Tackling health inequalities in Liverpool's communities

north west

Introduction

As communities across the country take stock of the many challenges they face, ranging from COVID-19 consequences to the cost of living crisis and future economic uncertainties, it's become starkly evident that some areas are at a significant disadvantage compared to others.

These inequalities have been highlighted across numerous facets of our society, including job opportunities, education, skills, transport, housing and – crucially – differences in health and wellbeing standards.
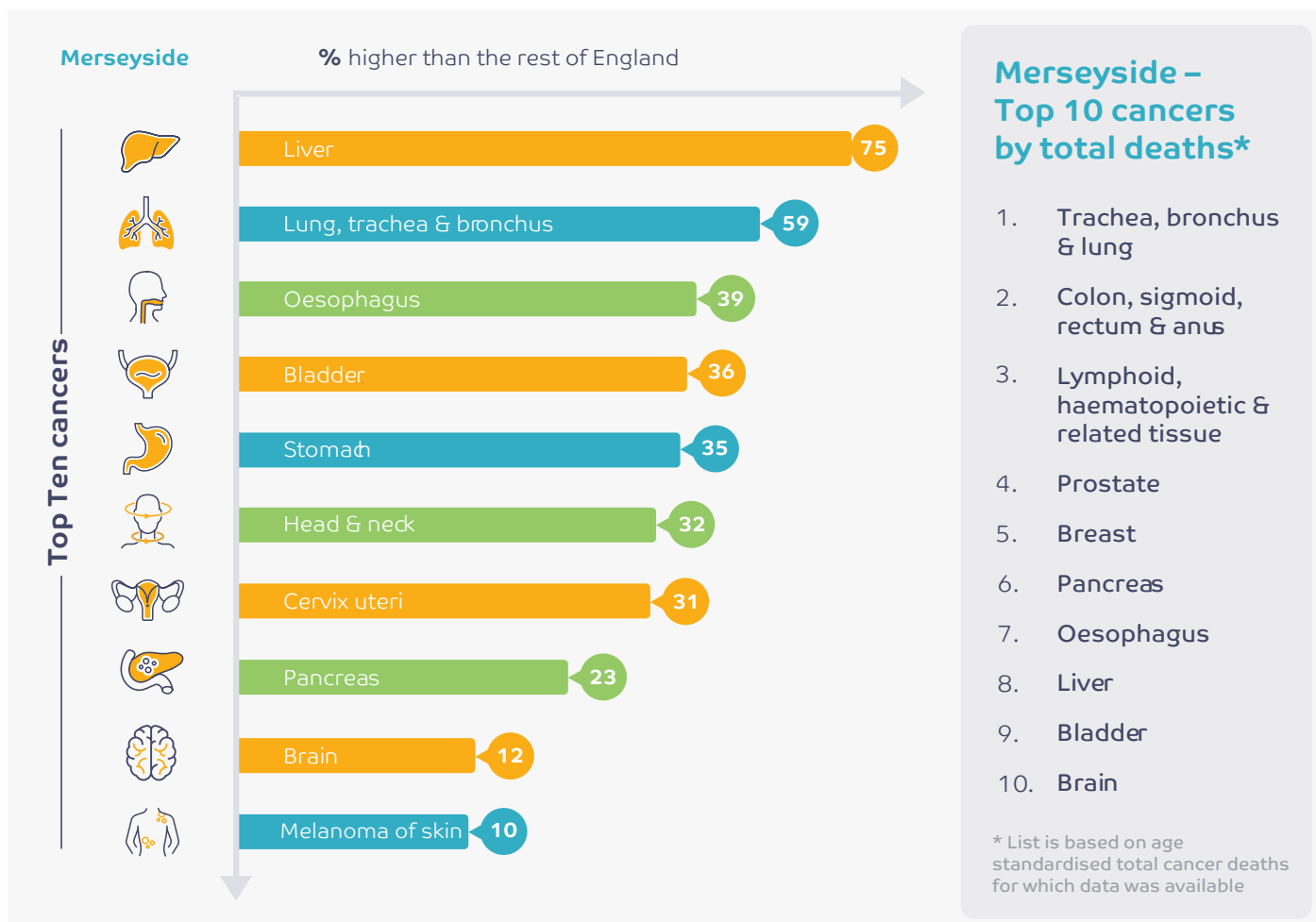
A recent study undertaken by North West Cancer Research underlined how Liverpool's communities in particular are facing some serious health issues. For example, cases of liver cancer across Merseyside, which is the most deprived county in the North West, are 75% higher than the national average. Lung, trachea and bronchus cancer rates are 59% higher than the rest of the country, while oesophagus cancer is 39% above the national average.

This illustrates the unbalanced nature of the UK's health landscape and exactly why urgent, localised support is needed to bring Liverpool's deprived communities into alignment with the rest of the UK.

