INSTITUTE of HEALTH EQUITY

ALL TOGETHER FAIRER: HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN CHESHIRE AND MERSEYSIDE

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GLOSSARY

HEALTH INEQUALITIES

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

HEALTHY LIFE EXPECTANCY

A key measure of health inequality is the number of years people spend in good health. This measures the time people spend in 'good' or 'very good' health, based on how people perceive their general health.

INDIVIDUAL HEALTH BEHAVIOURS AND PREVENTION

Prevention programmes and initiatives often focus on individual health behaviours, such as smoking, physical exercise, diets/nutrition, alcohol, and drugs. 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 but addressing the causes of the causes requires partnerships with wider systems, supporting people with good education and employment, fair pay and incomes, good quality homes and neighbourhoods.

INDEX OF MULTIPLE DEPRIVATION (IMD)

This is the most common measure of the socioeconomic circumstances, the places where 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 based on the Lower-layer Super Output Areas (LSOA), which, though small, may include areas of high and low deprivation. Quintiles 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 (decile 1) of small areas nationally to the least deprived 20 percent (decile 5) of small areas nationally.

LIVING WAGE

Set by the Resolution Foundation, the 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". In 2021/22 the living wage was £9.90 for areas outside of London.

MINIMUM INCOME STANDARD

The basket of goods and services used to calculate the living wage is based on the minimum income standard, developed to measure the income needed to live a healthy life. The minimum income standard is higher than the living wage and in 2021 it was calculated that a single person needed to earn £20,400 a year to reach a minimum acceptable standard of living in 2021, yet the living wage paid around £17,400 for a single person working full-time.

PROPORTIONATE UNIVERSALISM

Universal policies and interventions are needed in every area but should be developed more intensely 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.

SOCIAL DETERMINANTS OF HEALTH

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 health care is a determinant of health but most of the social determinants of health lie outside the health care system. These social determinants include: education in early and later childhood and adolescence, as well life-long 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.

SOCIAL GRADIENT

The social gradient shows health inequalities are experienced by all of society, not just those at the very bottom and top. Health outcomes, such as life expectancy, improve as deprivation falls.

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 looking 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

In 2021, the Institute of Health Equity (IHE) was commissioned by the Population Health Board of the Cheshire and Merseyside Health and Care Partnership (HCP) to support work to reduce health inequalities through taking action on the social determinants of health and to build back fairer from COVID-19. The HCP and each of Cheshire and Merseyside's nine boroughs have been central to the creation of this report. Our work builds on existing efforts to address health inequalities in the region and aims to develop new momentum and ensure that the most effective approaches are developed, with health inequalities prioritised by the HCP, local authorities, and place-based partnerships.

The title of this report, 'All Together Fairer,' reflects the views of many we heard from in Cheshire and Merseyside since we began work in July 2021. Health inequalities were significant before the COVID-19 pandemic, as our IHE 2020 report *Health Equity in England: The Marmot Review 10 Years On* found. Life expectancy in England has stalled and austerity policies have damaged health and increased health inequalities (1). The 2021 IHE 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 (2).

"We need to do something different or nothing will change!" Views such as this, from a workshop participant in Cheshire and Merseyside, were common. If we keep doing what we've done in the past, inequalities will continue to worsen. Despite a deteriorating national and regional context, and lack of national action, there is scope for local areas to make a real difference. We repeatedly heard enthusiasm for local actions to mitigate the impacts of national decisions and for sustainable longer-term actions. Frustrations were also expressed about well-intentioned sentiments and meetings that rarely ended up resulting in funding or actions. The development of the integrated care system in Cheshire and Merseyside presents an opportunity to forge an action-based, accountable system that will generate greater health equity in the region based on partnerships with other sectors.

This report sets out inequalities in health and the social determinants of health in Cheshire and Merseyside and assesses the impacts of the COVID-19 pandemic on these. It points to the role of austerity policies and associated funding cuts between 2010-20 in driving these inequalities. On the other side of the ledger, the report highlights existing and developing actions and partnerships addressing health inequalities. It includes recommendations to facilitate actions on the social determinants of health and to develop a regional system or partnership to take forward these actions and develop a healthier and more equitable region. To facilitate this equitable system and associated actions, a set of indicators for monitoring health inequalities and the social determinants of health in Cheshire and Merseyside are proposed.

OUR APPROACH: CO-CREATING ACTIONS

IHEs work in Cheshire and Merseyside began in July 2021, at a launch attended by more than 280 participants. We sought to engage collaboratively with partners to identify the key priorities in reducing health inequalities in Cheshire and Merseyside and the required actions, capacity, and roles required to achieve them.

A Cheshire and Merseyside Marmot Leads Group, comprising the nominated leads from the nine areas, and a Cheshire and Merseyside Community Advisory Board were established to drive delivery of the programme. The Advisory board includes elected members, the IHE, the Health and Care Partnership, Champs Public Health Collaborative, Cancer Alliance, NICE, NHS England and NHS Improvement North West region, Office for Health Improvement and Disparities (OHID), Local enterprise partnerships, the voluntary, community, faith and social enterprise (VCFSE) sector and academic institutions. The first meeting of the Advisory board was held in December 2021. The board is accountable to the Cheshire and Merseyside Population Health Board, and, in turn, the Integrated Care Board.

We worked in partnership with Champs Public Health Collaborative to create programme governance; develop local, regional and national data analysis; undertake multidisciplinary consultation meetings; and organise nine place-based workshops. Our approach sought to collaboratively engage with partners to identify the key priorities in reducing health inequalities in Cheshire and Merseyside and the required actions, capacity, and roles required to achieve them.

As a result of this work and the development of the indicators and recommendations, a five-year Cheshire and Merseyside Marmot strategy has been created to drive at-scale actions. It includes:

- Supporting NHS and local authority leaders and partners, including the VCFSE sector, to deliver a coordinated and collaborative social determinants of health approach.
- Working with ICS leaders and systems to deliver leadership commitments and increase investments to transform the role of the NHS in addressing the social determinants of health.
- Assessing place-based plans to decrease health inequalities in Cheshire and Merseyside NHS including analysis of social value practices.
- Continuing to support the Cheshire and Merseyside Marmot Leads Group and Marmot Advisory Board.

WORKSHOPS

IHE developed and ran workshops in each of the nine local authorities. Prior to the nine workshops IHE published an executive summary and nine bespoke, place-based data packs to inform workshop participants of local needs and to support discussions. The purpose of the workshops was for participants to discuss priorities and approaches and inform IHE about the local priorities, system context and recommendations for future actions. The workshops were held in each of the nine local authorities and attended by 371 participants from local governments, the NHS, public services, the VCFSE sector, housing organisations and general public.

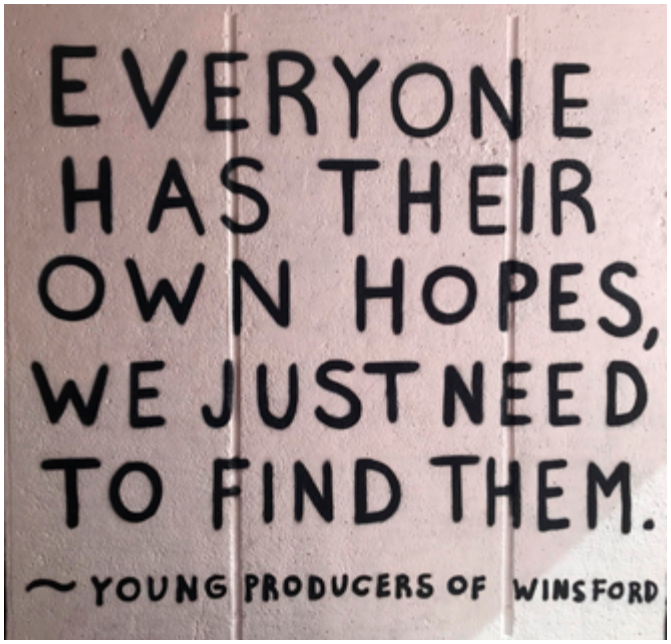
The workshops identified priorities and whilst all eight Marmot themes were discussed, there was a high level of agreement about key issues to address in Cheshire and Merseyside: providing good quality work and improving aspirations; decreasing poverty; improving housing and local places; and identifying ways for local areas to address low income. In addition, the workshops also highlighted the different approaches needed including:

- Shifting from short-term to longer-term approaches for those both inside and outside the NHS.
- Adopting a joined up approach (one workshop participant said: “We are still working in silos.”)
- Asking hard questions and focussing on action (one workshop participant stated: “We talk a lot but we need to make progress, we need action groups!”)
- Addressing accountability and structures so that ownership of health inequalities is shared.
- Bringing services to where they are needed such as employment support in foodbanks.
- Ensuring regeneration is equitable and that local people are able to take advantage of new employment opportunities.
- Shifting investment into the VCFSE sector.

- Investing in prevention (one workshop participant said: "It's not enough to keep pulling people out of the river, we need to stop them being pushed in.")
- Investing in local community services to avoid people being referred repeatedly, often not to the appropriate services.
- Working with residents to identify what works well for them.
- Presenting data in a way that is understandable and accessible.

INDICATORS FOR HEALTH EQUITY

An indicator working group was established before the workshops to define a set of indicators to monitor inequalities in health and the social determinants of health. The Marmot Beacon indicators were developed in partnership with hundreds of local stakeholders between August 2021 and January 2022. The Marmot Beacon indicator set will sit within the Combined Intelligence for Population Health Action (CIPHA) dashboard and serve as a barometer of inequalities in Cheshire and Merseyside. Section 5G outlines the full methodology used to develop the indicators and Section 6 lists the proposed Marmot Beacon indicators for Cheshire and Merseyside.



THE RECOMMENDATIONS

The final set of recommendations included in this report evolved from the draft *Actions to Consider* included in our interim report, published in November 2021. Cheshire and Merseyside HCP and Champs Public Health Collaborative led consultations about the proposed *Actions to Consider*. In addition, local stakeholders shared their comments on the draft *Actions to Consider* and the recommendations were refined and redeveloped in response to this feedback. The recommendations will be central to the Cheshire and Merseyside Strategy and will aim to improve population health and address inequalities in the social determinants of health across the region.

The recommendations cover a number of areas and are the responsibility of many stakeholders and organisations. Following an initial assessment of health inequalities in the region and the actions and responsibilities of a variety of stakeholders, IHE has made recommendations under the eight Marmot principles and seven taking action recommendations - these are system-wide recommendations for action across the Cheshire and Merseyside system. The taking action recommendations are important to enable and support actions in the eight Marmot thematic areas. In this report, the relevant recommendations are set out in each section, along with the relevant indicators.

The recommendations are classified in two categories: Year 1 (2022/23) and Years 2-5 (2023-27). A lead organisation is suggested for each recommendation although most, if not all, should be developed and implemented in partnership. Just as the recommendations and indicators were co-created with local stakeholders in and outside of the NHS, the subsequent actions are the responsibility of all of these partners, as well as other stakeholders across Cheshire and Merseyside.

The recommendations and this report are the beginning of a process which will involve assembling local stakeholders to develop local approaches and ownership for taking actions, deciding who is delivering which services and who will be held accountable to ensure health inequalities are addressed and which stakeholders will be accountable for implementing the Marmot Beacon indicators. It is important that the recommendations are locally relevant and meaningful. The pressures on local authority budgets and increasing demands on the NHS are immense, and as such, it is suggested that each of the nine areas in Cheshire and Merseyside identify the recommendations most relevant to them. There is a role for the Population Health Board, enabled by Champs Public Health Collaborative to monitor the status and implementation of the recommendations in each place to help other areas develop actions in subsequent years.

CHAPTER 2

THE CHESHIRE AND MERSEYSIDE CONTEXT

The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. There are nine places coterminous with individual local authority boundaries, 18 NHS Provider Trusts and 51 Primary Care Networks. The Cheshire and Merseyside Health and Care Partnership is made up of NHS, local authority and VCFSE organisations from the nine local authority areas that make up Cheshire and Merseyside, Figure 2.1.

Figure 2.1. Cheshire and Merseyside Health and Care Partnership (ICS)

Local council leaders and health and wellbeing chairs have stated that structural reforms during the pandemic were "a distraction" but nonetheless they agree that "addressing health inequality at place should be a central guiding principle of the ICS, and all its decisions should be measured against that principle" (3).

The region has areas of substantial wealth and substantial deprivation. Some 31 percent of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared with an England average of 20 percent. Despite the relative wealth in Cheshire West and Chester, 16 percent of neighbourhoods in Cheshire West and Chester are in the lowest two income deciles (4). Overall a third (33 percent) of the Cheshire and Merseyside population live in the most deprived 20 percent of neighbourhoods in England, with significant negative implications for health (5). The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England (4).

The nine boroughs within the Cheshire and Merseyside region have existing priorities for improving the health and wellbeing of their residents and all have identified health inequalities and the social determinants of health as areas for action. Existing local public health plans, for example, refer to: "taking action on the social determinants of health"; "focusing on prevention and early intervention"; "taking a life-course approach"; "giving every child the best start in life"; "being asset-based"; "working in partnerships, including the voluntary and community sectors".

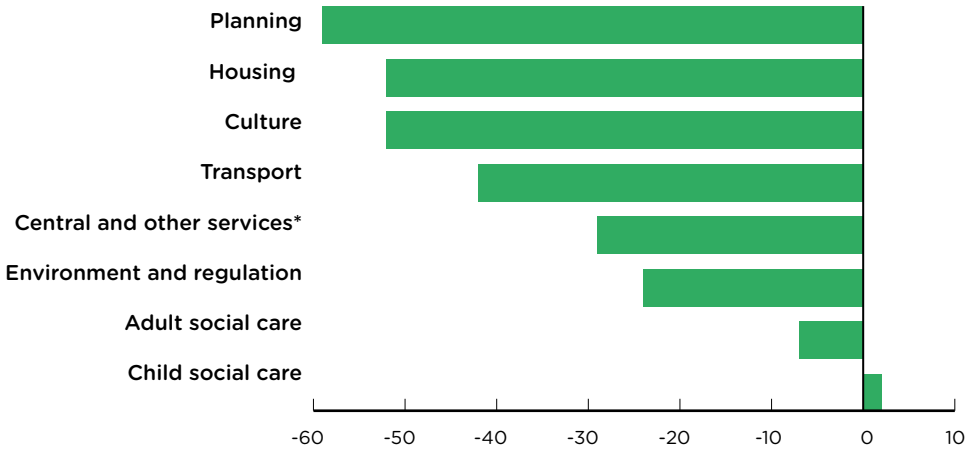
Our work in Cheshire and Merseyside — including this report, indicators and recommendations — provides momentum for these actions, as well as offering additional approaches to be implemented at pace and over the long-term. These require effective collaboration and partnerships between the NHS, local authorities, businesses, public services, the VCFSE sector and communities themselves. Aligning different sectors and organisations' priorities, budgets, levers, and incentives to enable these partnerships is an essential next step for Cheshire and Merseyside's HCP.

2A AUSTERITY AND FUNDING CUTS IN CHESHIRE AND MERSEYSIDE

Austerity policies during the decade 2010-20 in England are associated with worse health and widening health inequalities. Across England, life expectancy stopped increasing and for those outside London and in more deprived areas, life expectancy declined and regional inequalities widened. Healthy life expectancy fell between 2014-16 and 2017-19 in England, men lost 1.6 months in healthy life expectancy and women lost 3.5 months (6). The IHE's *10 Years On* report found this likely related to policies of austerity, including deteriorating quality of work, stagnating wages, cuts to public services, local authority funding and benefits, as well as declining investment in deprived communities (1).

A marked feature of the decade 2010-20 was steep and inequitable cuts to local authorities. In this decade, cuts to funding and the impacts of tax and benefit changes were higher in areas of greater deprivation (1). These cuts had a significant impact on health, wellbeing and inequalities, as councils were forced to cut back or stop offering services. The Local Government Association estimates an £8 billion shortfall in funding by 2024/25 for councils to maintain 2021 services in England (7). Figure 2.2 shows local authority cuts between 2010 and 2020, reduced spending in every aspect of council services, except child social care (although increased demands eliminated the increased funding).

Figure 2.2. Change in net spending per person by local authority service, percentage, England, 2009/10 to 2019/20



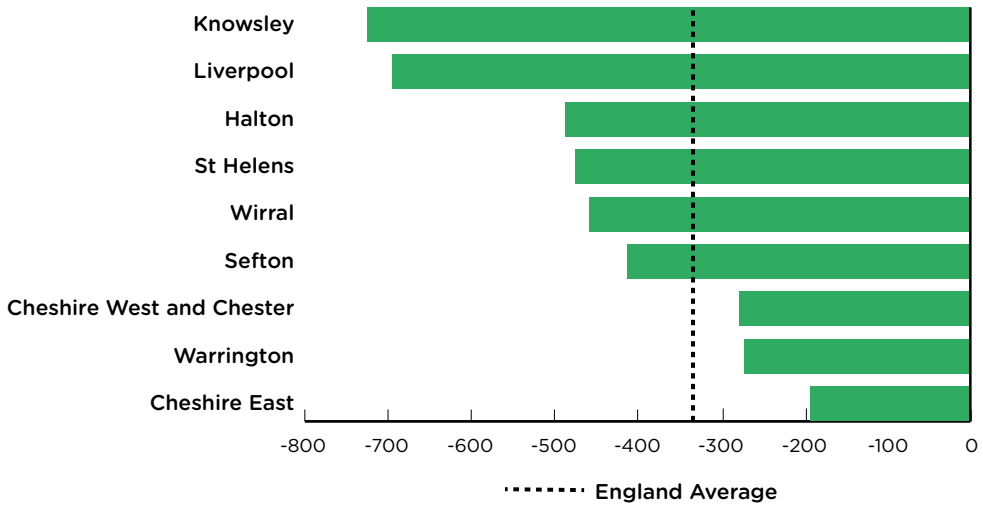
Notes: *Services such as council tax administration and corporate services*

Source: *IFS calculations of Ministry of Housing, Communities and Local Government data (8)*

Figure 2.2 shows funding to children's social care slightly increased between 2009 and 2019. however spending on children's social care only increased due to the significant increase in the number of children taken into the care of local authorities, and spending on this increased in England by 68 percent during this period (9). Overall, between 2009 and 2019 there has been "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, and with the greatest declines in the most deprived areas (9).

On a per capita basis, between 2010 and 2018, Liverpool had the largest cuts of any city in England with a population over 250,000[1]. Examining the nine boroughs within Cheshire and Merseyside shows that Knowsley, the most deprived local authority in the HCP, had the highest spending cuts at £725 per head of population, Figure 2.3. In areas such as Knowsley, and in other Northern cities, there are high levels of deprivation, more homes in lower council tax bands and as a result, less income from residents. Prior to 2010, the funding formula for local areas reflected this inequality, however in 2010 this weighting changed, leading to decreased spending per head.

Figure 2.3. Change in local authority spending power (real terms), per head of population, Cheshire and Merseyside lower-tier local authorities and England, 2010-18



Source: *Ministry of Housing, Communities & Local Government (9)*

Since 2010 Cheshire West and Chester have lost more than £330 million in funding from central government and Warrington has lost £173 million (10) (11). During this period, the revenue grant to Cheshire East reduced by 36 percent and Sefton Borough Council has had budget cuts of £115 million in real terms. In October 2020 Cheshire West and Chester Council stated it faced a budget shortfall of between £34 million and £43 million, depending on what national funding becomes available (12).

The COVID-19 pandemic has worsened the state of local government funding: while central government funding has been touted as helping local authorities manage the increased pressures, this funding has not been sufficient and instead most local authorities in England are further in debt than before the pandemic. In 2020/21 local government funding increased as a result of the increased costs associated with the pandemic and lost revenue (from losses associated with business rates, for example). The National Audit Office reported that local authorities had £9.7 billion of COVID-19 cost pressures (primarily adult social care, housing and public health services costs) and income losses (council tax and business rates) in 2020/21 yet only £9.1 billion in financial support from government (13). The Institute of Financial Studies estimates that local councils in England would need a £10 billion increase in revenues between 2019/20 and 2024/25 to maintain current service levels due to the additional demands and costs associated with the pandemic (14).

A systematic review of the effects of social security policies in high-income countries found that policies associated with austerity, such as reducing eligibility/ generosity,, were related to worse mental health, and tended to increase health inequalities (15). Research also shows that short-term gains in budgets through cuts have led to more deaths and increased demands on services:

- Researchers from the University of Liverpool examined funding reductions in local government budgets between 2013 and 2017 in more deprived areas, and found increased health inequalities between the most and least deprived areas. They estimate that without the cuts, in the most deprived areas of England, male life expectancy would have been three months longer and female life expectancy would be 2.8 months longer, and an additional 9,600 deaths in people younger than 75 years old would not have occurred. They suggest this could be attributed to decreased local government budgets in adult social care, housing and homelessness prevention, and environmental and regulatory services (16).

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

- Adult social care budgets decreased between 2009/10 and 2017/18 and at the same time, the average number of annual accident and emergency (A and E) visits for a person aged 65 and above increased by almost a third, with researchers stating that public spending cuts to social care could explain between a quarter and a half of this growth. The increased pressures on A and E departments were most pronounced among older people and those living in the most deprived areas (17).

- The closure of Sure Start centres has been found to affect levels of obesity and hospital admissions. Between 2010/11 and 2017/18 in England, the prevalence of childhood obesity increased more in areas that experienced greater cuts to spending on Sure Start. For each 10 percent cut in spending, a 0.3 percent relative increase in obesity prevalence was associated in the following year, leading to an estimated additional 4,575 children were obese and 9,174 children who were overweight or obese (18). The Institute for Fiscal Studies found that more than 13,000 hospital admissions of children per year were avoided by the work of Sure Start centres between 2010 and 2020 and the biggest impact was on the children in the most deprived neighbourhoods (19).

All local authorities are affected by reduced incomes during the pandemic (from, for example, reduced income from business rates, leisure facilities and car parking), but more deprived local authorities will be more greatly affected, as their funding was lower per capita before the pandemic. Additionally, central government has shifted from providing longer-term funding to one-off (and often ring-fenced) grants. One quarter of all grants available to local governments are worth less than £1 million, and a third of them last a year (20). Spending on prevention is a long-term commitment, and short-term, one-off grants are the antithesis of the type of longer-term funding needed to address prevention and reduce health inequalities. The Chartered Institute of Public Finance and Accountancy states that these short-term grants have "reduced the ability for joined-up planning" (21).

In October 2021, the Autumn Budget and Spending Review committed 1.25 percent of national insurance contributions to the new health and social care levy, which will fund increases to the budget of the Department of Health and Social Care. Whilst this is welcome, the increase in funding is inadequate compared to the breadth of cuts, the effect of rising costs and inflation, and rising demand – this additional funding is highly unlikely to combat the continuing rise of inequality and damage done by a decade of austerity. While the government has declared that "austerity is over" (22) (23), as we stated in our *10 Years On* report:

> ***It is not enough for the government simply to declare that austerity is over. Actions are needed in the social determinants to improve the lives people are able to lead and hence achieve a greater degree of health equity and better health and wellbeing for all.***
>
> *10 Years On IHE report*

We make the case for business to be involved in places and our work consistently recommends empowering and building resilience in communities (24).

LEVELLING UP?

The 2022 Levelling Up white paper highlighted geographical inequalities including differences in life expectancy, pay and productivity. The paper set out four areas of action with 12 missions to be achieved by 2030. 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.**

All four areas of action are relevant to our agenda. However, the four missions under the second area are particularly relevant to addressing the social determinants of health:

- 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 more than 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 (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.
- By 2030, wellbeing will have improved in every area of the UK, with the gap between top performing and other areas closing (25).

The allocation of Levelling Up funding does not necessarily follow need. In the first round of funding, a number of areas that are the wealthiest in England received more than £100 a head, while Knowsley, one of the most deprived areas in England, received no funding from these Levelling Up funds (26). Table 2.1 shows the inconsistency in the Levelling Up funding categories in Cheshire and Merseyside. Four local authorities have been placed in the highest priority category and Halton is in category 2, yet its levels of income deprivation are worse than St Helens and Wirral, which are in category 1 and Sefton, with similar levels of deprivation to Wirral, is in category 3.

Table 2.1 Levelling Up priority categories and levels of income deprivation in Cheshire and Merseyside

	Levelling Up Priority Category	Percent of population income-deprived	Ranking of income deprivation in England's 316 local authorities
Knowsley	1	25	2
Liverpool	1	23.5	4
St. Helens	1	18	33
Wirral	1	17	38
Cheshire West and Chester	2	11	161
Halton	2	18.5	31
Warrington	2	11	153
Cheshire East	3	8	226
Sefton	3	16	54

Sources: *Office for National Statistics, Department for Levelling Up, Housing and Communities (27) (28)*

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 the focus is on infrastructure, rather than investing in the domains (the social determinants) that would actually level up health and other outcomes. IPPR North analysis showed the Levelling Up fund will provide £32 per head for people in Northern England yet the fall in annual local council service spending since 2010 in Northern England was £413 per head (29). Academics from the University of Liverpool have shown that the UK Shared Prosperity Fund does not match the EU funding previously available to these areas and point to the lack of transparency in awarding Ministry of Housing Communities and Local Government funding (30).

Citizens Advice has identified that people are one and a half times more likely to claim Universal Credit in places the government has prioritised for levelling up investment. They also found for every £1 that could be invested from the Levelling Up Fund in England, £1.80 would be taken from these local economies following the government ending the pandemic-related uplift in Universal Credit (31).

FUNDING CUTS: THE PUBLIC HEALTH GRANT

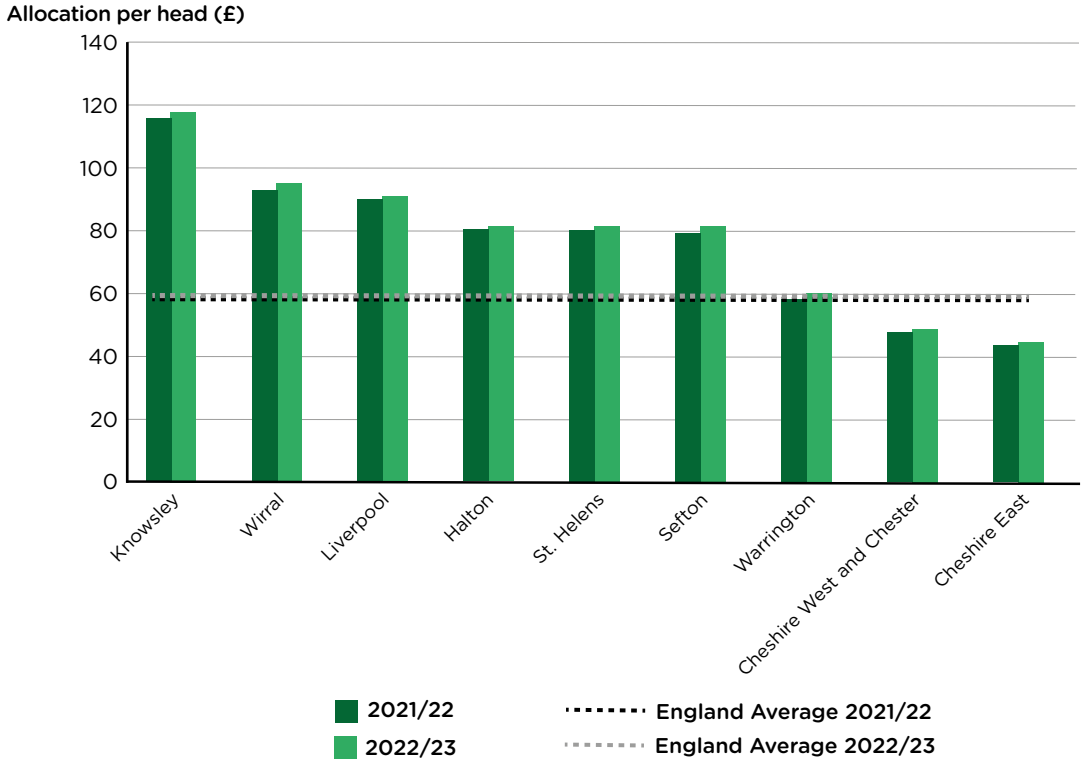
The public health grant had already declined significantly before the pandemic. The Institute for Public Policy Research (IPPR) estimates that there was an £870-million decline in net expenditure to public health services (such as sexual health, obesity, physical activity, and drug and alcohol services) 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 (32). In 2016, the British Medical Association warned cuts to public health would have significant effects:

> *Cuts to the public health grant will inevitably lead to service reduction and will, in the longer term, result in greater costs for both the NHS and the taxpayer. While it is too early to assess the impact of these cuts, there is evidence that local authorities are disinvesting in areas such as prevention, addiction services, sexual health, and weight management (33).*

These predictions have come to fruition. Public health funding is not sufficient in light of the extensive cuts to local authority budgets, the pandemic and the 24 percent decrease in real-terms public health funding that has been experienced since 2015/16 (34) (35). In 2022/23, the overall public health grant increased by 2.7 percent in England compared to 2021/22. The Bank of England expects inflation to rise to 8 percent in the spring of 2022 and potentially rising higher by the end of the year, as such, an increase of 2.7 percent represents a substantial decrease in spending (36).

Figure 2.4 shows the impact of the increases in 2022/23 on local allocations is minimal, rising by £1.07 a head in Cheshire West and Chester and £2.31 a head in Wirral. Due to higher levels of deprivation, in the Liverpool City Region, local authorities receive a higher per-head allocation compared to the England average.

Figure 2.4. Public health grant, allocation per head of population, Cheshire and Merseyside lower tier local authorities, 2021/22 to 2022/23



Source: *Department of Health and Social Care (37)*

FUNDING CUTS: PUBLIC SERVICES

In addition to cuts to local government spending, there were cuts to a range of public services, all of which affect health outcomes and harm more deprived and excluded communities the most. Between 2009/10 and 2019/20, school spending per pupil fell by 9 percent in real terms in England, with schools in deprived areas experiencing the deepest cuts per pupil (38). Between 2017/18 and 2020/21 schools in the most deprived quintiles in England had a 1.2 percent average real-terms decrease in per-pupil schools block funding. In contrast, there was a 2.9 percent increase for the least deprived quintile of schools. Analysis from the National Audit Office found that the minimum per-pupil funding worsened inequalities, concluding: "In recent years, there has been a relative redistribution of funding from the most deprived schools to the least deprived schools" (39).

The COVID-19 pandemic has increased the education divide. The Education Policy Institute stated that £13.5 billion was needed over three years to reverse the damage related to school closures and other factors associated with the pandemic (40). In June 2021, the government's education recovery commissioner resigned because of the lack of funding offered. The commissioner called for £15 billion in funding to help pupils recover from the pandemic, but in October 2021 the government announced additional funding of £5 billion for catch-up and tutoring classes in England (41). There are signs the additional funding is exacerbating inequalities. The cross-party House of Commons Education Select Committee found the National Tutoring Programme (NTP) reached 100 percent of its target numbers of schools in South West England, 96 percent in the South East, but 59 percent in the North West and North East. In addition to these geographical inequalities, there are concerns the NTP is not reaching the children and young people living in the most deprived areas. Randstad, the company providing the NTP, concluded: "It remains unclear whether the NTP will reach the children and young people who are most in need of it" (42).

Cuts between 2010 and 2020 also reduced the number and capacity of children and youth services, police services and the VCFSE sector (43). Between 2009/10 and 2019/20, 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 (44) (45). In 2009, Liverpool City Council employed 110 youth workers and in 2019, they employed 26 with the budget reduced by more than two-thirds (46). Warrington's budget for youth services fell from £3.4 million in 2010/11 to £668,000 in 2019/20 (47). Cuts to youth services have significant impacts on young people's education, mental health and wellbeing (1).

FUNDING CUTS: POLICING AND LEGAL SERVICES

Across England and Wales, spending on police services fell by 16 percent between 2009/10 and 2018/19 (48). In 2019 Cheshire's police and crime commissioner and chief constable stated that cuts to public services, including policing, were impacting on the number of violent crimes in Cheshire. Some 135 police officer roles were lost between 2010 and 2019 (49) and in Merseyside, the police and crime commissioner stated that between 2010 and 2021 they had 1,110 fewer police officers (50). In 2019/20 violence was estimated to cost £185.4 million in Merseyside alone, including costs to the healthcare system, police and criminal justice system, and in lost productivity (51). Cuts to policing affect community safety and sense of belonging in local areas.

Violence Reduction Units have a key role in reducing crime, yet government funding for a regional network of Violence Reduction Units and other preventative initiatives (such as the Youth Endowment Fund) still falls well short of the amount it costs the economy and overall budgets for police (52). In 2021/22 funding for all Violence Reduction Units in England was £35.5 million, whereas the (provisional) police budget in Cheshire was £232 million and in Merseyside, £400 million (53) (54). Violent offences committed by those aged 24 and under involving the use of a knife or a gun are rising and are associated with rising costs, from approximately £790 million per year in 2014/15 to £1.3 billion in 2018/19 (55).

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

Box 1. Merseyside Violence Reduction Partnership (MVRP)

The Merseyside Violence Reduction Partnership (MVRP) has a public health approach to violence reduction. The MVRP strategy has a strong emphasis on addressing the root causes of serious violence and mitigating the impacts of violence. The MVRP believes that violence is preventable. By understanding the drivers of crime, the risk of offending can be reduced and therefore the number of victims will be reduced. To achieve this, the MVRP believes a multi-agency public health approach is essential and this underpins MVRP activities.

The MVRP supports and delivers a variety of interventions around prevention (early, therapeutic and desistance) whilst also focusing on primary, secondary, and tertiary prevention. The MVRP works in partnership across the region and its work is divided into key areas including: early help - early years; speech and language therapy and readiness for school; targeted interventions (with at risk young people); youth diversion and mentoring and local education initiatives. In 2020/21, more than 22,000 young people benefitted from MVRP interventions and more than 3,000 of these were potentially high-risk.

One of MVRP's programmes is the Mentors in Violence Prevention Programme which incorporates five core components: exploring violence through a gendered lens; developing leadership; adopting a bystander approach; recognising the scope of violent behaviour and challenging victim-blaming. It supports a whole-school approach to early intervention and prevention of bullying, harassment, and risky behaviours, empowering students to identify and communicate concerns with peers and school staff.

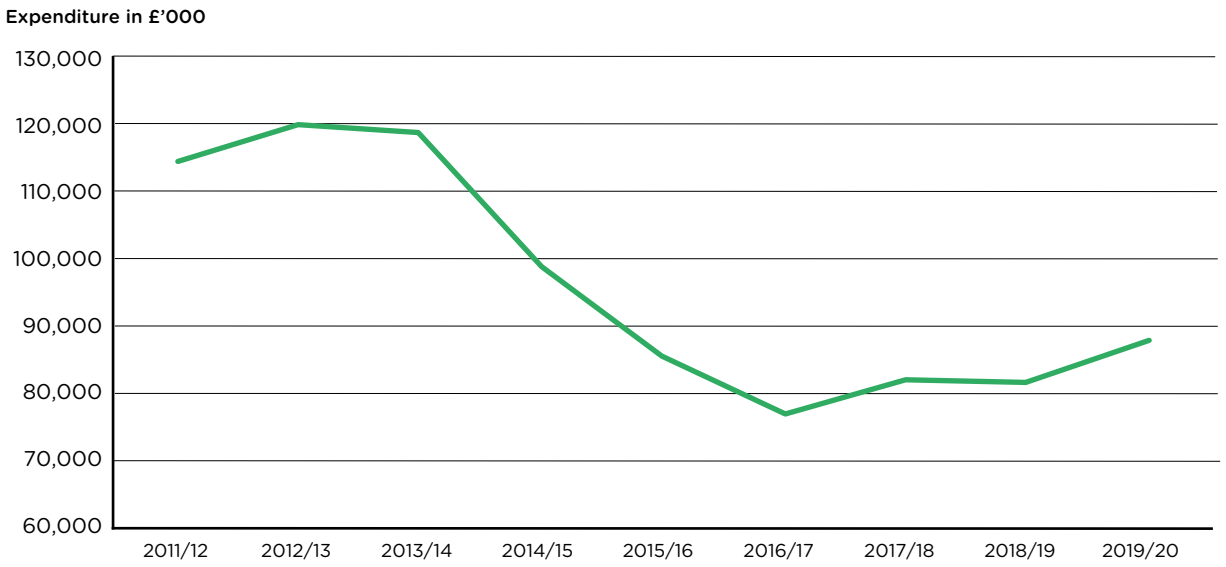
MVRP developed additional guidance for schools to use when considering permanent exclusion. By highlighting the principles, consequences and identifying local level support, MVRP sees this guidance as a valuable tool to assist schools when undertaking decisions about exclusion.

Weapons Down Gloves Up (WDGU) is a 10-week boxing initiative which offers an introduction and access to boxing, combining this with employability training for unemployed young people who have left school or college and are aged between 19 and 25. The aim is to improve confidence, resilience and work-ready skills and keep young people safe, off the streets and prevented from turning to crime. At the end of the WDGU programme, young people are able to transfer into a two-week careers session to gain accredited health and safety qualifications, work experience and the opportunity of employment (56) (57).

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

These cuts affect community safety and sense of belonging in local areas, just as cuts to legal aid also affect social justice and fairness. There have been deep cuts to legal aid which have impacted on people living on lower incomes, who are more likely to depend on legal aid. Between 2010/11 and 2017/18 there was a 37 percent decrease in legal aid spending, and between 2009 and 2019 there was a 40 percent decrease in funding for law centres (58). Legal aid makes seeking legal redress accessible to the UK's poorest citizens and affects gender and ethnic inequalities. Women are the majority of applicants for legal aid, and ethnic minority populations, on average, account for 72 percent of legal aid cases (59). These cuts also affect a number of social determinants of health, importantly, income. The Department of Work and Pensions faces a number of legal cases appealing decisions to deny various benefits, most of these cases are funded by legal aid and many have proved to be successful (60). In September 2021, a freedom of information request revealed seven in 10 cases arguing decisions to deny disability benefits were successful (61). Figure 2.5 shows a 23 percent decline in legal aid provider offices, reflecting the decline in legal aid providers across England and Wales.

Figure 2.5. Legal aid provider expenditure, £'000, North West region, 2011/12 to 2019/20



Source: *Bolt Burdon Kemp (62)*

As legal aid provision and the number of law centres have declined, other interventions have been developed to support people on low incomes who require legal advice. Whilst these interventions cannot fully compensate for the loss of legal aid funding and law centres, projects such as Health Justice Partnerships, have been shown to be a valuable tool to increase incomes and thus address the social determinants of health, Box 2.

Box 2. Health Justice Partnerships

Health Justice Partnerships (HJPs) are an intervention tackling poverty-related issues that affect the health of populations. HJPs involve the integration of free community legal services with patient care. These services provide advice and assistance relating to matters of social welfare law, such as welfare benefits, debt, housing and employment. Ensuring access to legal advice is not only a matter of social justice but addresses the root causes of poor health and health inequality.

Social welfare legal issues predominantly affect low-income groups (63). People experiencing social welfare legal problems commonly suffer mental and physical health consequences, due to chronic anxiety about the issue or its effects on living and working conditions (64). Community legal services such as HJP help individuals to gain access to the support they are entitled to by law, and are a key partner for the NHS in the fight against health inequality.

HJPs exist in many healthcare settings across England, including GP practices, hospital clinics, mental health services, hospices, maternity services and others. There are different ways in which legal advice services can be linked with healthcare, for example by integrating welfare rights advisors directly within multidisciplinary care teams, or using referral systems to coordinate service delivery.

HJPs can achieve a range of positive impacts (65). Providing advice in healthcare settings facilitates timely access to assistance and reaches people who would otherwise not seek help. The legal interventions achieve significant improvements for individuals, notably with income and finances, as well as other material and social circumstances. This has been shown to have positive benefits for mental health. In-house legal services also support care teams in managing welfare-related workload and enable a more personalised and responsive approach to patient care.

Free community legal services are diverse, and can include local authority welfare rights units, law centres, local and national charities. Advice networks operate in some regions, bringing together local providers to coordinate activity. An example in Cheshire and Merseyside is the Liverpool Access to Advice Network, which operates a local referral network (66). Many HJPs are localised and small-scale projects. In order to achieve the greatest impact, these partnerships should be scaled to operate across regions (67).

FUNDING CUTS: THE VCFSE SECTOR

The voluntary, community, faith and social enterprise sector has a vital role in providing services and supporting community health and wellbeing. These include direct support for mental and physical health or by offering support to improve the social determinants of health, through community-based projects such as gardening, sports and youth groups, education offers, support for income, debt advice, access to benefits, housing issues and more.

The 10 Years On report showed the cuts to local authorities have resulted in significant cuts to the VCFSE sector (1). Between 2010/11 and 2015/16 £802 million was cut from the VCFSE sector by local government (68). The location of charities does not necessarily correspond to areas with highest need: in 2016/17 the greatest density of charities was in the South West and the lowest in the North East, North West and London (69). The VCFSE sector tended to be "weaker and less well funded" in the areas of highest deprivation (70).

Pro Bono Economics predicted in 2021 that one in 10 UK charities would face bankruptcy, with smaller charities, the vast majority of charities in the North West, expected to fare worse (71) (72). In January 2021, the VCFSE sector in Cheshire and Warrington reported a 16 percent drop in income. Merseyside has 807 micro charities, (with a turnover of less than £10,000), and 919 with a turnover of between £10,000 and £100,000. Micro and small charities make up 66 percent of all charities in the area. 70 percent of charity chief executives said they had seen a serious drop in income as a result of the pandemic and 68 percent said demand for their services had increased (73).

The pandemic has led to cuts in the VCFSE sector. One in four charities in England experienced a drop of more than 40 percent in their income and this is expected to decrease further as the cost of living and inflation increase and lead to reductions in charitable donations. Funding pressures have increased in the VCFSE sector at the same time as demand has increased. In 2021, 55 percent of charities stated an increase in calls for their help and in January 2022, Citizens Advice reported that demand for their services was higher than at any point since the beginning of the pandemic (they report a 55 percent increase in the number of people seeking advice about fuel debts between April 2021 and February 2022 compared with the same period 12 months before).

It is estimated charitable income will decrease in real terms by 3 percent between 2021 to 2022, or approximately £2 billion. In addition, due to increases in inflation, money already committed to charities will be worth less. A £20 donation in 2021 will be worth £17.60 in 2024, while a grant of £100,000 in 2021 will only be worth £88,100 by 2024 (71).

This report focuses on the partnerships between the VCFSE sector, public services, local authorities and businesses as an essential partner (Section 5E explores the role businesses have in reducing inequalities). Larger organisations can liaise with the VCFSE sector to establish the support needed to provide guidance in bidding for contracts and be recognised financially for the work they do in supporting health and the social determinants of health and reducing demand on public services and local authority services.

2B 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 and the inequities in access to power, money and resources which underpin these. Unfair distribution of these resources creates *avoidable* health inequalities, known as health inequities.

Good-quality healthcare is a determinant of health, and access, affordability, and suitability of healthcare services are socially and politically determined, but most of the social determinants of health lie outside the healthcare system. These are encompassed by the Marmot 8 principles (74) (75).

THE MARMOT 8 PRINCIPLES

Reducing health inequalities requires action on the six policy objectives outlined in the first Marmot review, *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 we have added another two principles to reflect increasing recognition of the health equity impacts of these domains:

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

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

PROPORTIONATE UNIVERSALISM

The 2010 *Fair Society, Healthy Lives* report illustrated 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 (76). 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 (76) (1).

Coventry, a Marmot City since 2013, outlined their experience of addressing the social determinants of health using a proportionate universal approach.

> ***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 (77).***

THE LANGUAGE OF DEPRIVATION

The language of deprivation can be stigmatising but the Index of Multiple Deprivation (IMD) is one of the best measures in helping to understand area deprivation. The IMD has been labelled as an index of social justice and our work is rooted in this concept. The Commission on Social Determinants of Health begins with the statement: "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." Whilst we support the idea of the IMD being an index of social justice, for simplicity, we continue to use deprivation throughout this report.

Box 3. The language of deprivation

Much of the research we use in this report, as we have in others, is based on the Index of Multiple Deprivation. Since 2000, the IMD has produced relative measures of deprivation for small local areas (Lower-layer Super Output Areas) 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 deciles, 10 equal groups, and this helps to demonstrate 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.

A POST-PANDEMIC NHS

Health inequalities existed across care in the NHS prior to the pandemic, with emergency services used more often by people living in the most deprived areas (the higher an area's deprivation, the higher the rate of A&E admissions) (78). But these are likely to increase as a result of rising demand – largely driven by the effects of the pandemic. The increasing demand will not be solved in six months or year and as such, an approach to reducing the waiting lists will require a shift of approach. The waiting lists are longer in the most deprived areas in England, on average, and the increase in elective waiting lists in the most deprived areas of England have increased by 55 percent compared to an increase of 36 percent in the least deprived areas (79). In February 2022, NHSE published its plan to tackle the backlog of elective care as a result of the pandemic. The three-year plan proposes that services and resources "be distributed fairly according to clinical need" and requires local systems to analyse waiting list data by deprivation, ethnicity and age (80).

As the NHS deals with this backlog, it should not be a choice of whether it has time and funding to also address social determinants, because without taking action on the social determinants of health, demand and health inequalities will increase.

Numerous analyses on demand and funding for the NHS require stronger commitments on prevention, from Derek Wanless' report in 2000 that recommends health promotion expenditure grow in line with expenditure on general practice and hospital care, to the Five Year Forward View in 2014 that called for a "radical upgrade in prevention" (81) (82). In 2019 the NHS Long Term Plan sought to increase the focus on prevention, requiring all local health systems to set out how they will specifically reduce health inequalities by 2023/24 and 2028/29 (83).

CHAPTER 3

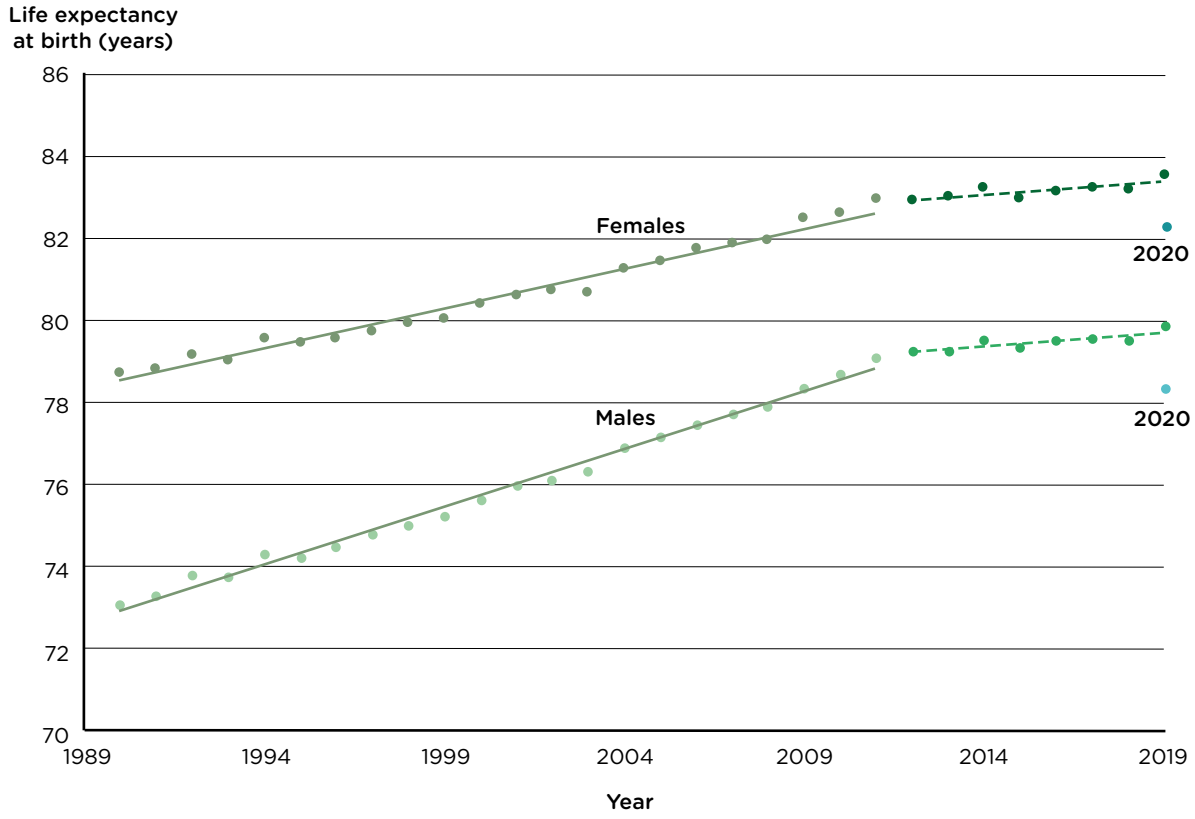
HEALTH INEQUALITIES IN CHESHIRE AND MERSEYSIDE

There are long standing inequalities in health in Cheshire and Merseyside, as in the rest of England. Health outcomes in many areas are lower in this region compared to the national average and health inequalities within local authorities are wider. Within each of the nine boroughs of Cheshire and Merseyside, there are wide areas or smaller pockets of deprivation.

3A HEALTH INEQUALITIES IN ENGLAND

The IHE *10 Years On* report found that increases in life expectancy had slowed since 2010 and the slowdown was greatest in more deprived areas of England (1). The COVID-19 pandemic has led to life expectancy in England dropping in 2020, falling by 1.3 years for men and 0.9 years for women, Figure 3.1.

