

All Together Fairer for Health Equity: Champs Public Health Collaborative and the IHE



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INTRODUCTION

Tackling health inequalities remains one of the most persistent and complex challenges facing local authorities, health systems and public health teams across the UK. In **Cheshire and Merseyside**, a region in North West England, **significant health inequalities persist**; regional collaboration and system-wide responses are central to tackling them and improving people's lives. In order to support action to reduce inequalities in health, the Cheshire and Merseyside Health and Care Partnership (HCP) commissioned the Institute of Health Equity (IHE) in 2021, to provide analysis, support and advice for the Region to develop as a Marmot Region. The partnership continues.

This report explores how **the Champs Public Health Collaborative** (the Collaborative) and the **IHE** have together formed a powerful system for tackling health inequalities in Cheshire and Merseyside. The Collaborative plays a critical role in enabling and coordinating delivery, while the IHE, in partnership with the Directors of Public Health (DsPH), provides strategic direction, academic credibility, and a framework for action. While the Collaborative ensures a consistent and practical focus on shared regional priorities, the IHE catalyses change by embedding the Marmot principles into the broader policy landscape. Both organisations have distinct but interdependent roles—and both must continue to build momentum to drive progress at scale.

The Collaborative brings together the Directors of Public Health from all nine local authorities in Cheshire and Merseyside, enabling senior public health consultants and teams to work together. It has become a well-established and trusted system, widely regarded as the backbone of public health leadership across the subregion. In 2023, its reach extended further when the newly appointed **Director of Population Health for NHS Cheshire and Merseyside** (a former Director of Public Health) was invited to join the Champs Collaborative Board, creating a deeper alignment between public health and the NHS. The work of the Collaborative is supported by a small central team, the Champs Support Team, which is hosted by Wirral local authority.

The work of the Collaborative and the IHE has been **marked by strong partnership**. The IHE was commissioned by the NHS but the commission was overseen and the work delivered in partnership with the Collaborative. The IHE has provided the strategy, the responsibility for translating the strategy into delivery fell to local systems and the system leadership fell to the Collaborative. *"It was the NHS, not Champs, that commissioned IHE... but Champs took ownership."*

The ICS and the Collaborative have played an essential role in setting strategic direction and maintaining visibility for health equity, while local authorities, the voluntary and community sector and wider partners have driven forward delivery on the ground, often through innovative, locally tailored approaches.

INVITING IHE TO CHESHIRE AND MERSEYSIDE

Cheshire and Merseyside's decision to become a Marmot Place marked a turning point. It facilitated a structured, evidence-based approach to tackling the social determinants of health, focusing on the drivers of health, such as early years development, education, employment, housing, and community resilience. While the IHE brought strategic coherence through the *All Together Fairer* report, published in 2022 (1), the Collaborative mobilised system partners, developed shared ownership, and ensured that the report's principles translated into practical, coordinated action. Together, they aimed not just to influence policy but to transform the culture and expectations of health equity across sectors.

This report draws on over **25 qualitative interviews** with professionals across the subregion. It examines **how the Collaborative and the IHE have contributed** to strengthening public health leadership, embedding the Marmot principles at scale, advancing whole-system collaboration, supporting professional resilience, and shaping responses to the wider determinants of health. It also considers how this model could inform efforts in other regions of England and how the Collaborative itself may need to evolve to meet future challenges.

At its core, this report is an evaluation of how a strategic framework, supported by operational leadership and embedded in a strong collaborative ethos, can catalyse meaningful and sustainable progress in reducing health inequalities. The Cheshire and Merseyside experience offers valuable insights into what it takes to make health equity a collective and enduring system ambition.

HEALTH INEQUALITIES IN CHESHIRE AND MERSEYSIDE

Cheshire and Merseyside, with a population over 2.7 million, encompasses a mix of urban, suburban, and rural communities. The region includes some of the most affluent neighbourhoods in England alongside some of the most deprived. This stark contrast is reflected in deep and persistent inequalities in income, employment, housing, education, and health.

¹All quotes are from interviews carried out for this research.

Life expectancy varies widely within and between the nine local authorities. In Cheshire East—a largely rural area with a population of over 400,000—female life expectancy at the neighbourhood level ranges from 77 to 91 years, a 14-year difference. There is nearly a **17-year difference in male life expectancy** between the highest and lowest **Middle Super Output** areas in **St Helens and Liverpool**.

Table 1 sets out **inequalities in life expectancy within each local authority in the subregion**. In every local authority in the subregion, the inequality in male life expectancy exceeds 9 years; in some cases, it is nearly double that. These differences reflect avoidable and unjust differences in conditions in which people are born, grow, live, work, and age, the social determinants of health.

Table 1: Highest and lowest life expectancy in years by MSOA, Cheshire and Merseyside Local Authorities and England, 2016-2020

FEMALE		Lowest	Highest	Difference
	Cheshire East	76.7	90.9	14.2
	Liverpool	75	88.6	13.6
	Sefton	75.7	89.2	13.5
	Wirral	74.4	87.4	13
	Knowsley	76.5	88.5	12
	St Helens	75.9	86.3	10.4
	Cheshire West and Chester	78.3	88.5	10.2
	Halton	77.8	86.9	9.1
	Warrington	78.7	86.1	7.4
	England average	83.2		NA
MALE		Lowest	Highest	Difference
	St Helens	68.5	85.4	16.9
	Liverpool	70.6	87.2	16.6
	Wirral	67.7	83.3	15.6
	Sefton	70.4	84.7	14.3
	Knowsley	70.9	82.4	11.5
	Cheshire West and Chester	73.6	84.7	11.1
	Cheshire East	74.5	85.2	10.7
	Halton	72.7	82.5	9.8
	Warrington	73.4	82.9	9.5
	England average	79.4		NA

Source: Source: Office for National Statistics (2)

Note: This is the most recent data at MSOA level. Middle-Layer Super Output Areas (MSOAs) are a statistical geography created for the Census. MSOAs have a typical population of 7,000-10,000 people. Each MSOA sits within a local authority, they are not the same as wards but are designed to be similar in size to wards. MSOAs can span across multiple wards, and wards can have different names and boundaries than MSOA.

Beyond overall life expectancy, healthy life expectancy (how many years people live in good health) reveals further stark inequalities. In some parts of the region, residents can expect to spend over a decade less in good health than their neighbours in more affluent areas just a few miles away.

“(The) Region has some of the starkest health inequalities in the country. If we don’t address the root causes—poverty, poor housing, insecure jobs—then we’re just treating symptoms, not solving the problem.”

These long-standing structural inequality challenges have been compounded by the cumulative effects of structural inequality, prolonged austerity, rising living costs, and the lasting impacts of the COVID-19 pandemic. Local authorities have had to navigate shrinking budgets and public health teams are increasingly overstretched.

“We cannot tackle health inequalities on goodwill alone. We need proper investment in people, skills, and systems.”

Despite these pressures, public health professionals across the subregion have found ways to adapt. Funding constraints have forced teams to be more focused, innovative and collaborative. The Collaborative plays a critical role in enabling this – bringing together Directors of Public Health, senior consultants, and system partners to coordinate efforts, share learning, and strengthen collective approaches. While the scale of inequality remains, progress is possible—particularly when efforts are aligned, resources are pooled, and achievable goals are pursued together through trusted regional infrastructure like the Collaborative.

CHESHIRE AND MERSEYSIDE'S REGIONAL COLLABORATIVE

"Champs is a conduit... not just an administrative network but a strategic, nurturing, and effective system."

The Collaborative was established in 2003 and is a respected regional public health collective serving the nine local authorities of Cheshire and Merseyside involving the Directors of Public Health and their teams. The Collaborative plays a **vital strategic and coordinating role in addressing health inequalities and improving health outcomes** across the region through system leadership, expert support, and delivery capacity on a range of shared prevention priorities, including taking actions on the wider determinants of health.

