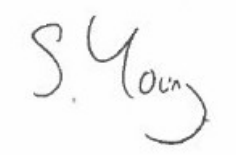
Health Policy and Performance Board

Tuesday, 27 September 2022 at 6.30 p.m.
Council Chamber - Town Hall, Runcorn



Chief Executive

BOARD MEMBERSHIP

Councillor Peter Lloyd Jones (Chair)	Labour
Councillor Sandra Baker (Vice-Chair)	Labour
Councillor Angela Ball	Labour
Councillor Laura Bevan	Labour
Councillor John Bradshaw	Conservative
Councillor Dave Cargill	Labour
Councillor Eddie Dourley	Labour
Councillor Louise Goodall	Labour
Councillor Rosie Leck	Labour
Councillor Tony McDermott	Labour
Councillor Louise Nolan	Labour
Mr David Wilson	Healthwatch Co-optee

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The next meeting of the Board is on Tuesday, 29 November 2022

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

Part I

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1.	**MINUTES**	1 - 8
2.	**DECLARATIONS OF INTERESTS (INCLUDING PARTY WHIP DECLARATIONS)** Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.	
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In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 15 February 2022 in the Council Chamber - Town Hall, Runcorn

Present: Councillors P. Lloyd Jones (Chair), Baker (Vice-Chair), Ball, Bevan, D. Cargill, Dourley, Leck and Ratcliffe, and D. Wilson (Healthwatch Co-optee)

Apologies for Absence: Councillors Goodall and J. Stockton

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, M. Vasic, A. Jones, D. Nolan, L Wilson, I. Onyia and D. Tierney

Also in attendance: L. Gardner – Warrington & Halton Teaching Hospitals NHS FT, Dr D. Wilson – Grove Partnership, D. Roberts – Deputy Chief Nurse NHS Halton CCG and Councillor J. Lowe (in accordance with Standing Order 33)

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA32 MINUTES

The Minutes of the meeting held on 23 November 2021 were signed as a correct record, subject to noting that Councillor Bevan had submitted her apologies prior to the meeting.

HEA33 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA34 HEALTH AND WELLBEING MINUTES

The minutes from the Health and Wellbeing Board meeting held on 6 October 2021, were attached for the information of the Board.

HEA35 BREAST SCREENING SERVICES

The Board considered a report from the Clinical Chief Officer – NHS Halton and NHS Warrington CCGs and the Director of Strategy and Partnerships – Warrington and

Halton Teaching Hospitals NHS Foundation Trust (Lucy Gardner in attendance), notifying them of the proposal to consolidate and expand Breast Screening Services at Bath Street, Warrington, by relocating Breast Screening Services from the Kendrick Wing at Warrington Hospital.

The report provided some general data relating to patient numbers on the service provided across the four Boroughs – Warrington, Halton, St Helen's and Knowsley. The Board was advised that Phase 1 of the Breast Service reconfiguration was complete and the Breast Assessment and Symptomatic Clinics had been relocated from Warrington Hospital to Halton Hospital's Captain Sir Tom Moore Building, where a new £2.1m Breast Centre had been created on the ground floor.

Phase 2 was now in progress and Lucy Gardner described to the Board the public consultation process that was required for the consolidation of the Warrington Breast Screening Service at Bath Street. A methodology plan was appended to the report for Members information, which included the timescales involved.

The following was noted after Members' questions:

- Attendance at a breast screening clinic was purely voluntary – not all patients who were invited attended their appointment;
- Halton was still on a 3 year cycle of appointments and these were currently on track; and
- The consultation would be shared with Healthwatch.

Members queries relating to comparisons with local and national attendance figures and a breakdown of the makeup of the 36 patients attending the Kendrick Wing would be sent following the meeting, as the information was not at hand.

RESOLVED: That the Board

Director of Adult Social Services

1) notes the report; and

2) supports the deployment of the consultation plan, as described.

HEA36 IMPROVING ACCESS TO PRIMARY CARE SERVICES

The Board considered a report from the Chief Commissioner for Halton, which provided an update of Primary Care Services in the Borough and the improvement

plans in place.

The Board welcomed Dr David Wilson from Grove House Partnership and Denise Roberts, Deputy Chief Nurse: NHS Halton CCG, who gave a presentation in support of the report, which showed some general practice and out of hours access data. This included the total number of consultations (face to face, on the telephone and e-consultations); data relating to NHS 111 calls passed to the GP Out of Hours service; and activity at the Urgent Treatment Centres, between August 2019 and December 2021.

It was reported that the NHS England and NHS Improvement (NHSEI) had provided additional Winter Access Funding (WAF) to support a local Primary Care Winter Access Plan. The local plan includes four elements (below) and these were outlined in the report:

- Expansion of General Practice appointments;
- Consistent offer across all Halton Practices for urgent/same day appointments;
- Data validation and improvement plans; and
- Community pharmacy consultation scheme.

Further to the information presented, the following comments/queries were made:

- Some Members felt the information given did not reflect what they were hearing in the community from constituents, for example experiencing long waiting times on the telephone when trying to get through to a surgery to make a doctor's appointment;
- The above scenario often forced patients to use A&E and others just gave up, meaning a diagnosis could be missed;
- Not all patients needed to see a GP and were triaged to other services; the resources were in place but it was difficult to change peoples' mind-set that they must see a GP;
- There were concerns that some clinicians and other hospital staff would leave their professions or reduce their hours due to demands made upon them over the past couple of years resulting from the impacts of Covid-19;
- All surgeries were contractually obligated to offer e-consultations – links to these were available on practice websites and the NHS App also leads the user to the e-consultation link.

RESOLVED: That the Board receives and notes the update provided.

HEA37 PUBLIC HEALTH RESPONSE TO COVID-19 CORONAVIRUS

The Director of Public Health and Protection provided the Board with an update on the Public Health response to Covid-19 Coronavirus.

The update and accompanying presentation included the most recent Covid-19 figures and data for Halton; how the Halton Outbreak Support Team (HOST) were working to successfully identify and manage local outbreaks; and gave details of the most recent information on testing and vaccination for people in Halton.

Responses to Members questions were given and the following additional information was provided:

- It was accepted that not all people who tested positive reported this to the NHS but took it upon themselves to isolate and do the right thing;
- Eventually the virus would move to an endemic stage and testing would cease for those without symptoms;
- A booster vaccination was needed in order to prolong the protection period of two vaccinations and reduce the risk of serious illness and/or hospitalisation;
- There was a plan to vaccinate vulnerable 5 to 11 year olds before the general population;
- Deaths caused by the virus in Halton totalled 375 – a comparison with other boroughs' would be included in a report at a future meeting; and
- When the Government do eventually cease all restrictions, schools would be supported as they were now and be encouraged to continue with Covid learned behaviours and the use of PPE.

RESOLVED: That the update be received.

HEA38 UPDATE ON ONE HALTON PLACE BASED PARTNERSHIP

The Board received an update from the Strategic Director – People, HBC and the Chief Commissioner, NHS Halton CCG, on the One Halton Place Based Partnership development with Cheshire Merseyside Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Further to the report to the Board in November 2021

where the requirements for the formation of Integrated Care Systems regionally and an Integrated Care Partnership at Place level was discussed, these were detailed in NHS Reforms and now set out in the White Paper *Integration and Innovation*, published in February 2021, and would build on the NHS long term plan.

Appended to the report was a Development Advisory Group briefing, dated 5 January 2022, which gave details of the new target date of 1 July 2022 for the statutory arrangements to take effect and ICBs to be legally and operationally established.

The briefing also contained information on recruitment to senior roles, a Covid-19 update and responses to key questions that had been raised. A response was provided to the Chair's query regarding funding arrangements and whether they would be pooled or aligned, as discussed in paragraph 3.7.

RESOLVED: That the report be noted.

HEA39 SAFEGUARDING UPDATE

The Board considered a report of the Strategic Director – People, which provided an update on safeguarding in Halton.

The report outlined the impacts of Covid-19 on individuals, families, communities and wider society and how it had touched every part of people's lives and that many of the existing protective factors in the lives of adults at risk of abuse and harm had been temporarily absent or limited.

The impact of the Pandemic on care homes and domiciliary care sectors was discussed, for both residents and staff, as well as the potential for compassion fatigue, and emotional and physical stresses amongst those continuing to provide support.

It was also reported that the implementation of the *Liberty Protection Safeguards* (LPS), the replacement for Deprivation of Liberty Safeguards (DoLS), had been delayed further. Members were advised that since writing the report, a new date for its implementation had been scheduled for April 2023.

RESOLVED: That the report is noted.

HEA40 HOMELESSNESS UPDATE

The Board received an update on the Homelessness Service provision and activity during the Covid-19 pandemic. This included future service development, highlighting agency engagement and activity towards reducing homelessness within the Borough.

As with the previous update it was announced that the Ministry of Housing Communities and Local Government (MHCLGH) issued guidance to all Local Authorities, designed to ensure that everyone known to be rough sleeping, or those deemed to be at imminent risk of rough sleeping, would be offered accommodation. Its purpose was to protect vulnerable clients from the risk of contracting Covid-19, with additional funding made available to support the response; Halton was allocated a total of £6,000.

The report outlined Halton's response to the pandemic and the Housing Solutions Team's robust approach to tackling homelessness and meeting the needs of vulnerable homeless clients. Data relating to the usage of commissioned provision and numbers of clients was also presented.

In relation to future activity, information was provided on rough sleepers, domestic abuse, armed forces personnel, prison release clients, the refugee resettlement programme, agency support, substance misuse support service and Government funding.

In response to Member's questions, Officers provided the process a person should follow if they were at risk of eviction and the steps the Council would take to assist and provide advice to them.

RESOLVED: That the report is noted.

HEA41 SCRUTINY TOPIC FOR 2022/23 REVIEW

The Board received a report of the Strategic Director – People, which presented proposals for scrutiny topic areas for the 2022-23 review.

It was noted that the 2021-22 scrutiny review: *North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission: The Impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities,* was still underway. The final recommendations from this had been delayed due to

pandemic related issues, but the final report would be included on the June agenda.

It was agreed that despite this delay a topic group for 2022-23 should still be identified, so the necessary arrangements could be put in place. As part of Member involvement in the current business planning process, a range of topic ideas had been identified for consideration:

1) Approaches to Adult Social Care Workforce Planning;
2) Provision of Learning Disability Services in Halton; and
3) Skills and Training Opportunities for Social Care Provider Staff.

Members discussed these proposals and a suggestion was made to link numbers one and three together, this was agreed. An outline brief for the topic areas would be brought to the next Board meeting in June for final approval.

RESOLVED: That the Board agrees

Director of Adult Social Services

1) '*Approaches to Adult Social Care Workforce Planning'* and '*Skills and Training Opportunities for Social Care Provider Staff*' be selected as the topic group for the year 2022-23; and

2) all Members of the Board were invited to join the membership of the topic group.

HEA42 PERFORMANCE MANAGEMENT REPORTS - QUARTER 3 OF 2021-22

The Board received the Performance Management Reports for quarter three of 2021/22.

Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in quarter three of 2021-22. This included a description of factors, which were affecting the service.

The Board was requested to consider the progress and performance information and raise any questions or points for clarification and highlight any areas of interest or concern for reporting at future meetings of the Board.

It was commented that due to some data no longer being required and some being reported annually, the format of the reports required changing; this would be looked at for future reports.	
RESOLVED: That the quarter three Performance Management reports be received.	Director of Adult Social Services

Meeting ended at 8.15 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 27 September 2022

REPORTING OFFICER: Operational Director – Legal and Democratic Services

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or

- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chair will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 27 September 2022

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes from the Health and Wellbeing Board meeting held on 23 March 2022 are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

8.1 There are no background papers under the meaning of the Act.

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
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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 Policy & Performance Board
DATE:	27th September 2022
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Adult Social Care Health & Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report : 2021/22
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board's Annual Report for April 2021 - March 2022

2.0 **RECOMMENDATION: That the Board:-**

i) note the contents of the report and associated Annual Report (Appendix 1).

3.0 **SUPPORTING INFORMATION**

3.1 During 2021/22, the Health Policy and Performance Board has examined in detail many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board are outlined in the appended Annual Report.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
There are no specific implications as a direct result of this report however the health needs of children and young people are an integral part of the Health priority.

6.2 **Employment, Learning & Skills in Halton**

None identified.

6.3 **A Healthy Halton**

The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

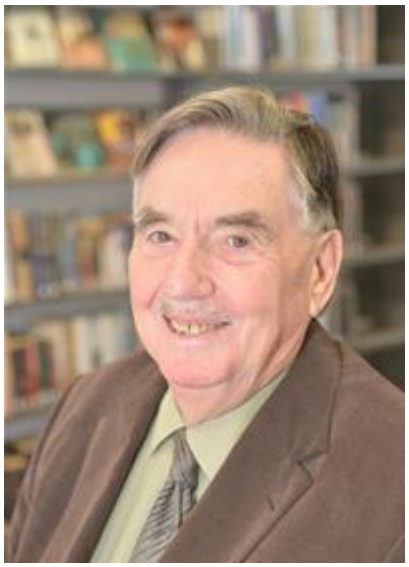
9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2021 - March 2022



I should firstly like to thank all staff, at all levels, for their sterling and unrelenting efforts throughout the difficulties of the last year, and indeed, during the whole of the Pandemic.

This very much includes all those in working Public Health involved in the very successful Halton Test and Vaccinations Centres, as well as carrying on with their normal work. It was a true baptism of fire for our new interim Director of Public Health & Protection!

I should also wish to thank my vice-chair, Councillor Sandra Baker, for her continuous support, and that of all members of the Health Policy & Performance Board, during this, my first year as chair.

Although this is essentially a report on the last year, it would seem inappropriate to ignore issues which will arise during the next six months.

The Health & Care Bill to establish the proposed Integrated Care structure has not yet been finally approved by Parliament, but nevertheless the new structure, Cheshire and Merseyside Integrated Care Services, is already established, and, astonishingly, funding for some projects has already been allocated to it, a non- legal structure!

The overall funding is not yet known, but we do know that the local regional structure is larger than the model structure.

Will funding for this structure be based on the actual structure, or limited to that of the model? How much will the funding be for the individual Places, or boroughs, such as Halton? What funding will be made available for Adult Social Care services, as Adult Social Care is not part of the integrated services? This is intended to be very much part of the local Place services, but how will this work out in practice, as Adult Social Care services are not included in the Bill's definition of Integrated Care?

The Board and I are very keen to understand the answers to these questions, and others, and will be monitoring developments closely.

We live in uncertain and troubling times!

Cllr Peter Lloyd Jones, Chair

Health Policy and Performance Board Membership and Responsibility

The Board:

Councillor Peter Lloyd Jones (Chair)
Councillor Sandra Baker (Vice Chair)
Councillor Angela Ball
Councillor Laura Bevan
Councillor Eddie Dourley
Councillor Dave Cargill
Councillor Andrew Dyer
Councillor Rosie Leck
Councillor Margaret Ratcliffe
Councillor Louise Goodall
Councillor John Stockton

During 2021/22, David Wilson was Halton Healthwatch's co-opted representation on the Board and we would like to thank David for his valuable contribution.

The Lead Officer for the Board is Sue Wallace-Bonner, Director of Adult Social Services.

Responsibility:

The primary responsibility of the Board is to focus on the work of the Council and its Partners, in seeking to improve health in the Borough. This is achieved by scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

The Board have met five times in 2021/22. Minutes of the meetings can be found on the Halton Borough Council website. It should also be noted that the Board, at each of their meetings, receive and scrutinise the minutes from Halton's Health and Wellbeing Board and monitors work/progress within this area.

This report summarises some of the key pieces of work the Board have been involved in during 2021/22.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

White Paper – Integration and Innovation: Working Together to Improve Health & Social Care for All

In February 2021, the Government published the above White Paper which set out legislative proposals for a Health and Care Bill which were due to be implemented by April 2022.

The Board received details of the proposals for NHS and social care reform, which focused on integrated care and services and although the White Paper recognised that the response to Covid-19 was the current priority, as the system emerged from the pandemic the legislative measures were aimed at assisting with the recovery by

bringing organisations together, removing barriers and enabling change and innovations.

Throughout the year, the Board have received regular updates on the development of the Integrated Care System and the impact that it would have within Halton and the resulting developments associated with the formation of the One Halton Partnership, including the One Halton place self-assessment against the Cheshire & Merseyside Development Framework and Transition programme to the new structure.

Staff Vaccination Regulations in Adult Care Homes
In September 2021, the Board heard how the Government were introducing new regulations (came into force 11th November 2021) which meant that all persons entering Care Quality Commission registered care homes must be fully vaccinated. Although there were some exemptions, the implications of implementing the regulations were that those staff who were not fully vaccinated or refuse to be vaccinated who work within care homes, or are required to visit care homes as part of their role could not continue to be employed in that role.

Although this legislation was expected to reduce the health risks to care home residents and staff, it would introduce a number of consequential risks, which threatened the operation of local health and care systems. The report received by Members explained these risks and the immediate actions that were to be taken to prepare for possible workforce reductions to arise as a result of the legislation.

A follow up report was presented to the Board in November 2021, which provided an overview of the impact of the legislation had had on workforce numbers. The Board heard how the proactive work which had been done with staff since the regulation s had been announced meant that workforce reductions were able to be kept to a minimum.

Since being presented to the Board, the Government launched a consultation to revoke vaccination as a condition of deployment across all health and social care.

SERVICES

Public Health Response to COVID-19 Coronavirus
Throughout the past 12 months, the Board has received updates at every Board meeting from the Director of Public Health & Protection on current figures, data and activity, such a testing and vaccination activity, being undertaken within the Borough in response to the Coronavirus pandemic.

Reconfiguration of Breast Screening, Assessment and Symptomatic Services - Warrington & Halton
Following a period of pre-consultation engagement with the general public, in June 2021, the Board were provided with an overview of planned changes in respect to the Reconfiguration of Breast Screening, Assessment and Symptomatic Services across Warrington & Halton, which were believed would help improve the quality of the services offered and future proof the delivery of the service in future years.

In February 2022, the Board received an update which outlined that Phase 1 of the Breast Service reconfiguration was now complete and the Breast Assessment and

Symptomatic Clinics had been relocated from Warrington Hospital to Halton Hospital's Captain Sir Tom Moore Building, where a new £2.1m Breast Centre had been created on the ground floor. Phase 2 was now planned which involved consolidating and expanding Breast Screening Services at Bath Street, Warrington, by relocating Breast Screening Services from the Kendrick Wing at Warrington Hospital. Details of the consultation plan were provided, which the Board supported.

Palliative and End of Life Review
Details were provided to the Board on the Palliative and End of Life project taking place within Halton.

The project had been ongoing since November 2020 following a successful funding bid from Macmillan Cancer Support. The work being undertaken within the project would support the requirements of Ambitions for Palliative and End of Life Care – a national framework for local action 2015-2020 and should provide Halton with a more integrated and co-ordinated provision of care for palliative patients and their families.

Intermediate Care & Frailty Service in Halton
The Board continued to receive updates on implementation of a new model for the delivery of Intermediate Care & Frailty Services in the Borough.

The key aspects of the new Service is the introduction of a Single Point of Access and the integration of the previous frailty service provided by the Halton Integrated Frailty Service, with the ability to provide a Community Rapid Response within 2 hours, if assessed as necessary.

As outlined in the report the Service went live on the 6th December 2021, initially operating 9am – 5pm, Monday – Friday, with plans to rapidly increase hours of delivery, the aim of which is to deliver the Service from 8am - 8pm, 7 days a week by the end of March 2022.

The Board would continue to monitor progress with regards to this development.

Quality Assurance in Care Homes and Domiciliary Care in Halton
In September 2021, the Board received a report which highlighted key issues with respect to Quality Assurance in Care Homes and Domiciliary Care.

The Board noted that during the pandemic both the Care Quality Commission (CQC) and Halton's Quality Assurance Team had to amend the way that they supported the sector undertaking a risk assessment approach and alternative arrangements for assessing and monitoring and only 'crossing the threshold' in relation to serious safeguarding issues.

This had resulted in reduced intelligence and notifications received by the services, which also had an impact on reporting of ratings. It was noted that the Quality Assurance Team had now started to undertake safe and well visits and the CQC had resumed inspection activities.

Mental Health Services

During 2021/22, the Board received updates on two developments within local mental health services – the current impact of the take-over by Mersey Care NHS Foundation Trust of the former North West Boroughs (NWB) Healthcare Foundation Trust and the implementation of the national Mental Health Breathing Space Scheme (MHBS).

It was reported that so far the take-over by Mersey Care of the former NWB had made very little impact locally on front line service delivery. A local multi-agency health partnership board was being re-established, which would include Mersey Care, and would make the transmission of information and service developments easier.

Members were provided details of the MHBS which was introduced by central Government and implemented in May 2021. The Scheme aimed to provide people who were in debt and who qualified for the scheme, with a period of respite during which they could not be pursued by their creditors until their debts had been addressed by a specialist debt adviser.

The Standards for Employers of Social Workers and the Social Work Health Check (Adult Social Care)
Information was presented to the Board in relation to the Standards for Employers of Social Workers in England, which was published by the Local Government Association (LGA).

It was reported that a self-assessment exercise had been undertaken locally to establish Halton's performance in relation to the Standards and staff had also taken part in the Social Work Health Check survey, which was required under one of the employer standards. Overall the results present were very positive.

The Board noted that approximately 40% of staff had responded to the survey and the aim would be to undertake the exercise again during 2021 as it was being run on an annual basis, so we would be able to check on any areas which needed to be improved. Outcomes of further surveys would be presented to the Board.

Transforming Cancer Care - Eastern Sector Cancer Hub
In October 2021, a special meeting of the Board took place to consider proposals relating to the establishment of a Cancer Hub at St Helens Hospital for Halton, Knowsley, St Helens and Warrington patients.

The Board was advised that commissioners in NHS Halton, NHS Knowsley, NHS St Helens and NHS Warrington Clinical Commissioning Groups (CCGs) and NHS England Specialised Commissioning had undertaken a review of non-surgical cancer care in the local area in line with the National Cancer Transformation Programme. The review was carried out via a structured evaluation approach following the NHS England Service Change Assurance Process, which had identified the most suitable site for the Hub would be at St Helens Hospital.

Members assessed whether the proposals constituted a substantial development or variation in the provision of health services for the residents of Halton; the Board confirmed that it did. As a result, it was advised that there would now be a joint scrutiny exercise with the other authorities affected by the proposals and that two members of

the Board would need to be nominated from within the Board membership to represent Halton at the Joint Scrutiny Committee.

At the time of writing this report, the joint scrutiny arrangements have not yet began as we are still waiting for further information from the CCG commissioners.

Improving Access to Primary Care Services
In February 2022, the Board welcomed Dr David Wilson from Grove House Partnership who provided an update on current issues and activity in respect to access to Primary Care Service in Halton, particularly in respect to the local Primary Care Winter Access Plan, which consistent of four elements:-

- Expansion of General Practice appointments;
- Consistent offer across all Halton Practices for urgent/same day appointments;
- Data validation and improvement plans; and
- Community pharmacy consultation scheme.

Some debate took place in respect to some constituent's experiences in respect to ability to access appointments and the impact that the Pandemic had had on services, clinicians and the members of the public.

Suicide Prevention
The effects of suicide are far reaching and have a devastating impact on families, friends, communities and colleagues. Suicide risk is greater in areas of deprivation, such as Halton, due to social and economic inequalities and the wider determinants of health.

In November 2021, the Board received an update in respect to the Suicide Prevention agenda within Halton.

The Board received details of the:-

- Public Health England Prevention and Promotion Mental health funding and it's use/outcomes;
- Work of Champs Public Health Collaborative;
- Core local activity, such as tackling Mental Health Stigma in men with Halton's Time to Change Hub; and
- Work being done with Mental Health Teams in Schools.

Homelessness Services
The Board received an update on the Homelessness Service provision and activity during the Covid-19 pandemic. This included future service developments, highlighting agency engagement and activity towards reducing homelessness within the Borough.

Details were provided to the Board on the approach being taken by the Housing Solutions Team's to tackle homelessness and meeting the needs of vulnerable homeless clients. Data relating to the usage of commissioned provision and numbers of clients were also presented to the Board.

SCRUTINY REVIEWS

At the Board's meeting in February 2021, it was agreed that the 2021/22 work topic would focus on the local implementation of the recommendations contained in the North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission report '*The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'.*

At the time of writing this report, the outcome from the scrutiny review is still be assessed and will be presented to the Board meeting in June 2022.

PERFORMANCE

The Health Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, during the year the Board has been provided with thematic reports which have included information on progress against key performance indicators, milestones and targets relating to Health.

The Board also received details of the Halton Safeguarding Adult Board (HSAB) Annual Report for 2020/21 which was developed in conjunction with HSAB partners to ensure the report encompassed a multi-agency approach. The Report included performance data and comparisons between years, achievements in the year and highlighted some of the good practice taking place in the Borough.

In respect to Safeguarding, the Board also heard how the Pandemic had impacted on individuals, families, communities and wider society and how it had touched every part of people's lives and that many of the existing protective factors in the lives of adults at risk of abuse and harm had been temporarily absent or limited.

INFORMATION BRIEFING

During 2021/22, the Board continued to receive an Information Briefing Bulletin in advance of each of the Board meetings.

The Information Briefing is a way of trying to manage the size of the agendas of the Board meetings better. Including information on topics which were previously presented to Board as reports only for the Board's information now into the Information Briefing bulletin allows the Board to focus more on areas where decisions etc. are needed.

Example of areas that have been included in the Information Briefing over the last 12 months have included:-

- Cheshire & Merseyside Acute Hospital Elective Recovery
- Healthwatch Halton Annual Report 2020-21
- Urgent Treatment Centres
- Blue Badge Policy

WORK TOPICS FOR 2022/23:

At the meeting of the Board in February 2022, it was agreed that the focus of Scrutiny topic for 2022/23 would be on workforce, specifically in relation to the approaches taken to Adult Social Care workforce planning and the skills and training opportunities that are available for Adult Social Care provider staff.

Report prepared by Louise Wilson, Commissioning & Development Manager, People Directorate
Email: louise.wilson@halton.gov.uk Tel: 0151 511 8861

REPORT TO:	Halton Health Policy and Performance Board
DATE:	27 September 2022
REPORTING OFFICER:	Director of Strategy and Partnerships - Warrington and Halton Teaching Hospitals NHS Foundation Trust
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Phase 2 - Reconfiguration of Breast Services provided to the boroughs of Halton, Knowsley, St Helens and Warrington.
WARD(S):	Borough-wide Halton

1.0 PURPOSE OF THE REPORT

To notify the Board of:

- Update on the proposal to consolidate and expand **Breast Screening Services** at Bath St Warrington and the impact on the proposed service change on users from Halton
- Proposal to cease the Breast Screening service at **Kendrick Wing Warrington Hospital**
- Report on the outcomes of the public consultation.

2.0 RECOMMENDATION

That the Board:

1) Note the contents of the report
2) Support the proposed next steps as described.

3.0 SUPPORTING INFORMATION

3.1 Reconfiguration of Breast Services across Halton, Knowsley, St Helens and Warrington - recap

Warrington and Halton Teaching Hospitals is the lead provider of Breast screening services for the boroughs of Halton, Knowsley, St Helens and Warrington (WHKSBSS). In the first half of 2021, The Trust, in partnership with NHS Specialist Commissioning and local commissioners NHS Halton CCG and NHS Warrington CCG, conducted a public consultation to seek support for a significant service change.

The change in service saw the breast assessment (anomalies found as part of routine screening) and breast symptomatic (anomalies found by patients – GP direct referral) services relocate from Warrington Hospital's Kendrick Wing and Halton Hospital's Delamere Centre to a new £2.1m specialist Breast Care Centre at Captain Sir Tom Moore building, Halton Hospital. Note that the assessment service continues at the Burney Centre, St Helens Hospital. At that time, there was no change to Breast Screening services other than the discontinuation of screening at Delamere Centre which relocated within the Halton Hospital site.

Impact on Halton Residents

Typically, approximately 10% of patients residing in NHS Halton CCG postcodes have elected to have their breast screening at Kendrick Wing, Warrington Hospital. Based on 2019/2020 data this was 342 users out of a total of 2,898 appointments who originate from the NHS Halton CCG area.

However, since the opening of the new Breast Centre at the Captain Sir Tom Moore building at Halton the number of Halton residents travelling to Kendrick Wing has decreased significantly. Between the beginning of July 2021 when the Centre opened and end of December 2021, just 36 Halton residents have attended Kendrick wing for screening.

3.2 The Breast Screening service:

Routine Breast Screening is offered every three years to all women aged 50 - 70 (up to their 71st birthday. Women over the age of 70 able to self-refer for screening if they choose to do so. Breast Screening refers to the three-yearly mammograms offered as part of the national programme to identify and treat breast cancers earlier. The eligible population vs uptake is described below – note that 2019-20 is used as the most representative year unaffected by the Covid-19 pandemic. Women can choose to have their screening at any one of the locations below – Warrington currently has both Bath St and Kendrick Wing locations.

	Female 50-74 Population	Screening Attendances 2019/20
Warrington	33,000	8,100
St Helens	29,000	7,100
Halton	21,000	5,000
Knowsley	9,000	2,200
	92,000	**22,400**

3.3 Update on the proposal to consolidate and expand Breast Screening Services at Bath St Warrington

In the second and final phase of the reconfiguration of breast services, work is underway to expand and improve the existing breast screening centre at Bath St. Health and Wellbeing Centre.

It is proposed that breast screening service in Warrington be consolidated at Bath St and discontinued at Warrington Hospital's Kendrick Wing (augmented as usual with mobile services as required.) As this is a cessation of service at one location, public consultation was required.

The consultation was held according to the Gunning Principles.

Halton's Health Policy and Performance Board has previously been fully appraised of the proposal to consolidate the Warrington breast screening services at Bath St. and has scrutinised:

- The proposal
- The Public Consultation plan and methodologies

- The timeline
- Reporting actions and decision-making plan

Public consultation was originally planned for 25 April – 3 June 2022 but this was postponed to 6 May – 20th June to accommodate the pre-election period of the Halton Borough Council elections. The revised timeline was as follows:

Public Consultation timeline:

Consultation commences	06.05 22
Issue stakeholder briefing – to all partners and advocacy groups, CCGs for GP newsletters and PPGs	06.05.22
Issue press release	06.05.22
Face to Face engagement @ Kendrick Wing, Warrington Hospital - Sessions - 1x per week during consultation period across a range of days/times	From 6.5.22
Recruit 'Experts by Experience' to inform design aspects at Bath St	From 6.5.22
Face to Face engagement @ Bath St., Warrington Hospital	From 6.5.22
Face to Face engagement @ Halton CSTM	From 6.5.22
Delivery of 1 x MS Teams LIVE virtual consultation event	26.5.22
Issue reminder press release and stakeholder update 10 days before consultation end date. Update SM message	08.06.22
Consultation closes – update website	20.06.22
Evaluation of consultation feedback and outcomes including identification of themes and suggestions	From 20.6.22
Outcomes to WHH Executive Team	From 20.6.22
Outcomes to NHS Warrington and NHS Halton CCGs	From 20.6.22
Halton Health Policy and Improvement Board meeting – slide pack of outcomes (consultation plan previously submitted – 15 Feb 22)	28th June 2022 (meeting abandoned not quorate)
Halton Health and Wellbeing Board	6th July

3.4 Consultation materials (and see appendices)

- Press release
- Slide pack – virtual sessions
- Poster
- Questionnaire
- Website link is Final phase of reconfiguration of Breast Services proposed :: Warrington and Halton Hospitals NHS Trust (whh.nhs.uk)

Social Media (Twitter, Facebook, Instagram)

3.5 The Case for Change – consolidation of Warrington breast screening services at Bath St. and cessation of services at Kendrick Wing (recap)

During the first phase of reconfiguration of breast screening services for the four boroughs, and in the associated formal public consultation (which closed in June 2021), numerous issues were identified relating to the service at Kendrick Wing. These were:

- Aged, inaccessible estate offering a poor patient experience
- Lack of available space elsewhere on the hospital site to relocate the service
- Constantly unreliable elevator access to the first-floor screening centre
- Parking issues relating to the highly congested hospital site

In addition, there are challenges relating to the operation of a two-centre service in Warrington including:

- The current multi-site nature of the screening service and split-site nature of the assessment service creates inefficiencies in use of estate, equipment and workforce
- The workforce challenges are significant with a local and national shortage of Breast Radiologists and Mammographers making recruitment into crucial posts challenging.
- There are real opportunities to create a significantly enhanced patient experience and improve access, as well as creating a more efficient service which would support the long-term sustainability of the service through consolidation in a modern, superior location.
- Bath St Health and Wellbeing Centre is circa 1mile from the existing Kendrick Wing site and has easily accessible, plentiful car parking spaces and parking is free for 90 minutes for those with an appointment (£2.50 at Warrington Hospital). It is closer to the public transport interchange in Warrington town centre thank Kendrick Wing.
- There is a local and national shortage of Mammographers making recruitment into crucial posts challenging. Current staff will relocate with their service, there is no intention to

decrease staffing levels and no member of staff will be disadvantaged by this relocation. The breast screening administration service will not relocate.
- The vacated service space at Warrington Hospital will be refurbished for use by the WHSKBSS administration team and any additional space reallocated for other non-clinical services.

3.6 Next Steps

- Conclude the interrogation of valuable commentary and suggestions from 85 participants
- Produce themes and mitigating actions (where possible), cross-checking against the Equality Impact Assessment, key themes from Phase 1
- Produce Full Consultation Outcomes Report with Commissioners (NHS C&M-Halton Place and NHSE Specialist Commissioning)
- Include all feedback from all Scrutiny committees
- Recommendations report to Trust Board
- Publish outcomes
- Implement/do not implement proposals – see Gunning Principles

4.0 POLICY IMPLICATIONS

None identified.

5.0 FINANCIAL IMPLICATIONS

Warrington and Halton Hospitals covered the costs of the consultation process.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

None identified

6.4 A Safer Halton

None identified

6.5 Halton's Urban Renewal

None identified

7.0 Risk Analysis

7.1 The project is governed in line with WHHNHS risk controls. A detailed risk log is available and mitigations are in place as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

A comprehensive equality impact assessment has been carried out and will be included in the outcomes report.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Proposal to Consolidate Warrington's Breast Screening Services

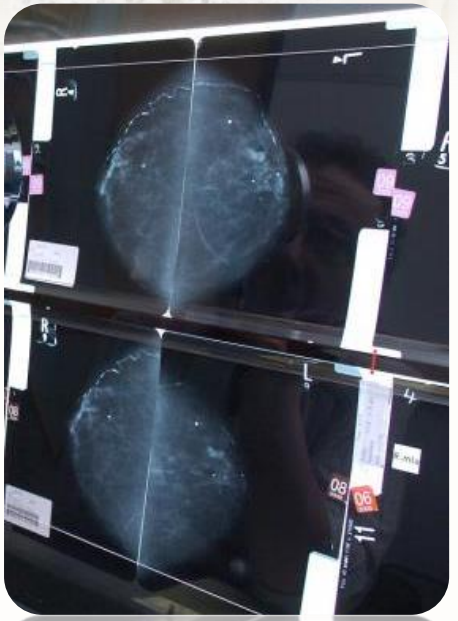
Lucy Gardner, Director Strategy & Partnerships
Pat McLaren, Director of Communications and Engagement

Recap – Reconfiguration of Breast Services for Halton, Knowsley, St Helens and Warrington

- Two phased process – phase 1 completed in summer 2021
- Phase 1 - opened £2.1m Breast Care Centre at Captain Sir Tom Moore bldg., Halton July 21 and relocated breast assessment and breast symptomatic clinics from Warrington Hospital and Delamere Centre to new Breast Care Centre
- All supported through public consultation first half of 2021, led by NHS Halton and NHS Warrington CCG
- Phase 2 proposes the consolidation of Warrington's breast screening services at Bath St Warrington and ceasing service at Kendrick Wing, Warrington Hospital
- Phase 2 option was not fully available at that at time of 2021 consultation, hence this second public consultation.

National Breast Screening Programme

- Offered to all women aged 50 - 70 years every three years
- Commissioned by NHS England Specialist Commissioning
- WHH is lead provider of the service for Halton, Knowsley, St Helens and Warrington



Halton Residents – Screening Location

- All service users currently have a choice of 5 locations: Breast Care Centre at Halton Hospital, Whiston Hospital, St Helens Hospital and Warrington (Bath St and Kendrick Wing) OR mobile unit if available.
- In 2019-2020 342 Halton service users selected Warrington from the 2,898 appointments offered.
- Since the new Breast Centre opened at Halton, 36 Halton residents attended Kendrick wing for screening (July-Dec 21).

Current Service Offer (females age 50-71)

Halton	**Breast Care Centre**	**20,600**
Knowsley	**Whiston Hospital**	**9,000**
St Helens	**St Helens Hospital**	**29,400**
Warrington	**1. Kendrick Wing** **2. Bath Street**	**32,900**
Regional	**Mobile Unit(s)**	**From above**

The Proposal

1. To consolidate Warrington's breast screening service at a single site, at the Bath Street Health and Wellbeing centre and:
2. To discontinue the breast screening service at Warrington's Kendrick Wing
3. To seek views on this service change public consultation took place between 6 May – 20th June 2022

The case for change

The Kendrick Wing service

- × Aged, inaccessible estate offering a poor patient experience
- × Lack of available space elsewhere on the hospital site to relocate the service
- × Constantly unreliable elevator access to the first-floor screening centre
- × Parking issues relating to the highly congested hospital site

Breast Service Reconfiguration – Phase 2
A single screening site

- ✓ **Opportunity to substantially enhance patient experience and improve access**
- ✓ **Consolidate scarce Breast Radiologists and Mammographers into single location**
- ✓ **Enhanced efficiencies in use of estate, equipment and workforce**
- ✓ **Kendrick Wing space refurbished for the screening administration team and any additional space reallocated for other non-clinical services**

Breast Screening at Kendrick Wing

Breast Screening at Bath St

- ✓ 1mile from the existing Kendrick Wing service
- ✓ Fully accessible, modern facility
- ✓ Dedicated car parking - free for 90 minutes
- ✓ Close to the public transport interchange in Warrington town centre

The Public Consultation – Phase 2

- Formal Public Consultation 6 May to 20 June inclusive (6 weeks)
- Consultation according to best practice (Gunning Principles)
- Targeted, accessible engagement - emphasis on diversity in participation
  Responses 163 – 66% of phase 1 (252 responses)

- *Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.*
- *People involved in the consultation need to have enough information to make an intelligent choice and input in the process. Equality Assessments should take place at the beginning of the consultation and published alongside the document*
- *Is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?*
- *Think about how to prove decision-makers have taken consultation responses into account.*

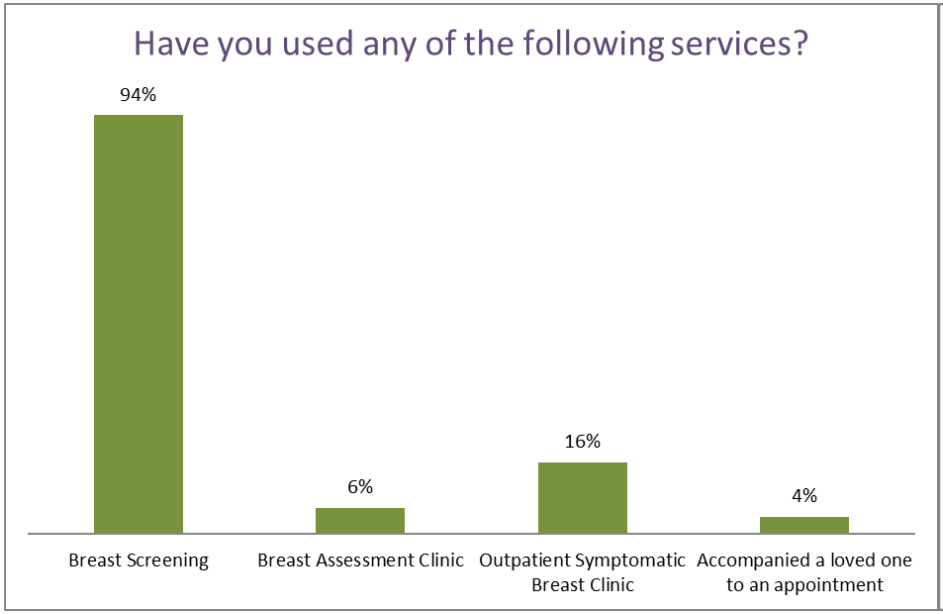
Consultation methodology – multiple formats

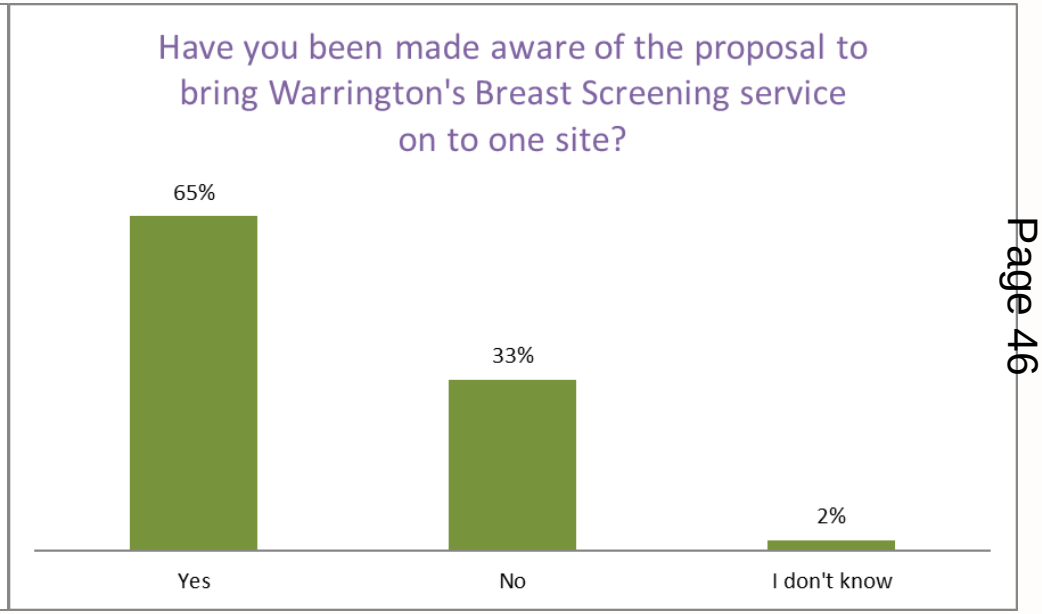
Consultation materials – range of formats plus paper/online response materials AND verbal scribe	**Face to Face engagement @ Kendrick Wing Tuesday 24th May - all day Wednesday 25th May – all day**
Website and social media campaigns	**Face to Face engagement @ Bath St Thursday 12th May 10.30-2.30pm Tuesday 17th May 10.30-2.30pm Monday 30th May 10.30-2.30pm**
Stakeholder Briefings	**MS Teams LIVE virtual consultation event**
Press coverage	**Consultation FAQs, continually updated**
Experts by Experience panel (6 members)	**Healthwatch Halton and Healthwatch Warrington**
GP and PCN communication	**Partner organisations PLACE level**

Targeted Inclusion and Involvement

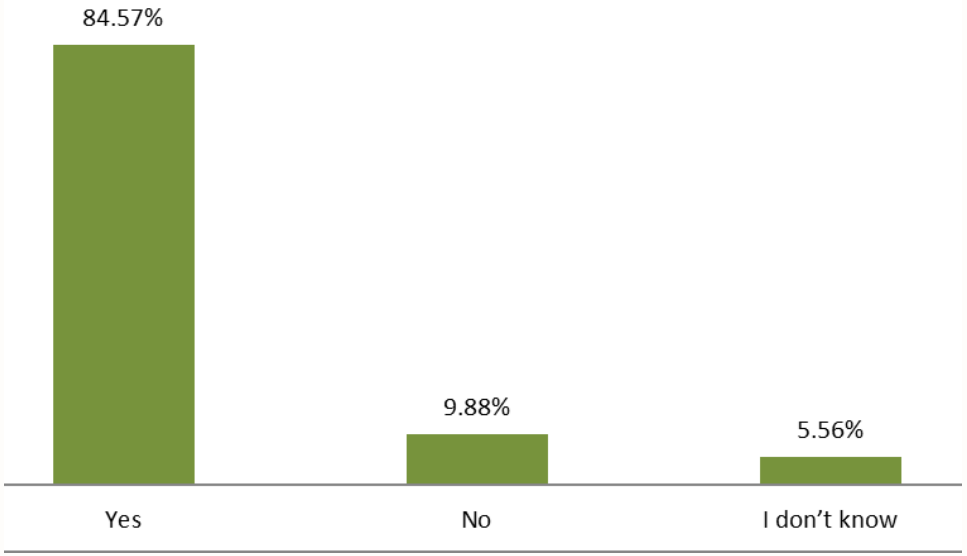
Protected Characteristics	Forum
Gender:	Groups for men – Directions for Men/Dads Matter/ Wolves Foundation Offload, WHH Menopause Cafe
Sexual Orientation:	TAGS - Teenagers, Gender and Sexuality 17-24yrs Warrington, Progress Staff Network
Gender Reassignment	Trans Warrington
Race:	Warrington Ethnic Community Association, Warrington Ethnic Women's Group, WHH Muti Ethnic Staff Network
Religion or Belief:	Council of Faiths plus race groups above
Disability:	Breast clinics (cancer), Halton Disability Partnership membership, Staying Connected Forum Warrington, WHH Disability Staff Network, Warrington Deaf Society, Alternative futures, Muscular Distrophy Lymm, Deafness Resource
Marriage and Civil partnership	All
Pregnancy and Maternity	Maternity Voices Partnership
Age:	Age UK Mid Mersey, Warrington Lifetime, Halton Carers Centre, Wired Carers Centre
Other Vulnerable/under-represented groups	Warrington BC Wellbeing lead for Asylum Seekers and Refugees, Cheshire Gypsy Roma Traveller Education Adviser, Change Group Live, Veterans Associations in Halton and Warrington, WHH Armed Forces Network

Public Consultation Phase 2 – the Responses

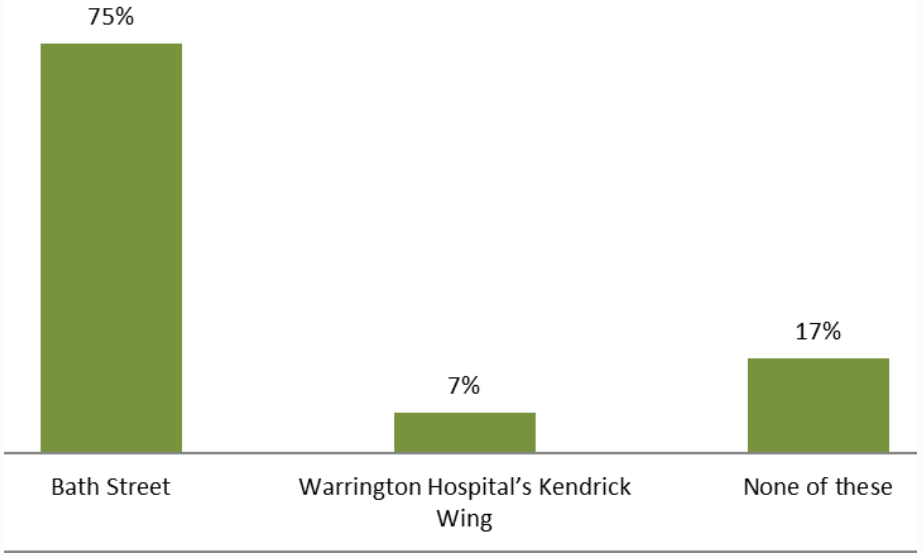


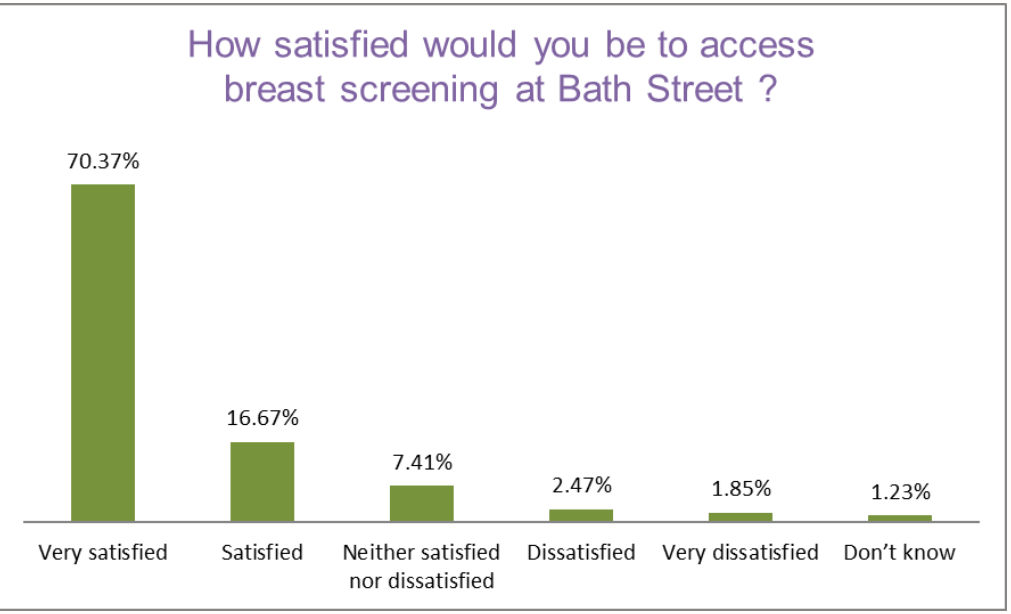


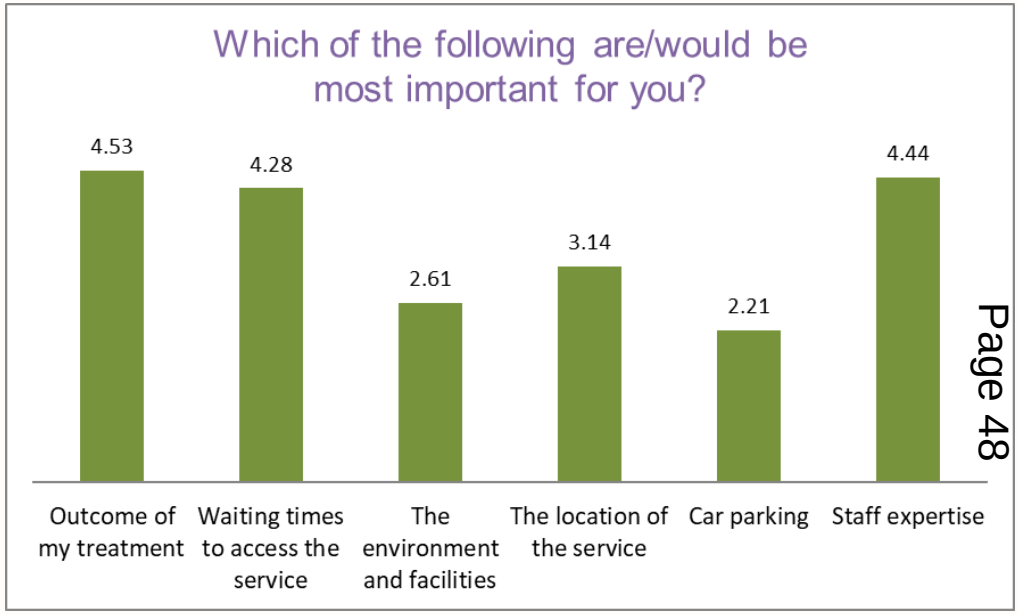
Do you feel that you have been given enough information to form an opinion on our proposals?