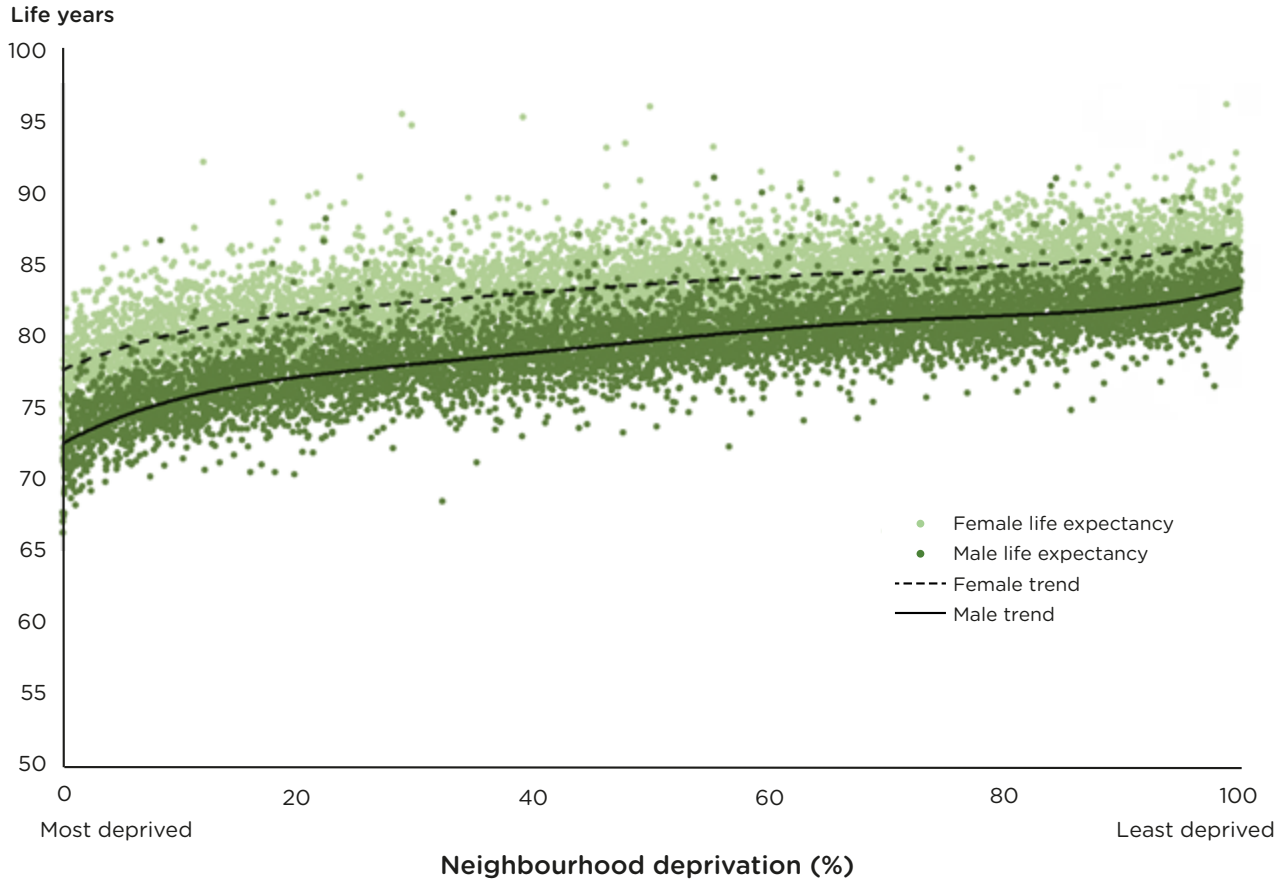
Figure 3.1. Life expectancy at birth for males and females, England and Wales 1989-2020



Source: *Office for National Statistics (84)*

Our 2010 and 2020 reports showed how the social gradient in health runs from the top of the socioeconomic spectrum to the bottom, that everyone below the top income deciles is likely to live shorter lives and develop a disability earlier than those at the top (76) (1). Figure 3.2 shows the social gradient in female and male life expectancy by neighbourhoods in England. The lines show that broadly as neighbourhood income increases, life expectancy increases. Our reports repeatedly state that this is unnecessary and unjust and that health inequalities can and should be reduced across the gradient.

Figure 3.2 Life expectancy at birth for neighbourhoods (MSOAs) by sex and deprivation percentiles, (IMD 2019), 2016-20, England

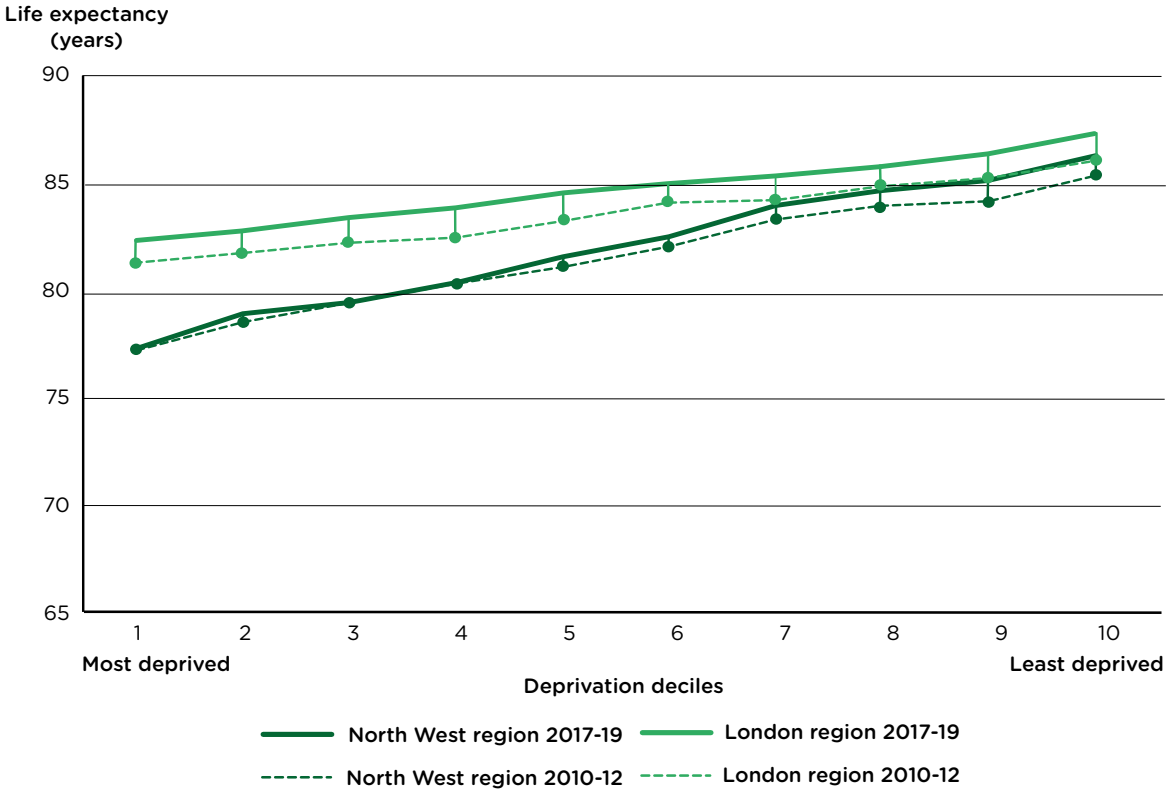


Notes: *Each dot represents life expectancy (LE) or disability-free life expectancy (DFLE) of a neighbourhood (middle level super output area)*
Source: *Office for National Statistics (ONS) and Department for Work and Pensions (85) (86)*

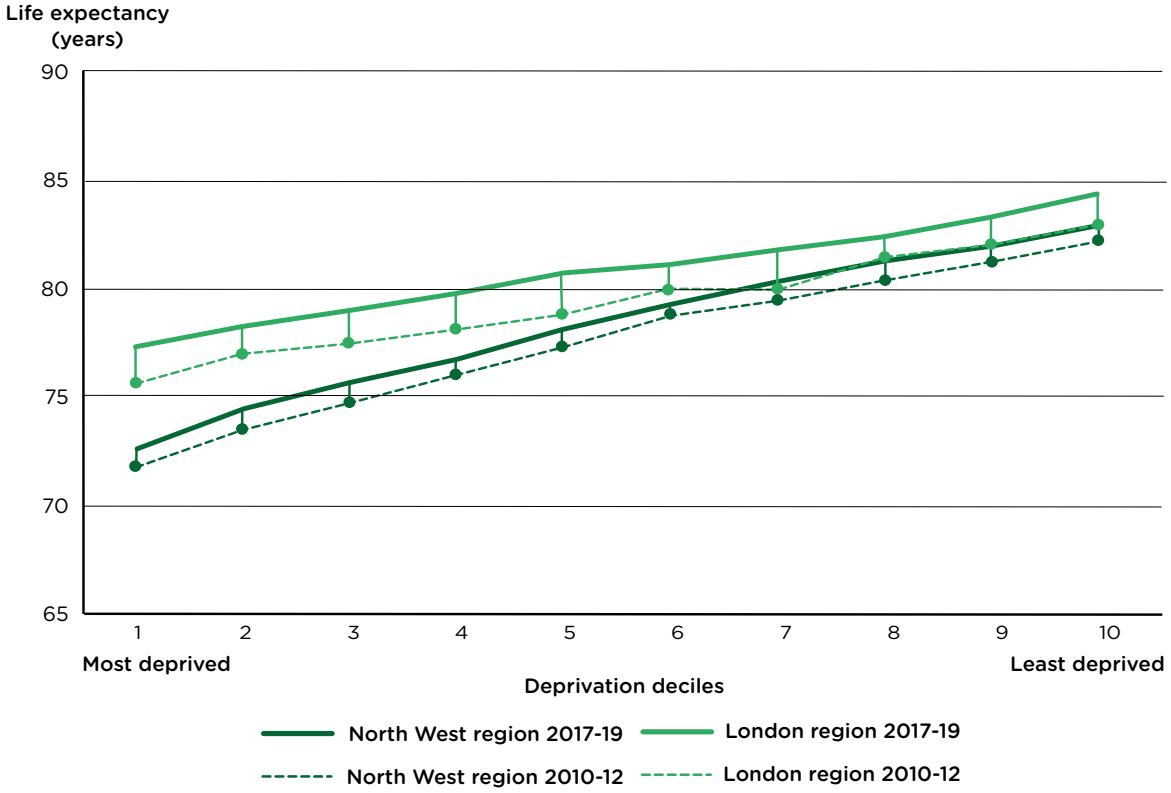
The 2020 *10 Years On* report showed the differences in life expectancy between England's regions. From 2010, London's life expectancy increased more rapidly than other regions. Figures 3.3A and 3.3B show life expectancy in the North West region is lower than London, and that there is steeper gradient for both men and women in the North West. 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, it's a 10.4-year difference in the North West and seven years in London.

Figure 3.3A and 3.3B. Estimated male and female 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



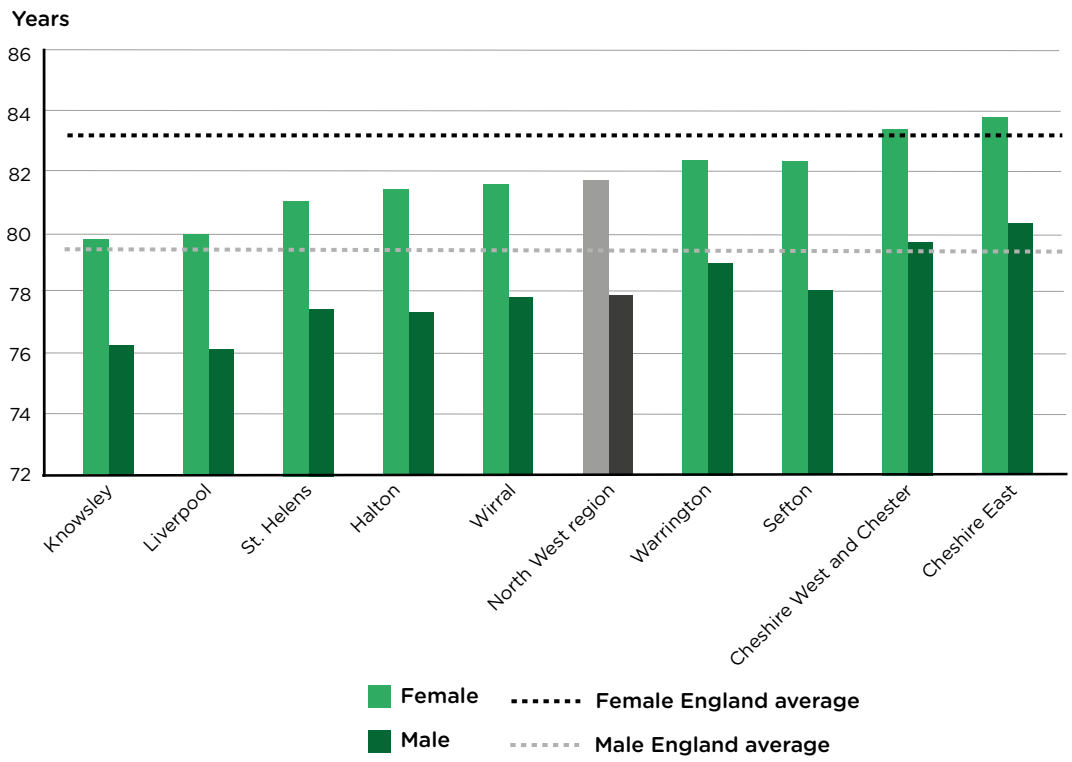
Source: *Based on PHE, 2020 (87)*

3B LIFE EXPECTANCY IN CHESHIRE AND MERSEYSIDE

Health inequalities are stark within Cheshire and Merseyside; the slope index of inequality, which represents the range in years of life expectancy across the social gradient from most to least deprived in an area, shows women in the least deprived decile in Cheshire and Merseyside, live, on average, 9.5 years longer than those in the most deprived deciles, and men in the least deprived deciles live, on average, 11 years longer (88) (89).

Life expectancy for women in Cheshire and Merseyside was 82.7 in 2018-20, lower than the average for England, of 83.1 years (90). For men in Cheshire and Merseyside, the average life expectancy of 78 years was also lower than the England average of 79.4 years. Figure 3.4 shows Cheshire East and Cheshire West and Chester are the only boroughs with longer life expectancy than the national average for both women and men. In the North West region, life expectancy at birth for men is 78.4 years and 82.1 years for women.

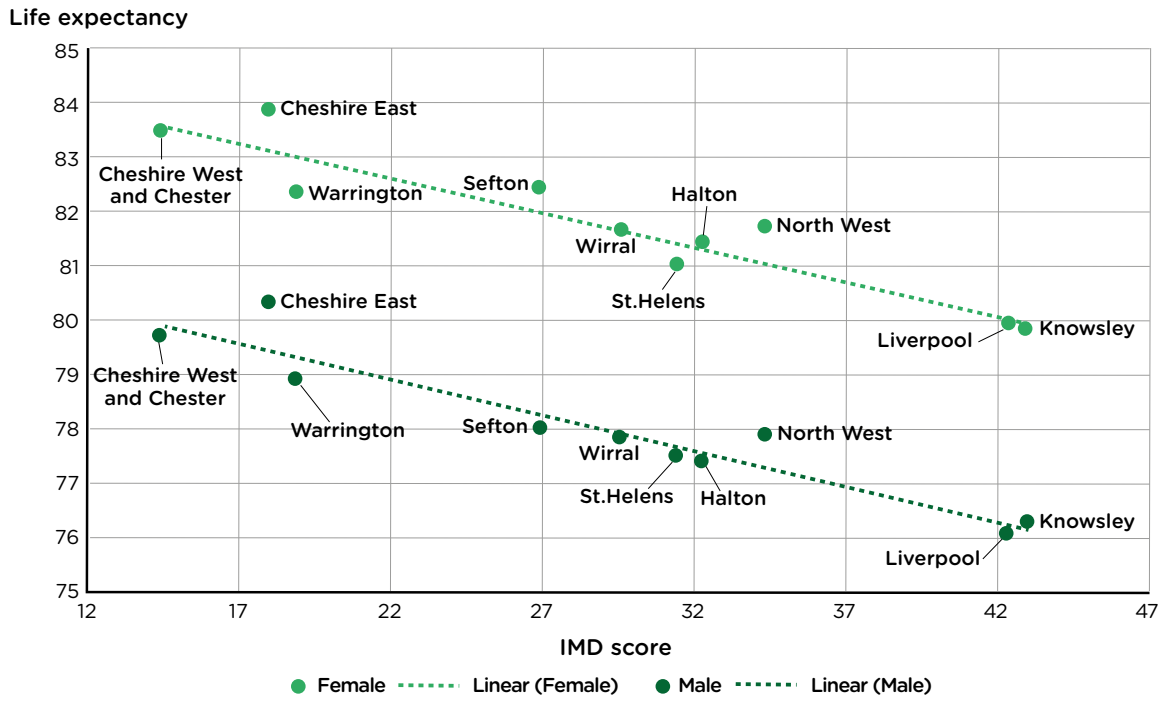
Figure 3.4. Estimated male and female life expectancy at birth, Cheshire and Merseyside lower-tier local authorities, North West region, and England, 2018–20



Source: *Office for National Statistics. (90)*

In Cheshire and Merseyside, as elsewhere, average life expectancy in a local authority is related to the extent of deprivation in the area, as shown in Figure 3.5. The graded relationship with deprivation is remarkably similar to that seen in England as a whole, where the higher the level of deprivation, the lower the life expectancy.

Figure 3.5 Estimated male and female life expectancy at birth by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2018-20

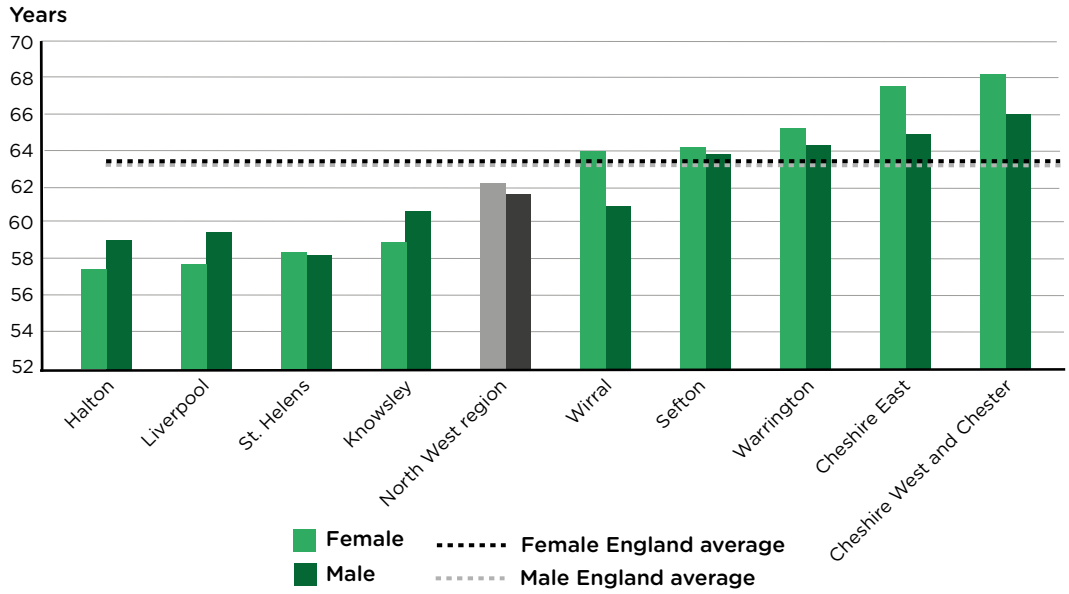


Source: *Office for National Statistics. (90)*

HEALTHY LIFE EXPECTANCY

Healthy life expectancy is the average number of years an individual is expected to live in a state of self-assessed good or very good health. Figure 3.6 shows women in Halton and Liverpool boroughs are six years below the national healthy life expectancy average, while in St. Helens and Knowsley they are five years below. Men in St Helens, Halton, Knowsley, Liverpool, and Wirral boroughs are also below the healthy life expectancy national average. Women have shorter healthy life expectancy than men in areas with the worst healthy life expectancy (Halton, Liverpool and Knowsley), but longer healthy life expectancy than men elsewhere. The greatest difference is in Cheshire East and Cheshire West and Chester.

Figure 3.6. Female and male healthy life expectancy at birth, Cheshire and Merseyside lower tier local authorities, North West region, and England, 2018–20



Source: *Office for National Statistics. (90)*

To better understand the health of the population in Cheshire and Merseyside, the NHS has commissioned data experts to analyse the population, as explained in Box 4. If the programme achieves its aims, it will lead to greater action and investment in the social determinants of health, with corresponding improvements to health and health inequalities.

Box 4. "System P"

The System P programme is a whole-system approach being developed by Cheshire and Merseyside ICS to facilitate population health management at place level. The programme aims to address wider social and economic challenges that negatively impact population health by using data and analytics to provide insight and inform future plans to influence change in care and payment models at both place and ICS level. System P is currently in the pilot stage and aims to provide places with additional analytical capacity to segment the population and identify how to redesign services to shift from a treatment to prevention model. The System P programme aims to foster collaborative relationships between the NHS and local authority partners to support integrated healthcare delivery and investment of NHS resources in primary and secondary prevention. System P is being developed with the assistance of a variety of places to shape how a bespoke System P offer may fit into their area.

MARMOT BEACON INDICATORS

- Life expectancy, female, male
- Healthy life expectancy, female, male

3C INEQUALITIES WITHIN LOCAL AUTHORITIES

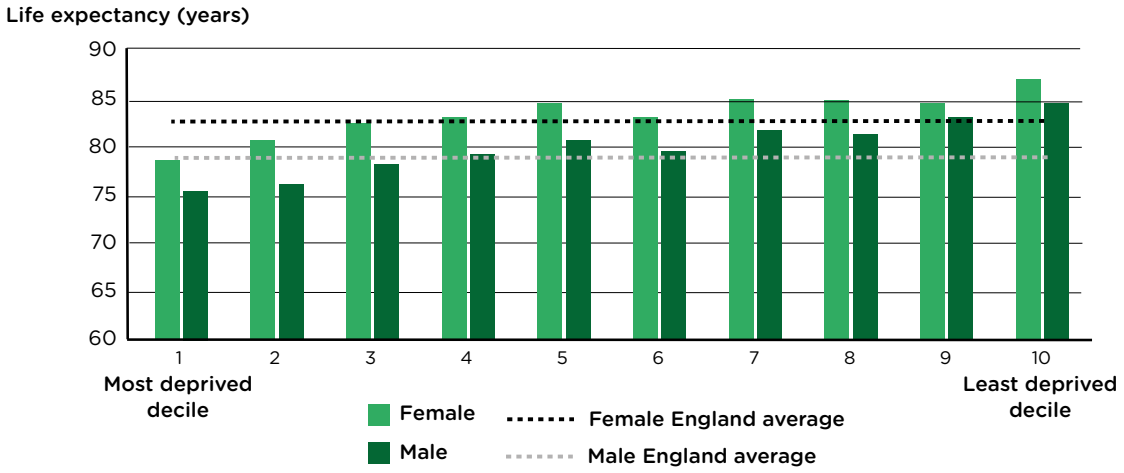
Within local authorities in the region, there is a life expectancy gap of more than 10 years between the least and most deprived deciles. In Wirral, measuring 60 square miles and with a population under 350,000, men in the most deprived quintiles live 13.8 years less than men in the least deprived quintiles. In St. Helens, 53 square miles with a population of just over 180,000, women in the most deprived quintiles live 10 years less than women in the least deprived quintiles.

In addition to urban deprivation and related health inequalities, there are also inequalities in towns and more rural areas and in the coastal parts of Cheshire and Merseyside. The most recent Chief Medical Officer's report analysed health in coastal communities, such as Sefton, with its 22 miles of coastline. The report describes a "coastal effect" on health, mainly caused by preventable diseases and higher levels of deprivation compared to non-coastal areas (91).

CHESHIRE EAST

Cheshire East, with a population of 386,000, had life expectancy at birth for women of 83.8 years in 2018-20, 0.7 years above the England average. For men it was 80.3 years, 0.9 years above the England average. Inequalities in life expectancy in Cheshire East are evident: Figure 3.7 shows in 2018-20 there was an 8.4-year gap for women in life expectancy between the most and least deprived deciles in Cheshire East, and 9.5 years for men.

Figure 3.7. Life expectancy at birth by deprivation deciles (IMD 2019), Cheshire East and England, 2018-20

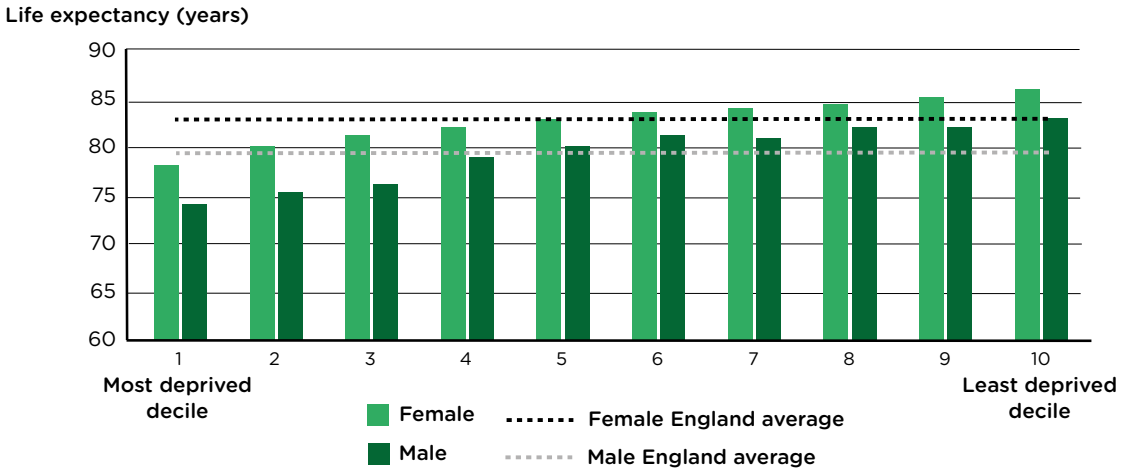


Source: *Office for National Statistics (90)*

CHESHIRE WEST AND CHESTER

In Cheshire West and Chester, with a population of 343,000, in 2018-20 life expectancy at birth for women was 83.4 years, 0.3 years above the England average. For men it was 79.7 years, 0.3 years above the England average. Inequalities in life expectancy in Cheshire West and Chester are evident: Figure 3.8 shows in 2018-20 there was an eight-year gap for women in life expectancy between the most and least deprived deciles, and 8.6 years for men.

Figure 3.8. Life expectancy at birth by deprivation deciles (IMD 2019), Cheshire West and England, 2018-20

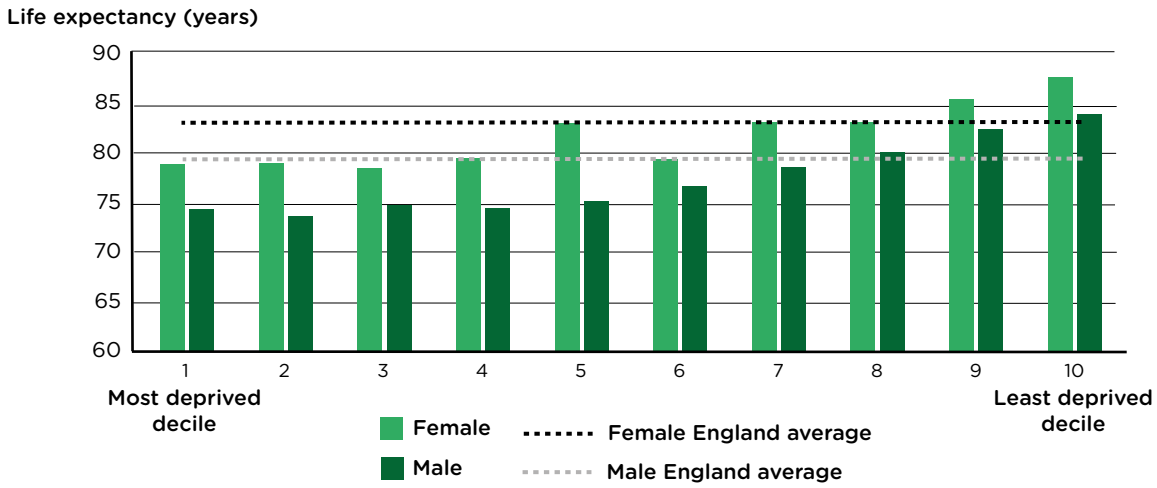


Source: *Office for National Statistics (90)*

HALTON

In Halton, with a population of 129,000, life expectancy at birth for women in 2018-20 was 81.4 years, 1.7 years below the England average. For men it was 77.4 years, two years below the England average. In addition, inequalities in life expectancy in Halton are evident: Figure 3.9 shows that in 2018-20 there was a 8.7-year gap for women in life expectancy between the most and least deprived deciles, 9.4 years for men. The life expectancy gap between the most deprived and least deprived wards (Halton Lea vs Birchfield) is 13.7 years for men and 9.3 years for women. Half of Halton's residents live in areas among the 20 percent most deprived in England.

Figure 3.9. Life expectancy at birth by deprivation deciles (IMD 2019), Halton and England, 2018-20



Source: *Office for National Statistics (90)*

KNOWSLEY

With a population of 152,000, in 2018-20 life expectancy at birth for women in Knowsley was 79.8 years, 3.3 years below the England average. For men it was 76.3 years, 3.1 years below the England average. In addition, inequalities in life expectancy in Knowsley are evident: Figure 3.10 shows that in 2018-20 there was a 10.9-year gap for women in life expectancy between the most and least deprived deciles, and 12.4 years for men.

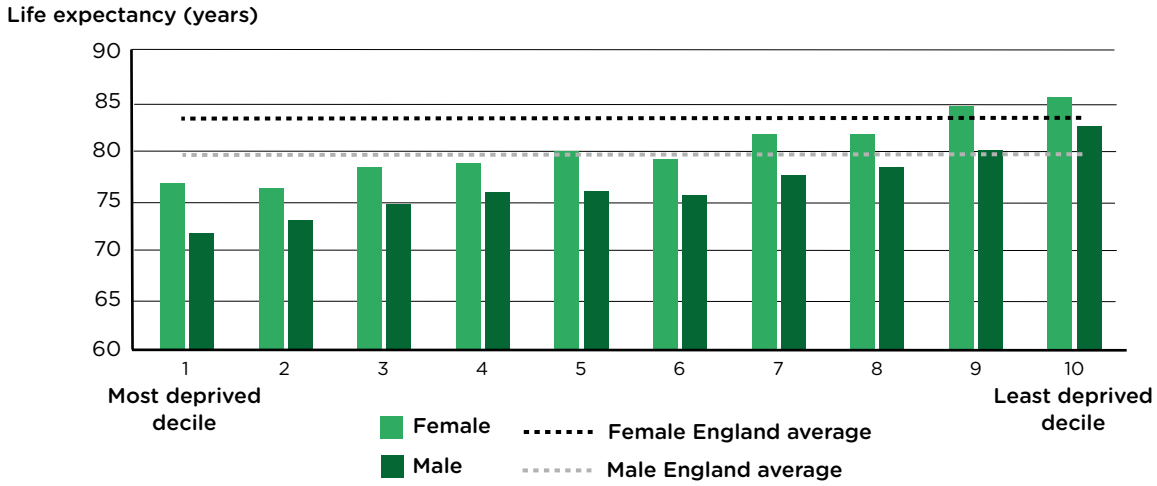
Figure 3.10. Life expectancy at birth by deprivation deciles (IMD 2019), Knowsley and England, 2018-20

Source: *Office for National Statistics (90)*

LIVERPOOL

With a population of 500,000, in 2018-20 life expectancy at birth for women in Liverpool was 79.9 years, 3.2 years below the England average. For men it was 76.1 years, 3.3 years below the England average. In addition, inequalities in life expectancy in Liverpool are evident: Figure 3.11 shows that in 2018-20 there was an 8.6-year gap for women in life expectancy between the most and least deprived deciles, and 10.6 years for men.

Figure 3.11. Life expectancy at birth by deprivation deciles (IMD 2019),Liverpool and England, 2018-20

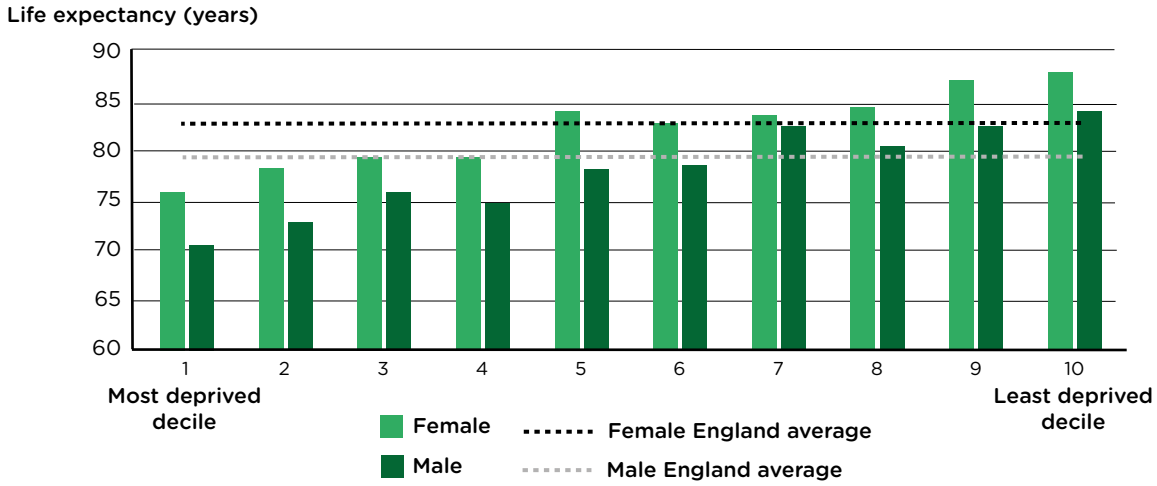


Source: *Office for National Statistics (90)*

SEFTON

With a population of 275,000, in 2018-20 in life expectancy at birth for women in Sefton was 82.4 years, 0.7 years below the England average. For men it was 78 years, 1.4 years below the England average. In addition, inequalities in life expectancy in Sefton are evident: Figure 3.12 shows that in 2018-20 there was a 12-year gap for women in life expectancy between the most and least deprived deciles, and 13.6 years for men.

Figure 3.12. Life expectancy at birth by deprivation deciles (IMD 2019), Sefton and England, 2018-20

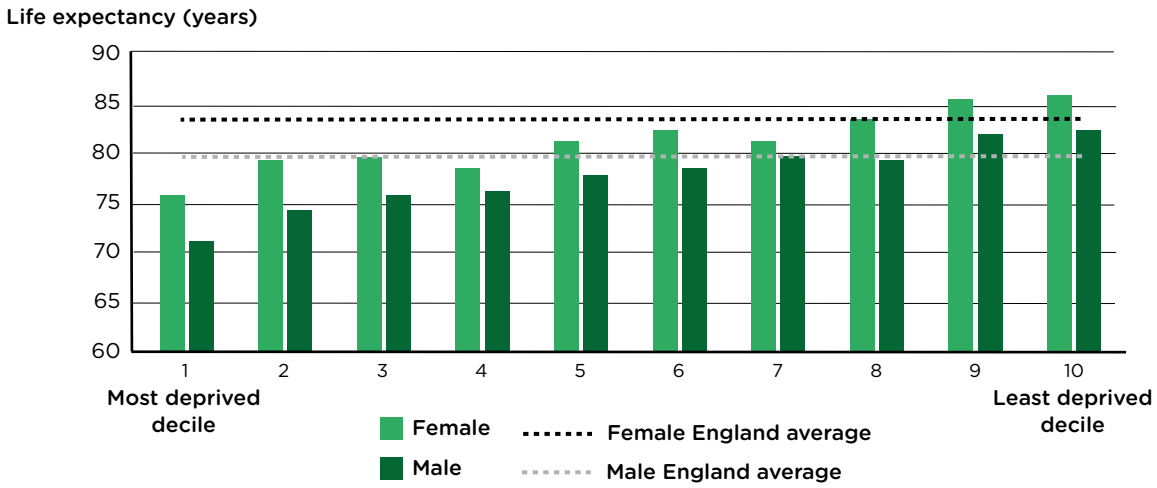


Source: *Office for National Statistics (90)*

ST HELENS

With a population of 181,000, in 2018-20 life expectancy at birth for women in St Helens was 81.0 years, 2.1 years below the England average. For men it was 77.5 years, 1.9 years below the England average. In addition, inequalities in life expectancy in St Helens are evident: Figure 3.13 shows that in 2018-20 there was a 9.8-year gap for women in life expectancy between the most and least deprived deciles, and 11.1 years for men.

Figure 3.13. Life expectancy at birth by deprivation deciles (IMD 2019), St Helens and England, 2018-20

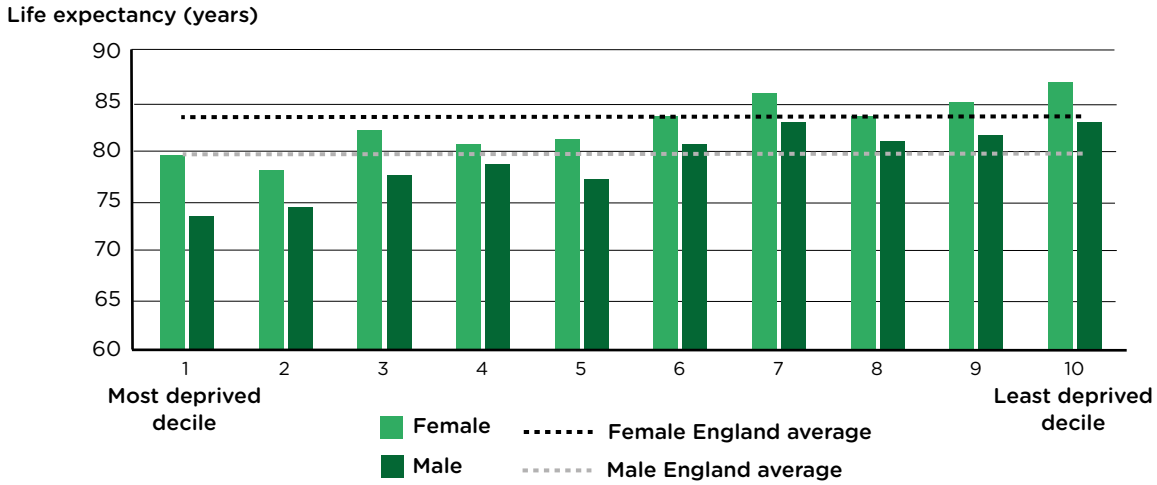


Source: *Office for National Statistics (90)*

WARRINGTON

With a population of 209,000, in 2018-20 life expectancy at birth for women in Warrington was 82.3 years, 0.8 years below the England average. For men it was 78.9 years, 0.5 years below the England average. In addition, inequalities in life expectancy in Warrington are evident: Figure 3.14 shows that in 2018-20 there was a 7.1-year gap for women in life expectancy between the most and least deprived deciles; and 9.6 years for men.

Figure 3.14. Life expectancy at birth by deprivation deciles (IMD 2019), Warrington and England, 2018-20

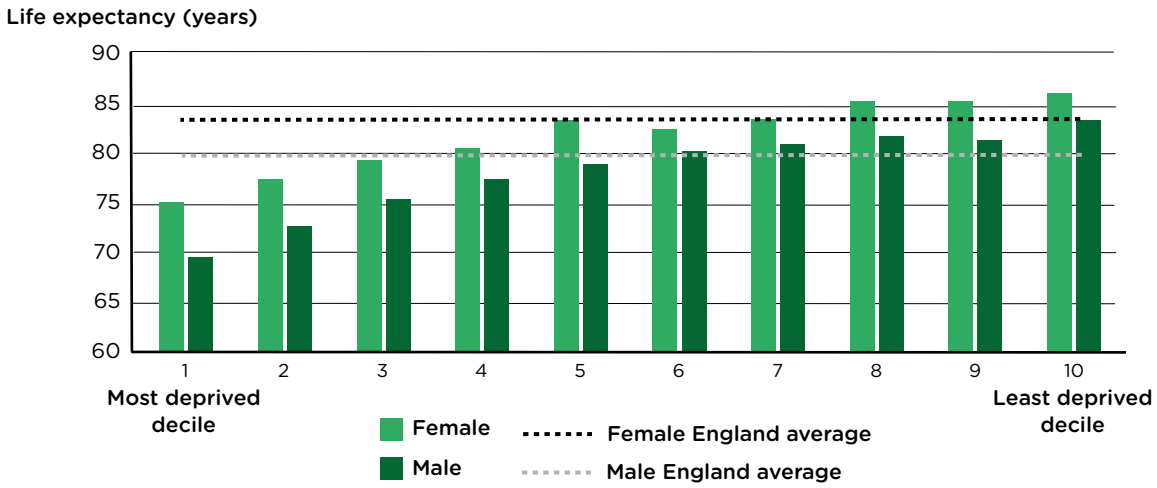


Source: *Office for National Statistics (90)*

WIRRAL

With a population of 324,000, in 2018-20 life expectancy at birth for women in Wirral was 81.6 years, 1.5 years below the England average. For men it was 77.8 years, 1.6 years below the England average. In addition, inequalities in life expectancy in Wirral are evident: Figure 3.15 shows in 2018-20 there was an 11-year gap for women in life expectancy between the most and least deprived deciles, and 13.8 years for men.

Figure 3.15. Life expectancy at birth by deprivation deciles (IMD 2019), Wirral and England, 2018-20



Source: *Office for National Statistics (90)*

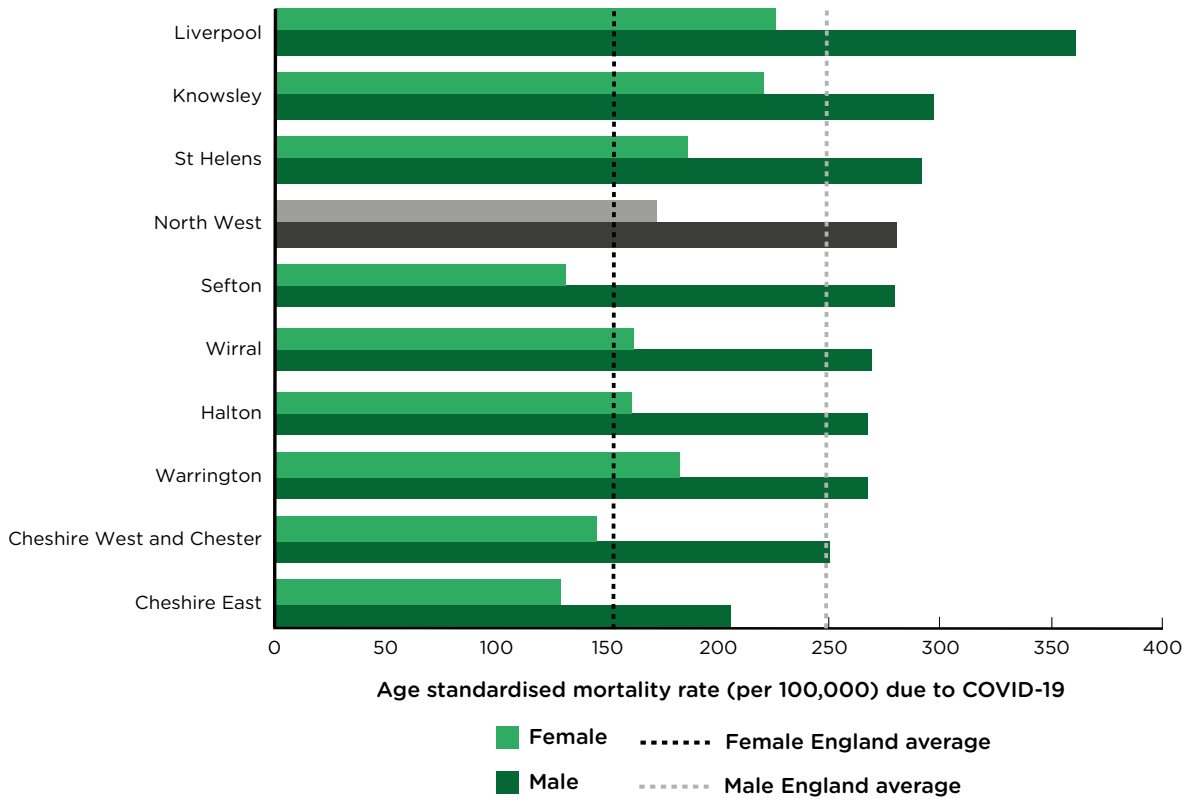
3D COVID-19 PANDEMIC AND HEALTH INEQUALITIES

The pandemic has revealed and amplified entrenched health inequalities. The IHE *Build Back Fairer* report stated:

> *There is an urgent need to do things differently, to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a wellbeing economy that puts achievement of health and wellbeing, rather than narrow economic goals, at the heart of government strategy; to build a society that responds to the climate crisis at the same time as achieving greater health equity (2).*

Compared to most other countries, England has reported high COVID-19 mortality rates (92). The age-standardised COVID-19 mortality rate in Cheshire and Merseyside has been higher than the national average. Between March 2020 and April 2021, the COVID-19 mortality rate in Cheshire and Merseyside was 276.7 per 100,000 population for men and 171.1 for women compared with 248.7 for men and 151.6 for women for England (93). Figure 3.16 shows that Cheshire and Merseyside as a whole, and all but one of its boroughs for men (Cheshire East) and three areas for women (Cheshire East, Cheshire West and Chester, Sefton), had higher mortality rates from COVID-19 than England, over the same period (94). Overall, COVID-19 mortality in Cheshire and Merseyside was 5 percent higher than the England and Wales average between March 2020 and April 2021.

Figure 3.16. Age-standardised COVID-19 mortality per 100,000, Cheshire, and Merseyside lower-tier local authorities, North West region, and England, 14-month total, March 2020 to April 2021



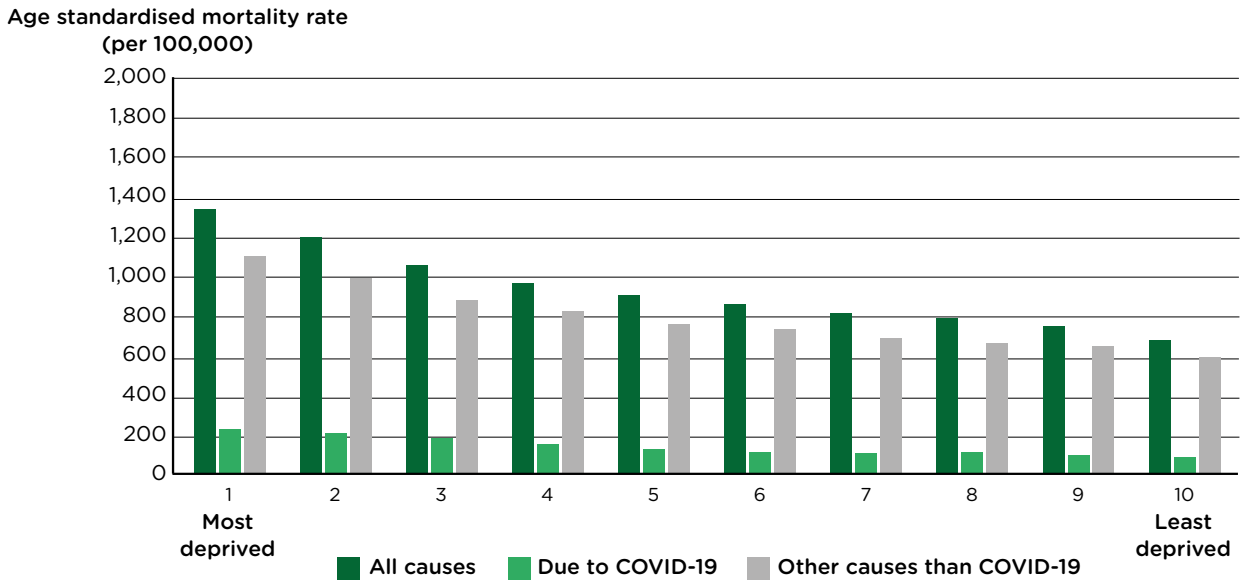
Notes: *Deaths 'due to COVID-19' only include deaths where coronavirus (COVID-19) was the underlying (main) cause.*

Source: *Office for National Statistics (95)*

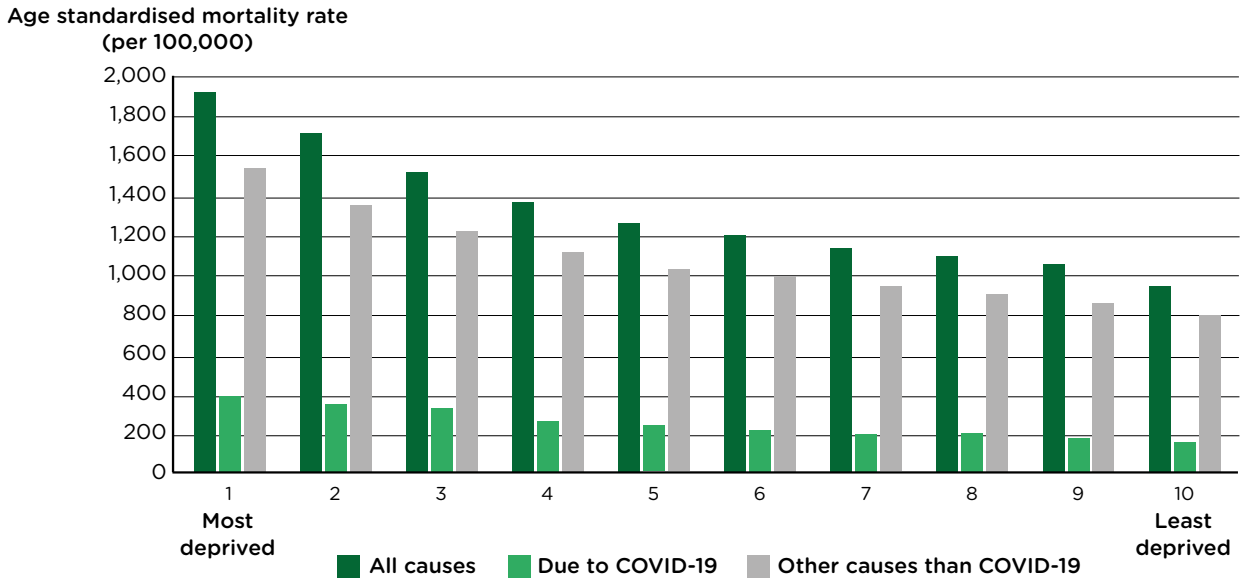
The relationship between all causes of mortality and deprivation in England reflects the relationship between deprivation and mortality from COVID-19, as seen in Figures 3.17A and 3.17B. The more deprived the area, the greater the mortality rate from COVID-19. The gradient was slightly steeper for COVID-19 than for all-cause mortality. The stark evidence of inequalities in COVID-19 cases and mortality have strengthened awareness for the national government and all sectors to take action. A survey of healthcare leaders in 2021 found 81 percent either agreed or strongly agreed that tackling health inequalities should be a key measure when reviewing the performance of senior NHS leaders and their organisations. Some 91 percent stated that addressing health inequalities should be a priority as the NHS moves forward from the COVID-19 pandemic (96).