Achieving this will be no easy feat. So, we brought together a number of influential voices from across health, politics and academia to reflect on what needs to be done in our region and, importantly, how we can make changes to continue on our path to a cancer-free future.

Cancer prevalence in Merseyside compared to the national average

Merseyside

% higher than the rest of England

Cancer	%
Liver	75
Lung, trachea & bronchus	59
Oesophagus	39
Bladder	36
Stomach	35
Head & neck	32
Cervix uteri	31
Pancreas	23
Brain	12
Melanoma of skin	10

Top Ten cancers

Merseyside – Top 10 cancers by total deaths*

1. Trachea, bronchus & lung
2. Colon, sigmoid, rectum & anus
3. Lymphoid, haematopoietic & related tissue
4. Prostate
5. Breast
6. Pancreas
7. Oesophagus
8. Liver
9. Bladder
10. Brain

* List is based on age standardised total cancer deaths for which data was available

Creating the conversation

The roundtable was chaired by Michael Taylor, North West Editor of The Business Desk, and attendees included:

Alastair Richards, CEO of North West Cancer Research

North West Cancer Research is an independent charity focused on the cancer needs of the region. The north-west has high levels of cancer cases, later diagnosis and high levels of mortality. Cancers which have their risks increased through a number of life-style factors are far more common in the region with high levels of head and neck, lung, liver and oesophogeal cancers amongst others.

Alastair qualified as an accountant before working in a number of charity roles in regulated organisations providing health and social care. He joined North West Cancer Research as CEO in 2017.

Alexis Darby, Senior Public Affairs Manager at Northern Health Science Alliance (NHSA)

The Northern Health Science Alliance brings together 10 universities, 10 research-intensive NHS Trusts and four Academic Health Science Networks in the North of England to advance health objectives and research.

Alexis' key responsibilities include working on the Child of the North project, which is focused on geographical inequalities for poverty among children. Prior to joining the NHSA, Alexis worked for the Northern Powerhouse Partnership and managed the Policy@Manchester team at The University of Manchester, she has also worked for Members of Parliament in research and campaign roles.

Dr Cheryl Lowes, GP Principle at Jubilee Medical Centre and Medical Director at General Practice Liverpool (at time of roundtable)

Cheryl is a GP at the Jubilee Medical Centre in Croxteth and played a key role in developing General Practice Liverpool, a new organisation to coordinate and communicate between Liverpool's GPs.

Cheryl was also the community development lead for primary care for Wellbeing Liverpool and was part of the Let's Get Vaccinated campaign.

Cheryl is passionate about community development, tackling inequalities and creating solutions to perceived health barriers.

Dan Carden, MP for Walton

Dan Carden MP has previously highlighted significant issues around Levelling Up, Housing and Health and Social Care; for example, by calling out the Minister for the Department of Health and Social Care on how many community diagnostic centres are operated fully by private sector organisations.

Dan's constituency includes some of the highest levels of deprivation in Liverpool. Unemployment in the Walton area remains significantly higher than the city average at 8.5% compared with the average of 6.5%. Violent crime is ranked third highest when compared with the other authorities across the city, and household income is below the Liverpool average by approximately £7,000.

Jane Corbett, Deputy Mayor and Cabinet member for Fairness and Tackling Poverty

Jane has been a Labour Councillor for the Everton Ward since 2002. As the current Deputy Mayor and Cabinet member for Fairness and Tackling Poverty, her responsibilities include acting as the Council's lead in making Liverpool a fairer city and standing up for people who need the most help.

Jane is also Joint Chair of the Citywide Strategy Group for Fairness and Tackling Poverty, along with the Bishop of Liverpool, Paul Bayes.

She works with the Cabinet to support the Mayor to drive forward the recommendations of the Liverpool Fairness Commission's report, 'Come Together', and to ensure that decisions made about the City's future are focused on overcoming inequalities within Liverpool.

Martin O'Flaherty, Institute of Population Health

Martin is a Professor in Epidemiology and the Interim Head of Department for Public Health, Policy & Systems at the Institute of Population Health, University of Liverpool.

In this role, he works to reduce the burden of non-communicable diseases in populations by addressing structural drivers of disease.

His interest in trend analyses of death rates developed the concept of rapid changes in cardiovascular mortality rates. Much of this novel work on the dynamics of coronary heart disease "epidemics" formed the basis of Martin's PhD awarded in 2012 and resulted in key publications in the BMJ and Lancet.

Dr David O'Hagan, GP at Brownlow Heath practice in Kensington

David is a GP in one of the most deprived wards in the city. He is one of the governing board members for Liverpool CCG and is part of the cancer team at Liverpool Place.

