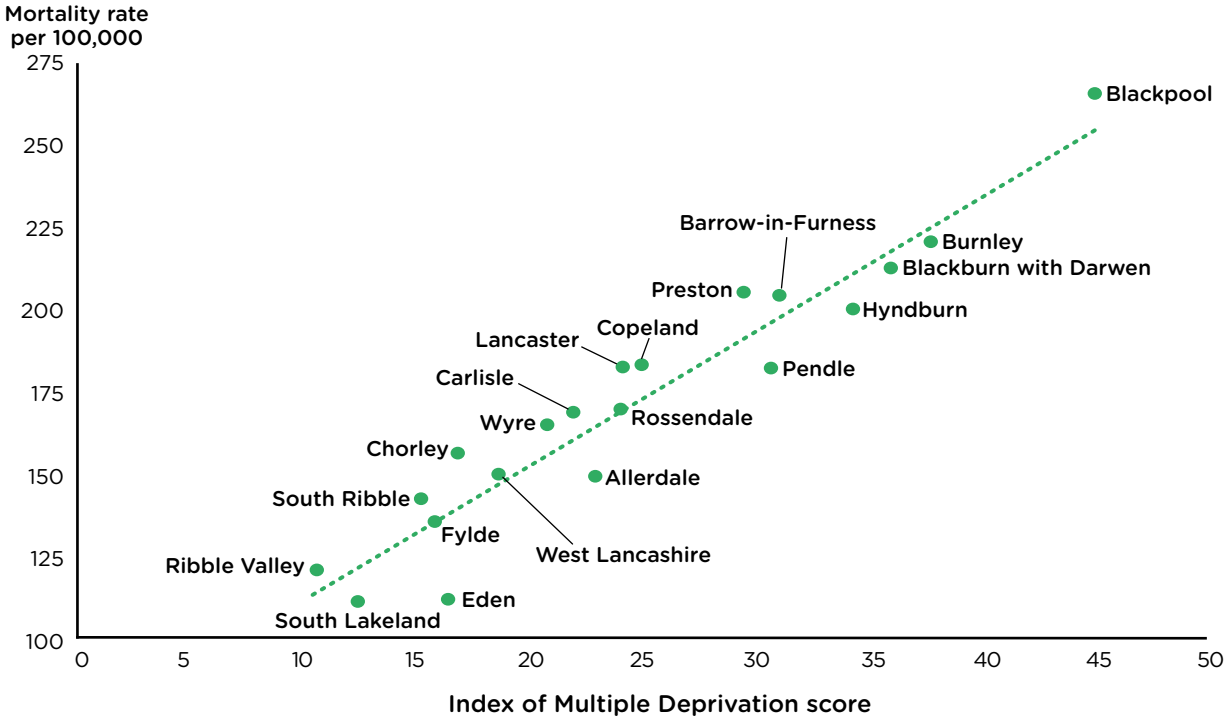
**Figure 2.7. Under-75 mortality rates from causes considered preventable, directly standardised rate per 100,000, Lancashire and Cumbria local authority districts and England, 2017–2019**




***Source:*** *Office for Health Improvement & Disparities (based on Office for National Statistics source data) (39)*

Figure 2.8 shows the strong relationship between deprivation and preventable mortality across Lancashire and Cumbria from 2017–2019. There is a steep increase in the number of preventable deaths as deprivation increases.

**Figure 2.8. Under-75 mortality rate from causes considered preventable by deprivation (IMD 2019), directly standardised rate per 100,000, Lancashire and Cumbria local authority districts, 2017–19**




***Source:*** *Office for Health Improvement and Disparities (based on Office for National Statistics source data) (39)*

These high levels of mortality from preventable causes reflect inequalities in the social determinants of health and also place an unnecessary burden on health services, other public services and businesses.

- Preventable deaths and diseases are costly: 40 percent of healthcare provision in the UK is being used to manage these conditions (40).
- In 2018 the British Medical Association concluded that 'preventable ill health accounts for an estimated 50 percent of all GP appointments, 64 percent of outpatient appointments and 70 percent of all inpatient bed days' (41).
- Demand, and spiralling costs, can be reduced by effective action on the social determinants. Research consistently shows investing in prevention and early intervention will save money by reducing demand on the NHS and public services and will improve health and wellbeing and support economic growth (42).

# 2C COVID-19 MORTALITY

**The COVID-19 pandemic has exposed and amplified inequalities in the social determinants of health, globally, in England, and in Lancashire and Cumbria (2). The work of the HEC was undertaken during the pandemic and throughout this report we outline the impact and inequalities in COVID-19 mortality and associated health and social determinants of health throughout this report.**

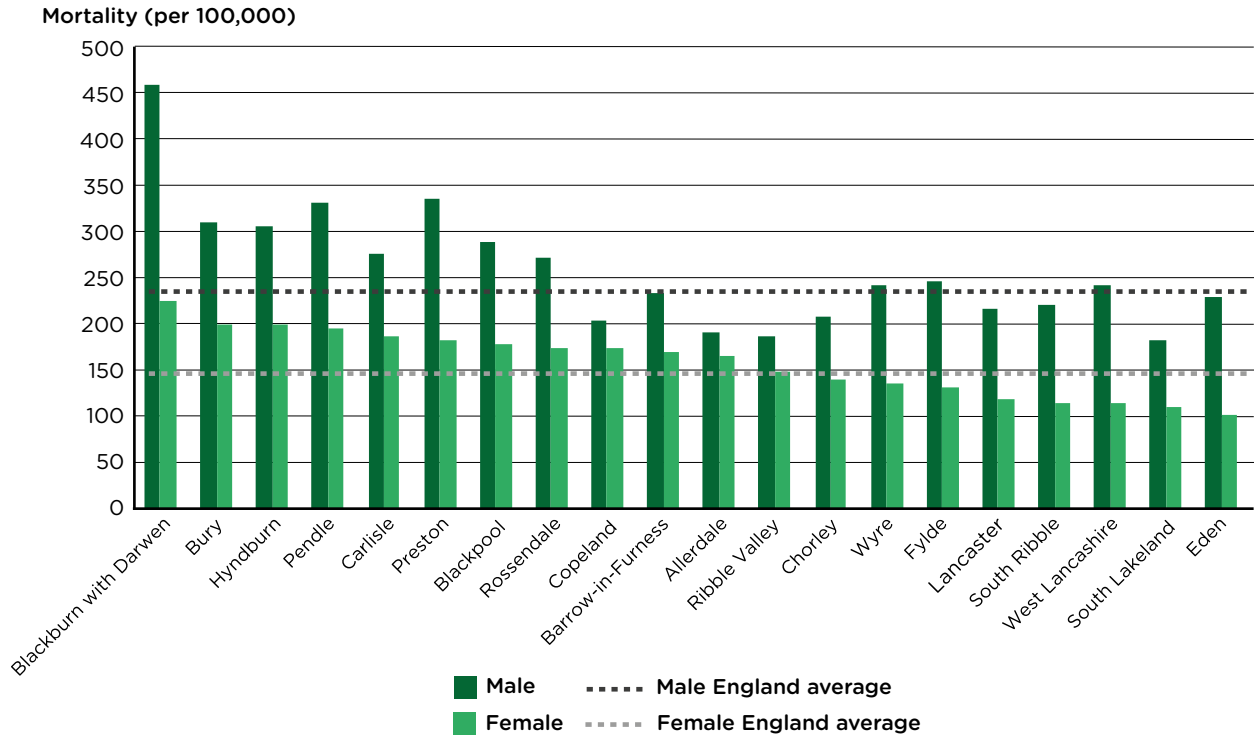
Overall, the North of England has suffered disproportionately during the pandemic from higher case rates, hospitalisations and deaths (43) and the North West has the second highest regional cumulative COVID-19 case rate in England (44). Cumulative COVID-19 death rates (COVID-19 mentioned on a death certificate) in the North West are 19 percent higher than the national average (44).

Mortality from COVID-19 is closely related to socioeconomic situation, which is in turn related to levels of poverty, occupational structure, ethnicity, age and housing conditions. There is a disproportionately high burden from COVID-19 and consistently higher mortality rates from COVID-19 among Black British people and those of South Asian descent across England compared with other ethnic groups, even accounting for area of residence and socioeconomic factors (2).

Lancashire and Cumbria have been heavily impacted by COVID-19. Five of the 16 local authorities in Lancashire and South Cumbria ICS had cumulative rates in the highest 5 percent of all local authorities – Blackburn with Darwen, Burnley and Pendle had the first, third and sixth highest cumulative COVID-19 rates, respectively, since the start of the pandemic. These are some of the most deprived and ethnically diverse areas in the region (45) (46).

Figure 2.9 shows these higher COVID-19 mortality rates in Blackburn with Darwen and Burnley compared with the average for England and with other areas in Lancashire and Cumbria between March 2020 and April 2021.

**Figure 2.9. Age-standardised COVID-19 mortality rate per 100,000, Lancashire and Cumbria local authority districts and England, March 2020–April 2021**




***Notes:*** *Deaths 'due to COVID-19' only include deaths where COVID-19 was the underlying (main) cause.*

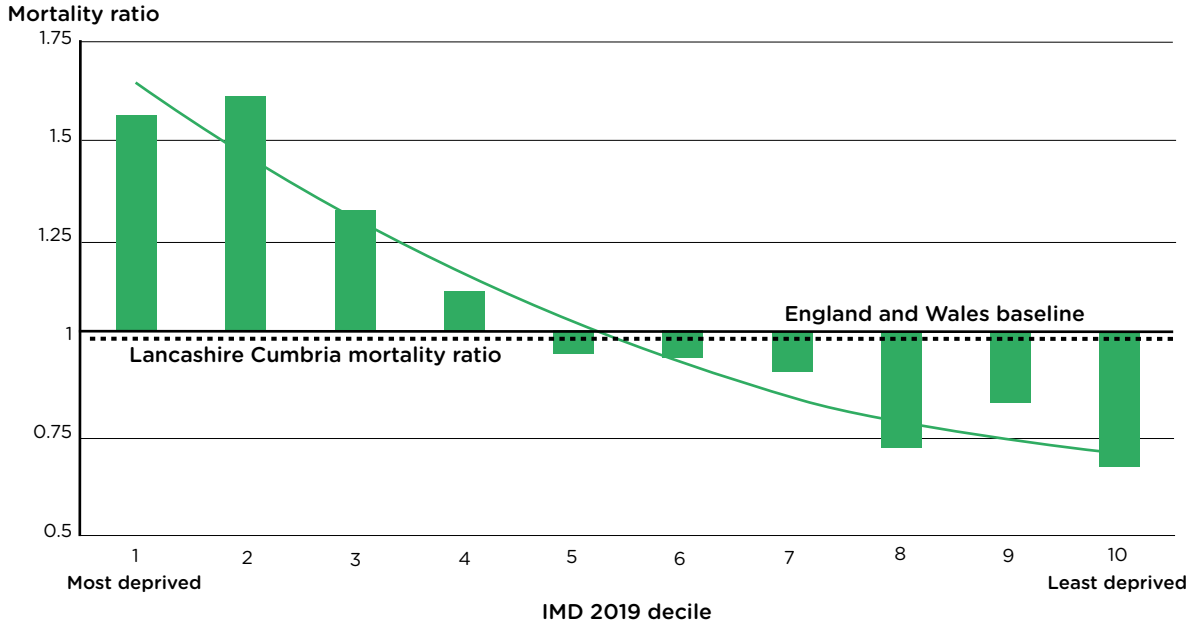
***Source:*** *ONS. Age-standardised rates from COVID-19, People, Local Authorities and Regions in England and Wales, deaths registered between March 2020 and April 2021. (47)*

At the time of writing, the pandemic continues to have a substantial effect on some areas in Lancashire and Cumbria. In February 2022 Blackburn with Darwen had the third highest COVID-19 mortality rate per 100,000 population in the UK, Blackpool had the fifth highest mortality rate per 100,000 of all upper tier local authorities and Burnley had the seventh highest mortality rate of lower tier local authorities in the UK (37).

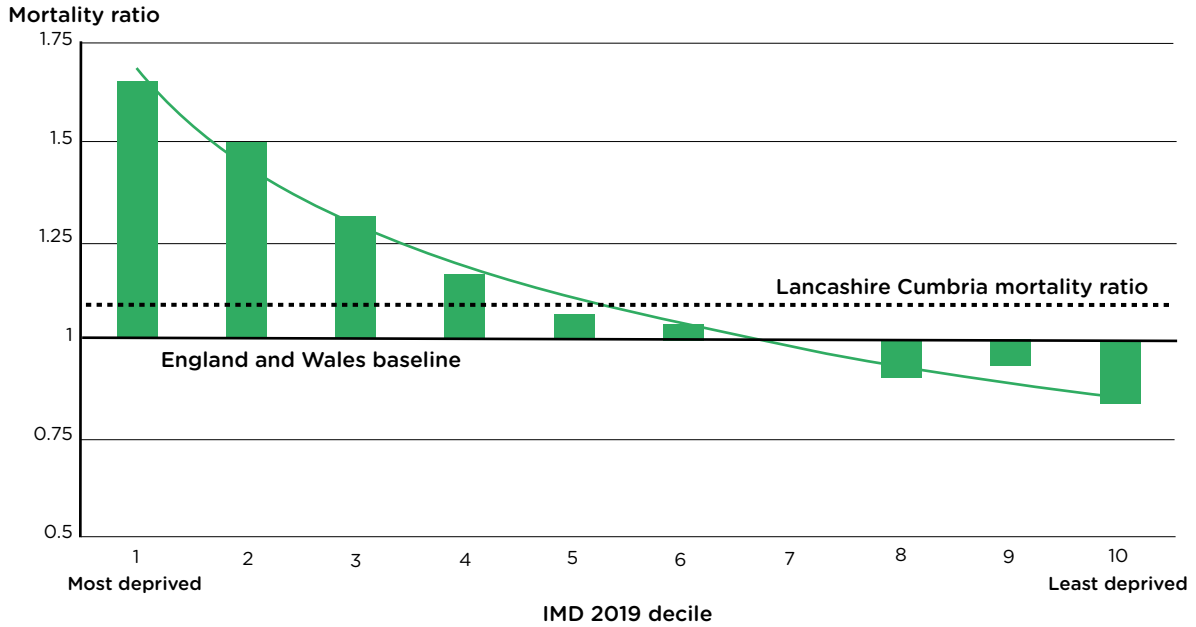
Figures 2.10A and 2.10B show the ratio of COVID-19 mortality by deprivation, using deciles in the IMD within Lancashire and Cumbria compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. The average COVID-19 mortality in Lancashire and Cumbria between March 2020 and April 2021 was marginally lower than England and Wales as a whole, with wide inequalities in mortality across deprivation deciles – it was highest in the two most deprived deciles and then decreased with declining level of deprivation. In half of all areas, mortality from COVID-19 was lower than the England and Wales average over the same period. In Lancashire and Cumbria, the COVID-19 mortality ratio in the most deprived decile was 2.3 times greater than in the least deprived decile, and the corresponding figure for all causes of death in Lancashire and Cumbria was 2. Compared with England as a whole, inequalities in COVID-19 mortality were slightly wider than for all-cause mortality.

Figures 2.10A and B. Age- and sex-standardised mortality ratios by deprivation deciles of neighbourhoods (MSOAs) in Lancashire and Cumbria against the England and Wales baseline, March 2020 to April 2021

**A. COVID-19 MORTALITY RATIOS**




**B. ALL-CAUSE MORTALITY RATIOS**

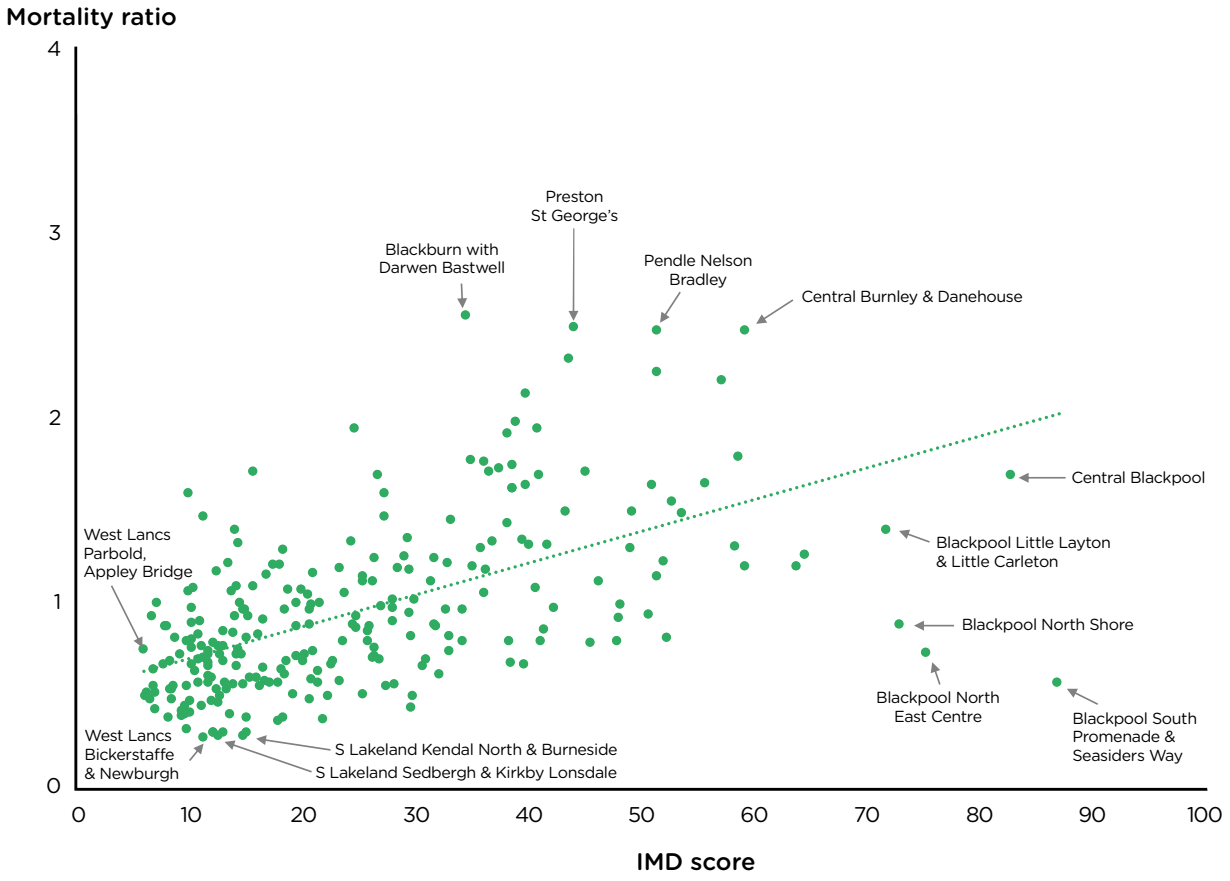



***Notes:*** *MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Lancashire and Cumbria by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these domains for each MSOA, as set out in the Technical Report on The English Indices of Deprivation 2019 (49) . Deciles were obtained by ranking each MSOA within Lancashire and Cumbria 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 Lancashire and Cumbria 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 (49).*

Figure 2.11 shows how mortality from COVID-19 varied between neighbourhoods in Lancashire and Cumbria over the same period. Neighbourhood mortality ratios are calculated for each middle layer super output area (MSOA) and each dot represents the mortality of a neighbourhood. Neighbourhood-level mortality ratios for COVID-19 are associated with deprivation.

**Figure 2.11. Age-adjusted COVID-19 mortality ratio of observed to expected deaths by level of deprivation, neighbourhoods (MSOAs) in Lancashire and Cumbria, March 2020 to April 2021**




***Source:*** *ONS. Number of deaths by Middle Layer Super Output Area, England and Wales, deaths registered between March 2020 and April 2021 (50); ONS. Mid-2019 Population Estimates for Middle Layer Super Output Areas in England and Wales by single year (50)*

Characteristics that contribute to the relationship between COVID-19 mortality and deprivation shown in Figure 2.11 include: having to continue working at a place of employment (outside the home) through lockdowns; type of employment, especially jobs in health and social care, and other frontline occupations such as security occupations, taxi drivers; not feeling secure enough financially to self-isolate; being in poor health prior to infection; and being from an ethnic minority group (51). These characteristics are often experienced simultaneously by lower income groups and lead to much higher risks of mortality. Ethnic minority groups are disproportionately represented among key workers and are more likely to live in more deprived neighbourhoods (2).

There has been an increasing focus on health and inequality as a result of the pandemic and also the development of new ways of working that more closely reflect and respond to the needs of communities. Submissions to the HEC frequently mentioned the good learning and good practice that occurred during the challenges of the COVID-19 pandemic, particularly during the first wave. Blackpool Public Health described their fortnightly Community COVID briefings:

*[...] we were able to reach the most vulnerable communities, regular briefings were set up with community and voluntary groups. These meetings were chaired by the Director of Public Health and attended by groups from across Blackpool. Information including local case rates, hot spots and programmes were presented to ensure our community leaders and representatives were at the forefront and able to provide accurate and timely information to their service users. These meetings also acted as a platform for communities to feedback local concerns and misconceptions, directly influencing and shaping local messaging to meet local need. The meetings proved popular and have continued to develop, building strong, positive relationships within neighbourhoods and recognising that in working together we are better able to support our residents. Key successes from these meetings included the development of a resident-led long COVID support group and utilisation of local people in COVID-19 communications. (52)*

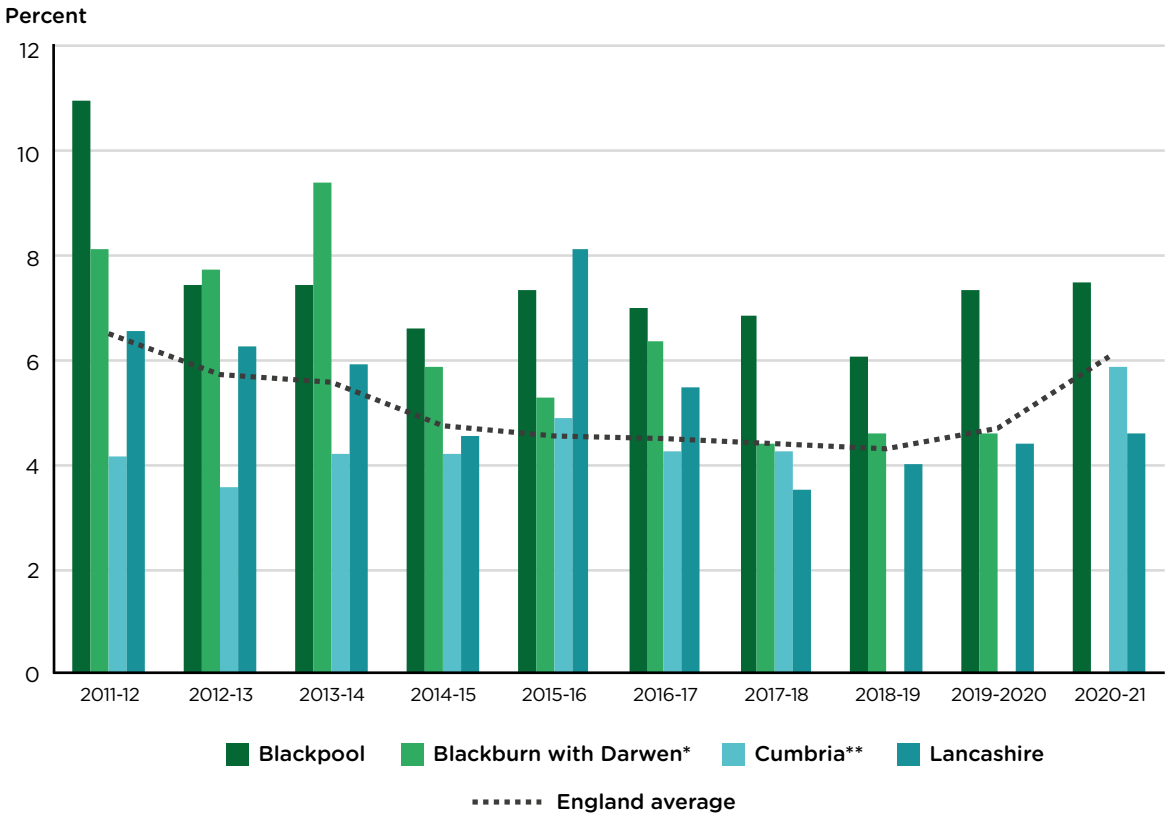
There is much to learn from community-based approaches like this and a core part of IHE's system for health equity proposals and for the social determinants of health is based on the principle that communities must be involved in a meaningful way at every stage of the identification of priorities, design, delivery and monitoring of interventions.

# 2D MENTAL HEALTH IN LANCASHIRE AND CUMBRIA

**Poor mental health is a major contributor to inequalities in health and the COVID-19 pandemic has worsened this situation. In this section we overview inequalities in life satisfaction, depression, loneliness, self-harm and suicide in adults.**

In the winter of 2021/22, the number of people (adults and children/young people) contacting the NHS for help with mental health problems was at a record high (53). Lockdowns and restrictions have had a significant negative impact on mental health for all age groups, but particularly for young people (2). Figure 2.12 shows Blackpool and Blackburn with Darwen have relatively high levels of poor life satisfaction, above the England average, while Cumbria has slightly better levels of life satisfaction. Lancashire has dipped above and below the England average since 2011/12.

**Figure 2.12. Percentage reporting 'poor' life satisfaction in Lancashire and Cumbria upper tier local authorities and England, 2011/12–2020/21**

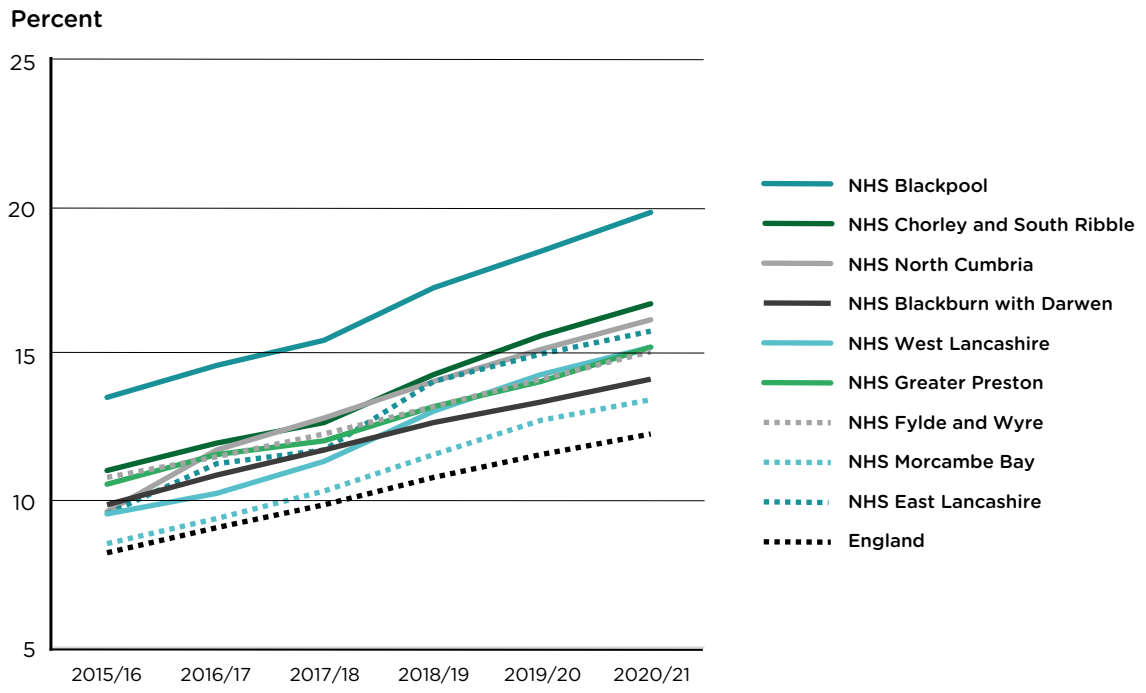



***Notes:*** **Missing 2020-21, ** Missing 2018-19, 2019-20*

***Source:*** *Office for National Statistics (54)*

While life satisfaction trends reveal a mixed picture in Lancashire and Cumbria, rates of depression in adults expose a widespread problem. The prevalence of depression across Lancashire and Cumbria increased in the years prior to the COVID-19 pandemic. Figure 2.13 shows all 10 of the clinical commissioning groups (CCGs) reported levels of depression higher than the England average, and depression increased in line with the national trend for all CCGs between 2015/16 and 2020/21. Note that reporting by CCGs, via the quality outcomes framework, is not the most robust measure of depression as it relates to diagnosis only.

Figure 2.13. Trend in the prevalence of depression in people aged 18 and over, percentage, Lancashire and Cumbria CCGs and England, 2015/16–2020/21

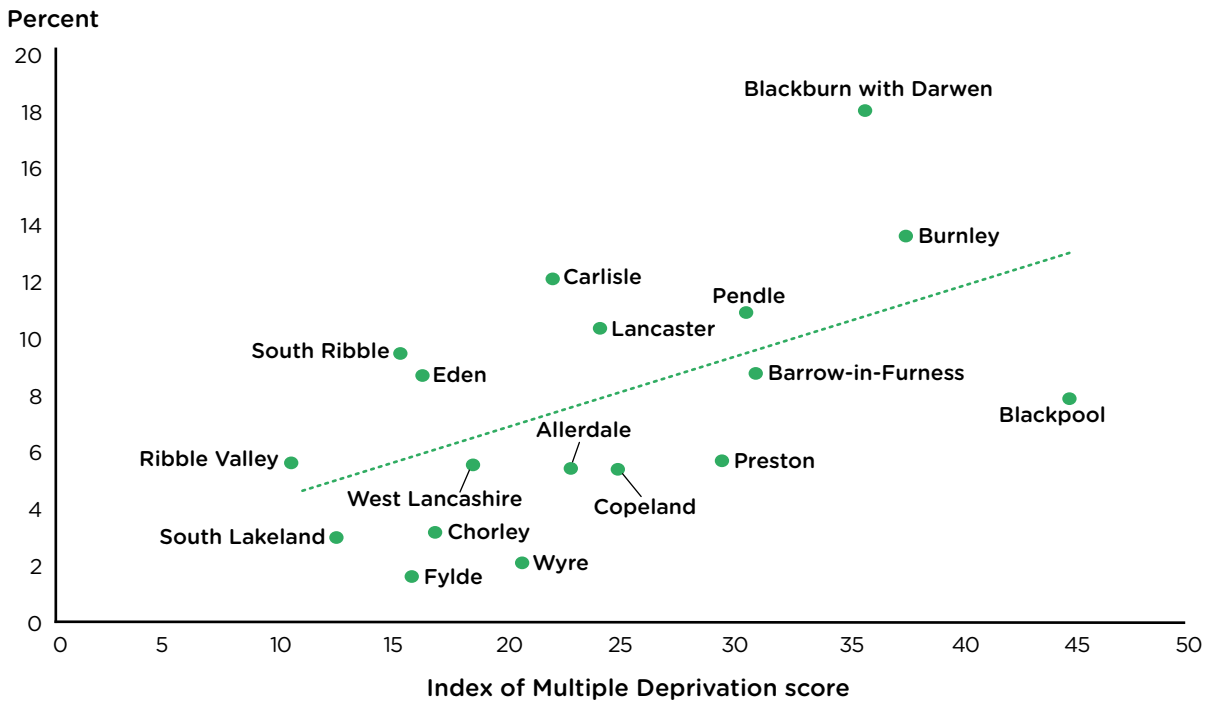



***Source:*** *NHS Digital (55)*

Loneliness is a significant contributor to poor mental and physical ill health and to inequalities in health. The feeling of loneliness is subjective, and information is collected through surveys. During the lockdown in the spring of 2020, rates of loneliness increased across different age groups (2).

There is a relationship between deprivation and loneliness, shown in Figure 2.14, with those areas with higher levels of deprivation generally having higher rates of loneliness.

Figure 2.14. Percentage of adults who feel lonely often/always or some of the time, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts*, 14 October 2020 – 22 February 2021




***Notes:*** *Data not available for Hyndburn or Rossendale*

***Source:*** *Office for National Statistics (56)*

Box 3 outlines the support the Inspire Motivate Overcome charity has been offering to women from ethnic minority communities to reduce social isolation in Blackburn with Darwen, Accrington, Burnley and Nelson.

## Box 3. Improving mental health and reducing isolation

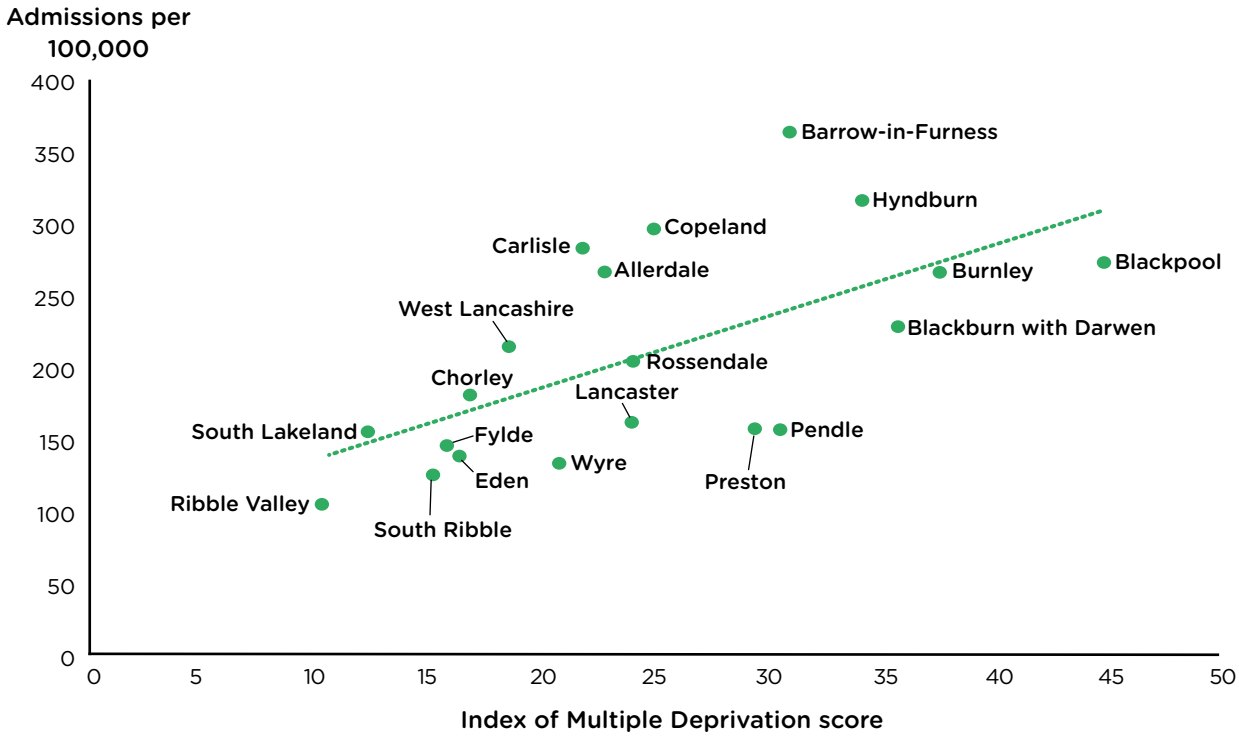
Inspire Motivate Overcome (IMO) started operating in Blackburn with Darwen in 2006, delivering projects to ethnic minority communities. Through feedback and research with IMO's grassroots connections and the local ethnic minority communities, the charity identified mental health as a significant issue, which was not being discussed among women from ethnic minorities, partly due to associated stigma. In 2013, the Women 4 Women group began as one of the charity's five health and wellbeing projects, delivering weekly sessions over eight weeks to support women to make friends and learn new skills in a friendly and welcoming environment.

Women 4 Women was piloted in 2013 and the initial course was found to be very popular with local women. However, while initially successful, there was a feeling that Women 4 Women being labelled a 'health and wellbeing' course was proving to be a barrier to some. IMO reframed the course and offered mental health support alongside activities. Topics related to mental health were introduced so that participants would gain knowledge and support almost imperceptibly, as participants have a chance to air their problems in a private supportive group, creating a sense of community. The topics are aimed at overcoming issues such as feelings of isolation, stress, anxiety and low mood. With peer support, members have the chance to engage in different activities such as crochet, hijab styling, cooking and reflexology, building skills and addressing their mental health in a judgement-free space without the fear of stigmatisation or negative comments.

Over the course of 2021, the project reached 340 women. Women 4 Women courses have been successfully delivered in Blackburn, Accrington, Burnley and Nelson, and IMO intends to start delivering the course in other areas of Lancashire (57).

A study of self-harm in the first year of the pandemic (1 April 2020 to 17 May 2021) found that a significant portion of UK adults may have been at increased risk of self-harm thoughts and behaviours at that time. Experiencing financial harm and worrying about finances increased the likelihood of self-harm in young (18–29 years) and middle-aged (45–59 years) adults (58). Figure 2.15 shows the relationship between self-harm and levels of deprivation in Lancashire and Cumbria.

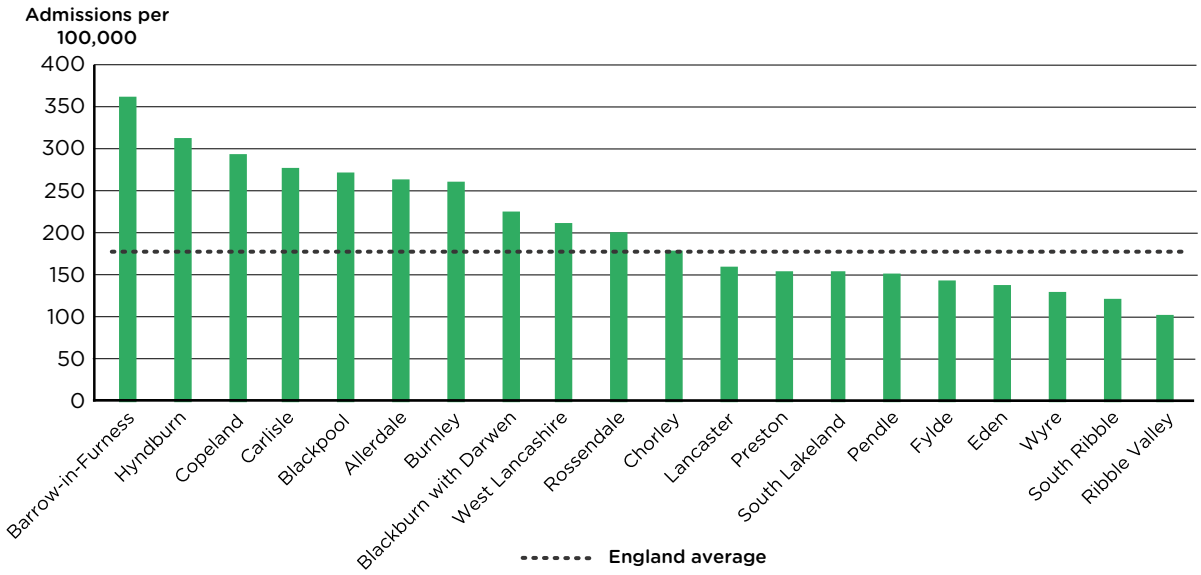
**Figure 2.15. Emergency hospital admissions for intentional self-harm, by level of deprivation (IMD 2019), directly standardised rate per 100,000, Lancashire and Cumbria local authority districts, 2020/21**




***Source:*** *NHS Digital Hospital Episode Statistics (59)*

Eleven of Lancashire and Cumbria's 20 areas had levels of hospital admissions for self-harm that were higher than the England average, with Barrow-in-Furness double the England average (Figure 2.16).

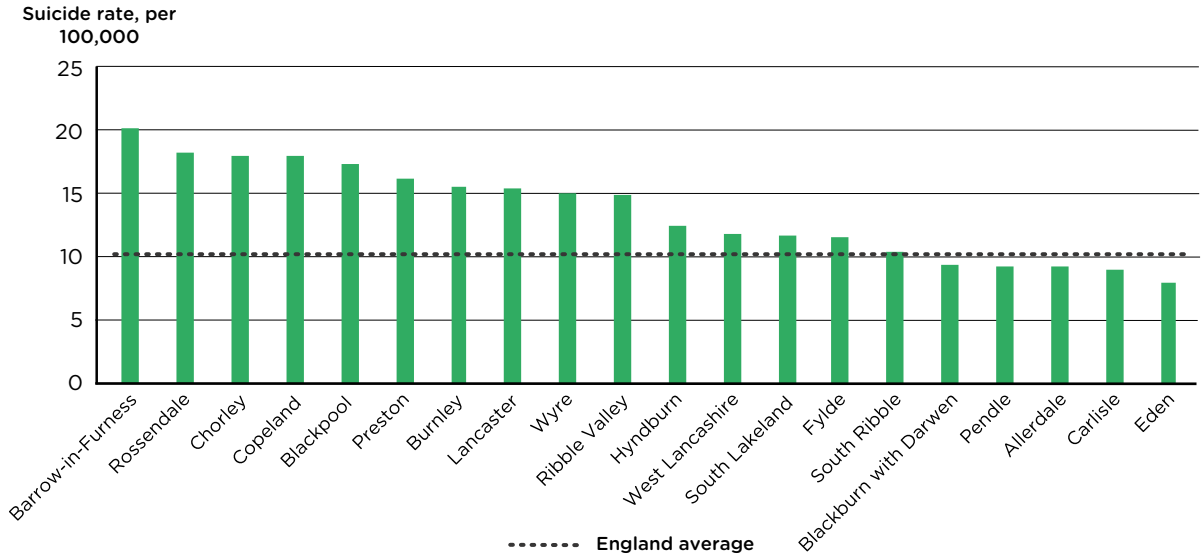
**Figure 2.16. Emergency hospital admissions for intentional self-harm, directly standardised rate per 100,000, Lancashire and Cumbria local authority districts and England, 2020/21**




***Source:*** *NHS Digital, Hospital Episode Statistics (59)*

For both men and women, rates of suicide are consistently higher in areas with the highest level of deprivation, with estimates that rates are double or three-times higher than in the least deprived areas (60). In all but five local authority districts in Lancashire and Cumbria in 2018–20 the suicide rate was above the England average. Figure 2.17 shows that the suicide rate in Barrow-in-Furness was close to double that of England. Reasons for this higher rate in Barrow-in-Furness are unclear and need further exploration.

**Figure 2.17. Suicide rate, directly standardised rate per 100,000, Lancashire and Cumbria local authority districts and England, 2018–20**




***Source:*** *Office for National Statistics (61)*

CHAPTER 3

# SOCIAL DETERMINANTS OF HEALTH IN LANCASHIRE AND CUMBRIA

**Our *10 Years On* review published in 2020 reiterated the relevance of the six areas of social determinants originally set out in the 2010 Marmot Review (1) (6). Both reports explored how inequalities in health in England are a result of inequalities in the social determinants of health. While there are clearly inequalities in the behavioural risk factors for ill health – obesity, smoking and alcohol – these are related to the underlying social, economic and environmental determinants of health. Being able to afford to eat healthily or have the time and access to exercise regularly is shaped by the conditions in which people are living. Living in poverty or on low incomes leads to increased levels of stress and anxiety, enormous demands on mental resources as well as lack of time and money and contributes to unhealthy behaviours and poor health and wellbeing.**

There is a real opportunity to engage with partners across the Lancashire and Cumbria system on the social determinants. While many partners are already knowledgeable about the social determinants, they lack tools, resources and time to take long-term and systematic changes. This section reviews the evidence on the social determinants of health in Lancashire and Cumbria – along the six original Marmot principles – and makes proposals for action to reduce inequalities in these areas and in two new areas: first, tackling discrimination, racism and their outcomes and second, addressing climate change and health equity in parallel (see Section 1).

# 3A GIVE EVERY CHILD THE BEST START IN LIFE

**KEY MESSAGES**

- Outcomes in the early years have lifelong impacts. Inequalities in the early years are significant contributors to inequalities in health throughout life.
- The early years are the period of life when interventions are most effective and cost-effective and yield significant returns on investment.
- Levels of child development are lower in areas of higher deprivation.
- Between 2009 and 2019 there was continuous disinvestment in the early years and declines in spending were greatest in the most deprived areas.

**HEALTH INEQUALITIES IN THE EARLY YEARS**

- Rates of infant mortality in the region are higher than the England average and increasing. They are closely related to deprivation.
- Three areas – Blackburn with Darwen, Hyndburn and Preston – have higher rates of low birth-weight babies than the average for England.
- In each of the 20 districts across Lancashire and Cumbria there are high rates of unintentional and deliberate injuries in babies children and young people.

**INEQUALITIES IN DEVELOPMENT DURING THE EARLY YEARS**

- There are wide inequalities in levels of development among young children in Lancashire and Cumbria. At reception children eligible for free school meals have levels of development considerably below the England average and well below those children who are not eligible for free school meals.
- The quality of early years support and services in the region is not sufficient for children living in poverty. Without effective intervention, inequalities will continue and amplify throughout life.
- The childcare workforce is vital in reducing inequalities in outcomes but is currently under-resourced and undervalued.

**Both the 2010 and 2020 IHE reports showed how health inequalities in the early years have lifelong impacts. Having a good start in life is closely associated with a range of beneficial long-term outcomes: better social and emotional development and performance at school, improved work outcomes, higher income and better lifelong health and longer life expectancy (1).**

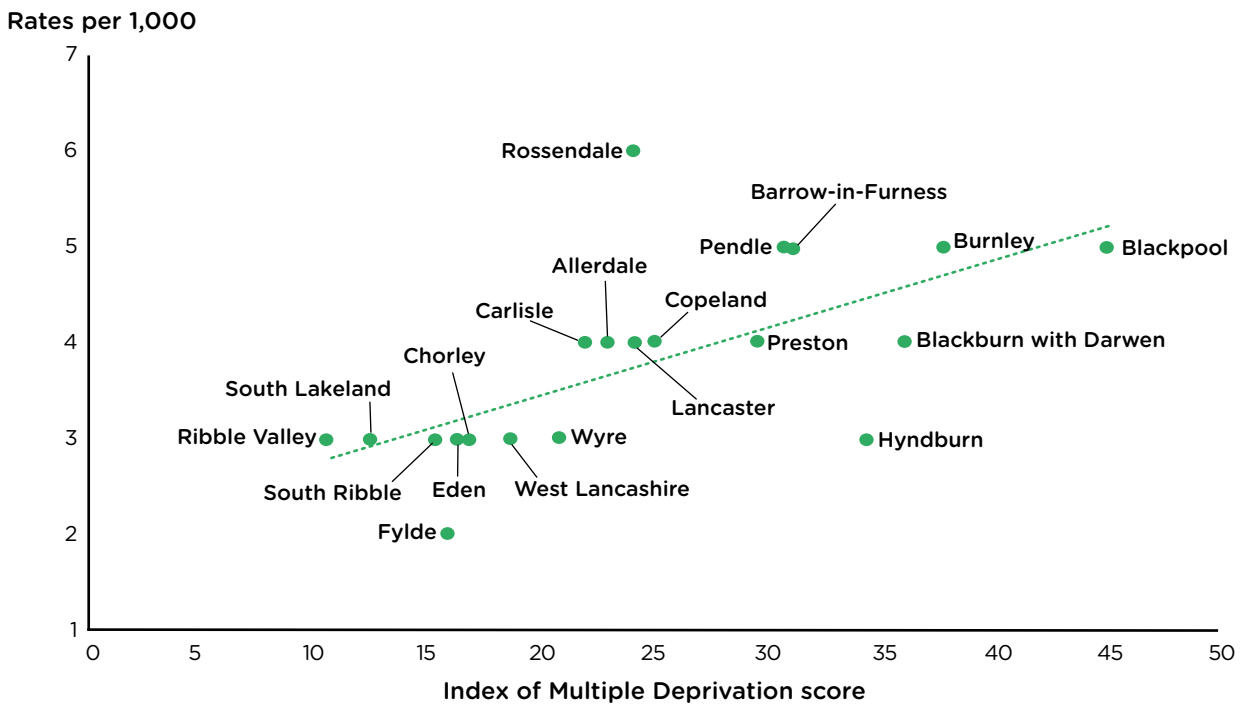
Having a poor start early in life relates closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health (1) (6). The early years are the period of life when interventions are most effective and interventions in the early years have been shown to be cost-effective and to yield significant returns on investment. The Early Intervention Foundation estimated in 2016 that failing to provide the acute, statutory and essential benefits and services for children and young people early in life cost England and Wales £16.6 billion. Specific costs to the public sector increased by 39 percent to local government; 22 percent to the NHS; 16 percent to welfare; 10 percent to the police; 9 percent to justice and 4 percent to education (62).

