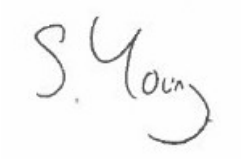
Public Document Pack

HALTON BOROUGH COUNCIL

***Please note venue**

Health and Wellbeing Board

Wednesday, 6 July 2022 2.00 p.m.
Council Chamber - Town Hall, Runcorn



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 12 October 2022

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 23 March 2022 at Bridge Suite - Halton Stadium, Widnes

Present: Councillors J. Lowe, T. McInerney, Woolfall and Wright (Chair) and L. Gardner, K. Hannay, S. Johnson Griffiths, T. Knight, D. Nolan, Dr I Onyia, K. Parker, S. Patel, S. Semoff, M. Vasic and D. Wilson.

Apologies for Absence: S. Constable, R. Foster, N. Goodwin, P. Jones, C. Lyons, D. Merrill and S Yeoman.

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB27 MINUTES OF LAST MEETING

The Minutes of the meeting held on 19 January 2022 having been circulated were signed as a correct record.

HWB28 PRESENTATION ON DENTAL SERVICES IN HALTON

The Board received a presentation from Tom Knight NHS England, which provided an update on dental services in the Borough. Tom outlined the difficulties and challenges faced during the COVID-19 pandemic which have resulted in long waiting times for the public in accessing dental services.

At the start of the pandemic, dentists closed down in line with National guidance. In June 2021, they were asked to open back up. However, due to infection prevention control guidelines, dentists were only allowed to see 10 patients a day, instead of the usual 40 patients a day and this was why there are long waiting lists for appointments.

Tom also gave some examples of the good work that was ongoing in Halton. There was a commissioning team that had worked with looked after children, the care homes and vulnerable people. Also additional resources had been added to a triage helpline.

A number of Councillors expressed their concerns about the issues their constituents were facing in accessing NHS dentists. Tom noted these concerns and provided reassurance that every efforts were being made to find a resolution.

Councillor Lowe expressed her thanks for the work undertaken in the care homes.

RESOLVED: That the Board note the presentation.

HWB29 LIVING WITH COVID IN HALTON

The Board received an update on the current situation regarding the COVID pandemic and the future managing recovery from and life beyond the COVID-19 pandemic.

The report outlined the next steps and how we learn to live with COVID safely. There had been guidance related to the management of COVID-19 and from 1st April 2022, the Government would update guidance setting out the ongoing steps that people with COVID-19 should take to minimise contact with other people. This would align with the changes to testing.

Halton's Public Health Team would continue to protect the public using a variety of tools including, expert help and advice, outbreak management, commissioning of appropriate services, provision of infection, prevention and control services and providing community outreach and support at a variety of levels.

It was noted that vaccinations remained a high priority and were still available to:

- anyone eligible for any of the 1st, 2nd, 3rd or booster dose;
- 12-15 year olds; and
- 4th/5th boosters for people over 75 years (or those significantly immunocompromised), and the 1st dose for 5-11 year olds, both from April.

There were significant pockets of vaccine hesitancy within Halton and those that had not yet received a vaccine would be contacted shortly and support would be provided.

The Chair, Councillor Marie Wright, thanked the Public Health Team for their continued work and support.

RESOLVED: The Board noted the report.

HWB30 UPDATE ON ONE HALTON PLACE BASED PARTNERSHIP & FEEDBACK ON LOCAL GOVERNMENT ASSOCIATION WORK WITH THE HEALTH AND WELLBEING BOARD WITH FORWARD RECOMMENDATIONS

The Board received an update on the One Place Based Partnership development with Cheshire Merseyside Integrated Care Board and Integrated Care Partnership Board. The report also set out some recommendations to the Board following the work with the Local Government Association.

The Board agreed:

i) the Terms of Reference and Membership of the Board;

ii) the frequency and format of meetings;

iii) that a thematic area would be agreed at the next meeting.

iv) the proposal for an induction process for all new members of the Board;

v) the suggestion of periodic Borough tours or visits to ensure the Board is familiar with the locality;

vi) the establishment of an action plan;

vii) that the HBC Partnership Officer would support to facilitate and co-ordinate the re-focussing of an agreed action plan and would provide continuous co-ordination support.

In addition, the Board was advised that a White Paper was published on 9th February 2022 called “Joining up Care for People, Places and Communities”. The paper built on the integrated approaches set out in the integrated care systems and place based partnerships.

RESOLVED: That the Board note the report and agreed the recommendations outlined above.

HWB31 JOINT STRATEGIC NEEDS ASSESSMENT

The Board received a report from the Director of

Public Health, regarding the Joint Strategic Needs Assessment (JSNA) which outlined the priority areas for 2022/23.

The JSNA is a statutory responsibility of the Health and Wellbeing Board and its main purpose is to support local efforts to improve the health and wellbeing of the local population and reduce inequalities for all ages. The core aim was to develop local evidence based priorities for commission which would improve the public health and reduce inequalities.

RESOLVED: The Board noted the report and subsequently agreed the following recommendations:

1. the Board to oversee the Annual Joint Strategic Needs Assessment work plan and support the development of a work plan for 2022/23;

2. contribute to the production of a Joint Strategic Needs Assessment to ensure all partners are working collectively in Halton using the same intelligence to support joint decision making; and

3. that their preferred approach to the development of the Joint Strategic Needs Assessment and governance arrangements for its delivery was via a Steering Group.

HWB32 SOCIAL CARE ANNUAL REPORT (LOCAL ACCOUNT) 2020-21

The Board received the Adult Social Care Annual Report (Local Account) for 2020-21. The report included information on the successes and achievements across Adult Social Care, details of progress against performance metrics, some of the challenges faced, how the Council responded to community needs and details of future activities to be further developed.

It was also noted that the Annual Report, also known as the 'Local Account', served as a review mechanism for Adult Social Care to consider as part of ongoing continuous service improvement measures.

The Board acknowledged, praised and thanked the work and achievements of Adult Social Care staff during the pandemic. Thanks were also extended to everyone who worked during the pandemic including across the Council, NHS, pharmacies, care homes, vaccination centres and

other services.

RESOLVED: The Board noted the report.

HWB33 SUSTAINING THE DISCHARGE TO ASSESS/HOME FIRST MODEL

The Board considered a report of the Director of Adult Social Services, which summarised how the Council had developed the Discharge to Assess/Home First Model in Halton and the issues associated with sustaining that model/approach.

One of the key pieces of guidance issued during the pandemic was the National Introduction of the COVID-19 Hospital Discharge Service Requirements. This guidance provided a renewed focus on the Discharge to Assess Model.

This new approach demonstrably improved the outcome for vulnerable adults, significantly older people whilst reducing the need for long-term services and hospital utilisation.

It was noted that the changes made across the Intermediate Care and Discharge to Assess/Home First Model, alongside the impact of hospital pressures resulted in a shift in financial spend. Due to the flexibility of the joint working arrangements, budgets against services were appropriate and were able to be realigned. However, it was noted that whilst this was a temporary solution to an increasingly pressured budget, it was expected that these pressures would continue throughout the coming financial year and beyond and would need to be addressed.

The Board extended their thanks and best wishes to David Parr - Chief Executive, who was due to retire from Halton Borough Council on 31st March 2022

RESOLVED: The Board noted the report.

HWB34 FUTURE MEETING DATES

6th July 2022
12th October 2022
18th January 2023
22nd March 2023

Meeting ended at 4.00 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2022

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health

SUBJECT: Public Health Annual Report

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on the development of the Halton Public Health Annual Report (PHAR).

2.0 RECOMMENDED: That the Board note the theme and development of the Public Health Annual Report.

3.0 SUPPORTING INFORMATION

3.1 Since 1988 Directors of Public Health (DPH) have been tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively.

3.2 The annual report is an important vehicle by which a DPH can identify key issues, flag problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action. The annual report remains a key means by which the DPH is accountable to the population they serve.

3.3 The Faculty of Public Health guidelines on DPH Annual Reports list the report aims as the following.

- Contribute to improving the health and well-being of local populations.
- Reduce health inequalities.
- Promote action for better health through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

3.3 The PHAR is the Director of Public Health's independent, expert assessment of the health of the local population. Whilst the views and contributions of local partners have been taken into account, the assessment and recommendations made in the report are those held by the DPH and do not necessarily reflect the position of the employing and partner organisations.

3.4 Each year a theme is chosen for the PHAR. Therefore it does not encompass every issue of relevance but rather focuses on a particular issue or set of linked issues. These may cover one of the three work streams of public health practice (health improvement, health protection or healthcare public health), an over-arching theme, such as health inequalities, or a particular topic such as mental health or cancer.

3.5 For 2021-2022 the Public Health Annual Report will focus on the social determinants of health, particularly highlighting how individuals, communities, services and organisations can contribute to opportunities for everyone to benefit from good health and protected from harm.

3.6 The report will use the social determinants model as a guide to the key issues including the following sections:

- Social and community networks
- Living and working conditions
- General socioeconomic, cultural and economic conditions

3.7 Each chapter will cover the following areas:

- Summary of topic and why it is important
- What work has been or will be done

3.8 Summary of Chapter Content: -

Section	Chapter
Overview of the social determinants of health	Current health challenges
	Halton life course statistics
	Update on 2020 priorities
Social and community networks	COVID-19 testing across Halton communities
	Reaching temporary and transient residents
	Supporting our right to vote during COVID
	Community vaccine champions
	Supporting people to self-isolate
Living and working conditions	Case study – working with the Port to vaccinate sailors
	Case study – Genlab Industrial Ovens, Widnes
	Education psychologists supporting families

	Adult Learning Service adapting to support learners throughout the pandemic
	Supporting Apprenticeships through COVID
	Giving people financial support through COVID – test and trace payments and adapting purchase to pay to give suppliers some flexibility difficult times
	Lessons learned in Adult Social Care
	Environment health overview
Recommendations – 2020-21- Responding to a global pandemic Recommendations Update – 2021-22 – Whole community approach to health	

4.0 POLICY IMPLICATIONS

4.1 The Public Health Annual Report should be used to inform commissioning plans and collaborative action for the NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The PHAR will highlight the Children's JSNA, which is a key piece of work for commissioners.

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

6.3 A Healthy Halton

All issues outlined in this report focus directly on this priority.

6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

There are also close links between partnerships on areas such as alcohol and domestic violence.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 Developing the PHAR does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This is in line with all equality and diversity issues in Halton.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None

Report Prepared by: Adam Major, Public Health Specialty Registrar
Contact: adam.major@halton.gov.uk

REPORT TO: Health and Wellbeing Board

DATE: 6 July 2022

REPORTING OFFICER: Director of Public Health

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with the final version of the Pharmaceutical Needs Assessment (PNA) and briefing on the results of the statutory 60-day consultation.

2.0 RECOMMENDATION: That:

i) The Board approve the PNA for publication

ii) The Board delegate the Steering Group to deal with production of supplementary statements needed throughout the lifetime of the PNA

3.0 SUPPORTING INFORMATION

3.1 The Pharmaceutical Needs Assessment (PNA) is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA; since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards (HWB).

3.2 Background to the PNA

National guidance states that the PNA should detail the current pharmaceutical service provision available in the area and where there may need to be changes to this in the future because of changes to the health needs or geographical location of the local population. The guidance, in line with regulations, includes both minimum content of a PNA and the process that must be followed.

The PNA is designed to be a statement of fact, both the current position and where there are ‘known firm plans’ in place to review or amend provision based on need, evidence of effective practice and identified gaps in provision. Also to assess where there are ‘known firm plans’ for

new developments or population changes which may impact on the needs of pharmaceutical services. It is designed to assess the need for pharmaceutical services and adequacy of provision of pharmaceutical services, not to assess general health needs. The latter is the role of the Joint Strategic Needs Assessment (JSNA). Preparation of the PNA has taken account of the needs identified in the JSNA, where they are relevant to pharmaceutical services.

3.4. **Public Consultation**

Information was gathered from pharmacy contractors on opening hours and the range of commissioned services they provide. However, the steering group felt it important to ask Halton residents what their experience of using community pharmacies was and what services they especially valued.

Steering group members, including Healthwatch and Halton & St Helens Council for Voluntary Services, publicised the survey widely.

117 people responded to the survey. Their responses were added across the document, suplementing the data from contractors

The vast majority were satisfied with their usual pharmacies opening hours and services provided.

3.3 **Statutory 60-day consultation**

The Regulations set out that HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA.

Regulation 8(1) states that the HWB must consult the following list as a minimum during the development of the PNA:

(a) Local Pharmaceutical Committee(s) (LPCs) for its area;
(b) Local Medical Committee(s) for its area;
(c) all pharmacy contractors and any dispensing doctors for its area;
(d) any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;
(e) Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area;
(f) NHS trusts or NHS foundation trusts in its area;
(g) NHS England;
(h) neighbouring HWBs.

Additionally the steering group recommended that the draft PNA be sent to:

- all GP practices, not just those that are dispensing doctors.
- NHS Halton Clinical Commissioning Group.
- Halton Borough Council Public Health lead commissioner for locally commissioned public health pharmacy services.
- The neighouring LPCs of Cheshire & Wirral and Liverpool.

3.4 **60-day statutory consultation process**

A standard letter was sent to all organisations detailed in Section 3.3. The draft PNA document was available via the council website, PNA page with paper copies available on request.

The consultation opened on Tuesday 8 March 2022 and ended at close of normal business hours on Monday 9 May 2022.

The consultation formed a set of questions to which respondents could agree or disagree with space in each question to make comments. The survey was available online or could be filled in using a word document form that was included with the invitation letter.

4 responses were received.

3.5 **60-day statutory consultation results**

The Steering Group met on 13 May 2022 to consider responses and any amends required in order to present this version of the PNA to the Health and Wellbeing Board as the final version.

The responses indicated that they agreed that:

- The purpose of the PNA had been sufficiently explained.
- The scope of the PNA was clear.
- The local context and implications of the PNA had been clearly explained.
- All commissioned services were reflected in the PNA with a reasonable description of each.
- The pharmaceutical needs of the local population were accurately reflected in the PNA.
- They agreed with the findings and future needs.
- There were no omissions within the PNA.

Some slight amends were noted concerning opening hours and provision of some advanced and locally commissioned services which had changed since the contractor survey and other data gathering exercises were completed. The document was updated to reflect these changes.

One respondent thought the document too long and repetitious in places. The PNA steering group noted this comment. Whilst it must include all the necessary content as laid out in national guidance and regulations, the steering group did reduce some of the content.

3.6 **Proposed next steps**

- The PNA must be published no later than 1 October 2022.
- The Health & Wellbeing Board are asked to approve the attached

version of the PNA as the publication version.

- The PNA will be uploaded onto Halton Borough Council's website as part of the Public Health pages detailing the JSNA.
- This is communicated to key stakeholders and the public.
- The Steering Group will meet periodically and/or communicate electronically as needed to produce supplementary statements during the lifetime of the PNA.

  These are needed if and when there are minor amends which do not substantially alter provision of pharmaceutical services. An example of this would be if a pharmacy changed their opening hours or in response to successful consolidations and mergers application.

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the PNA.

The PNA provides a robust and detailed assessment of the need for pharmaceutical services across Halton borough. As such it should continue to be used in the decisions around 'market entry' as well as inform local pharmacy services commissioning decisions. Local groups and partnerships should also take the findings of the PNA into account when making decisions around the need for pharmaceutical services.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the HWB up to Judicial Review. This can have significant financial implications. It is therefore vital that the HWB continues to follow national guidance in the implementation of the Regulations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

6.2 **Employment, Learning & Skills in Halton**
Not applicable

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 RISK ANALYSIS

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 The risk of challenge to the HWB who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 A sound process, using national guidance and with support from local expertise, should be established to ensure this risk does not materialise.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

Halton Health and Wellbeing Board

Pharmaceutical Needs Assessment

2022-2025

Foreword

Halton's Health and Wellbeing Board has responsibility for the on-going review, development and publication of the Pharmaceutical Needs Assessment.

This is a statutory document, by virtue of the National Health Services (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Its content has to be taken into account by those responsible for the approval of pharmacy contract applications (at NHS England) as well as those commissioning all other health services for our local population. From a primary care perspective this includes clinical commissioning groups (from 1 July 2022 Integrated Care Boards) and local authorities looking to commission and develop local services from pharmacy contractors, general practice, dental and optometry.

As such we are very happy to present our third formal Pharmaceutical Needs Assessment 2022-2025 which outlines the pharmaceutical services available to our population. This document provides information around current services being commissioned and proposals for future changes and developments.

This document will assist us when reviewing our commissioning strategies upon which we base our decisions. It is recognised that our community pharmacy colleagues have a key role to play in helping us develop and deliver the best possible pharmaceutical services for our population.

We commend this report to you and we look forward to your continuing involvement as this document is annually reviewed and updated.

Portfolio Holder Health & Wellbeing, Halton Borough Council

Chair Halton Health & Wellbeing Board

Director of Public Health, Halton Borough Council

Sponsor, Pharmaceutical Needs Assessment

Version Control

Main Authors: Sharon McAteer and Katherine Woodcock

Editor: Sharon McAteer along with members of the PNA* Steering Group

Issue Date: 1 October 2022

Review Date: Supplementary Statements as necessary with a formal review by 1 October 2025

Version	Summary of Changes	Date of Issue
2011 PNA	First formally approved PNA for Halton & St Helens PCT	1st February 2011
2015 PNA	Published Halton Health and Wellbeing Board's first PNA	1 April 2015
2018 PNA	Published Halton Health and Wellbeing Board's second PNA	1 April 2018
2022 PNA	Draft 1 presented to the PNA steering group	November 2021
	Draft 2 presented to the PNA steering group	January 2022
	Final draft presented to the PNA steering group	February 2022
	Final report presented to the PNA steering group	May 2022
	Completed version to Halton Health and Wellbeing Board	July 2022
	Published Halton Health and Wellbeing Board's third PNA	1 October 2022

***PNA = Pharmaceutical Needs Assessment**

PNA Steering Group Members

Ifeoma Onyia	**Director of Public Health (chair), Halton Borough Council**
Sharon McAteer	**Public Health Development Manager (deputy chair), Halton Borough Council**
Katherine Woodcock	**Public Health Intelligence Manager, Halton Borough Council**
Helen Murphy	**Chief Officer, Local Pharmaceutical Committee (Knowsley, Halton and St Helens)**
Jackie Jasper	**Primary Care Manager, NHS England**
Lucy Reid	**Head of Medicines Management, NHS Halton Halton Clinical Commissioning Group (CCG) (left post March 2022)**
Nathan O'Brien	**Medicines Management, NHS Halton CCG (joined steering group April 2022)**
Kath Parker	**Chair, Halton HAB, Healthwatch**
Sally Yeoman	**Chief Officer, Halton and St Helens Council for Voluntary Services**
Cllr Marie Wright	**Elected member, Portfolio Holder Health & Wellbeing, Halton Borough Council, chair Halton Health & Wellbeing Board**

Further acknowledgements

- Leanne Molyneux, Helena Leach and Vicki Yarwood for their administration skills throughout the PNA process.
- Cheshire & Merseyside colleagues for support throughout development of PNA together with NHS England for arranging the sub-regional steering group.
- Pharmacies for providing information on the services they provide.
- Dave Barker, Engagement Officer, Halton, St Helens & Knowsley Local Pharmaceutical Committee for supporting the pharmacies in achieving 100% compliance within the deadline date.
- HBC Customer Intelligence Unit for managing the statutory consultation.
- Sophie Kelly, Public Health, Liverpool City Council for setting up and administering the public survey on behalf of Cheshire & Merseyside.
- Halton networks for distributing the public survey to their members and Halton public for taking the time to complete the questionnaire.
- Simon Bell, Public Health, Halton Borough Council; Anne Moyers, Alasdair Cross and Kenneth Bowen, Planning & Transport Policy, Halton Borough Council; Sarah Vickers NHS Halton CCG.
- Midland & Lancashire Commissioning Support Unit on behalf of Medicines Management at NHS Halton CCG, for providing prescribing data.

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Executive Summary

The Pharmaceutical Needs Assessment (PNA) aims to identify the pharmaceutical needs of people living in Halton.

The main objectives for this project were to:
1. Describe the scale and consequences of the main health issues in Halton.
2. Describe the existing pharmacy services in relation to needs, policy and evidence-based practice.
3. Make recommendations to commissioners based on findings of the PNA.
4. Provide information for NHS England (NHSE) contracts committee when deciding pharmacy applications.

Background

In April 2008 the White Paper, *Pharmacy in England: Building on Strengths – Delivering the Future* was published. This sets out the Government's programme for a 21st century pharmaceutical service and identifying ways in which pharmacists and their teams could contribute to improving patient care through delivering personalised pharmaceutical services in the coming years.

Following consultation in autumn 2008, two clauses were included in the Health Act 2009:

- To require Primary Care Trusts to develop and publish pharmaceutical needs assessments (PNAs) by 1st February 2011; and
- Then to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision.

Pharmacy in England: Building on Strengths – Delivering the Future – Regulations under the Health Act 2009: Pharmaceutical Needs Assessments –Information for Primary Care Trusts was published to assist Primary Care Trusts in the development of their first and subsequent PNAs produced under the new statutory duty set out in the NHS (Pharmaceutical Services) Regulations 2005, as amended. In developing their PNA, Regulation [3G] outlines a series of matters that Primary Care Trusts must have regard to, these are summarised as:

-

- The Joint Strategic Needs Assessment (JSNA)
- The needs of different patient groups
- The demography of the area
- The benefits from having a reasonable choice in obtaining services
- The different needs of the localities
- The effect of pharmaceutical services provided under arrangements with neighbouring areas
- The effect of dispensing services or other NHS services provided in or outside its area
- Likely future needs.

Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012

From 1st April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). Guidance outlines the steps required to produce relevant, helpful, and legally robust PNAs.

The PNA is a key document used by NHS England local area teams to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. It is also used by commissioners reviewing the health needs for services within their area. Pharmacy has much more to offer than the safe and effective dispensing of medicines. It is increasingly expanding its provision of additional clinical services, becoming a persuasive force in improving the health and wellbeing of individuals and communities, and reducing health inequalities. These developments are underpinned by the The Pharmacy Quality Scheme (PQS) which forms part of the Community Pharmacy Contractual Framework (CPCF). Pharmacy Quality Scheme is designed to support delivery of the NHS Long Term Plan and reward community pharmacies that deliver quality criteria in three quality dimensions:

- Clinical Effectiveness
- Patient Safety
- Patient Experience

On 1 July 2022 Clinical Commissioning Groups (CCGs) ceased and were replaced by integrated care boards that will be able to take on delegated responsibility for pharmaceutical services. From April 2023 NHS England and NHS Improvement expects all integrated care boards to have done so. Services that were commissioned by NHS Halton CCG at the time of writing the PNA will move to the integrated care boards and will fall under the governance of the wider Integrated Care System (ICS).

This 2022-2025 PNA has been written at a time of significant NHS reorganisation. The Introduction of the ICS and integrated place-based commissioning was still in its transition stage when the PNA was signed off by the Health & Wellbeing Board. As such we recognise that the new commissioning arrangements are still emerging. Consequently some of the language used and commissioning arrangements described in this PNA may change over time. The service specifications will remain as described. The steering group will monitor changes and make decisions of how to reflect these during the lifetime of the PNA.

Process undertaken to develop the PNA

Key principles of the PNA are:

- It is an iterative process involving patients, the public and key stake holders
- It is a developing, live document to be reviewed annually
- It continues to focus on identifying health needs which can be supported by pharmaceutical services and makes recommendations for the commissioning of those services
- It is done through a multidisciplinary PNA steering group

Development of the Halton PNA has been initiated and overseen by the Public Health Evidence & Intelligence Team operating through a multi-professional steering group. The steering group consists of representatives from the following:

- Halton Borough Council Public Health Evidence and Intelligence
- NHS Halton Clinical Commissioning Group (CCG)
- Halton, St Helens & Knowsley Local Pharmaceutical Committee
- NHS England
- Halton Healthwatch
- Halton & St Helens Council for Voluntary Services
- Halton Borough Council elected member, Portfolio holder for Health and Wellbeing

The process of developing this PNA has drawn heavily on the 2009 NHS Employers guidance documents[1,2] and the 2021 Department for Health and Social Care guidance document[3].

It uses the Joint Strategic Needs Assessment (JSNA) and the priorities of the newly developing One Halton, Joint Health and Wellbeing Strategy (JHWBS) to identify how pharmacy services support local health needs.

Patient and Public Involvement

During November 2021 we asked the people of Halton for their experiences of using pharmacy services and their views on how services might be improved. We wanted to know this because:

- We want to make sure that pharmacies provide services people need and use
- We want to know what services we can improve in Halton
- We want to let pharmacies know what patients think of the services they provide
- We want to work with patients and pharmacies to improve services

117 people filled in the questionnaire, less than for the last PNA but similar to previous PNAs. Feedback from this has been incorporated throughout the report.

60-day consultation

A formal 60-day consultation is required for the development of the PNA. This began 9am Monday 7 March 2022 and closed midnight on Monday 9 May 2022. It was distributed widely to local pharmacies, neighbouring HWBs, acute trusts, local strategic partnerships, Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC), all GP practices and to community & voluntary sector groups throughout the borough. Comments have been collated and a consultation response included in the PNA. Each comment was assessed by the steering group and amendments required as a result of them made to the final PNA. Details of feedback can be found in Appendix 9.

Developments which may precipitate the need for changes to pharmacy services

Any conclusions gained from this PNA need to take account of the fact that future developments, such as but not limited to, changes in population, changes in sources/numbers of prescriptions may take place. This could influence the demand for pharmaceutical services. Hence this PNA is a 'dynamic' document.

Workload and demand in pharmacy is driven by two factors:

- Halton's population structure is predicted to shift over the next decade. All age groups aged under 70 are forecast to decrease proportionally between 2020 and 2043, particularly those aged 5-14. Conversely, the proportion of those aged 75 and over is predicted to increase from 7.4% of Halton's population to 12.8%. This is an increase of around 7,900 people. The working population is forecast to shrink proportionally. This 'ageing population' is likely to increase pressures on NHS and social care as this age group makes up a disproportionately large percentage of GP consultations, hospital admissions and social services. This is likely to have an impact on prescribing levels and therefore pharmacy workload, assuming current prescribing patterns persist.

- For 2020/21 2,925,855[4] prescription items were prescribed in Halton. The average number of prescription items per month per 1,000 population was 1,832.8, more than both Cheshire & Merseyside average (1,806.5) and England (1,527.5).

The combined effects of population change and prescribing volume have a compounding effect on the pharmacy workload. This is especially pertinent as the pharmacies operating across Halton currently dispense more prescription items than the average for England and this has grown each year. It is anticipated that growth in the future will continue at a similar rate. Prescription volumes and service provision needs to be monitored to identify where demand is likely to exceed supply. Planned developments, e.g. any major new housing developments, must also be monitored to ensure we are able to respond to the needs of our population for pharmacy services.

Key Findings

Taking into account information gathered for this PNA

The provision of pharmacy services within Halton in terms of location, opening hours and services provided is considered adequate, to meet the needs of the population.

As such this PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

The PNA has also identified actions to optimise the potential of the pharmacy contract for our population; these are:

Focus on **enhanced and advanced services** specifically:

- Support active providers to increase their provision of enhanced and advanced services in line with identified need and commissioning priorities.

Locally commissioned services:

- Whilst locally commissioned services are outside the scope of the PNA they do provide an opportunity to enhance local service provision. It is important that provision is audited regularly to ensure that if gaps develop, a plan to address these is developed with current providers.

This PNA provides a base from which commissioning plans for pharmacy can be developed which combine our local priorities with national strategy for community pharmacy services. The PNA will be used as a basis for 'control of entry regulations' so that NHS England is clear and transparent about where services may or may not be needed in the future. Therefore the PNA needs to be explicit about its gaps in service. It will be used in the development of local service provision alongside specific health strategies and plans.

However, there may be aspirations to develop local services but these need to be developed in a cost effective way and in light of current financial constraints.

PNA Conclusions

Access to pharmacies

- ***Overall access in terms of location, opening hours and services is considered to be adequate to meet the needs of the population of Halton.***
- ***The PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.***

There is no simple way to determine this. As such a number of factors have been taken in to account including:

- Compared to the national average, Halton has a higher pharmacy: population ratio than the national average.
- However, there is wide variation in the pharmacy–to-population ratio across wards, even taking town centre locations into account. Any decisions regarding new pharmacies need to take the population-to-pharmacy ratio in to account. Conversely, any closures need to be carefully monitored to determine the impact this will have on access, especially in those wards where the population-to-pharmacy ratio is already low.
- There is a great deal of satisfaction with pharmacy services. Overall, members of the public find them accessible, friendly and helpful.
- Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends.

Advanced and Enhanced Services Provision

- Community Pharmacist Consultation Service is a new advanced service. Access to it is adequate.
- There is generally adequate access to New Medicines Service (NMS) across the borough.
- Influenza vaccination for at risk adults is now available through nearly all Halton community pharmacies and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice.
- Appliance Use Reviews (AUR) and Stoma appliance customisation (SAC) service are both specialist services. Whilst there is less provision across Halton community pharmacies the specialised nature means access is adequate.
- Hepatitis C antibody testing service is a specialist service. Any community pharmacy can provide it but it is likely to be of most interest to those providing Needle-Syringe Exchange Service. Whilst there is less provision across Halton community pharmacies the specialised nature means access is adequate.
- The Hypertension Care Finding Service is a new service. At this stage of the service access is deemed adequate. We would expect more pharmacies to sign up to provide it over time.
- There is one Enhanced service commissioned by NHS England Cheshire & Merseyside, an antiviral stock control service. This is a specialised service to be deployed in a particular set of circumstances and only a few pharmacies across Cheshire & Merseyside provide it. There is one community pharmacy providing the service in Halton. Access is adequate.

MAIN DOCUMENT

Key Findings

A Pharmaceutical Needs Assessment (PNA) forms part of the commissioning function for pharmacy services. It relates the current provision of pharmaceutical services to the characteristics of the local population and Health & Wellbeing Board (HWB) priorities for improving health and wellbeing and reducing health inequalities in Halton.

The PNA addresses the following broad questions:

- What is the provision of pharmacy service to our population and is this adequate?
- How is the pharmacy contract utilised for the benefit of the population of Halton?
- How can community pharmacy through its nationally commissioned or locally commissioned services support us to deliver our priorities for health and wellbeing for the population of Halton?

The provision of pharmacy services within Halton in terms of location, opening hours and services provided is considered adequate, to meet the needs of the population.

As such this PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

This assessment is based on the following observations:

- Halton has an average of 22.3 pharmacies per 100,000 population. This compares to 19.3 per 100,000 for England as a whole and 23.5 per 100,000 across Cheshire & Merseyside.
- It is possible to compare prescribing volume by converting total items prescribed in to a monthly prescribing rate per pharmacy per 1,000 population. In 2020/21 Halton had a higher prescribing rate than both the England and Cheshire & Merseyside averages.
- There is adequate access to pharmacy services throughout the week, with provision in the evening and at weekends across Halton. This takes into account needs in both Widnes and Runcorn. Members of the public commented however, that it is not always easy to access pharmacy services in the evening, i.e. after 7pm, and weekends. Where any specific service gaps develop these will be addressed initially through dialogue with existing contractors. Our existing network provides a comprehensive essential pharmaceutical service to our population.
- There is adequate provision of locally commissioned services across our population. We will continue to work with our existing contractors to ensure that this provision continues to match the needs of our population and that any inequalities in activity which arise are addressed.
- Feedback and information provided by patients, the public and other stakeholders consulted during the development of the PNA showed people feel the community pharmacies offer a valuable service, are convenient and staff are friendly and helpful.

Developments which may precipitate the need for changes to pharmacy services

Any conclusions gained from this PNA need to take account of the fact that future developments, such as but not limited to, changes in population, changes in sources/numbers of prescriptions, may take place. This could influence the demand for pharmaceutical services. Hence this PNA is a 'dynamic' document.

Workload and demand in pharmacy is driven by two factors, changes to the population changes and to prescribing volume:

- Halton's population structure is predicted to shift over the next decade. All age groups aged under 70 are forecast to decrease proportionally between 2020 and 2043, particularly those aged 5-14. Conversely, the proportion of those aged 75 and over is predicted to increase from 7.4% of Halton's population to 12.8%. This is an increase of around 7,900 people. The working population is forecast to shrink proportionally. This 'ageing population' is likely to increase pressures on NHS and social care as this age group makes up a disproportionately large percentage of GP consultations, hospital admissions and social services. This is likely to have an impact on prescribing levels and therefore pharmacy workload, assuming current prescribing patterns persist.
- In 2020/21 2,925,855[5] prescription items were prescribed in Halton. The average number of prescription items per month per 1,000 population was 1,832.8, more than both Cheshire & Merseyside average (1,806.5) and England (1,527.5).

The combined effects of population change and prescribing volume have a compounding effect on the pharmacy workload. This is especially pertinent as the pharmacies operating across Halton currently dispense more prescription items than the average for England and this has grown each year. It is anticipated that growth in the future will continue at a similar rate. Prescription volumes and service provision needs to be monitored to identify where demand is likely to exceed supply. Planned developments, e.g. any major new housing developments, must also be monitored to ensure we are able to respond to the needs of our population for pharmacy services.

PNA Conclusions

Access to pharmacies

- ***Overall access in terms of location, opening hours and services is considered to be adequate to meet the needs of the population of Halton.***
- ***The PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.***
    - Halton has a higher pharmacy: population ratio than the national average.
    - However, there is wide variation in the pharmacy–to-population ratio across wards, even taking town centre locations in to account. Any decisions regarding new pharmacies need to take the population-to-pharmacy ratio in to account. Conversely, any closures need to be carefully monitored to determine the impact this will have on access, especially in those wards where the population-to-pharmacy ratio is already low.
    - There is a great deal of satisfaction with pharmacy services. Overall, members of the public find them accessible, friendly and helpful.
    - Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends.

Advanced and Enhanced Services Provision

- Community Pharmacist Consultation Service is a new advanced service. Access to it is adequate.
- There is generally adequate access to New Medicines Service (NMS) across the borough.

- Influenza vaccination for at risk adults is now available through nearly all Halton community pharmacies and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice.
- Appliance Use Reviews (AUR) and Stoma appliance customisation (SAC) service are both specialist services. Whilst there is less provision across Halton community pharmacies the specialised nature means access is adequate.
- Hepatitis C antibody testing service is a specialist service. Any community pharmacy can provide it but it is likely to be of most interest to those providing Needle-Syringe Exchange Service. Whilst there is less provision across Halton community pharmacies the specialised nature means access is adequate.
- The Hypertension Care Finding Service is a new service. At this stage of the service access is deemed adequate. We would expect more pharmacies to sign up to provide it over time.
- There is one Enhanced service commissioned by NHS England Cheshire & Merseyside, an antiviral stock control service. This is a specialised service to be deployed in a particular set of circumstances only a few pharmacies across Cheshire & Merseyside provide it. There is one community pharmacy providing the service in Halton. Access is adequate.

Pharmaceutical Needs Assessment

Part 1: Purpose, process and explanation of pharmaceutical services

Statements from pharmaceutical regulations (2013)

Regulatory Statements

The National Health Service (NHS) Pharmaceutical and local Pharmaceutical services Regulations (2013) set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/ Schedule 1 of these regulations it sets out the minimum information to be contained in the PNA. Detailed below are the six statements included in schedule 1 and the necessity for a local PNA map of service providers.

Statement One: Necessary services: Current provision

Provide a statement of the pharmaceutical services that the Health and Wellbeing Board (HWB) has identified as services that are provided:

a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and
b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).

Community pharmacy services for Halton are provided across a range of reasonable geographical locations; with good accessibility and sufficient provision throughout the borough. Halton has 30 community pharmacies (plus 4 distance selling 'internet-only' pharmacies), serving a population of 134,654 (total GP registered population, as at 1 August 2021), who provide a comprehensive service with a full range of essential services and some advanced services. This equates to approximately one pharmacy for every 3,960 Halton GP patients[i] (England average is 5,172 patients per pharmacy). Consequently the population is well served by pharmacy services.

Halton pharmacies dispense more prescriptions per head of population each month, 1832.8 items per 1,000 patients per month in 2020/21 compared to 1806.5 across Cheshire & Merseyside and 1527.5 for England.

Halton residents will also access pharmacy services in the neighbouring boroughs of Cheshire West and Chester (Frodsham), St Helens, Knowsley, Liverpool and Warrington. Services are considered sufficient for the population's needs.

Statement two: Necessary services: Gaps in provision

Provide a statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied:

a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.
b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

i Note this calculation includes the 4 distance selling pharmacies so comparison can be made with the England value. This is because it has not been possible to sift out the distance selling pharmacies from the overall England list.

Current provision across Halton as a whole is adequate. No gaps in the provision of essential pharmaceutical services have been identified in this PNA. There are on-going housing developments planned over the lifetime of this PNA. It is anticipated that capacity within existing services should be able to support the pharmaceutical needs of future populations of overall, however there will be a need for regular review to ensure provision remains adequate in light of development.

Some geographical differences in provision have been highlighted through this PNA. In keeping with the national picture, services are predominantly situated in more densely populated areas of the borough. Thus, less densely populated areas of Halton have fewer pharmacies per head of population.

Despite the overall geographical differences, and those for availability of extended hour pharmacy provision, the need for 'emergency prescriptions' will almost always be centred on patients using 'out of hours services.' Halton is currently covered by GP Out of Hours (via NHS 111) and the two Urgent Care Centres at Widnes Healthcare Resource Centre and Runcorn Urgent Care on the Halton Hospital site. Pharmacy provision is available on-site or close to these sites with a range of extended hours or 100 hour contract pharmacies available to access.

Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends. Added to this there is a continuation of the extension of GP opening hours and 7-day week services as the norm. Access to community pharmacy provision needs to be assessed in line with these developments. We will continue to work with our existing contractors to ensure that this provision continues to match the needs of our population and that any inequalities in activity which arise are addressed.

Statement three: Other relevant services: Current provision

Provide a statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided:

a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access to pharmaceutical services in its area.
b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area.
c) in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (A) or (B), or paragraph one, of the 2013 regulations, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.

Halton is split by the River Mersey into Widnes and Runcorn. It has geographical borders with all other local authorities in Cheshire & Merseyside apart from Wirral and Sefton. Members of the Halton population will cross these borders for leisure and work purposes and also to access pharmacy services if it is more convenient for them and not due to there being a lack of service in Halton.

The NHS England out of hours bank holiday rota looks at services across boundaries to ensure geographical coverage.

In addition to essential services, there is adequate access to the full range of advanced services and locally commissioned public health and CCG services to meet local needs.

Statement Four: Improvements and better access: Gaps in provision

Provide a statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied:

a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type, in its area.
b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services or a specified type, in its area.

There is a need to be mindful that community pharmacy services should strive to support the changes that face the NHS as commissioning intentions change or evolve and they should aspire to reduce the pressures on other patient facing services such as GPs and Accident & Emergency. However, in the current financial climate there is limited capacity to deliver additional services within static or reducing budgets. There should also be recognition and understanding of the context related to a number of national, regional and local strategies and policies from which opportunities may arise in their delivery such as Next Steps on the NHS Five Year Forward View then locally the One Halton Health and Wellbeing Strategy that seek to transform how health and wellbeing services are delivered and designed in Halton, putting residents at the heart of services.

The skills and expertise of community pharmacists could be further utilised in the provision of locally commissioned services aimed at improving population health. Assessment of future plans for housing development within Halton has highlighted potential growth in both Runcorn and Widnes. It is envisaged that capacity within existing services overall will be able to absorb the increased demand anticipated over lifespan of this PNA; however regular review will be needed to ensure equitable distribution of provision in light of population growth.

Based on the information available at the time of developing this PNA, no gaps have been identified in essential, advanced enhanced or locally commissioned services that if provided either now or in the future would secure improvements, or better access, to pharmaceutical services.

Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends. Added to this there is a continuation of the extension of GP opening hours and 7-day week services as the norm. Access to community pharmacy provision needs to be assessed in line with these developments. We will continue to work with our existing contractors to ensure that this provision continues to match the needs of our population and that any inequalities in activity which arise are addressed.

Statement five: Other NHS services

Provide a statement of any NHS services provided or arranged by the Halton HWB, NHS England, NHS Halton CCG, any NHS trusts or any NHS foundation trust to which the HWB has had regard in its assessment, which affect:

a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area or
b) whether further provision of pharmaceutical services in its area would secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type in its area.

Based on the information available at the time of developing this PNA, no gaps in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified.

Statement Six: How the assessment was carried out

Provide an explanation of how the assessment has been carried out, in particular:

a) how it has determined what are the localities in its area
b) how it has taken into account (where applicable)
   - the different needs of different localities in its area, and
   - the different needs of people in its area who share a protected characteristic and
c) a report on the consultation that it has undertaken.

Halton is split by the River Mersey into Widnes and Runcorn. It has geographical borders with all other local authorities in Cheshire & Merseyside apart from Wirral and Sefton. It has one local authority with one coterminous Clinical Commissioning Group (CCG). This has meant that mapping and consultation can be managed and applied without any caveats. As the statutory responsibility of the PNA falls within the remit of Halton Health & Wellbeing Board (HWB) then analysis and mapping was carried out at whole borough and ward level, taking into account the different needs of people across the borough. As such the PNA has taken into the account One Halton Health & Wellbeing Strategy and Halton Joint Strategic Needs Assessment (JSNA) content and so will inform commissioning decisions by Halton HWB, NHS Halton CCG, Halton Borough Council and NHS England. Part 1, section 2 of the PNA goes into specific detail on how the public and pharmacy consultation processes was undertaken. Appendices provide details of the contractor survey, public consultation and 60-day consultation. Responses from the public consultation have been used throughout the report to supplement our understanding of needs and views. Responses to the 60-day consultation are included as well as the HWB response to this feedback (Appendix 9).

Map of provision

A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB.

A map of provision of pharmaceutical services, Map 4, page 66, shows the geographical distribution of both community pharmacies and distance selling pharmacies together with key health services.

There are nine other maps within the PNA that demonstrate good access to pharmaceutical services in areas with highest population density and highest deprivation as well as most of the population being within 20 minutes walking and public transport distance from a pharmacy and the whole population being covered by a 20 minute drive time even in rush-hour times. Finally, the map of pharmacies outside the Halton HWB area shows that there is choice of pharmaceutical services within a 2-mile radius in Cheshire West & Chester, Liverpool, Knowsley, St Helens and Warrington.

1. Introduction and Purpose

The effective commissioning of accessible primary care services is central to improving quality and implementing the vision for health and healthcare. Community pharmacy is one of the most accessible healthcare settings. Nationally 99% of the population, including those living in the most deprived areas, can get to a pharmacy within 20 minutes by car. 96% of people living in the most deprived areas have access to a pharmacy either through walking or via public transport.

The PNA presents a picture of community pharmacies and other providers of pharmaceutical services, reviewing services currently provided and how these could be utilised further. Community pharmacies can support the health and wellbeing of the population of Halton in partnership with other community services and GP practices. Services can be directed towards addressing health inequalities and supporting self-care in areas of greatest need. Mapping of service provision and identifying gaps in demand are essential to afford commissioners with the market intelligence they need to take forward appropriate and cost-effective commissioning of services.

The Health Act 2009 outlined the process of market entry onto a "Pharmaceutical List" by means of Pharmaceutical Needs Assessments and provided information to Primary Care Trusts for their production. It amended the National Health Service Act 2006 to include provisions for regulations to set out the minimum standards for PNAs. The regulations came into force on 24 May 2010 and

- required Primary Care Trusts to develop and publish PNAs; and
- required them to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision.

Following the abolition of Primary Care Trusts, this statutory responsibility passed to Health and Wellbeing Boards (HWB) by virtue of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, which came into force on 1st April 2013. These Regulations also outline the process that NHS England must comply with in dealing with applications for new pharmacies or changes to existing pharmacies.

The Health and Social Care Act 2012 further describes the duty of "commissioners", in accordance with Regulations, to arrange for the adequate provision and commissioning of pharmaceutical services for their population.

The PNA is thus a key tool, for NHS England and local commissioners, to support the decision making process for pharmacy applications and to ensure that commissioning intentions for services that could be delivered via community pharmacies, in addition to other providers, are incorporated into local planning cycles. Local commissioning priorities need to be driven by the Joint Strategic Needs Assessment (JSNA) of which the PNA is a key component.

On 1 July 2022 Clinical Commissioning Groups (CCGs) ceased and were replaced by integrated care boards that will be able to take on delegated responsibility for pharmaceutical services. From April 2023 NHS England and NHS Improvement expects all integrated care boards to have done so. Services that were commissioned by NHS Halton CCG at the time of writing the PNA will move to the integrated care boards and will fall under the governance of the wider Integrated Care System.

This 2022-2025 PNA has been written at a time of significant NHS reorganisation. The Introduction of the Integrated Care System (ICS) and integrated place-based commissioning was still in its transition stage when the PNA was signed off by the Health & Wellbeing Board. As such we

recognise that the new commissioning arrangements are still emerging. Consequently some of the language used and commissioning arrangements described in this PNA may change over time. The service specifications will remain as described. The steering group will monitor changes and make decisions of how to reflect these during the lifetime of the PNA.

See Appendix 1 for policy context

2. Scope and Methodology

2.1. Scope of the PNA

The scope of the assessment of need must address the following principles:

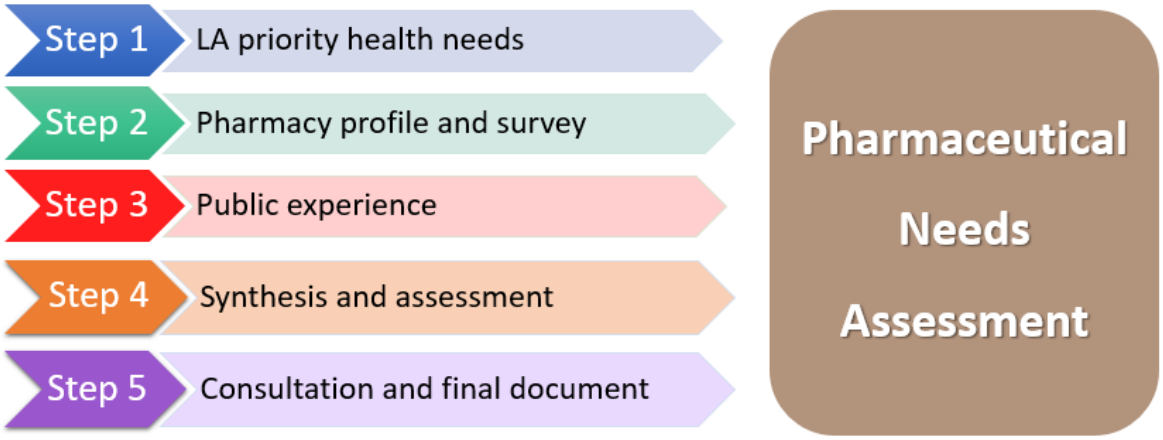
- The safe and efficient supply of medicines.
- Pharmaceutical care that provides quality healthcare and public health information and advice to all members of the population.
- High quality pharmacy premises that increase capacity and improve access to primary care services and medicines.
- Local enhanced services which increase access, choice and support self-care.
- Locally commissioned enhanced pharmaceutical services that have the potential to reduce avoidable hospital admissions and reduce bed-days.
- High quality pharmaceutical support to prescribers for clinical and cost-effective use of resources.

2.2. Methodology and Data Analysis

Key principles of the PNA are:

- It is an iterative process involving patients, the public and key stake holders.
- It is a developing, live document to be refreshed annually.
- It continues to focus on identifying health needs which can be supported by pharmaceutical services and makes recommendations for the commissioning of those services.
- It is developed through a multidisciplinary PNA Steering Group.

Figure 1: PNA development process



Development of the Halton Health and Wellbeing Board's PNA has been initiated and overseen by the Public Health Evidence and Intelligence Team and a multi-professional steering group. The steering group consists of representatives from the following:

- Halton Borough Council Public Health (chair and officers)
- Community Pharmacy Contract leads from NHS England
- Head of Medicines Management, NHS Halton Clinical Commissioning Group (CCG)
- Local Pharmaceutical Committee
- Halton Healthwatch

- Halton and St Helens Voluntary and Community Action
- Halton Borough Council elected member, Portfolio holder for Health & Wellbeing

The content of the document is closely linked to the local JSNA and has been produced by means of a structured analysis and distillation of complex and comprehensive data sources in order to identify the following:

- the health and pharmaceutical needs of the population .
- evidence of best practice in meeting need through community pharmacy services.
- current local provision of pharmaceutical services, and subsequently.
- gaps in provision of pharmaceutical services.

The following information sources have been used for the purposes of this PNA:

- Joint Strategic Needs Assessment
- Joint Health & Wellbeing Strategy
- Office for Health Improvement and Disparities' (formerly PHE)[ii] Fingertips tool for additional data on health and wellbeing
- Public Health England's SHAPE tool for travel time maps
- Data on socio-economic circumstances of the local area
- Community pharmacy providers questionnaire
- NHS Business Services Authority
- Public pharmacy services questionnaire
- Delivery and Allocations Plan (DALP)

This PNA has undergone a formal 60 day consultation and relevant amendments have been made.

2.3 Consultation

A draft PNA was published 9am Monday 7 March 2022 inviting comments to be made prior to closing midnight Monday 9 May 2022.

The draft document was distributed as follows:-

Community and Hospital Providers, All Local Pharmacies, Professional Bodies, NHS Bodies and Staff

- All **34** Pharmacies in Halton (30 community pharmacies and 4 distance selling pharmacies)
- All **14** General Practices in Halton
- Bridgewater Community Healthcare NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Both main Hospital Trusts serving Halton's population:
    - Warrington and Halton Hospitals NHS Foundation Trust
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Halton, St Helens and Knowsley Local Pharmaceutical Committee (LPC)
- Neighbouring LPCs of Cheshire & Wirral and Liverpool
- Mid Mersey Local Medical Committee

[ii] Note PHE as an organisation split in to UK Health Security Agency (UKHSA) and Office for Health Improvement & Disparities (OHID) on 1 October 2021. OHID is an office of the Department of Health & Social Care. The Fingertips and other data tools are now part of OHID

- Neighbouring Local Authority Health and Wellbeing Boards (or equivalent): St Helens, Warrington, Liverpool, Knowsley, Cheshire East, Cheshire West & Chester
- NHS England
- NHS Halton Clinical Commissioning Group (CCG)

Patients and Public

- Halton Healthwatch
- Voluntary Sector Groups via Halton and St Helens Voluntary and Community Action

Full documentation was published on Halton Borough Council's website with an online facility to help readers make comments on the PNA. Respondents were offered paper copies of the PNA if required and they could also complete the survey using a copy of the questions supplied with the invitation letter. Written comments could therefore be made online, completion of the questionnaire electronically or print version sent back to the Public Health team.

Responses received during the consultation period can be found in Appendix 9.

2.4. PNA Review Process

The PNA will be reviewed as an integrated part of the annual commissioning cycle as well as when any changes to the pharmacy contractor list occurs. This action will be overseen by Halton Health and Well Being Board with input from the NHSE Pharmacy Contracts Group. The task is delegated to the Public Health Evidence & Intelligence Team and the multi-professional steering group who have developed the PNA.

Examples of changes that might dictate a new or diminished pharmaceutical need are:

- New pharmacy contracts
- Pharmacy closures
- Changes to pharmacy locations
- Pharmacy opening hours
- Local intelligence and significant issues relating to pharmacy enhanced service provision
- Appliance provision changes
- Significant changes in health need, housing developments or primary care service developments that may impact either complimentary or adversely on pharmacy based services
- Significant changes in workforce due to movement of local businesses/employers

Typically this would be in the form of issuing a Supplementary Statement, unless the changes were significant enough that a new PNA was warranted and did not form a disproportionate response to the level of change identified. The PNA has to have a complete review every 3 years.

Successful applications for 'consolidations and mergers' as part of the revised pharmacy regulations would also necessitate the development of a supplementary statement. (See Appendix 1 Policy Context for details about this).

2.5 How to use the PNA

The PNA should be utilised as a service development tool in conjunction with the Joint Strategic Needs Assessment (JSNA) and the strategic plans from local commissioners. Mapping out current services

and gaining a sense of future service needs will pinpoint the areas where the development of local pharmaceutical services may be necessary.

The PNA can be used by patients, current service providers, future service providers and commissioners alike in the following way:

- Maps and tables detailing specific services will mean patients can see where they can access a particular service.
- Current service providers will be better able to understand the unmet needs of patients in their area and take steps to address this need.
- Future service providers will be able to tailor their applications to be added to the pharmaceutical list to make sure that they provide the services most needed by the local community.
- Commissioners will be able to move away from the 'one-size fits all approach' to make sure that pharmaceutical services are delivered in a targeted way.
- NHSE will be in a better position to judge new applications to join the pharmaceutical list to make sure that patients receive quality services and adequate access without plurality of supply.

2.6 Localities used for considering pharmaceutical services

Halton borough is split into 18 electoral wards. Halton has a natural physical divide in the form of the River Mersey with Widnes to the north and Runcorn to the south. However for the purpose of the PNA, Halton was not split into localities as it is a geographically compact unitary authority. In making a judgement of adequacy of provision, consideration has been given to provision in both Widnes and Runcorn. Spatial mapping of service provision has been included to draw conclusions about access to pharmacies and advanced services.

3. National Pharmaceutical Services Contract

All national NHS pharmaceutical service providers must comply with the contractual framework that was introduced in April 2005. The national framework is set out below and can be found in greater detail on the Pharmaceutical Services Negotiating Committee (PSNC) website:
http://www.psnc.org.uk/pages/introduction.html
https://psnc.org.uk/contract-it/the-pharmacy-contract/

The pharmaceutical services contract consists of three different levels:

- Essential services
- Enhanced services
- Advanced services

https://psnc.org.uk/services-commissioning/

3.1. Essential Services and Prescription Volume

Consist of the following and have to be offered by all pharmacy contractors.

3.1.1. Dispensing - Supply of medicines or appliances, advice given to the patient about the medicines being dispensed and advice about possible interactions with other medicines. Also the recording of all medicines dispensed, significant advice provided, referrals and interventions made using a Patient Medication Record.

3.1.2. Prescriptions - During 2020/21 the GP practices in Halton issued a total of 2,897,604 individual prescription items with a further 44,420 items prescribed by other healthcare providers (total 2,942,024 individual prescription items). 93.4% of total prescription items *(2,746,696 items)* were dispensed by Halton pharmacies. 3.8% (*112,320)* were dispensed by pharmacies in bordering areas (boroughs in Cheshire & Merseyside). A further 2.8% (83,008*)* were dispensed nationwide.

Table 1: Number and Percentage of prescription items, per area dispensed, 2020/21

Number of Items Area	Total 2020/2021	% Items Area	% to Total 2020/2021
⊟Halton	2,746,696	⊟Halton	93.36%
⊞Runcorn	1,338,995	⊞Runcorn	45.51%
⊞Widnes	1,407,701	⊞Widnes	47.85%
⊞Cheshire & Merseyside	112,320	⊞Cheshire & Merseyside	3.82%
⊞Nationwide	82,637	⊞Nationwide	2.81%
⊞Scotland	147	⊞Scotland	0.00%
⊞Wales	224	⊞Wales	0.01%
Grand Total	2,942,024	Grand Total	100.00%

Source: NHS Business Services Authority (NHSBSA), epact2 data

This is a 1.8% reduction compared to the previous year 2019/20.

3.1.3. Repeat dispensing - Management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need

for a repeat supply of a particular medicine. The pharmacist will communicate all significant issues to the prescriber with suggestions on medication changes as appropriate.

3.1.4. Disposal of unwanted medicines - Pharmacies act as collection points for patient returned unwanted medicines from households and individuals. Special arrangements apply to Controlled Drugs (post Shipman Inquiry) and private arrangements must be adopted for waste returned from nursing homes.

3.1.5. Promotion of Healthy Lifestyles (Public Health) - Opportunistic one to one advice provided on healthy lifestyle topics such as smoking cessation, weight management etc. to certain patient groups who present prescriptions for dispensing. Also, this service has involvement in local public health campaigns throughout the year, organised by the HWB and NHS England.

The Healthy Living Pharmacy (HLP) framework is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. HLP became an essential service requirement in 2020/21. As such, community pharmacy contractors were required to become an HLP in 2020/21[iii] as agreed in the five-year CPCF; this reflects the priority attached to public health and prevention work.

Pharmacy contractors had to ensure they were compliant with the HLP requirements from 1st January 2021, however the Distance Selling Pharmacy (DSP) website requirements did not have to be complied with until 1st April 2021.

3.1.6. Signposting patients to other health care providers - Pharmacists and their staff will refer patients to other healthcare professions or care providers when appropriate.

3.1.7. Support for self-care - The provision of advice and support by pharmacy staff to enable patients to derive maximum benefit from caring for themselves or their families. The service will initially focus on self-limiting illness, but support for people with long term conditions is also a feature of the service.

3.1.8. Clinical Governance – pharmacists must ensure the following processes are in place:

- Use of standard operating procedures
- Patient safety incident reporting
- Demonstrating evidence of pharmacist Continuing Professional Development
- Operating a complaints procedure
- Compliance with Health and Safety legislation
- Compliance with the Disability Discrimination Act
- Significant event analysis
- Commitment to staff training, management and appraisals
- Undertaking patient satisfaction surveys

Discharge Medicines Service (DMS)

The Discharge Medicines Service (DMS) became a new essential service within the Community Pharmacy Contractual Framework (CPCF) on 15th February 2021.[iv]

[iii] https://www.england.nhs.uk/wp-content/uploads/2020/12/B0274-guidance-on-the-nhs-charges-pharmaceutical-and-local-pharmaceutical-services-regulations-2020.pdf

This service, which all pharmacy contractors have to provide, was originally trialled in the **5-year CPCF agreement**, with a formal **announcement regarding the service** made by the Secretary of State for Health and Social Care in February 2020.

From 15th February 2021, NHS Trusts were able to refer patients who would benefit from extra guidance around new prescribed medicines for provision of the DMS at their community pharmacy. The service has been identified by NHS England Medicines Safety Improvement Programme to be a significant contributor to the safety of patients at transitions of care, by reducing readmissions to hospital.

3.2. Advanced Services

There are eight advanced services[iv] within the NHS community pharmacy contract. Community pharmacies can opt to provide any of these services as long as they meet the necessary requirements. These, together with full service specifications and funding details are available on the PSNC website http://psnc.org.uk/services-commissioning/advanced-services/.

3.2.1. Community Pharmacist Consultation Service (CPCS)

The NHS Community Pharmacist Consultation Service launched on 29th October 2019 as an Advanced Service. Since 1st November 2020, general practices have been able to refer patients for a minor illness consultation via CPCS.

The service, which replaced the **NUMSAS** and **DMIRS** pilots, connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy.

Referrals from general practices is for minor illness, with the service also taking referrals to community pharmacy from NHS 111 (and NHS 111 online for requests for urgent supply of medicine or appliances).

The CPCS aims to relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet their needs. Since the CPCS was launched, an average of 10,500 patients per week are being referred for a consultation with a pharmacist following a call to NHS 111; these are patients who might otherwise have gone to see a GP.

The CPCS provides the opportunity for community pharmacy to play a bigger role than ever within the urgent care system.

3.2.2. Appliance Use Review (AUR)

An Appliance Use Review was the second advanced service, introduced into the NHS community pharmacy contract in April 2010. This service is similar to that above where it relates to patients' prescribed appliances such as leg bags, catheters, and stoma products. This service can be provided by either a community pharmacy or appliance contractors and can be carried out by a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home.

AURs should improve the patient's knowledge and use of any specified appliance by:

- Establishing the way the patient uses the appliance and the patient's experience of such use.

[iv] Medicines Use Reviews, included in previous PNAs, are no longer part of the Advanced Services within the NHS community pharmacy contract.

- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient.
- Advising the patient on the safe and appropriate storage of the appliance.
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted.

3.2.3. Stoma appliance customisation (SAC) service

Stoma appliance customisation was the third advanced service introduced in April 2010. This service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve how long they are used for, thereby reducing waste and unnecessary patient discomfort. This service can be provided by either pharmacy or appliance contractors.

3.2.4. New Medicines Service (NMS)

This service was introduced in October 2011. It can be provided by pharmacies only. The NMS was expanded from the original 4 conditions - asthma / chronic obstructive pulmonary disease (COPD), type 2 diabetes, hypertension and antiplatelet / anticoagulation therapy - the changes were agreed as part of the Year 3 5-year CPCF deal, with these implemented from 1st September 2021:

Additional eligible conditions were added to the service. The rationale for selection of the conditions mirrors that used in identifying the original four therapy areas/conditions: firstly, there is evidence from research that adherence to medication in this condition could be improved, and secondly that reviews of available research suggest these are areas where community pharmacists are best able to support improvements in patient understanding and adherence to treatments. Conditions included are:

- Asthma and COPD:
- Diabetes (Type 2);
- Hypertension;
- Hypercholesterolaemia;
- Osteoporosis;
- Gout;
- Glaucoma;
- Epilepsy;
- Parkinson's disease;
- Urinary incontinence/retention;
- Heart failure;
- Acute coronary syndromes;
- Atrial fibrillation;
- Long term risks of venous thromboembolism/embolism;
- Stroke / transient ischemic attack; and
- Coronary heart disease.

The antiplatelet/anticoagulant therapy eligibility continues, but it is now included in the above list by reference to the underlying condition/reason for prescribing.

Contractors who have received an exemption from the requirement to have a consultation room (due to their premises size) from their regional NHS England team, can provide the service remotely or at

the patient's home. All other contractors providing the service can similarly continue to provide the service remotely, where appropriate, and in the patient's home.

- The cap on the number of NMS which can be provided by contractors increased from 0.5 percent to one percent of monthly prescription volume and additional bandings were included;
- The service can be offered to support parents/guardians/carers of children and adults newly prescribed eligible medicines who could benefit from the service, but where the patient is not able to provide informed consent; and
- A catch-up NMS was introduced for 2021/22 to provide support to patients who were prescribed a new medicine during the COVID-19 pandemic but who did not receive the NMS at that time. This catch-up NMS also supports patients identified through the Pharmacy Quality Scheme who have missed inhaler technique checks to optimise use of their inhaler.

The pharmacist provides advice about the medicine at the point when the patient is prescribed a new medicine. If the patient wishes to accept the NMS arrangements are then regarding the intervention method, typically 7-14 days after patient engagement. This may be face-to-face in the pharmacy's consultation room or alternatively via telephone or video consultation. The pharmacist will provide advice and further support and where no problems have been identified, will agree a time for the follow up stage, typically between 14 and 21 days after the intervention stage. All stages of the service provide an opportunity for healthy living advice to be provided, as appropriate to the individual.

3.2.5. NHS Influenza Vaccination Programme

Research has shown that immunisation services can be safely provided in community pharmacy settings,[6] and that the review of medication records is a useful tool in flagging up those 'at risk' and inviting them to take part in the programme.[7] Such programmes are also well received by both patients and doctors.[8]

As part of the community pharmacy funding settlement, community pharmacies in England are now able to offer a seasonal influenza 'flu' vaccination service for adults in at-risk groups, as outlined in the annual flu letter.

The pharmacy service is not available for children who are eligible under the overarching NHS Influenza Vaccination Programme. They will continue to receive the vaccination through their usual primary care provision.

This service is the fifth advanced service in the English CPCF. Immunisation is one of the most successful and cost-effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health. For most healthy people, influenza is an unpleasant but usually self-limiting disease. However those with underlying disease are at particular risk of severe illness if they catch it. The aim of the seasonal influenza vaccination programme is to protect adults who are most at risk of serious illness or death should they develop influenza, by offering protection against the most prevalent strains of influenza virus.

The service can be provided by any community pharmacy in England that fully meets the requirements for provision of the service and has notified NHS England of their intention to begin providing the service, by completing a notification form on the NHS Business Services Authority (NHSBSA) website.

3.2.6 Hepatitis C testing service

The UK Government is a signatory to the World Health Assembly resolution and World Health Organization (WHO) goal of eliminating Hepatitis C virus as a major public health threat by 2030.

In 2015, NHS England established 22 Operational Delivery Networks to support treatment and testing efforts across the country and over 50,000 patients have been treated so far, with around 95% being cured of the disease.

