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Executive Summary

Background
This report provides a high-level overview of inequalities in Cheshire West and Chester, focusing on employment, housing and health. The report sets out a range of evidence-based actions that the Council could take to address these inequalities, highlighting where resources should be focused.

It is envisaged that this report is the first in a series that will explore inequalities from a number of angles. It is anticipated that this, and subsequent reports will generate new questions and further lines of enquiry that need answering using our corporate strategic intelligence.

Key facts
- Health and social inequalities arise from a complex interaction of many factors including housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- There is a clear and well-established evidence base on policies and actions that can improve inequalities
- Tackling inequalities requires action across all the social determinants of health including education, occupation, income, home and community
- Effective local delivery requires effective participatory decision-making at a local level. This can only happen by empowering individuals

Wards with high levels of multiple inequalities in Cheshire West and Chester:
- Blacon ward in Chester
- Lache ward in Chester
- Grange ward in Ellesmere Port
- Ellesmere Port Town ward in Ellesmere Port
- Netherpool ward in Ellesmere Port
- St Paul’s ward in Ellesmere Port
- Rossmore ward in Ellesmere Port
- Frodsham ward in Rural
- Winsford Over and Verdin ward in Winsford and Northwich
- Winnington and Castle ward in Winsford and Northwich

Reducing social inequalities requires action on six policy objectives:
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 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

The Council should prioritise policies and interventions that reduce inequalities by:

- Fully integrating the planning, transport, housing, environmental and health systems to address the social determinants
- Supporting locally developed community regeneration programmes
- Improving the energy efficiency of housing
- Reducing fuel poverty
- Improving access to good jobs and reduce long-term unemployment
- Making it easier for people who are disadvantaged in the labour market to obtain and keep work
- Improving the quality of jobs across the social gradient
- Improving active travel across the social gradient
- Improving the availability of good quality open and green spaces
- Improving the food environment in local areas
- Removing barriers to community participation
- Reducing social isolation
Glossary

Decile A method of splitting up a set of ranked data into 10 equally large subsections. In the Index of Multiple Deprivation maps in this report, decile one areas are areas that are in the 10% most deprived in England.

Index of Multiple Deprivation/Indices of Deprivation Tools that describes the most deprived areas in Cheshire West and Chester in the context of the most deprived areas in England. Therefore national quintile one describes those areas of Cheshire West and Chester that are amongst the 20% most deprived in England.

LSOA Lower-layer Super Output Areas (LSOAs) are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 Lower-layer Super Output Areas (LSOAs) in England. They were produced by the Office for National Statistics for the reporting of small area statistics and are a standard way of dividing up the country.

NOMIS/Nomis Nomis is a service provided by the Office for National Statistics (ONS) to give free access to the most detailed and up-to-date UK labour market statistics from official sources.

Quintile A method of splitting up a set of ranked data into five equally large subsections. In the Index of Multiple Deprivation maps in this report, quintile one areas are areas that are in the 20% most deprived in England.

Mean/Median/Mode Three types of average. The mean is the total of the numbers divided by how many numbers there are. The median is the middle value. The mode is the value that appears the most.
1. Introduction

Local authorities are uniquely placed to tackle health and social inequalities, as many of the social and economic determinants of our wellbeing, and the services or activities which can make a difference, fall within their remit (see figure one). The challenge is to reduce the difference in outcomes between rich and poor and to increase the quality of life and sense of wellbeing of the whole local community.

Social and economic inequalities underpin the determinants of health, the range of interacting factors that shape our health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. Therefore taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

**Figure 1: The determinants of health and wellbeing**

This report focuses on three key indicators: employment, housing and health. It is anticipated that this report will generate further questions and areas for further examination.
2. Measuring inequalities

At a local level, we commonly measure inequalities by using the Indices of Deprivation. The Index of Multiple Deprivation, commonly known as the IMD, is the official measure of relative deprivation for small areas (Lower-layer Super Output Areas or LSOAs) in England. The Index of Multiple Deprivation ranks every small area in England from one (most deprived area) to 32,844 (least deprived area). It combines information from seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights:

1. Income deprivation (22.5%)
2. Employment deprivation (22.5%)
3. Education, skills and training deprivation (13.5%)
4. Health deprivation and disability (13.5%)
5. Crime (9.3%)
6. Barriers to housing and services (9.3%)
7. Living environment deprivation (9.3%)

The weights are derived from consideration of the academic literature on poverty and deprivation, as well as the levels of robustness of the indicators. All of the maps used in the report highlight areas in Cheshire West and Chester, based on their decile or quintile position, where decile one is the 10% most deprived in England and quintile one is the most deprived 20% in England.