In Warrington where would you prefer to have your breast screening appointment?



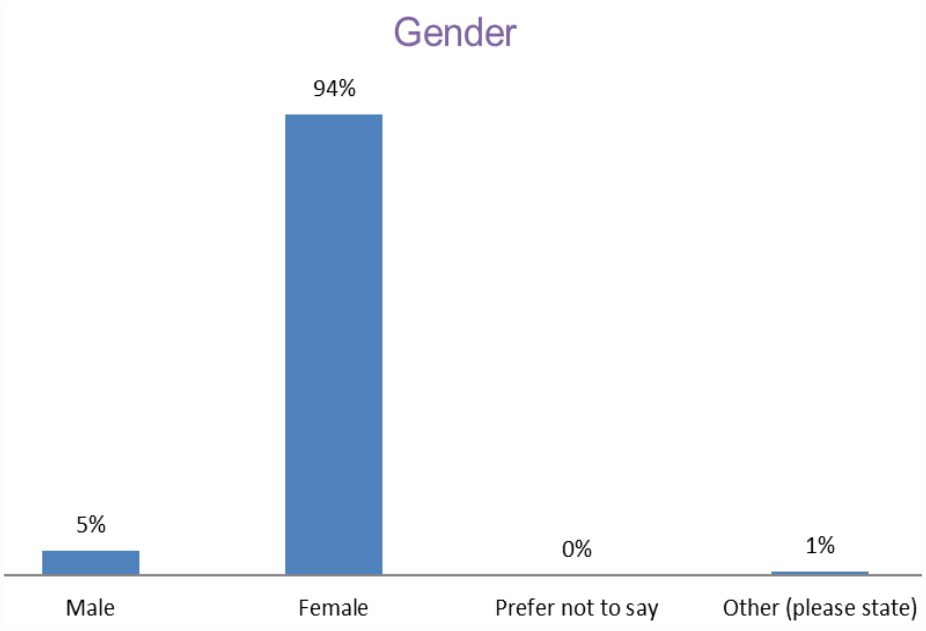

How satisfied would you be to access breast screening at Bath Street ?
70.37%
16.67%
7.41%
2.47%
1.85%
1.23%
Very satisfied
Satisfied
Neither satisfied nor dissatisfied
Dissatisfied
Very dissatisfied
Don't know

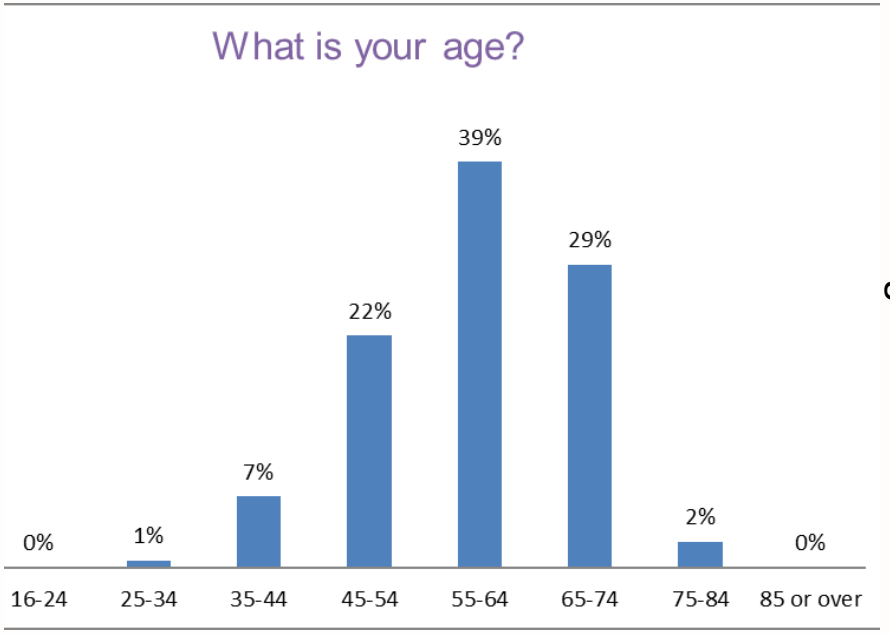

Which of the following are/would be most important for you?
4.53
4.28
2.61
3.14
2.21
4.44
Outcome of my treatment
Waiting times to access the service
The environment and facilities
The location of the service
Car parking
Staff expertise

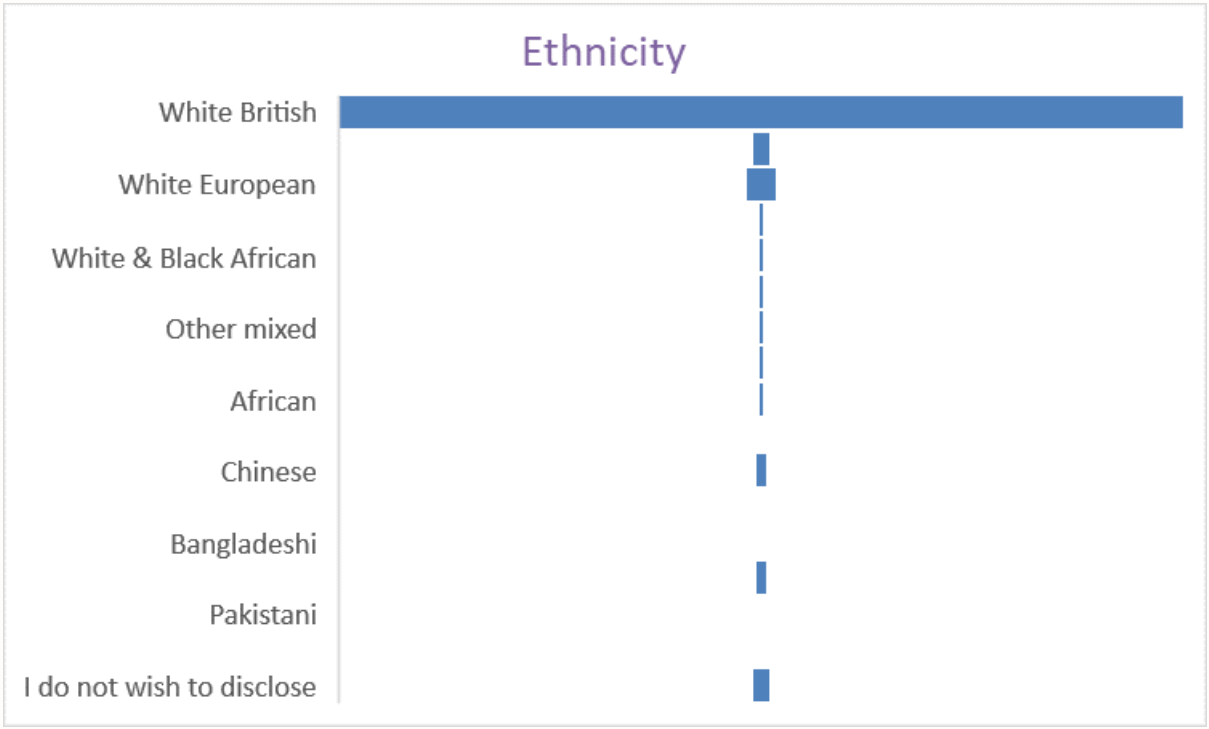
The Public Consultation – Summary Outcomes

- 94% participants had used the Breast Screening Service
- 65% participants had been made aware of the proposals
- 85% had enough information to form an opinion
- 75% would prefer to have their screening at Bath St.
- 87% would be very satisfied or satisfied to have screening at Bath St.
- Most important considerations are (1 is high):
  1. Outcome of screening
  2. Staff Expertise
  3. Waiting times
  4. Location
  5. Environment and facilities
  6. Car parking

Public Consultation Phase 2 - About the Participants

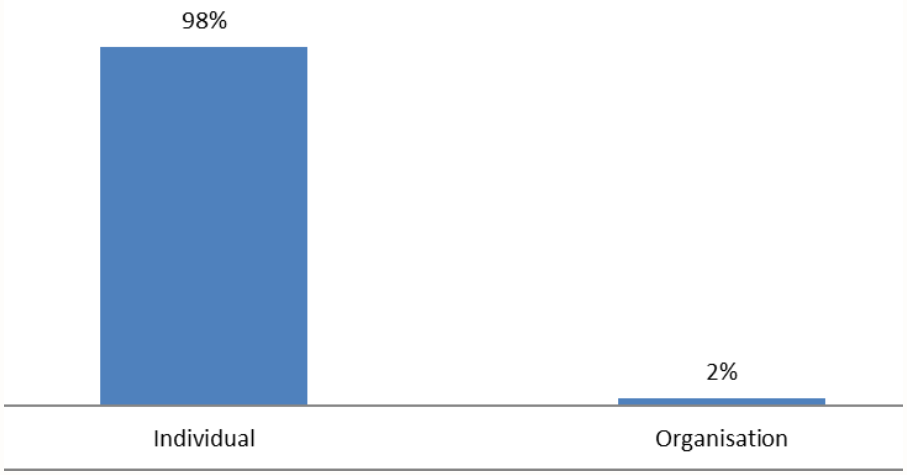




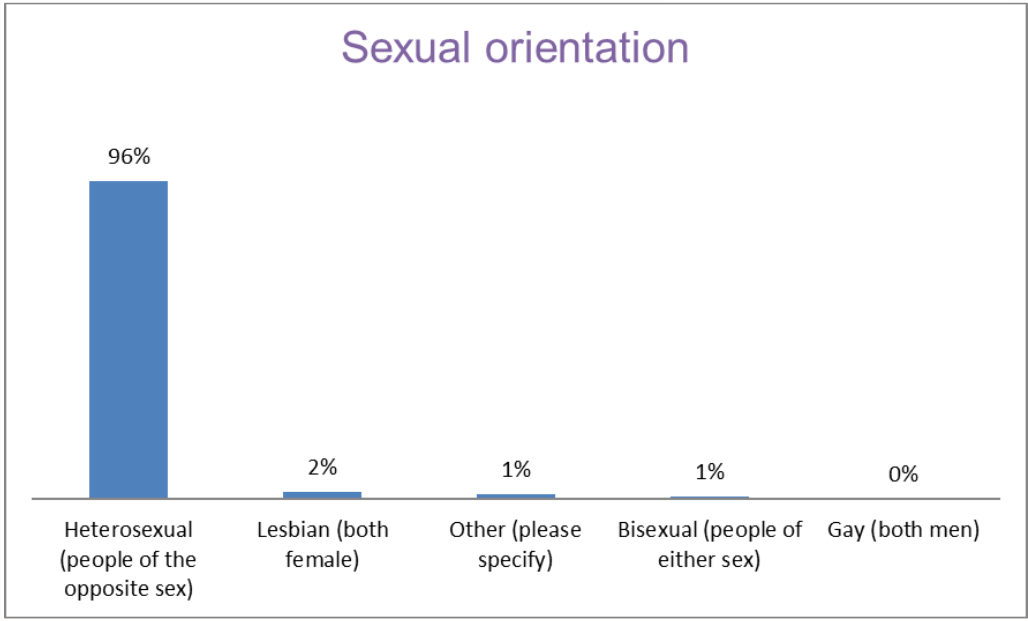


White British	142
White European	5
White Irish	3
I do not wish to disclose	3
Chinese	2
Indian	2
White & Black Caribbean	1
White & Black African	1
White & Asian	1
Other mixed	1
Caribbean	1
African	1
Other Black	0
Other Asian	0
Bangladeshi	0
Pakistani	0
Other Ethnic Group	0
Total	**163**

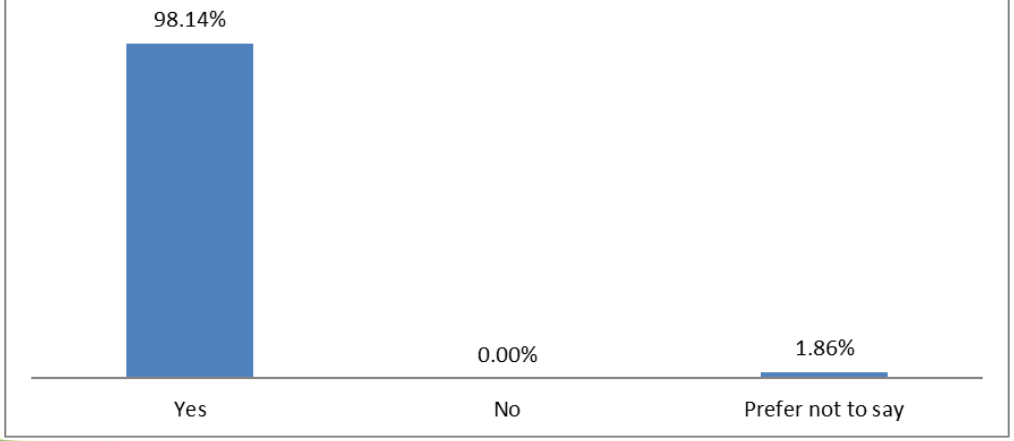
Are you completing the survey as an individual or representative of an organisation?

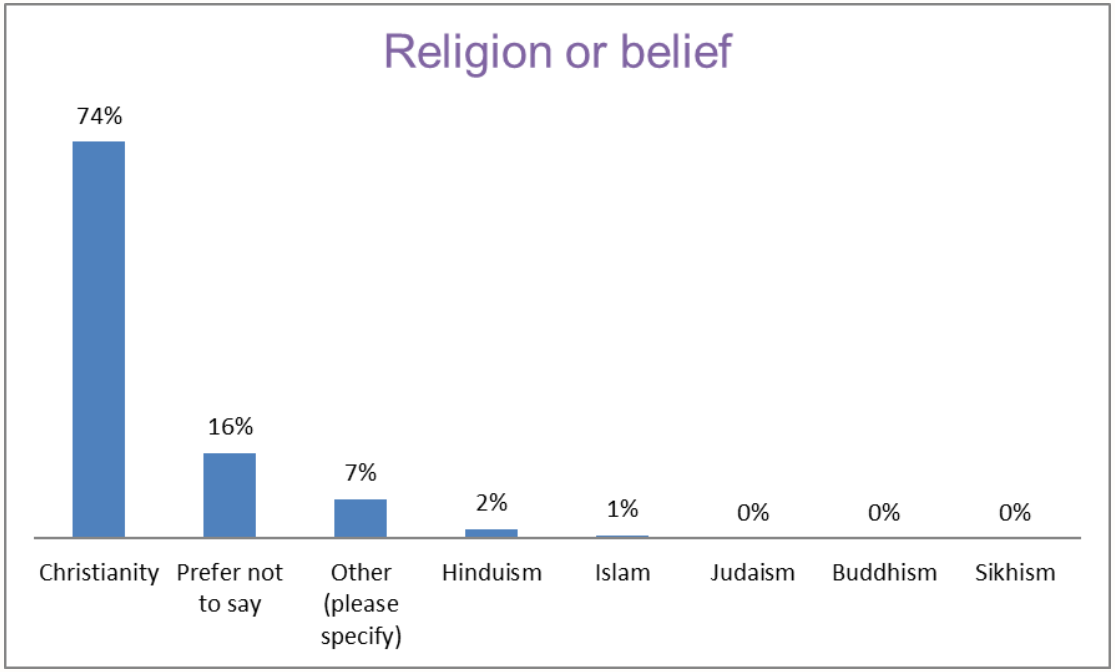


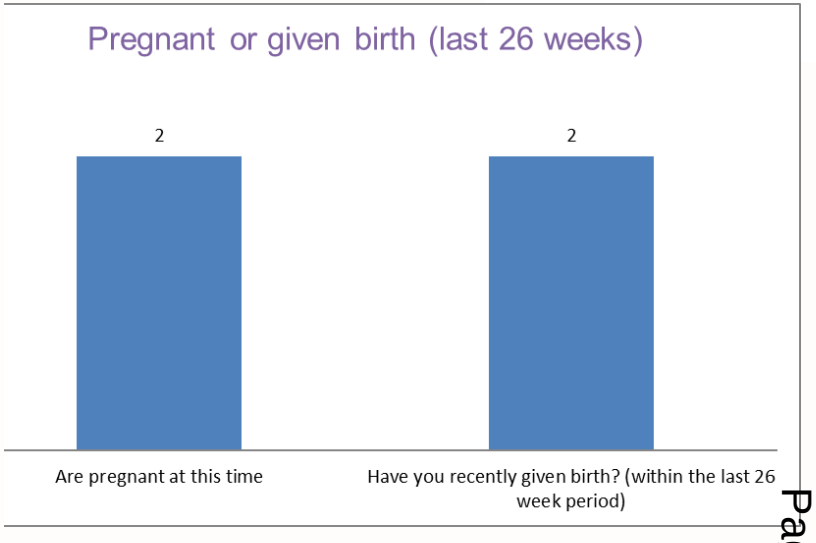
Sexual orientation

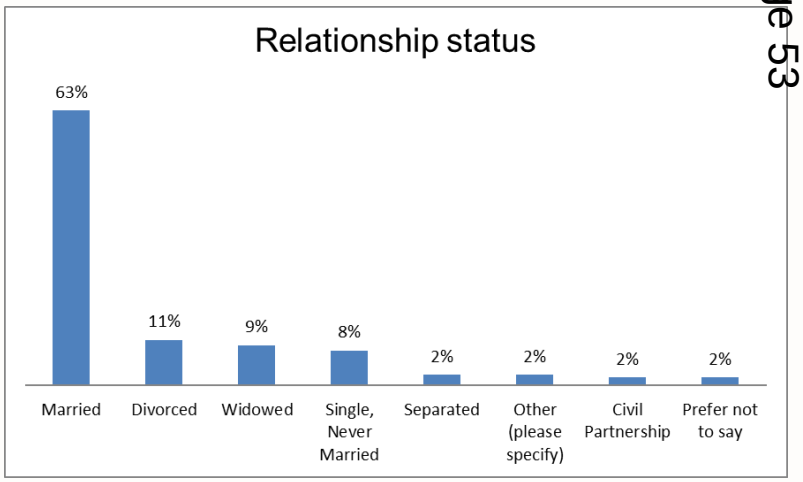


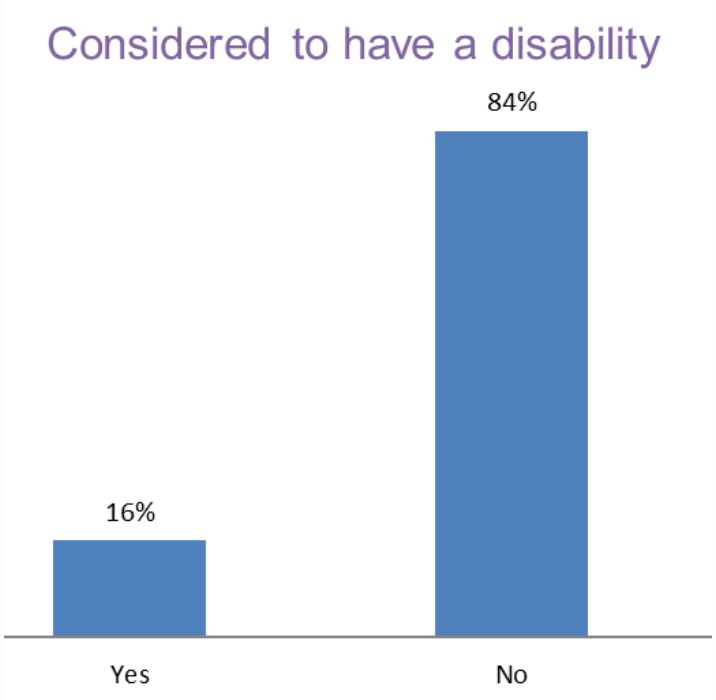
Do you identify as the same gender you were assigned at birth?

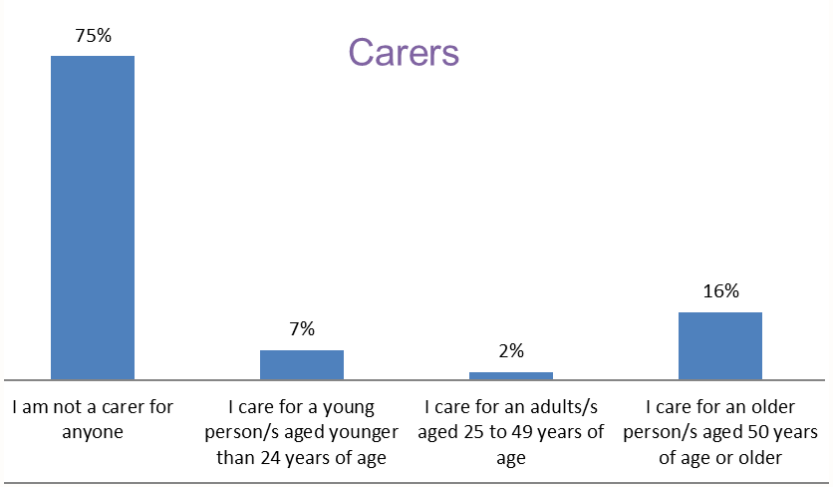



Religion or belief
74%
16%
7%
2%
1%
0%
0%
0%
Christianity
Prefer not to say
Other (please specify)
Hinduism
Islam
Judaism
Buddhism
Sikhism


Pregnant or given birth (last 26 weeks)
2
2
Are pregnant at this time
Have you recently given birth? (within the last 26 week period)


Relationship status
63%
11%
9%
8%
2%
2%
2%
2%
Married
Divorced
Widowed
Single, Never Married
Separated
Other (please specify)
Civil Partnership
Prefer not to say


Considered to have a disability
84%
16%
Yes
No


Carers
75%
7%
2%
16%
I am not a carer for anyone
I care for a young person/s aged younger than 24 years of age
I care for an adults/s aged 25 to 49 years of age
I care for an older person/s aged 50 years of age or older

The Public Consultation – Representation

- 94% participants were female
- 97% participants were in the eligible age range for breast screening
- 16% considered themselves to have a disability
- 25% cared for someone
- 2.5% had recently given birth or were pregnant
- Representative of patient population in religious belief, sexual orientation, gender identity, ethnicity and relationship status

2 organisations responded and 161 individuals

Next Steps/1

- Interrogate and classify valuable commentary and suggestions from 85 participants
- Produce themes and mitigating actions (where possible), cross-checking against the Equality Impact Assessment (see below, key themes from Phase 1)
- Produce Full Consultation Outcomes Report with Commissioners (CCG, NHSE Specialised Commissioning)
- Include all feedback from all Scrutiny committees
- Recommendations report to Trust Board
- Publish outcomes
- Implement/do not implement proposals – see Gunning Principles

Next Steps/2

- Recommendations report to Trust Board
- Publish outcomes
- Implement mitigations
- Implement/do not implement proposals – see Gunning Principles

Common Themes	Participant Feedback	Proposed solutions/ Action
Transport and Costs		
Accessibility		
Patient Choice		
Treatment and Care		
Communication		
Other		

Example

Questions

REPORT TO: Health Policy & Performance Board

DATE: 27th September 2022

REPORTING OFFICER: Strategic Director of Partnerships

PORTFOLIO: Adult Social Care

SUBJECT: Mental Health, Learning Disabilities and Autism

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to provide the board with information on Mersey Care NHS Foundation Trust's internal organisational developments, the local performance measures against national standards and to assure the board of the Trust's continuous pursuit of excellence with the borough.

2.0 RECOMMENDATION: That the Board:

i) Notes the organisational developments within the Mersey Care Operating model; and

ii) Notes the commissioning activity and performance for the borough against national standards.

3.0 SUPPORTING INFORMATION

3.1 Mersey care will present a series of slides within a Power Point Presentation covering the commissioned services within the borough of Halton. This slide show will cover Adult Mental Health services, Learning Disabilities and Autism.

3.2 Key performance Indicators and local data intelligence will be presented to the board and its partners to provide assurance and insights into the services as commissioned by NHS & HBC.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
The effective and efficient provision of related Services in Halton is directly linked to this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None associated with this report.

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NHS Foundation Trust

Community and Mental Health Services

Mersey Care in Halton
September 2022

Mersey Care NHS Foundation Trust
Presented by: Donna Robinson

Overview:

NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

- Introduction to Mersey Care
- Organisational Change
- Local structures
- Mersey Care Services within Halton
- Adult Mental Health Services
- Autism Assessment & Diagnostic Service
- Learning Disabilities
- IAPT services

Board of Directors

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

BEATRICE FRAENKEL

Chairman

JOE RAFFERTY

Chief Executive

ANYA AHMED

Non-Executive Director

SCOTT ETHERINGTON

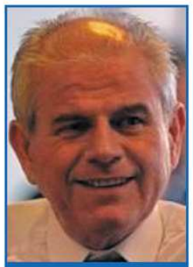
Non-Executive Director

MURRAY FREEMAN

Non-Executive Director

AISLINN O'DWYER

Non-Executive Director



GERRY O'KEEFE

Non-Executive Director

NICK WILLIAMS

Non-Executive Director

VACANT

Non-Executive Director

VACANT

Non-Executive Director

TRISH BENNETT

Executive Director of Nursing and Operations and Deputy Chief Executive of Clinical Services

ELAINE DARBYSHIRE

Executive Director of Communications, Corporate Governance and Estates

LOUISE EDWARDS

Executive Director of Strategy

CHRIS LYONS

Director of Strategic Programmes

AMANDA OATES

Executive Director of Workforce

NOIR THOMAS

Executive Medical Director

ROB COLLINS

Executive Director of Finance

NEIL SMITH

Deputy Chief Executive of Non Clinical Services

Voting Board member

Non-voting Board member

11_7_22

Bringing together our expertise to support our patient and service user's journey

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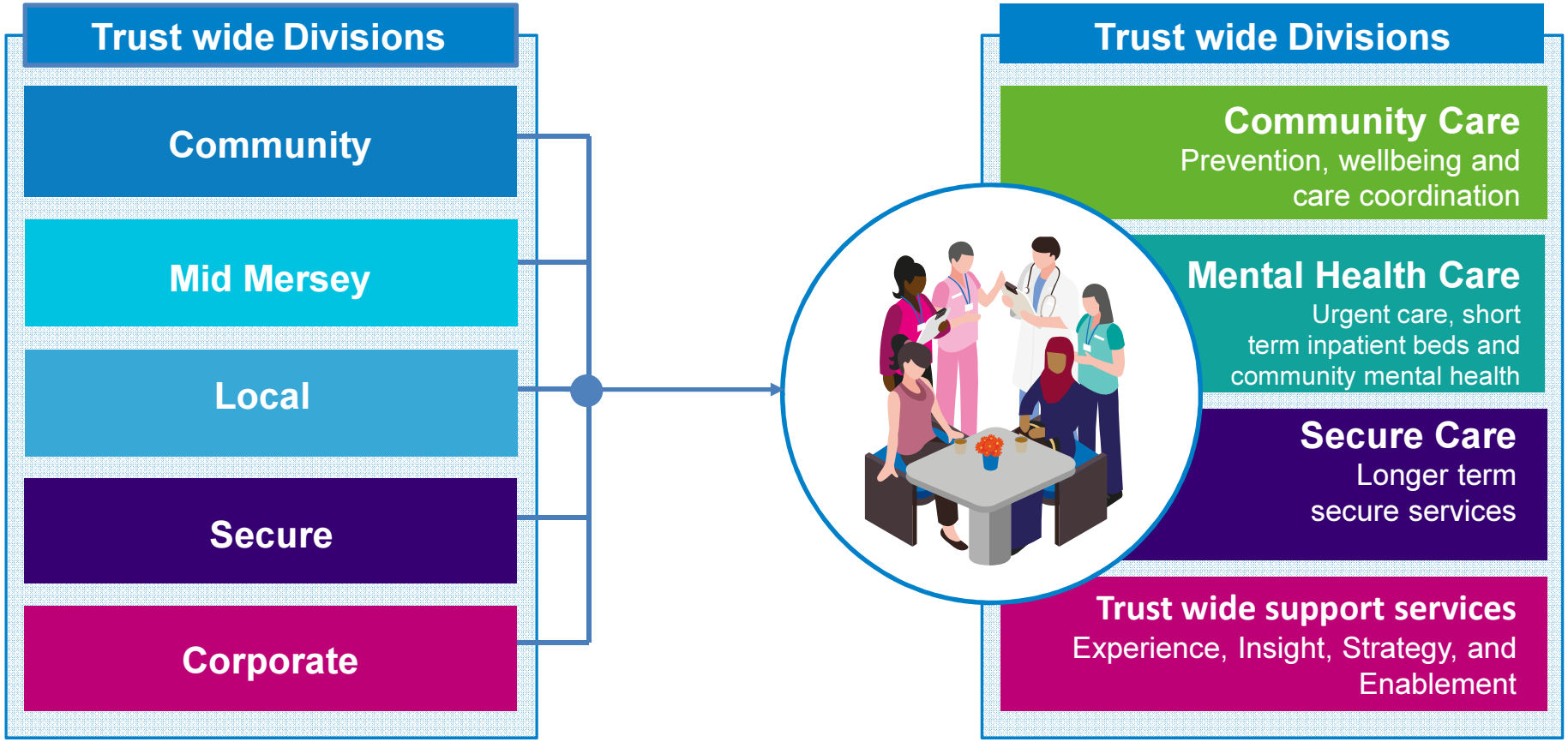
Initial step change, phase two to come



Operational management structure with place alignments

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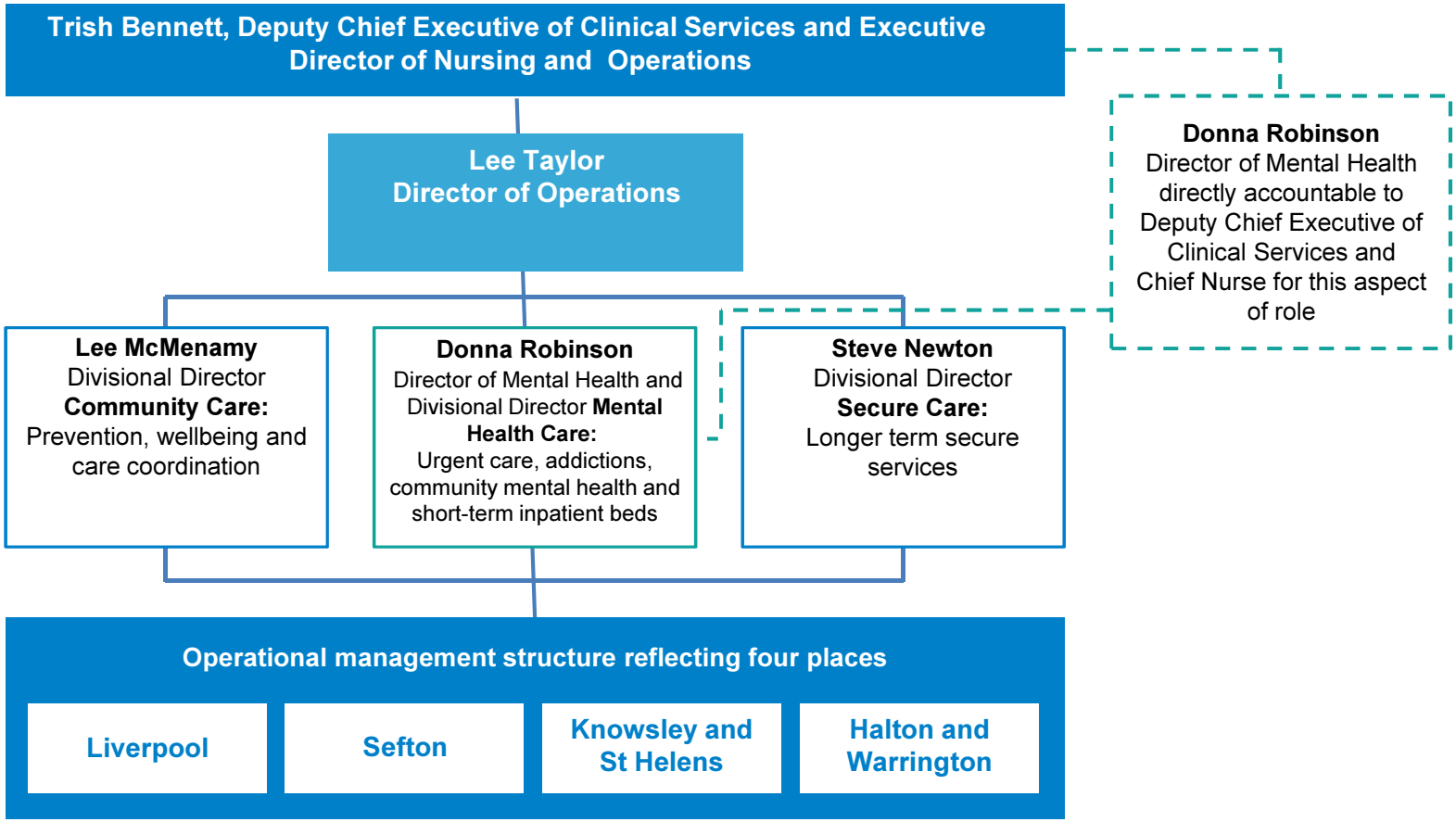

Halton Place Contacts

NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

Director of Operations

Lee Taylor, Director of Operations
Lee.Taylor@merseycare.nhs.uk

Mental Health Care

Donna Robinson, Mental Health Care Divisional Director
Donna.Robinson@merseycare.nhs.uk

Andy Williams, Deputy Divisional Director (Community Mental Health Services)	Andrew.Williams@merseycare.nhs.uk
Lyndsey Kelly, Deputy Divisional Director (Inpatient Capacity and Flow)	Lyndsey.Kelly@merseycare.nhs.uk
Lynn Hughes, Deputy Divisional Director (Urgent Care)	Lynn.Hughes@merseycare.nhs.uk
Zoe Prince, Associate Director of Nursing and Patient Experience	Zoe.Prince@merseycare.nhs.uk
Angela King, Associate Director of Strategic Operations	Angela.King@merseycare.nhs.uk

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Community and Mental Health Services

Mental Health Services- Halton

Mersey Care NHS Foundation Trust
Presented by:

Mersey Care Services Provided for Halton Residents

NHS Mersey Care NHS Foundation Trust

Community and Mental Health Services

Adults Community Services
Admiral Nurses.
Attention Deficit and Hyperactivity Disorder (ADHD).
Life Rooms
Building Attachment and Bonds Service (BABS).
Cheshire and Mersey Specialist Perinatal Service.
Early Intervention for Psychosis.
Later Life And Memory Services.
Mental Health Urgent Response Services
Primary Care Mental Health Service
Psychological Therapies Step 4
Recovery Team
Think Wellbeing (IAPT)

Learning Disability Services
Autism and Mental Health Support
Byron Unit - LD
Community Learning Disability Services
LD Intensive Support
Adult Inpatient Mental Health Services
Bridge Ward
Weaver Ward
Secure Mental Health Services
Cheshire Liaison Service
Chesterton Unit - Low Secure
Integrated Anti-stalking Unit
Marlowe Unit - Low Secure
Merseyside Criminal Justice Liaison
Tennyson Unit - Low Secure
Medium Secure Inpatient Services
High Secure Inpatient Services

Children's Services
Baby and Infant Bonding Support
C&YP Mental Health Service Community
C&YP MHS Assess and Response
C&YP Community Eating Disorder Service
C&YP CAMHS Community
Mental Health Support Teams (Schools)

Mental Health Care Division

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- 3 x service lines – community Mental Health (MH), inpatient capacity & flow, MH urgent care with named deputy directors
- Strengthened clinical & operational leadership
- Standardisation of processes – building on best practice across Mental Health, Physical Health and Learning Disability

Mental Health Urgent Care

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Community and Mental Health Services

24/7 Crisis Line:

We provide telephone support for people experiencing a mental health crisis.

This was and is an NHSEI strategy implementation as part of the 5 year forward view. It was 'planned' to go live in 2021. Due to the national pandemic, this initiative and crisis response service was requested with immediate effect following a national directive, thus it commenced Mid 2020.

24/7 Crisis Resolution Home Treatment Service :

Home Treatment Team provides intensive home support for adults with mental health problems in Halton to support them to manage their conditions in a community setting and prevent readmission to hospital.

CORE 24:

24/7 provision at our AED in the event of a MH crisis along side a medical condition.

Street Triage:

Supports with the strain on emergency services. This service provides an RMN and police officer who will support an individual who is in crisis and direct to the appropriate service.

Liaison & Diversion:

This service supports our custody suites in supporting individuals with mental health conditions working in conjunction with our partners in Cheshire Police.

Mental Health Inpatient Beds

Mersey Care NHS Foundation Trust
Community and Mental Health Services

Halton estate

Bridge ward – 17 bed acute
Weaver ward – 15 bed acute
Organic beds – provided on Hollins Park site

Areas to resolve

Functional older adult beds
Organic beds
Psychiatric Intensive care

Quality Improvements

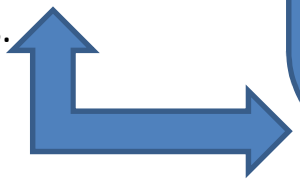
QRV visits conducted on each area
Action plans in place
Estates improvements needed

Community Mental Health Transformation

NHS Mersey Care NHS Foundation Trust
Community and Mental Health Services

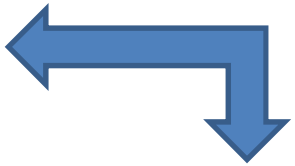
Halton Primary Care Mental Health Service (PCMHS)

- PCN ARRS (Annual Role Reimbursement Scheme) roles have been introduced in Halton.
- Runcorn and Widnes PCNs are covered by 3x Band 6 PCN ARRS practitioners based within GP surgeries. Line managed by Band 7 PCMHS Clinical lead.
- PCN ARRS offer:
  - assessment, signposting, support and onward referral (VCSFE sector, IAPT, other appropriate services).
  - up to 3 appointments,
  - for those with moderate mental health problems.



New DAILY 'bridging the gap' MDT meeting live on 4/7/22.

- Provides closer link between Primary and Secondary Care
- Attended by Recovery Team Practitioners, Complex care lead, PCMHS Clinical lead/representation from PCMHS, Psychiatry, Psychology.
- Referrals to MDT are triaged and pathway decision made.
- Quick decision making process.
- Trusted assessor model.



Halton Recovery Team

- Recovery Team are now accepting referrals from the Daily MDT for Routine Assessments.
- New low intensity intervention for those with personality related difficulties- Structured Psychological Support due to go live in September.
- 2x Band 7 Complex Care Leads, Band 6 Transformation Practitioner, 4 x Band 4 Assistant Psychologists recruited to assist in new model.
- Community Rehabilitation and Personality Disorder (RESP) Pathway developed.

Attention Deficit Hyperactivity Disorder (ADHD) service

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Who we are?

- Halton Adult ADHD Service provides assessment, diagnosis and treatment for adults with symptoms of attention deficit hyperactivity disorder (ADHD) in Halton and Knowsley. We can also signpost you onto other mental health services if you need any extra support.
- The team is made up of staff from a range of backgrounds, including medical, nursing and occupational therapy.

Challenges:

- The Team have seen a significant increase in referrals by approximately 3 times from the initial predicted referral rates
- Mersey Care are in discussions with the ICS place commissioner reviewing capacity and demand.

Autism Assessment & Diagnostic Service

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Who we are?

- Autism assessment and diagnosis Team, we provide autism assessments for adults who do not have a learning disability with a registered GP in Halton, Knowsley, St Helens or Warrington. We provide person centred reports with recommendations and make appropriate onward referrals.

Our Autism and Mental Health Support team provide:

- A time limited Consultation service to mental health practitioners working with autistic service users.
- Autism Awareness and Reasonable Adjustments training (we have currently trained over 2000 people).
- Support for Dynamic Support Database for Autistic People held within Mental Health teams

Our service currently have Support Workers, this is a 12 month proof of concept project following a successful bid to Transforming Care Programme. They aim to:

- Reduce any barriers for people with social communication difficulties accessing services (health, housing, employment, social care etc)

Challenges

- Current lack of post diagnostic group to support our client group and their carers upon receiving a diagnosis of autism
- Clients who's primary difficulties are around their autism struggle to access an appropriate service
- Referral numbers continuously increasing, the previous years around 450,on track to exceed 1200 for this financial year
- Lack of services within the community to support autistic adults.
- Difficulties within transition from CAMHS to Adult services in terms of assessment of autism.
- Lack of provision for sensory assessments and support.

Halton Community Learning Disability (LD) therapy team and intensive support function

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Community and Mental Health Services

The team is a specialist multidisciplinary health team including Psychology, Occupational Therapy, Speech and language therapy and Physiotherapy who work closely with social care colleagues to provide support to adults with learning disabilities and mental health difficulties, complex behavioural needs, autism spectrum conditions, epilepsy and profound and multiple learning disabilities

The team also has an intensive support function with an overall aim of providing extra support for service users in the community to reduce the need for hospital admissions when this is not really required in line with Transforming Care agenda

Challenges:

- Recruitment challenges – particularly Clinical Psychology
- Differential configuration of Community LD team in Halton – nursing team sat within local authority

Next steps:

- Development of Trust wide learning disability and autism strategy with investment in strong LD clinical leadership structure
- Opportunity for joint working and sharing good practice with colleagues across Merseyside within the local community LD structure
- Halton LD team have received Transforming Care Partnership funding for proof of concept around sensory integration across mid-Mersey LD teams

Think Wellbeing Service – (IAPT)

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Community and Mental Health Services

Think Wellbeing Service is for adults aged 18 and over with common mental health problems like mild to moderate depression, anxiety and stress. We can help with other problems like panic attacks, phobias and post traumatic stress disorder.
Our service is available for anyone who lives within Runcorn or Widnes or who is registered with a Halton GP.

Challenges:

- Increase demand in patients that require interpreter and challenges around resourcing appropriate interpreter.
- Recruitment & Retention of workforce

Next Steps:

- Long Term Conditions (to support national increase of prevalence target)- *Will work with system colleagues to implement this in a manageable way.*
- Working with other IAPT teams within the Trust and External Partners in Acute Trusts to develop Long Term Conditions treatment pathway.

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NHS Foundation Trust

Community and Mental Health Services

Questions

,

REPORT TO: Halton Health Policy & Performance Board (PPB)

DATE: 27th September 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 policy and performance 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.

3.0 SUPPORTING INFORMATION

BACKGROUND

3.1 All Together Fairer was presented at an event by Sir Michael Marmot 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 was written by Sir Michael and his team of researchers in partnership with Cheshire and Merseyside's local authorities. The executive summary is available via this link https://www.champspublichealth.com/wp-content/uploads/2022/05/Cheshire-and-Merseyside_Executive-Summary-FINAL.pdf

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. They conducted the Strategic Review of Health Inequalities in England and

published the 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 that set out how little progress had taken place over the intervening years.

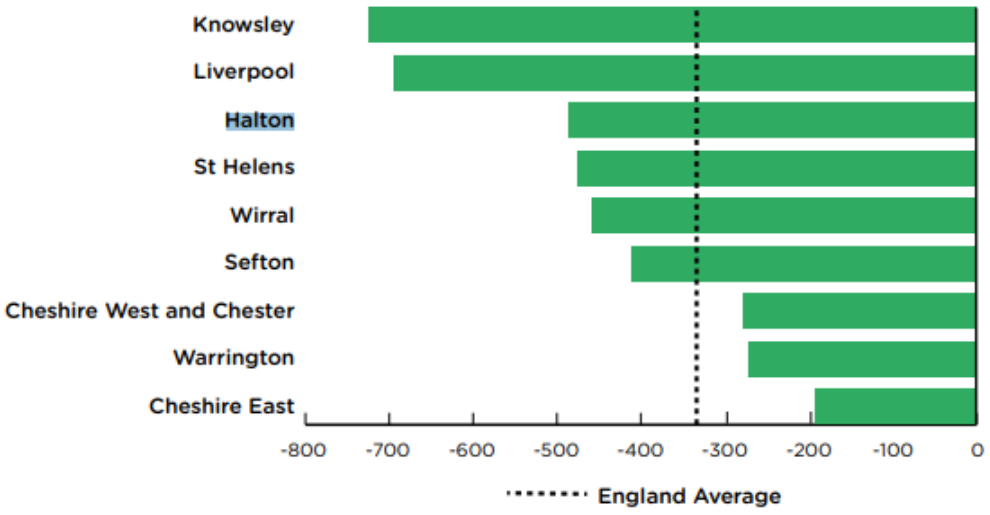
4.0 Implications for Halton

4.1 Half of Halton's residents live in areas among the 20 percent most deprived in England. 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.

4.2 The spending power of local authorities in real terms has fallen significantly between 2010 and 2018. The spending power (real terms), per head of population, Cheshire and Merseyside lower-tier local authorities and England 2010-2018 is shown below in Fig 1.

After Knowsley and Liverpool, Halton has been most impacted with spending power loss being much higher than loss on average across England.

Fig 1. Change in local authority spending power (real terms), per head of population, Cheshire and Merseyside lower-tier local authorities and England, 2010-18



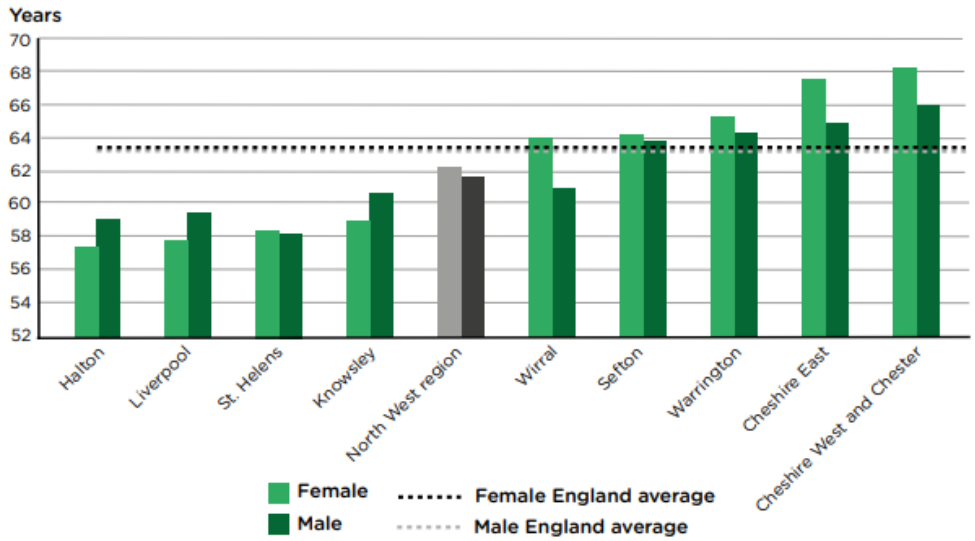
Source: *Ministry of Housing, Communities & Local Government (9)*

Researchers from the University of Liverpool 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.

4.3 The report also questions the allocation of allocation of Levelling Up funding as it does not necessarily follow need. Despite being identified as a local authorities in the highest priority category Halton has been placed in category 2, which is lower than some more relatively affluent locsl authorities.

4.4 Healthy life expectancy is the average number of years an individual is The figure below shows women in Halton and Liverpool boroughs are six years below the national healthy life expectancy average that is 63 years.

Fig 2. Female and male healthy life expectancy at birth, Cheshire and Merseyside lower tier local authorities, North West region, and England 2018- 2020.



Source: Office for National Statistics. (90)

4.5 Other areas where Halton had a lower than the England average experience included :

- Percentage of children achieving a good level of development at the end of reception, (figures from 2018/19)
- Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0 to 14, (figures from 2022/21)
- Rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24, (figures from 2022/21)
- Children eligible for Free School Meals perform below the average across all measures of educational attainment.
- Average weekly earnings in Halton for people aged over 16 are among the lowest in the region
- Higher rates of children in relative poverty households compared to the England average. 18.5% of Halton residents live in poverty
- Estimated levels of fuel poverty is above the England average
- Lower rates of physical activity including walking and cycling
- Low Public transport use for work
- Higher rates of obesity and smoking, including at time of delivery

It is noted in the report that Halton, alongside Knowsley and St Helens is still experiencing the long-term effects on unemployment from the recession of 2008.

4.6 Areas where Halton performed as well as or better than England average

- the number of jobs per resident aged 16 to 64, is similar to the national average
- The rate of long term claimants of Jobseeker's Allowance, (aged 16 to 64) is one of the lowest in C&M and lower than England average
- Low reported homelessness
- Lower deaths from drug misuse
- Lower deaths due to exposure to poor air quality

4.7 Whilst Halton is not very ethnically diverse, the report highlighted the adverse experience through educational attainment, employment and income as well as health experienced by people from ethnically minority populations.

4.8 Using modelling it is estimated by 2080 that the climate in 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. Halton has higher than England average for carbon dioxide emissions per capita

5.0 **Actions required**

As is evident from the foregoing, whilst the impact of the economic and social environment has affected people's health and wellbeing. The actions required to make a positive change cannot come from the health system. There is a general acknowledgement through the Marmot report that to make any change the following "Marmot 8 principles" should be adopted:

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

The Marmot Report sets out recommendations at system as well as local place level and suggests the lead organisation for a number of these. It is acknowledges that financial pressures mean that organisations would need to work in partnership and that the recommendations most relevant to their area should be the focus of action.

6. 0 **Examples of action already in place**

6.1 **Work taking place at One Halton Level**

- CORE20Plus5 work with local voluntary sector CVS. CORE20Plus5 is a national approach to support the reduction of health inequalities. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. Halton secured additional funding to develop a partnership approach across local authority, NHS and CVS to target the most vulnerable and hard to reach

6.2 **Work taking place at local authority level**

- **Transformation work looking at early years outcomes** in bringing systems together to develop equitable early interventions
- Development of **Family Hubs** has started
- **Holiday Activity Fund** provides meals and activities for children during school holidays
- **Compendium of sources of support** on offer for people struggling with current financial crisis.
- Linked to networks to enable sharing of best practice at local as well as national level.
- **Lifestyle survey** to gather additional information in people's lifestyle choices commissioned
- Halton's Health Improvement Team has partnered with a range of stakeholders to **target health advice to unemployed people, asylum seekers and refugees** offer includes NHS Health check, smoking, vaccination, alcohol.
- The **Public Health Bus goes into underserved community** providing a range of advice and signposting to other sources of support
-

6.3 **Work taking place a regional "system level"**

- **Establishment of a multi-agency Board** and local leads group to ensure action at local and system level. Halton is well represented
- Ongoing work with local acute NHS trusts on **anchor institutions** work and Prevention pledge,
- Recommendations into the ICB / Place Strategy.
- The **System P programme** is using data and analytics to provide insight and inform future plans Halton is supporting the programme, an area of study: Complex Families Mental Health is underway across C&M. Halton Public Health analyst linked in.
- **Community of Practice** established to encourage collaboration, share learning and best practice
- **Completion of an evaluation** of NHS Prevention Pledge by the Institute of Health Equity to inform future delivery
- Completion of the Cheshire and Merseyside '**Citizen's Inquiry on Alcohol'**,
- Implementation of early identification of Alcohol Related Liver Disease (ARLD) **liver scan pilot**. The programme enabled 50 frontline staff to be trained and more than 600 liver scans completed.