The advanced service is part of NHS England's national programme to eliminate the Hepatitis C virus by 2025, five years earlier than the World Health Organization goal. The service uses community pharmacies to target people who inject drugs (PWIDs) for testing, as they are the healthcare venue most likely to be visited by that group of people.

The Community Pharmacy Hepatitis C Antibody Testing Service was added to the Community Pharmacy Contractual Framework (CPCF) in 2020, commencing on 1st September. The introduction of this new Advanced Service was originally trialled in the 5-year CPCF agreement, but its planned introduction in April 2020 was delayed by five months because of the COVID-19 pandemic.

The overall aim of the service is to increase levels of testing for Hepatitis C virus amongst PWIDS who are not engaged in community drug and alcohol treatment services to:

a) increase the number of diagnoses of Hepatitis C infection;
b) permit effective interventions to lessen the burden of illness to the individual;
c) decrease long-term costs of treatment; and
d) decrease onward transmission of Hepatitis C.

As the national Hepatitis C Programme is an elimination exercise, the service will be time limited. In the first instance ran until 31st March 2022, but in March 2022, NHS England, the Department of Health and Social Care and PSNC agreed that the service should continue to be commissioned until 31st March 2023.

3.2.7. Hypertension Case Finding Service

In February 2019, as part of the Cardiovascular Disease (CVD) Prevention System Leadership Forum, NHS England published new national ambitions for the detection and management of high-risk conditions.

The ambition for hypertension is that 80% of the expected number of people with high blood pressure (BP) are detected by 2029, and that 80% of the population diagnosed with hypertension are treated to target levels of BP.

At the time of publication of the NHS Long Term Plan, NHS England and Public Health England (PHE) estimated that fewer than 60% of people with hypertension had been diagnosed, with an estimated 5.5 million people having undiagnosed hypertension across the country.

The Community Pharmacy Hypertension Case-Finding advanced Service has been added to the NHS Community Pharmacy Contractual Framework (CPCF) as part of year three of the five-year CPCF deal. The service will support the NHS Long Term Plan ambitions for prevention of cardiovascular disease.

There are two stages to the service - the first is identifying people at risk of hypertension and offering them blood pressure measurement (a 'clinic check'). The second stage, where clinically indicated, is offering ambulatory blood pressure monitoring (ABPM). Patients identified with high or very high blood pressure will be referred to their general practice.

The service aims to:

• Identify people with high blood pressure aged 40 years or older (who have previously not had a confirmed diagnosis of hypertension) referring them to general practice to confirm diagnosis and for appropriate management;

• At the request of a general practice, undertake ad hoc clinic measurements and ABPM; and

• Provide another opportunity to promote healthy behaviours to patients.

The service will support the work that both general practices and wider Primary Care network (PCN) teams will be undertaking on CVD prevention and management, under changes to the PCN Directed Enhanced Service which **commenced on 1st October 2021.**

Contractors opting to provide the service must undertake both stages of it, where clinically required, i.e. it is not possible to just undertake clinic BP readings and not ABPM.

3.2.8. Stop Smoking

The 5-year Community Pharmacy Contractual Framework (CPCF) agreement reached in July 2019 included the proposal that stop smoking support for those beginning a programme of smoking cessation in secondary care and referred for completion in community pharmacy should be piloted.

NHS England have piloted the service in several hospitals. Following the initial findings of the pilot the Department of Health and Social Care (DHSC) and NHS England proposed the commissioning of a new Stop Smoking service, as an Advanced Service, in the Year 3 negotiations. This pilot ran from 14 September 2020 to 31 January 2022.

Patients admitted to hospital will be offered smoking cessation support during their admission and upon discharge will receive a referral to a community pharmacy of choice for continuing treatment, advice and support with their attempt to quit smoking.

Currently smoking cessation services exist in secondary care, primary care and community services. This service aims to address the gap in the handover between secondary care and primary care, testing a model for transferring the care and creating capacity in primary care with a service commissioned through community pharmacy.

This service enables NHS trusts to refer patients discharged from hospital to a community pharmacy of their choice to continue their smoking cessation care pathway, including providing medication and behavioural support as required; in line with the NHS Long Term Plan care model for tobacco addiction. Only patients who have been referred during their discharge from secondary care are eligible to receive advice and treatment under this service. An electronic transfer of data to support the referral will be sent from secondary care to a participating local community pharmacy.

Patients who wish to consult another healthcare provider for smoking cessation support are still free to do so. Patients being referred through this pathway have already agreed to be referred to community pharmacy.

Information on these services downloaded 12/11/21 from:

https://psnc.org.uk/services-commissioning/advanced-services/stop-smoking-advanced-service/

and https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/smoking-cessation-referral-secondary-care-community-pharmacy-service-pilot

3.3. Enhanced Services

Enhanced services are those commissioned, developed and negotiated locally based on the needs of the local population. They are commissioned by NHS England either directly or on behalf of other organisations such as local authority public health teams or clinical commissioning groups. The PNA will inform the future commissioning need for these services. The term local enhanced services can only be used to describe services commissioned by NHS England.

3.3.1. Antiviral Stock Holding Service

This is specifically (although not exclusively) to support the patient pathway for access to antiviral medication to protect patients exposed to influenza 'flu' or Influenza-like illness (ILI) in an institution or care setting providing accommodation and care for people who are unable to look after themselves (e.g. care home).

Following declaration of an outbreak of Flu or ILI in a care setting Oseltamivir (Tamiflu) medication in specified amounts and dosages are expected to be in stock for dealing with public health emergencies. The stock is accessed via local NHS (formerly CCG) prescribing arrangements to provide prescriptions for affected patients or residents in the case of an influenza outbreak.

The pharmacy dispenses against these prescriptions and will arrange (where required) to have the stock delivered or couriered to the care home. Medication should be administered within 48 hours of a confirmed outbreak and as such this courier arrangement is to facilitate supply should the care home have difficulty in accessing the pharmacy. The pharmacies are available 365 days a year and their opening hours are published as part of the NHS England rota arrangements.

Outside of bank holidays or weekends the care homes normal dispensing pharmacy may easily be able to furnish such prescriptions within the defined timescales. As such this arrangement is designed to support the periods where access to the care homes pharmacy may be more difficult e.g. bank holidays or weekends.

3.4 Locally commissioned services

Under the current regulations "locally commissioned services" may still be developed and negotiated based on the needs of the local population. These services can be commissioned from a pharmacy by the local authority public health teams (LAPHT) or NHS organisations.

It is possible for neighbouring organisations to commission similar services from pharmacies at differing remuneration rates or using different service specifications / patient group directions. This is because financial / commissioning arrangements for services are based on local negotiation and are

dependent on available resources as well as local need. This does however lead to duplication of effort for commissioning staff and difficulties for locum pharmacists working across place-based boundaries. Wherever possible commissioners are advised to work together to eliminate such anomalies and provide continuity of patient care across local boundaries.

The continuity of local service provision is often difficult for contractors to achieve as individual pharmacists/locums who are accredited to provide these services may move around. Thus gaps in service can appear especially if training isn't available for new staff. This should be addressed by both the contractors and commissioners but may result in some of the information in this document relating to local service provision being subject to change. This has improved with self-declaration of competency.

Pharmacy based locally commissioned services will vary from area to area depending on needs. A full list of which pharmacy is commissioned to provide which service is included in Appendix 4. Service specifications for each can be found on the LPC website[v]. In Halton, the following are commissioned by either the NHS or LAPHT:

- Minor ailment management – Care at the Chemist (NHS)
- On demand palliative care services (NHS)
- Minor Eye Conditions Pharmacy Service (NHS) *** new since the 2018-2021 PNA**
- Emergency hormonal contraception provision (LAPHT via Axess Integrated Sexual Health Service, Liverpool University Hospitals NHS Foundation Trust)
- Substance misuse medication services: Supervised consumption (LAPHT)
- Substance misuse services: needle exchange scheme (LAPHT)
- Smoking cessation services (LAPHT):
    - Nicotine Replacement Therapy vouchers,
    - intermediate smoking cessation support
    - Varenicline provision (via a PGD)

3.5. Funding the pharmacy contract

The essential and advanced services of the community pharmacy contract are funded from a national 'Pharmacy Global Sum' agreed between the PSNC and the Treasury. This is divided up and devolved to NHS England as a cash-limited budget which is then used to reimburse pharmaceutical service activity as per the Drug Tariff (www.drugtariff.com). Funding for locally commissioned services is identified and negotiated from commissioners' own budgets.

[v] https://psnc.org.uk/halton-st-helens-and-knowsley-lpc/services/services-commissioned-within-halton/public-health-services-in-halton/

3.6. Community pharmacy contract monitoring

3.6.1. National contract

NHS England requires all pharmaceutical service providers to meet the high standards expected by patients and the public. All Pharmacies are included within a programme of contract monitoring visits as independent providers of services provided under the national pharmacy contract. The delivery of any locally commissioned enhanced services is also scrutinized.

As stated within the NHS review 2008,[9] high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual. This statement is as meaningful to pharmacies as to other NHS service providers and is the principle that the NHS England adopts when carrying out the Community Pharmacy Contract Monitoring visits for essential, advanced services and locally commissioned enhanced services.

The community pharmacy contract assurance process follows a structured sequence of events including:

- A rolling programme of pre-arranged visits to pharmacies for observation of processes and procedures and a detailed interview with the pharmacist in charge and support staff
- Self-assessment declarations
- Scrutiny of payment submission processes
- Scrutiny of internal processes for confidential data management
- Recommendations for service development or improvement
- Structured action plan with set timescales for completion

In addition to the structured process outlined above, the NHS England will also take account of the voluntary submission of the findings from the annual community pharmacy patient questionnaire that is undertaken by the pharmacy contractor as well as any patient complaints relevant to pharmacy services. In cases where the professional standards of an individual pharmacist is found to fall below the expected level, the NHS England will work with the relevant professional regulatory body such as the General Pharmaceutical Council to ensure appropriate steps are taken to protect the public.

3.6.2. Locally commissioned public health services

Halton Borough Council has developed a provider assessment process to support the commissioning of locally commissioned public health pharmacy services. The council supports the local provision of:

- Emergency hormonal contraception (EHC)
- Smoking cessation services
- Substance misuse services

Pharmacies seeking to provide any of the above services need to register on the council's electronic procurement system and complete a mandatory service questionnaire and quality questions to ensure that they meet the required minimum standards. They must also complete all of the relevant qualifications / training to deliver these services and submit a self-declaration of competency.

Services are monitored on a monthly basis using an electronic reporting tool and quality visits are conducted to premises on at least an annual basis.

3.6.3. Locally commissioned NHS services

There are three locally commissioned NHS services:

- Minor ailments service – Care at the Chemist
- On demand access to palliative medicines
- Minor Eye Conditions Pharmacy Service

Up to 1 July 2022, pharmacies seeking to provide any of the above services contacted the Medicines Management Team at the CCG. There is a requirement to complete all of the relevant qualifications and/or training to deliver these services. Services are monitored on a regular basis using an electronic reporting tool or via monthly stock checks, communication with providers and feedback from patients and healthcare professionals. It is anticipated that through the integrated 'place' working that the NHS can work with the local authority public health team to continue to review the monitoring and procurement process to ensure it is robust.

4. Overview of current providers of Pharmaceutical Services

4.1. Community Pharmacy Contractors

Community pharmacy contractors can be individuals who independently own one or two pharmacies or large multinational companies e.g. Lloyds, Boots, Sainsbury's etc. who may own many hundreds of pharmacies UK wide.

Halton has 34 "pharmacy contractors" who between them operate out of a total of 30 community pharmacy premises, plus 4 distance selling 'internet' pharmacies.

Based on the number of community pharmacies (as at 1 June 2021) as a rate per 100,000 GP registered population (as at 1 August 2021), Halton has a larger number of pharmacies in relation to the size of its population (22.3 per 100,000) when compared to the England (19.3 per 100,000). However it is a slightly smaller number compared to Cheshire & Merseyside (23.5 per 100,000) and the North West (23.1 per 100,000 population).

Every pharmacy premise has to have a qualified pharmacist available throughout all of its contractual hours, to ensure services are available to patients. In general pharmacy services are provided free of charge, without an appointment, on a "walk–in" basis. Pharmacists dispense medicines and appliances as requested by "prescribers" via both NHS and private prescriptions.

In terms of the type of community pharmacies in our area there are:

25 - delivering a minimum of 40 hours service per week
5 - delivering a minimum of 100 hours service per week, one in Runcorn and 4 in Widnes
4 - providing services via the internet or "distance selling", all located in Runcorn

Further details of community pharmacies operating in Halton can be found in Chapter 5 of this PNA, as well as in Appendix 3 & 4.

4.2. Dispensing Doctors

Dispensing doctors services consist mainly of dispensing for those patients on their "dispensing list" who live in more remote rural areas. There are strict regulations which stipulate when and to whom doctors can dispense. Halton has **9** dispensing doctor practices, 6 located in Widnes and 3 in Runcorn.

4.3. Appliance Contractors

These cannot supply medicines but are able to supply products such as dressings, stoma bags, catheters etc. Currently Halton **does not have** an appliance contractor physically located within its area, but patients can access services from appliance contractors registered in other areas.

4.4. Local Pharmaceutical Services (LPS)

This is an option that allows commissioners to contract locally for the provision of pharmaceutical and other services, including services not traditionally associated with pharmacy, within a single contract. Given different local priorities, LPS provides commissioners with the flexibility to commission services that address specific local needs which may include services not covered by the community pharmacy contractual framework. There are currently **no** LPS contracts in Halton.

4.5. Acute Hospital Pharmacy Services

There are 2 main Acute Hospital Trusts within Halton catchment area: St Helens & Knowsley Teaching Hospital NHS Trust and Warrington and Halton Hospital NHS Foundation Trust. Some Halton residents may also access services at the Countess of Chester Hospital NHS Foundation Trust and other hospitals. Hospital Trusts have pharmacy departments whose main responsibility is to dispense medications for use on the hospital wards for in-patients and during the out-patient clinics.

4.6. Mental Health Pharmacy Services

The population of Halton is served by the Mersey Care NHS Foundation Trust. As of 1 June 2021, Mersey Care NHS Foundation Trust completed the acquisition of North West Boroughs Healthcare NHS Foundation Trust to provide an enlarged range of mental health and community health services across Merseyside, Cheshire and the North West region. They employ pharmacists to provide clinical advice within their specialist areas and they also commission a "dispensing service" from a community pharmacy in order to dispense the necessary medications for their patients at the various clinics across the patch.

4.7. GP Out of Hours Services and Urgent Care Centres

There is currently one 'out of hours' service operating from two locations. The service also visits patients within their own homes if necessary. Since 1st April 2021 there is now one provider across all areas across Merseyside and this supports a more consistent and efficient service for patients. The provider covers Halton, Knowsley, Liverpool, a number of practices in St Helens, South Sefton, Southport & Formby and Warrington, serving a patient population of just over 1.3 million. All patients received into the service are triaged by a GP over the phone prior to a decision being made regarding the medical care they may require. This consultation may result in a face-to-face consultation or a home visit from one of their GPs. During normal pharmacy opening hours, patients who subsequently require a medicine are provided with a prescription that is usually sent electronically to a local community pharmacy. During evenings and part of the weekends, when pharmacy services may be more limited, patients may be provided with pre-packaged short courses of medication directly or a prescription may need to be sent to a pharmacy outside of the local area i.e. outside of Halton. By default this service operates a limited formulary and tends to provide medications needed for immediate, acute use.

There are two Urgent Treatment Centres (UTC) in Halton that can see patients for urgent injuries or illnesses and will provide access to any medication deemed necessary as a result. Access to medication will be via a Patient Group Direction, Patient Specific Direction or via a prescription to take to their local pharmacy. This will depend on the nature of the problem and the medication required.

Consideration is given to the availability of pharmacy services in the out of hours period, at weekends and bank holidays to ensure patients do not experience undue delay in accessing urgent treatment.

The Widnes UTC is located at the Health Care Resource Centre, Caldwell Road off Ashley Way. It is open 8am to 8pm 7 days a week. The Runcorn UTC is located at the Halton Hospital site. It is open 8am to 9pm 7 days a week.

4.8. Bordering Services / Neighbouring Providers

The population of Halton can access services from pharmaceutical providers not located within the local authority's own boundary. When hearing pharmacy contract applications or making local service commissioning decisions, the accessibility of services close to the borders will need to be taken into account. For further information on such services please refer to the relevant neighbouring Health and Wellbeing Boards' own PNA.

4.9 Quality Standards for Pharmaceutical Service Providers: Community Pharmacy Assurance Framework

The NHS England area team requires all pharmaceutical service providers to meet the high standards expected by patients and the public. All Pharmacies providing NHS services are included within a programme of assurance framework monitoring visits. The delivery of any locally commissioned services are scrutinised by the commissioner of each of the services under separate arrangements. As stated within the NHS review 2008, high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. This statement is as meaningful to pharmacies as to other NHS service providers and is the principle that the NHS England area team adopts when carrying out the Community Pharmacy Assurance Framework Monitoring visits for essential and advanced services.

The Community Pharmacy Assurance Framework process follows a structured sequence of events including:

- Self-assessment declarations.
- A rolling programme of pre-arranged visits to pharmacies for observation of processes and procedures and a detailed interview with the pharmacist in charge and support staff.
- Scrutiny of internal processes for confidential data management.
- Recommendations for service development or improvement.
- Structured action plan with set timescales for completion.

In addition to the structured process outlined above, the NHS England team will also take into account findings from the annual community pharmacy patient questionnaire that is undertaken by the pharmacy contractor as well as any patient complaints relevant to pharmacy services. In cases where the professional standards of an individual pharmacist is found to fall below the expected level, the NHS England area team will work with the relevant professional regulatory body, such as the General Pharmaceutical Council, to ensure appropriate steps are taken to protect the public.

Pharmaceutical Needs Assessment

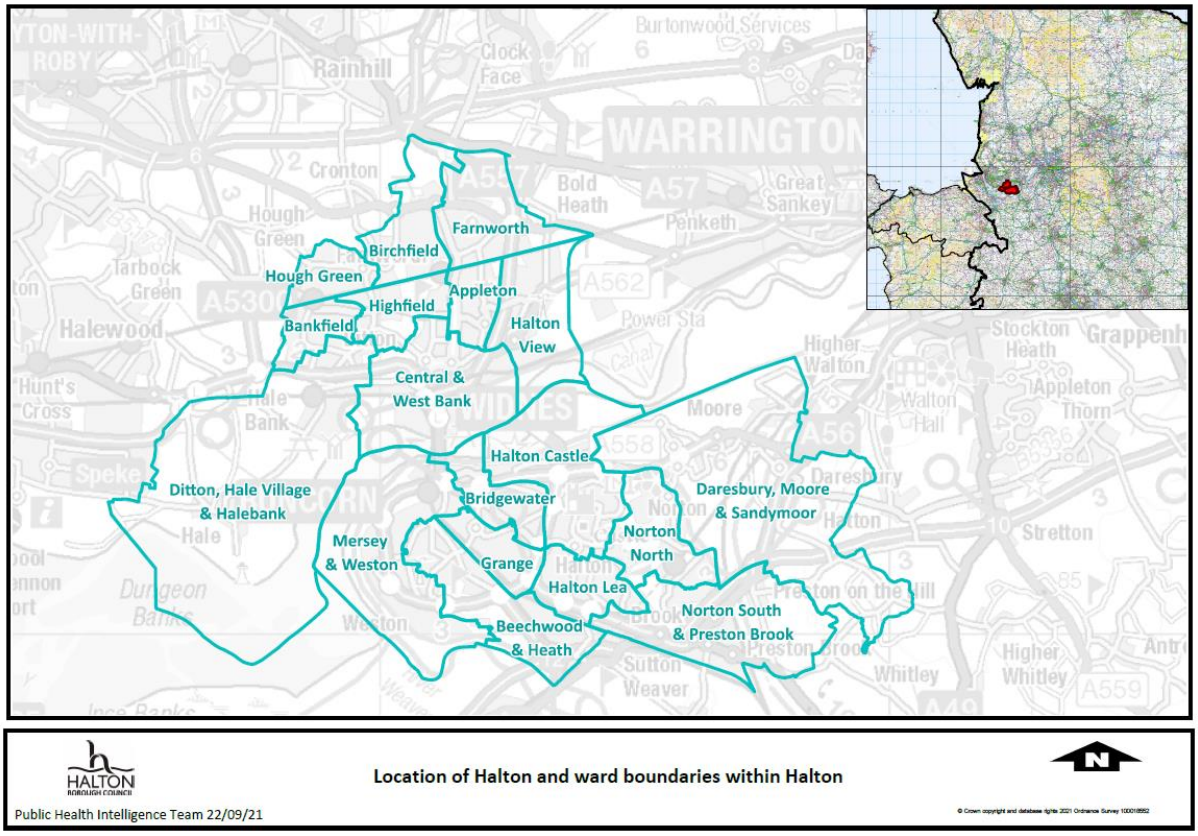
Part 2: Health needs based on demography, localities and linked to JSNA

5. Population Profile of Halton

5.1. Location

Halton is located on the Mersey estuary and is made up of the towns of Runcorn and Widnes. It has a legacy of chemical industry and 1960s Runcorn New Town development providing an influx from the neighbouring city of Liverpool. With the reduction of the chemical industry the area has struggled with high local unemployment rates. Newer service and communication industry developments have taken place in Daresbury and Manor Park and the science park has high quality laboratories.

Map 1: Location of Halton Borough



5.2. Population Structure and Projections

The estimated resident population of an area includes all people who usually live there, whatever their nationality. Members of UK and non-UK armed forces stationed in the UK are included whilst UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

5.2.1. Resident population

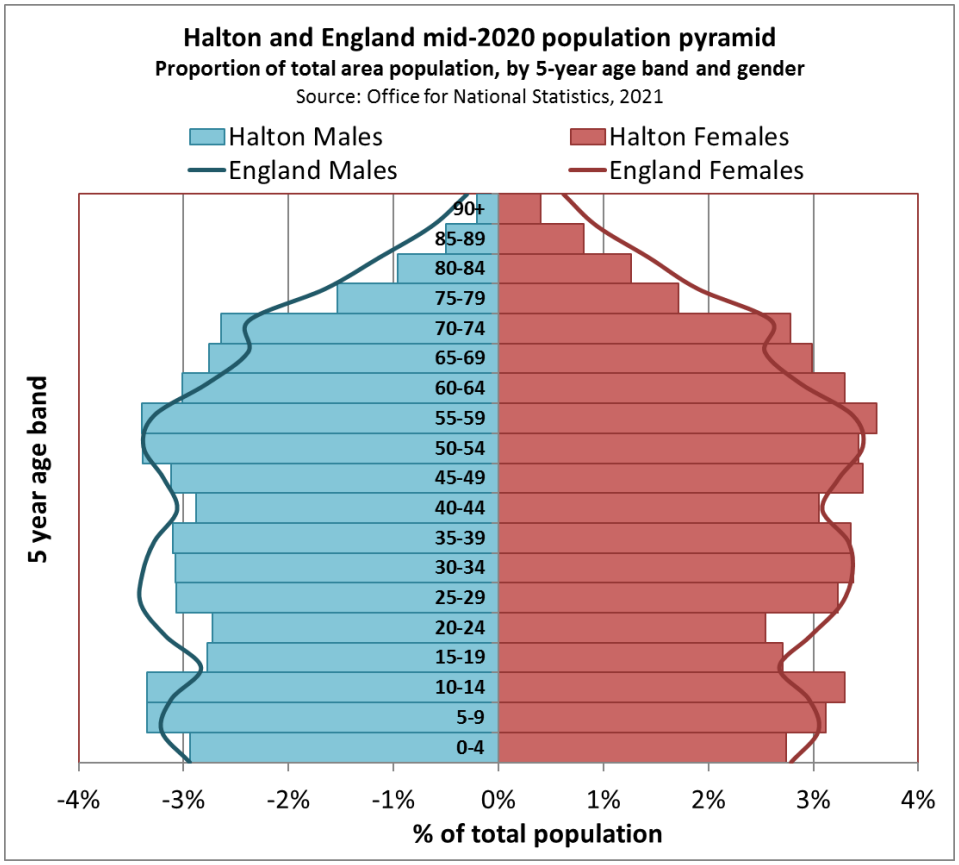
Population estimates are **estimates** of what the resident population make-up should look like at that time, based on previous years' births, deaths and net migration. Office for National Statistics (ONS) mid-2020 population estimates:

- 129,759 people live in Halton
- 49% of these are male and 51% female (63,295 and 66,464 respectively)

The population age structure is detailed in Figure 2. Compared to the England average the resident population of Halton has a slightly different structure in the following ages:

- Ages 10-14 year olds: slightly larger proportion than England
- Age bands covering 20-44 year olds: smaller proportion than England for males
- Age bands covering 55-74 year olds: larger proportion than England
- Age bands covering 75+ year olds: smaller proportion than England

Figure 2: Halton resident population compared to England, mid-2020 estimated age and gender structure



5.2.2. GP Registered Population

The majority of people who reside in Halton are registered with a Halton GP for their primary health care. However, there is not a 100% match. People who move into and out of the borough may prefer to stay with their original GP. This means some people residing in neighbouring boroughs are registered with Halton GPs and some Halton residents will be on a GP register outside the borough. There are more people registered with a Halton GP than there are residents, 134,894 registered (as at September 2021) compared to 129,759 resident (2020 mid-year estimate).

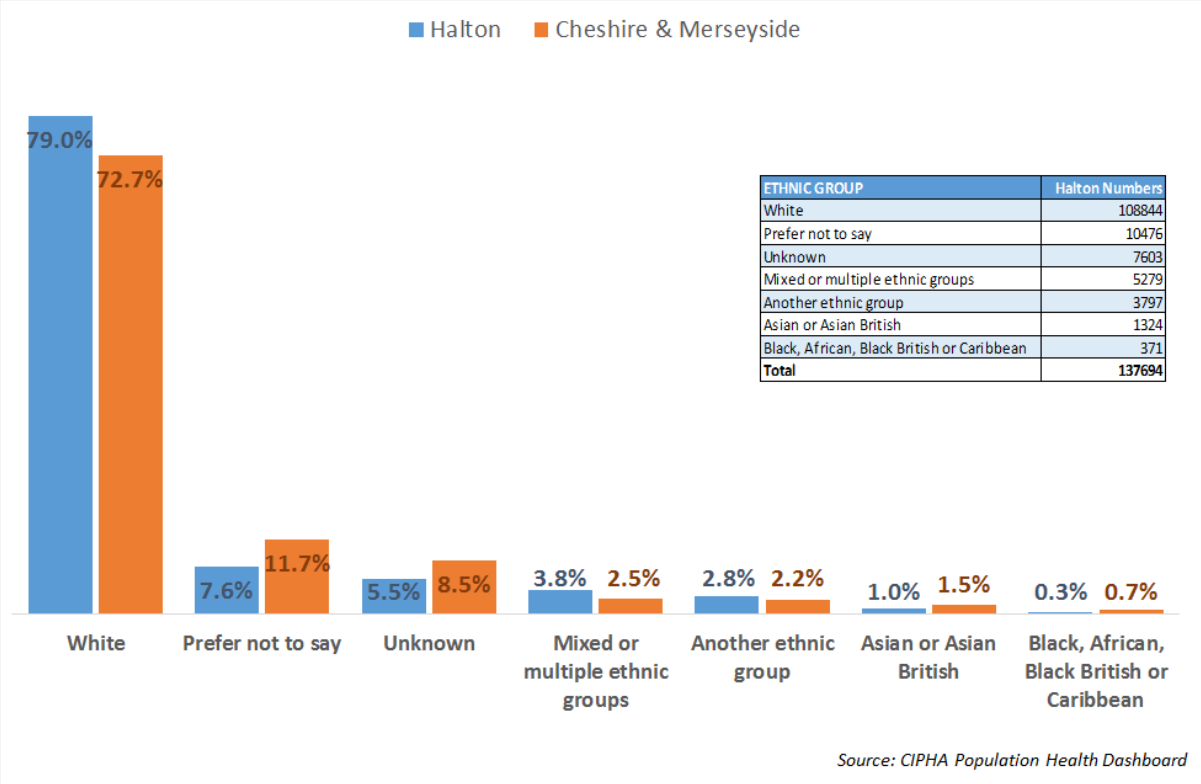
5.2.3. Ethnicity

In terms of ethnic breakdown of the population, data has only routinely been available from each Census. Census data, published by the ONS, is the gold standard for ethnicity recording in England and Wales. However the 2011 Census data is now 10 years old and may no longer reflect the ethnic breakdown of the current population. Data from the 2021 Census had not been published at the time

this PNA was drafted. However, a recent 2020 Cheshire & Merseyside development, the Combined Intelligence for Population Health Action (CIPHA), a programme established initially for Covid-19 surveillance, is now able to provide near real-time data for population health. As long as an individual is registered with a GP in Cheshire and Merseyside, it is able to use the GP records, assign the person to their local authority of residence, and provide some demographic breakdowns including broad ethnic categories.

Data as at 19 October 2021 shows that Halton has a larger white population than Cheshire & Merseyside as a whole, as well as a slightly larger as mixed or multiple ethnic group. However it has a smaller proportion of Asian and black ethnic groups.

Figure 3: Cheshire & Merseyside GP registered population living in Halton, by broad ethnic group



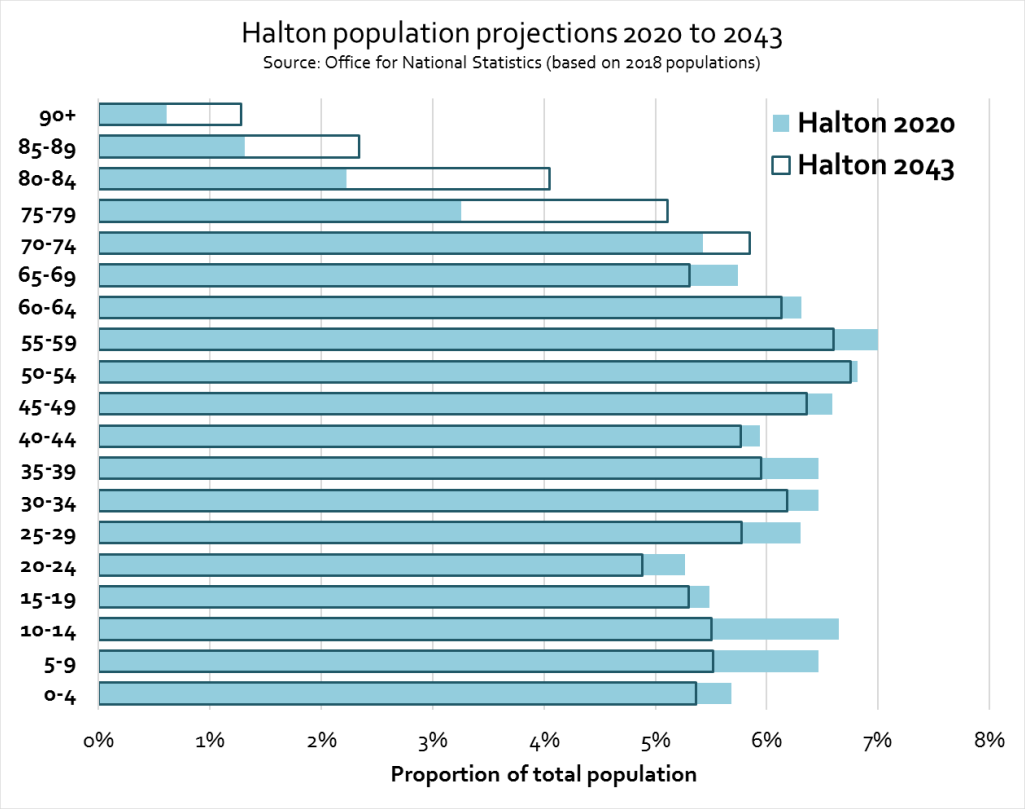
ETHNIC GROUP	Halton Numbers
White	108844
Prefer not to say	10476
Unknown	7603
Mixed or multiple ethnic groups	5279
Another ethnic group	3797
Asian or Asian British	1324
Black, African, Black British or Caribbean	371
Total	**137694**

Source: CIPHA Population Health Dashboard

5.2.3. Resident Population Forecasts

Halton's population structure is predicted to shift over the next decade. Figure 4 shows all age groups aged under 70 are forecast to decrease proportionally between 2020 and 2043, particularly those ages 5-14. Conversely, the proportion of those aged 75 and over is predicted to increase from 7.4% of Halton's population to 12.8%. This is an increase of around 7,900 people. The working population, i.e. aged 16-64 years of age, is forecast to shrink proportionally. This 'ageing population' is likely to increase pressures on NHS and social care as this age group makes up a disproportionately large percentage of GP consultations, hospital admissions and social services. This is likely to have an impact on prescribing levels and therefore pharmacy workload, assuming current prescribing patterns persist.

Figure 4: Population projections 2020 to 2043



The projections form a "baseline" view of what the population dynamics would be in the given areas if recent demographic trends were to continue into the future. It is important to note that these projections are consistent across England as a whole.

- In the short term (2020 - 2025) Halton's population is projected to grow by less than 2% from 129,800 to 131,800.
- In the medium term (2020 - 2030) Halton's population is projected to grow by almost 3% from 129,800 to 133,500.
- In the long term (2020 - 2043) Halton's population is projected to grow by almost 6% from 129,800 to 137,400. This is lower than the North West region which is projected to grow by almost 9% and nationally, which is projected to grow by 7.5%.
- Younger people (0 - 15 year olds) - population projected to be smaller, both in total numbers and as a proportion of the total population (2020 - 2043) – this is the case for Halton, the North West and England.
- Working age (20 - 64 year olds) - population projected to be similar in terms of total numbers, whilst shrinking very slightly as a proportion of the total population (2020 - 2043) – this is the case for Halton, the North West and England.
- Older people (75+) - population projected to grow by almost 83% from 9,600 in 2020 to 17,500 in 2043. A large increase is also forecast in the North West (60%) and England (67%).

5.3. Populations with Protected Characteristics

There is widespread evidence to demonstrate that some communities, such as people from ethnic minority groups and people from lesbian, gay, bisexual and transgender (LGBT) communities, can experience worse health outcomes. Other groups, such as refugees and asylum seekers and disabled people may face barriers to accessing health and social care services as well as support services to move into good employment. This can have an impact on their health and wellbeing.

Under the Equality Act 2010 there are 9 'Protected Characteristic' groups. The numbers and main health issues facing each are detailed in this section. Whilst some of these groups are referred to in other parts of the PNA, this section focusses on their particular health issues.

5.3.1. Age

Population

See section 5.2 for detailed breakdown

- Under age 18: 28,845 (22.2% of total population)
- 18-64: 76,809 (59.2% of total population)
- 65-74: 14,498 (11.2% of total population)
- 75+: 9,607 (7.4% of total population)
- Total population 129,759 (ONS 2020 mid-year population estimate)

Health issues

Health issues tend to be greater amongst the very young and the very old.

For children:

- Breast feeding is well evidenced to provide health benefits for both mother and baby and to promote attachment. Young mothers are among the groups least likely to breast feed.
- More than eight out of 10 adults who have ever smoked regularly started before the age of 19.
- Eight out of 10 obese teenagers go on to become obese adults.
- Nationally the diagnosis of sexually transmitted infections in young people, such as Chlamydia, has increased by 25% over the past ten years. Young people's sexual behaviour may also lead to unplanned pregnancy which has significant health risks and damages the longer term health and life chances of both mothers and babies.
- Alcohol misuse is contributing to increased pressure on a wide range of agencies including health, housing, social care, police and the voluntary sector.

For older people (65+):

- They are less likely to smoke or drink alcohol to riskier levels. They are less likely to take drugs although the age of people in alcohol & substance misuse services is increasing.
- A high proportion of people aged 65+ live alone and this percentage increases with age. This can lead to loneliness and social isolation.
- The proportion of the population with long-term conditions increases with age.

5.3.2. Sex

Population

See section 5.2 for detailed breakdown

- Women 66,464 (51.2%)
- Men 63,295 (48.8%)

Health issues

- Overall life expectancy (LE), healthy life expectancy (HLE) and life expectancy at 65 are lower for Halton residents than the England average.
- Male LE for all these measures is lower than females.
- Internal variation, i.e. at Halton deprivation decile and electoral ward level, is higher for men than for women.
- Men tend to use health services less than women and present later with diseases than women do. Consumer research by the Department of Health and Social Care into the use of pharmacies in 2009 showed men aged 16 to 55 to be 'avoiders' i.e. they actively avoid going to pharmacies, feel uncomfortable in the pharmacy environment as it currently stands due to perceptions of the environment as feminised/for older people/lacking privacy and of customer service being indiscreet.
- The mortality rate for coronary heart disease is much higher in men and men are more likely to die from coronary heart disease prematurely. Men are also more likely to die during a sudden cardiac event. Women's risk of cardiovascular disease in general increases later in life and women are more likely to die from stroke.
- The proportion of men and women who are obese is roughly the same although men are markedly more likely to be overweight than women. Present trends suggest that weight-related health problems will increase among men in particular. Women are more likely than men to become morbidly obese.
- Women are more likely to report, consult for and be diagnosed with depression and anxiety. It is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men as are all forms of substance abuse.
- Alcohol disorders are twice as common in men although binge drinking is increasing at a faster rate among young women. Among older people the gap between men and women is less marked.
- Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex-specific. At the same time cancer morbidity and mortality rates are reducing more quickly for men than women.
- Victims of domestic violence are at high risk of serious injury or death. The majority of victims are female.

5.3.3. Disability

The definition of disability is consistent with the core definition of disability under the Equality Act 2010. A person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. Some people classified as disabled and having rights under the Equality Act 2010 are not captured by this definition, that is people with a long-standing illness or disability which is not currently affecting their day-today activities.

Population

The 2011 Census indicates 26,124 people in Halton have a disability or illness that affects their day-to-day activities; this constitutes 20.9% of Halton's population, higher than the North West (19.8%) and England (17.2%).

The 2020/21 GP Quality Outcomes Framework (QOF) register shows there were 823 people with learning disability (LD) known to their general practice. This is a prevalence rate of 0.61%, compared to 0.56% in Cheshire & Merseyside and 0.53% England.[10]

Data from the 2021 GP Patient survey[11] suggests that 65% of Halton patients surveyed had a long-term physical or mental health condition. Of those, 26% said it affected their daily life a lot and a further 39% said it affected them a little. 35% said it did not affect ability to carry out their day-to-day activities at all. This is based on a representative sample.

Health issues

- There is a strong relationship between physical and mental ill health. Being physically disabled can increase a person's chances of poor mental health.
- Co-morbidity of disabling conditions can occur.
- People with LD are living longer and as a result the number of older people with a LD is increasing. Despite the fact that people with LD are 58 times more likely to die before the age of 50 than the rest of the population, life expectancy for people with LD has increased over the last 70 years. Older people with LD need more to remain active and healthy for as long as possible.
- Despite this data from NHS Digital suggests people with learning disabilities still have a 4-5 times higher mortality rate than those without LD.
- Recent data by PHE suggests those with severe mental illness (SMI) have 2-3 times higher premature (under age 75 years) mortality rates compared to those without SMI. This is driven by higher mortality from cardiovascular disease, cancers and respiratory disease. One other feature is lower cancer screening uptake rates amongst people with SMI.
- Research by the Disability Rights Commission in 2006 found that people with a learning disability are two and a half times more likely to have health problems than the rest of the community.

5.3.4. Pregnancy and maternity

Population

See section 6.2. for fertility rates and live births data.

Health issues

There are many common health problems that are associated with pregnancy. Some of the more common ones are:

- Backache
- Deep vein thrombosis
- High blood pressure and pre-eclampsia
- Itching
- Nosebleeds
- Piles (haemorrhoids)
- Stretch marks
- Tiredness
- Constipation
- Faintness
- Incontinence
- Leaking nipples
- Urinating a lot
- Skin and hair changes
- Swollen ankles, feet, fingers
- Vaginal discharge or bleeding
- Cramp
- Headaches
- Indigestion and heartburn
- Morning sickness and nausea
- Pelvic pain
- Sleeplessness
- Swollen and sore gums, which may bleed
- Varicose veins

5.3.5. Race

Population

See section 5.2.3.

Health issues

- Although ethnic minority groups broadly experience the same range of illnesses and diseases as others, there is a tendency of some within ethnic minority groups to report worse health than the general population and there is evidence of increased prevalence of some specific life-threatening illnesses.
- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, Human Immunodeficiency Virus (HIV), tuberculosis and diabetes.
- An increase in the number of older people from ethnic minority groups is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- Ethnic minority groups may face discrimination and harassment and may be possible targets for hate crime.

Traveller and gypsy communities

Travellers are a group considered to face some of the highest levels of health deprivation, with significantly lower life expectancy, higher infant mortality, and higher maternal mortality alongside mental health issues, substance, misuse and diabetes. These issues are representative of various lifestyle factors alongside issues of poor education, lack of integration with mainstream support services and a lack of trust in such institutions.

Refugees and asylum seekers

Asylum seekers are one of the most vulnerable groups within society often with complex health and social care needs. Within this group are individuals more vulnerable still including pregnant women, unaccompanied children and people with significant mental ill health. Whilst many asylum seekers arrive in relatively good physical health, some asylum seekers can have increased health needs relative to other migrants due to the situation they have left behind them, their journey to the UK and the impact of arriving in a new country without a support network.

Irregular or undocumented migrants such as those who have failed to leave the UK once their asylum claim has been refused, or those who have been illegally trafficked, also have significant health needs and are largely hidden from health services. Some asylum seekers will have been subjected to torture as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical complaints. Stigma may also be attached to mental ill health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and underdiagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area.

5.3.6. Religion and belief

Population

Data from the 2011 Census for Halton residents showed:

- Christian 75.0%
- Buddhist 0.2%
- Hindu 0.2%
- Jewish 0.0%
- Muslim 0.2%
- Sikh 0.0%
- Other religion 0.2%
- No religion 18.7%
- Religion not stated 5.4%

Health issues

- Possible link with 'honour based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals.
- Female genital mutilation is related to cultural, religious and social factors within families and communities although there is no direct link to any religion or faith. It is a practice that raises serious health related concerns.
- There is a possibility of hate crime related to religion and belief.

5.3.7. Marital status

Population

Data from the 2011 Census for Halton showed:

- Single (never married or never registered a same-sex civil partnership): 35.4%
- Married: 44.9%
- In a registered same-sex civil partnership: 0.2%
- Separated (but still legally married or still legally in a same-sex civil partnership): 2.4%
- Divorced or formerly in a same-sex civil partnership which is now legally dissolved: 9.8%
- Widowed or surviving partner from a same-sex civil partnership: 7.2%

Health issues

- Literature on health and mortality by marital status has consistently identified that unmarried individuals generally report poorer health and have a higher mortality risk than their married counterparts, with men being particularly affected in this respect.[12]
- A large body of research suggests that the formalisation of opposite-sex relationships is associated with favourable mental health outcomes, particularly among males. Recent analysis of wave 8 (2016-18) of Understanding Society: the UK Household Longitudinal Study suggests this is also the case for females in same-sex civil partnership.[13]

5.3.8. Sexual orientation

Population

The preferred estimate up until now has been that provided by the Department of Trade and Industry of an LGB population of between 5 to 7%, as provided in the Final Regulatory Impact Assessment: Civil Partnership Act 2004 (DTI, 2004).

The GP Patient Survey for England includes a question relating to sexual orientation. The survey suggests between 92% of Halton CCG patients define themselves as being heterosexual / straight, with 5% stating their sexual orientation as being either Gay/Lesbian (3%) or Bisexual (2%). None defined themselves as Other and 4% preferred not to disclose their sexual orientation. Transgender was not specifically asked about and would likely be included in the 'Other' category.

Health issues

- Attitudes toward the community may have an impact on some of their key health concerns around sexual and particularly mental health. A Stonewall survey[14] found:
- Half of LGBT people (52%) said they've experienced depression in the last year.
- One in eight LGBT people aged 18-24 (13%) said they've attempted to take their own life in the last year.
- Almost half of trans people (46%) have thought about taking their own life in the last year, 31% of LGB people who aren't trans said the same.
- 41% of non-binary people said they harmed themselves in the last year compared to 20% of LGBT women and 12% of GBT men.
- One in six LGBT people (16%) said they drank alcohol almost every day over the last year.
- One in eight LGBT people aged 18-24 (13%) took drugs at least once a month.
- One in eight LGBT people (13%) have experienced some form of unequal treatment from healthcare staff because they're LGBT.
- Almost one in four LGBT people (23%) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In the last year alone, six per cent of LGBT people – including 20% of trans people – have witnessed these remarks.
- One in twenty LGBT people (5%) have been pressured to access services to question or change their sexual orientation when accessing healthcare services.
- One in five LGBT people (19%) aren't out to any healthcare professional about their sexual orientation when seeking general medical care. This number rises to 40% of bi men and 29% of bi women.
- One in seven LGBT people (14%) have avoided treatment for fear of discrimination because they're LGBT.

5.3.9. Gender re-assignment

Population

Currently there are no standard national sources of transgender statistics, nor is there standard data on the use of health services or referrals to gender identity clinics. However, GIRES (the Gender Identity Research and Education Society) estimate that 0.6-1% of the population may experience gender dysphoria.

In the 2021 GP Patient Survey 99% said their gender identity was the same as the sex they were registered at birth, 1% preferred not to say. The national figures showed 1% did not have the same gender identity as the sex they were registered at birth but 0% of Halton registered population sampled said this was the case.

Health issues

Research from Stonewall shows:

- Drugs and alcohol are processed by the liver as are cross-sex hormones. Heavy use of alcohol and/or drugs whilst taking hormones may increase the risk of liver toxicity and liver damage.
- Alcohol, drugs and tobacco and the use of hormone therapy can all increase cardiovascular risk. Taken together, they can also increase the risk already posed by hormone therapy.
- Smoking can affect oestrogen levels, increasing the risk of osteoporosis and reducing the feminising effects of oestrogen medication.
- Many transgender people struggle with body image and as a result can be reluctant to engage in physical activity.
- Being transgender, non-binary or non-gender and any discomfort a person may feel with their body, with the mismatch between their gender identity and the sex originally registered on their birth certificate, their place in society, or with their family and social relationships is not a mental illness. Gender dysphoria is the medical term used to describe this discomfort. Transgender people are likely to suffer from mental ill health as a reaction to the discomfort they feel. This is primarily driven by a sense of difference and not being accepted by society. If a transgender person wishes to transition and live in the gender role they identify with, they may also worry about damaging their relationships, losing their job, being a victim of hate crime and being discriminated against. The fear of such prejudice and discrimination, which can be real or imagined, can cause significant psychological distress.

5.4. Deprivation and socio-economic factors

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

The Indices of Deprivation 2019 (ID 2019) 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.

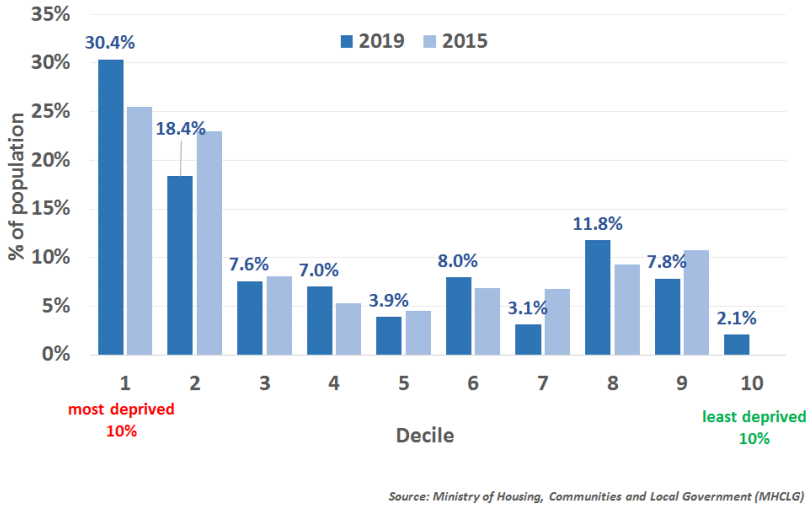
Each LSOA in England is ranked in order of deprivation, and then grouped into ten percentage groups knows as deciles. LSOAs in decile 1 are in the 10% most deprived in the country, and LSOAs in decile 10 are in the 10% least deprived in the country. Halton has 79 LSOAs.

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%**, an increase from 25.5% in 2015. This is almost **6,700** more people, a total of **38,750** Halton residents.

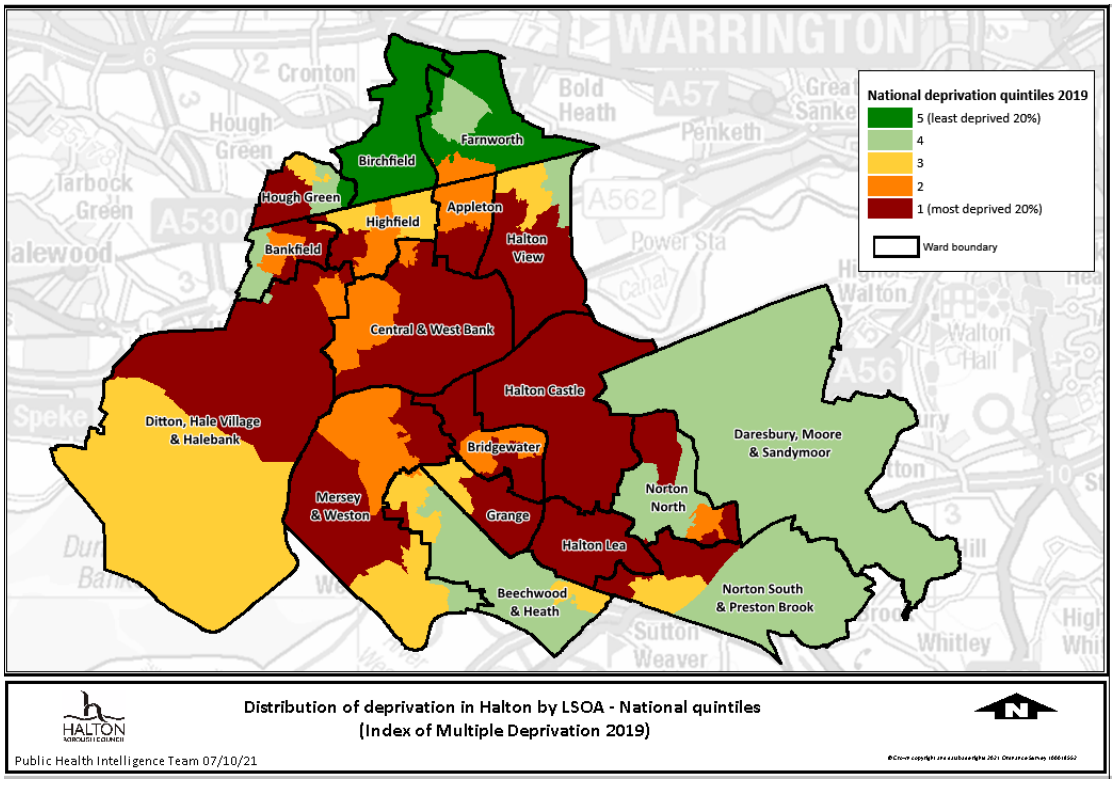
The chart below shows the distribution of Halton's population by national deprivation decile, both in 2019 and 2015.

Figure 5: Halton population distribution by national deprivation decile, IMD 2019 and 2015



The proportion living in the most deprived 20% nationally is almost the same as in 2015: 48.7% up from 48.4%. Map 2 shows the levels of deprivation across the borough, by lower super output area or LSOA (statistical geographical areas of approximately 1,500 population), using national quintiles.

Map 2: Geographical distribution of deprivation, IMD 2019



Halton is ranked as the 23rd most deprived local authority in England (out of 317 local authorities) putting it in the most deprived 10% nationally. In 2015 it was the 27th most deprived local authority, which means that Halton is now relatively more deprived. Deprivation data is not published using the new 2020 Halton wards, but we can see from Map 2 that there are particular pockets of deprivation

in Halton Lea, Halton Castle and around both Runcorn old town and Widnes town centre. Conversely Birchfield and Farnworth are the least deprived wards.

5.5. Future Planning: Housing Developments

The examination into Halton's new Local Plan, the Delivery and Allocations Local Plan (DALP) considered the supply of sites for housing development in the period through to 2037.

- 0-5 years: 'Deliverable' supply of residential sites
- 6-10 years: 'Developable' supply of residential sites
- 11+ years

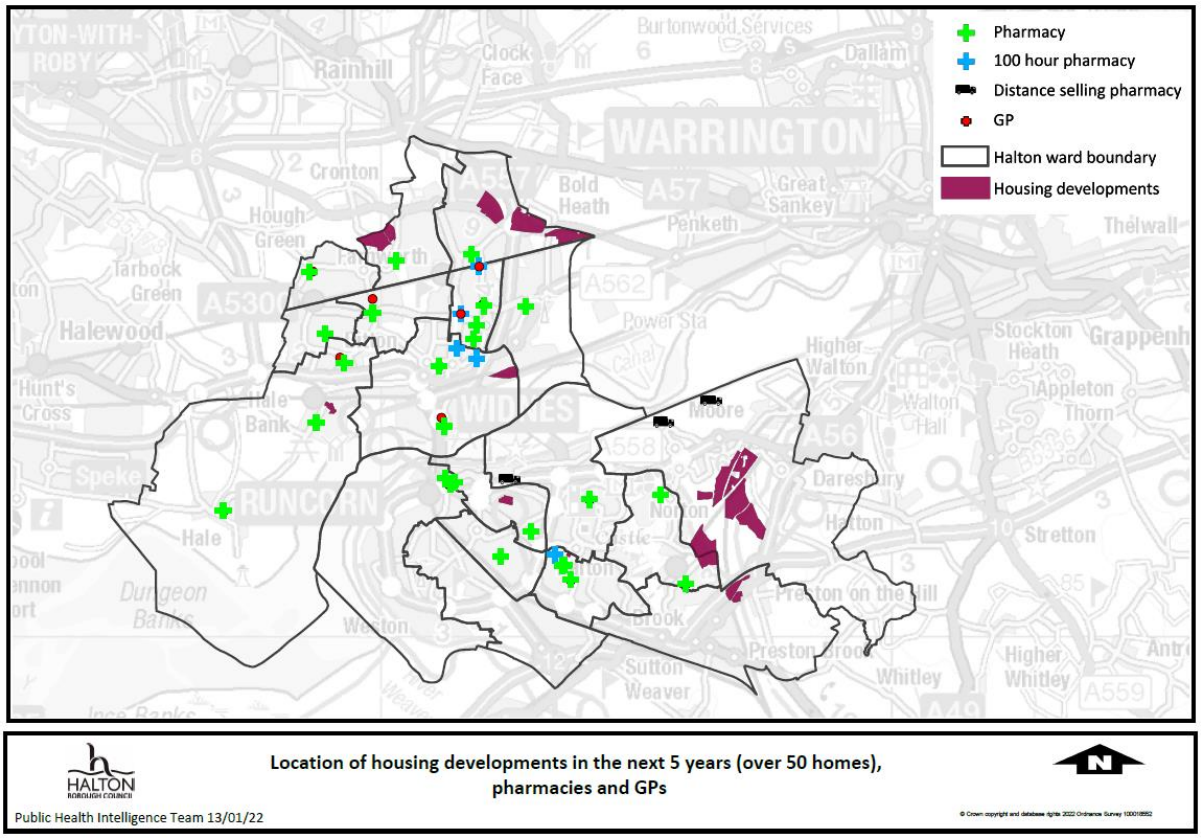
In total the DALP examination identified land supply with a potential for 7,315 dwellings.

The expected potential supply over the next 5 years totals 2,843 dwellings being made up of 1,482 units on sites either under construction or with planning permission, 400 units on other urban sites and 917 units on sites proposed to be released from the Green Belt. In the period beyond the initial 5 years, the DALP projects potential for an additional 4,472 dwellings of which 661 are on sites either under construction or with planning permission, 2,111 are on other urban sites and 1,528 are on proposed green belt release sites.

The Mid Mersey Strategic Housing Market Assessment 2015[15] identified there is a net need for 119 new affordable homes to be made available each year. In line with Government Guidance the DALP has sought to 'front load' the assessment for deliverability of affordable housing on market sites, and is seeking 20% affordable units on strategic housing sites and 25% on non-strategic greenfield sites. This should provide a new source of social rent and intermediate tenure stock going forward. The DALP encourages a proportion of new dwellings to be developed to the higher building regulations standards that support future adaptations assisting people to remain living independently in the properties for longer.

The geographical location of the deliverable supply of housing for the next 0-5 years (within the 'life' of this PNA) is shown in Map 3, alongside pharmacy locations. The shaded areas are those where developments exceed 50 homes. There are numerous smaller developments across both Widnes and Runcorn. The map indicates that additional pharmacy provision will not be required, as plans are located within areas of adequate existing provision.

Map 3: Housing developments



6. Health Profile of Halton

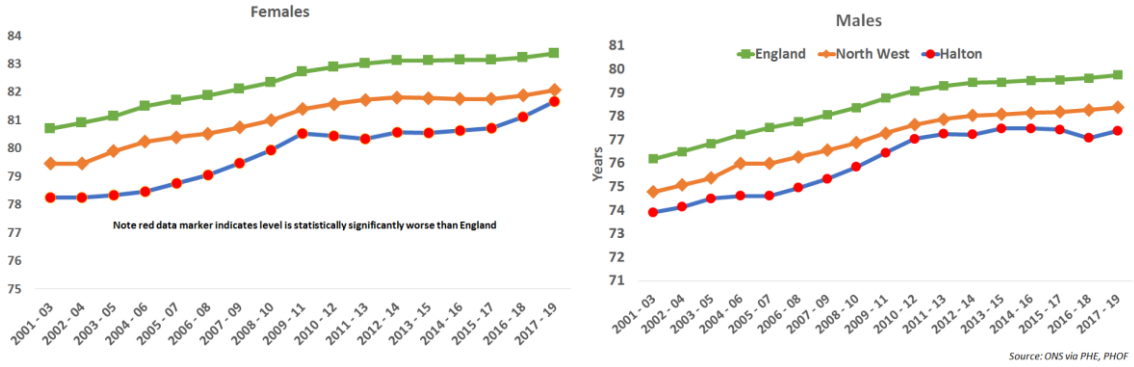
6.1. Life Expectancy

As a result of the reduction in mortality life expectancy in Halton has improved but remains substantially below the North West and England rates. The gap between the national and local life expectancy rates has reduced over recent years. However, Halton women have some of the lowest life expectancy in England.

Life expectancy in Halton is lower than England for both men and women. The difference is statistically significantly worse than England (denoted by the red data points on Figure 6). 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).

Reducing all age all-cause mortality inequalities between Halton and the national average will in turn reduce the life expectancy difference.

Figure 6: Trend in life expectancy at birth, males and females, 2001-03 to 2017-19

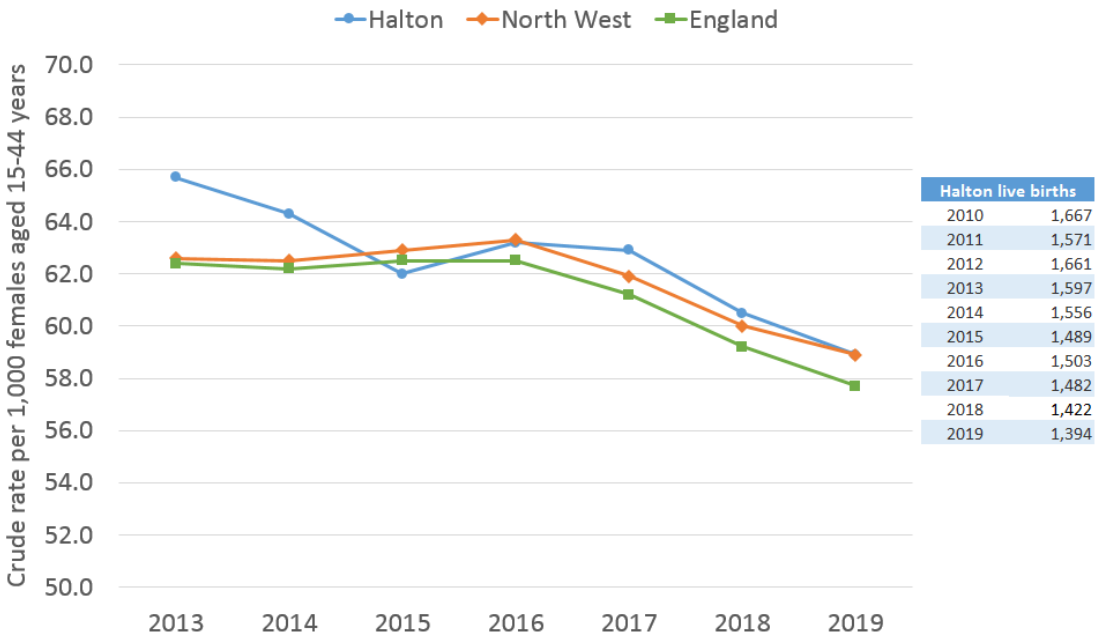


6.2. Birth rate

Fertility rates are closely tied to growth rates for an area and can be an excellent indicator of future population growth or decline in that area. It is calculated using the number of live births per 1,000 female population aged 15 to 44.

Figure 7 shows that the trend in fertility rate in Halton is similar to that of the North West and England. Halton's rates have been statistically similar to the England average since 2015 and all areas have seen a gradual decline. The number of live births to Halton residents was 1,394 in 2019, down from 1,667 in 2010.

Figure 7: Crude fertility rate, live births per 1,000 females aged 15-44

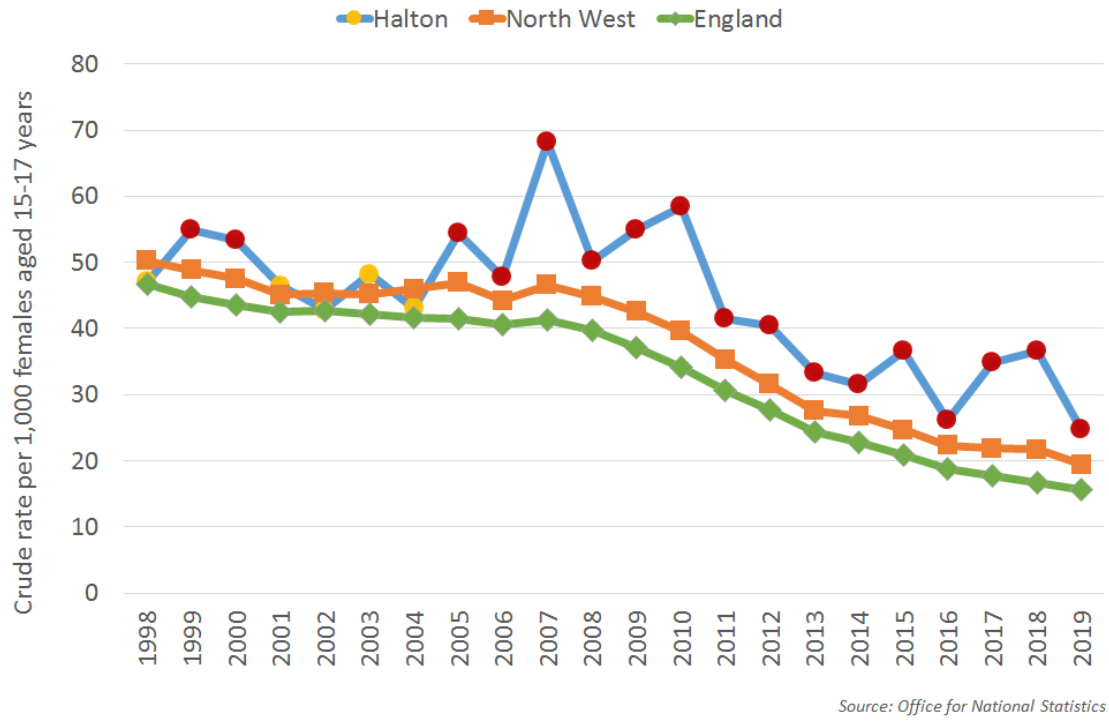


Halton live births	
2010	1,667
2011	1,571
2012	1,661
2013	1,597
2014	1,556
2015	1,489
2016	1,503
2017	1,482
2018	1,422
2019	1,394

Source: Office for National Statistics via NOMIS

The rate of under-18 conceptions has generally reduced since 2007 but fluctuates from year to year due to relatively small numbers. Apart from the years denoted by the amber data marker Halton rates have been statistically higher than the England average. The latest data for 2019 indicates there were 53 conceptions in Halton females aged 15 to 17 years old.

