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Sefton Council

MEETING: OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)

DATE: Tuesday 23 January 2024

TIME: 6.30 pm

VENUE: Birkdale Room - Southport Town Hall, Lord Street, Southport, PR8 1DA

Member	**Substitute**
Cllr. Carla Thomas (Chair)	Cllr. Carol Richards
Cllr. Greg Myers (Vice-Chair)	Cllr. Michael Roche
Cllr. Iain Brodie - Browne	Cllr. Dr. John Pugh
Cllr. Tony Brough	Cllr. Sir Ron Watson C.B.E.
Cllr. Linda Cluskey	Cllr. Daniel McKee
Cllr. Sean Halsall	Cllr. Sonya Kelly
Cllr. Phil Hart	Cllr. Veronica Webster
Cllr. John Joseph Kelly	Cllr. Paul Tweed
Cllr. Laura Lunn-Bates	Cllr. Mike Desmond F.R.C.A.
Cllr. Dave Robinson	Cllr. Christopher Page
Ms Diane Blair, Healthwatch	
Mr. Brian Clark, Healthwatch	

COMMITTEE OFFICER: Laura Bootland, Senior Democratic Services Officer

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If you have any special needs that may require arrangements to facilitate your attendance at this meeting, please contact the Committee Officer named above, who will endeavour to assist.

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A G E N D A

1. Apologies for Absence

2. Declarations of Interest

Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda.

Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation.

Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.

3. Minutes of the Previous Meeting (Pages 5 - 12)

Minutes of the meeting held on 17 October 2023.

4. Melling Surgery Update (Pages 13 - 26)

Report of the Sefton Place Director, NHS Cheshire and Merseyside.

5. Cheshire and Merseyside Cancer Alliance Update (Pages 27 - 72)

Jon Hayes, Managing Director, Cheshire and Merseyside Cancer Alliance, to attend.

6. NHS Cheshire and Merseyside, Sefton Place Update Report (Pages 73 - 76)

Report of the Sefton Place Director, NHS Cheshire and Merseyside

7. NHS Cheshire and Merseyside, Sefton Place Primary Medical Care Update Report (Pages 77 - 88)

Report of the Sefton Place Director, NHS Cheshire and Merseyside.

8. NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard (Pages 89 - 96)

Report of the Sefton Place Director, NHS Cheshire and Merseyside

9. Report on the Public Health Performance Framework (Pages 97 - 142)

Report of the Director of Public Health

10. Adult Social Care Performance Data Review (Pages 143 - 184)

Report of the Executive Director of Adult Social Care and Health.

11. 2024 Winter Planning (Pages 185 - 190)

Report of the Executive Director of Adult Social Care and Health.

12. Serious Violence Duty (Pages 191 - 260)

Report of the Assistant Director of People (Communities)

13. Cabinet Member Reports (Pages 261 - 272)

Report of the Chief Legal and Democratic Officer

Cabinet Member Update – Adult Social Care, report to follow.

14. Work Programme Key Decision Forward Plan (Pages 273 - 300)

Report of the Chief Legal and Democratic Officer

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THIS SET OF MINUTES IS NOT SUBJECT TO "CALL IN".

'ERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)

EETING HELD AT THE COMMITTEE ROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE
ON TUESDAY 17TH OCTOBER, 2023

PRESENT: Councillor Carla Thomas (in the Chair)
Councillor Greg Myers (Vice-Chair)
Councillors Iain Brodie - Browne, Linda Cluskey, Phil Hart, John Joseph Kelly and Dave Robinson

ALSO PRESENT: Councillor Cummins (Cabinet Member – Adult Social Care) and Councillor Moncur (Cabinet Member – Health and Wellbeing).

24. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Tony Brough, Councillor Laura Lunn-Bates, Diane Blair, Healthwatch Sefton and Brian Clark, O.B.E., Healthwatch Sefton.

25. DECLARATIONS OF INTEREST

No declarations of any disclosable pecuniary interests or personal interests were received.

26. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 5 September 2023, be confirmed as a correct record.

27. NHS CHESHIRE AND MERSEYSIDE, SEFTON - UPDATE REPORT

The Committee considered the report of the Sefton Place Director, NHS Cheshire and Merseyside, that provided an update about the work of NHS Cheshire and Merseyside, Sefton. The report outlined details of the following:

- Pioneering stroke assessment centre opens at Aintree University Hospital
- Covid & Flu Vaccination Update
- Children's flu vaccination programme gets underway
- Region-wide AI deal to help tackle waiting lists across nine NHS trusts
- Latest NHS Cheshire and Merseyside Board meeting

RESOLVED:

That the update report submitted by the Sefton Place Director, NHS Cheshire and Merseyside (Sefton) be noted.

28. NHS CHESHIRE AND MERSEYSIDE, SEFTON - HEALTH PROVIDER PERFORMANCE DASHBOARD

The Committee considered the report of the Sefton Place Director, NHS Cheshire and Merseyside, that provided data on key performance areas for North and South Sefton, together with responses for the Friends and Family Test for both Southport and Ormskirk Hospital NHS Trust and Liverpool University Hospital NHS Foundation Trust (LUHFT). Information on the monitoring of the 7-day GP extended access scheme, and ambulance response times were also included within the data.

Members noted a drop in performance for Southport and Ormskirk Hospital. It was agreed that a response to the query would be circulated to the Committee.

RESOLVED: That

(1) the information on Health Provider Performance be noted;

(2) the Assistant Director of Adult Social Care be requested to obtain a response to the query around the drop in performance for Southport and Ormskirk Hospital, to be circulated to the Committee.

29. PERFORMANCE REPORT REVIEW

The Committee considered the report of the Sefton Place Director, NHS Cheshire and Merseyside that set out details of:

- Current Performance Reporting;
- The future of Performance Reporting, in relation to the Cheshire and Merseyside Integrated Care Board;
- Whole Life Sefton Plan Themes; and
- Recommendations

Members of the Committee asked questions/commented on the following issues:

- Statistics and data should continue to be presented to the Committee in interests of openness and transparency.
- Themed reports should be presented to the Committee alongside the performance report, it should not be an either/or.
- It would have been helpful for the Committee to have received an example of alternative options for performance reporting.
- Performance data was useful to enable the Committee to scrutinise and monitor what is happening in healthcare and particularly important in terms of the ongoing impact of the pandemic.

- Scrutiny committees can be open to criticism for not fulfilling their duties, and the scrutiny of data was an important part of the Committee's role.

RESOLVED: That

(1) It be confirmed that the Overview and Scrutiny Committee (Adult Social Care and Health) wishes to continue to receive the Performance Dashboard at all future meetings;

(2) the Sefton Place Director, NHS Cheshire and Merseyside be requested to include a narrative to explain future variations in data, where possible;

(3) Sefton Plan themes be considered under Minute No. 33 below.

30. MELLING SURGERY CLOSURE

The Committee considered the report of the Sefton Place Director, NHS Cheshire and Merseyside that set details of the following:

- Purpose
- Background
- Melling Surgery
- Impact of COVID-19
- Premises/Lease arrangements
- Contractual
- Options Appraisal
- Overall impact on patients
- Impact Assessments (EIA and QIA) Summary
- Impact on patients from Sefton
- Changes in accessibility
- Bus Routes
- Patient Transport
- Community Pharmacy Support
- Home Visit Support
- Complaints received during the closure
- Patient communication
- Patient Information Event
- Actions taken by NHS Cheshire and Merseyside

Members of the Committee asked questions/commented on the following issues:

- The reasons for the lease not being renewed and the legalities around that.
- It was confirmed that Ward Members had reported that residents were complaining about the closure.

- The population in the Melling area was increasing with a development of 140 new houses, which added the concern about access to GP surgeries.
- The bus routes to other surgeries were quite long and not acceptable for people who were sick. However, it was noted that the offer of taxis had not been widely taken up by melling surgery patients.
- The circumstances of the closure were understood, but it was apparent that the closure would be a substantial change.

RESOLVED:

That the impact of the closure of Melling Surgery for Sefton residents constitutes a substantial change.

31. HEALTH SUBSTANTIAL RECONFIGURATION PROPOSALS

The Committee considered the report of the Chief Legal and Democratic Officer proposing amendments to the process for considering substantial reconfiguration proposals. The Protocol for Joint Health Scrutiny Arrangements was attached to the report at Appendix A.

The report indicated that some 63 substantial reconfiguration proposals are likely to be forthcoming to each of the nine local authorities in Cheshire and Merseyside in the near future, as part of the Harmonisation of Clinical Policies within the Cheshire and Merseyside Integrated Care System.

Rather than submit all future substantial reconfiguration proposals received directly to the Overview and Scrutiny Committee (Adult Social Care and Health), it was proposed that the Statutory Scrutiny Officer, in consultation with the Chair and Vice-Chair of the Committee, should review substantial reconfiguration proposals received to inform an initial decision which would be conveyed to the relevant Health Provider. Details of substantial reconfiguration proposals received would be emailed to Committee Members inviting feedback and once an initial decision had been reached, the outcome would be reported to the next meeting of the Overview and Scrutiny Committee (Adult Social Care and Health), for formal approval.

RESOLVED:

That the Statutory Scrutiny Officer, in consultation with the Chair and Vice-Chair of the Overview and Scrutiny Committee (Adult Social Care and Health), be authorised to review substantial reconfiguration proposals received, in order to inform an initial decision, as set out in paragraphs 3.1 to 3.3 of the report.

32.CABINET MEMBER REPORTS

The Committee considered the report of the Chief Legal and Democratic Officer submitting the most recent update reports from the Cabinet Member – Adult Social Care, and the Cabinet Member – Health and Wellbeing, whose portfolios fell within the remit of the Committee.

The Cabinet Member update report – Adult Social Care, attached to the report at Appendix A, outlined information on the following:

- The National Assurance Update for Adult Social Care
- Integrated Care Teams (ICT) Development
- Strategic Commissioning:
    - Domiciliary Care
    - Day Opportunities
    - New Directions
    - Care Homes
    - Quality Monitoring
    - Grant Funding
    - Extra Care Housing

- Care Transfer Hubs - ASC involvement in Hospital Discharge/Preparation for Winter
- Adult Social Care Budget
- Adult Social Care Complaints, Compliments and MP Enquiries
- Principal Social Worker Update (PSW):
    - Practice Audits
- Performance and Key Areas of Focus
    - Admission into care and reablement
    - Self-directed support and direct payments
    - Employment
    - Housing
    - Safeguarding

The Cabinet Member update report – Health and Wellbeing, attached to the report at Appendix B, outlined information on the following:

Public Health:

- Combatting Drug Partnership
- Staff Flu Vaccination Programme 2023
- Sexual Health Extension
- Parent Champion for Respiratory Health Pilot

Leisure:

- Leisure Update

Councillor Cummins, Cabinet Member – Adult Social Care and Councillor Moncur, Cabinet Member - Health and Wellbeing, attended the meeting to present their reports and to respond to any questions.

Members noted the following points:

- The challenging financial position relating to Adult Social Care
- The issue of a high number of staff vacancies in social care across the independent and voluntary sector.

RESOLVED: That

(1) the update reports from the Cabinet Member – Adult Social Care and the Cabinet Member – Health and Wellbeing be noted; and

(2) the Assistant Director of Adult Social Care be requested to submit further data to Committee Members on vacancies and staffing in the social care in the independent and voluntary sector.

33. WORK PROGRAMME KEY DECISION FORWARD PLAN

The Committee considered the report of the Chief Legal and Democratic Officer that sought to:

- seek the views of the Committee on the Work Programme for the remainder of the Municipal Year 2023/24;
- identify any items for pre-scrutiny by the Committee from the Key Decision Forward Plan;
- seek the views of the Committee on the Programme of informal briefings/workshop sessions for the remainder of 2023/24,
- note the intention for the Local Government Association to provide training from Members and Substitutes of the Committee;
- receive an update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee;
- receive an update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee; and
- note the update by Healthwatch Sefton.

The following appendices were attached to the report:

- Appendix A – Work Programme for 2023/24;
- Appendix B – Latest key decision forward plan items relating to this overview and scrutiny committee.
- Appendix C – Draft programme of informal briefings/workshop sessions for 2023/24
- Appendix D – Update of recent activities taken by Healthwatch Sefton.

Members noted the addition of the following items to future agendas:

- Cancer Alliance
- Winter Plan for Adult Social Care
- Ormskirk/Southport Hospital

RESOLVED: That

(1) the Work Programme for 2023/24, as set out in Appendix A to the report be agreed, along with any additional items (as above) to be included and thereon agreed;

(2) the following additional items be included in the Work Programme for the dates indicated:

- Cheshire and Merseyside Cancer Alliance – January 2024
- Winter Pressure and Plan for Adult Social Care – January 2024
- Southport and Ormskirk Hospital NHS Trust – Shaping Care Programme – February 2024;

(3) the contents of the Key Decision Forward Plan for the period 1 November – 29 February 2024, be noted;

(4) the Programme of informal briefings/workshop sessions for 2023/24, as set out at Appendix C to the report, be noted, along with any additional informal items to be included and thereon be agreed;

(5) the intention for the Local Government Association to provide training from Members and Substitutes of the Committee be noted;

(6) the update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee be noted;

(7) the update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee be noted; and

(8) the recent activities undertaken by Healthwatch Sefton, as outlined in Appendix D to the report, be noted.

34. DATE OF NEXT MEETING

RESOLVED:

That the next meeting of the Committee be re-arranged to Tuesday, 23 January 2024, to be held at the Town Hall, Southport, commencing at 6.30 p.m.

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Sefton Council

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting**	23 January 2024
Subject:	Update: Melling Surgery Closure		
Report of:	NHS Cheshire and Merseyside	**Wards Affected:**	Molyneux
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Emma Robinson		
Tel:	07407 876415		
Email:	Emma.robinson@cheshireandmerseyside.nhs.uk		

Update: Closure of Melling surgery

1. PURPOSE

1.1 The purpose of the report is to provide the Sefton Overview and Scrutiny Committee members with a further update on the steps taken by NHS Cheshire & Merseyside to manage and mitigate the impact of the closure of the Melling branch site of Dr Maassarani and Partners based on Waddicar Lane.

1.2 The Adult Social Care and Health Committee is requested to:

- Review the content of this report and any additional information during the committee discussion.

2. BACKGROUND

2.1 Dr Maassarani and Partners is a practice located in Kirkby with a current combined list size of approximately 16,700 patients spread across 3 sites (see Table 1 below).

Table 1: Dr Maassarani and Partners practice locations

Site	Location	Ward	Type	Approx registered population
Dr Maassarani and Partners	Tower Hill, Kirkby, L33 1XT	Shevington (Knowsley)	Main	8,400
Trentham Medical Practice ***(Merged July 23)***	St Chads Centre, Kirkby, L32 8RE	Whitefield (Knowsley)	Branch	5,900
Melling	**Waddicar Lane, Sefton, L31 1DY**	**Molyneux (Sefton)**	**Branch**	**2,425**

3. Melling branch surgery

3.1 In 2017, Dr Maassarani and Partners Melling site provision was reduced to operating on 3 days a week, with the offer to all Melling residents to attend the main Tower Hill site as required.

Melling branch was open three days per week 8am – 6.30pm on the following days and times.

- Monday
- Wednesday
- Thursday

The branch was closed on Tuesdays and Fridays.

3.2 Since 2017, patients from Melling have been able to access a free transport service to Tower Hill provided by the practice to ensure they could access clinical services on the two days the branch surgery was closed.

3.3 As a direct result of the COVID-19 pandemic and the requirements on general practice to change the way that they safely operated and delivered services, the **Melling surgery site fully closed in April 2020**.

3.4 During this time, the practice Patient Participation Group (PPG) was actively involved with the discussions and the requirement to relocate all clinical services to the main site at Tower Hill.

3.5 Trentham Medical Centre merged with Dr Maassarani & Partners in July 2023 to become a new branch site and is situated in St Chad's Health Centre building, Kirkby. This site is available to all registered patients to attend in addition to Tower Hill.

4. Change Event

4.1 In July 2023, a letter was received from the current owner (Landlord) of the building informing Dr Maassarani & Partners that he wishes to repurpose the current building and has no intention to make the building fit to resume clinical services.

4.2 There is no compliant lease in place for the premises and this issue has remained unresolved between the practice, property owner and NHSE since 2017.

4.3 In August 2023, a further request was made by the property owner to the practice to expedite the vacation of the building to enable preparation work for commercial/residential use.

5. Timeline of events

	Action	Outcome
April 2020	Melling surgery fully closed (due to COVID social distancing restrictions) *N.B Melling surgery - open 3 days a week since 2017*	All registered patients informed to attend Towerhill site for all face-to-face consultations. Patients from Melling reminded that they have access to a free taxi service to Tower Hill for clinical consultations, provided by the practice.
July 2022	A 6 Facet Premises Survey (comprising: Physical, Functional stability, Space utilisation, Quality, Fire and Health & Safety and environmental management) was undertaken by independent surveyors commissioned by NHS Cheshire & Merseyside funded by NHSE.	The survey for the Melling site concluded that the overall site rating for Functionality was scored as an "A – Can be expected to perform adequately over its design life;" however, a maintenance cost of approx. £8600 to bring the fabric/condition of the building back would be required.
October 2022	The practice submitted a request to NHS Cheshire & Merseyside to permanently close the Melling branch surgery.	NHS Cheshire & Merseyside acknowledged receipt and requested further information to support the request.
January 2023	NHS Cheshire & Merseyside and the practice agreed to set up a formal programme of work to ensure the appropriate governance was followed for proposed changes.	To support the practice to appropriately plan the patient consultation and engagement. This would help inform the decision to be made by NHS Cheshire & Merseyside to accept or decline the proposal to formally close the Melling branch site.
April 2023	In April 2023, Dr Maassarani & Partners were issued with a breach notice due to the Melling branch site failing to re-open following the withdrawal of the COVID-19 restrictions in July 2021.	The practice was requested to set out new proposals that would demonstrate how they will meet their contractual obligations to open the site whilst awaiting the outcome of the required patient consultation and engagement.

	Action	Outcome
June 2023	The practice responded to the breach notice issued by NHS Cheshire and Merseyside	The practice confirmed that a meeting had taken place with the property owner to discuss the lease renewal for the Melling site. However, the property owner outlined that they have decided not to renew the lease and their intention is to repurpose the estate for other opportunities that have been presented to them. NHS Cheshire & Merseyside requested that this intention needs to be shared in writing from the Landlord.
July 2023	NHS Cheshire & Merseyside completed a Pre-Consultation QIA in preparation for full consultation with the registered patients.	Information obtained from the practice regarding their vulnerable patients
July 2023	NHS Cheshire & Merseyside were informed that a letter was received by Dr Maassarani from the current property owner (Landlord).	The property owner confirmed in writing that there is an intent to repurpose the current building and that there is no intention to make the building fit to resume clinical services nor make the current lease compliant for NHS use.
August 2023	A further request was made by the property owner to the practice to expedite the vacation of the building to enable work to the site in preparation for commercial/residential use.	Practice partners advised to speak to the property owner to request that no amendments/building work is to be started prior to patient communication.
September 2023	All Dr Maassarani & Partners patients were informed of the decision to close the Melling surgery on 8th September 2023 and that this would be effective from 30th September 2023	All registered patients received a text message, letter and in addition a phone call for all vulnerable patients to explain the change and circumstances surrounding this.

	Action	Outcome
September 2023	All Melling registered patients were invited to attend an information event held on 21st September 2023.	5 residents from Melling attended the drop-in patient information event on 21st September 2023, where they were able to discuss any queries or concerns with the practice management team and patient forum reps.

6. Options Appraisal

6.1 NHS Cheshire and Merseyside has responsibility for meeting the health needs and arranging the provision of health services for the population of Knowsley.

6.2 As a result of the property owner's decision, several options have been considered by NHS Cheshire and Merseyside:-

1. Do nothing.
2. Re-negotiate the Lease.
3. Purchase/build new premises.
4. Lease suitable alternative accommodation.
5. Permanently vacate premises and close the branch.

The only viable option was ***No. 5 – Permanently vacate the premises and contractually close the branch site.*** *(See Appendix 6 for more details on each option)*

7. Impact Assessments (EIA and QIA) Summary

7.1 An Equality and Quality Impact Assessment (see Appendix 1 and 2) has been undertaken on the option to close the Melling branch surgery.

7.2 This decision has been taken considering the property owners request to repurpose the current building for commercial usage and in addition, the property owner not wishing to make the building fit to resume clinical services nor make the lease compliant for NHS usage.

7.3 The Equality Impact Assessment (EIA) identified key areas that needed to be managed during the transition period to ensure that section 149 Equality Act 2010 (Public Sector Equality Duty) is satisfied and met. The specific areas of concern and mitigating actions are listed below:

Communication	Mitigating actions
No patients 'slip through the net' and that all patients, including vulnerable patients and patients with information, communication and language needs (Disability, age, sex, race, people who experience health inequalities/ poverty) are targeted in the communication exercise, encouraged to air their views and offered choice and support if appropriate to secure alternative GP provision.	In addition to sending a letter and text message out, all vulnerable patients were contacted by telephone by the practice to ensure that they understood the changes and to listen to any specific concerns.
Removing a GP service from a community can be a disheartening process for the people who live there and there may be some heightened anxiety amongst patients, specifically those who live near the Melling branch site. It is essential that Dr Maassarani and Partners and Knowsley Place ensure that all patients receive a full explanation of why the practice is closing. Explain to patients how the existing services can absorb Melling branch patients and not cause a restriction in appointments.	All registered patients received a letter with an explanation of the change and how they can engage further with the practice including a FAQ. A patient information event was set up for the registered patients to ensure that they have an opportunity to discuss any concerns with the practice and PPG in person. 5 residents from Melling attended the drop-in patient information event on 21st September 2023. The key issues raised were:- Transport service – The practice emphasised the provision of the taxi service and agreed to add a message on the telephone and website about the availability of the service for patients who had no transport and may need to attend the practice for a face-to-face appointment. Lack of public transport – The bus service was discussed, and the practice highlighted that although they had no control over this, they agreed to write a letter of support to enable further discussions on improving the bus service.

Accessibility	Mitigating actions
Since April 2020, many patients will have adapted to travelling to the Tower Hill site. For those who have no personal transport and/or are unable to drive and/ or access public transport, a taxi service has been provided at no cost to the patient. It is important that service continues and is promoted to accommodate patients who are unable to access face to face appointments due to their inability to pay, personal circumstances, disability / impairment.	The practice continues to promote and provide transport for any Melling registered patients who require assistance to attend clinical appointments. The Telephone system has been altered to remind patients of this transport service whilst in the queue for booking an appointment. The practice website is in the process of being updated by an external supplier and the communication regarding the transport will be included once amended.

8. Actions taken by NHS Cheshire and Merseyside

8.1 NHS Cheshire and Merseyside has responsibility for meeting the health needs and arranging the provision of health services for the population of Knowsley.

8.2 NHS Cheshire and Merseyside understands that it has not been able to undertake the required patient engagement and consultation regarding the closure of the Melling branch site due to extenuating circumstances outside of NHS Cheshire and Merseyside's control.

8.3 NHS Cheshire and Merseyside had conducted a Pre-consultation Equality Impact Assessment (EIA) to help understand the potential impact and start to inform the content of the required consultation and engagement with the registered patients.

8.4 Following the property owner's notification, NHS Cheshire and Merseyside then conducted a full Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) of the branch closure (See Appendix 1 & 2).

8.5 Due to the immediacy of the property owners request to obtain the building, NHS Cheshire and Merseyside were unable to meet the required engagement and consultation with patients and wider stakeholders around the permanent branch closure. However, the following actions/communications were undertaken as a priority:-

Patients/Carers:

- Text messages sent out on 8th September 2023 with a link to a letter which **informed all registered patients** of the changes and the services offered at Tower Hill and Trentham Medical Centre and the reasons for the closure.
- A posted letter with FAQ was sent to all Melling residents who reside in the L31 postcode area which also included information on translation services (See Appendix 3)
- In addition to the above, all vulnerable patients and those with disabilities were contacted by Telephone by the practice to offer further support.
- Display of posters and information regarding the drop-in patient information event at the main practice.
- NHS Cheshire & Merseyside email contact provided for further support for registered patients.

Key Stakeholders: (See Appendix 5)
An email with the attached Key Stakeholder letter had been sent out to the following:

- NHS Cheshire & Merseyside ICB -Sefton team
- Local Councillors & MP's – Knowsley & Sefton
- Local Acute & Community Health Providers
- Healthwatch Knowsley & Healthwatch Sefton
- Local Medical Committee (LMC) Rep
- Local Community Pharmacies
- Primary Care Network Managers and Clinical Directors for onward circulation to member GP's/practices

8.6 The above communication had been undertaken in advance of the relevant scrutiny committee meetings, however a stakeholder briefing (Appendix 4) was circulated on 12th September 2023.

8.7 NHS Cheshire and Merseyside approved the contract variation to formally close the branch on the 30th September 2023.

9. Summary

9.1 NHS Cheshire and Merseyside believe that the overall provision to meet the health needs is sufficient for the patients impacted by this change.

9.2 NHS Cheshire and Merseyside acknowledge the public transport links are not as flexible as other areas and therefore will ensure that the transport provision for Melling residents remains in place to make certain that no patients are disadvantaged with access to clinical appointments because of the branch closure.

9.3 NHS Cheshire and Merseyside can confirm that the usage/uptake of the "free" transport service for Melling residents has been as follows; despite the addition of the message to the telephone system:-

September 23 = 0 journeys booked
October 23 = 0 journeys booked
November 23 = 1 journey booked from Melling to Towerhill
December 23 = 0 journeys booked to date

9.4 NHS Cheshire and Merseyside considered the car ownership within the Molyneux ward and after review of the Molyneux ward profile updated in 2022, it is evident that this ward area has a higher rate of car ownership than in other comparator areas.

There are approximately 805 vehicles per 1,000 driving age people in the ward (those aged 17 and over). This is considerably higher than the comparator areas (Figure 11).

Figure 11: Rate of Vehicle Registrations (2019)

Source: Molyneux Ward Profile

9.5 NHS Cheshire and Merseyside can confirm that the overall list size has remained stable since the closure of the branch with a small monthly increase in the Melling (L31) residents registered with Dr Maassarani & Partners:-

August 23 = 2,426 patients
September 23 = 2,427 patients
October 23 = 2,433 patients
November 23 = 2,437 patients
December 23 = 2,439 patients

9.6 NHS Cheshire and Merseyside can confirm that there have been no complaints received either at the ICB or at the practice since the closure.

9.7 In summary, based on the information provided throughout the report and including the findings of the Equality Impact Assessment, NHS Cheshire and Merseyside conclude that:

- The branch site has been closed for over 3 years (Apr 2020) and patients have been accessing services from Tower Hill since this time.
- The transport provision for Melling residents has been fully established and in place since 2017 to support vulnerable patients and those who require assistance to visit the main site for a face-to-face appointment and will continue to be made available.
- The numbers of patient complaints have been minimal since the Melling branch site closed in 2020.
- The total number of registered patients from Melling has increased during this time of change.
- The main site at Towerhill hosts the full range of GP services in a fit for purpose building and has provided adequate capacity to all patients since 2020.
- There are suitable alternative GP practices available for Melling residents should they choose to re-register with an alternative practice across Knowsley and Sefton.

10. Scrutiny Action

10.1 Members of the Health and Adult Social Care Scrutiny Committee are requested to: -

- Review the content of this report and any additional information during the committee discussion.

Appendices

Appendix 1: Equality Impact Assessment

Melling Surgery Closure EIA v3-1708

Appendix 2: Quality Impact Assessment

QIA-MellingClosure-Phase2-2023.08.23v3

Appendix 3: Patient communication

Melling Pt-Briefing Letter+FAQ-Aug23-v5

Appendix 4: Stakeholder briefing

MellingClosure-StakeholderLetter-Aug23-v

Appendix 5: Stakeholders

Appendix 5 - Stakeholder Informati

Appendix 6: Options Appraisal

Appendix 6 - Options appraisal - Melling Cl

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Sefton Council

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting**	23 January 2024
Subject:	Cancer Alliance Update		
Report of:	Cheshire and Merseyside Cancer Alliance	**Wards Affected:**	All
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Jon Hayes, Managing Director, Cancer Alliance		
Tel:			
Email:	jon.hayes1@nhs.net		

Purpose / Summary of Report:

To update the committee on the activities of the Cheshire and Merseyside Cancer Alliance.

The attached paper provides an overview of the Cancer Alliance and its current work programme across Sefton.

Recommendation(s)

That the committee supports the ongoing work of the Cancer Alliance to improve cancer outcomes for the population of Sefton and the wider region.

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Cheshire and Merseyside Cancer Alliance

Place Plan 2023/24

Sefton

NHS

v1.0 15.09.23

Contents

Cheshire and Merseyside Cancer Alliance

Introduction

The challenges we face in achieving our vision of better cancer services, better cancer care and better cancer outcomes for the people we serve in Merseyside, Cheshire and the Isle of Man have grown over recent years – but are far from insurmountable.

The focus of Cheshire and Merseyside Cancer Alliance (CMCA) is on improving NHS cancer services in our sub-region – but we are also working to ensure that all people are able to access those services equitably and striving to educate and empower our population in a way that reduces the incidence of cancer in the first place.

Over the last year, we have been able to grow our team so we can enhance our work in achieving the vision of the NHS's Long Term Plan to save many thousands of lives each year by dramatically improving how we diagnose and treat cancer.

We now have the organisational structure to realise our passion and energy to enhance outcomes for people living with and beyond cancer in all parts of Cheshire and Merseyside.

With new colleagues have come new ideas, and we are excited by the broad range of projects our team is now devising, delivering and evaluating across a range of geographies and communities. This work has already been recognised in a number of our teams being shortlisted for prestigious healthcare awards.

But CMCA does not do this alone. We collaborate with many organisations inside and outside the NHS which have cancer as a focus. We continue to work with our Place-based colleagues across Cheshire and Merseyside to build up strong and supportive relationships.

It is clear that both a sub-regional, system-wide approach, and a grassroots and community-based focus are necessary to effectively align cancer services to be most effective for all our population – and give everyone touched by cancer the very best outcome that can be achieved.

We look forward to working with you over the next 12 months to deliver positive change in cancer care for Cheshire and Merseyside.

Dr Liz Bishop
Senior Responsible Officer

Jon Hayes
Managing Director

Dr Chris Warburton
Medical Director

Meet the board

Liz Bishop
Chair
Senior Responsible Officer

Jon Hayes
Managing Director

Chris Warburton
Deputy Chair
Medical Director

Debbie Harvey
Primary Care Lead

Mark Bakewell
Finance Lead
Liverpool Place Director, C&M ICS

Sarah Barr
Digital Lead
Chief Information Officer, CCC

Andrew Bibby
Assistant Regional Director, NHS Specialised Commissioning Team

Sinead Clarke
Associate Medical Director for System Quality and Improvement, C&M ICS

Ann Coffey
User Representative

Tra Cole
Diag s Programme Director, C&M

Rob Cooper
Operational Lead
Managing Director (Operations), MWL

Teresa Cope
Chief Executive, Manx Care

Andrew Crawshaw
Assurance Lead
NW Regional Director of Performance and Delivery, NHSE

Steve Fenwick
North Mersey Clinical Lead
Consultant Hepatobiliary Surgeon, LUHFT

Sarah Johnson-Griffiths
Prevention & Public Health Lead
Consultant in Public Health, Halton Borough Council

Terry Jones
Research and Innovation Lead
Director of Research and Innovation, LUHFT

Sheena Khanduri
Oncologist
Medical Director, CCC

Karen Mason
Nurse Lead
Cancer Nurse Transformation Manager, WHH

Ray Murphy
User Representative

Lesley Neary
Chief Operating Officer, MWL

Emer Scott
Communications Lead
Associate Director of Communications, CCC

Nikki Stevenson
Wirral Lead
Medical Director, WUTH

Andrew Wilson
Cheshire Lead
Clinical Director, Cheshire East, C&M ICS

Greg O'Mara
Associate Director

Tracey Wright
Associate Director

Sarah Grice
Associate Director

David McKinlay
Associate Director

Meet the team

Liz Bishop
Senior Responsible Officer

Jon Hayes
Managing Director

Chris Warburton
Medical Director

Debbie Harvey
Primary Care Lead

Greg O'Mara
Associate Director

Tracey Wright
Associate Director

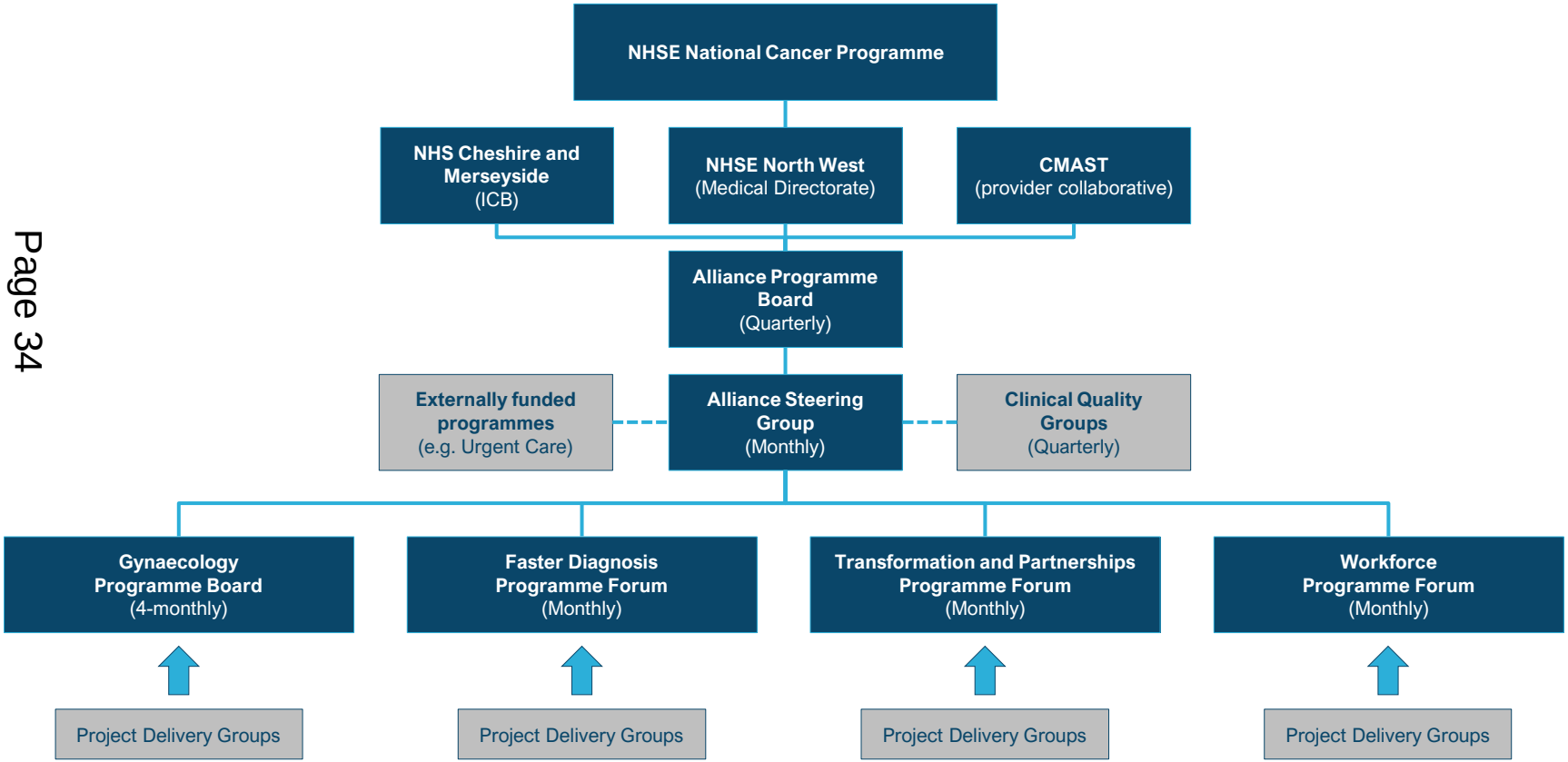
Gemma Hockenhull Sen ogramme Manager	**Anna Murray** Senior Programme Manager	**John Gale** Senior Programme Manager	**Sarah Houghton** Senior Programme Manager	**Liam Connolly** Senior Programme Manager	**Steve Jones** Senior Programme Manager
Fast agnosis Tele atology Live veillance	Faster Diagnosis FIT	NHS ACCEND Programme	Personalised Care Psychosocial Support Treatment Variation	Primary Care Targeted Lung Health Checks	Genomics Timely Presentation

Sarah Grice
Associate Director

David McKinlay
Associate Director

Lynn Young Senior Programme Manager	**Sam Cross** Head of Performance	**Katie Lawson** Senior PMO Lead	**Paul Ogden** Communications Manager	**Jo Trask** Patient Experience and Health Inequalities Manager	**Jen Burgess** Senior Project Manager
Workforce	Business Intelligence Cancer Performance	PMO Administrative Support	Communications	Health Inequalities Patient Experience	Gynaecology

Governance


NHSE National Cancer Programme
NHS Cheshire and Merseyside (ICB)
NHSE North West (Medical Directorate)
CMAST (provider collaborative)
Alliance Programme Board (Quarterly)
Externally funded programmes (e.g. Urgent Care)
Alliance Steering Group (Monthly)
Clinical Quality Groups (Quarterly)
Gynaecology Programme Board (4-monthly)
Faster Diagnosis Programme Forum (Monthly)
Transformation and Partnerships Programme Forum (Monthly)
Workforce Programme Forum (Monthly)
Project Delivery Groups
Project Delivery Groups
Project Delivery Groups
Project Delivery Groups

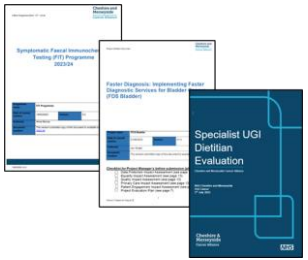
Corporate services

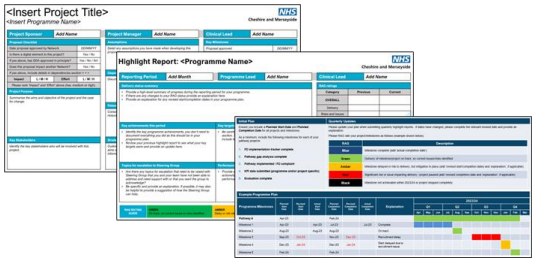
CMCA has an established corporate services division that provides a range of functions which support the day-to-day management of the organisation. It provides expertise and guidance for all CMCA transformation programmes, ensuring consistent and effective project delivery.

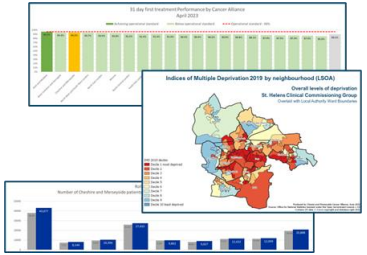
CMCA is also supporting the development and implementation of new PMO functions for the Cheshire and Merseyside Diagnostics and Community Diagnostic Centres programmes.

The corporate services division provides the following functions:

- Business intelligence and performance
- Programme management office (PMO)
- Communications, engagement and event planning
- Programme and project evaluation
- Administrative support
- Organisational development
- Health inequalities and patient engagement
- Workforce education and training
- Finance and budget management
- Governance and assurance reporting







Working in partnership

People and communities are at the heart of **everything we do**. At CMCA, we **build partnerships** with local and national organisations to deliver transformational change.

Cheshire and Merseyside Cancer Alliance

Innovation and sustainability

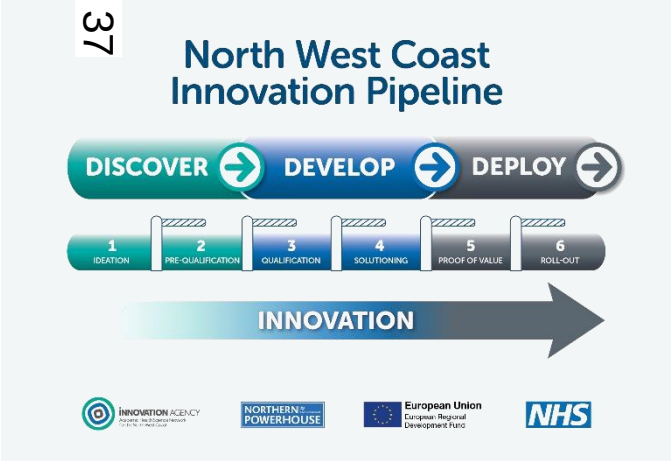
The NHS Innovation Agency and CMCA has formed a strategic partnership to deliver access to the latest innovations, and improve sustainability of cancer services.

The partnership will be supported by joint managerial and clinical posts, hosted by CMCA. The Innovation Agency will provide access to the national innovation pipeline and expertise in innovation evaluation and deployment.

The programme will focus on ensuring that services can be delivered sustainably, through innovation and will connect directly to the Cheshire and Merseyside digital community.

The team will have access to innovation funding to deploy and scale evaluated innovations and will coordinate system proposals for national funding opportunities to bring additional resource to Cheshire and Merseyside.

The programme team is in place and the programme will be fully established in Q3 2023/24.



Cheshire and Merseyside
Cancer Alliance

INNOVATION AGENCY
Academic Health Science Network
for the North West Coast

Programme aims

- **Connect CMCA systematically to the latest innovations for cancer**
- **Maintain and build Cheshire and Merseyside's reputation as the place to test and scale innovations**
- **Ensure Cheshire and Merseyside is best placed to respond to innovation funding opportunities**
- **Support whole pathway transformation in cancer care and service provision**
- **Ensure those innovations with the highest benefit are identified, tested and scaled**
- **Create the conditions for a consistent and coordinated focus on innovation**
- **Open more routes for frontline teams to identify, test and scale innovations**

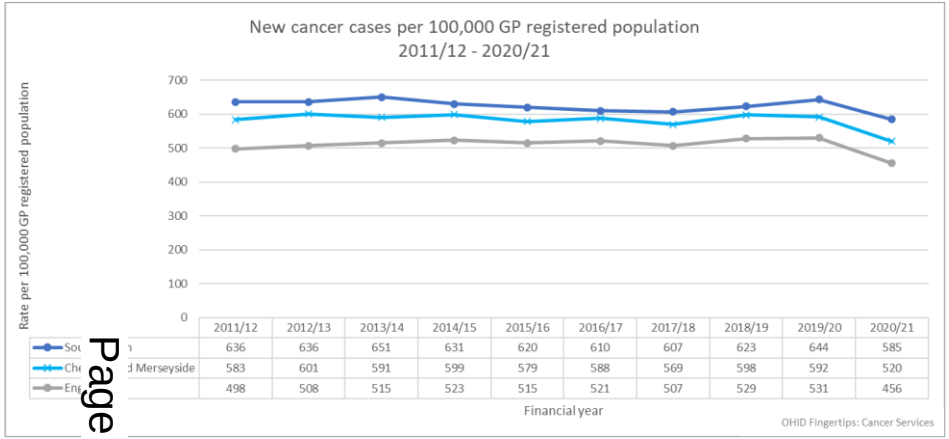
Cheshire and Merseyside Cancer Alliance

Agenda Item 5

Data overview

Sefton

Cancer incidence



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
So	636	636	651	631	620	610	607	623	644	585
Ch d Merseyside	583	601	591	599	579	588	569	598	592	520
En	498	508	515	523	515	521	507	529	531	456

The most recent cancer incidence data refers to 2020/21.

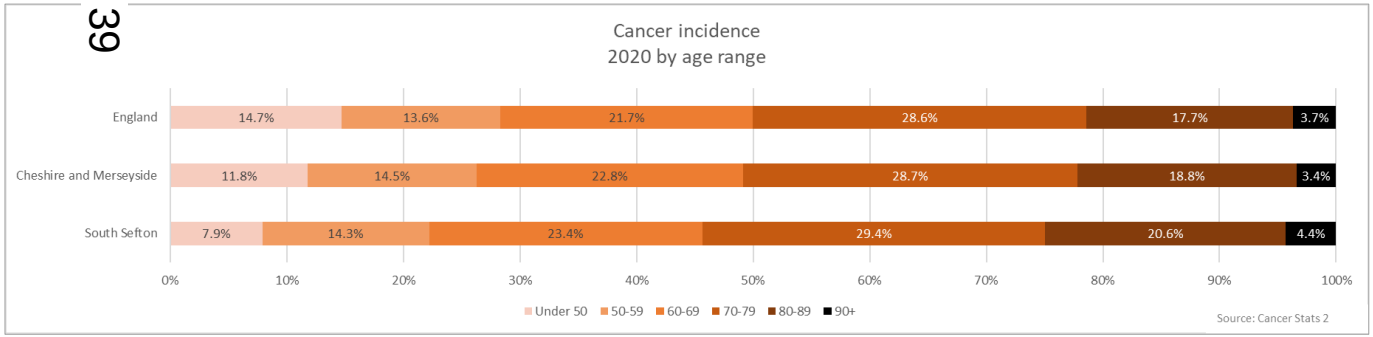
In South Sefton, cancer incidence (rate per 100,000) is **higher** than in Cheshire and Merseyside, and higher than in England as a whole.

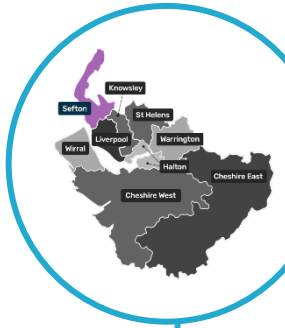
For every 100,000 people registered with a GP practice in South Sefton, 585 were diagnosed with a new cancer in 2020/21 compared to 520 in Cheshire and Merseyside and 456 in England as a whole.

In 2020, the proportion of new cancers in the under 50 age group (7.9%) was **significantly lower** than Cheshire and Merseyside (11.8%) and England (14.7%) averages.

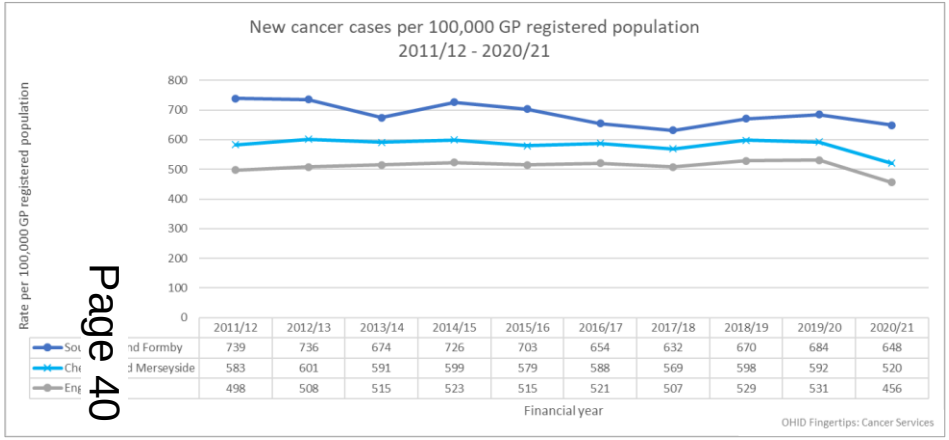
The proportion of new cancers in the 80-89 age group was **significantly higher** than England (20.6% vs 17.7%), but statistically similar to Cheshire and Merseyside.

The proportion of new cancers in the other age ranges were **statistically similar** to Cheshire and Merseyside and England.





Cancer incidence



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
So…nd Formby	739	736	674	726	703	654	632	670	684	648
Ch…d Merseyside	583	601	591	599	579	588	569	598	592	520
Eng…	498	508	515	523	515	521	507	529	531	456

The most recent cancer incidence data refers to 2020/21.

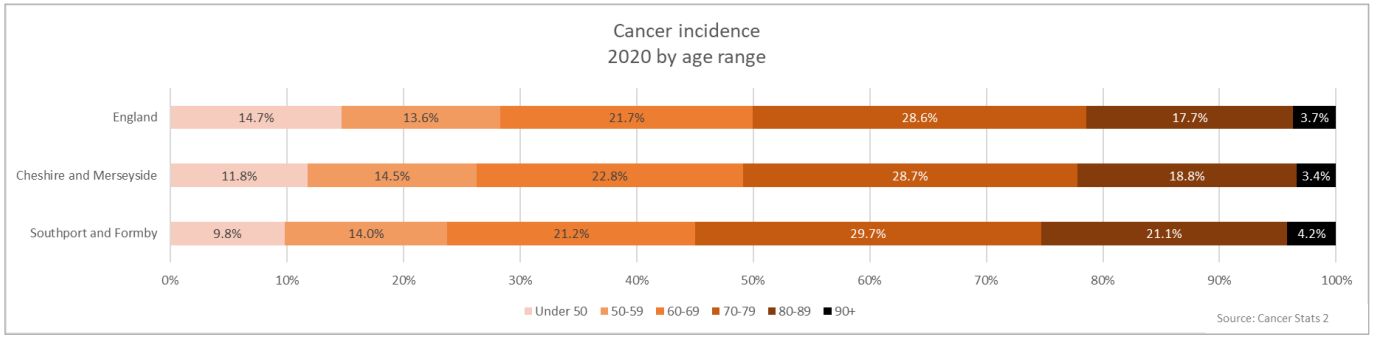
In Southport and Formby, cancer incidence (rate per 100,000) is **higher** than in Cheshire and Merseyside and higher than in England as a whole.

For every 100,000 people registered with a GP practice in Southport and Formby, 648 were diagnosed with a new cancer in 2020/21 compared to 520 in Cheshire and Merseyside and 456 in England as a whole.

In 2020, the proportion of new cancers in the under 50 age range was **significantly lower** than England (9.8% vs 14.7%), but statistically similar to Cheshire and Merseyside.

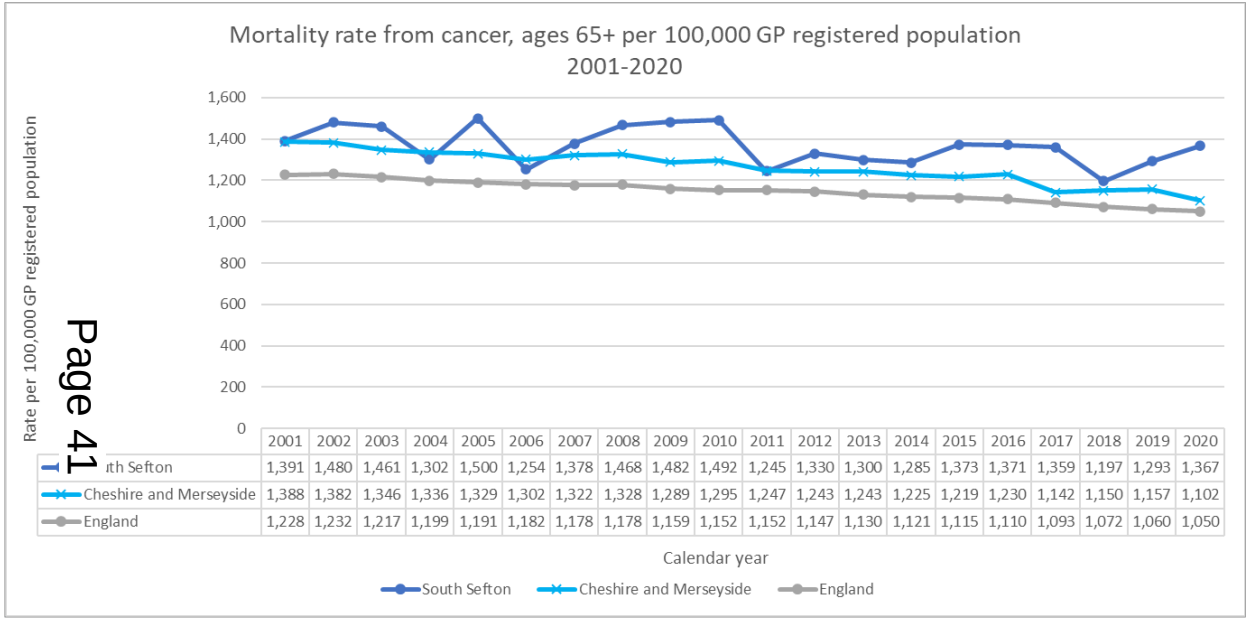
The proportion of new cancers in the 80-89 age range was **significantly higher** than England (21.1% vs 17.7%), but statistically similar to Cheshire and Merseyside.

The proportion of new cancers in the other age ranges were **statistically similar** to both Cheshire and Merseyside and England.



Sefton

Cancer mortality (65+)

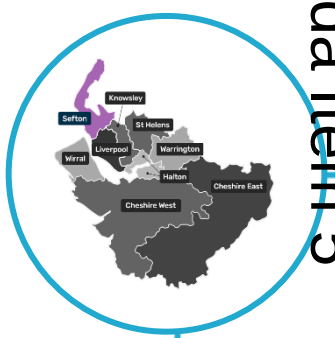


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
South Sefton	1,391	1,480	1,461	1,302	1,500	1,254	1,378	1,468	1,482	1,492	1,245	1,330	1,300	1,285	1,373	1,371	1,359	1,197	1,293	1,367
Cheshire and Merseyside	1,388	1,382	1,346	1,336	1,329	1,302	1,322	1,328	1,289	1,295	1,247	1,243	1,243	1,225	1,219	1,230	1,142	1,150	1,157	1,102
England	1,228	1,232	1,217	1,199	1,191	1,182	1,178	1,178	1,159	1,152	1,152	1,147	1,130	1,121	1,115	1,110	1,093	1,072	1,060	1,050

The most recent cancer mortality data refers to 2020*.

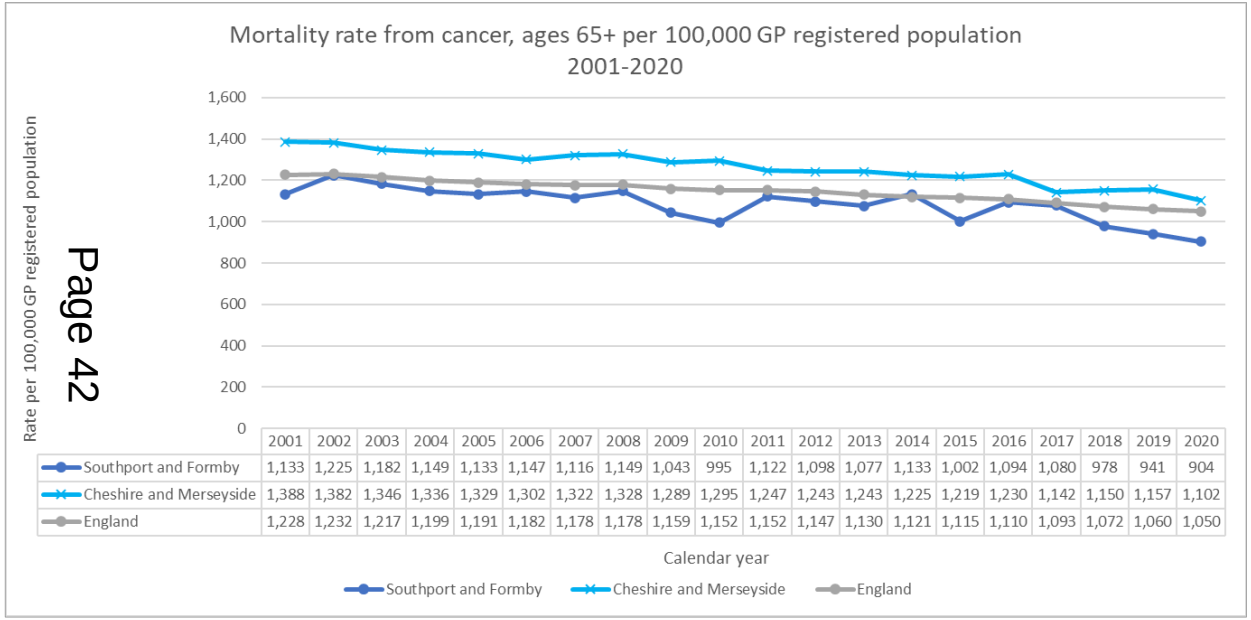
In South Sefton, cancer mortality in people aged 65 and over (rate per 100,000) is **higher** than in Cheshire and Merseyside, and **higher** than in England as a whole.

* Trend data including new 2021 data were not available on Fingertips as at July 2023.



Sefton

Cancer mortality (65+)



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southport and Formby	1,133	1,225	1,182	1,149	1,133	1,147	1,116	1,149	1,043	995	1,122	1,098	1,077	1,133	1,002	1,094	1,080	978	941	904
Cheshire and Merseyside	1,388	1,382	1,346	1,336	1,329	1,302	1,322	1,328	1,289	1,295	1,247	1,243	1,243	1,225	1,219	1,230	1,142	1,150	1,157	1,102
England	1,228	1,232	1,217	1,199	1,191	1,182	1,178	1,178	1,159	1,152	1,152	1,147	1,130	1,121	1,115	1,110	1,093	1,072	1,060	1,050

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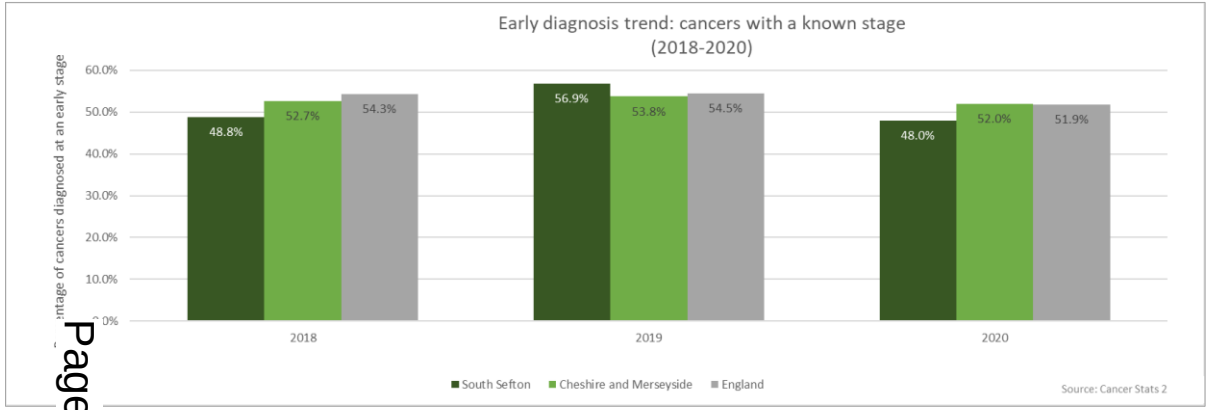
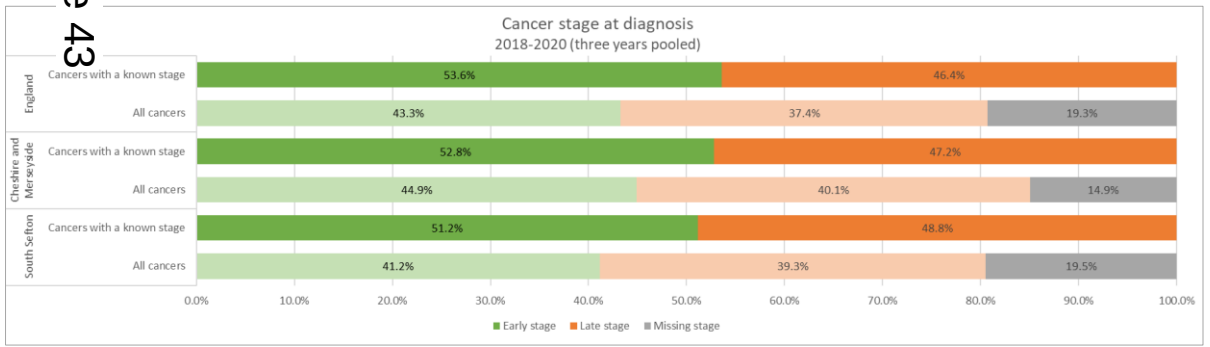
In Southport and Formby, cancer mortality in people aged 65 and over (rate per 100,000) is **lower** than in Cheshire and Merseyside, and **lower** than in England as a whole.

* Trend data including new 2021 data were not available on Fingertips as at July 2023.

Sefton

Early diagnosis



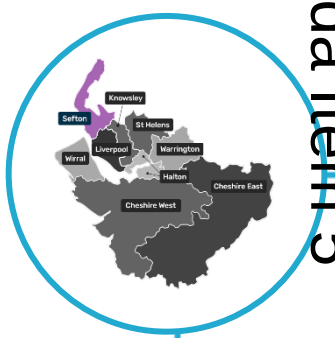


Early diagnosis in South Sefton **decreased** between 2018 and 2020 (from 48.8% to 48.0%).

In Cheshire and Merseyside, early diagnosis rates **decreased slightly** between 2018 and 2020, from 52.7% in 2018 to 52.0% in 2020. This is in line with England as a whole.

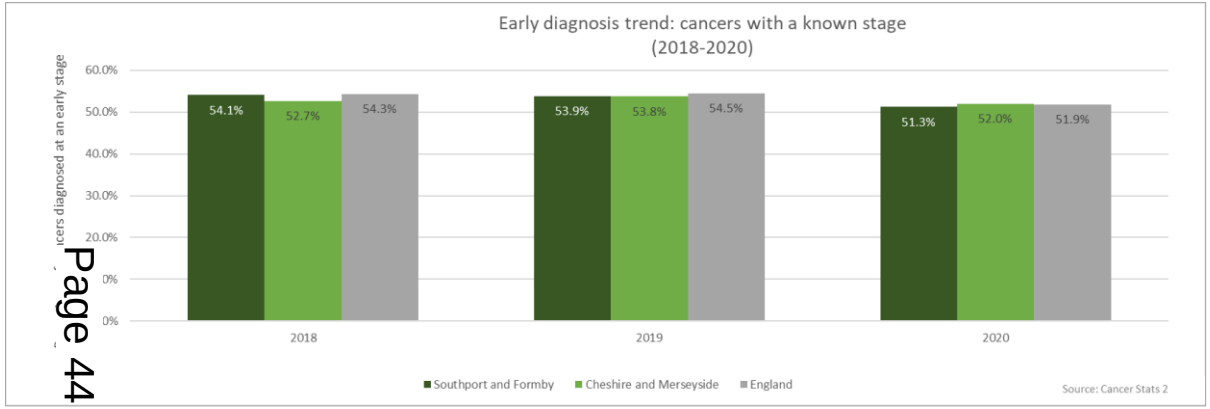
In South Sefton, 51.2% of cancer diagnoses with a known stage between 2018 and 2020 (three years pooled) were diagnosed at an early stage. This is **lower** than the proportion of early diagnoses in Cheshire and Merseyside as a whole (52.8%), and **lower** than the proportion of early diagnoses in England (53.6%).

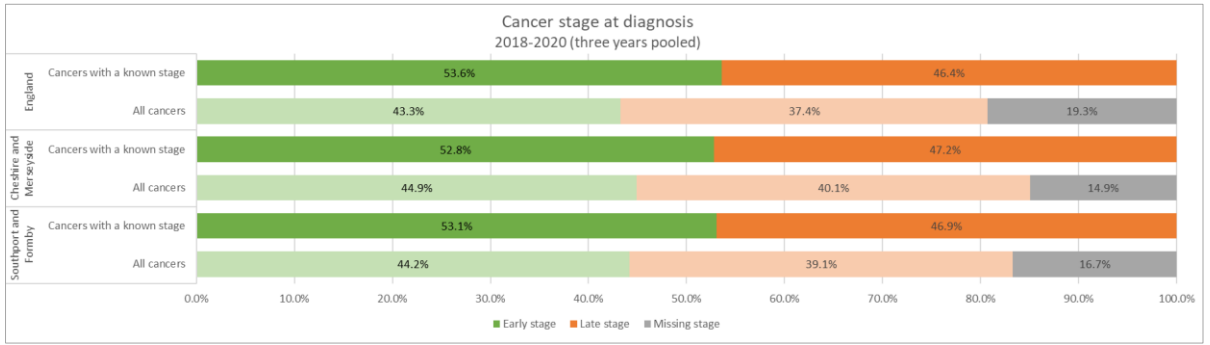
80.5% of all cancer diagnoses in South Sefton (2018-2020) had a known stage, compared to 85.1% in Cheshire and Merseyside and 80.7% in England as a whole.



Sefton

Early diagnosis





Early diagnosis in Southport and Formby **decreased** between 2018 and 2020 (from 54.1% to 51.3%).

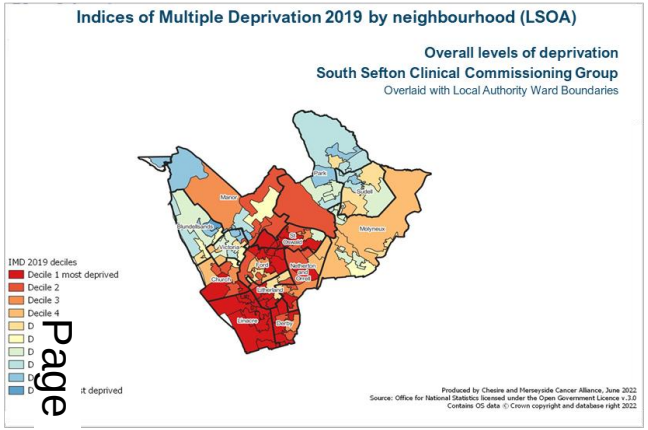
In Cheshire and Merseyside, early diagnosis rates **decreased slightly** between 2018 and 2020, from 52.7% in 2018 to 52% in 2020. This is in line with England as a whole.

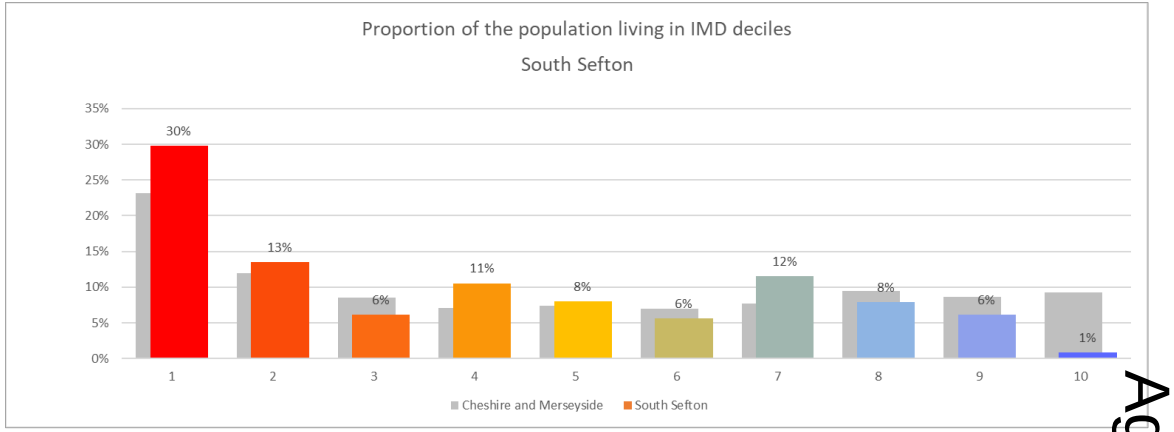
In Southport and Formby, 53.1% of cancer diagnoses with a known stage between 2018 and 2020 (three years pooled) were diagnosed at an early stage. This is **higher** than the proportion of early diagnoses in Cheshire and Merseyside as a whole (52.8%), and **lower** than the proportion of early diagnoses in England (53.6%).

83.3% of all cancer diagnoses in Southport and Formby (2018-2020) had a known stage, compared to 85.1% in Cheshire and Merseyside and 80.7% in England as a whole.

Sefton

Deprivation





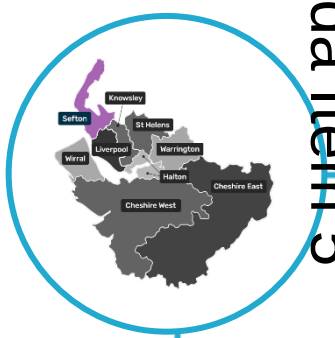
T g health inequalities is a key priority of the Cancer Alliance. Part of the project initiation process includes consideration of the impact projects could have on health inequalities.

The Indices of Multiple Deprivation (IMD) rank neighbourhood areas called Lower Super Output Areas (LSOAs) in England based on seven domains of deprivation: Income, Employment, Education, Health, Crime, Barriers to Housing and Living Environment.

LSOAs are then grouped into Deciles, with Decile 1 being the top 10% most deprived areas in England and Decile 10 being the 10% least deprived areas in England.

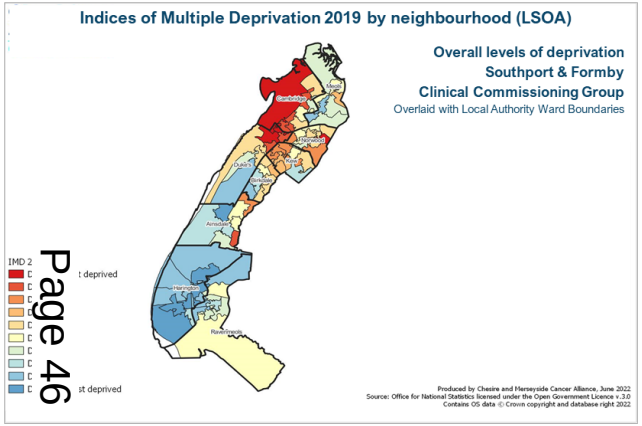
Approximately 1,600 people live in each LSOA.

