

Halton Joint Strategic Needs Assessment 2021

Inequalities in life expectancy



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Related documents	PHE Health inequalities data pack January 2020

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Key messages

Despite overall increases in life expectancy, the differences in health outcomes between the most and least deprived communities continues to grow. Nationally, there is a 19 year-gap in healthy life expectancy (years lived in good health) between the most and least deprived areas of England. People living in the most deprived areas spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas. These health inequalities are unfair and avoidable.

They cut people's lives short; lead to avoidable years living with impaired health and wellbeing; and cost the NHS, local authorities and our national and local economies billions of pounds. The Marmot Review¹ estimated that health inequalities cost society £31 billion in lost production, in 2010 prices. Whilst this is a national figure, it is in local jobs and economies where this impact is borne out. This variation is generating additional need and demand for health care services including an estimated £4.8 billion of additional expenditure on ambulatory care alone.

Thus, the high burden of disease in deprived areas generates higher use of health and social care services, higher unemployment, and lower productivity.

What is happening locally with life expectancy?

Whilst there have been improvements in life expectancy for Halton residents there are a number of issues to note:

- The gap between Halton life expectancy for both men and women compared to the England average remains significant
- The internal gap in life expectancy between the poorest and most affluent areas in Halton is even wider
- People living in Halton not only die sooner than the England average, but spend more of their lives in poor health and less being disability-free
- The main drivers for this remain the 'top 3 killers': cancers, cardiovascular disease and respiratory disease. Diseases of the digestive system, most notably cirrhosis of the liver related to alcohol use are also important

There has been a drop in life expectancy (based on provision 'unofficial' analysis) during 2020. This is because life expectancy is calculated using data on the number of deaths that occur. The Covid-19 pandemic resulted in an extra 171 deaths during 2020. There was a fall in some causes of death during 2020 compared to 2019 but we cannot say if this was due to a reduction in levels of disease or whether some of these deaths were coded as Covid-19 deaths.

What can we do about it?

It is important to continue an emphasis on ensuring a good start in life. This is reflected in Halton's One Halton Health & Wellbeing Strategy. This starts with efforts during the maternity period:

- Reducing the proportion of women who smoke during pregnancy
- Increasing the proportion of babies who are breastfeed

¹ Marmot M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. 2010

- Excellent early years offer and uptake
- Continued efforts to reduce the number of children who are overweight and obese
- Continued efforts to ensure as few children as possible to not start smoking
- Reducing levels of drug and alcohol use amongst children and young people
- Reducing levels of injuries – both accidental and intentional (due to abuse or self-harm)
- Supporting young people's mental health and wellbeing

In adulthood chronic long-term conditions contribute the largest proportion of the gap in life expectancy, both compared to England and the differences seen across the borough. Our One Halton Health & Wellbeing Strategy emphasises:

- The need to increase levels of physical activity and reduce levels of adult overweight & obesity
- Smoking prevalence has reduced substantially. However, the gap between overall smoking prevalence that that amongst routine and manual workers remains. Targeted work is needed here.
- We have made great improvements in cancer, cardiovascular disease and respiratory death rates. However there is more we need to do. Where we are unable to prevent these diseases from developing through the actions above, it is important to ensure as many people as possible:
 - Are diagnosed early through improved uptake of NHS Health Checks, cancer screening and urgent referrals. We can monitor the latter through what proportion of cancers are diagnosed at stages 1 & 2
 - Have their blood pressure well managed
 - Are managed within the NICE recommended care processes, reducing variation in access, experience and outcomes from treatment and care in conditions such as cancer, mental health, cardio-vascular disease (CVD), respiratory disease and diabetes

Interventions to close the gaps in life expectancy and improve healthy life expectancy don't stop at any stage of life. In particular in older age we can:

- Work to support those with dementia & Alzheimers disease
- Reduce deaths from influenza and pneumonia through increased uptake of vaccination offer

Both of these, together with work to further reduce levels of cardiovascular disease will reduce excess winter deaths.

The health inequalities we see are borne out of inequalities in society, often referred to as the wider determinants of health. Not everyone has the same opportunity to remain healthy or recover from/overcome the impact of ill health. Life opportunities impact on health outcomes from the very beginning of life and continue throughout life. This includes:

- The impact of education on life chances
- The impact this has on getting and job and the impact the type of work a person is able to secure has on their physical and mental health
- The impact a secure and warm home has on cardiovascular disease, respiratory disease, educational chances, and mental health

- The impact poor health literacy has on opportunities to access health information and act on health and care advice
- The impact of digital exclusion on those who do not have access to the internet or who do not have the skills or motivation to use it to access things like job opportunities or local service
- The impact social connections can have on our feelings of worth, opportunities for civic participation and whether or not we feel lonely

We have the opportunity to really start to make a difference to these by working as part of the Marmot sub-region, with the world-renowned Institute for Health Equity (IHE). It is important that interventions aimed at supporting individuals to change health-related behaviour and improve uptake of care packages are done within a whole-system approach that aims to impact on the environment in which people make such decisions. There have been and continue to be some fantastic examples of this locally, including the Tobacco Control Strategy and whole-systems approach to tackling obesity.

1. Introduction

Life expectancy is an important measure of population health. It is an estimate of the average number of years a new-born baby would live if he or she experienced the age-specific mortality rates of the area for the time period throughout his or her life. The figures reflect current mortality rates and are not the number of years a baby born in the area could actually expect to live, because the mortality rates will change in the future. The life expectancy estimates are therefore an alternative way of presenting mortality rates, and can offer some insights in to the impact of COVID-19.

The importance of life expectancy as a summary measure of population health is reflected in its inclusion in the high level outcomes for the Public Health Outcomes Framework (PHOF).

Official statistics put the life expectancy at birth for female residents of Halton borough at 81.7 years and for males 77.4 (Office for National Statistics, 2017-19). These expectancies are both below the national rates of 83.4 and 79.8 respectively.

Until recently the trend in mortality over the last 100 years in England had been relatively clear: since World War 1 every decade has seen people living longer than before. But since 2011 improvement in mortality rates and life expectancy in England has slowed down considerably for both men and women. For some age groups, and for some parts of England, improvement has stopped altogether.

There has also been an increase in the number of deaths in some recent winters. Excess winter deaths in 2017 to 18 were the highest in over 40 years.

The increases in life expectancy observed throughout the 1990s and 2000s have gradually started to level off, leaving a gap between Halton and the rest of the North West and England. Much of this gap is explained by differences in life expectancy in affluent and less affluent populations.

The data show that in the first 6 months of 2020, life expectancy for both sexes in England was lower than in the same period in each of the previous 5 years. All English regions saw decreases in life expectancy between the first 6 months of 2019 and 2020, with the greatest decreases in London.

The newly developed Wider Impacts of Covid on Health (WICH) tool from Public Health England (PHE) show inequalities in life expectancy in England, and the English regions, for the first six months of 2020, and the first six months of the previous five years. Figures for the whole year up to 2019 are also shown for comparison. Decreases in life expectancy were observed across all deprivation deciles in England in the first 6 months of 2020 compared to the same period in 2019. Inequality in life expectancy for England increased for both males and females. At regional level, there was variation in the trend in inequality over this time period. In London, there was a significant widening of inequality for both males and females. There was also a significant widening of inequality for females in West Midlands.

What is premature mortality and how does it affect life expectancy?

Premature mortality is considered to be deaths before the age of 75. Some, but not all of these deaths are preventable. Average life expectancy in Halton is lowest in our poorest population groups. Therefore we know that the majority of premature deaths must occur in these groups. This means that tackling early deaths should narrow the gap in health inequality.

The main causes of the difference in life expectancy between Halton and England are cancers (accounting for over 30% of the difference), in particular lung cancer (especially in women), circulatory disease (including heart disease and stroke - accounting for 10% of the difference for men and 25% for women), respiratory diseases (especially chronic obstructive pulmonary disease) and cirrhosis of the liver.

PHE review in to slowing improvements in life expectancy²

The main findings from the review suggest that the overall slowdown in improvement is due to factors operating across a wide range of age groups, geographies and causes of death. It has also been seen, to some extent, in many other countries. However, it is not possible to attribute the recent slowdown in improvement to any single cause and it is likely that a number of factors, operating at the same time, need to be addressed.

The review summarises work done by others on the association between changes in health and social care provision and trends in mortality. This is one area where further work would be required to understand any potential causal mechanisms which may be operating within England and across different countries.

The analysis shows the importance of stepping up efforts to reduce the risk of heart disease and stroke and address the increase in deaths due to accidental poisoning in younger age groups.

The review also highlights the need to support the most vulnerable, particularly older people, to reduce the impact of poverty, cold winters, and diseases such as dementia and flu.

The slowdown has not been observed for long enough for statistical analysis to determine whether it will continue. The future trend is uncertain for both sexes but PHE will continue to closely monitor trends in mortality rates and life expectancy in England.

² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827518/Recent_trends_in_mortality_in_England.pdf

2. Deprivation and health inequalities

Differences in health between and across a population can exist due to a variety of “*social, geographical, biological or other factors*.”³ These inequalities can shape health and residents of areas of greatest socioeconomic deprivation are more likely to be in worse health and spend more of their lives in poor health; requiring greater access to healthcare services, but seeing these greater needs underserved. There are many wider determinants of health, which are to varying degrees, alterable, and therefore someone’s health and life expectancy are alterable.⁴

The wider determinants of health include those of *socioeconomic status, education, physical environment and social environment*⁵ and are unequally distributed across England and within Local Authorities. Poorer education, lower quality housing, lack of available transport and transport links, higher unemployment rates and lower income are all linked to worse health and lower life expectancy. People from more socioeconomically deprived areas are often at the sharp-end of the scale in relation to wider determinants⁶, which can impact on health and create health inequalities.

Health inequalities are thus rooted on social inequalities. An overall indicator for this is deprivation.

2.1 Levels of deprivation in Halton

The English Indices of Deprivation provide data on relative deprivation for small areas in Halton and nationally.

The Indices of Deprivation 2019 (ID2019) are the primary measure of deprivation for small areas or Lower layer Super Output Areas (LSOAs) in England. The indices were published by the Ministry of Housing, Communities & Local Government (MHCLG) in September 2019 and replace the 2015 indices. Each LSOA in England is ranked in order of deprivation, and then grouped into ten percentage groups known as deciles. – LSOAs in decile 1 are in the 10% most deprived in the country, and LSOAs in decile 10 are in the 10% least deprived in the country. Halton has 79 LSOAs.

The main output of the Indices of Deprivation is the Index of Multiple Deprivation (IMD) which combines measures across seven distinct aspects of deprivation: income, employment, education, health, crime, barriers to housing and services, and living environment. The IMD is the most widely used output of the indices, but each domain provides insight into a particular area of deprivation.

More of Halton’s population are living in areas classified as the 10% most deprived nationally: **30.4%** up from 25.5% in 2015. This is almost **6,700** more people, a total of **38,750** people.

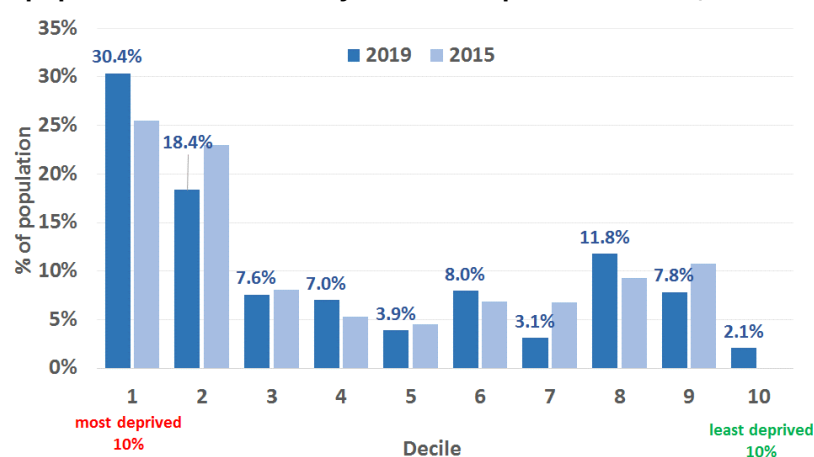
The chart below shows the distribution of Halton’s population by national deprivation decile, both in 2019 and 2015.