A MODEL OF COLLABORATION

The Champs Support Team coordinates campaigns, programme management, and joint commissioning across the nine boroughs, delivering consistent actions and approaches. It acts as a system **connector**, bringing together local authorities, NHS partners and public health teams to work towards shared goals.

One of the Collaborative's defining strengths lies in its ability to foster collaboration, leadership development, and collective learning. Interviewees consistently described how the Collaborative creates *"spaces to connect, reflect, and share,"* helping to overcome siloed ways of working and instilling a shared identity among public health professionals.

STRATEGIC LEADERSHIP AND SYSTEM INFLUENCE

The Collaborative is regarded as a **strategic enabler**, providing the infrastructure, leadership, and coordination necessary for public health teams to tackle cross-cutting issues such as health inequalities and the social determinants of health.

"Champs makes sure everyone's on the same page—it creates the capacity to lead."

Through its work with the IHE, the Collaborative has elevated the health inequalities agenda not only within local authority public health teams but across the NHS and combined authority partners.

"The thing Champs does is get us to focus on the greater good of Cheshire and Merseyside."

"Champs is about collective impact. No single organisation can fix health inequalities alone, but together, we can shift the dial."

The Collaborative has enabled DsPH to **speak with a collective voice**, influencing regional policy and commanding attention.

"When we speak as 9 or 10 DPHs for 2.7 million people, it has an impact."

The Collaborative's leadership has gained national attention:

"Champs gives Cheshire and Merseyside an identity and a profile... When we get our act together, people look at us with envy... We made a statement about vaping and kids... it got picked up by the Local Government Association, and now the Tobacco Bill is actually happening."

EMBEDDING HEALTH EQUITY IN DEVOLUTION

Interviewees emphasised the role of the Collaborative in ensuring health equity remains central to **economic, social, and environmental strategies, especially within** the Liverpool City Region and through the evolving Cheshire and Warrington devolution agenda.

"Devolution gives us a chance to do things differently, but we have to be bold in prioritising health."

Despite the Collaborative playing a vital coordinating role in public health across the region, its position within the emerging governance structures of the Liverpool City Region Combined Authority and the emerging Cheshire and Warrington devolution structures remains unclear. Devolution presents both a challenge and an opportunity. It is essential that public health priorities, including health equity, are embedded at the heart of devolution plans. To achieve this, the Collaborative must evolve to engage more proactively with the Combined Authority and establish itself as a key player in regional reform. This includes advocating for stronger governance, clearer integration of public health and health equity into Combined Authority policies, and drawing lessons from areas like Greater Manchester, where public health is embedded within devolution frameworks.

ENABLING AND SUPPORTING DIRECTORS OF PUBLIC HEALTH

The Collaborative's Executive Board comprises of the DsPH from all nine boroughs and the Director of Population Health for the region.. Together they shape shared priorities and oversee joint programmes, with accountability to the Cheshire and Merseyside Integrated Care Partnership. It **provides continuity** amid disruption; *"Champs has been really constant... a focus on public health at subregional level."* In a context of organisational flux in the NHS and local authority reorganisations and cuts, **the Collaborative offers continuity, trusted relationships**, and embedded infrastructure for joint working.

The Collaborative also strengthens the leadership role of DsPH across the Integrated Care System (ICS), via the Population Health Partnership. This ensures that public health expertise shapes system-wide decisions.

"Champs gives us a platform to lead collaboratively on the things that matter most—where working across boundaries adds value and where we can genuinely shift the dial on inequalities."

Equally important is the Collaborative's **emotional and professional support for DsPH**. In a demanding policy environment marked by austerity, shifting NHS structures, and intensifying inequalities, the Collaborative is described as a *"lifeline"* for those in senior public health roles.

"It's important to me because... you have that safe space with your DsPH... it just energises you."

"It's actually really good for our mental well-being and resilience, you know, because we've got that tight group."

The network reduces professional isolation, supports alignment and nurtures resilience. *"Without Champs you'd be calling in individual favours...relying on personal relationships rather than a systematised culture of collaboration."*

STRENGTHENING CAPACITY THROUGH EXPERTISE AND DEVELOPMENT

The Collaborative provides technical expertise, delivery support, and policy insight. Its core team helps design and implement large-scale prevention programmes and ensures intelligence-led decisions.

Public health teams benefit from training, continuing professional development (CPD), and best practice sharing, building professional identity and capability across boroughs.

"Champs supports upskilling the system... they put on system leadership coaching and CPD training."

DRIVING REGIONAL ACTION ON HEALTH INEQUALITIES

At a time when many regions lack dedicated public health infrastructure at scale, the Collaborative has been central for **maintaining regional alignment on health inequality actions and approaches**, especially where national policies remain fragmented.

"Without Champs, we wouldn't have the same ability to act at scale, to learn from one another, or to speak with one voice on the big issues that shape health."

The Collaborative provides what one interviewee called a *"do once, share widely"* model, enabling shared learning. This helps to reduce duplication, pool expertise, and deliver region-wide programmes that have more reach and consistency than local efforts alone.

"We're not having to reinvent the wheel every time—we know who to speak to, who's already tried something, and how to build on it."

"Just having someone who's done it... removes some of the need to do that initial grunt work."

PARTNERSHIP WITH THE NHS: THE HEALTH AND CARE PARTNERSHIP

The Collaborative plays a pivotal role in embedding health inequalities into NHS strategies across Cheshire and Merseyside. Working with the Cheshire and Merseyside Health and Care Partnership (HCP), the Collaborative used the All Together Fairer report to align NHS plans with the Marmot principles and ensure health inequalities are prioritised. As a result, the HCP strategy explicitly reflects the social determinants of health and provides a structured approach to reducing inequalities across the system. *"We wouldn't be anywhere near where we are now without Champs' involvement... Champs created capacity, leadership, engagement... they made sure everyone was on the same page."*

This commitment is reinforced in the NHS Cheshire and Merseyside Joint Forward Plan, with health inequalities integrated across delivery structures and a system-wide commitment to addressing inequalities.

The Collaborative also ensured public health leadership is embedded in the Cheshire and Merseyside Integrated Care Board (ICB), with a trained **public health professional having a visible and influential role**, ensuring **health inequalities stay on the NHS agenda**.

“We are rare in that we have a public health trained person embedded within the ICB...the proposal was that this person is not isolated but part of this team.”

The **Director of Population Health** role is **critical** to ensuring that health inequalities and prevention are built into system-wide NHS thinking.

“Having (a Director of Population Health) really helps us pivot that conversation...he’s thinking all the while about how to systematically draw the NHS buy-in into the health inequalities work.”

Without this role, there would be significant risks to the progress made in reducing health inequalities and health inequalities could become a **secondary priority**, overshadowed by **NHS performance targets**.

One of the unique strengths of the Collaborative-IHE partnership is its influence on system-wide decision-making. The Marmot approach has been embedded into key documents and governance processes across the ICS, **health equity** is a central organising principle in the region’s approach to health and care. As a senior ICS leader stated: *“The Marmot Region work has brought a sharper focus to our role as a system in reducing inequalities. It’s helped us move from warm words to real accountability.”*



CHAMPS PUBLIC HEALTH COLLABORATIVE AND THE INSTITUTE OF HEALTH EQUITY: STRATEGIC PARTNERSHIP FOR SYSTEM CHANGE

The Collaborative's partnership with the Institute of Health Equity (IHE) has deepened its strategic commitment to addressing health inequalities across Cheshire and Merseyside. Since 2021 this collaboration developed the Marmot Principles into practice, embedding them into system planning and place-based strategies.

The partnership signalled a shift: from understanding inequalities to **taking coordinated, system-wide action** to reduce them.