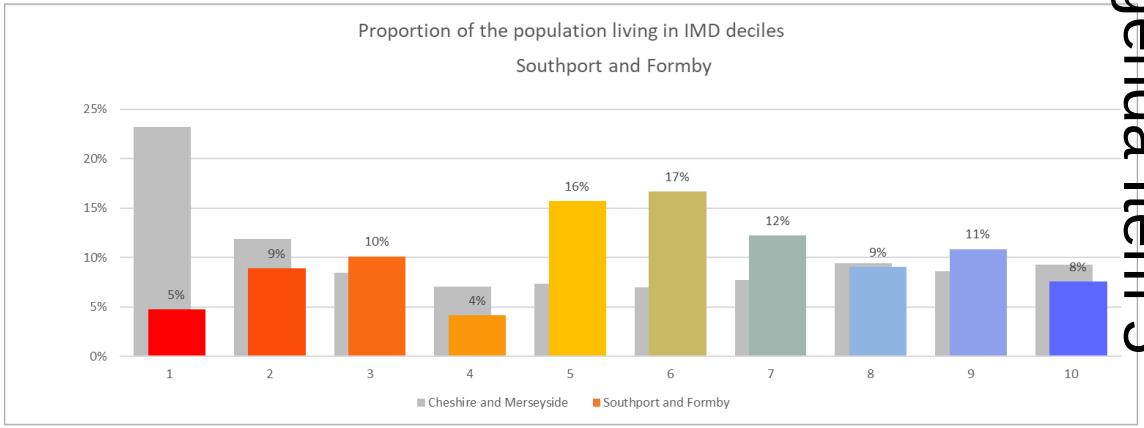
Of the 159,434 people living in South Sefton, 30% live in areas classed as the top 10% most deprived nationally. 43% live in areas classed as the top 20% most deprived nationally.



Sefton

Deprivation





Tackling health inequalities is a key priority of the Cancer Alliance. Part of the project initiation process includes consideration of the impact projects could have on health inequalities.

The Indices of Multiple Deprivation (IMD) rank neighbourhood areas called Lower Super Output Areas (LSOAs) in England based on seven domains of deprivation: Income, Employment, Education, Health, Crime, Barriers to Housing and Living Environment.

LSOAs are then grouped into Deciles, with Decile 1 being the top 10% most deprived areas in England and Decile 10 being the 10% least deprived areas in England.

Approximately 1,600 people live in each LSOA.

Of the 114,416 people living in Southport and Formby, 5% live in areas classed as the top 10% most deprived nationally. 14% live in areas classed as the top 20% most deprived nationally.

Cheshire and Merseyside Cancer Alliance

Programme overview

Sefton

NHS

Faecal Immunochemical Test (FIT)

Programme SRO:	Greg O'Mara, Associate Director gregomara@nhs.net	Programme Lead(s):	Anna Murray, Senior Programme Manager anna.murray@nhs.net

Programme Aims

- Ensure the provision of sufficient commissioned capacity so that every urgent suspected Lower GI (LGI) cancer referral is accompanied by a faecal immunochemical test (FIT) result where clinically appropriate and in line with national guidance and evidence.
- Ensure provision of an agreed, consistent model for provision of symptomatic FIT to patients across Cheshire and Merseyside, which reflects current national guidance and evidence.
- Work with local pathology networks to ensure sufficient lab capacity is available to turn around FIT results efficiently for results to inform the LGI Faster Diagnosis (FDS) Pathway.
- Engage with Primary Care via appropriate forums and organisations to increase clinically appropriate FIT usage through GP focused communications campaigns, reducing inequalities and resolving local challenges in effective use of FIT, for example.
- Ens ppropriate secondary care processes and pathways are in place and FIT results are used to inform triage decisions for patients.
- Imp FIT data collection, monitoring and evaluation through establishment of an effective automated data stream and Key Performance Indicators (KPIs) to support continued commissioning and service provision.
- Ens here is an understanding of health and service inequalities/inequities to reduce unwarranted variation and increase uptake of FIT across the C&M population.

Progra e Objectives	Description
Established pathway in place in primary care to limit referrals in those with FIT <10ug and no other concerning symptoms, in line with BSG/ACPGBI guidance	During 2022/23, we worked with stakeholders to agree the new Cheshire and Merseyside Urgent Suspected LGI Cancer Pathway Guidance to ensure that it aligns with joint guidance for FIT testing published by the British Society of Gastroenterology (BSG) and the Association of Coloproctology of Great Britain & Ireland (ACPGBI). This pathway has now been implemented across Cheshire and Merseyside with a main priority for 2023/24 being continued engagement with Primary Care to ensure full compliance. Publication of the updated NICE Guidance in August of this year further supports the Cheshire and Merseyside pathway with a review to take place any differences in September.
Established protocol in secondary care for patients referred on the Lower GI FDS pathway with FIT <10ug, FBC and normal examination, either to be discharged back to their GP or rerouted onto an alternative pathway	During 2022/23, the Secondary Care Negative FIT Pathway and LGI Prioritisation Guidance was developed and agreed in collaboration with 100+ stakeholders across endoscopy, imaging, pathology, colonoscopy services, cancer services. This will ensure that patients are triaged for investigation based on their clinical risk of colorectal cancer. During 2023/24, we will continue to support implementation activities across all trusts, including monitoring and further improvements to support increased compliance with new FIT Pathway Guidance. A full evaluation plan has been produced and will be implemented to fully analyse our position during 2023/24.
Ensure 80% of LGI urgent referrals accompanied by a FIT result and <20% of colonoscopies performed on the LGI FDS pathway do not have an accompanying FIT result. Minimise the number of colonoscopies performed on patients with FIT<10ug.	During 2022/23, data showed that the estimated total number of FIT requests during that year was 68,900. There was an 84% uptake from patients and for those referred on an Urgent Suspected Cancer Referral, 72% had a FIT result. Activities during 2023/24 will include ensuring FIT KPIs are automated and submitted by all acute trusts to explore variations at Trust, Place, PCN and GP Practice level. A main priority for 2023/24 is to engage with Place and PCNs to ensure that urgent suspected cancer referrals and FIT tests are being coded accurately by Primary Care to support accurate data and, importantly, compliance with and remuneration of incentives as part of the Primary Care DES.
Work with the ICB to develop a viable long-term commissioning model for FIT	CMCA is working with the Cheshire and Merseyside ICB to confirm sustainable commissioning arrangements for FIT for 2023/24 onwards. Funding has been agreed for 2023/24 and discussion concerning 2024/25 has commenced.

FIT Next Steps

It has been an important year for symptomatic FIT. Place FIT Leads, Associate Directors, GP Leads and Clinical Directors have been very supportive and active during this implementation phase. Although now live, FIT is now in a monitoring phase where it has become clear that further work is needed to fully embed the new guidance and ensure full compliance.

2023/24 key deliverables at Place-level

Place to further support full compliance of new guidance by continuing to **take the lead for communication and engagement with Primary Care**. Trusts will be in a position to share challenges and communicate where guidance has not been foll . This would be supported by GP Place and CMCA FIT Leads funded for Pla s has been the case for the last two years. This includes ensuring that FIT is use propriately and in line with guidance.

Pla continue to **share key information and support materials** to Primary Care coll es, which are available on the CMCA and Cancer Academy sites.

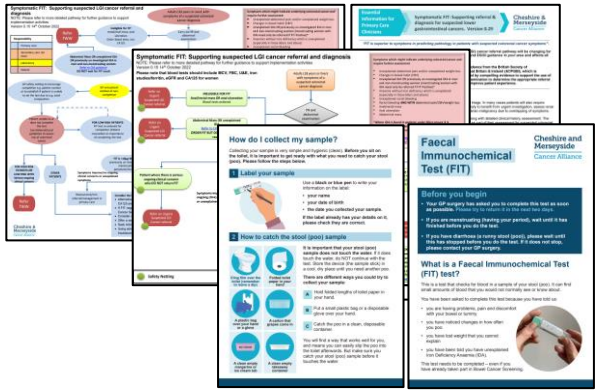
Place to engage with Primary Care Colleagues via PCNs or directly with GP Practice to **ensure that all urgent suspected cancer referrals and FIT tests are coded within practice systems**. This will ensure that PCNs receive optimum payments as part of the Primary Care DES and will also enable effective monitoring and evaluation, helping to identify where further communication and engagement is needed.

Key changes to the urgent suspected LGI cancer referral pathway

- **Adults (18 years or over) with symptoms of a suspected LGI cancer diagnosis.** This has REPLACED the NG12 and DG30 guidance in your area.
- **Inclusions and exclusions for FIT testing:**
  - ALL patients with sign/symptoms of LGI cancer require a FIT and a result BEFORE referral. EXCEPT:
    - Patients with unexplained IDA and/or abdominal mass – order FIT and refer on Urgent Suspected Cancer Referral (TWW).
    - Patients with anal/rectal mass and/or anal ulceration excluded from FIT – refer immediately on Urgent Suspected Cancer Referral (TWW).

Further Notes

- Patients where there is serious ongoing clinical concern and FIT not returned – refer on Urgent Suspected Cancer Referral (TWW).
- Individual clinical judgement can still be used.
- It is understood that there will be a transitional period, there will not be a 'turn off and turn on' approach.



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Faster Diagnosis (FD)

Programme SRO:	Greg O'Mara, Associate Director gregomara@nhs.net	Programme Lead(s):	Anna Murray, Senior Programme Manager, anna.murray@nhs.net Gemma Hockenhull, Senior Programme Manager, gemma.hockenhull@nhs.net

Programme Aims

- Support earlier and faster diagnosis through the development of efficient diagnostic pathways
- Support the improvement of Cancer Waiting Times performance with a focus on achieving the Faster Diagnosis Standard (FDS)
- Provide an improved personalised diagnostic experience, whilst reducing unwarranted variation and addressing health inequalities, ensuring patient voice informs development
- Deliver standardisation across services where clinically appropriate and share best practice, with a focus on evaluation and sustainability of all faster diagnosis developments
- Support innovative solutions to earlier diagnosis, risk stratification and patient care, enabling teams to innovate to achieve better patient experience and outcomes
- Improve opportunities for cancer workforce development and deliver new ways of working
- Ens rimary Care Network and GP involvement is a core part of faster diagnosis design and delivery, reducing barriers between primary and secondary care
- Wo h the Community Diagnostic Centre (CDC) Programme to ensure we take every opportunity to improve and optimise access to diagnostic capacity for cancer pathways and ensure the CDC programme aligns with the r diagnosis principles

Progra e Objectives	Description
Deliver 100% population coverage for Non-Specific Symptom (NSS) Pathways by March 2024	NSS pathways are currently in place for six trusts across Cheshire and Merseyside, with an overall population coverage of 74%. During 2023/24 we will work to achieve 100% population coverage and continue work with existing NSS services to expand referrals from re-direct and tumour-specific pathways. We will work with the National Team, ICB and providers to develop a sustainable approach for current live services and a viable long-term commissioning model. We will work with primary care colleagues to increase GP uptake and education of NSS pathways to increase referrals from GP practices.
Deliver Best Practice Timed Pathway (BPTP) milestones in suspected prostate, lower GI, skin and breast cancer pathways	During 2023/24 we will deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways, with a focus on those performing below the England FDS average and/or with significant 62d+ backlogs in priority pathways. Where local priorities do not align with the four priority pathways, we will draw on BPTP documents for other areas (e.g. gynaecology) to agree plans. Health inequalities will remain a key focus for the programme and all projects will have an overarching aim of standardisation across trusts striving for equity of access, performance expectations and clinical outcomes. We will continue work with diagnostic network colleagues to support opportunities to increase capacity.
Work with systems and providers to achieve the Faster Diagnosis Standard (FDS)	During 2023/24 we will ensure CMCA meets the Faster Diagnosis Standard target of 75% by March 2024 and ensure all Alliance plans for FD funding distribution and project work are based on an assessment of performance challenges across the FDS. We will work with partners to identify opportunities where funding can be used to expand diagnosis and treatment capacity to meet increasing levels of demand.
Provide intensive support to tier 1 & 2 providers to support improvement of performance against priority cancer pathways	CMCA will continue to assist the National Cancer Programme in providing intensive support to Tier 1 and 2 providers with the greatest performance issues for the four priority pathways. We will ensure sufficient funding is provided to the most challenged pathways to facilitate pathway improvements and agree provider plans and allocations of place-based funding targeting the four priority pathways, bringing together system partners to ensure commissioning of sufficient diagnostic capacity.
Support the implementation of teledermatology	From May 2023, the regional teledermatology programme will be delivered by CMCA on behalf of the Elective Care Transformation & Recovery Programme. During 2023/24 we will continue the roll-out of teledermatology to remaining GP practices and trusts (supporting training, deployment of equipment, troubleshooting, and tracking and monitoring of benefits) up to full capacity.

FD Framework and Objectives

Faster Diagnosis Framework Objectives

NSS Pathway rollout to 100% population coverage

Best Practice Timed Pathways Implementation

- **By March 2024, BPTPs will be published for all suspected cancer pathways, including for Non-Specific Symptoms**
- **Teledermatology and Community Spot Clinics should be made available**

Priority Pathway Improvements

- **Single point of contact and appointment reminders**
- **Cancer Decision Support Tools**
- **Electronic Referrals**
- **Straight to test and clinically-led triage**
- **Coordinated Testing**
- **Optimal and appropriate onward referral**
- **More effective feedback loops**

Locally Defined Pathway Innovations

elf-referral, virtual triage hubs, combined pathway approaches, supporting accessibility and reducing health inequalities

Work with ICS and Providers to ensure that sufficient diagnostic capacity is available

Faster Diagnosis Key Principles

Early identification of patient where cancer is possible, including outreach to target existing health inequalities	**Timely referral** based on standardised referral criteria and appropriate filter function tests	**Broad assessment of symptoms** resulting in effective triage, determining whether and which tests should be carried out and in what order, based on individual patient need
Coordinated testing which happens in fewer visits and steps for the patient, with a significantly shorter time between referral and reaching a diagnosis	**Timely diagnosis of patients' symptoms**, cancer or otherwise, by a multi-disciplinary team where relevant, and communicated appropriately to the patient	**Appropriate onward referral** to the right service for further support, investigation, treatment and/or care

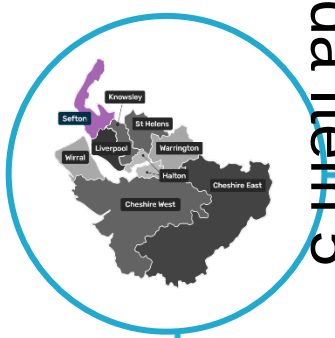
Excellent patient coordination and support with patients having a single point of contact throughout their diagnostic journey, alongside access to the right information, support and advice.

The team will be aware of clinical trials and research opportunities available with their specialty and will support all eligible patients to access this.

23/24	Overall CMCA FDS performance			
	Q1	Q2	Q3	Q4
Target	67.5%	70.0%	72.5%	75.0%
Actual	69.9%			

CMCA will continue to work with **Mersey and West Lancashire Teaching Hospitals NHS Trust** and **Liverpool University Hospitals NHS Foundation Trust** to implement optimal pathways, published Best Practice Timed Pathways (BPTP) and priority pathway improvements whilst adhering to the FD key principles outlined above.

Achieving 75% FDS performance is a key requirement of Planning Guidance for 2023/24, with each individual trust required to achieve the standard.



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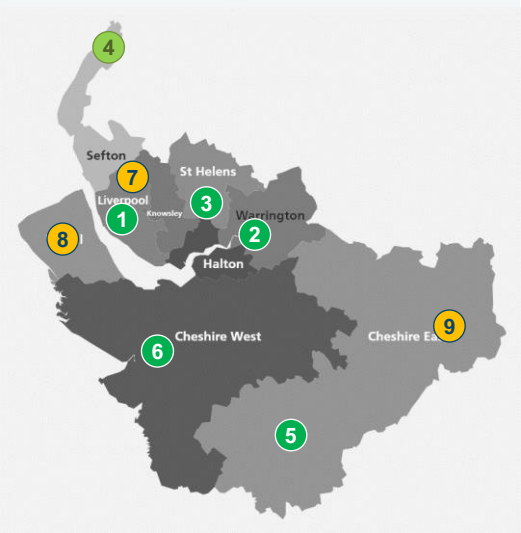
Non-Specific Symptoms (NSS) Pathways

CMCA will work with **LUHFT (Aintree site)** to implement a new NSS service in Q3 2023/24. We will support the existing NSS services at **MWL (StHK and S&O sites)** and **LUHFT (Royal site)** to support increases in referrals from Primary Care and other Secondary Care specialties.

The national programme to roll out NSS services to 100% popu coverage, and associated transformation funding, is due t concluded by March 2024. **Alliance funding for NSS servi will cease at the end of March 2024** (for live sites).

The /24 NHS Priorities and Operational Planning Guidance highlight that ICBs are expected to commission NSS services to ensure their continuation as business as usual urgent suspected cancer pathways that support FDS.



1	Liverpool University Hospitals NHS Foundation Trust (Royal site)	SITE LIVE
2	Warrington and Halton Hospitals NHS Foundation Trust	SITE LIVE
3	Mersey and West Lancashire Teaching Hospitals NHS Trust (St Helens site)	SITE LIVE
4	Mersey and West Lancashire Teaching Hospitals NHS Trust (Southport site)	SITE LIVE
5	Mid Cheshire Hospitals NHS Foundation Trust	SITE LIVE
6	Countess of Chester Hospital NHS Foundation Trust	SITE LIVE
7	Liverpool University Hospitals NHS Foundation Trust (Aintree site)	Implementation to commence Q3
8	Wirral University Teaching Hospital NHS Foundation Trust	Implementation to commence Q3
9	East Cheshire NHS Trust	Implementation to commence Q3

23/24	Total NSS referrals			
	Q1	Q2	Q3	Q4
Target	383	430	470	481
Actual	429			

During Q3 2023/24, CMCA will develop an options appraisal which will provide a comparison, assessment, and evaluation of a range of long term options for NSS services. We will work with Sefton Place and ICB colleagues to agree a sustainable approach for the full and recurrent commissioning of this service.

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Teledermatology

From May 2023, the regional teledermatology programme will be delivered by CMCA on behalf of the Elective Care Transformation & Recovery Programme. Teledermatology has been nationally recognised as an important tool in promoting timely care in the most appropriate setting. The NHS planning guidance requires ICSs to utilise teledermatology services to reduce pressure on dermatology services and increase capacity for those patients who need face to face appointments. face appointments. Quarterly reporting to the NHSE Cancer Programme of the percentage of suspected skin cancer cases managed through teledermatology pathways is mandated.

During 2023/24 we will continue the roll-out of teledermatology to remaining GP practices and trusts (supporting training, deployment of equipment, troubleshooting, and tracking and monitoring of benefits) up to full capacity.

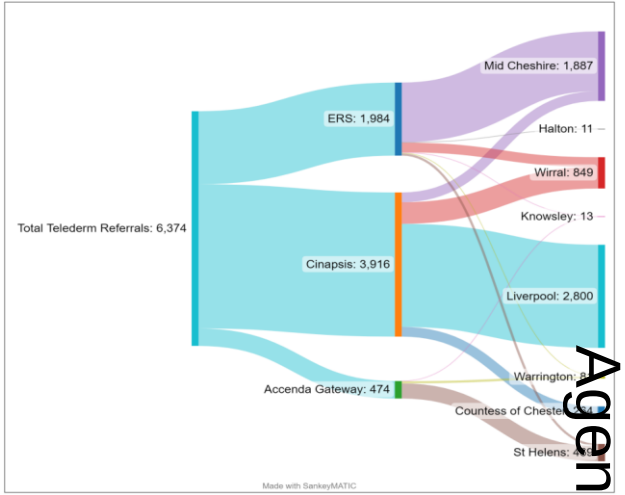
CMC ill support the Elective Care Transformation & Recovery Programme in the development of an options appr paper to explore the model of teledermatology moving forward. We will also undertake a separate inde lent evaluation to explore the current teledermatology IT platforms to inform the procurement of a system-wide form in 2024/25.

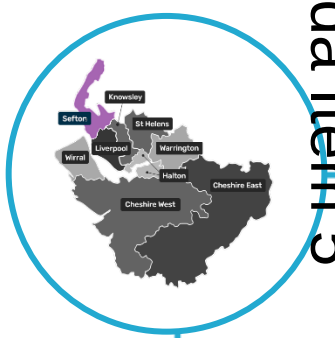
Working in partnership with:

Cheshire and Merseyside Health and Care Partnership

Data sources: Cinapsis distinct case referrals, Accenda Gateway referrals with an image and ERS referrals with images. ERS data was supplied by STHK (June 23) and MCH (August 21 - start of July 23) has been included in the figures. Warrington assumption 10 referrals for 2 months from BI team. Wirral waiting on confirmation on pathway assumption of platform split made based on Cinapsis figures.

Teledermatology outcomes by Place and platform





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Agenda Item 5

Genomics

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Steve Jones, Senior Programme Manager stephen.jones42@nhs.net

Programme Aims

The role of NHS England and NHS Improvement is to enable the NHS to harness the power of genomic technology and science to improve the health of our population and deliver on the commitments in the NHS Long Term Plan. The intention is that the NHS will be the first national health care system to offer whole genome sequencing as part of routine care and deliver a single national testing directory covering use of all technologies from single genes to whole genome sequencing. As part of our remit, CMCA is working with the Genomic Laboratory Hub (GLH) and Genomics Medicines Service Alliance (GMSA) within the Northwest footprint and is continuing to develop our roles and how we align with their priorities and workstreams.

- Improve and modernise genomics pathways across Cheshire and Merseyside through engagement, education, and support of clinical teams, MDT's, pathology and the wider genomic system.
- Ful[illegible]age with the Genomic Medicines Service Alliance in developing a shared workplan for cancer.
- Pilo[illegible] approaches using genomic testing to diagnose cancers earlier.

Progra[illegible]e Objectives	Description
Implement the Galleri test across Cheshire and Merseyside to establish if the test can accurately and reliably detect cancer early in people not suspected as having a cancer.	The NHS-Galleri trial is looking into the use of a new blood test to see if it can help the NHS to detect cancer early when used alongside existing cancer screening. Early research has shown that the Galleri® test could help to detect cancers that are typically difficult to identify early. The trial has over 22,000 participants from Cheshire and Merseyside and will for the third year be reinviting these participants for their final appointment. Trial results are expected to be available from 2026.
Testing for Lynch Syndrome in Colorectal and Endometrial cancers.	During 2023/24 we will ensure through audit that we have 100% compliance in testing for Lynch Syndrome in all trusts across Cheshire and Merseyside for colorectal and endometrial cancers. This will support earlier diagnosis of these cancers. CMCA will also ensure that there is a lynch lead nurse, lynch champions and appropriate education accessible across all trusts and laboratories.
Improving the Molecular Pathway and Turnaround Times	During 2023/24 we will be working with the Northwest GMSA to improve the pathways and turnaround times for colorectal, gynaecology, breast and teenage and young adult pathways across Cheshire and Merseyside. We will map, audit and assess variances in turnaround times. We aim to identify and act upon areas to improve overall turnaround times within the molecular pathway. We will be working with your local trusts and pathology providers to complete this work.

NHS Galleri Trial

The NHS-Galleri clinical trial – involving 140,000 participants nationally and 22,000 from Cheshire and Merseyside – has been running since 2021, with blood samples taken over three years to research the test.

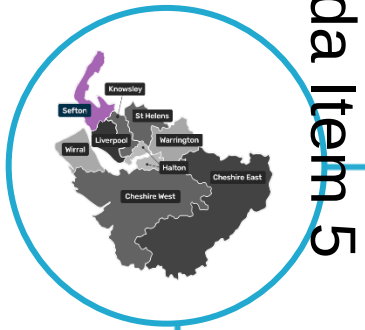
The Galleri™ test has been developed that can detect many types of cancer from a single blood sample. Thousands of volunteers taking part in the trial have started receiving invitations to book their last of three appointments for the trial.

Research has shown that the Galleri test could help to detect cancers that [t]ypically difficult to identify early – such as head and neck, bow[e]l, pancreatic, and throat cancers. The test works by finding chem[ical] changes in fragments of DNA that leak from tumours into the bloo[d]stream.

If the clinical research trials are successful, the NHS in England plans to roll out the test to a further one million people during 2024 and 2025.

The NHS-Galleri trial is being run by Cancer Research UK and King's College London Cancer Prevention Trials Unit in partnership with the NHS and healthcare company, GRAIL, which has developed the Galleri test.

Indicative trial schedule (third appointment)		
Location	**Invitation Letters**	**Appointments**
Runcorn	20 Jul 23 – 17 Aug 23	16 Sep 23 – 02 Oct 23
Warrington	23 Aug 23 – 18 Sep 23	04 Oct 23 – 27 Oct 23
St Helens	22 Sep 23 – 16 Oct 23	31 Oct 23 – 27 Nov 23
Widnes	18 Oct 23 – 10 Nov 23	27 Nov 23 – 18 Dec 23
Liverpool	23 Nov 23 – 18 Dec 23	09 Jan 24 – 05 Feb 24
Knowsley	30 Dec 23 – 15 Jan 24	12 Feb 24 – 22 Feb 24
Southport	17 Jan 24 – 06 Feb 24	26 Feb 24 – 18 Mar 24
Chester	08 Feb 24 – 27 Feb 24	21 Mar 24 – 12 Apr 24
Wirral	01 Mar 24 – 26 Mar 24	17 Apr 24 – 07 May 24
Crewe	30 Mar 24 – 15 Apr 24	10 May 24 – 28 May 24
Macclesfield	18 Apr 24 – 06 May 24	31 May 24 – 14 Jun 24
Knowsley	09 May 24 – 21 May 24	17 Jun 24 – 28 Jun 24



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Gynaecology

Programme SRO:	David McKinlay, Associate Director d.mckinlay@nhs.net	Programme Lead(s):	Jen Burgess, Senior Project Manager jen.burgess@nhs.net

Programme Aims

The programme is expected to be multi- year focussing on all aspects of care for gynaecological cancer. The programme will deliver improvements across prevention, the point of cancer suspicion and referral, diagnostic treatment processes, follow up and late effects. All trusts delivering gynaecological cancer diagnosis and treatment are involved. Overall, the programme aims to deliver the recommendations of the 2022 Gynaecology Services Review and deliver the following vision and mission:

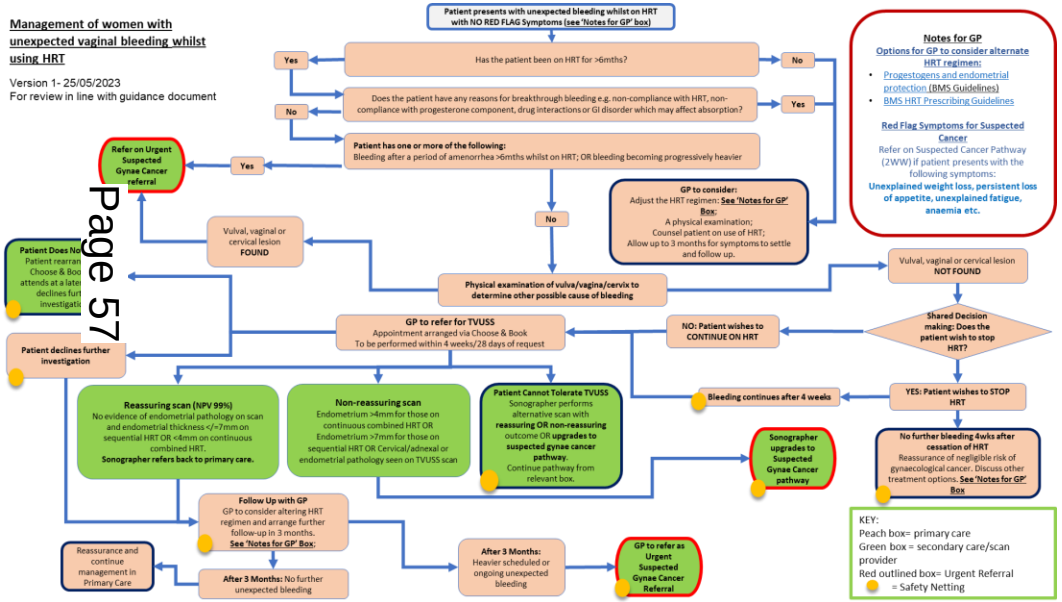
Vision
For all gynaecological cancer services in C&M to work as a partnership and collectively be recognised for excellence in patient care, teaching, education, and research.

Mission
To prov atient centred, personalised, timely responsive, high quality, evidence-based care for patients with proven or suspected gynaecological cancer.

Progra e Objectives 2023/24	Description
Improve diagnostic pathways	CMCA will work with all trusts in 2023/24 and 24/25 to review current diagnostic processes and implement new models where required. This will include ensuring best practice timed pathways are implemented at all sites, implementing a one stop approach to diagnostics and supporting achievement of the 28 day faster diagnosis standard.
MDT Optimisation	CMCA will work with the specialist and local MDTs to optimise delivery. This will include development and implementation of a shared MDT policy across Cheshire and Merseyside, reviewing MDT processes and developing standards of care.
Develop and implement and unexpected bleeding pathway	CMCA will work with Liverpool Women's Hospital to develop and pilot a pathway for women on HRT who experience unexpected bleeding. This pathway will support GPs to manage expected and unexpected bleeding and access urgent ultrasound if required. The pathway aims to reduce unnecessary referrals on cancer diagnostic pathways, improve patient experience and improve GP confidence to manage unexpected bleeding. The pathway will be piloted in Liverpool and, if successful, expanded across Cheshire and Merseyside. Background and draft pathway are provided on the next slides.
Establish additional gynaecological cancer units	CMCA will work with Warrington and Halton and Mersey and West Lancashire Teaching Hospitals to establish cancer units at these sites. These units will enable additional local diagnostics and treatments to be delivered locally and avoid onward referral to other sites.
Implement personalised follow up	Building on existing pathways, the programme will enable more patients to access additional options for follow up. This will include the use of remote monitoring, digital, face to face and blended follow up methods. The programme will also support patients to access support services as close to home as possible, particularly where they have received treatment in a specialist centre.
Workforce	The programme will review existing workforce and identify where additional capacity is required. Initially, the programme will focus on developing additional sonography capacity. The programme will also focus on developing clear delineation of responsibilities between support workers and clinical nurse specialists and support improved communication, particularly where a patients journey crosses multiple trusts for diagnosis and treatment.

Unexpected Bleeding on HRT Pathway

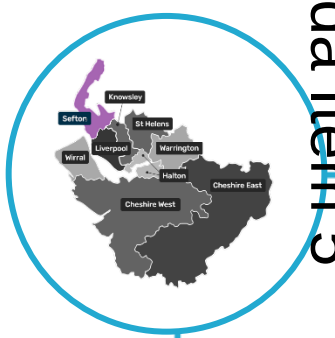
CMCA is working with Liverpool Women's Hospital (LWH) to **develop and pilot a pathway for women on hormone replacement therapy (HRT) who experience unexpected bleeding**. Unexpected vaginal bleeding is extremely common in the first few months of starting HRT and contributes to up to 50% of users ceasing treatment within 12 months. It is seen in approximately 80% of those on HRT within the first 3 months of treatment. In a recent audit, 20% of those referred to the Rapid Access Cancer Clinic at Liverpool Women's Hospital were experiencing unexpected bleeding on HRT.



The risk of endometrial cancer is lower in this population compared to those not on HRT (1.2% vs 6.5%). The current approach often results in referral to secondary care on a suspected cancer pathway. This can cause distress for patients and may lead to unnecessary investigations.

The pathway offers an alternative route for referral, including direct access to an ultrasound scan, and support to provide management in primary care. It is hoped that the pathway will free up resources to see the most urgent suspected cancer patients more quickly, reduce potentially unnecessary investigations and improve patient experience.

CMCA and LWH are undertaking an evaluation to understand the impact of the pathway pilot on processes, outputs and outcomes and assess the appropriateness of expansion of the pathway across Cheshire and Merseyside.



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Health Inequalities and Patient Engagement (HIPE)

Programme SRO:	Sarah Grice, Associate Director s.grice1@nhs.net	Programme Lead(s):	Jo Trask, Patient Experience and Health Inequalities Programme Manager jo.trask@nhs.net

Programme Aims

- Reduce health inequalities for vulnerable communities, who have been affected by cancer, within Cheshire and Merseyside.
- Collaborate with a diverse range of patients, carers, and community members in the development, launch and maintenance of projects led by CMCA.
- Develop regional infrastructure to support CMCA in building a network of health providers who are confident in tackling health inequality and engaging with patients and carers at all stages of development and delivery.
- Deliver communication and engagement activities to achieve a response rate of more than 50% for the Quality-of-Life survey and increase uptake within underrepresented groups.

The HIP m projects have a focus on patient, carer and community involvement, patient experience, and health inequalities, but critically on both empowering patients to engage with appropriate services at an early stage and em ring staff to take a "small change-big impact approach" to health inequalities and patient engagement in their planning and project management.

Progra e Objectives	Description
Embed a focus on health inequalities and patient experience into the work of Cheshire and Merseyside Cancer Alliance	The HIPE team work collaboratively across the Alliance to ensure that a focus on health inequalities and patient experience is embedded and sustained within each of the programmes. We will enhance our existing 'Reader's Panel' featuring diverse members of the community, and develop a web-based platform for patient representatives, to provide feedback on project proposals and CMCA developments. We will continue to develop and embed the patient engagement toolkit, training, and support for project managers, to support them throughout the project lifecycle.
Reduce and remove, unfair and avoidable differences in access to, and quality of, care received by patients in Cheshire and Merseyside	We will continue to design and deliver specific projects, in partnership with people with lived experience and/or community organisations, to address health inequalities within vulnerable communities. We will identify and recruit interested volunteers who are happy to share their story and share these on a regular basis via meetings, social media and training sessions.
Increase diversity amongst those consulted and involved	CMCA now has over 40 diverse patient and carer representatives. Our ambition is to create a patient and carer network to aid and support new and existing representatives. Following on from our 2022 roadshows, we will create more opportunities for involvement and co-production. Our 2023 roadshow events will bring together, and create opportunities for CMCA colleagues to interact with the public; and complements the foundation for engagement by increasing public awareness. An additional aim is to increase the number of patient and carer representatives supporting CMCA and continue to diversify the patient voice.
Improve the patient experience of those living with and beyond cancer	This initiative will promote, and act upon the results of, national annual cancer surveys including the National Cancer Patient Experience Survey (CPES), Under 16 Cancer Patient Experience Survey and Quality of Life Survey at a regional level. We will deliver communication and engagement activities to achieve a Quality-of-Life Survey response rate of more than 50% and increase uptake within under-represented groups.
Sustainability of the HIPE programme	We will continue to grow our HIPE champion scheme across CMCA, providing advocates for health inequalities and patient experience within their own area of work. We will continue to develop a regional health inequalities staff network for NHS colleagues working in cancer services who have an interest in tackling health inequalities.

CMCA Roadshows 2023

CMCA introduced roadshows in 2022, travelling to 10 locations across Cheshire and Merseyside, in partnership with Healthwatch and Macmillan Cancer Support, between May and July 2022. The purpose of these roadshows was to listen to people's cancer experiences and understand how people were feeling about cancer services in their local area. **More than 300 interactions were held with the public and representatives from community organisations**, and many great anecdotal observations were made. Diverse patient representatives and patient storytellers were recruited in most places, changing the shape of the Patient Engagement process at CMCA, and influencing projects from a much wider range of perspectives.

Our 2023 roadshows aim to **tackle health inequality and create opportunities for involvement in Allia projects and programmes**. Our aim is to create opportunities for other CMCA projects to inter with the public, with a specific focus in areas across Cheshire and Merseyside where there are gaps ur patient representative community. This will complement the engagement work, increasing publi areness and the number of patient representatives supporting the Alliance. We are also taking the opportunity to speak to the public about cancer screening and what barriers they may face.

Roadshow Dates	
Royal Cheshire County Show 20th – 21st June 2023	3 new patient representatives recruited 100 cancer screening surveys completed
Crewe Lifestyle Centre 26th June 2023	5 new patient representatives recruited 47 cancer screening surveys completed
Kirkby Market 27th June 2023	1 new patient representative recruited 55 cancer screening surveys completed
Cherry Tree Shopping Centre, Wallasey: 13th September 2023	
Bootle Car Boot: 17th September 2023	
Isle of Man: 19th – 20th September 2023	

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Liver Surveillance

Programme SRO:	Greg O'Mara, Associate Director gregomara@nhs.net	Programme Lead(s):	Gemma Hockenhull, Senior Programme Manager gemma.hockenhull@nhs.net

Programme Aims

- Identify the number of people identified as at high risk of liver cancer (with cirrhosis/advanced fibrosis) across Cheshire and Merseyside
- Support liver services to invite >80% of patients with cirrhosis to a six-monthly ultrasound surveillance appointment
- Support liver services to achieve >60% of those invited to attend their surveillance appointment

Liver cancer rates have more than doubled over the past decade and are continuing to rise. NICE Guidance recommends six-monthly ultrasound surveillance for those with cirrhosis, but current delivery of this recomm tion is extremely mixed. CMCA will work collaboratively with regional partners to improve liver surveillance services, and in identifying more people at high risk of liver cancer, to diagnose more liver cancers at an early st cross Cheshire and Merseyside.

Progra e Objectives	Description
Support the Community Liver Health Checks pilot being led by the Cheshire and Merseyside Viral Hepatitis ODN	CMCA will continue to work collaboratively with the Cheshire and Merseyside ODN to support the Community Liver Health Checks pilot. CMCA will continue to work closely with the ODN and monitor outcomes from the pilot project to assess if, through the pilot work, the number of patients eligible for active liver surveillance is increasing. We will use outcomes from the pilot to further inform the development and streamlining of Liver Surveillance Programmes across providers to ensure that we can manage increasing numbers of eligible patients into surveillance programmes.
Develop a focused plan for liver surveillance improvement work and provide clinical oversight	CMCA will continue to work with providers to understand data collection systems and identify challenges with accessing data, and data quality. We will utilise targeted funding to support, where necessary, the collection and provision of data to increase submissions against the national data requirements. Targeted funding will also be used for project management resources to develop a focused plan for Liver Surveillance improvement work, and for clinical oversight of the project.
Support providers to establish systems and processes to invite those eligible for liver surveillance where these do not exist.	CMCA will work closely to understand the methodology for improving the Liver Surveillance programme and the transfer to an automated surveillance system currently being implemented by one of our providers. Learning, including resource requirements, identifying appropriate systems, KPIs, and impact on service delivery will be shared with other providers across Cheshire and Merseyside. This learning will support CMCA with plans and targeted investment to support other providers to streamline and automate their programmes to ensure there are robust systems in place for the appropriate management of patients once they enter surveillance.
Ensure sufficient ultrasound capacity is commissioned	We will work with the relevant ICB and the local CDC programme to ensure sufficient ultrasound capacity is commissioned to provide six-monthly liver surveillance to people with cirrhosis/advanced fibrosis.
Reduce health inequalities by successfully increasing invitations to and attendance at liver surveillance appointments	Many people at high risk of liver cancer face health inequalities (e.g. homeless people, individuals with alcohol or substance addiction, sex workers, people in prison systems, disabled people and older people). By identifying more people at high risk of liver cancer, and improving surveillance services, Alliances will reduce health inequalities. Alliances will reduce health inequalities by successfully increasing invitations to and attendance at liver surveillance appointments and ensuring disadvantaged patients at high risk of liver cancer are identified.

Community Liver Health Checks Pilot

Around 6,100 people are diagnosed with liver cancer each year. However, incidence of liver cancer has increased by 50% over the past decade and is expected to continue to rise. Existing evidence suggests between 1 in 3 and half of liver cancers are currently diagnosed at an early stage (1 or 2).

The most common form of liver cancer is hepatocellular carcinoma (HCC) which makes up 85% of all liver cancers.

NICE guidance recommends that people at high risk of liver cancer (those with Hepatitis B and/or cirrhosis) receive 6-monthly liver surveillance. The high-risk population for Hepatitis B/C and cirrhosis includes people enrolled in addiction servi people experiencing homelessness and sex workers.

To c bute to achieving the Long Term Plan (LTP) ambition to diagnose 75% of c rs at an early stage (1 or 2) by 2028, the CMCA Liver Surveillance prog me aims to:

- **Detect more hepatocellular carcinomas (HCC), the most common type of liver cancer at an early stage, so patients can benefit from curative treatment.**
- **Ensure more people at high risk of HCC are referred and continue to engage with liver surveillance pathways/programmes.**

National priority work areas

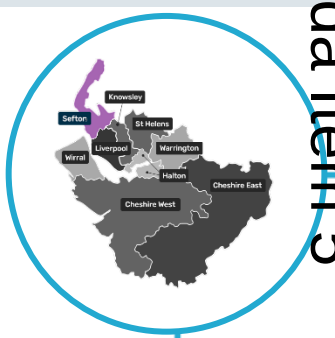
Community Liver Health Checks pilots which will identify and refer people at high risk of liver cancer into liver surveillance pathways in partnership with Hepatitis C (HCV) Operational Delivery Networks (ODNs).

Ensuring that >80% of patients are invited for and >60% of patients attend their 6 monthly ultrasound surveillance appointments as per NICE guidance (NG50, CG165, CG115).

Pilot a primary care case finding tool with Primary Care Networks (PCNs) and refer those identified to have cirrhosis/advanced fibrosis into liver surveillance.

The **Cheshire and Merseyside Viral Hepatitis ODN** are a Community Liver Health Checks pilot site, offering mobile fibroscans and other diagnostic activity to people at high risk of cirrhosis and liver cancer.

During Q1, the team **delivered 543 scans across 30 different sites** in Cheshire and Merseyside.



Sefton

Personalised Care

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Sarah Houghton, Senior Programme Manager sarahhoughton@nhs.net

Programme Aims

- Ensure individualised care and support to cancer patients that includes a holistic needs assessment, care and support plan, and access to health and wellbeing services.
- Personalised stratified follow-up pathways are in place for people at the end of treatment so clear and appropriate follow-up plans are in place.
- Reduce risks and improve long term outcomes and quality of life amongst those diagnosed with cancer.
- Ensure a positive experience of care and support.

Programme Objective	Description
Personalised care	CMCA will recruit a Clinical Lead to support the delivery of the Personalised Care Interventions, Personalised Stratified Follow Up (PSFU) and wider Personalised Care Projects. CMCA will explore how the learning from the evaluation of the Warrington community personalised care project and evaluation of the Cheshire community personalised care project can be developed into a Cancer Alliance wide plan to support more personalised care in the community closer to patient's homes. CMCA will support all trusts to have implementation plans in place to support delivery of Personalised Care Interventions (PCI) to all patients and to improve performance across all sectors. CMCA, with partners, will develop a set of Holistic Needs Assessment (HNA) / PCSP principles agreed at local Cheshire and Merseyside level. We will also work with the CMCA Primary Care Team to link with the Suspected Cancer Referrals project around the potential to highlight patient needs / reasonable adjustments at point of referral. We will develop a CMCA Dashboard that shows, for example, the number of patients diagnosed, offered a HNA and PCSP, Quality of Life Survey response. These will be aligned to national metrics. CMCA will work with the lead cancer nurses, cancer managers and CMCA Analyst Team to inform and shape the dashboard. CMCA will write formally to trust Executive Teams setting out the PCI and data requirements which will secure and confirm their commitment to this work. We will work with The Clatterbridge Cancer Centre NHS Foundation Trust and The Walton Centre NHS Foundation Trust to ensure submission of LWBC (Living with and Beyond Cancer) data to COSD.
Personalised stratified follow-up (PSFU)	CMCA will work with all appropriate trusts to ensure they sustain live and operational PSFU protocols for breast, prostate, colorectal and low-grade endometrial cancer patients. This will go through an audit process within Q4. Mersey and West Lancashire Teaching Hospitals NHS Trust (Southport site) will go live and operational with a lung cancer PSFU protocol. The Clatterbridge Cancer Centre NHS Foundation Trust will develop and deliver a metastatic breast and spinal cord compression PSFU protocols.
Prehabilitation	CMCA will work with the ICB to support the development of a local prehab strategy. CMCA will support the local system to operationalise and evaluate a comprehensive prehab delivery model.
Personalised care – Lead Cancer Nurse	CMCA will work with trusts, Primary Care and community providers to explore and define a Community / Primary Care Lead Cancer Nurse role to strategically support personalised care in the Community / Primary Care. We will begin to implement and pilot this role in Cheshire and Merseyside.
Personalised care – Dementia Nurse	CMCA will work with local trusts to explore, define, and assess the need for a dementia liaison nurse role for cancer and / or end of life patients within Cheshire and Merseyside. We will commence a pilot of this role.

Primary Care

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Liam Connolly, Senior Programme Manager l.connolly6@nhs.net

Programme Aims

This programme sets out the CMCA plan to improve cancer outcomes in Cheshire and Merseyside through supporting Primary Care with implementation of the early cancer diagnosis and prevention components of their network contracts with the aim to:

- Save or extend more lives and improve quality of life for people affected by cancer through earlier diagnosis.
- Improve cancer outcomes across Cheshire and Merseyside population by identifying and approaching inequalities.
- To detect and refer patients with suspected cancer earlier.

Programme Objectives	Description
CMCA Primary Care Clinical Leader	CMCA will fund a Place based GP Cancer Lead to each of the nine Places in Cheshire and Merseyside. These GPs will support their local Place Primary Care teams to advise with the requirements for cancer within their contracts and specifications of the Direct Enhanced Service (DES) and Quality and Outcomes Framework (QOF). They will work in close partnership with the Primary Care Cancer Engagement Leads. CMCA will also introduce a GP clinical lead for overall clinical leadership of the primary care programme.
CMCA er Engagement Leads	CMCA will recruit to three Primary Care Cancer Engagement Posts that will work with PCNs and GP Practices with the implementation of the cancer early diagnosis specification in the PCN DES. They will highlight and signpost to evidence-based solutions/interventions and support transformation to achieve cancer-related early diagnosis objectives aligned to the GP contracts and the Cancer Alliance's cancer plan. The postholders will also ensure that any projects across CMCA with interdependencies with primary care are supported e.g. FIT testing.
Primary Care Education	CMCA will continue to build materials, educational training/resources and deliver education on their Cancer Academy platform, making it a go-to place for primary care. CMCA will deliver interactive webinars for primary care, facilitate communities of practice and create newsletters to support primary care with prevention and early diagnosis of cancer.
Clinical Decision Support (CDS) Tools	CMCA will ensure that all GP practices across Cheshire and Merseyside have access to CDS tools via Ardens clinical template software. CMCA will continue to link with the regional ICB Digital team to ensure the continuation of this Ardens contract. This will include developing a structured community of practice and implementation of Clinical Decision Support Tools.
Urgent suspected cancer referral templates	CMCA will provide primary care with a suite of suspected cancer referral EMIS templates with in-built CDS style educational tools for GPs so that when a suspected cancer referral is considered, it is optimised with minimal additional work. These templates are up to date with best practice cancer guidance and will help to improve referral quality and patient experience through ensuring all relevant information is captured, the correct diagnostic tests are referred, and appropriate examinations are undertaken.
Safety netting	CMCA will provide primary care with an overview of the importance of safety netting for suspected cancer and also an auditable electronic solution to ensure patients with a high clinical suspicion of cancer are managed, reviewed and diagnosed in an efficient and safe manner in GP clinical systems.
Data dashboard	CMCA alongside primary care, Integrated Care Board and other stakeholders will scope, develop and implement a cancer data dashboard for primary care. This will include data such as; health inequalities, screening uptake, referral rates, cancer staging, various early diagnosis of cancer programmes and routes to diagnosis.
Primary Care Innovation	CMCA will complete an expressions of interest process from the Primary Care system for a provider to pilot an innovation or new approach that can support the achievement of early diagnosis in cancer. The Primary Care Clinical Quality Group will support the Cancer Alliance with this project. The innovation that will be selected by a panel will effect changes in health inequalities, increase utilisation of risk stratification tools and support management of service demand to support faster diagnosis for patients.

Psychosocial Support

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Sarah Houghton, Senior Programme Manager sarahhoughton@nhs.net

Programme Aims

The importance of psychosocial support for people affected by cancer is widely recognised and evidenced through the Quality of Life survey. Locally, it has shown significantly higher rates of both mild and moderate mental health problems for those who have experienced a cancer diagnosis. There are known gaps in this area of service provision identified by the Cancer Alliance in their 2022/23 mapping and gap analysis.

The aims of this work taking forward the Psychosocial Development Plan include:

- Improving engagement and understanding between roles, teams and services; mapping the psychosocial pathways including known referral pathways.
- Explore, define, and assess the need for a role which will have a holistic approach in reducing health inequalities by identifying people with pre-existing mental health problems and supporting access into and engagement with cancer services.

Programme Objectives	Description
Psychosocial Development Plan	CMCA will deliver the Psychosocial development plan in line with gap analyses findings (themes below) and in collaboration with the Psychology Clinical Quality Group, Talking Therapies Services, Acute and Tertiary trusts, Community Cancer Centres, ICB / Place Teams, CMCA programmes of work where interdependencies exist (e.g. Community Engagement and Primary Care) and wider partners. Themes pulled from the gap analyses to work upon in 2023/24 include: • Inequity in Psychology Service provision. • Inconsistent offer of Level 2 psychosocial training. • Inconsistent offer of Level 2 psychosocial supervision. • Variation in psychosocial provision to assess the needs of all patients. • Limited Talking Therapies Long Term Condition pathways which are specific to cancer or includes cancer. • Defining pathways, perceptions / increasing mutual understanding of service offers and complexity of supporting patients from a wide area.
Psychosocial Pathways	CMCA will map psychosocial pathways including known referral pathways to improve engagement and understanding between roles, teams, and services.
Clinical Leadership	CMCA will strengthen the governance structure and Clinical Leadership to ensure priority is given to delivery / implementation of the Psychosocial development plan.
Mental Health & Cancer Health Inequalities	CMCA will explore, define, and assess the need for a role which will have a holistic approach in reducing health inequalities by identifying people with pre-existing mental health problems and supporting access into and engagement with cancer services. We will work with key stakeholders to identify the need, shape and define the role and remit.

Targeted Lung Health Checks (TLHC)

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Liam Connolly, Senior Programme Manager l.connolly6@nhs.net

Programme Aims

Reduce mortality and inequalities from lung cancer through a targeted invitation to a lung health check and where appropriate a Low Dose CT scan every two years for people between the ages of 55 and 74 who have ever smoked. The programme will:

- Proactively diagnose lung cancer (via a lung health check and low dose CT where appropriate) when it will typically be found at an earlier stage and is more treatable.
- Give participants the chance, through information and support, to maintain and improve their lung health through signposting to Smoking Cessation Advice where clinically indicated.
- Help to change attitudes to cancer – raising awareness of signs and symptoms, and helping to promote positive messages around early diagnosis.
- Participate in the NHSE/I national evaluation of the TLHC Programmes until 31st March 2024 which will inform how this programme transitions into a national screening programme.

Programme Objectives	Description
Phases [illegible] and Two – Liverpool, Halton and Knows	Liverpool, Halton and Knowsley went live with the TLHC programme in December 2021 as they were identified as having the highest mortality and inequality from lung cancer in Cheshire and Merseyside. This followed the successful healthy lung programme that Liverpool had delivered. The TLHC programme is now reviewing the re-call and re-engage component to ensure that there is maximum uptake to a TLHC. 24 month follow up scans have commenced for appropriate patients.
Phase [illegible] – St Helens and South Sefton	St Helens and South Sefton went live with the TLHC programme in September 2022.
Phase Four – Warrington, Wirral and North Sefton	It is anticipated that Warrington, Wirral and North Sefton will go live with the TLHC programme during Q4 2023/24. A procurement process through a VEAT notice for a direct award to the Liverpool Heart and Chest Hospital is planned to start for delivery of this programme in September 2023.If necessary a full procurement process will follow, but this would delay roll out. Significant engagement is taking place across multiple stakeholders in preparation for the programme to go live.
Phase Five - Cheshire	It is anticipated that Cheshire will go live with the TLHC programme during 2024/25. The procurement of this will need to be considered. This will give 100% coverage of the programme across Cheshire and Merseyside ahead of the national ambition to achieve 100% coverage by 2029/30.
Programme Governance	The provider is reviewing the skill mix of the workforce in delivering the TLHC programme to ensure best use of capacity and resource. A bid is being placed for additional mobile CT capacity. The financial aspects to the programme are being reviewed and discussed with the national cancer team to reflect the introduction of a new funding model in April 2023. Smoking cessation and spirometry pathways are to be reviewed. It has been announced that the TLHC programme will transition into a national screening programme by 2029/30. The details around this transition are yet to be confirmed. Currently Cancer Alliances are held accountable working with the ICB for the TLHC programme delivery.

TLHC Programme Update

The TLHC programme targets those most at risk of lung cancer and CMCA has prioritised NHS place areas which have some of the highest rates of mortality from lung cancer.

Nationally, the TLHC programme has diagnosed over 1,350 lung cancers so far, more than 75% at stage one or two. **By February 2023, the Cheshire and Merseyside programme had diagnosed 131 lung cancers of which 73% of were detected at stage 1 or 2 with 66.4% of patients going on to receive curative treatment.**

The Cheshire and Merseyside Cancer Alliance, in partnership with the Liverpool Heart and Chest Hospital and the regional ICB has deliv the Targeted Lung Health Checks Programme in line with national specification. This started in July 2021 across Liverpool, Know and Halton and was then further expanded across South Sefton and St Helens in December 2022.

Thro 2023/24 we will be onboarding Wirral, Warrington and North Sefton to grow the Cheshire and Merseyside TLHC Programme to c 69% of our eligible population by year end (from current reach of 42%). Planning will continue to reach 100% coverage by March 2025 which will be one of the fastest rollouts in the UK.

Targeted Lung Health Check Programme

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Halton Knowsley	Liverpool	St Helens South Sefton	Warrington Wirral North Sefton	Cheshire
2021/22	2021/22	2022/23	2023/24	2024/25

Sefton

Timely Presentation

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Steve Jones, Senior Programme Manager, stephen.jones42@nhs.net

Programme Aims

- Fewer people being diagnosed with preventable cancers (Reduce the overall growth in the number of all cancer cases).
- More people surviving for longer after a diagnosis (Improve survival of people diagnosed with cancer at one, five and ten years).
- More people having a cancer diagnosed at an early stage (Cancer staging).
- More people engaging in cancer screening programmes (Increase in cancer screening programme uptake).
- More people making healthier lifestyle choices (Smoking prevalence and obesity measures).

Programme Objectives	Description
Tobacco control; developing local programmes of work aimed at reducing smoking rates as a risk factor for cancer	CMCA will continue the work with Alder Hey Children's Hospital to tackle smoking in Children and Young People, targeting parents and carers of children who suffer smoking related harm. CMCA will pilot a cancer pre-op outpatient variation of the CURE / Long Term Plan model of smoking cessation. This will be targeted in LUHFT departments that are particularly impacted by smoking related harm. This project will include analysis to assess longer term impacts on bed stays, readmission & post operative impact. A TB tobacco smoking cessation project will target clinically vulnerable patients with TB, who face additional inequality driven by their immigration and language statuses.
Obesity strategic approach to reducing obesity as a risk factor for cancer and improving outcomes following a cancer diagnosis	CMCA in partnership with the procured project lead (Health Equalities Group) will engage in a whole systems approach to promoting, encouraging and empowering people to have healthier lifestyles, reducing obesity as a risk factor for cancer and improving outcomes following cancer diagnosis, to include efforts towards MECC for raising awareness of early cancer symptoms. A three-to-five-year strategic plan has been developed and some direct intervention work with hard-to-reach groups is taking place. In addition, the NHS Moving Medicines model is being implemented at Alder Hey. Evaluation with external university support is in-built into the strategic plan.
Community engagement on earlier diagnosis and prevention of cancer	The CMCA Early Diagnosis Community Engagement project aims to directly engage with high risks groups and communities identified as facing the most significant challenges to early diagnosis. CMCA is doing this by working with all CVS organisations across Cheshire and Merseyside covering each place. Each of these organisations have been commissioned to provide community engagement roles, with allocated funding to support grass-roots organisations to run projects that raise awareness of early signs and symptoms and improve earlier presentation of cancer, including through screening uptake.
Timely presentation campaigns	CMCA will develop a campaign, communications and social media function within the timely presentation workstream, to drive large-scale awareness raising and screening uptake, building on existing national, regional, and local resources and campaigns as well as creating bespoke locally tailored resources for Cheshire and Merseyside.
Early diagnosis of cancer innovations	CMCA will complete an expressions of interest process from the system for a provider to pilot an innovation or new approach that can support the achievement of early diagnosis in oesophageal cancer. CMCA will continue to work with LUHFT on Europac plus (risk stratified screening) project for the population of Cheshire and Merseyside. The aim is to offer all predisposed individuals personalised pancreatic cancer screening stratified on both their family risk and their germline DNA risk. CMCA will also develop and deliver an action plan to support with the national requirement for case finding of pancreatic cancer.
Cancer screening programmes	CMCA will continue to support NHSE's Northwest Commissioners of the Cancer Screening Programmes (breast, bowel and cervical). We will also lead on local screening projects and introduce a new CMCA primary care screening post that will work collaboratively and strategically across the region to address issues relating to the three cancer screening programmes across Cheshire and Merseyside.

Timely Presentation Projects

Pancreatic cancer early diagnosis projects

CMCA will continue to work with LUHFT on the Europac plus (risk stratified screening) project for the population of Cheshire and Merseyside. The aim is to offer all predisposed individuals personalised pancreatic cancer screening stratified on both their family risk and their germline DNA risk. The outcome is to detect either, early pancreatic cancer before it has become invasive or (ideally) pre-neoplastic lesions, which will allow absolute cure.

CMCA will develop and deliver an action plan to support with the national requirement for case finding of pancreatic cancer. This plan will i le working closely with the regional Europac team in relation to planning, promotion, progress and data and effective prom of Europac for case finding and referral routes into screening navigators.

Time esentation campaigns

CMCA will develop a campaign, communications and social media function within the timely presentation workstream, to drive large-scale awareness raising and screening uptake, building on existing national, regional, and local resources and campaigns as well as creating bespoke locally tailored resources for Cheshire and Merseyside.

We will develop an awareness campaign for the region, based on specific communities of need, and working through local, regional or national organisations with a particular reach and understanding of those communities. Initial scoping will place a particular focus on our ageing population additionally focusing on the most socio-economically deprived 20% of the population.

This workstream will also seek to translate national communication campaigns into something ED/CE grass-roots organisations can use, and well as co-producing relevant messaging to targeted communities facing additional inequality.

Maternity screening project

CMCA will partner with the Local Maternity Service to deliver training to the midwifery workforce to increase effective engagement and referral into Primary Care screening services, with a measurable increase in uptake of cervical screening.

Sefton

Treatment Variation

Programme SRO:	Tracey Wright, Associate Director traceywright1@nhs.net	Programme Lead(s):	Sarah Houghton, Senior Programme Manager sarahhoughton@nhs.net

Programme Aims

- The programme aims to reduce treatment variation in three of the areas identified in the National Lung Cancer Getting it Right First Time (GIRFT) report and one area in each of the four National Cancer Clinical Audits for breast, prostate, and bowel cancer.
- To engage Clinical Quality Groups (CQGs) around treatment variation and support trusts to put in place data collection to monitor progress.
- Undertake data reporting against the recommended targets and gain feedback on barriers to improved performance and support trusts to test ideas to improve performance across Cheshire and Merseyside.

Programme Objectives	Description
Variati ung cancer outcom	Pathological services should provide a maximum ten calendar day turnaround time for molecular profiling according to the national test directory of lung cancers to meet the requirements of the National Optimal Lung Cancer Pathway. CMCA will engage with the North-West GLH pathology service to improve the turnaround times for lung molecular profiling and testing. This will include the installation of a new genomics testing panel. CMCA will ensure that turnaround times are monitored, and variation highlighted as a risk within the project. All trusts should have an overall radical treatment rate of 85% or more in those patients with Non Small Cell Lung Cancer stages I-II and of performance status 0-2. CMCA will work with trusts to understand how to capture the metrics and their support requirements. We will provide support to trust teams undertaking service delivery changes, consider internal and external requirements and provide clear project structure, governance and clinical leadership to ensure improvements. Trusts in partnership with CMCA will audit the reasons for those eligible for radical treatment but decline and identify themes emerging, ensure patient facing materials to support decision making are available. All trusts should have an overall surgical resection rate for Non Small Cell Lung Cancer of over 20%. CMCA will work with trusts to understand how to capture the metrics and their support requirements. Trusts in partnership with CMCA will audit the reasons for those eligible for radical treatment but decline and identify themes emerging, ensure patient facing materials to support decision making are available.
Variation in prostate cancer outcomes	Investigate why men with high-risk/locally advanced disease are not considered for radical treatment. CMCA will work with trusts and the Clinical Quality Group (CQG) to understand how to capture the metrics, undertake service delivery changes and provide clinical leadership. Trusts in partnership with CMCA and the CQG will audit the reasons why men with high-risk/locally advanced disease are not considered for radical treatment and gain qualitative data collection from patients to identify themes emerging to inform transformation.
Variation in bowel cancer outcomes	Reduce variation in neoadjuvant radiotherapy treatment in rectal cancer patients undergoing resection and ensure evidence-based local radiotherapy policies are in place. CMCA will work with trusts and the Clinical Quality Group (CQG) to understand how to capture the metrics, undertake service delivery changes and provide clinical leadership. Trusts in partnership with CMCA and the CQG will audit the reasons for variation in neoadjuvant radiotherapy treatment in rectal cancer patients and gain qualitative data collection from patients to identify themes emerging to inform transformation.
Variation in breast cancer outcomes	Breast cancer surgical teams should examine their reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation. CMCA will work with trusts and the Clinical Quality Group (CQG) to understand how to capture the metrics, undertake service delivery changes and provide clinical leadership. Trusts in partnership with CMCA and the CQG will audit the reasons for reoperation rates to identify themes emerging to inform transformation.

Workforce

Programme SRO:	Sarah Grice, Associate Director s.grice1@nhs.net	Programme Lead(s):	Lynn Young, Senior Programme Manager lynn.young9@nhs.net

Programme Aims

- Support our cancer workforce to reach their full potential through the delivery of training and education
- Provide a standardised approach to cancer education delivery across Cheshire and Merseyside in collaboration with educational partners
- Proactively support the health and well-being of our cancer workforce and continuously improve equality, diversity and inclusion.
- Attract, recruit and retain people within Cheshire & Merseyside, to secure the skills and people needed across our system for the future.
- Support the transformation of our workforce to respond to new challenges, deliver new ways of working and offer the best possible patient care

This pla ns with the main workforce priority areas highlighted as part of the NHS Long Term Plan , the NHS People Plan 2020/21: actions for us all , the Cancer Workforce Plan and the Diagnostics: Recovery and Renewal report.

Progra e Objectives	Description
Develop our online cancer education platform, The Cancer Academy	The Cancer Academy is an online platform developed by CMCA to provide cancer education, knowledge and learning for all healthcare professionals. During 2023/24 we will align with the national Aspirant Cancer Career and Education Development programme (ACCEND) Programme, supporting our workforce with what this means for them in their role. We will focus on further development of our primary care training and education programme and will also offer a new health inequalities workshop for our cancer workforce.
Recruit, retain and upskill our cancer workforce	To meet the ever increasing needs of people living with cancer now and in the future, we need to develop and invest in the cancer workforce and address key issues. CMCA will continue to work with NHS England (NHSE) and local systems to ensure we have the right numbers of skilled staff to provide high quality care and services to cancer patients at each stage in their care. We will increase the workforce and develop knowledge and skills in the priority specialisms identified in the National Cancer Workforce Strategy. Funded by the NHSE ACCEND programme, we will deliver over 40 national cohorts of the Principles of Cancer Programme (PCCP) training between 2023 and March 2025, training over 600 of our assistive and supportive workforce. We will also start to plan delivery of a 'Train the Trainer' programme and focus on ARRS training and education, with a view to offer a customised version of the PCCP, ensuring continued alignment to the ACCEND programme.
Support new ways of working and delivering care	CMCA will support the transformation of our workforce to introduce new ways of working to deliver the best possible patient care. We will continue to support a regional programme of work looking to provide a sustainable workforce model for speech and language therapy provision for patients diagnosed with head and neck cancer. Our three-year MDT coordinator (MDTC) training programme will enter its second year and will continue to upskill MDTCs and other relevant roles, ensuring they have equal access to the appropriate learning, and provide standardised knowledge and skills across the region.
Cancer workforce planning and transformation	Expansion and reform of the cancer workforce across all levels and specialties has long been recognised as a priority to meet the ever-increasing demands on cancer services. During 2023/24, CMCA will commission a modelling exercise for the cancer workforce across Cheshire and Merseyside. The aim of the work will be to test out a methodology for effective future workforce planning, based on current and future population needs and activity increases required to deliver quality and timely services.

The Cancer Academy

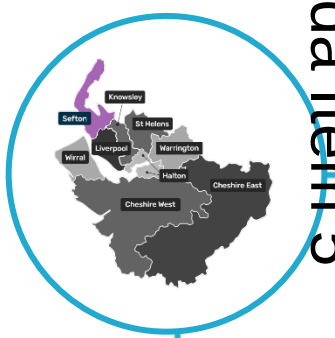
The Cancer Academy
Excellence in cancer education

The Cancer Academy is an online platform hosted by CMCA to provide **cancer education, knowledge and learning for all healthcare professionals**. Following a successful launch in September 2022, we now have more than 1150 registered users.

The site aims to **further develop, upskill and train the cancer workforce**, through the provision of high-quality, appropriate, relevant, and up-to-date education, training, and resources. The overall long-term aim is that this will support improvements in cancer prevention, early diagnosis, and care. The site is aimed at all healthcare professionals supporting cancer patients at any point of their pathway.

Click here to access The Cancer Academy

Cancer Academy Aims
Improve the reach and inclusivity of cancer related training and education for the cancer workforce and broader healthcare workforce.
Improve workforce confidence, skills, and knowledge to support delivery of services and care, enhancing patient experience.
Increase the flexibility of access to learning and education. Reduce the time spent searching for latest guidance and cancer related resources.
Provide the ability for all registered users to maintain an individual learning and education area, tailored to their requirements, including recommended resources for their area of work.
Improve training efficiency and productivity through the provision of content which can be recorded and re-used.
Embrace new ways of working and offer a sustainable training model with an increased provision of online content, whilst continuing to support our workforce to embrace digital transformation.
Provide accurate and up-to-date resources, working with stakeholders to provide high quality and accurate information to users.



Cheshire and Merseyside

Cancer Alliance

Website: www.cmcanceralliance.nhs.uk
General Enquiries: ccf-tr.admin.cmca@nhs.net

NHS

Sefton Council

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting**	23 January 2024
Subject:	NHS Cheshire and Merseyside, Sefton place Update Report		
Report of:	NHS Cheshire and Merseyside ICB (Sefton place)	**Wards Affected:**	All
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Deborah Butcher		
Tel:	0151 317 8456		
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Purpose / Summary of Report:

To provide the Committee with an update about the work of NHS Cheshire and Merseyside, Sefton

Recommendation

The Overview and Scrutiny Committee (Adult Social Care and Health) is requested to receive this report.

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NHS Cheshire and Merseyside, Sefton Update Report

January 2024

Shaping Care Together

(for more information contact: Tracy.jeffes@cheshireandmerseyside.nhs.uk)

- Shaping Care Together (SCT) is a health and care transformation programme operating across Southport, Formby and West Lancashire. This partnership programme is supported by Mersey and West Lancashire Teaching Hospitals NHS Trust, NHS Cheshire and Merseyside Integrated Care Board (ICB) and NHS Lancashire and South Cumbria ICB. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect.
- The Shaping Care Together programme has focused on the potential transformation of service provision in north Sefton and West Lancashire and has undertaken extensive engagement with local residents to gain views on future service provision.
- Recovery post Covid-19 pandemic is ongoing and the Shaping Care Together programme has continued to engage and review its purpose in light of system changes. In July 2023, Southport and Ormskirk NHS Hospitals Trust and St. Helens and Knowsley Teaching Hospitals Trust came together as one Trust to form Mersey and West Lancashire Teaching Hospitals NHS Trust. This has provided an opportunity to review the scope of what is possible in terms of service development, as the case for change for bringing the Trusts together noted the potential to address some service challenges (for example, workforce and finance) across a wider footprint.
- Following the formal creation of Mersey and West Lancashire Teaching Hospitals NHS Trust, our system partners agreed that a refresh of the programme was required and will initially focus on developing options for improving the provision of urgent and emergency care in north Sefton and West Lancashire.
- The programme objectives for the first phase of the rescoped Shaping Care Together programme is to improve the safety and quality of urgent and emergency care in Southport, Formby and West Lancashire. In doing so we want to: -
    - Deliver sustainable, responsive urgent and emergency care services;
    - Improve the integration of services across the health and care system;
    - Deliver services close to the local community, wherever possible.
- This does not mean that other services fall outside the remit of the programme, just that Phase 1 of the refreshed programme will focus on Urgent and Emergency Care in Sefton and West Lancashire as a priority.
- An updated communication and engagement plan is being development in the context of the overall programme timetable and it is anticipated that proactive engagement with key stakeholder and the wider public will recommence in the first part of 2024.