Figure 3.17A and 3.17B. Age-standardised mortality rates from all causes, COVID-19 and other causes per 100,000, by sex and deprivation deciles (IMD 2019), England, March 2020 to April 2021

A) FEMALE



B) MALE

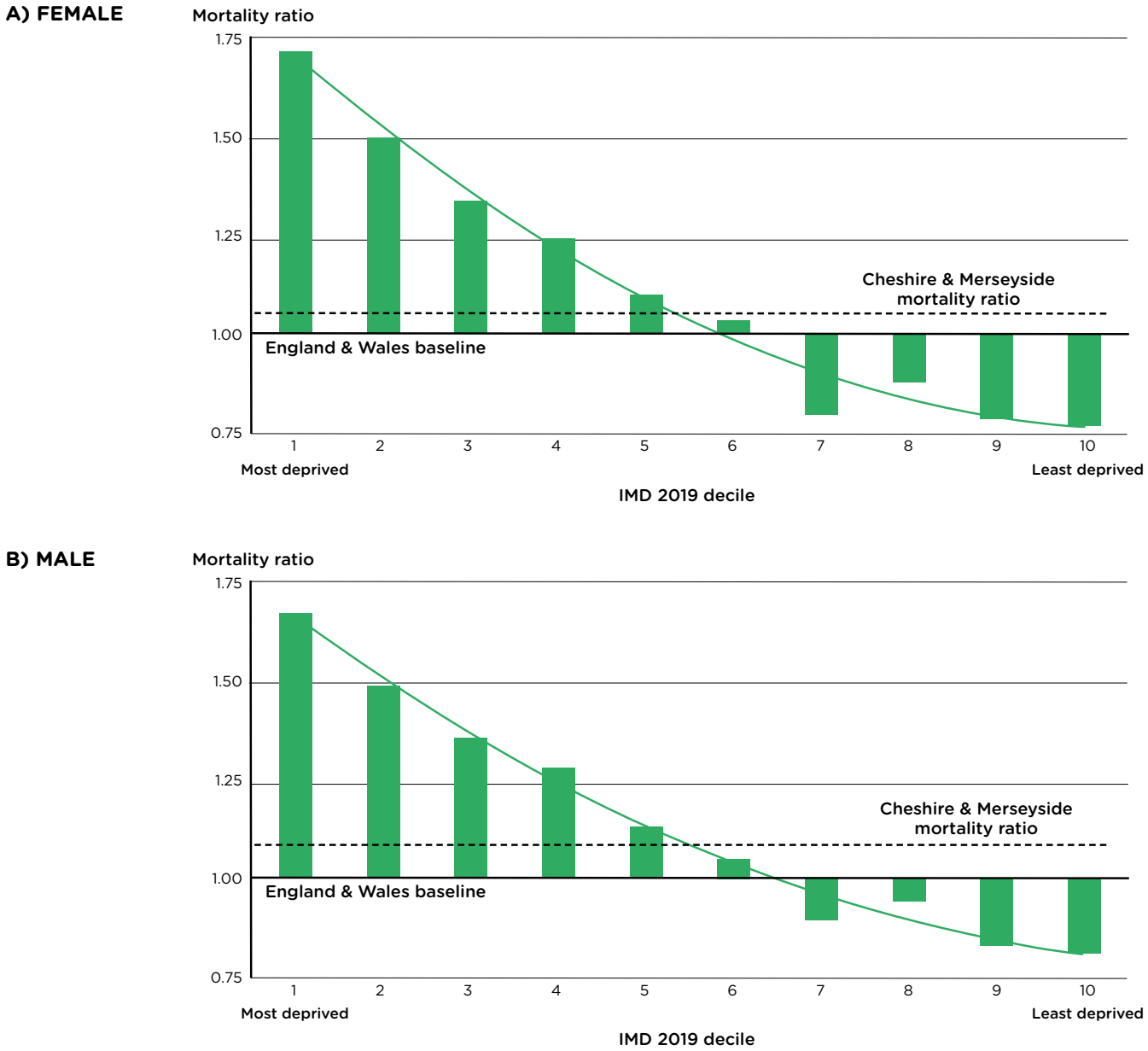


Source: *Office for National Statistics (95)*

Inequalities in COVID-19 mortality are prevalent across Cheshire and Merseyside. In the four least deprived areas (measured by the Index of multiple deprivation), mortality from COVID-19 was lower than the England and Wales average over the same period, but in the other six deciles, COVID-19 mortality in Cheshire and Merseyside was greater than the England and Wales average. For the most deprived decile in Cheshire and Merseyside, the mortality ratio was 2.23 times higher than that of the least deprived decile.

Figures 3.18A and 3.18B show the ratio of COVID-19 mortality by deprivation, using deciles in the Index for Multiple Deprivation (IMD) within Cheshire and Merseyside compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. In the region, as for England as a whole, inequalities in COVID-19 mortality are slightly wider than for all-cause mortality.

Figure 3.18A and 3.18B. Age and sex standardised mortality ratios by IMD 2019 deciles of MSOAs* Cheshire and Merseyside, March 2020 to April 2021

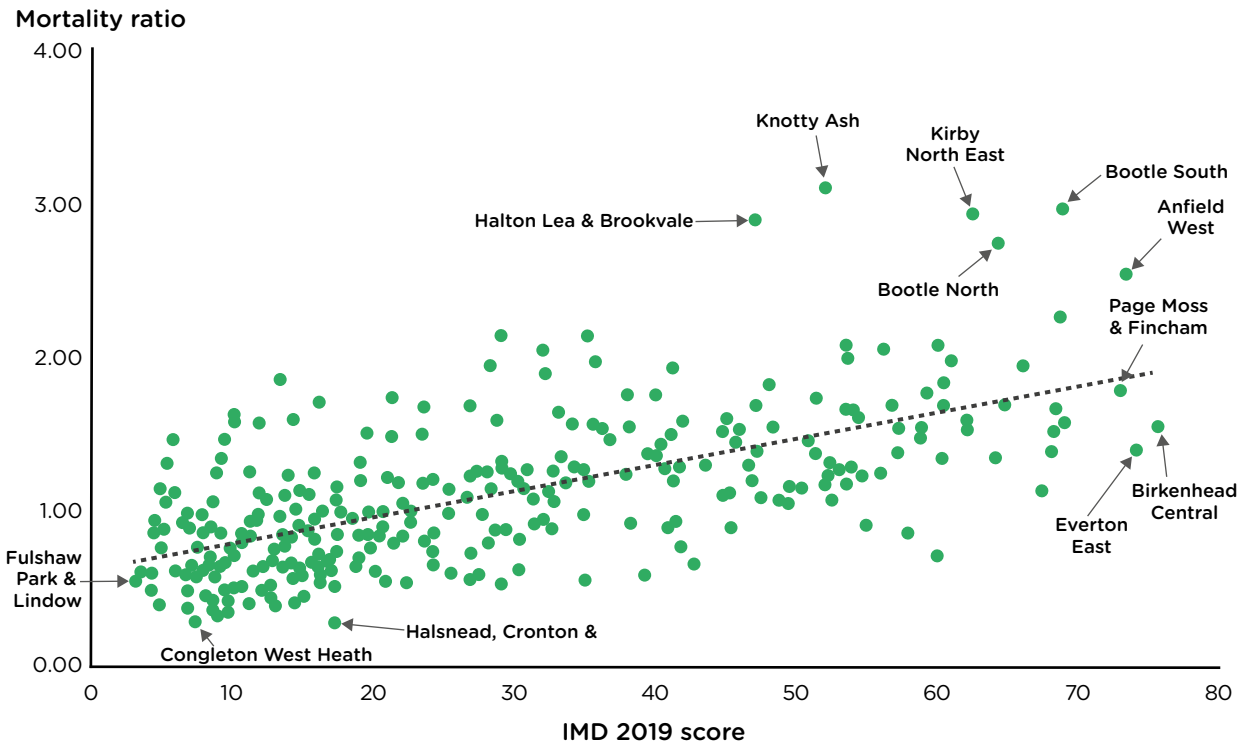


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these domains for each MSOA, as set out in the Technical Report on The English Indices of Deprivation 2019 (97). Deciles were obtained by ranking each MSOA within Cheshire and Merseyside and then population weighting these ranks to split all MSOAs into 10 groups with equal sized populations, ordered according to the IMD scores of the MSOAs in each group. Mortality ratios were obtained by applying England and Wales COVID-19 mortality rates to the age and sex specific populations of each decile to obtain an expected number of deaths and then dividing the observed number in each decile by this figure. The horizontal black line shows a ratio equal to one, representing the England and Wales average. Deciles above this line have more deaths than expected based on this average, those below the line fewer deaths. The ratio of COVID-19 mortality for Cheshire and Merseyside as a whole is shown by the horizontal green dotted line.*

Source: *Office for National Statistics (93)*

Figure 3.19 shows the mortality ratios for each neighbourhood (middle layer super output area) to explore how mortality from COVID-19 varied between neighbourhoods in Cheshire and Merseyside. Each dot represents the mortality of a neighbourhood and its association with deprivation. There is considerable variation around the trendline, suggesting that factors other than deprivation (as measured by the IMD) may have influenced the size and effect of local disease outbreaks during 2020. These include the outbreaks in care homes, particularly in the period March to July 2020.

Figure 3.19. Age-adjusted COVID-19 mortality ratio of observed to expected deaths by level of deprivation, Cheshire and Merseyside neighbourhoods (MSOAs), March 2020 to April 2021

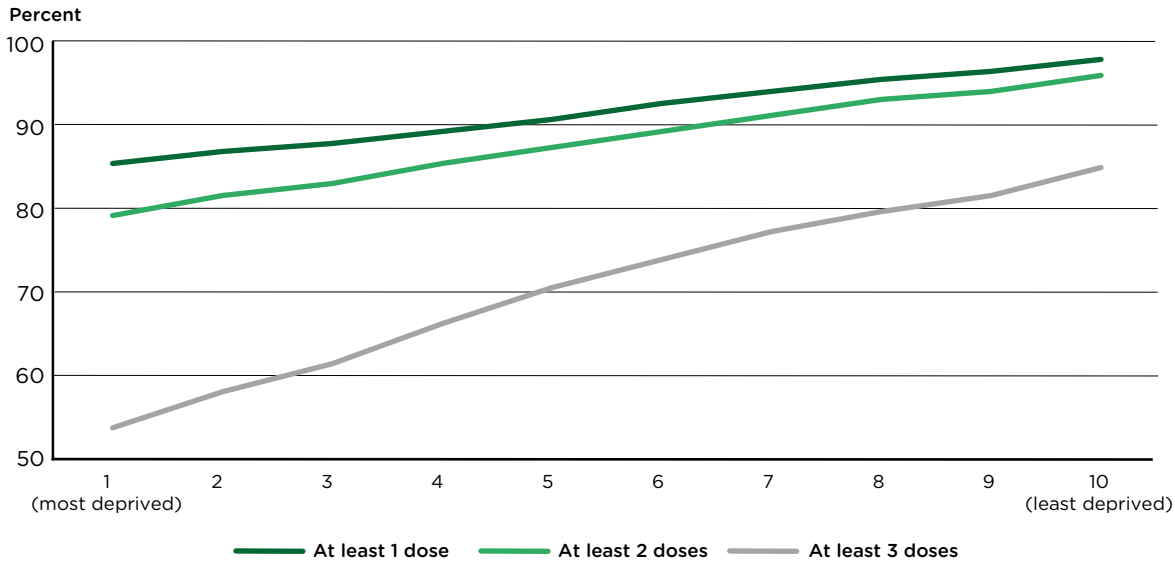


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these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

Source: *Office for National Statistics (98)*

The IHE *Build Back Fairer* report outlined the causes of lower vaccine uptake: it is associated with difficulty in accessing vaccinations, inability to take time off work, lack of awareness about the programme and vaccine hesitancy (when individuals delay or refuse vaccination despite the opportunity to be vaccinated being provided to them) (99). In every vaccine programme there are inequalities in uptake and research shows a strong correlation between deprivation and vaccine uptake, with less deprived areas more likely to have high vaccination uptake (100). In April 2021 adults living in the most deprived areas of England were more likely to report vaccine hesitancy (16 percent) than adults living in the least deprived areas (7 percent) (101). Figure 3.20 shows this hesitancy in people living in the most deprived areas has continued.

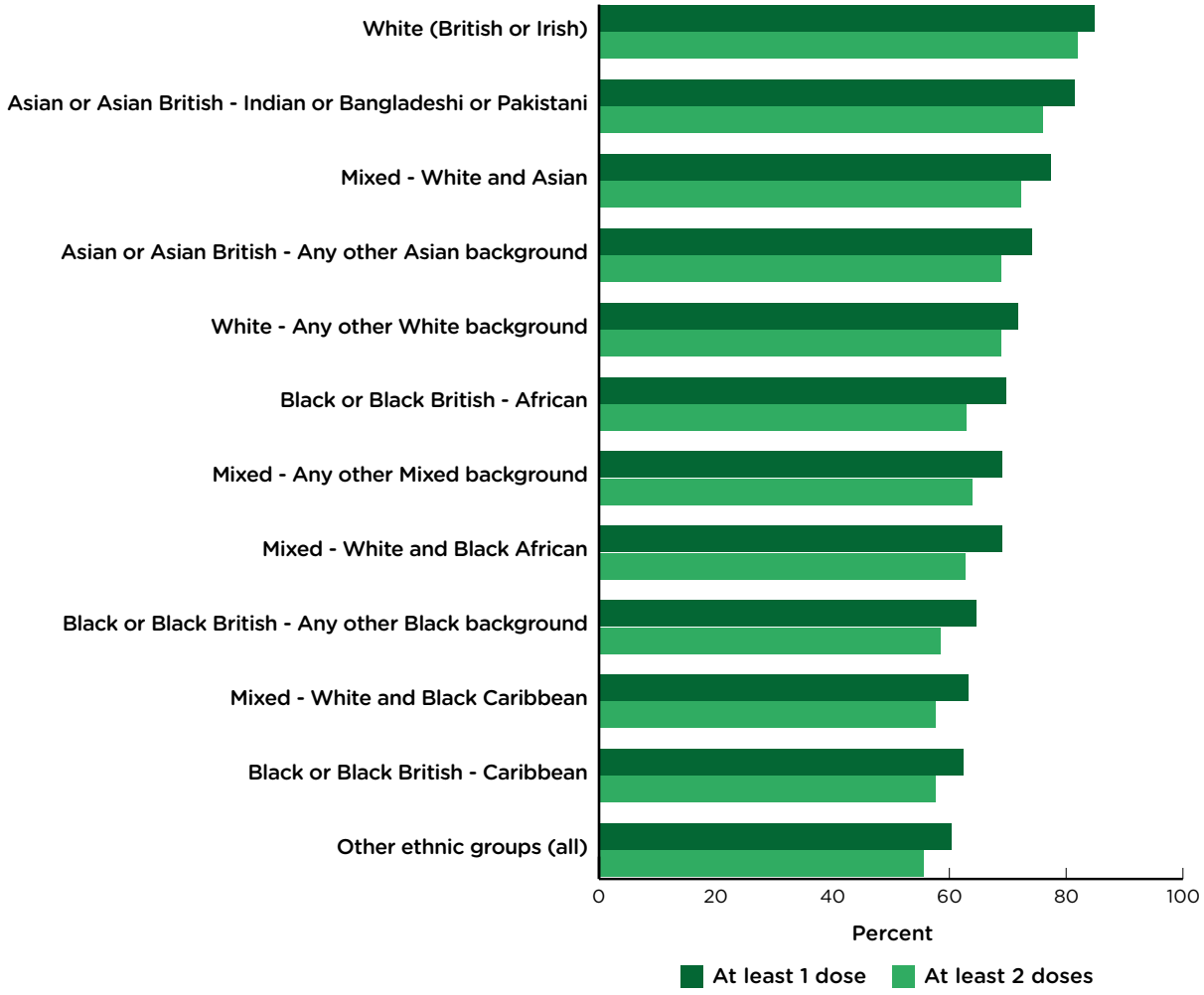
Figure 3.20. People vaccinated for COVID-19, by deprivation decile (IMD 2019), North West region, 8 December 2020 to 28 February 2022



***Source**: National Immunisation Management System (NIMS) (102)*

Since the beginning of the COVID-19 vaccination programme, data shows that Black or Black British–Caribbean adults had the lowest levels of vaccination compared with all ethnicities, Figure 3.21 outlines the COVID-19 vaccination uptake by ethnicity in the North West region.

Figure 3.21 People vaccinated for COVID-19, by ethnicity, North West region, 8 December 2020 to 28 February 2022



Source: *National Immunisation Management System (NIMS) (102)*

The pandemic has shown that NHS place-based approaches can address inequalities in uptake related to deprivation and ethnicity. There are numerous examples in Cheshire and Merseyside and across England which show the NHS working in partnership with local authorities, the VCFSE sector to reduce inequalities in COVID-19 vaccination uptake, Box 5.

Box 5. Reducing inequalities in vaccination uptake in Warrington

All areas in Cheshire and Merseyside have taken actions to reduce inequalities in COVID-19 uptake. For example, Warrington had a COVID-19 Community Champions team that worked directly with local communities to communicate the latest accurate health information to residents. It was delivered by a partnership including the council, Warrington Disability Partnership, Warrington Voluntary Action and Speak-Up. Part of this included a door-knocking campaign carried out by Warrington Borough Council and the COVID-19 Community Champions with the support of the National Surge Rapid Response Team and a range of other local partners to support uptake and signpost to local vaccination offers. The local Warrington bus company worked with the council and NHS to offer vaccines on the bus and offered free transport to COVID-19 vaccination venues. The local mosque became one of the main vaccination sites and the Warrington public health team worked in partnership with Imaan pharmacy and Warrington Islamic Association encouraging uptake within the local community.

Our *Build Back Fairer* analyses in England outlined how the pandemic has also widened inequalities in the social determinants including experiences in the early years and through education, employment, housing, income, health behaviours and public health (2). These worse outcomes in the social determinants of health will affect health and worsen inequalities, Box 6.

Box 6. Summary of COVID-19 containment impacts on inequalities

EARLY YEARS AND DURING SCHOOL-AGE EDUCATION

- More children who are eligible for free school meals have been disproportionately harmed by closures of early years settings and levels of development have been lower than expected among poorer children.
- Parents with lower incomes, particularly those who continued working outside the home, have experienced greater stress when young children have been at home.
- Many early years settings in more deprived areas are at risk of closure and of having to make staff redundant as a result of containment measures.

EDUCATION

- Compared with children from wealthier backgrounds, more children who are eligible for free school meals were disproportionately harmed by closures in the following ways:
  - Greater loss of learning time
  - Less access to online learning and educational resources
  - Less access to private tutoring and additional educational materials
  - Inequalities in the exam grading systems
- Children with special educational needs and their families were particularly disadvantaged through school closures.
- School funding continues to benefit schools in the least deprived areas the most, widening educational outcomes.

CHILDREN AND YOUNG PEOPLE

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

EMPLOYMENT AND GOOD WORK

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

STANDARDS OF LIVING AND INCOME

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

PLACES AND COMMUNITIES

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

PUBLIC HEALTH

- The priority and importance of public health has increased during the pandemic and public health is now a central concern of the public and government, with a new focus on the importance of protecting and improving health in England.
- The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
- Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
- There have been some significant changes in behaviours during lockdown – including potentially increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.
- We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of building back fairer.
- Inequalities in health behaviours should also be a priority area for action.
- The public health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
- The public health system needs higher levels of investment and resourcing from central government – sustained cuts of 22 percent in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
- Underfunding and planned reorganisation of Public Health organisations and workforce has undermined capacity to contain the pandemic and improve health through the containment measures (2) (103).

CHAPTER 4

THE SOCIAL DETERMINANTS OF HEALTH IN CHESHIRE AND MERSEYSIDE

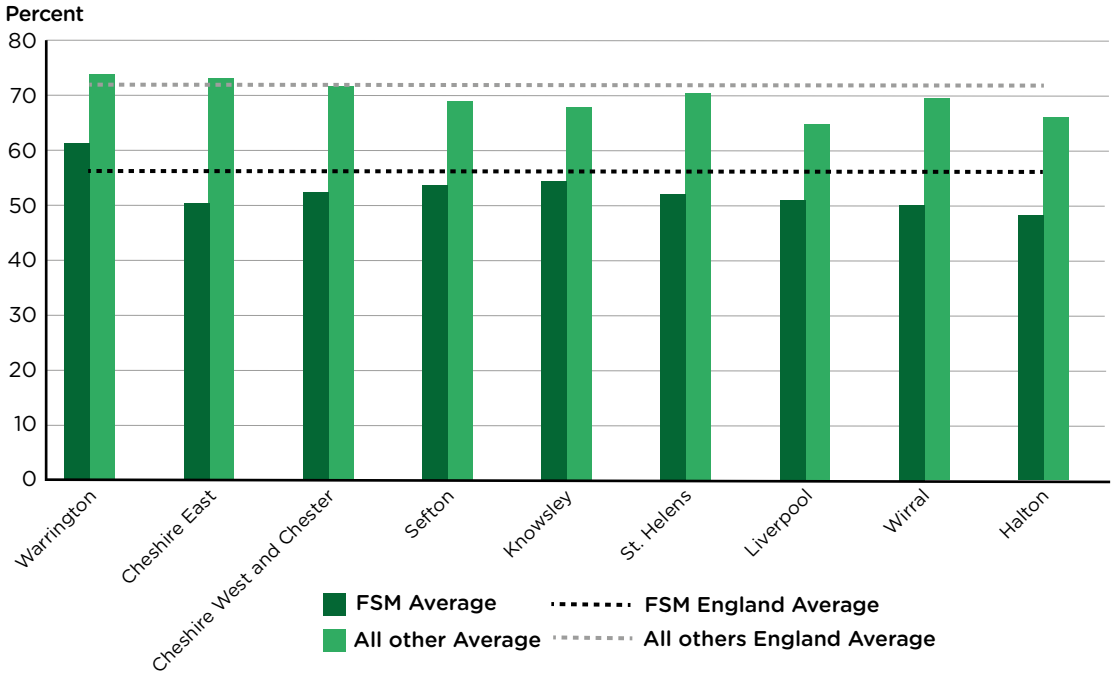
In this section we overview outcomes in the Marmot 8 themes across Cheshire and Merseyside, as outlined in Section 1. Recommendations and relevant indicators for monitoring are included and are the areas in which action by all partners need to be directed.

4A GIVING EVERY CHILD THE BEST START IN LIFE

Experiences during the early years and in education are particularly important for immediate and longer term health and outcomes in other social determinants of health such as education, employment and income (1) (76).

There are marked inequalities in levels of development between children eligible for free school meals and those who are not eligible, which are already apparent at the age of 5. Figure 4.1 shows that in Cheshire and Merseyside, in all but one borough (Warrington), there are lower levels of school readiness compared to the England average for children eligible for free school meals at the end of reception. The data also shows that children eligible for free school meals have lower achievement levels than children not eligible for free school meals in each local authority and for children not eligible for free school meals, achievement is below the England average in most local authorities, in particular in Halton, Liverpool and Knowsley.

Figure 4.1. Children achieving a good level of development at the end of reception, percentage, Cheshire and Merseyside lower tier local authorities and England, 2018/19



Source: *Department for Education (DfE), EYFS Profile. (104)*

The issue of school readiness was raised in many workshops in the region, and participants were unclear as to which organisations were, or should be, addressing school readiness and experiences in the early years more broadly. Improvement in these areas requires a partnership approach, as they relate to good maternal mental health, availability of parenting support programmes, availability of high-quality early years services and supportive home environments where learning activities (such as speaking to babies and reading to children) and physical activities are encouraged (105). Evidence is emerging of the effect on young children's development as a result of the pandemic. Ofsted's inspection of early year providers in January and February 2022 found "lingering challenges" related to young children's development and early years providers reported young children behind in social interaction, social confidence, potty-training, physical development (gross motor skills, crawling, walking) and speech and language development (106). The Social Mobility Commission found that at the start of the new academic year in September 2020, pupils from low-income areas in primary school were seven months behind more wealthy peers (107).

RECOMMENDATION: GIVE EVERY CHILD THE BEST START IN LIFE

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Review inequitable outcomes in early years and bring systems together within each place to ensure equitable early intervention, involving all partners (such as education, social care - children's services, communities and the VCFSE sector, children's boards, public services, NHS, local authorities). • Assess early years provision and parental support within each place and provide further support for early years settings in more deprived areas and in collaboration with communities in these areas and / or families with disabilities, or English as a second language for example. • Assess how the ACEs agenda links to the early years approach in Cheshire and Merseyside and ensure families' voices are included in this agenda.	• Work in partnership to improve school readiness for all and reduce inequalities between children eligible and not eligible for free school meals. Ensure support is focussed to develop children's early learning, especially with regard to speech and language skills and the ACEs agenda. • Ensure shared accountability across the system and within each place to give every child the best start in Cheshire and Merseyside (include children's public health, early years and wider family services including education and VCFSE sector).
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Assess maternity leave policies and support for child care by all employers, including private business.	• Develop a region-wide childcare workforce standard, which includes training and qualifications on the job to a higher standard and pay than national requirements.

MARMOT BEACON INDICATORS

- Percentage unemployed (aged 16-64 years).
- Proportion of employed in permanent and non-permanent employment.
- Percentage employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter.
- Percentage of employees earning below the real living wage.

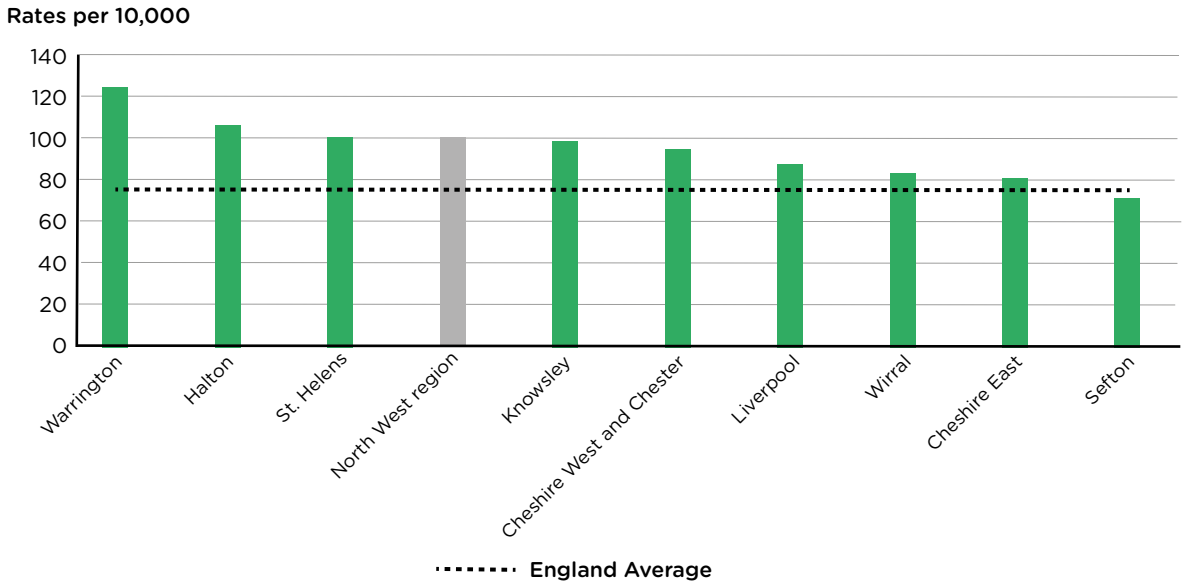
4B ENABLING ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

The experiences of young people during their school years continues to impact people throughout their lives, affecting employment opportunities, income and health.

Children and young people who grow up in poverty are more likely to have poor physical and mental health, lower educational outcomes and less access to training and decent jobs and worse health (108).

Figures 4.2 and 4.3 show that across Cheshire and Merseyside there are high rates of unintentional and deliberate injuries in children and young people, and all areas are above the England average for unintentional injuries in young people aged 0-24 years. Unintentional injuries are identified as external causes of harm, such as road traffic collisions, sports injuries, falls, accidental contact with machinery, burns and drowning. Deliberate injuries include different types of assaults and deliberate self-harm (109). These high rates across the region indicate a need to further prioritise these issues.

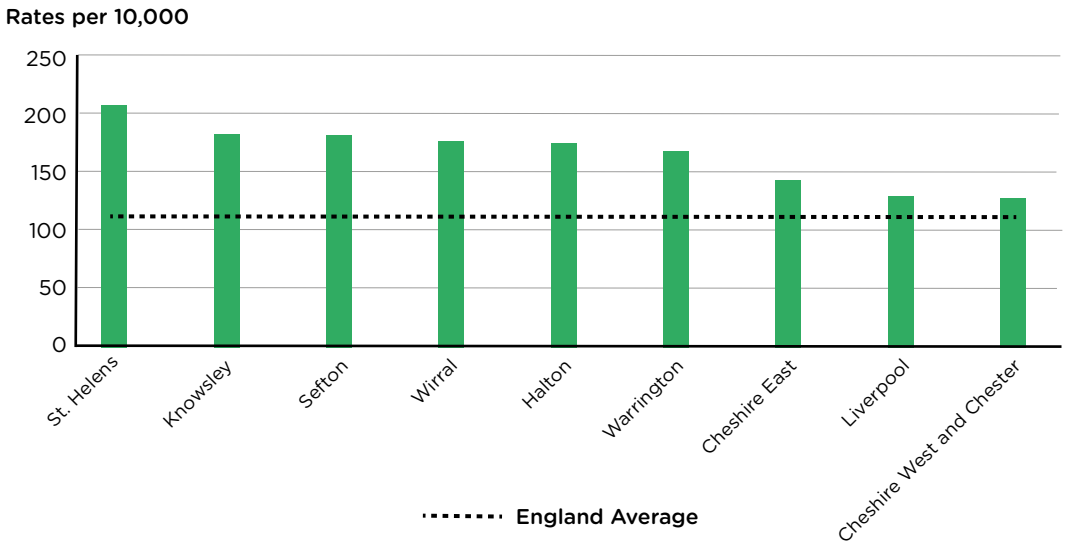
Figure 4.2. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14), rate per 10,000, Cheshire and Merseyside lower-tier local authorities and England, 2020/21



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 etc. Deliberate injuries include different types of assaults and deliberate self-harm (110).*

Source: *Hospital Episode Statistics (109)*

Figure 4.3. Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24), crude rate per 10,000, Cheshire and Merseyside lower-tier local authorities and England, 2020/21

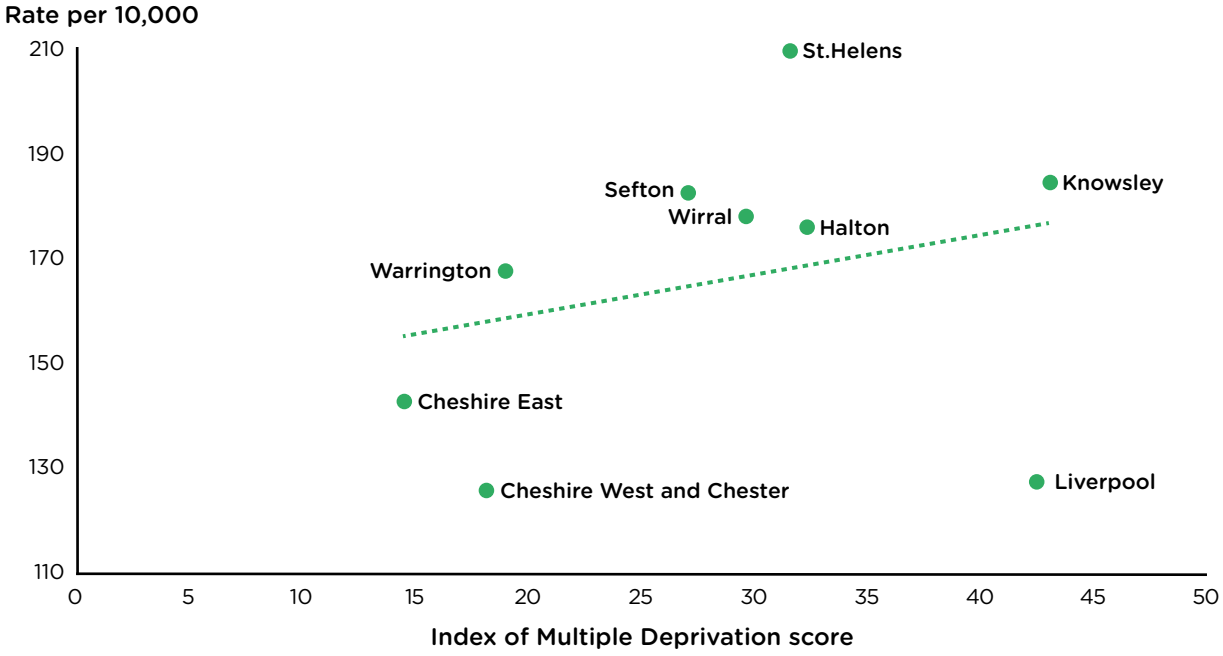


Notes: *Unintentional injuries are identified as external causes of harm, such as, road traffic collisions, sports injury, falls, accidental contact with machinery, burns and drowning etc. Deliberate injuries include different types of assaults and deliberate self-harm (110).*

Source: *Hospital Episode Statistics (109)*

The rate of injuries is somewhat related to level of deprivation: Figure 4.4 indicates that these need to be a priority in reducing inequalities in the region. St Helens has the seventh highest rate of unintentional and deliberate injury hospital admissions for 15– to 24-year-olds in England, while Liverpool has a lower rate than might be expected given levels of deprivation.

Figure 4.4. Hospital admissions caused by unintentional and deliberate injuries* in young people (aged 15 to 24) by deprivation (IMD 2019), crude rate per 10,000, Cheshire and Merseyside lower tier local authorities, 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 etc. Deliberate injuries include different types of assaults and deliberate self-harm (110).*

Source: *Hospital Episode Statistics (109)*

YOUNG PEOPLES' MENTAL HEALTH AND WELLBEING

Research prior to the pandemic found one in 10 children and adolescents in the UK experiencing a diagnosable mental health disorder and mental health problems early in life. These have lasting consequences. Close to three-quarters of lifetime mental health disorders have their onset before age 25 years (111). The pandemic has had a considerable effect on the wellbeing of young people and their average life satisfaction is low. In February 2022 higher education students' average life satisfaction score was 6.6, compared with an average of 7.0 in the adult population in Great Britain. Students in higher education also had higher levels of loneliness than adults in February 2022, when 17 percent stated they felt lonely often or always, compared with 7 percent of adults (112).

A National Foundation for Educational Research report found that secondary school leaders have witnessed "a deterioration in pupils' wellbeing during the pandemic, especially increased anxiety", and that many of those pupils had no known vulnerability or previous mental health issues. Early years, primary and secondary school leaders also stated that pupils were "less well prepared for transition than usual in 2019/20 and 2020/21, both academically and emotionally". Schools also reported that it was "very difficult to secure specialist external support", and that they had to increase in-school pastoral support and wellbeing activities in the absence of external support (113).

NHS funding for mental health in young people is not meeting demand. A survey of more than 1,000 GPs in the UK in early 2022 found that 95 percent felt children's mental health services were either in crisis (46 percent) or very inadequate (49 percent), increasing from 90 percent in 2018. Half of GPs surveyed stated that at least six in 10 referrals made for anxiety, depression, conduct disorder and self-harm are routinely rejected because young people do not meet the threshold for treatment as their symptoms are regarded as not severe enough (114). The IHE *10 Years On* report stated children and young people living in poverty had higher risk of mental health problems (1).

Services for young people have also been substantially cut and it is estimated these spending cuts on preventative services for adolescents is 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-olds entering care (per 100,000 per year). They estimate this has led to an additional 1,000 children aged 16 and 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 has been added to councils' care bills to support these children in care (115).

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 which support the family and make improvements in a range of social determinants: improving adult employment opportunities, reducing levels of debt, and improving housing conditions, for example. However, these effective approaches that support children and families to improve mental wellbeing, are frequently no longer provided by public service organisations.

EDUCATIONAL INEQUALITIES

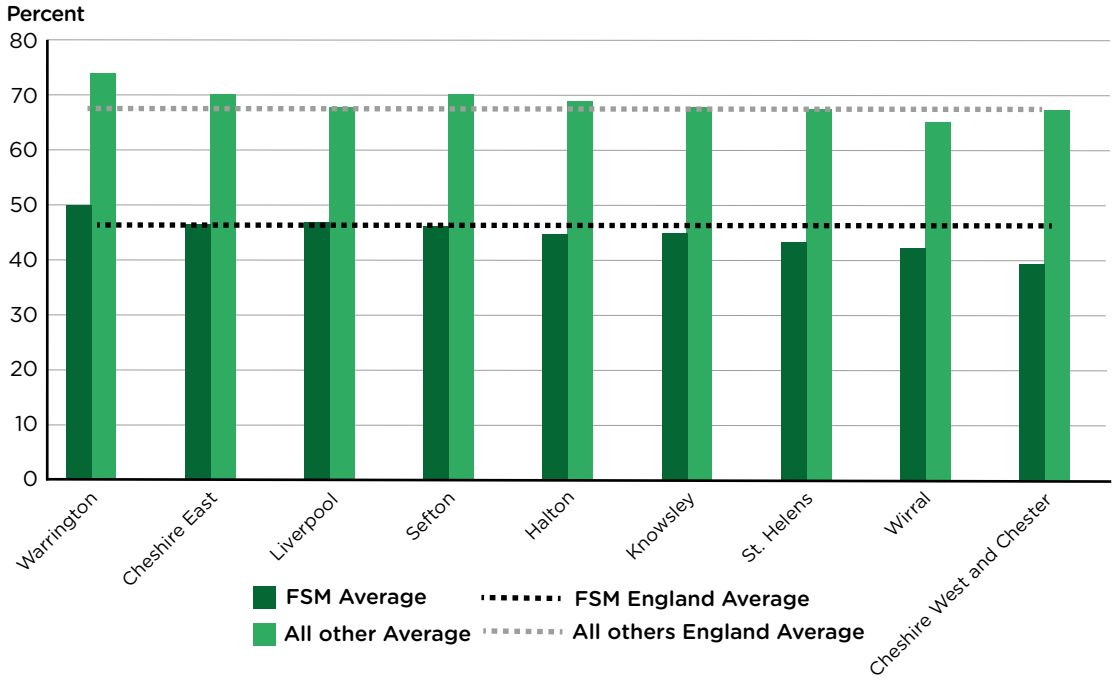
Inequalities in education related to socioeconomic position were persistent prior to the pandemic. Pupils eligible for free school meals for more than 80 percent of their school life were 18 months behind their peers by the time they finished their GCSEs, a gap that has not changed in the last five years (116). The number of pupils in persistent poverty was also increasing prior to the pandemic. For pupils eligible for free school meals, the percentage eligible their entire time at school increased from 19 percent in 2017 to 25 percent in 2020 (117).

The pandemic has further increased inequalities in educational attainment, with children and young people from more deprived areas falling even further behind than they were before the pandemic (40). Less than five months into the pandemic, in July 2020, 53 percent of teachers from schools in the most deprived areas reported that pupils were four months or more behind on average. By comparison, only 15 percent of teachers in the least deprived areas stated pupils were four months or more behind (118). In the 2021 summer term, pupils in primary school had lost, on average, 0.9 months in

reading and 2.2 months in mathematics and secondary-aged pupils were approximately 1.2 months behind in reading. In the summer of 2021, the gap between children eligible for free school meals and their more affluent peers in reading was approximately 0.4 months for primary pupils and 1.6 months for secondary pupils (117). At key stage 4 and at A-level, Knowsley has the widest gap in England between children who are eligible for free school meals and their more affluent peers (117). There is an urgent need to tackle widening educational inequality.

Inequalities between those eligible for free school meals and those ineligible are present in all boroughs in Cheshire and Merseyside at the end of Key Stage 2, as they are across England. Three of the nine boroughs have levels below the England average for pupils eligible for free school meals, and six boroughs have the same or slightly better than the average for England. However, eight of the nine boroughs meet or better the England average for students not eligible for free school meals, Figure 4.5.

Figure 4.5. Pupils reaching expected standard at the end of Key Stage 2 in reading, writing and maths by free school meal eligibility, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2018

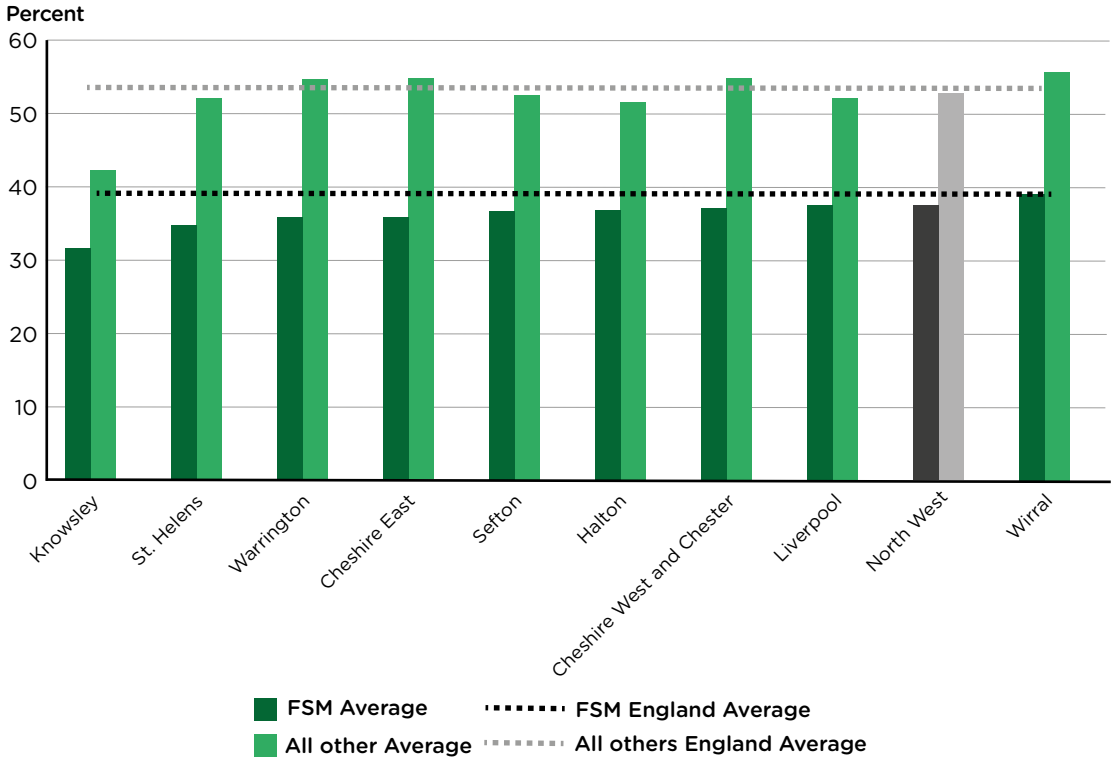


Source: *Department for Education (119)*

Attainment 8 scores measure attainment in key stage 4, which young people usually finish when they are 16 years old. Attainment scores are out of 90 and in England in 2019/20 students not eligible for FSM scored 52.3 on average, while students eligible for FSM scored an average of 38.6 (119). Inequalities in Attainment 8 are slightly wider in Cheshire and Merseyside compared to the English average and at this stage all boroughs have levels below the England average for pupils eligible for free school meals, Figure 4.6.

In all but one local authority in the region, non-free school meal achievement is relatively similar to the England average.

Figure 4.6. Average Attainment 8 mean score by free school meal eligibility, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *Department for Education (120)*

In addition to Attainment 8 scores, Progress 8 scores measure progress students make between 11 and 16 years, compared with other students with similar starting points. A score of 0 means the school is average, a score above 1 means pupils are doing better at this stage than those with similar prior attainment nationally. A negative score means pupils have done worse than prior attainment nationally. In all areas in Cheshire and Merseyside, students eligible for FSM are performing below the average. In four of the nine regions, pupils not eligible for FSM also perform below the national averages at Key Stage 4, Table 3.1. The high scores of children from Asian and Chinese ethnic backgrounds in all areas are highest.

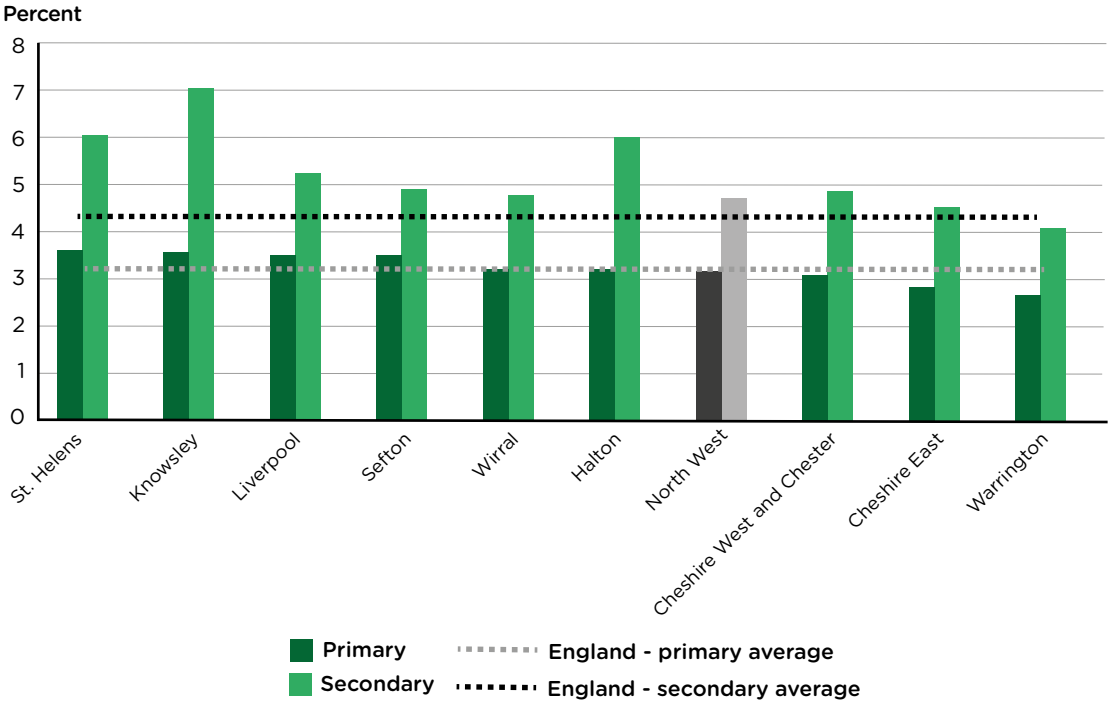
Table 3.1. Average Progress 8 Score*, Ethnicity and free school meal eligibility, in Cheshire and Merseyside lower-tier local authorities, 2018/19

	Average	Asian	Black	Chinese	Mixed	White	FSM eligible	Non-FSM eligible
Cheshire East	-0.01	0.79	-0.05	0.91	0.07	-0.02	-0.76	0.07
Cheshire West and Chester	-0.10	0.59	-0.05	0.51	-0.04	-0.11	-0.89	0.02
Halton	-0.13	0.82	NA	1.13	0.46	-0.15	-0.62	0.02
Knowsley	-0.81	0.34	-0.9	0.27	-0.70	-0.82	-1.01	-0.69
Liverpool	-0.31	0.77	0.01	0.58	-0.08	-0.39	-0.80	-0.12
Sefton	-0.35	0.90	-0.54	0.25	-0.32	-0.31	-0.97	-0.24
St Helens	-0.25	1.02	0.79	1.36	0.05	-0.24	-0.59	-0.19
Warrington	0.01	0.58	0.51	0.44	0.23	-0.01	-0.68	0.09
Wirral	0.01	1.02	0.81	0.75	0.04	-0.02	-0.68	0.17

Source: *Department for Education (120)*

Pupil absences can lead to a decline in academic achievement and pupils from low-income households experience more substantial effects from each day of school absence (121). In Cheshire and Merseyside, using pre-pandemic data, only Cheshire East and Warrington have lower absences than the England average for both primary and secondary pupils, Figure 4.7.

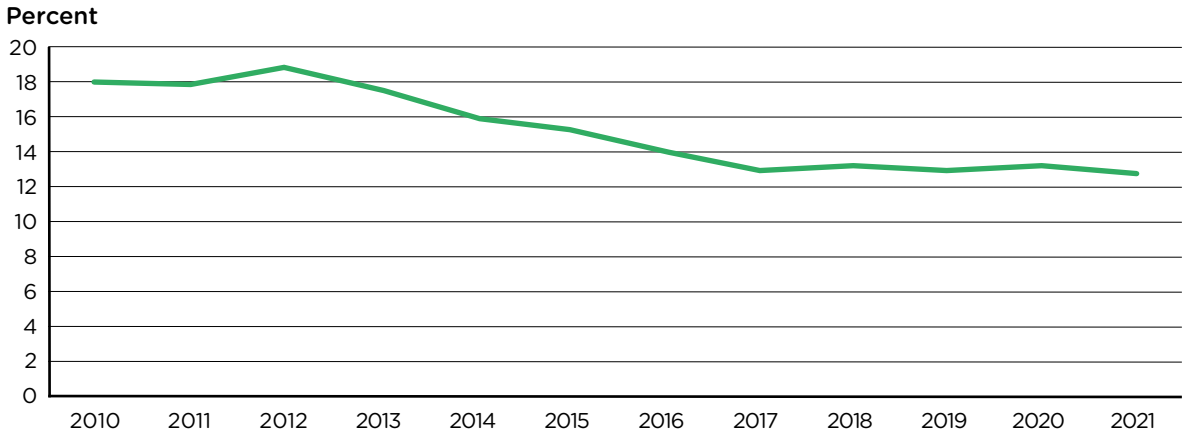
Figure 4.7. Pupil absences, autumn and spring terms combined, primary and secondary, percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020-21



Source: *Department for Education (122)*

In 2021, 13 percent of all people aged 18 to 24 in England were Not in Education, Employment or Training (NEETs), and of these 45 percent were unemployed and 55 percent were economically inactive (not working, not seeking work and/or not available to start work) (123). Time spent NEET has a detrimental effect on physical and mental health and this effect is greater when time spent NEET is at a younger age or lasts for longer. Being NEET increases the chances of being unemployed, receiving low wages or low-quality work later in life, further damaging health throughout life (124). The likelihood of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement and school experiences (125). In England, the number of NEETs has remained stable since 2017, Figure 4.8.