Map one: Index of Multiple Deprivation for Cheshire West and Chester
3. Employment

There is a clear relationship between position in the social hierarchy and mortality, and a social gradient in employment status and working conditions. People in more disadvantaged socioeconomic groups are at a higher risk of unemployment and, if employed, of poor working conditions. Patterns of employment therefore both reflect and reinforce the social gradient of health and there is inequality of access to labour market opportunities. This is a result of a number of factors including skills/training, availability of jobs in the area and transport.

The nature of work adversely affects mental and physical health through:

- Physical conditions e.g. exposure to physical / chemical hazards, long hours, shift work
- Psychosocial conditions e.g. conflict, lack of autonomy, lack of control
- Poor pay or insufficient hours
- Temporary work, job insecurity and risk of redundancy
- Job satisfaction and wellbeing

Key sectors affected include:

- Construction industry – highest physical injury rate because of physical hazards.
- Health and social care workers are most susceptible to both stress and musculoskeletal disorders while shift work is most prevalent for these groups.
- Long hours (+45 hours per week) are most associated with the agricultural sector and managers.
- Stress is most prevalent for welfare and housing professionals, followed by workers in teaching and education.
- Low paid work is most prevalent in retail, for waiting staff and in residential care.

Map two: Employment deprivation

![Map of Employment Deprivation](image)
The employment domain of the Indices of Deprivation measures the employment deprived, defined as those that would like to work but are unable due to unemployment, sickness or disability (map two). In 2010, Cheshire West and Chester had two lower super output areas in the 1% most deprived in relation to employment deprivation. The 2015 IMD shows that now there is only one - Lache ParkL1, which has gone from the 122nd most deprived in England, to the 290th most deprived for employment in England (note: this does not necessarily mean that Lache ParkL1 has become less deprived since 2010, as the Indices of Deprivation is a relative measure based on all LSOAs in England).

In terms of wards with multiple lower super output areas (LSOAs) in the 10% most deprived, Blacon has four, Winsford Over and Verdin has three, as does Ellesmere Port Town. St. Pauls and Rossmore both have two LSOAs that are in the 10% most deprived. In short, Winsford and Ellesmere Port are hardest hit when it comes to employment deprivation.

**Job Seeker Allowance (JSA) Counts**

JSA figures only include those claiming Job Seekers Allowance. It should therefore not be seen as an indicator of total unemployment. It is, however, the only relative measure of those unemployed without medical reasons at ward level.

In August 2015, the five wards with the highest rates of JSA claimants were Rossmore (2.7%); Grange (2.6%); and Ellesmere Port Town (2.3%); with Neston, Netherpool and St. Pauls all at 1.5%. The wards with the highest numbers of JSA recipients are Ellesmere Port Town (138 people); Blacon (102); Winnington and Castle (89); Winsford Over and Verdin (82); and St. Pauls (81). This matches those wards listed in the 10% most employment deprived above.

**Employment Support Allowance (ESA)**

Employment Support Allowance (ESA) is available to those people aged 16-64 that, due to medical reasons, may have no or very limited capacity for work. Latest available data is from February 2015 from NOMIS.

The most recent data at ward level for ESA is from 2013. In that year, wards with the highest rates of ESA as a percentage of the 16-64 year old population were Rossmore (13.3%); Netherpool (11.1%); Blacon (10.5%); Ellesmere Port Town (10.1%); Lache and St Pauls (9.7%). Behavioural and mental health issues account for around 50-60% of ESA claims in these wards.

**Household Income**

CACI Paycheck is a data set that contains modelled data that provides postcode level measures of income. The current (2014) version provides counts of households within income bandwidths, mean, median, modal and lower quartile summaries at postcode, LSOA and ward levels.
a) Living Wage

The living wage is the hourly rate of pay required to cover the basic cost of living in the UK. Currently it is £7.85/hr for areas outside of London; and while not normally expressed as a salary, it can be worked out by the following method: £7.85 x 38 hrs per week x 52 weeks a year = £15,511.60.

The numbers and percentages of households in the income bands of £0-5k; £5-10k and £10-15k have been calculated for each ward:

- In Cheshire West and Chester, 23% of households (32,286 households) have an income that is less than the living wage
- 17 wards have over 25% of households with an income that is less than the living wage
- The ward with the lowest rate is Kingsley with 12% of households below the living wage; the ward with the highest rate is Grange with 39% of households

b) Median Income disparities

The gap between the lowest and highest levels of household income helps to highlight income disparities at ward level. The ratio between the lowest median household income and the highest median household income is calculated using LSOAs that make up the ward.