- It is proposed to bring a more detailed update regarding the programme plan to the Overview and Scrutiny Committee once finalised.

Lincoln House Surgery update

(for more information contact: Jan.leonard@cheshireandmerseyside.nhs.uk)

Lincoln House Surgery is a GP practice in Birkdale with a registered list of approximately 2000 patients. The GP who has run the practice for the past 7 years has had to leave the practice at short notice due to ill health. Local practices, the Primary Care Network and the GP Federation supported the practice over this period whilst the commissioners invited local providers who may wish to run the practice to apply to manage the contract in the interim. Southport and Formby Health (the local GP Federation) were awarded the contract from 1st January 2024. There is no change to the practice site or phone number and the staff who work in the practice will remain the same. We will now work with Southport and Formby Health and patients to look at options for the future for the practice.

Latest NHS Cheshire and Merseyside Board meeting

The next NHS Cheshire and Merseyside Board meeting takes place on 25 January 2024.

All meetings are live streamed via NHS Cheshire and Merseyside's YouTube channel for anyone not able to attend.

You can find details of all forthcoming meetings here:
https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/

Papers from all previous meetings can be found here:
https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/

Sefton Council

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting**	23 January 2024
Subject:	NHS Cheshire and Merseyside, Sefton place Primary Medical Care Update Report		
Report of:	NHS Cheshire and Merseyside ICB (Sefton place)	**Wards Affected:**	All
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Jan Leonard		
Tel:	0151 317 8456		
Email:	Jan.leonard@cheshireandmerseyside.nhs.uk		

Purpose / Summary of Report:

To provide the Committee with an update on the Delivery Plan for Recovering Access to Primary Care and Primary Care Networks.

Recommendation

The Overview and Scrutiny Committee (Adult Social Care and Health) is requested to receive this report.

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Sefton Partnership

NHS
Cheshire and Merseyside

Sefton Place Update

Primary Medical Care Update

Jan Leonard

January 2024

Sefton Plan 2023 - 2025

Agenda Item 7

Presentation Overview

Update on the Delivery Plan for Recovering Access to Primary Care

- Access data
- Friends & Family data

Primary Care Networks

Delivery Plan for Recovering Access to Primary Care

NHS England

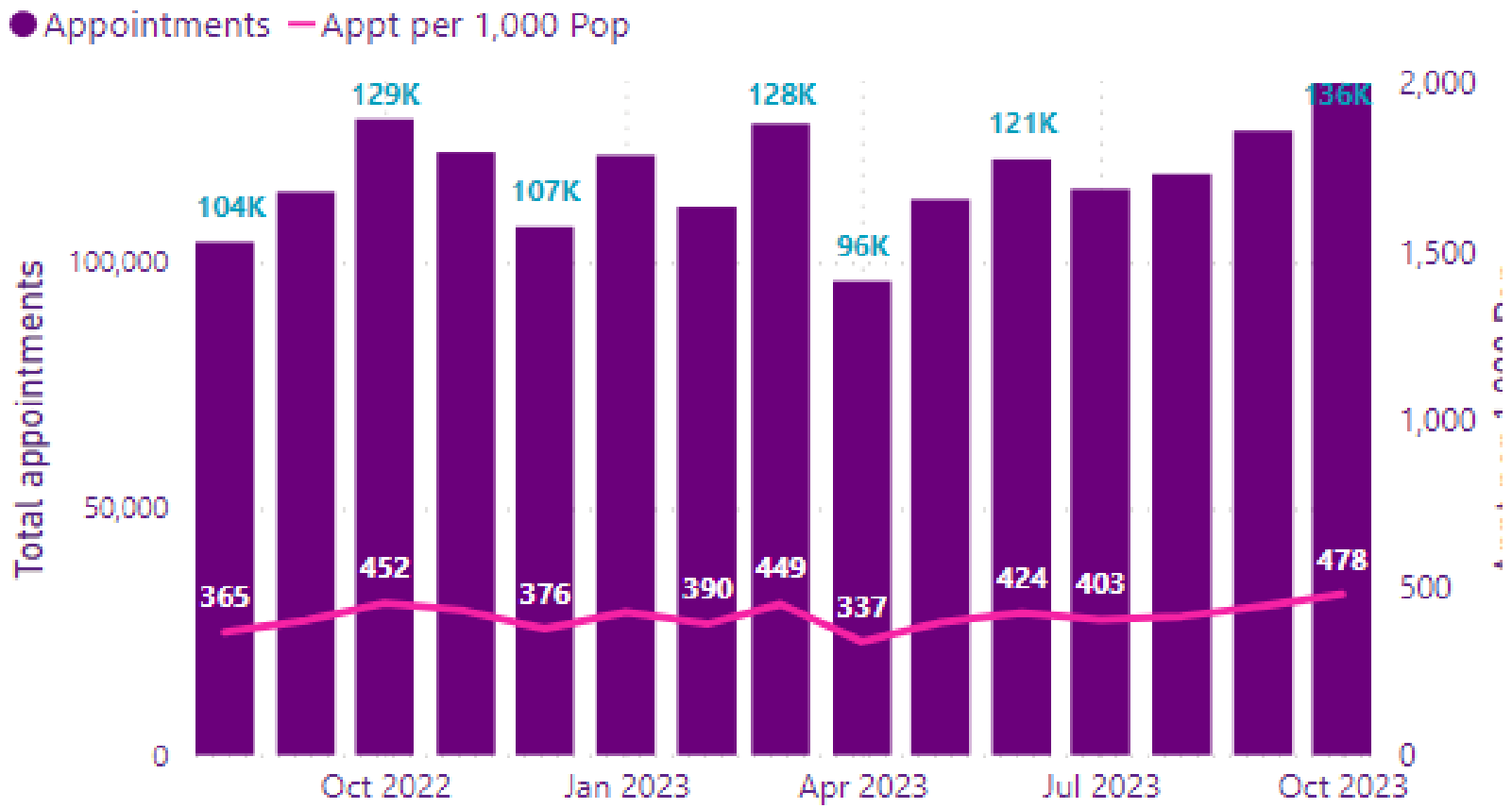
The plan headlines

The plan focuses on four areas to improve and recover access to primary care:

1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3	**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources	

Appointment Data – October 23

Appointment and Rate per 1,000 population trends



Appointment data

70% of appointments captured are face to face

24% are via the telephone

The acute visiting service operates Monday to Friday and delivers home visits for practices – this data is not included in the figures

Time to appointments

45% of appointments are same day

Enhanced Access – evening and weekend appointments 2000+ appointments in each PCN area per month.

Winter Plans

South Sefton PCN - Access Hub

Clinics in four localities, Bootle: May Logan, Crosby: 42 Kingsway Surgery, Maghull Westway Practice, Seaforth & Litherland Ford Surgery.

10,000 patients seen since go live. Average 2000 appointments a month.

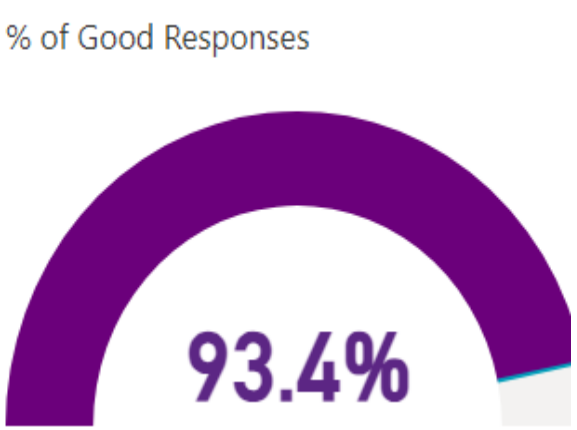
Southport and Formby Winter Hubs

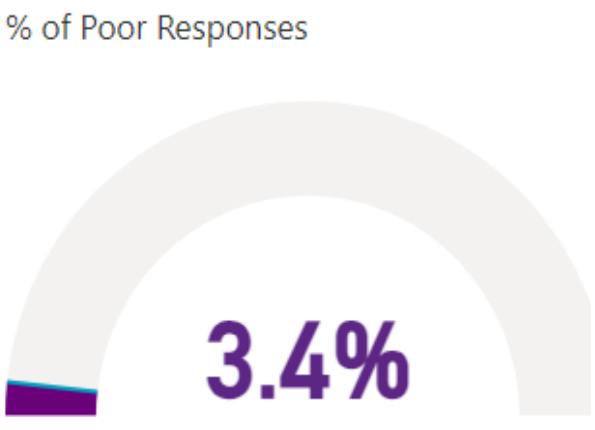
Southport Centre for Health & Wellbeing – same day urgent appointments

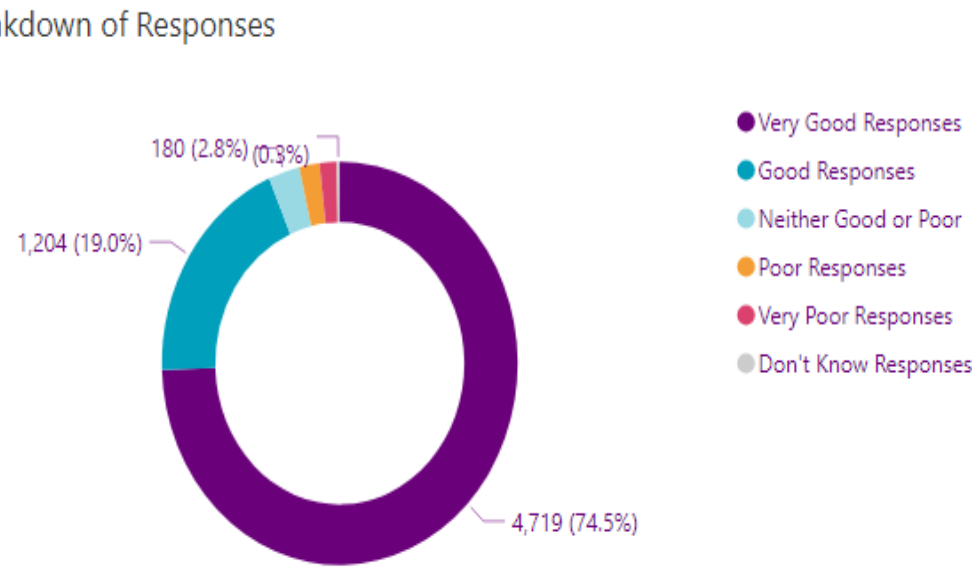
Formby Practices - weekend appointments

Family Surgery Enhanced Access service – increased weekend appointments

Friends and Family Test - Sefton







% of Good Responses
England Average

91.4%

% of Poor Responses
England Average

4.3%

Primary Care Network Services

South Sefton

Enhanced Health at Home

Enhanced Health in Care Homes

Learning Disability Health Checks

Mental Health Primary Care Team:

- ACEs recovery programme
- Associate Psychological Practitioners offering talking therapy and brief interventions
- Mental Health Practitioners for assessment complex mental health needs eg bipolar disorder,
- Social Prescribing Link Workers
- Children & Young People Mental Health Practitioners

Primary Care Network Services

Southport and Formby

Enhanced Health in Care Homes

Social Prescribing Link Workers and Health & Wellbeing Coach

Mental Health Practitioners

Cancer coordinators

Complex Lives Complete Care Community

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Sefton Council

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting**	23 January 2024
Subject:	Health Provider Performance Dashboard		
Report of:	NHS Cheshire and Merseyside ICB (Sefton place)	**Wards Affected:**	All
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Luke Garner		
Tel:	0151 317 8456		
Email:	Luke.garner@cheshireandmerseyside.nhs.uk		

Purpose / Summary of Report:

To present NHS Cheshire and Merseyside performance against key strategic, NHS constitution, quality and safety indicators for the main providers Sefton Place commission from.

Time periods vary for the indicators presented and are indicated in the tables.

Recommendation(s)

The Overview and Scrutiny Committee (Adult Social Care and Health) is requested to receive this performance dashboard.

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NHS
Cheshire and Merseyside

Main Provider Performance January 2024

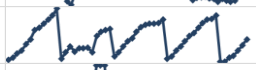
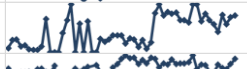
The following slides present performance against key strategic, NHS constitution, quality and safety indicators for the main providers the Sefton Place commission from.

Time periods vary for the indicators presented and are indicated in the tables latest data available displayed.

To Note: Following a consultation on the cancer waiting times standards, NHS England had approval from the government to implement changes to the standards from 1 October 2023, this data for Cancer is reflected within the report for these new metrics (62 day combined, 31 day combined and 28 day FDS).

Sefton Place – North Sefton

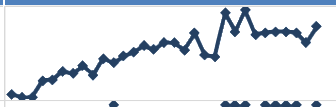
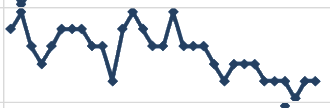
NHS Cheshire and Merseyside

Key Performance Area	Time Period	Performance	C&M	National	Target	Trend
A&E 4 hour Waits, All Types MWLTH from July 23 (Mersey & West Lancashire Teaching Hospital) prev SOHT	Oct-23	66.77%	69.73%	70.25%	76%	
Cancer 28 Day FDS (MWLTH from July 23)	Oct-23	72.98%	70.00%	71.07%	75%	
Cancer 62 Day - combined new from Oct-23 (MWLTH from July 23)	Oct-23	78.50%	70.10%	63.09%	85%	
Cancer 31 Day - combined new from Oct-23 (MWLTH from July 23)	Oct-23	90.23%	93.43%	89.44%	96%	
RTT -18 Weeks Incomplete (MWLTH from July) snapshot	Oct-23	60.41%	55.96%	58.18%	92%	
C.Difficile (Southport & Ormskirk) cumulative YTD	Oct-23	24	-	-	2023-24 Target </=39	
MRSA (Southport & Ormskirk) cumulative YTD	Oct-23	0	-	-	zero tolerance	
Stroke (80% of Pts spending 90% of time on Stroke Unit, Southport & Ormskirk)	Aug-23	78.30%	-	-	80%	 <<-- latest data
% TIA assessed and treated within 24 hours (Southport & Ormskirk)	Oct-23	76.50%	-	-	60%	
Ambulance Category 1 Mean 7 minute response time (NS Place Level)	Oct-23	00:10:25	00:08:19 (NWAS)	00:08:32	<=7 Minutes	
Ambulance Category 1 90th Percentile 15 minute response time (NS Place Level)	Oct-23	00:20:22	00:14:07 (NWAS)	00:15:08	<=15 Minutes	
Ambulance Category 2 Mean 18 minute response time (NS Place Level)	Oct-23	00:41:25	00:32:12 (NWAS)	00:38:30	<=30 Minutes	
Ambulance Category 2 90th Percentile 40 minute response time (NS Place Level)	Oct-23	01:21:02	01:06:54 (NWAS)	01:22:07	<=40 Minutes	
Ambulance Category 3 90th Percentile 120 minute response time (CCG Level)	Oct-23	06:39:56	06:33:15 (NWAS)	05:25:46	<=120 Minutes	
Ambulance Category 4 90th Percentile 180 minute response time (NS Place Level)	Oct-23	13:21:10	05:49:48 (NWAS)	06:04:54	<=180 Minutes	
Mental Health: IAPT 16.8% Access (NS Place Level)	Oct-23	0.71%	-	-	1.59% per month Qtr 1-3 1.83% per month Qtr 4	
Mental Health: IAPT 50% Recovery (NS Place Level)	Oct-23	53.8%	-	-	50%	
Mental Health: IAPT waiting <6 weeks (NS Place)	Oct-23	94.0%	-	-	75%	
Mental Health: IAPT waiting <18 weeks (NS Place)	Oct-23	99.0%	-	-	95%	

Mersey & West Lancashire Teaching Hospital NHS Trust

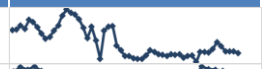
Friends & Family

NHS
Cheshire and Merseyside

Measure	Time Period	MWLTH	C&M	National (Target)	Trend
Inpatient – Response Rate	Oct-23	40.4%	31.9%	21.2%	
Inpatient Recommended	Oct-23	95.0%	95.0%	94.0%	
Inpatient Not Recommended	Oct-23	3.0%	3.0%	3.0%	
A&E – Response Rate	Oct-23	18.6%	16.1%	11.3%	
A&E Recommended	Oct-23	84.0%	78.0%	79.0%	
A&E Not Recommended	Oct-23	11.0%	15.0%	14.0%	

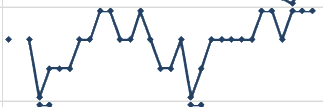
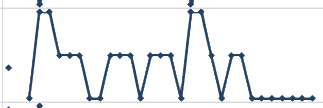
Sefton Place – South Sefton

NHS Cheshire and Merseyside

Key Performance Area	Time Period	Performance	C&M	National	Target	Trend
A&E 4 hour Waits, All Types (LUHFT)	Oct-23	68.00%	69.73%	70.25%	76%	
Cancer 28 Day FDS (LUHFT)	Oct-23	71.86%	70.00%	71.07%	75%	
Cancer 62 Day - combined new from Oct-23 (LUHFT)	Oct-23	67.75%	70.10%	63.09%	85%	
Cancer 31 Day - combined new from Oct-23 (LUHFT)	Oct-23	87.65%	93.43%	89.44%	96%	
RTT -18 Weeks Incomplete (LUHFT) Snapshot	Oct-23	54.85%	55.96%	58.18%	92%	
C.Difficile (LUHFT) cumulative YTD	Oct-23	93	-	-	2023-24 Target </=133	
MRSA (LUHFT) cumulative YTD	Oct-23	1	-	-	zero tolerance	
Stroke (80% of Pts spending 90% of time on Stroke Unit) (LUHFT)	Qtr 4 Mar-23	60.2%	-	-	80%	 <-- latest data
% TIA assessed and treated within 24 hours (LUHFT)	Oct-23	-	-	-	60%	
Ambulance Category 1 Mean 7 minute response time (SS Place Level)	Oct-23	00:07:25	00:08:19 (NWAS)	00:08:32	<=7 Minutes	
Ambulance Category 1 90th Percentile 15 minute response time (SS Place Level)	Oct-23	00:12:07	00:14:07 (NWAS)	00:15:08	<=15 Minutes	
Ambulance Category 2 Mean 18 minute response time (SS Place Level)	Oct-23	00:40:43	00:32:12 (NWAS)	00:38:30	<=30 Minutes	
Ambulance Category 2 90th Percentile 40 minute response time (SS Place Level)	Oct-23	01:18:53	01:06:54 (NWAS)	01:22:07	<=40 Minutes	
Ambulance Category 3 90th Percentile 120 minute response time (SS Place Level)	Oct-23	07:56:29	06:33:15 (NWAS)	05:25:46	<=120 Minutes	
Ambulance Category 4 90th Percentile 180 minute response time (SS Place Level)	Oct-23	09:24:03	05:49:48 (NWAS)	06:04:54	<=180 Minutes	
Mental Health: IAPT 16.8% Access (SS Place Level)	Oct-23	0.80%	-	-	1.59% per month Qtr 1-3 1.83% per month Qtr 4	
Mental Health: IAPT 50% Recovery (SS Place Level)	Oct-23	50.6%	-	-	50%	
Mental Health: IAPT waiting <6 weeks (SS Place)	Oct-23	92.0%	-	-	75%	
Mental Health: IAPT waiting <18 weeks (SS Place)	Oct-23	100.0%	-	-	95%	

Liverpool University Hospital NHS FT
Friends and Family

NHS
Cheshire and Merseyside

Measure	Time Period	LUHFT	C&M	National (Target)	Trend
Inpatient – Response Rate	Oct-23	22.3%	31.9%	21.2%	
Inpatient Recommended	Oct-23	93.0%	95.0%	94.0%	
Inpatient Not Recommended	Oct-23	4.0%	3.0%	3.0%	
A&E – Response Rate	Oct-23	16.5%	16.1%	11.3%	
A&E Recommended	Oct-23	70.0%	78.0%	79.0%	
A&E Not Recommended	Oct-23	21.0%	15.0%	14.0%	

NWAS – Paramedic Emergency Services (PES) Summary

Data Source: Provider Level (NWAS)

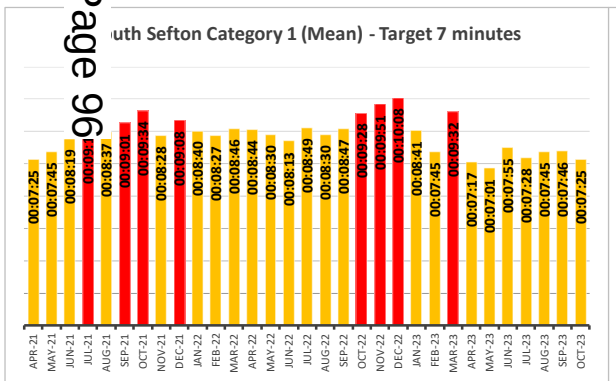
Agenda Item 8

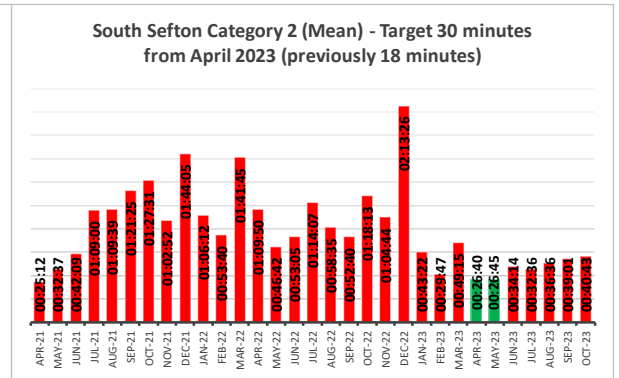
Dashboard

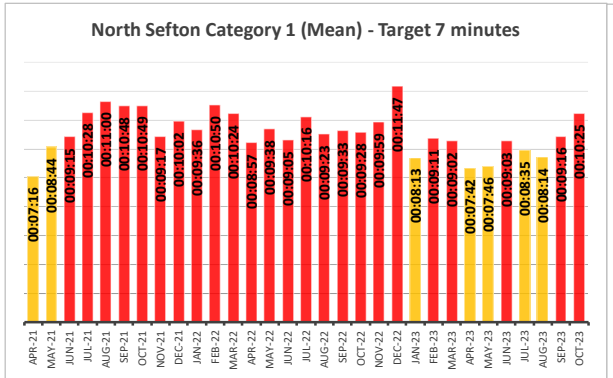
Key: Risk Data — ▲Low (P) Published — ▲ Moderate (L) Local — ▲ High (X) Not available

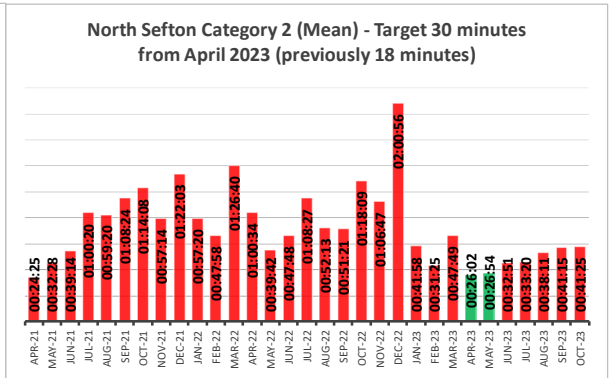
Oct-23	Cat 1 (Mean)	Cat 2 (Mean)	Cat 3 (90th Percentile)	Cat 4 (90th Percentile)
Target	00:07:00	00:30:00	02:00:00	03:00:00
South Sefton	00:07:25	00:40:43	07:56:29	09:24:03
North Sefton	00:10:25	00:41:25	06:39:56	13:31:10
NWAS	00:08:19	00:32:12	06:33:15	05:49:48
Risk	▲	▲	▲	▲
Data	Published	Published	Published	Published

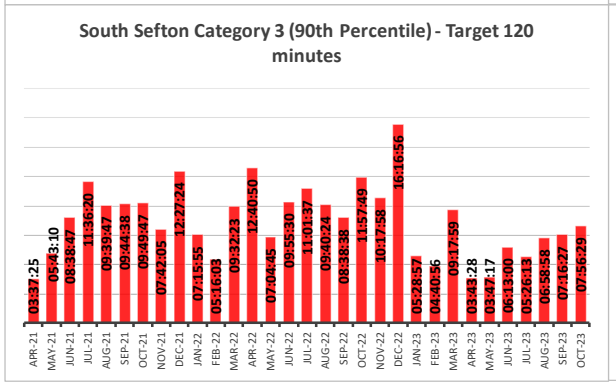
Performance Charts

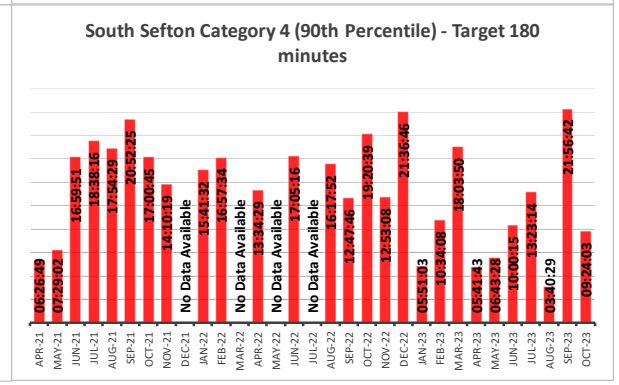


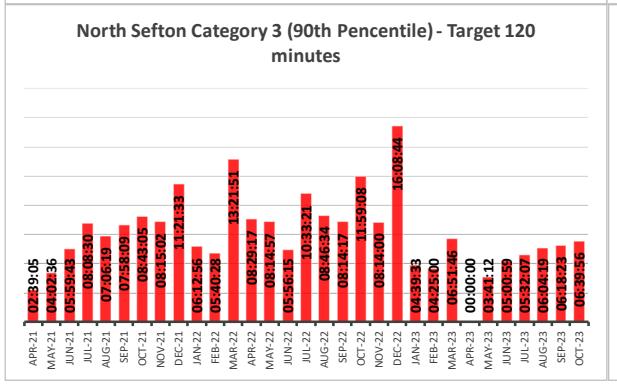


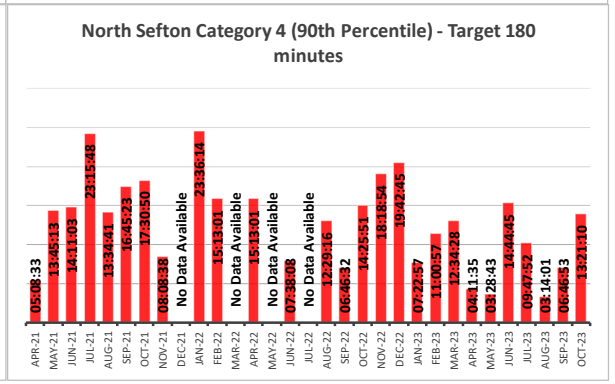












Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting:**	Tuesday 23 January 2024
Subject:	Report for information on the Public Health Performance Framework		
Report of:	Director of Public Health	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

This is a six-monthly report, which focuses on 11 out of the 26[1] indicators which make up the Public Health Performance Framework, and which were updated in the larger national Public Health Outcomes Framework (PHOF) [2] from March 2023 through August 2023.

These indicators serve to describe the scale and distribution of population health problems, their underlying social, economic, and environmental causes and associated health inequalities. Where available, the overview includes trends over time and relevant comparisons with the national picture, other local authorities in the North West and Liverpool City Region, and areas with similar characteristics to Sefton (Statistical Neighbour Group). Information is also provided about Public Health led improvement actions that target these high-level indicators. The report highlights ongoing impacts on public health services and population groups from the pandemic and high costs of living.

Recommendation:

Members of the Overview and Scrutiny Committee (Adults Social Care and Health) are recommended to,

(1) Note and comment on the information contained in this report, which was previously presented at the December briefing of the Cabinet Member for Health and Wellbeing.

Reasons for the Recommendation:

[1] Sections of the report not updated in this edition are highlighted.

[2] Public Health Outcomes Framework - OHID (phe.org.uk)

Committee Members have asked to receive this report routinely.

Alternative Options Considered and Rejected: (including any Risk Implications)

None

What will it cost and how will it be financed?

(A) Revenue Costs

No additional costs are identified within this report.

(B) Capital Costs

No additional costs are identified within this report.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
Not applicable

Legal Implications:
Not applicable

Equality Implications:
The equality implications have been identified and risk remains, as detailed in the report.

Where the information is available, epidemiological data in this report has been discussed separately for population groups defined by some protected characteristics – age, sex, ethnicity, as well as socio-economic status.

Equality implications are described in terms of health inequality and this report provides actionable intelligence that feeds into ongoing population health improvement initiatives.

Impact on Children and Young People: Yes
There is an impact on children and young people because two of the indicators describe health behaviours that directly affect this age group (under 18 conception rate and smoking in pregnancy. The health of young people is also discussed elsewhere in the report where information is available.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

The report itself does not directly lead to action that will have a positive or negative

impact on climate, so it is considered neutral. However, climate is identified as one of three important, contemporary risks to population health over and above those which existed before. These three risks are: the continuing unequal impacts of the Coronavirus pandemic; the high cost of living; and the likelihood of serious and destructive climate events.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Data is used to identify vulnerable populations and this intelligence informs continuing service improvement aimed at reducing risks to health and improving health outcomes across vulnerable groups in our population.
Facilitate confident and resilient communities: Data helps identify the mix of harmful and protective factors outside of services that influence health and wellbeing across communities (social and wider determinants of health). Connecting support across a range of issues rather than just one is more effective and increases resilience. This is a recurring theme in the updates from public health initiatives and services.
Commission, broker and provide core services: Data informs strategic and service delivery response to community needs. This report is also available to other staff and partners to aid their planning and delivery of health-promoting services and support.
Place – leadership and influencer: The public health performance framework enables comparison with other areas highlighting outcomes that may require further investigation.
Drivers of change and reform: The data in this report are key health and wellbeing indicators that are used to plan and monitor the impact of the health and social care system as well as wider public policy.
Facilitate sustainable economic prosperity: Not applicable, but many of the themes identified here feed into allied evidence-led improvement plans, for example the child poverty strategy.
Greater income for social investment: No applicable
Cleaner Greener: Not applicable

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD7484) and the Chief Legal and Democratic Officer (LD5584) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Committee / Council meeting.
This is a report for information and assurance.

Contact Officer:	Helen Armitage
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Appendices:

The following appendices are attached to this report:

Cabinet Member / OSC (ASCH) Public Health performance Framework Update Report

This is the full report originally presented at Cabinet Member for Health and Wellbeing's December 2023 briefing.

Copy of Public Heath Performance Framework indicators August 2023

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 The aims of the appended briefing report are to:

- Present and interpret population health indicators from the Public Health Performance Framework,
- Provide relevant information about public health programmes and service developments,
- Highlight aspects related to the Coronavirus pandemic and high cost of living,
- Make and receive recommendations as required.

The complete Public Health Performance Framework – August 2023 is copied in Appendix A of the attached Cabinet Member report, and separately. Appendix B of that report reproduces some background information from previous reports, which covers how statistics from the Public Health Outcomes Framework are arrived at and important issues to be aware of when interpreting population health data.

2. Summary

Updates in this report include indicators associated with health behaviours (smoking, physical activity in adults, and under 18 conceptions); health risks (excess weight in adults); and service activity (successful drug treatment rates, and NHS Health Checks).

An important aspect of this report is that the latest indicators, which span a range of time intervals from March 2021 to June 2023 continue to register trends linked to the pandemic in 2020-21. Subsequent updates are likely to reveal population health consequences associated with higher cost of living and reduced living standards, and adverse climate events.

As Sefton's large gap in life expectancy at birth shows (updated in a previous report – see section 3.20), unequal health outcomes caused by unequal experiences of healthy and unhealthy social, economic, and environmental influences ('health determinants'), remain the defining challenge.

Overall, progress on smoking remains very positive and provides an important equalising effect on health chances, especially at the start of life. Excess weight in adults still affects over 7 in 10 of the population in Sefton. Although the increase in physical activity seen during the pandemic has been sustained for a second year, the absolute level of metabolic risk in the population presented by excess weight is of concern and is expected to be compounded by rising risk from lower dietary quality due to the high cost of food, fuel, and other essentials.

3. Overview

3.1 Strengths and improvements

This review of updated performance indicators includes some notable areas of continuing good performance and improvement.

- **Smoking:** The best estimate from a large, routine survey in 2022 is that one in thirteen (7.9%) of adults in Sefton currently smokes**.** Sefton has the lowest adult prevalence of smoking in the North West and amongst statistical neighbours. Sefton achieved the Government's target of reducing adult smoking prevalence to under 12.0% by 2022. Smoking rates decrease in later life and Sefton's relatively low prevalence in part reflects the larger proportion of senior adults in our population. Smoking remains a leading cause of premature illness and disability and health inequalities. The Government has set out new policy proposals to help achieve its ambition of a smokefree generation and to prevent youth vaping, which include a public consultation.
- **Smoking in pregnancy:** Although Sefton has not achieved the national target reduction to 6% in 2022, a further 1.0% reduction to 9.0% in 2021/22 means that compared to similar areas, and former CCG (Clinical Commissioning Group) geographies in the North West, Sefton continues amongst the best performing areas on this indicator. The Government has announced two years of funding to

financially incentivise not smoking in pregnancy, with up to £400 worth of vouchers available to women who demonstrate smokefree status at each checkpoint during their pregnancy.

- **Under 18 conceptions:** Despite a small increase in the year to December 2021 (15.7/1000, 69 conceptions) Sefton's rate remains in line with England and ranks lowest in LCR.
- **Physical activity:** A large increase in the proportion of physically active adults from 61.3% in 2019/20 to 66.0% in 2020/21 has been maintained in the latest data (65.9%, 2021/22).

3.2 Points to note

- **Excess weight in adults:** The excess weight rate (% overweight or obese) for adults in Sefton in 2021/22 is 71.2% - similar to 2020/21 (71.5%), and up from 66.3% in 2019/20. This level of increase has been seen previously in recent years, but it continues to place Sefton's rate significantly higher than the national average (63.8%) and towards the upper end of the distribution in the North West and amongst similar areas.
- **Physical inactivity:** Relatively high rates of inactivity (one in four), high rates of obesity in all age groups, and lower dietary quality associated with rising food poverty each add individual chronic disease risk. **Epidemiological research shows these risk factors are not simply different sides of the same coin**, which is why integrated approaches to behavioural change remain central to the public health approach in Sefton.
- **Successful completion of drug treatment (opiates):** In the year to December 2022 **3.0% of service users in Sefton achieved this outcome** – significantly lower than the England average (5.0%). Sefton has dropped down 6 places in the North West rankings and has the lowest opiate treatment success rate from amongst five statistical neighbours and in LCR. It is important to note that in most areas **numbers of successful treatment outcomes each year is small** (e.g., 30 to 50 Sefton). This means that small year on year improvements or reductions in service outcomes can be obscured by random variation. More recent data from the National Drug Treatment Monitoring System shows that the service provider **CGL has almost closed this performance gap compared to England**.
- **Successful completion of drug treatment (non-opiates):** fell back to 17.6% in the year to December 2022. The current success rate is half of what it was in the previous year (34.2%) and a quarter of the rate at baseline in 2011. Sefton's rate is lowest in the North West, LCR and amongst statistical neighbours. These data also reflect a period of transition to the current provider, CGL. Following this numbers of people in treatment is approaching 2000 and has increased by 67%, and continuity of care is 80% - well above the Government target of 75% and performance in most other areas.
- **Smoking:** there are early signs of a possible divergent trend in smoking, distinguishing the professional and intermediate groups (continuing reductions) and the unemployed and routine and manual groups (steady or increasing). This is a concern for Sefton's health inequalities.

3.3 Health inequality

- The **social gradient in smoking** continues to be a powerful driver of health inequality in Sefton. Of note from Sefton-level data is the higher rate of smoking in males compared to females (10.1% vs 5.9%), accompanied by some signs that smoking reduction is taking place more slowly amongst males. Younger age, and lower incomes/income security are behind large differences in smoking rates separating home renters from homeowners; and managerial and professional from routine and manual occupations (3.5-fold difference)
- The **external inequality in smoking in pregnancy has been closed** (Sefton 9.0% vs England 9.1%) and the internal difference in smoking in pregnancy rates in Sefton continues to narrow (south Sefton 9.1%, vs North Sefton 7.4%). This represents a major gain for health and health equity at the start of life and reflects the ongoing success of partnership work spear-headed in Sefton.
- As the overall influence of smoking on health continues to wane, **socio-demographic risk factors for obesity** (lower educational attainment, being male, being of White or Black ethnicity, being aged 45 or above (highest prevalence of excess weight is in the 55-64 age group) and having a disability) are pertinent to Sefton's population and the continuation health inequalities due to long-term conditions.

3.4 COVID-19 and cost of living

- Updated indicators discussed in **this report reflect data collected either during the later pandemic phase in 2021, or early post-pandemic period from 2022 through 2023.**
- As discussed in earlier reports, pandemic disruption to usual ways of life, the delivery of health services, and people's behaviour in terms of seeking healthcare combined to cause distinct impacts on population health. A good example, is the marked reduction in smoking rates in lower income groups during 2020, followed by a rebound to pre-pandemic rates by 2022.
- The unequal health and social impacts of the pandemic continue to be well documented. **The negative effects of high cost of living on health fundamentals such as adequate diet, social connection, and protection from cold will further tip the scales towards greater health inequality in Sefton. A third strand of health risk also comes the rapidly growing likelihood of serious climate events**.

3.5 Response

- **Public Health services have an important part to play in responding to and preventing high levels of population health need.** However, as the scale of socio-economic and other inequalities in health reveals, the fundamental causes of this need are found in the complex interaction of different health determinants across the life-course.

- Updates in this report describe several examples of how the public health team and services are **enabling system improvements**, for example the current mapping and review of Sefton's weight management service offer against evidence-based recommendations.
- Sefton's **Combatting Drugs Partnership** has now been in place for one year. A **notable success** has been the two thirds increase in the overall number of people in **drug treatment** (1912), recent improvements in drug treatment outcomes (yet to appear in PHOF data), and the exceptionally strong record of continuity of care provided by the current substance use service provider, CGL.
- A wide range of activity is also taking place to improve community access to oral, long-acting, and emergency forms of contraception. Public health officers are also contributing to a **teenage pregnancy** self-assessment exercise with other local authorities to identify further improvements.

Cabinet Member / OSC (ASCH) Update Report Agenda Item		
Councillor	**Portfolio**	**Period of Report**
Ian Moncur	Health and Wellbeing	March – Aug 2023
Title: Public Health Performance Framework		

1. Reason for Briefing

The aims of this briefing are to:

- Present and interpret population health indicators from the Public Health Performance Framework,
- Provide relevant information about public health programmes and service developments,
- Highlight aspects related to the Coronavirus pandemic and high cost of living,
- Make recommendations as required.

This report is usually provided on a six-monthly basis. The previous report spanned September 2022 to February 2023. This report concentrates on 11 out of 26[1] indicators from the Public Health Performance Framework, which received updates in the much more extensive Public Health Outcomes Framework (PHOF) [2] from March 2023 through August 2023.

These indicators serve to describe the scale and distribution of population health problems, their underlying causes and associated health inequalities. Where available, the overview includes trends over time and relevant comparisons with the national picture, other local authorities in the North West and Liverpool City Region, and areas with similar characteristics to Sefton (Statistical Neighbour Group). Information is also provided about Public Health led improvement actions that target these high-level indicators. The report highlights ongoing impacts on public health services and population groups from the pandemic and high costs of living.

The complete Public Health Performance Framework – August 2023 is provided in Appendix A. Updated indicators are shaded pale purple. Rankings low to high indicate best to worst amongst North West and statistical neighbour groups, with colour coding to show relative change from the previous edition of the framework (red for a relatively worse position, green for a relatively better position and yellow for no change in ranked position). The framework also includes coloured arrows to show how each indicator has changed in comparison to its previous value; summary bar charts to enable comparison with local authorities in Liverpool City Region; line charts showing Sefton and England trends; and an indication of the size and statistical significance of the difference in values for Sefton and North West England (the z-score).

[1] **Sections of the report not updated in this edition are highlighted.**
[2] Public Health Outcomes Framework - OHID (phe.org.uk)

Appendix B reproduces some background information from previous reports, which covers how statistics in the Public Health Outcomes Framework are arrived at, and important issues to be aware of when interpreting population health data.

2. Summary

Updates in this report include indicators associated with health behaviours (smoking, physical activity in adults, and under 18 conceptions); health risks (excess weight in adults); and service activity (successful drug treatment rates, and NHS Health Checks). In view of several positive developments to support better population mental health service, updates have also been included for relevant indicators (section 3.14, 3.15).

An important aspect of this report is that the latest indicators, which span a range of time intervals in the period March 2021 to June 2023 continue to register trends linked to the pandemic in 2020-21. Subsequent updates are likely to reveal population health consequences associated with higher cost of living and reduced living standards, and adverse climate events.

As Sefton's large gap in life expectancy at birth shows (updated in a previous report – see section 3.20), unequal health outcomes caused by unequal experiences of healthy and unhealthy social, economic, and environmental influences ('health determinants'), remain the defining challenge.

Overall, progress on smoking remains very positive and provides an important equalising effect on health chances, especially at the start of life. Excess weight in adults still affects over 7 in 10 of the population in Sefton. Although the increase in physical activity seen during the pandemic has been sustained for a second year, the absolute level of metabolic risk in the population presented by excess weight is of concern and is expected to be compounded by rising risk from lower dietary quality due to the high cost of food, fuel, and other essentials.

- **Strengths and improvements**: This review of updated performance indicators includes some notable areas of continuing good performance and improvement.
    - **Smoking:** The best estimate from a large, routine survey in 2022 is that one in thirteen (7.9%) of adults in Sefton currently smokes**.** Sefton has the lowest adult prevalence of smoking in the North West and amongst statistical neighbours. Sefton achieved the Government's target of reducing adult smoking prevalence to under 12.0% by 2022. Smoking rates decrease in later life and Sefton's relatively low prevalence in part reflects the larger proportion of senior adults in our population. Smoking remains a leading cause of premature illness and disability and health inequalities. The Government has set out new

policy proposals to help achieve its ambition of a smokefree generation and to prevent youth vaping, which include a public consultation.

- **Smoking in pregnancy:** Although Sefton has not achieved the national target reduction to 6% in 2022, a further 1.0% reduction to 9.0% in 2021/22 means that compared to similar areas, and former CCG (Clinical Commissioning Group) geographies in the North West, Sefton continues amongst the best performing areas on this indicator. The Government has announced two years of funding to financially incentivise not smoking in pregnancy, with up to £400 worth of vouchers available to women who demonstrate smokefree status at each checkpoint during their pregnancy.
- **Under 18 conceptions:** Despite a small increase in the year to December 2021 (15.7/1000, 69 conceptions) Sefton's rate remains in line with England and ranks lowest in LCR.
- **Physical activity:** A large increase in the proportion of physically active adults from 61.3% in 2019/20 to 66.0% in 2020/21 has been maintained in the latest data (65.9%, 2021/22).

- **Health inequality**
  - The **social gradient in smoking** continues to be a powerful driver of health inequality in Sefton. Of note from Sefton-level data is the higher rate of smoking in males compared to females (10.1% vs 5.9%), accompanied by some signs that smoking reduction is taking place more slowly amongst males. Younger age, and lower incomes/income security are behind large differences in smoking rates separating home renters from homeowners; and managerial and professional from routine and manual occupations (3.5-fold difference)
  - The **external inequality in smoking in pregnancy has been closed** (Sefton 9.0% vs England 9.1%) and the internal difference in smoking in pregnancy rates in Sefton continues to narrow (south Sefton 9.1%, vs North Sefton 7.4%). This represents a major gain for health and health equity at the start of life and reflects the ongoing success of partnership work spear-headed in Sefton.
  - As the overall influence of smoking on health continues to wane, socio-demographic **risk factors for obesity** (lower educational attainment, being male, being of White or Black ethnicity, being aged 45 or above (highest prevalence of excess weight is in the 55-64 age group) and having a disability) are pertinent to Sefton's population and the continuation health inequalities due to long-term conditions.

- **Points to note**
  - **Excess weight in adults:** The excess weight rate (% overweight or obese) for adults in Sefton in 2021/22 is 71.2% - similar to 2020/21 (71.5%), and up from 66.3% in 2019/20. This level of increase has been seen previously in recent years, but it continues to place Sefton's

rate significantly higher than the national average (63.8%) and towards the upper end of the distribution in the North West and amongst similar areas.

- **Physical inactivity:** Relatively high rates of inactivity (one in four), high rates of obesity in all age groups, and lower dietary quality associated with rising food poverty each add individual chronic disease risk. **Epidemiological research shows these risk factors are not simply different sides of the same coin**, which is why integrated approaches to behavioural change remain central to the public health approach in Sefton.
- **Successful completion of drug treatment (opiates):** In the year to December 2022 **3.0% of service users in Sefton achieved this outcome** – significantly lower than the England average (5.0%). Sefton has dropped down 6 places in the North West rankings and has the lowest opiate treatment success rate from amongst five statistical neighbours and in LCR. It is important to note that in most areas **numbers of successful treatment outcomes each year is small** (e.g. 30 to 50 Sefton). This means that small year on year improvements or reductions in service outcomes can be obscured by random variation. More recent data from the National Drug Treatment Monitoring System shows that the service provider **CGL has almost closed this performance gap compared to England**.
- **Successful completion of drug treatment (non-opiates):** fell back to 17.6% in the year to December 2022. The current success rate is half of what it was in the previous year (34.2%) and a quarter of the rate at baseline in 2011. Sefton's rate is lowest in the North West, LCR and amongst statistical neighbours. These data also reflect a period of transition to the current provider, CGL. Following this numbers of people in treatment is approaching 2000 and has increased by 67%, and continuity of care is 80% - well above the Government target of 75% and performance in most other areas.
- **Smoking:** there are early signs of a possible divergent trend in smoking, distinguishing the professional and intermediate groups (continuing reductions) and the unemployed and routine and manual groups (steady or increasing). This is a concern for Sefton's health inequalities.

- **COVID-19 and cost of living**
  - Updated indicators discussed in **this report reflect data collected either during the later pandemic phase in 2021, or early post-pandemic period from 2022 through 2023.**
  - As discussed in earlier reports, pandemic disruption to usual ways of life, the delivery of health services, and people's behaviour in terms of seeking healthcare combined to cause distinct impacts on population health. A good example, is the marked reduction in smoking rates in

lower income groups during 2020, followed by a rebound to pre-pandemic rates by 2022.

- The unequal health and social impacts of the pandemic continue to be well documented. **The negative effects of high cost of living on health fundamentals such as adequate diet, social connection, and protection from cold will further tip the scales towards greater health inequality in Sefton**. A third strand of health risk also comes the rapidly growing likelihood of serious climate events.

- **Response**
  - **Public Health services have an important part to play in responding to and preventing high levels of population health need**. However, as the scale of socio-economic and other inequalities in health reveals, the fundamental causes of this need are found in the complex interaction of different **health determinants** across the life-course.
  - Updates in this report describe several examples of how the public health team and services are **enabling system improvements**, for example the current mapping and review of Sefton's weight management service offer against evidence-based recommendations.
  - Sefton's **Combatting Drugs Partnership** has now been in place for one year. A **notable success** has been the two thirds increase in the overall number of people in drug treatment (1912), recent improvements in **drug treatment** outcomes (yet to appear in PHOF data), and the exceptionally strong record of continuity of care provided by the current substance use service provider, CGL.
  - A wide range of activity is also taking place to improve community access to oral, long-acting, and emergency forms of contraception. Public health officers are also contributing to a **teenage pregnancy** self-assessment exercise with other local authorities to identify further improvements.

Recommendation

The Cabinet Member for Health and Wellbeing is recommended to,

1) Note and comment on the information contained in this report, which will also be presented in full at the meeting of the Overview and Scrutiny Committee (Adult Social Care and Health) on 23rd January 2024.

3. Overview

Appendix A contains the Public Health Performance Framework dashboard as at August 2023.

Six of the 11 updated indicators have a green direction of travel arrow, showing the current figure has improved when compared to the previous figure

(prevalence of smoking and excess weight in adults). **Five indicators have red arrows, showing that the latest data is less favourable** compared to the previous value (rates of conceptions in under 18s, successful drug treatment outcomes, and physically active/inactive adults).

It is important to note that the arrow symbol encompasses both chance variation – expected ups and downs, as well as larger ('statistically significant') changes. These significant changes are more likely to be caused by a consistent change in one or more influences upon an indicator.

Seven out of the 23 indicators lack trend data; however, this does not affect any of the updated indicators (shaded purple), which are the focus in this report. For the alcohol-related hospital admissions indicator this is because it is a newly introduced measure for this outcome and so comparable past data is not available. The change arrow is also missing for the 'life is worthwhile' dimension of wellbeing because numbers were too small to allow for a reliable year to year comparison; and for the five mortality indicators because past figures are being updated to take account of Census 2021 population data.

The North West RAG-rated rankings are split - four are green, showing a relative improvement (smoking, excess weight in adults) **and five red**, showing a relative deterioration (conceptions under 18, physical activity and successful drug treatment outcomes).

In comparison to **Sefton's five closest statistical neighbours**, Sefton has maintained its position in the rankings (yellow) for smoking and physical inactivity indicators but ranked position has worsened (red) for conceptions under 18, physical activity, and excess weight.

3.1 Smoking Prevalence

Issue description

At both a population and individual level, **smoking (including passive smoking) is the single most harmful health behaviour**. In Sefton, past and present smoking habits still account for around 51% of all deaths due to chronic respiratory disease, 31% deaths from cancer,15% of deaths from cardiovascular disease, and 11% of deaths from neurological disease. **Differences in smoking rates across the population are the number one driver of social inequalities in healthy life expectancy and life expectancy**. People with smoking-related illness are more likely to require formal and informal care several years before non-smokers and parental tobacco dependence is a risk factor for continuing child poverty.

Changes in the law have brought smoking rates down in England to their lowest recorded level. The Government has previously set out its intention to incorporate tobacco control policy into a new Major Conditions strategy[3], rather than produce a

[3] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)

standalone update to the most recent Smokefree Generation Plan[4]. Proposed measures on smoking, youth vaping, and enforcement are set out in a new policy paper[5] accompanied by a live consultation.[6]

Key points

- The adult smoking rate in 2021 is given by the PHOF indicator C18 'Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)'. The data comes from a telephone survey undertaken as part of the Annual Population Survey.
- **Sefton has achieved the Government's target of reducing adult smoking prevalence to under 12.0% by 2022.**
- The proportion of adults who self-reported currently smoking in 2022 in Sefton was **7.9%. This rate is similar to 2020 (7.7%) and a notable reduction from 10.0% recorded mid-pandemic in 2021.**
- **Sefton local authority area has the lowest adult smoking prevalence in the North West region (range: 7.9% to 20.2%) and from amongst close statistical neighbours.**
- Sefton's reducing trend stands out because it has **fallen more quickly than in England**. Contributory factors may be the relatively larger proportion of people aged over 60 in Sefton – smoking prevalence is currently highest in the 25-29 years age group and reduces with increasing age, and the continuing public health strategy of prioritising more intensive smoking cessation support for young people and more disadvantaged groups.
- There are three inequalities breakdowns available for this indicator at a Sefton level – by sex, by socio-economic group (18-64 years), and housing tenure type.
- In 2022, **10.1% of adult males are estimated to smoke compared to 5.9% of females.** This difference may be exaggerated slightly by the noticeably larger number of females aged over 60. While female smoking prevalence has shown year on year reductions, prevalence for males has fluctuated around the current level since 2019.
- **Just under one in five people who rent their accommodation from a housing association or the council currently smoke.** The figure is just over one in five people who rent privately. **This compares to one in 17 people who have a mortgage on their home and one in 25 of those who own their home outright.** This striking disparity likely reflects both age and socio-economic differences across tenure types.
- There were small falls in smoking across all tenure types, but the largest relative reductions were in the mortgage holder and outright owner group. **Conceivably this could reflect differing capacities to make healthy changes post-Covid. This breakdown is likely to reflect cost of living pressures in future updates**.

[4] Smoke-free generation: tobacco control plan for England - GOV.UK (www.gov.uk)
[5] Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk)
[6] Creating a smokefree generation and tackling youth vaping - GOV.UK (www.gov.uk)

- The socio-economic breakdown for Sefton shows that **intermediate and managerial and professional occupational groups have the lowest smoking rates in the 18 to 64 age group**, 3.9% and 4.8% respectively. The intermediate group shows a one-year spike in smoking rates up to 14.7% in 2021, possibly reflecting the effect of psycho-social stressors during the pandemic.
- In contrast, smoking rates amongst the **long-term unemployed and never worked** groups increased from 7.9% in 2021 (after a long period of steadily falling rates) to 13.5% in 2022. There has been a levelling off in smoking rates in the lower income **routine and manual occupational group** beginning in 2017, and briefly interrupted by a large drop in 2020. **The 2022 smoking rate in this group is 17.3%, which is 3.5 times the rate in the highest income group**.
- **Signs of a possible divergent trend in smoking,** distinguishing the professional and intermediate groups (continuing reductions) and the unemployed and routine and manual groups (steady or increasing) **is a concern for Sefton's health inequalities**. The **new smoking cessation service,** which is currently being commissioned **will continue to address this through the design and delivery of a range of evidence-based support**.

Action and progress update

- The process of recommissioning Sefton's smoking cessation service as part of Living Well Sefton continues.
- An application and proposal to participate in the Government's Swap to Stop intervention is to be submitted. Swap to Stop will encourage current smokers to swap cigarettes for a free trial of e-cigarettes (the scheme does not permit disposable vapes).
- The stop smoking service is now receiving referrals through the Targeted Lung Health Check programme delivered by NHS partners which identifies people aged 55 to 74 who have ever smoked and are registered with GPs in South Sefton.
- The stop smoking service has developed an offer for young people with a focus on vaping cessation as well as smoking. An education programme delivering workshops and assemblies has been delivered in secondary schools and community youth groups, with 16 assemblies being delivered and 14 workshops in the last quarter with a total of 2849 young people engaged in this delivery.
- Demand for support in primary schools was also requested and an initial assembly for years 4,5 and 6 was completed in one school, followed by two further workshops for year 5. Following this pilot, a delivery package is now on offer to all primary schools across Sefton.

3.2 Smoking at the time of delivery (smoking in pregnancy)

Issue description

Smoking in pregnancy is a common cause of pregnancy and post-natal complications associated with low birth weight. Passive smoking in infancy is a leading risk factor in sudden infant deaths.

Smoking in pregnancy shows a strong association with younger age and socio-economic and educational disadvantage. Risk also increases with second or subsequent pregnancy, white ethnicity, and for women with complex social needs.

The social gradient for women who are identified as continuing to smoke at the end of their pregnancy is less steep, compared to in early pregnancy. This shows that Maternity and Stop smoking services are delivering effective support for women who experience multiple challenges. But it also underlines the necessity of building in wider psycho-social support in the post-natal period to improve mental wellbeing and lower risk of relapse or continuation of smoking.

The Government had previously set a target to reduce **smoking in pregnancy to 6% or less by the end of 2022.**

The NHS Long Term Plan states that all pregnant smokers should receive specialist opt-out support as part of a new maternity-led pathway and wider investment into NHS-funded tobacco treatment services in hospitals. Furthermore, up to £10 million will be provided in England over two years to offer financial incentives to encourage all pregnant smokers to quit. Vouchers will be issued at specified time points during the quit journey, contingent on ongoing engagement with behavioural support and evidence of smokefree status. The maximum value is £400.

Key points

- In 2021/22 **9.0% (n=220) of pregnant women in Sefton were identified as continuing to smoke at time of delivery.** This compares to 10.0% in 2020/21; 10.6% in the North West (Sefton's rate rank's 6th lowest), and 9.1% in England. Sefton is now in line with the national average rate for the third successive year.
- The latest updated data for the former CCG areas of South Sefton and Southport and Formby dates from April 2022 through March 2023 and show further reductions: **South Sefton 9.1% and Southport and Formby 7.4%.** The dark blue trendline for South Sefton in the framework (Appendix A) illustrates the impressive decrease in smoking throughout pregnancy that has been achieved.
- Although Sefton has not achieved the target reduction to 6% in 2022 the **external inequality in smoking in pregnancy has been closed** and the internal difference in smoking in pregnancy rates in Sefton continues to narrow. **Compared to similar areas, and former CCG geographies in the North West, Sefton continues amongst the best performing areas on this indicator.**

Action and progress update

- Southport and Ormskirk Hospital Maternity Unit has a dedicated midwife who provides targeted support to pregnant women throughout their antenatal period. It is worth noting that some of these women give birth at Liverpool Women's Hospital and so there is also positive impact on SATOD data for South Sefton; similarly, some women who give birth in Southport and Ormskirk Hospital, have received their antenatal care, from another team, who may not provide the same level of support for pregnant women.
- There have been several changes and improvements in practice:
    - CO monitoring has now fully recommenced at the hospitals. This ensures an objective measure of women's smoking status, rather than self-report.
    - Guidelines were updated at Ormskirk hospital in October to include CO and smoking status at every antenatal contact with all pregnant women.
    - The NHS long-term plan model for smoking in pregnancy, is being implemented in Southport and Ormskirk and the current evidence-based pathway is being amended.
    - There has been an increase in referrals to the smoking in pregnancy advisor from Liverpool Women's Hospital. This is attributed to weekly catch ups between the service and the hospital's specialist midwife.

3.3 Under 18 conceptions

Issue description

Most teenage pregnancies are unplanned and around half end in an abortion. For most young people who become parents in their teenage years, bringing up a child is extremely difficult and typically has a negative impact on the life chances and future health and wellbeing of the parent and the child. It is imperative to try and reduce the number of unplanned teenage pregnancies and offer as much support as possible for any individuals who find themselves in this situation.

Research has also shown that the youngest mothers are more likely to be lone parents, to experience mental illness, and to live in poverty. Infant mortality is also significantly higher. Smoking during and after pregnancy is an important risk in this group. Empowering women and men of all ages to take control of their own reproductive and sexual health and choices is a core aim of sexual health services.

Key points

- In December 2021, the rate of conceptions in women under the age of 18 increased slightly to 15.7/1000 (n=69) from 13.8/1000 at the end of 2020. This pattern is likely to reflect factors associated with the pandemic, which temporarily suppressed the conception rate in 2020. Nevertheless, **Sefton's rate remains in line with England and ranks lowest in LCR**.

- Sefton's rate ranking has dropped slightly amongst statistical neighbours and local authorities in the North West. However, it is very important to recognise the expected degree of variation associated with the relatively small number of conceptions that give rise to the rates for each area.
- It is still unclear from this data what the **possible longer-term impacts of the pandemic, ongoing high cost of living, and higher prevalence of mental health need** amongst young people will be for the under 18 conception rate in Sefton. This will be important to understand as more quantitative and qualitative data becomes available.

Action and progress update

- During lockdowns Sefton Sexual Health clinics experienced reduced capacity, the Sexual Health Service has proposed plans to amend service delivery to increase access and improve capacity.
- Pharmacy emergency hormonal contraception provision has been recommissioned by the Sexual Health Service.
- Following the completion of the pilot for the continuation of oral contraception by community pharmacists, the pilot has been approved for national rollout. The Sexual Health Service is now discussing how this offer can be promoted and utilised as part of the wider sexual health offer.
- One Sefton pharmacy has been included in the national pilot for the initiation of oral contraception directly from a pharmacist without a prior prescription from a GP or the Sexual Health Service.
- Following a review of the fees structure for GPs delivering long-acting reversible contraception (LARC), the Sexual Health service has increased the fees paid to GP practices for the delivery of LARC. The service has also introduced a training offer to GP and non-GP clinicians in primary care. The aim of the interventions is to increase patient access to LARC and therefore improve delivery activity in primary care.
- The Sexual Health Commissioner and 0-19 Commissioner are attendees of the C&M Teenage Pregnancy Forum and are establishing a teenage pregnancy task and finish group to complete the teenage pregnancy prevention self-assessment to confirm current situation and identify any gaps.

3.4 Obesity in reception year

Issue description

Childhood obesity is likely to track into adulthood. In childhood, obese children may experience isolation and low self-esteem, which is damaging to present and future mental wellbeing. The incidence of Type 2 Diabetes is known to be increasing in children nationally. Previously, this condition which has obesity as its leading risk factor, was almost unheard in childhood. Latest national guidance recommends at least 60 minutes of moderate physical activity per day for children and young people.

The longer a person lives with obesity the greater their chances of developing complications such as elevated blood glucose and blood lipids, and high blood pressure. In adulthood, these are important causes of type 2 diabetes, and premature blood vessel disease affecting the heart and lungs, liver, kidneys and brain. Obesity is also a growing cause of cancer.

The Government has published 'Childhood obesity: a plan for action, chapters 1 and 2' and has set a goal of halving childhood obesity and reducing the gap in obesity between children from the most and least deprived areas by 2030. **In 2020, a further policy paper was published called, 'Tackling obesity: empowering adults and children to live healthier lives'.** This brought in legislation to require largescale restaurants, cafes and takeaways to use energy labelling on their menus and preventing retailers from offering promotional deals on the unhealthiest foods.

Nationally, the proportion of children who are obese is over twice as high in the most compared to the least deprived tenth of the population in reception. The social gradient remains **in year 6, but the prevalence of obesity is twice as high in this end-of- primary school age group compared to reception**. Health inequality in childhood excess weight has increased over time because of rising prevalence of obesity and severe obesity in children experiencing the highest levels of disadvantage. The rate of obesity is matched in boys and girls in reception but is slightly higher in boys in year 6.

In reception, obesity is most prevalent in children of Black African ethnicity and lowest in children of Chinese ethnicity (these groups are separated by an almost four-fold difference). White British children fall in the middle of this range. In year 6, this gap is halved because the rate of increase in obesity is faster in other ethnic groups than in the Black African Group. Taken together, these data illustrate the **powerful interactions between food poverty, food environments and 21st century food habits, and the importance of not depending on individualistic interventions to deliver high impact change**.

Key points

- The prevalence of obesity in **reception age** children is **11.3% in 2021/22 – effectively unchanged from the baseline measure of 11.4% in 2007/08**. The trend over this time is stable.
- In 2021/22 **Sefton is slightly, but statistically significantly higher than England (10.1%)**.
- Sefton ranks approximately in the middle of North West local authorities, but **continues to have the highest prevalence amongst statistical neighbours.**
- Only Trafford in the North West shows a sustained downward trend below the national average in recent years, with most local authorities in the region static, and some rising.

3.5 Obesity in year 6

Key points

- Trend from 2007/8 to 2021/22 shows that nationally, the percentage of children in year 6 who are overweight or obese has risen from 18.3% to 23.4%. **During this period the year 6 obesity rates in Sefton have closely tracked the national trend, rising from 17.3% to 23.3% in 2021/22.**
- **Over half of local authorities in the North West have year 6 reception rates that are above Sefton's. However, this is the case for only one of Sefton's five closest statistical neighbours.**
- **Over their primary school years the prevalence of obesity in the current year 6 cohort increased from around one in ten at reception to close to one in four.**
- Trafford and Stockport are notable for maintaining a trend below the national average over several years.

Action and progress update

- The Integrated Wellness Service for children 'Happy 'N' Heathy' is now operational as an integrated partnership and due to be launched publicly by summer 2023. It brings together all public health commissioned programmes, including the 0-19 Service, Kooth (mental health support), Active Sefton (physical activity, weight management and mental wellbeing provision), ABL Stop Smoking Service, CGL (substance use service) and sexual health. As part of this offer, training will be carried out with staff to increase their competence and confidence relating to public health messaging, including having the conversation around weight with families. Signposting across services should also mean that children, young people and families reach appropriate support for healthy weight.
- The children and family weight management service 'Move It' continues to be delivered. Due to increased demand, additional capacity is due to be added to the service to focus on children aged 0-5 years. 178 children and young people accessed the service in 2022/23, with 60% of those completing reducing weight and 68% reducing waist circumference.
- The universal programme for schools 'Active Schools', which delivers healthy lifestyle support, has delivered to 8,552 Primary School children in 2022/23.
- The 0-19 Service continue to promote messaging around healthy eating and physical activity as part of their routine contacts, signposting into support where necessary, in addition supporting young people that have concerns via the anonymous Chat Health Service.
- Delivered through the 0-19 Service, Sefton are participating in the research pilot study for 'Map Me', an intervention tool, which aims to improve parental acknowledgement and understanding of child overweight and obesity. As a result of greater understanding, the aim is to improve weight outcomes for children who are classified as being outside the desired weight range. The

pilot will be completed by the end of the summer. The pilot is being evaluated by Newcastle to ascertain whether the tool should be brought in as part of the National Child Measurement Programme (NCMP).

- Piloted in summer 2022 following NCMP results, the School Health Team began making follow up phone calls to parents and carers of children who received overweight or very overweight letters, offering them advice and support, and signposting into the MOVE IT Programme. This led to a significant increase in referrals to MOVE IT, and due the success has been mainstreamed as part of the 0-19 Service.
- As part of a 12-month pilot programme, 10 front line practitioners across the 0-19 Service, Active Sefton and Early Help are due to be trained in HENRY, a weight management programme for families with 0–5-year-olds. It will allow them to deliver the HENRY course, whilst increasing competence and confidence to talk about weight.
- Under the Obesity Action Plan and its life course approach, a 'Start Well' Obesity sub-group has been developed. With representatives across the children's partnership, the group intend to push forward the obesity agenda and actions to improve it locally.
- All Active Sefton facilities and services are back up and running, including all physical activity support services for children and young people (Active Schools, MOVE IT, the 121 Programme, Be Active and Park Nights).
- Linked to healthy weight, Public Health continue to support the breast feeding offer delivered through Mersey Care, in addition to updating Sefton Councils breast feeding policy to ensure breast feeding mothers can continue after returning to work.

3.6 Excess weight in adults

Issue description

At a population level, risk of chronic long-term conditions increases with body mass index (weight for height) of 25kg/m^2 and above. Carrying excess body fat increases the risk of type 2 diabetes, high blood pressure, vascular disease, many cancers, musculoskeletal problems and complications in pregnancy. **In the UK, overweight and obesity are fast gaining on smoking as a leading preventable cause of life-limiting long-term conditions**. The data for adults comes from a large representative sample of people who are asked to self-report their weight in the Active Lives Survey each year.

Population level predictors of adult overweight and obesity are lower educational attainment, being male, being of White or Black ethnicity, being aged 45 or above (highest prevalence of excess weight is in the 55-64 age group) and having a disability.

Looking at national data, the socio-economic group with the lowest rate of excess weight is the least deprived 10%, but overweight and obesity still affects six out of

ten. The group with the highest rate of excess weight is found in the population living in the most deprived 10% of areas – approaching 7 out of ten adults are overweight or obese. **This high prevalence across the socio-economic gradient shows the influence of pervasive changes to our food environment and way of life** that impact everyone – widely available, high-energy foods, rising food cost and insecurity, more sedentary lifestyle, and more eating away from home. It is now widely accepted that a **whole system approach** which uses the full range of national and local policy levers to create a less 'obesogenic' environment, as well as evidence-based services and targeted interventions is the only approach capable of delivering change on the scale that is now required.

Key points

- **The excess weight rate (% overweight or obese) for adults in Sefton in 2021/22 is 71.2%** - similar to 2020/21 (71.5%) and up from 66.3% in 2019/20. This level of increase has been seen previously in recent years, but it continues to **place Sefton's rate significantly higher than the national average (63.8%).**
- The national trend shows a gradual increase (0.5 -1.0% per year) in the prevalence of excess weight.
- Sefton ranks **towards the higher end of rate rankings in the North West, LCR and compared to close statistical neighbours.**

Action and progress update

- The six-week weight management programme 'Weigh Forward', delivered by Active Sefton, continues to be delivered, in a group format, virtually and face to face.
- The Living Well Sefton Service are also delivering the Weigh Forward Programme, in addition to cook and eat sessions in the community.
- Under the Obesity Action Plan and its life course approach, 'Live Well' and 'Age Well' Obesity sub-groups have been developed, the Live Well group focusing on implementation of the Healthy weight Declaration and Age Well focusing on development of an adult weight management pathway. With representatives across the partnership, the groups intend to push forward the obesity agenda and actions to improve it locally.
- Separate to the above, meetings are also taking place with ICB colleagues regarding the adult weight management pathway and related commissioned services from tier one to four. A piece of work is also being completed by a Local Authority Public Health Registrar focusing on gaps in provision and best practice.

3.7 Physical activity in adults (active)

Issue description

Physical activity has wide-ranging benefits for cardiovascular health, mental health, and maximising functional independence throughout life. Current guidance is that adults should do at least 2.5 hours of moderate physical activity or 75 minutes of vigorous physical per week, include strength-building exercise on two days per week and avoid prolonged periods of sitting. As for excess weight, our way of life - transport options, leisure and recreation opportunities, access to open spaces, job role and employment all influence levels of physical activity. Participation in many recreational opportunities to exercise is favoured by higher household income.