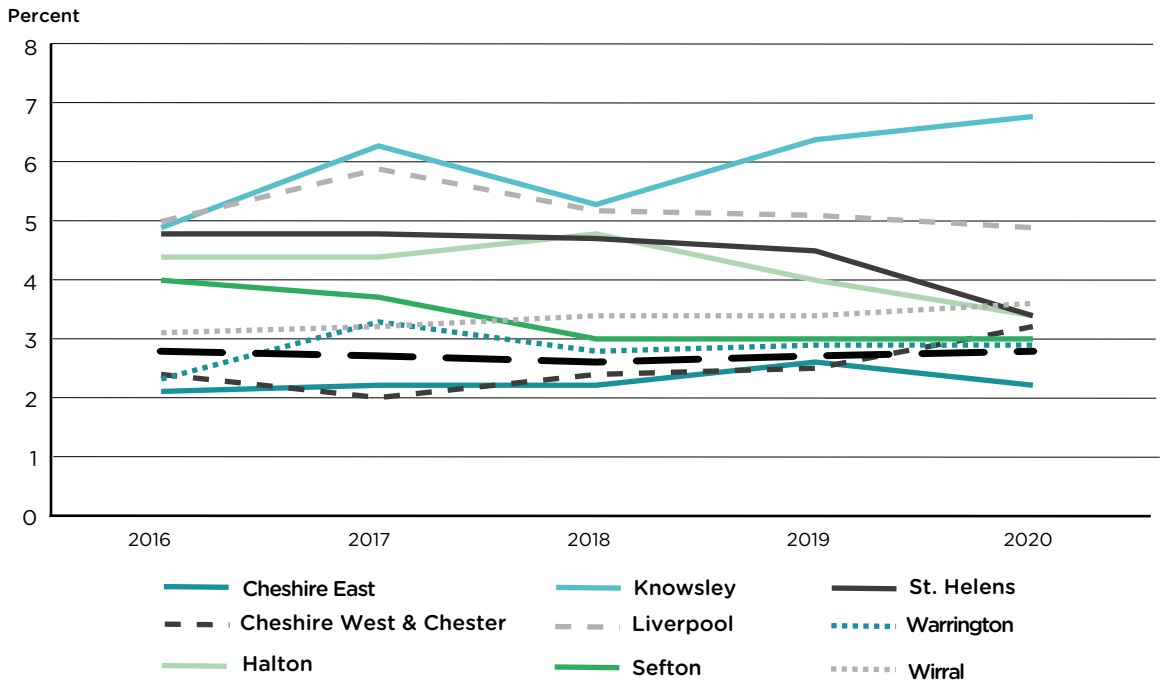
Figure 4.8 Not in Education Employment of Training (NEET), (aged 18 to 24), percentage, first quarter, England, 2010-21



Source: *Office for National Statistics (123)*

In Cheshire and Merseyside the number of NEETs has also remained stable since 2016, Figure 4.9, though Fingertips only measures NEETs aged 16 and 17.

Figure 4.9. Not in education or training, NEETS, (aged 16-17), percentage known to the local authority, Cheshire and Merseyside lower tier local authorities and England, 2016-20



Source: *Department for Education (126)*

Apprenticeships are frequently suggested as a tool to reduce NEETs. The apprenticeship programme in England in the last decade has shifted from being aimed at younger people to being a tool to get older people back into employment. In England, over-25-year-olds outnumber under-19-year-olds in apprenticeships by two to one (127). The IHE *10 Years On* report also 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 stated that apprentices were failing to "reach their social mobility potential" and that "the majority of apprentices are not from lower socio-economic backgrounds" (107). Every local authority in Cheshire and Merseyside has seen the number of apprenticeships drop since 2011 and the COVID-19 pandemic led to a further decline (127). In building back fairer, Cheshire and Merseyside have an opportunity to develop a fairer apprenticeships programme able to contribute to reducing health inequalities.

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

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Better communicate available youth services and reduce inequalities in access to these, including transport costs. • Assess provision of career guidance and aspiration approaches in primary, secondary schools and FE colleges at each place. • LEP/Chamber of Commerce work with businesses to support links with schools for training and recruitment and offering mentorships and for provision of youth services. • Work with young people to hear their views about what is needed in local areas.	• Extend free school meal provision for all children in households in receipt of Universal Credit and resource holiday hunger initiatives adequately at each place. • All young people who are able are either in training, employment and education up until the age of 21. • Commission the VCFSE sector to provide leisure and recreation opportunities in each place.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• ICS to develop NHS actions to support young people's education and skills and liaising with schools and employers and NHS recruitment and training.	• Develop a regional young persons' skills strategy in partnership with the LEP and businesses with a focus on areas with higher levels of deprivation and those most at risk of exclusion and a focus on apprenticeships and in-work training.
Responsible: Children and Young People Board	**Responsible: Local Enterprise Partnership and anchor partners**
• Jointly commission (NHS, local government and national government) and increase funding for programmes to support young peoples' mental health in schools, the community and at work.	• Increase minimum wage for apprenticeships (LEP, businesses). • Work in partnership to provide skills development and training opportunities for young people in each place.
Responsible: Mental Health Board	**Responsible: Mental Health Board**
• Review mental health support team funding to ensure it is reducing inequalities.	• Based on review carried out in year 1, monitor outcomes for equity based on mental health support team work.

MARMOT BEACON INDICATORS

- Average Progress 8 score.
- Average Attainment 8 score.
- Hospital admissions as a result of self-harm (15-19 years).
- NEETS (18 to 24 years).
- Pupils who go on to achieve a level 2 qualification at 19.

4C CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Being unemployed, and in particular long-term unemployed, can have long-lasting negative effects on health and wellbeing, increasing mortality and acts as a significant driver of inequalities in physical and mental health and early mortality (1) (76) (128). While unemployment is particularly damaging for health, poor-quality and stressful work also undermines health. The 2010 Marmot Review and the *10 Years On* report in 2020 outlined the protective health impacts of being in a good-quality job and feeling valued (76) (1).

The conditions associated with good-quality work involve job security; adequate pay for a healthy life; ability to build strong working relationships and social support; a job that promotes health, safety and psychosocial wellbeing; support for employee voice and representation; varied and interesting work; possible promotion of learning development and skills use; a good effort–reward balance; support for autonomy, control and task discretion; and good work–life balance. Good-quality work is beneficial to the health of employees and is also beneficial to employers as it increases productivity, retention and reduces the amount of sick pay required.

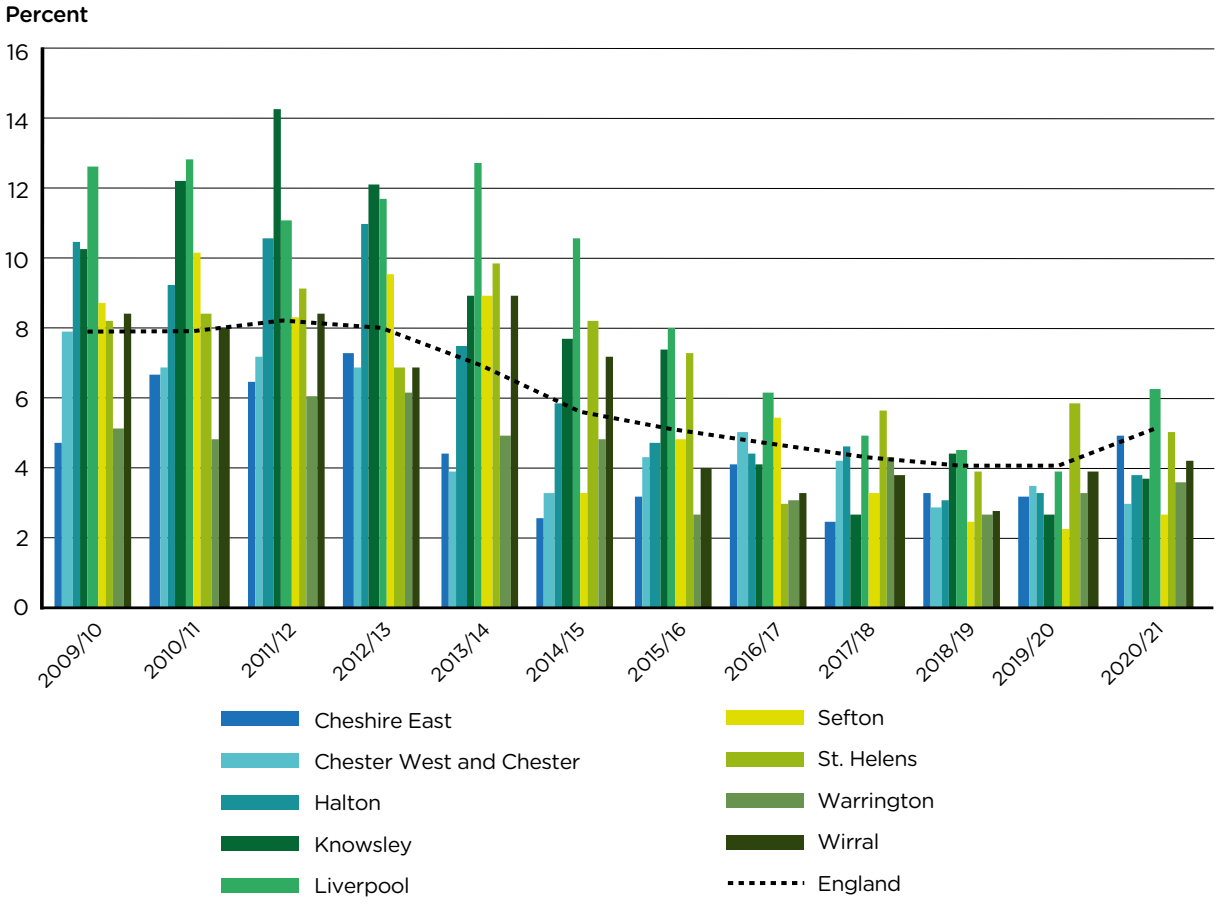
Further analysis of how employers can contribute to reductions in health inequalities is set out in Section 5E.

UNEMPLOYMENT AND ECONOMIC INACTIVITY

The pandemic has had considerable effects on local economies in Cheshire and Merseyside. Some 28 percent of all those in employment in the Liverpool City Region were furloughed at some point during the pandemic and the claimant count rose by 54 percent from 41,505 in March 2020 to more than 63,110 in August 2021 (129). In the Cheshire and Warrington local enterprise partnership region, recovery has been quicker: claimants numbered 29,615 in March 2020 and dropped to 21,780 in August 2021, a 26 percent decrease (130).

Whilst official unemployment figures show declining unemployment in the region, research shows these figures underestimate the reality of unemployment. In 2017, the Organisation for Economic Cooperation and Development estimated that if Liverpool's figures included those who are economically inactive, its unemployment rate was 19.8 percent as opposed to the official rate, which was just below 6 percent (131). The economic recession in 2008/09 had significant effects in Liverpool; Figure 4.10 shows the recession of 2008 had long-term effects on unemployment in Knowsley, Halton, and St Helens.

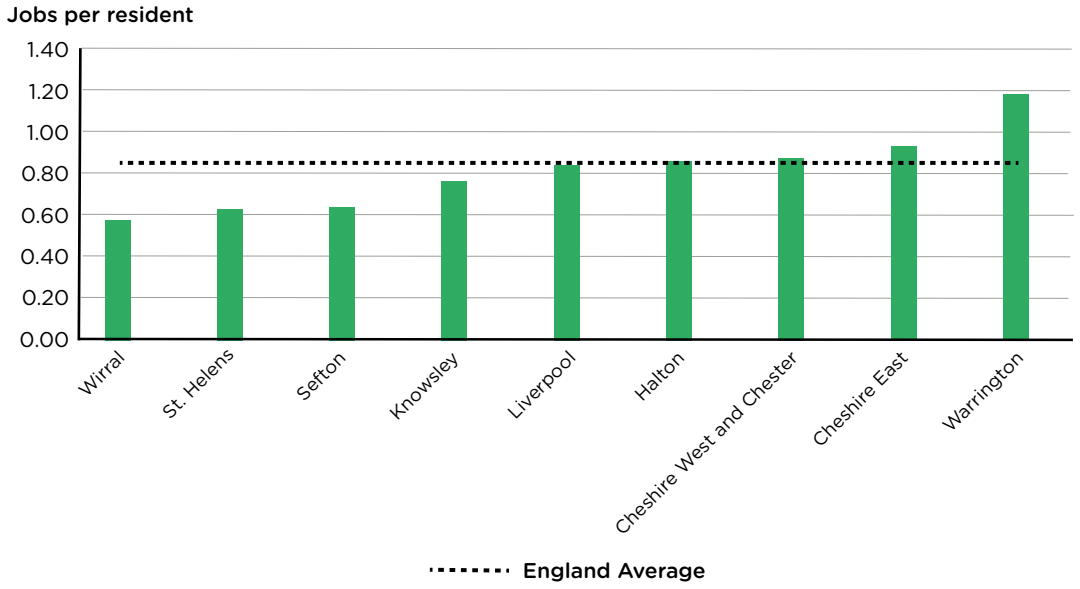
Figure 4.10. Unemployment rate, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, July-June 2009/10 to 2020/21



***Source**: Office for National Statistics (132)*

In four local authorities in the region, Wirral, St Helens, Sefton and Knowsley, the number of jobs per resident aged 16 to 64, is below the national average in 2020, Figure 4.11. (133).

Figure 4.11. Number of jobs per resident, (aged 16-64), Cheshire and Merseyside lower tier local authorities and England, 2020



***Source:** Office for National Statistics (132)*

Box 7 outlines the Households Into Work programme, covering the Liverpool City Region, which offers long-term and sustained support to people who are long-term unemployed.

Box 7. Supporting Households Into Work in Liverpool City Region

Launched in February 2018 and developed through the Liverpool City Region Devolution Agreement, the £4.5m Households into Work (HiW) is a significant labour activation programme for the Liverpool City Region. As a collaboration between the Liverpool City Region Combined Authority (LCRCA), six local authorities and Department for Work and Pensions, HiW was designed to address the systemic issues associated with long-term and entrenched worklessness in a region where there were around 130,000 residents in receipt of out of work benefits, representing one of the highest rates of any economic area nationally.

Unlike more traditional employment support programmes, which focus on developing an individual's progress through skills-based interventions alone, HiW adopts a flexible, person-centred approach to take account and respond to the multiple employment barriers that many people face, ranging from skills assessment, community engagement, debt and finance advice, mental health support, drugs and alcohol and housing issues.

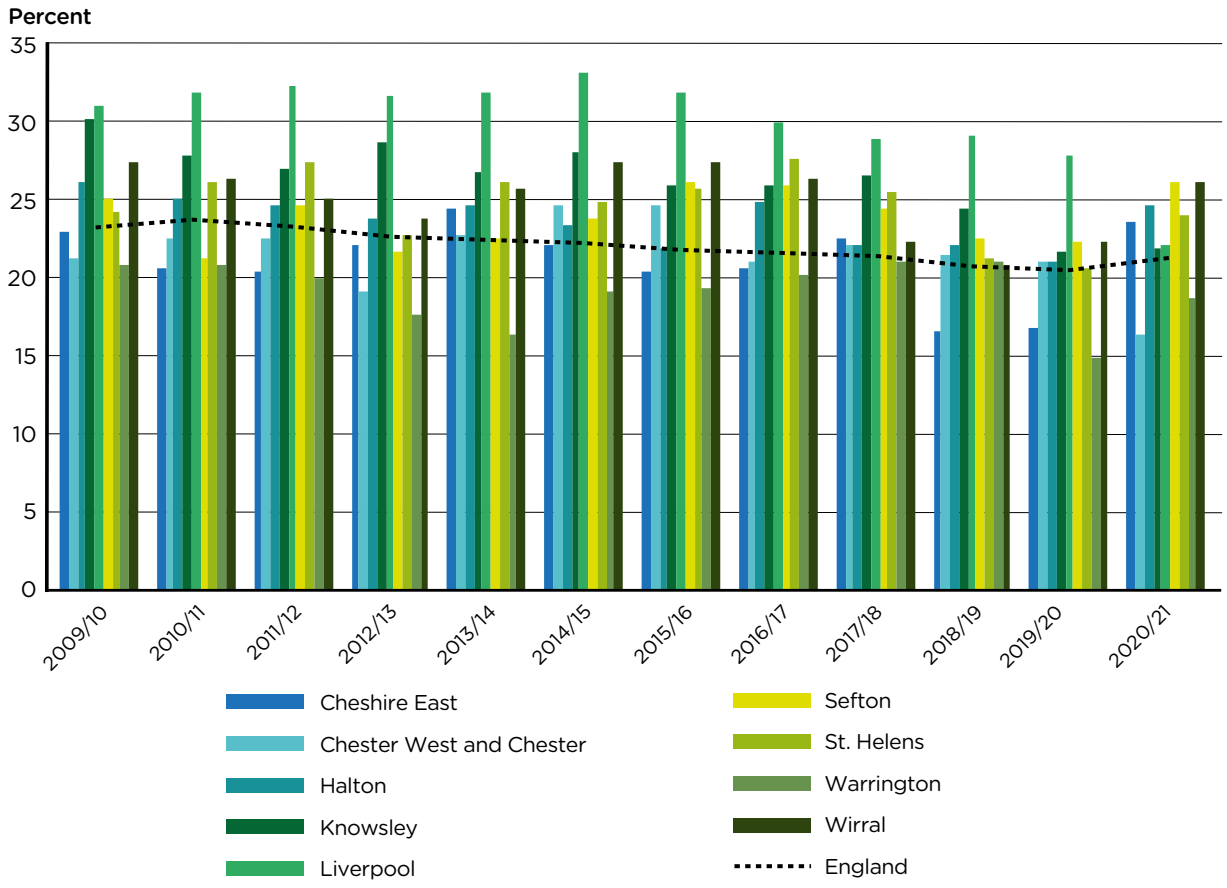
An evaluation of pilot programme data (covering February 2018-20) found that the key barriers to employment in this client group were mental health issues (65 percent); chronic health conditions (23 percent); and care responsibilities (26 percent). Clients also experienced financial inequality. Some 72 percent of those on the HiW programme are living on incomes below £13,000 per year with 40 percent reporting that they live on less than £6,000 a year.

Another evaluation of the programme found that HiW demonstrated the value of an asset-based approach, placing the client at the centre of both service design and delivery, which helps to better tackle long-standing and entrenched worklessness. Additionally, the evaluations found the programme brought together collective skills and knowledge assets that existed within organisations from across the City Region, translating them into a single source of service delivery and thereby adopting a whole systems approach.

Following on from the completion of the pilot phase of the programme in March 2020, HiW was extended for a further two years and has become a component of the LCRCA levelling up plans. Policymakers and practitioners are working together to plan for secure resourcing to continue the work of the programme beyond 2023 (134) (135).

A person is classified as economically inactive if they are not looking for work or available to start work. The main reasons for being economically inactive are being in full-time education; caring for family; temporary or long-term sickness, or retirement. In the UK in 2021, the most common reason for being economically inactive was being in full-time education, (27 percent) and the second most common reason was being long-term sick (25 percent) (136). Figure 4.12 shows levels of economic inactivity in Liverpool, Knowsley and Sefton have consistently been higher than the England average for the past decade.

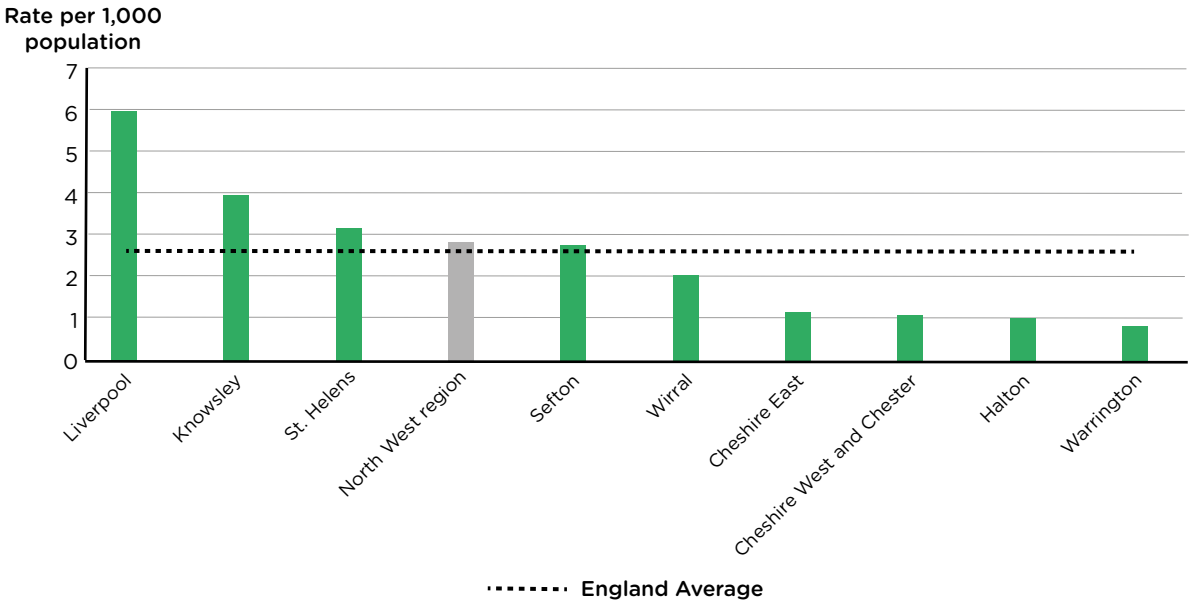
Figure 4.12. Economically inactive population, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, 2009/10 to 2020/21



Source: *Office for National Statistics (132)*

Figure 4.13 shows the high levels of long-term claimants of Jobseeker's Allowance in 2020, notably, in Liverpool where the rate is more than double the England average.

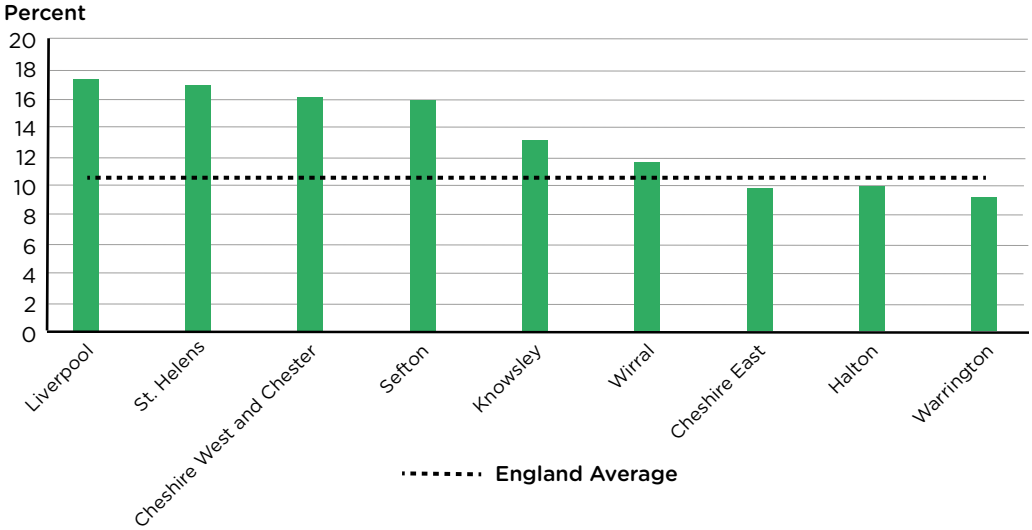
Figure 4.13. Long term claimants of Jobseeker's Allowance, (aged 16 to 64), rate per 1,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



Source: *Office for National Statistics (132)*

Of those who are economically inactive, approximately 20 percent would like to be working (136). Whilst people with long-term health conditions have lower rates of employment, many still want to work but require more support to return to work, and many employers do not provide this support or training (1). Being out of work can contribute to further deterioration in health among people with a long-term health condition or disability (1). Six of Cheshire and Merseyside's nine areas have a higher gap in the employment rate between those with a long-term health condition and those without, many in the areas with higher levels of deprivation, Figure 4.14.

Figure 4.14. Gap* in the employment rate between those with a long-term health condition and the overall employment rate, gap – percentage points, Cheshire and Merseyside lower-tier local authorities, 2019/20



Notes: *Gap in the employment rate between those with a long-term health condition and the overall employment rate - The percentage point gap between the percentage of respondents in the Labour Force Survey who have 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).*

Source: *Office for National Statistics (132)*

Box 8 outlines Sew Halton, a locally developed project that works with a range of partners, including the Department of Work and Pensions, to improve wellbeing and employment skills for those who are long-term unemployed and with health conditions.

Box 8. Improving health, wellbeing, and employment skills in Halton

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

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

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

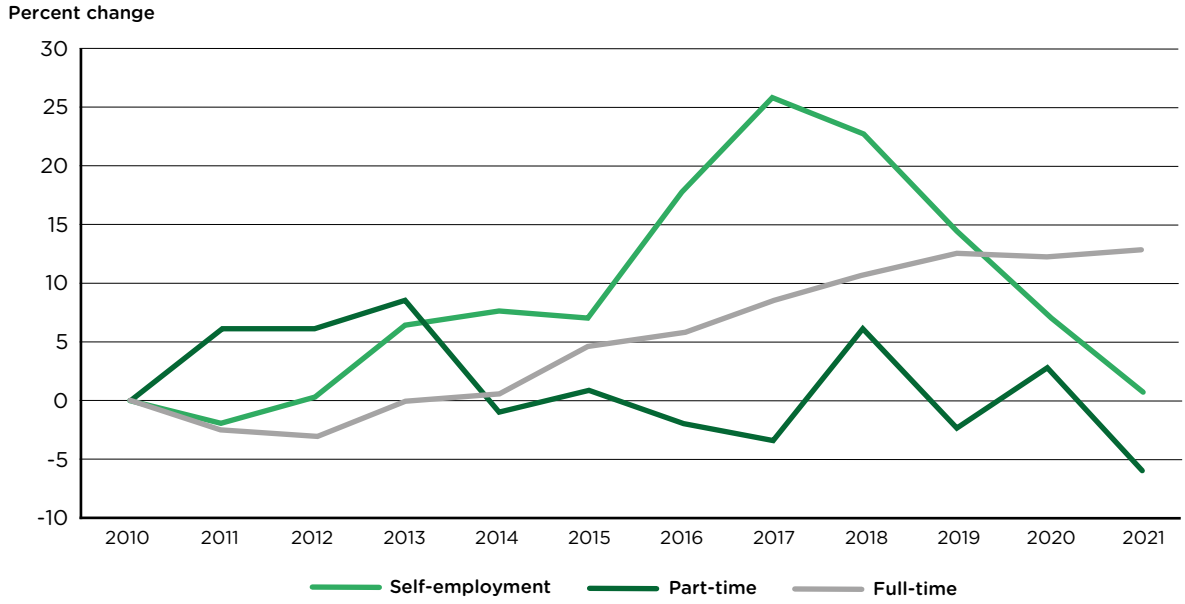
Sew Halton also acted as a signposter, directing participants to a variety of partners including Citizens Advice, Halton Carers Centre, urgent care centres, domestic abuse services, local councillors, and many others.

QUALITY OF WORK AND FAIR PAY

Since 2010 there have been profound shifts in many aspects of the labour market and employment practices in England. Whilst pre-pandemic unemployment fell, the jobs that have been created are often low-paid, low-skilled, self-employed, and either short-term or zero-hours contracts. Rates of pay have not increased and, notably, rates of in-work poverty have increased (1).

Zero-hours contracts are generally harmful to health; the increased insecurity and lack of benefits which are offered with full-time employment undermines their mental and physical health (137). In Cheshire and Merseyside, rates of self-employment have fallen sharply after reaching a peak in 2017, and part-time work has also decreased. The rate of full-time employment has increased steadily between 2010 and 2020, as seen in Figure 4.15. These averages hide the uneven growth of full-time work, with Liverpool, Warrington, and Wirral all having a nearly 30 percent increase in full-time workers since 2010, contrasting with Knowsley which has had a 26 percent decrease. Full-time work has also not grown uniformly across age groups. Cheshire West and Chester has seen an overall increase in full-time work of 10 percent between 2010 and 2020, however, in those over 50, this increase is 36 percent whilst in the 20 to 24 age group there has been a 33 percent reduction in full-time workers in 2020. A similar pattern can be identified in Halton, Liverpool, and St. Helens.

Figure 4.15. Change in employment type, (aged over 16), (indexed to 2010 level), Cheshire and Merseyside, 2010-21



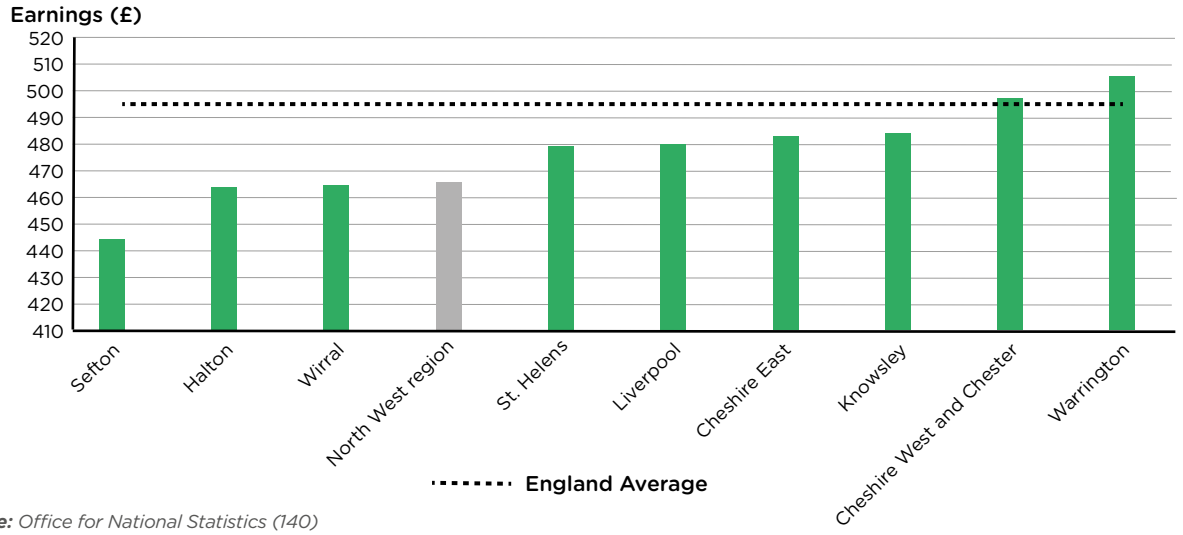
Source: *Office for National Statistics (132)*

PAY AND IN-WORK POVERTY

Despite the introduction of the minimum and living wages, wage growth in the UK since 2010 has been low and rates of in-work poverty have increased. 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 (138). Between 2001 and 2021 households where both adults work, one full-time and one part-time, have increasingly been pulled into poverty, and the chances of being pulled into poverty doubled from one in 20 to one in 10 (139). 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 which have not kept up with increasing rental, fuel, heating and other costs and a lack of flexible and affordable childcare (139). During the pandemic, pay also decreased across England. In 2020, 2,085,000 jobs (7.4 percent of employee jobs) were paid below the minimum wage and by 2021, the rate paid below minimum wage had fallen but still not returned to 2019 figures. In 2021 1,084,000 jobs paid below the minimum wage, 3.8 percent of all jobs.

In April 2022 the minimum wage in the UK was £9.50. 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). There are a number of opportunities to improve employment conditions in Cheshire and Merseyside, particularly related to wages through, for example increasing pressure on employers to pay the real living wage for employees, contract workers and through the supply chain. Figure 4.16 shows only Cheshire East and Cheshire West have average earnings above the England average.

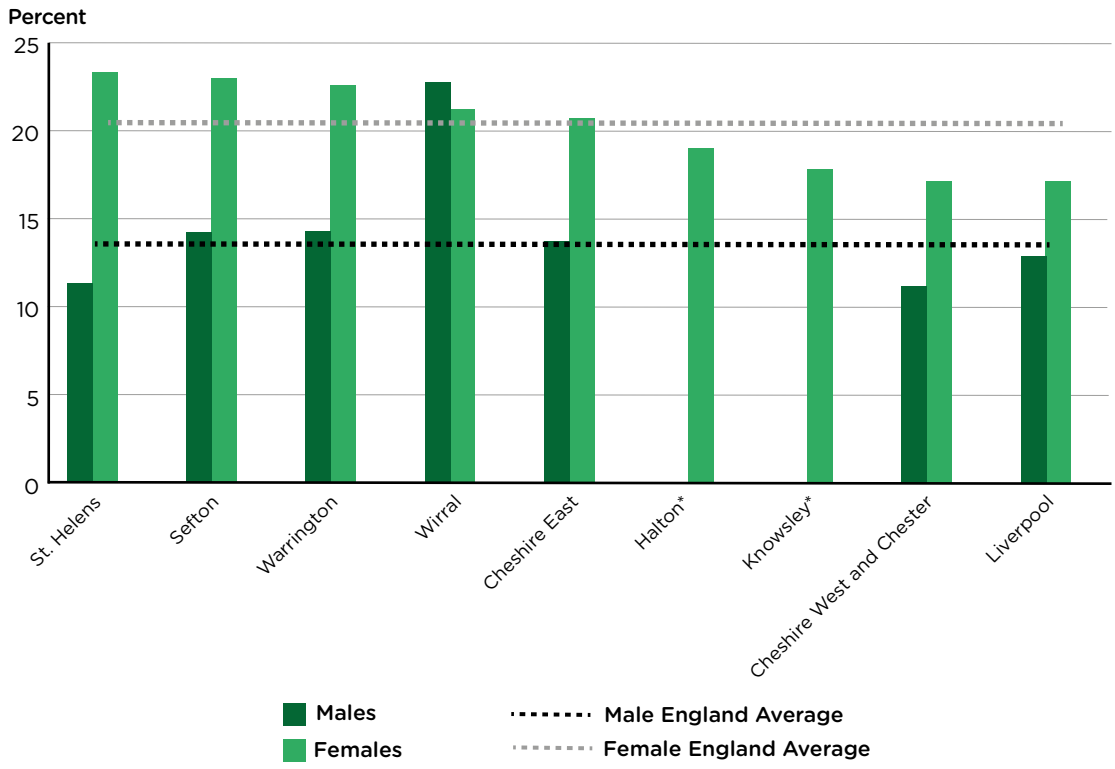
Figure 4.16. Average weekly earnings, (aged 16 and over), pounds (£), Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



Source: *Office for National Statistics (140)*

In 2021 average hourly pay had recovered for most workers, however, for people working part-time in the lowest-paying time jobs, pay remained below pre-coronavirus levels, down 6.7 percent compared with 2019 (141). Before the pandemic, wages in the North of England were lower compared to the rest of England and fell further during the pandemic, from £543.90 to £541.30 per week. In England average wage increased, from £600.80 to £604.00 per week (142). Figure 4.17 shows the percentage of employees in Cheshire and Merseyside earning below the UK real living wage rates in 2021, when it was £9.50 (the UK minimum wage was £8.21). Across the region, except in Wirral, women have much higher rates of low pay than men. St Helens has the highest percentage of women earning below the real living wage whereas Wirral has the highest percentage of men earning below the real living wage.

Figure 4.17. Earning below *real living wage* rates, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2021



Notes: *Data missing as estimates for some areas are considered unreliable.*

Source: *Annual Survey of Hours and Earnings (143)*

A research project is bringing together partners in Liverpool City Region to adopt a public-health centred approach to labour market programmes, Box 9.

Box 9. Economies for healthier lives

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

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

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

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

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

RECOMMENDATION: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

2022/23

Responsible: Place

- Assess local workplaces and their capacity to produce and implement policies to recruit and retain people with a disability or long-term condition.

Responsible: Cheshire and Merseyside System

- Establish criteria for healthy workplace standards for public and private sectors. To include:
  - Wages to meet the minimum income for healthy living.
  - Provision of in-work benefits including sick pay, holiday and maternity/paternity pay.
  - Provision of advice and support e.g. debt and financial management, housing support at work.
  - Provision of education and training on the job.
  - Strengthen equitable recruitment practices including provision of apprenticeships and in work training, recruitment from local communities and those underrepresented in the workforce.

2023/27

Responsible: Place

- Monitor policies to recruit and retain people with a disability or long-term condition.
- Build on actions to increase local recruitment into all jobs and work with employers to improve retention rates.
- Provide guidance to workplaces to recruit and retain people with a disability or long-term condition.
- Work with businesses, chambers of commerce, public sector, NHS and local authorities to improve support for mental health, housing and finances in all workplaces.
- Target funding for adult education in more deprived communities and link to job market demands. Offer training and support to older unemployed adults and ensure the private sector participates in training and skills development and link this to the regional good work standard.

Responsible: Cheshire and Merseyside System

- Implement adoption of the healthy business and healthy employment / regional good work standard. Include within commissioning contracts.

Responsible: Local Enterprise Partnership and anchor partners

- ICS and LEPS to work together to develop relationships with local large and small and medium-sized enterprises (SMEs) to make the case for healthy employment and health equity. Large businesses to take the lead and share best practice.
- Offer on the job training and skills development and link this to the regional good work standard.

MARMOT BEACON INDICATORS

- Percentage unemployed (aged 16-64 years).
- Proportion of employed in permanent and non-permanent employment.
- Percentage employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter.
- Percentage of employees earning below the real living wage.

4D ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

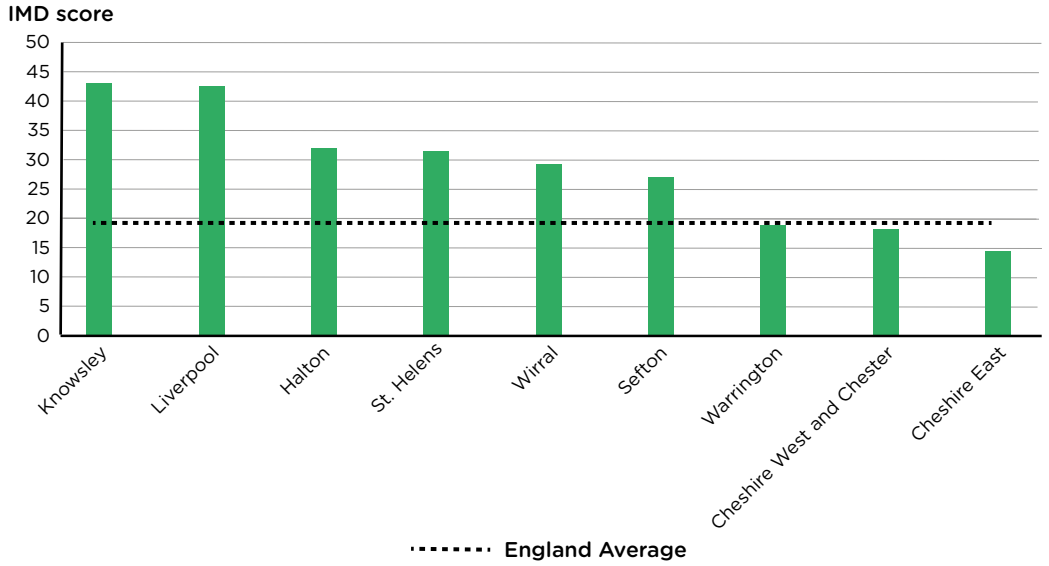
Poverty affects the ability to purchase sufficient goods and services and to have a social life - all essential components of a healthy life. Poverty also affects control over one's life which is critical to health and wellbeing and the ability to lead a dignified life (1).

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 and lower than average life expectancy. Poverty affects the social determinants of health; affecting access to decent housing and the ability to heat one's home, the ability to have a healthy diet, reduces access to employment and harms educational attainment. It increases levels of debt, which are harmful to health. Poverty is also stressful, leads to mental health issues and reduces the 'mental bandwidth' available to deal with problems and live a healthy life (1).

The people and places in England who were struggling financially before the pandemic continued to face the greatest risk of poverty throughout the three waves of the pandemic, directly because of increased risks of COVID-19 for those on lower incomes and also due to the unequal impacts of COVID-19 containment measures. Official data on poverty levels during the first year of the COVID-19 pandemic show the increases in benefits, including the £20 uplift in Universal Credit, led to increases in incomes in households on the lowest incomes and reductions in poverty, for the first time since 2010/11. In 2020/21, relative poverty (after housing costs) fell from 22 percent to 20 percent, and child poverty (after housing costs) fell from 31 percent to 27 percent in England. Incomes in the poorest 10 percent of households grew by 3.8 percent, between 2011 and 2019 incomes for this quintile grew by 0.5 percent (144). Increasing incomes for the poorest households lifted them out of poverty. However, the decision to take away the £20 uplift in Universal credit, alongside increasing inflation and cost of living will return many of these and additional households into poverty in subsequent years.

A third of Cheshire and Merseyside's residents live in the most deprived 20 percent of neighbourhoods in England (4). Across all local authorities in Cheshire and Merseyside, in both rural and urban areas, there are high levels of poverty. Figure 4.18 shows the Index of Multiple Deprivation scores across Cheshire and Merseyside. Whilst IMD scores are higher in Merseyside, there are areas of poverty within each of the local authorities in Cheshire and Merseyside. In Cheshire West and Chester, 11 percent of the population is income-deprived and in Cheshire East, 8 percent and Warrington 11 percent, rising to 18.5 percent in Halton. Within areas there are huge variations in wealth and while Cheshire East is relative wealthy, in the most deprived neighbourhood of Cheshire East, 36 percent of people are estimated to be living in poverty. Similarly, in the most deprived neighbourhood in Cheshire West and Chester, 41 percent of people are estimated to be living in poverty (27).

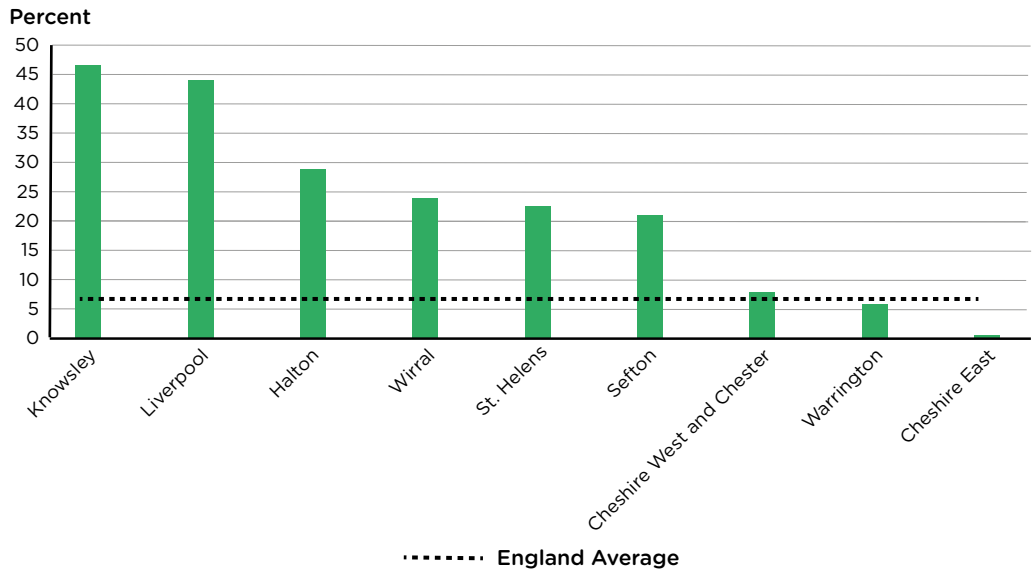
Figure 4.18. Index of Multiple Deprivation score, Cheshire and Merseyside lower-tier local authorities and England, 2019



Source: *Ministry of Housing, Communities and Local Government (4)*

The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England, Liverpool the third. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households. Liverpool has the fourth highest proportion, with 24 percent living in income deprived households (4). Figure 4.19 shows the level of deprivation within Cheshire and Merseyside and that seven of nine local authorities have a higher proportion of most deprived LSOAs compared to the England average.

Figure 4.19. Proportion of LSOAs in most deprived 10 percent, Cheshire and Merseyside lower-tier local authorities and England, 2019



Source: *Ministry of Housing, Communities and Local Government (4)*

Boxes 10 and 11 outline the actions some councils in Cheshire and Merseyside are offering to provide emergency financial support to residents. These short-term interventions are valuable in preventing residents from becoming homeless, however, as highlighted by Liverpool Council, these emergency funds do not address the underlying causes of poverty caused by the high cost of living and welfare benefits and wages which are not adequately supporting households. The number of people living in poverty is likely to significantly increase as a result of increases in cost of living and inflation from 2022 onwards.

Box 10. Knowsley Better Together Hardship Fund

In March 2021, Knowsley Council launched the £2.5m Knowsley Better Together Hardship Fund, which aimed to support the residents who need it most at the right time. The Hardship Fund was created as part of the councils' COVID-19 recovery response, to help relieve the pressure on those who are struggling the most, without going through the often long and difficult-to-navigate means testing process associated with conventional benefits.

The fund was initially made available until March 2022 and invested in projects and services delivered by the council and community partners. The fund was put in place to support access to food and essentials, heating, housing support, debt advice, and job and training support. Knowsley residents are referred to the fund through partner agencies and council services including Children's Services and Revenues and Benefits.

Funding from the scheme has been used to support Merseyside Fire and Rescue Service's Winter Warmth and Safe Heating schemes, providing 400-oil filled radiators in homes to replace unsafe heat sources, and provide effective heating for residents on low incomes. The councils' Strategic Housing service also provides emergency boiler and central heating repairs for eligible residents, including those on benefits or low incomes and this offer was boosted by Hardship Fund monies. The council's Local Welfare Assistance scheme known locally as the Emergency Support Scheme was extended beyond its original remit to support residents not in receipt of means tested benefits. This was to provide a broader offer to all residents in fuel poverty with a prepayment metre. Through this, eligible households receive fuel vouchers worth £49 towards heating costs in winter and £30 in summer.

The fund also part-funded a pilot rent guarantor scheme with Strategic Housing to give homeless households access to rented accommodation. Tailored packages of support to improve the lives of tenants and local residents were joint funded with Livv Housing and For Housing. The packages included mental health engagement, benefit advice and support to reduce household bills. Residents who had fallen behind with rent could access additional support to ensure they did not risk becoming homeless.

An additional money adviser role was created within the council, offering specialist support to residents. This includes income maximisation, help to reduce outgoings and access to discretionary financial support such as discretionary housing payments and council tax hardship. A two-year pilot project led by Prescot Advice, in partnership with Merseycare, aims to deliver bespoke welfare benefit, debt and housing support to residents working with local mental health services. Recognising the cyclical impact of finances on mental health, this project takes direct referrals from mental health practitioners and provides access to specialist support including the Breathing Space and Mental Health Breathing Space schemes.

Under a series of grant agreements, food and essentials have been distributed through Knowsley's community and voluntary organisations, with the offer being tailored to reflect local need.

Box 11. Liverpool Citizens Support Scheme

Liverpool Citizens Support Scheme (LCSS) is a local welfare provision scheme providing urgent assistance to people without funds for essentials (food, fuel and so on) as well as help with furnishing their homes with white goods and furniture. It also incorporates benefits advice and maximisation. It offers two types of funding: the urgent need award, offering funding for food, essential items for children, essential clothing, fuel costs or help where people have suffered an emergency or crisis, for example a fire or flood; and a home needs award that covers furniture, new white goods, domestic appliances and essentials such as bedding and crockery to help maintain or establish a home.

Much of the demand for urgent assistance is driven by structural issues within national benefits, including Universal Credit. There is a risk in providing short-term assistance as it cannot address the underlying causes, leaving a high risk of repetition and, ultimately, destitution. In providing urgent assistance, the underlying effects of welfare restrictions and reductions does not address the issue that current benefit levels and restrictions do not leave enough funds for people to pay for food, fuel, rent and other essential costs and as a result, they are at persistent risk of crisis (145).

COST OF LIVING CRISIS AND INCREASING INCOME INEQUALITY

The IHE report *Build Back Fairer* found that in the first two months of the pandemic, one-third of families in the top income quintile saved more than usual, whereas lower-income families were more likely to have taken on additional debt (2). As the pandemic has progressed, income inequalities have grown. The aggregate pay of the UK's highest earners increased 23 percent between 2020 and 2022 while for those in the lowest-paid jobs, earnings fell by 10 percent (146).

The average cost of living is increasing in the UK and, alongside increasing inflation, this will lead to increases in poverty. In February 2022, inflation in the UK was at a 30-year high. The consumer price index rose at an annual rate of 6.2 percent in February 2022 with significant single year increases in key important prices:

- Clothing and footwear prices rose by 8.8 percent.
- Furniture, household equipment and maintenance rose by 9.2 percent.
- Food and non-alcoholic beverages rose by 5.1 percent.
- Electricity prices rose 19.2 percent.
- Gas (home heating) prices by 28.3 percent.

Average petrol prices at the end of March 2022 were 37 pence higher than March 2021 and prices have since increased to reach the highest recorded (147) (148).

Relative poverty is projected to rise. in particular for households with more than two children. The Resolution Foundation estimates that by 2026/27, the majority of children in large families (three or more children) may be living in relative poverty (149). Pro Bono Economics estimates a single parent with one child will have to spend an additional £315 on food and heating in 2022 compared with 2019 to purchase the same amount, while a family of four must find £580 more (146).

The Office for Budget Responsibility states that household finances are experiencing the highest increases in costs since records began in 1956/57 and estimates that the very poorest will suffer most as benefits will rise by 3.1 percent in 2022/23 whilst cost of living is expected to rise by 10 percent (150). The Joseph Rowntree Foundation estimates that a further 600,000 people will be living in poverty in 2022/23 because of the failure to increase benefits in line with inflation, and the 1.25 percent increase in National Insurance (NI) and changes to the earning threshold at which NI is paid (151).

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 before the large increases in energy, 28 percent already reported being unable to heat their homes for financial reasons. As a result, two-thirds, 66 percent stated their mental health would improve if they earned a wage that covered their basic living costs (152).