Figure 8: Trend in 18 conception rates, conceptions per 1,000 females 15-17 years of age

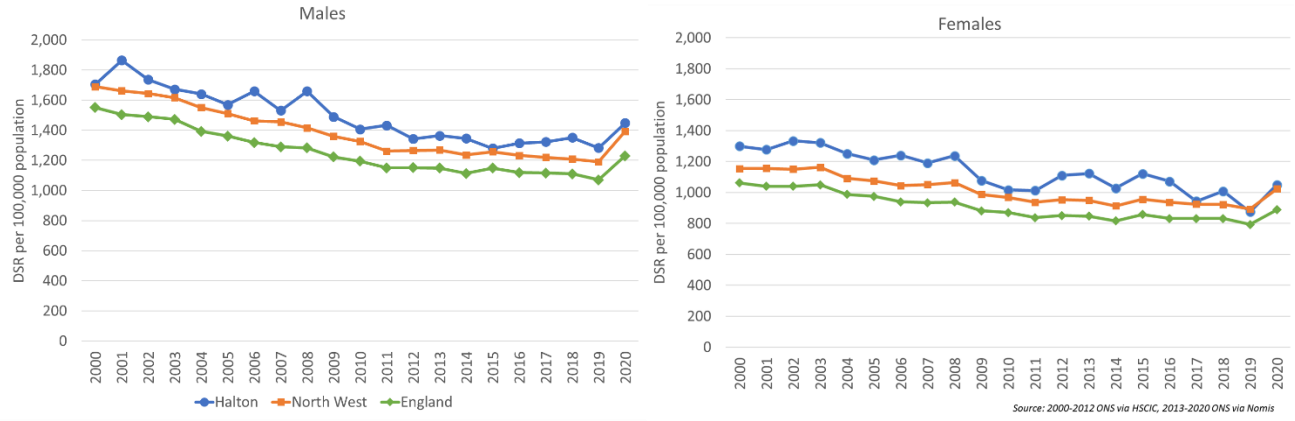


Source: Office for National Statistics

6.3. All Age All-Cause Mortality

Reducing all age all-cause mortality is one of the key priorities for the partner organisations in Halton as it is crucial to tackling health inequalities. Whilst mortality rates have declined they remain above the national and regional averages. All areas saw an increase in mortality during 2020 mainly due to excess deaths associated with the COVID-19 pandemic.

Figure 9: Trends in all age all-cause mortality for males and females, 2000 to 2020



6.4. Health & Wellbeing Board Priorities

The Joint Strategic Needs Assessment (JSNA) has been used to inform leaders and commissioning decisions about the health and wellbeing needs of the borough, as well as the wider determinants that impact on these issues. Following an extensive engagement and prioritisation process, Halton's Health and Wellbeing Board agreed a core set of priorities for its 2018-21 Joint Health and Wellbeing Strategy (JHWBS). With a focus on prevention and early detection, these are:

Children and Young People: improved levels of early child development

Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol

Long-term Conditions: reduction in levels of heart disease and stroke

Mental Health: improved prevention, early detection and treatment

Cancer: reduced level of premature death

Older People: improved quality of life

Action plans for each priority are overseen by various multi-agency partnership groups. Each priority area has a core set of indicators that are measured over time. Challenges remain across all six priorities, including where there has been progress. Data within the 2021 JSNA summary[vi] shows things are generally worse than the national average.

[vi] This can be found on the council website at https://www3.halton.gov.uk/Documents/public%20health/JSNA/JSNASummary.pdf

A new strategy is in development at the time of writing this PNA. Whilst details are still being worked on, the strategy will be focus on one or two priorities within four broad themes:

- Tackling the Wider Determinants
- Starting Well
- Living Well
- Ageing Well

Tackling the Wider Determinants

Halton, as part of the wider ICS, is participating in the Marmot Community work. Considering action to address the social (or wider) determinants of health.

"The wider determinants of health are the social, economic and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do and the homes they live in". King's Fund (2020)

They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes. Variation in the experience of wider determinants (i.e. social inequalities) is considered the fundamental cause (the 'causes of the causes') of health outcomes. As such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist. Addressing the wider determinants of health has a key role to play in reducing health inequalities.

Starting Well

The first few years of life are a key period in which the actions of parents, carers and those around us influence our physical, emotional and mental health in later life. Our earliest experiences of life, starting in the womb, through pregnancy and birth and into our early years, are vital in laying the foundations for our future health and wellbeing. Research consistently shows that even short term improvements in physical development (e.g. obesity and physical activity), cognitive development (e.g. school achievement), behavioural development (e.g. antisocial behaviour) and social/emotional development can lead to benefits throughout childhood and later life. In Halton, the proportion of children and young people within the overall population has remained relatively stable over the years, certainly in comparison to older people. However, the proportion is expected to reduce over the next 20 years. What has changed rapidly is the sort of society and problems that children and young people face, the increase in children being referred to agencies, and the complexity of the children that our services are working with. We know that to make our services better, we have to work with and listen to what young people and their families tell us.

Living Well

Good health is important at any age. Halton, in line with the national trend, has seen a greater increase in the older population and this is set to continue. Action is needed now to deal with the considerable expansion in older people and to improve mid-life. Setting up the conditions to enable people to enter

older age healthier will be increasingly important. This is not just to reduce pressure on health and social care services but to also sustain the ability to work as the age-dependency ratio increases. There are some concerns that this age group is more likely to be engaged in unhealthy behaviours (smoking, poor diet, inactive lifestyle and higher levels of alcohol consumption) than previous generations and this may be partly responsible for the recent stalling observed in healthy life expectancy. Lifestyle is important but housing and employment are also key determinants of health that need to be addressed. Evidence shows that good quality work is beneficial to an individual's health and wellbeing and protects against social exclusion.

Ageing Well

The population of Halton, like the rest of the country, is changing, with a larger proportion being of older age i.e. aged 65 years and over. Many older people in Halton live active, independent lives. They play a vital role in contributing to the life of their communities and increasing numbers are continuing in paid employment well past state pension age. Around one in seven older people provide unpaid care to a family member or friends. Unfortunately, many others suffer poorer health than the national average. With age comes the increased likelihood of living with one or more long term health conditions and/or sensory impairment. Older people have increased risk of dementia and large numbers of older people suffer falls. Older people are also vulnerable to social isolation and/or loneliness. All of these can result in a reduced quality of life and increased use of health and care services. Strategies to identify those at risk and early interventions are key.

Pharmaceutical Needs Assessment

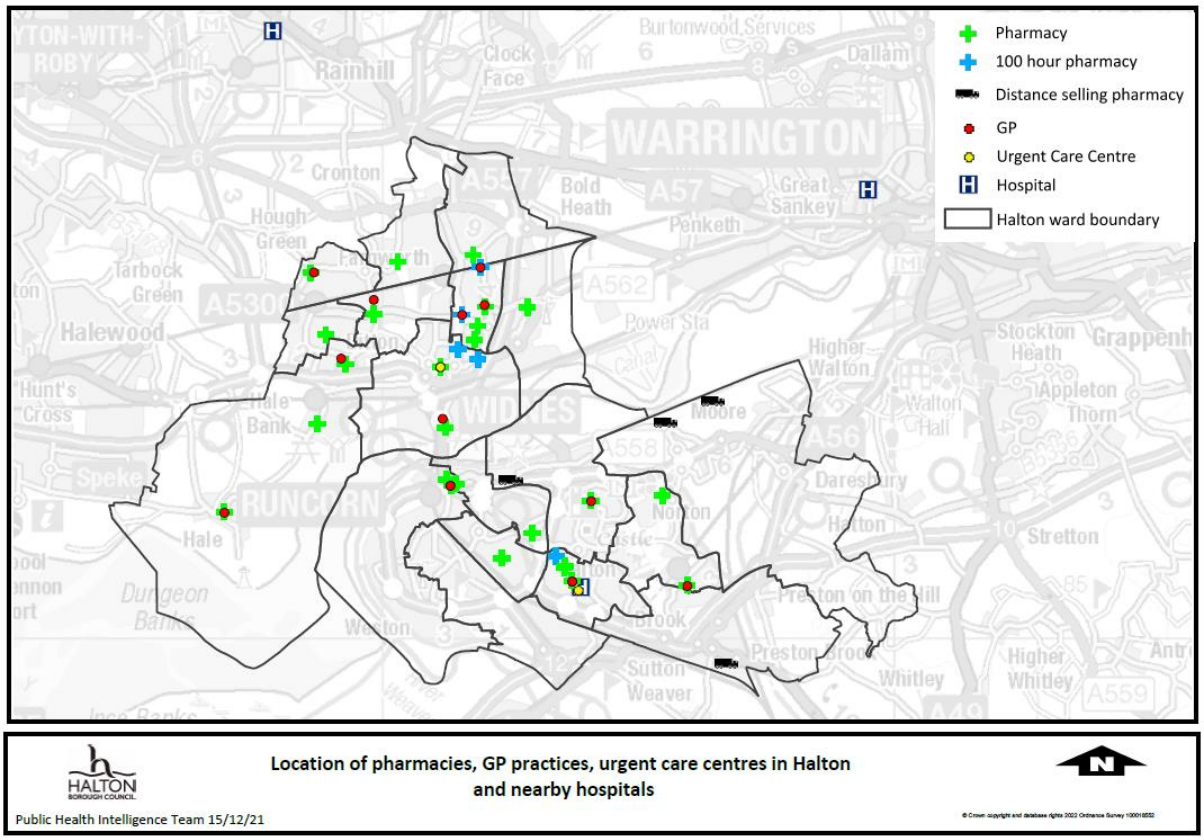
Part 3: Current service provision: access; prescribing; advanced and locally commissioned services

7. Pharmacy Premises

7.1. Pharmacy locations and level of provision

As of June 2021 there are 30 community pharmacies across Halton with a further 4 distance-selling 'internet only' pharmacies making a total of 34 pharmacies in Halton (see Map 4 and Appendix 3 for full list of community pharmacies). Nationally there are a total of 11,800 community pharmacies[vii] for a GP registered population of 61,032,314 (as at 1 August 2021)[viii], giving an average of approximately one community pharmacy for every 5,172 members of the population. Halton has one pharmacy for every 3,960 people (based on GP registered population of 134,654). This is based on total pharmacies, both 'high street' and distance-selling as it was not possible to sift the distance-selling pharmacies from the national list.

Map 4: Location of pharmacies in Halton mapped against other health services



There are 12 pharmacies in Runcorn and 18 in Widnes. This is excluding the four distance selling pharmacies which have their office base in Runcorn, on its industrial estates.

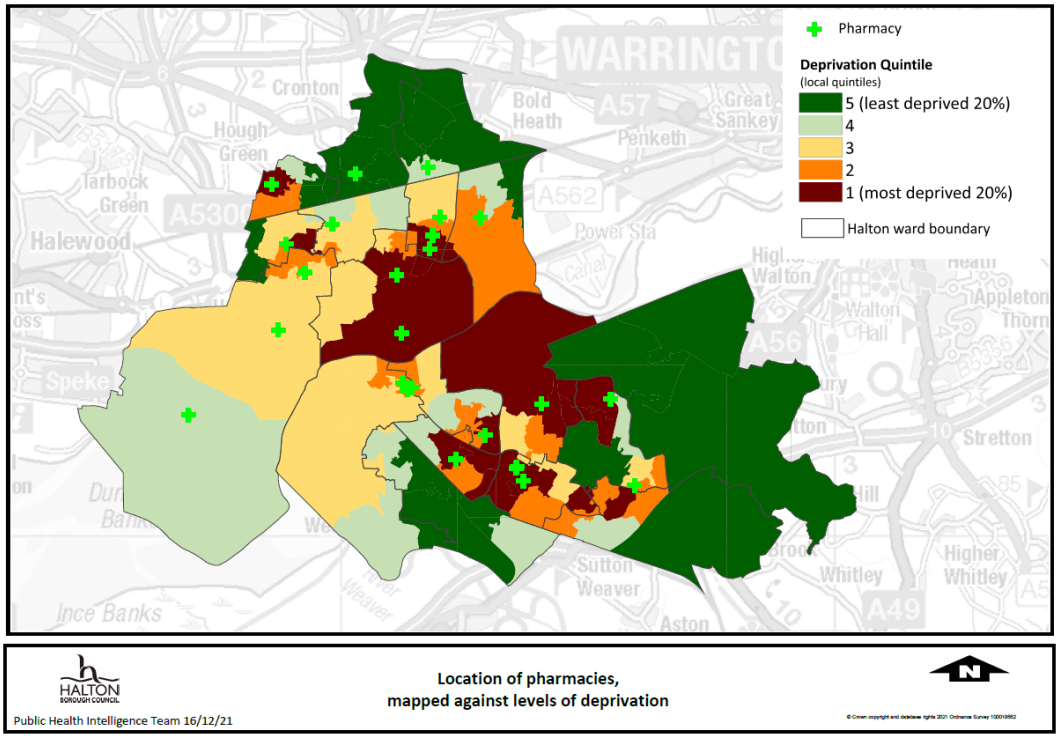
Map 5 shows that generally there is a good provision of pharmacies in the most deprived areas of Halton. The only lower super output areas (LSOA) in the most deprived quintile without a pharmacy have at least one nearby. As shown in Map 7, these areas are within a 5 minute drive of a pharmacy. For residents who do not have access to a car, the travel time would be around 20 minute walk or trip

[vii] As at 2019/20 latest data available via https://www.nhsbsa.nhs.uk/statistical-collections/general-pharmaceutical-services-england/general-pharmaceutical-services-england-201516-201920

[viii] As at 1 August 2021 data via https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/august-2021

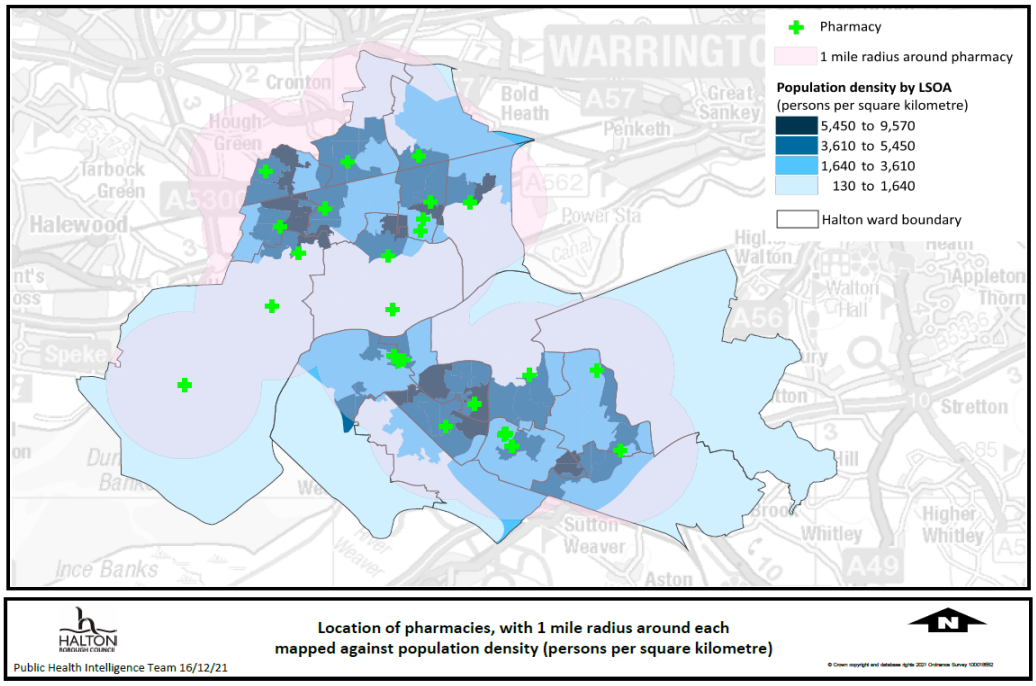
on public transport (see Maps 9 and 10 for further details on walking and public transport travel times).

Map 5: Pharmacy locations mapped against levels of local deprivation



Map 6 shows that in all areas of high population density there is pharmacy provision within an 'as the crow flies' one mile distance. Only areas with the lowest population density have to travel more than one mile. (This map excludes the distance selling pharmacies).

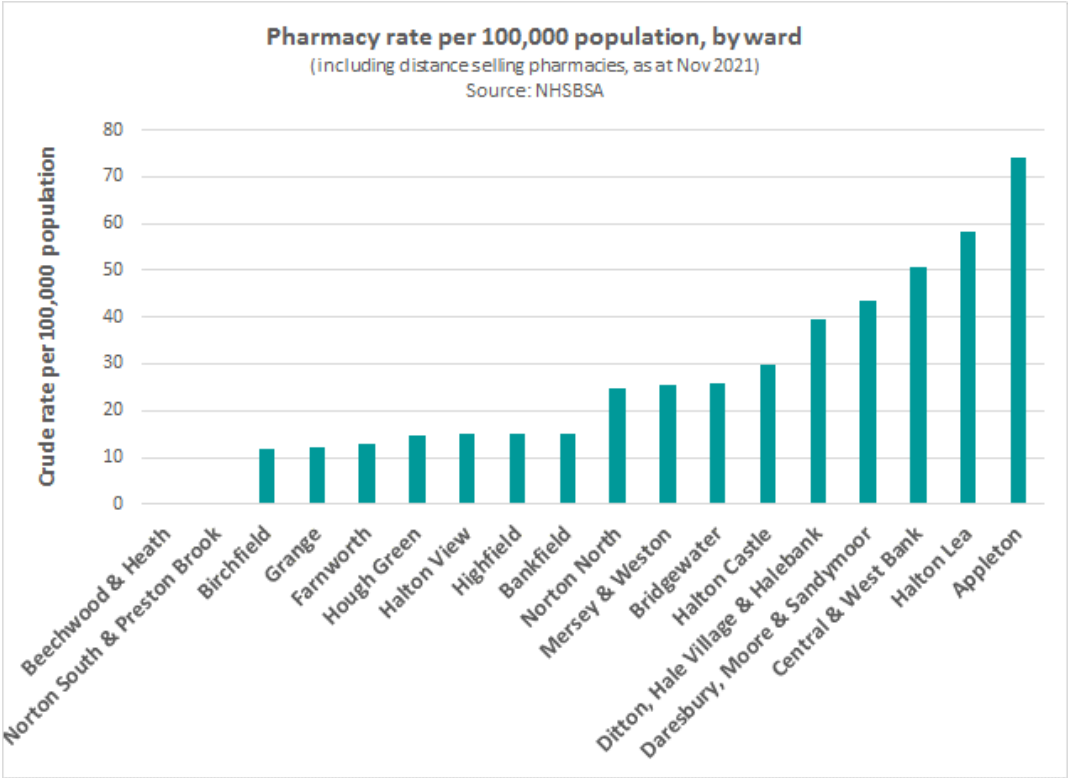
Map 6: Pharmacy locations mapped against population density



Based on the number of community pharmacies (as at 1 June 2021) as a rate per 100,000 GP registered population (as at 1 August 2021), Halton has a larger number of pharmacies in relation to the size of its population (22.3 per 100,000) when compared to the England (19.3 per 100,000). However it is slightly smaller number compared to Cheshire & Merseyside (23.5 per 100,000) and the North West (23.1 per 100,000 population).

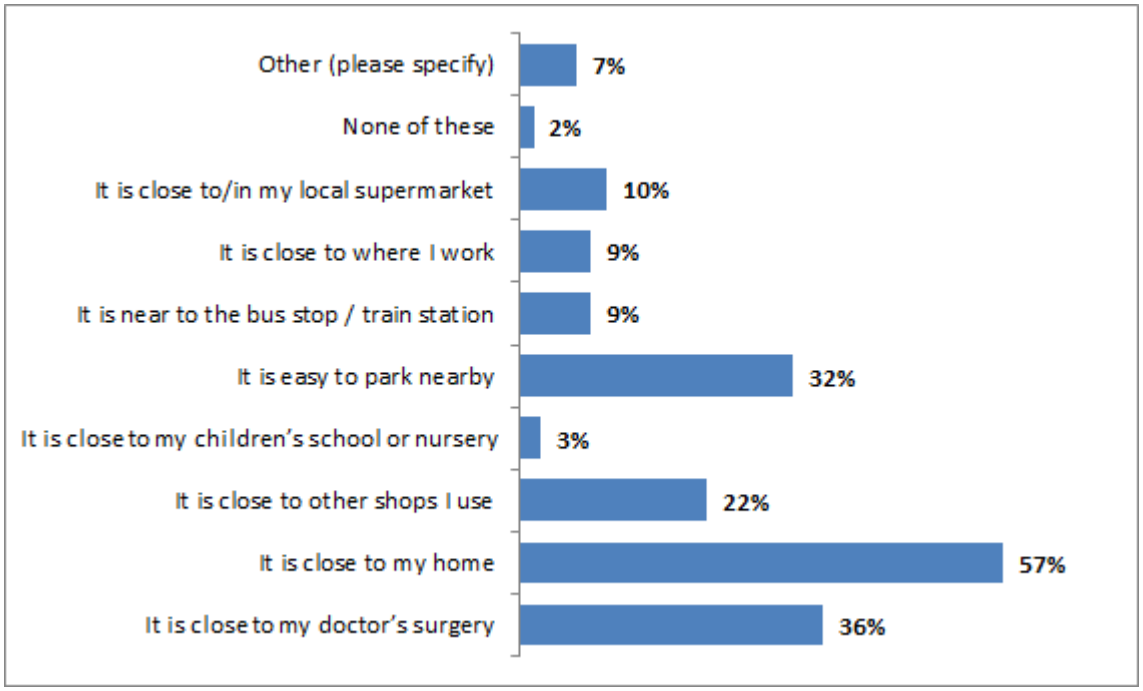
Figure 10 shows this value ranges widely across the borough when analysed in terms of pharmacies per 100,000 population at electoral ward level. In several wards there are no pharmacies, while in others there are several (see Map 3 or 4). The three electoral wards containing the highest concentration of pharmacies are in the retail centres, Appleton ward (which covers Widnes Town Centre), Halton Lea (which covers Runcorn New Town Shopping City) and Central & West Bank in Widnes.

Figure 10: Crude rate of pharmacies in Halton wards per 100,000 population



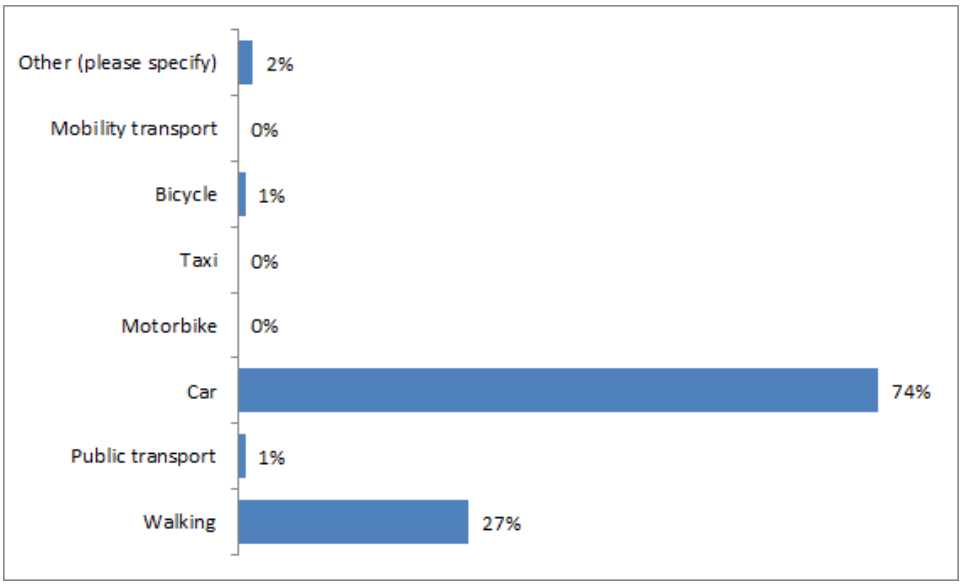
In the public survey of community pharmacy services 57% stated the most important reason for choosing the pharmacy they regularly use was that it was close to their home, with 37% saying because it was easy to park nearby and 36% because it was close to their doctor's surgery.

Figure 11: importance of location, question 5 of public survey of community pharmacy services



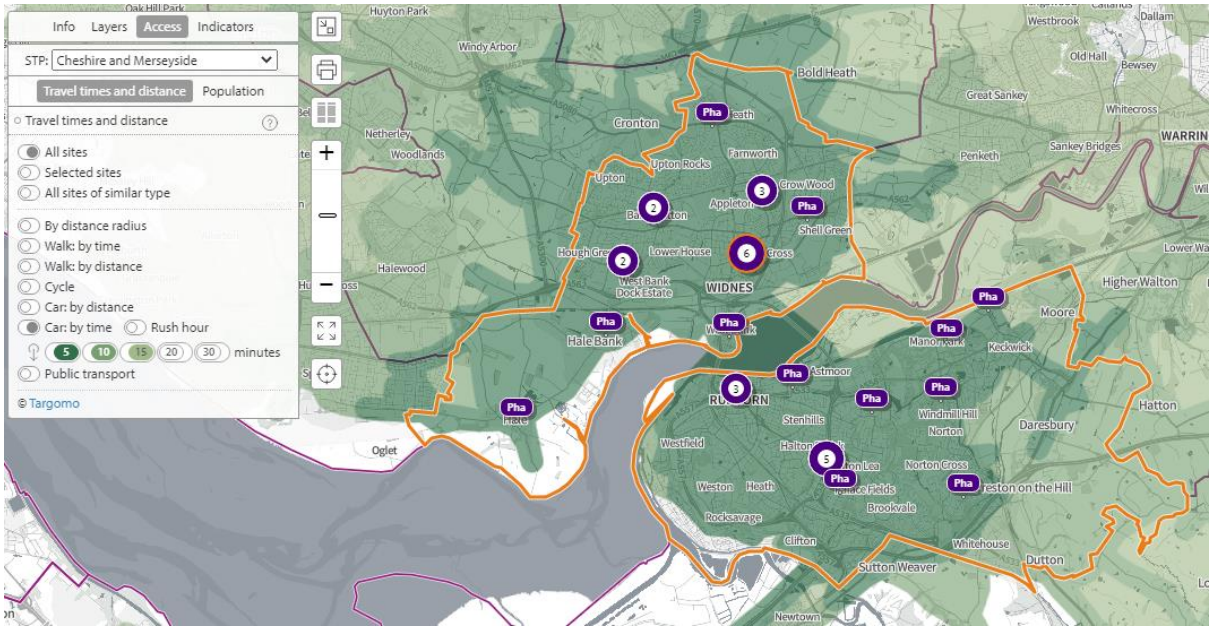
Respondents to the community pharmacy services survey were also asked how they got to the pharmacy. In a similar vein to the 2018 PNA, nearly 3 in 4 people responded that they used the car and 27% that they walked. Only a small number of respondents used other forms of transport.

Figure 12: method used to get to the pharmacy, Q4 of public survey of community pharmacy services 2014



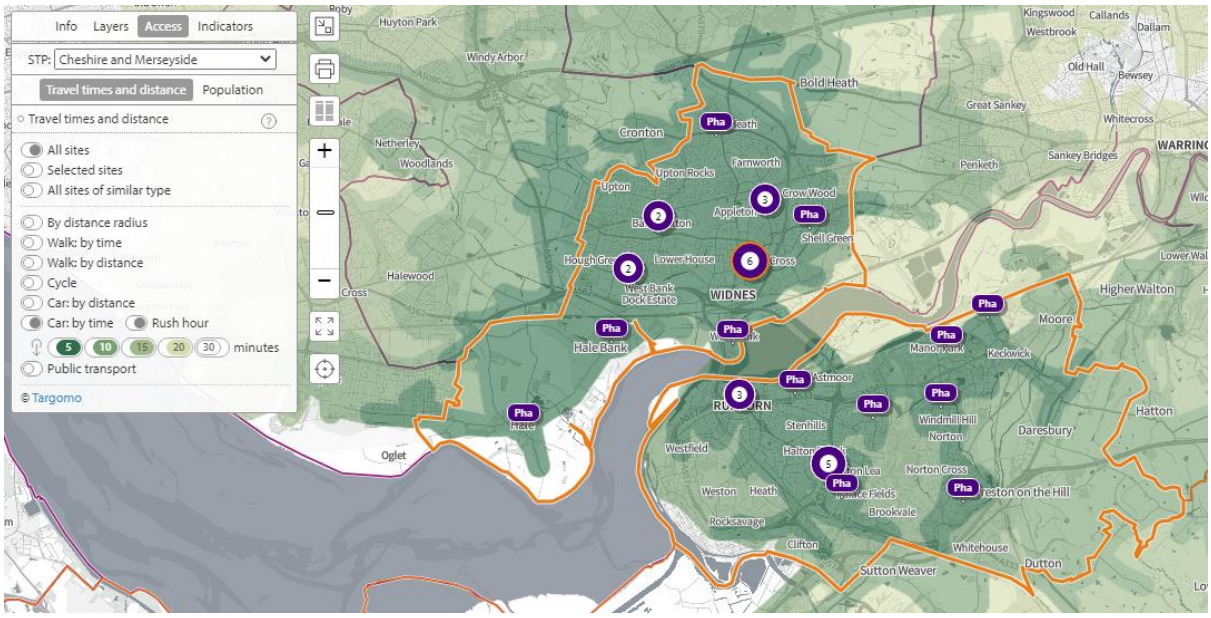
Mapping drive times during the day and during rush hour shows that no location in Halton is more than a 15 minute drive from a pharmacy and 20 mins away during rush hour.

Map 7: Drive times to community pharmacies during the day



Source: PHE SHAPE tool

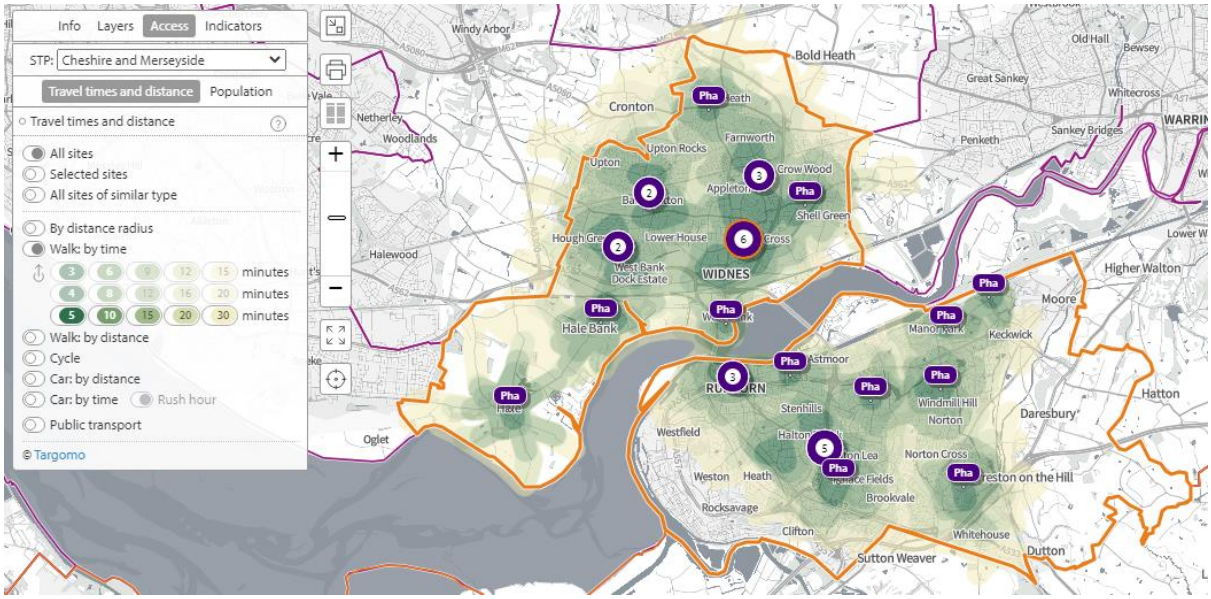
Map 8: drive times to community pharmacies during rush hour



Source: PHE SHAPE tool

For those choosing to walk (about 20% of respondents to the public survey indicated they use this mode of transport), accessibility is slightly more limited. Access is easier in Widnes than Runcorn, with some areas being more than a 30 minute walk away from the nearest pharmacy (note these are predominantly areas without GP practices as well). These areas are no more than a 12-16 minute drive away even in rush hour times.

Map 9: walking times to community pharmacies

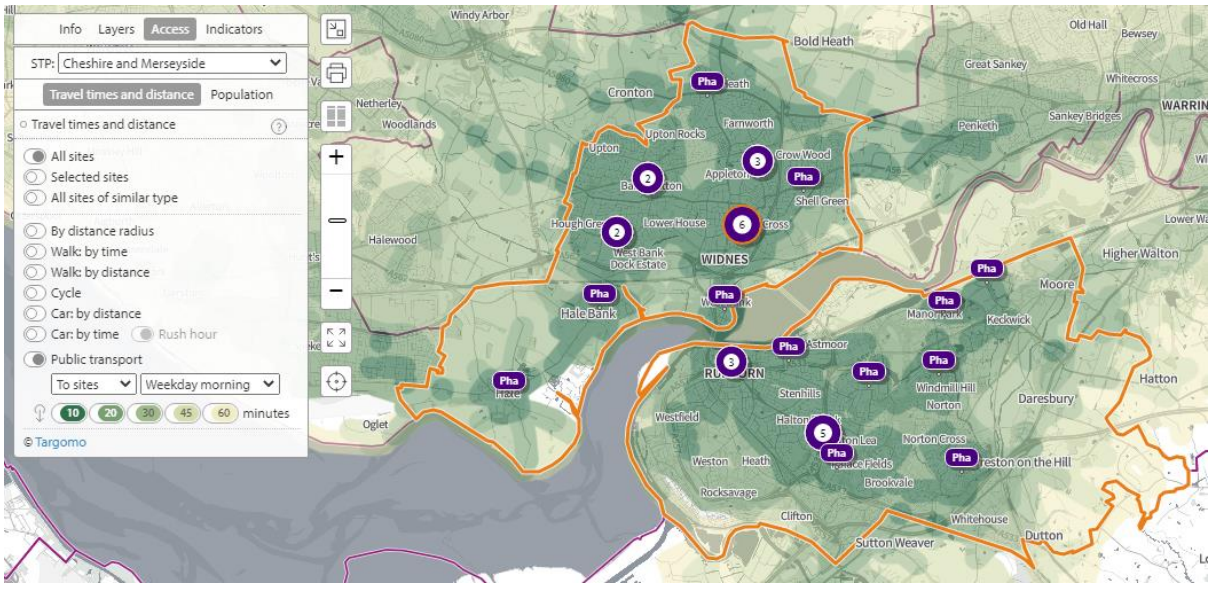


Source: PHE SHAPE tool

The majority of Halton is within 60 minutes travel time via public transport to a pharmacy on an average weekday morning (see

Map 10).

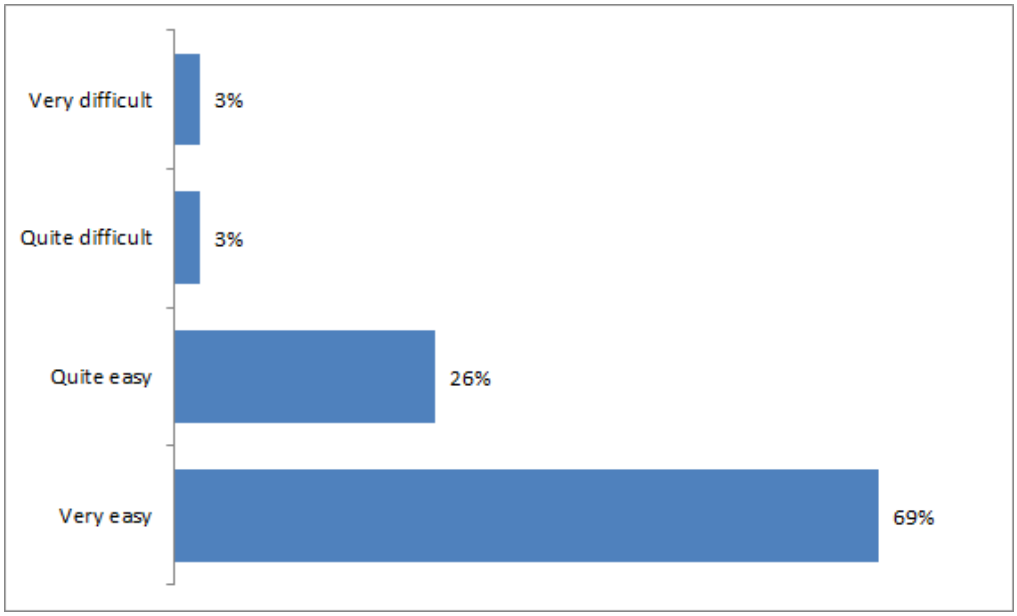
Map 10: travel time to pharmacies by public transport on a weekday morning



Source: PHE SHAPE tool

It is not surprising therefore that the majority of respondents to the public survey stated that it was very easy (69%) or quite easy (26%) to get to the pharmacy.

Figure 13: ease of access usual pharmacy, Q6 public survey of community pharmacy services



Conclusion
• All of this information, used together, means that access is adequate • This PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

7.2. Pharmacy opening hours, including 100 hour pharmacies and distance selling pharmacies

Under the contract, community pharmacies must be open for a minimum of 40 hours each week but they are free to set their own hours of opening as long as this minimum is provided.

- 17 out of 30 community pharmacies in Halton are open between 40 and less than 50 hours per week. 8 of 12 in Runcorn and 9 of 18 in Widnes.
- 8 pharmacies are open for 50 hours or more per week but less than 100 hours. The pharmacies that have extended opening hours are located in areas with good transport links. 5 are in Widnes and 3 in Runcorn.
- There are 5 100-hour pharmacies which are open to the public for essential services. 4 are in Widnes and 1 in Runcorn.

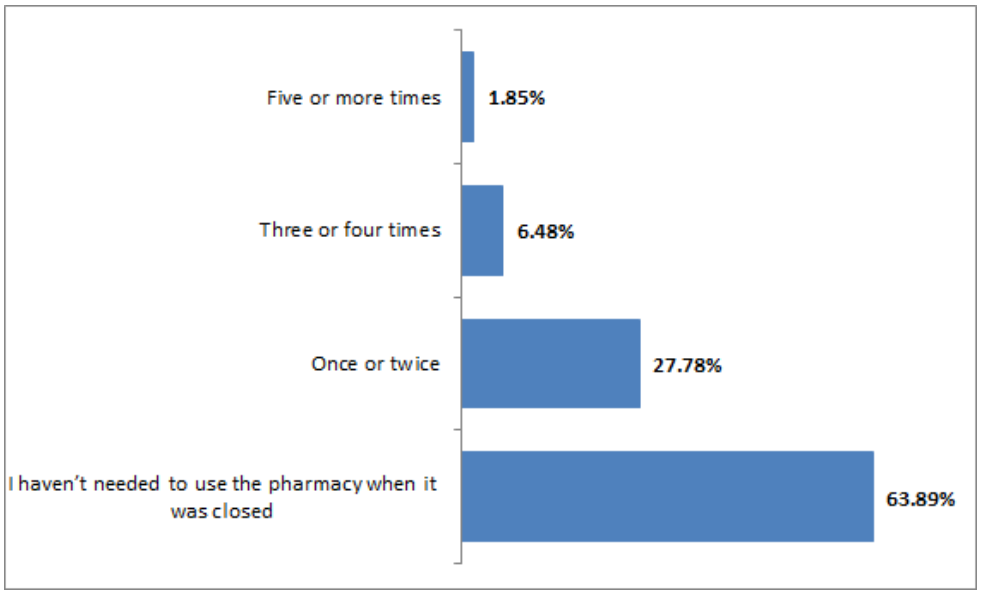
Full details of each pharmacy opening can be found in Appendix 3. They highlight the following:

- From Monday to Friday, all 30 community pharmacies are open between at least 9am to 5pm, with only 3 closing over the lunchtime period for between ½ and 1 hour each day, between the hours of 1pm to 2pm. 7 of the 12 Runcorn community pharmacies are open until 6:00pm each weekday evening with 15 of the 18 Widnes community pharmacies also open until this time.
- Cover is also available throughout the week at the extreme hours from 6:30am and up to 11:00pm. 11 pharmacies are open after 6pm with the latest opening being 11:00pm; 2 Runcorn pharmacies open until 6:30pm and 1 until 11:00pm with 8 Widnes pharmacies open between 6:30pm-11:00pm.
- On Saturday, 20 of the 30 community pharmacies are open in the morning and 8 of these remain so into the afternoon until 5pm; 12 of 18 in Widnes provide at least 9:00am-11:30am provision, with 7 open Saturday afternoon. In Runcorn 8 of 12 are open on Saturday providing at least 9:00am-12:30pm cover and 3 also being open Saturday afternoon.
- Sundays sees less pharmacies being open, with 6 out of 30 open. All but one of these is a 100 hour pharmacy; 1 is in Runcorn and 5 are in Widnes. Provision is between 10:00/10:30am-4:00/4:30pm. 1 Widnes Pharmacy is open 10:00am – 8:00pm.
- Beyond this time, cover continues via 100 hour pharmacies across Halton, with provision in both Runcorn and Widnes.

There are 4 distance selling, 'internet only' pharmacies. These are not open to the public for essential services. The location of 100-hour and internet only pharmacies is shown in Map 4.

88.7% of respondents to the public survey of community pharmacy services said they were satisfied with the opening hours of their pharmacy. 63.9% hadn't needed to use their usual pharmacy when it was closed but the rest had.

Figure 14: How many times recently have you needed to use your usual pharmacy (or the pharmacy closest to you) when it was closed, Q14 public survey?



In one in four (25%) cases where people had found their usual pharmacy closed, was between Monday and Friday, but the majority of time it was a Saturday (49%) or Sunday (14%) with the remaining not being able to remember (12%). Afternoon or late evenings were the most cited times of day. 54% of people experiencing a closed pharmacy waited until it was open with 36% going to another pharmacy and 10% using another NHS service. A few also commented that their pharmacy sometimes was not open at the advertised times or that the pharmacy was open but there wasn't always a pharmacist to dispense prescriptions.

Bank and public holiday opening

NHS England is required to ensure that the population within any given Health & Wellbeing Board area is able to access pharmaceutical services on every day of the year. Under the terms of their contract, pharmacies and dispensing appliance contractors are not required to open on bank holidays or Easter Sunday. In order to provide adequate provision, contractors must confirm to NHS England their opening hour intentions for each of the days. Where a gap in provision is identified, NHS England will then direct a contractor to open part or all of the day.

100 hour and internet-based/mail order pharmacy provision

Of the five 100 hour pharmacies, 4 are in Widnes and 1 in Runcorn. They are identified on Map 4 by a blue marker. The four distance selling pharmacies are all located in industrial parks in Runcorn; they are identified on Map 4 by a black lorry marker. Further details of opening hours and locations of 100 hour and distance selling pharmacies can be found in Appendix 3.

7.3. GP opening hours including extended hours

GP practices are contracted to provide services between 8.00am and 6.30pm, Monday to Friday, excluding bank and public holidays. They may open outside of those hours under the extended hour access scheme commissioned by either NHS England or the CCG. This scheme is commissioned on an annual basis and is subject to change following national negotiations between NHS Employers and General Practitioners Committee. GP dispensaries will generally be open at the same time as the GP

practice and dispense prescriptions issued as part of a consultation during this time as well as dispensing repeat prescriptions.

There has been a programme of expansion across Halton over recent years. Pharmacy opening hours now reflect these changes. This move to provision in the evenings and weekends is likely to continue and it will be important to continue to ensure that patients are able to get any prescriptions issued at these appointments, filled either at their preferred pharmacy or an alternative that is convenient to them in terms of travel times/arrangements.

As details for this continuation were not known during the drafting of this PNA, it has not been possible to assess its impact on the need for pharmaceutical services. However, NHS England has the ability to address any shortfall in pharmacy opening hours by directing existing pharmacies to open for longer hours where necessary.

There are no confirmed plans for GP practice mergers or relocations that may affect access to pharmaceutical services during the lifetime of this PNA.

7.3. Access for people with a disability and/or mobility problem

The majority of pharmacies have wheelchair access or are able to make provision for consultations for anyone in a wheelchair. 25 stated (via the September 2021 contractor survey) that their entrance was suitable for wheelchair access unassisted, 3 stated this was not the case and 2 did not answer this question. In respect of people with mobility problems, 25 of the 30 pharmacies (excluding distance selling) have parking provision within 50 metres of the pharmacy, 3 stated this was not the case and 2 did not answer this question. 19 out of the 30 pharmacies also have disabled parking available.

A question on access for people with mobility problems was included in the public survey. 56% said this was not applicable to them, 35% said yes they had mobility problems and were able to park close enough to the pharmacy for their needs, with 8.5% saying that they could not park close enough.

Additionally, AccessAble[ix], the UK leading source of information on access, has independently assessed 13[x] of Halton's 30 community pharmacies. Information is gathered by sending a surveyor to visit each venue. Every venue on their website is contacted each year to find out if their access has changed. A venue owner or customer can contact them at any time to inform of changes to venues. They use a wide range of criteria which have been designed in consultation with disabled people and represent important information that disabled people want to know about public venues.[xi]

- 12 of the 13 assessed have ramp/slope access to either manual or automatic doors.
- All 13 have Mobility Impaired Walker status. This means the entrance to the building has no more than three medium steps. If there is more than one step, a handrail must be provided. Internal level changes can be overcome by moderate/easy ramps and/or lifts.
- All 13 have seating available.

[ix] https://www.accessable.co.uk/

[x] There are 14 Halton pharmacies assessed on the AccessAble website but 1, Lloyd's Pharmacy, Granville Street, Runcorn has since closed so is not included in the figures

xi. how we assess some of the key access features and key terms used in the access guides please click here.

- 10 out of 13 have hearing systems, meaning a sound enhancement system is available at certain locations within the premises.
- 10 out of the 13 have Blue Badge/ accessibility parking.

In relation to other facilities for disabled people a range of services were identified by pharmacies:

- 22 said they provide large print labels
- 13 said they provide large print leaflets
- 6 have a bell at the front door
- 8 could provide toilet facilities suitable for wheelchair access
- 9 have automatic door assistance
- 9 have hearing loop
- 14 have wheelchair ramp access

7.4. Access for clients whose first language is not English

NHS England commission Language Line which is available to all pharmacies. From the contractor survey, September 2021, 10 out of the 34 pharmacies advised that they had a pharmacist or other member of staff who could speak at least one language in addition to English. The languages listed were Spanish, Italian, Polish, Romanian, Portuguese, Arabic, Gujarati, Punjabi, Hindi, Urdu, Bangladeshi and Vietnamese. Some pharmacies have more than one non-English language spoken.

7.5. Pharmacy consultations

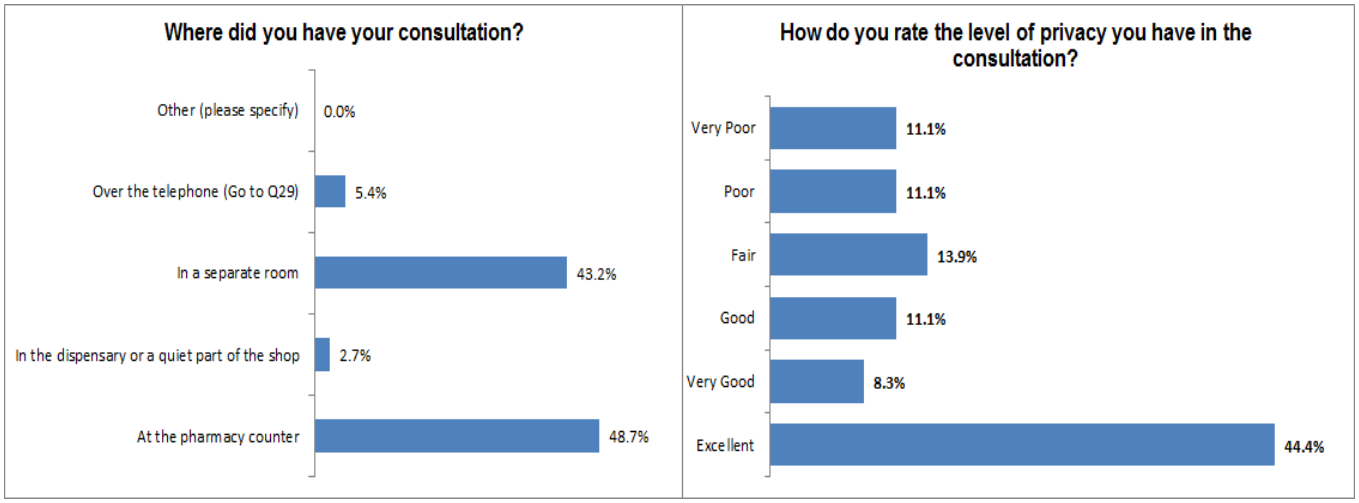
Being able to walk in to pharmacy to seek advice and/or treatment, usually without an appointment, is one of the key features of community pharmacy provision. Advice may be given at the counter or in a private consultation room. All pharmacies must have a private consultation room. 24 out of the 30 community pharmacies have handwashing facilities in the consulting room or close to it in and 6 have toilet facilities. 10 are willing to undertake consultations in patients own homes or other suitable sites.

In relation to a client being able to seek advice from someone of the same sex as them:

- 11 pharmacies judged that this would be available at all times
- 18 pharmacies thought this would be available by arrangement
- Only 1 did not think they could provide this.

32% of respondents to the public survey had a consultation with their pharmacist within the last 12 months. Of these 48.7% of consultations being undertaken at the pharmacy counter and 43.2% of consultations where undertaken in a consultation room. 63.8% of people who had a consultation with a pharmacist found privacy levels excellent, very good or good, whilst 36.1% of people rated privacy levels between fair, poor or very poor.

Figure 15: consultations and satisfaction with privacy during them, public survey



7.6. Pandemic response

The early process of responding to the pandemic resulted in many services moving to an online offer. One of the key features of community pharmacy is their physical position in the community, providing the opportunity for people to walk in and receive advice and services as and when required or on an appointment basis.

Community pharmacies have been key partners throughout the pandemic, demonstrating a willingness to respond to need and an ability to do so at pace. Utilising their knowledge of their local communities has been key in enabling them to flex and step up new services and ways of working at speed.

Key activities have included the use of new technology to ensure patients remained able to access medication, stepping up to deliver medication as part of the Pandemic Delivery Service for anyone self-isolating and providing Lateral Flow Device packs, as well as supporting vaccination for Covid-19 and flu.

They therefore played a vital part in the public health response to the pandemic.

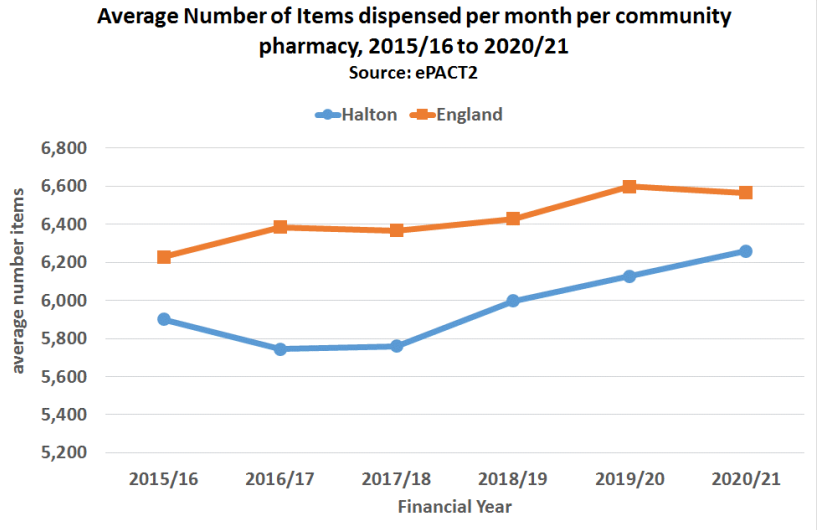
8. Prescribing

8.1. Prescribing volume

Benchmarking data is available from NHS Business Services Authority (BSA) epact2 data. It is useful to be able to analyse Halton prescribing against England data.

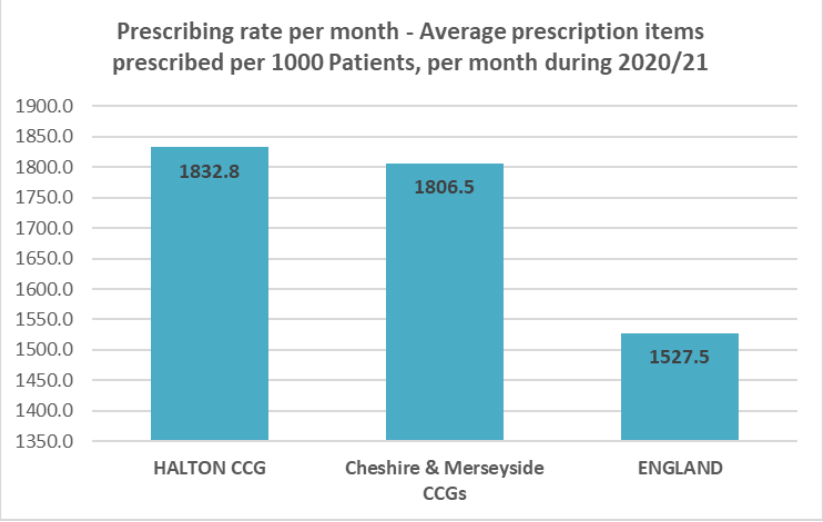
Figure 16 shows that NHS Halton CCG, community pharmacy dispensing volume pattern has consistently been below the England average when looking at average items dispensed per month, per pharmacy

Figure 16: Prescribing trend, 2015/16 to 2020/21: Trend in prescription items dispensed each month



However, analysis of per month prescribing levels within Halton CCG, as a crude rate per 1,000 population, between 1 April 2020 and 31 March 2021 shows that Halton prescribing rate is above both the England average and Cheshire & Merseyside levels.

Figure 17: Prescribing rate per month, 2020/21



In terms of the types of diseases and conditions, drugs prescribed for cardiovascular disease accounts for the largest single cause, followed by conditions of the central nervous system. Together these accounted for just under half of all prescription items dispensed during 2020/21. The percentages are broadly similar to those seen across Cheshire & Merseyside and England as a whole, as Table 2 shows.

Table 2 : Items dispensed by Halton CCG, NW CCG's and England during 2020/21, by therapeutic area.

	HALTON CCG (01F00)		Cheshire & Merseyside CCGs		ENGLAND (1)		Difference in % from Halton	
BNF Chapter	**Items**	**% to Total**	**Items**	**% to Total**	**Items**	**% to Total**	**C&M**	**England**
Cardiovascular System	804,417	27.3%	16,470,267	28.4%	329,483,518	29.7%	**1.04%**	**2.35%**
Central Nervous System	661,498	22.5%	12,420,163	21.4%	218,968,298	19.7%	**-1.08%**	**-2.75%**
Gastro-Intestinal System	297,704	10.1%	5,836,084	10.1%	103,945,835	9.4%	**-0.06%**	**-0.75%**
Endocrine System	263,793	9.0%	5,270,481	9.1%	114,554,722	10.3%	**0.12%**	**1.36%**
Respiratory System	224,483	7.6%	4,142,493	7.1%	72,328,009	6.5%	**-0.49%**	**-1.11%**
Nutrition and Blood	162,451	5.5%	3,461,242	6.0%	59,580,850	5.4%	**0.44%**	**-0.15%**
Musculoskeletal and Joint Diseases	82,201	2.8%	1,498,871	2.6%	29,107,355	2.6%	**-0.21%**	**-0.17%**
Infections	82,115	2.8%	1,564,815	2.7%	34,145,613	3.1%	**-0.09%**	**0.29%**
Skin	71,467	2.4%	1,482,683	2.6%	25,638,541	2.3%	**0.13%**	**-0.12%**
Appliances	71,127	2.4%	1,385,455	2.4%	30,484,983	2.7%	**-0.03%**	**0.33%**
Obstetrics, Gynaecology and Urinary-Tract Disorders	71,096	2.4%	1,488,386	2.6%	30,868,586	2.8%	**0.15%**	**0.36%**
Eye	33,368	1.1%	742,442	1.3%	16,240,002	1.5%	**0.15%**	**0.33%**
Immunological Products and Vaccines	30,829	1.0%	622,781	1.1%	12,996,819	1.2%	**0.03%**	**0.12%**
Ear, Nose and Oropharynx	25,793	0.9%	530,198	0.9%	10,117,514	0.9%	**0.04%**	**0.03%**
Stoma Appliances	21,120	0.7%	360,214	0.6%	6,390,802	0.6%	**-0.10%**	**-0.14%**
Dressings	16,769	0.6%	273,839	0.5%	5,690,952	0.5%	**-0.10%**	**-0.06%**
Malignant Disease and Immunosuppression	8,750	0.3%	199,960	0.3%	4,639,136	0.4%	**0.05%**	**0.12%**
Incontinence Appliances	6,537	0.2%	120,927	0.2%	2,251,463	0.2%	**-0.01%**	**-0.02%**
Anaesthesia	3,648	0.1%	87,785	0.2%	1,325,148	0.1%	**0.03%**	**0.00%**
Other Drugs and Preparations	2,858	0.1%	65,011	0.1%	1,070,509	0.1%	**0.01%**	**0.00%**
Preparations used in Diagnosis		0.0%	2	0.0%	114	0.0%	**0.00%**	**0.00%**
	2,942,024	100.0%	**58,024,099**	100.0%	**1,109,828,769**	100.0%		

The majority of people surveyed, visit a pharmacy to get a prescription, with 88% using their pharmacy within the month prior to completing the survey for this reason (see Figure 18 and Figure 19).

Figure 18: Reasons for visiting the pharmacy, public survey

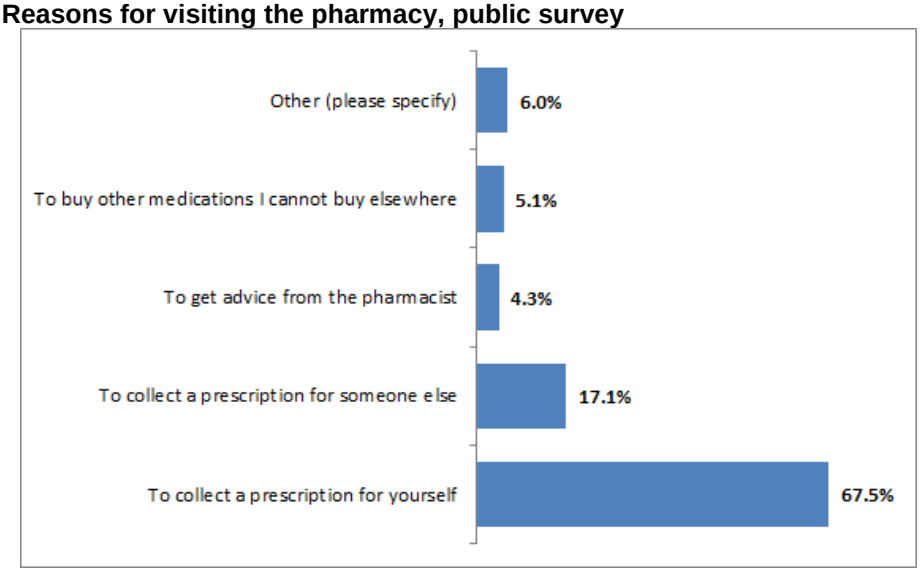
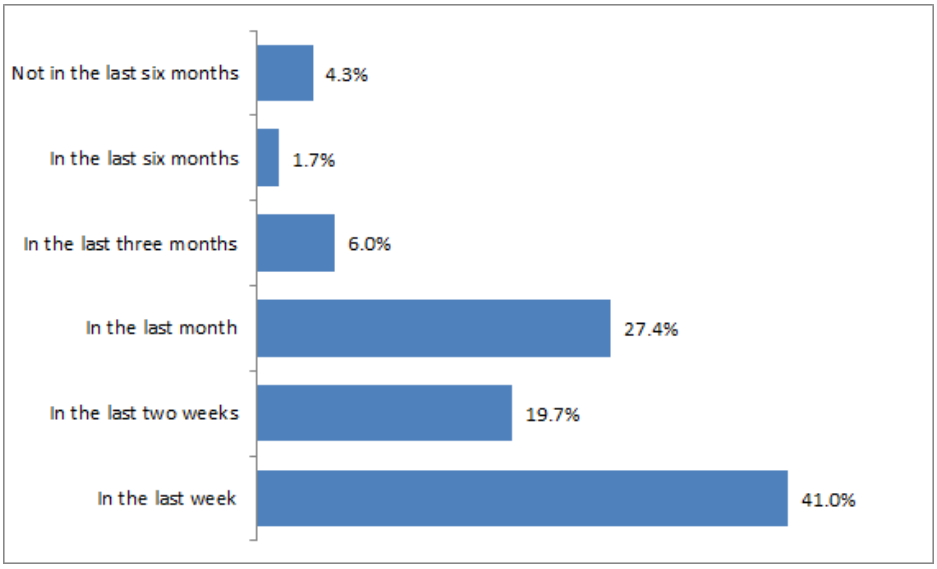


Figure 19: When did you last use a pharmacy to get a prescription, buy medicines or to get advice?



56% of people were informed of how long it would take to have their prescription filled, 24% were not told and would have liked to have been and 20% not told but stated that they did not mind this. 73% of people said that they thought they waited for a reasonable period of time for their medicines.

84% percent of people surveyed, stated that they got all the medicines they needed, however, 15% stated that they did not.

50% of people stated that the reason for not receiving their entire prescription was because 'the pharmacy had run out of my medicine'. Of the remainder, the most common responses were some other reason (27%), with 11% saying the pharmacy told them their medicine was unavailable, 5.5% that the prescription had not arrived at the pharmacy when they went to collect it and 6% of respondents stating their doctor had not prescribed something they wanted.

When people had not received all the items prescribed, 20% got them later the same day, 25% of people received their medicines the day after, with 45% receiving it within 2-7 days. However, 10%

had waited over a week. Unfortunately, there is no way to determine the impact of these longer waiting periods on the patient, or whether this was measured at the pharmacy and alternative arrangements discussed.

64.5% of people stated that they would like to be able have their hospital prescription dispensed at their local chemist, while 9% said 'No'. 26% had never used a hospital pharmacy.

8.2. Prescription Delivery Services

Although community pharmacies are not contracted to do so, 23 out of 30 offer a home delivery service free of charge. 7 do not offer a free delivery service. Of these 7, 4 do offer delivery service at a charge whilst 3 do not offer any delivery service. This service improves access to medicines for a wide range of people. 44% of public survey respondents said the pharmacy they use offers a delivery service, 9.5% said they did not but 46.5% were either not aware of the service or had never used it.

8.3. Multi-compartment Compliance aids (MCA) - Reasonable Adjustments

Community pharmacies are required to support patients in taking dispensed medications by making reasonable adjustments for patients with identified needs as per the Equality Act 2010. From 2005 the funding of the NHS Pharmaceutical Services has included an element to recognise the additional cost of complying with disability legislation.

The requirement of the community pharmacy is to ensure that an appropriate assessment is undertaken of the patient to establish their needs and ascertain what type of reasonable adjustment would be required. There is no exhaustive list of what a reasonable adjustment could be and community pharmacies are not required to provide a multi-compartment compliance aid (MCA).

An MCA is usually in the form of a blister pack divided into days of the week and is a medication storage device designed to support patients to take their own medicines and to maintain their own independence. Prime candidates for MCA are patients at risk of confusing their medication, including those whose ability to manage their medication is affected by disability or their living arrangements or who have multiple medications.[16] If patients have significantly impaired mental self-care abilities MCA dispensing is likely to be of little help to them.[17,18]

In 2013 the Royal Pharmaceutical Society published *Improving Patient Outcomes – the better use of multi-compartment compliance aids.* The report highlighted that there was a limited evidence base behind the use of MCAs. The report also recommends that a patient-centred approach to identifying the best intervention must be through a sustainable and robust individual assessment of both the level of care required by the individual, the reasons for both intentional and non-intentional non-adherence and the most suitable solution.