- Over £200k funding secured from NHSE/I for the 'Early identification of co-occurring **Alcohol and Mental Health disorders' (ExAMH) project,** which is aimed at preventing people 'falling through the gaps' when they need access to concurrent interventions
- Development of a **Cheshire and Merseyside Physical Activity Strategy**, undertaking a two-phase consultation and engagement process in order to secure system wide and public buy-in. Led by the two Sports Partnerships,
- Implementation of the **BP@Home/national Blood Pressure optimisation programme**
- **Commissioning of the Suicide Bereavement service Amparo,** with 132 referrals being made during 2021 and 2022.
- In 2019 Liverpool City Region declared a climate emergency, pledging the region to reach net zero carbon by 2040.

Note that these are just a few examples, as the reach and ambition is wide.

7. 0 **Marmot Indicators**

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.

Life expectancy	
1 Life expectancy, female, male	
2 Healthy life expectancy, female, male	
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)	
4 Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	
Enable all children, young people and adults to maximise their capabilities and have control over their lives	
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	
Create fair employment and good work for all	

10 Percentage unemployed (aged 16-64 years)
11 Proportion of employed in permanent and non-permanent employment
12 Percentage of 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
Ensure a healthy standard of living for all
14 Proportion of children in workless households
15 Percentage of individuals in absolute poverty, after housing costs
16 Percentage of households in fuel poverty
Create and develop healthy and sustainable places and communities
17 Households in temporary accommodation
Strengthen the role and impact of ill health prevention
18 Activity levels
19 Percentage of loneliness
Tackle racism, discrimination and their outcomes
20 Percentage of employees who are from ethnic minority background and band/level***
Pursue environmental sustainability and health equity together
21 Percentage (£) spent in local supply chain through contracts***
22 Cycling or walking for travel (3 to 5 times per week)

***12, 20 and 21 do not as yet have routinely collected data

8.0 POLICY IMPLICATIONS

8.1 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.

8.2 The social determinants of health are the focus of the eights recommendations of the report

9.0 FINANCIAL IMPLICATIONS

9.1 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.

10. IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

10.1 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.

10.2 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

10.3 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.

10.4 A Safer Halton

As above

10.5 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

11 RISK ANALYSIS

There are no major risks associated with the report.

12 EQUALITY AND DIVERSITY ISSUES

13.1 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 and inequalities on health.

14 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

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ACKNOWLEDGEMENTS

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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.

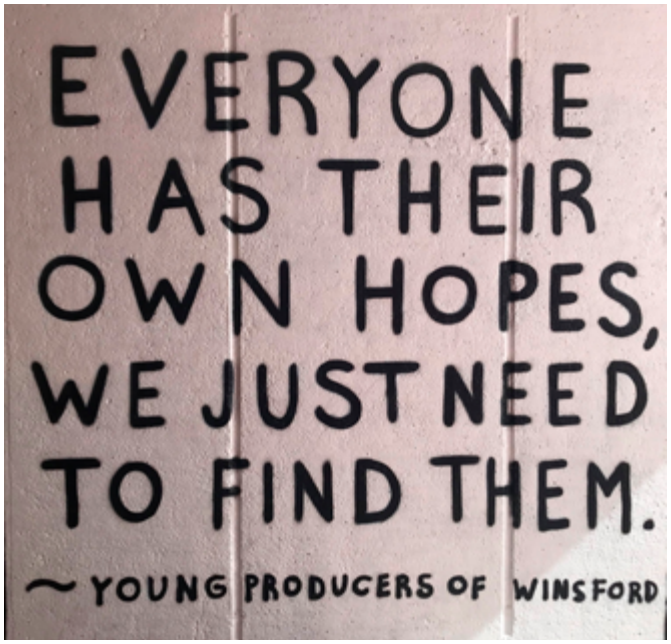
The workshops identified priorities and whilst all eight Marmot themes were discussed, there was a high level of agreement about key issues to address in Cheshire and Merseyside: providing good quality work and improving aspirations; decreasing poverty; improving housing and local places; and identifying 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".

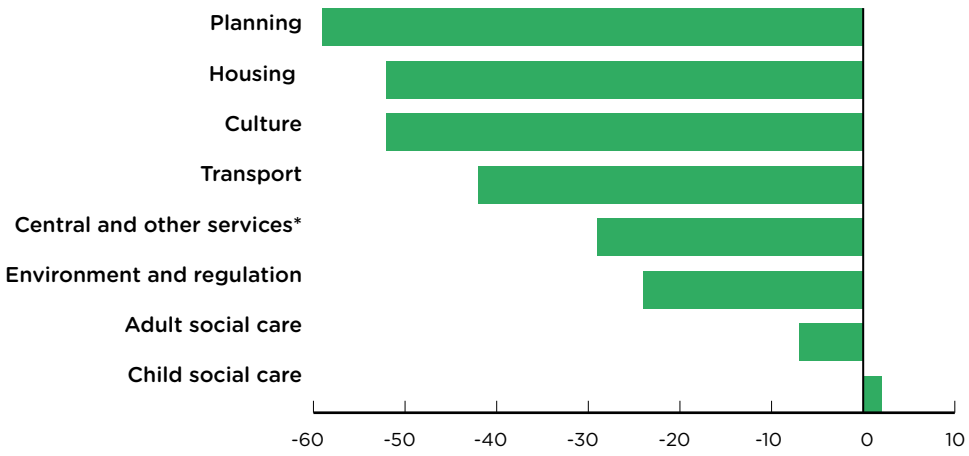
Our work in Cheshire and Merseyside — including this report, indicators and recommendations — provides momentum for these actions, as well as offering additional approaches to be implemented at pace and over the long-term. These require effective collaboration and partnerships between the NHS, local 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



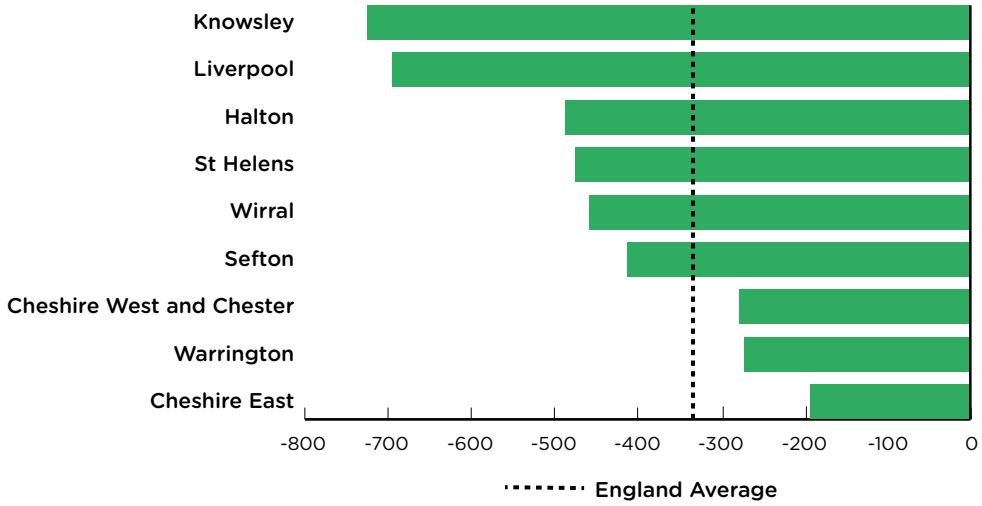
Notes: *Services such as council tax administration and corporate services*

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

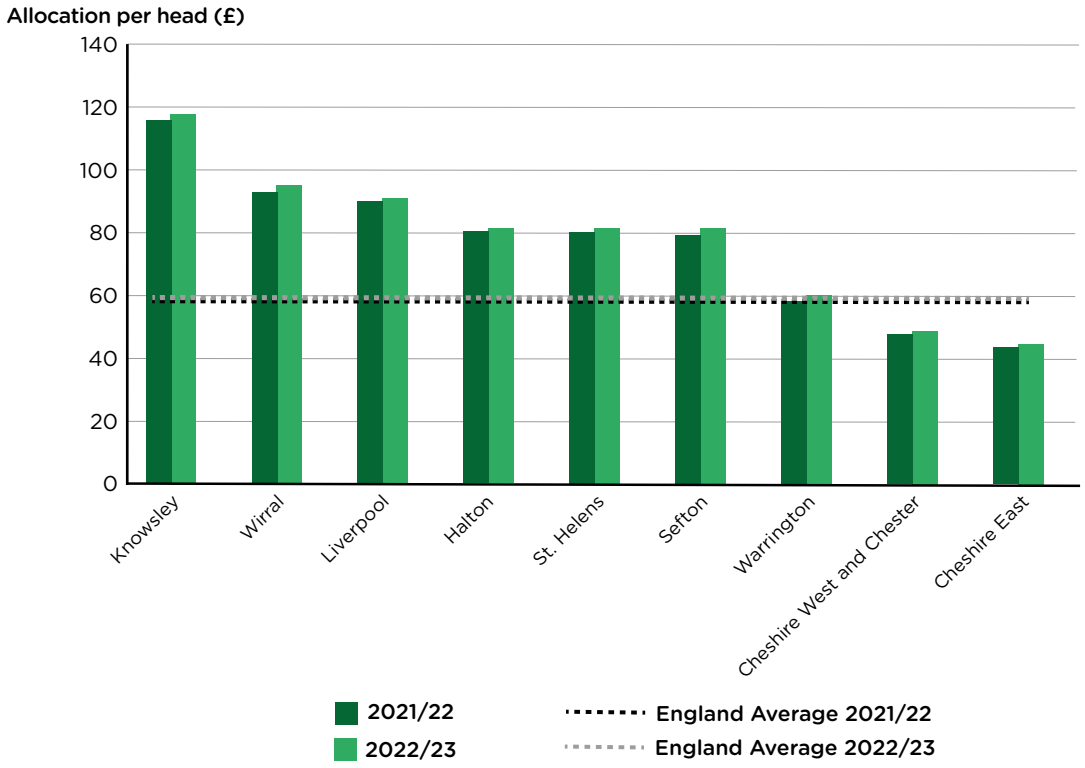
The public health grant had already declined significantly before the pandemic. The Institute for Public Policy Research (IPPR) estimates that there was an £870-million decline in net expenditure to public health services (such as sexual health, obesity, physical activity, and drug and alcohol services) 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.

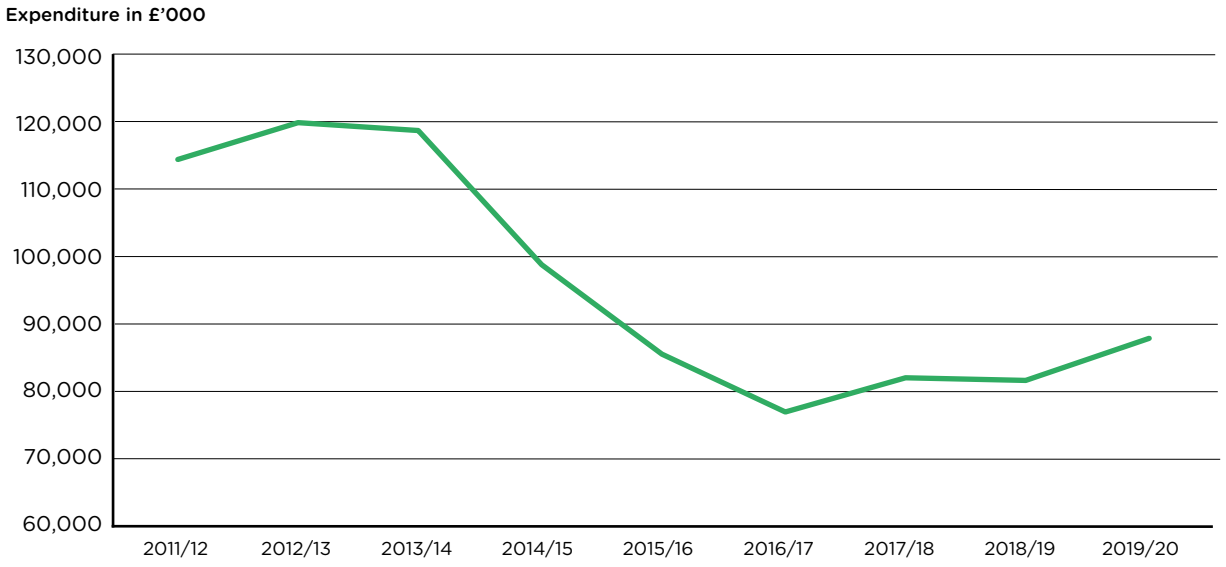
MVRP developed additional guidance for schools to use when considering permanent exclusion. By highlighting the principles, consequences and identifying local level support, MVRP sees this guidance as a valuable tool to assist schools when undertaking decisions about exclusion.

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

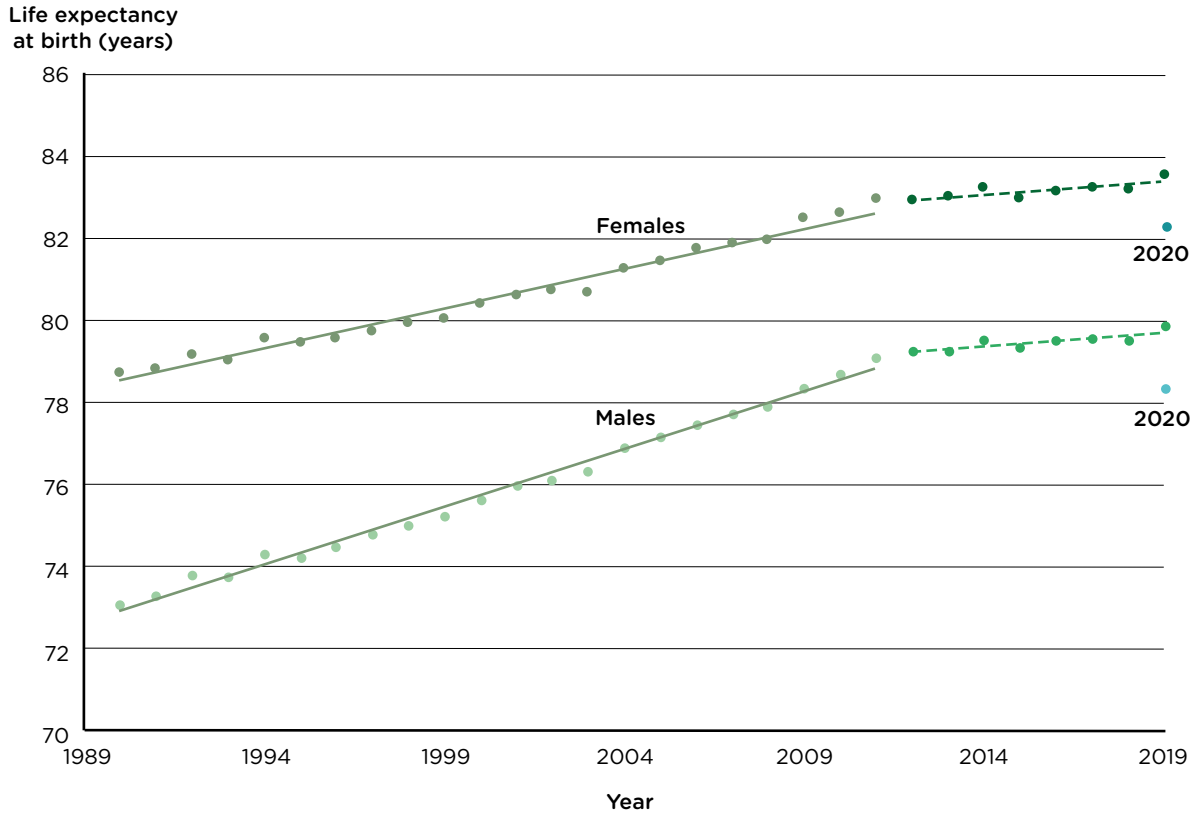
HEALTH INEQUALITIES IN CHESHIRE AND MERSEYSIDE

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.

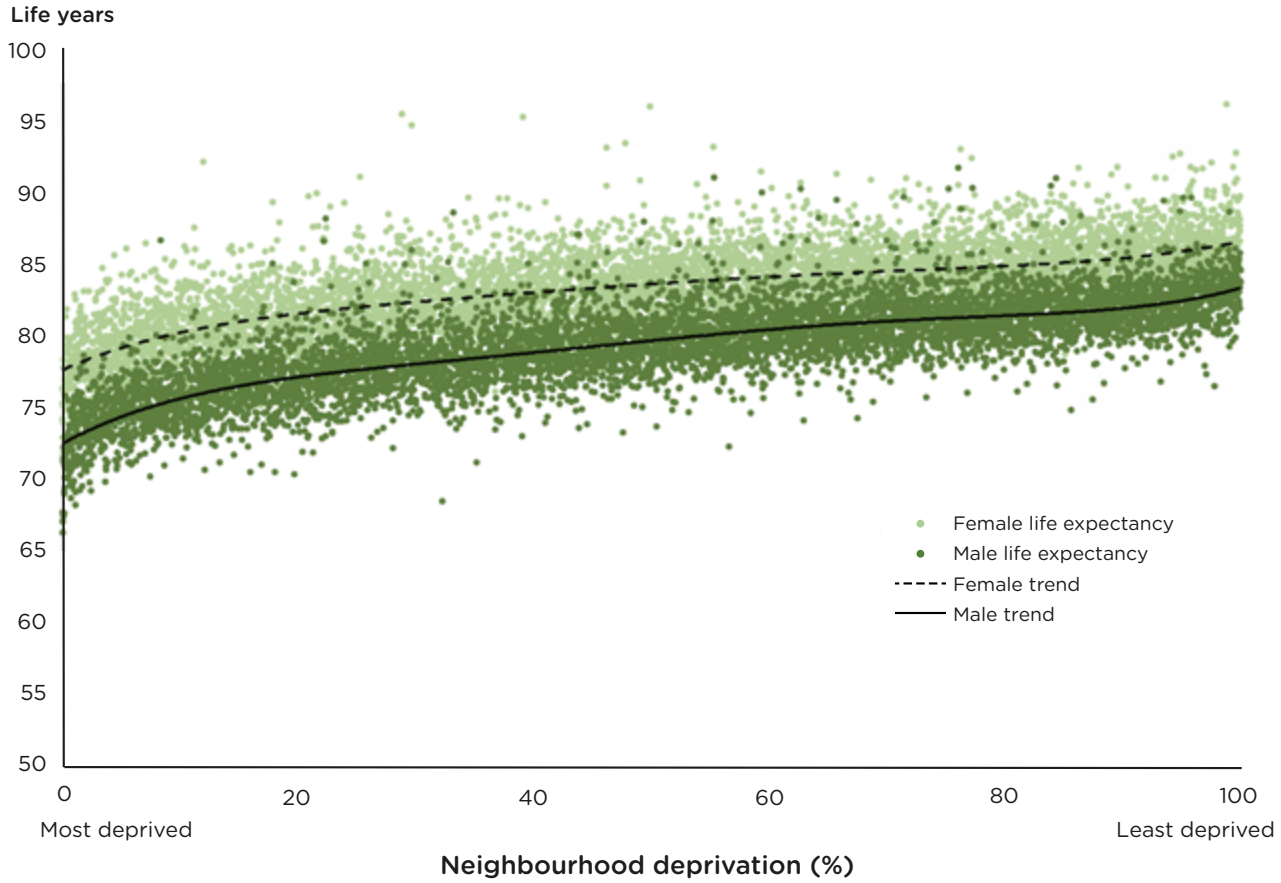
Figure 3.1. Life expectancy at birth for males and females, England and Wales 1989-2020



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

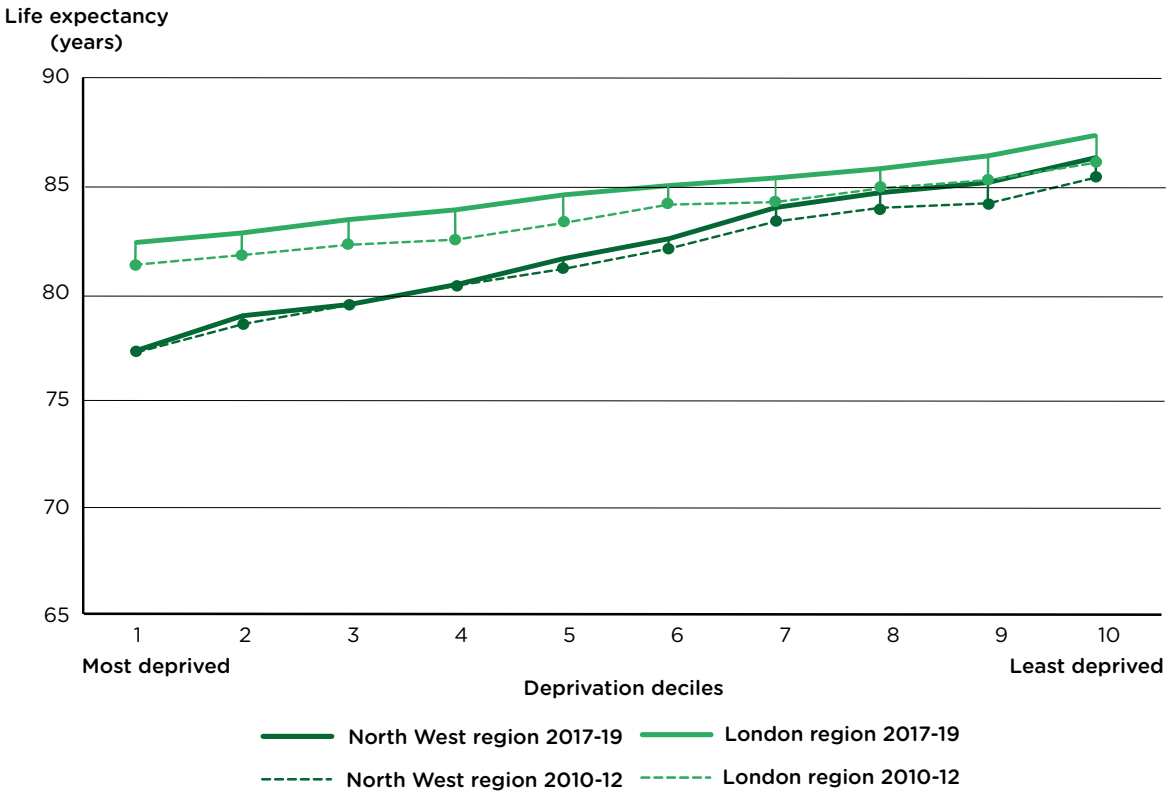


Notes: *Each dot represents life expectancy (LE) or disability-free life expectancy (DFLE) of a neighbourhood (middle level super output area)*
Source: *Office for National Statistics (ONS) and Department for Work and Pensions (85) (86)*

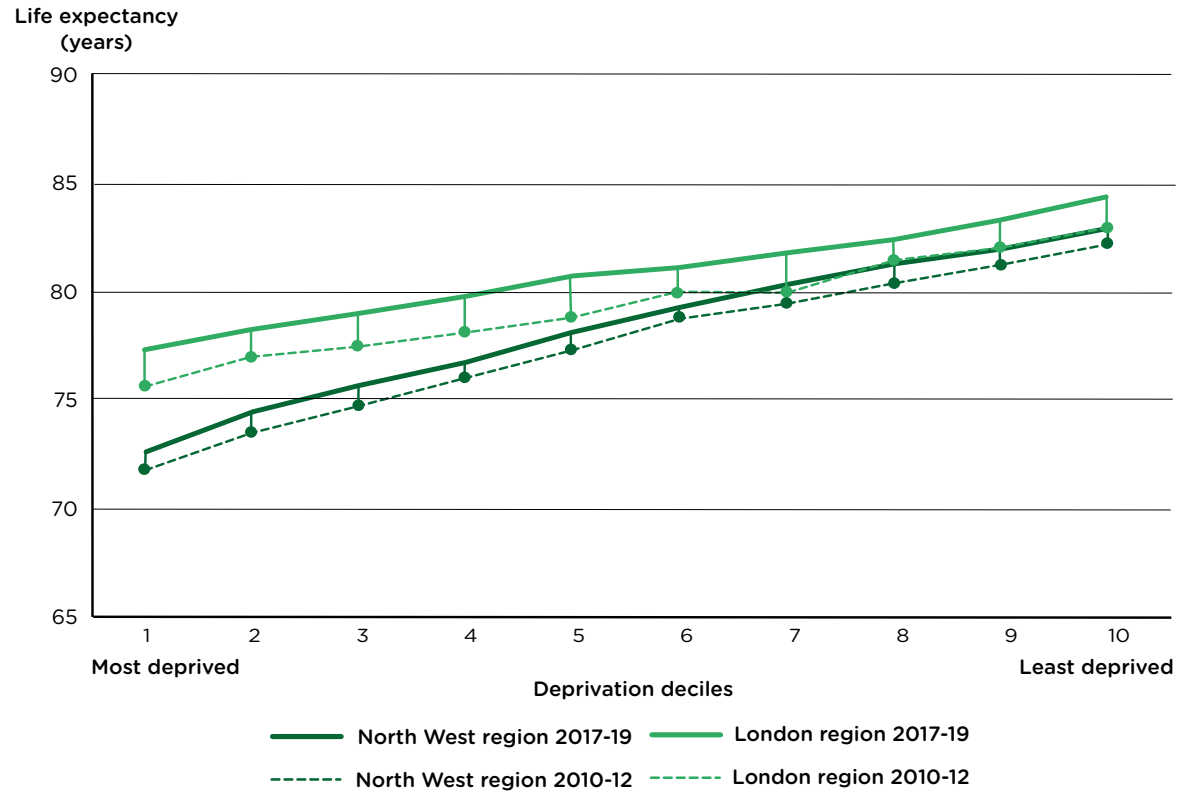
The 2020 *10 Years On* report showed the differences in life expectancy between England's regions. From 2010, London's life expectancy increased more rapidly than other regions. Figures 3.3A and 3.3B show life expectancy in the North West region is lower than London, and that there is steeper gradient 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



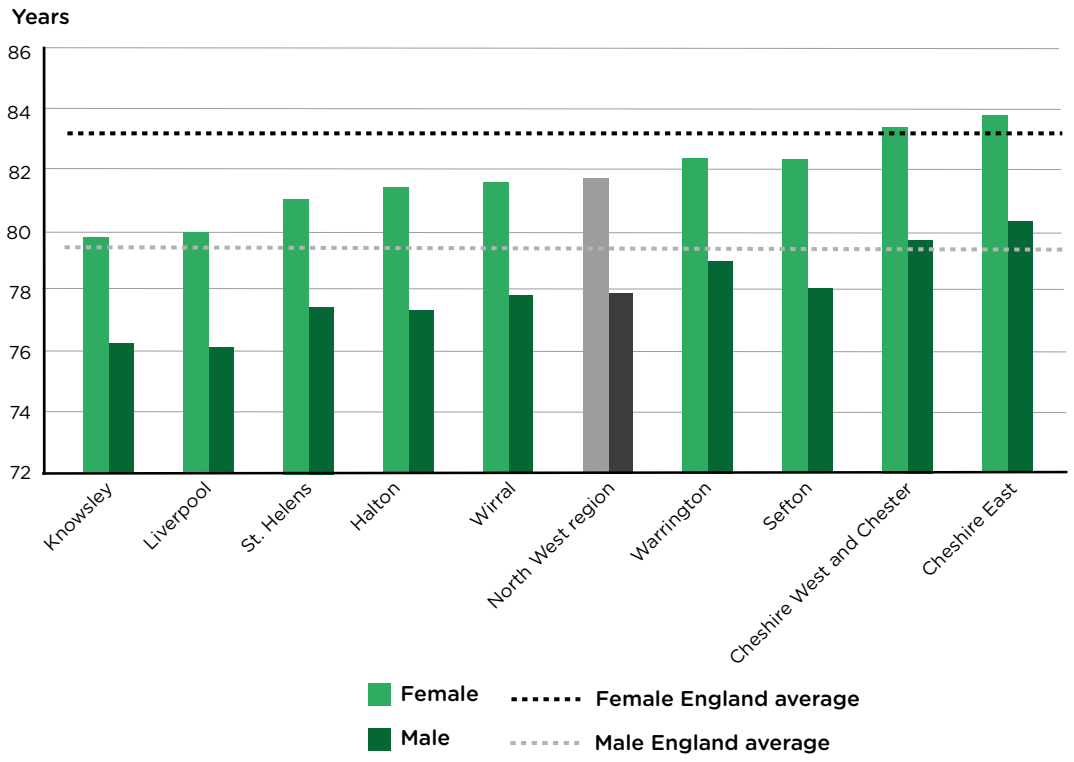
Source: *Based on PHE, 2020 (87)*

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.

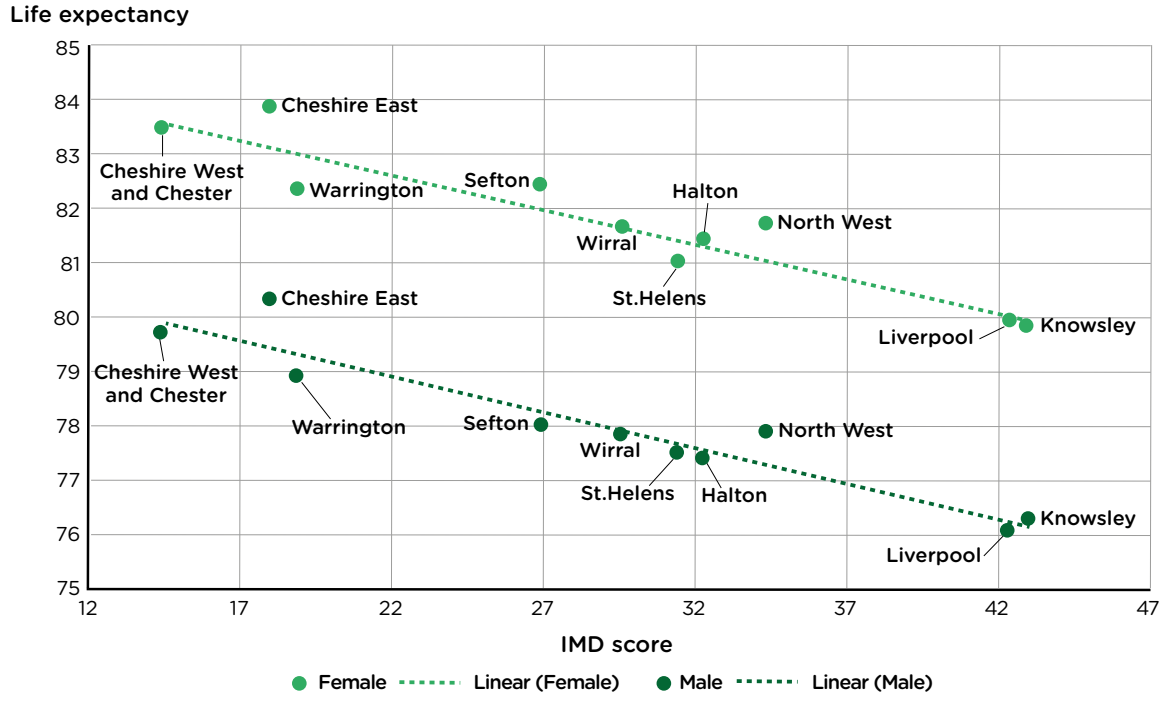
Figure 3.4. Estimated male and female life expectancy at birth, Cheshire and Merseyside lower-tier local authorities, North West region, and England, 2018–20



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

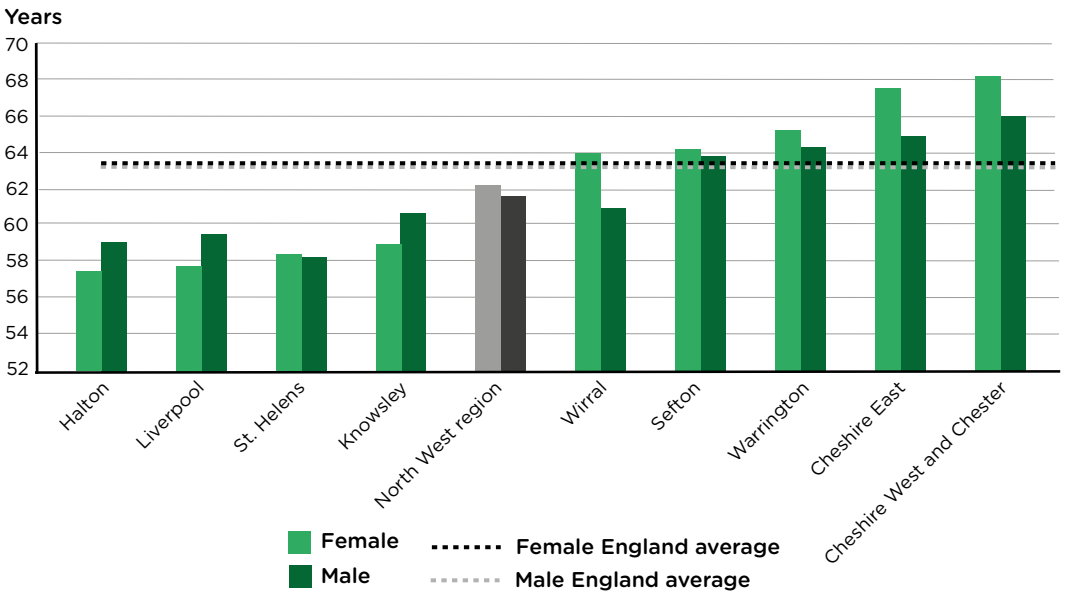


Source: *Office for National Statistics. (90)*

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

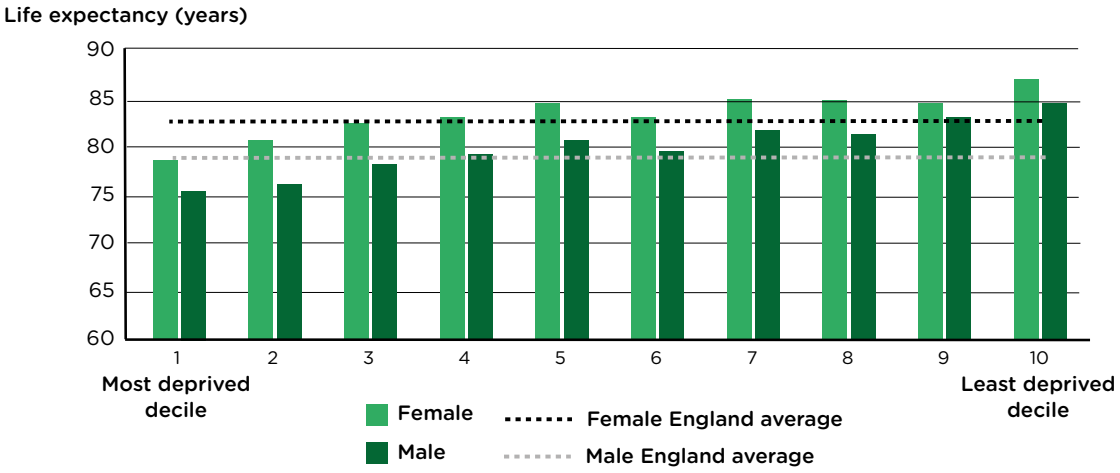
Within local authorities in the region, there is a life expectancy gap of more than 10 years between the least and most deprived deciles. In Wirral, measuring 60 square miles and with a population under 350,000, men in the most deprived quintiles live 13.8 years less than men in the least deprived quintiles. 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

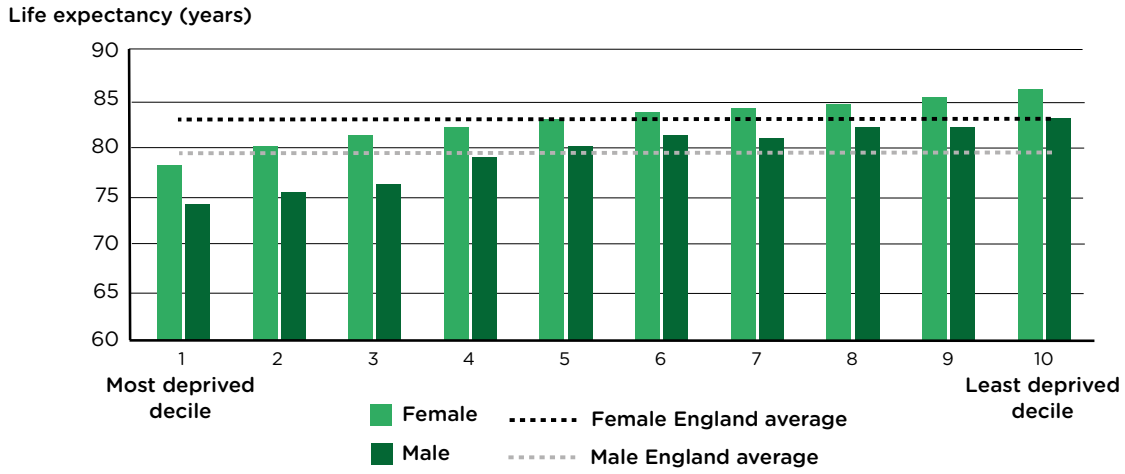


Source: *Office for National Statistics (90)*

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

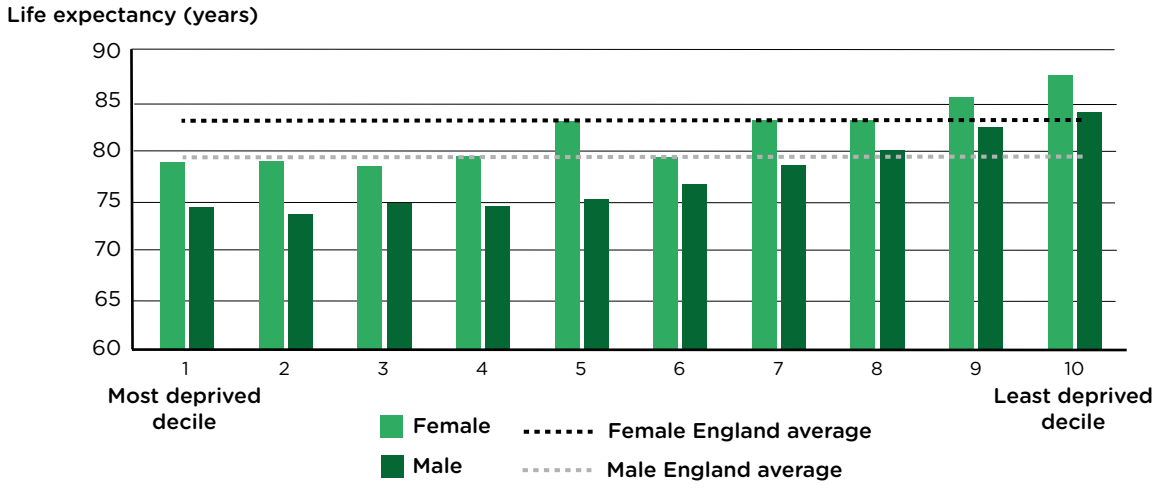


Source: *Office for National Statistics (90)*

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

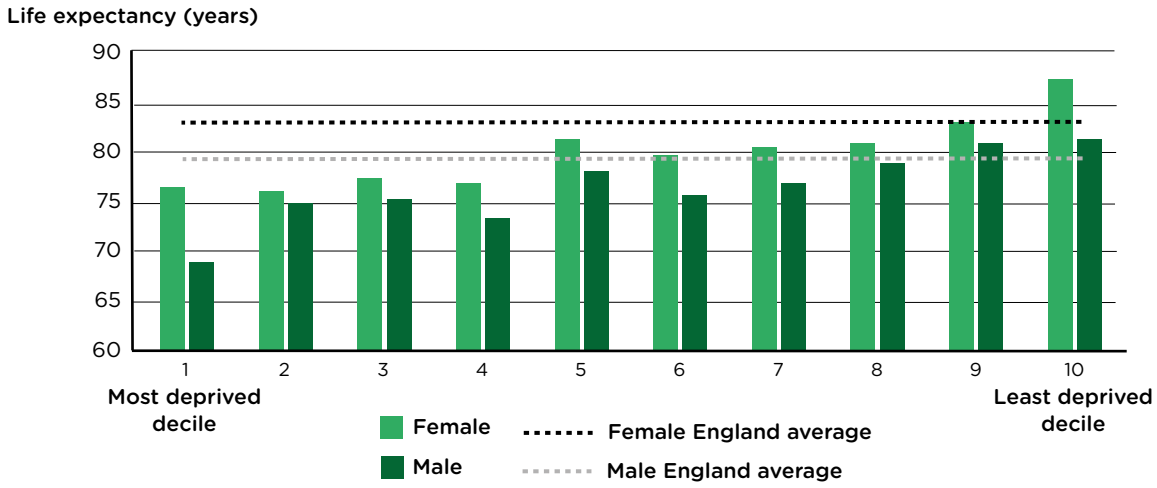


Source: *Office for National Statistics (90)*

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

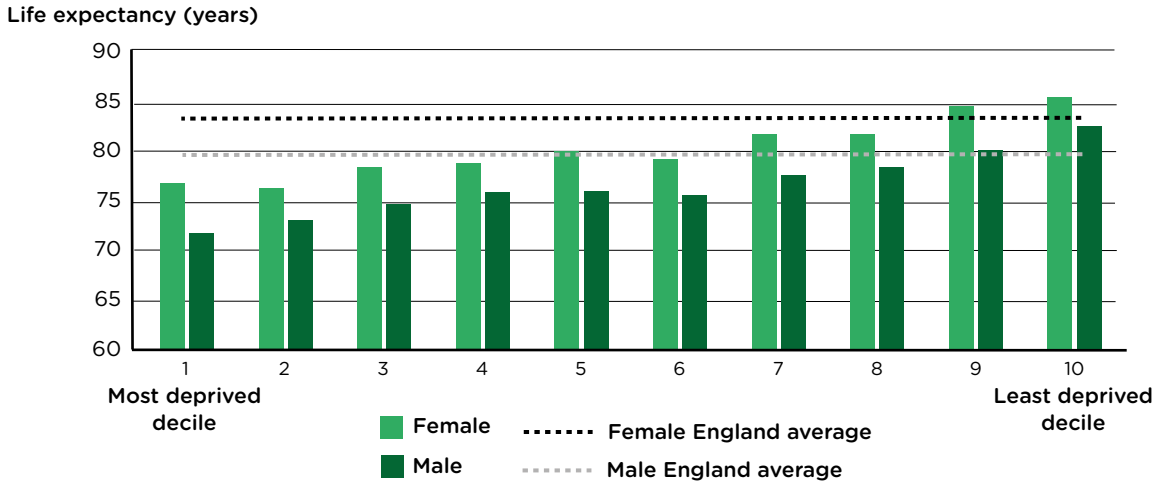


Source: *Office for National Statistics (90)*

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

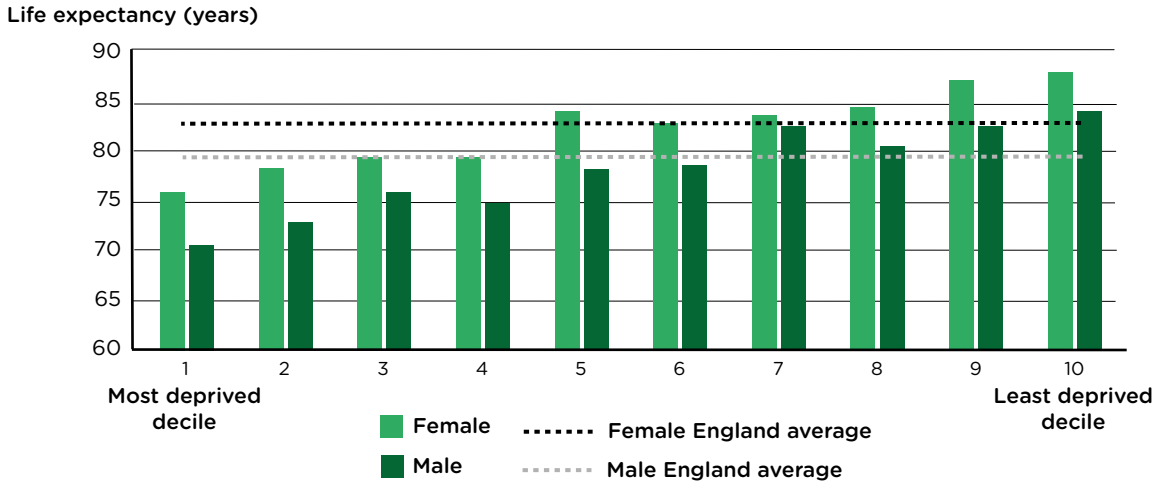


Source: *Office for National Statistics (90)*

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

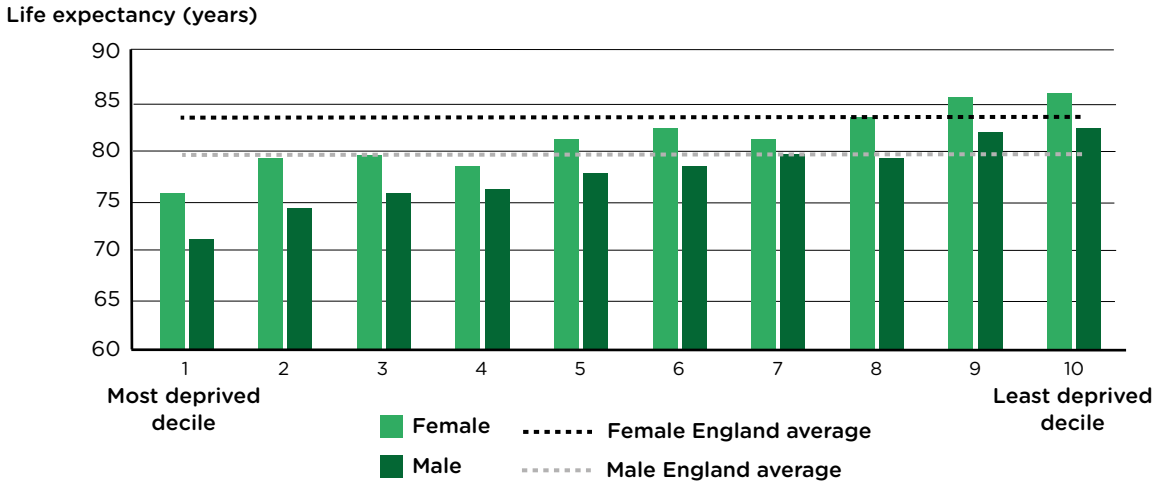


Source: *Office for National Statistics (90)*

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

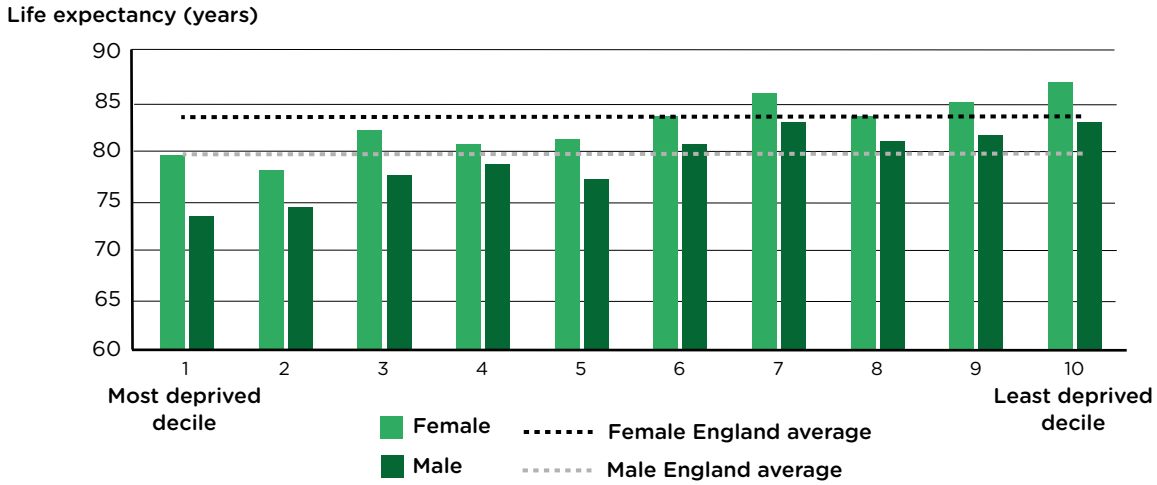


Source: *Office for National Statistics (90)*

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

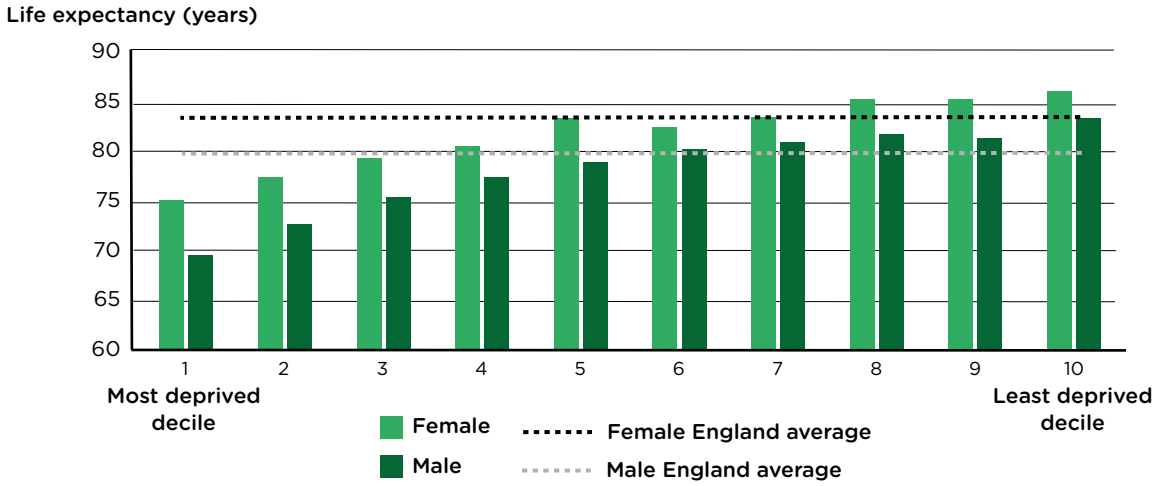


Source: *Office for National Statistics (90)*

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)*

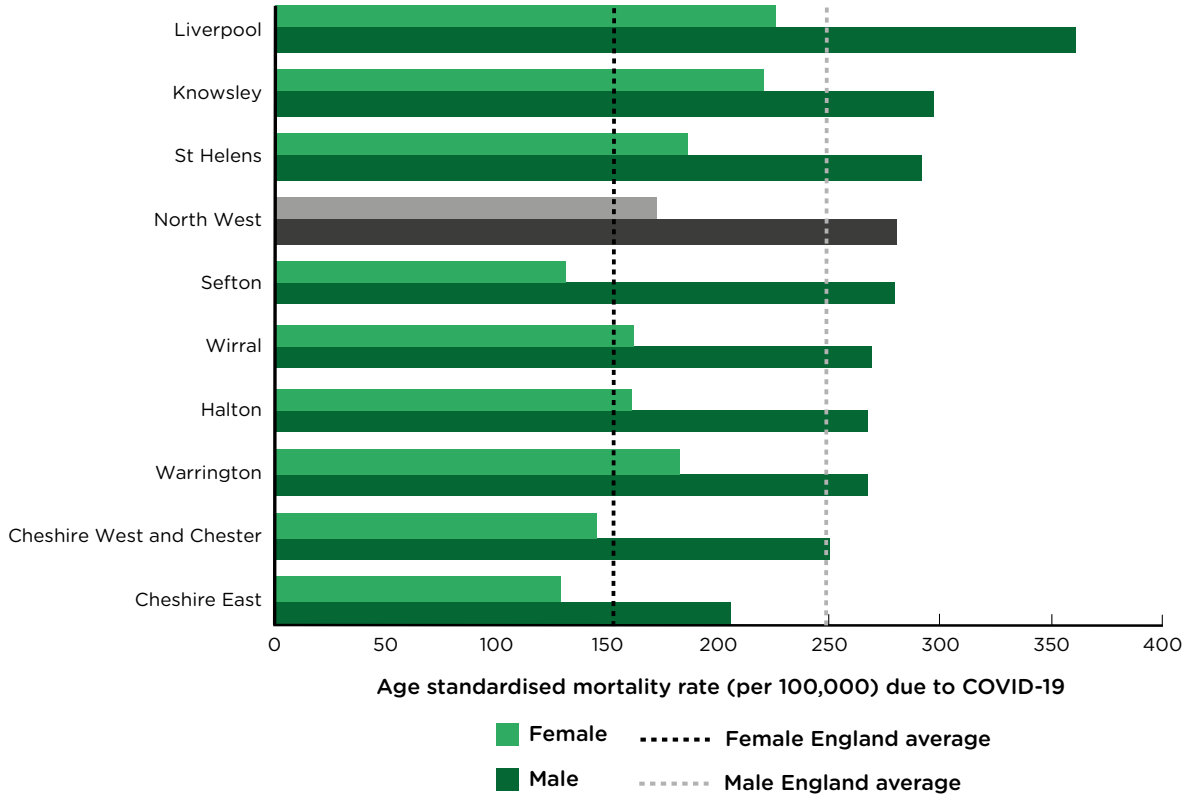
3D COVID-19 PANDEMIC AND HEALTH INEQUALITIES