³ National Institute for Health and Clinical Excellence (2012) *Health inequalities and population health*

⁴ <https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health>

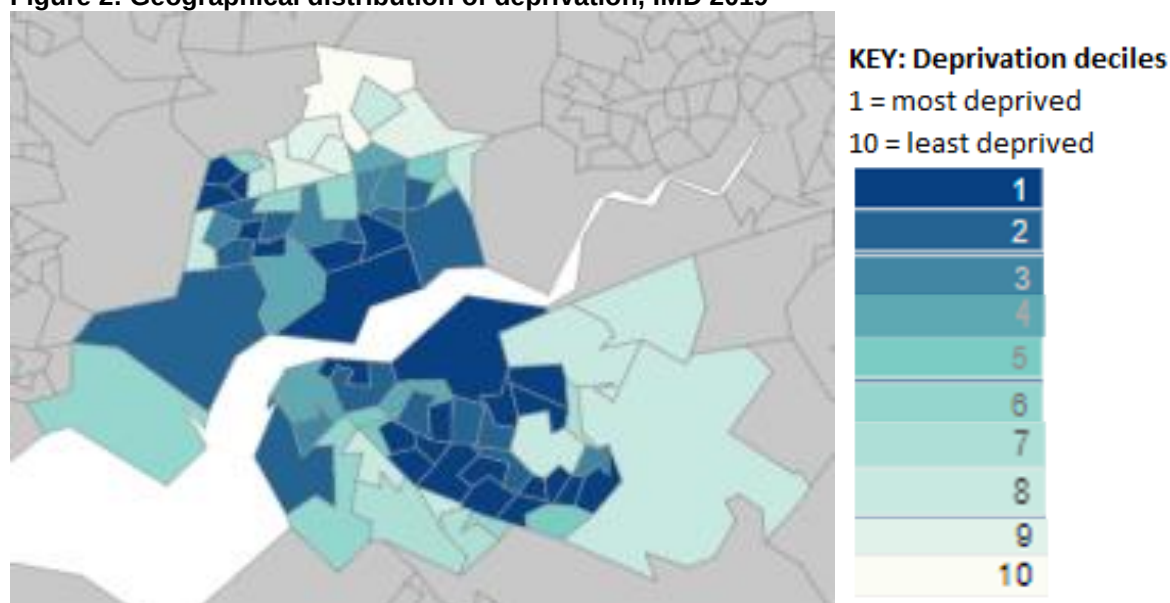
⁵ <http://publichealth.warwickshire.gov.uk/wider-determinants/>

⁶ <https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133043/pat/6/par/E12000002/ati/102/are/E06000006>

Figure 1: Halton population distribution by national deprivation decile, IMD 2019 and 2015

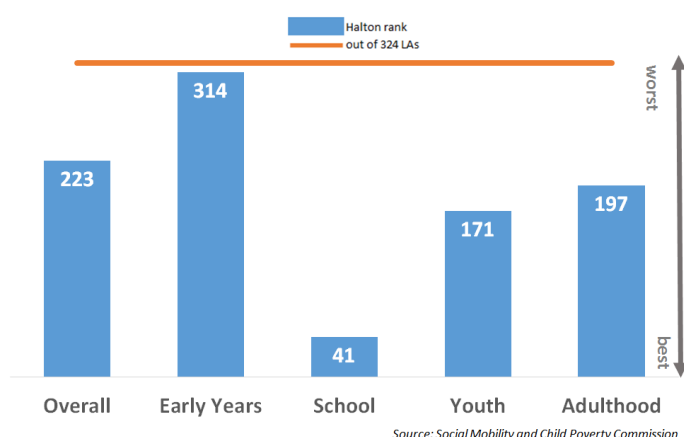
Source: Ministry of Housing, Communities and Local Government (MHCLG)

The proportion living in the most deprived 20% nationally is almost the same as in 2015: 48.7% up from 48.4%. The map below shows the geographic distribution of deprivation in Halton, using national deciles.

Figure 2: Geographical distribution of deprivation, IMD 2019

Source: Ministry of Housing, Communities and Local Government

The social mobility index sets out the differences between where children grow up and the chances they have of doing well in adult life. It measures the likelihood of overcoming disadvantage and attaining good outcomes in each local authority in England through 16 indicators across each major life stage.

Figure 3: Social Mobility Index, Halton ranked position (1 – most socially mobile)

This shows that Halton performs relatively well for school years but particularly poorly for early years. This demonstrates the importance of our continued emphasis on children having a good start in life as seen in the On Halton Health & Wellbeing Strategy.

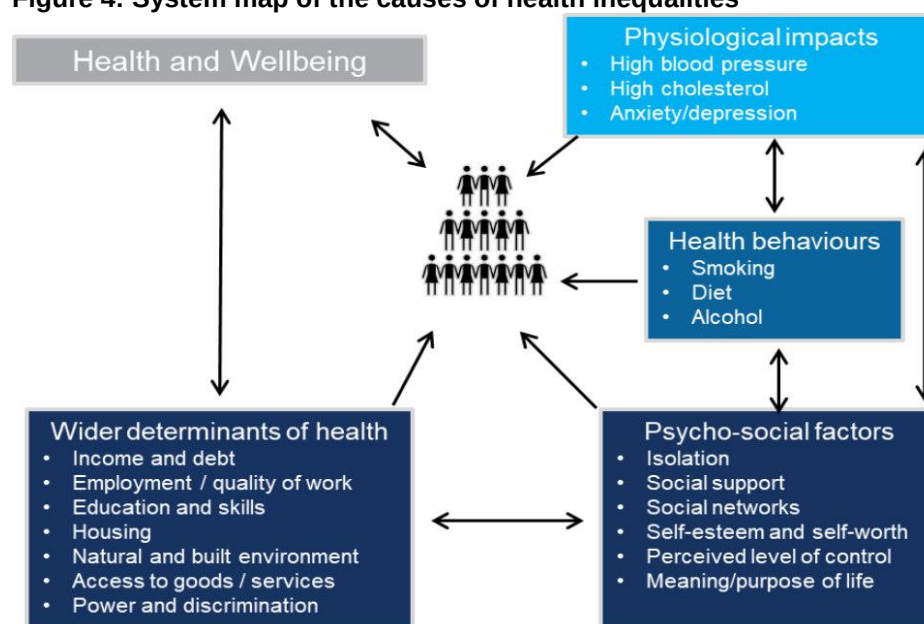
2.2 Causes of health inequalities and why Place matters

“Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated.”

National Institute for Health and Clinical Excellence (2012) Health inequalities and population health

To effectively reduce health inequalities, it is important to start with a clear conceptual framework which analyses the causes, and opportunities for action. There are many models, all with different merits for use in different purposes. One adapted from the Labonte models provides a simple but effective structure, as shown in Figure 4. This model highlights why interventions must focus on treating place and not just people.

Figure 4: System map of the causes of health inequalities

Source: Labonte via <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report>

Health inequalities stem from variations in the wider determinants of health and the presence of, or access, to psycho-social mediating and protective factors – this means that people do not have the same opportunities to be healthy.

Health inequalities arise because of **the conditions in which we are born, grow, live, work and age**. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Whilst interventions that aim to impact behaviours and conditions are important, they need to be addressed within the context of their root causes in the wider determinants of health. Otherwise these efforts may widen inequalities even if population level health outcomes improve. This includes action on:

Figure 5: Selected impacts of wider determinants on our health⁷

Sector	Examples
Income	Income determines people's ability to buy health-improving goods, from food to gym memberships. Managing on a low income is a source of stress, and emerging neurological evidence suggests that being on a low income affects the way people make choices concerning health-affecting behaviours. Children from households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those in the highest fifth.

⁷ <https://www.kingsfund.org.uk/publications/what-are-health-inequalities#pathways>

Housing	Poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular diseases, respiratory diseases, depression and anxiety. As external temperature falls, death rates rise much faster for those in the coldest homes. Households from minority ethnic groups are more likely than White households to live in overcrowded homes and to experience fuel poverty.
Environment	Access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Levels of access are likely to be worse for people in deprived areas, and for areas with higher proportions of minority ethnic groups. Exposure to air pollutants is estimated to cut short 28–36,000 lives a year in the United Kingdom. Exposure has been linked to both deprivation and ethnicity. For example, within the most deprived areas of London, people from non-White groups have been found to be more exposed to high concentrations of nitrogen dioxide, one of the main pollutants associated with traffic fumes.
Transport	Those living in the most deprived areas have a 50 per cent greater risk of dying in a road accident compared with those in the least deprived areas. Children in deprived areas are four times more likely to be killed or injured on the road than those in wealthier areas.
Education	On average among 26 OECD countries, people with a university degree or an equivalent level of education at age 30 can expect to live more than five years longer than people with lower levels of education.
Work	Unemployment is associated with lower life expectancy and poorer physical and mental health, both for individuals who are unemployed and for their households. The quality of work, including exposure to hazards, job security and whether it promotes a sense of belonging, affects the impact it has on both physical and mental health. Non-White groups experience higher levels of work stress, controlling for other demographic factors.

There are a number of foundations that we need to consider when building local programmes to tackle the wider determinants, action on prevention and high quality clinical and social care.

Health literacy: What do we mean by this? The World Health Organisation defined it as:

“The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.”

It is important we tackle it because research in England tells us that between 43% and 61% of English working age adults routinely do not understand health information.⁸ Some of the human costs to poor health literacy are demonstrated in Jonathan Berry’s blog also.

Digital exclusion: There has never been a more important time to consider the impact of digital exclusion, also called the digital divide. The Covid-19 pandemic saw services accelerating plans to delivery digital or telehealth opportunities. Many consultations went online, with access to face-to-face appointments being triaged before such appointments could be booked. This has provided improved access for some, providing services in a way they prefer, in line with how many

⁸ <https://www.england.nhs.uk/blog/jonathan-berry/>

people conduct their day-to-day interactions with friends and family. However, not everyone has the same chances to take advantage of this way of interacting.

- The number of adults who have either never used the internet or have not used it in the last three months, described as “internet non-users”, has been declining over recent years. Since 2011, this number has almost halved, but in 2018 there were still 5.3 million adults in the UK, or 10.0% of the adult UK population, in this situation.⁹ People may be digitally excluded for multiple reasons, including not having access to the required infrastructure and/or devices, lack of skills, or lack of motivation to use technology. The main factors that influence the digital divide in the UK include age, region, socioeconomic status and whether a person has a disability.¹⁰

The internet is increasingly being used to interact with public authorities or services, including online only job application processes, finding out about and paying for council services and obtaining and completing official forms.

There have been particular concerns about the digital divide during the COVID-19 pandemic, as people have been more reliant on the internet to access services and health information, and socialise with friends and family.

Social connections: evidence around inequalities, especially in later life, notes outcomes associated with social connections can broadly be categorised into four themes:¹¹

1. Social contacts, networks, and support - broadly speaking, social connectedness – refer to the relationships people have with others, such as the frequency and nature of contact with family or friends. Social connectedness can also refer to people coming together to achieve a goal and is fostered when the relationships are positive for the individual
2. Social isolation and loneliness refer to the potentially negative experiences related to (a lack of) social connections.
3. Social participation and engagement relate to people’s activities in society. The English Longitudinal Study of Ageing (ELSA), which collects data from a representative sample of people over the age of 50 in England, proposes four elements of social participation:
 - Civic participation, e.g. membership of a political party, trade union, church, etc.
 - Leisure activities, e.g. taking part in arts, education, and/or social or sports clubs.
 - Cultural engagement, e.g. going to the cinema, art gallery, etc.
 - Social networks, e.g. being in contact with and/ or having friends, family, children.
4. Social inclusion/exclusion, integration, and cohesion explore how people’s access to social activities and experiences manifest and are shaped by external factors, including the societal

⁹

<https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04>

¹⁰ <https://post.parliament.uk/covid-19-and-the-digital-divide/>

¹¹ https://ilcuk.org.uk/wp-content/uploads/2018/10/Health_and_Wellbeing_Innovation_Commission_Inquiry_-_Social_Connections.pdf

barriers that limit individuals' opportunities with respect to the other themes of social connections as well as other facets of modern life

Thus it is important that actions tackle place as well as people. Halton's approach to tackling obesity using a whole-system approach is an excellent example of how individual level interventions such as weight management services can be placed within the context of tackling the underlying causes and creating supportive environments that help rather than hinder individual decision-making.

It is important that actions focus on those living in the most deprived areas and on those most vulnerable/ experiencing the worst outcomes whilst maintaining high quality services for all; such as efforts to level-up access to high quality primary, community care and secondary care

As such there needs to be a focus on community led initiatives to support the most vulnerable and build resilience, a shift from reactive treatment of ill-health towards proactive, preventative management of long-term conditions and the establishment of local hospital trusts as places of benefit for the whole community as anchor institutions.

Across local place-based systems different organisations have different strengths and ways of reaching in to local communities. Annex 2 of the national PBA outlines the roles each type of organisation can take. This is replicated in Appendix 1 of this report.

The NHS Long Term Plan (LTP) sets out specific ambitions for the NHS, through local planning and national programmes to take a 'more concerted and systematic approach to reducing health inequalities.' In support of this ambition, NHS England, collaborating with Public Health England (PHE) and partners in the voluntary and community sector and local government, has worked to develop a 'menu of evidence-based interventions for addressing health inequalities. The Menu¹² provides a catalogue of interventions that local healthcare systems and commissioners, working with partners across the system, can draw on to take effective action at neighbourhood, place and system-level to reduce health inequalities. It is being developed through a phased approach, which will run through the life of the NHS Long Term Plan.

Alongside developing the Menu, Public Health England (PHE), the Local Government Association (LGA) and the Association of Directors of Public Health have published complementary guidance to this work, entitled Place Based Approaches for Reducing Health Inequalities (PBA).¹³ The PBA focuses on how the system can work together through civic, service and community centred approaches to reduce health inequalities; the Menu identifies specific evidence-based interventions that can support this holistic approach. A summary of the PBA guidance and recommended approach is provided in the first part of the Menu.