- The ratio between the lowest and highest median household income for Cheshire West and Chester is 4.0 (lowest median £14,387 to highest median £57,515). In other words, the LSOA with the highest median household income is four times higher than the lowest LSOA
- The ward with the highest ratio is Davenham and Moulton at 3.4 (£16,721 to £57,515), followed by Winsford Over and Verdin at 3.2 (£15,436 to £49,633)
- The ward with the lowest ratio is Farndon 1.0 (£39,830 to £40,503)

Children living in poverty (under 16s)

Children living in poverty is defined as the percentage of children in low-income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for the under 16s only population.

Cheshire West and Chester has lower rates of children living in poverty compared to England and sits in the second best quartile of ranked Local Authorities in England. Year on year trends have shown Cheshire West and Chester child poverty rates have reduced from 15.8% in 2006 to 15.4% in 2012, this is in line with the national and regional trends which show a slight decline. Locally there is some variation amongst localities with higher rates in Ellesmere Port locality (18.5%) and lower rates in the Rural locality (8.2%). Vale Royal Clinical Commissioning Group (CCG) area has higher rates of child poverty compared to West Cheshire CCG area.
Though Cheshire West and Chester experiences relatively low child poverty compared to England, at a very local level some small areas record rates in excess of 40%.

**Map three: Proportion of children in poverty (under 16s)**

4. Housing

The importance of good quality housing and mixed tenure communities, in order for people to feel secure in their neighbourhood and for reducing inequalities, cannot be underestimated. Housing impacts directly and indirectly on health. Direct effects include excess winter deaths due to fuel poverty; home accidents; increases in infectious diseases such as tuberculosis linked to overcrowding; and excess death rates. Indirect effects are mediated by factors such as overcrowding, reduced access to amenities, and perceptions of low social capital in the neighbourhood, and include health problems associated with crime, pollution, noise, heavy traffic, and accessing health and welfare services. Living in heavily trafficked streets impacts on mental and physical wellbeing (e.g. social isolation; children’s respiratory illness; and injuries as a result of road traffic collisions).

**Housing quality**

Housing quality is inextricably linked to health. Poor housing conditions can contribute to physical and mental health problems and people with no housing experience some of the worst health inequalities of all. A safe, warm and well-designed home helps to provide the best start in life for children, enables those leaving hospital to return home sooner and, with appropriate
support, means that older and disabled people can continue to maintain their independence and stay in their own home for longer.

The borough’s housing stock is in relatively good condition; 20% of the borough’s homes do not meet the decent homes standard, compared to 25% of all private dwellings in England, but rates of disrepair in the borough’s private housing sector remain above the national average and have increased since 2010.

Rates of non-decency, highest in the private rented sector, are most likely to be present in the homes of the poorer households, with the youngest and oldest household’s worst affected.

Cheshire West and Chester contains 26,224 vulnerable households representing 21.7% of all private sector households; currently, 7,337 vulnerable households (28.0%) live in non-decent homes.

Poor housing conditions are not evenly distributed across the borough; in the rural areas non-decency is around 22% and, in a small number of rural and urban wards, over 30% of homes are non-decent.

While energy efficiency levels have improved since 2010, fuel poverty remains an issue in the light of sustained high energy costs; 23,979 households (19.9%) spend in excess of 10% of annual income on fuel and are in fuel poverty. The highest levels of fuel poverty are recorded for households living in the private rented/tied housing sector. Elderly households are particularly affected.

**Map four: Barriers to housing**
The Index of Deprivation 2015 barriers to housing and services domain, measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: ‘geographical barriers’ which relate to the physical proximity of local services, and ‘wider barriers’ which includes issues relating to access to housing such as affordability.

It is this wider barriers sub domain that has been mapped to show issues relating to accessibility of affordable housing and homelessness. The indicators used to construct the wider barriers subdomain are:

- Household overcrowding - The proportion of all households in a lower-layer super output area which are judged to have insufficient space to meet the household’s needs
- Homelessness - Local authority district level rate of acceptances for housing assistance under the homelessness provisions of the 1996 Housing Act, assigned to the constituent lower-layer super output areas
- Housing affordability - Difficulty of access to owner-occupation or the private rental market, expressed as the inability to afford to enter owner-occupation or the private rental market

**Affordability**

Whilst there are undoubtedly some areas in the borough where house prices are more accessible, Cheshire West and Chester is a largely high-value housing area and affordability has long been an acknowledged issue for residents across different tenures and socio-economic groups. The sustained recession has had a further negative impact on affordability in terms of reducing household incomes in real terms. In addition, West Cheshire has a higher proportion of detached and semi-detached homes than the national average contributing to the barriers faced by residents.