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



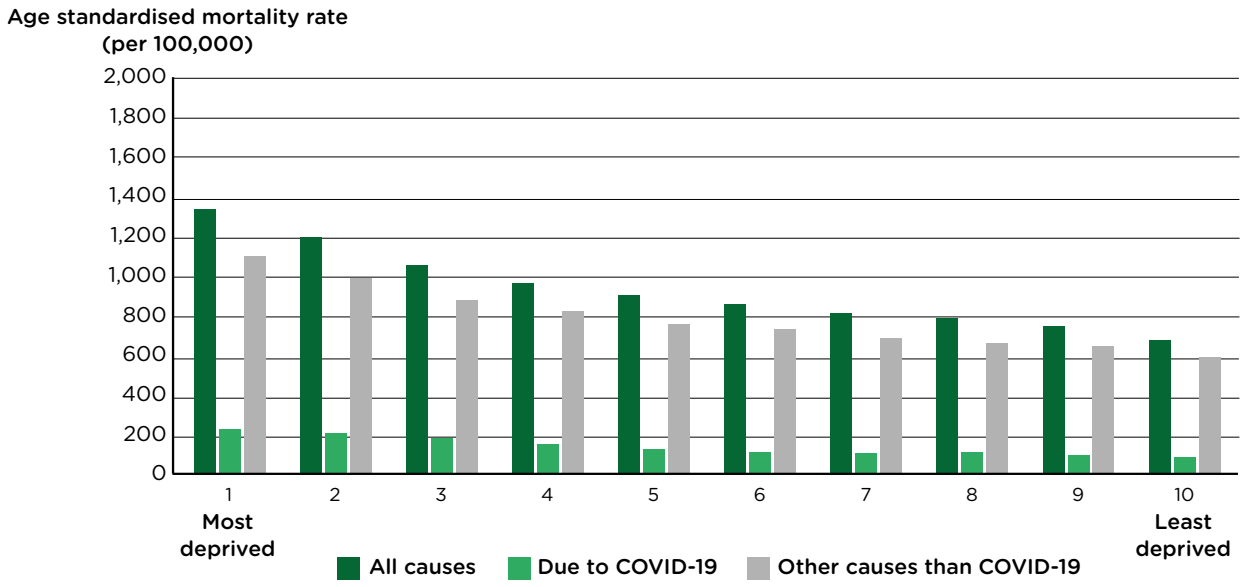
Notes: *Deaths 'due to COVID-19' only include deaths where coronavirus (COVID-19) was the underlying (main) cause.*

Source: *Office for National Statistics (95)*

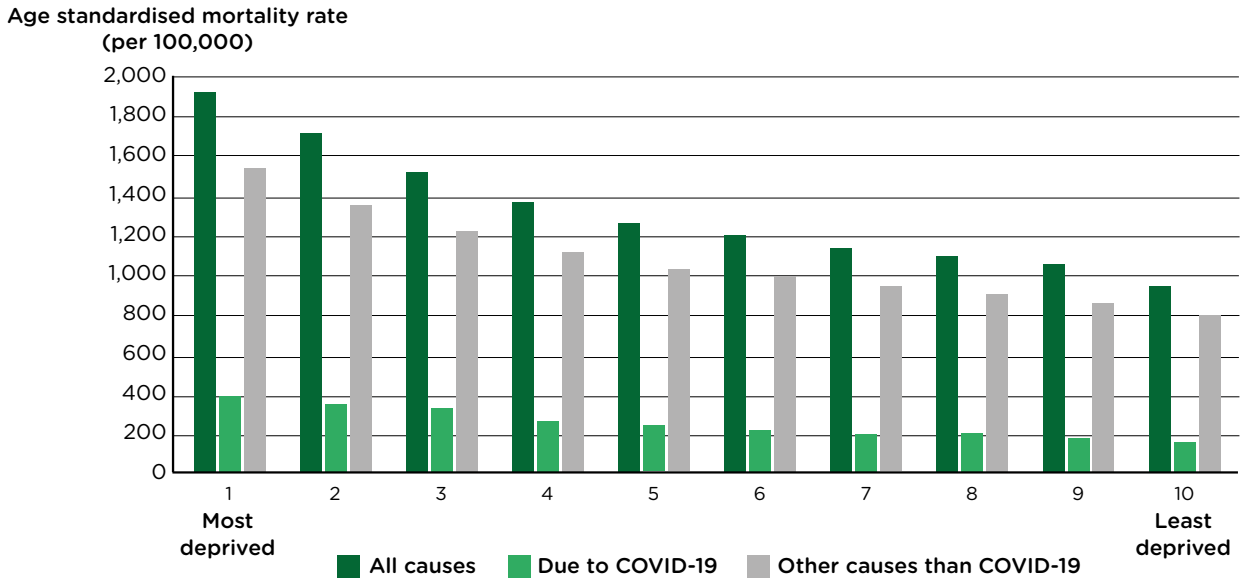
The relationship between all causes of mortality and deprivation in England reflects the relationship between deprivation and mortality from COVID-19, as seen in Figures 3.17A and 3.17B. The more deprived the area, the greater the mortality rate from COVID-19. The gradient was slightly steeper for COVID-19 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



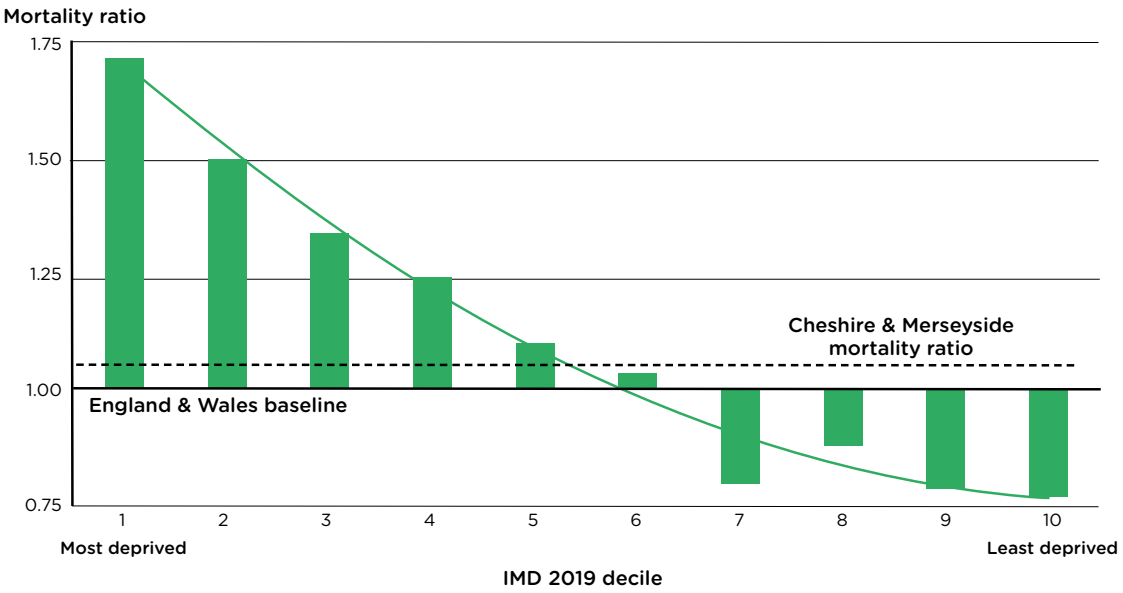
Source: *Office for National Statistics (95)*

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.

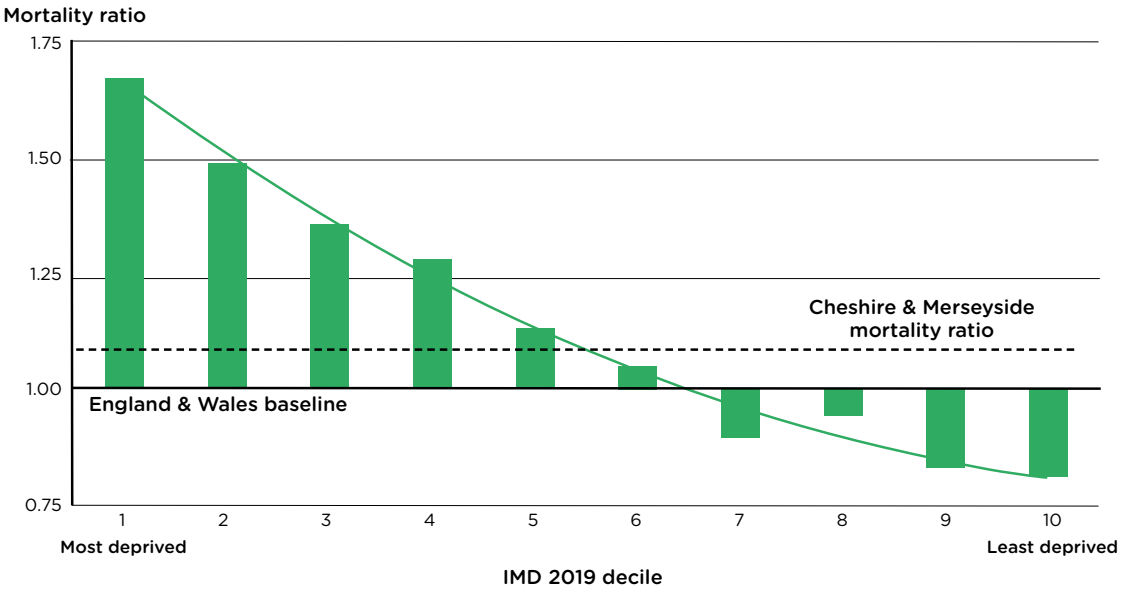
Figures 3.18A and 3.18B show the ratio of COVID-19 mortality by deprivation, using deciles in the Index for Multiple Deprivation (IMD) within Cheshire and Merseyside compared with the number expected on the basis of COVID-19 mortality rates (age- and sex-specific) in England and Wales. In the region, 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

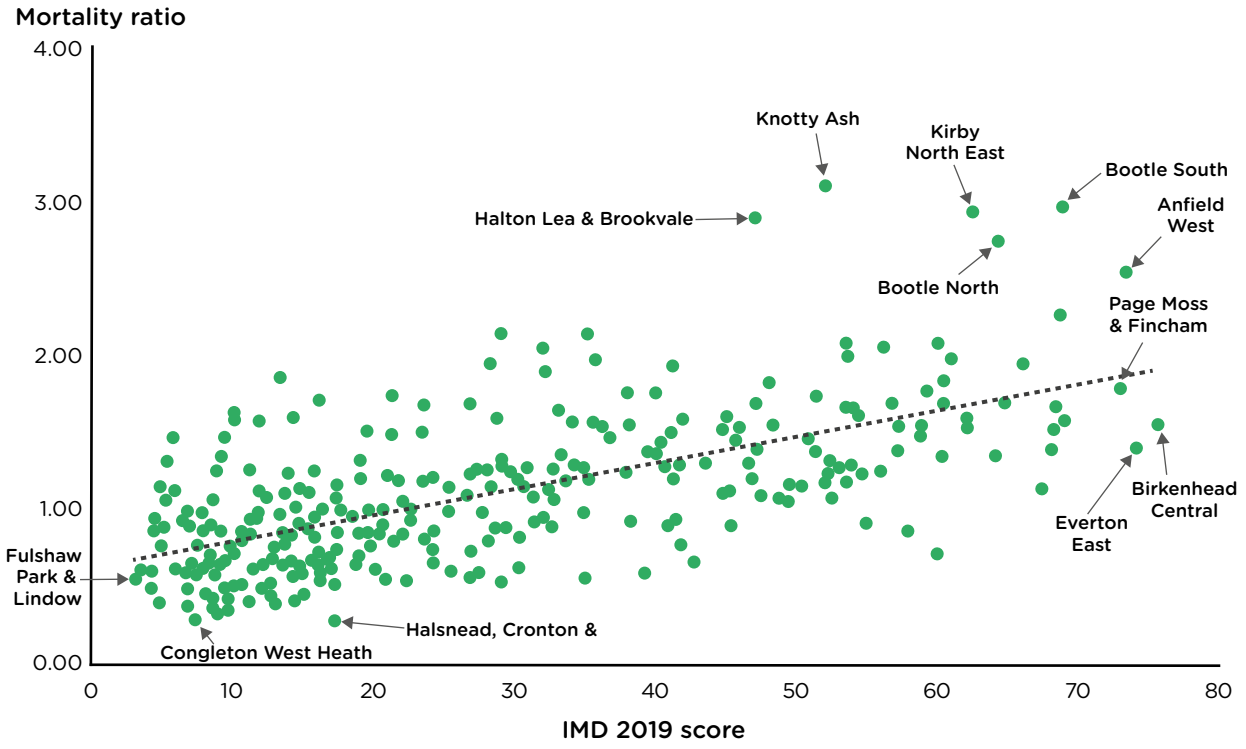


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these 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

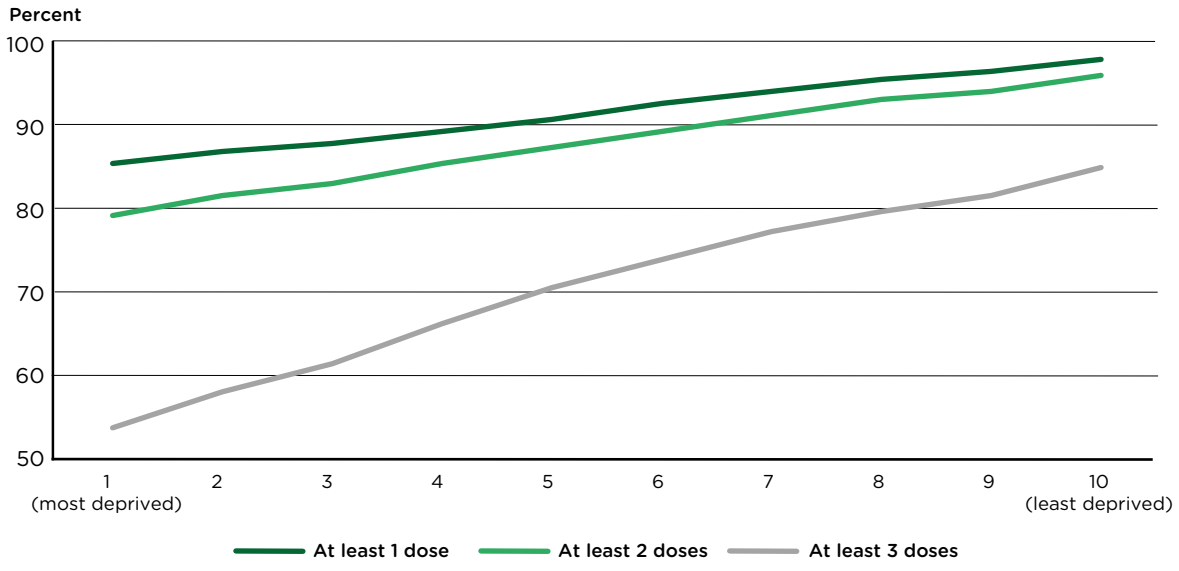


Notes: **MSOA = middle layer super output area. Uses the Index for Multiple Deprivation (IMD) 2019, calculating the score for each MSOA in Cheshire and Merseyside by taking the average of the lower super output area (LSOA) scores for each domain of the IMD and then taking a weighted average of these 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.

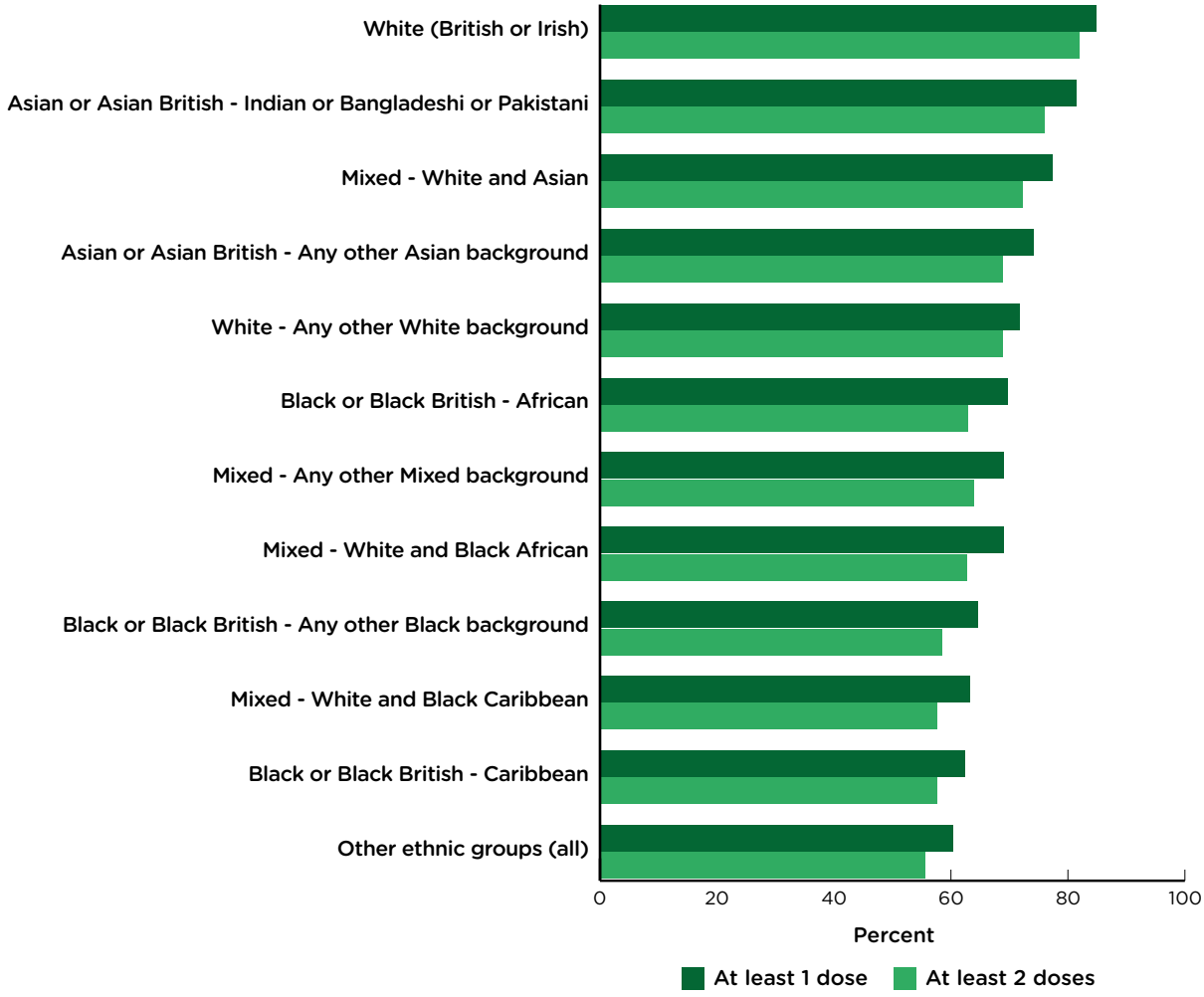
Figure 3.20. People vaccinated for COVID-19, by deprivation decile (IMD 2019), North West region, 8 December 2020 to 28 February 2022



***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

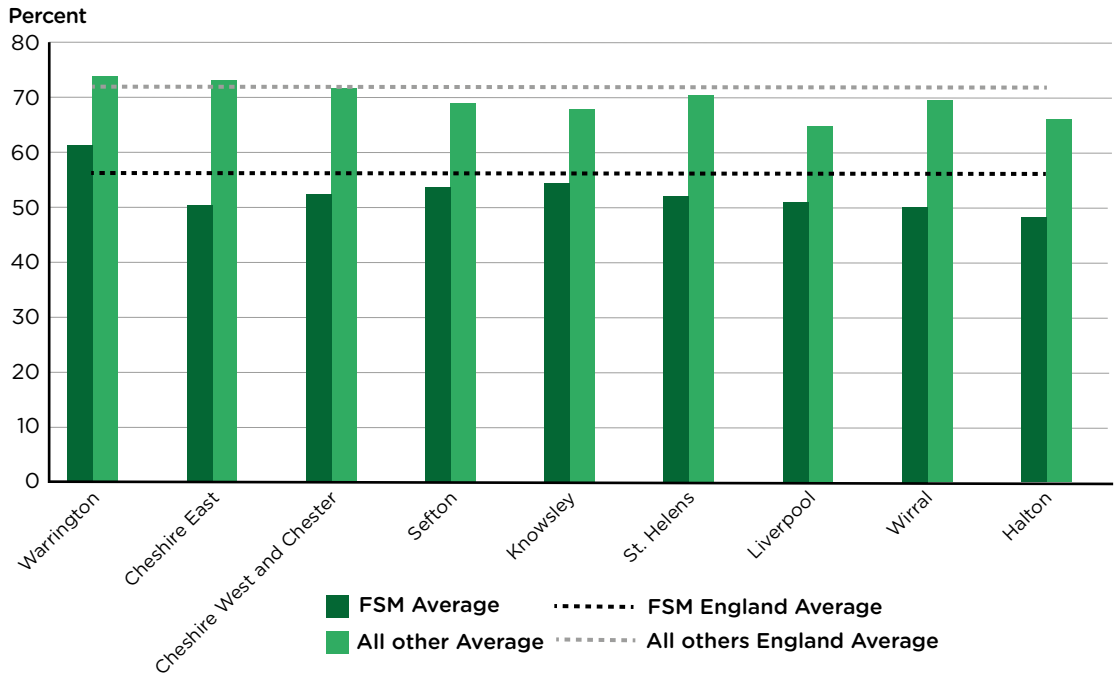
In this section we overview outcomes in the Marmot 8 themes across Cheshire and Merseyside, as outlined in Section 1. Recommendations and relevant indicators for monitoring are included and are the areas in which action by all partners need to be directed.

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 of children achieving a good level of development at 2-2.5 years (in all five areas of development)
- Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)

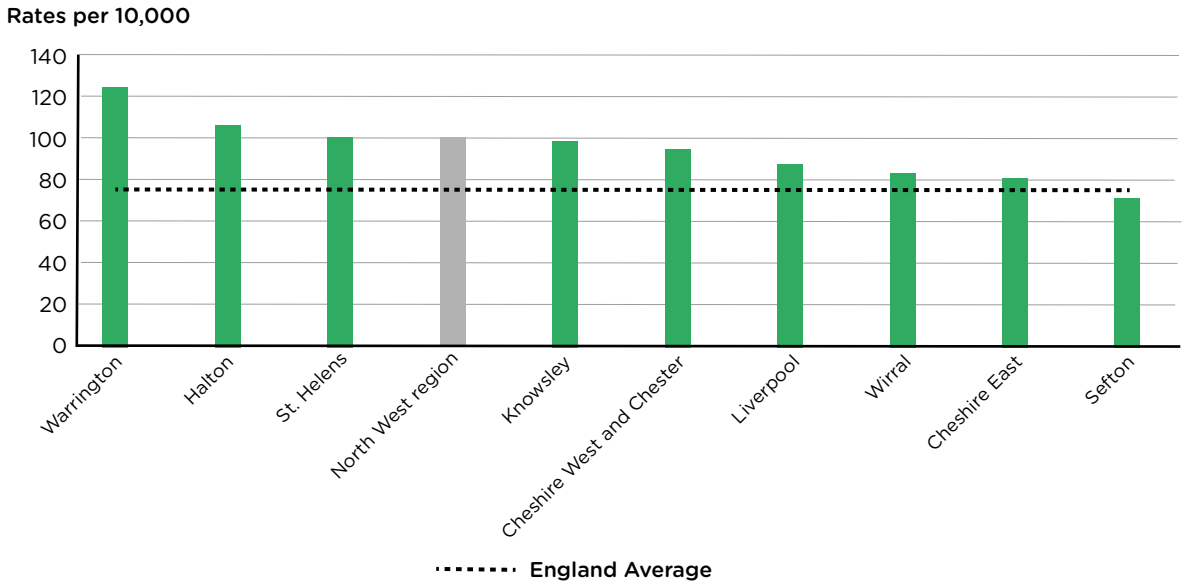
4B ENABLING ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

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.

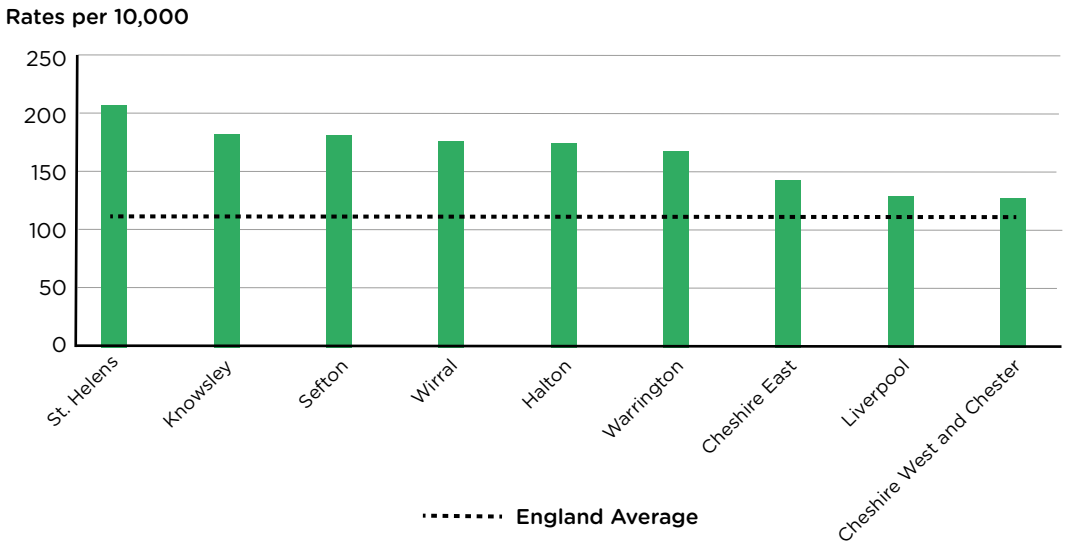
Figure 4.2. Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14), rate per 10,000, Cheshire and Merseyside lower-tier local authorities and England, 2020/21



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

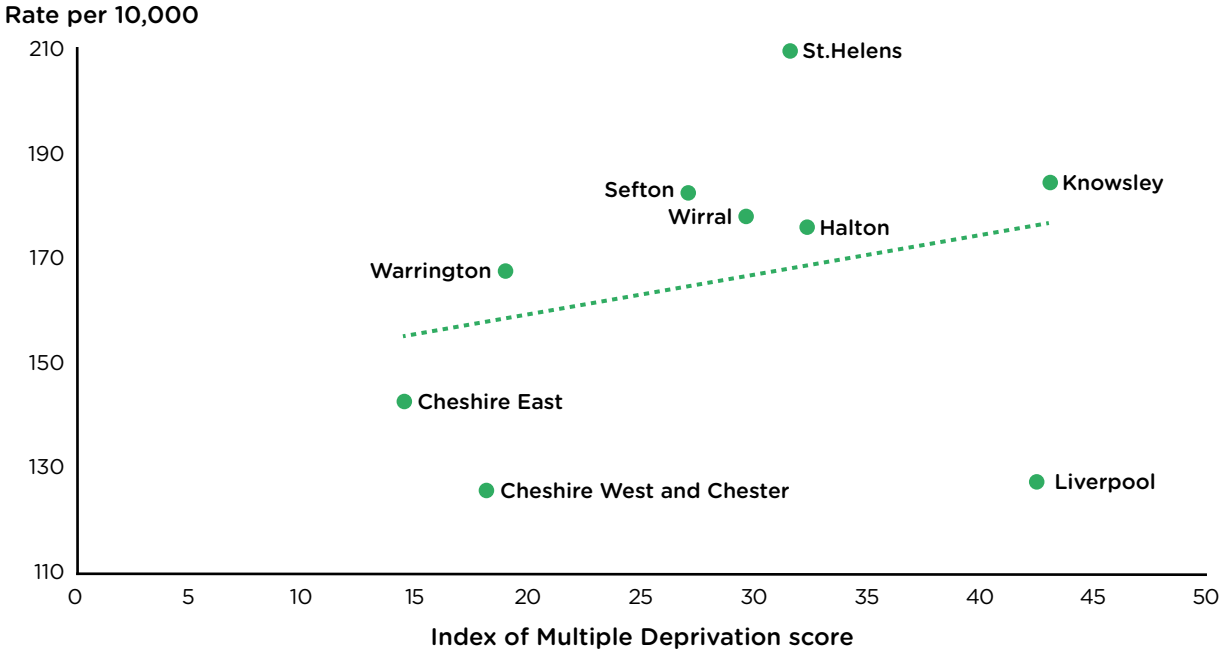


Notes: *Unintentional injuries are identified as external causes of harm, such as, road traffic collisions, sports injury, falls, accidental contact with machinery, burns and drowning etc. Deliberate injuries include different types of assaults and deliberate self-harm (110).*

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

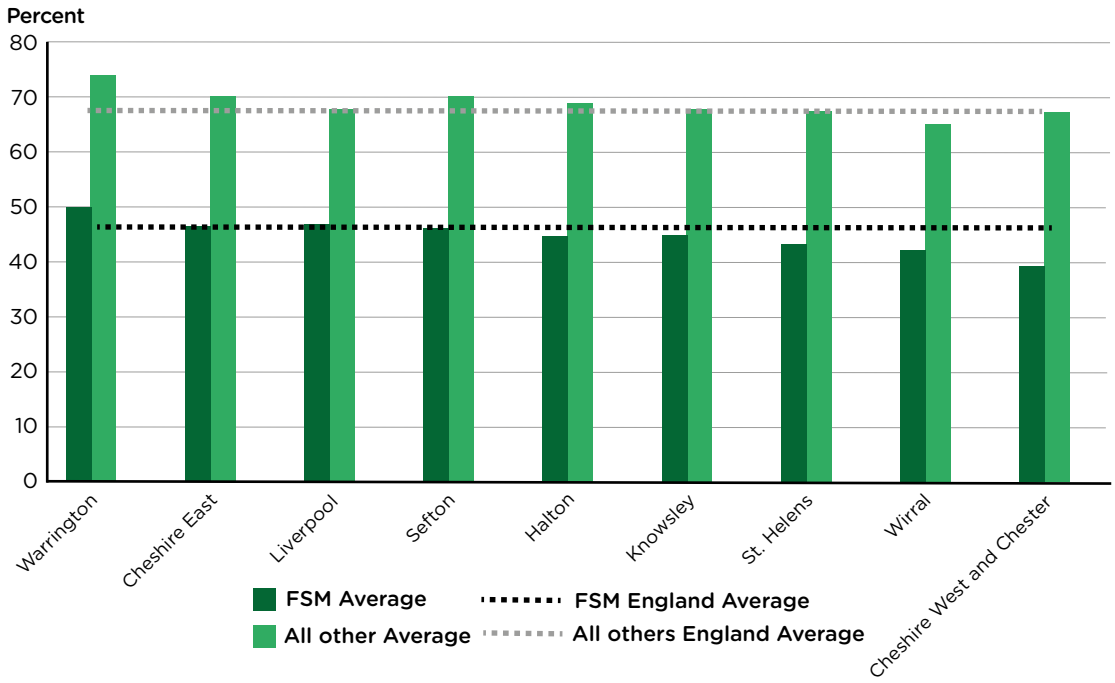
Inequalities in education related to socioeconomic position were persistent prior to the pandemic. Pupils eligible for free school meals for more than 80 percent of their school life were 18 months behind their peers by the time they finished their GCSEs, a gap that has not changed in the last five years (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

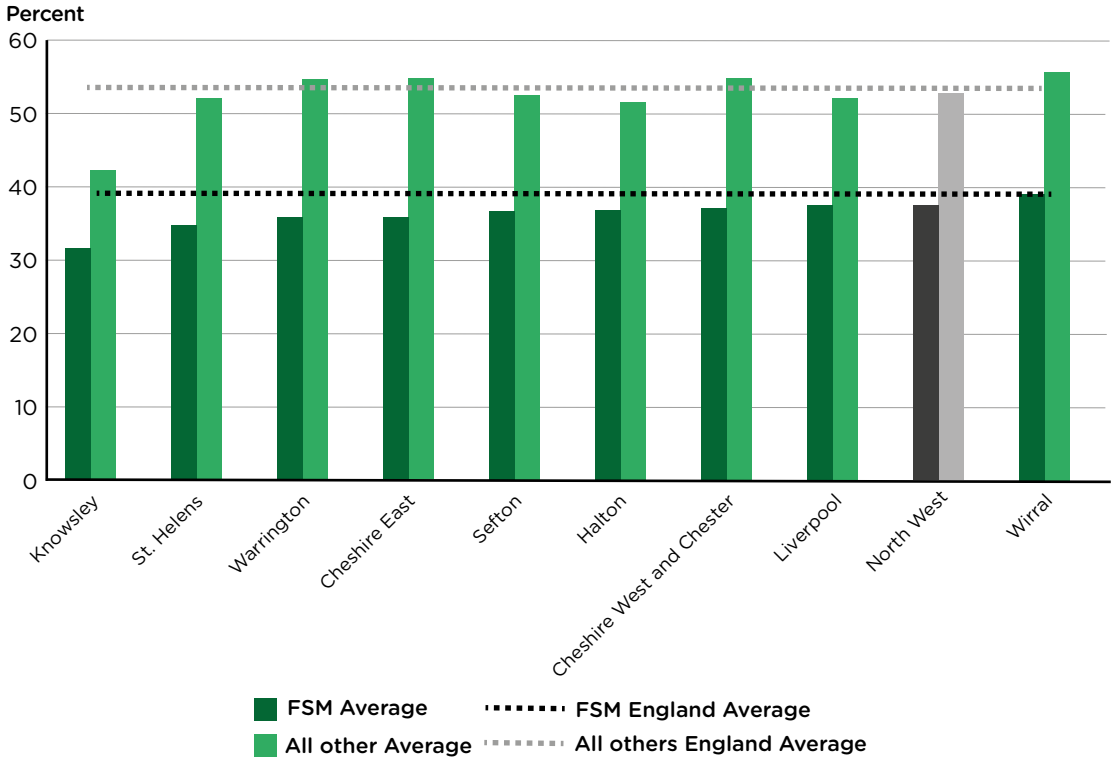


Source: *Department for Education (119)*

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.

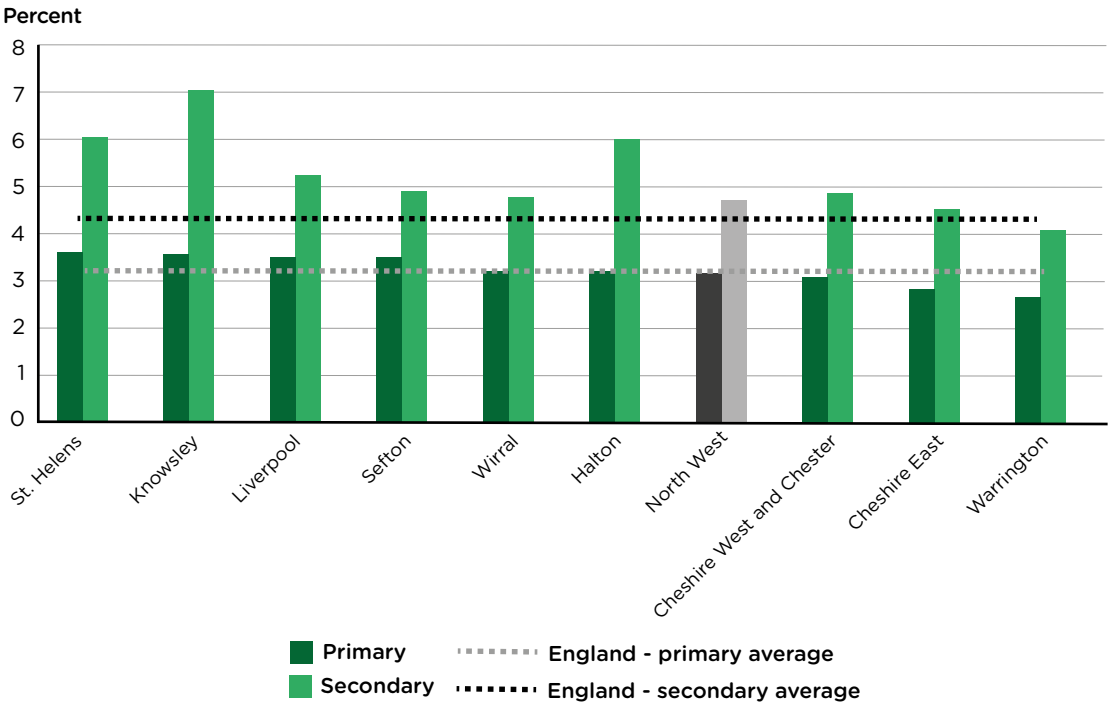
Table 3.1. Average Progress 8 Score*, Ethnicity and free school meal eligibility, in Cheshire and Merseyside lower-tier local authorities, 2018/19

	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.

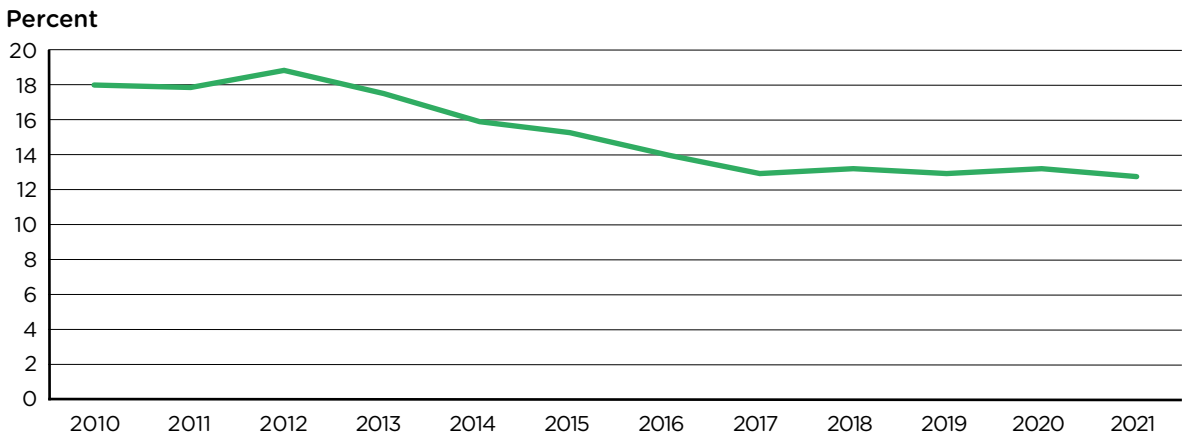
Figure 4.7. Pupil absences, autumn and spring terms combined, primary and secondary, percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020-21



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.

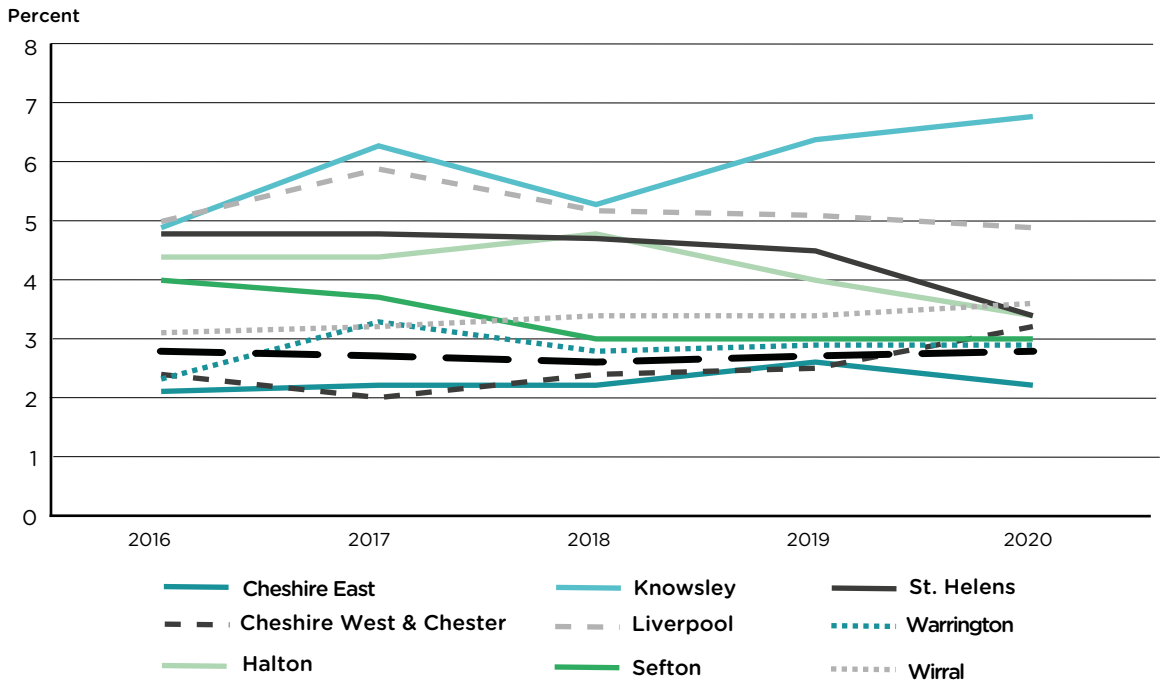
Figure 4.8 Not in Education Employment of Training (NEET), (aged 18 to 24), percentage, first quarter, England, 2010-21



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.

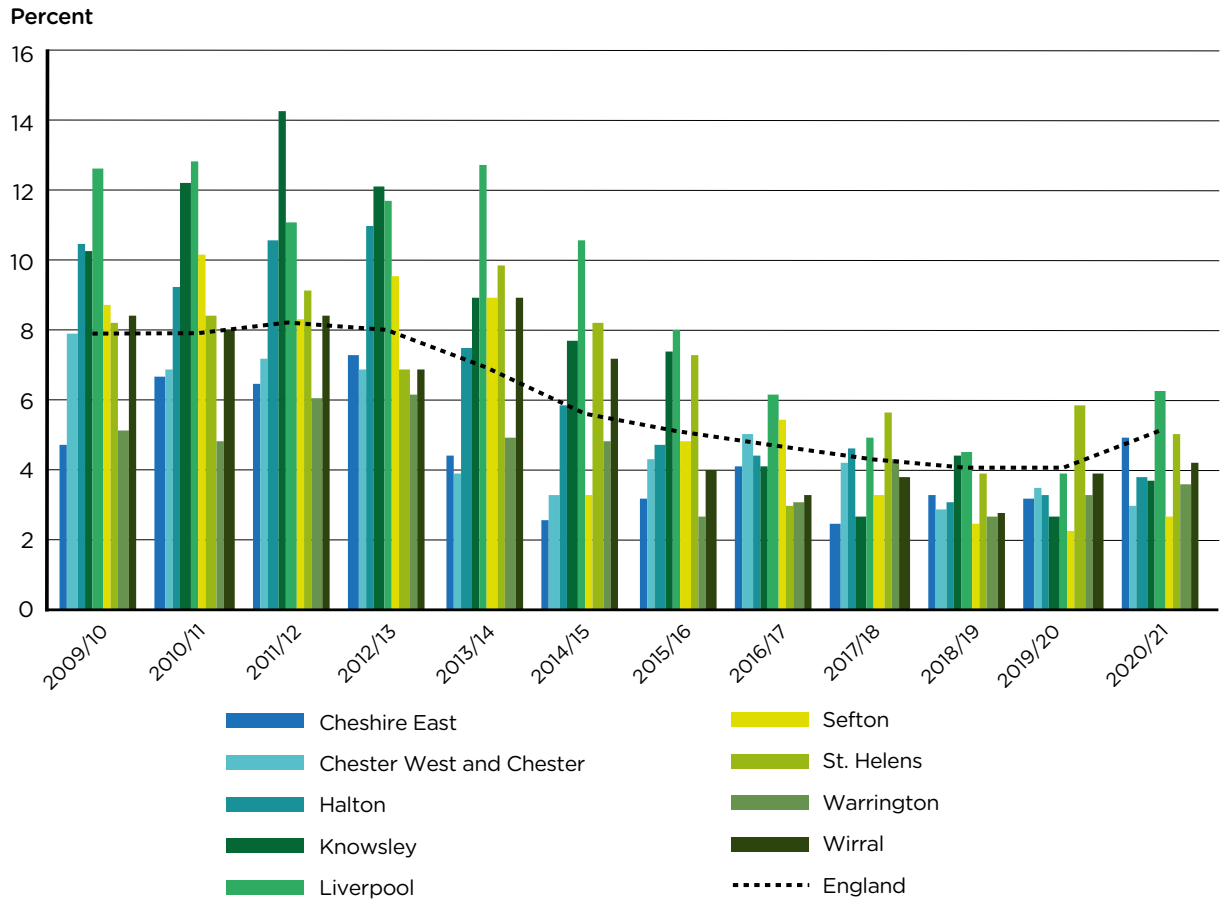
Further analysis of how employers can contribute to reductions in health inequalities is set out in Section 5E.

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.

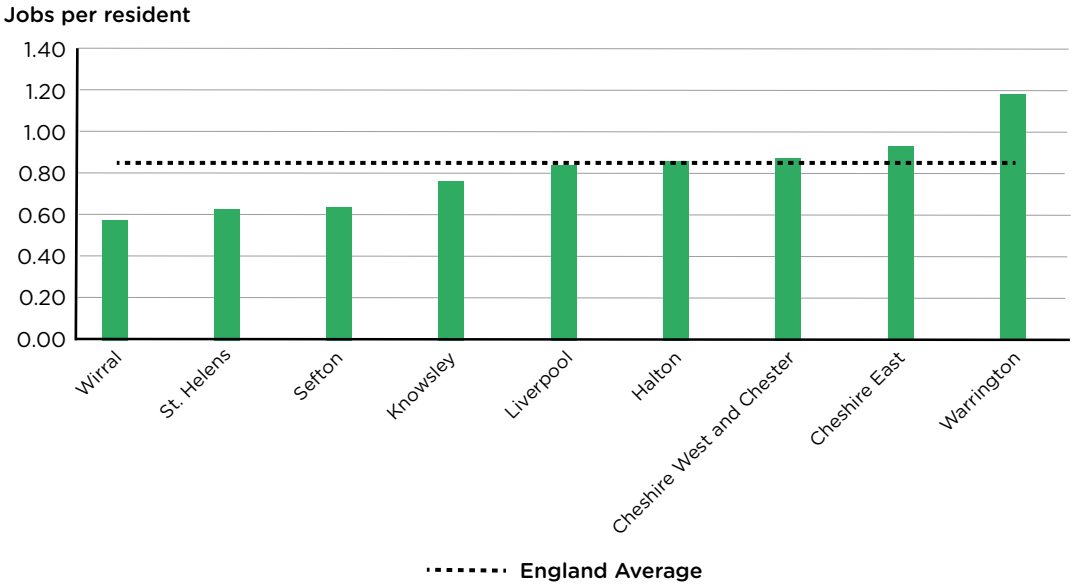
Figure 4.10. Unemployment rate, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, July-June 2009/10 to 2020/21



***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.

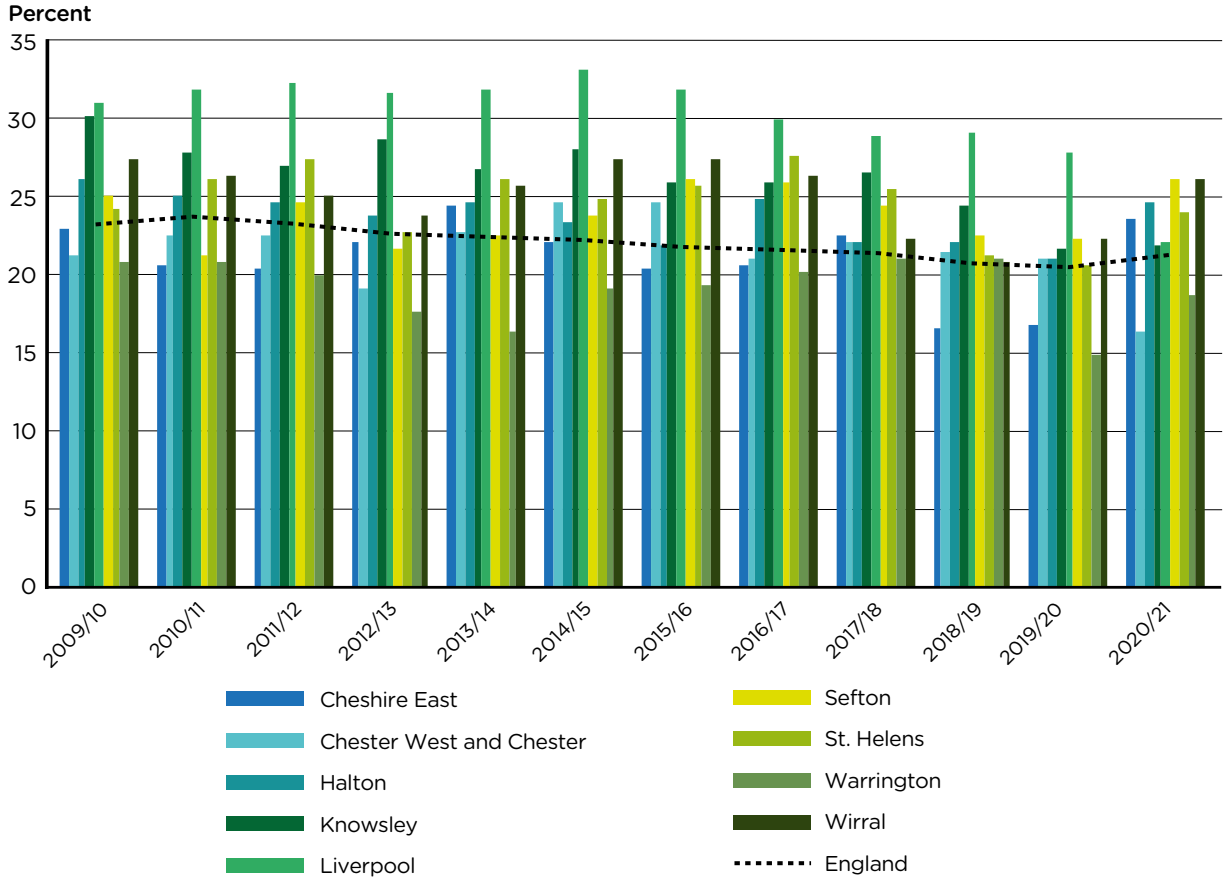
An evaluation of pilot programme data (covering February 2018-20) found that the key barriers to employment in this client group were mental health issues (65 percent); chronic health conditions (23 percent); and care responsibilities (26 percent). Clients also experienced financial inequality. Some 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.