Rahima Farah, Network Engagement Lead at the Central Liverpool Primary Care Network

Rahima Farah works as a social prescriber with a focus on tackling health inequalities. She's particularly keen to connect with the "plus" population groups identified in the NHS' Core20PLUS5 approach and is interested in how lifestyle factors affect health outcomes.

The plus group includes ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; and other groups that share protected characteristics. It also includes groups experiencing social exclusion.

Mansha Bhiryani, Medical Student, University of Liverpool

Mansha is a medical student currently studying at the University of Liverpool who is passionate about community-level engagement and healthcare research. She is looking forward to graduating and starting her career as a doctor.

Connections with communities

The key to tackling health inequalities is bridging the gap between the NHS and local communities, according to Rahima Farah. She says that, crucially, we must tailor our approach to each community and that there is no 'one size fits all'.

Rahima said: "One thing I learned through COVID-19 was around the presence of health inequalities and how important it is to get the message out to communities, and how one message does not work for every community. We all access information differently.

"For example, I experienced this first-hand when I first ran an event in Liverpool and had materials translated into the Somali language, but no-one turned up which I couldn't understand. I then realised that the language used came out in the 1970s, meaning that no-one could actually read the literature."

She added: "People don't want to share that they can't read though so we need to make sure that the most vulnerable people are able to access information. I think we need to go back to pictures to reach as many people as we can."

Mansha Bhiryani illustrated this point with a recent real-world example in which "a woman was trying to read out the letters on a chart but it turned out that she didn't read English, only Arabic. We didn't have any charts in other languages and it took about 20 minutes to find a picture one. This shouldn't be the case and it's small things like this that can impact a person's healthcare."

Empowering communities to share messages also plays a major role in reducing inequalities, says Martin O'Flaherty.

Dr Cheryl Lowes agreed, saying: "We need to think about what community building work is already going on with our system partners and system organisations, and align our efforts in an integrated way for bigger, sustainable, longer-lasting impact.

"We are trying to do this with the One Liverpool programme. For example, if you receive input from a Neighbourhood Integrated Care Team, you're on a caseload for seven to eight weeks, benefitting from a whole team of experts wrapped around you. At the end of that time you then get discharged back into the community and, if it isn't strong and cohesive enough for you to maintain your improved health, you're in a revolving door situation with public services and it's up to you to get the support you will likely inevitably need again.

"That's why community building has to go hand in hand with development and integration of public services. Another similar example is being led by the police in the implementation of the 'Clear, Hold, Build' model – if they clear organised crime

in an area, unless you fill it with something else good i.e., community building, then organised crime will likely move back in."

Dan Carden underlined the need to build stronger support structures into Liverpool's communities, saying: "There is a societal breakdown, with people being forced to work too hard, having too little personal time, too little family life, and not having the space to connect with the people that they love. Often, they are women in their 50s and 60s or people with bad physical mental health, and instead of offering them the support and the safety net they need, the system penalises people.

"You can't have a healthy lifestyle if you're working eight, nine, ten-hour days and have a family to look after and everything else. So, we have to look at how we improve people's lives and how we build a community that does that."

On how communities are approached, David O'Hagan said: "You don't want people to feel that we're pushing health on them. Using goodwill type approaches and cultural approaches and general leisure type approaches can mean that we can maximise the assets that we've already got."

Education and engagement

If we are to make real steps towards closing health equality gaps, we need the people living in our region to be fully behind our cause. But, they can only do that if they understand why we - the health and support infrastructure in the city - exist and feel a part of what we are doing.

This starts with education and ensuring the right information is being delivered.

Rahima said: "In a previous role, we did targeted work with local schools to increase immunisations among children. We actually found that parents were being misinformed but, once they had the correct facts, they went on to get their children immunised.

"However, due to this engagement dropping recently, the number of children being immunised has lowered again. It shows that engagement needs to be constant – we need to be consistently promoting the idea of prevention and making sure that the information doesn't stop.

"We have the data to prove that collaboration and forming partnerships – rather than operating in silos – does work. We are all here for one purpose and that is get better outcomes. So collaboration needs to be constant and frequent."

Reflecting on Rahima's experience, Mansha Bhiryani said that it's important "to study why misinformation spreads? And how does it spread? Because let's be honest, misinformation spreads a lot quicker than actual validated information."

The role of primary care and GPs' influence was also discussed, with Dr David O'Hagan, championing the level of trust that people have in their communities.

David O'Hagan said: "We need our primary care professionals, like GPs, to become part of our communities, not separate from them. Increasingly, as primary care networks get bigger, we're no longer seen as being part of these communities but, instead, we're seen as being overloaded.

Building on this point, Cheryl Lowes said: "So we need to utilise those trusted partners, such as the voluntary organisations and the community leaders, to help increase public health."