There is a particular shortfall in terms of smaller homes and accommodation for older people; this could have major repercussions for the borough in terms of lack of availability of smaller, more affordable homes for first time buyers and in light of our ageing population. It could also have implications for those seeking to downsize.

The latest Strategic Housing Market Assessment for the borough (2013) demonstrates that there is still a considerable level of housing need in the borough. Supply-side issues due to the recession, mean that increasing supply is becoming more and more challenging and we will have to be increasingly innovative in our approach and in how we work with partners to deliver the homes that our residents need.

The Strategic Housing Market Assessment also shows that 75% of households living in the intermediate housing sector earn less than £15,600 per year and 52% earn less than £10,400 per year. These latter households would currently be unable to access even social housing in the borough without financial assistance.
Demand for owner occupation remains high in the borough, but many first time buyers are unable to afford even entry level house prices. Hometrack data show that based on a mortgage multiplier of three times average income, over 40% of first time buyers cannot afford to purchase a flat in the borough, rising to 50% for a terraced house and 63% for a semi-detached house. Even raising the multiplier to four times annual income, over 40% of first time buyers would still not be able to afford to buy a flat and 49% would not be able to afford to purchase a terraced house in the borough.

The cost of renting a one bed home in the borough’s private rented sector is higher than the cost of servicing a mortgage. This may be due to the limited supply of one bed properties available, compounded by increased demand due to the Government’s welfare reform programme and reduced housing benefit availability.

Although the borough’s private rented sector is growing as a proportion of the total housing stock, private sector rents would be unaffordable for many households without financial assistance, including working households. The median weekly private sector rent in the borough for a two-bed home is £138, which equates to around £598 per calendar month; this is equivalent to over a quarter of the median gross full-time wage¹ in the Cheshire West and Chester area (£27,977). Individuals with incomes in the lower quartile range would only be able to afford a bedsit or shared accommodation at most and would probably have to spend more than a third of their total annual income on rent. Moreover, the common practice of requiring a substantial deposit for rented property excludes many local people from accessing even the private rented sector without financial assistance.

**Tenure**

The local housing market has changed over the last decade. The number of people living in the owner-occupied and social housing sectors has fallen and there has been a corresponding increase in the number of people living in the private rented sector. Housing market trends show a significant reduction in owner-occupation among those aged between 16 and 34 years and an increase of this age group renting in the private sector.

This is likely to reflect current economic conditions and affordability constraints, rather than changing aspirations, as home ownership is still the preferred tenure for the majority of the population.

Owner-occupation is the predominant tenure in the borough, comprising 71% of all the housing stock. 15% is social rented and 14% is private rented. This means there is a limited choice of tenures other than owner-occupation available to newly-forming households and results in sustained pressure on house prices and private sector rents.

¹ Based on data from the Annual Survey of Hours and Earnings (ONS).
The tenure profile by spatial area shows notable variations in tenure, for instance relatively higher proportions of privately renting households in Chester; rates exceeding 20% in Farndon and Tattenhall; higher proportions of affordable/social rented households in Ellesmere Port and Winsford; and higher proportions of owner-occupying households in the wider rural areas (and exceeding 85% in the Rural East and Chester Villages areas).

Economic circumstances vary significantly between the owner-occupied and private rented sectors. Although rates of head of household employment are similar, private rented sector households exhibit higher levels of economic disadvantage: 7.7% of heads of household in the private rented sector are unemployed, compared to 1.2% of owner-occupied households. 30.9% of private rented households are economically vulnerable compared to 19.7% of owner-occupied households.

**Housing Register**

The Housing Register is the main route to permanent social accommodation. As at the end of July 2015, there were 3,187 households registered (see map five). Applications are now only accepted from those households who are considered to be in housing need. Although the majority of households on the housing register are reliant on benefits, applications from working households are increasingly being received, indicating the mounting financial pressures facing the borough’s residents.

**Map five: Number of housing register applications by ward**
Homelessness

Since 2009 the number of applications has fluctuated and last year 204 homeless applications were recorded. This is currently higher than the neighbouring authorities of Cheshire East and Halton Borough Council, but it is a lower figure than the two previous years. This is also against a national increase in the levels of homelessness and welfare reform.