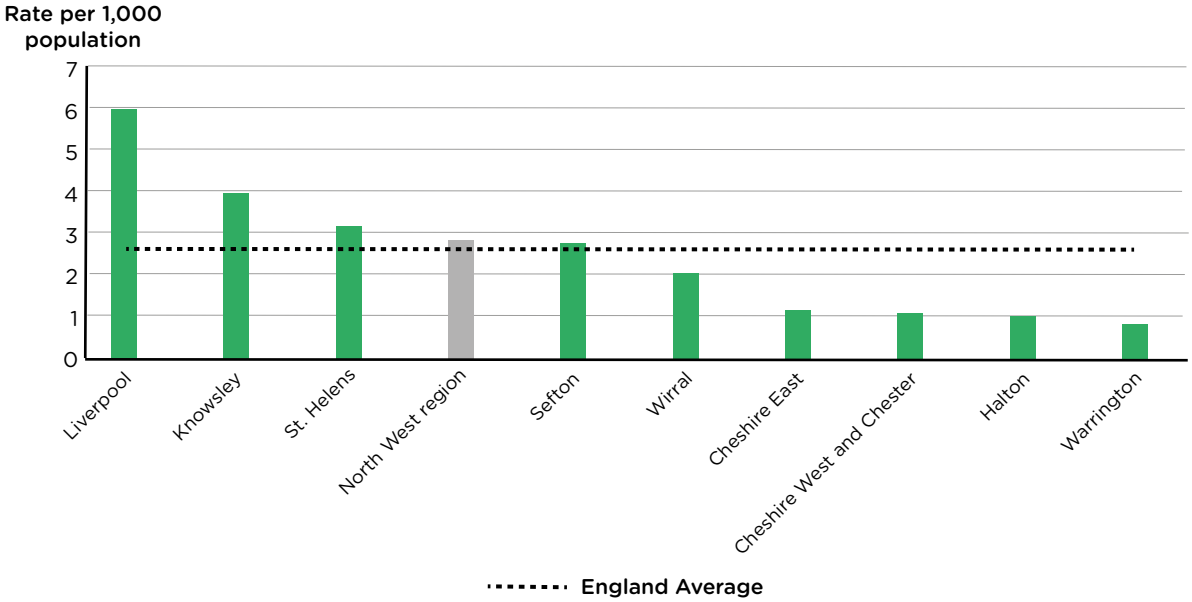
Figure 4.12. Economically inactive population, (aged 16 to 64), percentage, Cheshire and Merseyside lower-tier local authorities and England, 2009/10 to 2020/21



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.

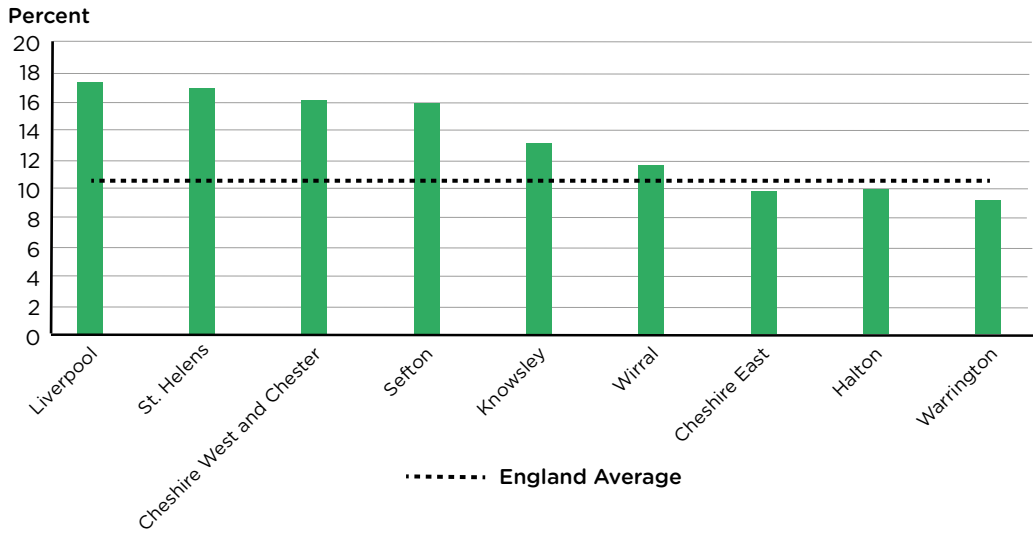
Figure 4.13. Long term claimants of Jobseeker's Allowance, (aged 16 to 64), rate per 1,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



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.

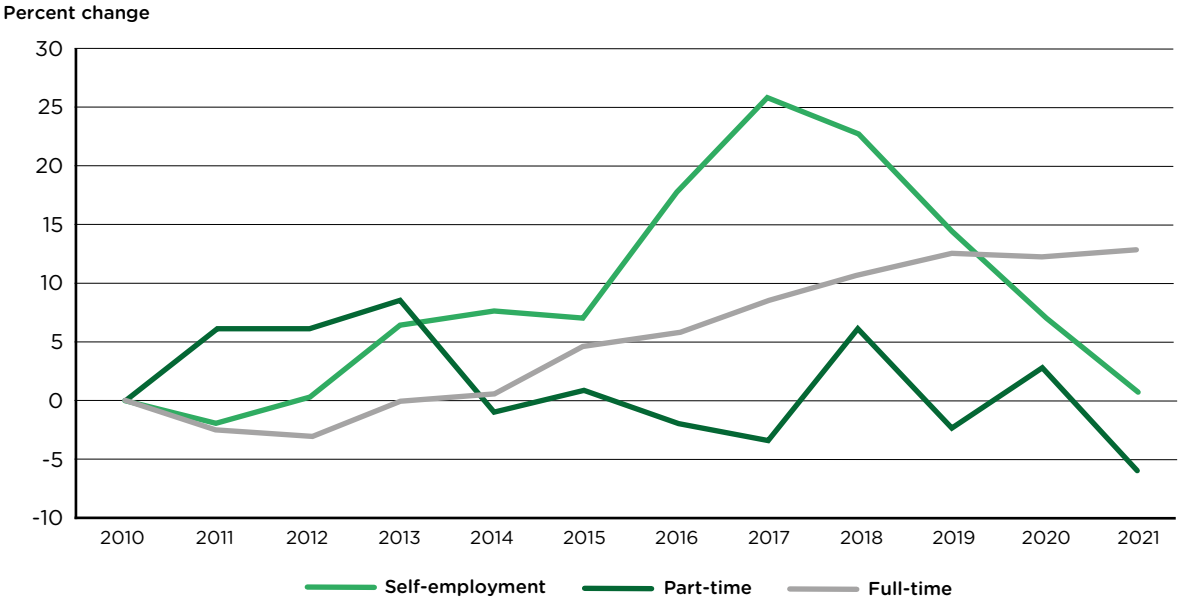
Sew Halton also acted as a signposter, directing participants to a variety of partners including Citizens Advice, Halton Carers Centre, urgent care centres, domestic abuse services, local councillors, and many others.

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



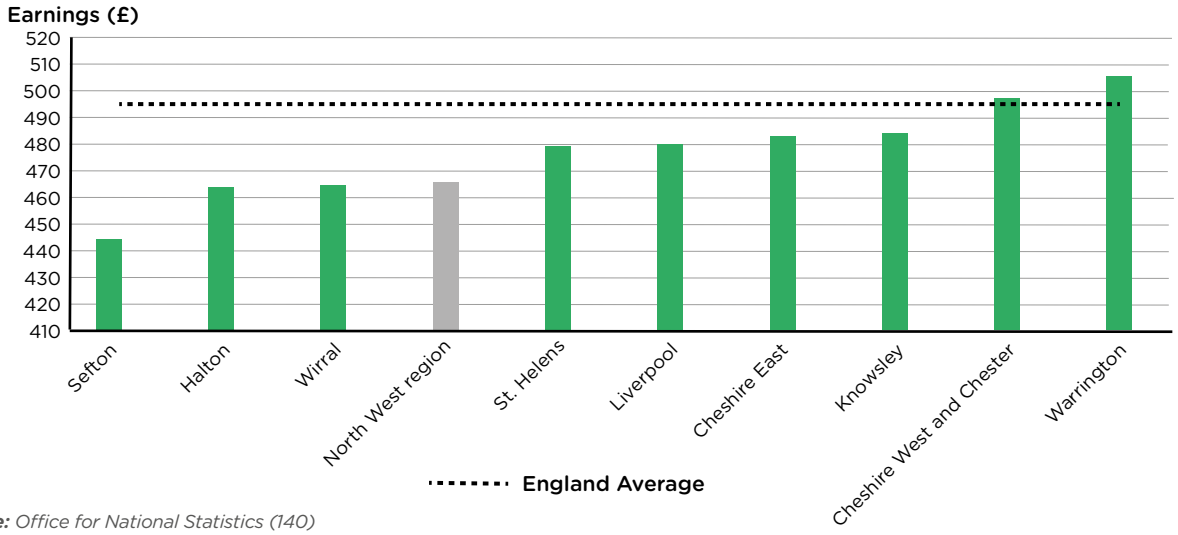
Source: *Office for National Statistics (132)*

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.

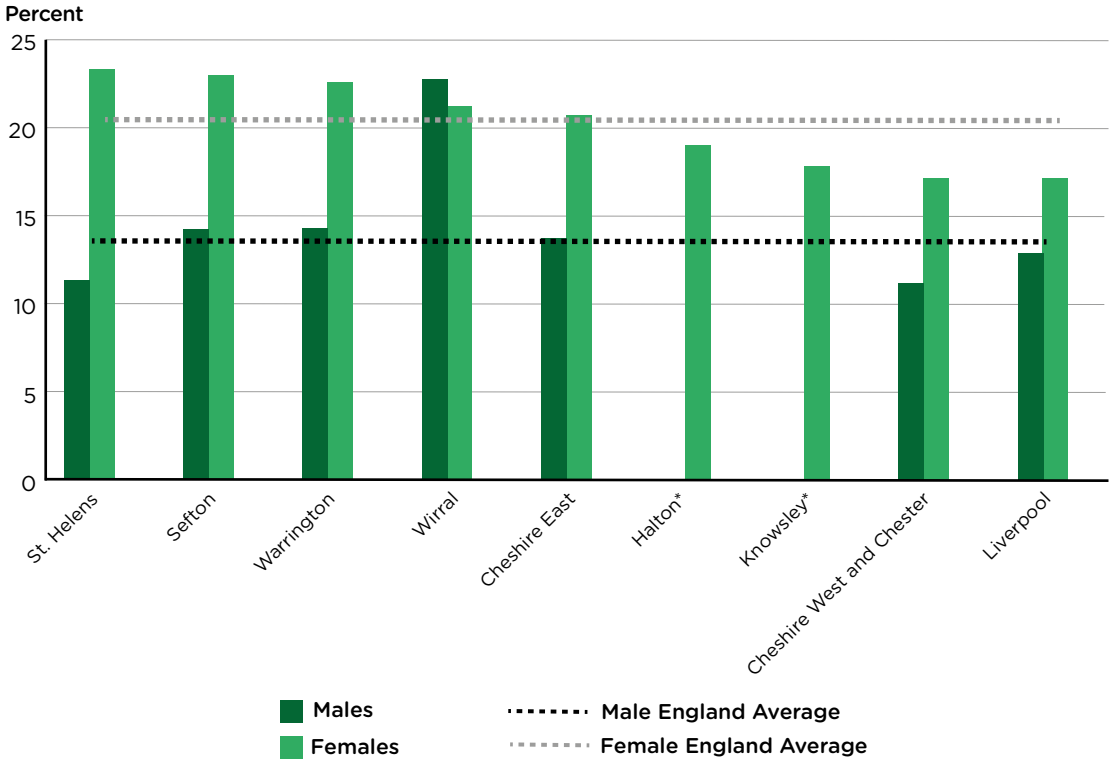
Figure 4.16. Average weekly earnings, (aged 16 and over), pounds (£), Cheshire and Merseyside lower-tier local authorities, North West region and England, 2020



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

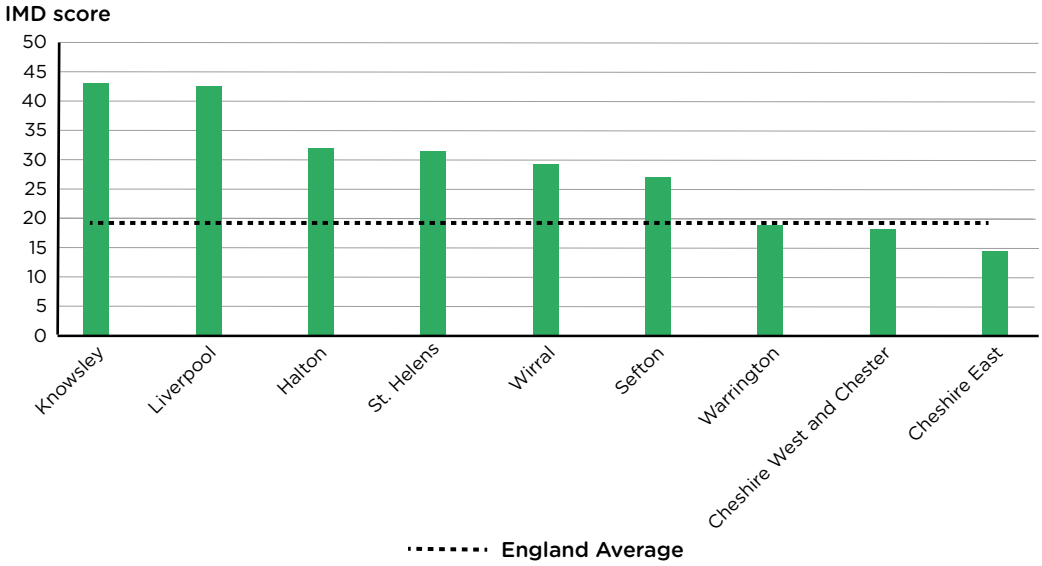
Poverty affects the ability to purchase sufficient goods and services and to have a social life - all essential components of a healthy life. Poverty also affects control over one's life which is critical to health and wellbeing and the ability to lead a dignified life (1).

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).

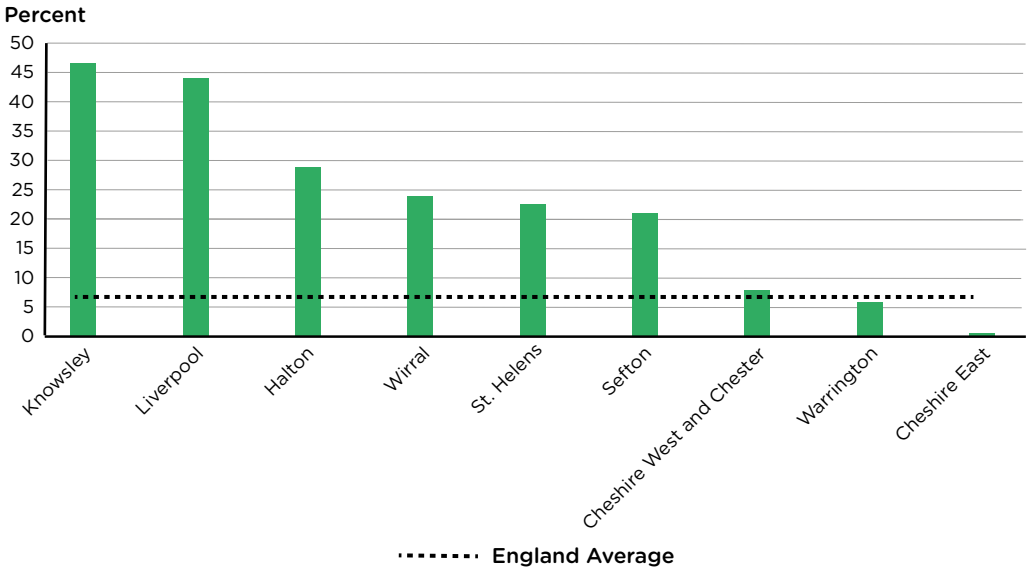
Figure 4.18. Index of Multiple Deprivation score, Cheshire and Merseyside lower-tier local authorities and England, 2019



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

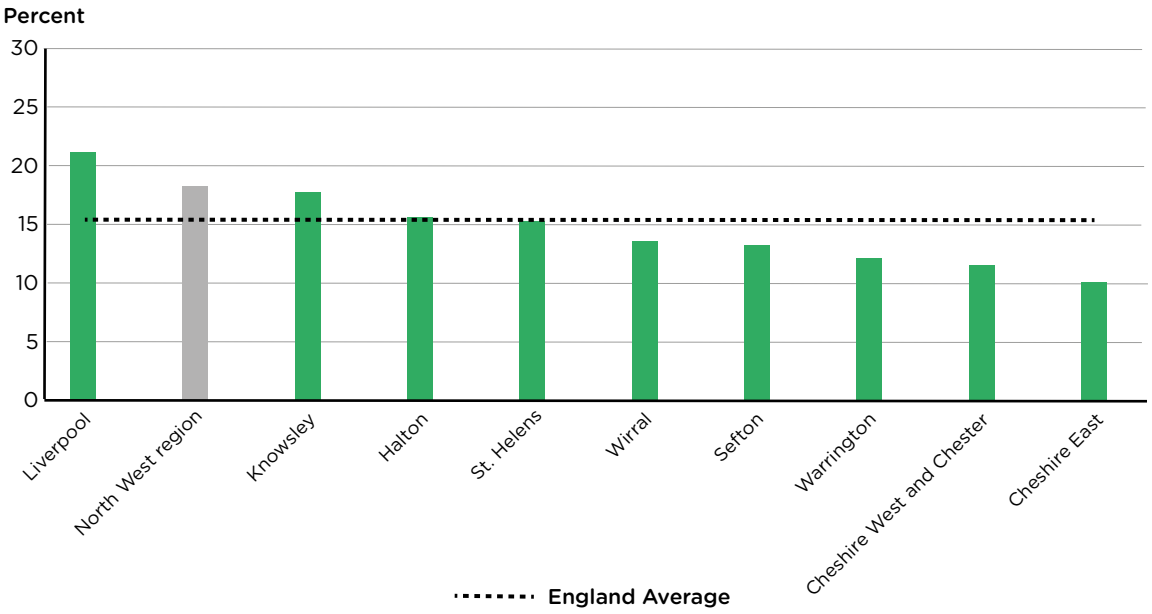
Persistent child poverty is associated with worse mental, social, and behavioural development in children, as well as worse educational outcomes, employment prospects, and earning power into adulthood.

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.

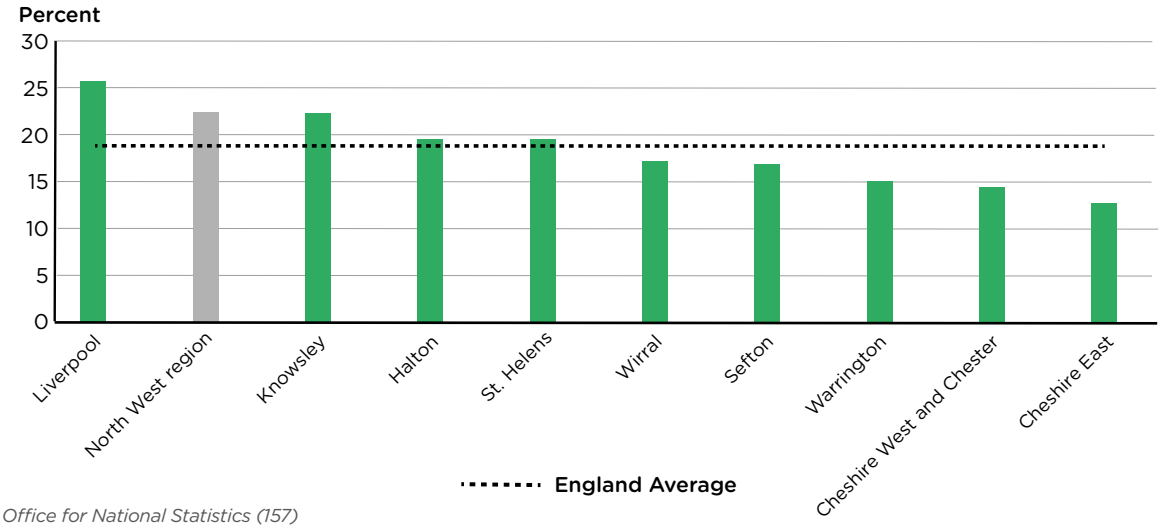
Figure 4.20. Children living in absolute poverty households (under-16s), percentage, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2019/20



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)*

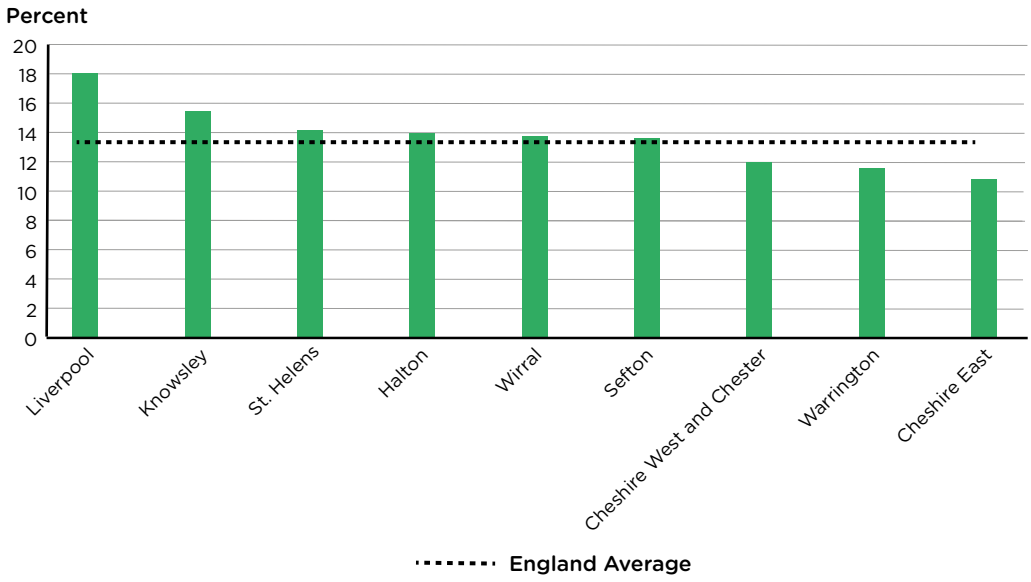
FUEL POVERTY

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.

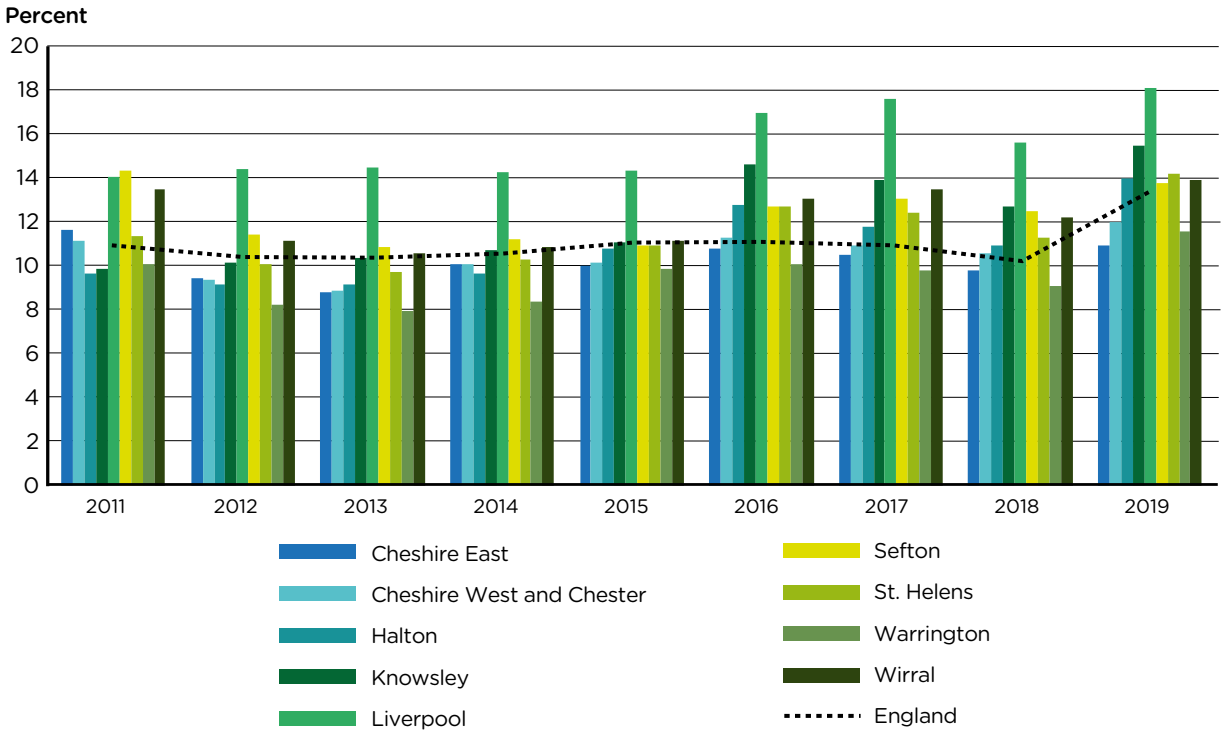
Figure 4.22. Fuel poverty, Cheshire and Merseyside lower-tier local authorities and England, 2019



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.

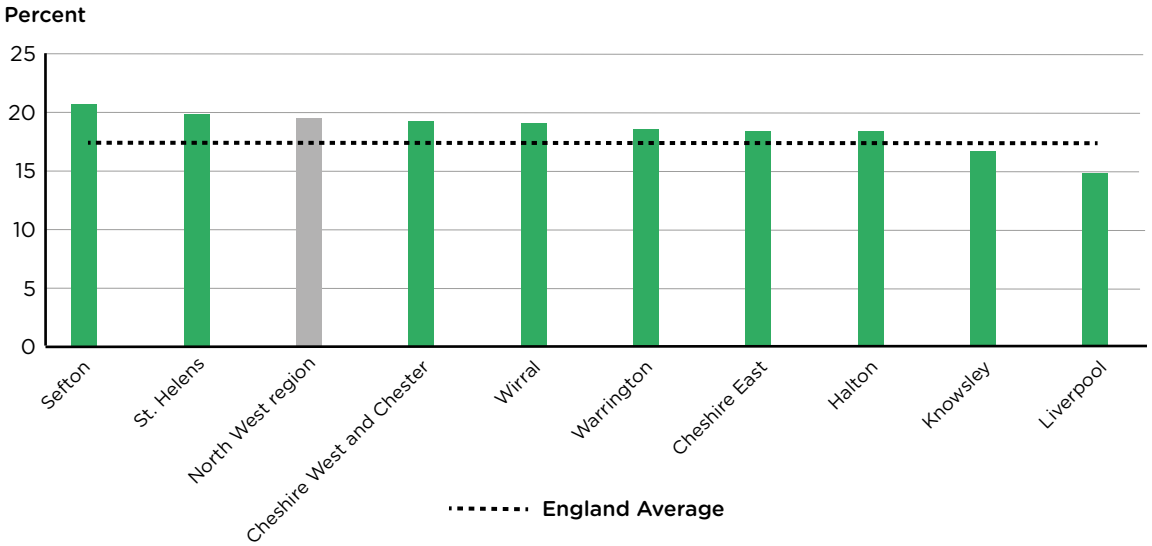
Figure 4.23. Homes in fuel poverty, percentage, Cheshire and Merseyside lower-tier local authorities and England, 2011/19



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.

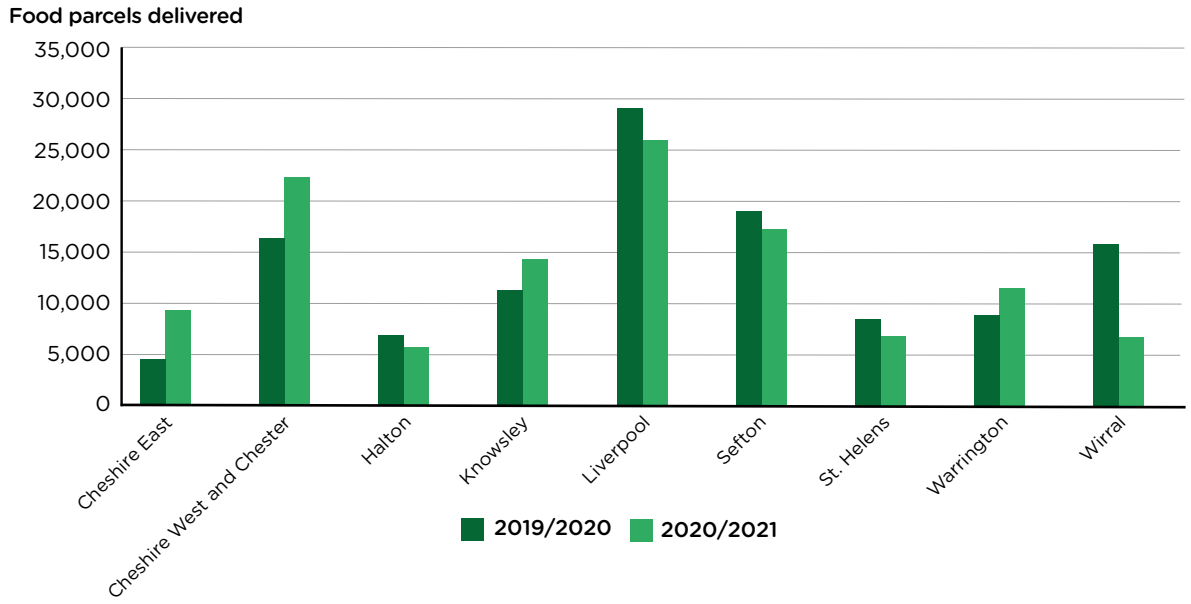
FOOD POVERTY

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

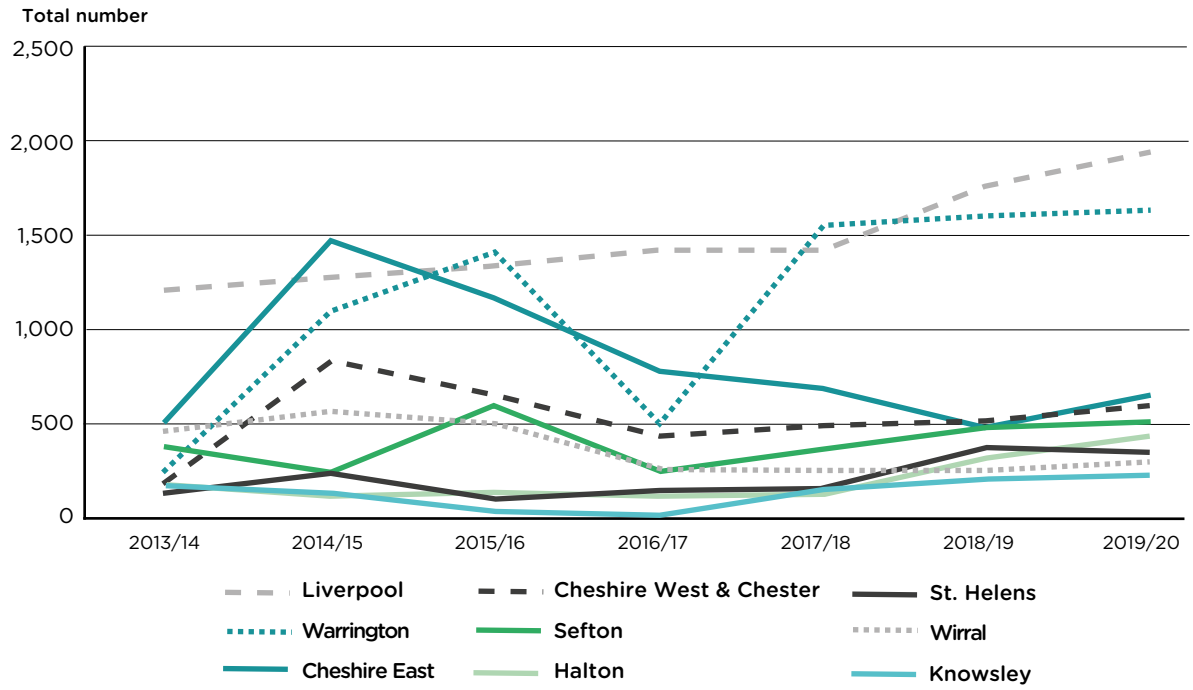
One of the most significant ways that healthy and sustainable places and communities can be forged is through quality housing and safe environments with good access to services, shops, community facilities, leisure and entertainment and good-quality natural environments. Cheshire and Merseyside comprises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

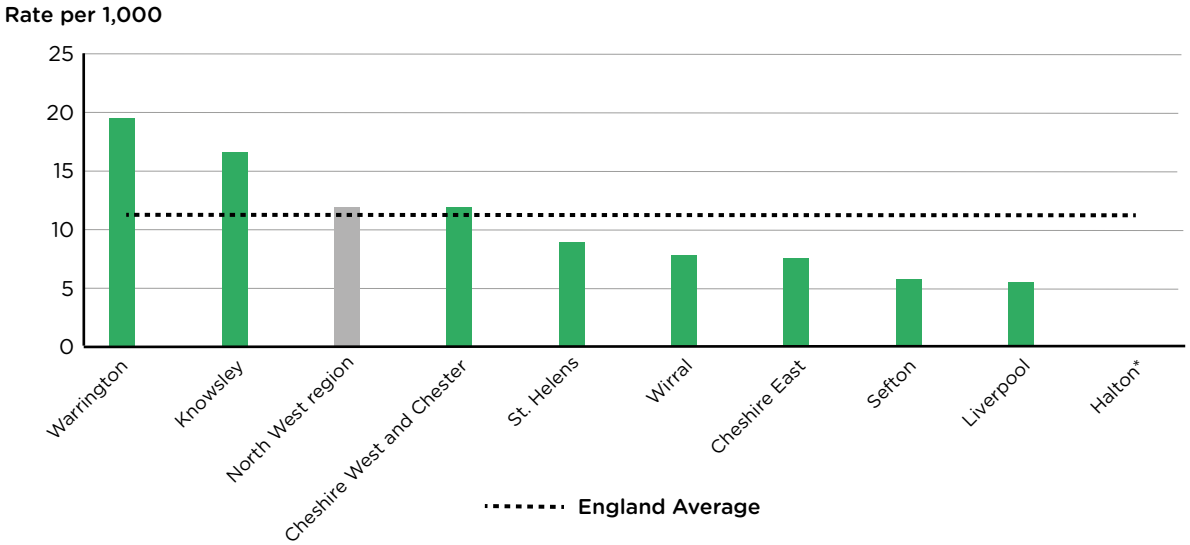
Unaffordable housing harms health, it increases stress and the risk of suffering from poor mental health; high housing costs lead to worse housing conditions, owner-occupiers are unable to make essential repairs and landlords have less incentive to improve conditions. Housing costs were increasing prior 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

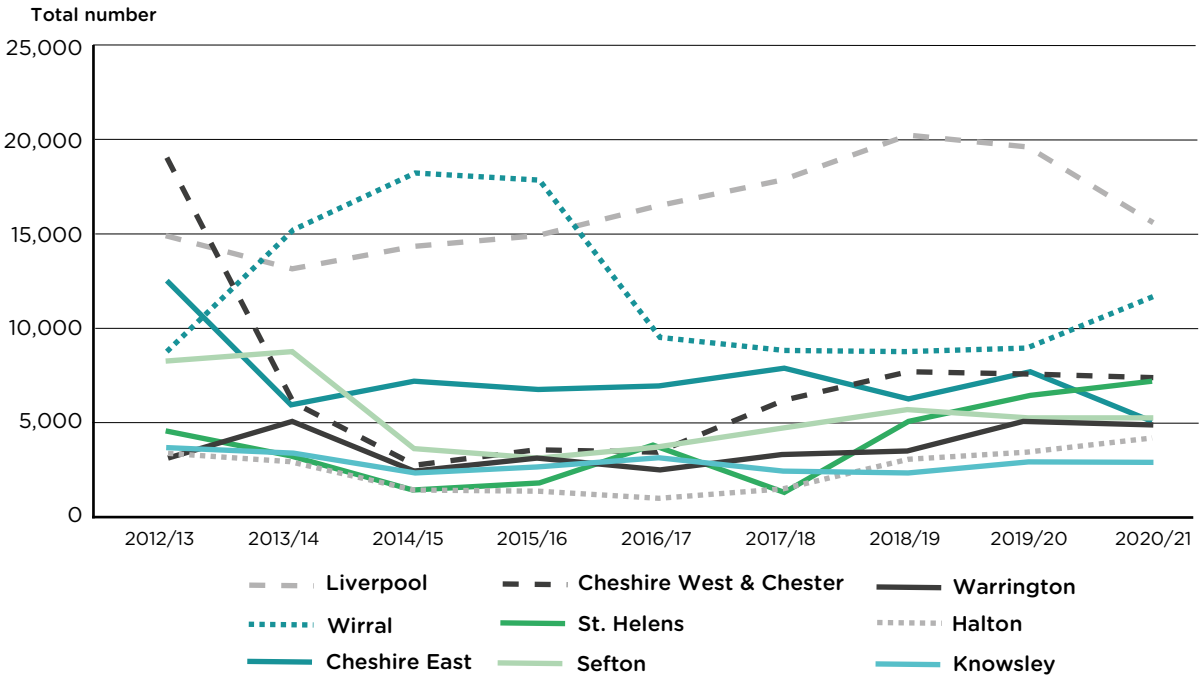


Notes: *Data not available.*

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.

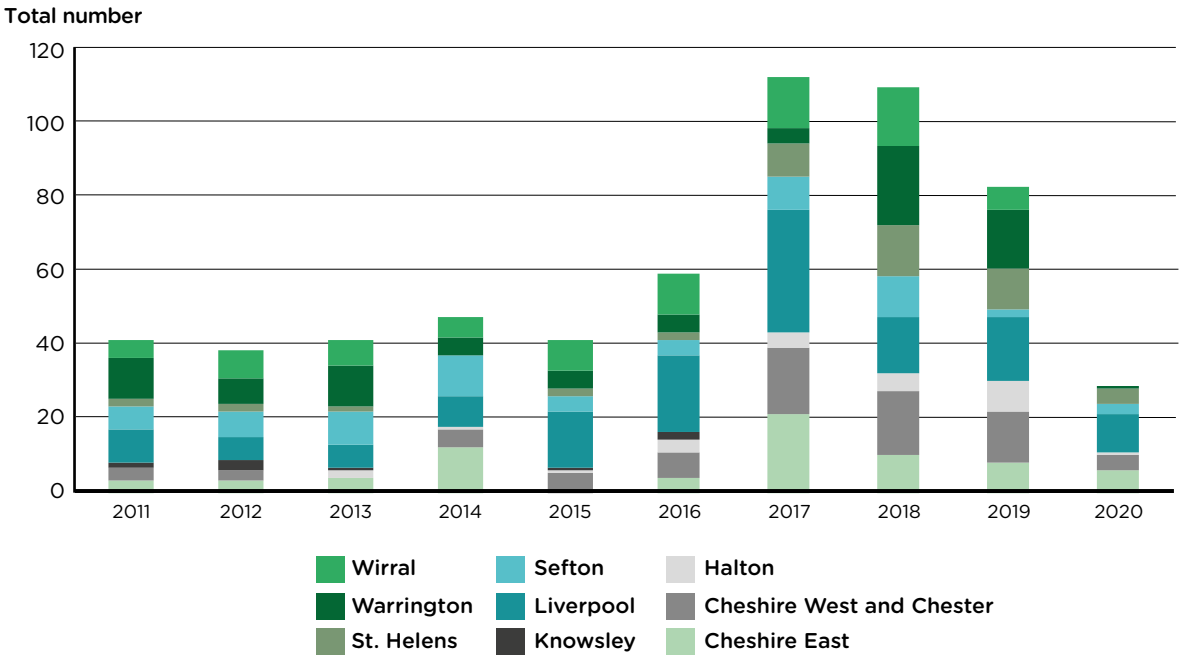
Figure 4.28. Households on housing waiting list, total number, Cheshire and Merseyside lower-tier local authorities, 2012/13 to 2020/21



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.

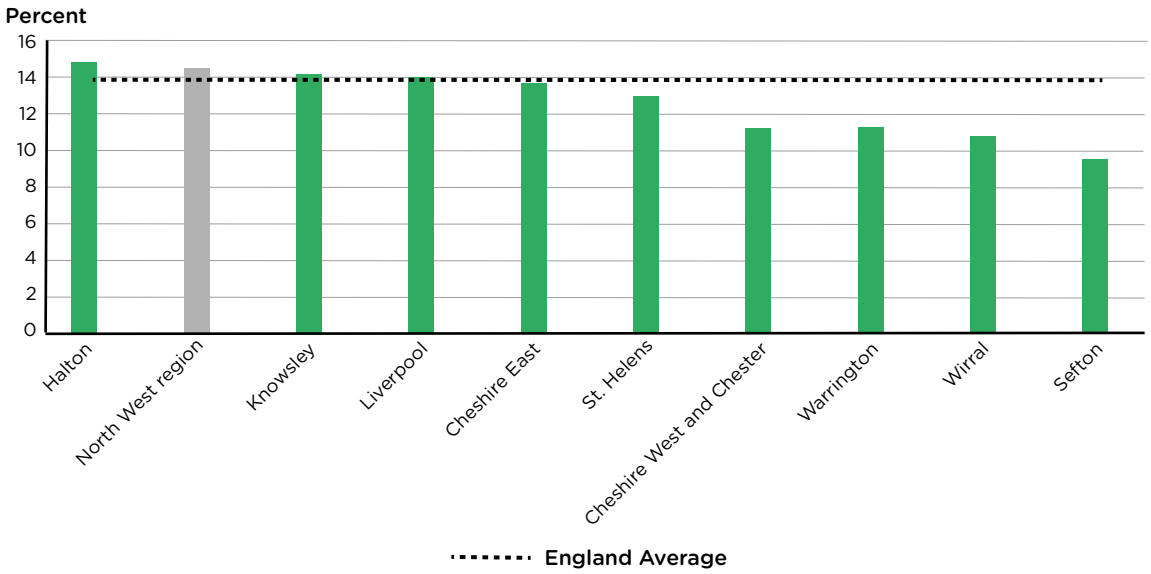
The partnership decided to more effectively join up and connect the existing interventions that were helping people. These included accessing the People's Network, and being supported by IT buddies in the Cheshire East libraries, for example to complete the Good Things Foundation online skills courses; 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.

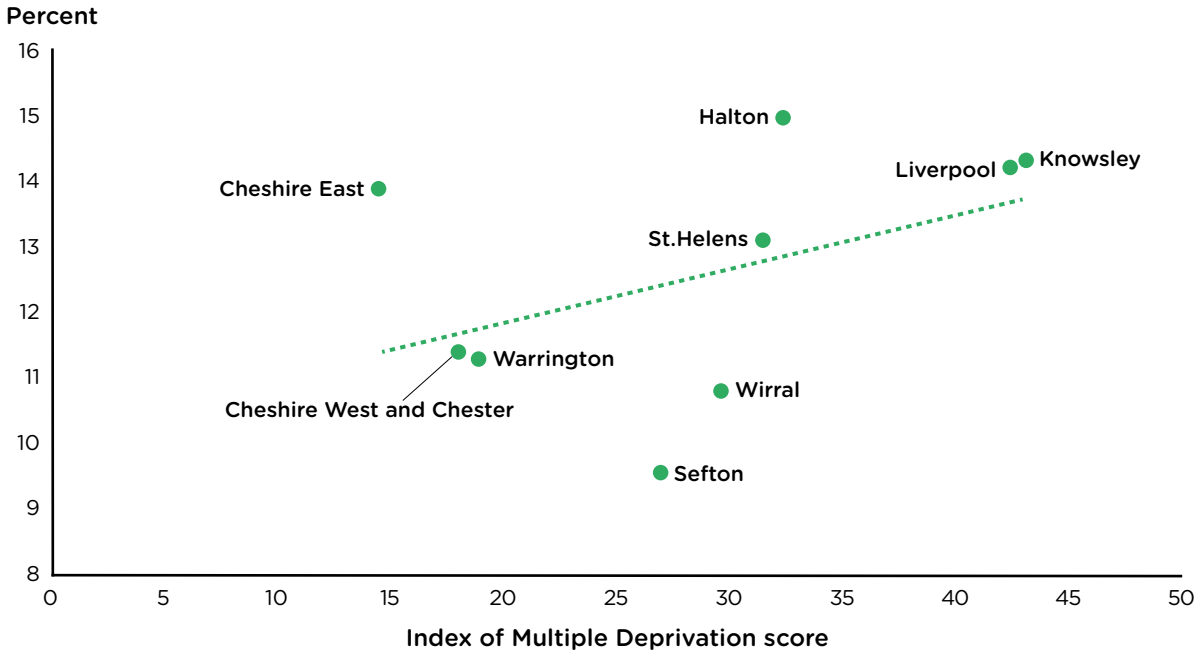
Figure 4.30. Smoking prevalence among adults aged 18 and over, Cheshire and Merseyside lower-tier local authorities and England, 2020



Source: *GP Patient Survey (GPPS) (196)*

Figure 4.31 shows the relationship between deprivation and smoking prevalence in the region.

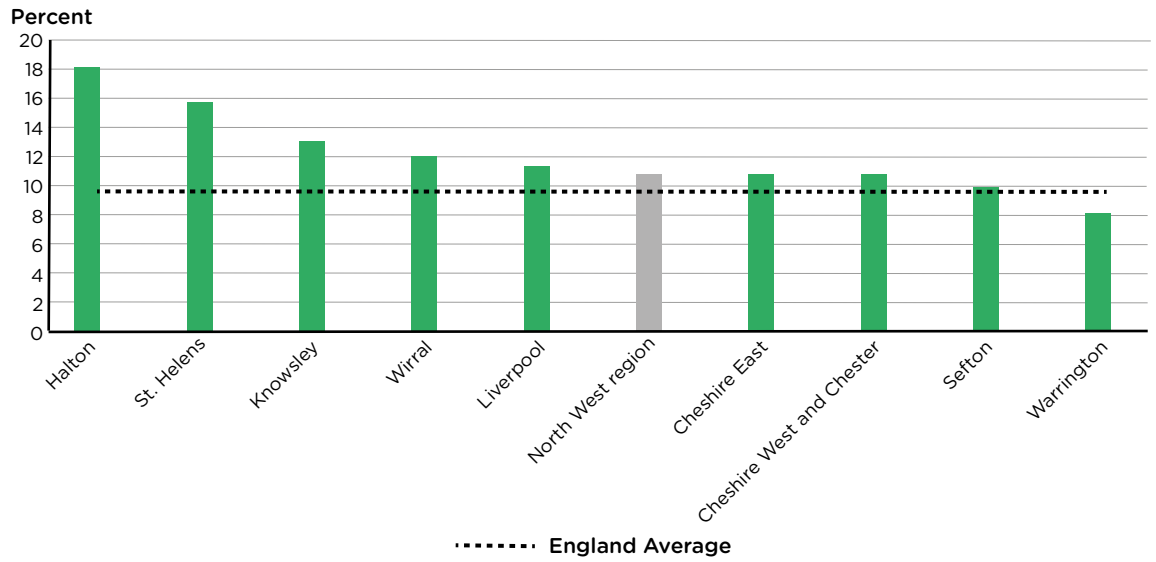
Figure 4.31. Smoking prevalence among adults aged 18 and over by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20



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

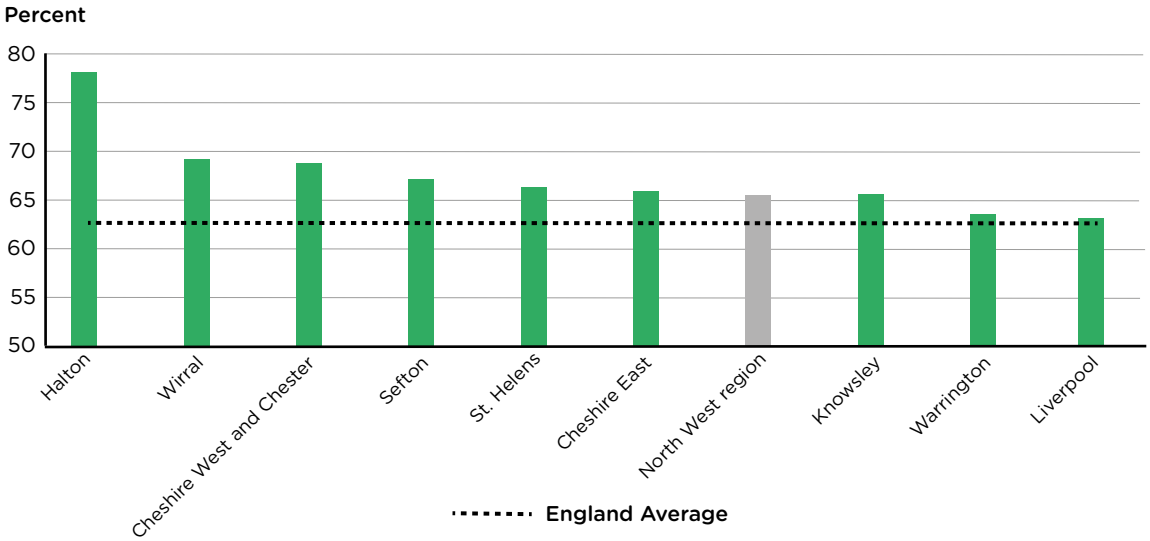


Source: *NHS Digital (197)*

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.

