EXECUTIVE SUMMARY

INSTITUTE of HEALTH EQUITY

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

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 in the region through action on the social determinants of health and to build back fairer from COVID-19.

The report's approach reflects the views of many we heard from in Cheshire and Merseyside since we began work in July 2021. "We need to do something different or nothing will change", "If we keep doing what we've done in the past, inequalities will continue to worsen".

The case for reducing health inequalities is clear - they are unnecessary and unjust, harm individuals, families, communities and place a huge financial burden on services, including the NHS, the voluntary and community sector and on the economy. Health inequalities are remediable by reasonable means and, even without national government support, are remediable to some extent. Despite deteriorating health and widening inequalities across the country and in Cheshire and Merseyside, there is scope for local areas to make a real difference. Changes in approach, allocation of resources and strengthened partnerships are essential.

The report sets out inequalities in health and in the social determinants of health in Cheshire and Merseyside and assesses the impacts of the COVID-19 pandemic on health inequalities and the social determinants. It points to the role of austerity policies and associated funding cuts between 2010-20 in driving these inequalities.

The recommendations made in the report cover the key social determinants of health – the eight Marmot principles and seven actions across for the Cheshire and Merseyside stakeholders and system. The recommendations are classified in two categories: Year 1 (2022-23) and Years 2-5 (2023-27) and they challenge the region to take actions on the social determinants of health, develop a regional system to take forward these actions and develop a healthier and more equitable region.

THE REGION

The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. The region has areas of substantial wealth and substantial deprivation.

Overall a third (33 percent) of Cheshire and Merseyside population live in the most deprived 20 percent of neighbourhoods in England, with significant negative implications for health (1). The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England (2).

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 (2). Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31 percent of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared to an England average of 20 percent, 16 percent of neighbourhoods in Cheshire West and Chester are in the lowest income deciles (2).

Extensive cuts to local authority budgets and increasing inflation has resulted in many of the social determinants of health – housing, education, early years, youth services, legal aid and police, the services offered by the voluntary, community, faith and social enterprise sector – to suffer real cuts for many years. The Public Health Grant fell by 22 percent between 2015-16 and 2020-22. Knowsley, the most deprived local authority in the HCP, had the highest spending cuts in the region at £725 per head of population (3).

The 2022 Levelling Up white paper is unlikely to provide sufficient funding to address health inequalities across all of Cheshire and Merseyside. Again, Knowsley, despite its high level of deprivation, received no funding from these Levelling Up funds whilst a number of areas that are the wealthiest in England received over £100 a head (4).