There has been a significant reduction in the number of applications accepted as homeless and the figure in Cheshire West is considerably lower than Cheshire East and Warrington.

Intentionally homeless decisions have been increasing year by year and last year most households were intentionally homeless due to rent arrears in the private sector. The most common type of household accepted as homeless is female lone parent but this figure has reduced significantly whilst the number of single men accepted has increased to over a quarter of all accepted applications. This is high when compared with the figure for the rest of the North West. The number of single people with a mental health disability is also rising.

The main reason for homelessness (disregarding ‘other reason’) when a household is accepted is the termination of an assured shorthold tenancy. This is followed by parents no longer willing to accommodate.

5. Health

The actions described in the unemployment and housing sections contribute to reducing health inequalities. 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.

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- There is a social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be

Table one shows that in Cheshire West and Cheshire’s most deprived areas, men on average live 9.7 years less than men in our least deprived areas. The difference for women is 8.1 years.
Table one – Life expectancy

<table>
<thead>
<tr>
<th>Life expectancy in Cheshire West and Chester 2010-2012</th>
<th>Men (years)</th>
<th>Women (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average life expectancy</td>
<td>79.2</td>
<td>82.8</td>
</tr>
<tr>
<td>Areas in the most deprived quintile (bottom 20%)</td>
<td>74.3</td>
<td>78.3</td>
</tr>
<tr>
<td>Areas in the least deprived quintile (top 20%)</td>
<td>82.1</td>
<td>85.1</td>
</tr>
<tr>
<td>Difference between top decile (10% least deprived) and bottom decile (10% most deprived)</td>
<td>9.7</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Life expectancy has been improving, but at a faster rate in men compared with women so the gender gap has narrowed. Heart disease and cancer are the key diseases that contribute to the inequality in life expectancy for men. Cancer accounts for the largest proportion of the life expectancy gap for women, particularly lung cancer.

Life expectancy has increased for both men and women in all localities but at different rates. Improvement has been slowest in Ellesmere Port for men and in Chester for women. Across Cheshire West and Chester, the variation in life expectancy becomes more pronounced when viewed at a lower geographical level. The statistics do need to be treated with caution however due to the small numbers involved.

The four wards in Cheshire West and Chester with the lowest male life expectancy are all in Ellesmere Port locality. Rossmore ward in Ellesmere Port has the lowest life expectancy at birth for both men and women.

Of the 46 wards in Cheshire West and Chester, nine have significantly low male life expectancy and 10 have significantly low female life expectancy compared to the England average.

Figure two: Life expectancy at birth, males and females, 2008-2012
The key causes of early death and poor health in the borough are circulatory disease, cancer and respiratory disease. Table two summarises the number of deaths that could be avoided in the most deprived quintile (ranked in the bottom 20% LSOAs locally) if the levels of health matched those in the least deprived.

**Table two – Excess deaths in men and women in Cheshire West and Chester**

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number of excess deaths in most deprived quintile</th>
<th>Number of excess deaths in most deprived quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory disease (including stroke, Coronary Heart Disease)</td>
<td>119</td>
<td>98</td>
</tr>
<tr>
<td>Cancer (including lung cancer)</td>
<td>113</td>
<td>104</td>
</tr>
<tr>
<td>Respiratory disease (including Chronic Obstructive Pulmonary Disease)</td>
<td>89</td>
<td>94</td>
</tr>
</tbody>
</table>
Map six: Health Deprivation and Disability

Map six shows the risk of premature death and the impaired quality of life through poor physical or mental health. The map is built using the following health indicators:

- Years of potential life lost
- Comparative illness and disability ratio
- Emergency admissions to hospital
- Mood and anxiety disorders (based on the rate of adults suffering from mood and anxiety disorders, hospital episodes data, suicide mortality data and health benefits data)

Map six shows our hotspots (red areas) of health deprivation and disability, which is similar to, but not identical with map seven on page 20 which shows self-reported poor health.
In the 2011 Census, 78.1% of local Cheshire West and Chester residents reported they were in good or very good health. 21.7% of adults aged 16 and over had a long term health problem compared to 20.9% nationally.