Filling and checking MCA's is a time-consuming process. MCA's used inappropriately may actually increase the likelihood of confusion and mistakes by patients and any changes to the patient's prescription within the 28 days may result in substantial waste. There is the possibility that use of them also increases the potential for dispensing errors due to having to repackage medicines. Some medications are not suitable for use in a MCA. The pharmacist is accountable and responsible for repackaging medicines in this way so must be assured that it is safe to do so.

Community pharmacies are encouraged to work collaboratively with prescribers, other health professionals and social care to support patient needs. Community pharmacies are not required to dispense medications into MCAs because it has been directed by another health professional or social care. Health professionals and social care should highlight patients who may require support with

medicines to enable the community pharmacy to carry out an assessment to determine appropriate medicines support.

- 20 out of 30 community pharmacies provide MCA free of charge.
- 3 out of 30 community pharmacies provide MCA at a charge where the patient did not meet the requirements for an adjustment under the Equality Act.
- 9 out of 30 community pharmacies provide MCA free only to patients who have a disability (as defined by the Disability Discrimination Act).

9. Patient & public satisfaction with pharmacy services

As per the previous public survey, the vast majority of people were very satisfied with the services they received. Convenience, expertise and friendly, helpful staff were the most commonly cited things people valued when they visited the community pharmacy. Being able to get advice on minor ailments quickly without visiting the GP, handling of repeat prescriptions and the delivery service were also valued. Typical respondent views can be summed up as follows:

'Your local pharmacy where you know the staff there and are a friendly community local business. Very personal touch.'

'Being spoken to as an individual and not just another patient that they have to deal with. Taking time to talk to and be sensitive if you do ask for assistance.'

'When I had Covid and couldn't get to the pharmacy they delivered it for me.'

62.6% of respondents to the pharmacy services survey were satisfied with the range of services pharmacies provide and 27.1% stated that they wished pharmacies could provide more services for them.

When asked which, if any, of a range of services they thought should be available locally through pharmacies, most thought the majority of services should be available. It was only when it came to drug and alcohol services that less than half of respondents gave positive responses.

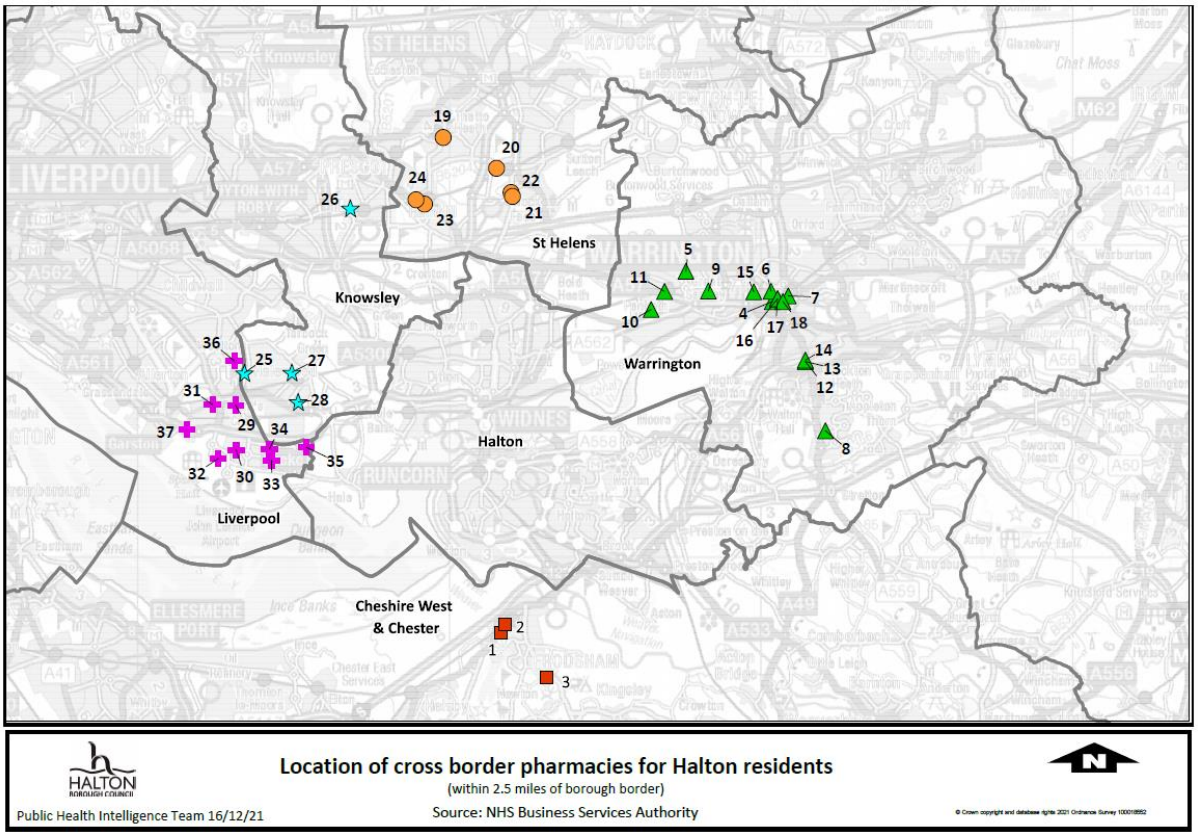
Figure 20: Which if any services should be available at the local pharmacy, public survey

Some respondents suggested that pharmacies could provide advice and supply of small medical instruments as additional services, e.g. a fingertip pulse oximeter, digital thermometer or Coaguchek instrument and the availability of a recycling box for all empty medication blister packs.

10. Access to and provision of community pharmacy services in local authorities bordering Halton

The framework for this PNA has been based largely on the 2015-2018 PNA, which was a collaborative process across Cheshire & Merseyside. This approach facilitated the identification of pharmaceutical services along the borders of neighbouring boroughs that Halton's population may access. For example, a pharmacy in a neighbouring borough may be closer to a resident's home or place of work, even though they are registered for NHS Services with a GP practice in Halton. Halton has geographic borders with a number of local authorities, namely Liverpool, St. Helens, Knowsley, Warrington, Cheshire East, and Cheshire West & Chester. Map 11 shows the locations of these cross border pharmacies. The numbers in Map 11 below correspond to the list of pharmacies in Appendix 5.

Map 11: Pharmacies in other boroughs most likely to be used Halton residents



Source: NHS Business Services Authority

Analysis of the information supplied, identified that there is adequate service provision on the borders of Liverpool, St. Helens, Knowsley, Warrington and Cheshire West & Chester. A list of the pharmacies is available in Appendix 5.

11. Advanced, enhanced and locally commissioned service provision

As detailed in sections 3.2-3.4 there are a range of services community pharmacies can chose to provide in addition to the essential services they must provide. Some are more specialist than others. As such, provision varies, service by service, from 100% community pharmacies providing to just a handful required to meet need.

Full details of which service each pharmacy provides are outlined in Appendix 4. Table 3 provides a summary of each service provision level and whether this is assessed as adequate.

Table 3: Summary of advanced, enhanced and locally commissioned service provision

Type of Service	Service Name	Number of pharmacies providing each service (out of 30 community pharmacies 12 in Runcorn and 18 in Widnes)			Is provision of this service adequate?
		Runcorn	Widnes	Total	
Advanced	Community Pharmacist Consultation Service	12 (plus 1 DSP[xii])	17	29	Yes
	Appliance Use Review	3	5	8	Yes. Whilst provision is low these are highly specialist services with only small numbers of the population likely to need them.
	Stoma appliance customisation service	0	1	1	
	New Medicines Service	12	18	30	Yes
	NHS Influenza Vaccination Programme	12	18	30	Yes
	Hepatitis C antibody testing service	2	3	5	Yes as this is a specialist service, likely to be of interest to those providing NSEx[xiii]
	Hypertension Case Finding Service	5 (plus 1 DSP)	7	12	Yes. This is a new service. We would expect more pharmacies to sign up to provide it over time.
Enhanced	Anti-Viral Stockholding Service	0	1	1	Yes. This is a specialised service to be deployed in a particular set of circumstances; only a few

[xii] DSP = Distance Selling Pharmacy

[xiii] NSEx = Need-Syringe Exchange service

Type of Service	Service Name	Number of pharmacies providing each service (out of 30 community pharmacies 12 in Runcorn and 18 in Widnes)			Is provision of this service adequate?
		Runcorn	Widnes	Total	
					pharmacies across Cheshire & Merseyside provide it.
Locally Commissioned NHS	Care at the Chemist	12	17	29	Yes
	Palliative Care Scheme	2	3	5	Yes as this is a specialist service
	Minor Eye Conditions Pharmacy Service	2	5	7	Yes. This is a new service. Uptake, along with the minor eye service, is regularly reviewed in relation to ongoing patient need.
Locally commissioned Public health	Emergency Hormonal Contraception	8	16	22	Yes
	Needle – Syringe Exchange	2	3	5	Yes as this is a specialist service
	Supervised consumption (of (methadone or buprenorphine)	9	11	20	Yes
	Stop Smoking Voucher Dispensing	7	13	20	Yes
	Stop Smoking Intermediate Service	2	3	5	Yes as this is a specialist service
	Varenicline	1	4	5	Yes as this is a specialist service

12. How essential and advanced pharmacy services support local priority health needs

In England there are an estimated 1.2 million visits to a pharmacy every day for health related issues[19], and these provide a valuable opportunity to support behaviour change through making every one of these contacts count. Making healthy choices such as stopping smoking, improving diet and nutrition, increasing physical activity, losing weight and reducing alcohol consumption could make a significant contribution to reducing the risk of disease, improving health outcomes for those with long-term conditions, reducing premature death and improving mental wellbeing. Pharmacies are ideally placed to encourage and support people to make these healthy choices as part of the provision of pharmaceutical services and services commissioned locally by Halton Borough Council public health team and the NHS. As can be seen from this section, it is important that NHS England, the CCG and the Public Health Team work together to maximise the local impact of public health communications, messages and opportunities. Promoting the services that pharmacies provide was highlighted in some of the responses to the patient and public engagement questionnaire. This can be undertaken in a number of ways including pharmacies ensuring that their NHS Choices profile is up-to-date.

Community pharmacy services can support Halton's Health & Wellbeing Strategy priorities in a number of ways.

12.1 Starting Well

The backbone of community pharmacy provision is the dispensing of prescriptions. This service is open to all ages. In addition to this, pharmacies can support the health and wellbeing of children and young people:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Signposting people using the pharmacy to other providers of services or support.
- As part of being a Healthy Living Pharmacy, community pharmacy engagement with the general public (including "Making Every Contact Count" - MECC) is relevant to young people.
- Provision of emergency hormonal contraceptive (EHC) services, commissioned by Halton Borough Council as part of the Integrated Sexual Health Service (known as Axess), run by Liverpool University Hospitals NHS Foundation Trust. It is not envisaged that within the lifetime of this PNA there is or will be a need for it to be commissioned as part of national pharmaceutical services. Where the pharmacy does not provide the locally commissioned service of EHC provision, signposting people using the pharmacy to other providers of the service.

12.2 Living Well

The living well priority covers a range of issues, taking a prevention and early detection approach.

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England. Public health campaigns could include raising awareness about the risks of alcohol consumption, cancer awareness and/or screening, self-management of long-term

conditions and minor ailments by displaying posters, distributing leaflets and other relevant materials.

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is required to give appropriate advice with the aim of increasing that person's knowledge and understanding of the health issues which are relevant to their circumstances.
- Signposting people who are potentially dependent on alcohol to local specialist alcohol treatment providers.
- Providing healthy living advice during consultations.
- Provision of the CPCS, AUR, SAC service, NMS and flu vaccination advanced services will also assist people to manage their long-term conditions in order to maximise their quality of life.

12.2.1. Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) framework is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

As of 20/21 all community pharmacy contractors were required to become a HLP as agreed in the five-year CPCF; this reflects the priority attached to public health and prevention work. HLP aims to maximise the role of the pharmacy in prevention of ill health, reduction of disease burden, reduction of health inequalities and in support of health and wellbeing. The HLP concept is designed to develop (in respect of health and wellbeing services):

- The community pharmacy workforce.
- Community pharmacy engagement with the general public (including "Making Every Contact Count" - MECC).
- Community pharmacy engagement with local stakeholders such as local authorities, voluntary organisations and other health and social care professionals.
- The environment in which health and wellbeing services are delivered.

12.3. Ageing Well

The One Halton Health & Wellbeing Strategy includes priority action aimed specifically at maintaining healthy ageing and supporting independence. As seen in section 3.2.5 community pharmacies provide NHS influenza vaccination to at risk adults through the advanced services contract. All community pharmacies in Halton provide this service.

In addition to dispensing prescriptions pharmacies can contribute to health and wellbeing issues relating to ageing well:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Signposting people using the pharmacy to other providers of services or support.
- Identify through CPCS and NMS where polypharmacy may potentially contribute to older people being at risk of a fall.

Pharmaceutical Needs Assessment

Part 4: Appendices

Appendix 1: Policy Context

'A Vision for Pharmacy in the New NHS'

In the last five years, the pace of change for NHS community pharmaceutical services has probably been more rapid than at any other time in the last 60 years. In that same period, community pharmacy has featured more prominently in how to improve services, how its potential can be more widely recognised by the NHS and by other health professionals, and how its ability to respond innovatively and creatively can be better utilised. That is what was intended when the Department of Health launched *A Vision for Pharmacy in the New NHS* in July 2003, which identified and aligned the ambitions for pharmacy alongside the wider ambitions for the NHS as a whole.

The current policy context shaping the direction of pharmacy services has its roots in the publication of '*Choosing Health'* published by the Government in 2004. This programme of action aimed to provide more of the opportunities, support and information people want to enable them to improve their health.

'Choosing Health Through Pharmacy'

As part of the *Choosing Health* programme, the Government made a commitment to publish a strategy for pharmaceutical public health which expanded the contribution that pharmacists, their staff and the premises in which they work can make to improving health and reducing health inequalities.

This strategy recognised that pharmacists work at the heart of the communities they serve and they enjoy the confidence of the public. Every day, they support self-care and provide health messages, advice and services in areas such as diet, physical activity, stop smoking and sexual health.

A New Contractual Framework

As part of the *Vision for Pharmacy* a new community pharmacy contractual framework was put in place in April 2005. It comprises three tiers of services – essential, advanced and local enhanced services.

- Essential services are those which every pharmacy must provide, including dispensing.
- Advanced services are those which, subject to accreditation requirements, a pharmacy contractor can choose to provide.
- Local enhanced services, such as health and lifestyle advice or help for substance misusers, are commissioned locally by PCTs direct with contractors.

Community pharmacies are remunerated through this national contractual framework, the majority of the income to community pharmacy is made through fees, allowances and retained purchasing profit, which is controlled at a national level to provide an agreed return on investment to pharmacy contractors. In return, pharmacy contractors must provide certain specified services at agreed times. Around 85% of community pharmacy income nationally comes from NHS services. A growing source of income to community pharmacies comes from providing enhanced services commissioned by PCTs. Pharmacies provide both NHS funded care and services that are paid for directly by the patient. Some community pharmacies provide these non-NHS services to our population. These include:

- Over the counter medication, including supply of emergency hormonal contraception and smoking cessation
- Measurements like blood pressure, weight and height
- Diagnostic tests like cholesterol and blood glucose

'Our health, our care, our say'

This White Paper in January 2006 set out a new strategic direction for improving the health and well-being of the population. It focused on a strategic shift to locate more services in local communities closer to people's homes. This recognised the vital role that community pharmacies provide in providing services which support patients with long term conditions and make treatment for minor illnesses accessible and convenient.

'NHS Next Stage Review'

The final report set out a vision of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. The changes that are now being taken forward, locally and nationally, will see the NHS deliver high quality care for all users of services in all aspects, not just some. It will see services delivered closer to home, a much greater focus on helping people stay healthy and a stronger emphasis on the NHS working with local partners. Pharmacy has a key role to play in delivering this vision, particularly as a provider of services which prevent ill-health, promote better health for all and improve access to services within communities.

'Pharmacy in England - Building on strengths delivering the future'

In April 2008 the government set out its plans in this Pharmacy White Paper and subsequently a consultation was undertaken on the proposed changes to the regulations for pharmacy.

This White Paper sets out a vision for improved quality and effectiveness of pharmaceutical services, and a wider contribution to public health. Whilst acknowledging good overall provision and much good practice amongst providers, it revealed several areas of real concern about medicines usage across the country. It seeks to address these through a work programme, which will challenge and engage PCTs, pharmacists and the NHS.

It identifies practical, achievable ways in which pharmacists and their teams can improve patient care in the coming years. It sets out a reinvigorated vision of pharmacy's potential to contribute further to a fair, personalised, safe and effective NHS. This vision demonstrates how pharmacy can continue, and expand further, its role in an NHS that focuses as much on prevention as it does on treating sick people, helping to reduce health inequalities, supporting healthy choices, improving quality and promoting wellbeing for patients and public alike.

This White Paper has put forward a broad range of proposals to build on progress over the last three years, which has succeeded in embedding community pharmacy's role in improving health and wellbeing and reducing health inequalities. An overview is set out below in Figure 21. This includes proposals for nationally commissioned additions to the contract in future years for how pharmacies will, over time:

- offer NHS funded treatment for many minor ailments (e.g. coughs, colds, stomach problems) for people who do not need to go to their local GP;
- provide specific support for people who are starting out on a new course of treatment for long term conditions such, as high blood pressure or high cholesterol;
- be commissioned based on the range and quality of services they deliver.

Figure 21: Pharmacy White Paper – Summary

Building on strengths – delivering the future
The Aims of the White Paper, Pharmacy in England

Supporting healthy living and better care
Community pharmacies will become 'healthy living' centres providing a primary source of information for healthy living and health improvement.

Pharmacy will be integrated into public health initiatives such as stop smoking, sexual health services and weight management, or offer screening for those at risk of vascular disease – an area where there are significant variations in access to services and life expectancy around the country.

Better, safe use of medicines
Safe medication practices should be embedded in patient care by identifying, introducing and evaluating systems designed to reduce unintended hospital admissions related to medicines use.

Identifying specific patient groups for MURs, using MURs and repeat dispensing to identify and reduce the amount of unused medicines and including pharmacists in care pathways for long term conditions are all examples of this.

Access and choice
Community pharmacies improve access and choice through more help with medicines. This will be realised by developing MURs, repeat dispensing, access to urgent medicines, emergency supply and working with hospitals on medicine reconciliation.

Integration and interfaces
Community based pharmaceutical care will be developed which will involve creating new alliances between hospital and community pharmacists as well as primary care pharmacists and pharmacy technicians.

Quality
Underpinning all of this in the White Paper and the other policy drivers mentioned earlier is continual improvement in quality. This is a recurring theme throughout all the policy drivers currently influencing the development of community pharmacy. This refers to staff, premises and services alike. PCTs have a responsibility to ensure continuous quality by monitoring the community pharmacy services against the strategic tests.

'Healthy lives, healthy people',

The public health strategy for England (2010) says:

> *"Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities."*

This is relevant to local authorities as they have responsibility for public health in their communities.

In addition, community pharmacy is an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and long term partner.

Equity and excellence: Liberating the NHS (2010)

> *"Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available. Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health".*

Community pharmacy is at the forefront of self-care, health promotion and is ably qualified to assist people to manage long term conditions, the vast majority of which are managed via the use of medication. Advanced services under the contract should be maximized to ensure patients get access to the support that they need.

October 2011 - Market entry by means of pharmaceutical needs assessments and quality and performance (market exit)

The NHS Act 2006 required the Secretary of State for Health to make Regulations concerning the provision of NHS pharmaceutical services in England. The Health Act 2009 amended these provisions by providing that PCTs must develop and publish PNAs; and PCTs would then use their PNAs as the basis for determining entry to the NHS pharmaceutical services market.

The Health Act 2009 also introduced new provisions which allow the Secretary of State to make regulations about what remedial actions PCTs can take against pharmacy and dispensing appliance contractors who breach their terms of service or whose performance is poor or below standard.

The first set of Regulations dealing with the development and publication of PNAs, the NHS (Pharmaceutical Services and Local Pharmaceutical Services)(Amendment) Regulations 2010 (S.I. 2010/914) were laid on 26 March 2010 and came into force on 24 May 2010.

Later the National Health Service (Pharmaceutical Services) Regulations 2012 ("the 2012 Regulations") and draft guidance came into force concerning the remaining provision under the Health Act 2009.

Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012

From 1st April 2013, every HWB in England will have a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a PNA. This is of particular relevance for local authorities and commissioning bodies. Guidance outlines the steps required to produce relevant, helpful and legally robust PNAs.

Consolidation Applications

On 5 December 2016, amendments to the 2013 Regulations come into effect.

NHS pharmacy businesses may apply to consolidate the services provided on two or more sites onto a single site. Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means they will not be assessed against the PNA. Instead, consolidation applications will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation. Some provision is also made in respect of continuity of services so, if NHS England commissions enhanced services from the contract the closing premises, then the applicant is required to give an undertaking to continue to provide those services following consolidation.

If NHS England is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application.

If NHS England grants the application, it must then refuse any further "unforeseen benefits applications" seeking inclusion in the pharmaceutical list, if the applicant is seeking to rely on the

consolidation as a reason for saying there is now a gap in provision, at least until the next revision of the PNA.

July 2019 - The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan

This builds upon the reforms started in 2015 with the introduction of the QPS to move pharmacies towards a much more clinically focused service whilst confirming community pharmacy's future as an integral part of the NHS, delivering clinical services as a full partner in local Primary Care Networks.

Appendix 2: Abbreviations Used

ABPM	Ambulatory Blood Pressure Monitor
ASCOF	Adult Social Care Outcomes Framework
AUR	Appliance Use Review
BP	Blood pressure
CATC	Care at the Chemist
CCG	Clinical Commissioning Group
CIPHA	Combined Intelligence for Population Health Action
CPAF	Community Pharmacy Assurance Framework
CPCF	Community Pharmacy Contractual Framework
CPCS	Community Pharmacist Consultation Service
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
DALP	Delivery and Allocations Local Plan
DMS	Discharge Medicines Service
DSP	Distance Selling Pharmacy
EHC	Emergency Hormonal Contraception
GIRES	Gender Identity Research & Education Society
GP	General Practice / General Practitioner
HBC	Halton Borough Council
HCV	Hepatitis C virus
HIV	Human Immunosufficiency Virus
HLE	Healthy life expectancy
HLP	Healthy Living Pharmacy
HWB	Health and Wellbeing Board
ICS	Integrated Care System
ID	(English) Indices of Deprivation
IMD	Index of Multiple Deprivation
JHWBS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs assessment
LAPHT	Local Authority Public Health Team
LD	Learning disability(ies)
LE	Life expectancy
LGB(T)	Lesbian, Gay, Bisexual (Transgender)
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
NHS	National Health Service
MCA	Multi-compartment Compliance Aids
MECC	Making Every Contact Count
MHCLG	Ministry for Housing & Local Government
NHS BSA	NHS Business Services Authority
NHSE	NHS England
NICE	National Institute for Health and Clinical Excellence
NMS	New Medicines Service
NRT	Nicotine Replacement Therapy

NSP	Needle & Syringe (exchange) Programme
OHID	Office for Health Improvement & Disparities
ONS	Office of National Statistics
PCDG	Pharmacy Contracts and Development Group
PCN	Primary Care Network
PCT	Primary Care Trust
PGD	Patient Group Direction
PHE	Public Health England
PNA	Pharmaceutical Needs Assessment
PQS	Pharmacy Quality Scheme
PSNC	Pharmaceutical Services Negotiating Committee
PWIDs	people who inject drugs
QOF	Quality Outcomes Framework
SAC	Stoma Appliance Customisation
SHLAA	Strategic Housing Land Availability Assessment
SMI	Severe Mental Illness
UKHSA	UK Health Security Agency
UTC	Urgent Treatment Centres
WHO	World Health Organization

Appendix 3: Community Pharmacy addresses and opening hours

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hour pharmacy
RUNCORN											
Asda Pharmacy	West Lane	Runcorn	WA7 2PY	08:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 22:00	10:30 - 16:30	Y
Boots the Chemist	90 Forest Walk	Halton Lea Shopping Centre	WA7 2GX	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:00	Closed	
Boots	Hallwood Health Centre	Hospital Way	WA7 2UT	07:00 - 18:30	07:00 - 18:30	07:00 - 18:30	07:00 - 18:30	07:00 - 18:30	Closed	Closed	
Boots Pharmacy	21 High Street	Runcorn	WA7 1AP	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 13:00	Closed	
Boots Castlefields	Castlefields Primary Care Centre	Runcorn	WA7 2ST	08:00 - 18:30	08:00 - 18:30	08:00 - 18:30	08:00 - 18:30	08:00 - 18:30	08:30 - 12.30	Closed	
Murdishaw Pharmacy	Gorsewood Road	Murdishaw	WA7 6DA	08:30 - 18:00	08:30 - 18:00	08:30 - 18:00	08:30 - 18:00	08:30 - 18:00	Closed	Closed	
Peak Pharmacy	51-53 Church Street	Runcorn	WA7 1LQ	09:00 - 13:00 13:30 - 17:30	09:00 - 13:00 13:30 - 17:30	09:00 - 13:00 13:30 - 17:30	09:00 - 13:00 13:30 - 17:30	09:00 - 13:00 13:30 - 17:30	09:00 - 13:00	Closed	
Peak Pharmacy	49 High Street	Runcorn	WA7 1AH	08:45 - 13:30 14:00 - 18:00	08:45 - 13:30 14:00 - 18:00	08:45 - 13:30 14:00 - 18:00	08:45 - 13:30 14:00 - 18:00	08:45 - 13:30 14:00 - 18:00	Closed	Closed	
Superdrug Pharmacy	89 Forest Walk	Halton Lea	WA7 2GX	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	09:00 - 17:30	Closed	
Well Pharmacy	11 Grangeway	Runcorn	WA7 5LY	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 12:30	Closed	
Wise Pharmacy Ltd	27 Hillcrest	Runcorn	WA7 2DY	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	09.00 - 17.30	Closed	Closed	
Wise Pharmacy Ltd	Windmill Hill Shopping Centre	Windmill Hill Avenue West	WA7 6QZ	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 12:00	Closed	
DISTANCE SELLING 'INTERNET' PHARMACIES											
Calea UK Ltd	Cestrian Court	Eastgate Way	WA7 1NT	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	Closed	Closed	
Remedi	Unit 16, Berkley Court	Manor Park	WA7 1TQ	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	Closed	Closed	
Wise Pharmacy Ltd	Unit 7. Jenson Court	Runcorn	WA7 1SQ	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Hey Pharmacist	1 Rivington Road	Preston Brook	WA7 3DJ	09:00 - 18:00	09:00 - 18:01	09:00 - 18:02	09:00 - 18:03	09:00 - 18:04	Closed	Closed	

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hour pharmacy
WIDNES											
Appleton Village Pharmacy	Appleton Village	Widnes	WA8 6EQ	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	08:00 - 22:00	10:00 - 16:00	Y
Asda Pharmacy	Widnes Road	Widnes	WA8 6AH	08:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 22:00	10:00 - 16:00	Y
Boots Pharmacy	Unit 7 Widnes Shopping Park	High Street	WA8 7TN	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 19:00	10:00 - 16:00	
Cohens Chemist	222a Liverpool Road	Ditton	WA8 7HY	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	Closed	Closed	
Cookes Ltd	76 Albert Road	Widnes	WA8 6JT	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Ditton Pharmacy	203 Hale Road	Widnes	WA8 8QB	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Farnworth Village	11 Farnworth Street	Widnes	WA8 9LH	09:00 - 13:00 14:00 - 17:30	09:00 - 13:00 14:00 - 17:30	09:00 - 13:00 14:00 - 17:30	09:00 - 13:00 14:00 - 17:30	09:00 - 13:00 14:00 - 17:30	09:00 - 11:30	Closed	
Hale Village Pharmacy	3 Ivy Farm Court	Hale Village	L24 4PG	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Lloyds Pharmacy	Hough Green Health Park	45-47 Hough Green Road	WA8 4NJ	08:45 - 18:00	08:45 - 18:00	08:45 - 18:00	08:45 - 18:00	08:45 - 18:00	09:00 - 13:00	Closed	
McDougalls's Pharmacy	Widnes Health Care Resource Centre	Oaks Place	WA8 7GD	09:00 - 19:00	09:00 - 19:00	09:00 - 19:00	09:00 - 18:30	09:00 - 19:00	09:00 - 17:00	Closed	
Nicholson's Pharmacy	17 Queens Avenue	Ditton	WA8 8HR	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 13:00 14:00 - 18:00	Closed	
Strachan's Chemist	445 Hale Road	Widnes	WA8 8UU	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 13:00	Closed	
Tesco In-store Pharmacy	Ashley Retail Park	Lugsdale Road	WA8 7YT	08:00 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:00	10:00 - 16:00	Y
Upton Rocks Pharmacy	12a Cronton Lane	Widnes	WA8 5AJ	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 13:00	Closed	
Well Pharmacy	Peel House Medical Plaza	Peel House Lane	WA8 6TN	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	Closed	Closed	
West Bank pharmacy	8a Mersey Road	West Bank	WA8 0DG	09:00 - 18:30	09:00 - 18:30	09:00 - 18:30	09:00 - 18:30	09:00 - 18:30	Closed	Closed	
Widnes Late Night Pharmacy	Peel House Lane	Widnes	WA8 6TE	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	10:00 - 20:00	Y
Wise Pharmacy Ltd	204 Warrington Road	Widnes	WA8 0AX	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 12:00	Closed	

Appendix 4: Community Pharmacy services

Runcorn																	
Pharmacy details			Advanced Services							Locally Commissioned: Public Health						Locally Commissioned: NHS		
Name	Ward Location	Post Code	CPCS	NMS	Flu	AUR	Stoma-Cust	HepC	Hypert	IM-SCESS	NRT	Varen	SUPCON	NS-Ex	EHC	CATC	PALL	MECPS
Asda Pharmacy, West Lane, Runcorn	Halton Lea	WA7 2PY	Yes	Yes	Yes	Yes			Yes		Yes	Yes	Yes		Yes	Yes	Yes	Yes
Boots Pharmacy, Halton Lea Shopping Centre, Runcorn	Halton Lea	WA7 2GX	Yes	Yes	Yes								Yes			Yes		
Boots Pharmacy, Castlefields Primary Care Centre, Runcorn	Halton Castle	WA7 2ST	Yes	Yes	Yes			Yes	Yes		Yes		Yes		Yes	Yes		
Boots Pharmacy, Hallwood Health Centre, Runcorn	Halton Lea	WA7 2UT	Yes	Yes	Yes			Yes	Yes		Yes		Yes			Yes		
Boots Pharmacy, 21 High Street, Runcorn	Mersey	WA7 1AP	Yes	Yes	Yes				Yes							Yes		
Murdishaw Pharmacy, Gorsewood Road, Runcorn	Norton South	WA7 6ES	Yes	Yes	Yes						Yes		Yes		Yes	Yes		Yes
Peak Pharmacy, 51-53 Church Street, Runcorn	Mersey	WA7 1LQ	Yes	Yes	Yes	Yes					Yes		Yes	Yes	Yes	Yes	Yes	
Peak Pharmacy, 49 High Street, Runcorn	Mersey	WA7 1AH	Yes	Yes	Yes				Yes		Yes				Yes	Yes		
Superdrug Pharmacy, Halton Lea Shopping Centre	Halton Lea	WA7 2BX	Yes	Yes	Yes	Yes					Yes		Yes		Yes	Yes		
Well Pharmacy, 11 Grangeway, Runcorn	Grange	WA7 5LY	Yes	Yes	Yes					Yes			Yes	Yes	Yes	Yes		
Wise Pharmacy Ltd, 27 Hillcrest, Runcorn	Halton Brook	WA7 2DY	Yes	Yes	Yes										Yes	Yes		
Wise Pharmacy Ltd, Windmill Hill Shopping Centre, Runcorn	Windmill Hill	WA7 6QZ	Yes	Yes	Yes					Yes			Yes			Yes		

Commissioned by	KEY	
NHSE	CPCS	Community Pharmacy Consultation Service
	NMS:	New Medicines Service
	Flu:	NHS Influeza Vaccination (all adults at risk)
	AUR	Appliance Use Review
	Stoma-Cust	Stoma Customisation
	HepC:	Hepatitis C antibody testing service
	Hypert:	Hypertension Case Finding
	Smok:	Smoking Cessation
LA PH	IM-SCESS:	Intermediate Smoking Cessation
	NRT:	Nictotine Replacement Therapy (NRT) Vouchers
	Varen:	Varenicline Initiation
	SUPCON:	Supervised Consumption - Methadone
	NS-Ex:	Needle & Syringe Exchange Service
	EHC:	Emergency Hormonal Contraception
NHS	CATC:	Care at the Chemist (minor ailments)
	PALL:	Palliative Care Medicines Service
	MECPS:	Minor Eye Conditions Pharmacy Service

Widnes																	
Pharmacy details			Advanced Services							Locally Commissioned: Public Health						Locally Commissioned: NHS		
Name	Ward Location	Post Code	CPCS	NMS	Flu	AUR	Stoma-Cust	HepC	Hypert	IM-SCESS	NRT	Varen	SUPCON	NS-Ex	EHC	CATC	PALL	MECPS
Appleton Village Pharmacy	Appleton	WA8 6EQ	Yes	Yes	Yes					Yes	Yes	Yes			Yes	Yes		Yes
Asda Pharmacy, Widnes Road, Widnes	Kingsway	WA8 6AH	Yes	Yes	Yes				Yes		Yes				Yes	Yes	Yes	Yes
Boots Pharmacy, Unit 7, Widnes Shopping Centre	Appleton	WA8 7TN	Yes	Yes	Yes								Yes	Yes	Yes	Yes		
Cohens Chemist, 22a Liverpool Road, Widnes	Broadheath	WA8 7HY	Yes	Yes	Yes				Yes		Yes		Yes		Yes	Yes		Yes
Cookes Ltd, 76 Albert Road, Widnes	Appleton	WA8 6JT	Yes	Yes	Yes	Yes					Yes		Yes	Yes	Yes	Yes		
Ditton Pharmacy, 203 Hale Road, Widnes	Ditton	WA8 8QB	Yes	Yes	Yes						Yes		Yes		Yes	Yes		
Farnworth Village, 11 Farnworth Street, Widnes	Farnworth	WA8 9LX	Yes	Yes	Yes	Yes		Yes	Yes				Yes		Yes	Yes		
Hale Village Pharmacy, 3 Ivy Farm Court, Widnes	Hale	L24 4AG	Yes	Yes	Yes			Yes			Yes	Yes			Yes	Yes		
Lloyds Pharmacy, Hough Green Health Park, Widnes	Hough Green	WA8 4NJ	Yes	Yes	Yes						Yes	Yes	Yes		Yes	Yes		Yes
McDougalls's Pharmacy, Health Care Resource Centre, Widnes	Kingsway	WA8 7GD	Yes	Yes	Yes					Yes	Yes		Yes			Yes		
Nicholson's Pharmacy, 17 Queens Avenue, Widnes	Ditton	WA8 8HR	Yes	Yes	Yes								Yes			Yes		
Strachan's Chemist, 445 Hale Road, Widnes	Ditton	WA8 8UU	Yes	Yes	Yes				Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Tesco In-store Pharmacy, Ashley Retail Park, Widnes	Riverside	WA8 7YT	Yes	Yes	Yes	Yes					Yes				Yes	Yes		
Upton Rocks Pharmacy, Fir Park Health Centre, Lanark Gardens, Widnes	Birchfield	WA8 9DT	Yes	Yes	Yes			Yes	Yes						Yes	Yes		
Well Pharmacy, Peel House Medical Plaza, Widnes	Appleton	WA8 6TN	Yes	Yes	Yes				Yes		Yes		Yes	Yes	Yes			
West Bank pharmacy, 8a Mersey Road, Widnes	Riverside	WA8 0DG	Yes	Yes	Yes	Yes	Yes		Yes		Yes		Yes		Yes	Yes		
Widnes Late Night Pharmacy, Peel House Lane, Widnes	Appleton	WA8 6TR	Yes	Yes	Yes	Yes					Yes				Yes	Yes	Yes	
Wise Pharmacy Ltd, 204 Warrington Road, Widnes	Halton View	WA8 0AX	Yes	Yes	Yes										Yes	Yes		

Appendix 5: Cross border Community Pharmacy service provision

Number on map	Pharmacy Name	Address	Postcode
CHESHIRE WEST & CHESTER			
1	Boots Pharmacy	Princeway, Frodsham	WA6 6RX
2	Boots Pharmacy	7 Church Street, Frodsham	WA6 7DN
3	Frodsham Pharmacy	59 Kingsley Road, Frodsham	WA6 6SJ
WARRINGTON			
4	Well Pharmacy	Baths Health & Wellbeing Centre	WA1 1UG
5	Chapelford Pharmacy	Chapelford Health Centre, Santa Rosa Boulevard	WA5 3AG
6	Green Cross Pharmacy	1 Allen Street	WA2 7JD
7	Superdrug Pharmacy	Inside Savers, Unit e, Cockhedge Way	WA1 2QQ
8	Well Pharmacy	45 Dudlow Green Road	WA4 5EQ
9	Hood Manor Pharmacy	Great Sankey Medical Centre, Dorchester Road	WA5 1UH
10	Lloyds Pharmacy	Penketh Medical Centre, Honiton Way	WA5 2EY
11	Aston Pharmacy	2 Station Road	WA5 1RQ
12	Thomas Brown Pharmacy	51 London Road	WA4 6SG
13	Boots Pharmacy	Unit 5, 19/25 London Road	WA4 6SG
14	Stockton Heath Pharmacy	Stockton Heath Med Centre, The Forge	WA4 6HJ
15	Rowlands Pharmacy	Guardian Street	WA5 1UP
16	Boots Pharmacy	19 The Mall, Golden Square	WA1 1QE
17	Superdrug Pharmacy	36-38 The Mall, Golden Square	WA1 1QE
18	Corker's Pharmacy	14-16 Buttermarket Street	WA1 2LL
ST HELENS			
19	Heath Pharmacy	18 Elephant Lane	WA9 5QW
20	Co-op Health	Lea Green Depot, Elton Head Road	WA9 5AU
21	Four Acre Chemist	1&2 Four Acre Lane	WA9 4BZ
22	Rowlands Pharmacy	Four Acre Health Centre, Burnage Avenue	WA9 4QB
23	Longsters Pharmacy	578 Warrington Road	L35 4LZ
24	Lloyds Pharmacy	473 Warrington Road	L35 4LL
KNOWSLEY			
25	Jacobs Pharmacy	18 Camberley Drive	L25 9PU
26	Boots Pharmacy	Old Colliery Road	L35 3SX
27	Cohens Chemist	The Pharmacy & Medical Ct, Hollies Road	L26 0TH
28	Boots Pharmacy	Halewood Health Res. Centre, Roseheath Drive	L26 9UH

LIVERPOOL			
29	Hunts Cross Pharmacy	4 Woodend Avenue	L25 0PA
30	Green Cross Pharmacy	West Speke Health Centre, Blacklock Hall Road	L24 3TY
31	Asda Pharmacy	Unit 20, Hunts Cross Shopping Centre	L24 9GB
32	Ritecare Pharmacy	Unit 106, Compass Network Centre	L24 1YA
33	Rowlands Pharmacy	New Neighbourhood Health Centre, South Parade	L24 2SD
34	Rowlands Pharmacy	15 Penketh Drive	L24 2WZ
35	Lloyds Pharmacy	109 East Millwood Road	L24 6TH
36	Woolton Late Night Pharmacy	267 Hunts Cross Avenue	L25 9ND
37	Boots Pharmacy	Unit 9, New Mersey Retail Park	L24 8QB

Appendix 6: Pharmacy Premises and Services Questionnaire

A questionnaire to gather information from all pharmacies was devised as a collaborative exercise with Cheshire & Merseyside local authority PNA leads, Local Pharmaceutical Committee (LPC) representatives and NHSE. It was conducted online via Pharm Outcomes. Both the LPCs and NHSE sent communications to pharmacies to encourage completion.

Premises Details

Contractor Code (ODS Code)	
Trading Name	
Pharmacy postcode	
Is this a distance selling pharmacy?	☐ Yes ☐ No
Pharmacy email address	
Pharmacy telephone	
Consent to store	☐ Yes ☐ No

Contact Details

Contact details of person completing questionnaire, if questions arise		
Name:	Phone:	Email:
Contact details for head office (if different/appropriate)		
Name:	Phone:	Email:

Opening hours

Day	Open from	To	Lunchtime (From – To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Potential for increased demand

Ability to adapt to demand (tick one)	We have sufficient capacity within our existing premises and staffing levels to manage an increase in demand in our area, or	☐
	We don't have sufficient premises and staffing capacity at present but could make adjustments to manage an increase in demand in our area, or	☐
	We don't have sufficient premises and staffing capacity and would have difficulty in managing an increase in demand.	☐

Consultation facilities

Is there a consultation area (tick one)	None, have submitted a request to NHSE&I that the premises are too small for a consultation room, or	☐
	None, NHSE&I has approved my request that the premises are too small for a consultation room, or	☐
	None (Distance Selling Pharmacy)	☐
	Available (including wheelchair access)	☐
	Available (without wheelchair access)	☐
	Planned before 1st April 2023	☐
	Other (specify)	☐
Is this enclosed?		☐ Yes ☐ No N/A ☐
Number of consultation rooms		1,2,3, 4+
Off-site arrangements (one of)	Off-site consultation room approved by NHS	☐ Yes ☐ No
	Willing to undertake consultations in patient's home / other suitable site?	☐ Yes ☐ No
	None apply	☐ Yes ☐ No
	Other	☐ Yes ☐ No
Facilities available (one or more of)	Handwashing in consultation area	☐
	Handwashing facilities close to consultation area	☐
	Have access to toilet facilities	☐
	None	☐

Essential Services (appliances)

Does the pharmacy dispense the following?

	Yes	No
Stoma appliances	☐	☐
Incontinence appliances	☐	☐
Dressings	☐	☐
Other (please specify)	☐	☐

Advanced services

Does the pharmacy provide the following services?

	Yes	Soon	No
New Medicine Service	☐	☐	☐
Appliance Use Review service	☐	☐	☐
Stoma Appliance Customisation service	☐	☐	☐
NHS Flu Vaccination Service	☐	☐	☐
NHS Community Pharmacist Consultation Service	☐	☐	☐

Commissioned Service

	CP: Currently providing NHS funded service	WA - Willing and able to provide if commissioned	PP - Currently providing company led/private service	NW - Not willing or able to provide service
Anticoagulant Monitoring Service	☐	☐	☐	☐
Anti-viral Distribution Service	☐	☐	☐	☐
Care Home Service	☐	☐	☐	☐
Gluten Free Food Supply Service	☐	☐	☐	☐

	CP: Currently providing NHS funded service	WA - Willing and able to provide if commissioned	PP - Currently providing company led/private service	NW - Not willing or able to provide service
Home Delivery Service (not appliances)	☐	☐	☐	☐
Language Access Service	☐	☐	☐	☐
Schools Service	☐	☐	☐	☐
Sharps Disposal Service	☐	☐	☐	☐
Urgent Care				
Minor Ailments Scheme	☐	☐	☐	☐
Out of Hours Services	☐	☐	☐	☐
On Demand Availability of Specialist Drugs Service	☐	☐	☐	☐
Palliative Care Scheme	☐	☐	☐	☐
Dressings	☐	☐	☐	☐
Disease specific medicines management service				
Allergies	☐	☐	☐	☐
Alzheimer's/dementia	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
CHD	☐	☐	☐	☐
Chronic Kidney Disease	☐	☐	☐	☐
COPD	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes type I	☐	☐	☐	☐
Diabetes type II	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Parkinson's disease	☐	☐	☐	☐
Other (please state, including funding source)	☐	☐	☐	☐
Public Health Services				
Emergency Hormonal Contraception Service	☐	☐	☐	☐
Quick Start Contraception Service	☐	☐	☐	☐
Contraception Service	☐	☐	☐	☐
Chlamydia testing	☐	☐	☐	☐
Chlamydia Treatment Service	☐	☐	☐	☐
Contraception Injection Service	☐	☐	☐	☐
Needle and Syringe Exchange Service	☐	☐	☐	☐
Obesity Management (adults and children)	☐	☐	☐	☐
NRT Voucher Dispensing Service	☐	☐	☐	☐
Smoking Cessation Counselling Service	☐	☐	☐	☐
Varenicline (Champix) PGD Service	☐	☐	☐	☐
Supervised Administration	☐	☐	☐	☐
If you provide supervised administration services, is this done in private	☐ Yes ☐ at patient request ☐ n/a			

	CP: Currently providing NHS funded service	WA - Willing and able to provide if commissioned	PP - Currently providing company led/private service	NW - Not willing or able to provide service
Medicines Optimisation				
Medicines Optimisation Service	☐	☐	☐	☐
Therapeutic areas covered (if providing)	Free text field			
Domiciliary Medicines Administration Records (MAR)	☐	☐	☐	☐
Medicines Assessment and Compliance Support Service	☐	☐	☐	☐
Independent Prescribing Service	☐	☐	☐	☐
Therapeutic areas covered (if providing)	Free text field			
Supplementary Prescribing	☐	☐	☐	☐
Which therapy area	Free text box			
Not Dispensed Scheme	☐	☐	☐	☐
Prescriber Support Service	☐	☐	☐	☐
Screening Services				
Alcohol	☐	☐	☐	☐
Atrial Fibrillation service	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Gonorrhoea	☐	☐	☐	☐
H. pylori	☐	☐	☐	☐
HbA1C	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Phlebotomy Service	☐	☐	☐	☐
Vascular Risk Assessment Service	☐	☐	☐	☐
Other (please state – including funding source)	Free text box			
Vaccinations				
Seasonal Influenza Vaccination Service (not NHS Service)	☐	☐	☐	☐
Childhood vaccinations	☐	☐	☐	☐
HPV	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Pneumococcal (PPV)	☐	☐	☐	☐
Meningococcal Vaccinations	☐	☐	☐	☐
Shingles	☐	☐	☐	☐
Travel vaccines	☐	☐	☐	☐
Whooping Cough	☐	☐	☐	☐
COVID-19 Vaccinations	☐	☐	☐	☐
Other – (please state – including funding source)	Free text box			

Collection and Delivery services

Collection of prescriptions from surgeries	☐ Yes ☐ No
Delivery of dispensed medicines – Free of charge on request	☐ Yes ☐ No
Delivery of dispensed medicines - Chargeable	☐ Yes ☐ No

Monitored Dosage Systems	
Monitored/Community Dosage Systems – Free of charge on request if not covered by Equality Act (DDA)	☐ Yes ☐ No
Monitored/Community Dosage Systems – chargeable if not covered by Equality Act (DDA)	☐ Yes ☐ No
Monitored/Community Dosage Systems - Not provided unless covered by Equality Act (DDA	☐ Yes ☐ No

Accessibility

Can customers legally park within 50 metres of the pharmacy?		☐ Yes ☐ No
How far is the nearest bus stop/train station?		☐ Within 100m ☐ 100m to 500m ☐ 500m to 1km ☐ 1km+ ☐ None
Do pharmacy customers have access to a designated disabled parking?		☐ Yes ☐ No
Is the entrance to the pharmacy suitable for wheelchair access unaided?		☐ Yes ☐ No
Are all areas of the pharmacy floor accessible by wheelchair?		☐ Yes ☐ No
Do you have any other facilities in the pharmacy aimed at supporting disabled people access your service?	Automatic door assistance	☐ Yes ☐ No
	Bell at front door	☐ Yes ☐ No
	Toilet facilities accessible by wheelchair users	☐ Yes ☐ No
	Hearing loop	☐ Yes ☐ No
	Sign language	☐ Yes ☐ No
	Large print labels	☐ Yes ☐ No
	Large print leaflets	☐ Yes ☐ No
	Wheelchair ramp access	☐ Yes ☐ No
	Other, please state	Free text field
Are you able to offer support to people whose first language is not English? If so how?	Use of interpreter/language line	☐ Yes ☐ No
	Staff at pharmacy speak languages other than English (please indicate which languages)	Free text field
Are you able to provide advice and support if a customer wishes to speak to a person of the same sex?	At all times	☐ Yes ☐ No
	By arrangement	☐ Yes ☐ No

Are you aware of any gaps in access or pharmaceutical need for any of the following groups, relating to their:

		If yes, please specify: Free text field
Age	☐ Yes ☐ No	
Disability	☐ Yes ☐ No	
Gender	☐ Yes ☐ No	
People who have had or about to have a reassignment of gender	☐ Yes ☐ No	
Marriage and civil partnership	☐ Yes ☐ No	
Pregnancy and maternity	☐ Yes ☐ No	
Race	☐ Yes ☐ No	
Religion or belief	☐ Yes ☐ No	
Sexual orientation	☐ Yes ☐ No	
Other, (please state)		

Appendix 7: Public Local Pharmacy Services Questionnaire

During November 2021 the public health team conducted a survey at a local health & wellbeing event and online. It asked local residents to give their feedback on their local pharmacy. The online version of the survey was sent out via a wide range of networks including Halton & St Helens Voluntary Action, Health watch, Halton Local Strategic Partnership groups and networks, Halton Clinical Commissioning Group engagement network, and others. 117 responses were received. A press release was also issued to the local paper. The online survey was open for four weeks. The following is the communication sent out and questionnaire.

Pharmacy Services in Halton - Have your say
Halton Borough Council are seeking your views about your local pharmacy.

Please help us to make sure that your local pharmacy is providing the right services and support for you and your family by completing a short survey.

Your responses will help Halton's Health and Wellbeing Board to produce its local Pharmaceutical Needs Assessment (PNA). This document will help to ensure that your local pharmacy provides the service you need both now and in the future.

Interim Director of Public Health, Dr Ifeoma Onyia said:
"The local pharmacy is often the first place residents will turn to when they have a concern about their health or that of their family. It is for this reason that it is important we look into the needs of Halton's population and how pharmacies can meet these needs. I would ask everyone to get involved and respond to this important survey, to help us shape the future of the service."

The questionnaire is anonymous and should only take a few minutes to complete.

How to get involved
To give us your views complete this questionnaire or go to https://www.surveymonkey.co.uk/r/GBTVKJD and fill in the on-line questionnaire.
Paper versions of the survey are available by calling 0151 511 7864 (Monday to Friday between 9:00 and 4:00pm) and providing your name and postal address

LOCAL SURVEY OF COMMUNITY PHARMACY SERVICES

Thank you for agreeing to complete this questionnaire which is asking for your views on the current provision of pharmacy services in your local area

A pharmacy or Chemist is a place you would use to get a prescription dispensed or buy medicines or ask a pharmacist for advice. A pharmacist is the most qualified person in the pharmacy to dispense and sell medicines and give advice

1. In which Local Authority do you live?

☐ Cheshire East ☐ Cheshire West & Chester ☐ Halton ☐ Knowsley

☐ Liverpool ☐ Sefton ☐ St. Helens ☐ Warrington ☐ Wirral

The following questions are about the last time you used a pharmacy

2. Why did you visit the pharmacy? (Please tick all that apply)

☐ To collect a prescription for yourself ☐ To collect a prescription for someone else

☐ To get advice from the pharmacist ☐ To buy other medications I cannot buy elsewhere

☐ Other (please specify)

3. When did you last use a pharmacy to get a prescription, buy medicines or to get advice?

(Please tick one answer only)

☐ In the last week ☐ In the last two weeks ☐ In the last month

☐ In the last three months ☐ In the last six months ☐ Not in the last six months

4. How did you get to the pharmacy? Please tick all that apply

☐ Walking ☐ Public transport ☐ Car ☐ Motorbike

☐ Taxi ☐ Bicycle ☐ Mobility transport ☐ Other (please specify)

5. Thinking about the location of the pharmacy, which of the following is most important to you? (Please tick all that apply)

☐ It is close to my doctor's surgery
☐ It is close to my home
☐ It is close to other shops I use
☐ It is close to my children's school or nursery
☐ It is easy to park nearby
☐ It is near to the bus stop / train station
☐ It is close to where I work
☐ It is close to/in my local supermarket
☐ None of these
☐ Other (please specify)

6. How easy is to get to your usual pharmacy? (*Please tick one answer only)*

☐ Very easy
☐ Quite easy
☐ Quite difficult
☐ Very difficult

7. If you have a condition that affects your mobility, are you able to park close enough to your pharmacy?

☐Yes ☐ No ☐ don't know ☐ not applicable

8. Does your pharmacy deliver medication to your home if you are unable to collect it yourself?

☐Yes ☐ No ☐ don't know/ I have never used this service

9. Can you remember a recent time when you had any problems finding a pharmacy to get a medicine dispensed, to get advice or to buy medicines?

☐ Yes ☐ No (Go to Q12)

10. If Yes, what was your main reason for going to the pharmacy?(*Please tick one answer only)*

☐ To get medicine(s) on a prescription ☐ To buy medicine(s) from the pharmacy
☐ To get advice at the pharmacy ☐ Other (please specify)

11. Please tell us what was the problem in finding a pharmacy?

12. Are you satisfied with the opening hours of your pharmacy?

☐ Yes ☐ No (please specify why below)

13. Were you satisfied with services received from your pharmacy during the pandemic?

☐ Yes ☐ No (please specify why below)

About the last time you found your usual pharmacy, or the one closest to you, closed

14. How many times recently have you needed to use your usual pharmacy (or the pharmacy closest to you) when it was closed?

☐ I haven't needed to use the pharmacy when it was closed (Go to Question 17)
☐ Once or twice ☐ three or four times ☐ four or more times

15. What day of the week was it?

☐ Monday to Friday ☐ Saturday ☐ Sunday ☐ Bank Holiday ☐ can't remember

16. What time of the day was it?

☐Morning ☐ Lunchtime (between 12pm and 2pm) ☐ Afternoon ☐ Evening (after 7pm)
☐ Can't remember

17. What did you do when your pharmacy was closed?

☐ Went to another pharmacy ☐ Waited until the pharmacy was open ☐ went to a hospital
☐ Went to a Walk in Centre ☐ Called NHS 111 ☐ Other (please specify)

About any medicines you receive on prescription and dispensed by your usual, or local pharmacy

18. Did you get a prescription the last time you used a pharmacy?

☐ Yes ☐ No (Go to Q20) ☐ can't remember (Go to Q20)

19. Did the staff at the pharmacy tell you how long you would have to wait for your prescription to be prepared?

☐ Yes ☐ No, but I would have liked to have been told ☐ No, but I did not mind
☐ Can't remember

20. Was this a reasonable period of time?

☐ Yes ☐ No ☐ not applicable

21. Did you get all the medicines that you needed on this occasion?

☐ Yes (Go to Q24) ☐ No ☐ can't remember (Go to Q24)

22. What was the main reason for not getting all your medicines on this occasion? (*Please tick one answer only)*

☐ The pharmacy had run out of my medicine
☐ My GP had not prescribed something I wanted
☐ My prescription had not arrived at the pharmacy
☐ Some other reason

23. How long did you have to wait to get the rest of your medicines?

☐ Later the same day ☐ the next day ☐ two or more days ☐ More than a week ☐ never got it

24. If you have needed to use a hospital pharmacy (e.g. as an outpatient or on discharge following a stay in hospital), would you like to have the option to have the prescription dispensed as your local pharmacy?

☐ Yes ☐ No ☐ I have never used a hospital pharmacy

About times when you needed a consultation, or wished to talk to the pharmacist in the pharmacy

25. Have you had a consultation with the pharmacist recently for any health related purpose?

☐ Yes ☐ No (Go to Q29) ☐ can't remember (Go to Q29)

26. What advice were you given during your consultation?

☐ Lifestyle advice (e.g. stop smoking, diet and nutrition, physical activity etc.)
☐ Advice about a minor ailment
☐ Medicine advice
☐ Emergency contraception advice
☐ Blood pressure monitoring
☐ Referred to other service
☐ Other (please specify)

27. Where did you have your consultation with the pharmacist?

Please tick one

☐ At the pharmacy counter
☐ In the dispensary or a quiet part of the shop
☐ In a separate room
☐ Over the telephone (Go to Q29)
☐ Other (please specify)

28. How do you rate the level of privacy you have in the consultation with the pharmacist?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

About what you feel pharmacies should be able to offer you

29. Please tell us how you would describe your feelings about pharmacies.

☐ I wish pharmacies could provide more services for me
☐ I am satisfied with the range of services pharmacies provide
☐ Don't know

30. Which if any of the services below do you think should be available locally through pharmacies? (Please tick one box in each row)

To get treatment of a minor illness such as a cold instead of my doctor (free of charge if you don't pay for prescriptions)	Yes ☐	No ☐	Not sure ☐
Advice on stopping smoking and/or treatment	Yes ☐	No ☐	Not sure ☐
Advice on contraception and supply of "morning after" pill free of charge	Yes ☐	No ☐	Not sure ☐
Weight management services and advice on diet/exercise for weight management	Yes ☐	No ☐	Not sure ☐
Screening for other conditions	Yes ☐	No ☐	Not sure ☐
Advice and treatment for alcohol misuse	Yes ☐	No ☐	Not sure ☐
Advice and treatment for drug misuse	Yes ☐	No ☐	Not sure ☐
Review of new medicines with advice on when it is best to take them, what they are for and side-effects to expect	Yes ☐	No ☐	Not sure ☐
Provision of the "Flu" vaccination	Yes ☐	No ☐	Not sure ☐
Other immunisations	Yes ☐	No ☐	Not sure ☐

31. Is there anything you particularly value as a service from pharmacies?

32. Is there anything else, or any service that you feel could be provided by local pharmacies?

Finally please provide some details about yourself

24. Are you? ☐Male ☐Female ☐ Non-binary ☐ Prefer not to say

25. How old are you?

☐ Under 16 years ☐ 16-20 years ☐ 21-30 years ☐ 31-40 years ☐ 41-50 years
☐ 51-59 years ☐ 60- 69 years ☐ 70 years or over

26. Please tell us your postcode

36. Disability: Do you have any of the following (Please tick all that apply)

☐ Physical impairment
☐ Visual impairment
☐ Hearing impairment/ Deaf
☐ Mental health impairment/ mental distress
☐ Learning difficulty
☐ Long term illness that affects your daily activity
☐ Other (please specify)

37. If you have ticked any of the boxes above, or you have cancer, diabetes or HIV this would be classed as 'disability' under the legislation. Do you consider yourself to be 'disabled'?

☐ Yes☐ No

38. Which ethnic group do you belong to? (Please tick the appropriate box)

☐ Asian - Bangladeshi ☐ Asian - Indian ☐ Asian - Pakistani ☐ Asian – Other Background
☐ Black - African ☐ Black - British ☐Black - Caribbean ☐ Black – other background
☐ Chinese ☐ Other Chinese Background
☐ Mixed Ethnic Background – Asian & White ☐ Mixed Ethnic Background – Black African & White
☐ Mixed Ethnic Background – Caribbean & White ☐ Mixed Ethnic Background – Other
☐ White - British ☐ White - English ☐ White - Irish ☐ White - Scottish
☐ White - Welsh ☐ White – Gypsy/ Traveller ☐ White – Other

The following questions are a little more personal and you can choose to stop here if you wish. However, it would be helpful if you would consent to complete these questions

39. Do you have a religion or belief?

☐ Yes ☐ No ☐ Prefer not to say

40. If "Yes" please tick one of the options below:

☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish
☐ Muslim ☐ Sikh
☐ Other (please specify)

41. How would you describe your sexual orientation?

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Pansexual ☐ Prefer not to say

42. Do you live in the gender you were given at birth?

☐ Yes ☐ No ☐ Prefer not to say

Thank you for taking the time to complete this survey. The findings will help inform the development of pharmacy services in your local area.
The data you have provided is private and confidential and will not be shared. Only overall anonymised results of this consultation will form part of the final report which will be used to improve the delivery of local services.

Appendix 8: 60-day statutory Consultation Letter and Questionnaire

Dear Sir / Madam

Pharmaceutical Needs Assessment (PNA) Consultation

Our Ref	IO/HL
If you telephone please ask for	Ifeoma Onyia
Date	7 March 2022
E-mail address	ifeoma.onyia@halton.gov.uk

Invitation to Participate

During the reorganisation of the NHS the responsibility for production of the Pharmaceutical Needs Assessments (PNAs) transferred to the Health and Wellbeing Boards (HWB) which are hosted by local authorities.

Halton Health and Wellbeing Board (HWB) is developing a new PNA. This is a statutory HWB responsibility, as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013(SI 2013 No. 349).

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy.

The HWB has established a PNA Task & Finish Group to oversee the development of the new PNA. This group includes membership from our partner organisations, Healthwatch and the Local Pharmaceutical Committee.

As part of the development process, the Regulations require that the HWB undertakes a formal consultation on a draft of its PNA. The key outcomes for this consultation are:

- To encourage constructive feedback from a variety of stakeholders
- To ensure a wide range of primary care health professionals provide opinions and views on what is contained within the PNA

Taking this into account, we would like to invite you to participate in this consultation, which will run from 9am Tuesday 8 March to 5pm Monday 9 May 2022:

- The draft PNA can be found on our website by via the following link

https://webapp.halton.gov.uk/survey_snap/pna.htm

All responses must be in writing.

- Submitting responses: You may choose one of the following options to submit your response:
  - Complete the survey online at

    https://webapp.halton.gov.uk/survey_snap/pna.htm

  - Complete the form sent with this letter and return it electronically via email to: sharon.mcateer@halton.gov.uk

  - complete the form and return it by post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

Halton Borough Council has decided to run this consultation electronically in order to limit the environmental impact of this consultation. However, if you require a paper version of the PNA, please contact Sharon McAteer on 0151 511 6849 or email Sharon.mcateer@halton.gov.uk who will arrange to provide this within 14 days of your request.

All feedback received by 5pm on Monday 9 May 2022 will be collated and presented to the PNA Steering Group, for consideration on behalf of the HWB. A consultation report will be included within the final PNA document. This will provide an overview of the feedback received and set out how the comments have been acted upon. An updated PNA including consultation process and responses will be presented to the HWB in July 2022 and published by 1 October 2022.

We look forward to receiving your feedback on the draft PNA.

Yours faithfully

Ifeoma

Dr Ifeoma Onyia
Interim Director of Public Health
PNA Sponsor, Halton Health & Wellbeing Board
Halton Borough Council

Halton Pharmaceutical Needs Assessment
Consultation Response Form

1. Has the purpose of the PNA been explained sufficiently within section 2 of the draft PNA document?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

2. Does Section 3 clearly set out the scope of the PNA?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

3. Does Section 4 and 6 clearly set out the local context and the implications for the PNA?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

4. Does the information in Sections 5 & 7 provide a reasonable description of the services which are provided by pharmacies in Halton?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

5. Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?

Yes ☐ No ☐ Not sure ☐

If "Yes", please explain why in the box below:

6. Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?