Spending on children's social care slightly increased its budget between 2009 and 2019, but this only occurred due to the significant increase in the number of children taken into the care of the local authorities (63). Overall, between 2009 and 2019 there was 'continuous disinvestment' in giving every child the best start in life with local government spending on preventative early years and youth services (including Sure Start) falling 21 percent in this period with these declines being greatest in the most deprived areas (63). In the North of England, between 2010 and 2018, spending on Sure Start children's centres fell by £412 per eligible child, compared with a fall of £283 in the rest of England (64).

## INEQUALITIES IN HEALTH DURING THE EARLY YEARS

Infant mortality rates are closely related to deprivation and are an indicator of the effect of family circumstances. Rates of infant mortality have increased since 2010 (1). Figure 3.1 shows that infant mortality rates in Lancashire and Cumbria follow deprivation scores. Rossendale stands out, but as infant mortality numbers are generally low, rates can be affected by changes in one year.

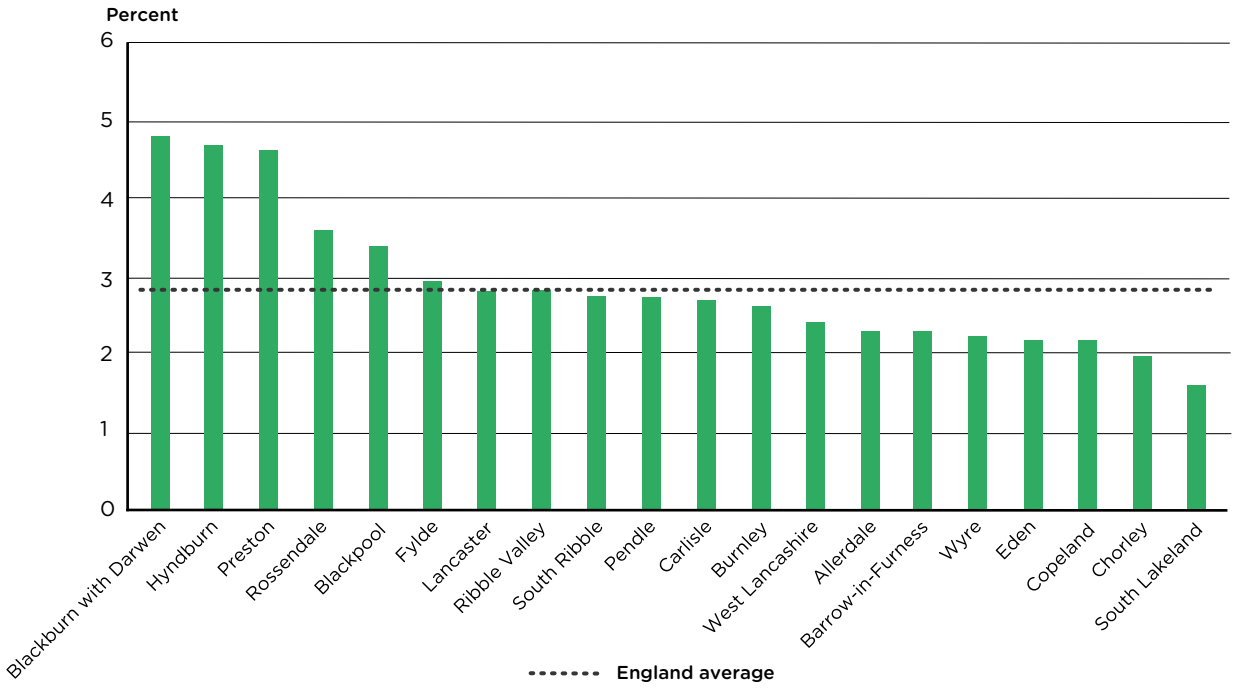
**Figure 3.1. Infant mortality rate per 1,000 live births, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2018–20**




***Source:*** *Office for National Statistics (65)*

Babies born at a low weight are more likely to have poor health and other outcomes throughout life, including higher levels of obesity and are likely to higher use of healthcare services (66) (67) (68). Low birthweight is related to deprivation and parental low income (69). A review found that improving income levels by increasing minimum wage and also improving parental leave decreases low birth weight births and infant mortality (70).The percentage of low birth-weight babies – babies born weighing less than 2,500g – has been stable since 2010 in England and in 2020 2.9 percent of babies were born with low birth weight. Three areas in Lancashire and Cumbria, Blackburn with Darwen, Hyndburn and Preston, have higher rates of low birth-weight babies than the average for England (Figure 3.2).

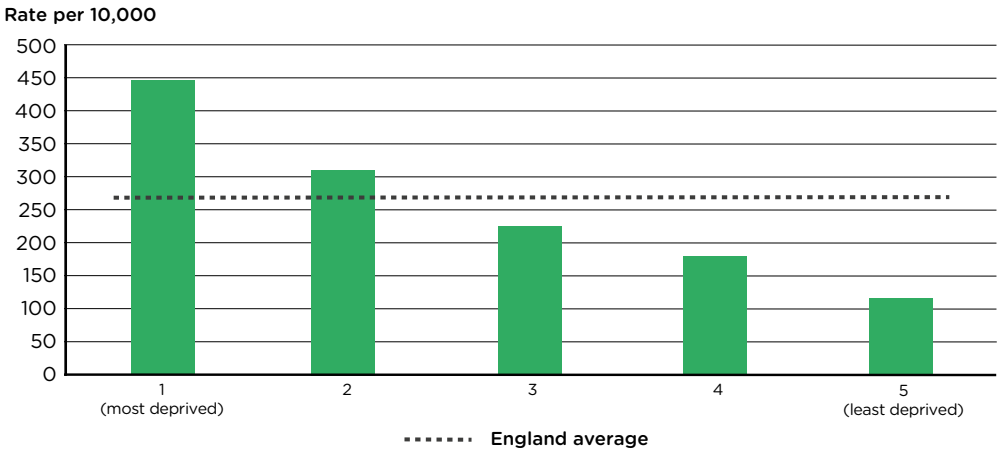
**Figure 3.2. Percentage of low birth-weight term babies, Lancashire and Cumbria local authority districts and England, 2020**




***Source:*** *Office for National Statistics (71)*

Deprivation is a key risk factor for dental decay (72) (73). Children living in the most deprived areas are close to three times more likely to experience tooth decay than children living in the least deprived areas (74). The COVID-19 pandemic has worsened oral health, as access to dental healthcare declined. Hospital admissions for tooth extractions for children increased and were more prevalent in children living in more deprived areas (Figure 3.3) (75). As more NHS providers shift into private provision, combined with an increasing demand for NHS dental services, there are concerns this could result in worse access to dental health services in children (76).

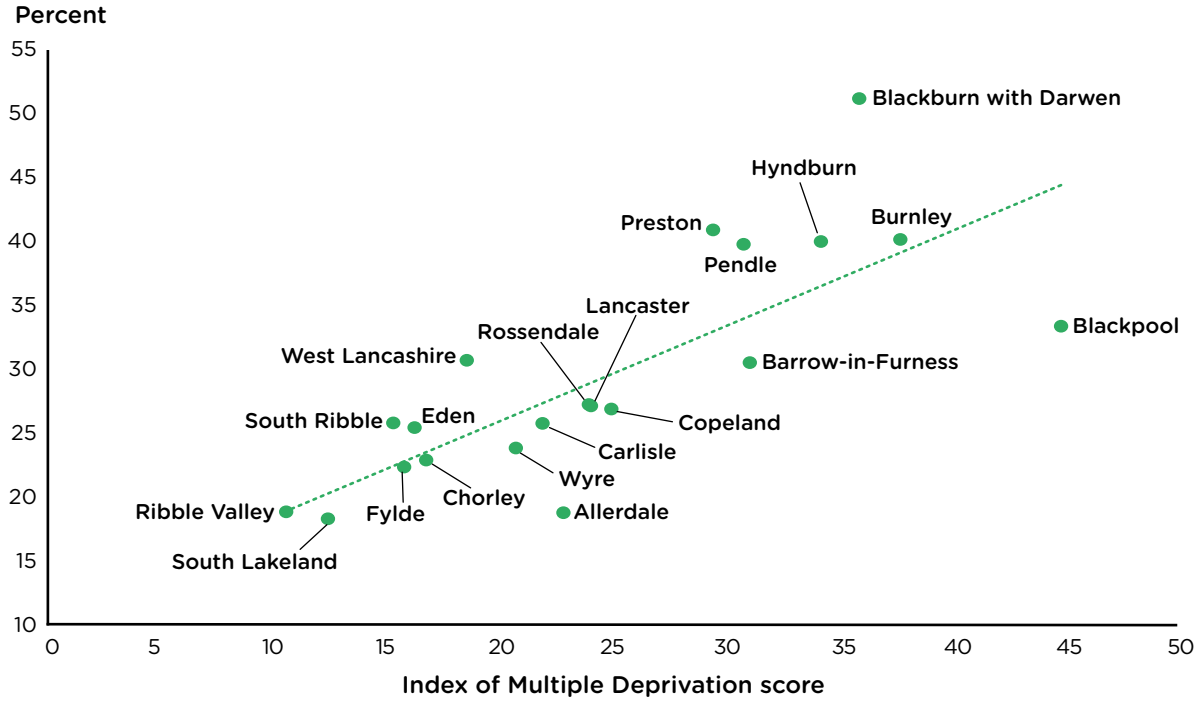
**Figure 3.3. Hospital extractions per 100,000 (aged 0 to 19), by deprivation quintile, England, 2019–2020**




***Source:*** *Public Health England (77)*

Blackburn with Darwen has the highest percentage of children at age five with experience of dental decay in England (lower-tier local authorities). Preston is fifth worst and Burnley sixth worst. Figure 3.4 shows the steep inequalities in the number of children at age five with experience of dental decay.

**Figure 3.4. Percentage of children with experience of dental decay, (aged 5), by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2019**

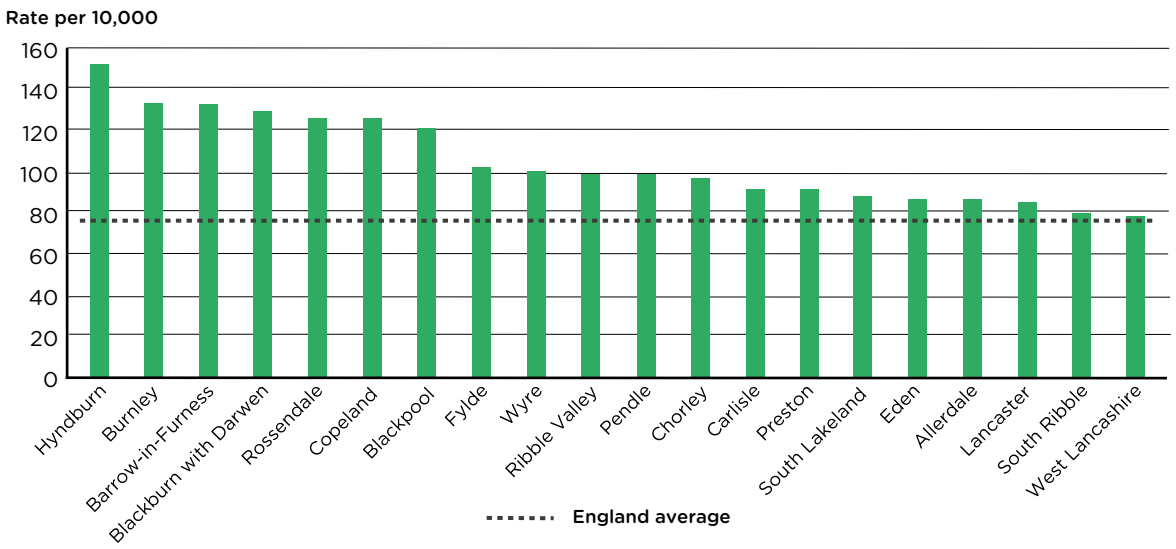



***Source:*** *Public Health England (78)*

In an encouraging intervention to improve oral health in North West England half the children were from the most deprived areas. Parents were encouraged to introduce a number of actions including increasing toothbrushing duration leading to reduced dental decay and plaque (79).

Across Lancashire and Cumbria there are high rates of unintentional and deliberate injuries in babies children and young people (Figure 3.5). These high rates across the region indicate a need to further prioritise these issues.

**Figure 3.5. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0–14), crude rate per 10,000, Lancashire and Cumbria local authority districts and England, 2020/21**



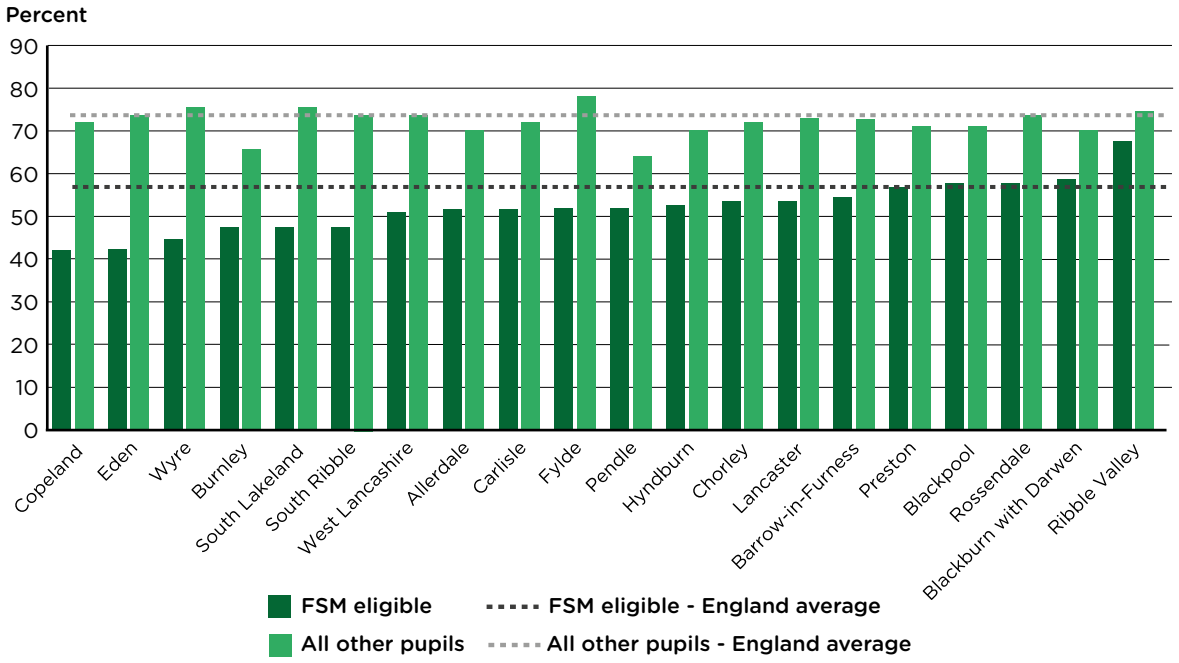

***Source:*** *NHS Digital Hospital Episode Statistics (59)*

## INEQUALITIES IN DEVELOPMENT DURING THE EARLY YEARS

Across England, pupils eligible for free school meals have a lower level of school readiness than children not eligible for free school meals. Inequalities during this period of life will translate into inequalities in health and in other social and economic outcomes throughout life.

In 2018/19, the North West region had the lowest percentage of children achieving a good level of development at the end of Reception, 69 percent, compared with a high of 75 percent in the South East (80). Figure 3.6 shows that in Lancashire and Cumbria in 2018–19, pupils who were not eligible for free school meals achieved a good level of development at the end of Reception, which is roughly comparable to the English average. As in the rest of England these levels were lower for children eligible for free school meals but in most of the region they were considerably below the England average for children eligible for free school meals. This indicates that the quality of early years support and services in the region is not sufficient for children living in poverty. Without effective intervention, inequalities will continue and amplify throughout life.

**Figure 3.6. Good level of development at end of Reception, by eligibility for free school meals (FSM),* percentage, Lancashire and Cumbria local authority districts and England, 2018/19**




***Notes:*** *All other pupils are those not eligible for free school meals and for whom free school meal eligibility was unclassified or could not be determined.*
***Source:*** *Department for Education, EYFS Profile (81)*

Nationally, over the last 12 years local areas have seen early years services cut (apart from within the NHS) due to declining budgets while simultaneously there have been increases in child poverty and increasing levels of need. In England there was a 21 percent cut to early years services and youth services (including Sure Start) between 2009 and 2019 and the reductions were greatest in the most deprived areas (82).

Given the relatively poor outcomes for children living in poverty across the region, it is important that provision of and funding for early years services be increased, particularly in more deprived, coastal and rural areas. Funding should cover additional support for parents that is well tailored to the needs of parents in those communities. Input into the HEC reinforced this and emphasised the need to better invest and support early years services, particularly in the most deprived areas. Investing in the early years yields lifelong benefits and has been shown to be the most effective and cost effective time to invest.

Nationally and locally there have been some attempts to address some of the growing problems in the early years. In the August 2021 Spending Review, the government announced £82 million to establish 'Family Hubs' in 75 local authorities over the next three years, which equates to £360,000 per year for each area if the funding is split equally, far below what is necessary to even begin to make an impact. Early in 2021 34 million was allocated to set up hubs in 12 pilot areas, create a national centre to coordinate practice and develop approaches to digital support. Lancashire was one of two local authorities to be recruited in round one of the Family Hubs – Growing Up Well project (83). These hubs will aim to provide a range of services for parents and older children (as opposed to the 0–5 focus offered by children's centres). However, many councils are unable to provide this service as a result of cuts to children and young people's budgets since 2010 (84) and the amount allocated by the government for their development is too low.

The 2022 Levelling Up white paper also commits an additional £300 million to building the network of Family Hubs and transform Start for Life services for parents and babies, carers and children in half of local authorities in England. In addition, there is an extra £200 million to expand the Supporting Families programme in England. The Levelling Up funding states it will be 'allocated based on need, and the formula has been updated using recent data. This should ensure that areas with higher levels of deprivation receive additional funding' (17). While Family Hubs will be vital for good-quality experiences in the early years, it is too early to tell whether they will be able to reduce inequalities in outcomes – this must be the indicator of whether the programme and funding is successful. As the reach of Family Hubs and funding will be lower than that of Sure Start, there is concern about the extent of impact of the Family Hubs and monitoring must be implemented when the Hubs are opened.

The Empowering Parents Empowering Communities programme has been working with families before and during the pandemic, providing parenting skills in areas with higher levels of deprivation in Lancashire, Box 4.

### Box 4. Parents as leaders in developing parental skills and knowledge

Lancashire Healthy Young Person and Family Service has established a team of trained volunteers, Empowering Parents Empowering Communities (EPEC). The team of volunteers provide support to parents to help them bring up happy, confident, and co-operative children. The programme is run by parents who are trained as parent group leaders by the EPEC hub team, giving them the skills and confidence to deliver sessions to other parents in their communities. The Parent Group Leaders get the opportunity to develop their own knowledge and share this with other parents to give their children the best start in life. Lancashire Healthy Young Person and Family Service have worked closely with Lancashire County Council and Lancashire Violence Reduction Network to secure funding and deliver the parenting programme.

The programme has been targeted at parents and children within some of the most deprived areas of Preston, Burnley, and Lancaster, targeting wards with high levels of deprivation and high rates of infant-related need. The course is delivered in the heart of the community, in local community centres and primary schools, encouraging attendance from local parents. The programme also has a translator available speaking Urdu and Punjabi (85).

In their submission to the HEC, Morecambe Bay Health and Care Partners called for a 'whole system approach to providing support in early years [...] to help protect future generations from disadvantage and poor health'. They argue for an end to working in silos, for developing 'a joint strategic plan to reduce health inequalities for children and young people across all partners' needs' and that the plan 'should be shared across planning departments, housing teams, health, social care, educational providers, child-care providers and many others – and most importantly, our communities'.

HEC submissions also:

- Emphasised that policies to provide the best start in life needed to adopt a proportionate universalist approach to ensure those who needed the support received it and that these policies should involve health equity impact assessments to understand 'reach and accessibility'.
- The need to better communicate the value of nursery provision to parents and carers with a focus on the importance of speech and language and cognitive development to future life chances.
- The importance of valuing early years education, showing it is as important as school, and of developing the early years workforce and involving local people in providing better early years support.

There is strong evidence that a skilled, well paid and motivated early years workforce can make significant impacts on early child development and parental support. Generally in England, the early years workforce is low paid, and lacking skills development and associated qualifications. In 2020 the Social Mobility Commission found 96 percent of England's early years workforce was female and paid, on average, £7.42 per hour (86). A survey of over 1300 early years staff in 2021 found 60 percent stated it was 'very difficult' to recruit staff and 49 percent had stopped taking on new children due to staff shortages. Survey respondents working in rural areas stated they had 'additional challenges' in attracting staff due to lack of public transport. The most common reason given for wanting to leave the sector was feeling undervalued, second stress and thirdly, poor pay (87). The HEC calls for higher pay and qualifications for the early years workforce and on-the-job training and support. The initial outlay of costs would be recovered through better outcomes throughout school and associated reductions in demand for crisis intervention and healthcare services.

## RECOMMENDATIONS: GIVE EVERY CHILD THE BEST START IN LIFE

**a)** Reduce the gap in level of development in reception age children and set a target that every child achieve above the national average at readiness for school at reception.

**b)** Increase access and provision of early years services in areas with higher levels of deprivation, and ensure allocation of funding is proportionately higher in areas of higher deprivation

**c)** ICS and local authorities equip all those working with young children to support parents in developing their children's early learning, especially with regard to speech and language skills.

**d)** Develop and adopt a region-wide childcare workforce standard that includes training and qualifications on the job, including access to NHS training and offer, as a minimum, the real living wage to all early years staff.

**Leads:** Local authorities, NHS

### NATIONAL ADVOCACY

- Increase levels of spending on the early years.
- Funding to provide real living wage as starting salaries for early years employees and clear progression routes for early years staff.

# 3B ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

**KEY MESSAGES**

- Experiences during school years and into early adulthood continue to impact people throughout their lives, affecting employment opportunities, lifetime earnings and health.
- Inequalities in educational attainment were wide before the pandemic and have since widened.
- Funding for secondary education declined between 2010-20 and youth services have been cut which have harmed young people, particularly those living in more deprived areas and households.
- Reducing inequalities in educational attainment and experiences at this stage of life are effective in reducing health inequalities throughout life.
- The mental health of young people has deteriorated and there is a sense of hopelessness among many young people particularly those living in more deprived areas and isolated communities.

**INEQUALITIES IN HEALTH**

- There are high rates of injuries among young people in some districts in the region which are closely related to levels of deprivation.
- Prior to the COVID-19 pandemic one in 10 children and adolescents in the UK were experiencing a diagnosable mental health disorder which often have lasting consequences. The pandemic has led to an increase in mental health problems among young people.
- Young people and children from low-income households report worse mental health and wellbeing, including higher levels of anxiety and loneliness.
- Child poverty is a significant risk factor for poor mental health in children and as poverty increases it is likely the mental health of young people will deteriorate still further.

**INEQUALITIES IN EDUCATIONAL ATTAINMENT**

- Children and young people who grow up in poverty are more likely to have poor educational outcomes and less access to training and decent jobs.
- Inequalities in educational attainment increased during the pandemic.
- There are wide inequalities during primary school between those eligible and those ineligible for free school meals. The region performs roughly as well as the average for England for both children eligible for free school meals and those ineligible although in Lancashire and Blackpool outcomes for children eligible for free school meals are a little lower.
- By age 16 inequalities in education have widened and all districts but Blackburn with Darwen are performing below the national average.
- Given its level of deprivation, Blackburn with Darwen has strong outcomes and low levels of inequality for educational attainment.

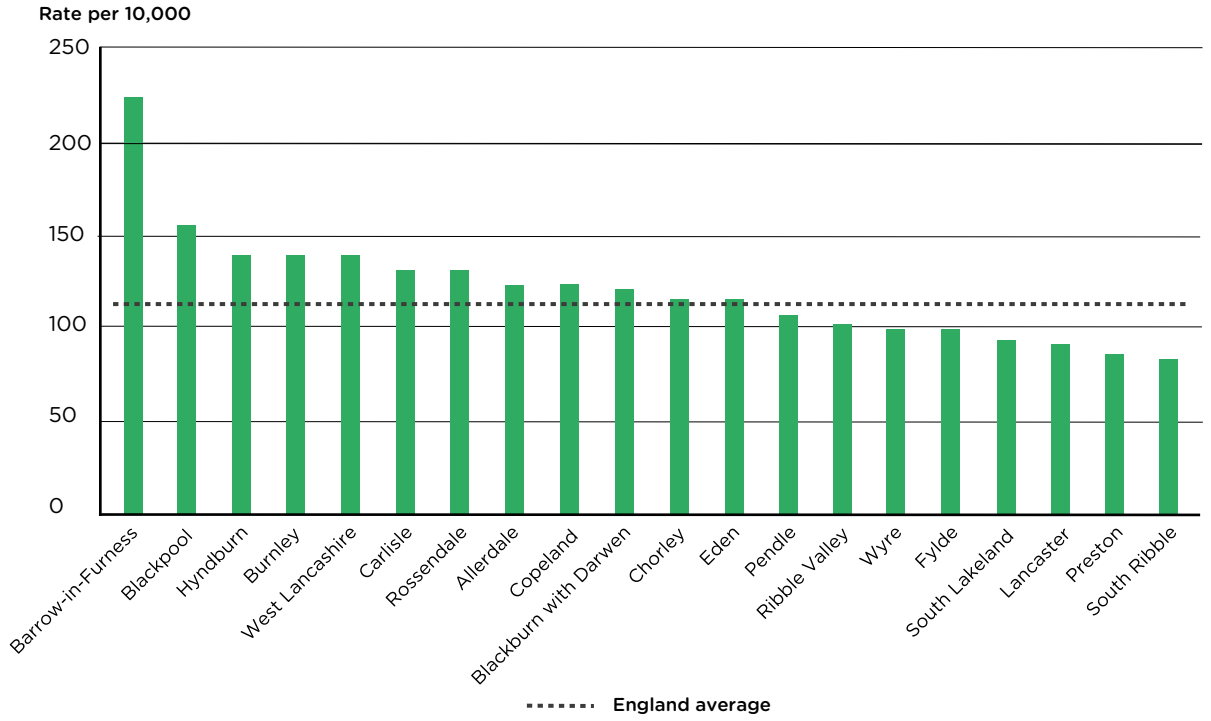
## Experiences during childhood and through school into early adulthood continue to impact people throughout their lives, affecting employment opportunities, lifetime earnings and health.

Adults with high literacy levels are at least twice as likely to earn more, have political efficacy, volunteer, trust others, be employed and be in good health, than those with lower literacy levels. In the UK, those who have no qualifications are over twice as likely to have a limiting illness as those who achieved university level (or equivalent) education (88). There is a clear and close relationship between health and experiences during this period of life; worse outcomes during childhood and early adulthood lead to worse health during the period and particularly later in life. Reducing inequalities in educational attainment and experiences at this stage of life are therefore effective interventions to reduce health inequalities and should be considered as such by all stakeholders involved – including healthcare and public health.

### INEQUALITIES IN HEALTH AMONG YOUNG PEOPLE

As for the younger age group, there are high rates of unintentional and deliberate injuries among young people for some local authority districts in the region, Figure 3.7. Again there needs to be concerted action to reduce these.

**Figure 3.7. Hospital admissions caused by unintentional and deliberate* injuries in young people (aged 15–24 years), crude rate per 10,000, Lancashire and Cumbria local authority districts and England, 2020/21**

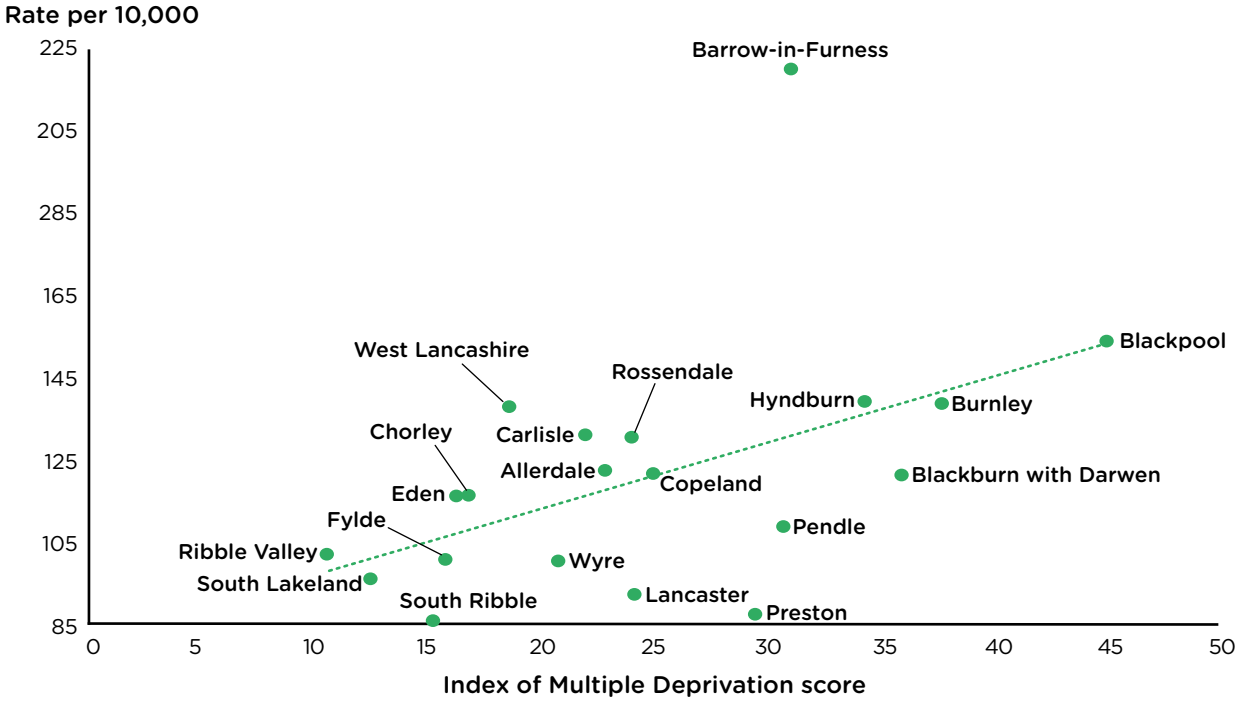



***Notes:*** *Unintentional injuries are identified as external causes of harm, such as road traffic collisions, sports injury, falls, accidental contact with machinery, burns and drowning. Deliberate injuries include different types of assaults and deliberate self-harm. (90)*

***Source:*** *NHS Digital Hospital Episode Statistics (59)*

The rate of injuries is closely related to the level of deprivation. Figure 3.8 indicates that this is an inequality issue, related to key social determinants of health, and that these need to be a priority issue in reducing inequalities in the region. Barrow-in-Furness has the fourth highest rate of unintentional and deliberate injury hospital admissions for 15- to 24-year-olds in England.

**Figure 3.8. Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15–24 years), by level of deprivation (IMD 2019), crude rate per 10,000, Lancashire and Cumbria local authority districts, 2020/21**




***Source:*** *NHS Digital Hospital Episode Statistics (59)*

Research prior to the COVID-19 pandemic found one in 10 children and adolescents in the UK experiencing a diagnosable mental health disorder and these mental health problems early in life have lasting consequences. Close to three-quarters of life-time mental health disorders have their onset before age 25 years (90). The pandemic has led to an increase in mental health problems among young people. Young people and children from low-income households have reported worse mental health and wellbeing, including higher levels of anxiety and loneliness (91).

Research consistently finds child poverty is a risk factor for poor mental health in children (92). Children living in persistent poverty and with a parent with poor mental health have six times the odds of having mental health problems compared with children not living in poverty and with healthy parents (93). This study of the UK Millennium Cohort also found 19 percent of children living in persistent poverty and with a parent with poor mental health had Pakistani or Bangladeshi mothers compared with 1 percent in the low poverty and adversity group (93). Interventions that seek to improve mental health without focusing on childhood poverty will only have limited benefits.

Services for young people have also been substantially cut and it is estimated these spending cuts on preventative services for adolescents are directly linked to rising rates of 16- and 17-year-olds entering care. Davara et al. argue that every £10 decrease in prevention spend per young person was associated with an estimated additional two 16- to 17-year-old young people entering care (per 100,000 per year). They estimate this led to an additional 1,000 young people aged 16–17 being taken into care between 2011 and 2019. Any claimed savings from cutting prevention services to young people disappeared as an extra £60 million was added to councils' care bills to support these children (94).

While access to mental health services for children and young people needs to be rapidly expanded, particularly in more deprived areas support and activities that can help to prevent mental health problems developing are vital. The most effective approaches are those that support the family and make improvements in a range of social determinants – for example, improving skills, training and employment opportunities, reducing levels of debt and improving housing conditions. Approaches that support children and families to improve mental wellbeing are also effective but are not provided by public service organisations.

Submissions to the HEC suggested:

- The need for 'wrap-around support, of schools as a "one-stop shop" or "hub" where children, young people and families can access other services'.
- That 'the system needs to focus on providing what families and schools need, where they need it, and make it much simpler to navigate so that people know where to go to get help'.
- Wrap-around services provide more than care for pupils before and after school: they are intended to support pupils in all senses, whether academic, social or behavioural.
- North Cumbria stated, 'As cost-of-living increases, opportunities for [children and young people] worsen [...] Children in low-income families have less access to activities that support their physical development and wellbeing e.g. days out, trips to the beach, farm parks etc. due to lack of family income. And rising housing/ fuel costs are expected to make this divide even larger.'
- VCFSE partners in Morecambe Bay described how providing free activities in local community centres attracts people, and those services need to be available when people need them – often this is outside of the typical '9 to 5' offer.
- The VCFSE sector described needing 'to put a scaffolding around our communities and around the front-line professionals like PCSOs, community centre volunteers and housing officers who work in them, because at the moment they see the problems but they do not know where they can go to for help.'
- Local headteachers stated that they felt their students were 'falling through the cracks' in mental health and social care because the diagnosis thresholds were too high and, because of cuts, services could only offer support when problems were very serious. Schools reported few prevention actions to improve health. Headteachers requested that they are provided with specific guidance on adopting a whole-school approach, stating that had been discussed in many previous policy documents but they were unclear on what changes were needed. They requested specific guidance on what was within the remit of schools in terms of supporting their pupils, beyond setting and meeting targets, and said they wanted to build relationships with the NHS but were unsure how to do this. They also wanted to know how to 'harness their voices' and share the copious information they have on families and children, to act as a bridge between health and education and social care. Many stakeholders stated that better data sharing was needed between the NHS, social and education organisations to better understand the needs of children and young people.

Other stakeholders pointed to programmes such as Mental Health Support Teams, an England-wide Department for Education initiative to improve mental health in schools, Box 5.

## Box 5. Mental Health Support Teams

The Department for Education launched Mental Health Support Teams (MHSTs) in 2017 with the publication of the green paper for transforming children and young people's mental health. The proposals focus on expanding access to mental healthcare for children and young people through additional support in schools and colleges and reducing waiting times for treatment. The national strategy is to achieve provision in half of schools. MHSTs offer a whole-school approach and provide interventions in schools as well as support to staff and families.

MHSTs act as a link between schools and Children and Young People's Mental Health (CYPMH) and were established to provide three core functions: delivering evidence-based interventions for mild-to-moderate mental health issues, to introduce or develop a whole-school approach to mental health, and to give timely advice to staff and liaise with external specialist services to help children and young people to get the appropriate support and stay in education.

There are two MHST teams in Morecambe Bay, one in Barrow in Furness serving 11 secondary, special, alternate and further education settings and another team in Morecambe which serves 22 primary, secondary, special, alternate and further education settings. Each MHST team is expected to serve a population of 7,000 to 8,000 children and young people and education allocations are informed by data about local need and existing gaps in provision. Both the Morecambe Bay MHST teams are supported by a Service, Team and Clinical Lead, and each team is made up of two Senior Practitioners and four Education Mental Health Practitioners (EMHPs). To date the practitioners have provided therapeutic intervention for 1,567 children and young people. The service also has a remit to support children and young people who are not on role in education settings and appointments are facilitated either through online platforms or in appropriate community environments. In the first wave of delivery, four 'trailblazer' teams were established in Lancashire and Cumbria, serving 51 schools and colleges across Blackburn with Darwen and Morecambe Bay. In these areas MHSTs have been assigned based on prevalence data, school population and deprivation. In Morecambe Bay the MHST provides direct support for child mental health and works with education settings to understand the reasons for withdrawals from education, advocating the use of local assets to improve the experience of learning. Their service encourages children, young people and their families, and education settings, to both co-design and co-produce inclusive education, given that a growing evidence base links education with emotional and mental wellbeing.

Following review, the teams state that there needs to be an increase in capacity across the system to enable the prioritisation of prevention and early identification. The voices of children and their families also need to be better heard to understand the reasons why people are not accessing services, or are disengaging, so that services can be delivered in ways that meet the greatest need. Further, while part of MHSTs' remit is to be delivered in a way to reduce health inequalities, in many areas it is unclear how the MHSTs are doing this. An evaluation of the first wave of sites concluded that as the programme is rolled out across more areas, 'a strong focus on addressing such inequalities is imperative'. The national team amended criteria for selecting successful sites, and prioritising and addressing health inequalities is now included in the requirement when applicants submit an expression of interest (95).

Other submissions to the HEC requested a 'clearer understanding' of where the Mental Health Support Teams fit with these groups. Lancashire and Cumbria have a number of MHSTs, as described in Box 5, but it is unclear if there is enough capacity to be able to provide this support to all schools that request this service. It is also unclear how partners who work across children and young people's health and wellbeing are able to contribute to whole-school approaches or to school readiness interventions.

Improving aspiration in young people was also a common theme in submissions to the HEC:

- Blackburn with Darwen discussed the 'lack of aspiration, lack of role models in some families who have no experience of higher education and so these conversations are not taking place in households [...] "We" need to step in and provide that role for young people, so that they can explore all of their options, to include mentoring/coaching'. They also stated that more work is needed at the end of the educational journey, too, to get young people 'employment ready' e.g. through forging links with key employers.
- Fylde Coast stated that young people 'don't believe they have a chance of a good career on Fylde Coast and leave for nearby cities such as Manchester or Liverpool, or move south for better prospects. We need help to attract people to come and stay'.
- Barrow-in-Furness reported that it was 'standard' for local people to not expect 'to live beyond their late 50s'.
- North Cumbria's priorities included: developing career entry points and progression for people with lower formal educational attainment, encouraging recruitment from those areas with higher deprivation, and providing access to economic prosperity.
- Areas rarely referred to adult education, a vital health equity intervention, although North Cumbria stated it had 'limited adult education offerings available'.

A unique partnership is seeking to raise aspirations in primary school children in Fleetwood and across the North West, Box 6.

### Box 6. Improving aspiration – the Positive Footprints Network

The Regenda Group is a group of companies across the housing and construction sector, care and support, and education, training and careers sectors, which helps to improve outcomes for people. They are North West-based with offices across Lancashire, Merseyside and Greater Manchester.

One of their businesses is Burnley-based Positive Footprints, which works with primary schools and businesses to inspire aspiration in young people. The first ever Positive Footprints programme was launched in Fleetwood, and was recently recognised as a sustainable model of best practice at the National Career Development Institute Awards.

Positive Footprints develops personal development programmes to be delivered in schools with the aim of enabling children and young people to explore the world of work and raise their aspirations. From the age of seven 36 percent of children base their aspirations on people they know, so it is vital that young people have exposure to various career paths during their early years to provide them with a wide range of career options. Positive Footprints programmes are integrated into the classroom and delivered by teachers as a quick and easy way to make a positive impact on the lives of children and young people. The programmes are 'out of the box' – they are fully resourced, career-led learning programmes which allow teachers to start teaching the modules straight away, with no additional training.

Since Positive Footprints began in 2012, 438 schools, supported by Lancashire County Council, have delivered Positive Footprints learning programmes to over 34,000 children and young people. Businesses can get involved and attend career events as an easy way to make a difference to young people's lives. Businesses that become Aspiration Partners are free to choose which schools or areas they work with so they can work in the communities where they think they will provide the most benefit. This is significant as young people who have two or more employer contacts during through their school or colleges were significantly less likely to become a 'NEET' (Not in Education Employment or Training) than those who did not have contact with employers (96).

In the two years leading up to the COVID-19 lockdown Fleetwood Positive Footprints engaged with 86 businesses, and with 1,150 primary school children, creating £162,000 of social value. The programme resumed for the 2021/22 academic year. An Ofsted inspection of a Fleetwood primary school stated: "The guidance that the students receive is excellent. Students are made fully aware of career opportunities through the school." (97) (98)

As stated in the previous section, there have been deep cuts between 2010 and 2020 that have reduced the number and capacity of children and youth services. Between 2009/10 and 20019/20, funding for youth services in the UK fell by 66 percent, and between 2012 and 2016, more than 600 youth centres and nearly 139,000 youth service places closed (99) (100). Despite these cuts, areas are trying to provide activities and support to children and young people. Box 7 describes an intervention in Lancaster that is aiming to change young peoples' lives in areas of high deprivation.

### Box 7. Re-establishing youth clubs in Lancaster

The Lancaster District Youth Partnership is a collection of VCFSE sector organisations that provide support to children and young people, particularly in Lancaster's areas of highest deprivation. The partnership was created around 15 years ago in response to the challenges facing the children and young people's sector, which the COVID-19 pandemic further exacerbated. A partnership was developed so that organisations could work collaboratively, share resources and knowledge, provide peer support and bring together the public and voluntary sectors to effect positive changes for children, young people and the communities they live in. Young people are at the heart of what the partnership does – they co-produce with young people with the aim of empowering children and young people to help them overcome the issues they face.

The partnership successfully secured one-year's funding from the Westminster Foundation to provide youth clubs. The aim is to be life-changing, life-saving and help children and young people to rebuild and maintain friendships, provide opportunities for physical, emotional and creative recreation and support children and young people to continue learning and ensure the COVID-19 pandemic does not have lasting implications for well-being. Specific projects include SHOUT (See Hear Our Unheard Teenagers), an emotional wellbeing programme; Activate – a physical activity programme; and a social action programme, Inspiring Futures – a school and work life preparation and one-to-one mentoring programme (101).

## INEQUALITIES IN EDUCATIONAL ATTAINMENT

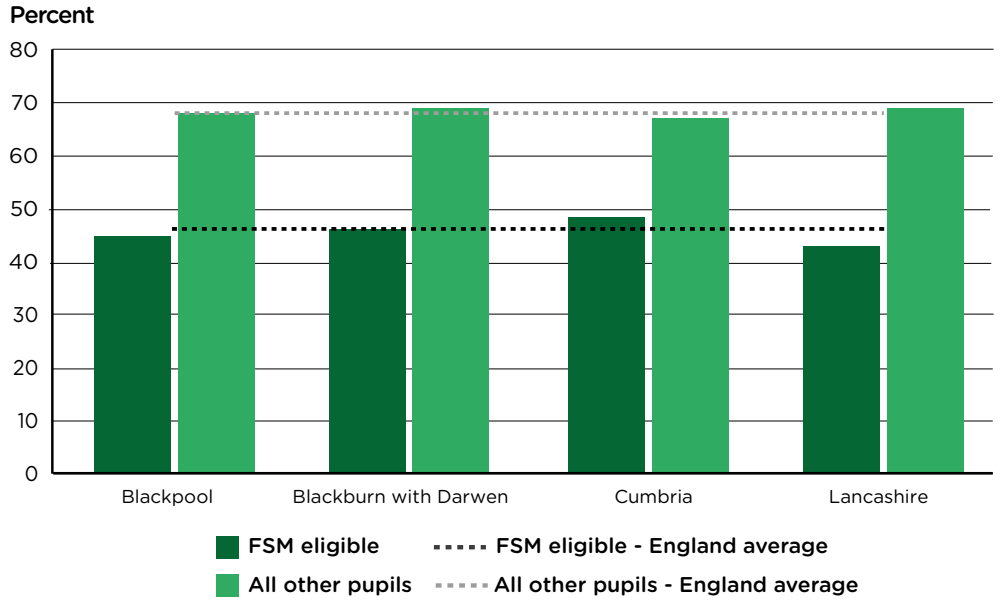
Children and young people who grow up in poverty are more likely to have poor educational outcomes and less access to training and decent jobs (102). The Education Policy Institute has shown pupils who live in persistent poverty, who have been eligible for free school meals for at least 80 percent of their time in school, 'have considerably worse outcomes than those who have moved in and out of free school meal eligibility' (103). Improving incomes has lasting impacts. A study of 4,600 randomly selected families in the USA over 20 years found significant positive lifelong impacts from reducing poverty. Children living with families given housing vouchers enabling them to move from high-poverty areas to lower-poverty neighbourhoods found the children who moved before adolescence were more likely to attend post-secondary education and went on to earn 30 percent more than those who did not move out of high-poverty areas (104).

As already described, education funding fell in England in the decade from 2010 for secondary and further education (105). These cuts will damage educational attainment, particularly for more disadvantaged students. Evidence shows that increasing funding to schools improves educational outcomes over the long run, particularly among the pupils living in the most deprived areas and from families on the lowest incomes, who are likely to have the poorest outcomes and who have fallen furthest behind during the pandemic (106).

Prior to the pandemic, research from the Education Policy Institute showed pupils living in more deprived areas or from families on low incomes had, on average, levels of attainment 18 months behind their more affluent peers and that the gap was not closing (2). The effect of the pandemic – less teaching in schools, lower educational achievement – has had a worse effect on young people living in more deprived areas or from families on low incomes, with potentially long-term effects on their educational progression and labour market performance (105) (2). Research from the Northern Health Science Alliance found the loss of learning in children in the North of England during the pandemic will cost an estimated £24.6 billion in lost wages over lifetime earnings (64).

The region performs roughly as well for children on free school meals at the end of year six, at Key Stage 2 level, an improvement compared with the early years period. Figure 3.9 shows Cumbria has slightly better outcomes for children eligible for FSM compared with other areas in the region and is above the England average at Key Stage 2.