Lifestyles

Smoking levels have fallen markedly in recent decades in Cheshire West and Chester; however rates have not fallen equally across all groups with smoking strongly associated with socio-economic deprivation and therefore a major cause of health inequalities. Cheshire West and Chester adult smoking prevalence in 2014 was 20.1% compared to the England average of 18%. However, in routine and manual workers, smoking prevalence in Cheshire West and Chester is 26.2% compared to an England average of 28%. Nationally, adult smoking rates are 21.4% and 20.1% respectively in those LSOAs classified as in the most deprived areas; decile one and two.

Obesity prevalence in England is associated with measures of socioeconomic position – with higher levels of obesity found among more deprived groups. This association is stronger for women than for men. Being overweight or obese is now the norm amongst adults, and becoming the norm in children. In Cheshire West and Chester, 64.6% of our adult population are overweight or obese, just under a quarter of our 4-5 year olds are overweight or obese, and a third of our 10-11 year olds are overweight or obese. In 2014/15, obesity rates almost double from 10 to 18% between reception children and year six children.
Estimates indicate that a higher percentage of Cheshire West and Chester residents aged 16 and over drink alcohol compared to the England average. Locally, 24% of people aged 16 and over were estimated to be binge drinkers. This is significantly higher than the England average of 20%. This equates to around 64,000 binge drinkers in Cheshire West and Chester. The locality with the highest proportion is Chester (27% approximately 18,000 people). Ellesmere Port, Northwich and Winsford and Rural localities all have binge drinking estimates of around 22%. All four localities have rates of binge drinking that are significantly higher than the England average. In the 10 year period 2001-2003 to 2011-2013, early death rates from liver disease in Cheshire West and Chester have seen a 22% increase. For those in deprived areas the increase is almost 35%.

6. Recommendations

Actions the council can take in these areas

Michael Marmot’s report Fair Society, Healthy Lives (2010) outlines a number of evidence-based actions that can be implemented to address inequalities and improve outcomes. These are summarised below, though it should be noted that Cheshire West and Chester is already undertaking many of these actions.

6.1 Employment

To develop better jobs for local populations, local partnerships should draw on what is known about the features of good and poor quality work to promote good quality jobs with employers. Local partners should encourage jobs where workers are valued, receive a living wage at minimum, have opportunities for promotion and are protected from adverse conditions where possible.

Working to improve the skills base of people in local labour markets may help to attract more skilled employment to the area to improve the quality of work.
<table>
<thead>
<tr>
<th>Action</th>
<th>Explanation</th>
<th>Application</th>
</tr>
</thead>
</table>
| Strengthening individuals      | Aimed at strengthening individuals in disadvantaged circumstances and using person-based agencies. Some build up self-confidence and skills in people, others address powerlessness of the worst-off in society | Person-based approaches, offer counselling and education to increase a person’s skill and capacity to cope with the stress produced by the work set up. Increase access and use of quality lifelong learning opportunities across the social gradient:  
  - Provide easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities  
  - Provide work-based learning, including apprenticeships for young people and those changing jobs/careers  
  - Increase the availability of non-vocational lifelong learning across the life course. |
| Strengthening living and working conditions | Improvements in day-to-day living and working conditions and access to services are important in reducing health inequalities. Examples include safer workplaces, better housing and better access to health and social care. | Redesigning production processes and management strategies that influence the tasks that individuals are asked to do. Examples include implementing borough-wide Good Work Charters, Mental Health and Employment Toolkits, schemes to reduce sickness absence and enable return to work. |
| Strengthening communities      | Aimed at building social cohesion and mutual support. These interventions encourage/foster interaction between members of the same group or different groups within the workforce.                                           | Improvements in communication and relations, providing opportunities for joint decision-making, joint problem-solving with workmates and constructive feedback on how the work is going. Examples include connecting communities to employment opportunities through affordable public transport and active travel. |
| Promoting healthy macro-policies | Promoting healthy macro-policies entails looking at which policies will reduce poverty. These policies tend to span several areas and work across the population as a whole. | There are entry points for interventions to influence the outside pressures imposed on workplace organisations. Market conditions and rules about competition, national labour relations programmes which influence employment rates, job security, wages and national levels of unemployment have a huge impact on the psychosocial stress experience in individual workplaces, even though the issues may be outside one organisation’s control. |
6.2 Housing
The delivery of housing in the borough, both affordable and market housing has fallen behind household growth for a number of years. As a result, pressure on house prices in the borough has increased considerably as demand for housing continues to outweigh supply and there is a significant shortage of affordable housing available to local people. First time buyers are effectively priced out of buying local homes, restricting movement throughout the rest of the market. More new housing, and especially affordable housing, is essential to meet increasing demand and support the Council’s ambitious plans for growth.