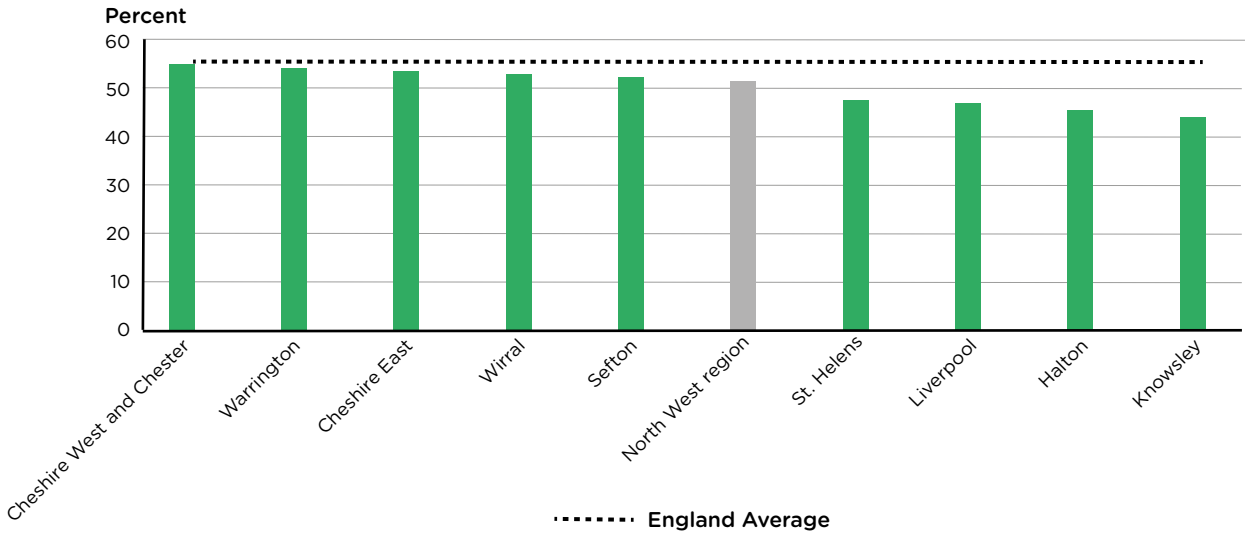
Figure 4.34. Year 6: Prevalence of overweight (including obesity) by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2019/20

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

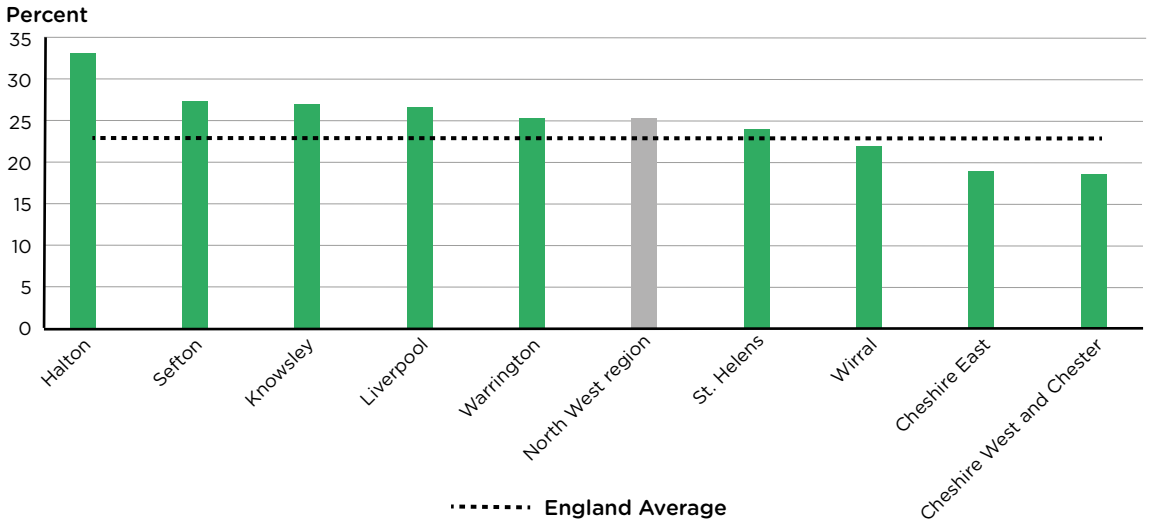


Source: *Sport England (198)*

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.

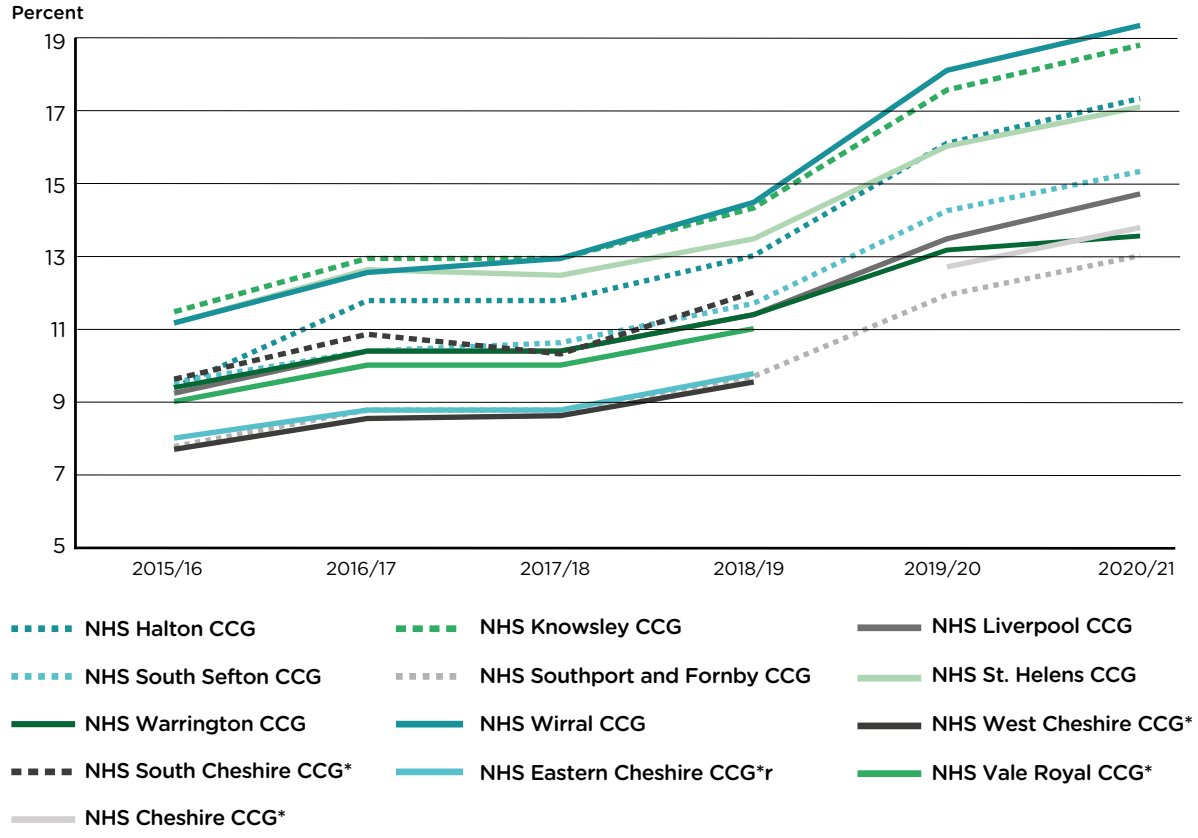
There are currently 70 members of EPCNSO and 10 volunteers. All the members of EPCNSO have learning disabilities and many experience complex challenges especially relating to mental health. Many of the members are also from low-income families. The group provides a vital opportunity to develop skills, 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.

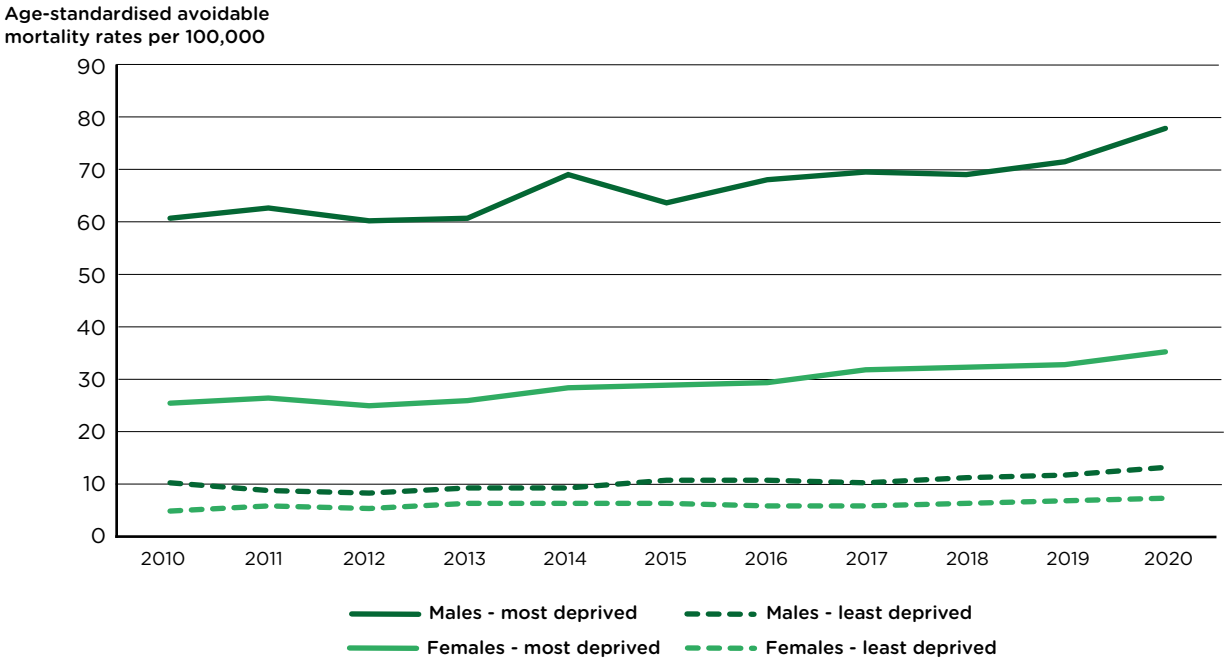
Residents can be directly referred by GPs, social services, housing providers and other professionals and services, or can self-refer and access Connect Us through word of mouth, advertisements in community venues and via Connectors, who knock on doors across Wirral.

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.

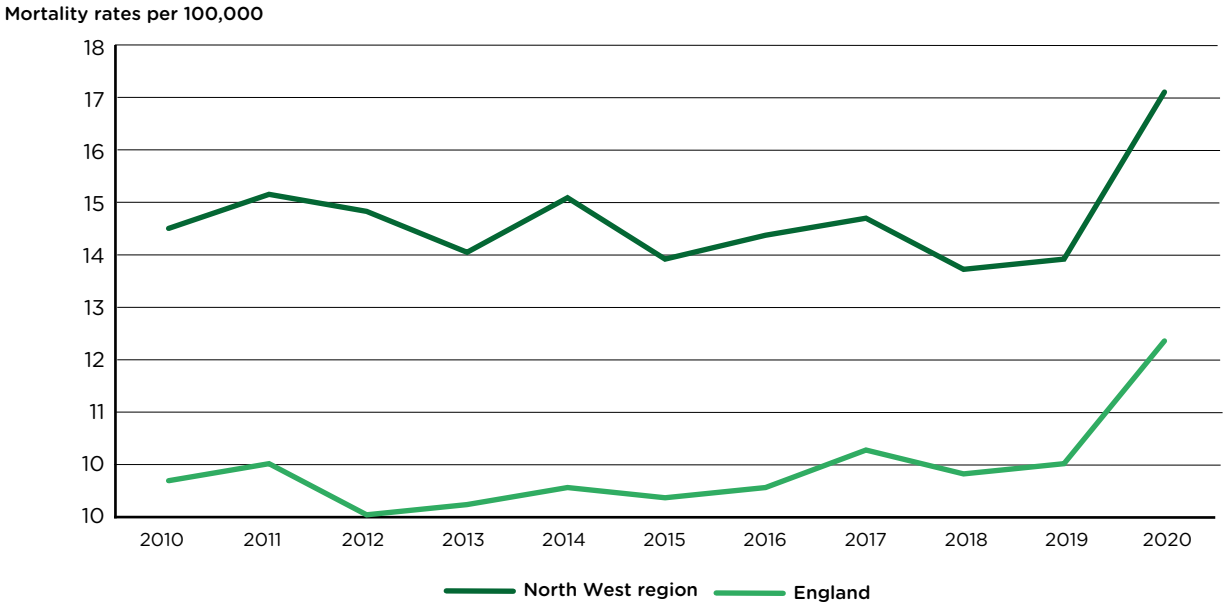
Figure 4.39. Avoidable mortality rates for alcohol and drug-related disorders 2010-20, England



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).

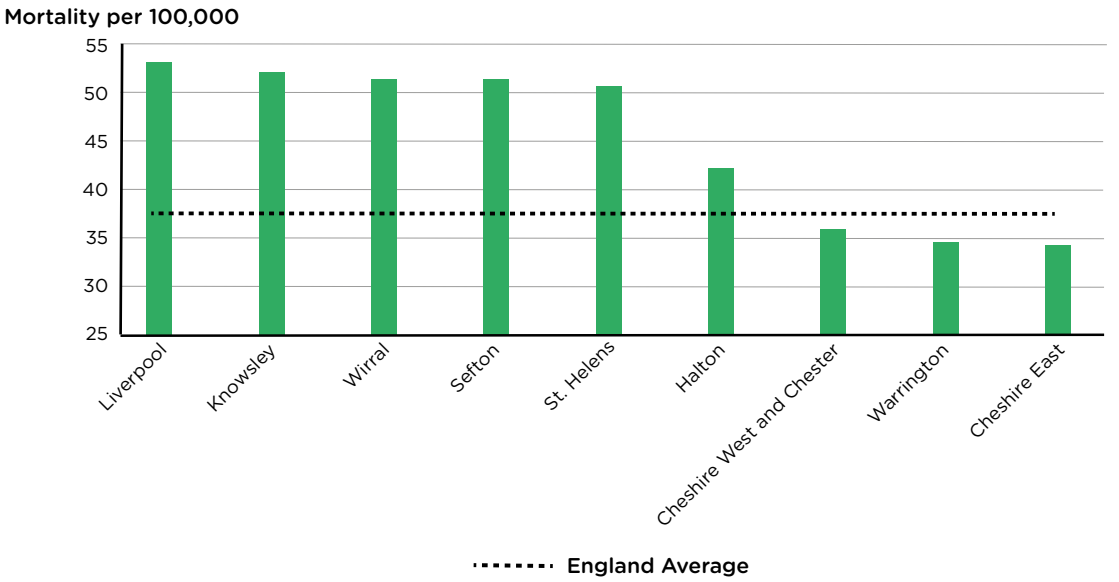
Figure 4.40 Age-standardised alcohol-specific death rates per 100,000 people; North West region and England, deaths registered between 2010 and 2020



Source: *Office for National Statistics (212)*

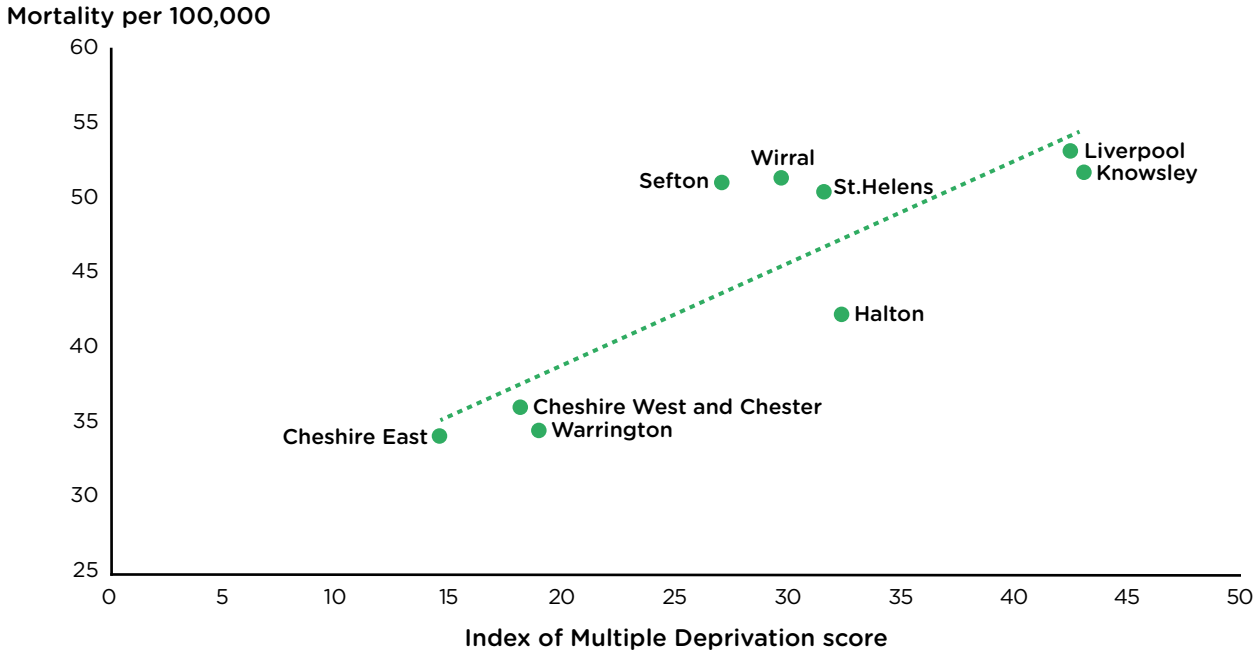
Figure 4.41 shows that six of Cheshire and Merseyside's local authorities have a rate of alcohol-related mortality above the England average and Figure 4.42 shows the strong relationship between deprivation and alcohol-related mortality.

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)*

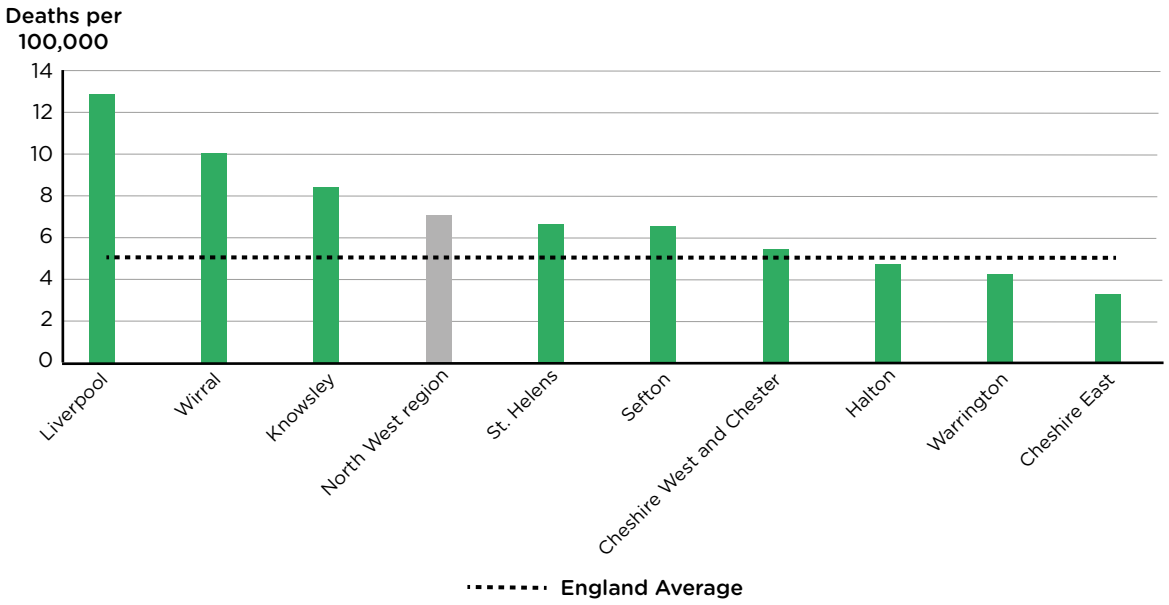
Figure 4.42. Alcohol-related mortality, directly standardised rate, per 100,000, by deprivation (IMD 2019), Cheshire and Merseyside lower-tier local authorities, 2020



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.

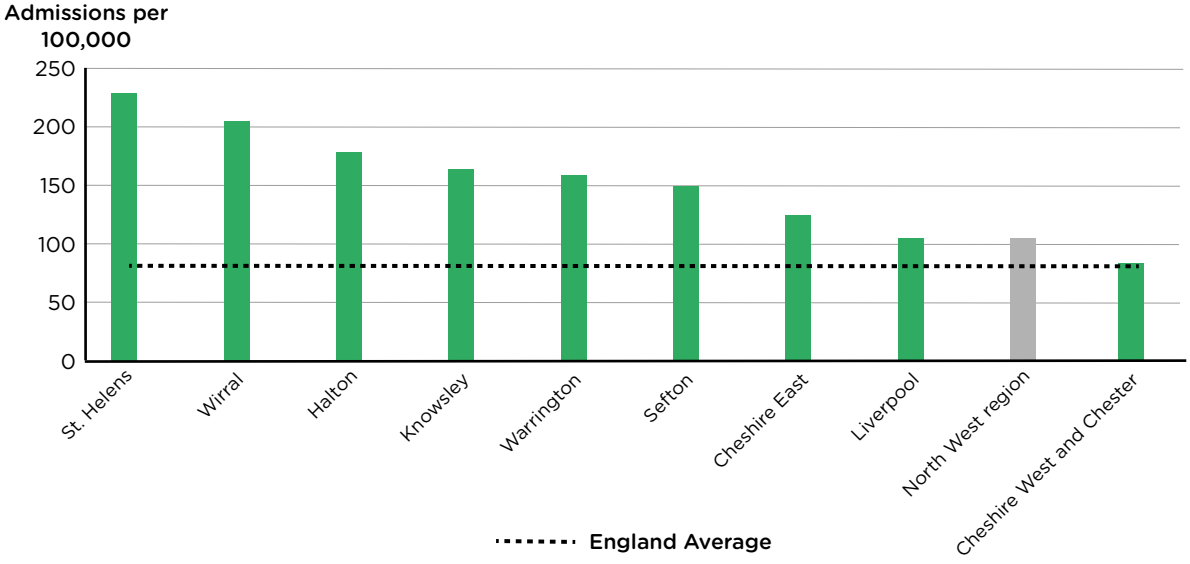
Figure 4.43. Deaths from drug misuse, directly standardised rate, per 100,000, Cheshire and Merseyside lower-tier local authorities, North West region and England, 2018-20



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

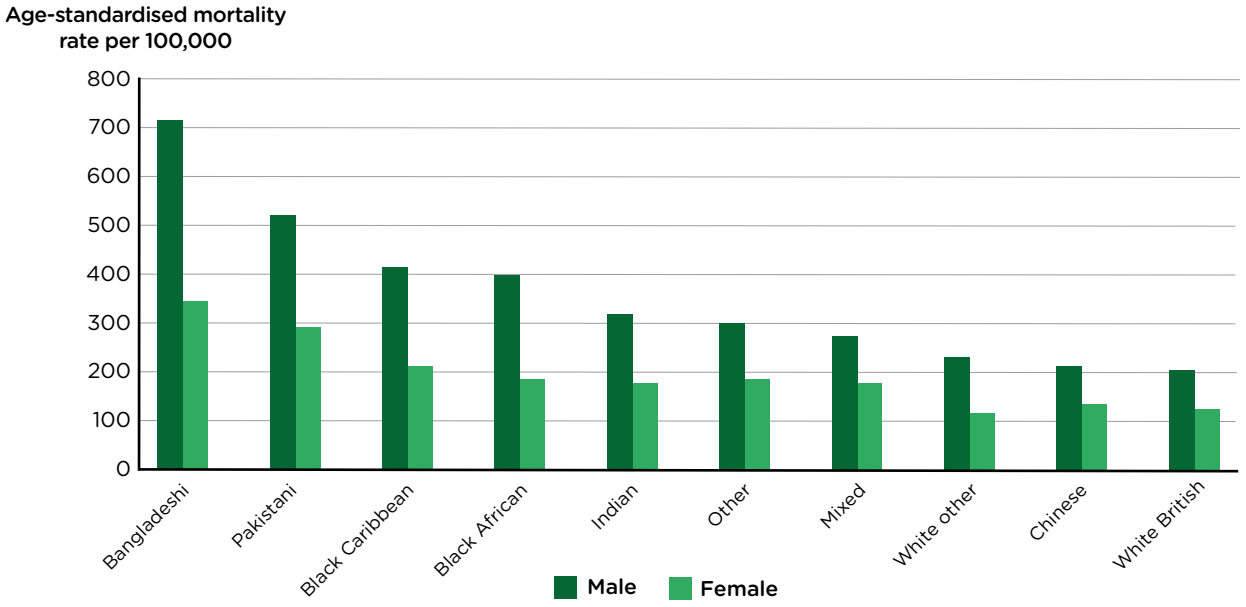
- Activity levels.
- Percentage of loneliness.

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

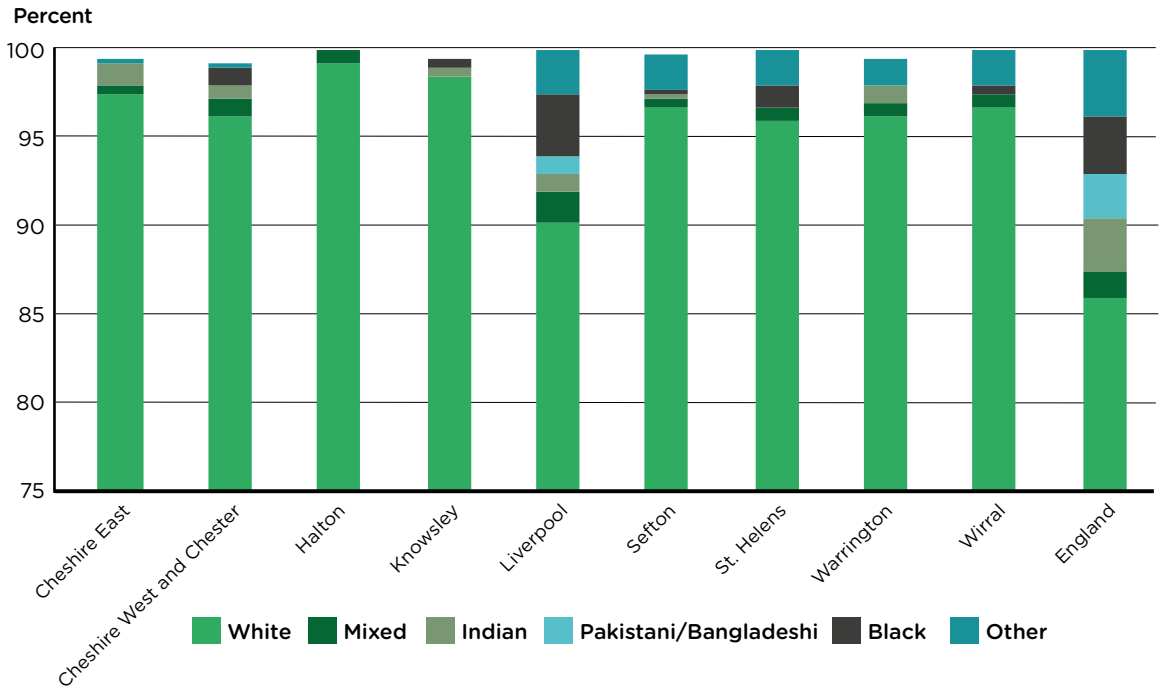


Source: *Office for National Statistics (217)*

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.

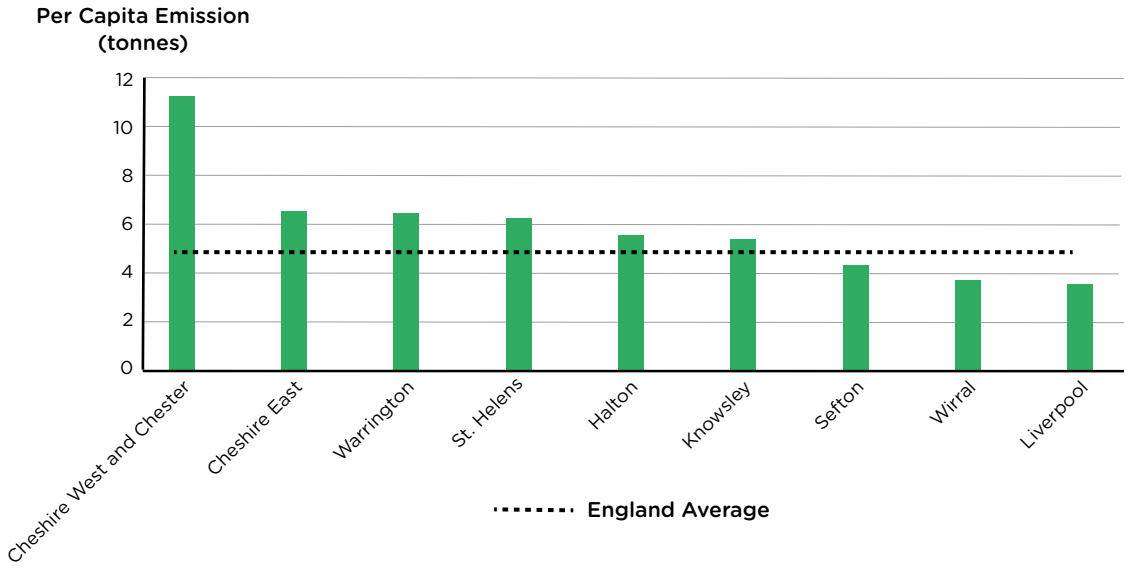
4H PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

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.

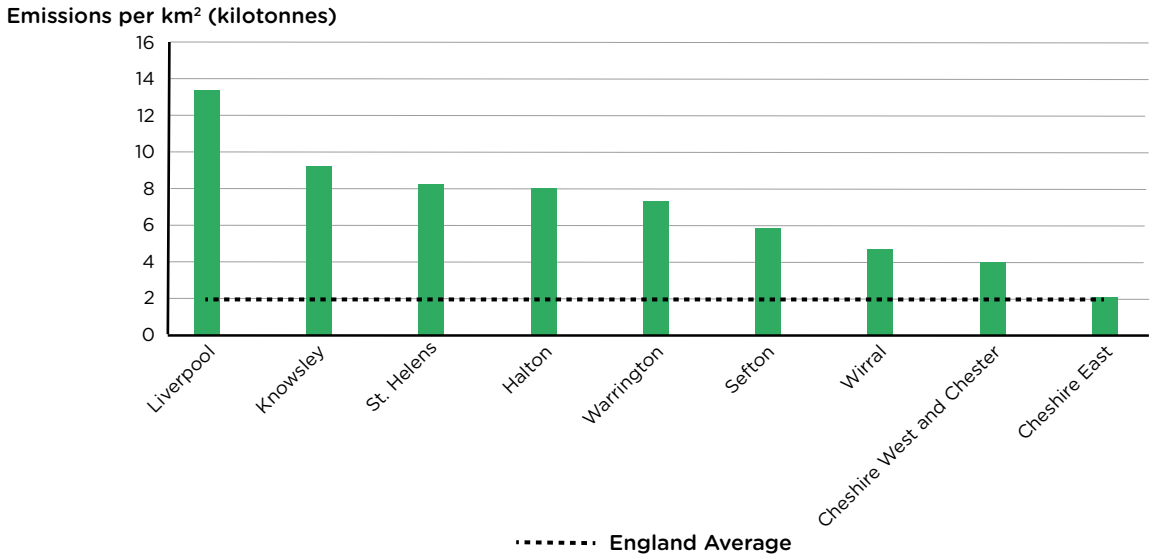
Figure 4.47. Carbon dioxide emissions per capita (tonnes) in Cheshire and Merseyside lower-tier local authorities and England 2019



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

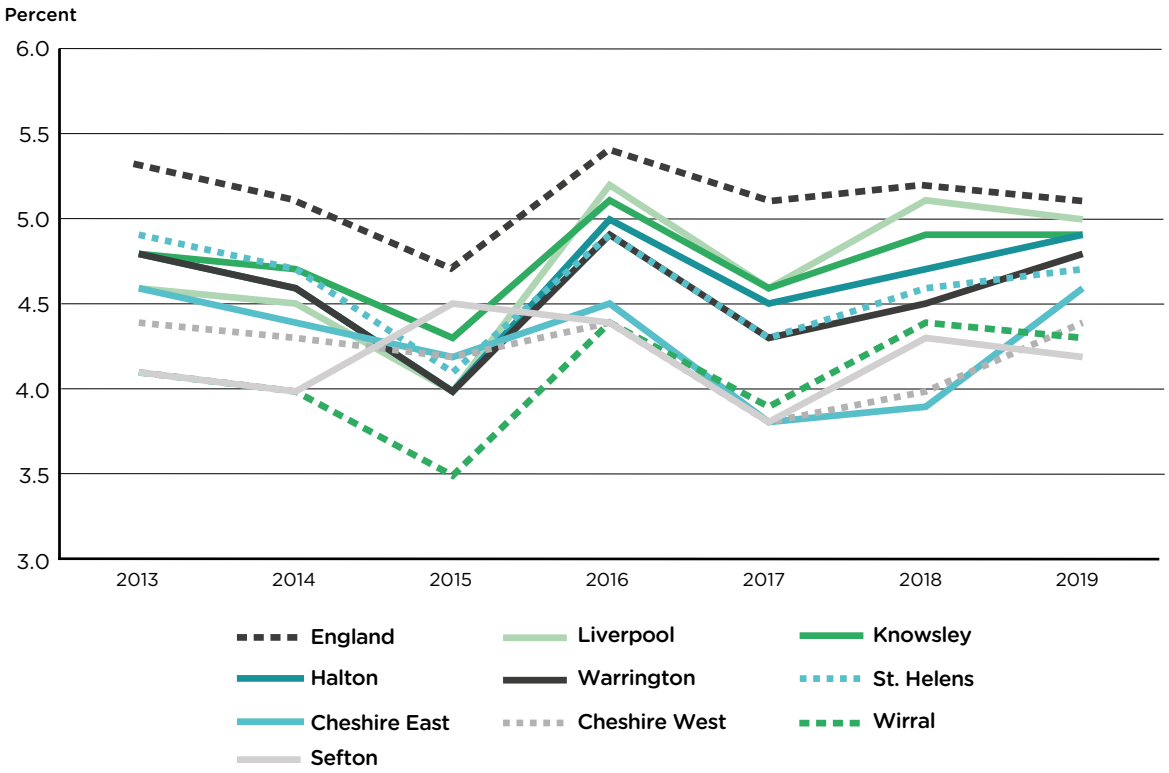


Source: *Department for Business, Energy & Industrial Strategy (223)*

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



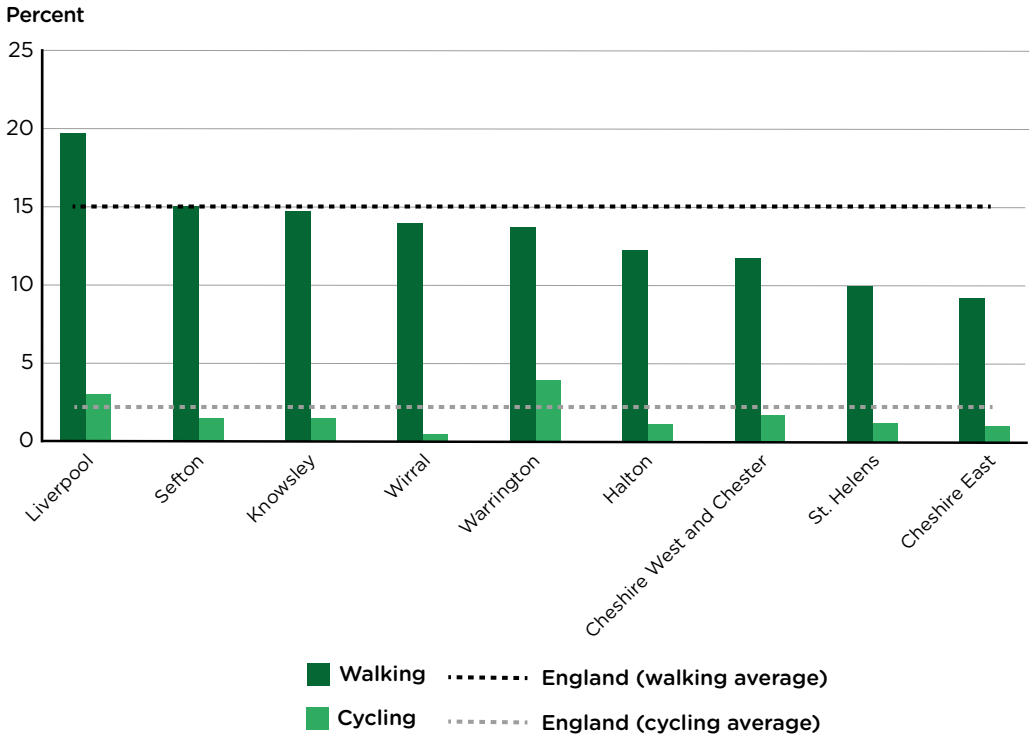
Source: *Department for Environment, Food & Rural Affairs (226)*

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	2023/27
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.

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.

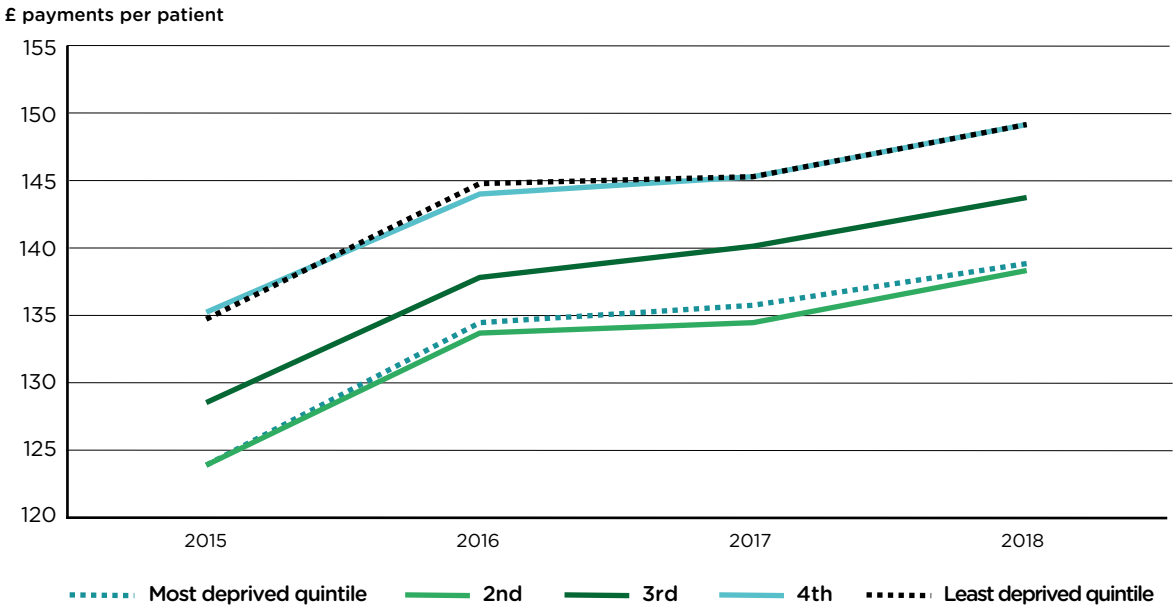
5A INCREASE AND MAKE EQUITABLE FUNDING FOR SOCIAL DETERMINANTS OF HEALTH AND PREVENTION

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

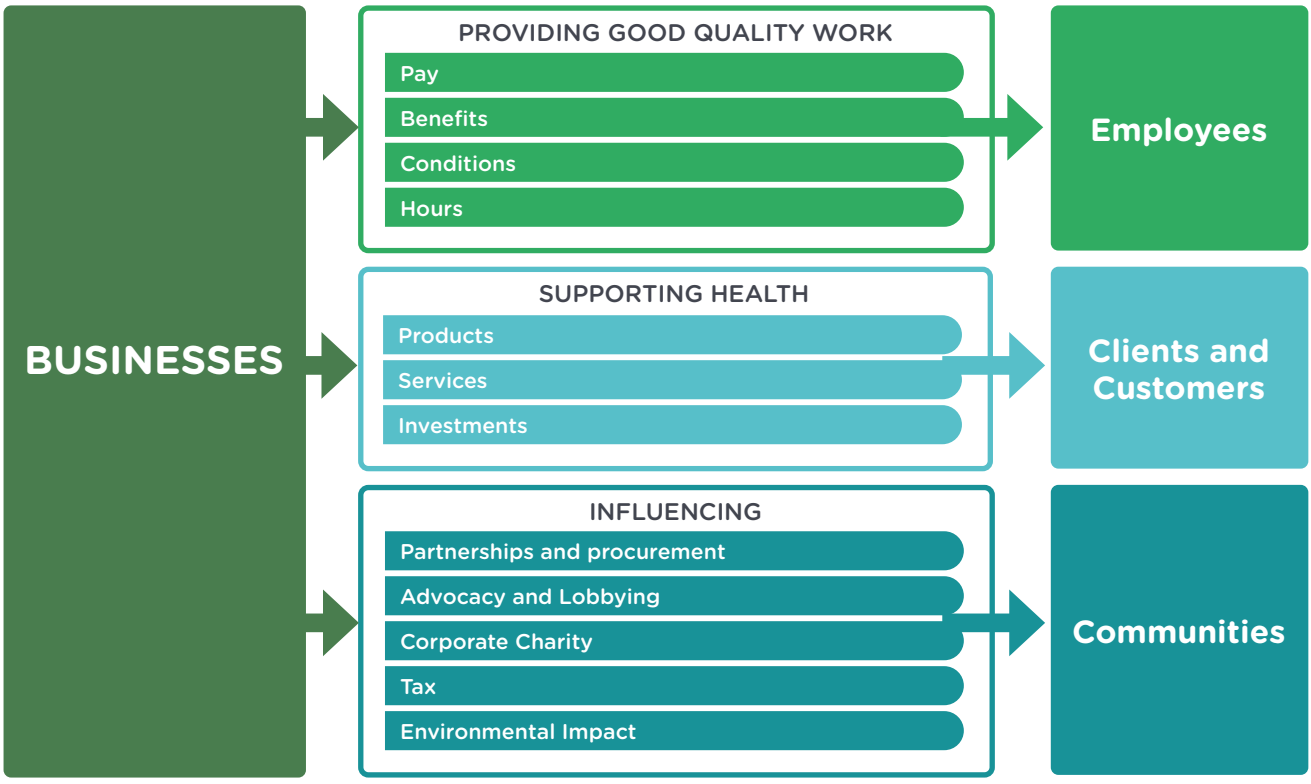
There are important and underdeveloped ways for businesses and the economic sector to use the many opportunities they have to reduce health inequalities.

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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Designed by UCL Educational Media

REPORT TO:	Health Policy Performance Board
DATE:	27th September 2022
REPORTING OFFICERS:	HBC Strategic Director, People
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Update on One Halton Place Based Partnership
WARDS:	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 RECOMMENDED: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 The Health Policy & Performance Board received a comprehensive report in November 2021, and a further report in February 2022 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 with the effective date of 1st July 2022 to implement Integrated Care System's (ICS's); all Clinical Commissioning Groups (CCG's) were 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. Within the footprint there will be nine place based partnerships reflecting the nine local authority areas, each will have

a NHS Place Director; this is a key role providing the interface between the ICS and place. Anthony Leo is Halton's Place Director and commenced in post 1st July 2022. The Place Director is supported by a Senior Team consisting of:-

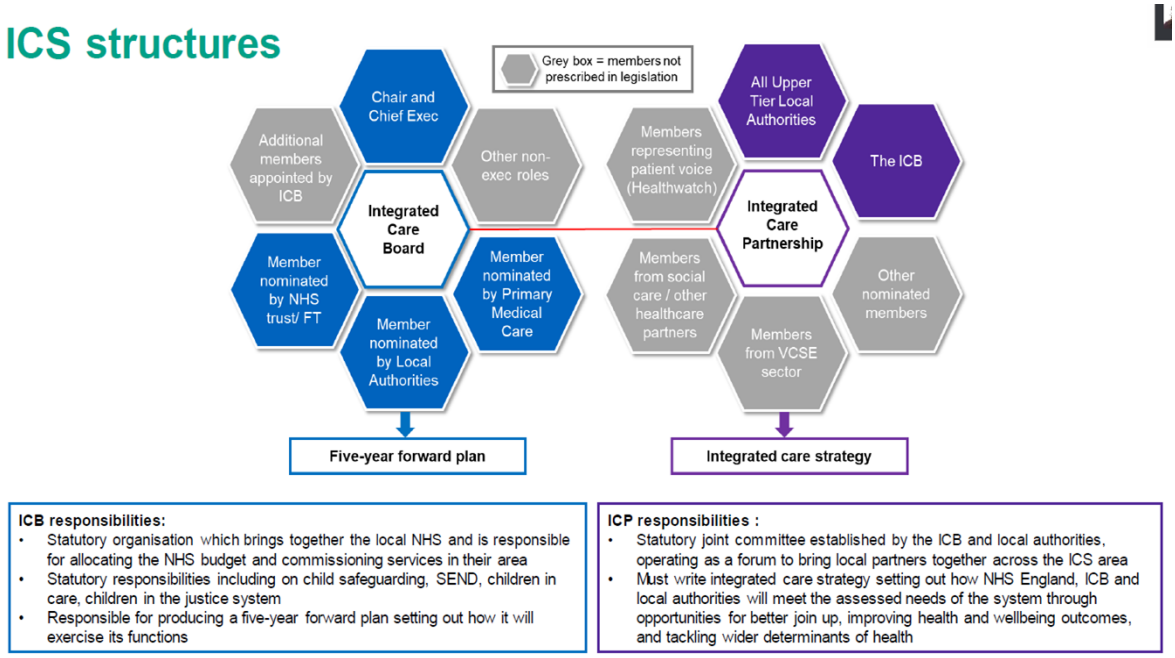
- Associate Director of Quality and Safety Improvement, Denise Roberts
- Associate Director Transformation and Partnerships, Philip Thomas
- Associate Director of Finance & Performance, Nigel Gloudon

and Integrated Care Board staff dedicated to Halton roles.

The ICS consists of an Integrated Care Board (ICB) and Integrated Care Partnership (ICP). Halton's representative on the ICB is Cllr Marie Wright, Anthony Leo will also attend these meetings. The ICB is the delivery arm of the structure and will be referred to as NHS Cheshire & Merseyside moving forward. The ICB will rotate board meetings around the nine places, Halton will host the ICB on 27 April 2023 providing an opportunity to showcase Halton.

The ICP is an alliance of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

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



3.4 CCG functions lifted and shifted to the ICB from the 1st of July. There are no delegations (financial or functions) to place partnerships

in this operating year, the focus is on landing the significant changes safely. The ICB's intention is the majority of activity continues to operate at place and where it is beneficial some things may be delivered at scale from the ICS, a principle of 80/20 is underpinning ICB planning.

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) have a local agreement between health and local authority organisations. Pre the 1st July 2022 the Joint Working Agreement (JWA) was 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 will be renegotiated with a new agreement set out from April 2023.

3.5 Overall, what was ring fenced resources to 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:-

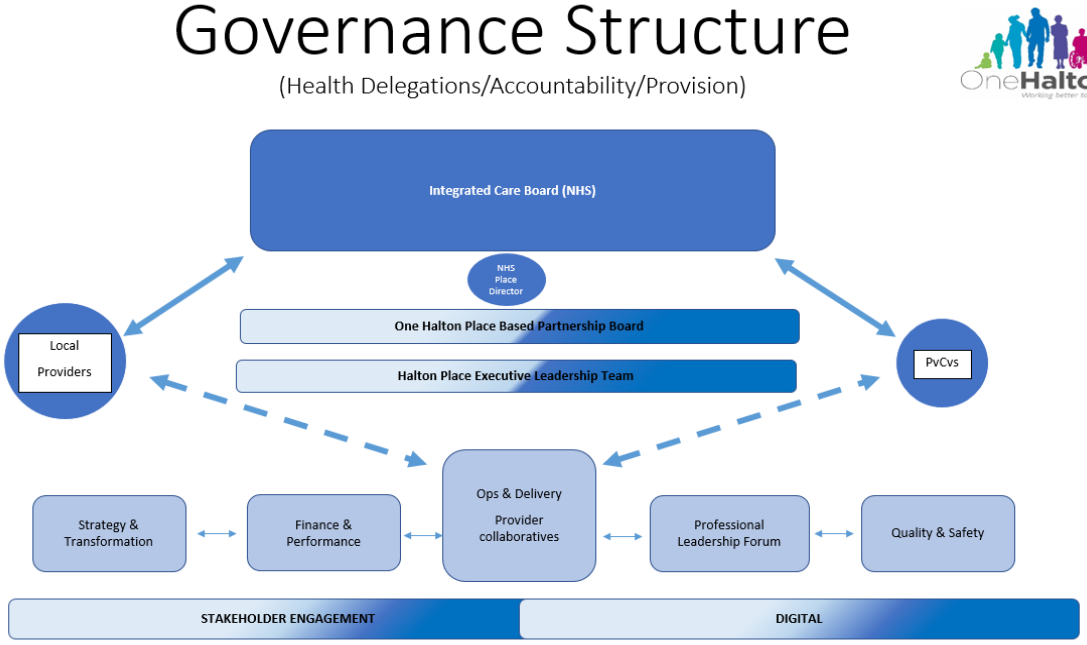
- Understand and work with Halton's communities
- Join up and co-ordinate services around population needs
- Address social and economic factors that influence health and wellbeing (wider determinants of health)
- Support quality and sustainability of local services

The One Halton partnership agreed a vision:-

"Improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them".

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 February 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 a clear understanding about HWBB's statutory responsibilities for the Joint Strategic Needs Analysis (JSNA) and the HWB Strategy with 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 3.6.1 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 the Associate Director of Finance and & Operational Director, Finance, Halton Borough Council
3. **Quality & Safety**, led by the Associate Director Quality and Safety Improvement
4. **Professional Leadership Forum,** led by the GP Clinical Lead for One Halton & Head of Transformation, Primary & Community Care, NHS Cheshire & Merseyside for Halton

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 supported by the ICB Communication team
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 the engine room of One Halton. This is where transformation delivery work streams/projects 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 both CCG and Council budgets. Key local providers also attend i.e. Halton & Warrington Hospital, St Helen's &

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. The Sub-Committee will commence in July 2022 and work is ongoing from a health perspective at ICB level regarding the whole system Quality Assurance. In Halton, the intention is to develop a thematic approach.

Strategy & Transformation – This is a key piece of work to develop the One Halton Strategy. This will replace the existing One Halton Health & Wellbeing Strategy for Halton which is the responsibility of the Health and Wellbeing Board. Public Health are leading this work, this commenced with the Marmot Community work with 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

There is also a fourth priority around the wider determinants of health focussing on employment and workforce.

A draft strategy is currently being consulted on 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.

This strategy will be presented to Octobers Health and Wellbeing Board; One Halton will develop a two year delivery plan by December 2022.

Communication & Engagement – this underpins all One Halton activity. A One Halton communication framework and delivery plan is currently being developed building upon the ICB framework. This will detail how we inform, consult, engage, co-design and co-produce. A key element of the work is the One Halton Voices mechanism which have two elements. Firstly, provide regular meetings that will be themed with speakers and have an undertaking and commitment to ensure feedback in appropriate timescales. The second element will developing a wider network of

engagement; utilising existing mechanisms and established communication networks in Halton.

There is also an immediate priority for workforce communication.

Building awareness and understanding of One Halton, the brand and its delivery is imperative to support system relationships and developing integrated approaches to health and care with improved outcomes.

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 and independent living and management of health and care needs.

3.10 The February 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 is was repeated ahead of implementation in June and the status remained at evolving. The ICB will be repeating the process in the autumn and developing a support offer to places.

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 embeds and is better understood through the transition.

4.0 POLICY IMPLICATIONS

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.

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

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

One Halton supports the Councils and the Health and Wellbeing Board priorities for a Healthy Halton. .

6.1 Children and 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 and 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.

There will be a One Halton work stream around assets to understand the public estate that supports delivery (in the widest sense) in Halton and work towards collaborative planning of the public estate.

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 will link 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

In developing One Halton and health delivery moving over to NHS Cheshire & Merseyside, 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.