"Cheshire and Merseyside are leading the way in showing what it means to become a Marmot Region. This is a chance to improve health and reduce inequalities by acting across the social determinants of health." (Michael Marmot at the launch of the partnership)

Key achievements included:

- Tailored workshops, briefings, and facilitation to embed Marmot approaches into local health and wellbeing strategies, economic development plans, and anchor institution work.
- The **All Together Fairer Report** (2022), which offers a strategic framework driving action on health equity. (1)
- A network of **All Together Fairer Leads** is responsible for implementing local initiatives aimed at creating fairer and healthier communities. (Including the case studies in this report and see also: *Pockets, Prospects, Places: Sefton's Child Poverty Strategy*. (3))
- **The Marmot Beacon Indicators Dashboard**, enabling partners to track progress across the wider determinants of health.
- The integration of *All Together Fairer* in the **HCP Strategy**.
- The implementation of the **healthy advertising policy** (see Box 3).

The *All Together Fairer* report set out clear priorities across all nine boroughs, positioning poverty, employment, housing and early years as key social determinants of health to be addressed across systems. For many interviewees, this provided a long-overdue framework for action, one interviewee reflected: *"Before we became a Marmot place, we were doing some of this work—but it was fragmented. Now, we're all pointing in the same direction."*

The Collaborative-IHE partnership has demonstrated the value of a shared framework. *All Together Fairer* provides partners a common language, structure and credibility, *"something to rally around"*, that aligns diverse efforts under a unifying vision for reducing health inequalities.

A SHIFT TOWARDS THE SOCIAL DETERMINANTS OF HEALTH

The *All Together Fairer* strategy has contributed to a significant shift in how system leaders across the subregion understand and approach health inequalities. There is now a stronger emphasis on tackling the **social determinants of health**, such as poverty, housing, education, and employment, rather than focusing solely on clinical or behavioural risk factors.

"For a long time, we worked on smoking and heart disease, but not poverty. Now we're seeing a shift—people are talking about poverty itself as a public health issue."

Interviewees agreed that public health efforts are increasingly framed around the **wider determinants of health**, with the system recognising that healthcare alone cannot address the scale or root causes of inequalities.

"It's been a slow journey, but the system now knows that you don't fix health through healthcare alone."

Directors of Public Health described *All Together Fairer* and the broader Marmot work as offering a **compelling narrative and a cohesive framework** to reinforce and legitimise existing efforts. Public health teams had long been advocating for these approaches, but the Marmot Region status provided **added authority and alignment**.

"It's the bread and butter of what a public health team does... but [IHE] has enabled us to have a framework to talk to people about it."

Many local authorities reported that the Marmot framework had helped drive a **culture shift**, embedding social determinants thinking more deeply into strategic plans and across departmental silos. This shift was described as both cultural and operational—helping departments understand their role in tackling inequalities.

"It does feel like a culture shift to be honest."

"It gave us something to hang our hat on."

While there are emerging workstreams—such as on **inclusive NHS recruitment or housing and health partnerships**—many felt these had yet to deliver tangible outcomes.

“Housing and health has a plan and a work programme... but I’m not sure it’s done anything impactful yet.”

This reflects a wider concern: while the strategy is more sophisticated, **delivery remains underdeveloped**, and sustained leadership is needed to translate ambition into measurable change.

“Strategy alone is not enough.”

STRENGTHENING COLLECTIVE PURPOSE AND ACCOUNTABILITY

The Collaborative-IHE partnership has sharpened the regional focus on tackling health inequalities, ensuring consistency, legitimacy and developing momentum across the subregion. It has also introduced a layer of accountability that has helped drive action and prioritisation.

Since the publication of the IHE report, all nine Health and Wellbeing Boards formally endorsed the *All Together Fairer* strategy, with several local authorities revising their own plans to align with its recommendations. Achieving this level of strategic coherence in a diverse and complex region is a significant accomplishment.

“Being able to point in health and well-being boards, all nine of them, that they’re in support of that... that’s really quite good, isn’t it?”

Interviewees consistently described the **IHE’s involvement as catalytic**—legitimising health inequalities as a strategic priority and providing a national framework that elevated local work.

“(IHE) gave us permission. It meant we weren’t just talking about inequalities—we were following evidence, backed by the Marmot brand.”

“It has given us that legitimacy... it’s not just something we’ve thought up. There’s real momentum behind this.”

IHE’s association with **Sir Michael Marmot brought further credibility**, helping secure leadership buy-in and moving the conversation from rhetoric to action.

“It was useful that it wasn’t our report ... it wasn’t the council saying the same thing again, it was somebody else saying ‘Look, this is bad.’”

“Being a Marmot Place gave us a structure, but also a badge. That matters.”

IHE played a pivotal role in galvanising interviewees across sectors:

“By having Michael’s inspiration, that’s brought people together... It’s really brought the whole system together for that commitment to work together to do something about it.”

Local teams reported that the Marmot framework provided a **powerful lever for embedding health equity across strategies**—from Council Plans to Health and Wellbeing Boards.

“(Marmot work) really helped as a lever... it’s embedded across everything.”

The IHE partnership has been effective in **keeping health inequalities work visible and sustained** amid competing priorities. It acts as a catalyst and external driver, encouraging progress where internal momentum may otherwise stall.

“If (IHE) hadn’t been there, despite best intentions, we probably wouldn’t have made as much progress because we wouldn’t have had that constant reminder that the meeting’s coming up.”

The partnership also fostered a stronger sense of **shared identity** with the partnership acting as both a **support network and unifying force** across the region.

“It does feel like you’ve got somebody on your side... if you really needed a push, you would get them to support whatever you were doing.”

Most local authorities have now embedded Marmot principles into their strategic plans.

“(Marmot work) really helped as a lever... it’s embedded across everything, in the Council Plan, the Health and Wellbeing Board.”

For many interviewees, the IHE has **accelerated decision-making, turning words and ambitions into tangible actions**.

“We kind of would have done this anyway, but (the IHE) has sped it up... There’s no guarantee we would have done it without this push.”

SHARPENING ACCOUNTABILITY ACROSS SYSTEMS

Interviewees stated the involvement of the **IHE in Cheshire and Merseyside has been instrumental in sharpening focus and strengthening accountability around tackling health inequalities** – a key driver for action. One of the key benefits has been the **external structure and discipline IHE has brought, keeping local teams focused on action and progress**.

This external stimulus has helped maintain a **collective sense of duty**:

“Things just drop off because something more important comes in, but because we all signed up to this, there’s been a collective sense of duty.”

Both **IHE and the Collaborative have been valued as external drivers**, helping to push the work forward and ensure continued attention on health inequalities. However, several interviewees acknowledged that **accountability mechanisms could still be strengthened**.

“Just asking for progress reports holds people accountable, even if it’s just ‘beating people with a feather.’”

This highlights a persistent disconnect between **policy commitments and on-the-ground implementation, with unclear lines of accountability and limited operational capacity**. Without a stronger focus on ownership, measurement, and follow-through, there is a real risk that health inequalities remain a **strategy and a brand rather than delivering real-world impact**.

The Collaborative can build on its established networks and leadership role to push for more action-oriented approaches to address health inequalities across the subregion. This could involve **using the Marmot Beacon indicators more effectively as tools not only for reporting, but to drive system-wide accountability and track delivery**. The current devolution discussions provide a timely opportunity to embed clearer responsibilities for tackling health inequalities into emerging governance structures. *“There needs to be clearer responsibility and accountability for engagement, particularly important as devolution occurs in the next few years.”* To achieve this, a **culture shift is needed**—one that recognises delivery as leadership and ensures those implementing change have a voice at the table.