Creating more balance in the local housing market through increasing delivery will help to address barriers to accessing a home, giving local people more choice and the ability to move up or down the housing ‘ladder’ as their needs and circumstances change. Moreover, it will help to promote greater flexibility by making it easier for local people to pursue employment opportunities, thus supporting economic growth. This in turn will help to support further development and encourage new employers to come to the borough, creating a cycle of growth that will benefit the borough and beyond, creating opportunities and revitalising communities.

Examples include:

- **Affordability**: Increasing the supply of affordable housing and the range and choice of general needs housing will help to ease affordability constraints and help the population to house itself.

- **Housing Tenure**: Housing insecurity is linked with poor mental and physical health outcomes as well as marginal workforce participation.

- **Increase diversity in the housing and tenure mix**: Ensure there is a suitable range of housing to meet local needs, from affordable housing for young people to suitable accommodation choices for older people, to stimulate movement throughout the market and help to sustain individual independence and ensure the housing offer attracts and retains people of working age, ensuring a sufficient workforce to sustain and grow the local economy.

- **High levels of mobility**: High levels of mobility can contribute to families being unable to remain in areas they have lived and worked in for many years. It is detrimental to creating sustainable and resilient communities.

- **Allow for mobility**: Although excessive housing mobility can contribute to families being unable to remain in areas they have lived and worked in for many years and can be detrimental to creating sustainable and resilient communities, it can also be a positive lifestyle choice and allows people the flexibility to move to be nearer new employment opportunities. A good range of housing and tenure choices ensures those households that want to move are able to. Increasing the supply of affordable housing will help to improve balance in the housing market so that households are not obliged to move frequently where they do not wish to do so.
- Lack of stability/security, particularly for people living in public housing and private rental: Housing insecurity is linked with poor mental and physical health outcomes as well as marginal workforce participation.
  - Offering stable tenancy agreements and tenures (for longer than six months) would alleviate anxiety. This should not be limited to key groups as if only the most vulnerable can access social housing there is a further risk of compounding deprived neighbourhoods and creating a rise in health inequalities unless there is adequate service provision.
  - There should be a “pepper-potting” approach to social housing so that boroughs do not have separate estates/areas where private and social housing do not mix. Such segregation can contribute to stigma which is not beneficial to mental wellbeing. The exterior of the houses is also important – social housing should look like private housing. Stigma also hinders social cohesion.

- Sustainable design: Encourage sustainable methods of construction and improve the standard of design of new build homes to ensure that they:
  - Meet the needs of people at all life stages (e.g. building for life standards)
  - Provide high quality homes in a high quality environment
  - Remain affordable to maintain and heat throughout the life of the building.

- Tackling fuel poverty: Better heating and better insulation are two of the most prevalent requirements identified to help support older people to continue to live safely and comfortably in their own homes. Installing these measures would help to combat fuel poverty among the older generation, as well as improving the health and wellbeing of our older residents.

- Neighbourhood: Social Cohesion and Community Resilience
  - Space for children to play as they get older with a concentration of environmental problems in the surrounding areas (such as heavily trafficked streets) and a sense of insecurity on streets, in parks and play areas.
  - Green space enhances the capacity of residents in urban public housing to cope with the effects of poverty. Residents who live in public housing with nearby nature show greater capacity to cope with stress than those who lived in dwellings without nearby nature.
  - Increased opportunities for participation and community activity among local residents, street safety initiatives, reduction in social isolation of elderly communities.

- Evaluation studies have shown that refurbished housing estates record 67% and 54% reductions in crime rates and a significant improvement in perception of safety after improvements.
These often include external landscaping and inclusion of security features within the residential properties.

Natural surveillance across the estate was maximised, secure areas were provided for cycles and refuse.

Other areas such as children's play areas were given distinct uses.

- Reduce levels of homelessness and prioritise the prevention of homelessness.
- End the use of bed and breakfast and improve temporary accommodation.
- Improve access to permanent accommodation and support.

6.3 Health

The actions described in the unemployment and housing sections contribute to reducing health inequalities. In addition, Marmot recommends the following actions across the life-course.

Starting well:

- Ensure schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience. Take a “whole child” approach to education.
- Develop the school-based workforce to build their skills in working across school-home boundaries and address social and emotional development, physical and mental health and wellbeing.
- Extend the role of schools in supporting families and communities and take a “whole child” approach to education.
- Improve programmes to address the causes of obesity and implement the children’s recommendations from the Cheshire West and Chester Health Inequalities Commission (overweight and obesity).