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 Policy and Performance Board (PPB)

DATE: 27th September 2022

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Adult Social Care

SUBJECT: Health PPB Scrutiny Review Report 2021/22

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide Health PPB with a copy of the report that concludes the Scrutiny Review undertaken in 2021/22 (attached).

2.0 **RECOMMENDATION: That:**

i) PPB note the contents of the report and provide any comments;
ii) PPB endorse the report and associated actions, which will go forward to Executive Board.

3.0 **SUPPORTING INFORMATION**

3.1 The scrutiny topic considered by Health PPB for 20221/22 was the North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission report entitled 'The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'.

3.2 The scrutiny topic was agreed by Health PPB in February 2021. The topic group was chaired by Councillor Peter Lloyd-Jones with Sue Wallace-Bonner as operational lead. The topic group met between July 2021 and January 2022 with all Health PPB members being invited to attend each meeting.

3.3 The Elected Member Social Care Commission was established as part of a North West ADASS approach to learning lessons from the Covid-19 pandemic. In particular, the role of The Commission was to investigate the impact of the pandemic on people and communities in the North West and what lessons could be learnt for further waves of infection and future service design.

3.4 The NWADASS report set out ten recommendations, which were the main focus of the scrutiny topic in terms of looking at local implementation.

3.5 The attached report explains how the review was conducted, the information that was considered by the topic group over the course of five

meetings and the actions agreed in relation to the each of the ten NWADASS recommendations.

3.6 In the course of the review, the topic group learned of the overwhelmingly positive work undertaken locally during the pandemic. Areas for further action in relation to each of the recommendations set out by NWADASS were agreed upon by the group and are outlined in the action plan included on pages 17-20 of the report.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The focus of the scrutiny review was a report by NWADASS looking at learning lessons from the COVID-19 pandemic; the scrutiny review report presented, and in particular the actions that are proposed, therefore support the Council's strategic priority of improving health.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 No specific risks identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

Not applicable.

Health Policy & Performance Board Scrutiny Review 2021/22

Scrutiny Topic: North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission – 'The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'

Final Report

March 2022

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Purpose of this report

The purpose of this report is to provide information on the Health Policy & Performance (HPPB) Scrutiny Review for 2021/22. It describes how the review was conducted and the recommendations/actions agreed upon by the topic group.

Overview of the scrutiny topic

The 2021/22 scrutiny topic focussed on the following report:

'North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission: The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'

The full report and additional information regarding the commission can be found on the NWADASS website via the following link: https://www.nwadass.org.uk/elected-member-social-care-commission

The Elected Member Social Care Commission was established as part of a NWADASS approach to learning lessons from the Covid-19 pandemic. In particular, the role of The Commission was to investigate the impact of the pandemic on people and communities in the North West and what lessons could be learnt for further waves of infection and future service design.

The Commission investigated the following question:

"*What has been the impact of the pandemic on people who use adult social care services, their families and our communities and what does this tell us about the role our communities should play in supporting people to live independently at home?"*

The NWADASS report made a number of recommendations for councils, which were the main focus of this scrutiny review, in particular looking at local implementation of the recommendations. A summary of the recommendations made by NWADASS is provided below:

Councils should…

I. Say thank you to all adult care and support services.

II. Take active steps to build the capacity of the community and voluntary sector to provide health, care and wellbeing services.

III. Strengthen the wellbeing support, guidance and information available to family and unpaid carers.

IV. Increase the use of direct payments and make them quick and easy to obtain and more flexible.

V. Use role as place-based leaders to communicate across organisations helping vulnerable and isolated people.

VI.	Build on the community volunteering capacity and energy to create stronger preventative and community solutions.
VII.	Support creativity in their providers.
VIII.	Work to make digital services part of blended approaches to meeting need.
IX.	Collaborate with care home providers and provide leadership to design approaches for safe visiting in care homes.
X.	Work with providers and people who use services to redesign day services and shape the market to allow for greater choice, flexibility and accessibility for people.

Topic brief

Please see **appendix 1** for the topic brief, which was agreed at the Health PPB meeting held on 23.02.21. The initial proposed commencement date of March 2021 was delayed to July 2021 due to elections taking place.

In addition, at the first meeting of the topic group (and following a change in membership and the Chair of HPPB following the elections), it was agreed to widen the scope of the topic to include consideration of the ongoing impact of the pandemic on hospital services, particularly waiting lists and back logs given the clear and direct link between adult social care and health.

Topic group membership

All elected members sitting on the Health Policy & Performance Board (as listed below) were invited to the meetings of the scrutiny topic group.

Councillor Peter Lloyd-Jones (Chair)

Councillor Sandra Baker (Vice-Chair)

Councillor Angela Ball

Councillor Laura Bevan

Councillor Dave Cargill

Councillor Eddie Dourley

Councillor Andrew Dyer

Councillor Louise Goodall

Councillor Rosie Leck

Councillor Margaret Ratcliffe

Councillor John Stockton

Council officer support for the scrutiny topic was as follows:

Lead Officer – Susan Wallace-Bonner, Director of Adult Social Services

Support Officer – Natalie Johnson, Service Development Officer (Adult Social Care)

Additional council officers and representatives from partner organisations were invited to individual meetings as appropriate to the focus of the scrutiny topic. Further details are outlined throughout the report.

Methodology

The review was completed by conducting a series of five meetings at which the group members received presentations on various elements related to the NWADASS recommendations. This allowed the group to consider the local position and determine suitable actions/recommendations for implementation in Halton.

Below is a summary of each of the topic group meetings, all of which were held via Microsoft Teams at 5.30pm.

Meeting date	Meeting agenda items
20th July 2021	Review of Topic Brief Discussion re widening the brief Overview of the NWADASS Elected Member Commission Report Next steps
21st September 2021	Lessons learned: COVID-19 Pandemic Reflections – bed-based adult social care services Briefing note re NWADASS Recommendation I – thank you to adult social care and support services Presentation re NWADASS Recommendation VII – facilitating providers to be creative Presentation re NWADASS Recommendation IX – safe visiting in care homes Revised meeting plan
19th October 2021	Hospital waiting lists updated Presentation re community and voluntary sector (NWADASS Recommendations II and VI)
14th December 2021	Presentation re NWADASS Recommendation III – wellbeing support for informal/unpaid carers Presentation re NWADASS Recommendation IV – direct payments Presentation re NWADASS Recommendation VIII – digital service delivery

18th January 2022	Presentation re NWADASS Recommendation X – day services Presentation re NWADASS Recommendation V – place-based leadership Recommendations/actions for final report

Timescales

The scrutiny review was originally intended to conclude in December 2021 to allow the final report to be presented to the February 2022 HPPB meeting. Unfortunately, due to neither the Chair nor Vice-Chair being available for the November meeting, rescheduling was required, resulting in some delays to the original timescales.

Therefore this report is to be presented to the HPPB meeting in June 2022, as no PPB meetings take place between March and May.

Evidence, analysis and conclusions

At the various topic group meetings, colleagues/partners were invited to give presentations/reports on the recommendations from the NWADASS report, looking at current performance in Halton and any gaps and areas for improvement. This section of the report provides further details about the information presented to the topic group and the resulting actions agreed.

This section is structured according to the recommendations from the NWADASS report and looks at the information considered / what we have already achieved and what we still need to do in relation to each recommendation. Please also see **appendix 2**, which displays this information in a table format and includes the original reports and presentations as embedded files.

The table at appendix 2 was shared with topic group members and those who had attended the meetings to give presentations on 01.02.22 following the conclusion of the meetings allowing time for feedback to be sent before finalisation of this report.

NWADASS Recommendation I – public thank you to services

Information considered / what we have already achieved

The topic group learned (via a briefing note presented by Sue Wallace-Bonner, Director of Adult Social Services) that a number of actions had already taken place to thank adult social care and support services:

- Weekly letter from the Director of Adult Social Services.
- Letter from the Chief Executive to care home settings along with a gift of chocolates.
- Easter eggs for members of staff.
- An expression of thanks from the Chair of the Health Policy & Performance Board (Cllr Joan Lowe at the time) within the Health PPB Annual Report for 2020/21.

In addition, there were various expressions of support and thanks that took place within provider organisations:

- Thank you cards and a £200 voucher for all staff (PossAbilities).
- A YouTube video of staff supporting and congratulating each other under the title ‘what have you done to make you feel proud?’ (ICare).
- Gifts and expressions of thanks from the community and local businesses, e.g.:
    - Free pizzas from Domino’s;
    - Free tyre puncture repairs from KwikFit;
    - Donation of toiletries from Savers;
    - Donations of cakes and biscuits from Poundland;
    - Donations from the community of items such as wine, bath bombs, candles, chocolates, hand lotion and uniform bags.

With regards to unpaid carers, the Council commissions Halton Carers Centre to provide support to unpaid/informal carers in Halton. The Carer's Centre continued to support carer's during lockdown through zoom sessions, online activities and regular phone calls where support workers would remind them how well they were doing during difficult times. As restrictions have eased, the centre has been able to offer face-to-face support once again, if preferred by carers.

The Council recognises the vitally important role played by unpaid carers, which is why it will continue to work with the Carer's Centre to ensure that carers are provided with the support they need to continue in their caring role.

What we still need to do

- When conditions allow, the Council will hold an event* to say a public thank you to commissioned and voluntary adult social care and support services and unpaid/informal carers. *(*Funding to be identified in the form of sponsorship from an external agency.)*

NWADASS Recommendation II – building capacity in the community and voluntary sector

Information considered / what we have already achieved

The topic group received a presentation from Sally Yeoman, Chief Executive Officer of Halton & St Helens Voluntary and Community Action (VCA) regarding the response of the voluntary, community, faith and social enterprise sector in Halton during the COVID-19 pandemic. It was noted that over 800 new volunteers were recruited and they took on a range of roles including delivering food and other emergency supplies, undertaking wellbeing and check-in calls and providing transport and general advice, guidance and support. Between April and June 2020 over 6,000 vulnerable were able to be supported through the volunteering effort.

What we still need to do

- Build on the volunteering legacy and sustain the growth in volunteers seen during the pandemic, making use of the Volunteering Portal.
- Involve the community and voluntary sector in the public thank you event (see recommendation I). Ensure that volunteers are encouraged to continue in their role by understanding the difference they make to people's lives.
- Ensure Halton's Market Position Statement (last updated in 2018 and therefore due for review) clearly sets out the role of the community and voluntary sector and the support that the council will provide.
- Continue to commission for outcomes, encouraging creativity within the community and voluntary sector.
- Further promote the comprehensive training offer available from the Council's External Funding Team, which can be accessed by the community and voluntary sector. The following training courses (which are free of charge for

organisations working in Halton/on behalf of Halton residents) are available to sign up for online (https://halton.me/external-funding-course-booking-form/):

- 'Basic Bid Writing' covering good bid writing techniques, ten key elements of a basic funding application and top tips to write a strong bid.
- 'Monitoring and Evaluation', which helps attendees to understand what monitoring and evaluation involves, where and how it should be used in grant-funded projects and best practice for producing good quality and effective data and reports.
- 'Now you have your grant' is a course that offers a basic introduction to the responsibilities of managing grant funding for those who are new to it or would like to improve their skills.
- 'Developing a Fundraising Strategy' helps attendees to develop their organisation's vision and focus its aims and objectives. It includes organisation analysis, action planning, understanding budgets, cash flow and risk and monitoring.

NWADASS Recommendation III – wellbeing support for informal carers

Information considered / what we have already achieved

The topic group received a presentation from Carl Harris, Chief Executive Officer of Halton Carers Centre who was supported by Emma Sutton-Thompson, Principal Manager of Policy, Performance & Customer Care within the Council's Adult Social Care department who is also the lead for the Carers Strategy.

The presentation covered information about the Carers Centre, the One Halton Carers Strategy, the wellbeing offer from the centre and partnership working. Information was also provided about the main triggers leading to carer breakdown, how the centre has supported carers throughout the pandemic along with feedback from carers and findings from the wellbeing survey.

It was noted that carers valued the wellbeing support most of all and it is clear that this warrants ongoing investment – 90% of carers surveyed by the centre said that if they weren't performing the caring role their loved one would need require more intervention from health and social care services.

Below is a quote from a carer who clearly values the support available from the Carers Centre:

> *I get everything out of coming here. It's like the centre is a part of me now. I get advice and support and the therapies are really important. Everyone gets a chance and everyone is included. There's a fun factor here. Life would be dull, dreary and boring if the centre didn't exist. There would be a lot of isolated people. People come together and let other people know how they really feel here. Without the centre there would be a lot of isolated people and there would be no way of getting the info you need.*

What we still need to do

- Continue to support the Carers Centre to deliver wellbeing support and other services to Halton carers in order to prevent breakdown.
- Help to enable the Carers Centre to provide support to any new carers that may have emerged during the pandemic but are as yet unidentified. Early support is key to avoid escalation / crisis.

NWADASS Recommendation IV – use of direct payments

Information considered / what we have already achieved

The topic group received a report from Marie Lynch, Divisional Manager for Care Management and Principal Social Worker. The report covered information about what direct payments are and how they are delivered in Halton, including the role of the Council's Direct Payments Team. Latest figures indicated that 827 people were receiving a direct payment in Halton. It was also noted that 35% of clients in Halton in receipt of long-term support have a direct payment, which compares favourably to the North West average of 25%.

What we still need to do

- Halton already performs well compared to regional averages in terms of the proportion of people receiving a direct payment; this should continue.
- Continue to work with the Liverpool City Region to address issues surrounding the recruitment of Personal Assistants.

NWADASS Recommendation V – place-based leadership

Information considered / what we have already achieved

The topic group received a presentation from Mil Vasic, Strategic Director for the People Directorate. The presentation covered information about the successful work that had taken place during the pandemic as a result of the Council's approach to facilitating partnership working:

- COVID-19 Asymptomatic Testing, which necessitated a place-based approach to targeting disproportionately impacted and underrepresented groups such as the Gypsy/Traveller community, asylum seekers/refugees, high-risk occupations, multi-generational households, areas of high population density and areas of socioeconomic deprivation.
- HBC COVID-19 Support including emergency food supplies and a single point of contact COVID-19 hotline;
- Supporting Families – providing support in creative ways during COVID-19 restrictions.

What we still need to do

- Continue to provide support for vulnerable adults in line with the learning from the pandemic (e.g. the success of the COVID hotline in signposting people to the appropriate place etc.)
- COVID has given us time to reflect on our working practices and be open to change and adaptations for the future. The Topic Group will progress the following suggestions:
    - Create a virtual and digital platform for families to access services both face-to-face and virtually;
    - Continue to learn and listen to what communities and families are telling us about services;
    - Continue to adapt and change and have the ability to re-design services mixing virtual support with face-to-face support and build on the increased involvement of the voluntary sector.

NWADASS Recommendation VI – build on volunteering capacity

Information considered / what we have already achieved

Recommendation VI and II (see above) were covered jointly through the presentation from Sally Yeoman, Halton & St Helens VCA CEO. As referenced earlier, there was a real increase in volunteering during the pandemic and it is essential that we attempt to maintain and build on that by ensuring people know what a difference it makes to the lives of vulnerable people.

What we still need to do

As with recommendation II:

- Build on the volunteering legacy from the pandemic to further strengthen the local community and voluntary sector;
- Ensure that volunteers are encouraged to continue in their role by understanding the difference they make to people's lives. This should be part of the public thank you event and there is also an ongoing role for Halton & St Helens VCA.

NWADASS Recommendation VII – facilitating provider creativity

What we have already achieved

The topic group received a presentation from Helen Moir, Divisional Manager for Independent Living and learned of the following examples of support provided by the Council and creative practice that had taken place during the pandemic:

- Support was provided to care homes, including the development of a resilience plan enabling the sector to respond to changes required as a result of the pandemic;
- IPads were distributed to all care homes;

- PenPal schemes were established;
- Contact for clients with family and friends was supported through the use of IPads, Skype, FaceTime and telephone calls;
- Communication with families was maintained via videos and newsletters;
- Networking between services and colleagues was facilitated through welfare calls to registered managers and monthly meetings, for example;
- Wellbeing activities were delivered including corridor quizzes, access to streaming services (e.g. Netflix), bingo, hairdressing, hand massage and spiritual and pastoral support delivered through online means.

What we still need to do

- Further develop IT skills amongst care home staff;
- Facilitate re-integration into the community for care home residents;
- Continue to support the wellbeing of staff in the care home sector;
- Support care homes to access national funding/grants;
- Continue to hold strategic meetings with care home operators.

NWADASS Recommendation VIII – digital service delivery

Information considered / what we have already achieved

The topic group received a presentation from Shelah Semoff, Partnerships Officer within the Enterprise, Community & Resources Directorate, which provided information regarding the work taking place in Halton and across the Liverpool City Region in relation to digital inclusion.

It was noted that a key issue is ensuring that the digital infrastructure is in place to allow people to get online – there were some issues during the pandemic around the Wi-Fi infrastructure not being sufficient to allow the use of IPads to keep in touch with loved ones. There is a local working group, linked in with the LCR work that is working to establish a baseline and determine actions required.

What we still need to do

- Progress the work around digital inclusion and infrastructure locally, linking in with the Liverpool City Region as necessary. The first step is to establish the baseline from a mapping exercise and then present an Action Plan to Management Team.

NWADASS Recommendation IX – safe visiting in care homes

Information considered / what we have already achieved

The topic group received a presentation from Jane English, Divisional Manager for Care Homes (in-house), which covered the following areas:

- The picture in care homes in March 2020 at the onset of the pandemic and the current picture in 2021;
- The restrictions in place surrounding visitors;

- Support from the council to care homes;
- National examples of care home staff going above and beyond;
- Challenges;
- Next steps – Covid is here to stay so how do we best support our most vulnerable and their families to maintain health lives living within our care homes?

It was noted that care homes are not hospitals; they are people's homes and we need to ensure that people are able to experience quality of life. Work took place locally to ensure people were able to see their loved ones including the use of pods, window visits and outdoor visits as well as ensuring ongoing virtual contact.

What we still need to do

- Develop a Communications Strategy to raise awareness that care homes are safe environments and people are invited to come in to enrich the lives of residents.
- Explore the role for the community and voluntary sector to be more involved in care homes in order to improve residents' quality of life. This should include exploring new opportunities as well as strengthening existing projects (e.g. Pen Pal schemes etc.)

NWADASS Recommendation X – flexibility within day services

Information considered / what we have already achieved

The topic group received a report from Eileen Clarke representing Day Services on behalf of Stiofan O'Suillibhan, Divisional Manager for Community. The report covered information about the journey experienced by Day Services through the pandemic. Key points highlighted were as follows:

- PPE was a big struggle at first;
- Regular management meetings helped keep services functioning;
- Nationally, people with a learning disability died at a rate of six times the normal average;
- Initially Day Services was closed down and staff redeployed to open services (predominantly Halton Supported Housing Network);
- Contact with people/families was maintained to help with feelings of loneliness, anxiety and depression etc.;
- In addition, activity packs were distributed and these helped to improve mental health;
- Following the first lockdown, Day Services looked at the areas that could re-open safely (e.g. outdoors);
- Service users who had reported having mental health struggles were prioritised for places;
- Transport was difficult to manage in terms of ensuring it was safe so this caused some delays;

- Into Summer 2020, indoor venues began to open with the service operating at 50% of pre-pandemic levels;
- Social distancing requirements meant that even with all venues open the service could only accommodate 70% of the usual attendee numbers;
- Currently, the service is still only 60% open but it is hoped that the service will be able to return to some kind of normality by the second quarter of next year;
- It's clear that the activities engaged in within Day Services are important to people and contribute to their wellbeing and self-worth – without these services, pressures occur elsewhere in the system (e.g. Care Management, Positive Behaviour Support Service and the NHS).

What we still need to do

- The Topic Group learned that outreach support offered by in-house Day Services during the pandemic was welcomed and greatly valued by clients and families (e.g. telephone check-ins and activity packs). A flexible approach to service delivery should continue once clients return to building-based services so that visits to day services are supplemented by access to digital support/activities and there is outreach support for those who may be feeling isolated. Day Services should also consider what learning they can take from the care home sector (e.g. Pen Pal schemes).
- This should link in with the review of the Adults with Learning Disabilities Strategy that is in progress.

Additional topic scope – hospital waiting lists

Martin Stanley, Head of Acute Commissioning at NHS Halton Clinical Commissioning Group (CCG) talked to the topic group about the position in relation to hospital waiting lists and recovery plans. Some key points highlighted by Martin are detailed below:

- The CCG is involved in the work around hospital recovery programmes;
- At the start of the pandemic, all aerosol generating procedures had to stop until the disease was more understood;
- It is estimated that it will take two years to get back to pre-pandemic levels with waiting lists;
- Those on waiting lists have been put into one of five priority groups – one being procedures of the highest priority that need to take place immediately (e.g. life-threatening conditions), group two being procedures that need to take place in four weeks, group three are those that can wait longer and groups four and five are those not relating to life-threatening conditions and in this case a discussion will take place with the patient who may choose to wait and manage their condition until they feel happy to proceed;
- There are three main factors contributing to the increased numbers on waiting lists:
- Physical space – infection control requirements slow things down and impact on the number of procedures that can take place (e.g. air must circulate before

the next patient); use of air conditioning units has helped create additional capacity but productivity is still down;

- Staffing issues – staff needing to isolate creates capacity issues;
- Covid patients in hospital – ICU beds being occupied means certain types of surgery cannot be undertaken – currently a low number of ICU beds are occupied by Covid patients so elective surgery can take place;
- Also, people must undergo a Covid test before going into hospital for a procedure and, if positive, this means cancellation and re-booking, which creates more pressure;
- In terms of recovery plans, the hope was for the level of activity to be 95% of what it was pre-Covid at the end of October 2021 and 100% by the end of March 2022 – local hospitals were doing well towards this until a couple of weeks ago due to the pressure on A&E (98-100% occupancy of medical beds);
- Increase in non-elective admissions puts pressure on elective capacity;
- Halton is doing well in relation to hospital discharges with just a few complex patients waiting on a care home placement (in Warrington there is a problem around domiciliary care with 98 beds occupied by those awaiting discharge with domiciliary care package);
- In general, Warrington and Whiston hospitals have been used for emergency, non-elective and Halton and St Helens have been used for elective, which has kept things moving;
- Information regarding the total waiting list was displayed – pre-Covid it was around 10,000 patients and now it is 12,500 patients;
- Information regarding 52 week waiters was displayed – pre-Covid nobody would wait more than one year but there are now a number of patients who have waited this long but some may be those in priority groups four/five who have chosen to wait (e.g. dermatology – varicose veins);
- The aim is to get the 52 week waits to zero by March 2022;
- In terms of the aim to be at 95% pre-Covid levels, nationally it is at 82% and two local trusts are at a similar level;
- There is concern that a winter surge could add further pressure;
- Hospital cells are working hard to keep on track and there is national support and a pot of money;
- Updates are received weekly and there is regular discussion with patients with public health support to ensure no-one slips through the net;
- GP referral rates are back to pre-Covid levels;
- Cancer referrals are at 110% of pre-Covid levels (due to wanting to make sure nothing is missed);
- Patients are encouraged to see their GP if required.

What we still need to do

The topic group felt it was important that they remained updated regarding the hospital situation and the following course of action was agreed:

- Regular summary updates regarding the hospital position to be provided to Health PPB meetings with a full update report in April 2022.

Action Plan

The information presented above outlines ‘what we still need to do’ in relation to each of the NWADASS recommendations; these actions have been incorporated into an Action Plan, which can be found on the following page.

2021/22 Scrutiny Review Action Plan

NWADASS Recommendation Councils should…		Action(s) for Halton (as agreed by Scrutiny Topic Group)	Responsibility	Timescale
I	Say a public 'thank you' to adult social care and support services (commissioned and voluntary) and unpaid carers for their hard work and sacrifices during the pandemic and beyond	Hold a public thank you event for commissioned and voluntary adult social care services and informal carers (to be funded via an external agency – i.e. sponsorship)	Care Home Development Group	When conditions relating to COVID-19 allow a physical event
II	Take active steps to build the capacity of the community and voluntary sector to provide health, care and wellbeing services	Build on the pandemic volunteering legacy, making use of the Volunteering Portal	Halton & St Helens VCA	Ongoing
		Involve the community and voluntary sector in the public thank you event (see above) ensuring they know the difference they make	Care Home Development Group	When conditions relating to COVID-19 allow a physical event
		Include reference to the role of the community and voluntary sector and the support the council will provide in the Market Position Statement	HBC Commissioning	Last Statement was 2018 so due to be updated
		Continue to commission for outcomes, encouraging creativity in the community and voluntary sector	HBC Commissioning	In line with contractual requirements
		Promote the comprehensive training offer of the Council's External Funding Team to the community and voluntary sector	HBC External Funding Team	Ongoing
III	Strengthen the wellbeing support available to informal/unpaid carers	Continue to support the Carers Centre so it is able to continue delivering wellbeing support and early	HBC Adult Social Care	Ongoing

NWADASS Recommendation Councils should…		Action(s) for Halton (as agreed by Scrutiny Topic Group)	Responsibility	Timescale
		intervention to avoid carer breakdown and crisis situations		
IV	Seek to increase the use of direct payments, making them quick and easy to obtain, and allowing for much greater flexibility for people in how they can be used	Ensure the already high take-up of direct payments in Halton can continue by working with the LCR to address the key issue of recruitment of Personal Assistants	HBC Direct Payments	2022/23
V	Use their place-based leadership role to facilitate communication with and across organisations helping vulnerable and isolated people	Create a virtual and digital platform for families to access services both face-to-face and virtually	One Halton Digital Group	2022/23
		Continue to learn and listen to what communities and families are telling us about services	HBC Quality Assurance Team	Ongoing
		Continue to adapt and change and have the ability to re-design services mixing virtual support with face-to-face support and build on the increased involvement of the voluntary sector	One Halton Digital Group	2022/23
VI	Build upon the new capacity for volunteering in the community (which people have demonstrated during the pandemic) to create stronger preventative and community solutions	As Recommendation II – see above		
VII	Support creativity in their providers	Further develop IT skills amongst care home staff	Care home providers	2022/23
		Facilitate re-integration into the community for care home residents	Care home providers	Spring / Summer 2022

NWADASS Recommendation Councils should…		Action(s) for Halton (as agreed by Scrutiny Topic Group)	Responsibility	Timescale
		Continue to support the wellbeing of staff in the care home sector	Care home providers	Ongoing
		Support care homes to access national funding/grants	HBC Quality Assurance Team	Ongoing
		Continue to hold strategic meetings with care home operators	HBC Quality Assurance Team	Ongoing
VIII	Work to make digital services part of blended approaches to meeting need	Progress the work around digital inclusion and infrastructure locally, linking in with the Liverpool City Region as necessary; the first step is to establish the baseline from a mapping exercise and then present an Action Plan to Management Team	HBC Digital Working Group	2022/23
IX	Collaborate with care home providers and provide leadership to design approaches for safe visiting in care homes	Develop a Communications Strategy to raise awareness that care homes are safe environments and people are invited to come in to enrich the lives of residents	HBC Care Homes Division / Care Homes Development Group	2022/23
		Explore the role for the community and voluntary sector to be more involved in care homes in order to improve residents' quality of life; this should include exploring new opportunities as well as strengthening existing projects (e.g. Pen Pal schemes etc.)	HBC Care Homes Division / Care Homes Development Group	2022/23
X	Work with providers and people who use services to redesign day services and shape the market to allow for greater choice, flexibility and accessibility for people	Continue with a flexible approach to service delivery once clients return to building-based services so that visits to day services are supplemented by access to digital support/activities and there is outreach support for those who may be feeling isolated	HBC Day Services	2022/23

NWADASS Recommendation Councils should…	Action(s) for Halton (as agreed by Scrutiny Topic Group)	Responsibility	Timescale
	Consider learning that can be taken from the care home sector (e.g. Pen Pal schemes)	HBC Day Services	2022/23

Appendix 1: Scrutiny Review 2021/22 Topic Brief

Scrutiny topic:	Recommendations of the NWADASS report 'The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'
Officer lead:	Sue Wallace-Bonner, Director of Adult Social Services
Start date:	July 2021
Target PPB meeting:	February 2022

Topic description and scope:

The scrutiny topic will focus on the outcomes from the ***'North West Association of Directors of Adult Social Services (NWADASS) Elected Member Commission: The impact of Covid-19 on People with Care and Support Needs, their Families, Carers and Communities'***[1] with a view to making recommendations for Halton.

The Elected Member Social Care Commission was established as part of a North West ADASS approach to learning lessons from the Covid-19 pandemic. In particular, the role of The Commission was to investigate the impact of the pandemic on people and communities in the North West and what lessons could be learnt for further waves of infection and future service design.

The Commission investigated the following question:

"*What has been the impact of the pandemic on people who use adult social care services, their families and our communities and what does this tell us about the role our communities should play in supporting people to live independently at home?"*

Why this topic was chosen:

The NWADASS Elected Member Commission was established to investigate the impact of Covid-19 on adults aged 18+, their families and communities and what this tells us about the role communities play in supporting people to live independently at home.

The report of the Commission provides a broad account of what was learned through eye-witness accounts from people/organisations and it identifies lessons learned. Recommendations are made for councils that look beyond the pandemic at how the learning can shape future service design.

The Commission's report will be scrutinised in order to consider how Halton will implement the recommendations.

[1] The full report and additional information regarding the commission can be found on the NWADASS website; https://www.nwadass.org.uk/elected-member-social-care-commission

Key outputs and outcomes sought:

The topic group will consider the recommendations set out in the report in order to determine implementation at a local level. The report recommendations for councils are summarised below (the NWADASS report should be consulted for full details):

- Councils should say a public 'thank you' to adult social care and support services (commissioned and voluntary) and unpaid carers for their hard work and sacrifices during the pandemic and beyond;
- Councils should take active steps to build the capacity of the community and voluntary sector to provide health, care and wellbeing services (the report details six suggestions in relation to this);
- Councils should strengthen the wellbeing support available to informal/unpaid carers (there are three suggestions sitting under this point);
- Councils should seek to substantially increase the use of direct payments, making them quick and easy to obtain, and allowing for much greater flexibility for people in how they can be used;
- Councils should use their place-based leadership role to facilitate communication with and across organisations helping vulnerable and isolated people
- Councils should build upon the new capacity for volunteering in the community (which people have demonstrated during the pandemic) to create stronger preventative and community solutions;
- Councils and other organisations should accept that digital becomes one of the primary mechanisms for service delivery in the future (there are four suggestions sitting under this recommendation);
- Councils can provide more local leadership and should collaborate with care home providers and relatives to design approaches to safe visiting in care homes which allows visiting to take place safely and in line with government guidance and the NWADASS statement on visiting
- Councils should work with providers and people who use services to redesign day services and to shape the market to allow for greater choice, flexibility and accessibility for people.

Following full consideration of the recommendations, an Action Plan will be developed to ensure that they are implemented locally, as appropriate.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

This topic contributes to the 'Healthy Halton' priority within the Council's Corporate Plan and the Sustainable Community Strategy.

Halton Borough Council Corporate Plan

A Healthy Halton: To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives.

Halton Strategic Partnership Sustainable Community Strategy

A Healthy Halton: To create a healthier community and work to promote wellbeing and a positive experience of life with good health, not simply an

absence of disease, and offer opportunities for people to take responsibility for their health with the necessary support available.

Nature of expected/desired PPB input:

Member-led scrutiny review of the NWADASS report, particularly the recommendations made for councils and consideration of how these could be implemented locally.

Preferred mode of operation:

- Desk-top review of the NWADASS report;
- Meetings/discussions with relevant officers from within the council and partner organisations;
- Review of current service provision in areas outlined within the recommendations in order to identify gaps and develop action plan for improvement.

Agreed and signed by:

PPB chair:		Date:	
Officer lead:		Date:	

Note re expansion of topic scope:

At the first meeting of the topic group in July 2021 (following a change in membership of Health PPB as a result of the elections), it was agreed that the scope of the scrutiny topic would be widened to include consideration of the ongoing impact of the pandemic on hospital services, particularly waiting lists and back logs.

There is a clear and direct link between adult social care and health services and it was therefore thought to be necessary to ensure that this scrutiny topic considered the position from a health perspective given that there will be an impact on the vulnerable people who receive support from adult social care services.

Appendix 2: NWADASS Recommendations with Halton Response

NWADASS Recommendation	Halton Response	
	Information considered by the Topic Group	**Topic Group Recommendation**
I. Councils should say a public 'thank you' to adult social care and support services (commissioned and voluntary) and unpaid carers for the hard work they are doing and the sacrifices they have made, and continue to make, during the pandemic and beyond. The Commission heard of the work done by organisations, paid and unpaid carers and volunteers to maintain vulnerable people in their communities so that vital NHS capacity was freed up.	Briefing note re what has been done locally to thank adult social care and support services shared at the September meeting:  4. Briefing note re Recommendation I.c	When conditions allow, the Council will hold an event* to say a public thank you to commissioned and voluntary adult social care and support services and unpaid/informal carers. **Funding to be identified in the form of sponsorship from an external agency.*
II. Take active steps to build the capacity of the community and voluntary sector to provide health, care and wellbeing services. The Commission saw and heard evidence that services developed in and by the community are not only able to respond quickly on a large scale for those who are vulnerable, but, if commissioned correctly and over a long period time, could deliver more responsive and personalised services to people. The Commission found that given the flexibility to create services to meet needs (in these circumstances driven by necessity) organisations were able to develop person-centred responses. a) Reward and acknowledge the work that community and voluntary sector organisations have done over the period of the pandemic e.g. recognition awards, certificates of achievement. b) Build on the energy and commitment shown throughout the pandemic by establishing community and voluntary sector fora to support the health and care sector.	Presentation from Sally Yeoman (Chief Executive, Halton & St Helens Voluntary and Community Action) re the community and voluntary sector at the October meeting:  4. Halton VCFSE Sector presentation	Build on the volunteering legacy and sustain the growth in volunteers seen during the pandemic, making use of the Volunteering Portal. Involve the community and voluntary sector in the public thank you event (see recommendation I). Ensure that volunteers are encouraged to continue in their role by understanding the difference they make to people's lives. Ensure Halton's Market Position Statement (last updated in 2018 and therefore due for review) clearly sets out the role of the community and voluntary sector and the support that the council will provide. Continue to commission for outcomes, encouraging creativity within the community and voluntary sector.

NWADASS Recommendation	Halton Response	
	Information considered by the Topic Group	Topic Group Recommendation
c) Start commissioning for outcomes and allow organisations the freedom to develop creative ways of supporting people to live the lives they want. d) Through 'innovation funding' type initiatives, provide community and voluntary sector organisations with opportunities to develop and test outcome-based services. e) Set out in clear terms the role Councils want the community and voluntary sector to play in meeting people's health and care needs and the support you will provide to achieve this e.g. in your Market Position Statement. f) Provide training to community and voluntary sector organisations on things like accessing funding though the council and partners and creating digital services.		The Council's External Funding Team already provides a comprehensive training offer, which can be accessed by the community and voluntary sector. The following training courses (which are free of charge for organisations working in Halton/on behalf of Halton residents) are available to sign up for online (https://halton.me/external-funding-course-booking-form/): • 'Basic Bid Writing' covering good bid writing techniques, ten key elements of a basic funding application and top tips to write a strong bid. • 'Monitoring and Evaluation', which helps attendees to understand what monitoring and evaluation involves, where and how it should be used in grant-funded projects and best practice for producing good quality and effective data and reports. • 'Now you have your grant' is a course that offers a basic introduction to the responsibilities of managing grant funding for those who are new to it or would like to improve their skills. • 'Developing a Fundraising Strategy' helps attendees to develop their organisation's vision and focus its aims and objectives. It includes organisation

NWADASS Recommendation	Halton Response	
	Information considered by the Topic Group	**Topic Group Recommendation**
		analysis, action planning, understanding budgets, cash flow and risk and monitoring. This training offer should be promoted to the community and voluntary sector.
III. Councils should strengthen the wellbeing support available to informal/unpaid carers. a) Establish a process of regular wellbeing checks with unpaid carers. For example, consider how a range of local organisations including voluntary, health and care, Police, Fire and Rescue and Housing providers can work together to check if more vulnerable people are coping. Combining capacity, data and knowledge could enable wellbeing checks for each carer who is under pressure ensuring early intervention to prevent carer breakdown. b) Identify the triggers which could lead to 'carer breakdown' and provide proactive support to them. c) Invest further in carers support and wellbeing services and look to carers and the community to design these. These are likely to include respite, peer support, counselling, flexible day services, information, advice and digital services.	Presentation from the Carl Harris, Halton Carer's Centre CEO supported by Emma Sutton-Thompson (Principal Manager, Policy, Performance and Customer Care and Carer's Strategy Lead) re wellbeing support available to informal carers at the December meeting: 3. Carers presentation.pptx	Continue to support the Carers Centre to deliver wellbeing support and other services to Halton carers in order to prevent breakdown. Help to enable the Carers Centre to provide support to any new carers that may have emerged during the pandemic but are as yet unidentified. Early support is key to avoid escalation / crisis.
IV. Councils should seek to substantially increase the use of direct payments, making them quick and easy to obtain, and allowing for much greater flexibility for people in how they can be used. People should be given the freedom to choose and control how their money is spent to a greater extent. The guidance is clear that payments must be used for meeting	Presentation from Marie Lynch (Divisional Manager, Care Management) re substantial use of direct payments in Halton at the December meeting:	Halton already performs well compared to regional averages in terms of the proportion of people receiving a direct payment; this should continue.

NWADASS Recommendation		Halton Response	
		Information considered by the Topic Group	Topic Group Recommendation
	people's needs and there is no need to specify how to spend funding.	4. Direct Payments report.docx	Continue to work with the Liverpool City Region to address issues surrounding the recruitment of Personal Assistants.
V.	Councils should use their place-based leadership role to facilitate communication with and across organisations helping vulnerable and isolated people. For example, ensure that referral pathways for those in greater need are clear and accessible; information about how people can help themselves and join up the dots locally.	Presentation from Mil Vasic (Strategic Director, People) re place based leadership at the January meeting: 4. Place based presentation.ppt	Continue to provide support for vulnerable adults in line with the learning from the pandemic (e.g. the success of the COVID hotline in signposting people to the appropriate place etc.) The presentation highlighted that COVID has given us time to reflect on our working practices and be open to change and adaptations for the future. The Topic Group will progress the following suggestions: • Create a virtual and digital platform for families to access services both face-to-face and virtually; • Continue to learn and listen to what communities and families are telling us about services; • Continue to adapt and change and have the ability to re-design services mixing virtual support with face-to-face support and build on the increased involvement of the voluntary sector.
VI.	The pandemic has shown how many people have volunteered in their community when they know they can make a difference to individual's lives. Build on this new capacity and	Presentation from Sally Yeoman (Chief Executive, Halton & St Helens Voluntary and	As with recommendation II:

NWADASS Recommendation		Halton Response	
		Information considered by the Topic Group	Topic Group Recommendation
	energy to create stronger preventative and community solutions.	Community Action) re the community and voluntary sector at the October meeting: *See file attached under Recommendation II above.*	• Build on the volunteering legacy from the pandemic to further strengthen the local community and voluntary sector; • Ensure that volunteers are encouraged to continue in their role by understanding the difference they make to people's lives. This should be part of the public thank you event and there is also an ongoing role for Halton & St Helens VCA.
VII.	Councils should expect and facilitate their providers to be creative. Many care agencies were able to safely protect individuals – but needed access to PPE, technology, the ability to swiftly change practice. They needed advice on safe contact with families, the ability to meet in groups, enabling service users to pay for their own services, promoting decision making, and reducing deterioration especially physically and mentally.	Presentation from Helen Moir (Divisional Manager, Independent Living) re facilitating providers to be creative at the September meeting:  5. Recommendation VII facilitating provic	Adopt the suggested 'focus for the future' actions from the presentation: • Further develop IT skills amongst care home staff; • Facilitate re-integration into the community for care home residents; • Continue to support the wellbeing of staff in the care home sector; • Support care homes to access national funding/grants; • Continue to hold strategic meetings with care home operators.
VIII.	Councils and other organisations should accept that digital becomes one of the primary mechanisms for service delivery in the future. In particular:	Presentation from Shelah Semoff (Partnership Officer, Enterprise, Community and Resources Directorate) re digital service delivery / digital inclusion at the December meeting:	Progress the work around digital inclusion and infrastructure locally, linking in with the Liverpool City Region as necessary. The first step is to establish the baseline from a mapping

NWADASS Recommendation	Halton Response	
	Information considered by the Topic Group	**Topic Group Recommendation**
a) Organisations who plan to use digital services should ensure these are co-designed with the people who will be using them. b) Councils should develop a digital inclusion strategy, alongside their commissioning strategies, for all ages and abilities which demonstrates how they will increase take up and ensure people are not disadvantaged. c) Councils should provide greater and more immediate support to people who are now accessing services online, perhaps for the first time, in the same way that some private sector companies have done. For example, 'digital navigators'. d) Councils should support voluntary and community organisations with online payment solutions and develop options in their local community.	 Digital presentation - topic	exercise and then present an Action Plan to Management Team.
IX. Councils can provide more local leadership and should collaborate with care home providers and relatives to design approaches to safe visiting in care homes which allows visiting to take place safely and in line with government guidance and the NWADASS statement on visiting. Spouses in particular were even prepared to self-isolate in order to facilitate contact and protect others, yet this never appeared to be discussed with them.	Presentation from Jane English (Divisional Manager, Care Homes) re safe visiting in care homes at the September meeting:  6. Recommendation IX care home visiting	Develop a Communications Strategy to raise awareness that care homes are safe environments and people are invited to come in to enrich the lives of residents. Explore the role for the community and voluntary sector to be more involved in care homes in order to improve residents' quality of life. This should include exploring new opportunities as well as strengthening existing projects (e.g. Pen Pal schemes etc.)

NWADASS Recommendation	Halton Response	
	Information considered by the Topic Group	**Topic Group Recommendation**
X. Councils should work with providers and people who use services to redesign day services and to shape the market to allow for greater choice, flexibility and accessibility for people. For example, more blended approaches to service delivery utilising digital, home and building based delivery; using a network of organisations who together can meet people's requirements more fully. An example was Wildlife Trusts across the NW who had designed and shared activity packs and stimulating content for online or groups to engage in.	Report from Eileen Clarke on behalf of Stiofan O'Suillibhan (Divisional Manager, Community) re day services at the January meeting:  3. Day services report.docx	The Topic Group learned that outreach support offered by in-house Day Services during the pandemic was welcomed and greatly valued by clients and families (e.g. telephone check-ins and activity packs). A flexible approach to service delivery should continue once clients return to building-based services so that visits to day services are supplemented by access to digital support/activities and there is outreach support for those who may be feeling isolated. Day Services should also consider what learning they can take from the care home sector (e.g. Pen Pal schemes). This should link in with the review of the Adults with Learning Disabilities Strategy that is in progress.

REPORT TO: Health Policy and Performance Board

DATE: 27th September 2022

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: Scrutiny Topic Brief and Proposed Activity Schedule

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To agree the Topic Brief for the Health Policy and Performance Board (PPB) Scrutiny Group and the proposed activity schedule for presentations and feed-in to the scrutiny.

2.0 **RECOMMENDATION: That:**

I. **The Topic Brief is approved; and**

II. **The proposed activity schedule for the topic group is approved as representative of the input required to fulfil the brief.**

3.0 **SUPPORTING INFORMATION**

3.1 Following on from feed-in to the last Health PPB meeting a scrutiny topic for 2022/23 was chosen. It was agreed that this would focus on the current issues around the Adult Social Care Workforce, including looking at workforce planning and development needs.

3.2 A meeting was further held with Councillor Peter Lloyd-Jones, as Chair of the Health PPB, Damian Nolan, as Divisional Manager lead for the topic area and Nicola Hallmark, as service development support for the group. Here, the focus areas of the scrutiny were agreed and meetings scheduled to start soon after the May elections.

3.3 The first topic group meeting took place on Thursday 12 May 2022 where an overview of some of the main themes to be considered was presented, together with looking at the draft Topic Brief and proposed activity schedule. As attendance was low Cllr. Peter Lloyd-Jones asked for both documents, together with the presentation, be shared with the wider group for further feed-in. Members were given until Friday 27th May to make any amendments. No further feedback has been received and further meetings have taken place according to the schedule.

3.4 It is requested that the Board ratify the documents – the Topic Brief and the proposed activity schedule – to take forward the programme of activity intended to fulfil the remit presented.

4.0 POLICY IMPLICATIONS

4.1 The scrutiny topic group will run to the end of 2022 whereupon recommendations will be put forward by Members. This may impact on the need for further policy and strategy work.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

This Topic Group intends to consider the workforce needs across the Adult Social Care sector in Halton, with a view to ensuring the services are delivered in a safely and effectively and empower choice and control for those who access services.

6.4 A Safer Halton

None identified

6.5 Halton's Urban Renewal

None identified

7.0 RISK ANALYSIS

7.1 None identified

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This report does not require an Equality Impact Assessment

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

None identified.

TOPIC BRIEF

Topic Title:	Adult Social Care Workforce – Planning and Development
Officer Lead:	Damian Nolan – Divisional Manager – Commissioning and complex care
Planned Start Date:	May 2022
Target PPB Meeting:	September 2022

Topic Description and Scope:

The 2022/23 scrutiny review for the Health Policy and Performance Board will examine the Adult Social Care Workforce in Halton. It will look at both Council staffing structures and those in the provider sector to consider how the Council supports workforce planning and development. The topic group will be apprised of the innovative projects and initiatives being undertaken to promote a sustainable and skilled workforce. It will consider the impact of external forces on the labour market for Adult Social Care and examine local and regional activity, partnership working and contractual arrangements aimed at supporting services to recruit, develop and retain staff.

Why this topic was chosen:

Sustaining Adult Social Care services across Halton is a statutory duty and a fundamental priority for the Council. Central to this is ensuring that services are staffing with a skilled, knowledgeable, competent and motivated workforce.

Skills for Care report annually on 'The State of the Adult Social Care Workforce'. Their most recent report highlights a national increased rates of staff turnover, high rates of vacancies and heightened absences. These trends are not new but have been compounded by a number of factors, including the pandemic. Nationally, public perception of the work, the pay, the contractual conditions and the career development and progression opportunities associated with Adult Social Care is low. In contract to this, the sector continues to grow to meet the needs of an ageing workforce.

From a local perspective, Halton Borough Council supports a range of creative and forward-thinking work to consider Adult Social Care workforce needs. The Council has responsibilities to work strategically to ensure its own workforce is fit for purpose; that workforce planning involves safe and robust processes for the recruitment of good quality candidates; that pay and conditions are competitive; that personnel are valued and offered ongoing support so that their services are retained; and that they are trained to deliver a high standard of care and support, as well as being offered continued development opportunities and career progression.

In addition, the Council works with commissioned providers and has a duty, within the Care Act 2014, to support and sustain the Adult Social Care provider market. The Board aim to better understand the Council's responsibilities and action in specific relation to supporting the provider sector with their own workforce needs.

Key outputs and outcomes sought:

- To identify the impact workforce has on good quality care.
- To understand the size and structure of the Adult Social Care Workforce across Halton, and consider the Council's role in sustaining and developing sector resilience in relation to workforce needs.
- To recognise the drivers for transforming approach to recruitment and retention, and benchmark Halton's position against these.
- To highlight the innovative work being undertaken to promote careers in the sector, provide new opportunities for existing staff and inspire new interest in being part of the Adult Social Care workforce.
- To examine the Council's own Adult Social Care workforce and its plans to recruit, train, retain and progress employees.
- To acknowledge the Council's duty in sustaining the provider market for Adult Social Care services and the impact of workforce needs on this.
- To appreciate the Council's contractual position in relation to delivery of provider services and the quality assurance role in respect of maintaining a competent workforce.
- To examine the Council's support to the provider sector in maintaining safe and effective staffing levels.
- To evaluate whether any further action can be taken to mitigate risks to market sustainability.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton – Our overall aim is to improve the health and wellbeing of Halton people so that they live longer, healthier and happy lives.

This topic group intends to gain knowledge and understanding of the Adult Social Care workforce across Halton. It will develop an effective oversight of the processes and practices for meeting and maintaining workforce needs across the sector to ensure good standards of provision to Halton residents who access services.

The topic group will gain input from different standpoint from across the sector to look at current workforce needs and measures being taken to alleviate them. Evaluation will be made of the Council's support to the provider sector on workforce issues.

Nature of expected/ desired PPB input:

Member-led scrutiny review of Adult Social Care Workforce planning and development across Halton and the impact this has on our ability to deliver quality services to local residents.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council and partner agencies to examine current services.
- Visit to community-based intervention sessions.
- Interviews with those who have accessed services.
- Desk top research in relation to outcome measures and best practice delivery methods.

Agreed and signed by:

PPB chair ……. **Officer …….**

Date …… **Date …….**

Schedule of Activity

Health Policy and Performance Board – Scrutiny Topic Group 2022-23 – Schedule of Activity
Topic: Adult Social Care Workforce Planning and Development

Meeting	Input	Areas to be covered	Proposed representation
Date: Thursday 12 May 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Review draft topic brief and proposed schedule of activities Overview of the size and structure of the Adult Social Care workforce in Halton	• Further discuss topic group remit and whether any other areas of enquiry are needed - any changes to be captured and progressed • Halton Borough Council's Adult Social Care workforce and the role of the provider sector • Brief overview of some of the activities aimed at supporting workforce needs, in anticipation of hearing more throughout the scrutiny. • Nation impactors driving workforce pressures across the sector. • Halton's Borough Council's own recruitment processes and learning offer.	Nicola Hallmark Nicola Hallmark
Date: Thursday 9 June 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Presentation: Skills for Care	• The Adult Social Care workforce – national picture • Support across Halton – Registered Manager's Network and Halton Employment Partnership •	Alison Everett – Skills for Care Michelle Carmon – CIC

28th June – Board Meeting	Board formally agree of Topic Brief		
Date: Thursday 14 July 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Presentation: Regional Workforce planning Presentation: Support for care homes	• Workforce planning activity on a regional basis • Overview of the innovative work within the Enhance Nursing Care project work and Care Home Development Group, including plans to attract and retain staff; develop work experience placements, student residencies and 'Grow your own' opportunities.	NW ADASS Jane English – Divisional Manager, Care Homes
Date: Thursday 8 September 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Presentation: Supporting our Domiciliary Care workforce Presentation: Innovative training solutions – the Learning Disability Training Alliance	• Outline Halton's contractual position with Premier care and the evolution of this through the Transforming Domiciliary Care work. Discuss the opportunities the contractual arrangements offer in relation to building a stable workforce. • Look at current recruitment and retention activity being conducted to assure service provision. • The approach taken to offer a range of learning on a co-operative basis and how this assures good practice.	Damian Nolan and representative from Premier Care Jane Birchall-Smith – The Bridges Learning Centre
Date: Thursday 13 October 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Presentation: Supporting workforce resilience Provider Sector – Workforce Development	• Looking at the support offered to the provider sector by the Council's Quality Assurance team, the approaches taken throughout the pandemic and maintaining relationships going forward. • Approaches taken to ensure workforce are equipped with skills, knowledge and competence to undertake their role.	Helen Moir or Benitta Kay

	Presentation: Large provider Presentation: Independent provider		Large provider – e.g. CIC or HC-One Independent provider
Date: Thursday 10 November 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Presentation: Fair Cost of Care	• Outcomes of findings for Halton and the potential impact on workforce needs.	Damian Nolan or Sue Wallace-Bonner
Date: Thursday 8 December 2022 Time: 6.30pm to 8pm Venue: Committee Room 1, Runcorn Town Hall	Review input and collate recommendations	• Towards the development of the final report	Led by Cllr Peter Lloyd-Jones

REPORT TO: Health Policy & Performance Board

DATE: 27th September 2022

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 1 2022/23

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 1 of 2022/23. This includes a description of factors which are affecting the service.