In Cheshire and Merseyside, as in other areas, local poverty truth commissions have sought to better understand the effects of poverty, looking at the reality of all care costs, in-work poverty, debt burden, tax credit and welfare reforms, benefits, and the cost of housing, transport, food and clothing. In October 2020 Cheshire West and Chester Council declared a poverty emergency, both in response to the pandemic but also reflecting the work of the two Poverty Truth Commissions held in the local authority since 2017, and Cheshire East have also recently initiated an Increasing Equality Commission, Box 12.

Box 12. Cheshire West and Chester Poverty Truth Commission and Cheshire East's Increasing Equality Commission

Cheshire West and Chester Council facilitated two Poverty Truth Commissions in 2017 and 2020 with the aim of tackling the root causes of poverty and addressing gaps in services across the borough. The local public health team and the Health and Wellbeing Board supported the commissions.

Community inspirers, volunteers with lived and living experience of poverty, shared their stories of the effect poverty had on them and their families. Through listening and collaboration, members of the commissions were able to reflect on how systems and processes could better support local people. There have been a range of outcomes from the commissions including:

- More collaborative and effective partnership working across a number of agencies.
- New support for frontline staff to understand the story of the person in front of them, their challenges, stresses and often complex problems and the need for compassion, empathy, and making any difference they can, no matter how small. As a result, one social housing provider moved from a process-driven approach to offering a person-centred, wellbeing service which focuses on early intervention and supporting people to sustain tenancies and they are now reporting a 75 percent reduction in evictions.

Another benefit was that the community inspirers reported a stronger sense of confidence, enabling them to have a voice, secure employment, develop their learning and become more independent.

Building on the learning from the Poverty Truth Commissions, it was agreed in early 2020 to mainstream this approach to inform and support all poverty work across the council and with local partner agencies, developing a programme of work that retains the ethos of putting people at the heart of policy development and service design.

In October 2020 the council declared a poverty emergency. The declaration sets poverty, alongside climate, in providing the framework for a fairer, greener recovery from COVID-19. Following the declaration a new Fairer Future Strategy 2022/32 has been developed, setting out an ambitious 10-year plan to reduce poverty. The strategy underlines the commitment to continue to hear the voices of people experiencing poverty and take action to address the issues they raise, taking urgent actions to alleviate the symptoms of poverty and addressing the underlying causes of poverty through long-term economic transformation (153) (154).

In Cheshire East the Increasing Equality Commission, a subgroup of the Health and Wellbeing Board, was established in December 2020. The commission adopted a coordinated approach to address issues related to where people live – the environment, green spaces, crime and anti-social behaviour, access to services – and factors affecting their individual circumstances, such as education and skills, employment, income, poverty, housing conditions, health and wellbeing. Their terms of reference endorse "courageous and honest" approaches that are evidenced-based and that promote dignity and respect.

The commission supports strategies that invest in prevention and sustainable and inclusive growth when addressing the increasing demand on public services. Its aim is to identify areas for local action and interventions to increase equality and opportunity within the population of Cheshire East. During its first year, the commission will focus on Crewe. Data and evidence gathering is underway to ensure a comprehensive understanding of the issues and opportunities in Crewe and how a joined up partnership approach might facilitate genuine long-term change that improves the life chances of residents in the more deprived parts of the town.

CHILDREN LIVING IN POVERTY

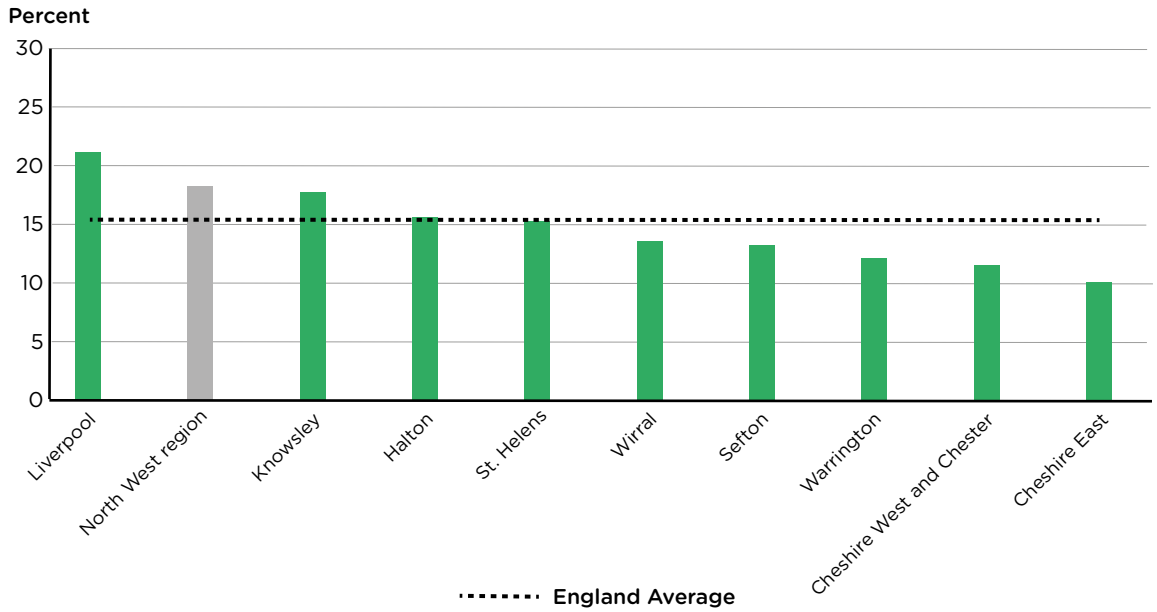
Persistent child poverty is associated with worse mental, social, and behavioural development in children, as well as worse educational outcomes, employment prospects, and earning power into adulthood.

Analysis of 10,652 children from the UK Millennium Cohort Study measured mental and physical health and relative poverty at 9 months, and at 3, 5, 7, 11 and 14 years of age. They found any period of poverty, from only a few months to persistent poverty (over many years), was associated with worse physical and mental health in early adolescence (after adjusting for the mother's education and ethnicity). Children living in persistent poverty had 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 to children who had never been poor (155).

In 2019/20 child poverty rates for both relative and absolute poverty increased, and there is no strategy to reduce child poverty (156). Due to the increases in basic income resulting from the furlough scheme and the £20 uplift in Universal Credit, child poverty fell from 31 percent to 27 percent in England in 2020/21 (144) but will increase rapidly given the cost of living and ending of the £20 uplift.

Across Cheshire and Merseyside, 14.7 percent of children lived in absolute poverty households in 2019/20, compared to 15.6 percent in England, but in Liverpool, Knowsley and Halton, that figure is higher, as seen in Figure 4.20. Absolute poverty is when equivalised income is below 60 percent of the 2010/11 median income adjusted for inflation.

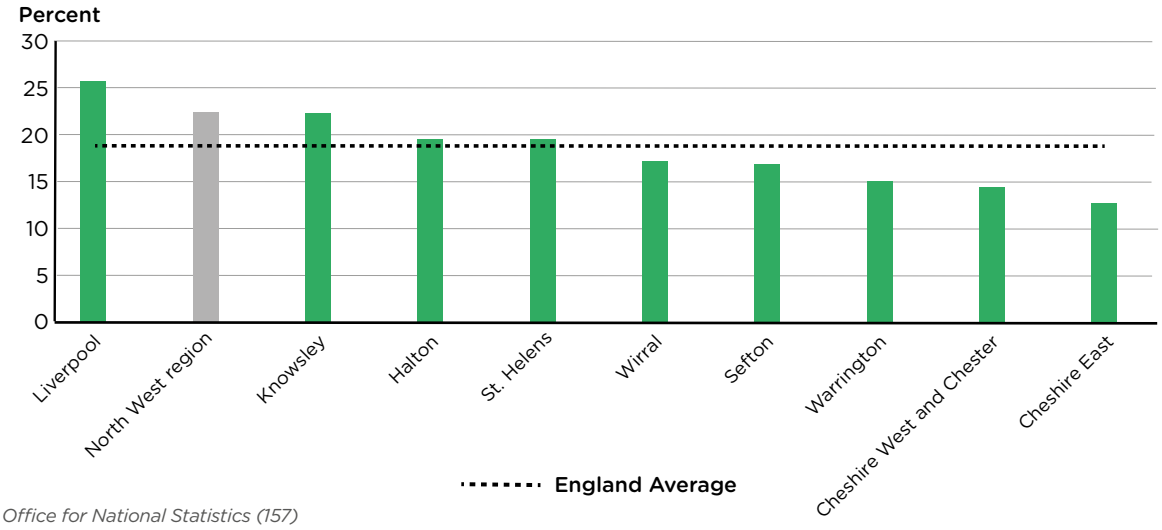
Figure 4.20. Children living in absolute poverty households (under-16s), percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *Office for National Statistics (157)*

In Cheshire and Merseyside HCP, 18.3 percent of children live in relative poverty households, compared to 19.1 percent in England, Figure 4.21. Relative poverty is defined as a household's equivalised income being below 60 percent of median income in the year measured. Liverpool, Knowsley, Halton and St Helens have higher rates of children in relative poverty households compared to the England average.

Figure 4.21. Children living in relative poverty households (under 16s), percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *Office for National Statistics (157)*

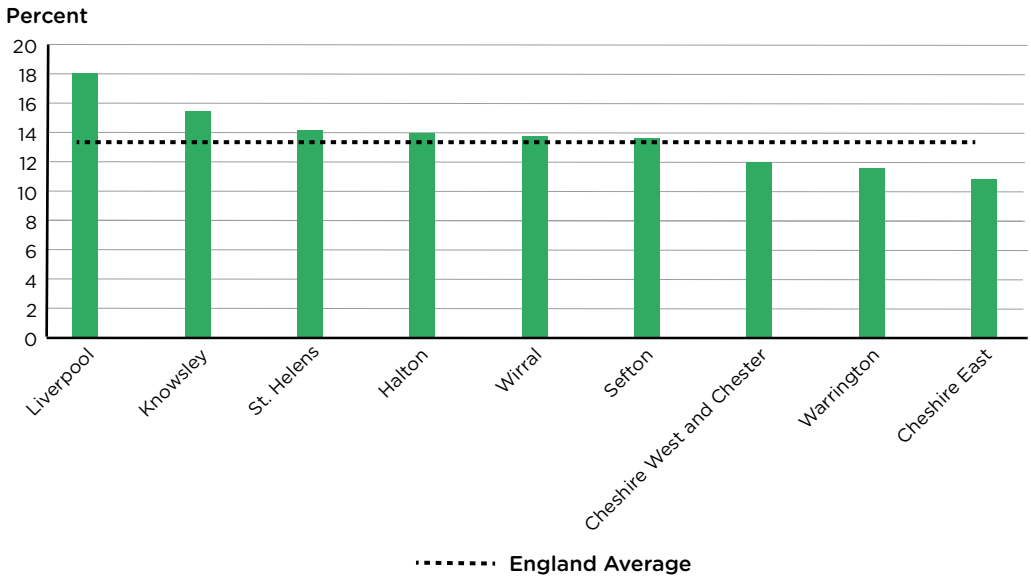
FUEL POVERTY

The increasing costs of energy have brought substantial attention to the issue of fuel poverty and the inability to heat one's home. Households are considered to be fuel poor if they are living in a property with a fuel poverty energy efficiency rating of band D or below and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line (158). Cold housing affects physical and mental health, directly and indirectly (159) and contributes to excess winter deaths, increases in circulatory and respiratory disease, colds and flu, chronic conditions such as rheumatism and arthritis, and negative mental health across all age groups.

The removal of the energy price cap in April 2022 significantly increased the number of households in fuel poverty. Ofgem estimates prices for 22 million customers will increase on average by more than £500 per year and prepayment customers, many of whom are on the lowest incomes, will have average increases of £700 (160).

The North West has the second highest proportion (14 percent) of fuel poor households amongst regions in England (161). Since 2016 levels of fuel poverty in several local authorities in Cheshire and Merseyside have been above the England average with the highest levels in Liverpool, Figure 4.22.

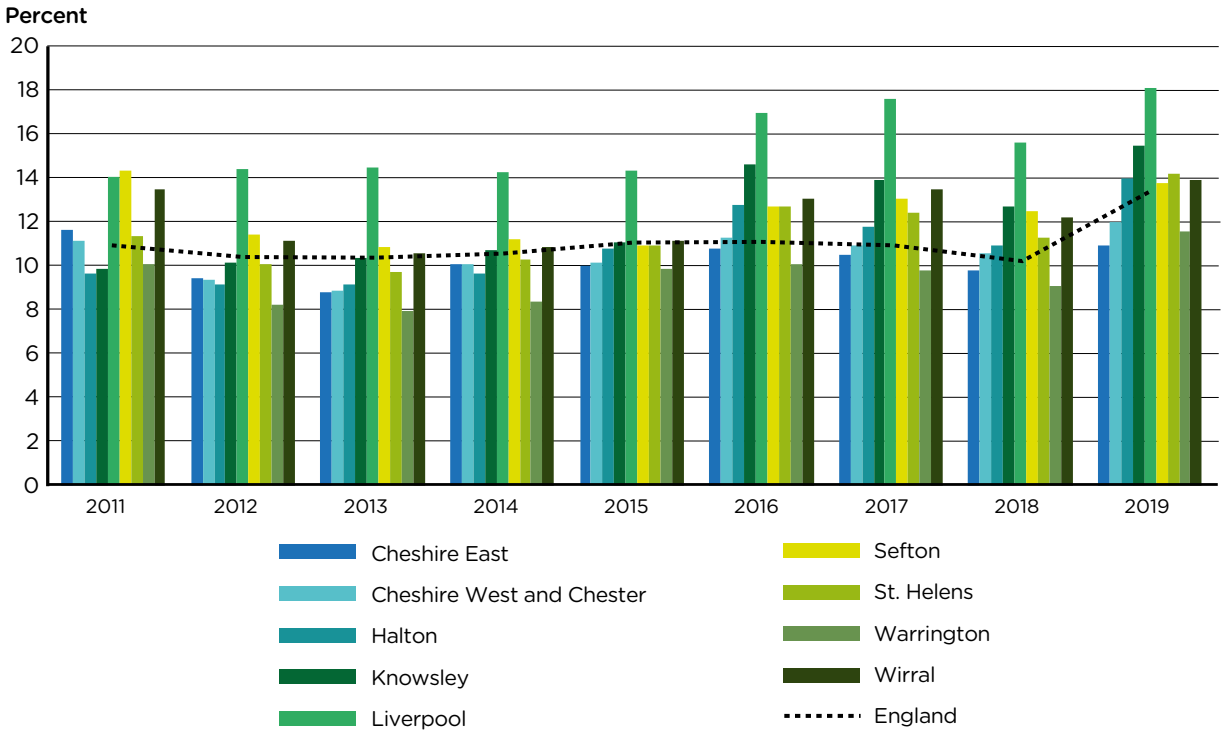
Figure 4.22. Fuel poverty, Cheshire and Merseyside lower-tier local authorities and England, 2019



Source: *Office for National Statistics (162)*

Figure 4.23 shows the persistent rates of fuel poverty in Liverpool and Knowsley as well as the rise in fuel poverty across the region since 2016.

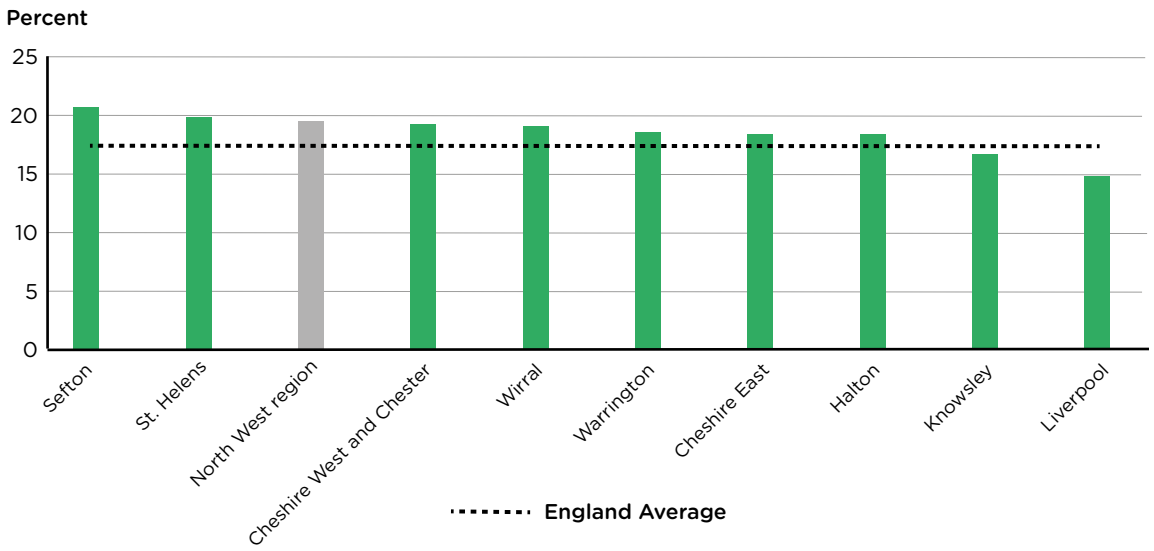
Figure 4.23. Homes in fuel poverty, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2011/19



Source: *Office for National Statistics (162)*

Living in a cold home, largely a result of fuel poverty and poor insulation, increases the risk of death. The Excess Winter Mortality Index (EWDs) is based on the number of deaths in December–March and the average deaths in the preceding August–November and the following April–July, expressed as a percentage. EWDs includes all deaths. IHEs analysis estimates that 21.5 percent of EWDs are due to living in a cold home (163). Figure 4.24 shows that seven of Cheshire and Merseyside's local authorities, EWDs are higher than the England average.

Figure 4.24. Excess Winter Deaths Index, Ratio, Cheshire and Merseyside lower-tier local authorities, North West region and England, August 2019 to July 2020



Source: *Office for National Statistics (164)*

Support for homes in council tax bands A to D in England are aimed at reducing energy bills in lower-income households and have provided local authorities with additional funding to provide discretionary support to low-income households as they deem appropriate. The minor increase in the warm home discount (WHD), from £140 to £150 will have limited impact on bills increasing by hundreds of pounds from 2022.

The increasing cost of energy has had immediate effects on fuel poverty. In the last three months of 2021, Citizens Advice reported that they offered support to 40 percent more people compared to the same period in 2020. In December 2021, they supported double the number of people who'd run out of money to top up their prepayment meter, compared to the same time last year (165). Some 32 percent were already cutting back on gas or electricity and as a result of increasing cost of living, while 53 percent were spending less on non-essentials and 26 percent were using their savings.

St Helens is taking a proactive way to address the effects of fuel poverty, Box 13.

Box 13. Fighting fuel poverty in St Helens

In St Helens an estimated 11,333 households were in fuel poverty in 2019. The St Helens public health and affordable warmth teams have been working together for a number of years to prevent and reduce excess winter morbidity and mortality by distributing a number of different packs targeting different populations. '"Winter Warmer" packs are given to people at risk of fuel poverty in the borough, and the teams use the adult health and social care 'clinically vulnerable' list to identify people aged 70 and over, or aged under 70 with a chronic health condition and health and social care needs. The pack contains a range of practical items such as gloves, hats, LED torch, hand sanitiser, pocket tissues, a reusable water bottle, a box of teabags with a message to look in on elderly neighbours. A calendar included in the pack contains information for people on how to stay safe, warm, and well in the winter months, including details of where and how to access available support.

In 2021 the teams also produced a "Winter Well" pack aimed at households who might be experiencing fuel poverty first time and may be unaware of the help that is available. The Winter Well pack was produced as a result of the economic impact of COVID-19, cuts to universal credit and the increase in gas prices, which has resulted in increased levels of fuel poverty and worse mental health.

The teams provided packs to 4,000 people aged 65 and over identified by St Helens Contact Cares, the integrated adult social care and health teams operating in the council, acute trusts and in the community. This pack contains information on respiratory hygiene to prevent spread of viruses, keeping distance where possible and keeping good ventilation. The packs also promoted the uptake of vitamin D. In winter, a quarter of all age groups in the general population are low in vitamin D (166). The teams worked with clinical commissioning group (CCG) colleagues and the local pharmaceutical committee to produce a voucher system to supply vitamin D safely. The voucher contained a QR code to exchange at one of six local pharmacies for vitamin D tablets. It is hoped a similar campaign promoting the uptake of vitamin D will take place next year.

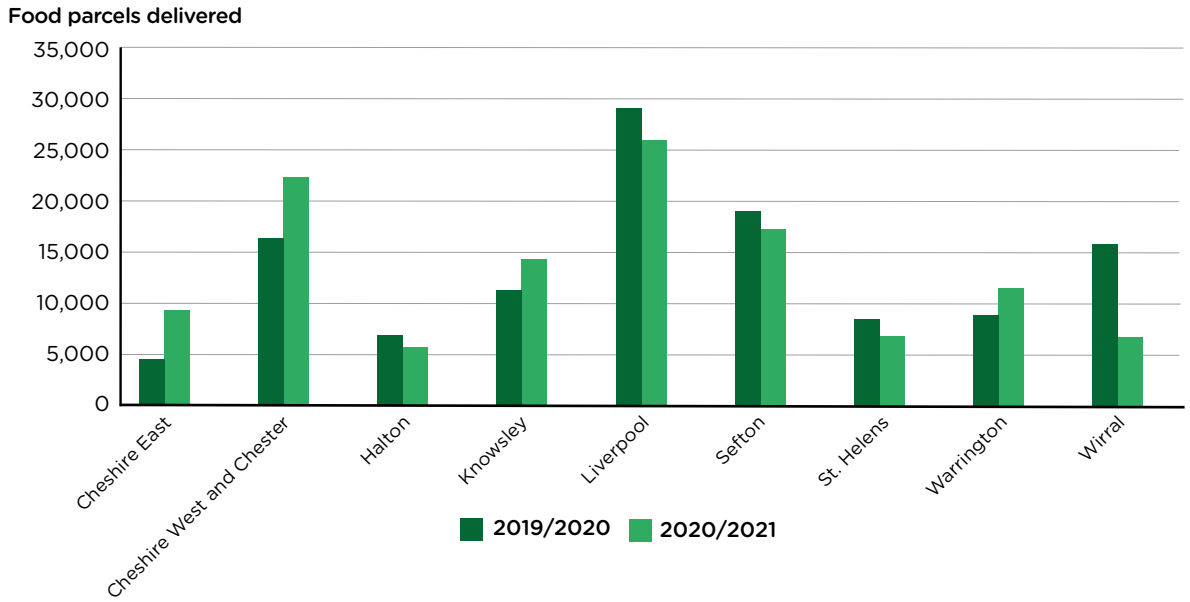
FOOD POVERTY

Measuring food poverty is difficult in the UK as the data is not routinely generated by government statistics, but 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.

Even before the expected increase in 2022, 4.7 million people were "food insecure" and unable to afford to eat properly (146). In the UK there remains a stigma around food security with people often waiting for long periods before reaching out for support, this also means that there may be underreporting of food security issues with many people not getting the support they need.

In Liverpool City region, one in five adults are understood to be food insecure (167). Figure 4.25 provides a partial picture of food poverty in the region but only shows the number of food parcels delivered by Trussell Trust food banks in Cheshire and Merseyside. Their valuable work takes place across the region, however there are a number of other local groups seeking to ameliorate food poverty Box 14.

Figure 4.25. Number of food parcels delivered by Trussell Trust, Cheshire and Merseyside lower-tier local authorities, April 2019 to March 2020 and April 2020 to March 2021



Source: *The Trussell Trust (168).*

Box 14. Reducing food poverty and maintaining dignity

Since 2015, Feeding Liverpool has been working to tackle hunger and food insecurity across the city. The charity draws on local knowledge and experiences to contribute to policy debates both locally and nationally. They are developing greater public understanding of food policy and related issues, sharing best practice in relation to good food and networking organisations, and are an example of residents and businesses working together towards a vision of creating a city where everyone can eat good food.

In the UK there remains a stigma around food security with people often waiting for long periods before reaching out for support this also means that there may be underreporting of food security issues with many people not getting the support they need.

Since July 2021, Feeding Liverpool has taken on responsibility for developing and driving forward Liverpool's Good Food Plan in partnership with communities and organisations across the city. The plan lays out five goals for the years ahead:

- **Goal 1** ensures that people in crisis can get access to good food quickly and easily.

- **Goal 2** assesses the true scale of food insecurity and introduces better food insecurity screening tools, to track how the problem changes over time and identify groups that are more at risk of food insecurity. Feeding Liverpool's two-question screening tool is simple to use and has a 97 percent sensitivity to identifying food insecurity.

- **Goal 3** encourages "food citizenship", which enables people to have the power, voice, and resources to shape their local food environments. Feeding Liverpool identified that people had little, if any, control over the food environment around them.

- **Goal 4** aims to influence policy to allow people to afford and access good food, including promotion of universal free school meals, promoting the Healthy Start Scheme and advocating for good employment practices.

- **Goal 5** seeks to connect and bring together a community of people and organisations with the goal of achieving good food for all.

The first phase of the Good Food Plan was co-produced with local residents to identify the challenges around access to good food identified in their local communities. The launch of the first phase in November 2021 was attended by over 300 people. Some £180,000 of funding was pledged to support the next phase of the Good Food Plan, and The Trussell Trust pledged to fund a three-year post at Feeding Liverpool to support the plan, and organisations, residents and businesses pledged support including committing to becoming living wage employers.

In 2022, Feeding Liverpool has focused on developing community food spaces across the city, supporting innovative ideas that promote access to good food, raising awareness of Healthy Start, encouraging community growing initiatives and undertaking listening work to identify areas where the city can improve access to culturally appropriate food (169).

The Warrington Food Network, established in 2021, is a partnership of community food providers, support providers and public sector representatives who have come together to tackle food insecurity across the town. The aims of the network are to develop sustainable, short- and long-term solutions to alleviate food poverty within Warrington; create a better understanding of the food provisions available across Warrington within both the VCFSE and public sectors; influence and tackle the underlying causes of food insecurity and develop strong links with connected support services; develop and promote a food support pathway; and use the collective knowledge and voice of the network to represent the community and influence change.

Warrington has a wide range of emergency food provisions, including both a Trussell Trust food bank and independent food banks and meal schemes. There are a growing number of affordable food provisions, including food pantries and food clubs, as well as community fridges. These are delivered by charities, community groups and faith organisations across the town.

The focus on developing additional affordable food provision has brought The Bread and Butter Thing (TBBT) to the town. This pop-up food club offers members from the local community three bags of food (chilled, cupboard, fruit and vegetables) for £7.50. Open to anyone, it provides access to good-quality food at a fraction of the usual price, saving members around £26 per week. There are currently two TBBT hubs within the town, with plans for an additional three hubs to launch by the summer (170).

The West Cheshire Food Plan has been in development by Cheshire West Voluntary Action since June 2020. The Food Plan was created in response to the emerging food needs during the COVID-19 pandemic and builds upon the work of the Welcome Network (Feeding West Cheshire), which has been funded by Cheshire West and Chester Council since May 2017. The Welcome Network brings together community groups, charities and local authority agencies in West Cheshire addressing the issue of food poverty.

The Welcome Network vision seeks to develop welcoming spaces for local people and agencies to come together around food; build networks and strengthening relationships with professionals, providers and the community; evidence local need and champion local voices to shape the policy required to create a fit-for-purpose food system. The Food Plan has been co-produced with members of the Welcome Network, members of Cheshire West Voluntary Action and attendees of the lived experience food focus group which emerged from the Poverty Truth Commission known as "Beans on Toast". The Food Plan has also been supported by a wider group of stakeholders known as the West Cheshire Food Partnership who have been meeting regularly since July 2021. The final version of the Food Plan is due to be published in June 2022 and it will be combined with a call to action for organisations and individuals to pledge their support and involvement in delivering the plan.

RECOMMENDATION: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Work with local residents and local stakeholders to understand "true" regional poverty and local financial pressures, including the reality of all care costs, in-work poverty, debt burden, tax credit and welfare reforms, benefits, and housing costs (such as through Poverty Truth Commissions). • Make the case to the VCFSE sector and local authorities to shift from only emergency provision to act on the social determinants of health. • Map social welfare and legal advice providers to facilitate development of registry of services for the NHS. ICS to support advice networks (such as Liverpool Access to Advice Network and Citizens Advice).	• Work with local community and employer institutions to provide credit, reduce levels of debt and increase financial management advice in schools and workplaces. • Shift from crisis to prevention approaches in delivering food security and have as a goal eliminating the need for food banks.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Define a minimum income for healthy living for the region. • Identify how primary and secondary NHS care can better refer to fuel and food insecurity support services.	• Monitor offer of minimum income for healthy living and include requirement to paying minimum income within commissioning contracts. • Collect and publish data on local employers paying minimum income for healthy living. • Support advocacy to increase national funding to eradicate all fuel and food poverty.

MARMOT BEACON INDICATORS

- Proportion of children in workless households.
- Percentage of individuals in absolute poverty, after housing costs.
- Percentage of households in fuel poverty.

4E CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

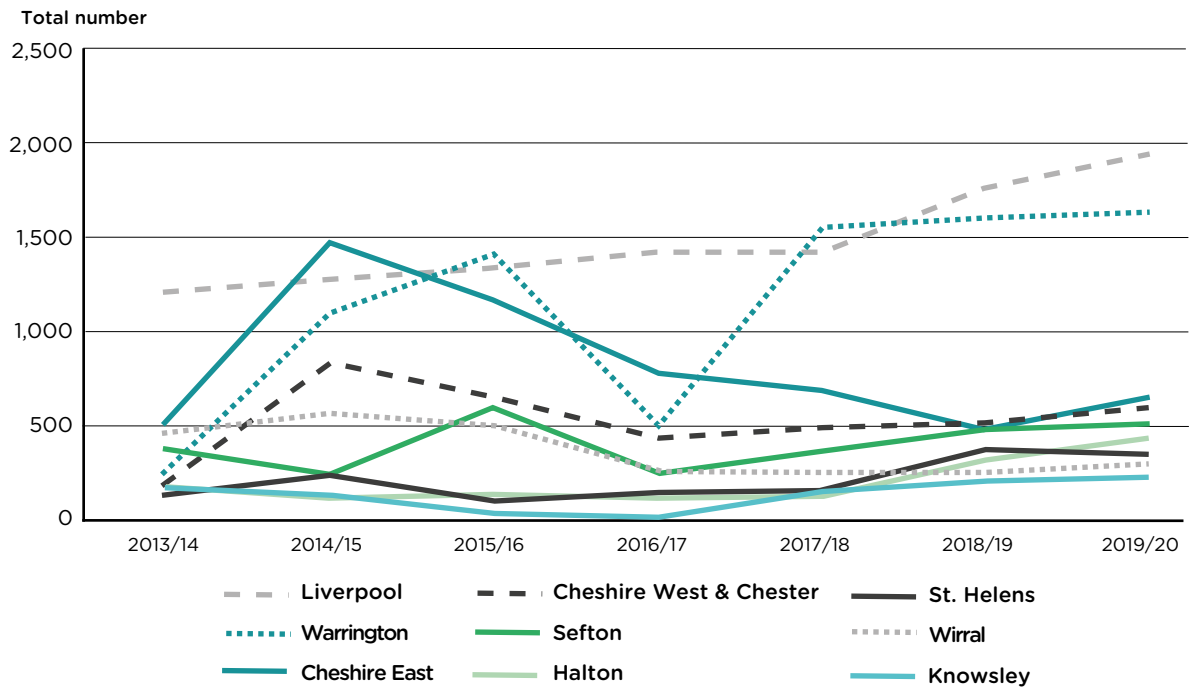
One of the most significant ways that healthy and sustainable places and communities can be forged is through quality housing and safe environments with good access to services, shops, community facilities, leisure and entertainment and good-quality natural environments. Cheshire and Merseyside comprises one of the UK's largest cities, as well as towns, rural areas and coastline and high levels of deprivation. Housing in the region includes areas with large concentrations of ageing and low-quality housing stock as well as pockets of poor-quality privately owned and rented housing.

HOUSING CONDITIONS AND COSTS

Poor-quality and overcrowded housing is harmful to health, widens health inequalities and inequalities in key social determinants of health (1) (2). A quarter of privately rented homes in England do not meet the decent homes standard, compared to 19 percent of owner-occupied homes and 13 percent of social rented homes (171). In the North in 2018, close to 1 million owner-occupied homes (24 percent of Northern households compared to 20 percent in England) and 354,000 private rented homes (26 percent of Northern households) did not meet the decent homes standard. Close to half of all non-decent homes in the North have at least one person with a long-term illness or disability (172). A quarter of private sector homes in the six boroughs of Liverpool City Region are over 100 years old with poor thermal efficiency. In Cheshire and Merseyside, 62 percent of all buildings have an energy performance certificate rating of D or less (173). The minimum energy efficiency standard regulations require all rented properties to achieve a minimum energy rating of Band E.

The deteriorating housing conditions prior to the pandemic, especially overcrowding, had a direct impact on COVID-19 infection and mortality rates. During lockdowns, households spent much of their time inside, increasing exposure to unhealthy and overcrowded conditions and adding to the stress of living in poor-quality housing. It is very concerning that the number of people living in insanitary, overcrowded, unsatisfactory housing conditions in Cheshire and Merseyside almost doubled between 2013/14 and 2019/20, with the highest number in Liverpool and Warrington, Figure 4.26.

Figure 4.26. Households occupying insanitary or overcrowded housing or otherwise living in unsatisfactory housing conditions, total number, Cheshire and Merseyside lower-tier local authorities, 2013/14 to 2019/20



Source: *Ministry of Housing, Communities and Local Government, , Department for Levelling Up, Housing and Communities (174)*

Poor housing conditions are affecting children's health in Cheshire and Merseyside. In 2022 the respiratory team at Alder Hey Children's Hospital are working with families to improve children's health in the long term and to give children the best possible chance to have their lungs develop as optimally as possible. They state that they "aren't just thinking of children now, we are thinking of them in decades to come', Box 15.

Box 15. Addressing housing conditions and reducing inequalities in respiratory disease

A team of respiratory paediatricians, specialist nurses, and Allied Health professionals at Alder Hey children's hospital are working together to advocate for individual children with respiratory difficulties, and their families. Suboptimal lung development in childhood predisposes children to early death in adulthood, and long-term problems such as chronic obstructive pulmonary disease (COPD). Children's living circumstances have a huge, lifelong, impact on the health of their lungs. For example, when children live in damp, dusty, mouldy, or overcrowded homes, their lungs are exposed to infections and allergens (such as those from house dust mite, cockroach, and rodents) that increase the likelihood of developing allergies, asthma, and lung damage. Children living in more deprived areas are more likely to miss out on certain protective factors, that help lung development, such as fresh fruit and vegetables, green space for exercise, and a comfortable night's sleep.

The team at Alder Hey children's hospital have adopted a number of actions including:

- Regularly phoning landlords, housing agencies and the council directly, explaining the urgency of good housing for children with respiratory problems. Phone calls are made during clinics, with the parent present. They have found this to be a powerful tool to help prioritise repairs or move families into new, more suitable accommodation.
- Setting up the world's first "children's clean air clinic", in which data about indoor and outdoor air quality is collected and correlated with a child's clinical story.
- The clinic focuses on empowering parents, at one level to use their houses better (with advice about cooking oils and kitchen extractor fans, home ventilation, where to place furniture, how to dry clothes to reduce humidity and so on); and empowering families to help them advocate for better housing for themselves.
- Working closely with community partners to develop exercise programs for children with asthma, and support them in any way possible to be active.

The team seeks to influence change as early as possible and has developed a model of care based in children's centres in deprived parts of the city. They have employed a group of mothers to work as "respiratory parent champions" and their role is to work with expectant and new mothers to identify and modify risks for their offspring's respiratory health - including making shared decisions based on up-to-date evidence around smoking, housing, breastfeeding, and stress. The team recognised that the credibility these mothers hold in their communities is different to what healthcare professionals and academics could offer, and has found these mothers' voices to be effective and powerful.

More recently, the team has sought to link their work to politicians and legal experts. For example, they are advocating for better regulation of industrial sources of air pollution, in particular landfill sites.

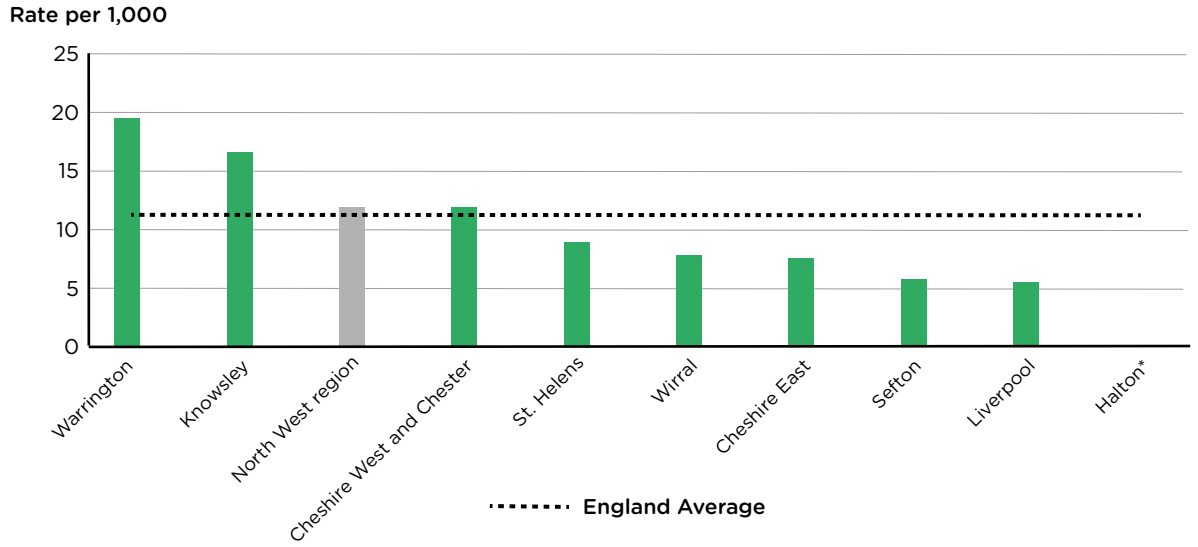
Unaffordable housing harms health, it increases stress and the risk of suffering from poor mental health; high housing costs lead to worse housing conditions, owner-occupiers are unable to make essential repairs and landlords have less incentive to improve conditions. Housing costs were increasing prior to the pandemic and the affordable homes budget available to local authorities has declined since 2010. Data from the Ministry of Housing, Communities and Local Government highlights a decrease in affordable housing of nearly 70 percent between 2010–11 and 2016–17, although it rose slightly in 2019/20 (1). The waiting lists for council housing are highest in Liverpool yet it is Cheshire West and Chester that has built the most affordable homes between 2010/11 and 2019/20 (175).

HOMELESSNESS AND ROUGH SLEEPING

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 (176). This definition includes those living in temporary accommodation, sofa-surfing and other forms of insecure housing as well as rough sleeping. During the COVID-19 pandemic, huge efforts were made to reduce rough sleeping and there were real achievements, which can be built on to ensure that all homelessness is reduced and the factors that drive homelessness are addressed (2). This includes increasing the supply of affordable housing, ensuring better-quality housing and implementing much tighter regulation of private sector rental housing including greater security to renters.

Warrington has the highest level of households owed a duty by local authorities to prevent homelessness in the region and both Warrington and Knowsley have higher levels compared to the England average, Figure 4.27.

Figure 4.27. Households owed a duty under the Homeless Reduction Act, rate per 1,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020/21

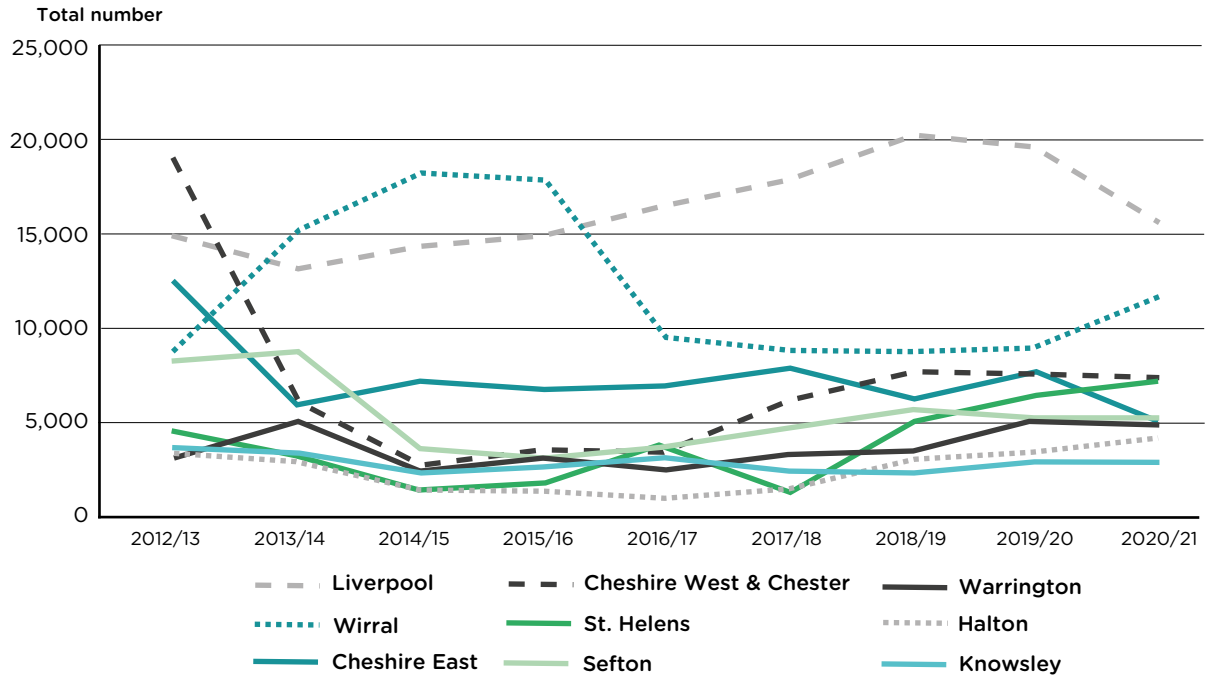


Notes: *Data not available.*

Source: *Ministry of Housing, Communities & Local Government (177)*

Local authorities control the allocation of council housing. Liverpool has the largest waiting list in Cheshire and Merseyside, and rates increased each year until 2019/20, then fell, as efforts to house people during the pandemic took effect, Figure 4.28.

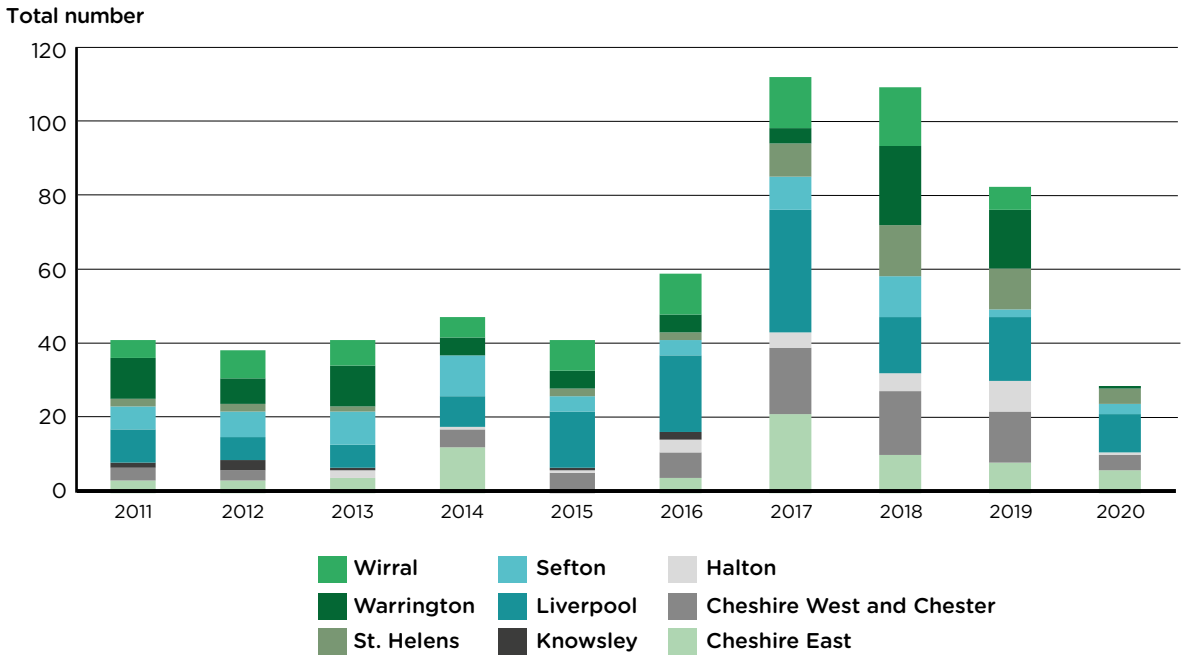
Figure 4.28. Households on housing waiting list, total number, Cheshire and Merseyside lower-tier local authorities, 2012/13 to 2020/21



Source: *Ministry of Housing, Communities & Local Government, , Department for Levelling Up, Housing and Communities (174)*

In the region rough sleeping reached a peak in 2017 and 2018 and since then has fallen significantly, particularly as a result of efforts during the early months of the pandemic, Figure 4.29.

Figure 4.29. Number of people estimated to be sleeping rough, Cheshire and Merseyside lower-tier local authorities, 2011-20



Source*: Department for Communities and Local Government (178)*

In the first weeks of the COVID-19 pandemic the government's 'Everyone In' programme funded local councils to provide additional support to those sleeping rough, Box 16 outlines how Warrington used this funding.

Box 16. Reducing number of people sleeping rough in Warrington

In Warrington, prior to COVID-19, various resources were available to address the needs within the homeless population, including two designated homeless hotels, properties utilised as temporary accommodation, and women's refuge supported accommodation. For people experiencing homelessness in Warrington, the impact of the pandemic has, and continues to be, significant. Measures such as self-isolation, testing and social distancing have been fraught with complexities, whilst existing health issues and clinical vulnerabilities have left many exposed. This in turn has caused significant pressures for frontline services and health and social care workers.

Despite this, there has been collaboration and resilience in Warrington during the pandemic within homeless services. Local services responded and adjusted and reported an unprecedented level of engagement and collaboration during this time. As part of the initial response to the pandemic in March 2020, the Warrington street homeless population were offered hotel accommodation as part of the "Everyone In" national campaign from March to June 2020. Thereafter the local authority, working with partners, devised new accommodation provision consisting of 22 units providing accommodation for up to 24 people. All those people in shared room space were given single rooms, as well as any new presentations to the Homeless and Housing Advice Service being placed there.

Afterwards, the council and partners were able to reconsider the needs of this group. The direct access beds were no longer required and a new offer of 22 rooms at Museum Street was launched in August 2020. Furthermore, hotel accommodation continued to be provided using local hotels. In addition, the Homelessness and Housing Advice Service assisted people to move into further accommodation building on from the "Everyone In" scheme:

- 10 percent were assisted into private rental accommodation.
- 10 percent were assisted to return to their former family home.
- 38 percent were assisted into social housing.
- 41 percent were assisted into supported housing.
- 1 percent had no recourse to public funds and were reconnected to their home country.

HIGH STREETS AND REGENERATION

A healthy high street supports good health, and unhealthy high streets undermine health – there are clear socio-economic inequalities in access to healthy high streets (1). Direct influences on physical and mental health arise from a lack of diversity in products and services on high streets, litter, high levels of traffic, crime and fear of crime, and inaccessible design. High streets can also affect health and worsen inequalities indirectly through rundown or inadequate communal areas, shelters, seating, and focal points, deterring people from visiting or spending time in high streets, potentially preventing community activities, and increasing the risk of social isolation and reducing the likelihood of community cohesion (179).

Increasing the number of takeaway food outlets may be regarded as a quick win for economies, but high takeaway food outlet concentrations can increase litter and anti-social behaviour, and the quality of their food, often energy-dense and nutrient-poor, makes them a public health concern. Increased exposure to takeaway food outlets is associated with greater odds of being overweight or obese (180).

A number of areas in the region have taken action to improve their high streets, including Sefton's Public Health team which has been involved with the regeneration of the Strand and Bootle High Street, Box 17.

Box 17. Planning healthier and more equitable spaces in Sefton

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

People living in this part of Sefton are more likely to have multiple long-term physical and mental health conditions, and to experience the impact of these earlier in life. Indicators from ward profiles highlighted other local issues, such as a higher number of people living alone, and most households not having access to their own vehicle. Whilst this part of Bootle has substantial green and blue space assets, it is also situated close to Sefton's air quality management areas and air pollution is a health concern for many in these communities. Applying a health determinants perspective helps to ensure that improvement schemes work for the needs of local people and create enriching environments for everyone to enjoy.

In 2021 work to identify options to revitalise the Strand and surrounding area continued and have been complemented through more recent input from Public Health into the Bootle Area Action Plan. This includes a pilot initiative launched when Sefton Council was selected as one of 14 areas to test out the multi-disciplinary approach behind the government's new national model design code, which aims to help planners and communities work more collaboratively to design good-quality built environments. Work to date has gathered in a broad range of health considerations from active travel barriers, to housing needs of people with long-term health conditions, the socio-economic determinants of obesity, options for maximising social value returns, policies that could bring more focus to local income inequality, and the importance of respecting the distinctive qualities of place that foster a sense of belonging and community. The first stage of community consultation on the Our Future, Our Bootle Area Action Plan was live until January 2022 (181).

One of the early successes from the workshops held during IHE's work programme in the region was in Halton, where a meeting was held between the Public Health senior management team and Halton's regeneration team to explore opportunities for collaboration and closer working. Decisions made resulted in Public Health consultants and the regeneration team meeting monthly to understand existing opportunities to work together. The director of public health will continue to attend quarterly regeneration meetings and provide input into the chief officer's management team. The teams will also share intelligence and a memorandum of understanding will be drafted to outline ways of working between the two teams in the future.

GOOD-QUALITY GREEN SPACES

Access to good-quality green space improves mental and physical health, improves community cohesion and also supports actions to mitigate the effects of climate change and protect biodiversity (182) (9). Green spaces have been shown to improve cognitive and immune functions and to reduce mortality rates and health inequalities (183). Access and use of good-quality green spaces tends to reduce as the level of deprivation increases, which was highlighted during the pandemic. Parks and green spaces are powerful tools to improve health and wellbeing, it is estimated they save the NHS £111 million per year in the UK, as a result of reduced GP visits (184).