Living well and ageing well:

- Prioritise investment in ill-health prevention and health promotion across departments to reduce the social gradient.
- Focus public health interventions (such as, but not limited to, smoking cessation programmes and alcohol reduction) on reducing the social gradient.
- Improve programmes to address the causes of obesity and implement the adult recommendations from the Cheshire West and Chester Health Inequalities Commission (overweight and obesity).
- Reduce the social gradient in skills and qualifications.
7. Conclusion

In Cheshire West and Chester there are some wards that experience multiple indicators of high deprivation and inequality. These wards include Blacon, Ellesmere Port Town, Lache, Netherpool, Rossmore, St Pauls and Winsford Over and Verdin.

Inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The actions of local government can ameliorate the impact of the wider determinants of health, promote good health and prevent disease. Whether it is housing, education, environment, planning or regulation, the local authority has a contribution to make. The actions of local authorities impact on the everyday lives of ordinary people. The places where we live, work and play are critically regulated, managed, controlled and/or monitored in various ways by local government.

The place-shaping role of local government should act as the catalyst to bring about greater levelling up between areas. Cheshire West and Chester Council is the planning authority for our area and as such, has huge opportunities to influence both the infrastructure and the services provided in the borough.

Actions to reduce health inequalities through the wider determinants agenda (housing and unemployment for example) are interlinked and contribute to improving health. The evidence base is not new but it is dispersed. Practical actions can include:

- Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants
- Support locally developed community regeneration programmes
- Improve the energy efficiency of housing
- Reduce fuel poverty
- Improve access to good jobs and reduce long-term unemployment
- Make it easier for people who are disadvantaged in the labour market to obtain and keep work
- Improve the quality of jobs across the social gradient
- Improve active travel across the social gradient
- Improve the availability of good quality open and green spaces
- Improve the food environment in local areas
- Remove barriers to community participation
- Reduce social isolation
8. References
Local Government Association, Understanding and tackling the wider social determinants of health, 2010, accessed online 13.10.2015

9. Further sources of Cheshire West and Chester information
Cheshire West and Chester Joint Strategic Needs Assessment (JSNA)
The Joint Strategic Needs Assessment (JSNA) is an interactive, self-serve data and intelligence tool that helps us understand the needs of our local population. The Strategic Intelligence Team manages the JSNA, which provides users with a wide range of information to help plan and re-shape local services to meet the needs of the local community. This freely available information includes a combination of statistics and the views of local people to produce a detailed picture of the borough. A few of the information products contained within the JSNA are listed below and can be accessed at www.cheshirewestandchester.gov.uk/jsna

- **Locality dashboards**
The locality dashboard is designed to provide intelligence to support decision making at locality level. Focusing on the four locality areas, the dashboard provides a high level and simple way of comparing demographic, health, community safety, education and economic data with Cheshire West and Chester as a whole and also with England.

The interactive version of the full locality dashboard allows users to select individual localities from a drop down list. It has three levels of information. PDF versions of each dashboard and thematic profile are also available.

1. The dashboard - a very high level and visually simple way of representing how a locality compares to both Cheshire West and Chester as a whole and England.
2. Thematic profiles - more detail at lower geographies along with a short interpretation.
3. Data tables - giving full access to the data.

- **Ward snapshots**
Ward snapshots have also been produced as an overview of key data for each ward. These snapshot reports produced in May 2015 provide a selection of key statistics for wards in Cheshire West and Chester. The aim is to present a range of information to help better understand our communities and to give a taster of the data available for the 46 wards in the borough.
Compendium of Health and Wellbeing Statistics

A quick reference guide to information on health and wellbeing of people living within Cheshire West and Chester. Covering five themes:

1. Demography and life expectancy
2. Wider determinants of health
3. Health improvement
4. Health protection
5. Healthcare, public health and preventing premature mortality

Views of residents and user groups

Understanding the views of residents and users is an essential part of the Joint Strategic Needs Assessment.

A range of research is undertaken by our View West Panel. This is a citizens' panel of about 2,500 residents who have agreed to take part in research and consultation on a regular basis. People are selected at random to get a cross section of people, and invited to be part of the panel for approximately three years. Consultation findings from the Strategic Intelligence Team are available as part of the JSNA.
Council information is also available in audio, braille, large print or other formats. If you would like a copy in a different format, in another language or require a British Sign Language interpreter, please email us at: equalities@cheshirewestandchester.gov.uk

Telephone: 0300 123 8 123  
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