Yes ☐ No ☐ Not sure ☐

If "Yes", please let us know which service(s) in the box below:

7. Do you agree with the key findings about pharmaceutical services in Halton?

Yes ☐ No ☐ Not sure ☐

If "No" please explain why in the box below:

8. Do you agree with the assessment of future pharmaceutical services as set out in sections 7?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

9. ***Community pharmacies & Dispensing Appliance Contractor only.*** Please can you review the information in Appendix 3 (Opening Hours) and Appendix 4 (Service Provision) for accuracy? If you identify any issues please provide details

	Is the information Accurate?				If "No", please provide details:
Opening Hours	Yes	☐	No	☐	
Service Provision	Yes	☐	No	☐	

10. If you have any further comments, please enter them in the box below (question applies to all):

11. About you - please can you provide the following information:

Name	
Job Title	
Pharmacy Name Or Organisation	
Address	
Telephone No.	
Please confirm that you are happy for us to store these details in case we need to contact you about your feedback?	Yes ☐ No ☐

Please return this feedback form:

- Via email to: Sharon.mcateer@halton.gov.uk
- Via post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

Appendix 9: 60-day statutory Consultation Response

4 responses were received

Questions	Responses	Response to comments
Q1: Has the purpose of the PNA been explained sufficiently within section 2 of the draft PNA document?	All answered YES the purpose was sufficiently explained	Noted
Q2: Does Section 3 clearly set out the scope of the PNA?	All answered YES the scope was clearly set out	Noted
Q3: Does Section 4 & 6 clearly set out the local context and the implications for the PNA?	All answered YES the local context and implications for the PNA were clear	Noted
Q4: Does the information in Sections 5 & 7 provide a reasonable description of the services which are provided by pharmacies in Halton?	All answered YES the information in sections 5 & 7 provided a reasonable description of pharmacy services provided	Noted
Q5: Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?	No respondents were aware of any services provided that have not been included in the PNA	Noted
Q6: Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?	All answered YES pharmaceutical needs of the population have been accurately reflected in the PNA	Noted
Q7: Do you agree with the key findings about pharmaceutical services in Halton?	All agreed with the key findings	Noted
Q8: Do you agree with the assessment of future pharmaceutical services as set out in sections 7?	All agreed with the assessment of future need	Noted
Q9: ***Community pharmacies & Dispensing Appliance Contractor only.*** Please can you review the information in Appendix B (Opening Hours) and Appendix C (Service Provision) for accuracy? If you identify any issues please provide details	One of the respondents stated the opening hours and service provision were accurate for their pharmacy One respondent stated the opening hours were accurate but that some minor amends were needed to the advanced and locally commissioned services they provide One respondent noted some minor changes to opening hours as well as some of the advanced	Noted Thank you both for providing an update of your opening hours as well as the advanced and locally commissioned services that you provide. The document has been updated to reflect these changes.

Questions	Responses	Response to comments
	and locally commissioned services they provide	

Q10: Further comments

Comments	Response from Steering group
I believe the document is too long. Some parts are repeated consistently. I believe that it could be in bullet points. Statistically I'm not too sure other than to provide the services and knowing when other patients have access to other pharmacies	Thanks you for your comment. Whilst this PNA is a long document, it provides all the sections required from the national guidance and in accordance with the regulations. However, in light of your comment we have reduced some sections, notably sections 11-13 have now been merged into a more streamlined single section, reducing duplication from previous sections of the PNA.
As an acute hospitals trust provider, I am pleased to see numerous references to services offered to patients on discharge from hospital. We particularly believe that the Discharge Medicines Service is a major opportunity for joint working for the overall benefit of patients and hopefully to reduce preventable admissions/attendances at hospital	Thank you for your comment.

Appendix 10: References

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19. Public Health England, Royal Society of Public Health (2016) *Building Capacity: Realising the potential of community pharmacy assets for improving the public's health*

REPORT TO: Health & Wellbeing Board

DATE: 6th July 2022

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Update on One Halton Place Based Partnership

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update on One Halton Place Based Partnership development with Cheshire Merseyside Integrated Care System (ICS) context.

2.0 **RECOMMENDATION: That the Board note the report.**

3.0 **SUPPORTING INFORMATION**

3.1 The Health and Wellbeing Board has received regular reports setting out the requirements for the formation of Integrated Care Systems regionally. This consists of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) along with at Place level, a Place Based Partnership (PBP). Locally this is One Halton Place Based Partnership; these arrangements are set out in NHS Reforms White Paper, Integration & Innovation published in February 2021. These are the most significant changes to health arrangements in a decade which aim to improve outcomes and reduce inequalities. This report provides some context, an overview of progress and the current position.

3.2 The Health and Care Bill received Royal Assent on 28th April 2022 hence, the target date of 1st July 2022 to implement Integrated Care System's (ICS's) will be achieved; all Clinical Commissioning Groups (CCG's) will be dissolved as of the implementation date.

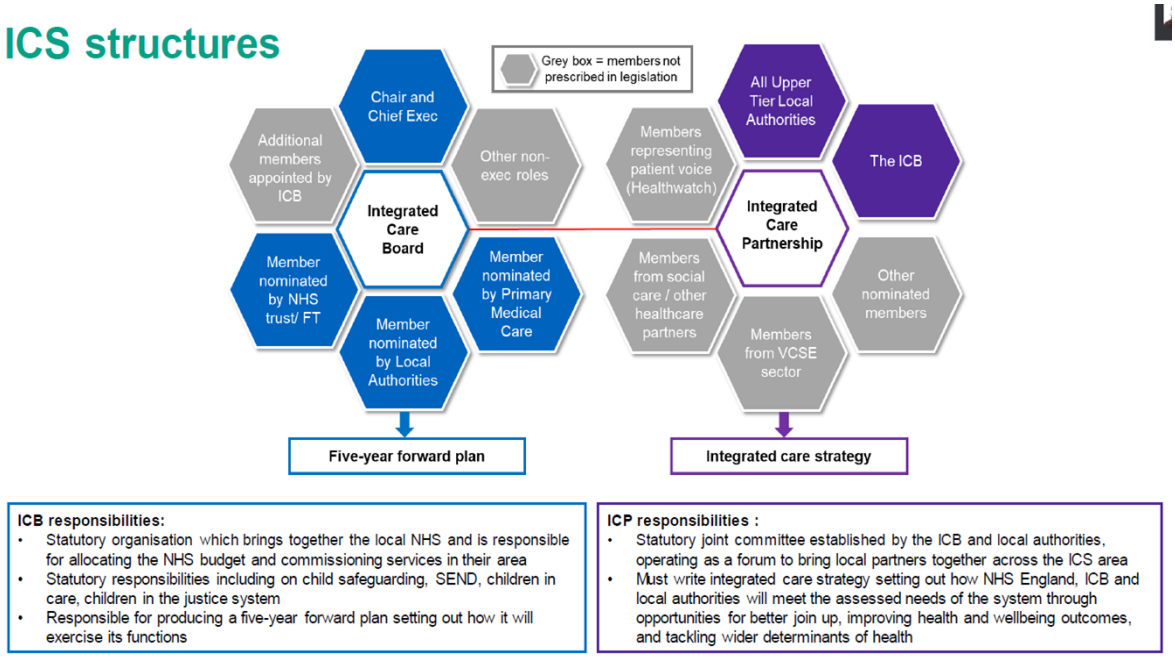
3.3 There are 42 Integrated Care System's (ICS) nationally; for Halton, the ICS footprint is Cheshire & Merseyside. The pre-existing Cheshire & Merseyside Health & Care partnership will become the ICS and has been operating as such in a state of readiness for some time having been through a process of assurance and due diligence with NHS England to become a statutory organisation. Within the footprint there are nine place based partnerships, each of which has a NHS Place Director; this is a key role providing the interface between the ICS and place. For Halton this is Anthony Leo

who commenced in post 1st July 2022.

The ICS consists of an Integrated Care Board (ICB) and Integrated Care Partnership (ICP). Halton's representative on the ICP is Cllr Marie Wright, Anthony Leo will also attend these meetings. The ICB is the delivery arm of the structure.

The ICP will bring together a wider range of partners, not just the NHS, to develop a plan to address the broader health, public health, and social care needs of the population. The ICP will retain the existing Cheshire and Merseyside Health and Care Partnership brand.

The following diagram is from a recent Department of Health and Social Care briefing webinar which is helpful to articulate the structure:-



3.4 CCG functions have now lifted and shifted to the ICB from the 1st of July. The first year will be a transition period with focus on ensuring functions land safely and supporting the work force. Delegations and responsibilities to place will be considered post implementation however, in 2022/23 there will be no delegations.

3.4.1 The Section 75 arrangements **(an agreement which allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services**) and Joint Working Agreement (JWA) was in place between the Council and Halton CCG. The JWA is in place until 31st March 2023, for the remainder of the term this has been transferred to the ICB and with a new agreement set out from April 2023.

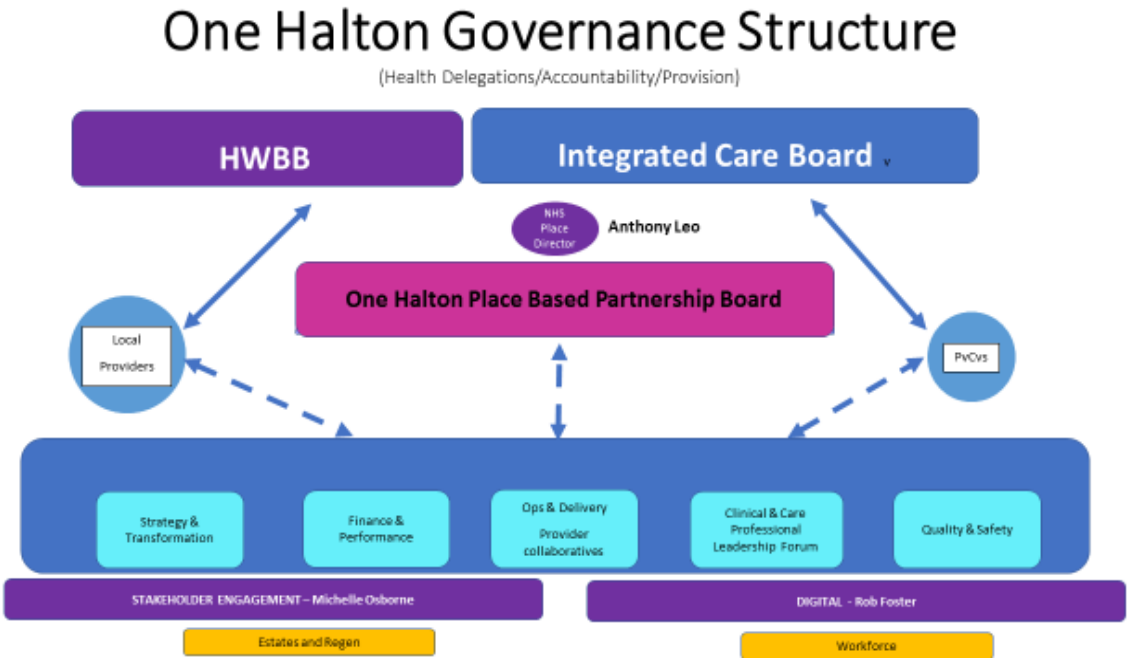
3.5 Overall, what was delivered by Halton CCG will now sit with Cheshire & Merseyside ICS. The ICB will want to consider any benefits of commissioning at scale along with ICB delivery and what is appropriate to delegate to place. The transition and future arrangements are iterative and evolving however, a consideration for this will be the credibility of the local place based partnership arrangements (One Halton).

3.6 One Halton, a local partnership (again pre-existing these arrangements) that brings together Halton stakeholders to work collaboratively on health and care arrangements has been evolving for some time to be Halton's place based partnership. The place based partnerships future role is to:-

- Understand and work with Halton's communities
- Join up and co-ordinate services around population needs
- Address social and economic factors that influence health and wellbeing (wider determinants of health)
- Support quality and sustainability of local services

It should be emphasised One Halton is continuing to develop, this is an iterative process with further guidance and structures emerging.

3.6.1 The governance structure which has been developed for Halton's place based partnership and how it relates to the ICS is:-



3.6.2 One Halton has been developed to be a Joint Committee to the ICS so it can receive delegated responsibilities from the Integrated Care

Board.

3.7 A Programme Management Office (PMO) has been established to support the One Halton governance structure. There is a Senior PMO and Project Manager in place, there will be some further Project Officer posts recruited to, to support One Halton Board, Sub-Committees and Work-Streams delivery. The PMO is providing regular reports across the One Halton architecture, Health and Wellbeing Board and Health Policy and Performance Board.

3.8 As detailed in the March 2022 report there has been support from external organisations to support the development of One Halton in recent months:-

- **Aqua** (NHS Advancing Quality Alliance) – facilitated workshops to support the development of One Halton Health and Wellbeing Strategy as detailed in 3.9.

- **LGA** (Local Government Association) – a peer support process with the Health and Wellbeing Board (HWBB) to clarify the distinction in roles between the HWBB and One Halton moving forward. This has led to a change in approach moving forward with thematic meetings that will follow the strategy priorities. There is clarity in roles with the HWBB's statutory responsibilities for the Joint Strategic Needs Analysis (JSNA) and the HWB Strategy and One Halton being the delivery arm to be held to account.

- **Hill Dickinson LLP**– this work supported the development of One Halton governance structure and as stated in 3.6.2 One Halton has endorsed a Committee of the ICB at Place (Halton) with delegated authority to make joint decisions about the use of resources with a Sub-Committee structure. Further propositions and maturity within the system will facilitate further integration by the means of a joint committee between partner organisations. The relevant statutory bodies will need to agree to delegate defined decision making functions to the joint committee in accordance with their scheme of delegation. A budget can be defined by statutory bodies relevant to the resources delegated to the committee. Proposed legislation will allow setting up of Joint Committees (currently only possible as part of S75). At this stage, there is no programme defined for this.

3.9 The current structure of One Halton (diagram 3.6.1) has four Sub-Committees:-

1. **Operations & Delivery**, led by the Director of Adult Social Care
2. **Finance & Performance**, led by Health Director of

Finance and & Operational Director, Finance, Halton Borough Council
3. **Quality & Safety**, led by the Deputy Chief Nurse
4. **Professional Leadership Forum,** led by the GP Clinical Lead for One Halton & Head of Transformation, Primary & Community Care

And three work streams to underpin One Halton delivery:-

1. **Strategy & Transformation**, led by the Director of Public Health
2. **Communication & Engagement**, led by the Council's Lead Officer for Communications & Marketing
3. **Digital**, led by Bridgewater's Programme Director of Collaboration & Integration

Operations & Delivery – Overseeing the operational delivery of the integrated local health and care system in Halton. This is where areas of focus and transformation work streams are agreed and progressed. Currently the delivery plan includes work on the integrated approach to the intermediate care and frailty service and a transformation project for place based multi-disciplinary/integrated working.

Finance & Performance – as it suggests this Sub-Committee monitors the financial position. There has been significant work to understand the combined Halton £ from statutory health & care budgets. Key local providers also attend i.e. Halton & Warrington Hospital, St Helens & Knowsley hospital, Bridgewater and Merseycare to report their financial positions.

Quality & Safety – This Sub-Committee is just forming as the Terms of Reference are being revised following the publication of the National Quality Board guidance. Work is ongoing from a health perspective at ICB level re the whole system Quality Assurance and other groupings. In Halton, the intention is to develop a thematic approach.

Strategy & Transformation – Developing a key piece of work on the One Halton Health and Wellbeing Strategy to replace the existing strategy which expires this year. This is a statutory responsibility for the Health and Wellbeing Board. Public Health are leading this work, three workshops were held in March facilitated by Aqua on starting, living and ageing well to agree three system priorities:-

1. Enabling children and families to live healthy independent lives
2. Provide a supportive environment where systems works

efficiently and support everyone to live their best life
3. Enabling older adults to live full independent healthy lives

A draft strategy is currently being produced for further stakeholder input to ensure it is co-produced and represents the Borough's needs and resident's voices.

Population health management is a significant element; the acid test of place based partnerships will be delivering integration at neighbourhood levels that improves resident outcomes; the wider determinants of health agenda.

Communication & Engagement – this underpins all One Halton activity. A communication strategy is currently being developed however, clarity is required on ICB arrangements and place delegations. An immediate priority is workforce and stakeholder communication and resident and patient representation. A One Halton communication and engagement framework is in development.

Digital – a One Halton Digital Strategy is currently being developed; this is a significant work stream to address integrated systems, shared health and care records and innovation to support service delivery, independent living and management of health and care needs.

3.10 The March report detailed the self-assessment One Halton completed in November 2021. This was completed by the nine place based partnerships in Cheshire & Merseyside with four assessment levels to demonstrate the partnerships maturity to be the place based partnership, the levels being emerging, evolving, established and thriving. One Halton's overall assessment was at **evolving.** This has just been repeated ahead of implementation and it is anticipated One Halton will be at **established**; an update can be provided on this at the meeting.

3.11 Regular update reports will be provided to the Health Policy & Performance Board and Health and Wellbeing Board to ensure Boards are up do date with arrangements as the new system is implemented and better understood through the transition.

4.0 POLICY IMPLICATIONS

4.1 White Paper, *Integrating Care: Next steps to building strong and effective integrated care systems across England* published February 2021. Once legislation is passed, a new NHS Framework will be shared which is likely to have impact on a number of policies and will need to be reviewed in due course.

4.2 White Paper, Joining Up Care for People, Places and Populations,

February 2022 sets out future ambitions for shared outcomes by 2023 with shared accountability and a single person accountable at place level. A single health & care record to be achieved by 2024 which has significant implications on resources and ways of working.

5.0 FINANCIAL IMPLICATIONS

5.1 Anticipated, but not yet known. Cheshire & Merseyside ICB need to agree services to be delivered direct from ICB, any at scale and provision delegated to One Halton to enable us to fully understand the resource and financial impacts; this will be worked through in the transition (first) year.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

One Halton supports the Council's Health & Wellbeing Boards priority of improving levels of early child development. One of the system priorities is Start Well.

6.2 Employment, Learning & Skills in Halton

One Halton shares the Council's priorities for employment, learning and skills in Halton. The workforce that supports the health & care system is significant in Halton and there will be a focussed work stream in the transition arrangements to ensure current staff are supported and there is planning and investment to develop skills and the future workforce.

6.3 A Healthy Halton

One Halton is a key stakeholder locally supporting the Council & Health and Wellbeing Boards priorities for supporting improved health outcomes and reducing health inequalities for Halton's population.

6.4 A Safer Halton

One Halton supports the Council's priorities to create a safer Halton. Health and wellbeing are pivotal characteristics of resilient communities; a whole system approach to place will intrinsically contribute to building a safer Halton.

6.5 Halton's Urban Renewal

The NHS reforms to Integrated Care Systems and Place Based Partnerships seek to engender a whole place collaborative approach. As arrangements progress there will be a work stream around assets to understand the estate that supports delivery in

Halton.

It is also imperative to plan appropriately for healthy communities utilising Public Health ensuring an evidence led approach to meeting the future needs of Halton's population. One Halton should be linked into future regeneration schemes and developments in the Borough to ensure appropriate planning and system partner involvement. There are recent examples of joint working with the delivery of a Hospital Hub in Shopping City (opening September 2022) and the development of the Town Deal for Runcorn Old Town.

7.0 RISK ANALYSIS

7.1 This will require further work to be shared in future reports as and when One Halton understands the services and activity that will be delivered at scale (Cheshire & Merseyside footprint) and those delegated to place (One Halton).

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 In developing One Halton, all services will continue to require equality impact assessments for any fundamental changes to service delivery to ensure equality and access to services is considered.

8.2 The One Halton Board and its sub-committees also has membership of Halton's Third Sector organisations and will actively work alongside them to consider equality and diversity issues. Many of Halton's voluntary sector organisations exist to support vulnerable, disadvantaged or disenfranchised cohorts of the community and have a reach often beyond public service delivery.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 6 July 2022

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Marmot Report: All Together Fairer

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 To inform the health and wellbeing board of the launch of the report by Professor Sir Michael Marmot on health inequalities. The report – All Together Fairer – has been written by Sir Michael and his team of researchers in partnership with Cheshire and Merseyside's local authorities, and sets out measurable actions for each area, as well as the sub region as a whole, to create a fairer, equitable society.

2.0 RECOMMENDED: That

1) the content of the reports is noted; and

2) the board discuss how the reports recommendation can be progressed and monitored.

3.0 SUPPORTING INFORMATION

BACKGROUND

3.1 All Together Fairer was presented at an event by Sir Michael on 26th May 2022. He delivered a keynote address to partners made up of local authorities, the NHS, private and third sector organisations, and interested members of the public.

3.2 All Together Fairer was a collaborative piece of work advised by workshops held across the sub region and informed by data and intelligence contributed by leads across local authorities. The full report itself, available via this link https://www.champspublichealth.com/all-together-fairer/ was written by Sir Michael and his team of researchers in partnership with Cheshire and Merseyside's local authorities. The executive summary is attached for ease of reference due to the size of the full report.

3.3 The Institute of Health Equity was established in 2011 and is led by Professor Sir Michael Marmot at University College London. The aim is

to develop and support approaches to health equity and build on work that has assessed, measured and implemented approaches to tackle inequalities in health. At the request of the British Government, he conducted the Strategic Review of Health Inequalities in England post 2010, which published its report 'Fair Society, Healthy Lives' in February 2010. (The Marmot Review).The first review identified the causes of inequality in particular social policy and set out 6 policy recommendations to government. This was followed by the Health Equity in England: the Marmot Review Ten Years On which set out how little progress had taken place over the intervening years.

3.4 A set of local Marmot Beacon indicators, developed in partnership with local stakeholders, will monitor actions on the social determinants of health in Cheshire and Merseyside. This is likely to be reported at Local Authority level. The report proposes 22 indicators, aligned with the 8 Marmot themes. The indicator set will be monitored by the Combined Intelligence for Population Health Action (CIPHA) programme.

4.0 POLICY IMPLICATIONS

4.1 Health is largely shaped by the social, economic and environmental conditions in which people are born, grow, live, work and age known as the social determinants of health.

4.2 The social determinants of health are the focus of the eights recommendations of the report or what are termed the Marmot 8 principles, which are also the basis for the analysis in the report:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill-health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together

5.0 FINANCIAL IMPLICATIONS

5.1 There is no additional funding available to support this area of work, it would be expected that the principles themselves are incorporated into practice to enable effective and value for money service provision.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Experiences during the early years and in education are particularly important for immediate and longer-term health and outcomes. Improving health and reducing health inequalities are the very first Marmot goals. Improving outcomes in the early years and in schools requires collaborations between early years providers, schools, employers and youth services working together with communities and families.

6.2 Employment, Learning and Skills in Halton

Businesses can have both positive and negative impacts on health through employment practices; through goods, services and investments; and through their impacts on communities and the environment. Reducing the harmful impact of business and enhancing the positive contribution is vital for health and wellbeing and reducing inequalities.
There is great potential for businesses to improve the health of their employees and communities more broadly

6.3 A Healthy Halton

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

6.4 A Safer Halton

As above

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

There are no major risks associated with the report.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Halton Borough Council led on a Marmot workshop in late 2021 and has continued to contribute to the agenda setting and report that acknowledges the direct impact of racism on health.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

INSTITUTE of HEALTH EQUITY

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

CONTENTS

ACKNOWLEDGEMENTS

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Peter Goldblatt, Tammy Boyce and Owen Callaghan coordinated production and analysis of tables and charts.

Team support: Scarlet Willis.

Suggested citation: Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Owen Callaghan (2022) All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside. London: Institute of Health Equity

AUTHORS' ACKNOWLEDGEMENTS

We are grateful to the many contributions from across Cheshire and Merseyside who have provided evidence, data and information. We have been guided by many and are thankful for their time and expertise: the Marmot Leads (Abi Deivanayagam, Gavin Flatt, Esther Hindley, Richard Holford, Guy Kilminster, Michelle Loughlin, Rebecca Mellor, Maureen Mandirahwe, Anna Nygaard, Jenny Smedley, Lisa Taylor, Rachel Zammit), the Directors of Public Health (Ian Ashworth, Matt Ashton, Ruth Du Plessis, Margaret Jones, Sarah McNulty Ifeoma Onyia, Thara Raj, Matt Tyrer, Julie Webster). We are also grateful to the members of the Cheshire and Merseyside Marmot Community Advisory Board which includes: Helen Bromley, Annie Coppel, Alison Cullen, Paul Cummins, Nicola Dunbar, Louise Edwards, Louise Gittins, Jon Hayes, Alan Higgins, Carianne Hunt, Rachel Joynes, Mzwandile (Andi) Mabhala, Sarah O'Brien, Eileen O'Meara, Charlotte Simpson, Dave Sweeney, Rob Tabb, David Taylor-Robinson, Angela White.

We are thankful for the support provided by staff at the Champs Public Health Collaborative and the guidance provided by many in the Cheshire and Merseyside Health and Care Partnership.

We are also grateful for Sharon McAteer and the team at Combined Intelligence for Population Health Action (CIPHA) who have provided a great deal of time, expertise and flexibility in creating the indicator set.

The authors are particularly indebted to the insights, support, coordination and commitment from Jo McCullagh.

Cover photo: Ant Clausen Photography (www.antclausen.com)

GLOSSARY

HEALTH INEQUALITIES

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

HEALTHY LIFE EXPECTANCY

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

INDIVIDUAL HEALTH BEHAVIOURS AND PREVENTION

Prevention programmes and initiatives often focus on individual health behaviours, such as smoking, physical exercise, diets/nutrition, alcohol, and drugs. These factors affect health inequalities but do not address the drivers of these behaviours—the causes of the causes. The NHS has a role in supporting people but addressing the causes of the causes requires partnerships with wider systems, supporting people with good education and employment, fair pay and incomes, good quality homes and neighbourhoods.

INDEX OF MULTIPLE DEPRIVATION (IMD)

This is the most common measure of the socioeconomic circumstances, the places where people live. The IMD summarises how 'deprived' an area is, based on a set of factors that includes: levels of income, employment, education and local levels of crime.

The IMD is based on the Lower-layer Super Output Areas (LSOA), which, though small, may include areas of high and low deprivation. Quintiles are calculated by ranking the LSOAs from 'most deprived' to 'least deprived' and dividing them into five equal groups. These range from the most deprived 20 percent (decile 1) of small areas nationally to the least deprived 20 percent (decile 5) of small areas nationally.

LIVING WAGE

Set by the Resolution Foundation, the living wage was created to better estimate the wage rate needed "to ensure that households earn enough to reach a minimum acceptable living standard as defined by the public". In 2021/22 the living wage was £9.90 for areas outside of London.

MINIMUM INCOME STANDARD

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

PROPORTIONATE UNIVERSALISM

Universal policies and interventions are needed in every area but should be developed more intensely where need is higher – to be proportionate to need. The aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher.

SOCIAL DETERMINANTS OF HEALTH

The social and environmental conditions in which people are born, grow, live, work, and age, which shape and drive health and wellbeing. Access to good quality health care is a determinant of health but most of the social determinants of health lie outside the health care system. These social determinants include: education in early and later childhood and adolescence, as well life-long learning; employment conditions and quality of work; income; housing, and built and natural environments. All of these are the building blocks to healthy and equitable societies – good jobs with fair pay; good quality housing and education.

SOCIAL GRADIENT

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

SOCIAL VALUE

The Social Value Act 2012 requires the public sector to ensure that the money it spends on services creates the greatest economic, social and environmental value for local communities. A social value approach involves looking beyond the price of each individual contract and looking at what the collective benefit to a community is when a public body chooses to award a contract.

VCFSE SECTOR

Voluntary, community, faith and social enterprise sector and partnership organisations that support the sector.

CHAPTER 1
INTRODUCTION

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

The title of this report, 'All Together Fairer,' reflects the views of many we heard from in Cheshire and Merseyside since we began work in July 2021. Health inequalities were significant before the COVID-19 pandemic, as our IHE 2020 report *Health Equity in England: The Marmot Review 10 Years On* found. Life expectancy in England has stalled and austerity policies have damaged health and increased health inequalities (1). The 2021 IHE report, *Build Back Fairer:* The *COVID-19 Marmot Review*, demonstrated that these inequalities had worsened the impact of the COVID-19 pandemic for those on the lowest incomes and would widen health inequalities in the longer term (2).

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

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

OUR APPROACH: CO-CREATING ACTIONS

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

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

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

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

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

WORKSHOPS

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

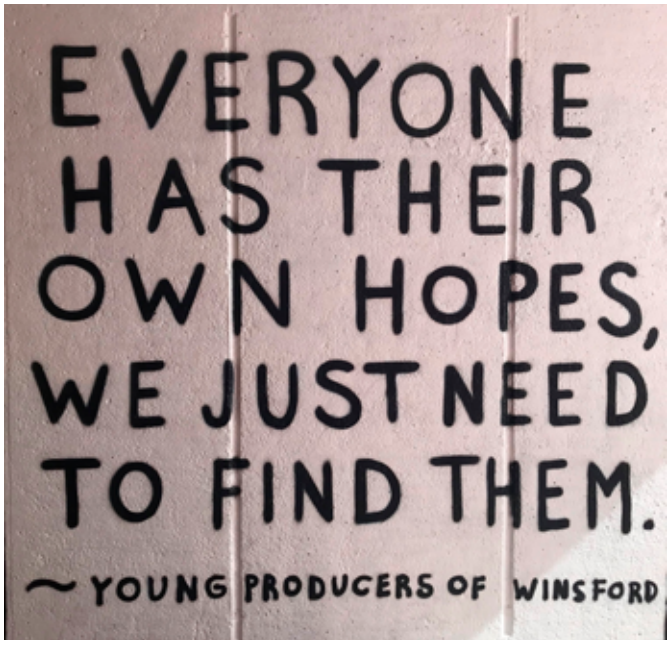
The workshops identified priorities and whilst all eight Marmot themes were discussed, there was a high level of agreement about key issues to address in Cheshire and Merseyside: providing good quality work and improving aspirations; decreasing poverty; improving housing and local places; and identifying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

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

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

INDICATORS FOR HEALTH EQUITY

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



THE RECOMMENDATIONS

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

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

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

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

CHAPTER 2

THE CHESHIRE AND MERSEYSIDE CONTEXT

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

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

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

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

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

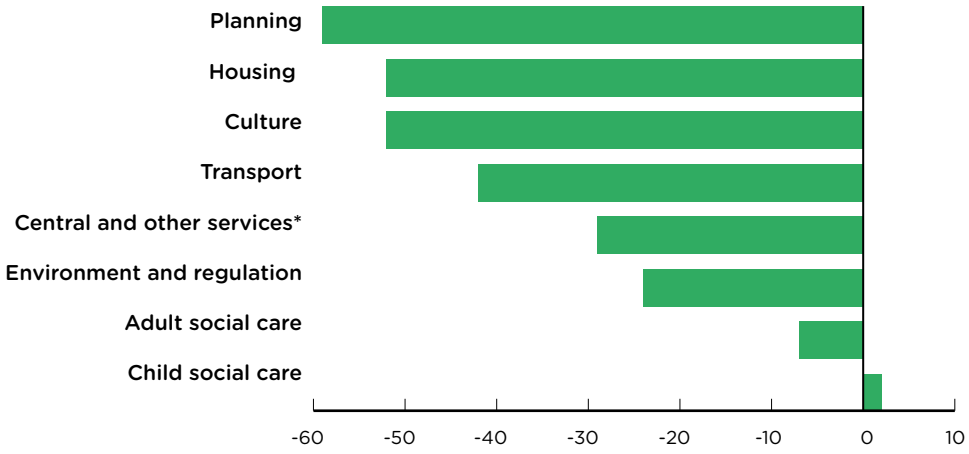
Our work in Cheshire and Merseyside — including this report, indicators and recommendations — provides momentum for these actions, as well as offering additional approaches to be implemented at pace and over the long-term. These require effective collaboration and partnerships between the NHS, local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

2A AUSTERITY AND FUNDING CUTS IN CHESHIRE AND MERSEYSIDE

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

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

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



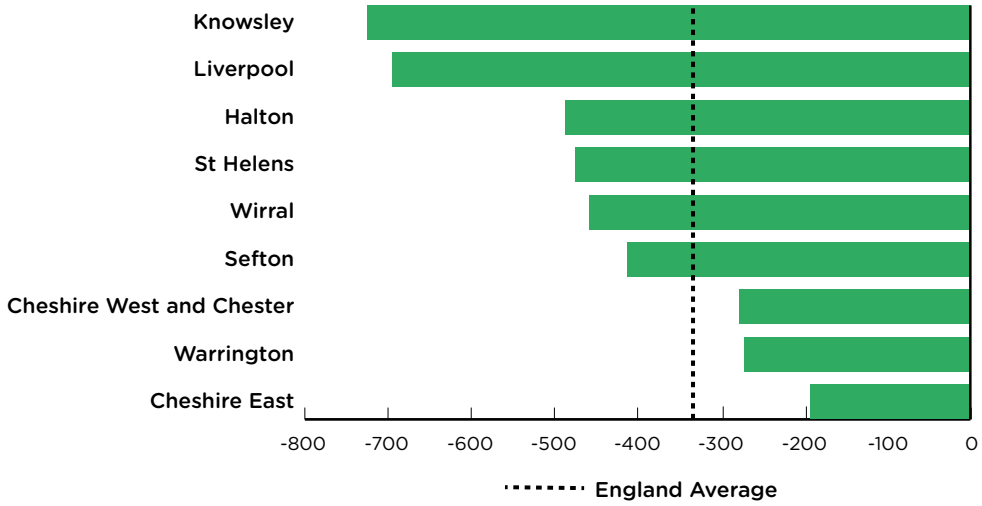
Notes: *Services such as council tax administration and corporate services*

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

Figure 2.2 shows funding to children's social care slightly increased between 2009 and 2019. however spending on children's social care only increased due to the significant increase in the number of children taken into the care of local authorities, and spending on this increased in England by 68 percent during this period (9). Overall, between 2009 and 2019 there has been "continuous disinvestment" in giving every child the best start in life, with local government spending on preventative early years and youth services (including Sure Start) falling 21 percent in this period, and with the greatest declines in the most deprived areas (9).

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

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



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

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

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

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

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

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

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

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

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

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

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

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

LEVELLING UP?

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

A → **To boost productivity and living standards by growing the private sector, especially in those places where they are lagging.**

B → **To spread opportunities and improve public services, especially in those areas where they are weakest.**

C → **To restore a sense of community, local pride and belonging, especially in those places where they have been lost.**

D → **To empower local leaders and communities, especially in those places lacking local agency.**

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

- By 2030, the number of primary-school children achieving the expected standard in reading, writing and maths will have significantly increased. In England, this will mean 90 percent of children will achieve the expected standard, and the percentage of children meeting the expected standard in the worst-performing areas will have increased by more than a third.

- By 2030, the number of people successfully completing high-quality skills training will have significantly increased in every area of the UK. In England, this will lead to 200,000 more people successfully completing high-quality skills training annually, driven by 80,000 more people completing courses in the lowest-skilled areas.
- By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.
- By 2030, wellbeing will have improved in every area of the UK, with the gap between top performing and other areas closing (25).

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

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

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

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

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

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

FUNDING CUTS: THE PUBLIC HEALTH GRANT

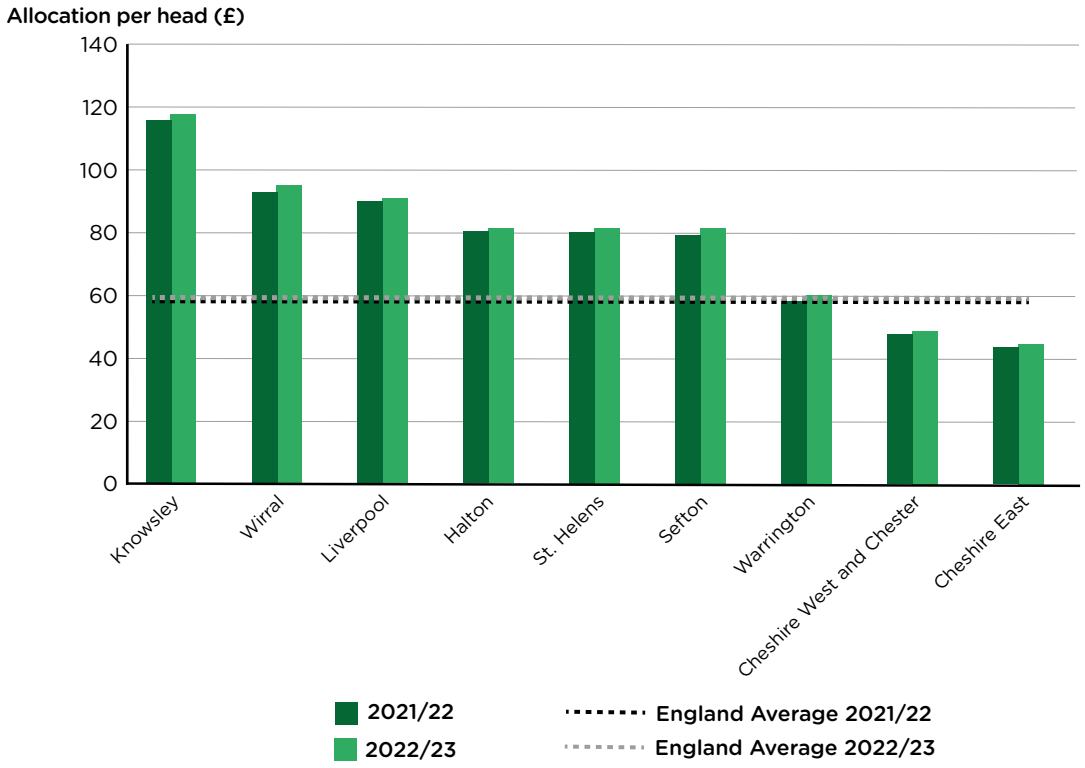
The public health grant had already declined significantly before the pandemic. The Institute for Public Policy Research (IPPR) estimates that there was an £870-million decline in net expenditure to public health services (such as sexual health, obesity, physical activity, and drug and alcohol services) in England between 2014 and the end of 2019, with absolute cuts in the most deprived areas six times larger than in the least deprived (32). In 2016, the British Medical Association warned cuts to public health would have significant effects:

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

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

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

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



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

FUNDING CUTS: PUBLIC SERVICES

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

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

Cuts between 2010 and 2020 also reduced the number and capacity of children and youth services, police services and the VCFSE sector (43). Between 2009/10 and 2019/20, funding for youth services in the UK fell by 66 percent, and between 2012 and 2016, more than 600 youth centres and nearly 139,000 youth service places closed (44) (45). In 2009, Liverpool City Council employed 110 youth workers and in 2019, they employed 26 with the budget reduced by more than two-thirds (46). Warrington's budget for youth services fell from £3.4 million in 2010/11 to £668,000 in 2019/20 (47). Cuts to youth services have significant impacts on young people's education, mental health and wellbeing (1).

FUNDING CUTS: POLICING AND LEGAL SERVICES

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

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

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

Box 1. Merseyside Violence Reduction Partnership (MVRP)

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

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

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

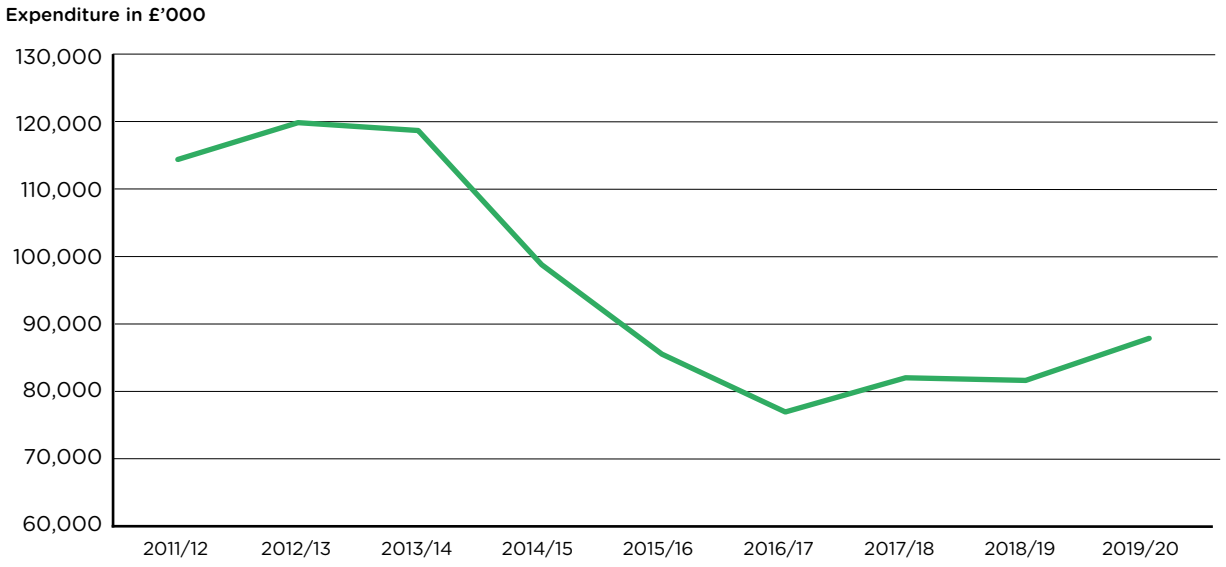
MVRP developed additional guidance for schools to use when considering permanent exclusion. By highlighting the principles, consequences and identifying local level support, MVRP sees this guidance as a valuable tool to assist schools when undertaking decisions about exclusion.

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

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

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

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



Source: *Bolt Burdon Kemp (62)*

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

Box 2. Health Justice Partnerships

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

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

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

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

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

FUNDING CUTS: THE VCFSE SECTOR

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

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

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

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

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

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

2B THE SOCIAL DETERMINANTS OF HEALTH APPROACH

The social determinants of health describe the social and environmental conditions in which people are born, grow, live, work and age, which shape and drive health outcomes and the inequities in access to power, money and resources which underpin these. Unfair distribution of these resources creates *avoidable* health inequalities, known as health inequities.

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

THE MARMOT 8 PRINCIPLES

Reducing health inequalities requires action on the six policy objectives outlined in the first Marmot review, *Fair Society, Healthy Lives and in the follow-up report, Health Equity in England: The Marmot Review 10 Years On*. The six Marmot principles are:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

To this list we have added another two principles to reflect increasing recognition of the health equity impacts of these domains:

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

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

PROPORTIONATE UNIVERSALISM

The 2010 *Fair Society, Healthy Lives* report illustrated that health inequalities are not limited to poor health in those who are the worst off, or the most socially disadvantaged. There is a social gradient in health, running from the top to the bottom of society (76). The 2010 and 2020 Marmot reports proposed adopting a proportionate universal approach, universal policies and interventions developed to be more intense where need is higher – to be proportionate to need. The aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher (76) (1).

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

> ***A Marmot approach demands that we resource and deliver services at a scale and intensity proportionate to the degree of need; just focusing on one group of disadvantaged individuals or one geographical area won't deliver change (77).***

THE LANGUAGE OF DEPRIVATION

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

Box 3. The language of deprivation

Much of the research we use in this report, as we have in others, is based on the Index of Multiple Deprivation. Since 2000, the IMD has produced relative measures of deprivation for small local areas (Lower-layer Super Output Areas) based on seven domains of deprivation (Income; Employment; Health Deprivation and Disability; Education, Skills Training; Crime; Barriers to Housing and Services; and Living Environment). Neighbourhoods are ranked from most deprived to least and then divided into deciles, 10 equal groups, and this helps to demonstrate where a neighbourhood is among the most or least deprived in England. As such, when we refer to people living in areas of deprivation, this is our measure.

A POST-PANDEMIC NHS

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

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

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

CHAPTER 3

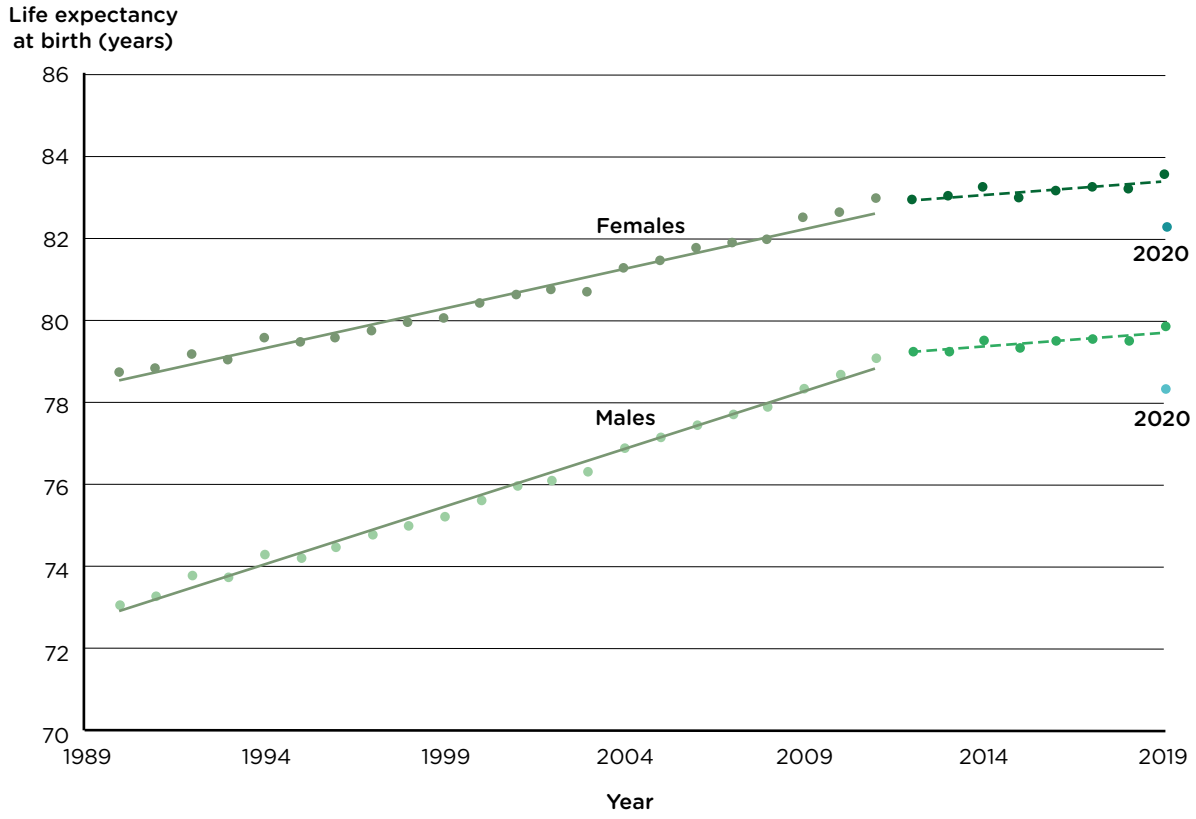
HEALTH INEQUALITIES IN CHESHIRE AND MERSEYSIDE

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

3A HEALTH INEQUALITIES IN ENGLAND

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

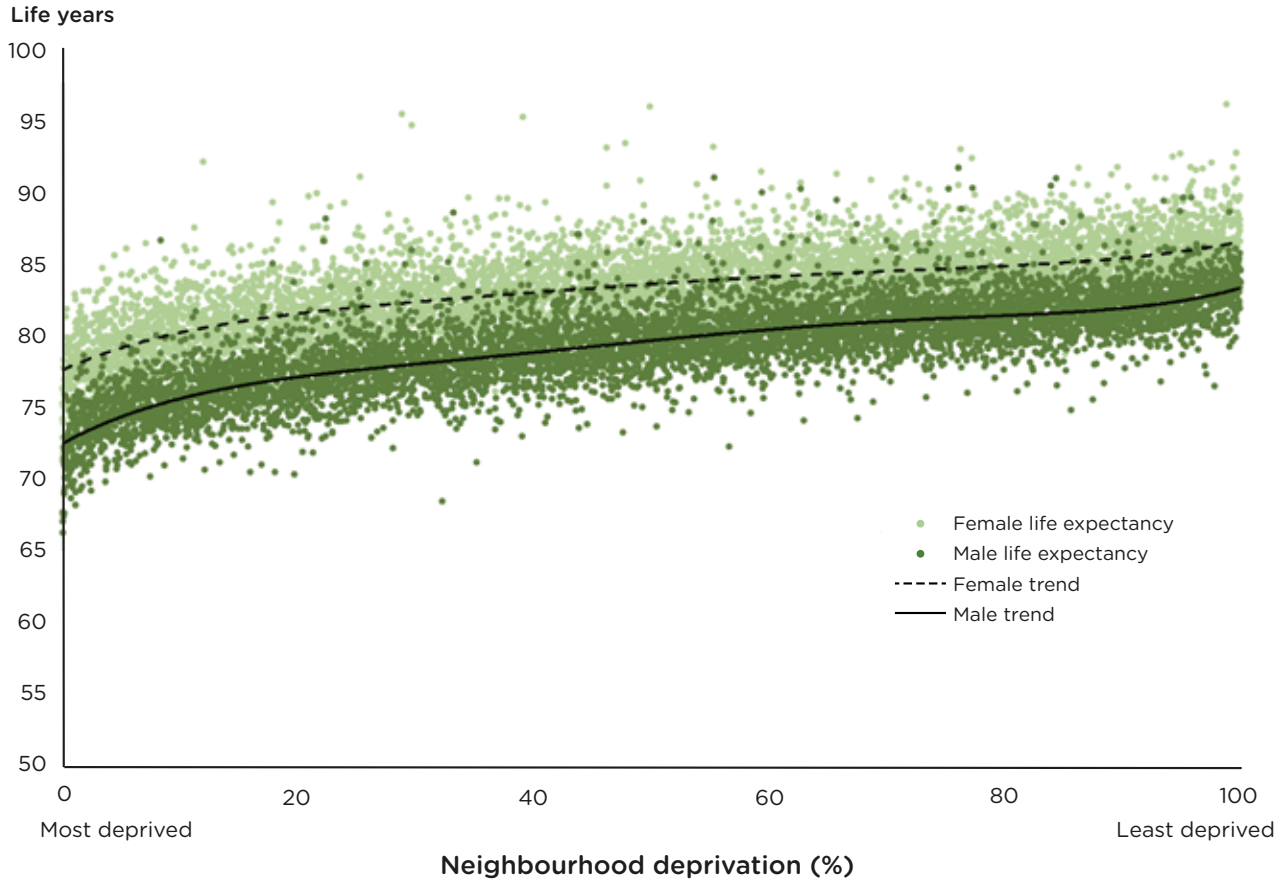
Figure 3.1. Life expectancy at birth for males and females, England and Wales 1989-2020



Source: *Office for National Statistics (84)*

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

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

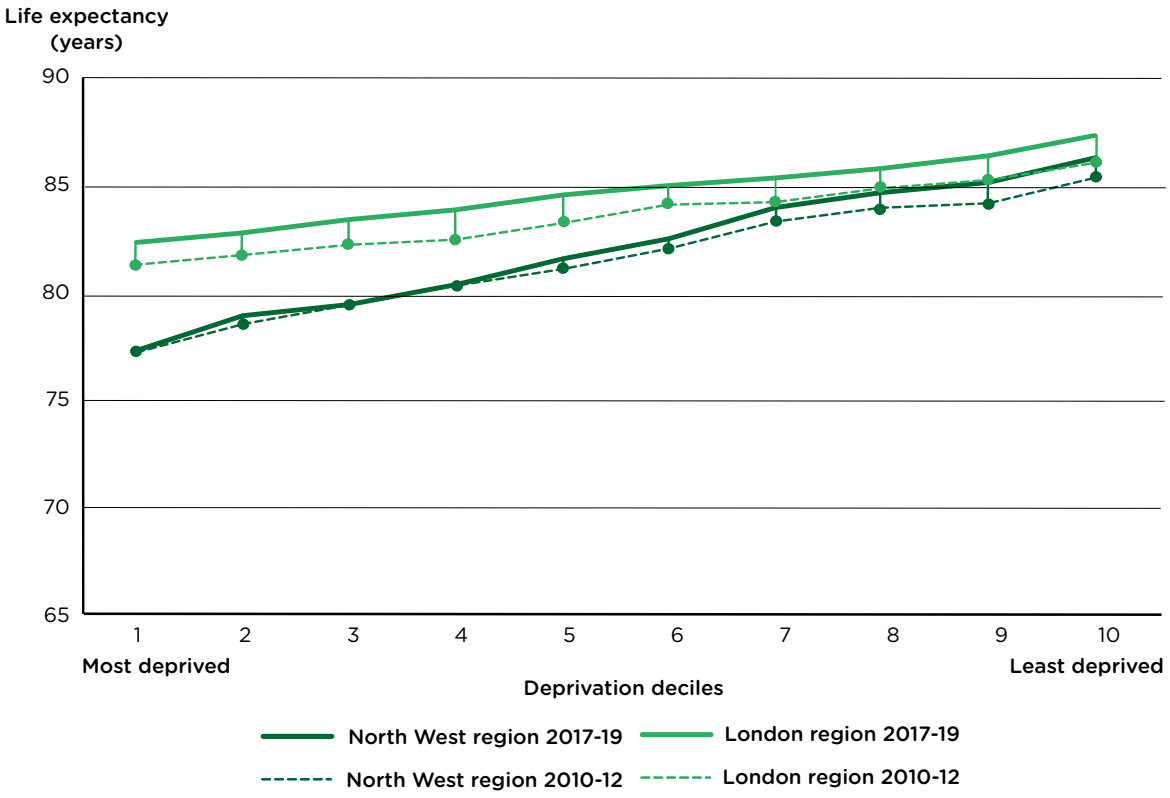


Notes: *Each dot represents life expectancy (LE) or disability-free life expectancy (DFLE) of a neighbourhood (middle level super output area)*
Source: *Office for National Statistics (ONS) and Department for Work and Pensions (85) (86)*

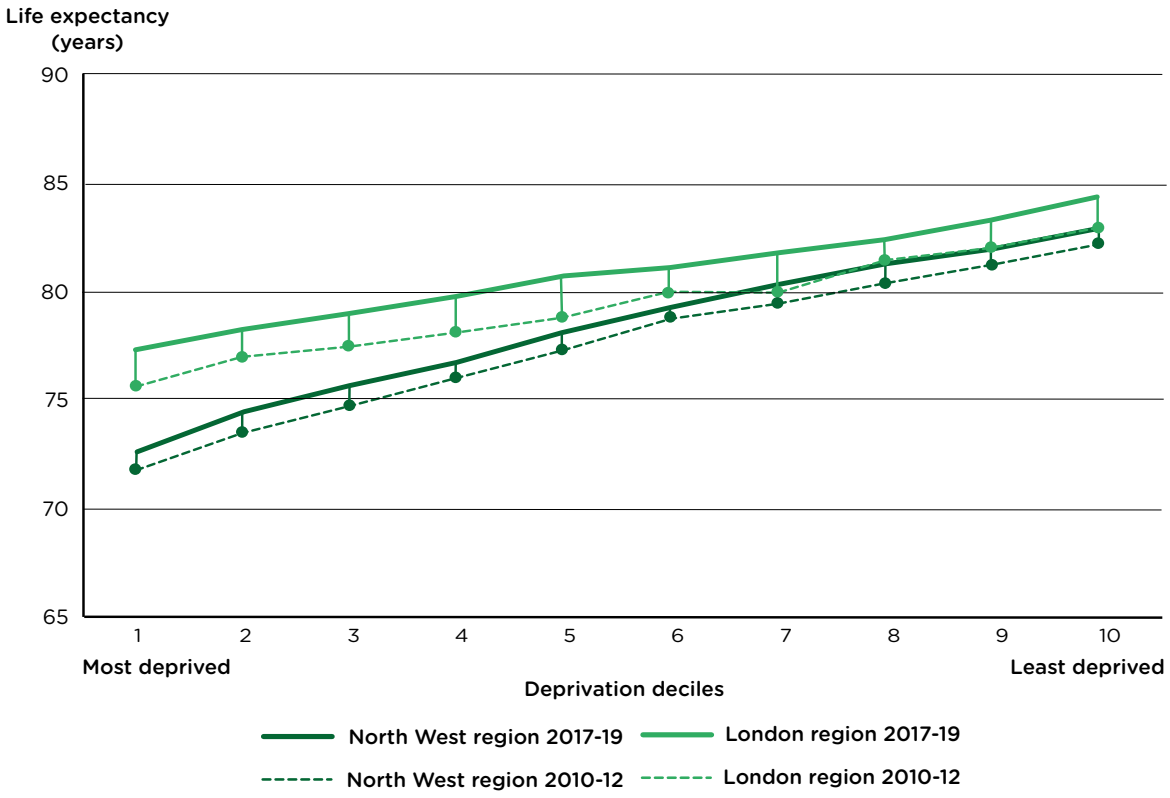
The 2020 *10 Years On* report showed the differences in life expectancy between England's regions. From 2010, London's life expectancy increased more rapidly than other regions. Figures 3.3A and 3.3B show life expectancy in the North West region is lower than London, and that there is steeper gradient for both men and women in the North West. There is an 8.8-year difference in life expectancy between women living in the most and least deprived areas in the North West, compared with a 4.9-year difference in London. For men, it's a 10.4-year difference in the North West and seven years in London.