There are reported differences in how ethnic minority populations use green spaces. A study of participants in England found people of Indian origin were most likely to visit their local urban green space to walk and be accompanied by someone. People of African-Caribbean, Bangladeshi, Pakistani origin and "other" ethnic minority populations were much less likely to visit green spaces compared with White groups and this was particularly pronounced in people of Bangladeshi origin, they were also less satisfied with urban green space quality (185). Actions must be made to ensure these ethnic inequalities are reduced and ethnic minority groups are encouraged to use green spaces in ways which are relevant and appropriate.

In the first lockdown in March and April 2020, people could only engage in one form of exercise for an hour outside of the home per day. A study of the use of green spaces in the UK during the first lockdown found people from areas of higher deprivation were less likely to visit green spaces before and while lockdown restrictions were introduced (186). In addition, there were inequalities associated with ethnicity in terms of who had access to private outdoor spaces. In England, 37 percent of Black people in 2020 had no access to outdoor space at home (private or shared garden, a patio or a balcony), compared with 10 percent of White people (187).

Mersey Forest NHS is working to improve access to green spaces to improve health, wellbeing and reduce inequalities in Cheshire and Merseyside, Box 18.

Box 18. The Natural Health Service in Cheshire and Merseyside: the Mersey forest

Mersey Forest's Natural Health Service was launched in 2015 and aims to use the natural environment to improve health and wellbeing across Merseyside and North Cheshire. The service uses parks, woodlands, and other green spaces to deliver a series of interventions aimed at preventing physical and mental health conditions and addressing local health inequalities. Access to green spaces and natural environments have been proven to support individuals in improving and maintaining health and wellbeing; being a regular greenspace user is associated with 4.2 percent greater likelihood of reporting good health.

The service consists of five evidence-based "products" or intervention pathways.

- Health walks, designed to help meet target exercise and activity levels whilst improving wellbeing.
- Horticultural therapy, consisting of gardening and food growing in a social setting to improve mental wellbeing.
- Mindful contact with nature, which has been shown to increase capacity to self-manage long-term chronic conditions.
- Forest school, targeted at young people, with the aim of increasing physical activity and improving mental wellbeing, through positive outdoor experiences.
- Healthy conservation, which can improve participants' strength and stamina, teach new skills and improve confidence.

These pathways are delivered in eight-to-12-week blocks with a range of delivery partners providing support including local businesses, community interest companies, local authority projects, housing associations and charitable trusts. The pathways are available to the NHS, local authorities, and other commissioners, as part of a holistic approach to health and social care.

3,714 people participated in the Natural Health Service project in the period 2015-20. Some 59 percent of participants were known to be in education, 20 percent were retirees, 14 percent in employment, and 7 percent were unemployed. 6 percent reported having a disability and 4.4 percent reported having further health issues. Valuations of the Natural Health service have found that, based on public sector cost savings and social, productivity and economic benefits, the service delivers a return on investment of £12.18 for every £1 spent (188) (189).

RECOMMENDATION: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Review private rented sector regulation actions in the Levelling Up white paper. • Support national advocacy to strengthen local powers and capacity within enforcing authorities across planning and housing. • Define affordable housing in Cheshire and Merseyside and link to "true" regional poverty. • Create a platform where housing and local residents can communicate about how housing is impacting on health and wellbeing. • Develop place-based partnerships to strengthen approaches to community policing (such as public and mental health, police, DWP, children's service), and develop a public health approach to violent crime. • Work with local residents and partners (such as businesses and the NHS) to improve quality of existing green spaces in areas of higher deprivation. • Develop region-wide actions to create health promoting environments (unhealthy advertising and planning decisions, for example). • NHS, local government work in partnership to regenerate areas. Work alongside local communities to better include their needs when reviving local high streets. • Extend incentives to encourage people back to public transport.	• Work in partnership to implement adoption of decent home standards in all social and private rented sector housing. • Ensure that all housing developments contain a minimum of 30 percent of dwellings classed as "affordable" and support local control of the local housing allowance and ensure it covers 50 percent of market rates. • Prioritise provision of new green spaces in areas of higher deprivation. • Adopt city-wide strategies that put health equity and sustainability at the centre of planning. • Develop and implement housing and social conditions assessment to be used in primary and secondary health care appointments and develop monitoring of these questions.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Appoint senior role in housing and health in ICS (including homelessness and rough-sleeping). • NHS to scale up provision of services and invest in preventing street homelessness and work with the VCFSE sector and local authorities. • Partner with NHS and local government, housing and tenant associations to assess housing standards in the private rented sector. • Develop health and wellbeing checks for people living in temporary accommodation and appropriate referral pathways (such as housing services, social welfare advice and employment).	• NHS to coordinate investment and action to take a leading role in strengthening partnerships with the housing sector, including the private rental sector and local residents.

Responsible: Liverpool City Region Combined Authority	Responsible: Cheshire and Warrington Travel
• Health equity assessment of Liverpool City Region additional transport investment and new proposals to create "London-style" transport system. Share findings with Cheshire and Warrington.	• Health equity assessment of transport provision in Cheshire and Warrington to support Cheshire and Merseyside approach.

MARMOT BEACON INDICATORS
• Households in temporary accommodation.

4F STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

Primary prevention and shifting to a social determinants of health approach is an opportunity to shift from managing and treating ill health at great cost to individuals and the public purse, to improving health and wellbeing and reducing inequality.

While recent moves from NHSE and the establishment of integrated care systems do offer opportunities for greater focus on prevention, the prevention agenda must be more than prevention of unhealthy behaviours but focus far more on the causes of those behaviours – the social determinants of health. Health behaviours are closely related to the social determinants of health and across the UK there are higher rates of smoking, obesity and harm from alcohol in lower socio-economic groups and among those living in the most deprived areas (1).

A social determinants of health approach to health behaviours involves working in partnership with the VCFSE sector and local authorities and delivering services in more accessible places. Cheshire Fire and Rescue Service's Safe and Well initiative addresses key health behaviours, meeting people in their homes, Box 19.

Box 19. Improving health at home: The Cheshire Fire and Rescue Service

The Cheshire Fire and Rescue Service (CFRS) have been performing Safe and Well home visits since February 2017 with the aim of addressing key local health priorities. In the first phase of Safe and Well, the health behaviours targeted were bowel cancer screening, falls prevention, and smoking and alcohol prevention.

Safe and Well visits help people to look after themselves and stay in their own homes safer for longer. As part of the service, CFRS staff identify people who are at risk of falling and can either give advice or refer on to the relevant service. Some 2.6 percent of visits resulted in a referral to a health agency in the year from April 2019 to March 2020. In this period, the CFRS performed 32,443 visits, including 2,980 atrial fibrillation screenings, 832 blood pressure tests taken, 3,166 loneliness and isolation screenings, and 104 affordable warmth referrals.

The groups who are at greatest risk of death or injury from fire are often the same groups at risk of other health concerns, such as older people, people living with disabilities, people living alone, and those who smoke or binge drink. Fire service staff are in a unique position in that they have a high degree of access to these groups and are well placed to successfully implement prevention and risk reduction strategies (190).

One of the key policies the Champs Public Health Collaborative is supporting to strengthen population health within the NHS is the NHS Prevention Pledge. The NHS Prevention Pledge aims to ensure prevention is embedded across all NHS providers across Cheshire and Merseyside. This work also involves helping NHS providers to become anchor institutions and system leaders in prevention. The Cheshire and Merseyside NHS Prevention Pledge was developed following extensive stakeholder consultations by the Cheshire and Merseyside Health and Care Partnership in collaboration with the Health Equalities Group (HEG) and the Champs Public Health Collaborative.

The Prevention Pledge serves to act as a facilitating tool to support prevention within secondary and tertiary care, as well as to support Trusts to recognise how environments and services can be shaped to support good health and reduce health inequalities. The NHS Prevention Pledge is a system enabler and mechanism to incorporate ill health prevention within secondary and tertiary care and support Trusts to transform services and environments to promote good health, reduce inequalities in chronic disease development and life expectancy. The Prevention Pledge includes 14 core commitments for NHS Trusts to universally undertake to support a healthier workforce, patients, and wider communities through encouraging changes to diet, physical activity, smoking and alcohol use, promoting mental wellbeing, welfare advice, and social value practice. Initially two Trust sites were selected for the pilot and testing of the Pledge, in 2021 these pilots were extended and the Prevention Pledge was rolled out to nine Trusts in Cheshire and Merseyside (191).

DIGITAL INCLUSION

Digital tools are increasingly being used to improve ill health. The COVID-19 pandemic showed the importance of digital platforms as well as revealing persistent inequalities in access to technology, and as more services shift online, digital inclusion will become increasingly important. Lack of access during the pandemic was often a result of cost (being unable to afford the hardware and data charges) and also poor digital literacy, particularly amongst older populations. This has had impacts on education for young people as well as excluding or making it very difficult for others to have access to health care and a range of other online services such as employment opportunities, skills training and access to resources and information (192) (193). The pandemic has significantly accelerated the shift to online usage for many day-to-day interactions including shopping, contact with health services and other public sector organisations, and social interactions with family and friends. Although this has forced some people to become more digitally active, there is evidence that those unable to be online have become more excluded.

In Cheshire East the Digital Inclusion Taskforce is a partnership of organisations working together to reduce digital exclusion, and Liverpool 5G are helping to reduce digital exclusion from lack of access to affordable broadband, Box 20.

Box 20. Cheshire East Digital Inclusion Taskgroup

The Cheshire East Digital Inclusion Taskgroup (CEDIT) group was established in 2017 in response to the Connecting Cheshire broadband rollout initiative. It was recognised that there would be people who were digitally excluded for reasons other than lack of connectivity and that Cheshire East needed to better understand the issues and work together on solutions to increase digital inclusion. CEDIT's focus will be to better understand who has been left behind and what can be done in partnership within the Cheshire East Place to support people to become digitally included.

CEDIT has membership from different parts of Cheshire East Council (public health, community development, libraries, adult services, environmental services and the web team), Cheshire Clinical Commissioning Group, the VCFSE sector and a volunteer "IT buddy". Initially the group undertook mapping and information-gathering to understand the local context and what might be necessary to overcome barriers to digital inclusion.

The first Cheshire East Digital Inclusion Strategy and Action Plan was published in January 2019, endorsed by the Cheshire East Health and Wellbeing Board as part of its approach to reducing inequalities. At that time, 14 percent of the borough's adult population had not been online in three months and 21 percent of adults lacked the five basic digital skills (communicating, transacting, problem-solving, creating and managing information).

The four main challenges to being online were:

- **Access** – the ability to go online and connect to the internet.
- **Skills** – to be able to use the internet, for example to apply for jobs, access information or pay bills and buy things.
- **Motivation** – knowing the reasons why using the internet is useful.
- **Trust** – a fear of cybercrime and invasion of privacy.

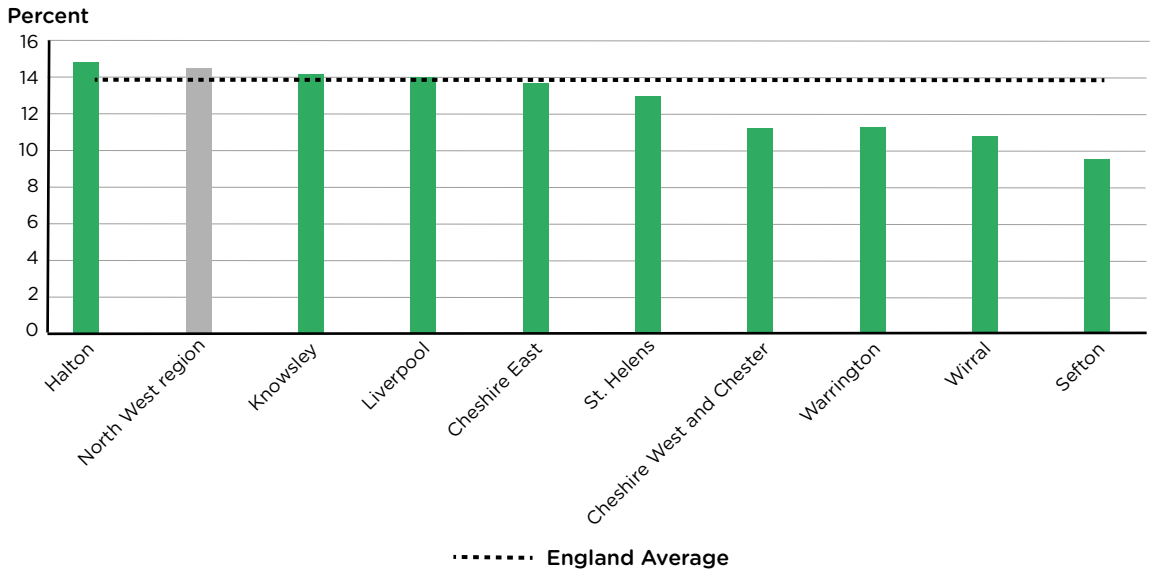
The partnership decided to more effectively join up and connect the existing interventions that were helping people. These included accessing the People's Network, and being supported by IT buddies in the Cheshire East libraries, for example to complete the Good Things Foundation online skills courses; the "I Tea and chat" sessions within the Connected Communities Centres (informal sessions helping people with their own digital device or using loaned devices to help people become familiar with what they can do); and device loan schemes from some of the local VCFSE sector organisations. The group is now in the process of updating the strategy.

Liverpool 5G, a consortium of public sector health and social care suppliers, is developing a civic private 5G network to provide free connectivity for health, social care and education purposes and to reduce digital poverty. They are working with Liverpool City Council and local NHS partners to deploy an independent standalone 5G network in Kensington. Local lampposts and key buildings host a mesh network and this provides connectivity into people's homes irrespective of whether they have a broadband connection. They supply and maintain the network and do not charge residents and there are no restrictions on data. Currently telehealth and telecare devices are being connected and they are working with a local primary school to enable the pupils who live in the area to connect to our network when they are at home (194).

SMOKING

There is a close link between smoking and inequality, and a North-South divide in England in smoking prevalence. UK smoking rates also vary by ethnicity, where the highest smoking rates are in the Mixed group and the lowest in Chinese, Asian and Black population groups (195). Figure 4.30 shows overall smoking rates in local authorities in the region compared with the English average in 2020.

Figure 4.30. Smoking prevalence among adults aged 18 and over, Cheshire and Merseyside lower-tier local authorities and England, 2020



Source: *GP Patient Survey (GPPS) (196)*

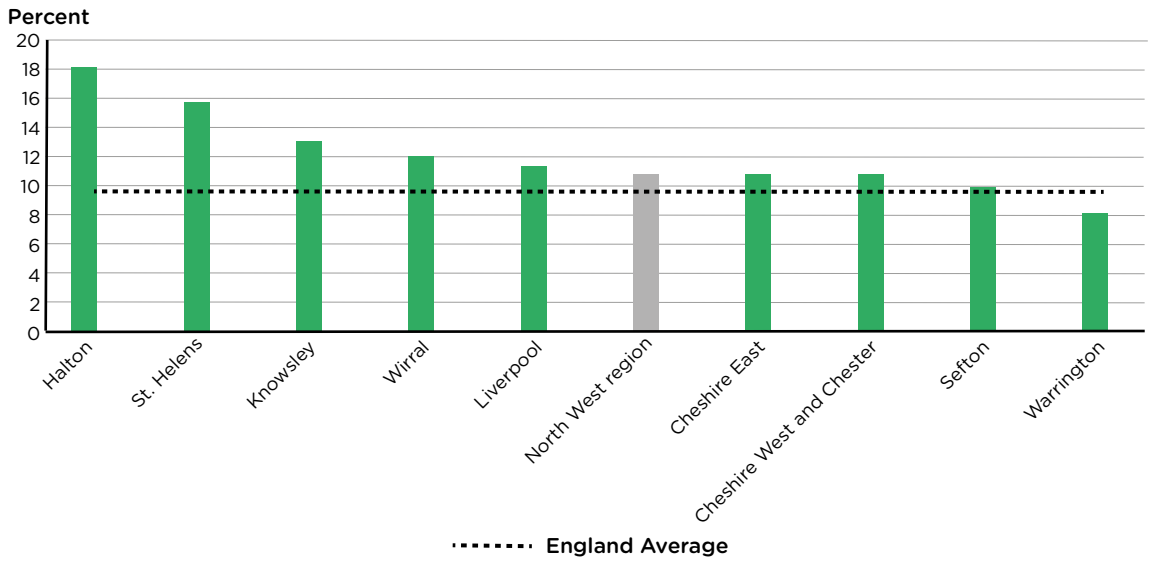
Figure 4.31 shows the relationship between deprivation and smoking prevalence in the region.

Figure 4.31. Smoking prevalence among adults aged 18 and over by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20

Source: *GP Patient Survey (GPPS) (196)*

Cheshire and Merseyside have comprehensive system-wide programmes targeting routine and manual groups to quit smoking. The targeted strategies also include programmes to support pregnant women to quit smoking. These additional interventions are needed in Cheshire and Merseyside where seven local authorities have smoking rates at the time of delivery above the England average (Figure 4.32).

Figure 4.32. Smoking rates at time of delivery, percentage, Cheshire and Merseyside lower-tier local authorities, North West region, and England, 2019/20

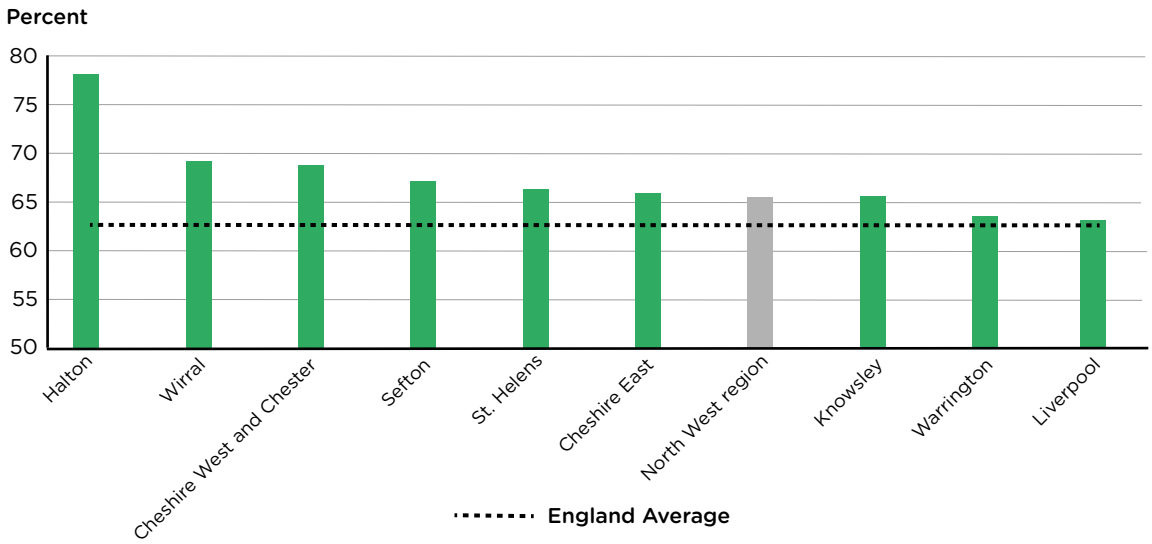


Source: *NHS Digital (197)*

OBESITY

Prior to the pandemic, the overall prevalence of obesity was increasing in Cheshire and Merseyside. Halton's rate of overweight or obesity, 78 percent, is the highest in the region. In 2019/20 there were higher rates of overweight or obesity in all of Cheshire and Merseyside's local authority districts compared to the England average, Figure 4.33.

Figure 4.33. Percentage of adults 18+ overweight or obese, Cheshire and Merseyside lower-tier local authorities and England, 2019/20

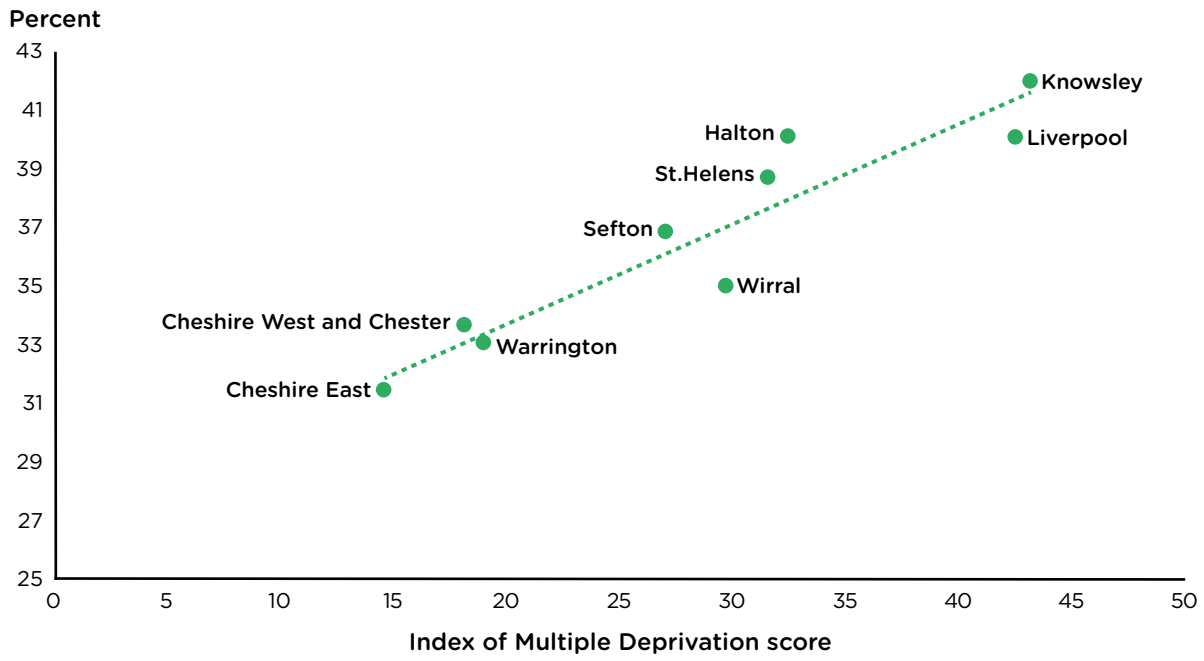


Source: *Sport England (198)*

Obesity disproportionately affects some ethnic minority groups as well as individuals with disabilities or mental health problems. Since 2015/16 Black adults have the highest percentage of overweight or obesity out of all ethnic groups in England (199). Obesity and diabetes are closely related to deprivation across England (200).

Figure 4.34 shows that there is also a close relationship between deprivation and overweight and obesity in year six children in Cheshire and Merseyside.

Figure 4.34. Year 6: Prevalence of overweight (including obesity) by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20

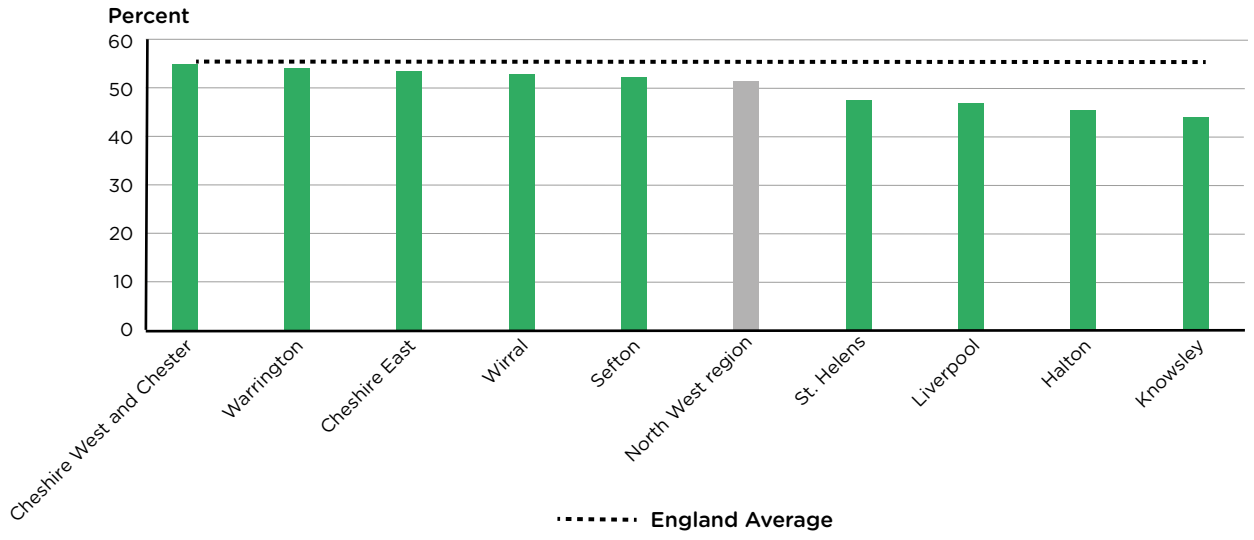


Source: *NHS Digital, National Child Measurement Programme (201)*

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, on average, by 53 percent between 2010/11 and 2016/17 with higher spending cuts in the most deprived areas. In these areas, funding decreased by £422 per child but 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 that there were an additional 4,575 children with obesity and 9,174 overweight or obese compared with expected numbers had funding levels been maintained (18).

Figure 4.35 shows that in the areas with higher rates of obesity, rates of good nutrition are lower.

Figure 4.35. Proportion of the population meeting the recommended 5-a-day on a usual day, adults, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20

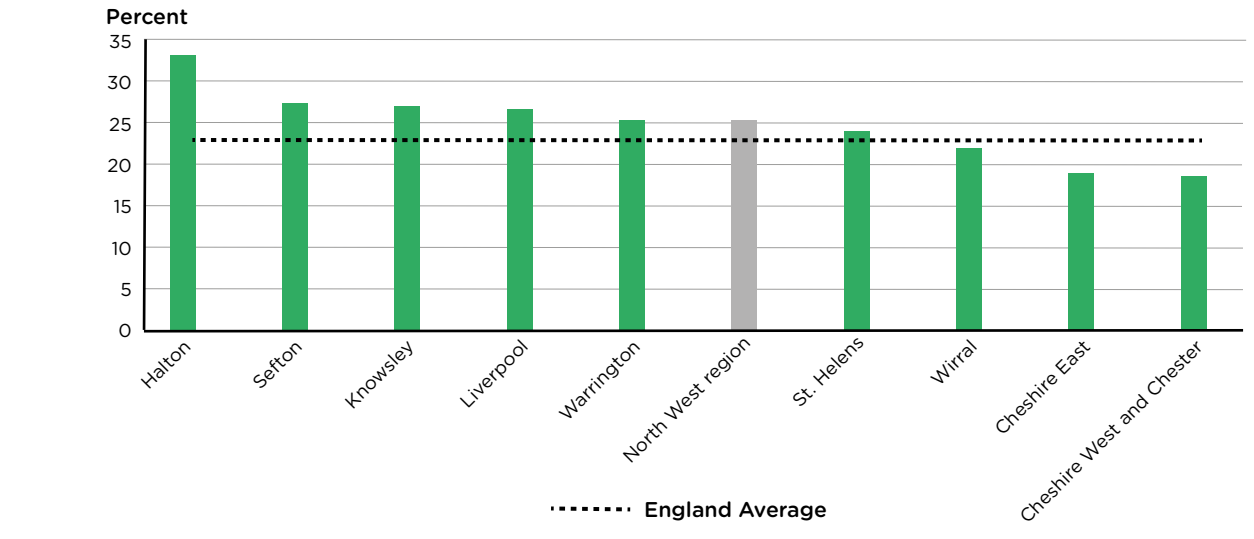


Source: *Sport England (198)*

PHYSICAL INACTIVITY

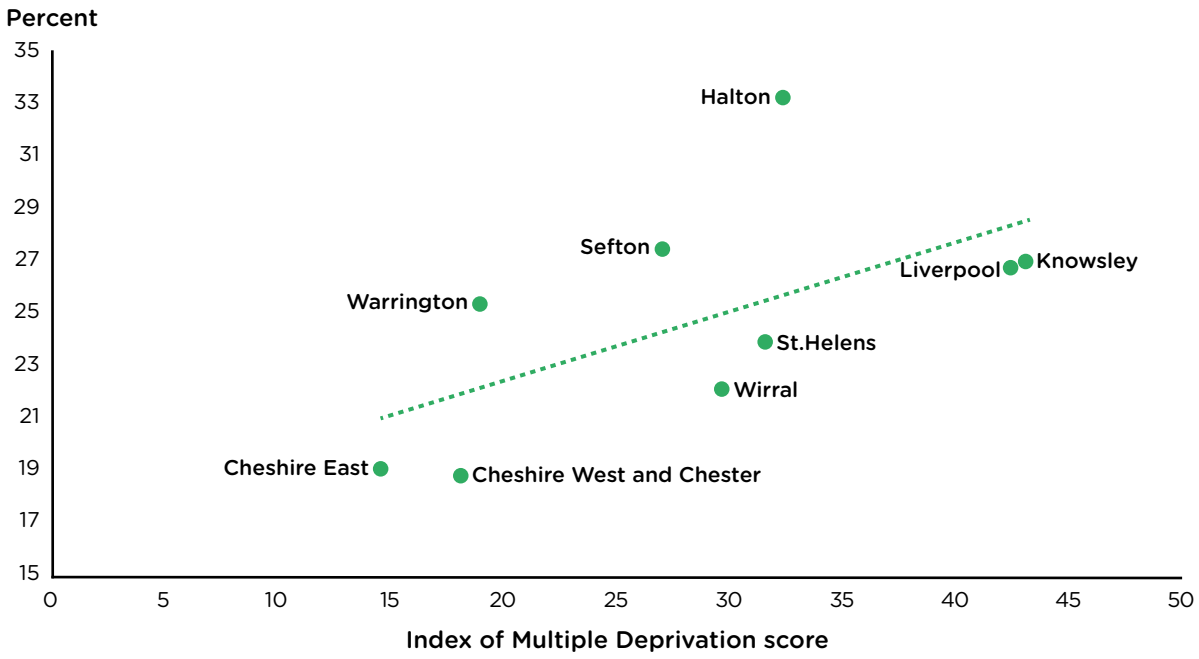
Physical inactivity is the result of a number of factors, many of which are present in more deprived areas: high levels of ill health and disability; lack of funds to pay for physical activity; low levels of access to green spaces and lack of active travel infrastructure. Figure 4.36 shows the high percentage of physically inactive adults and Figure 4.37 demonstrates the strong relationship between physical activity and deprivation.

Figure 4.36. Percentage of physically inactive adults, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *Sport England (198)*

Figure 4.37. Percentage of physically inactive adults, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *OHID (202)*

The cuts to local government have had a significant impact on access to sport and leisure spaces as councils are the biggest investor in sport, leisure, parks, and green spaces, spending £1.1 billion per year in England (9). Some 72 percent of schools use public swimming pools to teach children how to swim. When the cost of using public leisure facilities increases, it means that opportunities, for example to learn how to swim, are made much more difficult for those on low incomes (203). During the pandemic, levels of physical activity reduced across England and there were higher drops in physical activity for people on lower incomes and people with mental health problems (204).

Box 21 outlines the work of Active Cheshire, who, along with Merseyside Sport Partnership (MSP), offer support to a range of organisations seeking to increase physical activities in all local residents. Sport England has committed to transforming the lives of England's communities, and its 10 year vision, Uniting the Movement, focuses on tackling health inequalities (205). With Active Cheshire and MSP funded through Sport England, their role as active partnerships is to apply this strategy at a local level and to develop a physical activity strategy for the region and work in partnership with the Cheshire and Merseyside Health and Care Partnership.

Box 21. Active Cheshire Ellesmere Port and Neston Special Olympics

Ellesmere Port, Chester and Neston Special Olympics (EPCNSO) is a charity which offers sporting and social opportunities for individuals with learning difficulties and individuals who do not fit into mainstream sporting activities. Prior to the pandemic, the charity delivered weekly Saturday morning and Monday evening sessions. Active Cheshire funded a project from their Tackling Inequalities Fund from August to November 2021. This project aimed to increase physical activity and wellbeing for individuals with disabilities, create inclusive activities for participants who do not attend conventional sporting activities, and to create a safe environment for socialising after COVID-19.

The project took place over three phases. Firstly, the group met online and six weeks of online sporting challenges were delivered to encourage members to reengage in physical activity. Secondly, a series of walks in local parks were arranged. Some members were nervous about returning to group activities and the gentle reintroduction in a safe and open environment, with no expectation around fitness or ability, eased the return. Finally, the group worked towards returning to the new normal with sessions tailored around fun and enjoyment.

The virtual sessions were a lifeline for many of the members of EPCNSO, giving them routine and the opportunity to keep in touch with friends. This, as well as the encouragement and opportunity to keep active at home, helped to support members with their mental health. The virtual sessions also helped to reengage old members. Members also ended up trying new sports which they had not tried before.

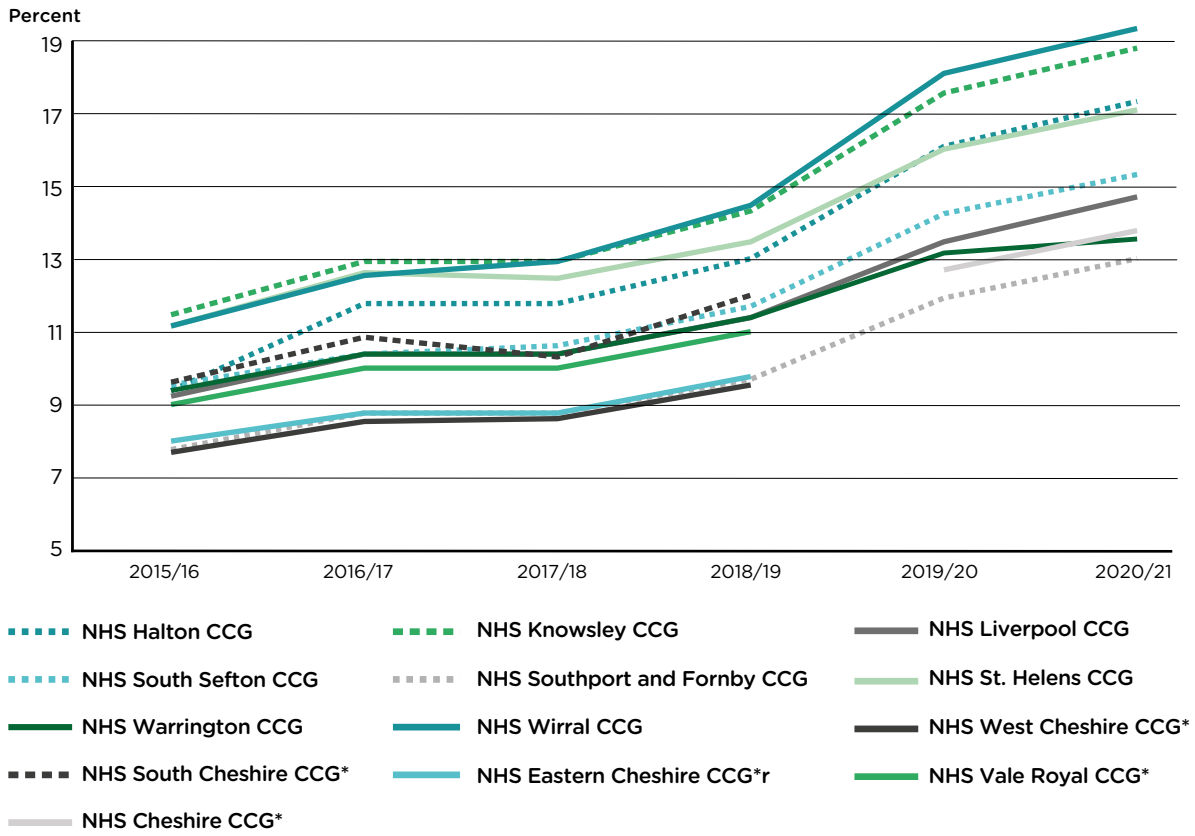
There are currently 70 members of EPCNSO and 10 volunteers. All the members of EPCNSO have learning disabilities and many experience complex challenges especially relating to mental health. Many of the members are also from low-income families. The group provides a vital opportunity to develop skills, build friendships, and stay active and well.

MENTAL HEALTH

In the summer of 2021, 17 percent of adults in Britain experienced some form of depression, a decrease since early 2021 but still above pre-pandemic levels, which were at 10 percent. Levels of satisfaction and happiness were also lower in 2021 and levels of anxiety higher compared to pre-lockdown levels (112). The increasing rates of poor mental health have had a significant impact on the NHS. Wirral's Public Health Annual report in 2020/21 stated referrals to its psychological therapies increased by 43 percent between 2019/20 and 2020/21 (comparing a single month) (206). A quarter of all GP appointments in Cheshire and Merseyside are for a mental health issue (207)

While the pandemic damaged mental health, rates of depression were increasing across Cheshire and Merseyside before 2020, Figure 4.38.

Figure 4.38. Trend in the prevalence of depression recorded for QOF purposes, in people aged 18 and over, Cheshire and Merseyside CCGs, 2014/15*–2020/21



Notes: *NHS Eastern Cheshire, NHS South Cheshire, NHS Vale Royal and NHS West Cheshire merged into Cheshire CCG on 1 April 2020. 2014-2019 QOF results for the four areas are combined into NHS Cheshire CCG. QOF is the Quality Outcomes Framework, the payments system for general practice.*

Source: *QOF (208)*

The Life Rooms project in Liverpool adopts a social determinants approach to address the causes of poor mental health, Box 22. It is a socially focused model that encourages the health system to shift its focus to the wider determinants of health and address problems related to social exclusion, poverty, unemployment, lack of education and opportunity, poor housing conditions and fuel poverty, digital exclusion, poor mental health and difficulties engaging with healthcare services.

Box 22. Life Rooms: addressing the social determinants, the NHS and local partners

Mersey Care NHS Foundation Trust launched its Life Rooms social model of health in May 2016.

The Life Rooms is an innovative community-centred service, and its main aim is to improve population health, based on a social and preventative non-clinical approach that integrates public, private and VCFSE sector services through the facilitation of existing and developing community-based assets.

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

The initial evaluations of the impact of this model indicate potential cost-savings, saving 41,000 hours of GP time each year and saving costs equivalent to £13 million if expanded across the Liverpool City Region.

The Life Rooms aims to offer a seamless pathway of advice, support and care where people are not required to navigate multiple complex systems based in different places.

Collaborative and cross-sector partnerships are central to The Life Rooms model and they work with more than 120 community organisations. The main collaborations are VCFSE sector organisations supporting people with practical and social issues (housing or benefits, for example); clinical and statutory services (primary care teams, integrated care teams, community mental health teams, and social care practitioners); and local people and communities themselves to deliver what is needed and wanted.

They adopt a social model to support the prevention and population health agendas and to support each person to become motivated to improve their own health. The model includes the following three pillars:

- **Learning:** delivering a wide range of evidence-based learning opportunities offering support in relation to mental and physical health as well as cultural and creative opportunities. Courses promote social inclusion and focus on lived experience as a key part of learning.

- **Social prescribing:** practical and social one-to-one support in areas such as employment, housing, debt. Individuals are connected to a wider system of community assets, including the VCFSE sector, and clinical or social care services.

- **Inclusion:** listening to communities to understand need and aspiration. Offering welcoming environments and opportunities for collaborative working with the community and individuals to co-design and embed culturally informed approaches to improved life and health outcomes.

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

- **Pathways adviser support (social prescribing)** - practical and social support in areas such as employment, housing or debt.

- **Learning** - courses offering support in relation to mental and physical health as well as cultural and creative opportunities. Life Rooms offer learning opportunities that support people with their mental health needs including courses that focus on understanding and managing conditions like depression and anxiety delivered in non-clinical setting.

- **Social activities** - informal groups promoting social inclusion and relationship building.

- **Employment support** - clear routes to employment, including training and work placement opportunities, support with job searches, CV-building and all areas of seeking and gaining meaningful employment.

- **Volunteering** - opportunities to build confidence and responsibility through volunteering opportunities within The Life Rooms or in the wider community.

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

In 2022 Liverpool City Council Public Health and The Life Rooms developed a pilot to offer a community-based mental health prevention offer to support individuals and communities affected by the COVID-19 pandemic. The pilot will operate for a 12-month period and tackle risk factors for poor mental health, self-harm and suicide as well as enhancing existing services to meet the needs of residents with low-level mental health conditions. The pilot will offer support to all ages and will be family-orientated. As part of the pilot, a £700k-fund will develop a series of projects from the VCFSE sector with projects focusing specifically on mental health and family wellbeing; social isolation and improved relationships; employability and physical activity in mental health (209).

Part of improving mental health is reducing loneliness, and the Connect Us project has been improving access to health and wellbeing as well as reducing isolation in Wirral, Box 23.

Box 23. Connect Us in Wirral

In 2017, Public Health Wirral commissioned Connect Us, a project aimed at reaching the individuals and communities that face barriers around accessing the services they need to improve their health and wellbeing, as well as gaining a sense of empowerment and reducing isolation. Connect Us was rolled out in January 2020 across Wirral and has a team of 44 connectors.

Connectors work on "what is strong and not what is wrong" and identify how people may want to develop their potential. They visit people in their own homes or in a place that is comfortable to them and together they explore the best ways to link in with local services and activities. The aim is to work in partnership with people to see how they want to go about expanding networks and knowledge of their local area, and ultimately the goal is for them to feel socially connected within their own community.

During the COVID-19 pandemic, Connect Us offered a wide range of support in Wirral, including food deliveries; free school meal provision; delivering 30,000 COVID-19 awareness leaflets; carrying out a Safer Streets consultation; supporting discharge from hospital; making wellbeing calls; working in partnership with Age UK to offer shopping and buddy services; prescription pick-ups and gas/electricity support.

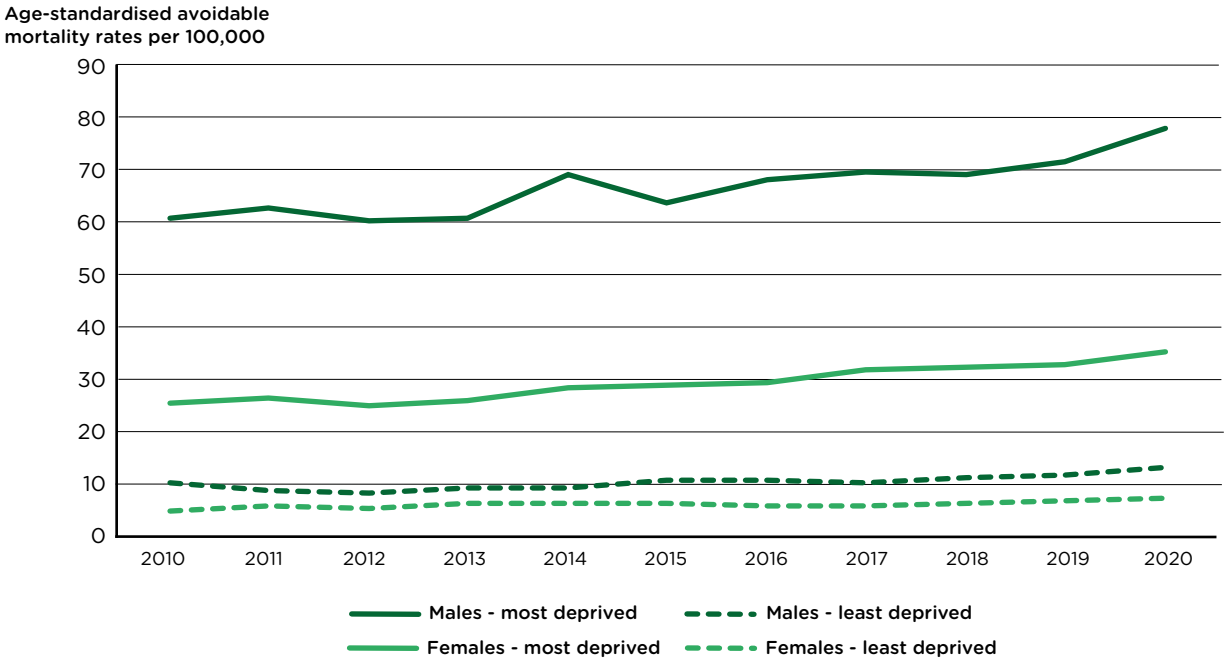
Residents can be directly referred by GPs, social services, housing providers and other professionals and services, or can self-refer and access Connect Us through word of mouth, advertisements in community venues and via Connectors, who knock on doors across Wirral.

Since 2017 Connect Us has had more than 45,000 conversations with community members on the doorstep. As a result, they have engaged with 130,000 individuals in Wirral, created 175 new groups in Wirral, signed up 450 people to move into volunteering; moved 360 people into further education or training and helped 220 find employment.

ALCOHOL AND DRUGS

In England since 2012, avoidable mortality from alcohol and drug-related disorders has significantly increased for women and men living in the most deprived areas. Figure 4.39 shows the number of people dying from alcohol- and drug-related disorders has increased regardless of income. In men, the number of deaths in the most deprived areas has increased significantly more compared to deaths related to alcohol and drugs in men in the least deprived areas.

Figure 4.39. Avoidable mortality rates for alcohol and drug-related disorders 2010-20, England



Source: *Office for National Statistics (210)*

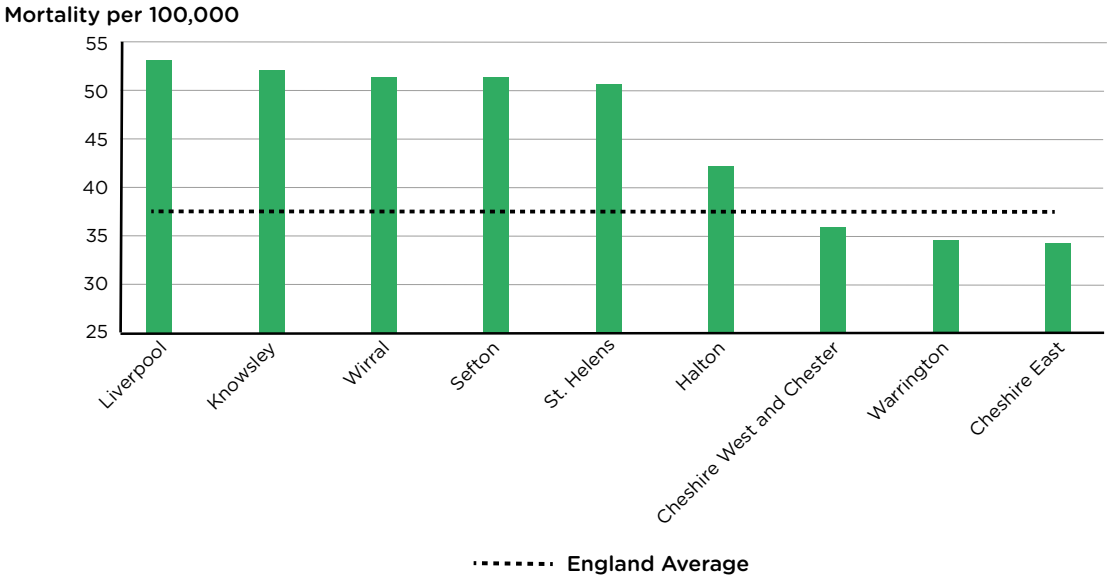
Alcohol consumption increased during the first COVID-19 lockdown and subsequent analysis shows that alcohol-related deaths also increased. Figure 4.40 shows the sharp increase in alcohol-related deaths in 2020, reflecting the increase in England. Analysis also shows the increase in drinking was in high-risk drinkers – the households already purchasing the highest amount of alcohol increased their purchases more than 17 times compared to those who purchased the least alcohol. People living in the most deprived areas in England increased their alcohol purchases more than in the least deprived areas (211).

Figure 4.40 Age-standardised alcohol-specific death rates per 100,000 people; North West region and England, deaths registered between 2010 and 2020

Source: *Office for National Statistics (212)*

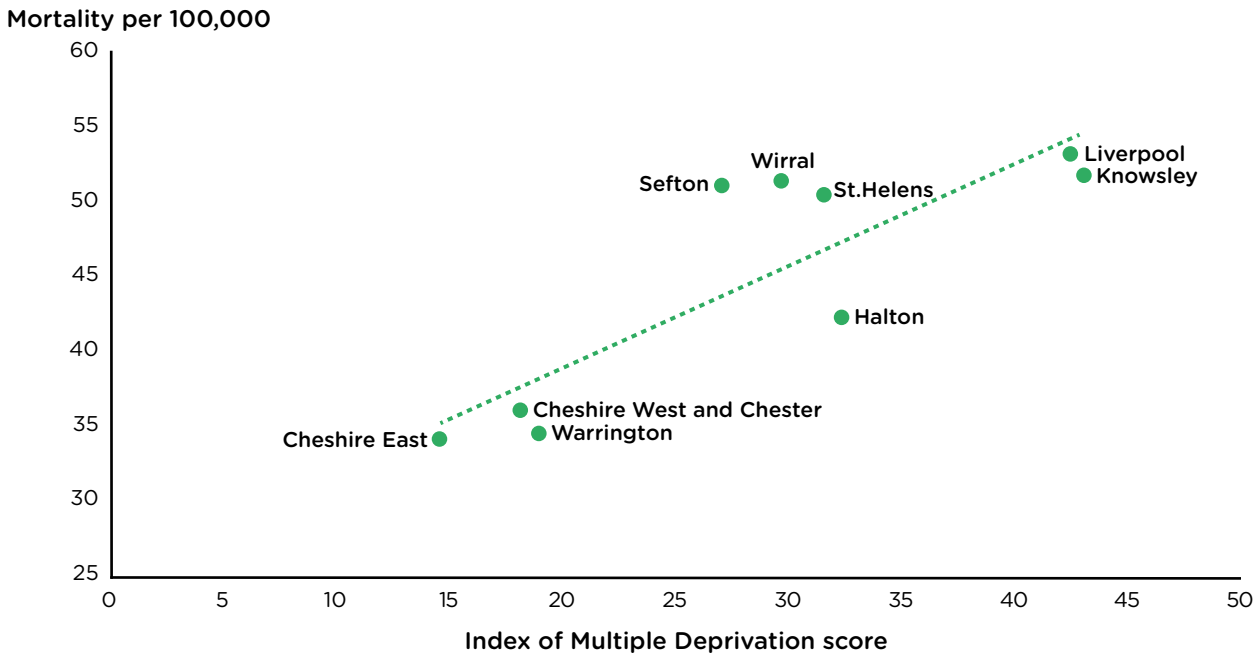
Figure 4.41 shows that six of Cheshire and Merseyside's local authorities have a rate of alcohol-related mortality above the England average and Figure 4.42 shows the strong relationship between deprivation and alcohol-related mortality.