Nationally, **predictors of being physically active include** being of White or Mixed ethnicity, being aged under 75, being male, living in an area of lower than average deprivation, not being disabled, being employed, particularly at a managerial level, and having a higher level of educational attainment.

Key points

- An increase from 61.3% in 2019/20 to 66.0% in 2020/21 is notable since it shows **an increase in physical activity during the pandemic**. This increase in the percentage of Sefton's population which is physically active has been **maintained in the latest data for 2021/22 at 65.9%, which is in line with the England figure (67.3%).**
- It is likely that different parts of the population have altered their physical activity in different ways and subject to different social and economic influences during this time. It is not possible to predict the impact on health inequalities with certainty, but it is probably the case that this change has increased or maintained health inequalities, given the associated demographic factors set out above.

3.8 Physical activity in adults (inactive)

Issue description

Physical inactivity is defined as engaging in less than 30 minutes of physical activity per week. Low activity is an independent risk factor for several long-term conditions. Low activity in Sefton is the fifth leading behavioural contributor to death and ill-health from common causes including cardiovascular disease, several cancers and osteoporosis. Low physical activity leads to changes in body composition that make it more difficult to maintain a healthy weight, muscular and skeletal strength and can limit functional independence.

National data for this indicator shows that prevalence of inactivity is higher in females, people aged 75 and over, people with a disability, people who are

unemployed or economically inactive, and people of Asian, Black, Chinese, and Other ethnicity. There is a strong education and socio-economic gradient, associating higher rates of physical inactivity with lower levels of qualifications, higher deprivation and lower paid occupations and economic inactivity.

Key points

- Sefton has tended to track alongside the national inactivity trend. However, there was a marked upturn from 22.1% in 2017/18 to 27.4% in 2019/20. In 2020/21 the proportion of the population estimated to be inactive returned to 24.2%, in line with the national average. **In the most recent data for 2021/22 inactivity in Sefton remains around this level (24.5%), while the England rate has reduced slightly to 22.3%.**
- High rates of obesity extending to children (one third) and young adults (half of 25-34 year-olds), in addition to rising food poverty linked to lower dietary quality all individually add to chronic disease risk; **epidemiological research shows these risk factors are not simply different sides of the same coin**, which is why integrated approaches to behavioural change remain central to the public health approach in Sefton.

Action and progress update

- All Active Sefton facilities and services continue to be delivered, including all physical activity support services for adults (GP Referral, Weigh Forward, Active Ageing) and universal physical activity access.
- Sefton continues to work with all LCR leads on the physical activity agenda.
- Sefton have procured a consultancy agency to develop a physical activity strategy. The consultation and engagement phase has now been completed and taken account of for the development of the strategy, which is now in draft.

3.9 Successful Completion of drug treatment (opiates), and didn't re-present within 6 months.

Issue description

The indicators for 'success' in opiate and non-opiate treatment programmes are defined as the **proportion of people in treatment who conclude their treatment and are not using these drugs, and who do not re-present over the next six months**. This definition may not always align with outcomes that service users and others value as successful.

The Office for Health Improvement and Disparities rationale for monitoring this indicator is that individuals achieving this outcome demonstrate a significant improvement in health and well-being, increased life expectancy, reduced blood-borne virus transmission, improved parenting skills and improved physical and

psychological health. Sustained recovery from addiction is also aligned with reduction in offending behaviour, with benefits for the wider community. UK Clinical Guidelines for Substance Use Treatment recognise that for older opiate users with other complex needs harm reduction rather than abstinence outcomes are often more appropriate.

It is important to understand this indicator within the local context. Sefton and neighbouring authorities work with an older cohort of opiate users, a legacy of more widespread heroin use on Merseyside in the 1980s and 1990s. Moreover, in Sefton a higher proportion of service users have other complex needs including mental health diagnosis. Sefton has significantly lower rates of unmet need in its opiate and crack cocaine using population and a history of strong continuing engagement with the substance use service.

Key points

- The latest data (appendix A) is for the for the year to December 2022 and shows **3.0% of service users in Sefton achieved this outcome** – significantly lower than the England average (5.0%). This is under half the success rate at baseline (8.6% in 2010/11).
- Sefton has dropped down 6 places in the North West rankings and has the lowest opiate treatment success rate from amongst five statistical neighbours and in LCR.
- It is important to note that in most areas numbers of successful treatment outcomes each year is small (e.g. 30 to 50 Sefton). This means that small year on year improvements or reductions in service outcomes can be obscured by random variation.
- An important relationship between higher socio-economic deprivation and lower treatment success rate is present. National data shows that the success rate for service users living in the 10% most affluent areas is almost twice that of those who live in the 10% most deprived.

3.10 Successful Completion of drug treatment (non-opiates), and didn't re-present within 6 months.

Issue description

Engaging with Sefton's substance use service offers a range of supportive and preventative benefits including access to testing and treatment for blood borne viruses, a route into mental health, welfare and employment support, and better relationships with family and other supporters.

Periods of chronic and acute stress and anxiety can trigger substance use or relapse. The continuing availability of substance use support services was recognised as a public health and NHS priority throughout the pandemic.

Key points

- Successful completion of drug treatment for non-opiate drug use **fell back to 17.6% in the year to December 2022. The current success rate is half of what it was in the previous year and a quarter of the rate at baseline in 2011.**
- The chart in appendix A shows that this indicator has z-score of -2.0, which indicates that **Sefton's rate at the end of 2022 was very significantly lower than the North West average** (31.6%). **A z-score like this is usually explained by a 'special cause' – an influence outside the previous day to day running of a service**, in this case the changeover to a new provider, CGL.
- Unsurprisingly, Sefton's rate qualifies as lowest in the North West, LCR and amongst statistical neighbours.
- National performance has stayed relatively steady since 2018. Just under half of North West local authorities have significantly better outcomes than England, and there is nearly a three-fold difference in the success rates of the top and bottom ranked authorities (Trafford, 51.0% vs Rochdale 18.6%).
- There is evidence at a national level that programmes to support the most disadvantaged service users have **disrupted expected social inequalities in this outcome to some extent**, in that the lowest success rates are often not associated with service users from this population group. However, the most recent data still places success rates for least disadvantaged services users well above other groups. This follows a striking increase in successful treatment outcomes amongst service users resident in the most affluent areas during the pandemic.

Action and progress update

- National Drug Treatment Monitoring System (NDTMS) as of August 2023 shows that Sefton opiate only successful completion rates have risen to 5% against an England average of 6%. This indicates signs of improvement in performance and the service will continue with a dedicated service action plan to further improve.
- As previously highlighted, since CGL took over as provider in Sefton the numbers in treatment have grown from 1152 to 1912 (a growth of 65.97%) which has taken capacity out of the system from successful completions. It also represents the best performing service in the country for increasing numbers in treatment a major current focus for OHID.
- During this time period CGL Sefton has also achieved 80% continuity of care compared to a national average of 44% and again above OHID target of 75%. Sefton is the 2nd highest performing in the country for this measure.
- Successful completions which do not represent within 6 months is a key focus and there is a service action plan in place to continue to improve performance.

3.11 Alcohol-related hospital admissions

Issue description

Harmful drinking is associated with a range of physical, mental and societal problems, including alcohol-related liver disease; many cancers; long-term mental health conditions; suicidality and self-harm; anti-social and criminal behaviour, and abusive relationships. **Harmful use of alcohol comes at a high cost to individuals, personal relationships, and community wellbeing**.

Compared to other common behavioural risk factors alcohol makes a **big contribution to years of life and productivity lost** because for the most dependent alcohol users serious premature illness and death arise earlier in the life course, usually in people of working age**.** In the remainder of the population, harm to physical and mental health due to alcohol is widespread.

This indicator gives the rate of admissions to hospital for which the main diagnosis is an alcohol-related condition. The number per 100 000 is standardised (adjusted to take account of differences in the age profile of local authority populations).

Key Points

- **The components that make up this indicator have been revised,** so the current rate of 598.0 per 100 000 in 2021/22 is also the baseline figure.
- **Sefton's admission rate is one fifth higher than the national average, which is a statistically significant difference.** This is also the case for half of the local authorities in the North West.
- **Sefton's rate ranks fourth highest in the North West, behind Blackpool, Wirral and Liverpool and above St. Helens and Knowsley,** but sits in the middle of admission rates among statistical neighbours.
- The previous version of this indicator had shown a faster than average reduction in Sefton's alcohol-related admission rates from 2019/20. **However, in 2020/21 the validity of the indicator as a reflection of alcohol-related need in the population is undermined by changes to hospital admissions linked to the pandemic.** In fact, mortality from alcohol-related liver disease rose markedly during 2020/21.
- As expected, national data shows that admission rates are 42% higher in the most disadvantaged tenth of the population compared to the least disadvantaged tenth. The group with the highest admission rate is the second most deprived tenth of the population.
- In Sefton, **admission rates are two and a half times higher in males** compared to females. Compared to the national picture, admission rates for females are similar, but Sefton's admission rate amongst males is one third higher compared to the national average.
- **Sefton continues to show a distinct rising trend in admission rates in under 18s, most notably amongst females.** In Sefton, there is a two-fold higher admission rate for females aged under 18. In England, female

admission rates are 50% higher in this age group, but the trend is a gradual decrease for both sexes.

Action and progress update

- The Sefton Council alcohol lead continues to participate in the multi-agency Optimisation Group, alongside representatives of the Integrated Commissioning Board, Clinical providers, CGL, Hospital Alcohol Care Teams, and Primary Care clinicians to review. The group's current priority is a review of the alcohol pathway, which is being conducted to identify opportunities to avoid unplanned hospital admissions and preventable readmissions.

3.12 NHS Health Checks (percentage of eligible population invited to screening)

3.13 NHS Health Checks (percentage of eligible population receiving screening)

Issue description

The NHS Health Check aims to detect and prevent early metabolic changes (high blood pressure, raised blood glucose and lipids) that increase risk of premature blood vessel disease and type two diabetes in people aged 40 to 74 These risks are well known targets for primary or secondary prevention advice and intervention, e.g., weight management, alcohol reduction, stopping smoking, increased exercise.

Local authorities are under a legal duty to make arrangements to provide the NHS Health Check to 100% of their eligible population over five years and to demonstrate continuous improvement in uptake of the Health Check offer.

This indicator is accompanied by **note b in the framework**, 'Sefton has adopted a new delivery model for its Health Check programme. Rankings and z-scores do not provide meaningful comparisons for this indicator and have not been calculated.'

Key points

- The indicators presented in appendix A give a quarter 1 comparison for 2023/24 and 2022/23 for the percentage of the eligible population who were offered screening in this period (0.5% up from 0.1%) and the percentage of the eligible population who received screening (0.4% up from 0.1%).
- **The PHOF provides cumulative outcomes for the last five-year cycle (2018/19 to 2022/23).** During these years, the proportion of the national eligible population which was offered a health check was 64.7%. In the North West the average was significantly higher – 84.9%. In Sefton the proportion was 3.0%.
- In the same period the proportion of the national eligible population which received a health check was 42.3%. In the North West the average was significantly lower – 38.1%. In Sefton the proportion of people offered a

check who went on to receive it was the highest in the North West (80.5%), albeit the total number of health checks was by far the lowest amounting to 2.4% of those eligible across the five years (compares to 27.4% in England and 32.3% in the North West).

Action and progress update

- There is a continuing need to increase identification of people in Sefton with cardio-vascular disease risk factors. This follows a significant reduction in case finding through the pandemic.
- The NHS Health Checks offer is currently under review in Sefton. Options for delivery are being developed with the support of OHID. The new offer will also seek to accommodate recommendations of the National review of the NHS Health Check Programme.
- Work is underway with the key stakeholders with a view to commissioning a GP based delivery route.

3.14 Mental health and wellbeing

Issue description

Several research studies measured changes in mental health during the pandemic and showed that population wellbeing fluctuated with waves of infection and restrictions. Higher risk of poor mental wellbeing was found amongst people with a pre-existing mental health or physical health condition. Being young, female, living alone, being unemployed or on a low income, and living in an area with fewer health-promoting resources, like green space were all associated with higher rates of mental distress. **Supporting population mental wellbeing in the context of ongoing cost of living pressures is one of the biggest population health challenges**.

The impact of unidentified and untreated mental health disorders can cause significant health impacts across the life course; early intervention can prevent problems escalating and brings major societal benefits. Evidence also shows that mental distress contributes to adoption of risk-taking behaviours and unhealthy coping strategies, e.g., substance use and gambling, which can introduce lifelong impacts on health and life chances. **Mental health problems have associations with other behaviours that pose a risk to health**, such as smoking, harmful alcohol use, risky sexual behaviour, and disordered eating.

The socio-economic context of people's lives will continue to be an important determinant of wellbeing. There is **constant interaction between how we feel emotionally and our physical health**. For example, financial or relationship stress presents practical and motivational barriers to making healthy choices, whilst living with a long-term health problem can be isolating and reduce social wellbeing. **Population health interventions, which recognise and act on both sides of this relationship have added value.**

Population wellbeing statistics presented in the PHOF are obtained by national **self-report survey** from a sample of Sefton's population. Previous disruption to the

survey in Sefton and elsewhere means that previous rankings could not be calculated in the low satisfaction and low wellbeing dimensions of wellbeing. In contrast to 2020/21, latest data for 2021/22 is provided for all four dimensions of wellbeing: life satisfaction, life is worthwhile, feeling happy, feeling anxious.

Key points

- At a national level, there was an increase in the percentage of people who reported feeling low satisfaction, low sense of life as worthwhile, low happiness and high anxiety at the height of the pandemic in 2020/21. This dropped back to just above pre-pandemic levels in 2021/22.
- Sefton follows this trend, and current figures are non-significantly above the national average.
- The survey estimates that nearly a quarter of Sefton's population (**22.6%) would have reported high anxiety**. The prevalence of this experience is high, but in context only five local authorities in the North West, and none in the statistical neighbour group reported a lower rate.
- **One in ten self-reported feeling unhappy (9.5%)**.
- **One in sixteen self-reported low satisfaction with life (6.2%)**,
- **One in twenty reported low feelings that life is worthwhile (4.8%)**

Action and progress update

The 121 Programme continues to be delivered both in the community and secondary schools, with the latter now mainstreamed and aimed at young people aged 11-19 and focusing on improving their physical and mental wellbeing. They are assigned a mentor who meets with them for an hour each week for between 6-12 weeks. Using activity and/or sports together with their mentor, the young person works towards gaining confidence, self-esteem and improved mental well-being. In 2022/23, 350 children and young people accessed the service, with 85% showing an improvement in mental wellbeing, as measured through the WEMWEB tool.

Sefton Place has agreed to recommission the Kooth wellbeing service as it has had favourable reported outcomes and a reasonable level of activity. Plans are in place as to how to better promote the service to our users with the education and local 0-19 sectors.

The "We're Here" campaign officially launches across Sefton via a roadshow across directly to local residents in their communities. An advertising company was commissioned including promotional staff who distributed stickers and posters for local businesses across the borough to display.

On the launch day there was a team supporting this process who travelled across the borough to promote the campaign including representation from the Sefton Public Health team, Sefton Council comms, the Crisis Café, Seans Place, Parenting 2000 and Sefton CVS. The team were accompanied by a digital advertising van and stopped off at 5 locations to give out business cards and chat to members of the public about the campaign and offer reassurance that help is available for anyone in need.

The locations visited were

- Bootle Oriel Road Station
- The Strand shopping Centre Bootle
- Waterloo Station
- The Hair Project, Southport
- Southport train station

The campaign is now visible across the borough with bus advertising, digital retail displays and kiosk advertising across Sefton that will continue to be displayed until at least mid-October aligning with both World Mental Health Day and World Suicide Prevention Day. The social media, and digital radio campaigns will run alongside this and beyond. An additional highlight of the launch day was the Radio City tower being lit in Green to celebrate the launch of the We're Here Campaign.

3.15 Suicide

Issue description

Suicide is a rare but devastating event. Traumatising whole population events such as war can increase suicide risk in relevant age groups for years to come. Aside from the impact of adverse events at a national scale, suicide has been shown to be linked to one or more individual triggers in the form of loss, e.g., loss of health or independence, relationship and support, role or identity e.g., partner, parent, professional, status and community standing, or loss of hope/'no way out'. Lack of support and substance use can heighten risk and trigger suicide attempts.

There is a clear socio-economic gradient reflected in national data, so that the rate of death by suicide is twice as high in populations in most compared to least deprived communities. This pattern of mortality from suicide and undetermined injury contributes to inequalities in life expectancy, particularly in males. **These common themes and risk groups help to underpin a well-developed evidence-base, covering a wide range of interventions that can effectively reduce the suicide rate**.

Key points

- Suicide rate is calculated as a rolling three-yearly average per 100 000, which is adjusted to take account of age differences across populations.
- In 2019-21 there were 71 deaths from suicide in Sefton, giving a **rate of 10.0 per 100 000, which is in line with the England average (10.4 per 100 000).**
- As elsewhere, the **rate in males is around three times higher than for females**.
- The national rate has varied very little over the past 20 years. Sefton's rate briefly rose significantly above the England average in the middle of the last decade. **However, rolling averages then reduced over the past 5 years, registering a small increase in these most recent figures for 2019-21.**

Action and progress update

- Sefton continues to engage with regional and national data collection, and surveillance through the annual suicide audit.
- An evidence and intelligence-led approach to suicide prevention has led to greater cross-working around the domestic abuse agenda.
- Business Intelligence conducted a deep dive into our local self-harm data after uncertainty regarding its true rate. This has been presented to the Emotional Health and Wellbeing Board and self-harm has since been added to the local Sefton Suicide Prevention Action Plan and Suicide Prevention Board as a standing agenda item.
- The Ripple tool has been presented to colleagues in education across the borough as software to prevent harmful material relating to suicide methods and self-harm behaviours for young people.

3.15 Mortality from causes considered preventable

Issue description

Apart from the very first months of life, **the number of deaths per head of population increases in step with rising age**.

The preventable mortality rate is an important public health indicator because it focuses on those deaths that are largely responsible for inequalities in life expectancy and healthy life expectancy. Leading causes of death are largely the same as those shown in the circle diagram (blood vessel disease, lung disease and cancer) but **happen earlier in life.** Mortality from causes considered preventable is **defined as** the number of preventable deaths in people aged under 75 per 100 000 population, adjusted to take account of differing age profiles of local authority areas. Cause of death is classified as preventable if all or most deaths could be prevented by primary public health interventions targeting diet and weight, exercise, and substance use (tobacco, alcohol, and drugs).

Having multiple behavioural risks is strongly associated with social, economic and environmental **deprivation**. **Psycho-social risk factors** e.g., chronic stress, past trauma, high uncertainty and low control over life's events and choices favour development of health-risking behaviours. These challenges also make it harder to start and maintain positive changes, and to access and benefit from medical and other individual interventions.

Large differences in healthy life expectancy and premature death rates are further **rooted in underlying social determinants**: level of education and training, job and housing security, opportunities for health in the built and commercial environment, the strength of community support, and accessibility of quality health and care services.

The **cost of health inequality** falls on individuals and society and is counted in lost potential, earnings, education, and healthy years of life. Health and Care services remain under-resourced in the face of large-scale, complex population health needs. **Health inequality is one of the main reasons why the Health and Care System is not operating on a sustainable footing.**

Key points

- As noted in the framework under **noted, 'data is only available for 2021, historical data will be re-calculated and published once updated populations for mid 2012 to 2020 based on the Census 2021 become available.'**
- In 2021, as for the last several years, the preventable mortality rate in Sefton is **significantly higher than for England** (590 deaths, 213.3 per 100 000 vs 183.2 per 100 000).
- **Most local authorities in the North West have higher rates for this indicator** and **Sefton also has the lowest rate in LCR**. By contrast, most of Sefton's close statistical neighbours have lower rates of preventable mortality.
- **Preventable mortality is twice as high in males compared to females**. This probably reflects historic differences in smoking, alcohol use, occupational risks, injury and suicide.
- The **difference in preventable mortality rates at extreme ends of the socio-economic scale in Sefton is likely to be two-fold or higher** – driven by earlier onset and a higher risk of developing more than one life-limiting condition.
- **Prevalence of obesity risks rising rates of preventable premature mortality in coming years**

3.16 Under 75 cardiovascular mortality

Issue description

This indicator captures premature death from heart disease and stroke. Change over time reflects the impact of primary prevention (not smoking, physical activity, healthy diet and weight, alcohol within recommended limits, clean air, warm housing) as well as secondary prevention (medical and behavioural interventions to lower risk from hypertension, raised blood glucose and blood lipids) and tertiary prevention (medical treatment to prolong life and quality of life after a cardiovascular event).

Key points

- In 2021, there were 221 deaths in Sefton residents aged under 75 due to cardiovascular disease. **The rate is similar to England** (80.2 per 100 000 vs 76.0 per 100 000).
- **Most local authorities in the North West have higher rates than Sefton**, and in LCR only Wirral has a slightly lower rate. **Most of Sefton's close**

statistical neighbours, like Wirral, have a lower rate of premature mortality from cardiovascular disease.

- The comments above about sex and socio-economic inequalities in preventable premature mortality apply equally to premature deaths from cardiovascular disease.
- Life-course interventions that will ultimately narrow this gap will not play out fully for some time.

3.17 Under 75 cancer mortality

Issue description

Cancer is the leading cause of death in people aged under 75. This indicator captures change in population exposure to preventable risk factors, as well as other influences on survival such as stage of detection and improvements in treatments.

Around 40% of cancers are substantially attributable to preventable risks – from smoking, alcohol, diet, activity and weight and sun exposure.

Key points

- There were 387 deaths from cancer in individuals aged under 75 in Sefton in 2021.
- **Sefton's rate is significantly higher than the England average** (135.1 per 100 000 vs 121.5 per 100 000), and Sefton ranks towards the middle of the range of values in the North West. Amongst close statistical neighbours, Wirral has the highest rate, followed by Sefton.
- **Males have a higher rate than females, but the difference is less than for cardiovascular mortality** and liver disease.
- Based on national health inequalities for this indicator, rates of **premature death from cancer are likely to be at least 50% higher in Sefton's most deprived communities** in comparison with Sefton's least deprived communities.
- It is likely that this indicator reflects some indirect mortality impacts from the Coronavirus pandemic and will show more influence from high prevalence obesity longer-term.

3.18 Under 75 liver disease

Issue description

Almost all liver disease is preventable, caused by alcohol, obesity and blood borne hepatic viruses. Death from liver disease usually happens in people of working age. **Liver disease is the leading cause of death in 35-49 year olds.**

Key points

- In 2021, there were 83 deaths from liver disease in residents aged under 75.
- Like most North West local authorities, **Sefton's rate of premature liver disease is significantly above the England average** (30.5 per 100 000 vs 21.2 per 100 000). Nine local authorities including Wirral have lower rates than Sefton. **However, Sefton has the highest rate amongst close statistical neighbours.**
- The rate of premature death from liver disease in males is approaching twice that in females.
- In England, **there is a step-wise increase in rates from least to most deprived populations. The overall difference is two-fold**, and the inequality in premature liver disease mortality is expected to be at least this large in Sefton.
- **The faster rate of increase in overweight and obesity in females and possibly also changes to patterns of alcohol use in females may see the gender gap in liver disease mortality narrow in coming years**.
- It is likely that this indicator reflects some indirect mortality impacts from the Coronavirus pandemic.

3.19 Under 75 respiratory disease

Issue description

The Global Burden of Disease Study latest update estimates that in Sefton, in 2019, around two thirds of premature deaths caused by chronic respiratory conditions and respiratory infections were caused by known risk factors, of which tobacco (49%), cold (22%), occupational exposure (11%), particulate air pollution (8%), and other preventable causes (10%).

Key points

- In 2021, there were 102 premature deaths from chronic respiratory disease in Sefton.
- **Sefton's rate is significantly higher than England's rate (35.7 per 100 000** vs 26.5 per 100 000), but close to the North West average.
- Wirral has a higher rate of premature mortality from chronic respiratory disease, but **Sefton's other statistical neighbours have lower rates, similar to the national average.**
- The **premature mortality rate for males is around one third higher than for females**, which is similar to the pattern seen for cancer mortality, and less marked than the larger excess in male deaths noted for liver and cardiovascular disease.
- Data for England, show a large health inequality. **The rate of premature death in the most deprived ten per cent of the population approaches three times that in the least deprived ten per cent**. The inequality in Sefton

is likely to be at least this great. This **may reflect more recent socio-economic trends in smoking as well as occupational and air pollution exposures**.

- It is likely that this indicator may reflect some indirect mortality impacts from the Coronavirus pandemic.

Action and progress update

- The many service and population health programme updates in this report all contribute towards lowering future premature mortality.
- The 2022/23 Public Health Annual Report took an in-depth look at the topic of ageing in Sefton. Recommendations challenged readers and decision-makers to look afresh at the concepts and language that apply to senior residents, and to support seniors to shape the places they live and services they use. Accessible communication and mental wellbeing were also important themes reflected through research evidence and the words of seniors themselves.
- Momentum to gear-up local action on child poverty continues and a second event is planned for the end of June focusing on the Prospects theme. Sefton's work on Child Poverty has fed into an increasingly inter-connected array of work focused on healthy places. Abundant evidence shows that action on the social and wider determinants of health has the largest and most cost-effective impact on population health and inequalities.
- Senior members of the Public Health Team have continued to provide population health expertise towards development of Sefton Partnership's Place Plan.

3.20 Healthy Life Expectancy

Issue description

Healthy life expectancy at birth (HLE) is often described as the years a person can expect to live in good health. It is calculated using current mortality rates for different age groups and information about how people rate their health, taken from an annual survey. **Growing up and living in poverty** is associated with development of significant, long-term health problems soon after the age of 50, well before retirement age. At the extremes, life expectancy in Sefton's most disadvantaged neighbourhoods is only slightly higher than healthy life expectancy in the most prosperous areas.

The impact of excess mortality related to excess heat and cold and the as yet unknown additional impacts of the 'cost of living crisis' and seasonal flu, Coronavirus and other respiratory illness will begin to be reported in these 3-year rolling statistics one to two years from now. These risks to health are likely to disproportionately impact those with fewest protective factors to safeguard their health, stable or increasing gaps in life expectancy and possibly healthy life expectancy may be seen.

Key points

- **HLE for males**

  In 2018-2020, HLE for men is 63.6 years for males – a second small reduction since 2016-2018 (64.0 years). However overall, Sefton's HLE for males trend is in line with the national average (63.1 years). **Sefton is middle-ranked amongst statistical neighbours and fifth highest amongst the 23 local authorities in the North West.**

- National data comparing health life expectancy in males living in the most deprived neighbourhood's vs the least gives a range in of: 52.3 years to 70.5 years. This emphasises the scale of socially determined health inequality underneath the statistics for Sefton as a whole.
- The PHOF also records that Sefton ranks **highest in the North West for inequality *in total life expectancy at birth* in 2018-20 in males**, with a gap of 14.1 years separating males in the most and least deprived areas
- This gap has been increasing since 2013-15 because life expectancy in the least deprived part of the population has risen, levelling off in 2018-20, reflecting earliest impacts of Covid-19, whilst life expectancy in the most deprived part of the male population had already stalled at 72.2 years before the pandemic and fell to 70.5 years in 2018-20, reflecting the social gradient in Covid-19 deaths. Nationally, the life expectancy gap is stable and Sefton's recent upward break with the national trend is more marked than for most other North West local authorities.

- **HLE for females**

  In 2018-2020, HLE is 63.8 years, showing a continued rise from 61.5 years in 2015-17, and remaining in line with the national average after a small fall of 0.4 year in 2018-2020. **Sefton has the seventh highest female healthy life expectancy in the North West and ranks best amongst statistical neighbours.**

- As for males, the PHOF also records that Sefton ranks **highest in the North West for inequality in *total life expectancy at birth* in 2018-20 in females**, with a gap of 12.3 years separating females in the most and least deprived areas compared to the national average of 7.9 years.
- The widening gap in life expectancy at birth for females is driven by stability in the most deprived 10% with a slight fall in 2018-20 to 76.2 years, accompanied by a shallow rise amongst females from the least deprived 10%, falling by 1.3 years to 88.2 years in 2018-20, likely reflecting the strong positive association between age and mortality risk from Covid-19.
- National data comparing health life expectancy in males living in the most deprived neighbourhood's vs the least gives a range in HLE of 51.9 years to 70.7 years. This emphasises the scale of socially determined health inequality underneath the statistics for Sefton as a whole.

Action and progress update

Healthy life expectancy is a measure of good health and wellbeing in the population As a borough-wide indicator, HLE is less good at revealing the differences in healthy lifespan from place to place and person to person. Several recent developments have helped to highlight health inequality as a top priority for action in Sefton:

- Sefton's 2021 Public Health Annual Report took an in-depth look at the effects of the pandemic.
- Development of a new child poverty strategy
- Work is ongoing through the Integrated Care Partnership and Cheshire and Merseyside Integrated Care System to develop system-wide action on Marmot indicators of health inequality across the life-course.

5. Recommendation

The Cabinet Member for Health and Wellbeing is recommended to,

1) Note and comment on the information contained in this report, which will also be presented in full at the meeting of the Overview and Scrutiny Committee (Adult Social Care and Health) on 23rd January 2024.

Margaret Jones, Director of Public Health
Helen Armitage, Consultant in Public Health
Claire Brewer, Public Health Analyst

Appendix A

Public Health Performance Framework - August 2023

Indicator	Unit	Geography	Baseline	Previous	Latest	Dir of Travel	Prev. NW Rank	Latest NW Rank	Prev. SNG	Latest SNG Rank	LCR Compare	Trend	Z-score
Healthy Life Expectancy at Birth (Males)	Years	UTLA	62.5 2009-11	63.7 2017-19	63.6 2018-20	▼	6	5	1	3			0.82
Healthy Life Expectancy at Birth (Females)	Years	UTLA	63 2009-11	64.20 2017-19	63.80 2018-20	▼	6	7	1	1			0.65
Smoking prevalence	Percentage	LAD	18.6% 2011	10.0% 2021	7.9% 2022	▼	4	2	1	1			-1.55
Smoking at the time of delivery (South Sefton)	Percentage	CCG	20.4% 2013/14 Q1	9.5% 2021/22 Q1-4	9.1% 2022/23 Q1-4	▼	9	7	1	1			-0.48
Smoking at the time of delivery (Southport & Formby)	Percentage	CCG	11.7% 2013/14 Q1	8.1% 2021/22 Q1-4	7.4% 2022/23 Q1-4	▼	3	2	2	2			-1.12
Under-18 Teenage Conceptions	Rolling annual rate per 1000	LAD	33.5 1998	13.8 Dec-20	15.7 Dec-21	▲	7	11	2	4			-0.28
Obesity in reception year[a]	Percentage	LAD	11.4% 2007/08	11.0% 2018/19	11.3% 2021/22	▲	25	23	6	6			0.49
Obesity in year 6[a]	Percentage	LAD	17.3% 2007/08	21.4% 2018/19	23.3% 2021/22	▲	24	17	5	5			-0.14
Excess weight in adults	Percentage	LAD	68.4% 2015/16	71.5% 2020/21	71.2% 2021/22	▼	35	31	5	6			1.07
Physical activity in adults (active)	Percentage	LAD	66.4% 2015/16	66.0% 2020/21	65.9% 2021/22	▼	16	18	3	4			0.29
Physical activity in adults (inactive)	Percentage	LAD	23.8% 2015/16	24.2% 2020/21	24.5% 2021/22	▲	19	22	5	5			0.10
Successful Completion of drug treatment (opiates), and didn't re-present within 6 months	Percentage	LAD	8.6% Nov 10 - Oct 11	4.67% Jan21-Dec21	2.99% Jan 22-Dec22	▼	16	22	2	6			-1.32
Successful Completion of drug treatment (non-opiates), and didn't re-present within 6 months	Percentage	LAD	64.6% Nov 10 - Oct 11	34.18% Jan21-Dec21	17.62% Jan 22-Dec22	▼	15	23	4	6			-2.00
Alcohol-relat[illegible]tal admissions (narrow)	Directly Standardised Rate per 100,000	LAD	598.0 2021/22		598.0 2021/22			36		3			1.13
NHS Health C[illegible] of eligible population invited to screening)[b]	Percentage	LAD	6.1% 2011/12 Q1	0.1% 2022/23 Q1	0.5% 2023/24 Q1	▲							
NHS Health C[illegible] of eligible population receiving screening)[b]	Percentage	LAD	2.2% 2011/12 Q1	0.1% 2022/23 Q1	0.4% 2023/24 Q1	▲							
Self-reported [illegible]g (low satisfaction score)	Percentage	LAD	5.7% 2011/12	7.2% 2020/21	6.2% 2021/22	▼	c	18	3	4			0.35
Self-reported [illegible]g (low worthwhile score)	Percentage	LAD	4.0% 2012/13	c 2020/21	4.8% 2021/22		c	13	c	4			0.07
Self-reported [illegible]g (low happiness score)	Percentage	LAD	9.6% 2011/12	10.5% 2020/21	9.5% 2021/22	▼	8	13	4	3			0.05
Self-reported wellbeing (high anxiety score)	Percentage	LAD	22.0% 2011/12	26.0% 2020/21	22.6% 2021/22	▼	10	6	3	1			-0.55
Under 75 mortality from causes considered preventable[d]	Directly Standardised Rate per 100,000	LAD	213.3 2021		213.3 2021			19		5			-0.15
Under 75 cardiovascular mortality[d]	Directly Standardised Rate per 100,000	LAD	80.2 2021		80.2 2021			13		6			-0.58
Under 75 cancer mortality[d]	Directly Standardised Rate per 100,000	LAD	135.5 2021		135.5 2021			19		5			0.02
Under 75 liver disease mortality[d]	Directly Standardised Rate per 100,000	LAD	30.5 2021		30.5 2021			20		6			0.17
Under 75 respiratory disease mortality[d]	Directly Standardised Rate per 100,000	LAD	35.7 2021		35.7 2021			22		5			0.06
Suicide and undetermined injury mortality	Directly Standardised Rate per 100,000	LAD	12.7 2001-03	9 2018-20	10 2019-21	▲	7	9	1	1			-0.70

Key:

- ▲▼ Improvement in Sefton Data
- ▲▼ Sefton Data Worsened
- ◀▶ No change in Sefton Data

- Rank Worsened
- Rank Improved
- Rank Stayed the Same

- Sefton
- England

Liverpool City Region (LCR)
Halton
Liverpool
Sefton
St Helens
Wirral
Knowsley

Statistical Neighbour Group

LA	Former South Sefton CCG	Former Southport & Formby CCG
Wirral	South Tyneside	Fylde & Wyre
North Tyneside	St Helens	Nottingham & Nottinghamshire
Northumberland	Sunderland	Castle Point & Rochford
Southend-on-Sea	North East Lincolnshire	Hampshire, Southampton & Isle of Wight
Torbay	Halton	Devon
	Rotherham	North Tyneside

The z-score provides a measure of how Sefton deviates when compared with the rest of the the North West. A score of ±1 shows Sefton is significantly different to the North West average

Key Issues

- Childhood Obesity indicators have increased (particularly for Y6), although NW rankings have improved and Sefton's rates do not differ significantly to SNG authorities
- Successful completion of drug treatment (opiates and non-opiates) have decreased and Sefton's rankings have worsened. Sefton has the worst rates of successful completion in the Liverpool City Region.
- Sefton's Under 75 mortality rates for causes considered preventable, liver disease, cancer and respiratory disease are significantly higher than England averages. Sefton's rate of liver disease is the highest of it's statistical neighbours
- Sefton's rate of alcohol related hospital admissions is significantly higher the England and North West averages. Sefton has the 4th highest rate in the NorthWest, only lower than Blackpool, Wirral and Liverpool.
- Sefton's proportion of overweight and obese adults has decreased slightly since the previous time period and Sefton's NW ranking has improved. However, Sefton's SNG ranking has worsened and Sefton's percentage continues to be significantly higher than the England average and the 2nd highest rate of LCR authorities.

Potential issues

- HLE estimates have worsened since the previous time period. However they remain the highest across the LCR and are not significantly different to the England average
- Teenage conception rate has increased since the previous time period and Sefton's North West and SNG rankings have worsened. However it remains the lowest across the LCR.
- Sefton's North West ranking for Suicide rate has worsened, although Sefton's rate does not differ significantly to the national and regional averages or to those of LCR and SNG authorities
- Sefton's proportion of active/inactive adults and NW rankings have worsened compared to the previous time period. However, these indicators do not differ significantly to the England or NW averages.

Notes

a Based on child's postcode of residence and may differ to other estimates (e.g. those based on children attending Sefton schools)

b Sefton has adopted a new delivery model for its Health Check programme. Rankings and zscores do not provide meaningful comparisons for this indicator and have not been calculated

c Values cannot be calculated due to too few cases

d Data only available for 2021, historical data will be re-calculated and published once updated populations for mid 2012 to 2020 based on the Census 2021 become available

Appendix B

Background notes on population health indicators and interpretation

Public Health England put together the first Public Health Outcomes Framework (PHOF) in 2012, and it is reviewed and refreshed on a three-yearly basis.[7] Sefton Council Public Health team submitted a response to the most recent consultation in February, which is due to report its conclusions in the summer[8].

At present, the PHOF comprises 2 top level outcomes, 4 domains, 66 categories and 159 indicators, presented on an open-access, interactive website. The Adult Social Care and NHS Outcomes Frameworks and other intelligence resources, including the Joint Strategic Needs Assessment, offer other measures of Health, Care and Wellbeing need and status for Sefton's population.
PHOF indicators are used to,

- Assess progress against a range of comparator geographies,
- Make local authorities more transparent and accountable in the local system
- Assist prioritisation and programme planning

erpretation

ere are some important points to bear mind when interpreting these statistics:

- **There are numerous positive and negative influences that all feed into the final number that is reported for each indicator**. The amount of direct influence the Public Health team and wider Council has varies depending on the indicator, but there are always other determining factors.

    - An example of an indicator which is expected to directly reflect a Public Health commissioned service is Health Checks.
    - Many indicators are also influenced by services commissioned elsewhere, as well as wider social and environmental factors, for example childhood obesity, smoking in pregnancy, and alcohol-related hospital admissions.

[7] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[8] https://www.gov.uk/government/consultations/public-health-outcomes-framework-proposed-changes-2019-to-2020

- Some indicators are substantially determined by our wider physical and socio-economic environment, e.g. levels of physical activity, and measures of wellbeing. Such indicators will usually take much longer to change, but may reflect more immediate impacts from major changes to national policy, e.g. welfare reform

- **Differing timeframes.** Some indicators reflect events in the here and now, e.g. non-re-presentation for drug treatment, while some are a better reflection of past influences on health, for example healthy life expectancy and disease-specific mortality rates.

- **What goes into an indicator?**

  - All PHOF measures relate to the Sefton population or a sub-set of the population and are presented as rates or percentages to enable comparison. The term standardised rate is used when differences in the age profile between areas have been accounted for. Standardisation enables meaningful and fair comparison between areas.
  - However, it is important to recognise that some indicators are based on precise counts, e.g. death by suicide and others are estimated from surveys, e.g. excess weight in adults and measures of wellbeing.
  - Some indicators count separate events, but not necessarily separate people for example, admissions to hospital, so a more detailed investigation can be helpful to build a more complete picture

- **Evaluating differences across time and place**

  - All measures fluctuate over time, and often it is necessary to check back over several years to see a real pattern of improvement, for example conceptions in under 18s.
  - Indicators based on small number of events are more prone to show large increases and decreases. Often data is combined over two or three years to give a more accurate picture, e.g. death rates in under 75s
  - The red, yellow and green colour-coding in the PHOF shows where the difference between the Sefton and England figures is highly likely to be real and due to more than chance fluctuations (also referred to as 'statistically significant' or simply 'significant')
  - The z-score on the Performance Framework Dashboard shows whether difference between Sefton and other local authorities is in the North West is significant (positive figures indicate significantly better, and negative figures, significantly worse).
  - The Performance Dashboard also uses colour-coding to highlight whether Sefton has moved up, down or stayed the same in rankings for the North West and our Statistical Neighbour Group, compared to our previous rank. It is important to interpret this

alongside the direction of travel arrows and recognise that a change in rank is also a reflection of the amount and direction of change in the figures for other Local Authority areas.

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Public Health Performance Framework - August 2023

Indicator	Unit	Geography	Baseline	Previous	Latest	Dir of Travel	Prev. NW Rank	Latest NW Rank	Prev. SNG Rank	Latest SNG Rank	LCR Compare	Trend	Z-score
Healthy Life Expectancy at Birth (Males)	Years	UTLA	62.5 2009-11	63.7 2017-19	63.6 2018-20	▼	6	5	1	3			0.82
Healthy Life Expectancy at Birth (Females)	Years	UTLA	63 2009-11	64.20 2017-19	63.80 2018-20	▼	6	7	1	1			0.65
Smoking prevalence	Percentage	LAD	18.6% 2011	10.0% 2021	7.9% 2022	▼	4	2	1	1			-1.55
Smoking at the time of delivery (South Sefton)	Percentage	CCG	20.4% 2013/14 Q1	9.5% 2021/22 Q1-4	9.1% 2022/23 Q1-4	▼	9	7	1	1			-0.48
Smoking at the time of delivery (Southport & Formby)	Percentage	CCG	11.7% 2013/14 Q1	8.1% 2021/22 Q1-4	7.4% 2022/23 Q1-4	▼	3	2	2	2			-1.12
Under-18 Teenage Conceptions	Rolling annual rate per 1000	LAD	33.5 1998	13.8 Dec-20	15.7 Dec-21	▲	7	11	2	4			-0.28
Obesity in reception year[a]	Percentage	LAD	11.4% 2007/08	11.0% 2018/19	11.3% 2021/22	▲	25	23	6	6			0.49
Obesity in year 6[a]	Percentage	LAD	17.3% 2007/08	21.4% 2018/19	23.3% 2021/22	▲	24	17	5	5			-0.14
Excess weight in adults	Percentage	LAD	68.4% 2015/16	71.5% 2020/21	71.2% 2021/22	▼	35	31	5	6			1.07
Physical activity in adults (active)	Percentage	LAD	66.4% 2015/16	66.0% 2020/21	65.9% 2021/22	▼	16	18	3	4			0.29
Physical activity in adults (inactive)	Percentage	LAD	23.8% 2015/16	24.2% 2020/21	24.5% 2021/22	▲	19	22	5	5			0.10
Succ Completion of drug treatment (opiates), and didn't re-present within 6 months	Percentage	LAD	8.6% Nov 10 - Oct 11	4.67% Jan21-Dec21	2.99% Jan 22-Dec22	▼	16	22	2	6			-1.32
Succ Completion of drug treatment (non-opiates), and didn't re-present within 6 months	Percentage	LAD	64.6% Nov 10 - Oct 11	34.18% Jan21-Dec21	17.62% Jan 22-Dec22	▼	15	23	4	6			-2.00
Alco ated hospital admissions (narrow)	Directly Standardised Rate per 100,000	LAD	598.0 2021/22		598.0 2021/22			36		3			1.13
NHS Checks (% of eligible population invited to screening)[b]	Percentage	LAD	6.1% 2011/12 Q1	0.1% 2022/23 Q1	0.5% 2023/24 Q1	▲							
NHS Health Checks (% of eligible population receiving screening)[b]	Percentage	LAD	2.2% 2011/12 Q1	0.1% 2022/23 Q1	0.4% 2023/24 Q1	▲							
Self-reported wellbeing (low satisfaction score)	Percentage	LAD	5.7% 2011/12	7.2% 2020/21	6.2% 2021/22	▼	c	18	3	4			0.35
Self-reported wellbeing (low worthwhile score)	Percentage	LAD	4.0% 2012/13	c 2020/21	4.8% 2021/22		c	13	c	4			0.07
Self-reported wellbeing (low happiness score)	Percentage	LAD	9.6% 2011/12	10.5% 2020/21	9.5% 2021/22	▼	8	13	4	3			0.05
Self-reported wellbeing (high anxiety score)	Percentage	LAD	22.0% 2011/12	26.0% 2020/21	22.6% 2021/22	▼	10	6	3	1			-0.15
Under 75 mortality from causes considered preventable[d]	Directly Standardised Rate per 100,000	LAD	213.3 2021		213.3 2021			19		5			-0.19
Under 75 cardiovascular mortality[d]	Directly Standardised Rate per 100,000	LAD	80.2 2021		80.2 2021			13		6			-0.58
Under 75 cancer mortality[d]	Directly Standardised Rate per 100,000	LAD	135.5 2021		135.5 2021			19		5			0.02
Under 75 liver disease mortality[d]	Directly Standardised Rate per 100,000	LAD	30.5 2021		30.5 2021			20		6			0.17
Under 75 respiratory disease mortality[d]	Directly Standardised Rate per 100,000	LAD	35.7 2021		35.7 2021			22		5			0.06
Suicide and undetermined injury mortality	Directly Standardised Rate per 100,000	LAD	12.7 2001-03	9 2018-20	10 2019-21	▲	7	9	1	1			-0.70

Key:

Improvement in Sefton Data

Sefton Data Worsened

No change in Sefton Data

Rank Worsened

Rank Improved

Rank Stayed the Same

Sefton

England

Live ity Region (LCR)

Halt

Liver

Seft

St Helens

Wirral

Knowsley

Statistical Neighbour Group

LA	Former South Sefton	Former Southport & Formby CCG
Wirral	South Tyneside	Fylde & Wyre
North Tyneside	St Helens	Nottingham & Nottinghamshire
Northumberland	Sunderland	Castle Point & Rochford
Southend-on-Sea	North East Lincolnshi	Hampshire, Southampton & Isle of Wight
Torbay	Halton	Devon
	Rotherham	North Tyneside

The z-score provides a measure of how Sefton deviates when compared with the rest of the the North West. A score of ±1 shows Sefton is significantly different to the North West average

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting:**	Tuesday 23 January 2024
Subject:	Adult Social Care Performance Data Review		
Report of:	Executive Director of Adult Social Care and Health	**Wards Affected:**	(All Wards);
Portfolio:	Adult Social Care		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

This is an interim performance report provided to Overview and Scrutiny Committee. It provides an overview of Sefton's data profile to support the upcoming Care Quality Commission (QCQ) assessment. This report helps Sefton Adult Social Care understand its strengths and areas for focus prior to a pending CQC and supports with strategic preparation and planning. The full report is contained within Appendix 1.

Future reporting will be done through the Power BI platform and will utilise real-time data to show Sefton's current position against our benchmarkable and local metrics, therefore going forward the format will look different. Regular updates will be provided to Committee as part of performance reporting and preparation for assurance.

Recommendation(s):

(1) Committee are asked to note the contents of the report, provide comment, and be assured on actions being taken in areas of identified performance.

(2) It is recommended that regular updates be provided to Committee as part of regular performance updates and preparation for CQC assurance.

Reasons for the Recommendation(s):

The national assurance framework for Adult Social Care was introduced in April 2023 and is a statutory requirement for all Councils. As part of the assurance process CQC will scrutinise key performance data before conducting onsite visits. CQC already have access to the data provided in the report which is provided for existing national returns, and whilst this is already utilised for strategic commissioning and service delivery, ongoing scrutiny and visibility is key in ensuring ongoing evaluation of performance and quality of practice.

Alternative Options Considered and Rejected: (including any Risk Implications)

None

What will it cost and how will it be financed?

(A) Revenue Costs

No additional costs identified for this specific report.

(B) Capital Costs

None identified.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):

Preparation for assurance has impacted on resources both within the Service and Corporately, however there are no specific implications identified as part of this report, requiring consideration from Committee.

Legal Implications:

The national assurance framework is a legislative requirement for all Local Authorities. The information provided in the report provides details of performance against statutory data sets.

Equality Implications:

Nonspecific identified

Equitability in outcomes and services is however a key aspect of the CQC assurance framework and is included within the services detailed preparation plans.

Impact on Children and Young People: Yes

In addition to adult services the new national assurance framework which will be overseen by CQC includes those young people transitioning from children's services.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for	Yes

report authors	

For more information contact gillian.birmingham@sefton.gov.uk **or** stephanie.jukes@sefton.go.uk **(tel. 0151 934 4552).**

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Working with people who have care and support needs is central to the assurance framework and performance data provides both a qualitative and quantitive overview.
Facilitate confident and resilient communities: Supporting communities and ensuring the adoption of a strength-based approach is a key aspect of the review.
Commission, broker and provide core services: Adult Social Care is responsible for delivering a number of core statutory duties including the provision of care and support services across the Sefton market.
Place – leadership and influencer: In addition to assessing Local Authorities, CQC will also assess Integrated Care Systems and the performance of the Council will be considered as part of this.
Drivers of change and reform: This is a new legislative requirement which will focus on assessing quality and delivery, within the framework local councils will be expected to have assessed areas requiring reform and have robust plans in place.
Facilitate sustainable economic prosperity: A key aspect of the assurance framework focuses on market sustainability and maintaining local community services. Developing workforce strategies is also a key part of the review.
Greater income for social investment: Effective management of demand and use of resource will ensure both sustainability and opportunities for reinvestment.
Cleaner Greener: Integrated approaches allow a greater focus on wider determinants of Health and promote independence for local residents.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD7491/24) and the Chief Legal and Democratic Officer (LD5591/24) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

None

Implementation Date for the Decision

Immediately following the Committee / Council meeting.

Contact Officer:	Sarah Alldis
Telephone Number:	07815465610
Email Address:	sarah.alldis@sefton.gov.uk

Appendices:

Appendix 1 contains the detailed slide deck detailing performance and benchmarking.

Background Papers:

None

1. Introduction/Background

1.1 In 2022, the Health and Care Act outlined a new Assurance Framework for Adult Social Care. This afforded CQC with the responsibility to assess all Councils. The new assurance and assessment framework came into effect on the 1st April 2023. As part of the assessment process CQC will review and scrutinise performance data provided by local councils, before undertaking onsite visits.

1.2 This is an interim performance report providing an overview of Sefton's data profile to support the upcoming CQC assessments. It utilises a number of data sources to provide an overview for Adult Social Care, identifying areas of strong performance and those requiring focus. This is key to support both strategic commissioning and service planning. The report also details key actions being taken within identified areas of focus. The full report is contained within Appendix 1.

1.3 At the time of producing this report, nationally CQC already have access to this data, which informed the State of Care national reporting of adult social care, informing the DHSC regarding each Councils profile; this included access to Councils local JSNA, pertaining to population of health data, that also informs Adult Social Care commissioning plans.

1.4 The following data sources have been used to assess and benchmark Sefton's Adult Social Care performance against the comparator groups:

- Adult Social Care Outcomes Framework (ASCOF)
- Carer and Client's surveys (SACE and ASCS)
- Short and Long Term Support statutory return (SALT)
- CQC data

- Financial data.

2 The report provides an overview to Committee and provides information on how Adult Social Care compare regionally, nationally and to our nearest statistical neighbour. It also details trends in performance. Future reporting will be done through the Power BI platform and will utilise real-time data to show Sefton's current position against our benchmarkable and local metrics. Regular update reports will be provided to the Executive Leadership Team on a quarterly basis, and it is recommended that these are provided to Overview and Scrutiny Committee for scrutiny, review and assurance. This will form part of regular reporting regarding performance and assurance preparation.

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Sefton's Adult Social Care

CQC Preparation Data Review

Overview and Scrutiny Committee January 2023

Sefton Council

Sefton 2030

Ready for the future

Contents

Purpose and Introduction

This is an interim performance report providing an overview of Sefton's data profile to support upcoming CQC assessment. Future reporting will be done through the Power BI platform and will utilise real-time data to show Sefton's current position against our benchmarkable and local metrics, therefore going forward the format will look different.

This report helps Sefton Adult Social Care understand its strengths and areas for focus prior to a pending Care Quality Commission Assessment, that supports Adult Social Care's service planning.

At the time of producing this report, nationally CQC already have access to this data, which informed the State of Care national reporting of adult social care, informing the DHSC regarding each Councils profile; this included access to Councils local JSNA, pertaining to population of health data, that also informs Adult Social Care commissioning plans.

The following data sources have been used to assess and benchmark Sefton's Adult Social Care performance against the comparator groups:

Adult Social Care Outcomes Framework (ASCOF)

Carer and Client's surveys (SACE and ASCS)

Short and Long Term Support statutory return (SALT)

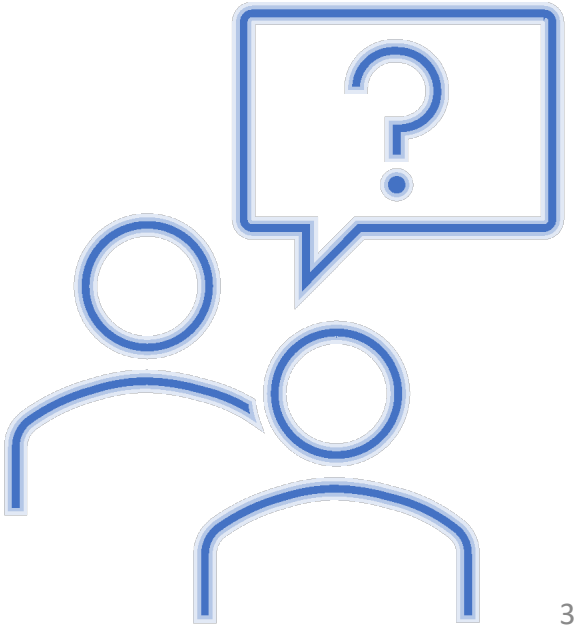
- CQC data
- Financial data

This document should help Sefton answer the following questions:

- How do we compare to the region, England and statistical nearest neighbours?

- What are the trends in our performance?

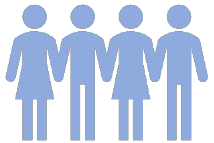
- Is Sefton's performance different from our comparator group



Sefton and comparator areas

National- Sefton is one of the 151 councils in England with adult social care responsibilities (CASSRs). When comparing Sefton's performance nationally, we use data from these 151 councils.

Regional- Sefton is benchmarked regionally against 23 local authorities within the North West region.



Statistical neighbours- Sefton is benchmarked against CIPFA's statistical nearest neighbours- a group of 16 local authorities in England sharing similar demographic traits.

Thematic Overview

Carers

- Carers reported quality of life in Sefton is largely in line with national, regional and statistical comparators as is the overall satisfaction of carers with social care services.
- Areas for concern lie in the proportion of carers who feel included or consulted in discussions about the person they care for and in the proportion of carers who find it easy to access information and advice.
- It should be noted that our response rate in 2021/22 was low, which resulted in a higher margin of error - this may mean that the decline in performance against these two measures is more extreme than the reality.
- An updated Carers Strategy is currently out for consultation with carers and system partners, and regular commissioning meetings are in place to oversee the new specification in place with the Carers Centre (a dedicated commissioning lead for Carers is planned). In addition, the Accelerating Reform Fund from the DHSC is being utilised to improve both information for carers and the availability of respite services. This will form part of a wider evaluation of the current commissioned support model and learning from local and national high performing areas, including St Helens and Northumberland.
- A deep dive audit programme into social work practice and carer support will be progressed and focus groups held to gather direct lived experience to improve practice.
- There is a need to undertake a co-produced review of the advice and information available to carers (like that provided for individuals detailed in Appendix 1).

Clients

- Reported quality of life for clients has remained stable over the past 4 years with our performance remaining in line with England, the North West and our statistical neighbours.
- We have typically performed well on the satisfaction with care and support of our clients. From 2018-2022 we were above national and regional levels and amongst the top performers of our statistical neighbours. In 2022/23 we did see a decline of almost 6 percentage points - this brings our performance in line with other authorities having previously been better. The new CQC single assessment framework has a clear focus on Continuity and Quality in care and this has been highlighted as an area requiring further work within our pt 1 self-assessment. The Partners 4 Change Transformation programme (commencing early 2024) will focus on improving personalisation through outcome based social work practice. Our oversight and quality assurance of the market will be strengthened with the implementation of consistent arrangements for gathering qualitative feedback from people accessing services.
- 2022/23 saw an increase in the proportion of clients that felt they had as much social contact as they wanted; this may reflect the impact of COVID in the previous year's survey.
- We saw a 10-percentage point improvement in the proportion of clients finding information about services easy to access.
- We also saw improvements in the proportion of clients feeling safe. 91.5% of our clients stated that the services that they receive made them feel safe and secure, this compares to 86.4% in the North West.

Residential & Nursing Care

- Sefton has traditionally had a higher rate of admission to residential and nursing care than other local authorities. Over the past two years we have brought our admission rate for over 65s down to levels that are now comparable with other North West authorities and our statistical neighbours. It is however recognised that as a system there remains a continued reliance on short term bed-based provision to support discharge from hospital , therefore key work is being undertaken to reduce the length of stay for people accessing short term placement (through a review of Intermediate Care/Discharge to Assess Services) and to increase capacity within “Home First” and reablement services, enabling more people to return home directly from hospital. From 2025 the current Extra Care Housing Programme will provide additional alternatives to long term care.
- Our admission rate for 18-64 year olds has come down over the past 12 months which puts us in line with our statistical neighbours, although we remain above our geographical neighbours in the North West and this remains a key area of focus. There is a programme of activity in place to address this which includes greater access to Shared Lives and Supported living provision, together with the development of a new short term assessment unit which will be available from May 2026.

Thematic Overview

Social Care Market

- Sefton's provider CQC ratings are in line with the rest of the North West with 85% being rated good or outstanding.
- Commissioners are currently using the Provider Assessment and Market Management Solution (PAMMS) tool to assess providers on a regular basis. The intelligence from this is then utilised alongside CQC data to provide an overall picture of the market in Sefton.
- Our social care market intelligence is used to create a risk profiler that offers insight into individual providers level of risk across a number of key metrics.
- There will be a further review of the Quality Assurance team and alignment with the Sefton Place Based Quality Team to enable a more proactive and integrated approach. The Enhanced Health in Care Home programme is now embedded across Sefton and an integrated Contracts, Commissioning and Quality Review Meeting is now in place.

Spend

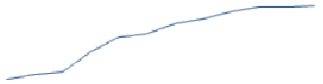
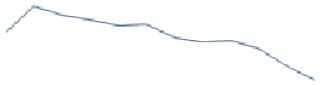
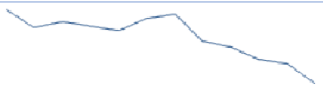
- Spend on Adult Social Care in Sefton is high when calculated per head of the population. However, when viewed as average spend per client, we are low comparatively to the rest of the country.
- The North West is the region with the highest spend per head of the population and Sefton is no exception. The reason for this is we have a higher proportion of adults receiving social care support from the local authority. In Sefton 2.45% of those aged 18 and over are receiving long term support from adult social care; this is a higher proportion than any region in England.
- This could be an indication of the high level of need in Sefton and the wider North West, it could also be indicative of a greater propensity to provide support to a greater number of individuals.
- There is need to review the current early intervention and prevention strategy, which has in part been delayed due to a resource challenge. This will align with the current digital and Tec Strategy which is in place (which includes the introduction of Ask Sara and remote monitoring pilots such as the CIC Care Builder which will commence in Jan 2024).
- The provision of Occupational Therapy at the front door has been enhanced and a further review of the current operating model (linked to the Partners 4 Change Programme) will commence in 2024. There are a number of key dependencies to this work including maximising community provision, progression of strengthened intermediate care offer and greater capacity within reablement and home first services in order to delay or reduce the need for long term services.

Demand , Reviews and Safeguarding Concerns

- The demand for social work and occupational therapy intervention remains high and whilst this is a challenge for most Local Authorities, effective oversight, escalation and risk management will be crucial lines of enquiry for CQC as part of regulation. Mitigations are in place in respect of people awaiting ongoing assessments including weekly scrutiny of performance data by Senior Managers and escalation to the Executive Director, use of risk-based rag rating of cases (and policy development), regular contact with individuals waiting, deployment of a managed team (to provide additional capacity), increased capacity at the front door to respond to urgent referrals and a focus on productivity within teams. Whilst remaining high, the numbers of social work cases has seen a reduction; this does remain an area of focus. Occupational Therapy cases remain high and dedicated action plan is in place.
- The percentage of long term clients receiving their annual review has remained largely static at around 46% which places us just outside of the bottom quartile in the North West but is below the median of 52%. Performance has been impacted by the need to redirect resources to unplanned reviews due to a number of home closures / quality concerns and the need to focus on delivery of the efficiencies programme. An improvement plan is however in place with a stretch target to reach 60% by March 2024. The use of national guidance to ensure proportionality of the review process is also being utilised.
- The number of safeguarding concerns has increased 10% since the beginning of the year, although Safeguarding enquiries has seen a slight decline. This increase is considered in part to be due to increased awareness raising via the SSAB and changes to CQC referral process. Safeguarding oversight has been strengthened operationally with the appointment of a new Senior Manager for Assurance and Safeguarding and an audit programme focusing on safeguarding practice has been introduced.

Adult Social Care Outcomes Framework (ASCOF)

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. The ASCOF is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

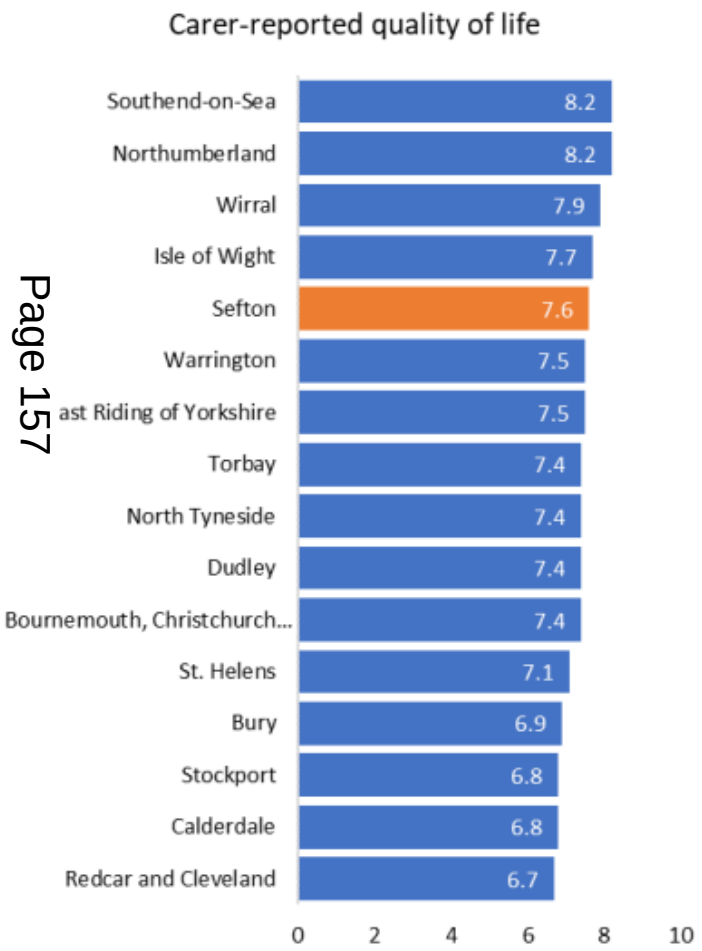
	Measure	What is good?	Sefton		England		North West		Statistical Neighbours	
			Current	Trend	21/22	Dif	21/22	Dif	21/22	Dif
ASCOF Me	Proportion of people using social care who receive self-directed support - Clients (1C1A)	High	**99.3**		94.5	4.8▲	93.6	5.7▲	97.4	1.8▲
	Proportion of people using social care who receive self-directed support - Carers (1C1B)	High	**97.7**		89.3	8.4▲	89.7	8.0▲	76.1	21.6▲
	Proportion of people using social care who receive direct payments - Clients (1C2A)	High	**23.0**		26.7	-3.7▼	26.1	-3.1▼	25.9	-2.9▼
	Proportion of people using social care who receive direct payments - Carers (1C2B)	High	**97.7**		77.6	20.1▲	82.3	15.4▲	53.3	44.4▲
	Proportion of adults with learning disabilities in paid employment (1E)	High	**2.4**		4.8	-2.4▼	4.1	-1.7▼	4.9	-2.5▼
	Proportion of adults in contact with secondary mental health services in paid employment (1F)*	High	**4.0**		6.0	-2.0▼	5.0	-1.0▼	6.0	-2.0▼
	Proportion of adults with learning disabilities who live in their own home or with their family (1G)	High	**88.5**		78.8	9.7▲	89.3	-.8▼	82.7	5.8▲
	Proportion of adults in contact with secondary mental health services who live independently, with or without support (1H)*	High	**17.0**		26.0	-9.0▼	26.0	-9.0▼	26.8	-9.8▼
	Long-term support needs of younger adults aged 18-64 met by admission to residential and nursing care homes, per 100,000 population (2A1)	Low	**19.0**		13.9	5.1▲	14.4	4.6▲	18.0	1.0▲
	Long-term support needs of older adults aged 65 and over met by admission to residential and nursing care homes, per 100,000 population (2A2)	Low	**612.0**		538.5	73.5▲	639.5	-27.5▼	640.4	-28.4▼
	Proportion of older people 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services effectiveness of the service (2B1)	High	**94.4**		81.8	12.6▲	86.0	8.4▲	84.6	9.8▲
	Proportion of those that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level (2D)	High	**76.4**		77.6	-1.2▼	75.9	.5▲	83.5	-7.1▼

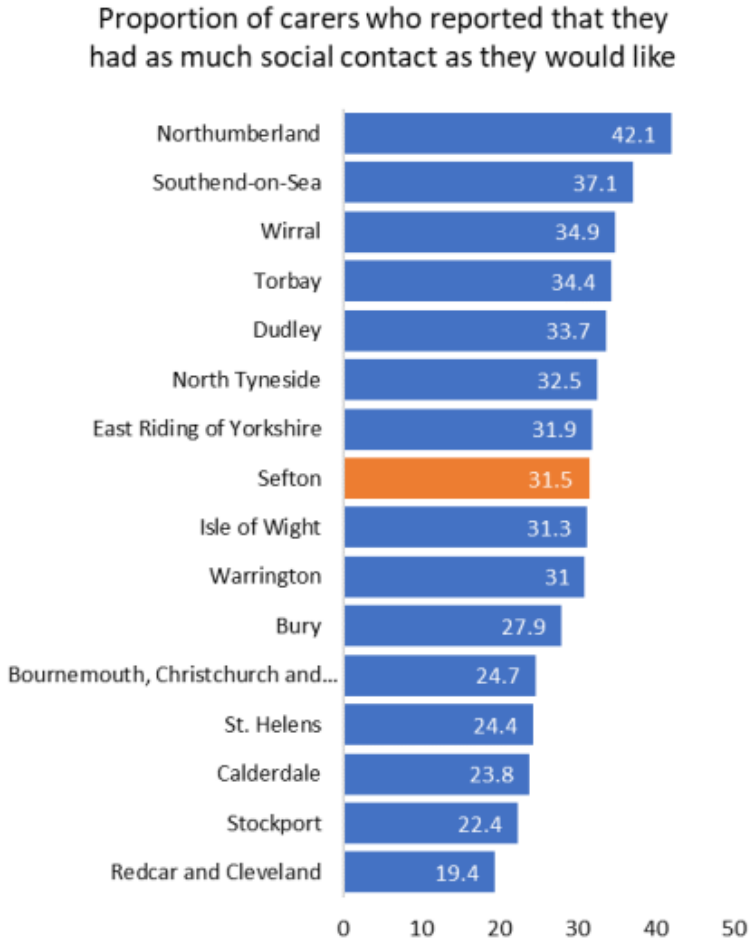
Survey of Adult Carers (SACE): 21/22

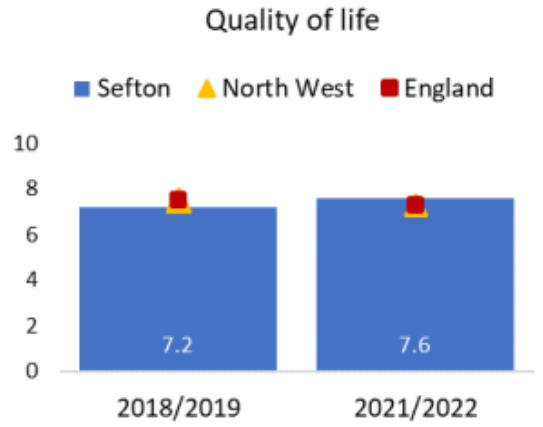
Quality of life and social contact

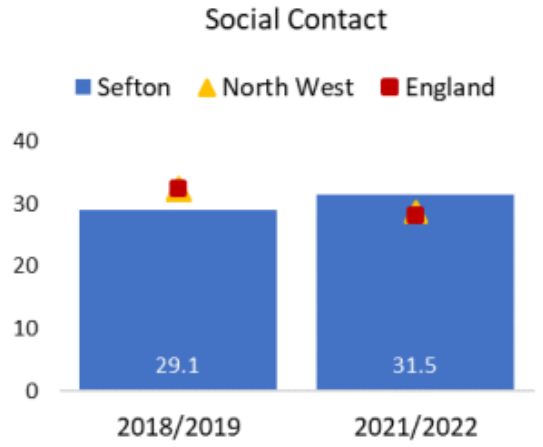
Carer-reported quality of life and proportion of carers having as much social contact as they would like remained fairly stable from 18/19 to 21/22 and close to the levels seen in England and the North West.