¹² <https://www.england.nhs.uk/ltphimenu/>

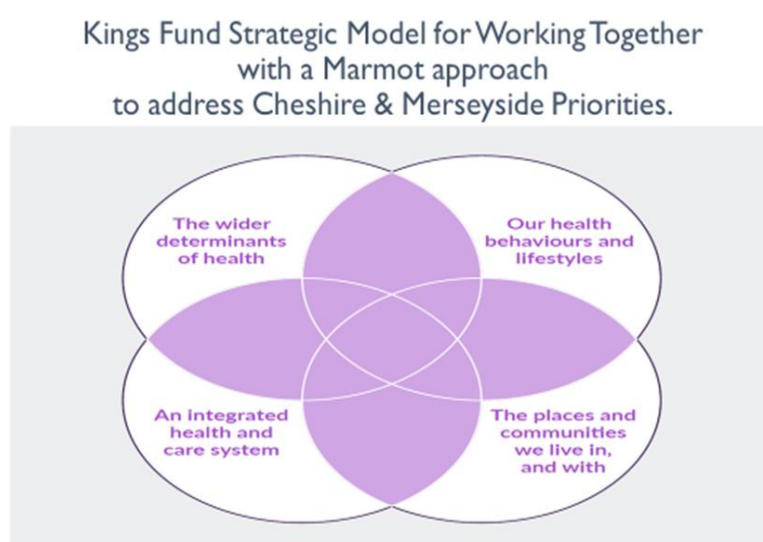
¹³ <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities>

2.3. The Cheshire & Merseyside Approach: becoming a Marmot Sub-Region

For Cheshire & Merseyside Integrated Care System and its constituent 9 local places, the collaboration with the Institute for Health Equity to become a *Marmot Sub-Region* offers us the opportunity to work with world leaders on health inequalities on actions to our tailored to our sub-regional health priorities.

In September 2019, a Cheshire & Merseyside wide event co-hosted with Sir Michael Marmot, the Local Government Association, Champs, and The King's Fund brought together over 150 system leaders from a wide range of backgrounds and across the political spectrum to explore opportunities and priorities for our population's health. At this event the Partnership endorsed taking a "whole population, whole system" approach.

Figure 6: Kings Fund Strategic Model for Population Health



Key benefits of becoming a Marmot Sub-Region

Access to international expertise

Being part of the Marmot Network will provide us with access to the international expertise of the Institute for Health Equity (IHE) based at University College London (UCL). We will be able to use their expertise and resources in supporting us in our plans for accelerated action on the social determinants of health in the region.

Developing excellence in systems leadership for Population Health

IHE could help to inspire and shape C&M strategic direction and implementation of place based, population and prevention focussed approaches, which maximise fully the opportunities in C&M and ensure a strong focus on health equity. The team could enthuse and build the knowledge and skills of particular key groups such as senior leaders in health

and social care. Practice based resources and tools could be shared to enhance knowledge across the system with practitioners.

Strengthening joint working with the NHS and local authorities

IHE will work with Cheshire and Merseyside local authorities and the ICS to develop a whole system approach to tackling health inequalities and governance and partnership arrangements to facilitate it. This will strengthen joint working with local government to enhance openness, co-production and dialogue at both a local and sub regional level. An effective engagement plan will be developed with advice from the lead local authority CEOs and the LGA.

Maximising our impact on health inequalities together

IHE will work across Cheshire and Merseyside to build upon existing strategies and policies to develop future plans and strategies which can make real impact across health inequalities – including providing evidence about what would make the difference, and how to do it in practice and evaluation of outcomes. Examples from other areas in England and internationally will be drawn on and from a range of organisations.

Promoting the excellence in practice in Cheshire and Merseyside

IHE will help to raise the profile of the strategic ambition and achievements in Cheshire and Merseyside in national and international forums. Becoming a Marmot sub-region provides the opportunity for national and international recognition for our local work to reduce health inequalities.

3. Life expectancy at birth

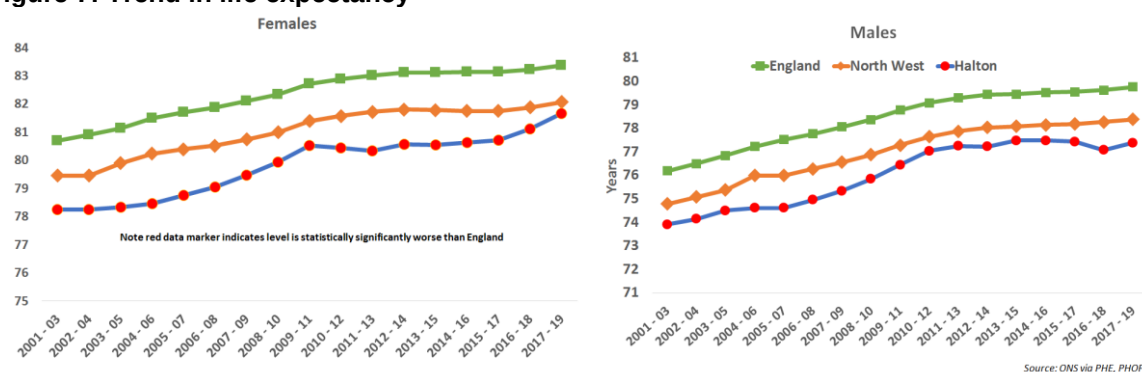
3.1 Trend in life expectancy

Declining mortality in the 19th and 20th century saw a significant rise in life expectancy. 2011 marked a turning point in long-term mortality trends in England, with improvements slowing after decades of steady decline, prompting much debate about the causes. The emergence of Covid-19 in 2020 will have significant implications for life expectancy.

Healthy life expectancy¹⁴ has also increased, but not as much as life expectancy, so more years are spent in poor health.

Life expectancy in Halton is lower than England, for both men and women. The difference is statistically significantly worse than England.

Figure 7: Trend in life expectancy



For 2017-19 female life expectancy was 81.7 years (compared to North West of 82.1 years and England of 83.4 years). For males it was lower at 77.4 years (compared to North West of 78.4 years and England of 79.8 years).

¹⁴ Healthy life expectancy is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their general health. Disability-free life expectancy is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities

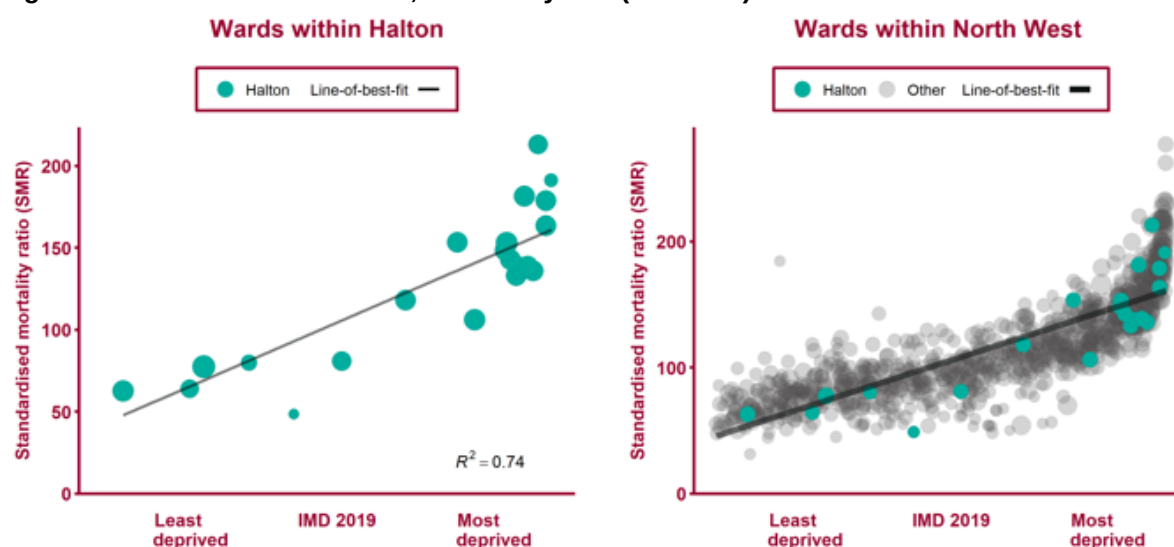
Figure 8: Key life expectancy indicators, local authorities in Cheshire & Merseyside (2017-19)

Indicator	Period	England	C & M	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Life expectancy at birth (Female) New data	2017 - 19	83.4	-	84.1	83.3	81.7	80.5	80.4	82.9	81.2	82.8	82.3
Life expectancy at birth (Male) New data	2017 - 19	79.8	-	80.3	80.1	77.4	76.8	76.6	78.9	77.8	79.0	78.5
Healthy life expectancy at birth (Female)	2016 - 18	63.9	-	66.8	66.3	57.5	59.1	57.8	62.4	60.3	64.0	63.7
Healthy life expectancy at birth (Male)	2016 - 18	63.4	-	66.5	65.4	59.5	58.3	60.7	64.0	60.2	64.7	61.4
Inequality in life expectancy at birth (Female) New data	2017 - 19	7.6	-	7.3	8.8	8.5	9.2	9.8	11.8	8.8	7.2	11.1
Inequality in life expectancy at birth (Male) New data	2017 - 19	9.4	-	8.9	10.6	9.9	9.9	10.2	12.5	11.7	9.7	13.0

3.2 What is driving the difference?

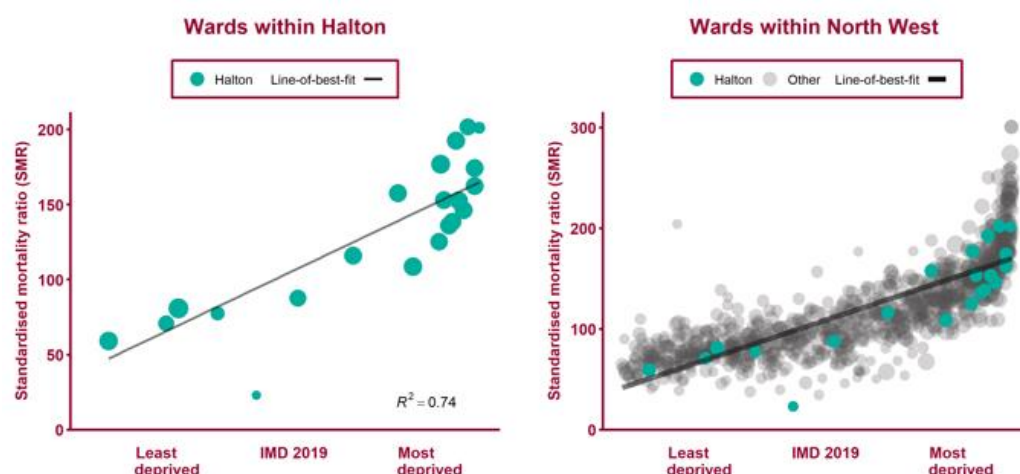
Levels of deprivation impact on death rates, both in Halton and generally across England. This can be seen by the chart showing all-cause mortality under age 75 by ward. Those more deprived wards have the higher overall death rates.

Deprivation accounts for nearly three quarters of the difference in life expectancy across wards in Halton, for premature mortality, all-causes

Figure 9: Deaths from all causes, under 75 years (2013 - 17)

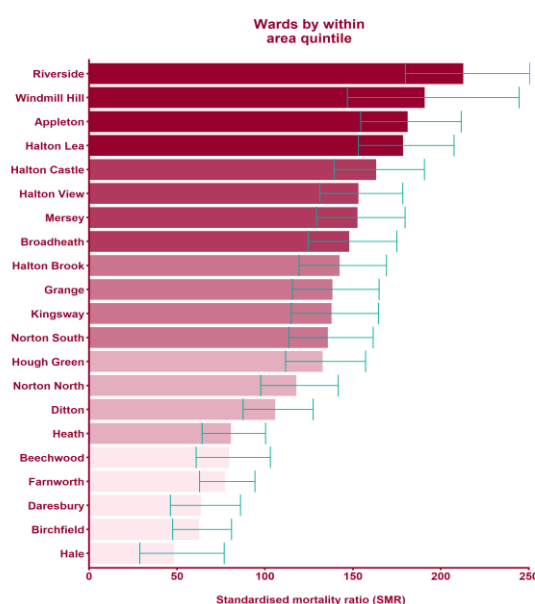
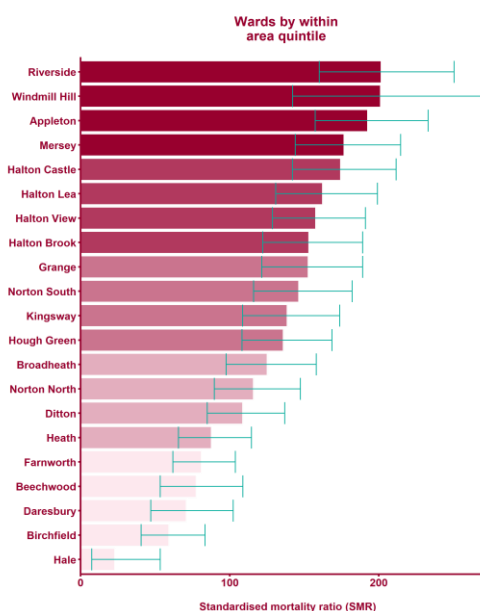
Source: PHE Health Inequalities Pack – Halton, January 2020

This same relationship is seen in analysis of deaths considered preventable

Figure 10: Deaths from causes considered preventable, all ages (2013 - 17)

Source: PHE Health Inequalities Pack – Halton, January 2020

Death rates from these causes are highest in Riverside, Windmill Hill and Appleton electoral wards. They are lowest in Hale, Beechwood and Daresbury. The difference between the top 5 and bottom 5 wards is statistically significantly different for both all-cause under 75 mortality and deaths considered preventable