Figure 4.41. Alcohol-related mortality, directly standardised rate, per 100,000, Cheshire and Merseyside lower-tier local authorities and England, 2020



Source: *Office for National Statistics (212)*

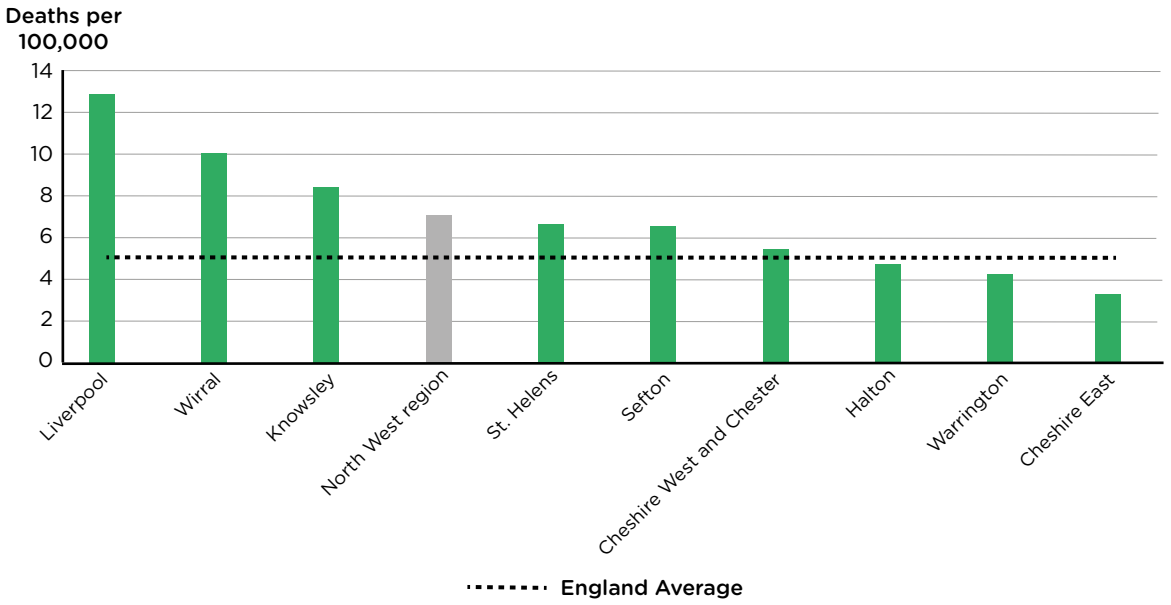
Figure 4.42. Alcohol-related mortality, directly standardised rate, per 100,000, by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2020



Source: *Office for National Statistics (212)*

In addition to having the worst alcohol-related mortality in Cheshire and Merseyside, Liverpool has the highest rates from drug misuse in the region, Figure 4.43.

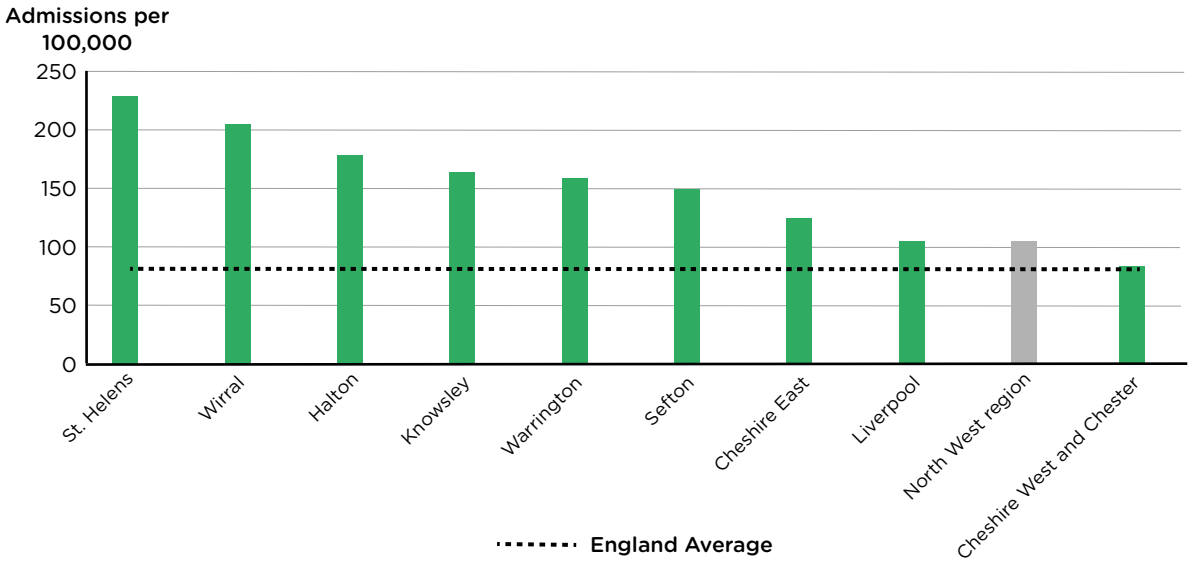
Figure 4.43. Deaths from drug misuse, directly standardised rate, per 100,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2018-20



Source: *Office for National Statistics (213)*

St Helens has substantial challenges in addressing drug misuse in young people. Figure 4.44 shows that St Helens hospital admissions related to substance misuse for 15- to 24-year-olds are the highest in the region and also the highest in England.

Figure 4.44. Hospital admissions due to substance misuse (aged 15 to 24), Cheshire and Merseyside lower-tier local authorities, North West region and England, 2018/19 to 2020/21



Source: *NHS Digital (214)*

Reducing addiction and deaths from alcohol and drugs requires long-term actions to improve mental and physical health as well as addressing the social determinants of health. The impact of alcohol and drugs can impact communities as well as individuals. Champs Public Health Collaborative and Cheshire West and Chester Council are working with local communities to find new ways to take action to reduce the harm from alcohol, Box 24.

Box 24. Community Engagement in Licensing Project

Community Engagement in Licensing is a project initiated and led by Cheshire and Merseyside Public Health Network in conjunction with Liverpool City Council's Public Health team. Cheshire West and Chester Council are the second local authority to become involved. The project aims to engage local residents in the alcohol licensing process with a view to influencing decisions that affect the whole community.

Alcohol availability, including the density of licensed premises, is associated with poorer health outcomes and areas of deprivation are disproportionately affected by alcohol-related harms. Yet communities often have very little control when it comes to licensing and alcohol availability in their area.

Local communities are not usually involved in licensing decisions as it is perceived to be too complex and there is a lack of accessible guidance aimed at local communities, despite the 2003 Licensing Act which states community involvement in licensing decisions should be encouraged, with local residents having a say in the decisions which might affect them.

The Community Engagement in Licensing project will develop a guidance document and online resource with the aim of empowering and guiding residents to take some control over the licensing process in their communities. These resources are aimed at members of the public, community organisations, service providers, and locally elected members. Through engaging with these four groups the Community Engagement in Licensing project hopes to engage communities at all levels in the decision-making process around alcohol licensing.

RECOMMENDATION: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

2022/23

Responsible: Cheshire and Merseyside System

- Cheshire and Merseyside Clinical Networks to work with the ICS to coordinate social determinants of health activity across the system to improve population health.
- Extend current ill health prevention policies and actions to adopt an equity and the social determinants of health approach, embed social determinants of health approach in ICP contracts and plans.
- Assess the total funding allocations and receipts by local area deprivation in Cheshire and Merseyside.
- Adopt Deep End approach (or equivalent) in primary care.
- ICS review social prescribing offer in Cheshire and Merseyside to ensure it is addressing the social determinants of health.
- Prioritise reducing social isolation as a health intervention with greater involvement from the NHS and make use of Local Enterprise Partnership's influence, connections with big businesses, skills and financial resources to increase social connectedness.

Responsible: Mental Health Board

- Map digital exclusion in the region and develop networks with partners in healthcare, local authorities, the VCFSE sector, education and businesses to identify tools to reduce digital exclusion.
- Align local poverty strategies to include commitment to reducing digital exclusion.

2023/27

Responsible: Place

- Reduce inequalities in digital exclusion by delivering hardware and funding support for basic digital skills.

Responsible: Cheshire and Merseyside System

- Review impact of Prevention Pledge and Making Every Contact Count in reducing inequalities.
- Allocate health resources proportionately, with a focus on the social determinants.
- Revise social prescribing offer to focus on the social determinants of health (such as housing, debt and financial advice).

MARMOT BEACON INDICATORS

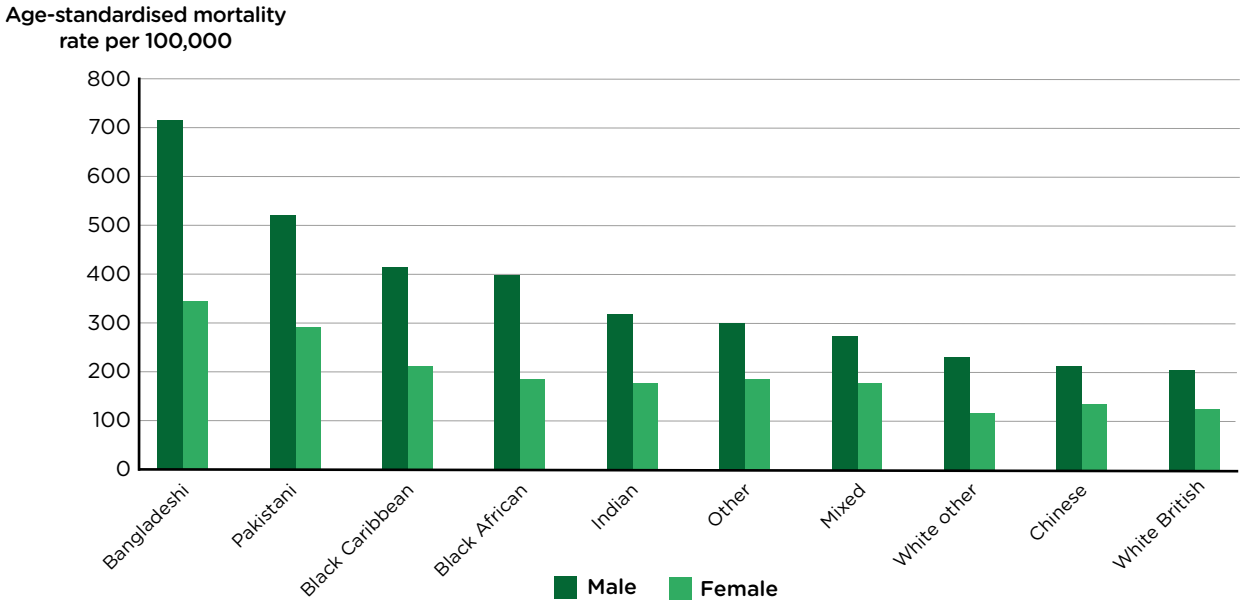
- Activity levels.
- Percentage of loneliness.

4G TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

The COVID-19 pandemic has revealed the stark inequalities in health and socio-economic factors for many of the UK's ethnic minority communities.

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. From January 2020 to February 2022, male and female Bangladeshi ethnic groups and males in the Black Caribbean and Pakistani ethnic groups had higher rates of death from COVID-19 compared with the white population, as seen in Figure 4.45 (215). Public Health England reported that front-line workers from ethnic minorities were given inadequate levels of PPE given their risk of exposure and that the individuals affected did not speak up because of fear of adverse treatment (215). Racism and discrimination is a factor in many of the adverse outcomes for minority ethnic group (216).

Figure 4.45. Age-standardised mortality rates of deaths involving COVID-19, (aged 10 to 100) by ethnic group and sex, England, 24 January 2020 to 16 February 2022

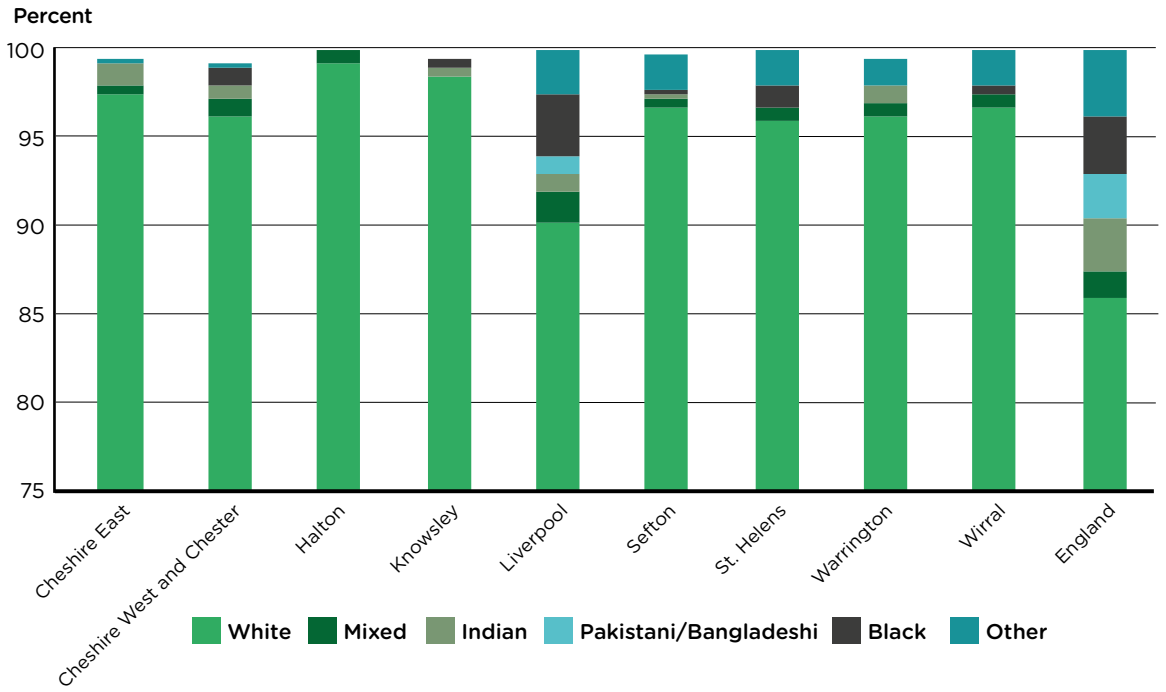


Source: *Office for National Statistics (217)*

Prior to the pandemic, life expectancy at birth was higher among ethnic minority groups than for white groups however this sole metric conceals several inconsistencies. In several ethnic minority groups, Black Caribbean, Other Black, Indian, Other Asian and some Mixed groups, Pakistani and Bangladeshi groups, disability-free life expectancy is estimated to be lower compared to the white population (218).

Rates of infant and maternal mortality, cardiovascular disease and diabetes are higher amongst Black and South Asian ethnic populations. People from ethnic minority groups are more likely to report being in poor health and have poor experiences using health services than the White British population (218). Figure 4.46 shows that on the whole Cheshire and Merseyside is less ethnically diverse than England with some areas such as Halton and Knowsley having very low levels of ethnic diversity.

Figure 4.46. Ethnicity as percentage of population, Cheshire and Merseyside lower-tier local authorities and England, year ending September 2021



Source: *Office for National Statistics (219)*

Mental health services have been identified as an area where there is a particular issue for individuals from ethnic minority backgrounds, with a lack of trust in healthcare professionals commonly cited as a problem (220). This is compounded by a lack of translators and interpreters. Where translators and interpreters are available, the service is often unreliable and there are also concerns about confidentiality due to the lack of professionally trained interpreters. The 2021 White Paper Reforming the Mental Health Act concluded that there continues to be a lack of national policy relating to race equality in the mental health service (220). The importance of making services appropriate to all communities is exemplified in Box 25, the Wirral Deen Centre works with women who do not speak English as a first language, and, as such, can have difficulties in accessing, or even knowing about, local services. Targeted interventions, developed and delivered in collaboration with the VCFSE sector who represent minority communities, is essential to ensuring that ethnic minorities populations receive appropriate support to address their physical and mental health needs.

Box 25. Tackling racism and Inequalities through the MSP Together Fund: Wirral Deen Centre

The Wirral Deen Centre is a mosque and community centre in Birkenhead and Tranmere which is within the 4 percent most deprived areas in England. The centre wanted to encourage people from predominantly minority ethnic populations to increase their activity levels. The charity saw a need as they saw many people, especially women, facing inequalities and barriers to accessing local services.

The charity identified that many of the women supported at the Wirral Deen Centre were on low incomes meaning buying appropriate clothing for exercise and spending money on travel were barriers to becoming active. Many of the women also had weaker spoken English meaning that learning about accessing services was more difficult and that they found it difficult to access suitable women's-only gym or swimming sessions.

MSP helped the Wirral Deen Centre to secure £3,126 of funding, which has been used to subsidise transport and purchase gym clothing. This fund has also paid for exclusive access for a group of women to access a nearby gym, as a result of which 15 women from diverse backgrounds have participated in group sessions, 80 percent of whom had never been to a gym before. The project has allowed women to build resilience, make new friendships, and improve their health.

RECOMMENDATION: TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Businesses, public sector and the VCFSE sector to actively communicate and publish how meeting equality duties in recruitment and employment including pay, progression and terms.	• Involve the VCFSE sector organisations and networks tackling racism in businesses and the public sector.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Work with NHS, local authorities, public sector and businesses to gather data on their workforce by ethnicity and by pay and grade. • Reinforce the efforts of health and social care providers to facilitate equitable access to their services and all health and social care providers are collecting data on service users by ethnicity. • Require all health and social care providers to collect data on service users by ethnicity. • ICS to establish effective engagement with all ethnic minority communities and involve communities, the VCFSE sector and community leaders in the assessment of current and development of new services and interventions.	• Based on findings in Year 1, set actions to reduce racism and its outcomes in the NHS, local authorities, public sector and businesses. • Ensure there is critical feedback and evaluation with involvement from ethnic minority communities. Develop improved data collection methods, including qualitative methods.

MARMOT BEACON INDICATORS

- Percentage of employees who are from ethnic minority background and band/level.

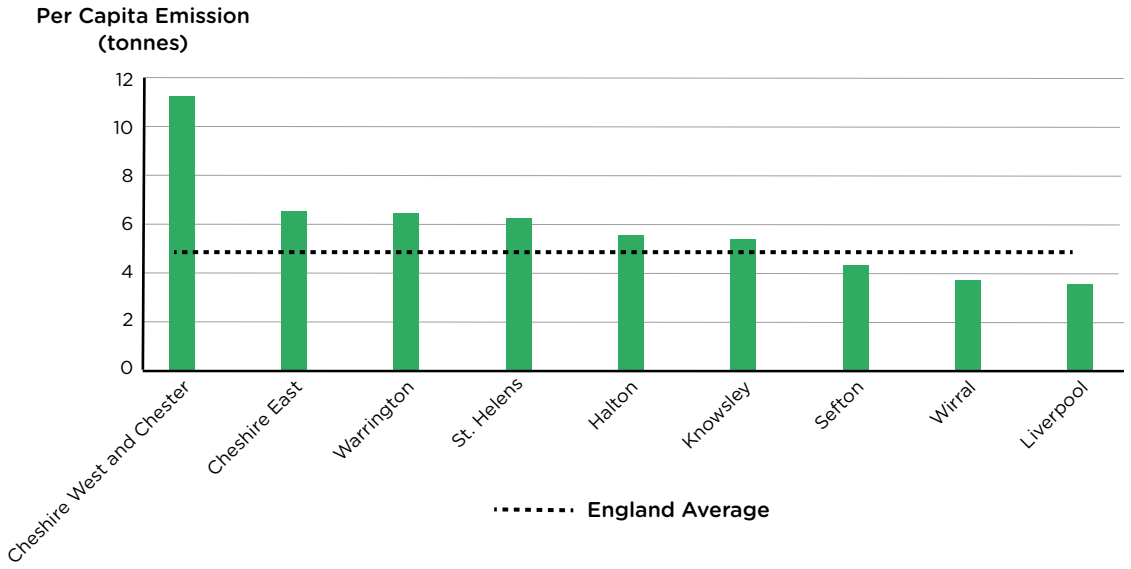
4H PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

There are direct and indirect impacts of climate change to mental and physical health, and unequal impacts which deepen health inequalities. As the climate warms and precipitation increases, harm to health from climate change will increase and, in the future, will affect people who live in the most deprived areas the most (221).

Many of the actions to reduce greenhouse gas emissions will also improve health and reduce existing health inequalities. However, there is a potential for interventions, such as increasing energy costs, to reduce consumption but widen inequalities (221). There must be an equity focus as well as a harm reduction and mitigation focus in interventions and policies to reduce the effects of climate change.

It is estimated that in the North West, 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, affecting subsidence, crop yields and water stress; and 16 percent more rainfall in the winter increasing flooding risks (222). Total emissions and emissions per capita have fallen in the UK since 2005. In England, in 2019, the North West region had the second highest level of carbon dioxide emissions in England, second only to the South East region. Figure 4.47 shows Cheshire West and Chester has the highest per capita emissions in Cheshire and Merseyside, however it has low population density compared with the highly populated areas in Merseyside.

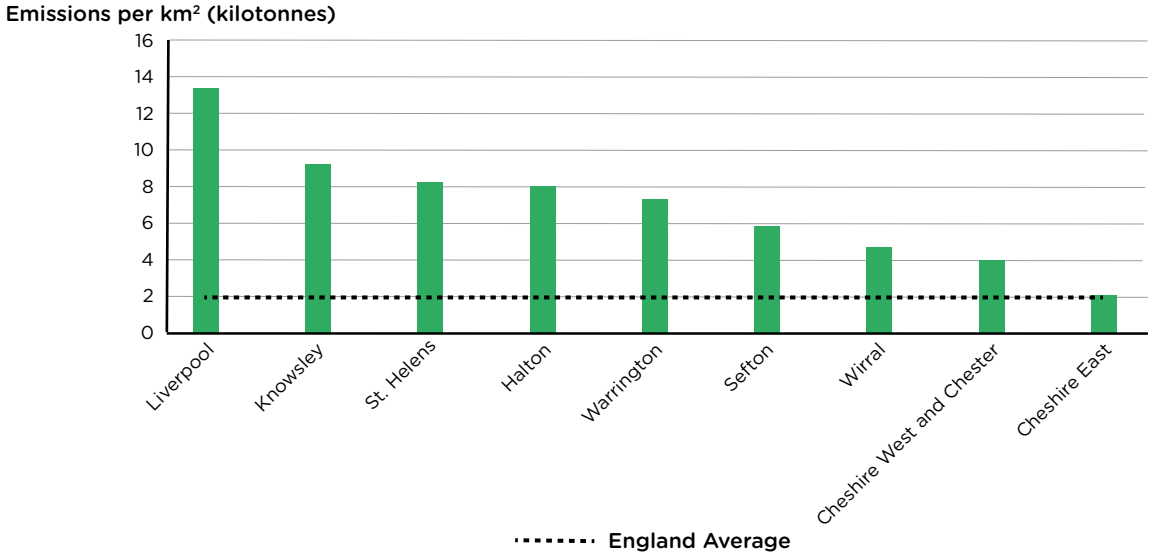
Figure 4.47. Carbon dioxide emissions per capita (tonnes) in Cheshire and Merseyside lower-tier local authorities and England 2019



Source: *Department for Business, Energy & Industrial Strategy (223)*

Emissions per kilometre squared, Figure 4.48, usually are higher in urban areas and those with large industrial sites.

Figure 4.48 Carbon dioxide emissions per km2 (kilotonnes) in Cheshire and Merseyside lower-tier local authorities and England, 2019

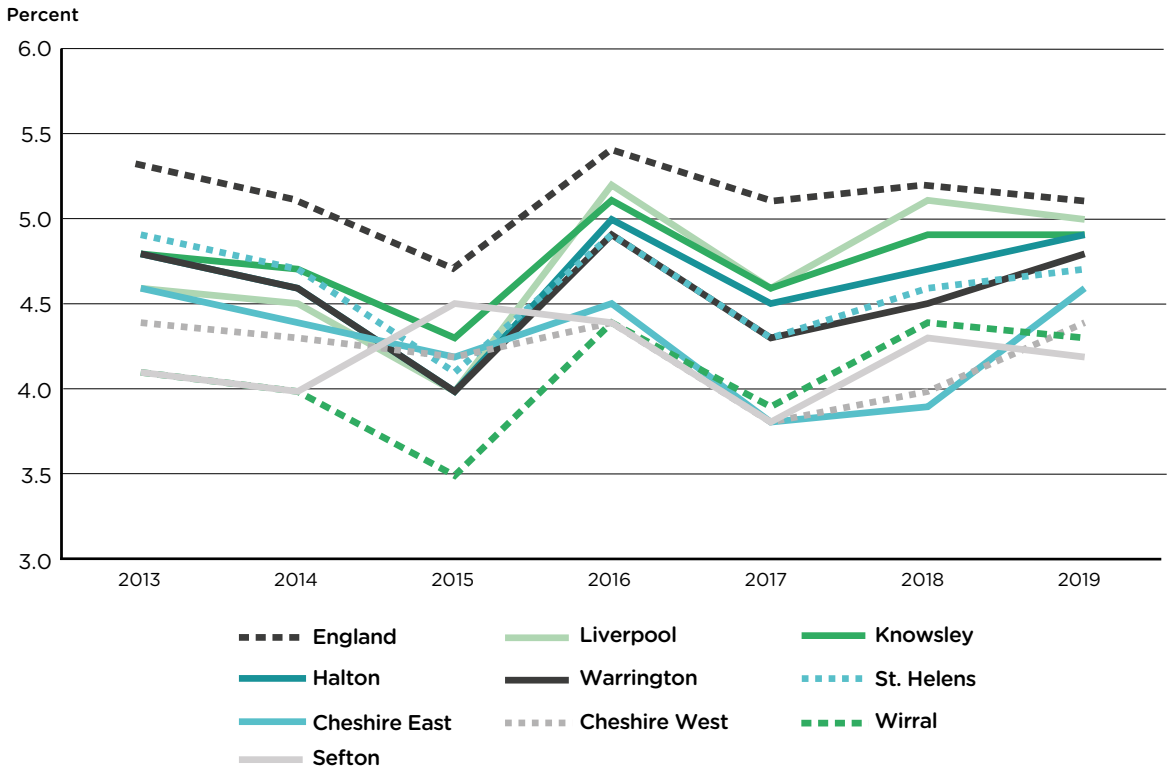


Source: *Department for Business, Energy & Industrial Strategy (223)*

In 2019 Liverpool City Region declared a climate emergency, pledging the region to reach net zero carbon by 2040. Actions to achieve net zero include introducing electric buses; investing £1.26m in low-carbon solutions in colleges and buildings, and promoting public transport and active travel. Addressing inequality and fairness are one of the plan's guiding principles, and health and wellbeing is one of the nine themes in the emergency plan, ensuring "actions to improve climate are aligned with actions needed to improve the collective health and wellbeing of our residents". Cheshire West and Chester also declared a climate emergency in May 2019 (224), and its climate plans are similarly ambitious but do not discuss health inequalities. We would encourage councils in the region to place inequalities as one of their guiding principles and ensure that actions to reach net zero do not inadvertently increase health inequalities (225).

On average, pollution levels are worse in areas of highest deprivation compared with areas of lowest deprivation, however in Cheshire and Merseyside, mortality attributable to exposure to poor air quality is lower than the England average, Figure 4.49.

Figure 4.49. Fraction of mortality attributable to particulate air pollution, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2013-19



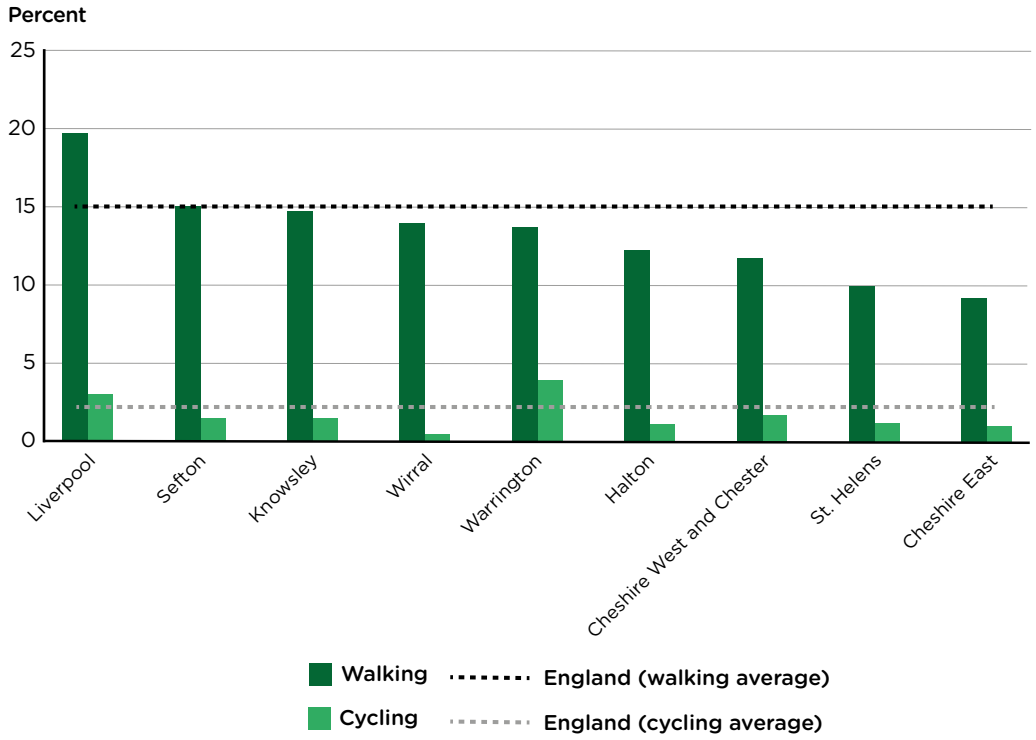
Source: *Department for Environment, Food & Rural Affairs (226)*

ACTIVE TRAVEL

Domestic transport is the largest contributor to greenhouse gas emissions in the UK, constituting 27 percent of the UK's total emissions in 2019 (227). Active travel is central to reducing these emissions. People living in the most deprived areas in England are less likely than those in less deprived areas to own a car (1). During the pandemic, public transport has taken a significant hit due to drops in ticket sales and publicly-owned systems, such as Merseyrail, have had extensive losses (228) (229).

The shift to home working in 2020 highlighted the need for alternative forms of working and transport. Cycling and walking infrastructure was expanded across the region, partly due to increased funding provided by the government's Active Travel Fund. However, too many of these were short-term interventions and many new cycle lanes were removed, with traffic levels returning to pre-pandemic levels (230). The LCR Local Cycling and Walking Infrastructure Plan aims to build a network of cycling and walking routes and make it more feasible and desirable for people to walk or cycle instead of using unsustainable modes. Within Cheshire and Merseyside, only in Liverpool do adults walk and cycle for travel higher than the England average, and in all of the local authorities, there is ample room to improve Figure 4.50.

Figure 4.50 Adults that walk or cycle, at least three times per week for travel, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2019/20



Source: *Department for Transport (231)*

Greener NHS is the target for the NHS for it to be the world's first net zero national health service. Greener NHS includes two targets:

- For the NHS carbon footprint (emissions directly controlled by the NHS), to reach net zero by 2040, with an ambition to reach an 80 percent reduction by 2028-32;
- For the emissions the NHS can influence (the NHS Carbon Footprint Plus), to reach net zero by 2045, with an ambition to reach an 80 percent reduction by 2036-39.

As part of the efforts to reach net zero, all NHS Trusts and ICSs have been asked to update green travel priorities and their Green Plans (232).

RECOMMENDATION: PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

2022/23	2023/27
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• ICS work with local government, housing associations to retrofit homes, including private homes, to reduce fuel poverty and greenhouse gas emissions. • Work with local authorities, businesses and chambers of commerce to prioritise the health and wellbeing of citizens and environmental sustainability in economic recovery and growth policies. • Enforce existing smokeless fuel standards. • Health equity assessment of Cheshire and Merseyside Green Plan and Place-based Green plans in each of Cheshire and Merseyside's nine local authorities.	• Passive cooling measures included as standard in retrofits and new builds that are at risk of high indoor temperatures. • Installations of new wood burning and gas stoves in urban areas eliminated and existing stoves phased out. • Ensure any new walking and cycling infrastructure reaches areas with the lowest rates of physical activity.

MARMOT BEACON INDICATORS

- Percentage (£) spent in local supply chain through contracts.
- Cycling or walking for travel (3 to 5 times per week).

CHAPTER 5

ROUTES FOR ACTION IN CHESHIRE AND MERSEYSIDE

Reducing health inequalities requires effective national prioritisation, policies, resources and action. As we have assessed in other reports, there have been serious limitations in national approaches to reducing health inequalities in the 12 years since the original Marmot Review. In the absence of national actions, many local authorities have developed effective action to tackle health inequalities, even in the context of austerity, highly limited resources and the COVID-19 pandemic.

Neither local authorities nor the NHS can, however, take on the required actions alone – they do not have sufficient resources, capacity and levers to achieve that. Other stakeholders, particularly businesses, the VCFSE sector and communities themselves, have the potential, much of this underdeveloped, to initiate and implement actions on the social determinants of health.

For the NHS reducing health inequalities means addressing the social determinants of health, shifting from solely treating the ill health arising from inequalities, important though that is, to preventing poor health and inequalities arising in the first place. The NHS Long Term Plan summarises:

> ***While we cannot treat our way out of inequalities, the NHS can ensure that action to drive down health inequalities is central to everything we do (83).***
>
> *NHS Long Term Plan*

In Cheshire and Merseyside the aim of each ICP is to "ensure local services (primary care, social care, community and mental health) are joined up and supporting people to manage their own wellbeing" (233). Each ICP should challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support and invest in interventions to improve the social determinants and strengthen neighbourhood engagement, ensuring the system is connected to the needs of every community it covers (234).

Knowsley and Liverpool local authorities have created posts to specifically address the wider determinants of health, Box 26.

Box 26. Posts to address the wider determinants of health

The Public Health team in Knowsley created the role of public health programme officer in March 2020 to support their core team in delivering its functions through influencing the wider determinants of health, reducing health inequalities and encouraging health improvement. They work across different parts of the council, wider partners and the community to embed health equity into policies, strategies and practice. The role also includes developing and contributing to programmes to promote emotional wellbeing and mental health across all ages.

Through evidence-based research, the public health programme officer develops projects, programmes and initiatives aimed at improving the wider determinants of health and contributes to policy and strategy decision-making. So far this role has been influential in ensuring health inequalities have been considered in the council's new strategies, such as housing and domestic abuse, in addition to the gambling policy, healthy weight plan, climate change agenda and amendments to planning documents, while developing the council's approach to "health in all policies" and health impact assessments.

The officer is also responsible for promoting a wider understanding about the significance of the social determinants in driving health inequalities. This is done through training and engaging with various different groups and partnerships.

Liverpool City Council have also employed a senior public health practitioner – wider determinants, who is leading multi-agency projects across the city to improve health and reduce health inequalities.

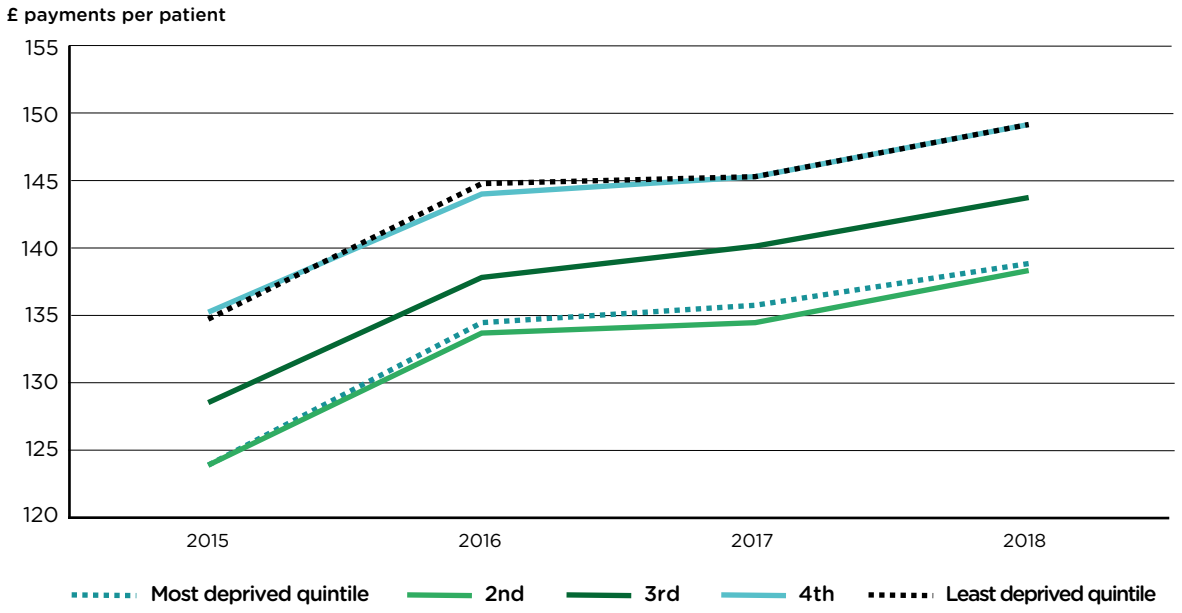
5A INCREASE AND MAKE EQUITABLE FUNDING FOR SOCIAL DETERMINANTS OF HEALTH AND PREVENTION

Section 2 outlined the cuts to local government, public health, education and youth services, the police and legal services and the VCFSE sector, the key partners who deliver many of the services needed to reduce health inequalities. Nationally, all of these budgets require a real-terms increase to strengthen the capacity to address the social determinants of health in Cheshire and Merseyside.

In relation to existing budgets and resources available for local areas to take action on the social determinants of health, there are several potential routes. Firstly investing a greater share of budgets in prevention, thereby reducing inequalities and reducing demand and costs on services. Secondly, ensuring that budgets are allocated in ways that facilitate greater equity. In the recommendations we propose that, having benchmarked spending over the next year, local government and NHS increase funding for the social determinants of health by 1 percent a year for the next 10 years. This will save costs in the long term, reduce health inequalities and improve quality of life and wellbeing for all.

The aim of primary care networks (PCNs) is to improve access to primary care and expand the range of services available. Cheshire and Merseyside HCP can work with PCNs to make GP access equitable and specifically target areas where general practice is either under the greatest pressure and of poor quality. General practice should be funded using proportionate universalism whereby all universal services are adequately resourced and additional funding is provided to areas where the degree of need is higher. GP practices serving more populations in areas of high deprivation receive around 7 percent less funding per patient than those serving more affluent populations, Figure 5.1.

Figure 5.1. Trends in general practice payments per patient by neighbourhood deprivation quintile (IMD 2019), net payments per registered weighted patient, England, 2015-18



Source: *NHS Digital, ONS, and MHCLG quintiles aggregated from LSOA 2011 neighbourhoods (235)*

In Section 1 we highlighted how proportionate universal approaches were the most effective way to level up the gradients in health, and how resource allocation formulae need to take into account deprivation and other drivers of ill health in order to facilitate greater investment in the people and communities who need them most. There are several existing weighted resource allocation formulae that allow for this and these are in keeping with the proportionate universal approach.

Primary care should enhance its equitable distribution of resources. ICS, primary care and public health NHS staff in Lancashire and South Cumbria are working on a weighted funding formula to ensure that primary care is allocated according to level of need - to be proportionate and equitable, Box 27. It is an example of how to reorganise resource allocations, within the NHS and beyond.

Box 27. 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 (236) .

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" (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.

RECOMMENDATION: INCREASE AND MAKE EQUITABLE FUNDING FOR SOCIAL DETERMINANTS OF HEALTH AND PREVENTION

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Assess the budget for addressing the social determinants of health in the NHS and local authorities across Cheshire and Merseyside in 2022/23. Work with the VCFSE sector to include their contributions to addressing the social determinants of health. • Assess resource allocation in Cheshire and Merseyside and develop and extend proportionate universal approaches. Assess possibility of local weighted funding formula to better address health inequalities. • Benchmark NHS and local government funding for social determinants of health.	• Increase local government funding for social determinants of health by 1 percent a year for the next 10 years (after accounting for inflation). • Increase NHS funding for social determinants of health by 1 percent a year for the next 10 years to address wider social determinant prevention (after accounting for inflation). • Develop resource allocation formula to ensure that funding allocations are equitable and proportionate.

5B STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY

Strong partnerships between different regional stakeholders are essential to reducing health inequalities. These stakeholders include the VCFSE sector, health and social care, business, the public sector, education, local governments, the NHS and local residents.

Budgets, incentives, work cultures and political, financial and delivery pressures are very different for each stakeholder, however there is an appetite to change and to collaboratively work towards greater health equity. Coventry has made considerable progress in developing joint action on health inequalities among a disparate set of stakeholders, with a Marmot working and delivery group (103) (77).

There remain significant challenges in achieving more effective partnerships for action on the social determinants, and such collaborations do not work without sustained efforts and actions, inside and outside of the NHS. Sustainability and Transformation Plans (STPs) in England were expected to increase local government involvement with health care, however they were ultimately "criticised by council leaders for not involving local government closely enough" (237). It is up to the Cheshire and Merseyside ICS and ICBs to identify and outline the role of the local authority in the HCP's and ICP's work, as it is not outlined in guidance from central government.

Health and Wellbeing Boards have been central to leading place-based partnerships and bringing together the key NHS, public health and social care stakeholders in local areas to work together to commission services (238). It is essential to learn from local health and wellbeing boards as to what has worked to address inequalities, what has enabled partnership working and identify the barriers to action. Councillors on health and wellbeing boards can be lead advocates for the social determinants of health and share their knowledge and ambition within their councils and more broadly.

Developing a network of chief executives in the NHS, local government, education, employment, housing and the VCFSE sector and beyond, who are committed to reducing inequalities and creating short- and long-term strategies to improve the social determinants of health is an important first step. These networks can then filter down to those delivering actions in Cheshire and Merseyside's local areas. For collaborations to succeed, partnerships need to occur at different levels, including at the highest level. The responsibility to forge strong cross-sector partnerships should not fall to a single person or post.

PARTNERSHIPS WITH THE VCFSE SECTOR

The VCFSE sector are indispensable partners in supporting communities and improving social and economic conditions for better health. They generally have a closer relationship and understanding of the experiences of residents and communities. Involving the VCFSE sector in the design and delivery of services should be a priority and contracts with the VCFSE sector prioritised in line with social value principles. Guidance from NHS-England to ICS states that the VCFSE sector is "a vital cornerstone of a progressive health and care system" (239). However, participants in the workshops held stated there were often many supportive words said of the VCFSE sector, but that actions need to happen.

> ***Health and care stick to their own solutions, they say nice things about the voluntary sector but have yet to shift money to the voluntary sector.***
>
> *Workshop Participant*

The NHS Confederation states that the VCFSE sector is "essential" in the shift towards prevention, as it has knowledge and networks that are assets for the NHS to reduce health inequalities (240).

The VCFSE sector is diverse, and different approaches are needed when working with large organisations delivering services compared to smaller, neighbourhood-based organisations. It is essential that Cheshire and Merseyside HCP are more aware of the make-up of the local VCFSE sector. The vast majority of the VCFSE sector is made of small organisations in the UK. Funding from the public sector, which includes the NHS, local and national government authorities, is more likely for larger VCFSE sector organisations. Only 23 percent of small VCFSE sector organisations rely primarily on public sector finance compared with 59 percent of the largest VCFSE sector organisations (241). The pandemic has had significant impacts on the VCFSE sector: a survey of 216 charitable organisations found that 84 percent

reported a decrease or a significant decrease in their total income, and 55 percent stated that they would likely have to make redundancies as a result of losing funds (242). In addition, the number of volunteers has dropped. Despite large numbers of first-time and more diverse volunteers coming forward during the pandemic, just 24 percent of charities reported an increase in volunteer numbers since March 2020, compared with 36 percent who saw a decline (243).

The VCFSE sector needs a stated, defined role within NHS and local government pathways to reduce health inequalities, involving the sector in strategic and operational thinking from the beginning and not as an afterthought. This should translate into pathways of emergency and ongoing support with the VCFSE sector delivering services. Many organisations in the VCFSE sector have extensive data sources that could help local areas to understand the social determinants of health (244).

There are many examples of good work between the VCFSE sector in the NHS in Cheshire and Merseyside, such as the Cancer Alliance reserving funds for the VCFSE sector to pilot new ways to deliver community cancer care, Box 28.

Box 28. The NHS and VCFSE sector working together to prevent cancer and improve access to services

The Cheshire and Merseyside Cancer Alliance is currently scoping and mapping cancer data, gathering detailed inequalities data, to assist their project managers in decisions to tackle inequality at a very local level. From this data, priorities have already been agreed with key stakeholders which have informed the piloting of two styles of community delivery.

To address poorer cancer outcomes and inequalities, the Alliance has reserved a percentage of its project budget into which VCFSE sector organisations can bid. This reserved pot, the Cancer Awareness Community Engagement project, will be administered by three groups: One Knowsley; St Helens and Halton Community and Voluntary Action and Warrington Voluntary Action. This project will fund small grants to organisations who deliver cancer awareness activities within their communities, in particular those communities who are in areas of high deprivation or identified as less likely to present to GPs. The aim of the project is to increase early cancer diagnosis via increased awareness of signs and symptoms within the community and improve access to screening and diagnosis. The project also seeks to improve understanding and awareness of the signs and symptoms of cancer and encourage appropriate health seeking behaviour.

The project aims to meet the early diagnosis of cancer ambition in the NHS Long Term Plan, which states by 2028 the proportion of cancers diagnosed at stage one and two will rise from half to three-quarters of all cancer patients (83).

THE HEALTH SYSTEM AND PARTNERSHIPS

As the social determinants of health are found outside of health systems, it is essential that the HCP and ICPs embed partnerships to influence these wider conditions – the homes where people live, the work they do, the schools they attend, the places where they spend time outside. the income they do, or do not, receive – all of these factors affect their health, wellbeing and quality of life. Whilst there are warnings from, for example, the Health Foundation, that ICSs may not have capacity to deliver effective collaborations (245), the director of partnerships in Cheshire and Merseyside has shown innovation and leadership in tackling the social determinants of health. Actions include a review of health justice partnerships, developing the Social Value Award and a memorandum of understanding signed with local housing partners. The memorandum of understanding, signed between Cheshire and Merseyside and a number of housing associations, is an example of embedding partnerships with the NHS in addition to helping the NHS become a stronger anchor within the area, Box 29.

Box 29. The Opening Doors Initiative

Under the leadership of the director of partnerships for Cheshire and Merseyside HCP, a strategic partnership across health, care and housing was formed with support from the CEO at the Housing Associations Charity Trust (HACT) as an independent chair. Their primary aim is to develop and deliver solutions that improve population health through identifying employment opportunities within social housing whilst addressing workforce challenges across the health and care sector. Through an agreed memorandum of understanding they have defined three strategic priorities:

- To reduce health inequalities through improving stable and meaningful employment opportunities in social housing.
- To reduce the workforce shortages across health and care by breaking down the barriers to access roles with proactive support and redesigned processes.
- To enable provider organisations to become anchor institutions by enhancing their role within communities through employment and community partnership development.

A strategic steering group has been established and a programme lead has been appointed with an initial focus to scope out the current state of access to health and care roles by social housing residents and to design a care and health academy approach in line with the needs of communities at place level. The Opening Doors Initiative is also working with the NHS Clinical Leaders Network to develop a bespoke integrated leadership training approach that will enable emerging leaders across care, health and housing to learn and innovate together. It is anticipated that the Opening Doors Initiative will pave the way across the Cheshire and Merseyside region for exploring the wide range of opportunities this tripartite partnership will have on maximising the population's health and wellbeing by bringing about effective, systematic change.

There are examples across England and more locally of systems working collaboratively to provide good-quality, locally relevant data (246). Liverpool CCG worked with the Citizens Advice and academics at the University of Liverpool to link NHS and non-NHS data, which enabled the Advice on Prescription service. Launched in 2014, the service enables all Liverpool GP's to refer patients for assistance from Citizens Advice advisers on a range of issues including housing, homelessness, job loss, complex debt issues and benefits advice, Box 30 (247).

Box 30. Advice on Prescription in Liverpool

Citizens Advice on Prescription Liverpool is a social prescribing service which aims to improve health and wellbeing by supporting patients with non-medical issues which may be having an impact upon their health. The service, first launched in 2014, is available to all Liverpool GPs and allows health professionals to refer patients to Citizens Advice for assistance on a wide variety of issues such as: housing, job loss, debt issues and welfare benefits advice. The service is made up of two parts.

- The Enhanced Citizens Advice Support service, which offers practical, anti-poverty support to patients on low incomes who need this support.

- The Wellbeing Link Worker Service, which provides patients with ongoing advice and support, by producing with them an individual wellbeing plan and then helping them to access the relevant community services. In developing the wellbeing plan, the link worker and referred patient use the Wellbeing Liverpool website, which provides information and links to wellbeing services around Liverpool. The majority of patients who are referred to the wellbeing service have practical concerns such as rent arrears or council tax debt, and these individuals are less likely to engage with wellbeing services until they have received support for their practical concerns such as benefits appeals, urgent debts, or eviction notices.

Service data has suggested that where a referral is made to either the Enhanced Citizens Advice Support or to the Wellbeing Link Worker Service, the patient is best served by a blended package of support from both services.

In October 2021 Liverpool CCG commissioned Citizens Advice on Prescription to expand to include all secondary care health staff and make for a straightforward referral process. This expansion aims to provide proactive support to patients who would normally leave a health setting with no additional support.

The social prescribing service can help to relieve health professionals of some of this non-clinical burden and help patients to receive the specialist support that they need. This specialist support on average each year includes securing £5 million in welfare benefit income, reducing household debt by over £3 million, and preventing evictions. The service receives an average of 10,000 referrals a year, each of which is assessed for priority need and responded to within two working days or sooner if urgent action is needed.

Citizens Advice on Prescription also offers dedicated support in mental health, respiratory conditions, cancer, and perinatal support (248) (249).