Sefton displayed an average performance against statistical nearest neighbours.





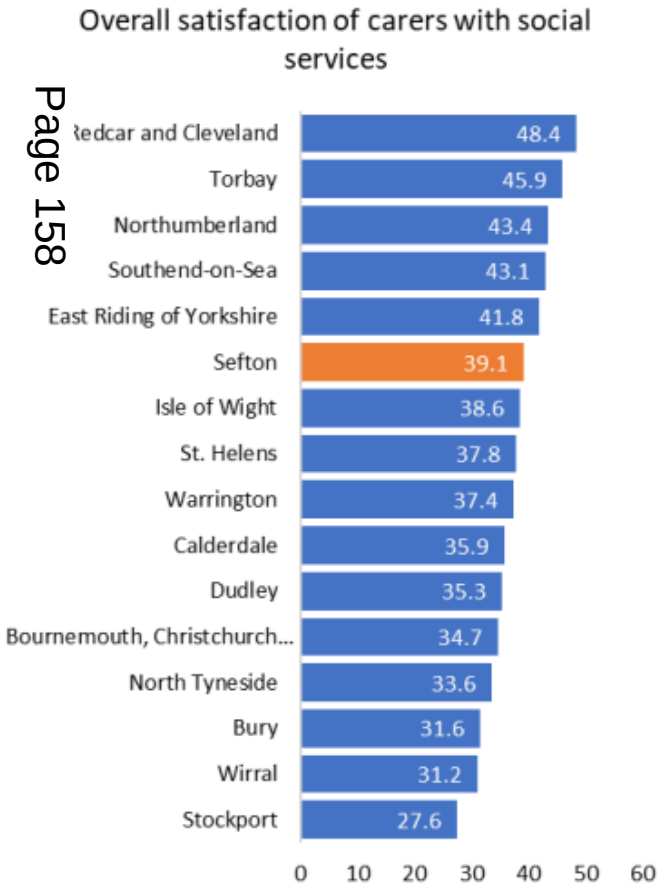


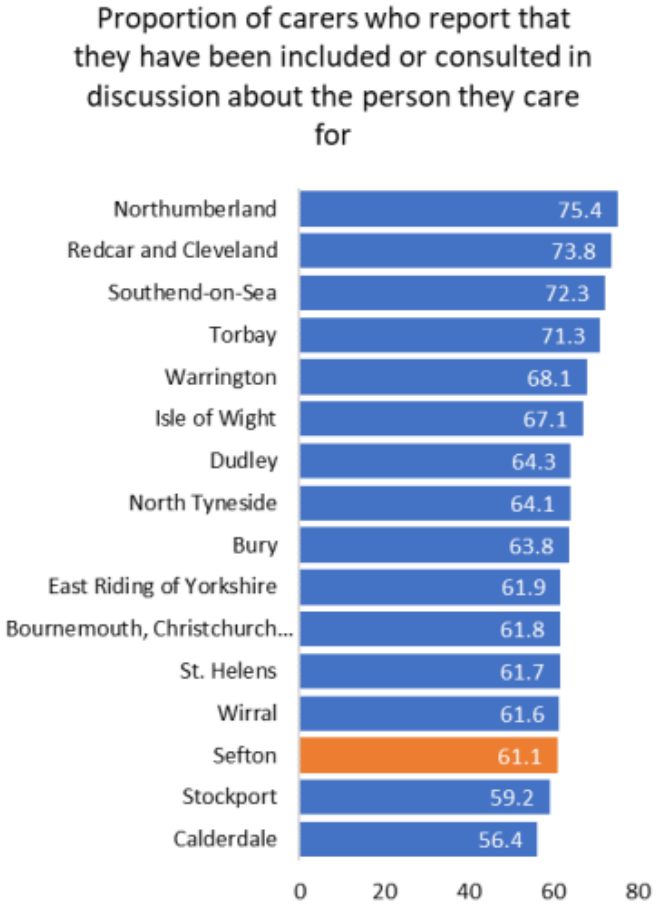


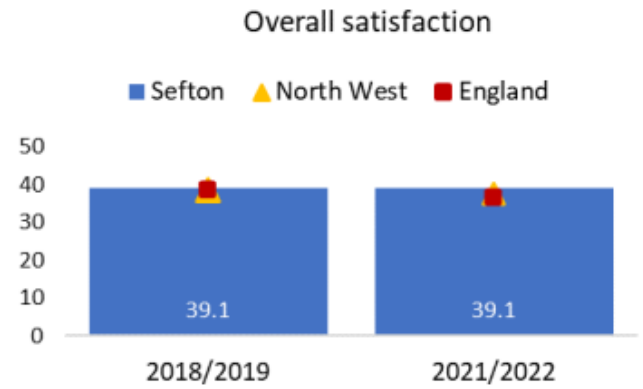
Satisfaction and involvement

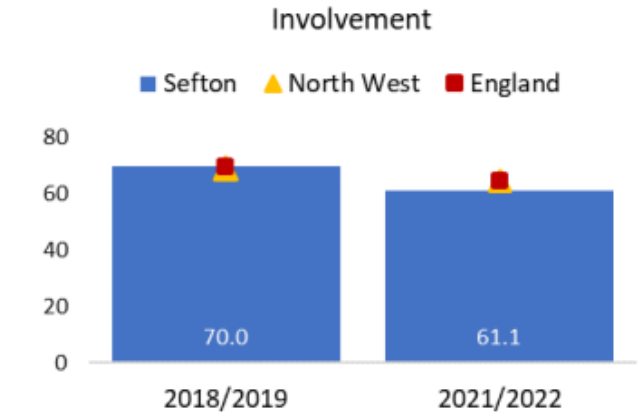
The overall satisfaction of carers remained stable from 18/19 to 21/22 and Sefton displayed an average performance against statistical nearest neighbours.

The proportion of carers involved in discussion about the person they care for saw a decline in 21/22 compared to 18/19 and we ranked low against statistical nearest neighbours and the North West and England.



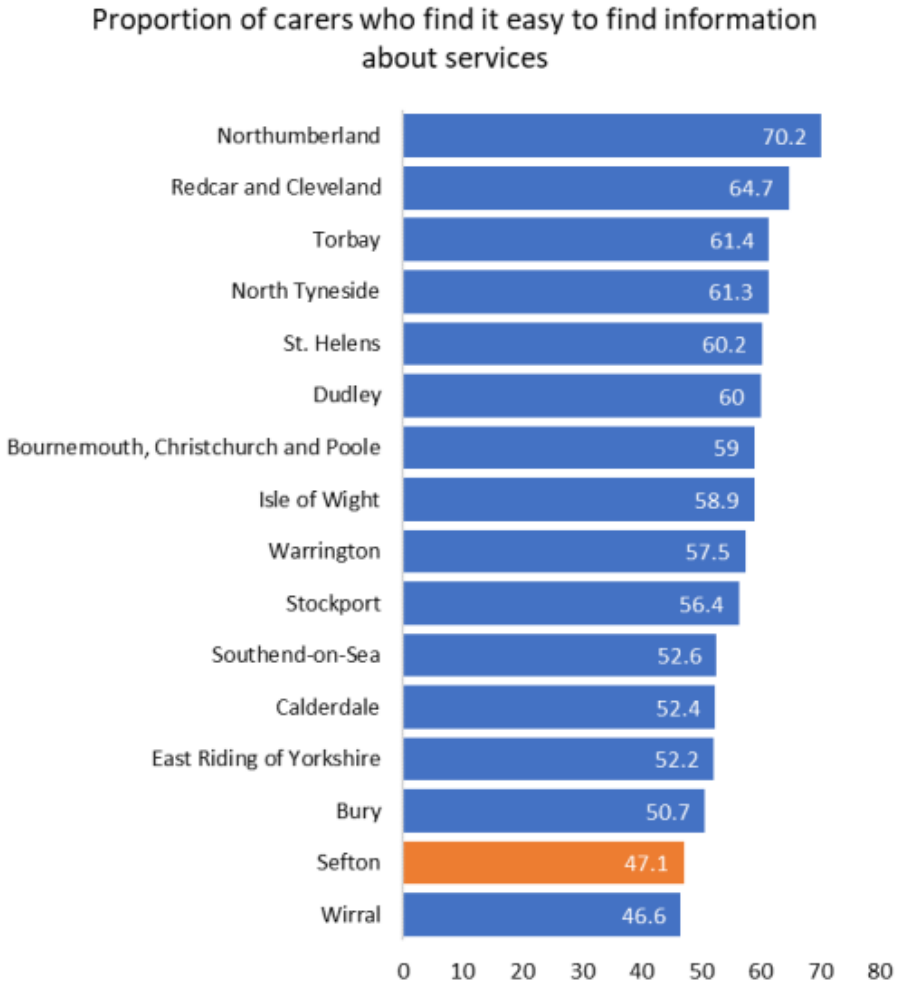


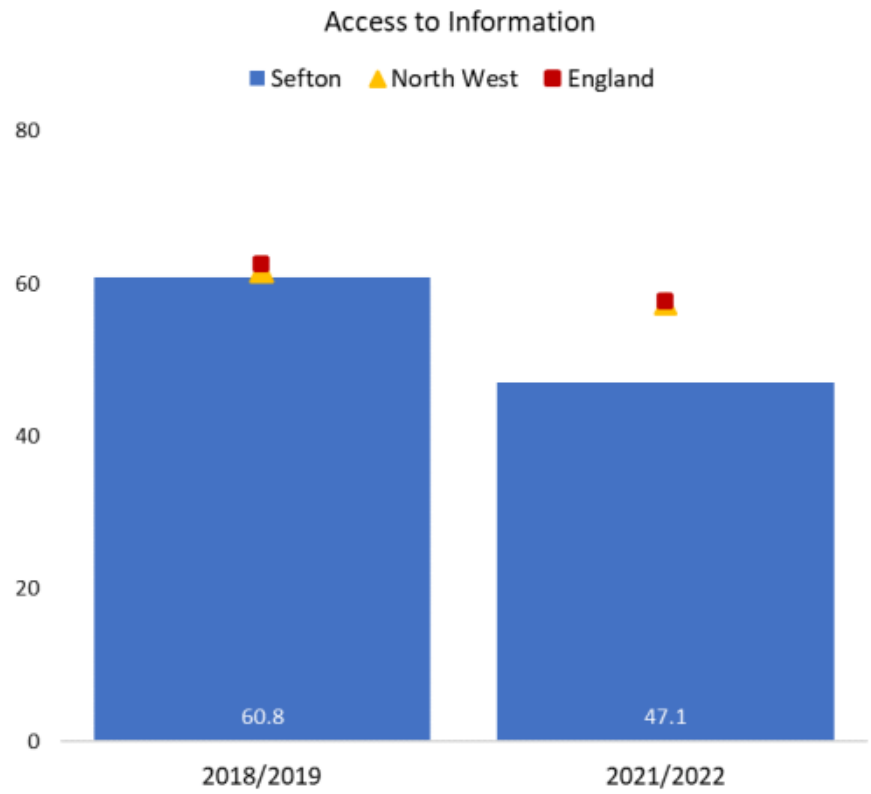




Access to information

The proportion of carers reporting that it was easy to find information declined from 18/19 to 21/22 and Sefton ranked low against statistical nearest neighbours, the North West and England.



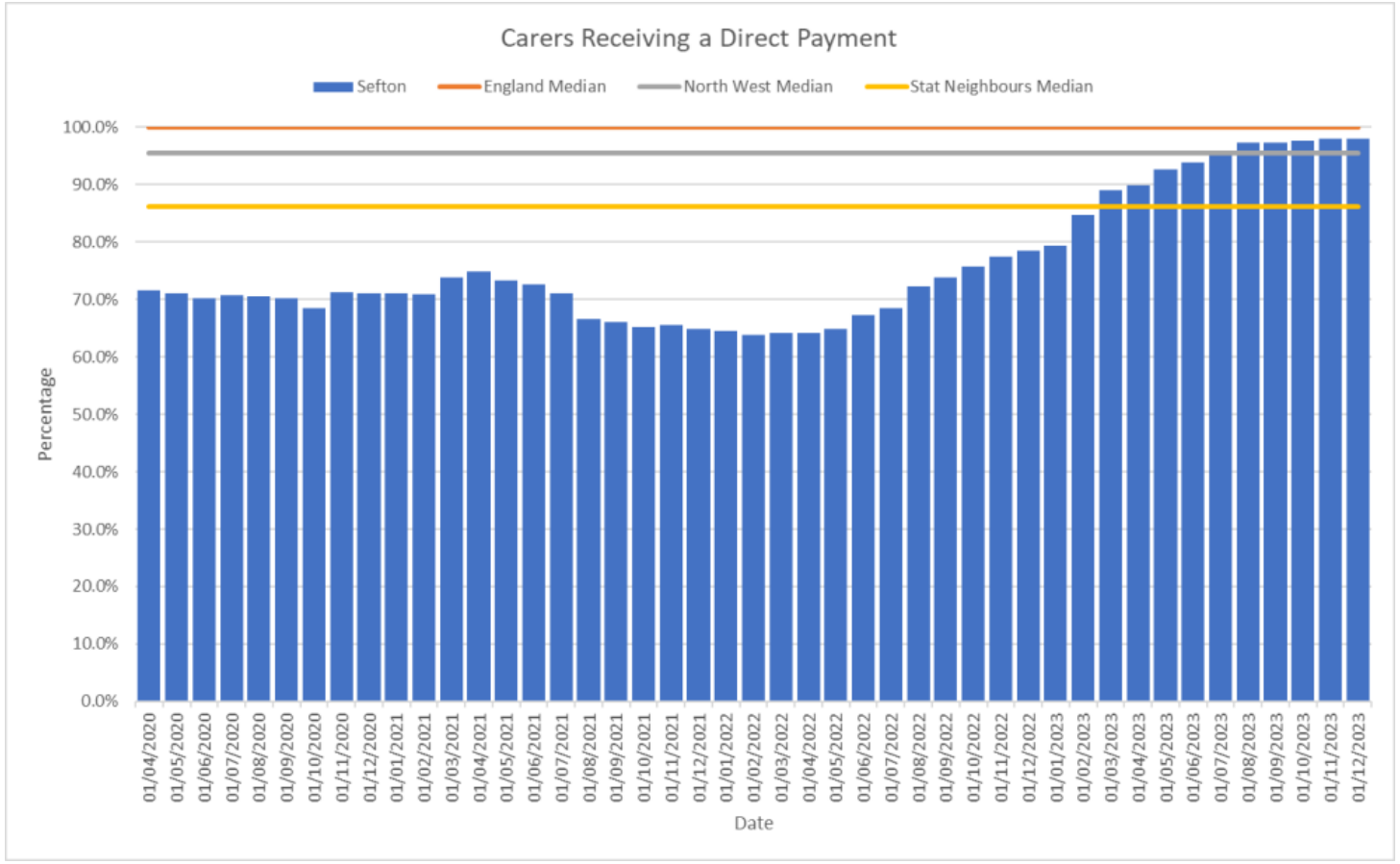


Carer Direct Payments

Over the past 12 months we have increased the proportion of our carers that are receiving a direct payment.

In 22/23 around two thirds of our carers were in receipt of a direct payment which placed us in the bottom quartile nationally, regionally and against statistical neighbours.

Currently 98% of our carers are now in receipt of a direct payment, this puts us above the North West and Statistical neighbours median figures.



Adult Social Care Survey (ASCS): 21/22

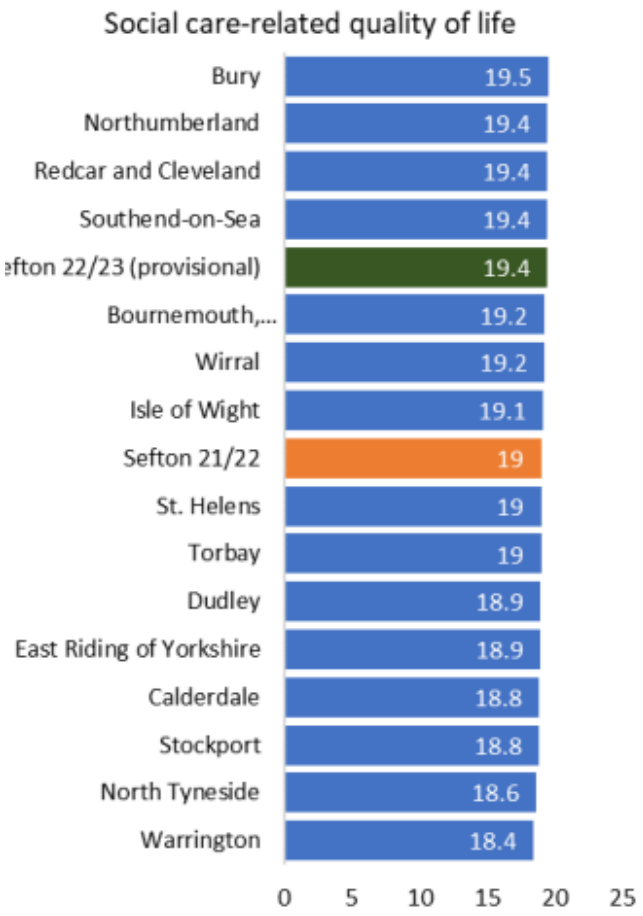
** No survey carried out in 20/21 due to Covid-19 pandemic*

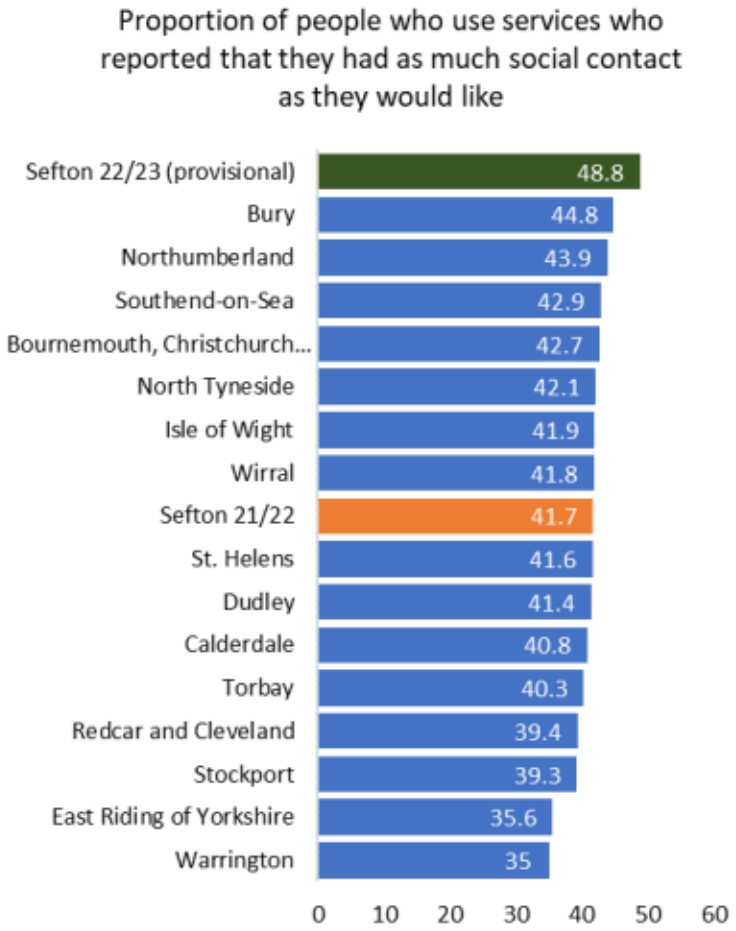
*** Sefton's 22/23 results will remain provisional until the publication of the results later in 23/24*

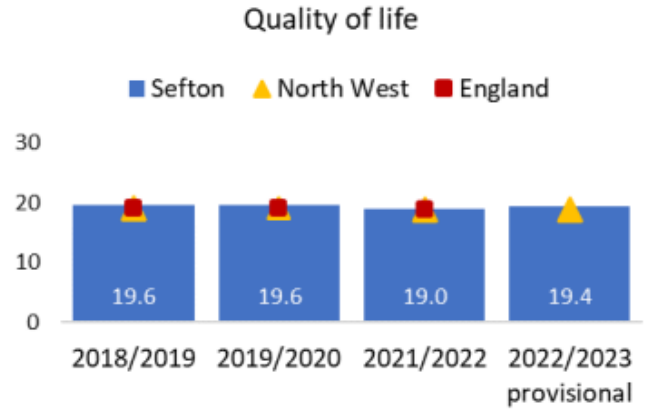
Quality of life and social contact

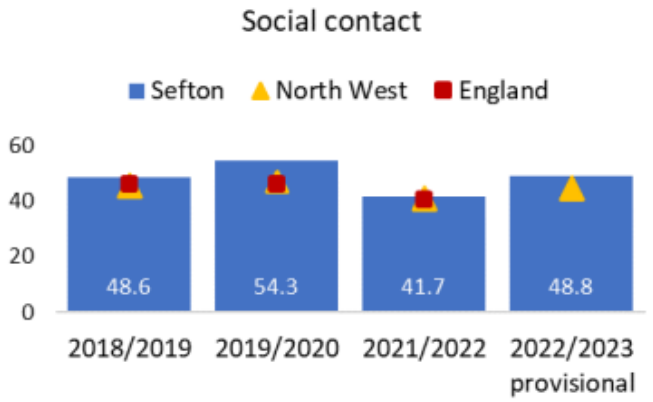
Social care-related quality of life performed in line with England and North West in the three previous years and 22/23 provisional results.

Social contact performed in line with national and regional comparators between 18/19 and 21/22. 21/22 saw a drop in the metric for both Sefton and our comparators, most likely linked to Covid and associated restrictions affecting socialising. The provisional results from 22/23 indicate an improvement in the measure.



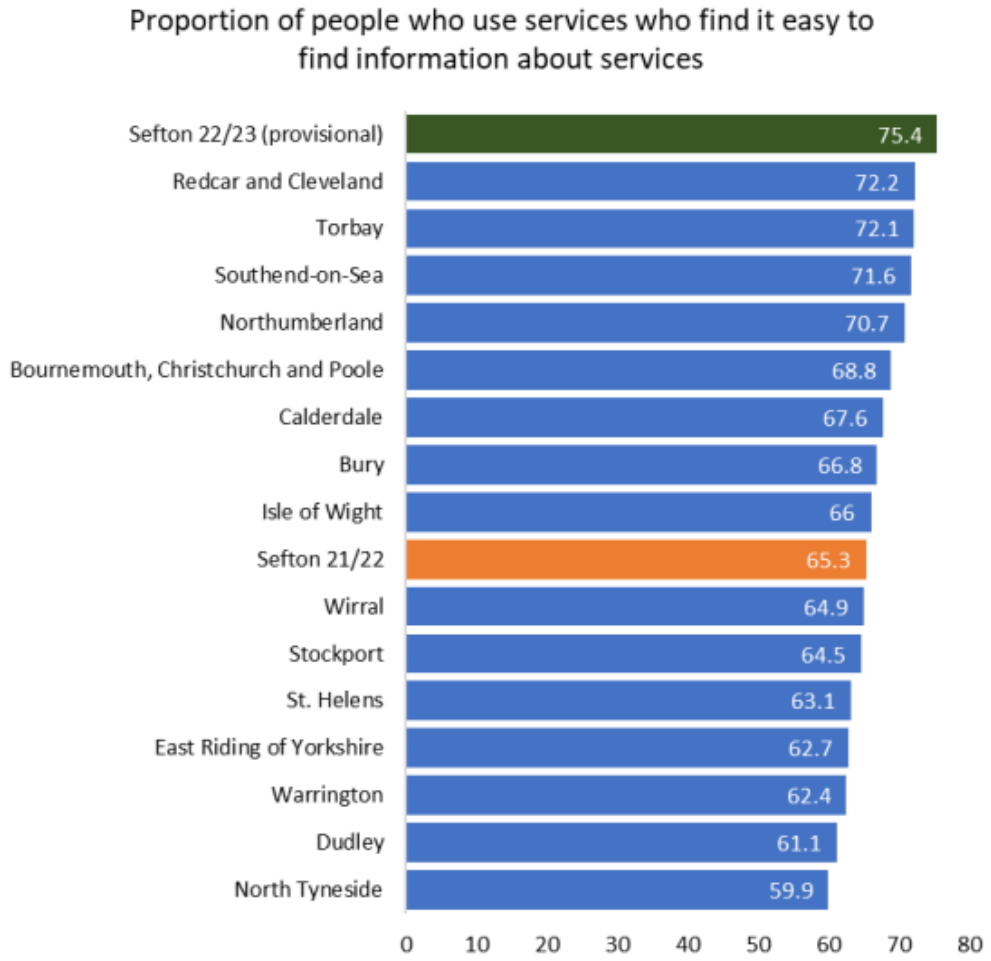


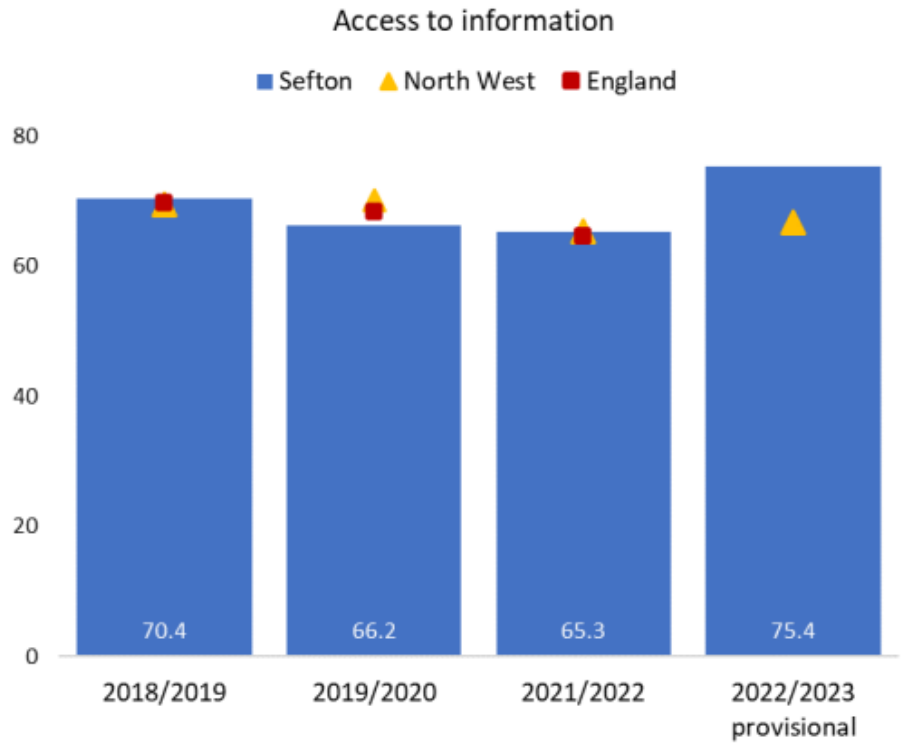




Access to Information

The proportion of service users who find it easy to find information about services was on a decline between 18/19 and 21/22. The provisional 22/23 results indicate a significant increase in the proportion putting us in a good position against statistical neighbours and the North West.

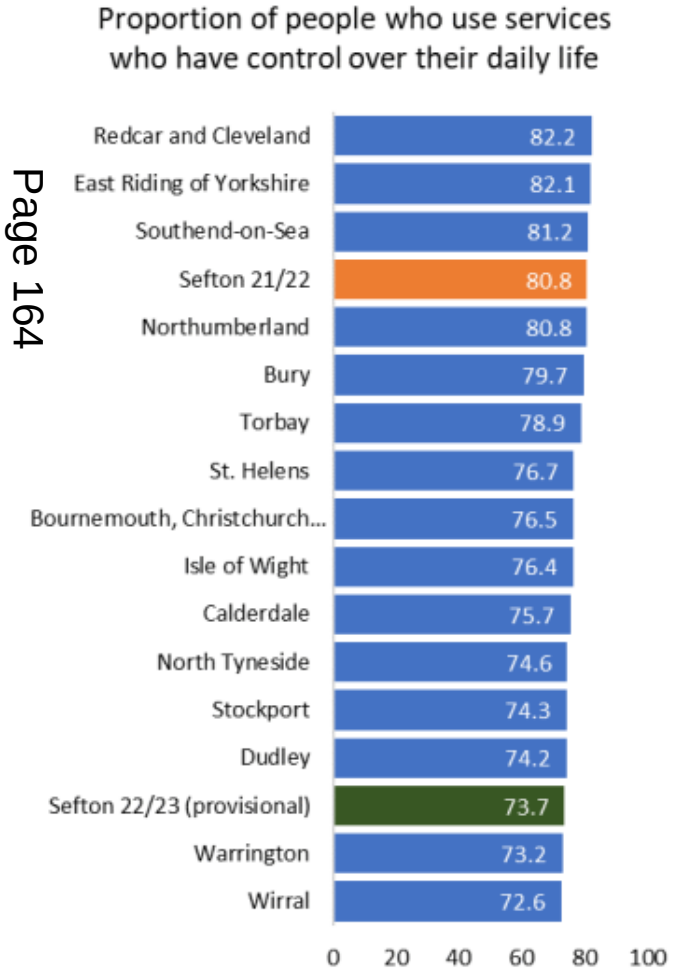


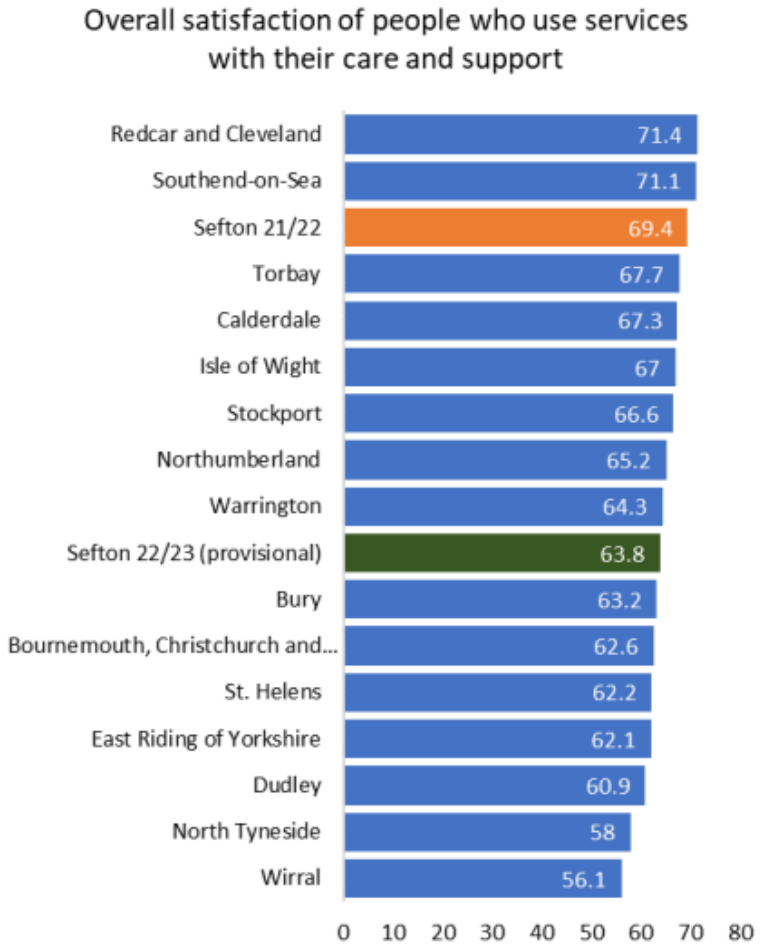


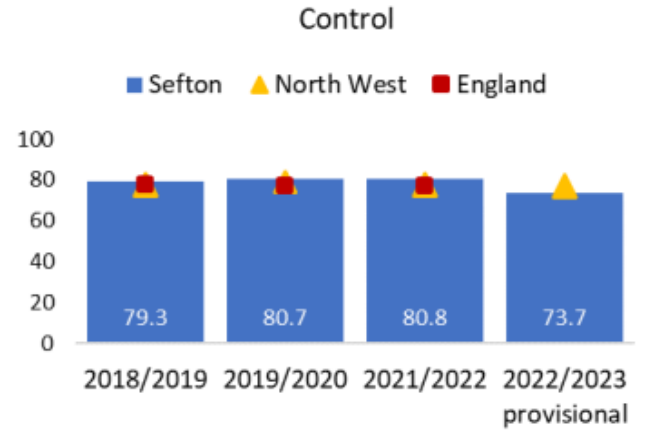
Control and Satisfaction

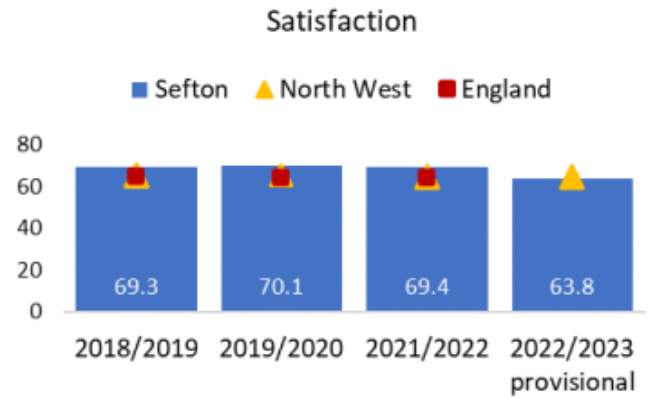
Levels of control among service users in Sefton were close to those reported by England and North West for the three previous years. The 22/23 provisional results indicate a decline in the measure, putting Sefton behind the North West.

Overall satisfaction in Sefton between 18/19 and 21/22 remained fairly stable and in line with regional and national comparators. In 22/23 Sefton's performance declined, whilst North West maintained similar level compared to the previous years. **More analysis is required**





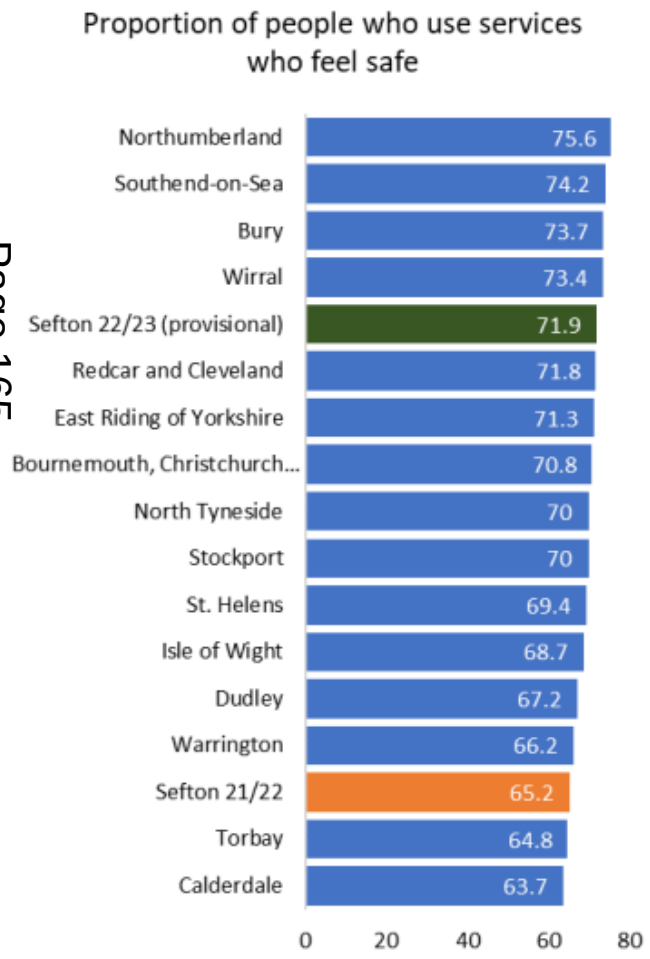


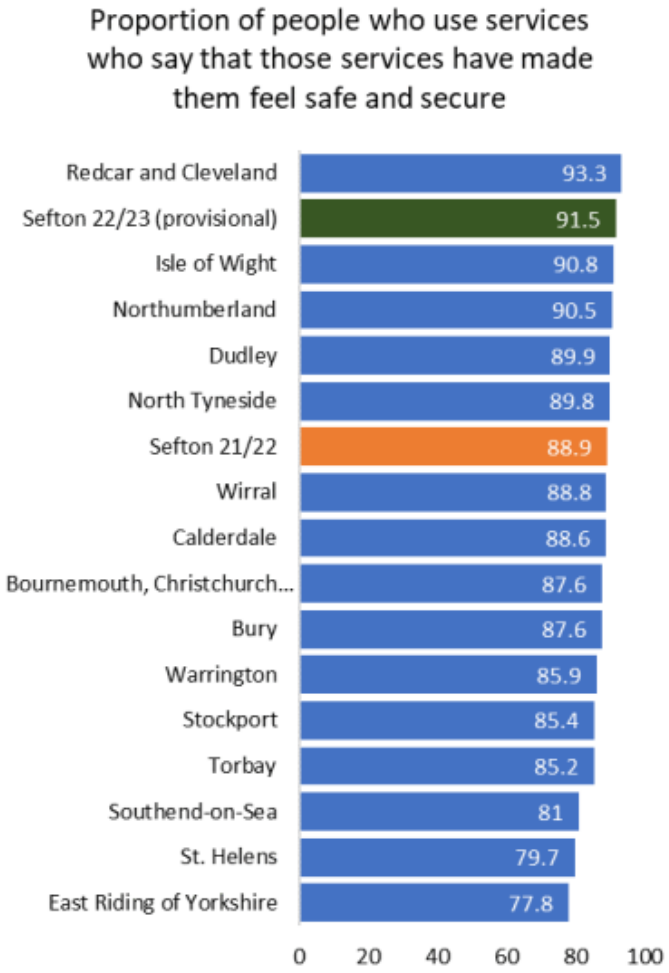


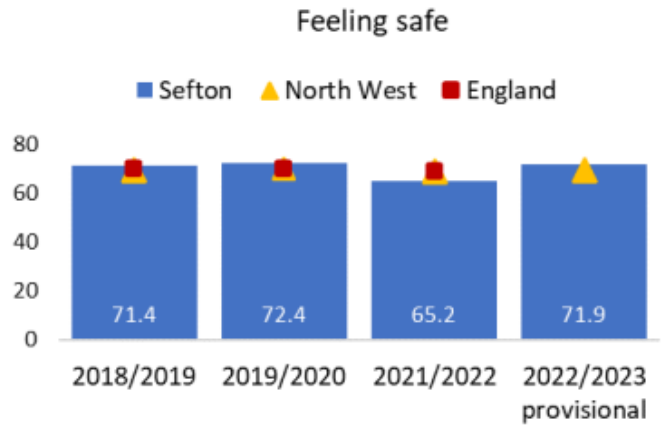
Feelings of Safety and Security

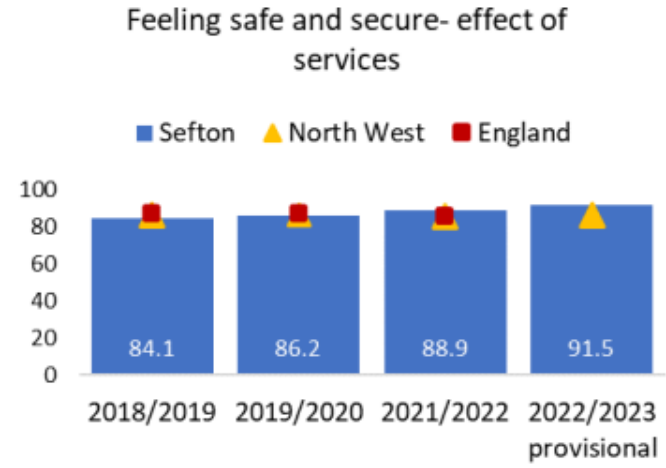
The proportion of clients who feel safe was fairly stable between 18/19 and 19/20. The figure dropped in 21/22 but increased to pre-pandemic levels in 22/23.

The proportion of service users who say that services have made them feel safe and secure has been on the rise since 18/19.









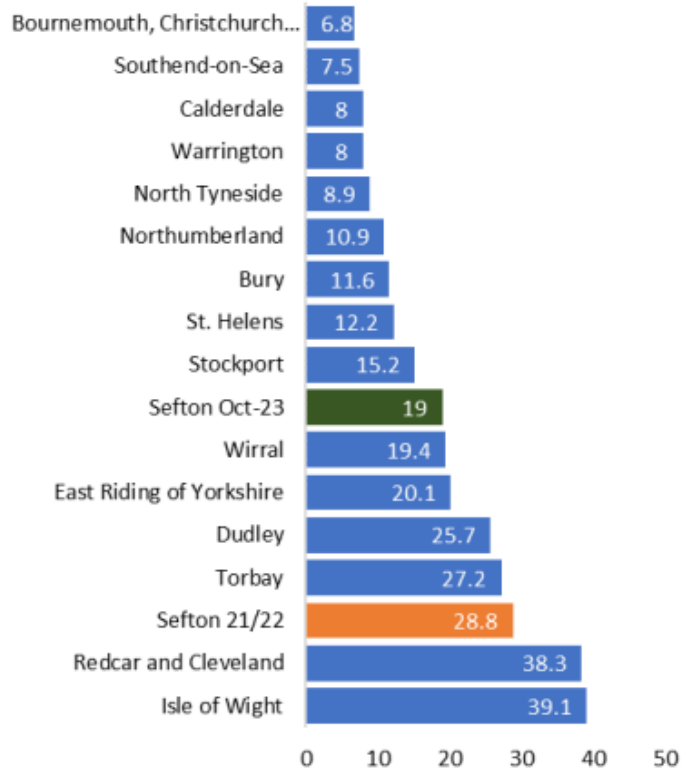
Short and Long Term Support (SALT)

Residential and Nursing care

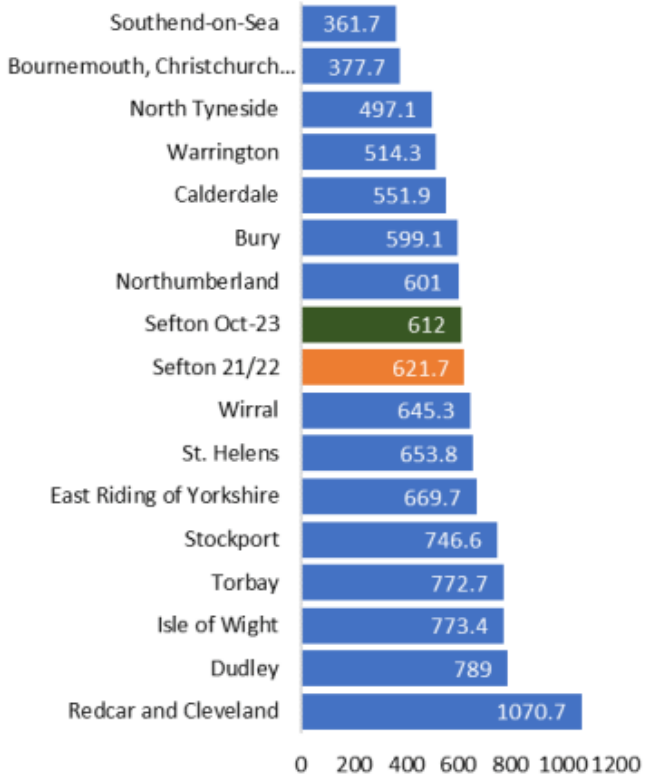
Historically, Sefton's care home admissions for both younger and older adults have been high.

In 23/24 number of admissions is no longer as high as it used to be, and Sefton displays an average performance against statistical nearest neighbours and the North West.

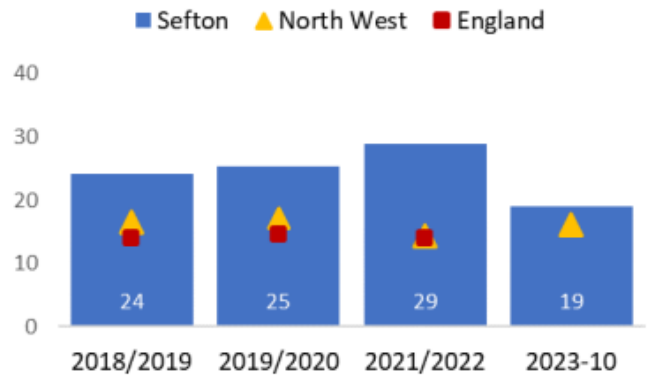
Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population



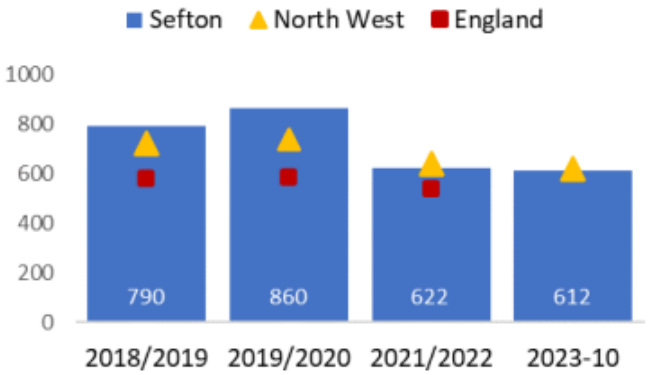
Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population



Admissions for adults aged 18-64

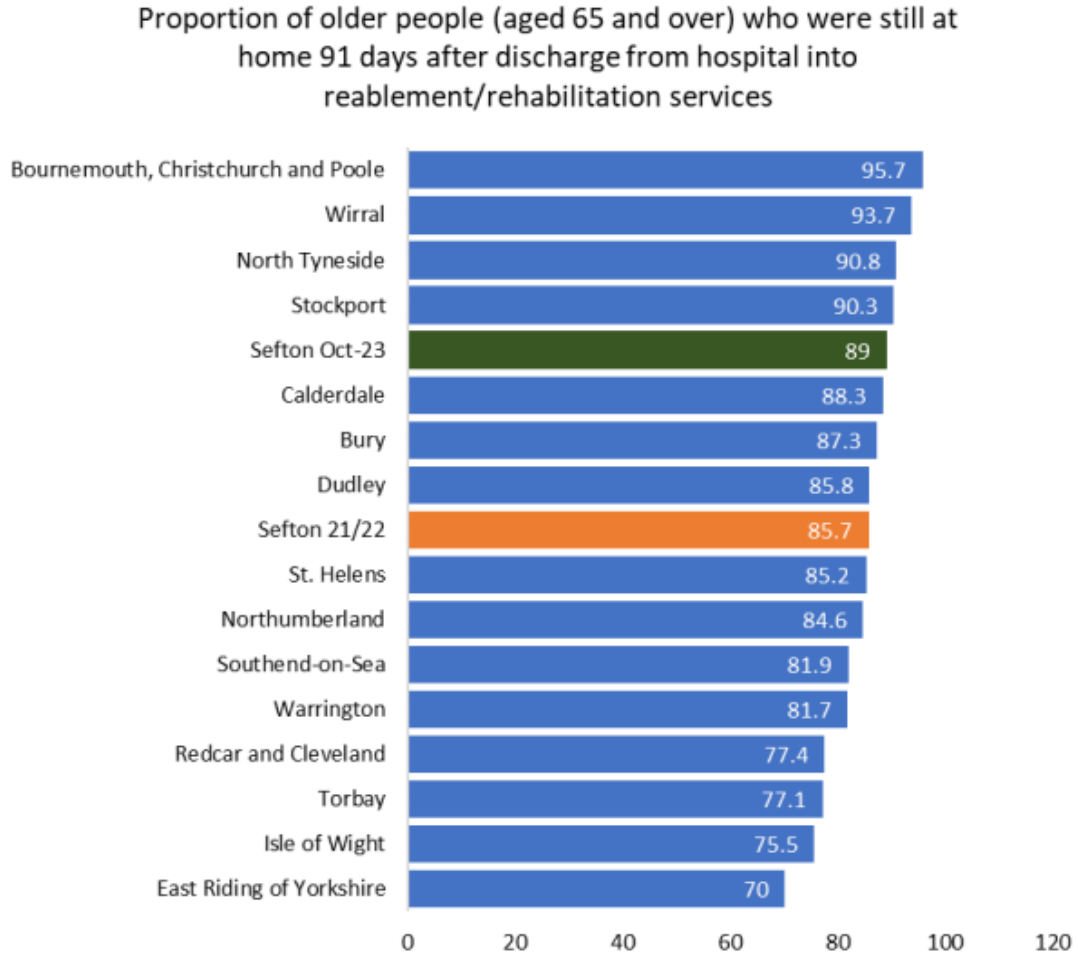


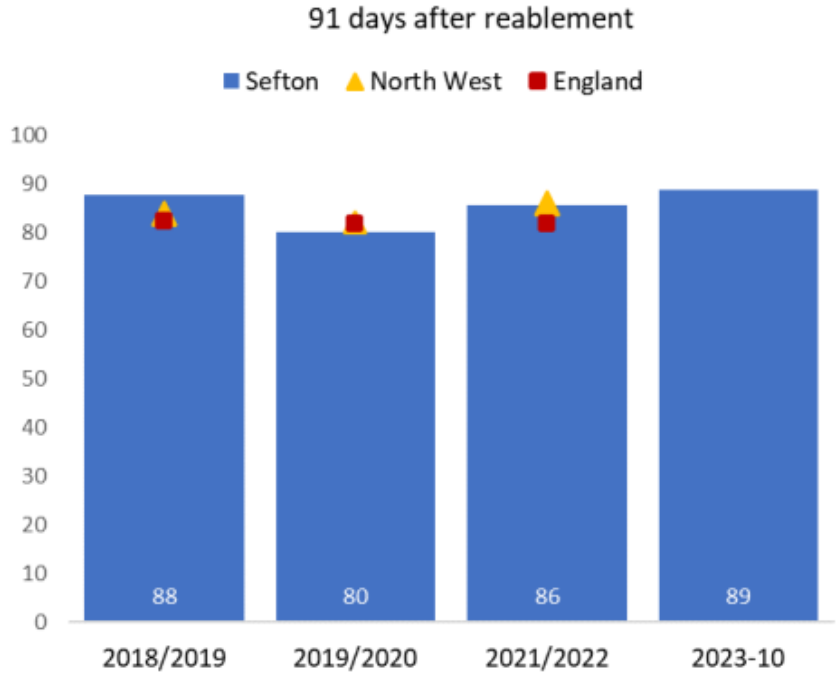
Admissions for adults aged 65 and over



Prevention re-admission

The proportion of older people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services dropped between 18/19 and 19/20 but has been on the rise since. Further work is in progress to develop the current reablement offer in order to reduce alternative to reablement provision



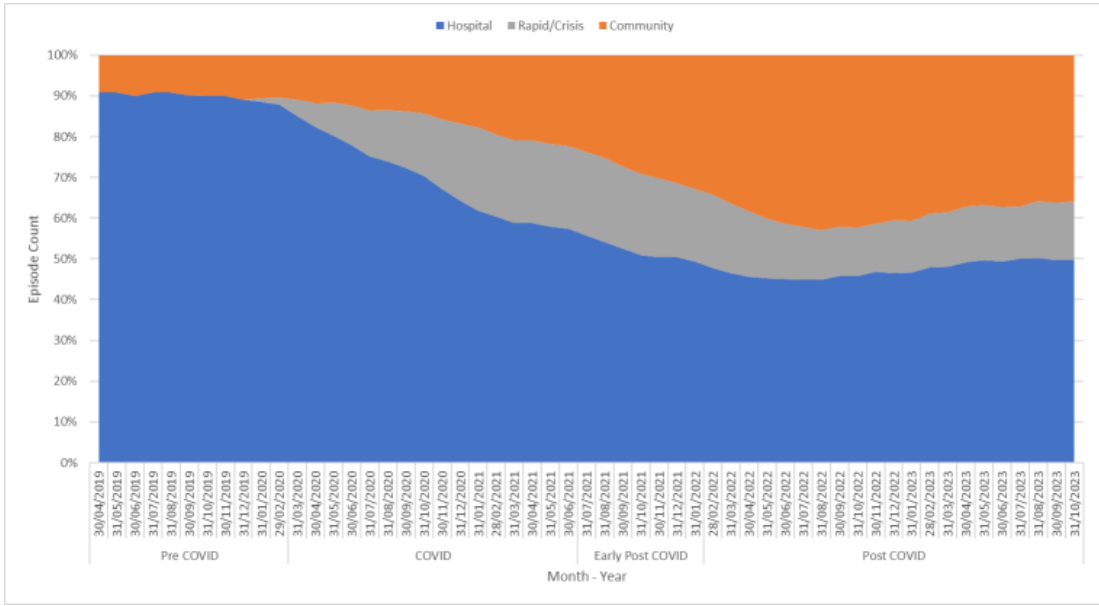


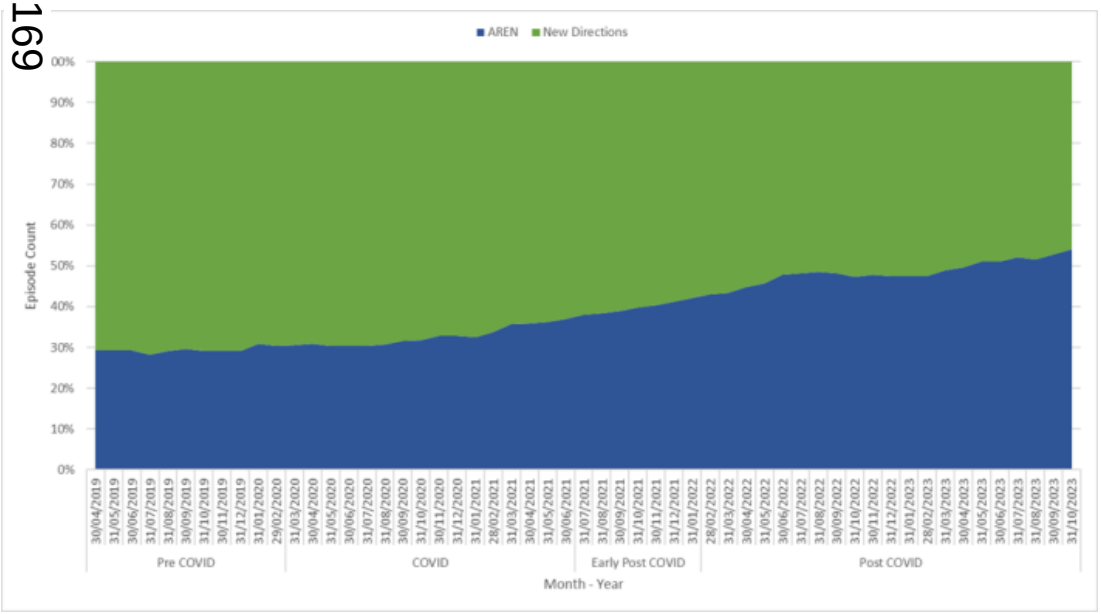
Reablement Delivery Trends

Prior to COVID, 90% of reablement services were delivered to those being discharged from hospital.

This is now around 50%. The New Directions Crisis Response service (designed to prevent hospital admission) makes up 15% with the remaining 35% coming from the community.

Pre-COVID, New Directions delivered 70% of Sefton's reablement; this is now under 50% and whilst capacity has been improving this does remain a challenge and more capacity is needed to meet the presenting need





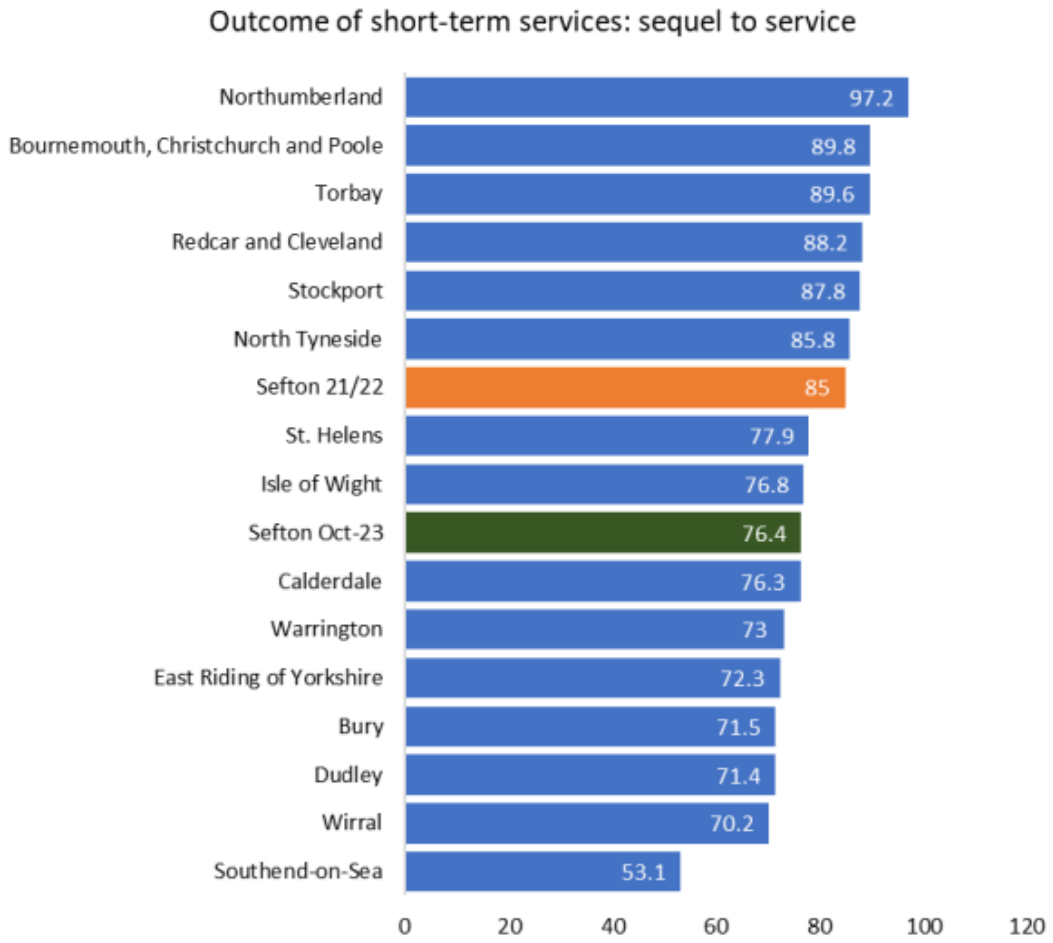
The past few years have seen a growth in the number of reablement services being delivered through Alternative-to-reablement (AREN), however this does a significant cost to the Department and can provide variable outcomes for individuals..

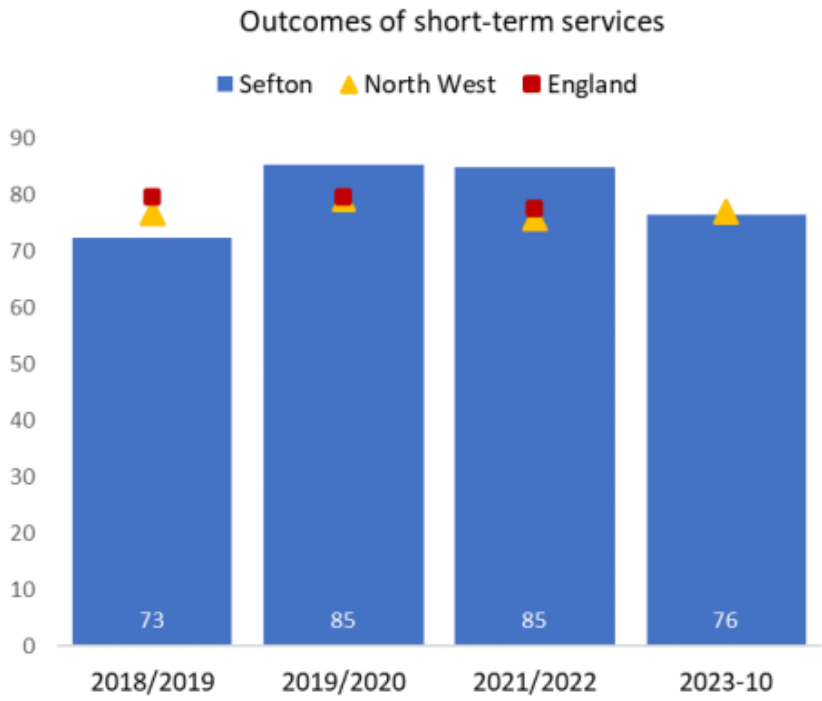
A whole scale review of the reablement provision is currently being carried out working in partnership with Sefton New Directions and colleagues from the NHS as this links very closely to the wider intermediate care provision.

Short-term support outcomes

The proportion of those that received a short term service during the year where the sequel to service was either no ongoing support or support of a lower level has fluctuated and current outcomes are lower compared to 19/20 and 21/22.

Our performance is average compared to the statistical nearest neighbours and the North West.

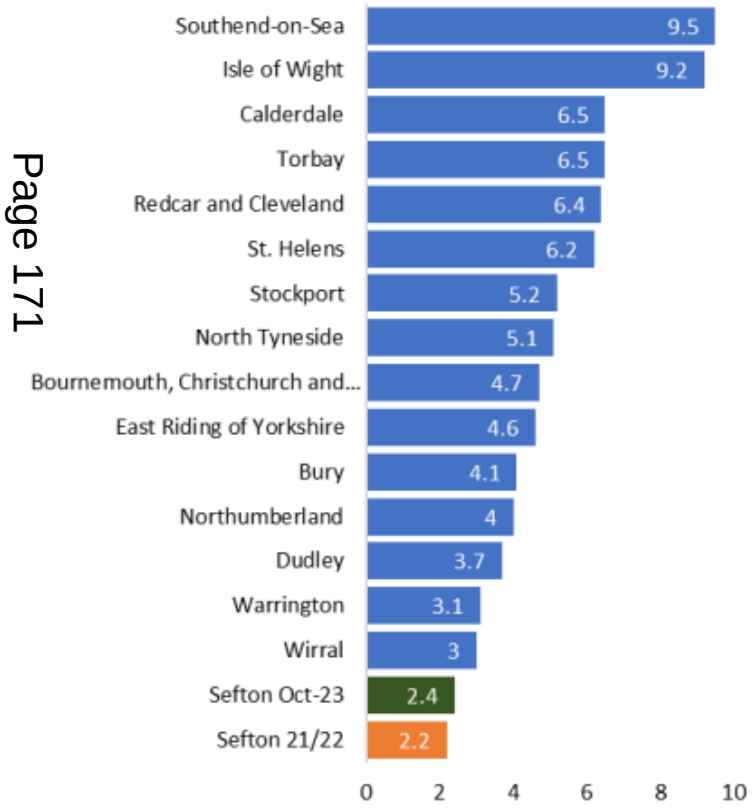


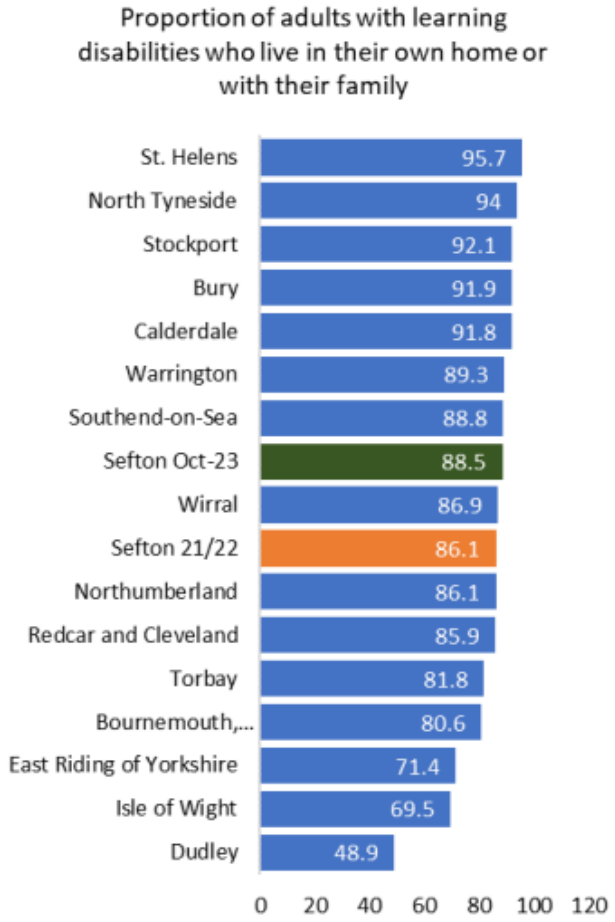


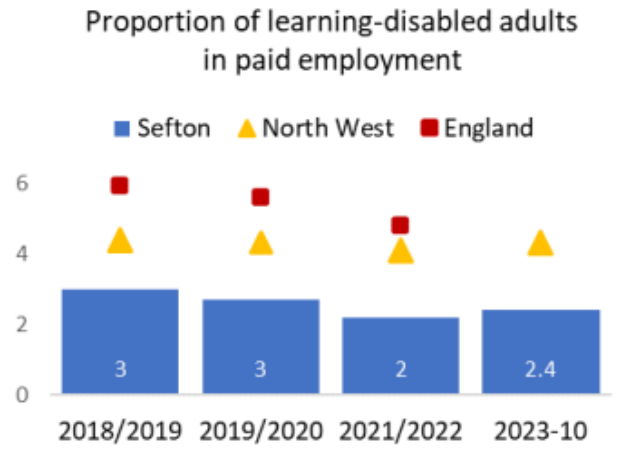
Learning Disabilities Employment and Independence

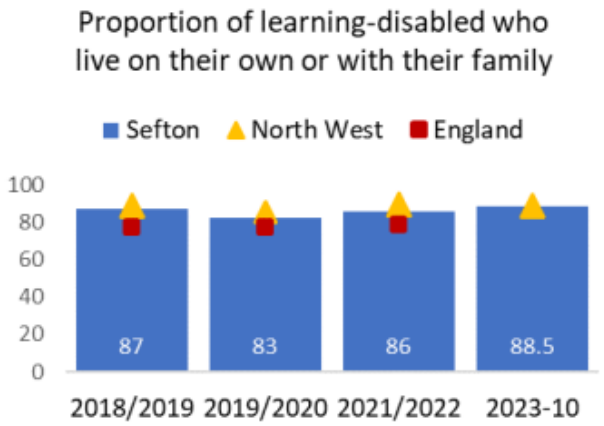
The proportion of learning-disabled adults in paid employment has been low both historically and most recently in 23/24. A development group with system partners is in place and a paper to Executive Leadership Team in Jan 2024 regarding proposals for improving this and opportunities to adopt a Council Wide approach

The proportion of learning-disabled adults who live in their own home of with their family performs average against all comparators.