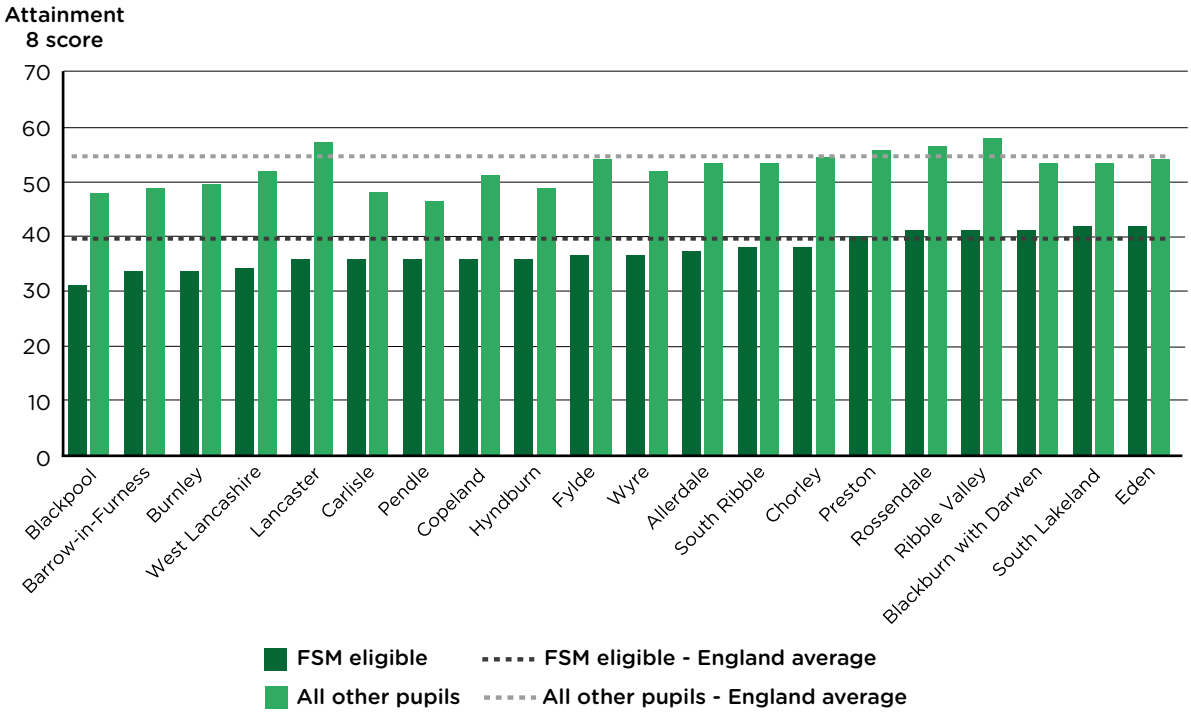
**Figure 3.9. Pupils reaching the expected standard at the end of Key Stage 2 in reading, writing and mathematics, by free school meals eligibility, Lancashire and Cumbria upper tier local authorities and England, 2018/19**




***Source**: Department for Education (107)*

Attainment 8 scores measure attainment at the end of Key Stage 4 (GCSEs), which pupils usually finish at age 16. Inequalities in average Attainment 8 scores are out of 90 and in 2019/20 students not eligible for FSM scored an average of 52.3 while students eligible for FSM scored an average of 38.6 (108). For children eligible for FSM, in most areas in Lancashire and Cumbria, average Attainment 8 scores in 2020/21 were below the England average, Figure 3.10. The progress made in reducing inequalities between the early years and primary school is not sustained in secondary education and inequalities widen still further during this period. Blackpool, which had lowered inequalities by the end of Year Six, had much higher inequalities by age 16, for example.

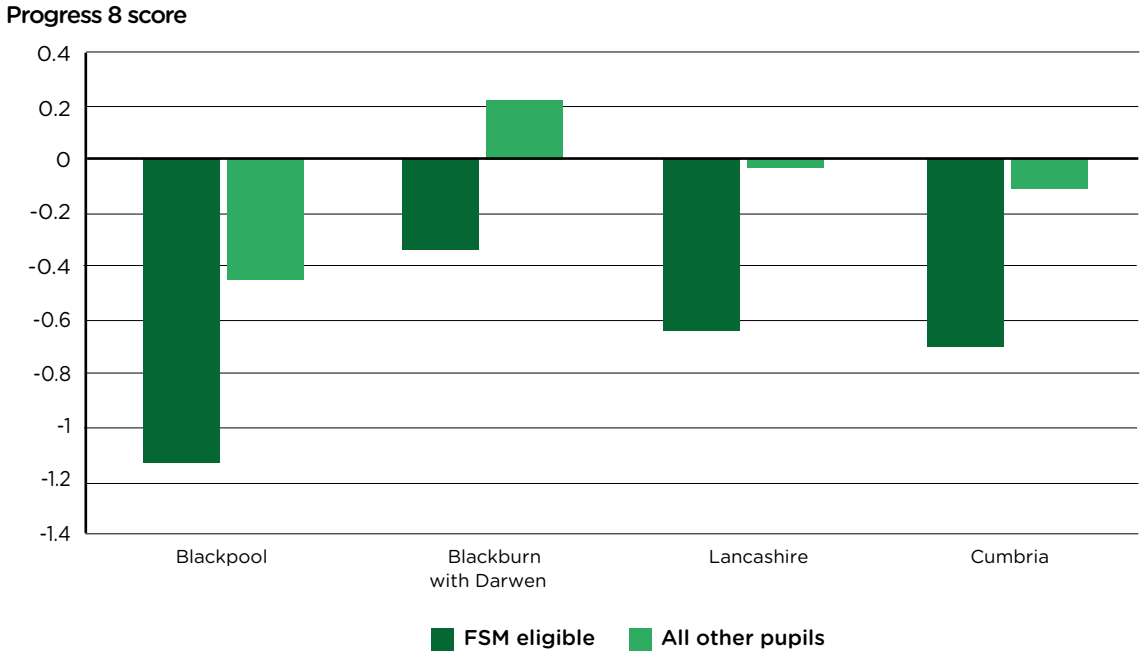
**Figure 3.10. Average Attainment 8 score per pupil (out of 90), by free school meal eligibility, Lancashire and Cumbria local authority districts and England, 2020/21**




***Source:** Department for Education (109)*

As a complement to Attainment 8 scores, Progress 8 scores measure the progress students make between ages 11 and 16, compared with other students with similar starting points. A score of 0 means the school is average, and any score above 0 means pupils are doing better at this stage than those with similar prior attainment and above the expected level of progress. A negative score means pupils have done worse than those with similar prior attainment nationally. In all areas in Lancashire and Cumbria, students eligible for FSM are performing below the average and for pupils not eligible for FSM, all but Blackburn with Darwen are also performing below the national average at Key Stage 4, Figure 3.11.

**Figure 3.11. Average Progress 8 score, by free school meal eligibility, Lancashire and Cumbria upper tier local authorities, 2018/19**




***Source:*** *Office for National Statistics (110)*

Across Lancashire and Cumbria, White and Mixed ethnicity students do worse than those of other ethnicities, Table 3.1.

**Table 3.1. Average Progress 8 score*, by ethnicity, in Lancashire and Cumbria upper tier local authorities, 2018/19**

| 2018/19 | Average | Asian | Black | Chinese | Mixed | White |
|---|---|---|---|---|---|---|
| **Blackpool** | -0.62 | 0.61 | 1.15 | 0.61 | -0.69 | -0.65 |
| **Blackburn with Darwen** | 0.13 | 0.56 | 0.34 | 0.48 | 0.09 | -0.31 |
| **Lancashire** | -0.11 | 0.29 | 0.08 | 0.71 | -0.06 | -0.16 |
| **Cumbria** | -0.16 | 0.58 | 0.55 | 0.43 | 0.03 | -0.15 |

***Notes:*** *If a student's Progress 8 score is equal to the national average (i.e. 0), their progress is in line with that of other students who started at a similar level.*
***Source:*** *Office for National Statistics (110)*

In parts of Lancashire and Cumbria there have been efforts to improve further education opportunities, Box 8 outlines the efforts of the West Lancashire School of Medicine to offer students an alternative pathway into a medical career.

### Box 8. An alternative way into medicine – West Lancashire School of Medicine

Until a few years ago, there was nowhere for students to study for A-levels in Skelmersdale, West Lancashire. Skelmersdale has the highest percentage of deprivation in West Lancashire and 14 percent of people in the area had no qualifications, compared with 8 percent in the North West (111). Students who wanted to study had to travel out of the town. With the annual bus fare costing around £600 a year, this was a substantial barrier for students from families living on low incomes.

In 2019 West Lancashire College, together with West Lancashire District Council, established the School of Medicine, funded by Lancashire Enterprise Partnership's Growth Deal Programme, offering the opportunity to pupils to study for A-levels. The School of Medicine is the first of its kind, offering 300 hours of work placement experience, aiming to act as a pipeline into health and care careers and help the NHS nurture the workforce of the future, grown from the community it serves. In 2021, every student enrolled on the School of Medicine programme who graduated secured a place at university.

This scheme is addressing health equity by nurturing local children and improving their education and employment prospects connected to health and health services, providing a local pipeline of skills for the health sector and involving local health services and health businesses (112).

## LIFELONG LEARNING

There is a substantial evidence base, reported on in the 2010 IHE and 2019 Review of Post-18 Education and Funding (Augar Review) which shows more years in education, and lifelong learning are associated with better physical and mental health and a range of other positive outcomes (6) (113). Despite this evidence and recommendations to better fund lifelong learning, budgets have been severely cut. Between 2010/11 and 2019/20, overall spending across adult education, apprenticeships and work-based learning fell by 35 percent in England (114). The 2021 Skills for jobs: lifelong learning for opportunity and growth white paper affirmed the importance of adult education and promised reforms to post-16 technical education and training and committed to investing in new higher-level qualifications and introducing a Lifetime Skills Guarantee. However, the small increases in funding included in the white paper did not nearly compensate for decade long decreases in adult education funding (115) (116). In 2022 the government stated the lifelong loan entitlement, which would give students access to loans worth up to the equivalent of four years of undergraduate study, would not be available 2025 – at the earliest (117).

The financial cuts to lifelong learning resulted in declining numbers of adult learners in England, down by 1.1 million between 2010/11 and 2018/19. The largest decline, around 800,000 people, was among those taking low-level qualifications (Skills for Life, English and maths, IT courses, food hygiene and other courses below Level 2) (114). Adults in lower socio-economic groups (DE) are twice as likely to not participate in learning after full-time education compared to those in higher socio-economic groups (AB). Numbers participating in adult education rose in 2020, due to better access during the pandemic, however, the inequality gap did not narrow (118). Across all social grades, learners from ethnic minority populations are more likely to engage in adult learning compared to the white population (118).

## APPRENTICES

There has been a welcome increase in government spending on apprentices over the last decade. However, in the last decade the apprenticeship programme in England has changed a great deal; and has shifted from offering younger people opportunities to being a way to get older higher-income people back into employment. In England, over-25-year-olds outnumber under-19-year-olds in apprenticeships by two to one (119). In addition, the IHE *Ten Years On* report outlines the decline in apprenticeships available to young people living in areas of high deprivation (1). The most recent report from the Social Mobility Commission states that apprentices were failing to "reach their social mobility potential" and that "the majority of apprentices are not from lower socio-economic backgrounds" (120). Between 2012/12 and 2018/19 in England, the number of apprentices working for large business (250+ employees) from the most deprived areas fell from 23 to 19 percent (119). Every local authority in Lancashire and Cumbria has seen a fall in the number of apprenticeships since 2011/12 and the COVID-19 pandemic led to a further decline (119).

## RECOMMENDATIONS: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

**a)** Reduce the gap in Attainment 8 progress scores between pupils eligible for free school meals and other pupils in every school and create the culture for every pupil to thrive with skills for life.

- Poverty proof all schools and define a whole-school approach for Lancashire and Cumbria.
- NHS and education review the circumstances in which data sharing is permitted.
- All schools to adopt a wellbeing survey among school children.
- Extend free school meal provision to all pupils living in households in receipt of Universal Credit and adequately resource holiday hunger initiatives for secondary school students.
- Jointly commission universal programmes to build resilience and support young people's mental health, and to support their families with additional resources in more deprived areas.

**b)** Anchor organisations and local economic partnerships to work closely with schools and colleges in areas with higher levels of deprivation to provide apprentices, job training and employment shadowing with a guaranteed employment, apprenticeship or training offer for 18-25 year olds.

**c)** Increase levels of funding for youth services, focusing on areas with higher levels of deprivation.

**Leads:** Education, NHS

### NATIONAL ADVOCACY

- Reverse the decline in per-pupil education expenditure.
- Advocate to significantly reduce inequalities in educational attainment by use of the Pupil Premium to increase teachers' pay and increase funding for schools in areas of high deprivation.

# 3C CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

**KEY MESSAGES**

- Unemployment and poor quality work harm health and increase mortality.
- Poor quality work and unemployment contribute to health inequalities and the quality of work has deteriorated over the last ten years.
- Poor health is affecting the economy of the region and lowering productivity and inward investment. In Lancashire, if productivity matched the English average, it is estimated £9.9 billion would be added to the national economy. Modelling for the Cumbria LEP estimates that increasing employment rates in the worst employability 'cold spots' could add 4,500 people to the workforce.
- Employers can do far more to improve the quality of work and improve health and reduce health inequalities. This is also beneficial to them as it improves recruitment, retention, reduces sick pay and increases productivity.

**UNEMPLOYMENT**

- Employment in Blackburn with Darwen and Blackpool is lower than the North West and England averages and in Barrow-in-Furness and Blackburn with Darwen less than 65 percent of people are in employment.
- Low levels of employment are closely related to poor health and deprivation.
- Lack of transport in rural and coastal areas is a significant barrier to employment.

**QUALITY OF WORK**

- In the region employment rates have increased since 2010 but many of these jobs are low skilled and self-employed jobs (often zero hours contracts).

**PAY**

- Across England wage growth has been low since 2010 and rates of in-work poverty have increased.
- Before the pandemic, wages in the North of England were lower than in the rest of England and they fell further during the pandemic.
- The percentage of women in the region earning below the national living wage is higher than the average in England. Men in Blackpool and Blackburn with Darwen are also less likely to earn the living wage than across England.

**Being unemployed, particularly in the long-term, has long-lasting negative effects on health and wellbeing, increases mortality and is a significant driver of inequalities in physical and mental health (1). While unemployment is particularly damaging for health, poor quality and stressful work also undermines health.**

We have outlined the protective health impacts of being in a good quality job and feeling valued in the 2010 Marmot Review, the 10 Years On report of 2020 and the report The Business of Health Equity (1) (6) (29).

While good quality work is beneficial to the health of employees, it is also beneficial to employers as it increases productivity and retention and reduces the amount of sick pay required. Good quality work and a healthier workforce can make significant contributions to better health and health equity and to the productivity and economic development of the region. In Lancashire, if productivity matched the English average, it is estimated £9.9 billion would be added to the national economy (121). Further analysis of how employers can contribute to reductions in health inequalities is set out in Section 4D.

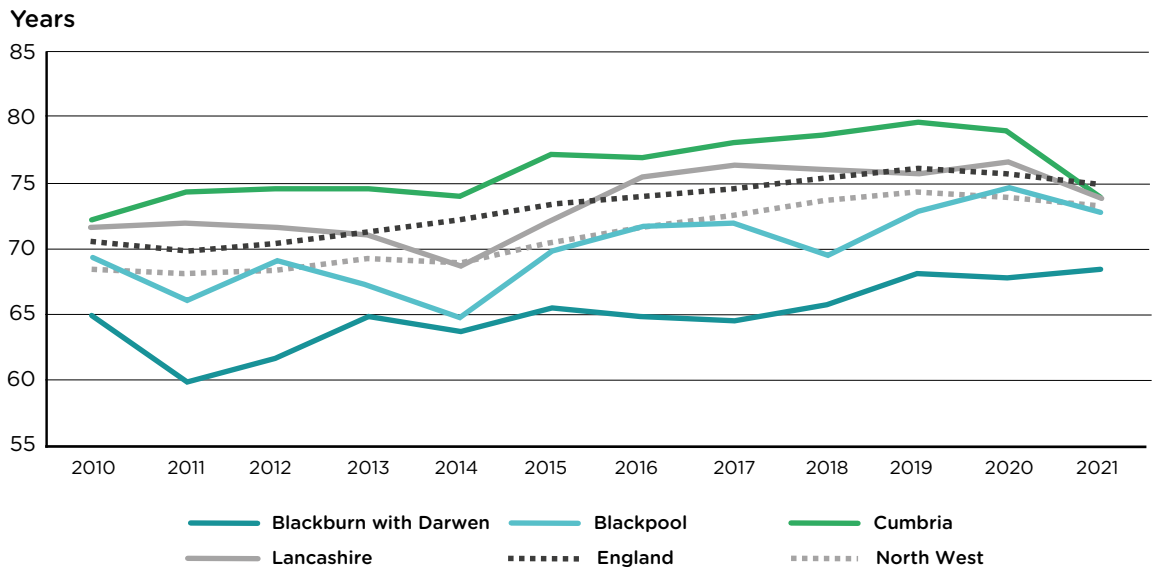
Good quality work is characterised by features including job security; adequate pay for a healthy life; strong working relationships and social support; promotion of health, safety and psychosocial wellbeing; support for employee voice and representation; inclusion of varied and interesting work; a fair workplace; promotion of learning development and skills use; a good effort–reward balance; support for autonomy, control and task discretion; and good work–life balance. Poor quality work is essentially work with the opposite to these features (1).

In 2021, 23 percent of the people in work in Lancashire and 24 percent in Cumbria were employed in the public sector, similar to the average of 23 percent in England. However, within the region, this varies from 37 percent of the workforce in Wyre to 24 percent in Preston and 13 percent in Eden (122). With close to one in four jobs in the region employed by the public sector, there is an opportunity to have a significant impact on the region if public sector employers became good anchors, paid the real living wage, and prioritised hiring and procuring locally and in areas with greater deprivation.

## UNEMPLOYMENT AND ECONOMIC INACTIVITY

There are varying rates of employment across the Region. In the last decade levels of employment in Blackburn with Darwen and Blackpool have consistently been lower than the North West and England averages. Figure 3.12 shows employment in Cumbria since 2010 has been higher than the England average while Lancashire has fluctuated below and above the average. The employment rate has yet to return to pre-pandemic levels in all areas. Blackburn with Darwen out-performed the England trajectory in 2020/21 however, overall, its employment rate remains below the England average.

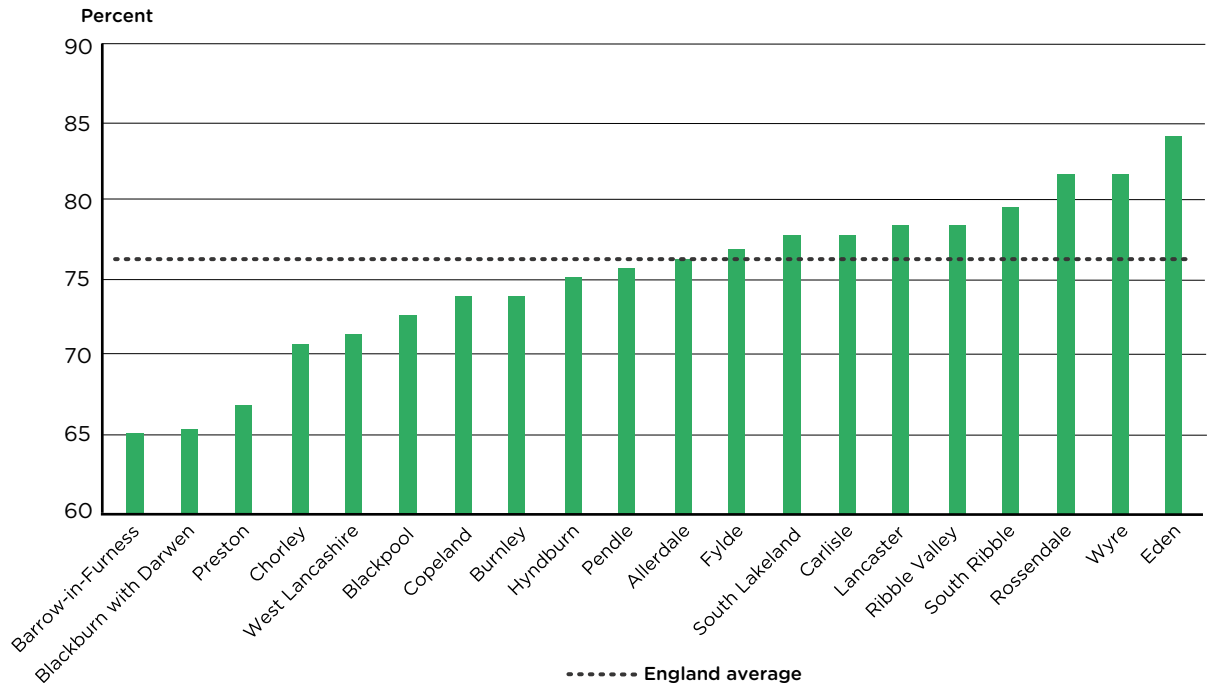
**Figure 3.12. Employment rate, percentage, Lancashire and Cumbria upper tier local authorities, North West and England, 2010–2021**




***Source:*** *Annual Population Survey – Labour Force Survey (123)*

Figure 3.13 shows the extent of the differences in employment rates between the region's local authority districts. In 2020/21 both Barrow-in-Furness and Blackburn were 11 percentage points below the England average and another seven districts in Lancashire and Cumbria were below the England average. Modelling for the Cumbria LEP estimates that increasing employment rates in the worst employability 'cold spots' could add 4,500 people to the workforce (124).

**Figure 3.13. People in employment, percentage, Lancashire and Cumbria local authority districts, 2020/21**

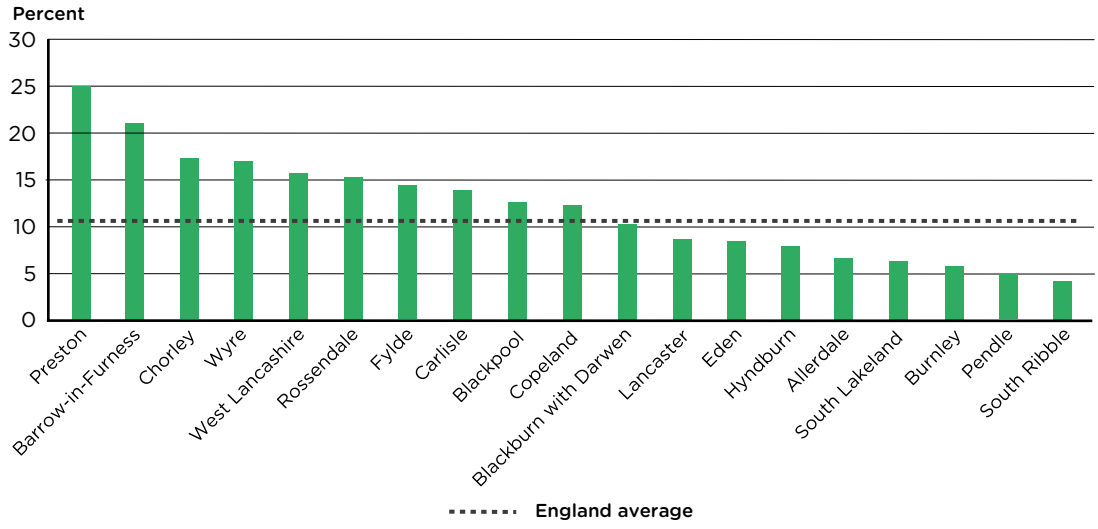



***Source:*** *Annual Population Survey – Labour Force Survey (125)*

Finding work in some areas is difficult due to poor and unaffordable transportation. In a submission to the HEC, a local resident from Maryport, Cumbria stated, 'There are job prospects, but you've got to travel to find them.' As a result, residents leave Maryport, either by commuting daily or they move away. Others reported that many people 'don't want to leave their homes, they don't want to leave their families' to move away for work. For those without a car, public transport will not necessarily get people to where they need to be at the right time. Furthermore, as much of the available employment in Maryport is low-paid and insecure, the result is that 'across Allerdale and Copeland [...] low income is the main crisis, not unemployment'.

Being in poor health is strongly linked with less likelihood of being in employment. In 2019 employment rates for people with long-term limiting health conditions were 17 percentage points lower than the national (UK) average (126). Many people with long-term health conditions want to work but they require more support to return to work and many employers do not provide this support or training (28). Being out of work can contribute to further deterioration in health among people with a long-term health condition or disability (127). Compared to the England average, half of the areas in Lancashire and Cumbria have a larger 'gap' in the employment rate between those with a long-term health condition and those without, many being located in areas with higher levels of deprivation (Figure 3.14).

**Figure 3.14. Gap* in the employment rate between those with a long-term health condition and the overall employment rate, percentage, Lancashire and Cumbria local authority districts*, 2019/20**




***Notes:*** *Gap in the employment rate between those with a long-term health condition and the overall employment rate is the percentage point gap between the percentage of respondents in the Labour Force Survey who declared a long-term condition who are classified as employed (aged 16-64) and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16-64). Ribble Valley results not included for methodology reasons.*

***Source:*** *Office for National Statistics. Annual Population Survey (128)*

Box 9 describes two projects working in partnership to improve employment prospects for people who are long-term unemployed.

## Box 9. Projects increasing employment opportunities in Lancashire

**More Positive Together** (MPT) launched in 2017. It addresses the needs of Lancashire residents furthest from the labour market and helps them to improve their employment prospects. MPT brings together Social Housing Organisations (SHOs) from across Lancashire, alongside several key delivery partners. MPT seeks to improve the skills and employability prospects of residents living in the most deprived neighbourhoods, many of whom have multiple and complex barriers to their progression, including mental and physical health problems, issues related to substance misuse, learning difficulties, caring responsibilities, poverty and debt.

The project provides a pathway to enable economically inactive residents to progress to self-sufficiency, providing intensive one-to-one mentoring followed by a range of support and opportunities to get involved in work experience, apprenticeships, volunteering and training.

There is a close correlation between the location of social housing stock in Lancashire and areas of highest deprivation, making SHOs well-placed to engage with the project's target population, many of whom are existing tenants. MPT is primarily targeted to the tenants of the SHO partners but its services are available to all residents in the targeted communities in Lancashire.

Despite the challenges posed by the COVID-19 pandemic the programme has shown continued success. Eight weeks after joining MPT, 60 percent of 757 participants stated their mental wellbeing was 'good', rising from 38 percent prior to joining MPT. 58 percent said their finances were 'good', rising from 38 percent. 52 percent felt good about their skills and qualifications, up from 34 percent. MPT has received European Social Fund funding that will expire in December 2024 (129).

**Changing Futures** is a project delivered in a partnership of 30 VCFSE sector organisations by Community Solutions in Pennine Lancashire. Changing Futures helps people facing multiple and complex barriers (such as people with physical or learning disabilities, women, including those with child care problems or victims of domestic abuse, ethnicity minority populations, people with mental health issues, learning disabilities, people with a criminal record) back into employment.

Each participant is support by a transformational coach who helps participants identify their abilities, skills and interests. Changing Futures has supported 1,500 people with multiple and complex barriers and as a direct result of the support, 300 people are employed, self-employed or in training.

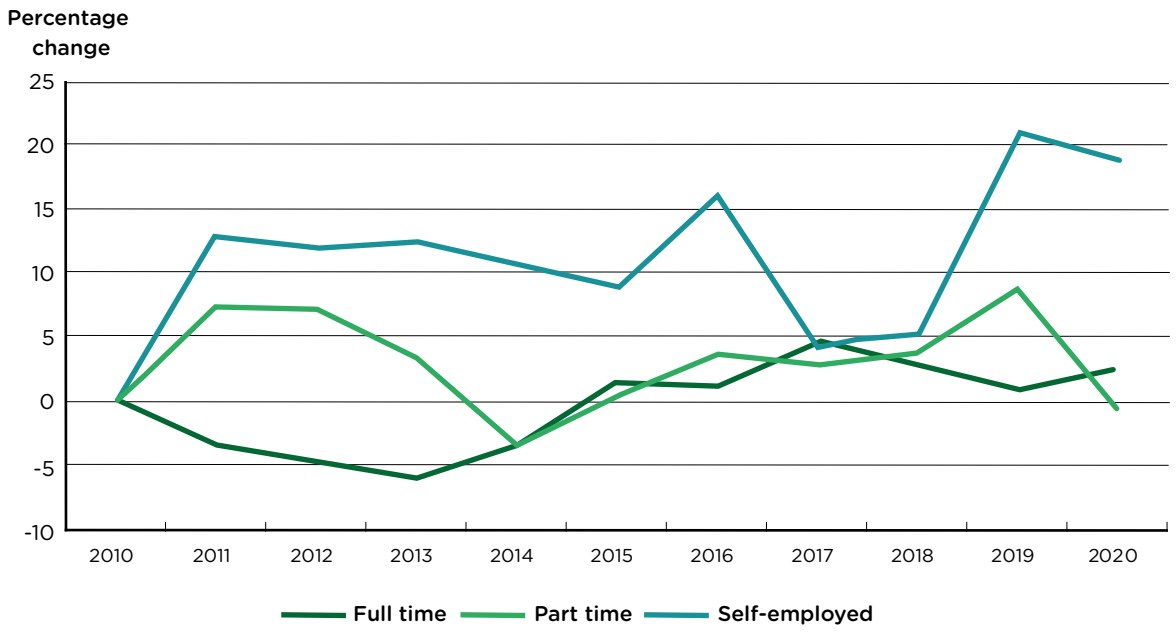
Currently funded by the National Lottery Community Fund and European Social Fund, Changing Futures is expected to end in 2022.

## QUALITY OF WORK

Since 2010 there have been profound shifts in many aspects of the labour market and employment practices in England. Increases in employment have often been in low-paid, unskilled, self-employed, short-term or zero hours contract jobs. Rates of pay have not increased and, notably, more people in poverty are in work than out of work (1).

Zero hours contracts are generally harmful to health. The lack of security and benefits associated with full-time employment, undermine mental and physical health. Since 2000, the number of people on zero hour contracts has increased, reaching a high of 3.3 percent of the UK workforce in the first three months of the pandemic (130). The rate of full-time and part-time employment in Lancashire and Cumbria did not alter much between 2010 and 2020. However, as shown in Figure 3.15, self-employment increased by 19 percent over the period (this does not include zero-hour contracts).

**Figure 3.15. Change in employment type (indexed to 2010 level), percentage change, Lancashire and Cumbria local authority districts, 2010–2020**




***Source:*** *Office for National Statistics Annual Population Survey (131)*

Lancashire and Cumbria's populations are ageing. Residents also have fewer degree-level qualifications, and more people have low or no qualifications compared with the England average (121) (132). Both of Lancashire and Cumbria's local enterprise partnerships state that improving skills is a priority – to improve productivity and reduce levels of ill health – and both are targeting unemployment in younger and older age groups and worklessness.

## PAY

Despite the introduction of the minimum wage and living wage, wage growth in England since 2010 has been low and rates of in-work poverty have increased. Work is viewed as a way out of poverty, but in the UK three-fifths of working-age adults who live in poverty are either in work or live with someone who is in work (133). Before the pandemic, wages in the North of England were lower than in the rest of England and they fell further during the pandemic, from an average of £543.90 to £541.30 per week. In England as a whole, average wages increased from £600.80 to £604.00 per week (43).

In 2020 7.4 percent of jobs in England were paid below the minimum wage, an increase from 1.4 percent in 2019. By 2021, the rate had fallen but still not returned to 2019 figures and 3.8 percent of all jobs in England were paid below the minimum wage (134).

IPPR suggests the reasons for the increase in in-work poverty are: increasing housing costs in low-income households; low wages and modest pay rises; benefits levels not keeping up with increasing rental costs; and a lack of flexible and affordable childcare (135). Between 2001 and 2021 households with one full-time and one part-time adult worker were increasingly being pulled into poverty, the chances of which doubled from one in 20 to one in 10 (135).

In April 2022 the minimum wage in the UK is:

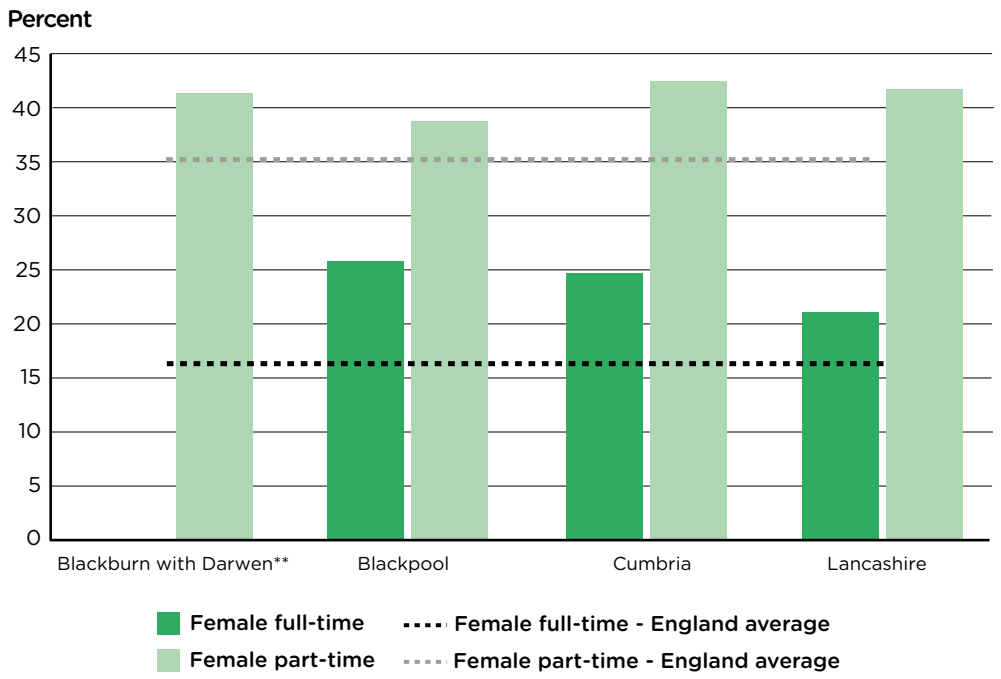
- £9.50: Age 23 and over
- £9.18: Age 21-22
- £6.83: Age 18-20
- £4.81: Under 18 and apprentices

The real living wage was created to better estimate the wage rate needed "to ensure that households earn enough to reach a minimum acceptable living standard as defined by the public". Calculated based on a basket of goods and services (including housing and childcare costs, council tax and travel) the real living wage in 2021/22 was £9.90 (for areas outside of London).

Figures 3.16A and B show the percentage of employees in Lancashire and Cumbria earning below the hourly national living wage in 2020, when it was £9.30 (the UK minimum wage was £8.21). Women in Lancashire and Cumbria working full- or part-time were more likely to be earning below the living wage compared with England averages. For men, male part- and full-time workers in Cumbria and men working part-time in Lancashire were as likely to receive the living wage as the England average. Men working full- and part-time in Blackpool and full-time in Blackburn were less likely to earn the living wage. There is clearly room for improvement, for employers to reach the England average, particularly for women and particularly for women in part-time work.

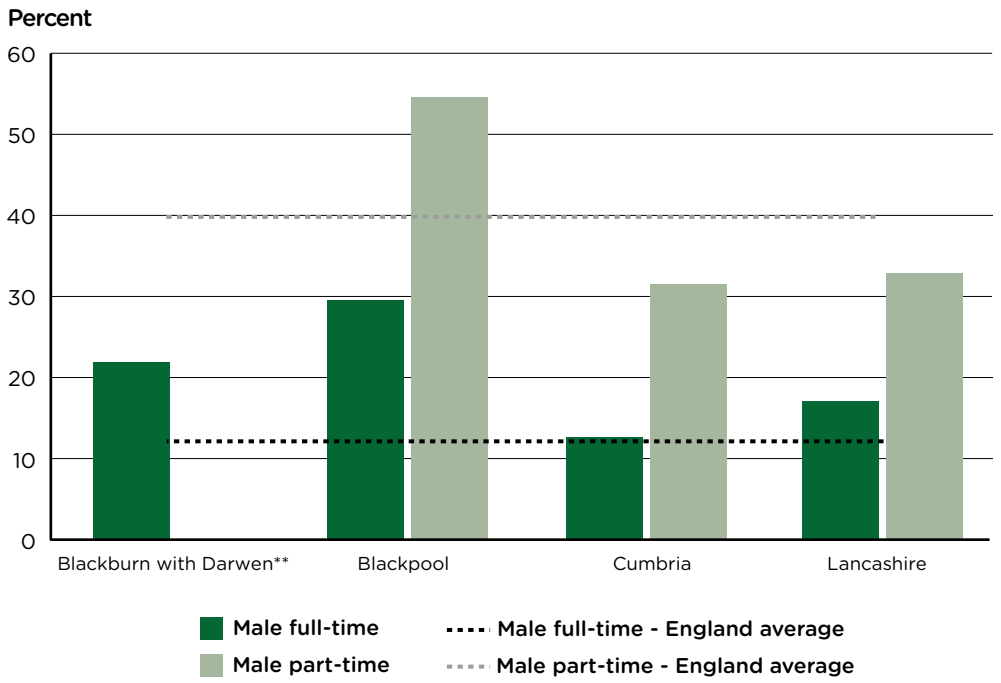
Figure 3.16A and B. Part- and full-time employees earning below the living wage*, by local authority, female and male, percentage, Lancashire and Cumbria upper tier local authorities, 2020

**A. FEMALE**




***Notes:*** **£9.30 in 2020; **Data not available.*
***Source:*** *Office for National Statistics (136)*

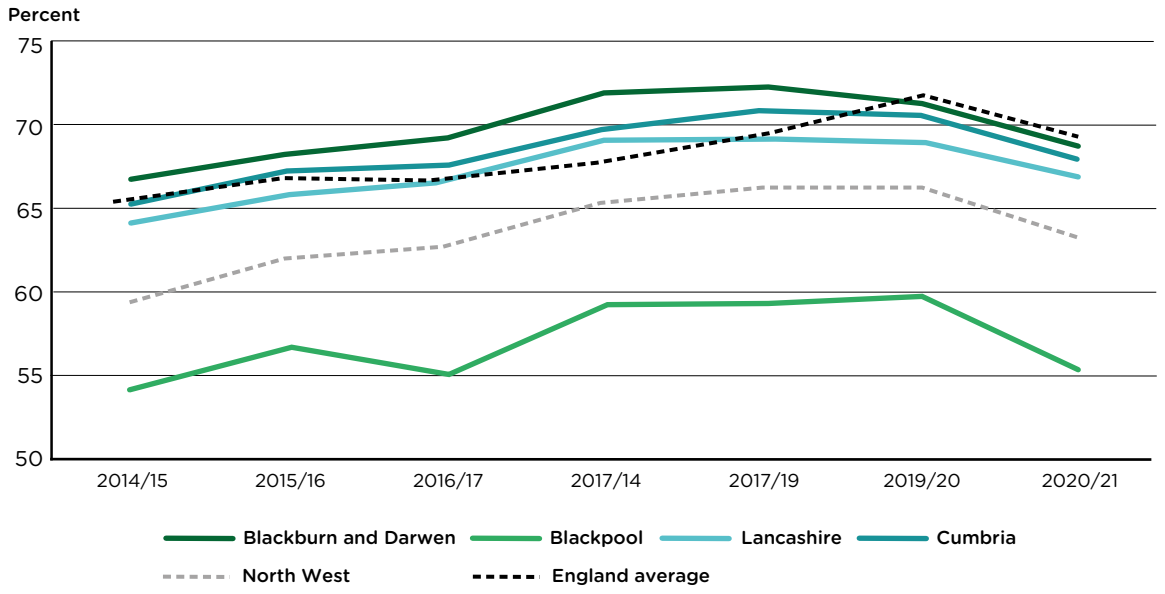
**B. MALE**




***Notes:*** **£9.30 in 2020; **Data not available.*
***Source:*** *Office for National Statistics (136)*

These low wages impact poverty levels. Figure 3.17 shows the majority of children in Lancashire and Cumbria who live in relative poverty live in families with at least one working parent/adult.

Figure 3.17. Children living in relative poverty, before housing costs, who are in households where at least one adult works, percentage, Lancashire and Cumbria upper tier local authorities, North West, and England, 2014/15-2020/21




***Source:*** *Department for Work and Pensions (137)*

In 2021 the minimum income standard calculated that an individual needed to earn £20,400 a year to reach a minimum acceptable standard of living; meanwhile, the national living wage paid around £17,400 for a single person working full-time (138). Adopting the minimum income standard in Lancashire and Cumbria will help to improve standards of living and quality of employment, driving increases in better health and wellbeing and reducing inequalities.

A number of HEC submissions called on the NHS to be better employers, including fairer rates of pay, and to lead by example. Box 10 outlines the actions being taken by the Morecambe Bay Anchor Collaborative.

## Box 10. Anchor institutions in Morecambe Bay

Anchor institutions are large organisations that have a substantial stake within a geographical area. These organisations can have a sizeable impact on the communities in which they are located, being a powerful voice in how and where resources are spent, which can influence the health and wellbeing of individuals within that community.

The Morecambe Bay Anchor Collaborative aims to help member organisations to evaluate and improve their anchor status and demonstrate the domains in which anchor institutions can best direct their efforts to improve the health and wellbeing of their community. The Collaborative is an approach being developed by the population health team of Bay Health and Care Partners, overseen by the Lancaster and South Cumbria Joint Committee. The Collaborative aims to support organisations across Morecambe Bay to become anchor institutions, or improve their efficacy as anchor institutions, to improve the lives of local people by widening access to quality work, purchasing and commissioning for social benefit, using buildings and spaces to support communities, reducing environmental impact, working closely with local partners, and reducing inequalities.

Part of the work of the Morecambe Bay Anchor Collaborative approach has been to produce a scoring system to be used by individual organisations to assess their anchor status. This self-assessment gives a status level – bronze, silver, gold or platinum – which can be used to assess an organisation's baseline anchor practices and will be repeated in order to measure progress. Furthermore, this has encouraged organisations to highlight what works well for them to encourage a shared learning approach. While organisations will work towards their own priorities as advised by the Collaborative, opportunities will also be provided for organisations to work in partnership towards agreed objectives.

## RECOMMENDATIONS. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

**a)** Local economic partnerships, NHS, local authorities and all public services to develop a regional good work charter and apply these obligations on public sector contracts. The charter should include:

- Wages to meet the minimum income standard for healthy living.
- Provision of in-work benefits including sick pay, holiday and maternity/paternity pay.
- Provision of advice and support at work, e.g. on debt, financial management and housing.
- Provision of education and training on the job for all ages.
- Strengthened equitable recruitment practices, including provision of apprenticeships and in-work training, and recruitment from local communities and those underrepresented in the workforce.
- No gender pay gap

**b)** Increase funding for adult education in areas of higher deprivation. Offer training and support to older unemployed adults, ensuring that the private sector participates

**c)** ICSs, LEPs and chambers of commerce to encourage and incentivise employers to recruit lone parents, carers and people with mental and physical health disabilities and long-term conditions.

**Leads:** Local economic partnerships and businesses, local authorities and NHS

### NATIONAL ADVOCACY

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life
- Engage in a national discussion on the balance of the work-life balance including consideration of a four day week.
- Increase pay for apprentices.

# 3D ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

**KEY MESSAGES**

- Poverty harms health affecting likelihood of living in healthy homes and environments and being able to access services, goods and quality employment – which are essential to good health.
- Poverty leads to stress and mental health problems and affects people's capacity to make healthy, long-term choices.
- The cost of living is rapidly increasing, pushing many more people into poverty and ill health.
- In-work poverty has been increasing and is set to increase further.
- Over the last twelve years, tax and benefit reforms have widened income and wealth inequalities.
- There are limits to the powers Lancashire and Cumbria have to increase household incomes but they can take actions to encourage employers to adopt the real living wage, advocate for changes to the benefit system as well as help reduce food and fuel poverty and support access to financial services and reputable lenders.
- Involving communities in developing actions to reduce poverty and impacts on health is vital.

**CHILD POVERTY**

- Child poverty is associated with poor mental, social, physical and behavioural development in children, as well as worse educational outcomes, employment prospects and earning power into adulthood.
- Child poverty has been increasing across England and across most of the 20 local authority districts in Lancashire and Cumbria.
- There are areas with high levels of child poverty in wealthy local authorities, which often 'go under the radar'.

**FUEL POVERTY**

- Fuel poverty rates are high in many rural and areas of high deprivation in the region.
- Cold, damp homes damage health and increase mortality. Excess winter deaths (partly related to living in a cold home) are high in many rural and deprived areas in the region.
- Fuel poverty will increase significantly, damaging the health of many more people, as fuel costs increase.
- Insulating homes is an effective way to reduce poverty, reduce the numbers of cold, damp homes and reduce greenhouse gas emissions.

**Living in poverty not only affects incomes, it also impacts physical and mental health. Living in poverty is stressful, it reduces the 'mental bandwidth' available to deal with problems and live a healthy life (1). Being able to live in society, to 'take your place in public without shame...is about having agency, a sense of self-worth, and participating in networks of family and friends. Lack of income threatens these fundamental components of living in society, and damages mental and physical health." (139)**

Poverty has a cumulative negative effect on health throughout a lifetime and insufficient income is associated with poor long-term physical and mental health and increased mortality at all ages, along with lower than average life expectancy. Poverty affects the social determinants of health: reducing the quality of housing and the ability to heat one's home, the ability to have a healthy diet, and access to employment. Poverty also harms educational attainment and increases levels of debt, which are harmful to health.

Assessments of poverty, exclusion and the social determinants of health often focus on major urban areas, and the proposals for action made are often most suitable to urban contexts. In Lancashire and Cumbria there are particularly poor health and social determinants outcomes in some coastal and rural areas with high rates of poverty, poor quality housing, poor access to education, employment, community facilities, entertainment, health and social care services and retail. Rural communities have higher rates of older people, so access to health and care services is particularly important. These factors all contribute to poor health, high rates of social isolation, mental health issues and poor outcomes in a range of social determinants.