Figure 11: ward level analysis (2013-17)**All cause, under 75****Deaths considered preventable**

Source: PHE Health Inequalities Pack – Halton, January 2020

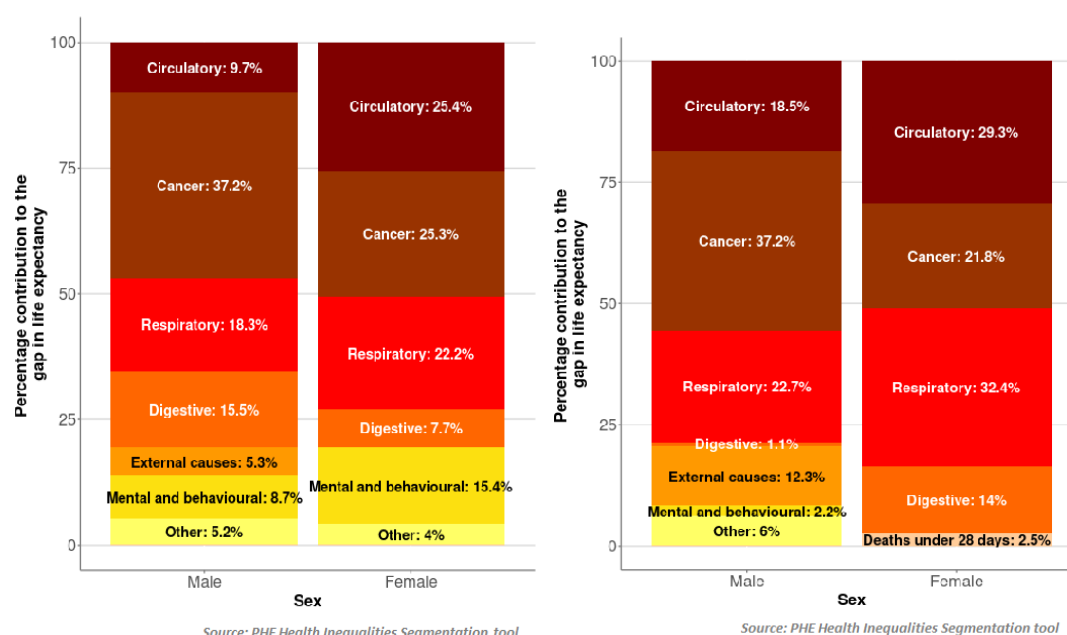
3.3 Analysis by cause of death

A number of causes account for the majority of the difference, with the top three - heart disease, cancers, respiratory diseases - accounting for over 65% (65.2% males and 72.9% females) of the difference compared to England and over 78% (78.4% males and 83.5% females) when comparing the most and least deprived quintiles across Halton

Figure 12: Causes of the gap in life expectancy in Halton

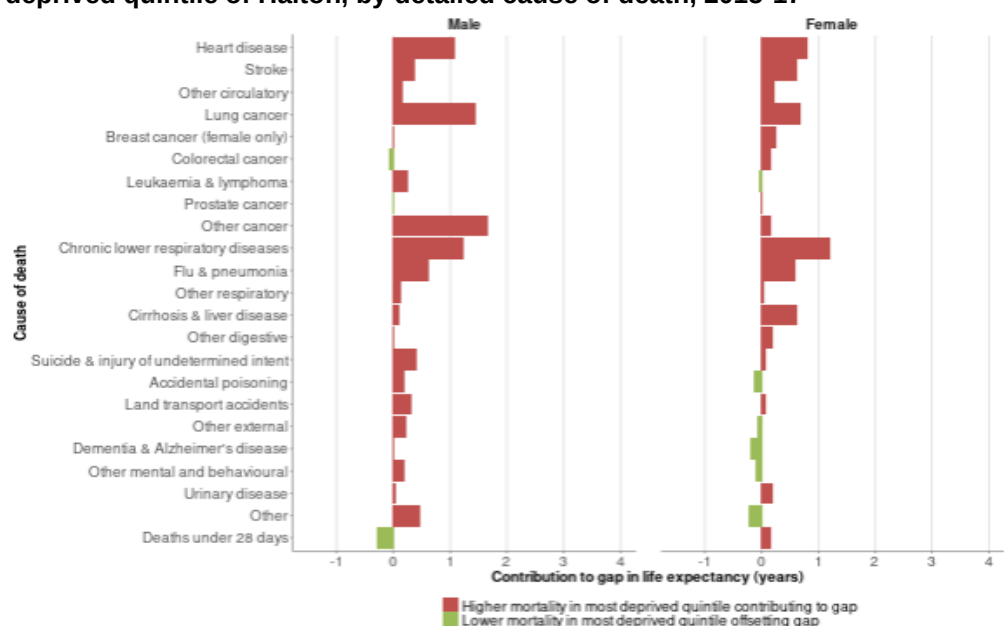
Between Halton and England

Between most and least deprived quintile of Halton



These are fairly broad disease categories. Looking at a more detailed analysis lung cancer, chronic lower respiratory disease as well as flu and pneumonia, heart disease and stroke are key features for both men and women. For men other cancers not listed separately and for women cirrhosis and liver disease are also key causes when looking at the difference in the life expectancy gap across Halton. To note when looking at Halton compared to England (not shown) cirrhosis and liver disease features higher for men and dementia and alzheimers disease for women.

Figure 13: breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Halton, by detailed cause of death, 2015-17



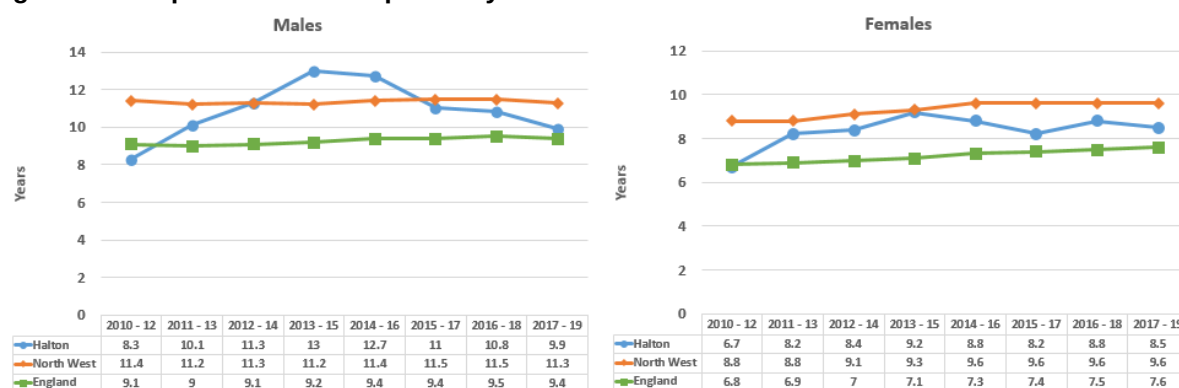
Source: PHE Health Inequalities Segmentation tool

3.4 Internal inequalities relate to deprivation

The Marmot Review: 10 years on showed the most significant changes since 2010 have been both a stalling of life expectancy increases and a greater widening of inequalities in life expectancy than in the previous decade. People in the most deprived area quintile experienced slower improvements in life expectancy than the rest of the population between 2001 and 2017. Nationally, the differences between the least and most deprived area quintiles in 2001 were 7.4 for men and 5.0 for women. These differences increased to 7.5 and 5.4, respectively, in 2010 and further increased to 7.7 and 6.1, respectively in 2017 – a substantially greater rate of increase in inequalities, especially for women, in the years since 2010 than in the previous decade.

The slope index of inequality (SII) is a measure of the social gradient in an indicator and shows how much the indicator varies with deprivation (by deprivation decile). It takes account of inequalities across the whole range of deprivation within England and summarises this into a single number. The SII represents the absolute difference in the indicator across the social gradient from most to least deprived.

For both males and females there has been a slight reduction in the gap in life expectancy, analysed by deprivation although the gap is larger than the England average especially for females. Whilst the gap has decreased steadily for males in Halton since 2012-14 the reduction has been less marked for females.

Figure 14: Inequalities in life expectancy trend


At electoral ward level the inequality gap for females is 12.0 for the period 2015-19, ranging from a in 88.7 in Daresbury to 76.7 in Halton Lea; for males it is 12.1 years, ranging from 85.2 years in Daresbury to 73.1 in Halton Lea.

Figure 15: Life expectancy at birth, by gender, 2015-19

Compared with England ■■■ Better 95% ■ Similar ■ Worse 95% ■ Not compared

Life expectancy at birth, (upper age band 90+) (Female) 2015 - 19

Life expectancy - Years

Area	Value	Lower CI	Upper CI
England	83.2	83.2	83.3
Halton	81.1	80.7	81.6
Daresbury	88.7	84.5	92.9
Beechwood	86.4	82.2	90.6
Farnworth	84.9	83.3	86.5
Halton Castle	84.9	81.5	88.2
Birchfield	84.8	82.5	87.1
Heath	84.5	83.0	86.0
Ditton	83.1	81.3	84.8
Mersey	82.2	80.2	84.3
Hough Green	82.1	80.1	84.1
Kingsway	81.8	80.0	83.7
Norton South	81.0	78.6	83.4
Norton North	80.8	77.6	84.1
Appleton	80.0	78.3	81.7
Grange	79.3	77.1	81.5
Halton View	79.3	77.3	81.3
Windmill Hill	79.2	75.9	82.5
Halton Brook	78.8	76.8	80.7
Broadheath	77.3	75.0	79.5
Riverside	77.0	75.3	78.6
Halton Lea	76.7	75.3	78.2
Hale	*	-	-

Compared with England ■■■ Better 95% Similar Worse 95% Not compared

Life expectancy at birth, (upper age band 90+) (Male) 2015 - 19

Life expectancy - Years

Area	Value		Lower CI	Upper CI
England	79.7		79.6	79.7
Halton	77.5		77.0	78.0
Daresbury	85.2		78.3	92.2
Birchfield	82.8		80.7	84.9
Beechwood	82.4		79.8	85.0
Norton North	80.4		78.5	82.4
Farnworth	80.3		78.7	81.9
Heath	80.0		78.0	82.1
Ditton	78.5		76.7	80.4
Kingsway	78.2		76.1	80.3
Halton Brook	78.0		75.8	80.1
Norton South	77.8		74.9	80.6
Grange	77.6		75.2	80.1
Hough Green	77.3		75.2	79.3
Broadheath	77.1		75.2	79.1
Halton View	75.9		73.8	78.1
Mersey	75.1		73.3	76.9
Windmill Hill	74.2		70.9	77.5
Appleton	74.0		72.1	76.0
Riverside	73.9		71.7	76.0
Halton Castle	73.6		71.1	76.1
Halton Lea	73.1		71.2	75.1
Hale	*		-	-

Note: values not calculated for Hale due to small number suppression

Source: ONS via PHE Fingertips, Local health tool

3.5. Impact of Covid on life expectancy

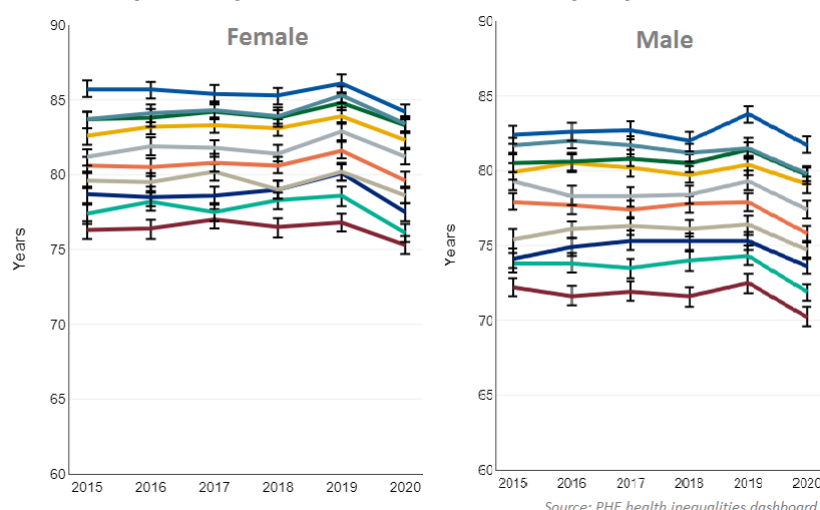
Public Health England completed some analysis on January to June 2020, which revealed that Covid has had a negative impact on average life expectancy for both men and women at a North West level. This fall in life expectancy can be seen across all deprivation deciles. This analysis was not replicated for Local Authority areas due to small numbers involved.

Provisional data is available to the Public Health Intelligence Team on Halton resident deaths during 2020. It is important to note that this is an early indication of the trend.