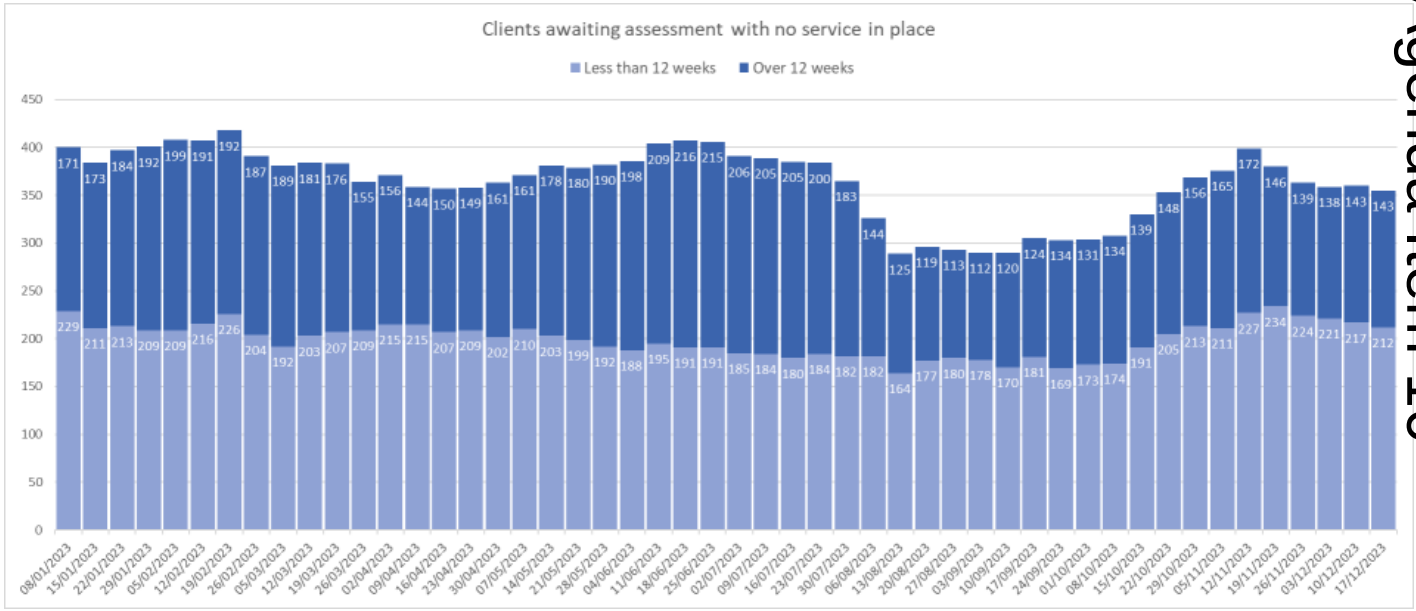


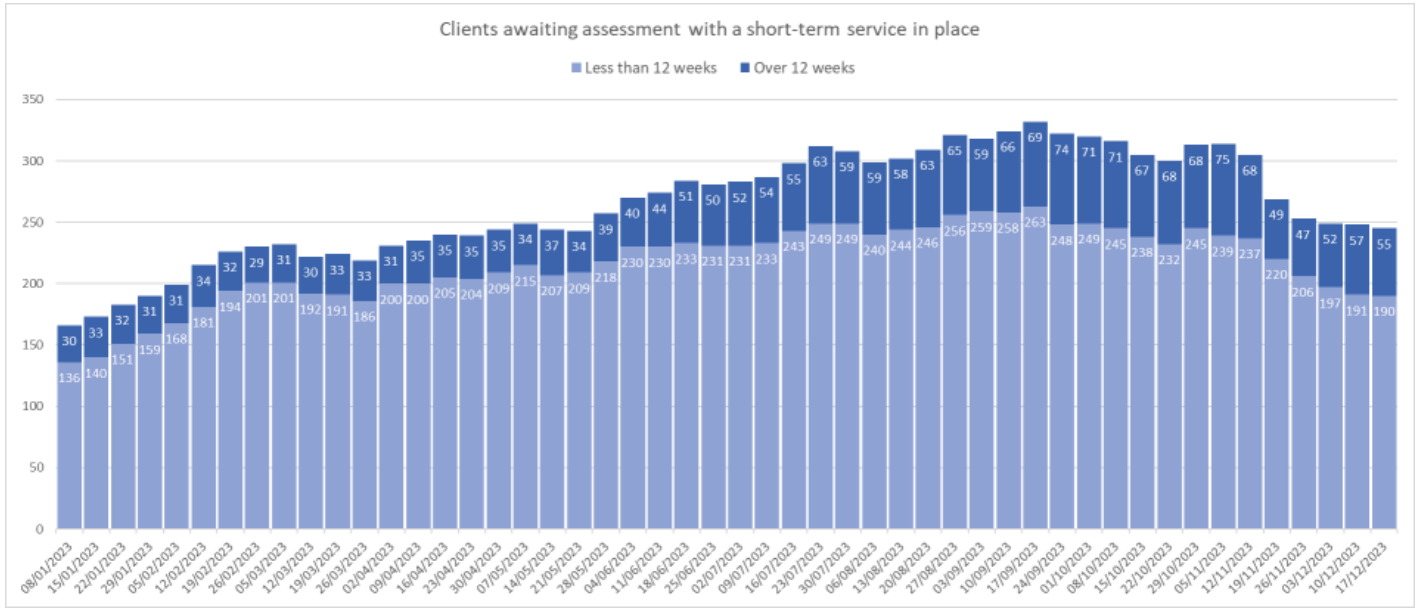
Social Work demand

We currently have 355 people waiting for a further assessment, this is 11% (55 people) fewer than the beginning of the year. This follows an initial contact being completed at the point people get in touch and urgent action being taken where needed.

Of those waiting 60% have been waiting less than 12 weeks, this is a similar proportion as has been seen throughout the last 12 months. Contact is maintained with individuals who are awaiting social work intervention and cases prioritised based on risk. Weekly monitoring is and oversight by the Exec Director is in place. Additional staffing resource has also been put in place to improve waiting times.

024 , a new local performance targets will be introduced with the of all assessments being completed within 28 days from the first it of contact. An improvement trajectory plan will be in place to port this target.





There are 245 clients with a short-term service in place (reablement or short-term/transitional care home bed).

The number of people requiring a short-term service increased from January 23 to the end of September 23, almost doubling during this period. Since then, numbers have however come down by 24%.

Of those waiting in a short-term service who require further assessment or longer term support, 80% have been waiting less than 12 weeks.

2024 will also see the introduction of local performance targets in this area, with the ambition to for all onward assessments to be completed within 6 weeks.

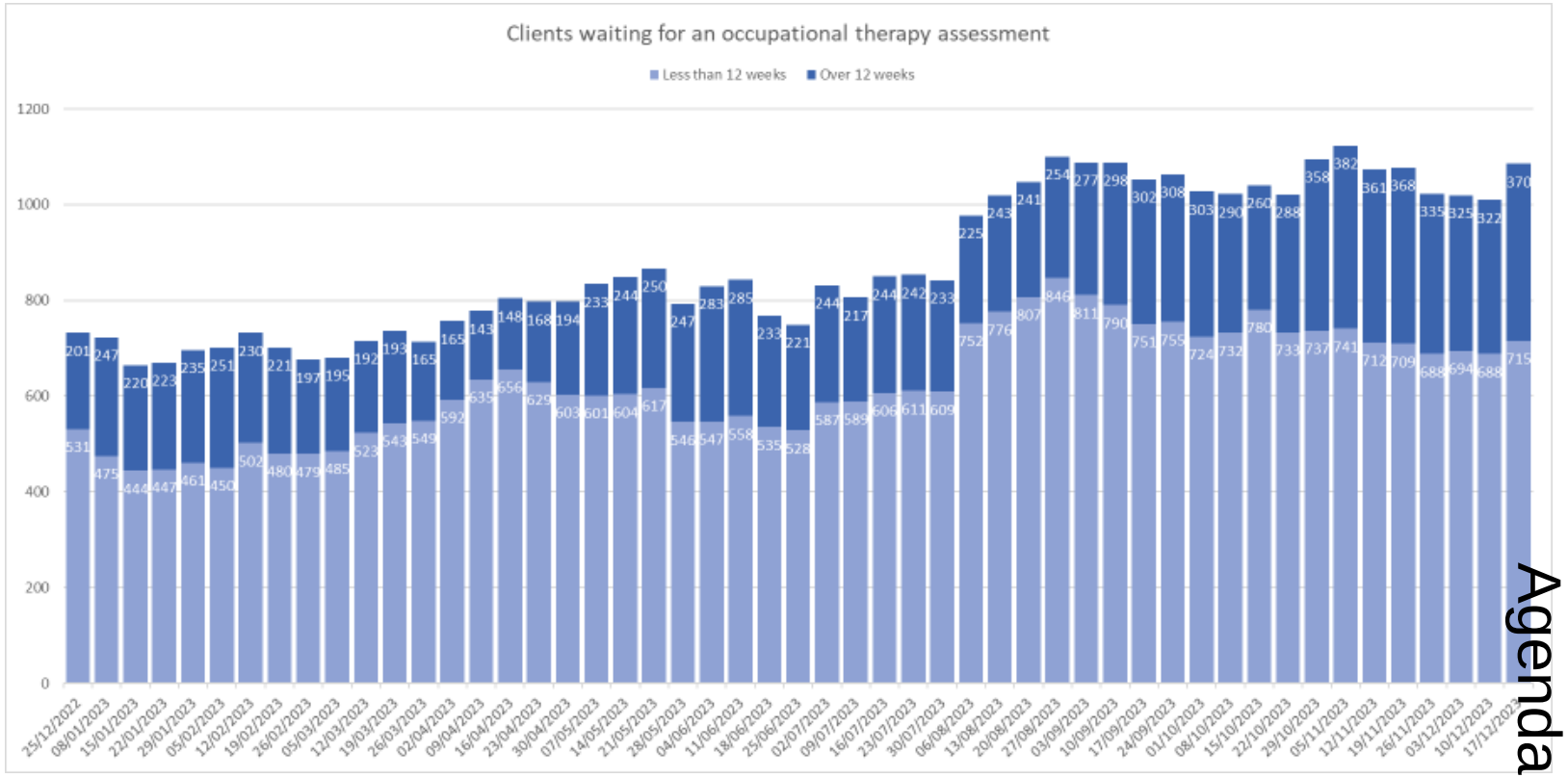
Occupational Therapy demand

Since August we have averaged around 1,000 people waiting for an occupational therapy assessment. This compares to 770 people during the first half of the year.

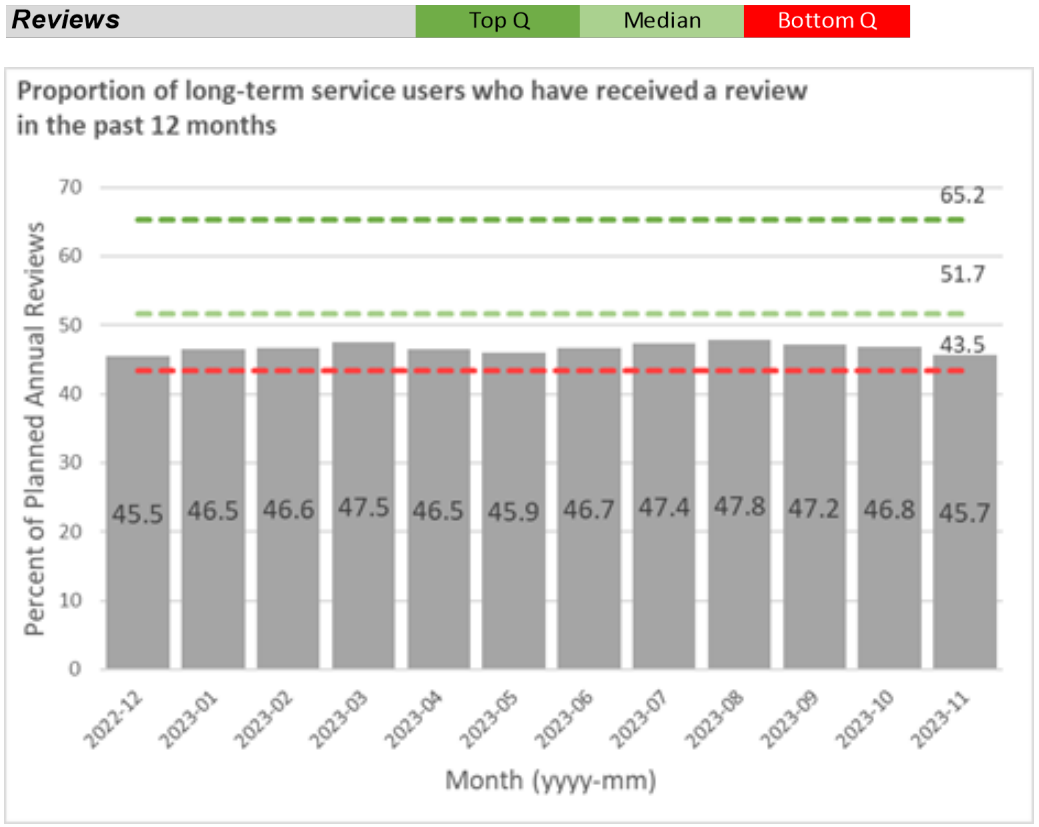
Around two thirds of our clients have been waiting for less than 12 weeks, this proportion has been consistent throughout the past year.

Currently, we are exploring an external targeted team to reduce the waiting list. Alongside this, an operational action plan has begun to implement long term changes in reducing referrals and waiting times. These include:

- *Strengthening the front door offer*- signposting, use of TEC, enhanced equipment provision and empowering self- management.
- *Workforce change*- enhancing the OT skill mix, implementing more efficient ways of working and introducing a collaborative approach to case management across the team.



Reviews



Of our long-term clients 46% have received their annual review within the last 12 months. This figure has been stable over the past 12 months.

This puts us just outside of the bottom quartile in the North West but is below the median of 52%.

Performance in this area has been impacted by the need to divert workforce resource to unplanned reviews, home closures, provider quality concerns and other targeted work.

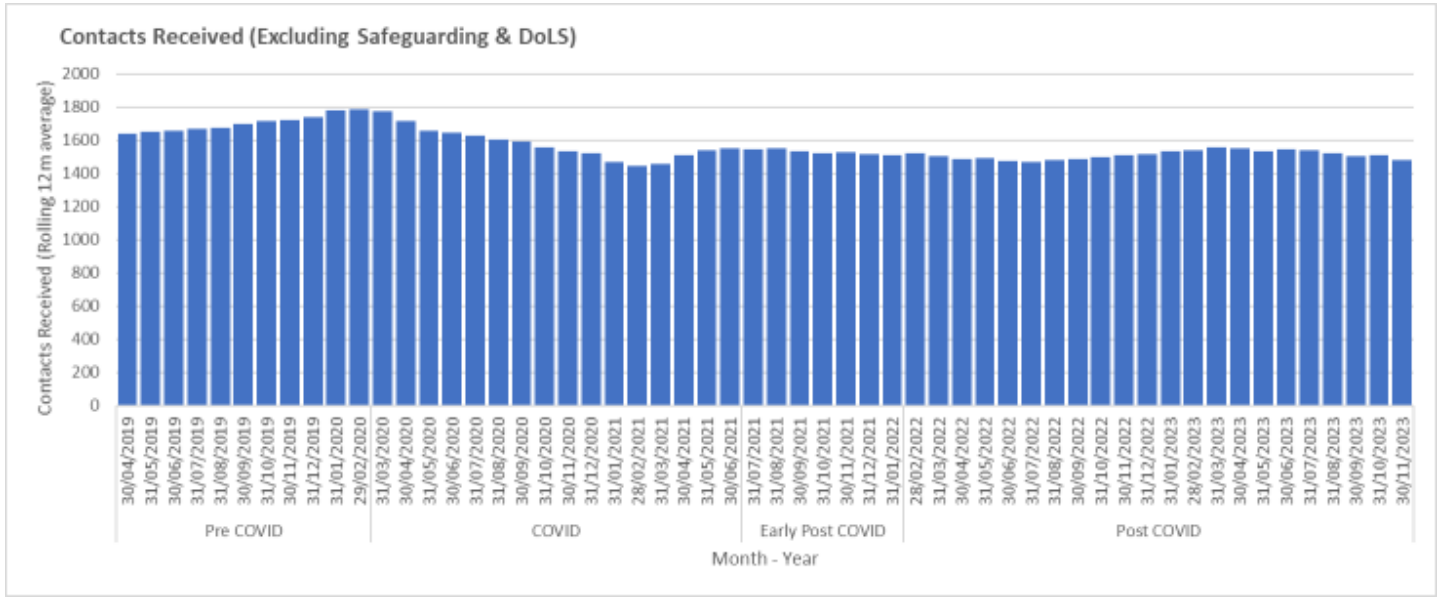
It does however remain a key area of focus with an improvement trajectory and action plan in place.

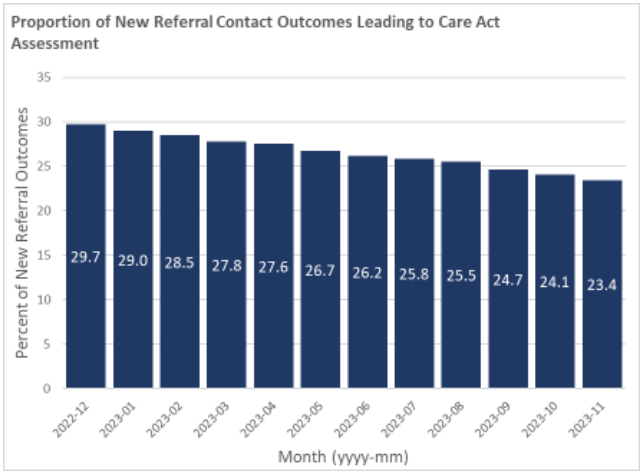
Front Door Activity

Front Door

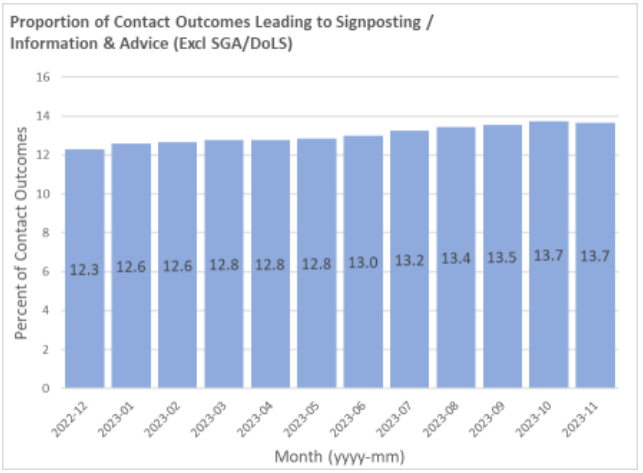
Adult Social Care receive around 1,500 general contacts per month, this is excluding those related to safeguarding and DoLS.

This figure has remained fairly stable in the years since the end of the COVID pandemic but is around 12% fewer contacts per month than we saw prior COVID.





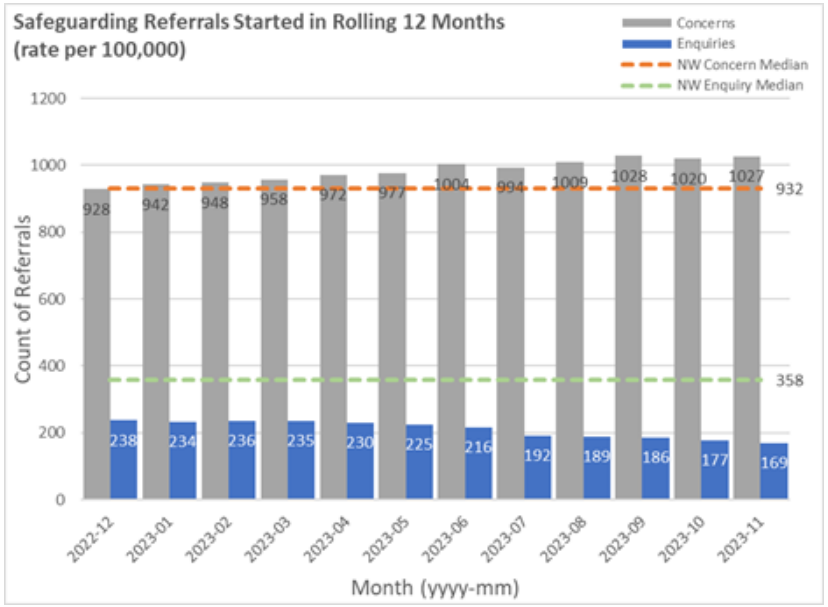
Over the past 12 months we have seen a reduction in the proportion of contacts resulting in a full Care Act assessment and an increase in the numbers of people provided with signposting and advice. Contacts resolved through signposting have increased by 1.4 percentage points whilst those resulting in an assessment have come down by 6.3 percentage points.

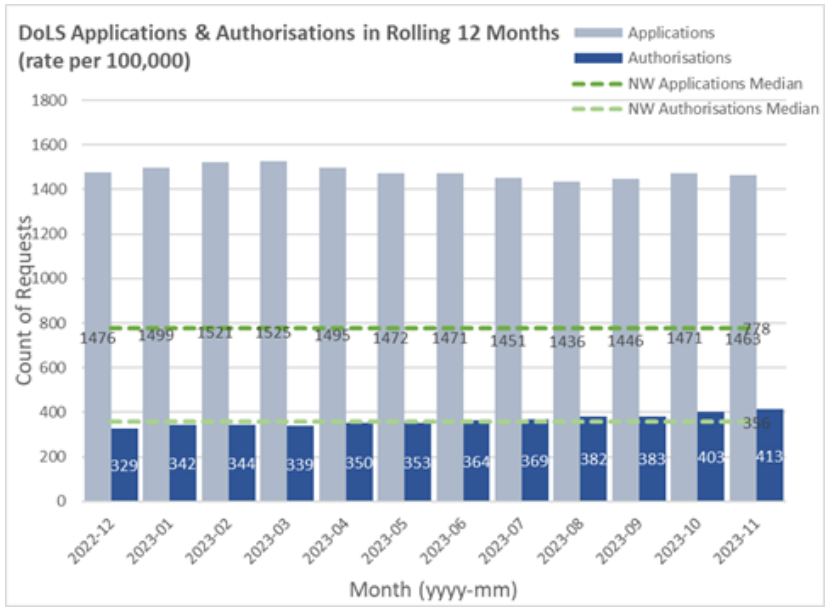


Safeguarding & DoLS

We have seen an increase in our rate of safeguarding concerns, at the beginning of the year we were at the same rate as the North West median. We are now 10% above that figure.

Safeguarding enquiries (section 42s and other safeguarding enquiries) have seen a slight decline over the past 12 months and is around half that of the North West median.





We receive a very high number of DoLS applications compared to our North West neighbours, around twice as many as the North West median. Further analysis is being undertaken regarding this.

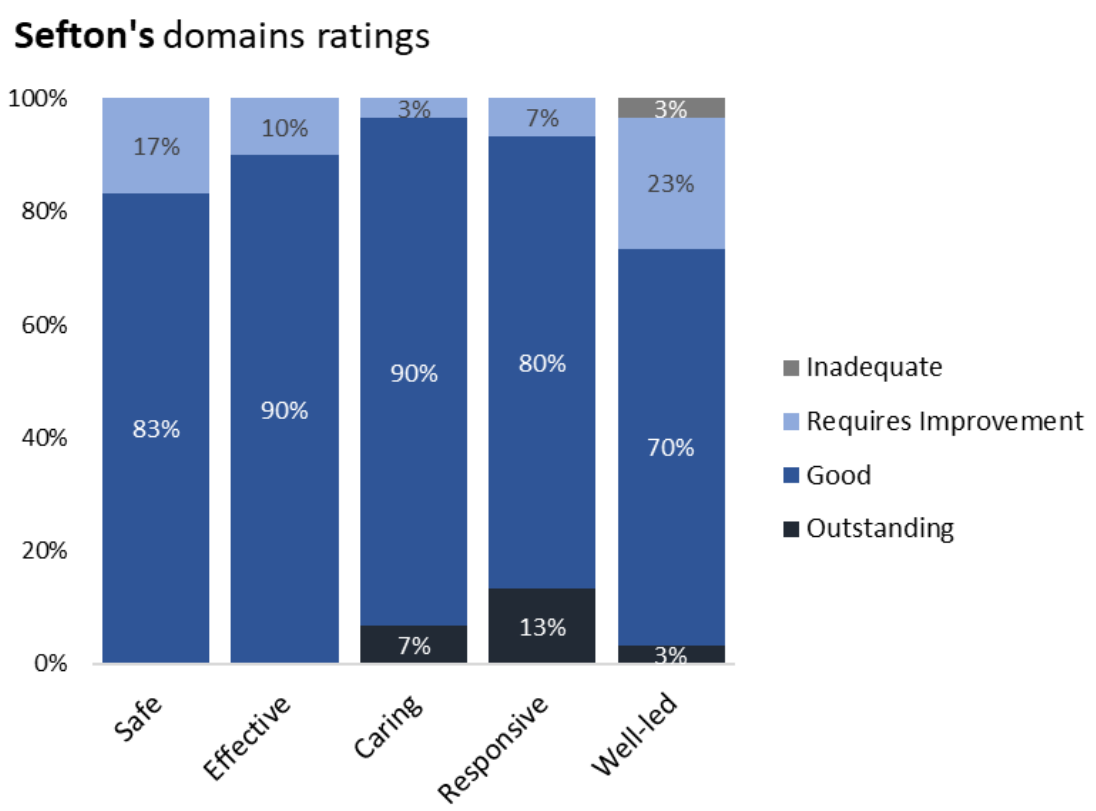
However, our authorisation rate is around the same as that in the North West.

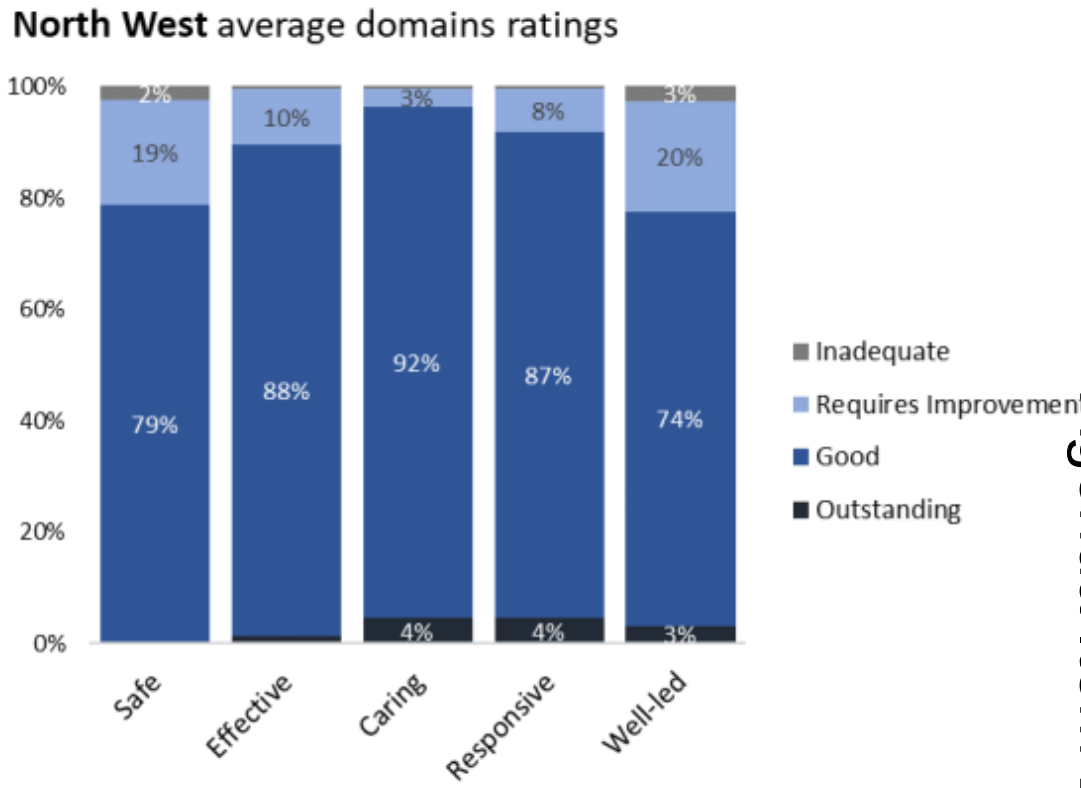
Sefton's Social Care Market and CQC data

Sefton's ASC Locations and domains ratings

As of November 2023, the CQC ratings of Sefton's providers was largely in line with those in the North West, with Caring and Responsive being the strongest areas.

Well led was the worst performing domain in Sefton, as it was in the North West. Just over one quarter of providers were assessed as not being well led.





Sefton's ASC Locations and CQC overall ratings

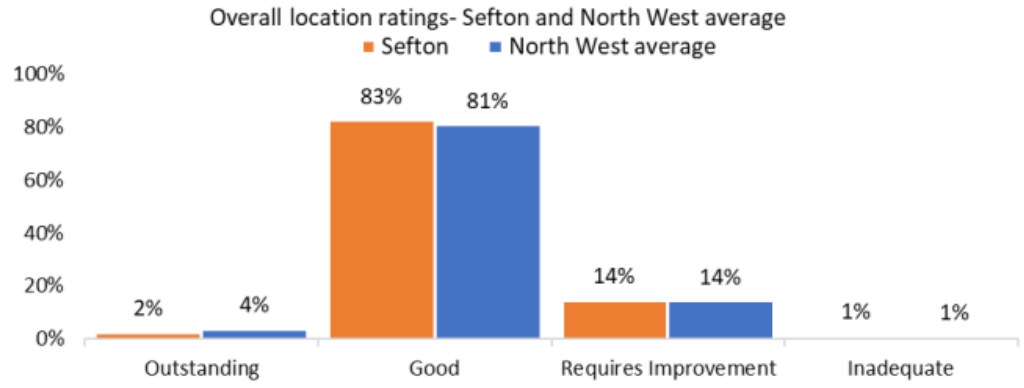
As of November 2023, Sefton had 179 registered locations operated by 137 providers. 69% of locations were classed as residential.

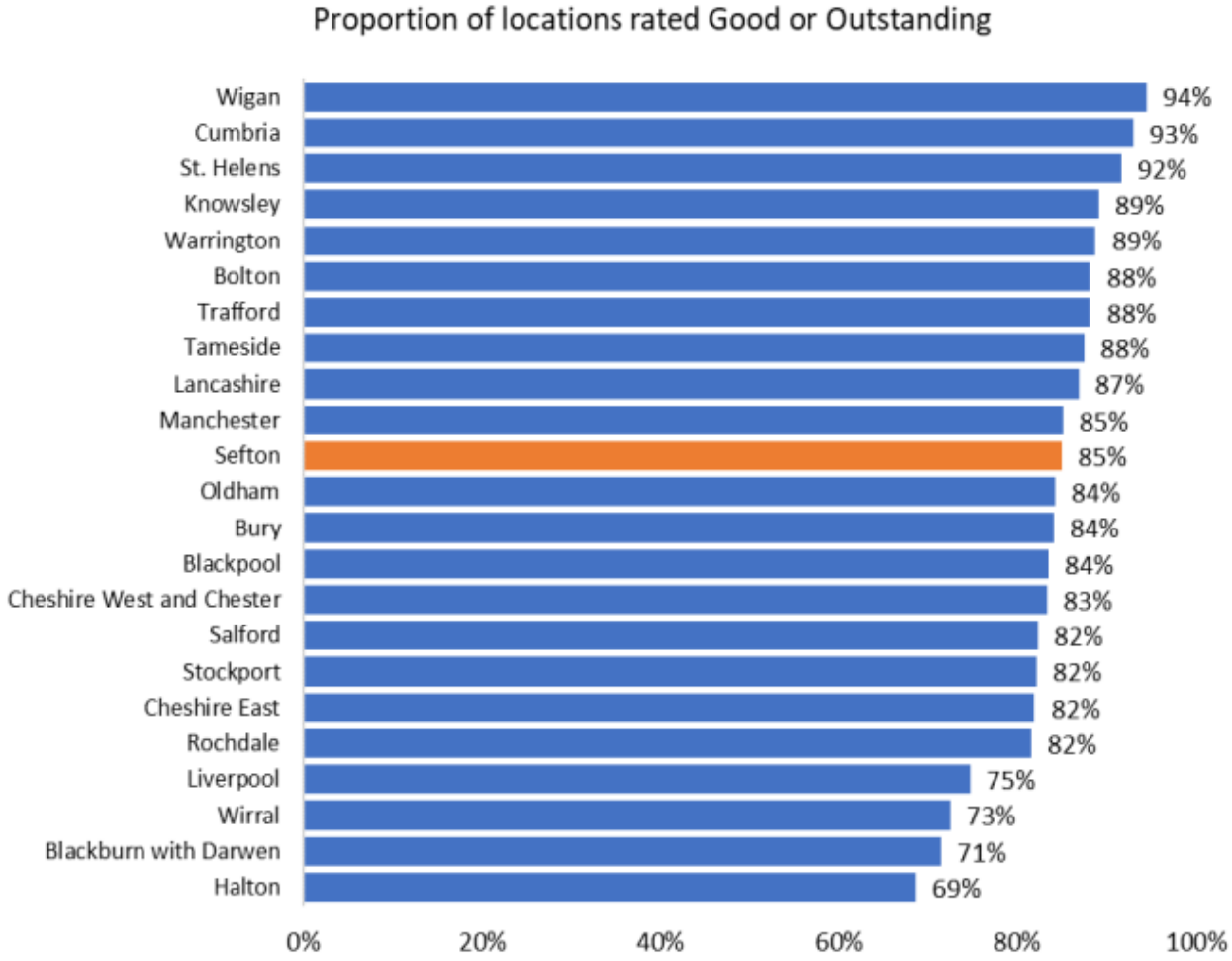
Sefton displayed an average performance against other local authorities in the North West for the overall CQC rating and the proportion of locations rated either Good or Outstanding.

Only one location in Sefton was rated Inadequate.

4 locations were rated Requires Improvement. The Quality ssurance Team are working with all providers to improve the uality of service being provided in these homes.

All placements are reviewed by health and social care staff to ensure safety and risk management. Moves are also facilitated wherever needed and concerns are managed under safeguarding procedures.





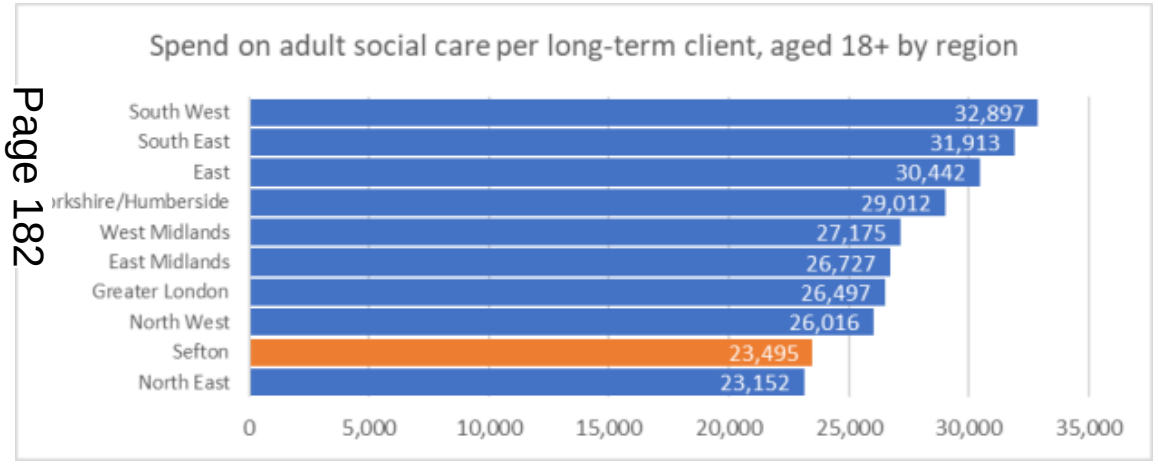
Sefton's Financial Return

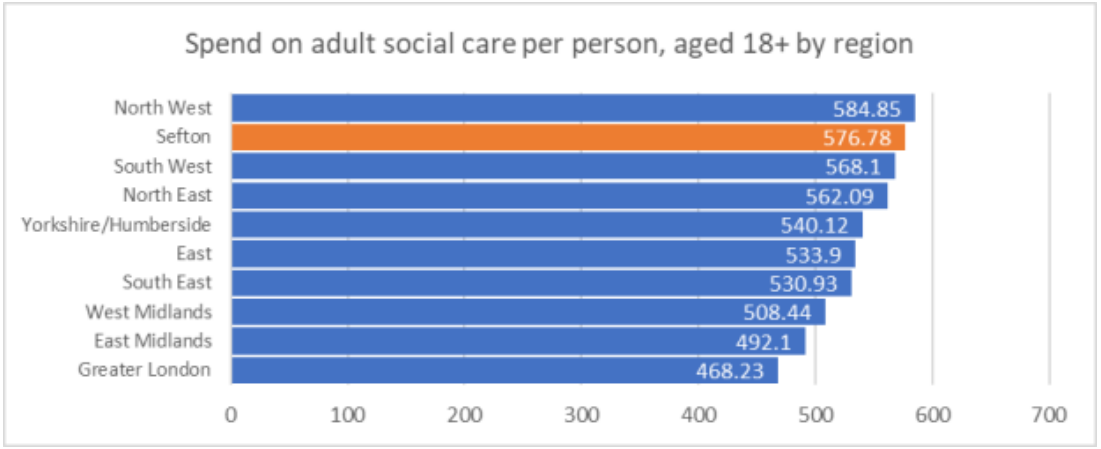
Sefton's ASC Locations and domains ratings

Sefton's spend on adult social care as a rate of the adult population is higher than in England and against our statistical neighbours.

However, when compared to other North West authorities our spend as a rate of the population is just below average.

In the Liverpool City Region only Wirral spend less per head of the population than we do in Sefton.





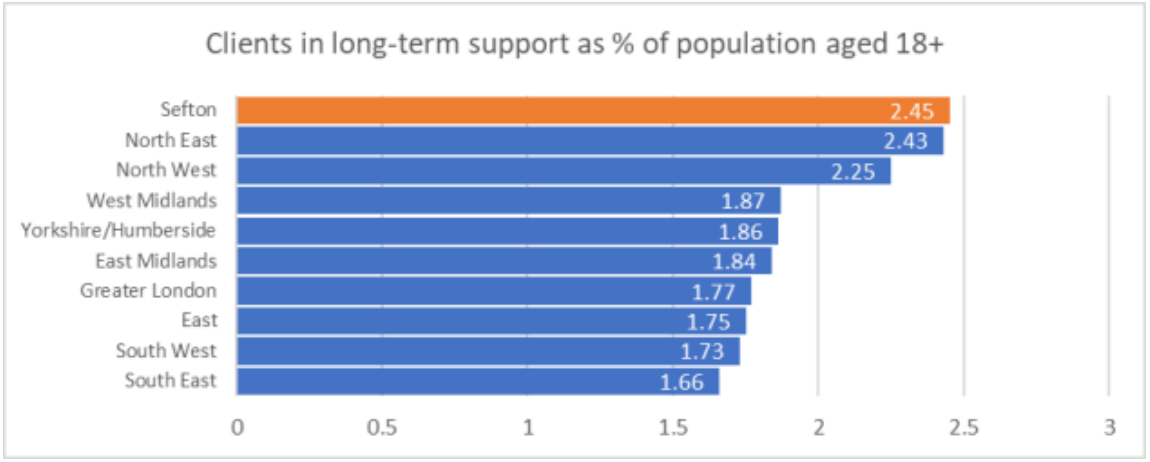
Our spend as a rate of our long-term clients is low compared the rest of England.

Like other authorities in the North West, in Sefton our ASC spend is high as a rate of the overall population but our spend per client is low.

In Sefton we spend around 10% less per client than other authorities in the North West.

This difference in Sefton and the North West is a result of higher proportions of the adult population receiving support from Social Care.

As we can see in the graphic to the right, 2.45% of adults in Sefton receive long term support from Adult Social Care, this is higher than all other regions in England.



Access to Information and Website

Appendix 1

We have continued to develop key Information on the ASC website, so to ensure information does support better the areas of the national CQC single assessment framework, and this shows in our overall improved position from the last 12 months.

This is also since the Council implemented both its easy read access standards and coproduction framework, which provides ASC with the tools to ensure that information is right, responding to the needs of p ole who do access and use ASC services.

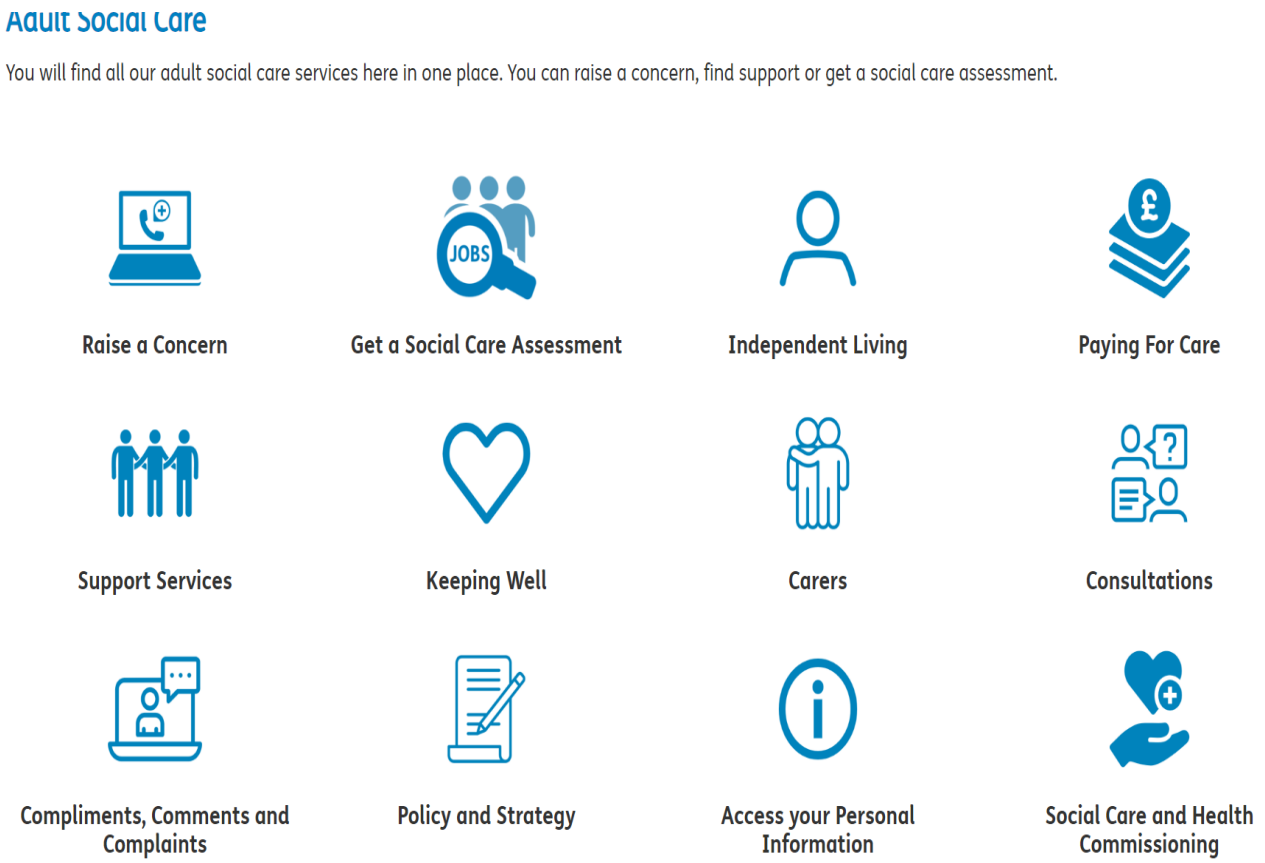
T webpages now include easy read pictures, sound video support r e and easy read information once you drill down into key subject r ers.

We are also working with community partners to update our local directories, so to ensure that people accessing ASC pre-front door are supported with information, advice and signposting to where they need to be. We have also invested in single point phone contacts, given we believe for ASC, having a direct person to talk to, makes a difference.

We have also commenced talks with people who access services, regarding their views of the website so we can improve the front facing page.

Whilst we are improving information on our website, there is further work to do and we are now in the process of putting a 6 -month plan in place with the Councils communications team.

There is a need to replicate for this carers



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Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting:**	23rd January 2024
Subject:	2024 Winter Planning		
Report of:	Executive Director of Adult Social Care and Health	**Wards Affected:**	(All Wards);
Portfolio:	Adult Social Care Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

This report gives an overview to the Committee of the activity that has taken place to plan additional services and prepare for Winter 2023/24 and the expected increased demand and challenge to service delivery this may bring.

Recommendation(s):

(1) The Committee are asked to receive and note the information contained within this report.

Reasons for the Recommendation(s):

To update the Committee on joint plans between the Cheshire and Merseyside ICB Sefton and Adult Social Care in Sefton for addressing winter pressures and to provide to the Committee with reassurance on the processes involved in formulating plans across the Sefton Health and Social Care system.

Alternative Options Considered and Rejected: (including any Risk Implications)

None.

What will it cost and how will it be financed?

(A) Revenue Costs

Costs associated with specific elements of the plan will be met from funding received from the Department of Health and Social Care to address winter / Health and Social Care system pressures. The report provides detail on an additional funding to the Sefton Health and Care System to support the Discharge process during winter.

(B) Capital Costs

There are no direct capital costs identified through the contents of this report.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
Grant from DHSC has been provided for the current financial year. This has to be spent by 31 March 24 and an expenditure return submitted following that. This funding is non recurrent.

Legal Implications:

Equality Implications:
There are no equality implications

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

The contents of this report represent a neutral impact on the climate emergency

Contribution to the Council's Core Purpose:

Protect the most vulnerable:

The winter plan proposals seek to ensure that patient experience is improved, and that vulnerable people identified as being ready for discharge from Hospital can do so as soon as possible and receive support to enable them to regain their independence.

Facilitate confident and resilient communities:

The plan seeks to further put in place services which are enabling and support people to regain their independence.

Commission, broker and provide core services:

The plan seeks to ensure that services are put in place which provide the best outcomes for people and support them to regain their independence in the most appropriate environment.

Place – leadership and influencer:

The plan outlines how Health and Social Care partners are working together to address winter pressures and work with the wider sector to put in place services to address pressures and deliver services to better meet people's needs.

Drivers of change and reform:

The plan is an example of how Sefton Place partners are working together to deliver an

integrated approach to dealing with system pressures.
Facilitate sustainable economic prosperity:
Greater income for social investment:
Cleaner Greener:

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD7495/24) and the Chief Legal and Democratic Officer (LD5595/24) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

The plan has been developed with Partners across the Sefton Health and Care System.

Implementation Date for the Decision

Immediately following the Committee meeting.

Contact Officer:	Eleanor Moulton
Telephone Number:	07779162882
Email Address:	eleanor.moulton@sefton.gov.uk

Appendices:

There are no appendices to this report

Background Papers:

There are no background papers available for inspection.

1. Background

1.1. As outlined by NHS (National Health Service) England it is envisaged that the winter period will be an incredibly challenging time for the Health and Social Care System.

1.2. Services are under continued, significant pressure, with challenges including timely discharge of patients impacting on patient flow within hospitals, alongside ongoing pressures in mental health services and increased demand due to Sefton's Ageing population.

1.3. Sefton, as with other areas, are required to formulate plans to address these pressures and to ensure that risks are effectively managed through the formulation of a Winter Plan.

1.4. Both Acute NHS Trusts in Sefton have already experienced significant challenges. Liverpool University Hospitals NHS Foundation Trust (Aintree site) has been in/out of Full Capacity Protocol over recent weeks; they have not been reporting challenges to the same extent, but over the last few weeks there has been a significant increase in demand and

reported higher acuity of individuals, both of which has had an impact on Long Length of Stay (LLoS).

2. Sefton Winter Planning Process

2.1. The Sefton Place winter plan has also been formulated to meet the following objectives:

- Support Sefton Place urgent care objectives in valuing patients time and improving patient experience.
- To support system pressures across North and South Sefton in what is expected to be a particularly challenging winter.
- To strive to meet capacity with demand and ensure resource allocation in the right areas to support patients to return to their own homes as quickly as possible.
- Collectively ensure delivery of a safe winter

3. The Sefton Place Winter Plan, Intelligence, and Impacts

3.1 This increased demand over Winter was expected, and there have been weekly planning meetings to prepare, with system partners, and a submission made to the Cheshire and Merseyside ICB around Key Lines of Enquiry was made in October:

a. High-impact interventions (those piece of work that are expected to make the biggest impact based on national evidence bases)
b. Discharge, intermediate care, and social care
c. Surge plans
d. Workforce

3.2 It is hoped the implementation of the Winter Plan will also lead to a reduced length of stay in NHS trust and community beds and a reduction in demand for community bed base. We have, since last winter, recommissioned our Domiciliary Care services and have an increased capacity compared to the previous winter period. We have also worked closely with New Directions to see an increased capacity in the reablement service that they offer to Sefton residents.

3.3 There has also been investment in additional Reablement beds at James Dixon Court and block-booking of additional Domiciliary Care capacity.

3.4 It should be noted that the Department of Health and Social Care would highlight the industrial action by Junior Doctors between the 3rd and 9th January and the impact that this could have.

3.5 Longer-term work is also taking place to develop and embed the Care Transfer HUB and the Home First model; this means more focus on community-based services, typically provided by a multi-skilled team to maximise independence and involve an assessment and intervention(s) to achieve goals set with the person. This is the active process of an individual regaining the skills, confidence, and independence to enable them to do things for themselves, rather than having things done for them. It is typically a time-limited service.

3.6 With respect to the Care Transfer Hub, first phase of implementation encompasses existing resources working differently to support admission avoidance and discharge with a focus on delivering the principles of HUB and Home First, including elements of integrated and a co-located base for the Hub staff. The second phase will aim to deliver the agreed model with increased capacity and fully integrated system working within the Hub. Patients will be identified for admission avoidance or the earliest possible planned discharge. All patients will be tracked throughout and assigned a case worker, and the Multi-Disciplinary Team will choose the appropriate pathway from Pathway 1-3, and the level of care required.

3.7 The above work includes the development of a revised Reablement pathway, linked to the Care Transfer Hub work and additional Care Arranger capacity to support with the timely arrangement of placements and care packages.

3.8 There has also been secured additional management capacity in both the Community and Hospital teams and agency staff to bolster the operational teams and help discharge people as quickly as possible. This resulted in more practitioners with the relevant experience deployed over the Christmas Shutdown period than in previous years to ensure an efficient and effective service continues.

3.9 The Care Home Market have been fully briefed on the pressures of the winter situation. They have supported to date and are committed to continue to do so through our well-established Sefton Care Home Partnership. Meetings have had a focus on subjects such as Protection and Control measures and supporting Hospital avoidance. Sefton CVS (Council for Voluntary Service) has also supported with home to hospital services which help to ensure people are able to return home safely and comfortably considering things like heating and enough supply of essential food and drink.

3.10 The winter metric ambitions were for 92% occupancy levels, 76% 4-hour ED target and <30 minute ambulance handover times, none of which are currently being achieved.

4. Cheshire and Merseyside Integrated Care Board (ICB) Oversight / Risk Oversight

4.1. Cheshire and Merseyside (C&M) ICB Winter Planning Operational Group is now established and has in place a C&M Urgent and Emergency Care Assurance Framework and Sefton Place has submitted a baseline assessment of the Winter Plan objectives, and this identified the following risks.

- Current significant challenge to recruit and retain Health and Social Care Workforce, although a national issue this is causing a significant level of individuals awaiting packages of care.
- There is a lack of community bed capacity and a budget challenge to resource this.
- The current Domiciliary care provision is not able to meet demand and there is an ongoing recommissioning process of this.
- There has been a long-held ambition to expand the Reablement offer in Sefton - although working to mobilise this now, there remains a risk to the system that Reablement does not have sufficient capacity to support all that would benefit from it. We have seen an increase in reablement capacity since last winter of 24%, but there is further to go.
- In a post covid environment there is still significant risk and pressure to deliver the elective recovery programme required.

4.2 System Escalation and Ready for Discharge calls are taking place several times a week to discuss system pressures and individual discharge cases, for all partners to work together to ensure people are discharged in a timely manner through the most appropriate discharge pathway for them.

5. How the Winter Plan will be funded

5.1 There was additional investment in high impact areas which included new investment in reablement growth and in domiciliary care support with a strong focus on Discharge to Recover and Assess. There was a strong focus on Long Length of Stays with each case being allocated a link Social Worker who ensures that every action possible is being taken to progress this is reported as working well.

5.2 In acknowledgement of these pressures the government has issued Local Authority's an Urgent and Emergency Care Support Fund, which is managed by the Department of Health and Social Care (DHSC). Sefton Council has secured £715,436 revenue funding from this support fund as of the 4th of December and outlined that the monies will be used to:

- Provide additional services to support with discharges for people who are homeless and/or require housing in-reach support.
- Increased one-off payments to support families/carers to support with timely discharges.
- Securing of short-term care home placements

6. Next Steps

6.1 The Health and Care system in Sefton continues to work closely together to ensure the greatest impact possible is made to support people to return home from Hospital safely and quickly, and to remain in their own home for longer. This is a challenging time to deliver high quality Care and Support; the contents of this report reflects the considerable work undertaken to ensure the Care Market and Social Care workforce are equipped to meet these challenges. It is hoped its content provides reassurance whilst recognising that the demand in the system remains high.

6.2 The Committee is asked to note the contents of this report and that further reports will be provided to the Committee on agreed priorities and updates on the implementation and delivery of them.

Report to:	Overview and Scrutiny Committee (Regeneration and Skills) Overview and Scrutiny Committee (Adult Social Care) Overview and Scrutiny Committee (Childrens Services & Safeguarding)	**Date of Meeting:**	Tuesday 16 January 2024 Tuesday 23 January 2024 Tuesday 30 January 2024
Subject:	Serious Violence Duty		
Report of:	Assistant Director of People (Communities)	**Wards Affected:**	(All Wards);
Portfolio:	Communities & Housing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

The serious violence duty came into force in January 2023 and requires specified authorities to publish a strategy by January 2024 to prevent and reduce serious violence. The work in preparing the strategy on Merseyside has been coordinated by the Office of the Police & Crime Commissioner. The purpose of this report is to update members on the work undertaken so far this year and seek views on the draft strategy.

Recommendation(s):

(1) Members note the contents of the report

(2) Make any suggestions for change to the strategy and/or local delivery plan

Reasons for the Recommendation(s):

The Serious Violence Duty is a statutory duty placed on relevant authorities of which Sefton is one. It is essential that members understand the work being undertaken to reduce and prevent serious violence.

Alternative Options Considered and Rejected: (including any Risk Implications)

There are no alternative options

What will it cost and how will it be financed?

(A) Revenue Costs

£101,161.68 – labour costs 2023/24
£122,302.81 – non-labour costs 2023/24

This funding has been retained and managed by the Office for the Police & Crime Commissioner to coordinate and deliver the duty across Merseyside.

(B) Capital Costs

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):

Within existing resources

Legal Implications:

Sefton is a relevant authority and is therefore statutorily required to deliver the duty.

Equality Implications:

The Equality implications have been considered as part of the strategic needs assessment carried out by the Office for the Police & Crime Commissioner and have been mitigated within the strategy.

Impact on Children and Young People: Yes

Much of the preventive work is focused on Children and Young people as we know they are, particular vulnerable children and young people, most likely to become involved in serious violence.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

The Duty will have a neutral impact on the climate.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Some of the most vulnerable members of our community are victims of serious violence and this strategy and delivery plan will serve to protect them.
Facilitate confident and resilient communities: The strategy and delivery plan places a huge emphasis at coproduction with our communities to make them more aware of and more resilient to serious violence
Commission, broker and provide core services:
Place – leadership and influencer:
Drivers of change and reform:
Facilitate sustainable economic prosperity:
Greater income for social investment:
Cleaner Greener

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.7492/24) and the Chief Legal and Democratic Officer (LD.5592/24) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Meetings, strategy groups, consultation focus groups, emails

Implementation Date for the Decision

Immediately following the Committee meeting.

Contact Officer:	Steve Martlew
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Email Address:	steven.martlew@sefton.gov.uk

Appendices:

Appendix 1 – Serious Violence Timeline
Appendix 2 – Merseyside Serious Violence Draft Strategy v1

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

1.1 Following public consultation in July 2019, the Government announced that it would introduce legislation relating to a serious violence duty. This aimed to ensure that relevant services work together to share information to target interventions, where possible through existing partnership structures, to prevent and reduce serious violence within their local communities. The Government also announced that it would amend the Crime and Disorder Act 1998 to ensure that serious violence is an explicit priority for Community Safety Partnerships and by making sure they have a strategy in place to explicitly tackle serious violence.

1.2 Whilst the guidance does not specify a particular partnership to lead, given the categories classed as "Serious Violence" are contained within the Community Safety Strategy, it makes sense that the Safer Sefton Together (SST) is the partnership lead body for Sefton.

1.3 The Duty requires partners to understand the causes and consequences of serious violence, focusing on prevention and early intervention. There is a requirement to focus on root causes relevant to the local area and produce a Strategic Needs Assessment with contributions from Partners. This assessment will support local areas to prepare and implement a Serious Violence Strategy, with the ambition to prevent and reduce violent crime through tangible actions. The guidance offers case studies from partnerships that have already developed this area of work. Partners expected to form part of the strategic network include Police, Local Authorities, Fire Service, Health agencies, Youth Justice Services, Voluntary and Community Sector, Schools, and local Prisons.

1.4 Serious violence relates to homicide, domestic abuse, as well as all violence against the person including gun and knife crime. Partners have the flexibility to include alcohol related crime, modern slavery and violence towards women and girls if this is relevant to their area. In addition, partnerships need to focus on areas of criminality where threats are inherent, such as county lines and drug dealing territories.

1.5 At a Merseyside level it was agreed at strategic level that domestic abuse will not form part of the serious violence definition for the purpose of the Duty. The scale of domestic abuse cannot be underestimated, and the partnership recognise the impact of these incidents on victims, survivors, and their families, and will continue to support the pre-existing mechanisms in place across the region to oversee and govern activity to prevent domestic abuse and protect victims. The partnership will also continue to ensure preventative activity is directed at addressing underlying risk factors which are shared between domestic abuse and serious violence, to ensure a whole-systems approach to reducing risk and harm.

1.6 There is an expectation for partners to share data from a number of sources to develop a local picture. The Police, Crime, Sentencing and Courts Act 2022 enables permissive information sharing.

1.7 Police and Crime Commissioners (PCCs) are not a specified authority under the Duty but have an important convening role and will be expected to carry out several functions relating to the Duty. In particular PCCs will have a role in convening partners, utilising their unique position as being responsible for the totality of crime and police in a force area. The 5 Local Authorities (LA's) agreed for the Merseyside PCCs office to coordinate the production of the Serious Violence Strategic Needs Assessment and the production of a pan-Merseyside Serious Violence Strategy. The small amount of new burdens funding that accompanied the duty was partly used to fund a Coordinator post within the PCCs office.

2 Work to date

2.1 Appendix 1 is a timeline of the work undertaken within the last year.

2.2 Readiness Assessment

The Home Office commissioned Crest Advisory to work with each Police & Crime area to assess their readiness for the duty. Crest carried out a number of local workshops and assessed the Merseyside area as Ready & Engaged and working towards mature. It also assessed the risk of serious violence in Merseyside as

- Violence Severity – High
- Violence Vulnerability – Extremely High

2.3 As part of their readiness assessment work, Crest identified a need to support the relevant authorities across Merseyside to facilitate stronger co-production across existing governance structures. These workshops took place in July 2023.

2.4 Consultation

In September 2023 a consultation exercise to understand the perception of the problem, causes and consequences was undertaken. The consultation also sought to understand respondents awareness of prevention work and views on ways to improve this, as well as developing an understanding of what prevention means to different people. A universal consultation questionnaire was available to residents across Merseyside. Hosted by Liverpool City Council there was questionnaire for adults (18+) and children 11+. The links were promoted through social media and through the school network. In addition we carried out targeted engagement with cohorts identified as particularly vulnerable in the Strategic Needs Assessment (SNA).

- Youth Justice Cohort
- Turnaround Cohort
- Youth Connectors Cohort
- Making A Difference Group
- Younger Care Experienced Group
- New Beginnings Group
- Uniformed Groups
- Commissioned Youth Providers

There were only 139 respondents to the universal questionnaires (adult and school) this poor response was replicated across the other Merseyside LA's. Unfortunately this means that the consultation response is not statistically reliable. The focus groups provided much richer feedback and this has been incorporated into the strategy.

2.5 Draft Strategy

The draft strategy (Appendix 2) was received on 8 December 2023 with initial feedback requested by 22 December 2023 so the version could be sent to the designers for a more polished version to be produced by 8 January 2024.

Members will note the strategy is very high level, very text heavy and requires a significant design work to make it more reader friendly. The version we are expecting from the designers in January 2024 will contain more photographs, infographics etc.

2.6 Local Delivery Plan

Members will be most interested in what this means locally for Sefton communities. The first draft of the Delivery Plan is currently being developed and will be mapped against the high level strategic aims of the strategy but also cross referenced to the priorities contained within the Safer Sefton Together Strategy 2023-26 and will be reviewed through 2024.

There is no additional funding for LA's to deliver the duty and therefore the delivery plan will reflect the work already underway in preventing and reducing serious violence in our Communities.

2.7 Strategy Launch

The strategy will be launched by the Police & Crime Commissioner on 9 February 2024.

3. Review & Governance

3.1 The duty requires relevant authorities to annually review their strategy and delivery plan. Given the tight timescales encountered in implementing the strategy a full review will take place in 2024 and provide an opportunity for Overview & Scrutiny members to take an active part in that review.

3.2 The governance for the strategy and delivery plan will rest with the SST partnership.

Serious Violence Duty – Milestones and Timeline 2023-24

Milestone	Activity	Timeframe	Resource/Responsible
Serious Violence Duty (SVD) becomes law		January 2023	
Merseyside readiness assessment	Completed and submitted to Crest Advisory (MVRP)	January 2023	MVRP Time
OPCC Advertises Merseyside SVD coordinator roles	Recruitment begins	March 2023	OPCC
SVD workshops	Run by Crest Advisory Service attended by Steve Martlew	March-April 2023	SMBC Time
Crest Advisory Readiness Assessment Due	Review of Crest Advisory Readiness Assessment for Merseyside in conjunction with local assessment	April-May 2023	Crest Advisory SMBC Time
OPCC Appointment of SVD Coordinator	Meet with new coordinators	April-May 2023?	OPCC/SMBC
Notify Comms teams of deadline for publishing Strategy	Senior Responsible Organisations (SRO) Reps to notify comms leads and plan for January 2024 publication of strategy on websites	April-May 2023	SROs and their respective comms teams
MVRP Publish Strategic Needs Assessment (SNA)	**Review MVRP SNA** for any addition data required for Sefton. Are there any new Information Sharing Agreements required?	May-June 2023	MVRP SMBC Time
Workshop 1 – with strategic leads – SRO & 1 Strategic Lead (Crest Advisory Support Work)	Strategic advice and support to Merseyside to facilitate stronger co-production across existing governance structures.	5 July 2023	MVRP Crest Advisory SMBC Time
Workshop 2 – with strategic leads – Strategic Lead (Crest Advisory Support Work)	Strategic advice and support to Merseyside to facilitate stronger co-production across existing governance structures.	13 July 2023	MVRP Crest Advisory SMBC Time
Consultation on development of Strategy:	Consultation on perception of the problem, causes and consequences. As well as awareness of prevention work and views on ways to improve this, as well as developing an	September 2023	LCC to host the pan-Merseyside survey on their website and their digital team will be monitoring demographics to increase engagement throughout the period of consultation. All SST partners to

Serious Violence Duty – Milestones and Timeline 2023-24

Milestone	Activity	Timeframe	Resource/Responsible
	understanding of what prevention means to different people. Universal Consultation as well as targeted engagement with cohorts identified as particularly vulnerable in the SNA. • LCC-led formal consultation. • Youth Justice Cohort • Turnaround Cohort • Youth Connectors Cohort • Making A Difference Group • Younger Care Experienced Group • New Beginnings Group • Uniformed Groups • Commissioned Youth Providers		participate and support facilitation/access to participants experts by experience.
Draft Strategy	MVRP to circulate the draft strategy Feedback by relevant authorities to be with MVRP	8 December 2023 22 December 2023	MVRP SMBC Time
SST Review of Strategy before publishing	Partners to provide any feedback as part of feedback process above	January 2024	SST Partners time
Report to O&S Committee	Share strategy with O&S Committee before final strategy published	January 2024	SMBC Time
Strategy Design and Easy Read / Child Friendly Version Produced	Submission of content to designer by Copy circulated to relevant authorities for review by	22 December 2023 8 January 2024 12 January 2024	MVRP MVRP SMBC Time

Serious Violence Duty – Milestones and Timeline 2023-24

Milestone	Activity	Timeframe	Resource/Responsible
	Feedback from relevant authorities on final amendments by		
Deadline for SV Strategy to be published on all Senior Responsible Organisations' websites	All SROs to publish copy of the Strategy on their websites.	31 January 2024	SRO Comms teams
SST Conference – Launch of SV Strategy	Launch Event 10.00 – 15.00 Venue to be confirmed	9 February 2024	**£££** Funding for Conference – Venue hire/refreshments? SST Partners' time
Review of SV Strategy	Annual review of strategy required under SVD Guidance	April 2024 - December 2024	SST Partnership
Deadline for reviewed SV strategy to be published on SRO websites	All SROs to publish copy of the Strategy on their websites if any amendments made	January each year	SMBC Time

Notes on the strategy

SVD Guidance states that the strategy should set out:

- Local Arrangements
- Multi-agency response to drivers identified in SNA
- Proposed actions - Measurable
- Consideration of joint-funding or investment
- How the partnership focuses on early intervention and prevention (and what this means to people in Sefton)

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STRATEGY TEMPLATE

Police Crime Sentencing and Courts Act 2022

Serious Violence Duty

Strategy

Merseyside

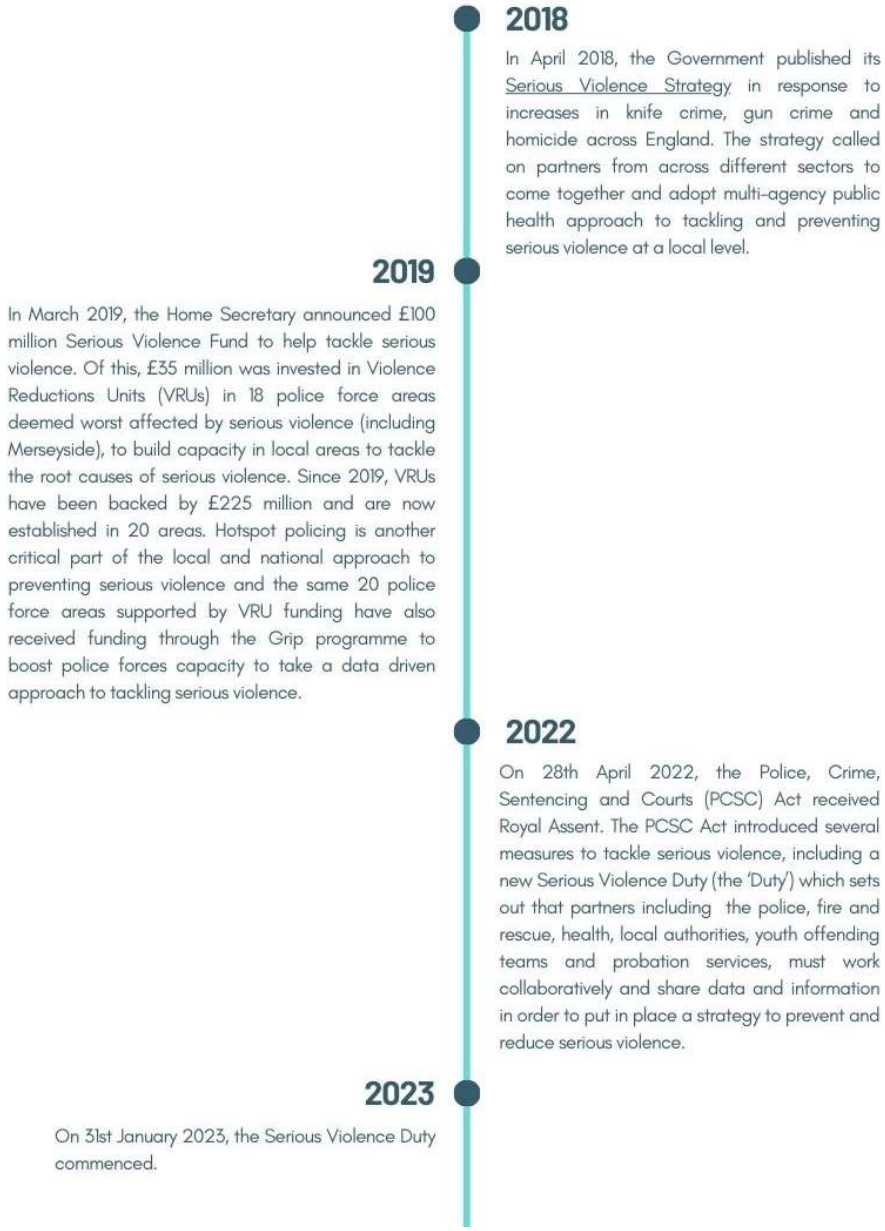
***Include high resolution logos from across each Specified and Relevant Authority.**

Foreword:

*Foreword to be drafted by PCC.

Introduction

National Context



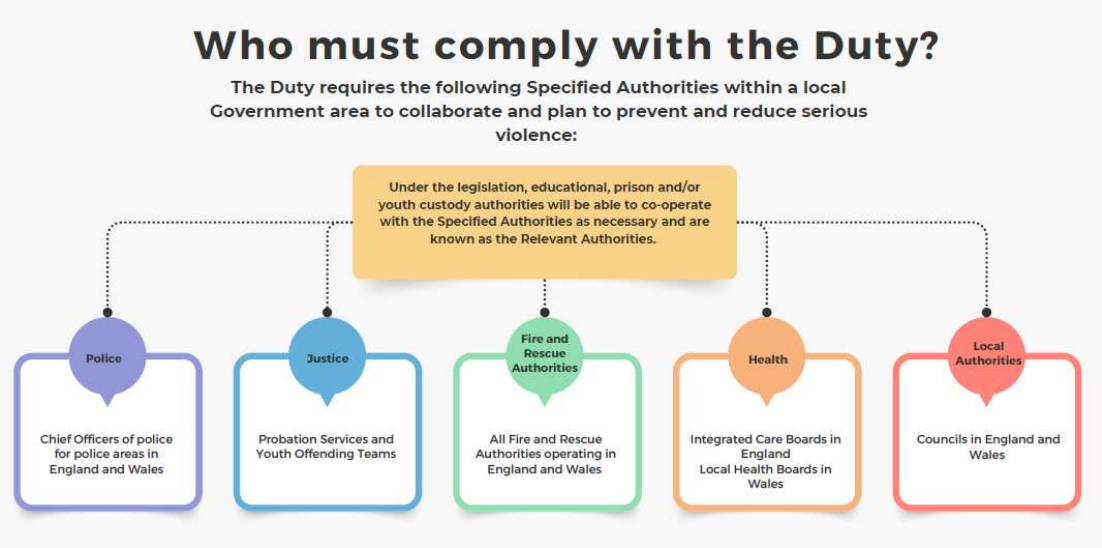
Serious Violence is complex and multi-faceted, and with an estimated cost of over £185.4 million to the Merseyside region, partners have both a moral responsibility to protect and prevent further harm to communities as well as a fiscal imperative to do so[1]. These lower-volume, higher-harm types of violence pervade society, causing significant harm to communities. However, **violence is preventable**, and this underlines the importance of partners working together in adopting a Public Health, Whole Systems Approach to violence reduction. It is within this context that the Government have introduced the Serious Violence Duty ("the Duty").