Building stronger accountability across systems also depends on local leadership and place-based coordination. In Liverpool, the Fairer, Healthier Liverpool (FHL) Partnership provides a strong example of how a city-wide approach can translate Marmot principles into focused action on the social determinants of health (Box 1).

Box 1. SYSTEM LEADERSHIP ON THE SOCIAL DETERMINANTS OF WOMEN’S HEALTH IN LIVERPOOL

The **Fairer, Healthier Liverpool (FHL) Partnership** has identified five priority areas to address health inequalities across the city: **housing, income, climate change, mental distress and health in all policies**. (4) These are underpinned by a **cross-cutting theme: Children and Young People**. The partnership is initially focusing on two strategic goals for its first two years: **improving health through housing and improving health through increasing incomes**.

The **Health 2040 Report** published by the Public Health team in 2024 calls for collective, city-wide action to reduce health inequalities. It promotes evidence-based interventions that address the social determinants of health, including **education, employment, housing, and social support**. The report highlighted a worse health outcomes for women living in the city’s most deprived areas. In response, a **Women’s Health Taskforce** was established to develop a city-wide strategy. The Taskforce includes NHS partners, community groups, academics, and local organisations. More than 30 groups took part in workshops and surveys, identifying key barriers and priorities, especially for women facing poverty, violence, disability, or involvement with the criminal justice system. The strategy aims to improve **access to care**, focus on **prevention**, and ensure **women’s voices are central** to shaping services. Next steps include targeted action on issues such as **menopause care** and using community assets like **Women’s Health Hubs**.

As part of the city’s approach to improving women’s health, **Citizens Advice on Prescription (CAP)** plays a key role in addressing the wider social factors that affect health and wellbeing. While CAP has operated for several years, since 2020 it has focused specifically on **pregnant women and families with babies under one**. CAP integrates **welfare advice into healthcare settings**, providing vital support to families experiencing poverty, poor health, and social isolation. Each year, the service reaches approximately **800 to 1,000 families**, many of whom are living with long-term health conditions or financial insecurity. The service has been particularly impactful for **ethnic minority families**, who account for more than **60% of referrals** from Liverpool Women’s Hospital. By connecting families to local services such as **Children’s Centres**, CAP helps to improve **financial stability**, reduce **reliance on health services**, and support **better long-term outcomes** for both women and children.



EMBEDDING HEALTH INEQUALITIES IN LOCAL SYSTEMS AND STRUCTURES

The Collaborative-IHE partnership raised the profile of health inequalities and helped **ensure that health equity is embedded in** the governance, planning, and strategic priorities of councils across the subregion. While much of IHE's impact has been strongest at the Director of Public Health, Director of Population Health and senior leadership levels, its **influence has cascaded into wider organisational structures and processes**.

Interviewees consistently described **IHE's contribution as essential** to embedding the health equity agenda within local systems.

"The Marmot badge gave it national visibility. Suddenly we were part of a wider movement—not just doing local stuff in isolation."

In several areas, **Marmot principles** have moved beyond strategy documents to **shape decision-making processes and governance**. In Cheshire West and Chester, for example, all cabinet decisions now include a section on how proposals contribute to All Together Fairer:

"All of our decisions that go through cabinet have a section on how this contributes towards All Together Fairer."

This kind of institutional embedding has created visible traction. One area reported organisation-wide engagement, with Marmot work discussed across

virtually every council meeting:

"There was a huge amount of engagement around some of the original work reports... it went into the entirety of... my council. I think we went to every single meeting that existed."

In other boroughs, IHE's influence has helped integrate health inequalities into corporate strategies. For example, Knowsley embedded health equity as a core aim in its five-year corporate plan, while in Liverpool IHE has enabled the development of a structured Marmot programme linked to broader council goals:

"For me personally, it's allowed me to set up a proper Marmot programme in Liverpool that is doing amazing things."

"We've actually managed to have inequalities as a primary aim for the Council Plan for the next five years."

This represents a significant shift: **inequality is no longer treated as a secondary issue or "bolt-on," but as a central concern embedded within councils' long-term vision and operations**. The CHAMPS-IHE report provided the evidence, legitimacy, and coherence needed to secure stronger political backing. The All Together Fairer local teams value the sense of shared direction and mutual support:

"It does feel like you've got somebody on your side... if you really needed a push, you would get them to support whatever you were doing."

Local teams feel that being part of a **larger regional effort** helps reinforce their work within their own councils.

The following case study of the Cheshire and Merseyside Cancer Alliance illustrates how collaboration with the Institute of Health Equity has embedded Marmot principles into a social determinants approach to cancer prevention, early diagnosis, and equitable care across the region.

Box 2. Cheshire and Merseyside Cancer Alliance – Embedding Marmot Principles to Tackle Cancer Inequalities

The Cheshire and Merseyside Cancer Alliance has become a leading example of how Marmot-informed thinking can transform cancer care. Inspired by its collaboration with the **Institute of Health Equity (IHE)** and the **All Together Fairer (ATF)** programme, the Alliance has embedded Marmot Principles into its regional strategy to reduce cancer inequalities. The Cheshire and Merseyside Cancer Alliance illustrates what is possible when cancer care is reimagined through the lens of the Marmot Principles

FROM CLINICAL FOCUS TO SOCIAL DETERMINANTS

Working with the IHE catalysed a fundamental shift in the Cancer Alliance's approach, from a predominantly clinical model to one focused on the **social determinants of health**. The Alliance now emphasises prevention, early screening, and better access to care for high-risk populations.

“Through collaboration with the ATF and IHE, we are shaping policies that go beyond medical treatment to address the root causes of poor health outcomes.”

LEADERSHIP AND SYSTEM ALIGNMENT

The Chief Executive of the Cancer Alliance is also a Board member of ATF group and they have been instrumental in aligning the Alliance's strategy with Marmot Principles. Their leadership has guided efforts to ensure that cancer services are both **effective and equitable**.

“By embedding health equity into our cancer strategies, we are seeing improved screening uptake in areas with historically low participation.”

This transformation has meant a stronger focus on prevention strategies, increasing the uptake of early screening, and tackling inequalities in access to care—especially among high-risk groups affected by poverty, low educational attainment, unemployment, and other structural disadvantages.

“The Cancer Alliance is committed to reducing health inequalities by ensuring that all patients, regardless of their background, have access to timely and effective cancer care... A key focus has been on targeted interventions for underserved communities, improving early diagnosis rates, and addressing barriers to healthcare access.”

COMMUNITY-DRIVEN APPROACHES AND POLICY INNOVATION

The Cancer Alliance has embraced community engagement as a central pillar of its strategy. Residents and local groups have been involved in shaping cancer care services, ensuring that interventions are designed with, not just for, the communities they serve. This has been particularly effective in reducing **late-stage diagnoses** in disadvantaged populations through culturally tailored outreach, targeted campaigns, and improved access to screening.

“The partnership with the Marmot Institute has strengthened policy development in Merseyside, ensuring that cancer services are integrated into broader health equity strategies.”

NATIONAL LEADERSHIP AND SHARED LEARNING

The Cancer Alliance approach in Cheshire and Merseyside is helping lead national conversations on cancer equity. One of its team members has shared their equity-informed models and tools with Cancer Alliances across England.

“(Staff) has been actively engaging with Cancer Alliance colleagues across England to share best practices and insights on tackling health inequalities... The dissemination of this knowledge has helped strengthen collective efforts to improve cancer care equity nationwide.”

STRENGTHENING PARTNERSHIPS

The Marmot framework encouraged stronger collaboration between local authorities, healthcare leaders, and political stakeholders **and the community and voluntary sector**. One *All Together Fairer* board member observed that IHE's involvement led to *"stronger partnerships between public health bodies and grassroots organisations."*

The **voluntary sector became more embedded** in local decision-making processes. Their presence on the *All Together Fairer* Board signalled a shift in influence.