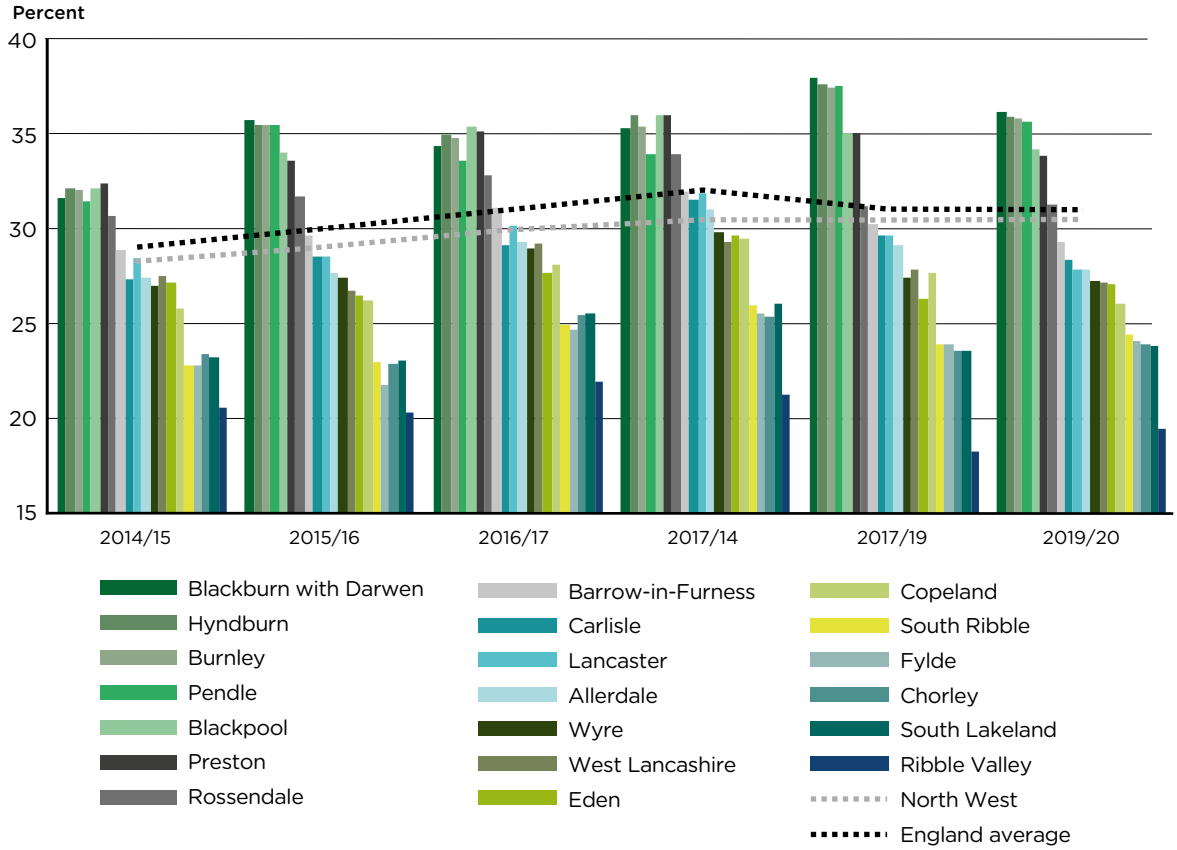
## CHILDREN LIVING IN POVERTY

Child poverty is associated with poorer mental, social and behavioural development in children, as well as worse educational outcomes, employment prospects and earning power into adulthood. Analysis of 10,652 children from the UK Millennium Cohort Study found children living in persistent poverty have a three times higher risk of mental ill health, a 1.5 times greater risk of obesity, and nearly double the risk of longstanding illness compared with children who have never been poor (140). It difficult and sometimes impossible for children and young people who grow up in poverty to participate in sports or other activities due to costs and this can lead to being teased and bullied (141). Children who do not participate in free-time activities due to poverty have fewer opportunities to create social relations with other children and interact with a range of adults (141).

The percentage of individuals in the UK living in relative low poverty in 2019 to 2020 was 18 percent before housing costs and 22 percent after housing costs. In the same period the percentage of children living in relative poverty before housing costs increased from 20 to 23 percent (142). As a result of the furlough scheme and the £20 uplift in Universal Credit, child poverty decreased between 2019/20 and 2020/21, however this decline is short-lived. The Resolution Foundation estimates there will be steep increases in the absolute rate of child poverty of five percentage points between 2020–21 and 2022–23 due to the increased cost of living (143). In its submission to the HEC, the Cumbria Health and Wellbeing Board reported that 2,483 new free school meal applications were accepted between March 2020 and 28 February 2021, an increase of 37 percent (an additional 667 pupils) on the previous year.

Figure 3.18 shows that the highest level of child poverty after housing costs in Lancashire and Cumbria between 2014/15 and 2019/20 was in 2018, when 38 percent of children in Blackburn with Darwen and Hyndburn were living in poverty. Figure 3.18 also shows the increase in rates of child poverty across England during this period. In the Lancashire and Cumbria region, eight districts had levels of child poverty higher than the England average. Even in areas with lower rates of child poverty, e.g. Ribble Valley, more than one in five children were living in relative poverty after housing costs before 2018/19.

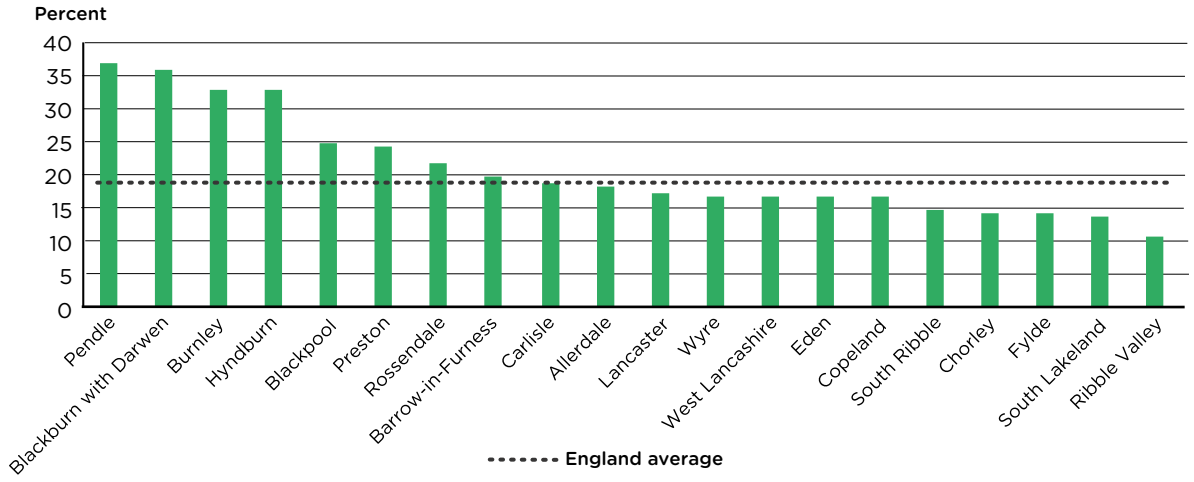
**Figure 3.18. Children living in poverty after housing costs, percentage, Lancashire and Cumbria local authority districts, North West, and England, 2014/15–2019/20**




***Source:*** *Department for Work and Pensions / HM Revenue and Customs (144)*

Relative rates of poverty are higher than absolute rates of poverty. Relative poverty is defined as households with less than 60 percent of contemporary median income and absolute poverty is defined as households with less than 60 percent of the 2011 median income adjusted for inflation. Figure 3.19 shows that in 2019/20 in Pendle and Blackburn with Darwen 37 percent of children were from families living in relative poverty and in half of the districts, relative child poverty is the same as or higher than the England average.

**Figure 3.19. Children (aged under 16) from families living in relative low-income and material deprivation*, percentage, Lancashire and Cumbria local authority districts and England, 2019/20**




***Notes:*** *A family is in low income and material deprivation if they have a material deprivation score of 25 or more and a household income below 70 percent of contemporary median income, before housing costs. This measure is in contrast to the usual relative poverty measure, which, as we state above, is when households' income is below 60 percent of the median.*

***Source:*** *Department for Work and Pensions / HM Revenue and Customs (144)*

These district-level rates can mask smaller areas of deprivation. For example, in the most deprived neighbourhood in Allerdale, 39 percent of people are estimated to be income-deprived and in the least deprived neighbourhood, 2 percent are estimated to be income-deprived (21).

North Cumbria has been working on 'poverty proofing' its local schools to reduce the stigma associated with poverty and provide more support for pupils who are growing up in poverty, Box 11.

## Box 11. Poverty proofing in schools in North Cumbria

***This has been one of the most impactful programmes we have ever been involved with. It is not a package: it is a process leading to a shift in ethos.*** (Headteacher in Cumbria)

'Poverty proofing' provides schools with a toolkit to reduce stigma and remove barriers to learning. It was developed by Children North East (CNE) in 2011 and continues to be delivered to schools in Cumbria and across the country. The poverty proofing process consists of an 'audit', a whole-school evaluation, written report, action plan and training for staff and governors. The process aims to uncover the institutional and cultural practices within a school that stigmatise pupils who are living in poverty. In 2016 Newcastle University evaluated poverty proofing and found the project to be successful in increasing attendance, free school meal (FSM) take-up, and attainment, with one school reporting a 5 percent rise in attendance and a 7 percent rise in FSM uptake.

The poverty proofing audit involves CNE practitioners visiting a school and living the school day through the eyes of a child living in poverty. This includes attending before- and after-school clubs, being in the playground during break and eating lunch with the children. The central component is that during lesson times CNE staff talk with all pupils in the school. This gives a rich insight into the experience of the school day and identifies key barriers that limit the ability of children who are growing up in poverty. Practitioners also engage with parents through questionnaires and face-to-face discussions in the playground before and after school. They talk to key staff and all staff and governors have the opportunity to complete a survey to share their views.

Once the audit is complete CNE provides detailed information to the school on the experiences that children who are living in poverty are having. CNE practitioners then work with the school to identify ways to overcome these challenges. The feedback and report process is about the school and CNE working together to identify how they can overcome some of the hurdles that pupils have identified. The report is given to the school at the end of the process and CNE works with schools to identify the best way to implement the recommendations. The result is an action plan tailored to each individual school to address any stigmatising policies or practices.

Recommendations have included reorganising the administration of free school meals, implementing free breakfast clubs using pupil premium funds to subsidise places, and distributing free uniform and PE kits. Due to increasing prices of uniforms and school trips several schools are also considering an annual statement to parents who can then budget in advance and are also examining the educational rationale behind some of their trips.

The project has highlighted the challenges facing children who are economically disadvantaged, including unintentional stigma and discrimination. Poverty proofing uses this learning to make targeted recommendations and promote staff understanding, empathy and person-centred practice based on the social, health, psychological and behavioural impacts of poverty.

Staff in schools have reported a growing understanding of the barriers faced by children who are growing up in poverty, and in 2022 CNE is hoping to expand the poverty proofing approach to healthcare and cultural organisations in Cumbria (145) (146).

## FUEL POVERTY

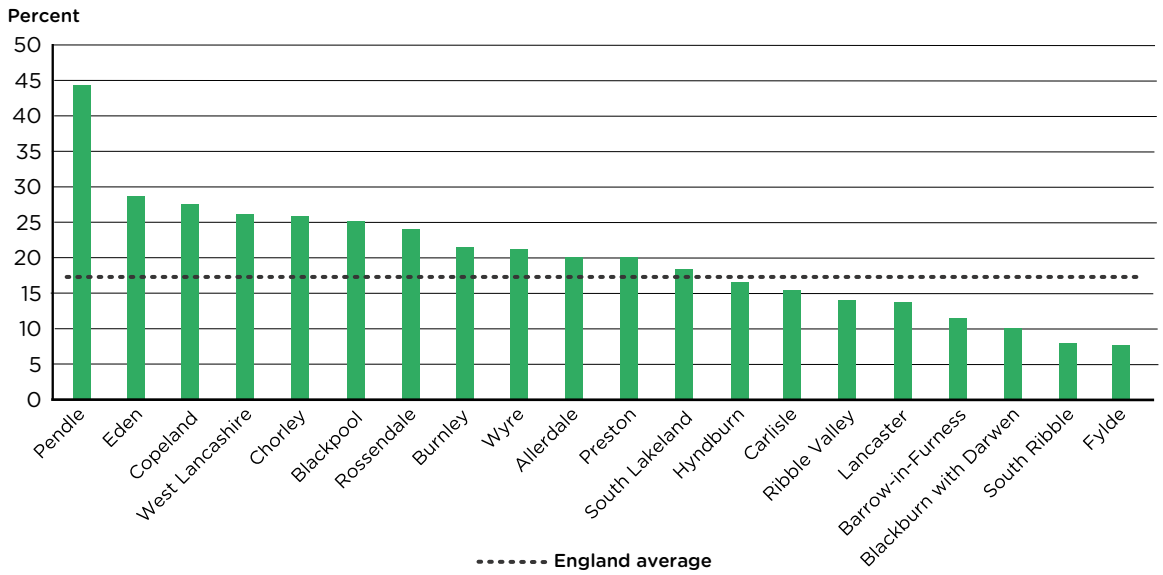
Fuel poverty and cold homes have a significant impact on people's lives and health. A household is defined as being in fuel poverty if they are living in a property with an energy efficiency rating in Band D (which is the average rating for England) or below and they are left with a residual income below the official poverty line after they spend the amount required to heat their home (147). Cold homes cause mental health issues and illness including; increases in circulatory and respiratory disease, colds and flu, chronic conditions such as rheumatism and arthritis, and negative mental health across all age groups.

In England cold homes are estimated to cost the NHS alone £857 million a year (148). This is only a small portion of the overall societal cost when considering care costs, loss of economic potential, and the cost of mental health suffering and trauma caused by living in a cold home. The wider costs to society are estimated to be around £15 billion per year (148).

Cold housing affects physical and mental health, directly and indirectly. As well as contributing to preventable deaths and physical ill health, cold homes also impact on the mental health of both young people and adults. More than one in four adolescents living in cold housing are at risk of multiple mental health problems compared with a rate of one in 20 for adolescents who have always lived in warm housing (1). Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes and there are also impacts on educational attainment (149). The least energy efficient homes are disproportionately in the North of England, as such, households in Lancashire and Cumbria are more vulnerable to rising gas prices and higher energy bills, increasing regional inequalities (150).

In older people a 1°C lowering of living room temperature is associated with a rise in blood pressure and lowered core body temperature (151). Older people are also more likely to be fuel-poor due to spending more time in their homes, and therefore requiring their houses to be heated for longer periods (152). This double vulnerability means that most excess winter deaths (EWDs) are among older people and are caused by respiratory problems, strokes and heart attacks due to cold temperatures (153). IHE's analysis estimates that 21.5 percent of EWDs are due to living in a cold home (154). This is not an inevitability: people in the UK are 23 percent more likely to die as a result of winter conditions than people in Sweden, where winters are colder (155). In the winter of 2018/19 there were 23,670 EWDs in England and Wales (156). The Excess Winter Mortality Index (EWMI) is the percentage of additional deaths in December to March compared with the average deaths in the preceding August to November and the following April to July. England's EWMI was 17.4 in 2019/20, which is high by international standards. As shown in Figure 3.20, Pendle had the third highest EWMI in England in 2019/20. There is a relatively weak association with deprivation for EWDs as these relate to the age of the house and the age of occupants as well as income. EWDs in isolated rural communities are high.

**Figure 3.20. Excess Winter Mortality Index, percentage, Lancashire and Cumbria local authority districts and England, August 2019 to July 2020**




***Source:*** *Office for National Statistics: Annual Births and Mortality Extracts (157)*

With proper insulation, heating and measures to tackle fuel poverty, many of the UK's yearly excess winter deaths could be prevented. The total cost of mitigating excess cold in homes in England is estimated to be £5.9 billion, which would take seven years to pay back in terms of direct savings to the NHS or under five months in terms of wider savings to society (148).

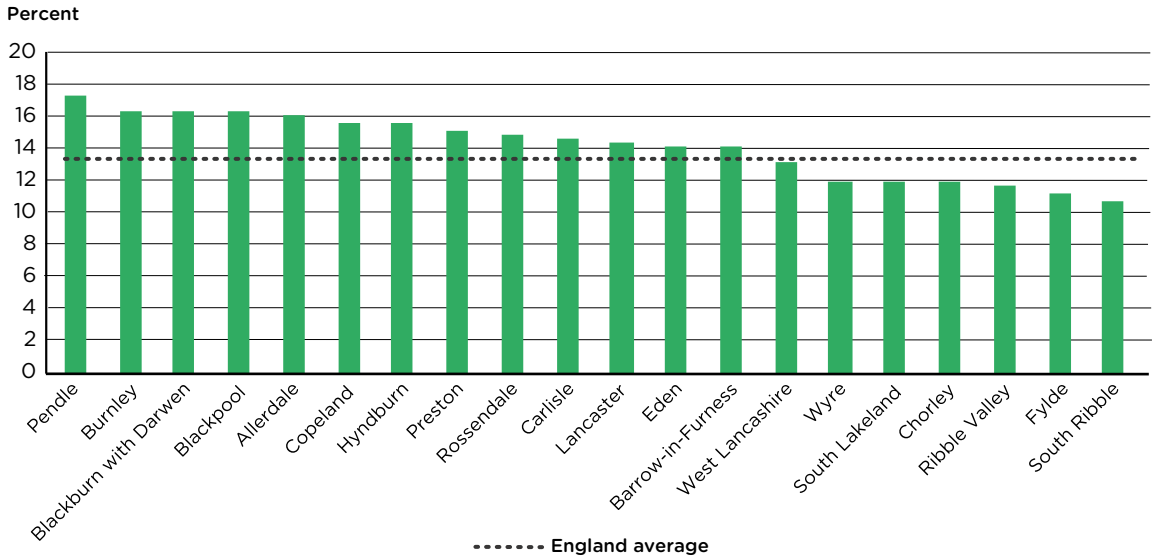
The prevalence of poor housing combined with the ongoing rises in energy prices have exacerbated the UKs fuel poverty problem (153). Households living in poverty disproportionately live in homes with worse energy efficiency (158).

Of the 15.3 million households living in homes rated EPC D or worse in England:

- 22 percent are in fuel poverty
- 60 percent have a below average income
- Are likely to need support with the upfront costs of energy efficiency (150)

The increasing costs of energy and rising poverty rates will lead to much higher rates of fuel poverty in England, including in Lancashire and Cumbria. There are new data tools available that enable local governments to better target their interventions to reduce fuel poverty, yet they report having 'massive levels of fuel poverty but few tools and very little funding [with which] to address [the problem]'. In 2019, 13 of Lancashire's and Cumbria's 20 districts had fuel poverty above the England average (Figure 3.21).

**Figure 3.21. Fuel poverty, percentage, Lancashire and Cumbria local authority districts and England, 2019**




***Source:*** *Department for Business, Energy & Industrial Strategy (159)*

The price of energy will increase substantially from spring 2022 due to the increase in April of the energy price cap and global increases in energy costs and this will lead to higher poverty rates and more health harm from cold homes. On average, prices for 22 million customers will increase by more than £500 per year, and prepayment customers, many of whom are on the lowest incomes, will have average increases of £700 (160). In January 2022 an Office for National Statistics survey found that of those who reported a rise in cost of living, 79 percent cited higher gas and electricity costs as a cause, before the substantial price increase from April 2022.

In the last three months of 2021, Citizens Advice reported they had offered support to 40 percent more people than in the same period in 2020 and in December 2021 they supported double the number of people who had run out of money to top up their prepayment meter than in the same time in the previous year (161). National government interventions to reduce the impact of cost of energy increases are insufficient and energy price increases will harm health and widen health inequalities.

The Council Tax Rebate and associated Discretionary Fund provides support for households in council tax bands A to D in England which aims to reduce energy bills in lower-income households. This has provided local authorities with additional funding to provide discretionary support to low-income households as they deem appropriate and in addition, there has been a minor increase in the Warm Home Discount, rising from £140 to £150, however this will have limited impact on bills increasing by hundreds of pounds. Insulating homes is an essential intervention to reduce the number of cold homes and associated ill health, as well as reducing the financial impacts of gas price rises and will also help reduce greenhouse gas emissions.

## FOOD POVERTY

Measuring food poverty is difficult in the UK as the data is not routinely generated by government statistics, and it is not possible to get reliable data for Lancashire and Cumbria. There have been widespread increases in food poverty and insecurity in the UK in recent years, which are expected to rise further due to the cost of living crisis. In April 2022, 7.3 million households in the UK stated they 'had gone without food or could not physically get it in the past month', including 2.6 million children (162). Food insecurity is significantly associated with low income, lower age groups (18-24 years report the highest levels of food insecurity) and those who rent their homes (163).

In March 2022 prices for commonly purchased food and drink items rose by 5.9 percent compared with a year before and prices are continuing to rapidly increase (164). As a result of this, and rising costs for other essentials, the numbers who are food insecure is also increasing quickly. In January 2022, the Food Foundation reported 4.7 million households were food insecure – by March 2022 this increased to 7.3 million households, a 57 percent increase in three months (162). Households with children, households on Universal Credit and people with disabilities and Asian/Asian British, Mixed and Black/African/Caribbean households are all more at risk food insecurity (162).

## COST OF LIVING CRISIS

As shown in Section 3C, being in work is no guarantee of having sufficient income to prevent poverty. This is set to worsen as wages and benefits do not keep up with increasing inflation and the rising prices of essential goods and services. In June 2022 inflation in the UK was at a 40-year high. The consumer price index rose by 9.4 percent in the 12 months to June 2022, with significant single-year increases in prices in the following:

- Gas (home heating) prices rose by 95.5 percent;
- Electricity prices rose 53.5 percent;
- Motor fuels prices rose 42.3 percent;
- Transportation prices rose by 15.2 percent;
- Food and non-alcoholic beverages prices rose by 9.8 percent;
- Clothing and footwear prices rose by 6.1 percent (165).

As a result of the removal of the price cap, a typical customer in the UK saw their energy bills increase by 78 percent between winter 2018-19 and the summer of 2022, from £1,105 to £1,970 (166). With gas prices close to doubling in a single year, and set to increase further in October 2022, the number of households in England in fuel poverty will increase substantially in 2022/23 with subsequent effects on health, wellbeing, mortality as well as declining quality of housing. Citizens Advice report that between January and April 2022 they received more cases of pre-payment meter users disconnecting themselves than in the whole of 2021 combined, signalling households were unable to afford higher costs for energy in the winter of 2022, prior to higher inflation rates and increased costs for fuel and expected higher costs of energy in the autumn of 2022 (167). It is not only those on the lowest incomes who are feeling the pressures of the increasing costs of living.

Between 22 June and 3 July 2022, 43 percent of adults who pay energy bills have found it very or somewhat difficult to afford them (168).

The negative impacts of increasing energy costs on household incomes are compounded by rising costs in other areas of life, too. The Joseph Rowntree Foundation modelled the impact of the rising cost of living on a couple with two children who are earning £20,000 a year. They estimated that weekly increases of £3 on gas and electricity costs, £8 on living costs and £2.50 on increased national insurance contributions would see the family's annual living costs rise by £710 in 2022–23. This increase, alongside the £1,040 lost from the removal of Universal Credit, would leave this couple with two children with a shortfall of £1,750 (169). As benefits are uprated with a lagging measure of inflation, the value of benefits will increase by 3.1 percent from April 2022, while inflation is already at 9.4 percent in June 2022 (170).

In the spring of 2022 the government announced three cost of living payments to help those on the lowest incomes:

- The main cost of living payment, worth £650 in total, for those on income-related benefits and tax credits.
- The pensioner payment, worth £300, for everyone who receives the winter fuel payment.
- The disability payment, worth £150, for those on non-means-tested disability benefits. (171).

However, due to the significant increases that have already occurred, this support is inconsiderable and late for many. As a result, local governments, such as Cumbria Council, have allocated emergency one-off funding to provide support to households dealing with these rising costs of living, Box 12.

### Box 12. Responding quickly to the cost of living crisis

In response to the cost of living crisis in 2022 Cumbria County Council created a £2m fund to provide additional and targeted support. The funding was split evenly to support: Cumbria Council's Ways to Welfare fund providing grants of up to £100 for individuals and families who are experiencing financial difficulty; parents of children in receipt of free school meals with a clothing grant to purchase school uniforms, £50 for children in primary school and £100 for those in a secondary school; an enhanced free school meals offer including provision for the summer 2022 school holidays and direct community support for individuals in need, including direct food purchases.

In 2020, the poorest 10 percent of households spent 54 percent of their average weekly expenditure on essentials such as housing (including electricity and gas), food and transport while the richest 10 percent spent 42 percent of their average weekly spend on the same essentials. In January 2022, a survey of 1,702 adults earning below the living wage found that 38 percent had fallen behind on household bills; 32 percent regularly skipped meals for financial reasons; and even before the large increases in energy costs, 28 percent already reported being unable to heat their homes for financial reasons. Two-thirds, 66 percent, stated that their mental health would improve if they earned a wage that covered their basic living costs (172).

Submissions to the HEC stated non-take-up of financial benefits is a problem. It is estimated around 500,000 people who were eligible for universal credit in the early part of the COVID-19 pandemic did not do so - either because they did not know they were eligible or they were discouraged by the expected hassle and stigma associated with applying for and being on benefits (173). In 2020/21 it is estimated that 1.3 million people in the UK do not receive universal credit who are eligible and that if they received what was due to them, 380,000 would be lifted out of poverty, including 140,000 children (173). People with complex problems, communication problems, and are unable to access or do not wish to access the services and benefits available to them others stated people are reluctant to claim financial benefits due to feelings of shame, anxiety and hopelessness and feelings associated with the stigma of being poor.

The staff and organisations that work with local communities to identify barriers found accessibility to be a real issue. For example, the impact of disabilities, lack of digital access, and the effects of previous traumas experienced all affect uptake of financial benefits. People eligible for financial benefits said it was easier to visit a food bank than to engage with a longer-term solution that requires a long wait and submission of evidence (e.g. of unemployment/income). As such it is important to provide services at the point people need them, as early on as possible, rather than allowing issues to escalate until people fall into arrears or face eviction, for example. People need to feel and believe they will receive help when they seek it, rather than face a list of administrative demands or tasks and a long waiting period.

In Blackpool the NHS have commissioned Citizens Advice to deliver social welfare advisers for over 20 years, it now sits as part of the social prescribing service, Box 13.

## Box 13. Social prescribing and Citizens Advice in Blackpool

Citizens Advice Blackpool works closely with GPs and has delivered advice in surgeries since 1997. Prior to the COVID-19 pandemic, weekly advice sessions were happening in 17 Blackpool general practices. This is being built back currently, with the long-term ambition being to have social welfare advisers in every GP practice in Lancashire.

In addition to their work providing social welfare advisers in general practices, Citizens Advice Blackpool are providers of social prescribing services. For example, in January 2020 five primary care networks agreed to work in partnership with Citizens Advice Blackpool to deliver a social prescribing model across the Fylde Coast. This led to delivering social prescribing services and also the creation of a network. A partnership between the Institute for Voluntary Action Research (IVAR) and the Lancashire and South Cumbria Health and Care Partnership saw there was a gap between primary care workers and those in the VCFSE sector, who did not often cross paths. A steering group was established, consisting of Lytham St Anne's PCN, Blackpool, Wyre & Fylde Volunteer Centre and Citizens Advice Blackpool, with the aim of establishing a social prescribing network, to share local experiences, listen to voices from the community, and make connections.

The social prescribing network allows for health providers to connect with social prescribing link workers across the Fylde Coast, and to refer individuals to a range of activities provided by the VCFSE sector. Social isolation was identified as prevalent in all the areas of Fylde Coast. The social prescribing link workers are able to reduce social isolation, with programmes such as setting up coffee mornings for specific populations. PCNs are also being made more aware of what resources already exist within the community, with the network inviting someone to talk about a particular service each time it meets, building new relationships and joining the needs of individuals with health services, and organisations delivering health and wellbeing services (174).

Given the multiple and increasing pressures on households, it is difficult to provide a summary definition of what constitutes poverty in the region. Looking at separate measures of poverty does not enable a full understanding of poverty. A regional understanding of costs – including of housing, food, energy, transport and child care – can help to better understand pockets of deep poverty, which are hidden under the larger area data currently used. Adopting a minimum income standard will help to provide a healthy standard of living.

### DEBT

Debt, like poverty, affects mental health, increasing stress and anxiety, and also worsens physical health (175) (176) (177).

Household debt in the UK has been increasing since 2012 and worsened during the pandemic. Our Building Back Fairer report showed low-income households had taken on additional debt whereas high-income households increased their savings during the first few months of the pandemic (178) (2). In 2021 a study of 1,252 people who had been forced to use loan sharks in the UK found 62 percent had an income below £20,000 and 65 percent had a long-term health condition (179). Levels of debt continued to increase and in 2021 the number of UK households with large debts increased by 35 percent, even before increases in energy prices and the removal of the £20 uplift in Universal Credit payments. Citizens Advice reported in 2021 that approximately three-quarters of the people they advise about benefits and debt would not have enough income to cover essential outgoings after the £20 uplift was removed and the energy price cap removed increased prices. This nationally survey was carried out prior to subsequent increases in inflation (180).

Local credit unions provide services to tackle financial exclusion and offer affordable loans. Box 14 outlines the work Lancashire Community Finance is doing to provide local residents with fairer financial services and stops reliance on high interest loans from loan sharks.

## Box 14. Tackling financial exclusion through fairer services

Lancashire Community Finance provides affordable and ethical loans at fair market rates to individuals and businesses across seven locations in Lancashire. It offers education and one-to-one financial advice and advocacy. Affordable credit is available to individuals (personal and home improvement loans), and start-up business loans. Between 2005 and 2017 Lancashire Community Finance helped over 11,000 people across Lancashire with affordable loans totalling over £8.3 million (181).

## RECOMMENDATIONS. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

**a)** Adopt the minimum income standard as a basis for minimum wage and assess if adapting for regional costs is needed.

**b)** Create and support community and employer finance institutions to supply credit, reduce levels of debt and provide financial management advice.

**c)** The NHS, local authorities, schools and employers to commission the VCFSE sector to provide of social welfare legal and debt advice, including fuel and food poverty support

**Leads:** Businesses and local economic partnerships, local authorities, NHS

### NATIONAL ADVOCACY

- Make the social safety net sufficient for people not in full-time work to receive the minimum income standard.
- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Additional funding in areas with high levels of deprivation including levelling up funds to better reflect deprivation.

# 3E CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

**KEY MESSAGES**

- One of the most significant ways in which health inequalities can be reduced is through good quality housing and safe environments, with access to transport, services and shops, healthy high streets, community facilities, leisure and entertainment and good quality natural environments.

**HOUSING**

- Across the region there is a substantial amount of inadequate housing stock – poor quality, poorly insulated and overcrowded homes. These issues have direct and indirect impacts on health.
- Many homes in the private rental sector have high levels of cold, damp and poor conditions, but there is a lack of enforcement and tenants are also vulnerable to eviction if they complain.
- There are long waiting lists on the social housing registers.
- In the region, Preston, Blackpool and Blackburn with Darwen have the highest rates of people sleeping rough. Blackpool, Chorley, Blackburn with Darwen and Burnley have the highest rates of homeless households eligible for assistance, all above the England average.
- Across the region there are some important interventions to improve quality of housing and reduce homelessness but these need to be extended more widely with adequate resourcing.
- Given the significance of housing to health, the NHS must be more involved in improving housing in the region.

**TRANSPORT**

- Preventing ill health is vital for reducing demand for NHS services, as well as beneficial for the population and the economy.
- Much of the ill health in the region is avoidable and action on the social determinants would improve health and reduce inequalities and reduce the burden on NHS and other services, reducing costs in the long run.
- There are good examples of services taking a social determinants of health approach in the region but these need to be rapidly expanded with adequate resources.

One of the most significant ways in which health inequalities can be reduced is through good quality housing and safe environments, with access to services and shops, healthy high streets, community facilities, leisure and entertainment and good quality natural environments (1).

## HOUSING CONDITIONS AND COSTS

Across the region there is a substantial amount of inadequate housing stock – of poor quality, poorly insulated and overcrowded homes. These issues have direct and indirect impacts on health. In the previous section we set out the health impacts of cold homes, insecure tenures, high rents, disrepair, overcrowding are also significant drivers of poor health and contribute to inequalities in health.

In its submission to the HEC, Blackburn with Darwen health and wellbeing board highlighted a number of housing issues that are affecting health inequalities:

- Long waiting lists on the social housing registers, with some households waiting two or three years.
- A lack of accommodation suitable for larger family groups, and lots of barriers to access that accommodation.
- Isolation for vulnerable families as transport costs are a major issue for service access. Outreach work could be provided in more easily accessible venues, such as schools and other community-based venues.
- Low incomes and arrears have led to families being unable to access private rentals due to poor credit ratings. Many cannot access social housing either, due to affordability issues.

Many submissions to the HEC stated that the 'integrated care system is not making connections' between poor health and poor housing. In addition, there were reports of clinicians failing to refer patients in need to fuel poverty support, despite offers of help and advice (e.g. training, joint meetings, IT adaptations) from local government and public health teams. Whilst much attention is paid to asthma and COPD clinical screening and treatment, the effectiveness of this is diminished as the ICS does not enable the joining up of interventions at an individual or population level. Improving housing associated with or exacerbating illness will be beneficial to the NHS but needs to be funded and clinicians supported to better identify and connect patients to housing improvement services. Improving housing will improve health and wellbeing in all age groups and reduce inequalities. However, local authority capacity to enforce quality housing standards has diminished across England due to significant cuts to teams responsible for enforcement. In addition, there are barriers to implementing licensing schemes for private rental properties. In the past housing has been the responsibility of local government but as the effects of poor housing continue to have multiple consequences for the NHS, providing core funding to address housing problems should be the business of the NHS.

HEC submissions suggested there are four key opportunities for housing to have a real impact on health inequalities:

1. Improving housing standards/conditions, including improving the private rented sector. Enforcement of regulations on housing quality and secure tenancies is vital and too often policies are weak and councils are only able to respond to complaints.
2. Increasing new housing supply and planning for new affordable homes.
3. Integrating housing support needs into care pathways.
4. Making housing associations and social housing organisations into anchor institutions.

Poor quality housing in the private rented sector is a problem in Lancashire and Cumbria, as it is across England. As well as being substandard, private rental accommodation is often in the form of HMOs, where private landlords earn substantial sums from housing benefit claimants and these homes have the highest levels of damp. Coastal towns were the topic of the 2021 Chief Medical Officer's report, outlining the significant health inequalities in coastal areas in England (182). It listed a range of issues in many coastal towns and set out recommendations to improve them. There is poor quality private rental sector stock in coastal areas and the privately owned sector is often in poor repair and has high levels of fuel poverty, with impacts on physical and mental health.

Cosy Homes in Lancashire (CHiL) is working with partners across Blackpool to provide funding for warm housing, Box 15.

## Box 15. Cosy Homes in Lancashire

The Cosy Homes in Lancashire (CHiL) initiative, launched in 2013, is led by Blackpool Public Health and supported by all the Lancashire local authorities. Blackpool Council acts as the lead authority in bids for funding opportunities on behalf of Lancashire. Its purpose is to provide funding to make homes warmer.

The CHiL administration hub manages the phone lines, processes referrals and applications, carries out marketing activity, deals with customers' complaints, has an in-house team of surveyors and engineers for heating-related work and manages a local supply chain of contractors, who together cover the full range of energy efficiency and low carbon measures that are available to Lancashire residents through the scheme.

There are a number of current funding pots available to residents who are in receipt of benefits or where a household income is less than £30,000:

**ECO Funding** – to install replacement boilers and some insulation measures. Boilers normally have to be over 10 years old and not working or working intermittently. The funding does not normally cover the full cost of work, so a customer contribution is required. Where a customer is unable to pay a contribution the CHiL Hub will investigate charitable funding streams to pay the contribution on behalf of the resident. Rented properties cannot access this funding as it is expected that a landlord should pay.

In recent years ECO funding has become increasingly complex – heating measures are only allowed to be fitted if the house is fully insulated. If insulation is required and either it is difficult to install due to the construction of the property or the resident does not want insulation, then the boiler cannot be installed unless other funding is available to cover the full cost of the boiler and ECO funding is not used.

**First Time Central Heating Fund** – funding to install first-time central heating into homes that are currently heated by other means, such as electric storage heaters, gas fires or coal fires. A full system is provided, including an energy-efficient boiler and radiators in every room. However, it has proven difficult at times to persuade owners, especially private landlords, to switch from electric storage heaters to a full gas central heating system despite the unreliability that storage heaters bring. This funding is available for all tenures and no contribution is required. The funding is due to end in late 2022. It can include gas or LPG systems and free connections to the gas network.

**Green Home Grant** – Local Authority Delivery (LAD) – £23 million has been secured from the Department for Business, Energy & Industrial Strategy for Lancashire residents. Grants of £10,000 are available to install all insulation measures – solid wall insulation, cavity wall insulation, loft insulation, underfloor insulation, room-in-roof insulation, single glazed window upgrades and renewable heating technologies such as air source heat pumps and solar panels. To qualify, a house needs to be energy-inefficient, i.e. with an energy performance certificate (EPC) rating of D to G. Qualifying residents also need to have a household income of less than £30,000. The funding is available until June 2022. This grant is available to the private rented sector but landlords are required to pay a contribution so take-up to date has been low.

**Home Upgrade Grants (HUG)** – this funding will run from April 2022 to March 2023. The grant will operate exactly as the Green Homes Grant but is specifically for off-gas properties and the grant is up to £25,000 for the most energy-inefficient properties.

Submissions to the HEC stated that the current minimum standards – the Decent Homes Standard – are set too low to prompt improvements in the private rented sector. Without adequate funding or regulatory powers, substantial improvements are impossible; for example, selective licensing is unable to address local housing issues such as problems with student flats in Blackpool.

Yet there are signs this is changing. Public health in Blackpool is piloting a project to implement the decent homes standards before the legislative changes come in 2025, to ensure good quality housing and hold landlords to account for that standard. There is also an option to withhold payment of benefits if poor quality housing is provided but this will require extra enforcement activity which the Department for Levelling Up, Housing and Communities is looking to support. Blackpool Council have taken direct action to improve non-decent homes, and buying and improving rental properties, Box 16.

### Box 16. My Blackpool home

My Blackpool Home (MBH) was set up by Blackpool Council to purchase former guest houses (some poorly converted into HMOs) in the highest density private rented sector areas. MBH renovates the homes and provides more spacious, good quality housing for rent. The not-for-profit scheme is running at a loss but it is hoped the rental income will help it to break even. It is a limited solution as not all owners will want to sell, or at the right price. Nevertheless, it is already making significant inroads in reducing densities and raising standards. MBH is part of the council's strategic space and place planning, which focuses on improving the private rented sector. The housing strategy also includes a range of linked housing and economic outcome measures over a long time span, from years 1 to 5 – stabilisation, years 6 to 10 – persistent and visible change and years 11 to 15 – entrenching permanent change.

The Levelling Up white paper included commitments to force private landlords to bring their properties up to a set of national standards for the first time, with the aim of reducing the number of non-decent rented homes by 50 percent by 2030, with the biggest improvements in the lowest performing areas. The white paper stated the government will explore introducing a National Landlord Register though no firm commitment to implement the Register has been made (17).

Within Lancashire and Cumbria, there are housing associations showing excellent national practice. Housing associations are important stakeholders for health, as well as housing, as the work they do has such an important bearing on the health of their residents. They often have close relationships with their residents, and there are many opportunities to work in partnership with other stakeholders. There are no examples in the region of embedded partnerships between housing associations and the NHS and these partnerships need to be developed; linking healthcare, public health and housing providers more closely in order to improve health and reduce health inequalities.

## HOMELESSNESS AND ROUGH SLEEPING

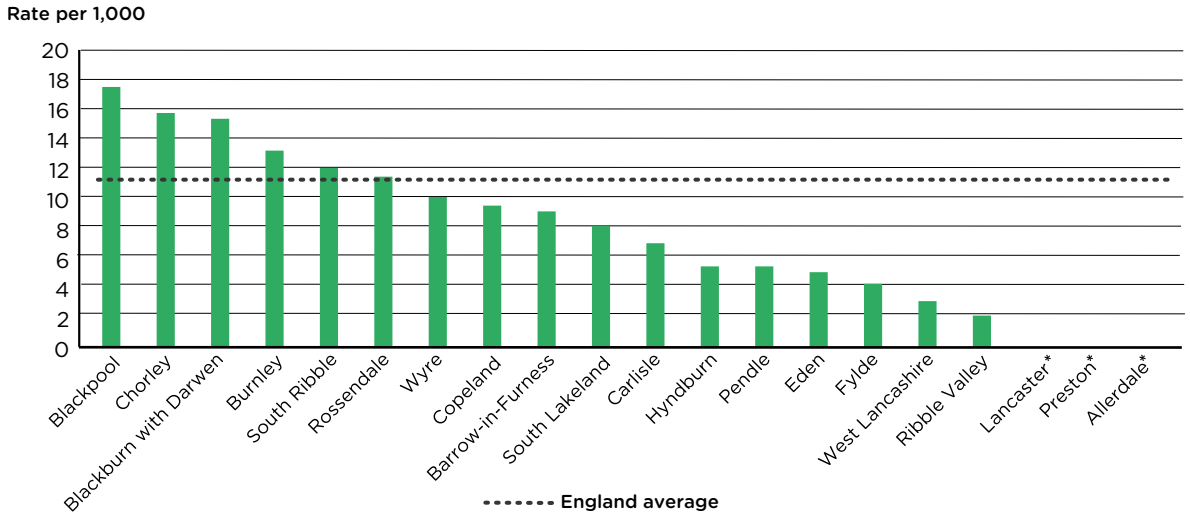
The first COVID-19 lockdown created an impetus to provide accommodation to people who were homeless. In Lancashire and Cumbria hundreds of homeless people were quickly found accommodation in hotels and B&Bs, and in many cases were offered additional support. Reflecting on these actions, stakeholders were impressed by the speed of the delivery, and that plans were created and implemented in a very short time. Stakeholders described positive experiences of working with other services and service providers, building new relationships and strengthening existing ones. There was a clear agreed goal for all partners to work towards and a solution-focused approach from all – less focused on what could or could not be done and more on how they could do what was needed.

Submissions to the HEC identified key factors that contributed to the success of these programmes, all helping to increase the willingness of external agencies to work collaboratively and break down barriers:

- A sense of urgency.
- Clear and concise direction from government policy.
- Additional funding.
- Being more creative in creating a personalised approach to working with clients (183).

A person is defined as homeless if they have no accommodation available in the UK or abroad; have a split household and accommodation is not available for the whole household; are at risk of violence from any person; are unable to secure entry to their accommodation or live in a moveable structure but have no place to put it (184). This definition includes those living in temporary accommodation, sofa surfing and other forms of insecure housing as well as rough sleeping. In the region, Preston, Blackpool and Blackburn with Darwen have the highest rates of people sleeping rough. Blackpool, Chorley, Blackburn with Darwen and Burnley have the highest rates of homeless households eligible for assistance, all above the England average, Figure 3.22.

**Figure 3.22. Homeless households eligible for assistance, crude rate per 1,000, Lancashire and Cumbria local authority districts and England, 2020/21**




***Notes:*** *Data not available.*

***Source:*** *Ministry of Housing, Communities & Local Government (185)*

Housing associations and the local VCFSE sector are key providers of accommodation for people with complex needs and support the needs of those with drug and alcohol addiction, who often have entrenched mental health problems, too. In most areas in Lancashire and Cumbria budgets are not commissioned to meet actual needs, and services for those who are sleeping rough are chronically underfunded. However, Blackpool has commissioned services to better meet the health and wellbeing of people sleeping rough and manage demand on the NHS, as shown by Box 17.

## Box 17. Improving health for those sleeping rough

The Homeless Health nursing team in Blackpool, Fylde & Wyre was set up in January 2021, originally as a pilot scheme, to provide a nurse-led service for the homeless community. Public Health provided the pilot funding with subsequent funding coming from the clinical commissioning group. The team provides a holistic health offer for the homeless community – they treat and refer patients, make every contact count and build trust with each person using their service. Key to the success of the service is having a team who have the interpersonal skills to make everyone welcome, the clinical skills to provide timely interventions and advice, and genuine empathy for people who are homeless.

Many of the people coming to the Homeless Health nursing team have complex needs, and the existing model of healthcare delivery is often unsuccessful with these patients because of the lack of flexibility in the service. The Homeless Health team focus on developing local knowledge and relationships so they can refer to the correct local service and provide personalised support to each person they work with. The team have developed referral pathways and personal contacts with the North West Ambulance Service, Blackpool Teaching Hospitals, Trinity Hospice, podiatry, urgent care, local out-of-hours (the local care coordination team is an invaluable contact that can be used to make referrals to the service 24 hours a day, seven days a week) and primary care providers. This wealth of relationships means the Homeless Health team is well situated to guide people with multiple needs through the complexities of the NHS system.

Flexibility and ease-of-access are key to the success of the Homeless Health team. Services are offered as a drop-in option and are also pre-bookable. The services are delivered at the local Salvation Army Bridge Project, the ADDER drop-in service, an outreach bus that is located in the town centre, and bespoke hostel and outreach clinics. Offering the service flexibly across locations is vital, as some patients may not be able to attend all clinic sites due to threats of violence or transport issues.

The CCG is currently funding a cancer screening pilot for people who are homeless and will initially focus on services for women in the form of cervical and breast screening. During 2021 a total of 254 patients were supported by the team, which comprises two nurses.

## TRANSPORT

Good, affordable public transport networks promote social cohesion, facilitate access to education, services, employment and reduce social isolation - all of which have positive benefits for health and reducing health inequalities. Lancashire and Cumbria make up a large geographical area, with a number of public transport providers and no single transport plan and in large parts of Cumbria and Lancashire, public transport is a considerable challenge. In many rural areas and in small communities it is difficult to make bus routes financially viable; there were substantial cuts to bus services between 2010 and 2020, as outlined in our 10 Years On report; and the pandemic worsened this situation (1). In submissions to the HEC, a number of areas identified transport as a major issue and stated that it is often regarded as 'too difficult' to fix or 'someone else's problem'.

The VCFSE sector has had to step in and offers a lifeline to many of communities without access to affordable public transport (see Box 18 for an example), but is frequently unable to offer sufficient capacity due to lack of resources.

### Box 18. Improving rural transport: the Northern Fells Group minibus service

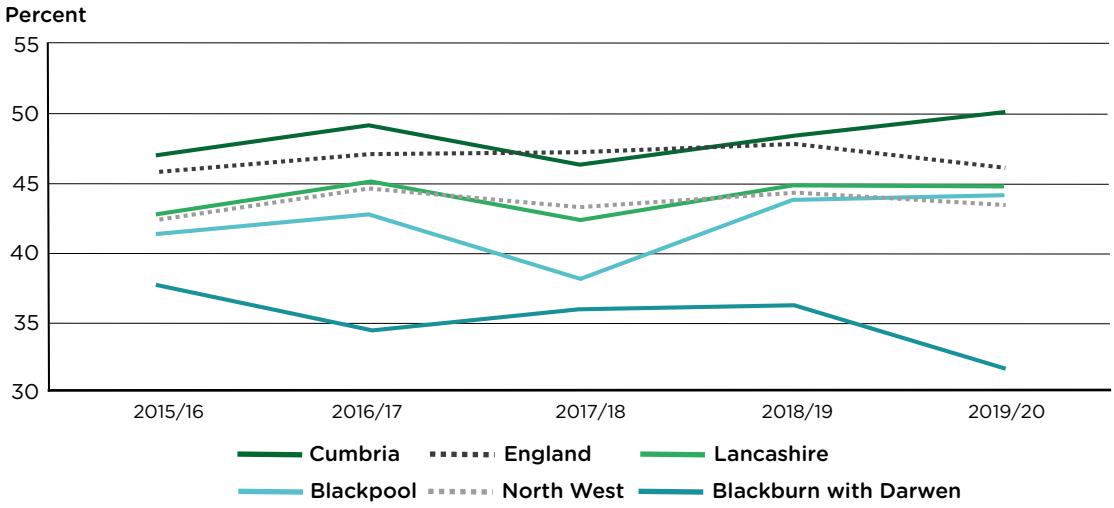
The Northern Fells Group is a community charity based in North Cumbria serving 3,700 residents over 200 square miles. The charity aims to combat rural social isolation and exclusion, to improve access to services, and to enable people to remain independent in their own homes. The Northern Fells Group runs a flexible minibus service, which may be used by anyone of any age who does not have their own transport, has limited access to shared transport or needs transport with disabled access. The service can be used to attend medical appointments, but can also be used for social visits.