What is the Duty?

The Duty commenced on **31st January 2023** and is one of many provisions included within the Police, Crime, Sentencing and Courts Act 2022 ("the PCSC Act", introduced to Parliament in March 2021[2]), forming a key part of the Government's commitment to reduce and prevent serious violence.

It places a Duty on public bodies (known as Specified and Relevant Authorities) to collaborate and plan to prevent and reduce serious violence, ensuring relevant services work together to share data and knowledge, and target interventions to prevent serious violence altogether.

Under the Duty, partners must work together to identify the kinds of serious violence that occur in their local area, the causes of that violence, and use this evidence-based analysis to develop a local Strategic Needs Assessment (SNA) and prepare and implement a strategy to prevent and reduce serious violence locally.



This strategy has been produced to comply with the legislative requirements, setting out how public bodies operating in the local policing body area of Merseyside will collaborate locally to ensure a co-ordinated approach to preventing and reducing serious violence. It sets out the agreed definition of serious violence and the

[1] Economic and Social Costs of Violence on Merseyside: A report for Merseyside Violence Reduction Partnership, Liverpool John Moores University.
[2] Police, Crime, Sentencing, and Courts Act 2022.

partnership arrangements which have been agreed locally to lead on the delivery of the Duty. It also provides an executive summary of the serious violence SNA produced by the Merseyside Violence Reduction Partnership (MVRP), details of the consultation activity to engage communities, and the bespoke actions that have been agreed by the partnership to prevent and reduce serious violence.

Specified and Relevant Authorities are referred to as the 'partnership' within this strategy, and include:

- Merseyside Police
- Merseyside Fire and Rescue Service
- Cheshire and Merseyside Integrated Care Board
- Probation.
- Youth Offending Teams.
- HMP Liverpool
- HMP Altcourse.
- Wirral Council
- Liverpool City Council
- Sefton Council
- Knowsley Council
- St Helens Council

What does this mean for Merseyside?

It means that partners, including police, probation, youth offending teams, fire and rescue authorities, health, and local authorities, are now required by law to work together to prevent and reduce serious violence. Whilst this is a new legal responsibility, preventing serious violence and harm has always been a priority for partners in Merseyside, and this new law

"this new law will support partners to work together in the most effective way."
"this new law will simply let partners work together better"
"this new law will simply allow partners to improve how they work together"
"and under this new responsibility, partners can improve how they work together"

Table above

Definition of Serious Violence

For the purposes of the Duty, Merseyside have adopted the local definition of serious violence used for data recording purposes by Merseyside Police and subsequently adopted by the MVRP. This ensures consistency across the region in relation to understanding demand and impact and aligns with the existing partnership focus on violent offending in public spaces. The local definition is:

Include the below definition in an infographic:

"All knife crime or firearms enabled offences, including the following categories:

- Attempt murder
- Assault with intent to cause serious harm (wounding with intent to do GBH (S18 Assault), causing bodily injury by explosion or torture)
- Business and personal robbery
- Threats to kill
- Assault with injury
- Racially or religiously and other form of hate aggravated assault with injury
- Assault with injury on a constable
- Rape
- Sexual assault against a female
- Sexual assault against a male
- Endangering life
- Homicide

Non-knife crime or firearms-enabled offences:

- Homicide plus attempt murder
- Assault with intent to cause serious harm (wounding with intent to do GBH (S18 Assault), Causing bodily injury by explosion or torture)
- Arson with intent to endanger life
- Assault with injury on a constable (only including cause GBH with intent to resist, prevent arrest, wounding with intent to do GBH and wounding with intent)
- All other robbery"

Include below in infographic:

Within the above definition, Merseyside Police recorded **45,543** serious violence incidents in 2022/23. This is a 3% reduction on the previous year.

Domestic Abuse

Locally, the partnership agreed at strategic level that **domestic abuse will not form part of the serious violence definition for the purpose of the Duty.** The scale of domestic abuse cannot be underestimated, and the partnership recognise the impact of these incidents on victims, survivors, and their families, and will continue to support the pre-existing mechanisms in place across the region to oversee and govern activity to prevent domestic abuse and protect victims. The partnership will also continue to ensure preventative activity is directed at addressing underlying risk factors which are shared between domestic abuse and serious violence, to ensure a whole-systems approach to reducing risk and harm.

Pre-existing mechanisms, set out below, lie at the heart of the Domestic Abuse Act 2021 and its wider programme of work.

Include definition of domestic abuse as per Domestic Abuse Act 2021 and the local strategies and governance structure in place to provide reassurance of the work underway to tackle domestic abuse and sexual violence - *or include in appendix.*

Include in infographic - Whilst a shared definition of serious violence brings consistency, this will not prevent the local partnership from focussing preventative activity on other areas of violence outside the scope of the definition, however the local partnership acknowledge that this activity will not be the subject of the Duty. (Include this in a box within design).

Purpose:

Vision & Core Function:

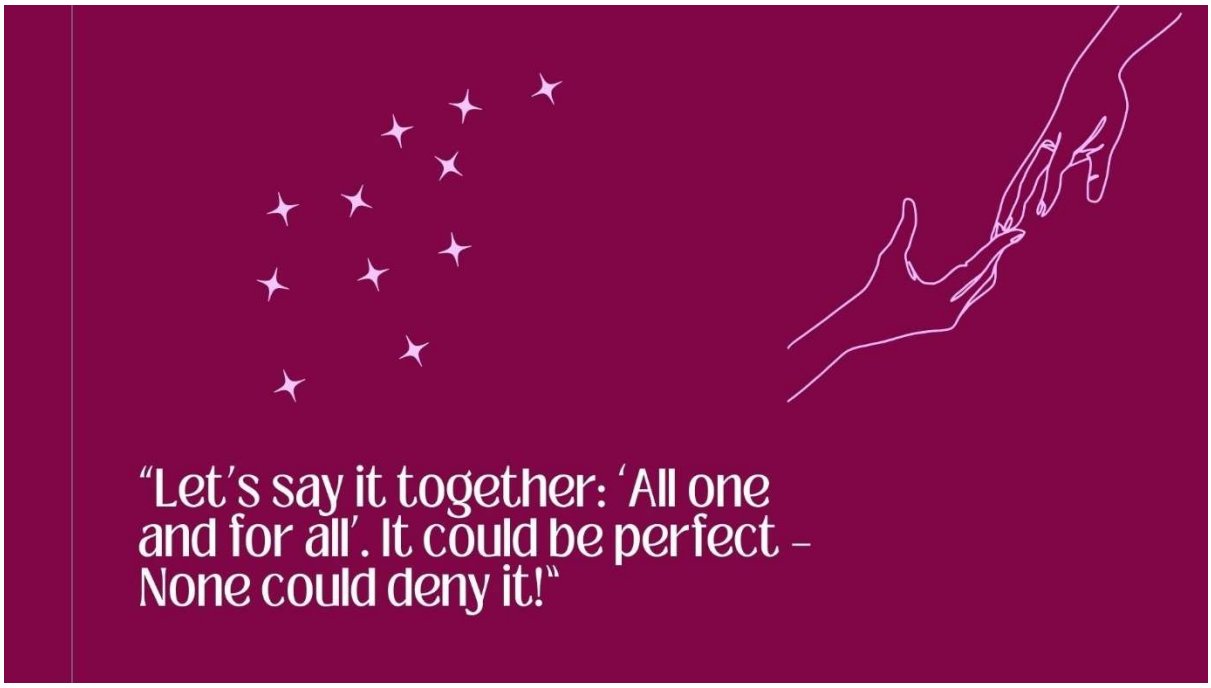
Vision:

Violence is preventable, not inevitable. Aligning to existing partnership visions, objectives, and deliverables, we want to create a safer, stronger, Merseyside, where communities are free from violence and the fear of violence.

Community cohesion is at the core of our vision.

Community cohesion fosters a sense of belonging – connecting individuals to a place, a group, and a community. This promotes positive interactions within a local area, which can enhance feelings of safety. It improves how communities feel about where they live, cultivates positive feelings towards others, including towards statutory services, and most importantly improves overall wellbeing.

To create a safer, stronger, Merseyside, we pledge to empower our communities to actively participate in matters that affect them and that they care about, providing support and capacity building to enable meaningful and mutually beneficial engagement.



With thanks to the children and young people at St Margaret Mary's, as well as the wider family and community members in Knowsley, who powerfully articulate the true power of people in contributing to a society free from violence and the fear of violence.

[The True Power of People - YouTube]

Core Function:

We want the prevention and reduction of serious violence related risk and harm to be everyone's responsibility. We recognise that the causes and consequences of serious violence are complex and require well-coordinated approaches with clear policy directives and interventions that are implemented across all relevant partners at a local level.

As a partnership, we will provide strategic direction, coordination, and leadership across Merseyside to embed and integrate a multi-agency, whole systems, public health approach to serious violence prevention. **Working closely with key stakeholders and communities, we will create a culture which fosters shared ownership, accountability, and mutually beneficial collaboration** – advocating for a system where everyone feels included and understands their role, and the role of others, in supporting communities at risk of, or affected by, serious violence.

What does this mean for Merseyside?

It means that partners and communities will work together to make Merseyside a safe place to live, visit, and work. Everyone will understand what they can do to support people who are affected by serious violence. It also means that as a partnership, we will be creating opportunities for people who are affected by serious violence so that they can tell us what is really needed to prevent serious violence from happening altogether.

Public Health Approach

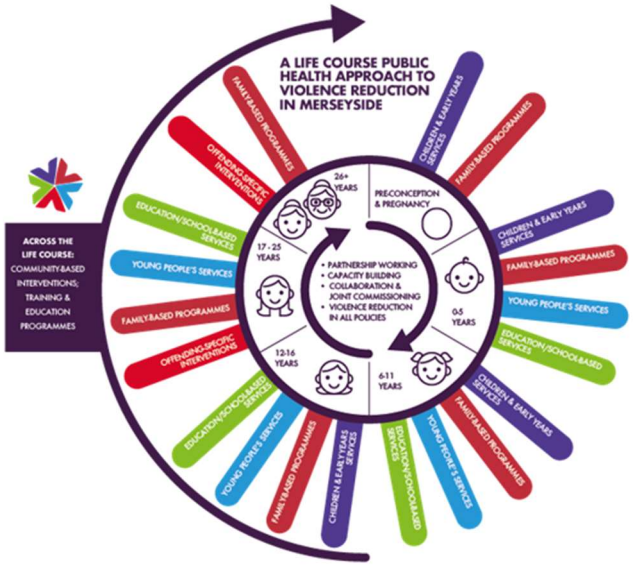
Include quotes as infographics / large texts to visualise the page

> "Violence is a public health issue because living without fear of violence is a fundamental requirement for health and wellbeing. It's also a public health issue because violence is a major cause of ill health and poor wellbeing and is strongly related to inequalities."

> "A public health approach to violence prevention seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence".

To deliver the aims and objectives of this strategy, the local partnership will collaborate and plan within a whole-systems, public health framework, to support the implementation of effective policies, processes, and interventions which seek to prevent and reduce serious violence.

Adhering to a public health approach, the partnership will seek to align delivery across multiple tiers of intervention; primary (interventions to prevent violence from happening in the first place), secondary (interventions to address risk factors and prevent an emerging problem becoming established), and tertiary (managing an ongoing problem to reduce harm, focussed on reducing offending and reoffending) to address risk factors and build resilience across different stages of the life course:



The life course approach, championed locally by the Merseyside Violence Reduction Partnership, addresses health and social needs across all stages of the life course when developing universal and targeted violence prevention policy and activity. [3]

[3] Homepage - Merseyside Violence Reduction Partnership (merseysidevrp.com)

In doing so, this strategy will have a strong emphasis on addressing the root causes of serious violence, whilst integrating a strengths-based model of delivery which focuses on identifying the strengths, as well as the needs, of communities, to build upon and strengthen protective factors to reduce serious violence at a population level more effectively.

We will adapt evidence of what works locally to direct resource allocation to areas of high demand, need, and vulnerability, coordinating and aligning sustainable preventative approaches across geographical and organisational boundaries. This will promote progressive cultural change, encouraging whole systems to think and act more innovatively, and work together to achieve shared outcomes through local integrated delivery plans, pooled resources, and expertise to embed long-term change.

Why a Public Health Approach?

"Violence is not something that just happens, nor is it normal or acceptable in our society. Many of the key risk factors that make individuals, families, or communities vulnerable to violence are changeable, including exposure to adverse experiences in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood, and older age. Understanding these factors means we can develop and adopt new public health-based approaches to violence. Such approaches focus on the primary prevention of violence through reducing risk factors and promoting protective factors over the life course" [4]

"Violence is a major cause of ill health and poor wellbeing as well as a drain on health services and the wider economy. However, it is preventable using measures that save much more money than they cost to implement. Interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational outcomes, employment prospects and long-term health outcomes. Abuse in childhood increases risks of violence in later life, but also risks of cancer, heart disease, sexually transmitted infections, substance use, and a wide range of health conditions that are currently stretching health care resources."

Our Approach: (below included an infographic to minimise text heavy summary)

1 - Defining the problem

It is important that we understand the extent and nature of serious violence within our local communities, including identifying who or where may be most vulnerable to serious violence.

- Effective multi-agency data sharing is critical to this, and we will continue to work with partners to improve the quantity and quality of the data we collect to develop our understanding of serious violence and the burden it imposes on individuals, families, communities, and wider society.

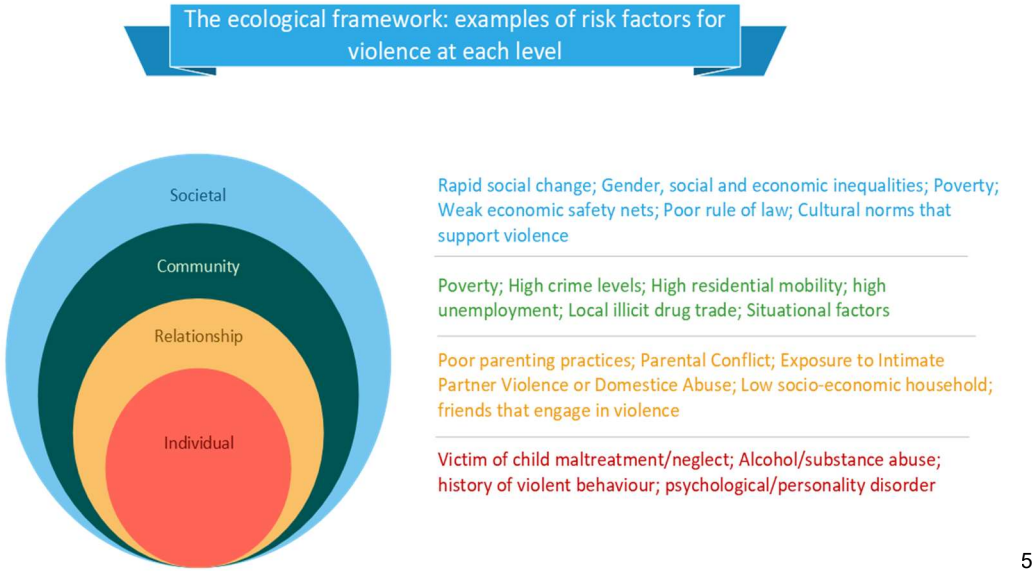
[4] Violence-prevention.pdf (publishing.service.gov.uk)

- To truly understand the nature of serious violence, we must also ensure that the voices and lived experiences of our communities are central to our approach, and we will continue to work with and for our local communities to develop our understanding of local drivers.
- Identifying the societal costs of violence also serves as a useful starting point to demonstrate the 'size of the problem' to policy makers, providing an evidence base for investing in preventative activity at strategic and operational level. Using the current cost analysis commissioned by MVRP and produced by Liverpool John Moores University, we can begin to understand the longer-term impact of investment on preventing the realisation of the costs of violence and reducing the future economic burden.

2 - Identifying risk and protective factors:

There exists a wide range of interconnected factors relating to individuals, their relationships, and the communities and societies in which they live, which may increase ('risk factors') or decrease ('protective factors') vulnerability to violence. Identifying these factors and understanding the complex cumulative impact of risk and protective factors on victimisation and perpetration of serious violence is key to our approach as it enables us to identify at risk populations and target resource allocation to meet local demand or need.

- We will continue to work with key stakeholders and our communities, remaining cognisant to changing political landscapes, to understand existing and emerging factors. This will involve working closely with the MVRP Evidence Hub, as well as with the Integrated Care Board who are developing a violence and injuries dashboard to identify patterns and understand the risk factors to violent crime.



5

3 - Develop and evaluate interventions

[5] https://www.who.int/groups/violence-prevention-alliance/approach

It is important that we understand the impact of our partnership approach on preventing and reducing serious violence. Considering evidence of impact does not mean we will suppress innovation; however, we will ensure the right balance between delivery with strong evidence of impact whilst creating the conditions to support partners in developing the evidence base for delivery which may have good potential.

- Using evidence-based resources, we will continue to develop and embed approaches which are known to deliver the highest impact for populations at risk of, or already involved in, serious violence.
- Whilst quantitative data is fundamental to evaluating effectiveness, we will also work closely with our key partners and communities to understand what works, where, and for whom, so that we can ensure strategic and operational activity is responsive to need at a hyper-local level.

4 - Implementing effective policy and programmes

It is important that we monitor and evaluate the impact and cost-effectiveness of partnership activity over the short, medium, and longer term when implementing processes and interventions which seek to prevent and reduce serious violence related risk and harm. This enables us to build upon our understanding of 'what works' and crucially 'what doesn't work'. Not only does this reduce harm to communities by ensuring maximum impact, but it also makes the case for investing in preventative activity and provides partners with an evidence base to prioritise resources more effectively in the long-term.

- This will involve working closely with the MVRP to build the evidence base on 'what works' at a local level, utilising the many evaluations which have been conducted by Liverpool John Moores University at whole system and intervention level to identify how we can work at scale to deliver improved outcomes for our communities.

What does this mean for Merseyside?

There are some factors which make people more vulnerable to serious violence. This means that some people may be more likely to be a victim or perpetrator of serious violence and may also be more likely to witness serious violence. It also means that certain places may have more serious violence than others.

A public health approach means that we will work together to understand these factors and work out how we can address them by stepping in early to prevent serious violence from happening altogether. Where serious violence may have already happened, it means preventing violence from getting worse to reduce the risk and harm to individuals, families, and communities.

Local examples of embedding a Public Health Approach.

Since 2019, the Merseyside Violence Reduction Partnership have been embedding a public health 'whole systems' approach to tackling the root causes of serious violence – seeing violence as preventable, not inevitable – and the evidence shows it's already having an impact.

The MRVP takes a multi-pronged approach. At strategic level, the MVRP provides leadership on the public health approach to violence reduction across Merseyside through a multiagency co-located delivery team and steering group, developing localised policy, practice, and targeted communications to support system change and capacity to prevent violence.

The MVRP also funds a suite of primary, secondary, and tertiary interventions to prevent violence with a focus on early intervention, life course, place-based, and community led approaches, delivered across five key priority areas: early years, education, health, whole family approaches, and preventing offending, with all decisions informed by the best available evidence.

Blue light datasets from the Trauma and Injury Intelligence Group (TIIG) provide the basis for all decision making. This data provides insight into demand, informing where and what interventions are prioritised. It's also used to monitor and evaluate the performance of interventions to measure success. This work is led by the MVRP's Evidence Hub who have been embedded within the team for the past two years and whose work has been invaluable - driving improvements in processes, data capture, and evidence identification. This has all helped to further deepen the MVRP's understanding of the serious violence landscape in Merseyside and the approaches needed to continue to reduce serious violence. This evidence-based approach is further enhanced by the frequent sharing of best practice, ideas and learning with local partners and other Violence Reduction Units, as well as also using external data sources.

Key achievements:

- A peer education programme - Merseyside Youth Association's Mentors in Violence Prevention – which provides young people with the language and framework to explore and challenge the attitudes, beliefs and cultural norms that underpin gender-based violence, bullying and other forms of abuse, while building resilience and promoting positive mental health. By supporting a 'whole school' approach to early intervention and prevention of bullying, harassment and risky behaviours, this programme empowers pupils to identify and communicate concerns with both peers and school staff.
- Nearly 300 professionals from 13 different organisations receiving training to identify the underlying causes of offending to help ensure people with neurodiverse conditions get the support they need to prevent them from reoffending. This training was the result of research carried out by The Brain Charity to better understand the local landscape and potential for criminal justice reform for neurodiverse people across the region – read the report here.
- Support for children born during the Covid-19 pandemic to help ensure they were ready to start school. With insight from the MVRP Evidence Hub, key hotspot areas were selected to receive targeted early years interventions,

including Reading to Bump, Monkey Bob, and Look Say Sing Play, which seeks to deliver improved long-term population health outcomes.

- One of the first organisations in the country to hold a gambling harms event, featuring case studies and input from counselling services and senior police officers to highlight the breadth and scope of gambling-related harms, with a focus on prevention, early intervention, and treatment.

These results are testament to the strong partnership and collaborative approach adopted by the MVRP and the tireless work of the many organisations involved, all of which are committed to ensuring Merseyside is a place where people can live, work, and visit free from violence and fear of violence.

Spotlight:

Department for Work and Pensions (DWP) and the Probation Service

Recognising the role that high quality employment and training opportunities can play in preventing prison leavers and those on probation from reoffending, the MVRP has forged strong links between the Department for Work and Pensions (DWP) and the Probation Service with a focus on co-location. This includes being the first VRU in the country to have a member of DWP staff seconded into the core team. This move has reaped significant results. Through DWP Prison Work Coaches (PWC) working part-time in Probation Service offices, ex-offenders now have direct access to training and employment opportunities

This work has been recognised as good practice at a roundtable with the Minister for Social Mobility & Youth Progression, Mim Davies MP, and Damian Hinds MP, Prisons & Probation Minister. It was also shortlisted for a national award for innovative partnership at the APCC-NPCC conference and other areas of the country are keen to replicate this model.

Local Partnership Arrangements

As a partnership, we want the prevention and reduction of serious violence related risk and harm to be everyone's responsibility. Building on existing partnership infrastructure, strengths, and capabilities, we will create a system which fosters shared ownership, accountability, and mutually beneficial collaboration so that everyone understands their role, and the role of others, in supporting communities at risk of, or affected by, serious violence.

Ensuring the principles of a public health approach are the golden thread through strategic, operational, and tactical delivery lies at the heart of our approach, and this strategy will provide the framework for partners to work together to implement whole-systems approaches to addressing serious violence. The public health approach is underpinned by community consensus, which recognises that the community's engagement in the serious violence response is essential, and the partnership will collaborate and co-produce with key stakeholders, including communities, to create a safer, stronger Merseyside.

Using the 5 C's principles, the partnership will work to deliver a shared vision which addresses and responds to the specific needs of the local community, establishing Merseyside as a place where people are free from violence and the fear of violence, and where there are meaningful opportunities for all. We will empower local communities, sustainably building skills, resilience, and resource to tackle serious violence, ensuring that diverse voices and perspectives within the community are not only heard, but amplified. [6]

By building our awareness on issues that are impacting our communities, we are better able to form a sustainable feedback loop to inform and focus partnership activity and improve the multi-agency approach to preventing and reducing serious violence. It will also enable the partnership to build effective and consistent approaches to serious violence communications, ensuring key messages are targeted and outcomes focussed so that partners and communities understand the actions being taken to prevent and reduce serious violence. This will play an important role in guiding the strategic direction of the partnership and should be underpinned by a shared set of values and behaviours.

Core Principles of Our Approach:

Innovative and Strengths Based → To ensure that our approach is responsive to the specific needs of the local community, building upon the capacity, skills, knowledge, connections, and potential in a community to prevent and reduce serious violence.

Apolitical and Tailored to Local Need → To support a cultural shift around embedding a public health approach to serious violence prevention within organisational and partnership ways of working, ensuring resilience against any potential for the funding environment to change our focus.

Inclusive → To empower diverse voices and perspectives within the community, providing us with a broader perspective on local serious violence issues and expertise that only those most impacted by serious violence can offer, including people with lived experience.

Meaningful → To ensure that stakeholders, especially members of the community, can see their input within the local approach to serious violence, through robust feedback loops and direct involvement in key decisions around the design and delivery of activities.

Aspirational → To ensure greater alignment between organisations and communities, supporting communities to develop new skills to ensure that work on serious violence prevention is sustainable, delivered by communities, as well as ensuring that existing community work is amplified, well-resourced, and valued.

[6] A whole-system multi-agency approach to serious violence prevention (publishing.service.gov.uk)

Trauma Informed → To understand that different life experiences can shape our behaviour and opportunities and ensure this is reflected in our interactions with partners and communities and influences our decision making.

Whole Systems → To develop a coordinated approach to tackle the root causes of violence, building capacity across organisations and communities so that everyone understand their role and contribution to the prevention serious violence.

Sustainable → To develop cultural and financial sustainability, ensuring policies, processes, and funding models are focussed on improving population health outcomes to embed long-term change and are unaffected by political and contextual changes.

- Collaboration – A collaborative approach requires those who understand the broader implications of violence to generate a collective understanding across all partners within the local system.
- Co-production - The approach and workstreams undertaken locally to prevent and tackle violence should be informed by the multi-agency perspectives of all partners.
- Co-operation in data and intelligence sharing – Data and information sharing is a key enabler for all multi-agency approaches.
- Counter narrative development – Work with community members to create opportunities for development and the option to pursue alternatives to criminal activities. Partnerships should help to support positive aspirations and promote positive role models.
- Community consensus - Community consensus lies at the heart of a place-based multi-agency approach to serious violence prevention. The approach must be with and for local communities, it should empower them to actively participate and get involved in tackling issues that affect them collectively. This is essential for legitimacy and for any 'new' work being carried out by partners (particularly statutory work) to be seen as valid by communities

*Include examples of effective co-production locally as spotlights

Liverpool SV forum? Jill/Susan to review if you think this is appropriate?

Probation Service User Forum? Mary/Jayne to review if you think this is appropriate?

We will:
To embed whole-systems, cultural change, we are committed to reviewing strategic, operational, and cultural assets available within the region to understand where we can build upon what is working well, as well as how we can use the Duty as an opportunity to add value to and compliment existing activity. We are also committed to working with communities to develop a coordinated and consistent approach to communications, empowering communities to actively participate in matters that affect them, supporting participatory approaches which meaningfully involve communities in the design, delivery, and evaluation of serious violence prevention work.

What does this mean for Merseyside?

This means that

Governance and Accountability:

Merseyside Strategic Policing and Partnership Board

Merseyside Police and Crime Commissioner, as lead convener for the Duty, will lead on supporting Specified and Relevant Authorities implementation and compliance with the Duty at a local level due to their responsibility for the totality of policing in their area, as well as services for victims. The Merseyside Strategic Policing and Partnership Board (MSPPB), chaired by the Police and Crime Commissioner, will act as the governance mechanism for delivery of the Duty and the Commissioner will collaborate with the local partnership to provide strategic leadership, coordination, and support to ensure compliance and delivery of the action plans contained within this strategy.

The MSPPB brings senior leaders from all the partner organisations together to focus on key policing and community safety issues across Merseyside and ensure the priorities set out in the Commissioner's Police and Crime Plan are being delivered. The Board acts as an oversight body for several existing sub-groups which focus on improving the effectiveness of the response to policing and community safety issues, including serious violence. Serious Violence Duty Senior Responsible Officers are key members of the Board and work across the partnership to ensure a safer Merseyside.

(Include in box within the design to make the strategy more visible?).

Serious Violence Duty Tactical Oversight Group

There is an established Tactical Oversight Group which drives local delivery of the Duty, including membership from representatives from each of the Specified and Relevant Authorities and the wider partnership. The Group enables knowledge and information exchange, dissemination of operational learning, and maximises opportunities for collaboration and co-commissioning to enhance the service being

delivered to communities. Using the Duty SNA, localised Strategic Intelligence Assessments, and consultation outputs, the Group seeks to understand implementation and impact to promote and maintain a high level of operational assurance that partnership activity is achieving anticipated outcomes. Membership is dynamic and we will continue to ensure that all partners to have an equal voice in decision making, identifying where there may be gaps in expertise and creating opportunities for partners to collaborate to embed serious violence outcomes in delivery and governance.

What does this mean for Merseyside?

This means that there are processes in place for us to make sure that we are achieving what we say we are going to do to prevent and reduce serious violence. If we are not seeing a reduction in serious violence and our communities do not feel safe, we will continue to work together to understand what else we can do to support our communities.

Interdependencies

Local partnership arrangements were agreed to minimise adding complexity to the current landscape, recognising the effective partnership work already embedded across the region to address violence and vulnerability. There are multiple interdependencies and multi-agency strategies established nationally and locally that deliver on the objectives of this strategy, and the partnership are committed to ensuring alignment and consistency in approach. The below is not an exhaustive list but visualises strategies implemented by statutory partners which play a crucial role in preventing and minimising the impact of serious violence locally.

What does this mean for Merseyside?

This means that there already lots of plans in place locally and nationally to prevent and reduce serious violence. However, we will be working together over the next two years to make sure that we can work together better to establish Merseyside as a place free from violence and the fear of violence.

Serious Violence in Merseyside (Summary of the Strategic Needs Assessment of Violence)

In order to identify the kinds of serious violence that occur, and so far as it is possible to do so, the causes of that serious violence, the Duty requires that the partnership work together to establish the local SNA – identifying the drivers of serious violence acting in the local area and the cohorts of people most affected or at risk.

The SNA, produced by the MVRP, has been used as a baseline product by the local partnership to meet the requirements of the Duty. It is a living document which provides an evidence-based, public health assessment of serious violence across Merseyside, within the definition set out above.

Specifically, the SNA:

- Highlights the prevalence of serious violence in Merseyside using multiple data and information sources to identify risks and opportunities for prevention.
- Provides an overview of the local context, as well as takes steps to identify the areas and populations most affected.
- Identifies the drivers of serious violence, as well as the risk and protective factors for violence in Merseyside. This includes an assessment of the impact of the cost-of-living crisis.
- Explores perceptions of serious violence and wider health determinants through continued youth and community engagement efforts to provide a holistic understanding of serious violence as experienced by individuals, families and communities.
- Highlights the estimate cost of serious violence in Merseyside.

Context:

Include the below in a concise infographic to visualise the context of Merseyside.

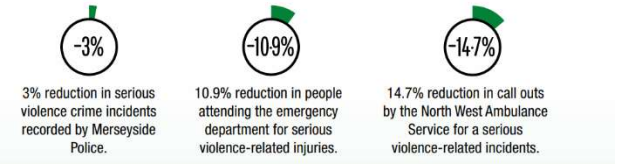
- Home to almost 1.5 million people, Merseyside comprises five boroughs, Knowsley, St Helens, Sefton, Wirral, and the city of Liverpool.
- Using the Index of Multiple Deprivation, two of Merseyside's Local Authorities are among the 10% most deprived in England. Knowsley (ranked 3) and Liverpool (Ranked 4). St Helens is ranked at 40, Wirral at 77 and Sefton at 89
- The most densely populated areas of Merseyside are found in Liverpool, in the wards of Walton South, Wavertree South, Kensington, Anfield East, and Toxteth Park.
- Knowsley continues to house the highest number of 0–15-year-olds.
- Liverpool sees the highest number of young adults (16-34), most older adults (35-64) are spread across Sefton and St Helens, and those of retirement age (65+) are spread across Sefton and Wirral.
- There are more females than males in Merseyside, with the highest percentage of female residents in Knowsley (52.2%).
- Liverpool has the largest LGB+ community in Merseyside, at 4.42% of the population which is higher than the England and Wales average of 3.2%; the smallest is Knowsley at 2.32%. Liverpool also has the largest community of people whose gender identity is different from what as registered at birth, at 0.69% of the local population.
- Considering ethnicity and race, the Local Authority with the highest proportion of White British residents is St Helens at 96.5%, followed by Sefton (95.8%), Knowsley (95.3%, a reduction from 98% in 2021/22), Wirral (95.2%), and Liverpool (84.0%).
- Within Liverpool, Toxteth Park ward is the most diverse area with 30.3% of residents identifying as White British. Interestingly, a very specific MSOA within this ward is 8% White British (E00176718), with 67.6% of residents identifying as Black, Black British, Black Welsh, Caribbean or African.
- As of July 2022 there are 171 Traveller caravans in Merseyside, 70 in Sefton, 56 in St Helens, 25 in Wirral, 20 in Liverpool, and 0 in Knowsley.
- 5% of the residents across Merseyside were born outside the UK. This percentage is significantly higher in Liverpool, in which 14.9% were born outside the UK. The top countries of birth are Poland, Northern Ireland, Wales, the Middle East, China, and EU countries.

- There are two Her Majesty's Prisons (HMP) in Merseyside, HMP Liverpool and HMP Altcourse. HMP Liverpool is a Category B local prison, receiving sentenced and remand adult male prisoners. For historical reasons it is known locally and indeed beyond as Walton prison, and it is situated to the North of the City Centre. The prison has the capacity to hold up to 870 males. HMP Altcourse is a Category B local prison, receiving sentenced and remand adult male prisoners as well as young offenders, from the Cheshire and Merseyside courts. The prison can accommodate up to 1,164 males and all are housed across seven house blocks.
- Almost 60% of the prison population are held in HMP Altcourse, whilst just over 40% of the prison population are held in HMP Liverpool.
- Most of the prison population are White British Nationals and are aged between 30 – 39.
- Most of the prison population have been sentenced, with a significant proportion also on remand.
- Both prisons received a 'good performance' rating on the annual prison performance rating.

Extent:

Merseyside Police, Emergency Departments, Merseyside Fire and Rescue Service and the North West Ambulance Service all recorded a reduction in incidents linked to serious violence from 2021/22 to 2022/23.

2021/22		2022/23
MerPol 46,953	3.0% ▼	MerPol 45,543
ED 4135	10.9% ▼	ED 3683
MFRS 3690	0.8% ▼	MFRS 3660
NWAS 920	14.7% ▼	NWAS 785



Include the stats like this? With the addition of FRS data.

- Merseyside Police data reveals that the highest number of serious violence offences fall into the category of Violence Against the Person (87%), followed by Violence Without Injury (58%). 0.05% of incidents are recorded as homicides, 0.5% are linked to firearms, and 3.6% are linked to knives/bladed articles.
- Stop & Search data reveals that the main residential for those stopped and searched was Liverpool (48%). The main Act cited was Misuse of Drugs Act (79%) and the main object found was controlled drugs (71%).

Nature:

- Police: Merseyside Police data reveals that the Local Authority with the most recorded Serious Violence incidents is Liverpool (39%). Serious violence incidents were fairly consistent throughout 2022/23, with a slight peak in May (11%).
- Ambulance: The highest percentage (40%) of North West Ambulance Service and Emergency Department patients reside in Liverpool.
- Fire: Merseyside Fire and Rescue Service saw 3,660 deliberate fires in 2022/23. The peak months include August (16%), April (13%) and July (13%). Liverpool sees the most deliberate fires (37%), followed by Wirral (22%). 1.4% linked to OCG activity and 0.3% domestic abuse.
- The SNA highlights specific ‘high crime high harm’ areas within Merseyside, the majority of which are in Liverpool, followed by Wirral, Sefton, and St Helens. Knowsley does not have a ‘high crime high harm’ area. 38% of homicides occurred in Liverpool, with peaks in October and August.
- Prisons: Drug offences and violence against the person are the most common recorded offence across both prisons. (HMP Altcourse, 268 drug offences and 315 violence against the person) (HMP Liverpool 210 drug offences and 200 violence against the person)

Include the below on its own page

High Crime High Harm Hotspots

Using the Cambridge Crime Harm Index, Merseyside Police identified 12 High Crime High Harm (HCHH) areas across the region. These HCHH areas make up just 0.5% of the force area but are responsible for 23% of serious violence crime and its associated harm.

Patrols are deployed to these identified HCHH areas to carry out normal police duties as well as a targeted response to serious violence. Results show that there has been a 54% reduction in serious violence within these areas, compared to a 31% reduction forcewide (when compared to the same period in 2021). This response has seen a positive impact on other crime types too, for example, Burglary Residential has decreased by 25% forcewide but has decreased by 49% in the HCHH areas. This supports the importance of implementing place-based approaches, by targeting resources to areas of high demand, need, and vulnerability.

Who is involved in serious violence in Merseyside?

- Where age is recorded, those involved in serious violence are most often aged between 20 – 35 years old.
- Across all BlueLight datasets, where gender is recorded, those involved in serious violence are mainly male.
- When looking at victim and perpetrator profiles using Merseyside Police data, victims of serious violence were mostly female, and suspects were mostly male.
- The North West Ambulance Service and Emergency Department report that the peak ages for those requiring medical assistance for serious violence incidents are from 15-19 years to 35-39 years. The peak age for ED attendances specifically is 20-24 years, compared with 30-34 years for NWAS. 60% of ED attendees for serious violence incidents were male. Of the people attending a Merseyside based ED with an assault injury, the relationship between victim and suspect was unknown. Of cases where it was known, the majority said the suspect was a stranger, 4.5% said their attacker was an acquaintance or friend.

What have our local communities told us about serious violence?

Community consensus lies at the heart of the local partnership approach to preventing and reducing serious violence. To embed a truly place-based, multi-agency, public health approach to serious violence prevention, we recognise the importance of working with and for our local communities, empowering them to actively participate in matters that affect them and that they care about.

In adopting a strengths-based approach, we want to support our communities to co-design solutions, ensuring their voices are at the heart of decision-making processes at a local and central Government level. In developing this strategy, we have delivered a series of consultations over the past 12-months to understand how violence affects our communities, to establish what we can do as a partnership to improve feelings of safety amongst our communities and minimise the fear of violence.

What does this mean for Merseyside?

What did we do?

Whilst we engaged **universally** with our communities' pan-Merseyside, we recognise the importance of engaging with members of our community who may be in receipt of the services and support that the agencies and bodies involved in this partnership provide, and who also may be particularly vulnerable.

Adopting a two-tiered approach, we delivered **targeted** consultation at 'place' and 'organisational' level. This enabled us to develop our understanding of the nature and causes of violence in different populations, whilst broadening our understanding of the localised nuances within and between local authorities. These insights have enabled us to develop meaningful and achievable actions which will be taken forward by the partnership over the short, medium, and longer-term, to ensure responsivity to local need.

Universal

Who did we speak to?

We engaged over 750 people from across Merseyside.

What did they tell us?

EMILY SPURRELL
MERSEYSIDE POLICE
& CRIME COMMISSIONER

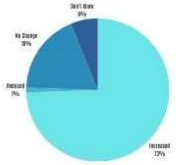
victim care
Merseyside

Your safety matters

750+ RESPONSES

PERCEPTIONS

HOW DO YOU THINK VIOLENT CRIME HAS CHANGED IN YOUR AREA IN THE PAST YEAR?

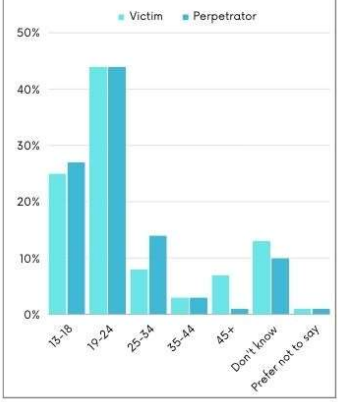


WHAT DOES OUR DATA TELL US?

Merseyside Police, Emergency Departments, Merseyside Fire and Rescue Service, and the North West Ambulance Service all recorded a reduction in incidents linked to serious violence from 2021/22 to 2022/23.

- 3% reduction in the number of serious violence incidents recorded by Merseyside Police.
- 10.9% reduction in the number of attendances at Emergency Departments for serious violence related incidents.
- 0.8% reduction in deliberate fires attended by Merseyside Fire and Rescue Services.
- 14.7% reduction in ambulance call outs by the North West Ambulance Service for serious violence related incidents.

WHICH OF THE FOLLOWING AGE GROUPS DO YOU THINK ARE MOST LIKELY TO BE A VICTIM OR PERPETRATOR OF VIOLENCE?

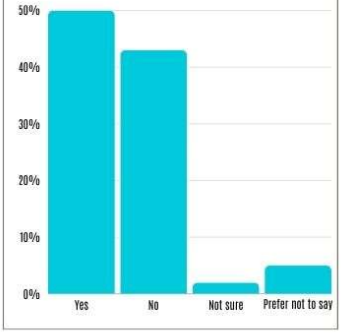


WHAT DOES OUR DATA TELL US?

Individuals involved in serious violence as victim or perpetrator are most often aged between 20 - 35 years.

- The North West Ambulance Service and Emergency Department report that the peak ages for those requiring medical assistance for serious violence incidents are from 15-19 years to 35-39 years.
- The peak age for Emergency Department attendances specifically is 20-24 years, compared with 30-34 years for North West Ambulance Service.

HAVE YOU BEEN A VICTIM OF VIOLENCE?

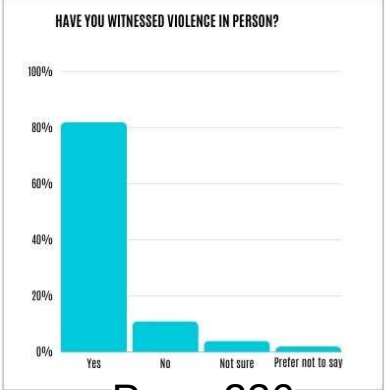


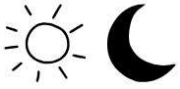
victim care
Merseyside

If you've been affected by crime, you can contact Victim Care Merseyside for free, confidential, non-judgemental advice and support.

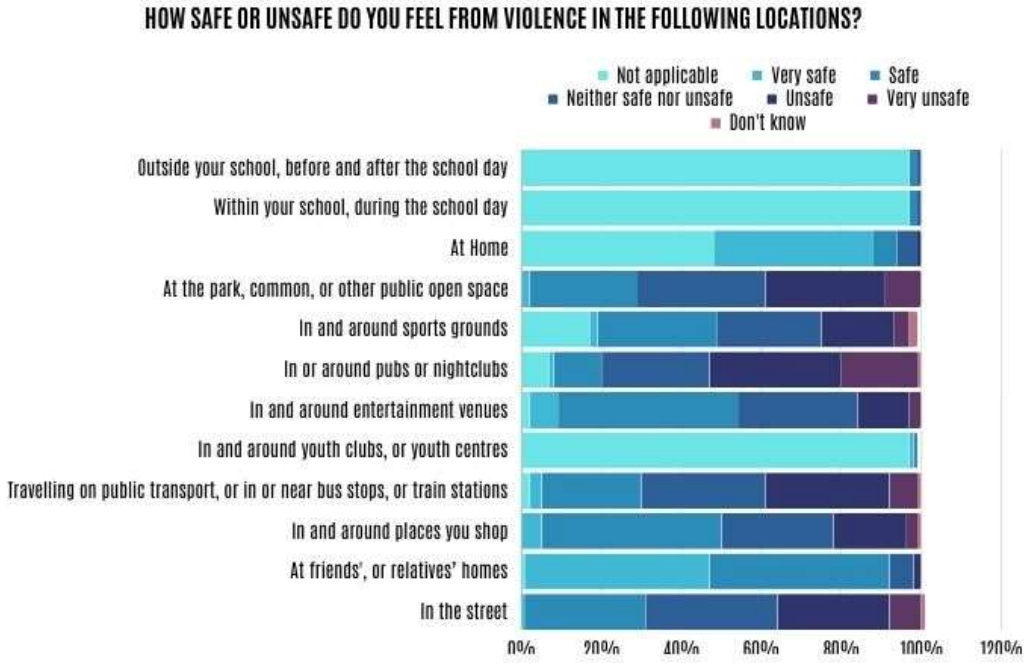
HTTPS://WWW.VICTIMCAREMERSEYSIDE.ORG/

HAVE YOU WITNESSED VIOLENCE IN PERSON?



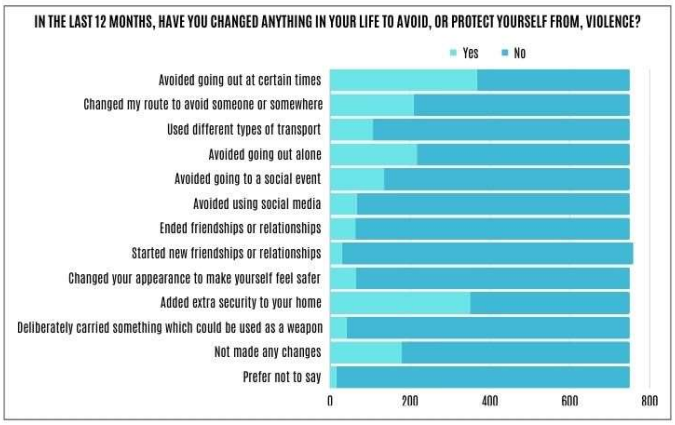


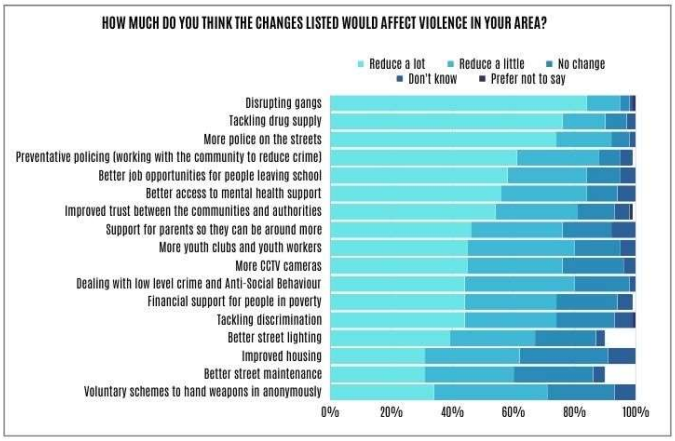
Merseyside residents witnessed violence mostly in the day time other than in the city or town centre, where violence was witnessed more frequently at night.



Merseyside residents told us that they feel least safe in or around pubs or nightclubs, at the park, common, or other open public spaces, and when travelling on public transport, in or near bus stops, or train stations.

IMPACT





Merseyside respondents prioritised policing initiatives overall as solutions which they felt would make the biggest reduction in violent crime where they live. In order of priority, solutions included:

- Disrupting gangs.
- Tackling drug supply.
- More visible policing.
- Preventative policing.

However, improving job opportunities for people leaving school, better access to mental health support, and improved trust between communities and authorities were also considered effective ways to reduce violent crime.

Targeted

Who did we speak to?

Community Safety Partnerships, Prisons, and the Probation Service, in collaboration with statutory and third-sector partners, delivered a series of targeted consultations with:

- Young people who have experience of the care system
- Families of children with additional needs
- Victims of violence
- Young people receiving support from the youth justice system
- Young people in alternative education settings
- Ethnic minority communities
- LGBTQ+ communities
- Refugees and asylum seekers
- People in prison
- People on probation

The below provides a snapshot of the views, needs, and experiences of the communities that we spoke to. Local authority specific reports are contained within the appendix to this strategy and provide a more in-depth assessment of the nuances within and between each locality.

Experience

- There was a general acceptance amongst community groups that violence is inevitable, as well as a view that violence and gang involvement has become normalised.
- Difficulty establishing healthy relationships can increase vulnerability to violence and exploitation, particularly for people with experience of the care system who can find it difficult to establish healthy boundaries.
- Young people open to the youth justice system reported experiencing stigmatisation as a result of their involvement in offending behaviour.
- People from Ethnic Minority Groups felt that it was true that people from certain ethnic minority groups are perceived as more likely to commit violence and are treated different as a victim of violence.
- Young Adults in Prison felt that living in deprived areas with established gangs increases susceptibility to involvement in serious violence as criminal behaviour becomes normalised.
- Families of children with additional needs spoke of isolation and loneliness.
- Filming of attacks by peers increases propensity for a more violent attack.

Drivers of serious violence

- Poverty and deprivation, alcohol use, drug use and supply, unmet mental health needs, lack of access to employment, education, and training opportunities, protection, gang membership, money, retaliation, and the impact of social media were all major driving factors for serious violence.
- Communities recognised the danger of being involved in a gang and the relationship between gang membership, drugs, and serious violence.

- In prison violence is mainly linked to gang related community violence. However, various risk factors can increase vulnerability to gang exploitation in prison, including substance misuse problems, poor mental health, and low self-esteem.
- Neurodiversity was a common factor identified as contributing to increased susceptibility to involvement in serious violence as victim or perpetrator.

Services:

- There is a lack of understanding and awareness of neurodiversity and how this impacts behaviour and interactions between authorities and community members, including a lack of understanding on the relationship between neurodiversity and child on parent violence.
- Systems, processes, and services in place to support families with children with additional needs are fragmented, with inconsistent communication to raise awareness of referral pathways and access to available support.
- There is a pressing need to improve relationships with statutory services, particularly the police, to build trust and confidence amongst communities.
- Communities expressed difficult in accessing services and there was a consensus that services offered are not always responsive to local need.
- Victims and their families were not always satisfied with criminal justice outcomes, often feeling that outcomes are too lenient. They also called for better understanding and awareness on enforcement and criminal justice tactics.

Solutions:

- Localised and accessible support.
- Interventions which address risk and protective factors (including poverty, drug misuse, gang involvement, mental health needs) and are tailored to local need.
- Policies, processes, and interventions to address the impact of implementation on inequalities and disproportionality.
- Increased police visibility.
- Improved access to free education, employment, and training opportunities.
- Interventions which integrate young people from out of area to break down barriers in a risk managed environment.
- Consistent and coordinated support and communication to increase visibility of partnership assets which communities can access.
- Multi-agency support to enable early intervention and prevention, including coordinated referral pathways.
- Improved offer of whole family support.
- A co-ordinated, quality assured toolkit for use within educational and community centres around violence prevent education.

Strategic Priorities and Objectives

Taking account of the SNA and consultation with communities and partners, the local partnership has agreed the following strategic priorities, actions, objectives, and actions, which we will take forward through this strategy over the next 12 months to prevent and reduce serious violence:

Priority 1: People

As a partnership, we want to ensure that individuals, families, and communities, are supported to be free from violence and the fear of violence.

Objectives

Work together to identify individuals, families, and communities at risk of, or affected by, serious violence, and intervene to reduce risk and harm, ensuring responsivity to identified need and a focus on addressing the root causes of serious violence. This involves bringing about long-term cultural, behavioural, and attitudinal change through challenging the acceptance of norms which promote violence as being inevitable.

Taking a multi-agency approach, partners will target resources on prevention and early intervention, rooted in evidence on 'what works' to prevent and reduce serious violence. Using evidence-based resources, the partnership will commission and embed interventions across the region which are known to deliver the highest impact for people at risk of, impacted by, or already involved in, serious violence.

Partners will provide timely, coordinated support, and monitor and evaluate the implementation and impact of interventions so that risk is reduced. Monitoring and evaluating is key to a public health approach to reducing violence, as it feeds back into our understanding of what works to reduce violence most effectively (WHO, 2017a). Not only does this reduce harm to communities by ensuring maximum impact, as well as uncovering what does not work, it also enables partners to prioritise resources more effectively in the long-term.

Ensure that the experiences, strengths, and needs of individuals, families, and communities are understood and that these views are clearly recorded so that co-production is central to the multi-agency approach. This will lead to greater alignment between organisations and communities and empower citizens to contribute towards a society free from violence and free from the fear of violence.

Priority 2: Places

As a partnership, we want to work collaboratively with key stakeholders, including our communities, to establish Merseyside as a place where people feel safe to live, work, and visit.

Objectives

Use information effectively to understand the prevalence of serious violence in their area to inform multi-agency strategy, planning, and actions, including targeting of resources in places and spaces to meet local need. This will ensure resource, intervention, and harm recovery efforts are targeted at priority hotspots where serious violence occurs.

Embed a strengths-based approach which focuses on identifying the strengths or assets, as well as the needs, of communities, to prevent and reduce serious violence. Adopting a strengths-based asset approach values the capacity, skills, knowledge, connections, and potential in a community, enabling the partnership to build upon and strengthen protective factors in a community to more effectively reduce violence at a population level.

Partners will collaborate to ensure consistent delivery of key messages relating to serious violence, empowering communities to build their resilience and confidence to prevent and respond to serious violence. The partnership is continuously striving to inform, consult, involve, collaborate, and empower key stakeholders and communities, using data in communications to support open and honest conversations about the extent of serious violence in Merseyside.

Partners will take ownership of embedding strategic and operational delivery at hyper-local level, ensuring action plans are dynamic and adapt to changing risk and need. This will enable partners to truly embed whole-systems, place-based multi-agency approaches which seek to improve long-term outcomes of the 'whole place' and not just individuals, whilst recognising that the impact of serious violence may be different in each local authority.

Priority 3: Partnerships

As a partnership, we want the prevention and reduction of serious violence related risk and harm to be everyone's responsibility, creating the right conditions for partners and communities to collaborate to take effective, co-ordinated action.

Objectives

Partners embed whole-systems, public health approaches to preventing serious violence at hyper-local level, with effective oversight and governance mechanisms to deliver improved outcomes. Ensuring the principles of a public health approach are the golden thread through strategic, operational, and tactical delivery, facilitating an understanding of the interoperability within and between organisational and geographical boundaries to integrate preventative action which tackles the root causes of serious violence.

Increase the effectiveness of partnerships at preventing/tackling serious violence, creating a system which fosters shared ownership, accountability, and mutually beneficial collaboration. Partners collaborate to ensure efficient allocation of resources to maximise impact and reduce silo working and duplication, including coordination of funding decisions and agreement to invest and pool resources for the long-term.

Engage in critical reflection to challenge and support practice to act upon system learning more habitually, promoting continuous improvement in the multi-agency approach for communities at risk of, or affected by, serious violence. Increasing public trust and confidence in the multi-agency approach to preventing and reduce serious violence related risk and harm.

Improve multi-agency data sharing and governance to enhance capacity and capability of the partnership in preventing and reducing serious violence related risk and harm. Supporting collaborative efforts across the partnership to enhance data capability and embrace evidence driven approaches to implementing public health interventions which address the root causes of serious violence. Using this understanding, partners will be better equipped to ensure responsivity to local need through the targeting of interventions and resources.

Commit to ensuring trauma informed practice is embedded across the partnership at all levels. Ensuring partners have access to training and support so that they are confident, knowledgeable, and understand the impact of serious violence on health and wellbeing.

Action to Prevent and Reduce Serious Violence

The results of the SNA and consultation with partners and communities has been used by the local partnership to formulate and prioritise bespoke actions to prevent and reduce serious violence, that the partnership will take forward through this strategy. Actions are aligned to thematic priorities (people, places, and partnerships) and are set out under several key workstreams, including:

- Governance and collaboration.
- Data sharing.
- Evidence based and system learning.
- Targeted interventions and local implementation.
- Access to education, employment, and training.
- Training and awareness.
- Accommodation.
- Enforcement.
- Communications.

The below strategic actions are pan-Merseyside actions and have been arrived at through consultation, planning, and a review of local action plans to identify how we can use the Duty as an opportunity to bring about cultural change, encouraging partners to think and act more innovatively when collaborating to prevent and reduce serious violence. However, we remain committed to ensuring that we implement processes, systems, and interventions as locally as possible, whilst also understanding that some of the partners subject to this strategy may be better equipped to lead on driving change across the whole system. Please therefore see the appendix for localised delivery plans which have been developed by Specified and Relevant Authorities, highlighting detailed actions at strategic, operational, and tactical level. The actions contained within this strategy and within the localised delivery plans are closely aligned to thematic priorities and will be governed and overseen through

the local partnership arrangements set up under the Duty. This will enable us to remain firm in our commitment to embed change across a whole system by delivering improved outcomes for a whole ‘place’, whilst enabling us to embed a public health approach which takes account of the localised nuances within and between local authorities.

PEOPLE

PRIORITY: PEOPLE	
	**Work together to identify individuals, families, and communities at risk of, or affected by, serious violence, and intervene to reduce risk and harm.**
	**Short Term** • More people aware of and accessing support and intervention **Medium Term** • More people are identified who are at risk of or in need of support. • More people are aware of and protected against serious violence risks. • Reduced repeat involvement in serious violence, either as perpetrator or victim. • Fewer people exposed to/witnessing serious violence • Decrease in risk and increase in protective factors **Long Term** • Reduced financial cost of serious violence
	• We will proactively identify populations and places susceptible to serious violence and intervene early to ensure appropriate interventions (universal and targeted) are in place to reduce serious violence offending, reoffending, as well as to build desistance for people on probation. • We will continue to develop and improve the quality of support provided to victims and witnesses to mitigate the impact of serious violence and vulnerability. This will involve working across the partnership to identify those at risk of repeat victimisation, employing an early help approach to minimise risk and harm. • We will continue to develop and support the implementation of interventions which address underlying risk and protective factors, to ensure a holistic approach to preventing and reducing serious violence by targeting resources to areas of high demand, need, and vulnerability. This

	includes developing interventions which address thinking, attitudes, and behaviours which lead to serious violence offending. • We will work across the whole system, including working closely with partners making referrals, to strategically map risk and protective factors and early indicators which are shared across multiple population health concerns e.g., serious violence, radicalisation, poor health. This will enable us to develop 'one system' to identify risk factors and support joined up efforts to provide those most at risk with appropriate support. • We will build consultation and feedback into partnership activities and timelines to ensure stakeholders and communities are engaged in: o Initial consultation on co-production o Development of the strategy, as well as annual consultation and feedback at the point of strategic review o Intervention commissioning, including feedback to beneficiaries as well as communities/ organisations who do not fall within the commissioning plan o Delivery plan, including consulting stakeholders to identify opportunities for joint working o Commit to providing feedback to stakeholders and ensuring feedback loops are in place when planning all consultation with stakeholders • We will co-produce with communities in some way across the whole of Merseyside, not just in hotspots, to ensure equality of voice.

PRIORITY: PEOPLE	
	**Taking a multi-agency approach, partners will target resources on prevention and early intervention, rooted in evidence on 'what works to prevent and reduce serious violence**.
	**Short Term** • Services offered reflect local and national best practice.
	Medium Term • Reduced risk of serious harm.

	• Decrease in risk and increase in protective factors. • Enhanced offer of whole family support • Improved health outcomes associated with wider determinants • Reduced health inequalities.
	Long Term • Long-term change in attitudes and behaviours which contribute to a culture where serious violence occurs • Reduced financial cost of violence
	• Using evidence-based resources, we will commission and embed interventions across the region which are known to deliver the highest impact for people at risk of, or already involved in, serious violence. This will involve working closely with the Violence Reduction Partnership to ensure decision making is informed by the wealth of local evidence on 'what works' at primary, secondary, and tertiary level. • We will continue to provide high quality interventions and targeted support for people under supervision, including people in prison and people on probation, who have unique needs, to improve outcomes across a range of areas, including accommodation, education, employment, and health, and address the thinking, attitudes, and behaviours that lead to reoffending. • We will ensure there is sufficient provision of evidence-based interventions and effective partnership arrangements in place to support the transition from custody to community, maximising opportunities to deliver the Short-Term Sentence Function (SSF). The SSF is an enhanced approach to sentence management and is primarily needs focussed with the intention of improving the continuity of provision from custody into the community. • We will continue to support and commission whole family approaches to preventing and reducing serious violence, including providing support for people in prison to initiate and maintain family ties whilst in custody. By whole family, we mean that we will triage family members for their individual needs, but interventions are concurrently delivered. Improving simultaneous access and availability of support for all family members in need, we can maximise and sustain the impact of interventions. • We will continue to deliver and develop educational programmes (universal and targeted) to engage and prevent serious violence, including working closely with the Merseyside Violence

	Reduction Partnership and Safer Schools Officers to develop a suite of trauma informed preventative interventions for use within educational settings.

PRIORITY: PEOPLE	
STRATEGIC OBJECTIVES	Partners will provide timely, coordinated support, and monitor and evaluate the implementation and impact of interventions so that risk is reduced
KPIs	**Short Term** • More people aware of and accessing support and intervention. • Services offered reflect local and national best practice
	Medium Term • Improved referral and referral pathways for people who are at risk of or in need of support. • More people are aware of and protected against serious violence risks • Decrease in risk and increase in protective factors. • Coordinated referral and support for the most vulnerable. • Improved health outcomes associated with wider determinants.
	Long Term • People feel safer.
STRATEGIC ACTIONS	• We will establish a robust system for monitoring and evaluating the effectiveness of strategic and operational processes and interventions, supporting the partnership to measure impact in the absence of significant funding required for robust evaluation. This will include regular reviews of policies and procedures, review of performance data, and consultation with partners and communities to understand the impact. • We will continue to build the local evidence base on 'what works', collating and sharing best practice spotlights, to develop a repository of local evidence.

	• We will conduct a mapping exercise to increase the partnerships' awareness of the occurrence and effectiveness of strategic and operational assets in place across the region to prevent and reduce serious violence, and use the output to inform our collaboration and planning going forward, ensuring resources are targeted effectively to reduce risk and harm felt by communities as a result of violent offending in public spaces. • We will establish clear referral pathways and ensure that statutory and third sector partners are equipped with knowledge of the referral processes, making it easier for partners to connect people most in need to other services and resources which address public health needs and risk and protective factors for serious violence (e.g., mental health services, drug and alcohol treatment, housing services, and employment and education opportunities). • We will work across the whole system to raise community awareness of the support available to those involved in, or impacted by, serious violence. This will include raising awareness of wider interventions as well as criminal justice and enforcement activity (such as Out of Court Disposal processes) to provide victim reassurance. • We will work across the whole system to monitor and evaluate levels of engagement and attainment in disproportionately represented groups open to services, including those open to the Youth Justice System, to develop improvement, including for children with an Educational Health Care Plan, children with SEN, children permanently excluded from school, out of court disposal cases, and children released under investigation. • We will work closely with partners to understand the impact of school exclusion policies on serious violence, including monitoring the extent of school exclusion in the youth justice system cohort, as well as the extent of additional support provided to children with Special Educational Needs, ensuring that every child with an Educational Health Care Plan has this reviewed on an annual basis.

PRIORITY: PEOPLE	
STRATEGIC OBJECTIVES	**Ensure that the experiences, strengths, and needs of individuals, families, and communities are understood and that these views are clearly recorded so that co-production is central to the multi-agency approach.**

	**Short Term** • Community engagement and co-production is a priority. • Community voice embedded in strategy to inform action planning at a local level.
	Medium Term • More people demonstrating positive engagement with services referred to. • Individuals, organisations, and communities work together to prevent serious violence. • Individuals, families, and communities are supported to feel safe. • Communities challenging acceptance of violence. • Reduced fear of violence within the community.
	Long Term • Long-term change in attitudes and behaviours which contribute to a culture where serious violence occurs. • Co-production is habitual. • People feel safer • Increased reporting of serious violence.
	• We will conduct a strengths-based asset mapping assessment and use the output of this to inform planning and collaboration to prevent and reduce serious violence, focussing on what is important to local communities and how system partners can help to build and expand the assets and resources within communities, including those which are led by communities for communities. • We will work across the whole system to drive a cultural shift around co-production to embed it within organisational and partnership ways of working as 'business as usual', ensuring that the views and needs of those most impacted by serious violence feed into strategic and operational planning, delivery, decision making, and review. • We will develop a consistent system of collaboration between workstreams, to keep operational approaches the same and ensure strategic join-up around who is engaged, how they are engaged, and priorities for engagement. • We will amplify the voices of those most impacted by serious violence, ensuring meaningful opportunities for communities to actively participate in matters that affect them and that they care about, particularly those who may not always be listened to. • We will utilise and build upon the success and impact of existing lived experience forums such as Liverpool City Council's Serious Violence Forum and the Service User Forum which is part of the

	strategic governance across the Probation Service, to develop and embed a permanent lived experience forum as part of the governance structure under the Duty to ensure that experts by experience can positively influence decision making at the highest level.

PLACES

PRIORITY: PLACES	
	Use information effectively to understand the prevalence of serious violence in their area to inform multi-agency strategy, planning, and actions, including targeting of resources in places and spaces to meet local need.
	**Short Term** • Improved identification of hotspot locations and trends to better target resource and intervention. • Ensure a coordinated, adaptable approach to the targeting of organised crime groups by the partnership.
	Medium Term • Risk of serious violence in hotspots is reduced. • Resource, intervention, and harm recovery efforts targeted at priority hotspots where serious violence occurs
	Long Term • Mature model of early identification embedded to respond to emerging need and risk to prevent and reduce serious violence.
	• We will review practical interventions, working closely with Designing Out Crime Units, to ensure regeneration plans effectively work to prevent serious violence and the opportunities for crime within the built environment. • We will continue to implement place-based approaches, using multiple data sets to identify the High Harm / High Crime hotspot locations across Merseyside where serious violence occurs and

	ensure these areas are subject to intensive support, including enhanced police visibility / patrolling, targeting of interventions to provide support and advice to those most in need, and continued efforts to problem solve with key partners to reduce risk and harm. • We will continue to build upon data capability and digital resources to develop integrative systems which identify any areas of Merseyside at risk of becoming a hotspot for Serious Violence, overlaying crime and environmental data, to intervene early and mitigate emerging risk. We will develop innovation in the way that this is visualised to support partners in embedding effective policies, processes, and interventions across the whole system. • We will continue to establish and build on learning from the roll out of the multi-agency partnership tactic called Clear, Hold, Build, which has been designed and part-funded by the Home Office to rescue and regenerate areas most affected by serious and organised crime. • We will work with Merseyside Police and Local Authority licensing teams to ensure there are suitable systems in place to deal with repeat issues of serious violence at locations.

PRIORITY: PLACES	
	Embed a strengths-based approach which focuses on identifying the strengths or assets, as well as the needs, of communities, to prevent and reduce serious violence.
	**Short Term** • Improved understanding, recognition, and use of community assets.
	Medium Term • Improved visibility and awareness of partnership assets to prevent and reduce serious violence, including awareness of operational programmes and initiatives.
	Long Term • Strengths-based approaches embedded and contribute to driving change and system level transformation at a local level.

 STRATEGIC ACTIONS	• We will conduct a strengths-based asset mapping assessment which identifies, describes, and visualises strategic, operational, and community assets that are available within the Merseyside region to support the partnership and communities in preventing and reducing serious violence. This will be used as an empowerment tool to build upon existing capacity, empowering meaningful co-production with communities to understand and respond to their concerns and ideas. • In line with building upon tangible and intangible assets within the community, we will ensure that serious violence prevention and reduction remains a priority for Community Cashback and participatory budget schemes, providing communities with the skills, tools, and resources to deliver their own serious violence work, sustainably amplifying the wider system coming together.

PRIORITY: PLACES	
 STRATEGIC OBJECTIVES	Partners will collaborate to ensure consistent delivery of key messages relating to serious violence, empowering communities to build their resilience and confidence to prevent and respond to serious violence
 KPIs	**Short Term** • Shared understanding of current opportunities to build and develop communications capacity. • Consistent and aligned communications plans across the partnership to deliver key messages, improving perceptions of safety.
	Medium Term • Increased local community awareness of serious violence and risk mitigation. • Coordinated and consistent messaging which builds awareness of the local approach to serious violence prevention. • Increase the partnerships' awareness of the occurrence and effectiveness of prevention and intervention activities implemented across the region to tackle serious violence. • Increased community cohesion through communities working together to address serious violence related concerns.
	Long Term

	• Communities are equipped with the tools to build confidence and resilience in preventing and responding to serious violence.
	• We will map and review current communications approaches, identifying examples of best practice and opportunities to engage communities with the serious violence agenda using an aspirational, strengths-based approach. • We will develop innovative ways to communicate the important role of public health approaches to serious violence prevention and to evaluate their effectiveness to provide future whole systems approaches that will support efforts across Merseyside. • We will raise awareness on the impact of serious violence on individuals and develop a strengths-based approaches which challenge the acceptance of norms which promote violence as being inevitable, highlighting the tangible and intangible partnership and community assets which can support in bringing about long-term cultural, behavioural, and attitudinal change. • We will develop coordinated and consistent messaging, which is targeted and outcomes focussed, to build awareness of the local approach to serious violence prevention, instilling trust and confidence in the work being done by the partnership to tackle and prevent serious violence. • We will share positive news with communities to further strengthen community resilience and provide transparency around activity undertaken to impact on serious violence. • We will ensure that messaging is tailored to local need and shared at hyper-local level through various channels, informed by data and community insight to understand how to consult communities where fear of violence may be a bigger problem than the actual threat of violence. • We will act as champions within our own organisations to deliver key messages relating to serious violence to embed a public health approach to serious violence prevention. • We will create a communication and campaign strategy with long-term and intermediate objectives to guide how the partnership will inform the community, co-produced with communities. • We will develop our understanding of how visible the partnership is to key population groups. • We will support the community to develop new skills to ensure that work on prevention and reduction is sustainable and allow the community to deliver interventions and their own serious violence work, ensuring existing work done by community members and groups is amplified, well-resourced, and valued.