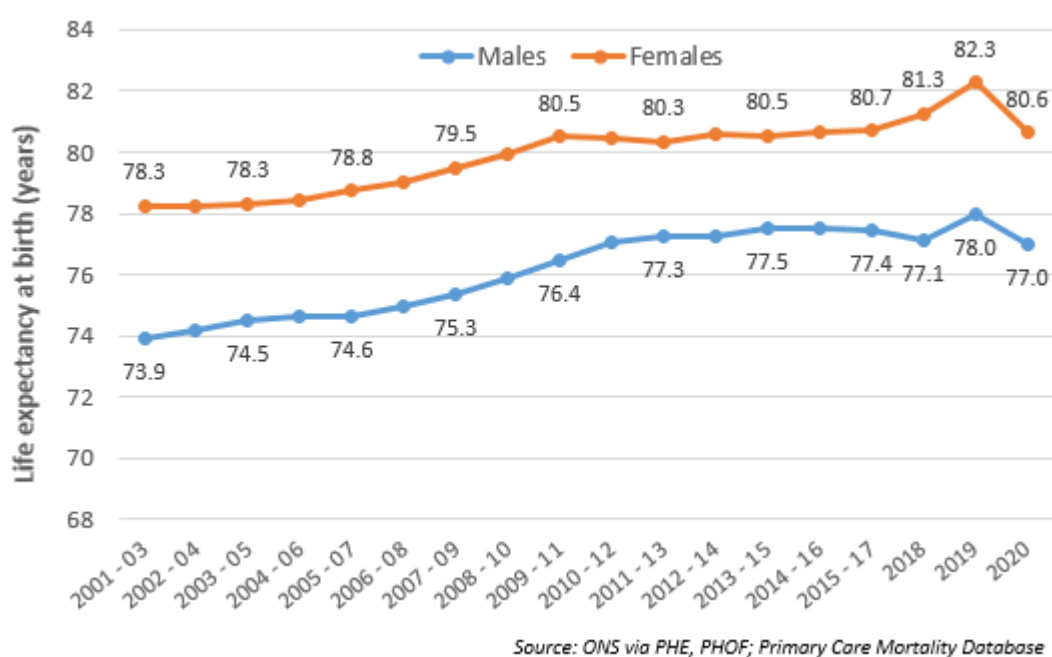
3.5.1. Overall trends

Usually life expectancy is analysed over a 3 year period to allow us to examine a smooth trend over time. However provisional analyses have been completed for each calendar year (where possible), to allow us to see the full effect of COVID-19 on life expectancy.

Figure 17 shows both male and female life expectancy dropped in 2020, as there were excess deaths from COVID-19. The reduction was 1 year for males and 1 year 7 months for females. Looking at the data as a 3 year average 2018-20, the reduction is 2 months for males and 6 months for females.

Figure 16: trend in life expectancy across the North West, by deprivation decile, January-June**Figure 17: Life expectancy at birth in Halton to 2020**

n.b. 2020 data is provisional



3.5.2 Life expectancy trends within Halton

Life expectancy generally correlates with levels of deprivation, with less deprived areas seeing higher life expectancies. Residents of more deprived areas are more likely to be in worse health and spend more of their life in poor health^{15,16}.

Deprivation varies within Halton and therefore there are borough level inequalities present. We can examine the extent of these by analysing life expectancy by deprivation decile. This means every

¹⁵ PHE: <https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health>

¹⁶ Cookson et al. (2016) *Socio-Economic Inequalities in Health Care in England*

small area in Halton is grouped into ten groups, from most to least deprived, and the life expectancy calculated for that group or decile.

Figure 18 and Figure 19 shows the trend by local decile in Halton for 2018-20, split by males and females. Halton does not have a perfect gradient as seen for the England average (where the lowest life expectancy is in decile 1 and the highest in decile 10). Halton's lowest male life expectancy was seen in decile 2 (the second most deprived 10th) and lowest for females was in decile 4.

Figure 18: Male life expectancy at birth (years) by Halton local deprivation decile 2018-20

Source: Primary Care Mortality Database (ONS; NHS Digital)

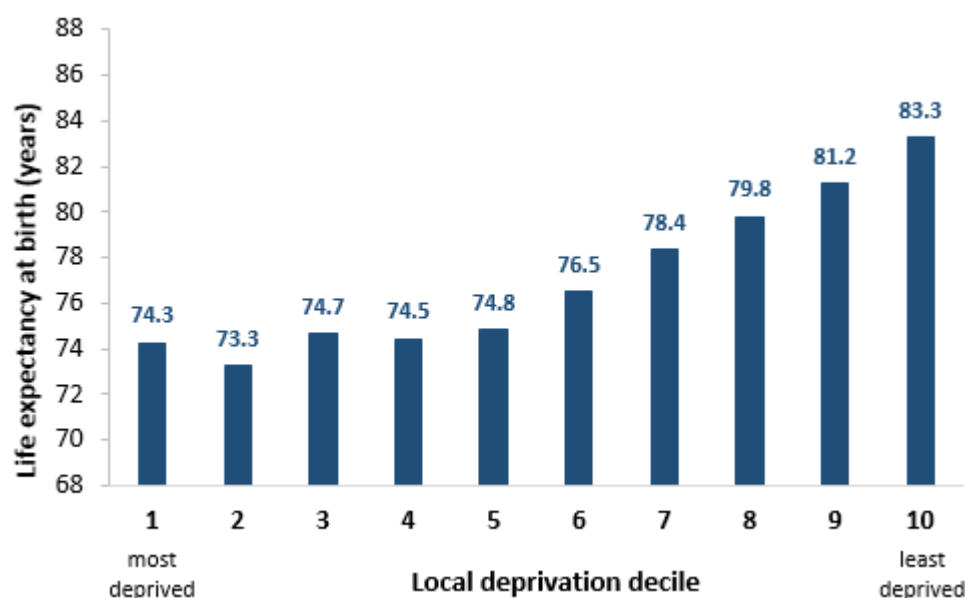
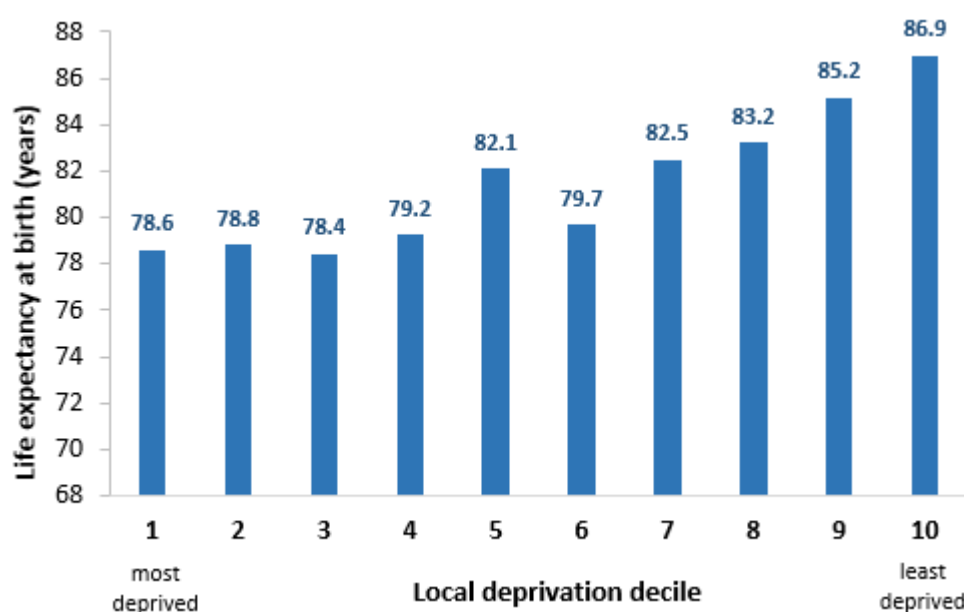


Figure 19: Female life expectancy at birth by Halton local deprivation decile, 2018-20

Source: Primary Care Mortality Database (ONS; NHS Digital)

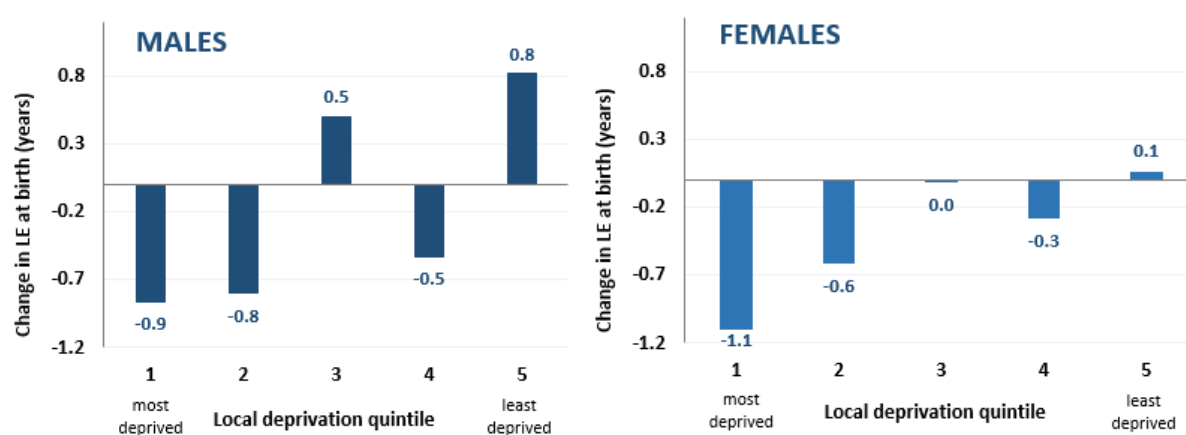


Looking at how this has changed since the last period 2017-19, the pattern is difficult to see across 10 decile groups. However it is clearer by using just 5 groups (local deprivation quintiles).

Figure 20 shows the most deprived two quintiles have seen the most impact on life expectancy by taking 2020 into account. Females in the most deprived fifth of Halton saw a 1 year 1 month reduction in life expectancy in 2018-20 compared to 2017-19 and males saw almost an 11 month reduction. Conversely the least deprived fifth saw an improvement for males and a very slight improvement for females. **This shows that the effects of COVID-19 deaths has had more impact on the more deprived areas of Halton.**

Figure 20: Change in life expectancy at birth by Halton local deprivation quintile, between 2017-19 and 2018-20, males and females

Source: Primary Care Mortality Database (ONS; NHS Digital)



The absolute life expectancy inequality (the difference between average life expectancy for the most deprived decile compared to the least) within Halton has increased since 2017-19 for both males and females. For males the difference is 9 years and for females 8 years 5 months.

3.5.3. Excess mortality across Cheshire Local Resilience Forum (LRF)

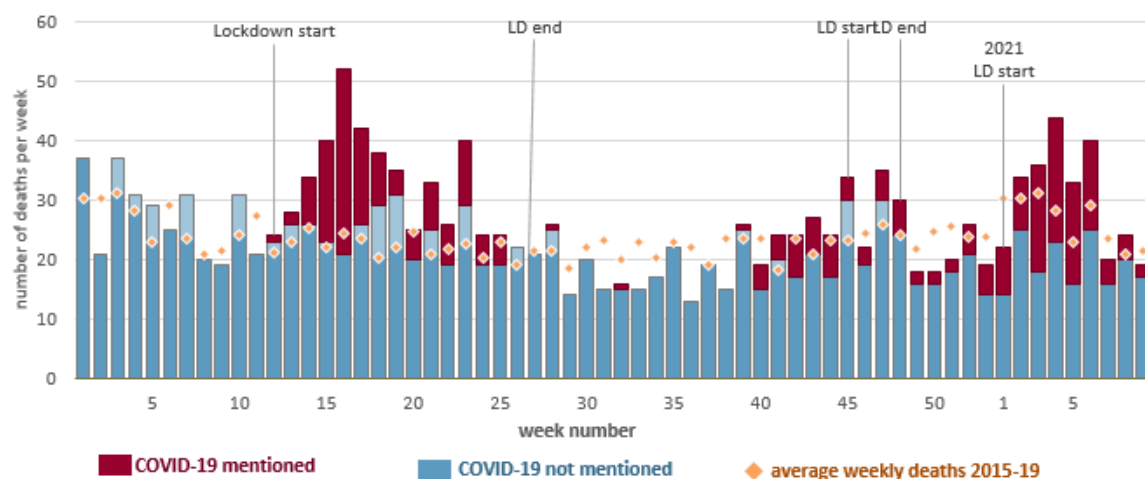
PHE have completed a comprehensive analysis of excess mortality down to Local Resilience Forum (LRF) level. This looks at the pattern of excess mortality over the last year overall and by categories of disease. The 2020 mortality was compared to the 2015-19 5-year average. Whilst most conditions have overall seen a similar level of mortality or even one below the 2015-19 5-year average, the notable exception is dementia & Alzheimer's disease during April 2020 where a sizable excess mortality was seen.