The service is delivered by 15 volunteer drivers and operates six days a week. The service continued throughout the COVID-19 pandemic, maintained by volunteers and with additional procedures in place. In the period April 2020 to March 2021 the minibus made 352 journeys, compared with 929 journeys in the equivalent period ending March 2019. With the easing of pandemic restrictions, journeys from April 2021 to Feb 2022 increased to 484 over the 11 months.

The service can help people during temporary or long-term periods of illness or disability, allowing them to remain safely in their own homes for longer, and can equally help those who cannot afford their own transport to avoid social isolation. It is a major community initiative and has been running successfully for 22 years. Funding for the service comes from Caldbeck Surgery Charitable Fund and parish council donations (186).

All of Lancashire had lower rates of active travel compared with the England average. Figure 3.23 shows that people in Lancashire were also less likely to walk 'for any purpose', compared with the England average, although the figure for Cumbria was mainly above the England average over the period in question. In 2019/20 in England, Blackburn with Darwen had the second lowest proportion of adults walking for 10 minutes or more, three times a week.

**Figure 3.23. Proportion of adults walking for any purpose* at least three times per week, Lancashire and Cumbria upper tier local authorities, North West, and England, 2015/16–2019/20**




***Notes:*** *Any continuous walk of over 10 minutes, for any purpose.*
***Source:*** *Department for Transport (187)*

## RECOMMENDATIONS. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

**a)** In partnership between local authority, NHS and VCFSE sector, develop a regional decent homes standard by 2025.

- Strengthen local enforcement powers and capacity across planning and housing and ensure decent homes standards in the private rented sector.
- Develop and support regional housing forums in Lancashire and Cumbria with members from housing associations, NHS, VCFSE sector, local authorities, estate agents and private rented sector.

**b)** Place reducing inequalities at the centre of local and regeneration plans including fit for purpose, affordable housing.

- Identify pilot neighbourhoods in areas of high deprivation and work with communities to create and sustain high-quality and connected neighbourhoods.
- Work in partnership (with local residents, NHS, chambers of commerce, local economic partnerships and local authorities) to develop healthier high streets.

**c)** Assess provision of public transport and address limitations in access. Resource VCFSE sector to provide adequate transport services in remote and rural communities.

**Leads:** Businesses and local economic partnerships, local authorities, NHS

### NATIONAL ADVOCACY

- Advocate for removal of obstacles to selective licensing schemes and ensure provision of funds to create and maintain a private landlord registry.
- Advocate for devolved powers to give control over transport with a London-style transport system that supports affordable access to rural and coastal communities.

# 3F STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

**KEY MESSAGES**

- Preventing ill health is vital for reducing demand for NHS services, as well as beneficial for the population and the economy.
- Much of the ill health in the region is avoidable and action on the social determinants would improve health and reduce inequalities and reduce the burden on NHS and other services, reducing costs in the long run.
- There are good examples of services taking a social determinants of health approach in the region but these need to be rapidly expanded with adequate resources.

**SMOKING, ALCOHOL, DRUG USE AND OVERWEIGHT AND OBESITY**

- Smoking, alcohol and drug use and obesity are linked with many of the avoidable deaths and long-term conditions and are higher in more deprived communities.
- Across most of the region mortality from alcohol is higher than the English average and closely associated with deprivation.
- In Blackpool, Cumbria and Blackburn with Darwen deaths from drugs are higher than the English average and hospitalisations from substance misuse are higher across the whole region.
- In most of Lancashire and Cumbria's local authority districts rates of overweight and obesity are higher than the England average and associated with deprivation particularly for children.
- Levels of physical activity are also associated with deprivation.

**DIGITAL EXCLUSION**

- While digital services and apps offer many benefits, they also risk widening inequalities unless effective action is taken to ensure there are still services and resources available to all.
- The prevalence of digital-only services is increasing and excludes many from healthcare, education, employment and local authority services, as well as from accessing resources and information and social interaction.
- Those who are the most in need of support, such as older people and those on the lowest incomes, are the least likely to engage with digital platforms.

Demand for NHS services is unsustainable and will continue to increase. Much of that demand is driven by non-communicable diseases (cancer, cardiovascular disease, chronic respiratory diseases and diabetes), which are the main causes of death and disability in the UK and around the world.

The WHO estimated non-communicable diseases caused 89 percent of all deaths in the UK in 2016 (188). Many of the non-communicable diseases are considered 'avoidable', because they result from causes considered avoidable, treatable or preventable given timely and effective healthcare or public health interventions. Smoking, alcohol and drug use and obesity are linked with many of the avoidable deaths and long-term conditions, such as type-2 diabetes, high blood pressure, high cholesterol and increased risk of respiratory, musculoskeletal and liver diseases.

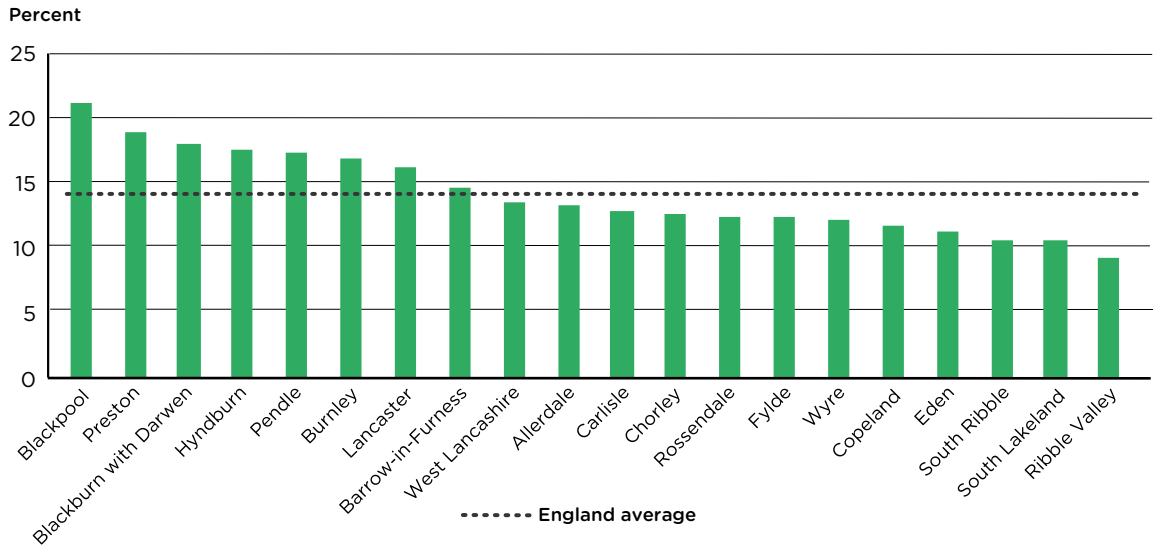
Avoidable mortality is higher in areas of greater deprivation. In 2020 avoidable deaths accounted for 40 percent of all male deaths and 27 percent of female deaths in the most deprived areas of England. In the least deprived areas, avoidable deaths accounted for

18 percent of all male deaths and 12 percent of female deaths (189). These enormous social inequalities in avoidable mortality must be tackled through action on the social determinants of health as pointed out throughout this report and programmes which are geared towards reducing unhealthy behaviours, must tackle inequalities in social and economic factors to be effective. NHS services, which are increasingly being asked to focus on 'prevention' must take an equity-focussed social determinants of health approach in order to reduce harmful health behaviours. Digital solutions are increasingly being offered as a way to modify health behaviours and reduce avoidable mortality and ill health - however, without close attention to inequities in access to digital devices, and capacity to use them, these 'digital solutions' can actually widen health inequalities.

## SMOKING

Seven local authorities in the region have smoking prevalence rates above the England average, Figure 3.24.

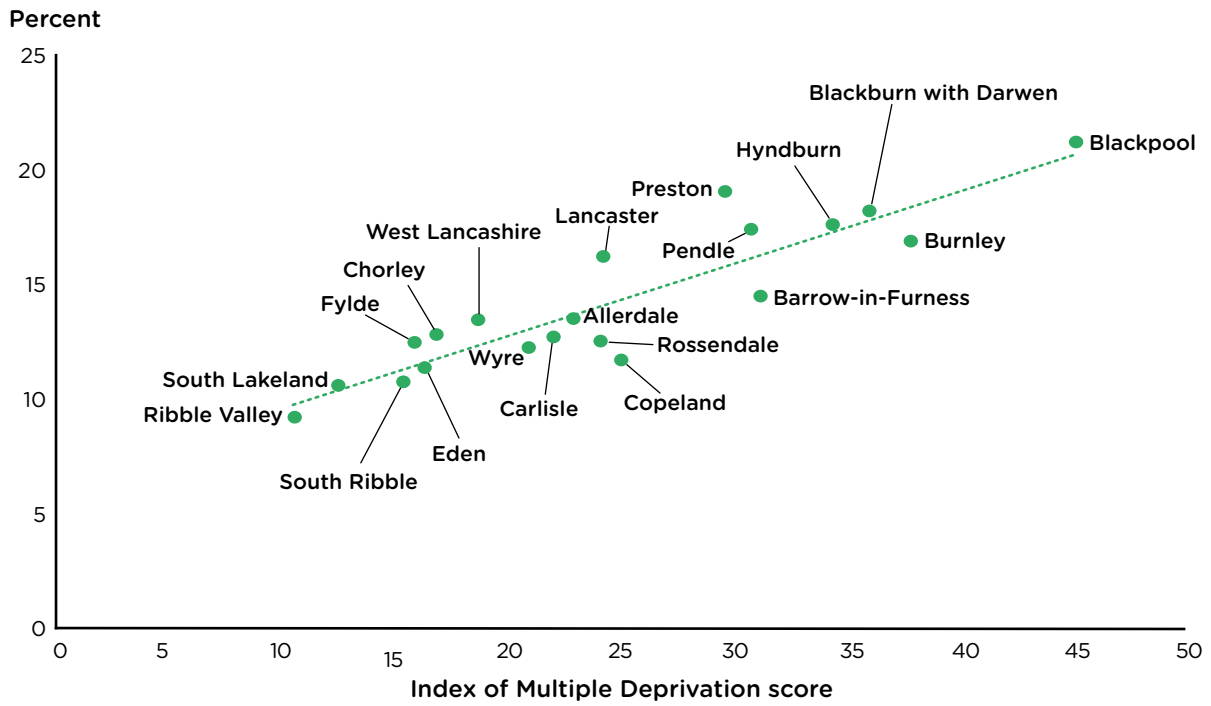
**Figure 3.24. Smoking prevalence among adults aged 18 and over, percentage, Lancashire and Cumbria local authority districts and England, 2020**




***Source:*** *GP Patient Survey (GPPS) (190)*

There is a close association between deprivation and smoking across Lancashire and Cumbria with much higher rates in more deprived areas, shown in Figure 3.25.

Figure 3.25. Percentage of smoking among adults aged 18 and over, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2019/20




***Source:*** *GP Patient Survey (GPPS) (190)*

## ALCOHOL AND DRUG MISUSE

In England since 2012, avoidable mortality from alcohol and drug-related disorders has increased. Alcohol and drug misuse is associated with long-term health risks including high blood pressure, depression, liver disease, certain types of cancer and pancreatitis (1).

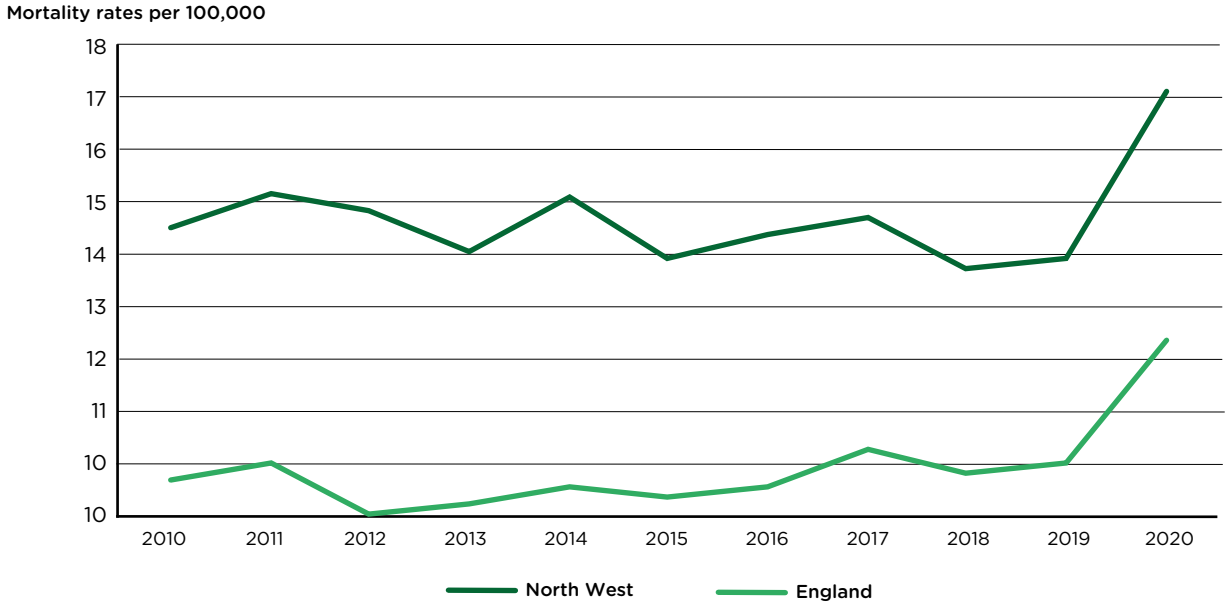
People living in the most deprived areas in England have a substantially higher rate of death from alcohol and drugs than do people living in the least deprived areas. Figure 3.26 shows deaths from alcohol and drug-related disorders are increasing, but increasing fastest in those living in the most deprived areas in England.

Figure 3.26. Avoidable mortality rates for alcohol and drug-related disorders, England, 2010-20

***Source:*** *Office for National Statistics (191)*

There is an inverse social gradient for alcohol consumption: harm from alcohol consumption is greatest in households on the lowest incomes yet alcohol consumption generally increases with level of household income (1). Alcohol consumption increased during the first COVID-19 lockdown and subsequent analysis shows that alcohol-related deaths also increased. Figure 3.27 shows the sharp increase in 2020 in the North West region, reflecting the increase in England, where there was a 20 percent increase in total alcohol-related deaths compared with 2019 (192). People living in the most deprived areas in England increased their alcohol purchases more than those in the least deprived areas (193).

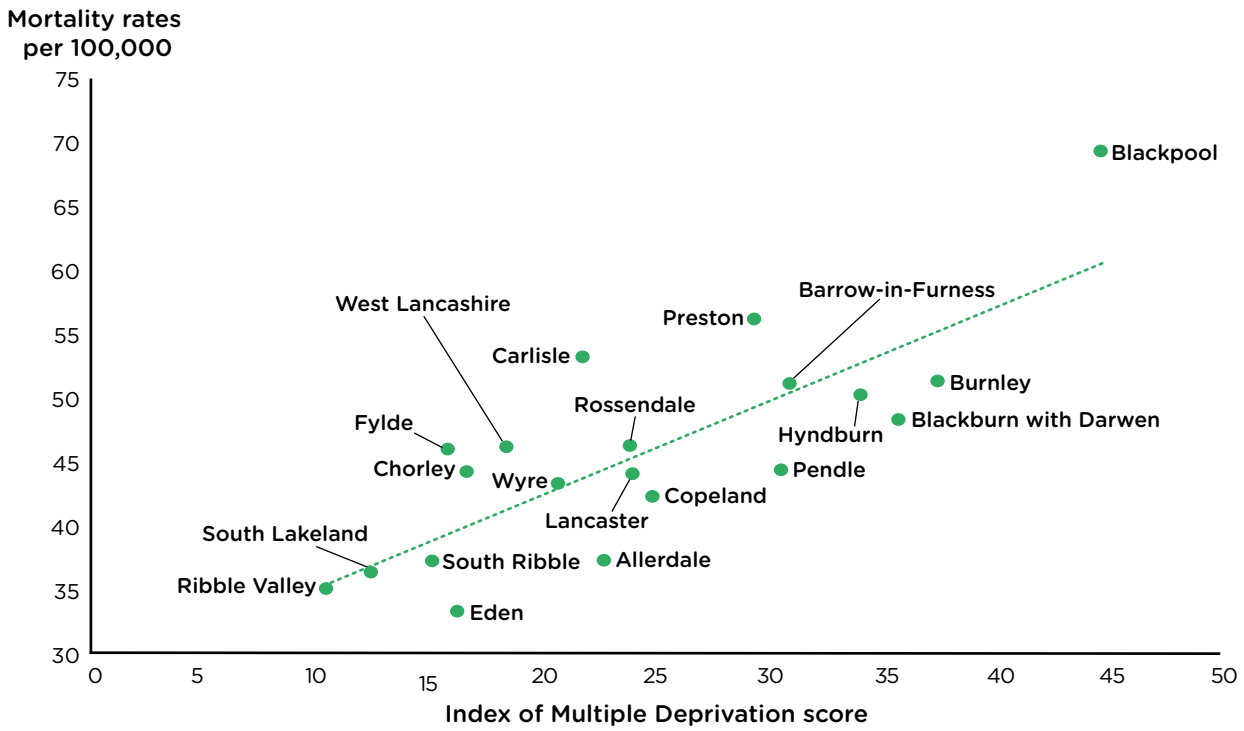
**Figure 3.27. Age-standardised alcohol-specific death rates per 100,000 people, North West and England, deaths registered between 2010 and 2020**




***Source:*** *Office for National Statistics (192)*

The majority of areas in Lancashire and Cumbria have an alcohol-related mortality rate above the England average of 38 deaths per 100,000. Blackpool's alcohol-related mortality is the worst in England, 82 percent higher than the England average (69 deaths per 100,000). There is a clear association in alcohol-related mortality and deprivation in Lancashire and Cumbria, shown in Figure 3.28, with more deprived areas having much higher rates of mortality.

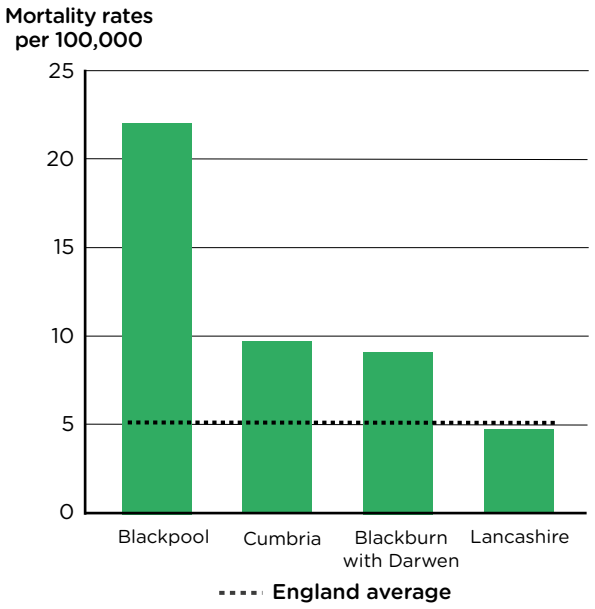
Figure 3.28. Alcohol-related mortality, directly standardised rate per 100,000, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2020




***Source:*** *Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid-Year Population Estimates (194)*

In addition to having some of the worst alcohol-related mortality, Blackpool has significant challenges related to drug misuse, with the highest mortality rates from drug misuse in England (Figure 3.29) and a major problem with drug misuse in young people.

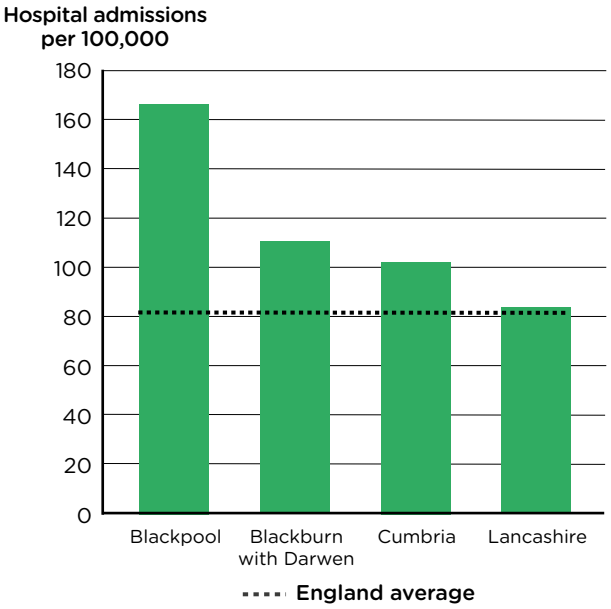
Figure 3.29. Deaths from drug misuse, directly standardised rate per 100,000, Lancashire and Cumbria upper tier local authorities and England, 2018–20




***Source:*** *NHS Digital Hospital Episode Statistics (195)*

Figure 3.30 shows that Blackpool's hospital admissions related to substance misuse in 15- to 24-year-olds are the highest in the region and the seventh highest in England.

Figure 3.30. Hospital admissions due to substance misuse in young people aged 15–24 years, Lancashire and Cumbria upper tier local authorities and England, 2018/19–20/21




***Source:*** *NHS Digital Hospital Episode Statistics (59)*

Interventions and actions to enable and encourage people who have long-term health conditions, including alcohol and drug additions, back into work can take time. The Well Communities, with hubs across Cumbria and Lancashire, offers employment support in their package of support available to people recovering from addiction, Box 19.

### Box 19. The Well: employment support for people with alcohol and drug addictions

The Well is a community interest company founded in 2012 by ex-offender and former drug addict David Higham, with the aim of helping people to recover from addiction. The Well has hubs in Barrow, Morecambe, Kendal and Carlisle. Of those who have used the Well's services, 69 percent have remained abstinent for six months or more.

The Well employs staff and volunteers who have lived experience of addiction, with the aim to support recovery and encourage stigma-free support. The organisation focuses on supporting clients for as long as is needed. The Well's services include supported housing, outreach support, mutual aid and a busy social activities programme. 93 percent of members said their health and wellbeing improved after joining.

The Well has also teamed up with Fareshare to provide an affordable weekly food club across two different sites in Barrow-in-Furness. Every week there is a fresh produce for people to purchase and take home, and an opportunity for people to get connected with their local community and access any support they might need.

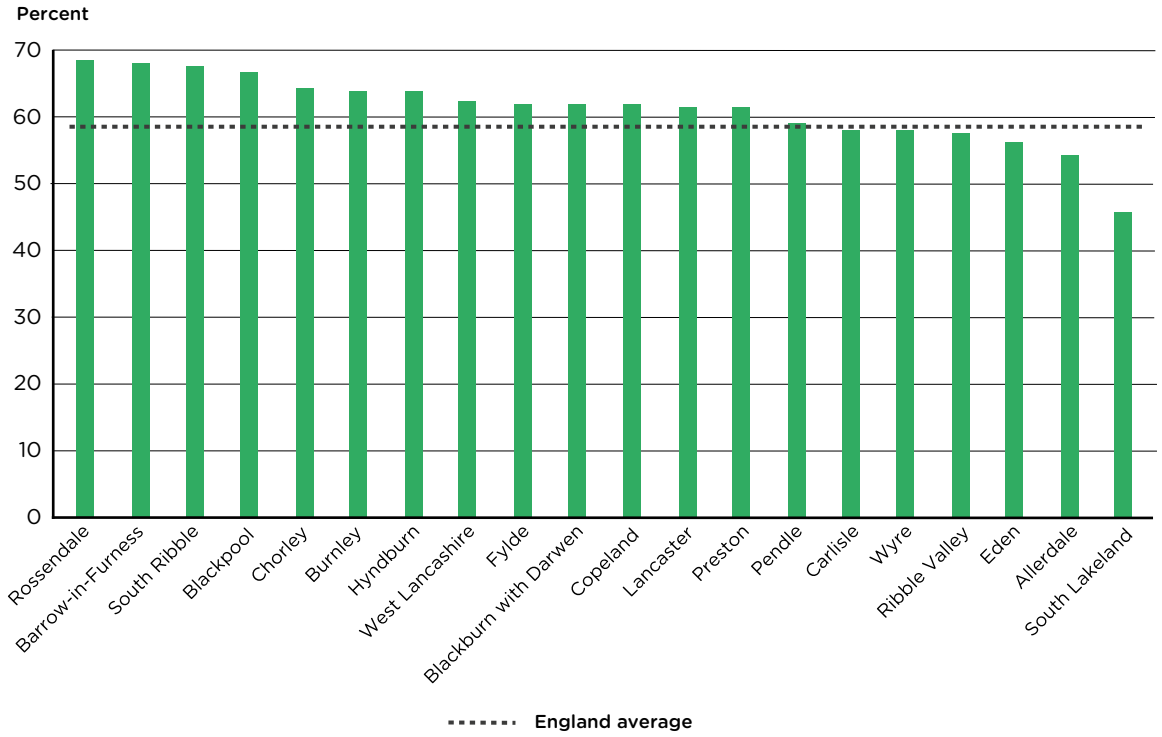
Many people supported by the Well say finding employment is one of the biggest challenges they face. The Well has links with local organisations to provide jobs, training and work experience. Green Heart Den in Barrow provides an opportunity for people to volunteer hours to Marsh Street Arches and Gardens CIC, developing a community 'grow your own' scheme with over 20 local partners. The Well has launched two social enterprises, Well Fed social supermarket and Maintained Well, a repairs and maintenance business, giving further opportunities to individuals for training, employment and volunteering.

The Well received joint funding from the National Lottery and the European Social Fund for the Building Better Opportunities (BBO) project, which aimed to support individuals based on their own identified obstacles and needs. Participants had a multitude of difficulties including substance abuse, mental health problems, lack of qualifications, social isolation and offending backgrounds. BBO ran from August 2017 until July 2021. Key to this project's success was establishing links with local employment and training services as well as many third sector organisations. Using these partners, participants were able to attend skills courses including courses on applying for a job, creating a CV and money management. Each participant of BBO had a personal development plan to develop motivation, overcome barriers, and help them move into or towards employment. One hundred individuals were supported throughout the BBO project, of which 15 were long-term unemployed and 85 were economically inactive. Of the 100 participants, seven moved into employment, 38 are now seeking employment and 25 moved into education or training. Over half have volunteer placements and none who came from a criminal background are believed to have reoffended (196).

## OBESITY AND OVERWEIGHT

In line with England, overall prevalence of obesity is increasing in Lancashire and Cumbria and the highest rates of obesity in adults are in Rossendale (74 percent), Barrow-in-Furness and South Ribble (both 73 percent) in 2019/20. The England average is 63 percent. In 2019–20 rates of obesity in most of Lancashire and Cumbria's local authority districts were higher than the England average (Figure 3.31).

**Figure 3.31. Percentage of adults aged 18-plus overweight or obese, Lancashire and Cumbria local authority districts and England, 2019/20**

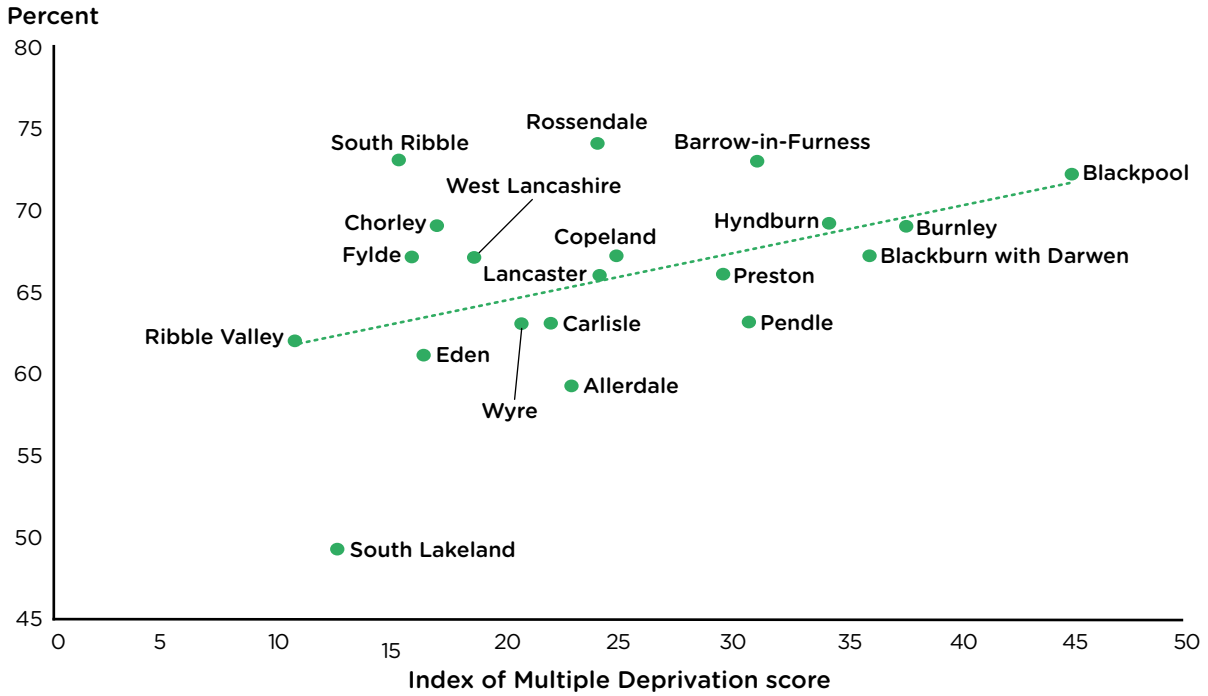



***Source:*** *Public Health England (based on Active Lives survey, Sport England) (197)*

Obesity disproportionately affects some ethnic minority groups as well as individuals with disabilities or mental health problems. Since 2015/16 black adults have had the highest percentage of overweight or obesity out of all ethnic groups in England (198). A systematic review found being overweight was associated with an increased risk of COVID-19-related hospitalisations but not deaths, while obesity led to an increased risk of both COVID-19-related hospitalisations and death (199). Analysis of England COVID-19 data found not only increased risks of COVID-19 severity associated with obesity, but also that risks increased in those with black ethnicity (200).

Obesity and diabetes are closely related to deprivation across England (201). Figure 3.32 shows higher levels of overweight and obesity are somewhat associated with increasing deprivation in Lancashire and Cumbria.

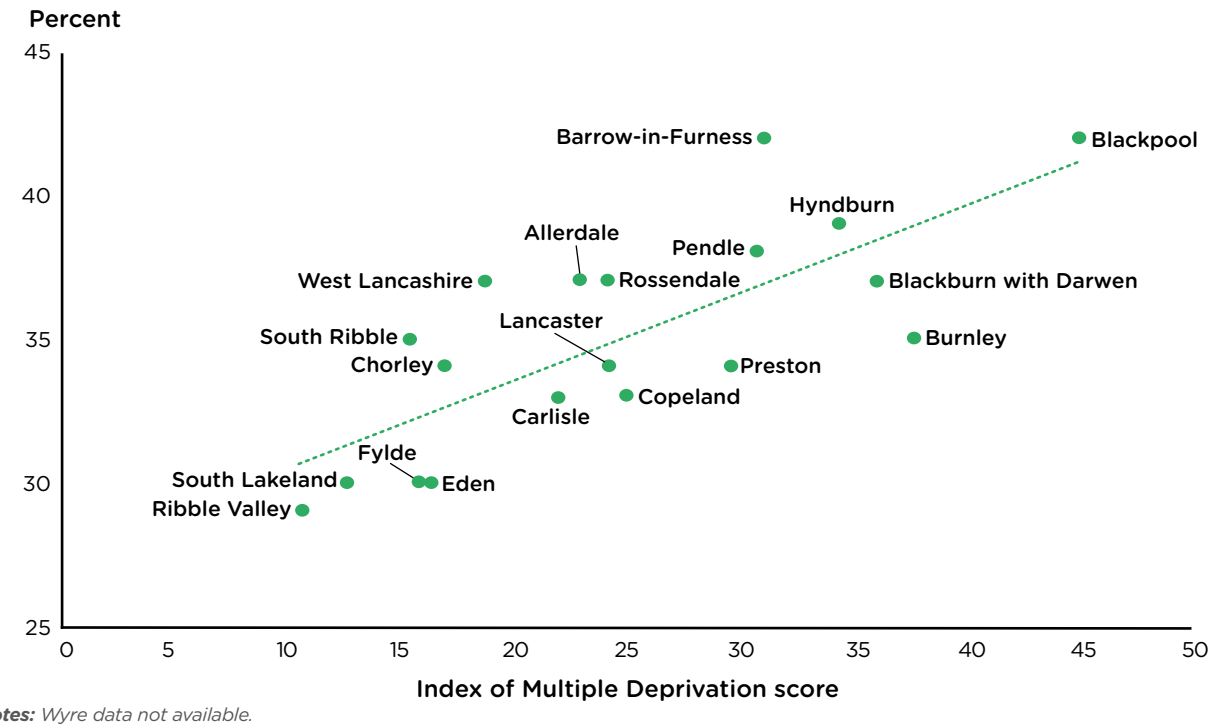
Figure 3.32. Percentage of adults aged 18-plus overweight or obese, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2019/20




***Source:*** *Public Health England (based on Active Lives survey, Sport England) (197)*

The relationship between deprivation and obesity has been analysed in relation to the cuts to Sure Start children's centres. Funding for Sure Start fell by 53 percent on average between 2010/2011 and 2016/2017. In the most deprived areas of local authorities in England, funding decreased by £422 per child and but they fell by only £133 per child in the least deprived local authorities. Analysis showed each 10 percent spending cut was associated with a 0.34 percent relative increase in obesity prevalence the following year, and it is estimated there were an additional 4,575 children with obesity and 9,174 overweight or obese compared with expected numbers had funding levels been maintained (202). Figure 3.33 shows the relationship between deprivation and obesity in Year 6 children in Lancashire and Cumbria.

Figure 3.33. Percentage of year 6 pupils who are overweight (including obesity), by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2019/20

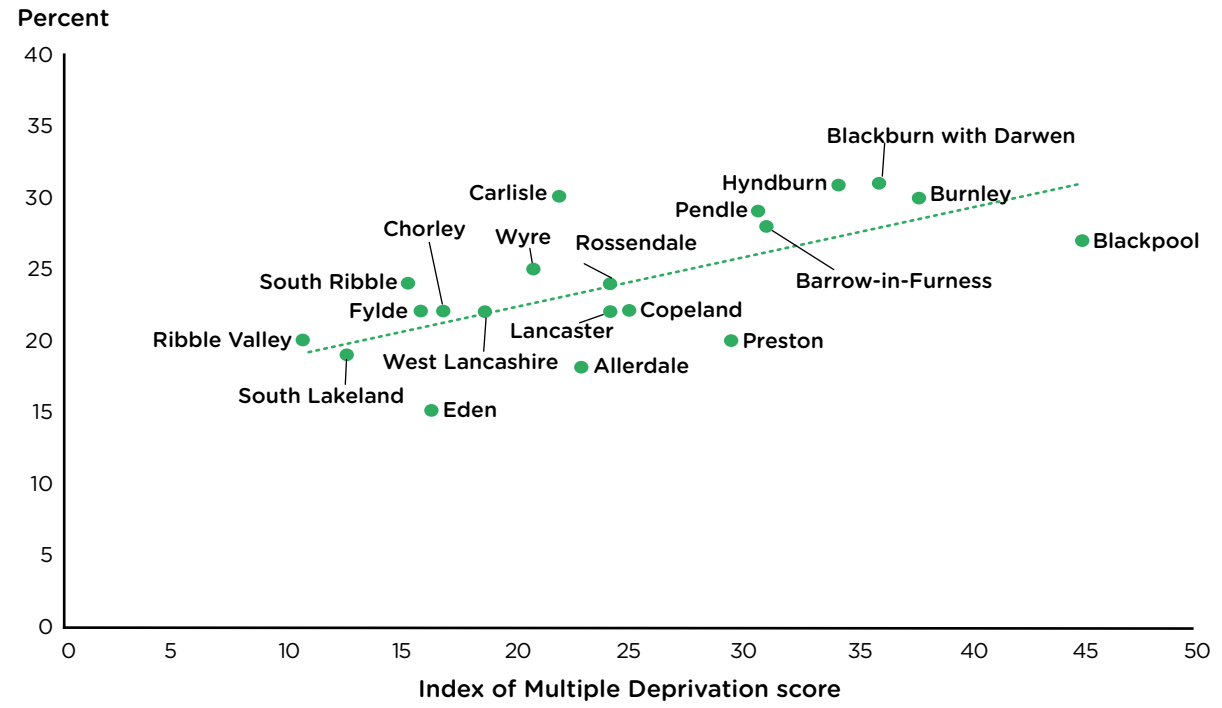



***Notes:*** *Wyre data not available.*

***Source:*** *NHS Digital, National Child Measurement Programme (203)*

Figures 3.34 and 3.35 show that in more deprived areas, rates of physical activity and good nutrition, are lower. Both are risk factors for obesity.

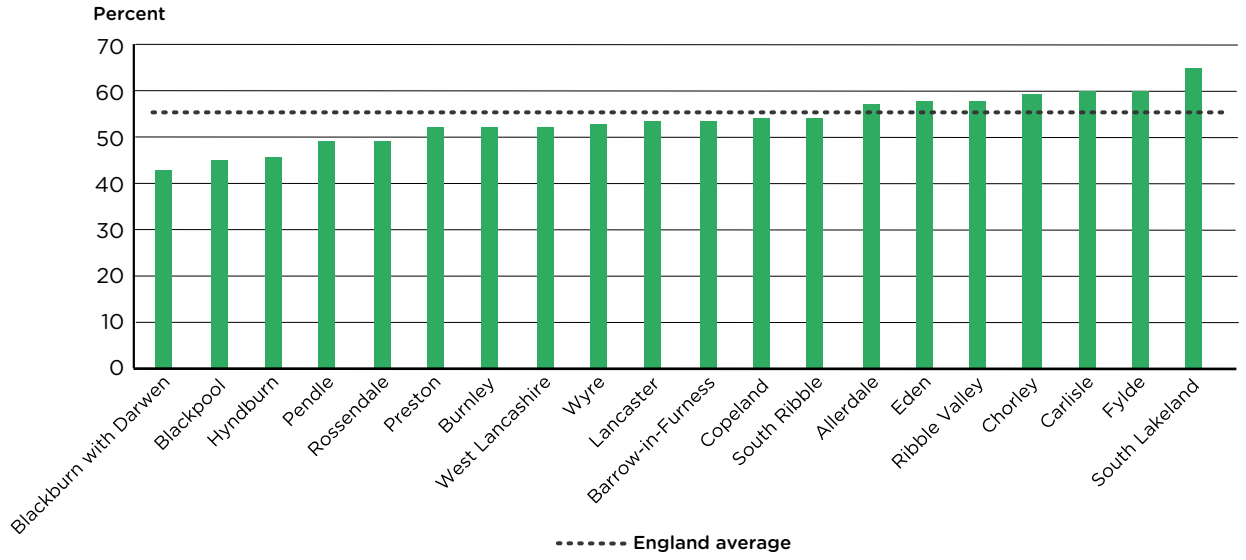
Figure 3.34. Percentage of physically inactive adults, by level of deprivation (IMD 2019), Lancashire and Cumbria local authority districts, 2019/20




***Source:*** *Public Health England (based on the Active Lives Adult Survey, Sport England) (197)*

In England, eating healthily is unaffordable for many families and individuals. The Food Foundation analysed price data for 94 healthy and unhealthy foods and drinks (using categories developed by the Food Standards Agency) in each year between 2007 and 2017 and found the average price of healthy food was more expensive than unhealthy food (204). Households with the lowest decile income would need to spend close to three-quarters of their disposable income on food to meet the guidelines in the NHS's Eatwell Guide, compared with only 6 percent of income for households in the richest decile (204). Recommendations to eat healthily will be ineffective for poorer households who simply cannot afford to eat healthily. A study of over 600 adults in North West England in 2019 examined the relationship between obesity and food insecurity (lack of stable access to nutritious food) and found people who were more food insecure tended to have a higher body mass index, which was explained by greater stress and coping with stress through eating and consuming poor nutritional food because it is cheap (205).

Figure 3.35. Adult population meeting the recommended 'five-a-day' fruit and vegetable portions on a 'usual day', percentage, Lancashire and Cumbria local authority districts and England, 2019/20




***Source:*** *Public Health England (based on Active Lives, Sport England) (197)*

## DIGITAL EXCLUSION

Digital exclusion is what occurs when an individual does not have access to the internet or digital technology – or will/cannot access it. Those who are the most in need of support, such as older people and those on the lowest incomes, are the least likely to engage with digital platforms (206). The cost of access to the internet is also a barrier, with devices and the cost of sufficient, private and secure mobile or broadband data being out of the financial reach of many in the UK. Ofcom estimated that 4.7 million UK homes struggled to afford their telecoms bills in 2019 (207).

Digital exclusion is important to consider as internet access has become an increasingly significant factor in the wider determinants of health. Employment, education and lifelong learning, social participation and community life, housing and the built environment, and access to health and healthcare can all be negatively affected by a lack of digital connection (207). Digital exclusion is linked with other forms of inequalities. Sixty percent of those without basic digital skills have no qualifications, 57 percent are aged over 65, and 49 percent are disabled (208). The COVID-19 pandemic particularly showed the importance of digital platforms, as healthcare, education, and social interaction moved online, as well as revealing persistent inequalities in access to technology (209). This has had impacts on young people's education and has made it more difficult to access GPs, particularly for older populations (210).

As such, those who are already facing increased levels of deprivation may be pushed into worse deprivation and higher rates of poverty as it becomes more difficult to navigate banking, education, employment healthcare or social interaction without access to technology and the internet. It is crucial that new barriers are challenged immediately (211). Digital healthcare and 'behaviour change' apps are often seen as a solution to health inequalities and managing demand in the NHS. Without attention to digital exclusion, digital solutions can widen health inequalities

## DEVELOPING EQUITABLE PREVENTION APPROACHES

There are widespread inequalities in health behaviours in Lancashire and Cumbria, which require effective action on the social determinants of health. Providing information or services to support smoking cessation or weight management, while vital, are not going to address the drivers of those behaviours. There is increasing focus on the importance of healthcare to 'do' prevention in order to reduce demand on services and to improve health, but to be effective prevention must encompass action on the social determinants. Many of the required mechanisms and system changes that are required for embedding these approaches are set out in Section 4.

In Fleetwood, Lancashire, there has been a 'quiet revolution', where there has been a focus on disadvantage and the types of 'healthcare' interventions needed to improve conditions in which people are living. Box 20 outlines this approach and shows how a number of organisations are working together to reduce inequalities, and are seeing positive impacts. This type of partnership working is recommended across Lancashire and Cumbria.

## Box 20. Healthier Fleetwood

Fleetwood is an area of widespread social disadvantage and life expectancy is lower than the average for England. In Pharos ward, life expectancy is 76 years for women (England: 83 years) and 74 years for men (England: 79.8 years), while healthy life expectancy is 55 years for men and 56 years women, compared with the English average for both men and women of 63 years (136). Fifty-three percent of Fleetwood's population are in England's most deprived quintile.

In 2016 local healthcare services in Fleetwood were struggling. There was a severe shortage in GPs, with the three GP practices missing half of their 16 GPs. This staffing crisis, and the need to address local health inequalities, prompted one local GP, Mark Spencer, to reach out to local partners to establish a cooperative solution. It was agreed that mobilising partnerships and working collaboratively offered the best chance of success, so Fleetwood, a strong partnership of residents, healthcare providers, local government, housing organisations, the VCFSE sector and other groups, was established.

The GPs have moved from managing illnesses to helping people to improve their lifestyles and preventing illnesses from developing. The partners meet weekly and work collaboratively, making it easier to identify who is needed to solve problems – for individual residents and the community as a whole. Healthier Fleetwood has had many successes in supporting positive changes in the town. Partners have listened to residents and worked to facilitate activities that enable them to improve their health and wellbeing. Activities connect people, address social isolation, improve diet, increase physical activity and promote better community cohesion. GPs have extended the surgery room to work with residents in community wellbeing projects. The local Health and Wellbeing Centre organises events such as free sports lessons, mental health support classes and drop-in sessions to engage residents with new programmes. Over 100 clinicians, including GPs, nurses and mental health teams, now work together to support Fleetwood residents in a range of areas from mental health to drug abuse. Local schools are also partners, providing mental health support and, after listening to parents, including more actions to build resilience and ambition in Fleetwood's school children.

Residents were central to the creation of Healthier Fleetwood and they continue to be active partners – residents chair and organise the scheme. In the initial meeting, local residents were asked what mattered most to them. Involving residents has made the initiative sustainable. Putting local residents in charge of their own communities and working together to design services appropriate to their needs gives residents a sense of ownership and creates a system with longevity at its core.

Mark Spencer says: 'This work doesn't take seven-to-eight months, it takes seven-to-eight years', yet the Fleetwood practices did see immediate impacts: in 2017/18 they had the worst rates for A&E attendance in the CCG but within the year these rates had dropped by 21.3 percent, 11.7 percent and 18.5 percent across the three practices.

When asked if Fleetwood could be implemented elsewhere, the local stakeholders spoke of 'replicating' but not 'scaling up'. Being able to work in smaller areas allowed partners to really get to know each other, to develop trusting relationships, and to be able to know 'who to contact to get things done'. Overall, they emphasised that it was essential for stakeholders to really listen to what local residents wanted and needed, and what was stopping them from living their best possible lives. A recent meeting with local residents highlighted the lack of opportunities for further education. Once people left school, many at age 16, there were no local places to go for training or further education. Healthier Fleetwood partners listened and then took action to provide further education in Fleetwood.

Healthier Fleetwood is a ground-breaking approach and it is increasingly being recognised around the world for its willingness to listen and change the practice and for the differences these changes are making to the health and wellbeing of Fleetwood's residents (212) (213) (214).

Social prescribing is one way the NHS can help to address the social determinants of health. It can be an effective support for important influences on health such as access to financial services, support for housing issues, access to community groups and VCFSE sectors. Non-clinical issues are estimated to take up at least one-fifth of GP consultation times. As such, outreach advice services within GP services can help reduce pressures on healthcare providers and improve patient care. Three-quarters of GPs stated that help from advice agencies has a positive effect on a patient's health and wellbeing (1).

In many areas, social prescribers and health and wellbeing coaches work in partnership with general practice, providing support for ill health prevention with a strong focus on equity. The Health and Wellbeing Coaches (HAWC) in Cumbria continued to work during the pandemic, providing links to support and services, Box 21.

## Box 21. Improving health and wellbeing with communities in Cumbria

The Health and Wellbeing Coaches (HAWC) team have been operating across Cumbria since 2017, their primary focus being to reduce health inequalities. Each HAWC works to an identified geographical area with focus being placed on those areas in the first to fourth deprivation deciles.

HAWCs support individuals by building rapport and trust with them through one-on-one coaching, helping to make changes to their lives that they may feel unable to do without support. All of the HAWCs undertake a 12-month advanced diploma in Health and Wellbeing Coaching. This ensures they have an appropriate level of knowledge and access to a range of coaching methods.