RECOMMENDATION: STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY	
2022/23	**2023/27**
Responsible: Place	**Responsible: Place**
• Integrate Place Plans in each place executive and create MoU between place executives and health and wellbeing boards to align health and wellbeing strategies and Place Plans. • Strengthen the role of the director of partnerships at board level.	• Embed partnerships across local systems with healthcare, the VCFSE sector, local economic plans, and strategies beyond leaders.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Develop a social determinants of health equity network to include business and economic sector, public services, the VCFSE sector, local government and communities.	• Continue to invest in the health equity network.

5C CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTH EQUITY

Taking action on the social determinants of health and forging the partnerships and collaborations needed to do this requires strong, effective leadership, which is focused on health equity. Where social determinants of health approaches have been successfully implemented they are usually driven by committed leaders (77).

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

There are specific ways leaders can embed and sustain action on the social determinants of health and health inequalities. We recommend that the Population Health Board takes a strong lead in developing partnerships for health, assessing health equity impacts of all activity, strengthening the social and economic impacts of commissioning and all expenditure with a greater focus on equity and ensuring that all staff understand and seek to improve the social and economic contexts of their patients and the areas in which they live. The approaches we advocate are compatible with the NHS Long Term Plan which requires every local area across England to create specific measurable goals and mechanisms to narrow health inequalities over the next five and 10 years (83).

The current Cheshire and Merseyside HCP Board is made up of 36 members, including the chair and chief officer. Nine local councillors sit on the board, along with one member representing the VCFSE sector. Of the remaining 27 members, three-quarters work for the NHS, most trained doctors or in executive positions. The directors of public health are not included in the HCP Board. Including the views of the directors of public health or representation within the evolving ICS Board will be essential if the proposed changes are to achieve the goal of reducing health inequalities in Cheshire and Merseyside.

IHE have previously set out potential routes for the healthcare workforce to take action on the social determinants, Box 31. These opportunities have become more important as health inequalities widen and as the development of place-based healthcare systems provides further opportunities for the NHS to act on the social determinants of health.

Box 31. The NHS, health inequalities and the social determinants of health

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

- **Workforce education and training**
  Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and referring patients to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses. Student placements in a range of health and non-health organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students' knowledge and skills related to the social determinants of health.

- **Working with individuals and communities**
  While gathering information, health professionals should be taking a social history of their patients as well as medical information. This should then be used in two ways: to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care. Providing information, health professionals should refer their patients to a range of services – medical, social, other welfare agencies and organisations, so that the root causes of ill health are tackled as well as the symptoms being medicated.

- **NHS organisations**

  Health professionals should utilise their roles as managers and employers to ensure that:

  > Staff have good-quality work, which increases control, respects and rewards effort, and provides services such as occupational health.

  > Their purchasing power, in employment and commissioning, is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.

  > Strategies on health inequalities are given status at all levels of the organisation, so the culture of the institution is one of equality and fairness, and the strategies outlined elsewhere in this document are introduced and supported

- **Working in partnership**

  In order to take effective action to reduce inequalities, working in partnership is essential. Evidence shows that effective action often depends on how things are delivered, as much as what is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector or draws on information and expertise from other sectors. Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of stakeholders that have the potential to affect social and economic conditions, including local government, business and the VCFSE sector (250).

RECOMMENDATION: CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTHEQUITY	
2022/23	**2023/27**
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• ICS to jointly appoint a lead in public health (qualified or experienced) with a supporting team in Champs Public Health Collaborative to work in partnership with the ICS medical director and nursing director and the directors of public health to lead on health inequalities and partners. • Champs Public Health Collaborative and nine directors of public health to work in partnership with the ICS to ensure sustained action to address inequalities is embedded in ICS strategy.	• Champs Public Health Collaborative and nine directors of public health to work in partnership with the ICS to ensure sustained action to address inequalities is embedded in ICS strategy.

5D CO-CREATE INTERVENTIONS AND ACTIONS WITH COMMUNITIES

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

Many local councils are experienced in working with local communities to develop priorities. In Warrington, the Central 6 masterplan was developed in partnerships with residents and as the project continues, the fundamental principle is to ensure the communities that live in the different areas are fully involved in decisions and projects that happen in their communities (251). The St Helens People's Board is an excellent example of how to adopt an inclusive approach to support better health and wellbeing for all local residents, Box 32.

Box 32. St Helens People's Board

The St Helens People's Board carries out the statutory functions of the health and wellbeing board and the community safety partnership. The board provides "democratic stewardship" and its wide membership across public services and the VCFSE sector includes housing associations, Merseyside Police and Fire and Rescue, the NHS, adult and social care leaders, local government and the probation service.

In existence since 2017, its aims are to promote greater health and social care integration; identify key actions needed to promote/improve health and wellbeing of local communities and to set the strategic direction for integrated health and care in the borough.

In 2018, the council's people's services department and the clinical commissioning group (CCG) came together to form St Helens Integrated People's Services (SHIPS). SHIPS covers CCG responsibilities, including devolved commissioning for general practice, adult social care, children's social care, educational improvement and public health. Budgets are combined through a Section 75 agreement and there is close oversight of performance and finance.

Public Health England stated that community-centred approaches are used in public health practice to enhance individual and community capabilities, create healthier places and reduce health inequalities' (252). However, there is still insufficient resource and know-how to develop effective co-designed strategies with the community, particularly within the NHS where there is still a culture of top-down national management and regulation. Cheshire and Merseyside ICS have yet to clarify how they will work with the local residents and communities.

The King's Fund recommend the following priorities for co-created integrated care:

- Identify the issues and challenges that only people and communities can bring to light.
- Start with what matters to people rather than what the system thinks is important.
- Engage with people and communities to ensure systems, services, and programmes are meeting all of the public's needs, especially in the most deprived communities, work with these specific population groups to tackle inequalities.
- Listen to what is meaningful and what matters, and shape HCP work around these insights. Working closely with VCFSE organisations, patient leaders and user representatives to make sure that issues important to the communities served are being raised and fed into the IC system.
- Stay in regular communication with local communities and be realistic and honest about what will be done with the work and when (253).

Community-based approaches offer several clear benefits to the efficacy of interventions:

- They are appropriate to local conditions and contexts.
- They involve local people in the design and implementation of appropriate strategies.
- It is often easier to forge the required cross-sector partnerships in local areas.

Disadvantages include:

- The often short-term duration (and funding) of interventions.
- The lack of funds for local areas.
- Pressure taken off larger, more visible political governance structures to take effective action.
- Data on local areas is often not available.
- The dependence on active community leadership and involvement which may exclude many communities, particularly those which are already deprived and where communities are under enormous pressures and time constraints (253).

As part of their approach to reduce health inequalities, local areas are expected to make decisions in consultation with the communities whose health and wellbeing they are seeking to improve and to collaborate with local partners to create sustainable joined-up, efficient and effective services (254).

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

RECOMMENDATION: CO-CREATE INTERVENTIONS AND ACTIONS WITH COMMUNITIES	
2022/23	**2023/27**
Responsible: Place	**Responsible: Place**
• Identify methods to involve local residents in the development of health inequalities assessments and remedies at place level, for example through the creation of community engagement panels aligned to each place executive.	• Involve local residents in the development of health inequalities assessments and remedies at place level.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Co-create clear strategic approaches and specific actions for health equity with local residents and in partnership with other sectors for each community.	• Place executives to share best practice to co-create solutions and involve communities in decisions about priorities and actions.

5E STRENGTHEN THE ROLE OF BUSINESS AND THE ECONOMIC SECTOR IN REDUCING HEALTH INEQUALITIES

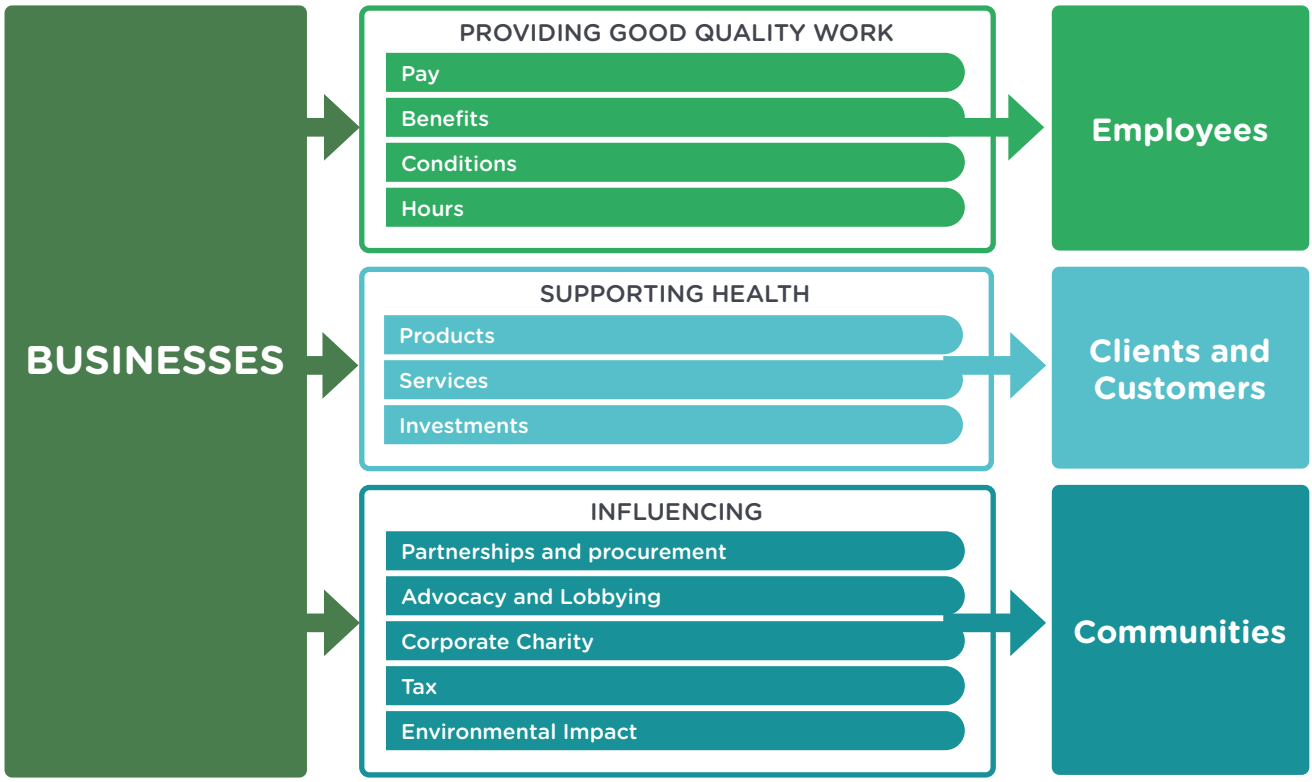
There are important and underdeveloped ways for businesses and the economic sector to use the many opportunities they have to reduce health inequalities.

Collaborations between businesses and the public sector, working in places to improve conditions and support good health are fairly uncommon, and there is great potential for businesses in the UK, including SMEs, to take further action to support health and advance positive social as well as economic impacts. This involves adapting what a successful economy looks like. Cheshire and Merseyside can support economic indicators that emphasise sustainable growth, social value and wellbeing.

Businesses can have both positive and negative impacts on health, through employment practices; through goods, services and investments; and through their impacts on communities and the environment. Reducing the harmful impact of business and enhancing the positive contribution is vital for health and wellbeing and reducing inequalities. Figure 5.2 outlines the key ways businesses shape health and inequalities.

- **Employees:** Businesses affect the health of their employees and suppliers through the pay and benefits they offer, through hours and job security, and through the conditions of work.
- **Clients and customers:** Businesses affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held.
- **Communities:** Businesses affect the health of individuals in the communities in which they operate and in wider society through local partnerships, through procurement and supply networks, and in the way they use their influence through advocacy and lobbying.

Figure 5.2. How businesses shape health: the IHE framework



Source: *Institute of Health Equity (24)*

Liverpool City Region has sought to improve the conditions for its local workforce by introducing the Fair Employment Charter, Box 33.

Box 33. Promoting fair employment in Liverpool City Region

The Liverpool City Region is delivering a Fair Employment Charter to highlight and spread good work and workplaces across Liverpool City Region. The charter was developed in partnership with employees, businesses and key partners such as trade unions, practitioners, and professional bodies and commits to ensuring:

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

Businesses in Liverpool City Region and those who want to work directly with LCR-CA are being encouraged to engage with the charter and it is being used as an avenue for how LCR-CA are seeking to tackle wider challenges and priorities around health inequalities and promoting good mental health in and out of the workplace.

National economic strategies emphasise growth and improving the competitiveness of the UK economy. In contrast, the local economy in the Cheshire and Merseyside HCP has been dealing with changing industrial patterns, years of underinvestment, all exacerbated by the COVID-19 pandemic. If economic recovery is to be healthy, more equitable, inclusive and climate-sensitive, the HCP should have a significant role. The Northern Health Sciences Alliance estimates that reducing health inequalities could generate an extra £13.2 billion GVA (2.4 percent based on 2021 quarter 4 UK GVA) for the UK economy (255) (256).

Local economic strategies can have a significant influence on local economies. The Lancashire LEP has shown the possibilities of tackling health inequalities in local economic growth plans, Box 34.

Box 34. Local Enterprise Partnerships tackling health inequalities

The Lancashire LEP has taken a strategic focus to invest in its most deprived areas, half of the growth initiatives they've introduced since 2011 have been in Lancashire's five most deprived areas. In addition, the LEP has also 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, to achieve better outcomes for all of Lancashire's residents. The Health Sector Group will work with healthcare providers and anchor institutions and employers, and will explore how better health and wellbeing provision can boost performance and drive more local economic growth.

RECOMMENDATION: STRENGTHEN THE ROLE OF BUSINESS AND THE ECONOMIC SECTOR IN REDUCING HEALTH INEQUALITIES

2022/23

Responsible: Place

- The ICS and local government make the case to businesses that they have underdeveloped impacts on health and health inequalities and should strengthen their social impacts.
- Include health in businesses environmental, social and governance strategies.

Responsible: Local enterprise partnership

- Embed wide-scale social value requirements in the Local enterprise partnerships.
- Coordinate a regional economic partnership to develop a health equity approach for businesses (for example with chambers of commerce and unions).

2023/27

Responsible: Cheshire and Merseyside System

AND

Responsible: Local enterprise partnership

- Develop a Healthy Business charter which establishes criteria for businesses who make positive contributions to the health of their workforce, through investments goods and services and through impact on more deprived communities. Meeting charter requirements enables qualification for public sector contracts. Healthy Business charter to include themes on:
  - > **Wider partnerships:** Businesses working closely with other organisations to improve local conditions and foster healthier local areas. Greater, more sustained collaborations between business, the VCFSE sector, local authorities and public services.
  - > **Workforce contributions:** Businesses to extend support for their staff to volunteer their time and expertise to support local communities so that all staff who wish to are able to support their local communities, including those employed in small and medium-sized enterprises (SMEs).
  - > **Advocacy:** Businesses to be powerful advocates for greater health equity and equity in the social determinants nationally and locally.

5F EXTEND SOCIAL VALUE AND ANCHOR ORGANISATIONS ACROSS NHS, PUBLIC SERVICES AND LOCAL AUTHORITIES

An important way for all organisations, including those in the NHS, local authorities, the VCFSE sector and businesses to reduce health inequalities and social outcomes is through adopting social value and anchor organisation approaches.

The development of anchor institutions has become an increasingly important mechanism for the NHS, and other public sector organisations to improve health and influence the social determinants of health in local areas. However, there is greater scope to further the role and expand the scope of anchor institutions in improving health in local areas, particularly the health of communities in the most deprived areas. Being a good employer is part of being an anchor. NHS organisations can build skills locally and bring those furthest from employment into meaningful employment and target recruitment, volunteering and apprenticeship opportunities in areas of greater deprivation (257). The NHS should be offering the real living wage; all contracts with minimum hours and minimal use of zero hour contracts (i.e. unless in agreement with employees); all employees offered training and development opportunities.

Many of the region's local authorities have already committed to being anchor institutions and work is occurring in many NHS institutions to integrate the concept into future planning. Cheshire and Merseyside HCP ran an interactive event in January 2022 to bring together relevant people across the system to gain a clear understanding of what it means to be an anchor institution, with a particular focus on the social and moral responsibilities of organisations. From this, and an earlier event that took place in November 2021, the HCP has drafted a framework with a set of anchor principles and priorities that form a charter for organisations to sign up to adopt. The framework will be taken out for public engagement to ensure all voices are heard on this important topic and the final framework is expected to be launched to coincide with the establishment of the ICB.

Cheshire and Merseyside HCP aim to have all 19 NHS trusts, as well as wider public sector, VCFSE sector and businesses, sign up to become anchor institutes, and state that it is their "duty" to ensure that they maximise social value opportunities, as a purchaser of goods and services, as an employer, and provider of services. In Cheshire and Merseyside, anchor institutions in the Social Value Accelerator site programme include:

- NHS providers
- Local authorities
- Clinical commissioning groups
- VCFSE sector
- Blue light services
- Schools, colleges and universities
- Business and industry

The Cancer Alliance overhauled its governance framework and working practices to ensure that all decisions on the allocation of resources are based on addressing health inequity and implementing a socially responsible supply chain. All Cancer Alliance staff have had mandatory three-hour health inequalities training and have developed supporting resources available on their website (258). The Cancer Alliance are revising their delivery of local health interventions and gradually changing the culture within their organisation; working more with VCFSE sector organisations, using community venues for workshops and events rather than large, multinational owned businesses.

SOCIAL VALUE PROCUREMENT

The Social Value Act came into force in 2013 and requires all public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental effects in the procurement of services and contracts. Social value procurement should be enhanced in NHS procurement. It is essential that the NHS takes action now to understand the broader effects of its commissioning and wider elements of social value, beyond cost minimisation (259). In August 2021, the Health Services Journal reported that a 10 percent social value weighting could become mandatory in all NHS procurement (260).

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

- The good that we can achieve within our communities, related to environmental, economic and social factors.
- An enabler for the growth of "social innovation" (SI), helping to reduce avoidable inequalities – linked to the Marmot Principles.
- A requirement of the public sector as anchor organisations to use their purchasing power to build capabilities, strengths and assets within our communities, ensuring that Cheshire and Merseyside is a great place to live and work – corporate social responsibility (CSR) is the response from suppliers, business and industry.

Health Procurement Liverpool (HPL) is an example of a local NHS Trust in Cheshire and Merseyside adopting a social value approach, Box 35.

Box 35. Health Procurement Liverpool

Health Procurement Liverpool (HPL) is a single shared procurement service set up in the spring of 2021. It is an alliance between four specialist trusts in Liverpool: Alder Hey Children's Hospital, Clatterbridge Cancer Centre, Liverpool Heart and Chest and The Walton Centre. Collectively, the alliance is one of the NHS supply chain's largest customers in the region. In 2021/22, total goods and service expenditure across the alliance was £698 million and HPL has identified that they can actively influence £131 million of this expenditure (excluding capital and payments to other NHS trusts/local authorities). It is expected this figure will increase in subsequent years.

HPL is the first procurement service in Cheshire and Merseyside to come together as one with each organisation remaining as a stand-alone legal entity. HPL has created a single procurement work plan, so where in the past each trust would procure taxi transportation four times, in the future HPL will procure a single service provider. The four trusts are at the beginning of this process and the first tasks involve aligning contract renewal dates to ensure single procurement across the alliance in order to achieve better pricing and single contract terms.

In addition to shifting procurement to local suppliers, HPL is also committed to offering procurement teams opportunities for career progression, development and growth, which they would have struggled to offer as single trusts. Procurement teams are shifting from being seen as a transactional service to a strategic supporting service, asking questions to encourage innovation and build value into all of their decisions.

COMMUNITY WEALTH-BUILDING

Community wealth-building, where local economies are reorganised so that wealth is not extracted from an area but recirculated, has been advanced in Preston, through 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 rather than focusing on attracting national or international investment.
- **Fair employment:** As larger employers, anchor institutions can make a massive impact on the prospects of local people by recruiting from lower-income areas, committing to paying the living wage, and promoting progression routes for workers.
- **Progressive procurement:** Developing dense local supply chains of SMEs, employee-owned businesses, social enterprises and cooperatives. These types of businesses are more likely to support local employment.
- **Socially productive use of land and property:** Anchor institutions often hold large amounts of land and property, these represent a base from which local wealth can be accrued.

New research in Cheshire and Merseyside is examining how to take approaches such as social value, anchors and community wealth building to become integrated into procurement and commissioning processes, Box 36.

Box 36. Community wealth-building in Cheshire and Merseyside

Community wealth-building in Preston, often referred to as "The Preston Model", began in 2011 when Preston City Council began discussions with the Centre for Local Economic Strategies (CLES) with the goal of tackling inequality in economic development. The first step was Preston City Council committing to paying all their 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 in researching the proportion of anchor institution procurement that was local to Preston and Lancashire.

The Preston Community Wealth Initiative involved all the large public and VCFSE sector organisations in Preston, and analysed how they spent their budgets, aiming to increase procurement from local suppliers, and where local suppliers were not available they helped establish new charities and cooperatives. The Preston Community Wealth Initiative also improved the conditions of their employees, increasing their wages and encouraging suppliers to do the same.

CLES found that 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 percent to 18.2 percent in Preston and from 39 percent 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.

Liverpool University is working with Preston City Council, the Centre for Local Economic Strategies (CLES) and the Universities of Lancaster and Central Lancashire in this National Institute of Health Research (NIHR) to understand the extent to which the Preston model has led to health and wellbeing benefits. The research will calculate the effect of the Community Wealth Initiative on mental health and will work with all the organisations involved in the initiative to understand what has helped or hindered this. It will involve a procurement analysis with anchor institutions in a selected number of local authority areas to estimate the percentage spent by these institutions in their local economy. The findings will be used in comparative analysis with Preston and will provide a baseline for assessing the development of future community wealth-building. In addition, a Community Wealth Building Community of Practice will also be set up for participating areas to share findings from the research and develop a toolkit to support implementation of the findings (261).

RECOMMENDATION: EXTEND SOCIAL VALUE AND ANCHOR ORGANISATIONS	
2022/23	**2023/27**
Responsible: Place	**Responsible: Place**
• Implement and enforce a 15 percent social value weighting mandatory in all NHS procurement.	• Work with local businesses to extend social value policies and focus on principles to reduce health inequalities.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Extend anchor organization approach within the NHS and to all other stakeholders (such as public services and local authorities, academic institutions, police).	• Establish anchor institutions network across the region to support each other in building community wealth, local training, and employment opportunities.

5G DEVELOP SOCIAL DETERMINANTS OF HEALTH IN ALL POLICIES AND IMPLEMENT MARMOT INDICATORS

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

As part of NHSE's actions to address health equity, they have introduced Core20PLUS5, which seeks 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. Core20PLUS5 also adopts a flexible approach, to add an additional focus on particular communities, which is defined at the local level of ICSs (262) (80). Whilst the work of Core20PLUS5 is much valued, there are two key concerns: first, the Core20PLUS5 programme targets the most deprived segment of the population and does not work across the social gradient, as such there will be parts of the population who miss out on this programme. Secondly, the Core20PLUS5 focuses on five clinical areas and not on the causes of ill health, as such, the impact of the social determinants of health is not yet included in the programme (2).

Adopting a health equity and social determinants of health approach means all stakeholders are expected to explicitly consider the health equity implications of decisions they make including investments made and policies enacted. A health equity in all policy approach identifies how processes can unknowingly exacerbate inequalities in policies, decision-making and resource allocation (75). Since the IHE's 2010 report, a number of organisations outside of the NHS, such as the police, fire fighters, social care, housing and early years workforces, have developed approaches to tackling health inequalities, by extending and adapting their day-to-day practices and procurement.

These examples illustrate the possibility of health equity in all policies. Box 37 outlines the Health Equity Assessment Tool (HEAT), a practical tool to identify and address health inequalities and improve health outcomes.

Box 37. The Health Equity Assessment Tool

HEAT is a tool developed by Public Health England for professionals in public health and beyond. HEAT can be, and has been, used by local authorities, NHS providers and commissioners (including ICSs and PCNs), the VCFSE sector and other sectors with a role in health, wellbeing and the social determinants of health (such as housing, welfare and education). HEAT is used to systematically address health inequalities and equity related to a programme of work or service and to identify what action can be taken to reduce health inequalities and promote equality and inclusion.

There are 4 main stages to HEAT:

Prepare: agree the scope of work and assemble the information you require

Assess: examine the evidence and intelligence related to your work area or service

Refine and apply: focus on the most impactful actions, informed by evidence

Review: consider progress against relevant targets/indicators, informed by evidence

The benefits of using the HEAT are that it: provides a clear and straightforward format; supports professionals to determine concrete actions to tackle inequalities; can be adapted for use across a range of different work programmes and services and can be embedded into existing systems and processes, for example, as part of business planning, the commissioning cycle, service review or COVID-19 recovery planning; and encourages ongoing monitoring and review, enabling consideration of lessons learned and continued areas for focus.

HEAT has been used in a number of settings and services across the North West; in Long COVID services, Smoking at the Time of Delivery (SATOD) programmes with maternity services and acute respiratory pathways. In addition, over 150 local authority staff across the North West have been trained in the use of HEAT (263).

MARMOT BEACON INDICATORS

The IHE 2010 and 2020 reports stated local, regional and national areas should focus on and measure what is important, not just what can be easily measured (76) (1). Health inequality indicators should include social determinants of health data and include factors that affect the early years, children and young people in school, work and through housing as well as health outcome data.

Part of our remit was to co-create a set of health inequalities indicators for Cheshire and Merseyside. We therefore proposed a social determinants indicator set which was locally appropriate, related to the communities themselves, covered the main drivers of health and was shared by all stakeholders known as the Marmot Beacon Indicators.

The NHS has many sets of indicators, however these Marmot Beacon Indicators are to be owned by the Cheshire and Merseyside system. The NHS are holders of the indicators but it is the responsibility of all partners across the Cheshire and Merseyside system to implement and deliver the Marmot Beacon Indicators. The Combined Intelligence for Population Health Action (CIPHA) programme is in its second year in 2022 and is key to monitoring of the Marmot Beacon indicators, as they provide access to and analysis of the data related to health inequalities and the social determinants of health.

The *Fair Society, Healthy Lives* report outlined the development of indicators to measure health inequalities, stating they should be SMART (specific, measurable, achievable, relevant and time-bound) (76). We include indicators to support and measure performance improvement in the short, medium and long term that, while ambitious, are realistic. We also worked with Cheshire and Merseyside partners to develop new, innovative, indicators to address current gaps in performance monitoring. This includes two new, social value metrics to monitor the strategic impact of future social value and anchor programmes (83) (264) and a metric covering discrimination and ethnicity to assess the proportion and banding of local authority and NHS employees from ethnic minority populations. These have been shared with NHSEI colleagues to inform national framework development.

In selecting indicators, the discussions in all meetings focussed on measuring indicators that are influenced by local actions, together these indicators are aiming to reduce health inequalities, as will be shown in the first two indicators, life expectancy and healthy life expectancy.

Currently, in 2022, not all proposed indicators are disaggregated by socioeconomic position or other stratifier. Ideally, each indicator would disaggregated by income or deprivation level, sex and ethnicity.

All of the proposed indicators are available at local authority level, however some are not at the level of granularity needed to monitor inequalities within local authorities. However, they can be used to compare local authority with national and regional outcomes. Throughout the process, a number of shortcomings were identified (such as the need for indicators to show outcomes below local-authority level, at, for example, MSOA level), and participants asked to include a wish list of aspirational indicators, these are found after the proposed indicators.

The proposed indicators are aligned with the Marmot themes that are outlined in this final report covering areas which are considered critical in reducing health inequalities. The stages in the development of the indicators are set out below.

Figure 5.3. Stages in the development of Marmot Beacon Indicators for Cheshire and Merseyside

STAGE 1

We initially met with representatives from CIPHA, the directors of public health and health analysts, as well as those holding data or interested in collecting data from outside of public health, including the VCFSE sector, to establish who were the key stakeholders and what might be possible.

During these discussions, IHE introduced the Marmot indicators recently published by Greater Manchester (103). This led to a long list of over 40 potential indicators for Cheshire and Merseyside. There was agreement that Cheshire and Merseyside should aim for 15-20 indicators which will sit within a specific tab in the CIPHA population health dashboard. Many of the indicators in Greater Manchester were aspirational and based on the creation of new and/or future data sets. There was agreement with stakeholders across the region that most indicators should be able to be collected in 2022/23. A separate list of aspirational indicators was collected at the same time.

Discussions with IHE, CIPHA and Champs Public Health Collaborative, reduced the long list of potential indicators to a shorter set, aligning to social determinants of health categories and also based on what data could be collected and analysed by CIPHA and levels of disaggregation.

STAGE 2

Two workshop sessions were held in the summer and early autumn of 2021. The first session brought together local authority and NHS analysts, the second with analysts and those interested in data from outside of the NHS. Based on these discussions, two new, innovative social value metrics have been developed to monitor the combined impact of healthy, inclusive economy interventions.

STAGE 3

The proposed indicators were discussed in each of the nine place-based workshops. Consultation during the nine place workshops also identified a number of aspirational indicators where data is not consistently collected at national or Cheshire and Merseyside level such as employers paying the real living wage and welfare support, which require development.

The indicators were also discussed at a meeting with the Marmot Advisory Board in December 2021.

As a result of this feedback, the indicators were further refined by IHE, CIPHA and Champs Public Health Collaborative.

STAGE 4

The final set of draft indicators were presented to the Champs Public Health Collaborative in January 2022. They were approved by the Marmot Advisory Board in April 2022.

NEXT STEPS

In 2022/23, CIPHA will work with system partners to integrate the Marmot Beacon indicators into organisational monitoring and to place them within CIPHA's Population Health dashboard in the summer of 2022.

Baseline data will be available for 18 indicators in Q1 2022/23.

Data on three of the indicators, those related to racism and social value, is not currently collected and will require considerable development during 2022/23, including agreement of data measurements, development of new NHS and LA recording fields, system upgrades and dataflows into CIPHA. It is expected these indicators will be available by the end of Q3 2022/23.

The Champs Public Health Collaborative, CIPHA and IHE will work together in 2022/23 to establish data recording and collection systems across the sector, agree improvement targets, provide ongoing analysis within the CIPHA Population Health dashboard and communication of indicator outcomes to the ICS, places and communities.

Integration of the Marmot Beacon indicators into the CIPHA Population Health dashboard will enable the following outcomes:

- Longitudinal monitoring of new, innovative social value metrics to demonstrate the impact of healthy and inclusive economies interventions across Cheshire and Merseyside.
- Development and analysis of new, aspirational Marmot data indicators to quantify and monitor population levels of real living wage employers and welfare need.
- Strategic monitoring of system-wide progress in reducing the inequalities gap in health and the social determinants of health between places in Cheshire and Merseyside and England.
- Organisational ownership and commitment to reducing inequalities in the social determinants of health and improving health outcomes.

The first report of the Marmot Beacon indicators for Cheshire and Merseyside will be published after the first year, establishing a baseline. Subsequently the Marmot Beacon Indicators will be reported on an annual basis, though some may be available quarterly.

The Cheshire and Merseyside Beacon indicators will be used to track and assess system progress on reducing inequalities in Cheshire and Merseyside and will be monitored annually.

RECOMMENDATION: DEVELOP SOCIAL DETERMINANTS OF HEALTH IN ALL POLICIES AND IMPLEMENT MARMOT INDICATORS	
2022/23	**2023/27**
Responsible: Place	**Responsible: Place**
• Adopt Cheshire and Merseyside's Marmot Beacon indicators in their own organisations (for example, NHS, local authorities, businesses and the VCFSE sector).	• Integrate social determinants of health in all policies and in all work commissioned. All local government, NHS strategies and decisions assessed for social determinants of health impacts.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Communicate annual indicator outcomes to local places, public.	• Use social determinants and ethnicity data collected from patients in primary and secondary care by CIPHA to influence how services are offered and how they are delivered to better meet the needs of communities. • Review and renew Marmot indicators every five years. • Develop a social determinants of health assessment tool to ensure social determinants of health are at the heart of interventions and policies in Cheshire and Merseyside including in the healthcare system.

CHAPTER 6

PROPOSED MARMOT BEACON INDICATORS

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

ASPIRATIONAL INDICATORS

Health and wellbeing of children and young people – Oxwell is a survey of selected schools in England and includes a number of potential indicators.

Percentage of employees employed by a living wage employer or number of living wage employers – the latter has been measured in Greater Manchester.

Debt and debt advice, food bank use – Citizens Advice Liverpool have been working with Liverpool CCG for a number of years and sharing data to monitor the Advice on Prescription programme. This partnership represents the opportunities to better understand the social determinants of health if data is shared between the NHS and external organisations. This would require consistent data collection by Citizens Advice across Cheshire and Merseyside.

Community resilience and cohesion – Greater Manchester carried out a series of representative surveys of their population which have provided data on information difficult to collect. These community surveys were often carried out in the past by local authorities and require funding in Cheshire and Merseyside.

CHAPTER 7
RECOMMENDATIONS

IHE proposes the following Marmot 8 and system-wide recommendations for action across the Cheshire and Merseyside system. The recommendations are classified in two categories: Year 1 (2022/23) and Years 2-5 (2023-27). They include recommendations for the system to further understand key issues as well as those directly focussing on improving outcomes.

The system recommendations are important to enable and support actions in the thematic areas. Recommendations are given for each of the Marmot 8 principles and system-wide themes in Year 1 and Years 2 to 5. A lead organisation is suggested for each recommendation though most, if not all, should be developed and implemented in partnership.

In light of pressures on local authority budgets, it is suggested that each of the nine places in Cheshire and Merseyside identify the recommendations most relevant to their area and focus on these. A mix of system and thematic recommendations is important. There is a role for the ICS/Champs Public Health Collaborative to monitor the status, implementation and best practice of the recommendations in each place to help other areas develop actions in subsequent years.

1. GIVE EVERY CHILD THE BEST START IN LIFE		
2022/23	**2023/27**	**RELATED MARMOT INDICATOR**
Responsible: Place	**Responsible: Place**	**3** Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development). **4** Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception).
• Review inequitable outcomes in early years and bring systems together within each place to ensure equitable early intervention, involving all partners (such as education, social care - children's services, communities and the VCFSE sector, children's boards, public services, NHS, local authorities). • Assess early years provision and parental support within each place and provide further support for early years settings in more deprived areas and in collaboration with communities in these areas and / or families with disabilities, or English as a second language for example. • Assess how the ACEs agenda links to the early years approach in Cheshire and Merseyside and ensure families' voices are included in this agenda.	• Work in partnership to improve school readiness for all and reduce inequalities between children eligible and not eligible for free school meals. Ensure support is focussed to develop children's early learning, especially with regard to speech and language skills and the ACEs agenda. • Ensure shared accountability across the system and within each place to give every child the best start in Cheshire and Merseyside (include children's public health, early years and wider family services including education and VCFSE sector).	
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**	
• Assess maternity leave policies and support for child care by all employers, including private business.	• Develop a region-wide childcare workforce standard, which includes training and qualifications on the job to a higher standard and pay than national requirements.	

2. ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Place • Better communicate available youth services and reduce inequalities in access to these, including transport costs. • Assess provision of career guidance and aspiration approaches in primary, secondary schools and FE colleges at each place. • LEP/Chamber of Commerce work with businesses to support links with schools for training and recruitment and offering mentorships and for provision of youth services. • Work with young people to hear their views about what is needed in local areas.	**Responsible: Place** • Extend free school meal provision for all children in households in receipt of Universal Credit and resource holiday hunger initiatives adequately at each place. • All young people who are able are either in training, employment and education up until the age of 21. • Commission the VCFSE sector to provide leisure and recreation opportunities in each place.	**5** Average Progress 8 score. **6** Average Attainment 8 score. **7** Hospital admissions as a result of self-harm (15-19 years). **8** NEETS (18 to 24 years). **9** Pupils who go on to achieve a level 2 qualification at 19.
Responsible: Cheshire and Merseyside System • ICS to develop NHS actions to support young people's education and skills and liaising with schools and employers and NHS recruitment and training.	**Responsible: Cheshire and Merseyside System** • Develop a regional young persons' skills strategy in partnership with the LEP and businesses with a focus on areas with higher levels of deprivation and those most at risk of exclusion and a focus on apprenticeships and in-work training.	
Responsible: Children and Young People Board • Jointly commission (NHS, local government and national government) and increase funding for programmes to support young peoples' mental health in schools, the community and at work.	**Responsible: Local Enterprise Partnership and anchor partners** • Increase minimum wage for apprenticeships (LEP, businesses). • Work in partnership to provide skills development and training opportunities for young people in each place.	
Responsible: Mental Health Board • Review mental health support team funding to ensure it is reducing inequalities.	**Responsible: Mental Health Board** • Based on review carried out in year 1, monitor outcomes for equity based on mental health support team work.	

3. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Place • Assess local workplaces and their capacity to produce and implement policies to recruit and retain people with a disability or long-term condition.	**Responsible: Place** • Monitor policies to recruit and retain people with a disability or long-term condition. • Build on actions to increase local recruitment into all jobs and work with employers to improve retention rates. • Provide guidance to workplaces to recruit and retain people with a disability or long-term condition. • Work with businesses, chambers of commerce, public sector, NHS and local authorities to improve support for mental health, housing and finances in all workplaces. • Target funding for adult education in more deprived communities and link to job market demands. Offer training and support to older unemployed adults and ensure the private sector participates in training and skills development and link this to the regional good work standard.	**10** Percentage unemployed (aged 16-64 years). **11** Proportion of employed in permanent and non-permanent employment. **12** Percentage employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter. **13** Percentage of employees earning below real living wage.
Responsible: Cheshire and Merseyside System • Establish criteria for healthy workplace standards for public and private sectors. To include: - Wages to meet the minimum income for healthy living. - Provision of in-work benefits including sick pay, holiday and maternity/paternity pay. - Provision of advice and support e.g. debt and financial management, housing support at work. - Provision of education and training on the job. - Strengthen equitable recruitment practices including provision of apprenticeships and in work training, recruitment from local communities and those underrepresented in the workforce.	**Responsible: Cheshire and Merseyside System** • Implement adoption of the healthy business and healthy employment / regional good work standard. Include within commissioning contracts. **Responsible: Local Enterprise Partnership and anchor partners** • ICS and LEPS to work together to develop relationships with local large and small and medium-sized enterprises (SMEs) to make the case for healthy employment and health equity. Large businesses to take the lead and share best practice. • Offer on the job training and skills development and link this to the regional good work standard.	

4. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Place	**Responsible: Place**	**14** Proportion of children in workless households. **15** Percentage of individuals in absolute poverty, after housing costs. **16** Percentage of households in fuel poverty.
• Work with local residents and local stakeholders to understand "true" regional poverty and local financial pressures, including the reality of all care costs, in-work poverty, debt burden, tax credit and welfare reforms, benefits, and housing costs (such as through Poverty Truth Commissions). • Make the case to the VCFSE sector and local authorities to shift from only emergency provision to act on the social determinants of health. • Map social welfare and legal advice providers to facilitate development of registry of services for the NHS. ICS to support advice networks (such as Liverpool Access to Advice Network and Citizens Advice).	• Work with local community and employer institutions to provide credit, reduce levels of debt and increase financial management advice in schools and workplaces. • Shift from crisis to prevention approaches in delivering food security and have as a goal eliminating the need for food banks.	
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**	
• Define a minimum income for healthy living for the region. • Identify how primary and secondary NHS care can better refer to fuel and food insecurity support services.	• Monitor offer of minimum income for healthy living and include requirement to paying minimum income within commissioning contracts. • Collect and publish data on local employers paying minimum income for healthy living. • Support advocacy to increase national funding to eradicate all fuel and food poverty.	

5. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Place	**Responsible: Place**	**17** Households in temporary accommodation
• Review private rented sector regulation actions in the Levelling Up white paper. • Support national advocacy to strengthen local powers and capacity within enforcing authorities across planning and housing. • Define affordable housing in Cheshire and Merseyside and link to "true" regional poverty. • Create a platform where housing and local residents can communicate about how housing is impacting on health and wellbeing. • Develop place-based partnerships to strengthen approaches to community policing (such as public and mental health, police, DWP, children's service), and develop a public health approach to violent crime. • Work with local residents and partners (such as businesses and the NHS) to improve quality of existing green spaces in areas of higher deprivation. • Develop region-wide actions to create health promoting environments (unhealthy advertising and planning decisions, for example). • NHS, local government work in partnership to regenerate areas. Work alongside local communities to better include their needs when reviving local high streets. • Extend incentives to encourage people back to public transport.	• Work in partnership to implement adoption of decent home standards in all social and private rented sector housing. • Ensure that all housing developments contain a minimum of 30 percent of dwellings classed as "affordable" and support local control of the local housing allowance and ensure it covers 50 percent of market rates. • Prioritise provision of new green spaces in areas of higher deprivation. • Adopt city-wide strategies that put health equity and sustainability at the centre of planning. • Develop and implement housing and social conditions assessment to be used in primary and secondary health care appointments and develop monitoring of these questions.	

Responsible: Cheshire and Merseyside System	Responsible: Cheshire and Merseyside System	
• Appoint senior role in housing and health in ICS (including homelessness and rough-sleeping). • NHS to scale up provision of services and invest in preventing street homelessness and work with the VCFSE sector and local authorities. • Partner with NHS and local government, housing and tenant associations to assess housing standards in the private rented sector. • Develop health and wellbeing checks for people living in temporary accommodation and appropriate referral pathways (such as housing services, social welfare advice and employment).	• NHS to coordinate investment and action to take a leading role in strengthening partnerships with the housing sector, including the private rental sector and local residents.	
Responsible: Liverpool City Region Combined Authority	**Responsible: Cheshire and Warrington Travel**	
• Health equity assessment of Liverpool City Region additional transport investment and new proposals to create "London-style" transport system. Share findings with Cheshire and Warrington.	• Health equity assessment of transport provision in Cheshire and Warrington to support Cheshire and Merseyside approach.	

6. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Cheshire and Merseyside System • Cheshire and Merseyside Clinical Networks to work with the ICS to coordinate social determinants of health activity across the system to improve population health. • Extend current ill health prevention policies and actions to adopt an equity and the social determinants of health approach, embed social determinants of health approach in ICP contracts and plans. • Assess the total funding allocations and receipts by local area deprivation in Cheshire and Merseyside. • Adopt Deep End approach (or equivalent) in primary care. • ICS review social prescribing offer in Cheshire and Merseyside to ensure it is addressing the social determinants of health. • Prioritise reducing social isolation as a health intervention with greater involvement from the NHS and make use of Local Enterprise Partnership's influence, connections with big businesses, skills and financial resources to increase social connectedness.	**Responsible: Place** • Reduce inequalities in digital exclusion by delivering hardware and funding support for basic digital skills. **Responsible: Cheshire and Merseyside System** • Review impact of Prevention Pledge and Making Every Contact Count in reducing inequalities. • Allocate health resources proportionately, with a focus on the social determinants. • Revise social prescribing offer to focus on the social determinants of health (such as housing, debt and financial advice).	**18** Activity levels **19** Percentage of loneliness
Responsible: Mental Health Board • Map digital exclusion in the region and develop networks with partners in healthcare, local authorities, the VCFSE sector, education and businesses to identify tools to reduce digital exclusion. • Align local poverty strategies to include commitment to reducing digital exclusion.		

7. TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Place	**Responsible: Place**	**18** Percentage of employees who are from ethnic minority background and band/level.
• Businesses, public sector and the VCFSE sector to actively communicate and publish how meeting equality duties in recruitment and employment including pay, progression and terms.	• Involve the VCFSE sector organisations and networks tackling racism in businesses and the public sector.	
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**	
• Work with NHS, local authorities, public sector and businesses to gather data on their workforce by ethnicity and by pay and grade. • Reinforce the efforts of health and social care providers to facilitate equitable access to their services and all health and social care providers are collecting data on service users by ethnicity. • Require all health and social care providers to collect data on service users by ethnicity. • ICS to establish effective engagement with all ethnic minority communities and involve communities, the VCFSE sector and community leaders in the assessment of current and development of new services and interventions.	• Based on findings in Year 1, set actions to reduce racism and its outcomes in the NHS, local authorities, public sector and businesses. • Ensure there is critical feedback and evaluation with involvement from ethnic minority communities. Develop improved data collection methods, including qualitative methods.	

8. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

2022/23	2023/27	RELATED MARMOT INDICATOR
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**	
• ICS work with local government, housing associations to retrofit homes, including private homes, to reduce fuel poverty and greenhouse gas emissions. • Work with local authorities, businesses and chambers of commerce to prioritise the health and wellbeing of citizens and environmental sustainability in economic recovery and growth policies. • Enforce existing smokeless fuel standards. • Health equity assessment of Cheshire and Merseyside Green Plan and Place-based Green plans in each of Cheshire and Merseyside's nine local authorities.	• Passive cooling measures included as standard in retrofits and new builds that are at risk of high indoor temperatures. • Installations of new wood burning and gas stoves in urban areas eliminated and existing stoves phased out. • Ensure any new walking and cycling infrastructure reaches areas with the lowest rates of physical activity.	**21** Percentage (£) spent in local supply chain through contracts. **22** Cycling or walking for travel (3 to 5 times per week).

SYSTEM CHANGE RECOMMENDATIONS

A. INCREASE AND MAKE EQUITABLE FUNDING FOR SOCIAL DETERMINANTS OF HEALTH AND PREVENTION

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Assess the budget for addressing the social determinants of health in the NHS and local authorities across Cheshire and Merseyside in 2022/23. Work with the VCFSE sector to include their contributions to addressing the social determinants of health. • Assess resource allocation in Cheshire and Merseyside and develop and extend proportionate universal approaches. Assess possibility of local weighted funding formula to better address health inequalities. • Benchmark NHS and local government funding for social determinants of health.	• Increase local government funding for social determinants of health by 1 percent a year for the next 10 years (after accounting for inflation). • Increase NHS funding for social determinants of health by 1 percent a year for the next 10 years to address wider social determinant prevention (after accounting for inflation). • Develop resource allocation formula to ensure that funding allocations are equitable and proportionate.

B. STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Integrate Place Plans in each place executive and create MoU between place executives and health and wellbeing boards to align health and wellbeing strategies and Place Plans. • Strengthen the role of the director of partnerships at board level.	• Embed partnerships across local systems with healthcare, the VCFSE sector, local economic plans, and strategies beyond leaders.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Develop a social determinants of health equity network to include business and economic sector, public services, the VCFSE sector, local government and communities.	• Continue to invest in the health equity network.

SYSTEM CHANGE RECOMMENDATIONS

C. CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTH EQUITY

2022/23	2023/27
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• ICS to jointly appoint a lead in public health (qualified or experienced) with a supporting team in Champs Public Health Collaborative to work in partnership with the ICS medical director and nursing director and the directors of public health to lead on health inequalities and partners. • Champs Public Health Collaborative and nine directors of public health to work in partnership with the ICS to ensure sustained action to address inequalities is embedded in ICS strategy.	• Champs Public Health Collaborative and nine directors of public health to work in partnership with the ICS to ensure sustained action to address inequalities is embedded in ICS strategy.

D. CO-CREATE INTERVENTIONS AND ACTIONS WITH COMMUNITIES

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Identify methods to involve local residents in the development of health inequalities assessments and remedies at place level, for example through the creation of community engagement panels aligned to each place executive.	• Involve local residents in the development of health inequalities assessments and remedies at place level.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Co-create clear strategic approaches and specific actions for health equity with local residents and in partnership with other sectors for each community.	• Place executives to share best practice to co-create solutions and involve communities in decisions about priorities and actions.

SYSTEM CHANGE RECOMMENDATIONS

E. STRENGTHEN THE ROLE OF BUSINESS AND THE ECONOMIC SECTOR IN REDUCING HEALTH INEQUALITIES

2022/23

Responsible: Place

- The ICS and local government make the case to businesses that they have underdeveloped impacts on health and health inequalities and should strengthen their social impacts.
- Include health in businesses environmental, social and governance strategies.

Responsible: Local enterprise partnership

- Embed wide-scale social value requirements in the Local enterprise partnerships.
- Coordinate a regional economic partnership to develop a health equity approach for businesses (for example with chambers of commerce and unions).

2023/27

Responsible: Cheshire and Merseyside System

AND

Responsible: Local enterprise partnership

- Develop a Healthy Business charter which establishes criteria for businesses who make positive contributions to the health of their workforce, through investments goods and services and through impact on more deprived communities. Meeting charter requirements enables qualification for public sector contracts. Healthy Business charter to include themes on:
  - > **Wider partnerships:** Businesses working closely with other organisations to improve local conditions and foster healthier local areas. Greater, more sustained collaborations between business, the VCFSE sector, local authorities and public services.
  - > **Workforce contributions:** Businesses to extend support for their staff to volunteer their time and expertise to support local communities so that all staff who wish to are able to support their local communities, including those employed in small and medium-sized enterprises (SMEs).
  - > **Advocacy:** Businesses to be powerful advocates for greater health equity and equity in the social determinants nationally and locally.

SYSTEM CHANGE RECOMMENDATIONS

F. EXTEND SOCIAL VALUE AND ANCHOR ORGANISATIONS

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Implement and enforce a 15 percent social value weighting mandatory in all NHS procurement.	• Work with local businesses to extend social value policies and focus on principles to reduce health inequalities.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Extend anchor organization approach within the NHS and to all other stakeholders (such as public services and local authorities, academic institutions, police).	• Establish anchor institutions network across the region to support each other in building community wealth, local training, and employment opportunities.

G. DEVELOP SOCIAL DETERMINANTS OF HEALTH IN ALL POLICIES AND IMPLEMENT MARMOT INDICATORS

2022/23	2023/27
Responsible: Place	**Responsible: Place**
• Adopt Cheshire and Merseyside's Marmot Beacon indicators in their own organisations (for example, NHS, local authorities, businesses and the VCFSE sector).	• Integrate social determinants of health in all policies and in all work commissioned. All local government, NHS strategies and decisions assessed for social determinants of health impacts.
Responsible: Cheshire and Merseyside System	**Responsible: Cheshire and Merseyside System**
• Communicate annual indicator outcomes to local places, public.	• Use social determinants and ethnicity data collected from patients in primary and secondary care by CIPHA to influence how services are offered and how they are delivered to better meet the needs of communities. • Review and renew Marmot indicators every five years. • Develop a social determinants of health assessment tool to ensure social determinants of health are at the heart of interventions and policies in Cheshire and Merseyside including in the healthcare system.

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