"The IHE's influence has led to the voluntary sector becoming more embedded in local health strategies. We are now a key player in local health strategies...with a stronger voice in decision-making processes."

However, some **voluntary sector representatives raised concerns** that involvement has not always translated into structural change:

"There's been policy rhetoric around greater involvement... but engagement with the Marmot approach has sometimes been superficial."

The partnership also significantly shaped regional NHS strategy. **Health inequalities are now central** to long-term planning across the **Health Care Partnership**, thanks in part to the influence of IHE and the Collaborative.

"We built our Healthcare Partnership Strategy around 'All Together Fairer'... CHAMPS made sure that happened... It pulled it all together and provided some glue."

This marked a notable shift, from a traditional NHS-led model to a strategy rooted in the social determinants of health. The **sub-region now has a unified health inequalities framework across local authorities and NHS bodies**.

"I'm over the moon that we have a healthcare partnership strategy that is an inequality strategy. I don't think that would have happened had we not done it."

Health inequalities are now consistently referenced in local NHS strategy documents:

"Right at the top in strategy, the thread of social determinants and health inequalities is there... but how impactful it has been is a different conversation."

While the strategic alignment is seen as a major step forward, some interviewees expressed concern that **progress has yet to translate into large-scale, system-wide action**. Still, the *All Together Fairer* programme helped coalesce efforts across nine areas, embedding

health equity into the region's long-term vision and providing a consistent point of reference:

"We coalesced nine areas... into their healthcare partnership with a strategy."

This collective approach has improved visibility, strengthened cross-sector alignment, and laid the groundwork for more integrated, sustainable action on health inequalities. For example, the **Beyond Programme** is NHS Cheshire and Merseyside's integrated health and care programme for children and young people. (5) It has **partnered with the Institute of Health Equity and the Dolly Parton Foundation to support early literacy and community engagement initiatives**, strengthening the region's commitment to advancing health equity through action on the social determinants of health.

INDICATORS AND RECOMMENDATIONS: A MIXED PICTURE

The Marmot Beacon indicators and recommendations, **set out in the *All Together Fairer* report**, were developed to inform and guide coordinated action on health inequalities across Cheshire and Merseyside. (1) These indicators and recommendations have provided a valuable **strategic framework**, bringing greater focus to the social determinants of health, and supporting local planning and discussions, they have yet to deliver significant, measurable improvements **in reducing health inequalities**.

"We definitely wanted to bottom out these indicators... but it's very slow and frustrating."

STRATEGIC VALUE BUT LIMITED UPTAKE

The indicators have helped frame **priorities and long-term ambitions**, especially by aligning local work with the Marmot principles. Some local authorities have incorporated them into key documents such as **Place Plans and Health and Wellbeing Strategies**, providing a foundation for embedding public health in wider system planning.

"We've got the Marmot Beacon indicators, but could we establish a Cheshire and Merseyside set of indicators that we're all working towards?"

Several interviewees noted that these indicators have not been **systematically monitored or embedded**, limiting their utility. Across the partnership, interviewees repeatedly raised concerns about the **lack of effective measurement**, weak **accountability structures**, and limited **performance tracking** related to action on health inequalities.

"We need to find a way... if I need to demonstrate if something's changed, it needs to be measured...If you don't measure it and report it, it's going to get cut."

While the indicator framework is in place, it has not been actively used to drive **programmatic decision-making** or to hold partners to account. Some interviewees lamented that the indicators felt disconnected from everyday responsibilities and lacked **real-time relevance**.

“The Beacon indicators are there, but they almost feel so far away from people’s day jobs that they’re not as focused on them.”

There was wide agreement that more needs to be done to **embed the Marmot Beacon indicators into operational practice**, link them directly to **programme delivery**, and **report against them systematically**. The IHE monitoring indicators were not rejected, some interviewees suggested modifying the indicators rather than abandoning them but all agreed they should be **used more actively to guide decisions and assess impact**.

“The indicators work hasn’t moved forward because no one has taken real ownership.”

Several participants warned that without visible, measurable progress, the **momentum behind Marmot work risks stalling**, particularly in the face of competing political and institutional pressures.

“It’s hard to keep people at the table if they can’t see what’s changing.”

STRUCTURAL AND PRACTICAL BARRIERS

Some challenges in **demonstrating impact** are inherent in the nature of health inequalities: they are **long-term, complex issues**, and meaningful change may take years. Attributing impact is especially difficult in a **multi-agency context**, where accountability is diffuse. Yet many barriers are more practical—such as the **lack of programme management, weak tracking mechanisms**, and insufficient use of the existing indicators.

“We have a reporting route... but what I think is really missing is programme management and tracking actual impact.”

Others cautioned against rebranding routine activity as transformational work:

“Just doing what we’ve always done but branding it ‘health inequalities’ isn’t enough.”

Interviewees highlighted the need for more investment in delivering and measuring action on health inequalities, calling it vital to maintaining progress and achieving equity.



DRIVING LOCAL ACTION: THE ATF LEADS

Each of the nine boroughs have a nominated *All Together Fairer* (ATF) Lead. The ATF Leads have been **instrumental in translating the Marmot principles into local practice** across the subregion. Supported by the IHE, this **network provides structure, challenge, and peer support**, helping local teams stay focused on tackling health inequalities. IHE's ongoing involvement—through regular engagement, expert advice, and facilitated learning—has enabled leads to connect strategy with delivery, reflect on progress, and refine their approaches.

“(IHE) providing challenge, questions, ideas, links, support. You're enabling them to share learning and learn together.”

The **ATF Leads network has fostered a stronger public health community** across the subregion. It has helped build shared accountability, enabled smoother collaboration across councils, and strengthened public health's strategic presence in local government.

“It has created that community a bit more... helped that become more of a cohesive thing.”

“It's felt like a genuinely collective endeavor, and that's been invaluable.”

Directors of Public Health consistently praised the leads for their role in embedding the Marmot agenda operationally—acting as credible internal advocates who could drive change across departments.

Strategic leadership from ATF leads embeds health equity across council departments, championed approaches and engaging effectively with Boards. The ATF programme provides confidence and tools to advocate effectively. They play a **key role in reporting and translating the** Marmot work across council departments, supporting DPHs by doing the operational groundwork.

The value of the network extends beyond strategic alignment. ATF leads describe practical benefits like **faster decision-making, informal peer support**, and the ability to access the right people across councils:

“I went to meet someone in St. Helens' benefits team. I only found them because I know the people on here who work for the authority.”

The shared commitment across all nine boroughs has also added internal leverage:

“I have regularly used the fact that all of the authorities are signed up to this as the stick to beat my council colleagues with.”

ATF leads are driving practical implementation of the Marmot framework and grassroots work; providing operational and mental health leadership, embedding reporting and action plans; and building on successes such as the healthier advertising initiative (Box 3), to other areas such as child poverty (Box 4).

Box 3. Healthier advertising – a model for regional action

One of the most celebrated achievements under the *All Together Fairer* programme is the introduction of healthier advertising policies across eight of nine local authorities. Spearheaded by **Esther Hindley**, one of the **All Together Fairer Leads** in the **Knowsley public health team**, the policy restricts the promotion of unhealthy food and drink on council-owned advertising spaces.

This initiative demonstrated the power of mid-level leadership, peer momentum, and practical, cross-borough collaboration.

“Once a few places did it, the pressure on others to follow really built up.”

“This is the kind of work we need to scale—practical, system-wide action that makes a difference.”

The success of this project highlights key ingredients for effective regional collaboration:

Peer influence: As more councils adopted the policy, others felt compelled to act.

“If three out of nine have done it, then really we should all be doing it.”

Healthy competition:

“Our Members don't like being second best at anything.”

Dedicated leadership: Esther's persistence ensured the initiative stayed on track.