Figure 3.3A and 3.3B. Estimated male and female life expectancy at birth for the least and most deprived deciles (IMD 2019), North West and London regions, 2010-12 and 2017-19

A. FEMALES



B. MALES



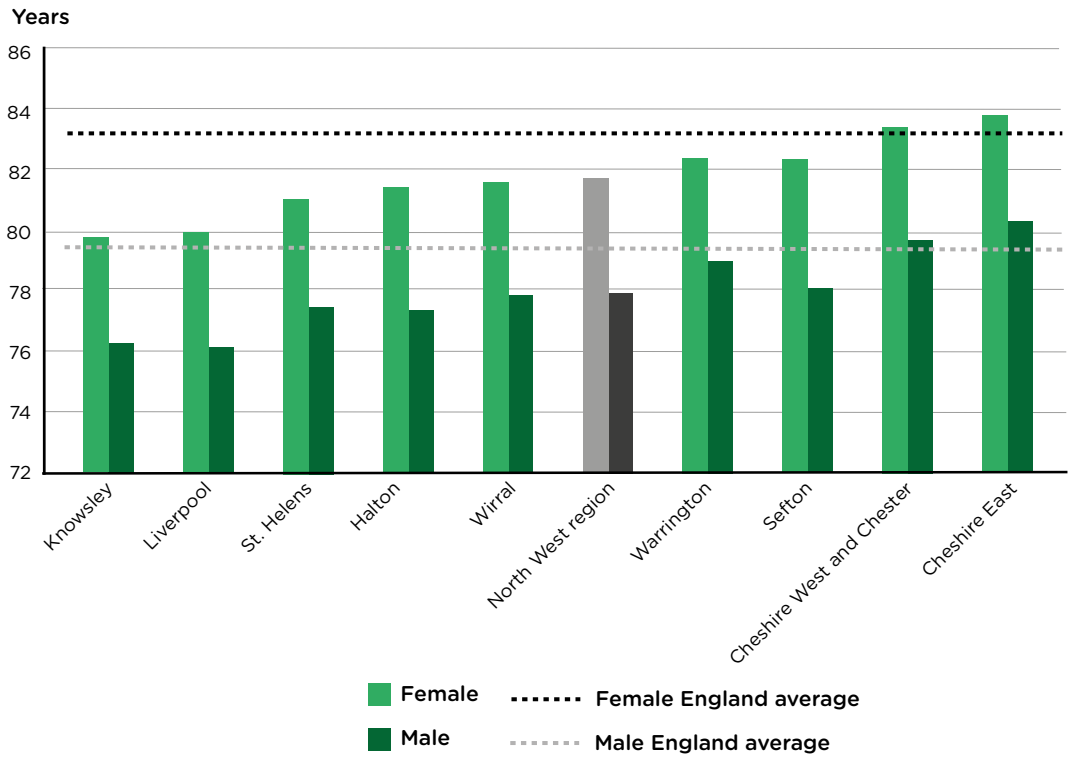
Source: *Based on PHE, 2020 (87)*

3B LIFE EXPECTANCY IN CHESHIRE AND MERSEYSIDE

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

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

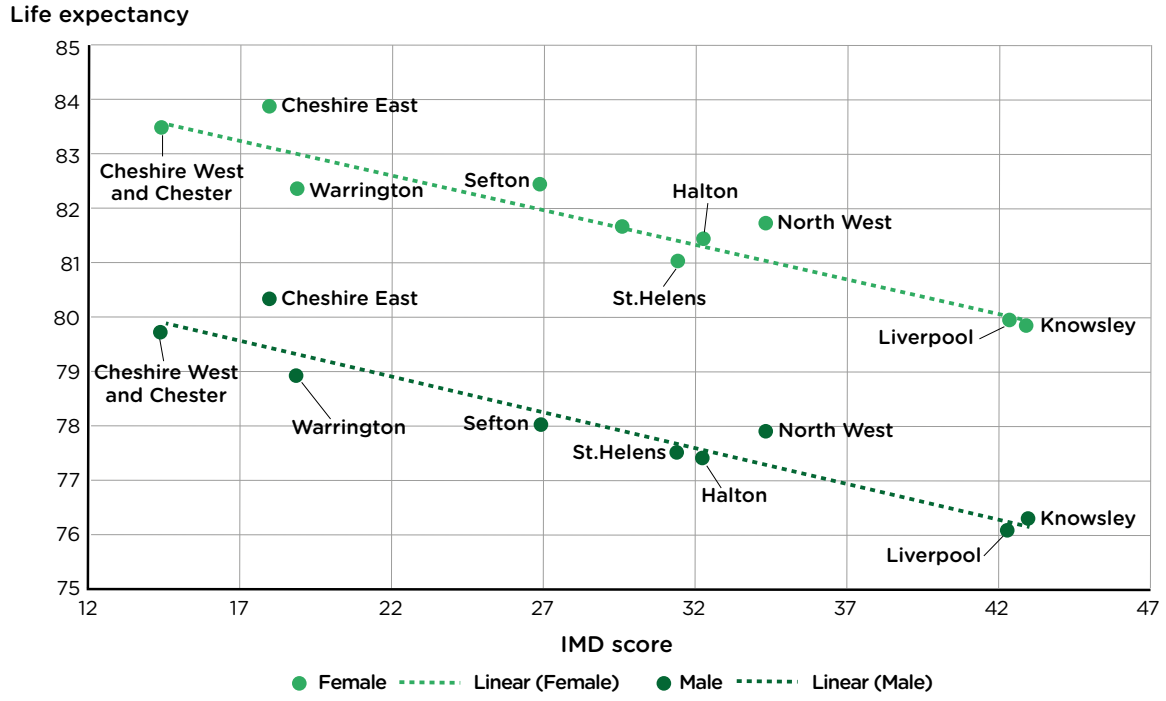
Figure 3.4. Estimated male and female life expectancy at birth, Cheshire and Merseyside lower-tier local authorities, North West region, and England, 2018–20



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

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

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

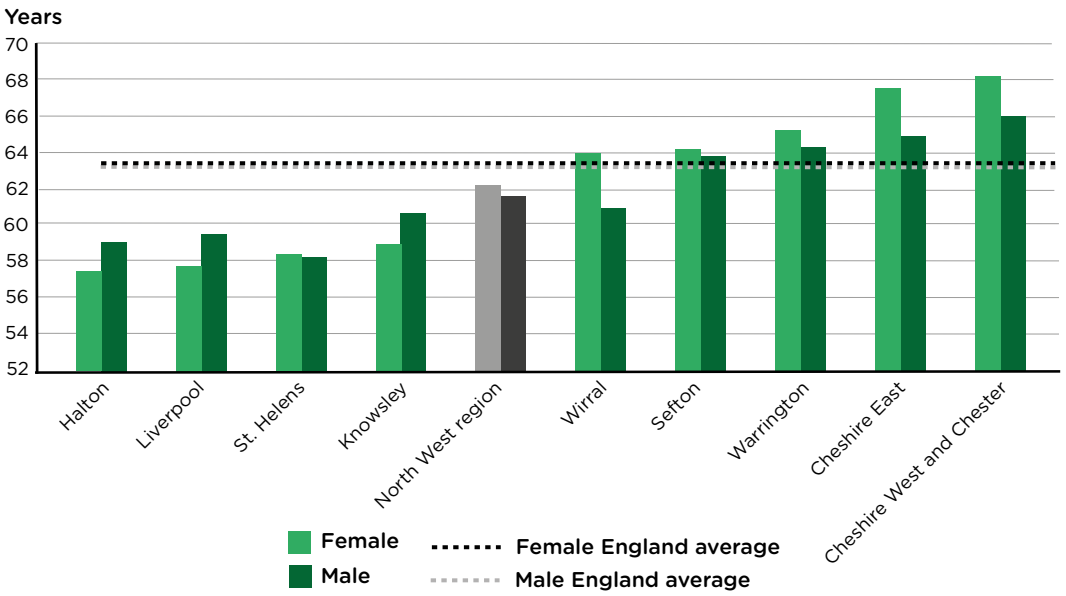


Source: *Office for National Statistics. (90)*

HEALTHY LIFE EXPECTANCY

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

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



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

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

Box 4. "System P"

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

MARMOT BEACON INDICATORS

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

3C INEQUALITIES WITHIN LOCAL AUTHORITIES

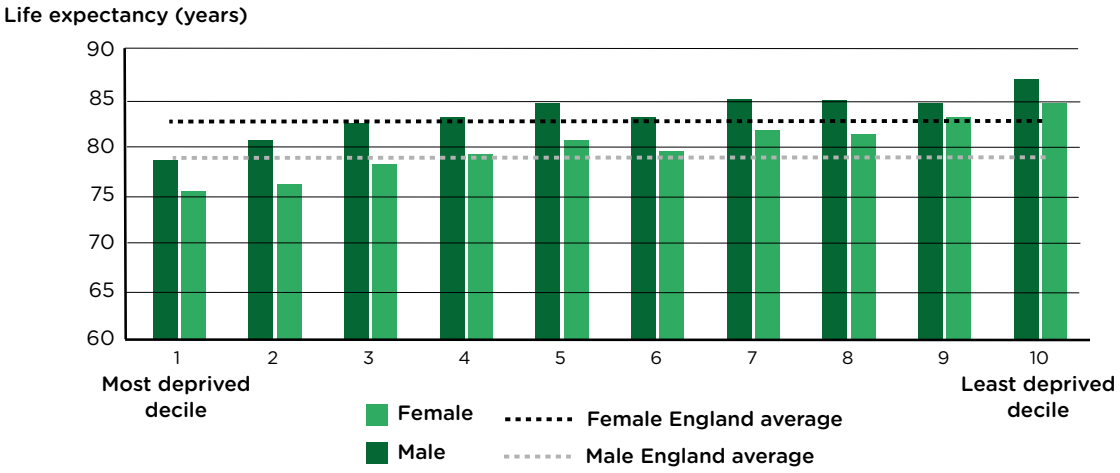
Within local authorities in the region, there is a life expectancy gap of more than 10 years between the least and most deprived deciles. In Wirral, measuring 60 square miles and with a population under 350,000, men in the most deprived quintiles live 13.8 years less than men in the least deprived quintiles.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

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

CHESHIRE EAST

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

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

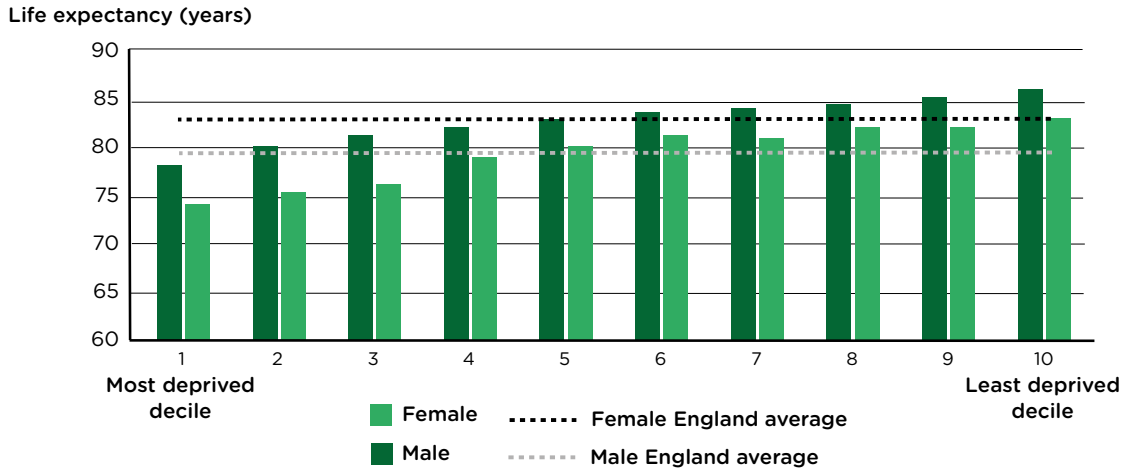


Source: *Office for National Statistics (90)*

CHESHIRE WEST AND CHESTER

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

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

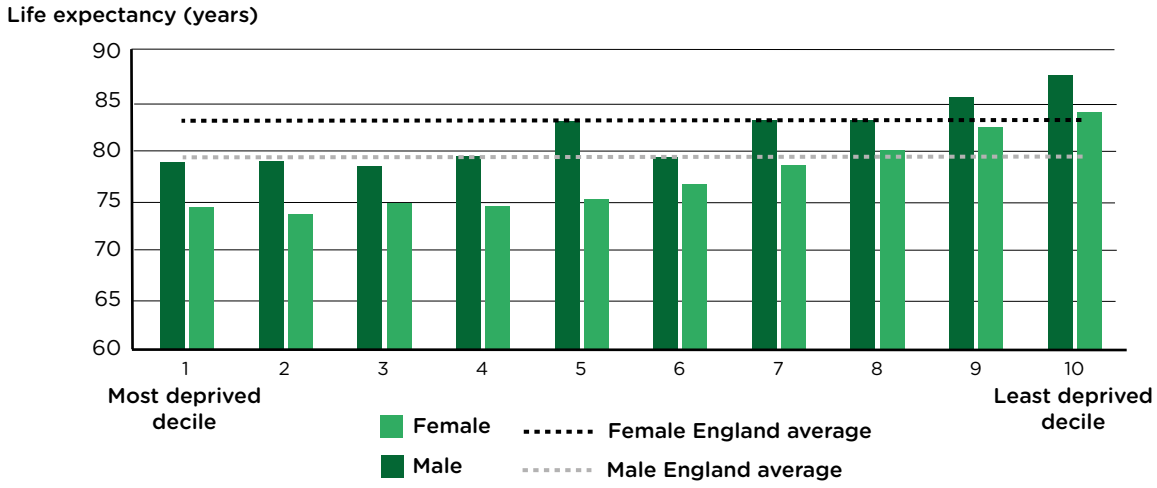


Source: *Office for National Statistics (90)*

HALTON

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

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

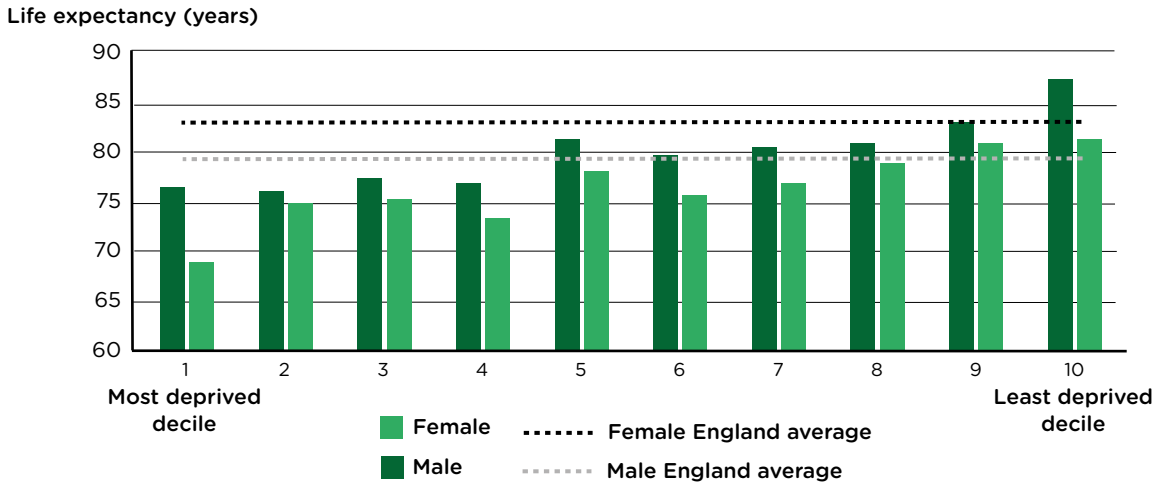


Source: *Office for National Statistics (90)*

KNOWSLEY

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

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

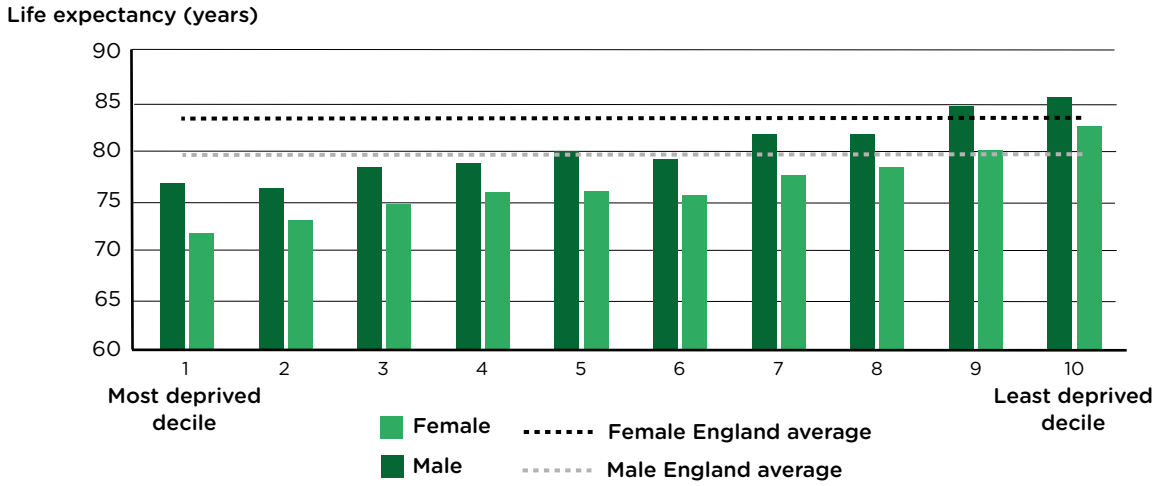


Source: *Office for National Statistics (90)*

LIVERPOOL

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

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

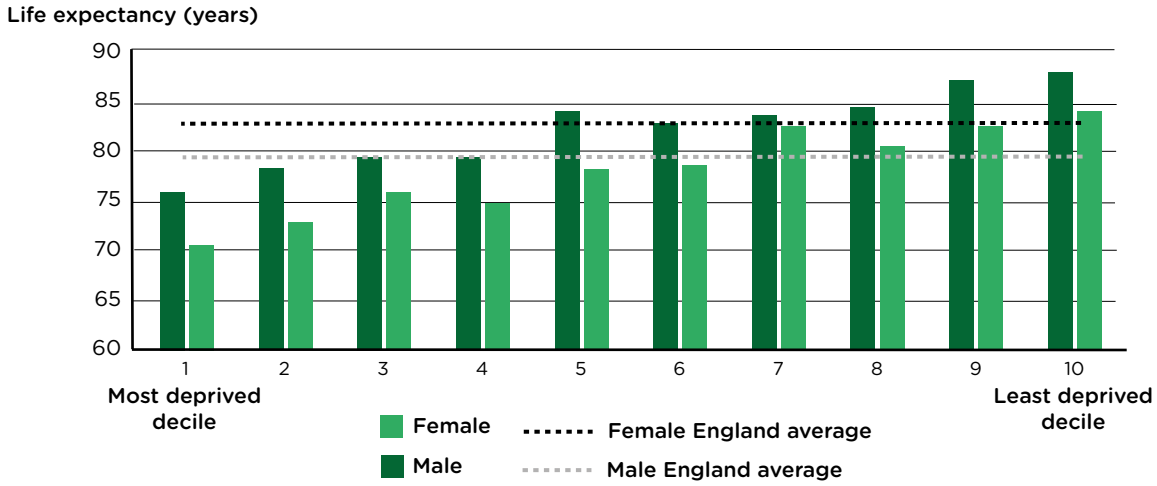


Source: *Office for National Statistics (90)*

SEFTON

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

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

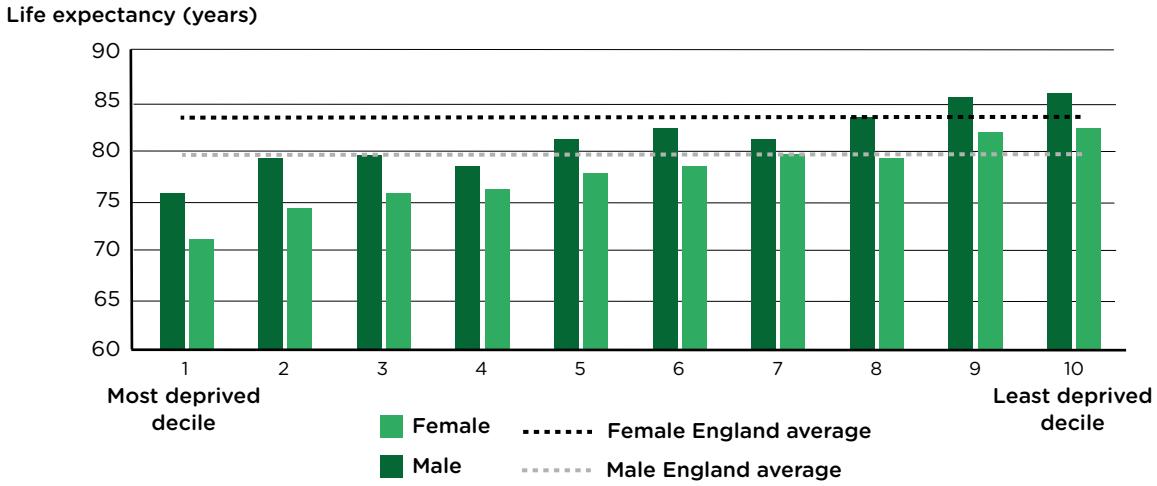


Source: *Office for National Statistics (90)*

ST HELENS

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

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

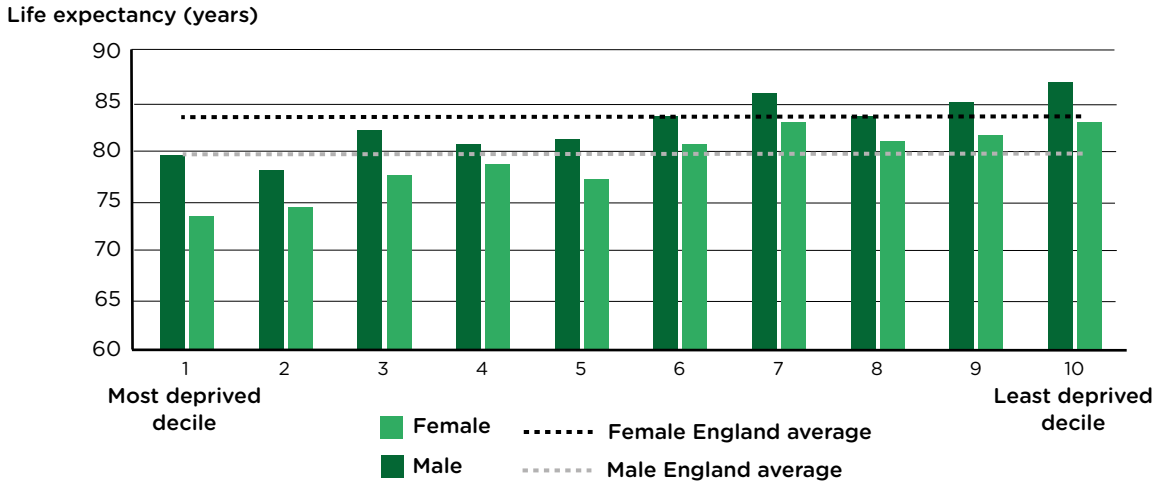


Source: *Office for National Statistics (90)*

WARRINGTON

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

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

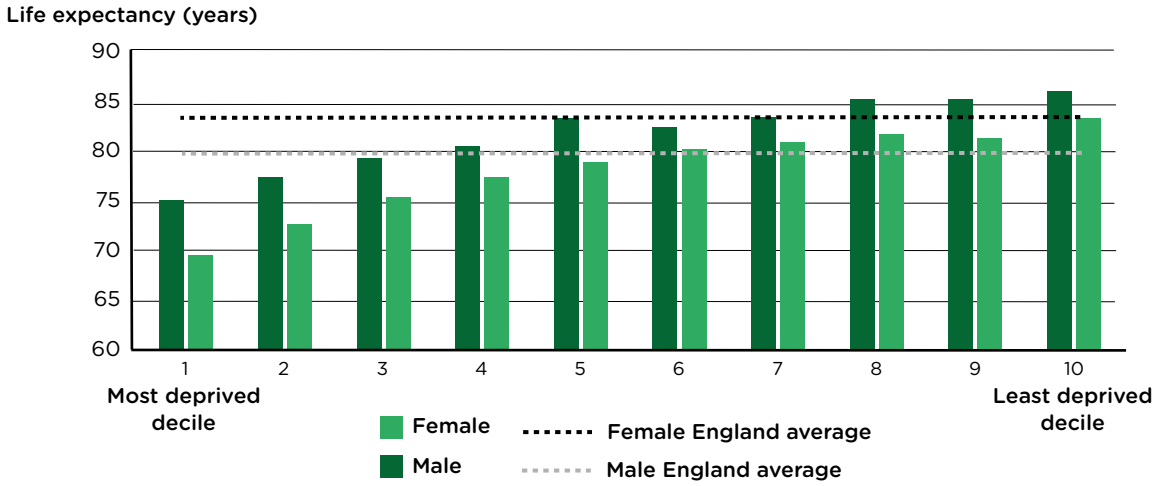


Source: *Office for National Statistics (90)*

WIRRAL

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

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



Source: *Office for National Statistics (90)*

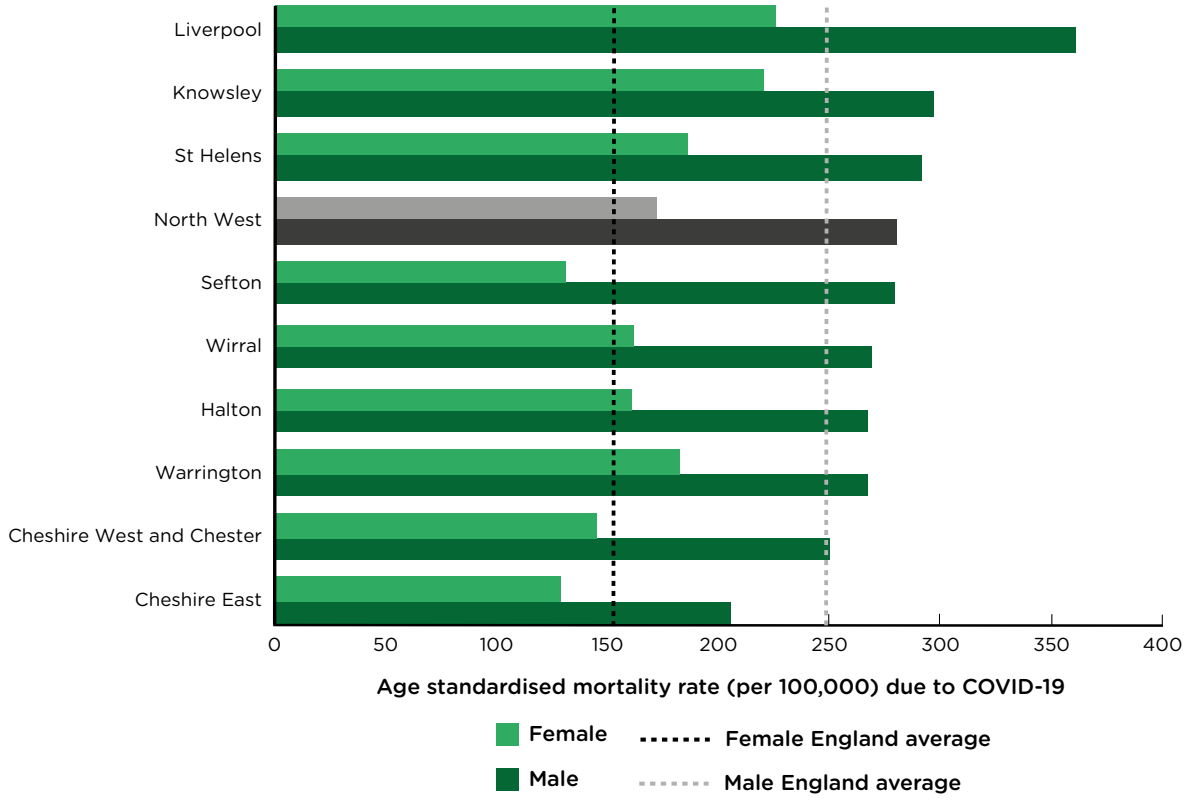
3D COVID-19 PANDEMIC AND HEALTH INEQUALITIES

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

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

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

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



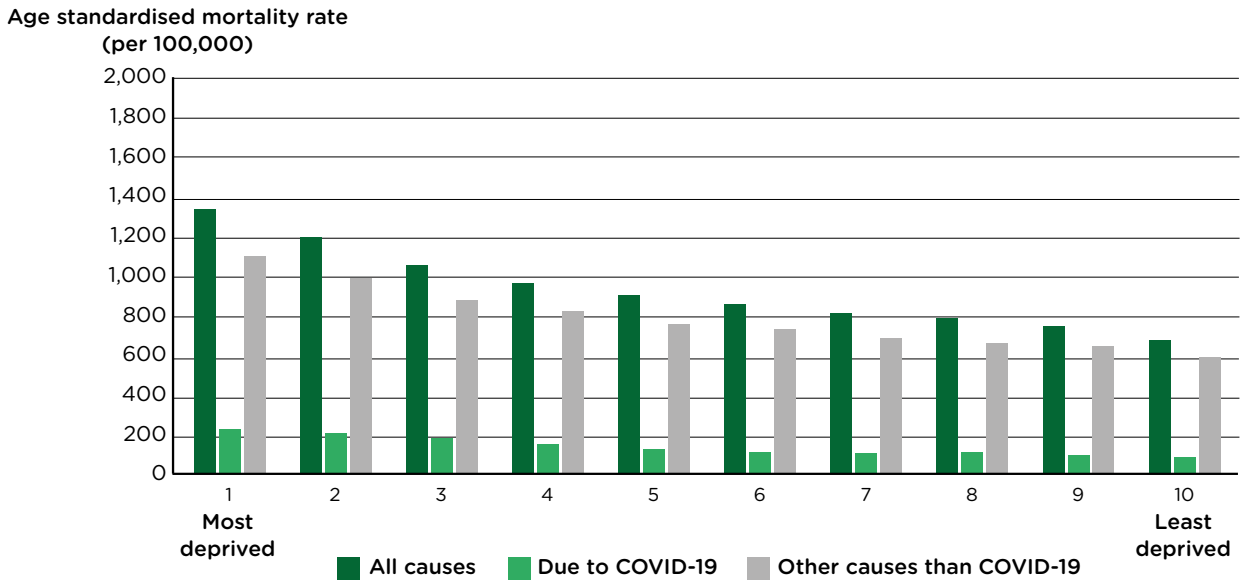
Notes: *Deaths 'due to COVID-19' only include deaths where coronavirus (COVID-19) was the underlying (main) cause.*

Source: *Office for National Statistics (95)*

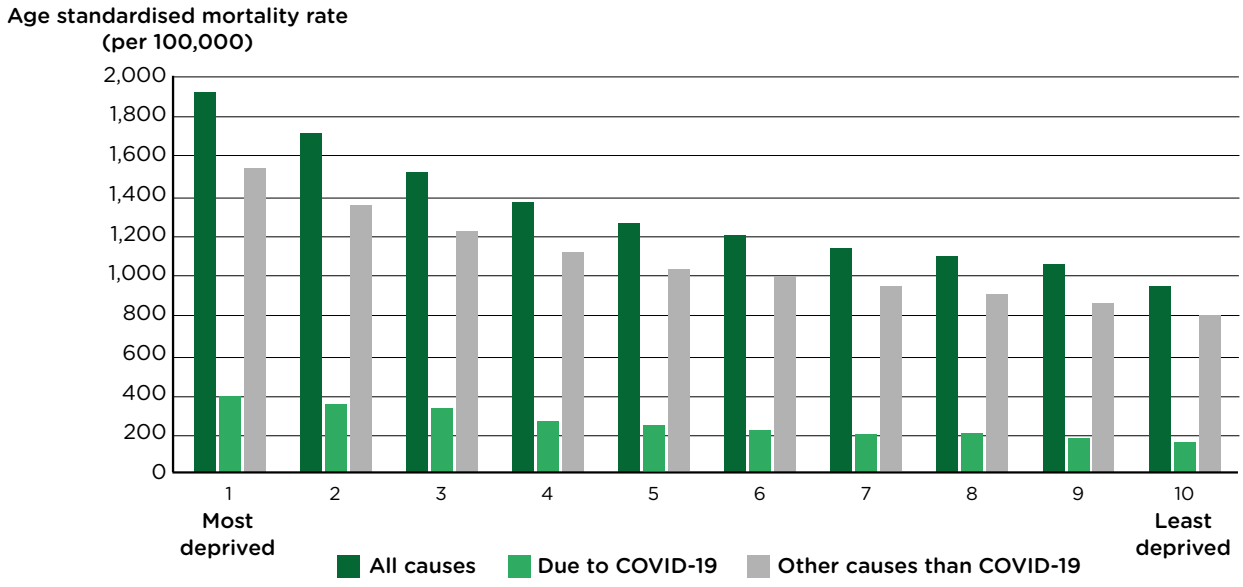
The relationship between all causes of mortality and deprivation in England reflects the relationship between deprivation and mortality from COVID-19, as seen in Figures 3.17A and 3.17B. The more deprived the area, the greater the mortality rate from COVID-19. The gradient was slightly steeper for COVID-19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

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

A) FEMALE



B) MALE



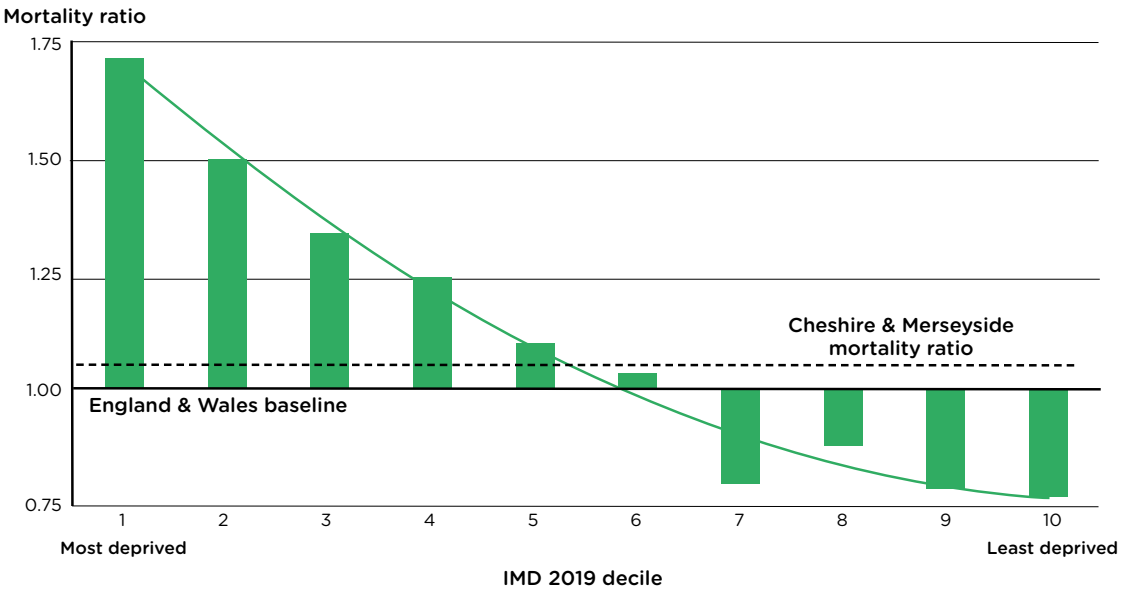
Source: *Office for National Statistics (95)*

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

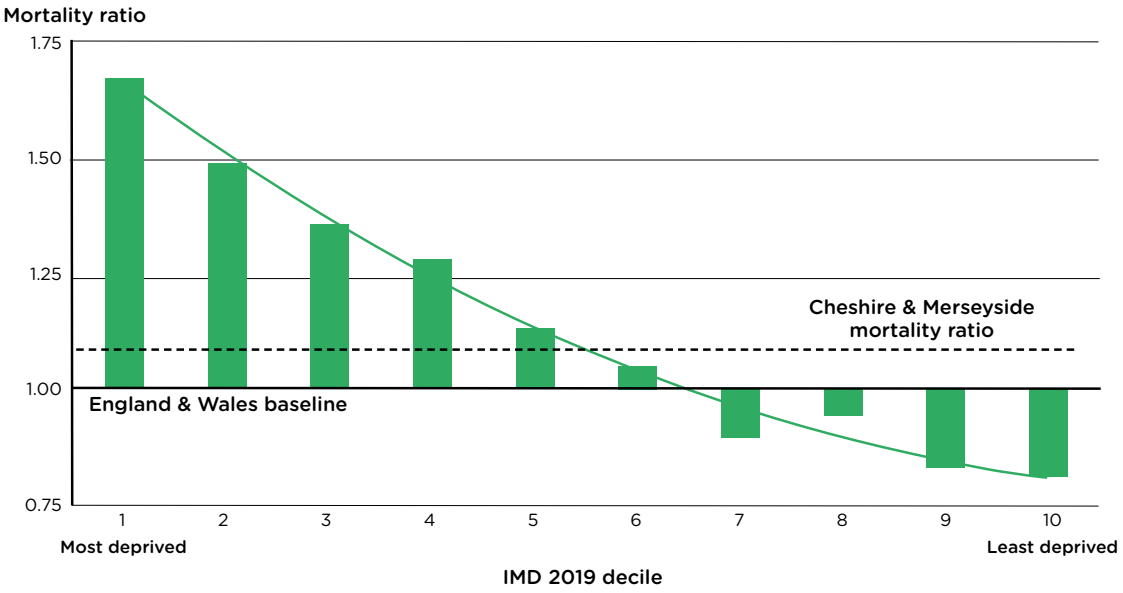
Figures 3.18A and 3.18B show the ratio of COVID-19 mortality by deprivation, using deciles in the Index for Multiple Deprivation (IMD) within Cheshire and Merseyside compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. In the region,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

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

A) FEMALE



B) MALE

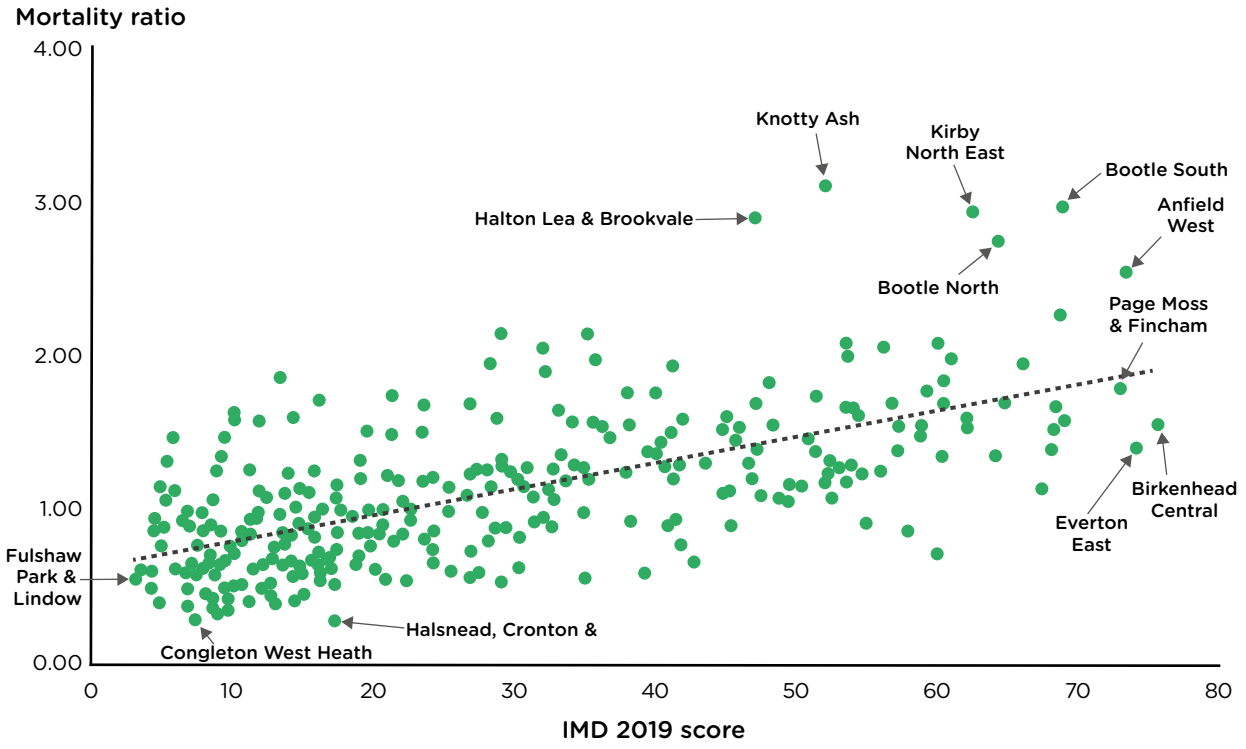


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these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

Source: *Office for National Statistics (93)*

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

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

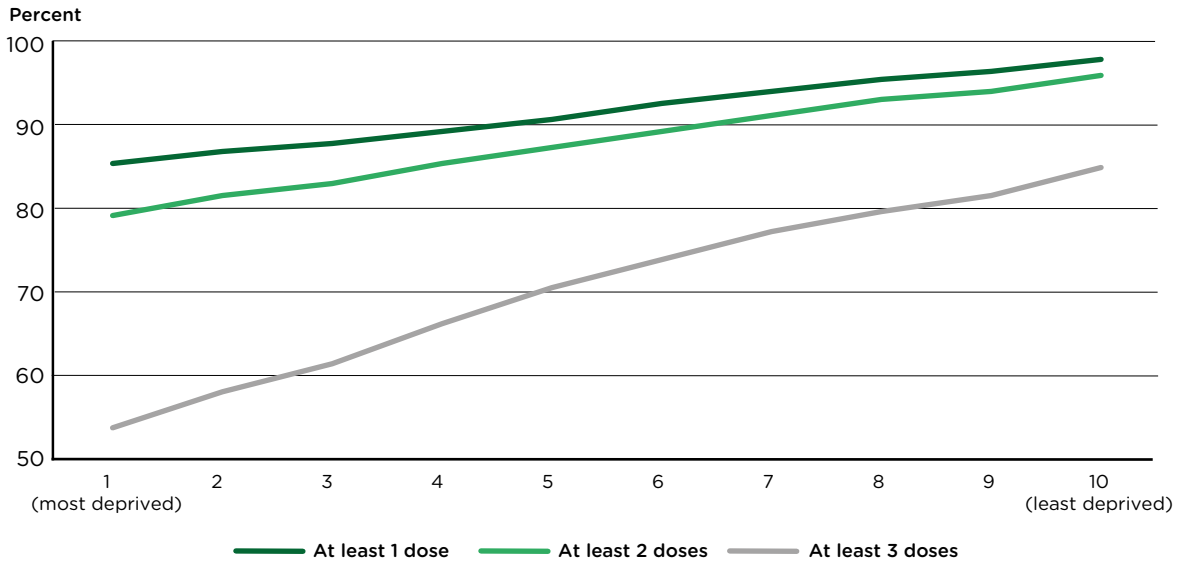


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these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

Source: *Office for National Statistics (98)*

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

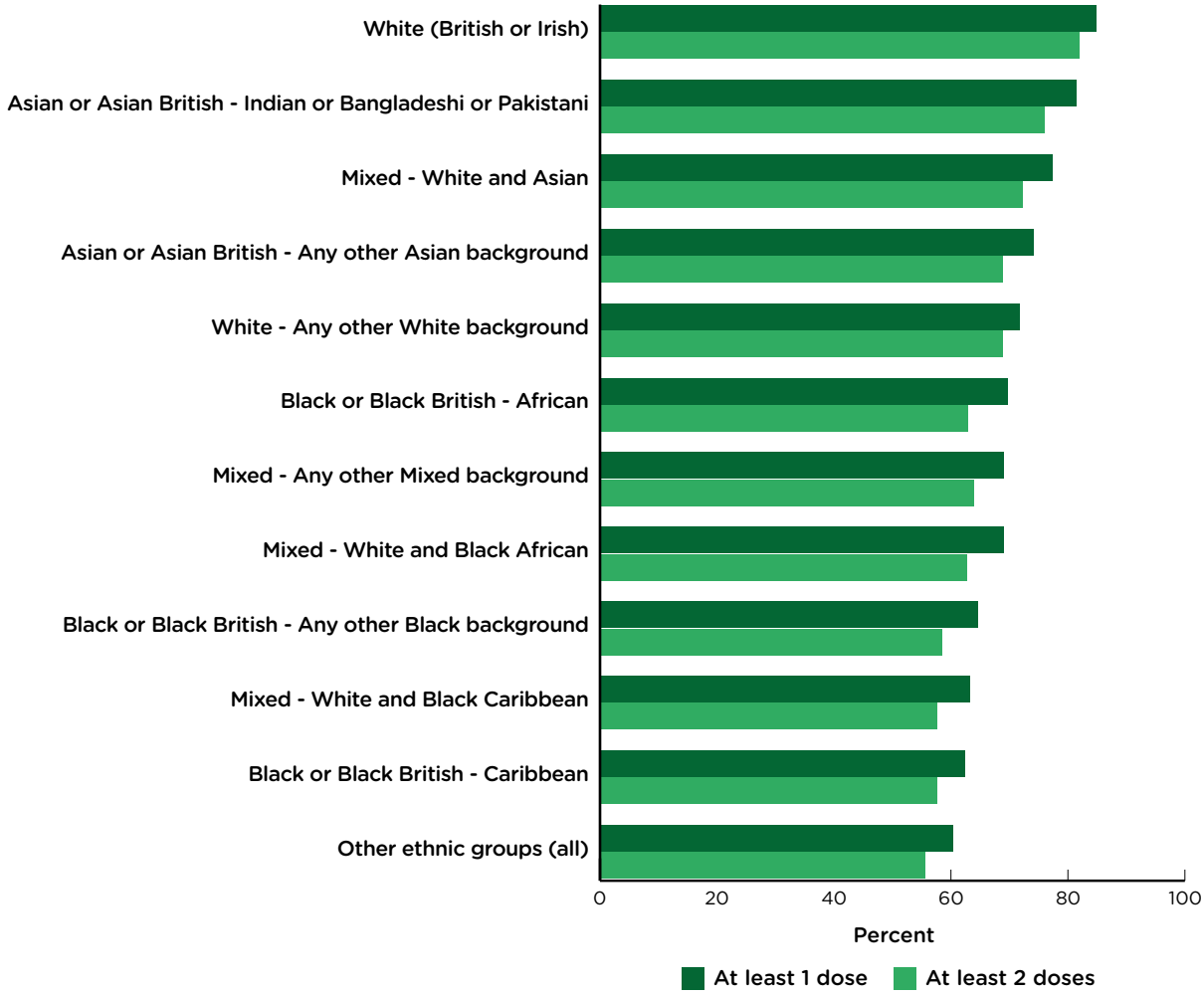
Figure 3.20. People vaccinated for COVID-19, by deprivation decile (IMD 2019), North West region, 8 December 2020 to 28 February 2022



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

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

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



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

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

Box 5. Reducing inequalities in vaccination uptake in Warrington

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

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

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

EARLY YEARS AND DURING SCHOOL-AGE EDUCATION

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

EDUCATION

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

CHILDREN AND YOUNG PEOPLE

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

EMPLOYMENT AND GOOD WORK

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

STANDARDS OF LIVING AND INCOME

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

PLACES AND COMMUNITIES

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

PUBLIC HEALTH

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

CHAPTER 4

THE SOCIAL DETERMINANTS OF HEALTH IN CHESHIRE AND MERSEYSIDE

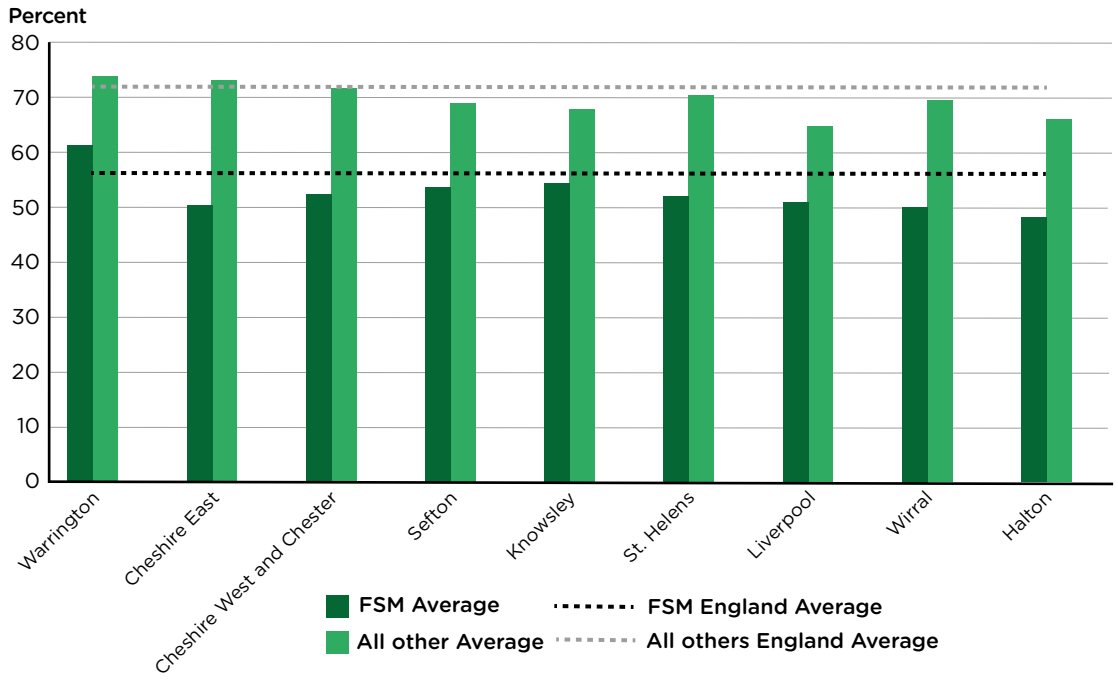
In this section we overview outcomes in the Marmot 8 themes across Cheshire and Merseyside, as outlined in Section 1. Recommendations and relevant indicators for monitoring are included and are the areas in which action by all partners need to be directed.

4A GIVING EVERY CHILD THE BEST START IN LIFE

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

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

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



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

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

RECOMMENDATION: GIVE EVERY CHILD THE BEST START IN LIFE

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

MARMOT BEACON INDICATORS

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

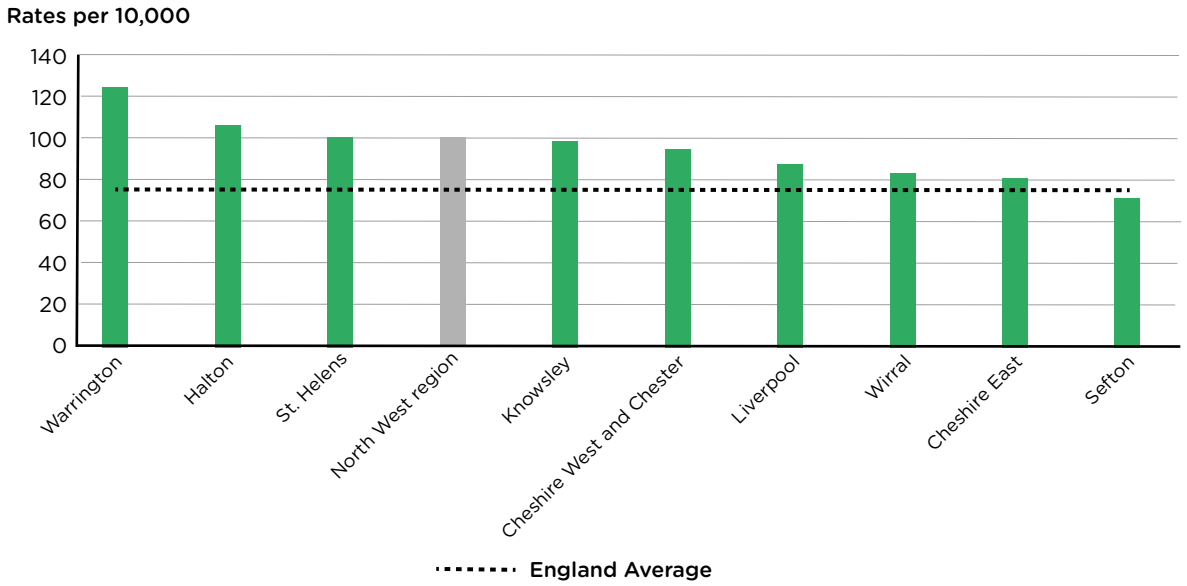
4B ENABLING ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

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

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

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

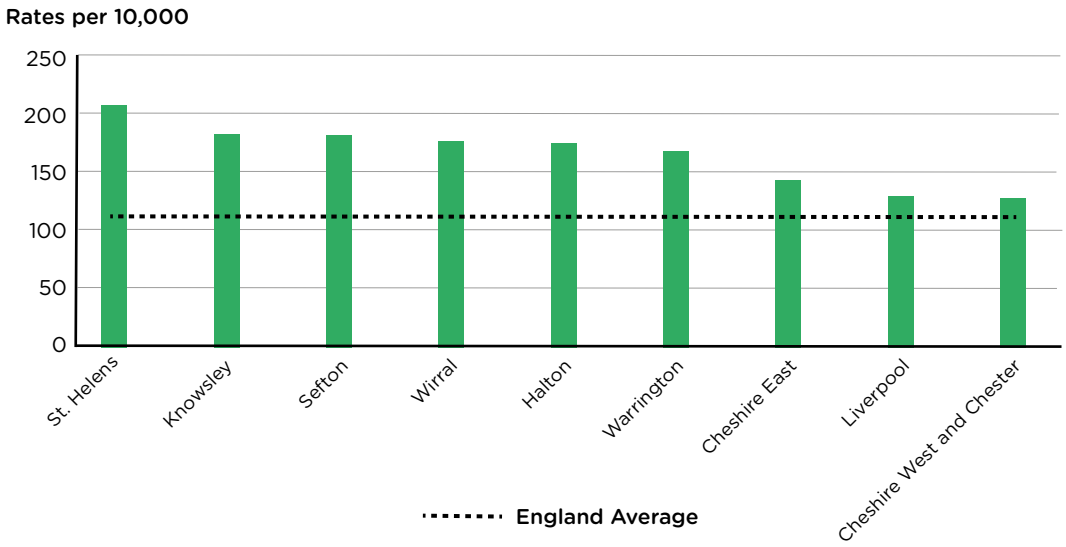
Figure 4.2. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14), rate per 10,000, Cheshire and Merseyside lower-tier local authorities and England, 2020/21



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

Source: *Hospital Episode Statistics (109)*

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

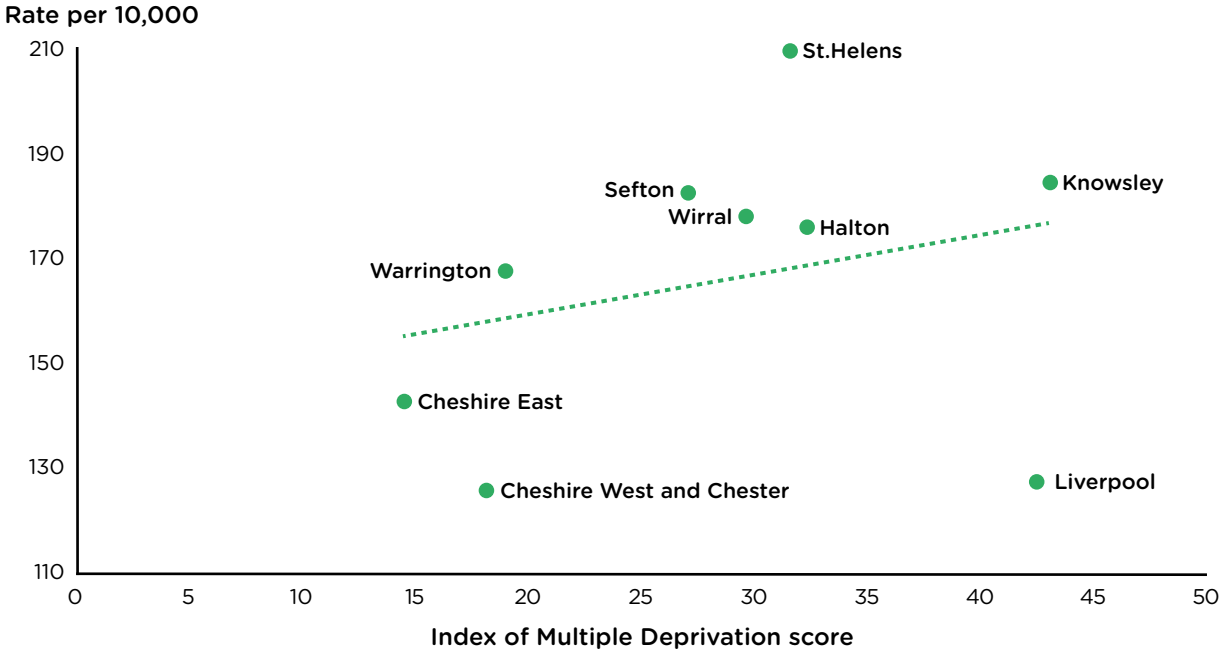


Notes: *Unintentional injuries are identified as external causes of harm, such as, road traffic collisions, sports injury, falls, accidental contact with machinery, burns and drowning etc. Deliberate injuries include different types of assaults and deliberate self-harm (110).*

Source: *Hospital Episode Statistics (109)*

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

Figure 4.4. Hospital admissions caused by unintentional and deliberate injuries* in young people (aged 15 to 24) by deprivation (IMD 2019), crude rate per 10,000, Cheshire and Merseyside lower tier local authorities, 2020/21



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

Source: *Hospital Episode Statistics (109)*

YOUNG PEOPLES' MENTAL HEALTH AND WELLBEING

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

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

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

Services for young people have also been substantially cut and it is estimated these spending cuts on preventative services for adolescents is directly linked to rising rates of 16- and 17-year-olds entering care. Davara et al. argue that every £10 decrease in prevention spend per young person was associated with an estimated additional two 16- to 17-year-olds entering care (per 100,000 per year). They estimate this has led to an additional 1,000 children aged 16 and 17 being taken into care between 2011 and 2019. Any claimed savings from cutting prevention services to young people disappeared as an extra £60 million has been added to councils' care bills to support these children in care (115).

While access to mental health services for children and young people needs to be rapidly expanded, particularly in more deprived areas, support and activities that can help to prevent mental health problems developing are vital. The most effective approaches are those which support the family and make improvements in a range of social determinants: improving adult employment opportunities, reducing levels of debt, and improving housing conditions, for example. However, these effective approaches that support children and families to improve mental wellbeing, are frequently no longer provided by public service organisations.

EDUCATIONAL INEQUALITIES

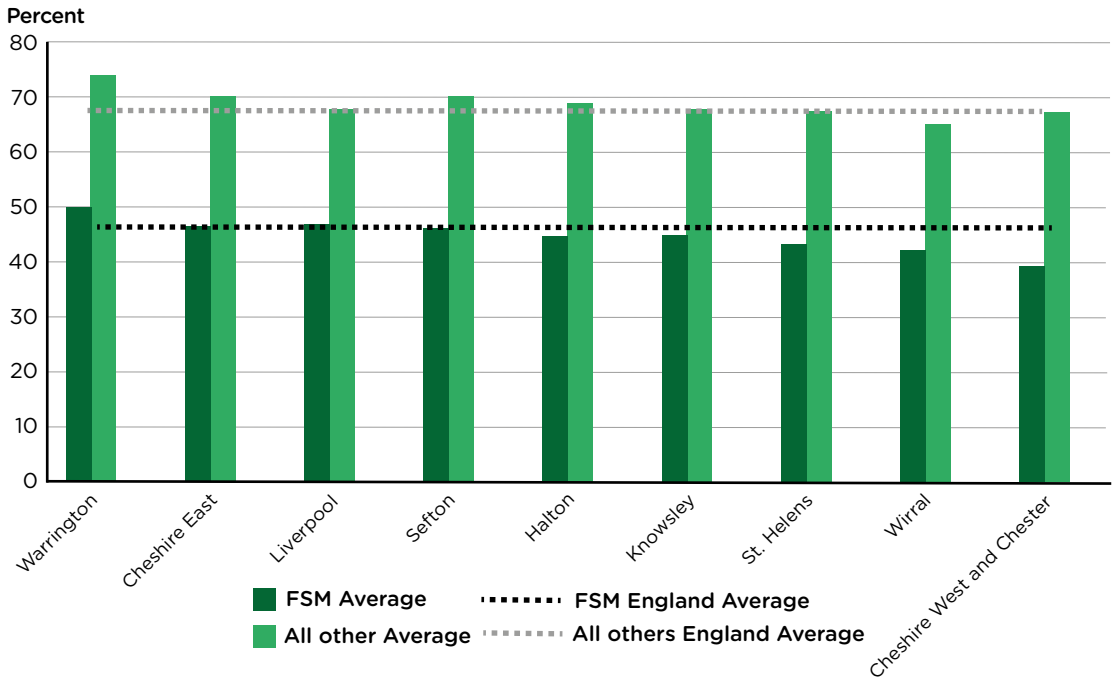
Inequalities in education related to socioeconomic position were persistent prior to the pandemic. Pupils eligible for free school meals for more than 80 percent of their school life were 18 months behind their peers by the time they finished their GCSEs, a gap that has not changed in the last five years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

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

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

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

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

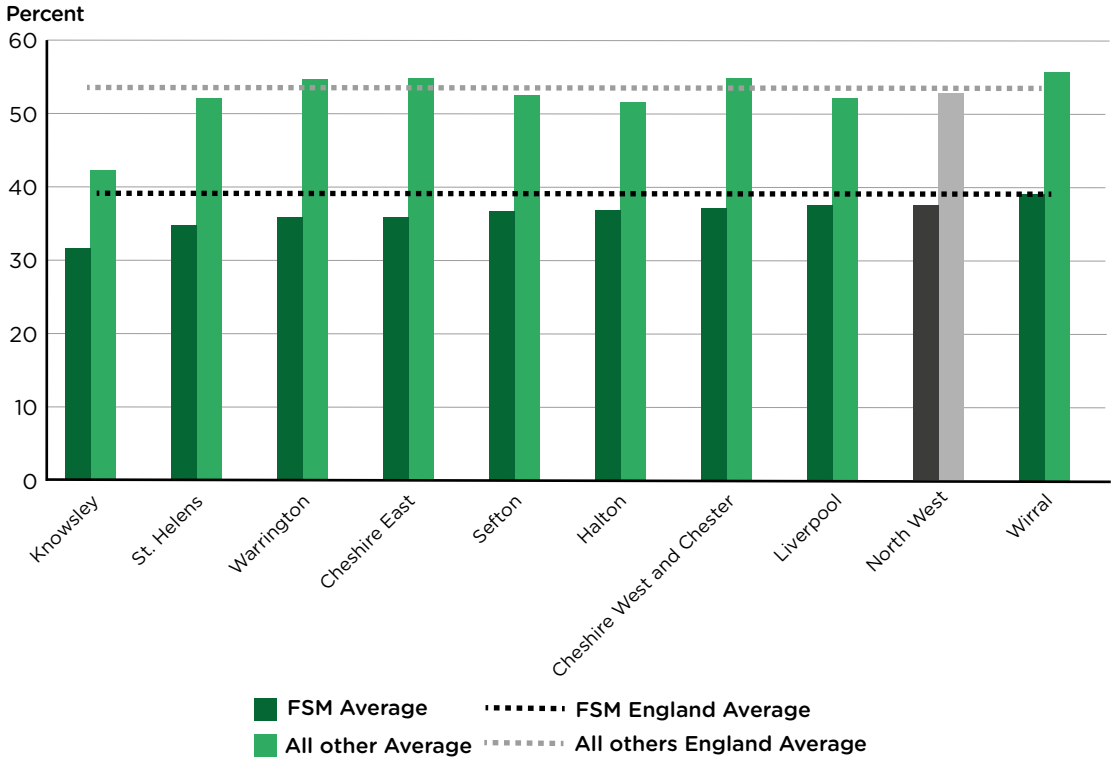


Source: *Department for Education (119)*

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

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

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



Source: *Department for Education (120)*

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

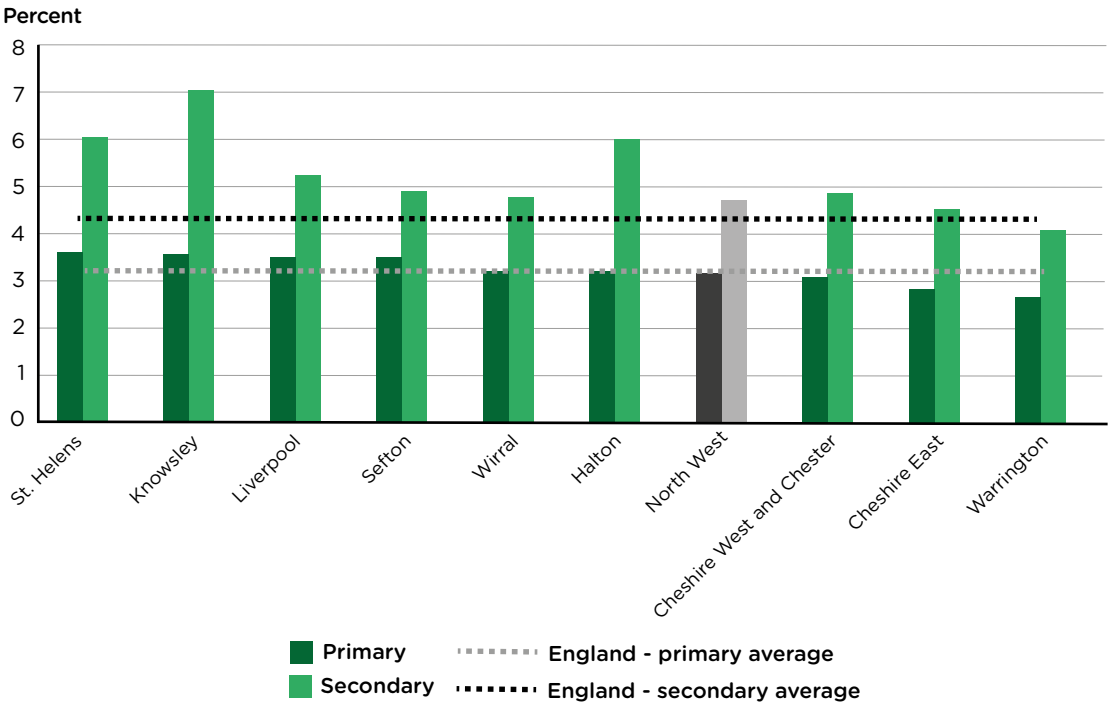
Table 3.1. Average Progress 8 Score*, Ethnicity and free school meal eligibility, in Cheshire and Merseyside lower-tier local authorities, 2018/19

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

Source: *Department for Education (120)*

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

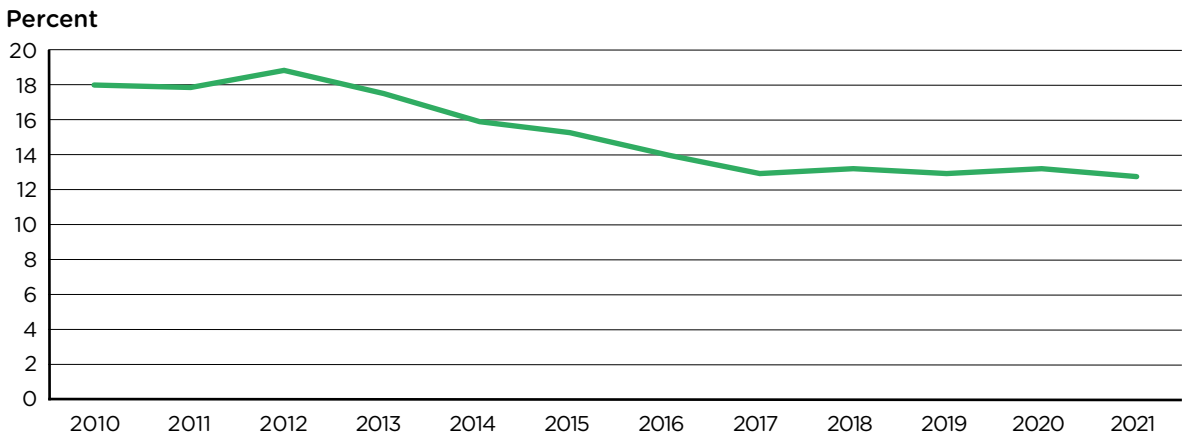
Figure 4.7. Pupil absences, autumn and spring terms combined, primary and secondary, percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020-21



Source: *Department for Education (122)*

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

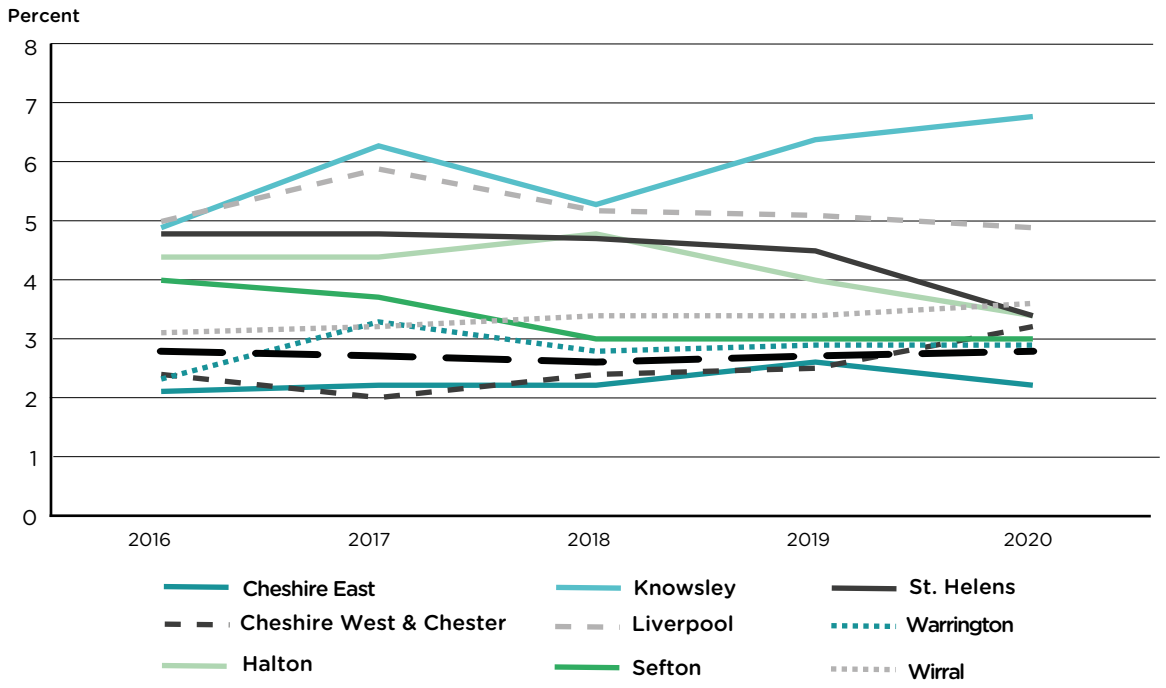
Figure 4.8 Not in Education Employment of Training (NEET), (aged 18 to 24), percentage, first quarter, England, 2010-21



Source: *Office for National Statistics (123)*

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

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



Source: *Department for Education (126)*

Apprenticeships are frequently suggested as a tool to reduce NEETs. The apprenticeship programme in England in the last decade has shifted from being aimed at younger people to being a tool to get older people back into employment. In England, over-25-year-olds outnumber under-19-year-olds in apprenticeships by two to one (127). The IHE *10 Years On* report also outlines the decline in apprenticeships available to young people living in areas of high deprivation (1). The most recent report from the Social Mobility Commission stated that apprentices were failing to "reach their social mobility potential" and that "the majority of apprentices are not from lower socio-economic backgrounds" (107). Every local authority in Cheshire and Merseyside has seen the number of apprenticeships drop since 2011 and the COVID-19 pandemic led to a further decline (127). In building back fairer, Cheshire and Merseyside have an opportunity to develop a fairer apprenticeships programme able to contribute to reducing health inequalities.