HAWCs continued to operate during the COVID-19 pandemic. Between April 2020 and March 2021, the HAWC team supported 1,194 people across Cumbria. For those people that engaged with a full HAWC assessment, 85 percent reported having mental health issues that in the last year had affected their lives daily, 45 percent were in debt, and 22 percent were in fuel poverty. As a result of the services offered, 68 percent reported an

improvement in their overall wellbeing, 59 percent improved their depression, 23 percent reported managing their finances better, and 18 percent reduced their alcohol intake.

The pandemic forced the service to change their delivery. As many of the service users who were being supported prior to the pandemic were already lonely, isolated and presenting with complex issues, ceasing contact was not an option. The team adapted by taking much of their service online, completing welfare checks on existing service users, developing online groups, webinars, online video calls, podcasts and continuing to maintain contact through telephone calls. HAWCs contacted individuals who had been supported within the previous 12 months to ensure the pandemic did not impact the progress they had made.

The HAWCs team reviewed its delivery model and in 2021 introduced the role of Health and Wellbeing Officers to work alongside those service users with low-level needs or requiring minimal support to maintain their progress. This enabled the HAWCs to work with those with greater needs. In February 2021, as part of the NHS Winter Pressures funding, HAWC supported people on acute mental health wards in Carlisle and Copeland to facilitate discharge and resettlement back into the community. From February 2021 to March 2022, HAWCs supported 110 people through hospital discharge and resettlement. The long-term impact of this work on reducing readmissions to hospital is currently being reviewed by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

## RECOMMENDATIONS. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

**a)** HCP and ICS review social social prescribing offer to ensure it is addressing the social determinants of health.

**b)** Adopt the Fleetwood and Deep End models to address the social determinants of health in primary care.

**c)** Include digital inclusion as an essential health equity requirement, and ensure that healthcare, local authorities, education and businesses work in partnership with local residents to invest in digital skills, including provision of funding to the VCFSE sector to support this.

- Prioritise improving skills in older people or alternative accessible services.
- Align local poverty strategies to include commitment to reducing digital exclusion.
- Work in partnership with local communities to assess digital exclusion priorities.

**Leads:** Local authorities, NHS

### NATIONAL ADVOCACY

- Advocate for a real-terms percentage increase in the regional budget for public health and overall funding for Public Health to be at a level of 0.5% of GDP.
- Strengthen accountability for health inequalities across all NHS organisations.

# 3G TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

**KEY MESSAGES**

- The pandemic revealed the stark inequalities in health and economic and social disadvantages in many of the UK's ethnic minority communities.
- These disadvantages are partly related to experiences of exclusion, racism and discrimination.
- Many ethnic minorities experience multiple exclusions linked also to gender and disability with cumulative damage to health – physical and mental.
- Rates of some diseases and infant and maternal mortality are higher in ethnic minority populations and access to, experience of, and outcomes from health services can also be worse for ethnic minority populations.
- Data on ethnicity is lacking in many key social determinants of health in the region so it is hard to monitor inequalities but there is much that employers and providers of services can do to reduce discrimination and inequalities.

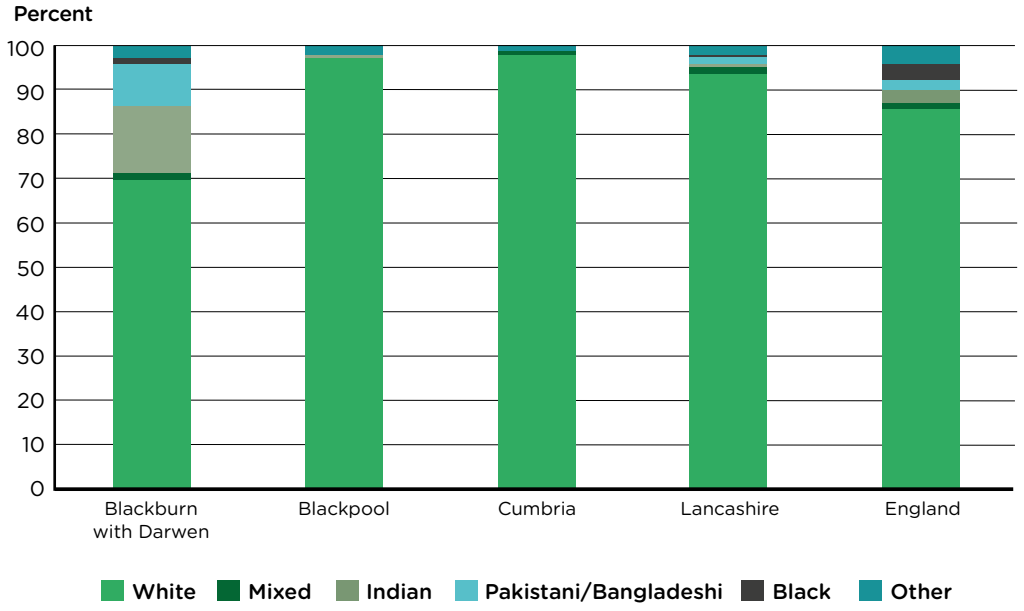
The pandemic revealed the stark inequalities in health and economic and social disadvantages in many of the UK's ethnic minority communities and including these dimensions in programmes to reduce health inequalities and inequalities in the social determinants is vital (2). Evidence is needed to better understand the variation between and within ethnic groups, particularly in areas with smaller ethnic minority populations. People from ethnic minority groups experience inequalities in health outcomes and access to – and experience of – health services compared with white groups.

At the height of the pandemic the diagnosis rate of COVID-19 per 100,000 population for black males was nearly three times that of white males. People of Chinese, Indian, Pakistani, other Asian, Black Caribbean, and other black ethnicity had between 10 and 50 percent higher risk of death from COVID-19 compared with the white Population (215). Much of this is attributed to the conditions in which people work and with living on low incomes. Structural racism is also a factor, as some ethnic groups are more likely to be exposed to adverse social and economic conditions than others (216) (217) (218). Public Health England reported how frontline workers from ethnic minorities were given inadequate levels of personal protective equipment (PPE) for their risk of exposure and that the individuals affected did not speak up because of fear of adverse treatment (215).

Prior to the pandemic, life expectancy at birth was higher among ethnic minority groups than for white groups. However, this sole metric conceals the bigger picture. Compared with the white population, disability free life expectancy is estimated to be lower among several ethnic minority populations and rates of infant and maternal mortality, cardiovascular disease and diabetes are higher among black and South Asian ethnic populations; people from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than the white British population. (217).

Figure 3.36 shows that Blackburn with Darwen is more ethnically diverse than England as a whole, while in some other parts of Lancashire and Cumbria, ethnic minorities are very small.

Figure 3.36. Ethnicity, percentage, Lancashire and Cumbria upper tier local authorities and England, 2020




***Source:*** *Office for National Statistics (219)*

Blackburn with Darwen's submission to the HEC reflected on their large percentage of people from ethnic minority populations, and that these groups are more likely to live in deprivation and have inequalities in access to services. However, there is a lack of available data about the inequalities in access to health outcomes and the inequalities in health outcomes experienced by ethnic minority populations. Efforts to improve the collection of ethnicity information in NHS records is welcome.

The Blackburn with Darwen HEC submission suggested:

- Reinforcing the efforts of health and social care providers to facilitate equitable access to their services.
- Imposing a duty on all Lancashire and Cumbria businesses, local authorities and public authorities to gather data on their workforce by ethnicity and by pay and grade, and to use this data to address wage gaps and inequalities in employment levels.
- Creating partnerships between police and communities and improving training to provide police officers with practical skills to interact with communities.
- All businesses, public and the VCFSE sector to ensure equality duties are met in recruitment and employment practices, including pay, progression and terms.
- Ensuring effective engagement with all ethnic minority populations and involving communities and community leaders in the development of services and interventions. Ensuring there is critical feedback and evaluation with involvement from ethnic minority populations.

## RECOMMENDATIONS. TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

**a)** Local economic partnership and chambers of commerce to work with Lancashire and Cumbria businesses, the NHS local authorities and public authorities to gather ethnicity data by pay and grade, and to use this data to address wage gaps and inequalities in seniority.

**b)** All businesses, public sector and VCFSE sector organisations to ensure equality duties are met in recruitment and employment practices, including pay, progression and terms.

**c)** Reinforce the efforts of health and social care providers to ensure equitable access to their services.

**d)** Ensure effective engagement with all ethnic minority populations in the development and delivery of services and interventions.

**Leads:** Local economic partnerships, NHS

### NATIONAL ADVOCACY

- Implement actions in NHS to ensure recording of ethnicity data occurs and act on this data and there are regular equity audits.
- Ensure that reports of racism in all sectors are investigated and changes made.

# 3H PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

**KEY MESSAGES**

- Tackling climate change and health inequalities in unison is vital so efforts to reduce health inequalities do not damage the environment and efforts to improve the environment do not damage equity.
- Harm to health from climate change will affect more deprived communities the most.
- There are predictions of significant environmental change in the North West including increasing temperatures, reduced summer rainfall and more extreme weather events and flooding.
- There are high levels of greenhouse gas emissions in some districts in the region, notably Eden and Ribble Valley.
- Transport is the largest contributor to the UK's poor air quality. Supporting public transport and active travel and reducing private car will improve air quality and improve health.
- There are many interventions which are beneficial to the environment and beneficial to health – home insulation, increased active and public transport and reduced meat consumption among them.

Tackling climate change and health inequalities in unison is vital to creating a just and sustainable society for all future generations (1) (220). Climate change directly and indirectly impacts on physical and mental health and inequalities. The direct impacts of climate change on physical and mental health include: effects due to longer exposure to extreme heat/cold and UV radiation, more pollen, flooding and associated water-borne diseases and other impacts from extreme weather events. The indirect impacts of climate change on health and inequalities include: increases in the price of food, water and domestic energy and subsequent increases in poverty, unemployment and anxiety.

As the climate warms and precipitation increases, harm to health from climate change impacts will increase and, in the future, will affect people who live in the most deprived areas the most (221). Climate change impacts population health, wellbeing and inequalities – both directly and indirectly. Residents living in the most deprived areas are among the most susceptible to the effects of climate change and extreme weather events and as such, climate change has the potential to widen existing health inequalities within the UK (221).

It is estimated that, under a medium greenhouse gas emissions scenario, in the 2080s the climate of the North West will see: average summer temperature increasing by 3.7 degrees; 21 percent less rainfall in the summer, which will make subsidence more likely, affect crop yields and cause water stress; and 16 percent more rainfall in the winter, leading to higher flooding risk (222).

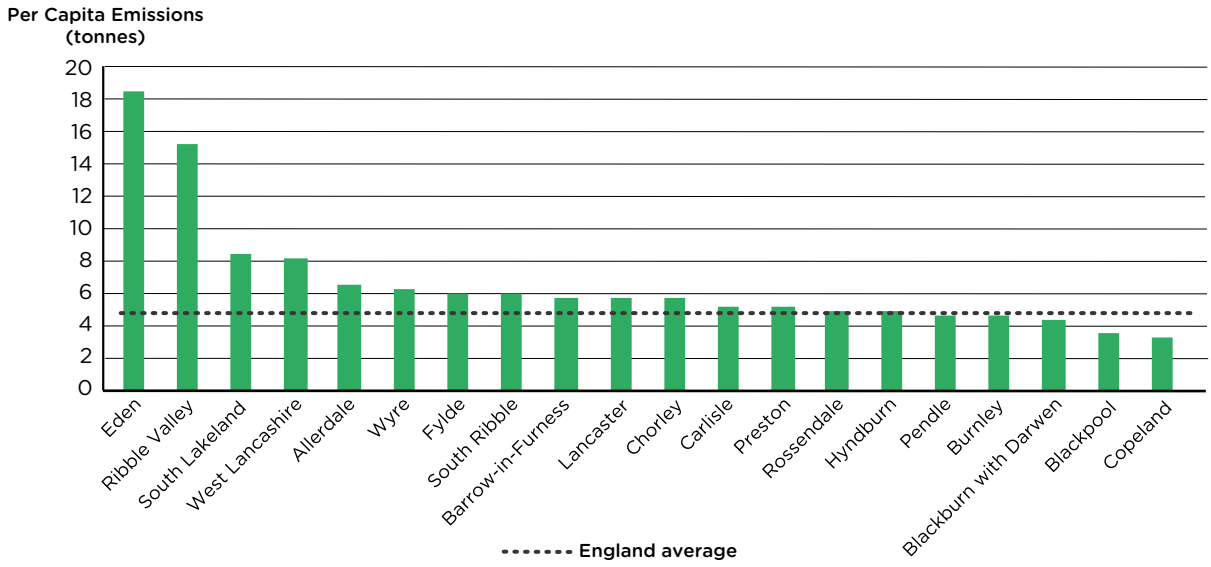
Many interventions to reduce health inequalities will alleviate or mitigate the impact of climate change too, such as improving quality of homes, reducing fuel poverty and improving public transport systems and active travel rates. There are opportunities to address inequalities and not only protect low-income households but to use these actions to reduce poverty and inequalities (223).

There are many short- and long-term benefits to health of mitigating climate change: many of the actions to reduce greenhouse gas emissions will not only improve health, but will also reduce existing health inequalities:

- Shifting away from cars and vehicles to active travel will reduce greenhouse gas emissions, improve physical activity levels and reduce local air pollution and reduce costs.
- Shifting to eating less meat will reduce greenhouse gas emissions associated with food production and transportation and reduce levels of obesity, cancer and cardiovascular disease, and will also reduce local air pollution.
- Insulating homes improves housing and reduces negative health impacts and reduces greenhouse gas emissions and energy costs (224).

In 2019, the North West region has the second highest level of carbon dioxide emissions in England, second only to the South East region. Nonetheless, since 2005, total emissions and emissions per capita have fallen in the UK. Eden has the highest per capita emissions in the region but also the lowest population density of all local authorities in England (Figure 3.37).

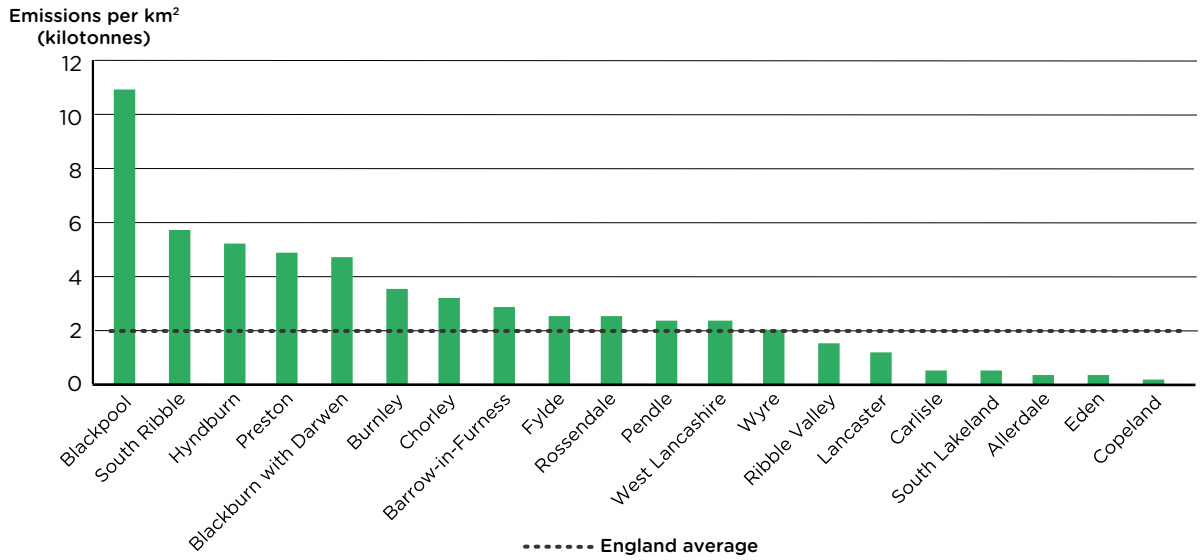
**Figure 3.37. Carbon dioxide emissions per capita (tonnes) in Lancashire and Cumbria local authority districts and England, 2019**




***Source:*** *Department for Business, Energy & Industrial Strategy (225)*

Emissions per kilometre squared are usually higher in urban areas and those with large industrial sites. Figure 3.38 shows Blackpool has the highest emissions per square kilometre in the region.

**Figure 3.38. Carbon dioxide emissions per km2 (kilotonnes) in Lancashire and Cumbria local authority districts and England, 2019**




***Source:*** *Department for Business, Energy & Industrial Strategy (225)*

Lancashire and Cumbria have taken a number of actions to mitigate the impacts of climate change. In 2019 Cumbria County Council and all six district councils and the Lake District National Park Authority formally adopted the Cumbria Joint Public Health Strategy with the aim of being a carbon-neutral county.

However, other actions taken in the region could potentially increase greenhouse gas emissions. A proposed new coal mine in Cumbria contradicts the advice of the Climate Change Committee which states the UK must stop burning coking coal by 2035 in order for the UK to meet its climate targets. Planning permission will be decided in July 2022 (226).

The Greater Lancashire Plan (GLP) explored three pathway scenarios for carbon reduction and concluded that even if all the emissions reduction interventions available to Lancashire came into effect, Lancashire would not achieve net-zero emissions by 2030 because

of high emissions from the transport and industrial sectors (In 2020 Lancashire County Council agreed it would meet its net zero targets by 2030, before the UK target, set for 2050) (227). In Lancashire most commuter journeys are made by private vehicle (69 percent). Only 7 percent of commuters travel to work using public transport (228). Therefore, interventions are needed to encourage walking, cycling, public transport access and use and demand reduction, and more provision for vehicle battery charging.

Lancashire's housing stock is inadequate, with poor insulation linked to high carbon dioxide emissions, fuel poverty and poor health outcomes. More than a quarter, 27 percent, of CO2 emissions in Lancashire result from the domestic sector and the GLP Environmental Commission states that retrofitting existing properties with insulation, double-glazing and so on would not only improve standards, but would also improve health and wellbeing and reduce inequalities (228). Improving a home's rating from energy performance band D to band C would reduce heating demand by approximately 20 percent, saving customers 20 percent on their heating costs (158). Not only would these interventions save households, making all homes energy efficient could create substantial savings to the state. The Warm Home Discount costs £350 million per year, Cold Weather Payments £98 million per year and the Winter Fuel Payment £1.9 billion per year, totalling around £2.3 billion.

The Commission has stated that large-scale interventions are also needed in large industrial installations, and carbon removal interventions such as peatland restoration and tree planting. However, many of the interventions to improve housing have been cut. Insulation rates peaked in 2012 but in 2013 financial support for insulation programmes from central government was cut and installation rates fell by approximately 90 percent (158). The Climate Change Committee stated, in 2019, installation of loft and wall insulation is at just 5 percent of peak market delivery in 2012 (229). The loss of insulation programmes also led to thousands of job cuts (230). In terms of green recovery, home insulation jobs are more cost effective, a home insulation job can be created for £59,000 whereas a road maintenance job is to cost more than £250,000 (231).

The Homes Upgrade Grant and Social Housing Decarbonisation Fund supports households on the lowest incomes to improve energy efficiency however there is no national programme for those classified as 'able-to-pay'. 92 percent of owner occupiers have no policy coverage at a national level, 18 percent of these owners live in homes that do not meet the Decent Homes Standard set for social housing. As cost of living rises, many households are unlikely to have the disposal income needed to invest in repairs and energy efficiency without any government support (150).

Box 22 outlines a retrofitting service in Lancaster which has expanded from offering statutory services for care and repair to improving housing conditions with the aim of reducing both excess winter deaths and greenhouse gas emissions.

## Box 22. Improving the quality of homes and reducing greenhouse gas emissions in Lancaster

The Home Improvement Agency (HIA) based in Lancaster City Council's Housing Services is dedicated to helping all older and disabled residents live safely and with dignity in their own homes and their actions are also improving the energy efficiency of housing in Lancashire. The agency is formally recognised by Foundations, the government's body for HIAs, and provides Care & Repair type services throughout the Lancaster district. The city council has delivered HIA type services since 2000 and has won a number of national awards, including the 2020 UK Housing awards for 'Innovative Service' and the 2021 National Healthy Homes Awards for 'Disabled home adaptations service of the year'. During 2020/21, 262 council homes benefited from energy efficiency measures, with 220 having new boilers fitted and solar panels installed on a further 42.

The HIA service integrates the delivery of both major and minor adaptations, aids and equipment into one service, placing the client at the centre of the adaptation process. The council's £2 million annual Disabled Facilities Grant (DFG) programme is delivered by the HIA without waiting lists, with all cases dealt with as priority. Over 60 percent of current DFGs are generated proactively by the HIA with all clients. The average completed DFG remains well below the national figure and all minor adaptations are completed in-house, typically within seven days. Patients being discharged from hospital are provided with a fast-track service, with many urgent works being completed the same day. Despite cuts to funding for HIA services, the HIA has been able to sustain all these core services free of charge and to continue to integrate them within the DFG programme.

The HIA is currently in discussion with the local college, which is developing courses to train installers to fit renewable energy solutions. The HIA has offered the services of the Retrofit Officer to provide training to students as part of the course and is exploring the possibility of recruiting and training in-house renewables installers, who will be based within the HIA and be capable of installing air source heat pumps, solid wall insulation and solar installations in the future.

## RECOMMENDATIONS. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

**a)** Ensure that the health and wellbeing of citizens and environmental sustainability is the basis of all local economic policy.

**b)** Deliver a five-year plan to retrofit homes, including private homes, to reduce fuel poverty and improve domestic energy efficiency in homes in areas of high deprivation.

**c)** Local economic partnerships and anchor organisations to support actions to adopt carbon-neutral modes of transport to work environments including investments in in green bus transport and improved active travel rates in all areas of Lancashire and Cumbria.

**Leads:** Local economic partnerships, local authorities, NHS

### NATIONAL ADVOCACY

- 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Align health and climate goals, to transition away from carbon and build resilient communities that are well adapted to respond to climate change impacts.

CHAPTER 4

# THE HEALTH EQUITY SYSTEM IN LANCASHIRE AND CUMBRIA

**To reduce health inequalities, it is essential to have systems in place that support the required activities and have stakeholders working together collaboratively.**

**KEY MESSAGES**

**A focus on equity and the social determinants of health in healthcare involves:**

- Increased and more equitably distributed resources.
- Strengthened partnership working.
- A greater role for businesses and the economic sector in supporting greater health equity and extending the ambition and actions of anchor institutions and social value approaches.
- Involvement of communities and the VCFSE sector as essential partners in the identification of priorities, the development of strategies and the delivery of programmes.
- Strong, accountable and identifiable leadership on health equity within organisations and a workforce that has the resources and capacity to take action.
- Development of a monitoring system that can indicate inequalities in the social determinants and health and is based on regularly reported, robust data systems.

Lancashire and Cumbria have a lot to do in this area, as currently organisations and sectors are quite separate from one another and health equity has not been taken forward as a priority across the system. Submissions to the Health Equity Commission suggested frustration with this situation; they emphasised the need for systems change, to stop 'talking' and to start 'doing', for learning from the partnership and actions achieved during the pandemic, and to stop doing what has been done before in the hope that inequalities will 'somehow' disappear. One of the most repeated comments was the need for stronger partnerships between the NHS and local government and with the VCFSE sector and communities. There was a sense of enthusiasm, that the time is now, that the pandemic had revealed the stark inequalities in society and stakeholders in Lancashire and Cumbria want systems change.

The following quotes from submissions are indicative of the mood:

> *Right now we all tolerate, and in some ways reproduce, the inequities that prevail [...] if we don't improve health equity we have failed.*
>
> *Do what we did during COVID-19 with the homeless, rip up the rule book, forget criteria and putting hurdles in place to access services. Listen and harness those with lived experience.*
>
> *Stop writing plans which are never implemented. There are lots of very good strategies with no action plans and no one taking ownership of the work required.*

This section of the report sets out the essential components of a health equity system for the region. The proposals are based on analysis of effective action in other local and national systems, as well as evidence gathered during the HEC. Given the required action on social determinants of health, a health equity system must encompass all the stakeholders across the region – the VCFSE, businesses, public services, local authorities and communities themselves. The title of this report reflects the many submissions to the HEC: that this work must provide a sense of hope that together the system can make improvements.

The approach advocated in this report and in the recommendations is centred on the objective of greater health equity and action on the social determinants but it is worth additionally clarifying the effectiveness of this approach and the financial case for it. As we have set out, ill health, avoidable mortality and hospitalisations are all much higher in more deprived area - reducing inequalities in the drivers of these inequalities will significantly reduce demand on services.

# 4A FOCUS ON EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN HEALTHCARE

**KEY MESSAGES**

- There is far more that healthcare services can do to reduce health inequalities and support action on the social determinants of health.
- Action from healthcare organisations must focus on the whole gradient, in a proportionate way, and on the social determinants. Reducing inequalities in access to healthcare is important but will not reduce the widescale inequalities we report on here and in other reports.
- There is a financial, as well as moral case, for the NHS to reduce health inequalities. Areas with higher deprivation have higher healthcare needs, and as a result, higher healthcare costs.

**THE ROLE OF THE ICS**

- Both ICSs in the region have a focus on reducing healthcare and population health but need to further strengthen action on the social determinants and build strong partnerships with local government, public services and the VCFSE sector and work with businesses.

**NHS TRUSTS**

- NHS Trusts can also strengthen action on the social determinants, extending activity beyond the usual anchor approach into collaborations on the social determinants with local government, public services, the VCFSE sector and employers.
- Social value is important in all procurement and contracting.

**PRIMARY CARE**

- Primary care is well placed to take action to improve health and reduce health inequalities through action on the social determinants and contributing to improving conditions in which people are living and preventing ill health.
- This can include access to services supporting better housing, support with debt and access to benefit entitlements, referrals to skills and training for employment.
- Social prescribers and Citizens Advice have been involved in many GP surgeries and across primary care but there is scope to do much more.
- GP practices serving areas with high levels of deprivation receive around seven percent less funding per patient than those serving more affluent populations and funding needs to be further weighted and adjusted to need.
- Many GP practices in more deprived areas face significant recruitment and staffing issues. Training and employing local populations may help and offering higher levels of pay in more deprived areas.

**ACCOUNTABILITY FOR HEALTH INEQUALITIES WITHIN THE NHS**

- Strengthened accountability within healthcare for health inequalities is essential. Accountability in the healthcare system is mostly related to specified targets around access to services.
- National NHS targets, which drive activity and priorities, do not include a wider assessment of the impact of policies on inequalities.
- Currently, in the region accountability for health inequalities is described as 'toothless'.

**As we have set out throughout the report, taking action on the social determinants is a cross sector, all of society endeavour. The agenda involves the VCFSE sector, early years services, transport, housing, leisure, education, criminal justice, public health, communities, businesses and the economic sector and many others.**

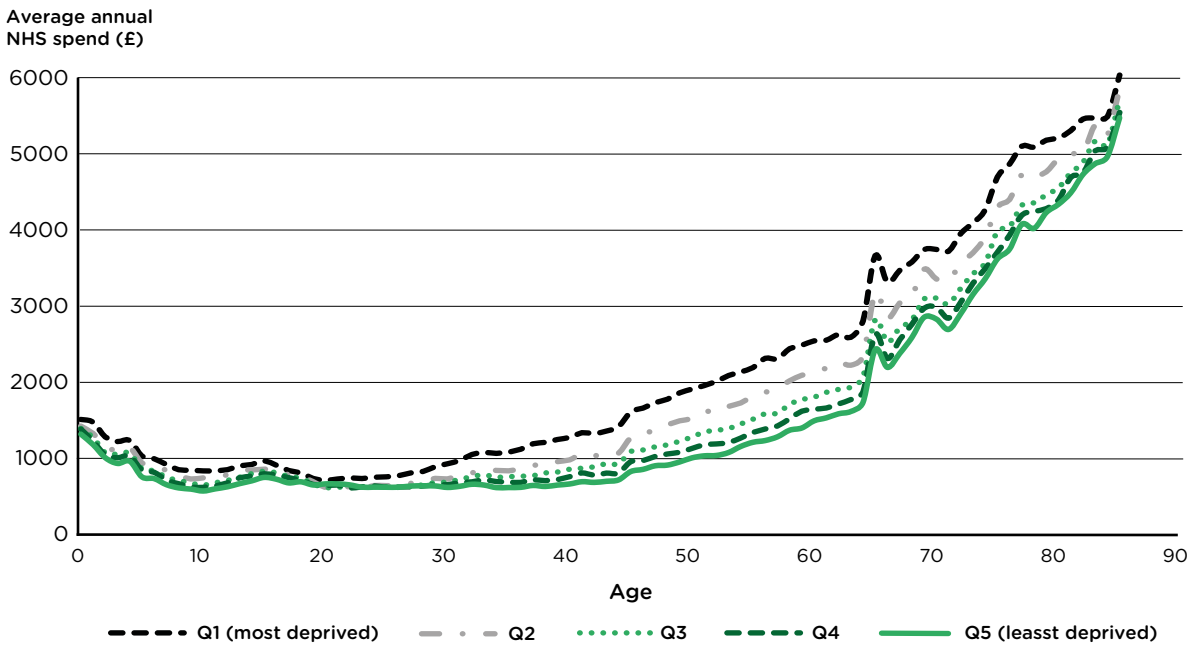
These sectors all have responsibility for important social determinants of health. But there is still far more that healthcare services can do to reduce health inequalities and support action on the social determinants of health. An assessment in five CCGs in England concluded local NHS leaders should stop looking for 'simple, cheap interventions to reduce inequalities in avoidable emergency admissions' as these are not to be found. Instead, 'long-term multifaceted interventions are required that embed inequality considerations into mainstream decision making' (232).

In 2016, researchers at the University of York calculated those socioeconomic inequalities cost the NHS acute sector £4.8 billion each year and that people living in the most deprived 20 percent of neighbourhoods had 72 percent more emergency admissions and 20 percent more planned admissions than those living in the most affluent 20 percent of neighbourhoods in England (233).

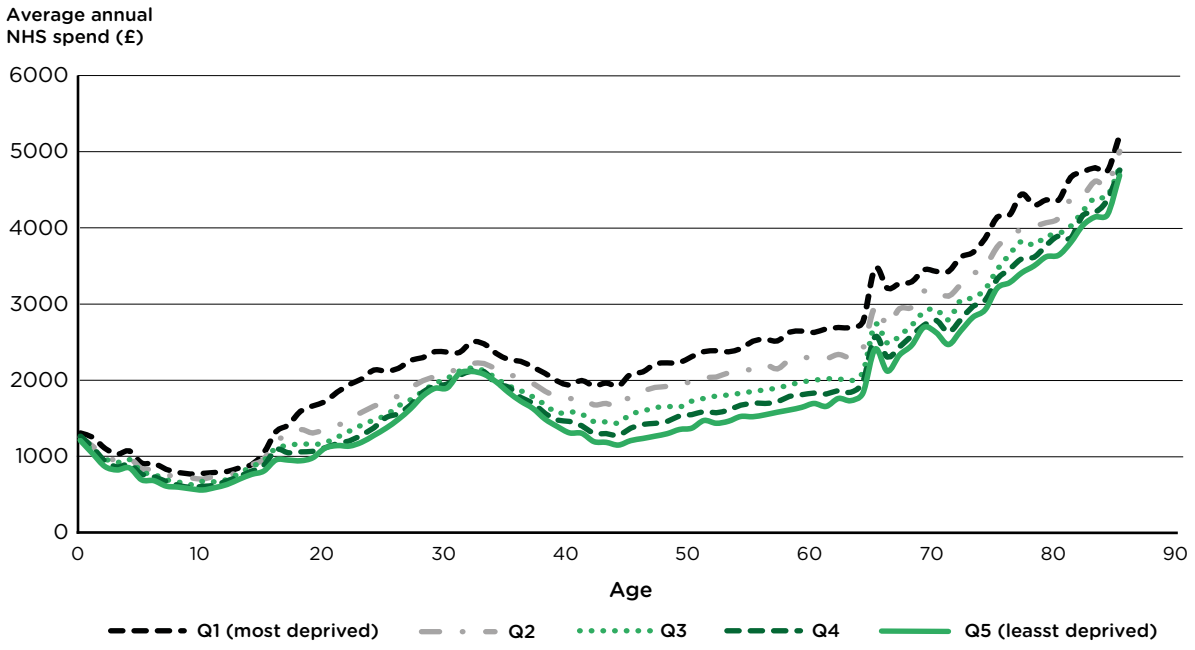
The IHE 2010 and 2020 reports outlined the financial costs of health inequalities. Figure 4.1 outlines the average additional annual NHS spend in each neighbourhood deprivation quintile compared with spend in the least deprived quintile. For both women and men the NHS spends more in areas of highest deprivation at every age. The British Red Cross analysed frequently attendance at Accident and Emergency departments and found people who live in the most deprived areas were more likely to frequently attend, as incomes increased, those who frequently attended Accident and Emergency decreased (234). If those living in the highest levels of deprivation cost the NHS more, it is in the financial as well as moral and health interest of the NHS to contribute to reducing deprivation in order to reduce costs and reduce demands. They cannot do this alone, and must work with partners, such as employers and the VCFSE sector to increase incomes and reduce deprivation.

Figure 4.1. Average annual NHS spend, by age and neighbourhood deprivation quintile group, England, 2011/12

**A) FEMALES**




**B) MALES**




***Source:*** *Institute of Health Equity (1)*

In 2016 it was estimated for England that socioeconomic inequalities cost the NHS £4.8 billion. Women living in the areas of highest deprivation cost the NHS 22 percent more than women living in the least deprived areas (and men 16 percent more), even though they had shorter life expectancy (233).

IHE have previously set out the potential for healthcare to take action on the social determinants and proposed how to do this (235) (236). In consideration of healthcare organisations supporting better health in places we suggested healthcare organisations strengthen the following approaches:

- Focus on place
- Cross sector collaboration
- Focus on population health
- Act on the social determinants of health
- Proportionate universal approaches

In relation to how workforce can take action on the social determinants of health, IHE worked with 22 Royal Colleges and the British Medical Association and proposed the following five areas for improving the social determinants of health:

- Education and training
- Work with individuals and communities
- Healthcare organisations
- Working in partnership
- Workforce as advocates

Both reports contain further recommendations and practical ways for healthcare organisations to improve the social determinants.

While healthcare organisations are under enormous resource and demand pressures, there is limited capacity to make changes. However, the advent of ICSs, and the clear demand and financial case for reducing health inequalities mean that action is now more important than ever.

A similar case has been made by the British Red Cross' in their study of high intensive users of Accident and Emergency services which suggests three areas of action to reduce demand on A&E services:

- Providing non-clinical, specialist support.
- Improving access to community-based support so that people do not need to reach A&E.
- Taking action on the social determinants of health, to address the causes of the high intensity use, such as poor housing and low income (234).

Throughout Section 4 we refer to helpful actions from the healthcare sector to develop a significant role in the Lancashire and Cumbria health equity system. Meanwhile in recognition of the central importance of the NHS in tackling health inequalities, there has been an increased focus on reducing health inequalities from national NHS organisations. The most recent, Core20plus5 is described below, although it focuses more on inequalities in access to healthcare services than on the social determinants of health; which as we have set out are vital to improving health and reducing inequalities. The approach is also mostly focused on the most deprived 20 percent - we show that action is needed across the whole gradient in a proportionate way, Box 23.

### Box 23. The Core20plus5 approach

The NHSE 'Core20PLUS5' approach aims to improve equity of access, experience and outcomes for the most deprived 20 percent of the population in England in five clinical areas: maternity, severe mental illness, chronic respiratory disease, cancer and hypertension case-finding, with an additional focus on particularly excluded communities to be defined by local ICSs (237) (238). The Core20PLUS5 programme brings a welcome focus on health inequalities to the NHS. However, as it is so targeted at the most deprived segment of the population, there is a concern it will not lead to the much needed health improvements across the social gradient. The social gradient in health shows that it is not only those on the lowest income who have poor health: as incomes decrease and levels of deprivation decrease, health and wellbeing also worsen across all incomes, not only for the poorest 20 percent. There is also a concern that as Core20PLUS5 is focussing on clinical areas, it will pull attention, resources and capacity away from the social determinants of health just when they are most needed, due to the negative impacts of the COVID-19 pandemic (2).

In the remainder of this section we set out the opportunities to further develop a social determinants of health approach within the NHS and highlight some examples of innovative and promising practice in Lancashire and Cumbria.

## INTEGRATED CARE SYSTEM APPROACHES TO HEALTH INEQUALITIES IN THE REGION

The NHS Long-Term Plan encourages all sectors across the NHS to address health inequalities and take active action on ill health prevention and requires all local health systems to set out how they will specifically reduce health inequalities by 2023/24 and 2028/29. The formation of ICSs does provide an opportunity to embed effective social determinants approaches, and there is more focus now among NHS trusts, primary care and among the healthcare workforce on taking action on the social determinants. The HEC was commissioned from the Lancashire and South Cumbria healthcare system - illustrating the focus on reducing health inequalities and the responsibility they have in developing much greater action on the social determinants of health throughout healthcare system.

### NORTH EAST AND NORTH CUMBRIA ICS

The North East and North Cumbria ICS focuses its health inequalities efforts on four priorities:

- Improving outcomes in population health and healthcare.
- Tackling inequalities in outcomes, experience and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

Population Health and Prevention is one of the NENC ICS's priorities. The NENC ICS aims to maximise the NHS's efforts to improve ill health prevention by working at scale and in partnership with local authorities, the VCSFE sector and local communities. This is supported by a Health Inequalities Advisory Group who provide strategic leadership to the NENC ICS. The Advisory Group builds capacity and capability across the NENC, assists in interpreting data and intelligence and disseminates good practice and opportunities, all with the aim of embedding a health inequalities approach across the ICS.

The focus of the NENC ICS Population Health and Prevention programme is to take action on: tobacco for a smoke-free NHS in the region; harmful drinking and alcohol dependence; improving healthier weights and treating obesity; and adopting a public health approach in maternity services. As pointed out in Section 3F, however, without effective action on the social determinants, the ambition for reductions in health inequalities through health behaviours is unlikely to be met.

### LANCASHIRE AND SOUTH CUMBRIA HEALTH AND CARE PARTNERSHIP

In Lancashire and South Cumbria Health and Care Partnership (HCP) the Population Health Operating Model (PHOM), approved in November 2021, is intended towards the HCP ambition of reducing health inequalities. The PHOM provides the blueprint for how the NHS in Lancashire and South Cumbria intends to align its resources to work in partnership with others with the aim of improving 'the health and wellbeing of our population through the reduction in inequalities in the short-, medium-, and long-term' and reducing 'inequalities and achieve a radical improvement in health outcomes by focusing on population health at place and neighbourhood level'. By committing resources to this approach, the HCP has demonstrated ambition to work with partners on population health and health inequalities.

The PHOM is a systems-level approach with six strands (illustrated as hexagons), focusing on the actions needed to address the health and social inequalities in Lancashire and South Cumbria. The six strands/hexagons are:

1. **Population health intelligence and insight:** Ensuring the region has the best possible data and intelligence to provide local teams with the information needed about local residents and communities and the knowledge required to generate insights, mobilise the workforce and drive action.

2. **Core team, leadership and organisational development:** Creating the right conditions, culture and leadership upon which a population health approach can anchor and grow.

3. **Participation and empowerment of communities:** Drawing on the depth of knowledge, skills, capability and expertise and investing in the VCFSE sector and helping teams know how to use the best engagement and participation tools available to work with their communities to build a social movement for population health.

4. **Nurturing protective behaviours and tackling social and/or multiple vulnerability:** Building, local, flexible care and support models around the needs of residents and their community, particularly those experiencing social and/or multiple vulnerability. Aligning the right resource in each neighbourhood to ensure that the 'front door' through which people access the services gets them the right help, at the right time.

5. **Place-based interventions for health inequalities:** Building the capacity and capability to deliver evidence-based, place-based approaches, led by primary care clinicians collaborating with all key partners (including the VCFSE) within their neighbourhoods to tackle health inequalities.

6. **Research and return on investment:** The PHOM sets out intentions to work with academic partners to oversee a research and return on investment approach that will demonstrate impact at neighbourhood, ICP and ICS levels.

The HCP and associated ICPs have developed population health management strategies. At this stage, these strategies have not involved external partners and tend to focus on more traditional NHS prevention activities or lifestyle behaviours.

The success of the PHOM will depend on the partnerships created, across the NHS and outside, working with and funding the communities and partners who work on a daily basis with these communities such as public health departments, the VSFSE sector, businesses, local government, housing, education and the police. If the investment in the PHOM infrastructure is to add value to the existing multiagency system (those already working to reduce health inequalities within Lancashire and South Cumbria) and to ensure that duplication of effort does not occur, these partnerships must be on an equal footing and recognise the expertise of each partner.

In both NENC ICS and the LSCHCP ICS the focus on population health is welcome, but must be more geared around equity and the social determinants and designed and rolled out with the involvement of all partners, particularly public health, which has, in many cases, already developed highly effective social determinants of health programmes. Both ICS can take a leading role among healthcare organisations to support action on the social determinants as there are many examples of individual good practice in the region. However, most often these actions are not at the scale or intensity that is required for sustainable change. There must be a sustained focus on the social gradient in the region.

## NHS TRUSTS AND THE SOCIAL DETERMINANTS OF HEALTH

Many of the HEC recommendations should support stronger partnerships, particularly the focus on networks, a Health Equity Commissioner and systemwide mechanisms to achieve greater collaboration and coherence among partners for health equity. Trusts in Lancashire and Cumbria, have expressed an interest in developing and extending their work on the social determinants of health. In support of that focus, we propose the establishment of a Marmot Trust Network in the region with strong links to other trusts across the UK that are extending their actions on the social determinants with their own workforce, with patients and through their impacts on the social determinants. (see example in Box 24).

### Box 24. Addressing the social determinants in health in East London Foundation Trust

The East London Foundation Trust [ELFT] is embedding a social determinants of health approach and is developing action that will improve social determinants of health for its own workforce, its patients and the communities in which it operates. The Trust sees these approaches as preventing ill health and reducing the demand for its services as well as reflecting its mission to improve health and reduce health inequalities. ELFT is the first 'Marmot Trust' in England. ELFT serves some of the most deprived boroughs in the country, with high rates of children living in poverty and many overcrowded households as well as small pockets of rural poverty (Central Bedfordshire). The pandemic highlighted the impact of inequalities and social injustice on ELFT's communities.

ELFT provides mental health, community health, primary care and inpatient services to children, young people, those of working age and older adults across East London. It operates in over 100 community and inpatient sites. As part of refreshing its strategy, in 2021 ELFT held a 'Big Conversation' and listened to service users, carers, staff and local communities and heard that ELFT should commit to improving the health and wellbeing of the communities it serves and promote social justice.

Ambition and support came from ELFT senior leadership to test the boundaries of what an NHS organisation can and should do to improve the health of communities, not just service users, and not just focused on clinical services. This means thinking more upstream and looking at how to improve the social determinants of health in ELFT's communities. It has also committed to not duplicate good already being delivered by local authority partners and the VCFSE sector and instead is seeking to work in partnership with stakeholders and contribute where ELFT can add value. It convened a Marmot Trust Steering Group, which met monthly at the start, to understand existing synergies and existing work and to agree priorities.

In Luton, one of the local authorities covered by ELFT services, roundtable discussion with stakeholders identified clear ambitions for employment and work in Luton. The key actions identified were to provide everybody with a mental health condition with the opportunity to be in employment if they so wished. As a mental health service provider, ELFT often saw service users whose conditions were caused by, or made worse, by unstable incomes, jobs and housing. In the past they had felt powerless to make changes to these building blocks of health. ELFT have also committed to work with businesses in Luton to support access to training and good quality jobs for young people and have committed to use their voice for advocacy within the NHS, Luton and the business and education sector. ELFT are also extending their role related to early childhood development and young children

in Newham, another borough they serve. In Newham ELFT are working closely with the local authority and communities to support families and children through extending service provision and enabling improvements in the conditions in which families are living.

The ELFT are also developing their workforce to take action on the social determinants of health. This includes the development of a population health learning programme to support individuals, teams and the organisation to: firstly, improve understanding of the impact of social determinants of health and health inequalities in communities, service users and staff; secondly, support organisational action to improve population health and identify inequalities in access, experience and outcomes from ELFT's services, and thirdly increase the capability and confidence of ELFT's teams and service users to address population health and inequalities.

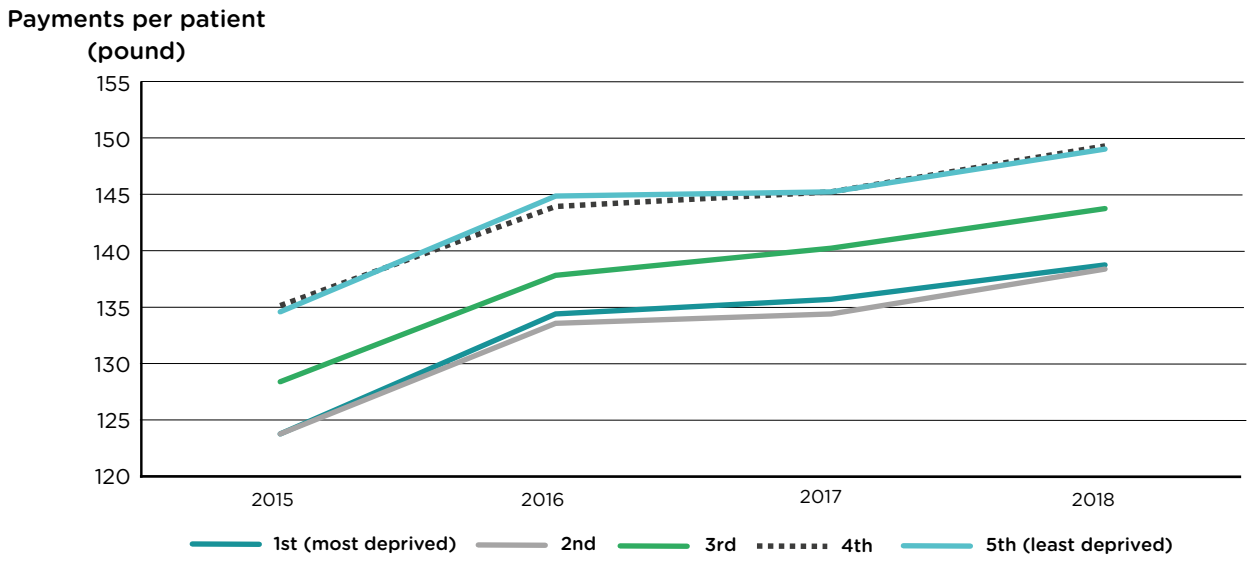
In a submission to the HEC, the North West Ambulance Service (NWAS) indicated that they, like other NHS partners, can have significant impact on improving health equity, and are already considering this with in-house specialist public health support.

## HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN PRIMARY CARE

Primary care is well placed to take action to improve health and reduce health inequalities through action on the social determinants to improve conditions in which people are living, to prevent ill health in the first place. This can include access to services supporting better housing, support with debt and access to benefit entitlements, referrals to skills and training for employment. Social prescribers and the Citizens Advice Bureau have been involved in this in many GP surgeries and across primary care - but there is a lot of scope to do more. The current funding and demand pressures on primary care mean that much of the work needed to improve health and reduce inequalities is being overlooked. Ill health prevention is too often regarded as optional and in submissions to the HEC, places reported health inequalities and actions on ill health prevention being taken away when other priorities were identified. In North Cumbria, the primary care network (PCN) contract includes a Tackling Inequalities and Anticipatory Care service specification and associated targets that should support work in this area. However, due to current pressures on primary care, the requirements have been delayed by NHS England, which has meant that local practices, while recognising the importance of this work, are struggling to find the capacity to do it.