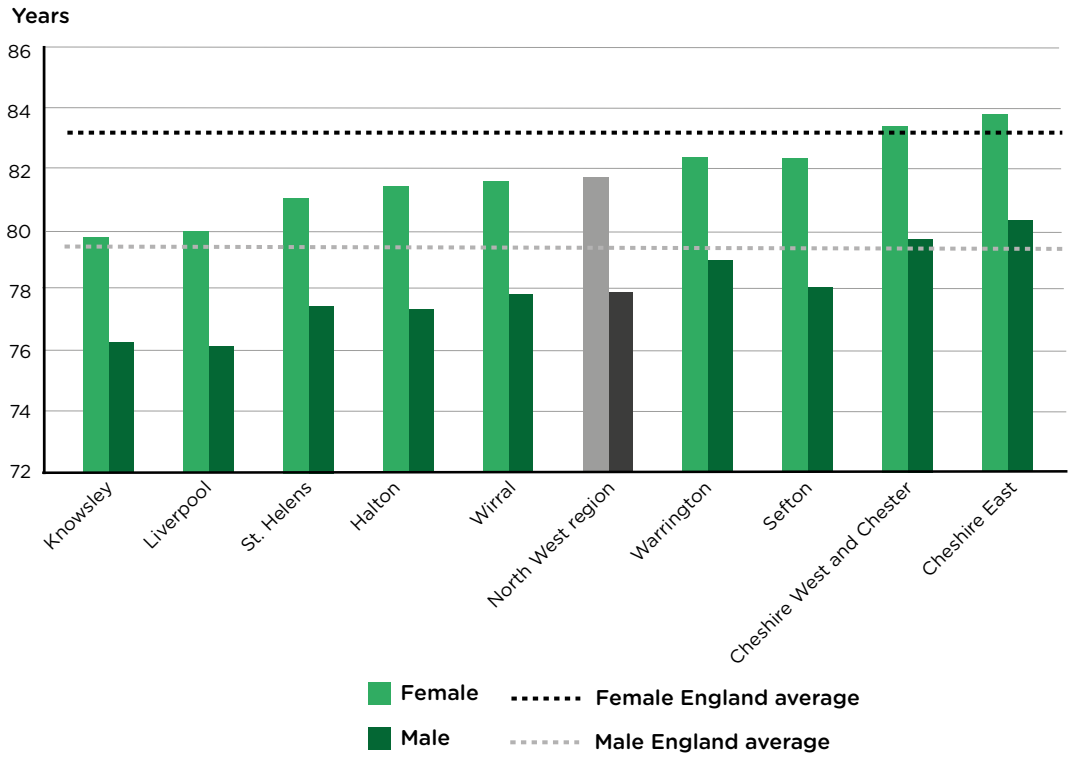
EVIDENCE

LIFE EXPECTANCY

Austerity policies from 2010-20 in England have had substantial impacts on services offered and subsequently on health and inequalities. Across England, life expectancy for the most deprived areas outside London declined, even before the pandemic and this is likely a direct result of cuts to public services and local government, reductions in benefits and low-quality work and low pay.

Within Cheshire and Merseyside life expectancy is generally below the average for England, except in Cheshire West and Chester and Cheshire East.

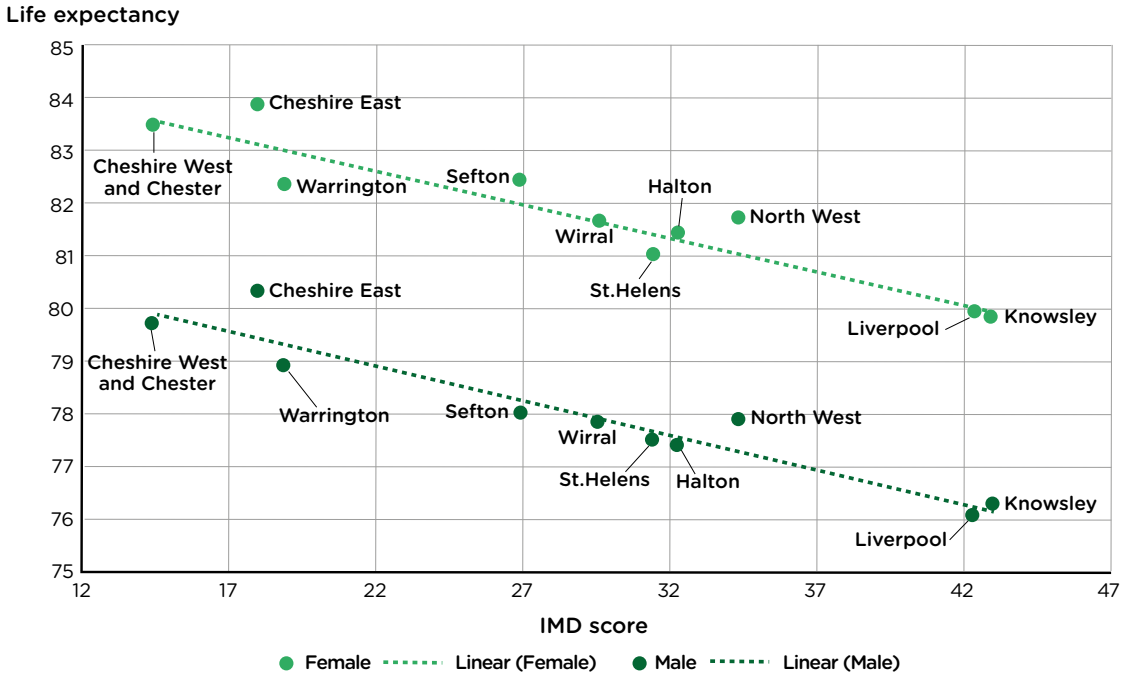
Estimated male and female life expectancy at birth, Cheshire and Merseyside lower tier local authorities, North West region, and England, 2018–2020



Source: *Office for National Statistics. (5)*

Women living in the most deprived areas live 12 years less than those in the least deprived areas, and for men, the difference is 13 years. Within local authorities there are even greater inequalities in life expectancy closely related to level of deprivation.