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

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

MARMOT BEACON INDICATORS

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

4C CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

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

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

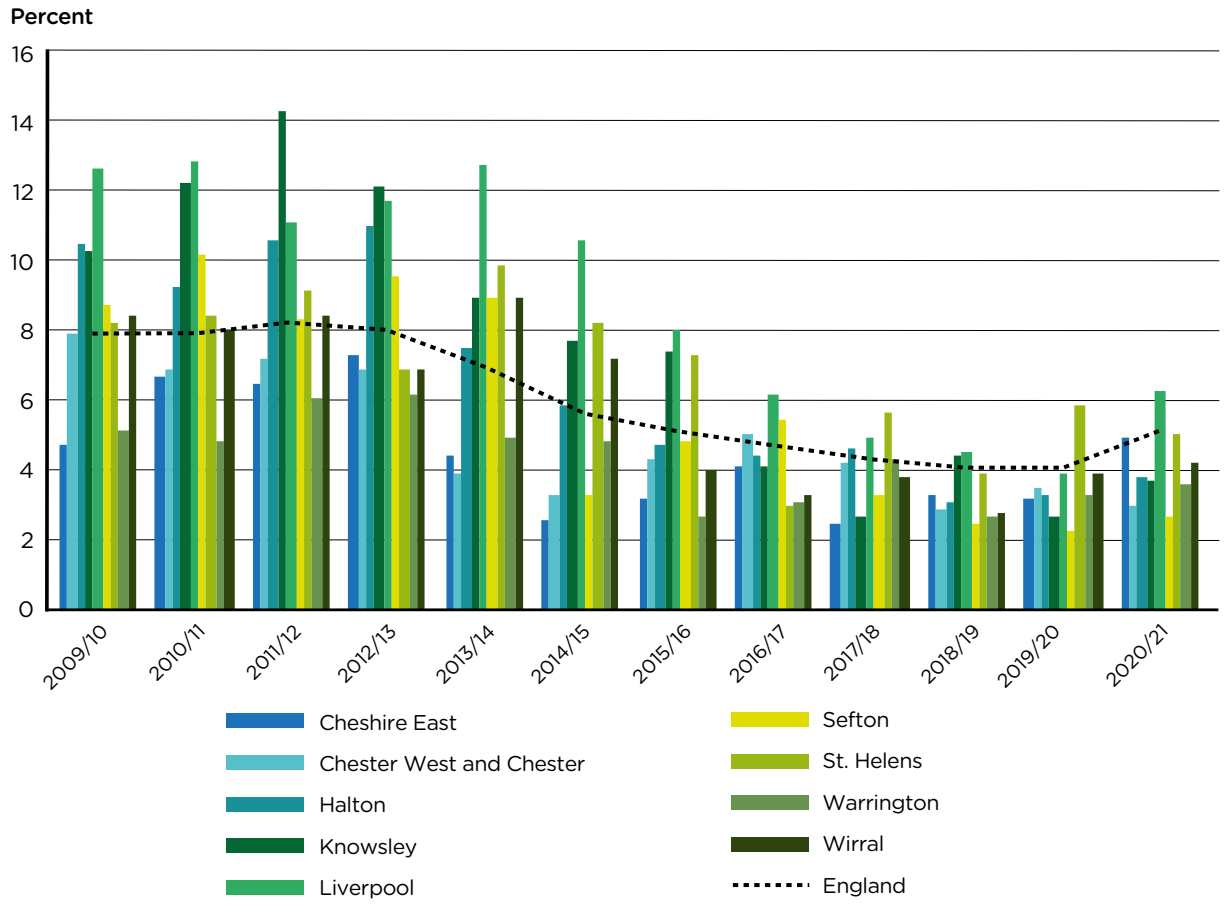
Further analysis of how employers can contribute to reductions in health inequalities is set out in Section 5E.

UNEMPLOYMENT AND ECONOMIC INACTIVITY

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

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

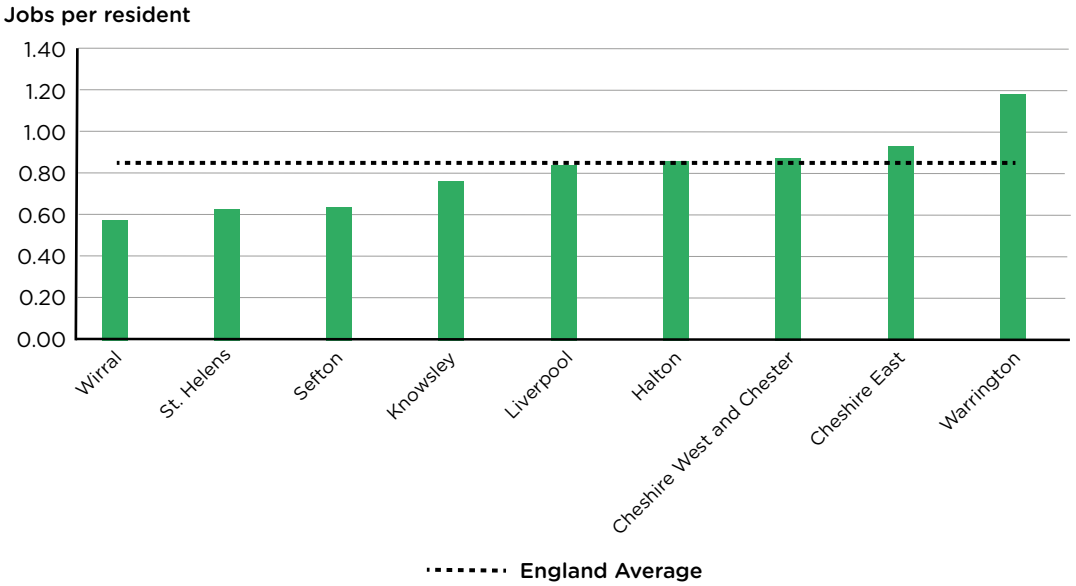
Figure 4.10. Unemployment rate, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, July-June 2009/10 to 2020/21



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

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

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



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

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

Box 7. Supporting Households Into Work in Liverpool City Region

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

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

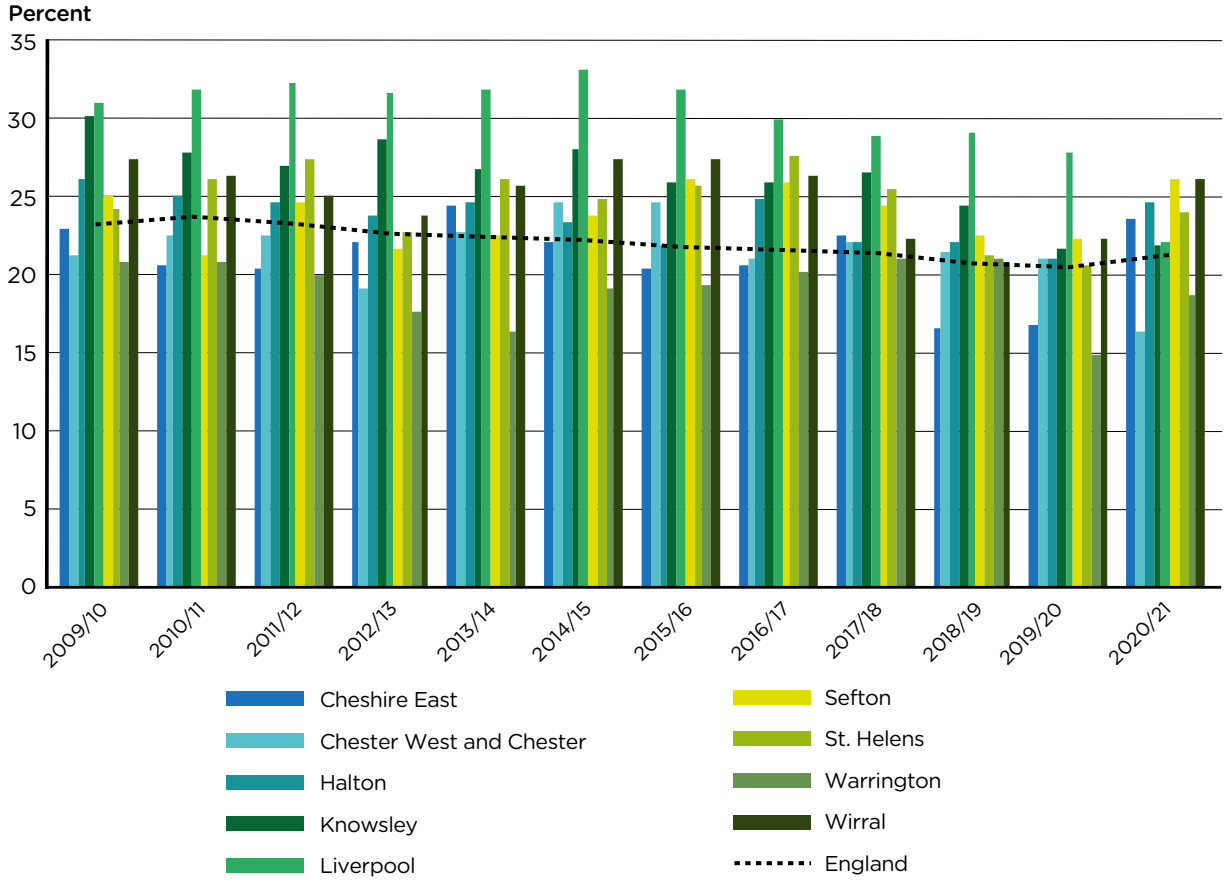
An evaluation of pilot programme data (covering February 2018-20) found that the key barriers to employment in this client group were mental health issues (65 percent); chronic health conditions (23 percent); and care responsibilities (26 percent). Clients also experienced financial inequality. Some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

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

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

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

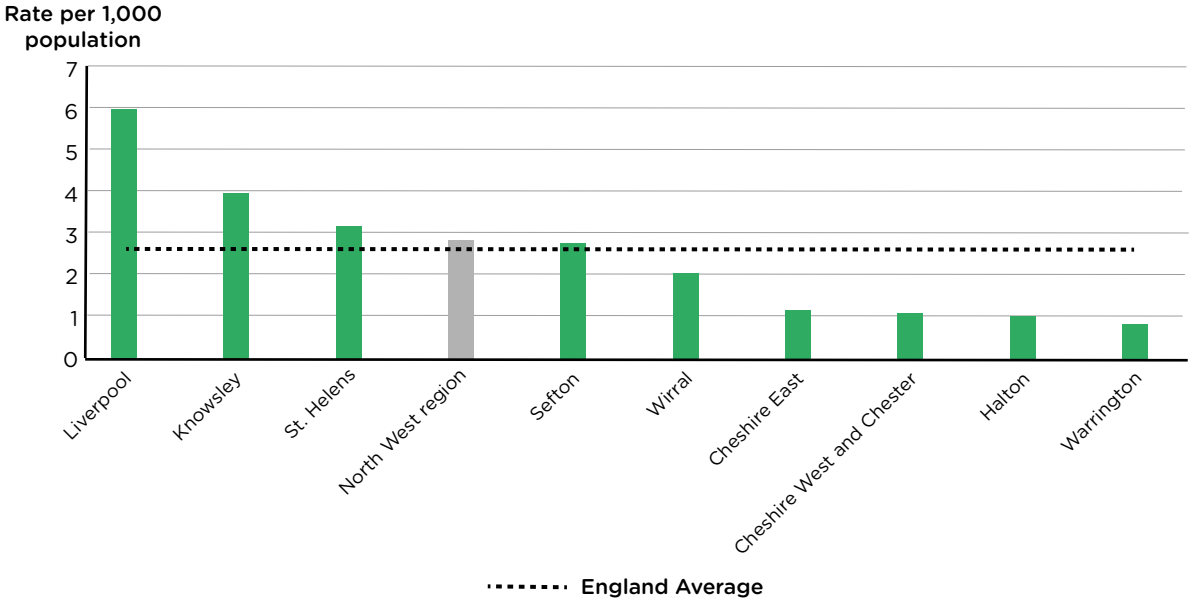
Figure 4.12. Economically inactive population, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, 2009/10 to 2020/21



Source: *Office for National Statistics (132)*

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

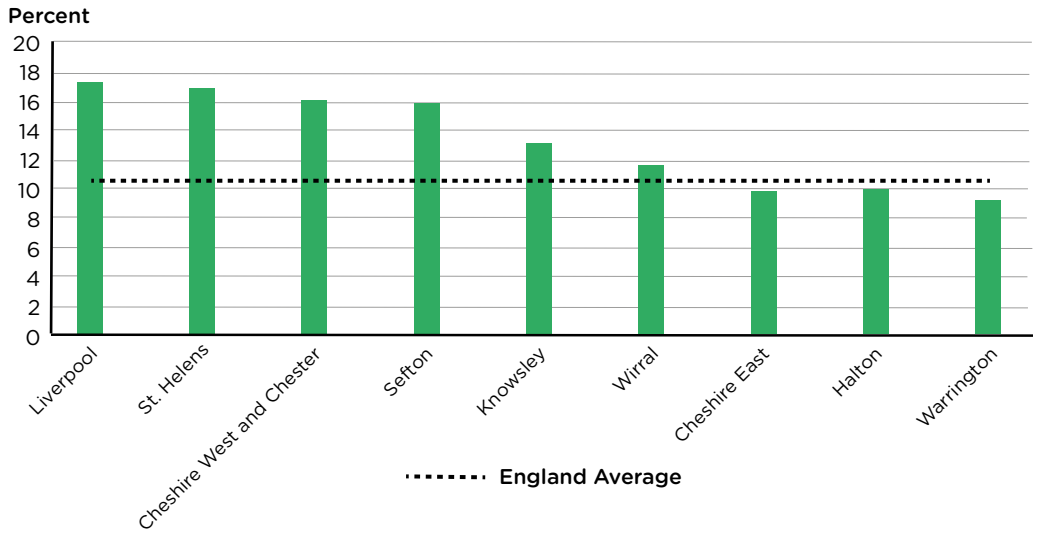
Figure 4.13. Long term claimants of Jobseeker's Allowance, (aged 16 to 64), rate per 1,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



Source: *Office for National Statistics (132)*

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

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



Notes: *Gap in the employment rate between those with a long-term health condition and the overall employment rate - The percentage point gap between the percentage of respondents in the Labour Force Survey who have a long-term condition who are classified as employed (aged 16-64) and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16-64).*

Source: *Office for National Statistics (132)*

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

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

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

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

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

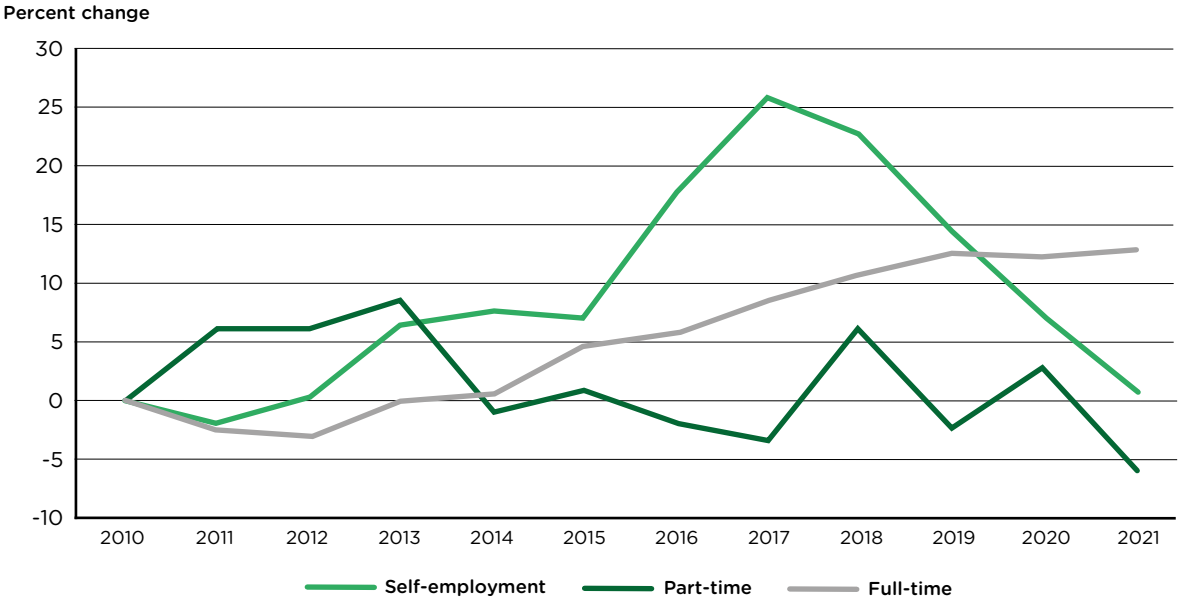
Sew Halton also acted as a signposter, directing participants to a variety of partners including Citizens Advice, Halton Carers Centre, urgent care centres, domestic abuse services, local councillors, and many others.

QUALITY OF WORK AND FAIR PAY

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

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

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



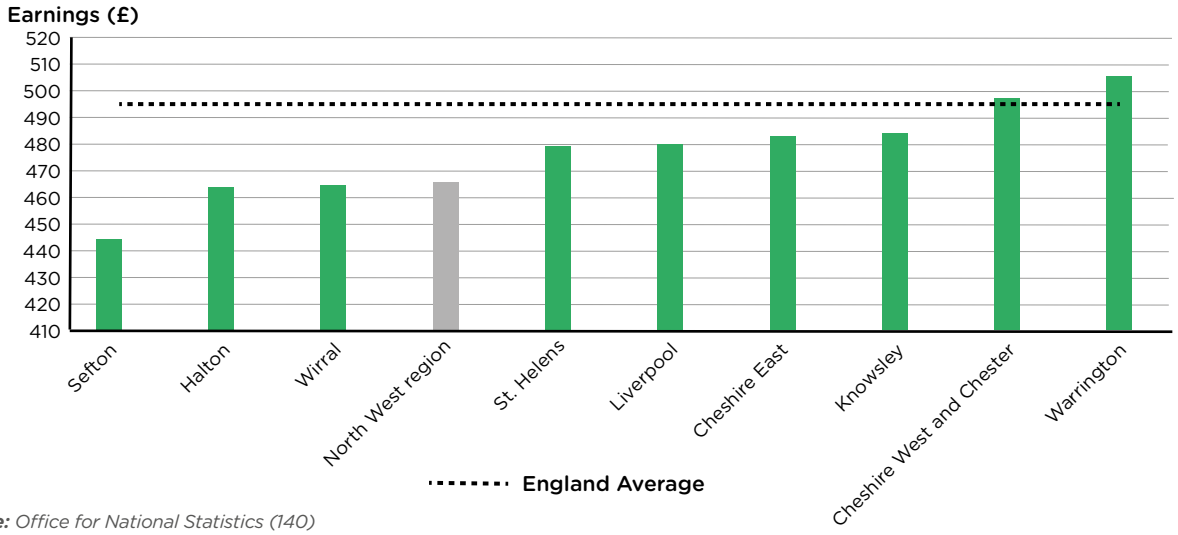
Source: *Office for National Statistics (132)*

PAY AND IN-WORK POVERTY

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

In April 2022 the minimum wage in the UK was £9.50. The real living wage was created to better estimate the wage rate needed "to ensure that households earn enough to reach a minimum acceptable living standard as defined by the public". Calculated based on a basket of goods and services (including housing and childcare costs, council tax and travel) the real living wage in 2021/22 was £9.90 (for areas outside of London). There are a number of opportunities to improve employment conditions in Cheshire and Merseyside, particularly related to wages through, for example increasing pressure on employers to pay the real living wage for employees, contract workers and through the supply chain. Figure 4.16 shows only Cheshire East and Cheshire West have average earnings above the England average.

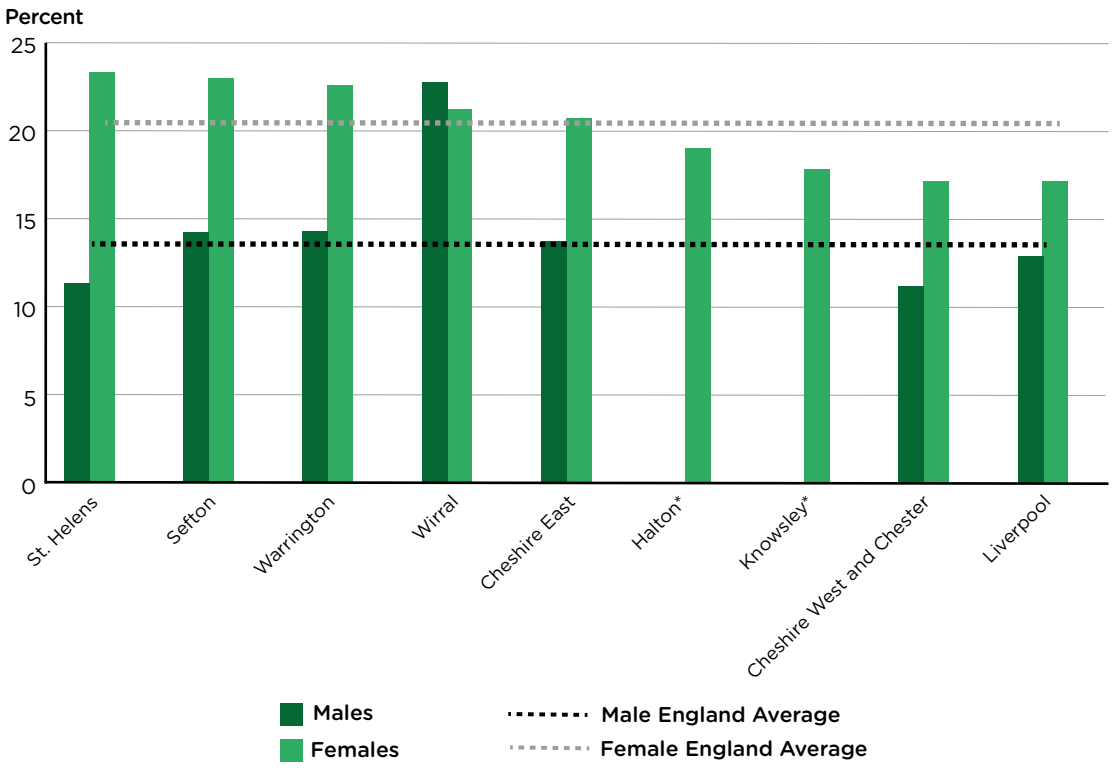
Figure 4.16. Average weekly earnings, (aged 16 and over), pounds (£), Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



Source: *Office for National Statistics (140)*

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

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



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

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

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

Box 9. Economies for healthier lives

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

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

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

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

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

RECOMMENDATION: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

2022/23

Responsible: Place

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

Responsible: Cheshire and Merseyside System

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

2023/27

Responsible: Place

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

Responsible: Cheshire and Merseyside System

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

Responsible: Local Enterprise Partnership and anchor partners

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

MARMOT BEACON INDICATORS

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

4D ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

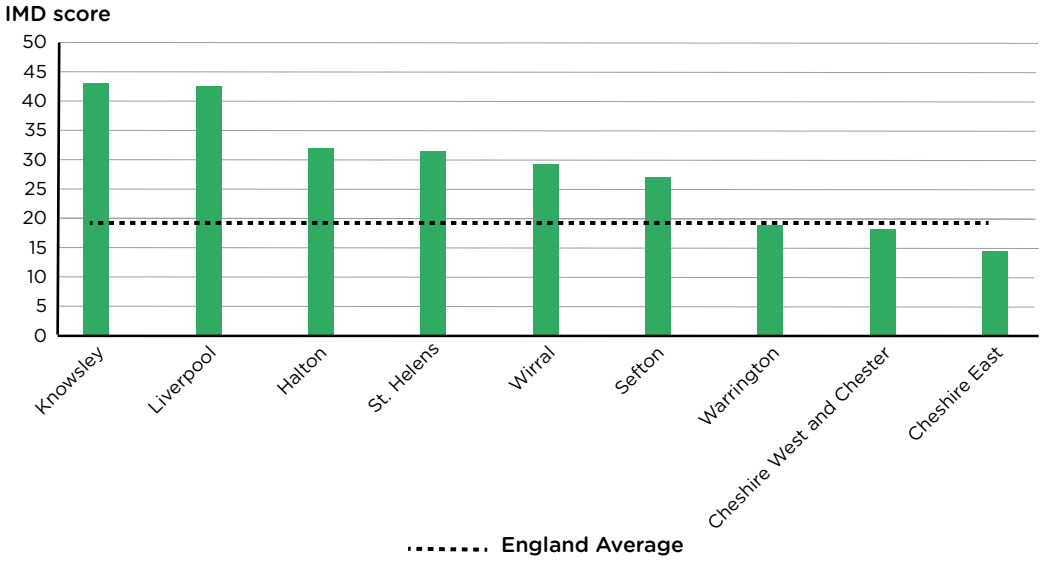
Poverty affects the ability to purchase sufficient goods and services and to have a social life - all essential components of a healthy life. Poverty also affects control over one's life which is critical to health and wellbeing and the ability to lead a dignified life (1).

Poverty has a cumulative negative effect on health throughout a lifetime and insufficient income is associated with poor long-term physical and mental health and increased mortality at all ages and lower than average life expectancy. Poverty affects the social determinants of health; affecting access to decent housing and the ability to heat one's home, the ability to have a healthy diet, reduces access to employment and harms educational attainment. It increases levels of debt, which are harmful to health. Poverty is also stressful, leads to mental health issues and reduces the 'mental bandwidth' available to deal with problems and live a healthy life (1).

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

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

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

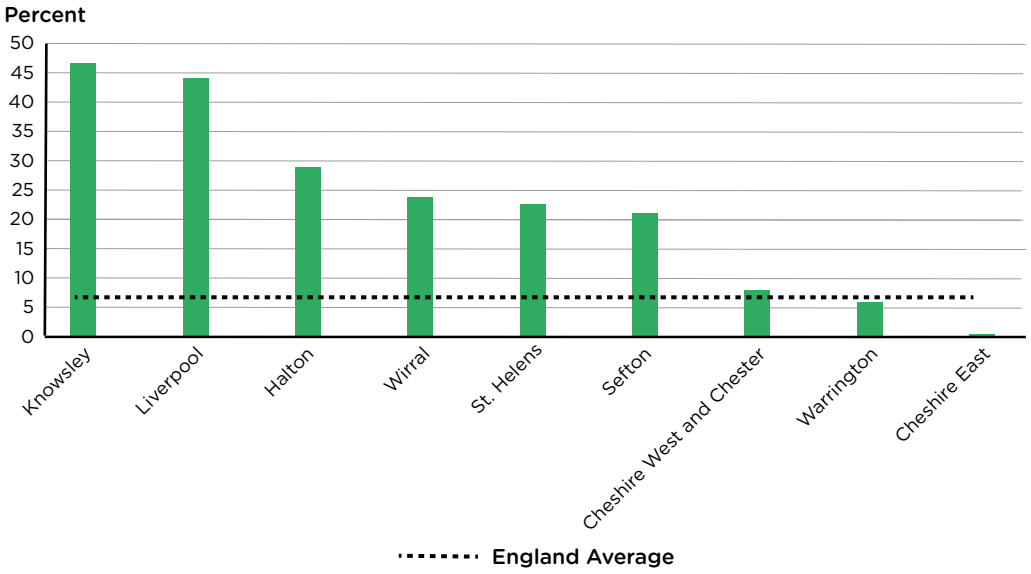


Source: *Ministry of Housing, Communities and Local Government (4)*

The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England, Liverpool the third. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households.

Liverpool has the fourth highest proportion, with 24 percent living in income deprived households (4). Figure 4.19 shows the level of deprivation within Cheshire and Merseyside and that seven of nine local authorities have a higher proportion of most deprived LSOAs compared to the England average.

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



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

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

Box 10. Knowsley Better Together Hardship Fund

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

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

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

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

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

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

Box 11. Liverpool Citizens Support Scheme

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

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

COST OF LIVING CRISIS AND INCREASING INCOME INEQUALITY

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

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

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

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

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

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

In January 2022, a survey of 1,702 adults earning below the living wage found that 38 percent had fallen behind on household bills; 32 percent regularly skipped meals for financial reasons; and before the large increases in energy, 28 percent already reported being unable to heat their homes for financial reasons. As a result, two-thirds, 66 percent stated their mental health would improve if they earned a wage that covered their basic living costs (152).

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

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

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

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

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

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

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

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

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

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

CHILDREN LIVING IN POVERTY

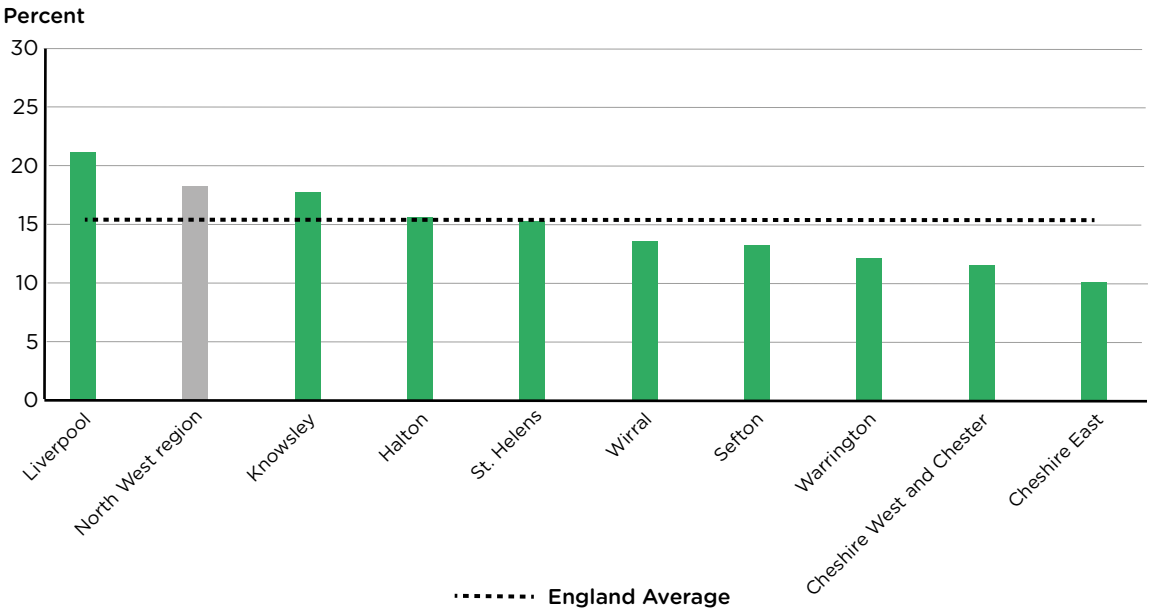
Persistent child poverty is associated with worse mental, social, and behavioural development in children, as well as worse educational outcomes, employment prospects, and earning power into adulthood.

Analysis of 10,652 children from the UK Millennium Cohort Study measured mental and physical health and relative poverty at 9 months, and at 3, 5, 7, 11 and 14 years of age. They found any period of poverty, from only a few months to persistent poverty (over many years), was associated with worse physical and mental health in early adolescence (after adjusting for the mother's education and ethnicity). Children living in persistent poverty had a three times higher risk of mental ill health, a 1.5 times greater risk of obesity, and nearly double the risk of longstanding illness compared to children who had never been poor (155).

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

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

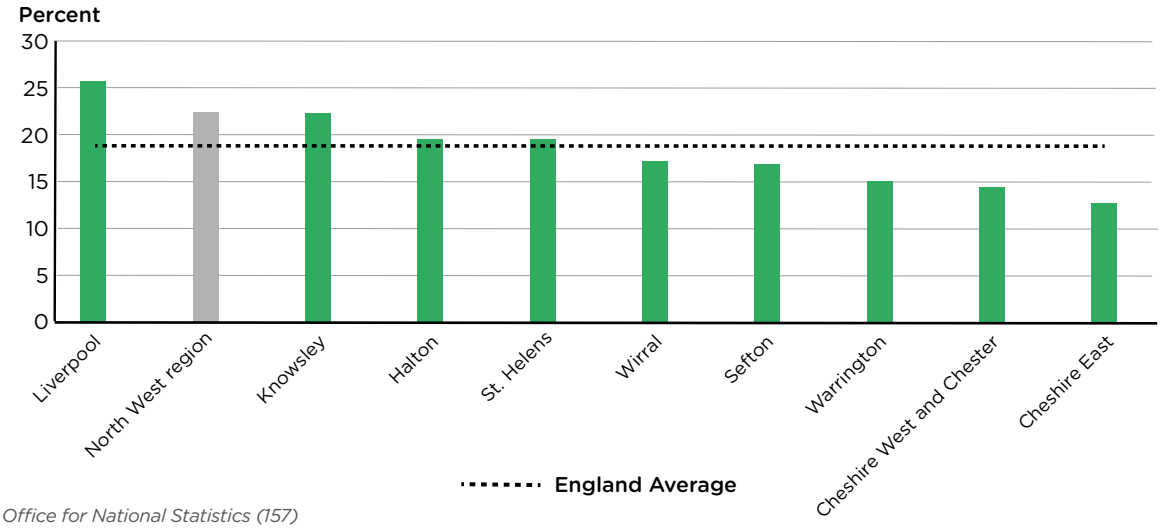
Figure 4.20. Children living in absolute poverty households (under-16s), percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



Source: *Office for National Statistics (157)*

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

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



Source: *Office for National Statistics (157)*

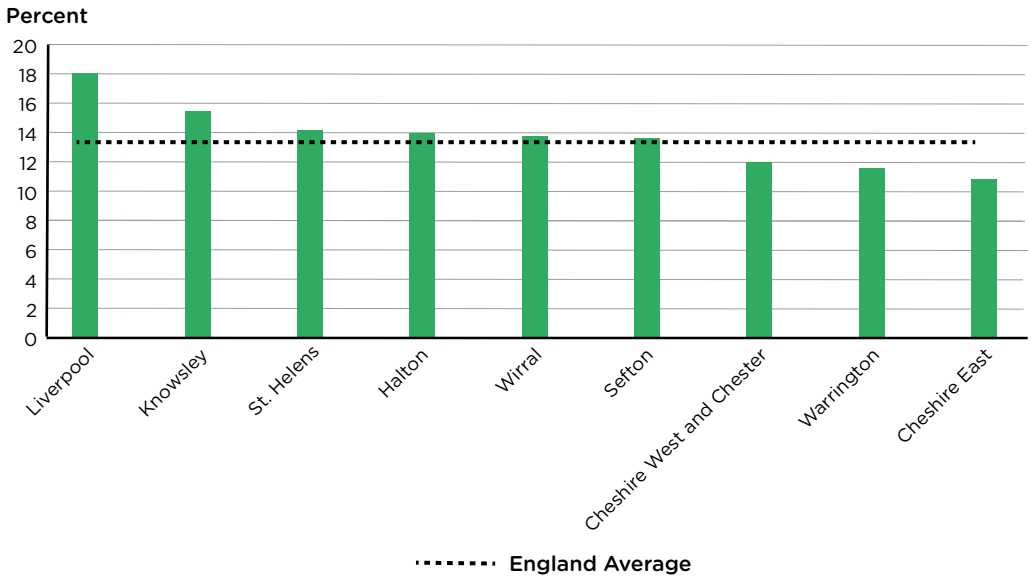
FUEL POVERTY

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

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

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

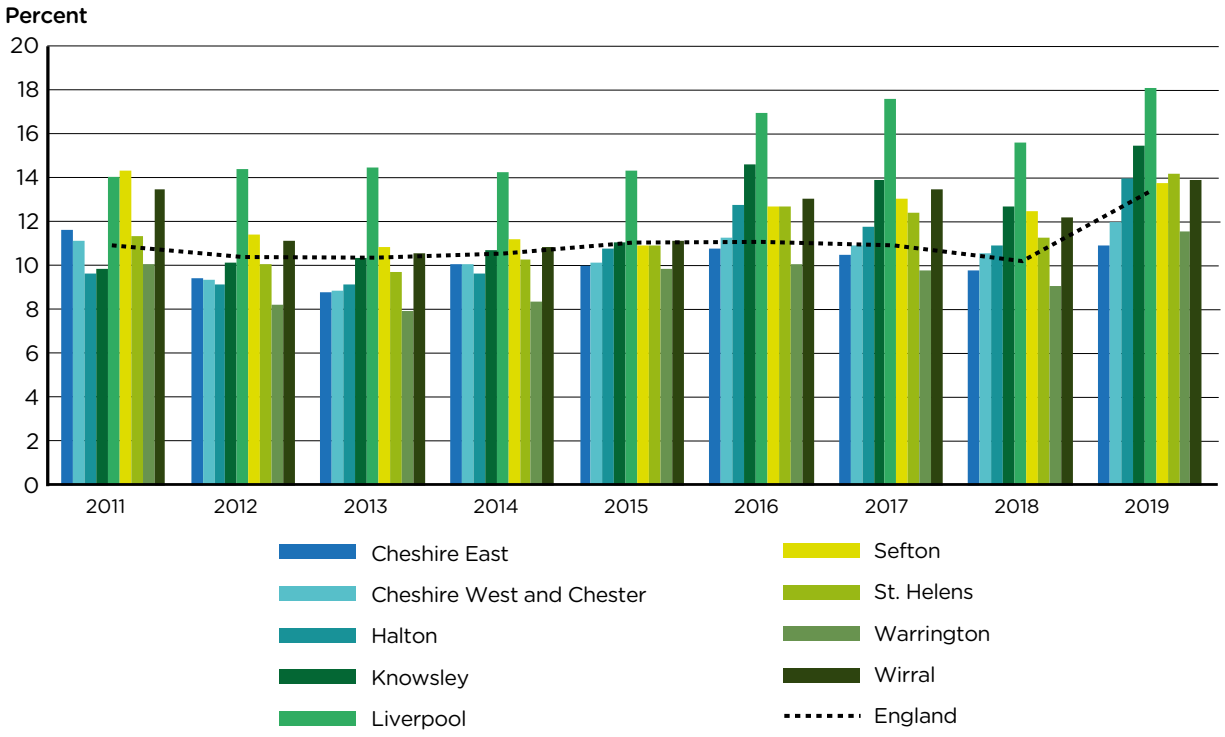
Figure 4.22. Fuel poverty, Cheshire and Merseyside lower-tier local authorities and England, 2019



Source: *Office for National Statistics (162)*

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

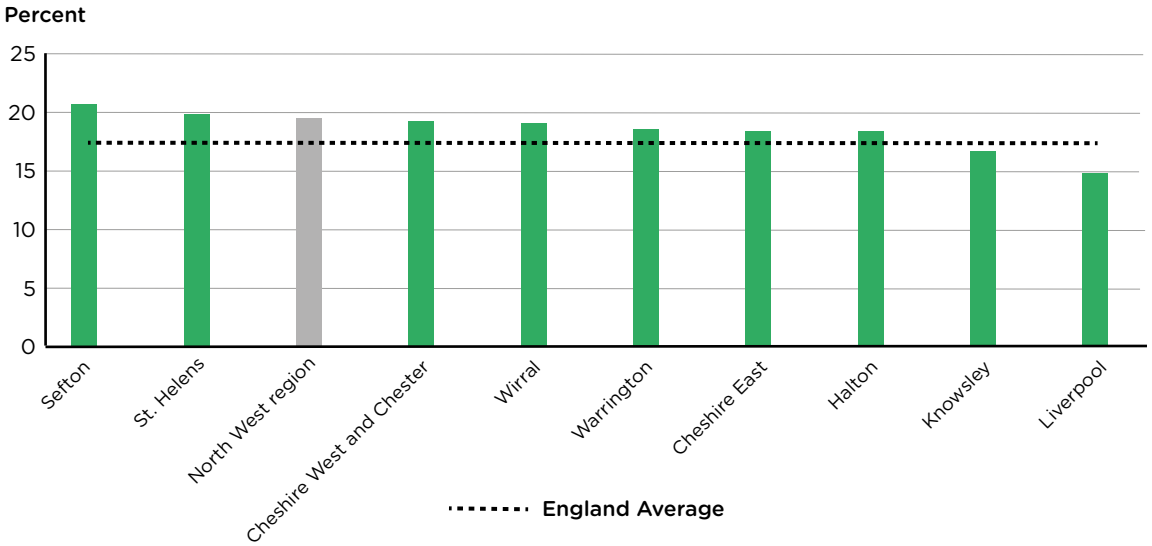
Figure 4.23. Homes in fuel poverty, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2011/19



Source: *Office for National Statistics (162)*

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

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



Source: *Office for National Statistics (164)*

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

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

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

Box 13. Fighting fuel poverty in St Helens

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

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

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

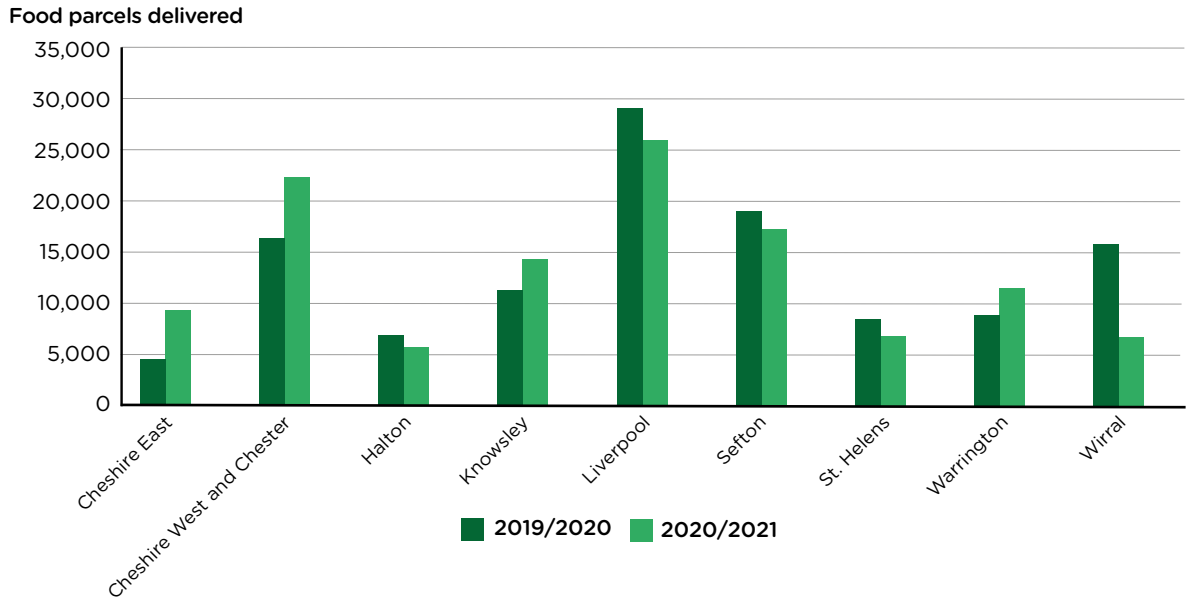
FOOD POVERTY

Measuring food poverty is difficult in the UK as the data is not routinely generated by government statistics, but there have been widespread increases in food poverty and insecurity in the UK in recent years, which are expected to rise further due to the cost of living crisis.

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

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

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



Source: *The Trussell Trust (168).*

Box 14. Reducing food poverty and maintaining dignity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

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

MARMOT BEACON INDICATORS

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

4E CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

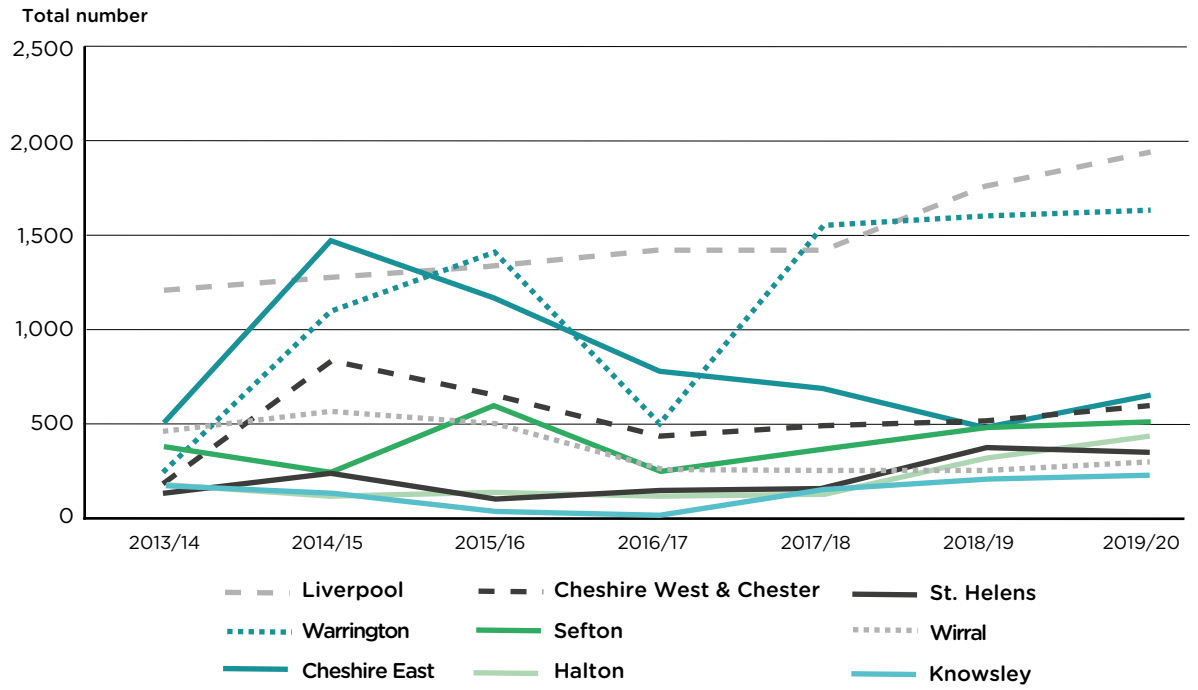
One of the most significant ways that healthy and sustainable places and communities can be forged is through quality housing and safe environments with good access to services, shops, community facilities, leisure and entertainment and good-quality natural environments. Cheshire and Merseyside comprises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

HOUSING CONDITIONS AND COSTS

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

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

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



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

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

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

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

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

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

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

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

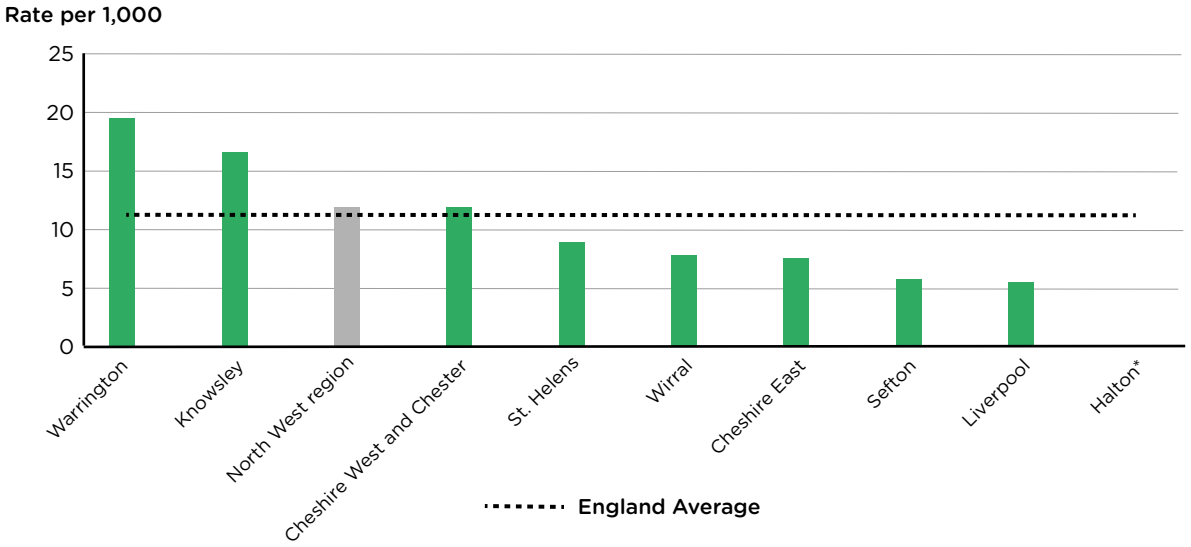
Unaffordable housing harms health, it increases stress and the risk of suffering from poor mental health; high housing costs lead to worse housing conditions, owner-occupiers are unable to make essential repairs and landlords have less incentive to improve conditions. Housing costs were increasing prior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

HOMELESSNESS AND ROUGH SLEEPING

A person is defined as homeless if they have no accommodation available in the UK or abroad; have a split household and accommodation is not available for the whole household; are at risk of violence from any person; are unable to secure entry to their accommodation or live in a moveable structure but have no place to put it (176). This definition includes those living in temporary accommodation, sofa-surfing and other forms of insecure housing as well as rough sleeping. During the COVID-19 pandemic, huge efforts were made to reduce rough sleeping and there were real achievements, which can be built on to ensure that all homelessness is reduced and the factors that drive homelessness are addressed (2). This includes increasing the supply of affordable housing, ensuring better-quality housing and implementing much tighter regulation of private sector rental housing including greater security to renters.

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

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

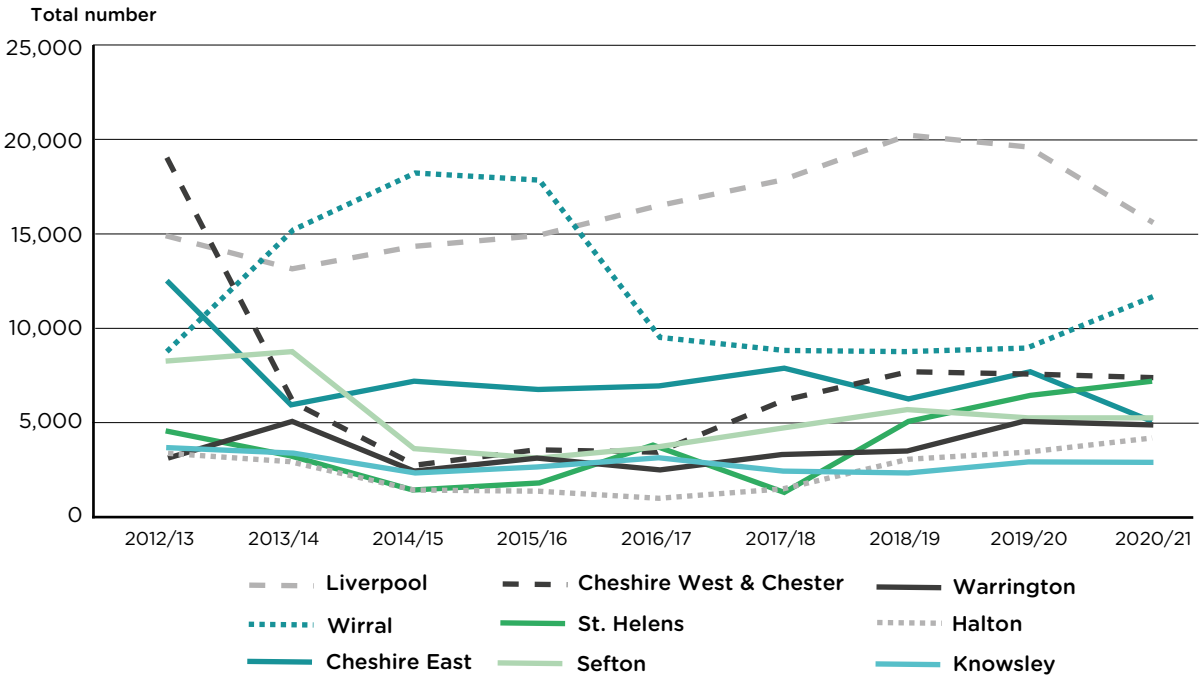


Notes: *Data not available.*

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

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

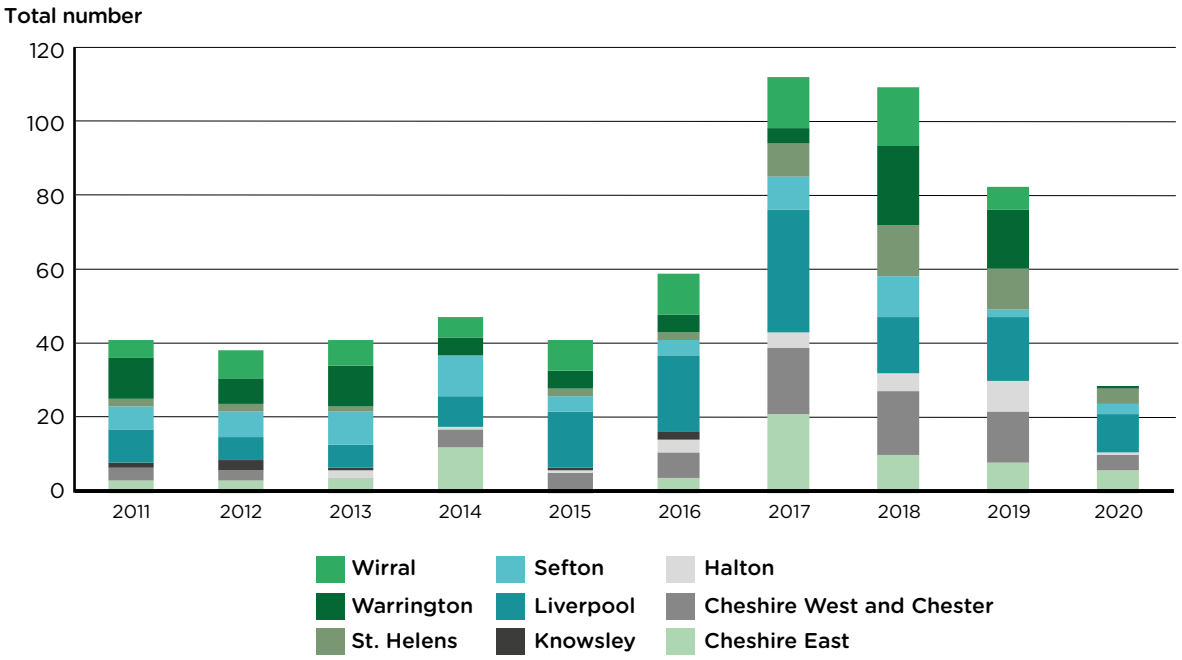
Figure 4.28. Households on housing waiting list, total number, Cheshire and Merseyside lower-tier local authorities, 2012/13 to 2020/21



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

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

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



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

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

Box 16. Reducing number of people sleeping rough in Warrington

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

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

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

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

HIGH STREETS AND REGENERATION

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

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

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

Box 17. Planning healthier and more equitable spaces in Sefton

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

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

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

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

GOOD-QUALITY GREEN SPACES

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

2022/23

Responsible: Place

- Review private rented sector regulation actions in the Levelling Up white paper.
- Support national advocacy to strengthen local powers and capacity within enforcing authorities across planning and housing.
- Define affordable housing in Cheshire and Merseyside and link to "true" regional poverty.
- Create a platform where housing and local residents can communicate about how housing is impacting on health and wellbeing.
- Develop place-based partnerships to strengthen approaches to community policing (such as public and mental health, police, DWP, children's service), and develop a public health approach to violent crime.
- Work with local residents and partners (such as businesses and the NHS) to improve quality of existing green spaces in areas of higher deprivation.
- Develop region-wide actions to create health promoting environments (unhealthy advertising and planning decisions, for example).
- NHS, local government work in partnership to regenerate areas. Work alongside local communities to better include their needs when reviving local high streets.
- Extend incentives to encourage people back to public transport.

Responsible: Cheshire and Merseyside System

- Appoint senior role in housing and health in ICS (including homelessness and rough-sleeping).
- NHS to scale up provision of services and invest in preventing street homelessness and work with the VCFSE sector and local authorities.
- Partner with NHS and local government, housing and tenant associations to assess housing standards in the private rented sector.
- Develop health and wellbeing checks for people living in temporary accommodation and appropriate referral pathways (such as housing services, social welfare advice and employment).

2023/27

Responsible: Place

- Work in partnership to implement adoption of decent home standards in all social and private rented sector housing.
- Ensure that all housing developments contain a minimum of 30 percent of dwellings classed as "affordable" and support local control of the local housing allowance and ensure it covers 50 percent of market rates.
- Prioritise provision of new green spaces in areas of higher deprivation.
- Adopt city-wide strategies that put health equity and sustainability at the centre of planning.
- Develop and implement housing and social conditions assessment to be used in primary and secondary health care appointments and develop monitoring of these questions.

Responsible: Cheshire and Merseyside System

- NHS to coordinate investment and action to take a leading role in strengthening partnerships with the housing sector, including the private rental sector and local residents.

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

MARMOT BEACON INDICATORS
• Households in temporary accommodation.

4F STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

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

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

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

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

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

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

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

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

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

DIGITAL INCLUSION

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

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

Box 20. Cheshire East Digital Inclusion Taskgroup

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

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

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

The four main challenges to being online were:

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

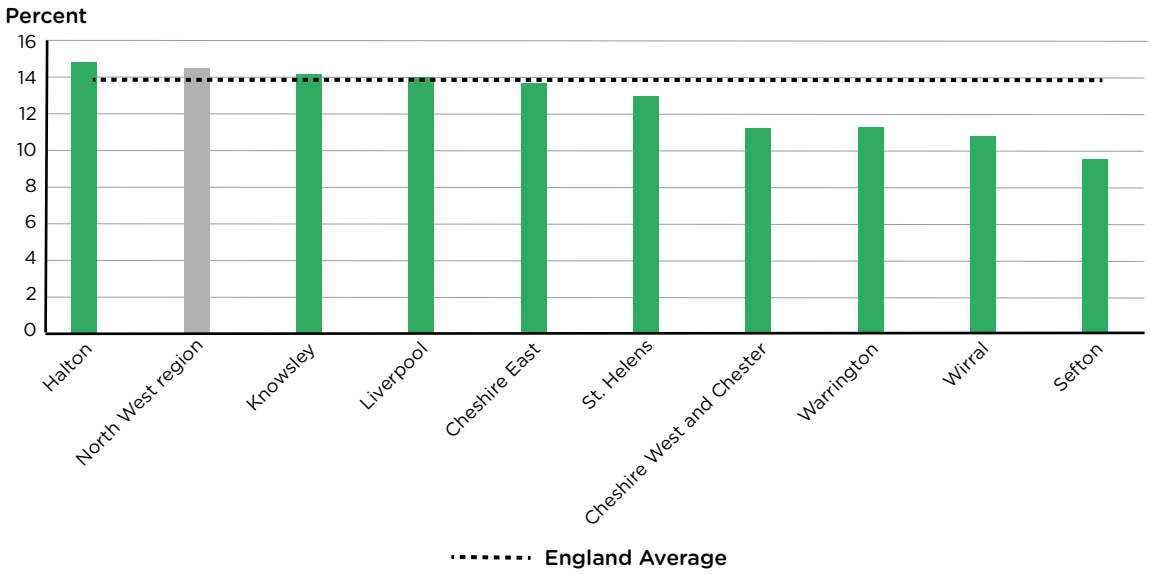
The partnership decided to more effectively join up and connect the existing interventions that were helping people. These included accessing the People's Network, and being supported by IT buddies in the Cheshire East libraries, for example to complete the Good Things Foundation online skills courses;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

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

SMOKING

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

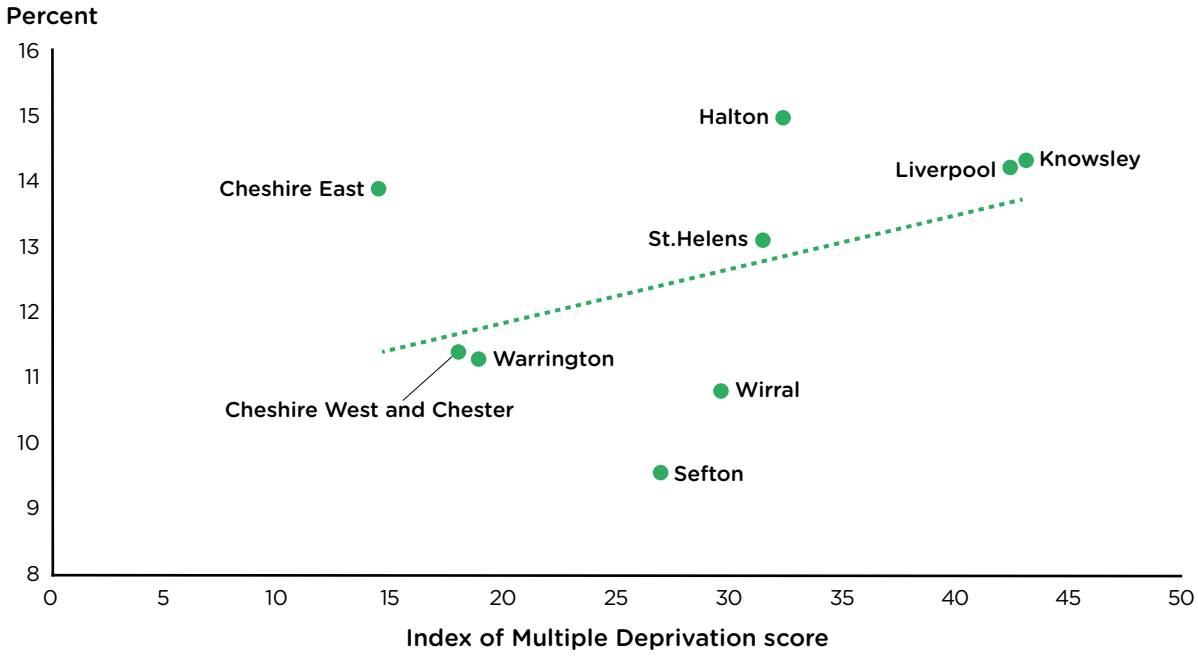
Figure 4.30. Smoking prevalence among adults aged 18 and over, Cheshire and Merseyside lower-tier local authorities and England, 2020



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

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

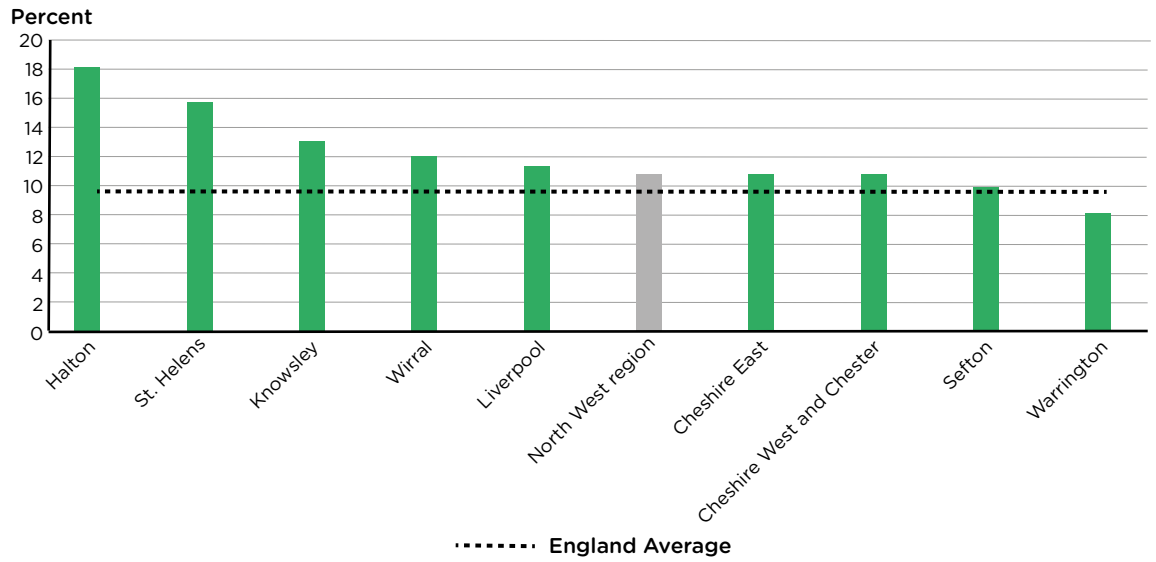
Figure 4.31. Smoking prevalence among adults aged 18 and over by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20



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

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

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

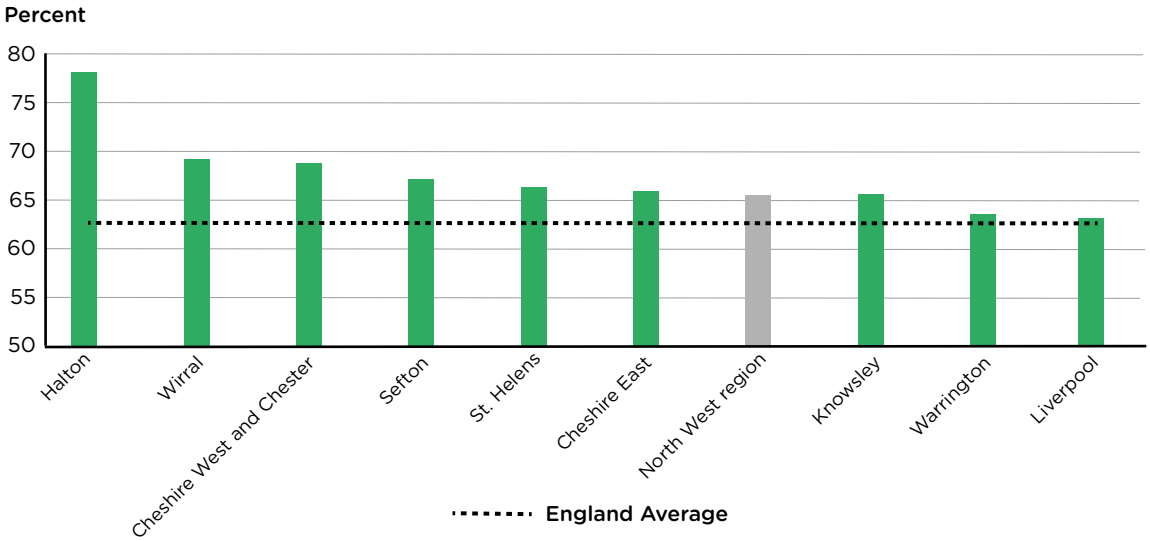


Source: *NHS Digital (197)*

OBESITY

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

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



Source: *Sport England (198)*

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

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

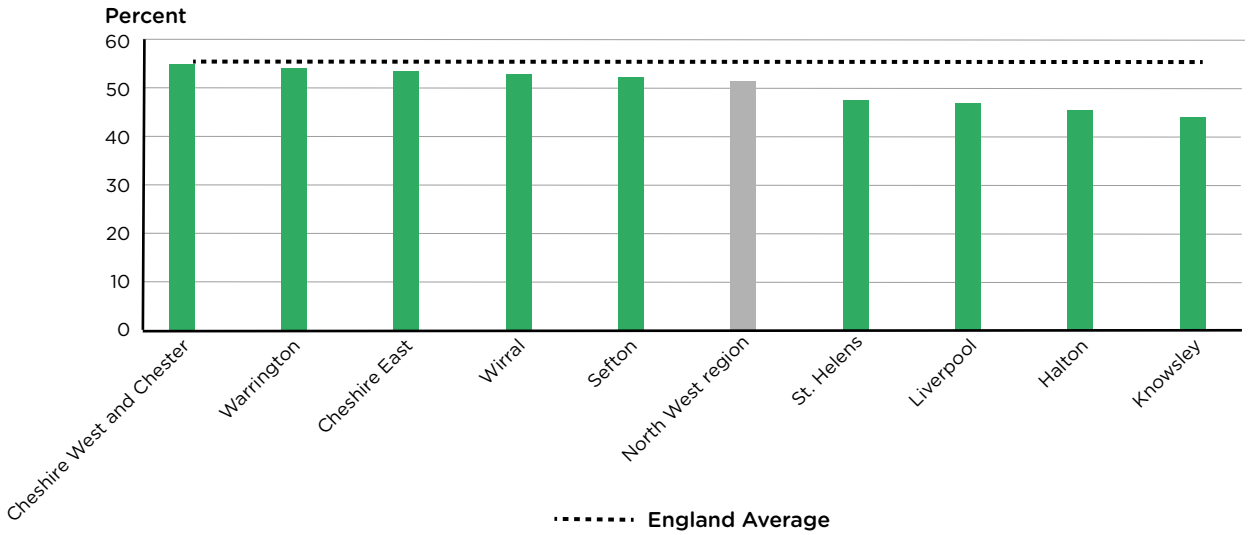
Figure 4.34. Year 6: Prevalence of overweight (including obesity) by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20

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

The relationship between deprivation and obesity has been analysed in relation to the cuts to Sure Start children's centres. Funding for Sure Start fell, on average, by 53 percent between 2010/11 and 2016/17 with higher spending cuts in the most deprived areas. In these areas, funding decreased by £422 per child but fell by only £133 per child in the least deprived local authorities. Analysis showed each 10 percent spending cut was associated with a 0.34 percent relative increase in obesity prevalence the following year and it is estimated that there were an additional 4,575 children with obesity and 9,174 overweight or obese compared with expected numbers had funding levels been maintained (18).