General practice should be funded using proportionate universalism whereby all universal services are adequately resourced and then additional funding is provided to areas where the degree of need is higher. GP practices serving areas with high levels of deprivation receive around 7 percent less funding per patient than those serving more affluent populations, Figure 4.2.

**Figure 4.2. Trends in general practice payments per patient by neighbourhood deprivation quintile (IMD 2019), net payments per registered weighted patient, England, 2015-2018**




***Source:*** *NHS Digital, ONS, and MHCLG quintiles aggregated from LSOA 2011 neighbourhoods (182)*

There are several existing weighted resource allocation formulae that allow for this and these are in keeping with the proportionate universal approach. Box 26 in the following section set out the weighted funding formula developed in Morecombe Bay with implementation planned across the region.

The Deep End practice in North Cumbria is an example in the region of a shift from the medical model of health and illness to a more preventative approach, this has also required working with patients to strengthen understanding about the drivers of ill health (Box 25). Patients often want prescriptions as a solution and GPs have spent time with patients to discuss alternative solutions (239).

### Box 25. Deep End GPs in the North East and North Cumbria

Originally set up in Glasgow in 2009, Deep End GPs is a network of GP practices based in the most deprived areas, aiming to address the social determinants of health through cooperation and the sharing of best practice. Deep End networks have been established across the UK, in Ireland and in Australia, with the goal of tackling health inequalities and championing primary care's role in tackling these inequalities. Populations living in Deep End practice areas have lower life expectancy and spend far more of their lives in poor health, physical and mental, than in more affluent areas.

In 2020, the Deep End primary care network in the North East and North Cumbria (NENC) was established. The network consists of 34 GP practices in NENC. Deep End NENC include GP surgeries whose practice population are ranked in the lowest IMD decile nationally as well as two practices with a large cohort of Deep End patients and one practice that was an outlying area of rural deprivation.

Deep End NENC focuses on working collaboratively to create the best outcomes for practices, patients and communities, addressing health inequalities. A local GP stated that 40 percent of appointments are booked by 5 percent of patients and that those 5 percent of patients are not having their needs met. Deep End practitioners are changing the way primary care is delivered so as to better meet the needs of this 5 percent: current projects include funding for a GP clinical psychologist to work two sessions a week in practice, and a scheme to reduce opiate and gabapentinoid prescribing. Deep End practices also offer longer than usual consultations, which allows for better opportunity for health screening, health promotion, and assessment of the medical problems of those in more deprived cohorts who might otherwise be missed. Researchers from the NIHR Applied Research Collaboration North East and North Cumbria have evaluated the key factors for success include catering for specific groups who may not feel comfortable in large groups, locating interventions in familiar spaces that are accessible, safe, and non-intimidating, and focussing on how an intervention is marketed, to avoid certain words or phrases that may be stigmatising.

Deep End NENC also aims to support and promote understanding of the health effects of inequalities. and to offer positive reasons for GPs to train and work in Deep End practices. It also advocates for deprivation to be more meaningfully considered when allocating funding. Deep End NENC also recognises the additional demands that come with working in practices with high levels of its population living in deprived areas. Being part of the network gives practitioners a sense of identity and recognition of the additional challenges. Deep End aims to support these practitioners and allow them the time and resources to develop interventions catered to the communities they work in (240).

Many HEC submissions referred to the need for better prevention approaches, as thresholds for eligibility for services were so high. For example, schools reported that thresholds for access to mental health services were only offered when pupils were in crisis. The VCFSE sector, primary care, housing, mental health, education – all referred to thresholds being so high that people ended up having to live with no support until they had reached a crisis.

## INEQUALITIES IN ACCESS TO CARE

While we are recommending that a social determinants of health approach is embedded across NHS organisations, it is important to recognise that there are still significant inequalities in access to care in the region.

Many GP practices in more deprived areas are unable to recruit and there are significant barriers in accessing care. Submissions to the HEC outlined the shortages in NHS staff and the effect this had on health inequalities.

For example:

- Cumbria stated that in some areas in the west of the county, GP vacancy rates are at 39 percent. North Cumbria reported the poorest places have the smallest number of GPs, leading to late presentations and poor outcomes for those on the lowest incomes. Workington and rural areas east of Eden have particular problems recruiting GPs, which has led to services struggling in 2022.

- Blackburn with Darwen reports the demand on GPs is growing: the number of patients registered with a GP has increased month on month between 2020/21. 18 of its 22 GPs have more patients registered in October 2021 than in October 2020, whereas in England as a whole the number of GPs per head declined slightly.

- Bay Health and Care Strategy stated it had 27 vacancies for GPs in the area – 11 percent of the total GP workforce; and 160 nurse vacancies in hospital – 9 percent of the total nurse workforce.

Some of these vacancies provide opportunities for the health and care system to work locally and retrain and employ local populations, and to work with post-16 education institutions as well as lifelong learning organisations.

## NHS ACCOUNTABILITY FOR HEALTH INEQUALITIES

Strengthened accountability within healthcare for health inequalities is essential. Accountability in the healthcare system is mostly related to specified on targets around access to health services. These are important but there should also be greater accountability for reducing health inequalities through the social determinants of health including for senior leadership in local and regional systems. Many of the accountability mechanisms are set nationally and HEC submissions pointed out that national NHS targets often prioritise saving money and reducing response times and do not include a wider assessment of the impact of policies on inequalities. Many submissions to the HEC stated local tools and actions were needed so that people within the NHS and beyond felt the pressure of accountability':

- Clinicians in the NHS admitted that current national performance management structures did not make them feel accountable to address health inequalities. One stated they did not feel the 'white heat of accountability' or the need to perform on health equity, and highlighted the lack of institutional mechanisms and incentives critical for success in addressing inequalities.

- Another leader said: 'In my NHS career I have a very strong accountability regime around NHS standards, e.g. A&E performance, but have never felt a systematic accountability around equity.

- One submission stated 'governance could be described as "toothless" in terms of making preventive work and reducing inequalities happen'.

### RECOMMENDATIONS. FOCUS ON EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN HEALTHCARE

**a)** NHS, local authority, and public sector leaders in Lancashire and in Cumbria to strengthen accountability for health equity.

**b)** Develop regional health equity and the social determinants of health action plans involving businesses, public services, local government and communities, prioritising early intervention through long-term investments.

**c)** Define and implement Marmot NHS Trusts approach across Lancashire and Cumbria.

# 4B INCREASED AND MORE EQUITABLY DISTRIBUTED RESOURCES

**KEY MESSAGES**

- Increasing resources is urgently needed to reduce health inequalities and to take action on the social determinants of health and recent spending announcements about future funding levels are insufficient.
- Over the last twelve years cuts to local authorities and public services have harmed health and widened inequalities. The cuts have been regressive: they are steeper in more deprived areas.
- The Levelling Up Fund is insufficient to redress the cuts or meet the needs in more deprived areas.
- Increases to the public health grant are far short of need and, given inflation, are effectively significant cuts.
- A larger proportion of NHS funding must be directly allocated to action on the social determinants of health increasing by 1 percent above inflation each year for the next 10 years.

**An increase in resources is urgently needed to reduce health inequalities and to take action on the social determinants of health, but recent spending and announcements about future funding levels will undermine such action. As this report and others have pointed out, funding for public services has declined even as need has increased.**

Cuts to local authorities have damaged the capacity of local authorities to take action on critical social determinants of health – and cuts have been far greater in more deprived areas than wealthier ones, further increasing inequalities. The Levelling Up Fund, meanwhile, is insufficient to compensate for historic underfunding of areas outside London and the South and will not enable areas to level up. Moreover, the lack of attention to levelling up health and social conditions means that even if successful, the wide regional inequalities in health described in Section 1 will not be reduced. Investment, used effectively and targeted correctly, is required if health inequalities are to be addressed (241).

During the course of meetings with stakeholders across Lancashire and Cumbria, we were told that:

- Places needed to shift from funding services in the wrong place to working with local residents to fund what is needed and wanted in the places where it will be best accessed.
- There needs to be more Systematic resourcing for health equity, population health and inequalities work to improve capacity, provide insight, inform interventions, measure impact and improve the approaches.

Since 2010 funding for local authorities has decreased. The National Audit Office shows local government spending on non-social care services in 2019–20 was 25 percent lower in real terms than in 2010–11 (242). Table 4.1 shows local government funding in Lancashire fell by 16 percent and in Cumbria by 26 percent between 2009/10 and 2019/20.

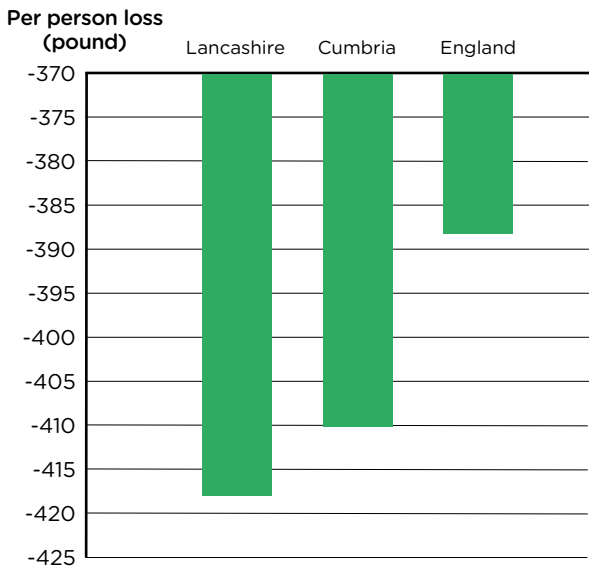
**Total revenue service spending per head in real terms, excluding education, public health, fire, and police, Cumbria, Lancashire and England, 2009/10 - 2019/20**

| | 2009/10 | 2019/20 | 2009/10 to 2019/20 |
|---|---|---|---|
| **Cumbria** | £1,555.19 | £1,145.58 | -26% |
| **Lancashire** | £2,041.86 | £1,623.99 | -16% |
| **England** | £1,571.20 | £1,183.48 | -18% |

***Source:*** *IPPR North (243)*

Overall, both areas experienced much higher service spending reductions per person between 2009/10 and 2019/20 than the England average (Figure 4.3).

**Figure 4.3. Per person loss of total revenue service spending, real terms, Lancashire, Cumbria and England, 2009/10–2019/20**

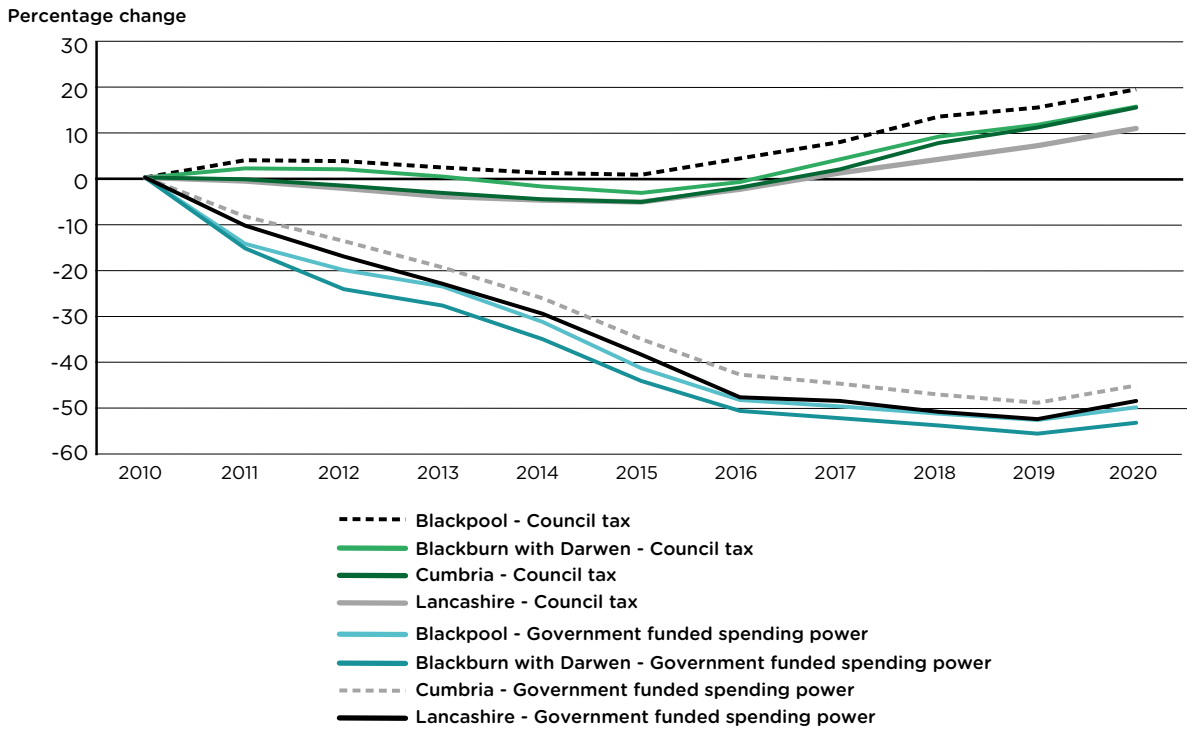



***Notes:*** *Excluding education, public health, fire and police.*

***Source:*** *IPPR North (243)*

The National Audit Office's assessment of government-funded spending powers measures the main streams of government funding to local authorities. Figure 4.4 shows the decrease in spending power in Lancashire and Cumbria, that Blackburn with Darwen's spending power falling by 53 percent in a decade, Blackpool's by 50 percent, Lancashire's by 49 percent and Cumbria's by 45 percent. The increases in council tax, also shown in Figure 4.4, have attempted to offset the cuts by placing the burden on households, but even these increases have not led to significant increases in spending power.

**Figure 4.4. Government-funded spending power and council tax, percentage changed, indexed to 2010, Lancashire and Cumbria upper tier local authorities, 2010–2020**

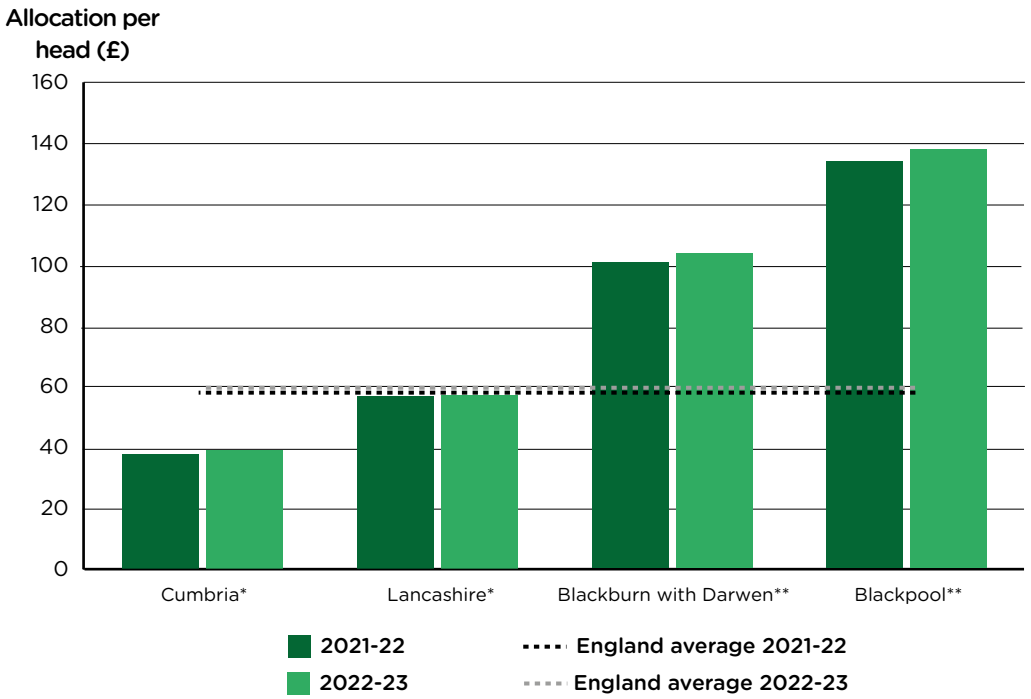



***Source:*** *National Audit Office (244)*

The pandemic exacerbated the financial strain on local governments. The National Audit Office reported that local authorities had £9.7 billion of COVID-19-related cost pressures (primarily adult social care, housing and public health service costs) and income losses (council tax and business rates) in 2020–21, yet only £9.1 billion in financial support from government (242).

The Public Health Grant, local government funding to enable local authorities to provide a range of services including sexual health, stopping smoking, tackling obesity and children's services for under-5s (including health visitors), fell by 24 percent in real-terms per capita between 2015/16 and 2021/22 (245). In this period smoking cessation spending fell by 33 percent in real terms. These cuts to public health continue. In April 2022 the national government cut the £100 million weight management grant to reduce obesity (246). Although in 2022/23 the overall public health grant will increase by 2.7 percent on 2021/22, as Figure 4.5 shows, the impact on local allocations will be minimal, rising by £1.05 per head in Cumbria and £3.83 per head in Blackpool. With inflation running at 5.4 percent in 2021, an increase of 2.7 percent represents a decrease in spending (247).

**Figure 4.5. Public health grant, allocation per head of population, Lancashire and Cumbria upper tier local authorities, 2021/22–2022/23**




***Notes:*** *Calculated by authors, *County; **Unitary authority. Based on population estimates (248).*
***Source:*** *Department of Health and Social Care (249)*

In order to understand the resources available within Lancashire and Cumbria, the overall available resources in an area need to be assessed, including both private and public spending, to assist in the identification of priority areas to receive greater funding. This must also be related to the level of deprivation within the area. Therefore, alongside the assessment of current resource allocations by area there needs to be a formula that allocates resources based on need. Responses from the HEC submissions indicated that funding was distributed equally between areas rather than distributed 'equitably', based on differential population need. For example, the 'Deep End 20' wards of North Cumbria, working in the most socioeconomically deprived areas of North East and North Cumbria, do not tend to receive extra resources, despite being home to people living with the greatest disadvantage and experiencing the corresponding worst health outcomes in North Cumbria.

The Lancashire and South Cumbria weighted funding formula, Box 26, is designed to ensure that funding is allocated according to level of need – to be proportionate and equitable. The formula should be applied to other service resource allocations, within the NHS and beyond.

## Box 26. Lancashire and South Cumbria weighted funding formula

The Lancashire and Cumbria weighted funding formula (formerly the Morecambe Bay funding formula) is helping to lead efforts in England to ensure funding for primary care is more equitable. The weighted funding formula was developed in an attempt to allocate resources to better reflect the inequalities faced by local communities and to allocate resources to the areas that need it the most. The formula is based 50 percent on the Carr-Hill formula and 50 percent on the proportion of the population living in the 20 percent most deprived areas. The purpose of the Carr-Hill formula is to create fair funding allocations based upon the cost of providing services for a given population and their respective needs. The formula is based on a number of variables including: patient age and sex; additional needs of patients; and rurality. Research shows the formula is 'very unlikely' to benefit more deprived areas (250).

The 50/50 formula aimed to reflect geographical differences in local deprivation and to acknowledge the impact that COVID-19 has had on communities. Morecambe Bay CCG studied its own General Practices serving atypical populations (e.g. more deprived than average) and looked at how other CCGs were supporting atypical populations across England. They found a number of CCGs were commissioning services for these atypical populations that had a greater need for improved access to local primary and community services in their local areas.

Currently 27 percent of the population health budget in Morecambe Bay is funded in this way and Morecambe Bay CCG is looking at other areas to apply the weighted funding formula, such as applying it to more of the population health budget or to other funding streams in the ICS, in order to better address inequalities. Whilst there is not yet evidence the weighted formula is having an impact, current funding models have not had a beneficial effect on health inequalities. The Weighted Funding Formula will be evaluated with academic partners to measure the short, medium and long-term impact on health inequalities.

While there has been some focus on increasing the level of spending on prevention within the NHS and public health, this 'prevention spend' is often not the same as spending on the social determinants of health, which is proposed by the Health Equity Commission. Prevention is often conceived as clinical or behavioural interventions, which evidence shows will not reduce inequalities in health on anything like the scale required. The spending on prevention and on reducing inequalities needs to be mapped and must relate to deprivation, and a significant proportion must be allocated to organisations that are working to achieve improved and more equitable outcomes in the social determinants of health.

The NHS has been awarded an increased funding settlement largely in order to cope with increased demand through the pandemic and the resulting backlogs and growing waiting lists. In February 2022 NHS England published its plan to tackle the backlog of elective care resulting from the COVID-19 pandemic. This three-year plan states services and resources should be 'distributed fairly according to clinical need' and requires local systems to analyse waiting list data by level of deprivation, ethnicity and age (238). Demand for health services is driven by inequalities and deprivation.

We propose that a proportion of this funding is directly allocated to the social determinants of health: benchmarking NHS and local authority prevention spending in 2022–23 and increasing funding for prevention by 1 percent above inflation each year for the next 10 years could help to address the social determinants.

### RECOMMENDATIONS. INCREASED AND MORE EQUITABLY DISTRIBUTED RESOURCES

**a)** Benchmark NHS and local authority prevention spend in 2022–23 and increase funding for prevention by 1 percent above inflation each year for the next 10 years to address inequalities in the social determinants.

**b)** Make resource allocations more equitable and extend the Lancashire and South Cumbria formula across the NHS in Lancashire and Cumbria.

# 4C STRENGTHEN PARTNERSHIP WORKING

**KEY MESSAGES**

- Reducing health inequalities requires robust partnerships between sectors and organisations that have an impact on health. These have not been established in the region and silo working is firmly entrenched.
- Partnerships must include local government, public services including healthcare, the police and education, the VCSFE sector, businesses and communities.
- There must be a focus on equity and the social determinants of health and on developing the necessary mechanisms to support such partnerships.
- The VCFSE sector are vital to the success of action on the social determinants of health but are frequently excluded from partnerships and not resourced for participation and contributions.

**The Health Equity Commission has received great support for a plan on the social determinants of health that involves all the partners in the system. While this report and the associated action plan is a start, an operational strategy requires engagement and commitment from all the partners.**

Reducing health inequalities requires robust partnerships between sectors and organisations that have an impact on health. As set out, these sectors and organisations include local government, public services including healthcare, the VCSFE sector, businesses and communities. There must be a focus on equity and the social determinants of health and on developing the necessary mechanisms to support such partnerships.

Submissions to the HEC referred to:

- The need to work in partnership in order to shift to a social determinants approach: 'with the LEP [local enterprise partnership], voluntary sector and housing etc; currently we [in the NHS] are not operating at that point, just thinking about acute provision and waiting lists and discharge rates'.

- Recognition that: 'No single agency alone can reduce inequalities. Partnership working across the local authorities, health, the third sector, the independent sector and local communities is vital to addressing the inequalities that lead to health inequalities.'

- The need to involve communities: 'Residents and local communities and the VCFSE are essential partners in addressing the social determinants of health. Too often it is still professionals who are involved in partnerships...It still feels quite paternalistic – we talk about co-production, but in reality, there's very little evidence of communities leading their own agendas.'

- The need for 'co-designed strategies', owned by all partners, removing silo working and bringing together health and care and local enterprise partnerships at all levels.

- Organisational silos being very entrenched and often a function of 'system pressures'.

- The need for an 'integrated vision, plans and data to showcase the benefits to each sector of working together to reduce inequalities' and the need to 'generate a shared sense of responsibility and moral duty [...] Need clarity of role and responsibility across system partnerships'.

The Jobs Friends and Houses project in Blackpool shows how the public sector – in this case a local authority and the police – can work closely in partnership to influence the social determinants of health, Box 27.

## Box 27. Working in partnership to improve wellbeing and health

Jobs Friends and Houses (JFH) is a community interest company set up in 2014 and is jointly 'owned' by Blackpool Council and Lancashire Police. Since 2017, JFH has been managed by Blackpool Coastal Housing.

JFH's key objective is to help people to heal from substance misuse and to begin thinking about their future. The company works with individuals often referred to as 'revolving door' clients, who repeatedly access treatment without ever being able to take control of their own recovery. JFH works on the model of long-term support, as evidence shows average recovery time from alcohol addiction is four to five years and from opiates is five to seven years.

A one-year evaluation in 2018 showed improvements in offending, substance misuse and wellbeing among service users. These outcomes were strongly associated with the length of time spent in the programme. The 48 clients involved in the first-year evaluation had, prior to joining JFH, a total of 1,142 recorded offences over 13 years between them. After joining JFH a total of five offences had been recorded, representing a 94.1 percent reduction in the annual recorded offence rate.

JFH helps people to build a future through support to recovery from addiction, to routes into employment, and to finding housing. JFH recognises that meaningful activity is good for an individual's wellbeing and when clients join the service their existing skills are identified and the team then seeks to raise aspirations of each client. They help clients find work and offer support to both employees and employers.

An important role of JFH is to connect clients who have been socially isolated or had destructive relationships with a positive community that cares about others. The JFH community is an important aspect of the programme, which is made up of those in recovery and the wider community. This includes a network of mentors who have lived experience of addiction but are further along their recovery journey and a psychologist who provides therapeutic support.

JFH's recovery houses have a crucial role in helping individuals heal and rebuild their lives, offering security and stability. When clients are ready to move on, they are supported to find secure and safe accommodation and begin independent living with the support of the recovery community.

JFH's commitment to partnerships is key to the organisation's success. It has a strong business and community representation so that it is viewed as a key part of the Blackpool community. This also means that JFH clients have increased access to a range of community resources (251) (252).

Achieving collaborative partnerships is particularly important in the region as it does not have a history of doing so and operates in a siloed way within and between areas. The partnerships between local government, particularly public health, and the NHS are especially important but presently are not always sufficiently strong or harmonious. We suggest appointments of a Director of Partnership, appointed at Board level within each ICS to support the development of new and stronger partnerships.

The VCFSE sector and communities are often not involved in work on health inequalities or in discussions among statutory organisations and local government. This is further elaborated on in Section 4E below, but it should be noted that VCFSE and business sector, Section 4D, are essential partners and the relationships need to be improved.

## RECOMMENDATIONS. STRENGTHEN PARTNERSHIP WORKING

**a)** Develop a health equity network in Lancashire and Cumbria to include business and economic sector, public services, VCFSE sector, local government.

**b)** Appoint a Director of Partnerships at Board level within each ICS.

**c)** As the default, ensure the involvement of the VCFSE sector in the design and delivery of services and support the VCFSE sector to bid for contracts.

# 4D STRENGTHEN THE ROLE OF BUSINESS AND THE ECONOMIC SECTOR AND EXTEND SOCIAL VALUE APPROACHES

**KEY MESSAGES**

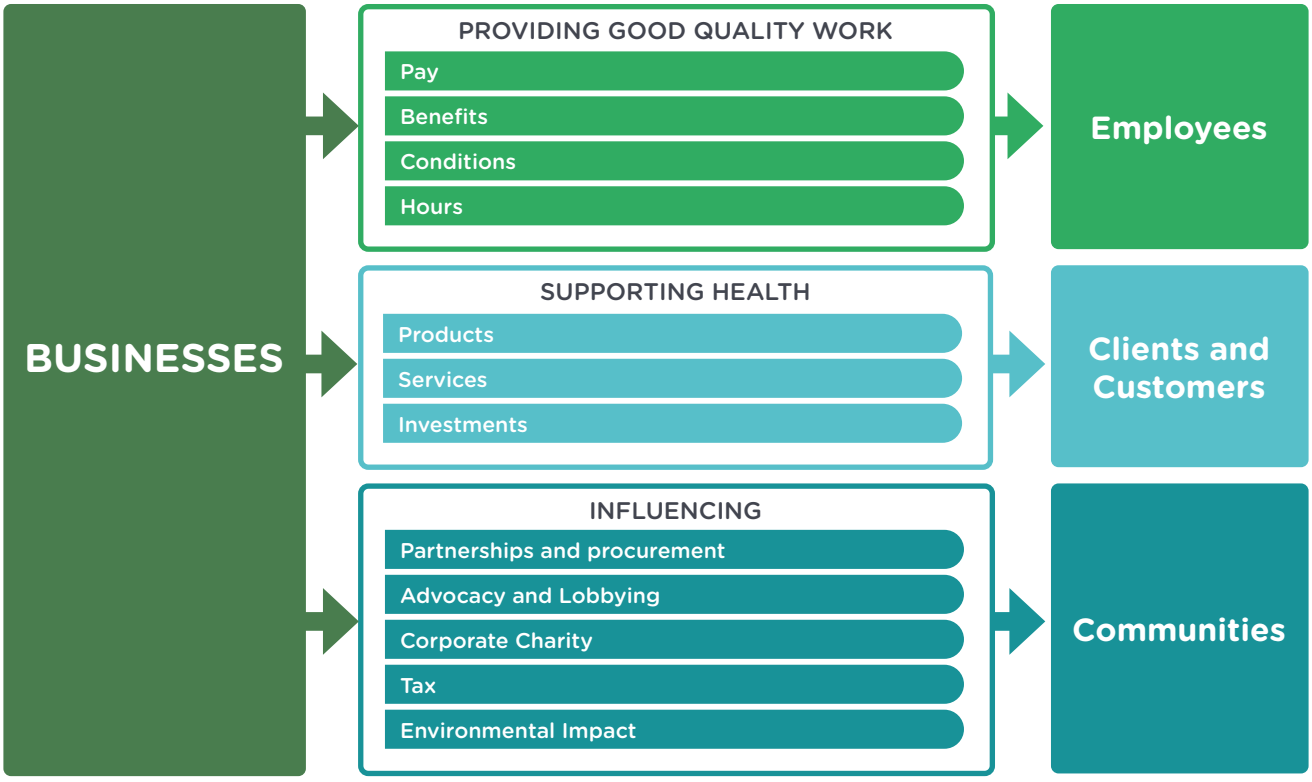
- Businesses and the economic sector have important impacts on health inequalities but have not been sufficiently involved in discussions and actions about how to reduce them.
- The costs of ill health are well known and productivity and staff retention are linked to the health of the working age population. Sick pay costs are also a burden for businesses. It is estimated that poor health costs the economy £100 billion per year nationally.
- Attracting inward investment is more successful where the working population is relatively healthy, and the relative poor health of the region undermines the case for economic investment in the region.
- Businesses and public sector employers can help reduce health inequalities by providing good quality employment and equitable recruitment; providing healthy products, services and investments; and influencing and partnering with communities.
- Social value contracting should become a general principle in procurement and commissioning for all public sector organisations.

**Businesses and the economic sector have important impacts on health but have not been sufficiently involved in discussions and actions about how to reduce them. To maximise the contributions of businesses to health, a clear case needs to be set out to businesses about why they should take action.**

The costs of ill health are well known to businesses, who find that productivity and staff retention are linked to the health of the working age population. Attracting inward investment into the region is essential for economic and social development and requires a healthy workforce. The social justice case for reducing health inequalities is clear and is also a motivation for many businesses that want to contribute to achieving better health and reducing inequality. But there is also a strong economic case for businesses to help improve health. The economic costs of poor health are high: it is estimated that poor health costs the economy £100 billion per year (253). The Northern Health Science Alliance's Health for Wealth report found regional inequalities in health are the key reason for the productivity differences between the best and worst-performing regions in England and that reducing the number of working-age people with limiting long-term health conditions by 10 percent would decrease rates of economic inactivity by 3 percentage points (28).

Again, there is significant potential for greater impact and we set out how to achieve this below and also in other relevant reports, most recently The Business of Health Equity: The Marmot Report for Industry (29). In this report we set out a three-part assessment of how businesses impact health and what they can do to further support health equity. These recommendations cover providing good quality employment and recruitment; supporting healthy products, services and investments; and influencing and partnering with communities. Figure 4.6 shows the framework for action.

Figure 4.6. How businesses shape health: the IHE framework




***Source:*** *Institute of Health Equity (29)*

Despite the potential for businesses to reduce health inequalities, their engagement in doing so has been relatively limited to date (254). Throughout the HEC, we have had some positive interactions with the business community and both Lancashire and Cumbria local economic partnerships. Some businesses in the region are using their purchasing power and other economic impacts to support local communities and improve economic conditions. There have also been efforts to improve employee health, support recruitment from excluded and disadvantaged communities and to build skills.

Sellafield Ltd in Cumbria has adopted a comprehensive social value approach and undertaken numerous activities in its local areas, many of which are areas of high deprivation, despite being situated near such a major employer, Box 28.

## Box 28. Sellafield Ltd: sharing wealth and building communities in Cumbria

Sellafield Ltd is responsible for decommissioning the Sellafield nuclear site on behalf of the Nuclear Decommissioning Authority (NDA). It is one of the largest employers in West Cumbria. In 2016/17, 59 percent of jobs in Copeland were directly or indirectly connected to Sellafield.

Sellafield Ltd has been keen to understand how to best use its position in Cumbria's local communities. In 2017 it commissioned Oxford Economics to report on the economic impact of Sellafield in Cumbria. The report emphasised the extent to which the area is dependent on the organisation and that this substantial dependence can mean that loss of jobs at Sellafield will threaten local economies.

Sellafield Ltd has invested £10 million of its annual funding allocation from its owner, the NDA, into a social impact budget, which it uses to support the communities closest to its sites and to develop the local economy in the nuclear sector, in other existing sectors and in new economic opportunities. The social impact programme was refreshed and relaunched in 2020 as 'SiX', social impact multiplied. The programme's new approach prioritises projects co-created with the community and stakeholders.

Transforming West Cumbria (TWC) is a three-year partnership from 2020 between Sellafield Ltd, the NDA and Cumbria Community Foundation (CCF), which promises to focus on the causes of inequality in some of the area's communities with the highest levels of deprivation. With a total investment of £4.4 million, among the initiatives are a £1.3 million fund for community and voluntary groups, £660,000 to support families, and £175,000 to fund financial education.

The West Cumbria Mental Health Partnership operates under TWC and was developed in response to the closure of Mind West Cumbria in 2019. The Partnership aims to create a coordinated and collaborative approach to community mental health provision in Copeland and Allerdale by improving communication between statutory, third and health sector organisations, and improving low-level mental health services for people with multiple needs. Four initial programmes have been established by the partnership: adult mental health led by Groundwork NE & Cumbria, youth mental health led by Cumbria Youth Alliance, financial wellbeing led by Citizens Advice, and Recovery College led by Together We.

Further projects within the TWC programme include Bedrock, which builds the resilience, capabilities and financial sustainability of third sector organisations, #CanDo, which aims to make community activism the norm for young people, Family Wellbeing, developed to improve the health and wellbeing of children and families living in the most deprived areas, Financial Wellbeing, which encourages conversations and empowers people on low incomes to better manage their money, Spark, which inspires and encourages both new and existing social entrepreneurs, and Positive Disruptors, which nurtures young entrepreneurs.

Business Health Matters is working across Lancashire to enable businesses to provide healthier workplaces, Box 29.

### Box 29. Businesses working in partnership to improve health and reduce inequalities

Business Health Matters (BHM) is a partnership that aims to empower employees to improve their health and employers are able to benefit from better productivity. BHM is led by Active Lancashire and supported by partners including the University of Central Lancashire, Lancashire Mind and UKactive. The project delivers training, health checks and interventions in workplaces.

Business Health Matters consists of two main projects. Firstly, the Workplace Health Champion Training project delivers free basic skills training and NCFE-accredited level 2 and 3 Workplace Health Champion qualifications to employees in small and medium enterprises (SMEs) across Lancashire, providing them with the tools, resources and guidance to be leaders and drive positive change in their organisation. The aim is to have a community of upskilled and passionate Workplace Health Champions in the county to inspire and motivate their colleagues to live happier and healthier lives.

Secondly, the Workplace Health Checks project targets businesses with employees aged 50-plus and SMEs with lower levels of productivity resulting from poor employee health. Qualified local gym and leisure centre staff carry out the checks, on both physical and mental health, to identify conditions that lead to poor health in later life. Businesses are then offered tailored interventions to support their employees to improve their health and wellbeing and as a result, businesses also benefit.

Business Health Matters launched in late September 2021, supported by the European Social Fund, and has since worked with 337 employees from 39 Lancashire businesses; 250 employees from 12 businesses have received a Workplace Health Check and wellbeing plan and 87 employees from 27 Lancashire SMEs successfully have completed accredited training to date (255).

Some businesses in the region have signed up to existing charters. For example, the Red Rose Awards in Lancashire include a built environment award, a corporate social responsibility award, an employer of the year award, a green award and a health and wellbeing award. While awards are helpful in recognising beneficial practices, we propose that an extended business charter is developed that establishes criteria for businesses to make positive contributions, as set out in the framework above. Those businesses who meet the requirements of the charter would qualify for contracts from the public sector.

The challenge for businesses to contribute more to reduce health inequalities is important but public sector organisations can also contribute considerably more through the same three mechanisms outlined in Figure 4.6; providing good quality work, healthy goods and services and supporting communities. The adoption of the anchor institution approaches by some public sector organisations in the region is promising but needs to be extended to all public sector organisations and to encompass a broader range of actions than is currently the case.

When it comes to good quality employment, pay which is sufficient to provide a minimum income for healthy living needs to be guaranteed and extended to all contractors and suppliers. Recruitment should benefit local and excluded communities and provide opportunities for progression and on-the-job training, with links to community and voluntary sector organisations, schools and colleges to support training and skills development.

Social value contracting should become a general principle in procurement and commissioning for all public sector organisations. 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. There are good examples of how to do this set out in various analyses and reports. A social value approach supports contracting that builds in social as well as economic value as a criterion for awarding contracts and spending public money (256). The 'Preston Model' has received international recognition for its innovation in using a community wealth approach, closely related to social value approaches, Box 30.

## Box 30. The Preston Model

Community wealth building in Preston, Lancashire, often referred to as 'the Preston Model', began in 2011 when Preston City Council began discussions with the Centre for Local Economic Strategies (CLES) about how to tackle inequality in economic development. As a first step, Preston city council committed to paying all its staff the living wage, becoming the first accredited living Wage Employer in the North of England in 2012. In 2013 the city council engaged CLES to research the proportion of anchor institution procurement that was local to Preston and Lancashire.

CLES found there was a collective procurement spend of £750 million by Preston's anchor institutions and that in 2012/13 only 5 percent was spent in Preston and 39 percent in Lancashire, meaning £450 million was leaving the Lancashire economy. This research was repeated four years later to assess the results of community wealth building. The results were promising, with locally retained spending increasing from 5 to 18.2 percent in Preston, and from 39 to 79.2 percent across Lancashire. Further, in 2018 there were 4,000 more employees earning the real living wage than at the beginning of the project.

Community wealth building, where local economies are reorganised so that wealth is not extracted from an area but recirculated, has been advanced by Preston through a promotion of five strategies:

- Plural ownership of the economy: a blend of ownership models in an area, small enterprises, community organisation, cooperatives and municipal ownership.
- Making financial power work for local places: increasing local investment as opposed to focusing on attracting national or international investment.
- Fair employment: anchor institutions as larger employers recruiting from lower income areas, committing to paying the living wage, and promoting progression routes for workers.
- Progressive procurement: developing dense local supply chains, SMEs, employee-owned businesses, social enterprises and cooperatives, types of business that are more likely to support local employment.
- Socially productive use of land and property: anchor institutions often hold large amounts of land and property, which represent a base from which local wealth can be accrued.

While the city council leads the way in implementing the community wealth building approach and the five strategies, it is through promoting the concept to other anchor institutions, which often have far greater spending power and assets, that success is to be found.

The National Institute of Health Research has invested £600,000 to investigate the Preston Model and whether it could be used as a national template for 'building back better' in the aftermath of COVID-19 (257).

## RECOMMENDATIONS. STRENGTHEN THE ROLE OF BUSINESS AND THE ECONOMIC SECTOR AND EXTEND SOCIAL VALUE APPROACHES

**a)** Coordinate a regional economic partnership to develop a health equity approach for businesses and implement the recommendations in the 'The Business of health equity' report for businesses to make positive contributions to the health of their workforce, ensure goods and services are healthy and to make social and economic investments in areas of deprivation.

**b)** Build on and extend the anchor institution approach and require that organisations, including businesses commission for social value and employ local and underrepresented groups.

# 4E INVOLVE COMMUNITIES AND THE VCFSE SECTOR

**KEY MESSAGES**

- Involving the VCFSE sector in the design and delivery of public and local government services is essential to ensuring that services are appropriate, relevant and bring benefits to local communities. Currently this is insufficient.
- The VCFSE sector has expertise and involvement in all the areas outlined in this report and are vital partners in action to reduce health inequalities and inequalities in the social determinants of health.
- Generally the VCFSE sector is overlooked by public services and local government yet they tend to have a closer relationship with local communities, and, as a result, have a better understanding of their experiences and what they need from public sector organisations.
- Lack of funding and other resources are undermining the capacity of VCFSE organisations to improve the social determinants of health. Grants and tenders are often burdensome with stringent requirements and often for small pots of money and short time frames.
- Where communities are involved with public sector and local government organisations, the process can be frustrating and outcomes limited. Community involvement must be meaningful, leading to benefits for communities.
- There are some good examples of constructive community involvement in the region, these approaches can be further utilised across the region.

**Involving the VCFSE sector and communities in the design and delivery of public and local government services is a long-touted ambition, but one that is rarely achieved effectively. The involvement of communities and people with lived experience should be at the heart of public sector and businesses' approaches and strategies.**

Many submissions to the HEC discussed the huge potential for better partnerships between the VCFSE sector and the NHS and that the VCFSE sector had significant expertise and experience in addressing the social determinants of health.

HEC submissions consistently stated that the VCFSE had much to offer on health equity and the social determinants but was frequently overlooked and under-utilised. The VCFSE sector are often underfunded and unable to tender for contracts as the process is onerous and they are not able to meet the stringent requirements required by the tenders. Grants applications tend to be burdensome and frequently are for small pots of funding and only for short time frames. Specific comments to the HEC include that:

- The VCFSE sector was under-utilised but was an 'essential partner'.
- The VCFSE had a 'good understanding of local communities and experiences of social injustice', and had been involved in prevention 'for years, it's their bread and butter', and the sector's 'wealth of experience in what has been tried before, what worked and what did not'.
- The NHS has yet to embrace the value the VCFSE sector could bring and a submission stated 'lived experience and third sector involvement seems to be tokenistic'.
- When asked for examples of actions to address the social determinants of health, many submissions to the HEC outlined in detail what the VCFSE sector was offering. One submission stated interventions delivered by the sector 'by their nature will also help foster a sense of community, support good mental health and wellbeing, and help protect those involved from becoming social isolated and/or lonely'.
- VCFSE sector organisations stated they wanted to deliver interventions, this was their strength, but they also could provide strategic knowledge and as such wanted 'a seat at the table to influence'.
- Areas spoke of the NHS moving away from treating the voluntary sector as an additional 'nice to have' and supported closer working with the VCFSE sector in relation to housing, employment and financial support.
- Submissions called on the NHS and ICS to work transparently with the VCFSE sector: 'The ICS is not transparent, [it is] difficult to know who does what, [it is] very focused on the NHS despite calls for it to work with communities.'
- Funding from the NHS for the VCFSE sector needs to be sustainable. Currently the sector is considered 'underfunded' and 'undervalued'. One area recently provided £26,000 to 15 local organisations through its integrated care community (ICC) and primary care network (PCN). This short-term, small funding is welcome but the ICC and PCN stated they had received applications for double the available funding and felt many applications demonstrated how they could support their populations. This type of short-term funding can make it more difficult for the VCFSE sector to build trust and long-term relationships in communities as projects end quite quickly.

The VCFSE sector generally has a closer relationship with local communities and a better understanding of their experiences and what they need from public sector organisations than public sector organisations do themselves. Box 31 describes the work of Ewanrigg Local Trust in Cumbria to improve the social determinants of health in partnership with their local residents, drawing on their experiences to inform the work. We recommend the NHS supports community-led projects, such as Ewanrigg, across all of its primary care services.

### Box 31. Ewanrigg Local Trust: the voluntary sector leading community health and wellbeing improvements

***We need to make it easier for people to improve their own and their community's health. Investment needs to be given to the communities themselves [...] to develop choice, influence and responsibilities.*** Sharon Barnes, chair of the Ewanrigg Local Trust

Ewanrigg is a residential suburb of the town of Maryport, Cumbria. The Index of Multiple Deprivation indicates that Ewanrigg is currently among the 2.5 percent most deprived Lower Super Output Area in England (31). The Ewanrigg Local Trust (ELT) is a voluntary organisation made up of residents who are working to ensure funding from the National Lottery Funded Big Local programme fund creates lasting change in their area.

A consultation with the Ewanrigg community identified mental health as the biggest crosscutting community public health issue. As a result, the ELT developed a now nationally acclaimed youth mental health campaign, 'WE WILL', and a local signposting service for mental health support, 'HUG A MUG' (258). HUG A MUG is housed in Maryport's NHS Health Services building in Ewanrigg, where community footfall is highest. Trained volunteers listen to those seeking support. The service is free, anonymous, no appointment is necessary, and people can self-refer. Everything is confidential and unlike social prescribing, no records are kept of the conversations. The space operates as a place where anyone can go if they feel overwhelmed, for a chat or for signposting on to the relevant service. HUG A MUG helps clients set up appointments, complete forms, and access other support.

The success of HUG A MUG comes from its focus on communication and community engagement, and provision of immediate help, which reduces pressure on Maryport Health Services as many of the referrals are to non-NHS services. Many of these services come from volunteer-led grassroots organisations which otherwise struggle to promote their services and to increase client take-up. They rely on HUG A MUG to signpost people directly to them.

Initial evaluations of the first three years show that out of 3,000 visits to HUG A MUG, 75 percent were for mental health reasons, finance problems were the second most common reason, accounting for 12 percent of visits. Most of those attending the service were self-referrals. The service also trains young volunteers, and many have gone into careers in health and social care as a result of their experiences with HUG A MUG.

The value of investing public funds into partnerships such as this – a community led project supported by local health services – can be clearly seen through direct savings to the public purse. It has been calculated that an expanded HUG A MUG would result in £86,400 savings of GP time per year. However, funding for delivering long-term community-led projects is hard to come by and, despite the proven track record of supporting the NHS, HUG A MUG has not received any NHS funding. Current Lottery funding lasts until the end of 2023, after which it is unclear how this valued service will be delivered (259).

Involvement of the VCFSE sector in the design and delivery of services should be a priority and contracts with VCFSE sector prioritised on principles of social value. The VCFSE sector is diverse and different approaches are needed when working with large statutory and corporate bodies compared with smaller, neighbourhood-based organisations.

Healthcare organisations tend to rely on patient groups for community involvement. While this is essential, it does not sufficiently enable effective partnerships with communities that bring insight and draw benefits to the communities themselves. Approaches need to be rapidly adopted to ensure that communities are at the heart of public sector decision-making in the region. Involving the VCFSE sector is an important first step but these organisations are not always fully representative of the broader community. Community involvement must be meaningful, that is leading to real change, with the process directly benefiting communities.