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



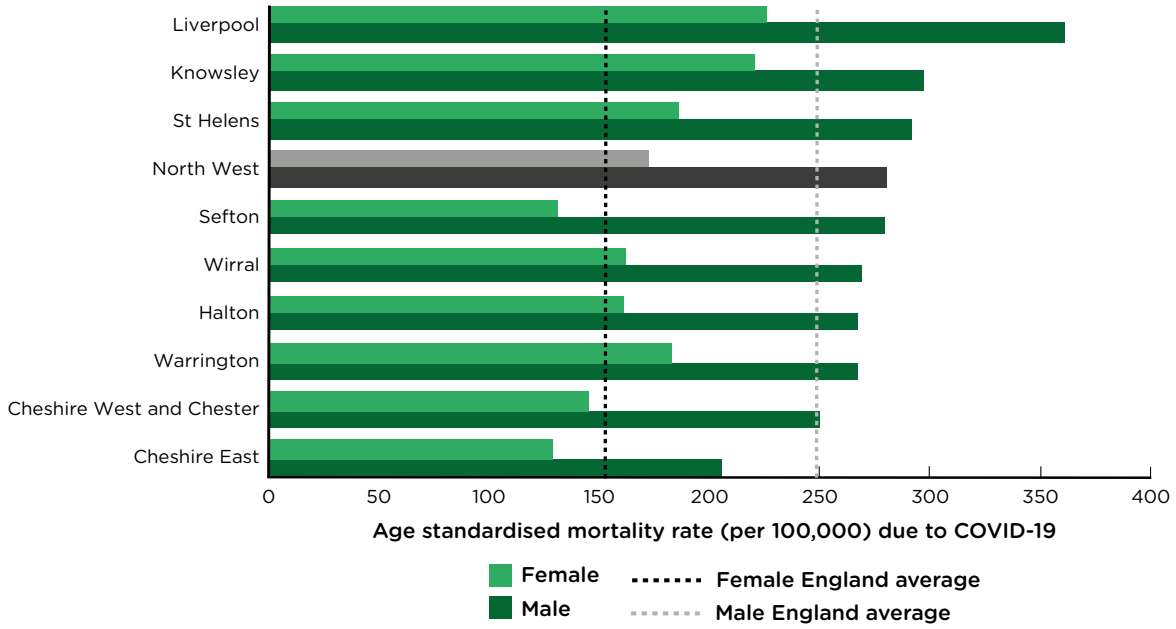
Source: *Office for National Statistics. (5)*

Healthy life expectancy (how long one can expect to live in good health) is also below the England average in Halton, Liverpool, Knowsley, St Helens and for men in Wirral.

The COVID-19 mortality rate in Cheshire and Merseyside has been high (5 percent higher than the England and Wales average between March 2020 and April 2021) and the pandemic has exposed and amplified inequalities.

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.

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 (6)*

THE SOCIAL DETERMINANTS OF HEALTH

Health is largely shaped by the social, economic and environmental conditions in which people are born, grow, live, work and age known as the social determinants of health. The social determinants of health are encompassed by the Marmot 8 principles, which are the basis for the analysis in the report and the recommendations (6) (7).

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

BEST START IN LIFE AND EARLY YEARS AND MAXIMISING CAPABILITIES FOR YOUNG PEOPLE

Experiences during the early years and in education are particularly important for immediate and longer-term health and outcomes in other social determinants of health such as education and income (8) (9).

Marked inequalities between children eligible for free school meals and those who are not eligible are already apparent at the age of five years in Cheshire and Merseyside. Levels of school readiness at the end of reception are lower for pupils eligible for free school meals compared to more affluent children and these lower levels of school readiness in pupils eligible for free school meals continues into primary and secondary school. Reductions in attainment and development associated with the pandemic have been worse in pupils eligible for free school meals.

Improving outcomes in the early years and in schools requires collaborations between early years providers, schools, employers and youth services working together with communities and families. All have been hit hard by recent funding cuts child poverty is increasing, harming development and outcomes still further. The NHS also has a role to play in supporting better conditions for children and young people – even beyond improving access to relevant services.

Actions addressing the social determinants of health in hospitals

At Alder Hey Children's Hospital a team of respiratory paediatricians, specialist nurses, and Allied Health professionals are working together with families to improve children's lung health. The team regularly phone landlords, housing agencies, and the council directly, explaining the urgency of good housing for children with respiratory problems. Their clinics focus on empowering parents – at one level to use their house better (with advice about cooking oils and kitchen extractor fans, home ventilation, where to place furniture, and how to dry clothes to reduce humidity and so on); and empowering families to help them advocate for better housing for themselves.