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

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

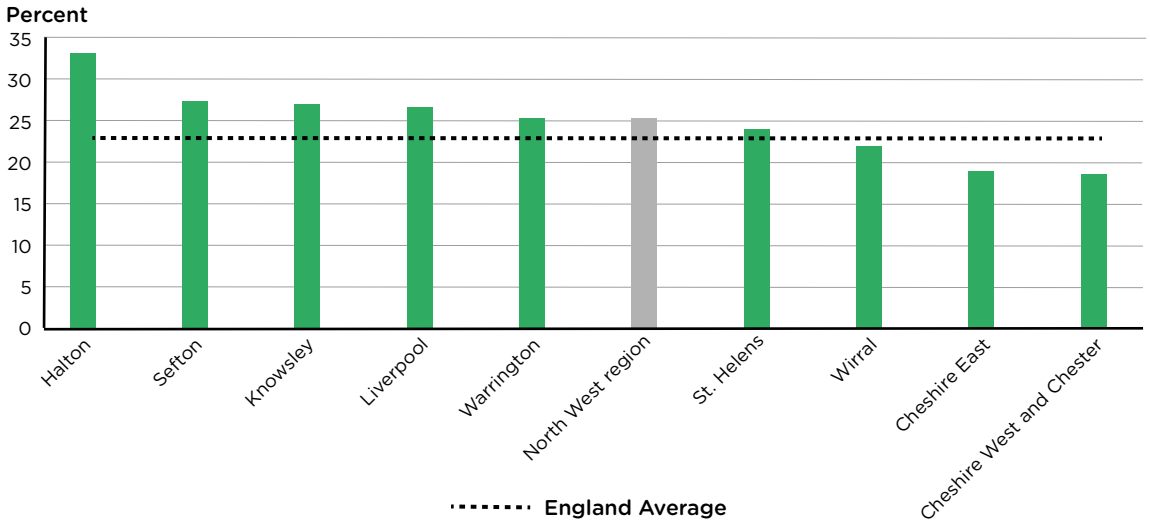


Source: *Sport England (198)*

PHYSICAL INACTIVITY

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

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



Source: *Sport England (198)*

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

Source: *OHID (202)*

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

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

Box 21. Active Cheshire Ellesmere Port and Neston Special Olympics

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

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

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

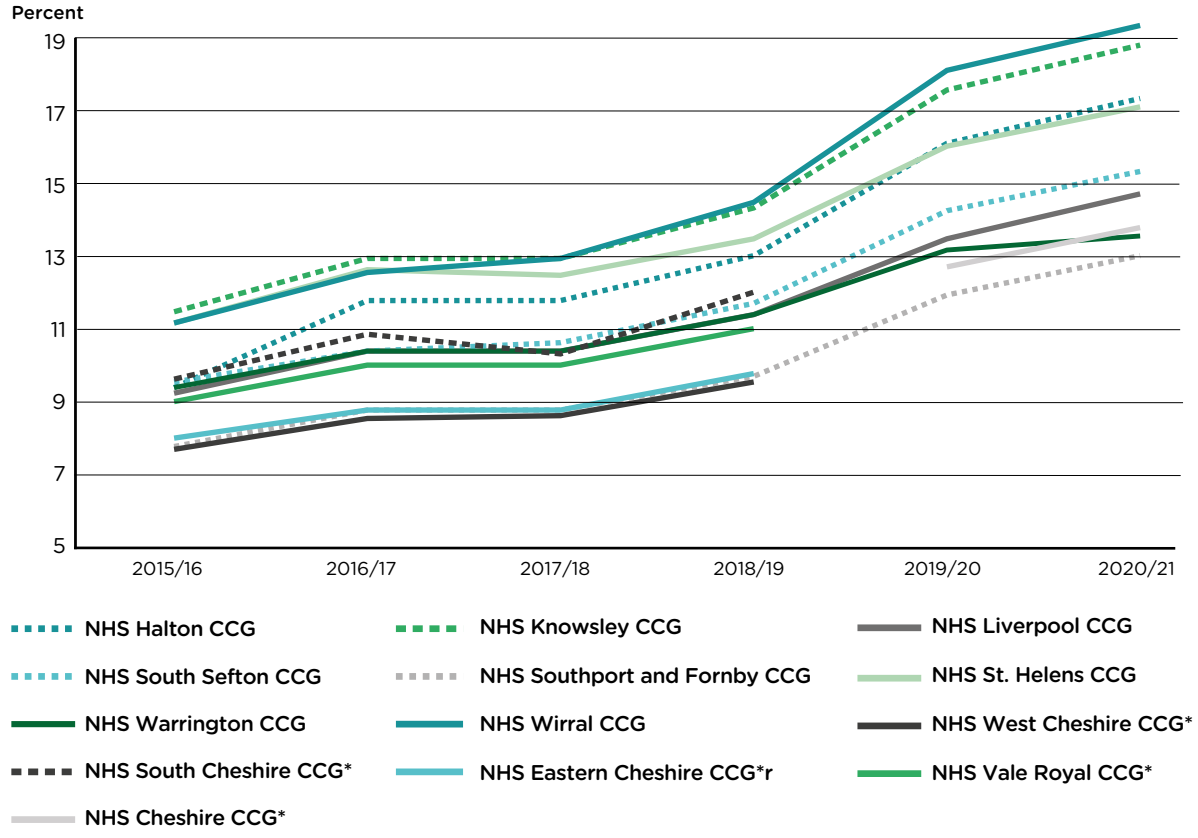
There are currently 70 members of EPCNSO and 10 volunteers. All the members of EPCNSO have learning disabilities and many experience complex challenges especially relating to mental health. Many of the members are also from low-income families. The group provides a vital opportunity to develop skills,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

MENTAL HEALTH

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

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

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



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

Source: *QOF (208)*

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

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

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

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

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

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

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

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

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

- **Learning:** delivering a wide range of evidence-based learning opportunities offering support in relation to mental and physical health as well as cultural and creative opportunities. Courses promote social inclusion and focus on lived experience as a key part of learning.
- **Social prescribing:** practical and social one-to-one support in areas such as employment, housing, debt. Individuals are connected to a wider system of community assets, including the VCFSE sector, and clinical or social care services.
- **Inclusion:** listening to communities to understand need and aspiration. Offering welcoming environments and opportunities for collaborative working with the community and individuals to co-design and embed culturally informed approaches to improved life and health outcomes.

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

- **Pathways adviser support (social prescribing)** - practical and social support in areas such as employment, housing or debt.
- **Learning** - courses offering support in relation to mental and physical health as well as cultural and creative opportunities. Life Rooms offer learning opportunities that support people with their mental health needs including courses that focus on understanding and managing conditions like depression and anxiety delivered in non-clinical setting.
- **Social activities** - informal groups promoting social inclusion and relationship building.
- **Employment support** - clear routes to employment, including training and work placement opportunities, support with job searches, CV-building and all areas of seeking and gaining meaningful employment.
- **Volunteering** - opportunities to build confidence and responsibility through volunteering opportunities within The Life Rooms or in the wider community.

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

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

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

Box 23. Connect Us in Wirral

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

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

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

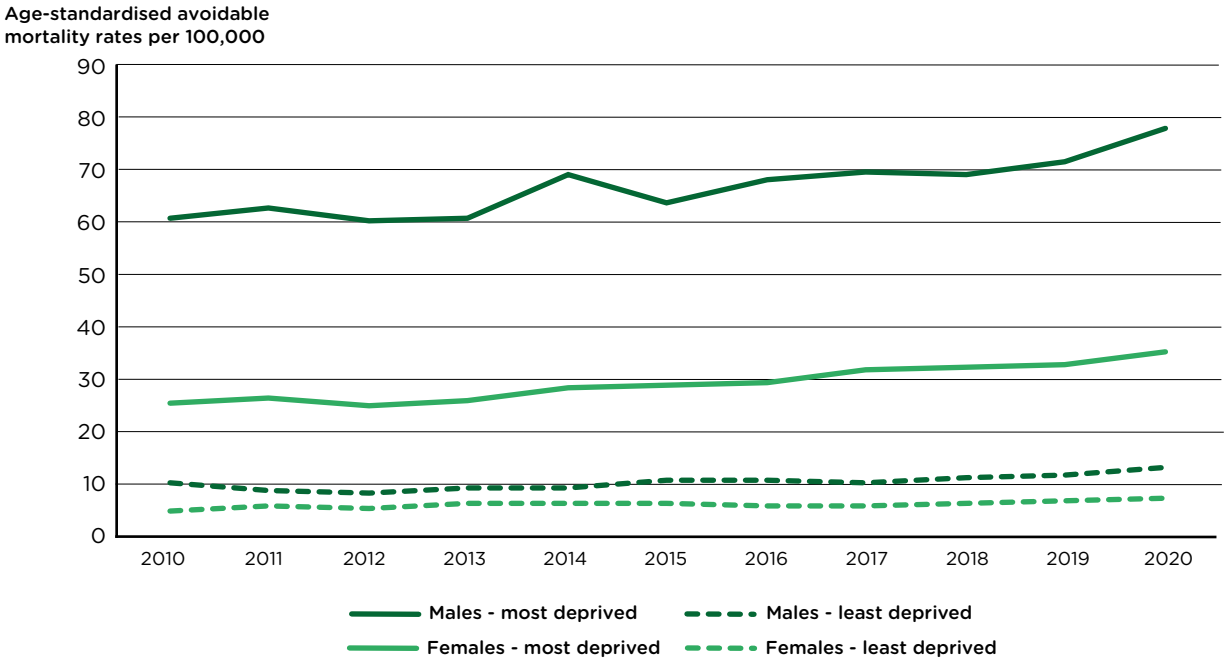
Residents can be directly referred by GPs, social services, housing providers and other professionals and services, or can self-refer and access Connect Us through word of mouth, advertisements in community venues and via Connectors, who knock on doors across Wirral.

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

ALCOHOL AND DRUGS

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

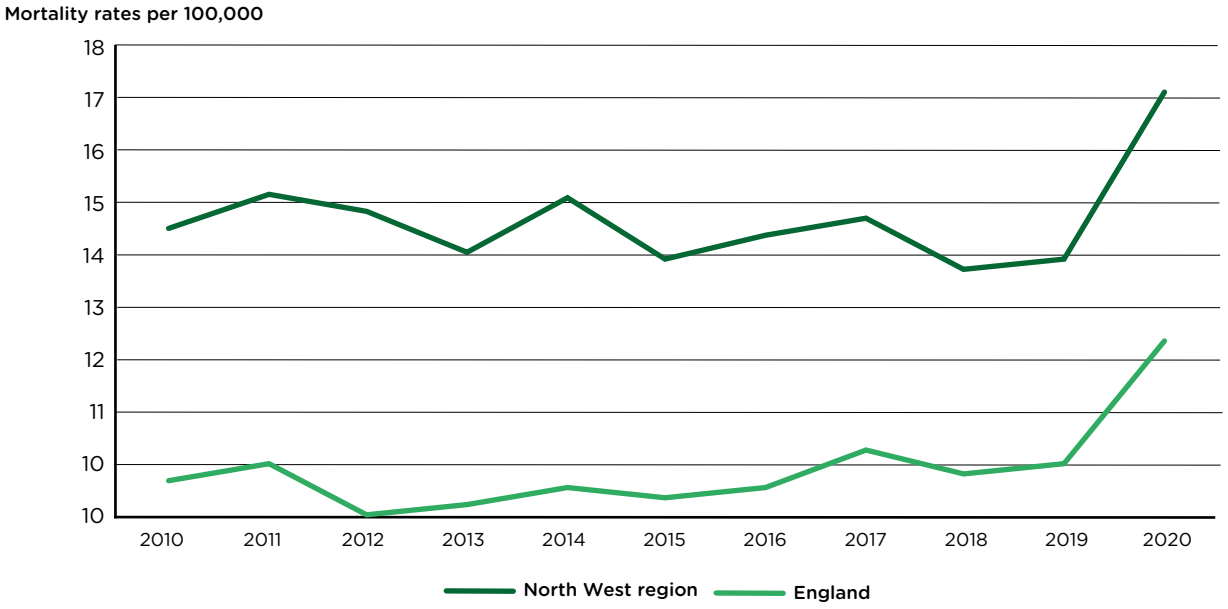
Figure 4.39. Avoidable mortality rates for alcohol and drug-related disorders 2010-20, England



Source: *Office for National Statistics (210)*

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

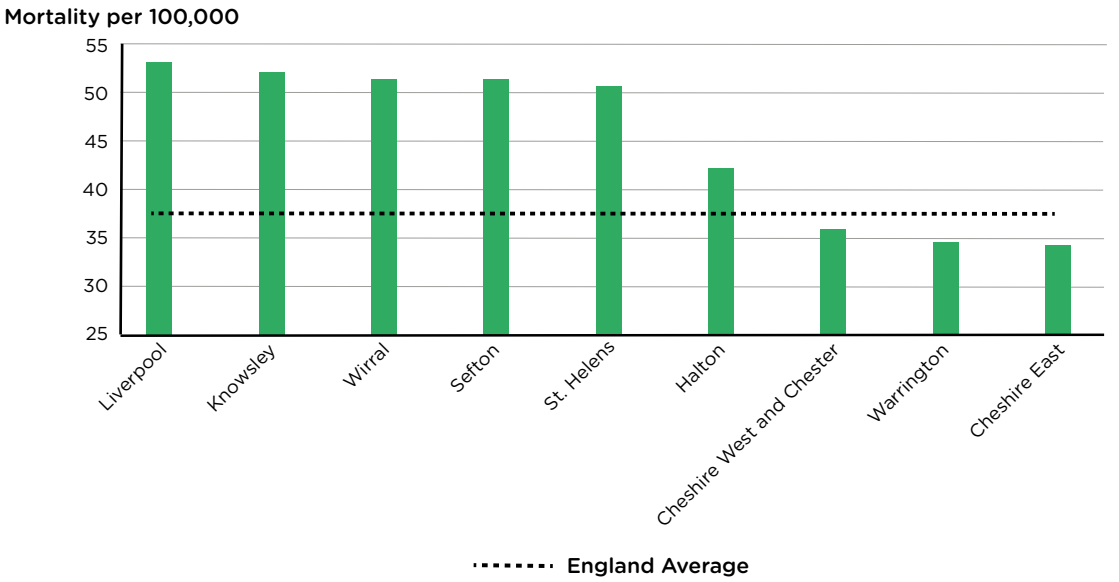
Figure 4.40 Age-standardised alcohol-specific death rates per 100,000 people; North West region and England, deaths registered between 2010 and 2020



Source: *Office for National Statistics (212)*

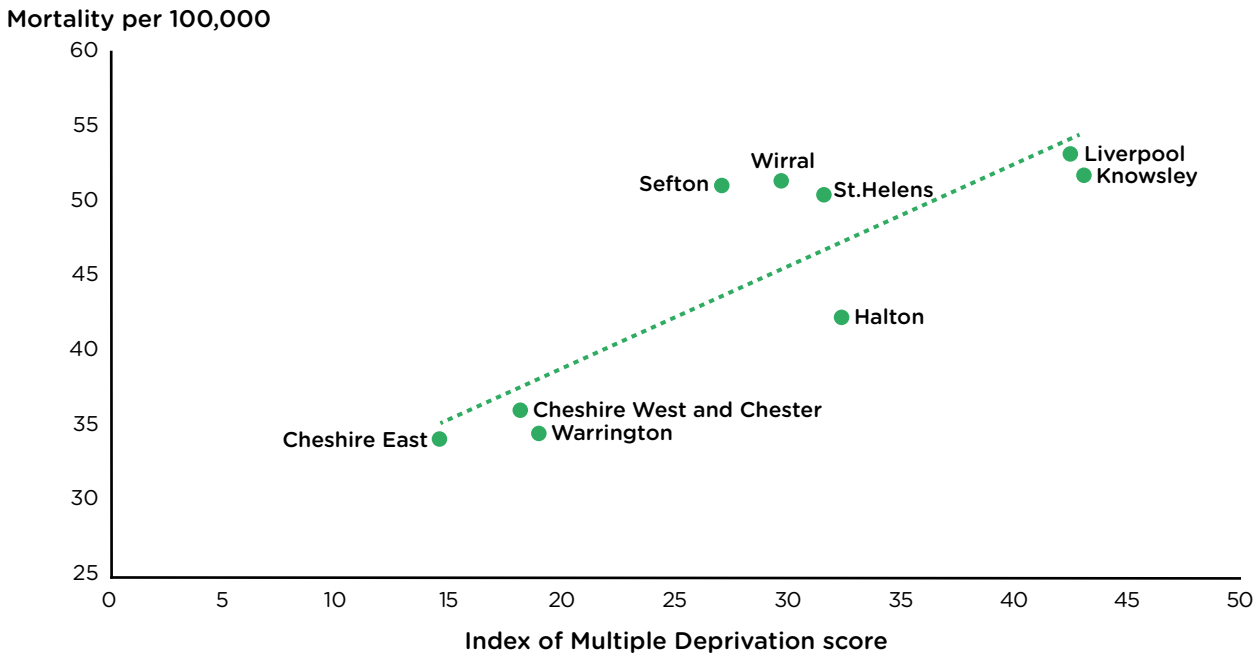
Figure 4.41 shows that six of Cheshire and Merseyside's local authorities have a rate of alcohol-related mortality above the England average and Figure 4.42 shows the strong relationship between deprivation and alcohol-related mortality.

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



Source: *Office for National Statistics (212)*

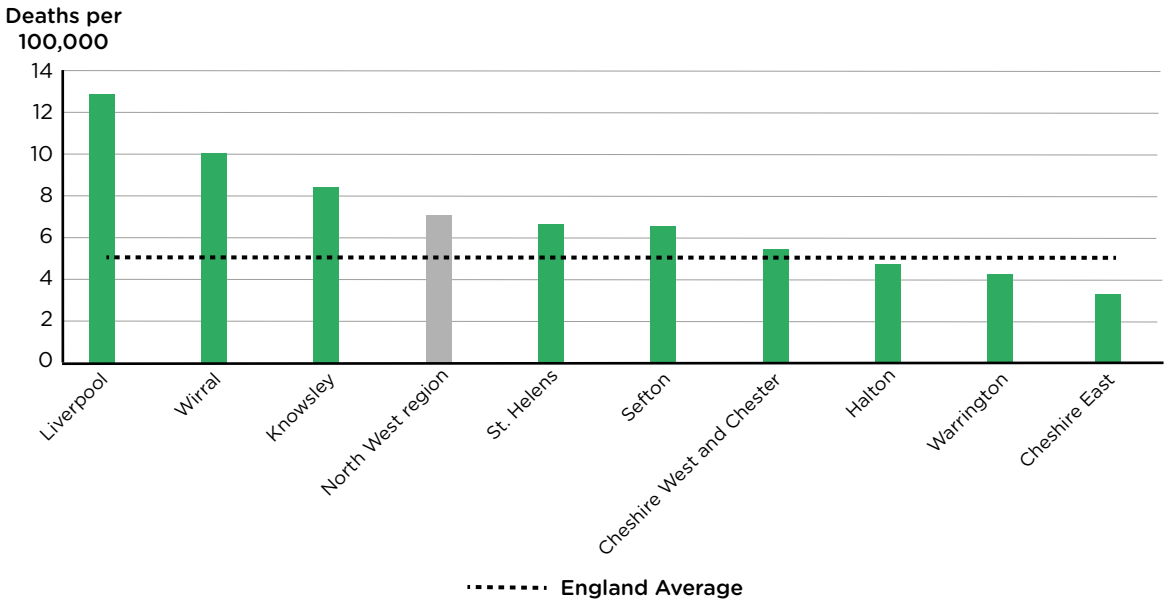
Figure 4.42. Alcohol-related mortality, directly standardised rate, per 100,000, by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2020



Source: *Office for National Statistics (212)*

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

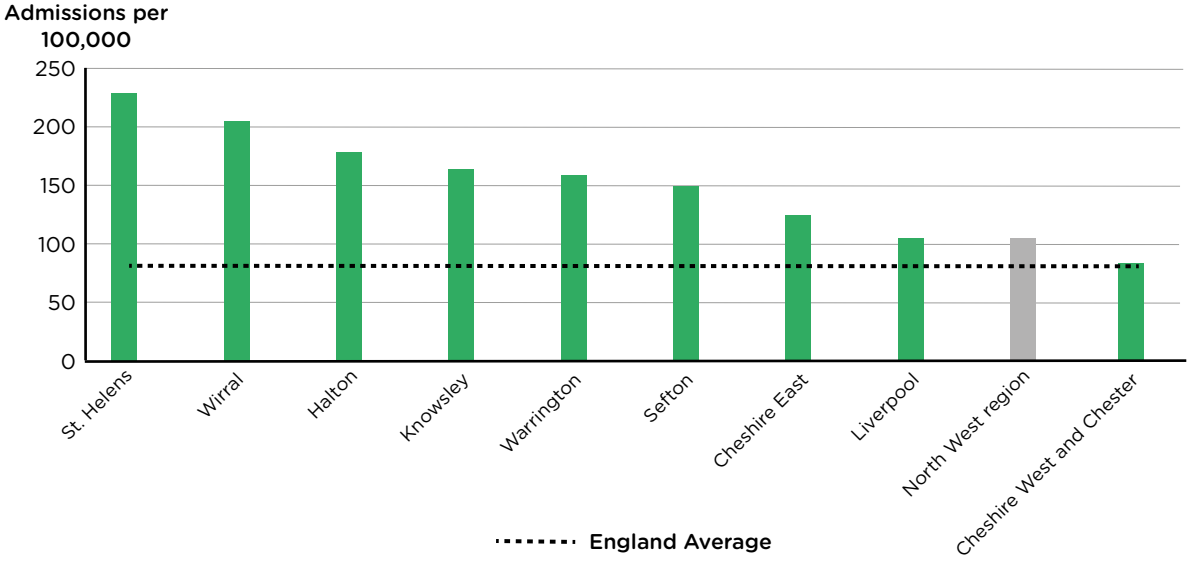
Figure 4.43. Deaths from drug misuse, directly standardised rate, per 100,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2018-20



Source: *Office for National Statistics (213)*

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

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



Source: *NHS Digital (214)*

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

Box 24. Community Engagement in Licensing Project

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

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

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

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

RECOMMENDATION: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

2022/23

Responsible: Cheshire and Merseyside System

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

Responsible: Mental Health Board

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

2023/27

Responsible: Place

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

Responsible: Cheshire and Merseyside System

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

MARMOT BEACON INDICATORS

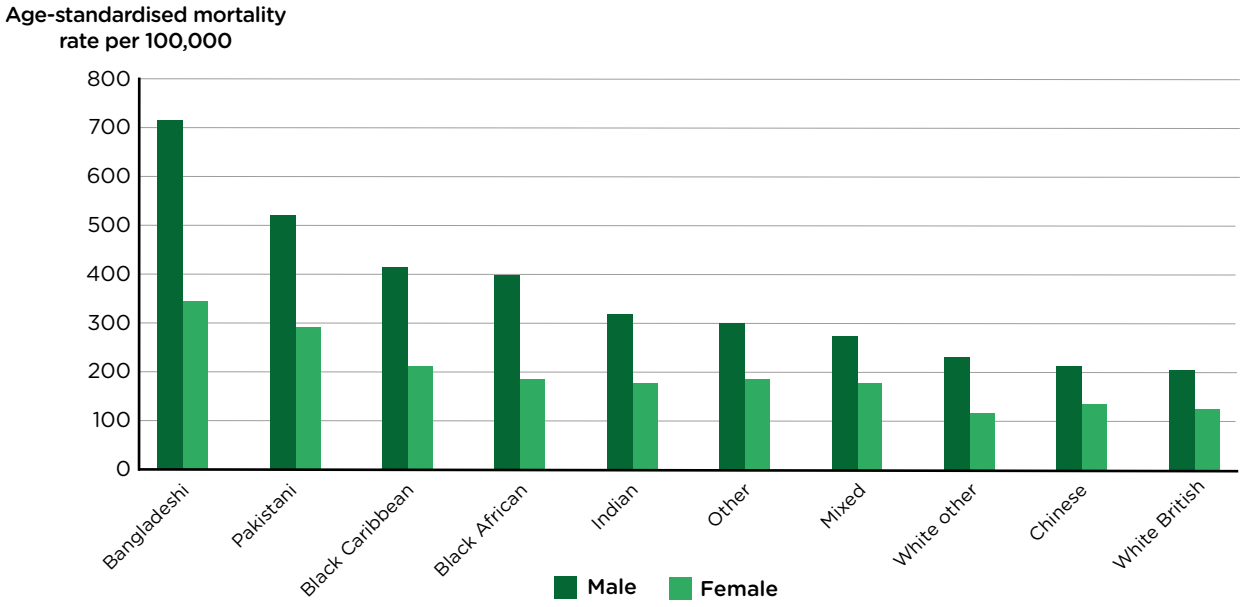
- Activity levels.
- Percentage of loneliness.

4G TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

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

At the height of the pandemic, the diagnosis rate of COVID-19 per 100,000 population for black males was nearly three times that of white males. From January 2020 to February 2022, male and female Bangladeshi ethnic groups and males in the Black Caribbean and Pakistani ethnic groups had higher rates of death from COVID-19 compared with the white population, as seen in Figure 4.45 (215). Public Health England reported that front-line workers from ethnic minorities were given inadequate levels of PPE given their risk of exposure and that the individuals affected did not speak up because of fear of adverse treatment (215). Racism and discrimination is a factor in many of the adverse outcomes for minority ethnic group (216).

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

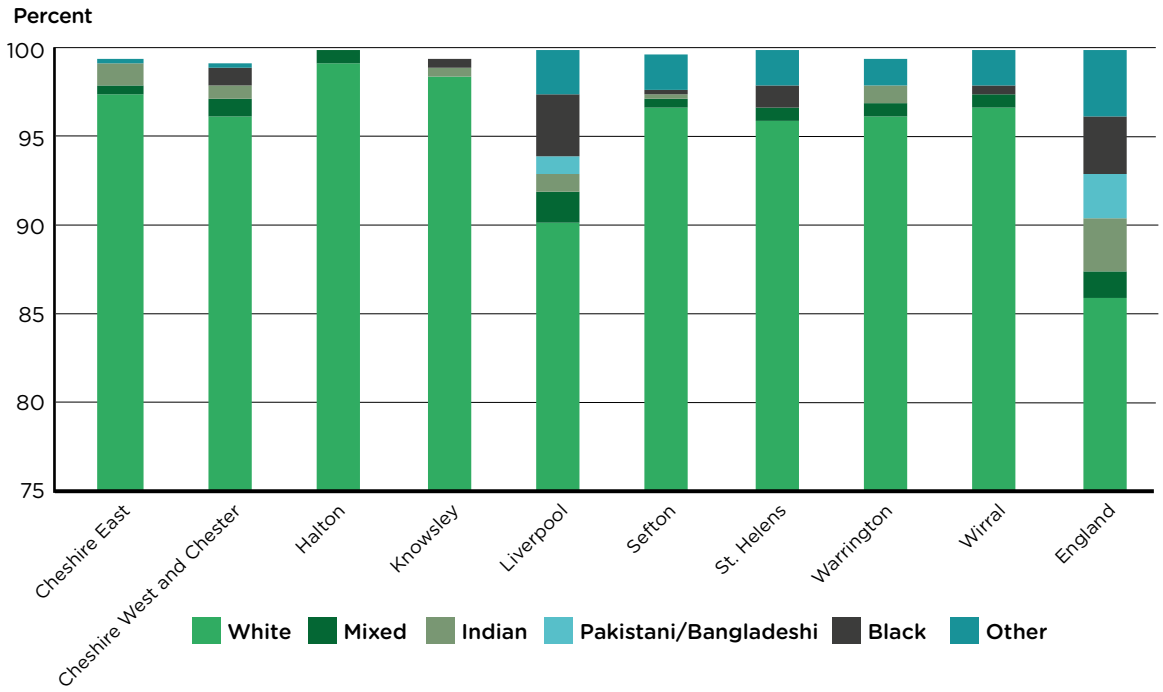


Source: *Office for National Statistics (217)*

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

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

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



Source: *Office for National Statistics (219)*

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

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

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

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

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

RECOMMENDATION: TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

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

MARMOT BEACON INDICATORS

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

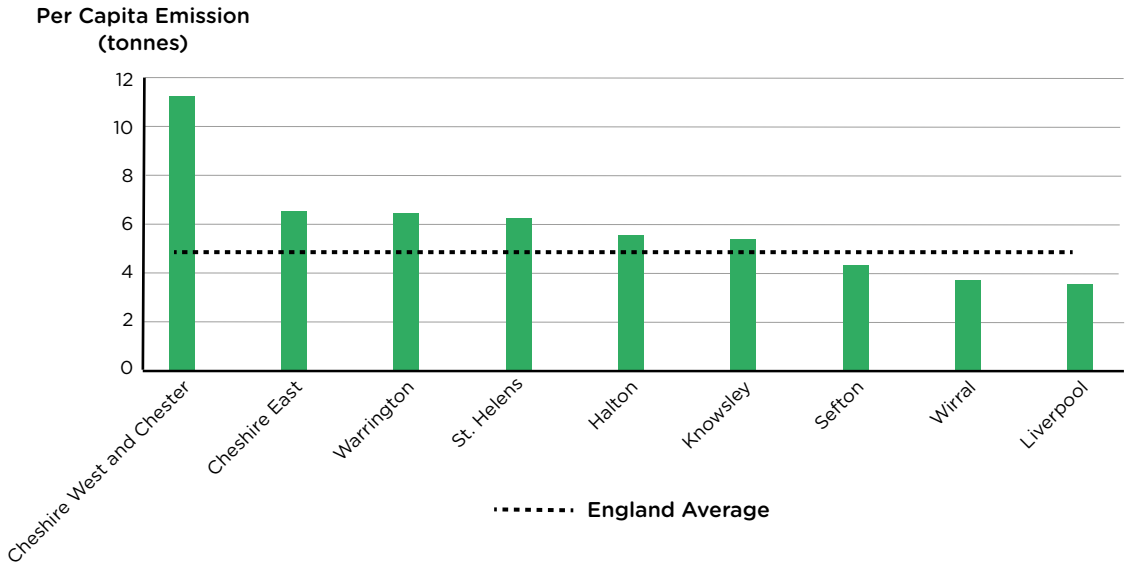
4H PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

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

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

It is estimated that in the North West, under a medium greenhouse gas emissions scenario, in the 2080s the climate of the North West will see average summer temperature increasing by 3.7 degrees; 21 percent less rainfall in the summer, affecting subsidence, crop yields and water stress; and 16 percent more rainfall in the winter increasing flooding risks (222). Total emissions and emissions per capita have fallen in the UK since 2005. In England, in 2019, the North West region had the second highest level of carbon dioxide emissions in England, second only to the South East region. Figure 4.47 shows Cheshire West and Chester has the highest per capita emissions in Cheshire and Merseyside, however it has low population density compared with the highly populated areas in Merseyside.

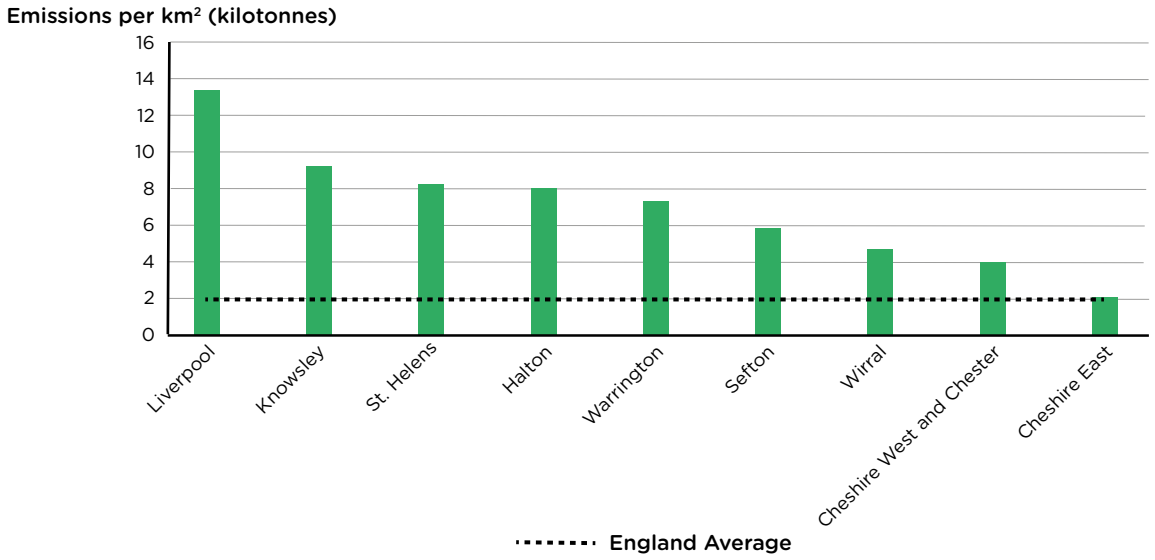
Figure 4.47. Carbon dioxide emissions per capita (tonnes) in Cheshire and Merseyside lower-tier local authorities and England 2019



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

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

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

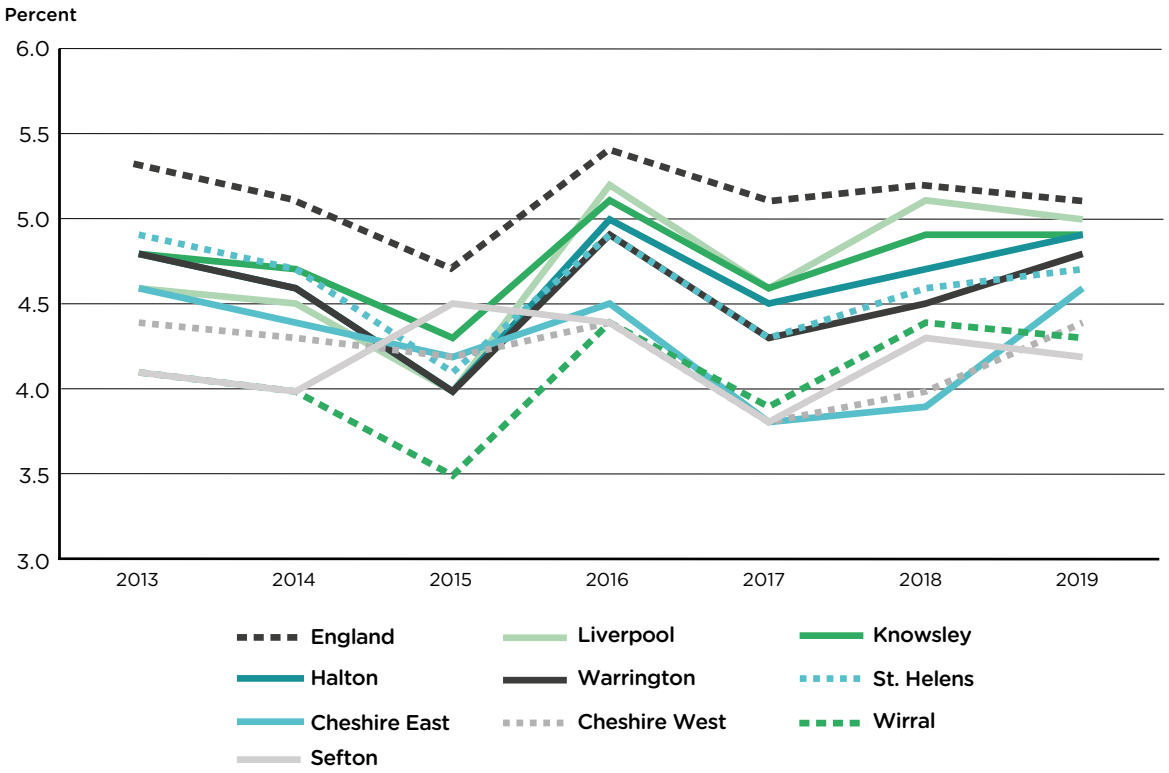


Source: *Department for Business, Energy & Industrial Strategy (223)*

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

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

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



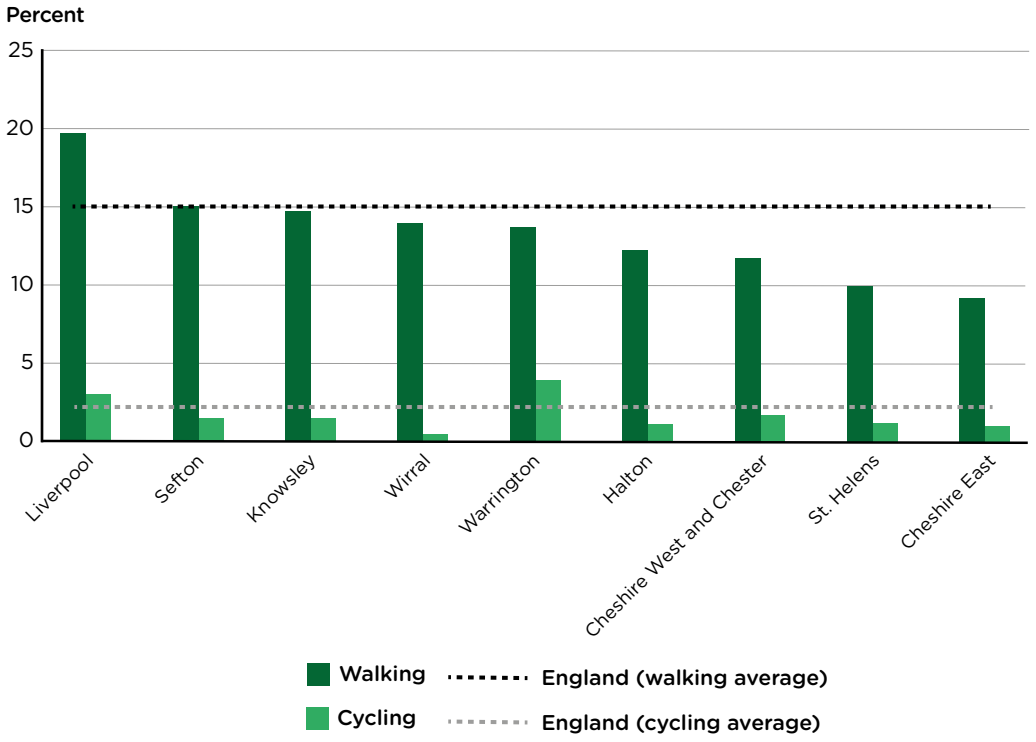
Source: *Department for Environment, Food & Rural Affairs (226)*

ACTIVE TRAVEL

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

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

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



Source: *Department for Transport (231)*

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

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

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

RECOMMENDATION: PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

2022/23

Responsible: Cheshire and Merseyside System

- ICS work with local government, housing associations to retrofit homes, including private homes, to reduce fuel poverty and greenhouse gas emissions.
- Work with local authorities, businesses and chambers of commerce to prioritise the health and wellbeing of citizens and environmental sustainability in economic recovery and growth policies.
- Enforce existing smokeless fuel standards.
- Health equity assessment of Cheshire and Merseyside Green Plan and Place-based Green plans in each of Cheshire and Merseyside's nine local authorities.

2023/27

Responsible: Cheshire and Merseyside System

- Passive cooling measures included as standard in retrofits and new builds that are at risk of high indoor temperatures.
- Installations of new wood burning and gas stoves in urban areas eliminated and existing stoves phased out.
- Ensure any new walking and cycling infrastructure reaches areas with the lowest rates of physical activity.

MARMOT BEACON INDICATORS

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

CHAPTER 5

ROUTES FOR ACTION IN CHESHIRE AND MERSEYSIDE

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

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

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

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

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

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

Box 26. Posts to address the wider determinants of health

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

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

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

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

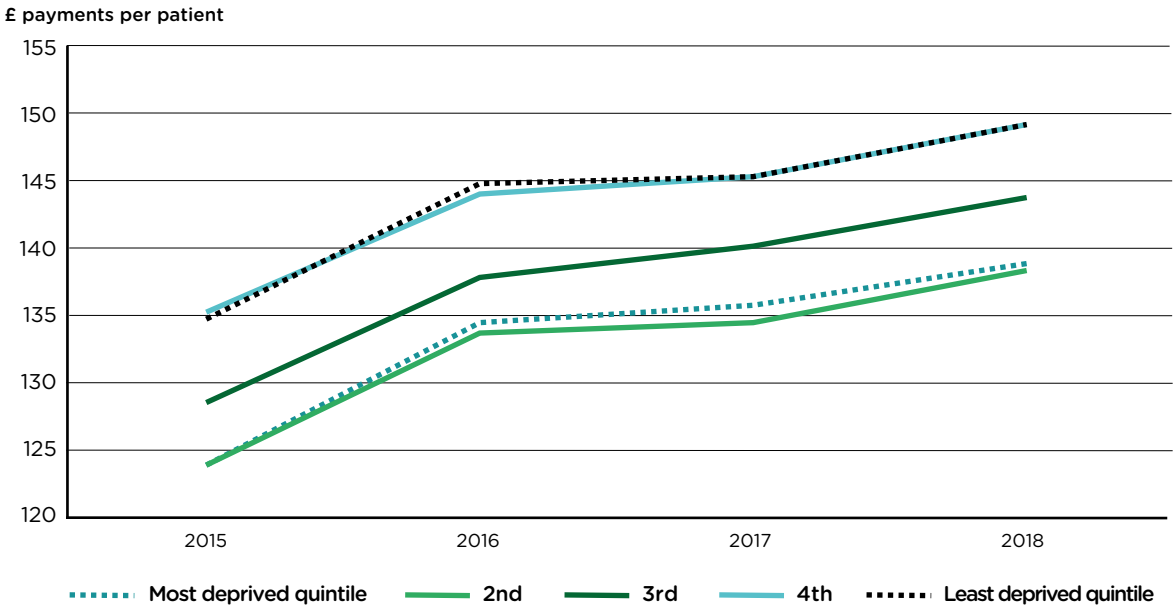
5A INCREASE AND MAKE EQUITABLE FUNDING FOR SOCIAL DETERMINANTS OF HEALTH AND PREVENTION

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

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

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

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



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

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

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

Box 27. Lancashire and South Cumbria weighted funding formula

The Lancashire and Cumbria weighted funding formula (formerly the Morecambe Bay funding formula) is helping to lead efforts in England to ensure funding for primary care is more equitable. The weighted funding formula was developed in an attempt to allocate resources to better reflect the inequalities faced by local communities and to allocate resources to the areas that need it the most. The formula is based 50 percent on the Carr-Hill formula and 50 percent on the proportion of the population living in the 20 percent most deprived areas. The purpose of the Carr-Hill formula is to create fair funding allocations based upon the cost of providing services for a given population and their respective needs. The formula is based on a number of variables including patient age and sex; additional needs of patients; and rurality. Research shows the formula is "very unlikely" to benefit more deprived areas (236) .

The 50-50 formula aimed to reflect geographical differences in local deprivation and to acknowledge the impact that COVID-19 has had on communities. Morecambe Bay CCG studied its own general practices serving "atypical populations" (more deprived than average) and looked at how other CCGs were supporting atypical populations across England. They found a number of CCGs were commissioning services for these atypical populations that had a greater need for improved access to local primary and community services in their local areas.

Currently 27 percent of the population health budget in Morecambe Bay is funded in this way and Morecambe Bay CCG is looking at other areas to apply the weighted funding formula, such as applying it to more of the population health budget or to other funding streams in the ICS, in order to better address inequalities. Whilst there is not yet evidence the weighted formula is having an impact, current funding models have not had a beneficial effect on health inequalities. The weighted funding formula will be evaluated with academic partners to measure the short, medium and long-term impact on health inequalities.

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

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

5B STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY

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

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

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

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

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

PARTNERSHIPS WITH THE VCFSE SECTOR

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

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

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

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

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

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

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

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

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

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

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

THE HEALTH SYSTEM AND PARTNERSHIPS

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

Box 29. The Opening Doors Initiative

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

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

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

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

Box 30. Advice on Prescription in Liverpool

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

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

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

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

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

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

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

RECOMMENDATION: STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY

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

5C CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTH EQUITY

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

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

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

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

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

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

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

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

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

- **NHS organisations**

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

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

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

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

- **Working in partnership**

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

RECOMMENDATION: CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTHEQUITY

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

5D CO-CREATE INTERVENTIONS AND ACTIONS WITH COMMUNITIES

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

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

Box 32. St Helens People's Board

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

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

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

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

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

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

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

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

Disadvantages include:

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

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

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

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

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

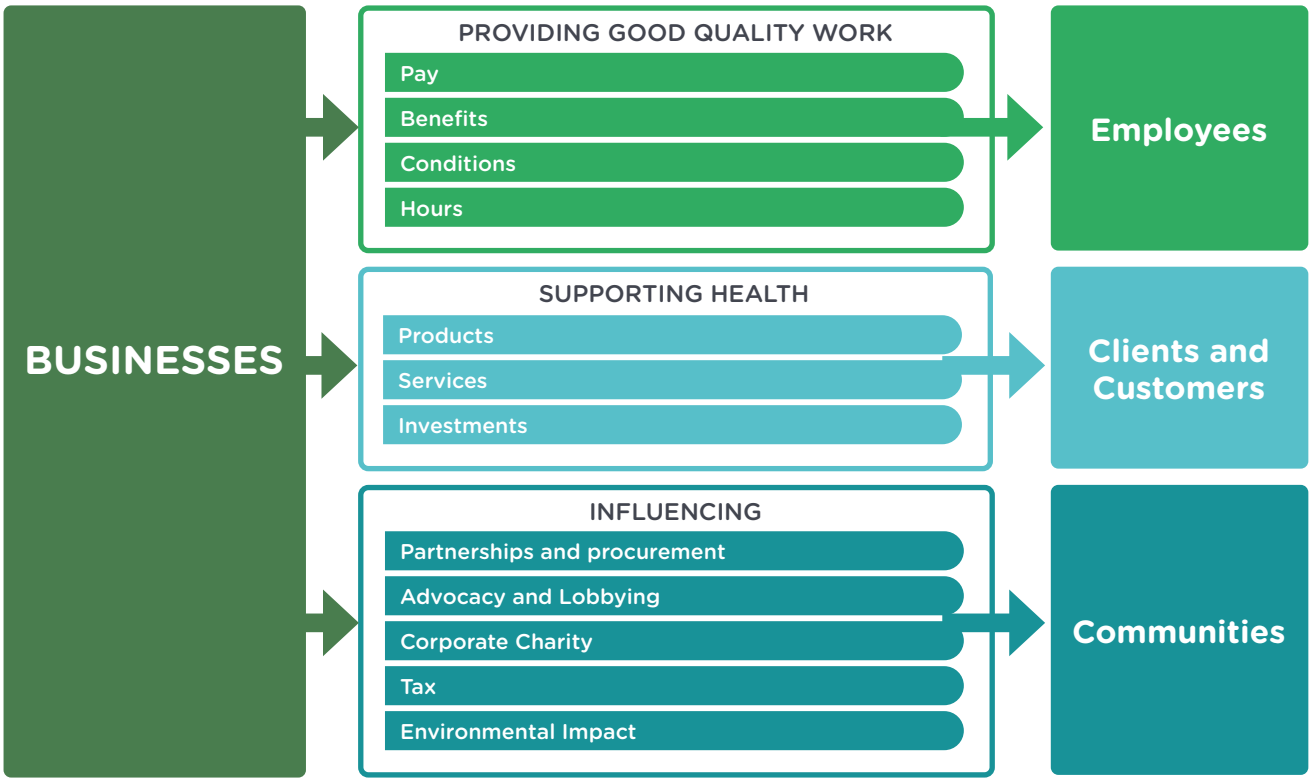
There are important and underdeveloped ways for businesses and the economic sector to use the many opportunities they have to reduce health inequalities.

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

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

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

Figure 5.2. How businesses shape health: the IHE framework



Source: *Institute of Health Equity (24)*

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

Box 33. Promoting fair employment in Liverpool City Region

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

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

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

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

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

Box 34. Local Enterprise Partnerships tackling health inequalities

The Lancashire LEP has taken a strategic focus to invest in its most deprived areas, half of the growth initiatives they've introduced since 2011 have been in Lancashire's five most deprived areas. In addition, the LEP has also established the Health Sector Group which takes a holistic view of health and prosperity, rooted in the belief that health is wealth and wealth is health. The Health Sector Group includes members from the public and private sectors and will work to improve opportunities for businesses to provide solutions to address some of Lancashire's health inequalities and increase productivity, to achieve better outcomes for all of Lancashire's residents. The Health Sector Group will work with healthcare providers and anchor institutions and employers, and will explore how better health and wellbeing provision can boost performance and drive more local economic growth.

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

2022/23

Responsible: Place

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

Responsible: Local enterprise partnership

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

2023/27

Responsible: Cheshire and Merseyside System

AND

Responsible: Local enterprise partnership

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

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

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

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

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

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

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

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

SOCIAL VALUE PROCUREMENT

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

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

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

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

Box 35. Health Procurement Liverpool

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

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

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

COMMUNITY WEALTH-BUILDING

Community wealth-building, where local economies are reorganised so that wealth is not extracted from an area but recirculated, has been advanced in Preston, through promotion of five strategies:

- **Plural ownership of the economy:** A blend of ownership models in an area, small enterprises, community organisation, cooperatives, and municipal ownership.
- **Making financial power work for local places:** Increasing local investment rather than focusing on attracting national or international investment.
- **Fair employment:** As larger employers, anchor institutions can make a massive impact on the prospects of local people by recruiting from lower-income areas, committing to paying the living wage, and promoting progression routes for workers.
- **Progressive procurement:** Developing dense local supply chains of SMEs, employee-owned businesses, social enterprises and cooperatives. These types of businesses are more likely to support local employment.
- **Socially productive use of land and property:** Anchor institutions often hold large amounts of land and property, these represent a base from which local wealth can be accrued.

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

Box 36. Community wealth-building in Cheshire and Merseyside

Community wealth-building in Preston, often referred to as "The Preston Model", began in 2011 when Preston City Council began discussions with the Centre for Local Economic Strategies (CLES) with the goal of tackling inequality in economic development. The first step was Preston City Council committing to paying all their staff the living wage, becoming the first accredited living wage employer in the North of England in 2012. In 2013 the city council engaged CLES in researching the proportion of anchor institution procurement that was local to Preston and Lancashire.

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

CLES found that there was a collective procurement spend of £750 million by Preston's anchor institutions and that in 2012/13 only 5 percent was spent in Preston and 39 percent in Lancashire, meaning £450 million was leaving the Lancashire economy. This research was repeated four years later to assess the results of community wealth-building. The results were promising, with locally retained spending increasing from 5 percent to 18.2 percent in Preston and from 39 percent to 79.2 percent across Lancashire. Further, in 2018 there were 4,000 more employees earning the real living wage than at the beginning of the project.

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

RECOMMENDATION: EXTEND SOCIAL VALUE AND ANCHOR ORGANISATIONS

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

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

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

As part of NHSE's actions to address health equity, they have introduced Core20PLUS5, which seeks to improve equity of access, experience and outcomes for the most deprived 20 percent of the population in England in five clinical areas: maternity, severe mental illness, chronic respiratory disease, cancer and hypertension case-finding. Core20PLUS5 also adopts a flexible approach, to add an additional focus on particular communities, which is defined at the local level of ICSs (262) (80). Whilst the work of Core20PLUS5 is much valued, there are two key concerns: first, the Core20PLUS5 programme targets the most deprived segment of the population and does not work across the social gradient, as such there will be parts of the population who miss out on this programme. Secondly, the Core20PLUS5 focuses on five clinical areas and not on the causes of ill health, as such, the impact of the social determinants of health is not yet included in the programme (2).

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

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

Box 37. The Health Equity Assessment Tool

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

There are 4 main stages to HEAT:

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

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

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

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

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

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

MARMOT BEACON INDICATORS

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

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

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

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

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

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

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

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

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

STAGE 1

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

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

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

STAGE 2

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

STAGE 3

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

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

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

STAGE 4

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

NEXT STEPS

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

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

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

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

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

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

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

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

RECOMMENDATION: DEVELOP SOCIAL DETERMINANTS OF HEALTH IN ALL POLICIES AND IMPLEMENT MARMOT INDICATORS

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

CHAPTER 6
PROPOSED MARMOT BEACON INDICATORS

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

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

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

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

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

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

ASPIRATIONAL INDICATORS

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

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

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

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

CHAPTER 7
RECOMMENDATIONS

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

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

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

1. GIVE EVERY CHILD THE BEST START IN LIFE

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

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

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

3. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

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

4. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

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

5. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

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

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

6. STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

2022/23

Responsible: Cheshire and Merseyside System

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

Responsible: Mental Health Board

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

2023/27

Responsible: Place

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

Responsible: Cheshire and Merseyside System

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

RELATED MARMOT INDICATOR

18 Activity levels

19 Percentage of loneliness

7. TACKLE RACISM, DISCRIMINATION AND THEIR OUTCOMES

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

8. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

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

SYSTEM CHANGE RECOMMENDATIONS

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

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

B. STRENGTHEN PARTNERSHIPS FOR HEALTH EQUITY

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

SYSTEM CHANGE RECOMMENDATIONS

C. CREATE STRONGER LEADERSHIP AND WORKFORCE FOR HEALTH EQUITY

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

D. CO-CREATE INTERVENTIONS AND ACTIONS WITH COMMUNITIES

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

SYSTEM CHANGE RECOMMENDATIONS

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

2022/23

Responsible: Place

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

Responsible: Local enterprise partnership

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

2023/27

Responsible: Cheshire and Merseyside System

AND

Responsible: Local enterprise partnership

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

SYSTEM CHANGE RECOMMENDATIONS

F. EXTEND SOCIAL VALUE AND ANCHOR ORGANISATIONS

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

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

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

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REPORT TO:	Health & Wellbeing Board
DATE:	6July 2022
REPORTING OFFICER:	Director Adult Social Services
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Better Care Fund (BCF) 2021-22 Year-End Return
WARD(S):	Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To update the Health and Wellbeing Board on the Better Care Fund 2021/22 Year-End return, for information, following its submission on 27th May.

2.0 **RECOMMENDATION: The BCF Year-End Return for 2021/22 be noted for information.**

3.0 **SUPPORTING INFORMATION**

3.1 **BCF Year-End Return 2021/22**

The BCF Year-End Return for 2021/22 is attached at the Appendix and details the following information:

Tab 3 – National Conditions

There are four national conditions which are confirmed as meeting:

- The plan includes all mandatory funding and is included in a pooled fund governed under Section 75 of the NHS Act 2006;
- Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF Policy;
- Agreement to invest in NHS commissioned out of hospital services; and
- Plan for improvement in outcomes for people being discharged from hospital.

Tab 4 – Metrics

There are five national metrics and we are currently on track with three of them. In terms of the metric for ***Length of Stay*** – Hospital lengths of stay, particularly stranded and super-stranded numbers, have been a focus for Halton as well as the Trusts and the Cheshire & Merseyside Hospital cell. The number of patients who have been super-stranded during the year has been greater than planned largely due to the wave of Covid that occurred over the winter which resulted in high hospitalisations, high number of patients having to remain in isolation and high number of care home closures due to outbreaks. During the spring, Halton

has recovered its position, but there are still more long stay patients than desired, but now largely due to increase acuity and mental health issues.

Tab 5 – Income and Expenditure Actual
Planned and actual expenditure has a difference of £1,994,703. This was due to the Disabled Facilities Grant (DFG) not being spent in year due to delays resulting from the pandemic, particularly in terms of accessibility to buildings. This funding has been committed to use in 2022/23.

Tab 6 – Year-End Feedback
Year-end feedback confirms that the overall delivery of the BCF in our locality has improved joint working between health and social care, and our schemes for 2021/22 were implemented as planned and had a positive impact.

Two main successes that are highlighted include:

- ***Integrated workforce*** – Throughout the year we have strengthened the approach for intermediate care and frailty services resulting in increased referrals, which have demonstrably improved the timeliness and effectiveness of hospital discharges and hospital admission avoidance.
- ***Pooled or aligned resources*** - The above has been facilitated by the long-held governance and financial arrangements associated with the pooled budget as well as enabling timely and appropriate re-direction of resources to meet changing demand.

Two main challenges that are highlighted include:

- ***Integrated electronic records and sharing across the system with service users -*** The theoretical idea of health and care records requires substantial cross-system work to make progress on achieving this.
- ***Joined-up regulatory approach -*** Whilst there is communication across health and social care, commissioning and quality assurance with some interaction with the Care Quality Commission (CQC), there is further work that is required to focus on a pathway approach to regulation with a focus on outcomes for individuals.

Tab 7 – Adult Social Care Fee Rates
This tab details the Adult Social Care Fee Rates in relation to:

- Average amount paid to external providers for home care, per contact hour - £18.18

- Average amount paid for external provider care homes without nursing, for clients aged 65+, per client week - £445.40

- Average amount paid for external provider care homes with nursing, for clients aged 65+, per client week - £656.86.

Further detail can be found within the spreadsheet.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The Better Care Fund sits within the wider pooled budget arrangement and the financial context of the local health and social care environment. The pooling of resources and integrating processes and approach to the management of people with health and social care needs will support effective resource utilisation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 A Healthy Halton

Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

7.0 RISK ANALYSIS

7.1 Management of risks associated with service redesign and project implementation are through the governance structures outlined within the Joint Working Agreement.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None within the meaning of the Act.

Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Halton

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to ex
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we a
consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contr
likely need to be calculated from records of payments paid to social care providers and

We are interested ONLY in the average fees actually received by external care provid
what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market suppor
management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have be
costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local a
Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund paymen
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purcha
directly commissioned by your local authority and fees commissioned by your local aut
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three servic
categories of 65+ residential without dementia, 65+ residential with dementia) **please**
each detailed category: 1. Take the number of clients receiving the service for each de
2. Divide the number of clients receiving the service for each detailed category (e.g. ag
the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for eac
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£18.91
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£445.40
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£656.86
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. **Please do not use more than 250 characters.**	

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2

** For column F, please calculate your fee rate as the expenditure during the year divided by pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last y Northamptonshire County Council.

ternal care providers, which is a key part of social care reform.

re exploring where best to collect this data in future, but have chosen to collect 2021-22 dat

ibutions/user charges) to external care providers for your local authority's eligible

the number of client weeks they relate to, unless you already have suitable manage

lers for your local authority's eligible supported clients (gross of client contribution

t such as the Infection Control Fund but otherwise, including additional funding to cover cos
een paid had the pandemic not occurred. This counterfactual calculation was intended to pro
actual rate paid to providers (not the counterfactual), subject to than the exclusions set out

not paid to care providers e.g. your local authority's own staff costs in managing the
uthority funding and client contributions/user charges, i.e. you should EXCLUDE third

nts.

sing system, payments for travel time in home care, any allowances for external prov
thority as part of a Managed Personal Budget.

e types of home care, 65+ residential and 65+ nursing requested below (e.g. you hav
calculate for each of the three service types an average weighted by the proportio
tailed category.
e 65+ residential without dementia, age 65+ residential with dementia) by the total

ch detailed category.

Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
£18.91	£18.18	-3.9%
£445.40	£532.05	19.5%
£656.86	£663.65	1.0%

2020-21 EoY report

' the number of actual client weeks during the year. This will

ear figures as reported by the former

ta through the iBCF for

clients. The averages will
ement information.

s/user charges), reflecting

st pressures related to
ovide data on the long term
t below.

e commissioning of places.
d party top-ups, NHS Funded

vider staff training, fees

ve the more detailed
n of clients that receive

number of clients receiving

Checklist


Complete:
Yes
Yes
Yes
Yes