Overall excess deaths by LA; cause by LRF

Excess deaths are defined as the number, or rate, of deaths that occur over and above the 'expected normal' based on mortality in earlier years. In this analysis, the 'expected' number of deaths is the five-

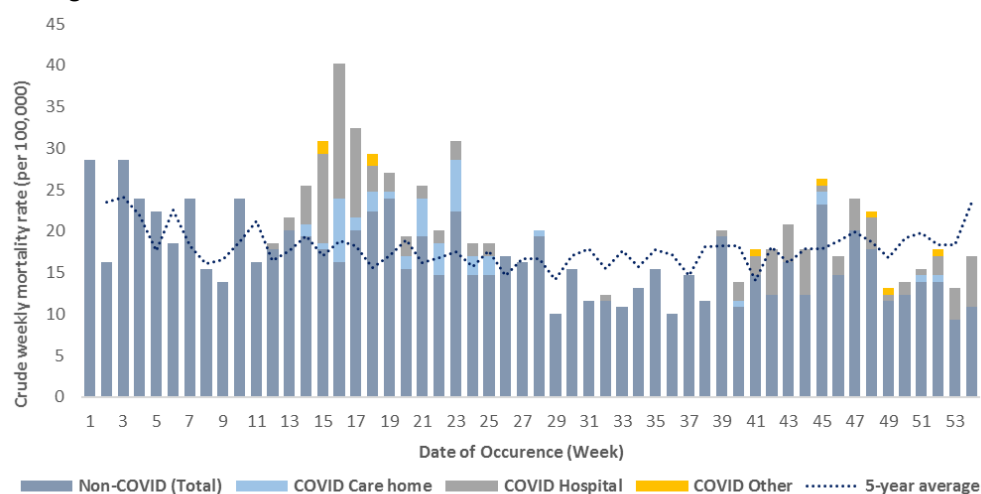
year average mortality for years 2015 to 2019. The analysis considers deaths between week 1 2020¹⁷ and week 6 2021. Excess deaths are estimated by week and in total, based on the date each death occurred.

Figure 21: 2020 weekly mortality Covid and non-Covid compared to 5-year average (2015-19)



Source: ONS via PHE LKIS Team

Figure 22: Crude Weekly Mortality Rate, Non-COVID-19 Deaths and COVID-19 Deaths, by Setting of Death for Halton



Excess mortality by leading cause of death

PHE have recently produced a 'Leading Causes' of excess mortality analysis by month from January to November 2020, compared to the monthly averages of 2015-2019. Leading causes have been used to produce large enough numbers to reduce the need for suppression, and the geographical selections only go down to LRFs, as even at this level suppression is having to be applied to some data (e.g. cirrhosis and liver disease). It remains a "product in development" and may be refined over time.

¹⁷ Note: In the early stages of the pandemic, it is possible that not all COVID-19 deaths were appropriately allocated, due to awareness of relevant symptoms and to testing strategies.

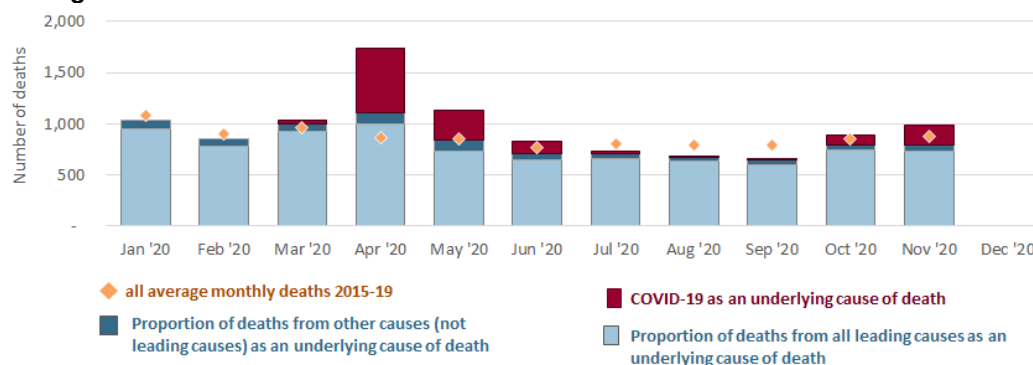
The leading causes shown have been chosen based on the numbers of deaths (i.e. to reduce the need for further suppression). Please note that not all cancers are included in the WHO's list of leading CANCER causes.

Only the top leading causes of death are selectable to avoid small numbers. These are:

- All leading causes
- Cancer (leading malignant neoplasms)
- Other cancers (not leading causes)
- Dementia and Alzheimer disease
- Ischaemic heart diseases
- Cerebrovascular diseases
- Chronic lower respiratory diseases
- Influenza and pneumonia
- Symptoms signs and ill-defined conditions
- Cirrhosis and other diseases of liver
- Other leading causes
- Other causes (other than leading causes)

What this work is not able to do is take in to account prevailing trend in deaths for particular conditions. So if for example, cancer deaths fell each year across 2015-2019, just taking an average may overestimate the 'expected' number of deaths and therefore reduce the excess mortality calculations.

Figure 23: all deaths in Cheshire LRF January 2020 to November 2020, with proportion due to leading causes

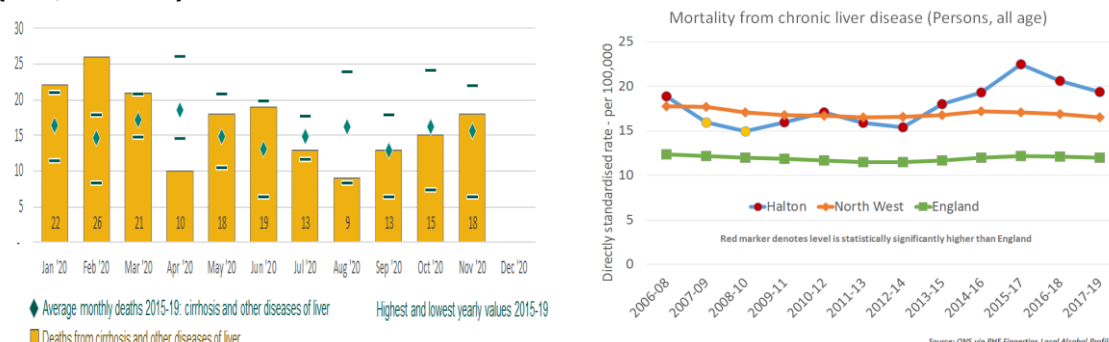


Source: ONS via PHE LKIS Team

Whilst most conditions have overall seen a similar level of mortality or even one below the 2015-19 5-year average, the notable exception is dementia & Alzheimer's disease during April 2020 where a sizable excess mortality was seen. As the very old were the ones most vulnerable to dying from Covid-19 in the first wave they are also the ones most likely to have this condition. Coding on the death certificates in the early stages of the pandemic were such that these may have been Covid-related deaths amongst people with dementia & Alzheimer's disease

Figure 24: Excess deaths for some main categories of disease during 2020, Cheshire LRF

There was also an excess of deaths due to cirrhosis and other liver disease compared to the 5-year average. The rise in death from chronic liver disease seen over the recent time period, fuelled mainly by an increase in alcohol consumption, had seen a fall for the last two reported periods. Whilst the excess deaths analysis is on a wider footprint and uses a slightly different set of ICD-10 codes, nevertheless it is worth considering the excess deaths analysis within the overall pattern of chronic liver disease (and other alcohol-specific and alcohol-related mortality). Research indicated that during the early part of the pandemic at least, those drinking within recommended levels did not consume more alcohol (indeed a preproportion of them consumed less) but those already at riskier levels of alcohol consumption increased their consumption further.¹⁸

Figure 25: deaths from cirrhosis and other liver disease (ICD-10 codes K70-K76) in Cheshire LRF January 2020-December 2020 compared to the trend in mortality from chronic liver disease (K70; K73-K74) in Halton

¹⁸ See for example 'Direct and indirect impacts of COVID-19 on health and wellbeing: a rapid evidence review' <https://www.ljmu.ac.uk/~media/phi-reports/2020-07-direct-and-indirect-impacts-of-covid19-on-health-and-wellbeing.pdf>

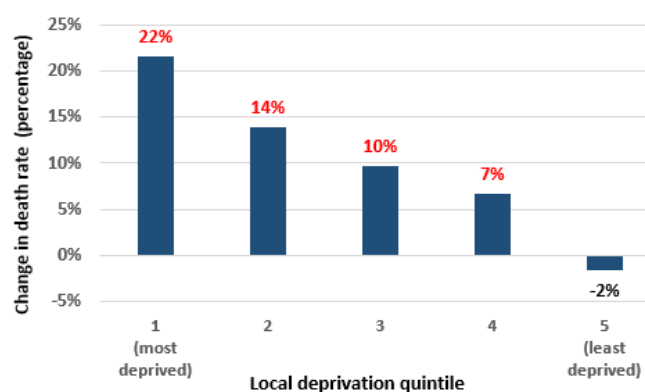
3.5.4 Halton mortality trends to 2020

Overall, 2020 saw around 9% extra (excess) deaths in Halton residents than the previous 5 year average 2015-19; this equates to 164 deaths.

Looking at trends for the main causes of death, rates were very slightly lower in 2020 compared to the 2015-19 average for cancer, cardiovascular disease and respiratory disease. It's possible that there was a bias towards death coding in favour of Covid-19; for example some that perhaps would have died from cancer, contracted Covid-19 and died, but the cancer was still an underlying cause of them being unable to fight the virus.

Looking at the change in death rate in 2020 compared to 2015-19, split by level of deprivation in Halton, we can see that the burden of excess mortality was not felt equally. Figure 26 shows that the largest increase in deaths in 2020 occurred in those living in the most deprived fifth areas in Halton: a 22% increase. Conversely, the least deprived fifth saw a slight reduction in deaths in 2020.

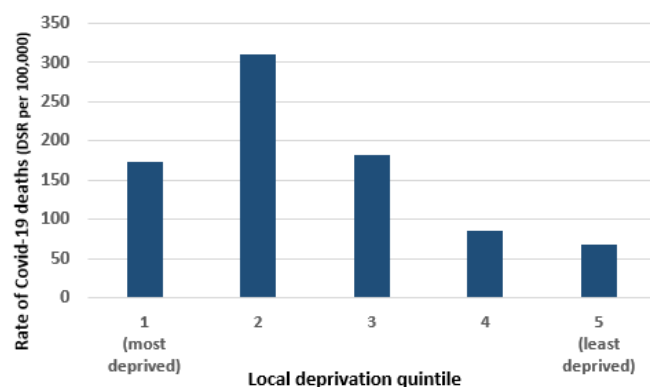
Figure 26: Difference in death rate (all causes) in 2020 compared to 2015-19 average, by local deprivation quintile (percentage change)



COVID-19 deaths in Halton

Just focussing on Covid-19 deaths in 2020, we can see that rates were higher in the most deprived 3 fifths ("quintiles"), than in the least deprived 2. Figure 27 shows the death rate in quintile 2 was over 4 times higher than the least deprived fifth.

Figure 27: Covid-19 death rate in 2020 by Halton deprivation quintile



3.6 Healthy Life expectancy

Another key measure of health inequality is how much time people spend in good health over the course of their lives, given how crucial good health is to wider quality of life and people's ability to do the things that they value.

Two important measures of the amount of time that people spend in good health are 'healthy life expectancy' and 'disability-free life expectancy'.

Inequalities in both healthy life expectancy and disability-free life expectancy are even wider than inequalities in life expectancy (illustrated by the steeper curves for disability-free life expectancy in Figures 1 and 2). People in more deprived areas spend, on average, a far greater part of their already far shorter lives in poor health.

The gap in healthy life expectancy at birth is stark. In 2015–17, people in the least deprived areas could expect to live roughly 19 more years in good health than those in the most deprived areas. People in the most deprived areas spend around a third of their lives in poor health, twice the proportion spent by those in the least deprived areas.

Healthy life expectancy is an estimate of how many years a person can expect to spend in "Very good" or "Good" health and is based on survey data on how individuals perceive their general health.

Figure 28: trend in healthy life expectancy at birth

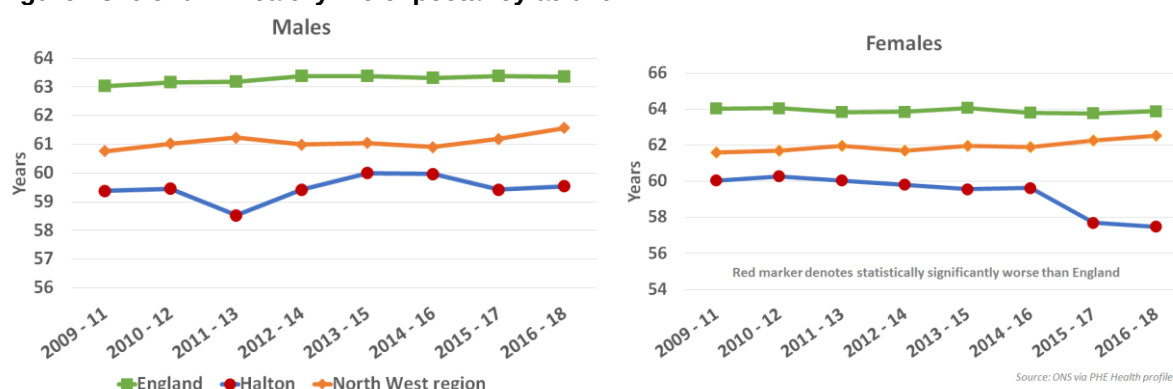
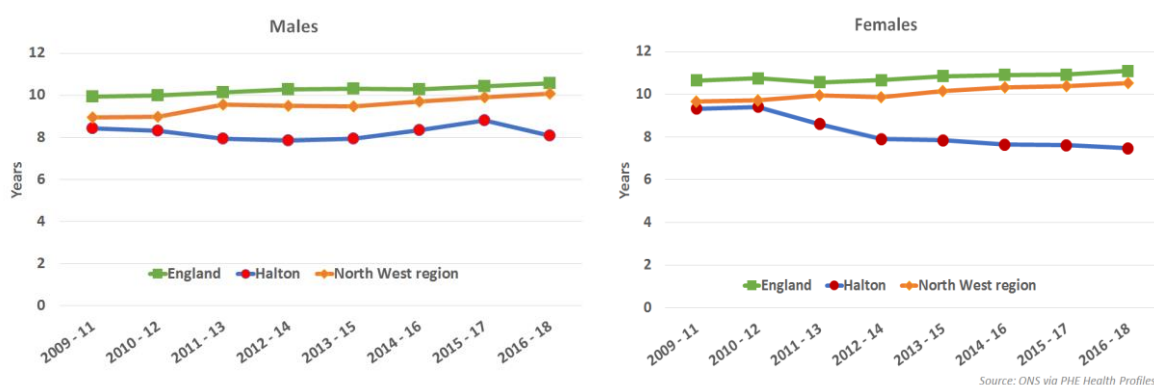


Figure 29: trend in healthy life expectancy at age 65



3.7. Disability free life expectancy

Disability-free life expectancy (DFLE) is an estimate of the number of years lived without a long-lasting physical or mental health condition that limits daily activities.