In Lancashire and South Cumbria HCP the Population Health Operating Model (Section 4A) is supporting the creation of poverty truth commissions. Poverty truth commissions seek to include people who are living in poverty in decisions made about tackling poverty (260). While we support poverty truth commissions for enabling the perspectives of communities to be heard, there has to be far greater integration of communities into the design and delivery of strategies and interventions addressing poverty in the NHS and public services. Submissions to the HEC referred to the need for all stakeholders to listen more. HEC submissions emphasised that:

- Organisations need to listen to local residents and that 'the voice of communities must be the driving force behind local action'.
- Listening to residents may involve shifting services and support to where people live and where it is convenient for people in their communities.
- Many submissions referred to the 'asset approach', which builds on the assets and strengths of specific communities and engages citizens in taking action for themselves. Not only is this empowering but it is also cost-effective and sustainable. As one submission described it: 'We all win, communities and citizens take control of what makes them well, which frees up public sector resource for those who simply are not able to take personal responsibility and need our help.'

In Morecambe Bay the NHS has been seeking ways to actively listen to local residents, Box 32.

## Box 32. Listening to communities in areas of high deprivation in Morecambe Bay

Bay Health and Care Partners worked closely with primary care networks (PCNs), integrated care communities (ICCs), local VCSFE organisations and local communities to identify and explore the impact of health inequalities within neighbourhoods across Morecambe Bay.

The first phase of the work was funded by NHS England/Improvement and Morecambe Bay CCG. Working with business intelligence colleagues, local teams, supported by staff from the population health team, segmented their population on the basis of deprivation, protected characteristics or membership of a group to select a target cohort with which to engage. The following cohorts were selected: families in Ulverston East; migrant workers in the hospitality sector in Grange and Lakes; young people aged 16–24 in Kendal; people living in rural poverty in the Western Dales; families in the Highfields Estate in Carnforth; women aged 25–64 in Skerton, Lancaster; and adults with learning disabilities living in the community in Morecambe.

The next phase of the work involved 'Co:Create' – working closely with the local teams to undertake a stakeholder and asset mapping exercise and an engagement planning exercise. These activities had to be conducted virtually, using a variety of online tools, due to the pandemic restrictions. Wherever possible, members of the local community and/or target community were involved in the planning process, which brought realism and greater insight into the engagement planning process.

The engagement work was carried out during a COVID-19 lockdown in the period February to May 2021. This precluded the use of a number of different engagement methodologies and meant that face to face engagement could only happen in restricted environments (e.g. schools and colleges). The questions asked in the engagement were broad and focused on what helped people stay healthy and well and what acted as a barrier to doing so. The sample size was not critical as it was felt that even a small response could give meaningful insight into the challenges faced by a community.

In order to both understand the social determinants of health within communities and support the required prioritisation and accountability, we propose, among other measures, that local social determinants of health data sets are developed and made widely available to communities. This type of data can help support a social movement for greater health equity, which would shape approaches to health and the roles and responsibilities of various sectors. The development of a digital directory of services for individuals and agencies could support community access to a range of services to support better health through acting on the social determinants.

In Ryelands, Lancashire, the VCFSE sector is leading a process of listening to local residents and developing actions based on their needs, Box 33.

## Box 33. Working in partnership to build futures and hope in Ryelands, Lancaster

Lancaster District Community and Voluntary Sector (LDCVS) has been actively working in Ryelands since 2018. Ryelands is one of the most deprived areas of the city of Lancaster, with a large proportion of children in receipt of free school meals. The youth club and Sure Start centre have been closed and the head of the CVS has said that Ryelands has been 'stripped of everything that it needs'.

LDCVS set up a network of local community partners called a Community Action Network (CAN). The CAN puts communities and reducing health inequalities at its centre. It first examines how to make the best use of local assets, and focuses on providing support 'for people who really need it but who are not always "seen"' and its goal is to empower residents and communities.

The CAN and local health and care services meet and seek to align their priorities and structures to work together better. The CAN seeks to embed health equity into local population health strategies. The work requires many meetings and time to develop trust between partners; as the LDCVS states, 'you can't march communities up a hill, you need to scratch heads and figure out how to invite people into the space'.

A 'Connecting Communities' approach brings community partners and residents are brought together to discuss issues that are important to them and to imagine a future for the community. The aim is for more effective actions to be implemented as a result of listening to residents. LDCVS provides support and infrastructure such as group development, training, volunteering set up, finance and insurance. LDCVS believes the Connecting Communities approach could be used by or complement the work of organisations such as PCNs, who could adopt the approach to better understand the communities where they work.

Through Connecting Communities, there is an opportunity for PCNs and community partners to develop joint leadership and training programmes, improve governance, and share data and resources, skilling up partners and the workforce to work in communities and improve relationships between community partners. A CAN approach would see the PCN being proactive, for example carrying out health checks and then working with local residents to identify next steps and how to work together to improve health.

In Ryelands the partners involved include: LDCVS, the head teacher and learning mentor from the primary school, the local integrated care communities officer, housing staff from Lancaster Council, neighbourhood policing team, a local shop owner and fish and chip shop owner, and local residents. This was the first time the headteacher and police had spoken to each other and partners learned, also for the first time, that children were being fed breakfast in school because they were arriving hungry. The meetings have led to actions such as community clean-up days to address litter problems. After hearing that teenagers in Ryelands had nowhere to go, a funding strategy for youth workers is being developed to provide support and activities to children and young people and a local campaign has been started to create a community venue.

The organisers are not paid to run the CAN programme but are doing so because the community came together to ask for change and LDCVS had spent time building relationships with local partners. The only funding from the NHS/CCG is for administering grants for the local CCG. No core funding has been received.

The community members themselves are now providing activities and support to their wider community. They have secured funding with the support from LDCVS development team to pay for, for example, room hire and equipment. They are leading on health and wellbeing programmes such as keep fit, outdoor programmes and nutrition courses. They found out that people could not afford to use the gym but wanted to exercise so the community approached the local gym, and women-only exercise classes are now attended by over 20 women. The community are also involved in improving green spaces, providing coffee mornings and reducing isolation for older people, digital programmes, after school activities for children, supporting neighbours through a friendly neighbour scheme, food clubs, literacy programmes, working closer with the city council on neighbourhood planning and on further plans to develop the skills of local residents. There are plans to work with the Community Learning Network, a partnership of education and training providers, to address barriers to learning and accessing community-based education courses.

The CAN provides opportunities for people to work together, to connect with each other, to get other people involved and support the people who are making efforts to improve the area. LDCVS sees its role as being to support these efforts (261).

## RECOMMENDATIONS. INVOLVE COMMUNITIES AND THE VCFSE SECTOR

**a)** Commission and ensure long-term funding for the VCFSE sector to enhance support for the social determinants of health.

**b)** Use community development approaches to have regular conversations with residents to identify the services and support they need to develop strong and resilient communities.

**c)** Involve local residents in the development of health inequalities assessments and remedies at place levels.

# 4F STRENGTHEN LEADERSHIP AND WORKFORCE ROLES FOR HEALTH EQUITY

**KEY MESSAGES**

- Strong leadership on health equity is essential for action on health inequalities and needs to be strengthened across the region.
- A complex regional administrative and geographic context means that strong leadership for health equity is a particular requirement in the region, supported by strong partnerships.
- A continuing health equity commission would help support effective leadership.
- Workforces in different organisations need to have greater capacity to take action on the social determinants of health. Provision of training and resources would help this and significant contributions to this could come from the VCFSE sector, if funded appropriately.
- Accountability for health equity in organisations across the region is weak and needs to be strengthened.

**Strong leadership on health equity is essential for action on health inequalities. This is the case for all the organisations that have a role in creating and reducing health inequalities, from business to local government, community and voluntary sector organisations and public services and within communities.**

In Lancashire and Cumbria systemwide leadership is urgently needed. As has been pointed out, the geography and administrative boundaries in the region are complicated and not conducive to systemwide action; other areas with more recognisable administrative boundaries or devolved powers have an advantage when it comes to regional leadership and systemwide actions.

Submissions to the HEC referred to the need for those holding leadership posts to more actively engage and act on health inequalities, particularly leaders within the NHS and for accountability for this to be strengthened.

Submissions to the HEC stated:

- Repeatedly, that leadership at the top was needed to change the way the ICS, ICPs, CCGs, acute, community trusts and primary care all address health inequalities.
- Addressing the health equity agenda needs to be written into leadership schemes and job descriptions.
- Trust needs to be extended to new leaders; for instance, the NHS should allow others besides clinical and management leads to be leaders. The following questions were asked: Is shared accountability viable? Is there a shared understanding of health equity in Lancashire and Cumbria?
- Commitment from leaders is needed to create and sustain the infrastructure to address inequalities, including business analytics/intelligence and carrying out insight work; and programme, project, managerial and administrative support.
- A 'pervasive culture, mindset and system, pressurised by national performance management and budget constraints, with sufficient understanding of, attention to, prioritisation of, and meaningful action on, health equity'.
- NHS clinicians admitted that current national performance management structures did not make them feel accountable for addressing health inequalities.
- NHS focus on targets set centrally, often with the aim of saving money and reducing response times without a wider assessment of the impact of these policies on local health inequalities.
- They wanted tools and ways for organisations and individuals to hold each other to account in taking action to address inequalities.

Organisational leadership on health equity needs to be strengthened. Components of this leadership include ensuring that the organisation has equity at the heart of all its own operations as well as the interventions and policies it leads. The newly established ICS has a remit and responsibility to reduce health inequalities; appointments for partnerships and health inequalities should be at board level with a clear remit to ensure action and investment in the social determinants of health.

The HEC heard that among different sectors and organisations, the leadership and workforce are often committed but do not know how to take the necessary steps to action. IHE has worked with medical Royal Colleges and designed online courses to build this knowhow among the health workforces and are currently running a course

with five ICSs in the South East of England to develop and strengthen workforce and leadership action on the social determinants of health (235). This kind of training and development should be available across Lancashire and South Cumbria and for different sectors and organisations. Resources for workforce development and training should be made available by the ICS and training developed in concert with the system partners, including the VCFSE sector. As partnerships between different sectors and organisations are vital to work on the social determinants of health, seconding VCFSE leaders into public services and vice versa would be and important step forward. Involving people with lived experience in training and development of leaders and workforce is important too and ensuring that there are multiple practical components to the course, which include joint work and outcomes between sectors.

## RECOMMENDATIONS. STRENGTHEN LEADERSHIP AND WORKFORCE ROLES FOR HEALTH EQUITY

**a)** Develop the workforce and provide training within each ICS, working alongside the VCFSE sector and local authorities, to identify and deliver local approaches to address the social determinants of health.

**b)** Appoint a public health consultant to the ICB to work with the Medical Director and Chief Nursing Officer, the Population Health Team and the Directors of Public Health to lead on health inequalities.

**c)** Allocate dedicated resource to the Lancashire and Cumbria Public Health Collaborative, to deliver coordinated public health actions at scale and knowledge and skills development.

# 4G MONITORING FOR HEALTH EQUITY

**KEY MESSAGES**

- To report on health inequalities and inequalities in the social determinants of health and evaluate the impact of policies and interventions, data that are relevant, robust, timely and disaggregated are needed.
- Such data are also needed to strengthen accountability for health inequalities and to increase public visibility of key issues.
- Development of a relevant health equity indicator set must involve collaborations between partners who have impact on health inequalities and in time, to be a shared indicator set.
- Many data sets are not available at sufficiently small scale, or for particular communities – particularly ethnic minority populations – and issues can remain hidden and go under the radar.
- Strengthening community involvement in action on the social determinants and health equity is supported by data which reflects their concerns, and data which is accessible and useful for them.

**To understand and report on health inequalities and inequalities in the social determinants of health, data that are relevant, robust, timely and disaggregated are needed. Such data are also essential to help evaluate and track the impact of policies and interventions, to identify new and emerging issues and to ensure there is accountability for health inequalities. An indicator set based on relevant data needs to be regularly reviewed and adapted to ensuring continuing relevance (262).**

Compared with many other countries, England has abundant data on outcomes and inequalities in health and the social determinants. Yet despite this relative abundance, there are limitations in the availability of data at sufficiently small geographic level to capture within local authority inequalities and also a lack of data disaggregated by ethnicity and by socioeconomic position such as income, occupation or education. Small area level data have been drawn on for this report and where possible data on socioeconomic position and ethnicity are included.

In Lancashire and Cumbria, a health equity indicator set for the region needs to be developed, to cover key health outcomes and social determinants based on data that is robust, timely, reliable and appropriately disaggregated. The indicators should be used to inform strategic approaches and help prioritise, to strengthen accountability, to develop most effective, evidence based approaches and monitor the impact of interventions and policies.

In Greater Manchester and Cheshire and Merseyside health equity indicator sets are being developed to establish baselines in order to monitor effects of actions to address health inequalities. Figure 4.7 outlines these proposed 'Marmot beacon indicators' for Greater Manchester. This proposed indicator set could serve as a starting point for the development of an indicator set on health inequalities and the social determinants of health for Lancashire and Cumbria.

Figure 4.7. Greater Manchester Marmot Beacon Indicators

## MARMOT BEACON INDICATORS

**Early years, children and young people**

- Indicator 1: School readiness
- Indicator 2: Low wellbeing in secondary school children (#Beewell)
- Indicator 3: Pupil absences
- Indicator 4: Educational attainment by FSM eligibility

**Work and employment**

- Indicator 5: NEETs at ages 18 to 24
- Indicator 6: Unemployment rate
- Indicator 7: Low earning key workers
- Indicator 8: Proportion of employed in non-permanent employment

**Income poverty and debt**

- Indicator 9: Children in low income households
- Indicator 10: Proportion of households with low income
- Indicator 11: Debt data from Citizens Advice

**Housing transport and the environment**

- Indicator 12: Ratio of house price to earnings
- Indicator 13: Households/persons/children in temporary accommodation
- Indicator 14: Average public transport payments per mile travelled
- Indicator 15: Air quality breaches

**Communities and place**

- Indicator 16: Feelings of safety in local area
- Indicator 17: People with different backgrounds get on well together
- Indicator 18: Antisocial behaviour

**Public health**

- Indicator 19: Low self-reported health
- Indicator 20: Low wellbeing in adults
- Indicator 21: Numbers on NHS waiting list for 18 weeks
- Indicator 22: Emergency readmissions for ambulatory sensitive conditions
- Indicator 23: Adults/children obese
- Indicator 24: Smoking prevalence

***Source:*** *Institute of Health Equity (262)*

As we have set out, a system for greater health equity requires involvement and collaboration between partners, including: healthcare, public services, local government, the community and voluntary sector and the business sector. Shared indicators between these stakeholders support an equity-focused and whole-system approach. The process for developing an indicator must involve collaboration with these partners and be developed with local information analysts and stakeholders and ultimately jointly owned between stakeholders in the region. The process of developing indicators in Greater Manchester and Cheshire and Merseyside is set out in the associated reports and was based on collaborations with stakeholders (262) (263). We propose a joint working group is established involving all the partners to develop a shared indicator set for health inequalities and the social determinants across the whole of Lancashire and Cumbria.

## EVALUATION

Regular and reliable data are also essential for evaluating the impacts of policies and interventions. Submissions to the HEC emphasised the importance of accurate and timely data.

- HEC submissions repeatedly asked for examples of 'what works' and 'what good looks like' with 'exemplars of outcomes and good practice and evidence'. However, evaluation evidence to provide this information is infrequently documented and where it is available is often at a small scale and only for pilots, many of which do not secure further funding despite promising results.

- The NHS and local government often want to fund 'innovations'. Services that are simply effective are often overlooked due to a lack of evidence that show their worth of the kind required by the NHS and local government. The VCFSE sector pleaded in a submission to 'stop reinventing the wheel. In many, many cases – we know what works.'

## HIDDEN INEQUALITIES

For some indicators data are not available at a sufficiently small area level and are thus unable to identify pockets of persistent poverty and deprivation. Moreover, some of the issues driving inequalities in isolated, rural communities are not generally included in measures of deprivation or routinely monitored in census and administrative data. In February 2022 the All-Party Parliamentary Group on Rural Health and Care found that current data is unable to adequately outline relevant problems and that current indicators, including the Index of Multiple Deprivation, can 'frequently mask pockets of deprivation and poor health outcomes in rural communities' (264). A submission to the HEC reflected on these issues:

> ***'The impact of rurality can be significant, with a lack of access to services, educational opportunities, cultural activities, social isolation and poor housing – all of which can contribute to health inequalities but can be hidden within the usual data.'***

Box 34 outlines work from the University of Cumbria that analyses the IMD and small pockets of deprivation in Cumbria.

### Box 34. Identifying pockets of deprivation in Cumbria

The IMD is calculated using Lower-layer Super Output Areas (LSOAs), which have an average population of 1,500. This means that if within a LSOA there is high polarisation between high and low deprivation, the IMD may 'average out' and show an area of middling deprivation, concealing the areas of high and low deprivation. Consequently, the IMD is most precise in areas with uniform characteristics. In geographically large areas such as Cumbria, this can be problematic.

Cumbria County Council is middle ranking across all IMD measures, suggesting relatively low levels of deprivation. North Cumbria CCG also sits in the middle of the table when considering all ranks, but for the 'rank of local concentration' Allerdale, Carlisle and Copeland district councils are ranked among the 20–40 percent most deprived district councils in England across all IMD measures. This illustrates the manner in which the IMD may conceal deprivation when viewing larger geographical areas.

The IMD is a valuable metric for identifying areas of deprivation but it is important to analyse and understand potential smaller pockets of deprivation in areas which, according to the IMD, are on the whole less deprived (265).

## COMMUNITY DATA AND PRIORITIES

To galvanise action on health inequalities and to ensure that communities' concerns are reflected, it is essential that communities have access to reliable and regular data about health inequalities and inequalities in the social determinants of health. Currently, data on inequalities in health is presented by public health departments through their Joint Strategic Needs Assessments and Health and Wellbeing Boards and the NHS monitors access to services and increasingly population health outcomes by area and socioeconomic position. But as in the rest of England, these data are largely not visible to the public or widely drawn on outside their respective organisations. Health equity indicators must also be clearly visible to the public and enable communities to hold leaders and national politicians accountable.

Health equity indicators should be related to concerns that have been voiced by the public and that are appropriate for local contexts. In Lancashire and Cumbria data about access to services, transport and social isolation in rural areas and about housing conditions and food poverty are community priorities but there is insufficient disaggregated and timely data on these issues. There is a need to develop local data about these and other issues raised by communities to inform strategies and policies. A more systematic approach to addressing community concerns and needs assessments is important and the HEC recommends developing a community health equity dashboard that is related to community concerns and that is accessible and actively promoted to all communities. The VCFSE may be best placed to develop these community dashboards, with funding made available from the NHS, local government and potentially businesses.

### RECOMMENDATIONS. MONITORING FOR HEALTH EQUITY

**a)** Develop a set of health equity and social determinants of health indicator set based on reliable, regular data which is disaggregated by key characteristics, including deprivation, ethnicity and gender, to be used by all sectors in Lancashire and Cumbria.

**b)** Collate data available in the VCFSE sector relevant to understanding and addressing the social determinants of health. Develop data sharing agreements between NHS and VCFSE sector.

# RECOMMENDATIONS

## IHE proposes the following Marmot 8 and system-wide recommendations for action across Lancashire and Cumbria. The system-wide recommendations enable and support actions in the Marmot 8 thematic areas.

These are the building blocks for building a healthier and more equitable society – some of the recommended actions and policies are already in place in Lancashire and Cumbria, but not at the scale or the pace needed. The recommendations cover the critical social determinants of health and are tailored to the circumstances in Lancashire and Cumbria. While many of the recommendations require investment, we highlight the importance of good health to the economy and businesses and the reduced demand, and costs to services which will result from better health and reduced inequalities.

There are other recommended actions which can be done without additional investment – many of these are in the remit of the broad system – public services, the community and voluntary sector, businesses and local authorities. Shifting ways of working can result in enormous benefits to health equity and support the leadership which is so important to health equity.

# MARMOT 8 RECOMMENDATIONS

## 1. GIVE EVERY CHILD THE BEST START IN LIFE

**KEY MESSAGES**

- Outcomes in the early years have lifelong impacts. Inequalities in the early years are significant contributors to inequalities in health throughout life.
- The early years are the period of life when interventions are most effective and cost-effective and yield significant returns on investment.
- Levels of child development are lower in areas of higher deprivation.
- Between 2009 and 2019 there was continuous disinvestment in the early years and declines in spending were greatest in the most deprived areas.

**HEALTH INEQUALITIES IN THE EARLY YEARS**

- Rates of infant mortality in the region are higher than the England average and increasing. They are closely related to deprivation.
- Three areas – Blackburn with Darwen, Hyndburn and Preston – have higher rates of low birth-weight babies than the average for England.
- In each of the 20 districts across Lancashire and Cumbria there are high rates of unintentional and deliberate injuries in babies children and young people.

**INEQUALITIES IN DEVELOPMENT DURING THE EARLY YEARS**

- There are wide inequalities in levels of development among young children in Lancashire and Cumbria. At reception children eligible for free school meals have levels of development considerably below the England average and well below those children who are not eligible for free school meals.
- The quality of early years support and services in the region is not sufficient for children living in poverty. Without effective intervention, inequalities will continue and amplify throughout life.
- The childcare workforce is vital in reducing inequalities in outcomes but is currently under-resourced and undervalued.

**RECOMMENDATIONS**

**a)** Reduce the gap in level of development in reception age children and set a target that every child achieve above the national average at readiness for school at reception.

**b)** Increase access and provision of early years services in areas with higher levels of deprivation, and ensure allocation of funding is proportionately higher in areas of higher deprivation

**c)** ICS and local authorities equip all those working with young children to support parents in developing their children's early learning, especially with regard to speech and language skills.

**d)** Develop and adopt a region-wide childcare workforce standard that includes training and qualifications on the job, including access to NHS training and offer, as a minimum, the real living wage to all early years staff.

**Leads:** Local authorities, NHS

**NATIONAL ADVOCACY**

- Increase levels of spending on the early years.
- Funding to provide real living wage as starting salaries for early years employees and clear progression routes for early years staff.

## 2. ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES.

### KEY MESSAGES

- Experiences during school years and into early adulthood continue to impact people throughout their lives, affecting employment opportunities, lifetime earnings and health.
- Inequalities in educational attainment were wide before the pandemic and have since widened.
- Funding for secondary education declined between 2010-20 and youth services have been cut which have harmed young people, particularly those living in more deprived areas and households.
- Reducing inequalities in educational attainment and experiences at this stage of life are effective in reducing health inequalities throughout life.
- The mental health of young people has deteriorated and there is a sense of hopelessness among many young people particularly those living in more deprived areas and isolated communities.

### INEQUALITIES IN HEALTH

- There are high rates of injuries among young people in some districts in the region which are closely related to levels of deprivation.
- Prior to the COVID-19 pandemic one in 10 children and adolescents in the UK were experiencing a diagnosable mental health disorder which often have lasting consequences. The pandemic has led to an increase in mental health problems among young people.
- Young people and children from low-income households report worse mental health and wellbeing, including higher levels of anxiety and loneliness.
- Child poverty is a significant risk factor for poor mental health in children and as poverty increases it is likely the mental health of young people will deteriorate still further.

### INEQUALITIES IN EDUCATIONAL ATTAINMENT

- Children and young people who grow up in poverty are more likely to have poor educational outcomes and less access to training and decent jobs.
- Inequalities in educational attainment increased during the pandemic.
- There are wide inequalities during primary school between those eligible and those ineligible for free school meals. The region performs roughly as well as the average for England for both children eligible for free school meals and those ineligible although in Lancashire and Blackpool outcomes for children eligible for free school meals are a little lower.
- By age 16 inequalities in education have widened and all districts but Blackburn with Darwen are performing below the national average.
- Given its level of deprivation, Blackburn with Darwen has strong outcomes and low levels of inequality for educational attainment.

**RECOMMENDATIONS**

**a)** Reduce the gap in Attainment 8 progress scores between pupils eligible for free school meals and other pupils in every school and create the culture for every pupil to thrive with skills for life.

- Poverty proof all schools and define a whole-school approach for Lancashire and Cumbria.
- NHS and education review the circumstances in which data sharing is permitted.
- All schools to adopt a wellbeing survey among school children.
- Extend free school meal provision to all pupils living in households in receipt of Universal Credit and adequately resource holiday hunger initiatives for secondary school students.
- Jointly commission universal programmes to build resilience and support young people's mental health, and to support their families with additional resources in more deprived areas.

**b)** Anchor organisations and local economic partnerships to work closely with schools and colleges in areas with higher levels of deprivation to provide apprentices, job training and employment shadowing with a guaranteed employment, apprenticeship or training offer for 18-25 year olds.

**c)** Increase levels of funding for youth services, focusing on areas with higher levels of deprivation.

**Leads:** Education, NHS

**NATIONAL ADVOCACY**

- Reverse the decline in per-pupil education expenditure.
- Advocate to significantly reduce inequalities in educational attainment by use of the Pupil Premium to increase teachers' pay and increase funding for schools in areas of high deprivation.

## 3. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

**KEY MESSAGES**

- Unemployment and poor quality work harm health and increase mortality.
- Poor quality work and unemployment contribute to health inequalities and the quality of work has deteriorated over the last ten years.
- Poor health is affecting the economy of the region and lowering productivity and inward investment. In Lancashire, if productivity matched the English average, it is estimated £9.9 billion would be added to the national economy. Modelling for the Cumbria LEP estimates that increasing employment rates in the worst employability 'cold spots' could add 4,500 people to the workforce.
- Employers can do far more to improve the quality of work and improve health and reduce health inequalities. This is also beneficial to them as it improves recruitment, retention, reduces sick pay and increases productivity.

**UNEMPLOYMENT**

- Employment in Blackburn with Darwen and Blackpool is lower than the North West and England averages and in Barrow-in-Furness and Blackburn with Darwen less than 65 percent of people are in employment.
- Low levels of employment are closely related to poor health and deprivation.
- Lack of transport in rural and coastal areas is a significant barrier to employment.

**QUALITY OF WORK**

- In the region employment rates have increased since 2010 but many of these jobs are low skilled and self-employed jobs (often zero hours contracts).

**PAY**

- Across England wage growth has been low since 2010 and rates of in-work poverty have increased.
- Before the pandemic, wages in the North of England were lower than in the rest of England and they fell further during the pandemic.
- The percentage of women in the region earning below the national living wage is higher than the average in England. Men in Blackpool and Blackburn with Darwen are also less likely to earn the living wage than across England.

**RECOMMENDATIONS**

**a)** Local economic partnerships, NHS, local authorities and all public services to develop a regional good work charter and apply these obligations on public sector contracts. The charter should include:

- Wages to meet the minimum income standard for healthy living.
- Provision of in-work benefits including sick pay, holiday and maternity/paternity pay.
- Provision of advice and support at work, e.g. on debt, financial management and housing.
- Provision of education and training on the job for all ages.
- Strengthened equitable recruitment practices, including provision of apprenticeships and in-work training, and recruitment from local communities and those underrepresented in the workforce.
- No gender pay gap

**b)** Increase funding for adult education in areas of higher deprivation. Offer training and support to older unemployed adults, ensuring that the private sector participates

**c)** ICSs, local economic partnerships and chambers of commerce to encourage and incentivise employers to recruit lone parents, carers and people with mental and physical health disabilities and long-term conditions.

**Leads:** Local economic partnerships and businesses, local authorities and NHS

**NATIONAL ADVOCACY**

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life
- Engage in a national discussion on the balance of the work-life balance including consideration of a four day week.
- Increase pay for apprentices.

## 4. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

**KEY MESSAGES**

- Poverty harms health affecting likelihood of living in healthy homes and environments and being able to access services, goods and quality employment – which are essential to good health.
- Poverty leads to stress and mental health problems and affects people's capacity to make healthy, long-term choices.
- The cost of living is rapidly increasing, pushing many more people into poverty and ill health.
- In-work poverty has been increasing and is set to increase further.
- Over the last twelve years, tax and benefit reforms have widened income and wealth inequalities.
- There are limits to the powers Lancashire and Cumbria have to increase household incomes but they can take actions to encourage employers to adopt the real living wage, advocate for changes to the benefit system as well as help reduce food and fuel poverty and support access to financial services and reputable lenders.
- Involving communities in developing actions to reduce poverty and impacts on health is vital.

**CHILD POVERTY**

- Child poverty is associated with poor mental, social, physical and behavioural development in children, as well as worse educational outcomes, employment prospects and earning power into adulthood.
- Child poverty has been increasing across England and across most of the 20 local authority districts in Lancashire and Cumbria.
- There are areas with high levels of child poverty in wealthy local authorities, which often 'go under the radar'.

**FUEL POVERTY**

- Fuel poverty rates are high in many rural and areas of high deprivation in the region.
- Cold, damp homes damage health and increase mortality. Excess winter deaths (partly related to living in a cold home) are high in many rural and deprived areas in the region.
- Fuel poverty will increase significantly, damaging the health of many more people, as fuel costs increase.
- Insulating homes is an effective way to reduce poverty, reduce the numbers of cold, damp homes and reduce greenhouse gas emissions.

**RECOMMENDATIONS**

**a)** Adopt the minimum income standard as a basis for minimum wage and assess if adapting for regional costs is needed.

**b)** Create and support community and employer finance institutions to supply credit, reduce levels of debt and provide financial management advice.

**c)** The NHS, local authorities, schools and employers to commission the VCFSE sector to provide of social welfare legal and debt advice, including fuel and food poverty support

**Leads:** Businesses and local economic partnerships, local authorities, NHS

**NATIONAL ADVOCACY**

- Make the social safety net sufficient for people not in full-time work to receive the minimum income standard.
- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Additional funding in areas with high levels of deprivation including levelling up funds to better reflect deprivation.

## 5. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

**KEY MESSAGES**

- One of the most significant ways in which health inequalities can be reduced is through good quality housing and safe environments, with access to transport, services and shops, healthy high streets, community facilities, leisure and entertainment and good quality natural environments.

**HOUSING**

- Across the region there is a substantial amount of inadequate housing stock – poor quality, poorly insulated and overcrowded homes. These issues have direct and indirect impacts on health.
- Many homes in the private rental sector have high levels of cold, damp and poor conditions, but there is a lack of enforcement and tenants are also vulnerable to eviction if they complain.
- There are long waiting lists on the social housing registers.
- In the region, Preston, Blackpool and Blackburn with Darwen have the highest rates of people sleeping rough. Blackpool, Chorley, Blackburn with Darwen and Burnley have the highest rates of homeless households eligible for assistance, all above the England average.
- Across the region there are some important interventions to improve quality of housing and reduce homelessness but these need to be extended more widely with adequate resourcing.
- Given the significance of housing to health, the NHS must be more involved in improving housing in the region.

**TRANSPORT**

- Preventing ill health is vital for reducing demand for NHS services, as well as beneficial for the population and the economy.
- Much of the ill health in the region is avoidable and action on the social determinants would improve health and reduce inequalities and reduce the burden on NHS and other services, reducing costs in the long run.
- There are good examples of services taking a social determinants of health approach in the region but these need to be rapidly expanded with adequate resources.

**RECOMMENDATIONS**

**a)** In partnership between local authority, NHS and VCFSE sector, develop a regional decent homes standard by 2025.

- Strengthen local enforcement powers and capacity across planning and housing and ensure decent homes standards in the private rented sector.
- Develop and support regional housing forums in Lancashire and Cumbria with members from housing associations, NHS, VCFSE sector, local authorities, estate agents and private rented sector.

**b)** Place reducing inequalities at the centre of local and regeneration plans including fit for purpose, affordable housing.

- Identify pilot neighbourhoods in areas of high deprivation and work with communities to create and sustain high-quality and connected neighbourhoods.
- Work in partnership (with local residents, NHS, chambers of commerce, local economic partnerships and local authorities) to develop healthier high streets.

**c)** Assess provision of public transport and address limitations in access. Resource VCFSE sector to provide adequate transport services in remote and rural communities.

**Leads:** Businesses and local economic partnerships, local authorities, NHS

**NATIONAL ADVOCACY**

- Advocate for removal of obstacles to selective licensing schemes and ensure provision of funds to create and maintain a private landlord registry.
- Advocate for devolved powers to give control over transport with a London-style transport system that supports affordable access to rural and coastal communities.

## 6. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

**KEY MESSAGES**

- Preventing ill health is vital for reducing demand for NHS services, as well as beneficial for the population and the economy.
- Much of the ill health in the region is avoidable and action on the social determinants would improve health and reduce inequalities and reduce the burden on NHS and other services, reducing costs in the long run.
- There are good examples of services taking a social determinants of health approach in the region but these need to be rapidly expanded with adequate resources.

**SMOKING, ALCOHOL, DRUG USE AND OVERWEIGHT AND OBESITY**

- Smoking, alcohol and drug use and obesity are linked with many of the avoidable deaths and long-term conditions and are higher in more deprived communities.
- Across most of the region mortality from alcohol is higher than the English average and closely associated with deprivation.
- In Blackpool, Cumbria and Blackburn with Darwen deaths from drugs are higher than the English average and hospitalisations from substance misuse are higher across the whole region.
- In most of Lancashire and Cumbria's local authority districts rates of overweight and obesity are higher than the England average and associated with deprivation particularly for children.
- Levels of physical activity are also associated with deprivation.

**DIGITAL EXCLUSION**

- While digital services and apps offer many benefits, they also risk widening inequalities unless effective action is taken to ensure there are still services and resources available to all.
- The prevalence of digital-only services is increasing and excludes many from healthcare, education, employment and local authority services, as well as from accessing resources and information and social interaction.
- Those who are the most in need of support, such as older people and those on the lowest incomes, are the least likely to engage with digital platforms.

**RECOMMENDATIONS**

**a)** HCP and ICS review social prescribing offer to ensure it is addressing the social determinants of health.

**b)** Adopt the Fleetwood and Deep End models to address the social determinants of health in primary care.

**c)** Include digital inclusion as an essential health equity requirement, and ensure that healthcare, local authorities, education and businesses work in partnership with local residents to invest in digital skills, including provision of funding to the VCFSE sector to support this.

- Prioritise improving skills in older people or alternative accessible services.
- Align local poverty strategies to include commitment to reducing digital exclusion.
- Work in partnership with local communities to assess digital exclusion priorities.

**Leads:** Local authorities, NHS

**NATIONAL ADVOCACY**

- Advocate for a real-terms percentage increase in the regional budget for public health and overall funding for Public Health to be at a level of 0.5% of GDP.
- Strengthen accountability for health inequalities across all NHS organisations.

## 7. TACKLE DISCRIMINATION, RACISM AND THEIR OUTCOMES

**KEY MESSAGES**

- The pandemic revealed the stark inequalities in health and economic and social disadvantages in many of the UK's ethnic minority communities.
- These disadvantages are partly related to experiences of exclusion, racism and discrimination.
- Many ethnic minorities experience multiple exclusions linked also to gender and disability with cumulative damage to health – physical and mental.
- Rates of some diseases and infant and maternal mortality are higher in ethnic minority populations and access to, experience of, and outcomes from health services can also be worse for ethnic minority populations.
- Data on ethnicity is lacking in many key social determinants of health in the region so it is hard to monitor inequalities but there is much that employers and providers of services can do to reduce discrimination and inequalities.

**RECOMMENDATIONS**

**a)** Local economic partnership and chambers of commerce to work with Lancashire and Cumbria businesses, the NHS local authorities and public authorities to gather ethnicity data by pay and grade, and to use this data to address wage gaps and inequalities in seniority.

**b)** All businesses, public sector and VCFSE sector organisations to ensure equality duties are met in recruitment and employment practices, including pay, progression and terms.

**c)** Reinforce the efforts of health and social care providers to ensure equitable access to their services.

**d)** Ensure effective engagement with all ethnic minority populations in the development and delivery of services and interventions.

**Leads:** Local economic partnerships, NHS

**NATIONAL ADVOCACY**

- Implement actions in NHS to ensure recording of ethnicity data occurs and act on this data and there are regular equity audits.
- Ensure that reports of racism in all sectors are investigated and changes made.

## 8. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

**KEY MESSAGES**

- Tackling climate change and health inequalities in unison is vital so efforts to reduce health inequalities do not damage the environment and efforts to improve the environment do not damage equity.
- Harm to health from climate change will affect more deprived communities the most.
- There are predictions of significant environmental change in the North West including increasing temperatures, reduced summer rainfall and more extreme weather events and flooding.
- There are high levels of greenhouse gas emissions in some districts in the region, notably Eden and Ribble Valley.
- Transport is the largest contributor to the UK's poor air quality. Supporting public transport and active travel and reducing private car will improve air quality and improve health.
- There are many interventions which are beneficial to the environment and beneficial to health – home insulation, increased active and public transport and reduced meat consumption among them.

### RECOMMENDATIONS

**a)** Ensure that the health and wellbeing of citizens and environmental sustainability is the basis of all local economic policy.

**b)** Deliver a five-year plan to retrofit homes, including private homes, to reduce fuel poverty and improve domestic energy efficiency in homes in areas of high deprivation.

**c)** Local economic partnerships and anchor organisations to support actions to adopt carbon-neutral modes of transport to work environments including investments in in green bus transport and improved active travel rates in all areas of Lancashire and Cumbria.

**Leads:** Local economic partnerships, local authorities, NHS

### NATIONAL ADVOCACY

- 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector
- Align health and climate goals, to transition away from carbon and build resilient communities that are well adapted to respond to climate change impacts.

# SYSTEM-WIDE RECOMMENDATIONS

## A. FOCUS ON EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH

**KEY MESSAGES**

- There is far more that healthcare services can do to reduce health inequalities and support action on the social determinants of health.
- Action from healthcare organisations must focus on the whole gradient, in a proportionate way, and on the social determinants. Reducing inequalities in access to healthcare is important but will not reduce the widescale inequalities we report on here and in other reports.
- There is a financial, as well as moral case, for the NHS to reduce health inequalities. Areas with higher deprivation have higher healthcare needs, and as a result, higher healthcare costs.

**THE ROLE OF THE ICS**

- Both ICSs in the region have a focus on reducing healthcare and population health but need to further strengthen action on the social determinants and build strong partnerships with local government, public services and the VCFSE sector and work with businesses.

**NHS TRUSTS**

- NHS Trusts can also strengthen action on the social determinants, extending activity beyond the usual anchor approach into collaborations on the social determinants with local government, public services, the VCFSE sector and employers.
- Social value is important in all procurement and contracting.

**PRIMARY CARE**

- Primary care is well placed to take action to improve health and reduce health inequalities through action on the social determinants and contributing to improving conditions in which people are living and preventing ill health.
- This can include access to services supporting better housing, support with debt and access to benefit entitlements, referrals to skills and training for employment.
- Social prescribers and Citizens Advice have been involved in many GP surgeries and across primary care but there is scope to do much more.
- GP practices serving areas with high levels of deprivation receive around seven percent less funding per patient than those serving more affluent populations and funding needs to be further weighted and adjusted to need.
- Many GP practices in more deprived areas face significant recruitment and staffing issues. Training and employing local populations may help and offering higher levels of pay in more deprived areas.

**ACCOUNTABILITY FOR HEALTH INEQUALITIES WITHIN THE NHS**

- Strengthened accountability within healthcare for health inequalities is essential. Accountability in the healthcare system is mostly related to specified targets around access to services.
- National NHS targets, which drive activity and priorities, do not include a wider assessment of the impact of policies on inequalities.
- Currently, in the region accountability for health inequalities is described as 'toothless'.

**RECOMMENDATIONS**

**a)** NHS, local authority, and public sector leaders in Lancashire and in Cumbria to strengthen accountability for health equity.

**b)** Develop regional health equity and the social determinants of health action plans involving businesses, public services, local government and communities, prioritising early intervention through long-term investments.

**c)** Define and implement Marmot NHS Trusts approach across Lancashire and Cumbria.

## B. INCREASED AND MORE EQUITABLY DISTRIBUTED RESOURCES

**KEY MESSAGES**

- Increasing resources is urgently needed to reduce health inequalities and to take action on the social determinants of health and recent spending announcements about future funding levels are insufficient.
- Over the last twelve years cuts to local authorities and public services have harmed health and widened inequalities. The cuts have been regressive: they are steeper in more deprived areas.
- The Levelling Up Fund is insufficient to redress the cuts or meet the needs in more deprived areas.
- Increases to the public health grant are far short of need and, given inflation, are effectively significant cuts.
- A larger proportion of NHS funding must be directly allocated to action on the social determinants of health increasing by 1 percent above inflation each year for the next 10 years.

**RECOMMENDATIONS**

**a)** Benchmark NHS and local authority prevention spend in 2022–23 and increase funding for prevention by 1 percent above inflation each year for the next 10 years to address inequalities in the social determinants.

**b)** Make resource allocations more equitable and extend the Lancashire and South Cumbria formula across the NHS in Lancashire and Cumbria.

## C. STRENGTHEN PARTNERSHIP WORKING

**KEY MESSAGES**

- Reducing health inequalities requires robust partnerships between sectors and organisations that have an impact on health. These have not been established in the region and silo working is firmly entrenched.
- Partnerships must include local government, public services including healthcare, the police and education, the VCSFE sector, businesses and communities.
- There must be a focus on equity and the social determinants of health and on developing the necessary mechanisms to support such partnerships.
- The VCFSE sector are vital to the success of action on the social determinants of health but are frequently excluded from partnerships and not resourced for participation and contributions.

**RECOMMENDATIONS**

**a)** Develop a health equity network in Lancashire and Cumbria to include business and economic sector, public services, VCFSE sector, local government.

**b)** Appoint a Director of Partnerships at Board level within each ICS.

**c)** As the default, ensure the involvement of the VCFSE sector in the design and delivery of services and support the VCFSE sector to bid for contracts.

## D. STRENGTHEN THE ROLE OF THE BUSINESS AND ECONOMIC SECTOR AND EXTEND SOCIAL VALUE APPROACHES

**KEY MESSAGES**

- Businesses and the economic sector have important impacts on health inequalities but have not been sufficiently involved in discussions and actions about how to reduce them.
- The costs of ill health are well known and productivity and staff retention are linked to the health of the working age population. Sick pay costs are also a burden for businesses. It is estimated that poor health costs the economy £100 billion per year nationally.
- Attracting inward investment is more successful where the working population is relatively healthy, and the relative poor health of the region undermines the case for economic investment in the region.
- Businesses and public sector employers can help reduce health inequalities by providing good quality employment and equitable recruitment; providing healthy products, services and investments; and influencing and partnering with communities.
- Social value contracting should become a general principle in procurement and commissioning for all public sector organisations.

**RECOMMENDATIONS**

**a)** Coordinate a regional economic partnership to develop a health equity approach for businesses and implement the recommendations in the 'The Business of health equity' report for businesses to make positive contributions to the health of their workforce, ensure goods and services are healthy and to make social and economic investments in areas of deprivation.

**b)** Build on and extend the anchor institution approach and require that organisations, including businesses commission for social value and employ local and underrepresented groups.

## E. INVOLVE COMMUNITIES AND VOLUNTARY, COMMUNITY, FAITH AND SOCIAL ENTERPRISE SECTOR

**KEY MESSAGES**

- Involving the VCFSE sector in the design and delivery of public and local government services is essential to ensuring that services are appropriate, relevant and bring benefits to local communities. Currently this is insufficient.
- The VCFSE sector has expertise and involvement in all the areas outlined in this report and are vital partners in action to reduce health inequalities and inequalities in the social determinants of health.
- Generally the VCFSE sector is overlooked by public services and local government yet they tend to have a closer relationship with local communities, and, as a result, have a better understanding of their experiences and what they need from public sector organisations.
- Lack of funding and other resources are undermining the capacity of VCFSE organisations to improve the social determinants of health. Grants and tenders are often burdensome with stringent requirements and often for small pots of money and short time frames.
- Where communities are involved with public sector and local government organisations, the process can be frustrating and outcomes limited. Community involvement must be meaningful, leading to benefits for communities.
- There are some good examples of constructive community involvement in the region, these approaches can be further utilised across the region.

**RECOMMENDATIONS**

**a)** Commission and ensure long-term funding for the VCFSE sector to enhance support for the social determinants of health.

**b)** Use community development approaches to have regular conversations with residents to identify the services and support they need to develop strong and resilient communities.

**c)** Involve local residents in the development of health inequalities assessments and remedies at place levels.

## F. STRENGTHEN LEADERSHIP AND WORKFORCE ROLES FOR HEALTH EQUITY

**KEY MESSAGES**

- Strong leadership on health equity is essential for action on health inequalities and needs to be strengthened across the region.
- A complex regional administrative and geographic context means that strong leadership for health equity is a particular requirement in the region, supported by strong partnerships.
- A continuing health equity commission would help support effective leadership.
- Workforces in different organisations need to have greater capacity to take action on the social determinants of health. Provision of training and resources would help this and significant contributions to this could come from the VCFSE sector, if funded appropriately.
- Accountability for health equity in organisations across the region is weak and needs to be strengthened.

**RECOMMENDATIONS**

**a)** Develop the workforce and provide training within each ICS, working alongside the VCFSE sector and local authorities, to identify and deliver local approaches to address the social determinants of health.

**b)** Appoint a public health consultant to the ICB to work with the Medical Director and Chief Nursing Officer, the Population Health Team and the Directors of Public Health to lead on health inequalities.

**c)** Allocate dedicated resource to the Lancashire and Cumbria Public Health Collaborative, to deliver coordinated public health actions at scale and knowledge and skills development.

## G. MONITORING FOR HEALTH EQUITY

**KEY MESSAGES**

- To report on health inequalities and inequalities in the social determinants of health and evaluate the impact of policies and interventions, data that are relevant, robust, timely and disaggregated are needed.
- Such data are also needed to strengthen accountability for health inequalities and to increase public visibility of key issues.
- Development of a relevant health equity indicator set must involve collaborations between partners who have impact on health inequalities and in time, to be a shared indicator set.
- Many data sets are not available at sufficiently small scale, or for particular communities – particularly ethnic minority populations – and issues can remain hidden and go under the radar.
- Strengthening community involvement in action on the social determinants and health equity is supported by data which reflects their concerns, and data which is accessible and useful for them.

**RECOMMENDATIONS**

**a)** Develop a set of health equity and social determinants of health indicator set based on reliable, regular data which is disaggregated by key characteristics, including deprivation, ethnicity and gender, to be used by all sectors in Lancashire and Cumbria.

**b)** Collate data available in the VCFSE sector relevant to understanding and addressing the social determinants of health. Develop data sharing agreements between NHS and VCFSE sector.

# ANNEX

# HEALTH EQUITY COMMISSION MEMBERS AND ORGANISATIONS

Sue Cotton, Child Action North West

John Donnellon, Blackpool Coastal Housing

Eileen Fairhurst, East Lancashire Hospital Trust

David Flory, Lancashire and South Cumbria Health and Care Partnership

Debbie Francis, Lancashire Enterprise Partnership

Julie Higgins, Lancashire and South Cumbria Health and Care Partnership

Mohammed Khan, Blackburn with Darwen Borough Council

Jo Lappin, Cumbria Local Enterprise Partnership

Adrian Leather, Active Lancashire

Jennie Popay, Lancaster University

Peter Rooney, NHS Cumbria Clinical Commissioning Group

Jon Rush, North Cumbria Integrated Care Partnership

Mohammed Sidat, IMO Charity

Lynn Williams, Blackpool Council

Phillipa Williamson, Lancashire County Council

Stuart Young, Cumbria County Council

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