	• We will champion the positive contribution made by communities to counteract the risk and harm felt as a result of violent offending in public spaces, and support community asset approaches which build community cohesion. • We will enhance our connectivity to communities, considering all partnership activity in terms of its inclusivity and accessibility, identifying and removing barriers to participation and ensuring that we build opportunities for engagement so that hat partnership engagement is held at times and places where individuals and groups can attend and participate.

PRIORITY: PLACES	
	Partners will take ownership of embedding strategic and operational delivery at hyper-local level, ensuring action plans are dynamic and adapt to changing risk and need.
	**Short Term** • Hyper-local strategy and action plans developed tailored to local need, with robust accountability and governance structures at hyper-local level to drive key actions.
	Medium Term • Localised strategies and approaches implemented. • Ensuring that local delivery to reduce serious violence is underpinned by mature co-production with communities, particularly those who are most adversely affected by violence.
	Long Term • Strategy and delivery embedded at hyper-local level in response to local need.
	• We will continue to ensure that the priorities and actions contained within this strategy align with the wider strategic and political context, and form part of an ongoing process of review and co-production with key stakeholders, including local communities, to support local ownership of the strategy and ensure that it is implemented as intended.

	• To monitor the impact of multi-agency public health approach to serious violence prevention, we will continue to use community insight data where possible to better understand impact, community confidence, and levels of reassurance, enabling us to adapt to changing risk and need. • We will ensure this strategy is owned at place, meaning that we will drive the actions contained within this strategy through local place-based strategic, tactical, and operational partnerships, to ensure that decision making is kept as local as possible and that we are able to respond to localised nuances within and between local authorities which may see the impact of serious violence differ.

PARTNERSHIPS

PRIORITY: PARTNERSHIPS	
	Partners embed whole-systems, public health approaches to preventing serious violence at hyper-local level, with effective oversight and governance mechanisms to deliver improved outcomes.
	**Short Term** • Alignment across local and national strategies and delivery plans to ensure a symbiotic approach.
	Medium Term • Partners demonstrate a comprehensive understanding of the public health approach and translate this into practice, recognising the link between serious violence and wider determinants of health and embed serious violence outcomes into planning and delivery. • Partners are confident and equipped to implement proactive, preventative approaches to serious violence, as opposed to implementing solely reactive approaches.
	Long Term • Partners work together to enable cultural change and achieve a sustainable approach to tackling serious violence.

	• Effectiveness of oversight and governance of serious violence prevention work locally, including an understanding of the senior leadership structure, funding landscape, and interoperability between partners at all levels to support a whole system, public health approach to serious violence prevention.
 STRATEGIC ACTIONS	• We will develop our understanding of existing governance arrangements for strategic and operational serious violence prevention work, identifying interoperability with cross cutting local and national strategies, delivery plans, operating systems, and existing partnerships. • We streamline governance mechanisms and establish clear lines of reporting and accountability to deliver improved outcomes through a multi-agency, public health approach, ensuring the right people have a seat at the table to drive long-term, sustainable change to processes, systems, and interventions, and reflect this in revised partnership terms of reference where appropriate. • We will review how the partnership supports the workforce to embed multi-agency, public health approaches, and develop a programme of training for the whole system so that partners have the right skills, knowledge, and working conditions to embed a public health approach to serious violence prevention, enabling improved and earlier identification of populations and places vulnerable to the impact of serious violence. • We will work collaboratively with partners to develop and deliver training and awareness raising of what is available in the community to prevent serious violence offending and reoffending, including what assets are available to support with resettlement for prison leavers and people on probation.

PRIORITY: PARTNERSHIPS	
 STRATEGIC OBJECTIVES	**Increase the effectiveness of partnerships at preventing/tackling serious violence, creating a system which fosters shared ownership, accountability, and mutually beneficial collaboration**
 KPIs	**Short Term** • Specified and relevant authorities feel included and understand their role, and the role of key stakeholders, in supporting those at risk of involvement in serious violence. • Partners demonstrate shared ownership, accountability, and collective responsibility in preventing serious violence.

	• Partners are aware of the funding landscape and assets across partnerships to deliver against serious violence strategic priorities, ensuring alignment of relevant funding streams.
	Medium Term • Partners are demonstrating maturity in co-production, engaging key stakeholders and communities in the Serious Violence Duty programme, including co-design and delivery of strategy and intervention. • Partners more effectively coordinate funding decisions and investments.
	Long Term • Improved joint working, decision-making, and commissioning. • Resources are targeted effectively, maximising impact, and reducing duplication. • Improved co-commissioning arrangements, including longer-term pooling of resources and agreement to invest for the long-term.
STRATEGIC ACTIONS	• We will deliver against a shared vision, and collaborate to ensure that partners understand their role, and the role of others, in violence prevention, including a common understanding of what the local multi-agency approach is currently and what each organisation's role within the collaboration is or can be. • We will continue to work collaboratively with partners to target delivery of services, maximising co-commissioning opportunities, to achieve the priorities set out in the Duty Strategy and deliver shared outcomes. A key focus in the first phase of strategy mobilisation is to explore co-commissioning opportunities between partners to reinstate the local evidence-based practice of the Departure Lounge in HMP Liverpool. • We will strive to develop serious violence and public health outcomes focussed funding models, prioritising making greater resources available for prevention, and reflecting this within grants and commissioning contracts to move beyond payment for activity to investment in longer-term population outcomes • We will develop our understanding of the funding landscape to identify funding streams available across the partnership which can be used to resource serious violence prevention activity, highlighting where we can pool budgets, and where funding streams enable longer-term funding which is not restricted to financial year funding cycles.

	• We will develop a coordinated, regional approach to serious violence across Prisons and Probation, aligning partnership work across the Duty strategy and Regional Reducing Reoffending Plans. This is an area of specific focus as we understand there are a number of people held in prison locally who are from out of area, thus requiring us to further join up efforts at regional level.

PRIORITY: PARTNERSHIPS	
	**Engage in critical reflection to challenge and support practice to act upon system learning more habitually, promoting continuous improvement in the multi-agency approach for communities at risk of, or affected by, serious violence.**
	**Short Term** • Partners have a shared vision and are committed to actively engaging and sharing learning across the partnership.
	Medium Term • Improved capacity for partners to share and act upon data and system learning more habitually.
	Long Term • Partners work together to enable cultural change and achieve a sustainable approach to tackling serious violence.
	• We will conduct an asset mapping assessment of strategic and operational serious violence prevention work to enable the partnership to facilitate a deeper understanding of the existing multi-agency response to serious violence at whole-system and intervention level, identifying gaps and opportunities to deliver improved outcomes. The output will be part of a broader iterative process of continual system learning which will be driven by the Tactical Oversight Group. • We will collaborate to share learning and examples of good practice that other partners can adopt, which we will collate and present in the form of an iterative toolkit which will be regularly updated and published on the Police and Crime Commissioners website, supporting the partnership in sharing advice, expertise, and intervention awareness to address local serious violence issues.

	• We will continue to work closely with the Merseyside Violence Reduction Partnership to develop system learning and sustainably embed a public health approach at whole-systems and intervention level, building on the evidence legacy from the work undertaken to date to inform and sustain ongoing violence prevention policy and activity. • We will build a shared understanding on current opportunities to evaluate and quality assure the impact of interventions, using our collective resources and expertise to support organisations to develop more robust evaluation of projects through applications to the Youth Endowment Fund and other local evaluation partner opportunities, and provide organisations with income generation support to sustainably resource initiatives. • We will work across the partnership to prepare for national HMICFRS inspections relating to serious violence, and review and act upon any recommendations and areas for improvement. • We will establish a multi-agency response structure and framework to support the whole system in preventing and responding to serious violence and emerging risk, empowering communities to sustain serious violence preventative activity.

PRIORITY: PARTNERSHIPS	
STRATEGIC OBJECTIVES	**Improve multi-agency data sharing and governance to enhance capacity and capability of the partnership in preventing and reducing serious violence related risk and harm.**
	Short Term • Partners have an increase understanding of the nature, extent, and impact of serious violence and related risk factors, using shared data and intelligence to identify support pathways and target resources. • Serious Violence analysts meet regularly.
	Medium Term • Improved individual data capacity and capability to support partnership understanding of population and pathway needs.

	• Partners have a better understanding of population need and risks, population receives more appropriate referral and support. •
	Long Term • Resources are targeted effectively, maximising impact, and reducing duplication. • Improved multi-agency data sharing with improved system-wide governance.
 	• We will establish a Serious Violence Analyst network, comprising of analysts from across Specified and Relevant Authorities, to enable us to support individual data capacity and capability and provide a 'one picture' of the truth. • We will establish a Data Protection / Information Governance Network among data leads in partner agencies to improve data sharing, providing reassurance on legislation and compliance around what can be shared, unblocking barriers, developing information and data sharing agreements to enable effective sharing of data. • We will continue to work across the partnership to improve the quantity and quality of data we collect, ensuring training is in place to support front line professionals in accurately recording serious violence offences and injuries within the definition set out in this strategy. • We will build our data capability across the partnership to improve joint working to identify populations and places most susceptible to serious violence, including identification of risk and protective factors operating at a local level, as well as to enable an effective flow of information and intelligence to support rehabilitation and resettlement planning for high-risk populations. • We will further develop our understanding of causal factors driving in-prison violence to inform resettlement and welfare services for prison leavers moving from custody to the community, and to mitigate the impact of in-prison violence on communities. • We will ensure processes and information sharing agreements are in place to facilitate the sharing of multi-agency data and information to inform the ongoing development of problem profiles and strategic needs assessments which we will use to inform resource allocation to maximise impact for communities. • In the long-term, we will work towards developing a system which enables us to track patients presenting to Emergency Departments, to develop an understanding of emerging and repeat risk

	and vulnerability, as well as to understand the impact of interventions on repeat victimisation and/or perpetration. • We will support the development of the Violence and Injuries Dashboard being developed by the Integrated Care Board, to develop our understanding of violent injuries and associated population health risk factors. We will ensure that this complements and supports the work of the Trauma and Injury Intelligence Group Data Hub.

PRIORITY: PARTNERSHIPS	
	**Commit to ensuring trauma informed practice is embedded across the partnership at all levels.**
	**Short Term** • All partners demonstrate trauma informed awareness
	Medium Term • All partners become trauma informed organisations, ensuring trauma informed practice is embedded across the partnership at all levels so that staff can identify early indicators of trauma and adversity and prevent retraumatising those who are most vulnerable.
	Long Term • Trauma informed practice is embedded across the partnership.
	• We will work embed trauma informed training across the workforce to ensure partners at all levels are trauma informed and embed trauma informed practice. To support this, we will undertake a review to identify which partners have undertaken appropriate training and enrol staff where gaps are identified. • We will develop multi-agency relationships and partnership working to embed a trauma informed approach across all partners, increasing access to a range of expertise for communities presenting with the most complex needs, developing an asset-based approach to community development.

	• We will develop our understanding of neurodiversity in the criminal justice system, including understanding how neurodiversity may serve as a driving factor for vulnerability to serious violence, to establish how we can embed a cohesive offer across the partnership to minimise serious violence related risk and harm which is linked to neurodevelopmental needs.

Understanding Impact

The three key success measures for the prevention and reduction of serious violence, as mandated by the Home Office, are:

- A reduction in hospital admissions for assaults with a knife or sharp object.
- A reduction in knife and sharp object enabled serious violence recorded by the police; and
- Homicides recorded by the police.

Whilst the above measures provide valuable insight into the impact of policies, processes, and interventions on recorded offences and reported injuries, as you will see from the action plan above, we are keen to understand the wider impact that our partnership activity has on mitigating risk and harm caused by local serious violence issues.

In adhering to a public health framework, we are committed to embedding a long-term approach to the prevention and reduction of serious violence, and therefore whilst we acknowledge that there will be some impact in the short-term, we anticipate much of our impact to be over the medium to longer-term. However, we cannot underestimate the importance of reviewing short term measures to maximise longer-term outcomes. By understanding short term outputs, we are able to act quicker to positively impact longer-term change, using evidence on what works within our local context to adapt to changing risk and need.

Measuring Impact

Whilst measuring impact against three key success measures is important, we are committed to understanding the lived experiences which sit behind the data to develop a holistic understanding of the effectiveness and efficacy of our partnership approach.

Our data tells us that serious violence is on a downward trend, however, we know that the harm and impact felt by our communities as a result of violent offending in public spaces is increasing. As such, we will ensure that whilst impact is measured through quantitative offence and injury data, we will place a strong emphasis on obtaining qualitative feedback from key stakeholders and communities regarding what's working, where it's working, and for whom.

Where possible, we will seek to develop processes and systems to enable tracking over the longer-term, to identify where preventative action has realised positive outcomes for populations through reduced risk and harm, as well as reducing future economic burdens by investing to save. This will also enable us to develop a solid performance framework, which looks at implementation and impact indicators, to create a clear understanding of the key contextual factors working to create the intended impact, and how we can adapt to embed long-term financial and cultural sustainability to serious violence prevention work.

What have we done so far?

As a region, we are relentless in our commitment to preventing and tackling serious violence, to minimise the harm caused to individuals, families, and the wider community.

Prevention is at the core of our approach, and we are steadfast in embedding a public health approach to tackling serious violence, investing in processes and interventions which seek to **prevent serious violence from happening altogether**.

Working in a preventative way enables us to work together in partnership to understand and address risk and protective factors which make populations and places more susceptible to serious violence, and over the past few years we have collectively supported a cultural shift towards being proactive instead of reactive – "There comes a point where we need to stop jus pulling people out of the river. We need to upstream to find out why they are falling in".

To embed whole systems, change, this has required the commitment from partners at the most senior level, ensuring that prevention underpins and guides the partnership response to serious violence at a hyper-local level. It also requires strong co-production with communities to ensure that work on prevention and reduction is sustainable and responsive to local needs, concerns, and aspirations, supporting communities to deliver interventions and their own serious violence work which is well-resourced and valued.

Locally, we have seen some powerful examples of partners working together to prevent and reduce serious violence within a public health framework, as set out below, with examples of participatory approaches which actively involve community members in the design, delivery, and evaluation of serious violence prevention work. However, we recognise that this is only the start, and we are committed to continuing a positive trajectory to influence whole system change to support the implementation and embedding of a public health approach to violence prevention.

From investing in our staff to ensure that they have the right training, skills, and working environment to embed long-term public health approaches, to creating meaningful and impactful opportunities for co-production with communities, as well as developing a robust evidence base to inform preventative policy and activity, we will continue to empower partners and communities to have direct involvement in key decisions which impact them and which they care about.

There is no doubt that we can more effectively prevent and reduce serious violence by working together, pooling our collective knowledge and expertise to respond to local need, demand and vulnerability – bolstering community cohesion and increasing feelings of safety.

Merseyside Violence Reduction Partnership

Merseyside is one of several areas allocated funding by the Home Office since 2019 to establish a multi-agency violence reduction unit. Merseyside Violence Reduction Partnership (MVRP) aims to take a whole system public health approach to prevention

that complements existing multi-agency partnerships and brings together partners to develop a coordinated approach to tackle the root causes of violence. The MVRP provides strategic leadership on the public health approach to violence in Merseyside through policy, practice, and targeted communication. MVRP also funds a suite of primary, secondary, and tertiary interventions to prevent violence with a focus on early intervention, life course, place-based, and community led approaches. MVRP works across five priority areas: early years, education, health, whole-family approaches and preventing offending.

Trauma Informed Training

Trauma is a global public health crisis according to the Centre for Disease Control and its prevention and should therefore be a priority for everyone. Being 'Trauma Informed' requires an understanding that different life experiences that shape the options available to us and our way of being and we can use this understanding to influence our interactions and decisions, both in work and in our daily life.

The Merseyside's Violence Reduction Partnership have developed (and evaluated) a multi-agency in-person training package to support Public Services in embedding Trauma Informed Practice. These trauma informed training sessions are being run across all 5 boroughs in Merseyside, with a focus on supporting public and third sector organisations to understand how psychological trauma can impact individuals. This in turn provides mechanisms as to how they can support individuals they come into contact with, whilst also ensuring that they consider the implications for their individual services.

Training takes place over 4 separate sessions and on consecutive weeks, with an emphasis on a multi-agency approach. Over these four sessions, practitioners gain an understanding of the neuroscience as to how individuals learn and develop, providing them with tools to best meet the needs of individuals and their communities. With a focus on the neuroscience of how we learn, the rationale is clear regarding the delivery of training over a number of sessions, practitioners learn then practice the techniques provided, thus embedding the Trauma Informed principles. Practitioners feel empowered to support their clients in the most appropriate manner and also to deliver change across their organisations.

'To promote a culture embedding the Trauma Informed Principles, we need to develop a multi-faceted response with the 6 Trauma Principles at the core. Organisations don't change behaviour, people do. We need to create a sense of Awareness, Desire, Knowledge, Ability and Reinforcement'. (Hiatt et al 2006).

Merseyside Police Preventative Policing Strand.

In 2021, Merseyside Police invested in a new Prevention Strand which brings together a number of key teams including the Community Engagement Unit, a new Rural Wildlife and Heritage team, the Early Help team, and the Missing Persons Unit, as well as a Prevention Hub, to help officers and staff deliver prevention across Merseyside. This strand has instilled a whole force approach to prevention through shared responsibility and collaborative effort and bolstered two-way engagement with communities to encourage community involvement in local policing activity. Not only

has this strand helped to reduce harm and offending, it has also created the conditions for partners to work together identify people and places of highest demand, ensuring effective problem solving approaches and interventions are implemented to address risk and protective factors in populations and places.

Safer Schools Officers

Merseyside Police Safer Schools Team work with schools to keep young people safe. Every day Safer Schools Officers are interacting and engaging with the young people of Merseyside in non-police related environment. They provide safeguarding and pastoral support, as well as personal, social and health education. They help to tackle truancy and instances of bullying, creating, and maintaining positive relationships with the school and young people. Safer Schools Officers also assist in early identification and support for victims and vulnerable individuals, working with schools and partners to improve outcomes for all, intervening early to prevent unnecessary criminalisation.

Operation Interface

A co-ordination cell that enhances police activity across the force relating to 3 distinct areas of Policing; Project Medusa, which focuses on County Lines drug activity and associated vulnerabilities; Project Adder, working across partnerships, ensuring more people are signposted to drug treatment providers and Operation Target, providing a focus on preventing serious violence and knife crime, affecting young people.

Operation Blue

Enhanced approach to Test Purchase operations focusing on preventing the sale of knives / weapons to underage individuals.

Evolve – Clear, Hold, Build

Merseyside Police is rolling out a multi-agency partnership tactic called Clear, Hold, Build, which has been designed and part-funded by the Home Office to rescue and regenerate areas most affected by serious and organised crime.

The three-phase initiative, known locally as EVOLVE, uses a combination of targeted high-visibility police operations and covert policing tactics alongside activity from partners and input from residents to protect our communities and prevent organised crime groups from operating.

What?

The strategy sees police ruthlessly pursue gang members using all available powers and tactics to clear an area; continue activity to hold the location, so another gang can’t take control in the vacuum; and then work with residents and partners to build the

community into a more prosperous area where people would love to live, work and visit and one less susceptible to being exploited by organised crime groups.

Where?

EVOLVE projects are taking place in areas of Wirral, Liverpool, Knowsley and Sefton.

When?

This is a long-term project and work will be continuous.

Why?

Implementing this holistic approach will make it more difficult for organised crime groups to operate. It will disrupt their activity and their incomes, and will help to protect those living, visiting and working in Merseyside. It will also assist those vulnerable to manipulation by gangs. By working together and listening to residents' needs, EVOLVE will regenerate areas blighted by serious and organised crime and will allow residents to reclaim their communities, building long-term resilience against organised crime groups and help prevent future threats to safety.

How?

Partners will work closely to share information and identify hot spots that need regeneration as well as targeted activity to remove and disrupt organised crime groups. In addition, partners will provide advice and services, in particular to those in need of assistance who may struggle to access help. Areas that will be focussed on include: the living, working and recreational environment for residents, opportunities for young people, help with employment, assistance to access funding, health issues, crime prevention and security advice.

Events will also be held with community groups that will provide opportunities for input from residents to determine how partners can best help and support communities.

Who?

Partners involved in EVOLVE include Merseyside Police, Merseyside's Police and Crime Commissioner, local councils, Merseyside Fire and Rescue, housing associations, health services, schools, colleges, local businesses, community groups and residents.

SAFE Taskforce – Liverpool

SAFE stands for Support, Attend, Fulfil, Exceed. The SAFE Taskforce is a group of mainstream secondary schools working together with other multi-agency structures and local experts to support young people at risk of serious violence and re-engage them in their education. The interventions will help:

Support young people with challenging behaviour.

Attend school regularly.

Fulfil their potential.

Exceed their expectations.

The Department for Education has allocated £3.7 million of funding over a 3-year period for the Taskforce to invest in, and commission school focused interventions to reduce involvement in serious violence and improve attendance at school. It will also help with behaviour in school and within the community and improve social and emotional regulation and wellbeing.

Intervention 1 – SAFE Workers: The implementation of SAFE workers in 11 schools who will provide 1-1 mentoring and support to the referred young person, working both in and out of school with the pupil and their family for a period of around 6 months.

Intervention 2 – Data Sharing Hub: The building of a data-sharing hub that will bring together information from multiple agencies that work with families and young people across the city. The information will include schools, social services, family support and police.

Intervention 3 – ELSA: The implementation of Emotional Literacy Support Assistants (ELSAs) in schools and training school staff in trauma-informed practice.

Intervention 4 – Cognitive Behavioural Approaches through Sport: The intervention involves 13 schools and offers a 12-week engagement programme for selected pupils to explore ‘Choice Theory’ and cognitive behavioural approaches through Sports sessions delivered by Liverpool School Sports Partnership Foundation. These engagement sessions will then lead to an extra-curricular offer including signposting to community sport plus an expedition.

Intervention 5 – Girls Out Loud: A 4-session programme to girls exploring the following key areas: Social Media & Me, Friendship Fix, Mental Health and Choices & Consequences.

Intervention 6 – Speech & Language Therapy Training: A training programme for school SENCos delivered by Speech & Language Therapists from Alder Hey. The SENCos will follow an 11–16-year-old specific programme and can opt to work towards the ELKLAN accreditation.

Date for review/annual review mechanism

This Strategy document will be reviewed annually, with the next review due by 31st January 2025.

Progress of this strategy, the objectives set out within it and the local action plan, will be reviewed at least quarterly through the Merseyside Strategic Policing and Partnership Board and Serious Violence Duty Tactical Oversight Group.

Summary of Annual Assessment of Progress

This section will be applicable 12 months after the local Strategy is produced and will provide a summary of the annual assessment of the partnership's performance against the previous years' strategy.

Format to be as follows: 'Year 1 Actions – What has been achieved – What has been the impact? E.g., using performance monitoring report outputs/outcomes, consultation feedback etc., - Year 2 Actions e.g., what are our learning points, what are we going to build on and how are we going to do that?

Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting:**	23 January 2024
Subject:	Cabinet Member Reports – October- December 2023		
Report of:	Chief Legal and Democratic Officer	**Wards Affected:**	All
Cabinet Portfolio:	Adult Social Care Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

To submit the Cabinet Member – Adult Social Care and the Cabinet Member - Health and Wellbeing reports relating to the remit of the Overview and Scrutiny Committee.

Recommendation:

That the Cabinet Member - Adult Social Care and the Cabinet Member - Health and Wellbeing reports relating to the remit of the Overview and Scrutiny Committee be noted.

Reasons for the Recommendation:

In order to keep Overview and Scrutiny Members informed, the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

Alternative Options Considered and Rejected:

No alternative options have been considered because the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

What will it cost and how will it be financed?

Any financial implications associated with the Cabinet Member reports which are referred to in this update are contained within the respective reports.

(A) Revenue Costs – see above

(B) Capital Costs – see above

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): None

Legal Implications: None

Equality Implications: There are no equality implications.

Impact on Children and Young People: No

Any implications on the impact on children and young people arising from the consideration of reports referred to in the Cabinet Member Reports will be contained in such reports when they are presented to Members at the appropriate time.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

There are no direct climate emergency implications arising from this report. Any climate emergency implications arising from the consideration of reports referred to in the Work Programme will be contained in such reports when they are presented to Members at the appropriate time.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: None directly applicable to this report. The Cabinet Member updates provides information on activity within Councillor Cummins' and Councillor Moncur's portfolios during the previous three-month period. Any reports relevant to their portfolios considered by the Cabinet, Cabinet Member or Committees during this period would contain information as to how such reports contributed to the Council's Core Purpose.

Facilitate confident and resilient communities: As above

Commission, broker and provide core services: As above

Place – leadership and influencer: As above
Drivers of change and reform: As above
Facilitate sustainable economic prosperity: As above
Greater income for social investment: As above
Cleaner Greener: As above

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Cabinet Member Update Reports are not subject to FD/LD consultation. Any specific financial and legal implications associated with any subsequent reports arising from the attached Cabinet Member update reports will be included in those reports as appropriate

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Committee meeting.

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Appendices:

The following appendices are attached to this report:

Appendix A - Cabinet Member - Adult Social Care - update report
Appendix B - Cabinet Member – Health and Wellbeing – update report

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

1.1 In order to keep Overview and Scrutiny Members informed, the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

1.2 Attached to this report, for information, are the most recent Cabinet Member reports for the Adult Social Care and Health and Wellbeing portfolios.

CABINET MEMBER UPDATE Overview and Scrutiny Committee (Adult Social Care) – 23 January 2024		
Councillor	Portfolio	Period of Report
Ian Moncur	Health and Wellbeing	Oct – Dec 2023

Public Health

We're Here Campaign

The "We're Here" campaign has been developed over the past 18 months and originated through discussion at the Sefton Suicide Prevention board. At this meeting Merseyrail colleagues raised concerns that there was potentially an increase in the frequency of members of the public presenting at train stations in a mentally distressed state and staff didn't know where best to signpost to. A steering group was established involving a range of representatives from the voluntary sector including Sefton CVS, suicide prevention organisations, Public Health and both the councils' and local NHS communications teams.

On Thursday 7th September the campaign was officially launched via a roadshow across Sefton directly to local residents in their communities. The advertising company commission included promotional staff who distributed stickers and posters for local businesses across the borough to display.

On the launch day there was a team supporting this process who travelled across the borough to promote the campaign including representation from the Sefton Public Health team, Sefton Council comms, the Crisis Café, Seans Place, Parenting 2000 and Sefton CVS. The team were accompanied by a digital advertising van and stopped off at 5 locations to give out business cards and chat to members of the public about the campaign and offer reassurance that help is available for anyone in need.

On the launch day the team handed out bags of fruit to help promote the purpose of the day which allowed for more detailed engagement with local residents to listen to their experiences and thoughts on "We're Here". Some residents who were engaged on the launch day gave some immediate feedback regarding the timeliness and benefits of having the "We're Here" campaign in the borough. Some highlights included:

- "My son has been struggling for a very long time and just doesn't know where he can go"
- "I am definitely going to check this out. I have been going through a lot of stuff with a relationship ending and would like to connect with other people going through something similar"

In November, evaluation data on the campaign from the advertising company and Radio city will be received and this should also help shape the direction of the campaign's next steps alongside data collected by Sefton CVS on usage of the directory.

Sefton Sexual Health LARC Revised GP Offer (LARC)
At Cabinet Member Briefing on 2nd October 2023, I was provided with an update on changes made to the long-acting reversible contraception (LARC) offer for GPs in Sefton. LARC is contraception that is non-user dependent; meaning the contraception is not dependent on individuals taking or using it to be effective, commonly known examples are the copper coil and the contraceptive implant. Sefton's rates for LARC delivered by GPs have historically been low, highlighting a need for improvement. The main barriers to delivery in Sefton were identified as inadequate funding, diminished workforce and training opportunities, and lack of support for those who can fit LARC.

Public Health and the commissioned Sexual Health service have implemented a number of interventions to address these barriers. These include an increase to the fees paid to GPs, a training offer to grow a workforce of trained fitters in the borough, and the creation of a peer support network for primary care fitters. It is hoped that this investment in GP contraceptive LARC will address the barriers that currently deter GP practices from delivering LARC in Sefton, increasing the activity of LARC being fitted within Sefton Primary care for contraceptive purposes, improving the contraceptive health of our local population.

Public Health Performance Framework
I received a six-monthly report on the Public Health Performance Framework. This report is also a standing agenda item at Overview and Scrutiny Committee. The framework comprises 26 indicators selected from the national Public Health Outcomes Framework. The latest report focused on 11 out of 26 indicators, updated in the period March 2023 through August 2023, and included descriptions of trend, comparisons, inequalities and relevant developments from public health services and programmes.

Key points included:

- The updated indicators discussed **reflect data collected either during the later pandemic phase in 2021, or early post-pandemic period from 2022 through 2023.**
- **Indicators continue to register impacts of the pandemic in 2020-21.** A good example, is the marked reduction in smoking rates in lower income groups during 2020, followed by a rebound to pre-pandemic rates by 2022. Subsequent editions of this report are likely to show population health consequences associated with **higher cost of living** and reduced living standards, and increasingly from **climate-related events**. Largescale adversity will tend to deepen current health inequalities.

- The best estimate from a large, routine survey in 2022 is that 7.9% of adults in Sefton currently smokes**.** Sefton has the **lowest adult prevalence of smoking in the North West** and amongst statistical neighbours. There are large differences in smoking rates separating home renters from homeowners; and managerial and professional from routine and manual occupations (3.5-fold difference). **Smoking remains a big driver of health inequality.** The Government has set out new policy proposals to help achieve its ambition of a smokefree generation and to prevent youth vaping, which included a public consultation.
- The **external inequality in smoking in pregnancy has been closed** (Sefton 9.0% vs England 9.1%) and the internal difference in smoking in pregnancy rates in Sefton continues to narrow (south Sefton 9.1%, vs North Sefton 7.4%). This represents a **major gain for health and health equity at the start of life** and reflects the ongoing success of partnership work spear-headed in Sefton.
- A large increase in the proportion of **physically active adults** from 61.3% in 2019/20 to 66.0% in 2020/21 has been maintained in the latest data from 2021/22. However, **higher than average rates of excess weight in adults (71.2%)**,relatively high rates of physical inactivity (24.5%), and **lower dietary quality** associated with rising food and fuel **poverty** all individually increase chronic disease risk.
- **Public Health services have an important part to play in responding to and preventing high levels of population health need**. However, as the scale of socio-economic and other inequalities in health reveals, the fundamental causes of this need are found in the complex interaction of different **health determinants** across the life-course.
- Updates in this report describe several examples of how the public health team and services are **enabling system improvements**, for example through the work of Sefton's **Combatting Drugs Partnership,** which has now been in place for one year, or input into a system-wide teenage pregnancy self-assessment exercise.

Happy 'n' Healthy

The briefing provided an update on the progress of the Children and Young Peoples Integrated Wellness Service over the past 9 months, recently renamed **Happy 'n' Healthy Sefton**, along with outlining the next steps in the development of the service.

Happy 'n' Healthy Sefton consists of a range of public health commissioned partners working collaboratively to improve children and young people's health and wellbeing, coordinated through the Happy 'n' Healthy Sefton hub. This will be achieved by facilitating strong partnership working, integration, co-production and co-delivery between the six children and young people's Public Health commissioned services (0-19 Healthy Child Programme, Kooth, Active Sefton, CGL 'Rise up', ABL (smoking cessation) and sexual health).

Key Developments

- Happy ‘n’ Healthy Sefton initially launched in July 2023. The team have taken a phased approach to the launch, allowing for the service to monitor demand.
- The team have provided opportunities for coproduction and cofacilitation between partners through regular meetings.
- Ensured that robust pathways are in place for support if families access the service with needs greater than universal (e.g. safeguarding and mental health).
- Supported work around the healthy weight agenda, including the development of a Children and Young People’s Healthy Weight Snapshot and the roll out of the ‘Why weight to talk?’ training.
- Continued to support work around children and young people’s mental health including facilitating a briefing session on Interpersonal Therapy (IAPT) across 0-19 workforce and supporting the dissemination of the Mental Health Snapshot across the children’s system and through health partners.
- The Public Health Team recognised that there is a need for a collaborative piece of work between Smokefree Sefton (ABL Health) and Rise Up (CGL) to address substance use and vaping. Happy ’n’ Healthy Sefton have facilitated shadowing opportunities between the teams to support this workstream.
- The team have worked with Early Help to develop a joined-up approach. Happy ‘n’ Healthy Sefton leads have attended a training session to support them to access the Early Help system. If a child or young person is being supported by Early Help, Happy ‘n’ Healthy Sefton will therefore offer support that will compliment and help achieve the outcomes outlined in Early Help plans.
- The team have worked with Trading Standards to facilitate completion of the Young Persons Alcohol, Tobacco and E- Cigarette surveys, in collaboration with the School Health and Active Sefton workforce. This resulted in a total of 10 secondary schools completing 812 surveys.
- Supported the wider cost- of living agenda by attendance from the partners at the Child Poverty Strategy event, supporting a working party to focus on food insecurity in families with infants under one and will be helping to raise awareness of programmes available to financially help families, such as the Healthy Start Programme.

Next Steps

- To further promote Happy ‘n’ Healthy Sefton by attending all relevant networking opportunities, particularly within education and primary care settings.
- Happy ‘n’ Healthy Sefton will continue to work with Early Help and progress discussions regarding how they can best support the Family Hub Model.
- It is the intention of the team to further integrate the offer with the voluntary, community and faith sector, including working with the adult Living Well Sefton

- The Happy ‘n’ Healthy Sefton team are working with the responsible Lead Commissioners from Public Health to determine how best to capture the impact of the work that Happy ‘n’ Healthy is doing with each of the partners and the impact that this is having on children and young people.

The report outlined key achievements and next steps in relation to each of these priorities.

Staff Flu
At Cabinet Member Briefing on 4th December 2023, the Public Health team provided me with an update following the completion of the Staff Flu Vaccination Programme 2023. 569 staff members were vaccinated as part of this year’s programme, an increase of 511 staff members from the previous year. This increase is likely the result of:

1. A change in delivery model from a community pharmacy model to work-based clinics, reducing barriers and improving access to vaccinations.
2. A change in the NHS eligibility criteria from last year, increasing the age from 50 to 65 years old, meaning more Council staff were not eligible for the NHS offer.

76.4% of staff members vaccinated as part of this year’s programme, had not received a flu vaccination the previous year. The departments with the largest increase in vaccine uptake were those which involve front-line roles including those who have contact with people from vulnerable groups, such as social care. A survey and evaluation of the programme will be carried out with staff to obtain feedback and learning to inform the delivery of next year’s programme to further increase uptake. I noted the content of the report and verbal update.

Leisure

Leisure Update October 2023
The report updated me on the activity and progress throughout August / September 2023.

As of 30th September 2023, there were a total of 14,176 members, once again a slight increase from the last report. This is an increase of 6,944 since reopening in April 2021 and an average of 224 additional members per month.

Work commenced at Bootle Leisure Centre on the 18.09.23 to replace the Sports hall roof. Wirral based firm Speedwell Roofing will help transform the roof at the Centre in a £200,000 investment. Works are expected to take around ten weeks to complete.

Following the analysis of diagnostic assessments around client barriers to progression Sefton@Work embarked on the delivery of a range of bespoke interventions working with other Council Departments. “Fit For Success” was designed with Active Sefton as a programme to tackle mental health, wellbeing, social inclusion, and mindset among clients who are disillusioned and disengaged. It promoted a positive mindset and included class-based activities in Water Sports such as rafting, kayaking and dragon boating for team working and confidence building. Following completion of the course clients were provided with a 3-month gym pass for Active Sefton Leisure Centres to continue their wellbeing pathway. The partnership work at Lakeside has proved an enormous success and more sessions are planned in the future.

Visitor numbers remain strong for Splash World since re-opening with the centre achieving over £700k in admissions - year to date. In comparison to 2019 figures (year Splash World was last open), we have achieved the same level of admissions income – year to date, considering Splash World re-opened late May, losing 26 days of Splash World income this is exceptional.

Splash World hosted the monthly inclusive ‘Quiet Night’ session for September with more than 65 families attending (approx. 120 people), with carers and siblings, supported by our Aiming High staff.

Active Aquatics Swim Inclusive service is aimed at children that need a smaller, bespoke group environment offering a progressive aquatic awareness programme by combining a flexible mix of lessons and activities through the Swim England Learn to Swim Framework. We want to make swimming accessible, fun, and easy for everyone.

To expand our disability offer, Active Aquatics worked in partnership with South Sefton’s community team of Specialist Paediatric Physiotherapists at Meadows leisure centre. During the summer holidays we ran a 5-week crash course of swimming lessons for children with physical disabilities supported by fully trained physios in the water and Active Aquatics Instructors on poolside. We hope to expand the lessons and run more sessions next year following the success of the initial programme.

All targeted health and wellbeing service, both for children and adults, remain at capacity with a high number of referrals. Between August - September, there were 510 referrals onto the Exercise Referral Scheme. The Active Ageing programme also continues to experience high demand, with 118 referrals made between August – September. There also continues to be high levels of referrals also being received for the MOVE IT children’s weight management service. Delivery continues to be adapted to allow residents to access as soon as is feasible without compromising the programmes.

Active Sefton are now part of the recently launched Team Around the School pilot project, where we sit within the ‘supporting team’, and attending launch events and alike will provide us an opportunity to make professionals and the public aware of our wider programmes.

We are now also attending other focus groups such as the Mental Health in Schools Team Operational Steering Group and an Early Help Developing Integrated Practice Sub-Group. These are in addition to existing groups/forums that we attend, such as The Thrive Network, Reducing Parental Conflict Steering Group, Mental Health and Education Network, the ECM forum and Happy ‘n’ Healthy Sefton partners meetings.

During the summer holidays, a total of 56 sessions and 292 hours of activity were delivered, with 1,336 participants taking part in a range of sessions. October half term is once again seeing a full programme of delivery including Ditch the Stabilisers sessions, football camps in partnership with LFC Foundation and dance camps. Discretionary places also continued to be offered to those most in need through Early Help or Social Care.

The summer also saw 8 weeks of free activity delivered in parks across the borough identified by key partners such as Area Coordinators, Merseyside Police and Green Sefton as part of our Park Nights programme. This led to 154 hours across 77 sessions were delivered with 1,630 people attending. This meant that safe, fun activities enabled young people to be active outdoors in the parks to improve their physical and mental wellbeing.

The team have started delivering HENRY (Health, Exercise, and Nutrition for the Really Young), which aims to provide parents with support and knowledge to give their children the best possible start in life. The programme was launched in Seaforth Family Wellbeing centre where 3 workshops were delivered.

Working with Invest Sefton, Living Well Sefton and Sefton’s Education Team, Active Workforce have recently recruited several new partners investing into their programme. From 1st September 2023, Southport Learning Rooms, Willow House Care and Barrington’s Funeral Directors are all investing into the programme, and from 1st November Active Workforce are welcoming 6 of the 7 Academies in Southport Learning Trust, Stanley High, Kew Woods, Greenbank, Meols Cop, Birkdale, and Bedford. The Active Workforce Team will be working closely with each of the organisations to establish their working pattern and requirements in order to tailor the health service to suit their needs.

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Report to:	Overview and Scrutiny Committee (Adult Social Care and Health)	**Date of Meeting:**	23 January 2023
Subject:	Work Programme 2023/24, Scrutiny Review Topics and Key Decision Forward Plan		
Report of:	Chief Legal and Democratic Officer	**Wards Affected:**	All
Cabinet Portfolio:	Adult Social Care Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

To:

- seek the views of the Committee on the Work Programme for the remainder of the Municipal Year 2023/24;
- identify any items for pre-scrutiny by the Committee from the Key Decision Forward Plan;
- seek the views of the Committee on the Programme of informal briefings/workshop sessions for the remainder of 2023/24;
- note the intention for the Local Government Association to provide training from Members and Substitutes of the Committee;
- receive an update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee;
- receive an update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee; and
- note the update by Healthwatch Sefton.

Recommendations:

That:

(1) the Work Programme for 2023/24, as set out in Appendix A to the report, be agreed, along with any additional items to be included and thereon be agreed;

(2) items for pre-scrutiny from the Key Decision Forward Plan which fall under the remit of the Committee, as set out in Appendix B to the report, be considered and any agreed items be included in the work programme referred to in (1) above;

(3) the Programme of informal briefings/workshop sessions for 2023/24, as set out at Appendix C to the report, be noted, along with any additional informal items to be included and thereon be agreed;

(4) the intention for the Local Government Association to provide training from Members and Substitutes of the Committee be noted;

(5) the update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee be noted;

(6) the update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee be noted; and

(7) the recent activities undertaken by Healthwatch Sefton, as outlined in Appendix D to the report, be noted.

Reasons for the Recommendation(s):

To consider the Work Programme of items to be considered during the remainder of the Municipal Year 2023/24; to identify scrutiny review topics which would demonstrate that the work of the Overview and Scrutiny Committee "adds value" to the Council; and to comply with a decision of the Committee to update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee.

The pre-scrutiny process assists Cabinet Members to make effective decisions by examining issues before making formal decisions.

Alternative Options Considered and Rejected: (including any Risk Implications)

No alternative options have been considered as the Overview and Scrutiny Committee needs to approve its Work Programme; to potentially consider scrutiny review topics; and consider other activities in relation to the work of the Committee.

What will it cost and how will it be financed?

There are no direct financial implications arising from this report. Any financial implications arising from the consideration of a key decision or relating to a recommendation arising from a Working Group review will be reported to Members at the appropriate time.

(A) Revenue Costs – see above

(B) Capital Costs – see above

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): None
Legal Implications: None

Equality Implications: There are no equality implications.

Impact on Children and Young People: No

Any implications on the impact on children and young people arising from the consideration of reports referred to in the Work Programme will be contained in such reports when they are presented to Members at the appropriate time.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

There are no direct climate emergency implications arising from this report. Any climate emergency implications arising from the consideration of reports referred to in the Work Programme will be contained in such reports when they are presented to Members at the appropriate time.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: None directly applicable to this report. Reference in the Work Programme to the approval of, and monitoring of recommendations, will contribute towards protecting vulnerable members of Sefton's communities.
Facilitate confident and resilient communities: None directly applicable to this report.
Commission, broker and provide core services: None directly applicable to this report.
Place – leadership and influencer: None directly applicable to this report.
Drivers of change and reform: None directly applicable to this report.
Facilitate sustainable economic prosperity: None directly applicable to this report.
Greater income for social investment: None directly applicable to this report.
Cleaner Greener: None directly applicable to this report.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Work Programme and Key Decision Forward Plan Report is not subject to FD/LD consultation. Any specific financial and legal implications associated with any subsequent reports will be reported to Members as appropriate.

Relevant Heads of Service have been consulted in the preparation of the Work Programme for the Committee.

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Committee meeting.

Contact Officer:	Laura Bootland
Telephone Number:	0151 934 2078
Email Address:	laura.bootland@sefton.gov.uk

Appendices:

The following appendices are attached to this report:

- Appendix A – Draft Work Programme for 2023/24;
- Appendix B - Latest Key Decision Forward Plan items relating to this Overview and Scrutiny Committee;
- Appendix C – Draft Programme of informal briefings/workshop sessions for 2023/24;
- Appendix D - Update of recent activities undertaken by Healthwatch Sefton.

Background Papers:

There are no background papers available for inspection.

Introduction/Background

1. WORK PROGRAMME 2023/24

1.1 The Work Programme of items to be submitted to the Committee for consideration during the remainder of the Municipal Year 2023/24 is set out at **Appendix A** to the report. The programme has been produced in liaison with the appropriate Heads of Service, whose roles fall under the remit of the Committee.

1.2 Members are requested to consider whether there are any other items that they wish the Committee to consider, that fall within the terms of reference of the Committee. The Work Programme will be submitted to each meeting of the Committee during 2023/24 and updated, as appropriate.

1.3 **The Committee is requested to comment on the Work Programme for 2023/24, as set out at Appendix A, and note that additional items may be submitted to the Programme at future meetings of the Committee during this Municipal Year.**

2. PRE-SCRUTINY OF ITEMS IN THE KEY DECISION FORWARD PLAN

2.1 Members may request to pre-scrutinise items from the Key Decision Forward Plan which fall under the remit (terms of reference) of this Committee. The Forward Plan, which is updated each month, sets out the list of items to be submitted to the Cabinet for consideration during the next four-month period.

2.2 The pre-scrutiny process assists the Cabinet Members to make effective decisions by examining issues beforehand and making recommendations prior to a determination being made.

2.3 The Overview and Scrutiny Management Board has requested that only those key decisions that fall under the remit of each Overview and Scrutiny Committee should be included on the agenda for consideration.

2.4 The most recent Forward Plan was published on **22 December 2023** and covers the period **1 February 2024 – 31 May 2024** A copy is attached at **Appendix B**. For ease of identification, items listed on the Forward Plan for the first time appear as shaded.

2.5 There are 4 items within the current Plan that falls under the remit of the Committee on this occasion, namely:

- Sefton Council Extra Care Allocations Policy
- Future Approach to Commissioning of Residential & Nursing Care Sector
- Existing Extra Care Housing Contract Arrangements
- Procurement of Community Infection Prevention and Control Service

2.7 Should Members require further information in relation to any item on the Key Decision Forward Plan, would they please contact the relevant Officer named against the item in the Plan, prior to the Meeting.

2.8 **The Committee is invited to consider items for pre-scrutiny from the Key Decision Forward Plan as set out in Appendix B to the report, which fall under the remit of the Committee and any agreed items be included in the Work Programme referred to in (1) above.**

3. SCRUTINY REVIEW TOPICS / INFORMAL BRIEFINGS 2023/24

3.1 It is good practise for Overview and Scrutiny Committees to undertake an in-depth scrutiny review of services during the Municipal Year.

3.2 At the meeting held on 20 June 2023, it was agreed that rather than establish a traditional working group, all Members of the Committee could be invited to participate in informal briefings/workshop sessions on developments in health and social care.

3.3 The agreed Programme of informal briefings/workshop sessions for 2023/24 is set out at **Appendix C** to the report.

Primary Care

An informal session took place on Microsoft Teams for Committee Members on 21 September 2023.

Workshop on CQC Assessment re: Adult Social Care

The above workshop took place on 8th November 2023.

3.4 **The Committee is requested to comment on the Programme of informal briefings/workshop sessions for 2023/24, as set out at Appendix C to the report, and note that additional informal items may be submitted to the Programme at future meetings of the Committee during this Municipal Year.**

4. TRAINING

4.1 A date has been agreed with the Local Government Association (LGA) for the provision of dedicated training for Overview and Scrutiny Committee (Adult Social Care and Health) Committee Members and Substitutes. This will take place on **Thursday 25th January at 6pm** in the Assembly Hall, Bootle Town Hall, and Members are encouraged to attend.

5. LIVERPOOL CITY REGION COMBINED AUTHORITY OVERVIEW AND SCRUTINY COMMITTEE

5.1 During the October/November 2019 cycle of meetings, the Overview and Scrutiny Management Board and the four Overview and Scrutiny Committees considered a report on the guidance produced by the Ministry of Housing, Communities and Local Government relating to Overview and Scrutiny in Local and Combined Authorities following on from the Communities and Local Government Select Committee's inquiry into Overview and Scrutiny. This Committee considered the matter at its meeting held on 15 October 2019 (Minute No. 32 refers).

5.2 The Overview and Scrutiny Management Board and the four Overview and Scrutiny Committees all agreed the recommendations contained in the report, one of which being, that updates on Liverpool City Region Combined Authority Overview and Scrutiny Committee (LCRCA O&S) be included in the Work Programme report considered at each Overview and Scrutiny Committee meeting.

5.3 In accordance with the above decision, information on the LCRCA O&S is set out below.

5.4 **Role**

The Overview and Scrutiny Committee was established by the Combined Authority in May 2017 in accordance with the Combined Authorities Order 2017.

The role of the Overview and Scrutiny Committee is to:

- Scrutinise the decision and actions taken by the Combined Authority or the Metro Mayor;
- Provide a "critical friend" to policy and strategy development;
- Undertake scrutiny reviews into areas of strategic importance for the people of the Liverpool City Region; and
- Monitor the delivery of the Combined Authority's strategic plan.

5.5 **Membership**

The Committee is made up of 3 elected Members from each of the constituent Local Authorities of the LCR Combined Authority, along with one elected Member from both the Liverpool City Region Liberal Democrat Group and the Liverpool City Region Conservative Group.

Sefton's appointed Members are Councillors Desmond, Hart and Howard (Scrutiny Link).

Representatives of the Liberal Democrat Group and Conservative group on the Committee will be reported to Members at the next meeting.

5.6 **Chair and Vice-Chair**

The Chair of the LCRCAO&S cannot be a Member of the majority group. The Chair was appointed at the first meeting of the Committee on 21 June 2022,

5.7 **Quoracy Issues**

A high number of meetings of the LCRCA O&S have been inquorate.

The quorum for meetings of the LCRCAO&S is 14, two-thirds of the total number of members, 20. This high threshold is not set by the Combined Authority but is set out in legislation. This has on occasion caused meetings to be inquorate.

5.8 **Meetings**

Information on all meetings and membership of the LCRCAO&S can be obtained using the following link:

https://moderngov.merseytravel.gov.uk/ieListMeetings.aspx?CId=365&Year=0

Latest Meeting – 17th January 2024

The latest meeting of the LCRCAO&S was held on 17th January 2024.

Matters considered at the meeting related to the following items:

- Mayoral Combined Authority Budget 2024-25
- Towards a Spatial Development Strategy for the Liverpool City Region – engagement

- Work Programme Update
- Bus Service Improvement Plan Update
- Transport Matters

The next meeting of the LCRCAO&S is scheduled to be held on 28 February 2024. Matters discussed at this meeting will be reported to Members at the next meeting of the Committee.

Details of all meetings can be obtained using the link referred to above

6.9 The Committee is requested to note the update on the Liverpool City Region Combined Authority Overview and Scrutiny Committee.

7. CHESHIRE AND MERSEYSIDE INTEGRATED CARE SYSTEM JOINT HEALTH SCRUTINY COMMITTEE

7.1 On 1 July 2022 the Health and Care Act required the Cheshire and Merseyside Integrated Care Board to commence operation.

7.2 A Joint Cheshire and Merseyside Scrutiny Committee has now been established to scrutinise the work of the Cheshire and Merseyside Integrated Care Board, comprised of representatives of local authorities from Cheshire and Merseyside.

7.3 Knowsley MBC is acting as secretariat to the Joint Cheshire and Merseyside Scrutiny Committee and agendas and Minutes of formal meetings of the Joint Scrutiny Committee are included on their website.

7.4 Meetings of the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee have been held as follows:

- 11 November 2022
- 10 March 2023 (Postponed)
- 23 March 2023
- 14 July 2023
- 6 October 2023
- 8 December 2023

The next meeting of the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee is scheduled for 9 February 2024, Council Chamber, Municipal Buildings, Huyton, at 2.00 p.m.

7.5 Details of all the meetings of the Joint Health Scrutiny Committee can be found via the following link:

Browse meetings - Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee - Knowsley Council

7.7 The Cabinet has appointed Councillor Desmond and Councillor Hart to be Sefton's representatives during 2023/24.

7.8 The Committee is requested to note the update on the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee.

8. HEALTHWATCH SEFTON

8.1 An update of recent activities undertaken by Healthwatch Sefton is attached to this report at **Appendix D**, for information.

8.2 ***The Committee is requested to note recent activities undertaken by Healthwatch Sefton.***

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Overview & Scrutiny

OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)
WORK PROGRAMME 2023/24

Tuesday, 20 June 2023, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	Liverpool Clinical Services Review – Representative to attend (Min. No. 49 (2) of 21/02/23)	Helen Johnson / Carole Hill / Mark Bakewell / Debbie Campbell
2.	Public Health Outcomes Framework (Min. No. 44 (4) of 03/01/23)	Helen Armitage
3.	Adult Social Care Preparation for Assurance	Sarah Alldis
4.	NHS Cheshire and Merseyside, Sefton - Update Report	Anna Kettle
5.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner / Anna Kettle
6.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Debbie Campbell
7.	Work Programme Update	Debbie Campbell
8.	Dates of Committee Meetings 2023/24	Debbie Campbell

Tuesday, 5 September 2023, 6.30 p.m., Town Hall, Southport		
No.	**Report/Item**	**Report Author/Organiser**
1.	Liverpool Clinical Services Review – Representative to attend (Min. No. 49 (2) of 21/02/23 refers).	Carole Hill / Debbie Campbell
2.	Domestic Abuse Update	Janette Maxwell / Steven Martlew
3.	Report for Information on Vaping Amongst Young People	Helen Armitage / Steve Smith
4.	GP Patient Survey (2023) - Sefton Place	Jan Leonard

APPENDIX A

5.	NHS Cheshire and Merseyside, Sefton - Update Report	Deborah Butcher
6.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
7.	Executive/Scrutiny Protocol	Paul Fraser
8.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Debbie Campbell
9.	Work Programme Update	Debbie Campbell

Tuesday, 17 October 2023, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	NHS Cheshire and Merseyside, Sefton - Update Report	Lisa Gilbert
2.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
3.	Performance Report Review	Deborah Butcher/ Luke Garner
4.	Melling Surgery Closure	Emma Robinson
5.	Health Substantial Reconfiguration Proposals	Debbie Campbell
6.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Debbie Campbell
7.	Work Programme Update	Debbie Campbell

Tuesday, 23 January 2024, 6.30 p.m., Town Hall, Southport		
No.	**Report/Item**	**Report Author/Organiser**
1.	Melling Surgery Closure - Update	Emma Robinson
2.	Cheshire and Merseyside Cancer Alliance Update Report	Jon Hayes
3.	NHS Cheshire and Merseyside, Sefton - Update Report	Lisa Gilbert
4.	NHS Cheshire and Merseyside, Sefton – Primary Care Update	Lisa Gilbert/Jan Leonard
5.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
6.	Public Health Outcomes Framework (Min. No. 44 (4) of 03/01/23)	Helen Armitage
7.	Adult Social Care Performance Data Review	Sarah Alldis
8.	Winter Pressures	Eleanor Moulton
9.	Serious Violence Duty	Steven Martlew
10.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Laura Bootland
11.	Work Programme Update	Laura Bootland

Tuesday, 20 February 2024, 6.30 p.m., Town Hall, Bootle		
No.	**Report/Item**	**Report Author/Organiser**
1.	NHS Cheshire and Merseyside, Sefton - Update Report	Lisa Gilbert
2.	NHS Cheshire and Merseyside, Sefton - Health Provider Performance Dashboard	Luke Garner
3.	Southport and Ormskirk Hospital NHS Trust – Shaping Care Programme	Sarah Alldis
4.	Sefton New Directions	Paul Reilly/|Eleanor Moulton
5.	Carers Strategy	Eleanor Moulton
6.	Cabinet Member Update Reports x 2	Julie Leahair/Julie Elliot/Debbie Campbell
7.	Work Programme Update	Debbie Campbell

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SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

FOR THE FOUR MONTH PERIOD 1 FEBRUARY 2024 - 31 MAY 2024

This Forward Plan sets out the details of the key decisions which the Cabinet, individual Cabinet Members or Officers expect to take during the next four month period. The Plan is rolled forward every month and is available to the public at least 28 days before the beginning of each month.

A Key Decision is defined in the Council's Constitution as:

1. any Executive decision that is not in the Annual Revenue Budget and Capital Programme approved by the Council and which requires a gross budget expenditure, saving or virement of more than £100,000 or more than 2% of a Departmental budget, whichever is the greater;

2. any Executive decision where the outcome will have a significant impact on a significant number of people living or working in two or more Wards

Anyone wishing to make representations about any of the matters listed below may do so by contacting the relevant officer listed against each Key Decision, within the time period indicated.

Under the Access to Information Procedure Rules set out in the Council's Constitution, a Key Decision may not be taken, unless:

- it is published in the Forward Plan;
- 5 clear days have lapsed since the publication of the Forward Plan; and
- if the decision is to be taken at a meeting of the Cabinet, 5 clear days notice of the meeting has been given.

The law and the Council's Constitution provide for urgent key decisions to be made, even though they have not been included in the Forward Plan in accordance with Rule 26 (General Exception) and Rule 28 (Special Urgency) of the Access to Information Procedure Rules.

Copies of the following documents may be inspected at the Town Hall, Oriel Road, Bootle L20 7AE or accessed from the Council's website: www.sefton.gov.uk

- Council Constitution
- Forward Plan
- Reports on the Key Decisions to be taken
- Other documents relating to the proposed decision may be submitted to the decision making meeting and these too will be made available by the contact officer named in the Plan
- The minutes for each Key Decision, which will normally be published within 5 working days after having been made

Some reports to be considered by the Cabinet/Council may contain exempt information and will not be made available to the public. The specific reasons (Paragraph No(s)) why such reports are exempt are detailed in the Plan and the Paragraph No(s) and descriptions are set out below:-

APPENDIX B

1. Information relating to any individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the financial or business affairs of any particular person (including the authority holding that information)
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the Authority
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
6. Information which reveals that the authority proposes a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or b) to make an order or direction under any enactment
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime
8. Information falling within paragraph 3 above is not exempt information by virtue of that paragraph if it is required to be registered under—
    (a) the Companies Act 1985;
    (b) the Friendly Societies Act 1974;
    (c) the Friendly Societies Act 1992;
    (d) the Industrial and Provident Societies Acts 1965 to 1978;
    (e) the Building Societies Act 1986; or
    (f) the Charities Act 1993.
9. Information is not exempt information if it relates to proposed development for which the local planning authority may grant itself planning permission pursuant to regulation 3 of the Town and Country Planning General Regulations 1992
10. Information which—
    (a) falls within any of paragraphs 1 to 7 above; and
    (b) is not prevented from being exempt by virtue of paragraph 8 or 9 above, is exempt information if and so long, as in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

Members of the public are welcome to attend meetings of the Cabinet and Council which are held at the Town Hall, Oriel Road, Bootle or the Town Hall, Lord Street, Southport. The dates and times of the meetings are published on www.sefton.gov.uk or you may contact the Democratic Services Section on telephone number 0151 934 2068.

NOTE:
For ease of identification, items listed within the document for the first time will appear shaded.

Phil Porter
Chief Executive

FORWARD PLAN INDEX OF ITEMS

Item Heading	Officer Contact
Sefton Council - Extra Care Allocations Policy	Steve Metcalf steve.metcalf@sefton.gov.uk
Future Approach to Commissioning of Residential & Nursing Care Sector	Kate Edgar kate.edgar@sefton.gov.uk
Existing Extra Care Housing Contract Arrangements	Eleanor Moulton eleanor.moulton@sefton.gov.uk
Procurement of Community Infection Prevention and Control Service	Alan McGee alan.mcgee@sefton.gov.uk

APPENDIX B

SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

Details of Decision to be taken	**Sefton Council - Extra Care Allocations Policy** The Extra Care Allocations Policy aims to promote independence and well-being; facilitate a balanced, vibrant, and sustainable community for residents with care and support needs within the setting of extra care housing which will play a key role in preventing and avoiding admissions to residential care and hospitals and contribute to our preventative agenda. This policy will cover all Extra Care Housing within Sefton and details the eligibility, process, and system for applying for Extra Care Housing in Sefton.			
Decision Maker	Cabinet			
Decision Expected	1 Feb 2024 8 November 2023 Decision due date for Cabinet changed from 07/12/2023 to 04/01/2024. Reason: To enable final amendments to be made to the Sefton Extra Care Allocations Policy and to reflect such changes in the Cabinet report 18 December 2023 Decision due date for Cabinet changed from 04/01/2024 to 01/01/2024. Reason: work is ongoing on the preparation of the report 18 December 2023 Decision due date for Cabinet changed from 01/01/2024 to 01/02/2024. Reason: work is ongoing on the preparation of the report			
Key Decision Criteria	Financial	No	Community Impact	Yes
Exempt Report	Open			
Wards Affected	All Wards			
Scrutiny Committee Area	Adult Social Care			
Lead Director	Executive Director of Adult Social Care and Health			
Persons/Organisations to be Consulted	Consultation was via the following methods: Dedicated Cabinet Member(s) briefing; One Council Brief; Intranet; Yammer; Dwayne's Blog; Internal meetings; E mails. External: Social Media – Twitter and Facebook; Sefton Council website; Your Sefton, Your Say website; Meetings			

	with strategic partners; Sefton Partnership for Older Citizens meeting; Health watch meeting; Residents' meetings (Parkhaven and James Horrigan Court extra care schemes); E mails.
Method(s) of Consultation	The public and key stakeholder consultation process was conducted from Friday 10th February 2023 for a period of two months to Tuesday 11th April 2023. The following consultation methods were used approved by the Public Engagement and Consultation Panel in November 2022: Dedicated Cabinet Member(s) briefing; One Council Brief; Intranet; Yammer; Dwayne's Blog; Internal meetings; E mails External: Social Media – Twitter and Facebook; Sefton Council website; Your Sefton, Your Say website; Meetings with strategic partners; Sefton Partnership for Older Citizens meeting; Health watch meeting; Residents' meetings (Parkhaven and James Horrigan Court extra care schemes); E mails; Public consultation online survey, using the "Your Sefton, Your Say" Platform; Attendance and presentation at various meetings; Distribution of the policy and questionnaire Documents for the consultation were produced in easy read, including the survey. Information relating to the consultation was distributed via the following channels: The survey consisted of five questions and comment sections for each and a generic comments section (also including twelve optional equality monitoring questions). The focus of the consultation and engagement was: (1) Extra Care Eligibility - a. Local Connection; b. Age Threshold; and c. Support needs; (2) Allocations Process; (3) Nominations Process
List of Background Documents to be Considered by Decision-maker	Sefton Council - Extra Care Allocations Policy
Contact Officer(s) details	Steve Metcalf steve.metcalf@sefton.gov.uk

APPENDIX B

SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

Details of Decision to be taken	**Future Approach to Commissioning of Residential & Nursing Care Sector** Report outlining and seeking approval around the future approach to commissioning of Residential & Nursing Care Sector			
Decision Maker	Cabinet			
Decision Expected	1 Feb 2024			
Key Decision Criteria	Financial	No	Community Impact	Yes
Exempt Report	Open			
Wards Affected	All Wards			
Scrutiny Committee Area	Adult Social Care			
Lead Director	Executive Director of Adult Social Care and Health			
Persons/Organisations to be Consulted	Council officers			
Method(s) of Consultation	Meetings and Emails, MS Teams Calls,			
List of Background Documents to be Considered by Decision-maker	Future Approach to Commissioning of Residential & Nursing Care Sector			
Contact Officer(s) details	Kate Edgar kate.edgar@sefton.gov.uk			

SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

Details of Decision to be taken	**Existing Extra Care Housing Contract Arrangements** Direct Award of a contract for a five year period for Extra Care Housing Services via the Liverpool City Region flexible purchasing system			
Decision Maker	Cabinet			
Decision Expected	1 Feb 2024			
Key Decision Criteria	Financial	Yes	Community Impact	Yes
Exempt Report	Open			
Wards Affected	All Wards			
Scrutiny Committee Area	Adult Social Care			
Lead Director	Executive Director of Adult Social Care and Health			
Persons/Organisations to be Consulted	Councillor Paul Cummins will have received a briefing through his Cabinet Member Briefing.			
Method(s) of Consultation	Internal consultation with Procurement, ASC SMT and within the Commissioning Team. Exec Director approval will be sought in advance of submission.			
List of Background Documents to be Considered by Decision-maker	Existing Extra Care Housing Contract Arrangements			
Contact Officer(s) details	Eleanor Moulton eleanor.moulton@sefton.gov.uk			

APPENDIX B

SEFTON METROPOLITAN BOROUGH COUNCIL
FORWARD PLAN

Details of Decision to be taken	**Procurement of Community Infection Prevention and Control Service** Seek approval of the procurement of Community Infection Prevention and Control Service			
Decision Maker	Cabinet			
Decision Expected	7 Mar 2024 15 December 2023 Decision due date for Cabinet changed from 08/03/2024 to 07/03/2024. Reason: to ensure compliance with the new arrangements for commissioning health related services and the Provider Selection Regime (PSR)			
Key Decision Criteria	Financial	Yes	Community Impact	Yes
Exempt Report	Open			
Wards Affected	All Wards			
Scrutiny Committee Area	Adult Social Care			
Lead Director	Director of Public Health			
Persons/Organisations to be Consulted	N/A			
Method(s) of Consultation	N/A			
List of Background Documents to be Considered by Decision-maker	Procurement of Community Infection Prevention and Control Service			
Contact Officer(s) details	Alan McGee alan.mcgee@sefton.gov.uk			

OVERVIEW AND SCRUTINY COMMITTEE (ADULT SOCIAL CARE AND HEALTH)
INFORMAL MEETINGS / WORKSHOPS 2023/24

Day/Date/Time/Venue to be arranged.		
No.	**Report/Item**	**Organiser**
1.	Informal on-line session with representatives of the Primary Care Networks (PCNs) on Primary Care, held on 21st September 2023. (Min. No. 27 (2) of 18/10/22 refers).	Debbie Campbell / Laura Bootland / Jan Leonard
2.	Workshop on CQC Assessment re: Adult Social Care, originally scheduled for 5 October 2023, took place on 8th November 2023.	Debbie Campbell / Laura Bootland / Sarah Aldiss / Lorraine Goude
3.	Informal discussions with a representative of North West Ambulance, date to be confirmed (Min. No. 8 (2) of 20/06/23 refers).	Laura Bootland

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UPDATE REPORT FROM HEALTHWATCH SEFTON – 23 JANUARY 2024

One residents story – Becoming a Carer.

We continue to support the development of the All Age Carers Strategy for Carers in Sefton and are currently promoting the live consultation in a number of different ways. To support this, we have recently shared one Sefton residents story as a Carer, in which they share their experience with Bootle Village Surgery, Sefton Council Adult Social Care, Aintree University Hospital (LUHFT), North West Ambulance Service (NWAS), Domiciliary Care – New Directions and Sefton Carers Centre during 2022 and 2023. Read their story here: https://healthwatchsefton.co.uk/.../read-one-sefton.../ This story has already been shared with members of the Sefton Carers Strategy Group, key stakeholders and our members and the Carer will be supporting both Liverpool University Hospitals and Adult Social Care in their future work to improve services.

Dental Access

The Department of Health and Social Care (DHSC) has now formally responded to recommendations on NHS dentistry made by a committee of MPs. The Health and Social Care Committee's inquiry into NHS dentistry drew heavily on evidence given in person by representatives from Healthwatch. In its (three-month late) response to the inquiry recommendations, the DHSC has rejected a major dental contract overhaul but accepted the need to improve patient access. We will to have to wait for the forthcoming dental care recovery plan to see the detail on how the government will make changes. Locally we continue to receive calls from residents who are needing access to emergency dental care/to share their frustrations about the lack of access for both children and adults. We were therefore disappointed to find out that Cheshire and Merseyside ICB will be using the current dental underspend to support their general deficit as NHS England guidance changed to allow this. We will be working with our Healthwatch and ICB colleagues on improving dental access pathways over the coming year.

Community Health provision delivered by Mersey Care NHS Foundation Trust.

In early 2023, Healthwatch Sefton spent three months visiting local clinics and surgeries which are run by Mersey Care NHS Foundation Trust. We talked to patients and staff about their experiences. Our report is now published.

✓ Healthwatch Sefton visited Mersey Care NHS Foundation Trust Community Health Centres across Sefton between January – March 2023.

✓ Mersey Care NHS Foundation Trust worked in partnership with us and organised our visits to each Community Health Centre across Sefton providing community services.

✓ This report shares feedback that you, the residents of Sefton, shared with us on accessing services at your local Community Health Centres. We also heard from staff and People First Merseyside.

✓ We believe that health and social care providers can best improve services by listening to people's experiences.

✓ We have listened to you, and you have shared both good experiences, and those where improvements could be made. We have shared this in the report with the Trust.

APPENDIX D

✓ A response was received from the Chief Executive of the Trust who confirmed the findings from the report had been shared with the Senior Leadership Team for Sefton Community Services and reported they are happy to confirm the findings in the report are accurate.
✓ The Trust also confirmed the findings will inform improvement plans based on the experiences of patients using their clinical services.
✓ We have met with Mersey Care NHS Foundation Trust during November 2023. They are working on an improvement action plan to ensure patient feedback is acted upon to make improvements to services.
✓ We will continue to work in partnership with the trust to drive forward service improvements.
Please read the report here https://healthwatchsefton.co.uk/.../2023-mersey-care-nhs.../

Diane Blair BA (Hons) MSc
Manager
07706 317749

You can receive newsletters and updates by signing up here

Don't forget our Healthwatch Sefton Signposting can help you find the right Health or Social care services. Call free today for independent up-to-date information.
Freephone:0800 206 1304

If you would like to keep up to date with us, please follow us on social media. Here are the links to our pages:

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Facebook https://www.facebook.com/healthwatchsefton2013
Twitter https://www.twitter.com/HWatchSefton

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