Figure 30: trend in disability-free life expectancy at birth

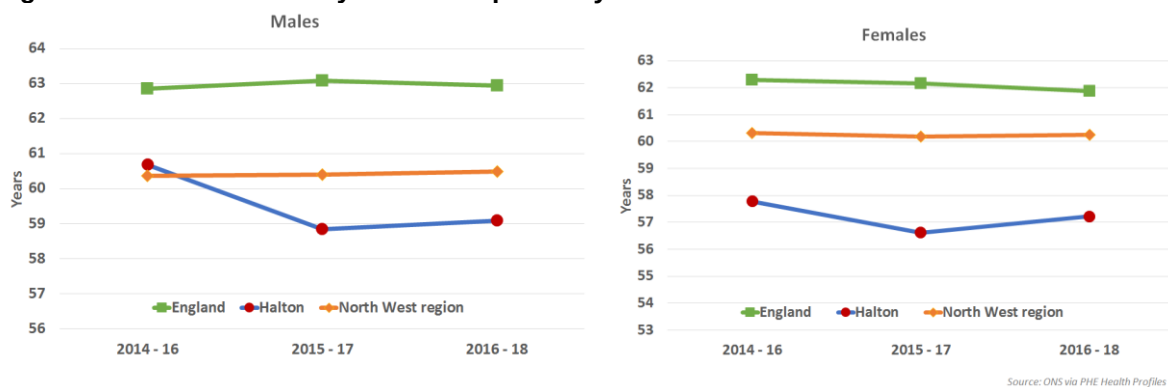


Figure 31: trend in disability-free life expectancy at age 65



4. Mortality analysis

The previous section has described the widening inequalities in life expectancy, with improvement in life expectancy being slower in the more deprived areas than the less deprived areas. This section examines a number of mortality trends the PHE review in to life expectancy identified as important in helping explain the slowing down of improvements in life expectancy

4.1 Heart disease and stroke

4.1.1. National context

Reductions in mortality from heart disease and stroke, which are leading causes of death, have historically driven improvements in life expectancy. Since 2011, there has been a slowdown in improvement in mortality rates for these causes which has therefore had a large impact on the trend in life expectancy. This slowdown has also been seen across many other countries.

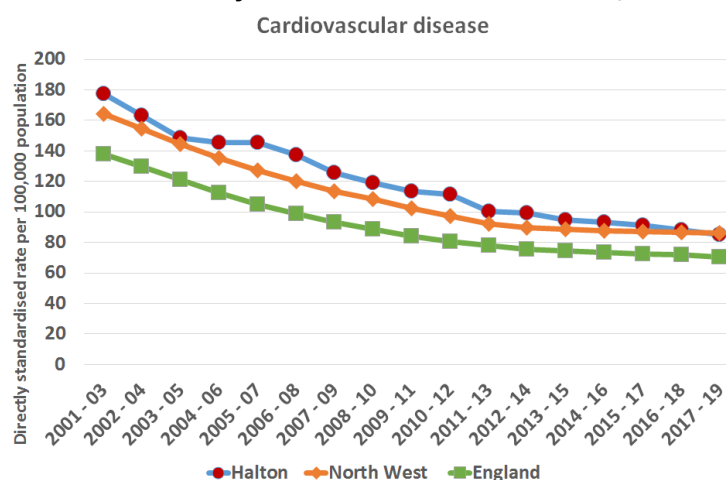
Over 84,000 people die from heart attacks or strokes each year, and one in four of these are happening in people less than 75 years of age. Up to 80% of these premature heart attacks and strokes are avoidable and this highlights the importance of focusing on preventative interventions such as stopping smoking, getting more physically active and lowering blood pressure and cholesterol levels.

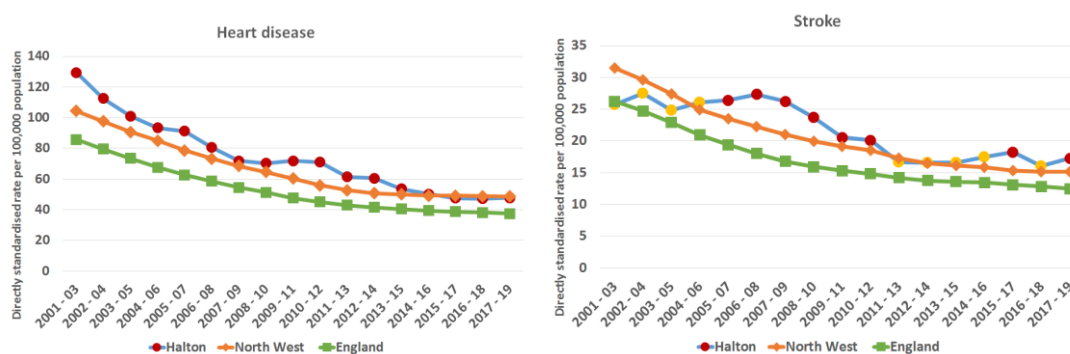
Stepping up efforts to reduce the risk of heart disease and stroke will also mean addressing the underlying wider determinants of health.

4.1.2. Halton position

Levels of heart disease and stroke have been higher in Halton than for England as a whole for many years. Whilst rates have fallen, the gap remains, with Halton rates statistically significantly higher than England (denoted by the red data marker in the chart). This pattern is seen across the reporting time period for both Cardiovascular disease and heart disease. For stroke the picture is more mixed (amber data marker denotes a rate statistically similar to England and the red data marker a rate statistically worse) but for the latest period is statistically significantly higher.

Figure 32: Trend in under 75 mortality from cardiovascular disease, heart disease and stroke





Source: ONS via PHE Health Profiles

4.2. Excess winter deaths

The ONS method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July. The calculation for EWD is winter deaths minus average non winter deaths. This measure makes no adjustment for the age structure of the population and so the ageing population is not taken into account in these estimates, but age-specific figures are released by ONS for the age groups 0-64, 65-74, 75-84 and 85+.

4.2.1. National context

There was a large increase in the number of deaths in the winters of 2014 to 15, 2016 to 17 and 2017 to 18. These increases were also seen across many other European countries and coincided with circulation of the flu subtype A(H3N2), known to predominantly affect older people. The review also shows that, in 2015, hospital admissions for flu increased at the time of the mortality increase.

The flu vaccine is one of the most effective ways of preventing flu although vaccine effectiveness has varied in recent years. Recent evidence of reduced flu vaccine effectiveness in older people has led to changes in the type of vaccine offered to this group.

There has been a substantial shift in the age structure of the population in recent decades: the number and proportion of people at older ages has increased. There are likely to be more people living with dementia and other long-term conditions that may make them particularly vulnerable to the effects of flu and other winter risk factors, and who may be particularly reliant on health and social care services.

Although respiratory diseases, including flu, are one of the leading contributors to excess winter deaths, there are also more deaths from heart disease and stroke and dementia in the winter months.

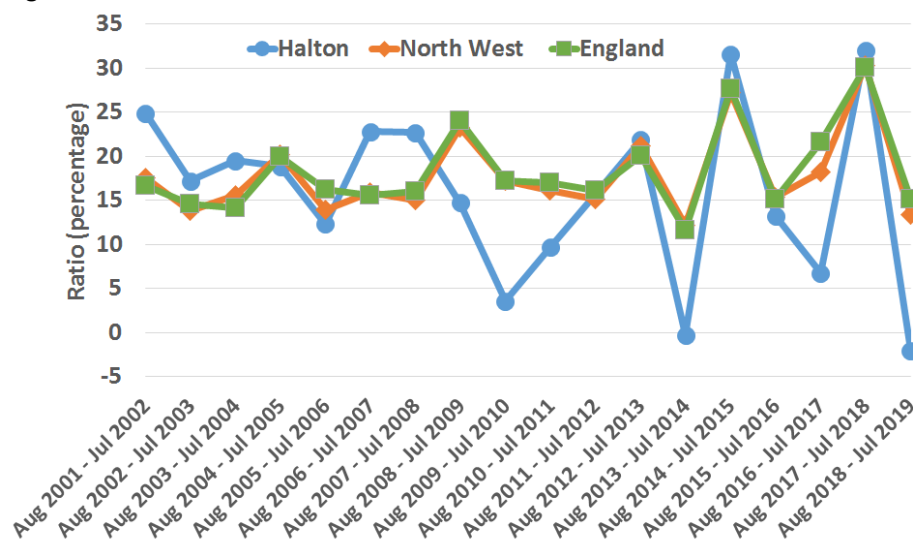
Low temperature can be a risk to all age groups, but risks are greatest in older people and young children. People with conditions like dementia are also at risk as they may be less aware that they need to change their behaviour to stay warm.

Recent winter peaks in mortality have contributed to the slowdown in mortality improvement since 2011. However, the review found that improvement in mortality rates for the non-winter months has also slowed in recent years.

4.2.2. Halton position

Whilst the pattern fluctuates must more than England and the North West (which more or less mirrors the England pattern), the ratio values are, overall, statistically similar to England.

Figure 33: Excess Winter Deaths Index



Source: ONS via PHE Health Profiles

Local analysis (2017-18) shows that respiratory deaths as well as cardiovascular disease were significant drivers. Dementia was also a key feature. This latter condition reflects deaths in the older age population are the most significant driver. The relationship with deprivation is less clear as EWD index is highest in local quintile 4.

Figure 34: underlying causes driving excess winter deaths

Period	Underlying cause of death					
	All deaths	Circulatory	Respiratory	Cancer	Dementia & Alzheimer's	Injury & poisoning
Aug 17 - Nov 17	395	85	53	130	44	16
Dec 17 - Mar 18	454	111	92	114	62	9
Apr 18 - Jul 18	370	81	56	121	34	16
Average: non winter	382.5	83	54.5	125.5	39	16
EWM	71.5	28	37.5	-11.5	23	-7
EWM Index	18.7	33.7	68.8	-9.2	59.0	-43.8

Period	0-64			65-84			85+			All ages		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
Aug 17 - Nov 17	51	40	91	88	85	173	67	64	131	206	189	395
Dec 17 - Mar 18	45	33	78	114	103	217	68	91	159	227	227	454
Apr 18 - Jul 18	40	28	68	118	81	199	37	66	103	195	175	370
Average: non winter	45.5	34	79.5	103	83	186	52	65	117	200.5	182	382.5
EWM	-0.5	-1	-1.5	11	20	31	16	26	42	26.5	45	71.5
EWM Index	-1.1	-2.9	-1.9	10.7	24.1	16.7	30.8	40.0	35.9	13.2	24.7	18.7

4.3. No improvement in death rates in young adults

4.3.2. National context

While flu, heart disease and stroke have partly determined the trend in mortality rates in older adults, other causes of death have influenced the trend in younger people.

Mortality rates among younger adults made almost no positive contribution to trends in life expectancy between 2011 and 2016, despite making small positive contributions in earlier years. The cause of death that had the biggest negative impact was accidental poisoning, with 70% of these deaths due to drug misuse and 10% due to alcohol.

4.3.2. Halton position

Levels of accidental poisoning in Halton (all age) are generally lower or similar to England, apart from 2014 and 2017. However, small numbers in Halton make rates more prone to fluctuations. These small numbers mean it is not possible to breakdown the data on accidental poisonings in to types at a local level due to suppression.

Figure 35: Directly standardised mortality rate due to accidental poisoning by and exposure to noxious substances (ICD-10 codes X40-X49)

	Halton	North West	England
2013	6.31	5.95	4.02
2014	11.77	7.48	4.92
2015	4.89	7.60	5.39
2016	3.14	7.54	5.41
2017	10.34	8.27	5.61
2018	6.31	8.44	6.39
2019	6.09	9.21	6.53

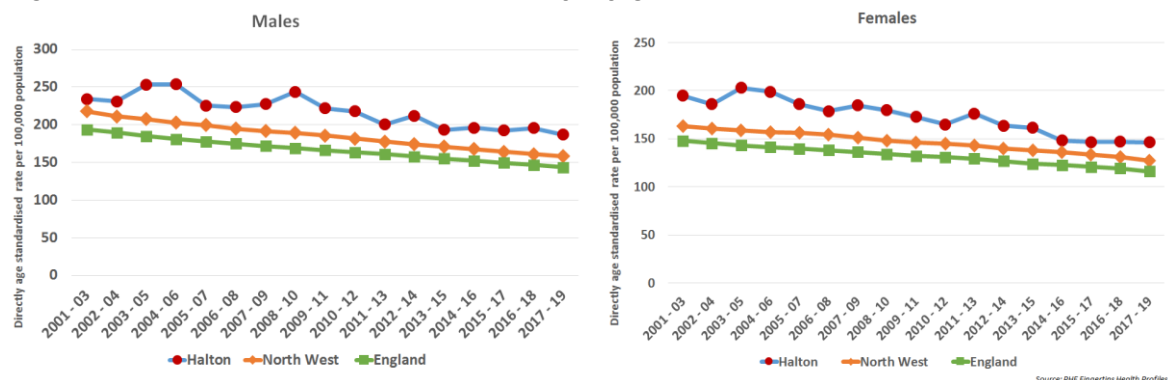
Source: ONS via Nomis

4.4. Local driver: cancer mortality

As seen in the previous section 3.3 Cancers are a significant contributor to the life expectancy gap between Halton and England and within Halton, accounting for over 20% of the gap for women and 37% for men.