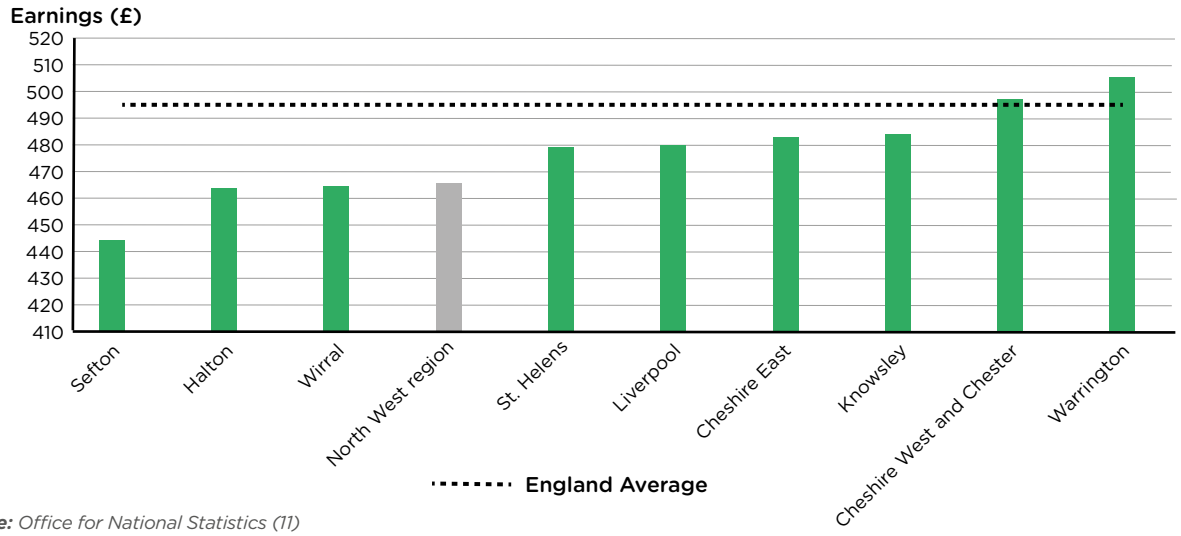
EMPLOYMENT AND INCOME

Good quality work is beneficial to the health of employees and also beneficial to employers as it increases productivity, retention and reduces the amount of sick pay required. 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. There is great potential for businesses in the region to improve the health of their employees and communities more broadly.

People with long-term health conditions have lower rates of employment but many still want to work; compared to the England average, 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.

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. In 2020 only Cheshire East and Cheshire West had average earnings above the England average in the region. Sefton's average weekly earnings in 2020 were £51 below the England average (£496 versus £445).

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 (11)*

A third of Cheshire and Merseyside's residents live in the most deprived 20 percent of neighbourhoods in England, 15 percent of children live in absolute poverty households and 18 percent of children live in relative poverty households, compared to 19 percent in England (12). Poverty is not only about money: poverty affects control over one's life which is critical to health and wellbeing and the ability to lead a dignified life. The average cost of living is increasing in the UK and these increases, alongside increasing in flation, will lead to increases in poverty.

Actions to improve health inequalities are challenging understandings of poverty

The Cheshire West and Chester Poverty Truth Commissions, held in 2017 and 2020, aimed to tackle the root causes of poverty and reduce gaps in services across the borough. Community inspirers, volunteers with lived and living experience of poverty, shared their stories of the effect poverty had on them and their families. Through true listening and collaboration, members of the commissions reflected on how systems and processes could better support local people. As a result of the commissions, there has been more collaborative and partnership working across a number of agencies and new support for front line staff. The approach has been mainstreamed, all poverty work across the council and with local partner agencies, will put people at the heart of policy development and service design.

PLACE AND ENVIRONMENT

One of the most significant ways that healthy and sustainable places and communities can be forged is through good quality housing and safe environments with good access to services, shops, community facilities, leisure and entertainment and good quality natural environments.

A quarter of privately rented homes in England do not meet the decent homes standard. 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' and rates are increasing (13). Levels of rough sleeping dropped dramatically during the first months of the COVID-19 pandemic when local councils were provided with additional funding.