“It does need that focus, and it needs somebody like Esther to corral us, to keep pushing, supporting, and sharing best practice.”

While the policy's adoption shows what is possible, progress in other areas—such as employment and housing—has been slower. This points to the need for continued support, clear evidence of impact, and flexible pathways that allow councils to progress at their own pace.

The initiative also underscores the value of shared focus. As one lead noted:

“The moment you start trying to spread yourself too thinly, then nothing happens. The great thing about healthy advertising was we all agreed to focus on it... and we achieved what we achieved.”

Box 4. Tackling child poverty through *All Together Fairer*

There is widespread agreement that the *All Together Fairer* framework has provided a vital unifying force for regional action, but also recognition that it represents just the starting point. It has enabled more coordinated, upstream public health efforts to address child poverty, with the Collaborative playing a key role in turning principles into practice.

In 2025, the Collaborative is supporting local authorities to implement automatic enrolment for free school meals and improve uptake of the Healthy Start scheme, an initiative directly encouraged by the *All Together Fairer* approach. This reflects a growing emphasis on acting on the social determinants of health, rather than simply describing them.

“Public health is now talking more directly about poverty rather than just its consequences.”

Local authorities are increasingly treating child poverty as a core public health issue. Several boroughs are jointly commissioning projects focused on tackling poverty in childhood.

“We’re going to work with Resolve Poverty² to do some research together... That wouldn’t have happened without these conversations.”

The *All Together Fairer* programme has strengthened cross-borough collaboration, with practical examples of peer learning accelerating uptake. The approach to auto-enrolment has mirrored the success of healthier advertising policies—once a few councils led the way, others quickly followed.

“The auto-enrolment stuff finally crystallised for me when Champs presented the ‘this is how you do it’ piece.”

This “demonstrator effect” highlights the power of collective progress: early adopters set a standard that others strive to meet. Shared ambition, combined with subtle peer pressure, has helped councils move more quickly on entrenched issues.

Although practical steps are emerging, participants emphasised the need for consistent scaling and clearer evidence of outcomes. Nonetheless, the *All Together Fairer* framework has clearly catalysed action on child poverty—shifting public health practice upstream and embedding equity-driven policies at a local level.

These local examples from across Cheshire and Merseyside demonstrate that **tackling health inequalities** requires more than policy statements; it **demand systems change, shared leadership, and deep engagement with residents**. Champs has played a pivotal role in connecting these efforts, amplifying learning, and ensuring health equity remains a shared regional goal. These examples provide evidence that when local systems are aligned and communities are empowered, meaningful change is possible.

EVALUATING MARMOT: SUSTAINING AND DEMONSTRATING IMPACT

As subregion approaches the mid-point of their journey as a Marmot Place, there is growing recognition of the need to plan for the long-term sustainability and evaluation of this work. While the partnership with the IHE has provided credibility, structure, and momentum, several interviewees voiced concerns about what happens after IHE’s formal involvement concludes in 2027.

“I fear that without someone external, this work won’t happen—because that’s what generally happens.”

“By 2028, the Marmot report will be dead in the water...”

²www.resolvepoverty.org/

do we still claim we're a Marmot community?"

Without a clear strategy, there is a danger that the Marmot designation becomes symbolic rather than a sustained driver of change. Interviewees stressed the importance of embedding the work within local systems so that it continues to influence strategy, commissioning, and practice.

A key recommendation emerging from interviewees is the need for a five-year evaluation in 2027. They suggested the review should revisit the original *All Together Fairer* recommendations, assess system-wide progress, and identify areas where further work is needed. Importantly, interviewees emphasised that this should not be a routine report written for internal consumption, but a visible, public-facing assessment of impact.

Suggestions for the five-year evaluation include:

- **Presenting findings to Health and Wellbeing Boards** and Integrated Care Partnerships, using evidence of progress to galvanise further commitment.
- **Developing creative outputs**, such as short films, community case studies, and infographics, to communicate outcomes in an accessible and engaging way.
- **Involving wider system partners**—including housing, education, and the voluntary sector—in the evaluation process, ensuring that the impact reflects whole-system change rather than just public health perspectives.

Several interviewees called for the **five-year milestone to be seen as a renewal point**, rather than an endpoint. There was a strong appetite for re-energising the work in 2027, engaging new partners, and ensuring the Marmot principles remain embedded in strategic planning.

"How do we make sure we carry on doing what we've been doing... rather than people going, 'Oh well, the Marmot community finished in 2027'?"

Coventry, the UK's longest-standing Marmot Place since 2013, recently renewed its commitment to tackling health inequalities following the appointment of a new chief executive, strengthening its partnership with the Institute of Health Equity and local institutions. (6)

Interviewees recommended that IHE's role in the final years of the programme should include:

- Supporting capacity-building within local systems to ensure the work is locally owned.
- Helping design the evaluation process and building in reflective learning.
- Advising on legacy planning to transition from externally driven momentum to internal sustainability.

The success of the Marmot work in Cheshire and Merseyside will not be measured only by how much has been achieved by 2027, but by whether the region continues to prioritise equity long after IHE steps back. The five-year mark should be seen not as a conclusion, but as a platform for renewal—demonstrating the value of the work, widening engagement, and embedding health equity into the region's long-term future.



REGIONAL ACTIONS ON HEALTH EQUITY

Cheshire and Merseyside stands out as a region that has moved beyond strategy into collective action on health inequalities. Through the sustained efforts of the Collaborative and the IHE, the region has embedded the Marmot principles into policy, created a robust public health infrastructure, and built trusted relationships that transcend organisational boundaries.

The IHE *All Together Fairer* framework gave coherence to fragmented efforts, while the Collaborative offered the capacity, credibility, and coordination needed to drive system-wide progress. Together, they have helped shift public health practice upstream—linking social determinants to practical policies, and embedding equity at the heart of shared delivery.

For regions considering becoming a Marmot Place, several key lessons emerge:

- **Start with shared purpose, not just strategy:** The ATF framework gave legitimacy to the region's equity ambitions—but its impact came from how it was used to drive action, not simply from its publication.
- **Embed Marmot principles in delivery mechanisms:** The most visible progress came where the framework was tied to concrete changes. Marmot Places must operationalise the social determinants of health—not just analyse them.
- **Leverage peer pressure and shared learning:** ATF fostered healthy competition and cross-borough momentum. As one official put it, *“once a few councils took action, others followed.”* This subtle pressure helped turn principles into policy.
- **Resource coordination, not just insight:** Commissioning IHE provided high-quality evidence and credibility, but progress required Champs Support Team senior and programme capacity to coordinate across organisations, support implementation, and keep equity on the agenda.
- **Sustain political and system engagement:** Health equity work needs ongoing senior leadership and formal integration with Combined Authorities, Integrated Care Systems, and anchor institutions. Becoming a Marmot Place is not a short-term project—it's a long-term commitment to transformation.

Interviewees agree that the region is at a pivotal moment: the foundations are laid, but the challenge now lies in implementation, sustainability, and system transformation. Maintaining focus will require ongoing investment in people, leadership, and collaboration—especially as public health teams face pressure, burnout, and constrained capacity.

For other regions considering commissioning IHE or creating a collaborative like the Collaborative, the lessons are clear:

- Build strong, trusted networks of Directors of Public Health and practitioners.
- Invest in dedicated, diplomatic shared leadership that can navigate complexity and sustain momentum.
- Create multi-level platforms for delivery, learning, and innovation—supporting not just senior leaders, but the wider workforce.
- Act as a bridge across public services, sectors, and geographies, enabling shared priorities and mutual accountability.

The **Champs Public Health Collaborative** shows what is possible when collaboration is nurtured, leadership is consistent, and equity becomes a shared ambition. The path forward is not to copy this model exactly, but to adapt its principles: lead locally, act collectively, focus relentlessly on outcomes, and make health equity everyone's business.