Although there have been significant improvements in cancer mortality rates locally, rates remain statistically significantly worse in Halton than for England. In terms of national ranking, male under 75 cancer mortality now ranks 7th with females ranking 10th and persons ranking 7th.

Figure 36: Trend in under 75 cancer mortality, by gender



5. Conclusions

Inequalities in life expectancy persist in Halton both in relation to how the borough compares to England but also to an even greater extent between the poorest and most affluent areas in the borough.

Not only do people in Halton not live as long but they spend less of their lives in good health and being disability-free. This is the case when considering both life expectancy at birth and at age 65.

These inequalities stem from inequalities in the wider determinants of health – those areas of life outside of health and care services such as having a good start in life, living in families that have stable and secure income, warm homes and secure tenancy as well as things like getting the right qualifications for the job you want and being able to secure employment that is stable and pays enough to meet your needs. Living in a pleasant neighbourhood, with low crime and a sense of belonging fosters good mental wellbeing and can help reduce a sense of loneliness. It is also important that the place we live, work and socialise is able to facilitate positive health behaviours and not make them more difficult to achieve.

The Mamot Review underlined the importance of having a fair society in order to reduce health inequalities. This needs to happen at all levels.

Action to address cardiovascular disease, cancers, diseases related to alcohol misuse as well as respiratory disease (especially influenza and pneumonia) and dementia are especially important as the key drivers for the gap in life expectancy in Halton and between Halton and England.

This needs to start early, with a focus on action to:

- address a good start in life
- the primary prevention of long-term conditions
- where this is not possible the reduction in variation of the management of these conditions
- addressing people mental health & wellbeing, including the relationship between secure employment and mental health as well as physical health and mental health
- all underpinned by an additional focus on those living in areas of deprivation or more at risk of poor health outcomes (due to having certain protected characteristics or vulnerabilities) is vital.

The last point is especially important as analysis in this report shows that deprivation accounts for nearly three quarters of the difference in life expectancy across wards in Halton, for premature mortality, all-causes.

The work of NHS England, Public Health England, Local Government Association and others working together has provided a suite of interventions that can be chosen, depending on our local health priorities, and local organisations and leadership should use these in developing local strategies and action plans.

Appendix 1: Annex 2 - Roles and responsibilities of local institutions

Replicated from <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-annexes#annex2>

A clear understanding of the different roles and potential actions of different organisations is a critical component of effective action to address health inequalities.

The following section draws on the evidence of effective approaches for addressing health inequalities set out throughout this framework, in the PHE publication ‘system, scale and sustainability’ [\[footnote 15\]](#), as well as wider in other systems approaches.

It provides further detail about the potential role and contributions to addressing health inequalities that different sectors and institutions could make.

Duties and potential actions for place-based approaches to health inequalities:

Health and Wellbeing Boards:

Health and Wellbeing Boards (HWB) have a duty to encourage integrated working between health and social care commissioners, the HWB, and commissioners of health-related services such as housing, and local government services [\[footnote 16\]](#).

Examples of good practice by HWBs to address health inequalities include:

- working with Directors of Public Health to undertake analysis of the main drivers of inequalities in health outcomes and access in an area
- developing integrated ‘SMART’ (specific, measurable, achievable, realistic and time-bound) plans to reduce health inequalities
- developing plans which incorporate the principles of system, scale and sustainability - and specific actions from all partners to address the wider determinants of health
- ensuring plans include locally agreed short, medium and longer-term targets to reduce health inequalities
- engaging with Voluntary, Community and Social Enterprise (VCSE) sector and local residents to ensure actions build connected and empowered communities
- ensuring local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives

Local authorities:

Local authorities have a responsibility to meet their duties in The Health and Social Care Act [\[footnote 17\]](#), the Care Act [\[footnote 18\]](#), and the Social Value Act [\[footnote 19\]](#).

The Health and Social Care Act [\[footnote 20\]](#) requires local authorities to take such steps as they consider appropriate for improving the health of the people in their areas.

The terms of the Public Health Grant to local authorities indicate that a local authority must, in using the grant have regard to the need to reduce inequalities between the people in its area, with respect to the benefits that they can obtain from that part of the health service provided in exercise of the

functions referred to in paragraph 3 (public health functions as specified in Section 73B(2) of the National Health Service Act 2006 (“the 2006 Act”) [\[footnote 21\]](#).

The [Care Act 2014](#) [\[footnote 22\]](#) indicates that local authorities must provide or arrange services that help prevent people developing needs for care and support, or delay people deteriorating such that they would need ongoing care and support.

Care and support planning considers a number of different things, such as what needs the person has, what they want to achieve, what they can do by themselves or with the support they already have, and what types of care and support might be available to help them in the local area.

In addition the [Social Value Act 2012](#) [\[footnote 23\]](#) requires public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental wellbeing in the procurement of services or contracts.

Creating social value has clear connections with efforts to reduce health inequalities through action on the social determinants of health – for example, by improving employment and housing.

Examples of the kind of actions that local authorities could consider to address health inequalities include:

- working with other system leaders to develop integrated SMART plans at neighbourhood and place-level, underpinned by analysis of local drivers of, and protective factors for addressing, health inequalities, including individual and community assets
- ensuring plans capture all council functions and local authorities’ place-based function in addressing health inequalities
- engaging community members and voice in planning and delivery, especially from the most marginalised communities
- identifying measurable cross-council targets for addressing health inequalities
- identifying and prioritising action with a specific focus on addressing health inequalities as part of delivering Care Act wellbeing duties
- considering how regulatory and other functions can contribute to place-based plans to better address health inequalities (for example planning, licensing, environment, transport, environmental health, leisure)
- utilising community-centred approaches to improve health and wellbeing, and building social capital to help communities to reduce inequalities
- working with employers, including the NHS, to improve access to employment and the health and wellbeing of employees
- considering addressing inequality by devolution of power and resources from the local to community level, through integrating communities into local decision making in line with findings from the Due North inquiry report [\[footnote 24\]](#).

Clinical commissioning groups

CCGs have duties regarding health inequalities under the [NHS Act 2006](#) as amended by the [Health and Social Care Act 2012](#) and Social Value Act 2012 (see details in local authority duties).

Examples of the kind of actions that public-sector commissioners, including CCGs, could consider to address health inequalities include:

- ensuring commissioning plans have a specific focus on improving the health of people with the poorest health outcomes fastest
- identifying and closing the gaps in care which have the most impact on health inequalities
- ensuring that all screening and vaccination programmes are designed to support a narrowing of health inequalities in access, uptake and outcomes
- ensuring procurement processes formally assess impact on health inequalities
- considering the potential of service models to inadvertently increase health inequalities (for example are psychosocial factors likely to impact on accessing services for some groups)
- undertaking and acting upon Health Equity Impact Assessment of plans and services
- using formal mechanisms to proactively identify people who are most likely to benefit from earlier intervention – based on the identification of risk, and early diagnosis
- targeting resources to support them and transforming care models and pathways to improve access, experience and outcomes
- employing targeted use of personal budgets and personalisation, to empower individuals and communities including those in positions of disadvantage

Sustainability Transformation Partnerships/ Integrated Care Systems

The [NHS Long Term Plan](#) indicates that ICSs provide stronger foundations for working with local government and voluntary sector partners on the broader agendas of prevention and health inequalities.

Examples of the kind of action that STPs or ICSs could consider to address health inequalities include:

- setting out specific measurable goals for narrowing inequalities, in line with the NHS Long Term Plan requirement. During 2019 they will set out how they will specifically reduce health inequalities by 2023 to 2024 and 2028 to 2029
- working with other system leaders, ICSs develop integrated SMART plans underpinned by analysis of local drivers and protective factors, to reduce health inequalities systematically at the different local levels of place-based organisation
- ensuring plans include co-ordinated action on the wider determinants of health including employment and poverty
- undertaking Health Equity Audit (HEA) plans, and completing audit change cycles
- ensuring plans include locally agreed short, medium and longer-term targets to address health inequalities at system, place and neighbourhood level
- ensuring plans engage the most marginalised communities in setting, delivering and monitoring priorities
- engagement with VCSE organisations, and inclusion of civil society organisations in strategic approaches

Health and social care (HSC) service providers

Examples of the kind of action that HSC service providers could take to support delivery of the NHS Long Term Plan, and the Care Act ambitions on Health Inequalities, include:

- targeting services to the needs of individuals, families and communities most likely to experience health inequalities (including through utilising available data, for example demographic, equality and diversity or wider determinants data)
- the use of evidence-based risk stratification tools, for example, the Patient Activation Measure (PAM) offers different levels of wellbeing support depending on individuals' health literacy as part of targeted self-care

- implementing structures that engage community members, especially the most marginalised groups, in decision-making about service needs, priorities and appropriate delivery methods with demonstrable resulting changes
- implementing an enhanced and targeted continuity of carer models, in particular, to help improve outcomes for the most vulnerable mothers and babies
- ensuring that by 2023 and 2024, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
- using their role as a system anchor to improve health outcomes through co-ordinated action on the wider determinants of health, including air pollution and employment. For example, through 'green' transport provision and targeted recruitment of people from deprived communities
- influencing supply chain to address health inequalities, for example through use of the Social Value Act
- utilising community-centred approaches to improving health and wellbeing
- continuing to take action on healthy NHS premises

Primary care networks

Primary care networks (PCNs) are expected to play a pivotal role, with local authority and community partners, in improving population health and reducing inequalities. They play a full part in co-producing and implementing ICS plans to reduce inequalities by 2023 to 2024 and 2028 to 2029.

PCNs from 2020 to 2021 will assess their local population at risk of unwarranted health outcomes and, working with local community services, make support available to those who need it most. The [Five Year Framework for GP Contract reform](#) ^[footnote 25] sets out ambitions on social prescribing including its role in addressing health inequalities, making social prescribing more widely available and accessible.

Examples of the kind of action that PCNs could take to contribute to addressing health inequalities include:

- recognising the impact of health literacy and psychosocial factors on demand, need and uptake of primary care services
- systematically targeting and adapting services to the needs of people most likely to experience health inequalities
- working closely and systematically with other front-line delivery partners to co-ordinate person and family-based approaches to addressing complex needs
- embedding community-centred approaches in their work with communities as part of developing social prescribing systems
- utilising community-centred approaches to improve health and wellbeing, building social capital to help communities to reduce inequalities

Voluntary and community sector

The [Health Foundation](#) ^[footnote 26] and [All Party Parliamentary Committee on Arts and Wellbeing](#) ^[footnote 27] have identified the contribution that specific elements of civil society make to improving health.

Examples of the kind of action that civil society organisations could take to further contribute to addressing health inequalities include:

- continuing to contribute knowledge of the strengths of local communities to inform cross-system plans to 'grow' the protective factors, and to better link communities with services
- further helping to create social capital to support communities to reduce inequalities
- aligning civil society resources with those of statutory partners to support the delivery of place-based plans (where appropriate)
- providing advocacy and voice for people and groups who face most barriers

Business

The Confederation of British Industry has identified the [business benefits of good workplace](#) ^[footnote 28] health. The [Industrial Strategy](#) ^[footnote 29] includes an ambition to narrow the gap between the experience (in relation to healthy independent years of life) of the richest and poorest.

Examples of the kind of action that the business sector could take to address health inequalities include:

- recognising their role as a system anchor through maximising social, environmental and economic impacts for the local communities' benefit
- business organisations, for example, Chambers of Commerce, encouraging their members to understand the business case for addressing health inequalities, and work with others to identify opportunities for business to participate in place-based health inequalities activity

Public Health England

The Health and Social Care Act 2012 ^[footnote 30] placed a legal duty on PHE to have due regard to the need to reduce health inequalities. PHE does this by:

- providing data and evidence of health inequalities trends and drivers
- supporting monitoring of local, regional and national outcomes in reducing health inequalities
- sharing good practice from across the country
- providing practical tools and resources to implement joined-up place-based approaches to health inequalities outlined in this in this framework

At a local level, PHE centres and regions support local areas through place-based approaches to:

- share learning and good practice
- build capacity and co-produce work
- support local action on reducing inequalities in health through evidence, information, guidance, partnerships and advice

Supporting areas to use the tools within this work is a key means of achieving of these objectives, and there is dedicated support available at both a national and local level to do this. If you are interested in drawing on this support, please contact health.equity@phe.gov.uk