2.0 RECOMMENDATION: That the Policy and Performance Board:

i) Receive the Quarter 1 Priority Based report

ii) Consider the progress and performance information and raise any questions or points for clarification

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 SUPPORTING INFORMATION

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 1 2022/23.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications associated with this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

There are no implications for Children and Young People arising from this report.

6.2 Employment, Learning & Skills in Halton

There are no implications for Employment, Learning and Skills arising from this report.

6.3 A Healthy Halton

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 A Safer Halton

There are no implications for a Safer Halton arising from this report.

6.5 Halton's Urban Renewal

There are no implications for Urban Renewal arising from this Report.

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 1 – Period 1 April 2022 – 30 June 2022

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the first quarter of 2022/23 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

2.1 There have been a number of developments within the Directorate during the first quarter which include:

Integrated Care Board – Halton Place Based Team

The senior leadership team came into place on the 1st July 2022. Work has commenced to review and progress the integrated approach to the commissioning and delivery of integrated health and social care services through One Halton.

Social Work

A newly developed "Social Work Accountability and Assurance Framework" to support Social Work across Adult Social Care has now been completed and agreed by senior management team. This framework has been developed as part of our work in assessing our performance against "The Standards for Employers of Social Workers" (published by the Local Government Association). There are eight standards to be met in total. This Framework was a requisite of Standard 1, which sets out a 'strong and clear social work framework' is a requirement for employers. In addition, it specifies that, "employers should implement a whole systems approach to supporting the social work profession and the Standards set out the key components of whole systems approaches and help to develop a working environment where social work practice and social workers can flourish". We have launched a working group to take this forward.

Covid rates for quarter 1 remained relatively stable with low rates of positive tests reported and very small and manageable outbreaks reported from care homes. No community outbreaks were reported in this time despite the relaxation of most of the community restrictions and regulations around Covid. Rates towards the end of June and in to quarter 2 have begun to steadily increase potentially as a result of several national mass gathering events.

The community health bus and Public Health response team continue to offer support to community sessions and engage in vaccination encouragement approaches.

Targeted Lung Health Check programme has continued to expand in to surrounding areas and have reported data to suggest that a positive uptake rate is being received in Halton. The programme as a whole has identified a number of early stage lung cancers that would have likely remained unnoticed for some time and received positive outcomes from early access to treatments.

The Team is working with cross sector partners to deliver CORE20PLUS5 at a community level. This intervention aims to reduce health inequalities in particular those that cause early deaths as outlined by the Marmot report. All Together Fairer.

3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the first quarter that will impact upon the work of the Directorate including:

CQC – Adult Social Care

From April 2023 the Care Quality Commission (CQC) commences new regulatory duties in relation to Local Authorities discharging their duties under the Care Act 2014. There is a range of work being undertaken locally, regionally and nationally to develop what this framework will look like. Halton has been undertaking work on self- assessment, peer review and benchmarking in preparation

Social Care Reforms – People at the heart of Care White paper

There are 2 areas of work underway following the white paper:

The ‘fair cost of care’ and ‘market sustainability plan’ are aimed at care home provision for the over 65’s and domiciliary care sector for the over 18’s. Local Authorities are required to submit the fair cost of care in October 2022 and a draft market position paper at the same time with a final version in February 2023 once local government finance settlement has been completed.

The ‘care cap’ and associated ‘care account’ requirements bring forward the financial cap on the amount an individual will contribute to their eligible care needs during their lifetime. National guidance continues to be revised and local and regional work is ongoing. The preparation for the cap and he creation of individual ‘care accounts’ needs to be in place in April 2023 with the ‘cap’ being commenced in October 2023.

Liberty Protection Safeguards

The Liberty Protection Safeguards (LPS)were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the current Deprivation of Liberty Safeguards (DoLS) system. The aim of the LPS framework is to deliver improved outcomes for people who are or who need to be deprived of their liberty. The new Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty. They will apply to people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

The LPS were originally due to be implemented in October 2020. This was put back to April 2022 due to the pandemic. The government have since announced a further delay and we are awaiting confirmation of the final commencement date. It is our understanding that the LPS will likely be implemented in October 2023, or 2024.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2018/19 Directorate Business Plans.

As a result, monitoring of all relevant 'high' risks will be undertaken and progress reported against the application of the risk treatment measures in Quarters 2 and 4.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Directorate. It should be noted that given the significant and unrelenting downward financial pressures faced by the Council there is a requirement for Departments to make continuous in-year adjustments to the allocation of resources in order to ensure that the Council maintains a balanced budget. Whilst every effort continues to be made to minimise any negative impact of such arrangements upon service delivery they may inevitably result in a delay in the delivery of some of the objectives and targets contained within this report. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

Commissioning and Complex Care Services

Adult Social Care

Key Objectives / milestones

Ref	Milestones	Q1 Progress

1A	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target	✓
1B	Integrate social services with community health services	✓
1C	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder.	✓
1D	Continue to implement the Local Dementia Strategy, to ensure effective services are in place.	✓
1E	The Homelessness strategy be kept under annual review to determine if any changes or updates are required.	✓
3A	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.	✓

Supporting Commentary

1A - The Better Care Fund resource use has been agreed for 22/23 and supports key health and social care services in the community to support people and their carers

1B - The One Halton plan continues to be progressed with further work agreed looking at options for a single point of access for health and social care and the development of multi-disciplinary teams in the community.

1C - Some work has progressed with the Strengths based programme of work with Professor Sam Baron, including review of Assessment approaches and aligned paperwork. Due to Sam Baron leaving her role this programme of work has drawn to a close and is now subject to review of how it is moved forward.

1D - Work started on refreshing the local dementia strategy, under the umbrella of One Halton. A strategic group was established with representation from all One Halton organisations. A self-assessment was undertaken against recommendations made by Alzheimer's Society for what local areas should be considering in their dementia strategies. The self-assessment process, cross referenced with NICE best practice and dementia 'I Statements', has formed the basis of identifying priorities and associated actions. The group will next meet in September 2022 to finalise the actions and progress the ratification process. The Dementia Friendly Communities approach has been adopted by Executive Board and is now underway across council service areas, with focus on raising awareness and improving practice to make HBC a more dementia friendly organisation for employees and the people we serve. New dementia friendly activities are emerging from within the community, such as a dementia café at Grangeway Community Centre and one due to open in Autumn at Catalyst museum. Through links with the LCR, Halton was able to secure a free day of the Liverpool Museum's 'House of Memories on the Road' mobile unit, with 46 people living with dementia in the community and local care home residents benefiting from cognitive stimulation/reminiscence sessions on the day. Halton Dementia Action Alliance (Coordinated by HBC Adult Social

Care) are working with a local legal firm to arrange free one off legal clinics for people living with dementia at any future community events, dementia cafes, libraries and GP practices.

1E – The homelessness strategy remains current and reflects the key priorities and agreed action plan for a five year period. The strategy action plan continues to be reviewed annually, to ensure it is current and reflects economic and legislative changes, with many actions successfully achieved.

Regular quarterly service reports will be submitted to outline the service delivery and detailed review of the homelessness strategy action plan.
The homelessness forum is planned for October 2022. to review the key priorities and agree actions for the following 12 month period.

The pandemic will continue to influence future activity and communication between partner agencies, which will further influence how services are commissioned and delivered in the future.

3A – No commentary provided.

Key Performance Indicators

Older People:						
Ref	**Measure**	**21/22 Actual**	**22/23 Target**	**Q1**	**Current Progress**	**Direction of travel**
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ ***Better Care Fund performance metric***	369.2	600	112	✓	↓
ASC 02	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population. ***Better Care Fund performance metric***	4071	No plan set	4243	U	↓

ASC 03	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehab ilitation services (ASCOF 2B) ***Better Care Fund performance metric***	79	85%	NA	NA	NA
Adults with Learning and/or Physical Disabilities:						
ASC 04	Percentage of items of equipment and adaptations delivered within 7 working days (VI/DRC/HMS)	72	97%	38 94.2% (5 days)	U	
ASC 05	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 1) SDS	81.5	80%	70	✓	
ASC 06	Proportion of people in receipt of SDS (ASCOF 1C – people in receipt of long term support) (Part 2) DP	31.6	45%	22	✓	
ASC 07	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G)	89.7	89%	92	✓	
ASC 08	Proportion of adults with learning	7	5.5%	5.4	✓	

	disabilities who are in Employment (ASCOF 1E)					
Homelessness:						
ASC 09	Homeless presentations made to the Local Authority for assistance In accordance with Homelessness Act 2017. Relief Prevention Homeless	1914	2000	767	✓	↑
ASC 10	LA Accepted a statutory duty to homeless households in accordance with homelessness Act 2002	247	200	48	✓	↑
ASC 11	Number of households living in Temporary Accommodation Hostel Bed & Breakfast	520	N/A	202	✓	↑
Safeguarding:						
ASC 12	Percentage of individuals involved in Section 42 Safeguarding Enquiries	30	30	28.8	✓	NA new measure
ASC 13	Percentage of existing HBC Adult Social Care staff that have received Adult Safeguarding Training, including e-learning, in the	62	85%	66	U	↑

	last 3-years (denominator front line staff only).					
ASC 14	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	83.9	89%	NA	NA	NA
Carers:						
ASC 15	Proportion of Carers in receipt of Self Directed Support.	98.8	99%	99.5	☑	↑
ASC 16	*Carer reported Quality of Life (ASCOF 1D, (this figure is based on combined responses of several questions to give an average value. A higher value shows good performance)*	7.5	N/A	NA	NA	NA
ASC 17	*Overall satisfaction of carers with social services (ASCOF 3B)*	39.3	N/A	NA	NA	NA
ASC 18	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)	69.5	N/A	NA	NA	NA

ASC 19	Social Care-related Quality of life (ASCOF 1A). (This figure is based on combined responses of several questions to give an average value. A higher value shows good performance)	17.9	20%	NA	NA	NA
ASC 20	The Proportion of people who use services who have control over their daily life (ASCOF 1B)	73.1	80%	NA	NA	NA
ASC 21	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	56.9	71%	NA	NA	NA

Supporting Commentary:

Older People:

ASC 01 Data provided during the year is not cleansed and therefore will not always reflect year end totals.

ASC 02 Non Elective Admissions, CCG's were abolished in July 2022, as such no plans have been set at a local LA/CCG level. We are however able to monitor activity and report against the historical position.

ASC 03 Non elective admissions remain around 15% those seen pre-pandemic, with the reductions seen particularly in 0 day LOS admissions, this is attributed to trusts having extreme bed pressure and having to bed down wards which would otherwise have been used as admit to assess wards (counted as 0 day LOS) this has led to increases in waiting times in A&E.

Adults with Learning and/or Physical Disabilities:

ASC 04 The down turn has been predominately around the difficulties around contacting customers and arranging suitable appointments within the 7 day timescales, however HICES is on target and 94.2% of equipment is delivered within 5 days.

ASC 05	Data may change towards the end of the year due to data cleansing.
ASC 06	Data may change towards the end of the year due to data cleansing.
ASC 07	Data may change towards the end of the year due to data cleansing.
ASC 08	Data may change towards the end of the year due to data cleansing.

Homelessness:

ASC 09	There continues to be a local and national increase in homelessness presentations. The service continue to make full use of all prevention options to prevent homelessness.
ASC 10	The figures show that statutory homelessness acceptances remain low. This is due to the increased emphasis upon homeless prevention.
ASC 11	The increased demand for temporary accommodation, resulted in the continued use of hotels.

Safeguarding:

ASC 12	We have a robust screening system in place which reduces the number of inappropriate concerns progressing to Section 42 Safeguarding Enquiries.
ASC 13	Although the target was not achieved last year the current figures have exceeded last years performance.

Carers:

ASC 14	Survey measures are reported annually for service users and bi-annually for carers. The results of these are provided in Quarter 4, however are not published until later in the year.
ASC 15	There are no issues with this measure and we are on track to meet this target. Figures may fluctuate during the year.
ASC 16 ASC 17	Survey measures are reported annually for service users and bi-annually for carers. The results of these are provided in Quarter 4, however are not published until later in the year.
ASC 18 ASC 19	The next Adult Social Care Survey is due to be administered in January 2023, for results to be reported in the 2022/23 period.
ASC 20	The Survey of Adult Carers will be administered later in 2023 for results to be captured in the 2023/24 period.
ASC 21	Further details on both surveys can be found here

Public Health

Key Objectives / milestones

Ref	Objective
PH 01	**Improved Child Development: Working with partner organisations to improve the development, health and wellbeing of children in Halton and to tackle the health inequalities affecting that population.**

Ref	Milestones	Q1 Progress
PH 01a	Facilitate the Healthy Child Programme which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being, stop smoking interventions and parenting advice and support.	✓
PH 01b	Maintain and develop an enhanced offer through the 0-19 programme for families requiring additional support, For example: teenage parents (through Family Nurse Partnership), Care leavers and support (when needed) following the 2 year integrated assessment.	✓
PH 01c	Maintain and develop an offer for families to help their child to have a healthy weight, including encouraging breastfeeding, infant feeding support, healthy family diets, physical activity and support to families with children who are overweight.	✓
Ref	**Objective**	
PH 02	**Improved levels of healthy eating and physical activity through whole systems working.**	
Ref	**Milestone**	**Q1 Progress**
PH 02a	Implementation of the Healthy Weight Action Plan	✓
PH 02b	Increase the percentage of children and adults achieving recommended levels of physical activity.	✓
PH 02c	Reduce the levels of children and adults who are obese.	✓
Ref	**Objective**	
PH 03	**Reduction in the harm from alcohol: Working with key partners, frontline professionals, and local community to address the health and social impact of alcohol misuse.**	
Ref	**Milestone**	**Q1 Progress**
PH 03a	Work in partnership to reduce the number of young people (under 18) being admitted to hospital due to alcohol.	✓

PH 03b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA).	✓
PH 03c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support in the community and within secondary care.	✓
Ref	**Objective**	
PH 04	**Cardiovascular Disease**	
Ref	**Milestone**	**Q1 Progress**
PH 04a	Ensure local delivery of the National Health Checks programme in line with the nationally set achievement targets	✓
PH 04b	Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups.	✓
PH 04c	Increase the percentage of adults who undertake recommended levels of physical activity and healthy eating.	✓
PH 04d	Improve early detection and increase the proportion of people treated in line with best practice and reduce the variation at a GP practice level.	✓
PH 04e	Reduce the premature (under 75) death rate due to cardiovascular disease and stroke.	✓
Ref 05	**Objective**	
PH 05	**Mental Health**	
Ref	**Milestone**	**Q1 Progress**
PH 05a	Reduced level of hospital admissions due to self-harm.	✓
PH 05b	Improved overall wellbeing scores and carers' wellbeing scores.	✓
PH 05c	Reduced excess under 75 mortality in adults with serious mental illness (compared to the overall population).	✓
PH 05d	Reduce suicide rate.	✓
Ref	**Objective**	
PH 06	**Cancer**	
Ref	**Milestone**	**Q1 Progress**

PH 06a	Reduce smoking prevalence overall and amongst routine and manual groups and reduce the gap between these two groups.	✓
PH 06b	Increase uptake of cancer screening (breast, cervical and bowel).	✓
PH 06c	Improved percentage of cancers detected at an early stage.	✓
PH 06d	Improved cancer survival rates (1 year and 5 year).	✓
PH 06e	Reduction in premature mortality due to cancer.	✓
Ref	**Objective**	
PH 07	Older People	
Ref	Milestone	**Q1 Progress**
PH 07a	Continue to develop opportunities for older people to engage in community and social activities to reduce isolation and loneliness and promote social inclusion and activity.	✓
PH 07b	Review and evaluate the performance of the integrated falls pathway.	U
PH 07c	Work with partners to promote the uptake and increase accessibility of flu and Pneumonia vaccinations for appropariate age groups in older age.	✓
Ref	**Objective**	
PH 08	**COVID-19**	
Ref	**Milestone**	**Q1 Progress**
PH 08a	Ensure local systems are in place to identify, support and minimise the impact of any COVID cases, clusters and outbreaks.	✓
PH 08b	Work with key partners to achieve the target rate of vaccination coverage rate across all of the JVC Priority groups.	✓
PH 08c	Work with local partners to minimise COVID infections and utilise early warning systems to monitor local infection rates with a goal of 25 or less per 100,000 population.	✓

PH 01a Triple P is commissioned by the Early Help commissioners to run 8 sessions of Triple P each year: this includes 0-12, Stepping Stones and Teen. Delivery has returned to face to face due to Covid restrictions being relaxed/removed at venues during Q1. All parenting referrals now go via the central parenting inbox, where they are triaged by Sam Edwards. Any Triple P referrals are now sent over to The Health Improvement Team for allocation on to the next available course.

This quarter, 3 programme were delivered face to face: 1x 0-12, 1x Stepping Stones and 1x Teen. 12 parents completed fully, 10 partially completed and 1 DNA.

PH 01b The 0-19 Service has continued to maintain support for children and families in Halton through the provision of the universal Healthy Child Programme series of visits and interventions and through additional activity such as the NCMP weighing and measuring programme, support for school age vaccinations, and drop in advice sessions at high schools and through the Chat Health Text programme.

The Family Nurse Partnership programme continues to work with first time teenage parents in Halton, and provides intensive support for some of our most complex families.

The Pause programme started in Halton in April 21, and works with women who have had children removed and are at risk of having future children being taken into care. Pathways have been developed to ensure that women on the programme have rapid access to family planning and sexual health services, with programmes in place to reduce their safeguarding risk and support their parenting capacity, should they choose to have a family in the future.

PH 01c Antenatal Infant Feeding workshops continued virtually throughout Q1, with the multi-agency Your Baby & You programme re-launching as a virtual offer in May; this was delivered in partnership between Health Visitors, Children's Centres and Health Improvement Team. Sessions include: Infant Feeding, Diet & Nutrition in Pregnancy, and Bringing Your Baby Home. Plans for a full return to face to face programme were hampered due to restrictions from Bridgewater; however, a planning meeting was held between all partners, including midwifery, to map out the new offer for Autumn.

Infant feeding team have continued to offer infant feeding support to all Halton mums upon hospital discharge, with home visits and telephone support. Throughout Q1, the team had difficulties retrieving discharge info from Warrington due to Badgernet not being able to accommodate the team's data requirements, but additional manual checks were carried out 1-2 times weekly to try to ensure that no new mums were missed. This process has not been easy, and the delay in received discharge info has resulted in delays for some mums receiving their first call from the Infant Feeding Team.

Introducing Solid Foods workshops have continued to be delivered virtually, and Terrific Twos sessions have been delivered face to face. HHEYS support and training was offered to all EY settings and childminders around Healthy Eating, Oral Health, Menu Planning, Brief Advice, Staff Wellbeing, HHEYS Award, 5 Ways to Wellbeing. Early Years settings are slowly engaging again with HHEYS, after a drop during the pandemic.

The Fit 4 Life app continues to be promoted via social media, schools and NCMP. Download frequency has dropped since an initial peak in Q4, but remains steady. Retention has been challenging; however, an app update

enabled families to choose the topics they want to access, rather than receive a standard full 12-week sequence. A review of this programme is planned for Q2, as capturing outcomes has also been challenging; this is due to families not completing the final questionnaire once they have accessed the info they chose to engage with. Almost all referrals have been self-referral, with a small number being prompted by the NCMP letter.

Parent/carer bite-size workshops are being delivered virtually, with most bookings coming from self-referrals. Sessions include Fussy Eating & Healthy Snacking, and Sleep & Screens. Bookings dropped during Q1, so the frequency of sessions may be reduced from Q2, with alternative options for sharing the information to be explored.

PH 02a There has continued to be a range of parenting programmes are available to families to support them to develop healthy habits for their children, with a new parenting coordinator now in post. Schools are engaging well with Halton Healthy Schools programme since easing of Covid restrictions. Schools are keen to sign up to access staff training around healthy lifestyles, pupil sessions around diet and exercise, and have also welcomed plans for a Healthy Schools Framework to follow, set goals and review progress in relation to healthy eating, physical activity, and risk-taking behaviours.

The Holiday Activity Fund (HAF) has supported children during the holidays, to access healthy and nutritious meals, physical activity sessions, nutrition education and enrichment activities. The aim is that 85% of children accessing HAF are entitled to free school meals; thus ensuring that children at high risk of experiencing health inequalities are benefitting from the programme.

The whole system obesity core working group has met to review strategy from pre-pandemic. It has been agreed that the strategy will be widened to include health and social care, primary care and secondary care with a more active role. This is currently in consultation phase with partners for review.

PH 02b Exercise referral program only started back in Q3 2021, so full 6 month data will not be available until next quarter. 56 Referrals received during this quarter.

Active Halton working group have met to discuss developing a strategy for all providers to work towards. This strategy is currently in the data and evidence finding stage to address the strategy. Updates on progress to follow.

PH 02c Tier 2 adult weight management service Q1 data: Please note that data is reported from following the 6 month journey of a patient so data reported is for patients who started the program Q3 2021-22.

Number of clients started	92
Number of clients from IMD <30%	22%
Percentage of people completing 12 weeks	45%
Percentage of clients losing 0-2.99% body weight at 12 weeks	61%
Percentage of clients losing 3-4.99% body weight at 12 weeks	53%
Percentage of clients losing 5-9.99% body weight at 12 weeks	10%
Percentage of clients losing 10%+ body weight at 12 weeks	2%
Percentage of clients who lost weight by 12 weeks	90%
Percentage of clients completing 6 months	15%
Percentage of clients losing 0-2.99% body weight at 6 months	50%
Percentage of clients losing 3-4.99% body weight at 6 months	29%
Percentage of clients losing 5-9.99% body weight at 6 months	7%
Percentage of clients losing 10%+ body weight at 6 months	7%
Total percentage of clients who lost weight at 6 months	93%

PH 03a We are continuing to engage with the provider services to ensure that work continues to focus on the need groups and return to pre pandemic levels of provision. Work is continuing to focus on reducing the rate at which young people need hospital care as a result of alcohol.

Year 6 pupils have been accessing the Alcohol Education session via Health Improvement Team's Healthy Schools programme. Schools who complete the Healthy Schools commitment can access this session for pupils, and sessions are booked based on a needs-assessment. Secondary schools who identify alcohol mis-use as a concern are flagged to HBC's Drug and Alcohol team, who have worked with small groups of pupils, when requested.

PH 03b Awareness is raised within the local community of safe drinking recommendations and local alcohol support services through social media campaign messages and the promotion of national campaigns via digital platforms. Champs Public Health Collaborative have launched a new campaign funded by Cheshire & Merseyside Health & Care Partnership to promote the Lower My Drinking platform, which is now available for use in Halton.
Health Trainers and Health Check Officers continue to deliver Audit C screening when delivering Health Checks to Clients across Halton.
The Stop Smoking Service has continued to deliver Audit C screening remotely during consultations with clients who are stopping smoking and who also wish to reduce their alcohol intake.

From 1/4/2022 – 30/6/2022 Health Trainers and Health Check Officers delivered 527 Audit C screenings to clients.
From 1/4/2022 – 30/6/2022 the Stop Smoking Service have delivered 151 Audit C screenings to clients.
Total Audit C screenings delivered = **678**

PH 03c The team continue to monitor performance of the substance misuse service and oversee new developments and approaches. The CGL service recently launched it new Café which offers and opportunity to support clients in new and different ways, creating a relaxed and informal location for meetings and catch ups, promoting volunteering and ensuring high quality low cost food for the more vulnerable service users.

The out of prison programme continues to support prion service leavers on their road to recover and has received exceptionally positive case studies, also recently opening their safe house in Halton.

PH 04a The NHS Health Check program has been working closely with CHAMPS to complete a research pilot to look at national priorities to priorities those most in need within services. A focus in reducing health inequalities has lead us to some specific research in those from low socio-economic deprivation and/or those who are from a ethnic minority population group. We have completed a public survey, individual interveiws to consult on experience and root causes of inequalities within health services and have had an F2 doctor on placement complete a literature review on the service. These have aided us to develop an action plan of how locally we are going to tackle barriers to accessing the NHS Health Check. Full review documents will follow.

Number of NHS Health Checks completed across Halton	753
Number of NHS Health Checks completed by Health Trainer in GP practice	359
Number of NHS Health Checks completed by Health Trainer in workplaces	108
Number of NHS Health Checks completed by Health Trainer in Community	25
Number of onward referrals to lifestyle service or other services.	73

PH 04b Halton Stop Smoking Service continues to deliver the service remotely and also face 2 face (hybrid model) to support local people to stop smoking. Face to face delivery of the service has now resumed in GP settings and Widnes market. Plans are afoot to steadily increase this offer. Remote working/telephone consultations for those clients who have difficulty attending stop smoking sessions due to ill health/childcare difficulties/ work commitments or accessibility will continue. Extra

emphasis is placed on pregnant smokers, routine and manual smokers, never worked or unemployed smokers, smokers with respiratory disease, smokers addicted to substance misuse as well as smokers with mental health conditions, where extra support is required. In Q1 the service has supported 244 clients of which 97 clients have successfully stopped smoking so far (40% quit rate) however there are 66 clients where quit outcomes are unknown as yet as they are midway through the programme.

In Q1 66 clients accessing the service have never worked or are unemployed or are routine and manual smokers - so far 20 of these clients have stopped smoking (30% quit rate); however, there are 23 clients where quit outcomes are unknown as yet as they have not reached their 4 week review appointment and are midway through the programme.

In Q1 the service has supported 11 pregnant smokers of which 3 pregnant smokers have stopped smoking (27% quit rate) and 4 smokers where outcomes are unknown as they are midway through the programme.
The service has been working closely with Liverpool Heart and Chest Hospital and Halton CCG on the Targeted Lung Health Check programme. To date the service has received an extra 183 referrals from the Targeted Lung Health Check programme. Out of 183 referrals 133 clients engaged with the service. At 4 weeks, 71 clients had stopped smoking (56 %quit rate). At 12 weeks 52 clients had stopped smoking (44% quit rate) with 14 clients where quit outcomes are unknown as yet as they have not reached their 12 week review appointment and are midway through the programme.

PH 04c See above weight management and exercise referral programs.

PH 04d No commentary provided.

PH 04e In addition to the NHS Health Check data above, blood pressure champions have been screening in the community, on the vaccination health bus and in workplaces. Halton has supported the World Hypertension Day campaign by relaunching blood pressure screening campaigns within the community. During Q1 this has seen the following outcomes from community non clinical screening

Number of BP checks completed	164
Number of people detected with an irregular heart rate.	7
Number of people recommended to have GP follow up within 1 week.	48
Number of people recommended to have same day GP recheck within 1 day.	3
Number of people who received brief lifestyle interventions and signposting	164

PH 05a Halton continues to deliver self harm awareness training to front line staff who work with children and young people as part of the wider preventative mental health agenda. Champs continue to lead a variety of projects across Cheshire and Mersesyside working towards reducing self harm in both children and young people and adults. Halton has received 12 months worth of self harm data from the self harm dashboard developed by NWAS and PHE. The data will be analysed as part of the updated local Suicide Prevention Plan to explore what actions can be taken locally to reduce self-harm. Self-Harm kits developed by the Cheshire and Merseyside Self Harm pathway development group overseen by the NHS England North West Coast clinical network have been evaluated by JMU. Number of respondents who utilised the self-harm kit was too low to draw any conclusions regarding effectiveness. Cheshire and Merseyside emotional health and wellbeing logic model has been developed with actions around self-harm.

The following PHE's Mental health Prevention and Promotion funded projects are now complete and evaluation is underway:

- 5 ways to wellbeing activities for children and young people
- Pilot programme aimed at engaging young males via Youth out reach

The following projects have received local funding to continue for a further 12 months:

- Bereavement support for children, young people and adults
- Parenting programme co ordinator
- Additional support for adults experiencing financial insecurity

All of the above programmes will contribute to improved mental health and wellbeing of the local population and subsequently the indirect reduction in self harm.

PH 05b No commentary provided.

PH 05c Latest available data for 2018-20 indicates that the excess under 75 mortality for adults with severe mental illness in Halton is 313.1%, this is significantly better than the England Average of 419.6%. Continuing to ensure local primary care undertake annual reviews and engage with health services is key to ensuring that people with SMI experience no poorer health outcomes and services than any other individual.

PH 05d The latest published suicide rate is 10.8 suicides per 100,000 persons for the years 2018-20, which is not considerably different to the England average of 10.7. We continue to work closely with partners and Champs on the Zero Suicide Agenda and consistently review the action plan for reduction of suicides in the community, even undertaking assessments for every individual suicide we are notified of.
The suicide prevention partnership board has continued to meet during the pandemic.

Champs have continued to work to address:

Self harm
Middle aged mens mental health
Quality improvement within mental health trusts
Primary care staff pilot
Workforce development training
Development of a lived experience network

Local Activity

The Mental Health Info Point continues to be promoted via social media and training. In Q1 it has recevied 1307 page views with 496 unique users and 161 visiting the need help now section for details of mental health crisis support. The local 24hr mental health crisis telephone number is continuously promoted by the Local Authority, Merseycare and partners. Schools and early year's settings continue to be supported to implement a whole setting approach to improve mental health and wellbeing. Mental health awareness and suicide awareness training continues to be available to HBC staff and partners. Anti-stigma steering group aimed at tackling mental health stigma in males is under development.

Halton has been awarded £267,206 to deliver 5 prevention projects focussing on the following: bereavement support for children and young people, bereavement support for adults, support to address financial insecurity and debt, support to improve children and young people's mental health and wellbeing and support to improve Halton's parenting programme offer. All of these projects will potentially contribute to the reduction in suicides in Halton. An evaluation is underway.

PH O6a *Please see PH04b*

PH 06b Work is continuing with CHAMPS and the Cancer alliance to focus on activities to increase the uptake of bowel and breast cancer. Regional meetings have not yet been recommences from UKHSA, though we are continuing to encuorage uptake of all screening programmes at all opportunities

PH 06c Detection of cancers at earlier stages is improving year on year with a small increase in the last few years.
We continue to work with the cancer alliance and partner organisation to raise awareness of early signs and symptoms and encourage early presentation. The Targetted Lung Health check programme is beginning to report early results which shows a positive detection rate of stage 1 cancers amongst people who have ever smoked in the targetted age cohorts

PH 06d Cancer survival is improving year on year though the improvement is slowing. We continue to work with the cancer alliance and local partners to ensure new and improved diagonistics and treatments are locally available. The improvement in survival is also a factor of earlier diagnosis, enabling more successful early treatments and interventions.

Cancer mortality is seeing a small improvement year on year, as a factor of the works being undertaken on screening, early diagnosis and presentation and improvements in diagnostic and treatment technology and access.

PH 06e

Sure Start to Later Life continue to support older people to engage in community activities to reduce the risk of loneliness and social isolation. We have received 83 referrals this quarter which is nearly double what we received last quarter. We have held 6 Get Together events, with a total of 212 people in attendance this quarter.

PH 07a

We held our first face to face Partners in Prevention meeting during this quarter. We had partners from British Red Cross, Wellbeing Enterprises, the Stroke Association, Cheshire Fire Service, Sports Development, Widnes and Runcorn Cancer Support Centre, The Carers Centre, Energy Project Plus, the Green Doctor, SCIP, Mental Health Later life and Memory team, the Womens Centre, Supporting people into jobs as well as many others. It was well attended with over 40 professionals in attendance.

Through funding secured from the CCG we have now had six activity tables delivered to care homes across the Borough .This means that all older people care homes have secured an activity table. They have proven very successful as a means to engage residents in meaningful activities and helping them to connect with their wide community. They come with pre-installed brain training apps and memory apps along with a host of enjoyable games and puzzles. The table can be utilized in several different ways as follows:

: Dementia and Brain training apps and games
: Collaborative games (multi-user)
: Listening to music
: Keep fit lessons, sing alongs & quizzes
: Watching films and documentaries
: Viewing the internet
: Skype calling
: Staff training

We are in the planning stages of doing some Intergenerational pieces of work that links in with Haltons 'Reading Strategy where we will ask young children to read stories to older residents in care homes virtually via the table and vice versa.

PH 07b

A decision was made to put the falls steering group on hold until further information is gathered about the future plan of the falls service.

The new Intermediate Care and Frailty Service was launched in December however referrals via the pathway remain minimal.

The Age Well service continues to deliver falls prevention exercise classes, 4 times per week. The number of referrals has dropped for the Single Point

of Access Service for the falls prevention class and wider exercise on referral sessions.

We are in the process of reviewing the Physical Activity Strategy in partnership with Active Halton, to explore ways to increase the number of older adults increasing their activity levels to reduce the risk of falls. This work also links in with the review of the Whole System Obesity Strategy where there will be a focus on Older adults.

We have now devised a falls prevention training offer to care homes aimed at reducing the risk of falls in care homes. We have had two homes that have completed the training to date. Two further homes had booked the training for this quarter but had to cancel due to staffing issues.

We have screened over 150 falls incident forms this quarter and provided supporting information as to how to reduce peoples' risk of falls including

PH 07c signposting to relevant services.

Uptake of flu vaccination for seasonal 2021/22 was higher than average for most cohorts with increased but under target performance especially for pregnant women and 2-3 year cohorts.

Information on the flu vaccination programme for the next season is slow to emerge and while we are working with primary care to ensure that orders are received and capacity within the system to deliver, there is little information regarding what the programmes should look like and any focus for national marketing camapaigns.
We continue to work with Warrington as a system for flu planning.

PH 08a

Outbreak response plans are still in place. The HOST team function is still being maintained, although scaled back which enables rapid response to increases in case numbers. Halton continues to work with system partners to plan for outbreak and surge management arrangements.

PH 08b

Halton public health team continue to work with NHSE, and local systems and providers to identify inequalities within vaccination uptake and target interventions to improve uptake in certain cohorts. The Local Authority maintain oversight of uptake but is not a accountable for delivery of

PH 08c vaccination programmes.

Outbreak response plans are still in place. The HOST team function is still being maintained, although scaled back which enables rapid respons eto increases in case numbers. Halton continues to work with system partners to plan for outbreak and surge management arrangements.

Key Performance Indicators

Ref	Measure	21/22 Actual	22/23 Target	Q1	Current Progress	Direction of travel
PH LI 01	A good level of child development (% of eligible children achieving a good level of development at the end of reception)	66.1% (2018/19)	N/A	N/A	U	**N/A**
PH LI 02a	Adults achieving recommended levels of physical activity (% of adults aged 19+ that achieve 150+ minutes of moderate intensity equivalent per week)	57.6% (2019/20)	58.2% (2020/21)	65.5% (2020/21)	✓	↑
PH LI 02b	Alcohol-related admission episodes – narrow definition (Directly Standardised Rate per 100,000 population)	493 (2020/21)	877.7 (2021/22)	N/A	U	**N/A**
PH LI 02c	Under-18 alcohol-specific admission episodes (crude rate per 100,000 population)	58.0 (2018/19-2020/21)	57.1 (2019/20 – 2021/22)	43.1 (2019/20-2021/22 provisional)	✓	↑
PH LI 03a	Smoking prevalence	14.9% (2019)	14.9% (2020)	13.1% (2020)	✓	↑

	(% of adults who currently smoke)					
PH LI 03b	Prevalence of adult obesity (% of adults estimated to be obese)	76.9% (2019/20)	77.5% (2020/21)	65% (2020/21)		
PH LI 03c	Mortality from cardiovascular disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	96.7 (2019-21 provisional)	96.7 (2020-22)	99.9 (Q2 2019-Q1 2022 provisional)		
PH LI 03d	Mortality from cancer at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note year for targets*	151.0 (2019-21 provisional)	150.2 (2020-22)	150.2 (Q2 2019-Q1 2022 provisional)		
PH LI 03e	Mortality from respiratory disease at ages under 75 (Directly Standardised Rate per 100,000 population) *Published data based on calendar year, please note*	46.6 (2019-21 provisional)	46.4 (2020-22)	46.7 (Q2 2019-Q1 2022 provisional)		

	year for targets					
PH LI 03f	Breast cancer screening coverage (aged 53-70) *Proportion of eligible women who were screened in the last 3 years*	58.8% (2021)	70% (national target)	N/A (annual data only)	U	**N/A**
PH LI 03g	Cervical cancer screening coverage (aged 25 – 49) *Proportion of eligible women who were screened in the last 3.5 years*	71.9% (2021)	80% (national target)	N/A (annual data only)	U	**N/A**
	Cervical cancer screening coverage (aged 50 – 64) *Proportion of eligible women who were screened in the last 5.5 years*	72.5% (2021)	80% (national target)	N/A (annual data only)	U	**N/A**
PH LI 03h	Bowel cancer screening coverage (aged 60 to 74) *Proportion of eligible men and women who were screened in the last 30 months*	55.5% (2021)	No national target as yet	N/A (annual data only)	U	**N/A**

PH LI 03i	Percentage of cancers diagnosed at early stage (1 and 2)	55.5% (2019)	55.7% (2020)	N/A (annual data only)	U	**N/A**
PH LI 03j	1 year breast cancer survival (%)	97% (2018)	97.25% (2019)	N/A	U	**N/A**
PH LI 03k	1 year bowel cancer survival (%)	79% (2018)	79.25% (2019)	N/A	U	**N/A**
PH LI 03l	1 year lung cancer survival (%)	41% (2018)	41.5% (2019)	N/A	U	**N/A**
PH LI 04a	Self-harm hospital admissions (Emergency admissions, all ages, directly standardised rate per 100,000 population)	312.6 (2020/21 provisional)	380.6 (2021/22)	283.5 (2021/22 provisional)	✓	↑
PH LI 04b	Self-reported wellbeing: % of people with a low happiness score	12.1% (2020/21)	11.9% (2021/22)	N/A	U	**N/A**
PH LI 05ai	**Male** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	17.2 (2019-21 provisional)	17.2 (2020-22)	17.1 (Q2 2019-Q1 2022 provisional)	✗	↔

PH LI 05aii	**Female** Life expectancy at age 65 (Average number of years a person would expect to live based on contemporary mortality rates) *Published data based on 3 calendar years, please note year for targets*	19.5 (2019-21 provisional)	19.5 (2020-22)	19.1 (Q2 2019-Q1 2022 provisional)		
PH LI 05b	Emergency admissions due to injuries resulting from falls in the over 65s (Directly Standardised Rate, per 100,000 population; PHOF definition)	2813 (2020/21)	2806 (2021/22)	2707 (2021/22 provisional)		
PH LI 05c	Flu vaccination at age 65+ (% of eligible adults aged 65+ who received the flu vaccine, GP registered population)	81.6% (2021/22)	75% (national target)	N/A		N/A

Supporting Commentary

PH LI 01_Department of Education are not publishing 2019/20 or 2020/21 data due to COVID priorities.

PH LI 02a Levels of adult activity increased in 2020/21. Data is published annually.

PH LI 02b Due to a national data change, quarterly data is currently unavailable.

PH LI 02c The rate of under 18 alcohol specific hospital admissions has reduced over 2019/20 to 2020/21. COVID-19 is likely to have had an effect on this.
(2021/22 data is provisional; published data will be released later in the year.)

PH LI 03a Smoking levels improved during 2019 and 2020; 2020 data met the target.

PH LI 03b Adult excess weight reduced during 2021 and met the target.

PH LI 03c The rate of CVD deaths (in under 75s) has increased in 2020 and 2021; it is likely that COVID-19 has had an effect.
(Data is provisional; published data will be released later in the year.)

PH LI 03d The rate of cancer deaths (in under 75s) has reduced slightly over 2020 and 2021. It is yet unclear how COVID-19 has affected death rates from other major causes.
(Data is provisional; published data will be released later in the year.)

PH LI 03e The rate of respiratory disease deaths (in under 75s) has reduced slightly over 2020 and 2021. It is yet unclear how COVID-19 has affected death rates from other major causes.
(Data is provisional; published data will be released later in the year.)

PH LI 03f Breast cancer screening coverage dropped in 2020 and again in 2021; COVID-19 has most likely affected this. Data is released annually

Cervical cancer screening coverage improved during 2020 in those aged 25-49. Halton performed better than the England average both in 2020 and 2021 but is still working towards the national standard of 80% coverage. Data is released annually.

Cervical cancer screening coverage remained static between 2018 and 2020 in those aged 50-64, but fell slightly during 2021. Halton did not perform as well as the England average and is still working towards the national standard of 80% coverage. Data is released annually.

PH LI 03h Bowel cancer screening coverage improved during 2020, but has fallen significantly in 2021. Halton did not perform as well as the England average in 2020 or 2021. Data is released annually

PH LI 03i The % of cancers diagnosed at early stage has fluctuated between 50% and 56% since 2013. The latest % is similar to the England average (55.1%). Data is released annually.

PH LI 03j 1 year breast cancer survival has improved steadily over the last 10 years. It was 97% in 2018, which was the same as the England average. Data is released annually.

PH LI 03k 1 year bowel cancer survival has improved steadily over the last 10 years. It was 79% in 2018, which was slightly lower than the England average (80%). Data is released annually.

PH LI 03l 1 year lung cancer survival has improved steadily over the last 10 years. It was 41% in 2018, which was lower than the England average (44.5%). Data is released annually.

PH LI 04a Provisional 2021/22 data indicates the rate of self-harm admissions has reduced since 2019/20 and has met the target.
(Data is provisional; published data will be released later in the year.)

PH LI 04b Happiness levels worsened during 2019/20 and again in 2020/21. COVID-19 is likely to have had an impact. Data is published annually.

PH LI 05ai Life expectancy has been impacted severely by excess deaths from COVID-19, both nationally and in Halton. Male life expectancy at age 65 reduced slightly during 2020 and 2021.
(Data is provisional; published data will be released later in the year.)

PH LI 05aii Life expectancy has been impacted severely by excess deaths from COVID-19, both nationally and in Halton. Female life expectancy at age 65 reduced during 2020 2021.
(Data is provisional; published data will be released later in the year.)

PH LI 05b Provisional 2021/22 indicates the rate of falls injury admissions has reduced slightly and has met the target.
(Data is provisional; published data will be released later in the year).

PH LI 05c Flu uptake for winters 2020/21 and 2021/22 exceeded the national target of 75%.

APPENDIX 1 – Financial Statements

ADULT SOCIAL CARE DEPARTMENT

Finance

Revenue Operational Budget as at 30 June 2022

	Annual Budget	Budget to Date	Actual	Variance (Overspend)	Forecast Outturn (Overspend)
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	15,145	3,663	3,609	54	160
Premises	334	110	116	(6)	(20)
Supplies & Services	471	95	87	8	0
Aids & Adaptations	38	9	4	5	0
Transport	187	47	62	(15)	(50)
Food Provision	187	38	36	2	0
Agency	617	152	158	(6)	0
Supported Accommodation and Services	1,426	212	212	0	0
Emergency Duty Team	105	27	27	0	0
Contacts & SLAs	567	312	309	3	0
Housing Solutions Grant Funded Schemes					
LCR Immigration Programme	400	100	96	4	0
Homelessness Prevention	356	88	70	18	0
Total Expenditure	**19,833**	**4,853**	**4,786**	**67**	**90**
Income					
Fees & Charges	-761	-187	-157	(30)	(50)
Sales & Rents Income	-417	-197	-198	1	0
Reimbursements & Grant Income	-1,198	-113	-118	5	0
Capital Salaries	-121	-30	-30	0	0
LCR Immigration Programme	-400	-100	-100	0	0
Homelessness Prevention	-356	-356	-356	0	0
Transfer From Reserves	-413	0	0	0	0
Total Income	**-3,666**	**-983**	**-959**	**(24)**	**(50)**
Net Operational Expenditure Excluding Homes and Community Care	**16,167**	**3,870**	**3,827**	**43**	**40**
Care Homes Net Expenditure	8,182	1,973	2,261	(288)	(735)
Community Care Expenditure	19,303	4,940	5,261	(321)	(1,284)
Net Operational Expenditure Including Homes and Community Care	**43,652**	**10,783**	**11,349**	**(566)**	**(1,979)**
Recharges					
Premises Support	460	115	115	0	0
Transport Support	587	146	165	(19)	(40)
Central Support	3,563	891	891	0	0
Asset Rental Support	13	0	0	0	0
Recharge Income	-122	-30	-30	0	0
Net Total Recharges	**4,501**	**1,122**	**1,141**	**(19)**	**(40)**
Net Departmental Expenditure	**48,153**	**11,905**	**12,490**	**(585)**	**(2,019)**

Comments on the above figures

Net Department Expenditure, excluding the Community Care and Care Homes divisions, is £0.024m below budget profile at the end of the first quarter of the 2022/23 financial year. Expenditure is currently projected to be to budget by end of the financial year.

Employee costs are currently £0.054m under budget profile, due to turnover savings being made above target on vacancies. The bulk of savings are being made within the Care Management division, which have historically experienced difficulties in recruiting to vacant posts.

The current overspends on premises and transport cost in the report largely relate to increased costs of gas, electricity and transport related fuel costs. These costs are projected to continue for the remainder of the year.

The projected shortfall in fees and charges primarily relates to Day Service trading activities, and the level reduced of consumer confidence post-pandemic. Such shortfall has been met from Covid related government grant funding in the previous two financial years, funding no longer exists for the current financial year.

Housing Strategy initiatives included in the report above include the LCR Immigration Programme and Homelessness Prevention Scheme. The Homelessness Prevention scheme is an amalgamation of the previous Flexible Homelessness Support and Homelessness Reduction schemes. Funding has increased significantly from £0.253m back in 2020/21 to the current level of £0.356m for 2022/23.

An overall balanced budget is projected for the financial year, with the pressures from increased utility costs and loss of trading income being offset by savings above target in respect of staff turnover.

COMPLEX CARE POOL

Revenue Budget as at 30 June 2022

	Annual Budget	Budget to Date	Actual	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Intermediate Care Services	6,242	1,059	1,015	44	176
Homecare First	1,300	0	0	0	0
HICaFS	3,584	138	84	54	216
Oakmeadow	1,165	293	300	(7)	(28)
Contracts & SLA's	3,325	72	72	0	0
Joint Equipment Store	802	196	196	0	0
Development Fund	784	0	0	0	0
Carers Breaks	428	107	154	(47)	(188)
Carers Centre	365	91	91	0	0
Health & Social Care:				0	0
Residential Care	1,074	268	268	0	0
Domicilliary Care and Supported Living	2,556	639	639	0	0
Total Expenditure	**21,625**	**2,863**	**2,819**	**44**	**176**
Income					
BCF Income	-12,078	-3,026	-3,026	0	0
HCCG Contribution to Pool	-2,831	-799	-799	0	0
Oakmeadow Income	-612	-153	-152	(1)	(4)
Ageing Well	-694	0	0		0
Transfer from Reserve	-700	0	0	0	0
Bal Cwfd 2021/22	-205	0	0	0	0
Total Income	**-17,120**	**-3,978**	**-3,977**	**(1)**	**(4)**
Net Departmental Expenditure	**4,505**	**-1,115**	**-1,158**	**43**	**172**

Comments on the above figures:

The overall position for the Complex Care Pool budget is £43,000 under budget profile at the end of June however this position is subject to change as we move through the financial year, as pressures on the budget are highlighted.

The pandemic enabled services to be provided in a different way and the community reablement model, as opposed to bed base, is proving to deliver better outcomes. Changes have been made recently across Intermediate Care and the Home First model, alongside the impact of hospital pressures resulting in a shift in service demand. Budgets have therefore, been realigned against service needs where appropriate.

In the main, expenditure is below budget profile due to Intermediate Care and the HICaF service which cumulatively, are £98k under expected budget at this point of the financial year. However, expenditure on carers' breaks is over budget profile by £47k at the end of the first financial quarter resulting overall, in a small favourable variance for quarter one.

Pooled Budget Capital Projects as at 30th June 2022

	2022-23 Capital Allocation £'000	Allocation To Date £'000	Actual Spend £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	650	150	119	531
Stair lifts (Adaptations Initiative)	250	60	48	202
RSL Adaptations (Joint Funding)	200	50	24	176
Telehealth Care Digital Switchover	400	0	0	400
Millbrow Refurbishment	1,200	0	0	1,200
Madeline Mckenna Refurb.	100	10	5	95
St Luke's Care Home	100	10	9	91
St Patrick's Care Home	400	100	0	400
Total	**3,300**	**380**	**205**	**3,095**

Comments on the above figures:

Allocations for Disabled Facilities Grants, Stair Lifts and RSL adaptations are consistent with 2021/22 and expenditure across these schemes is anticipated to be within budget overall.

The capital allocation for Millbrow refurbishment includes funds carried forward from 2021/22 as work was rescheduled due to the pandemic. The refurbishment programme is scheduled to start in the latter part of the financial year

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Revenue Budget as at 30th June 2022

	Annual Budget	Budget to Date	Actual	Variance (Overspend)	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Expenditure					
Employees	4,120	1,004	994	10	22
Premises	5	0	0	0	0
Supplies & Services	312	101	98	3	19
Contracts & SLA's	6,751	1,181	1,181	0	0
Transport	5	2	2	0	0
Other Agency	21	21	21	0	0
Transfer to Reserves	50	0	0	0	0
Total Expenditure	**11,264**	**2,309**	**2,296**	**13**	**41**
Income					
Fees & Charges	-252	-152	-150	(2)	(8)
Reimbursments & Other Grants	-123	-90	-90	0	0
Government Grants	-10,982	-1,995	-1,995	0	0
Transfer from Reserves	-645	0	0	0	0
Total Income	**-12,002**	**-2,237**	**-2,235**	**-2**	**-8**
Net Operational Expenditure	**-738**	**72**	**61**	**11**	**33**
Recharges					
Premises Support	126	32	32	0	0
Transport Support	23	6	9	(3)	(5)
Central Support	1,324	331	331	0	0
Recharge Income	-482	-120	-120	0	0
Net Total Recharges	**991**	**249**	**252**	**-3**	**-5**
Net Departmental Expenditure	**253**	**321**	**313**	**8**	**28**

Comments on the above figures

The net Department spend is £0.008m under budget profile at the end of Quarter 1 and the estimated outturn position for 2022/23 is for net spend to be £0.028m under the available budget.

Employee costs are currently £0.010m under planned budget at this point in the year. This is a result of savings made on vacancies. Two posts with the Environmental, Public Health & Health Protection Division have recently been filled and a third is in the recruitment process and the level of savings from vacancies is expected to reduce during the remaining 3 quarters of the financial year. The anticipated full year underspend is projected to be £0.022m. The employee budget is based on 89.7 full time equivalent staff. The staff turnover saving target of £0.048m is expected to be achieved in full.

Transport recharges are £0.003m over budget profile at the end of Quarter 1. This is due to higher than budgeted diesel and repair costs for Pest Control vehicles and the forecast full year overspend is estimated to be £0.005m. This is the result of significant inflation increases.

The balance of £0.368m carried forward from last year's allocation from the Contain Outbreak Management Fund (COMF) is being used to fund continued spend within the Outbreak Support Team. Funding is being used to target low COVID-19 vaccine uptake, enhanced communication and marketing, workplace prevention and contain measures and to help the clinically extremely vulnerable remain well. COMF spend during Quarter 1 is £0.190m and this is 51.6% of the

available funding, with £0.182m spent on employee costs. The remaining £0.178m is expected to be spent with the next quarter of 22/23.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*