By scaling this approach and engaging more deeply with communities and mid-level leaders, Cheshire and Merseyside can sustain their momentum and inspire a national movement **for health equity** grounded in **the social determinants of health**, system-wide responsibility, long-term commitment, and genuine co-production.

HEALTH EQUITY IN ACTION: LOCAL CASE STUDIES ON TACKLING HEALTH INEQUALITIES

As part of the All Together Fairer approach, the following two case studies highlight how Marmot principles are being put into practice to tackle health inequalities in Cheshire and Merseyside. The first focuses on Northwood in Knowsley, where a deeply community-led approach is reshaping local systems. The second examines the Poverty Truth Commission in Cheshire West and Chester, which brings lived experience to the heart of service design and policy. Together, they illustrate the power of co-production, trust-building, and place-based action in addressing the root causes of health inequalities.

Case study: Tackling Health Inequalities in Northwood, Knowsley: A Community-Led, Place-Based Approach

Northwood, in the borough of Knowsley, is one of the most deprived areas in England. Northwood rank 407th out of 32,844 Lower Layer Super Output Areas in the Index of Multiple Deprivation—placing it within the top 2% of most deprived neighbourhoods.

This inequality is reflected in income, health, education, housing, and community safety. Northwood residents experience significantly worse outcomes across all indicators of the social determinants of health (education, housing and community safety) a pattern that has persisted for decades and underpins low life expectancy and quality of life compared to other wards in the borough.



Social Determinants Driving Health Inequalities

In Northwood there are deep-rooted social and economic conditions leading to stark health inequalities. Over half (56%) of households in the area earn less than £20,000 per year, and unemployment stands at 7%, significantly higher than the borough average. Fuel poverty affects 17% of households, and housing conditions are often poor—cold, damp homes contribute to respiratory illness, school absences, and poor mental health.

- **Female life expectancy** is **76.8 years**, compared to **83.2 nationally**.
- **Low birth weight**, an early indicator of disadvantage, affects **11.4% of babies**, nearly three times the rate in Roby, another ward in Knowsley.
- **Emergency hospital admissions** are more than double the national average.
- Rates of **depression, obesity, and poor general health** are also significantly higher than national averages.

Beyond the numbers, residents describe a sense of disconnection, isolation, and being overlooked. Chronic stress, limited local opportunities, and fear of crime all contribute to a cycle of poor health and limited life chances.

The Northwood Project: A New Way of Working

In response, **Knowsley Council and the Cheshire and Merseyside Integrated Care Board (ICB)** launched the **Northwood Population Health Project**—a pioneering, community-led initiative designed to tackle the root causes of health inequality. The aim is to work collaboratively with local residents, health professionals, community champions, and voluntary and public sector partners to improve health outcomes, reduce inequalities, and enhance access to services in communities facing high deprivation. The approach recognises that **how** change is delivered is just as important as **what** is delivered.

This approach marks a deliberate shift away from siloed interventions and short-term programmes, and toward a place-based, population health model that puts local people at the heart of decision-making. The vision was to build a replicable model that could eventually be rolled out to other wards in Knowsley.

The project is funded by Public Health in partnership with the ICB. However, the majority of interventions have been done under business as usual from services at no cost or through social value from local businesses.

A Five-Phase, Iterative Approach

The project is structured into five interlinked phases, all rooted in co-production and community engagement:

- 1. Developing a Shared Vision** – involving local residents, partners and services in defining what matters most.
- 2. Health Needs Assessment (HNA)** – collecting robust data on population health, community assets, service gaps, and lived experience. This included:
 - > Demographic and clinical data across Start Well, Live Well, and Age Well life stages.
 - > Asset mapping to identify community strengths.
 - > Engagement with residents.
 - > Alignment with Marmot Beacon indicators to address the wider determinants of health.
- 3. Prioritisation** – using evidence and community input to agree the priority local challenges.
- 4. Innovation** – launching targeted co-designed interventions
- 5. Monitoring, Learning, and Scaling Up** – evaluating impact and informing future borough-wide rollouts.

The Underlying Principles and Assumptions of the project:

- Begin with Northwood and focus intensively on one area before expansion.
- Base decisions on community engagement and local intelligence.
- Prioritise areas with the potential for greatest impact on inequality.
- Strengthen the link between health services and the wider social determinants of health.
- Ensure timely evaluation and use of data to guide next steps.
- Promote shared ownership of solutions through resident empowerment and cross-sector collaboration.

Listening First: Building Trust and Shifting Power

One of the key lessons from Northwood is that change must begin with trust. The community had grown sceptical of outside interventions and “tick-box” consultations. It took over 18 months of sustained engagement to build genuine relationships.

A critical success factor was the appointment of **Paul Mavers**, a local resident and community development manager. Paul was not only familiar with the area, he was trusted. His presence gave credibility to the programme and helped unlock local voices.

Initially the Knowsley Healthier Together board priorities set the direction of travel, such as reducing Accident and Emergency attendances and improving GP access, but these were quickly changed by residents. People spoke instead about feeling unsafe in parks and the quality of local green space, the lack of youth provision, isolation, and a general sense of neglect. Recognising this, the project pivoted: **rather than impose solutions, it supported the community to set its own agenda.**

This led to the formation of **Your Northwood**, a grassroots group with a health focus that now co-designs and oversees local initiatives. Early wins—like revitalising an underutilised park with community-led safety improvements and leading a consultation on new play equipment, shaping a local youth commission —were symbolic and practical achievements that built momentum.

The “Your Northwood” model highlights that **a sense of belonging, trust, and connection are vital foundations for health.** By investing time in community relationships, the programme has enabled residents to co-produce services, influence commissioning, and lead on local projects. This includes the design and oversight of a youth programme commissioned through the place-based change organisation, Right to Succeed – Cradle to

Career Northwood, the promotion of NHS health campaigns through local champions, and the establishment of a community information hub.

Importantly, this work resists top-down targets. The team uses **qualitative data and individual stories** to measure success. This approach has been slower—but more authentic and sustainable.

Real Outcomes, Real Change

Three main programme areas emerged from both community insight and system priorities:

1. Creating a “Single Front Door” for Health Advice

A coordinated access point for health, wellbeing, and social support services is being developed. This responds to feedback that services are fragmented and difficult to navigate.

2. Joining the Dots

A dedicated task group made up of local organisations, voluntary and faith sector leaders, service providers and community groups, is working to deliver services in a more joined-up way. This strengthens impact and better responds to community needs.

3. Building relationships

An open and honest approach has brought together a wide range of community members and activists, including many who had not previously engaged. Coordinated action supports a more holistic offer for residents and creates equal space for both service providers and community organisations.

These priorities are underpinned by community-led projects including a youth programme, a community newsletter, and peer-led health promotion campaigns.

Community-led Art Projects: A Lasting Legacy

In addition to health-focused initiatives, the community also played a key role in shaping two public art projects: **Strong Women**, now prominently displayed in Kirkby town centre, and a vibrant mural at **St Marie’s School**. These projects, developed in partnership with **Heart of Glass**, celebrate local identity and resilience, further illustrating how creative, place-based action can promote wellbeing and community pride.

Key Learnings from Northwood

- **Change takes time** – Trust-building is not a ‘nice to have’; it is foundational.
- **Local people matter** – Services should be shaped around community priorities, not the other way around.
- **Shift power** – When residents shape the agenda (e.g., focusing on green space and safety over Accident and Emergency use), outcomes improve.
- **Success looks different** – Don’t start with key performance indicators. Start with people. Give communities control, support them to lead, and build the system around their priorities. Traditional KPIs miss the impact of someone feeling safe enough to walk to the shops or re-engage with their GP.
- **Sustainability matters** – Much of this work is funded through short-term pilots. To embed change, long-term investment is essential.