PUBLIC HEALTH, HEALTH AND THE SOCIAL DETERMINANTS

Shifting to a social determinants of health approach means taking action in the drivers of ill health as well as treating ill health when it is presented in healthcare settings: the prevention agenda must focus on improving living and working conditions, and reducing poverty – as well as focussing on healthy behaviours. As set out in the report, it is almost impossible to live healthily when in poverty.

Six of Cheshire and Merseyside's local authorities have alcohol-related mortality rates above the England average and six also have above average deaths related to drug misuse. Prior to the pandemic 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 (14). Analysis shows each 10 percent spending cut for early years services was associated with a 0.34 percent relative increase in obesity prevalence the following year (10).

NHS AS AN ANCHOR INSTITUTION

Many local authorities in the region have already committed to being anchor institutions and work is occurring in many NHS institutions to integrate the concept into future planning. There is greater scope to expand the role of anchor institutions in improving health in local areas, particularly in the most deprived areas. Being a good employer is part of being an anchor. The NHS should be offering the real living wage; all contracts with minimum hours and minimal use of zero-hour contracts (unless in agreement with employees); all employees offered training and development opportunities. Beyond improving conditions for employees, anchor organisations can work to build health in local communities through buying locally, supporting and advocating for communities and investing to reduce inequality.

TACKLING RACISM AND DISCRIMINATION

Ethnic minority groups often experience worse outcomes in the social determinants of health, such as income, quality of employment and housing conditions – this relates to experiences of discrimination and exclusion. Ethnic minority populations are more likely to report being in poor health and have poor experiences using health services than the White British population. The COVID-19 pandemic has revealed the stark inequalities in health and economic and social inequalities for many of the UK's ethnic minority communities.

Actions to improve health inequalities are being led by the VCFSE sector

Merseyside Sport Partnership (MSP) is working with the Wirral Deen Centre, a mosque and community centre in Birkenhead and Tranmere. The project works with women who do not speak English as a first language, who have difficulties accessing, or even knowing about, local services. The charity identified that appropriate clothing for exercise and money to travel were barriers for women who wanted to become physically active. Many of the women had minimal spoken English, which meant accessing services was more difficult, especially for those who wanted women's-only gym or swimming sessions. MSP helped the Wirral Deen Centre secure funding to subsidise transport costs, purchase gym clothing and paid for exclusive access for a group of women to access a nearby gym.

CLIMATE CHANGE

It is estimated that in the North West region, under a medium greenhouse gas emissions scenario, in the 2080s the North West will have summer temperatures increasing by 3.7 degrees; 21 percent less rainfall in the summer and 16 percent more rainfall in the winter. Harm to health from climate change will worsen as the climate warms and precipitation increases and this harm will be more substantial for those who live in the most deprived areas.

Many of the actions to reduce greenhouse gas emissions and mitigate impacts can also improve health and reduce health inequalities but there is also potential that interventions will widen inequalities. Active travel is central to reducing these emissions. In Cheshire and Merseyside, except for Liverpool, adults walk and travel less than the average for England.

TAKING ACTION IN CHESHIRE AND MERSEYSIDE

Local authorities and/or the NHS cannot take on the required actions to reduce health inequalities alone; many lie outside their direct remit and they do not have sufficient resources, capacity and levers to achieve that. It is important that the HCP and ICPs embed partnerships with the VCFSE sector, other public services, local authorities and businesses to influence these wider conditions which shape health.

IHE proposes recommendations covering each of the Marmot 8 themes and the following system-wide recommendations for action across the Cheshire and Merseyside system.

1. Increase and make equitable funding for social determinants of health and prevention.

2. Strengthen partnerships for health equity.

3. Create stronger leadership and workforce for health equity.

4. Co-create interventions and actions with communities.

5. Strengthen the role of business and the economic sector in reducing health inequalities.

6. Extend social value and anchor organisations across the NHS, public services and local authorities.

7. Develop social determinants of health in all policies and implement Marmot Beacon indicators.

A set of local Marmot Beacon indicators, developed in partnership with hundreds of local stakeholders, will monitor actions on the social determinants of health in Cheshire and Merseyside.

The report proposes the following 22 indicators, aligned with the 8 Marmot themes, covering areas which are considered critical in reducing health inequalities. This social determinants indicator set was co-created with Cheshire and Merseyside and will be monitored by the Combined Intelligence for Population Health Action (CIPHA) programme.

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.

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