Long-term funding

A lack of cohesion between community needs and the programmes that are created is an ongoing issue, according to Alastair Richards.

He said that there is often an issue with how some projects are tendered: "It's often the case that what started off as a community-based activity, those people who started off doing it are not in that tendering space.

"A community project becomes something which is studied, turned into an academic paper, before it's decided that a contract should be issued for it. So suddenly, what started as a community activity is something delivered by an organisation like Serco."

This trend is worsening, according to Dr David O'Hagan, who says that there are often small pots of money to deliver very specific projects, which ultimately leads to short-term intervention.

Jane Corbett added: "We need to have that consistency. Yes, we all want the same thing, like better health outcomes for our communities. And the only way to do that is to power up levelling up and really work with these communities."

Looking at health in a new way is key to achieving this long-term success said Dan Carden, as "while we have a health system that is only looking at how we treat illness, and the final stages, and how we prescribe a certain drug to deal with a certain symptom, I don't see any possibility of restoring society and community to what it could be."

Measuring success and moving forward

Measurement is something we don't do enough of, with Alastair Richards saying it is often "forgotten about" and that it costs money.

Jane Corbett added: "Measurement is important. But, in order to get the money, you quite often have to put forward a case, that includes outcomes and what you are going to measure. This is totally counterintuitive – we don't want to 'do to people', we want them to co-produce whatever the outcomes are going to be so that they are part of the solution.

"They need to be part of defining what the outcomes are going to be. But, at the moment, in order to get the money, you have to predefine something."

The first steps to measurement could be simple though, according to Martin O'Flaherty. He says: "[At events], you could count how many people are in attendance and then you can start to get some views from the people, finding out what they want.

"This sort of evidence is extremely valid, as you don't need to have millions of data points, if a well-constructed qualitative case is put together."

However, evaluation should be a multi-organisational approach, Cheryl Lowes feels. She said: "I do think there is something about the opportunity for evaluation around the implementation of the City Plan and I think that's a gap we need to address if we are going to move forwards effectually.

"When we think about the assets that this city has – we have seven hospital trusts and we have four universities, but we haven't spoken to each other in a way that will align resources and expertise effectively in order to meaningfully evaluate and communicate the positive impact of outcomes and lessons learned."

Alexis Darby pointed out that it's important for measurement to be focused at the local level. She said: "At the NHA we do a lot of reports into statistics and use this to inform recommendations, such as the need for more place-based funding and the allocation of funding. But I think one thing we all need to work more on is how to bridge that with what's happening in our communities – because the research and measurement has to be localized and tailored to tackle inequalities.

"We can't just look at the national level or even what powers are devolved to Metro mayors for example, but really analyse issues such as 'what will get more people from this place to go for a mammogram?' or 'how can we get people that live here more involved?.'"

Alastair Richards added: "Cancer is often the point at which the pressures of society meet medicine.

"We've talked a lot about the importance of community and what communities can be doing for each other. But, at the point where cancer develops, it is often down to multiple factors such as the environment, income, background and stress – that's where it all starts to hit the NHS.

"For us at North West Cancer Research, the measurement could actually be the point where we come in, helping community groups to achieve what they want to achieve and document what they do.

"We are part of these communities so it's vital that people know who we are and feel connected to us."

Key takeaways

1   Cancer is often the point at which the pressures of society meet medicine. Cancer is tied to people's genetic background, environment, housing, income, lifestyles, experiences and the communities they live in. Effective cancer prevention and treatment as well as wider health promotion therefore requires the medical world to holistically understand these core determinants of health and the roles they play.

2   We need to look at how we analyse projects and measure success. This is a layered issue, as not only are accurate assessments in this field often very difficult but it's important that we don't only focus on what can be measured and risk overlooking that which can't. While this is all true for academic and clinical organisations, how can we also ensure that community groups are supported so that they can effectively evaluate their work and take it to the next level?

3   Community connections are vital. We need to understand the people in our city and how to best communicate with them. This includes understanding the language requirements across Liverpool as well as the required communication channels, most effective messaging, and barriers to confidence in our public sector organisations.

4   Funding pots are often short term. We need to ensure that the most deprived areas of the city have long-term investment in their health needs and that the groups working to improve health outcomes have confidence in the longevity of the support they receive. Funding that requires outcomes to be defined before the project has started can also impede 'co-production', leading to communities disengaging and the project becoming unsustainable. Long-term thinking is crucial to solving entrenched health issues.

5   Education and information sharing is central to improving health outcomes. This includes school-based learning to ensure that children have access to the best information as well as commitments to life-long learning opportunities for everyone regardless of age, income or background. Education isn't just the responsibility of schools, as charities, local authorities, and medical organisations all have important roles to play in ensuring that the right information is circulated throughout Liverpool's communities.

north west
cancer research
Putting our region's cancer needs first

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