Towards a Fairer Future

The Northwood case study highlights that tackling health inequalities requires more than clinical solutions. It demands action on the **social determinants of health**—housing, income, education, transport, safety, and social connection.

Place-based approaches like the Northwood project show what is possible when systems work with communities rather than doing things to them. Shifting power allows residents to shape priorities, co-produce services, and lead change.

Knowsley’s strategy for addressing inequality is now being informed by the lessons from Northwood. As more wards come into focus, the emphasis will remain on deep, sustained engagement and tackling the root causes of poor health—not just the symptoms.

Case Study: Tackling Health Inequalities through Lived Experience – Cheshire West and Chester’s Poverty Truth Approach

“It’s not about fixing people – it’s about fixing systems. And now, we’re doing that together.”

Antony, Community Inspirer

Cheshire West and Chester on average a borough of affluence, has deep-rooted inequalities. Seven percent, over 25,000 people, live in the most deprived 10% of neighbourhoods in England—Lache and Winsford neighbourhoods ranks among the most deprived 2%. Over 7,000 children live in absolute poverty, affecting their long-term health and wellbeing and education outcomes.

In response to these inequalities, Cheshire West and Chester Council (CW&C) pioneered an innovative and long-term approach to tackling poverty, grounded in a belief that those with lived experience must be at the heart of service design, strategy, and change. Initially a two-year initiative, this approach has evolved into an **embedded and ongoing model of co-production and collaboration**, with the **Poverty Truth Commission (PTC)** at its core.

From Poverty Truth Commission to Embedded Service

Launched in 2017, the first West Cheshire Poverty Truth Commission was the first in the UK to be led by a local authority. (7) Its purpose was to create space for those with lived experience—known as **Community Inspirers**—to share their direct experience of living in poverty, enabling authentic conversations that challenge stereotypes and work alongside CW&C council leaders and business leaders to influence policy and practice.

This was never intended to be a short-term project. Rather than ending with a set of recommendations, CW&C committed to embedding the PTC’s ethos into council practice. The model has evolved into a **permanent, embedded service** sitting within the **Public Health team**, aligning closely with the borough’s efforts to reduce **health inequalities** and address the **social determinants of health**.

The Commission’s focus on listening, removing stigma, and fostering human connection has led to significant impacts. For every £1 spent, the second Poverty Truth Commission generated £9.17 in social value—over £1.6 million—highlighting its impact across housing, health, and community services. (8)

Community Inspirers: Driving Change from the Inside

Community Inspirers are individuals with lived or living experience of poverty—whether through food insecurity, homelessness, mental health difficulties, or financial hardship. Their role is voluntary but vital. They are not simply asked to give feedback but are treated as equal partners in change, offering insight that drives 50% of the team’s current work.

Inspirers are frequently approached to **provide advice and input on** service design, recently, for instance, meeting with the **Integrated Care Board (ICB)** Chair to discuss barriers to accessing services. They’ve worked with transactional service teams to review and simplify systems, and have supported projects like **Her Place / Motherwell**, which provide support for women and girls. (9)

One success story includes the creation of **“Beans on Toast”**—a borough-wide food partnership tackling food insecurity, born directly from conversations in the Commission. (10) Another involved identifying the prohibitive cost of school uniforms, prompting immediate action from council teams. (10)



Embedding Lived Experience Across the Council

CW&C has made systemic changes to embed lived experience into council culture. All council staff undergo **poverty awareness training**, developed and delivered in collaboration with Community Inspirers. These sessions are not one-size-fits-all; they're interactive, two-way learning experiences, helping staff understand the complex, real-life challenges residents face.

This ethos is supported by a strong governance structure. The Council has established a **multi-agency Poverty Truth Advisory Board** comprising Public Health, Jobcentre Plus, Cabinet Members, and other partners. This group ensures co-production is reflected across policy areas, including housing, education, health improvement, and economic development.

The decision to house the Poverty Truth team within the **Public Health team** has reinforced its focus on health inequalities. While some coordination functions were stronger when the team sat corporately, Public Health offers a practical base for commissioning and delivering place-based action that responds directly to need.

Direct Employment and Responsive Action

A unique strength of CW&C's approach lies in the direct employment of Poverty Truth staff by the Council. This means they understand governance, can navigate internal systems, and act quickly on feedback from Community Inspirers. For example, where Inspirers identified barriers in local welfare access, the Council swiftly implemented a **freephone number** and enhanced **face-to-face support**, particularly for the **HELP scheme** and housing helpline.



This direct connection has made it easier for Council teams—such as housing and homelessness services—to engage meaningfully with Inspirers, enabling more agile, human-centred problem-solving.

Health Inequalities and the Social Determinants of Health

The Commission's work directly addresses the social determinants of health. Inspirers have contributed to improved service access, reshaped housing strategies, and helped build more compassionate systems.

Key outcomes include:

- **Reduction in evictions** by 75% from one housing provider after shifting from a punitive model to a wellbeing-based tenancy support approach.
- **Early interventions and creation of the Community Connector service**, run by Citizens Advice, providing timely, localised support and advice.
- **Improvements to homeless provision**, such as ending the use of temporary Bed and Breakfasts for families and increasing housing options for people leaving prison.
- **Mental health and confidence gains** for Inspirers themselves, many of whom have secured employment, volunteering roles or training as a result of their involvement.



Inspirers co-produced the ten year Fairer Future Strategy setting out a long-term transformational approach to tackling poverty based on the three pillars of:

- **Voice:** Ensuring the voices of those experiencing poverty are heard and their issues addressed.
- **Alleviation:** Providing immediate support to tackle the consequences of poverty.
- **Root Cause:** Transforming society and the economy to address the underlying causes of poverty.

The strategy embeds poverty as an issue of equality and fairness, aiming to create opportunities for people from all backgrounds to improve their quality of life.

Removing Stigma and Changing Narratives

A major achievement of the Poverty Truth approach has been its success in **challenging stigma**. Initiatives like the **“Walking Further Together”, a partnership** exhibition with the **University of Chester** showcased personal stories and academic research on issues like food poverty, period poverty and media representation. Feedback described it as “powerful” and “challenging social ignorance,” reinforcing the value of lived experience in public discourse.

A Model for Others: Lessons for Local Authorities

CW&C’s commitment is a **long-term investment** – both financially and culturally – recognising that sustainable change requires consistent leadership, dedicated staffing, and a whole-system approach. CW&C’s approach embeds lived experience and tackles health inequalities systemically, key lessons include:

- **Go beyond consultation:** CW&C didn’t stop at listening once—they built **long-term relationships**, ensuring Community Inspirers are consistently engaged and empowered.
- **Embed co-production across the organisation:** Poverty Truth is now part of council **induction, training, policy design, and strategy** - culture shifts, not projects.
- **Position the work where it can have impact:** Housing the service in **Public Health** aligns it with health outcomes, but direct links to operational teams (like housing or education) ensure faster and more effective responses.
- **Invest in people and structure:** The team is **directly employed**, removing barriers to implementation and enabling swift action. Backing from Council leadership has been instrumental in unlocking resources and driving change.
- **Make the practical ask:** Service teams are challenged to rethink processes from a lived experience perspective, from application forms to referral pathways.

Ultimately, CW&C’s success shows that **poverty reduction and health equity require more than good intentions**—they require sustained commitment, systems **change and listening to those who know poverty best**. Tackling poverty is not a matter of charity or crisis management, CW&C shows it is a transformational model and a route to **healthier, more resilient, and more equal communities**.

‘With being a part of this work, I no longer feel helpless, I feel hopeful. Hopeful that continuing this work will see change in misconceptions, stereotypes and how society views poverty. Hopeful that through these projects we can continue to reach those that need help.’

Sarah, Community Inspirer

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